



2022 Community Health Assessment

Austin/Travis County,
Texas
May 2022



Together We Thrive
Austin/Travis County Community Health Plan

Correction 08/12/22: Previous online version of the 2022 CHA contained misleading diabetes prevalence information and incorrect dental services survey findings and colorectal screening data.

Photos on the front and back cover of this report were submitted by community members on Facebook, Twitter, and Instagram with the hashtag #LiveHealthyATX in response to the question, "What makes you healthy?"

This social media campaign was used as a creative method to gather public input for the Austin/Travis County Community Health Assessment (CHA).

To our Organizing Partners

- Ascension Seton
- Austin Public Health
- Austin Transportation Department
- Baylor Scott & White Health
- Capital Metro
- Central Health
- Integral Care
- St. David's Foundation
- Travis County Health and Human Services
- The University of Texas at Austin Dell Medical School
- The University of Texas Health Science Center at Houston (UT Health) School of Public Health in Austin

Thank you!



Austin Travis County 2022 CHNA Draft Report

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Dove Springs Proud
El Buen Samaritano
Healthy Williamson County

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LifeWorks
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Mobile Loaves and Fishes
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EXECUTIVE SUMMARY

BACKGROUND

The 2022 Austin/Travis County Community Health Assessment (2022 CHA) involved a number of stakeholders, including health centers, hospitals, university partners, local school districts, community-based organizations, foundations, governmental agencies, and Austin Public Health.

The overarching goals of the 2022 Austin/Travis County Community Health Assessment were to:

- Examine the current health status across Austin/Travis County as compared to state and national indicators
- Explore the current health priorities among Austin/Travis County residents within the social context of their communities
- Identify community strengths, resources, forces of change, and gaps in services to inform funding and programming priorities of Austin/Travis County

To support the 2022 CHA, Austin Public Health hired Health Resources in Action (HRiA), a non-profit public health organization, as a consultant to support and provide strategic guidance on the community engagement and planning process and the collection and analysis of data, and to develop the report.

METHODS

The 2022 CHA leverages a social determinants of health framework. Health is not only affected by genes and lifestyle factors, but by upstream factors such as employment status, quality of housing, and economic policies.

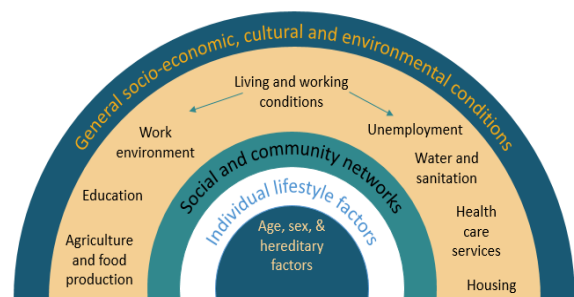
Informed by the Mobilizing for Action through Planning and Partnership (MAPP) framework, developed by the National Association of County and City Health Officials (NACCHO), the 2022 CHA includes three main assessments:

The **Community Partner Assessment** included a summit (n=27) to identify the organizations to involve in the community health planning process. This process identified the priority of engaging direct service providers, organizations affiliated with school districts, resident volunteers or ambassadors, grass-roots initiatives, and faith-based organizations. Participants prioritized focusing on older adults; Black, Indigenous, and People of Color (BIPOC) and Asian communities; and behavioral health.

The **Community Status Assessment** involved the analysis of existing social and health data. These data were drawn from state, county, and local sources, such as the U.S. Census, County Health Rankings, Texas Department of State Health Services, Austin Area Sustainability Indicators Project, Behavioral Risk Factor Surveillance System (BRFSS), and vital statistics based on birth and death records.

The **Community Context Assessment** involved several qualitative methods, including key informant interviews with community leaders (n=20), in-depth interviews with community members (n=2), seven

Social Determinants of Health Framework



SOURCE: World Health Organization, Commission on the Social Determinants of Health, Towards a Conceptual Framework for Analysis and Action on the Social Determinants of Health, 2005.

focus groups with community members (n=48), a radio talk show (n=3), a virtual community forum with community members and leaders (n=16), and photo outreach campaign (n=23) to elicit perceptions of community strengths, needs, and opportunities for change. Content analysis of local assessments provided important context regarding priority communities and topics.

LIMITATIONS

As with all data collection efforts, there are several limitations to the 2022 CHA. Secondary data involve a time lag from the time period of data collection to data availability and some data are not available for specific population groups or at more granular geographic levels due to small sample sizes. In some cases, quantitative data across multiple years need to be aggregated to provide more accurate estimates for a specific group or geographic area. The COVID-19 pandemic introduced some challenges for community outreach and completion of focus groups. Several communities were underrepresented, including refugees, youth, indigenous communities, people with disabilities, and faith leaders.

FINDINGS

POPULATION CHARACTERISTICS

Travis County and Austin experienced an estimated population growth of 26.0% and 20.0%, respectively, from 2010 to 2020, exceeding population growth for Texas (15.9%) and the US (7.4%) during the same period. Several focus group participants and community leaders described the Austin and Travis County region as growing substantially in recent years and perceived that higher income residents were the largest segment of new residents. One focus group participant shared, *“There are no more people born and raised from Austin because they were all priced out.”*

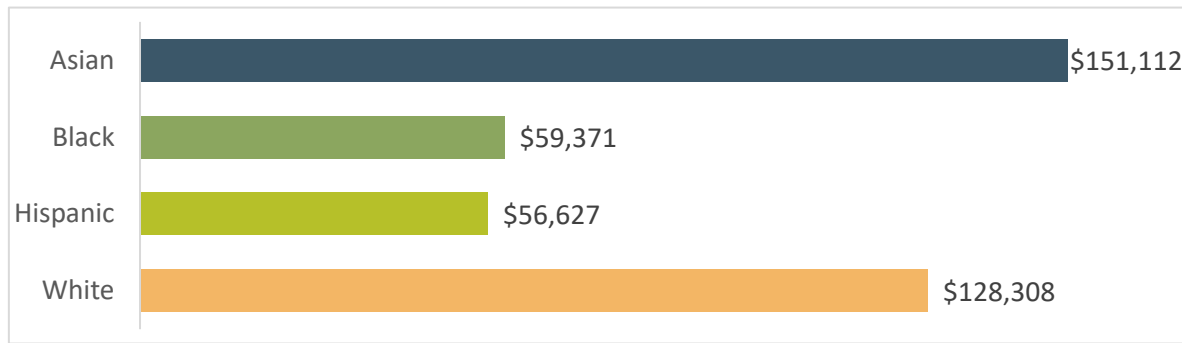
The Austin-Round Rock-Georgetown metropolitan area had the 3rd largest percentage of LGBTQIA+ people in the U.S., with about 5.0% or 90,000 people identifying as LGBTQIA+. About half of residents in Travis County (52.2%) identified as people of color. More than one-third, 34.8%, of Travis County residents identified as Hispanic/Latino, 8.2% identified as Black/African American, and 6.6% identified as Asian. Nearly one-third (30.8%) of residents in Travis County speak a language other than English at home. Several community members and leaders noted the importance of ensuring that information about health and available resources are provided in residents’ primary language. One community leader shared: *“Language access is key. If you don’t have any material to educate yourself about a health disease, then changes can’t really be made.”* Legal status emerged as a barrier to accessing services and resources for undocumented immigrants.

COMMUNITY SOCIAL AND ECONOMIC CONTEXT

Economic Indicators

Income influences where people live, their ability to access higher level training, and their access to resources to help them cope with stressors and health-promoting resources such as healthy food and health care. Low community wealth is linked with more limited educational and job opportunities, greater community violence, environmental pollution and disinvestment in essential infrastructure and resources. In 2019, the median household income in Travis County was \$80,726, a 14.6% increase between 2015 and 2019. The median household income for White households was 2.2 times the household income for Black/African American households and 2.3 times the household income for Hispanic/Latino households in 2019. An estimated one-quarter (25.0%) of LGBTQIA+ survey respondents reported having incomes less than \$24,000. About 13.6% of Travis County children lived in poverty.

Median Household Income, by Race/Ethnicity, by Travis County, 2019



DATA SOURCE: U.S. Census Bureau, American Community Survey 1-Year Estimates, 2019

Many community members and leaders described the cost of living in the area as high and rising and disproportionately affecting low-income residents, residents of color, and older adults. One community leader described, *“If you look at some of our communities, there is no quality of life, it’s just survival.”* Several community members and leaders described residents who work in low-wage jobs that are stressful, hard to get, and offer limited incomes and discussed job loss and reduced hours for low-wage workers during the COVID-19 pandemic. Regarding childcare needs for working individuals, about two-fifths of Black/African American (42.9%) and Hispanic/Latino (41.1%) respondents and 34.2% of White respondents reported difficulty finding affordable childcare.

Education

Education improves employment opportunities, economic and social resources, and health literacy, which shapes understanding of medical information and enables patients to advocate for themselves. Low-income communities and communities of color are affected by inequities in educational funding and access to educational resources. The majority (90.4%) of Travis County adults have a high school degree or higher and 53.0% have a bachelor’s degree or higher. The Hispanic/Latino population has the highest percentage of population without a high school diploma (26.6%). Among students who dropped out of high school, 8.2% were Black/African American, followed by Hispanic/Latino students (6.4%).

Housing

Home and neighborhood environments may promote health or be a source of exposures that may increase the risk of adverse health outcomes. Housing is generally the largest household expense. A key theme was the high and rising cost of housing that disproportionately affects low-income residents, residents of color, older adults, and persons with disabilities and displaced residents from urban areas to rural areas. One community leader shared, *“[B]ecause of [the] increasing cost of living in central core in Austin and due to gentrification, elderly and disabled [residents] are now in more rural areas.”* According to a Housing Market Analysis, about 65% of respondents reported spending greater than or equal to 30% of their monthly income on housing and 17% reported spending greater than or equal to 50% of their monthly income on housing – a severe cost burden. In Austin, White households faced severe cost burden 15% of the time, compared to 25% for Black/African American households; 23% for Hispanic/Latino households; and 20% for Asian households. As such, people of color are more vulnerable to the negative consequences of rising housing costs. Homelessness was an area of concern and disproportionate among LGBTQIA+ youth, people of color, and, more specifically, queer and transgender people of color. Additionally, Travis County census tracts with higher proportions of Black/African American residents have high community-level homelessness risk factors.

Built Environment and Neighborhood

Air, water, and land quality in rural areas and access to grocery stores and community and recreational centers in both urban and rural areas emerged as features of the built environment of concern. Several community members described development as stressful and affecting health. One community member shared, “[There is] demolition across the street [...] the dust coming into the apartment.” The growth of businesses that primarily serve high income residents contributed to the need to travel further to access affordable food and some community members described feeling excluded by the neighborhood design. Several community members and leaders discussed the need to improve access to services, including banks, pharmacies, grocery stores, and urgent care clinics in low-income communities.

Internet and Computer Access and Training

Residents described internet and computer accessibility and training as important for accessing information and resources, staying connected, and participating in remote education. Some community members and leaders noted that internet and computer access was more difficult for low-income residents and rural communities and was critical during the COVID-19 pandemic and Winter Storm Uri.

Transportation

Transportation emerged as a barrier for conducting day-to-day activities such as getting groceries, going to school, and going to the doctor. In 2019, an estimated 60% of Travis County residents spent <30 minutes commuting, around one-third (33%) spent 30-60 minutes commuting and 7% spent over an hour commuting. Community members and leaders described several barriers to using public transit and limited public transportation and medical or senior transit options in rural areas. Senior community members noted that medical ride services were limited and made for long and exhausting travel.

Access to Healthy Food and Food Security

In 2019, around 15.6% of Travis County residents reported consuming 5+ servings of fruits and vegetables daily, which is lower than patterns in 2011 (22.6%). Focus group participants described the high cost of healthy foods, affordability and accessibility of fast foods, and long work hours as barriers to healthy eating. Nearly one-quarter (23.0%) of LGBTQIA+ survey respondents reported that they experienced food insecurity, compared to 13.0% of respondents who did not identify as LGBTQIA+. Several community members and leaders shared that it was more difficult to eat healthy foods during the COVID-19 pandemic and observed an increased need for food assistance.

Physical Activity

Many community members and leaders described active living and exercise as important for health. Some residents described safe access to green space as facilitating physical activity. As one focus group participant shared, “[I]f you have a park close by you have more initiative to go out instead of staying in the house.” About one-third of Travis County adults reported being highly active in 2011-2019.

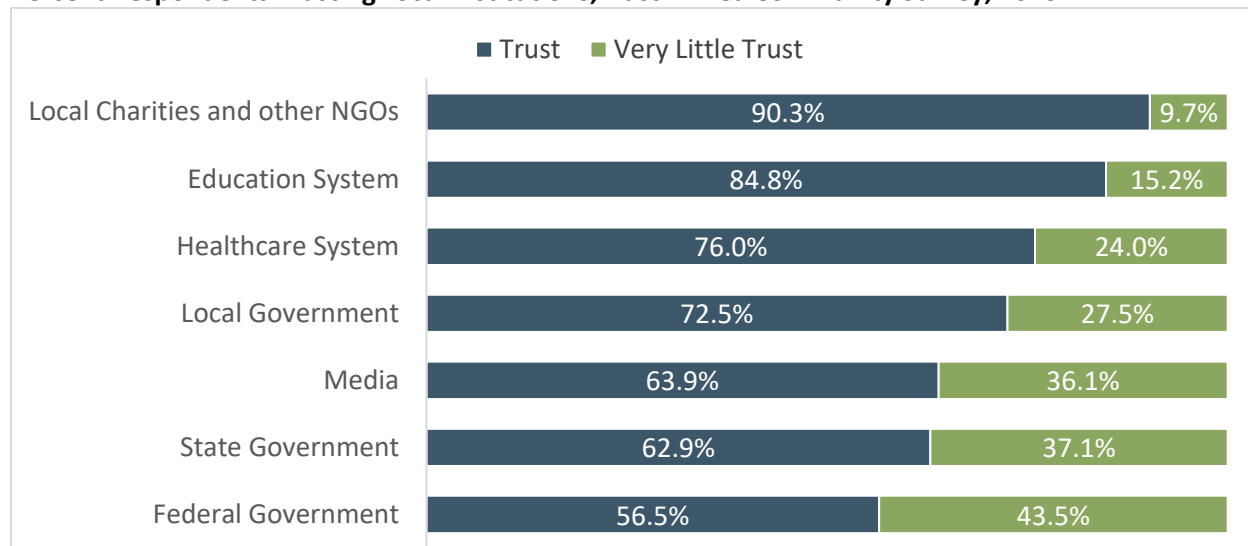
Social and Community Context

Community Connectedness and Civic Engagement

Relationships are important for physical and mental well-being, including encouraging positive healthy behaviors. Conversely, discrimination as part of one’s social environment can negatively affect health. In Travis County in 2015-2019, 5.7% of teens aged 16-19 years were disconnected, defined as teens neither in school nor working. In 2018, 6.3% of Travis County residents aged 65+ lived alone. When asked about trust in institutions, the highest percentage of respondents reported trusting local charities and non-governmental organizations (90.3%) and the education system (84.8%), with less trust towards the

federal (56.5%) and state (62.9%) government and media (63.9%). Over half of respondents felt informed about neighborhood issues (70.5%) and agreed that neighbors are improving the area (60.5%).

Percent Respondents Trusting Local Institutions, Austin Area Community Survey, 2020



DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2020

NOTE: This data combines the survey responses of "Some", "Quite a lot", and "A great deal" as "Trust".

Safety

Crime and safety are additional aspects of community health related to the social environment. Crime rates remained similar in 2019 compared to 2015. In 2019, the property crime rate (3,244.9 crimes/100,000 population) was higher than the violent crime rate (381.6 crimes/100,000 population). A few community members described concerns about physical violence, including gun violence, vandalism, break-ins, and robberies, and police violence.

Racism and Discrimination

Some community leaders described institutional racism as an important factor that shapes adverse childhood experiences and trauma, access to jobs, educational experiences, housing, family cohesion, where residents can live, and trust towards the government, which they linked with health. One community leader shared, *"We have to first accept that racism is real; we see it every day."* Some community leaders described community-based and faith-based organizations as bridges between historically marginalized groups and the government. Some community members cited incidents of hate, including verbal attacks and physical violence towards people of color and of non-Christian faith.

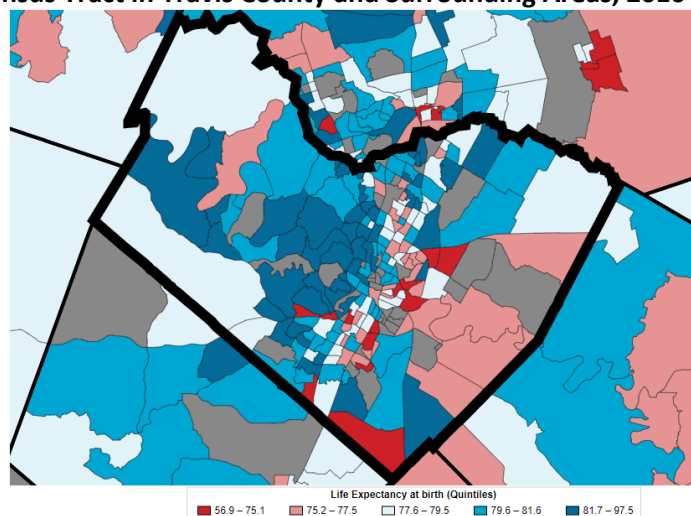
COMMUNITY HEALTH OUTCOMES AND BEHAVIORS

General Health Outcomes

The leading causes of death in Travis County in 2020 were heart disease, cancer, unintentional injuries, and COVID-19. Life expectancy in Travis County and surrounding areas ranges from 68.6 years to 88.9 years, and is highest in northern and western census tracts. In 2018, 16.2% of Travis County adults reported fair or poor health. Almost half (47.3%) of LGBTQIA+ respondents reported poor or fair physical health. In 2020, on average LGBTQIA+ respondents reported 6.0 days of poor physical health in the last month. In 2019, 13.8% of Del Valle residents and 11.3% of Montopolis residents reported poor physical health for 14 days+ of the last 30 days, compared to 9.6% of Austin residents. Several community members and leaders described health as including happiness, quality of life, safety, spiritual well-being,

access to healthy foods, an active lifestyle, and limited stressful life circumstances, which are referred to as social determinants of health.

Life Expectancy, by Census Tract in Travis County and Surrounding Areas, 2010-2015



DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, 2010-2015

Maternal and Child Health

In 2013-2019, the rate of births among females aged 15-19 in Travis County (23.8 per 1,000 population) was lower than the teen birth rate across Texas (31.4 per 1,000 population). The teen birth rate from 2013-2019 was higher for Hispanic/Latino teens (43.0 per 1,000 population) than other racial/ethnic groups. In 2019, 7.6% of infants in Travis County were born with a low birth weight.

Chronic Disease

About one-fifth (22.4%) of Travis County Medicare recipients have been diagnosed with diabetes. From 2011 to 2019, a higher percentage of Hispanic/Latino residents and those aged 65 and over reported being diagnosed with diabetes compared to their counterparts. In 2017, the heart disease and stroke mortality rate in Travis County (121.6 and 28.8 deaths per 100,000 population, respectively) was lower than that in Texas (163.4 and 39.0 deaths per 100,000 population, respectively).

Cancer

Overall cancer incidence in 2013-2017 in Travis County was 391.9 per 100,000 population. Prostate and lung cancer had the highest incidence rates compared to colon and female breast cancer. The female breast cancer incidence rate in Travis County (32.5 per 100,000 population) was higher than Texas and the US (22.5 and 29.8 per 100,000 population, respectively). In 2017, the cancer mortality rate was lower in Travis County (117.0 per 100,000 population) compared Texas and the US (141.4 and 146.2 per 100,000 population, respectively).

Behavioral Health Outcomes

In 2017-2019, the rate of drug poisonings, also referred to as overdoses, was 12.6 deaths per 100,000 population in Travis County. Substance use disorders and mental illness are closely linked and often co-occurring. Among Travis County residents, the suicide rate was 12.2 deaths per 100,000 population and highest among males (18.5 deaths per 100,000 population) and White residents (17.1 deaths per 100,000 population) in 2016-2020. In 2020, a higher percentage of females (33.0%) compared to males (20.9%) reported poor mental health, and the prevalence of poor mental health days has increased

overall for both genders. In the same year, a higher percent of Hispanic/Latino adults (31.5%) reported poor mental health compared to White (26.3%) and Black/African American (22.9%) adults. In 2020, the highest proportion of adults experiencing poor mental health was seen among adults aged 18-29 (32.6%) and 30-44 years of age (34.3%). Significant mental health needs, stigma around mental health, and limited access to mental health care were common themes among community members and leaders. Some residents perceived an increase in mental health issues during the COVID-19 pandemic, which they linked with the stress and trauma of the COVID-19 pandemic, social isolation, and economic suffering. One community leader shared, *“Then we look at the physical piece: depression and anxiety are at an all-time high which affect our physical health. The brain-body connection is huge and I cannot stress that enough.”*

General Health Behaviors

In 2018, about one-fifth (22.2%) of Travis County adults reported binge drinking in the past 30 days and 12.7% reported that they currently smoke. The majority of Travis County adults reported using a seatbelt (females: 95.0%, males: 91.9%).

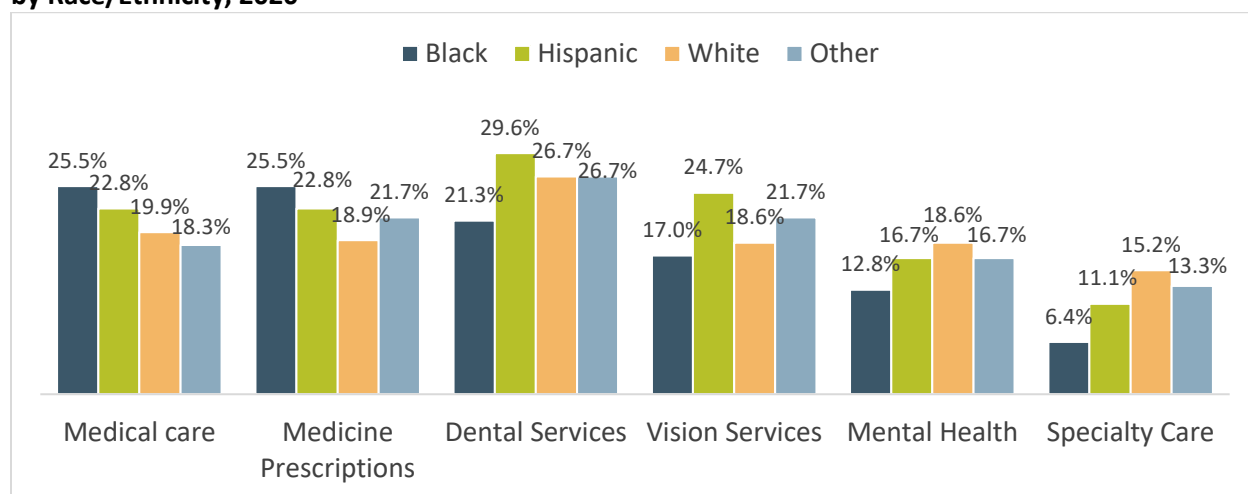
Sexual Health

The rate of HIV was 14.5 per 100,000 population, and the rate of AIDS was 6.2 per 100,000 in Travis County in 2019; a decline from 2015. In Travis County, the syphilis, gonorrhea, and chlamydia rates increased from 2014 to 2018. Black/African American residents and 15-24 year olds generally had the highest rates of these infections. In 2021, 20% of LGBTQIA+ survey respondents reported receiving sexual health education without content specific to LGBTQIA+ populations, 16% received abstinence-only education, and 17% reported receiving no comprehensive sex education.

HEALTH CARE ACCESS

Access to comprehensive, quality health care services is important for promoting and maintaining health, preventing and managing disease, and reducing the chance of premature death. In 2019, 14% of Travis County residents were without health insurance. Nearly one-quarter of LGBTQIA+ respondents reported lacking health insurance (23.0%). Almost half (48.6%) of LGBTQIA+ respondents reported not seeking care when having a health problem, followed by nearly one-quarter (24.3%) of respondents who reported going to a public clinic. The high cost of healthcare and insurance were the most commonly cited barriers to medical care. About 29.6% of Hispanic/Latino survey respondents and 26.7% of White respondents were not able to access dental services. Approximately 25.5% of Black/African American respondents reported being unable to receive medical care and medical prescriptions. Nearly one-quarter (24.7%) of Hispanic/Latino respondents listed barriers to accessing vision care.

Percent Unable to Receive Healthcare Services among Austin Area Community Survey Respondents, by Race/Ethnicity, 2020



DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2020

When discussing access to health care, common themes were gaps in health insurance coverage for low-income residents, including lapses of health insurance coverage, few providers who accept Medicare, and difficulty accessing preventive care (e.g., primary, vision, dental), emergency services, specialists, and providers who care for older adults. According to participants, the Medical Access Program (MAP) is helpful for accessing health care services for qualifying low-income, uninsured Travis County residents. However, some participants felt that there were bureaucratic barriers to accessing MAP.

Discrimination, Culturally Sensitive Care, and Interpretation Services in Health Care Settings

Experiences of discrimination in health care settings also emerged among some community members and leaders, who described how past experiences of racial discrimination shaped distrust in health care providers for residents of color and cited experiences of limited culturally sensitive care for patients of color and low-income patients. A lack of bilingual health providers and interpretation services emerged as a health care barrier among some focus group participants and community leaders, including in primary care, specialty services and home health assistance.

Delays in Health Care Use Due to the COVID-19 Pandemic

Some community members and leaders described delays in accessing health care services and screenings due to the COVID-19 pandemic, which they noted may have consequences for late diagnoses. Vaccinations emerged as another gap in health care that was aggravated by the COVID-19 pandemic.

Preventive Care

Just over half of adults in Del Valle (57.6%) and Montopolis (50.5%) reported receiving screening for cholesterol, compared to 70.7% of Austin adults. About two-thirds Travis County adults (65.7%-68.6%) reported being up-to-date on colorectal cancer screenings in 2020.

Women’s Health Care

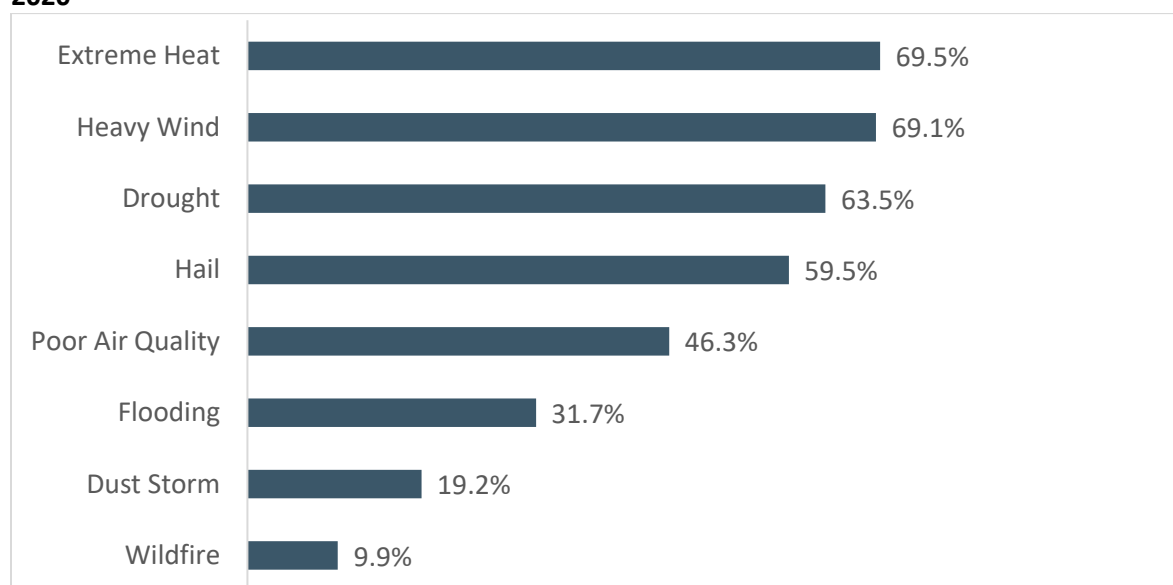
In 2016, about three-quarters (75.7%) of childbearing individuals in Travis County reported receiving prenatal care in the first trimester. Around three-fifths (62.8%) of females aged 18+ reported having a pap smear within the past 3 years in Austin in 2020, marking a decline from pap smear patterns in 2012

through 2018. About 70.2% of females aged 40+ reported having a mammogram within the past 2 years in Austin in 2020. A slightly higher percentage of White females (76.6%) reported having a mammogram compared to Hispanic/Latino females (61.3%) in 2020.

EMERGENCY PREPAREDNESS

Given the COVID-19 pandemic, heat waves and Winter Storm Uri, emergency preparedness was top of mind for many assessment participants. From the Austin Area Community Survey, the majority of survey respondents reported experiencing emergencies of extreme heat (69.5%), heavy wind (69.1%), drought (63.5%) and hail (59.5%) in the last 10 years. About three-fifths (60.8%) of White respondents agreed that they had a safe place to shelter; this was slightly lower among Black/African American (57.6%) and Hispanic/Latino respondents (53.1%).

Percent Experienced Emergency in Last 10 Years among Austin Area Community Survey Respondents, 2020



DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2020

COVID-19

The COVID-19 pandemic has had broad and deep impacts on Travis County residents. In Travis County, COVID-19 vaccination completion was highest among Asian (65.5%) residents, followed by White residents (57.0%) and Hispanic/Latino residents (47.6%) and lowest among Black/African American residents (34.3%) in 2021. Several community members and leaders noted that the COVID-19 pandemic has worsened economic suffering, increased social isolation, exacerbated mental health issues, and highlighted barriers to accessing information and health care resources for lower-income residents, residents for whom English is not their primary language, and communities of color.

WINTER STORM URI/EMERGENCY PREPAREDNESS

Some residents described Winter Storm Uri as traumatic and increasing social isolation and technological barriers to accessing pressing information and resources. Several community members described struggling to meet basic needs such as food and electricity during the storm. One interview participant shared: *“I didn’t have money and the ATM was down, and when I went to the store to get gas*

there was no gas, so I starved through the winter storm.” Some residents described an ongoing and significant financial toll of Winter Storm Uri, including disruptions of income and high utility bills.

COMMUNITY RESOURCES

Some community leaders cited resident support for each other, including sharing resources and information, as an important community strength. According to community leaders, community health workers, community-based organizations, faith-based organizations, and established community networks have been central to meeting the needs of residents most affected by health inequities. One community leader shared, “...As an organizer I feel that the power is at the bottom, and we should all be working to disassemble the hierarchy and [distribute] power. People give me energy.” Many community leaders and some community members described cross-sectoral partnerships as important community strengths. One focus group participant described: “We go out of our way to build partnerships.”

VISION FOR THE FUTURE

Building on the perceived community assets and thinking ahead to the future, assessment participants outlined the following suggestions for making Austin and Travis County overall a healthier place.

LONG-TERM HEALTH EQUITY PLANNING PROCESSES

Many community leaders recommended that the City of Austin and Travis County deepen their relationships with communities across the region, including building relationships with and incorporating into planning processes community leaders from diverse geographic communities, such as communities on the outskirts of Austin, and identity-based communities, such as racially minoritized groups. Given sizable population growth across the region and displacement of longstanding residents, some residents recommended intentionally including long-time residents in planning processes, not just relatively new residents. According to community leaders, there is a need to improve quality of outreach to residents when engaging them in planning processes, including ensuring that information about resident engagement opportunities reaches residents through realistic and culturally appropriate communication channels and in residents’ primary language.

In terms of priority areas, some community leaders discussed the need to address systemic racism in criminal justice, education, and health care sectors and build capacity to counteract hate. Several community members and leaders recommended expanding community gardens programs, food pantries, and farmer’s markets. Some community leaders highlighted the need to expand Medicaid to improve access to health care for low-income residents and recommended improving the capacity of clinics that currently serve low-income residents to expand their hours and days of operation. Another recommendation included coordinating the release from the hospital for people who are homeless by bringing together hospitals, EMS, and organizations who serve people who are experiencing homelessness. The need to address bureaucratic barriers to expanding mental health supports, improve funding for mental health services, and to make mental health services available to people who are experiencing homelessness and low-income residents also emerged. Some community members and leaders cited the need to coordinate health care across specialties in order to strengthen chronic disease management and the need to support older adults and residents with significant health needs for aging in place.

FOSTER COLLABORATIONS AND COMMUNICATION ACROSS ORGANIZATIONS

Community leaders recommended leveraging collaborative planning spaces as opportunities to build connections and relationships across local community-based health equity organizations since many organizations reported that they did not know each other. They noted that this process had potential to build collective strategies and action and coordinate efforts and discussed the importance of shifting from a competitive environment among non-profit organizations.

FUNDING EQUITY

Shifting the funding model when supporting the work of small community-based organizations and racial equity organizations was a common theme among many individuals representing community-based organizations. Another funding recommendation included re-hauling the current reimbursement model to enable the City and County to meaningfully partner with smaller organizations who have smaller reserves and who cannot wait for reimbursement. One community leader shared, *“Building capacity in orgs. and smaller orgs. There needs to be a concerted efforts to strengthen orgs, because if we strengthen these organizations, they strengthen us.”* A few community leaders noted the need to be more transparent about how funding priorities are made. Some community forum participants observed that racism, patriarchy, other systemic factors, and the historical underinvestment in public health create and maintain inequities that affect community health.

KEY THEMES

This assessment included a review of secondary data and collection of primary data to shed light on the social and economic context, community health issues, and community visions of residents Austin/Travis County. The following key themes emerged through this synthesis:

- ***Social determinants of health, such as access to healthy food and financial security required to be healthy, were viewed as more pressing concerns than health outcomes themselves.*** While some chronic health issues were discussed and are of concern, assessment participants focused on upstream issues of daily life, which are referred to as social determinants of health.
- ***Housing affordability continues to be concerns in Austin/Travis County.*** Due in large part to significant population growth, a key theme was the high and rising cost of housing that disproportionately affects low-income residents, residents of color, older adults, and persons with disabilities, and displaced residents from urban areas to rural areas. While median income has steadily increased in recent years, cost of living in the area is high and increasing as well.
- ***The COVID-19 pandemic has had substantial impact on the lives and the physical and mental health of residents in Austin/Travis County.*** The COVID-19 pandemic has exacerbated many of the issues that existed as well as highlighted new issues. COVID-19 pandemic has worsened food security, economic suffering, increased social isolation, exacerbated mental health issues, and highlighted barriers to accessing information and health care resources for lower-income residents, residents for whom English is not their primary language, and communities of color.
- ***Emergency preparedness is an emerging public health issue in the region.*** Given the COVID-19 pandemic, heat waves and Winter Storm Uri, emergency preparedness was top of mind for many assessment participants. Most residents reported experiencing a natural disaster emergency in the past decade and many described the immediate an ongoing personal and community challenges these emergencies have caused.

- ***Mental health was identified as a important community health concern.*** Significant mental health needs, stigma around mental health, and limited access to mental health care were common themes among community members and leaders. Some residents perceived an increase in mental health issues during the COVID-19 pandemic, which they linked with the stress and trauma of the COVID-19 pandemic, social isolation, and economic suffering.
- ***Healthcare access – specifically high cost of healthcare and insurance – is a significant concern in Austin/Travis County, especially among people of color.*** When discussing access to health care, common themes were gaps in health insurance coverage for low-income residents, including lapses of health insurance coverage, few providers who accept Medicare, and difficulty accessing preventive care (e.g., primary, vision, dental), emergency services, specialists, and providers who care for older adults.
- ***A strength of Austin/Travis County are the strong network of residents and organizations in the area.*** Community residents are supportive of each other and generous with sharing resources and information. Cross-sector partnerships among schools, community-based organizations, private companies and others also represent a community strength. Community-based institutions were seen as important access points for information and access to services. Faith-based organizations were highlighted as a key strength and a bridge between historically marginalized communities and local/county government.

BACKGROUND

INTRODUCTION

Health is affected by where and how we live, work, play, and learn.¹ Understanding these factors and how they influence health is critical to efforts aimed to improve the health of the community. Identifying the health issues of an area and their larger context and then developing a plan to address them are key steps in the larger health planning process. To accomplish these goals, a collaboration among various community partners, including Austin Public Health, Travis County Health and Human Services, Central Health, St. David’s Foundation, Central Metro, Austin Transportation Department, Integral Care, Ascension Seton, Baylor Scott & White Health, UTHealth School of Public Health in Austin, and UT Dell Medical School is leading a comprehensive community health planning effort to measurably improve the health of Austin/Travis County, TX residents, the Austin/Travis County Community Health Plan. This effort entails two major phases:

1. A community health assessment (CHA) to identify the health-related needs and strengths of Austin/Travis County
2. A community health improvement plan (CHIP) to determine major health priorities, overarching goals, and specific strategies to be implemented in a coordinated way across the Austin/Travis County

In addition to guiding future services, programs, and policies for these agencies and the area overall, the CHA and CHIP are also prerequisites for the health department to earn accreditation from the Public Health Accreditation Board (PHAB), which indicates that the agency is meeting national standards.

This report presents the findings from the 2022 Assessment for Austin/Travis County, which was conducted July – December 2021 using a collaborative, participatory approach. These findings will inform discussions and priority areas for the CHIP, scheduled to take place August 2022 – February 2023.

PURPOSE AND GEOGRAPHIC SCOPE OF THE AUSTIN/TRAVIS COUNTY COMMUNITY HEALTH ASSESSMENT

The 2022 Austin/Travis County CHA was conducted to fulfill several overarching goals, specifically:

- To examine the current health status across Austin/Travis County as compared to state and national indicators
- To explore the current health priorities among Austin/Travis County residents within the social context of their communities
- To identify community strengths, resources, forces of change, and gaps in services to inform funding and programming priorities of Austin/Travis County

This CHA focuses on Travis County, which is home to numerous communities, including Austin, Texas state capital. While the largest proportion of the population in Travis County (“the County”) resides in the City of Austin, given the fluidity of where people work and live in the County and that numerous social service and health organizations in the area serve individuals across the County, a focused effort was made to include data and the community voice from across the County.

This community health assessment provides a snapshot in time of community strengths, needs, and perceptions. It should be acknowledged that there are numerous community initiatives and plans, expansion of health and social services, and improvements in programs and services that have recently been undertaken. This report does not delve into these areas, but further examination of these initiatives will occur during the CHIP process when discussions focus on specific health issues.

METHODS

With the aim of better understanding not only the priority health needs of the Austin/Travis County community- but the social factors that influence these needs as presented in Figure 10, a mixed methods approach based in qualitative and quantitative assessment methods of inquiry formed the foundation of the 2022CHA. Guided by a stakeholder-engaged, collaborative approach assessment aimed to identify both the strengths and needs of Austin/Travis County community residents via the following methods: secondary analysis of existing health and social data; primary data collection via focus groups, interviews, and community forums; and content analysis of existing local partners' assessment reports.

MAPP FRAMEWORK

In guiding the 2022 CHA, we followed the Mobilizing for Action through Planning and Partnerships (MAPP) framework, a community-driven strategic planning process developed and hosted by the National Association of County and City Health Officials (NACCHO). This framework was helpful for guiding the 2012 and 2017 Austin/Travis County CHAs and the 2022 CHA builds on the organizational infrastructure established in previous cycles, while incorporating changes made to the framework in the latest, MAPP 2.0 version. The new process centers three main assessments [see Appendix H for further information]:

- Community Partner Assessment: reflective assessment by community partners to look critically within their own systems and processes and assess their role in the community's health and well-being.
- Community Status Assessment: quantitative description of the status of the community, including community demographics, health status, contributing factors (e.g., social/structural determinants), health equity indicators, and across all these variables, existing inequities.
- Community Context Assessment: focus on perspectives from community members with lived experience, as well as a deep analysis of historical, systemic, and structural information which elucidate the root causes of inequity.

Components of all three assessments are incorporated throughout the report to provide a more contextualized narrative of health and well-being for the Austin/Travis County area.

Table 1. Components & Methodologies of Assessments

Assessment	Methodology used to Address
Community Partner Assessment	Community Partner Assessment Summit Community Partner Survey (not included due to low response rate)
Community Status Assessment	Secondary Data Collection Content Analysis
Community Context Assessment	Primary Data Collection Content Analysis Historical Overview

SECONDARY DATA

To develop a social, economic, and health portrait of Austin/Travis County through a social determinants of health framework, existing data were drawn from state, county, and local sources. Sources of data included, but were not limited to, the U.S. Census, U.S. Bureau of Labor Statistics, County Health Rankings, Texas Department of State Health Services, Austin Area Sustainability Indicators Project, and Quality of Life Reports. Types of data included self-report of health behaviors from large, population-based surveys such as the Behavioral Risk Factor Surveillance System (BRFSS), public health disease surveillance data, as well as vital statistics based on birth and death records. The BRFSS, a telephone survey of adult residents, asks respondents about their behaviors that influence health, as well as whether they have had or currently have specific conditions.

The Data & Research Sub-Committee, composed of subject-matter experts from partner organizations, reviewed past indicators and provided updates and recommendations for inclusion in the 2022 CHA. A variety of partners gathered data for this report, including Austin Public Health, CAN, Integral Care, LBJ School of Public Policy, and Travis County HHS. Additionally, IBM Watson Consultants provided data as part of a larger realignment between APH’s CHA and hospital partners’ Community Health Needs Assessments (CHNAs). The secondary data collection, compilation and analyses addressed one of the goals of this assessment—to examine the current health status across Austin/Travis County as compared to state and national indicators.

Local assessments informed the 2022 CHA by providing further context for specific priority communities and topics. Several organizations shared their reports for inclusion which staff then reviewed for relevant data. Citations for these reports can be found in Appendix K.

PRIMARY DATA: INPUT FROM COMMUNITY REPRESENTATIVES

This assessment sought to elevate community voices and gather input from a diverse and representative group of individuals. Local community leaders and organizations, participants of the Community Engagement Sub-Committee, assisted in developing materials and identifying and targeting residents for outreach for focus groups, In-depth interviews, Key interviews, and possible community forums. The Community Engagement Sub-Committee also reviewed 2017 CHA Interview guides and provided updates and edits for the 2022 CHA interview guides [see Appendix D]. A variety of qualitative data collection methods were employed in the 2022 CHA (Table 2) and are further detailed below.

Table 2. Overview of Qualitative Data Collection

Type of Outreach	Target Population	# of events	# of Participants
Community Partner Assessment	Health Stakeholders	1 Event	27 Participants
General Key Interviews	Community Leaders	17 Interviews	20 Participants
In-Depth Interviews	Community Members	2 Interviews	2 Participants
Focus Groups	Community Members	7 Focus Groups	48 Participants
Virtual Community Forum	Community Members and Leaders	1 Event	16 Participants
Radio Talk-Show	Community Members	1 Event	3 Participants
Photo Outreach Campaign	Community Members	41 Submissions	23 Participants
Total			139 Participants

Community Partner Assessment Summit

In the fall of 2021, partners attended a Community Partner Assessment Summit as a part of the 2022 Community Health Assessment efforts. The event was a component of the new Mobilizing for Action through Partnerships and Participation Evolution process (i.e. MAPP 2.0) and took place on Sept. 10, 2021 via a virtual Teams meeting with 27 individuals representing 21 unique organizations.

As part of the Summit, participants completed a “Circles of Involvement” activity in which participants provided feedback on which organizations to involve in the community health planning efforts and how to do so efficiently.

Major themes in the responses included:

- organizations and/or providers that provide direct care, including CHWs, Primary Care Physicians (PCP), Doulas, Caregivers, FQHCs, etc.
- Organizations involved in school districts, including School Health Advisory Council, PTAs, and Parent Support Specialists as well as CATCH (Coordinated Approach to Child Health) nights at schools.
- Participants also highlighted the need to engage with residents in a variety of capacities, engaging retired volunteers as paid engagement ambassadors; similarly, grassroots efforts and organizations were also mentioned as a point of focus.
- Other major themes included a focus on older adults and behavioral health and engagement with faith-based organizations and/or churches. Significantly, several coalitions were cited, drawing attention to the importance of aligning community health planning efforts with existing collaboratives and alliances. Specific communities were also identified in the exercise, such as focusing on Black, Indigenous, and People of Color (BIPOC) and the Asian communities.

Participants also shared the following **barriers to community representation**:

- participant fatigue,
- lack of representation,
- lack of participation from residents directly impacted by services provided, e.g. “...many people who plan transit don’t rely on transit (should get more representation from the people that receive the services; giving a paid consulting position to community members that use these services)...”

- Other concerns included language barriers and the lack of translated materials as well as digital divides and tailoring work to meet community needs, e.g. work schedule, financial needs, transportation, etc.

Discussion about how the community factors into the process included mentions of youth, church leaders, schools, and pregnant individuals' partners: *"Sexual health efforts are mostly being led by professionals right now... trying to amend by creating more opportunities for youth to participate."* Additionally, one participant challenged assumptions of "community" and expanding on those limitations. Additionally, references were made regarding "trust" and the use of existing networks as critical to reaching communities of color. Several participants declared the need for increased community involvement overall.

Participants also discussed **lessons learned** from COVID and the need to be creative with solutions as well as the need to listen to people and meet them "where they are."

- One participant shared that *"Thinking about flexibility as we had to change a lot of the way we do things with a huge shift to virtual events and appointments."*
- Another also noted the benefits of having online applications that individuals can access through mobile as very successful.
- One participant noted the role funding plays in ensuring collaboration and providing incentives to share data.
- Other data concerns mentioned by organizations included duplication of efforts and sharing data. *"When you are funded by different agencies with different data requirements for each then you can burden the data services and cause the data to become a barrier and it is no longer streamlined."* They shared how different data requirements lead to information that cannot be used across different programs.

In addition to the Community Partner Assessment Summit, several qualitative methods were employed to gather complementary data.

Interviews

After identifying target communities, Austin Public Health contacted individuals and organizations for potential participation in the interview process. Staff from Austin Public Health and Travis County assisted with the data collection, completing 19 total interviews (Key and In-Depth), either in person or virtually. Interviewers and support staff completed outreach to community leaders and other participants via e-mail to schedule interviews and completed note-taking during the meetings. Only in-depth interviewees received \$20 Target gift cards for their participation.

Focus Groups

The Community Engagement Sub-Committee assisted with identifying 13 preliminary communities for focus groups based on under-representation, being underserved communities, or lack of existing information. Austin Public Health completed seven focus groups ranging from 4 to 12 individuals, either in-person or virtually, with the following groups: Latino individuals (English and Spanish sessions), older adults, subsidized-housing residents, parent support specialists, and Pflugerville representatives. Focus group residents not acting in a professional capacity received \$20 Target gift cards for their participation. IBM Watson and Community Coalition for Health (C2H) also provided focus group findings from community health leaders and the African American male population respectively.

Radio Talk Show

In an effort to improve outreach and engage with a greater variety of audiences, Austin Public Health collaborated with KAZI FM, a radio station predominantly serving the African American community, to host a call-in radio program and gather community input regarding major health concerns and priorities. The radio station promoted the event ahead of time as did Austin Public Health. The night of the program, hosts introduced the segment and prompted community members to call in with their responses. Unfortunately, hosts only received three calls, too small of a sample size that the call contents could not be included in this report.

Community Forum

A virtual community forum was organized to allow community members to provide their insight with regards to 1) barriers, 2) available resources, and 3) solutions for healthy living. City of Austin, Austin Public Health, and partner organizations promoted the event in three languages, English, Spanish, and Vietnamese ahead of the event. 16 forum participants joined break-out groups, divided by language and facilitated by community partners, and utilized Google slides to document their input for incorporation in the assessment.

Photo Outreach

In the summer of 2021, Austin Public Health engaged with the public for their LiveHealthyATX Photo Outreach project where they encouraged Austin and Travis County residents to submit photos via social media sites answering the question “What Makes You Healthy?” APH produced materials in English, Spanish, Vietnamese, and Chinese to engage with a diverse population and offered the top “liked” images gift cards for their submissions as well as publication in our 2022 Assessment. The project received 41 submissions by 23 unique participants. Images contained in this report were selected from individuals’ submissions.

Qualitative Data Analysis

The qualitative data from interviews, focus groups and the community forum were coded and then analyzed thematically for main categories and sub-themes using NVivo, Version 12. Data analysts identified key themes that emerged across all discussions as well as unique issues noted by specific individuals or groups. Frequency and intensity of discussions on a specific topic were key indicators used for extracting main themes. While regional or other differences are noted where relevant, analyses emphasized findings common across Travis County. Illustrative quotes (paraphrased and direct) are presented throughout this report.

LIMITATIONS

As with all data collection efforts, there are several limitations that should be acknowledged. Numerous secondary data sources were drawn upon in creating this report and each source has its own set of limitations. Overall, it should be noted that different data sources use different ways of measuring similar variables (e.g., different questions to identify race/ethnicity). There may be a time lag for many data sources from the time of data collection to data availability. Some data are not available by specific population groups (e.g., race/ethnicity) or at a more granular geographic level (e.g., city or zip code) due to small sub-sample sizes. Data visualizations may exclude categories or data labels for values under 5%. Some data for the population are estimates based on data collected from a subset of the total population. In some cases, data from multiple years may have been aggregated to allow for more accurate data estimates at a more granular level or among specific groups.

There were also severe limitations to outreach work and ability to complete focus groups due to the ongoing COVID pandemic; instead, researchers sought to connect with representatives and service providers targeting specific communities as well as pull information from local assessments and reports to supplement primary data collection. Communities that were underrepresented in data collection efforts for this assessment include refugee communities, youth, indigenous communities, people with disabilities, and faith leaders.

FINDINGS

FINDINGS: POPULATION CHARACTERISTICS



POPULATION CHARACTERISTICS

The following section provides a demographic overview of Austin and Travis County.

Overall Demographics

The most current figures from the 2020 Decennial Census show that the population experienced a growth nationally, in Texas, Travis County and Austin compared to the 2010 Decennial Census (Table 3). Texas experienced a 15.9% increase in population, resulting in a total population of 29,145,505. Travis County and Austin experienced population growth of 20.0% or more. Notably, the population growth in Texas from 2010 to 2020 was more than double the percent increase in population seen nationwide during this same period. In Travis County and Austin, the percent increase in population was approximately three times the percent increase in population across the US from 2010 to 2020.

Table 3. Total Population, by US, State, County and City, 2010 and 2020

	2010	2020	% Population Change from 2010 to 2020
United States	308,745,538	331,449,281	7.4%
Texas	25,145,561	29,145,505	15.9%
Travis County	1,024,266	1,290,188	26.0%
Austin	801,829	961,855	20.0%

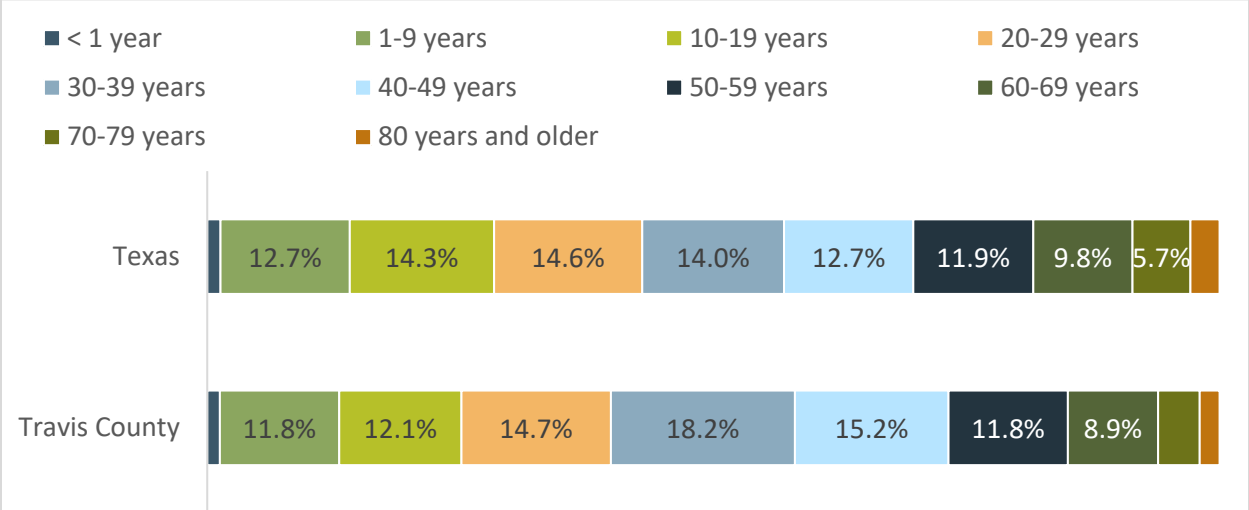
DATA SOURCE: U.S. Census Bureau, Decennial Census of Population and Housing, 2010 and 2020

Several focus group participants and community leaders described the Austin and Travis County region as growing substantially in recent years. When discussing population growth in recent years, several focus group participants suggested that higher income residents were the largest segment of new residents in the region. Several participants noted that the region has a transient feeling linked with growth of the population. One focus group participant observed, *“There are no more people born and raised from Austin because they were all priced out.”*

Age

In Travis County, about one-quarter (25.1%) of the population was under 19 years of age in 2019, which is slightly lower compared to the state of Texas (28.3%) (Figure 1). About half (48.1%) of Travis County’s population is comprised of residents aged 20-49 years, higher than in Texas overall (41.3%).

Figure 1. Age Distribution, by State and County, 2019



DATA SOURCE: Texas Demographic Center, University of Texas at San Antonio, 2019

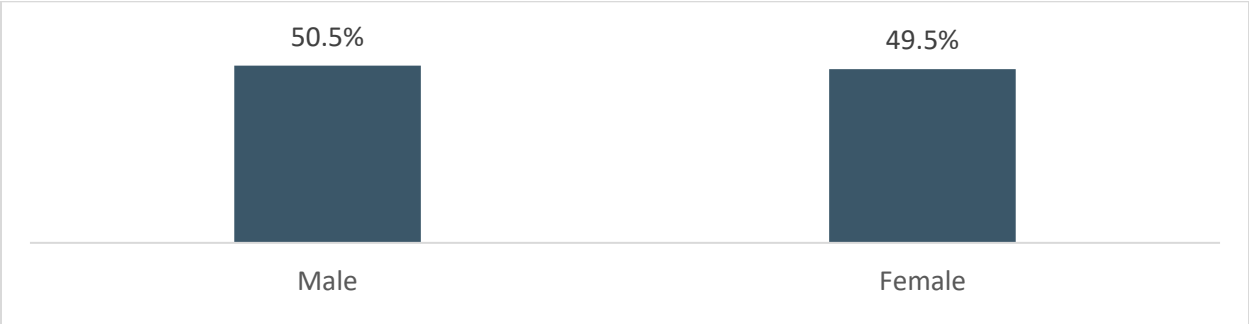
NOTE: Data labels ≤ 5% not shown

A focus group participant explained that health issues are common among older adults: “[There are] many issues that hit you as you age. Always one thing or another.” Several focus group participants and community leaders also discussed the importance of providing more health care and social supports for older adults, which is discussed later in this assessment.

Gender and Sexual Orientation

According to the 2015-2019 Community Survey (U.S. Census), Travis County was comprised evenly of male (50.5%) and female (49.5%) residents (Figure 2).

Figure 2. Sex Distribution, by Travis County, 2019



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2015-2019

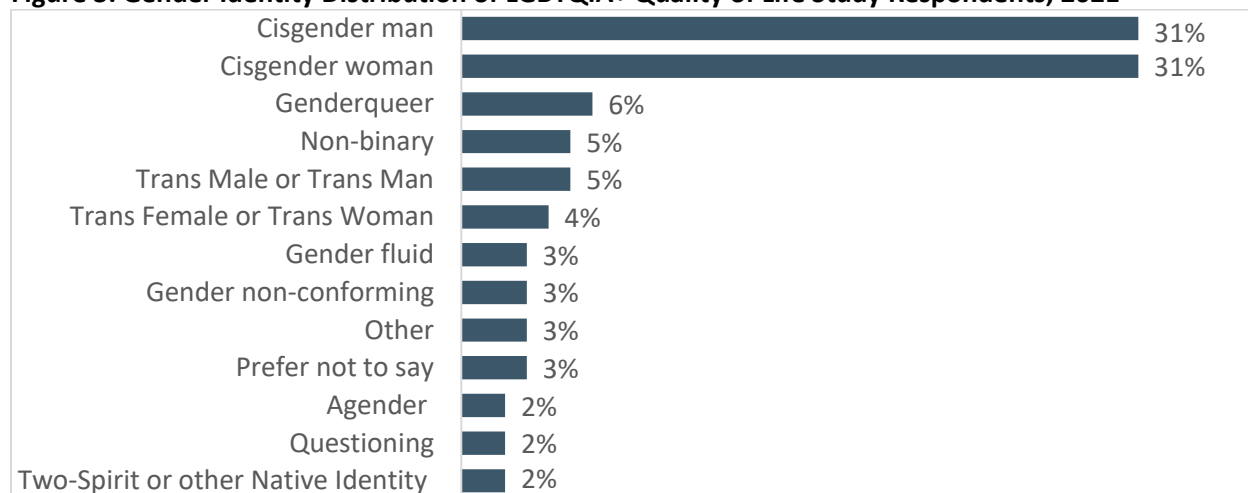
LGBTQIA+ Community in Austin

LGBTQIA+ is an acronym that brings together many different gender and sexual identities that often face marginalization across society. The acronym stands for lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, and the + holds space for the expanding and new understanding of different parts of the very diverse gender and sexual identities. In a March 2021 report, the Williams Institute estimates that the Austin-Round Rock-Georgetown metropolitan area had the 3rd largest percentage of LGBTQIA+ people (relative to the overall population size of the metro area) in the

country; they estimate that about 5.0% or 90,000 people in Austin-Round Rock-Georgetown metropolitan area identify as LGBTQIA+.

The ShoutOut Austin LGBTQIA+ Quality of Life Study gender identity definitions can be found in Appendix B: Gender Identity Definitions. Cisgender men and cisgender women each comprised 31% of survey respondents, followed by 6% genderqueer people (Figure 3). Note that respondents may not be statistically representative of the population in Austin, but robust findings may provide insight into the larger breakdown of the LGBTQIA+ residents of Austin.

Figure 3. Gender Identity Distribution of LGBTQIA+ Quality of Life Study Respondents, 2021

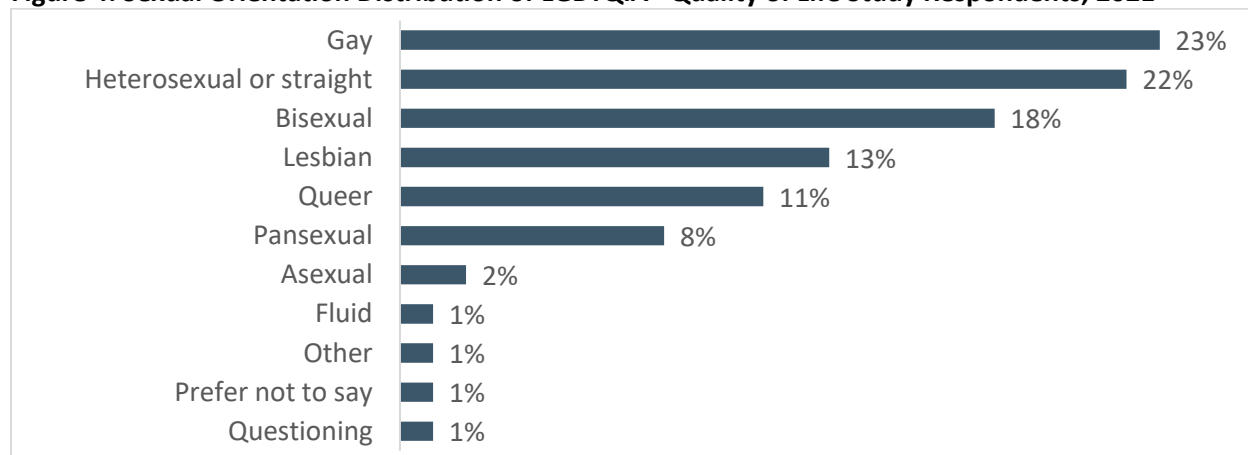


DATA SOURCE: City of Austin, Equity Office and LGBTQIA+Q Quality of Life Advisory Commission, ShoutOut Austin LGBTQIA+ Quality of Life Study, 2021

NOTE: Respondents may not be statistically representative of the population in Austin, but robust findings may provide insight into the larger breakdown of the LGBTQIA+ residents of Austin.

About one-fifth of respondents to the LGBTQIA+ Quality of Life Study identified as either gay (23.0%), heterosexual or straight (22.0%) or bisexual (18.0%) (Figure 4).

Figure 4. Sexual Orientation Distribution of LGBTQIA+ Quality of Life Study Respondents, 2021



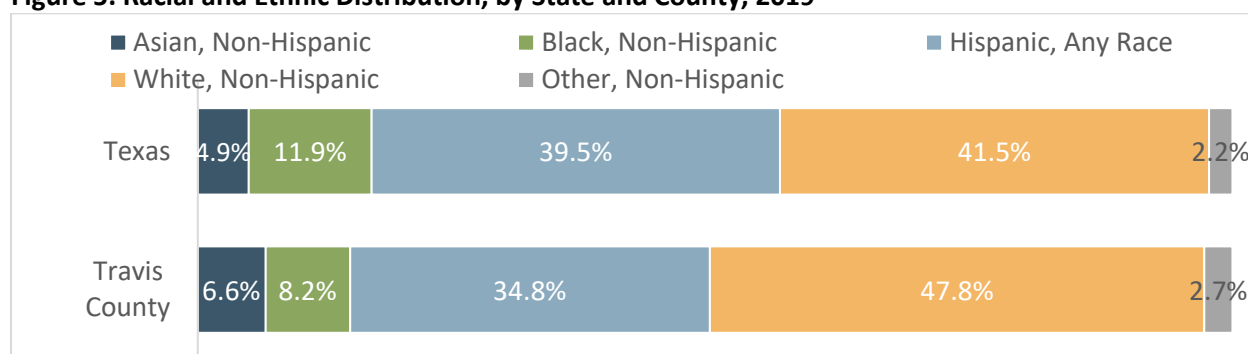
DATA SOURCE: City of Austin, Equity Office and LGBTQIA+ Quality of Life Advisory Commission, ShoutOut Austin LGBTQIA+ Quality of Life Study, 2021

NOTE: Respondents may not be statistically representative of the population in Austin, but robust findings may provide insight into the larger breakdown of the LGBTQIA+ residents of Austin.

Race/Ethnicity

In addition to gender and sexual orientation, population data were examined by race/ethnicity. More than half of residents in Travis County (52.2%) identified as people of color, a proportion that was slightly lower than across Texas (59.5%) (Figure 5). Almost half (47.8%) of Travis County residents identified as non-Hispanic White (henceforth, *White*), which was slightly higher than the percent of Texas residents (41.5%) who identified as White. More than one-third (34.8%) of Travis County residents and almost two-fifths (39.5%) of Texas residents identified as Hispanic/Latino. Non-Hispanic Black/African American (henceforth, *Black/African American*) residents made up 8.2% of Travis County and 11.9% of Texas populations; non-Hispanic Asian residents (henceforth, *Asian*) made up around 7% of the Travis County and less than 5% of Texas populations.¹

Figure 5. Racial and Ethnic Distribution, by State and County, 2019



DATA SOURCE: Texas Demographic Center, The University of Texas at San Antonio, 2019

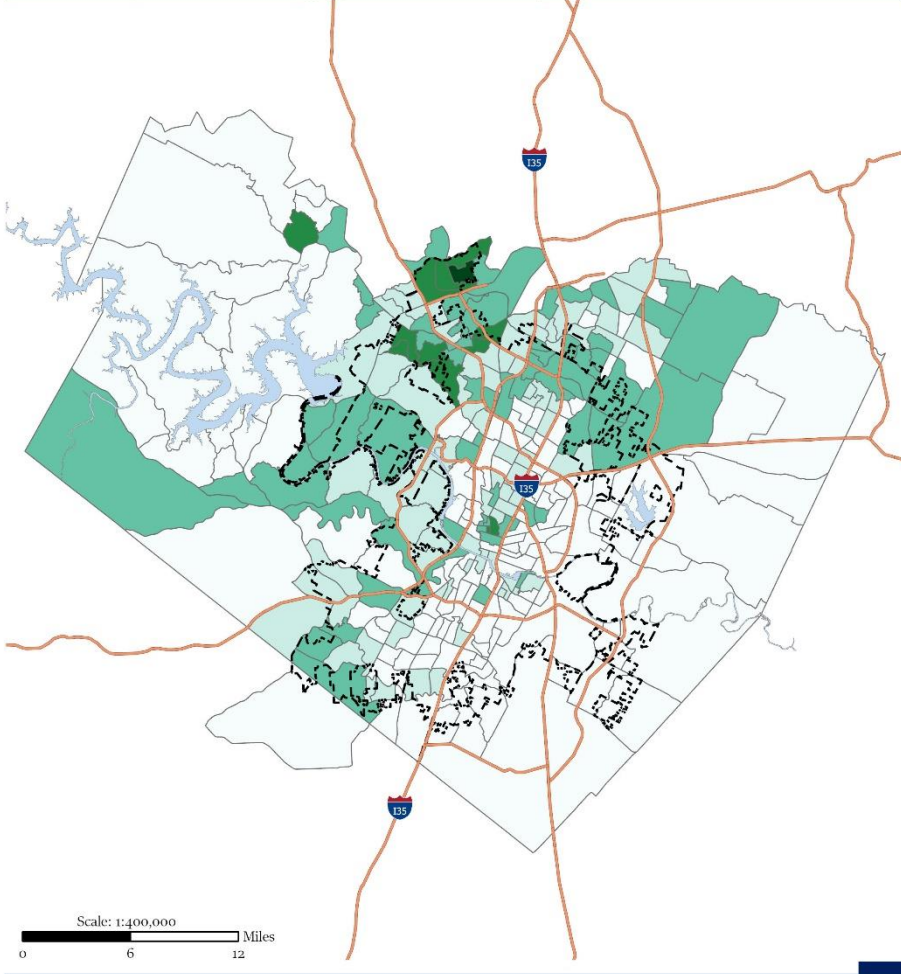
While the total population in Travis County increased by 26.0% from 2010 to 2020 according to the U.S. Decennial Census, when examining Travis County by census tract, there were varying percent changes in population by race/ethnicity.

¹ Racial and ethnic terminology: The term “Hispanic/Latino” is used to refer to persons who identify as Hispanic or Latina/o/x. The terms Black, White, and Asian to refer to non-Hispanic persons who identify with these racial/ethnic groups.

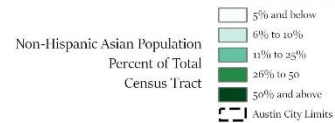
Census 2020, Travis County, TX



Non-Hispanic Asian Geographic Distribution by Census Tract



Scale: 1:400,000
0 6 12 Miles

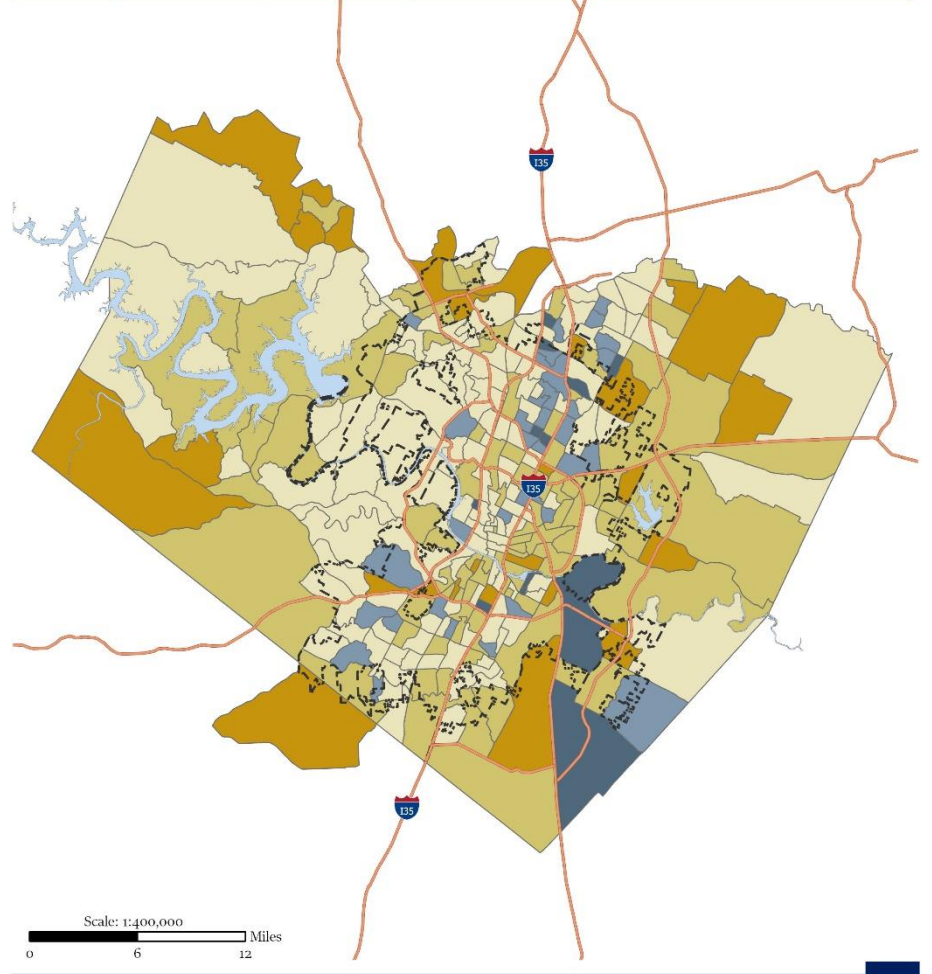


Author: City of Austin Housing and Planning Department
Date: 2.09.2022
Credit: U.S. Census Bureau, 2020 Decennial Census P.L. 94-171 File

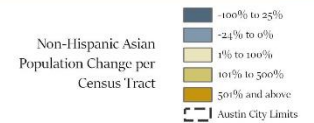
Census 2020, Austin TX MSA



Change in Non-Hispanic Asian Population, 2010-2020



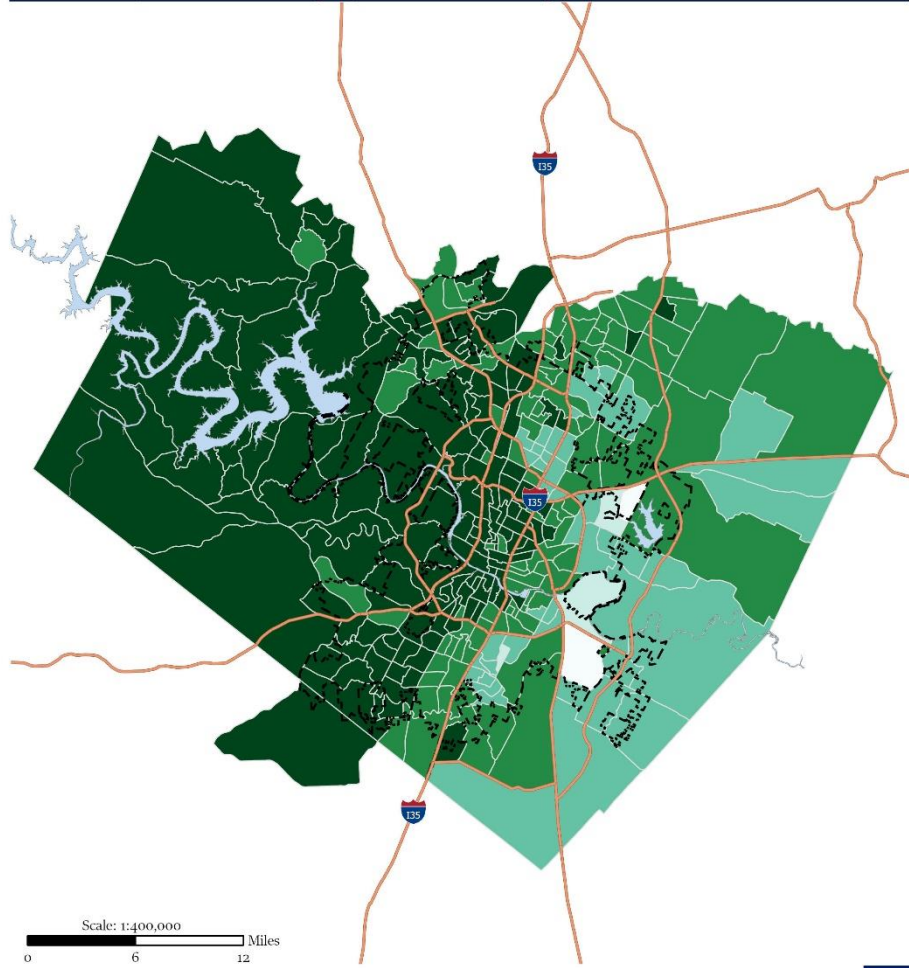
Scale: 1:400,000
0 6 12 Miles



Author: City of Austin Housing and Planning Department
Date: 2.09.2022
Credit: U.S. Census Bureau, 2020 Decennial Census P.L. 94-171 File

Census 2020, Travis County, TX

Non-Hispanic White Geographic Distribution by Census Tract



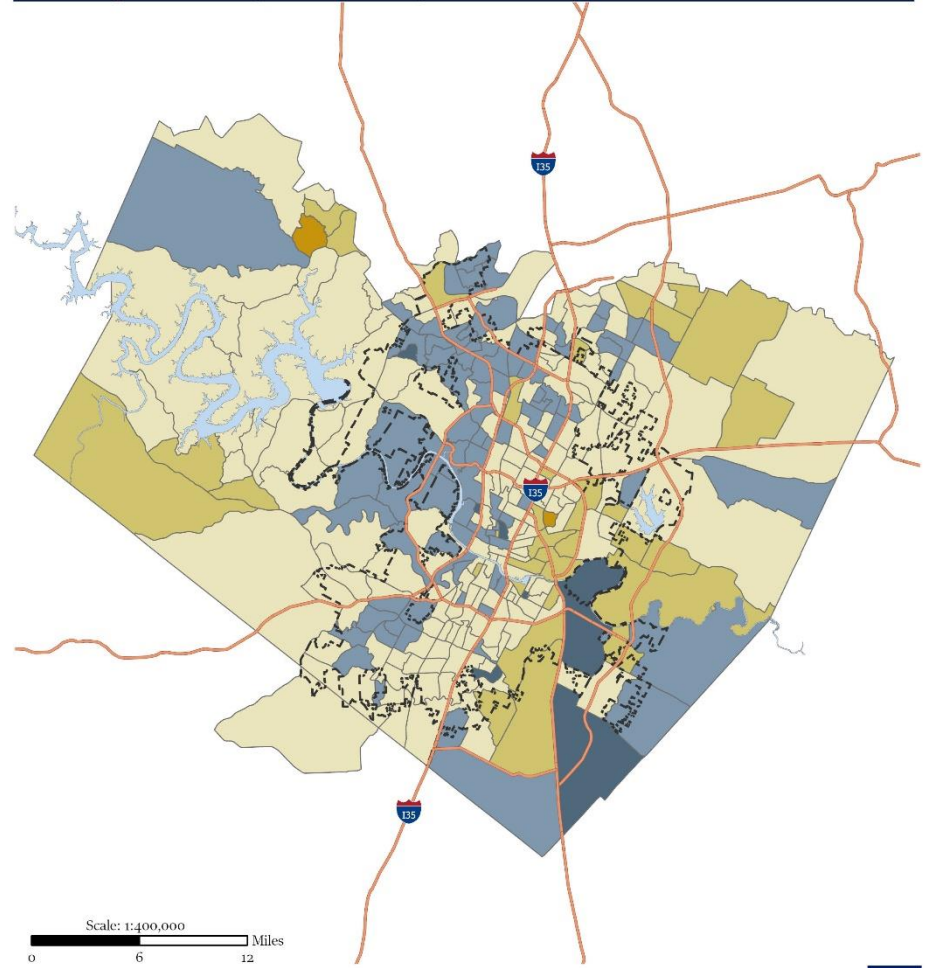
Author: City of Austin Housing and Planning Department
 Date: 2.09.2022
 Credit: U.S. Census Bureau, 2020 Decennial Census P.L. 94-171 File

Non-Hispanic White Population
 Percent of Total
 Census Tract



Census 2020, Travis County, TX

Change in Non-Hispanic White Population, 2010-2020



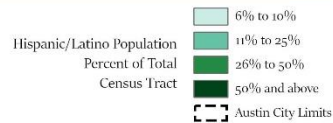
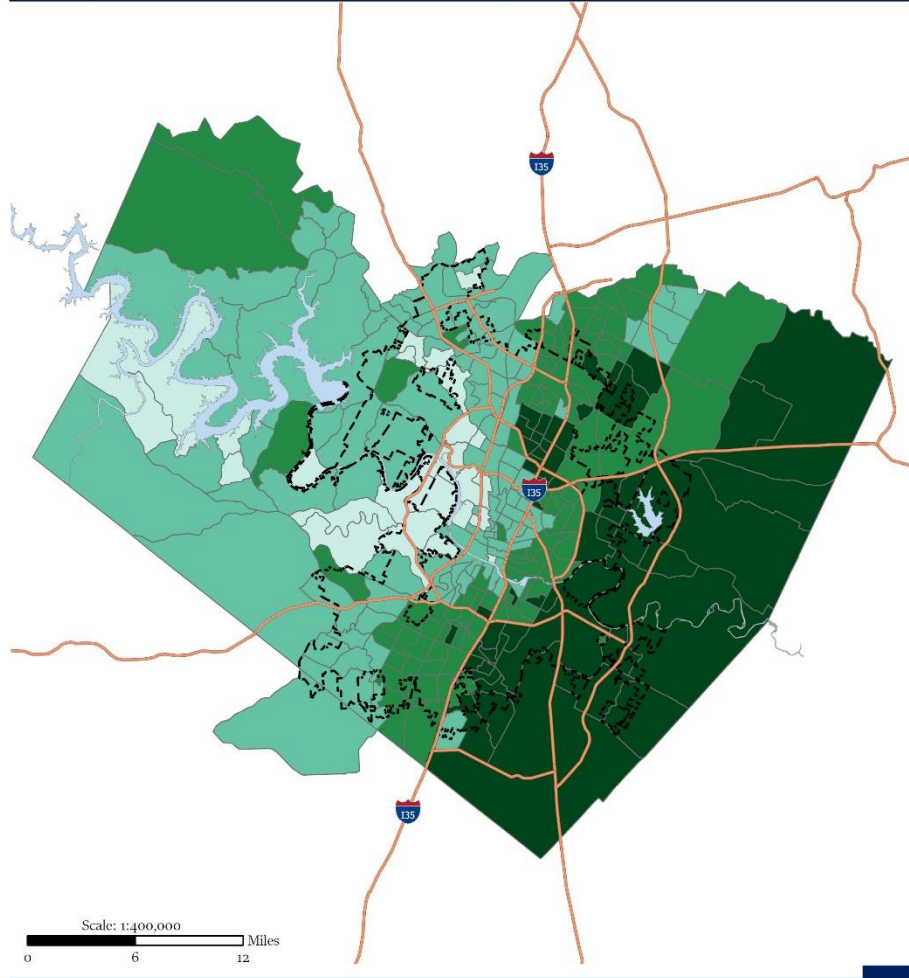
Author: City of Austin Housing and Planning Department
 Date: 2.09.2022
 Credit: U.S. Census Bureau, 2020 Decennial Census P.L. 94-171 File

Non-Hispanic White
 Population Change per
 Census Tract



Census 2020, Travis County, TX

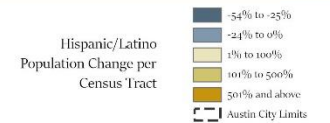
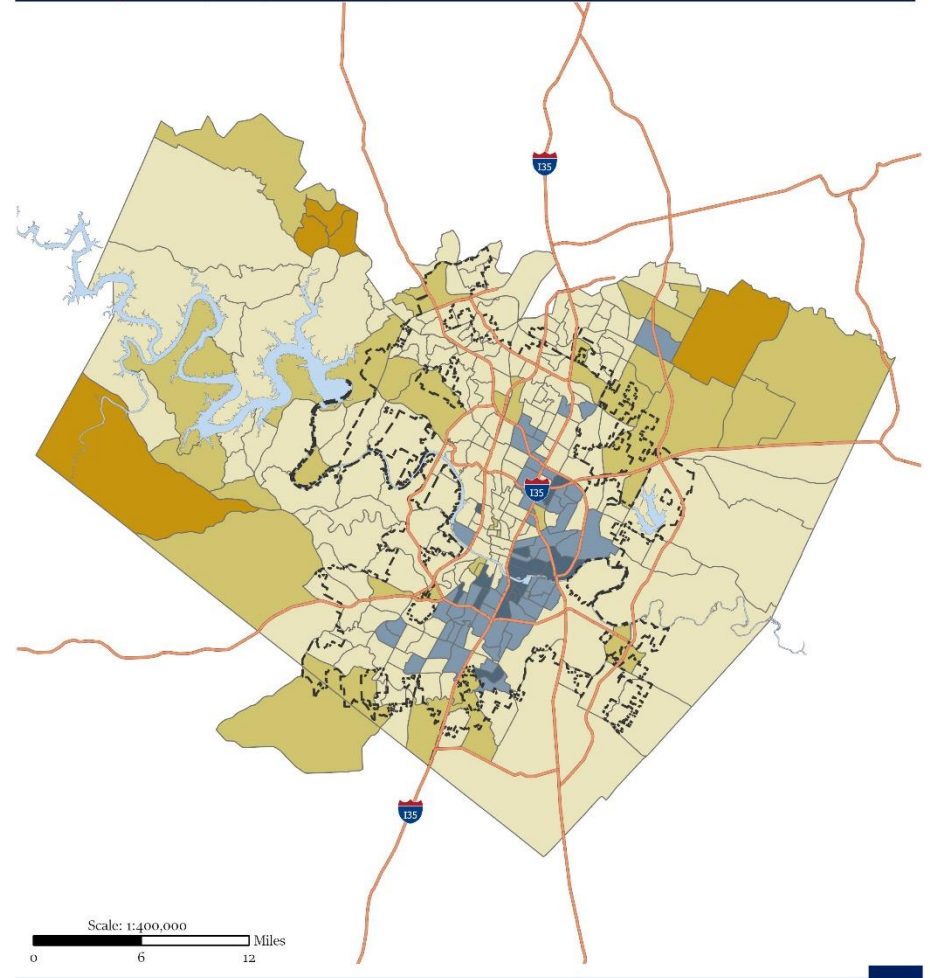
Hispanic/Latino Geographic Distribution by Census Tract



Author: City of Austin Housing and Planning Department
 Date: 2.09.2022
 Credit: U.S. Census Bureau, 2020 Decennial Census P.L. 94-171 File

Census 2020, Travis County, TX

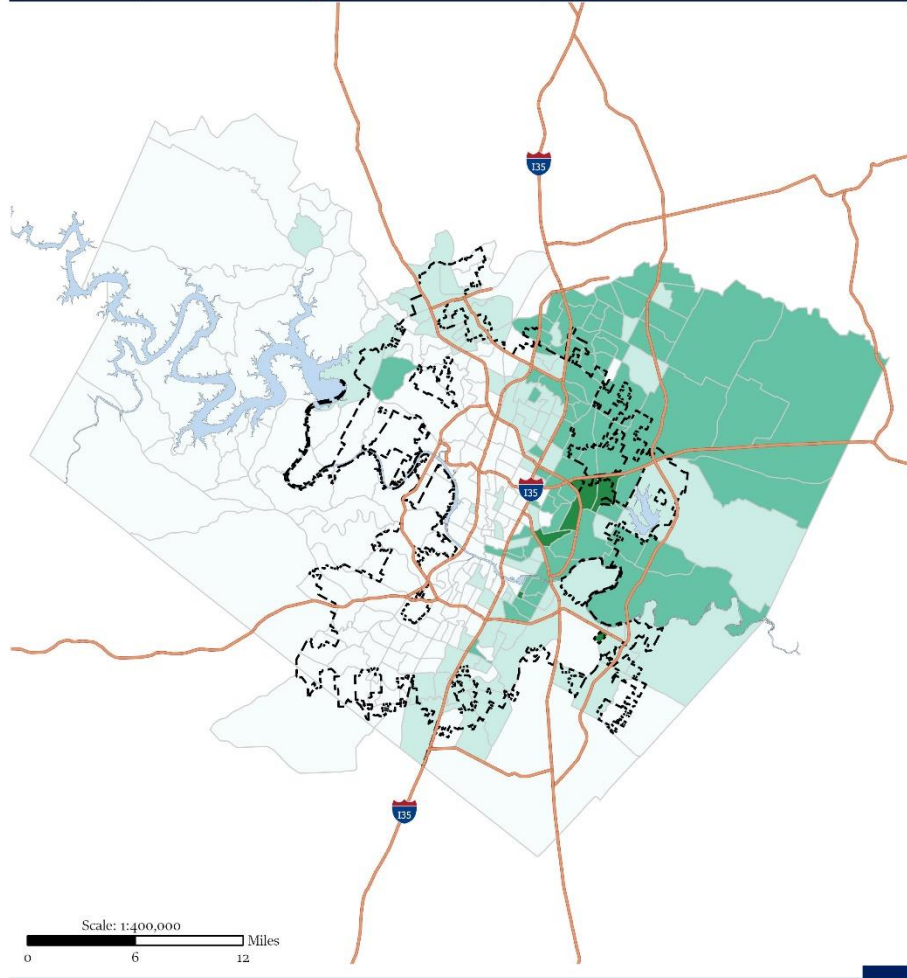
Change in Hispanic/Latino Population, 2010-2020



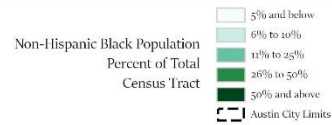
Author: City of Austin Housing and Planning Department
 Date: 2.09.2022
 Credit: U.S. Census Bureau, 2020 Decennial Census P.L. 94-171 File

Census 2020, Travis County, TX

Non-Hispanic Black Geographic Distribution by Census Tract

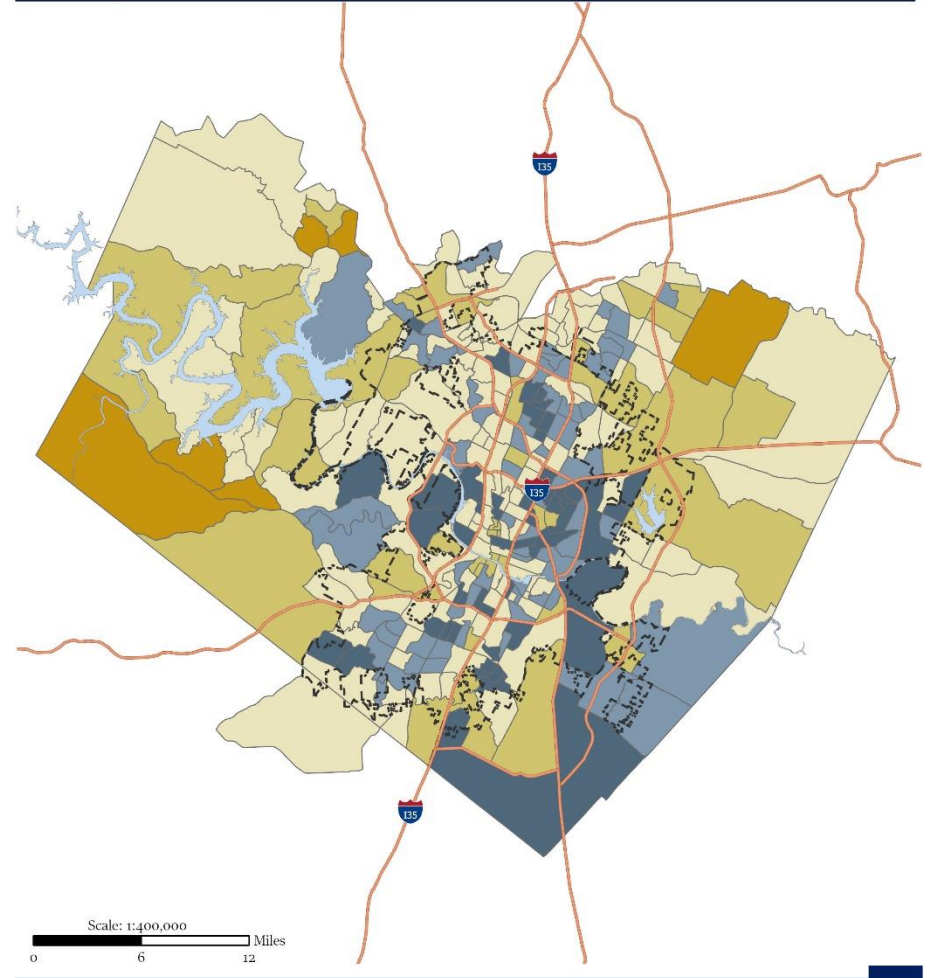


Author: City of Austin Housing and Planning Department
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 Credit: U.S. Census Bureau, 2020 Decennial Census P.L. 94-171 File

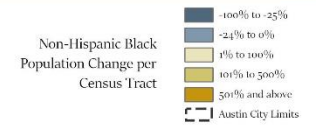


Census 2020, Travis County, TX

Change in Non-Hispanic Black Population, 2010-2020

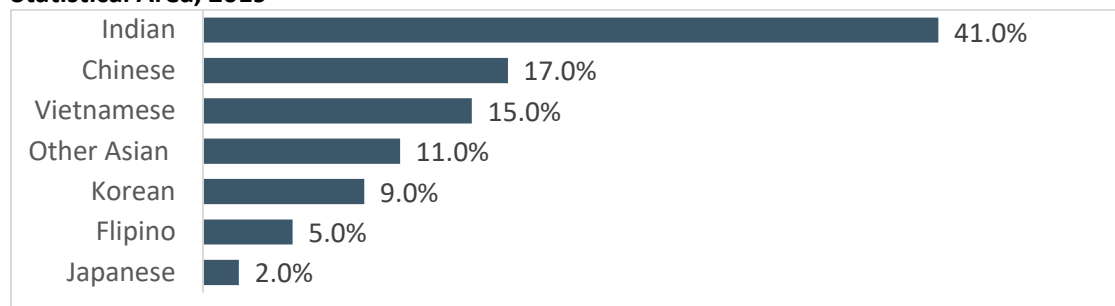


Author: City of Austin Housing and Planning Department
 Date: 2.09.2022
 Credit: U.S. Census Bureau, 2020 Decennial Census P.L. 94-171 File



According to ACS data (U.S Census) cited by Greater Austin Asian Chamber of Commerce, Asian Americans in Austin are the fastest growing demographic group, with the Asian population doubling every twelve years.² About 8% of residents in the Austin metropolitan statistical area (MSA) identified as Asian American, with the highest percentage of the Asian population originating or descending from India (41.0%) and China (17.0%) (Figure 6). In addition to the groups listed in Figure 6, Austin is home to emerging refugee populations from Nepal, Burma, Cambodia and Laos.

Figure 6. Percent Asian Population by Countries of Origin, by Austin Round Rock Metropolitan Statistical Area, 2019



DATA SOURCE: U.S. Census Bureau, American Community Survey; as cited by Greater Austin Asian Chamber of Commerce, 2019

When asked to describe the population in the Austin and Travis County region, focus group participants and community leaders described the population as very diverse racially and ethnically, including Hispanic/Latino, South Asian, Black/African American, and Korean residents. Several community leaders and focus group participants observed growing socioeconomic inequities in the region that particularly affect residents of color.

One community leader described outlying regions of Travis County where Korean communities are established: *“There are some [Koreans] in Pflugerville, Round Rock, Cedar Park, Georgetown ... Many Koreans including some older populations live here, [they are a] population of less than 10,000, but more are moving in.”*

Another community leader described the Muslim community in the area as socioeconomically diverse: *“It is a very diverse population economically with people who have lucrative careers or are more financially well-off, but you also have recent arrivals of refugees.”*

According to another community leader, there is a need for greater support for African American residents in the area: *“In the African American community, ‘we need everything,’ it’s alignment of services, awareness, mak[ing] sure [that] services are where and when they need to be. That they’re communicated how they need to be to those most in need. We see a lot of gaps to the most vulnerable populations. It’s not just diabetes, it’s holistically.”* – Community Leader

Immigration and Language Needs

According to community leaders, the immigrant populations in the region includes Hispanic/Latino immigrants and some refugees from Middle Eastern and Asian countries. One community leader observed that the growth of the refugee community has slowed due to federal immigration restrictions in recent years that limited refugee migration to the United States (US).

Several participants described growth of the bilingual population in the region and a sizable population for whom English is not their first language. One focus group participant observed, *“The population is growing a lot, wherever you go there are bilingual people.”* Inadequate access to information and social and health care services in residents’ primary language emerged as a barrier to getting COVID-19 information, health information, and accessing social services and health care, which is discussed in later sections of this assessment.

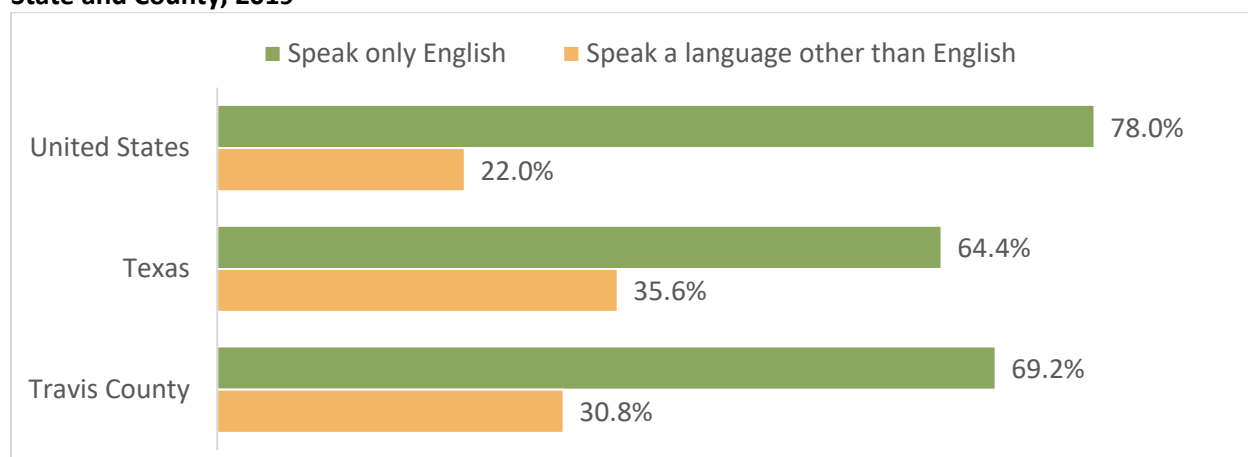
Some community leaders noted that a sizable proportion of Hispanic/Latino immigrants primarily speak Spanish, citing a need for services and information available in Spanish. One community leader who provides health care services to low-income residents described their patient population: *“75 to 85% of patients are Hispanic, most are immigrants, about 75% prefer Spanish, which is the best indicator for high rate of immigrants.”*

One community leader observed that the expansion of several tech industries in the area has attracted Asian immigrants who are fluent in English and/or whose educational experiences have prepared them for high-income careers that are booming in the region. Another community leader echoed that growth of immigrant communities linked with tech industries in the area have attracted younger immigrant workers who are fluent in English.

In contrast, according to one community leader, refugees are generally less likely to be fluent in English. This community leader emphasized the importance of investing in bilingual education programs for refugee communities: *“I want a language program [...] to teach English to our refugee population. Most immigrants who are non-refugees are here because they have an advanced skill set already. A big component of their community is those who are in the IT industry already.”*

According to Census data, a higher proportion of residents in Travis County (30.8%) and Texas (35.6%) speak a language other than English at home compared to the U.S. overall (22.0%) (Figure 7).

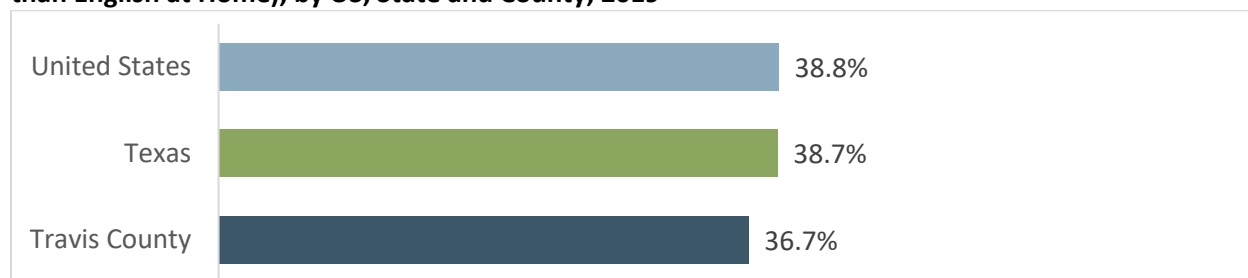
Figure 7. Percent Households Speaking Only English or Language Other than English at Home, by US, State and County, 2019



DATA SOURCE: U.S. Census Bureau, American Community Survey 1-Year Estimates, 2019

About one-third of households in Travis County (36.7%) and Texas (38.7%) that speak a language other than English at home are considered non-English speaking households, defined as households that speak English less than “very well”; this percentage was similar for households across the US (38.8%) (Figure 8).

Figure 8. Percent Households Non-English Speaking (Among Households Speaking a Language Other than English at Home), by US, State and County, 2019

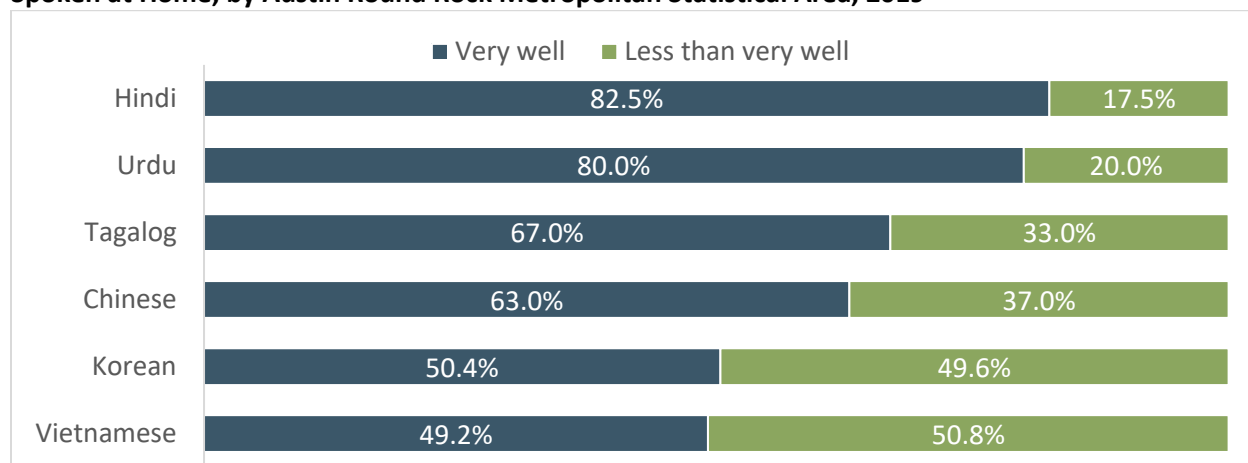


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2015-2019

NOTE: Percentage of households that speak English less than “very well” within all households that “speak a language other than English”

Among Asian American households in the Austin Round Rock MSA, the percentage of households who speak English “less than very well” was highest among Vietnamese speaking (50.8%) and Korean speaking (49.6%) households and lowest among households that speak Hindi (17.5%) and Urdu (20.0%) at home (Figure 9).

Figure 9. Percent Households Speaking English “Very Well” and “Less than Very Well,” by Language Spoken at Home, by Austin Round Rock Metropolitan Statistical Area, 2019



DATA SOURCE: U.S. Census Bureau, American Community Survey; as cited by Greater Austin Asian Chamber of Commerce, 2019

NOTE: The primary Chinese dialects are Mandarin and Chinese

Several community leaders and focus group participants noted the importance of making sure that information about health and available resources, as well as services, are readily available in residents’ primary language. One community leader highlighted the centrality of providing information in language: *“Language access is key. If you don’t have any material to educate yourself about a health disease, then changes can’t really be made. Each community has a very nuanced way of looking at wellbeing.”* Another community leader echoed the need for language justice to promote health equity, *“Language is a barrier to the people that need resources the most.”*

Community forum participants concurred. Language access emerged as an important barrier to information about resources and to receiving quality services for community members for whom English is not their primary language. Forum participants recommended improving outreach efforts by ensuring that information is available in residents’ primary language, using in-person modes of communication, and leveraging the language skills of community-based organizations to address language gaps in public health services and information.

One community leader characterized the current limited state of **language support** from local governmental leaders, a gap which their organization has had to fill to address information and resource gaps that affect the diverse Asian and Pacific Islander community in the region: *“We have no language support from the city. We have about 40 different [Asian and Pacific Islander] languages spoken in Travis County.”* One community leader described the importance of local governmental representatives collaborating with and supporting community-based initiatives in **improving access to information** and resources in residents’ primary language. To address the gap in information available in residents’ primary language, one community leader shared how Korean communities in the region rely on information made available by other cities:

“We are intertwined with other cities with Korean associations. We don’t get our information from Austin. We get our information from other cities, so I think this association will take a good role in this

community and it would be nice to be a part of what the city is trying to do. It is very important how the city supports us.” – Community Leader

One community leader identified the need to **improve outreach** to Spanish-speaking communities who are increasingly living in the outskirts of the City.

“I think trying to continue to reach Spanish speaking and organizations that provide or cater to Spanish speaking population. A lot of them may exist in Central and East Austin, but [you] don’t see many providing services as far out here [Del Valle]. So, how can we get them out here doing more targeted work?” – Community Leader

Another community leader emphasized that **translation of information** must be culturally tailored: *“Translation must also relate to the cultures, such as having community outreach things such as fliers being made by people from that community.”*

Some Hispanic/Latino focus group participants and some community leader described **legal status as a barrier** to accessing services and resources.

“I know that not having it [authorized US presence], being scared to ask for services, it’s about what they will ask [for]. If they ask for your Social Security card, that could be an impediment for a person seeking additional services, because they fear what if they ask me for it and I don’t have one. What if something happens and... I think it could be a factor that keeps them from looking for additional services.” – Focus Group Participant

Some Hispanic/Latino focus group participants mentioned not being able to access federal stimulus payments linked with the COVID-19 pandemic due to their **legal status**, including assistance for US citizen children. One focus group participant shared, *“They [...] also said that the parents of children who were citizens were going to obtain some of the money through the children, for me that is not true because they never sent us anything.”* A community leader elaborated on the challenges that undocumented communities face in accessing financial assistance that to which they are entitled:

“[For] undocumented people in Del Valle, [there is] a lot of misinformation about ability to apply for financial assistance. If they don’t qualify for federal dollars, other pots of money are available, with their account; water and gas, even with no documentation, there are still services available.” – Community Leader

One focus group participant explained how state-issued government identification card policies that exclude undocumented immigrants from accessing a usual state ID or driver’s license make it difficult to access resources linked with having a current state ID and also limit one’s sense of belonging. They explained:

“I would like it if we were all treated equally. Even the ID they used to issue here in Texas they no longer do it. There are places where they ask for a Texas ID, they don’t accept registration, so you feel bad. And they forbid it, because one feels like a second-class person because we are

not the same as those who can show their driver's license or identification. In that I have felt quite [excluded].” – Focus Group Participant

Notably, in-depth interview participants also discussed at length the challenges of navigating day-to-day activities, such as seeing a doctor or securing housing, due to lack of a current state-issued ID or driver’s license.

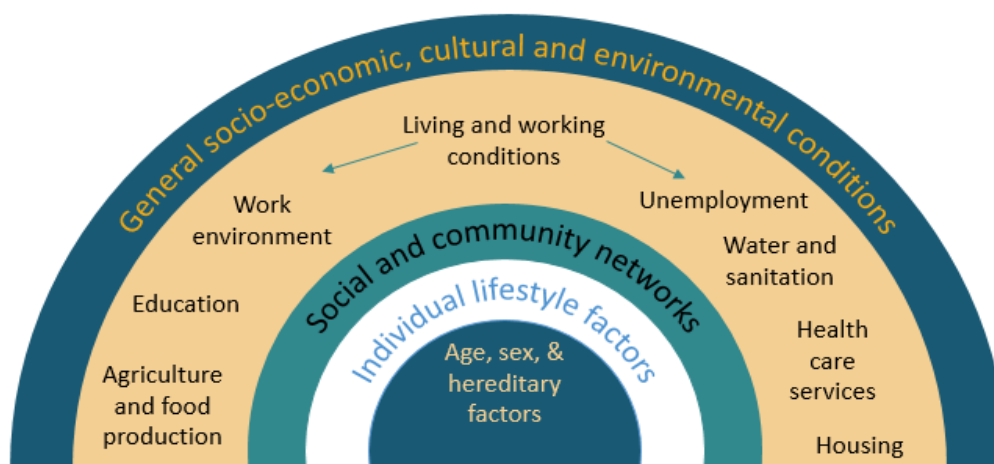
FINDINGS: COMMUNITY SOCIAL AND ECONOMIC CONTEXT



COMMUNITY SOCIAL AND ECONOMIC CONTEXT

As noted previously, this assessment focused on the social and economic issues that affect a community's health. Where a person lives, learns, works, and plays all have an enormous impact on health. Health is not only affected by people's genes and lifestyle behaviors, but by upstream factors such as employment status, quality of housing, and economic policies. Figure 10 provides a visual representation of these relationships.

Figure 10. Social Determinants of Health Framework



SOURCE: World Health Organization, Commission on the Social Determinants of Health, Towards a Conceptual Framework for Analysis and Action on the Social Determinants of Health, 2005.

The data to which we have access is often a snapshot in time, but the people represented by that data have lived their lives in ways that are constrained and enabled by economic circumstances, social context, and government policies. To this end, much of this report is dedicated to discussing the social, economic, and community context in which residents live. We hope to understand the current health status of residents and the multitude of factors that influence their health to enable the identification of priorities for community health planning, existing strengths and assets upon which to build, and areas for further collaboration and coordination.

Economic Indicators

Income is a powerful social determinant of health. At an individual level, income influences where people live, their ability to access higher education and skills training, and their access to resources to help them cope with stressors, all of which affect health and well-being. Income also shapes access to health-promoting resources such as healthy food, health care, and technological advances (e.g., new medical treatments).³ Compared to their higher income counterparts, low-income individuals have higher rates of smoking, obesity, and physical inactivity; more limited access to healthy foods, opportunities for physical activity, and healthy environments; higher rates of physical limitations, heart disease, diabetes, stroke, and other chronic conditions; and more limited access to health care.⁴ At a community level, regardless of individual level of income, low community wealth often correlates with more limited educational and job opportunities, greater community violence, environmental pollution and disinvestment in essential infrastructure and resources.⁵ While income, education, and employment are all associated with health outcomes in slightly different ways, many of the same population groups—communities of color, women, immigrants, and others—experience the compounded

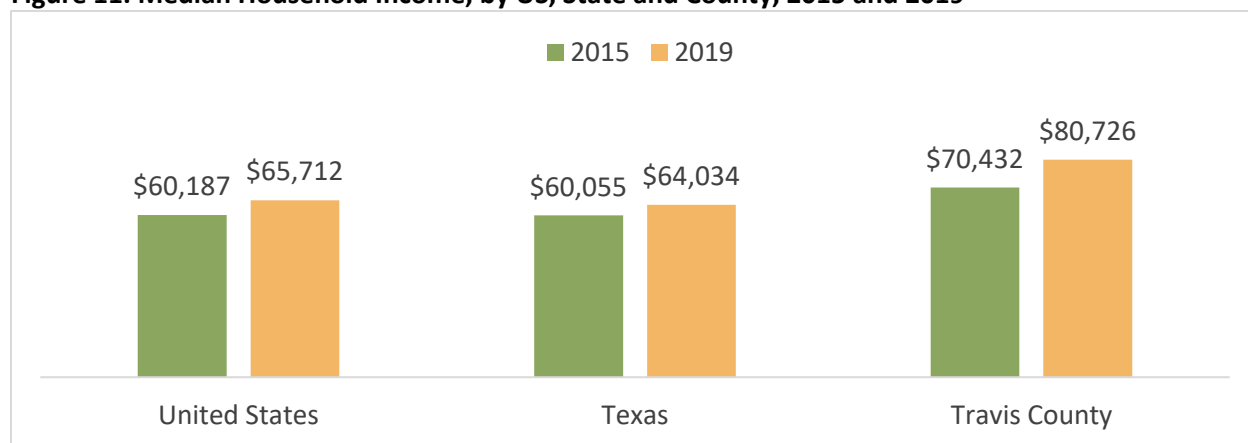
challenges and structural inequities across the myriad of systems related to economic advancement and upward mobility.

Austin’s history is rooted in **the exploitation of the labor of many communities of color**, which has led to the devaluation of the labor of these communities. Austin’s history, like many other communities in this country, was shaped by public policies that invested in wealth-generating opportunities for white communities while excluding communities of color from the same resources. Additionally, the role of housing in wealth generation for or wealth stripping from communities was split largely along racial and socioeconomic lines. More recently with the 2008 recession, Black communities were targeted for subprime mortgages, and the result of the crash was that many Black households have even less equity through homeownership than before 2008.⁶

“And the deal is, those problems [financial stress] how do they trickle [sic] down to the child: lack of food, diapers, lack of healthcare, lack of a job, the ability to have the necessary education, or tablet, so they can be ready for school, first day grade one reading on grade level.” – Community Leader

American Community Survey (U.S Census) estimates from 2019 indicate that the median household income was higher in Travis County (\$80,726) and slightly lower in Texas (\$64,034) compared to the US overall (\$65,712) (Figure 11). Between 2015 and 2019, median household incomes increased the least in Texas (6.6%) and the most in Travis County (14.6%).

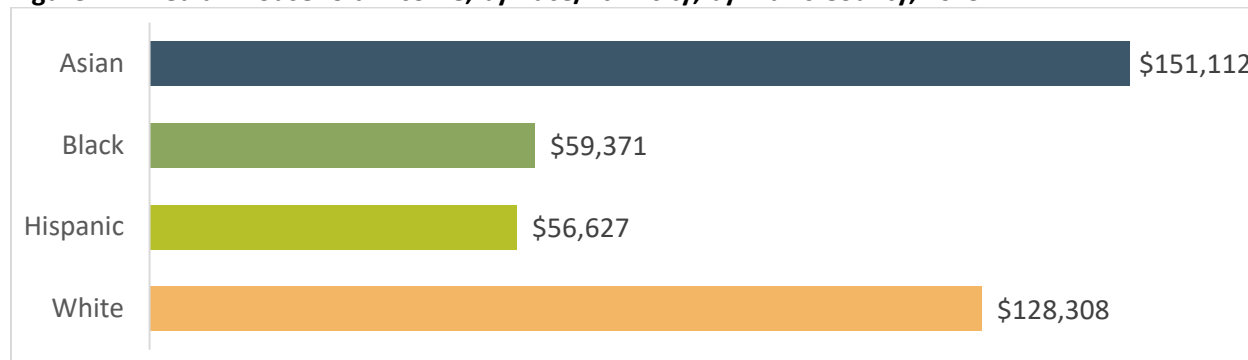
Figure 11. Median Household Income, by US, State and County, 2015 and 2019



DATA SOURCE: U.S. Census Bureau, American Community Survey 1-Year Estimates, 2015 and 2019

When comparing median household income by race/ethnicity in Travis County, Asian households had the highest median household income (\$151,112), followed by White households (\$128,308) (Figure 12). In contrast, the median household income for White households was 2.2 times the household income for Black/African American households and 2.3 times the household income for Hispanic/Latino households in 2019.

Figure 12. Median Household Income, by Race/Ethnicity, by Travis County, 2019

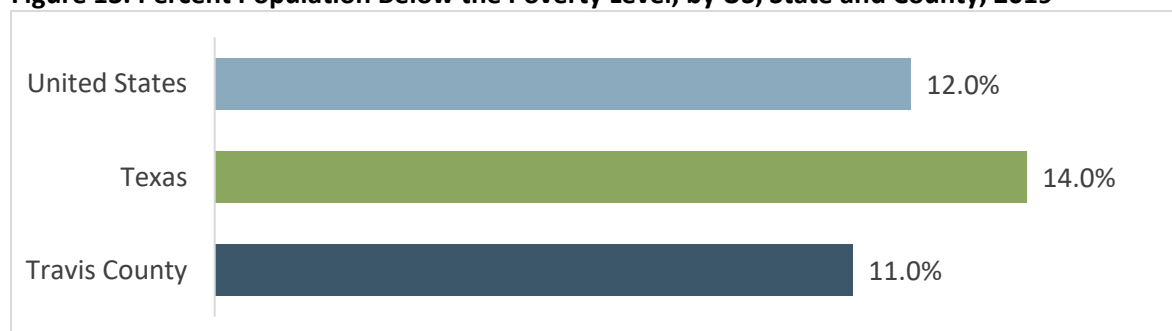


DATA SOURCE: U.S. Census Bureau, American Community Survey 1-Year Estimates, 2019

Additionally, about one-quarter (25.0%) of LGBTQIA+ respondents to the LGBTQIA+ Quality of Life Study survey reported having incomes below \$24,000, compared to nearly one-fifth (18.0%) of non-LGBTQIA+ respondents.

More than one-tenth of the population in Travis County (11%), Texas (14%), and the US (12%) lived below the federal poverty line, according to 2019 ACS estimates (Figure 14). In Travis County, 143,785 residents lived below the federal poverty level (data not shown).

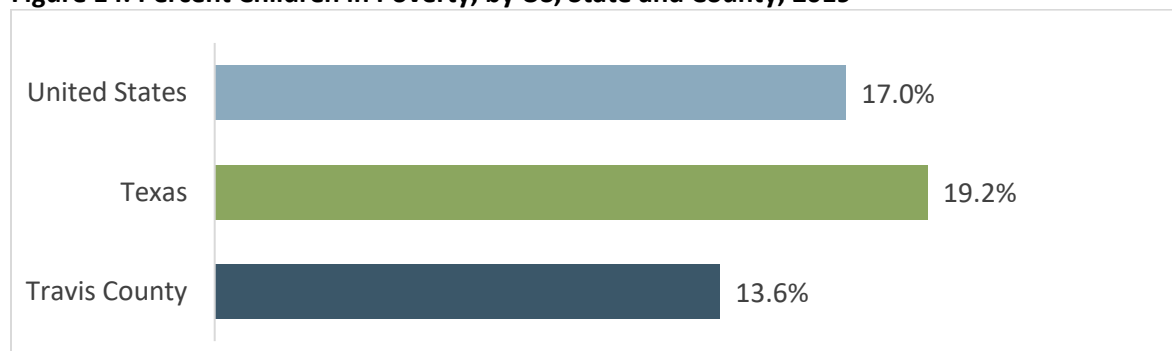
Figure 13. Percent Population Below the Poverty Level, by US, State and County, 2019



DATA SOURCE: U.S. Census Bureau, American Community Survey, 1-Year Estimates, 2019

According to 2019 County Health Rankings data, almost one-fifth of children in the US (17.0%) and Texas (19.2%) lived in poverty; this percentage was slightly lower in Travis County (13.6%) (Figure 14).

Figure 14. Percent Children in Poverty, by US, State and County, 2019



DATA SOURCE: Small Area Health Insurance Estimates (SAHIE), U.S. Census Bureau; as cited by County Health Rankings & Roadmaps, 2019

Many focus group participants, community leaders, and in-depth interview participants described the **cost of living** in the area as high and rising, which they linked with the **growing tech industry**. Several participants perceived that companies coming to the area were getting a tax break, while residents were experiencing increases in taxes. One Hispanic/Latino focus group participant who has lived in Austin for decades shared their experience with the rising cost of living:

“[T]he cost of living in Austin, I’ve been here 40+ years and it keeps going up. Austin keeps asking companies to come and they are coming and coming, but they’re not giving us regular people here a break, because taxes keep going up, I don’t know if this is part of health, but it is stressful, so I guess it is health. But they’re giving them a lot of [tax] break[s], where they’re putting the burden back on the taxpayer. They’re making a lot of the older residents where they don’t want to be here.”
– Focus Group Participant

One community leader characterized the day-to-day experiences of low-income residents as **survival**: *“If you look at some of our communities, there is no quality of life, it’s just survival.”* Another community leader described how due to rising gas costs in their neighborhood, they often traveled farther to fill up their gas tank, highlighting the day-to-day impacts and adjustments that residents are making due to the rising cost of living.

Some focus group participants and community leaders described the impossible equation of living on income from minimum wage jobs and paying for rent, childcare, and transportation. One community leader described this dilemma for a low-income family with young kids, particularly for single parents:

“[F]or the families, childcare cost is a problem. And a living wage. For example, a single mother with four kids, they can’t have a 15 or 16 dollar an hour job, and be able to afford an apartment in Austin. The high cost of apartments, if you have 3-4 kids in childcare, a car payment, rent, you are struggling. [...] Some of the mothers are trying to work 2 and 3 jobs. How do you work 2-3 jobs and not get caught up with CPS [Child Protective Services] looking at you to see if you’re a fit mother or a fit household. That’s the reality.” – Community Leader

According to focus group participants and several community leaders, **limited income and rising costs of living** are very stressful and negatively affect health for low-income residents, residents of color, and older adults across the region. One community leader described how Asian residents are often overlooked when thinking about low-income residents in the region.

Key informants identified several socioeconomic challenges that immigrants navigate, including securing work opportunities and responsibilities to financially support their kin networks. One community leader shared, *“Many immigrants are still trying to find work, [experiencing] language barriers.”* According to one community leader, barriers to job opportunities are compounded by economic responsibilities to family and communities in the United States and in their home countries. This community leader shared, *“You have an additional responsibility as well as an opportunity [regarding immigrants who are wanting to just work and send money home] to be a contributing member of this community that is now your community.”*

One Hispanic/Latino focus group participant highlighted the irony that Hispanic/Latino immigrants are employed in industries that are classified as “**essential work**” during the COVID-19 pandemic. This resident noted that construction industry in particular has been central to sustaining the growth across the region, yet their income and treatment does not honor these contributions.

Several focus group participants and community leaders described their communities and/or the communities they serve as including residents who work in low-wage jobs that are stressful, hard to get, and with incomes that make it difficult to make ends meet, while also observing a growth in high-income job opportunities that are attracting residents outside of the region. One community leader described the community in which they work:

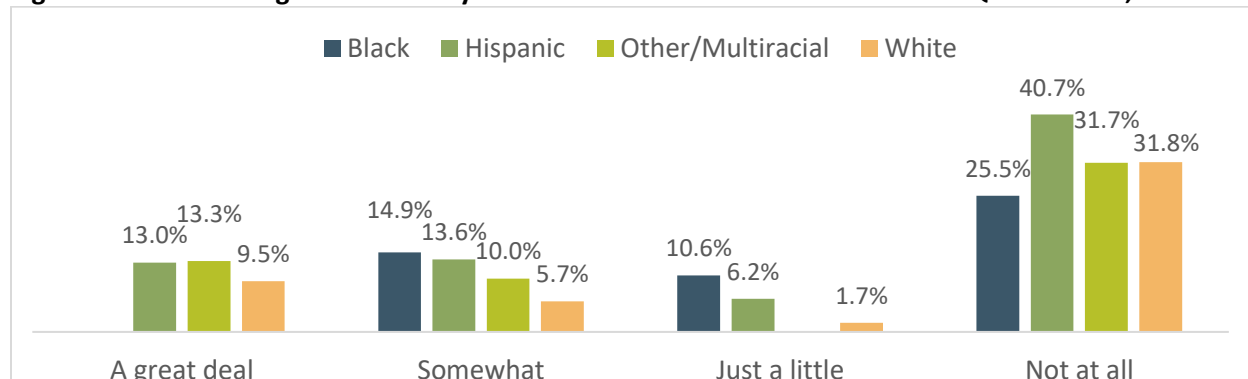
“Dove Springs is a working-class neighborhood, so these things mentioned affect everyone and the residents work all kinds of shifts due to their blue collar jobs.” – Community Leader

The perception of the **availability of quality education, professional development or training for jobs** remained roughly the same between 2008 and 2018, although a higher percentage of people (57%) viewed this kind of training as “usually available,” rather than “very available” than in past years. A higher percentage of Black/African American (26%) and Hispanic/Latino (19%) residents did not believe trainings for the kinds of jobs they sought were available, as compared to other racial/ethnic categories.⁷

One in-depth interview participant described how prison vocational programs inadequately prepare people to re-enter the workforce once they have been released from prison, making it difficult to re-integrate into society. *“...If the prison system is not going to help reentering citizens develop marketable skills, it’s to the advantage the community to do so. The more successful people are at reintegrating back into society the less of a threat they are, the more they will desire to integrate into norms of society.”*

When examining the effect of English proficiency on the potential to get a job they are otherwise qualified for, about two-fifths of Hispanic respondents (40.7%) reported that the lack of English proficiency did not affect them. In contrast, the highest percentages of Hispanic (26.2%) and Other/Multiracial (23.3%) respondents somewhat or a great deal affected their potential to get a job they would be otherwise qualified for (Figure 15). These findings could underscore the need for enhanced educational support for English training and other additional language support.

Figure 15. Effect of English Proficiency on the Potential to Get a Job Otherwise Qualified For, 2020



DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2020

NOTE: No response or N/A responses are excluded.

When discussing work, often focus group participants and several community leaders discussed the **impact of COVID-19 on work and stress** for low-wage workers. One focus group participant described how stress levels for residents working in low-wage jobs have worsened with the COVID-19 pandemic and contribute to increases in chronic disease:

“I see people that are working in construction almost all day and with a very low salary and they are the only ones that are outside, they are essential workers, all of them, many in restaurants, and lately with the pandemic, stress is building up. This is leading to more chronic diseases or, as I said before, it causes triglycerides to skyrocket, this is also a reason why we are seeing a poor diet, sleeplessness, and hard work.” – Focus Group Participant

Regarding **childcare needs for working individuals**, among Austin Area Community survey respondents with children under 6 years of age in the household, approximately one quarter (24.1%) of parents reported having difficulty finding childcare, with 36.0% reporting difficulty finding childcare during the evening or weekend. According to respondents, approximately two-fifths (42.9%) of Black/African American (42.9%), and (41.1%) of Hispanic/Latino (41.1%) respondents and 34.2% of White respondents reported that they had trouble finding affordable childcare not provided by a relative in the past two years. Some focus group participants and community leaders mentioned the role of older adults in caregiving to young children, and the importance of supporting older adults in their caregiving roles. One focus group participant explained, *“We have a lot of older people taking care of younger kids (children with their grandparents). [T]hey don’t have the resources or energy to take care of the kids, and we don’t have any specific support for that.”*

Some focus group participants and community leaders also discussed **limited supports for childcare**, including insufficient day care options, particularly in areas where the population is growing. One focus group participant in a rural community that was experiencing population growth explained the importance of investing in infrastructure to support families with young children:

“We need to have more daycares as well to make sure that as our community grows, we are able to meet some of those demands for our families. The more opportunities we open up for families to where Manor is self-sustaining and not needing to head to other towns/cities [would be helpful], because for now all of our families travel.” – Community Leader

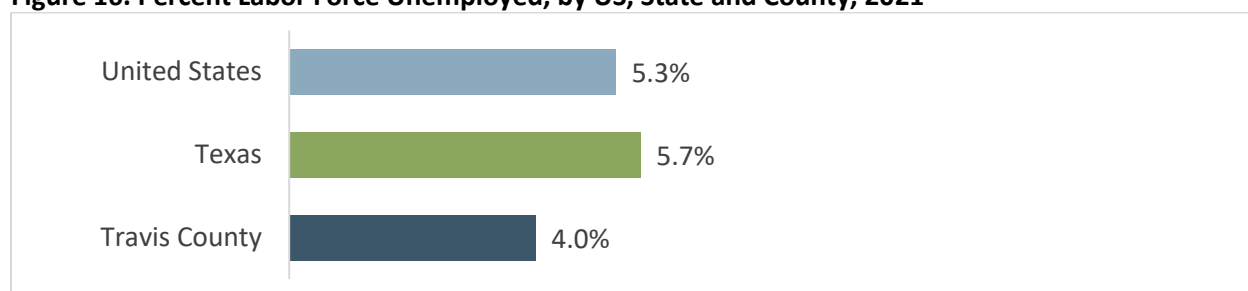
One community leader discussed the importance of providing **affordable childcare** for low-income households, many of whom rely on unlicensed childcare providers:

“We also work with unlicensed childcare providers. The reason being a single parent cannot afford to pay 500-800 a child in childcare. So someone that is unlicensed, on Social Security or disability, a big mama, a big papa, somebody in that apartment complex is taking care of those kids. Nine times out of ten, a lot of those parents are dropping kids off with not enough pampers, with not enough milk, with not enough food, so we try to support those unlicensed childcare centers.” – Community Leader

Unemployment

In 2019, the unemployment rate was 2.6% in Travis County, 3.5% in Texas, and 3.7% in US overall. Despite high employment levels of 96% to 95% of the working population in Del Valle and Montopolis, respectively, one out of four residents of Del Valle and one out of three residents in Montopolis lived in poverty.⁸ This low unemployment rate - taken together with the high level of residents living in poverty - may point to a major structural barrier for health and well-being for Del Valle and Montopolis families and residents: the lack of a living wage that allows people to move out of poverty while employed.⁹ Notably, the unemployment rate fluctuated during the COVID-19 pandemic and in 2021, the rate was 4.0% in Travis County, 5.7% in Texas and 5.3% in the US overall (Figure 16). Unemployment varied by race/ethnicity and in the US in 2021, Black residents had the highest rate of unemployment at 8.6%, followed by Hispanic at 6.8%; the unemployment rate was 5.0% for the Asian population and 4.7% for the White population.

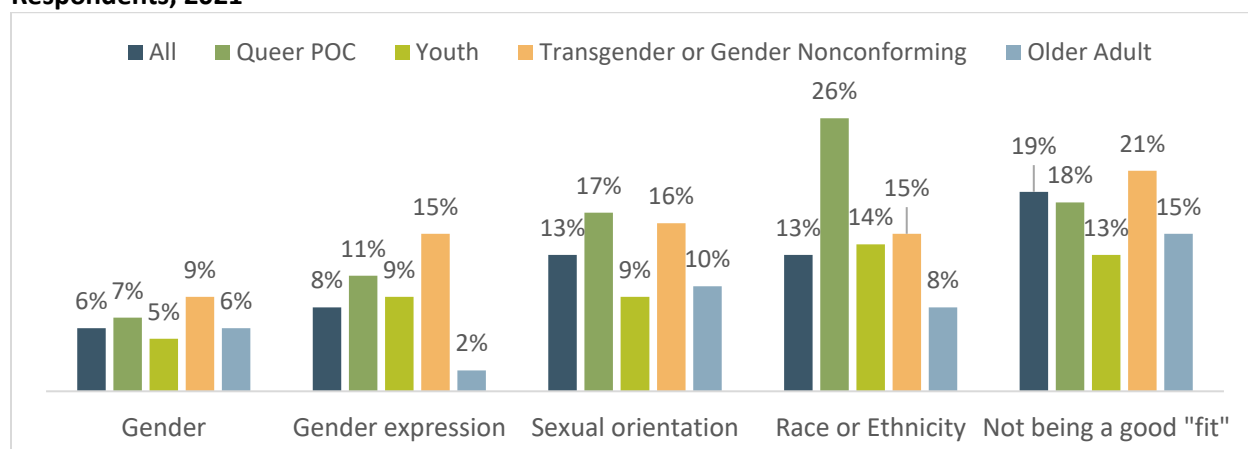
Figure 16. Percent Labor Force Unemployed, by US, State and County, 2021



DATA SOURCE: Local Area Unemployment Statistics (LAUS), Bureau of Labor Statistics; as cited by Texas Labor Market Information, 2021

A slightly higher percent of LGBTQIA+ respondents (7.0%) to the LGBTQIA+ Quality of Life Study survey reported being unemployed, compared to non-LGBTQIA+ respondents (5.0%). When respondents to the LGBTQIA+ Quality of Life Study survey were asked about reasons they were denied employment, queer people of color (POC) and transgender or gender nonconforming respondents indicated higher percentages of employment denials/terminations compared to all respondents. Queer POC cited that race or ethnicity (26%) and not being a good “fit” (18%) were the most common reasons for denial or termination of employment while transgender or gender nonconforming respondents indicated that not being a good “fit” (21%), sexual orientation (16%), gender expression (15%), and race/ethnicity (15%) were the most common reasons (Figure 17).

Figure 17. Reasons Denied Employment or Terminated of LGBTQIA+ Quality of Life Study Respondents, 2021



DATA SOURCE: City of Austin, Equity Office and LGBTQIA+Q Quality of Life Advisory Commission, ShoutOut Austin LGBTQIA+ Quality of Life Study, 2021

NOTE: Respondents may not be statistically representative of the population in Austin, but robust findings may provide insight into the larger breakdown of the LGBTQIA+ residents of Austin.

Several focus group participants and an in-depth interview participant mentioned that they had **job loss or had their work hours reduced** due to the COVID-19 pandemic. One focus group participant shared, *“We have been affected during the pandemic because many of us have lost our jobs.”* A community leader also highlighted how small business owners and workers have been affected by the COVID-19 pandemic: *“[Many] restaurants [...] lost revenue, they had to shut down many times so I’m not so sure how they have been handling it.”* One community leader mentioned difficulty hiring staff as small businesses reopen:

“They [Korean businesses] are struggling to find employees now that they are opening again, so that is one of the challenges right now. One of my friends owned a shop and she couldn’t find employees to release her, so she had to shut down for a day to get some rest. I think it’s just for everyone, not just the Korean stores.” – Community Leader

Education

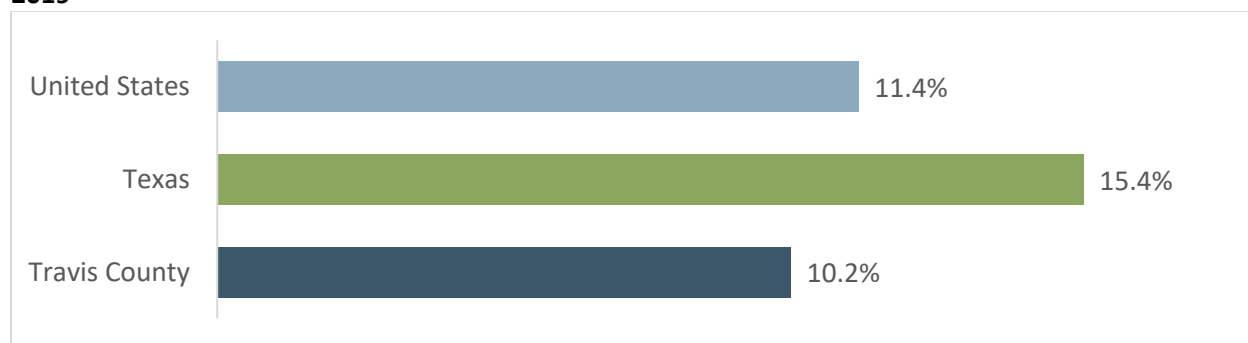
Education affects health in multiple ways. Individuals of lower educational attainment generally have less favorable health profiles compared to their counterparts with greater educational attainment.¹⁰ Most directly, education increases economic and social resources.¹¹ Those with higher levels of education are less likely to experience unemployment and economic hardship and have more social connections than those with lower levels. Those with lower levels of education are more likely to be engaged in jobs that are lower paying or unstable, lack employer-provided health insurance benefits, or that are more risky or unsafe. Research has also found that adults with higher educational levels have higher levels of health literacy, causing them to better comprehend medical instructions, understand medications, and advocate for themselves with health providers than their counterparts with lower educational attainment.¹² Inequities in educational funding and unequal access to key educational resources, including culturally-appropriate teachers and quality curriculum, are concentrated in low-

income communities and communities of color and are interconnected with the unequitable and discriminatory housing and neighborhood policies these same communities experience.¹³

The history of housing and services segregation in Austin has direct ties to the segregation of Austin's schools. The closure of old Anderson High School is also an example of the way that systemic racism shifts the burdens of desegregation on Black communities – i.e. the closure of a predominantly Black school and then the division of its student body and bussing them to separate white schools across the city. The closure of this school also had an impact on the community cohesion and sense of place for East Austin's Black community. There is also a history of unequal educational offerings across Austin's schools, related to the Chicano Civil Rights movement and how that looked in schools in East Austin. East Austin high schools have vocational programs that routed students into technical programs such as printmaking and brick laying while high schools in West Austin were preparing students for college careers and work in the rapidly developing technology sectors.¹⁴

One tenth of adults aged 25 years or older in Travis County (10.2%) and the US (11.4%) do not have a high school degree; this percentage is slightly higher across Texas (15.4%) (Figure 18)

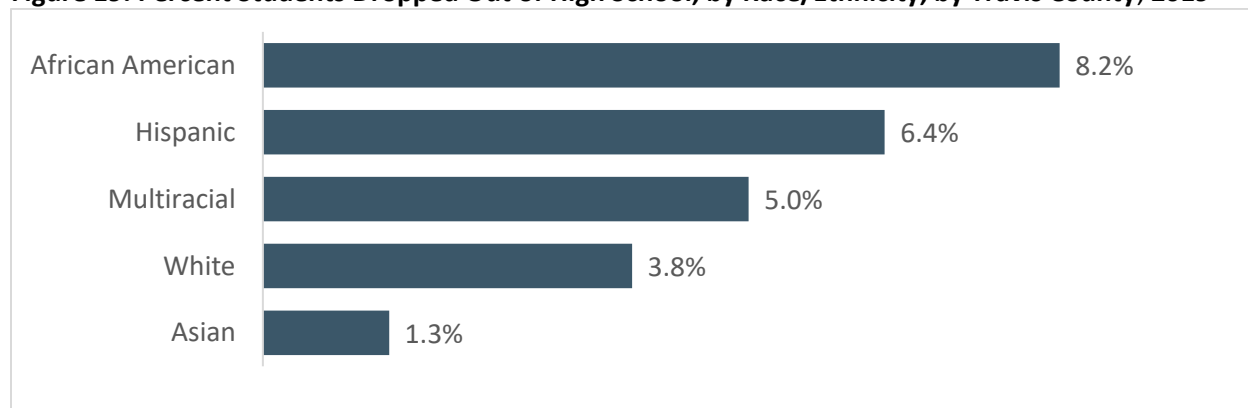
Figure 18. Population Aged 25+ With Less Than a High School Degree, by US, State and Travis County, 2019



DATA SOURCE: U.S. Census Bureau, American Community Survey 1-Year Estimates, 2019

Of students who dropped out of high school, dropout patterns were highest among students of color. For example, among students who dropped out of high school, 8.2% were Black/African American, followed by 6.4% Hispanic/Latino and 5.0% multiracial students (Figure 19).

Figure 19. Percent Students Dropped Out of High School, by Race/Ethnicity, by Travis County, 2019



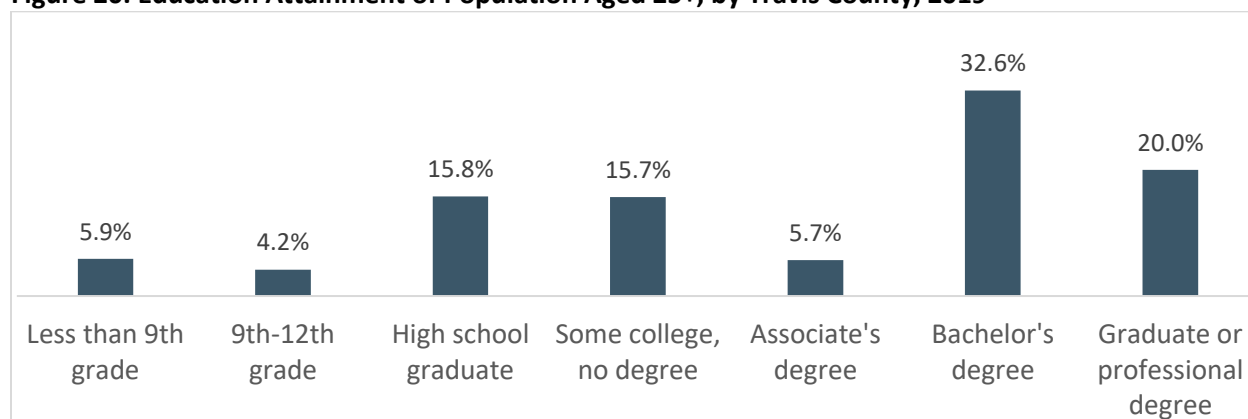
DATA SOURCE: Texas Education Agency, 2019

One community leader cited educational opportunity gaps for Black/African American boys in the Austin Independent School District (AISD), highlighting high levels of suspension, disciplinary action, and policing of Black/African American youth and the importance of a trauma-informed approach to supporting Black/African American youth:

“Back in 2006, -07, 08, the stats were-, with the Higher Education Coordinating Board, that they could only track less than 100 boys coming from AISD, for three consecutive years. But those same years, you could track more than 1,000 going to department of correction. [...] Black kids make up less than 10% [of students], but ¼ of arrests this year alone were Black kids. [...] So bottom line, we gotta say, are we really doing everything we can? Are we doing an assessment to find out why they’re acting [the way] they’re acting today? Is there a lack of something? Is there a lack of utilities, food, etc. Something that caused me to act this way today? Trauma is real.” – Community Leader

The majority of adults aged 25 or older in Travis County have a high school degree or higher (90.4%), similar to patterns across Texas (90.0%) and slightly higher than the average across the US (88.6%). Over half (53.0%) of Travis County residents have a bachelor’s degree or higher (Figure 20).

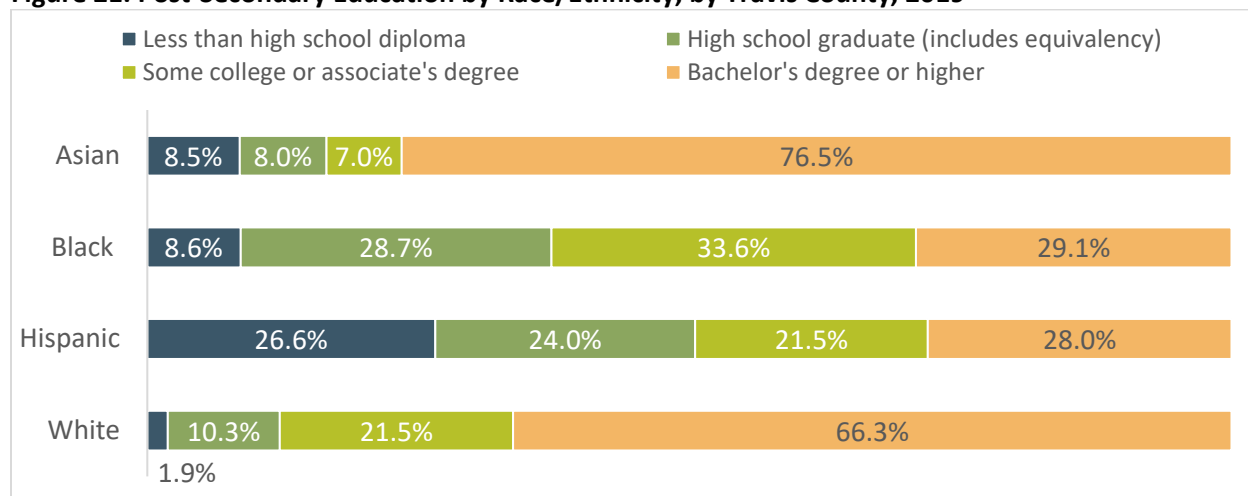
Figure 20. Education Attainment of Population Aged 25+, by Travis County, 2019



DATA SOURCE: U.S. Census Bureau, American Community Survey 1-Year Estimates, 2019

The majority of Asian (76.5%) and White (66.3%) populations have a bachelor’s degree or higher; however, the Hispanic/Latino population has the highest percentage of population without a high school diploma (26.6%), with a relatively similar percentage of Hispanics/Latinos with only a high school diploma (24.0%), some college education (21.5%) or a bachelor’s degree or higher (28.0%). About one-third of the Black/African American population has some college or associate’s degree (33.6%), bachelor’s degree or higher (29.1%) or high school diploma (28.7%).

Figure 21. Post-Secondary Education by Race/Ethnicity, by Travis County, 2019



DATA SOURCE: E3 Alliance, 2019

Several focus group participants, community leaders, and in-depth interview participants described the importance of education. One community leader noted that members of their community have to “create their own resources” to compensate for underfunded schools and libraries in low-income communities. Several community leaders described working class communities served by their organizations and the importance of investing in educational and career pathways to ensure that people of color are represented in service sectors and in upper-level administrative roles at school and beyond. One community leader explained:

“We need to focus on getting more Black teachers, more Black administrators in the school, not just janitors. Work on building a staff-, if you’re going to be a service provider, make sure the service providers look like those that you’re providing service too.” – Community Leader

For a resident who previously experienced incarceration, the use of educational technology such as computers and software created a barrier when pursuing higher education after being released from prison. This resident described their experience:

“[I] [w]ent to student services and found it difficult to tell [...] them about changes in technology and how to navigate (hadn’t been on cell phone or internet before) and it got overwhelming really quickly. Disabled services at universities or other agencies need to be trained to deal with people in recovery including people that were formerly incarcerated.” – In-Depth Interview Participant

Housing

Where people live is integral to their daily lives, health, and well-being. The conditions in the home and neighborhood environment may promote health or be a source of exposures that may increase the risk of adverse health outcomes.¹⁵ Housing is generally the largest household expense. For homeowners, it can be an important source of wealth.¹⁶ However, housing instability and stress of housing affordability have been found to be associated with poorer mental health outcomes and disruptions in work, school,

and day care arrangements.¹⁷ Housing instability has been associated with poorer outcomes for children related to risk for developmental delays, being underweight, and lower school attendance. Poor housing quality can have direct negative health impacts such as respiratory conditions (e.g., asthma) due primarily to poor indoor air quality—and can be one of the strongest drivers for asthma-related emergency department visits among children. Housing conditions can also result in cognitive delays in children from exposure to neurotoxins (e.g., lead), and accidents and injuries as a result of structural deficiencies.¹⁸

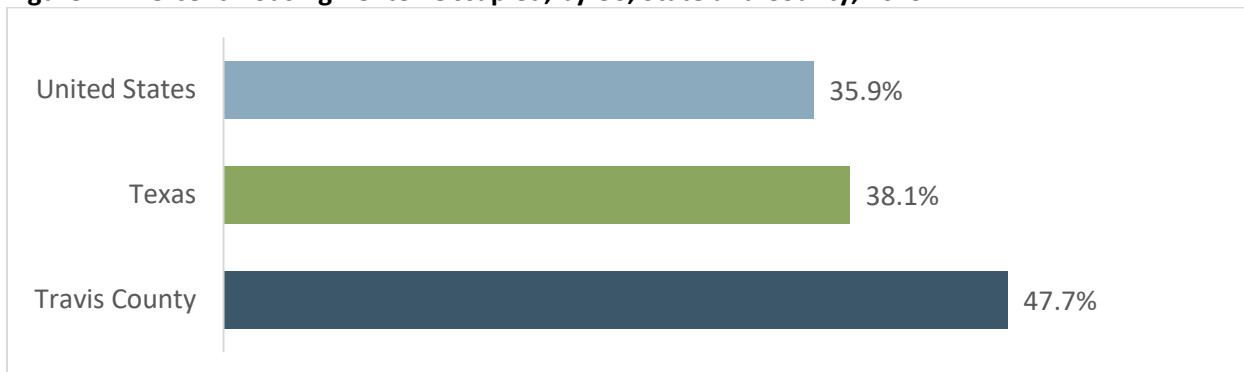
Years of structural racism have contributed to inequities in Austin’s environmental and housing policies, contributing to environmental health hazards and risk factors being concentrated into low-income and communities of color; examples of discriminatory historical planning efforts include the 1928 Plan, the 1957 Industrial Development Plan, siting of the Austin airport, the placement of Interstate Highway 35, Tank Farm, BFI Recycling Facilities, and the Pure Castings facilities to name several. Historical context allows us to gain a clearer understanding of the foundational roots of housing inequities that continue in Austin today, including the East/West divide, along with increasing gentrification² and displacement: “The metro area has one of the highest rates of income segregation in the country, a factor that could ultimately limit the ability of Austin’s youth to climb the income ladder and bolster the region’s future prosperity.”¹⁹

Cost burden is an important indicator of how well households can manage housing costs. According to the City of Austin Comprehensive Housing Market Analysis, about 65% (1,166) of total respondents reported spending 30% or more of their monthly income on housing and 17% (307) reported spending 50% or more of their monthly income on housing. Severe cost burden (paying more than 50% of monthly gross income on a household rent or mortgage plus basic utilities helps determine which households may be at-risk of losing their housing. This measure of need can also help identify which residents are disproportionately affected by lack of affordable housing. In Austin, White households faced severe cost burden 15% of the time. This compares to 25% of the time for Black/African American households; 23% for Hispanic/Latino households; and 20% for Asian households. As such, people of color in the City are much more vulnerable to the negative consequences of rapidly rising housing costs.²⁰ Also, the availability of affordable housing and space for the LGBTQIA+ community emerged as a priority among interviewees. Specifically, homelessness was an area of concern and disproportionate among LGBTQIA+ youth, people of color, and particularly queer and transgender people of color.²¹

In Travis County, almost half (47.7%) of housing units were renter-occupied, which was higher than in Texas (38.1%) and the US overall (35.9%) in 2019 (Figure 22).

² Gentrification is often defined as the transformation of neighborhoods from low value to high value. This change has the potential to cause displacement of long-time residents and businesses. Displacement happens when long-time or original neighborhood residents move from a gentrified area because of higher rents, mortgages, and property taxes. [CDC - Healthy Places - Health Effects of Gentrification](#)

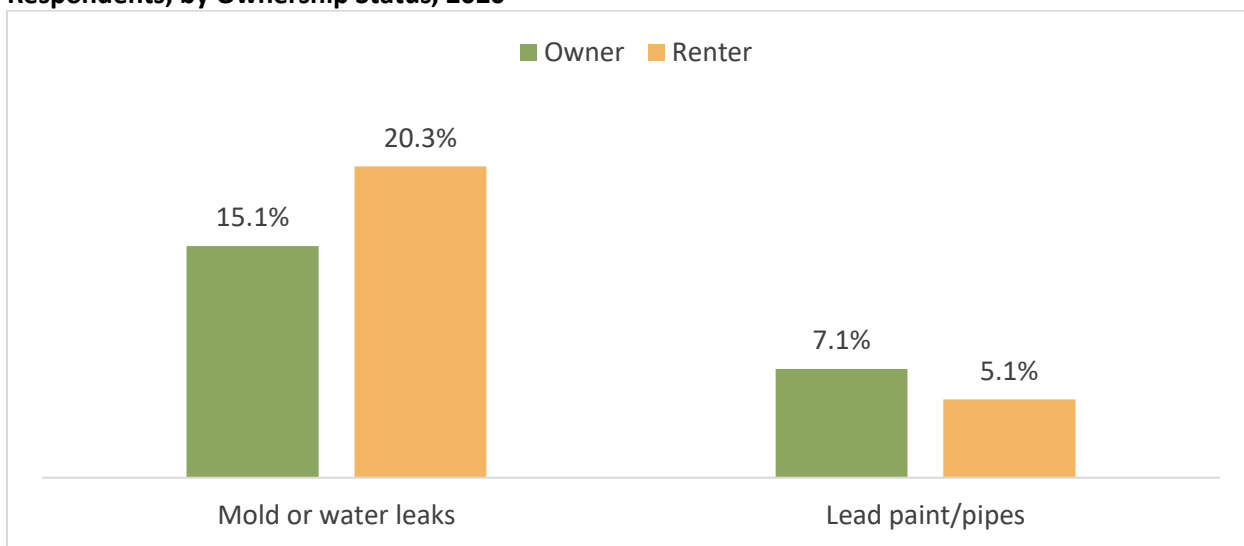
Figure 22. Percent Housing Renter-Occupied, by US, State and County, 2019



DATA SOURCE: U.S. Census Bureau, American Community Survey 1-Year Estimates, 2019

Both owner and renter respondents to the Austin Area Community Survey cited mold or water leaks (owners: 15.1%, renters: 20.3%) as the top severe housing problem, followed by lead paint/pipes (owners: 7.1%, renters: 5.1%) (Figure 23).

Figure 23. Percent Households with Severe Housing Problems among Austin Area Community Survey Respondents, by Ownership Status, 2020



DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2020

Housing Affordability

Several focus group participants and some community leaders explained that **industry and population growth** in the region have contributed to rising housing costs. One community leader explained how population growth has accompanied the growth of several industries in the area:

“[It is a] fast evolving community, we have a Tesla plant opening in our backyard. [The] influx of industry will change and provide job opportunities but it also creates more competition for resources as well. Land resources [and] housing, when we’re already seeing [a] large influx to rising cost of living in the central core and gentrification. 1,000 employees [are] seeking resources along with those under FPL [Federal Poverty Level], [which] creates housing scarcity. [There is] a lot of space,

but limited ability to find safe accommodating and adequate housing. It's hard to be within proper distance to available resources."
- Community Leader

Several focus group participants, community leaders, and both in-depth interview participants described the **high and rising cost of housing** that is not meeting the needs of longstanding and low-income residents in the area and the displacement of residents from the region due to a lack of affordable housing. A focus group participant observed, *"Something that I've heard is people struggling to pay rent."* One focus group participant explained, *"Housing prices [are] too high, [which is] pushing out families."* As a consequence of high housing costs in the region, some residents described housing arrangements where multiple families live together to make ends meet. One focus group participant shared, *"More families are renting a room from a family. That is definitely happening more."*

Residents described mixed experiences with rental assistance during the COVID-19 pandemic, with some reporting rental assistance support that they attributed to being linked with the City of Austin. Others were familiar with rental assistance programs that were linked with non-profit organizations. For example, one focus group participant described receiving rental and utility assistance through City of Austin as well as local non-profit Austin Voices. Another focus group participant shared how their family benefited from a City rental assistance program after getting sick with COVID-19 affected the earnings of the major breadwinner in their family.

While some focus group participants and community leaders mentioned the importance of rental assistance that they received during the COVID-19 pandemic, others mentioned that rents increased during the COVID-19 pandemic and they struggled to find assistance.

"I sought help from the city to pay the rent because those of us who made money for our household, meaning my wife and I, both got sick (with COVID). And we knocked on the door of various places and they didn't serve us, they didn't help us." – Focus Group Participant

One community leader described difficulty connecting low-income renters with rental assistance programs:

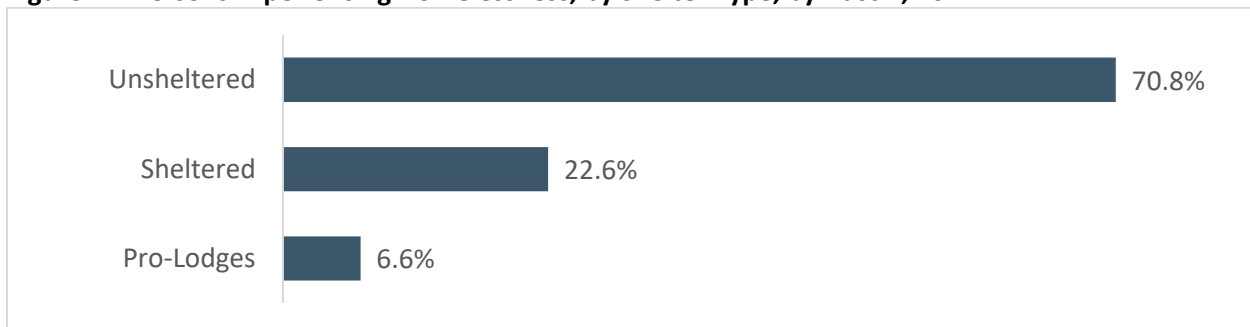
"We were wondering where the help was, and we knew there was help but we could not get connected. For example, I saw news on the TV say that they offer rental benefits, but our community, especially the poor community, did not have anyone from the city to reach out and see if any of us need rental help. We also found out later that COA [City of Austin] provided utility bill support." – Community Leader

Another focus group participant observed limits on the level of rental and other assistance for residents experiencing chronic economic challenges: *"[T]hey've applied to different programs and sometimes they already applied and can't apply again and they're struggling to find ways to cover the rent."* One focus group participant noted the importance of partnerships to increase access to housing vouchers: *"HACA could partner with a lot of our homeowners to offer section 8 vouchers, because I looked on the HACA booklet and there was only one place in Manor currently."*

Homelessness

According to the Ending Community Homelessness Coalition (ECHO), the Austin/Travis County Continuum of Care lead agency that plans and coordinates community-wide strategies to end homelessness in Austin and Travis County, there were 3,160 individuals experiencing homelessness during the 2021 count in January 2021.²² Among respondents experiencing homelessness, 70.8% were unsheltered and 22.6% were sheltered (Figure 24).

Figure 24. Persons Experiencing Homelessness, by Shelter Type, by Austin, 2021

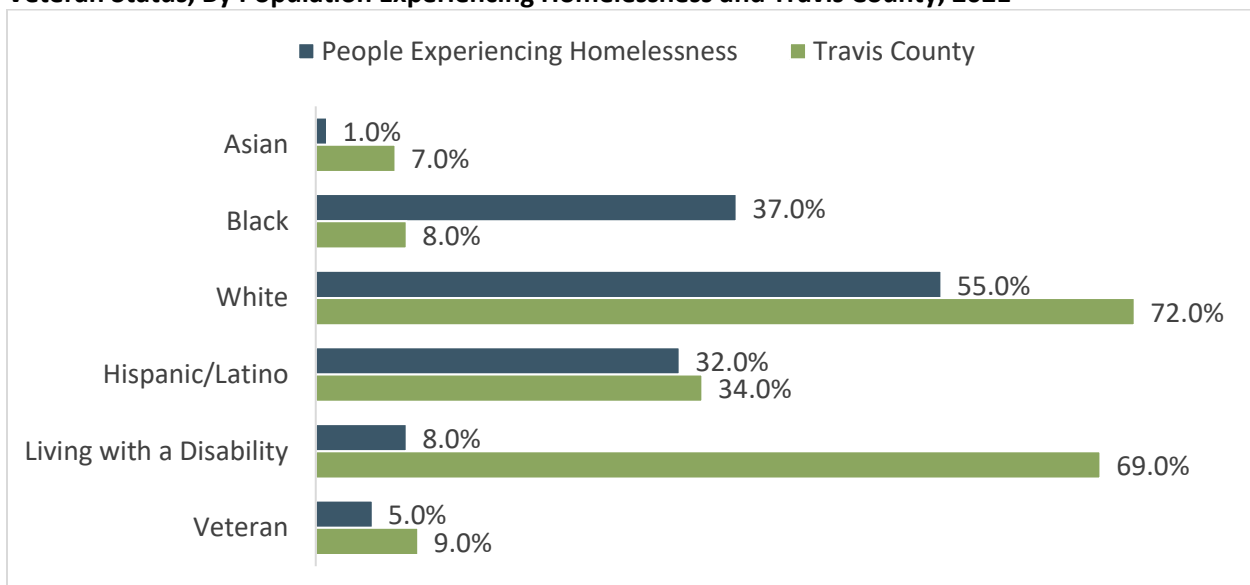


DATA SOURCE: Homeless Management Information System; as cited by Ending Community Homelessness Coalition (ECHO), 2021

NOTE: Data represents a single day snapshot

Figure 25 displays the percent of people experiencing homelessness by selected indicators relative to the Travis County population in 2021. Notably, the Black/African American population in Austin/Travis County was overrepresented among people experiencing homelessness more than any other racial/ethnic group. The probability of experiencing homelessness in Travis County for a Black/African American person was approximately six times higher than that of a White person.

Figure 25. Percent of People Experiencing Homelessness by Race, Ethnicity, Disability Status, and Veteran Status, By Population Experiencing Homelessness and Travis County, 2021



DATA SOURCE: American Community Survey and Homeless Management Information System; as cited by Ending Community Homelessness Coalition (ECHO), 2021

Additionally, Black/African American and Hispanic/Latino clients who obtained stable housing after participating in a permanent housing program lost their housing and returned to homelessness faster than White clients. Among clients who returned to homelessness within one year of exiting from a Permanent Housing program (Rapid Re-Housing or Permanent Supportive Housing) to a permanent housing destination in 2019, Black/African American and Hispanic/Latino clients returned to the system within a shorter period of time than White clients. This suggests not only unsustainable housing instability in the long term for non-White and/or Hispanic/Latino clients, but in the short term as well.²³

In Travis County, census tracts with higher proportions of the population who are Black/African American have heightened levels of all community-level homelessness risk factors analyzed: lower median income, greater proportion experiencing rent burden and overcrowded rental units, higher eviction rates, higher likelihood of gentrification, and lower percent with health insurance (Table 4). As a consequence, Black/African American people in Austin/Travis County are likely to be at higher risk of falling into homelessness than any other racial or ethnic group.

Table 4. Median Values of Community Level Indicators of Homelessness Risk, By Census Tract in Travis County, 2016

	Census tracts with higher proportion Black/African American population	Census tracts with lower proportion Black/African American population	Travis County
Median population size	5,514	4,522	4,794
% Black African American	10.0%	1.8%	4.9%
Median Income	\$59,401	\$80,813	\$68,769
% Rent Burdened	31.8%	28.7%	29.6%
% Over-crowded rentals	2.4%	0.0%	1.0%
Annual eviction rate	2.0%	0.8%	1.4%
% Tracts potentially gentrifying	46.2%	30.6%	38.1%
% w/o health insurance	25.7%	13.3%	18.1%

DATA SOURCE: United States Bureau 2018 American Community Survey 5-Year Estimates, Centers for Disease Control and Prevention 2019 National Health Interview Survey, Eviction Lab 2016 Eviction Rate Data

Some in-depth interview participants and a community leader highlighted **barriers to securing stable housing** for individuals who were formerly incarcerated, experienced homelessness, or lack identifying documents. For example, one in-depth interview participant described the difficulties of renting an apartment given their record of incarceration:

“Barriers to housing are massive. When I got on my feet financially, I looked for apartments and all 30 I visited wouldn’t take anyone that was on parole and they have to have been off parole for 10 years. It is easier to buy a house than it is to rent.” – In-Depth Interview Participant

This participant also highlighted the connections between histories of incarceration, difficulties accessing housing after incarceration, and experiencing homelessness and noted that experiencing homelessness is considered a parole violation:

“There are a number of formerly incarcerated [people] that are homeless that find a friend that register that person’s address as their formal address but are actually homeless. [The] [a]ddress is for parole. A lot are homeless/semi-homeless and couch surfing.” – In-Depth Interview Participant

Urbanicity

In addition to housing affordability and access emerging as a central theme across interviews and focus groups, some community leaders and focus group participants highlighted the **unique issues in rural areas**. Focus group participants across the region shared how rising housing costs linked with population growth contributed to the displacement of long-term residents – mostly low-income residents, older adults, and people with health issues or disabilities – from dense urban areas to rural areas on the outskirts of Travis County. One focus group participant explained, *“Where [population growth] is affecting us is that the rent is more expensive, it is difficult to live in the city. Many people are forced to go to the outskirts in order to have a home.”* One community leader echoed, *“[B]ecause of [the] increasing cost of living in central core in Austin and due to gentrification, elderly and disabled [residents] are now in more rural areas.”* Another focus group participant echoed, *“Manor is not the rural town that it was years ago. It has grown and is projected to continue growing.”*

Focus group participants in the Manor region described their community as rural, with **limited access to the internet and healthy, affordable food options**. One focus group participant noted, *“Food as well, we only have a Walmart as a place to shop for food, so it is kind of like a food desert.”* Another focus group participant explained, *“Internet connection is another thing that our families struggle with especially in our more rural areas.”* One participant described the underlying context of limited allocation of resources and social services to their rural community: *“We feel like we’re still kind of forgotten about. It has improved in its recognition from when I moved to Austin 17 years ago, but we are still very much a bedroom community.”*

One community leader emphasized the importance of investing in planning for rural communities that are rapidly growing, noting that investing in rural areas with growing populations should be a public health priority:

“If we look at the trends and where people are being shoved to, we need to be intentional about the planning in our rural communities that are not in Austin proper but maybe in Travis County. [Y]ou know that by looking at demographics, these issues are going to be prevalent in those areas, because that’s where people are being force[d] to move just because of the economics. And so what are we doing so that unincorporated areas have the services that we know will be needed in those area[s], or those numbers will skyrocket for mortality and morbidities. [W]e’ll be acting in a reactionary-mode, and trying to deal with unincorporated areas that haven’t been involved. Now Travis County, what’s the plan for that situation we know is about to happen?”
– Community Leader

Built Environment and Neighborhood

Community leaders and focus group participants described several features of the built environment as areas that would benefit from improvement, including air, water, and land quality in rural areas and access to grocery stores and community and recreational centers in both urban and rural areas.

One community leader described how low-income residents of color in rural communities are affected by a host of environmental challenges such as poor **water and air quality** and live on land that is vulnerable to **climate disasters** such as flooding and droughts. This community leader shared:

“[We] [s]ee and hear complaints about water and air quality in Del Valle [...] We hear there’s a lot of desert and swamps where marginalized community is being pushed to live. Choices are not good there in terms of food quality and lifestyle. There’s environmental racism, economic issues. All of these critical health factors and how this structure is set-up is having an adverse effect.” – Community Leader

Several focus group participants described **development** in the area as stressful and making their day-to-day routines more difficult. One focus group participant elaborated on the stress that development in the region and increased traffic has added to their daily routine:

“Stress that we have, just going back five years, [development] has grown so much and there is no... the plan that they made they didn’t think about... now we get stressed about the traffic. All the time that we spend on the streets nowadays, whatever used to take me 15 minutes to get to work, now takes me half an hour.” – Focus Group Participant

Some focus group participants described **construction and development** as a health issue. One participant shared, “[There is] demolition across the street. All the dust. Watching them pulverize the concrete and the dust coming into the apartment.” Another resident echoed, “[Construction is an issue] especially those of us that have allergies. As soon as I step out of my house, I have a mask on.”

In addition to the growth of businesses that primarily serve high income residents contributing to the need to travel further to access affordable food, some focus group participants described how they felt **excluded by the neighborhood design**. One participant shared: “The neighborhood is built for yuppies and is catered towards the tech savvy young group.” Another participant recalled, “They brought scooters and I can’t get on a scooter. They were pushing that for us, and I can’t use that due to health issues. They’re trying to build another beer garden and that’s not what we need. [W]e need a ma and pop store. The bus to the HEB takes an hour to go when [the store is] only 5 minutes away.” According to one focus group participant: “...once [the neighborhood] got gentrified, they forgot the elderly and the poor and built beer gardens and expensive restaurants/stores.” Another focus group participant echoed: “The Whole Foods is too expensive, so most of the residents can’t cook a healthy meal.”

Several focus group participants and community leaders discussed the need to **improve access to services**, including banks, ATM machines, pharmacies, and urgent care clinics in low-income communities, which residents noted are critical basic resources linked to health. One community leader described their community as “like a third world country” because of limited access to basic resources. According to one community leader, “[the] biggest ‘lack’ in the community is a nearby grocery store

lack [of a] pharmacy, as well as emergency care clinic, and “basic needs.” Another community leader observed that when services are available in a community, the working hours are not usually flexible enough for residents to access them: *“And when the facilities are put there, the hours of the facilities don’t line up with need and they are placed in obscure locations, the population doesn’t flow there.”*

A couple of community leaders identified the need for community pools, recreation centers, libraries, and safe walking paths in their communities. According to some residents, access to these resources was difficult during the early phase of the COVID-19 pandemic, and is particularly important during the summer given the hot climate. One focus group participant explained:

“Another thing was there were lots of closures of pools in the summer and given brutal Texas summers it’s hard to keep your kids indoors. I’m young and healthy and could go and drive to Lady Bird Lake and take my kids out there but not everyone has that opportunity.” – Focus Group Participant

Another community leader described their community as having *“a nice recreation center, swimming pool, park, and library,”* while also noting that *“[the community’s recreational] center doesn’t have things like a pool or walking area, and they have had to push to add things like that ... they always have to ‘fight’ to add resources.”*

Internet and Computer Access and Training

Another facet of the environment frequently discussed was **internet accessibility**. Many focus group participants, community leaders, and in-depth interview participants described stable access to the internet and a computer at home as an important resource for accessing information and resources, staying connected, and participating in remote education. According to residents and community leaders limited internet access was an issue for low-income residents across the region. Additionally, some community leaders and focus group participants observed that internet access was more difficult in rural areas. One focus group participant shared, *“Internet connection is another thing that our families struggle with, especially in our more rural areas.”* One focus group participant and a community leader noted that where they live, internet was temporarily provided as a free service, which they were able to use to access virtual health care services: *“Now that you have free Google fiber you can schedule virtual appointments.”*

According to participants, internet and computer access have become increasingly important during the **COVID-19 pandemic** given the need to stay at home and during **Winter Storm Uri**. One focus group participant described the ongoing challenges and stress of adjusting to working online: *“[W]e have to switch our live[s] completely from being present at work [to] working online. That was a lot to learn in a quick time and we’re still learning.”* Another focus group participant who was an older adult described the importance of internet access during the COVID-19 pandemic for continuing adult education: *“I’d liked to do learning, but I can’t leave my home [because] my doctor doesn’t want me to. But if I can do it over the internet or something; I need to learn how to use the internet.”*

The COVID-19 pandemic and Winter Storm Uri highlighted the need to have **stable internet access** to access critical and changing emergency information:

“That’s what the pandemic has taught us, especially the winter storm, is that we can’t rely on our normal old landline phone to be our lifeline

any more, we really need to get everybody connected because that's where all those resources are. Society has moved to the web, but it's left too many people behind who either can't afford it or who don't know how to do it." – Focus Group Participant

Additionally, children's education was referenced as a challenge due to the reliance on **online education** during the early phase of the COVID-19 pandemic. According to one focus group participant, limited computer and internet access, and limited familiarity with these tools posed a challenge for children during online learning when schools were operating in remote teaching mode due to the COVID-19 pandemic:

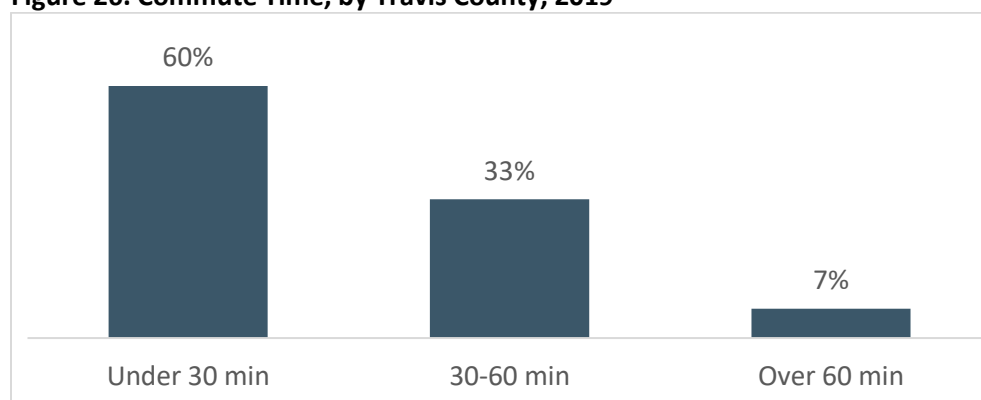
"Prior to kids going back to school there were lots of issues of students not having laptops or internet to access school or didn't have the knowledge to use that equipment if they had it. They weren't learning. [We] had working parents that couldn't get their child to sit down and do online school." – Focus Group Participant

One in-depth interview participant who experienced homelessness described school hotspots and services that provide computers as key to continuing their education during COVID-19: *"I have been given a little portable hotspot provided by school, so I've been using that because my Wi-Fi was cut off. My school provided a computer and LifeWorks also provided me with my own personal computer. [...] I took some technology classes with it."*

Transportation

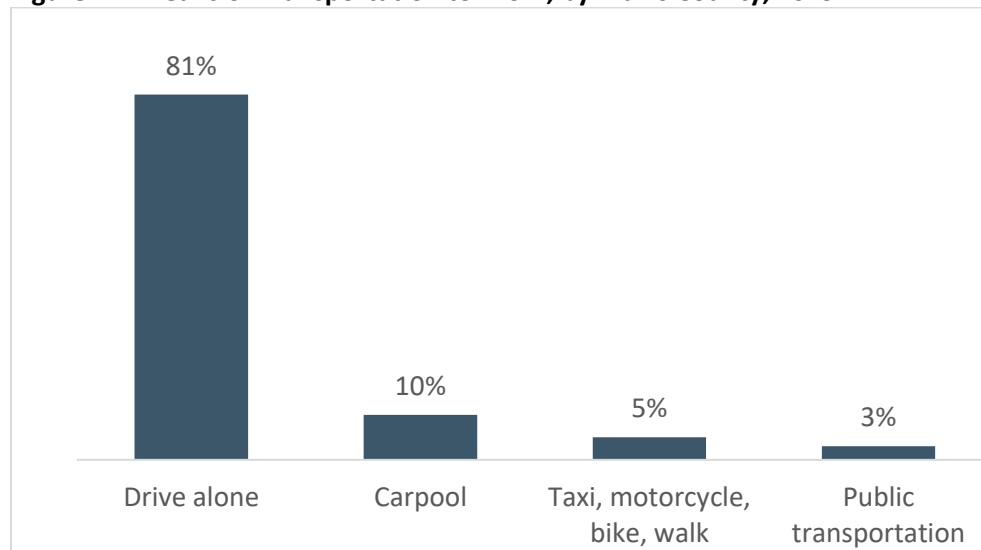
Transportation emerged as an important component of the environment and a barrier for conducting day-to-day activities such as getting groceries, going to school, and going to the doctor. According to 2019 ACS estimates, about 60% of Travis County residents spent under 30 minutes commuting, around one-third (33%) spent 30-60 minutes commuting and 7% spent over an hour commuting (Figure 26). The majority (81%) of commuters drove alone to work (Figure 27).

Figure 26. Commute Time, by Travis County, 2019



DATA SOURCE: U.S. Census Bureau, American Community Survey 1-Year Estimates, 2019

Figure 27. Means of Transportation to Work, by Travis County, 2019



DATA SOURCE: U.S. Census Bureau, American Community Survey 1-Year Estimates, 2019

Focus group participants and community leaders described **limited public transportation** and medical or senior transit options in more rural areas, including Pflugerville, Manor, and Del Valle. One focus group participant described the importance of transportation to their community that had limited public transportation options, “*Transportation is such a big issue out in Manor because we don’t have [access to] transportation.*” One community leader described the lengths that residents have to take in order to get to where they need to go:

“There’s limited transportation for individuals. For example, the Drive a Senior program: if you look at map on website, it does not include Del Valle. [It] includes other outlying areas. [I am] [n]ot sure why, but [it] is a service for other communities to get by on. The bus line is cumbersome. People walk down the highway, to the other side of 71 to the route that can access more routes. Those not able-bodied may not be able to make that trek.” – Community Leader

One community leader described the difficulties of getting around in their rural community, and how limited access to grocery stores are made even more difficult by limited public transportation routes:

“[My community is] just outside of city limits. Cap Metro comes 7 days a week, but [it is] still challenging; HEB (grocery store) takes 3 hours and is a two-bus ride; [if they need to go] anywhere else in the city, [they] will be gone the whole day.” – Community Leader

Barriers to accessing and using public transportation for residents who did not have access to a vehicle included the following: limited and reduced bus routes, concerns about safety on the bus, overcrowded buses, financial barriers to paying for public transportation, difficulty using the bus system on hot days, and concerns about COVID-19 protocols (e.g., physical distancing, sanitizing seats). One interview participant shared, “*Transportation is another thing. I ride the city bus a lot. [T]hey don’t follow the*

social distancing rule, don't wipe down seats." One in-depth interview participant noted that the app for the city bus was useful though other changes, such as route changes, were a barrier:

"I currently either walk or use public transit to get around. [I have] been impressed with Austin public transit system. I was more impressed before some major changes happened to redo and remove some routes. There are some parts of town I can't get to but in general it is reliable, [I] can look at the app, and it's only off by maximum of 5 minutes. I've been able to get a discount on bus passes due to my disability." – In-Depth Interview Participant

Seniors also described experiencing issues with the **bus routes**, including changes to bus routes, not knowing where to go, and the significant time that it takes to travel by bus. Several older adult focus group participants noted that current transportation options for accessing medical care, such as ride services, were limited and made for long and exhausting days traveling to and from their appointments and ride services were difficult to schedule on short notice. Some focus group participants shared:

"Bus transportation [is] helpful for people who want to gather and go to the same place together. But, it's not practical for people who just need to go to the doctor. When you have six people and they are going to six different doctors, they're on the bus for so long they're worn out. Just the transportation time wears them out." – Focus Group Participant

"I have access to Metro Access for rides to the doctors/grocery store, things like that, but I still have need for transportation when I don't have a whole day to set it up, if I need transportation within a few hours ahead of time. It's hard to know a day ahead of time that you're going to need it." – Focus Group Participant

Another focus group participant explained that **transportation benefits** are insufficient to provide access to all of the medical appointments that a patient may need in a given year. This participant described their experience: *"For seniors a lot of insurances provide 12 rides per year. And they are not reliable, they can leave you out there 2-3 hours. It's gotten more prevalent because they don't have enough drivers."*

With limited public transportation options for residents who do not have a car, one community leader observed informal support from others as an important resource: *"[I see] a lot of informal assistance, people giving others rides. There are informal support networks to find transportation."*

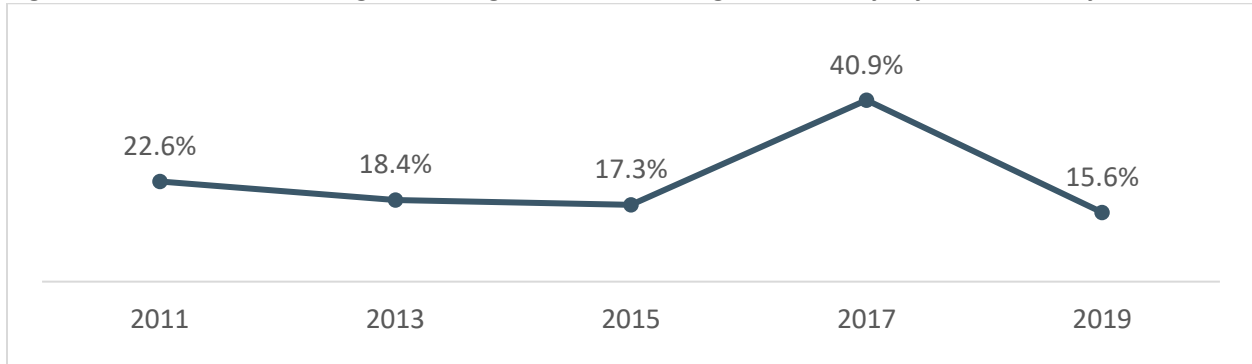
Focus group participants and community leaders identified several areas of improvement for pedestrian and public transportation, ranging from creating pedestrian bridges over major highways, to improving streets [See Appendix G for more information on Project Connect a local public transit improvement initiative].

Access to Healthy Food and Food Security

In 2019, around 15.6% of Travis County residents reported consuming 5 or more servings of fruits and vegetables daily; this percentage is lower than reported from 2011-2017 and indicates a gradual decline

from 2011, with the exception of 2017, when the percentage was much higher at 40.9%. Trends were similar when examining these patterns by gender, race/ethnicity and age. Of note, in most years a slightly higher proportion of female adults than male adults reported eating 5+ servings of fruits and vegetables daily. In 2019, self-reported fruit and vegetable consumption was highest among adults 65 years of age and older (21.4%) and lowest among adults 45-64 years of age (12.2%).

Figure 28. Percent Consuming 5+ Servings of Fruits and Vegetables Daily, by Travis County, 2011-2019



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2011-2019

One focus group participant described how a healthy lifestyle is a challenge particularly for Hispanic/Latino residents due to the financial burden of healthy organic foods. Another focus group participant explained how they wanted to eat healthy, organic food, but only fast food was affordable and accessible:

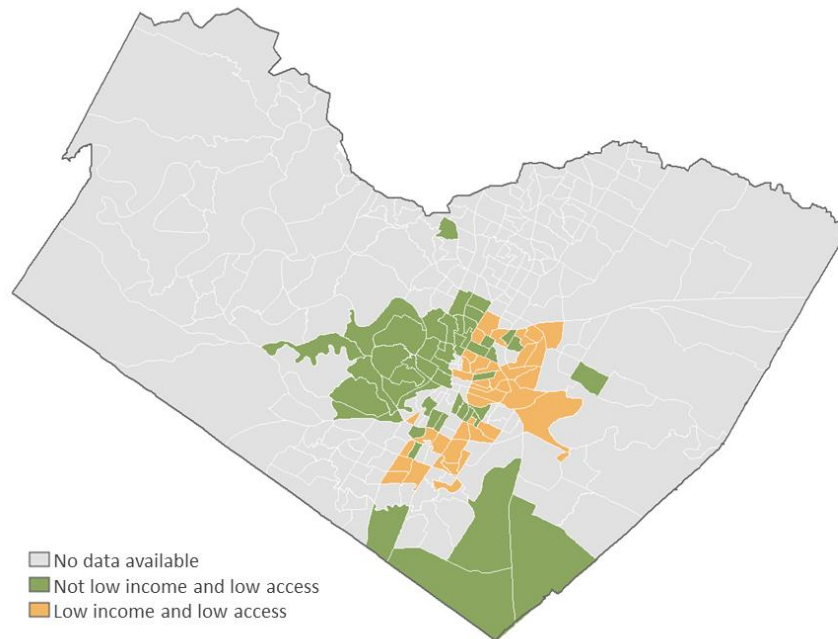
“One of the most important obstacles is organic food, the kind that could help us, is very expensive. So, the more practical option is to eat fast food and we know that in the long run that could cause problems for our health. But it is what we have most accessible to us [...] because it’s fast, for all of us that work outside the home.” – Focus Group Participant

Some Hispanic/Latino focus group participants explained how working multiple jobs and long hours makes it difficult to prepare healthy meals. For example, one focus group participant explained, *“I’d say that an important factor is the amount of hours that a person works. It could impede or cut into their sleep time or the hours it takes to arrive at an appropriate time to fix something for dinner. So it is faster to buy something to take home instead of cooking.”* Another focus group participant in a more rural community observed an increase in fast-food options in their community in recent years:

“[W]e have been fortunate that in the last few years we have had a lot more restaurants pop up, but it is more fast-food options. It would be nice to have more restaurants that have healthy options. It would offer more jobs and things for families to go out and eat.” – Focus Group Participant

Figure 29 shows areas of Travis County considered low income and having low access to healthy food, characterized as being half a mile or more away from a supermarket, supercenter, or larger grocery store for urban areas, and 10-miles or more for rural areas and considers vehicle availability for all tracts.

Figure 29. Low Income and Low Access to Healthy Food by Census Tract, by Travis County, 2019

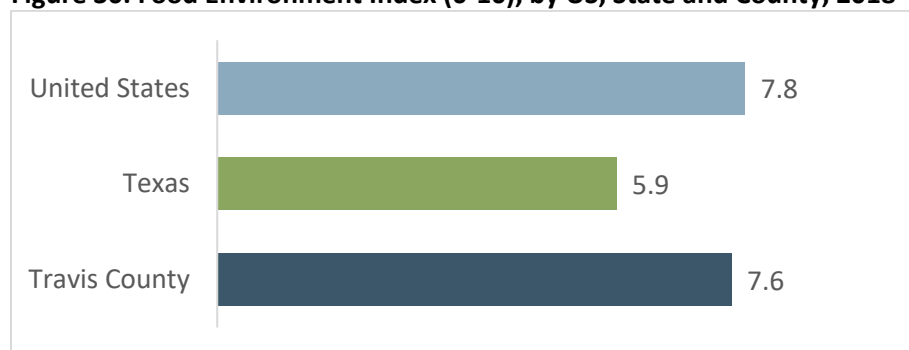


DATA SOURCE: U.S. Department of Agriculture (USDA), Economic Research Service (ERS), 2019

NOTE: Low income and low access tract measured at 1/2 mile for urban areas and 10 miles for rural areas

Low-income census tracts with a substantial number or share of residents with low levels of access to retail outlets selling healthy and affordable foods are defined as food deserts. The food environment index accounts for proximity to healthy foods and income, with a higher number indicating a better food environment (Figure 30). Food deserts are correlated with high prevalence of overweight, obesity and premature death.

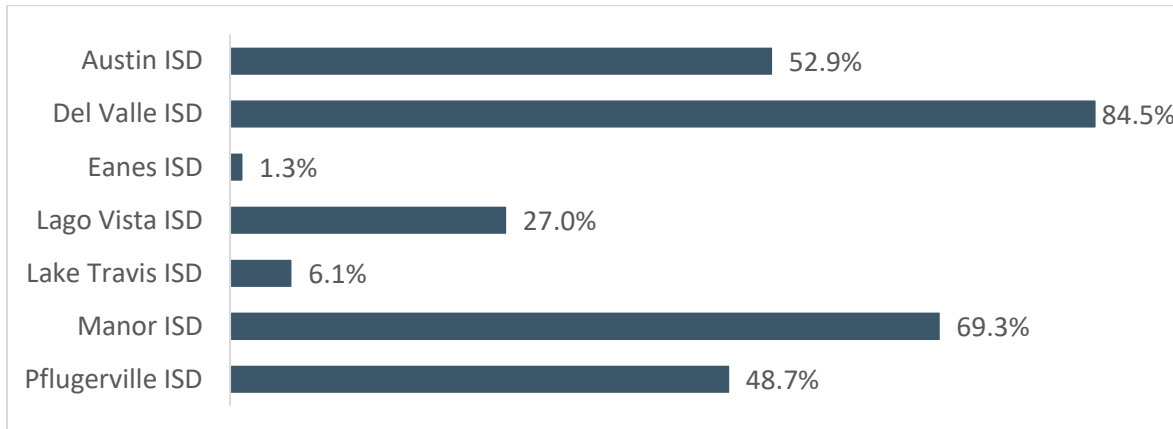
Figure 30. Food Environment Index (0-10), by US, State and County, 2018



DATA SOURCE: USDA Food Environment Atlas, Map the Meal Gap from Feeding America, United States Department of Agriculture (USDA), as cited by County Health Rankings & Roadmaps, 2018

Among Travis County independent school districts (ISD), the majority of students in the Del Valle (84.5%) and Manor (69.3%) districts and about half of students in the Austin (52.9%) and Pflugerville (48.7%) districts received free or reduced lunch in 2018-2020 (Figure 31).

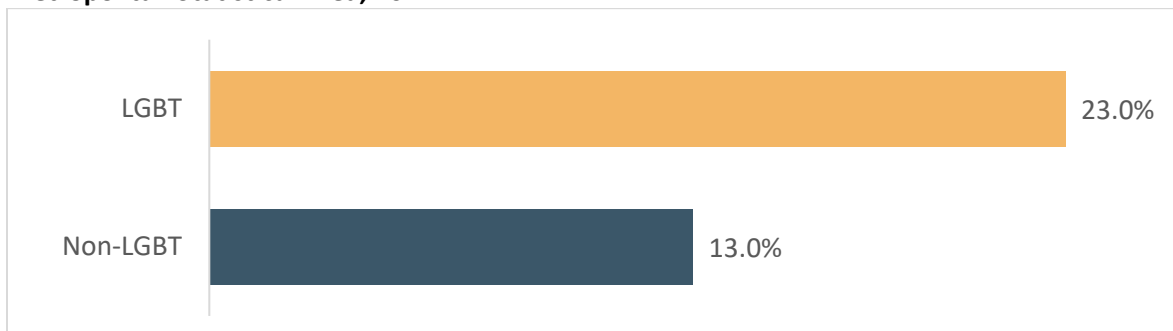
Figure 31. Percent Students Receiving Free or Reduced Lunch, by Independent School District (ISD), 2018-2020



DATA SOURCE: Texas Education Agency, 2018-2020

Nearly one-quarter (23.0%) of LGBTQIA+ respondents to the LGBTQIA+ Quality of Life Study survey reported that they experienced food insecurity, compared to 13.0% of respondents who did not identify as LGBTQIA+ (Figure 32).

Figure 32. Percent Food Insecure for LGBTQIA+ vs non-LGBTQIA+ Population, Austin-Round Rock Metropolitan Statistical Area, 2021



DATA SOURCE: Gallup Daily Tracking Survey, as cited by City of Austin, Equity Office and LGBTQIA+ Quality of Life Advisory Commission, ShoutOut Austin LGBTQIA+ Quality of Life Study, 2021

Several residents noted that healthy eating is important to promoting health, and also described several **barriers to accessing healthy food**. Focus group participants shared that healthy food is expensive and difficult to access, noting that low-income residents often live in food deserts.

“[A] [m]ajor need is food access, food insecurity; lack of fresh food, food desert, no grocery stores. I went recently to Dollar General and it had a small produce section but it was mostly sold out; they had some fruit. ... We provide some fresh fruit and veggies at [the] food pantry as available, but it’s not enough.” – Community Leader

Several community leaders and focus group participants shared that it was more difficult to eat healthy foods during the COVID-19 pandemic and observed a substantial increase in residents requesting food assistance. While focus group participants mentioned food banks as important sources of support, residents also noted that food banks often only distributed non-perishable foods and food often ran out

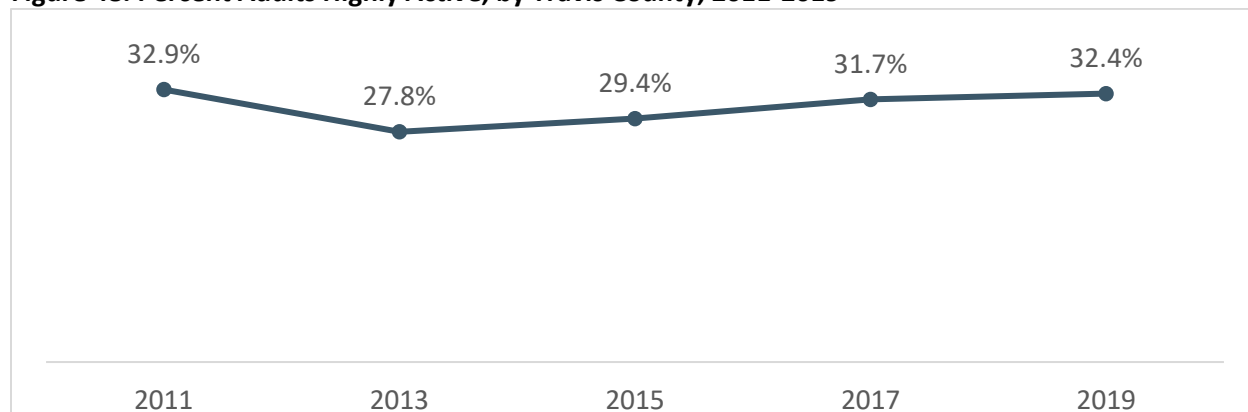
at during food drives. According to one older focus group participant, “Food pantries set up at senior apartment complexes cleaned out quickly.”

Other comments included insight into the quality of the food and access to food pantries; “I have gone to the food banks but the food that they give us is to get full, it is not healthy food.” Another noted that the Central Texas Food Bank was too far way, and only visited once monthly, which was too infrequent. One in-depth interview participant who previously experienced homelessness highlighted how lack of a current state-issued ID or driver’s license posed a significant barrier to accessing food through food pantries that require ID, and public transportation makes it difficult to bring food home. They also described other difficulties in accessing food benefits, including declined food benefit applications and the significant time and effort that it takes to talk with a case worker.

Physical Activity

Along with access to healthy foods, physical activity is a key component of a healthy lifestyle. About one-third of Travis County adults reported being highly active in 2011-2019, with men being more highly active than women. When looking at patterns by race/ethnicity, about one-third of White adults (36.0% in 2019) in Travis County reported being highly active, slightly higher than Hispanic/Latino and Black/African American adults. Older adults 65+ reported being more active than other age groups.

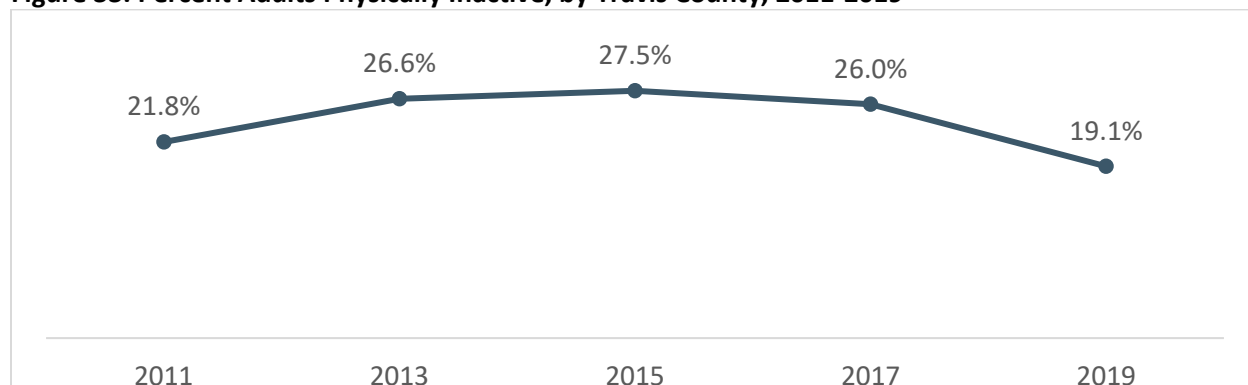
Figure 48. Percent Adults Highly Active, by Travis County, 2011-2019



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2011-2019

When examining self-reported physical inactivity patterns in Travis County from 2011-2019, the percent of adults who reported being physically inactive remained around 20% (Figure 33) with men being slightly less active than women and White adults less active than non-White adults.

Figure 33. Percent Adults Physically Inactive, by Travis County, 2011-2019



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2011-2019

NOTE: Physical inactivity defined as adults aged 20 and over reporting no leisure-time physical activity.

Many focus group participants and community leaders described **active living and exercise** as important for promoting health. One focus group participant described their routine: “[I] [w]alk my dogs once a day. Just walking around, getting to know the area, getting muscles moving.” Some residents described access to green space as a factor that makes it easier to be physically active. As one focus group participant shared, “Communities like green areas around where we live, I feel like if you have a park close by you have more initiative to go out instead of staying in the house.” Another focus group participant described how not every community has access to a safe green space or park:

“...Although there are parks they are not accessible to everyone, I mean, the parks that have more...hmm, that are integrated with more things are not close to the areas with all the people, the whole community.” – Focus Group Participant

Several Hispanic/Latino focus group participants described how long work schedules made it difficult to exercise. As one focus group participant shared, “Another factor is also that when the two of us in the house work, we get home late and tired and I get home to make food and we eat late so we end up not exercising, that also adds to us being overweight.” Other barriers to physical activity included the COVID-19 pandemic restrictions, hot weather, and neighborhood safety.

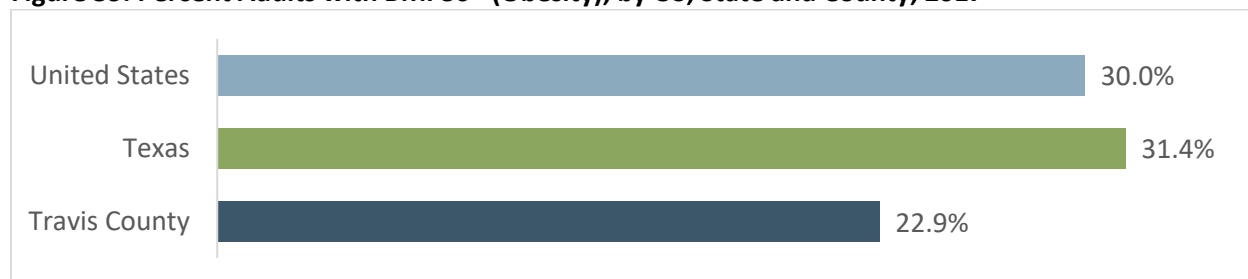
One focus group participant described **feeling unsafe trying to exercise in their neighborhood** in the evenings: “Winter was hard because I got home after work around 6 and it was getting dark and I wasn’t going to walk in my neighborhood because I don’t feel safe, because I kept hearing about what was happening.” According to the Austin Area Sustainability Indicators report, crime was the top reason for feeling afraid to walk outside. Other reasons included vehicles driving too fast and lack of sidewalks.

Residents offered some solutions, including walking in the mall and pedestrian barriers that were set up in the street to enable more active living during early phases of the COVID-19 pandemic. One focus group participant shared her experience:

“You can go walking, [it] is one of my favorite things. [W]hen it is not hot you can go walk in the park. Even in this weather, you can go to the mall. My husband used to hate that, but I didn’t mind going to walk in the mall, you’re still walking.” – Focus Group Participant

The built environment and its associations with healthy eating and active living are strongly linked to body weight. In 2017, about one-fifth (22.9%) of adults in Travis County were categorized as having obesity, defined as having body mass index of 30 or more; a proportion that was lower than the percent of adults classified as obese across Texas (31.4%) and the US overall (30.0%) (Figure 59).

Figure 59. Percent Adults with BMI 30+ (Obesity), by US, State and County, 2017



DATA SOURCE: CDC Diabetes Interactive Atlas, The National Diabetes Surveillance System; as cited by County Health Rankings, 2017

Social and Community Context

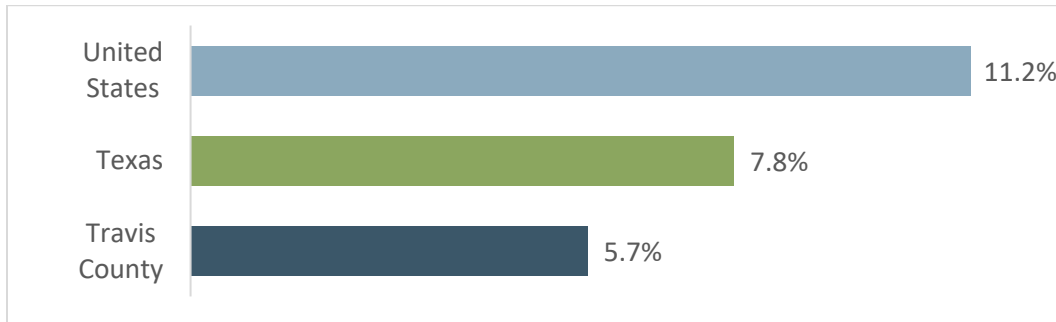
Relationships are important for physical and mental well-being. At an individual level, social networks spread social behaviors: social support can help encourage people to engage in more positive healthy behaviors.²⁴ By contrast, lack of connectedness has been shown to be linked to depression and is a risk factor for early mortality.²⁵

At the community level, the cohesiveness of a community has been shown to be positively related to self-reported health and mortality.²⁶ Conversely, discrimination as part of one's social environment can have a negative impact on health. Structural discrimination such as segregation, inequitable access to quality education, and disparities in incarceration rates can limit opportunities, resources, and well-being of less privileged groups.²⁷ Individual discrimination may have high physical and emotional health costs as well. Research suggests that routine discrimination can be a chronic stressor and increase vulnerability to physical illness.^{28,29} The report "Those Who Left: Austin's Declining African American Population" outlines the steady decline of the Austin African American population, greatly outpacing other major cities. Among the top reasons for leaving was racism and feeling unwelcome in their neighborhoods.³⁰

Community Connectedness and Cohesion

The strength of social connections, feelings of inclusion and support in individual and community relationships, is integral to health. Connectedness is particularly important for youth and older adults. In Travis County, 5.7% of teens aged 16-19 years were disconnected, defined as teens neither in school nor working, according to aggregated data from 2015-2019 (Figure 34). The proportion of disconnected teens was slightly higher in Texas (7.8%) and in the US (11.2%).

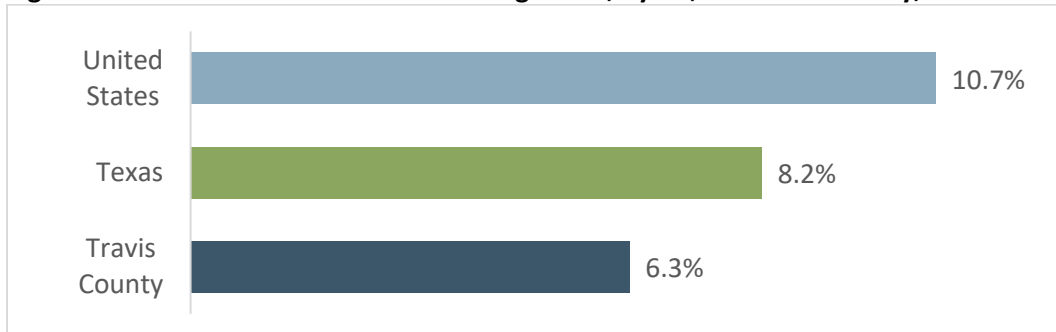
Figure 34. Percent Teens (16-19) Disconnected (Not in School or Work), by US, State and County, 2015-2019



DATA SOURCE: Measure of America; as cited by County Health Rankings, 2015-2019

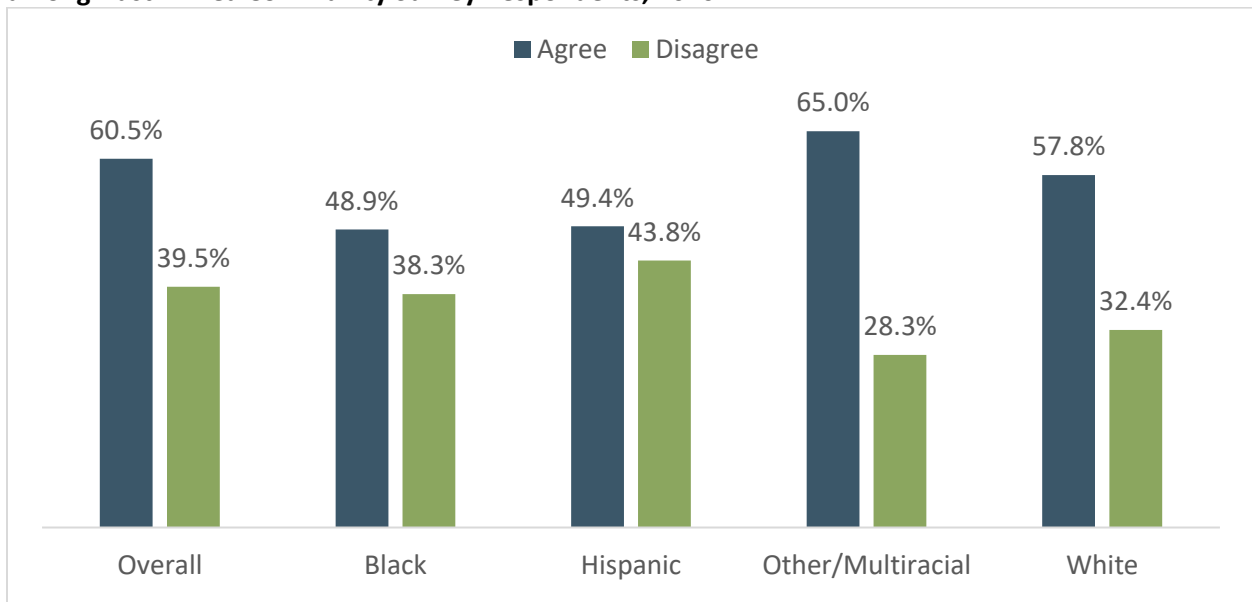
According to 2018 ACS data, a slightly lower proportion of the population aged 65 and over in Travis County (6.3%) and Texas (8.2%) were living alone, compared to about one-tenth (10.7%) of older adults in the US (Figure 35).

Figure 35. Percent 65+ Householders Living Alone, by US, State and County, 2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018

Figure 36. Percent Perceiving Neighbors Working Together Towards Local Community Improvement among Austin Area Community Survey Respondents, 2020

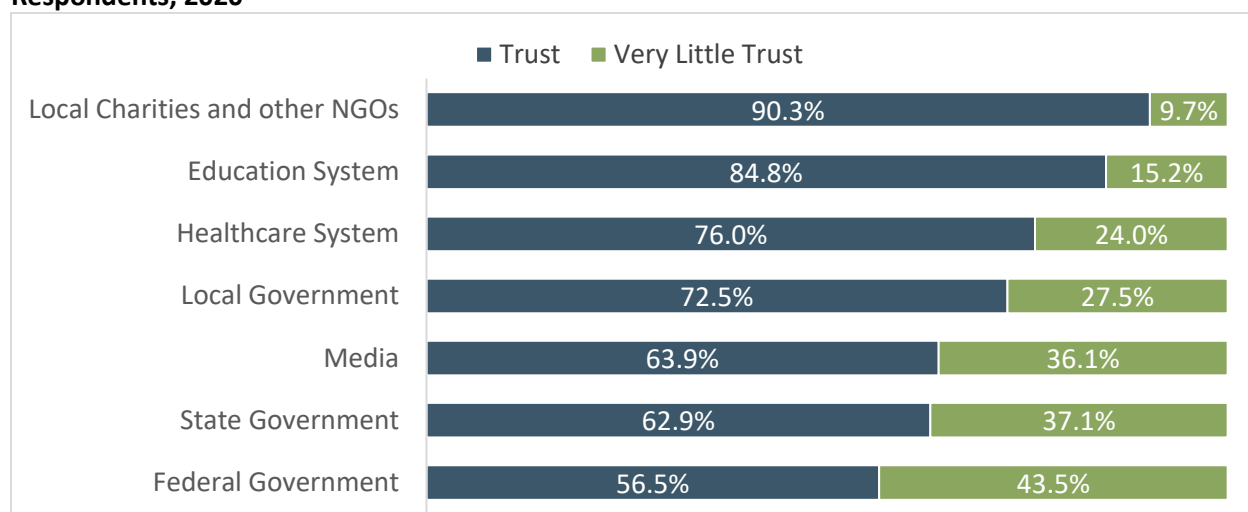


DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2020

Community forum participants discussed the importance of social connections, including relationships with family members and friends and connections to networks and organizations such as faith-based and community-based organizations. Such connections, according to forum participants, support healthy lifestyles and connect residents with community resources.

Another facet of community connectedness is trust in local institutions. When Austin Area Community Survey respondents were asked about their trust in local institutions, the highest percentage of respondents reported trusting local charities and other non-governmental organizations (NGOs) (90.3%) and the education system (84.8%) (Figure 37). About three-quarters (76.0%) of respondents reported trusting the healthcare system. In contrast, there was less trust among respondents towards the federal (56.5%) and state (62.9%) government and the media (63.9%).

Figure 37. Percent Respondents Trusting Local Institutions among Austin Area Community Survey Respondents, 2020



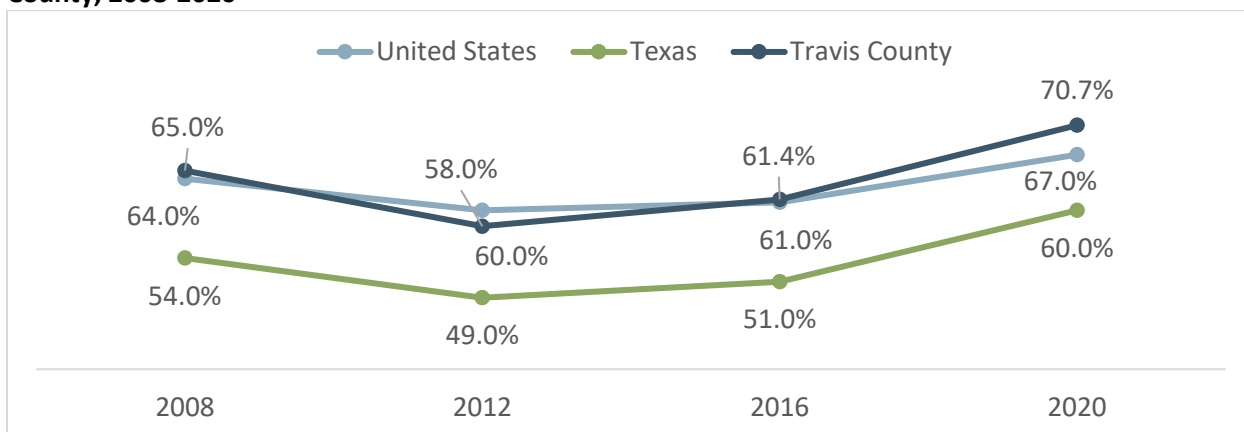
DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2020

NOTE: This data combines the survey responses of "Some", "Quite a lot", and "A great deal" as "Trust".

Civic Engagement

Higher civic engagement – voting, volunteering, social organizing and such activities – is linked to population health. In 2020, 70.7% of Travis County residents who were eligible to vote cast a ballot in a national election; this percent was lower in the US overall (67.0%) and in Texas (60.0%) (Figure 38). Throughout the 2008-2020 elections, the percentage of voters who voted in a national election dipped in all noted geographies in 2012 and slightly increased both in 2016 and 2020.

Figure 38. Percent of Voting Eligible Population Who Vote in National Elections, by US, State and County, 2008-2020



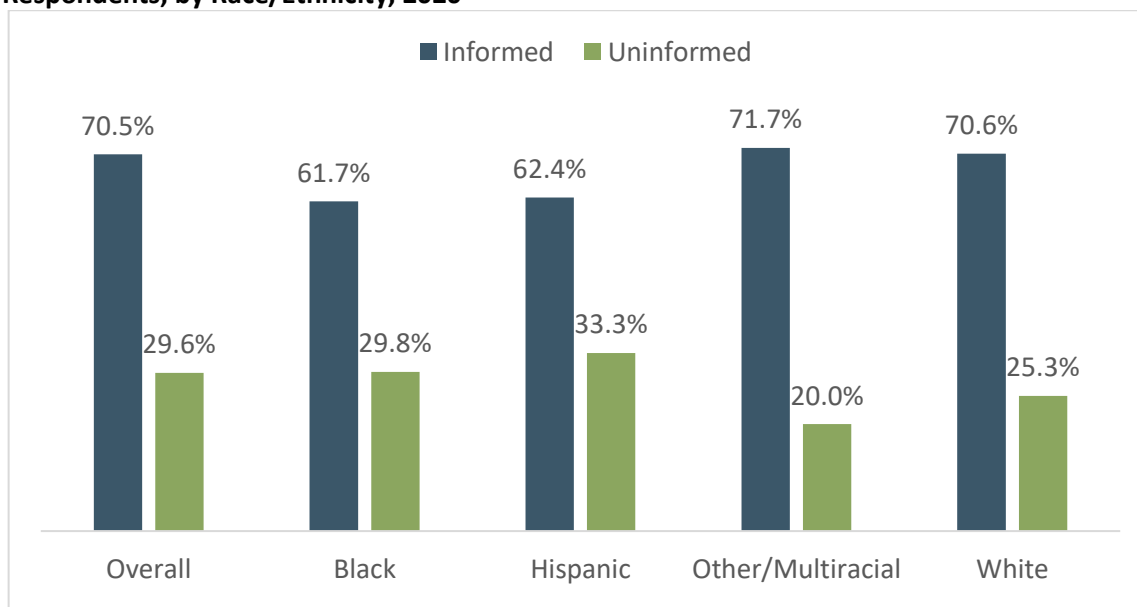
DATA SOURCE: U.S. Census Bureau, American Community Survey 1-Year Estimates, 2008-2020

NOTE: The percentage reported represents 'Total Ballots Cast' as a percentage of the Voting Eligible Population, where this number was available. For cases in which 'Total Ballots Cast' was unavailable, votes for 'Highest Office' as a percentage of the Voting Eligible Population was used instead.

Limited Awareness of Existing Resources

Of Austin Area Community Survey respondents, 70.5% reported feeling informed about key issues in the neighborhood (Figure 39) and three-fifths (60.5%) of respondents agreed that neighbors are working together towards local community improvement; this percentage was similar across race/ethnicities with the highest percentage of Other/ Multiracial respondents feeling informed (71.7%). The percentage of resident respondents who reported trusting their neighbors declined slightly from 2018 (90.4%) to 2020 (84.5%).

Figure 39. Percent Informed on Key Issues in Neighborhood among Austin Area Community Survey Respondents, by Race/Ethnicity, 2020



DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2020

As discussed earlier, **internet access** emerged as an important barrier to accessing information about resources as well. According to one focus group participant, *“I think a big problem has to do with access, like internet access, for communication, and getting the word out about stuff so you know what’s available.”* In addition to improving internet access, another focus group participant explained the importance of supporting residents in learning how to use resources available on the internet: *“Internet access too, just providing people access when you’re completely computer illiterate, you need personal one-on-one live-in help almost to learn how to use some of these features.”*

Language emerged as another barrier to accessing information that is usually available on the internet. One community leader shared their vision for making information available on the internet more accessible to residents whose primary language is not English: *“[We need] technology that allows access. We serve older adults and a lot of them were left out. One button access to a person that speaks your language, you can trust, and understands your culture is very important.”*

One community leader shared their vision of **improving internet and technology access across the life course**, enabling everyone to access resources and tools needed that are increasingly available via the internet, and to also stay connected and share information and resources with loved ones:

“Getting at least one technology piece per family and allowing them to easily contact someone they can trust. We have some funding for this right now. Goal of intergenerationally connecting the entire family to resources. Seniors in the family could become the source of support in the family given proper technology to connect during the pandemic.”

- Community Leader

Despite these technological barriers to accessing information about safety net resources and social services, some participants cited churches as an important source of information. One focus group participant described their experience in the COVID-19 pandemic, *“But also the churches, when we have access to them, they have information too. And sometime during the pandemic they were contacting members to make sure they had what they needed.”*

Additional Information and Resource Barriers

While one community leader recommended improving outreach and education to promote **2-1-1** as a strategy for residents to learn about available resources and services, residents shared mixed experiences with information hotlines such as 2-1-1, with some residents noting that it was an occasional resource and others reporting the hotline as difficult to navigate. One older focus group participant recalled being aware of 2-1-1 and using the service occasionally: *“I might call once in a blue moon; a lot of people need it.”* Another shared that they have not used the information hotline but know that it is available: *“We need a hotline that will direct people where you-, I know 3-1-1 is supposed to help with that, but I haven’t used it enough to know how.”*

One older focus group participant shared, *“I’ve never been able to get any help from that [local information hotline] and it takes hours to get ahold of anybody and then you wasted your time.”* One participant described the complexity of the information menus, *“My experience with 2-1-1 is that those menus are so complicated, level after level.”* In addition to difficulty accessing the menus, another participant observed that the 2-1-1 representatives do not always have information available to share

As discussed previously, some residents who previously experienced homelessness or incarceration or knew someone with an undocumented legal status discussed the importance of having a **state-issued identification card**, like a state ID or driver's license. They described state IDs as critical identifying documents to secure housing and health care resources. One in-depth interview participant who previously experienced homelessness explained the difficulty of accessing health care providers without ID. This participant described the catch-22 of needing identifying documents in order to get a state ID, and the difficulty of getting these identifying documents with a history of homelessness and past catastrophic events.

Some focus group participants described **limited access to safe recreational spaces for young children** to play in their rural community. One focus group participant observed that the area lacked a library, organized sports for young children, and safe activities for teens:

"A place for a recreation center, boys and girls club, or YMCA to have something for the kids/community to do. I see it posted all the time new families moving here that ask what to do here. There's no real community center unless you are a senior citizen." – Community Leader

Another community leader shared, *"They need to provide more after-school programs for kids, to keep them busy and "out of trouble."* One focus group participant shared their vision for improving community-based recreational opportunities for children and young families:

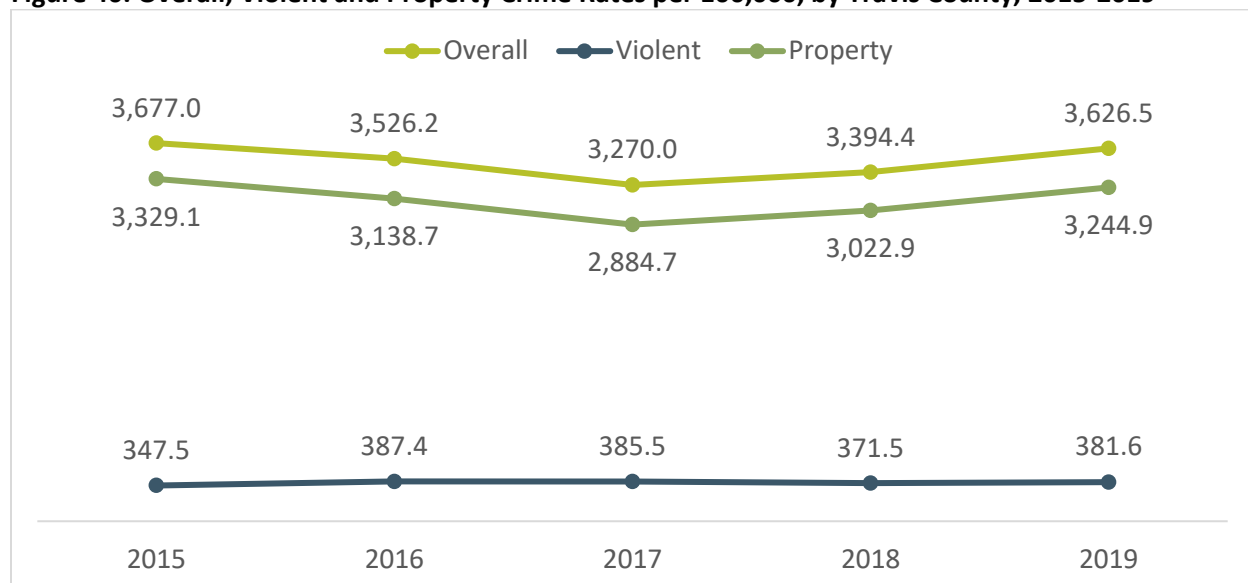
"There is a lack of designated recreation centers for our scholars to have access to. If we are going to grow, we should grow to add skate parks and greener type facilities to decrease our carbon footprint and start to teach our younger generation how to take care of what we have left." – Focus Group Participant

An important subgroup of youth identified as needing more resources was LGBTQIA+QIA youth. The need to improve supports for LGBTQIA+QIA students emerged among some focus group participants in more rural communities and some community leaders. One focus group participant shared *"We also don't have resources for LGBTQIA+QIA here. Which I really wish we had more of a listed department in our school district to support our students."* Another focus group participant noted that residents had to travel quite far to access resources: *"We do have access to LGBTQIA+QIA services, but you have to go all the way to Camina la Costa through People's Community Clinic."*

Safety

Crime and safety are additional aspects of community health related to the social environment. Crime data reported by the Texas Department of Public Safety Crime Reports indicate that crime rates remained similar in 2019 compared to 2015 (Figure 40). According to 2019 data, the overall crime rate was 3,626.5 crimes per 100,000 population in Travis County, with a much higher property crime rate (3,244.9 crimes per 100,000 population) compared to violent crime rate (381.6 crimes per 100,000 population).

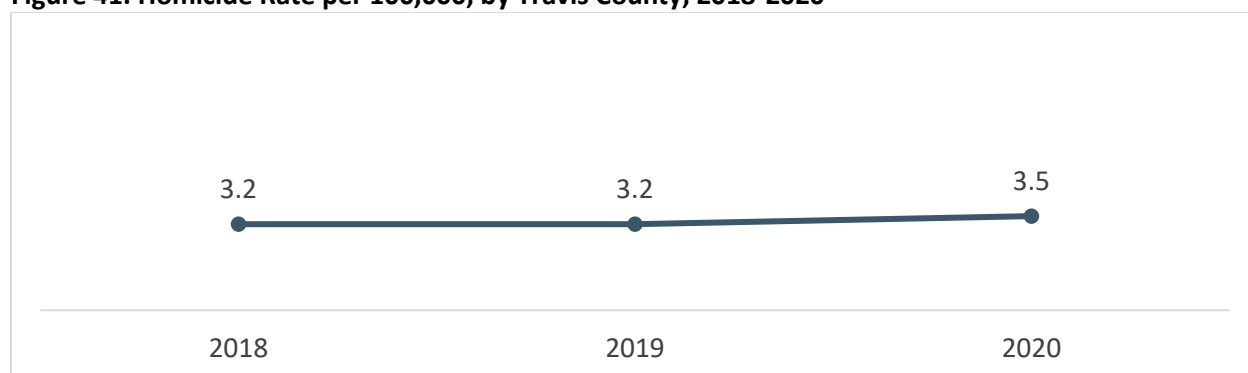
Figure 40. Overall, Violent and Property Crime Rates per 100,000, by Travis County, 2015-2019



DATA SOURCE: Texas Department of Public Safety Crime Reports, Crime by Jurisdiction, 2015-2019

According to CDC Wonder data, the homicide rate is 3.5 per 100,000 population in Travis County, remaining similar from 2018 through 2020 (Figure 41).

Figure 41. Homicide Rate per 100,000, by Travis County, 2018-2020



DATA SOURCE: CDC Wonder, 2018-2020

When probed about safety, one Hispanic/Latino focus group participant had a **holistic definition of safety**, sharing: *“When I hear safety, or safety net, what comes to my mind is community. Feeling safe with people that I’m familiar, you’re engaged with your community. You feel in Familia. Knowing who is in my community and or the people that protect/care for us.”* A few focus group participants described **concerns about physical violence**, including gun violence, vandalism, break-ins, and robberies. One focus group participant noted, *“[E]ven in my neighborhood, I know there are break-ins and things that happen, and robberies.”* One focus group participant shared their concern about gun violence with the state’s open carry laws, with particular concern about the safety of children in school:

“Now that it’s legal to open carry weapons, we have heard of more people bringing weapons or guns to school, that is a bit scary and we have to be cautious. Like a lot of caution. Those of us who are parents

have an interest and an obligation to be more present, but if we do not have the tools it is more complicated.” – Focus Group Participant

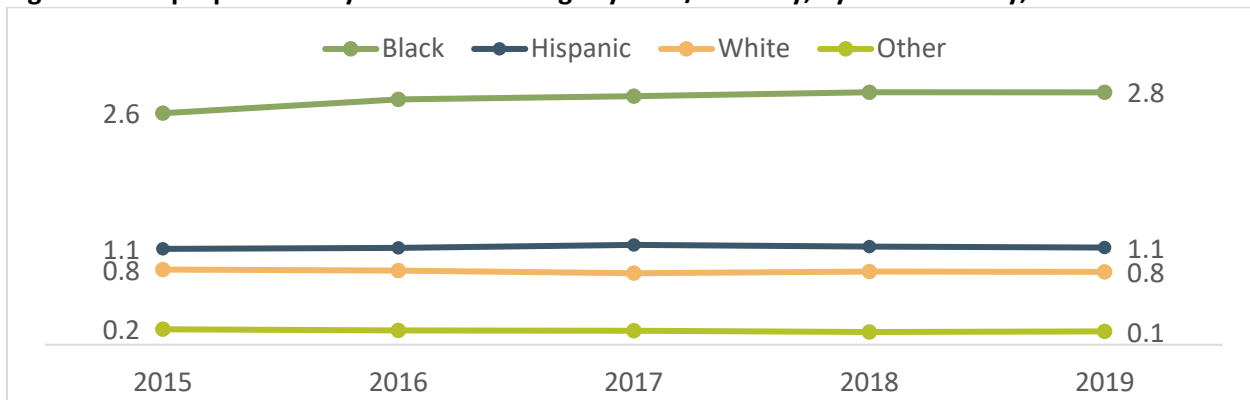
A couple of Hispanic/Latino focus group participants and a resident who previously experienced incarceration described **police violence as a safety concern**, and one focus group participant described an incident of police violence. Another focus group participant explained: *“Young men being affected by policing and policing that is not done right. I’ve seen young men of color being murdered in our streets.”* An in-depth interview participant who was previously incarcerated also expressed concern about interactions with police given their history of incarceration:

“[W]hen on parole or formerly incarcerated, you are almost kind of scared to have any involvement with law enforcement. Any “adverse” event goes against parole, so you worry how perception of former incarceration affects things. So, you always worry about what will happen when they run your ID and they see you are formerly incarcerated.” – In-Depth Interview Participant

One Hispanic/Latino focus group participant perceived that darker skin residents are more vulnerable to police attention and violence, sharing: *“I’m going to be honest, thankfully my skin is light enough that people ask me if I am American. I am a proud to be Mexican, thankfully I have lighter skin and I don’t have to go through those experiences [tearing up]”.*

Shown in Figure 42 is the ratio of the percent of crime bookings by the percent of the racial/ethnic population over 18 years of age in Travis County. This ratio was consistently highest among the Black/African American population (2.8 in 2019), followed by the Hispanic/Latino population (1.1 in 2019) in Travis County.

Figure 42. Disproportionality of Crime Bookings by Race/Ethnicity, by Travis County, 2015-2019



DATA SOURCE: U.S. Census Bureau, American Community Survey 1-Year Estimates and Travis County Sheriff's Office, 2015-2019

NOTE: Ratio calculated as percentage of bookings by percentage of racial population over 18.

Racism and Discrimination

Acknowledging the **history of systemic racism** in Austin is critical to understanding the unequal landscape of social determinants of health in our community and disparities in health outcomes. Many of the racial inequities that exist today are a direct result of past and current laws, ordinances, and city planning efforts. Understanding this history helps us to better understand the root causes of

disparities in our community today, which is a foundational step towards improving the health and quality of life of all Austinites and working towards healing in our community. *“We have to first accept that racism is real; we see it every day.”* – Community Leader

Some community leaders described **institutional racism** as an important factor that shapes adverse childhood experiences and trauma, access to jobs, educational experiences, housing, family cohesion, where residents can live, and trust towards the government, which they linked with health. One community leader shared:

“One of the biggest issues Black and Brown folks face, especially African Americans, is racism, institutional racism. [I]t causes all sorts of disruptions in the household, from jobs... you know, if you face discriminatory practices day in and out, every week, month after month, it affects your health, it affects the kids.” – Community Leader

One community leader described Asian communities’ **distrust of the government**, such as cities, and cited the importance of community-based organizations as a bridge between historically marginalized racial groups and government services: *“The trust that forms between two communities [city vs. Asian Americans] is a huge barrier. [They] may rather go to [a] nonprofit than the city.”*

One participant described an experience when emergency medical responders diminished the health needs and pain of their Black/African American partner when they had a health emergency: *“The problem was with EMS, which came because [my boyfriend] twisted his ankle. EMS was asking if he wanted to be taken to the hospital, when they were speaking, they were saying he was a Black dude and was stronger than that and could wait.”*

Another community leader described distrust of African American communities towards the government, which they linked with past experiences of discrimination and broken promises from governmental organizations:

“There’s frustrations and mistrust, from what we hear. Broken promises about what’s coming, and it takes years to come if ever. Critical era, trust is at zero for African American and faith community, they trust their leadership and pastors. There’s an oversight from powers that be to direct services without not tapping into their relational networks.”
- Community Leader

When residents discussed racism and discrimination, some cited incidents of hate, including verbal attacks and physical violence towards people of color and residents of non-Christian faiths. One participant from a minority religion described their experience of being verbally and physically attacked on public transportation. Another community leader discussed ongoing hate towards Asians that they described as increasing since the COVID-19 pandemic. This community leader went on to describe the longer-term mental health and community impacts of anti-Asian sentiments and hate:

“After COVID, the mental health, anxiety, uncertainty and safety are barriers that will haunt us for the next 2-3 years. Our community feels like we are being targeted all the time. This is historical. We have been attacked throughout history.” – Community Leader

FINDINGS:
COMMUNITY HEALTH OUTCOMES AND BEHAVIORS



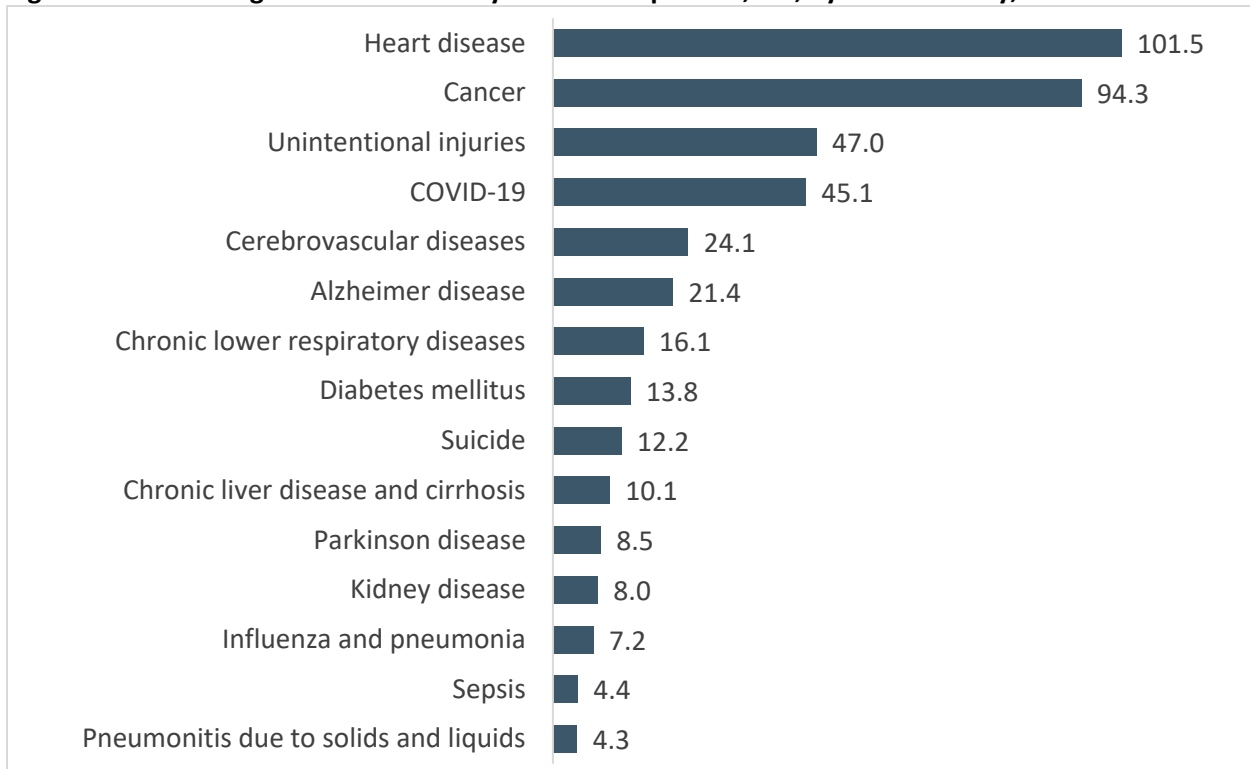
COMMUNITY HEALTH OUTCOMES AND BEHAVIORS

General Health Outcomes

The following section provides an overview of the population’s general health outcomes including the leading causes of death, life expectancy, current health status, and community perceptions of health.

According to 2020 data from the CDC wonder, the top leading causes of death (according to crude rates per 100,000 population) in Travis County were heart disease (101.5 deaths per 100,000 population), and cancer (94.3 deaths per 100,000 population), followed by unintentional injuries (47.0 deaths per 100,000 population) and COVID-19 (45.1 deaths per 100,000 population) (Figure 43).

Figure 43. 15 Leading Causes of Death by Crude Rate per 100,000, by Travis County, 2020



DATA SOURCE: CDC Wonder, 2020

When examining crude death rates in 2020 by race/ethnicity, cancer was among the top two causes of death among all race/ethnicities shown among Travis County residents (Figure 44). In 2020, the leading cause of death was COVID-19 for the Hispanic/Latino population and heart disease was the leading cause of death for the White population.

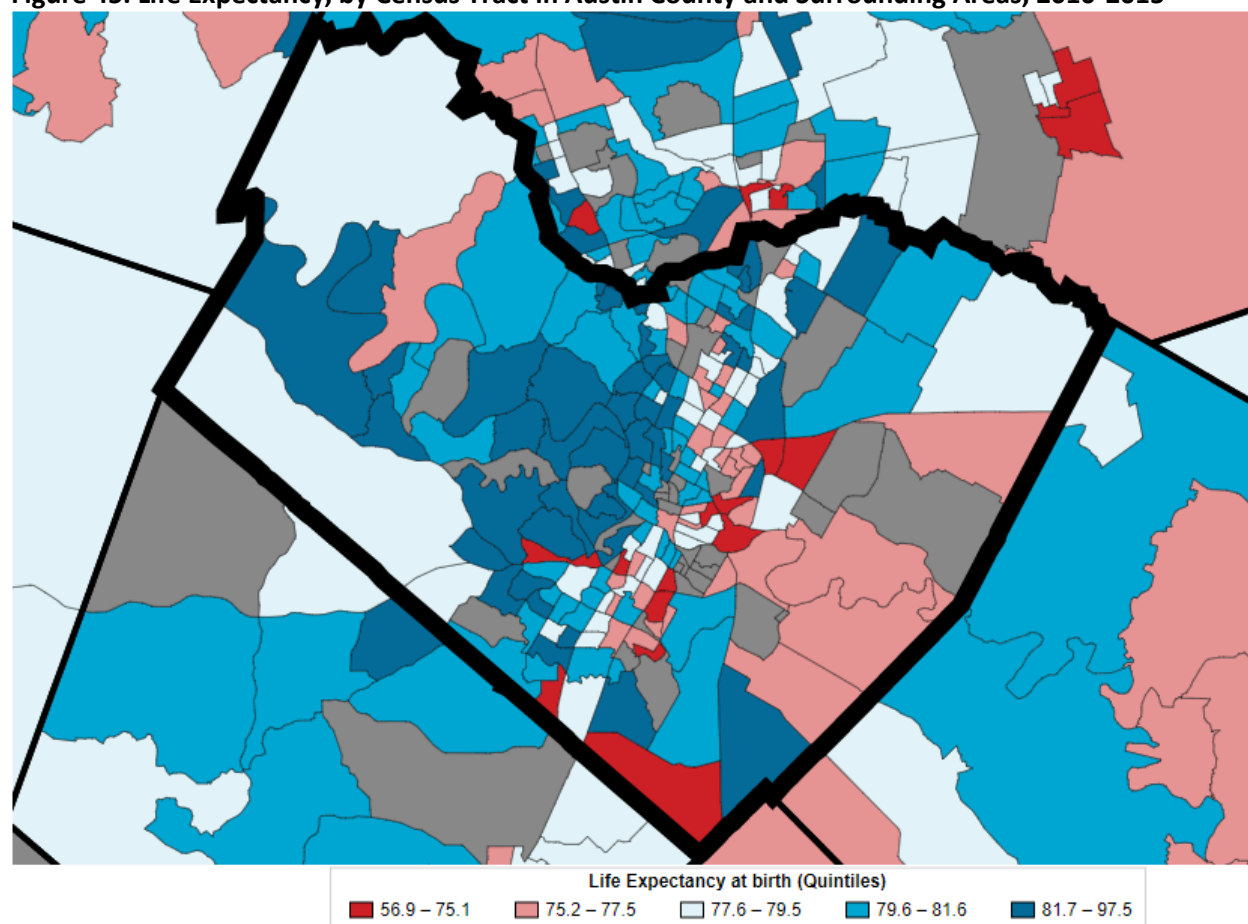
Figure 44. Leading Causes of Death (Crude Rate per 100,000), by Race/Ethnicity, by Travis County, 2020

Asian	Black	Hispanic	White
Cancer (42.0)	Cancer (116.3)	COVID-19 (65.3)	Heart Disease (107.3)
Heart disease (29.0)	Unintentional Injuries (57.7)	Cancer (54.0)	Cancer (100.9)
N/A	COVID-19 (50.1)	Heart Disease (45.2)	Unintentional Injuries (51.1)
N/A	Cerebrovascular diseases (43.3)	Unintentional Injuries (36.7)	COVID-19 (50.1)
N/A	Diabetes mellitus (30.6)	Cerebrovascular Diseases (16.2)	Cerebrovascular Diseases (24.2)

DATA SOURCE: CDC Wonder, 2020

Life expectancy by census tract in Austin County and surrounding areas is depicted below (Figure 45); among these census tracts, expectancy ranges between 68.6 years and 88.9 years.

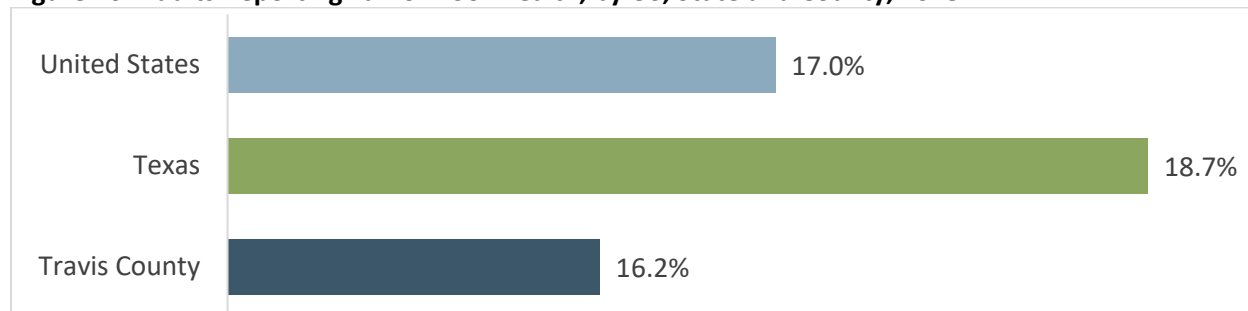
Figure 45. Life Expectancy, by Census Tract in Austin County and Surrounding Areas, 2010-2015



DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, 2010-2015

NOTE: Geographic areas with no data available are filled in gray.

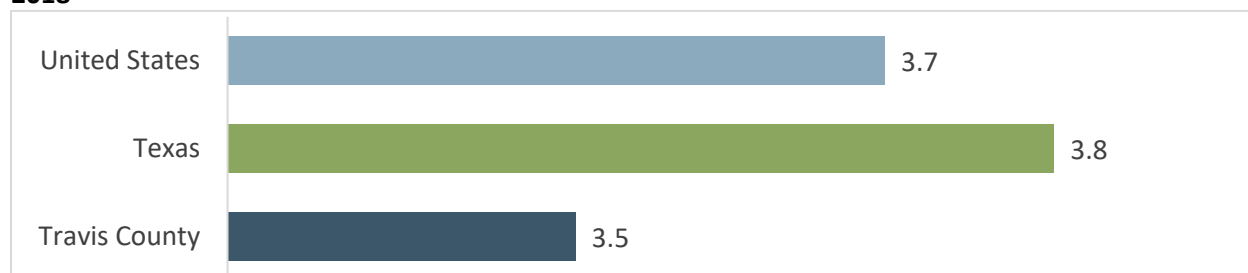
Figure 46. Adults Reporting Fair or Poor Health, by US, State and County, 2018



DATA SOURCE: The Behavioral Risk Factor Surveillance System (BRFSS); as cited by County Health Rankings, 2018

In 2018, 16.2% of Travis County adults reported fair or poor health, a proportion that was slightly lower than that across Texas (18.7%) and the US overall (17.0%) (Figure 46). By comparison, according to the LGBTQIA+ QWELL Wellbeing survey of respondents in the Greater Austin area, almost half (47.3%) of LGBTQIA+ respondents in Greater Austin reported poor or fair physical health. In 2019, on average LGBTQIA+ respondents reported 4.8 days of poor physical health in the last month; this number increased to 6.0 days in 2020.³¹ Travis County, Texas, and US adults had an average of almost 4 self-reported days of physically unhealthy days in the past month in 2018 (Figure 47).

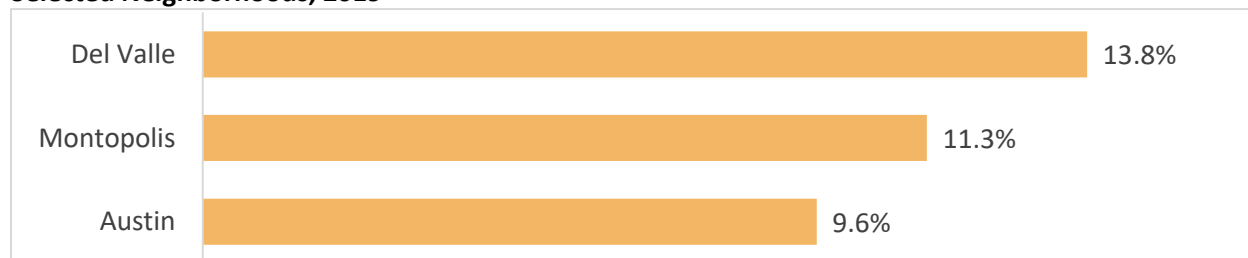
Figure 47. Average Number of Physically Unhealthy Days Reported in Past 30 Days (Age-Adjusted), 2018



DATA SOURCE: The Behavioral Risk Factor Surveillance System (BRFSS); as cited by County Health Rankings, 2018

In 2019, 13.8% of Del Valle residents and 11.3% of Montopolis residents reported poor physical health for at least 14 days of the last 30 days, compared to 9.6% of Austin residents, highlighting disproportionate adverse health outcomes in Del Valle (Figure 48).

Figure 48. Residents Reporting Poor Physical Health for More Than 14 Days in the Past 30 Days, by Selected Neighborhoods, 2019

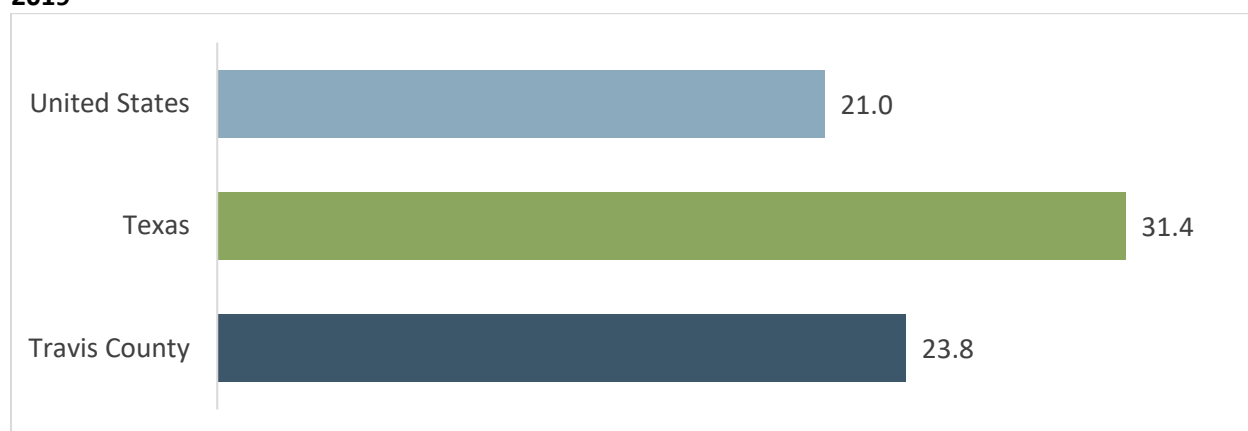


DATA SOURCE: Community Health Indicator Analysis (Del Valle & Montopolis), 2019

Maternal and Child Health

The rate of teen births among females aged 15-19 in Travis County (23.8) was similar to the teen birth rate nationwide (21.0), and lower than the teen birth rate across Texas (31.4) according to 2013-2019 aggregated data (Figure 49).

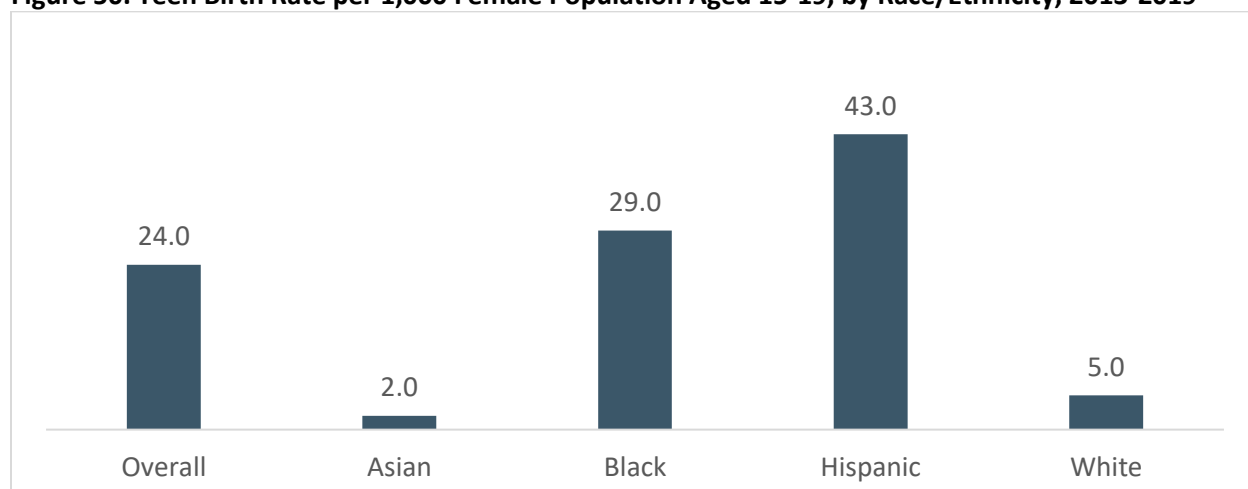
Figure 49. Teen Birth Rate per 1,000 Female Population Aged 15-19, by US, State and County, 2013-2019



DATA SOURCE: National Center for Health Statistics, Natality files, National Vital Statistics System (NVSS); as cited by County Health Rankings, 2013-2019

From 2013-2019 the teen birth rate was significantly higher for Hispanic teens than other racial and ethnic groups as well as the population overall.

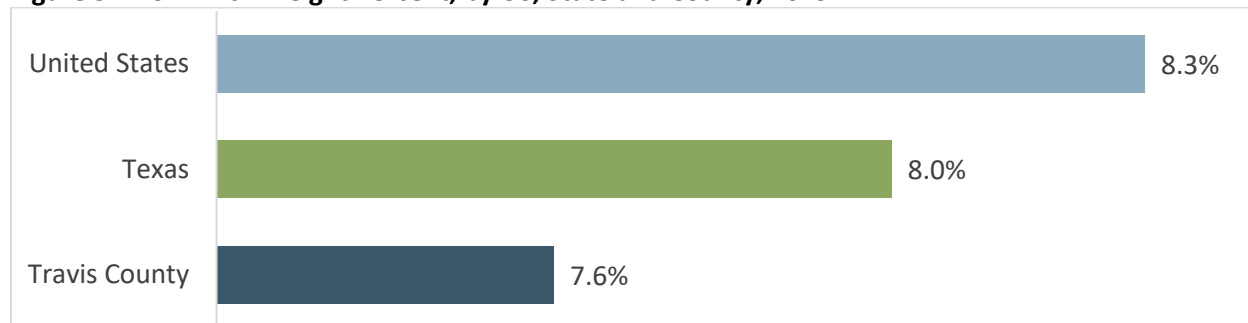
Figure 50. Teen Birth Rate per 1,000 Female Population Aged 15-19, by Race/Ethnicity, 2013-2019



DATA SOURCE: 2021 County Health Rankings & Roadmaps; National Center for Health Statistics - Natality files, National Vital Statistics System (NVSS)

In 2019, 7.6% of infants in Travis County were born with a low birth weight, meaning they weighed less than 2,500 grams; this proportion was similar in Texas (8.0%) and the US (8.3%) (Figure 51).

Figure 51. Low Birth Weight Percent, by US, State and County, 2019



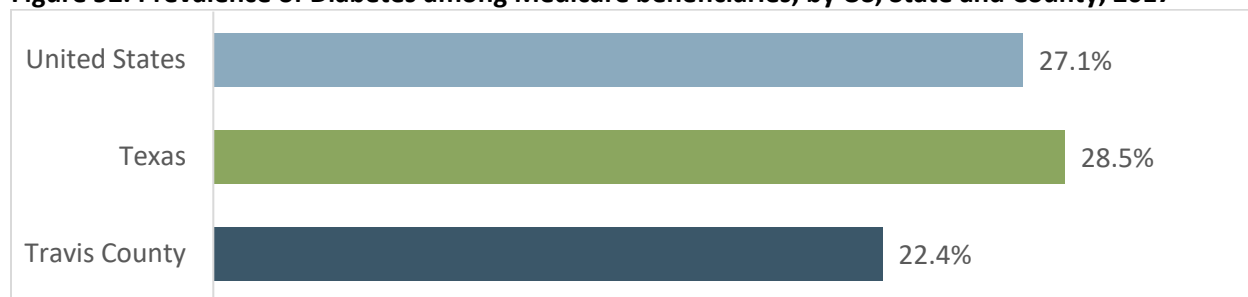
DATA SOURCE: Texas Certificates of Live Birth, 2019

NOTE: Low birth weight is defined as babies who are born weighing less than 2,500 grams

Chronic Disease

According to 2017 County Health Rankings data, about one-fifth (22.4%) of Travis County Medicare recipients have been diagnosed with diabetes, which is slightly lower than the prevalence in Texas (28.5%) and the US overall (27.1%), where more than one-quarter of Medicare recipients have been diagnosed with diabetes (Figure 52).

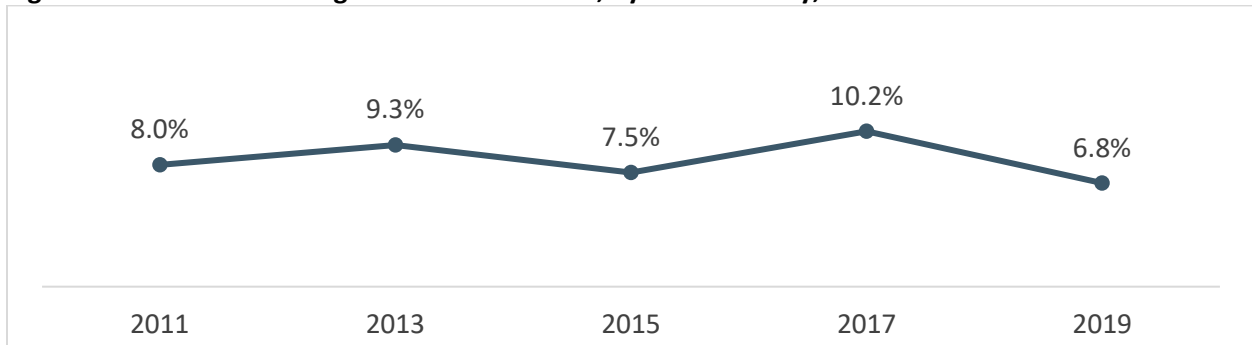
Figure 52. Prevalence of Diabetes among Medicare beneficiaries, by US, State and County, 2017



DATA SOURCE: CDC Diabetes Interactive Atlas; as cited by County Health Rankings, 2017

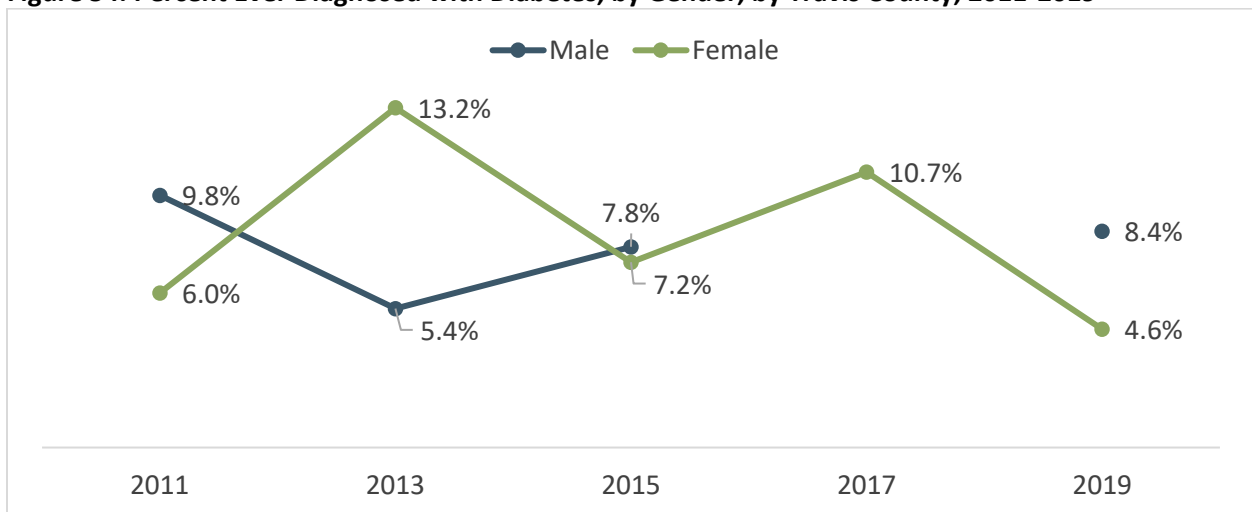
The percent of Travis County residents who report ever being diagnosed with diabetes in 2019 was 6.8%, which is slightly lower than the prevalence from 2011 to 2017 (Figure 53). The percent of adults reporting a diabetes diagnosis varied by gender and over time, ranging from a high of 9.8% in 2011 to a low of 5.4% in 2013 for males and a high of 13.2% in 2013 to a low of 4.6% in 2019 for females (Figure 54). From 2011 to 2019, a higher percentage of Hispanic/Latino residents (Figure 55) and those aged 65 and over (Figure 56) reported being diagnosed with diabetes compared to other groups in those stratifications. For example, in 2019, approximately one-tenth (10.0%) of Hispanic/Latino adults reported a diabetes diagnosis, compared to 4.6% of White adults. In 2019, about one-fifth (21.6%) of adults 65+ years of age reported being diagnosed with diabetes, followed by 8.0% of adults 45-64 years of age.

Figure 53. Percent Ever Diagnosed with Diabetes, by Travis County, 2011 -2019



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2011-2019

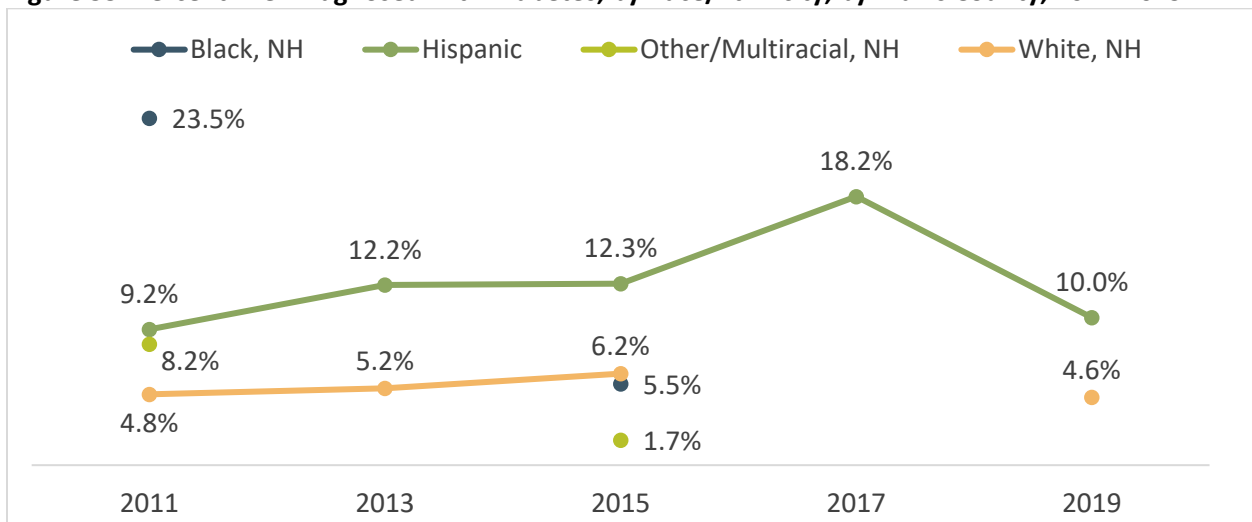
Figure 54. Percent Ever Diagnosed with Diabetes, by Gender, by Travis County, 2011-2019



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2011-2019

NOTE: Missing data points indicate unreliable data.

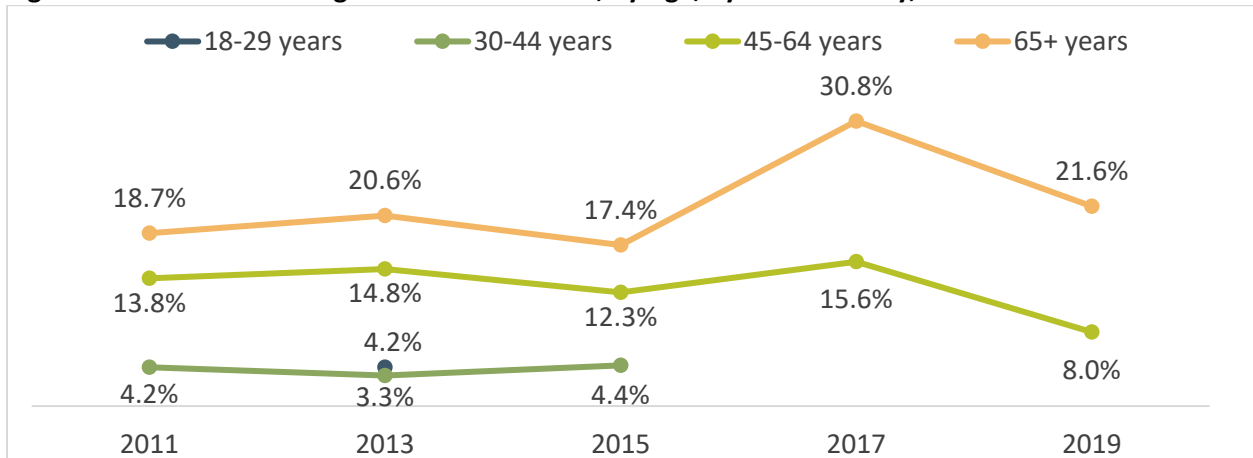
Figure 55. Percent Ever Diagnosed with Diabetes, by Race/Ethnicity, by Travis County, 2011-2019



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2011-2019

NOTE: Missing data points indicate unreliable data.

Figure 56. Percent Ever Diagnosed with Diabetes, by Age, by Travis County, 2011-2019

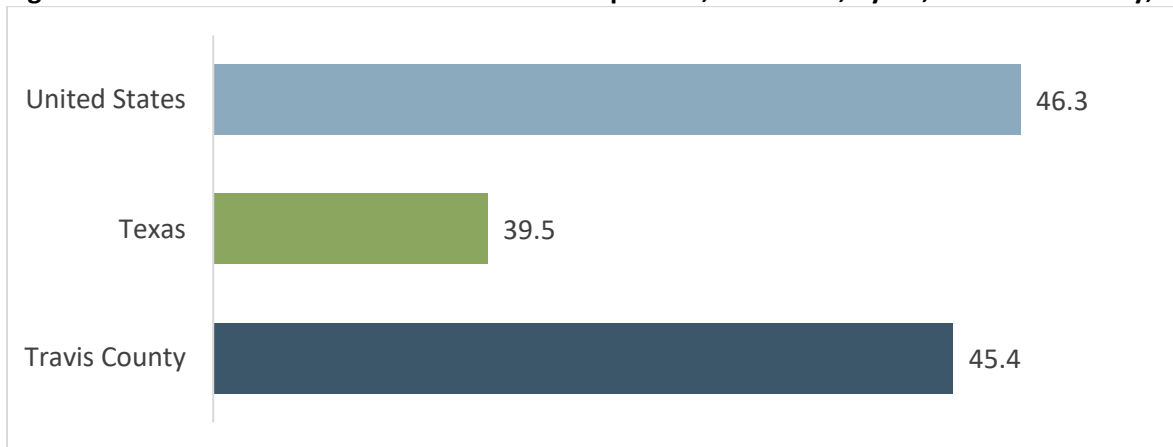


DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2011-2019

NOTE: Missing data points indicate unreliable data.

The uncontrolled diabetes hospital admission rate in Travis County and the US overall (45.4 and 46.3 admissions per 100,000 adults, respectively) was slightly higher than the rate in Texas (39.5 admissions per 100,000 adults) in 2018 (Figure 57).

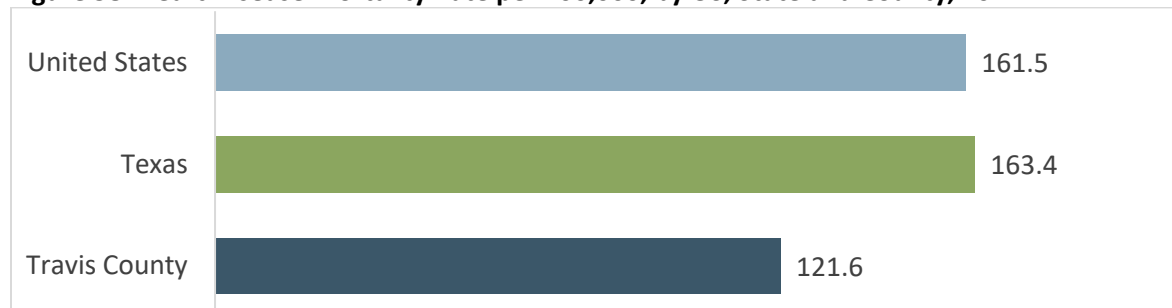
Figure 57. Uncontrolled Diabetes Admission Rate per 100,000 Adults, by US, State and County, 2018



DATA SOURCE: Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations, 2018

In 2017, the heart disease mortality rate in Travis County (121.6 deaths per 100,000 population) was lower than that in Texas and the US overall (163.4 and 161.5 deaths per 100,000 population, respectively) (Figure 58).

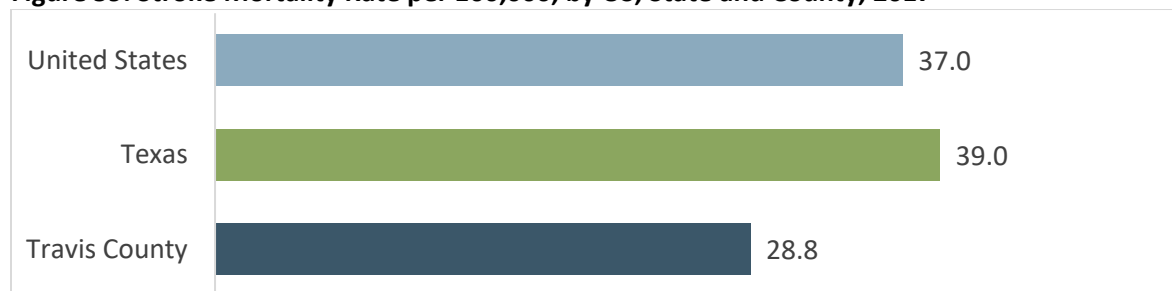
Figure 58. Heart Disease Mortality Rate per 100,000, by US, State and County, 2017



DATA SOURCE: Texas Health Data, Center for Health Statistics, Texas Department of State Health Services, 2017

The stroke mortality rate in Travis County (28.8 deaths per 100,000 population) was lower than that for Texas and the US (39.0 and 37.0 deaths per 100,000 population, respectively) in 2017 (Figure 59).

Figure 59. Stroke Mortality Rate per 100,000, by US, State and County, 2017



DATA SOURCE: Texas Health Data, Center for Health Statistics, Texas Department of State Health Services, 2017

Cancer

Overall cancer incidence in 2013-2017 aggregated data was lowest in Travis County (391.9 per 100,000 population), followed by Texas (407.7 per 100,000 population) and the US (448.7 per 100,000 population) (Table 5). Prostate and lung cancer generally had the highest rates of incidence compared to colon and female breast cancer in these geographies. The female breast cancer incidence rate in Travis County (32.5 per 100,000 population) was higher than Texas and the US (22.5 and 29.8 per 100,000 population, respectively).

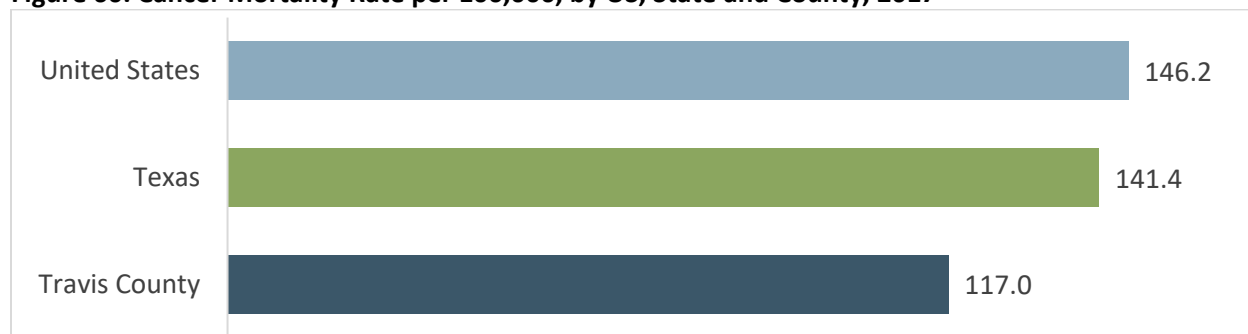
Table 5. Cancer Incidence per 100,000, by US, State and County, 2013-2017

	Overall	Female Breast	Colon	Lung	Prostate
United States	448.7	29.8	38.4	58.3	104.5
Texas	407.7	22.5	37.6	50.6	94.0
Travis County	391.9	32.5	32.9	41.7	92.2

DATA SOURCE: State Cancer Profiles, National Cancer Institute (CDC), 2013-2017

The cancer mortality rate was slightly lower in Travis County (117.0 deaths per 100,000 population) compared to that for Texas and the US (141.4 and 146.2 deaths per 100,000 population, respectively) in 2017 (Figure 60).

Figure 60. Cancer Mortality Rate per 100,000, by US, State and County, 2017



DATA SOURCE: Texas Health Data, Center for Health Statistics, Texas Department of State Health Services, 2017

Community Perceptions of General Health

When asked “What does health mean to you?” several residents described a **holistic definition of health**, which they mentioned included happiness, quality of life, safety, spiritual well-being, as well as living an active lifestyle. One focus group participant described health as *“Being happy in your family life, work life; all together happy in your community and safe.”* Another focus group participant shared, *“If going to mass, or a religious service is good for my emotional health, then that is a part of health.”* According to one community leader, health is influenced by several factors outside of the health care setting: *“I have a broad definition of health and if someone feels safe and comforted, then that is health. I am invested and interested in what happens outside the clinic.”* Many participants and community leaders described mental and physical health as linked. One focus group participant shared: *“For me, it’s mentally, physically, all of it, one does not outweigh the other one. If you’re not physically healthy then mentally, you can[not] bring yourself from that. It all ties into one thing.”*

For several focus group participants, healthy lifestyle and access to health-promoting resources such as **healthy foods and spaces to be physically active** were important for promoting health. One focus group participant explained, *“Eating healthy, exercising, going to the doctor regularly, having control over all diseases, and especially sleeping well and having zero stress although it is difficult to avoid stress but you must go get a checkup at the doctor regularly.”* Some focus group participants mentioned the importance of sufficient and high quality of sleep. One focus group participant shared, *“Resting and sleeping well, that also counts a lot.”*

“Daily walks, for those of us who can. Access to a store with fruits and vegetables, close by.” – Focus Group Participant

“For me, [health] means wellbeing, eating healthy, getting medical checkups, trying to be well and in good health.” – Focus Group Participant

Stress was a common theme among Hispanic/Latino focus group participants, who noted that stress is connected with health and observed the importance of limiting stressful circumstances. As one focus group participant shared, *“Maintaining a low level of stress is very important for me.”* Another focus group participant shared how multiple responsibilities and strains on time make it difficult to prioritize health: *“I also think that time is a factor because we work a lot and we don’t have time to take the time to take care of our health.”*

One in-depth interview participant who had previously been incarcerated cited the **structural conditions** of people’s lives, including incarceration, as shaping health. This resident noted, *“At some point they will have to recognize long-term incarceration as a disability.”*

Some focus group participants described **health insurance** and access to medical and dental providers as important supports for health. One focus group participant explained, *“Good health insurance [is important] so when you get sick you can go to the doctor and get treated.”* Another focus group participant shared, *“[Health] requires care like doctors’ visits, healthcare visits, visits with specialists.”* A couple of participants mentioned acupuncture and water therapy as important forms of support for health. One provider serving primarily low-income and Hispanic/Latino described significant oral health needs for patients in their clinic:

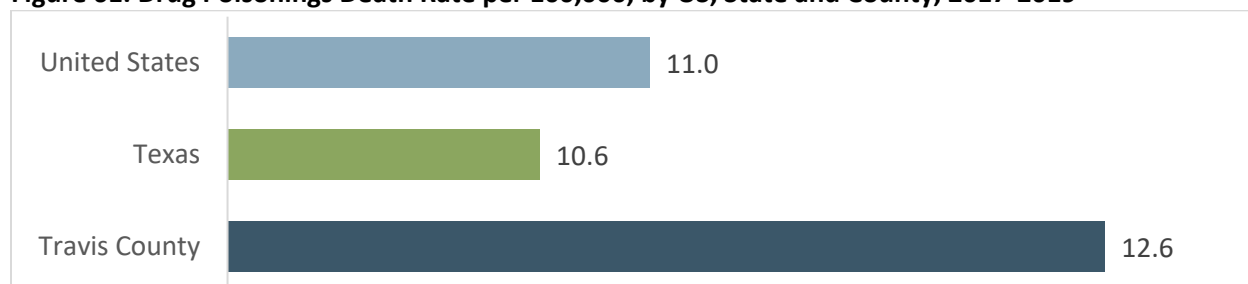
“Before dentistry, we had patients with complex dental needs because they have been without dental care for so long. We are getting people up to speed, stasis, and need a lot of restorative dental services.”
- Community Leader

Behavioral Health Outcomes

In addition to general health outcomes discussed above, the following section describes outcomes related to behavioral health, including substance use and mental health, as well as community perceptions of behavioral health.

In 2017-2019 aggregated data, the rate of drug poisonings, also referred to as overdoses, was 12.6 deaths per 100,000 population in Travis County, which was slightly higher than Texas and the US (10.6 and 11.0 deaths per 100,000, respectively) (Figure 61).

Figure 61. Drug Poisonings Death Rate per 100,000, by US, State and County, 2017-2019



DATA SOURCE: CDC WONDER Mortality Data; as cited by County Health Rankings, 2017-2019

Substance use was not widely discussed in interviews or focus groups. However, some residents and community leaders did describe the importance of de-stigmatizing addiction. One focus group participant observed that addiction is often invisible and stigmatized, which contributes to limited supports for people living with addiction:

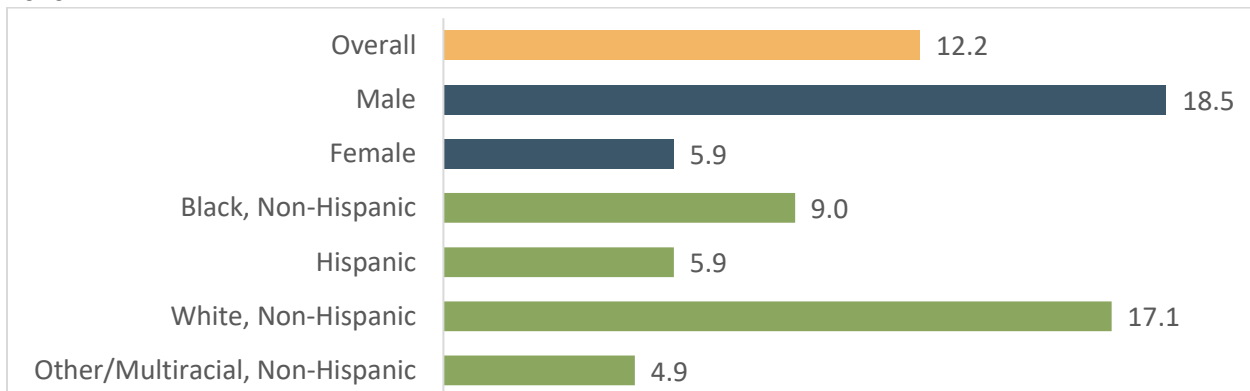
“...[I]t doesn’t always show, so many people out there [with addiction], we need to have programs where people feel safe coming forward and there’s no stigma involved. People who were prescribed and then became addicted, they shouldn’t be blamed for that.” – Focus Group Participant

One in-depth interview participant who was previously incarcerated highlighted the intersections of stigma towards people who have been incarcerated and people who struggle with addiction, highlighting how current group addiction support programs can be unwelcoming for people who have been incarcerated, even if their attendance is mandatory:

“[It is] [m]andatory for everyone to go to AA [Alcoholics Anonymous] first, but they find out you’re formerly incarcerated and the members of AA are often unwelcoming (shame and stigma). I had a woman (who had been in that group for a few years) tell me that because I was formerly incarcerated, I wasn’t welcome at the AA meeting.” – In-Depth Interview Participant

Substance use disorders and mental illness are closely linked and often co-occurring. Among Travis County residents, the suicide rate was 12.2 deaths per 100,000 population and highest among males (18.5 deaths per 100,000 population) and White residents (17.1 deaths per 100,000 population) in data aggregated from 2016-2020 (Figure 62).

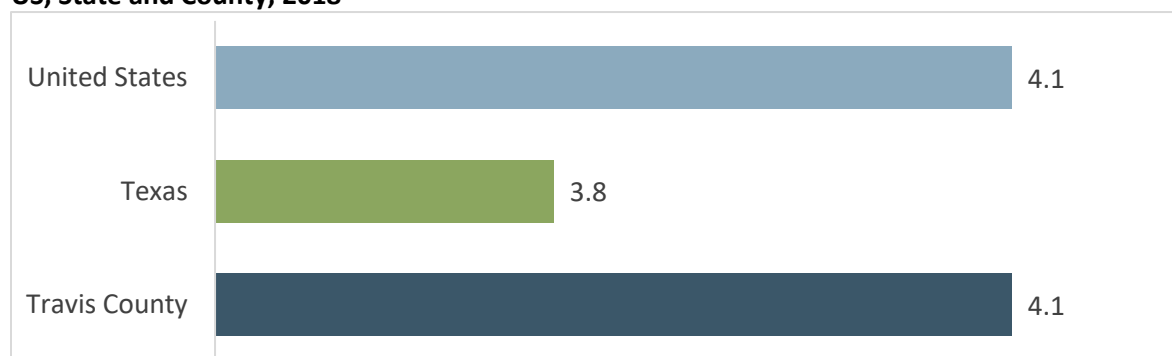
Figure 62. Suicide Rate by 100,000, Overall and by Gender and Race/Ethnicity, by Travis County, 2016-2020



DATA SOURCE: CDC Wonder, 2016-2020

In 2018, the average number of **mentally unhealthy days** reported in the past 30 days was relatively similar in Travis County, Texas, and the US overall, at around 4 days (Figure 63).

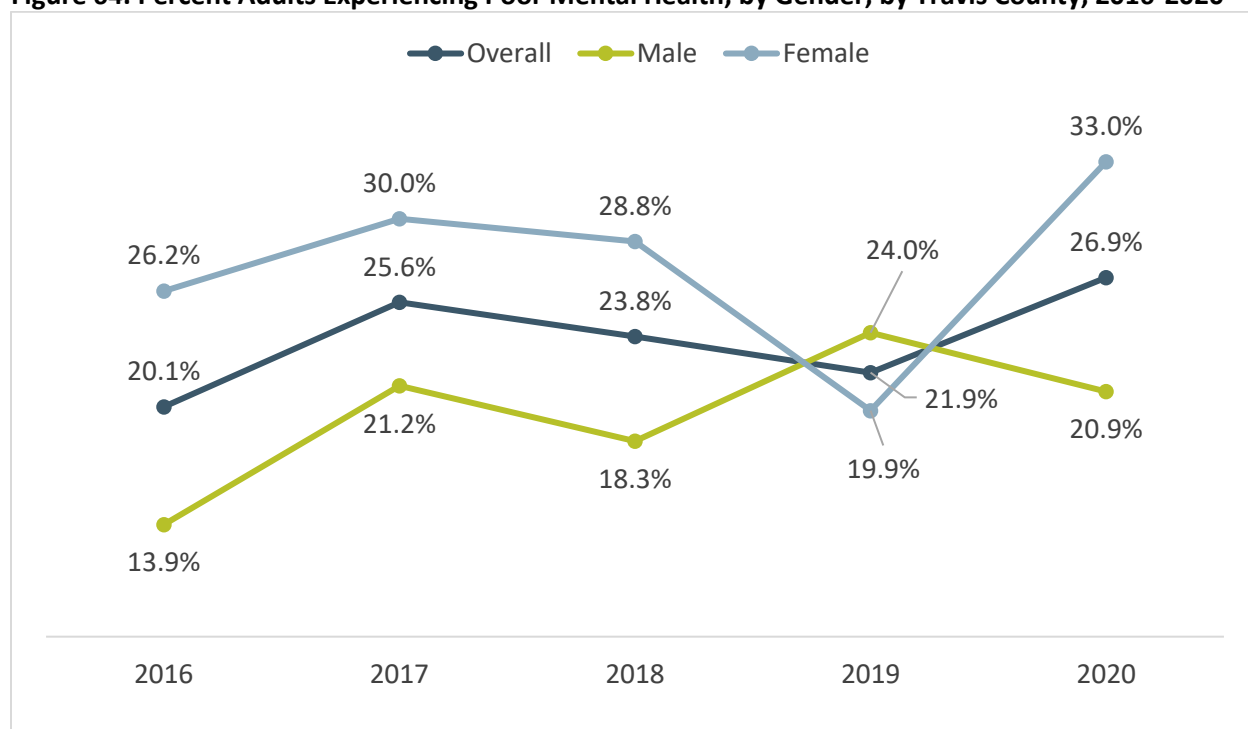
Figure 63. Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted), by US, State and County, 2018



DATA SOURCE: The Behavioral Risk Factor Surveillance System (BRFSS); as cited by County Health Rankings & Roadmaps, 2021

With the exception of 2019, throughout 2016 to 2020 a higher percentage of females (33.0% in 2020) compared to males (20.9% in 2020) reported poor mental health, defined as having 5 or more days of poor mental health in the past 30 days (Figure 64). Since 2016, the prevalence of poor mental health days has increased overall for both genders.

Figure 64. Percent Adults Experiencing Poor Mental Health, by Gender, by Travis County, 2016-2020



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2016-2020

NOTE: Adults who self-report 5 or more days of poor mental health in the past 30 days.

Over one-fifth of adults in all race/ethnicity categories reported poor mental health in 2020 (Table 6). In the same year, a higher percent of Hispanic/Latino adults (31.5%) reported poor mental health compared to White (26.3%) and Black/African American (22.9%) adults.

Table 6. Percent Adults Experiencing Poor Mental Health, by Gender, Race/Ethnicity, Age, by Travis County, 2016-2020

	2016	2017	2018	2019	2020
Overall	20.1%	25.6%	23.8%	21.9%	26.9%
Male	13.9%	21.2%	18.3%	24.0%	20.9%
Female	26.2%	30.0%	28.8%	19.9%	33.0%
Black, Non-Hispanic	-	-	26.5%	-	22.9%
Hispanic	19.6%	30.4%	20.0%	25.7%	31.5%
Other/Multiracial, Non-Hispanic	-	-	-	-	-
White, Non-Hispanic	22.5%	24.9%	25.8%	23.4%	26.3%
18 to 29	29.0%	36.6%	39.7%	34.4%	32.6%
30 to 44	18.1%	30.4%	19.6%	22.8%	34.3%
45 to 64	18.2%	18.6%	23.6%	16.3%	22.0%
65+	13.6%	-	11.2%	12.7%	17.5%

DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2016-2020

NOTE: Adults who self-report 5 or more days of poor mental health in the past 30 days; dashes (-) indicate unreliable estimates or inadequate number of responses.

Over one-fifth of adults younger than 65 years of age reported poor mental health in 2020 (Table 6). Generally, the highest proportion of adults experiencing poor mental health was seen among adults aged 18-29 (32.6% in 2020) and 30-44 years of age (34.3% in 2020), while reports of poor mental health were lowest among adults 65+ years of age (17.5% in 2020) (Table 6).

Significant mental health needs, **stigma** around mental health, and **limited access to mental health care** was a common theme among community leaders, focus group participants, community forum participants, and in-depth interview participants. Residents cited mental health issues affecting older adults, children, young and middle-aged adults, LGBTQIA+Q residents, residents of color, and people experiencing homelessness. One community leader described the importance of governmental support for sharing information about mental health resources:

“I don’t feel like there are mental health resources for the Asian community. We lack support from government and other local channels. This is why I feel like your assessment is important, we need to be connected. Resources don’t always have to be money, sometimes they are communication channels and learning who to reach out: doctors, psychiatrists, etc.” – Community Leader

As discussed above, some residents perceived an increase in mental health issues during the COVID-19 pandemic, including depression and anxiety, which they linked with the **stress and trauma of the COVID-19 pandemic**, loss of loved ones, social isolation, and economic suffering. One community leader characterized the mental health crisis facing residents during the ongoing COVID-19 pandemic:

“Then we look at the physical piece: depression and anxiety are at an all-time high which affect our physical health. The brain-body connection is huge and I cannot stress that enough.” – Community Leader

One community leader also mentioned the importance of addressing addiction and mental health issues affecting people who are experiencing homelessness: *“Dealing with mental health is a huge issue and dealing with addiction and there is nothing that really helps with that.”* Several residents described mental health as stigmatized. One focus group participant shared: *“I think [...] one [issue] that is taboo is mental health.”* A couple of community leaders also discussed stigma around mental health. One community leader observed, *“Mental health support is difficult because nobody likes to talk about their mental health struggles.”*

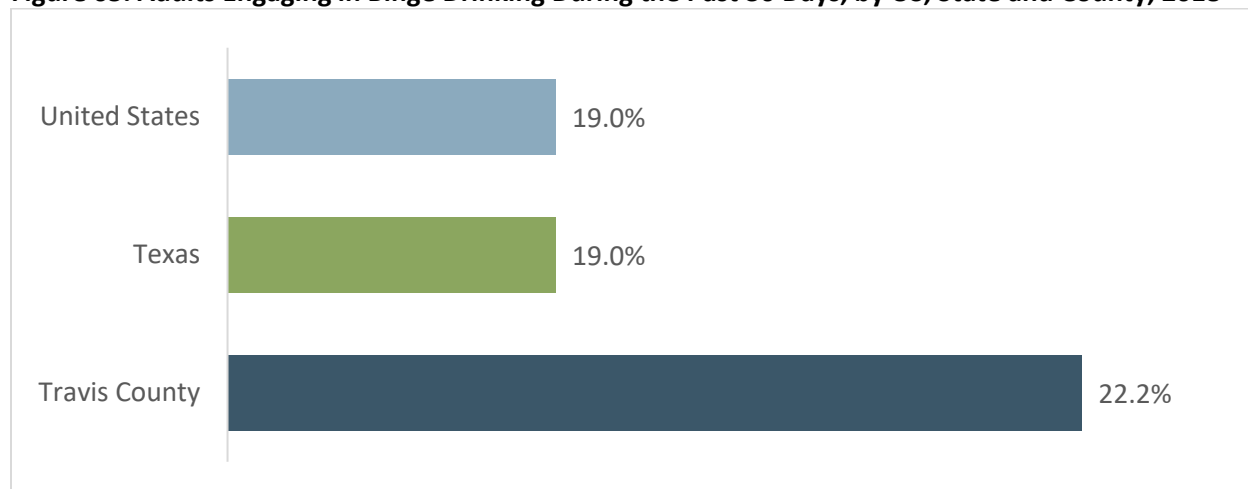
In reflecting on community mental health, community forum participants cited several strategies to improve mental health, including improving funding for mental health, providing culturally appropriate mental health services, increasing the number of mental health providers, and delivering mental health services for children through schools. Some participants also noted that a positive coping strategy, such as mindfulness, getting outside, and laughing, can help to reduce stress.

General Health Behaviors

The following section provides a snapshot of general health behaviors of the population, including substance use, seatbelt use and sexual health indicators.

Approximately one-fifth of adults across Travis County (22.2%), Texas (19.0%), and the US overall (19.0%) reported binge drinking in the past 30 days according to 2018 data (Figure 65).

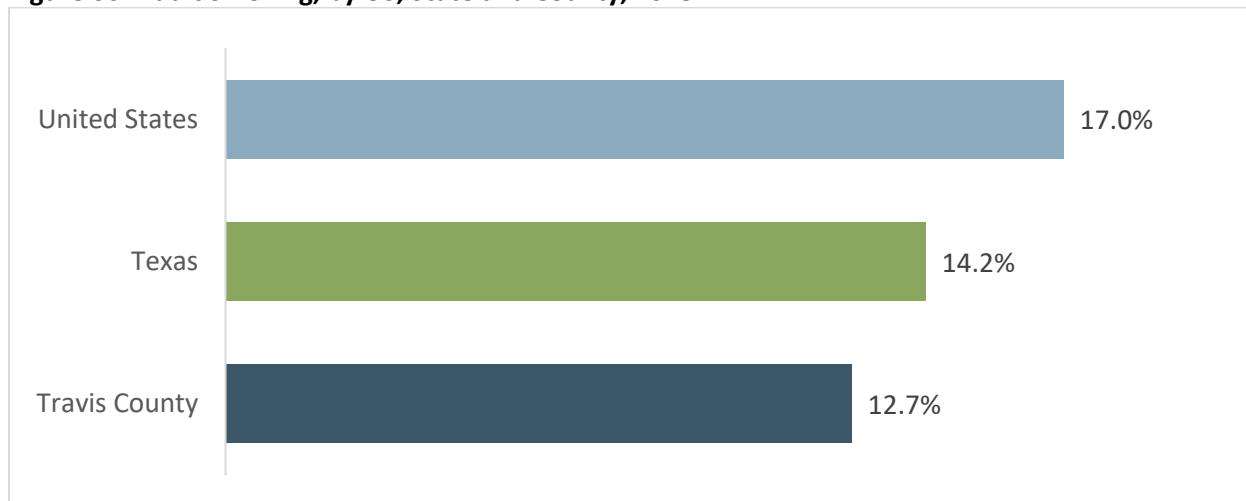
Figure 65. Adults Engaging in Binge Drinking During the Past 30 Days, by US, State and County, 2018



DATA SOURCE: The Behavioral Risk Factor Surveillance System (BRFSS); as cited by County Health Rankings & Roadmaps, 2021

In 2018, about one-tenth (12.7%) of Travis County adults reported that they currently smoke, a proportion that is slightly lower than patterns across Texas (14.2%) and lower than the percent of US adults who report smoking (17.0%) (Figure 66).

Figure 66. Adult Smoking, by US, State and County, 2018



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS); as cited by County Health Rankings, 2018
NOTE: Percentage of the adult population who both report that they currently smoke every day or most days and have smoked at least 100 cigarettes in their lifetime.

The majority of Travis County adults reported using a seatbelt. The percent of Travis County adults reporting seatbelt use was slightly higher among females (95.0%) compared to males (91.9%) (Figure 67).

Figure 67. Seatbelt Use, by Sex, by Travis County, 2020

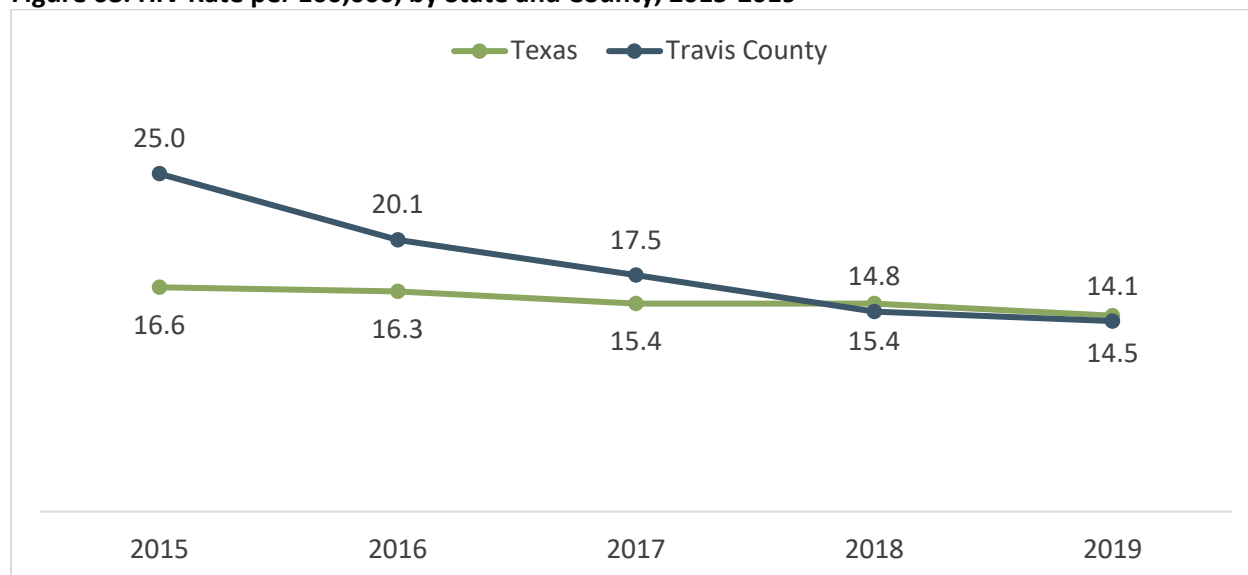


DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2020

Sexual Health

The rate of HIV was around 14 per 100,000 population (Figure 68), and the rate of AIDS was around 6 per 100,000 in both Texas and Travis County in 2019 (Figure 69); these rates declined from 2015.

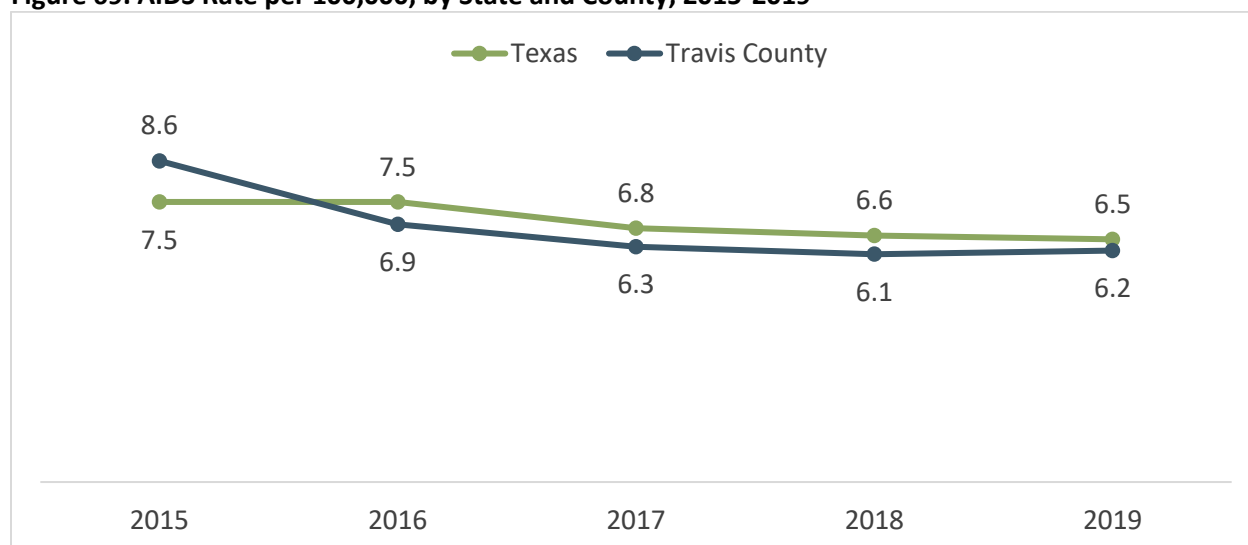
Figure 68. HIV Rate per 100,000, by State and County, 2015-2019



DATA SOURCE: Texas Department of State Health Services, Texas STD Surveillance Report, 2015-2019

The AIDS rate decreased slightly in Travis County, from 8.6 cases per 100,000 population in 2015 to 6.2 cases per 100,000 population in 2019, more closely mirroring the rate across Texas in 2019 (6.5 cases per 100,000 population).

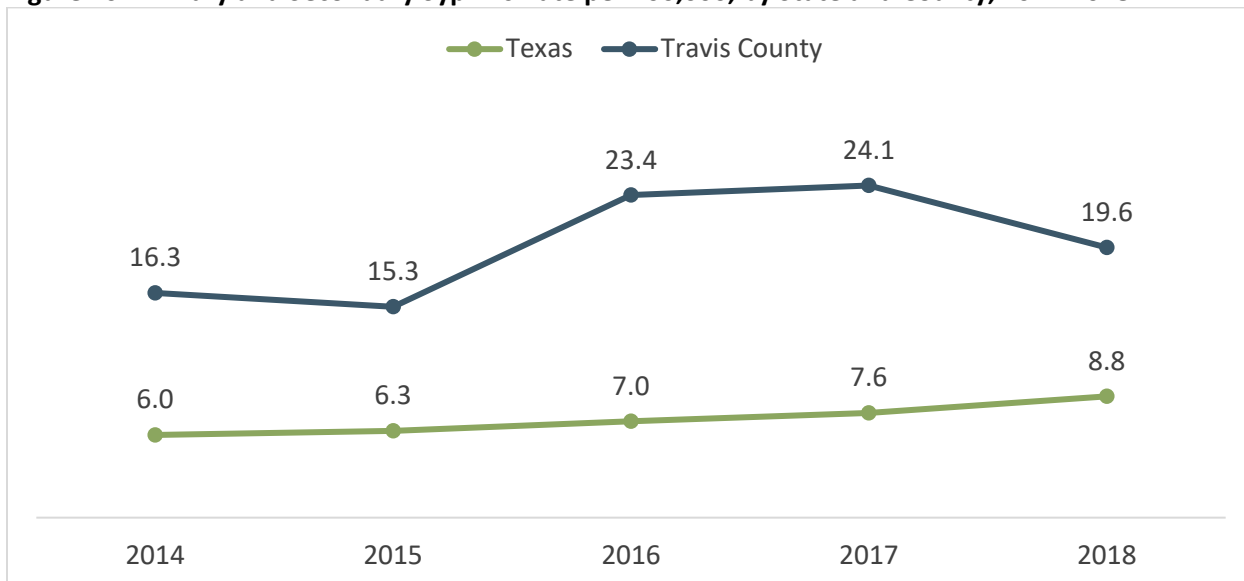
Figure 69. AIDS Rate per 100,000, by State and County, 2015-2019



DATA SOURCE: Texas Department of State Health Services, Texas STD Surveillance Report, 2015-2019

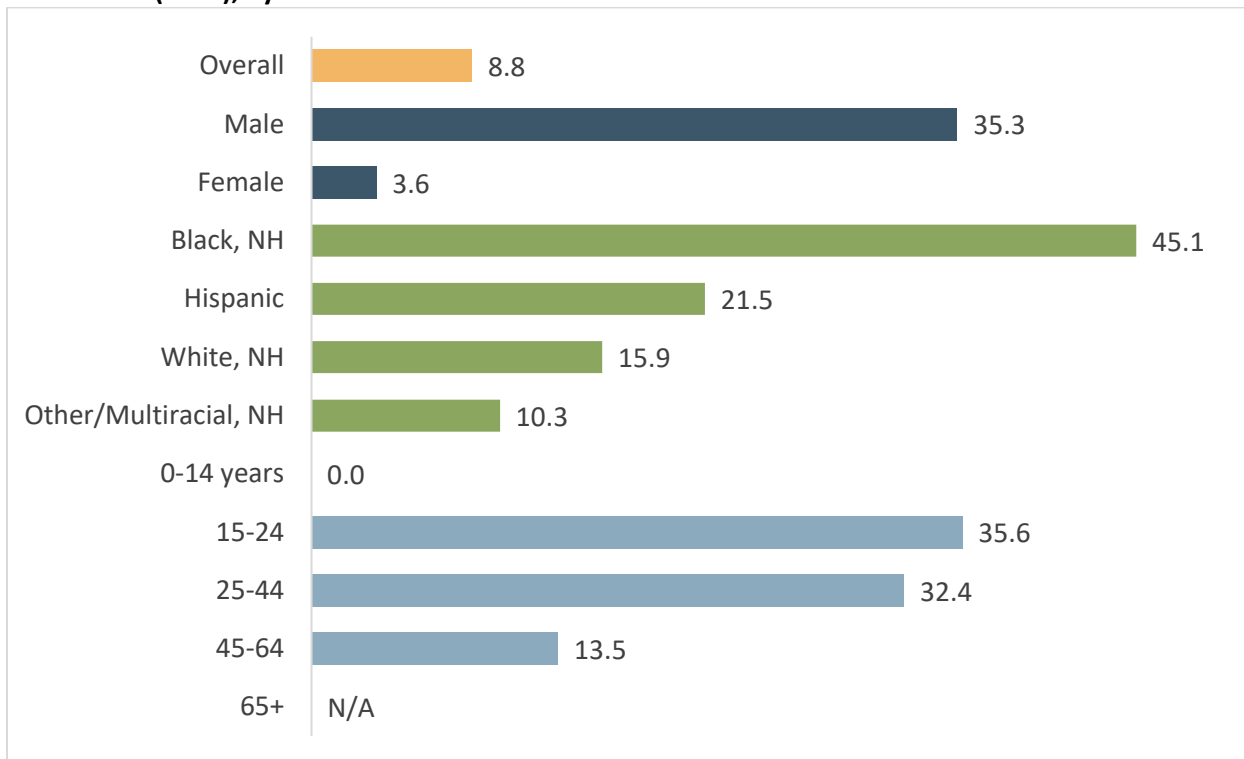
In 2018, the rate of syphilis was higher in Travis County than Texas (19.6 and 8.8 cases per 100,000 population, respectively) (Figure 70). In Travis County, the syphilis rate increased slightly from 2014 to 2018. Aggregated 2014-2018 data show that in Texas, Black/African American residents (45.1 cases per 100,000 population), 15-24 year olds (35.6 cases per 100,000 population), males (35.3 cases per 100,000 population), and 25-44 year olds (32.4 cases per 100,000 population) had the highest rates of syphilis (Figure 71).

Figure 70. Primary and Secondary Syphilis Rate per 100,000, by State and County, 2014-2018



DATA SOURCE: Texas Department of State Health Services, Texas STD Surveillance Report, 2014-2018

Figure 71. Syphilis (Primary and Secondary) Rate per 100,000, by Selected Stratifications (2014-2018) and Overall (2018), by Texas



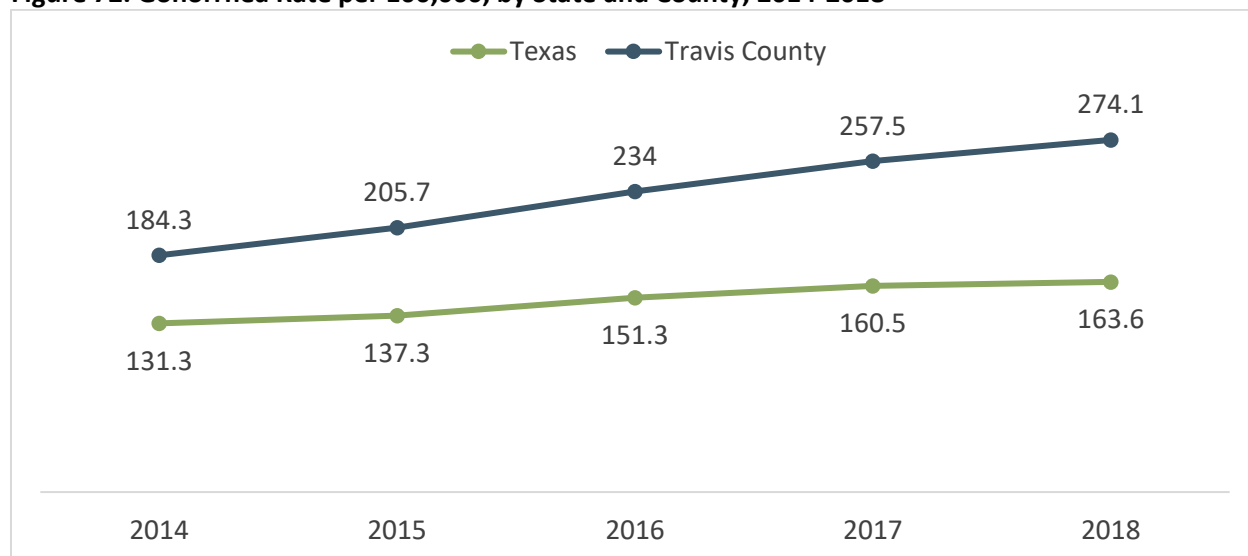
DATA SOURCE: Texas Department of State Health Services, Texas STD Surveillance Report, 2014-2018

NOTE: 245 cases with unknown age.

From 2014 to 2018, the rate of gonorrhea was higher in Travis County than in Texas (274.1 and 163.6 cases per 100,000 population, respectively in 2018) (Figure 72). Over this same period, the gonorrhea rate increased by about 49% in Travis County, compared to 25% across Texas. Aggregated 2014-2018

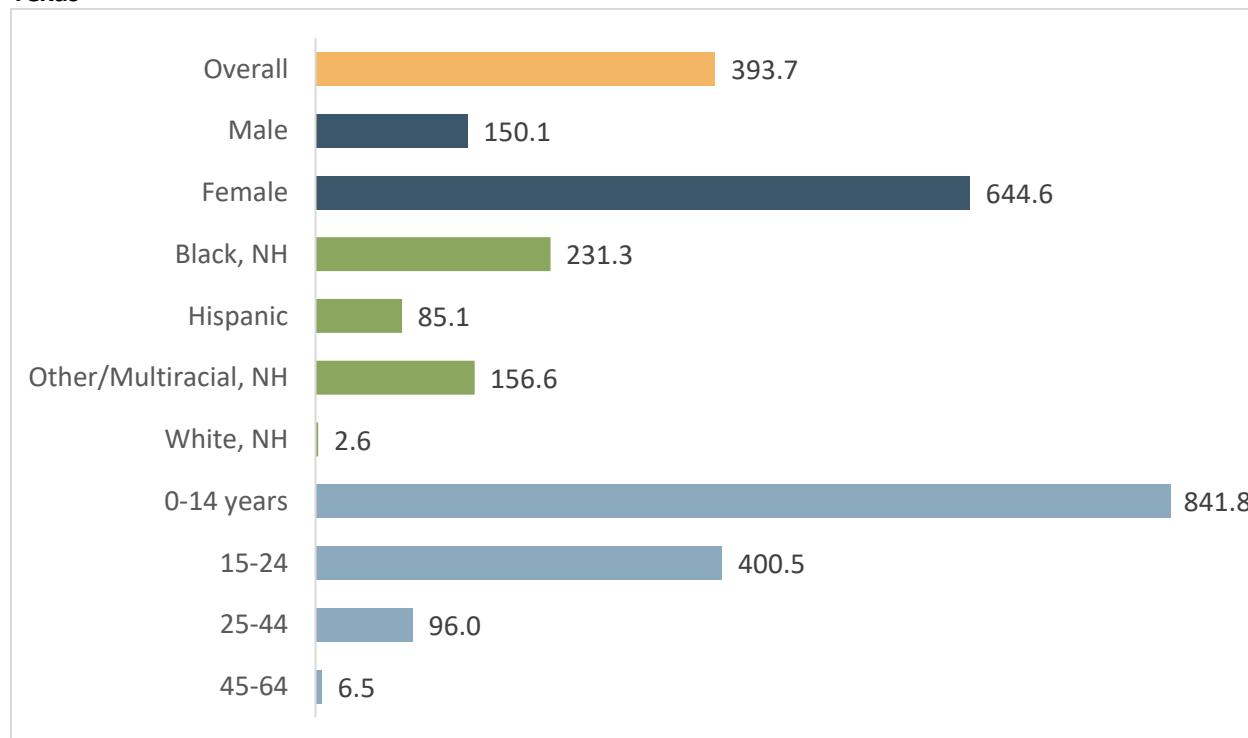
data across Texas show that 15-24 year olds (841.8 cases per 100,000 population) and female residents (644.6 cases per 100,000 population) had the highest rates of gonorrhea (Figure 73).

Figure 72. Gonorrhea Rate per 100,000, by State and County, 2014-2018



DATA SOURCE: Texas Department of State Health Services, Texas STD Surveillance Report, 2014-2018

Figure 73. Gonorrhea Rate per 100,000, by Selected Stratifications (2014-2018) and Overall (2018), by Texas



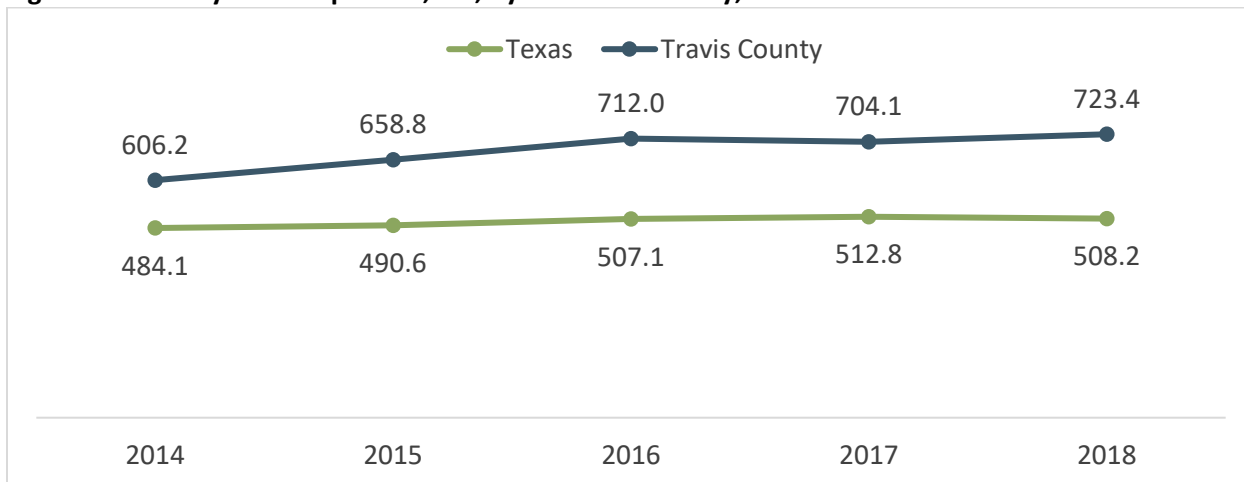
DATA SOURCE: Texas Department of State Health Services, Texas STD Surveillance Report, 2014-2018

NOTE: 748 cases with unknown race or ethnicity

From 2014 to 2018, the chlamydia rate was higher in Travis County than in Texas (723.4 and 508.2 cases per 100,000 population in 2018) (Figure 74). Chlamydia rates increased from 2014 to 2018, representing

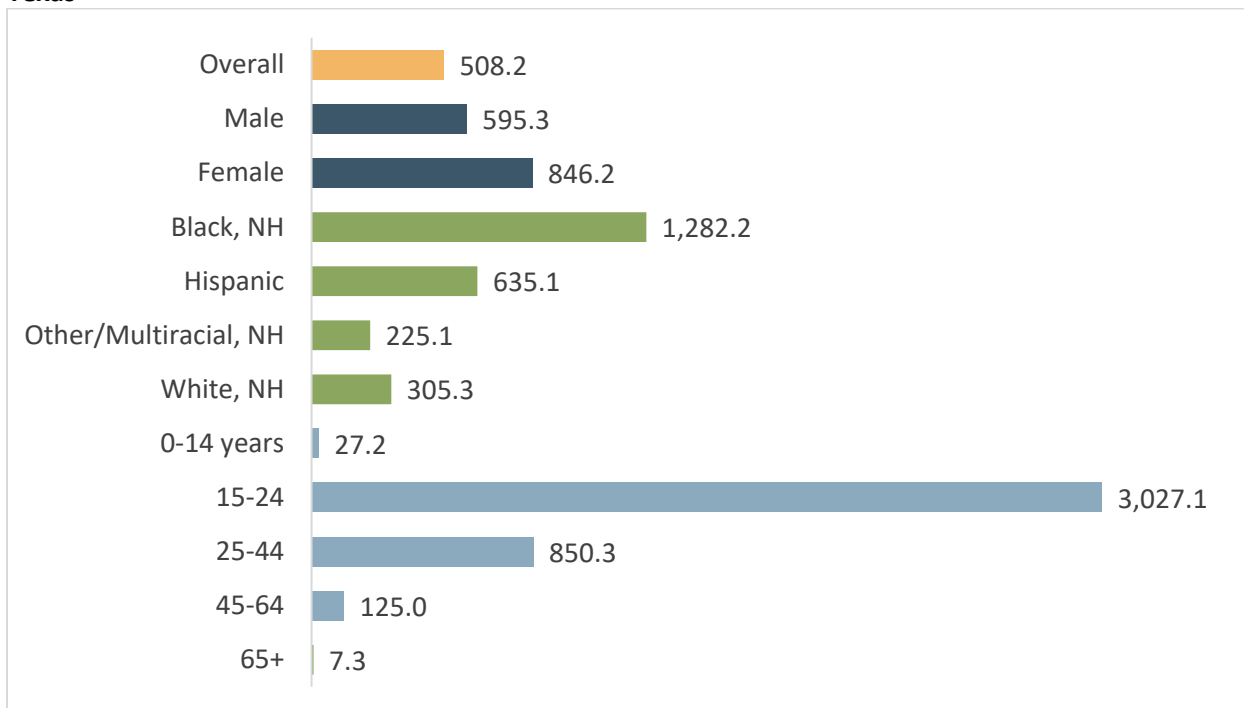
about a 19% increase in Travis County and a 5% increase across Texas. Aggregated 2014-2018 data across Texas show that 15-24 year olds (3,027.1 cases per 100,000 population) and Black/African American residents (1,282.2 cases per 100,000 population) had the highest rates of chlamydia (Figure 75).

Figure 74. Chlamydia Rate per 100,000, by State and County, 2014-2018



DATA SOURCE: Texas Department of State Health Services, Texas STD Surveillance Report, 2014-2018

Figure 75. Chlamydia Rate per 100,000, by Selected Stratifications (2014-2018) and Overall (2018), by Texas

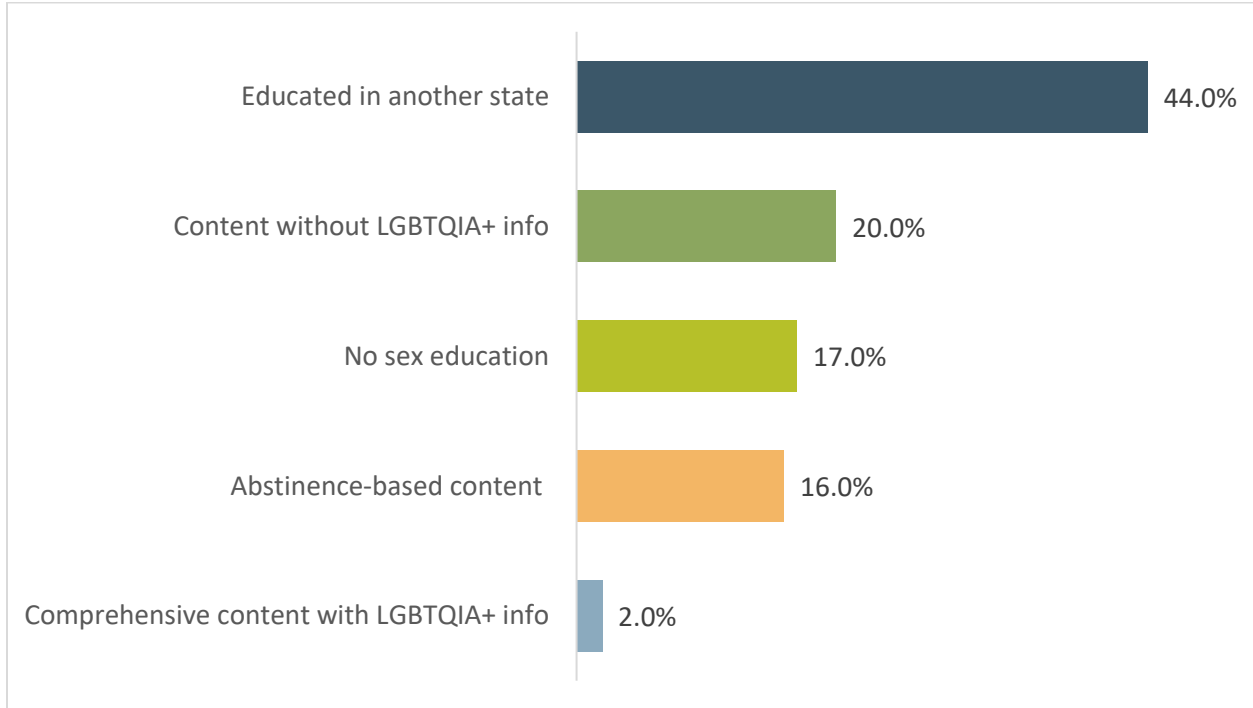


DATA SOURCE: Texas Department of State Health Services, Texas STD Surveillance Report, 2014-2018

LGBTQIA+ Quality of Life Study surveyed participants about their access to sexual education and 44% of respondents receiving sex education outside of the state and 20% reported getting education without content specific to LGBTQIA+ populations (Figure 76). Further, 17% of respondents did not receive

comprehensive sex education at any point and 16% received abstinence-only education. Of these respondents who engaged in sex in the past 12 months (1,512), 56% did not use either internal or external condoms.

Figure 76. Percent Respondents Receiving Sex Education of LGBTQIA+ Quality of Life Study Respondents, by Texas, 2021



DATA SOURCE: City of Austin, Equity Office and LGBTQIA+Q Quality of Life Advisory Commission, ShoutOut Austin LGBTQIA+ Quality of Life Study, 2021

NOTE: Respondents may not be statistically representative of the population in Austin, but robust findings may provide insight into the larger breakdown of the LGBTQIA+ residents of Austin.

FINDINGS: HEALTH CARE ACCESS AND UTILIZATION

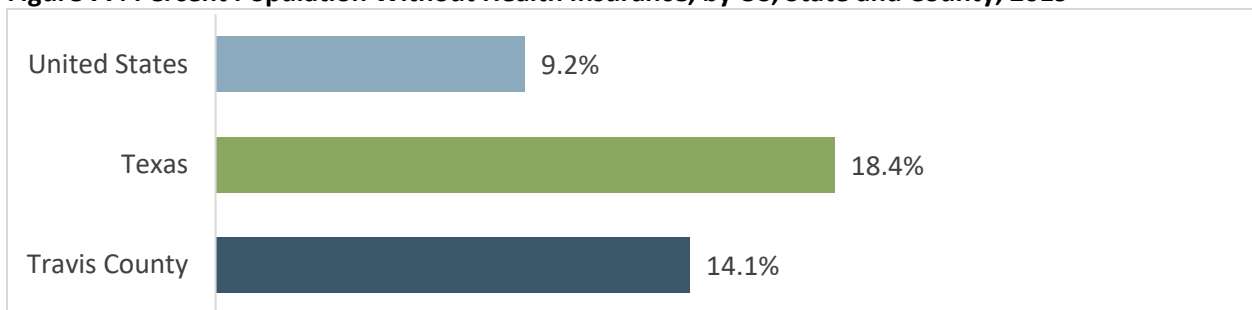


HEALTH CARE ACCESS AND UTILIZATION

Access to comprehensive, quality health care services is important for promoting and maintaining health, preventing and managing disease, and reducing the chance of premature death. Access is multi-faceted and includes components such as the ability to enter the health care system (largely by having insurance coverage), having a regular source of health care, and being able to access health care services when needed.³² However, inequities exist and not all who need high quality health care are able to access it. Those who face barriers to access are less likely to receive medical care, more likely to delay care, and less likely to use prevention services, resulting in poorer health status and outcomes. From a community perspective, lack of access may result in increased incidence of preventable diseases, excessive and inappropriate use of hospital emergency rooms, and higher overall health care costs.

Fourteen percent of Travis County residents were without health insurance in 2019, which is slightly below the percent of Texas residents who are uninsured (18.4%) and higher than the US uninsured population (9.2%) (Figure 77). And according to the LGBTQIA+ Quality of Life Study Survey nearly one-quarter of LGBTQIA+ respondents reported lacking health insurance (23.0%), compared to 17% of non-LGBTQIA+ respondents in 2021.

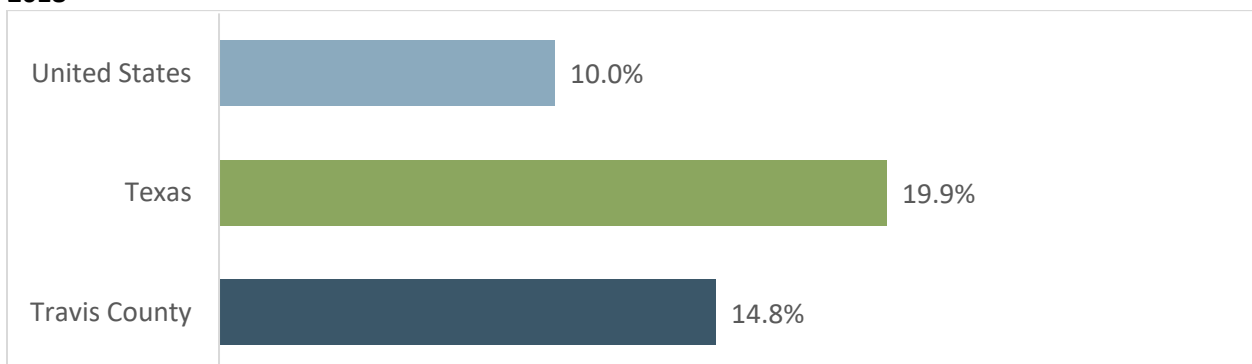
Figure 77. Percent Population Without Health Insurance, by US, State and County, 2019



DATA SOURCE: U.S. Census Bureau, American Community Survey 1-Year Estimates, 2019

In 2018, 14.8% of the population under 65 years of age was without health insurance, a proportion that is lower than the uninsured population in Texas (19.9%) and higher than the uninsured population across the US (10.0%) (Figure 78).

Figure 78. Percent of Population Under Age 65 without Health Insurance, by US, State and County, 2018



DATA SOURCE: Small Area Health Insurance Estimates (SAHIE), United States Census Bureau; as cited by County Health Rankings, 2018

Locally, Central Health’s Medical Access Program (MAP) and MAP BASIC provide coverage for low-income residents in need of primary care and prescription services (Table 7). Additionally, the Premium Assistance Program covers health insurance premium costs for musicians and other chronically ill patients.

Table 7. Central Health Medical Access Program (MAP) Enrollment, 2018-2021

	MAP	MAP Basic	Premium Assistance
2018	46,750	--	2,267+
2019	47,532	27,415*	1,883
2020	47,973	54,559	2,271
2021	47,641	60,661	2,081

DATA SOURCE: Central Health, MAP Enrollment, 2018-2021

NOTE: Plus (+) indicates premium Assistance plan expanded to provide insurance to chronically ill patients along with musicians; Asterisk (*) indicates that a new program launched in April 2019.

According to the LGBTQIA+ QWELL Wellbeing survey conducted in Greater Austin, almost half (48.6%) of LGBTQIA+ respondents reported not seeking care when having a health problem, followed by nearly one-quarter (24.3%) of respondents who reported going to a public clinic.

Health Insurance for Low-Income Residents

When discussing access to health care, a common theme among participants across interviews, focus groups, and community forums were **gaps in health insurance coverage for low-income residents and residents of color**. One community leader who works with residents who have experienced homelessness emphasized the importance of addressing socioeconomic barriers to health care: *“Preventative care is difficult to establish. Situations such as getting your yearly flu shot, how to properly take your medications, how to manage your chronic diseases properly.”* One focus group participant described fragility of health insurance coverage, noting the possibility of health insurance coverage lapsing:

“A lapse in health insurance can happen also during a job change. For me, because I work, they give me health insurance, but if I for some reason couldn’t work, that benefit goes away. Both go away, which can be a health and economic problem. Because you don’t have an income or access to health insurance.” – Focus Group Participant

Some focus group participants mentioned that **few providers accept adults who have Medicare** coverage and described Medicare as complicated. One focus group participant shared their experience: *“Nowadays its hard if you’re over 65 to find a new physician. They don’t get enough money from Medicare.”*

According to participants, MAP is helpful for accessing health care services, the **Medical Access Program (MAP)** and MAP Basic are local programs provided by Central Health that covers medical care for qualifying low-income, uninsured Travis County residents. One focus group participant explained: *“If you have a MAP card they do take care of you at the dentist and at the doctor.”*

One focus group participant described how the Medical Access Program was critical to supporting their hospital and rehabilitation care when they were recovering from COVID-19, though they also had

remaining health care costs that are difficult to pay down because of limited work opportunities and low wages:

"[Laboratory bills] have been a bit difficult because my husband's workload also went down, but the good thing is that they told me that I could send \$10, or \$20, however I could pay those bills. And since I don't work, sometimes my husband would, to pay the rent, to pay other 'bills' and because of that we have, I have gotten behind because of that. But the big 'bills' are paid by MAP."

However the coverage program comes with specific requirements for renewing coverage, many of which are mandated by the State of Texas, and as a result, some participants felt that there were **bureaucratic barriers to accessing MAP**, particularly for renewing coverage, or in accessing healthcare services with their cards, , *"[They] gave me an appointment for my teeth, and the card expired and they refused to see me because they told me that my card was expired. They told me that I had to apply again for MAP for them to be able to see me."* One community leader discussed difficulties securing and renewing health insurance coverage under the Medical Access Program:

"Even trying to sign people up for MAP, it's a long process and it's not integrated into a system that's accessible to community. Then they have to wait for a letter from Central Health if they don't qualify, no one is going to pick [up] that letter." – Community Leader

A community leader implicated a lack of health insurance expansion, racism, and anti-immigrant sentiments as contributing to the difficult patchwork of subsidized health insurance for low-income residents:

"Lack of expansion to [Medicaid] and other legislative barriers are very clear in Texas. There is a lot of racism that goes behind that. Anti-immigrant rhetoric and marginalization of these communities are active challenges that we have to acknowledge and face and address."
- Community Leader

Some focus group participants and community leaders discussed how **socioeconomic factors** and limited to no health insurance coverage served as barriers to getting needed care, including primary care, emergency services, vision care, dental care, and specialists such as cardiologists and endocrinologists. Although about 80% of the population Central Health and CommUnityCare's populations serve are people of color the perception of one community leader was that health care services are often not in close proximity to where low-income residents and people of color live or are otherwise inaccessible to them for socioeconomic reasons (see also Appendix F):

"Besides clinics which are few and far between; how many equitable places are there? How many have access within a 5-10 mile car ride? How accessible? Central Health and CommUnityCare try, but it's not accessible by non-Whites." – Community Leader

A community leader cited the need to **improve access to health care** for low-income residents in order to reduce the use of emergency services for preventable emergencies:

“Increase access to healthcare, primary and specialty care. [Residents] [c]hronically call EMS and are taken to emergency. [They] mainly [have] negative experiences which leads to a lack of trust and suspicion in the healthcare system, still have lack of access to (primary) medical care and this becomes more of an issue as we grow.” – Community Leader

One focus group participant cited concerns about extensive **medical expenses** as a barrier to seeking health care and emergency services:

“...that is what people are very afraid of, not wanting to go to the hospital, even if they are very ill because they know that it will be too much, especially if they start off with not a lot of money. We know from the moment one enters the emergency room, it generates an expense.” – Focus Group Participant

Provider Supply

Another facet of access to health care is provider availability. Travis County had more providers per capita compared to Texas overall and the US for primary care, dental care, and mental health care (Table 8). For example, according to most recent estimates, there was one primary care physician per 1,158 residents, one dentist per 1,385 residents, and one mental health provider per 343 residents.

Table 8. Ratio of Physician and Non-Physician Primary Care Providers, Dentist and Mental Health Providers, by US, State and County

	Primary Care Physician (2018)	Non-Physician Primary Care Provider (2020)	Dentist (2019)	Mental Health Provider (2020)
United States	1,320	-	1,400	380
Texas	1,642	1,128	1,677	827
Travis County	1,158	1,000	1,385	343

DATA SOURCE: Primary Care Physician: Area Health Resource File/American Medical Association, Non-Physician Primary Care Provider, Dentist and Mental Health Provider: CMS, National Provider Identification Registry (NPPES). As cited by County Health Rankings, 2018-2020

NOTE: Primary care physicians include practicing non-federal physicians (M.D.s and D.O.s) under age 75 specializing in general practice medicine, family medicine, internal medicine, and pediatrics. Non-physician primary care providers include nurse practitioners, physician assistants, and clinical nurse specialists. Registered dentists with a National Provider Identification are counted. Mental health providers are defined as psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and mental health providers that treat alcohol and other drug abuse, as well as advanced practice nurses specializing in mental health care.

Additionally, one focus group participant described the mental health care landscape as having *“almost no mental health [providers].”* Another focus group participant noted, *“We also don’t have a lot of organizations for mental health support or counseling. That is a huge gap in service that we really need.”* Residents also observed that there was limited access to social workers and peer-support services to help address mental health needs and connect residents with resources.

Several residents mentioned difficulty finding and affording home care support for low-income older residents. One community leader cited a discrepancy between the low rate of pay and intense physical labor of home care attendants, which they perceived contributed to workforce shortages and barriers to affording this form of regular care for low-income residents:

“Another thing to solve is the hard time we face getting personal care attendants out here. One of the seemingly big reasons is that they are paid crappy wages; a little above minimum wage where you could go to McDonalds and get 15/hr, attendants get paid 8 or less an hour. These are hard jobs, cleaning up people with difficulties going to the restroom, cleaning up feces, sheets with accidents, light housework like washing sheets or other various housework or just trying to be their friend. Let’s figure out a way to pay people good living wages to take care of people in need.” – Community Leader

Other barriers to health care that residents cited included that the health care system is not growing with the population growth in the region and the health care system is difficult to navigate.

Discrimination, Culturally Sensitive Care, and Interpretation Services in Health Care Settings

Experiences of **discrimination in health care settings** also emerged among some community leaders and residents. One in-depth interview participant described their Black/African American partner’s hesitance to see providers based on past experiences of racial discrimination:

“My boyfriend doesn’t want to go to hospitals even with me because he doesn’t trust the hospital because of their prejudice. It took me a minute to kind of understand it [...] Even going into hospitals or doctor’s appointments it’s not a willing thing, I have to beg him to come in because of stuff like that. Prejudiced people target people thinking they’re strong and can take on pain of certain things. [...] Stuff like that causes people to not trust health care providers, even vaccines and stuff like that. I know a lot of people that are like that.” – In-Depth Interview Participant

One community leader also shared about a friend’s hesitance to see providers out of concern about discrimination: *“An [Asian] family friend was stranded in Austin but was afraid to seek medical care because of a lack of insurance and fear from physical harassment due to discrimination.”*

Some focus group participants and several community leaders cited experiences of **limited culturally sensitive care** for patients of color and low-income patients. One community leader shared, *“[My] long-term [vision] is primary care physicians [being] culturally competent to serve clients. White doctors only provide good care if you have a certain financial status. If [you are a] Medicare/Medicaid patient, you don’t get the best care.”* Another community leader linked linguistically congruent care and taking time to ensure that patients understand their health condition and treatment plan as central to high quality care:

“People are not into who is giving care, but how. They want to be treated as a person and not cattle, not in and out. Would like to healthcare organizations to speak their languages: ‘explain why I’m taking this medicine so I can understand. Explain to me so I can understand.’ One thing we’re teaching people is, don’t leave until your questions are answered. We find that people are taking things because they are told to, not knowing why.” – Community Leader

Another community leader described the need for providers to improve their understanding of the experiences of low-income residents and residents experiencing homelessness in order to improve interactions with patients, “...[We need] [m]ore relational vs. transactional [interactions] in the doctors’ offices and [providers who] really care about that person.”

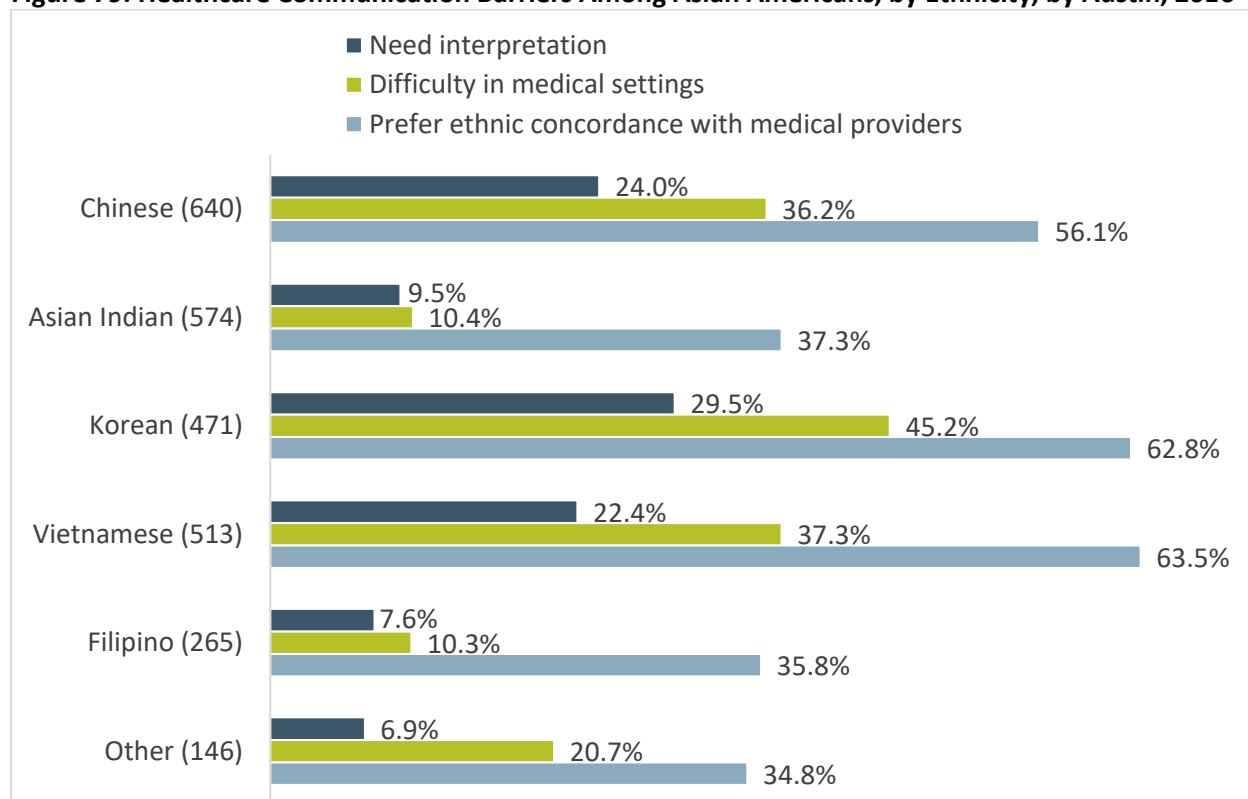
A **lack of bilingual health providers** and **interpretation services** emerged as a health care barrier among some focus group participants and community leaders, including in primary care and specialty services and home health assistance. One bilingual focus group participant noted that while it is not their responsibility, they are often called up on to provide ad hoc interpretation services in clinical settings, and observed delays in receipt of health care Spanish-speaking patients:

“Because I’m bilingual they look for me, ‘Hey, can you translate’ then I say ‘Yes but... is there no one in your department that can do that?’ [They say] ‘No.’ Let’s say that in a clinic with 100 people I am the only one that can translate. It depends on whether the person is a patient, or whether they are looking for health services, I feel that they could lack certain types of people that could interpret. They do find them, but there is a higher waiting time to receive medical care if the person only speaks Spanish.” – Focus Group Participant

Another community leader shared, “It is difficult to find home health aides that speak their language.” Notably, one focus group participant noted that a health care clinic they frequent regularly employs bilingual staff: “There are more bilingual people in the clinics we visit. [...] There are bilingual people working there all the time.”

Healthcare communication barriers among Asian Americans in Austin are depicted in Figure 79. For each aspect of healthcare communication, Chinese, Korean, and Vietnamese respondents reported the highest level of healthcare communication barriers. About three-fifths of Vietnamese (63.5%) and Korean (62.8%) respondents and more than half of Chinese respondents (56.1%) reported preferring ethnic concordance with medical providers. More than one-fifth of Korean (29.5%), Chinese (24.0%), and Vietnamese (22.4%) respondents report needing interpretation services in healthcare settings. Additionally, more than two-fifths (45.2%) of Korean respondents and one-third of Vietnamese (37.3%) and Chinese (36.2%) respondents report experiencing difficulty in medical settings.³³

Figure 79. Healthcare Communication Barriers Among Asian Americans, by Ethnicity, by Austin, 2016



DATA SOURCE: Asian American Quality of Life Survey, 2016

Additional Healthcare Services

Some community leaders and focus group participants described dental care in the region as very limited, particularly for low-income residents, and cited limited funding for dental care as a critical barrier to promoting oral health. One focus group participant described how **lack of access to dental care** affected oral health and was also linked with other health outcomes: *“If you don’t get those services, you can’t eat or chew. If you have cavities that can get into your heart.”* Another community leader characterized the difficulties of getting dental care and the severity of oral health issues that low-income residents experience, which they also noted affects nutrition:

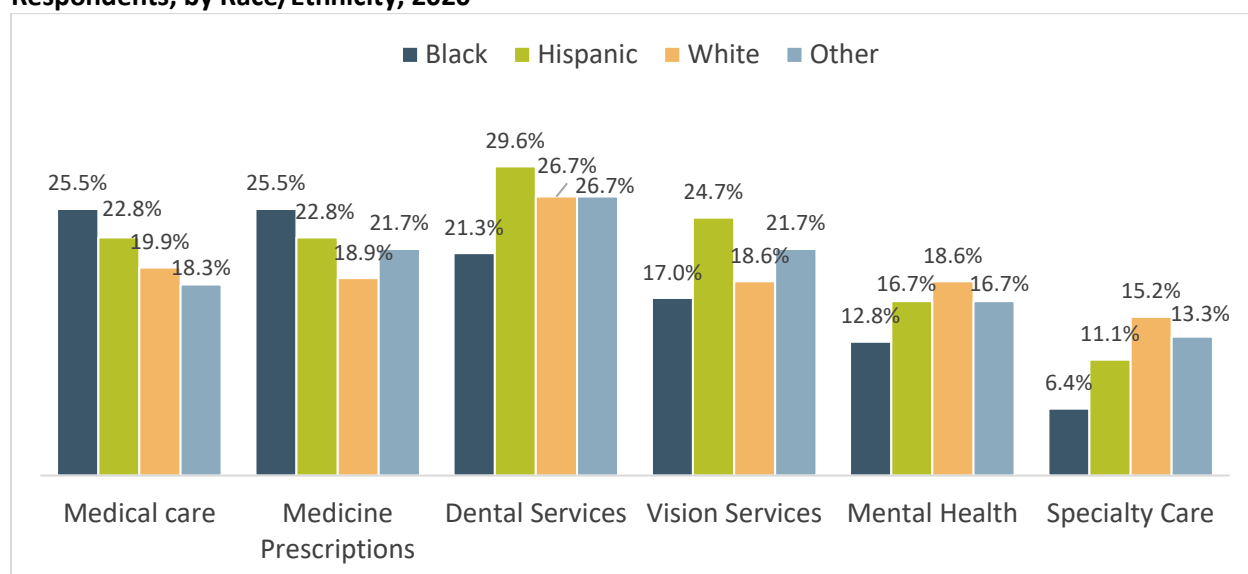
“Dental is ginormous. [It] [s]eems like you have to wait forever to get in if you need dental work. If their teeth are all pulled, which is usually the case, they get the cheapest dentures (about \$250) where they are incompatible. The quality of these dentures is very low. Our neighbors deserve comfortable teeth. Having such discomfort provides difficulty and challenge in obtaining adequate nutrition if they are in pain from chewing.” – Community Leader

Access to optometry and/or ophthalmology providers and glasses emerged as an unmet need for homeless residents and low-income residents of color. One focus group participant shared: *“What a Hispanic person struggles with most, it’s finding an eye doctor or a dentist because we don’t have medical insurance and these services are very expensive for us.”*

Some community leaders and focus group participants discussed the need for more specialized providers, including those who specialize in caring for older adults. Community leader described the patchwork of systems designed to fill gaps in specialty care, such as oncology, for low-income adults and noted that a systems change is needed given the multitude of health conditions among low-income residents that necessitate the care of a specialist.

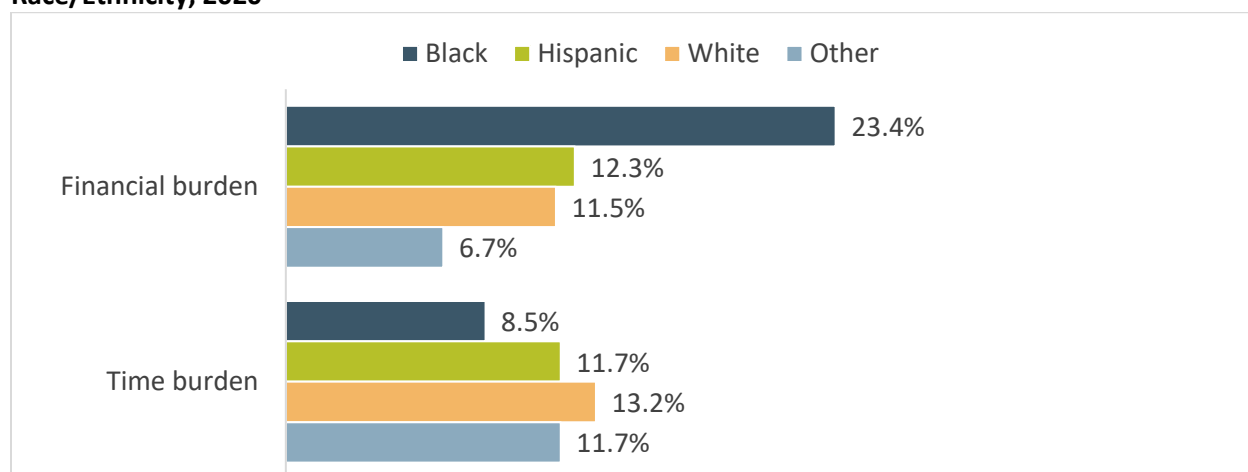
According to Austin Area Community Survey respondents, about 29.6% of Hispanic/Latino respondents and 26.7% of White respondents were not able to access dental services (Figure 80). Approximately 25.5% of Black/African American respondents reported being unable to receive medical care and medical prescriptions. Nearly one-quarter (24.7%) of Hispanic/Latino respondents noted an inability to access vision care. The cost of healthcare and insurance and the time burden in accessing care were the most cited barriers to healthy living (Figure 81). More than one-fifth of Black respondents cited financial burden (23.4%) as a barrier, followed by 12.3% of Hispanic and 11.5% of White respondents; time burden was also cited as a barrier, with highest percentages of White (13.2%), Hispanic and Other race/ethnicity (11.7%) populations considering time a barrier.

Figure 80. Percent Unable to Receive Healthcare Services among Austin Area Community Survey Respondents, by Race/Ethnicity, 2020



DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2020

Figure 81. Barriers to Healthy Living among Austin Area Community Survey Respondents, by Race/Ethnicity, 2020



DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2020

Delays in Health Care Use Due to the COVID-19 Pandemic

Some focus group participants and community leader described **delays in accessing health care services** and screenings due to the COVID-19 pandemic, which they noted may have consequences for late diagnoses of health conditions. One focus group participant shared their experience of delays in preventive services: *“You can’t get medical checkups as often as we used to. I haven’t had a mammogram in a couple years because COVID impacted the health system.”* A community leader also highlighted the consequences of the COVID-19 pandemic on the delivery of preventive care services and early detection of medical conditions because health care settings have been operating at limited patient capacity:

“Currently, because of COVID a lot of our patients have fallen behind on wellness visits. During peak of COVID, no one was brought into the building at all. It was not possible to do well-child, well-women visits to get people caught up. Otherwise, you’ll end up with more severe diagnoses later on like cancer in later stages.” – Community Leader

Vaccinations emerged as another gap in health care that was aggravated by the COVID-19 pandemic. One community leader shared how updating residents on their vaccinations needs to be a priority: *“For general health, it is about getting people back for regular wellness checks, doing vaccines and boosters and working the way everyone else is to get people immunized.”* Residents noted that it was important to build upon strategies to bring health care services in to the community, including making vaccination sites available beyond the walls of doctor’s offices.

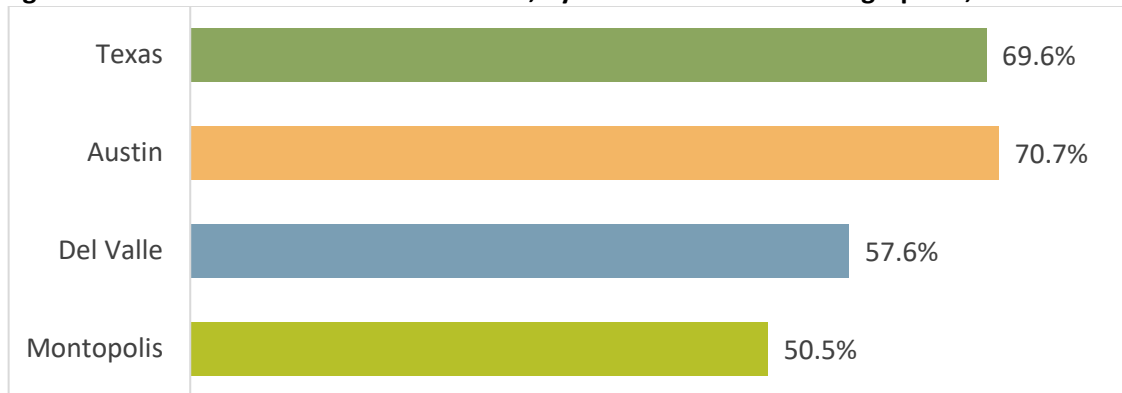
One community leader described significant strains of the COVID-19 pandemic on health care providers and staff, which affects the overall health care system. This community leader observed declining **morale among health care providers** and staff and the **outmigration of providers** and staff from the field. They perceived that long work hours and changing needs throughout the COVID-19 pandemic added to the difficulties of the high cost of living in the region, as well as some staff’s opposition to vaccine mandates, may have contributed to an exodus of trained staff and the need to increase wages. They shared:

“At the outset of COVID, there is this real esprit de corps where people in a crisis worked together where people worked long hours, and experienced fast changes. I was extremely proud of the organization and all we were able to accomplish. But, the longer something drags on, and more changes, and more anxiety there is, it takes a real toll on personnel. A lot of people are leaving healthcare and looking for other jobs. There is high turnover and hard to fill positions. We have had to raise base pay. [...] A lot of our frontline can’t afford Austin anymore and do not live in Austin. So they are left with longer commutes.” – Community Leader

Preventive Care

While the percent of adults who reported receiving cholesterol screening in Austin (70.7%) was similar to the state average (69.6%), just over half of adults in Del Valle (57.6%) and Montopolis (50.5%) reported receiving screening for cholesterol (Figure 82).

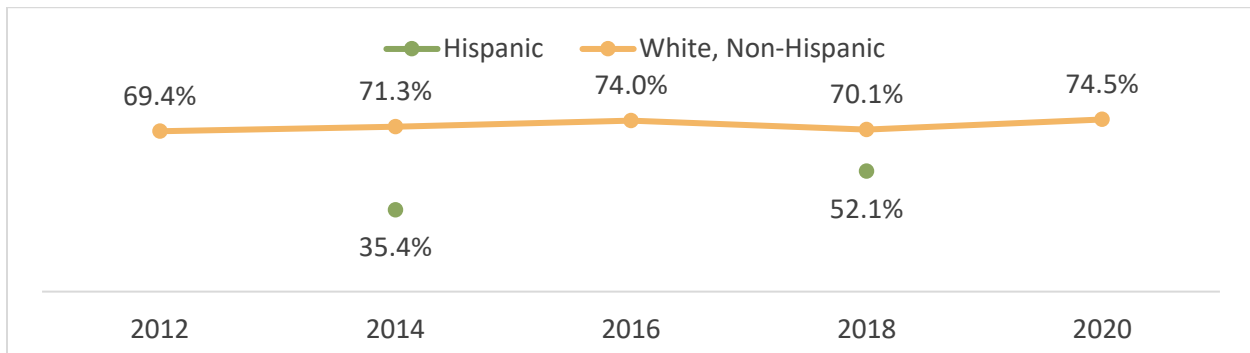
Figure 82. Percent Screened for Cholesterol, by State and Selected Geographies, 2018



DATA SOURCE: CDC 500 Cities, 2018

About two-thirds of male (65.7%) and female (68.6%) residents in Travis County reported being up-to-date on colorectal cancer screenings in 2020; this percent increased slightly since 2012 (62.0% and 61.3%, respectively). When examining self-reported up-to-date colorectal cancer screenings by race/ethnicity, in 2018 about 70.1% of White adults reported having an up-to-date colorectal screening compared to just half (52.1%) of Hispanic/Latino adults (Figure 83). When stratified by age groups, only two-thirds (66.6%) of adults aged 50-64 reported having up-to-date colorectal screenings compared to more than four-fifths (87.2%) of those 65-75 years of age (Figure 84).

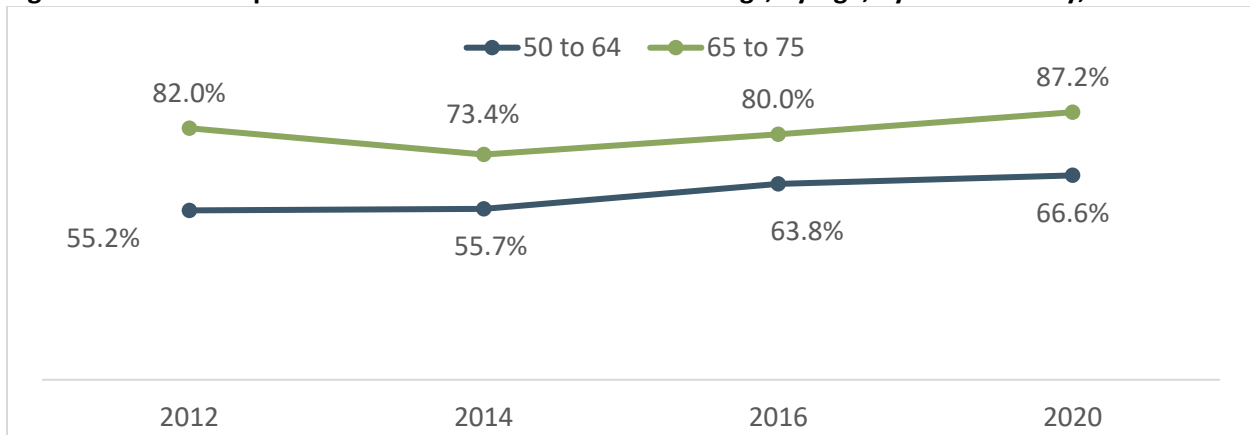
Figure 83. Percent Up-to-Date on Colorectal Cancer Screenings, by Race/Ethnicity, by Travis County, 2012-2020



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2012-2020

NOTE: Missing data points indicate unreliable data.

Figure 84. Percent Up-to-Date on Colorectal Cancer Screenings, by Age, by Travis County, 2012-2020



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2012-2020

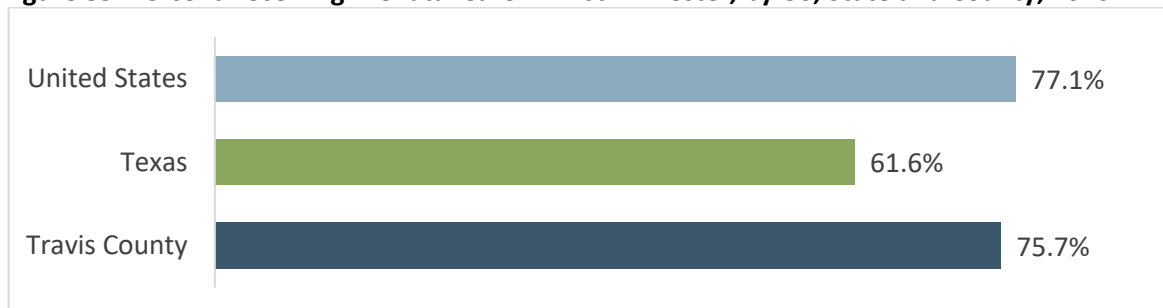
NOTE: The indicator's corresponding question was not asked in the 2018 BRFSS Survey.

Some focus group participants mentioned the importance of vaccines for supporting health, and references to vaccines were both general and specific to COVID-19. When asked about things that keep them healthy, one focus group participant shared: *“Get your yearly flu shot, vaccines you need to keep safe. Take consideration of if there is a vaccine that will help you, it’s in your best interest to get it.”* One focus group participant noted a need to improve access to immunizations for children and another focus group participant linked low vaccination rates to medical mistrust and barriers to accessing health information.

Women’s Health Care

In 2016, about three-quarters (75.7%) of childbearing individuals in Travis County reported receiving prenatal care in the first trimester, which is similar to patterns across the US (77.1%) and above prenatal care patterns for Texas (61.6%) (Figure 85).

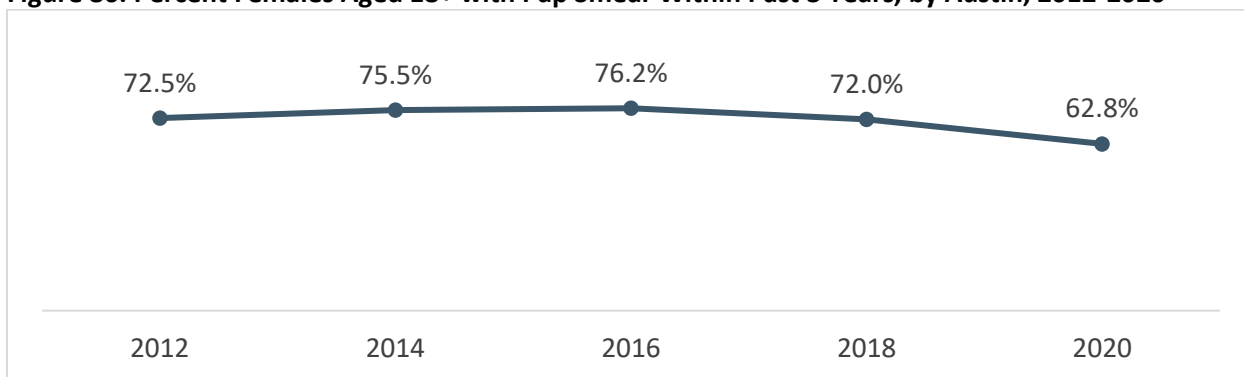
Figure 85. Percent Receiving Prenatal Care in First Trimester, by US, State and County, 2016



DATA SOURCE: Texas Health and Human Services, Vital Statistics Annual Report, 2020

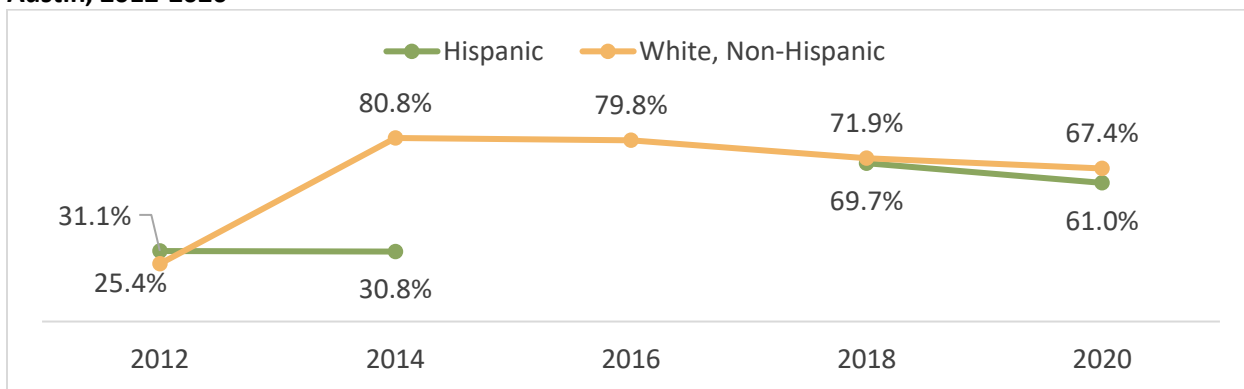
Around three-fifths (62.8%) of females aged 18 and over reported having a pap smear within the past 3 years in Austin in 2020, marking a decline from pap smear patterns in 2012 through 2018 (Figure 86). When examining pap smear patterns by race/ethnicity, in 2020 a slightly higher percentage of White females (67.4%) reported having a pap smear compared to Hispanic/Latino females (61.0%) (Figure 87). Notably, reported pap smear tests increased among Hispanic/Latino females, from a low of 30.8% in 2014 to a high of 69.7% in 2018 (in years in which data were available). When stratified by age groups, a higher proportion of females 30-44 years of age (73.0%) and 45-64 years of age (71.8%) reported having a pap smear compared to females 18-29 years of age (49.9%) and females over 65 years of age (46.2%) (Figure 88).

Figure 86. Percent Females Aged 18+ with Pap Smear Within Past 3 Years, by Austin, 2012-2020



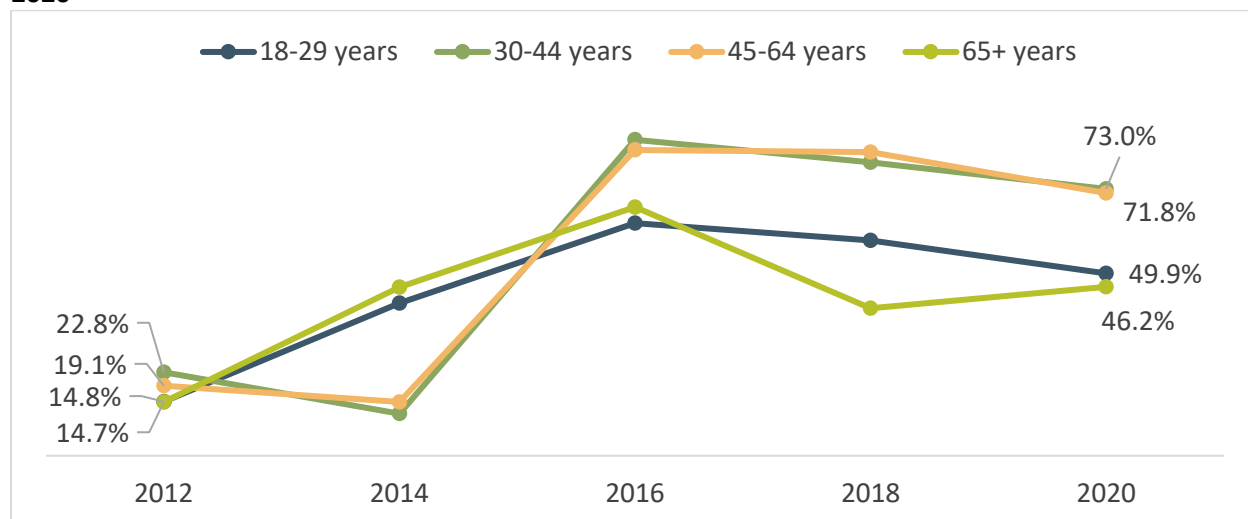
DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2012-2020

Figure 87. Percent Females Aged 18+ with Pap Smear Within Past 3 Years, by Race/Ethnicity, by Austin, 2012-2020



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2012-2020

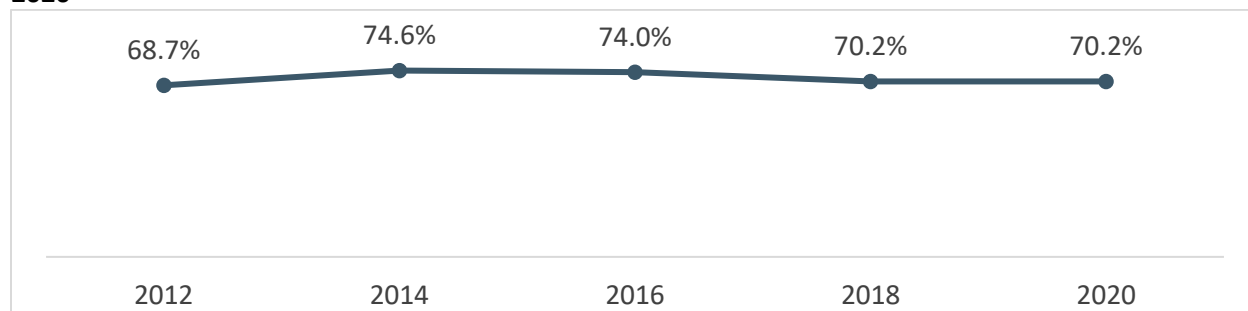
Figure 88. Percent Females Aged 18+ with Pap Smear Within Past 3 Years, by Age, by Austin, 2012-2020



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2012-2020

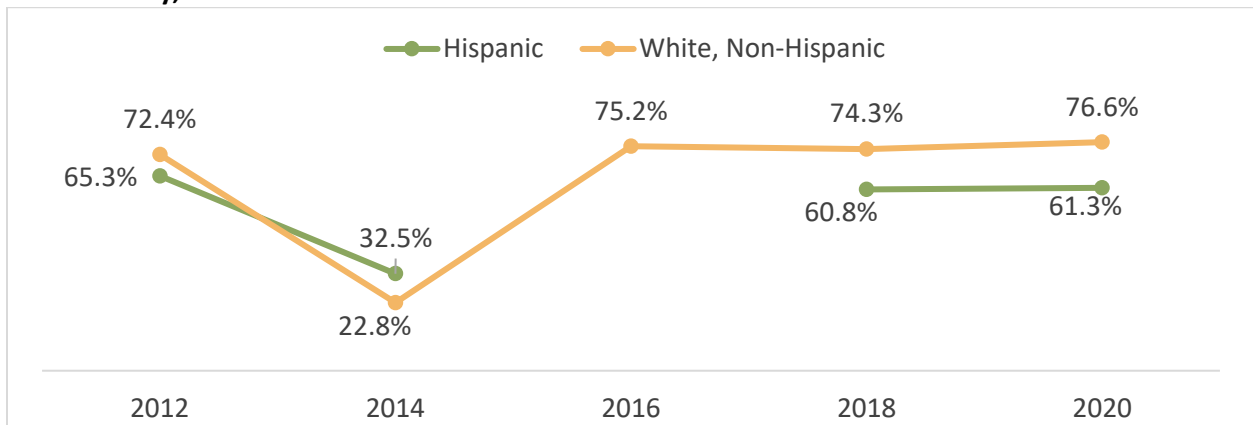
About 70.2% of females aged 40 and over reported having a mammogram within the past 2 years in Austin in 2020, compared to 68.7% in 2012 (Figure 89). When examining the percent of females who reported receiving a mammogram by race/ethnicity, a slightly higher percentage of White females (76.6% in 2020) reported having a mammogram compared to Hispanic/Latino females (61.3% in 2020) (Figure 90). When stratified by age groups, in 2020 81.0% of females aged 65 and older reported having a mammogram compared to 70.4% of females 40-64 years of age (Figure 91).

Figure 89. Percent Females Aged 40+ with Mammogram Within Past 2 Years, by Travis County, 2012-2020



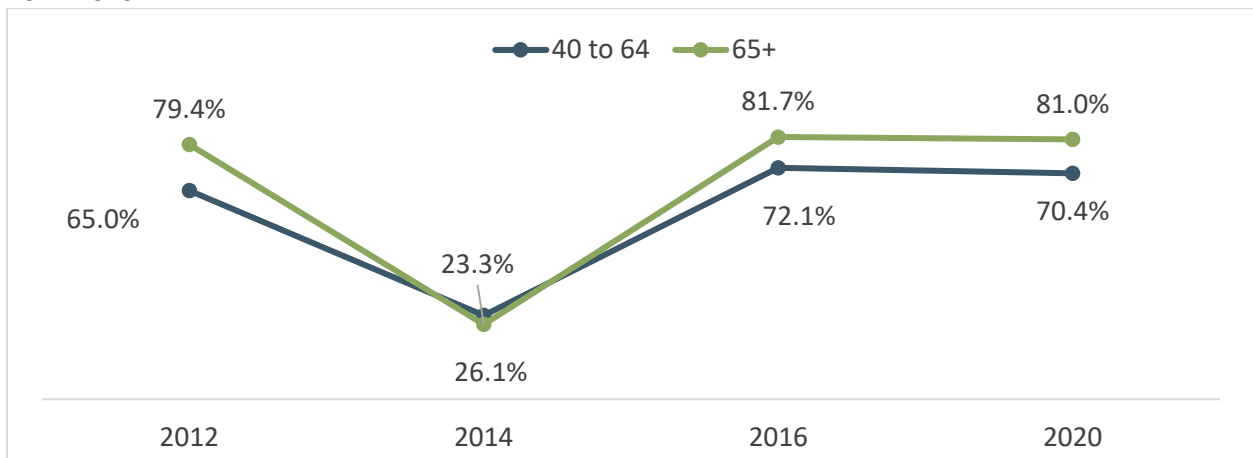
DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2012-2020

Figure 90. Percent Females Aged 40+ with Mammogram Within Past 2 Years, by Race/Ethnicity, by Travis County, 2012-2020



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2012-2020

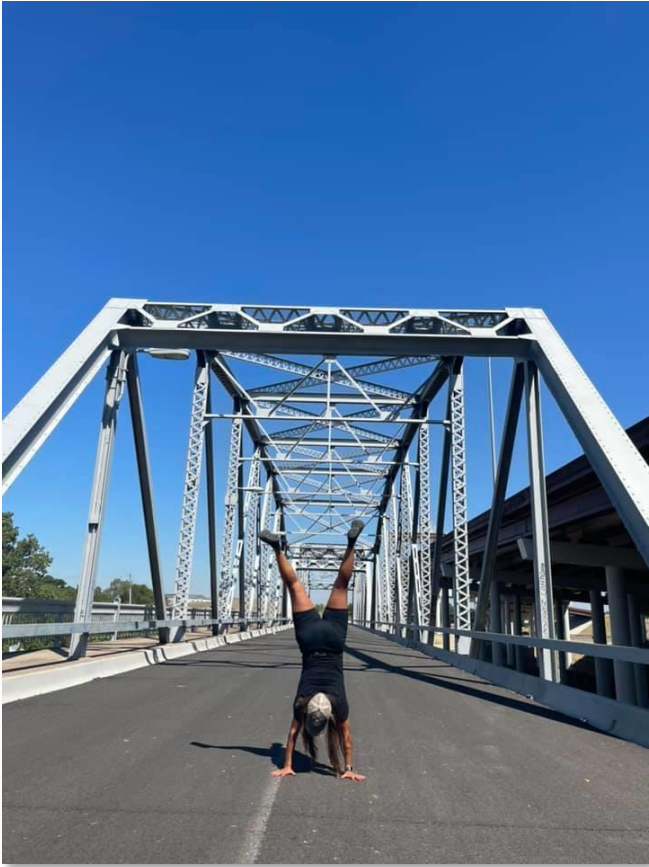
Figure 91. Percent Females Aged 40+ with Mammogram Within Past 2 Years, by Age, by Travis County, 2012-2020



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2012-2020

NOTE: The indicator's corresponding question was not asked in the 2018 BRFSS Survey.

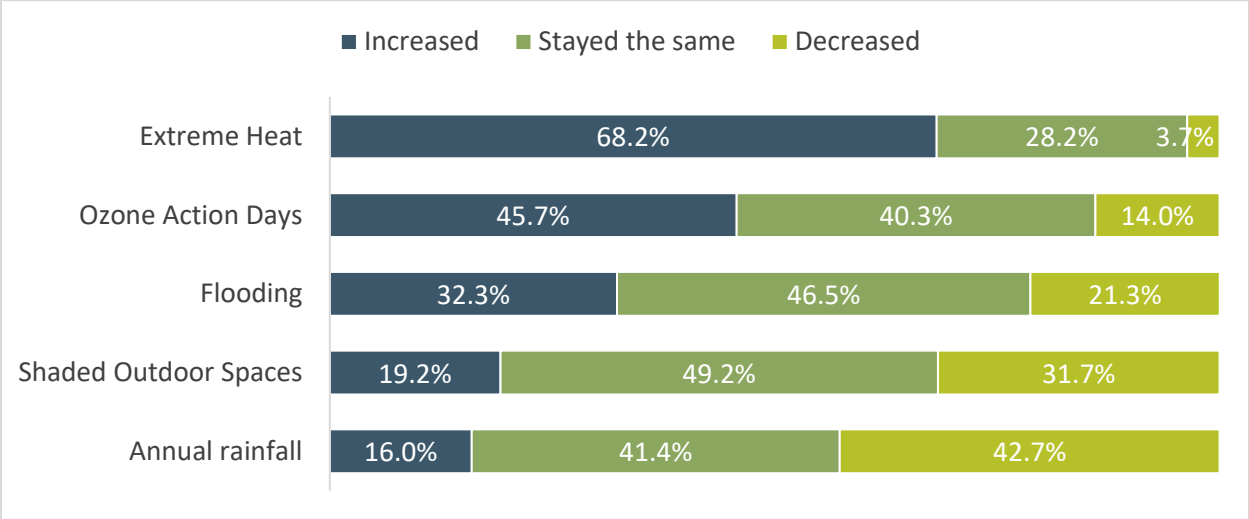
FINDINGS: EMERGENCY PREPAREDNESS



EMERGENCY PREPAREDNESS

When Austin Area Community Survey respondents were asked their perception of increases in types of emergencies, the majority of respondents indicated that they believed there was an increase in extreme heat (68.2%); followed by ozone action days (45.7%) and flooding (32.3%) (Figure 92). Relatedly, respondents perceived a decrease in annual rainfall (42.7%) and shaded outdoor spaces (31.7%).

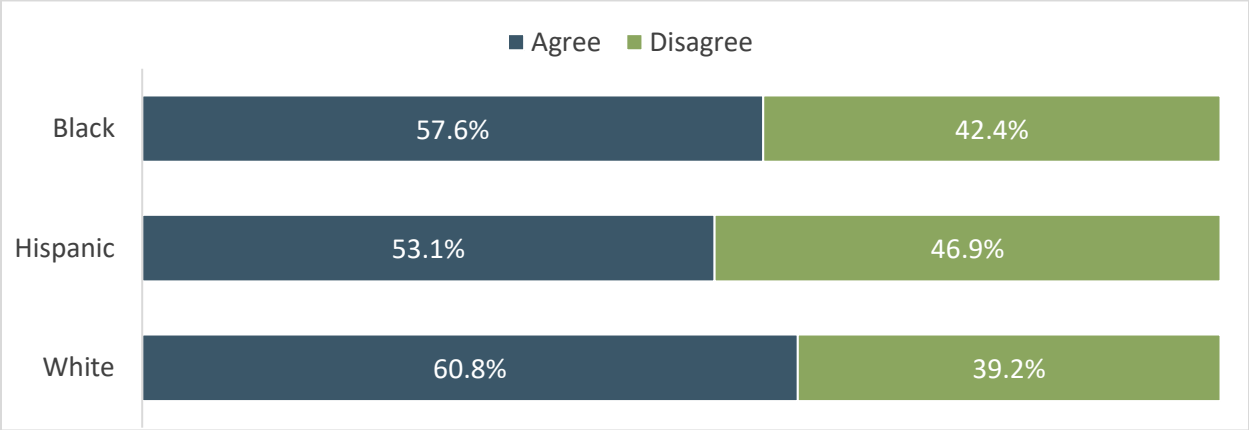
Figure 92. Percent Perceived Increase in Emergencies among Austin Area Community Survey Respondents, 2018



DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2018

Among Austin Area Community Survey respondents, about three-fifths (60.8%) of White respondents agreed that they had a safe place to shelter; this was slightly lower among Black/African American (57.6%) and Hispanic/Latino respondents (53.1%) (Figure 93).

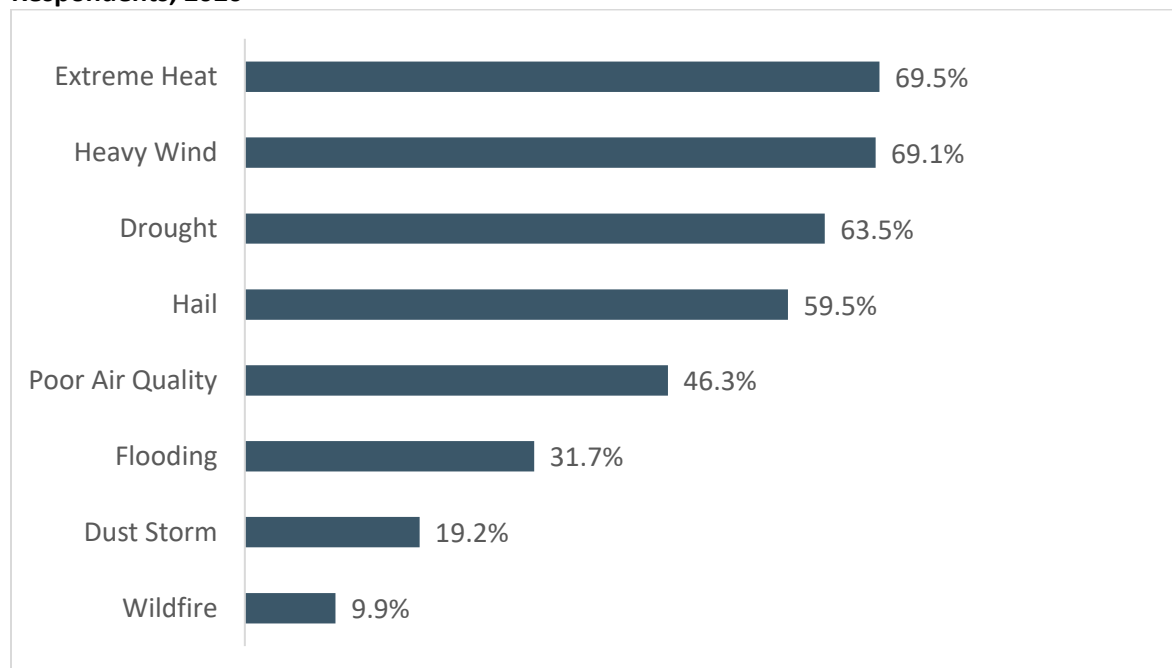
Figure 93. Percent with Safe Place to Shelter among Austin Area Community Survey Respondents, by Race/Ethnicity, 2020



DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2020

Among Austin Area Community Survey respondents, the majority reported experiencing emergencies of extreme heat (69.5%), heavy wind (69.1%), drought (63.5%) and hail (59.5%) in the last 10 years (Figure 94).

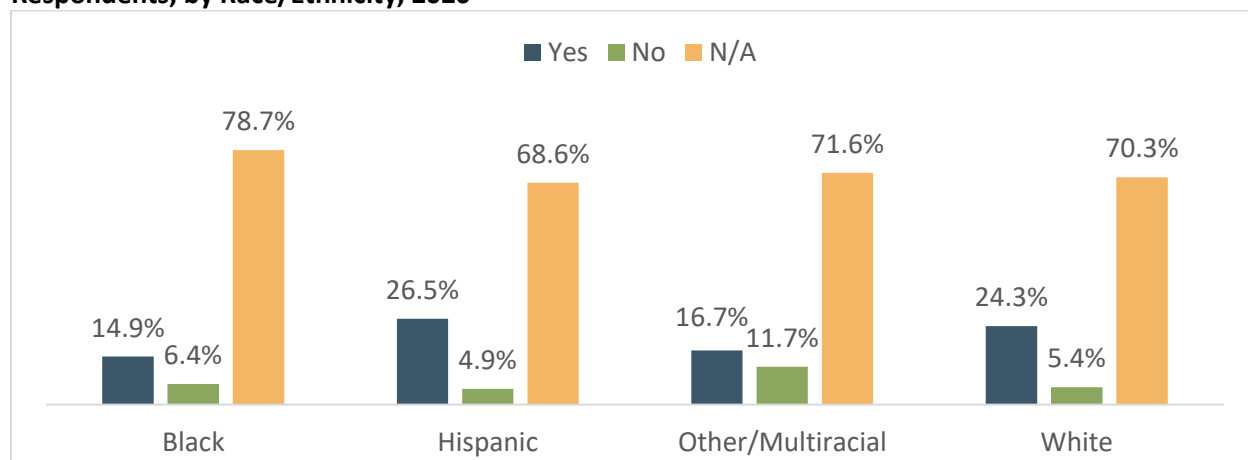
Figure 94. Percent Experienced Emergency in Last 10 Years among Austin Area Community Survey Respondents, 2020



DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2020

Among Austin Area Community Survey respondents Hispanic (26.5%) and White (24.3%) respondents represented the highest proportion of respondents who were registered to receive alerts (Figure 95); among all race/ethnicities, the majority of respondents had not signed up for or did not answer the question which could mean they are not signed up to receive alerts.

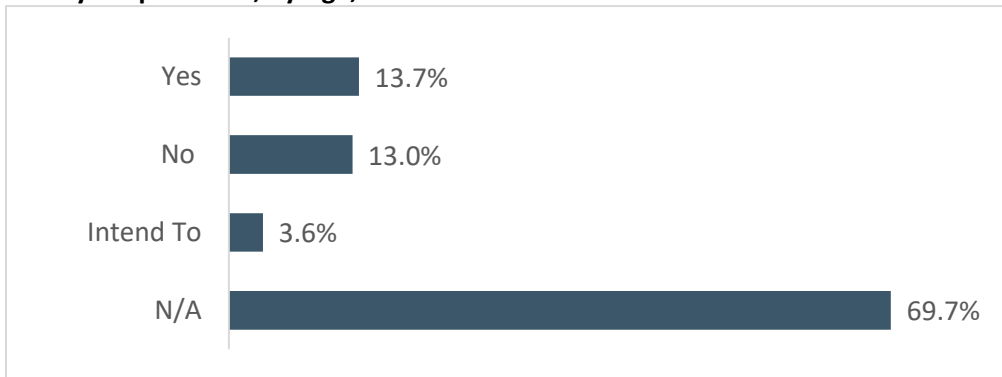
Figure 95. Percent Registered to Receive Emergency Alerts among Austin Area Community Survey Respondents, by Race/Ethnicity, 2020



DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2020

NOTE: N/A represents not applicable, signifying that the respondent did not respond to question.

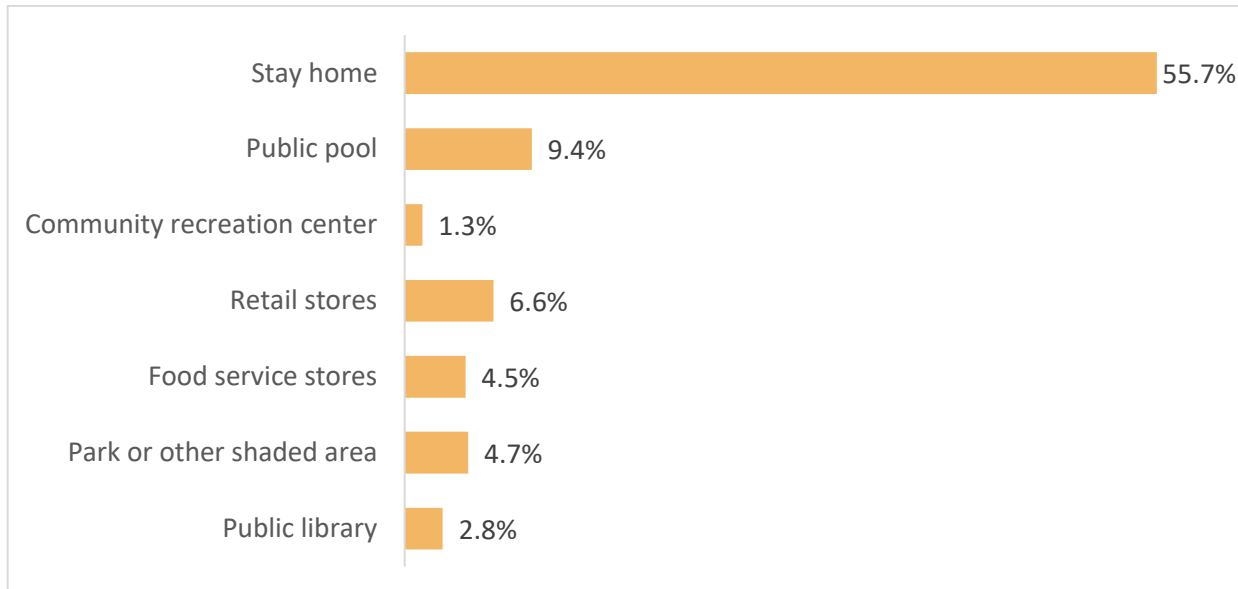
Figure 96. Percent With a Household Disaster Preparedness Plan among Austin Area Community Survey Respondents, by Age, 2018



DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2018

When asked about preferred locations to be during extreme heat, the majority of respondents across all age groups indicated that they preferred to be at home during extreme heat (Figure 97). The second choice for seeking reprieve during extreme heat varied by age, with younger adults and respondents 65+ years of age preferring a public pool and respondents aged 45-54 and 55-64 years of age preferring retail stores.

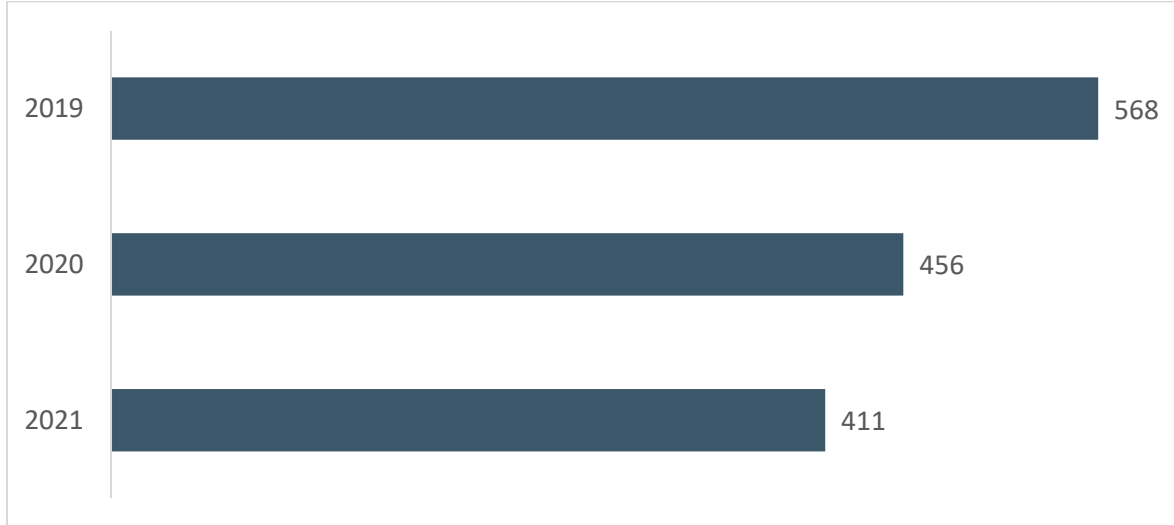
Figure 97. Preferred Locations in Extreme Heat among Austin Area Community Survey Respondents, 2020



DATA SOURCE: Austin Area Sustainability Indicators, Austin Area Community Survey, 2020

Among Travis County hospitals, there were 568 emergency department visits related to heat in 2019, 456 in 2020 and 411 in 2021 according to data from Travis County Hospitals.³⁴ These visits represent patients who had an initial complaint, concern or discharge related to heat and likely represent severe cases.

Figure 98. Emergency Department Visits Related to Heat, by Travis County Hospitals, 2019-2021



DATA SOURCE: Travis County Hospitals, Biosense Platform, 2019-2021

NOTE: These numbers represent people who visited emergency rooms with either an initial complaint or discharge related to heat. This isn't considered diagnostic, and these cases are likely more severe, necessitating hospitalization.

FINDINGS: COVID-19

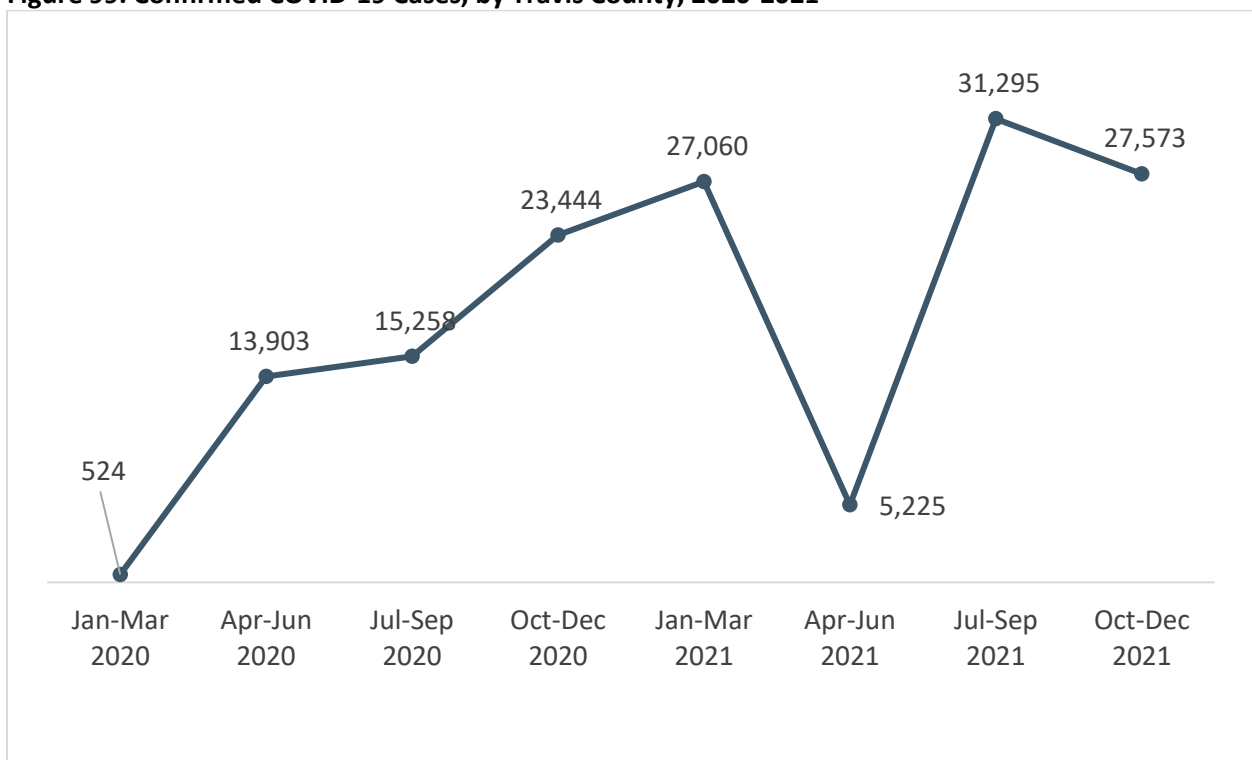


COVID-19

COVID-19 is a contagious respiratory disease caused by SARS-CoV-2. On March 6th, 2020, the City of Austin declared a disaster and the city confirmed its first COVID-19 cases on March 13, 2020, and its first fatality two weeks later.³⁵ In the two years that followed, the COVID-19 pandemic has had substantial impact on the lives of residents in Austin and Travis County.

From January to March 2020, there were around 524 confirmed cases of COVID-19 in Travis County. Confirmed COVID-19 cases fluctuated throughout the rest of 2020 and 2021: confirmed COVID-19 cases increased through December 2020, reached a low point in April-June 2021, then rose to the highest number of confirmed cases in July-September 2021 (Figure 99). Deaths due to COVID-19 followed a similar pattern, with the highest number of deaths in a three-month period occurring July-September 2021 (285 deaths) (Figure 100).

Figure 99. Confirmed COVID-19 Cases, by Travis County, 2020-2021



DATA SOURCE: Austin Public Health, Texas Department of State Health Services, 2020-2021

Figure 100. Confirmed COVID-19 Deaths, by Travis County, 2020-2021



DATA SOURCE: Austin Public Health, Texas Department of State Health Services, 2020-2021

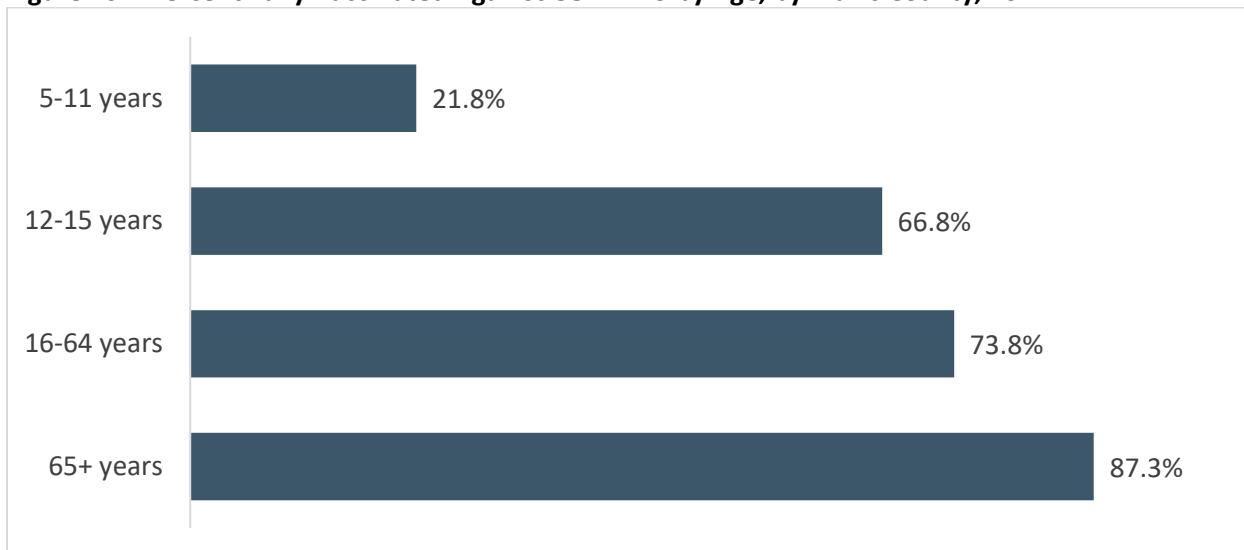
Some focus group participants mentioned that they got sick with COVID-19 early in the pandemic and in one case a focus group participant mentioned getting sick with COVID-19 more than once. One focus group participant described the long-lasting effects of COVID-19 on their health and finances:

“Well it has impacted us really hard, unfortunately I got COVID. I was in the hospital for almost three months. You do lose a lot of control. Financially, mentally, in every aspect. But we are getting out of it little by little and recovering as well. Because after COVID, you are not the same. [...] I struggle to walk, I feel my legs, I don't have strength in my hands. No, it's a whole thing... I'm using oxygen at night. It's not the same. It affected me - unfortunately.” – Focus Group Participant

“It will never go back to normal, there is no after-pandemic. [It] has made a huge impact and changed our lives. Somehow... there will be something on our minds and we'll never forget. It was impactful.” – Focus Group Participant

The percent of the Travis County population who received the COVID-19 vaccine as of December 2021 was highest among residents over 65 years of age (87.3%) and 16-64 years old (73.8%). Differences in COVID-19 vaccine completion patterns should be interpreted cautiously, as they may be influenced by vaccine eligibility requirements (Figure 101). At the time this reported was completed, vaccines were available for people 5 years and older.

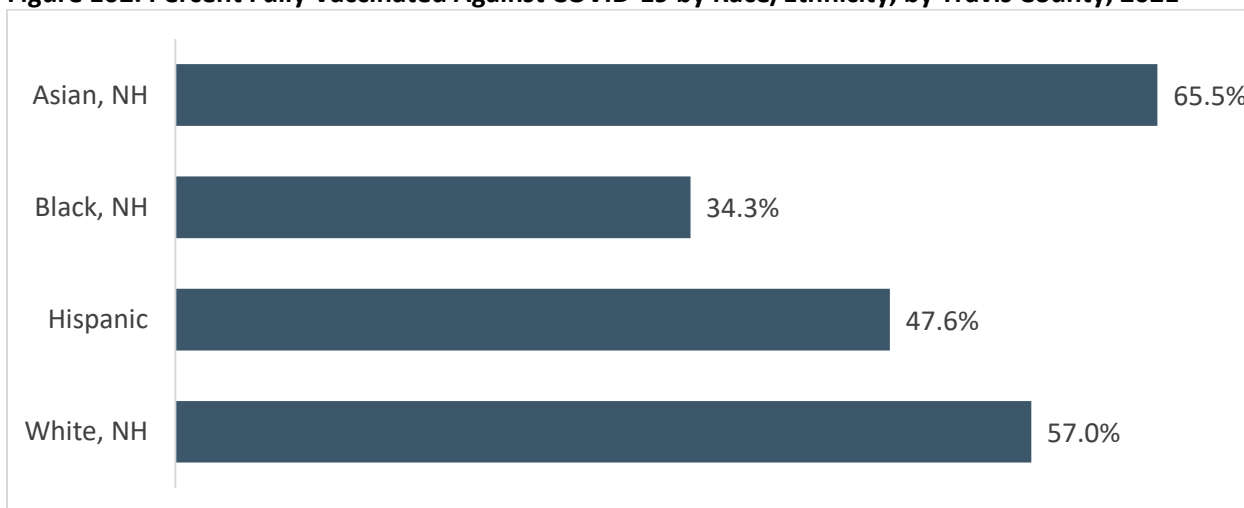
Figure 101. Percent Fully Vaccinated Against COVID-19 by Age, by Travis County, 2021



DATA SOURCE: Austin Public Health, Texas Department of State Health Services, 2021

In Travis County, COVID-19 vaccination completion was highest among Asian (65.5%) residents, followed by White residents (57.0%) and Hispanic/Latino residents (47.6%) and lowest among Black/African American residents (34.3%) in 2021 (Figure 102).

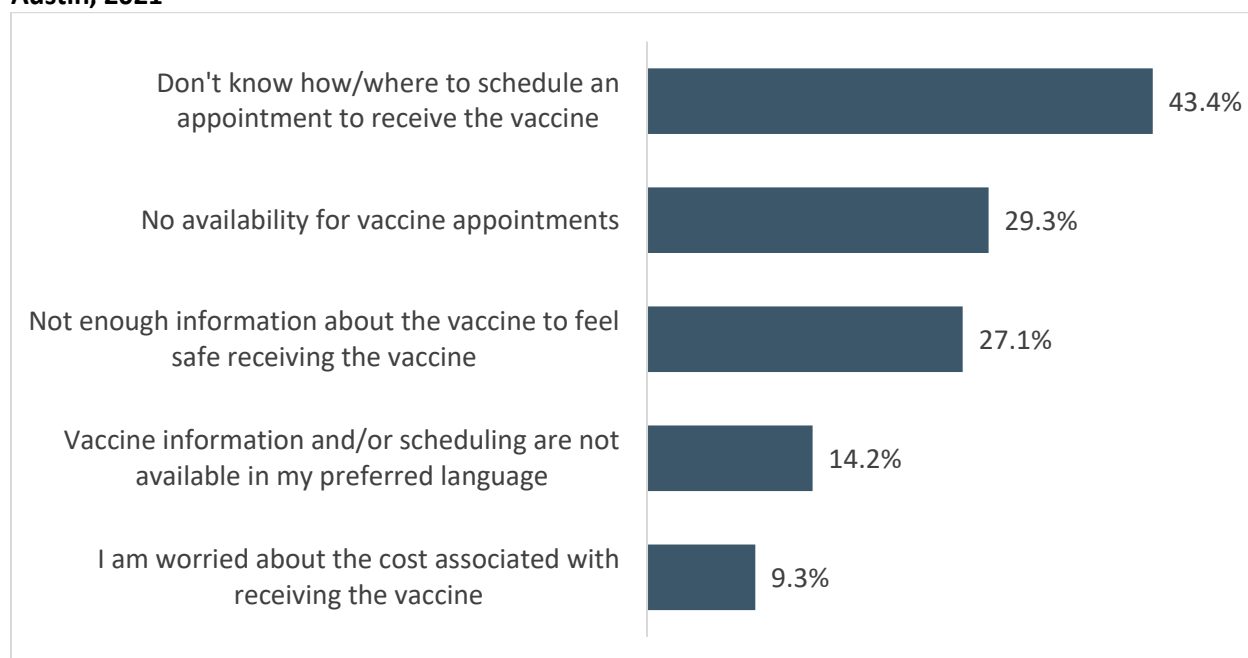
Figure 102. Percent Fully Vaccinated Against COVID-19 by Race/Ethnicity, by Travis County, 2021



DATA SOURCE: Austin Public Health, Texas Department of State Health Services, 2021

Among Asian Americans (according to the Austin Asian Community Health Initiative Survey³⁶), top barriers for accessing COVID-19 vaccines included not knowing how or where to schedule an appointment (43.4%) and no availability for vaccine appointments (29.3%) (Figure 103). About one-quarter (27.1%) of Asian American respondents identified having insufficient information about the vaccine as a barrier to feeling safe to receive the vaccine.

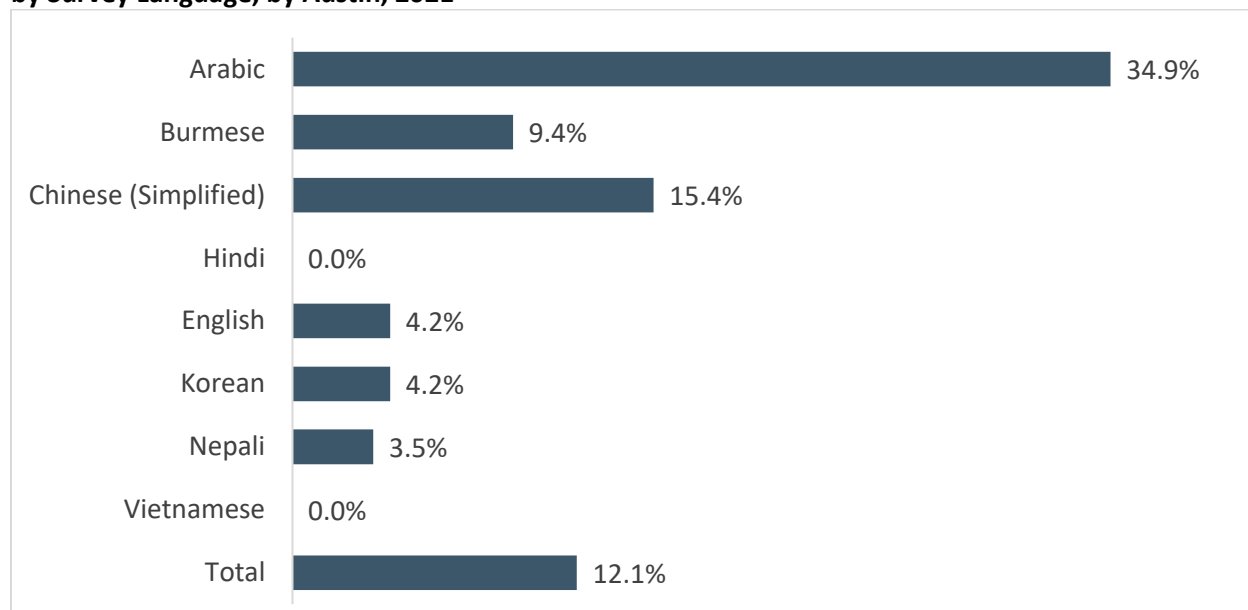
Figure 103. Top Barriers to Accessing COVID-19 Vaccines Among Asian American Population, by Austin, 2021



DATA SOURCE: Austin Asian Community Health Initiative Survey, 2021

Among Asian American respondents (according to the Austin Asian Community Health Initiative Survey), disinterest in getting the COVID-19 vaccine was highest among Arabic (34.9%) and Chinese (15.4%) residents (Figure 104).

Figure 104. Percent Not Interested in Receiving COVID-19 Vaccines Among Asian American Population, by Survey Language, by Austin, 2021



DATA SOURCE: Austin Asian Community Health Initiative Survey, 2021

Community Perceptions of the COVID-19 Pandemic

Managing Ongoing COVID-19 Risks

COVID-19 **safety precautions**, such as wearing a mask, practicing physical distancing in public, avoiding large crowds, and frequent hand washing, emerged among residents as important steps to prevent the spread of the virus that causes COVID-19. One in-depth interview participant characterized COVID-19 safety measures as critical to health: *“Health is also about safety. In particular, safety given the pandemic right now, the first thing that comes to mind when I think about health is COVID, like safety measures, washing hands, and things like that.”* Additionally, one older adult focus group participant described the importance of taking protective measures such as staying home and keeping a safe distance, particularly to protect the health of older adults, though at the cost of social isolation: *“You just have to stay isolated. You’re going to have to go out, but then you’re paranoid. Greg Abbott should shut some of this down. At our age, we can get it faster. Right now, you’re trying it on us. If you’re older it’s a paranoid thing.”*

When probed about safety, several Hispanic/Latino focus group participants cited the importance of continuing to practice COVID-19 safety measures such as wearing a face mask. One focus group participant shared: *“Specifically, now with COVID [s]afety, I take precautions, even though I have my shots I still wear my mask. Thinking of safety, not only for yourself but for other people.”* Another focus group participant described the steps that they take to protect themselves and their family during the pandemic: *“I continue to do the things the same, wear my mask when I am supposed to. Trying not to go home with the virus, staying healthy and away from groups of people. Take whatever medication I need to, to stay healthy.”* One focus group participant highlighted how they feel less safe in public now that distancing and masking requirements are relaxed and there are highly contagious variants circulating, despite being vaccinated:

“It was getting better because I was getting out a little more after getting vaccinated, now we’re in Stage 5, I’m having more problems, because I know there’s a Delta variant, and there’s a real risk involved. I go to the stores, and I’m finding not everyone’s back to wearing masks, it’s almost like I have to isolate all over again.” – Focus Group Participant

Some older adult focus group participants expressed concern about others not taking COVID precautions. One older focus group participant described how they did not feel safe with lax masking practices in their apartment complex. This participant explained, *“[People are] [g]etting in the elevator unmasked. Happens every day in the resident building.”* Participants also shared how they felt disrespected when others did not practice COVID-19 safety measures and felt that safety came down to a matter of personal responsibility.

COVID-19 Pandemic Worsens Economic Suffering

Several participants noted that the COVID-19 pandemic has worsened economic suffering for residents, which they characterized as ongoing and long lasting. One focus group participant explained:

“Things were not too great beforehand. [...] [M]aybe during COVID, but I think happening before, younger people having to move in with their

families because of cost of living, inflation, and low-pay rates. There was a lot going on before COVID and it got pushed behind because [...] the virus [...] add[ed] to poverty and a whole lot of other things.” – Focus Group Participant

According to residents, **job loss and reduced work hours** were some of the primary ways in which the COVID-19 pandemic affected income. Additionally, some residents mentioned not being eligible for, but needing, stimulus checks, or experiencing a disruption in work hours. One participant who described the lasting impact of both reduced work hours and delayed stimulus payments: *“I had to get my car repossessed because I didn’t have enough money between hours cutting back and late stimulus checks.”*

One focus group participant described how the economic toll of the pandemic made it additionally challenging to access and eat healthy food due to the economic impact and many losing their jobs. Another focus group participant described how the stress of making ends meet and feeding one’s family in the COVID-19 pandemic affect health: *“It adds up, mental health, stress... not having enough money, not having food on the table, all this at the end of the day, it will impact your health. Little by little we might focus on something, but if you keep adding, your health itself is being impacted at large.”*

Social Isolation and Social Support During the COVID-19 Pandemic

Social isolation emerged as a key theme when discussing the COVID-19 pandemic. According to several focus group participants, the need to stay at home and **avoid gatherings** increased social isolation, including connection with family, friends, and neighbors, and access to tangible forms of support that they would typically share, such as emotional support, information, and meals.

“I feel isolated. My daughter comes to stay with me once in a while, but I’m a widow, my husband passed away a year ago. So you feel isolated, I do. I have a lot of friends and we call each other and try to keep it touch so you don’t feel so by yourself. But it has made it harder because you can’t go out and meet with your friends.” – Focus Group Participant

Some focus group participants shared how **losing access to established gathering** opportunities and spaces to connect with neighbors contributed to their isolation. As one focus group participant explained: *“Another thing we saw, some of these elderly properties [...] [were not] permitting visitors or socializing in common areas. I can understand that, but at the same time you now have isolated elderly who are falling into bigger depression because they can’t have family visiting to drop of meals or come for holidays.”*

Churches emerged as an important source of support during the COVID-19 pandemic, and some focus group participants described phone and video calls as important ways to stay connected to church members and church services. *“There is always someone in my [church] group that we can call and talk to each other, bring ourselves up, my church and my friends have been a real good support.”*

COVID-19 Pandemic Affects Mental Health

Related to social isolation, according to several community leaders, focus group participants, and both in-depth interview participants, the need to practice physical distancing to prevent the spread of the virus that causes COVID-19 contributed to and/or **worsened mental health issues**. One focus group

participant recalled the mental health impacts on their community, “During COVID we couldn’t have our resident council meetings, so we miss fellowship, social gatherings. It meant a great deal to have that, by the time we did go out I would see people who would say they were depressed.” One interview participant observed the toll on their mental health and challenge of re-integrating socially as society opens back up, “COVID has made my depression worse, social isolation has been brutal. [...] Me trying to go back to normal now is way harder with being around other people.” One community leader cited **mental health assistance** as a key priority given the high levels of anxiety, depression, domestic violence, and family deaths in the community they serve.

One resident described the mental health impacts on children and their caregivers, which they anticipated also affects other chronic conditions:

“Everything that we hold on to and also our kids that couldn’t go to school last year [...]. All of that leads to a lot of depression [...] if they had a job or if they ate, how the rent was paid, one situation after another. And then having no access to healthcare. You are getting sick little by little inside, right? That is more mental health related [...] And everything is a little more complicated and everything happening now will lead in the long term to more chronic illnesses.” – Focus Group Participant

A community leader emphasized the importance of addressing the mental health of children in the aftermath of the COVID-19 pandemic:

“Mental health/behavioral health particularly through the year of COVID where kids were out of school and families [were] juggling multiple responsibilities. There is more kids in need of mental health support. I don’t have statistics, but my impression is that it’s true for adults as well.” – Community Leader

Some participants discussed **loss of loved ones** due to COVID-19. One community leader highlighted the importance of remembering the toll of losing loved ones due to the COVID-19 pandemic, particularly for communities who have been disproportionately impacted by deaths due to COVID-19. Another community leader described the need for a **public health approach to addressing the mental health** toll of the pandemic, ranging from intensive mental health services to counseling for children and adults alike.

Changing COVID-19 Information and Supporting Resources

Several focus group participants and community leaders described how the COVID-19 pandemic highlighted and worsened **barriers to accessing information** for lower-income residents and residents for whom English is not their primary language. Several residents described a need for more health information and for information about resources to promote health. As one focus group participant shared, “I think there are many resources, but I also think that we suffer due to a lack of information. Many of us don’t have the information and others also don’t inform us of the resources there are.”

A couple of community leaders described the **difficulties of delivering services** to and engaging with low-income residents when they needed to restrict the number of residents or patients who frequented

their building to minimize the risk of virus transmission. One community leader described the challenge of connecting residents with safety net resources when their community center was off-limits to residents due to the COVID-19 pandemic:

“Right now, it’s tough, and [I] understand the decision-making, but our community centers are not open to the public right now. And I do think that’s a concern for some people, because while people can still drop off [an] application, we’re lacking the ability to really provide effective [...] assistance for residents of Travis County. We don’t get them in our lobby and sit down with them and help them fill out applications. And that’s a COVID Barrier.” – Community Leader

Community-based organizations, food banks, and grassroots initiatives emerged as critical providers of COVID-19 information, COVID-19 resources (e.g., testing, vaccines), and food and rental assistance during the pandemic. Some focus group participants shared about transportation services or delivery of groceries for older adults.

Vaccine Distribution Efforts

Some focus group participants and several community leaders described initial COVID-19 vaccine distribution efforts as chaotic and initially overlooking low-income residents and residents of color. An older adult focus group participant described the **difficulties of trying to access the COVID-19 vaccine** when they became available to older adults given that vaccine scheduling systems were largely only available online:

“During the first part of the pandemic, when they first started offering vaccines through APH, if you didn’t have internet access you couldn’t really get on, you couldn’t call them and try to sign up and it was very hard to do even with internet access, so I think there should be an easier way for that to happen and a way to have it happen without using the internet.” – Focus Group Participant

Additionally, vaccine distribution efforts were impeded by Winter Storm Uri, including **physical damage to vaccine distribution sites** and the ability to preserve the vaccines during power outages and distribution delays.

Other barriers also included confusion about how to access vaccines: *“Not knowing where to search/where to go [for vaccines]. We were getting the information from other resources, word of mouth, nothing directly from a health clinic.”* One community leader observed **inequities in where COVID-19 vaccine sites were located** and how frequently vaccine sites were open, particularly for low-income communities and communities of color.

Despite these initial challenges, one focus group participant observed improved access to COVID-19 testing and vaccination as the pandemic has gone on: *“There have been more places to get tested for COVID and to get vaccinated It’s a good change.”* One focus group participant praised Austin Public Health’s (APH) collaboration with local community-based organizations to deliver COVID-19 and flu vaccines to residents, a novel model that made health care resources available to residents outside of clinics:

“I want to thank APH for collaborating with us and providing COVID/flu vaccines. The ability to bring vaccines to our sites has been great. It’s been a new thing, I’ve been with HACA for 3 years and it was a pivot with COVID, and right away we overcame the barriers of transportation.” – Focus Group Participant

Several community leaders representing community-based initiatives also noted that **small community-based institutions** were critical to ensuring that low-income residents and people of color had access to the COVID-19 vaccine. One community leader shared, *“And we noted that even when we did vaccination clinic, we had higher numbers if not the highest in the city for [number] of vaccinations given that day.”*

FINDINGS: WINTER STORM URI/EMERGENCY PREPAREDNESS



WINTER STORM URI/EMERGENCY PREPAREDNESS

In February of 2021, a series of winter and ice storms referred to as Winter Storm Uri impacted the Austin/Travis County area overlapping with the COVID-19 pandemic and drastically impacting individuals' access to power, water, transportation, access to communications, and livelihoods. At this time, emergency responses staff, residents, neighbors, community-based organizations, private sector groups all worked together to provide food, water, shelter, and other services. The winter storm lasted from February 10 through the 18th.³⁷

Ongoing Trauma from Winter Storm Uri

Some residents described Winter Storm Uri as traumatic, a trauma that they characterized as ongoing. Some also recalled significant health-related needs during the storm, which was worsened by uncertainty about the duration of the storm, power outages, and lack of safe, fresh water. As one focus group participant described:

"We weren't positive what the next day held. It was a scary moment for everyone. Being without power or water... electricity, cellphone. I didn't have a cellphone for 3-4 days. It was a second nightmare for some people. I have anxiety and depression and it was a scary time for myself and whole lot of other people." – Focus Group Participant

Another focus group participant described their anxiety and health needs during the storm: *"At one point I thought I was having a heart attack because of the anxiety."* Several older adult focus group participants also described trauma from the storm and characterized their trauma as ongoing, particularly with uncertainty about when the next storm or crisis will occur and what supports will be available.

Difficulties Meeting Basic Needs During Winter Storm Uri

One in-depth interview participant described their **struggle to meet basic needs** and their hunger during the storm, sharing: *"I didn't have money and the ATM was down, and when I went to the store to get gas there was no gas, so I starved through the winter storm."* Another focus group participant recalled their difficulty getting out of their house and making do with the limited food they had in stock during the storm.

Some residents described **food insecurity** during Winter Storm Uri as being traumatic and affecting children and adults, with one focus group participant noting the importance of ensuring kids had access to free lunch during the storm. One focus group participant described the emotional toll of food shortages during Winter Storm Uri:

"I sat down after the 3rd day and cried. I had people up in Philadelphia sending me packets. I waited in line at Trader Joe's for an hour and when I finally got to the front there was nothing. I came home and just cried." – Focus Group Participant

In addition to struggling to meet basic needs during the storm, some residents described a significant **financial toll** of Winter Storm Uri. For example, one focus group participant mentioned needing to take out a loan to cover electricity and other basic needs because of mounting costs and limited income linked with the COVID-19 pandemic and winter storm:

“Financially it did affect us a lot because we went 15 days without working and those are the only resources we have, the money we make is from working and well I do have many several bills to pay. And we asked for help with the electricity bill, because it was too high and nobody helped us, even though my wife is a citizen of the U.S. And she requested several [forms of support], but nobody listened.” – Focus Group Participant

Social Isolation and Social Support During Winter Storm Uri

Many residents described significant **social isolation** during the storm, at a time when they needed support the most. For example, some older adult focus group participants described lacking any support during Winter Storm Uri. One focus group participant recalled: *“I was stuck here for the whole time and nobody stopped to see if I was ok. I had to fend for myself, I had no phone. What stuck with me is nobody came to check with me until after the electricity came back on.”* Another focus group participant described how the winter storm prevented residents from supporting each other: *“Nobody checked on anybody, they wanted to, but nobody could do it.”*

Several focus group participants noted that many residents did not learn about resources such as **warming centers** available to help survive the storm until they had emerged out of the worst of the storm. One older adult focus group participant shared:

“I didn’t know until after the storm was over, that I found out that there was a warming center a few blocks away. Because of the steep hills where I live, I don’t know that I would have tried to go there, but if the power had been out for an extended period, I probably would have, but didn’t find out until everything was over.” – Focus Group Participant

Another older adult focus group participant explained how smartphones were critical to **accessing information** about resources to support residents during the storm, and lack of access to a smartphone worsened socioeconomic and age-related barriers to time-sensitive information. Indeed, one Hispanic/Latino focus group participant shared how access to social media was critical for connecting with other residents to exchange goods:

“I don’t know how to drive in the snow, so how can I make it to where they’re distributing food if I can’t navigate in the storm? So it was helpful to make use of the Facebook groups [...] Being able to be in communication with my neighbors helped a lot. When we needed food, you saw people exchanging goods for other goods.” – Focus Group Participant

Similarly, several residents described **neighbors coming together** during the storm to support each other in the **perceived absence of governmental support and information** about other social services during the worst days of the storm. One focus group participant shared:

“I think [Winter Storm Uri] brought us together. [W]e’re in a little community of several condos. One lady had her daughter drop off food and water at the bottom of the hill because we’re on the top of a very steep hill. We all got to know each other, we were charging our cellphones, and giving logs to people with power still out and offering to give them more meals. In our little community, we got closer.” – Focus Group Participant

Another focus group participant described how **community response efforts**, both locally and from outside of the region, were helpful for meeting basic needs during the winter storm:

“After the snowstorm there was not a lot of reaction here from [name of organization], immediately from the city, but a group came from Wisconsin and helped us with water and we distributed food and water. A lot of times it is very difficult to access this type of help because it comes with many requirements. That’s when you realized that it was the people themselves, the community itself, that was aiding each other.” – Focus Group Participant

Government Distrust

When recalling Winter Storm Uri, several residents described a **slow government response**. One participant described how groups had to fill the gaps, *“[we] had to organize aid, [it was] not automatic.”* Another focus group participant shared, *“volunteers helped, but [the] county needed to be quicker and more helpful.”* Another older adult focus group participant explained how difficult it was to get information from the local government during the storm:

“Information is not always the best in the city as far as when we’re having disasters; there’s a lot of things you can get help with, even with the pandemic still going on, but if you don’t know... what are you supposed to do?” – Focus Group Participant

Several residents discussed how their experiences of a slow government response and social isolation during Winter Storm Uri, combined with the COVID-19 pandemic response, contributed to **growing mistrust towards the government**. For example, one Hispanic/Latino focus group participant described their growing sense of mistrust towards the government in times of crisis:

“For me it would be knowing that in extreme times of weather or pandemic or stuff like that, we as a community can’t be too dependent on our city or our federal government. Because when help does get here, I know sometimes it’s too late and I know people died because of the winter storm. We can’t be too dependent on the government, because we’ve seen too many times, they can’t give us all the help we need.” – Focus Group Participant

Another focus group participant shared how they observed an increase in gun ownership among young adults after the COVID-19 pandemic and winter storm, which they perceived as a response to **inadequate sense of safety** and delayed governmental responses during both crises.

Significant and Longstanding Physical Damage to Residences

Some focus group participants and an in-depth interview participant described **longstanding damage to residences** due to the storm. One participant shared that senior living facilities flooded and the damage to residences still needed to be addressed. Another participant described the damage to their apartment during the storm, which prompted them to stay with a friend: *“My apartment got flooded because a water pipe burst, it messed up my appliances (fridge, blender, microwave), and my clothes got all wet.”* A couple of focus group participants described unaddressed damage on mobile homes: *“My mobile home’s roof was damaged and it is still leaking. I have not been able to solve that because fixing the roof is too expensive.”* Another focus group participant described:

“I don’t know why they [the City] waited to respond to the needs of the community. I think still today there are people suffering from the storm, not able to fix their places at 100%, especially when it comes to mobile homes [there are] still a lot of struggles for people in need and [who are] still unable to get a positive response.” – Focus Group Participant

According to some focus group participants, rental units are still damaged from the storm.

Preparing for Future Emergencies

While residents and community leaders described several gaps in the COVID-19 and Winter Storm Uri response, one community leader praised the public health response to COVID-19:

“I think it [Public Health] is taken for granted by the general population and generally undervalued. I think this pandemic has illustrated the importance for a need for a good public health system. We had fewer deaths, and I think it’s because of leadership and because the system functioned well and worked collaboratively. There will be other events, HIV, SARS, Ebola, etc. There will always be something on the horizon. If we can value pieces of our government that are working effectively, the better.” – Community Leader

One community leader described several gaps in emergency preparedness efforts, which were illuminated by the COVID-19 pandemic. This community leader cited a **high level of turnover** among public health emergency preparedness leadership, few permanent emergency preparedness staff, and an understaffed environment when COVID-19 crisis was escalating, which they attributed in part to hiring freezes. This community leader also described the emergency preparedness team as growing and having demonstrated significant resourcefulness despite these challenges. They also recalled that regulations to prevent overtime made it difficult for the understaffed emergency preparedness department to meet the needs of the moment, noting that this policy resulted in a lot of unpaid work

that may have contributed to staff turnover during the COVID-19 pandemic: *“These policies need to be refined, I feel they contributed to the burnout and loss of employees during the initial pandemic start.”*

This community leader also observed that despite emergency planning, advance emergency preparedness planning was not very effective because partner organizations were not accustomed to major crises or emergencies. They recalled: *“We have not used a lot of the plans we created. This is a common thread. When there [are] no emergencies happening it’s hard to get people on board. A lot of people were not familiar with plans we already had developed, and we couldn’t use them.”*

Another barrier to responses by the emergency preparedness office included needing to rely on **contract agencies** who were not versed in emergency response during surge capacity events. Other barriers included dependence on federal funding for emergency response, barriers to coordinating emergency response efforts with other City departments or organizations, and limited emergency preparedness among other departments within the city so they can readily be deployed in emergencies.

One recommendation for strengthening emergency preparedness included **exchanging information with and other large cities** such as Houston and Dallas to learn about and share best practices and support each other. Additionally, this community leader emphasized the importance of ensuring that the emergency preparedness department and planning processes are attuned to community realities to inform the development and deployment of feasible and locally relevant emergency preparedness responses:

“We need to remain connected to the people being served so we understand the issue/needs and not responding to issues that don’t exist. Don’t assume what their needs are, ask what they are. Go out and have a discussion with people you are trying to help.” – Community Leader

Other recommendations that emerged included preparing for the City or County to be a mass distributor and providing more **training in emergency response** to build local capacity. This community leader shared:

“We need more training and more access to training for people that aren’t necessarily in emergency response. I hope this issue highlights the need for preparation and is taken more seriously and to understand why we teach Incident Command System. There should be more required/mandated trainings and that’s a policy decision. Further, these trainings should reflect relevant disaster possibilities within our community. Emergency preparedness should take these trainings and make them more accessible to the public.” – Community Leader

COMMUNITY RESOURCES

Some community leaders cited resident support for each other, including **sharing resources and information**, as an important community strength. According to one community leader:

“Community supports one another; they help each other. One person hears about one resource: they use their phone tree to connect others. It’s people that have lived out here for generations. They share resources to the best of their ability.” – Community Leader

One focus group participant echoed:

“The pandemic affected us all and changed our lives, but we also realized that we are a community, we are quite united, there are resources but sometimes we don’t know where to go or where to ask for them.” – Focus Group Participant

According to some community leaders, **community health workers** have been central to meeting the needs of residents most affected by health inequities. One community leader shared, *“I get inspired by the work that all community health workers do. I wish that every working group of the CHA-CHIP had a community health worker.”* This community leader also shared, *“...As an organizer I feel that the power is at the bottom, and we should all be working to disassemble the hierarchy and [distribute] power. People give me energy.”*

Another community leader described how Asian residents organized to address needs at different moments of the COVID-19 pandemic, including supporting health care professionals, providing access to food, and vaccine outreach:

“I am proud of the Asian community [being] willing to give, to save, and support the community. We supported our frontline workers with PPE [personal protective equipment] in places such as hospitals, ERs, [and the] police force. [We supported] food distribution for homeless [residents and] refugees. Now we are doing vaccine outreach and we are trying to connect with our community despite the barriers and attacks.” – Community Leader

This community leader also described established networks in the Asian community as important sources of information and support: *“Our community is very strong connected. If I want to reach out to the Korean community we will reach out to a leader and they will get the message out [through] social media, newsletter or whatever channel. We are DEEPLY connected.”*

Another community leader described the **faith-based community** as an important resource that brings disparate groups together:

“Another asset is the diversity in the socioeconomic class. You could be next to someone in a sermon who is a millionaire and across from them is someone who is homeless, standing foot to foot, shoulder to shoulder.”

That feeling of a social contract with your fellow Muslim's is strong.”
- Community Leader

One in-depth interview participant who previously experienced incarceration also highlighted the importance of faith-based communities and other forms of social support:

“Engaging with my spiritual community, finding support groups [...] Finding a healthy social network is the single most important thing. I find most of my social network through my spiritual community and yoga community.” – In-Depth Interview Participant

PARTNERSHIPS

Many community leaders and some focus group participants described several **cross-sectoral partnerships** as important community strengths. They cited partnerships between organizations representing the City of Austin and/or Travis County (e.g., Austin Public Health, Emergency Medical Services) and community-based organizations; community-based organizations and private companies; community-based organizations and programs at the University of Texas at Austin; and across community- and/or faith-based organizations. One focus group participant characterized this environment: *“We go out of our way to build partnerships.”* Another community leader described the importance of partnering with community-based organizations to implement COVID-19 response efforts, such as testing sites and information: *“Relying on these partners is incredibly important. As we have grants or money available, we will do some grant making (giving grant money) to help push response efforts out through community-based organizations to be effective in reaching priority community.”* Another community leader praised a partnership between Austin Public Health, health care services, and community-based organizations: *“Pilot and reinvest in the right way. APH partnered with Urban League and Allied Health institute. [The] same thing with RENT and direct support relief. [It is the] [p]erfect combination, I can trust APH.”*

One community leader described a set of collaborations with **academic partners** as *“a lot of collaborations and partnerships that will [take] a long-term or [be] far-reaching. [We’re] not looking to be reactionary in totality, we’re looking to be people who impact the bottom line of wellbeing. That’s a paradigm shift.”* These collaborative planning processes focus on, for example, infrastructure investments such as renewable energy, as well as jobs and economic development.

One focus group participant described a partnership between **local schools and a private company**: *“[W]e do have Samsung and Applied Materials, which partner really closely to our schools and help us out with materials. Last year they helped us out with a big grant and they usually help us out with holidays.”* Another community leader cited a partnership between an organization working alongside people experiencing homelessness and EMS services, which has been helpful for addressing health care barriers for people experiencing homelessness:

“What makes relationship with EMS so successful [is they] have come out, they know who we are. They are passionate about people. It is a great partnership and were open to having someone on property to help work through solving some of those 9-1-1 calls and helping educate neighbors. They understand the plight of our neighbors. This level of competency helps because you can’t just say stop it, they need more in-

depth help and assistance. Navigating complicated world of healthcare is complicated, even for college educated. People without healthcare in early years now have problems because no preventative care. This is a new exposure to healthcare industry for them.” – Community Leader

COMMUNITY-BASED INSTITUTIONS

Several focus group participants and community leaders described community-based organizations, faith-based organizations, libraries, schools, and community health centers as important access points for information and access to services such as rental assistance, nutritional assistance, health care, and other resources. Many residents and community leaders recalled that community-based resources incorporated COVID-19 response efforts into their day-to-day work, including mutual aid and community-based COVID-19 testing and vaccination sites. For example, some residents mentioned the role of schools in providing free/reduced lunch for children and as a food distribution resource. One community leader shared, *“Regular food drives that happen at elementary schools [is a strength].”* One focus group participant echoed, *“And in my kids' school they helped us, at both schools. Thank God, there were also many people that would bring boxes of food here to my husband, they would bring him a plate of food, but thank God, we had a lot of help.”*

VISION FOR THE FUTURE

Building on the perceived community assets and thinking ahead to the future, assessment participants outlined the following suggestions for making Austin and Travis County overall a healthier place.

LONG-TERM HEALTH EQUITY PLANNING PROCESSES

“Along the lines of trust, having members and leaders from the community involved in decision making is important. Ideally, hire someone from the neighborhood you serve.” – Community Leader

Many community leaders recommended that the City of Austin and Travis County **deepen their relationships with communities** across the region. Some community leaders identified the need to build relationships with representatives from diverse geographic communities, such as communities on the outskirts of Austin, and identity-based communities, such as racially minoritized groups. One community leader described the current state, sharing: *“[There is] distrust of the City. [A] [n]eed to build rapport with the African American community.”* Some community leaders emphasized the importance of bringing community leaders to the table for planning discussions across sectors given that multiple sectors such as housing, development, and energy are deeply connected with health. One community leader described the **importance of incorporating community-based leaders and community voices into planning processes** for a range of issues that affect health and health equity:

“There’s structural barriers within the city. As an organization we have to start working with Office of Sustainability, the Equity office. We have to get in discussions about housing, and infrastructure, energy, and travel. Those elements put us in a position where we can plan for longer-term sustainability for those marginalized communities. But we need to move the powers that be to understand that we need to be in those discussions. Because we can help them when they’re making decisions about planning, travel infrastructure, that we end up having to fix 15 yrs. later. That structural inertia of ‘we’ll get to them, but they don’t need to be on this level,’ we need to be communicating on that level so we can avoid long-term outgrowth of plans that didn’t consider certain things, that’s a structural thing.” – Community Leader

As a first step in bringing together community leaders to guide health equity planning, one recommendation included **conducting an asset map of organizations leading health equity work** in the region and bringing those organizations to the planning table. One community leader described the importance of ensuring that organizations that center members of impacted communities – not just major non-profit organizations – are incorporated into collaborative opportunities:

“Many non-profits try to serve people and have no idea, it is paternalistic, disrespectful, and disconnected. I serve on advisory boards and one of my first questions is show me the leadership team of this organization and if they form part of the community. [...] It all goes to a lack of critical analysis. We need to step back and say that this is a system where these institutions benefit from this unequal distribution of

resources and power. We need to distribute the power and wealth and establish democratizing decision making through community inclusion.”
– Community Leader

Given sizable population growth across the region and displacement of longstanding residents, some residents recommended the need to intentionally **include long-time residents** in planning processes, not just relatively new residents. In addition to bringing community-based organizations to the table, some community leaders noted the importance of strengthening mechanisms to elevate the voices of residents and the need for sustained investments to support communities at large. One community leader explained that the success of programs, practices, and policies that emerge from planning processes is contingent on the extent to which residents are engaged in the design:

“Many times, when people say community engagement they refer to planning 2-3 interventions and then taking them to the community, But then the community does not like any of the options.” – Community Leader

According to community leaders, there is a need to **improve quality of outreach** to residents when engaging them in planning processes, including ensuring that information about resident engagement opportunities reaches residents through realistic and culturally appropriate communication channels and in residents’ primary language. *“The people believe their leaders. They trust the leaders that speak their language. I don’t speak some languages, but I know who does and who can pass the message along. It is important to have these outreach channels.”* One community leader noted the importance of reflecting on current outreach strategies that may not be reaching residents, particularly when it comes to enrolling in services. This community leader shared:

“We do a lot of, did you get the -email, they didn’t fill out the e-mail, then things are taken away. If African Americans and Latinos don’t respond to something, the assumption is they don’t care or they don’t need it. The case is they didn’t receive how they need it so they can respond to how they feel about it. A lot of time it’s ‘Apparently they don’t want it.’ But that’s not true, maybe you didn’t ask them right, maybe you didn’t make it accessible to understand. We get e-mails from APH and Central Health, it’s like you have to comb through them to find out where meetings are, what time they are, what are you asking us for, it’s a Where’s Waldo.” – Community Leader

FOSTER COLLABORATIONS AND COMMUNICATION ACROSS ORGANIZATIONS

Another recommendation included **leveraging collaborative planning spaces** as opportunities to build connections and relationships across local community-based health equity organizations since many organizations reported that they did not know each other. While several community leaders characterized cross-sectoral partnerships and inter-faith collaborations as an important strength, several community leaders representing community-based organizations described limited familiarity with other community-based organizations and initiatives. Accordingly, several community leaders recommended **fostering collaborations and communication across organizations** to build collective strategies and action and coordinate efforts. One community leader described the current state of limited familiarity with other organizations:

“There’s a lot of ‘this org [is] doing this, this org is doing this...’ I don’t even know if we are getting close enough where toes are getting stepped on. I just know they’re not cohesive with community and their needs. So, we know what’s wrong, if you help us, we’ll help. If you give us the infrastructure, we’ll work it.” – Community Leader

Community leaders discussed the importance of **shifting from a competitive environment** among non-profit organizations, which is linked with limited funding, to bringing organizations working with a range of racially minoritized communities together to build community power, collaborate, and improve efficiencies:

“Black organizations that have connections in the community, Latino organizations, there needs to be concerted efforts, to not have them fight over the crumbs but to build a model that promotes collaboration and not competition amongst them. Like bringing in Latino Healthcare Forum, LULAC, may have a voice. I don’t know that there’s a forum where there’s intentional collaboration to where health is holistically addressed. It’s segmented off, here’s some money go do food sustainability, housing. There’s no comprehensive plan that brings them all together and makes money and work more efficient and then tells us how to work directly with organizations.” – Community Leader

Relatedly, one community leader perceived that by building a collaboration across sectors, the City and County could transform current dynamics with research partners. This community leader perceived an opportunity to encourage research partners to invest in action to promote community health:

“All [university] wants to do is research but they don’t want to do any practical work with the information they gathered, so how do we make all these entities come together with all their power money and resources to develop a comprehensive plan that can make Austin a better place for everybody.” – Community Leader

Also, some community leaders discussed the importance of providing data to guide community-based health equity work to better inform collaborative processes.

FUNDING EQUITY

Shifting the funding model when supporting the work of small community-based organizations and racial equity organizations was a common theme among many individuals representing community-based organizations. Some community leaders and community forum participants discussed inequitable funding relationships between community-based organizations and the City and County and identified the need to **shift how funding operates** to improve health equity. For example, one community leader stressed the importance of equitably bringing community partners to the table by inviting them to planning meetings, and compensating them for their time: *“Because we don’t have time nor energy and resources to drive around and be at all of these meetings for free [...] So we’re spending a lot of time at tables where our knowledge is needed without getting supplemented for it [...] We were at one meeting where we asked for funds, and they pretty much laughed at us. We’re the only ones at this table not*

being paid and we're here just like you." Another funding recommendation included **re-hauling the current reimbursement model** to enable the City and County to meaningfully partner with smaller organizations who have smaller reserves and who cannot wait for reimbursement. Community leaders shared:

"The structure of the funding in the city: [you] can't have a reimbursement-oriented structure. That doesn't work unless you've been around for X amount of year[s] and you have all this money in reserves. [T]he reason we don't have reserves is because there's still a need and we spend on the need." – Community Leader

Relatedly, some community leaders recommended providing more information about funding opportunities particularly to small or newer community-based organizations. Additionally, a few community leaders noted the need to **be more transparent about how funding priorities are made**. As one community leader shared:

"We have applied and received a few grants. We don't have a specific person responsible (grant writer), the grant application process and access needs to be more transparent and intentionally reached out to organizations who could fulfill them. Collaboration to other agencies to help inform them about funding opportunities. Accessing the grants is our largest barrier." – Community Leader

Some community leaders noted that strengthening relationships between the City, County, and local community-based organizations and even places of worship could improve channels of communication with residents and could improve trust in City and County programs and information:

"A partnership where when we are helping someone here, we let them know the City also has this help and this is how you get access to it. They will hopefully feel a sense of trust that when they hear it from the mosque it becomes more legitimate and there is a responsiveness to them when seeking that help." – Community Leader

Another community leader envisioned that **investing in these collaborations and strengthening funding models** would build the capacity of small community-based organizations: *"Building capacity in orgs. and smaller orgs. There needs to be a concerted efforts to strengthen orgs, because if we strengthen these organizations, they strengthen us."*

ADDRESS SYSTEMIC RACISM

Some community leaders discussed the need to *"lead with race"* and address systemic racism in criminal justice, education, and health care sectors and build capacity to counteract hate. Additionally, one community leader described role of bystander trainings in sharpening residents' ability to address ongoing anti-Asian hate: *"We have bystander trainings: teaching people to do something when they see something that is not right."* In addition to bystander trainings, this community leader cited the need for policies to address rising hate towards Asian communities.

To address systemic racism in healthcare settings, one community leader shared their vision for appropriately staffing clinics to meet the health care needs of residents across multiple racial identities: *“Equity, 4 mobile clinics, clinics that cater to Black, Brown, Asian, and White communities; “straightforward talk” we need cultural relevance and competence. A Black doctor to tell me what I need to do; Black nurse practitioners.”*

IMPROVE FOOD SYSTEMS AND THE FOOD ENVIRONMENT

Several focus group participants and community leaders recommended strategies for improving food systems and the food environment, taking a long-term view to improving access to healthy food. One community leader described the current food environment in a food desert: *“We haven’t figured out long-term solutions: we want to incentivize a grocer to come out in some way like Austin incentivized Tesla to come out. How do we get social services, food grocers, food providers, more options for community?”* Residents also suggested expanding community gardens programs, food pantries, and farmer’s markets. A focus group participant shared their vision for a community garden: *“Garden center where you could go and work on your own project and get fresh food.”* Another focus group participant remarked, *“It would be helpful to have a farmers’ market close by.”*

IMPROVE QUALITY OF AND ACCESS TO HEALTH CARE, WITH A FOCUS ON LOW-INCOME RESIDENTS

The need to address lack of or limited access to health care for low-income residents emerged in interviews, focus group, and community forum discussions. Some community leaders highlighted the **need to expand Medicaid** to improve access to health care for low-income residents. One community leader described the importance of state or local-level strategies to **expand health insurance coverage** for low-income residents:

“The state absolutely needs to expand Medicaid. It’s a crime, a sin, an embarrassment that Texas hasn’t done this. They don’t need to call it Medicaid expansion, God forbid it is politically incorrect. Oklahoma and Arkansas have gotten it passed and it would ensure better quality of care for people throughout the state. ...That would be the number one priority if that’s an option where the city and county get to that. It would go the farthest in affecting people.”

– Community Leader

Community forum participants cited the importance of supporting residents in enrolling in health insurance through the marketplace during open enrollment, ensuring that these supports are available in residents’ primary languages to enable them to understand benefits and policies. Participants also recommended reducing wait times at community clinics and making resources available during later hours.

Some community leaders recommended a short-term strategy for improving access to health care for low-income residents by **improving the capacity of clinics** that currently serve low-income residents to **expand their hours and days of operation**. One community leader recommended **mobile clinics** as a

short-term solution to addressing limited access to health care for low-income residents and residents of color through having a regular presence at an established community location located along public transit lines.

Another recommendation included coordinating the release from the hospital for people who are homeless by bringing together hospitals, EMS, and organizations who serve people who are experiencing homelessness. One community leader described the need to collaborate with hospitals to deepen their understanding of the need to **coordinate discharge** so that patients have continuity of services once out of the hospital.

The need to address bureaucratic barriers to expanding mental health supports, improve funding for mental health services, and to make mental health services available to people who are experiencing homelessness and low-income residents also emerged from interviews and focus group discussions. One community leader highlighted the importance of **community-based mental health** models:

“We want to help meet mental health needs through various grants. People come to the mosque before the psychiatrist. No assigned social worker or mental health specialist at the mosque. Would like a part-time person to be the figure we can refer to for mental health needs.”

– Community Leader

Some community leaders and focus group participants cited the need to **coordinate health care across specialties** in order to strengthen chronic disease management. One community leader described the importance of coordinating care:

“If somehow in the healthcare system there was a way to be more holistic, where say you have a cardiologist, neurologist, orthopedist, those people don’t necessarily talk to one another and each one is prescribing something different, and this disconnect of communication could be better. This might lead to better hope for chronic disease management. Transition of care has a lot of room for improvement.” – Community Leader

This community leader also observed that different electronic health care platforms pose a barrier to coordinating care across providers. *“Everyone has different software for health records. The solve is coming up with a platform where hospitals talk to one another, and everyone has access within reason and rights and utilizes the same software.”*

SUPPORT AGING IN PLACE

Some focus group participants mentioned the need to **support older adults** and residents with significant health needs for aging in place and keeping them out of institutions such as assisted living and nursing homes for as long as possible. One community leader noted that **planning for aging in place** was particularly important for residents who do not have family nearby. One focus group participant shared about why an aging in place model was important for them: *“I’m in a wheelchair, I don’t need nursing care at all, I need someone to help with the dishwashing and getting groceries and things like that.”* One community leader shared their vision for aging in place:

“Aging in place: neighbors to stay in place; attendants that can help in location [...] to help with housework, laundry, hygiene issues, grocery shopping and help when folks need to go to a skilled facility; more access to respite care.” – Community Leader

A community leader identified the need to build partnerships across organizations that serve older adults: *“We don’t have that partnership available; I know that Meals on Wheels provides some level of service for those that used to drop in, but now it’s hard to engage and learn their needs for folks not able to come into the center.”*

KEY THEMES AND PRIORITY HEALTH NEEDS OF THE COMMUNITY

KEY THEMES

This assessment included a review of secondary data and collection of primary data to shed light on the social and economic context, community health issues, and community visions of residents Austin/Travis County. The following key themes emerged through this synthesis:

- ***Social determinants of health, such as access to healthy food and financial security required to be healthy, were viewed as more pressing concerns than health outcomes themselves.*** While some chronic health issues were discussed and are of concern, assessment participants focused on upstream issues of daily life.
- ***Housing affordability continues to be concerns in Austin/Travis County.*** Due in large part to significant population growth, a key theme was the high and rising cost of housing that disproportionately affects low-income residents, residents of color, older adults, and persons with disabilities, and displaced residents from urban areas to rural areas. While median income has steadily increased in recent years, cost of living in the area is high and increasing as well.
- ***The COVID-19 pandemic has had substantial impact on the lives and the physical and mental health of residents in Austin/Travis County.*** The COVID-19 pandemic has exacerbated many of the issues that existed as well as highlighted new issues. COVID-19 pandemic has worsened food security, economic suffering, increased social isolation, exacerbated mental health issues, and highlighted barriers to accessing information and health care resources for lower-income residents, residents for whom English is not their primary language, and communities of color.
- ***Emergency preparedness is an emerging public health issue in the region.*** Given the COVID-19 pandemic, heat waves and Winter Storm Uri, emergency preparedness was top of mind for many assessment participants. Most residents reported experiencing a natural disaster emergency in the past decade and many described the immediate and ongoing personal and community challenges these emergencies have caused.
- ***Mental health was identified as a important community health concern.*** Significant mental health needs, stigma around mental health, and limited access to mental health care were common themes among community members and leaders. Some residents perceived an increase in mental health issues during the COVID-19 pandemic, which they linked with the stress and trauma of the COVID-19 pandemic, social isolation, and economic suffering.
- ***Healthcare access – specifically high cost of healthcare and insurance – is a significant concern in Austin/Travis County, especially among people of color.*** When discussing access to health care, common themes were gaps in health insurance coverage for low-income residents, including lapses of health insurance coverage, few providers who accept Medicare, and difficulty accessing preventive care (e.g., primary, vision, dental), emergency services, specialists, and providers who care for older adults.

- ***A strength of Austin/Travis County are the residents and organizations in the area.*** Community residents are supportive of each other and generous with sharing resources and information. Cross-sector partnerships among schools, community-based organizations, private companies and others also represent a community strength. Community-based institutions were seen as important access points for information and access to services. Faith-based organizations were highlighted as a key strength and a bridge between historically marginalized communities and local/county government.

PROCESS AND CRITERIA FOR PRIORITIZATION

Findings from this report will guide the upcoming 2023 Community Health Improvement Plan development process, set to begin August of 2022 and to be completed by February of 2023. Key Themes as well as further community input from residents, partners, stakeholders, etc. will inform the prioritization processes and the development of goals, objectives, and strategies. The 2023 Improvement Plan will be the Community Health Plan's guiding document for the following three years during which working groups, comprised of partner organizations, will work together to implement the proposed goals until the following 2025-2026 Assessment/Implementation cycle.

APPENDICES



APPENDIX A: ADDITIONAL DATA

Table 9. Percent Adults Consuming 5+ Servings of Fruits and Vegetables Daily, by Gender, Race/Ethnicity, Age, by Travis County, 2011-2019

	2011	2013	2015	2017	2019
Male	18.7%	19.0%	14.9%	38.6%	13.6%
Female	26.7%	17.9%	19.7%	43.4%	17.8%
Black, Non-Hispanic	23.5%	-	15.6%	-	-
Hispanic	23.2%	18.9%	18.0%	48.0%	13.4%
White, Non-Hispanic	12.6%	16.7%	17.5%	41.7%	16.1%
Other/Multiracial, Non-Hispanic	26.8%	-	11.4%	-	-
18 to 29	14.8%	14.8%	14.2%	33.6%	-
30 to 44	22.8%	22.8%	16.5%	37.0%	18.8%
45 to 64	19.1%	19.1%	19.9%	41.8%	12.2%
65+	14.7%	14.7%	19.8%	58.0%	21.4%

DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2011-2019

NOTE: Dashes (-) indicate unreliable data or an inadequate number of respondents.

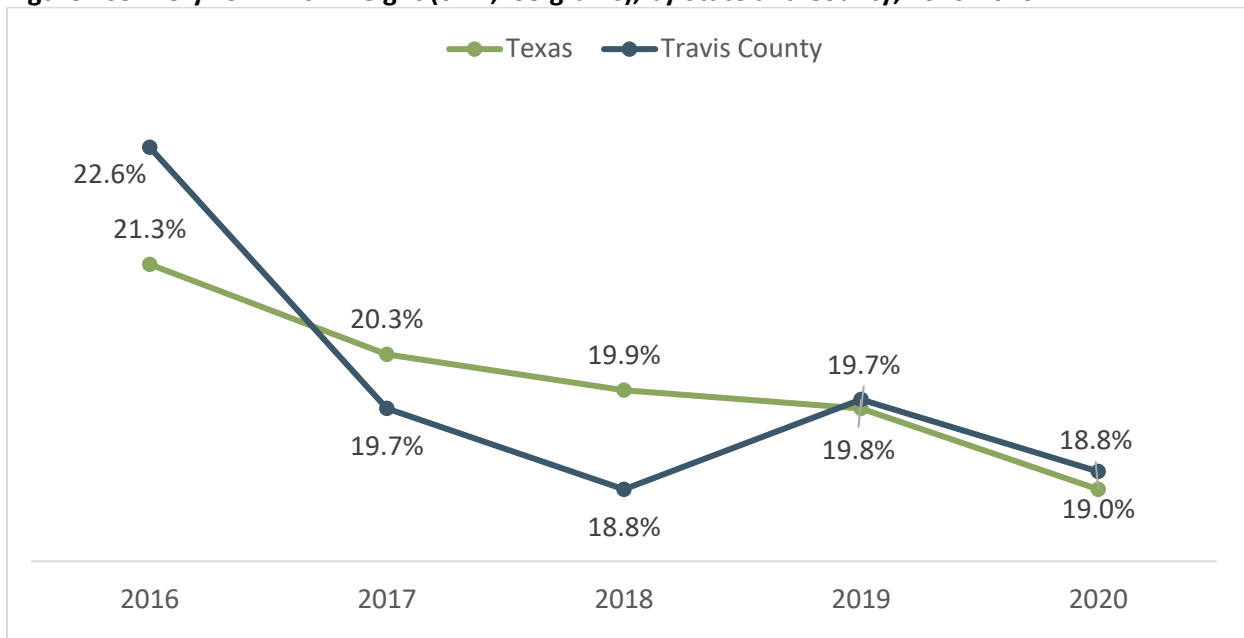
Table 10. Percent Adults Physically Inactive, by Gender, Race/Ethnicity, Age, by Travis County, 2011-2019

	2011	2013	2015	2017	2019
Male	22.3%	31.4%	29.3%	23.1%	17.8%
Female	21.4%	22.0%	25.9%	29.0%	20.4%
Black, Non-Hispanic	21.3%	-	23.6%	31.4%	-
Hispanic	30.7%	22.4%	25.9%	24.2%	30.0%
White, Non-Hispanic	35.4%	31.3%	31.6%	37.4%	36.0%
Other/Multiracial, Non-Hispanic	35.2%	-	32.9%	-	-
18 to 29	12.6%	23.6%	24.6%	22.1%	16.8%
30 to 44	23.5%	27.9%	25.4%	26.5%	20.4%
45 to 64	23.2%	23.3%	30.4%	28.2%	17.8%
65+	26.8%	38.2%	27.7%	23.4%	21.2%

DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2011-2019

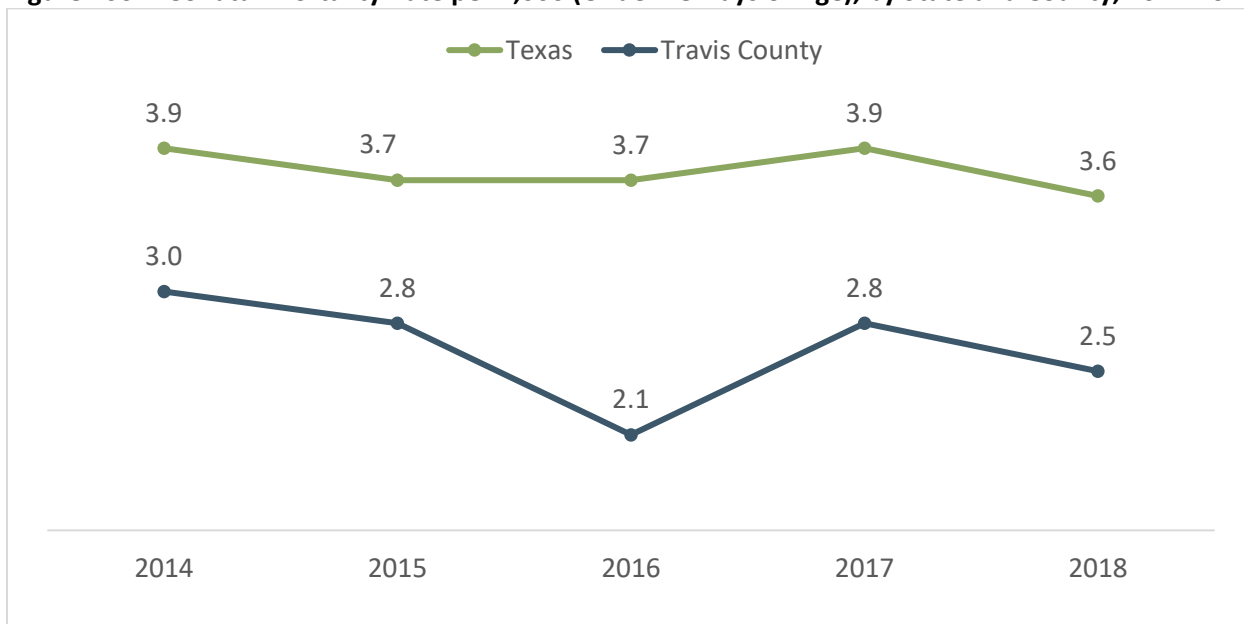
NOTE: Physical inactivity defined as adults aged 20 and over reporting no leisure-time physical activity.

Figure 105. Very Low Birth Weight (0 - 1,499 grams), by State and County, 2016-2020



DATA SOURCE: CDC Wonder, Natality expanded results, 2016-2020

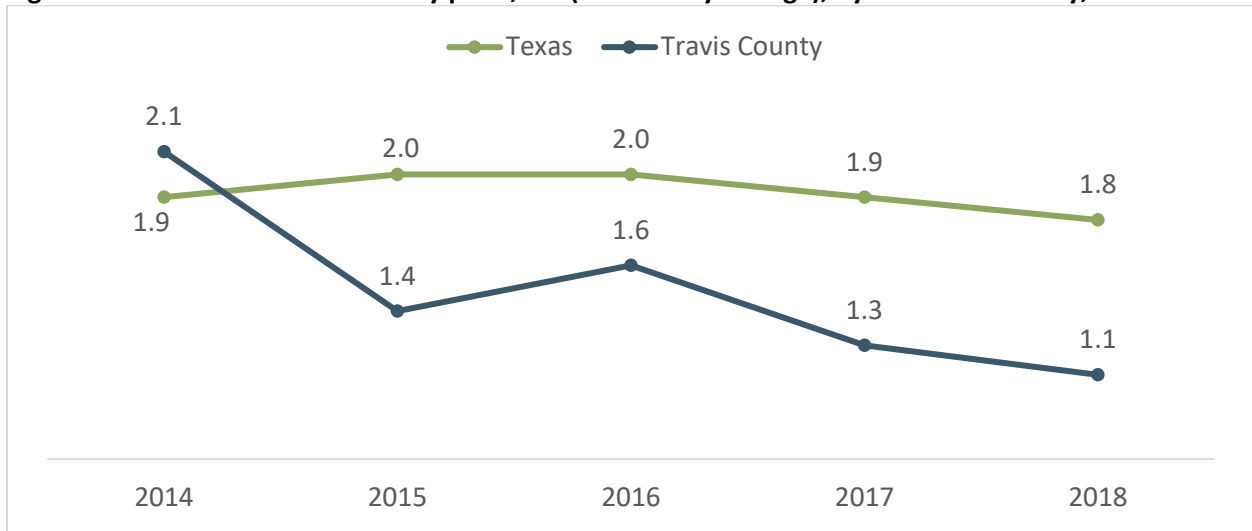
Figure 106. Neonatal Mortality Rate per 1,000 (Under 28 Days of Age), by State and County, 2014-2018



DATA SOURCE: CDC Wonder, 2014-2018

NOTE: Neonatal mortality represents the number of deaths during the first 28 completed days of life per 1000 live births in a given year or other period.

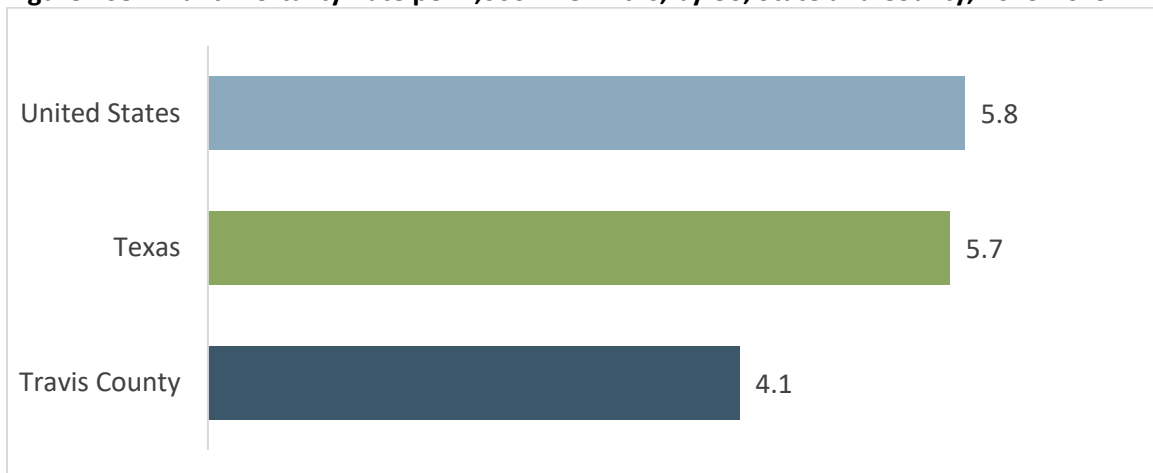
Figure 107. Post Neonatal Mortality per 1,000 (28-364 Days of Age), by State and County, 2014-2018



DATA SOURCE: CDC Wonder, 2014-2018

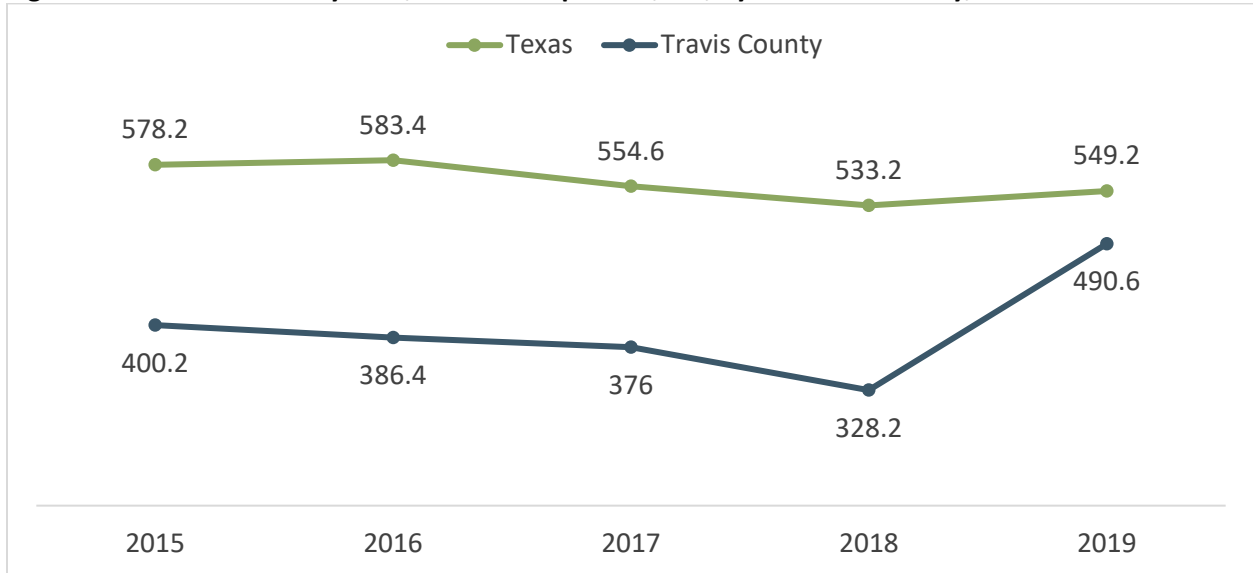
NOTE: Post neonatal mortality represents the number of deaths during 28-364 completed days of life per 1000 live births in a given year or other period.

Figure 108. Infant Mortality Rate per 1,000 Live Births, by US, State and County, 2013-2019



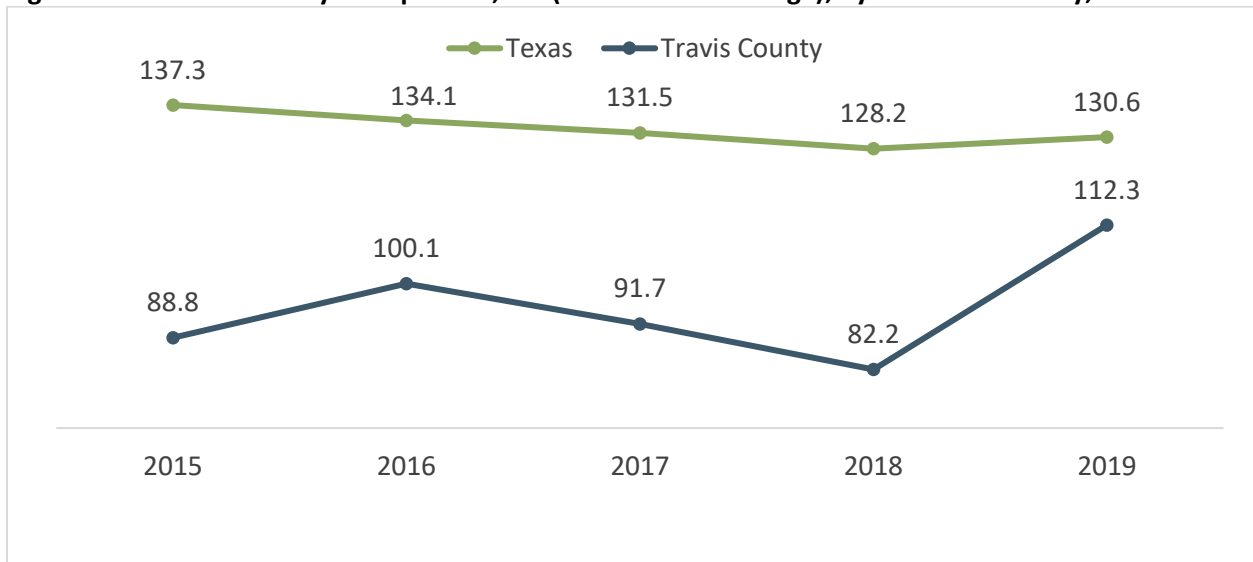
DATA SOURCE: CDC WONDER Mortality Data; as cited by County Health Rankings & Roadmaps, 2013-2019

Figure 109. Infant Mortality Rate, Crude Rate per 100,000, by State and County, 2015-2019



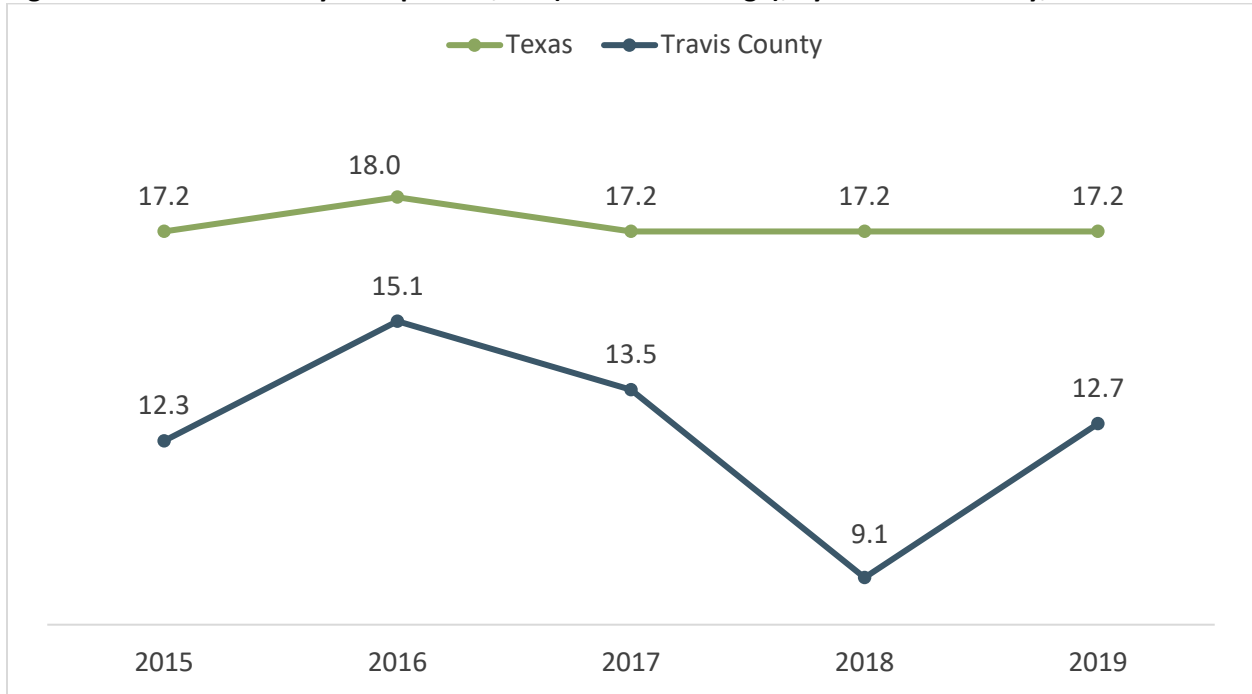
DATA SOURCE: CDC Wonder, 2015-2019

Figure 110. Child Mortality Rate per 100,000 (Under 5 Years of Age), by State and County, 2015-2019



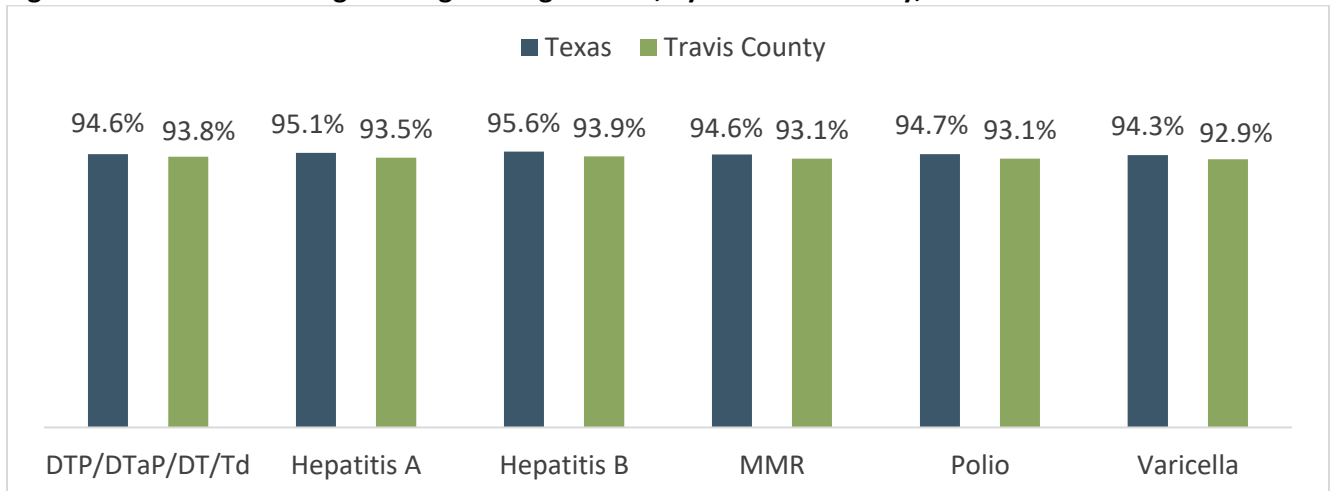
DATA SOURCE: CDC Wonder, 2015-2019

Figure 111. Child Mortality Rate per 100,000 (1-14 Years of Age), by State and County, 2015-2019



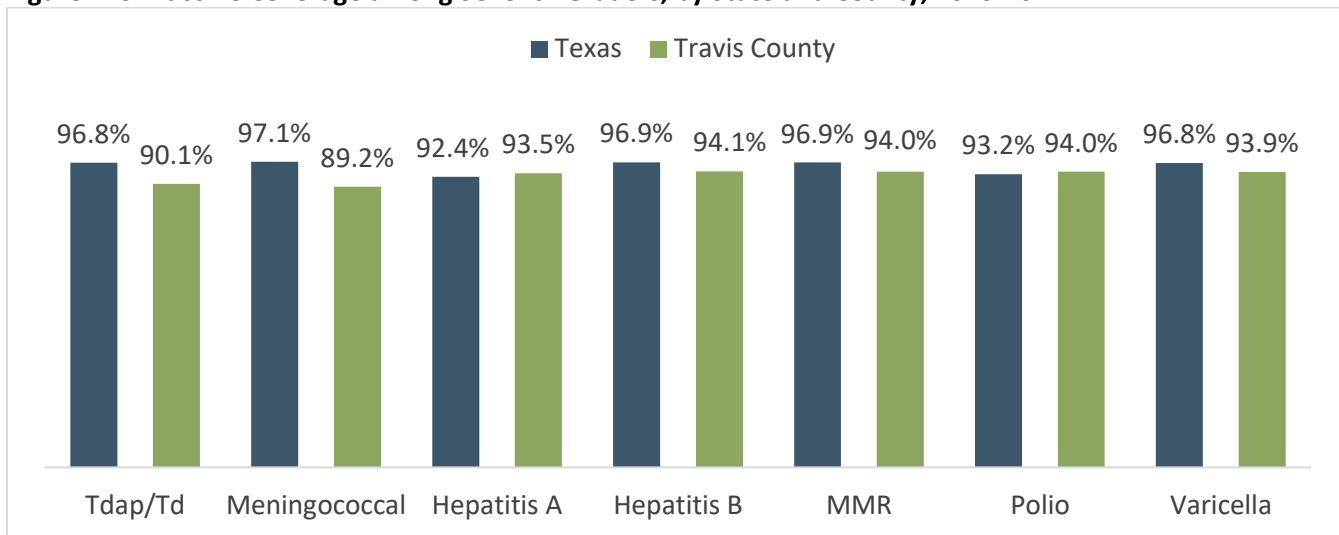
DATA SOURCE: CDC Wonder, 2015-2019

Figure 112. Vaccine Coverage among Kindergarteners, by State and County, 2020-2021



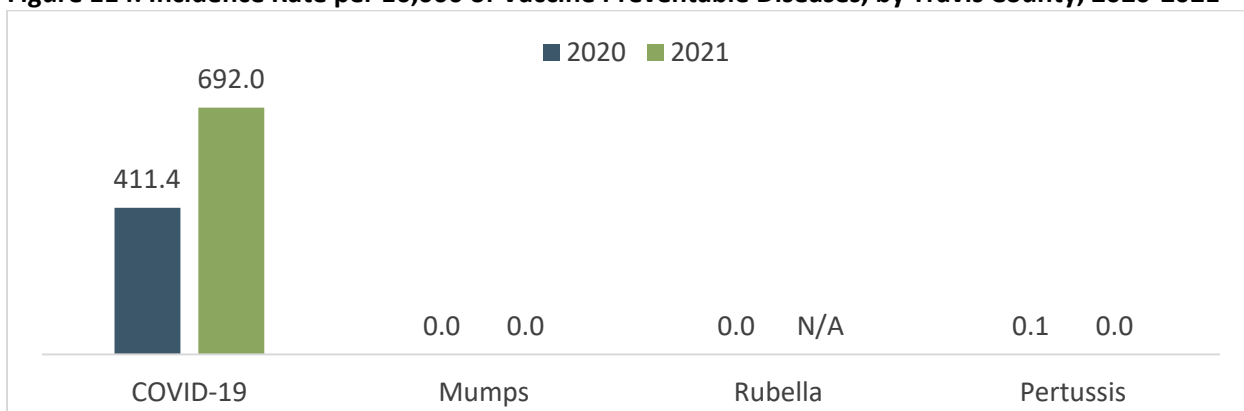
DATA SOURCE: Austin Public Health, 2020-2021

Figure 113. Vaccine Coverage among Seventh Graders, by State and County, 2020-2021



DATA SOURCE: Austin Public Health, 2020-2021

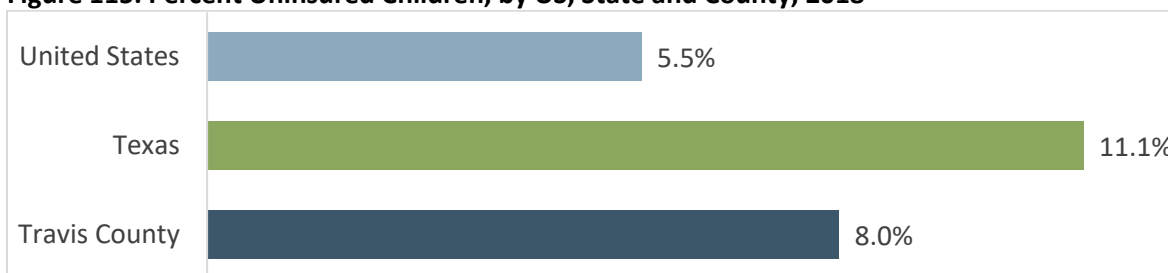
Figure 114. Incidence Rate per 10,000 of Vaccine Preventable Diseases, by Travis County, 2020-2021



DATA SOURCE: Austin Public Health, Epidemiology and Disease Surveillance Unit, 2/10/2022

NOTE: 2021 case counts are provisional and subject to change.

Figure 115. Percent Uninsured Children, by US, State and County, 2018



DATA SOURCE: Small Area Health Insurance Estimates (SAHIE), United States Census Bureau; as cited by County Health Rankings, 2018

APPENDIX B: GENDER IDENTITY DEFINITIONS³⁸

Agender	Denoting or relating to a person who does not have a gender identity or identifies as gender neutral.
Cisgender	A term used to describe a person whose gender identity aligns with those typically associated with the sex assigned to them at birth.
Gender-fluid	A person who does not identify with a single fixed gender or has a fluid or unfixed gender identity.
Genderqueer	A term used to describe people who typically reject notions of static categories of gender and embrace a fluidity of gender identity and often, though not always, sexual orientation. People who identify as "genderqueer" may see themselves as being both male and female, neither male nor female or as falling completely outside these categories.
Gender non-conforming	A broad term referring to people who do not behave in a way that conforms to the traditional expectations of their gender, or whose gender expression does not fit neatly into a category. While many also identify as transgender, not all gender nonconforming people do.
Transgender	An umbrella term for people whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth.
Two-spirit or other Native Identity	Refers to a person who identifies as having both a masculine and a feminine spirit and is used by some Indigenous people to describe their sexual, gender and/or spiritual identity.
Questioning	A term used to describe people who are in the process of exploring their sexual orientation or gender identity.

APPENDIX C: FOCUS GROUP/IN-DEPTH INTERVIEW GUIDE

FOCUS GROUP/IN-DEPTH INTERVIEW GUIDE

Introduction

Thank you very much for joining us today! I am [your name] from [name of organization]. We are working with Austin Public Health to conduct a Community Health Assessment, which is a process developed with a collaborative group of community partner organizations working toward the common goal of a healthy community for all. This process was previously completed every 5 years but is now moving to a 3-year cycle and the previous assessment was completed in 2017. We want to get your perspective on the health of your community and the health-related needs of your community. We would like this discussion to be informal, honest, and thoughtful. We want to hear from everyone in the room. Ideally, we the facilitators will hardly talk at all. Our role is to ask questions, keep us on topic, and help keep the discussion flowing.

Consent:

What is said in this room is confidential and will not be reported out except in general themes or anonymous comments. We are recording this conversation so we can listen again for context and clarity. What you tell us will be summarized into a report, however, no names will be attached to any of the experiences, opinions, or suggestions. The questions I will ask do not have right or wrong answers. They are about your experiences and opinions, so do not hesitate to speak.

Your participation is entirely voluntary and you can decide to leave at any point. If you could please let us know if you consent to this discussion with a verbal “yes.”

[Go over [Focus Group Rules](#)]

Intro:

Before we start asking you some questions, I would like each of you to introduce yourself with **only your first name** (or a name you would like to be referred to as) and how long you have lived in Austin/Travis County.

[Health Behavior and Environment – 30 minutes]

1. What does health mean to you?

Probes:

- a. physical health
- b. mental health

2. What do you do to stay healthy?

3. What do you see as the major health-related problems in your community?

4. What does a healthy community mean to you? Sometimes there are factors that can help people to be healthy or prevent them from being healthy.

- a) What are the things that help YOU to be healthy?
- b) What are the things that make it harder for YOU to be healthy?

Probes:

- a. Access to healthy foods
- b. Access to places for physical activity
- c. Safety
- d. Access to doctor’s office
- e. Access to mental health providers

- f. Exposure to lots of advertisements for alcohol/tobacco
- g. Housing
- h. Income and Employment
- i. Affordability
- j. Education
- k. Transportation
- l. Immigration Status
- m. Access to services in your primary Language
- n. Isolation
- o. Drug Use
- p. Access to Child Care (safety/affordability)

5. How has your race or ethnicity impacted your physical and/or mental health?

[Additional Questions – 20 minutes]

6. What impact has the COVID-19 pandemic had in your life?
- How has your life changed since before the pandemic?
 - What were the resources, people, agencies that helped support you during the pandemic?
 - What, if any, ongoing effects are you experiencing from the pandemic?
7. What impact did Winter Storm Uri have on your life?
- What were the resources, people, agencies, that helped support you during the winter storm?
 - What, if any, ongoing effects are you experiencing from the storm?

[Challenges in Health Services – 15 minutes]

8. What are other health services that you need but do not receive currently? [Probe on medical care, mental care, drug use treatment and services]
9. What has prevented you from receiving them? What are the greatest challenges to you in accessing health services?
10. If you cannot find services, where do you get help?
- What are the consequences of not being able to get help?
11. What other resources would you suggest that are not currently available? In other words, what are some solutions to these problems?

[Strengths in Health Services – 10 minutes]

12. What are the strengths (good things) of the health services available in your community?
13. What resources (e.g., agencies, institutions, programs, services, people, etc.) do we have in the community that seem to be working to address the health-related problems you see? In other words, what has worked for you, your family or someone you know?

[Changes over time – 10 minutes]

14. Have you noticed any change in the quality of health services and opportunities and the way in which they are provided in the past five years?
- How has it changed?
 - What impact has the change had on you?

Wrap-Up

15. Is there any other issue impacting your physical or mental health that you'd like to discuss/share?

APPENDIX D: GENERAL STAKEHOLDER INTERVIEW GUIDE

GENERAL STAKEHOLDER INTERVIEW GUIDE

Thank you very much for meeting with me today. I am working with Austin Public Health to complete their regular Community Health Assessment, which is a process previously completed every 5 years, the previous assessment was completed in 2017, but transitioning to a 3-year cycle. The assessment is completed in collaboration with a group of community partners working toward the common goal of a healthy community. We want to get your perspective on the health status and needs of Austin/Travis County.

What is said in this interview is confidential and will not be reported out except as part of general themes or anonymous comments. What you tell us will be summarized into a report. However, no names will be attached to any of the experiences, opinions, or suggestions.

[Organization's Basics]

1. Can you tell me about what your organization does and how that relates to the health of Austin/Travis County residents?
 - a. Please tell me your role at this organization.
2. What communities or audiences does your organization serve? (geographic, race/ethnicity, age, socio-economic status, gender, specific health condition)

[Organizational Evaluation]

3. How does your organization measure success? How are the programs/services in your organization evaluated? (What does success look like?)
4. What are the most significant accomplishments of your organization in service to the community over the past 3-5 years?
 - a. What significant accomplishments did you have during the past year and a half during COVID?
5. What are the most significant barriers the organization is facing in the next few years?
 - a. How prepared is the organization to meet those challenges?

[Community Needs]

6. What are the greatest assets of the clients/community you serve?
7. What are the health and social concerns you see most often in the community you serve?
8. What are the unmet needs or barriers in the community you work with that most affect your clients? (social determinants of health).
 - a. How does your organization select which barriers to address? How do you determine how to address them?
 - b. How would you prioritize the needs you have listed?

9. What changes are needed in the short-term to meet those needs? Who is responsible for making those changes?
 - a. What policies or resources are needed to help address the top needs?
10. What changes are needed In the long-term to meet those needs? Who is responsible for making those changes?
 - a. What policies or resources are needed to help address the top needs?

[Level of Engagement with larger Community Health Plan]

The Austin/Travis County Community Health Plan is a collaborative planning effort that brings community partners together to address community health needs. We'd like to learn more about your organization's connections to other partners and opportunities for linkage and additional support.

11. What types of support does your organization need to be successful?

Probes:

 - a. If they mention funding, funding for what needs?
 - b. Resources
 - c. Partner connections
12. How connected is your organization to others doing similar work?
 - a. Which partners do you regularly work with and in what capacity?

APPENDIX E: COMMUNITY FORUM MATERIALS

Austin Public Health held a virtual community forum on Thursday, November 18, 2021, to allow community members to provide their insight on major community health needs and priorities.

Forum Agenda:

Time	Topic	Speakers	Notes
6:30 - 6:40 pm (10 min)	Welcome & Housekeeping	Planner	Interpretation required
6:40 – 6:50 pm (10 min)	Orientation- Overview of the Community Health Plan and the 2022 Assessment	Planner	Interpretation required
6:50 - 7:40 pm (45 min)	Break-Out Sessions (by Language) Question 1: Barriers Question 2: Resources Question 3: Solutions	Guest Facilitators	Break-out groups by language
7:40 – 7:55 pm (15 min)	Debriefing	Guest Facilitators	Interpretation Required
7:55 – 8 pm (5 min)	Wrap-Up & Next Steps	Planner	Interpretation required

16 forum participants joined break-out groups, divided by language and facilitated by community partners, and utilized Google Slides to document their input with regards to 1) barriers, 2) available resources, and 3) solutions for healthy living. Participants used “sticky notes” to first generate ideas and then used stars to prioritize answers as a group. For those unable to access the online Google Slides, notetakers documented verbal input as well as comments in the Zoom chat.

Participants answered the following questions per slide:

Barriers to Healthy Living:

1. What makes it hard to stay healthy?
2. What makes your neighborhood unhealthy? What barriers exist in your community that make it more difficult to live a healthier life?
3. What is difficult about using services in your neighborhood?

Resources for Healthy Living

1. What helps you stay healthy?
2. What makes your neighborhood healthy?
3. What is good about the services in your neighborhood?

Solutions for Healthier Living

1. What could make services in your neighborhood better?

What improvements to services have you seen that work well?

APPENDIX F: CENTRAL HEALTH SAFETY NET COMMUNITY HEALTH NEEDS ASSESSMENT REPORT EXCERPT



CENTRAL HEALTH

Safety Net Community Health Needs Assessment Report – EXCERPT

February 10, 2022

Today, Central Health serves approximately 100,000 patients each year through the Medical Access Program (MAP) and Medical Access Program - Basic (MAP-Basic). A comprehensive review of Travis County’s safety-net population found Central Health-enrolled patients represent a little more than one-half of those that may be eligible for services. Significant opportunity exists to expand reach and strengthen the impact on health and wellness for those that are low-income and particularly the most marginalized populations across Travis County.

Central Health patients face high poverty rates, unemployment rates, and metrics of poor health. The assessments conducted to develop this Equity-focused Service Delivery Strategic Plan indicate Central Health’s patient population fares worse than Travis County and Texas averages in a number of measures of health. With significant health care access challenges across Travis County, patients struggle to receive essential preventive, primary, and specialty care services across the care continuum, and often use the Emergency Department in place of these services due to limited access and transportation barriers. Further, educational opportunities and access to healthy, affordable food, and housing are scarce and act as additional barriers to health.

In 2018, Central Health worked closely with community members to identify and refine the healthcare district’s strategic objectives for the years ahead. These objectives are defined as follows:



Figure 1. Central Health Strategic Plan Objectives FY2019-FY2024

Recognizing that economic opportunities, environmental factors, and social networks are key determinants of health, Central Health continues to focus on opportunities that will expand access to critically needed health care services across the continuum of care – while building health equity and improving outcomes for the low-income populations that are currently Central Health patients or are potentially eligible for services.

To support this effort, Central Health completed a comprehensive Equity-focused Service Delivery Strategic Plan to best position itself to meet the immediate and evolving health-related needs of its eligible population and work toward long-term solutions that maximize use of community resources to improve the health of those populations. Central Health conducted an in-depth safety-net community health needs assessment (CHNA), a voice of the community analysis, and a capabilities and gap analyses in collaboration with community members, activists, stakeholders, and partners to systematically identify and prioritize health needs in low-income populations and to understand the safety-net health care delivery system across Travis County. The outputs of these assessments are foundational to the comprehensiveness and effectiveness of an Equity-focused Service Delivery Strategic Plan.

Our Community

For the purposes of the safety-net CHNA, Central Health divided Travis County into 14 planning and assessment regions to understand health care needs at a more local level. These planning and assessment regions were developed based on census tract analysis and other characteristics, including geographic borders, level of urbanization, transportation resources, and population density.

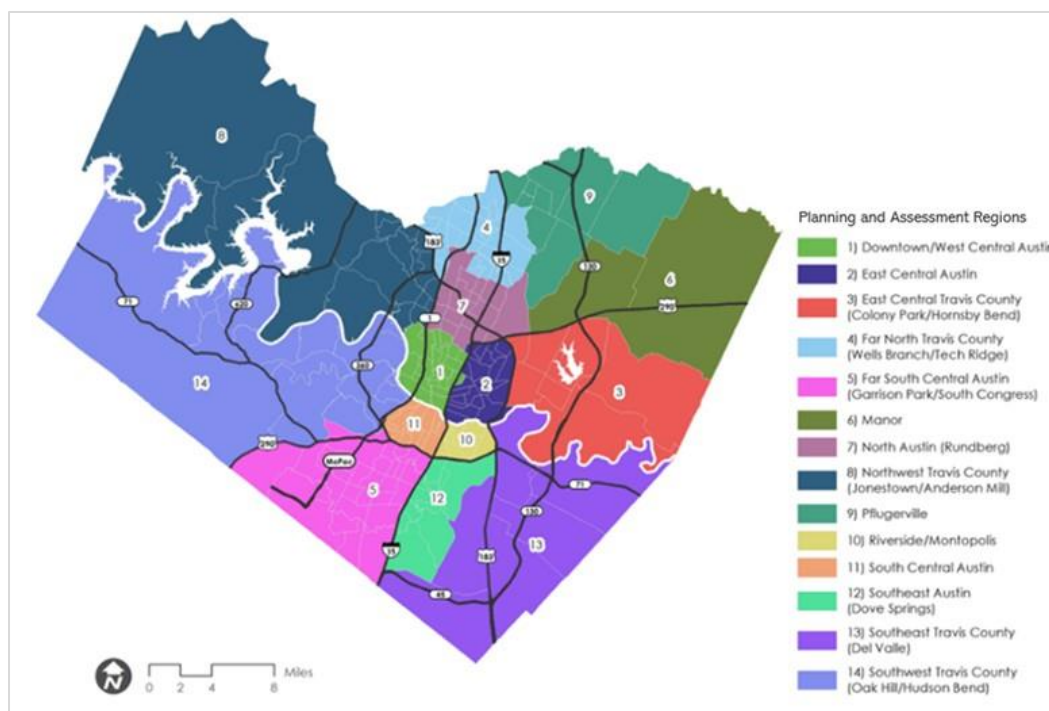


Figure 2. Central Health Planning and Assessment Regions

Source: Planning and assessment regions defined by Central Health

Core to this analysis is understanding the scope, scale and severity of health care needs of low-income Travis County populations at the local level. The map below illustrates the geographic distribution of the healthcare district’s low-income population, specifically those with incomes less than or equal to 200% of the FPIL, across each of the 14 planning and assessment regions.

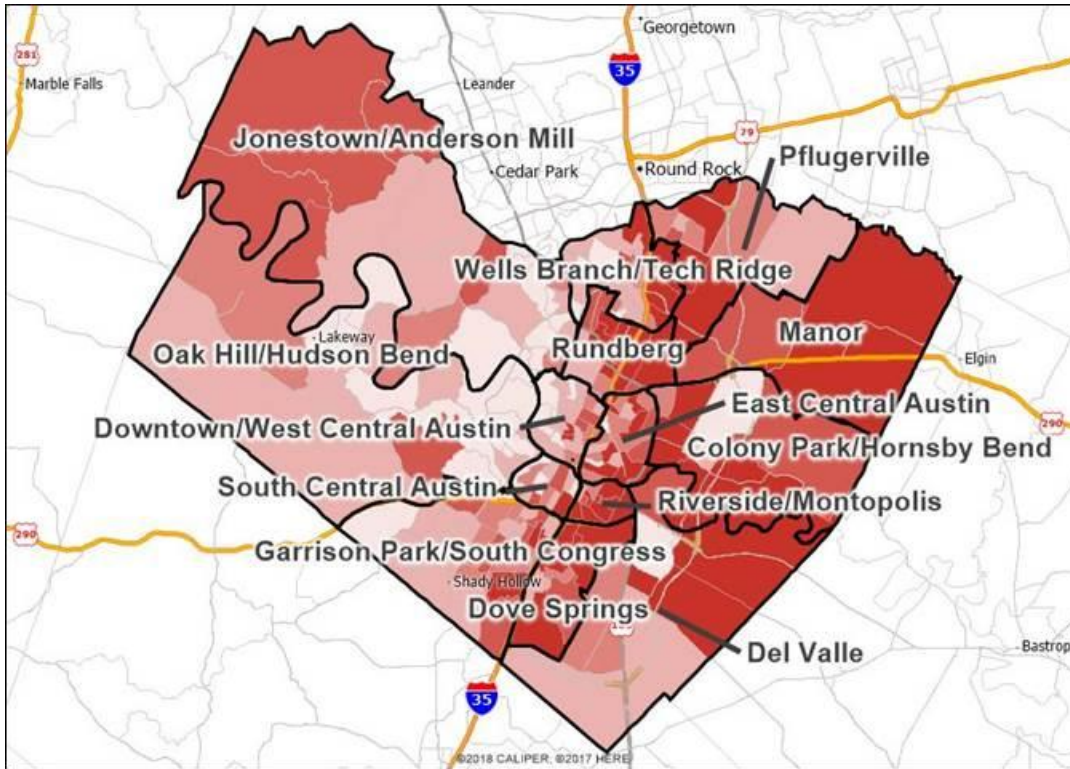


Figure 3. Absolute Population below 200% of FPIL by Census Tract

Source: American Community Survey (ASC) 2015 -2019

74% of Travis County’s 241,774 residents with incomes below 200% FPIL reside in the I-35 corridor. Central Health’s current enrollment is highest (*total and percent eligible enrolled*) in this I-35 corridor focus area. This focus area also represents the area with the greatest opportunity to expand Central Health’s enrollment to low-income residents (69,230 residents), as home to approximately 75% of additional currently unenrolled residents who may be eligible for Central Health or other safety-net services in Travis County.

Planning and Assessment Region		# of Census Tracts	Square Miles	Total Population - 2021	Enrolled Population - FY20	Families in Poverty - 2025	% of Population Below 200% FPIL - 2019	Enrollment Opportunity
I-35 Corridor	Rundberg	20	25.4	127,323	21,022	4,905	17.2%	16,233
	Garrison Park/South Congress	31	67.0	199,593	8,335	2,406	11.2%	12,683
	East Central Austin	20	17.5	80,803	7,161	2,968	9.3%	8,550
	Dove Springs	11	27.9	72,963	10,701	2,219	8.2%	8,331
	Wells Branch/Tech Ridge	24	30.6	120,717	8,471	1,944	8.1%	8,558
	Downtown/West Central Austin	22	16.3	97,596	1,259	770	8.1%	2,433
	Riverside/Montopolis	10	7.5	53,514	7,487	1,938	8.0%	6,720
	South Central Austin	12	9.7	56,025	2,459	850	3.7%	5,722
East Travis County	Pflugerville	9	63.0	112,254	7,311	1,431	6.2%	5,334
	Colony Park/Hornsby Bend	7	81.8	43,465	9,207	1,632	5.9%	4,792
	Del Valle	8	120.4	32,432	8,353*	1,044	3.2%	2,025
	Manor	3	100.0	28,253	3,532	781	2.3%	1,255
West Travis County	Jonestown/Anderson Mill	22	218.6	155,652	2,681	1,188	5.1%	3,267
	Oak Hill/Hudson Bend	19	206.4	127,318	2,606	1,211	3.3%	5,192
Grand Total		218	992.2	1,307,908	100,585	25,287	100.0%	91,095

Figure 4. Central Health Enrollment and Opportunities for Enrollment Expansion by Planning and Assessment Region

Sources: Central Health Census Tract Planning and Assessment Region; Land area data obtained from the U.S. Census Bureau. Total population of families in poverty data obtained from Claritas ©. Population <200% FPIL data obtained from American Community Survey (ACS) Table S1701.

Notes: Enrolled population counts are based on patients with addresses that could be geocoded. Consequently, the Downtown/West Central Austin Planning and Assessment Region likely represents an undercount of enrolled patients. * Travis County Correctional Complex/Austin Transitional Center is in Del Valle and a significant number of inmates were enrolled into MAP when they didn't have a permanent address

Summary of Significant Health Needs from the Safety-Net Community Health Assessment

The primary objective of the safety-net CHNA is to understand the magnitude and distribution of health care needs of Travis County's low-income, safety-net population. Using various sources, the CHNA evaluated quantitative data and trends for Central Health's current patient population and low-income residents who are potentially eligible patients to identify opportunities to better serve these communities. Significant areas impacting health needs were identified based on a comprehensive review of publicly available and proprietary quantitative data collected throughout the CHNA process. Areas for significant opportunity impacting health needs are:

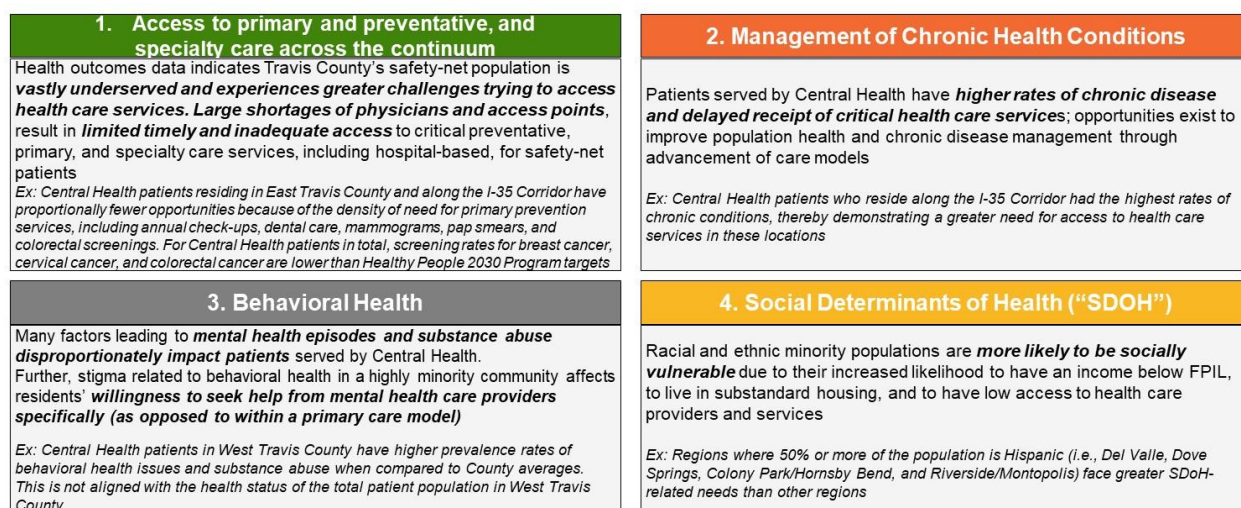


Figure 5. Summary of Significant Health Needs for the Safety-Net Community in Travis County

- 1. Access to preventative, primary, and specialty care across the continuum:** Health outcomes data indicates Travis County's safety-net population experiences greater challenges trying to access health care services compared to other populations in the county. Major disparities and health care inequities continue to exist across the care continuum for Central Health's patients, making it nearly impossible to achieve the objectives of the Institute for Healthcare Improvement's Triple Aim™ Initiative of better health outcomes, improved patient experiences, and lower costs of health care. The health care disparities faced by the safety-net population in Travis County continue to be substantial and include:
 - An overall and increasing need for more comprehensive, multidisciplinary health care, treatment planning and care coordination across providers and settings for the safety-net population. Overall capacity for primary care including walk-in and same day access should be increased to meet more

of the enrolled population's needs. More robust post-acute services are needed, especially in East and West Travis County.

- Large shortages of physicians exist in some primary and across most medical and surgical specialties and will most likely increase in the future across all payors and patients seeking medical services. The shortage will be exacerbated for the safety-net system as it attempts to compete for the necessary level of physicians to meet the service levels required for patient care. Shortages will limit timely access to critical preventative, primary, and specialty care services for safety-net patients, which will likely result in undesirable health outcomes. This is demonstrated on a micro-level, with patients residing in East Travis County and along the I-35 Corridor having lower utilization for preventive services, including annual check-ups, dental care, mammograms, pap smears, and colorectal screenings. For Central Health patients in particular, screening rates for breast cancer (64.0%), cervical cancer (73.5%) and colorectal cancer (47.0%) are lower than target rates set by the Healthy People 2030 Program (77.1%, 84.3% and 74.4%, respectively).⁵
- A limited number of health care providers: (1) treat the safety-net population, which results in delays in care; and (2) demographically resemble the diverse nature of Travis County's safety-net population today and can care for residents in their language and through their specific cultural lens.
- 74% of Travis County's residents (241,774) with incomes below 200% FPL reside in the I-35 Corridor. By a significant margin, the Rundberg area is home to the highest number of residents below 200% FPL in Travis County (56,132 individuals). As Central Health considers strategies that expand access to care for Travis County's safety-net community, it must ensure that geographic distribution and health care needs of its patient population are aligned with sufficient access to meet demand for services.

2. Management of Chronic Health Conditions:

- Patients served by Central Health need additional resources to address chronic diseases. From a geographic perspective, Central Health patients who reside along the I-35 Corridor had the highest rates of chronic conditions, thereby demonstrating a greater need for access to health care services in these locations.
- Further, there is a need to expand comprehensive, multi-disciplinary care, treatment planning, and care coordination across care settings and providers to facilitate individualized care management planning with seamless coordination across settings. This is further compounded by the fact that there is not a central electronic health record or robustly utilized health information exchange to tie providers together through data sharing and encourage seamless transitions in care. Additionally, opportunities exist to improve population health and chronic disease management by leveraging advanced care models for the safety-net population.

3. Behavioral Health: Many factors leading to mental distress and substance abuse impact patients served by Central Health disproportionately. Inequity, low-income, poor physical health, unemployment, and high cost of living are common in the county. The prevalence, incidence and severity of these illnesses has been exacerbated further by the ongoing COVID pandemic. On a micro level:

- Most of the regions in the I-35 Corridor (five out of eight) and all regions in East Travis County have a lower rate of local mental health providers per 100,000 residents (i.e., credentialed professionals specializing in psychiatry, psychology, counselling, child, adolescent, or adult

mental health, or clinical social work) than the county overall. However, these areas represent some of the highest needs for mental health services in the county.

- The safety-net population needs additional access to behavioral health services. In East and West Travis County, access and capacity to serve the safety-net are limited.
 - Central Health patients residing in the West Travis County communities of Jonestown/Anderson Mill and Oak Hill/Hudson Bend have less access to substance abuse providers when compared to the overall patient average, yet these patients have some of the highest substance abuse rates among the organization's patient population.
4. **Social Determinants of Health:** Safety-net patients are facing many social and economic disparities impacting physical and mental wellness. Regions where 50% or more of the population is Hispanic (i.e., Del Valle, Dove Springs, Colony Park/Hornsby Bend, and Riverside/Montopolis) face greater SDoH-related needs than other regions. Specific to the communities served by Central Health:
- Lower median income, high unemployment rates, and high rate of households below FPIL in the I-35 Corridor and East Travis County are indicative of populations that may have limited access to adequate preventative care and lack other necessary resources to achieve health and wellness.
 - A larger proportion of adults in East Travis County and in the I-35 Corridor do not have high school diplomas. Research shows that not having a high school diploma is an indicator of limited ability to secure employment resulting in lower wages, and poverty, and can lead to negative health outcomes.
 - High housing costs, substandard housing, and overcrowding are prominent issues in Riverside/Montopolis (I-35 Corridor) and Colony Park/Hornsby Bend (East Travis County). These challenges can exacerbate certain chronic illnesses as they often limit a household's ability to allocate sufficient income to necessities, such as food and health resources, in addition to creating housing instability and potential homelessness.
 - A large portion of patients residing in East Travis County and along the I-35 Corridor speak Spanish as their primary language. It is important that health care providers offer written medical information in different languages, including Spanish, to ensure patients can read and understand health care information that is critical to improving their health (e.g., discharge instructions, treatment plans, phone numbers for providers so that patients can ask follow-up questions).
 - Households in the I-35 Corridor and East Travis County are less likely to have stable access to computers and the internet. These challenges must be considered as Central Health's network of providers begin to deploy innovative technologies to expand access to health services for safety-net communities.

To access the full report, please visit: <https://www.centralhealth.net/knowledge-base/healthcare-equity-plan/>

APPENDIX G: PROJECT CONNECT

Project Connect is a public transportation network project designed for the entire Central Texas region, including new light rail, a subway under downtown and an accessible bus system to better connect neighborhoods in and outside our great city. Project Connect is designed to improve access to essential jobs, health care and education—making our communities more livable, equitable and sustainable. Capital Metro and the City of Austin have formed the Austin Transit Partnership (ATP), an independent organization that will guide the Project Connect investment with transparency and accountability throughout the program.

Through the development process and recognizing that displacement and demographic shifts are ongoing in Austin, the City of Austin Housing and Planning Department developed a mapping tool to guide affordable housing investments and retain existing residents along transit corridors. This dashboard illustrates demographic characteristics of areas within 1 mile of a Project Connect stations in communities with vulnerable, active, and chronic displacement risk. To determine displacement risk, researchers at the University of Texas conducted a three-part analysis: the presence of vulnerable populations, residential market appreciation, and demographic change.

Definitions:

Vulnerable: Neighborhoods in this category include areas with vulnerable residents and no significant demographic change. Some neighborhoods are near or contain areas with high property values and/or high rates of appreciation.

Active Displacement Risk: Neighborhoods in this category include areas with vulnerable residents, active demographic change, and accelerating or appreciating housing market.

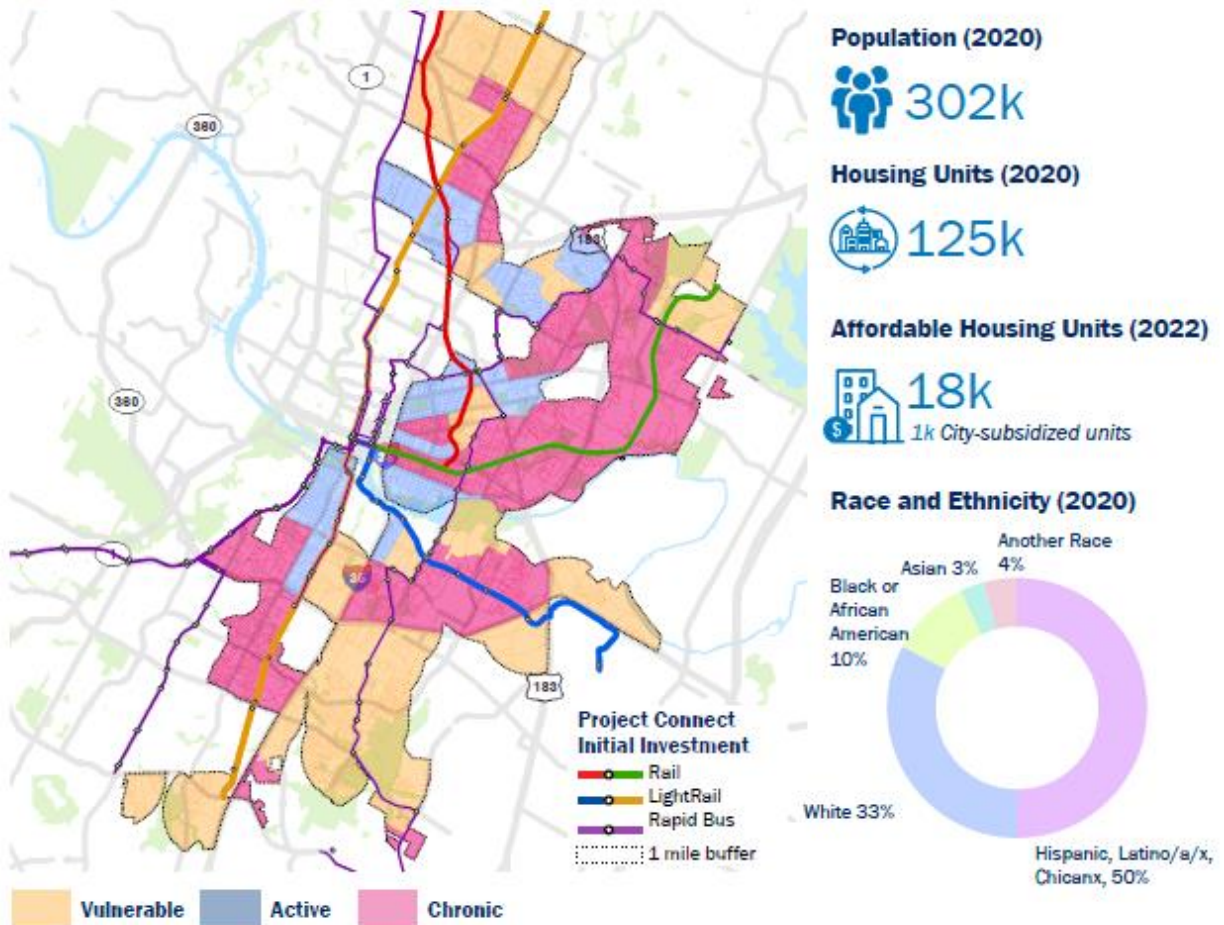
Chronic Displacement Risk: Neighborhoods in this category include areas where vulnerable residents have been displaced, significant demographic change has occurred, and the housing market is high value and appreciated.



HOUSING & PLANNING

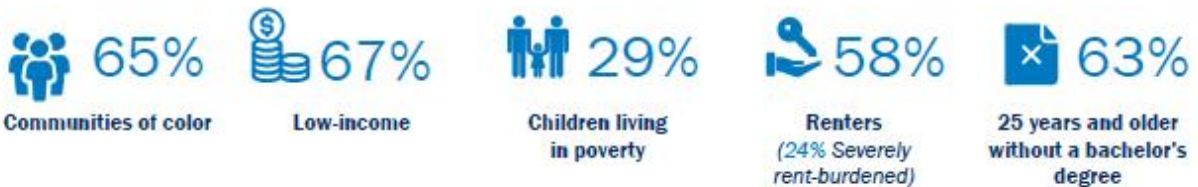
Displacement Risk Areas within 1 mile of Project Connect

To determine displacement risk, researchers at the University of Texas conducted a three-part analysis: the presence of vulnerable populations, residential market appreciation, and demographic change.



Indicators of vulnerability (2019)

Five factors were used to determine a neighborhood's vulnerability to displacement as a result of rising housing costs. The presence of more factors increases vulnerability.



APPENDIX H: MAPP PROCESS

In guiding the 2022 CHA, we followed the Mobilizing for Action through Planning and Partnership (MAPP) framework. This framework had been previously used to inform the 2012 and 2017 Austin/Travis County CHAs:

“Developed in 2001, the National Association of County and City Health Officials (NACCHO’s) Mobilizing for Action through Planning and Partnerships (MAPP) framework is now one of the most widely used and reputable community health improvement (CHI) frameworks in the field. MAPP provides a structure for communities to assess their most pressing population health issues and align resources across sectors for strategic action...”

Although a health equity supplement had been added in 2014, NACCHO sought to incorporate social determinants of health and root causes of health inequities more explicitly into the foundation of the MAPP framework. In 2020, NACCHO began discussions for how best to implement health equity efforts and improve engagement and partnerships with those most impacted by inequities. “It is imperative that public health work with other sectors to move beyond traditional and more remedial health and human services to policy, systems, and environmental (PSE) change.” MAPP 2.0 (aka MAPP Evolution) has begun redesigning assessment strategies to further support and integrate health equity into MAPP with formal supports and guidance to facilitate success across diverse communities.

The 2022 CHA builds on the organizational infrastructure established in previous cycles, while incorporating changes made to the framework in the latest, MAPP 2.0. Main changes are succinctly summarized in the following table:

Alignment Across Revised and Historical MAPP Phases	
Historical MAPP Framework	Revised MAPP Framework
Phase 1: Organize for Success Phase 2: Visioning	Phase 1: Build the CHI Foundation
Phase 3: Conduct the Assessments <ul style="list-style-type: none"> • Community Health Status • Local Public Health System • Community Themes and Strengths • Forces of Change 	Phase 2: Tell the Community Story <ul style="list-style-type: none"> • Community Status • Community Partner • Community Context
Phase 4: Identify Strategic Issues Phase 5: Develop Goals & Strategies Phase 6: The Action Cycle	Phase 3: Continuously Improve the Community

DATA SOURCE: National Association of County and City Health Officials (NACCHO), MAPP Evolution Blueprint Executive Summary, November 2020.
<https://www.naccho.org/uploads/downloadable-resources/MAPP-Evolution-Blueprint-Executive-Summary-V3-FINAL.pdf>

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Together We Thrive

Austin/Travis County Community Health Plan

