



2024

Community Health Needs Assessment

Cook Children's Medical Center – Fort Worth
Cook Children's Medical Center – Prosper



This report is provided in fulfillment of the Internal Revenue Service Section 501(r)(3)(A) requirements for Charitable Hospitals to conduct a community health needs assessment (CHNA). This 2024 CHNA was approved by Cook Children's Board of Trustees on April 29, 2025 and is now posted for public comment. Public comment on this report is encouraged and should be sent via email to CHNAFeedback@cookchildrens.org.

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For parent/caregiver results only:

Parent/caregiver survey. (2024). Cook Children's Health Care System, Fort Worth, Texas; or Parent/Caregiver 2024 at <https://www.cookchildrenscommunity.org/data> (accessed month/year).

For all other CHNA data results:

Community Health Needs Assessment Report. (2024). Cook Children's Health Care System. Fort Worth, Texas; or Cook Children's CHNA 2024 at www.cookchildrens.org/chna (accessed month/year).



Our promise and values

For well over a century, Cook Children's has been privileged to meet the needs of the children, families and communities we serve. We share our guiding mission in the form of a pinky promise—**everything for the child.**

As our communities have grown, so have we. We have two medical centers, a physician network, a home health company, surgery centers, a health plan, health services, and health foundation. We strive to help families access our top-ranked specialty programs and services to help kids become the healthiest version of themselves.

We mix the art of caring with the latest technology and amazing teamwork to provide exceptional care for every child. That is why kids and their families come to us from all over the country and even the world for life-saving pediatric care.

Cook Children's is proud to be recognized for our outstanding efforts and results in pediatric health care. We believe childhood should be simple and fun. But when things get tough, we also believe **every child** deserves the very best care possible.

Cook Children's locations include:



2 Medical centers



7 Urgent care offices



7 Neighborhood health centers



5 Home health offices



50 Pediatric offices

Exceptional care is about medical expertise, advanced technology and research, and working together with our communities and partners to improve the health of every child in our eight-county service area.

Our 2024 Community Health Needs Assessment (CHNA) serves to:

- Fulfill our promise to improve the well-being of every child in our service area.
- Identify and prioritize health needs and the resources available.
- Increase access to health care for children, with an emphasis on those under-resourced.
- Enhance community capacity to prevent injury and illness, and to promote wellness.
- Support community partnerships, programs, research, and policy.
- Share findings with the community through [Cook Children's website](#), an [interactive data dashboard](#), presentations, social media and more.
- Serve as a joint CHNA report for Cook Children's Medical Centers in Fort Worth and Prosper.
- Meet IRS requirements addressing the CHNA for non-profit hospitals in section 501(r)(3).

Joint report

The 2024 CHNA serves the flagship Cook Children's Medical Center in Fort Worth and the new Cook Children's Medical Center in Prosper. A more detailed description of characteristics for our population served within these areas is included in the section titled—[Our community served](#).



Cook Children's Medical Center – Fort Worth



Cook Children's Medical Center – Prosper

A message to our community

Dear valued community member:

At Cook Children’s, our mission is more than a statement, it’s a promise:

Knowing every child’s life is sacred, we promise to improve the well-being of every child in our care and our communities.

This promise drives everything we do, from medical care to community outreach and everything in between, as we work to make North Texas one of the healthiest places to raise a child. One impactful way we keep our promise is through collaborative programs, partnerships, and community research led by Cook Children’s Center for Community Health (the center).

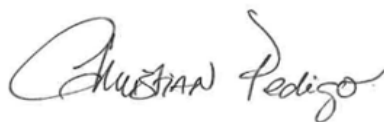
Since 2009, we’ve conducted a Community Health Needs Assessment (CHNA) every three years to listen, learn, and respond to the evolving health needs of children across our rapidly growing eight-county service area. The insights we gather help us identify the most pressing health priorities, shape key outreach efforts, and ensure that children and families have access to the care and support they need.

We know that creating real, lasting change takes all of us—health care providers, educators, social service organizations, community leaders, and more working together. That’s why the center is committed to sharing CHNA findings and using them to develop data-driven, evidence-informed strategies that directly benefit children and families.

Your voice is essential to this work. The perspectives of families, community leaders, and partners like you guide our efforts and help us create solutions that truly make a difference. We are grateful for your continued collaboration and look forward to strengthening our impact—*together*.

Thank you for being part of this mission.

Sincerely,



Christian Pedigo, MHA, RN

Senior Vice President

Chief Strategy, Education, and Community Health Officer

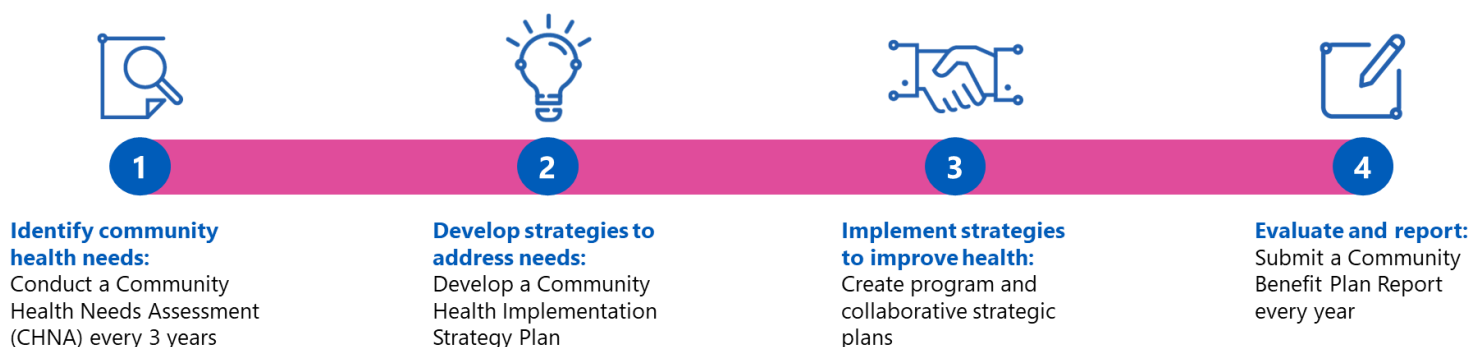
Cook Children’s Health Care System

Overview of the assessment process

Since 2009, Cook Children’s has conducted a formal Community Health Needs Assessment (CHNA) **every three years** to identify the health needs of children in our service area(s). To determine or confirm community health priorities, we established a parent/caregiver survey (formerly the Community-wide Children’s Health Assessment and Planning Survey (CCHAPS)), reviewed publicly available data, and conducted interviews with caregivers and community leaders. Additionally, to enhance our collective knowledge, Cook Children’s engages community partners to research, understand, communicate, and address children’s health issues. Assessments were conducted, priorities confirmed by our board, and implementation strategies developed in 2009, 2012, 2015, 2018, 2021, and now 2024.

Cook Children’s Center for Community Health (the center), formerly the Center for Children’s Health, was created in 2011 to provide an infrastructure for conducting the triennial CHNA, lead community research, and guide community programs and stakeholder collaborations. These combined activities focus on increasing access to preventive services for under-resourced populations. Figure 1 illustrates our Cook Children’s **community benefit process** in relation to the Internal Revenue Service (IRS) Section 501(r)(3)(A) requirements. Our 2024 CHNA fulfills step 1 within the figure below. A separate Community Health Implementation Strategy Plan outlines strategies tailored to address identified needs, with one plan designated for Cook Children’s Medical Center in Fort Worth and a separate plan for Cook Children’s Medical Center in Prosper. The center also utilizes the [Spectrum of Prevention](#) as a guiding framework to categorize and align its work across multiple levels of influence, from individual education to policy advocacy, ensuring a comprehensive approach to improving community health outcomes.¹

Figure 1. Cook Children’s Community Benefit Process



Priority health issues

Based on the initial assessment, our Cook Children’s Board of Trustees prioritized seven children’s health issues identified by parents and community leaders on April 28, 2009, using group process techniques followed by a nominal voting exercise. Findings from subsequent CHNAs confirmed the importance of these issues for continuing focused intervention. Although progress in addressing these issues is consistent, the growing number of children and the overwhelming need outlined in this and earlier reports show that continued focus on these issues is critical.

Our 2024 CHNA focuses on the child health issues previously re-prioritized by our board, with an emphasis on **community-level non-medical drivers of health**—“the conditions in which people are born, grow, live, and age, and the wider set of forces and systems shaping the conditions of daily life.”¹ Figure 2 outlines the seven child health priorities and they are described in more details throughout the [2024 CHNA findings](#) section. It is important to note that caregiver support is an encompassing term aimed at mitigating child abuse and neglect. Cook Children’s understands the **intersectional approach** needed to address these seven health priorities in our community.

Figure 2. Children’s health issues reprioritized from the Cook Children’s 2024 CHNA



2024 CHNA methodology

To assess the status of the prioritized health issues and the estimated number of children impacted, Cook Children's applied academic research standards for both primary and secondary data collection. Community respondents were located in the eight-county service area comprising the primary service areas for Cook Children's Medical Centers in Fort Worth and Prosper. Methodologies are revealed in the following pages and a 2024 CHNA overview can be found in this 3-minute video ([CHNA process video](#)).

Primary data

Quantitative data

1. Parent/caregiver survey

The parent/caregiver survey, formerly known as the Community-wide Children's Health Assessment and Planning Survey (CCHAPS), was administered by ETC Institute by mail, internet, or phone to a random sample of primary caregivers of children from birth to age 17 across the eight counties. Additional survey sampling and administration information is located in Appendix 2.

Survey design: The 57 survey questions assessed access to health care, health insurance, overall health and well-being, oral health, emotional and mental health, healthy lifestyles (nutrition, physical activity), home and neighborhood safety, and family and caregiver support. Many survey questions aligned with national and state data benchmarks, such as the [National Survey for Children's Health \(NSCH\)](#), [Healthy People 2030](#), [Youth Risk Behavior Surveillance](#), [Mental Health America](#), and [Safe Kids Worldwide](#). Questions were enhanced to better identify the impact of non-medical factors that influence child health. The survey was available in English or Spanish and included a cover letter that explained the purpose. The average response time was 25 minutes.

Sample: The survey sampling plan was designed to gather statistically representative data of children from birth to age 17. A total of 43,500 parents and caregivers in the service area were randomly selected to receive the survey. Only one caregiver per household was selected. Oversampling occurred in counties with lower populations to ensure that geographic distribution of the survey sample was comparable to the actual distribution of the eight-county population.

Data collection: From June to August 2022, May to July 2023, and April to July 2024, ETC Institute administered this survey. A total of 6,877 randomly selected parents and caregivers completed the survey, which represents a 16% response rate. Respondent demographics were monitored throughout the data collection process to ensure a representative sample according to gender, race and ethnicity, marital status, education, and household income. With 57 questions and 160 sub-questions, 1.1 million data points can be analyzed from the survey responses.

Reliability: Findings are representative of children from birth to age 17 at the eight-county and individual-county levels. The overall results for 6,877 completed surveys have a precision of at least plus or minus 1.2% at the 95% level of confidence. The survey findings presented in this report were weighted by county to ensure the geographic distribution of the survey sample was comparable to the actual distribution of the service area population. The survey data was expanded to match the 2022 United States (U.S.) census estimates for the 1,181,591 children under age 18 living in the eight-county area with regard to age, race, income, Hispanic ancestry, and gender.

Limitations: Parent/caregiver perception and knowledge may have influenced results. Findings are descriptive, not causal. Additionally, multiple factors could impact response rates from hard-to-reach populations; therefore, additional data collection methods outlined below aim to address these potential limitations.

2. Face-to-face survey interviews

Through one-on-one interviews, MHMR of Tarrant County surveyed an intentional sample of 227 caregivers with families experiencing homelessness (i.e., unhoused) or with at least one undocumented member. Interviews were conducted at Mission Arlington, Presbyterian Night Shelter, Union Gospel Mission, and the Arlington Life Shelter. This sample of respondents is not representative of our entire service area, yet provides a better understanding of the unique challenges these families face with accessing health care and community resources for their children.

Limitations: Due to challenges in counting parents and caregivers experiencing homelessness or who are undocumented, it is difficult to assess the sample size required to be representative. Interviews were conducted at organizations providing services and/or shelter to the participants. Findings may not be representative of unhoused or undocumented caregivers who are not receiving services or who live outside these organizations' service regions.

3. Community leader survey

The center and ETC Institute administered an email survey to community leaders. The survey included general questions about children's health priorities and the impact of Adverse Childhood Experiences (ACEs) in their communities. The distribution list included 1,002 representatives from city and county governments, county public health departments and agencies, nonprofit organizations, schools, faith-based organizations and clergy, health care, and business leaders. A total of 239 responses represented a 24% response rate. The percentages of survey respondents by role within the community and by primary county represented are included in Appendix 2.

Limitations: The sample represents community leaders at the eight-county level according to how we defined "community leader." However, findings are not representative of community leaders at the individual-county level. In addition, findings represent respondents' perceptions and opinions of children's health issues.

Qualitative data

1. Family/caregiver interviews

From January through March 2023 and February through March 2024, Community Health Workers (CHWs) from the center conducted 27 interviews with English and Spanish-speaking caregivers, totaling approximately 540 minutes spent with families. CHWs who had already built trust with the family/caregiver led the interviews. This provided an opportunity for caregivers to share additional information beyond questions on the parent/caregiver survey. Additional protocol information is available upon request.

2. Patient family interviews

From October through December 2023, Dr. Marc Mazade supported interviews with 4 caregivers of children seeking health care in the service area and who speak a language other than English and Spanish, totaling approximately 140 minutes spent with families. These interviews offered an important opportunity for caregivers to share their experiences navigating the North Texas health care system, identify obstacles to quality care, and provide information on ways to enhance family-centered care, particularly for immigrant families.

3. Community leader interviews

From November 2023 through January 2024, the center conducted 12 virtual interviews with community leaders across the eight-county service area, totaling approximately 720 minutes spent with leaders. Collaborating with community partners and program staff, participants were selected based on their expertise and varied roles within the community. Interviewees discussed pressing community issues or concerns, offering valuable context to complement the community leader and parent/caregiver survey findings. Priority topics discussed included mental health, ACEs, housing and food security, healthy lifestyles, injury prevention, and access to health care for all children.

Limitations for all qualitative interview methodology: Interview findings are contextual. The sample size is considerably smaller than the parent/caregiver survey and community leader survey sample size. For this reason, the findings from these methods serve as additional qualitative insight into survey findings rather than a statistically valid comparison. Limitations of interview methodology in general may also affect data quality. Findings may not be representative of all caregivers in the service area, those experiencing homelessness or who are undocumented, or community leaders at the individual-county level. In addition, findings represent respondents' perceptions and opinions of child health issues.

Secondary data

The University of North Texas Health Science Center at Fort Worth, College of Public Health conducted a comprehensive secondary data review from October 2023 through February 2024 using approximately 10 sources for each of the seven priority health issues to determine national, state, and local trends when available. This data provided a deeper understanding of complex social, economic, and environmental factors that influence child health outcomes at the individual and community levels.

External advisory committee

From 2022 through 2024, the center convened an external advisory committee consisting of 17 community partners across the eight-county service area. The committee helped create awareness of our surveys during data collection, some provided community leader interviews, and many of these individuals shared incredibly helpful feedback on CHNA materials. Committee members represented backgrounds in academia, public health, health care, local government, public school systems, and nonprofit organizations serving medically underserved or low-income families.

Meeting IRS requirements

Input provided through our community leader survey, community leader interviews, and external advisory committee fulfilled the following requirements:

- "Solicit and take into account input received from persons who represent the broad interests of that community, including those with special knowledge of or expertise in public health."¹
- "State, local, tribal, or regional governmental public health department (or equivalent department or agency), or a State Office of Rural Health described in Section 338J of the Public Health Services Act, with knowledge, information, or expertise relevant to the health needs of the community,"¹ served by Cook Children's.

Oversampling hard to reach areas for our parent/caregiver survey, face-to-face survey interviews, family/caregiver interviews, and patient family interviews fulfilled the following requirements:

- "Solicit and take into account input received from...members of medically underserved, low-income, and minority populations in the community served by the hospital facility, or individuals or organizations serving or representing the interests of these populations."¹
- Public comments were not incorporated into CHNA findings because none were received from Cook Children's email address created specifically for that purpose (CHNAFeedback@cookchildrens.org).

Our community served

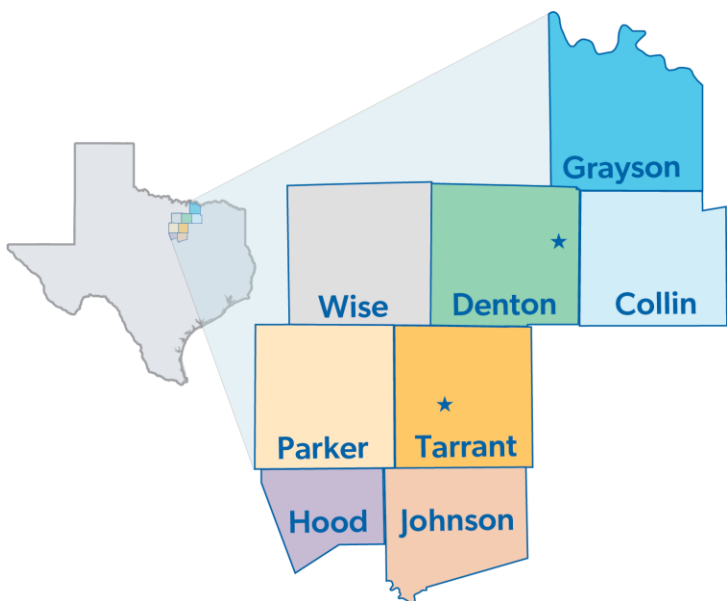
Description of service area

Cook Children’s defines its primary community served as the eight counties of Collin, Denton, Grayson, Hood, Johnson, Parker, Tarrant, and Wise within North Central Texas. This area is home to the **Cook Children’s Medical Centers in Fort Worth and Prosper**. Both medical centers define their community and population served characteristics to be the same. The findings presented here address insights for the combined eight counties, and notable findings for the Fort Worth Service Area (FWSA), Prosper Service Area (PSA), and individual counties. Denton County is included in both service areas due to its proximity to both campuses but is only represented once within the eight-county parent/caregiver survey results. The following section highlights select [Health Resources and Services Administration](#) characteristics of each of these counties.¹

Children and families within service area

Cook Children’s eight-county service area is home to a population of 4,711,284 people, and **1,181,591 (21%) of this population are children 17 years and younger**. The FWSA total population of 3,495,123 includes 877,448 children from birth to age 17, while the PSA total population of 2,131,031 includes 522,823 children from birth to age 17. Below are the number of children from birth to 17 within each county.² Details regarding each county are provided on the following pages.^{1,2}

Figure 3. Map of Cook Children’s eight-county service area

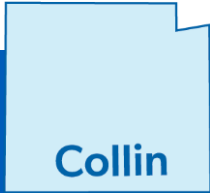


Fort Worth Service Area (FWSA: 877,448 children)

- Denton: 218,680
- Hood: 12,922
- Johnson: 46,951
- Parker: 37,266
- Tarrant: 544,440
- Wise: 17,189

Prosper Service Area (PSA: 522,823 children)

- Collin: 271,621
- Denton: 218,680
- Grayson: 32,522



Collin County

Cook Children’s PSA

Population Estimates

Total: **1,079,153**

Children under 18: **271,621**

FAMILY FINANCIALS

Median family income

\$140,962

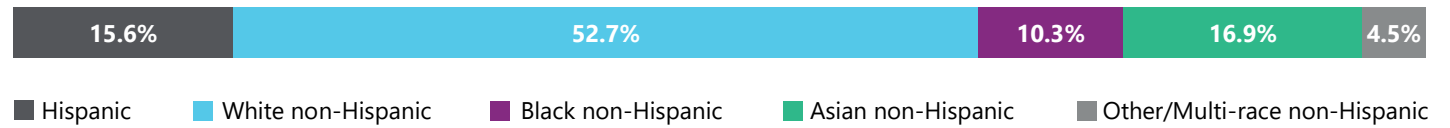
Children living below the poverty level

18,927 (7%)

Children in a household receiving Supplemental Security Income (SSI), cash public assistance, or food stamps/Supplemental Nutrition Assistance Program (SNAP)

20,685 (8%)

RACE & ETHNICITY



HEALTH PROVIDER SHORTAGE AREA

- Collin County has one population group as a designated **mental health** professional shortage area.



Denton County

Cook Children’s FWSA & PSA

Population Estimates

Total: **914,870**

Children under 18: **218,680**

FAMILY FINANCIALS

Median family income

\$130,127

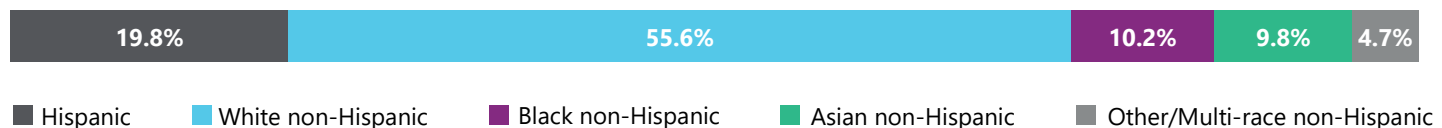
Children living below the poverty level

18,182 (8%)

Children in a household receiving SSI, cash public assistance, or food stamps/SNAP

29,167 (11%)

RACE & ETHNICITY



MEDICALLY UNDERSERVED AREA

- Primary care** poverty population area with a Governor’s Exception designation.

HEALTH PROVIDER SHORTAGE AREA

- Primary care, dental health, & mental health** facility shortage designation.
- Mental health** low-income population group designation.



Grayson

Cook Children's PSA

Population Estimates

Total: **137,008**

Children under 18: **32,522**

FAMILY FINANCIALS

Median family

\$73,993

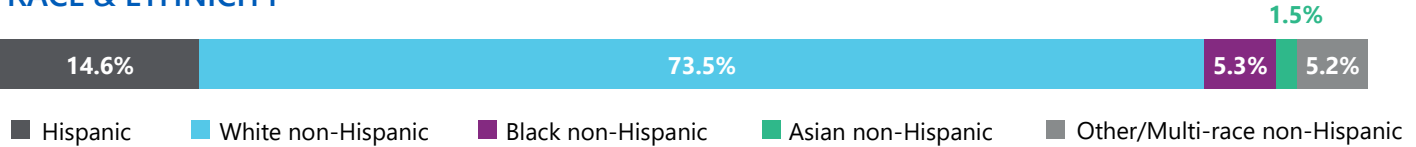
Children living below the poverty

5,071

Children in a household receiving SSI, cash public assistance, or food stamps/SNAP

6,513 (20%)

RACE & ETHNICITY



MEDICALLY UNDERSERVED POPULATION

- **Primary care** low-income designations.

HEALTH PROVIDER SHORTAGE AREA

- **Primary care & mental health** low-income population group designation.



Hood County

Cook Children's FWSA

Population Estimates

Total: **62,459**

Children under 18: **12,922**

FAMILY FINANCIALS

Median family

\$97,477

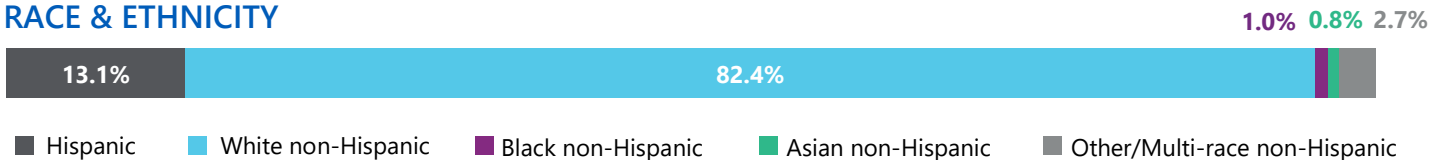
Children living below the poverty

1,481

Children in a household receiving SSI, cash public assistance, or food stamps/SNAP

1,998 (15%)

RACE & ETHNICITY



HEALTH PROVIDER SHORTAGE AREA

- Hood County has a geographic area designated **mental health** professional shortage area.



Johnson

Johnson

Cook Children's FWSA

Population Estimates

Total: **182,690**

Children under 18: **46,951**

FAMILY FINANCIALS

Median family

\$86,974

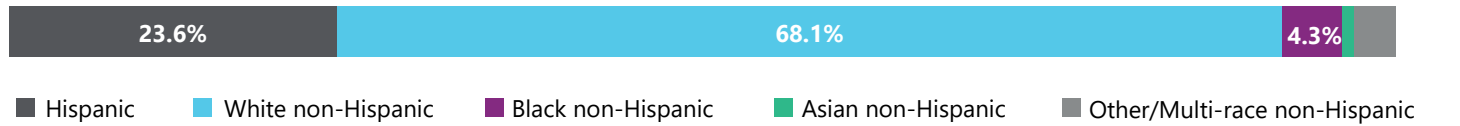
Children living below the poverty

6,462 (14%)

Children in a household receiving SSI, cash public assistance, or food stamps/SNAP

8,847 (19%)

RACE & ETHNICITY



HEALTH PROVIDER SHORTAGE AREA

- Johnson County has a population group designated **mental health** professional shortage area.



Parker

Parker County

Cook Children's FWSA

Population Estimates

Total: **151,188**

Children under 18: **37,266**

FAMILY FINANCIALS

Median family

\$116,678

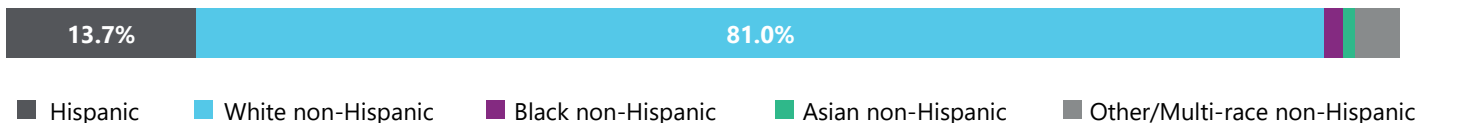
Children living below the poverty

3,221 (9%)

Children in a household receiving SSI, cash public assistance, or food stamps/SNAP

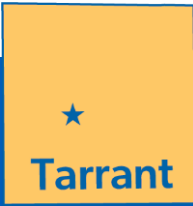
4,572 (12%)

RACE & ETHNICITY



HEALTH PROVIDER SHORTAGE AREA

- Primary care, dental health, & mental health** facility designation.
- Primary care & mental health** geographic area designation.



Tarrant County

Cook Children's FWSA

Population Estimates

Total: **2,113,854**

Children under 18: **544,440**

FAMILY FINANCIALS

Median family income



\$86,236

Children living below the poverty level



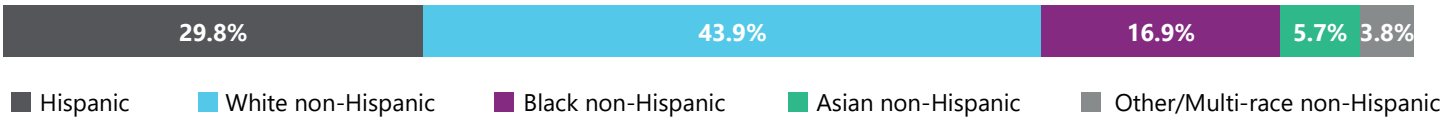
84,216 (16%)

Children in a household receiving SSI, cash public assistance, or food stamps/SNAP



128,315 (24%)

RACE & ETHNICITY



MEDICALLY UNDERSERVED AREA

- Two **primary care** designations.

MEDICALLY UNDERSERVED POPULATION

- **Primary care** low-income designation.

HEALTH PROVIDER SHORTAGE AREA

- Three **primary care, dental health, & mental health** facility designations.
- **Mental health** population group designation.



Wise County

Cook Children's FWSA

Population Estimates

Total: **70,062**

Children under 18: **17,189**

FAMILY FINANCIALS

Median family income



\$96,750

Children living below the poverty level



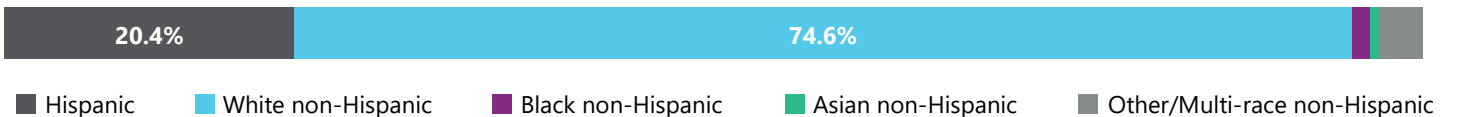
1,973 (12%)

Children in a household receiving SSI, cash public assistance, or food stamps/SNAP



3,788 (22%)

RACE & ETHNICITY



HEALTH PROVIDER SHORTAGE AREA

- **Primary care** low-income population group designation.
- **Mental health** geographic area designation.

Community challenges

Families in Cook Children's eight-county service area contend with a range of non-health care-related challenges that can impact a child's overall well-being. The factors presented below emerged consistently across our 2024 CHNA data collection methods and were substantiated through secondary research presented below. Recognizing their impact helps us gain a deeper understanding of the multifaceted challenges families face.



Inflation

From 2021 to 2022, families saw escalating prices impacting their essential needs. In November 2022, consumer prices increased by 7% compared to the previous year. Similarly, food costs have increased by 11%, gasoline prices have risen by 10%, rent has increased by 8%, and health care services are up by 4%.³ However, a majority of workers' wages are not keeping up with inflation. Recent studies show **inflation leads to significant stress** on personal and inter-personal levels, intensifies concerns for further price increases, and disproportionately impacts low-income households.⁴

Housing affordability

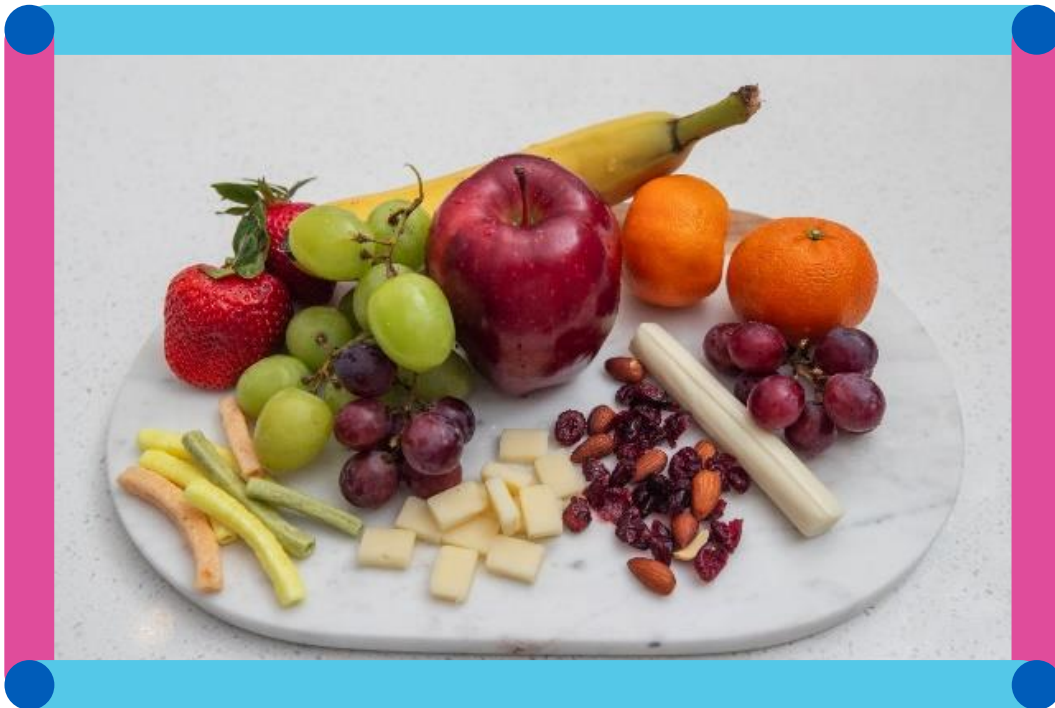
In the Dallas-Fort Worth Metroplex, approximately 1 in 10 homeowners and 1 in 4 renters **spend more than 50%** of their income on housing.⁵ From 2011 to 2019, Texas lost 49% of its low-rent units, ranking second in the nation for such losses. Currently only 16% of rental units in Texas are classified as low-rent.⁶ About 50% of renters and 25% of homeowners in Collin, Denton, and Tarrant Counties spend more than 30% of their income on rent.² When rent consumes a significant portion of income, families have less money for other essential needs, such as food, transportation, health care, and savings. Rent burden can lead to financial stress, housing instability, and in severe cases, homelessness, exacerbating socio-economic disparities.

Child care cost

Texas child care costs rose nearly 8% in 2020, stabilized in 2021, and increased by another 10% in 2022.⁷ Between 2020 and 2023, the average maximum childcare rate in North Texas increased by 48% (from \$17.5 to \$25.9), while in Tarrant County it rose by 51% (from \$25.9 to \$39.1).⁷ As of August 2023, a \$1,200 monthly budget in Fort Worth was **insufficient for high-quality childcare**, prompting some caregivers to leave their jobs.^{7,8} This situation not only affects families but also has a broader impact on the state's economy and children's development.⁹

Infant and maternal mortality

Infant and maternal mortality rates in North Texas remain a significant public health concern, reflecting broader challenges in access to health care, socioeconomic disparities and systemic inequities. In 2022, the Texas infant mortality rate was 5.72 per 1,000 live births, while most recent rates of counties in the Cook Children's service area are higher than the state including Hood (7.7), Grayson (7.4), and Tarrant (6.1) Counties.¹⁰ Infant mortality rates are highest among non-Hispanic Black infants. Additionally, the Texas maternal mortality ratio (MMR), without COVID-19 cases, was 23 per 100,000 live births, with non-Hispanic Black, women over the age of 40, and living in rural areas experiencing the highest rates.¹¹ Tarrant County has the **second-highest maternal mortality rate** among Black women in Texas (43.3 per 100,000 live births) leading to further address these issues in the service area.



Food insecurity

Individuals experiencing food insecurity lack regular access to nutritious food. About **1 in 5 children** are food insecure in the U.S., and Texas has the largest number of food insecure children in the nation (~1.7 million children).^{12,13} The rate and number of children experiencing food insecurity is the highest it's been since 2014, with the largest one-year increase since 2008.¹² The table below provides an overview of food insecurity metrics in the eight-county service area, in Texas, and nationally.¹³ Food insecurity will be further discussed in the healthy lifestyles section of this needs assessment.

Table 1. Food insecurity among children by population^a

	Food insecure child population	Prevalence of children who are food insecure (rate, %)	Average meal cost (\$)	Proportion of children in families with income eligible for federal nutrition programs ^b
By population				
U.S.	13,394,000	18.5	3.99	70%
Texas	1,697,870	22.8	3.45	65%
Cook Children's 8-county service area				
Collin	40,060	14.7	4.22	41%
Denton	34,320	15.7	4.16	44%
Grayson	7,390	22.7	3.77	72%
Hood	2,400	18.6	3.66	57%
Johnson	9,000	19.2	3.53	67%
Parker	5,890	15.8	3.81	49%
Tarrant	119,460	21.9	3.90	63%
Wise	3,260	18.9	3.84	61%

^aAdapted from Feeding America, 2022¹³

^bIncome at or below 185% of poverty level

Cook Children’s patients and facilities

In fiscal year 2024 (September-October), **Cook Children’s Medical Center in Fort Worth**¹⁴:

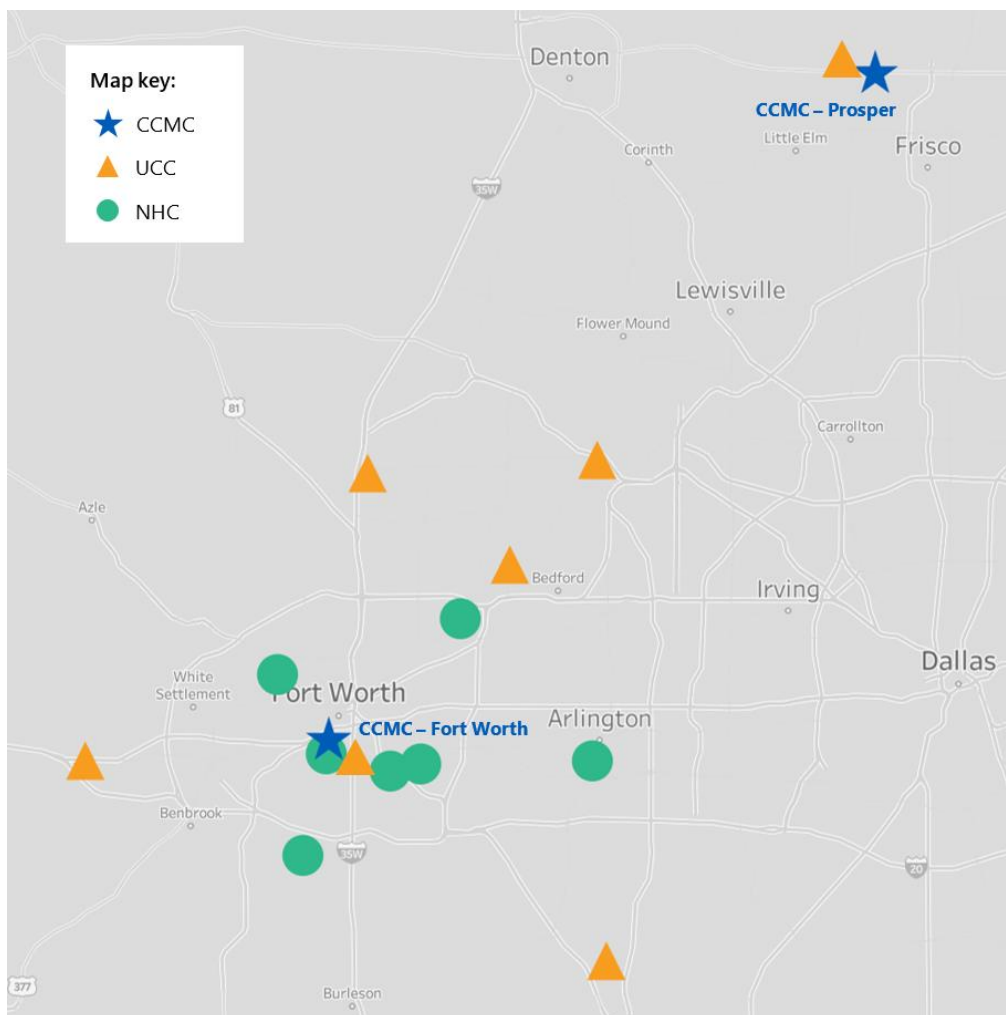
- Contained 462 licensed beds, with 453 beds staffed.
- Received 10,425 patient admissions with an average length of stay of 8.6 days.
- Provided 3,117 patient transports and 21,829 skilled home visits.
- Conducted 2,514 inpatient and 10,840 outpatient surgeries.

In fiscal year 2024, **Cook Children’s Medical Center in Prosper**¹⁴:

- Contained 37 licensed beds, with 31 beds staffed.
- Received 1,075 patient admissions with an average length of stay of 3.2 days.
- Conducted 139 inpatient and 705 outpatient surgeries.

System wide, Cook Children’s provided 386,429 visits at [Neighborhood Health Centers \(NHCs\)](#) and 225,464 visits at [Urgent Care Centers \(UCC\)](#) in medically underserved and low-income communities during fiscal years 2022 through 2024. Figure 4 demonstrates these NHCs in relation to the Cook Children’s Medical Center (CCMC) in Fort Worth and Prosper, and UCC. During fiscal year 2023 alone, the seven NHCs saw 133,194 patient visits total and more than 40% of those patients were on Cook Children’s Health Plan.¹⁴

Figure 4. Access to care for medically underserved and low-income communities



2024 CHNA findings

Introduction to priority health issues

The following sections of our 2024 CHNA findings are organized around the [priority health issues](#) identified and reprioritized by our Board of Trustees. After an overview of overall health and well-being in the eight-county service area, detailed findings are presented for each priority issue, highlighting those that affect the greatest number of children based on our parent/caregiver survey results. While each priority is addressed individually, the interconnected nature of these health issues underscores that all are equally significant.

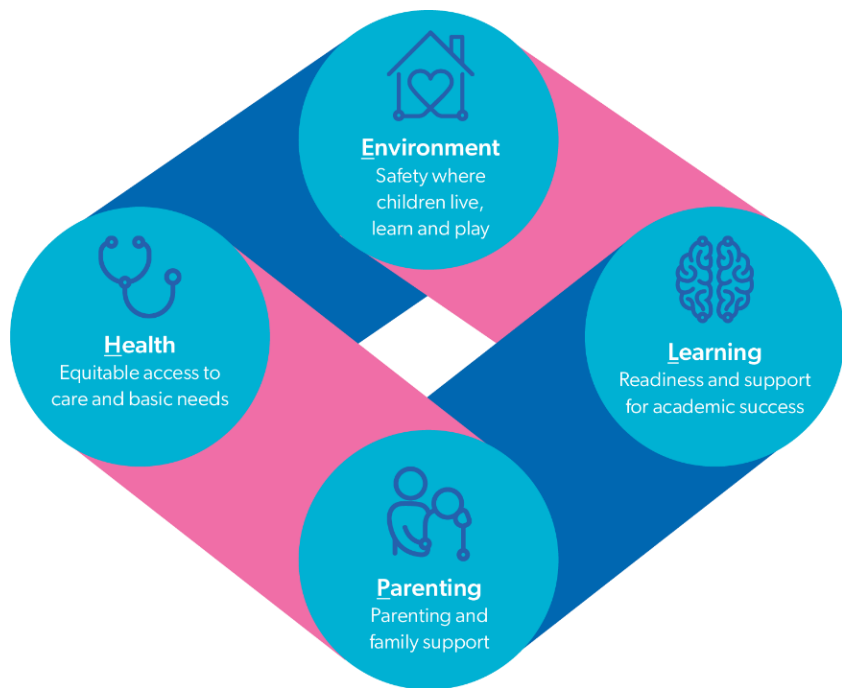
In the following priority health issue section, unless specified, results for the eight-county service area are from our 2024 parent/caregiver survey. Where relevant, findings are shared by Fort Worth Service Area (FWSA) and Prosper Service Area (PSA), or may emphasize results from specific counties.

- [Overall health and well-being](#)
- [Oral health](#)
- [Mental health](#)
- [Injury prevention](#)
- [Caregiver support](#)
- [Healthy lifestyles](#)
- [Asthma](#)

H.E.L.P. for health equity

This assessment recognizes the profound impact of non-medical drivers on children’s health and well-being, particularly for those from under-resourced families and communities. Key factors that influence the development, learning, and overall health of kids include: economic stability, access to quality education, neighborhoods and built environments, and social support networks. To further understand these challenges, we utilize the H.E.L.P. (Health, Environment, Learning, and Parenting) framework and integrate insights from caregivers and community leaders.

Figure 5. H.E.L.P. (Health, Environment, Learning, and Parenting) Framework



“Health equity is the state in which everyone has fair and just opportunity to attain their highest level of health.”¹

Overall health and well-being

Eight in 10 children in our eight-county service area have excellent or very good health.

Percentage of children who have excellent or very good health status

Benchmarks ¹	U.S.	NSCH (2022): 90%
	Texas	NSCH (2022): 87%
Service areas ² (2024)	8-county service area	84%
	FWSA // 6-county	84%
	PSA // 3-county	82%
Individual counties ² (2024)	Collin	84%
	Denton	80%
	Grayson	77%
	Hood	84%
	Johnson	87%
	Parker	88%
	Tarrant	85%
Wise	86%	

*Response options: excellent, very good, good, fair, or poor

Overview

Basics of overall health and well-being

A child's overall health encompasses a range of factors including physical, oral, and mental health. In the eight-county service area, the majority of children have excellent or very good health according to caregivers. This includes 84% of children (birth–17 years) for **overall health**, 72% of children (6–17 years) for **mental health**, and 71% of children (1–17 years) for **oral health**.² Ensuring that children receive care in all these areas helps to build a strong foundation for their future, fostering resilience and well-rounded growth. This overall health and well-being section will focus on a child's physical health, while the following sections will dive into other aspects of health (i.e., oral and mental health).

Preventive care

Pediatric preventive care can be very effective in influencing long-term health.³ In the eight-county service area, **89% of children (about 1,041,400)** received preventive care compared to 74% in Texas and 78% nationally.^{1,2} Caregivers across counties and demographics identified preventive health care as the **highest need** in health services for their children.²

Another vital part of preventive health care is childhood immunization status. Immunizations protect children from serious diseases such as measles, polio, pertussis (whooping cough), and help maintain community health.^{4,5} According to their caregiver, approximately **89% of children (about 1,022,200)** in the eight-county service area are up-to-date on vaccinations for their age (FWSA-89%, PSA-84%).² Similarly, **86% of children approaching school-age** (3 to 5 years) are up-to-date on vaccinations. While this vaccination rate seems high, and 58% of community leaders surveyed reported immunizations are accessible within their community, the percentage of caregivers reporting children are up-to-date on vaccinations has decreased by almost 8% from what caregivers reported in the 2021 CHNA (97%).^{2,6}

Vaccine hesitancy is a challenge where caregivers might feel uncertain about vaccinating their children. This uncertainty can come from worries about safety, mixed messages or different beliefs. Unfortunately, the COVID-19 pandemic has affected rates not only of COVID-19 vaccinations, but also the rates of other vaccines against preventable diseases. Pediatricians and other health care providers providing evidence-based information and having conversations caregivers can help them feel more comfortable and confident about utilizing vaccines to protect their children.⁴



“Cook Children’s physicians are unified in a continuing effort to vaccinate our patients. We collaborate with community immunization partners and remain committed to answering parents’ many questions about vaccine safety, vaccine schedules, dispelling misinformation, and overcoming vaccine hesitancy. Our goal is to have every vaccine-eligible child become fully vaccinated.”

—Marc Mazade, MD, MPH

Sick care

Inevitably, children will fall ill at some point, and while many of these instances are managed with minor medical intervention, some cases will require hospitalization. **Nearly 5 in 7 children (about 784,600)** in the eight-county service area saw a health care provider for sick-child care in the past year (FWSA-66%, PSA-71%). Additionally, nearly **1 in 5 children (about 217,600)** saw a health care provider for hospitalizations (FWSA-18%, PSA-23%).²

When asked about a child’s usual place of care, caregivers in the eight-county service area usually take their child to a doctor’s office first (73%), followed by a clinic or health center (13%), and then urgent care clinic (8%). **Only 3% of caregivers (about 35,000)** reported utilizing the hospital emergency rooms as a first stop for care; however, children experiencing homelessness or living with an undocumented family member were seven times more likely to visit a hospital emergency department when first sick.²

Family-centered care

Family-centered care is crucial for child health outcomes, as it not only supports the emotional well-being of both the child and their family but also improves communication and collaboration between health care providers and patients, leading to more tailored and responsive care strategies.⁷ In the eight-county service area, approximately **1 in 2 children (about 533,500)** always experienced family-centered care according to the five metrics highlighted in Table 2 below.²

In addition, a majority of caregivers (81%) shared they have one or more personal health care provider(s) they turn to when needing advice or care for their child. This percentage has slightly increased from 2021 (77%) after seeing a large decrease (19%) in prior CHNAs.^{2,6}

Table 2. Family-centered care experience for children birth to 17 by population^a

According to caregiver ^b	Spends enough time with child	Listen carefully to caregiver	Show sensitivity to family’s values and customs	Provide specific information needed for child	Help caregiver feel like a partner in child’s care	For all 5 metrics
By population						
NSCH: U.S. (2022)	60%	70%	72%	72%	73%	53%
NSCH: TX (2022)	52%	64%	65%	68%	68%	47%
8-county service area	63%	67%	65%	67%	65%	47%
FWSA // 6-county	65%	70%	70%	70%	69%	51%
PSA // 3-county	61%	65%	62%	63%	61%	42%
Unhoused & undocumented	57%	67%	64%	68%	71%	45%

^aIndividual health care providers for respondents are unknown

^bResponses are for those that responded always to listed metrics

Developmental delays and disabilities

Developmental delays and disabilities can significantly affect a child's learning, communication, and social skills, making early identification and intervention essential. Caregivers need to be aware of typical developmental milestones to recognize if their child is not meeting them. Early detection allows for timely interventions that can improve outcomes and help children reach their full potential.⁸ Health care providers and educators play a key role in supporting caregivers by helping them recognize early signs of developmental delays. Through regular check-ups, family-centered care, and screenings, they can guide caregivers in understanding what to watch for as their child grows.

In the eight-county service area, **39% of caregivers** have been asked by a health care provider if they have **concerns about their child's learning, development or behavior**. More specifically, 11% of caregivers have been informed by a health care provider or educator that their child has a developmental delay, 6% have been informed of an intellectual disability and 11% of a learning disability.²

Table 3. Delay and disabilities of children ages 3 to 17 by population, race/ethnicity, income, and age group

According to caregiver	Ever told has developmental delay	Ever told has intellectual disability	Ever told has learning disability
By population			
8-county service area	11%	6%	11%
FWSA // 6-county	11%	6%	12%
PSA // 3-county	11%	6%	10%
Unhoused & undocumented	11%	5%	11%
By race/ethnicity			
Hispanic	11%	6%	13%
White, non-Hispanic	10%	6%	10%
Black, non-Hispanic	11%	7%	13%
Asian, non-Hispanic	9%	6%	6%
Other/Multi-race, non-Hispanic ^a	18%	12%	21%
By income			
Under \$50K	16%	11%	16%
\$50K-\$99,999K	10%	5%	12%
\$100K-\$149,999K	8%	5%	9%
\$150,000+	10%	6%	12%
By age group			
Ages 3-5	14%	8%	9%
Ages 6-17	10%	6%	12%

^aOther/Multi-race: Non-Hispanic children whose parents or caregiver did not solely select white, Black or Asian on survey.

Gray highlight indicates small sample size; interpret the data with caution.

H.E.L.P. for health equity

Access to overall health care

Access to health care is fundamental for children, as it ensures they receive timely, preventive care and the support necessary for healthy development and well-being. Unfortunately, **1 in 4 children birth to age 17 (about 287,100)** in the eight-county service area did not receive all needed health services in the past year (i.e., forgone care; see Table 4).²

The top three reasons that contributed to a child not receiving needed health services include: (1) could not afford the cost of care (46%), (2) there were problems getting an appointment when the child needed one (42%), and (3) insurance did not cover some or all health care services (42%).²

Table 4. Children birth to age 17 unable to receive needed health services in the past year by population

According to caregiver	Forgone medical care	Forgone dental care	Forgone mental health services	Prescribed medications	Child received all care
By population					
8-county service area	12%	12%	7%	7%	76%
FWSA // 6-county	11%	12%	6%	6%	77%
PSA // 3-county	12%	11%	8%	7%	75%
Unhoused & undocumented	15%	27%	8%	4%	45%
Collin	14%	13%	10%	9%	73%
Denton	9%	10%	5%	4%	79%
Grayson	12%	12%	10%	11%	68%
Hood	13%	17%	6%	9%	72%
Johnson	11%	16%	5%	5%	75%
Parker	13%	14%	7%	8%	78%
Tarrant	12%	12%	6%	6%	76%
Wise	11%	14%	7%	7%	79%

Insurance coverage

Insurance coverage often acts as a barrier to care for children and families, limiting their access to essential health services and preventive care. In 2022, 11% of children did not have insurance in Texas compared to the national uninsured rate of 5%.⁹ **A majority of children (88%)** in the eight-county service area had continuous insurance or health coverage within the past year. The top three sources of medical insurance coverage were: (1) insurance through employer (68%), (2) Medicaid or CHIP for medical care (32%), and (3) medical assistance or any kind of government assistance plan (19%).²

However, 5% of children had a **gap in coverage** (about 54,700), and 7% are **currently uninsured** (about 81,400).² Children experiencing homelessness or living with an undocumented family member are approximately three times more likely to report being uninsured (23%). In the eight-county service area, caregivers of children that were not covered by health insurance in the past year shared the top three reasons were: (1) dropped coverage because it was unaffordable (35%), (2) problems with the renewal process (31%), and (3) change in employer or unemployment (29%).² In the 2021 CHNA, the top reason for a gap in insurance coverage was a change in employment or unemployment (48%), while issues with the renewal process accounted for 19%.⁶



Caregiver quotes

Across the eight-county service area, caregivers, families and leaders provided in-depth information regarding the challenges with access to care. A few quotes regarding access to care are shared below.

From family/caregiver interviews

- "If I had insurance it would be easier because not having insurance **gives me stress.**"
- "Not having a dependable working car to take my daughter to her appointment [makes it difficult to receive care]. Another challenge is having to **miss work.** I am a single parent so every day of work I miss affects my family."
- "Having other children **without childcare** makes it hard to keep appointments. Family appointments or childcare accommodations at the Doctor's office would be helpful."

From patient family interviews

- "**Language [challenges]** makes it difficult [to get health care for child] also the cost to take my children to the doctor is very expensive. We live with very limited resources, we only have money for our needs."
- "**I did not know how to get insurance.** So we usually just pay out of pocket at the doctor. A Vietnamese friend told me about Texas Benefits, but I still had to try to fill out the forms that were all in English and it was very difficult. I have no idea how to keep his insurance from lapsing."
- "After moving here from Afghanistan, it was **very difficult** at first to find a regular doctor. We had a really tough time. I talked to Medicaid [through a translator] and the Medicaid worker gave me the number of a provider."

From community leader interviews

- "The challenge is with **scheduling appointments,** arranging to take time off of work to transport the child back and forth, and insurance coverage. These are some of the layers of complexity that impact utilization of preventive health care. There tends to be a lot of catchup when it is time for back to school vaccines. The situation varies from family to family based on resources and ability."
- "Access is there. Using it is a matter of funds, insurance, Medicaid, etc. Do I have the time to take off from work? Do I have a vehicle to get us there? Those kinds of factors **impact access.**"
- "The health status of children depends in large part on their **access to insurance.** There are some resources to support children's health in the county if a family has insurance and access to services in other counties for more specialized care. But, for children whose families do not have insurance, the options are **very limited.**"

H.E.L.P. for health equity in overall health and well-being

The following table summarizes highlights from the parent/caregiver survey and caregiver interviews to better understand access to care and disparities in child overall health and well-being.



Health

Access to care and basic needs

One in 4 children (about 287,100) were unable to receive all needed health services including medical care (12%), dental care (12%), mental health services (7%), and prescribed medications (7%).

A majority of children (88%) in the eight-county service area had continuous insurance or health coverage within the past year; however, 5% (about 54,700) had a gap in coverage and 7% (about 81,400) are currently uninsured.



Environment

Safety where children live, learn, and play

Children experiencing homelessness or living with an undocumented member were nearly seven times more likely to report using an emergency room as a first stop for care. They're also three times more likely to report not having insurance coverage in the past year compared to other children in the eight-county service area.



Learning

Readiness and support for academic success

A majority of children (89%) ages 3 to 5 in the eight-county service area are ready to be in school based on their developmental growth and skill.

Approximately 3 in 4 school-age children (about 591,400) missed school due to physical illness and 3 in 5 school-age children (about 454,500) missed school due to medical appointments in the past year.



Parenting

Parenting and family support

Caregivers reported significant obstacles to care, including lack of insurance, high health care costs, and challenges securing childcare for their other children. Transportation difficulties, long distances to health care facilities, and limited appointment availability further compounded these issues. Many also highlighted the financial impact of missing work for appointments.

Non-English or non-Spanish speaking patient families interviewed expressed that language challenges in the health care setting made it at times impossible to understand urgent medical needs. They also highlighted confusion with the insurance process and the high cost of care.

Overall health and well-being training and collaboration opportunities

- Draw on the power of community partnerships to increase the reach for health care information and services to disproportionately impacted populations.
- Explore opportunities to connect families to permanent or stable housing solutions through our community health worker programs.
- Support partnerships with homeless shelters to provide a medical home and increase access to pediatric medical care for children experiencing homelessness.
- Serve as an active partner on collaborations to advocate for and improve the system of care for children with disparities.
- Address non-medical drivers of health, such as food insecurity, that impact the well-being of mothers and babies, while reducing overall health care costs through targeted support programs.
- Expand access to preventive care by providing access to women's health programs and enhancing their capacity to ensure timely care before, during and after pregnancy.
- Foster innovative approaches like telehealth services to reach rural areas and provide necessary resources to comprehensively support mothers and caregivers.
- Disseminate accurate vaccine information and education to the public.
- Collaboratively plan, host and promote community-wide events to increase access to immunizations.
- Assure access to vaccines for patients and communities and provide accurate, safe and timely immunizations.
- Advocate at regional, state, and national levels for strong immunization policies to protect children.



Oral health

Percentage of children ages 1 to 17 with good, fair, or poor condition of teeth

Benchmarks ¹	U.S.	NSCH (2022): 23%
	Texas	NSCH (2022): 27%
Service areas ² (2024)	8-county service area	29%
	FWSA // 6-county	28%
	PSA // 3-county	30%
Individual counties ² (2024)	Collin	30%
	Denton	30%
	Grayson	32%
	Hood	29%
	Johnson	24%
	Parker	23%
	Tarrant	28%
Wise	29%	

*Response options: excellent, very good, good, fair or poor

Two in 7 children in our eight-county service area do not have excellent or very good oral health.

Overview

Basics of oral health

Oral health is fundamental for a child's overall health and well-being. In the United States, the most common chronic—yet preventable—disease among children is cavities (also known as caries or tooth decay).³ Poor oral health can cause pain, infections, and difficulties with eating and speaking, negatively impacting a child's health and development. Additionally, children with poor oral health often suffer from lower self-esteem, miss more school days, and perform worse academically than their peers due to sleep disturbances, difficulty focusing and increased absenteeism.⁴

In the eight-county service area, approximately **5 in 7 children ages 1 to 17 (about 818,900)** have excellent or very good oral health. The majority of caregivers reported that their children engage in healthy oral hygiene behaviors, such as having their own toothbrush and brushing their teeth daily. However, in the past year, nearly **1 in 5 children (about 217,700)** have experienced chronic or frequent dental problems. Additionally, **1 in 5 school-age children (about 150,400)** have missed more than one day due to dental pain.²

The American Academy of Pediatric Dentistry (AAPD) recommends that children receive preventive dental care every six months—starting as early as one year old—to prevent oral health problems.⁵ Early oral health visits allow for the detection and treatment of diseases, provide caregivers with guidance on maintaining or improving their child's oral health, and reduce the need for invasive and costly dental care and emergency room visits.

In the eight-county service area, **20% of children ages 1 to 17 (about 220,900)** did not visit a dentist or other oral health professional for any care in the past year. Although overall rates are similar to Texas (21%) and national (18%) averages, four counties—Grayson (31%), Hood (25%), Wise (23%), and Collin (22%)—**exceeded** both the state and national rates.^{1,2}

Almost **25% of community leaders** surveyed indicated it is difficult for children to access preventive dental care and treatment for dental problems in their community. However, in alignment with AAPD recommendations, nearly **3 in 5** children (651,300 children) received two or more preventive dental care services (such as check-ups, dental cleanings, fluoride treatments), with those ages 7 to 12 most likely to meet these guidelines.²



“There are not enough providers, and of those that are available, not many families can afford to use them. Even more so, there is a lack of knowledge and awareness of the importance of oral health on the growth and development of a child.”

—Community leader interview

“I worried most about my child's oral health. Before Save a Smile's [oral health program at the center] help, she was in pain and I had no way of getting her to see a dentist.”*

—Family/caregiver interview

Children who do not have routine oral health services are at an increased risk of emergency dental visits, more invasive procedures and higher treatment costs.⁶ From 2021 to 2023, Cook Children’s Medical Centers in Fort Worth and Prosper treated and released 1,308 children after visiting the emergency department for dental problems; 326 were hospitalized, and 3,937 had a surgical procedure to treat a dental problem.⁷ These numbers underscore the importance of preventive dental care in avoiding any emergency room visits, hospitalizations, or surgical procedures.

Table 5. Oral health data of children ages 1 to 17 by population, race/ethnicity, and income

According to caregiver	One or more missed school days due to dental pain (6–17 years)	Did not have recommendation from medical professional for preventive dental care	Did not have a preventive dental care visit in the past year	Did not receive all needed dental care in the past year (forgone care)
By population				
8-county service area	19%	31%	16%	12%
FWSA // 6-county	18%	31%	15%	12%
PSA // 3-county	24%	30%	17%	12%
Unhoused & undocumented	10%	44%	30%	27%
Collin	20%	30%	19%	13%
Denton	27%	29%	14%	10%
Grayson	34%	37%	25%	12%
Hood	18%	38%	23%	17%
Johnson	19%	32%	20%	16%
Parker	17%	36%	18%	15%
Tarrant	15%	30%	15%	12%
Wise	18%	42%	22%	14%
By race/ethnicity				
Hispanic	14%	31%	16%	14%
White, non-Hispanic	22%	31%	17%	12%
Black, non-Hispanic	20%	27%	21%	12%
Asian, non-Hispanic	9%	30%	11%	7%
Other, non-Hispanic ^a	15%	37%	12%	12%
By income				
Under \$50K	23%	41%	28%	19%
\$50K-\$99,999	18%	33%	21%	15%
\$100K-\$149,999	24%	24%	13%	9%
\$150K or more	9%	25%	6%	8%

^aOther/Multi-race: Non-Hispanic children whose parents or caregiver did not solely select white, Black or Asian on survey.

Gray highlight indicates small sample size; interpret the data with caution.

*For more information about Save a Smile, please visit www.healthysmilesforkids.org

H.E.L.P. for health equity in oral health

The following table summarizes highlights from the parent/caregiver survey and caregiver interviews to better understand access to care and disparities in child oral health.



Health

Access to care and basic needs

Three in 10 children ages 1 to 4 (about 78,100) and 1 in 8 children ages 5 to 17 (about 107,400) did not have a preventive dental visit in the past year, which was most common among Black non-Hispanic and younger children.

One in 8 children ages 1 to 17 (about 139,600) was unable to receive all needed dental care in the previous year.

Three in 8 children ages 1 to 17 (about 378,900) are covered by private dental insurance and 1 in 4 children (about 254,400) are covered by Medicaid or CHIP for routine dental care, cleanings, X-rays, and examinations.



Environment

Safety where children live, learn, and play

Children ages 1 to 17 who are living in households with a family income below \$100,000 or who are experiencing homelessness or living with an undocumented caregiver are more likely to report not having preventive dental care visits and not receiving needed dental care compared to other children in the eight-county service area.



Learning

Readiness and support for academic success

One in 10 school-age children (about 86,100) has fair or poor oral health, making them twice as likely to miss school due to dental problems. Black and White non-Hispanic children were more likely to report more missed days of school due to dental problems than other races.



Parenting

Parenting and family support

Caregivers shared difficulties accessing dental care, including long wait times for appointments, challenges taking time off work, concerns about treatment costs, and inadequate dental insurance coverage.

Oral health training and collaboration opportunities

Medical-dental integration

Since children visit pediatricians more frequently than dentists, collaboration between medical and dental professionals has emerged as an evidence-based practice to improve overall health outcomes for children through screening and education.⁸ In the eight-county service area, **nearly 2 in 3 children (about 776,400)** had a medical professional recommend regular dental checkups for preventive care, and **nearly 1 in 3 children (about 399,200)** were advised to visit a dentist for a dental problem (e.g., dental pain, cavities).² Medical-dental integration has been shown to reduce oral health disparities, especially among under-resourced populations.⁸

Cook Children’s Neighborhood Health Center–Renaissance, located in Fort Worth, is a pediatric medical and dental clinic. For more than 10 years, Renaissance has offered medical and dental services under one roof, and provides additional coordinated care to help remove obstacles to care for families. This integration of general and oral health services ultimately enhances a child’s overall well-being by providing comprehensive care in a convenient setting. Additionally, having both types of care in one location fosters better communication between medical and dental professionals, leading to more coordinated and effective treatment plans for children.

Awareness and education

In the eight-county service area, about **62% of children (about 726,200)** have a caregiver who is unaware a child should have their first dental visit **by age one**. Additionally, **31% of children** did not have a medical professional recommend regular dental checkup for preventative care.² Health care professionals, public health professionals, community health workers, educators, school administrators, and other community leaders need to be continually educated on the importance of child oral health and prevention strategies.

An often-overlooked opportunity for education and awareness is during prenatal care. During pregnancy, oral health conditions like dental caries, gingivitis, and periodontitis are more common, potentially affecting the health of both the mother and baby.⁹ Obstetrician-gynecologists and other health care professionals can play a vital role in educating all patients about the significance of oral health, particularly during the prenatal and postpartum periods. Increased awareness can contribute to better health outcomes for both the mother and baby.

Additional strategies to improve child oral health include:

- Improve access to preventive dental care and prompt treatment, especially for children who have higher rates of oral health disease. Enlist the services of community health workers and other sources who can establish trust with families and provide coordinated care services.
- Provide evidence-based education to caregivers and professionals, focusing on the importance of oral health to overall health, the need to seek preventive care before age one, and how to access community resources.
- Raise awareness in the community about good oral health practices and the importance of accessing care.
- Support community awareness campaigns, events, and advocacy efforts to encourage good oral health practices and access to care.
- Provide evidence-based professional development for health care providers, school nurses, and community partners targeting services to populations with higher rates of oral health disease.
- Explore and address obstacles to oral health care for pregnant teens and women.
- Explore potential medical-dental integration opportunities to enhance coordinated care services.
- Facilitate tracking of community-level oral health screening outcomes to monitor progress.

Mental health

Percentage of children ages 6 to 17 with at least 1 commonly diagnosed mental health condition*

Benchmarks ¹	U.S.	NSCH (2022): 26%
	Texas	NSCH (2022): 29%
Service areas ² (2024)	8-county service area	29%
	FWSA // 6-county	29%
	PSA // 3-county	26%
Individual counties ² (2024)	Collin	27%
	Denton	25%
	Grayson	28%
	Hood	36%
	Johnson	35%
	Parker	29%
	Tarrant	31%
	Wise	28%

*Conditions: anxiety, depression, behavioral/conduct problems or ADHD

Two in 7 children in our eight-county service area has at least one of the four most commonly diagnosed mental health conditions.

Overview

Basics of mental health

The declaration of a National State of Emergency in Child and Adolescent Mental Health by the major pediatric health organizations remains a pressing issue today.³ Children’s mental health is a strong determinant of overall quality of life and involves a child’s ability to reach certain developmental and emotional milestones, engage with others in social settings, and cope with challenges that may arise.

The Centers for Disease Control and Prevention (CDC) estimates nearly 1 out of every 5 children in the United States will experience a mental health disorder each year.⁴ The four most commonly diagnosed mental health disorders in children are attention-deficit/hyperactivity disorder (ADHD), anxiety, behavioral problems, and depression. In the eight-county service area, **nearly 2 in 7 children ages 6 to 17 (about 237,000)** has a diagnosed mental health need with the **top two** reported diagnosed mental health conditions being anxiety and attention deficit disorder or attention deficit/hyperactivity disorder (ADD/ADHD).² The local rates of each of the most commonly diagnosed conditions are outlined in Table 6.

Across the eight-county service area, every community leader interviewed reported mental health care or counseling for behavioral/emotional concerns as the most needed health service in their community.

Table 6. Mental health diagnoses of school-age children ages 6 to 17 by population, race/ethnicity, and income

According to caregiver	Diagnosed with at least 1 of the 4 most common disorders	Ever told has ADHD	Ever told has anxiety	Ever told has depression	Ever told has behavioral or conduct problems
By population					
NSCH: U.S. (2022)	26%	14%	15%	7%	10%
NSCH: TX (2022)	29%	16%	13%	5%	13%
8-county service area	29%	16%	17%	10%	13%
FWSA // 6-county	29%	16%	18%	10%	13%
PSA // 3-county	26%	14%	15%	10%	12%
Unhoused & undocumented	23%	11%	12%	8%	13%
By race/ethnicity					
Hispanic	29%	18%	17%	10%	13%
White, non-Hispanic	30%	16%	18%	10%	13%
Black, non-Hispanic	29%	10%	16%	10%	15%
Asian, non-Hispanic	10%	6%	8%	5%	7%
Other/Multi-race, non-Hispanic ^a	37%	29%	26%	13%	19%
By income					
Under \$50K	33%	17%	20%	15%	16%
\$50,000–\$99,999	30%	15%	20%	10%	14%
\$100,000–\$149,999	24%	12%	14%	6%	11%
\$150K or more	32%	22%	18%	11%	13%

^aOther/Multi-race: Non-Hispanic children whose parents or caregiver did not solely select white, Black or Asian on survey.

Gray highlight indicates small sample size; interpret the data with caution.

Undiagnosed mental health disorders

Undiagnosed mental health disorders can disrupt many aspects of a child’s life. Symptoms for mental health disorders may begin in early childhood, but many do not occur until reaching adolescence.⁴ Because symptoms of mental disorders in children vary from those exhibited in adults, it can be difficult for all cases to be adequately diagnosed. In addition, existing misconceptions and stigma can result in undiagnosed conditions. Undiagnosed or untreated mental health disorders can lead to:

- Disruptions in children’s education including higher rates of school absences, needing to repeat grades and dropout.⁵
- Long-term involvement with the criminal justice system.⁶
- Higher risk of developing a substance use disorder.⁷
- Self-harm or suicide.⁸

Impact of trauma on mental health

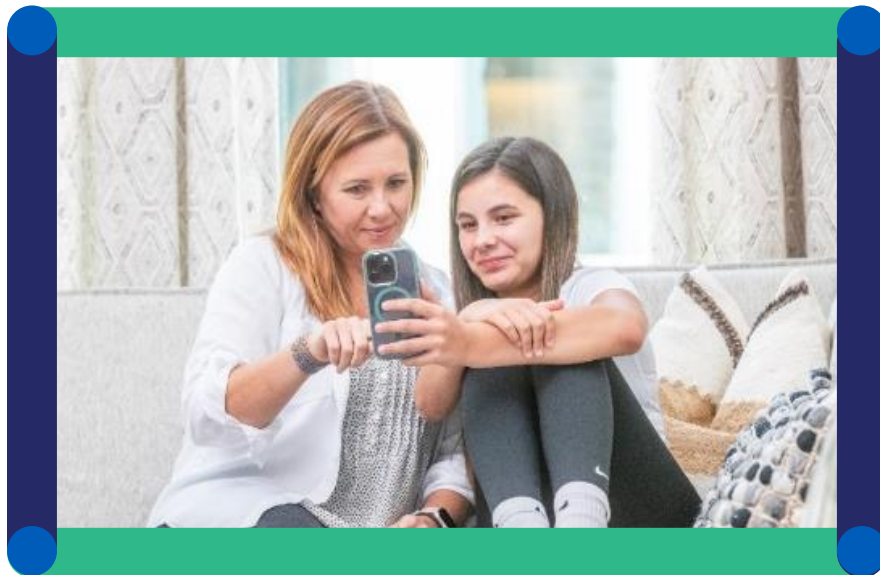
Childhood trauma refers to the distressing experiences that children face when exposed to events or situations that affect them emotionally and physically. Trauma can include natural disasters, Adverse Childhood Experiences (ACEs), violence and abuse, and other types of accidents.⁹ Children and adolescents can have a number of responses to traumatic events, including showing regression in developmental stages, increasing behavioral issues, and developing mental health conditions such as depression, anxiety, suicidal thoughts and self-harm.

Substance use and self-harm

Research indicates a strong correlation between mental health conditions and substance use among children and adolescents.^{10,11} Children and adolescents with mental health disorders are more likely to engage in drug and alcohol use to cope with their emotions and feelings, and are at an increased risk for developing a substance use disorder in the future.^{7,11} On the other hand, substance use is also a risk factor for triggering mental health conditions.¹¹

In addition, self-injury (e.g., self-harm, self-abuse) and suicide is a rising concern. Self-injury is associated with mental health conditions and is often used by adolescents to overcome emotions.¹² Children and adolescents who self-injure are more likely to attempt suicide. Suicide is the **second leading cause of death among adolescents ages 10 to 14**, and the third leading cause of death among those ages 15 to 24 in the United States.⁵ From 2021 to 2023, Cook Children's Medical Centers in Fort Worth and Prosper treated 638 non-fatal self-harm patients in the emergency room and 837 patients were hospitalized.¹³

When a child arrives for a medical complaint at Cook Children's Emergency Department (ED) in Fort Worth, every patient ages 8 and older is screened for suicide risk. Cook Children's ED nurse manager Kara Dorman, RN, BSN and ED chaplain Cameron Brown D.Min., M.Div., BSSW shared: "From January 2022 through December 2023, our ED nurses screened 64,602 *medical, non-behavioral health* patients, identified 4,399 children who were *struggling with sadness and worry*, 1,353 children who were *at risk for suicide*, and 46 who were *currently suicidal*, but they were visiting our ED for a medical complaint, not a behavioral concern." Dorman and Brown further explained: "These children, who sought care for medical complaints on arrival to our ED, received additional resources they needed due to **our ED nurses' diligent screening and care.**"



Social media and mental health

In June 2024, the U.S. Surgeon General called for a warning label to be placed on social media platforms, advising parents that using the platforms might damage youth mental health—expanding on the previous mental health advisory.¹⁴ In the eight-county service area, only half of children have a caregiver who reported they are always in communication with their child about internet safety.² Research studies show there is a connection between heavy social media use and increased rates of anxiety, depression, loneliness and body-image issues.^{15,16} However, limited social media use has been shown to provide positive community and connection for youth, leading to the need to further understand how social media can impact children.¹⁶



“We now have significant evidence-based research that has shown the harmful impact of too much screen time, whether that is video games, mindless games on a screen, YouTube, social media etc. The negative impact is profound, permanently damaging the structure and functionality of our brains, not to mention we have proof of technology addiction. And if this is not alarming enough, we have evidence that supports impairment in emotional and social intelligence; severely impacting relationships. This is only highlighting the most significant areas – others include disrupted sleep, learning and memory impairments, increased risk to severe bullying and safety in general. These risks impact not only our children and teens but adults as well.

It is critical that parents have discussions with their kids weekly about phone use, to check their devices, to stay educated about technology, put safeguards and contracts for device use in place and even more importantly to model healthy screen use with their kids.”

—Dr. Lisa Elliott, PhD

Impact of child’s sexual identity

Research on child sexual identity and mental health continues to emerge, shedding light on the experiences and needs of children. Anxiety and depression often disproportionately affect LGBTQ+ children.¹⁷ Nearly half of LGBTQ+ youth have had thoughts of suicide and they are nearly four times more likely to attempt suicide than heterosexual youth.³ Across the eight-county service area, **3% of children (about 24,500)** have a caregiver who indicated their child has been treated or judged unfairly because of their sexual orientation and gender identity. A larger percentage (27%) of community leaders indicated sexual orientation and gender identity discrimination was a serious problem for children in their community.²

Long-term effects of COVID-19

The COVID-19 pandemic has had a significant and enduring impact on children and adolescents’ mental health. Rates of clinically elevated depression (13% to 25%) and anxiety (12% to 21%) among children and adolescents have doubled since the pandemic began,¹⁸ with marginalized groups disproportionately affected.¹⁹ Other child health outcomes associated with the COVID-19 lockdowns include loneliness, psychological distress, anger, irritability, boredom, fear, stress, and reactivation of previous eating disorders.²⁰ Although the pandemic has ended, the challenges that persist for children will continue into the future.

H.E.L.P. for health equity

Access to mental health care

According to community leaders surveyed, **approximately 69%** expressed children have difficulties accessing mental health care or counseling services in their community. More specifics related to mental health care access are highlighted in Table 7 below.

Table 7. Mental health access to care for children ages 6 to 17 by population, race/ethnicity, and income

According to caregiver	Needed mental health treatment or counseling	Experienced difficulty accessing needed care	Not possible to get needed mental health treatment or counseling
By population			
NSCH: U.S. (2022)	N/A	50%	5%
NSCH: TX (2022)	N/A	45%	3%
8-county service area	269,703 (36%)	129,526 (48%)	15,346 (6%)
FWSA // 6-county	186,542 (34%)	92,688 (50%)	10,590 (6%)
PSA // 3-county	125,202 (37%)	58,715 (47%)	7,586 (6%)
Unhoused & undocumented	N/A	19%	17%
By race/ethnicity			
Hispanic	47,736 (18%)	25,867 (54%)	4,709 (10%)
White, non-Hispanic	155,028 (58%)	74,429 (48%)	6,201 (4%)
Black, non-Hispanic	33,690 (13%)	11,893 (35%)	1,769 (5%)
Asian, non-Hispanic	9,309 (4%)	4,481 (48%)	411 (4%)
Other/Multi-race, non-Hispanic ^a	20,270 (8%)	11,524 (57%)	2,256 (11%)
By income			
Under \$50K	60,341 (24%)	36,321 (60%)	3,770 (6%)
\$50K-\$99,999	61,423 (25%)	27,295 (44%)	4,036 (7%)
\$100K-\$149,999	85,201 (34%)	31,181 (37%)	3,468 (4%)
\$150K or more	42,059 (17%)	21,937 (52%)	3,401 (8%)

^aOther/Multi-race: Non-Hispanic children whose parents or caregiver did not solely select white, Black or Asian on survey.

Gray highlight indicates small sample size; interpret the data with caution.

H.E.L.P. for health equity in mental health

The following table summarizes highlights from the parent/caregiver survey and caregiver interviews to better understand access to care and disparities in child mental health.



Health

Access to care and basic needs

Of the approximately 269,700 school-age children who needed mental health treatment or counseling, 48% have a caregiver who experienced difficulty getting care for their child, and 6% were unable to get needed care. Hispanic and Other/Multi-race non-Hispanic children were more likely to report experiencing difficulty receiving needed mental health treatment or counseling compared to other races.



Environment

Safety where children live, learn, and play

Mental health diagnoses in children transcend geographic, race/ethnicity, and economic boundaries, affecting children from all backgrounds and underscoring the urgent, widespread nature of the mental health challenges.



Learning

Readiness and support for academic success

Nearly 1 in 5 school-age children (about 146,900) have missed more than one day of school due to mental or emotional concerns, 2 in 5 (about 304,100) have been bullied at school, and 1 in 8 (about 103,500) does not care about doing well in school.



Parenting

Parenting and family support

Only 1 in 3 school-age children (about 252,000) have a caregiver who reported being asked by their health care provider or educator if they had concerns about their child's mental health. In addition, only 2 in 5 children (about 288,900) have a caregiver who reported being asked if they had concerns about their child's learning, development, or behavior.

Nearly 1 in 3 school-age children (about 237,900) have a caregiver who reported they were somewhat unfamiliar or not familiar at all with mental health services in their community.

Mental health training and collaboration opportunities

Signs of mental health conditions

Teaching caregivers, teachers, health care providers and others that have close interactions with children to identify early warning signs of mental health conditions is critical in getting them timely mental health care. Signs can include:²¹

Younger children

- Often fearful or worried.
- Complain about frequent stomachaches or headaches with no medical cause.
- Not interested in playing with other children or has difficulty making friends.
- Struggle academically or recent decline in grades.
- Sleep too much or too little, frequent nightmares, or sleep during the day.

Older children and adolescents

- Lost interest in previous activities enjoyed.
- Low energy.
- Sleep too much or too little.
- Spend more time alone and avoid activities with friends or family.
- Diet or exercise excessively.
- Engage in self-harm behaviors.
- Have thoughts of suicide.
- Substance use.

Leaves on Trees

By Everly

"My feelings are like leaves on a tree. They fall and grow back, and some are bigger than others."



Tangled Octopus

By Adalynn

"It shows how feelings can mix up and how to talk about it."



The Opposite of Me

By Rickard

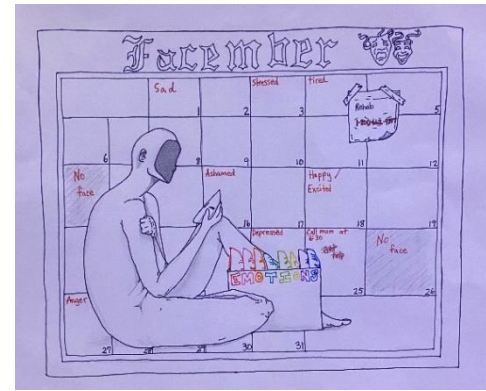
"My brain tells me that I am not good enough even though I know I am smart. That feeling changes my mood into anger. It makes me not smart at the moment because I can't think straight."



The Face of the Day

By Fabian

"People have a lot of different faces they put on, to hide real emotions of how they feel from others. You never know what someone could be really going through in their lives and how it makes them feel."



Understanding of resources

Nearly **2 in 3 children ages birth to 17 (about 739,100)** have a caregiver who is not very familiar with mental health services in the community.² Organizations across communities, including schools, non-profit organizations, hospital systems, faith-based organizations, and others can work to help connect families to mental health resources that are available in the community.

Additionally, working together to facilitate evidence-based conversations surrounding mental health can help reduce the associated stigma and misconceptions. By promoting informed discussions, individuals and organizations can create a more understanding and supportive environment for children affected by mental health disorders.

Mental health collaboration strategies

Community organizations have been diligently working to address child mental health issues. The impact of the COVID-19 pandemic and the U.S. Surgeon General mental health warnings have brought greater publicity to this issue and highlighted the need for collaborative efforts. Strategies for collaborative community action based on CHNA findings include:

- Improve access to prompt mental health care and treatment.
- Add family support services from trusted peer advocates to delivery of mental health care.
- Provide support to mental health providers as they work to address this crisis by reaching out to determine exactly what support they need, offering opportunities for professional development and for care coordination through networking.
- Support organizations in capacity building to form impactful and sustainable mental health practices and policies.
- Support local school districts in providing comprehensive, evidence-based mental health training for all staff who interact with students, equipping them to recognize signs of mental health and substance use challenges and how to provide support and resources to students.
- Provide professional development opportunities for mental health providers who will share skills, knowledge, and tools with colleagues and caregivers within their reach.
- Provide caregiver and community training on the signs of mental health disorders in children, building healthy coping skills, accessing care, and available resources.
- Raise community awareness about the importance of resiliency and treating mental health disorders, the danger of suicide in children with mental health disorders, and how to help children struggling with these conditions.
- Provide education around social media use in children.
- Expand the reach of mental health messaging to strengthen connections between families, health care, and community resources to help reduce the stigma associated with mental health disorders and treatment.

Injury prevention

One in 5 children in our eight-county service area received emergency care for an accidental injury.

Percentage of children who received emergency care for accidental injury

Benchmarks ¹	U.S.	NSCH (2022): N/A
	Texas	NSCH (2022): N/A
Service areas ² (2024)	8-county service area	20%
	FWSA // 6-county	18%
	PSA // 3-county	25%
Individual counties ² (2024)	Collin	25%
	Denton	23%
	Grayson	34%
	Hood	24%
	Johnson	17%
	Parker	17%
	Tarrant	16%
	Wise	23%

N/A= No corresponding injury prevention data from the National Survey of Children’s Health

Overview

Basics of injury prevention

Unintentional injuries, also known as accidental injuries, includes both nonfatal and fatal injuries that occur without deliberate intent to cause harm.³ Unintentional injuries remain a leading threat to the safety of children and teens in the United States.⁴ According to the CDC, unintentional injuries are the leading cause of death for youth ages 1 to 17.⁵ Age-specific patterns for unintentional injury include:

- **Infants (under 1 year old):** Suffocation-related fatalities, mostly due to unsafe sleep environments.
- **Children ages 1-4:** Drowning.
- **Children ages 5-17:** Motor vehicle accidents.

Nonfatal, unintentional injuries place significant mental, physical, and financial burdens on children and their families. Children who suffer unintentional injuries often miss time from school, not only disrupting their education but also placing additional strain on caregivers, who may struggle with missed work. In the eight-county service area, approximately **1 in 5 children ages birth to 17 (about 233,300)** received emergency care for an unintentional injury and **1 in 5 school-age children (about 153,500)** missed more than one day of school due to accidental injury.²

Drowning

Drowning is a leading cause of unintentional injury, with children between the ages 1 to 4 at the highest risk. In drowning incidents, every second counts; it is silent and can happen in an instant.

From 2021 to 2023, Cook Children’s Medical Centers in Fort Worth and Prosper treated 224 drowning related injuries that occurred in bathtubs, open water (i.e. lakes, rivers, ponds), and pools or hot tubs. Of the drowning-related injuries, 85% were pool/hot tub related, and 8% were fatal, with a majority of fatalities occurring with children ages birth to 4 (80%) and the remainder ages 5 to 11.⁶

Bathtub safety

In the eight-county service area, **1 in 5 children (about 50,800)** between the ages of 1 to 4 were not always within reach of an adult during bath time.² To prevent bathtub drownings, it is important for caregivers to:

- Ensure an adult stays at the side of the tub in reach of the child.
- Avoid multi-tasking.
- Ignore distractions (doorbell or phone calls).
- Drain the tub after each use.
- Be prepared with all needed supplies.
- Safe proof the home so young children cannot access the bathroom without an adult.

Pool and open water safety

While children between the ages of 1 to 4 are at the highest risk for drowning in pools, older children—even those who are confident swimmers—are also at risk. In the eight-county service area, approximately **1 in 6 children between the ages 1 to 4 (about 43,300)** are not always in reach of an adult when swimming. For children between the ages 5 to 11, nearly 2 in 7 children (about 117,700) are not always supervised and only approximately **1 in 3 children (about 148,100) always wear a life jacket** around water or pools. Additionally, only **1 in 2 children (about 165,600)** between the ages 12 to 17 always wears a life jacket when around lakes or open water.

To prevent drownings in pools and open water, it is important for caregivers to⁷:

Pool and open water	Always wear life vests with U.S. Coast Guard-approved labels. Designate an adult to be a “water watcher” and be in reach and supervise at all times.
Pool	Install safety measures such as fences and gates around pool. Limit access, install barriers, and door alarms.
Open water	Have a safety plan in place. Know the water conditions and avoid risky behavior.

Firearm accidents

In June 2024, the U.S. Surgeon General issued an advisory on the public health crisis of firearm violence in the United States.⁸ In 2022, firearm injuries were the **leading cause of death** among children and teens ages 1 to 19.^{9,10}

From 2021 to 2023, Cook Children’s treated 23 patients for injuries related to firearms and handguns and 44 patients for injuries related to other gun types (i.e., bb guns, airsoft guns).⁶ Of households with guns in the eight-county service area, approximately **1 in 5 children (about 120,300)** live in a home with guns that are **not always safely locked away**.²

Dan Guzman, MD., pediatric emergency medicine physician and founder of the Aim for Safety™ Program, says: “Unfortunately, we see this tragedy [unintended fatal shootings] many times a year in our ED at Cook Children’s, which has long-lasting effects on families and staff.” Dr. Guzman says the most secure place for your firearm is in a safe with the ammunition stored separately. If you are unable to purchase a gun safe, then separating the ammunition from the firearm and using a cable or trigger lock will help reduce the risk of unintentional injury to your child.¹¹

Motor vehicle crashes

In 2022, the U.S. Department of Transportation released the National Roadway Safety Strategy to address the crisis of injuries and deaths on the roadways.¹² The leading cause of motor vehicle injuries and fatalities is human behavior—particularly, speeding, distracted driving (e.g., phone use), and driving under the influence of drugs or alcohol.¹³ The risk of severe injuries and fatalities in motor vehicle crashes can be greatly reduced by ensuring that children are **correctly secured in car seats, booster seats, or seat belts** that are appropriate for their age and size. For example, compared to using seat belts alone, car seats can reduce the risk for injury in a crash by 71% to 82% for children, with age appropriate prevention methods showing similar results.¹³

From 2021 to 2023, Cook Children’s Medical Centers in Fort Worth and Prosper treated 2,366 non-fatal injuries related to motor vehicle crashes and 611 injuries related to ATV or off-road vehicle injuries.⁶

In the eight-county service area, approximately **3 in 4 children (about 200,150)** between the ages of 1 and 4 always ride in a car seat and nearly 1 in 2 (188,600) children between the ages 5 and 11 always ride in a car seat or booster seat.² With a decrease in children using a car or booster seat between the ages of 5 to 11, it is important for caregivers to be aware of the **appropriate child restraint** in a booster seat until a child can safely transition to a seat belt.



Poisoning

Children of all ages are at risk of poisoning for different reasons. Infants are often incorrectly dosed with medications, toddlers are interested in exploring and mistake poison for juice or candy, school-age children may mistakenly take medication without supervision, and teens are exposed to social media and peer pressure leading to the use of substances that are not prescribed to them. In the eight-county service area, **1 in 2 children (about 570,400)** live in homes where medications are not always locked up and **4 in 7 children (about 618,500)** where cleaning products are not always stored in a locked area.²

Between 2021 and 2023, Cook Children’s Medical Centers in Fort Worth and Prosper treated 1,696 children with unintentional non-fatal injuries due to poisoning, with 1,270 poisonings related to medication/illicit drugs and 426 related to other substances/materials (i.e., cleaning and household products).⁶ In alignment with the literature, Cook Children’s has seen a rise in drug poisonings related to cannabis (222 patients) and opioids (54 patients).^{6,14,15}

Fentanyl

Fentanyl, a synthetic opioid, poses a **significant danger to children** due to the small amount that can cause an accidental overdose. Children and teens are exposed unknowingly, which has led to pediatric deaths across the United States, with a majority of deaths coming from teens ages 15-19 years.^{16,17} Caregiver communication with children is important in raising awareness about the dangers of substance use, including the dangers of fentanyl. Approximately **half of children** in the eight-county service area between the ages of 12 and 17 are always talking with their caregiver about drugs and alcohol.²



Medications come in all different shapes and sizes, often look like candy, and are made to taste good. They can even be liquid and gummies, over the counter, prescribed, or even “fake.” It is vitally important to talk to kids about medication safety, which includes use, storage, and disposal. They should only take medicines prescribed by a physician, given by a nurse, or trusted adult. Counterfeit medications may be laced with dangerous substances that can be life threatening and not worth the risk.

—Dr. Artee Gandhi, MD

Unsafe sleep environments

Sudden Unexpected Infant Death (SUID) is a tragic event often resulting from unsafe sleep environments. SUID includes Sudden Infant Death Syndrome (SIDS), Accidental Suffocation and Strangulation in Bed (ASSB), and other sleep-related deaths that frequently occur without warning. Many of these cases are linked to factors such as infants sleeping on soft surfaces, sharing a bed with adults, or being surrounded by loose bedding, pillows, or stuffed toys. Ensuring a safe sleep environment is critical, which means placing babies on their backs to sleep, using a firm mattress with a fitted sheet, and keeping the crib free of any objects that could pose a suffocation risk.¹⁸

Nearly **2 in 5 infants (about 10,800)** in the eight-county service area do not always sleep alone in their own crib or bed, and **1 in 4 (about 6,500) infants** are not always placed on their back to sleep.² According to the Texas Department of Family and Protective Services, between fiscal year 2021 and 2023, 506 infant deaths occurred where bed sharing was a factor.¹⁹

Unsafe schools and neighborhoods

Ensuring a safe school and neighborhood environment is vital for preventing injuries and promoting overall well-being among children. Safe schools provide secure, well-maintained facilities and enforce policies that protect students from accidents and violence. Similarly, a safe neighborhood features well-lit streets, safe playgrounds, and accessible emergency services, reducing the risk of injuries from accidents of crime.

In the eight-county service area, an overwhelming majority (95%) of school-age children have a caregiver who feels their child is safe in school and in the neighborhood; however, there are still children that may not feel safe in their environment. Caregivers of children experiencing homelessness were **3 times as likely to report feeling unsafe** in their community/neighborhood.² Approximately **35% of community leaders** expressed children being victims of violence, or witnessing violence in their neighborhoods, is a problem in their community.

Table 8. Safety of children by population, race/ethnicity, and income

According to caregiver	Received care for injury (0-17 years)	Missed school due to injury (6-17 years)	Child does not always ride in a car seat (1-4 years)	Child is not always within reach during swim (1-4 years)	Child does not always wear a life jacket around water or pools (5-11 years)	Meds not always locked up (0-17 years)	Guns not always locked-up (0-17 years)
By population							
8-County Service Area	20%	21%	22%	18%	64%	52%	21%
FWSA // 6-County	18%	21%	15%	17%	64%	52%	20%
PSA // 3-County	25%	25%	33%	23%	63%	54%	24%
Unhoused & Undocumented	19%	13%	18%	19%	33%	26%	21%
By race/ethnicity							
Hispanic	18%	19%	17%	15%	59%	41%	12%
White, non-Hispanic	23%	24%	25%	21%	65%	57%	25%
Black, non-Hispanic	24%	28%	21%	13%	50%	43%	22%
Asian, non-Hispanic	5%	3%	28%	59%	75%	70%	19%
Other/Multi-race, non-Hispanic ^a	16%	18%	26%	15%	76%	59%	15%
By income							
Under \$50K	28%	28%	27%	24%	62%	41%	35%
\$50k-\$99,999K	21%	23%	24%	12%	60%	47%	20%
\$100K-\$149,999K	18%	19%	21%	20%	56%	52%	20%
\$150K+	16%	16%	12%	20%	87%	67%	15%

^aOther/Multi-race: Non-Hispanic children whose parents or caregiver did not solely select white, Black or Asian on survey.

Gray highlight indicates small sample size; interpret the data with caution.

H.E.L.P. for health equity in injury prevention

The following table summarizes highlights from the parent/caregiver survey and caregiver interviews to better understand access to care and disparities in child injury prevention.



Health

Access to care and basic needs

Approximately 1 in 5 children (about 233,300) received emergency care for accidental injury. Black and White, non-Hispanic children and children living in lower-income households were most likely to require emergency medical attention for an accidental injury.



Environment

Safety where children live, learn, and play

Drowning:

- For children 1 to 4 years old, nearly 1 in 5 children (about 50,800) are not always within reach of an adult during bath time.
- For children between 5 to 11 years old, nearly 2 in 7 children (about 117,700) are not always supervised when around water or pools.
- For children 12 to 17 years old, nearly 1 in 2 children (about 185,700) do not always wear a life jacket around lakes or open water.

Firearm: For children birth to 17 years old, nearly 1 in 5 children (about 120,300) live in a home where guns are not always stored in a locked area and 1 in 4 children (about 135,000) live in a home where ammunition is not always stored separately from guns.

Motor vehicle: For children 1 to 4 years old, nearly 1 in 5 children (about 55,200) do not always ride in a car seat.

Poison: For children birth to 17 years old, nearly 1 in 2 children (about 570,400) live in a home where medications are not always stored in a locked area and nearly 4 in 7 children (about 618,500) live in a home where cleaning products are not always stored in a locked area.

Unsafe sleep: Nearly 2 in 5 children under 1 year (about 10,800) do not always sleep alone in their own crib or bed.



Learning

Readiness and support for academic success

One in 5 school-age children (about 153,500) missed school due to an accidental injury.



Parenting

Parenting and family support

A majority of caregivers report they live in a community where their children are safe and neighbors help each other. By fostering strong community support, families can benefit from sharing evidence-based knowledge and resources helping enhancing injury prevention efforts for children.



Injury prevention training and collaboration strategies

Preventing unintentional injuries in children is a complex challenge that requires coordinated efforts from caregivers and communities. As discussed in this section, injury prevention involves various aspects, each with its own prevention methods. Additionally, injury prevention intersects with mental health issues such as self-harm, suicide, substance abuse, and opioid addiction.^{20,21} However, many child injuries and fatalities are preventable—but achieving this requires a systemic approach.

Policy makers, school systems, community leaders, and caregivers all have roles in preventing unintentional injuries. Effective strategies include:

- ➔ Provide evidence-based resources, prevention tools, education, and training for children, adolescents, and caregivers to increase awareness of the importance of injury prevention.
- ➔ Provide evidence-based professional development for health care providers, school nurses, and community partners targeting services to populations with higher rates of unintentional injuries.
- ➔ Increase awareness in the general community about the importance of injury prevention measures.
- ➔ Increase family and provider awareness about community resources available for injury prevention.
- ➔ Develop and strengthen partnerships including first responders to increase the reach of injury prevention messaging, resources, and education.
- ➔ Advocate for public policy changes that support injury prevention, including child restraint laws, distracted driving messaging, pool ordinances, etc.
- ➔ Promote the implementation and sustainability of hospital-based violence intervention programs to interrupt the cycle of community violence and promote community healing.
- ➔ Recognize the emotional impact that physical trauma can have on victims and their loved ones and increase opportunities for post-injury mental health follow-up and support.

Caregiver support

Percentage of children with two or more ACEs*

Benchmarks ¹	U.S.	NSCH (2022): 18%
	Texas	NSCH (2022): 18%
Service areas ² (2024)	8-county service area	18%
	FWSA // 6-county	18%
	PSA // 3-county	18%
Individual counties ² (2024)	Collin	20%
	Denton	15%
	Grayson	23%
	Hood	23%
	Johnson	21%
	Parker	14%
	Tarrant	19%
	Wise	16%

*ACEs: Traumatic events that occur during childhood that can have lasting mental and physical health effects into adulthood⁴

Nearly 1 in 5 children in our eight-county service area currently has two or more ACEs.

Overview

In August 2024, the U.S. Surgeon General called attention to an urgent public health issue—parental mental health and well-being.³ The recent advisory emphasizes the **significant stress** parents face from financial instability, work-life balance, children’s health, technology and social media, and lack of social support. Parents experience significantly higher stress than non-parents, with 33% of parents reporting high levels of stress, and 48% expressed their stress was completely overwhelming in the past month (compared to 20% and 26%, respectively).³ Despite these challenges, families can build resiliency through **protective factors** such as strong relationships, social support, and safe, nurturing environments.



“Raising children is sacred work. It should matter to all of us. And the health and well-being of those who are caring for our children should matter to us as well.”

- U.S. Surgeon General Advisory Report

Adverse Childhood Experiences (ACEs)

Adverse Childhood Experiences, or ACEs, are traumatic events that occur during childhood that can have lasting mental and physical health effects into adulthood.⁴ The list of adverse experiences is robust and includes multiple aspects such as experiencing child abuse and neglect, witnessing violence, home and neighborhood safety, and systemic discrimination. ACEs are common, but certain factors **increase the risk**. These factors include poor parent-child relationships, high parenting and economic stress, and living in communities with high rates of poverty and limited education and economic opportunities.⁵

The list of ACEs examined and discussed in this needs assessment include the following ten measures, which are also included in the National Survey of Children’s Health:⁵

- Hard to cover the basics, like food or housing, on family’s income.
- Parent or guardian divorced or separated.
- Parent or guardian died.
- Parent or guardian served time in jail.
- Saw or heard parents or adults slap, hit, kick, punch one another in the home.
- Was a victim of violence or witnessed violence in their neighborhood.
- Lived with anyone who was mentally ill, suicidal, or severely depressed.
- Lived with anyone who had a problem with alcohol or drugs.
- Treated or judged unfairly because of their race or ethnic group.
- Treated or judged unfairly because of their sexual orientation or gender identity.

In the eight-county service area, **nearly 216,600 children (18%)** have at least two ACEs, which is comparable to both Texas (18%) and national (18%) estimates (see Table 9).^{1,2} The most common ACEs in the service area included having **difficulty covering basics (i.e., food or housing) on the family income** followed by caregiver divorce or separation.²

From the community leader’s perspective, access to quality and affordable housing, access to affordable, healthy food, and living with someone with a substance use disorder or a mental health condition are the most concerning problems for children within their community. Please see Table 9 for a full list of ACEs locally and nationwide.

Table 9. Prevalence of ACEs for children birth to 17 by population

According to caregiver	NSCH U.S. (2022)	NSCH Texas (2022)	8-county service area	FWSA // 6-county	PSA // 3-county	Unhoused & undocumented
Has 2 or more of the listed ACEs	18%	18%	18%	18%	18%	34%
Hard to cover basics on family income	14%	16%	17%	17%	15%	36%
Parent or guardian divorced or separated	22%	23%	16%	17%	13%	34%
Lived with anyone who was mentally ill, suicidal or severely depressed	9%	12%	10%	10%	11%	13%
Lived with anyone who had a problem with alcohol or drugs	8%	9%	10%	9%	10%	14%
Parent or guardian served time in jail	6%	6%	6%	6%	5%	16%
Treated or judged unfairly because of race or ethnic group	4%	3%	7%	6%	8%	10%
Saw or heard parents or adults slap, hit, kick or punch one another in the home	5%	8%	7%	6%	9%	16%
Was a victim of violence or witnessed violence in their neighborhood	4%	5%	6%	5%	8%	13%
Parent or guardian died	3%	2%	5%	5%	5%	8%
Treated or judged unfairly because of sexual orientation or gender identity	2%	1%	3%	3%	3%	2%
Has none of the listed ACEs	60%	57%	61%	61%	63%	40%

Confirmed child abuse and neglect

Understanding the nuances of child abuse and neglect is crucial because these experiences can have profound and lasting effects on a child’s physical, mental, and psychological development.^{6,7} Overall, the trends of confirmed victims of child abuse or neglect in the service area align with Texas state patterns showing a decline in rates over the past decade; however, **6 out of 8 counties** in the service area have confirmed rates exceeding the state of Texas (see Table 10).⁸

Table 10. Rate per 1,000 children of confirmed victims of child abuse or neglect by county, 2021-2023^a

	Years		
	2021	2022	2023
Texas	9.0	7.4	7.5
Cook Children’s 8-county service area			
Collin	4.9	4.1	4.1
Denton	6.9	5.0	5.2
Grayson	11.5	8.6	8.3
Hood	21.0	17.3	15.7
Johnson	11.7	9.5	11.9
Parker	13.7	14.3	9.4
Tarrant	11.9	10.0	9.7
Wise	13.3	12.4	12.8

^aAdapted from Texas Department of Family and Protective Services, 2024⁸



Exposure to adverse childhood experiences and other traumatic events can affect the health and wellness of children. That is why it is important for health professionals to be knowledgeable and mindful of trauma-informed care. We can help create safe environments and bolster resiliency. We can make a difference.

—Elizabeth Peeler, DO, MS, MSCS



H.E.L.P. for health equity

Access to caregiver support and disparities

Approximately **57% of children (about 668,900)** have caregivers in the eight-county service area reporting they are coping very well and 39% (about 455,600) are coping somewhat well with day-to-day demands of raising children—aligning with Texas and national estimates.² Additionally, a majority of children have caregivers (81%) who report having a source of **emotional support** with parenting or raising children, positively exceeding Texas (72%) and national (76%) estimates.^{1,2}

While these findings are vital for showing caregiver support across the service area, it is important to remember that there are about 43,100 children (4%) with caregivers who are not coping well (i.e., not very well or not well at all) with demands and **217,600 children (19%)** with caregivers who don't have someone to turn to for emotional support.²

The ability to view parent coping and emotional support trends across community needs assessment years provides an additional layer of understanding to what is changing in the community. Since the 2021 CHNA, two trends worth emphasizing are (1) a slight increase in caregivers reporting that they are coping very well with parenting demands (from 54% to 57%), and (2) a **continued decrease** in caregivers reporting they have source of emotional support with parenting (from 86% to 81%).^{2,9}

Table 11. Percentage of children birth to 17 with two or more ACEs by population, race/ethnicity, income, and age

According to caregiver	Children with 2 or more ACEs
By population	
NSCH: U.S. (2022)	18%
NSCH: TX (2022)	18%
8-county service area	18%
FWSA // 6-county	18%
PSA // 3-county	18%
Unhoused & undocumented	34%
By race/ethnicity	
Hispanic	24%
White, non-Hispanic	15%
Black, non-Hispanic	21%
Asian, non-Hispanic	12%
Other/Multi-race ^a	26%
By income	
Under \$50k	30%
\$50K-\$99,999K	21%
\$100K-149K	13%
\$150K+	13%
By age	
0-5 years	17%
6-11 years	18%
12-17 years	20%

^aOther/Multi-race: Non-Hispanic children whose parents or caregiver did not solely select white, Black or Asian on survey.

Gray highlight indicates small sample size; interpret the data with caution.

H.E.L.P. for health equity in caregiver support

The following table summarizes highlights from the parent/caregiver survey and caregiver interviews to better understand access to care and disparities in caregiver support.



Health

Access to care and basic needs

Nearly 1 in 5 children (about 216,600) has two or more ACEs. Children with two or more ACEs compared to children who have no ACEs are:

- Two times more likely to report fair or poor overall health and oral health.
- Two times more likely to report not receiving all needed medical care.
- Three times more likely to report fair or poor mental health.
- Three times more likely to report not always being able to afford to eat nutritious meals.



Environment

Safety where children live, learn, and play

Children experiencing homelessness, living with an undocumented caregiver, or having a family income below \$50,000, are about two times more likely to report two or more ACEs compared to children with no ACEs.

Children with two or more ACEs are less likely to meet daily healthy lifestyle recommendations including physical activity, eating fruits and vegetables, having a family meal with household members, sleeping at least eight hours per night, and limiting recreational screen time.



Learning

Readiness and support for academic success

Approximately 1 in 5 school-age children (about 157,000) have two or more ACEs. Compared to children with no ACEs, these children are:

- Less likely to care about doing well in school.
- More likely to bully others and get bullied themselves.
- More likely to have been diagnosed with at least one of the four most common mental health conditions (ADD/ADHD, anxiety, behavioral/conduct problems, and depression).



Parenting

Parenting and family support

Approximately 8 in 10 children (about 932,200) have a caregiver who has a source of emotional support with parenting. The top five reported sources of support include, spouse or domestic partner, other family or close friend, health care provider, place of worship or religious leader, and peer support group, respectively.

Caregiver support training and collaboration opportunities

Benefits and best practices

Positive childhood experiences (PCEs) are beneficial events that can help repair the brain after trauma and support mental and overall well-being into adulthood.¹⁰ PCEs can help develop resiliency within a family and provide children an opportunity to thrive even if they have adverse childhood experiences.

The HOPE National Resource Center created the *Four Building Blocks of Hope* in response to ACEs.¹⁰ This framework can be used within families and throughout communities to promote PCEs. The four building blocks and ways for parents, caregivers, and community members/organizations to utilize the framework are outlined below:

Relationships

- Foster supportive relationships within families and with community members, including children, coaches, teachers, pastors and mentors.
- Identify and create opportunities for children to play and connect regularly.

Environment

- Ensure children feel physically and emotionally safe in all environments such as home, school, playgrounds and neighborhoods.
- Listen to children discuss their environment and identify community program needs.
- Find and promote safe outdoor play areas.

Engagement

- Engage children and youth in activities with their peers.
- Volunteer together as a family or group in the community.
- Encourage youth to take on leadership roles.

Emotional growth

- Help children recognize and express their emotions appropriately.
- Support school-led programs on emotional learning.



Another approach to building strong, resilient families and preventing child abuse and neglect is through parent and family community support groups. Many evidence-based programs provide structured curricula and a safe space for families to discuss parenting successes, challenges, and share ideas, tips, and techniques.¹⁰⁻¹² These support groups also educate parents and caregivers on various child health topics, such as mental health, child development, effective discipline strategies, and how to promote positive childhood experiences.

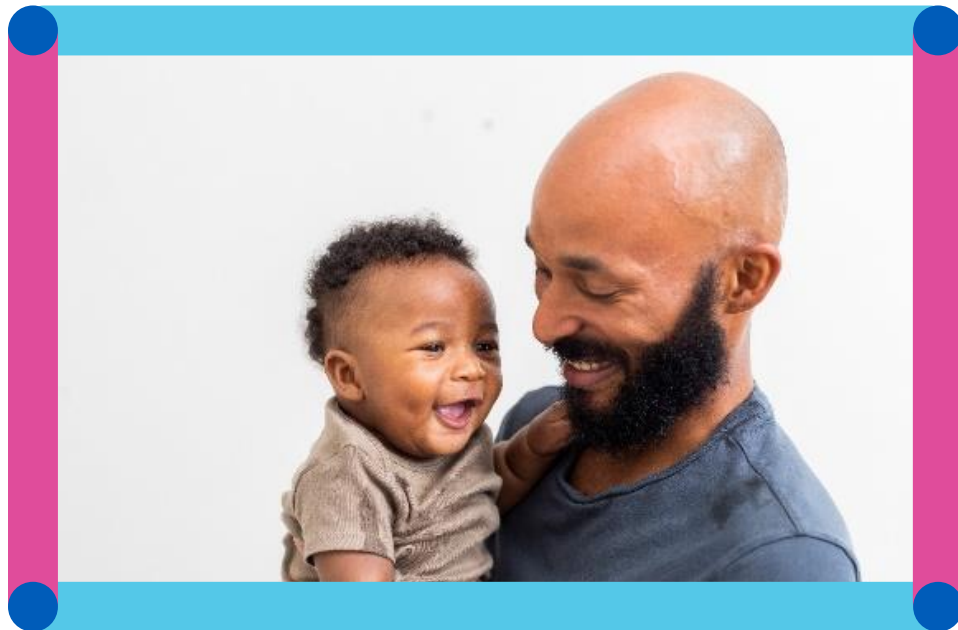
Lastly, but importantly, the fourth trimester (i.e., 12 weeks after giving birth) is a crucial time for a mother's health, caregiver support and child development. During the fourth trimester, caregivers face significant physical, emotional, and social adjustments as they bond with their newborn and recover from childbirth.¹³ Supporting caregivers during this phase is essential, as their well-being directly impacts the baby's development. Encouraging practices such as responsive caregiving, skin-to-skin contact, and establishing routines helps foster secure attachment and early brain development in the child. Additionally, this period provides a unique opportunity to address caregiver mental health, offer education on infant care, and connect families with community resources.¹³ Prioritizing support during the fourth trimester not only promotes a strong foundation for the child's growth, but also ensures that caregivers are equipped to thrive in their parenting journey.

Collaboration opportunities

Caregiver and family support often benefit from community collaboration opportunities, where community partners can create a supportive space and network for families. Everyone hears the saying that raising children takes a village—and while that holds true, feelings of isolation among parents and families continues to rise. By fostering strong communities ties and offering accessible programs, these collaborative efforts aim to ensure parents and families receive the necessary support to help them thrive in their role and to see lasting benefits for their children.

Additional prevention strategies include:

- Ensuring a strong start for children, including early childhood home visitation, high-quality and affordable child care, and preschool enrichment with family engagement.
- Connect families with coordinated care services as well as community resources to address immediate social service needs utilizing community health workers.
- Develop and distribute evidence-informed education, resources, and interventions that provide networks of support for parents and caregivers.
- Provide evidence-informed education and training to providers and community members (e.g., school counselors) who will share skills, knowledge, and tools with caregivers.
- Provide resources and trainings specific to positive childhood experiences to build family and community resiliency, enabling caregivers to create nurturing environments that support children’s emotional, social, and cognitive development.
- Connect caregivers and families to infant and maternal support especially during the fourth trimester including maternal health services, and promote local resources (e.g., Parent Pass).
- Collaborate with local organizations and maternal and infant health coalitions to expand access to critical resources such as postpartum mental health support, treatment, and programs to meet the needs of mothers and families during the fourth trimester.



Healthy lifestyles

Percentage of children ages 10 to 17 without normal Body Mass Index-for-age*

Benchmarks ¹	U.S.	NSCH (2022): 39%
	Texas	NSCH (2022): 50%
Service areas ² (2024)	8-county service area	38%
	FWSA // 6-county	38%
	PSA // 3-county	37%
Individual counties ² (2024)	Collin	38%
	Denton	34%
	Grayson	42%
	Hood	48%
	Johnson	40%
	Parker	37%
	Tarrant	39%
Wise	33%	

*Includes children with an underweight, overweight or obese BMI-for-age category. Based on the CDC BMI categories.

Nearly 2 in 5 children ages 10 to 17 in our eight-county service area have an unhealthy body weight.

Overview

Basics of healthy lifestyles

Healthy lifestyles for children include daily decisions that can significantly influence overall health for years to come. Key aspects of a healthy lifestyle include consuming a diet rich in fruits, vegetables, and whole grains, engaging in regular physical activity, reduced screen time, and ensuring adequate sleep each night. By making informed decisions and establishing healthy habits early on, children can maintain a healthy weight, grow strong bones and teeth, achieve good brain development, improve mental health, attain academic success and prevent chronic diseases into adulthood.^{3,4}

The focus on maintaining a healthy weight for children has been a priority for public health and health care professionals for many years. Reasons for excess weight gain in children may include non-medical factors, individual behavior choices, access to nutritious food, and genetics. Body Mass Index (BMI) is a screening tool used to assess weight, height, sex, and age to determine if there is an indication of a health risk. The Centers for Disease Control and Prevention (CDC) categorizes BMI weight status for children ages 10 to 17 into four categories (see Table 12).⁵ Tracking BMI over time, along with other health factors, can help health care professionals identify weight concerns and provide guidance on necessary lifestyle and environmental changes.

Table 12. CDC child weight categories based on BMI^a

Weight status category	Percentile range
Underweight	Less than the 5 th percentile
Healthy weight	5 th percentile to less than the 85 th percentile
Overweight	85 th to less than the 95 th percentile
Obese	Equal to or greater than the 95 th percentile

^aAdapted from Centers for Disease Control and Prevention, 2024⁵

In the eight-county service area, **13% of children (about 70,700)** ages 10 to 17 are overweight and **16% of children (about 90,000)** are obese.² The local rates of children who are overweight are similar to Texas (15%) and national (15%) estimates; however, Texas has a higher rate of children who are obese at 22% of children.¹ Children across the eight-county service area are not **consistently** engaging in healthy lifestyle behaviors that contribute to maintaining a normal BMI and reduce the risk for various health conditions (see Table 13 below).²

Table 13. Healthy lifestyle behaviors by BMI result compared to children 6-17 within the eight-county service area

	Children 10-17 years		Children 6-17 years
	Normal BMI	Obese/overweight BMI	All in 8-County service area
Eats fresh fruits and/or vegetables daily	34%	33%	35%
Eats a family meal with household members daily	43%	49%	47%
Participates in physical activity for more than 1 hour daily	20%	17%	19%
Sleeps more than 8 hours every night	42%	43%	46%
Spends 2 hours or less of recreational screen time daily	4%	5%	6%

Additionally, overweight children often face stigmatization, which increases their risk of bullying and can lead to lifelong struggles with body weight, self-esteem, and body satisfaction.⁶ Children in the eight-county service area without a normal BMI were more likely to report getting **teased or bullied by peers**. This negative treatment can cause significant emotional and psychological distress, contributing to a cycle of unhealthy eating behaviors, reduced physical activity, and further weight gain. The impact on child self-esteem and body satisfaction can persist into adulthood, affecting their overall well-being and quality of life.^{7,8}

On the other hand, **9% (about 46,900) of children ages 10 to 17** in the eight-county service area are underweight, compared to 13% in Texas and 7% nationally, which can also be an indication of underlying medical conditions or undernutrition.^{1,2} Reasons for children being underweight may include inadequate food intake, medication side effects, food allergies, hormonal or digestive problems, mental health conditions, or other underlying chronic diseases.⁹

H.E.L.P. for health equity

Access to healthy lifestyles

While it is evident, that living a healthy lifestyle significantly benefits children's overall health, many children in the service area face obstacles that prevent them from making healthy choices. These obstacles can be both individual, such as a lack of knowledge about healthy food choices and exercise, and community-based, such as limited access to safe recreational spaces and affordable healthy food options. As a result, working to address these obstacles is essential to ensure that all children have the opportunity to lead healthier lives.

Physical activity

Children and adolescents ages 6 to 17 should participate in at least 60 minutes of physical activity daily.¹⁰ However, only **1 in 5 children (about 137,800)** in the eight-county service area align with the physical activity recommendation. Many family and home environment factors can play a role in the lack of physical activity. Children living in Parker, Wise, and Hood counties were the most likely to report not having access to sidewalks or walking paths, and those living in Parker, Wise, and Johnson were most likely to report not having access to a park or playground. Caregivers also reported **2 in 5 children (about 421,500)** in the eight-county service area do not have access to a recreation or community center. Additionally, 35% of community leaders surveyed felt it was difficult or very difficult for children to access wellness opportunities within their communities.²



It's important that we not only provide children in our own communities with the right tools they need to practice healthy habits today, but teach and empower them at a young age so they can grow up to become great leaders who strive for positive change globally and locally.

—Kid Power focus group

Food insecurity

Food insecurity occurs when an individual does not have access to sufficient nutritious food. This lack of access can stem from various factors including financial hardship, limited availability of healthy food options, and inadequate support systems.¹¹ In the eight-county service area, approximately **34% of children ages birth to 17 (about 390,100)** live in households that **cannot always** afford to eat good, nutritious meals, compared to 40% of children in Texas and 33% nationally (see Table 14).^{1,2}

Children experiencing food insecurity may suffer from inadequate nutrient intake, leading to deficiencies that can hinder their growth and development. Additionally, the stress and anxiety associated with food insecurity can affect both the children and their households, creating an environment of instability that further impedes healthy development.¹²

Table 14. Households with children 0-17 years that could afford to eat good, nutritious food

	Could always afford to eat good, nutritious meals	Could always afford to eat, but not always nutritious meals	Sometimes/often could not afford enough to eat
NSCH: U.S. (2022)	67%	28%	5%
NSCH: TX (2022)	60%	35%	6%
8-county	66%	26%	8%
FWSA // 6-county	67%	25%	9%
PSA // 3-county	69%	25%	7%
Unhoused & undocumented	49%	28%	23%
Collin	67%	28%	6%
Denton	73%	19%	8%
Grayson	52%	35%	13%
Hood	65%	26%	10%
Johnson	66%	27%	8%
Parker	70%	23%	7%
Tarrant	64%	27%	9%
Wise	67%	24%	10%

The short- and long-term health outcomes for children facing food insecurity are concerning. These children are more likely to experience poor overall health, chronic conditions, academic and behavioral problems, and higher rates of hospitalization.¹¹⁻¹³ For instance, children experiencing food insecurity are more prone to frequent infections and illnesses due to weakened immune systems, which can result in school absenteeism and can negatively impact learning and social interactions.¹⁴



“The community faces significant challenges in ensuring access to affordable, healthy food, with issues such as rising food prices.”

—Community leader interview

Disparities in access to healthy lifestyles

Supplemental Nutrition Assistance Program (SNAP)

The Supplemental Nutrition Assistance Program (SNAP) is an important component in the fight against food insecurity, providing support to millions of individuals and families. SNAP provides financial assistance to purchase nutritious food, helping to alleviate hunger and improve dietary quality. In the eight-county service area, **21% of children (about 236,400)** live in a household that reported receiving food stamps or SNAP benefits in the past year.²

Understanding participation rates in each county is crucial for assessing the effectiveness and reach of programs like SNAP. Only 7 out of 10 eligible Texans are enrolled in SNAP, which is one of the lowest rates in the United States.¹⁵ While the difference in the number of people eligible for SNAP and the number actively receiving benefits—referred to as the “SNAP gap”—was not available by county, variability in participation levels across the eight counties can highlight disparities in access to essential resources and services, which is highlighted in Table 15 below.¹⁶

Table 15. Household received food stamps/SNAP in the past 12 months^a

	Total households	Total households with children under 18 years	Households with children under 18 years who received food stamps/SNAP
U.S.	125,736,353	37,956,469 (30%)	6,945,057 (6%)
Texas	10,490,553	3,734,897 (36%)	733,535 (20%)
Collin	383,675	154,723 (40%)	7,071 (5%)
Denton	334,504	124,721 (37%)	10,403 (8%)
Grayson	52,084	16,790 (32%)	2,711 (16%)
Hood	24,743	7,004 (28%)	707 (10%)
Johnson	62,297	24,438 (39%)	2,902 (8%)
Parker	52,622	18,817 (36%)	1,436 (8%)
Tarrant	754,969	269,817 (36%)	47,629 (18%)
Wise	24,079	9,385 (39%)	1,301 (14%)

^aAdapted from U.S. Census Bureau, American Community Survey, 2022¹⁶



Julien Ybarra, MPH, CHW shared:

“The biggest obstacles preventing children and families from accessing the resources and care they need include prolonged delays and repeated denials in the processing of benefit applications such as SNAP and Medicaid.”

He further explained the families he serves “frequently encounter challenges such as complex application processes, extended processing times, and lack of clear communication from government agencies when completing applications for Medicaid, WIC, SNAP, or housing assistance programs.”

He elaborated that these complications lead to repeated denials and unresolved applications resulting in ongoing financial and health care instability for children and families.



The rollback in SNAP benefits in February 2023 will continue to have a **profound impact** on vulnerable individuals and families, particularly those already facing economic hardships. In Texas, the total amount of reductions from ending emergency allotments, introduced during the COVID-19 pandemic, was about \$189 per household and \$81 per person.¹⁷ The reduction of SNAP emergency allotments also places additional strain on local food banks and community organizations to bridge the gap left by the reduced benefits. **Reduced benefits** may lead to increased food insecurity, limiting access to nutritious meals and negatively affecting the health of families and children, ultimately exacerbating social and economic inequalities.



“Just this last month they cut off our SNAP and Medicaid, I had to take time off from work to go to the office to renew the benefits. I had to go to the food pantry three to four times and sometimes I reach out to the school and [the school] sends the kids home with a bag of food, snack packs on Friday for the weekend.”

—Family/caregiver interview

Table 16. Children’s access to healthy lifestyles by population, race/ethnicity, and income

According to caregiver	Children 10–17 years	Children 6–17 years			
	BMI overweight/obese	Can’t always afford to eat good, nutritious meals	No food assets ^b	Does not get recommended daily physical activity	No physical activity assets ^c
By population					
8-county service area	29%	32%	13%	81%	14%
FWSA // 6-county	30%	32%	13%	80%	16%
PSA // 3-county	26%	29%	14%	86%	9%
Unhoused & undocumented	44%	51%	21%	74%	5%
Collin	26%	30%	12%	87%	5%
Denton	25%	25%	17%	84%	12%
Grayson	33%	50%	21%	83%	21%
Hood	29%	34%	17%	81%	30%
Johnson	34%	37%	20%	81%	42%
Parker	33%	30%	23%	71%	59%
Tarrant	32%	35%	10%	78%	11%
Wise	24%	33%	19%	79%	49%
By race/ethnicity					
Hispanic	37%	42%	9%	81%	13%
White, non-Hispanic	26%	30%	15%	82%	18%
Black, non-Hispanic	35%	35%	7%	81%	4%
Asian, non-Hispanic	17%	16%	8%	87%	<1%
Other, non-Hispanic ^a	41%	31%	19%	72%	11%
By income					
Under \$50K	32%	69%	18%	81%	20%
\$50K-\$99,999	35%	42%	10%	81%	12%
\$100K-\$149,999	27%	20%	11%	84%	10%
\$150K or more	25%	6%	13%	76%	15%

^aOther/Multi-race: Non-Hispanic children whose parents or caregiver did not solely select white, Black or Asian on survey.

^bNo food assets – no stores that sell fresh fruits and vegetables in neighborhood.

^cNo physical activity assets – no sidewalks, parks/playgrounds/recreation centers in neighborhood.

Gray highlight indicates small sample size; interpret the data with caution.

H.E.L.P. for health equity in healthy lifestyles

The following table summarizes highlights from the parent/caregiver survey and caregiver interviews to better understand access to care and disparities in child healthy lifestyles.



Health

Access to care and basic needs

Approximately, 2 in 7 children ages 10 to 17 (about 160,700) have a BMI classified as overweight or obese. Children who are Hispanic, Black non-Hispanic, or Other/Multi-race non-Hispanic, as well as those from lower-income households, are more likely to have a higher BMI compared to other children in the eight-county service area.



Environment

Safety where children live, learn, and play

Approximately 1 in 3 children (about 390,100) live in households that cannot always afford to eat nutritious meals. Food insecurity is highest among children experiencing homelessness or living with an undocumented parent or caregiver (51%). Caregivers reporting food insecurity is also higher among Hispanic and Other/Multi-race non-Hispanic, and children living in low-income households.

Approximately 1 in 7 children (about 84,700) live in an area where they have no physical activity assets (sidewalks, parks/playgrounds, recreational centers), and 1 in 8 children (about 144,300) live in an area where they do not have stores that sell fresh fruits and vegetables—mostly in the rural counties (Grayson, Parker and Wise).



Learning

Readiness and support for academic success

Approximately 2 in 7 school-age children (about 243,100) benefit from free or reduced-cost breakfasts or lunches at school, shown to help reduce food insecurity, obesity rates and poor health.¹⁸



Parenting

Parenting and family support

Children with caregivers who report having a source of emotional support are more likely to engage in daily healthy lifestyle recommendations including physical activity, eating fruits and vegetables, having a family meal with household members, sleeping at least eight hours per night and limiting recreational screen time.

Healthy lifestyles training and collaboration opportunities

Awareness and education

Nearly **2 in 3 children (about 103,700)** classified as having an overweight or obese BMI have a caregiver who is not concerned about their child's weight.² In addition, as mentioned earlier in this section, many children or families across the service area are navigating obstacles that likely make adopting healthy lifestyle habits challenging.

Parents and caregivers are imperative in teaching and demonstrating healthy choices for children and adolescents. One example of teaching parents/caregivers about healthy lifestyles is through the 5-2-1-0+ approach. The 5-2-1-0+ approach is a public health initiative aimed at promoting healthy lifestyles among children and families.^{19,20} The numbers stand for five servings of fruits and vegetables daily, two hours or less of recreational screen time, one hour of physical activity, and zero sugary drinks, with the "+" representing additional healthy habits such as adequate sleep and minimal consumption of junk food. This simple, easy-to-remember formula encourages balanced nutrition, regular exercise, and overall wellness, helping to prevent childhood obesity and related health issues. By following the 5-2-1-0+ guidelines, children and families can develop healthy habits that contribute to their long-term physical and emotional well-being.

Collaboration opportunities

Beyond educating caregivers and families about healthy lifestyle choices, it is also important for health care providers, educators, and the broader community to receive education and work together to develop opportunities for promoting healthy behaviors. Through collaborative efforts, these groups can establish and support community programs that encourage physical activity, balanced nutrition, and overall wellness. This collaborative approach maximizes the impact of health initiatives and ensures that different resources and support networks are available to help children and families embrace and sustain healthy lifestyles. Strategies for these collaborative approaches may include:

- Provide evidence-based healthy lifestyles training to providers and community members who will share skills, knowledge, and tools with caregivers within their reach to increase awareness of the importance of healthy nutrition, physical activity, adequate sleep, and limited screen time.
- Develop and distribute evidence-informed education and interventions for children to promote healthy lifestyles, nutritious food consumption, and physical activity.
- Recruit faith-based, social service, business and government community members to help maintain a community culture that promotes healthy lifestyles.
- Provide food directly to families identified as food insecure.
- Establish, strengthen and leverage community partnerships to build their capacity to address food insecurity.
- Increase access to food resources for families through establishing, strengthening, or leveraging community partnerships and education opportunities.
- Increase access to physical activity assets across the community, ensuring children have safe and engaging spaces to play and exercise.
- Increase access to health insurance for children who are eligible for coverage but not enrolled, including CHIP, SNAP and WIC to improve nutrition, health, and well-being of families.
- Connect families with resources via warm handoffs to increase the likelihood that families will actively engage with resources
- Provide support to physicians and mental health providers to extend their expertise to community education efforts, including educating school staff about the importance of including rules against weight-based bullying in school policies; and helping educate other providers, youth-targeted media, and the general community to learn to use appropriate language and word choices.
- Raise community awareness about and recruit advocates for reducing weight-based stigmatization.

Asthma

Nearly 1 in 10 children in our eight-county service area currently has asthma.

Percentage of children with asthma

Benchmarks ¹	U.S.	NSCH (2022): 7%
	Texas	NSCH (2022): 6%
Service areas ² (2024)	8-county service area	9%
	FWSA // 6-county	10%
	PSA // 3-county	7%
Individual counties ² (2024)	Collin	7%
	Denton	7%
	Grayson	5%
	Hood	9%
	Johnson	13%
	Parker	5%
	Tarrant	11%
Wise	11%	

Overview

Basics of asthma and triggers

Asthma is a chronic lung disease affecting approximately 7% of children (about 4.7 million) in the United States and 6% (about 438,200) in Texas.¹ **Nine percent (about 104,500) of children** in the eight-county service area currently have asthma, with Black, non-Hispanic (14%), Other/Multi-race (13%), and Hispanic (11%) disproportionately affected.² Characterized by inflammation and narrowing of the airway, asthma can lead to shortness of breath, wheezing, a tight feeling in the chest, coughing often and even death. Common asthma triggers include tobacco smoke, dust mites, allergies, cockroaches, weather changes, exercise or active playing, infections, and strong odors and fumes.³

Uncontrolled asthma can lead to increased emergency department visits and hospitalizations.⁴ Of the children who currently have asthma in the eight-county service area, approximately **4 in 7 (about 59,600) children** had an episode of asthma or asthma attack in the past year and nearly **1 in 4 (about 25,700) children** have been to the emergency room because of asthma symptoms.²



“The long wait [makes it difficult to take child to doctor]. His medical issues are intense and I prefer to take him to the ER than to wait for appointments.”

—Family/caregiver interview

Between 2021 and 2023, Cook Children's Medical Centers in Fort Worth and Prosper recorded 7,798 emergency department visits for asthma, treated 5,629 children, and 2,637 children were hospitalized for asthma symptoms.⁵

Managing childhood asthma often involves a combination of medical treatment, environmental controls, and education. Caregivers of children with asthma reported **1 in 13 children (about 6,400)** did not receive all the medication prescribed for asthma. Additionally, nearly **1 in 5 children (about 19,700)** with asthma do not have an individualized asthma action plan (see table 17).² Partnership between children, caregivers, and health care providers is critical for understanding the chronic disease, trigger avoidance, and maintaining appropriate treatment plans and understanding medication adherence.



“I worry when they are not in my presence, if they had an emergency, that someone would know what to do with asthma. With my son’s asthma, the doctors said we have to worry about his heart.”

—Family/caregiver interview

In addition, children with asthma often face unique challenges compared to their peers. Asthma is one of the **leading causes** of children missing school.⁶ **Nearly half of school-age children** with asthma in the eight-county service area missed at least one day of school due to asthma symptoms.² Asthma symptoms, doctors’ appointments, and hospitalizations can lead to multiple school absences and cause a child to fall behind and struggle academically, while also requiring caregivers to face challenges in balancing work and caring for their child. Also, children may find it difficult to avoid asthma triggers at school and may feel left out for having to stay away from certain activities, which can ultimately affect their physical, emotional and social well-being.



“For the most part my kids are healthy, but my youngest one has asthma and sometimes the way he breathes scare me, and I stay up at night to watch him.”

—Family/caregiver interview

Table 17. Children with asthma by population

According to caregiver	Currently has asthma	Had an episode attack in the past 12 months	Does not have an individualized asthma action plan	Did not receive all medication prescribed for asthma	Been to the ER in the past year b/c of asthma
By population					
NSCH: U.S. (2022)	7%				
NSCH: TX (2022)	6%				
8-county service area	9%	57%	19%	8%	25%
FWSA // 6-county	10%	58%	20%	7%	21%
PSA // 3-county	7%	58%	16%	11%	30%
Unhoused & undocumented	11%	41%	35%	10%	27%

H.E.L.P. for health equity in asthma

The following table summarizes highlights from the parent/caregiver survey and caregiver interviews to better understand access to care and disparities in children with asthma.



Health

Access to care and basic needs

For the 104,500 children with asthma in the eight-county service area:

- Approximately 1 in 6 children (about 17,200) does not have a personal doctor.
- Approximately 1 in 4 children (about 23,600) did not receive needed medical care in the past year.
- Approximately 1 in 13 children (about 6,400) did not receive the asthma medication prescribed to them.



Environment

Safety where children live, learn, and play

Children experiencing homelessness, living with an undocumented caregiver or in households with an income under \$50,000 are more likely to have visited an emergency department due to asthma symptoms in the past year compared to other children in the eight-county service area.



Learning

Readiness and support for academic success

Approximately 1 in 2 school-age children with asthma (about 50,100) missed at least one day of school due to asthma symptoms.



Parenting

Parenting and family support

Caregivers of children with asthma shared that they struggle to balance work, attend appointments, and manage daily worry about their child's condition, emphasizing the importance of providers understanding these challenges alongside the child's medical history.



Asthma training and collaboration opportunities

Asthma is a leading chronic disease among children.^{1,6} Managing a child's asthma symptoms requires education and collaboration across a child's social network. Strategies to help improve health outcomes for children with asthma include:

- ➔ Parents and caregivers should work with their child's health care provider to create a personalized asthma action plan. The plan will help guide caregivers, family members, teachers, and others to understand the steps to manage the child's asthma symptoms. These plans often include emergency contact information and a list of medications categorized by the severity of symptoms.
- ➔ Connect families with coordinated care services as well as community resources to address immediate social service needs utilizing community health workers.
- ➔ Develop and distribute evidence-informed education, resources, and interventions that provide networks of support for parents and caregivers.
- ➔ Offer continuous evidence-informed education and training so that health care providers, community health workers, pharmacists, and others can provide parents and caregivers with updated information regarding managing asthma triggers inside and outside the home, recognizing escalation signs, and appropriate use of asthma medications. As the asthma triggers, symptoms, and treatment options may change over time, ongoing education will help caregivers and children with long-term asthma management.
 - Cook Children's Healthy Homes Asthma Program focuses on addressing and mitigating environmental factors present in the household that may be causing the child's asthma symptom exacerbation. This program has been shown to reduce missed school days by 82% and has saved \$12,680 in federal funds from fiscal year 2021 to 2024.^{3,5}
- ➔ Create a safe school environment for children with asthma is critical. Programs such as [Asthma 411](#) located in Tarrant County equip school nurses with resources and training to help respond to a child in respiratory distress, work to enhance school asthma services, and support prevention-oriented care.⁷ Other initiatives such as [Asthma Friendly Schools](#) provide a framework to help guide communities and schools through a comprehensive approach to asthma management.⁸
- ➔ The entire community including health care professionals, advocacy organizations, schools, and caregivers can help advocate for children with asthma. Advocating for these children can include (1) promoting safe and healthy environments in homes, schools and childcare settings, (2) improving access to health care for needed asthma services, (3) reducing out of pocket cost of asthma medications, and (4) promoting public policy to reduce exposure to indoor and outdoor asthma triggers.

Recommendations and next steps

To enhance the health and well-being of children across the eight-county service area, we recommend fostering partnerships focused on these key priorities:

- Prioritize non-medical drivers of health, such as food security, safe environments, housing, reliable transportation, and economic stability, as essential factors in supporting children's health.
- Broaden the definition of health to encompass not only physical but also mental and oral health, as well as the effects of childhood trauma.
- Strengthen collaboration across programs and services to extend community outreach and coordinate efforts to address multiple health challenges simultaneously.
- Review and advocate for systemic solutions and policies that address children's health needs influenced by societal and community factors.

Please join us

Improving children's health requires a collaborative approach, engaging organizations and individuals across the community. We encourage you to partner with us in tackling the health challenges highlighted in this assessment.

We value our community partners and we're committed to fostering growth, cultivating positive relationships and providing resources to our North Texas community. Please visit our website or simply scan the QR code below to learn more.



2024 Implementation Strategy Plans

Cook Children's has created targeted implementation strategies to address the priority health issues identified in this assessment. Detailed strategy plans for both Cook Children's Medical Centers in Fort Worth and Prosper can be accessed on our [website](#), or simply scan the QR code below.



Available resources

Below is a list of selected key resources addressing the identified children’s health needs within the eight-county service area. These are organized by priority health topic area and specific counties served, along with other general health resources. Family and caregivers can access additional resources through 211 Texas (www.211texas.org) or Tarrant Cares and TXT4Tarrant Care (www.tarrantcares.org).

Selected Community Resources		
Priority	Organization	County
Caregiver support	ACH Children and Family Services	Johnson, Parker, Tarrant
	Center of Hope	Parker
	Children’s Advocacy Centers of Texas	Collin, Denton, Grayson, Hood, Johnson, Parker, Tarrant, Wise
	Children at Risk (C@R)	Collin, Denton, Grayson, Hood, Johnson, Parker, Tarrant, Wise
	City House	Collin
	Court Appointed Special Advocates (CASA)	Collin, Denton, Grayson, Hood, Johnson, Parker, Tarrant, Wise
	Family Resource Center – Denton ISD	Denton
	Help Me Grow North Texas	Collin, Denton, Grayson, Hood, Johnson, Parker, Tarrant, Wise
	Lena Pope Counseling Services	Parker, Tarrant
	MasterKey Ministries of Grayson County	Grayson
	Mission Granbury	Hood
	Rancho Brazos Community Center	Hood
	The Women’s Center of Tarrant County	Tarrant
Injury prevention, mental health and general health	Beautiful Feet Ministries Homeless Services	Tarrant
	Clinica Guadalupe	Tarrant
	Southeast Community Health Center	Tarrant
	Health Equity Alliance (HEAL)	Tarrant
	Community Healthcare Clinic	Collin
	Cornerstone Assistance Network and Medical Services	Tarrant
	Crowley House of Hope Clinic	Tarrant
	Denton County MHMR	Denton
	Grapevine Relief and Community Exchange (GRACE)	Tarrant
	Grand Prairie Community Health Center	Tarrant
	Grapevine Relief and Community Exchange	Tarrant
	Grayson County MHMR	Grayson
	JPS Health Network	Tarrant
	LifePath Systems (Collin County MHMR)	Collin
	MHMR Tarrant County	Tarrant
	Mission Arlington	Tarrant
	North Texas Area Community Health Centers	Tarrant
	Open Arms Health Clinic	Tarrant
UNT Health Science Center, Patient Care Center, Pediatrics	Tarrant	

Priority	Organization	County
Oral health	Catholic Charities Dental	Tarrant
	Collin County Community College Dental Hygiene Center	Collin
	Community Dental Care	Collin, Grayson
	Dental Health Arlington	Tarrant
	Denton County Public Health – Dental Services	Denton
	Denton Kiwanis Club Children’s Clinic	Denton
	Family Health Center on Virginia	Collin
	First Refuge Ministries Dental Clinic	Denton
	Fort Worth District Dental Society	Tarrant
	Four Rivers Dental Clinic	Denton
	Mercy Clinic (Medical, Dental)	Tarrant
	Mission Arlington	Tarrant
	Tarrant County College Dental Hygiene Clinic	Tarrant
	Texas Woman’s University Dental Hygiene Clinic	Denton
Hospitals	Baylor Medical Center Irving	Collin, Denton
	Baylor Scott and White Health	Collin, Denton, Grayson, Tarrant
	Children’s Medical Center	Collin, Denton, Grayson
	Denton Regional Medical Center	Denton
	Huguley Memorial Medical Center	Tarrant
	Lake Granbury Medical Center	Hood
	JPS Health Network	Tarrant
	Medical City Healthcare	Collin
	Methodist Charlton Family Medicine Center	Collin
	North Texas Medical Center	Grayson
	Plaza Medical Center of Fort Worth	Tarrant
	Presbyterian Hospital of Denton	Denton
	Texas Health Resources / Texas Health Presbyterian	Collin, Denton, Grayson, Johnson, Parker, Tarrant
	Texoma Medical Center	Grayson, Collin
	University Behavioral Health of Denton	Denton
	Wilson N. Jones Regional Medical Center	Grayson, Collin
Wise Health System	Wise	
Last resort funding	Community Services, Inc.	Collin, Denton
	Christian Community Action	Denton
	Family Promise of Collin County	Collin
	Family Promise of Grayson County	Grayson
	Gill Children’s	Tarrant
	Masonic Children and Family Services of Texas	All counties
	Northwest Christian Community Services	Denton
	Patient Access Network Foundation	All counties
	UnitedHealthcare Children’s Foundation	All counties
Public health agencies	Collin County Public Health	Collin
	Denton County Public Health	Denton
	Parker County Hospital District	Parker
	Tarrant County Public Health	Tarrant

Cook Children’s Health Care System offers a medical center, **seven** neighborhood clinics to serve low-income families in Tarrant County, and over **50** primary care offices and urgent care centers in Collin, Denton, Hood, Johnson, Parker and Tarrant counties. Please see www.cookchildrens.org for specific locations.

Child health issues not directly addressed

This assessment has highlighted a range of health challenges faced by children and families that extend beyond Cook Children's capacity to directly address through community programs. Many of these issues are being addressed collaboratively across the community, with Cook Children's playing a leading or supportive role in areas such as infant mortality, teen pregnancy, child substance abuse, school graduation rates, and vision and hearing screenings, among others. Cook Children's is currently engaged in community-wide initiatives listed below.

Community-wide initiatives	
Best Place for Kids (Tarrant)	MHMR-Help Me Grow North Texas (all eight-counties)
Blue Zones Project Fort Worth	NorTex Community Advisory Board
Burleson Be Healthy Initiative (Johnson)	North Texas Asthma Consortium
Challenge of Tarrant County (SOAR & Stay on Track) (Tarrant)	North Texas Food Bank
Child Fatality Review Team (Tarrant)	North Texas Health Alliance
Children at Risk - North Texas	Nurse Family Partnership Advisory Board (Tarrant)
Children's Hospital Association, Community Health Group	One Second Collaborative (Tarrant)
Children's Well-Being Collaborative (Tarrant)	Parker County Community Resource Group
Community Response to Homelessness in Early Childhood (Tarrant)	Tarrant Area Food Bank
Cornerstone Community Action Agency	Tarrant Cares (Governance Committee) (Tarrant)
Denton County Behavioral Health Leadership	Tarrant County Food Policy Council
Denton County Healthy Communities Coalition	Texas Child Heat Stroke Task Force
Denton Regional Suicide Prevention Coalition	Texas Drowning Prevention Alliance Fort Worth Safe Communities (Tarrant)
DFW Hospital Council – North Texas	TexProtects
Early Childhood Wellness Council (Tarrant)	THR Collin County Collaborative (Collin)
Early Learning Alliance of North Texas (Tarrant)	THR Harris Fort Worth Community Health Council (Tarrant)
First 3 Years (All eight-counties)	Turning Point Rape Crisis Center (The Violence Prevention Workgroup) (Collin)
Fort Worth Drowning Prevention Coalition (Tarrant)	United Way Steering Committee – Arlington (Tarrant)
Fort Worth Housing Solutions (Tarrant)	UNT Health Science Center - Community Advisory Board (Tarrant)
Health Equity Alliance (HEAL) (Tarrant)	UNT Health Science Center SaferCare Texas (Tarrant)
Healthy Tarrant County Collaboration	WestAid (Tarrant)
Hood County Substance Abuse Council	Wise County Health Forum
Immunization Collaboration of Tarrant County	
Johnson County Community Resource Group	
Johnson County Mental Health Connection	
LVT Rise (Tarrant)	
Mental Health Connection of Tarrant County (Tarrant)	

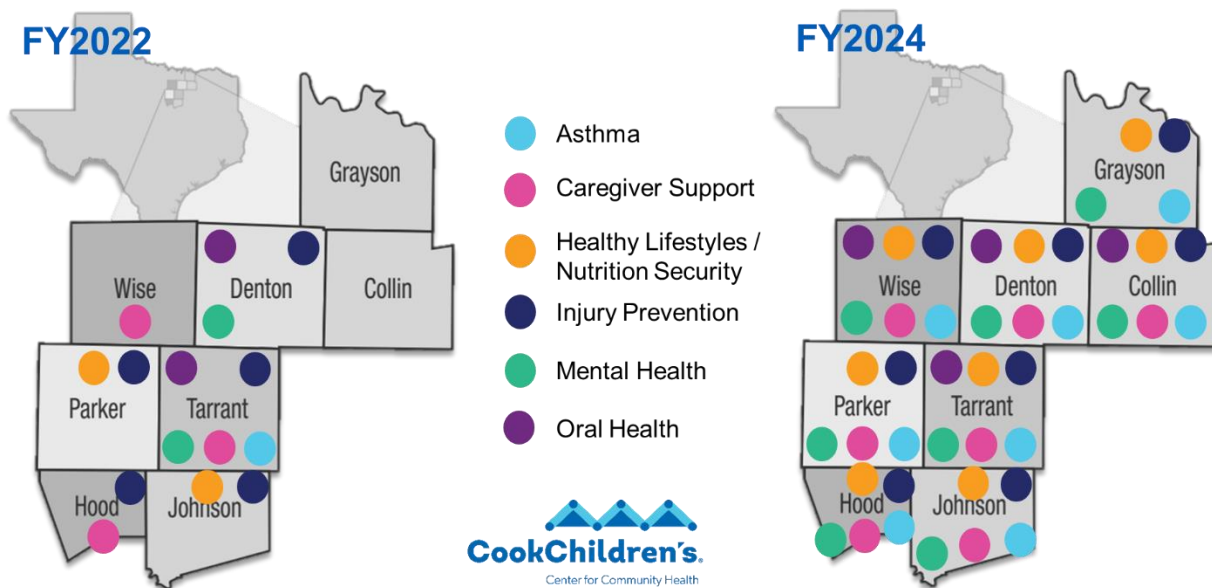
Note: These issues were not included in the Cook Children's Board of Trustees prioritization process.

Progress made since the 2021 CHNA

The seven health priorities outlined in the 2021 Community Health Needs Assessment (CHNA) provided the strategic foundation for Cook Children’s [community outreach initiatives](#) through 2024. The following pages feature one-page summaries highlighting the impact of these efforts in addressing key priorities: oral health, caregiver and family support, mental health, injury prevention, healthy lifestyles, asthma, and overall health and well-being, with an emphasis on access to care. Detailed evaluation results and outreach activities are included to offer a comprehensive overview. These priorities also guided Cook Children’s policy and advocacy strategies. Progress on each focus area is described through the lens of the [Spectrum of Prevention](#) framework.

The 2021 CHNA was a joint assessment between Cook Children’s Medical Center-Fort Worth and Cook Children’s Medical Center-Prosper. This collaboration expanded Cook Children’s community benefit efforts to include new counties within the primary service area for Prosper, informing its implementation strategy plan. Efforts to address priority focus areas were further scaled across the combined 8-county service area. Figure 6 below illustrates growth from Fiscal Year 2022 through Fiscal Year 2024, showcasing expanded strategy efforts.

Figure 6. Progress made in expanding efforts across the eight-county service area from Fiscal Year 2022 – Fiscal Year 2024



Combined evaluation metrics across all priority health issues from Fiscal Year 2022 – Fiscal Year 2024:

<p>Led and organized 3,200 events, trainings, & meetings</p>	<p>Supported over 1,000 partner-led events</p>	<p>Distributed 1.6M resources at a value of \$2.5M</p>	<p>Provided 27,000+ social services and referrals from CHWs</p>
<p>Engaged 1,700+ partners representing 740 organizations</p>	<p>Coordinated 16,000 hours of volunteer support valuing \$890,000</p>	<p>Delivered 74,770 minutes of education to families and partners</p>	<p>Received 3.4M views on produced educational videos</p>

Priority health issue: Oral health

Evaluation highlights since 2021 CHNA: Fiscal Year 2022 – Fiscal Year 2024

Say cheese!



Influencing policy & legislation	<ul style="list-style-type: none"> • Advocated for four legislative priorities, successfully supporting House Bill 12, which extended postpartum Medicaid coverage from 2 months to 12 months.
Changing organizational practices	<ul style="list-style-type: none"> • Secured funding from the AAPD Foundation for a three-year medical-dental integration pilot program, demonstrating the connection between oral health, overall health and wellness. • Utilized this medical-dental integration pilot opportunity at Cook Children’s Renaissance Neighborhood Health Center through coordinated care led by a Community Health Worker (CHW), addressing obstacles such as transportation, translation and social support. • Transitioned part-time Oral Health Director to a new role of Dental Integration Director, enhancing system-wide support and clinical expertise, and hired a full-time Director of Community Oral Health.
Fostering coalitions & networks	<ul style="list-style-type: none"> • Celebrated the 25th anniversary of the Children’s Oral Health Coalition, engaging 70+ active partner organizations. • Marked the 20th anniversary of Save a Smile, which received national recognition from the American Dental Association for over 20 years of service. • Engaged 260 community partners, contributing over 4,000 volunteer hours valued at \$125,000 to support oral health initiatives. • Annually collaborated with numerous partners to expand programming and outreach across the 8-county service area.
Educating providers	<ul style="list-style-type: none"> • Partnered with Concorde Career College to establish a dental hygiene clinic day, where hygiene students performed preventive dental care and procedures. • Earned the “Best Practices for Overcoming Barriers” award at the AAPD Foundation grantee workshop. • Updated and rebranded the Oral Health Train-the-Trainer curriculum, training 150 ambassadors to educate parents on children’s dental care using best practices.
Promoting community education	<ul style="list-style-type: none"> • Increased awareness during National Children’s Dental Health Month through expanded signage, targeted messaging, resource distribution and volunteer-led events. • Presented at multiple national conferences, highlighting the critical link between oral health and overall well-being. • Hosted over 400 oral health related events, meetings, and trainings for families and partners, while supporting over 130 events led by community partners.
Strengthening individual knowledge & skills	<ul style="list-style-type: none"> • Delivered over 3,000 minutes of education to children, caregivers, families and partners. • Conducted more than 20,000 limited oral health evaluations across 21 elementary schools. • Provided 7,000 dental treatment procedures, valued at over \$1 million, through the efforts of 80+ volunteer dentists. • CHWs provided over 7,100 social support services and referrals to community resources, including transportation to dental care, application and translation assistance. • Distributed over 250,000 prevention and education materials, valued at more than \$194,000, including oral health kits, brushing timers, and informational brochures. • Received over 2,300 views of organized and produced oral health educational videos.

Priority health issue: Mental health

Evaluation highlights since 2021 CHNA: Fiscal Year 2022 – Fiscal Year 2024

You matter!



Influencing policy & legislation	<ul style="list-style-type: none"> • Every city (20) in Denton County, including the Denton County Commissioners Court, declared May as Children’s Mental Health Awareness month.
Changing organizational practices	<ul style="list-style-type: none"> • Collaborated with community partners to develop and support workplace wellness rooms, promoting employee well-being. • Maintained the Tarrant Cares website and texting program, enabling families in Tarrant County to locate community resources.
Fostering coalitions & networks	<ul style="list-style-type: none"> • Partnered with 200 community partners, contributing more than 1,000 volunteer hours valued at \$43,700 to support mental health initiatives. • Received the Denton Independent School District (ISD) Stand Up for Texas Public Schools award for advancing mental health awareness and programming. • Provided financial support to the Mental Health Connection of Tarrant County, serving as a foundational member dedicated to improving access to and education about mental health services.
Educating providers	<ul style="list-style-type: none"> • Hosted Wellness Workshops offering over 2,600 CEUs to 1,380+ attendees, with 93% reporting validation or improvement in their practice. Topics included resilience, adverse childhood experiences, and recognizing and responding to commercially sexually exploited youth. • Transitioned the “Children’s Feelings Are a Work of Art” initiative into a Train-the-Trainer model, enhancing community capacity.
Promoting community education	<ul style="list-style-type: none"> • Collected 540+ unique art submissions from children and youth through the “Children’s Feelings Are a Work of Art” initiative, raising mental health awareness and reducing stigma. Submissions inspired t-shirt designs and engaged the community during Mental Health Awareness Month. • Created over 2,100 counselor kits to support school districts and community partners in promoting mental health. • Expanded Mental Health Awareness Month into a comprehensive system-wide and community initiative, increasing access to resources and engagement. • Hosted 275 mental health-related events, meetings and trainings, while supporting nearly 40 partner-led community events.
Strengthening individual knowledge & skills	<ul style="list-style-type: none"> • Delivered over 2,300 minutes of mental health education to children, caregivers, families and partners. • Streamlined digital mental health resources and videos for caregivers and families on the center’s website. • Created the “Roadmap to Children’s Mental Health” video series, which improved access to mental health resources for families and caregivers, generating over 350,000 views. • Distributed more than 14,000 mental health education and prevention materials, valued at \$230,300, including coping card decks, sensory gadgets, grief journals and emotional health materials. • Provided grief support items to schools and organizations to help navigate the loss of students or employees.

Priority health issue: Injury prevention

Evaluation highlights since 2021 CHNA: Fiscal Year 2022 – Fiscal Year 2024

Safety first!



<p>Influencing policy & legislation</p>	<ul style="list-style-type: none"> Expanded addition of safe baby sleep education materials in all new birth certificate requests and vital records mailings across Hood, Tarrant and Wise Counties through County Clerk. Collaborated with three major cities (Prosper, Arlington, and Alvarado) to officially declare August as Gun Safety Awareness Month.
<p>Changing organizational practices</p>	<ul style="list-style-type: none"> Launched an innovative, interactive gun safety artificial reality platform at a local gun store for firearm purchasers and their children, with a mobile version utilized in classroom settings for school-based gun safety education. Established five new fitting stations with community organizations to provide car seat checks and resources across the service area. Expanded poison prevention programming to address older adolescent age groups, focusing on the risks of unintended and intentional ingestion injuries. This included staff training on Naloxone use and partnerships to provide it to caregivers and community partners.
<p>Fostering coalitions & networks</p>	<ul style="list-style-type: none"> Partnered with 600 community partners, contributing more than 6,000 volunteer hours valued at over \$181,000 to support injury prevention initiatives. Expanded injury prevention programming to all eight counties in Cook Children’s service area by leading a collaborative effort and supporting five action teams. Collaborated with partners to establish programming for teen driver safety, offering IMPACT Teen Driver education and roadside kit incentives.
<p>Educating providers</p>	<ul style="list-style-type: none"> Expanded National Child Passenger Safety Technician training opportunities to community organizations and partners in the Prosper service area. Developed a Train-the-Trainer program for gun safety, equipping community partners to educate families about safe storage and play practices. Continued hosting the annual Safe Baby Sleep Symposium, featuring public health, public safety, and health care professionals, and providing Continuing Education credits for participants.
<p>Promoting community education</p>	<ul style="list-style-type: none"> Supported 24 Cook Children’s life jacket loaner stations across lakes and pools in 11 counties, while maintaining 22 partner-managed stations with Cook Children’s life jackets. Created a Fentanyl Awareness Art Gallery displayed in community settings such as libraries. Lifeguard Your Child 2023 video is the Gold Telly Winner in Branded Content – Social Responsibility. Poison Prevention 2023 video is the Silver Telly Winner in Branded Content - Social Responsibility and Social Impact. Poison Prevention 2023 video is the Silver Telly Winner in Social Video - Public Service & Activism. Hosted 1,000 injury prevention outreach events and supported 290 community partner events.
<p>Strengthening individual knowledge & skills</p>	<ul style="list-style-type: none"> Delivered 37,200 minutes of education to children, parents, and community partners through outreach and programming. Distributed more than 803,000 prevention tools and educational resources, valued at over \$1,000,000. Developed and distributed poison prevention materials tailored to adolescent safety, emphasizing proper Naloxone use. Continued providing roadside safety kits to teens as part of driver safety programming. Reached 772,100 views of center-produced educational videos.

Priority health issue: Caregiver support

Evaluation highlights since 2021 CHNA: Fiscal Year 2022 – Fiscal Year 2024

Building connections!



Influencing policy & legislation	<ul style="list-style-type: none"> Actively engaged with Children at Risk to identify top legislative opportunities for improving children’s health access and well-being, while serving as one of the Leadership Chairs for the Texas Family Leadership Council to foster statewide insights and collaboration.
Changing organizational practices	<ul style="list-style-type: none"> Continued contracting with a Caregiver Support Champion to support and sustain programming growth. Actively participated in the Tarrant County Maternal and Infant Health Coalition working to improve maternal health outcomes by increasing closed-loop referrals to needed services, boosting Parent Pass downloads for new mothers as a centralized resource, and capturing actionable data insights to support hospital and community partners.
Fostering coalitions & networks	<ul style="list-style-type: none"> Partnered with 290 community partners, contributing more than 1,200 volunteer hours valued at over \$37,800 to support caregiver support initiatives. ACEs Task Force expanded partnership beyond Tarrant County and merged with the Thriving Communities Collaborative to provide additional support with the intersection of caregiver support and mental health. Expanded caregiver support programming across Cook Children’s eight-county service area by leading a collaborative initiative and supporting a caregiver support action team.
Educating providers	<ul style="list-style-type: none"> Provided training for community professionals that defines what Adverse Childhood Experiences (ACEs) are, their impact, and prevention strategies. An additional training for providers is focused on the importance of Positive Childhood Experiences (PCEs).
Promoting community education	<ul style="list-style-type: none"> Expanded Parent Cafés and Counselor Roundtables to additional counties across the 8-county service area. Collaborated with partner organizations to distribute Child Abuse Prevention Month materials across 8-county service area. Developed an educational video series for caregivers, focusing on the importance of establishing a medical home and engaging in well-child visits. Reached 278,700 views of center-produced educational videos. Hosted over 450 outreach events and supported 130 community partner events, serving and engaging 1,420 families and community partners.
Strengthening individual knowledge & skills	<ul style="list-style-type: none"> Designed and implemented the Build-a-Bridge™ program alongside the companion Caregiver Alliance. These initiatives strengthen protective factors for families facing adversity, increase parent awareness of the importance of establishing medical homes for children, and enhance access to community resources. Caregiver Alliance provides education on parenting topics and helps build social support systems for families. Build-a-Bridge™ Community Health Workers (CHWs) provided over 1,250 social support services and referrals to community resources connecting families to medical homes and other basic needs. Promoted Roadmap to Mental Health video series among caregivers through Build-a-Bridge™ program and Parent Cafés. Delivered 13,125 minutes of education to children, parents, and community partners through outreach and programming. Distributed 23,900 prevention tools and educational resources, valued at \$62,720.

Priority health issue: Healthy lifestyles

Evaluation highlights since 2021 CHNA: Fiscal Year 2022 – Fiscal Year 2024

Happy, healthy, active!



Influencing policy & legislation	<ul style="list-style-type: none"> Joined and maintained membership with the Tarrant County Food Policy Council, focusing on the promotion of Summer Meal Sites and advocating for local policies against sugar-sweetened beverages.
Changing organizational practices	<ul style="list-style-type: none"> Implemented food security screening across the center’s programs using the Hunger Vital Signs tool in collaboration with Community Health Workers. Expanded healthy lifestyles programming to include Nourishing Communities, addressing nutrition security needs identified in the 2021 CHNA. Executed a contract with the first Healthy Lifestyles Champion to support and sustain programming growth.
Fostering coalitions & networks	<ul style="list-style-type: none"> Partnered with 130 community partners, contributing more than 800 volunteer hours valued at over \$23,900 to support healthy lifestyles initiatives. Expanded healthy lifestyles programming to the entire Cook Children’s 8-county service area through leading a collaborative and supporting a healthy lifestyles action team. Executed contract with the first Healthy Lifestyles Champion to support and sustain programming growth. Established new partnerships to address the food and nutrition needs of underserved communities including supporting food pantries and backpack programs, piloting food delivery programs, establishing community gardens at 11 Tarrant County Head Start locations), and providing kitchen supplies to 55 families moving into permanent supportive housing. Established joint partnership between the center, Cook Children’s Health Plan, and the Tarrant Area Food Bank to increase access to food for families and support clinical, educational, and Medicaid/CHIP/SNAP application assistance through a mobile market. Began screening families served in the center’s programs for food insecurity, while providing connection to immediate food and SNAP and WIC application assistance.
Educating providers	<ul style="list-style-type: none"> Transitioned the microgreen curriculum from a direct-education model to a Train-the-Trainer format, increasing local organizations capacity to educate children and families about healthy eating.
Promoting community education	<ul style="list-style-type: none"> Implemented the first Every Kid Healthy Week in collaboration with Texas AgriLife, providing activity bags, garden workshops, and 5-2-1-0+ education. Strengthened the Kid Power partnership through Classroom Champions, addressing social-emotional wellness, mental health, and philanthropy via an interactive technology platform, with 131,000 children engaging in 70,600 minutes of educational video content.
Strengthening individual knowledge & skills	<ul style="list-style-type: none"> Hosted over 460 center-led outreach events and supported 50 community partner events related to healthy lifestyles, serving more than 6,700 families and community partners. Delivered 4,275 minutes of education to children, parents, and community partners through outreach and programming. Distributed 46,300+ prevention tools and educational resources, valued at over \$92,700. Achieved 1,400 views of educational videos produced by the center.

Priority health issue: Asthma

Evaluation highlights since 2021 CHNA: Fiscal Year 2022 – Fiscal Year 2024

Breathe easier!



Influencing policy & legislation	<ul style="list-style-type: none"> Tarrant County Commissioner’s Court recognized May as Asthma & Allergy Awareness Month in support of the collaborative efforts across North Texas highlighting the importance of education, prevention, and management for children affected by asthma.
Changing organizational practices	<ul style="list-style-type: none"> Hired an additional Community Health Worker (CHW) to support programmatic growth and serve more families. Piloted three new referral streams to the Healthy Homes Asthma Program in collaboration with Cook Children’s Health Plan and their Asthma Disease Management Program. Active and supporting member of Asthma 411 which provided resources for school nurses to help children who have trouble breathing. As part of the program, a school nurse can give a breathing treatment to a child who is struggling to breathe while at school. At the close of 2024, 10 school districts and over 350 school campuses participated in the program.
Fostering coalitions & networks	<ul style="list-style-type: none"> Partnered with various community partners, contributing more than 30 volunteer hours valued at over \$950 to support asthma-related initiatives. Expanded Asthma 411 services to three new school districts: Joshua ISD, Alvarado ISD and Keene ISD. Collaborated with school districts and regional partners to expand Asthma 411 School Nurse In-service educational opportunities to school health staff across Texas. Founding partners of the North Texas Pediatric Asthma Coalition, which launched the inaugural Pediatric Asthma Summit to foster collaboration and address regional needs.
Educating providers	<ul style="list-style-type: none"> Provided training to school health staff, enhancing their ability to recognize and manage asthma-related incidents.
Promoting community education	<ul style="list-style-type: none"> Developed 10 new asthma educational videos and translated key materials into nine languages to ensure accessibility for families. Healthy Homes Asthma Program piloted expanded services for families on the waitlist, including group education sessions with one-on-one follow-up.
Strengthening individual knowledge & skills	<ul style="list-style-type: none"> Healthy Homes Asthma Program CHWs provided more than 9,000 social support services and referrals to community resources, such as rental assistance and food. Healthy Homes also provided over \$51,000 of contract services, such as air duct and carpet cleaning, along with pest removal—mitigating environmental asthma triggers in program families’ homes. Hosted over asthma related outreach events and supported over 140 community partner events, engaging more than 2,400 families and community partners. Delivered 270 minutes of asthma-related education to children, parents, and community partners. Distributed over 48,000 prevention tools and educational resources, valued at \$255,000. Achieved 4,800 views of center-produced asthma educational videos.

Priority health issue: Access to care

Evaluation highlights since 2021 CHNA: Fiscal Year 2022 – Fiscal Year 2024

Care for all!



Influencing policy & legislation	<ul style="list-style-type: none"> • Played a vital role in supporting caregivers during the Medicaid unwinding process by providing education, resources, and direct assistance to families navigating coverage changes.
Changing organizational practices	<ul style="list-style-type: none"> • Integrated a full-time liaison coordinator between the center and Cook Children’s Health Plan to enhance access to health care through a community-based service delivery system. This coordinator led nearly 30 stakeholder meetings and presentations, educated over 850 children and families on prevention efforts to keep children healthy and safe, and assisted with resource distributions. • Integrated a Medical Director to provide clinical expertise across all priority focus areas. • Transitioned the Director of Oral Health to the Dental Integration Director role to support system-wide oral health education and opportunities while continuing to provide clinical expertise and representing Cook Children’s on national and state committees. • Hired two Evaluation, Operations, and Research Managers, along with a Community Health Analyst, to support the community health needs assessment, community benefit initiatives and program evaluation. • Streamlined research processes and timelines for the Community Health Needs Assessment.
Fostering coalitions & networks	<ul style="list-style-type: none"> • Further researched and developed a new center outreach model to enhance collaboration, extend reach across entire eight-county focus area, and expand capacity while maintaining consideration of limited resources. • Transitioned coalitions into action teams to better support workloads and expand efforts across the eight-county service area.
Educating providers	<ul style="list-style-type: none"> • Ensured Cook Children’s Health Plan member-facing staff receive annual training from the center on ACEs, asthma, healthy lifestyles, injury prevention and oral health. • Collaborated with the University of North Texas Health Science Center, vaccine clinics, and the Immunization Collaboration of Tarrant County (ICTC) to engage Tarrant County ISDs and increase vaccination efforts.
Promoting community education	<ul style="list-style-type: none"> • Supported Cook Children’s Health Plan as they led the Public Health Emergency (PHE) Work Group to develop communications on Medicaid changes, while the center promoted this information across North Texas to help ensure families remained covered. • Provided financial support for the Immunization Collaboration of Tarrant County’s efforts of delivering 51,400 vaccine doses to over 22,000 eligible children at their August back-to-school events.
Strengthening individual knowledge & skills	<ul style="list-style-type: none"> • Established an annual parent survey methodology for the community health needs assessment to ensure regular feedback from parents and caregivers, supporting trend analysis. • Provided education to low-income families on the importance of immunizations, available resources, and vaccine requirements across multiple venues. • Cook Children’s Health Plan staff distributed 40,100 center resources to members and potential members, 9,800 unique provider emails, and mailed 89,200 newsletters to new Health Plan members, incorporating key messaging from the center.

Acknowledgements

The center recognizes the vital role of community partners, families and local voices in shaping the 2024 CHNA. By listening to insights and experiences, we have identified some key priorities, assets, and challenges impacting children and families across the eight-county service area. We are proud to collaborate with other community members and organizations dedicated to improving children’s health through innovation and perseverance.

Community stakeholders

External advisory committee members

Heather Beal, MHCM

Wise Health System

John Biggan, Ph.D.

ACH Child and Family Services

Godfred Boateng, MPhil, PhD

York University

Stephanie Chandler, MBA

Community Well TX

Sharla Caro

Rancho Brazos Community Center

Margaret Cohenour, MSW

Paluxy River Children’s Advocacy Center

Leah King, CFRE

JPS Foundation

Lexi Lee, MA, LPC

Lee Counselling Services

Tammy Mahan, MA, LPC-S

Lifepath Systems

Keely McCrady, BA

Texas A&M AgriLife Extension

Micky Moerbe, MPH, CPH

Tarrant County Public Health

Patricia Rivera, BS, CFLE, CHW, CPST

Texas Department of State Health Services

Nicole Rosenbaum

Children’s Advocacy Center for North Texas

Mia Ruiz

Rancho Brazos Community Center

Linsey Schafer, DSW, LCSW, MSSW

Communities in Schools of North Texas

Community leader interviews

Heather Beal

Healthy Wise County
Wise County

Kathleen Burton

Cornerstone Community Action Agency
Wise County

Lisa Elliott, PhD

Cook Children's Health Care System
Denton County

Claudia Gonzalez

Texas Health Resources
Tarrant County

Dan Guzman, MD

Cook Children's Health Care System
Tarrant County

Tammy Mahan

Lifepath Systems
Collin County

Crystal Moore

United Way of Hood County
Hood County

Cintia Ortiz

Parker County Offices
Parker County

Alex Reed

Denton County Public Health
Denton County

Julia Richardson

Granbury Housing Authority
Hood County

Nicole Rosenbaum

Children's Advocacy Center for North Texas
Wise County

Carlos Walker

Fort Worth ISD
Tarrant County

Research partners

Linda Fulmer, MEd

Cook Children's CHNA Administrator

Chris Tatham, MBA

ETC Institute

Erika Thompson, PhD, MPH, CPH

University of Texas School of Public Health
San Antonio

Evaluation and Outcomes Division

MHMR of Tarrant County

Marc Mazade, MD, MPH

Cook Children's Health Care System

Stacey Griner, PhD, MPH, RDH

University of North Texas Health Science Center at Fort Worth

Ashenafi Cherkos, PhD, MPH

University of North Texas Health Science Center at Fort Worth

Grace Maynard, MPH

University of North Texas Health Science Center at Fort Worth

Cook Children's interdepartmental support

Center for Community Health

Compliance

Education

Finance

Health Care Analytics

Health Plan

Internal Audit

Legal

Media Services

Research

Strategic Marketing and Communications

Trauma Services

Contact information

Cook Children's

Center for Community Health

Chris Pedigo, MHA, RN

Senior Vice President

Chief Strategy, Education and Community Health Officer

Becki Hale, EdD, MA, RDH

Assistant Vice President

Lauren Purvis, MPH, CPH, MCHES®

Director, Child Health Evaluation

Mandy Spadine, Ph.D., MPH, CPH, CHES®

CHNA/Research Manager, Child Health Evaluation

Rishita Parikh, MPH

Evaluation Manager, Child Health Evaluation

Jennifer Wright, MPH, CIC®

Operations Manager, Child Health Evaluation

Savannah Panagopoulos, MPH, CHES®

Community Health Analyst, Child Health Evaluation

Allison Christian, MPH, CPH, CHES®

Community Health Analyst, Child Health Evaluation

Veronica Maples, MPH, CHES®

Community Health Analyst, Child Health Evaluation

Additional contributors

Courtney Barnard, EdD, LMSW-AP

Director, Child Wellness

Lenee Bassham, MSSW

Director, Child Injury Prevention

Ottis Goodwin, MA, LPC-S

Director, Community Oral Health

Tonya Fuqua, DDS

Director, Dental Integration

Julien Ybarra, MPH, CHW

Program Coordinator, Adverse Childhood Experiences

Manal Ayub, MPH, CPH

Intern, University of North Texas Health Science Center

Sonal Mehrotra, MPH, CPH

Intern, University of North Texas Health Science Center

Suha Taha, MPH, CPH

Intern, University of North Texas Health Science Center

Partner Contributors

Linda Fulmer, M.Ed.

Cook Children's CHNA Administrator

Fulmer & Associates

Erika L. Thompson, PhD, MPH, CPH

Associate Professor, Department of Quantitative and Qualitative Health Sciences

University of Texas School of Public Health San Antonio



For more information or questions email CHNAfeedback@cookchildrens.org or visit cookchildrenscommunity.org

Appendix 1

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Appendix 2

The data collection methods for this CHNA are outlined in the [methodology](#) section. Additional details regarding the parent/caregiver survey are provided below. Full protocols and survey instruments of all methods are available upon request.

Eight-county parent/caregiver survey

Sampling

- ETC Institute utilized Data Axle as the primary source of the sample.
- ETC Institute prepared a sampling plan to manage the administration of the parent survey to at least 2,000 parents/caregivers per year for three years of the rolling survey.
- The sample was stratified to ensure the goals for each of the eight counties and 149 sub-sampling areas would be obtained.
- The sample included two types of respondents: (1) The Panel and (2) Random Sample.
 - The Panel: recruited households that participated in the 2021 Parent Survey. If ETC Institute was not able to complete 1,000 Panel surveys per year, they will complete additional surveys with the random sample to ensure that a minimum of 2,000 surveys are completed each year.
 - Random Sample: recruited at least 1,000 new households at random each year.
- The sample was address-based and each residential household type (i.e., house, condominium, apartment, mobile home) had an equal probability of being selected.
- ETC Institute oversampled parents/caregivers in hard-to-reach areas and/or among demographic groups that are less responsive.

Administration

ETC Institute mailed the survey and a cover letter to each of the households selected for the survey:

- The survey included a letter that explained the purpose of the survey. The letter listed the website for the online version of the survey. The letter also contained a PIN number that the respondents had to provide to complete the survey online to ensure participation in the random survey was limited to those selected as part of the random sample.

Residents who received the survey had the option of completing it in the following ways:

- By mail using a postage-paid return envelope, included with the survey.
- By going online to a website, the website and QR code were printed on the survey.
- By calling a toll-free number, which was printed on the survey. ETC institute provided interviewers who answered inbound calls from residents who preferred to complete the survey by phone in English or Spanish.

ETC Institute followed up with households that did not respond to the survey to maximize participation in the survey as follows:

- By sending emails and texts for households for whom email addresses/phone numbers can be obtained. The communication contained a link to the online survey.
- By calling households and leaving voice messages about the survey that did not answer their phone. ETC Institute will give those who answer their phone an opportunity to complete the survey by phone in English and Spanish.
- By sending reminder postcards to encourage participation.

ETC Institute conducted follow-ups by phone and email until each of the sampling goals were met and a minimum of 6,000 surveys and priority zip code data collection was completed.

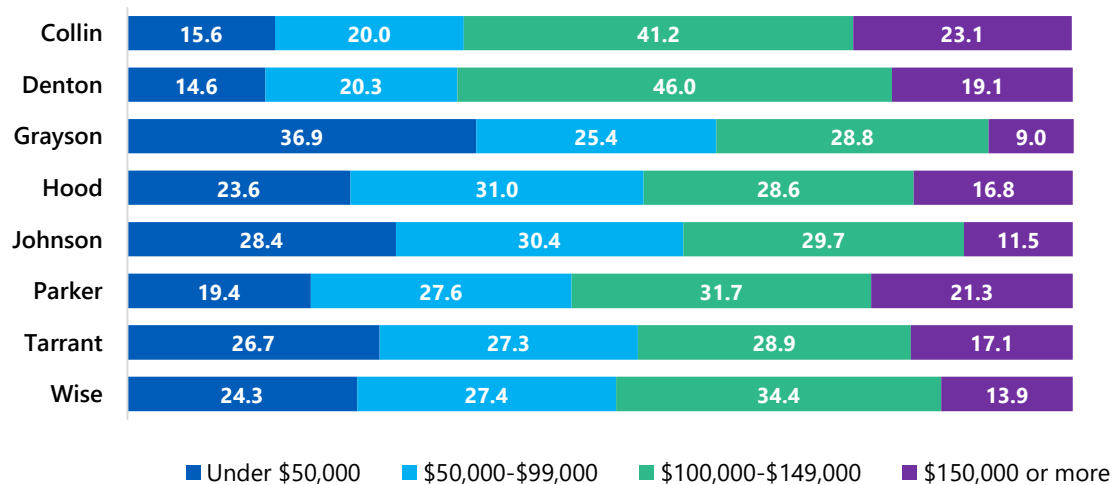
Distribution of respondents

County	Goal for completed surveys	Completed surveys
Collin	450	505
Denton	1,290	1,510
Grayson	310	361
Hood	210	223
Johnson	460	504
Parker	440	474
Tarrant	2,590	2,985
Wise	250	315
Total	6,000	6,877

Weighting and representation of parent/caregiver survey results

The parent/caregiver survey data was expanded to match 2022 census estimates for the 1,181,591 children under the age 18 living in the eight-county service area with regard to age, race, income, Hispanic ancestry and gender. According to 2022 American Community Survey five-year estimates, the median family income of households with children of each county in the eight-county service area is as follows: Collin, \$140,682; Denton, \$130,127; Grayson, \$73,993; Hood, \$97,477; Johnson, \$86,974; Parker, \$109,857; Tarrant, \$86,236; and Wise, \$96,750.

The graph below details weight income levels of households with children by county according to the caregivers who completed the survey.



The table below shows the comparison of the race and ethnicity of parent/caregiver survey respondents' children with 2022 U.S. census estimates.

	Hispanic		White, non-Hispanic		Black, non-Hispanic		Asian, non-Hispanic		Other/Multi-race*, non-Hispanic	
	Census	Weighted results	Census	Weighted results	Census	Weighted results	Census	Weighted results	Census	Weighted results
Collin	16.2%	16.3%	54.8%	54.5%	10.7%	9.2%	18.3%	13.1%	0.7%	6.9%
Denton	21.5%	20.8%	60.4%	58.3%	11.1%	9.7%	7.1%	5.1%	0.7%	6.2%
Grayson	15.2%	14.4%	76.6%	77.6%	5.5%	5.2%	2.6%	0.6%	1.0%	2.2%
Hood	13.4%	12.5%	84.3%	83.5%	1.0%	1.0%	1.3%	0.0%	0.5%	3.0%
Johnson	24.3%	24.1%	70.1%	69.2%	4.4%	3.5%	1.2%	0.1%	0.3%	3.1%
Parker	14.1%	13.9%	83.2%	82.9%	1.4%	3.5%	1.3%	0.5%	0.5%	1.4%
Tarrant	30.7%	30.2%	45.2%	45.5%	17.4%	15.2%	6.7%	3.3%	0.8%	5.7%
Wise	19.8%	19.9%	72.6%	73.2%	1.3%	1.2%	6.3%	0.6%	0.8%	5.1%
Unhoused & undocumented	N/A	63.2%	N/A	2.7%	N/A	32.3%	N/A	0.0%	N/A	1.8%

* Other/Multi-race: Non-Hispanic children whose parent or caregiver did not solely select White, Black, or Asian on survey

Community leader survey

The survey instrument is available upon request or can be found on our [CHNA dashboard](#). Survey respondents' selected roles within the community and primary county are located in the tables below.

Role in community	
Business	3%
Clergy, religious or faith-based	2%
Community volunteer	11%
Educator/school official	15%
Elected official	2%
Government employee or public health	23%
Medical, dental or mental health professional	23%
Social services or nonprofit	36%
Other	3%

Primary county	
Collin	11%
Denton	9%
Grayson	14%
Hood	9%
Johnson	10%
Parker	10%
Tarrant	33%
Wise	5%

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