Texas Health Mansfield

2025 Community Health Needs Assessment

Southern Region Report

Texas Health®

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Executive Summary

Introduction and Purpose

Texas Health Resources is proud to present its 2025 Community Health Needs Assessment (CHNA). This report outlines the process and methodology used to identify and prioritize significant health needs across the system, in accordance with federal requirements under the Affordable Care Act. The CHNA covers Texas Health's total service area and is divided into the following six geographic regions: Collin, Dallas and Rockwall, Denton, Kaufman, Southern, and Tarrant. The purpose of the CHNA is to offer a deeper understanding of regional health needs to guide Texas Health's planning efforts in support of actionable, community-engaged initiatives. This report highlights the Southern region.

Key Focus Areas for 2025–2028

1. Healthcare Access, Navigation, and Literacy
2. Transportation
3. Connectedness
4. Food Insecurity

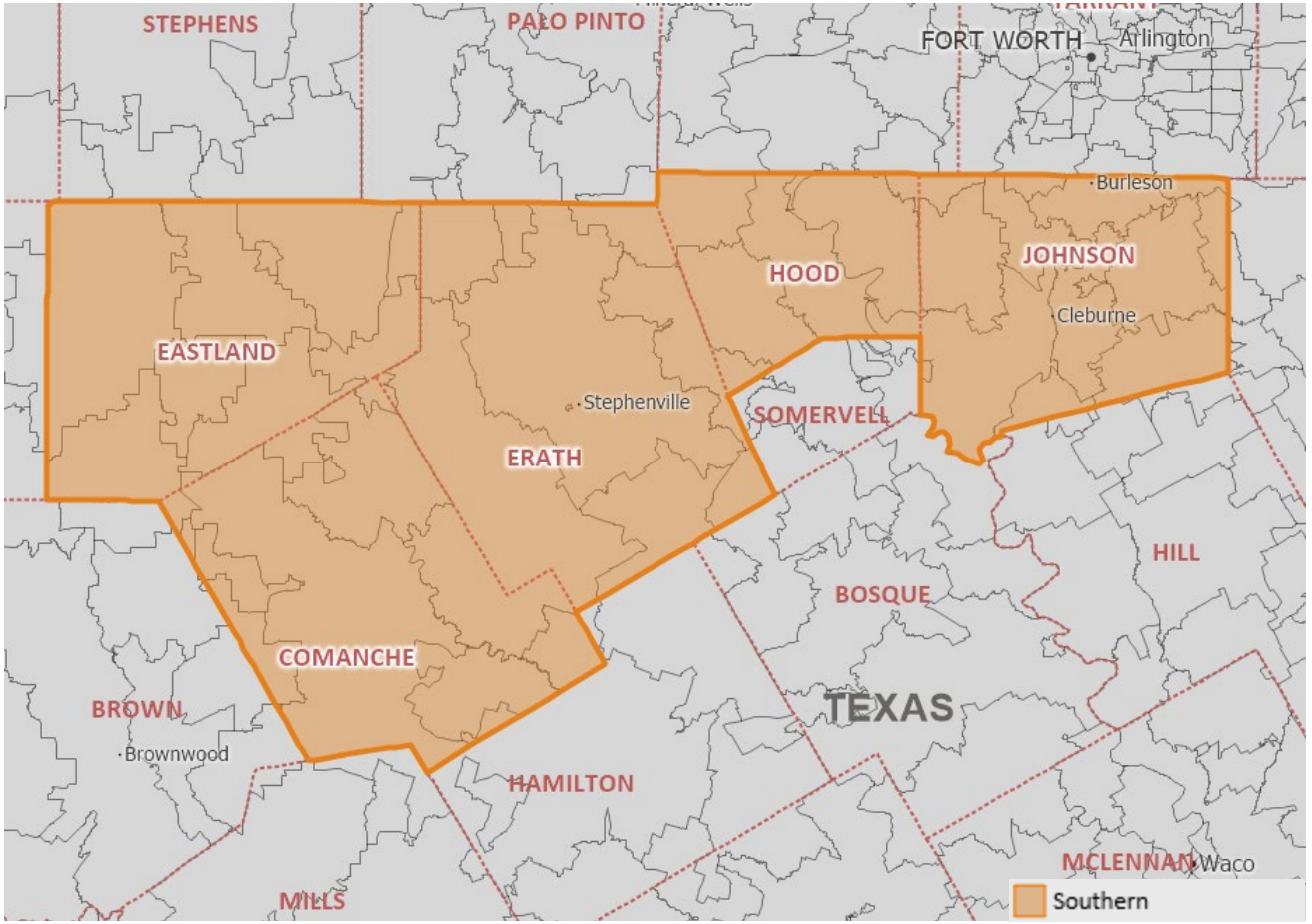


Figure 1: Southern Region

Acknowledgments

"We would like to extend our sincere gratitude to the Texas Health team, community members, partner organizations, and the ECG Management Consultants' team for their dedication and contributions throughout this process." – Texas Health Resources

The development of Texas Health's CHNA was a collective effort that included Texas Health employees, community serving organizations, and community members from within areas of focus that gave us input and knowledge of issues and solutions and those who share our commitment to improve health and quality of life.

Texas Health commissioned ECG Management Consultants to support report preparation for its 2025 CHNA. ECG is a leading healthcare focused consulting firm in the country. The following ECG team members were involved in the development of this report: Jennifer Moody, Partner; Niki Petroff, Senior Manager; Richard Beaton, Manager; Ezra Washington Gore, Senior Consultant.

Letter from President,

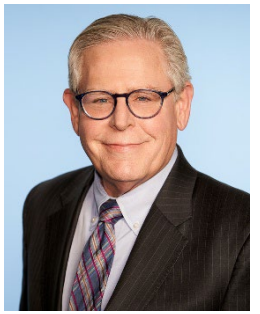
At Texas Health, we live by **Our Texas Health Promise: Individuals Caring For Individuals, Together.** This means that we are committed to meeting the needs of our ever-growing communities. But we can't do that alone.

So when we develop a Community Health Needs Assessment (CHNA) every three years, we collect data through key interviews with those who are in the community each day to better understand what the community needs. After all, when we work together, we can make a difference in Mansfield and its surrounding areas.

Through our 2025 CHNA, we identified several key areas that are impacting our communities: food security; connectedness; transportation; and healthcare access, navigation and literacy. We'll take a closer look at how we're collaborating within North Texas to address these challenges and focusing on the end goal – a healthier community.

Keeping in mind our Vision — partnering with you for a lifetime of health and well-being – I hope you'll find the work we do through our CHNA represents exactly that. Together, we can address the social and environmental factors affecting overall health and well-being in North Texas.

Eulanie Lashley, President



Barclay Berdan, FACHE, Chief Executive Officer, Texas Health Resources

Identified Priority Areas

This section outlines the priority areas Texas Health has chosen to focus on from 2025 to 2028.

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The integration of primary and secondary data provided a holistic view of community health across the Texas Health service area. While the secondary data revealed measurable disparities in health outcomes and non-medical drivers of health, the primary data offered context and lived experience from residents, community partners, and local leaders. Taken together, these perspectives highlighted not just where gaps exist, but also how they are experienced on the ground. From this synthesis, a set of priority areas emerged that represent the most pressing health and social needs facing the community. Presented alphabetically, these priorities served as the foundation for Texas Health's community health improvement strategies: **Access/navigation, Behavioral health, Chronic disease (e.g., high blood pressure, diabetes), Food insecurity, Health literacy, Housing insecurity, Personal safety, Connectedness, and Transportation.**

Better physical and mental health begins with addressing the non-medical drivers that influence health. Recognizing this impact, Texas Health has chosen to improve both physical and mental health by focusing on non-medical drivers of health. This approach supports an overall goal of prevention and management of chronic diseases and mental health conditions while simultaneously addressing the non-medical barriers that hinder individuals from achieving overall health and well-being. Based on extensive community feedback and analysis of data, the following non-medical drivers have been identified as top concerns:

- **Healthcare Access, Navigation, and Literacy:** With an overall goal of improving an individual's ability to navigate and utilize the healthcare system, healthcare access, navigation, and literacy includes improving access to affordable care, assistance in navigation through the continuum of care and strengthening health knowledge to allow for informed decision-making.
- **Transportation:** Transportation directly affects a person's ability to access healthcare, healthy food, employment, and other non-medical support. Without reliable, affordable, and safe transportation, individuals may face delays in care, increased isolation, and limited opportunities for maintaining overall well-being.
- **Connectedness:** Having a sense of belonging, social support and meaningful relationships within a community is directly linked to better health outcomes. Connectedness includes fostering connections that help build resilient, healthier communities.
- **Food Insecurity:** Food insecurity refers to the lack of consistent access to safe, nutritious, and affordable food. Addressing this issue supports overall well-being by ensuring individuals can obtain healthy foods and gain the knowledge needed to make informed choices about nourishing their bodies.

Healthcare Access, Navigation and Literacy
- Provider availability
- Insurance coverage
- Health education
- Ability to navigate the system

Connectedness
- Community Engagement
- Programs for older adults that experience social isolation
- Childcare

Transportation
- Rideshare partnerships
- Vouchers
- Policy

Food Insecurity
- Nutrition security
- Food partnerships

Introduction

This section introduces Texas Health's Mission, Vision, and Values; facilities included in the assessment; previous CHNA and community highlights; and the overarching 2025 CHNA process.

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Texas Health is a faith-based, nonprofit health system that cares for more patients in North Texas than any other provider.

With a service area that consists of **16 counties and more than eight million people,** the system is committed to providing quality, coordinated care through its Texas Health Physicians Group and **29 hospital locations** under the banners of Texas Health Presbyterian, Texas Health Arlington Memorial, and Texas Health Harris Methodist. Texas Health access points and services, ranging from acute care hospitals and trauma centers to outpatient facilities and home health and preventive services, provide the full continuum of care for all stages of life. The system has **more than 4,300 licensed hospital beds, 6,400 physicians** with active staff privileges, and **over 29,000 employees.**

MISSION

To improve the health of the people in the communities we serve.

VISION

To partner with you for a lifetime of health and well-being.

VALUES

- Respect
- Integrity
- Compassion
- Excellence

For more information about Texas Health, call 1-877-THR-WELL or visit www.TexasHealth.org.

Texas Health Service Area and Facilities

Headquartered in Arlington, Texas, the organization serves the fourth-largest metropolitan region in the US: the Dallas–Fort Worth area. The health system includes 20 acute care hospitals, 4 short-stay hospitals, 3 rehabilitation hospitals, 1 long-term care hospital, 1 wellness center, and a network of physician practices. Figure 2 shows the three acute care Texas Health facilities included in the assessment of the Southern region.

Below is a breakdown of the counties included in the Southern region.

- **Southern:** Commanche County, Eastland County, Erath County, Hood County, and Johnson County

The acute care facilities in this region include the following:

- **Texas Health Harris Methodist Hospital Stephenville**
- **Texas Health Harris Methodist Hospital Cleburne**
- **Texas Health Hospital Mansfield**

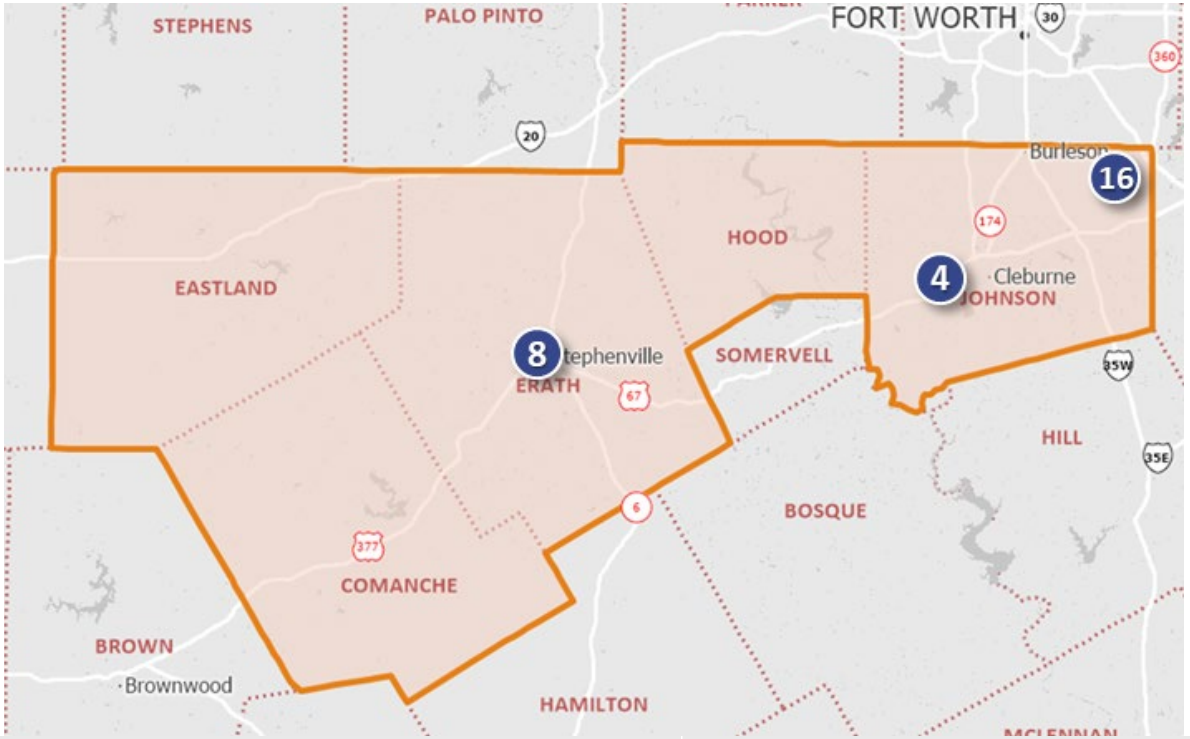


Figure 2: Map of Texas Health Acute Care Hospitals across the Southern Region

Previous CHNA Insights

Priority Areas Strategies

In the previous CHNA conducted in 2022, Texas Health identified three priority areas:

This section focuses on the 2023–2025 implementation strategies that addressed these priority areas.

For more information about these programs highlighted below please visit Texas Health Community Hope.

Behavioral Health

GOAL

Improve quality of life through awareness, detection, treatment, and management of behavioral health conditions.

ACTIONS

- Embed resiliency training in schools to improve resiliency skills among youth overcoming adverse childhood experiences.
- Reduce isolation and improve quality of life in adults 50+.

SPOTLIGHTS

THRIVE: THRIVE (Together Harnessing Resources to give Individuals Voice and Empowerment) is a Texas Health initiative dedicated to supporting the mental and physical well-being of at-risk students and their families.

Reduce Silos: Reduce SILOS (Social Isolation and Lift Outcomes for Seniors) is a free program for adults age 50+ designed to serve low-income individuals that report feeling lonely or socially isolated.

School Mental Health Executive Learning Communities: Texas Health and the Meadows Mental Health Policy Institute (the Meadows Institute) developed new School Mental Health Executive Learning Communities (ELCs). These ELCs bring senior school district officials together for monthly training sessions, in-depth discussions, and important collaborations to effectively implement school mental health programming and improve student outcomes, wellbeing and academic achievement.

Mental Health First Aid: Texas Health offers Mental Health First Aid training, developed by the National Council for Mental Wellbeing, to equip community members and work site partners with essential skills to recognize and respond to mental health challenges.

Progress Highlights:

5
THRIVE sites opened between 2023–2025

70%
of 199 patients in Reduce SILOS reduced their depression scores

19
School districts with ELCs

627
Individuals trained in Mental Health First Aid (2023–2024)

Chronic Disease

GOAL

Improve quality of life and preventable healthcare utilization through the continued prevention and management of chronic conditions.

ACTIONS

- Increase community-level access points, resources and referral streams to preventive chronic disease. management programs and community initiatives.
- Improve health outcomes, readmission rates and cost savings among unhoused individuals.
- Improve access to medical care and services among unhoused individuals through medical respite care.

SPOTLIGHTS

- **Wellness for Life-Mobile Health:** Mobile Health provides access to quality preventive care services for adults 18 and older across Texas Health's service areas.
- **Health Education Lifestyle Program (HELP):** HELP delivers diabetes and hypertension management for uninsured populations.
- **Health to Home (H2H):** Provides medical recuperation services to unhoused individuals.
- **Community Resource Center (CMRC):** The CMRC located at Texas Health Allen (opened in May of 2025), offers access to condition-specific care, including bloodwork and education, personalized navigation services, and access to nutrition counseling and support groups—all in one location.
- **Clinic Connect:** In 2016, Texas Health launched Clinic Connect, a streamlined process for receiving and evaluating funding requests from clinics that reach vulnerable populations and serve as outpatient resources for our acute care hospitals.
- **Health Food Access:** Texas Health supported multiple food access programs including Good For You Healthy Hubs, Culled Produce Recovery, Growing Good Food Grants, Double Up Food Bucks and Fresh Access.
- **Progress Highlights 2023–2024:**

5,645 Mobile Patients Seen

682 Mobile Health site visits

176 Individuals served in H2H

48 Individuals connected to an appropriate housing solution

Over 1.3M pounds Food distributed to 273,584 individuals

Awareness, Health Literacy and Navigation

GOAL

Increase individual awareness of health information and services that are accurate, accessible and actionable; address non-medical drivers of health by partnering with community organizations

ACTIONS

- Increase community-level access points, resources and referral streams to disease management programs and community initiatives
- Convene multiple congregations/faith-based organizations for activities and/or programs that provide resources/services addressing community needs.
- Improve health outcomes and readmission rates among uninsured and underinsured populations
- Coordinate and provide comprehensive care to patients with the complaint of sexual assault.
- Establish plan that increases capacity for the Sexual Assault Nurse Examiner (SANE) program-related outreach and education.

SPOTLIGHTS

- **Faith Community Nursing:** Faith Community Nursing quips communities of faith to provide care through health-related ministries.
- **Continuum of Care:** The Continuum of Care Program is designed to assist patients with chronic health conditions who are at high risk for hospital readmission and poor health due to risks associated with non-medical drivers of health.
- **SANE:** Texas Health's Sexual Assault Nurse Examiner (SANE) program helps victims of sexual assault.
- **Community/Congregational Health and Hospital Ministry Partners (CHAMPs):** Six times a year, pastoral care teams welcome clergy to CHAMPs meetings, offering resources to help them support hospitalized patients and their families.
- **School Based Programs:** Programs include School Learning Gardens, Enhancing Childhood Literacy, Wellness Innovation Grants, Recess Refresh, Educator and Student Summits and School Wellness Network.
- **Progress Highlights 2023–2024:**

$9.9M+
FCN cost savings

1,286
Continuum of Care patients

1,650
SANE victims served

3,015
Individuals Reached through SANE

40,755
Students receiving free books

119
Schools Supported

Texas Health Community Impact

In 2019, Texas Health Resources launched Texas Health Community Impact to address health needs identified through the CHNA, focusing on residents within designated priority ZIP codes. This collaborative effort brings together organizations across various sectors to tackle the social, physical, and behavioral health challenges facing underserved communities, with the overarching goal of reducing poor health outcomes.

Since its inception, the initiative has awarded **more than $23 million** to community-based organizations, **including $10 million in funding** distributed following the release of the 2022 CHNA. Each grant cycle spans two years, with grantees eligible for one renewal. One full cycle (2023–2024) since the 2022 CHNA has been completed, and the current cycle (2025–2026) is underway. Ten grants were awarded during the 2023–2024 cycle, and eighteen grants have been awarded for the 2025–2026 cycle.

Progress Highlights (2022–2024 Grant Cycle):

14,528
North Texans Served

76,670
Services Provided

75%
of programs demonstrated significant improvements in their target priority areas

For additional information, including information on funded projects, visit: https://www.texashealth.org/Community-Health/Community-Impact

Policy

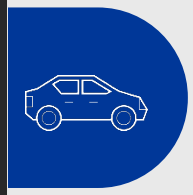
Texas Health believes that advancing health requires more than clinical care—it demands a strong voice in the public policy arena. Through its **Government Affairs and Advocacy** team, Texas Health actively engages at the local, state, and federal levels to shape policies that strengthen healthcare delivery and improve community well-being.

In 2024, this program focused on:

- **Advocating for legislation** that expands access to care, supports behavioral health infrastructure, and addresses non-medical drivers of health
- **Educating the public and stakeholders** through voter education initiatives and community engagement
- **Building strategic partnerships** with organizations like the American Hospital Association, Texas Hospital Association, and Dallas-Fort Worth Hospital Council to amplify impact
- **Promoting civic engagement** and responsible corporate citizenship through employee volunteerism and charitable giving

Additional Analysis

In addition to the priority areas listed above, the 2022 CHNA specifically highlighted additional gaps for **transportation**, **substance abuse** and **childcare**. These gaps were analyzed further for strategy development. To enhance previous work in food access, an additional study was completed to identify multi-level barriers and solutions to **nutrition security** from the perspectives of community residents, food system workers, and policymakers in a three-county area.



Transportation

Expanding access to flexible, on-demand transportation services—such as door-to-door options—and offering programs conveniently located within residential communities could help reduce transportation barriers.

Substance Abuse

Between 2019 and 2022, the rate of drug poisoning deaths increased in Texas from 9.5 to 16.1 (per 100,000 population). In 2022, Dallas County and Parker County had the highest drug poisoning death rates in the North Texas area with Dallas County at 18.5 and Parker County at 18.6 (per 100,000 population). Review of data shows that substance abuse involving fentanyl and methamphetamine are a growing and persistent problem in North Texas. A geographical analysis showed a higher priority for community programs throughout Dallas County and Tarrant County as well as more targeted areas surrounding Weatherford and Springtown.

Childcare

In Texas, 48% of individuals live in a childcare desert—areas with limited access to licensed childcare providers. Nine priority zip codes were identified as daycare deserts: **75180, 75220, 75057, 76431, 76031, 75161, 75106, 76115, 76164**.

Nutrition Security

Qualitative research was conducted among policymakers, food system workers (FSW), and community members around nutrition security. These three groups undoubtedly agreed that food programs were a key to increasing nutrition security, from increasing awareness of current programs, to increasing the availability, hours, and locations of food programs.

2025 CHNA Process

Building on the insights from the previous CHNA, Texas Health approached the 2025 assessment with a structured, data-informed methodology, shown in figure 3. First, Texas Health assessed the priority ZIP codes from the previous CHNA and curated a new targeted list accounting for any shifts in the patient population and internal non-medical drivers of health screening data. Once the targeted communities were identified, Texas Health engaged nearly 650 stakeholders—including community leaders, residents, and partner organizations—through interviews, focus groups, and a distributed survey to ensure the assessment reflected a wide range of perspectives. Then, a comprehensive secondary data analysis was conducted across the full-service area, focusing on a range of non-medical and medical drivers of health. The qualitative input, referred to as primary data, was synthesized alongside secondary data to identify the most pressing health needs. These insights will guide Texas Health's strategic priorities from 2025 to 2028.

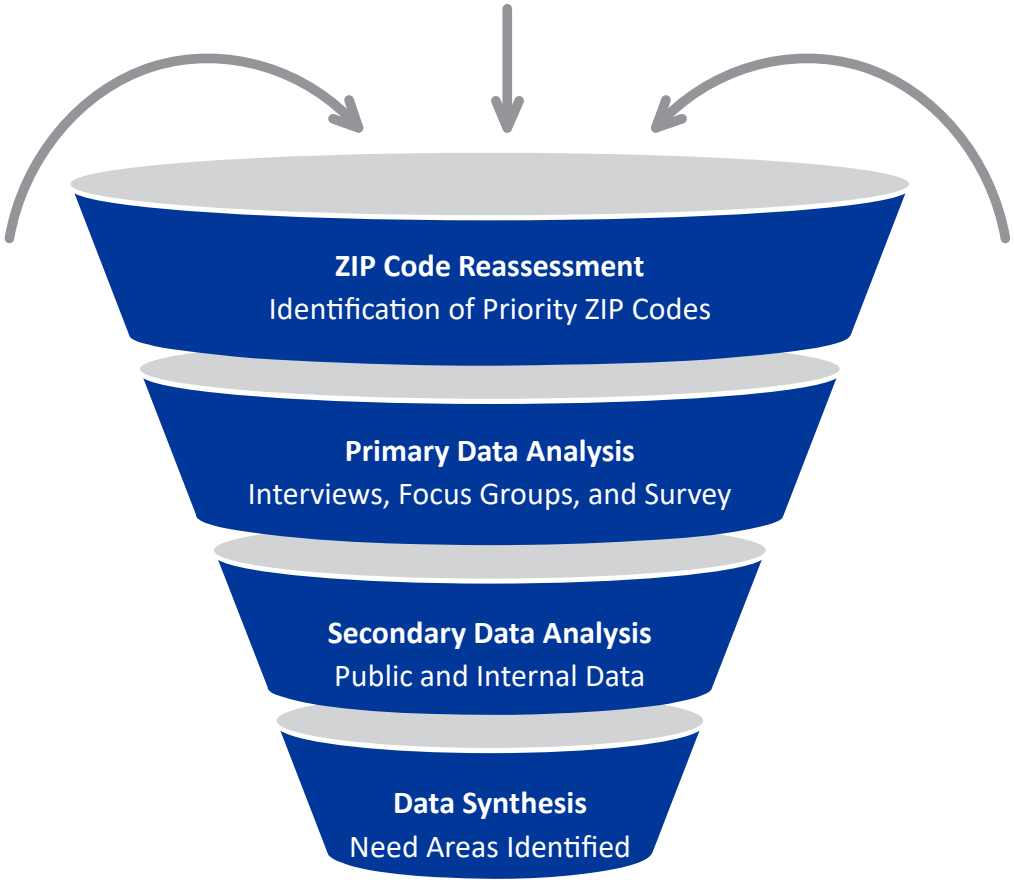


Figure 3: 2025 Texas Health CHNA Process

Prioritization Process

This section outlines Texas Health's methodology for identifying priority ZIP codes for the 2025 CHNA and provides a brief overview of key characteristics within those communities.

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Overview

Before conducting the primary and secondary analyses for the 2025 CHNA, Texas Health reassessed its priority ZIP codes to ensure alignment with current community needs detailed in Appendix D. This evaluation focused on areas with a high proportion of Texas Health patients as well as those showing greater need based on internal social risk screening data. Figure 4 displays the location of these prioritized ZIP codes in the Southern region. While these areas will help inform targeted CHNA strategies, Texas Health remains committed to serving the needs of all individuals across the Southern region. It is important to note that while the urban, or more densely populated counties, reflect more prioritized ZIP codes per region, the ZIP codes in the more rural counties cover more geographic territory.

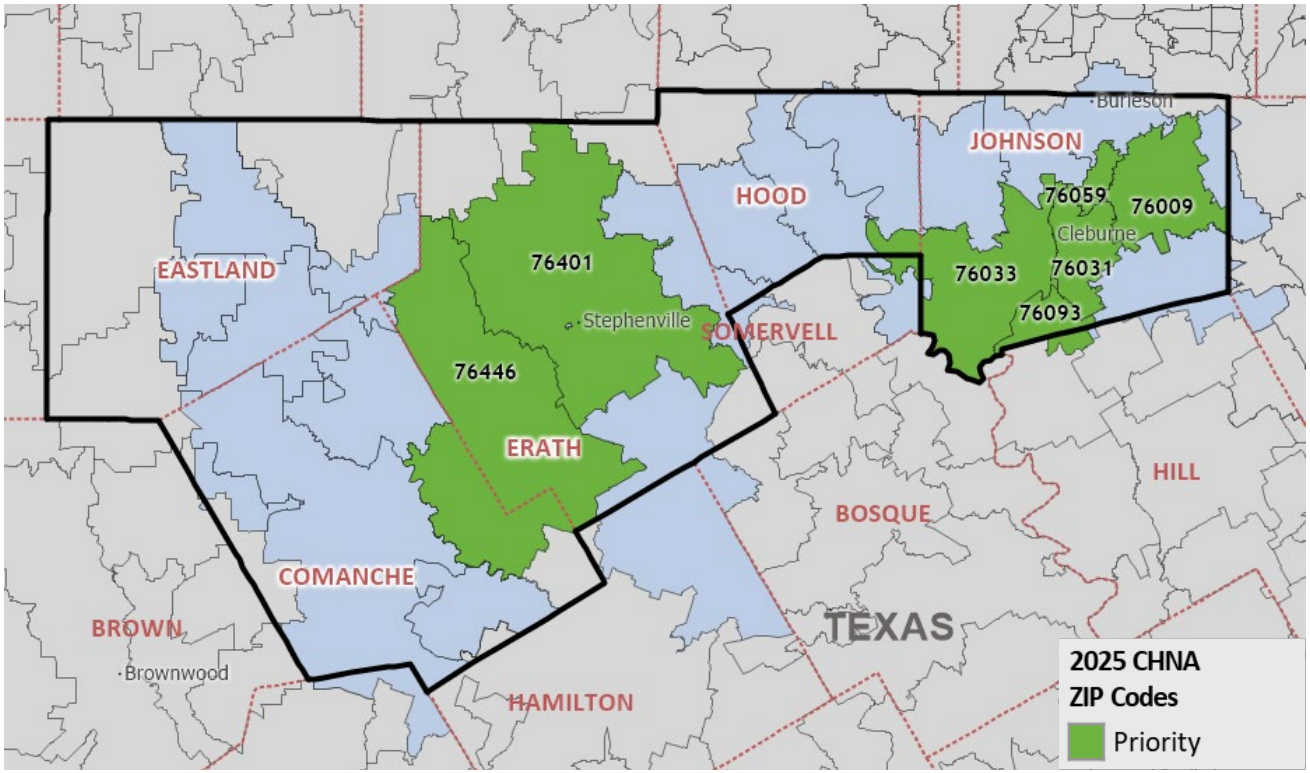

Figure 4: Priority ZIP Codes in Southern Region

Region	Number of Priority ZIP Codes
Southern	7

Priority ZIP Codes

The total population for the priority ZIP codes in the Southern region in 2025 is 126,518, with a significant 7% projected growth rate by 2030. **Table 1** shows the 2025 population and projected five-year growth of the priority ZIP codes. More detailed ZIP code characteristics are provided in the appendix.

Region	Priority ZIP Code	City	2025 Population	Five-Year Growth Rate
Southern	76009	Alvarado	26,588	11%
	76031	Cleburne	19,473	9%
	76033	Cleburne	31,350	9%
	76059	Keene	5,414	9%
	76093	Rio Vista	2,886	13%
	76401	Stephenville	32,016	2%
	76446	Dublin	8,791	3%

Table 1: Priority ZIP Codes Population

Demographics

This section provides an overview of the demographic composition within Texas Health's service area. Key indicators evaluated include population and age distribution, language spoken at home, and race and ethnicity.

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Population and Age Distribution[1]

With a total population of 362,072, the Southern region has a higher proportion of children under the age of 18 (23%) and a greater proportion of adults aged 65 and older (18%) compared to national benchmarks (22% and 17%, respectively). Population growth is robust, with a projected five-year growth rate of 9%. Figure 5 shows the distribution of age in the Southern region. More detailed population and age characteristics by ZIP code are provided in the appendix.

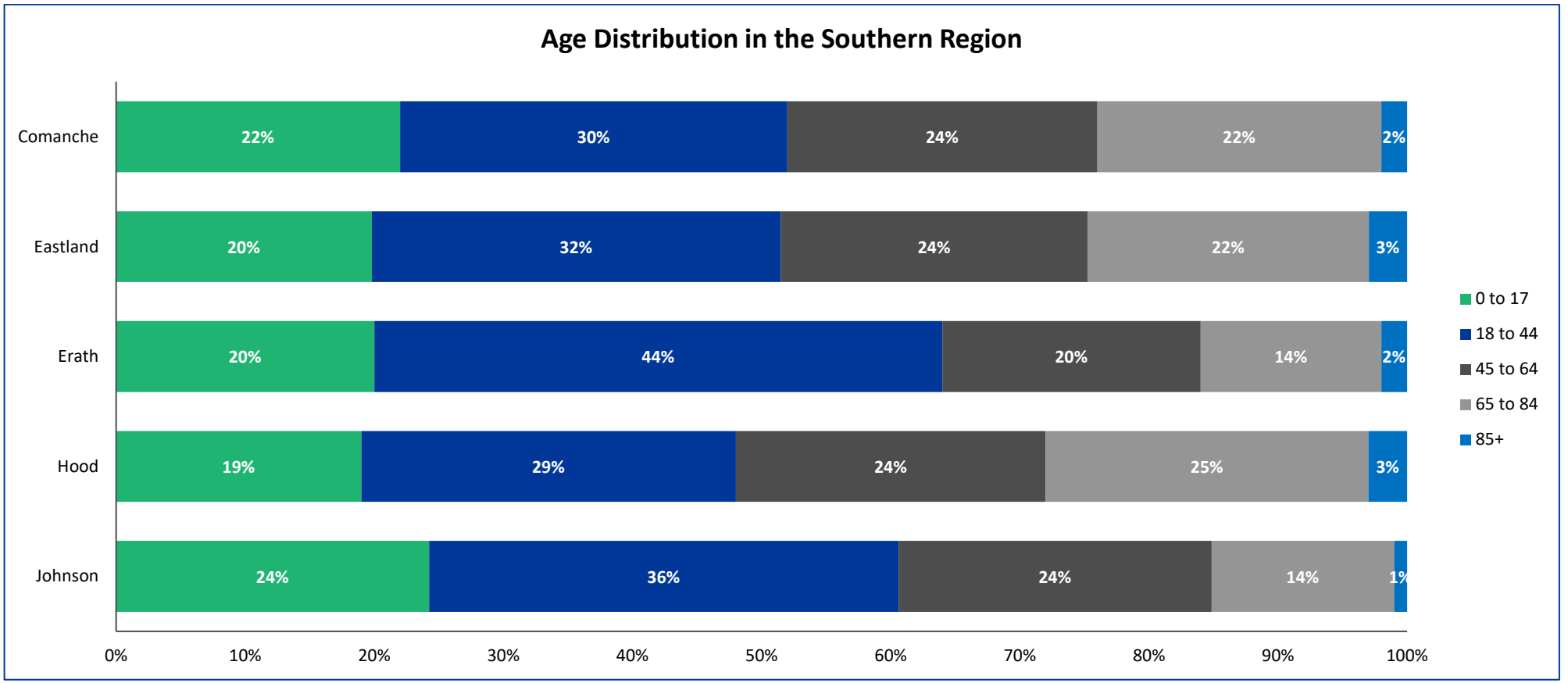

Figure 5: Age Distribution in the Southern Region by County

[1] Claritas (2025).

Language[2]

English proficiency in the Southern region is 94%, which is above the national average (92%) and Texas average (87%). Spanish is the next most common language spoken, with 14% of residents speaking Spanish at home. Comanche and Johnson County have the greatest concentration of Spanish speaking residents. Figure 6 shows the distribution of languages spoken at home and English proficiency in the region. More detailed language characteristics by ZIP code can be found in the appendix.

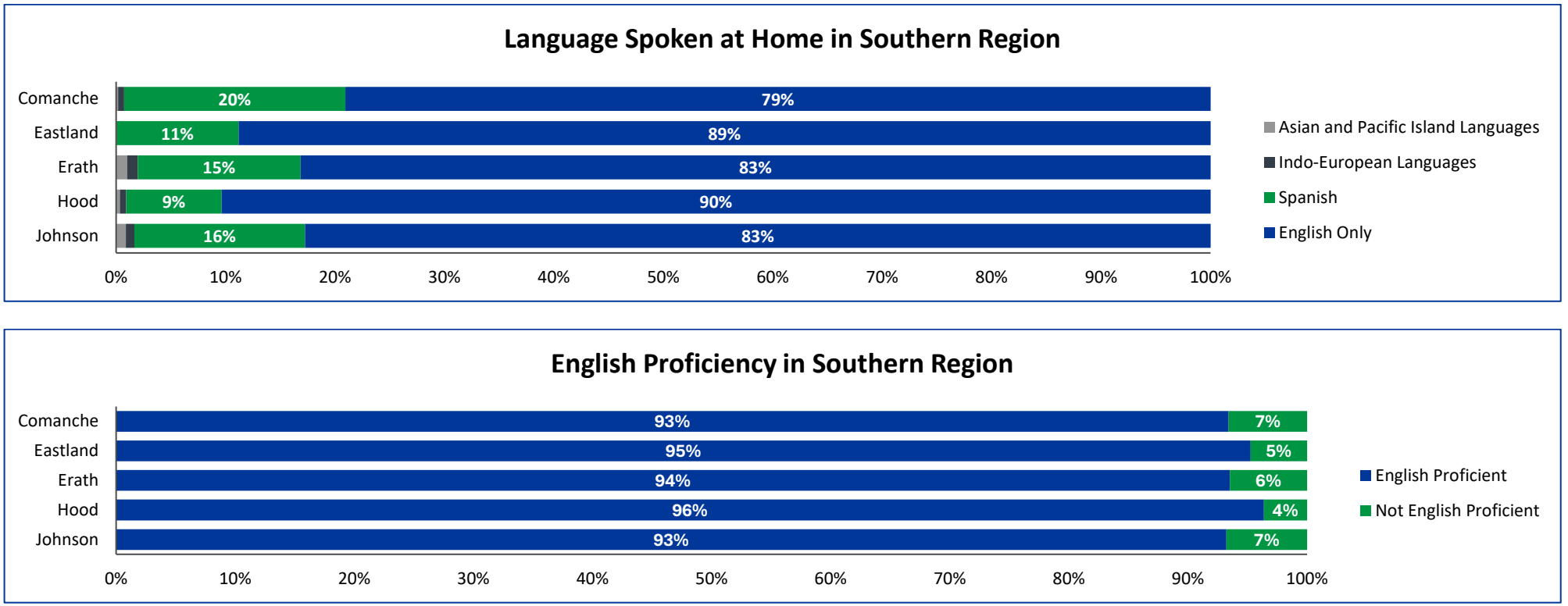

Figure 6: Language Spoken at Home and English Proficiency by County

[2] *American Community Survey* (2019–2023).

Race and Ethnicity[3]

The majority of the population in the Southern region is White (78%), which is well above the national average (63%) and the state average of 54%. Residents that are two or more races represent 12% of the population. Black/African American residents are the third-largest racial group (3%) in the Southern region. Additionally, Hispanic residents make up 23% of the service area population, which is above the national average (19%) and Texas average (40%), with the highest concentration in Johnson and Commanche County. The Southern region reflects less racial and ethnic diversity than the broader service area. Figure 7 shows the race and ethnicity distribution by county in the region. More detailed race and ethnicity characteristics by ZIP code can be found in the appendix.

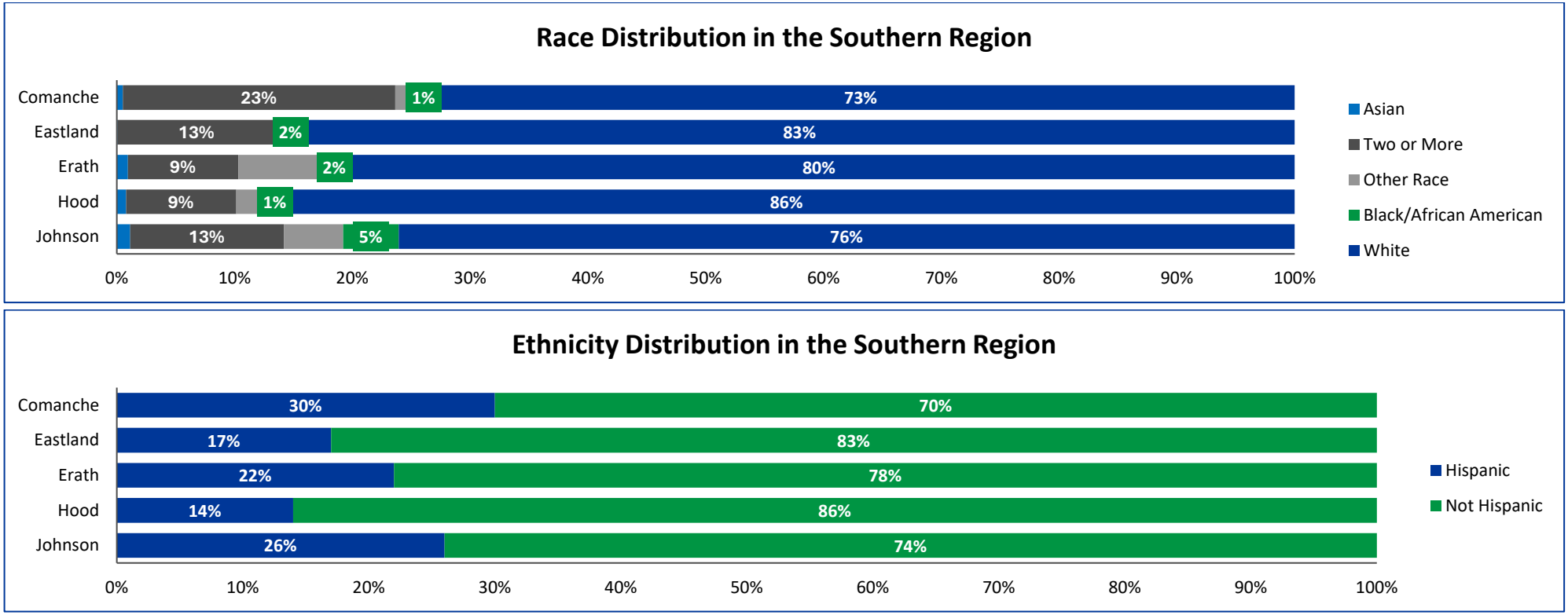

Figure 7: Race and Ethnicity Distribution by County

[3] *American Community Survey (2019-2023)*

Methodology

This section outlines the methodology used to evaluate the service area, including a detailed description of the primary and secondary data sources that informed the assessment.

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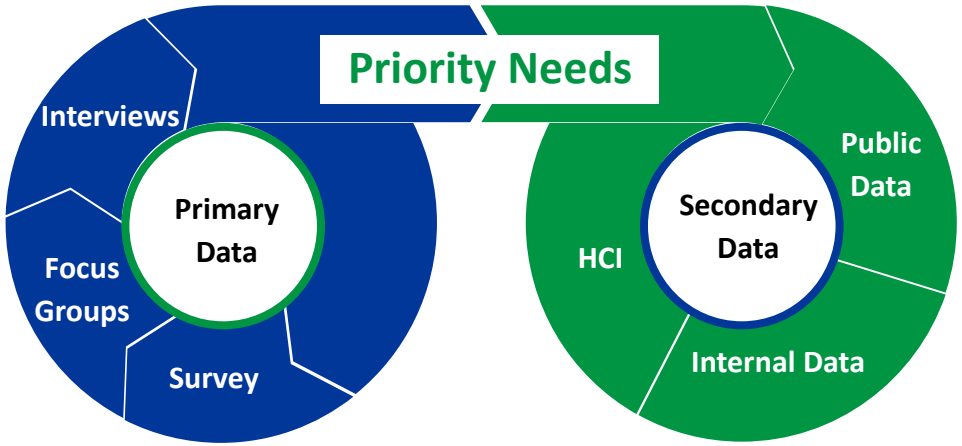
Data Triangulation

Data triangulation is a method used in research and evaluation to enhance the credibility, validity, and richness of findings by combining data from multiple sources.

For the 2025 CHNA process, there were two main sources of data.

- Primary Data: Key informant interviews, the community organization survey, and focus groups
- Secondary Data: Healthy Communities Index (HCI), Texas Health Non-medical Drivers of Health Screening data, and other public national and state datasets

The diagram below demonstrates how key themes were developed, illustrating the intersectionality of these two sources.



Primary Data: Key Informant Interviews, the Community Organization Survey, and Focus Groups

Key Informant Interviews

ECG and Texas Health interviewed 39 key informants (i.e., Texas Health hospital representatives) across the six regions. Interview questions focused on community needs, trends that have emerged since the last CHNA, and the extent to which Texas Health is known to community partners.

Focus Groups

A total of 216 individuals participated in 24 focus groups (8 organizational and 16 community based) conducted by ECG and Texas Health across the six regions. Each focus group addressed community health needs, recent health trends, and Texas Health's visibility to community partners.

Community Organization Survey

A community organization survey sent to organizations within the six regions yielded 379 responses representing 312 unique organizations. Questions in the survey covered Texas Health's community contributions, unmet community needs, and potential shifts in priorities since the last CHNA.

Secondary Data: HCI, Texas Health Risk Screening Data, and Other Public National and State Datasets

Healthy Communities Index (HCI)

While primary data provides critical insight into community perspectives and lived experiences, quantitative data helps illustrate the broader, structural conditions impacting health across the service area. To support this, Texas Health utilized ECG's comprehensive HCI to identify and compare key barriers to health across the six regions. The HCI integrates publicly available data from the *American Community Survey (2019–2023)* and CDC PLACES (2024 ZCTA release) to evaluate social and structural factors that influence health. Grounded by the US Department of Health and Human Services' Healthy People 2030 plan and informed by current literature, the tool organizes metrics into 13 core domains that represent non-medical and medical drivers of health. To quantify these barriers, each ZIP code receives a standardized domain score using z-score methodology that measures its relative standing compared to national averages. Each ZIP code is then placed into one of five tiers across each domain, which reflect national percentile-based ranking, as follows:

Tier	Description	National Percentile Range
5	Highest barriers (most at risk)	80th to 100th
4	High barriers	60th to 79th
3	Moderate barriers	40th to 59th
2	Low barriers	20th to 39th
1	Lowest barriers (most advantaged)	0 to 19th

This five-tiered system supports clear and consistent prioritization. ZIP codes in higher tiers often face greater social and structural challenges, correlating with lower self-rated health and shorter life expectancy. The HCI provides a robust foundation for identifying underserved areas, supplementing stakeholder insights from the primary data collection.

Domains Included in the HCI

The 13 domains assessed through the HCI represent a comprehensive view of health-related conditions and access.

These include insurance access and preventive care access, which reflect the ability to afford and receive timely medical services; educational attainment and income, which shape economic stability and health literacy; and employment, which provides not only income but often health benefits. Housing stability and food security are key determinants of chronic disease management and stress, while transportation access influences a person's ability to reach care, employment, and essential resources. Technology access is increasingly critical for telehealth and health information access, and social connections play an important role in mitigating isolation and promoting mental well-being. The index also accounts for the prevalence of chronic diseases, such as diabetes and hypertension; the existence of behavioral health conditions, including mental illness and substance use disorders; and the presence of physical, mental, or cognitive disabilities that may limit a person's ability to achieve optimal health. Figure 8 highlights the 13 domains included in the assessment.

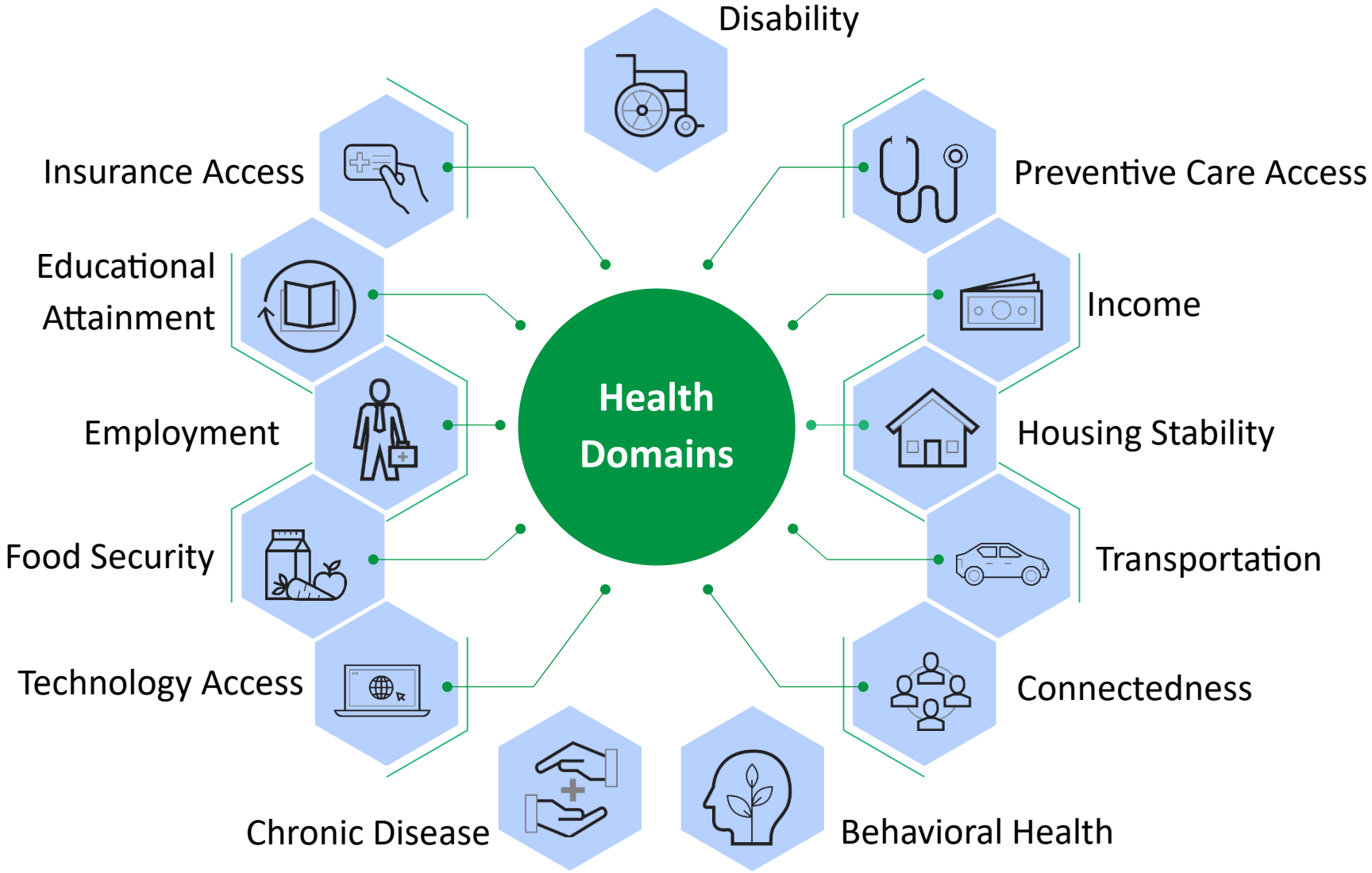


Figure 8: HCI Core Health Domains

Other Public National and State Datasets

In addition to the data in the HCI, other data from national and state sources at the county level were considered for more evidence. Some of these include aggregated sources from County Health Rankings & Roadmaps and individual government sources such as the US Environmental Protection Agency.

Texas Health Non-medical Drivers of Health Screening Data

As of Jan. 1, 2024, the Centers for Medicare & Medicaid Services now requires hospitals participating in the Hospital Inpatient Quality Reporting Program, such as Texas Health, to screen all adult inpatients (aged 18 and older) for the following five key non-medical drivers of health:

- Food Insecurity: Identifies whether patients have experienced worry about their ability to or the actual inability to afford enough food in the past 12 months
- Housing Instability and Quality: Assesses whether patients have a stable living situation and whether their housing environment poses health or safety risks
- Transportation Access: Screens for the lack of reliable transportation that may interfere with medical care, work, or daily activities
- Utility Needs: Determines whether utility services (electricity, gas, water) have been shut off or threatened to be shut off
- Personal Safety: Evaluates whether patients have experienced physical harm, threats, or emotional abuse from others, including family or friends

Limitations

ECG and Texas Health acknowledge that both primary and secondary data sources have inherent limitations. While these limitations do not invalidate the data, they underscore the importance of interpreting findings within the appropriate context, recognizing that no data collection effort is without imperfections

Primary Data Limitations

Community Organization Survey: Survey contains limited geographic coverage due to the availability of participating organizations within the service area.

Key Informant Interviews and Focus Groups: Personal or group bias, limited geographic coverage (due to the inability to represent every area of the service region), and small sample sizes may limit the extent to which findings reflect the full range of community perspectives.

Secondary Data Limitations

HCI: The use of public data often presents a reporting lag of two to three years.

Texas Health Non-medical Drivers of Health Risk Assessment: This assessment only includes data from Texas Health patients.

County-Level Sources: These do not account for ZIP code–level variation, and the use of public data often presents a reporting lag of two to three years.

Secondary Data:
13 Health Domains

This section provides a narrative overview of the 13 health domains included in the HCI, supplemented by county-level data and internal Texas Health sources to offer additional context and insight.

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Each health domain in the HCI was analyzed across the Southern region. Table 2 presents the average barrier level for each domain within each county in the Southern region, calculated as the population-adjusted, weighted average of health domain scores for all ZIP codes in that county.

Barrier levels are categorized as follows:

- Tier 5: The domain reflects severe barriers that significantly threaten community health and well-being.
- Tier 4: The domain presents notable challenges that may contribute to poor health outcomes if unaddressed.
- Tier 3: The domain includes some barriers that could affect access, outcomes, or quality of life.
- Tier 2: The domain shows generally supportive conditions, with only minor concerns present.
- Tier 1: The domain reflects strong, supportive conditions that promote optimal health and stability.

Additionally, it is important to note that (1) barriers vary within each county and (2) ZIP code–level differences may be masked by county averages. More granular analyses at the ZIP code level are provided in the appendix.

County	Insurance Access	Preventive Care Access	Educational Attainment	Income	Employment	Housing Stability	Food Security	Transportation	Technology Access	Connectedness	Chronic Disease	Disability	Behavioral Health
Comanche	🔴	🟡	🟠	🟠	🟡	🟡	🟠	🟠	🟠	🟠	🟠	🔴	🟡
Eastland	🔴	🟠	🟠	🔴	🟡	🟡	🟠	🟠	🟠	🟠	🟠	🔴	🟠
Erath	🔴	🟠	🟡	🟠	🟡	🟠	🟠	🔴	🟡	🟠	🟡	🟠	🟠
Hood	🟠	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟢	🟠	🟠	🟡	🟡
Johnson	🔴	🟠	🟠	🟡	🟢	🟠	🟠	🟠	🟡	🟠	🟡	🟡	🟠

Table 2: 13 Health Domain Barriers by County

Table 2 highlights significant differences between Comanche, Eastland, Erath, Hood, and Johnson County across the 13 measured domains. Notable disparities are seen in income, technology access, and disabilities. These findings illustrate how, even within the same broader region, sub–service areas can experience vastly different non-medical drivers of health. The following pages provide a detailed breakdown of each domain within the Southern region and identify specific ZIP codes where residents face greater barriers to health.

Insurance Access

Lack of insurance can lead to delayed care or make healthcare services financially inaccessible.[4] Figure 9 shows the level of barrier by ZIP code in the Southern region for the insurance access domain. This domain considers one measure: the rate of insured adults aged 18 to 64. This is a particularly important population, as adults aged 18 to 64 make up the largest age group in the service area.

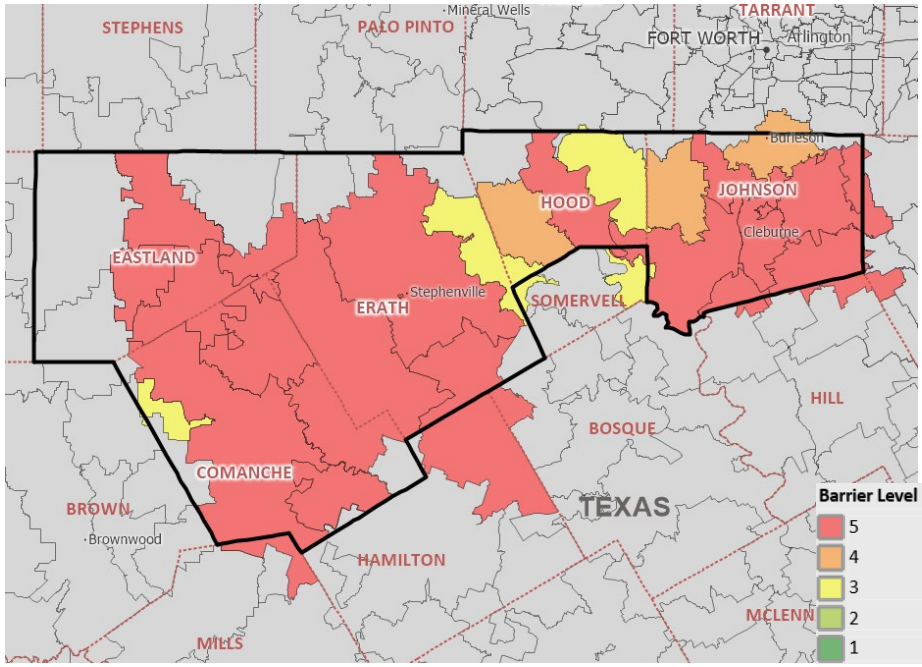

Figure 9: Insurance Access Barriers

Figure 10 shows that all five counties fall below the national benchmark for insured adults aged 18 to 64, highlighting a significant barrier to insurance access. Although all five counties surpass the Texas state average, the data highlights the ongoing need for expanded healthcare coverage and access, as Texas continues to lag behind national levels. In the Southern region, Comanche County exhibits the highest barriers. County-level data[5] further reinforces this challenge: both counties in the service area exceed the national average for uninsured children (5%), with the highest rate in Erath County at 13%. These patterns highlight persistent gaps in insurance coverage across both adult and pediatric populations.

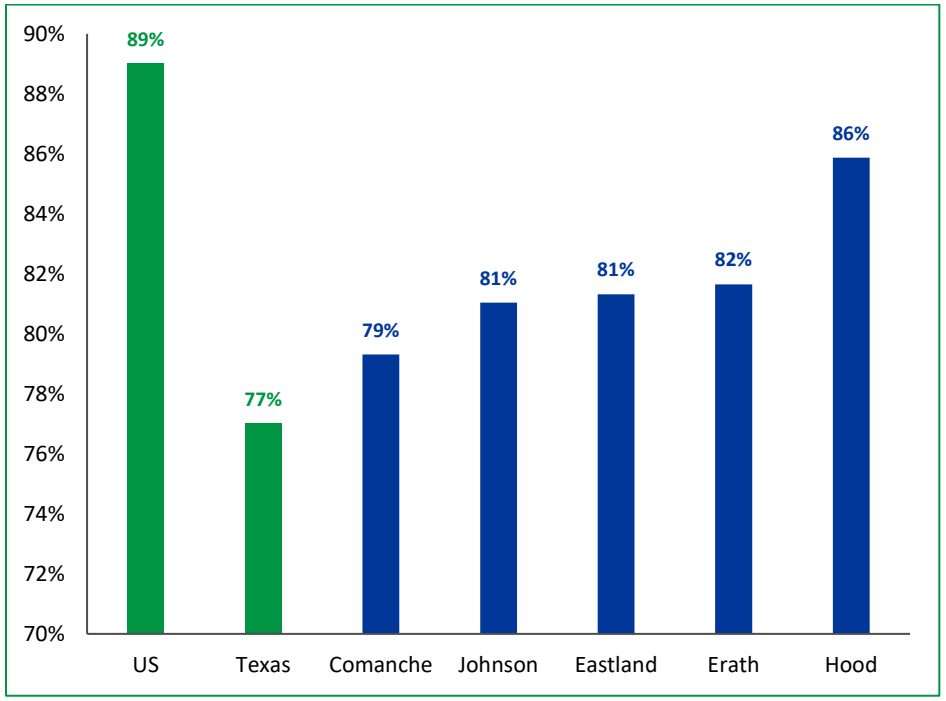

Figure 10: Insured Rate by County Among Adults Aged 18–64 (CDC PLACES [2024]). Higher insurance rates typically lead to more favorable health outcomes.

[4] KFF (2023).

[5] County Health Rankings & Roadmaps (2025).

Preventive Care Access

Research shows that limited access and low participation in preventive services—such as cancer screenings, routine primary care, and medication adherence for chronic conditions—are associated with significantly poorer health outcomes.[6] Figure 11 shows the level of barrier by ZIP code in the Southern region for the preventive care access domain. Five measures are considered in this domain: blood pressure medication access, mammography screening rate among adults aged 50 to 74, colon screening rate among adults aged 45 to 75, annual dentist visit among adults, and annual visit to the doctor for routine checkup among adults. Together, these measures serve as a proxy for the ease of accessing screenings, primary care, and essential medications.

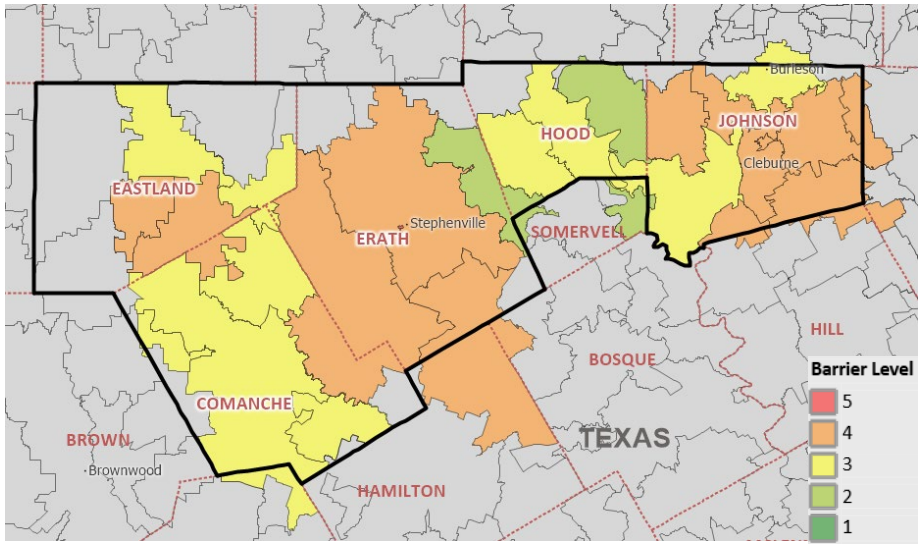

Figure 11: Preventive Care Access Barriers

Figure 12 shows all five counties (except Hood County) are at or below the national average for annual primary care visits and colon screenings among adults aged 45 to 75, reflecting a significant barrier of access to preventive care in the service area. Erath County has the greatest barriers in the region. Additionally, county-level data revealed that all five counties in the service area have an insufficient supply of primary care providers, mental health providers, and dentists, with provider-to-population ratios worse than the national average,[7] further hindering access to preventive care.

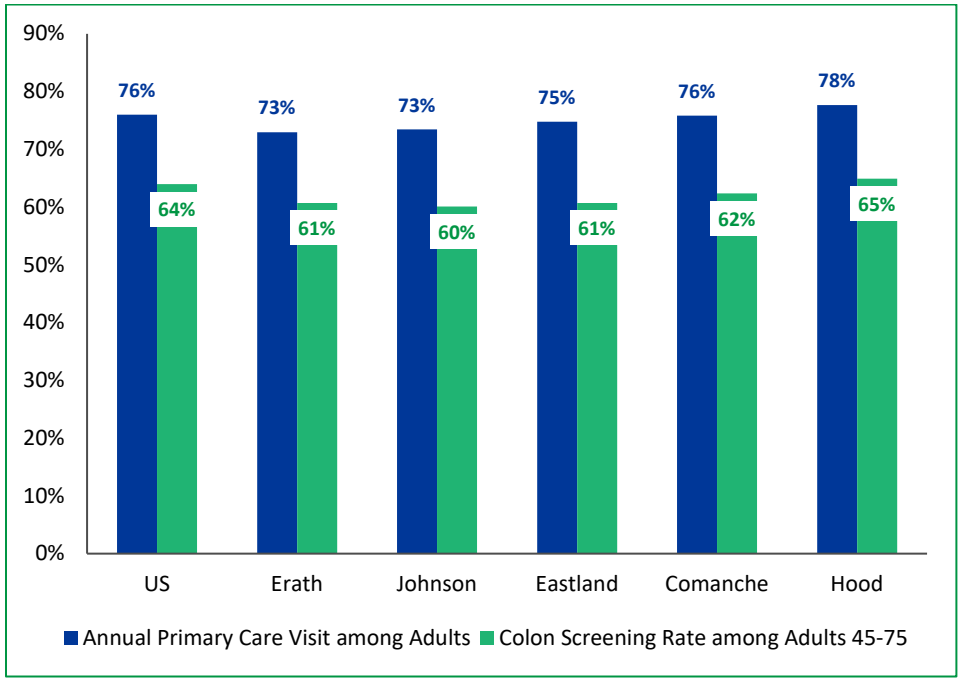

Figure 12: Preventive Care Access Measures by County (CDC PLACES [2024]). Higher primary care visits and colonoscopies typically lead to more favorable health outcomes.

[6] US Department of Health and Human Services, Healthy People 2030: Preventive Care.

[7] County Health Rankings & Roadmaps (2025).

Educational Attainment

Research shows that educational attainment is correlated with health literacy, which affects chronic disease management and healthcare navigation.[8] Figure 13 shows the level of barrier by ZIP code in the Southern region for the educational attainment domain. Two measures are considered in this domain: adults over 25 years of age with at least a high school diploma and adults over 25 years of age with at least a bachelor's degree. These metrics are a proxy for health literacy.

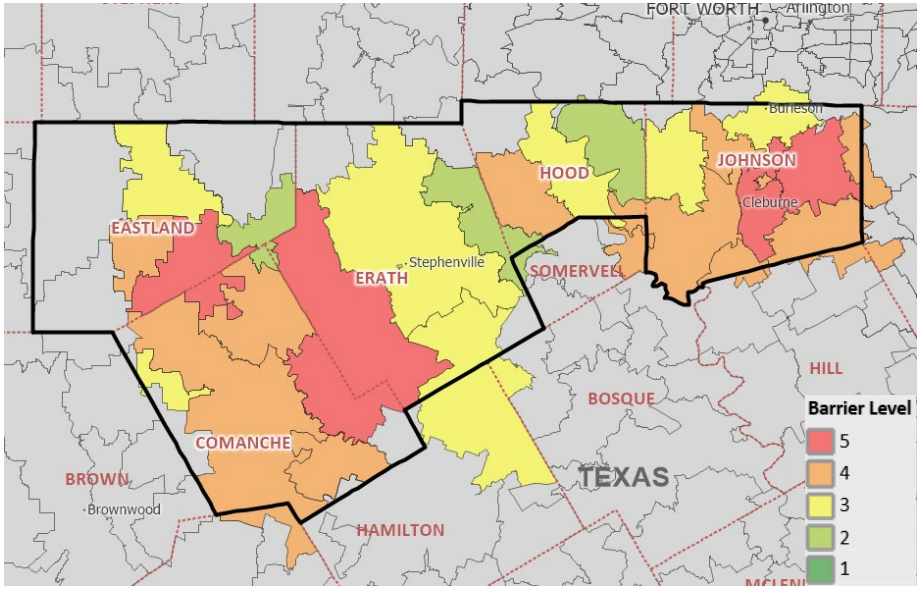

Figure 13: Educational Attainment Barriers

Figure 14 shows four of five counties in the region (except Hood County) are below the national average for adults aged 25 and older with at least a high school diploma or bachelor's degree, potentially reflecting a significant barrier of health literacy in the Southern Region. However, figure 13 shows central Johnson County and southwest Erath County is more vulnerable than the rest of the Southern region.

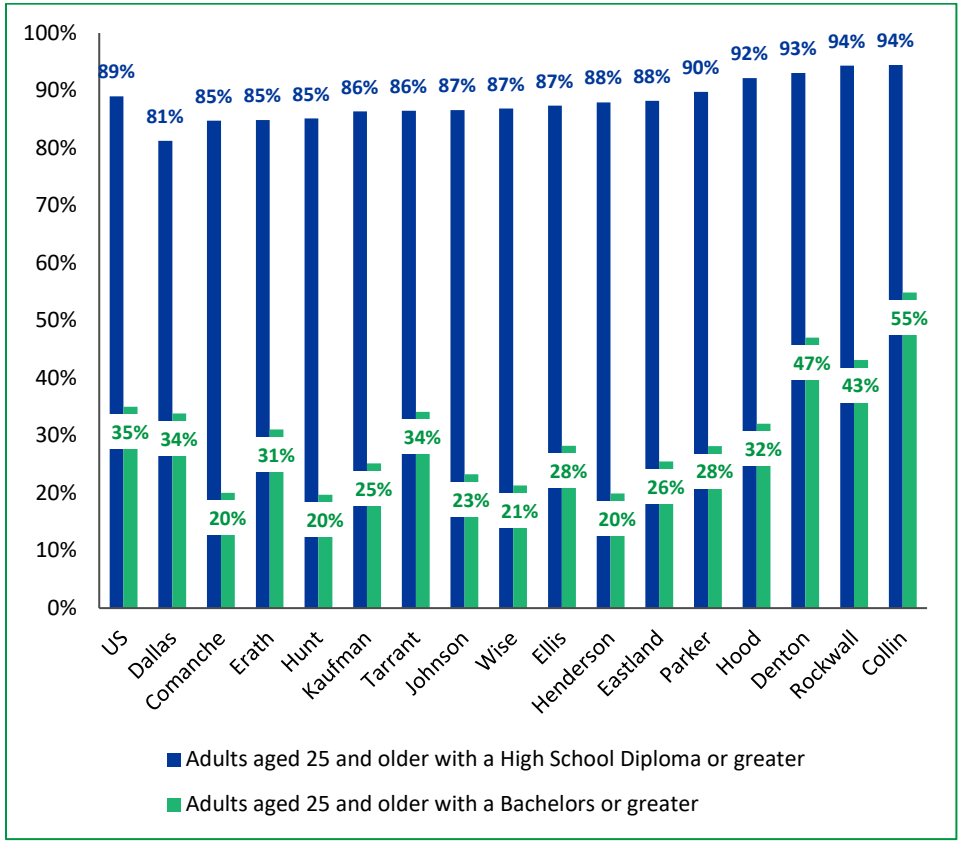

Figure 14: Educational Attainment Measures by County (American Community Survey [2019–2023]). Higher rates of adults with at least a high school diploma typically lead to more favorable health outcomes.

[8] National Assessment of Adult Literacy and the Agency for Healthcare Research and Quality.

Income

Income is a significant predictor in one's ability to afford out-of-pocket medical costs.[9] Figure 15 shows the level of barrier by ZIP code in the Southern region for the income domain. This domain considers one measure: median household income.

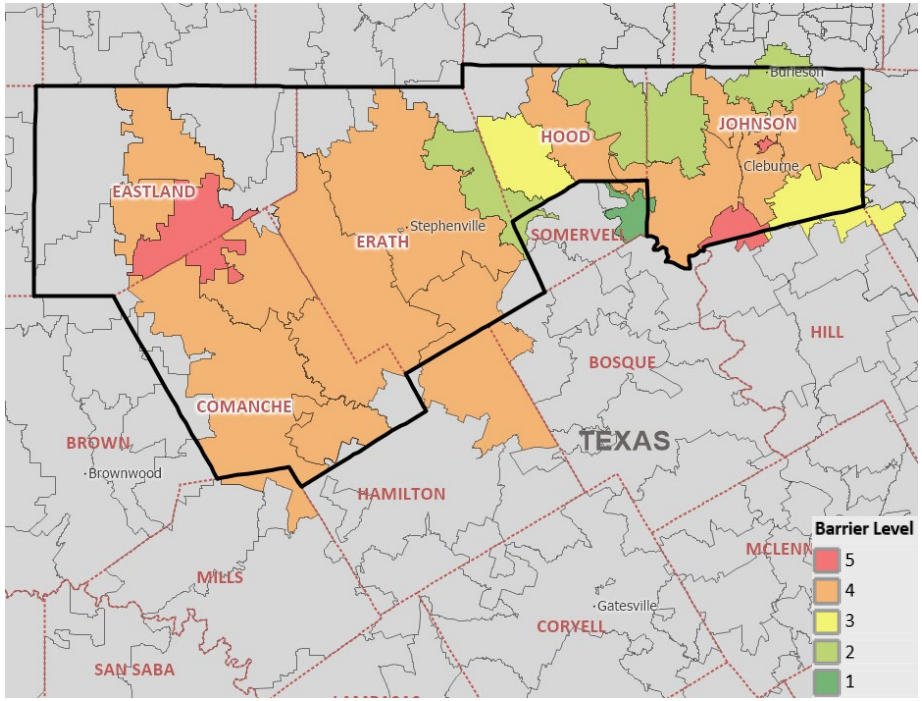

Figure 15: Income Barriers

Figure 16 shows four of five counties in the region (except Hood County) is below the state and national benchmarks for median household income, potentially reflecting income barriers in Southern region.

However, figure 15 shows the greatest barriers are concentrated in central Johnson, Comanche, Erath, and Eastland County.

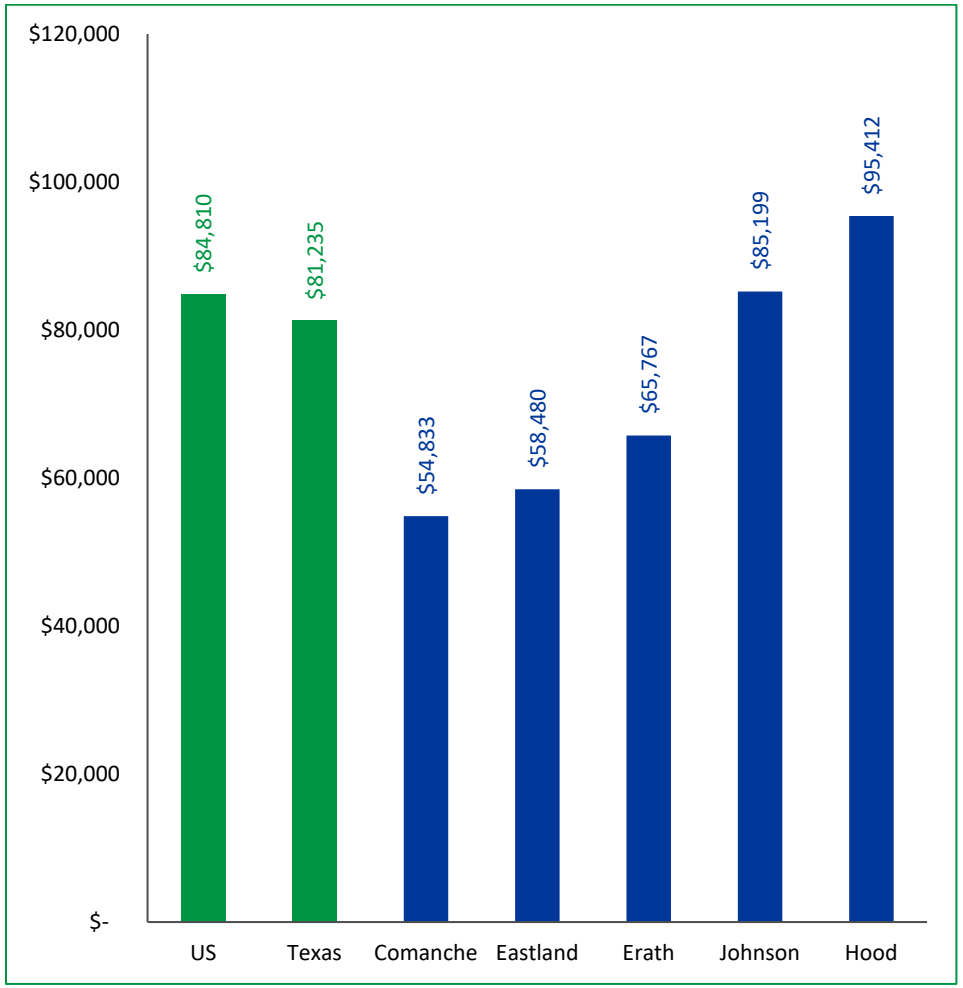

Figure 16: Median Household Income by County (American Community Survey [2019–2023]). Higher income typically leads to more favorable health outcomes.

[9] KFF, "Key Facts About the Uninsured Population" (2023).

Employment

Employment is a significant predictor in one's ability to access commercial health insurance, as most health insurance in the US is employer-sponsored insurance (ESI).[10] Figure 17 shows the level of barrier by ZIP code in the Southern Region for the employment domain. One measure is considered in this domain: the civilian unemployment rate.

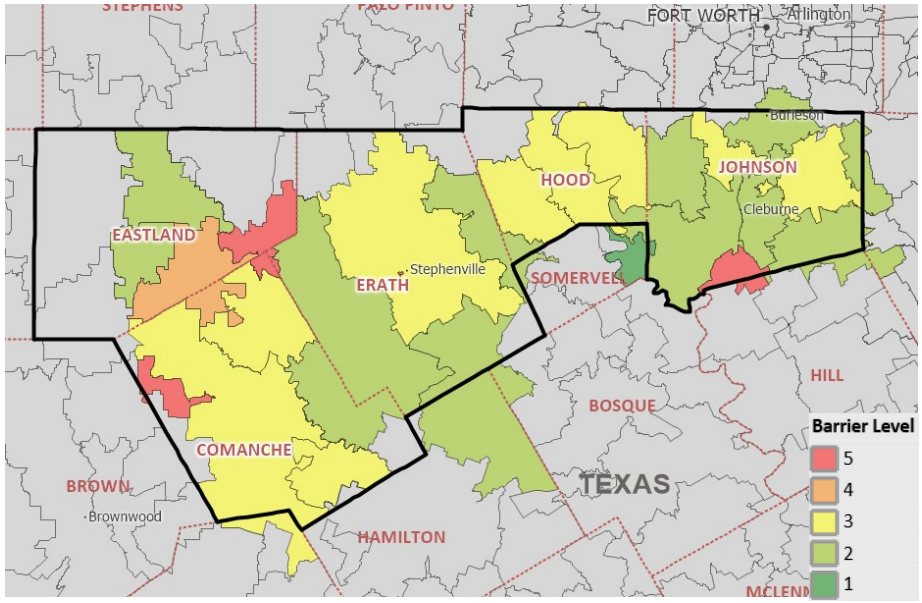

Figure 17: Employment Barriers

Figure 18 shows that Erath, Hood, and Comanche County has a slightly higher unemployment rate than the national and state benchmarks. It is also important to note that in Texas, 94.9% of large firms (i.e., 50 or more employees) offer ESI, while 28.7% of small employers offer ESI.[10]

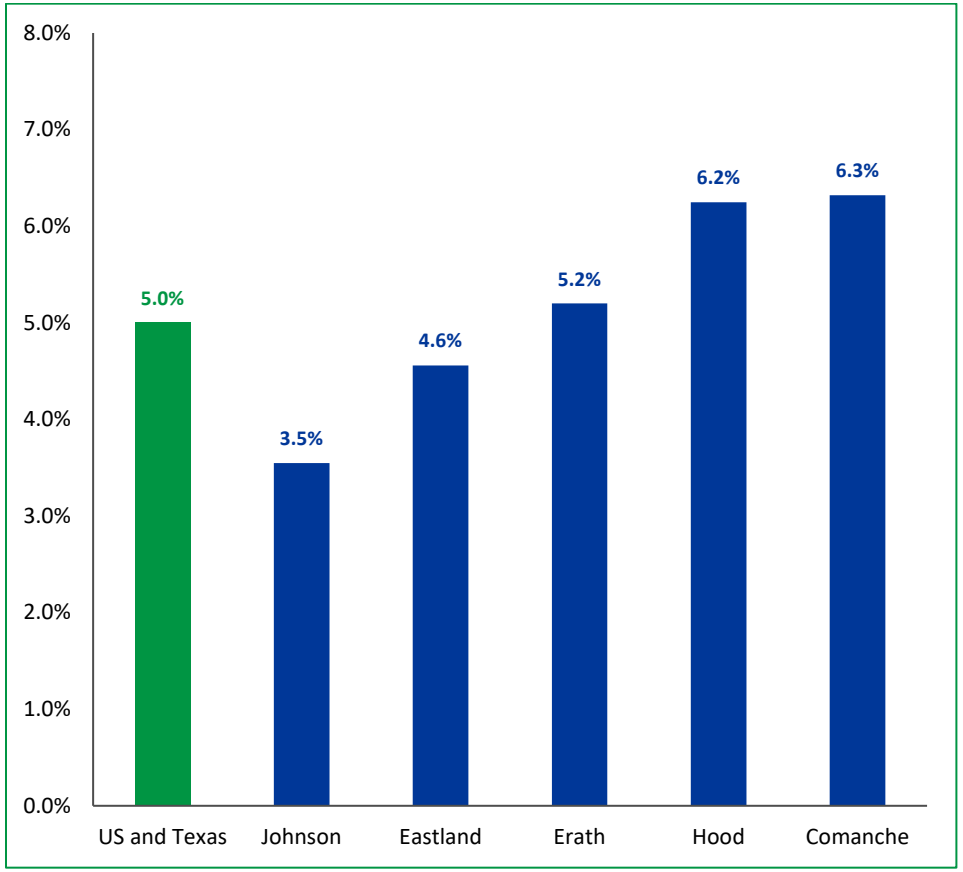

Figure 18: Civilian Unemployment Rate by County (American Community Survey [2019-2023]). Higher unemployment typically leads to less favorable health outcomes.

10 KFF, *Employer Health Benefits Survey* (2023).

Housing Stability

Housing instability can lead to exposure to toxins, reduced ability to manage chronic disease and other illnesses, and stress.[11] Figure 19 shows the level of barrier by ZIP code in the Southern region for the housing stability domain. Three measures are considered in this domain: housing insecurity among adults in the last 12 months, threat of utilities shutting off among adults in the last 12 months, and percentage of households with a housing burden (i.e., spending more than 30% of income on housing). These metrics all describe the housing stability of a service area.

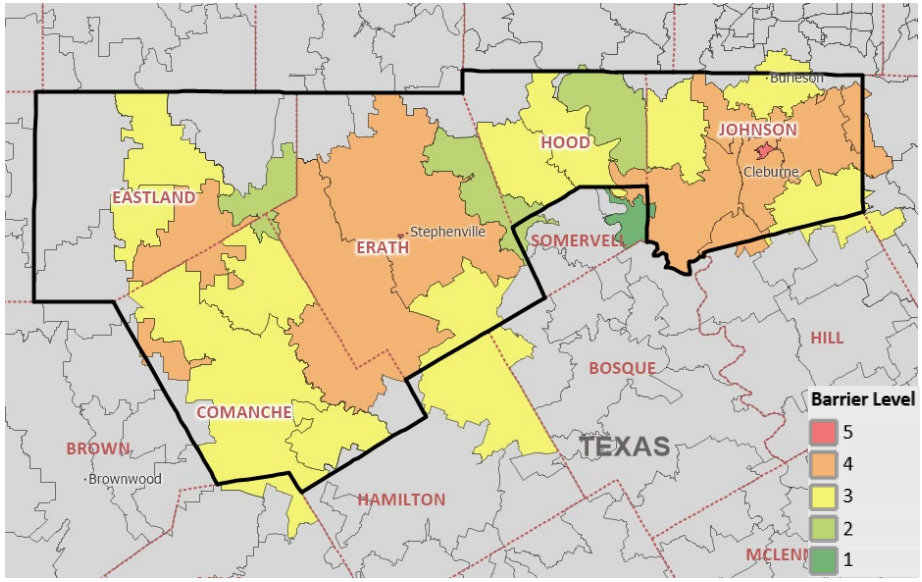

Figure 19: Housing Stability Barriers

Figure 20 shows four of five counties in the region (except Hood County) are above the national benchmark for housing insecurity and threat of utilities shutting off, potentially reflecting a significant barrier of housing stability in the Southern region. However, figure 19 shows central Johnson and Erath County have the greatest barriers. While Hood County as a whole falls below the national benchmark, southwest Hood County may still experience localized challenges related to housing stability.

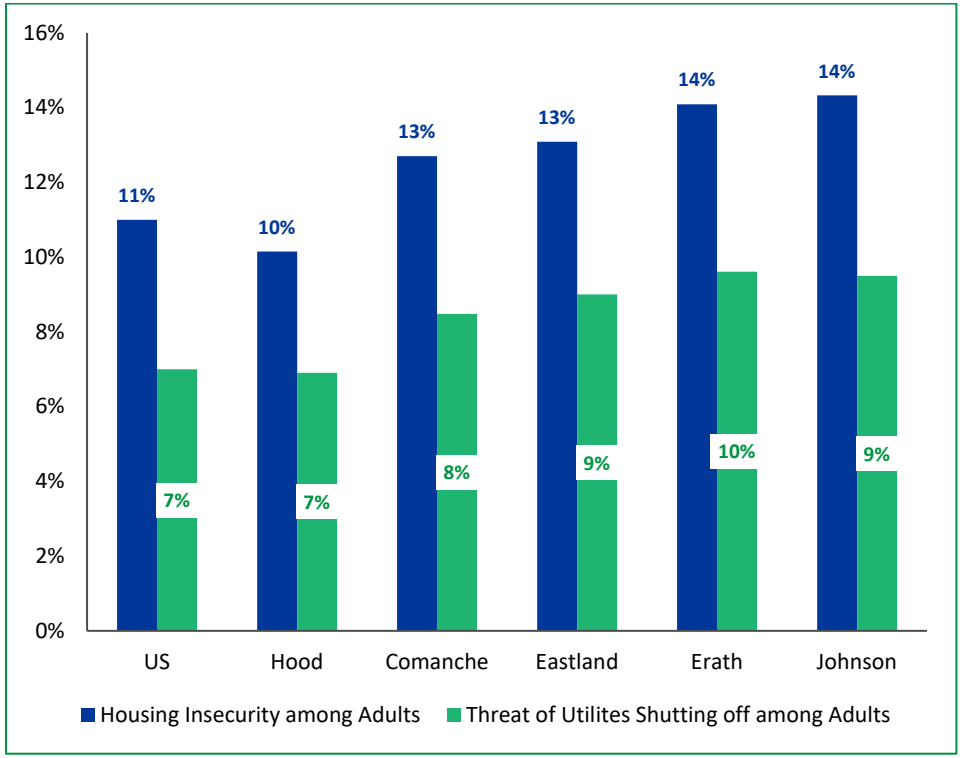

Figure 20: Housing Stability Measures by County (CDC PLACES [2024]). Higher housing insecurity and threat of utilities shutting off typically lead to less favorable health outcomes.

[11] US Department of Health and Human Services, Healthy People 2030.

Food Security

Food security is essential for managing chronic disease and illnesses.[12] Figure 21 shows the level of barrier by ZIP code in the Southern region for the food security domain. Two measures are considered in this domain: food insecurity among adults in the last 12 months and receiving food stamps among adults in the last 12 months. The food insecurity metric describes the lack of consistent access to enough food for every person in a household to live an active, healthy life. The metric for receiving food stamps is an additional indicator to understand who needs and utilizes food assistance in the service area.

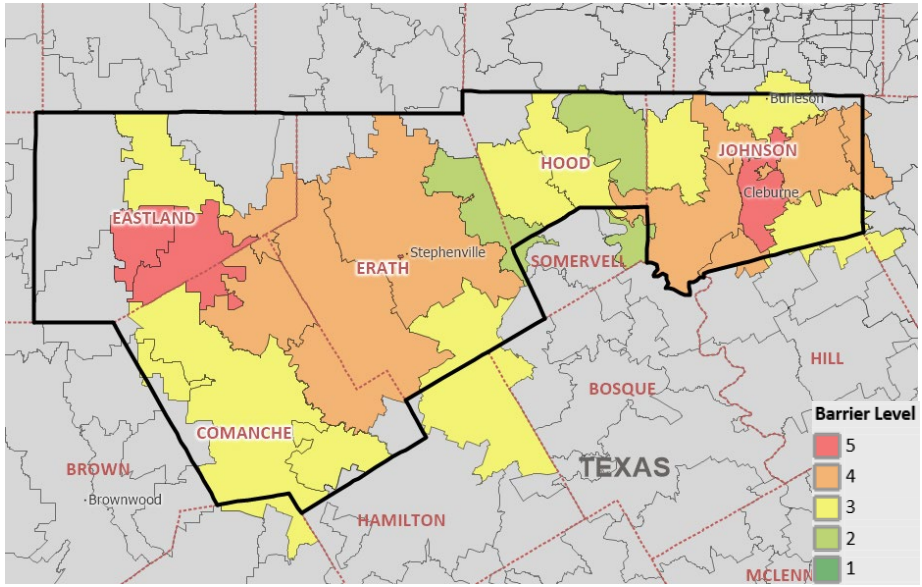

Figure 21. Food Security Barriers

Figure 22 shows all five counties (except Hood County) are above the national benchmark for food insecurity and adults receiving food stamps. Although Hood County is below the national benchmark, figure 21 shows that southwestern Hood County may face food security barriers.

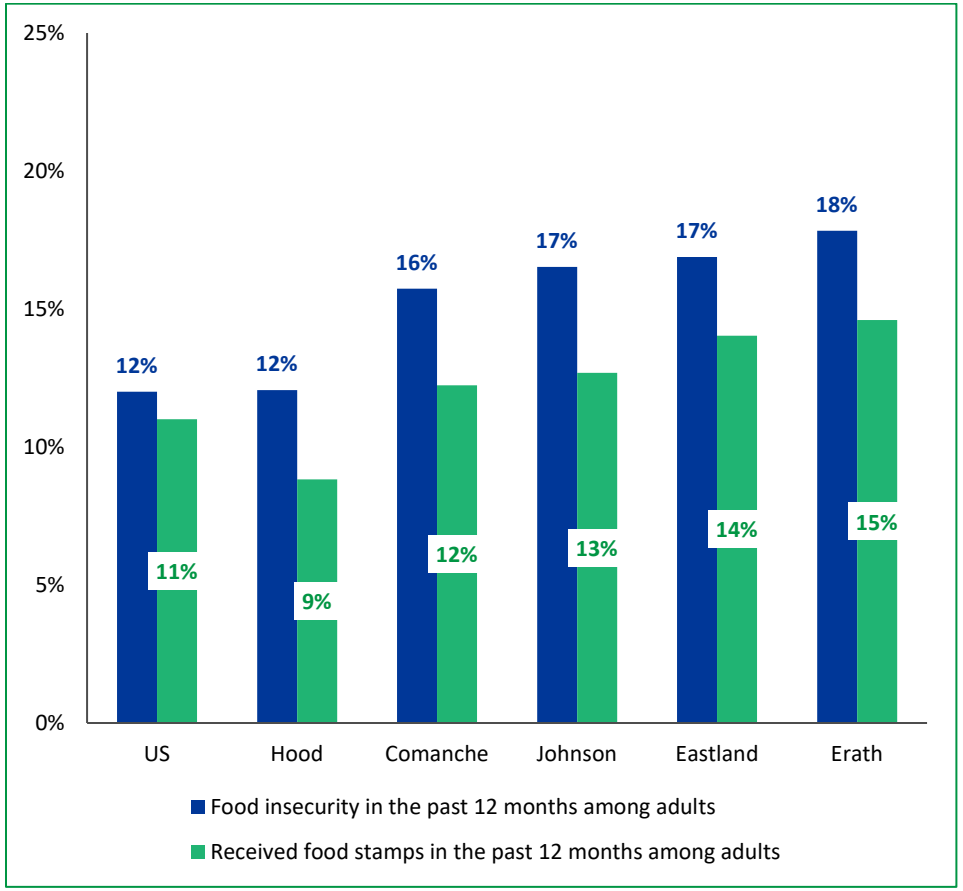

Figure 22: Food Security Measures by County (CDC PLACES [2024]). Higher food insecurity typically leads to less favorable health outcomes.

[12] Gregory and Coleman-Jensen, USDA Economic Research Service (2017; updated 2022).

Transportation

Reliable transportation is essential for accessing care, particularly in a service area where patients often need to travel to receive services. Transportation includes public transit, personal vehicles, and alternative modes such as rideshare or community shuttles. Expanding access to transportation options can have a significant positive health impact, especially for older adults who may face greater mobility challenges.[13] Figure 23 shows the level of barrier by ZIP code in the Southern region for the transportation domain. One measure is considered in this domain: lack of reliable transportation among adults in the last 12 months.

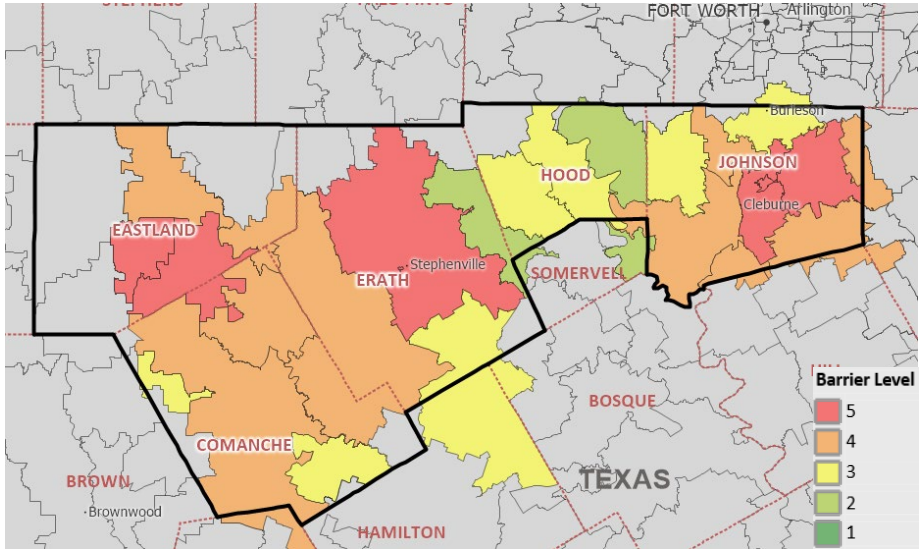

Figure 23: Transportation Barriers

Figure 24 shows that all five counties are at or below the Texas benchmark for lack of reliable transportation, highlighting a broader, systemic transportation challenge within the service area. All five counties face significant gaps in public transportation options, particularly for individuals without access to a personal vehicle. Additionally, county-level data[14] revealed both counties were above the national average for average distance to the nearest public transit, contributing to the elevated rates of lack of reliable transportation in the service area.

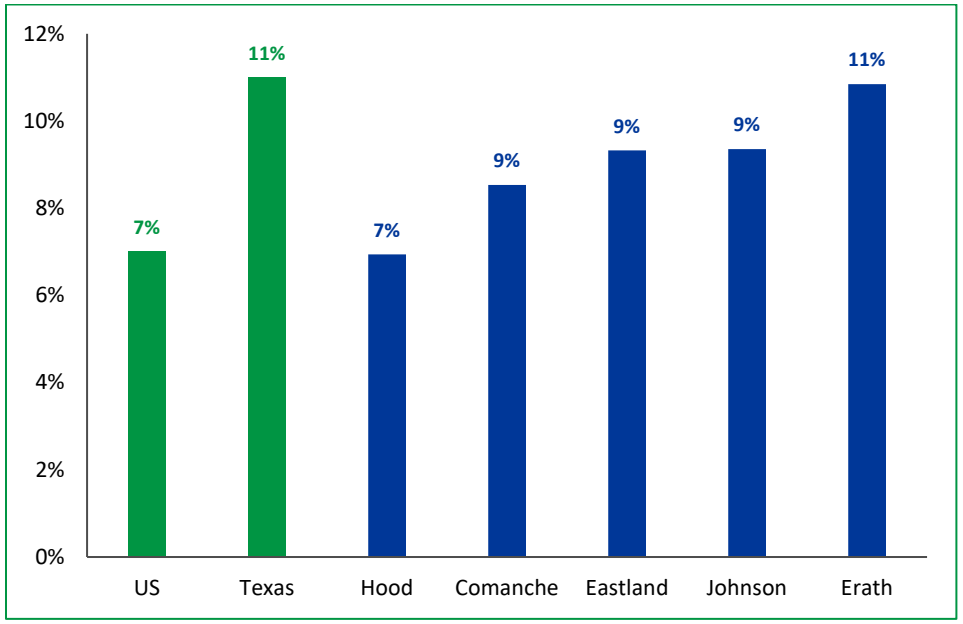

Figure 24: Lack of Reliable Transportation Among Adults by County (CDC PLACES [2024]). Higher transportation insecurity typically leads to less favorable health outcomes.

[13] National Aging and Disability Transportation Center.

[14] U.S Environmental Protection Agency Smart Location Database

Technology Access

Access to technology is increasingly important as the healthcare landscape becomes more digital, with greater reliance on electronic health records, patient portals, and telemedicine.[15] Figure 25 shows the level of barrier by ZIP code in the Southern region for the technology access domain. Two measures are considered in this domain: residents without at least one computer device and residents without some type of internet subscription. These metrics reflect the level of technology access within the service area.

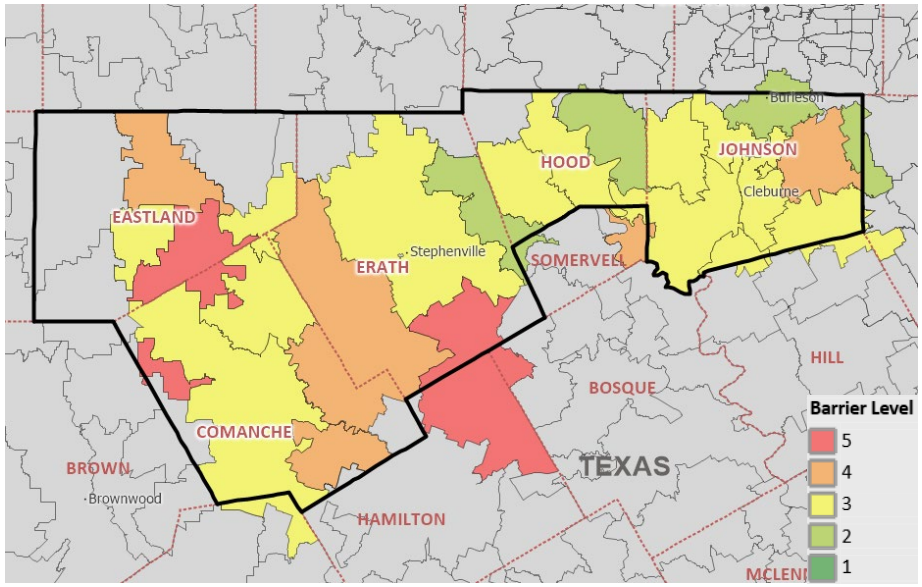

Figure 25: Technology Access Barriers

Figure 26 shows Erath, Comanche, and Eastland County are above the national benchmark in residents without some type of internet subscription, reflecting a barrier of technology access in these counties.

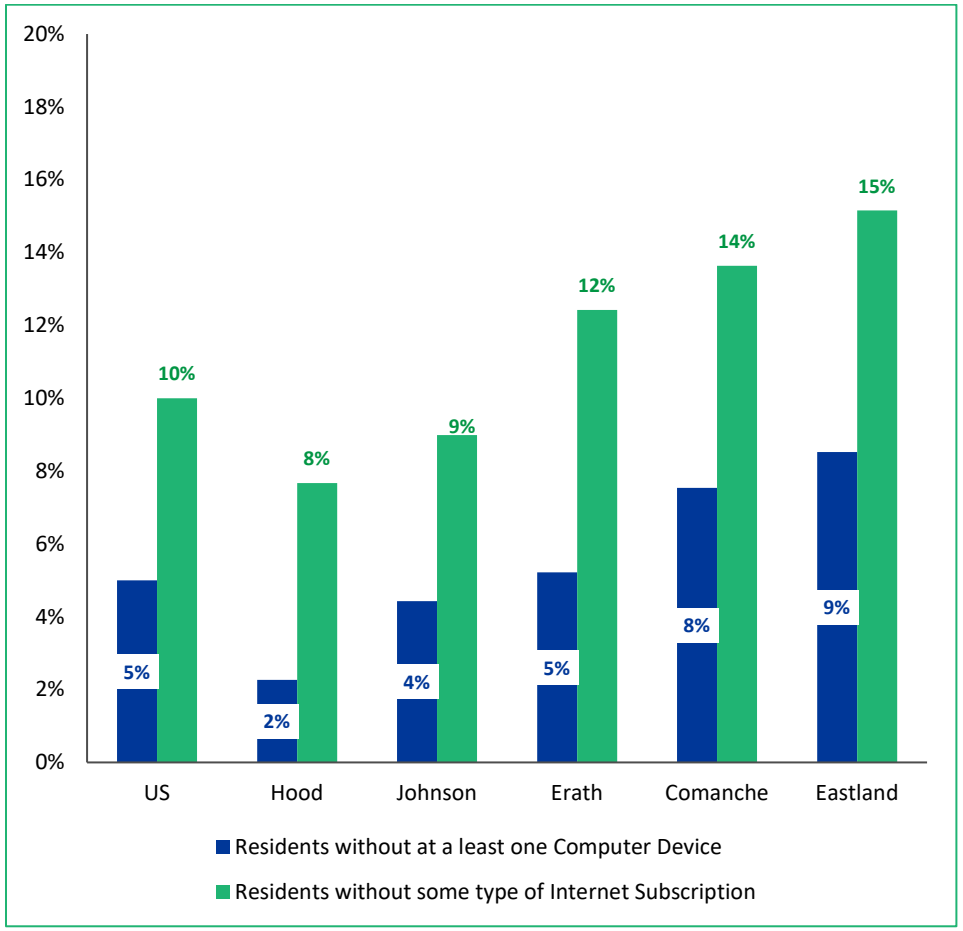

Figure 26: Technology Access Measures by County (American Community Survey [2019–2023]). Higher technology insecurity rates could lead to less favorable health outcomes.

15 ONC, "Individuals' Access and Use of Patient Portals and Smartphone Health Apps" (2023).

Connectedness

Connectedness is a key driver of health, as strong social connections are associated with lower rates of depression, anxiety, and stress and improved chronic disease management.[16] Figure 27 shows the level of barrier by ZIP code in the Southern region for the connectedness domain. Three measures are considered in this domain: lack of emotional support among adults, feelings of social isolation among adults, and households headed by a single parent. These metrics reflect the level of social support experienced by adults in the service area.

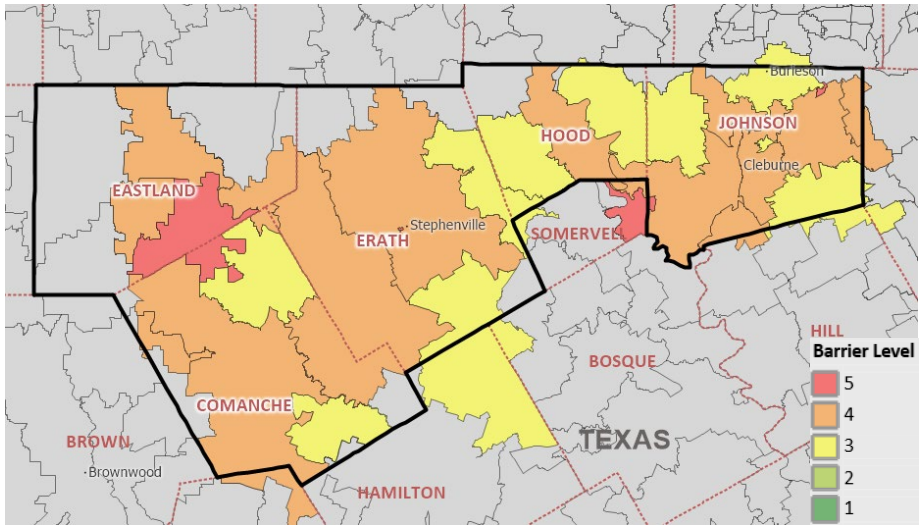

Figure 27: Connectedness Barriers

While not all single-parent households lack social support, they are statistically more likely to encounter barriers that impact their ability to maintain consistent emotional or logistic support.[17] Figure 28 shows all five counties are above the national benchmark for isolation and lack of emotional support among adults, reflecting a significant barrier of social support in the service area. Additionally, internal non-medical drivers of health screening data from Texas Health[18] revealed the category with the most risk in the region was personal safety, aligning with the vulnerability of social support in the service area.

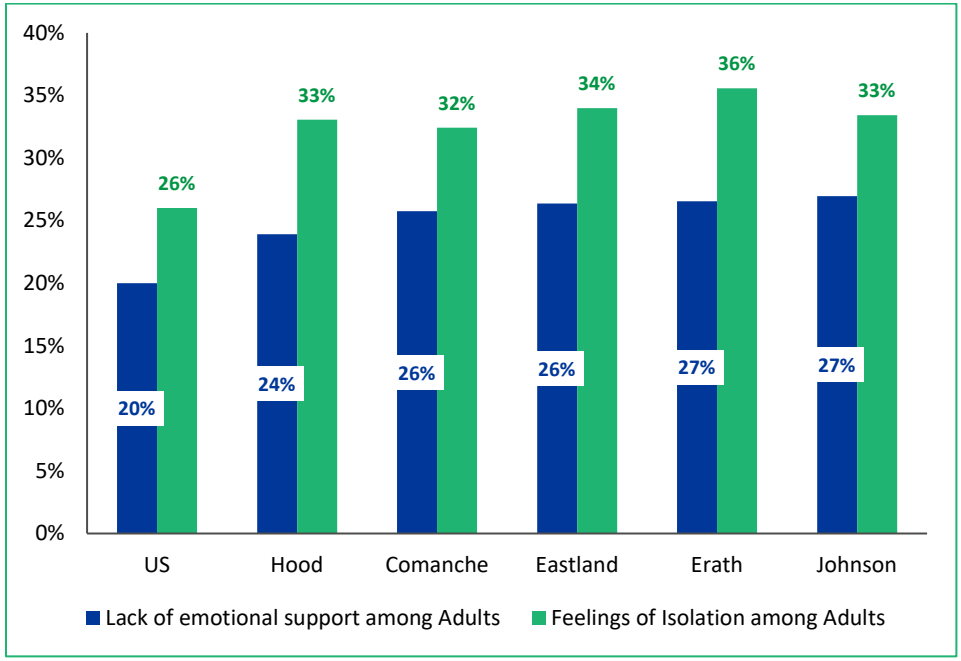

Figure 28: Social Support Measures by County (CDC PLACES [2024]). Higher lack of emotional support typically leads to less favorable health outcomes.

[16] Harvard T.H. Chan School of Public Health, "The Importance of Connections: Ways to Live a Longer, Healthier Life" (2023).

[17] Springer, *Journal of Family and Economic Issues* (2018).

[18] Internal Texas Health data.

Chronic Disease

A chronic disease is a long-lasting health condition that typically persists for one year or more and requires ongoing medical attention and/or limits daily activities. This domain evaluates adult prevalence rates of coronary heart disease (CHD), cancer, chronic obstructive pulmonary disease (COPD), high blood pressure (HBP), diabetes, asthma, and obesity across the service area. Table 3 summarizes these rates in the Southern region. **Green** indicates the measure is at or below the national average, and **Red** indicates the measure is above the national average.

County	CHD	Cancer	COPD	HBP	Diabetes	Asthma	Obesity
Comanche	10%	10%	10%	40%	16%	10%	39%
Eastland	10%	10%	11%	41%	16%	10%	37%
Erath	7%	8%	8%	32%	12%	10%	37%
Hood	9%	11%	9%	38%	14%	10%	35%
Johnson	7%	8%	8%	34%	13%	10%	40%
Texas	**7%**	**6%**	**7%**	**33%**	**14%**	**10%**	**37%**
US	**7%**	**8%**	**7%**	**31%**	**12%**	**11%**	**34%**

Table 3: Chronic Disease Prevalence by County (CDC PLACES [2024])

The findings indicate that HBP, obesity, and diabetes are the most prevalent chronic conditions across the Southern region. The highest rates are concentrated in Eastland and Comanche County, indicating a high need for chronic disease management in these areas. ZIP code–level data for all chronic disease indicators can be found in the appendix, which can be used to support localized planning and intervention efforts.

Figure 29 shows the barrier levels for chronic disease in the Southern region. ZIP codes with a higher barrier level typically experience more chronic disease compared to national benchmarks.

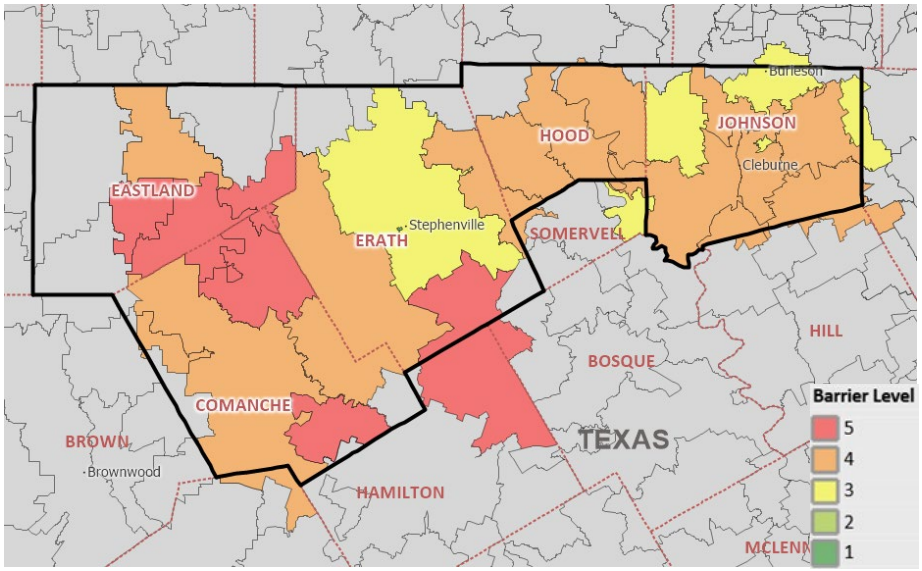

Figure 29: Chronic Disease Barriers

Behavioral Health

Behavioral health refers to the connection between behaviors, mental well-being, and physical health. It encompasses the prevention, diagnosis, and treatment of mental health conditions, as well as substance use disorders. Therefore, this domain examines rates of frequent mental distress, depression, cognitive disability, binge drinking, and cigarette smoking among adults. Frequent mental distress, depression, and cognitive disability all indicate the prevalence of mental disorders in the service area. Binge drinking and cigarette smoking can be risk factors for substance use disorders. Table 4 summarizes these rates in the Southern region. **Green** indicates the measure is at or below the national average, and **Red** indicates the measure is above the national average.

County	Frequent Mental Distress	Depression	Cognitive Disability	Binge Drinking	Cigarette Smoking
Comanche	17%	23%	16%	16%	16%
Eastland	19%	24%	17%	16%	18%
Erath	20%	26%	17%	19%	15%
Hood	16%	22%	13%	17%	15%
Johnson	18%	23%	15%	19%	16%
Texas	**18%**	**22%**	**16%**	**18%**	**15%**
US	**17%**	**22%**	**15%**	**17%**	**15%**

Table 4: Behavioral Health Measures Among Adults by County (CDC PLACES [2024])

The findings indicate there is a need for behavioral health services in the service area, as frequent mental health distress, depression, and cognitive ability affect 13% to 26% of adults in the region. Erath County has the highest rates of frequent mental health distress, depression, and cognitive disability. Table 4 suggests there are more behavioral health challenges in Erath County than the rest of the Southern region.

Figure 30 shows the barrier levels for behavioral health in the Southern region. ZIP codes with a higher barrier level typically have a higher risk of experiencing worse behavioral health outcomes.

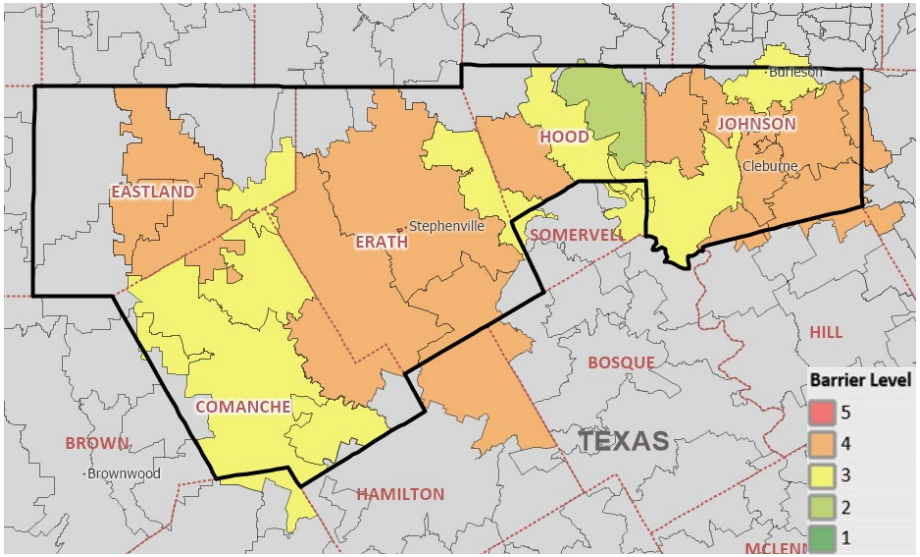

Figure 30: Behavioral Health Barriers

Disabilities

Disabilities encompass any physical or mental impairment that may limit an individual's ability to perform everyday activities and participate fully in social, economic, or community life.[19] Therefore, this domain examined rates of deafness or difficulty in hearing (hearing); difficulty in doing errands alone, such as visiting a doctor's office or shopping (independent living); difficulty in walking or climbing stairs (mobility); difficulty in dressing or bathing (self-care); and blindness or difficulty in seeing (vision). Table 5 summarizes these rates in the Southern region. **Green** indicates the measure is at or below the national average, and **Red** indicates the measure is above the national average.

Region	Any Disability	Hearing	Independent Living	Mobility	Self-Care	Vision
Comanche	38%	10%	10%	19%	5%	7%
Eastland	39%	10%	11%	20%	5%	7%
Erath	35%	8%	10%	15%	4%	6%
Hood	33%	9%	8%	17%	4%	5%
Johnson	32%	7%	9%	15%	4%	6%
Texas	**33%**	**7%**	**9%**	**15%**	**5%**	**7%**
US	**31%**	**7%**	**8%**	**14%**	**4%**	**6%**

Table 5: Disability Measures Among Adults by County (CDC PLACES [2024])

The findings indicate mobility limitations are the most common disability across both counties, signaling a need for transportation and daily living supports. Eastland, Erath and Comanche County have the highest prevalence of disabilities in the Southern region.

Figure 31 shows the barrier levels for disabilities in the Southern region. ZIP codes with a higher barrier level typically have more disability-related barriers to good health.

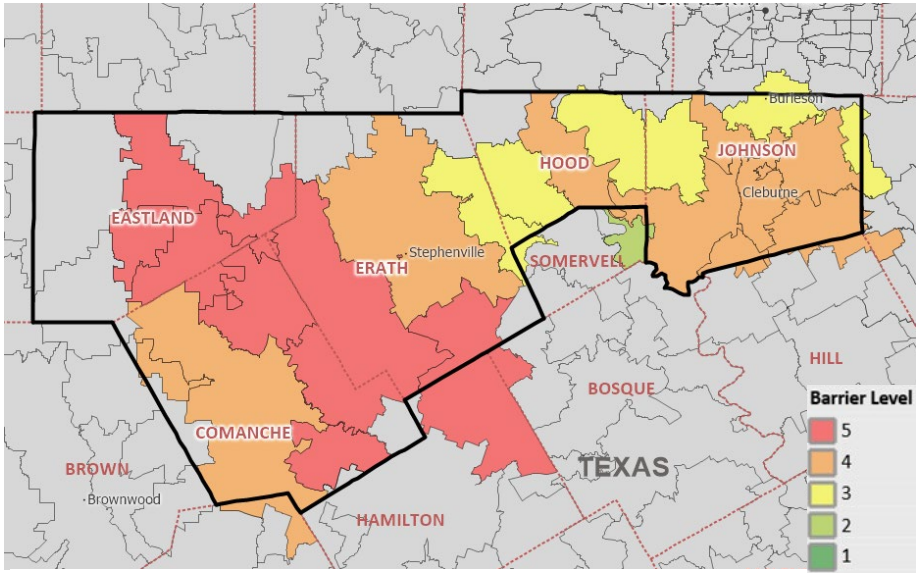

Figure 31: Disabilities Barriers

[19] CDC, Disability and Health.

Primary Data:
Themes

This section provides a summary of key themes in the Southern region, synthesized from findings across the community survey, stakeholder interviews, and focus groups. The survey explored trends that have emerged since the last CHNA and identified the most pressing community health needs. Interviews and focus groups centered on the core question: "What are the top three health-related problems in your community that you would like to see changed or improved?".

Texas Health®

Primary Data: Themes

Overview

This section summarizes key themes in the Southern region, drawing on findings from the community survey, stakeholder interviews, and focus groups. The survey explored trends that have emerged since the last CHNA and identified the most pressing community health needs. Interviews and focus groups were designed around the core question: *"What are the top three health-related problems in your community that you would like to see changed or improved?"*

Key Informant Interviews

Key informant interviews are structured, one-on-one conversations with individuals who have specialized knowledge about a community or organization. For this CHNA, ECG and Texas Health conducted interviews with 2 key informants across the Southern region. Importantly, these key informants were care transition managers—primarily nurses and social workers—who work directly with patients and families. The interviews focused on understanding community needs, identifying trends since the last CHNA, and gauging the visibility and reputation of Texas Health among community partners. By speaking directly with care managers, the CHNA captured insights from professionals who have firsthand knowledge of the health challenges faced by community members.

Across the Southern region, behavioral health, transportation, and housing and utility costs emerged as the most frequently cited challenges. Care managers described limitations in transportation options, noting that there is no uber or taxi, and the public bus has limited hours as one informant noted: *"patient sometimes wait in the lobby for hours, even days."*

Behavioral health was also highlighted as a critical medical driver affecting health. As one informant explained: *"We need more behavioral health access – both acute and non-acute".*

Lastly, housing and utility costs were highlighted as a top concern, with gaps in homeless shelters. Key informants emphasized the growing homeless population as the region has *"few social services available – no true homeless shelter and small food pantries"*

Focus Groups

Focus groups are guided group discussions that bring together multiple participants to explore shared experiences and perspectives. For this assessment, 38 individuals participated in four focus groups across the Southern region, including two organizational sessions with local partner organizations and two community-based sessions with residents. Facilitators guided the conversation around community health needs, emerging health trends, and Texas Health's presence and reputation.

Community participants emphasized the importance of transportation, access and navigation, and behavioral health. Transportation was described as a major barrier when public transit (CleTran) or familial support is not available. Many participants noted not all insurance is accepted, forcing some participants to have to travel to Fort Worth. Additionally, one participant noted *"Not knowing where to go look for information is one of the biggest issues, so where do I go, where do I start?".* Specifically in Cleburne, the lack of OB services has impacted the community as one participant noted *"very sad to not have [OB services] in the community"*. Lastly behavioral health was a major issue as there was a sentiment *"where can we go for mental health services in the community?"*

Organizational participants similarly agreed with transportation but emphasized food insecurity and nutrition and housing costs as well. In Cleburne, one participant noted *"[we] need more access to food banks and food pantries – especially in Eastside community."*

Community Organization Survey

The community organizational survey provides a complementary lens to the qualitative data from focus groups and interviews, capturing the perspectives of organizations that serve the six regions. Across regions, the survey highlights both progress and areas where community health has worsened since the last CHNA.

Southern

Among 140 respondents in the Southern region, 31% were aware of Texas Health initiatives.

2022 Priority Area	Improved	Stayed the Same	Worsened	n/a
Health literacy and navigation	23%	41%	6%	30%
Behavioral health	13%	41%	17%	29%
Chronic disease	13%	46%	11%	30%

While 23% reported improvements in health literacy and navigation, 17% indicated behavioral health had worsened, and 11% reported declining chronic disease outcomes.

Organizations highlighted support for substance use disorders and the unhoused, food insecurity and food-is-medicine initiatives, and mental health service expansion, particularly in rural areas. Access to providers, healthcare navigation, and loneliness among older adults were noted as ongoing challenges.

Summary

Summary Table of Top Three Health-Related Problems Identified in Southern

Region	Key informant Interviews	Community Organization Focus Groups	Community Member Focus Groups
All Sixteen Counties	• Transportation • Behavioral Health • Housing and Utility Cost	• Behavioral Health • Access and Navigation • Transportation	• Transportation • Housing and Utility • Access and Navigation
Southern	• Behavioral health • Transportation • Housing and utility cost	• Food insecurity and nutrition • Transportation • Housing and utility cost	• Transportation • Access and navigation • Behavioral health

Closing Remarks

The 2025 CHNA for Texas Health combined extensive public data, internal risk screening tools, key informant interviews, focus groups, and a community organization survey to comprehensively evaluate health and quality-of-life needs within Texas Health Resources' primary service area and beyond. This multifaceted approach helped to ensure that diverse perspectives and reliable data informed the assessment. Texas Health will further explore these priorities during the development of the Implementation Strategy and create targeted plans to address the identified needs. We welcome your feedback on this CHNA report to help shape and improve future assessments.

If you have any feedback or remarks, please send them to THRCHI@texashealth.org

Appendix

A. **Interview and Survey Questions**

B. **List of Community Partners**

C. **Data Tables**

D. **ZIP Code Prioritization**