CENTRAL HEALTH

2024 Demographic Report

Updated February 25, 2025

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Front Cover: DeiAndre, Central Health coverage program member and former medical respite patient
Photographs in section dividers represent Central Health patients, staff and community members at locations throughout Travis County.

Above: Demographic Report Team. From left to right: Drew Kotlarczyk, Jessie Patton-Levine, Monica Crowley, JP Eichmiller, Sarita Clark Leach, Ashley Toth (Levulett), Connor Favreau, and Matt Richardson.

Acknowledgments

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Executive Summary

In 2015, Central Health released its first Demographic Report in an attempt to better understand the age, poverty and racial composition of Travis County residents from a geographic perspective. As the public hospital district dedicated to ensuring quality health care is available to the low income and uninsured residents of Travis County, we felt it was vital to understand the nuances of population changes. At the time we felt as though this analysis was cutting edge – we'd shifted from analyzing zip codes to census tracts! We had five-year projections!

Looking back, the reporting of 10 years ago seems quaint compared to the standards we've set for ourselves today. But the most important part of that initial report – despite the limitations in scope, analysis and personnel – was the foundational standards we established. Central Health elected to push the boundaries of analysis and understanding of the population we serve, and every time we've developed this report it is a reflection of our improved knowledge and capabilities. Today, I have the honor of working with a gifted group of data analysts and scientists who bring years of expertise in regression analysis, significance testing, relative risk and other areas of knowledge. This year we've also added new aesthetic features to make the report more inviting and fun to explore. Throughout these pages you'll find an updated style and feel to align with Central Health's new brand standards, accompanied by dozens of photographs of patients, community members, staff and local landmarks intended to provide readers with a sense of place and the communities we serve.

If you've read any of our previous reports, welcome back. If this is your first time exploring the report, we're excited to continue informing community members about what we do and who we serve. Rather than focusing on a single assessment, this report analyzes numerous factors at play in Travis County – and considers the interconnectivity between poverty, demographics, geography and health. The 2024 edition includes:

- A regional assessment looking into the local economic, social and public health factors affecting how we all live and experience one another in Central Texas;
- An analysis of families in poverty within Travis County and the surrounding six counties;
- Our focus area analysis divides up the nine areas with the projected highest counts of poverty in 2029 and analyzes the demographics of the population, the counts of enrollees in Central Health coverage programs, the health care utilization patterns of patients in the area, and other factors such as chronic condition prevalence rates, public resources, and social determinants of health indicators;
- A look into the demographics of the enrollees in Central Health's various health coverage programs, which include the Medical Access Program (MAP), MAP Basic and the Central Health Assistance Program (CHAP);
- A comprehensive list and maps of the 172 Travis County provider locations within Central Health's network of care, including updates on projects in development;
- An expanded analysis of the 10 most common and preventable chronic conditions affecting Central Health's patient population including contributing factors, changes over time and comparisons with local and national prevalence rates;
- A look into special populations served by Central Health including homeless patients, post-hospital discharge patients who have passed through our Medical Respite program, and high-risk patients enrolled in our CHAP Expansion program.

The Central Health Demographic Report is a strategic planning document intended to help guide and assist our board and leadership. Two years ago, Central Health adopted a Service Delivery Strategic Plan (the Plan) to serve as the organization's North Star. While we navigate through the complex process of operationalizing and financing all the work detailed in the Plan, the Demographic Report will continue to analyze and report out on the most important component of our planning: improving the health and lives of the patients we're honored to serve.

The 2024 Demographic Report would not have been possible without the collaboration of multiple departments throughout the Central Health Enterprise, which includes CommUnityCare Health Centers and Sendero Health Plans. Through collaborative exercises, our core report team identified four broad themes:

Key Themes

- Your background impacts your health.
- Where you live impacts your health.
- Service growth is meeting needs.
- Understand implications and opportunities.

These themes build upon the key findings found throughout this report, such as the signals of vulnerability found in the health of our black and homeless populations; and the marked indicators of underdiagnosis among key chronic conditions such as cancer. These findings provide us with a call to action to address health inequities and create new pathways for diagnosis and treatment where they are needed. If you would like to learn more about how our Key Themes and Key Findings summarize the 100-plus pages of information we've compiled, I invite you to visit Central Health's Youtube channel and watch our presentation of the 2024 Demographic Report to the Central Health Board of Managers Strategic Planning Committee.

Respectfully,

JP Eichmiller
Vice President of Strategy

CENTRAL HEALTH

Regional Assessment

Introduction

The city of Austin, Travis County, and the surrounding Central Texas counties continue to grow quickly, but as of 2023[1] Austin and its surrounding communities are now in second place as the fastest-growing large metropolitan area in the United States. This ends a twelve-year stint in first place. Income in the area is rising, but so is the cost of living. This continued growth has spurred initiatives and policies to address systemic challenges. Here, we cover recent developments in health care, housing and affordability, and transportation that are shaping Travis County and the city of Austin's present and future.

Austin Alcon, Eligibility and Enrollment Specialist, helps a client sign up for an appointment to apply for a Central Health coverage program with the on-site enrollment team.

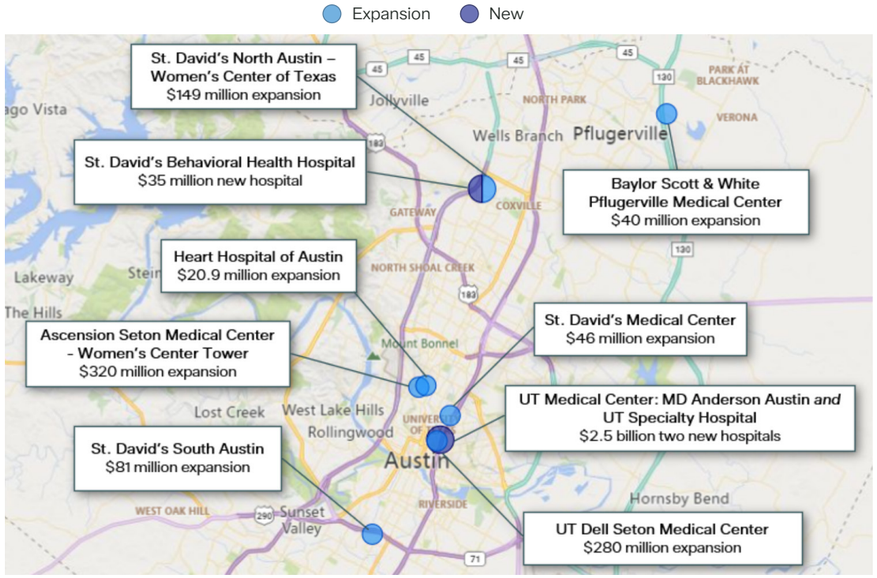
Health Care

End of National Coronavirus Policies

For three years during the Coronavirus pandemic public health emergency, states were incentivized with additional funds to allow continuous enrollment in Medicaid health coverage. After this agreement ended in 2023 [2], against federal guidelines and expert recommendations, Texas quickly removed more than two million Texans – mostly children - from the program. Some families also lost food assistance. This left vulnerable Texans with limited options, and months-long wait times to re-enroll if they were in fact still eligible, all the while having to avoid medical care or pay high out-of-pocket costs with the hope of being reimbursed by retroactive coverage. Safety-net health care providers throughout the state also saw decreases in Medicaid revenue, leading to provider layoffs and reductions in services, further reducing health care access. Locally, Central Health's coverage programs helped keep eligible Travis County residents covered, whether as their new health coverage or as temporary coverage while re-applying for Medicaid.

CommUnityCare provides on-site medical care at a local organization, and refer clients to the Central Health enrollment team, also on-site. From Left to Right: Itzayana Mondragon, Medical Assistant / Medical Admitting Clerk; Cayce Anderson, Advanced Practice Provider

NEW AND EXPANDING HOSPITALS IN TRAVIS COUNTY - JANUARY 2025



Changing Hospital Landscape

As Travis County and the surrounding region's population grows, hospital systems are expanding their footprints. In Travis County alone, three new hospitals and expansions of seven existing hospitals are underway. In 2023, the University of Texas (UT) System announced the launch of The University of Texas at Austin Medical Center, estimated to cost $2.5 billion, which includes two new hospitals near downtown Austin — the Specialty Hospital at UT, and a hospital to be built by MD Anderson Cancer Center. A $280 million addition to the existing Dell Seton Medical Center at UT Austin began in 2023. Ascension Seton is building a $320 million Women's Center Tower to its main campus. St. David's plans to construct a new $35 million behavioral health hospital, and to expand its north, south, and central Austin medical centers for an estimated total of $276 million. Baylor Scott & White is growing its Pflugerville medical center with a $40 million project.

The Heart Hospital of Austin is also increasing its capacity with a $20.9 million expansion. Just outside of Travis County, four new hospitals – including two completed specialty children's hospitals – and three expansions to existing hospitals are underway or already completed, for a total of over $1.5 billion. The expansions aim to boost capacity in high-demand specialties, including those services that greater Austin-area residents often travel to the Dallas or Houston area to receive, such as cancer and transplant care. While Central Health is legally limited to Travis County residents with low incomes, we work closely with area hospital systems to ensure quality care.

Dr. Hemali Patel, Director Transitions of Care

Mental Health

Travis County is making strides in improving and expanding its acute mental health care services. 2024 saw the launch and conclusion of several major projects, covered below.

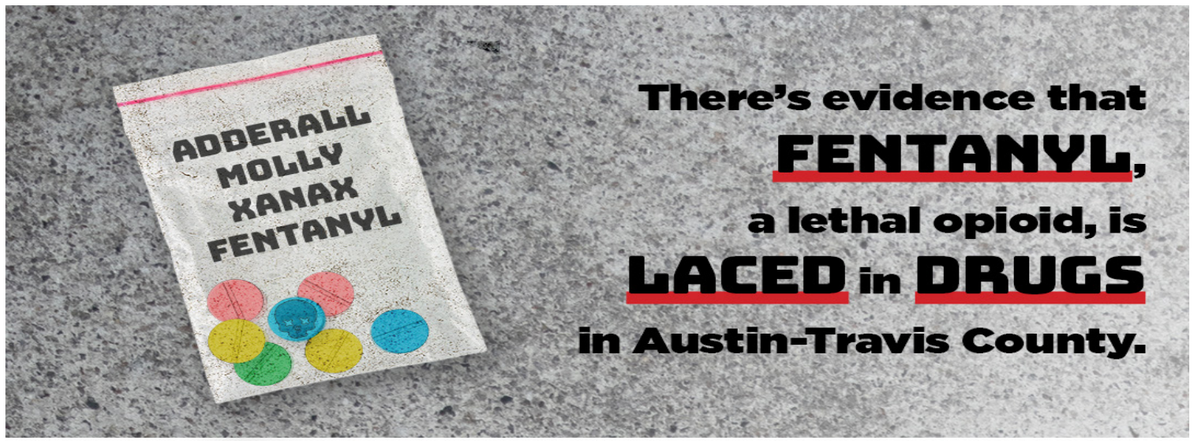
After a five-year redevelopment, the redesigned Austin State Hospital (ASH) opened in May. This redevelopment was part of a statewide effort to improve hospitals run by the Texas Health and Human Services Commission, including ASH. ASH's current service area for adults covers twenty-six counties, with this number more than doubling for youth and children's services. Despite the redevelopment, ASH continues to face capacity challenges due to a lack of alternatives for patients who no longer need acute-level care, but still require more intensive mental health supports. Appropriate alternatives for those residing in the hospital long-term could free up more than a third of the hospital's 240 beds for new admissions. State and local governments and local health care organizations continue to explore ways to improve the system.

In August, Integral Care, the Travis County mental health authority, opened a new Youth Crisis Respite Center [3], currently serving children between the ages of 13 and 17. Addressing the rising instances of teens experiencing mental health crises, this provides an alternative to often full inpatient hospitals.

In October, Travis County launched the Crisis Care Diversion Pilot Program [4], operated by Integral Care. This is in response to findings that at least 40% of the Travis County jail population has a mental health diagnosis. The county, the city of Austin, Central Health and Integral Care are collectively funding the pilot phase of the program through 2027. This pilot [5] starts with law enforcement officers and paramedics being able to drop someone in crisis off to be stabilized at a walk-in clinic in East Austin and expanding to include a 90-day care and treatment program in an existing facility, with the hope of eventually building a larger, more permanent facility by 2030.

Substance Use Disorders

In May 2022, the Travis County Commissioners Court unanimously declared [6] the opioid overdose epidemic a public health crisis, renewing [7] this declaration in November 2024 through October 2026. From 2019 to 2023 [8], Travis County experienced a three times increase in the rate of accidental drug-related deaths, with rates in Travis County higher than other metropolitan areas in Texas. This crisis has drawn the attention and efforts of all levels of government and community-based organizations. Their efforts include educational media campaigns; increasing legal penalties for those distributing lethal doses of fentanyl; Austin Police Department operations; increased access to Narcan overdose treatment; increased funding for medication-assisted substance use disorder treatment and supports, including services [9] for Travis County Jail inmates. Funding for many of these programs comes at least in part from federal grants and national opioid settlement funds. These efforts appear to be working; in the first half of 2024, deaths from opioid overdose are declining. However, as both the Chronic Conditions and Special Populations section of this report highlight, certain groups remain disproportionately impacted by substance use disorders.



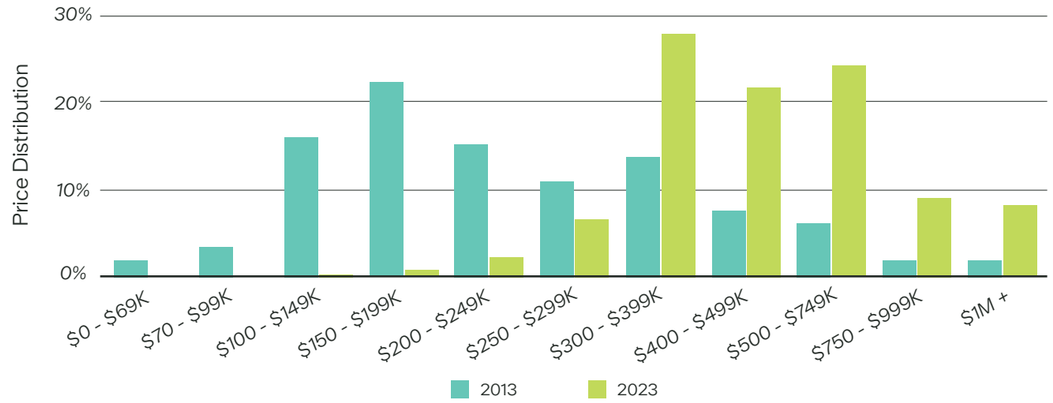
Above and Below: Ads from "One Dose & It's Over" Campaign Central Health joined along with the City of Austin and Travis County

Housing and Affordability

According to the federal government, the 2024 median family income for a family of four in the Austin - Round Rock – San Marcos MSA is $126,000 [10], or approximately four times the federal poverty level. Over the past five years the median income rose by $30,100 [11]. For Texas overall, the 2024 median family income is $91,600. In Travis County, with the notable exception of record highs in the spring of 2020 (e.g., April 2020 at 11.8%) during the COVID-19 pandemic, the unemployment rate [12] was under 4% for the past five years. This is slightly lower than the overall unemployment rate [13] for Texas, which with the exception of a COVID-related spike has hovered just below and just above 4%.

While income is on the rise, so are costs. In the past five years, the median cost of a single-family home in the region increased by $113,000 to about $438,000. Austin - Round Rock – San Marcos MSA single-family average monthly rent rose by $500 to $2,300. As of August 2024, the median housing prices for Austin-Round Rock-San Marcos was approximately $100,00 higher than the median housing cost statewide. In Travis County, from 2018-2022 [14], rates of cost-burdened renters (2018, 47% and 2022, 45%) and owners (2018, 23% and 2022, 22%) have remained stable.

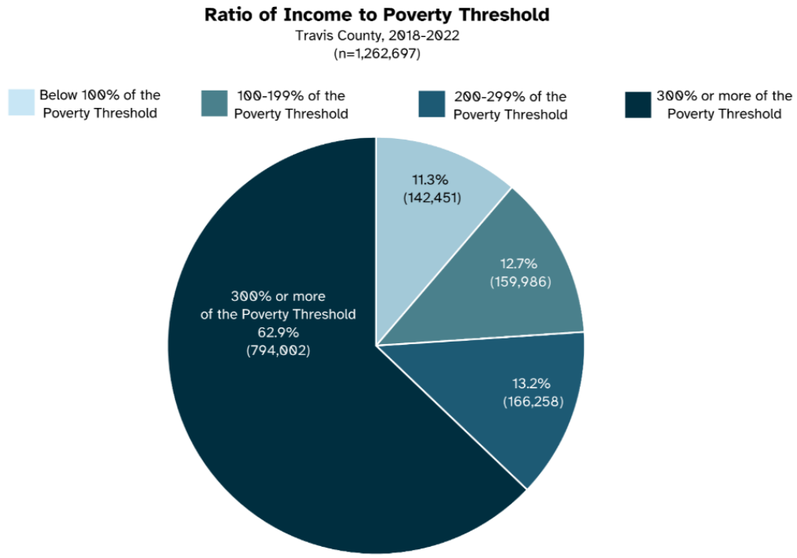
AUSTIN-ROUND ROCK-SAN MARCOS: PRICE DISTRIBUTION OF HOUSING



Source: Texas A&M University Texas Real Estate Research Center Housing Activity Data by Metropolitan Statistical Area (MSA)

Though critical, housing is just one piece of the affordability puzzle. In 2023, using primarily federal data, the Economic Policy Institute [15] estimates that the income a family of two adults and two children annually needs to attain a modest yet adequate standard of living in Travis County is $108,585. This includes expenses for housing, food, childcare, transportation, health care, other necessities, and taxes. The population Central Health serves lives on incomes at or below 200% of the Federal Poverty Level, or $62,400 for a family of four in 2024. In comparison with the income and expense estimates above, as of 2024, 7.4%, of families in Travis County live with incomes below the Federal Poverty Level. The 2024 Federal Poverty Level is set at $31,200 for a family of four, or less than a third of the funds estimated to be needed to adequately support that family in Travis County. While challenging to count, homelessness also remains a persistent issue in Travis County. Both poverty and homelessness for Travis County at large and members of Central Health's coverage programs are explored further in subsections of this report.

Initiatives and policies implemented by Travis County and the City of Austin, where roughly 73% of Travis County residents live (979,882 [16]/1,334,961 [17]), indicate that despite gains in median income, housing and other aspects of affordability are key issues. Below, we summarize examples of major local housing and affordability initiatives.



Created By: Travis County HHS Research and Planning, 2024; Source: US Census Bureau, 2022 American Community Survey 5-Year Estimates C17002 and B17024

Travis County

As part of the Supportive Housing Initiative Pipeline (SHIP) [18], the county will loan approximately $110 million to non-profits building affordable housing for people experiencing homeless or at risk of becoming homeless. Over 2,000 new affordable units will be built through this program, funded by Coronavirus State and Local Fiscal Recovery Funds (SLFRF) program authorized by the American Rescue Plan Act. These units [19] will serve different populations (single adults, family, elderly, youth), develop a mix of housing types, and help organizations new to developing supportive housing.

In addition to housing developments, in November 2024, county voters passed a ballot funding measure to support subsidized childcare. In 2023, Travis County had the highest cost of childcare in the state.

City of Austin

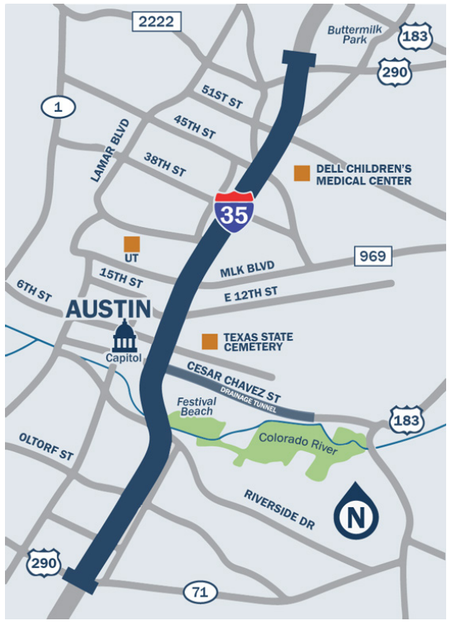
After years of blocked attempts to change the Land Development Code, in December 2023, the Austin City Council adopted phase 1 of the "Home Options for Mobility and Equity" (HOME) code amendments (Ordinance No. 20231207-001). This marked the beginning of a series of updates to the city's Land Development Code aimed at promoting a mix of housing types and increasing housing density in single-family zoned areas of Austin. Phase 2 of HOME passed in May 2024. Supporters hope HOME will increase affordable housing stock, while detractors

warn this will lead to accelerated gentrification. The first six-month report [20] on HOME phase 1, released December 2024, indicates a shift towards smaller units for new housing. For renters, the city has continued funding for the I Belong Austin [21] rent assistance program, which will prioritize applicants 50% or below AMI and provide financial assistance with rent, moving, storage, and relocation costs for tenants at risk of eviction.

Despite national and local controversies around addressing homelessness, local government and organizations continue to push for change. That same December, the city also established a separate Homeless Strategy Office (HSO). In concert with Travis County and local community-based organizations, among other initiatives the HSO anticipates a 630% [19] increase in permanent supportive housing units from 2019-2026. This includes SHIP-funded housing.

Transportation

Residents throughout the greater Austin area, and particularly Central and East Austin, can expect to be impacted by four major transportation-related projects: Project Connect[22] and the I-35 Capital Express Central [23], North [24] and South [25] highway expansion projects (I-35 CapEx). Central, North and South projects will significantly expand I-35 and displace more than 100 homes and businesses. While intended to decrease traffic congestion and introduce improvements for bicycles and pedestrians, concerns about urban sprawl and environmental impacts persist. Construction on the North and South sections are scheduled for 2022-2028 and 2023-2028 respectively, and Central is expected to take from 2024-2034.



Source: I-35 Capital Express Central Project Fact Sheet, Capital Area Mobility and Texas Department of Transportation (TxDOT)

In November 2020, voters approved a property tax rate for the operations and maintenance portion of the City's tax rate for Project Connect [22]. Project Connect aims to expand and improve Austin's transit network, adding new light rail lines, new CapMetro Rapid bus lines, and more services across the city. This includes $300 million dollars in anti-displacement funding. The latest estimates [26] have construction starting in 2027, with trains running by 2033.

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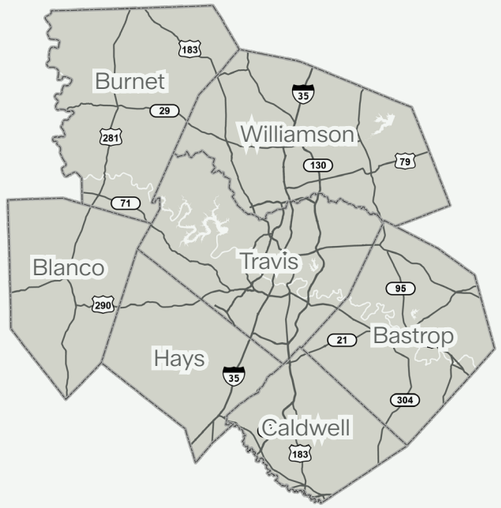
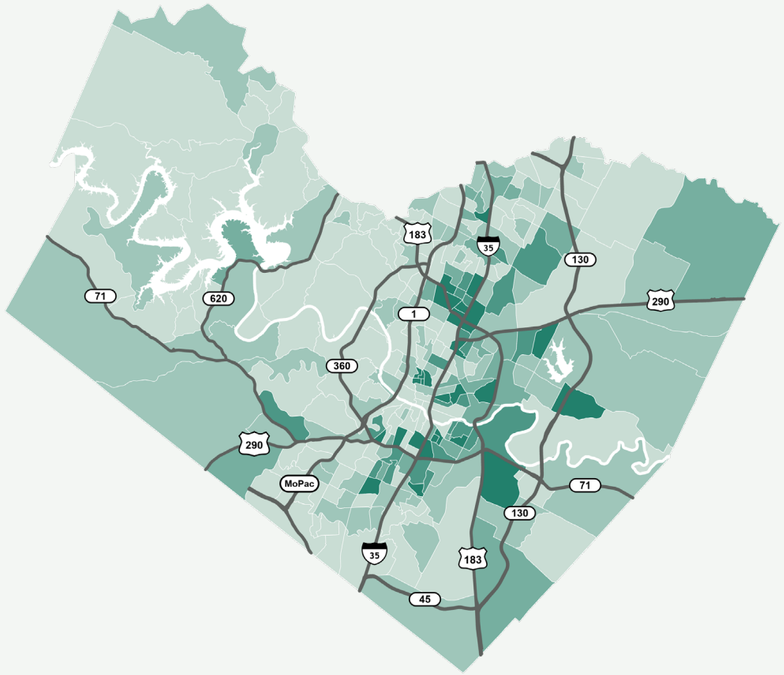
Terms & Definitions



Seven County Area

This report includes an analysis of projected geographic changes in poverty within Travis County and in its six surrounding counties. The additional counties included in this report are:

- Williamson (North)
- Bastrop (East)
- Caldwell (South)
- Hays (South)
- Blanco (West)
- Burnet (West)



Census Tracts

This report utilizes census tracts to identify population and demographic trends in Travis County. Census tracts are geographic boundaries identified by the U.S. Census Bureau, whose primary purpose is to provide stable geographic units for the presentation of statistical data. According to the Census Bureau:

- Census tracts generally have a population between 1,200 and 8,000 people, with an optimum size of 4,000 people.
- A census tract usually covers a contiguous area; however, the spatial extent of census tracts varies widely depending on the density of settlement.

Every ten years, the Census Bureau works with local communities to determine if and how census tracts should be split up or merged to account for population growth and decline. Since the last Central Health Demographic Report, data is now available using the new 2020 census tract boundaries. The change from 219 to 290 unique census tracts in Travis County allows for better population comparisons across the county. As of 2024, the population by census tract in Travis County ranges from 0 (Austin-Bergstrom International Airport) to 13,805 (Manor).

Counts, Proportions, and Rates

Counts: Counts are the number of times an item of interest occurs, such as the number of clinics or people in a geographic area. The count gives an idea of the magnitude of the item and can be compared to counts of other items.

Proportions: A proportion is a comparison of a part to the whole, usually presented as a percentage or fraction.

Rates: Rates are the measure of the frequency (count) with which an event occurs: 1.) in a defined population, and 2.) over a specified period of time.

Prevalence Rate: This is the proportion of people who have a condition at a particular time period. These are standardized to the same denominator to allow for comparisons. For example, if there were 200 cases in 2,000 people the prevalence rate would be 100 cases per 1,000 people. Prevalence is often used for chronic conditions.

Age-Adjusted Rate: Age is the single most important factor that influences the prevalence of chronic health conditions. Because different subgroups have different age populations (i.e., one area may have more people under age 50, whereas another area has fewer), it is important to adjust for these differences before making any comparisons. Central Health's analysis of chronic conditions makes use of age-adjusted prevalence rates, which are all standardized to the same reference population (in this case, the 2000 Census standard population). This is consistent with epidemiological best practices.

Ratio: A ratio is the relative magnitude of two quantities, dividing one number by another (e.g., the number of cases in one group divided by the number of cases in another group).

Prevalence Equity Index: The Prevalence Equity Index is the ratio of the observed prevalence rate to the expected prevalence rate (the county rate). A value of 1.0 indicates that the two rates are the same, which is what we would expect if no inequities existed. A value less than 1.0 indicates lower risk compared to the county rate (e.g., 0.8 would be 20% less than expected). A value more than 1.0 indicates higher risk compared to the county rate (e.g., a 1.5 would be 50% more than expected). The Equity Index, as applied to these age-adjusted prevalence rates, gives us an indication of which subgroups may be experiencing a health inequity. However, the reasons for the inequity are many and are not explored in this report.

Poverty Thresholds vs. Poverty Guidelines

The federal government utilizes two standards to determine poverty status for U.S. residents: poverty thresholds and poverty guidelines. According to the U.S. Department of Health & Human Services (HHS):

The **poverty thresholds** are the original standard for measuring poverty. They are updated each year by the Census Bureau. The thresholds are used mainly for statistical purposes — for instance, preparing estimates of the number of Americans in poverty each year.

This report utilizes poverty threshold data collected by the Census Bureau for tracking and projecting families in poverty. For context, for a family of four with two wage earners, the threshold would equal $31,812 per year, $2,651 per month, $611 per week, and an hourly wage of $7.65 per earner.

Poverty Thresholds for 2024

Size Of Family Unit	Weighted Average Threshold	Range (depending on age and number of children)
1	$15,940	$15,045 - 16,320
2	$20,260	$18,961 - 21,621
3	$24,940	$24,537 - 25,273
4	$32,120	$31,812 - 32,884
5	$38,080	$36,863 - 39,586
6	$43,090	$41,131 - 45,057
7	$49,080	$45,100 - 51,961
8	$54,410	$51,177 - 58,263
9+	$64,760	$60,645 - 69,810

Source: U.s. Census Bureau

Poverty guidelines are the other federal poverty measure and are often referred to as the **"federal poverty level"** or **FPL**. They are issued each year in the Federal Register by HHS. The guidelines are a simplification of the poverty thresholds and are used for administrative purposes — for instance, determining financial eligibility for subsidy assistance programs.

FPL guidelines are used to determine eligibility for Central Health, state-funded health care programs, and Affordable Care Act Marketplace subsidies.

How are families, households, enrollees, and utilizers defined?

Families: This report measures and provides comparisons of changes in families in poverty. A unique family counts as two or more related people living together. To calculate total family income, every related family member's annual income is added together. If the family's total income is below the poverty threshold, then the family and every individual in it is considered to be living in poverty.

In Travis County in 2024, there were an estimated:

- 319,953 families
- 23,812 families in poverty
- 7.4 percent of families living in poverty (100% FPL)

Households: In this report, data collected at the household level is used to compare family structures, transportation access, and income between census tracts. A household is considered as one or more people who reside within a single housing unit. A household can include people who are not related to one another.

In Travis County in 2024 there were an estimated 556,620 households.

Enrollees: In this report, enrollees are defined as individuals who are enrolled in one of the following programs:

- The Central Health Medical Access Program (MAP);
- The Central Health Medical Access Program Basic (MAP Basic);
- Local sliding fee scale (SFS) subsidy programs reimbursed by Central Health;
- Central Health Assistance Program (CHAP).

MAP provides a defined benefit package to eligible residents who are at or below 100% of the FPL. MAP Basic covers uninsured residents who are at or below 200% of the FPL. Residents who earn up to 200% of the FPL may receive subsidized health care on a sliding fee scale through Central Health's network of primary care providers.

Utilizers: This report looks at the utilization of services by census tract for defined focus areas. A utilizer is defined as an enrollee who had a medical, dental, behavioral health, urgent care, or other encounter with a provider in Central Health's network in Fiscal Year 2023.

Review of Data Sources

2029 population projections as well as data on 2024 total population demographics, families, families <= 100% of poverty, households without vehicles, average commute times, employment, educational attainment, income, median rent, and home values come from Claritas's Pop-Facts Premier database. This database incorporates the U.S. Census Bureau's American Community Survey (ACS) data and other market data sources to provide current year and five year projection data at the level of Census geographies. Additional separate ACS poverty estimates for families <149% (B07012) and <200% FPL (S1702) have informed this work.

This report also utilized several publicly available data sets. To determine the number of affordable housing units and developments that exist within Travis County as of October 2024, data from the City of Austin's Affordable Housing Inventory, the National Housing Preservation Database, and the U.S. Department of Housing and Urban Development (HUD) was deduplicated and compiled into a single data set. CapMetro data on bus routes, bus stops, transit hubs, and Pickup service areas was used in conjunction with Capital Area Rural Transportation Service (CARTS) data to map and identify the availability of public transportation within the focus areas of this report. Additionally, publicly available geography files from the U.S. Census Bureau, City of Austin, and Travis County have been leveraged to create the maps featured in this report.

The Central Health Analytics and Reporting team compiled enrollee-level data from internal eligibility and claims databases. Additionally, Sendero provided data on individuals who were part of the CHAP Expansion Initiative. Enrollee addresses have been geocoded so that enrollee-level data may be mapped at the census tract level. 94.8 percent of enrollees had complete addresses that could be matched to a location in Travis County. 97 percent of enrollees without a valid address reported experiencing homelessness at least once during the fiscal year. Note that for Central Health, the fiscal year runs from October through September. So, for example, Fiscal Year 2023 was from October 2022 to September 2023.


Hungry
Please H
Thank
Jeep

Poverty

This section includes an analysis of current and projected poverty within Travis County. To understand broader geographic shifts in poverty, an analysis of poverty within the six surrounding counties is also included in this section. These counties are: Williamson (North), Bastrop (East), Caldwell (South), Hays (South), Blanco (West), and Burnet (West).

Poverty

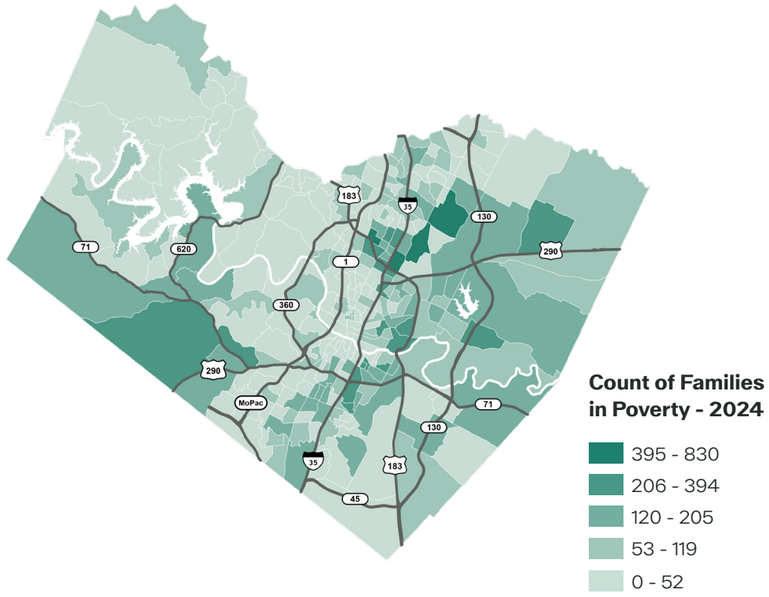
2024	2029
23,812 (7.4%) OF FAMILIES IN TRAVIS COUNTY IN POVERTY (< 100% FPL)	**25,589 (7.5%)** OF FAMILIES IN TRAVIS COUNTY IN POVERTY (< 100% FPL)

As of 2024, there are 23,812 families in poverty residing in Travis County. This represents 7.4% of all families in Travis County. Over the next five years, it is projected that there will be an additional 1,777 families living below 100% of the Federal Poverty Level (FPL) within the county.

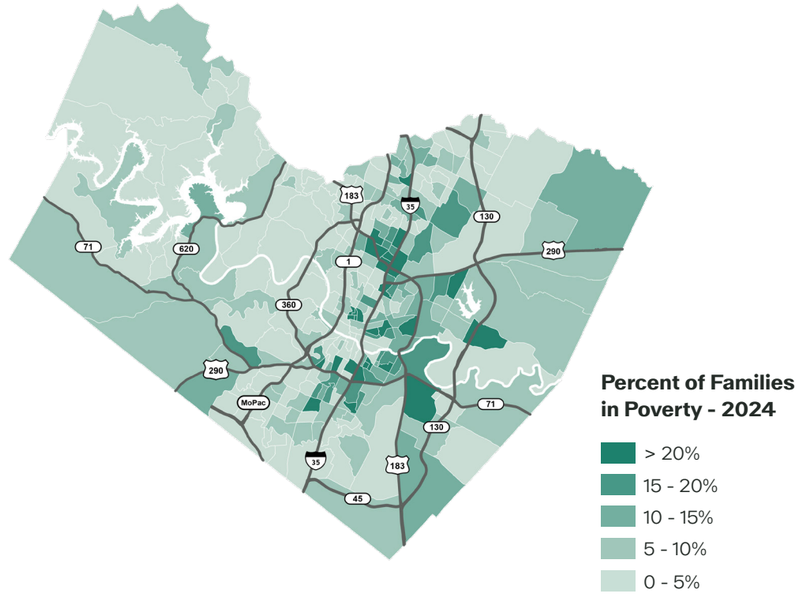
This projected 7.5% increase in the number of families in poverty is expected to occur primarily in areas of existing moderate and high poverty. These areas are primarily located along the I-35 corridor, but over the past decade the proportion of families in poverty that live in East and West Travis County has grown and is expected to continue to grow.

The next section of this report will provide an in-depth analysis of the areas in Travis County that are projected to have high concentrations of poverty in 2029. This analysis will divide the census tracts into nine distinct focus areas and share information such as the demographic characteristics of the population, Central Health enrollment in these areas, chronic condition prevalence, and other factors compared to Travis County as a whole.

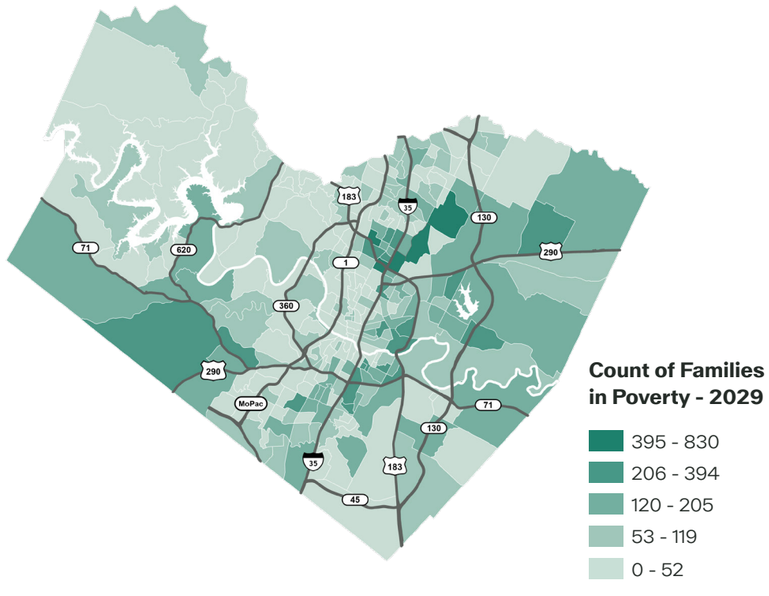
COUNT OF TRAVIS COUNTY FAMILIES IN POVERTY - 2024



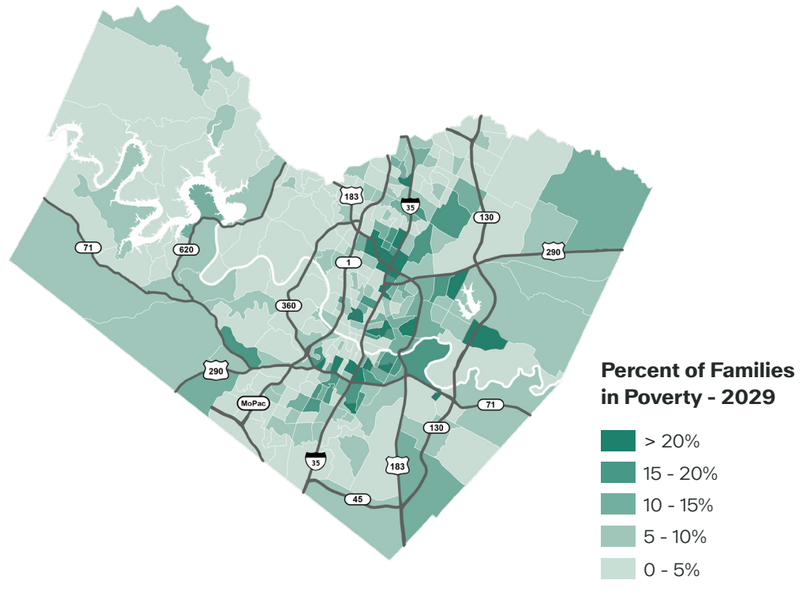
PERCENT OF TRAVIS COUNTY FAMILIES IN POVERTY - 2024



COUNT OF TRAVIS COUNTY FAMILIES IN POVERTY - 2029



PERCENT OF TRAVIS COUNTY FAMILIES IN POVERTY - 2029



Poverty In Surrounding Counties

To understand broader geographic changes in poverty, this section includes a review of the six counties surrounding Travis County. These counties in clockwise order are: Williamson (North), Bastrop (East), Caldwell (South), Hays (South), Blanco (West), and Burnet (West).

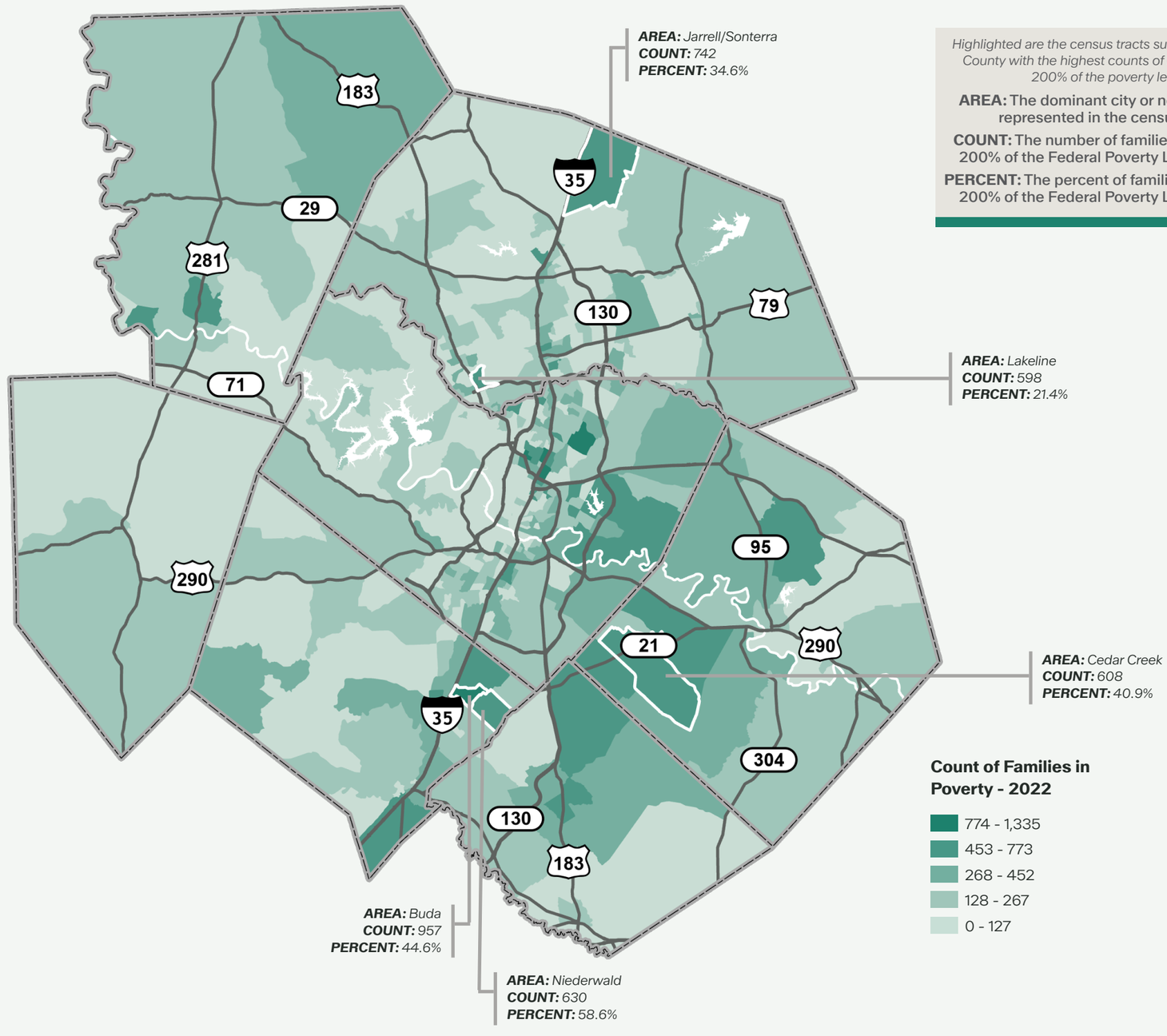
In previous Demographic Reports, Central Health has shown that historically the largest concentrations of poverty have been along the I-35 corridor. While a large portion of families under 200% FPL are still located in communities along I-35, in surrounding counties there are sizable concentrations of poverty centered mainly around larger towns and cities as well. Some of the areas with the highest counts and percentages of families in poverty outside of Travis County include Marble Falls, Jarrell, McDade, Cedar Creek/Elroy, Lockhart, Buda, and San Marcos.

Travis County still has the highest number of families in poverty in the area, but Caldwell County has the highest percentage of families in poverty with more than 1 in 4 families below 200% FPL. Williamson County has the second highest count of families in poverty, but the lowest proportion of families in poverty in the Seven County Area.

Families in Poverty (<200% FPL) - 2022

Region	Families <200% FPL	Total Families	Percent of families <200% FPL
Bastrop County	6,195	23,758	26.1%
Blanco County	644	3,362	19.2%
Burnet County	2,893	13,066	22.1%
Caldwell County	2,942	10,595	27.8%
Hays County	11,575	58,878	19.7%
Travis County	53,891	302,407	17.8%
Williamson County	21,730	163,835	13.3%

FAMILIES WITH INCOME BELOW 200% OF THE POVERTY LEVEL IN THE SEVEN COUNTY AREA - 2022 (ACS 5-YEAR ESTIMATES)



Highlighted are the census tracts surrounding Travis County with the highest counts of families below 200% of the poverty level

AREA: The dominant city or neighborhood represented in the census tract

COUNT: The number of families living below 200% of the Federal Poverty Level in 2022

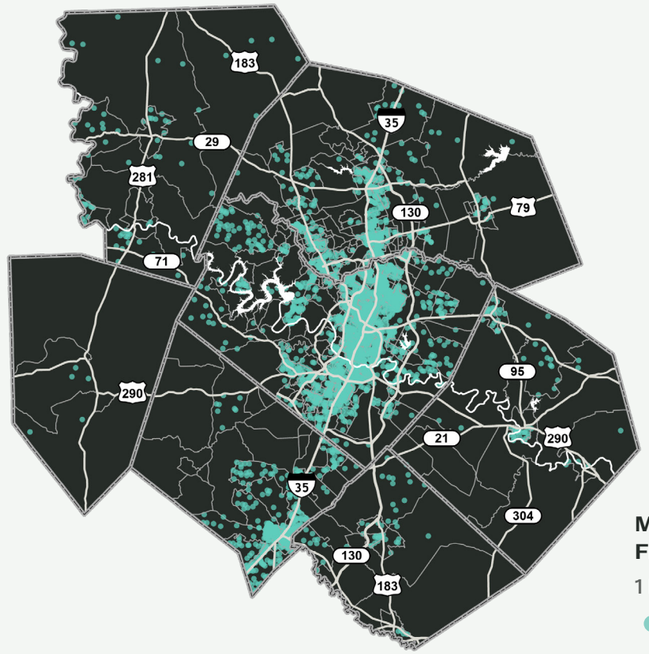
PERCENT: The percent of families living below 200% of the Federal Poverty Level in 2022

Geographic Movement of Individuals in Poverty in the Seven County Area

The American Community Survey (ACS) estimates that on average from 2017 to 2022 24.4% of individuals below 150% FPL moved during the previous twelve months. For each county in the Seven County Area, at least 75% of individuals that have recently moved either moved within their original county of residence or from a different Texas county. In Bastrop, Blanco, Caldwell, and Hays Counties, most of the movement of those in poverty were people moving into the area from other Texas counties. In Burnet, Travis, and Williamson Counties, most of the movement of those in poverty was within the original county of residence. 3.0% of those in poverty in the Seven County Area moved from a different state in the past year, and only 1.8% moved to the area from abroad.

In the maps to the right, each dot has been randomly generated to a place within a given census tract and represents ten individuals that moved to the census tract. Blanco, Cedar Creek/Elroy, and Luling are a few of the areas that have a much higher proportion of people in poverty moving to them from other Texas counties than anywhere else. The Blackhawk area of East Pflugerville stands out as being one of the few areas where most of those who have recently moved came from a different state. While there are many areas in the region where a majority of those of moved came from other areas within the county, Del Valle, Hornsby Bend, Lago Vista, and Manor are areas that have a particularly high proportion of those in poverty moving there from elsewhere in the county.

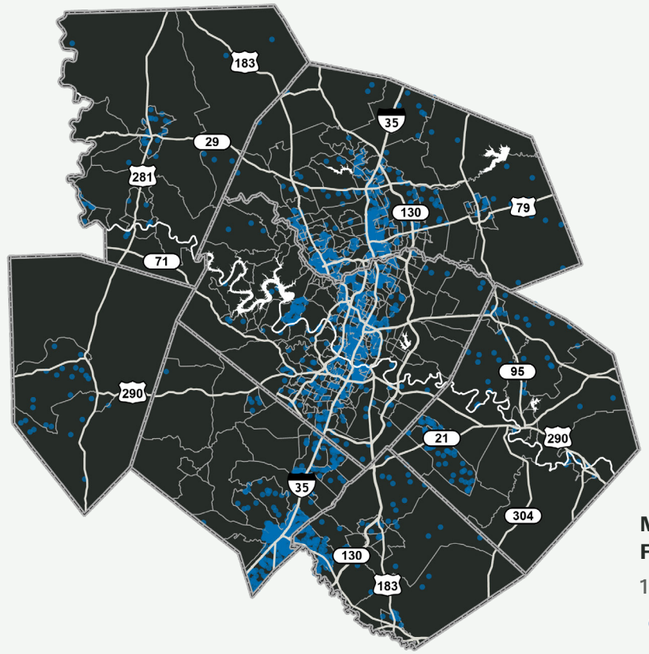
GEOGRAPHIC MOVEMENT OF INDIVIDUALS BELOW 150% OF THE POVERTY LEVEL DURING THE PAST YEAR - 2022 (ACS 5-YEAR ESTIMATES)



Movement of < 150% FPL Individuals

1 Dot = 10 Individuals

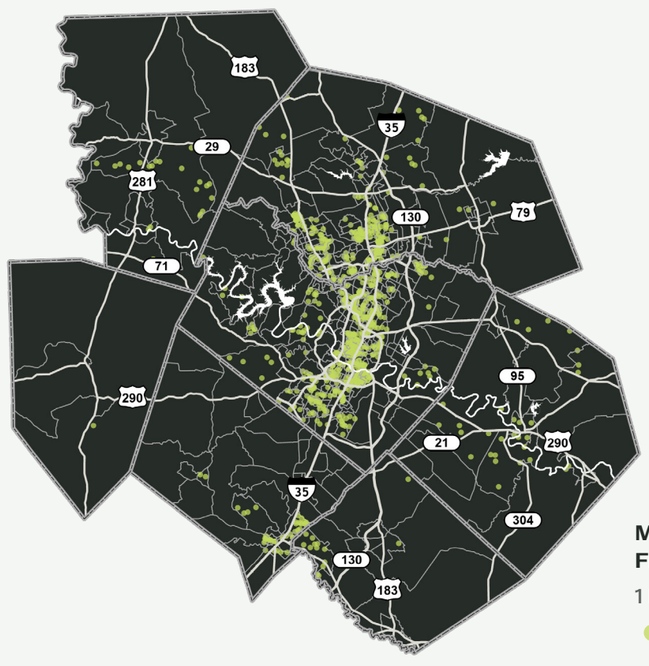
Moved Within the County



Movement of < 150% FPL Individuals

1 Dot = 10 Individuals

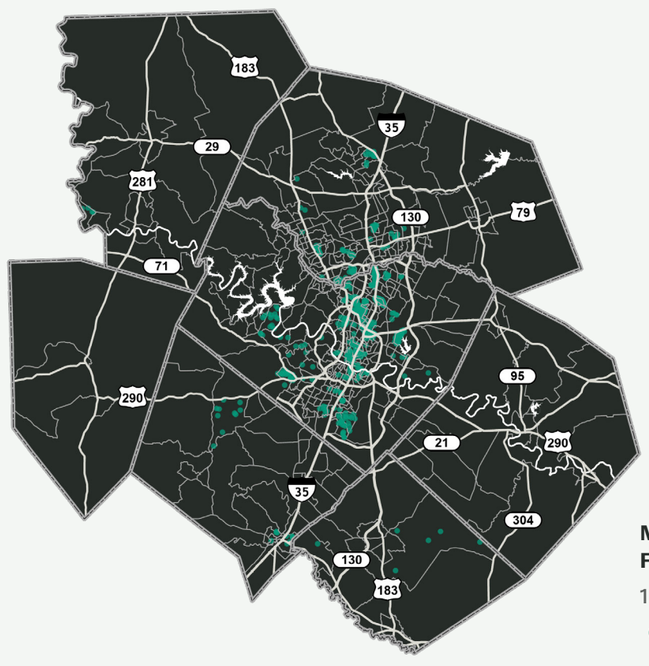
Moved from Other Texas County



Movement of < 150% FPL Individuals

1 Dot = 10 Individuals

Moved from Different State



Movement of < 150% FPL Individuals

1 Dot = 10 Individuals

Moved from Abroad

Travis County is estimated to have the most individuals below 150% FPL who have moved during the past twelve months among the counties in the Seven County Area. Additionally, Travis County has the highest number and percentage of individuals in poverty that relocated within their original county of residence. Those below 150% FPL have greater geographic mobility than the overall population. For example, while 9.6% of all Blanco County residents were estimated to have moved during the past year, 17.1% of Blanco County residents below 150% FPL are estimated to have moved during the same period. Bastrop County is the only county in the region that is estimated to have similar rates of movement among the total population and those experiencing poverty.

Population that Moved During the Past Year - 2022

Region	Percent of Individuals <150% FPL	Percent of Total Population
Bastrop County	9.9%	10.6%
Blanco County	17.1%	9.6%
Burnet County	15.4%	12.8%
Caldwell County	16.6%	10.0%
Hays County	22.5%	15.8%
Travis County	26.7%	18.7%
Williamson County	25.1%	20.2%

A later section of this report will cover the geographic movement of those enrolled in Central Health programs over the past five fiscal years. The percentage of enrollees who move year-over-year is lower than these ACS estimates for those below 150% FPL. There are a few reasons why these figures are different. First, ACS data are survey estimates that aim to accurately determine population figures. Because these are estimates, they have a margin of error and that means that the figures will not always perfectly align with real population counts. Central Health enrollment data; however, represents actual individuals in poverty who are known to have moved within a given period of time. Second, Central Health's enrollment programs cover up to 200% FPL, not just 150% FPL. Third, ACS counts any movement out of a residence as having moved, but for the purposes of studying broader geographic shifts, the enrollee movement analyzed later in this report focuses only on movement outside of a census tract.

Digging Deeper: Understanding Historic and Future Changes in Poverty

Looking at both the broader estimates of poverty as well as Central Health's enrollment data is important to get the best understanding of how Travis County and Central Texas are changing and how those in poverty are impacted by those changes. According to the Department of Health's Office of Disease Prevention and Health Promotion[1], individuals with lower incomes are more likely to be subject to housing instability and therefore more likely to need to move. Knowing where those in poverty are moving to is important to ensure that service planning efforts account for where there is shifting need in the community. Better understanding the movement of those in poverty is also important because cost-burdened households that have to move more frequently often face additional health consequences due to poor quality housing, an increased difficulty in establishing access to resources, and heightened stress impacting mental health. The rest of this report will expand upon where poverty is anticipated to be the highest in Travis County by 2029 and provide deeper insights into the health of Central Health enrolled population.

Historic Changes in Population and Families in Poverty (<100% FPL) in Travis County

Time Period	Families <100% FPL	Total Population
2020	23,181	1,283,790
2022	23,655	1,330,492
2024	23,812	1,367,492
2020 to 2024	▲ 2.7%	▲ 6.5%

2024 Demographic Report Focus Area: Southeast Austin, View of Apartments Near Burton Drive

2024 Demographic Report Focus Area: Northeast Austin, I-35 and 290 Intersection

2024 Demographic Report Focus Area: East Central Austin, Facing Downtown Austin

2024 Demographic Report Focus Area: Manor, Downtown Manor at the Intersection of Lexington and Old Highway 20

[1] *Healthy People 2030: Housing Instability.U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/housing-instability*


HE STILL
DOES
MIRACLES

Focus Areas

The purpose of this section is to further focus on the 27 Travis County census tracts projected to have high and moderate levels of poverty in 2029. The analysis in this section will:

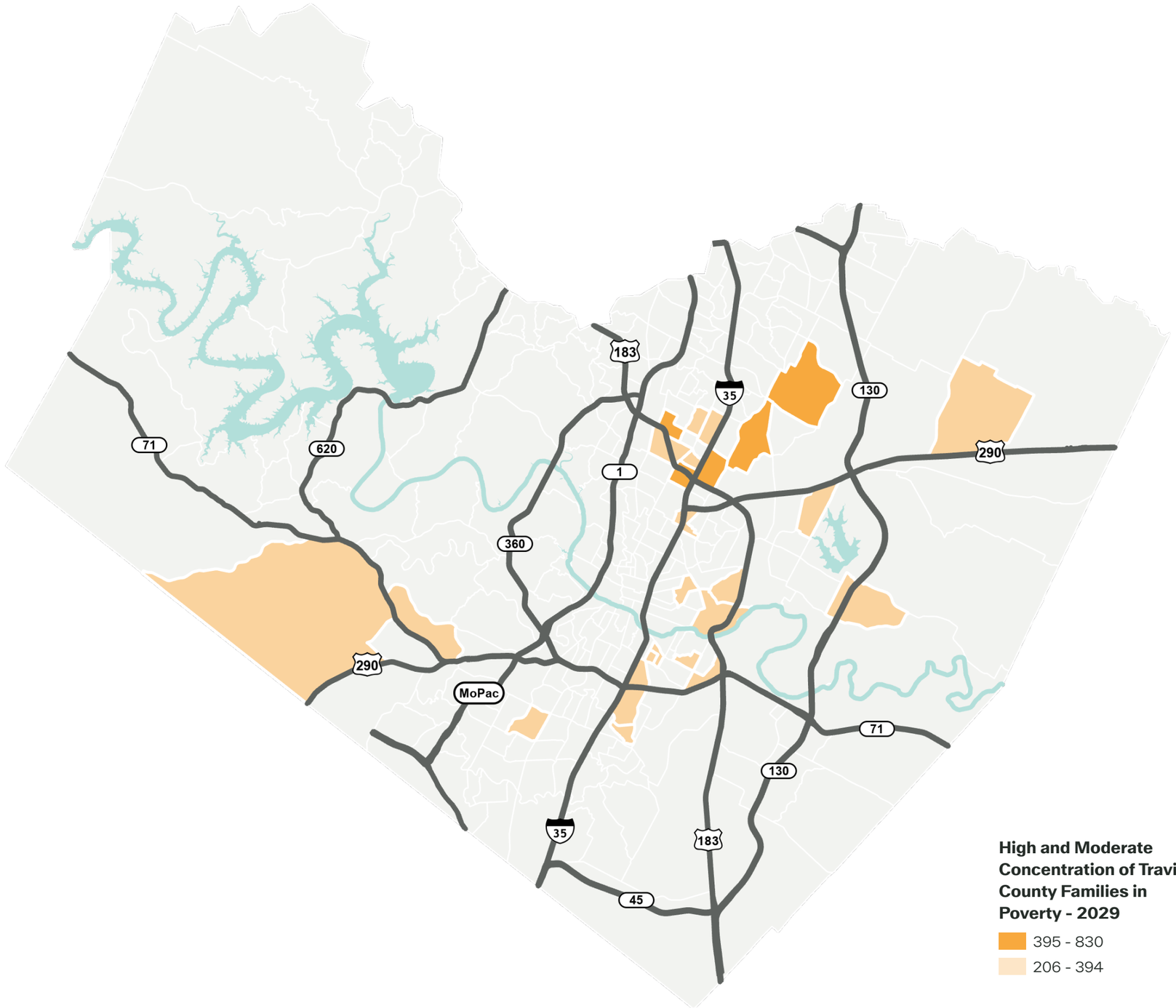
- Divide the highlighted census tracts into nine focus areas based primarily on distinct topographical divides such as roads, bodies of water, and geopolitical boundaries
- Share current and historic demographic characteristics of each focus area
- Provide data analyzing the number of residents enrolled in Central Health programs and the number utilizing services through Central Health contracted providers
- Compare the prevalence rates of chronic conditions; public transportation and affordable housing availability; and Social Determinants of Health (SDoH) indicators at the focus area level versus Travis County overall

Focus Areas

Overview

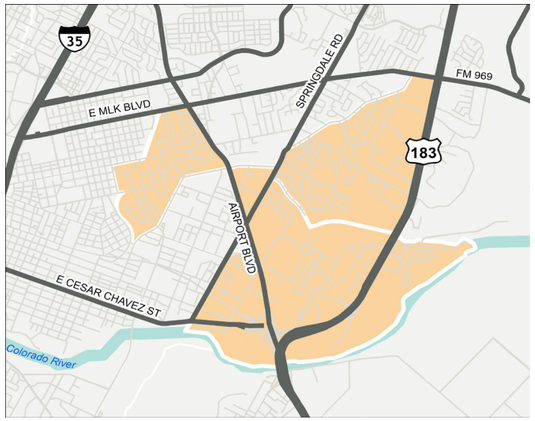
The purpose of this section is to focus in on the 9% of Travis County census tracts (27 of 290) projected to have high and moderately-high levels of poverty in the next five years (i.e. 2029). The analysis in this section will:

- Divide the highlighted census tracts into nine focus areas with distinct topographical divides such as roads, bodies of water, and geopolitical boundaries.
- Compare current and past demographic data for Travis County, each focus area, and for enrollees residing in focus areas.
- Assess social determinants of health characteristics for each focus area including income, education, employment, and housing.
- Provide data analyzing the number of residents enrolled in Central Health programs and the number utilizing services through Central Health contracted providers.
- Compare the prevalence rates of chronic conditions within focus areas and the broader enrolled population.
- Provide data on utilization factors including proximity to hospitals and clinics; types of services accessed; and locations with the highest number of visits.



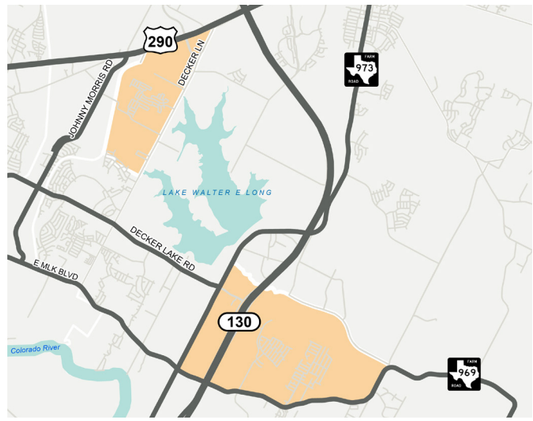
East Central Austin

Population: 14,407



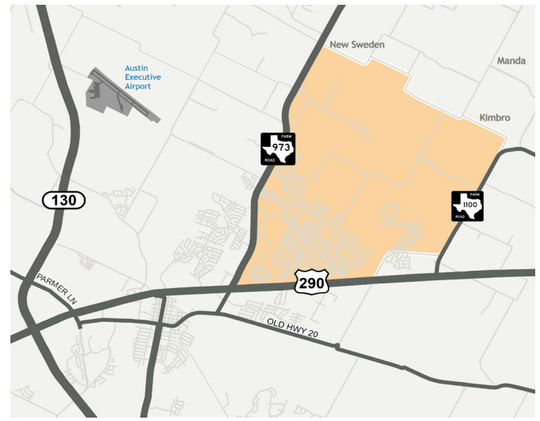
East Central Travis County

Population: 9,051



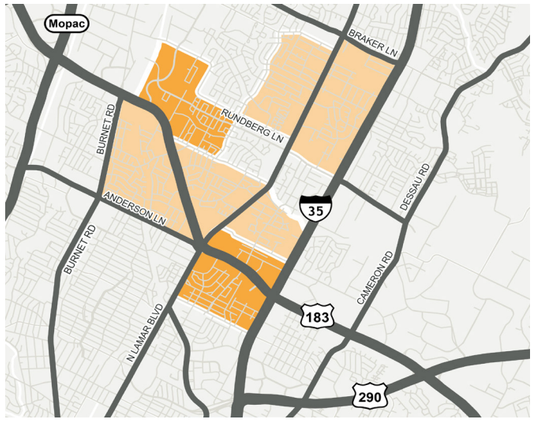
Manor

Population: 13,805



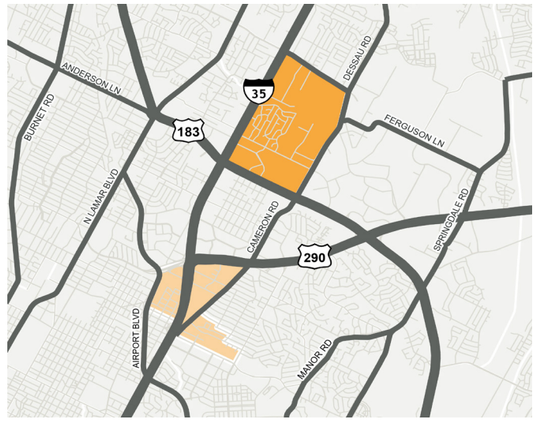
North Central Austin (Rundberg)

Population: 40,235



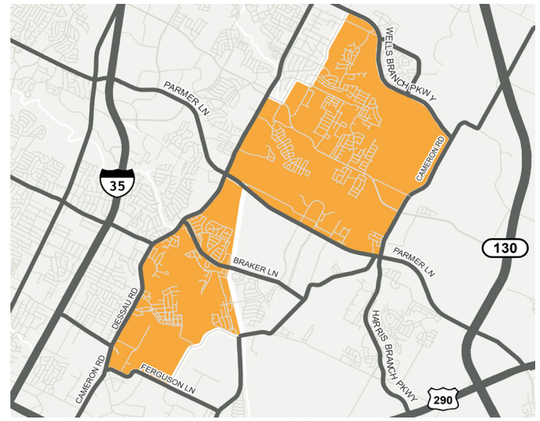
Northeast Austin

Population: 13,457



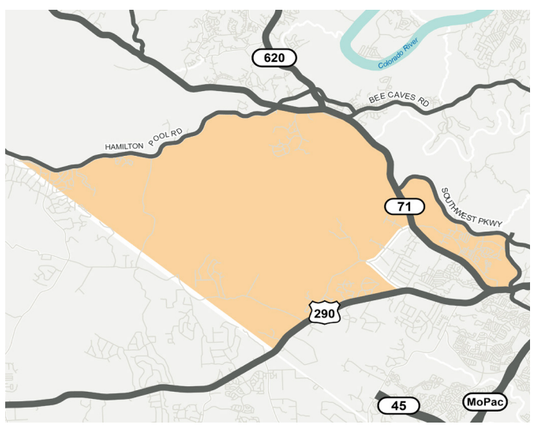
Northeast Travis County

Population: 19,962



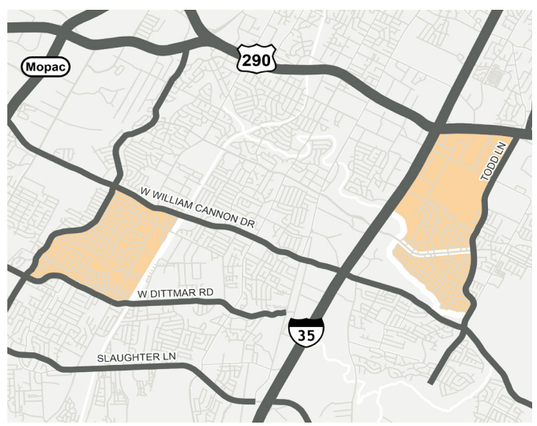
Oak Hill

Population: 17,012



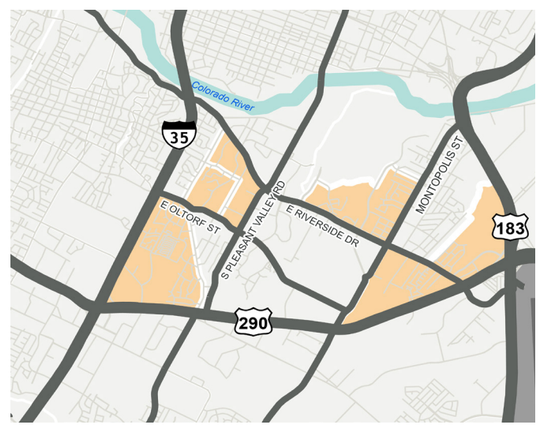
South Central Austin

Population: 18,258



Southeast Austin

Population: 23,400



Focus Areas

East Central Austin

TOTAL POPULATION: **14,407**
LAND AREA: **4.6 SQMI**

NEIGHBORHOODS

A. **Rosewood/Chestnut (Census Tract 8.05)**
B. **MLK-183 (Census Tract 22.10)**
C. **Govalle/Johnston Terrace (Census Tract 21.11)**

HEALTH CARE ACCESS [1]
Primary Care: **6**

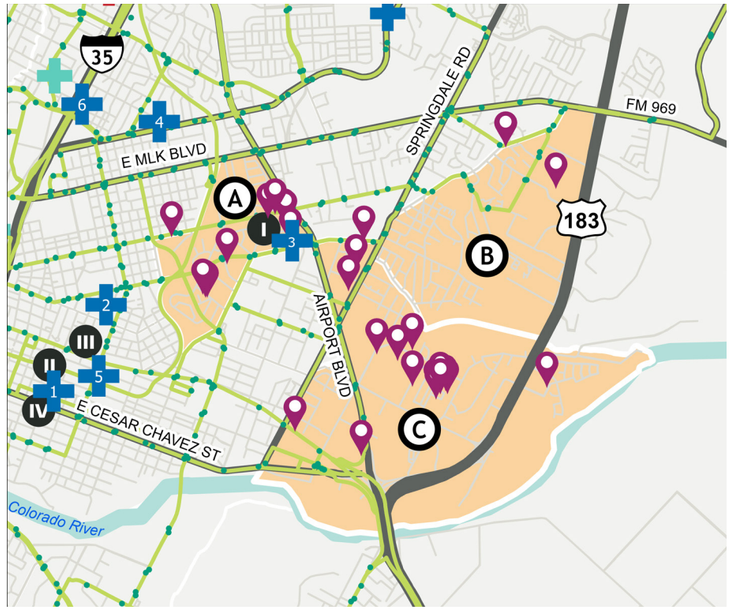
1. **CUC East Austin**
2. **CUC Sandra Joy Anderson**
3. **LSCC OB/GYN Oak Springs**
4. **PCC Center for Women's Health**
5. **Planned Parenthood Downtown**
6. **UT School of Nursing Family Wellness Center**

Urgent/Convenient Care: **0**
Hospital: **0**

AFFORDABLE HOUSING
Housing Developments: **30**
Housing Units: **1,697**

PUBLIC TRANSPORTATION

There are **14 CapMetro bus routes and 54 bus stops** within East Central Austin. Pickup by CapMetro offers services in portions of all three census tracts in the focus area. Additionally, there are **5 Capital Area Rural Transportation System (CARTS) Interurban Routes** that stop at the Eastside Bus Plaza and offer transportation within and outside of Travis County.



KEY

- High Concentrations of Poverty
- Moderate Concentrations of Poverty
- Affordable Housing Developments
- Bus Routes and Stops
- Hospital
- Primary Care Clinic
- Convenient/Urgent Care Clinic

Ribbon Cutting Ceremony at Central Health's Rosewood-Zaragosa Specialty Clinic

Central Health East Austin Specialty Clinic

MLK Jr. Community Festival at Huston-Tillotson University

View Above Central Health's East Austin Specialty Clinic, Facing Downtown Austin

KEY ▲ **Above Overall County** = **At Overall County** ▼ **Below Overall County**

INCOME

▼ **$81,205** Median Household Income

HOUSING

▼ **$1,239** Median Rent
▼ **$571,620** Median Housing Unit Value
▲ **8.2%** Mobile Homes

EDUCATION [2]

▲ **17.2%** Less than HS Diploma
▲ **18.0%** HS Graduate
▼ **31.3%** Bachelor's Degree
▼ **15.1%** Post-Grad Degree

EMPLOYMENT [3]

▼ **14.7%** Professional/ Scientific/ Technical Services
▲ **12.5%** Educational Services
▲ **9.5%** Retail Trade

FAMILY

▼ **43.3%** of Households Have Married or Cohabiting Couples
▼ **21.3%** of Households Have Children <18 Years Old

TRANSPORTATION

▲ **11.3%** of Housing Units Do Not Have a Vehicle
▼ **25 Minute** Average Commute to Work

[1] *Funded by central health and located within 1 mile of the focus area.* [2] *Educational attainment is based on the population age 25+.* [3] *Employment industry data is representative of the civilian population age 16+.*

Travis County

2020 | **2024**

1,367,492
TOTAL POPULATION
▲ 6.0% SINCE 2020

23,812 (7.4%)
FAMILIES IN POVERTY [1]

AGE

<18	**20.2%**	21.2%
18-44	**45.6%**	46.6%
45-64	22.0%	**22.7%**
65+	10.3%	**11.6%**

MEDIAN AGE: 37

LANGUAGE

English	**70.4%**
Other	**8.3%**
Spanish	**21.3%**

SEX

49.6%	**50.4%**
50.0%	50.0%
Female	Male

RACE/ETHNICITY [2]

Asian	7.8%	**8.5%**
Black	7.8%	**7.9%**
Latino	32.6%	**32.6%**
Other	29.3%	**29.6%**
White	**53.9%**	55.0%

East Central Austin

2020 | **2024**

14,407
TOTAL POPULATION
▲ 14.4% SINCE 2020

701 (19.2%)
FAMILIES IN POVERTY [1]

AGE

<18	**22.6%**	24.4%
18-44	**49.5%**	50.4%
45-64	17.0%	**18.6%**
65+	8.2%	**9.2%**

MEDIAN AGE: 33

LANGUAGE

English	**72.2%**
Other	**1.2%**
Spanish	**26.6%**

SEX

49.7%	**50.3%**
49.7%	50.3%
Female	Male

RACE/ETHNICITY [2]

Asian	1.9%	**2.3%**
Black	**18.7%**	21.9%
Latino	**41.0%**	43.6%
Other	**31.7%**	33.7%
White	42.5%	**47.3%**

Enrollees in Focus Area

FY21 | **FY23**

1,584
[1 IN 10 RESIDENTS]
ENROLLED IN CENTRAL HEALTH PROGRAMS
▼ 3.1% SINCE FY21

AGE

<18	**14.7%**	22.9%
18-44	45.9%	**49.1%**
45-64	27.6%	**30.5%**
65+	3.6%	**5.7%**

MEDIAN AGE: 38

LANGUAGE

English	**42.0%**	51.4%
Other	3.9%	**4.3%**
Spanish	37.2%	**46.9%**
Unreported	**6.8%**	7.5%

SEX

57.5%	**42.5%**
58.1%	41.9%
Female	Male

RACE/ETHNICITY [2]

Asian	*%	***%**
Black	**16.5%**	18.5%
Latino	65.0%	**66.4%**
Other	5.6%	**7.2%**
Unreported	*%	***%**
White	**6.6%**	7.1%

Utilization

60.7% OF ENROLLEES UTILIZED SERVICES IN FY23

Between FY21 and FY23, the number of health care visits enrollees had increased by **20.0%**. Out of the East Central Austin enrollees who utilized care, **73.2%** visited a primary care physician, **23.6%** had a specialty care visit, and **26.5%** had a visit in an Emergency Department (ED).

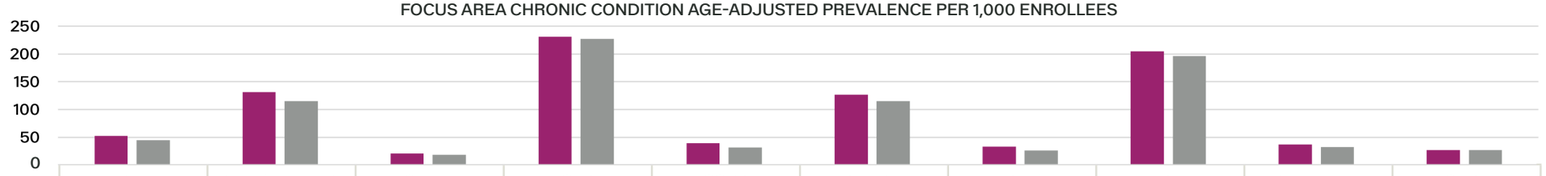
Top 5 provider locations visited by enrollees in focus area

		Number of visits in FY21	FY23
1	Central Health Southeast Health & Wellness Center	581	**760**
2	CUC Anderson Health & Wellness Center	**704**	728
3	Dell Seton Medical Center at The University of Texas	428	**592**
4	CUC North Central	205	**386**
5	Seton Medical Center Austin	285	**382**

Chronic Conditions

The top three chronic conditions by prevalence for members living in the East Central Austin focus area were 1.) **Cardiovascular Disease** (231/1,000 persons), 2.) **Hypertension** (205/1,000), and 3.) **Behavioral Health** (132/1,000). There were no statistically significant differences in the prevalence rates for people living in this focus area. Overall, people living in this focus area were 10% less likely to have a diagnosis for one or more of these chronic conditions.

FOCUS AREA CHRONIC CONDITION AGE-ADJUSTED PREVALENCE PER 1,000 ENROLLEES



	Asthma	Behavioral Health	Cancer	CVD	COPD	Diabetes	Heart Failure	Hypertension	Renal Failure	SUDs
Focus Area Prevalence	52.5	131.6	20.8	231.4	39.4	126.5	32.8	205.1	36.9	26.9
All Enrollees Prevalence	44.8	114.7	18.6	227.2	31.5	115.1	26.3	196.6	32.3	26.6

The Equity Index is a ratio of the observed prevalence rate to the expected prevalence rate (the county rate) among Central Health's patients. A value less than 1.0 indicates lower risk compared to the county rate. A value more than 1.0 indicates higher risk compared to the county rate. This Equity Index, as applied to these age-adjusted prevalence rates, gives us an indication of which subgroups may be experiencing a health inequity.

	Asthma	Behavioral Health	Cancer	CVD	COPD	Diabetes	Heart Failure	Hypertension	Renal Failure	SUDs
Equity Index	**1.2**	**1.1**	**1.1**	**1.0**	**1.3**	**1.1**	**1.2**	**1.0**	**1.1**	**1.0**

*[1] Families whose income was ≤100% FPL in 2024. [2] Ethnicity and race are separate for total population counts and combined for Central Health enrollment counts. * Data suppressed to maintain privacy standards.*

Focus Areas

East Central Travis County

TOTAL POPULATION: **9,051**
LAND AREA: **6.4 SQMI**

NEIGHBORHOODS

A. Daffan/Decker (Census Tract 22.21)

B. Hornsby Bend (Census Tract 22.15)

HEALTH CARE ACCESS [1]

Primary Care: **1**

1. **Central Health Hornsby Bend Health & Wellness Center**

Urgent/Convenient Care: **0**

Hospital: **0**

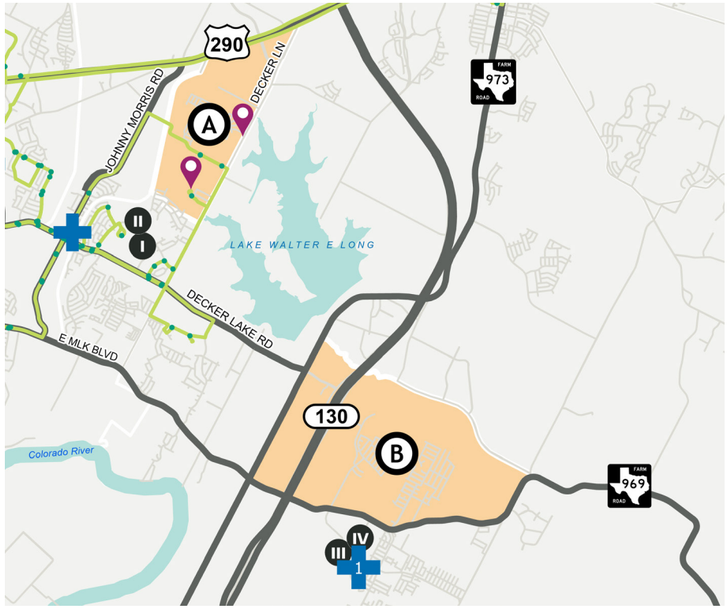
AFFORDABLE HOUSING

Housing Developments: **2**

Housing Units: **502**

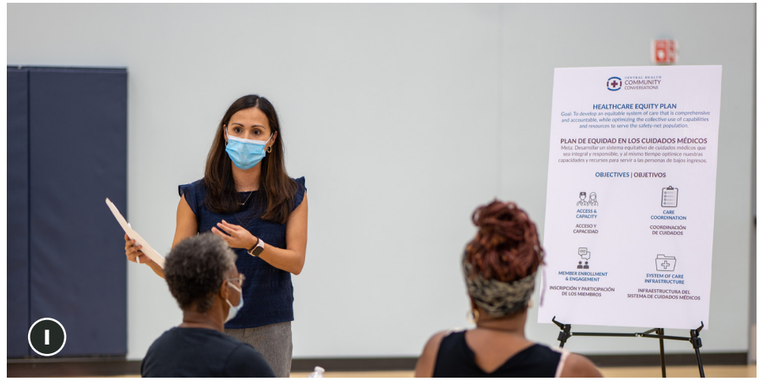
PUBLIC TRANSPORTATION

There is **1 CapMetro bus route** that stops within East Central Travis County. Route 233 has **3 bus stops** in the focus area. CapMetro has proposed a new Pickup by CapMetro Decker Zone that would cover portions of Census Tract A.



KEY

- High Concentrations of Poverty
- Moderate Concentrations of Poverty
- Affordable Housing Developments
- Bus Routes and Stops
- Hospital
- Primary Care Clinic
- Convenient/Urgent Care Clinic



Colony Park Community Conversation at Turner Roberts Recreation Center

Turner Roberts Recreation Center & Overton Elementary

SNAP-A-THON at Hornsby Bend Health & Wellness Center

Central Health Hornsby Bend Health & Wellness Center

KEY ▲ **Above Overall County** = **At Overall County** ▼ **Below Overall County**

INCOME

▼ **$68,772**
Median Household Income

HOUSING

▼ **$1,370** Median Rent
▼ **$173,966** Median Housing Unit Value
▲ **31.9%** Mobile Homes

EDUCATION [2]

▲ **25.5%** Less than HS Diploma
▲ **34.6%** HS Graduate
▼ **13.2%** Bachelor's Degree
▼ **8.7%** Post-Grad Degree

EMPLOYMENT [3]

▲ **22.5%** Construction
▲ **13.1%** Educational Services
▲ **12.7%** Health Care/ Social Assistance

FAMILY

▲ **57.9%** of Households Have Married or Cohabiting Couples
▲ **39.7%** of Households Have Children <18 Years Old

TRANSPORTATION

▼ **4.2%** of Housing Units Do Not Have a Vehicle
▲ **36 Minute** Average Commute to Work

[1] *Funded by central health and located within 1 mile of the focus area.* [2] *Educational attainment is based on the population age 25+.* [3] *Employment industry data is representative of the civilian population age 16+.*

CENTRAL HEALTH

Travis County

2020 **2024**

1,367,492
TOTAL POPULATION
▲ 6.0% SINCE 2020

23,812 (7.4%)
FAMILIES IN POVERTY [1]

AGE

<18	**20.2%**	21.2%
18-44	**45.6%**	46.6%
45-64	22.0%	**22.7%**
65+	10.3%	**11.6%**

MEDIAN AGE: 37

LANGUAGE

English	**70.4%**
Other	**8.3%**
Spanish	**21.3%**

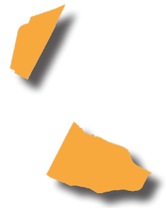
SEX

49.6%	**50.4%**
50.0%	50.0%
Female	Male

RACE/ETHNICITY [2]

Asian	7.8%	**8.5%**
Black	7.8%	**7.9%**
Latino	32.6%	**32.6%**
Other	29.3%	**29.6%**
White	**53.9%**	55.0%

East Central Travis County



2020 **2024**

9,051
TOTAL POPULATION
▲ 31.3% SINCE 2020

520 (27.2%)
FAMILIES IN POVERTY [1]

AGE

<18	**32.4%**	35.5%
18-44	**43.8%**	44.4%
45-64	15.9%	**18.6%**
65+	4.2%	**5.2%**

MEDIAN AGE: 29

LANGUAGE

English	**24.6%**
Other	**5.2%**
Spanish	**70.2%**

SEX

50.3%	**49.7%**
49.6%	50.4%
Female	Male

RACE/ETHNICITY [2]

Asian	0.9%	**1.2%**
Black	**14.7%**	15.0%
Latino	**73.5%**	73.7%
Other	**61.4%**	61.5%
White	22.6%	**22.7%**

Enrollees in Focus Area

FY21 **FY23**

2,221
[1 IN 4 RESIDENTS]
ENROLLED IN CENTRAL HEALTH PROGRAMS
▲ 13.6% SINCE FY21

AGE

<18	**17.0%**	26.5%
18-44	51.9%	**55.6%**
45-64	18.7%	**23.8%**
65+	2.8%	**3.5%**

MEDIAN AGE: 36

LANGUAGE

English	**16.5%**	22.3%
Other	*%	***%**
Spanish	67.8%	**74.3%**
Unreported	*%	***%**

SEX

56.2%	**43.8%**
57.1%	42.9%
Female	Male

RACE/ETHNICITY [2]

Asian	*%	***%**
Black	**3.8%**	4.6%
Latino	84.7%	**87.7%**
Other	*%	***%**
Unreported	**4.2%**	5.3%
White	**1.8%**	2.0%

Utilization

63.6% OF ENROLLEES UTILIZED SERVICES IN FY23

Between FY21 and FY23, the number of health care visits enrollees had increased by **39.0%**. Out of the East Central Travis County enrollees who utilized care, **80.2%** visited a primary care physician, **22.4%** had a specialty care visit, and **20.6%** had a visit in an Emergency Department (ED).

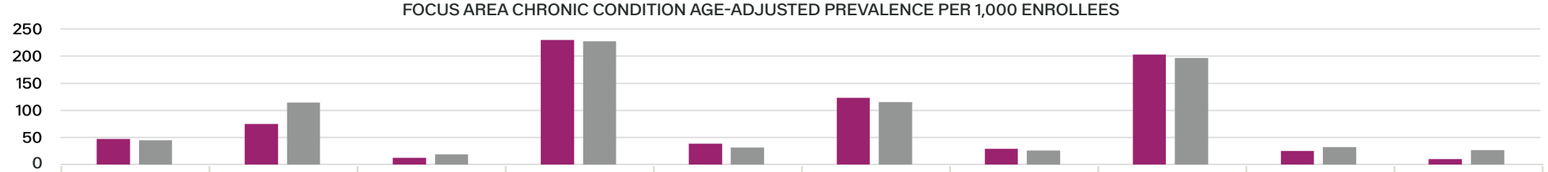
Top 5 provider locations visited by enrollees in focus area

		Number of visits in FY21	FY23
1	CUC North Central	685	**1,153**
2	Central Health Southeast Health & Wellness Center	520	**629**
3	Dell Seton Medical Center at The University of Texas	317	**501**
4	Ascension Seton Medical Center Austin	304	**496**
5	People's Community Clinic North	391	**424**

Chronic Conditions

Enrollees in the East Central Travis County focus area had the following top chronic conditions: 1.) **Cardiovascular Disease** (230/1,000 persons), 2.) **Hypertension** (203/1,000), and 3.) **Diabetes** (132/1,000). None of the chronic conditions included in the analysis were in significant excess compared to the overall enrollee population. People living in this focus area were 10% less likely as the total enrollee population to have a diagnosis for one or more of these chronic conditions.

FOCUS AREA CHRONIC CONDITION AGE-ADJUSTED PREVALENCE PER 1,000 ENROLLEES



	Asthma	Behavioral Health	Cancer	CVD	COPD	Diabetes	Heart Failure	Hypertension	Renal Failure	SUDs
Focus Area Prevalence	46.9	75.0	12.6	230.0	38.5	123.0	29.4	202.8	25.3	10.0
All Enrollees Prevalence	44.8	114.7	18.6	227.2	31.5	115.1	26.3	196.6	32.3	26.6

The Equity Index is a ratio of the observed prevalence rate to the expected prevalence rate (the county rate) among Central Health's patients. A value less than 1.0 indicates lower risk compared to the county rate. A value more than 1.0 indicates higher risk compared to the county rate. This Equity Index, as applied to these age-adjusted prevalence rates, gives us an indication of which subgroups may be experiencing a health inequity.

	Asthma	Behavioral Health	Cancer	CVD	COPD	Diabetes	Heart Failure	Hypertension	Renal Failure	SUDs
Equity Index	1.0	0.7	0.7	1.0	1.2	1.1	1.1	1.0	0.8	0.4

*[1] Families whose income was ≤100% FPL in 2024. [2] Ethnicity and race are separate for total population counts and combined for Central Health enrollment counts. * Data suppressed to maintain privacy standards.*

Focus Areas

Manor

TOTAL POPULATION: **13,805**
LAND AREA: **10.7 SQMI**

NEIGHBORHOODS

A. Manor (Census Tract 459)

HEALTH CARE ACCESS [1]

Primary Care: **1**

1. CUC Manor

Urgent/Convenient Care: **0**
Hospital: **0**

AFFORDABLE HOUSING

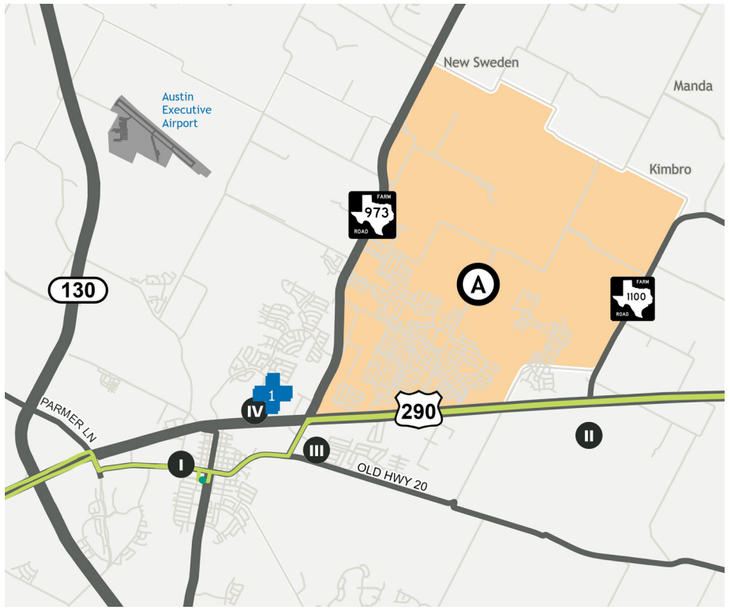
Housing Developments: **0**

Housing Units: **0**

There are not currently any affordable housing developments located within the Manor focus area census tract. Recently, the developer for Hidden Earth Apartments announced their plans to build 324 affordable apartment units in the area.

PUBLIC TRANSPORTATION

There are no bus routes that stop within the Manor focus area. The 990 Manor/Elgin Express route goes along the southern boundary of the focus area, but the nearest available stop to get on the bus is in Downtown Manor. Capmetro has a Park and Ride space available for that bus stop. Additionally, Pickup by CapMetro offers services in portions of the focus area. The Capital Area Rural Transportation System (CARTS) offers limited curb-to-curb bus pickup in Manor.



KEY

- High Concentrations of Poverty
- Moderate Concentrations of Poverty
- Affordable Housing Developments
- Bus Routes and Stops
- Hospital
- Primary Care Clinic
- Convenient/Urgent Care Clinic

Manor's Historic Downtown Water Tower with CapMetro's Manor Park and Ride Location Behind

Manor's 4th of July 2024 Celebration [4]

2024 Manor Community 5k at Timmermann Park

Shadowglen Medical Tower, Facing East Towards Forthcoming Manor Crossing Development

KEY ▲ Above Overall County = At Overall County ▼ Below Overall County

INCOME

▲ **$102,891** Median Household Income

HOUSING

▲ **$1,968** Median Rent
▼ **$288,093** Median Housing Unit Value
▼ **2.9%** Mobile Homes

EDUCATION [2]

▲ **15.9%** Less than HS Diploma
▲ **26.0%** HS Graduate
▼ **25.3%** Bachelor's Degree
▼ **5.8%** Post-Grad Degree

EMPLOYMENT [3]

▲ **17.0%** Public Administration
▲ **15.3%** Manufacturing
▲ **9.7%** Construction

FAMILY

▲ **75.4%** of Households Have Married or Cohabiting Couples
▲ **54.3%** of Households Have Children <18 Years Old

TRANSPORTATION

▼ **1.4%** of Housing Units Do Not Have a Vehicle
▲ **38 Minute** Average Commute to Work

[1] *Funded by central health and located within 1 mile of the focus area.* [2] *Educational attainment is based on the population age 25+.* [3] *Employment industry data is representative of the civilian population age 16+.* [4] *Photo courtesy of the City of Manor*

Travis County

2020 | **2024**

1,367,492
TOTAL POPULATION
▲ 6.0% SINCE 2020

23,812 (7.4%)
FAMILIES IN POVERTY [1]

AGE

<18	**20.2%**	21.2%
18-44	**45.6%**	46.6%
45-64	22.0%	**22.7%**
65+	10.3%	**11.6%**

MEDIAN AGE: 37

LANGUAGE

English	**70.4%**
Other	**8.3%**
Spanish	**21.3%**

SEX

49.6% 50.0% Female	**50.4%** 50.0% Male

RACE/ETHNICITY [2]

Asian	7.8%	**8.5%**
Black	7.8%	**7.9%**
Latino	32.6%	**32.6%**
Other	29.3%	**29.6%**
White	**53.9%**	55.0%

Manor

2020 | **2024**

13,805
TOTAL POPULATION
▲ 17.8% SINCE 2020

228 (6.9%)
FAMILIES IN POVERTY [1]

AGE

<18	**27.4%**	30.3%
18-44	**44.7%**	45.3%
45-64	19.4%	**21.7%**
65+	4.9%	**6.2%**

MEDIAN AGE: 33

LANGUAGE

English	**52.6%**
Other	**1.8%**
Spanish	**45.5%**

SEX

50.3% 50.2% Female	**49.7%** 49.8% Male

RACE/ETHNICITY [2]

Asian	3.7%	**4.5%**
Black	23.5%	**24.6%**
Latino	**50.3%**	50.5%
Other	41.5%	**41.6%**
White	**29.4%**	31.3%

Enrollees in Focus Area

FY21 | **FY23**

1,523
[1 IN 9 RESIDENTS]
ENROLLED IN CENTRAL HEALTH PROGRAMS
▲ 14.4% SINCE FY21

AGE

<18	**14.0%**	23.7%
18-44	46.4%	**50.4%**
45-64	24.5%	**28.7%**
65+	5.4%	**7.0%**

MEDIAN AGE: 39

LANGUAGE

English	**27.2%**	29.8%
Other	**5.9%**	6.6%
Spanish	50.3%	**57.4%**
Unreported	**9.5%**	13.3%

SEX

57.9% 57.4% Female	**42.1%** 42.6% Male

RACE/ETHNICITY [2]

Asian	**5.0%**	5.7%
Black	**8.5%**	9.9%
Latino	64.8%	**71.3%**
Other	**3.4%**	5.5%
Unreported	**7.9%**	9.9%
White	**3.9%**	4.2%

Utilization

63.2% OF ENROLLEES UTILIZED SERVICES IN FY23

Between FY21 and FY23, the number of health care visits enrollees had increased by **45.7%**. Out of the Manor enrollees who utilized care, **84.0%** visited a primary care physician, **24.6%** had a specialty care visit, and **14.4%** had a visit in an Emergency Department (ED).

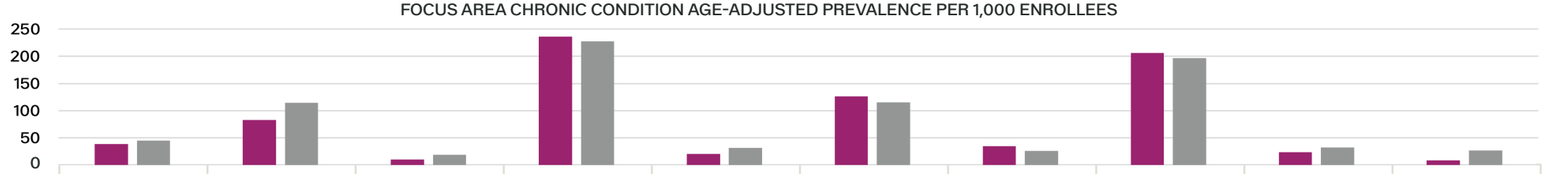
Top 5 provider locations visited by enrollees in focus area

		Number of visits in FY21	FY23
1	CUC North Central	540	**1,078**
2	People's Community Clinic North	291	**413**
3	CUC Manor	221	**333**
4	Ascension Seton Medical Center Austin	150	**324**
5	Dell Seton Medical Center at The University of Texas	141	**310**

Chronic Conditions

Enrollees living in the Manor focus area had the following top chronic condition prevalence rates 1.) **Cardiovascular Disease** (236/1,000 persons), 2.) **Hypertension** (207/1,000), and 3.) **Diabetes** (127/1,000). Overall, Manor enrollees were about 20% less likely to have a diagnosis for one of the chronic conditions of interest and had a statistically significant 70% lower likelihood of having a substance use disorder diagnosis.

FOCUS AREA CHRONIC CONDITION AGE-ADJUSTED PREVALENCE PER 1,000 ENROLLEES



	Asthma	Behavioral Health	Cancer	CVD	COPD	Diabetes	Heart Failure	Hypertension	Renal Failure	SUDs
Focus Area Prevalence	38.6	82.6	10.1	236.4	20.4	126.5	34.4	206.5	23.8	8.2
All Enrollees Prevalence	44.8	114.7	18.6	227.2	31.5	115.1	26.3	196.6	32.3	26.6

The Equity Index is a ratio of the observed prevalence rate to the expected prevalence rate (the county rate) among Central Health's patients. A value less than 1.0 indicates lower risk compared to the county rate. A value more than 1.0 indicates higher risk compared to the county rate. This Equity Index, as applied to these age-adjusted prevalence rates, gives us an indication of which subgroups may be experiencing a health inequity.

Equity Index	0.9	0.7	0.5	1.0	0.7	1.1	1.3	1.1	0.7	0.3

*[1] Families whose income was ≤100% FPL in 2024. [2] Ethnicity and race are separate for total population counts and combined for Central Health enrollment counts. * Data suppressed to maintain privacy standards.*

Focus Areas

North Central Austin (Rundberg)

TOTAL POPULATION: **40,235**
LAND AREA: **5.2 SQMI**

NEIGHBORHOODS

A. **W Rundberg & Metric/Northgate/ Colony Creek (Census Tract 407)**
B. **Quail Creek (Census Tract 409)**
C. **North Lamar (Census Tract 410)**
D. **Georgian Acres (Census Tract 432)**
E. **Georgian Acres/Highland/ St.John's (Census Tract 400)**
F. **North Lamar/Payton Gin (Census Tract 401)**
G. **Wooten (Census Tract 405)**

HEALTH CARE ACCESS [1]

Primary Care: **6**

1. **Carousel Pediatrics North Lamar**
2. **CUC North Central**
3. **CUC Rundberg**
4. **Lone Star Circle of Care Adult Medicine at St. John**
5. **People's Community Clinic North**
6. **Planned Parenthood North**

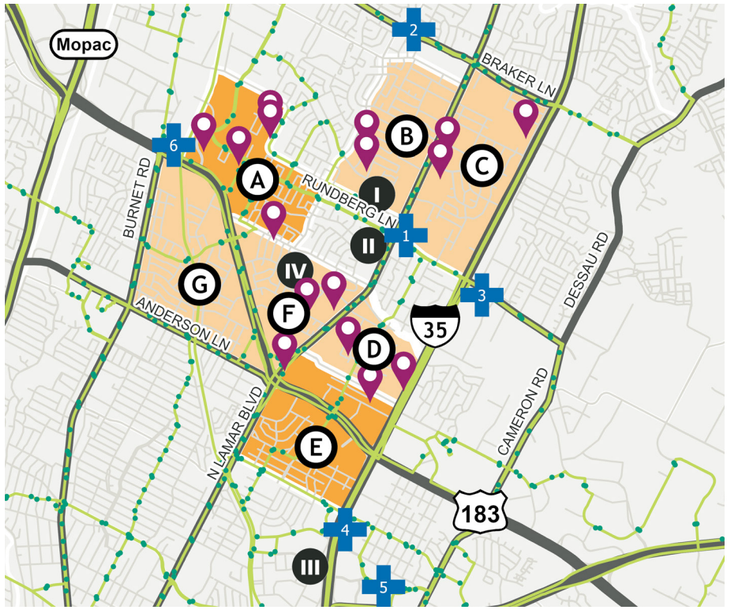
Urgent/Convenient Care: **0**
Hospital: **0**

AFFORDABLE HOUSING

Housing Developments: **16**
Housing Units: **1,992**

PUBLIC TRANSPORTATION

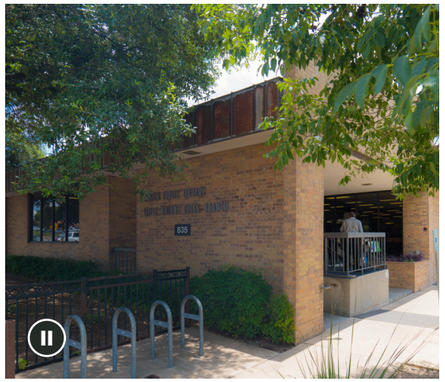
There are **17 CapMetro bus routes** that have a combined **107 bus stops** in the focus area. Additionally, CapMetro offers a Park & Ride option at the North Lamar Transit Center.



KEY

- High Concentrations of Poverty
- Moderate Concentrations of Poverty
- Affordable Housing Developments
- Bus Routes and Stops
- Hospital
- Primary Care Clinic
- Convenient/Urgent Care Clinic

View Looking Northwest Towards North Austin YMCA on Rundberg Lane



City of Austin's Little Walnut Creek Library

2024 Central Health Rundberg Accelerated Health Champions Program Graduation Ceremony

Austin Independent School District's Juan P Navarro Early College High School

KEY ▲ **Above Overall County** = **At Overall County** ▼ **Below Overall County**

INCOME

▼ **$48,280**
Median Household Income

HOUSING

▼ **$1,137** Median Rent
▼ **$382,312** Median Housing Unit Value
▼ **1.3%** Mobile Homes

EDUCATION [2]

▲ **23.1%** Less than HS Diploma
▲ **26.7%** HS Graduate
▼ **21.2%** Bachelor's Degree
▼ **9.2%** Post-Grad Degree

EMPLOYMENT [3]

▲ **13.8%** Construction
▲ **13.3%** Accommodation/ Food Services
▼ **10.2%** Professional/ Scientific/ Technical Services

FAMILY

▼ **41.7%** of Households Have Married or Cohabiting Couples
▲ **26.5%** of Households Have Children <18 Years Old

TRANSPORTATION

▲ **8.6%** of Housing Units Do Not Have a Vehicle
▲ **26 Minute** Average Commute to Work

[1] *Funded by central health and located within 1 mile of the focus area.* [2] *Educational attainment is based on the population age 25+.* [3] *Employment industry data is representative of the civilian population age 16+.*

Travis County

2020 **2024**

1,367,492
TOTAL POPULATION
▲ 6.0% SINCE 2020

23,812 (7.4%)
FAMILIES IN POVERTY [1]

AGE

<18	**20.2%**	21.2%
18-44	**45.6%**	46.6%
45-64	22.0%	**22.7%**
65+	10.3%	**11.6%**

MEDIAN AGE: 37

LANGUAGE

English	**70.4%**
Other	**8.3%**
Spanish	**21.3%**

SEX

49.6% 50.0% Female	**50.4%** 50.0% Male

RACE/ETHNICITY [2]

Asian	7.8%	**8.5%**
Black	7.8%	**7.9%**
Latino	32.6%	**32.6%**
Other	29.3%	**29.6%**
White	**53.9%**	55.0%

North Central Austin (Rundberg)

2020 **2024**

40,235
TOTAL POPULATION
▲ 1.1% SINCE 2020

2,629 (27.5%)
FAMILIES IN POVERTY [1]

AGE

<18	**24.2%**	25.5%
18-44	**46.7%**	47.8%
45-64	20.0%	**21.2%**
65+	6.6%	**7.9%**

MEDIAN AGE: 35

LANGUAGE

English	**44.8%**
Other	**8.3%**
Spanish	**46.9%**

SEX

46.1% 46.4% Female	**53.9%** 53.6% Male

RACE/ETHNICITY [2]

Asian	3.7%	**3.9%**
Black	**9.0%**	9.1%
Latino	**62.3%**	62.8%
Other	54.4%	**54.4%**
White	**32.6%**	32.8%

Enrollees in Focus Area

FY21 **FY23**

11,219
[1 IN 4 RESIDENTS]
ENROLLED IN CENTRAL HEALTH PROGRAMS
▲ 13.9% SINCE FY21

AGE

<18	**20.7%**	25.8%
18-44	50.2%	**54.6%**
45-64	21.4%	**21.5%**
65+	2.6%	**3.2%**

MEDIAN AGE: 33

LANGUAGE

English	**11.2%**	17.7%
Other	2.0%	**7.8%**
Spanish	71.6%	**79.4%**
Unreported	**1.6%**	8.7%

SEX

54.2% 54.5% Female	**45.8%** 45.5% Male

RACE/ETHNICITY [2]

Asian	**1.4%**	2.5%
Black	**2.2%**	3.7%
Latino	81.6%	**86.7%**
Other	**2.3%**	2.8%
Unreported	**4.0%**	5.6%
White	**3.4%**	3.8%

Utilization

62.1% OF ENROLLEES UTILIZED SERVICES IN FY23

Between FY21 and FY23, the number of health care visits enrollees had increased by **28.1%**. Out of the North Central Austin (Rundberg) enrollees who utilized care, **75.1%** visited a primary care physician, **21.1%** had a specialty care visit, and **24.2%** had a visit in an Emergency Department (ED).

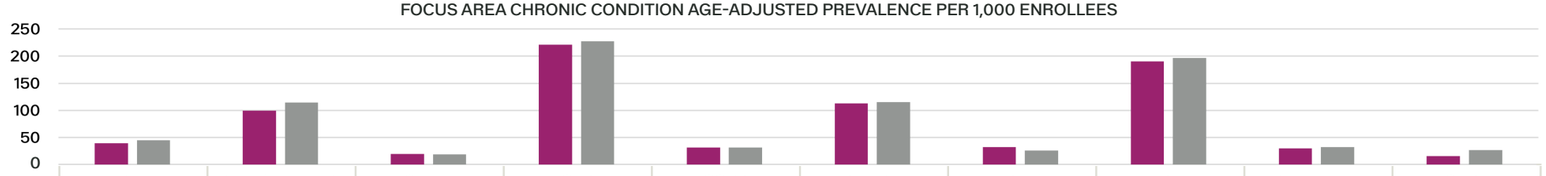
Top 5 provider locations visited by enrollees in focus area

		Number of visits in FY21	FY23
1	CUC North Central	7,630	**10,935**
2	CUC Rundberg	2,092	**2,402**
3	Ascension Seton Medical Center Austin	1,398	**1,960**
4	Dell Seton Medical Center at The University of Texas	1,165	**1,816**
5	Ascension Seton Northwest Medical Center	1,258	**1,608**

Chronic Conditions

Enrollees in the North Central Austin (Rundberg) focus area experienced the following chronic conditions the most: 1.) **Cardiovascular Disease** (221/1,000 persons), 2.) **Hypertension** (191/1,000), and 3.) **Diabetes** (113/1,000). None of the chronic condition rates included in the analysis were in significant excess compared to the overall enrollee population. Overall, enrollees in this focus area were 10% less likely to have a diagnosis of one or more chronic conditions.

FOCUS AREA CHRONIC CONDITION AGE-ADJUSTED PREVALENCE PER 1,000 ENROLLEES



	Asthma	Behavioral Health	Cancer	CVD	COPD	Diabetes	Heart Failure	Hypertension	Renal Failure	SUDs
Focus Area Prevalence	39.7	99.2	19.9	221.0	31.4	113.2	32.5	190.7	29.8	16.1
All Enrollees Prevalence	44.8	114.7	18.6	227.2	31.5	115.1	26.3	196.6	32.3	26.6

The Equity Index is a ratio of the observed prevalence rate to the expected prevalence rate (the county rate) among Central Health's patients. A value less than 1.0 indicates lower risk compared to the county rate. A value more than 1.0 indicates higher risk compared to the county rate. This Equity Index, as applied to these age-adjusted prevalence rates, gives us an indication of which subgroups may be experiencing a health inequity.

	Asthma	Behavioral Health	Cancer	CVD	COPD	Diabetes	Heart Failure	Hypertension	Renal Failure	SUDs
Equity Index	**0.9**	**0.9**	**1.1**	**1.0**	**1.0**	**1.0**	**1.2**	**1.0**	**0.9**	**0.6**

*[1] Families whose income was ≤100% FPL in 2024. [2] Ethnicity and race are separate for total population counts and combined for Central Health enrollment counts. * Data suppressed to maintain privacy standards.*

Focus Areas

Northeast Austin

TOTAL POPULATION: **13,457**
LAND AREA: **2.1 SQMI**

NEIGHBORHOODS

A. **Heritage Hills (Census Tract 403)**
B. **Ridgetop/ West Windsor Park (Census Tract 21.05)**

HEALTH CARE ACCESS [1]

Primary Care: **7**

1. **CUC Black Men's Health Clinic**
2. **Carousel Pediatrics North Lamar**
3. **CUC David Powell Health Center**
4. **CUC Rundberg**
5. **Lone Star Circle of Care Adult Medicine at St. John**
6. **People's Community Clinic North**
7. **People's Community Clinic at Austin Children's Shelter**

Urgent/Convenient Care: **1**

8. **CUC Hancock Walk-In Care**

Hospital: **2**

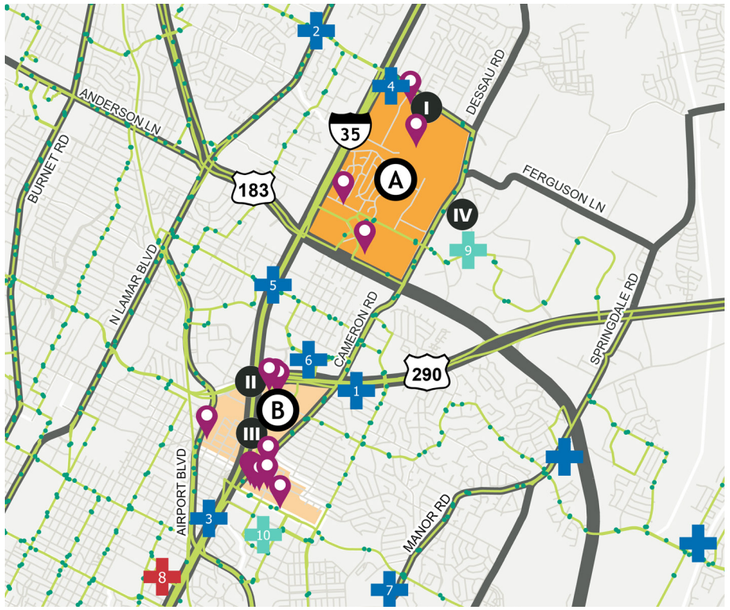
9. **Cross Creek Hospital**
10. **Dell Children's Medical Center**

AFFORDABLE HOUSING

Housing Developments: **15**
Housing Units: **1,651**

PUBLIC TRANSPORTATION

There are **7 CapMetro bus routes and 33 bus stops** within Northeast Austin. The Norwood Transit Center is also located within this focus area.



KEY

- High Concentrations of Poverty
- Moderate Concentrations of Poverty
- Affordable Housing Developments
- Bus Routes and Stops
- Hospital
- Primary Care Clinic
- Convenient/Urgent Care Clinic

Gustavo "Gus" L. Garcia Recreation Center

Intersection of I-35 and US 290

Staff at Central Health's Capital Plaza Specialty Clinic

Asian American Resource Center (AARC)

KEY ▲ **Above Overall County** = **At Overall County** ▼ **Below Overall County**

INCOME

▼ **$49,806**
Median Household Income

HOUSING

▼ **$1,172** Median Rent
▼ **$396,261** Median Housing Unit Value
▲ **10.1%** Mobile Homes

EDUCATION [2]

▲ **25.6%** Less than HS Diploma
▲ **26.2%** HS Graduate
▼ **19.3%** Bachelor's Degree
▼ **10.6%** Post-Grad Degree

EMPLOYMENT [3]

▲ **18.9%** Construction
▲ **11.6%** Accommodation/ Food Services
▲ **8.7%** Administrative/ Support/Waste Management

FAMILY

▼ **40.5%** of Households Have Married or Cohabiting Couples
▲ **28.2%** of Households Have Children <18 Years Old

TRANSPORTATION

▲ **9.8%** of Housing Units Do Not Have a Vehicle
▼ **26 Minute** Average Commute to Work

[1] Funded by central health and located within 1 mile of the focus area. [2] Educational attainment is based on the population age 25+. [3] Employment industry data is representative of the civilian population age 16+.

Travis County

2020 **2024**

1,367,492
TOTAL POPULATION
▲ 6.0% SINCE 2020

23,812 (7.4%)
FAMILIES IN POVERTY [1]

AGE

<18	**20.2%**	21.2%
18-44	**45.6%**	46.6%
45-64	22.0%	**22.7%**
65+	10.3%	**11.6%**

MEDIAN AGE: 37

LANGUAGE

English	**70.4%**
Other	**8.3%**
Spanish	**21.3%**

SEX

49.6%	**50.4%**
50.0%	50.0%
Female	Male

RACE/ETHNICITY [2]

Asian	7.8%	**8.5%**
Black	7.8%	**7.9%**
Latino	32.6%	**32.6%**
Other	29.3%	**29.6%**
White	**53.9%**	55.0%

Northeast Austin

2020 **2024**

13,457
TOTAL POPULATION
▲ 9.8% SINCE 2020

693 (22.5%)
FAMILIES IN POVERTY [1]

AGE

<18	**25.4%**	26.4%
18-44	**48.5%**	49.9%
45-64	17.0%	**18.7%**
65+	6.7%	**7.4%**

MEDIAN AGE: 32

LANGUAGE

English	**42.7%**
Other	**6.0%**
Spanish	**51.3%**

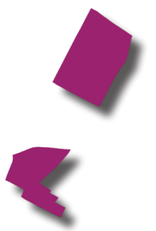
SEX

46.9%	**53.1%**
47.4%	52.6%
Female	Male

RACE/ETHNICITY [2]

Asian	3.1%	**3.4%**
Black	**9.7%**	10.2%
Latino	65.7%	**66.1%**
Other	57.4%	**58.3%**
White	**28.7%**	29.3%

Enrollees in Focus Area



FY21 **FY23**

3,588
[1 IN 4 RESIDENTS]
ENROLLED IN CENTRAL HEALTH PROGRAMS
▲ 12.8% SINCE FY21

AGE

<18	**21.3%**	27.5%
18-44	51.4%	**55.3%**
45-64	18.4%	**20.2%**
65+	2.7%	**3.2%**

MEDIAN AGE: 32

LANGUAGE

English	**10.0%**	15.3%
Other	**1.1%**	1.4%
Spanish	74.2%	**80.9%**
Unreported	**8.0%**	9.1%

SEX

55.4%	**44.6%**
55.5%	44.5%
Female	Male

RACE/ETHNICITY [2]

Asian	**1.2%**	1.3%
Black	**2.3%**	3.0%
Latino	85.3%	**87.2%**
Other	**2.0%**	2.3%
Unreported	**4.6%**	5.8%
White	2.4%	**2.7%**

Utilization

63.4% OF ENROLLEES UTILIZED SERVICES IN FY23

Between FY21 and FY23, the number of health care visits enrollees had increased by **39.7%**. Out of the Northeast Austin enrollees who utilized care, **78.2%** visited a primary care physician, **22.7%** had a specialty care visit, and **23.2%** had a visit in an Emergency Department (ED).

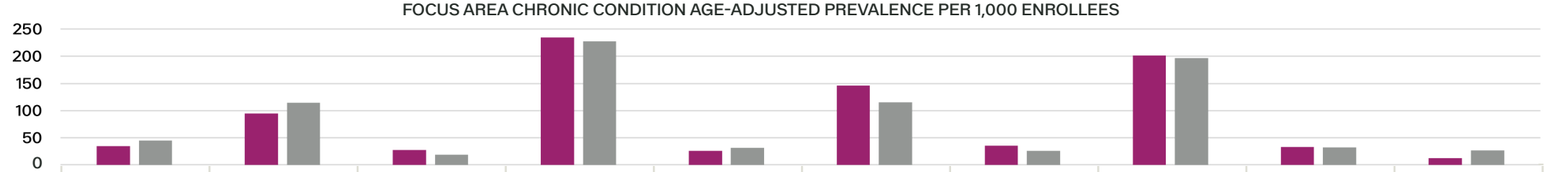
Top 5 provider locations visited by enrollees in focus area

		Number of visits in FY21	FY23
1	CUC North Central	1,852	**2,807**
2	CUC Rundberg	1,062	**1,371**
3	Dell Seton Medical Center at The University of Texas	394	**780**
4	Ascension Seton Medical Center Austin	507	**648**
5	People's Community Clinic North	**598**	619

Chronic Conditions

For enrollees in the Northeast Austin focus area, the top three chronic conditions were 1.) **Cardiovascular Disease** (235/1,000 persons), 2.) **Hypertension** (201/1,000), and 3.) **Diabetes** (146/1,000). Enrollees in Northeast Austin had increased probability of diagnosis for 5 of the 14 conditions, but none of these increases were statistically significant. Overall, enrollees in this focus area were as likely as the total enrolled population to have a diagnosis of one or more chronic conditions.

FOCUS AREA CHRONIC CONDITION AGE-ADJUSTED PREVALENCE PER 1,000 ENROLLEES



	Asthma	Behavioral Health	Cancer	CVD	COPD	Diabetes	Heart Failure	Hypertension	Renal Failure	SUDs
Focus Area Prevalence	34.7	94.6	27.3	234.7	26.2	146.2	35.7	201.3	32.7	12.2
All Enrollees Prevalence	44.8	114.7	18.6	227.2	31.5	115.1	26.3	196.6	32.3	26.6

The Equity Index is a ratio of the observed prevalence rate to the expected prevalence rate (the county rate) among Central Health's patients. A value less than 1.0 indicates lower risk compared to the county rate. A value more than 1.0 indicates higher risk compared to the county rate. This Equity Index, as applied to these age-adjusted prevalence rates, gives us an indication of which subgroups may be experiencing a health inequity.

	Asthma	Behavioral Health	Cancer	CVD	COPD	Diabetes	Heart Failure	Hypertension	Renal Failure	SUDs
Equity Index	**0.8**	**0.8**	**1.5**	**1.0**	**0.8**	**1.3**	**1.4**	**1.0**	**1.0**	**0.5**

*[1] Families whose income was ≤100% FPL in 2024. [2] Ethnicity and race are separate for total population counts and combined for Central Health enrollment counts. * Data suppressed to maintain privacy standards.*

Focus Areas

Northeast Travis County

TOTAL POPULATION: **19,962**
LAND AREA: **9.0 SQMI**

NEIGHBORHOODS

A. **Canterra/River Ranch (Census Tract 449)**
B. **Walnut Creek/Pioneer Crossing (Census Tract 435)**

HEALTH CARE ACCESS [1]

Primary Care: **1**

1. **CUC Rundberg**

Urgent/Convenient Care: **0**

Hospital: **1**

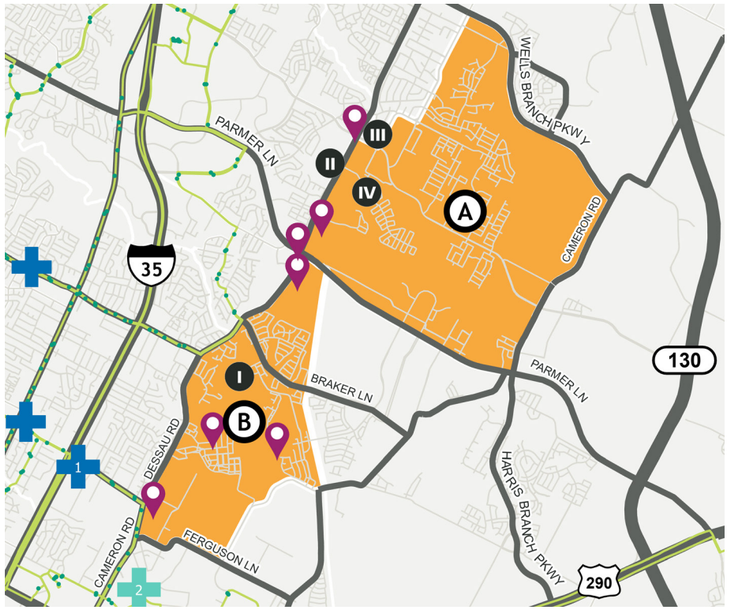
2. **Cross Creek Hospital**

AFFORDABLE HOUSING

Housing Developments: **7**
Housing Units: **1,484**

PUBLIC TRANSPORTATION

There is **1 CapMetro bus route that has 1 bus stop** within Northeast Travis County. Pickup by CapMetro offers services in portions of the focus area.



KEY

- High Concentrations of Poverty
- Moderate Concentrations of Poverty
- Affordable Housing Developments
- Bus Routes and Stops
- Hospital
- Primary Care Clinic
- Convenient/Urgent Care Clinic

Pioneer Farms, a Living History Museum Located Off of East Braker Lane

Pflugerville ISD's Dessau Middle School

Food Truck Park Near Dessau Road and East Howard Lane

Entrance to River Ranch Mobile Home Park

KEY ▲ **Above Overall County** = **At Overall County** ▼ **Below Overall County**

INCOME

▼ **$86,668**
Median Household Income

HOUSING

▼ **$1,416** Median Rent
▼ **$320,748** Median Housing Unit Value
▲ **14.7%** Mobile Homes

EDUCATION [2]

▲ **17.1%** Less than HS Diploma
▲ **21.6%** HS Graduate
▼ **23.9%** Bachelor's Degree
▼ **15.2%** Post-Grad Degree

EMPLOYMENT [3]

▲ **13.6%** Educational Services
▲ **12.5%** Health Care/ Social Assistance
▼ **9.7%** Professional/ Scientific/Technical Services

FAMILY

▲ **56.8%** of Households Have Married or Cohabiting Couples
▲ **29.3%** of Households Have Children <18 Years Old

TRANSPORTATION

▼ **4.2%** of Housing Units Do Not Have a Vehicle
=27 Minute Average Commute to Work

[1] *Funded by central health and located within 1 mile of the focus area.* [2] *Educational attainment is based on the population age 25+.* [3] *Employment industry data is representative of the civilian population age 16+.*

Travis County

2020 **2024**

1,367,492
TOTAL POPULATION
▲ 6.0% SINCE 2020

23,812 (7.4%)
FAMILIES IN POVERTY [1]

AGE

<18	**20.2%**	21.2%
18-44	**45.6%**	46.6%
45-64	22.0%	**22.7%**
65+	10.3%	**11.6%**

MEDIAN AGE: 37

LANGUAGE

English	**70.4%**
Other	**8.3%**
Spanish	**21.3%**

SEX

49.6%	**50.4%**
50.0%	50.0%
Female	Male

RACE/ETHNICITY [2]

Asian	7.8%	**8.5%**
Black	7.8%	**7.9%**
Latino	32.6%	**32.6%**
Other	29.3%	**29.6%**
White	**53.9%**	55.0%

Northeast Travis County

2020 **2024**

19,962
TOTAL POPULATION
▲ 23.4% SINCE 2020

809 (17.1%)
FAMILIES IN POVERTY [1]

AGE

<18	**23.9%**	25.3%
18-44	**47.1%**	48.1%
45-64	19.8%	**20.8%**
65+	6.7%	**8.1%**

MEDIAN AGE: 33

LANGUAGE

English	**47.3%**
Other	**17.8%**
Spanish	**35.0%**

SEX

49.6%	**50.4%**
49.8%	50.2%
Female	Male

RACE/ETHNICITY [2]

Asian	16.4%	**17.8%**
Black	15.0%	**15.3%**
Latino	43.3%	**43.4%**
Other	37.6%	**37.9%**
White	**29.0%**	31.0%

Enrollees in Focus Area

FY21 **FY23**

3,100
[1 IN 7 RESIDENTS]
ENROLLED IN CENTRAL HEALTH PROGRAMS
▲ 20.6% SINCE FY21

AGE

<18	27.3%	**17.6%**
18-44	47.7%	**53.0%**
45-64	21.7%	**24.3%**
65+	3.3%	**5.0%**

MEDIAN AGE: 35

LANGUAGE

English	**18.9%**	23.1%
Other	**3.2%**	4.7%
Spanish	59.9%	**68.2%**
Unreported	**9.7%**	12.3%

SEX

56.5%	**43.5%**
57.8%	42.2%
Female	Male

RACE/ETHNICITY [2]

Asian	**4.6%**	7.0%
Black	**4.2%**	5.4%
Latino	70.9%	**79.2%**
Other	**3.1%**	4.4%
Unreported	**5.1%**	9.2%
White	3.3%	**3.8%**

Utilization

66.0% OF ENROLLEES UTILIZED SERVICES IN FY23

Between FY21 and FY23, the number of health care visits enrollees had increased by **52.0%**. Out of the Northeast Travis County enrollees who utilized care, **79.5%** visited a primary care physician, **23.5%** had a specialty care visit, and **19.7%** had a visit in an Emergency Department (ED).

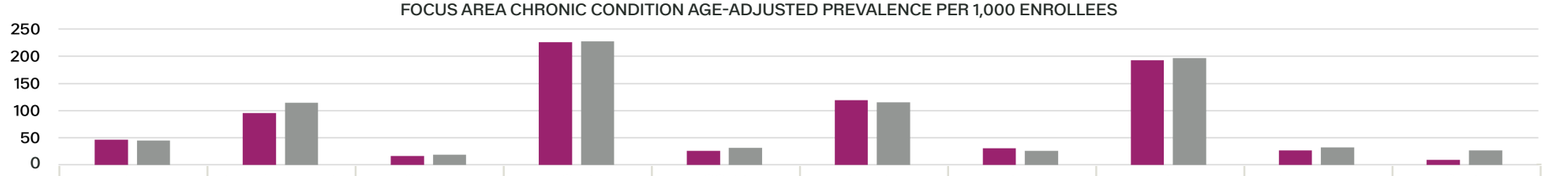
Top 5 provider locations visited by enrollees in focus area

		Number of visits in FY21	FY23
1	CUC North Central	1,926	**3,200**
2	Ascension Seton Medical Center Austin	320	**531**
3	CUC Rundberg	376	**496**
4	Dell Seton Medical Center at The University of Texas	248	**487**
5	CUC Pflugerville	196	**482**

Chronic Conditions

The top three chronic conditions by prevalence for enrollees in the Northeast Travis County focus area were 1.) **Cardiovascular Disease** (226/1,000 persons), 2.) **Hypertension** (193/1,000), and 3.) **Diabetes** (120/1,000). Enrollees in Northeast Austin had increased probability of diagnosis for 5 of the 14 conditions, but none of these increases were statistically significant. Enrollees in this focus area had a statistically significant 70% lower likelihood of having a substance use disorder diagnosis.

FOCUS AREA CHRONIC CONDITION AGE-ADJUSTED PREVALENCE PER 1,000 ENROLLEES



	Asthma	Behavioral Health	Cancer	CVD	COPD	Diabetes	Heart Failure	Hypertension	Renal Failure	SUDs
Focus Area Prevalence	46.7	95.8	16.4	225.6	25.6	119.6	30.5	192.7	27.0	9.2
All Enrollees Prevalence	44.8	114.7	18.6	227.2	31.5	115.1	26.3	196.6	32.3	26.6

The Equity Index is a ratio of the observed prevalence rate to the expected prevalence rate (the county rate) among Central Health's patients. A value less than 1.0 indicates lower risk compared to the county rate. A value more than 1.0 indicates higher risk compared to the county rate. This Equity Index, as applied to these age-adjusted prevalence rates, gives us an indication of which subgroups may be experiencing a health inequity.

Equity Index	1.0	0.8	0.9	1.0	0.8	1.0	1.2	1.0	0.8	0.3

*[1] Families whose income was ≤100% FPL in 2024. [2] Ethnicity and race are separate for total population counts and combined for Central Health enrollment counts. * Data suppressed to maintain privacy standards.*

Focus Areas

Oak Hill

TOTAL POPULATION: **17,012**
LAND AREA: **41.7 SQMI**

NEIGHBORHOODS

A. Barton Creek/ Bee Cave/ West Oak Hill (Census Tract 366)

B. West Oak Hill (Census Track 19.20)

HEALTH CARE ACCESS [1]

Primary Care: **1**

1. CUC Oak Hill

Urgent/Convenient Care: **1**

2. NextCare Urgent Care

Hospital: **0**

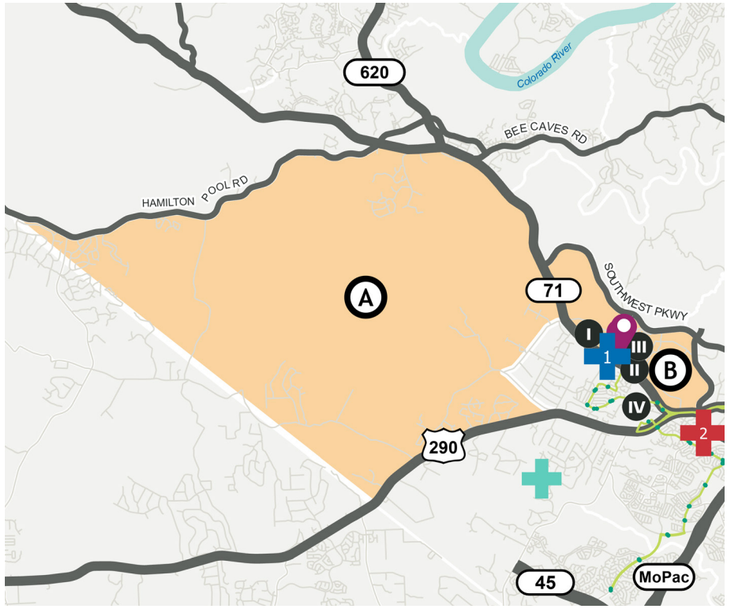
AFFORDABLE HOUSING

Housing Developments: **2**

Housing Units: **218**

PUBLIC TRANSPORTATION

There are no bus routes that stop within the Oak Hill focus area. The 171 Oak Hill Flyer and 315 Ben White routes go near the focus area, but the nearest available stops to get on the bus are across the highway or over a mile outside of the area. Pickup by CapMetro offers services in portions of the focus area.



KEY

- High Concentrations of Poverty
- Moderate Concentrations of Poverty
- Affordable Housing Developments
- Bus Routes and Stops
- Hospital
- Primary Care Clinic
- Convenient/Urgent Care Clinic

CommUnityCare's Oak Hill Health Center

Country Aire Mobile Home Park, Facing South

Country Aire Mobile Home Park, Facing Northeast

Oak Hill Parkway Project Construction at the 'Y' Intersection of US 290 and SH 71

KEY ▲ Above Overall County = At Overall County ▼ Below Overall County

INCOME

▲ **$120,895**
Median Household Income

HOUSING

▲ **$1,709** Median Rent
▲ **$755,681** Median Housing Unit Value
▲ **7.9%** Mobile Homes

EDUCATION [2]

▼ **6.4%** Less than HS Diploma
▼ **11.6%** HS Graduate
▲ **39.2%** Bachelor's Degree
▲ **22.3%** Post-Grad Degree

EMPLOYMENT [3]

▲ **18.0%** Professional/ Scientific/Technical Services
▲ **12.5%** Educational Services
▲ **9.3%** Retail Trade

FAMILY

▲ **66.6%** of Households Have Married or Cohabiting Couples
▲ **40.2%** of Households Have Children <18 Years Old

TRANSPORTATION

▼ **1.1%** of Housing Units Do Not Have a Vehicle
▲ **31 Minute** Average Commute to Work

[1] *Funded by central health and located within 1 mile of the focus area.* [2] *Educational attainment is based on the population age 25+.* [3] *Employment industry data is representative of the civilian population age 16+.*

Travis County

2020 | **2024**

1,367,492
TOTAL POPULATION
▲ 6.0% SINCE 2020

23,812 (7.4%)
FAMILIES IN POVERTY [1]

AGE

<18	**20.2%**	21.2%
18-44	**45.6%**	46.6%
45-64	22.0%	**22.7%**
65+	10.3%	**11.6%**

MEDIAN AGE: 37

LANGUAGE

English	**70.4%**
Other	**8.3%**
Spanish	**21.3%**

SEX

49.6%	**50.4%**
50.0%	50.0%
Female	Male

RACE/ETHNICITY [2]

Asian	7.8%	**8.5%**
Black	7.8%	**7.9%**
Latino	32.6%	**32.6%**
Other	29.3%	**29.6%**
White	**53.9%**	55.0%

Oak Hill

2020 | **2024**

17,012
TOTAL POPULATION
▲ 8.2% SINCE 2020

469 (11.5%)
FAMILIES IN POVERTY [1]

AGE

<18	**23.6%**	25.2%
18-44	**37.5%**	38.4%
45-64	25.6%	**26.2%**
65+	10.7%	**12.7%**

MEDIAN AGE: 38

LANGUAGE

English	**73.5%**
Other	**5.9%**
Spanish	**20.6%**

SEX

50.6%	**49.4%**
50.6%	49.4%
Female	Male

RACE/ETHNICITY [2]

Asian	6.0%	**6.4%**
Black	2.3%	**2.6%**
Latino	23.7%	**23.7%**
Other	23.1%	**23.1%**
White	**67.9%**	68.7%

Enrollees in Focus Area

FY21 | **FY23**

872
[1 IN 20 RESIDENTS]
ENROLLED IN CENTRAL HEALTH PROGRAMS
▼ 1.5% SINCE FY21

AGE

<18	**18.2%**	27.3%
18-44	47.7%	**50.5%**
45-64	22.5%	**27.1%**
65+	3.3%	**4.2%**

MEDIAN AGE: 36

LANGUAGE

English	**16.4%**	23.1%
Other	***%**	*%
Spanish	69.7%	**77.1%**
Unreported	***%**	*%

SEX

55.4%	**44.6%**
56.3%	43.7%
Female	Male

RACE/ETHNICITY [2]

Asian	***%**	*%
Black	***%**	*%
Latino	82.1%	**85.3%**
Other	***%**	3.1%
Unreported	**3.1%**	3.8%
White	7.3%	**7.5%**

Utilization

63.3% OF ENROLLEES UTILIZED SERVICES IN FY23

Between FY21 and FY23, the number of health care visits enrollees had increased by **22.5%**. Out of the Oak Hill enrollees who utilized care, **75.4%** visited a primary care physician, **20.5%** had a specialty care visit, and **26.3%** had a visit in an Emergency Department (ED).

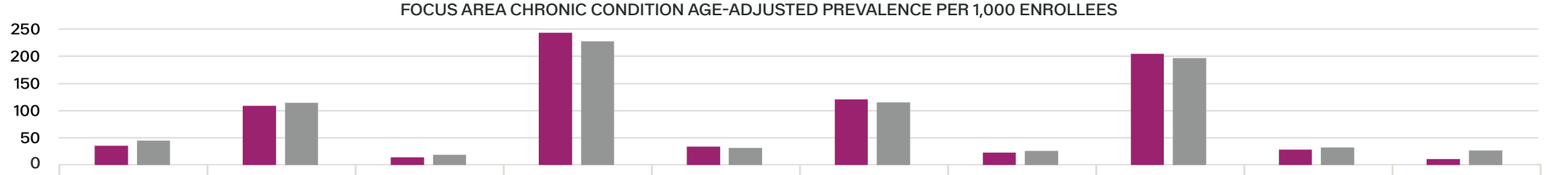
Top 5 provider locations visited by enrollees in focus area

		Number of visits in FY21	FY23
1	CUC Oak Hill	458	**570**
2	Central Health Southeast Health & Wellness Center	232	**388**
3	CUC South Austin	144	**259**
4	Ascension Seton Southwest Hospital	162	**253**
5	Ascension Seton Medical Center Austin	103	**192**

Chronic Conditions

Oak Hill enrollees had the following top chronic conditions by prevalence 1.) **Cardiovascular Disease** (244/1,000 persons), 2.) **Hypertension** (204/1,000), and 3.) **Behavioral Health** (109/1,000). Overall, Oak Hill enrollees were about 10% less likely to have a diagnosis for one of the chronic conditions of interest.

FOCUS AREA CHRONIC CONDITION AGE-ADJUSTED PREVALENCE PER 1,000 ENROLLEES



	Asthma	Behavioral Health	Cancer	CVD	COPD	Diabetes	Heart Failure	Hypertension	Renal Failure	SUDs
Focus Area Prevalence	35.8	109.0	14.3	243.6	33.5	120.6	22.7	204.3	28.5	11.0
All Enrollees Prevalence	44.8	114.7	18.6	227.2	31.5	115.1	26.3	196.6	32.3	26.6

The Equity Index is a ratio of the observed prevalence rate to the expected prevalence rate (the county rate) among Central Health's patients. A value less than 1.0 indicates lower risk compared to the county rate. A value more than 1.0 indicates higher risk compared to the county rate. This Equity Index, as applied to these age-adjusted prevalence rates, gives us an indication of which subgroups may be experiencing a health inequity.

Equity Index	**0.8**	**1.0**	**0.8**	**1.1**	**1.1**	**1.0**	**0.9**	**1.0**	**0.9**	**0.4**

*[1] Families whose income was ≤100% FPL in 2024. [2] Ethnicity and race are separate for total population counts and combined for Central Health enrollment counts. * Data suppressed to maintain privacy standards.*

Focus Areas

South Central Austin

TOTAL POPULATION: **18,258**
LAND AREA: **3.5 SQMI**

NEIGHBORHOODS

A. Cherry Creek/ Southwest Oaks (Census Tract 309)
B. Franklin Park (Census Tract 24.12)
C. Franklin Park (Census Tract 24.11)

HEALTH CARE ACCESS [1]

Primary Care: **4**

1. **Carousel Pediatrics-Southbrook**
2. **CUC Williamson Cannon**
3. **Lone Star Circle of Care at El Buen Samaritano**
4. **Planned Parenthood South Austin**

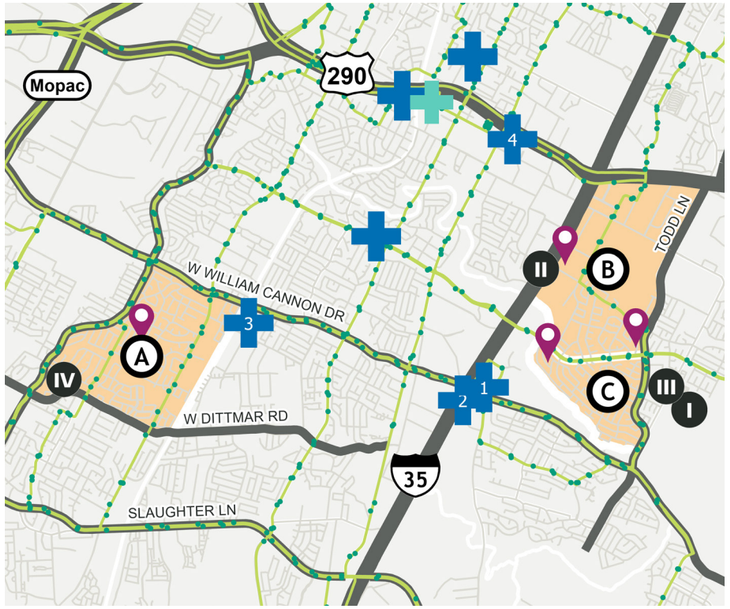
Urgent/Convenient Care: **0**
Hospital: **0**

AFFORDABLE HOUSING

Housing Developments: **4**
Housing Units: **254**

PUBLIC TRANSPORTATION

There are **6 CapMetro bus routes and 55 bus stops** within South Central Austin. Pickup by CapMetro offers services in portions of census tracts B and C in the focus area.



KEY

- High Concentrations of Poverty
- Moderate Concentrations of Poverty
- Affordable Housing Developments
- Bus Routes and Stops
- Hospital
- Primary Care Clinic
- Convenient/Urgent Care Clinic

George Morales Dove Springs Recreation Center

Interstate 35 Near Stassney Lane

Austin ISD's Widen Elementary School

Cameron Loop Mobile Home Park

KEY ▲ Above Overall County = At Overall County ▼ Below Overall County

INCOME

▼ **$74,204** Median Household Income

HOUSING

▼ **$1,403** Median Rent
▼ **$310,332** Median Housing Unit Value
▼ **2.3%** Mobile Homes

EDUCATION [2]

▲ **22.5%** Less than HS Diploma
▲ **23.9%** HS Graduate
▼ **21.2%** Bachelor's Degree
▼ **9.4%** Post-Grad Degree

EMPLOYMENT [3]

▲ **11.4%** Accommodation/ Food Services
▼ **11.2%** Professional/ Scientific/ Technical Services
▲ **10.6%** Retail Trade

FAMILY

▲ **56.2%** of Households Have Married or Cohabiting Couples
▲ **29.6%** of Households Have Children <18 Years Old

TRANSPORTATION

▼ **4.1%** of Housing Units Do Not Have a Vehicle
▲ **28 Minute** Average Commute to Work

[1] Funded by central health and located within 1 mile of the focus area. [2] Educational attainment is based on the population age 25+. [3] Employment industry data is representative of the civilian population age 16+.

Travis County

2020 **2024**

1,367,492
TOTAL POPULATION
▲ 6.0% SINCE 2020

23,812 (7.4%)
FAMILIES IN POVERTY [1]

AGE

<18	**20.2%**	21.2%
18-44	**45.6%**	46.6%
45-64	22.0%	**22.7%**
65+	10.3%	**11.6%**

MEDIAN AGE: 37

LANGUAGE

English	**70.4%**
Other	**8.3%**
Spanish	**21.3%**

SEX

49.6%	**50.4%**
50.0%	50.0%
Female	Male

RACE/ETHNICITY [2]

Asian	7.8%	**8.5%**
Black	7.8%	**7.9%**
Latino	32.6%	**32.6%**
Other	29.3%	**29.6%**
White	**53.9%**	55.0%

South Central Austin

2020 **2024**

18,258
TOTAL POPULATION
▲ 1.2% SINCE 2020

715 (15.9%)
FAMILIES IN POVERTY [1]

AGE

<18	**22.3%**	23.6%
18-44	**42.3%**	43.3%
45-64	22.5%	**23.4%**
65+	10.7%	**12.0%**

MEDIAN AGE: 35

LANGUAGE

English	**54.6%**
Other	**1.2%**
Spanish	**44.2%**

SEX

48.2%	**51.8%**
48.4%	51.6%
Female	Male

RACE/ETHNICITY [2]

Asian	1.5%	**1.6%**
Black	5.9%	**5.9%**
Latino	**58.4%**	60.5%
Other	**47.8%**	49.1%
White	43.5%	**44.7%**

Enrollees in Focus Area

FY21 **FY23**

2,599
[1 IN 7 RESIDENTS]
ENROLLED IN CENTRAL HEALTH PROGRAMS
▼ 6.1% SINCE FY21

AGE

<18	**9.9%**	19.0%
18-44	42.7%	**44.6%**
45-64	33.9%	**38.3%**
65+	4.3%	**7.1%**

MEDIAN AGE: 42

LANGUAGE

English	**26.9%**	33.0%
Other	*%	***%**
Spanish	58.6%	**65.7%**
Unreported	*%	***%**

SEX

55.3%	**44.7%**
55.2%	44.8%
Female	Male

RACE/ETHNICITY [2]

Asian	*%	***%**
Black	**1.9%**	3.0%
Latino	83.2%	**84.0%**
Other	2.6%	**2.9%**
Unreported	*%	***%**
White	6.5%	**6.8%**

Utilization

67.7% OF ENROLLEES UTILIZED SERVICES IN FY23

Between FY21 and FY23, the number of health care visits enrollees had increased by **12.8%**. Out of the South Central Austin enrollees who utilized care, **78.6%** visited a primary care physician, **25.9%** had a specialty care visit, and **20.3%** had a visit in an Emergency Department (ED).

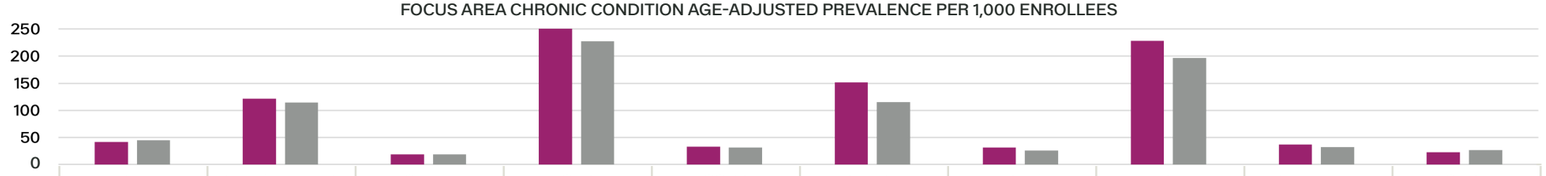
Top 5 provider locations visited by enrollees in focus area

		Number of visits in FY21	FY23
1	Central Health Southeast Health & Wellness Center	1,473	**1,981**
2	CUC South Austin	1,302	**1,319**
3	Dell Seton Medical Center at The University of Texas	640	**919**
4	Lone Star Circle of Care at El Buen Samaritano	656	768
5	CUC William Cannon	534	**582**

Chronic Conditions

Enrollees living in the South Central Austin focus area experienced the following top chronic conditions by prevalence 1.) **Cardiovascular Disease** (254/1,000 persons), 2.) **Hypertension** (229/1,000), and 3.) **Diabetes** (152/1,000). Overall, enrollees in South Central Austin had the highest geographic disparity, having a 20% increased probability of diagnosis for one or more of the chronic conditions. Enrollees in this focus area had a statistically significant higher likelihood of having a hypertension diagnosis.

FOCUS AREA CHRONIC CONDITION AGE-ADJUSTED PREVALENCE PER 1,000 ENROLLEES



	Asthma	Behavioral Health	Cancer	CVD	COPD	Diabetes	Heart Failure	Hypertension	Renal Failure	SUDs
Focus Area Prevalence	42.1	121.7	19.1	254.3	33.2	151.9	31.3	228.5	37.0	22.7
All Enrollees Prevalence	44.8	114.7	18.6	227.2	31.5	115.1	26.3	196.6	32.3	26.6

The Equity Index is a ratio of the observed prevalence rate to the expected prevalence rate (the county rate) among Central Health's patients. A value less than 1.0 indicates lower risk compared to the county rate. A value more than 1.0 indicates higher risk compared to the county rate. This Equity Index, as applied to these age-adjusted prevalence rates, gives us an indication of which subgroups may be experiencing a health inequity.

Equity Index	**0.9**	**1.1**	**1.0**	**1.1**	**1.1**	**1.3**	**1.2**	**1.2**	**1.1**	**0.9**

*[1] Families whose income was ≤100% FPL in 2024. [2] Ethnicity and race are separate for total population counts and combined for Central Health enrollment counts. * Data suppressed to maintain privacy standards.*

Focus Areas

Southeast Austin

TOTAL POPULATION: **23,400**
LAND AREA: **2.7 SQMI**

NEIGHBORHOODS

A. **Parker Lane (Census Tract 23.07)**
B. **East Riverside/ Oltorf (Census Tract 23.15)**
C. **East Riverside (Census Tract 23.16)**
D. **Pleasant Valley/Montopolis (Census Tract 23.25)**
E. **Montopolis (Census Tract 23.20)**

HEALTH CARE ACCESS [1]

Primary Care: **2**

1. **Central Health Southeast Health & Wellness Center**
2. **Planned Parenthood South Austin**

Urgent/Convenient Care: **1**

3. **Central Health Southeast Health & Wellness Center Walk-In Clinic**

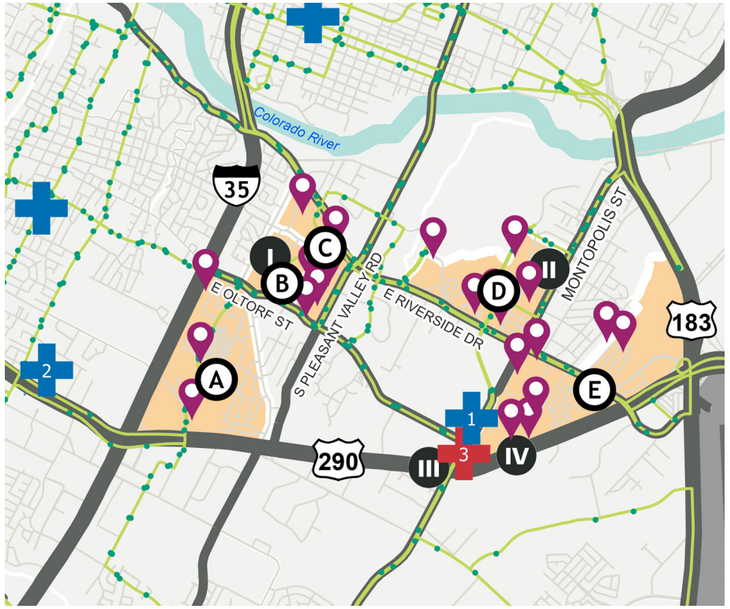
Hospital: **0**

AFFORDABLE HOUSING

Housing Developments: **22**
Housing Units: **3,303**

PUBLIC TRANSPORTATION

There are **12 CapMetro bus routes and 59 bus stops** within Southeast Austin.



KEY

- High Concentrations of Poverty
- Moderate Concentrations of Poverty
- Affordable Housing Developments
- Bus Routes and Stops
- Hospital
- Primary Care Clinic
- Convenient/Urgent Care Clinic

Burton Drive Apartments Facing Downtown Austin

Pop-Up Resource Clinic at Montopolis Recreation Center

Farm Share Austin at Central Health SEHWC

Community Conversation at Central Health Southeast Health & Wellness Center

KEY ▲ **Above Overall County** = **At Overall County** ▼ **Below Overall County**

INCOME

▼ **$56,517**
Median Household Income

HOUSING

▼ **$1,198** Median Rent
▼ **$489,620** Median Housing Unit Value
▼ **1.6%** Mobile Homes

EDUCATION [2]

▲ **17.8%** Less than HS Diploma
▲ **22.9%** HS Graduate
▼ **29.1%** Bachelor's Degree
▼ **9.1%** Post-Grad Degree

EMPLOYMENT [3]

▲ **16.7%** Accommodation/ Food Services
▼ **11.3%** Professional/ Scientific/ Technical Services
▲ **10.0%** Retail Trade

FAMILY

▼ **30.3%** of Households Have Married or Cohabiting Couples
▼ **17.0%** of Households Have Children <18 Years Old

TRANSPORTATION

▲ **9.1%** of Housing Units Do Not Have a Vehicle
= **27 Minute** Average Commute to Work

[1] Funded by central health and located within 1 mile of the focus area. [2] Educational attainment is based on the population age 25+. [3] Employment industry data is representative of the civilian population age 16+.

Travis County

2020 | **2024**

1,367,492
TOTAL POPULATION
▲ 6.0% SINCE 2020

23,812 (7.4%)
FAMILIES IN POVERTY [1]

AGE

	2020	2024
<18	**20.2%**	21.2%
18-44	**45.6%**	46.6%
45-64	22.0%	**22.7%**
65+	10.3%	**11.6%**

MEDIAN AGE: 37

LANGUAGE

English	**70.4%**
Other	**8.3%**
Spanish	**21.3%**

SEX

49.6% 50.0% Female	**50.4%** 50.0% Male

RACE/ETHNICITY [2]

	2020	2024
Asian	7.8%	**8.5%**
Black	7.8%	**7.9%**
Latino	32.6%	**32.6%**
Other	29.3%	**29.6%**
White	**53.9%**	55.0%

Southeast Austin

2020 | **2024**

23,400
TOTAL POPULATION
▲ 9.4% SINCE 2020

1,269 (24.0%)
FAMILIES IN POVERTY [1]

AGE

	2020	2024
<18	**19.0%**	19.2%
18-44	**57.6%**	59.7%
45-64	15.5%	**16.7%**
65+	5.6%	**6.8%**

MEDIAN AGE: 32

LANGUAGE

English	**57.4%**
Other	**6.0%**
Spanish	**36.5%**

SEX

46.8% 46.8% Female	**53.2%** 53.2% Male

RACE/ETHNICITY [2]

	2020	2024
Asian	4.9%	**5.2%**
Black	9.0%	**9.0%**
Latino	**52.0%**	54.5%
Other	**44.6%**	46.4%
White	39.7%	**41.1%**

Enrollees in Focus Area

FY21 | **FY23**

4,740
[1 IN 5 RESIDENTS]
ENROLLED IN CENTRAL HEALTH PROGRAMS
▲ 31.9% SINCE FY21

AGE

	FY21	FY23
<18	**19.8%**	23.9%
18-44	51.3%	**57.0%**
45-64	**20.1%**	22.0%
65+	2.8%	**3.1%**

MEDIAN AGE: 31

LANGUAGE

English	**19.0%**	26.8%
Other	**2.0%**	3.8%
Spanish	61.3%	**71.6%**
Unreported	**7.4%**	8.1%

SEX

54.2% 53.6% Female	**45.8%** 46.4% Male

RACE/ETHNICITY [2]

	FY21	FY23
Asian	**1.3%**	3.6%
Black	**3.1%**	4.4%
Latino	78.0%	**82.8%**
Other	4.0%	**4.1%**
Unreported	**3.4%**	3.7%
White	**5.4%**	6.5%

Utilization

60.3% OF ENROLLEES UTILIZED SERVICES IN FY23

Between FY21 and FY23, the number of health care visits enrollees had increased by **42.6%**. Out of the Southeast Austin enrollees who utilized care, **74.4%** visited a primary care physician, **17.3%** had a specialty care visit, and **23.3%** had a visit in an Emergency Department (ED).

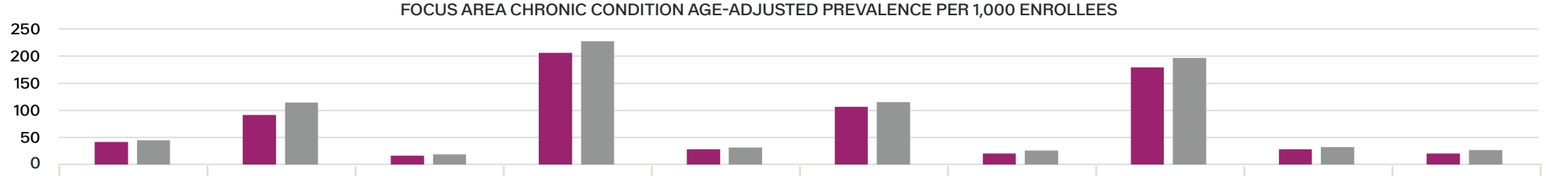
Top 5 provider locations visited by enrollees in focus area

		Number of visits in FY21	FY23
1	Central Health Southeast Health & Wellness Center	2,177	**2,990**
2	Dell Seton Medical Center at The University of Texas	783	**1,408**
3	CUC South Austin	995	**1,232**
4	Ascension Seton Medical Center Austin	465	**740**
5	CUC Sandra Joy Anderson	401	**603**

Chronic Conditions

For enrollees in the Southeast Austin, the top three chronic conditions by prevalence were 1.) **Cardiovascular Disease** (206/1,000 persons), 2.) **Hypertension** (179/1,000), and 3.) **Diabetes** (106/1,000). Overall, enrollees in Southeast Austin were 20% less likely to have a diagnosis for one or more of the chronic conditions. None of the chronic condition rates included in the analysis were in excess compared to the overall Central Health enrolled population.

FOCUS AREA CHRONIC CONDITION AGE-ADJUSTED PREVALENCE PER 1,000 ENROLLEES



	Asthma	Behavioral Health	Cancer	CVD	COPD	Diabetes	Heart Failure	Hypertension	Renal Failure	SUDs
Focus Area Prevalence	41.7	91.3	16.2	206.1	28.3	106.2	20.7	179.3	28.6	20.3
All Enrollees Prevalence	44.8	114.7	18.6	227.2	31.5	115.1	26.3	196.6	32.3	26.6

The Equity Index is a ratio of the observed prevalence rate to the expected prevalence rate (the county rate) among Central Health's patients. A value less than 1.0 indicates lower risk compared to the county rate. A value more than 1.0 indicates higher risk compared to the county rate. This Equity Index, as applied to these age-adjusted prevalence rates, gives us an indication of which subgroups may be experiencing a health inequity.

	Asthma	Behavioral Health	Cancer	CVD	COPD	Diabetes	Heart Failure	Hypertension	Renal Failure	SUDs
Equity Index	0.9	0.8	0.9	0.9	0.9	0.9	0.8	0.9	0.9	0.8

*[1] Families whose income was ≤100% FPL in 2024. [2] Ethnicity and race are separate for total population counts and combined for Central Health enrollment counts. * Data suppressed to maintain privacy standards.*

Focus Areas

Conclusion

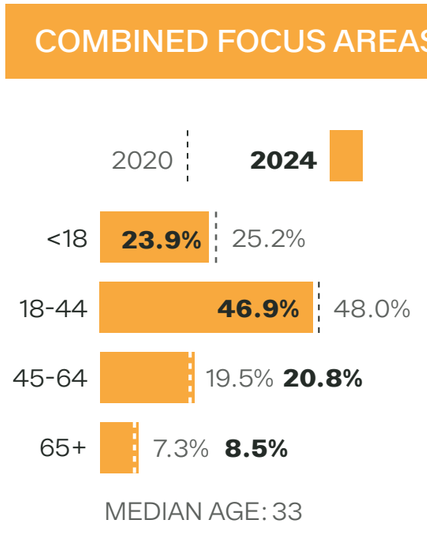
From 2020 to 2024, the total population in the nine focus areas identified in this report has increased by 9.7%. The population growth experienced in these focus areas over the past four years has been greater than in Travis County as a whole. Additionally, between FY21 and FY23, enrollment in focus areas has increased by 13.3%. As of FY23, more than 1 in 6 focus area residents were enrolled in Central Health funded programs.

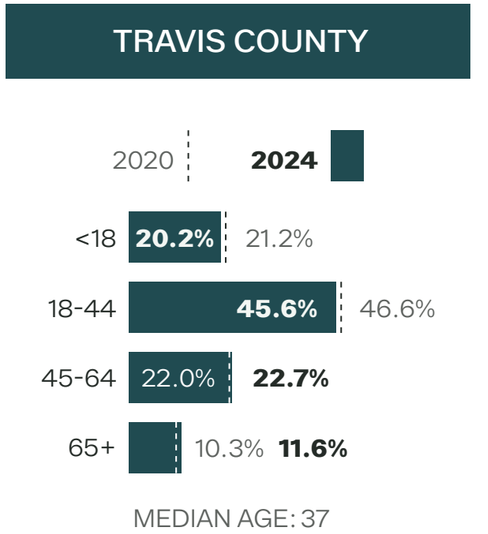
As Travis County continues to grow, it becomes even more important to understand the needs of the changing population that Central Health serves. In this conclusion section are some of the key takeaways regarding the demographics and social determinants of health for residents in these areas.

- In areas of high and moderate levels of poverty, the overall population is younger than in Travis County as a whole.
- While English is the preferred language spoken by most residents in both focus areas and Travis County, the percentage of Spanish speakers in focus areas is almost twice that of the county overall.

AGE

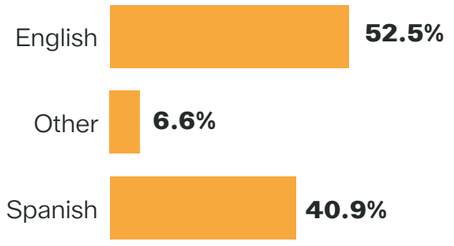
In areas of high and moderate levels of poverty, the overall population is younger than in Travis County as a whole. The median age in focus areas is 33 compared to 37 for Travis County. The proportion of children ages 0-17 is 3.7% higher than the county rate. And the proportion of those age 18-44 is 1.3% higher in focus areas than the county. East Central Travis County has the highest percentage of people ages 0-17 (32.4%), Southeast Austin has the highest percentage of people ages 18-44 (57.6%), and Oak Hill has the highest percentage of people ages 45-64 (26.2%) and 65+ (12.7%). Both the combined focus areas and Travis County overall have seen the median age of their populations increase by one year between 2020 and 2024.

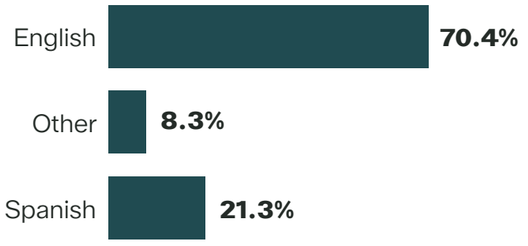




LANGUAGE

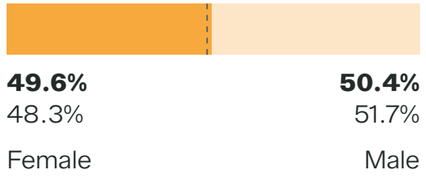
In areas of high and moderate levels of poverty, English is the primary language spoken by those age 5+. In focus areas, Spanish is the preferred language for 40.9% of residents, which is almost twice as high as the countywide rate. Oak Hill has the highest percentage of residents whose preferred language was English (73.5%). East Central Travis County has the highest percentage of residents whose preferred language was Spanish (70.2%), and Northeast Travis County has the highest percentage of Other Language speakers (17.8%). The most-widely spoken languages outside of English and Spanish among focus areas in 2024 was Vietnamese (1.2 %).





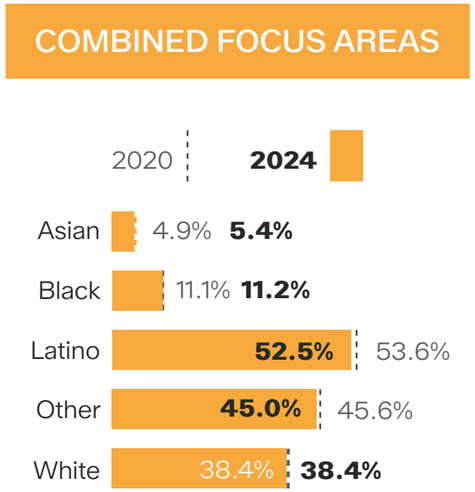
SEX

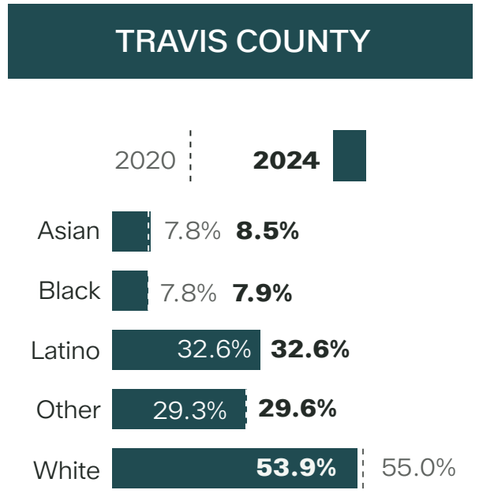
The percentage of females and males in low-income areas of Travis County is the same as the countywide rate. Three of the nine focus areas— East Central Travis County, Manor, and Oak Hill—have majority female populations. North Central Austin (Rundberg) has the highest percentage of males (53.9%), and Oak Hill has the highest percentage of females (50.6%).



RACE/ETHNICITY[1]

Across focus areas, the 52.5% of the population identified as Latino. This was 19.9% less than Travis County's overall population. The other race demographic was the highest in East Central Travis County (61.4%). Oak Hill had the highest percentage of White residents (67.9%) , Manor had the highest percentage of Black residents (24.6%), and Northeast Travis County had the highest percentage of Asian residents (17.8%). In six of the nine focus areas featured in this report, more than half of the total population identified as Latino. Across focus areas, the proportion of Latino residents ranges from 73.5% in East Central Travis County to 23.7% in Oak Hill.





OVERALL POPULATION

Residents of the nine focus areas in this report represent 12.4% of Travis County's population and 33.7% of the county's families in poverty. Total population growth in the past four years has been greater in focus areas than Travis County as a whole. North Central Austin (Rundberg) has had the lowest population growth since 2020 (1.1%), while East Central Travis County has had the largest population growth (31.3%).

169,587
TOTAL POPULATION
▲ 9.7% SINCE 2020

8,033 (20.0%)
FAMILIES IN POVERTY [2]

1,367,492
TOTAL POPULATION
▲ 6.0% SINCE 2020

23,812 (7.4%)
FAMILIES IN POVERTY [2]

HEALTH CARE ACCESS

Each focus area in this report had at least one primary care clinic located within one mile that was a part of Central Health's provider network. Across focus areas, there are twenty-three distinct primary care clinics, three convenient/urgent care clinics, and two hospitals that are in-network for enrollees. While CUC North Central, Central Health Southeast Health & Wellness Center, Dell Seton Medical Center at the University of Texas, and Ascension Seton Medical Center Austin are among the top locations visited regardless of geography, nearby clinics also appear in the top locations visited at the focus area level. In Oak Hill, for example, the most visited location by enrollees was CommUnityCare's Oak Hill Health Clinic.

Top 5 Provider Locations Visited by Enrollees Residing in Focus Areas

	FY21	FY23 (Number of visits)
1 CUC North Central	13,191	20,305
2 Central Health Southeast Health & Wellness Center	6,027	8,429
3 Dell Seton Medical Center at The University of Texas	4,191	6,977
4 Ascension Seton Medical Center Austin	3,900	5,849
5 CUC Rundberg	4,039	4,982

Top 5 Provider Locations Visited by Enrollees Residing in Travis County

	FY21	FY23 (Number of visits)
1 CUC North Central	38,714	58,759
2 Central Health Southeast Health & Wellness Center	26,175	36,748
3 Dell Seton Medical Center at The University of Texas	15,940	26,565
4 Ascension Seton Medical Center Austin	14,732	21,198
5 CUC South Austin	15,623	18,442

[1] Ethnicity and race are two separate categories for total population counts, but have been combined in the charts (e.g. a resident could identify as both Latino and White) [2] Families whose income was ≤100% FPL in 2024.

Focus Areas

Conclusion

- Like with language, race and ethnicity breakdowns are quite varied across different focus area locations. Overall, a focus area resident is more likely to identify as Black, Latino, or Other Race than the average Travis County resident.
- Eastern Travis County focus areas have seen greater population growth from 2020 to 2024 than those in Central and Western Travis County.
- Among focus areas, Northeast Travis County and Southeast Austin had the largest increases in enrollment in Central Health programs from FY21 to FY23.
- Although Central Health patients will visit nearby health care providers, often the same main provider locations are among the most visited regardless of where patients live. This could be due to multiple factors including a greater awareness of these locations, provider preference, differences in services offered, and the proximity of these locations near work or school.
- The median income for a focus area household is $33,616 less than the county average.

Conclusion

- Median rent in focus areas is 16.1% lower than the county rate and the median home value is 27.0% less than the median value for Travis County.
- More than 1 in 10 housing units in East Central Travis County, North Central Austin (Rundberg), and Northeast Travis County are mobile homes.
- In both focus areas and Travis County the most prevalent educational attainment for residents age 25+ is a Bachelor's Degree. The percentage of residents who have an education less than or equivalent to a high school diploma is 17.8% higher in focus areas than in Travis County overall.
- Focus areas outside of Central Travis County have higher percentages of households with married or cohabiting couples and children under 18 years old.
- The focus areas that had the highest percentages of utilizers with primary care visits in FY23 were also the focus areas with the lowest percentage of utilizers that had an Emergency Department visit during the fiscal year.

		COMBINED FOCUS AREAS	TRAVIS COUNTY
INCOME	The median household income in Travis County is 49.3% higher than the median household income of residents in the nine focus areas identified in this report. Among focus areas, Oak Hill had the highest median household income ($120,895) and North Central Austin (Rundberg) had the lowest median household income ($48,280).	**$68,220** Median Household Income	**$101,836** Median Household Income
HOUSING	Median rent in focus areas is 16.1% lower than the county rate and the median home value is 27.0% less than the median value for Travis County. Manor has the highest median rent ($1,968) and Oak Hill has the highest median home values ($775,681) among focus areas. North Central Austin (Rundberg) has the lowest median rent ($1,137). East Central Travis County has the lowest median home value ($173,966) which can partially be attributed to this focus area having the largest percentage of mobile homes as housing units (31.9%).	**$1,303** Median Rent **$421,898** Median Home Value **6.3%** Mobile Homes	**$1,553** Median Rent **$578,139** Median Home Value **3.4%** Mobile Homes
EDUCATION [1]	Among focus areas, 42.3% of residents age 25+ have attained an education that is less than or equivalent to a high school diploma. 1 in 4 residents of focus areas, and over half of residents in Travis County, have obtained a bachelor's or post-graduate degree. The focus areas in this report are covered by five independent school districts: Austin, Del Valle, Lake Travis, Manor, and Pflugerville ISDs.	**19.1%** Less than HS Diploma **23.2%** HS Graduate **25.2%** Bachelor's Degree **11.6%** Post-Grad Degree	**8.5%** Less than HS Diploma **16.0%** HS Graduate **34.2%** Bachelor's Degree **20.2%** Post-Grad Degree
EMPLOYMENT [2]	The main industries employing residents of focus areas are construction, professional/scientific/technical services, and accommodation/food services. About 1 in 5 people in East Central Travis County and Northeast Austin work in the construction industry. Other top industries among workers in focus areas include educational services, health care/social assistance, manufacturing, public administration, and retail trade.	**11.3%** Construction **10.9%** Professional/Scientific/ Technical Services **10.4%** Accommodation/Food Services	**16.7%** Professional/Scientific/ Technical Services **9.8%** Educational Services **9.7%** Health Care/Social Assistance
FAMILY	In areas that have high and moderate levels of poverty, there is a lower percentage of households with married or cohabitating couples and a higher percentage of households with children <18 years old. Manor has the highest percentage of married or cohabiting couples (75.4%) and households with children (54.3%). Southeast Austin has the lowest percentage of married or cohabiting couples (30.3%) and the lowest percentage of households with children (17.0%).	**48.3%** of Households Have Married or Cohabiting Couples **28.9%** of Households Have Children <18 Years Old	**51.0%** of Households Have Married or Cohabiting Couples **24.9%** of Households Have Children <18 Years Old
TRANSPORTATION	Focus areas overall have a higher percentage of houses without access to a vehicle than the rest of the county. East Central Austin has the highest percentage of housing units without vehicles (11.3%), while Oak Hill has the lowest (1.1%). This makes sense given the greater availability of alternative transportation options that exist closer to Central Travis County. While average commute times vary by only a few minutes between geographies, someone residing in Manor would on average spend an extra 92 hours commuting to and from work in a year than the average Travis County resident.[3]	**6.7%** of Housing Units Do Not Have a Vehicle **28 Minute** Average Commute to Work	**5.0%** of Housing Units Do Not Have a Vehicle **27 Minute** Average Commute to Work

[1] Educational attainment is based on the population age 25+. [2] Employment industry data is representative of the civilian population age 16+. [3] Based on someone commuting to and from work five days a week and fifty weeks in a year.

AFFORDABLE HOUSING

As of October 2024, there are currently 11,101 housing units available for families <= 100% Median Family Income (MFI) within the 2024 focus areas. In 2024, 100% MFI in the Austin-Round Rock MSA for a four-person household is $126,000, while 100% of the Federal Poverty Level (FPL) for a family of four is $31,200. 99.8% of affordable housing units in focus areas are within multi-family developments. Currently, there are no affordable housing units or developments within the Manor focus area. 324 affordable apartment units are in the planning phase in Manor. While portions of the county may appear to have enough housing units to meet or exceed the current number of families in poverty, it is important to recognize that certain developments may have restrictions or wait lists that result in unmet need. Restrictions may include age (55+), income level (% of MFI), and disability status.

COMBINED FOCUS AREAS		TRAVIS COUNTY	
11,101	HOUSING UNITS FOR FAMILIES <=100% MFI	47,880	HOUSING UNITS FOR FAMILIES <=100% MFI
94	HOUSING DEVELOPMENTS FOR FAMILIES <=100% MFI	577	HOUSING DEVELOPMENTS FOR FAMILIES <=100% MFI
8,033	FAMILIES IN POVERTY (< 100% FPL)	23,812	FAMILIES IN POVERTY (< 100% FPL)
128	AFFORDABLE HOUSING UNITS PER SQMI	47	AFFORDABLE HOUSING UNITS PER SQMI

PUBLIC TRANSPORTATION

North Central Austin has the highest number of bus stops and transit hubs (107) and East Central Austin has the highest number of bus routes among focus areas (19). Manor and Oak Hill tie for the lowest number of bus routes (0) and the lowest number of bus stops (0). There are two CapMetro transit hubs within the focus areas: one in North Central Austin (North Lamar Transit Center) and one in Northeast Austin (Norwood Transit Center). The Eastside Bus Plaza is the only Capital Area Rural Transportation System (CARTS) bus stop that falls within a focus area. CapMetro's rideshare service, Pickup, currently serves portions of seven of the nine focus areas. CARTS also offers limited curb-to-curb service by appointment for the Manor area.

315	BUS STOPS & TRANSIT HUBS	2,262	BUS STOPS & TRANSIT HUBS
56	BUS ROUTES	76	BUS ROUTES
33.1%	OF AREA COVERED BY CAPMETRO'S RIDESHARE SERVICE PICKUP	4.9%	OF AREA COVERED BY CAPMETRO'S RIDESHARE SERVICE PICKUP

UTILIZATION

Utilization rates between the combined focus areas and Travis County were similar for enrollees in FY23. The focus area with the highest percentage of enrollees utilizing services was South Central Austin (67.7%) and the focus area with the lowest percentage was Southeast Austin (60.3%). Manor had the highest proportion of utilizers who visited a primary care physician (84.0%) and the lowest proportion of utilizers that had a visit in an Emergency Department (ED) (14.4%). South Central Austin enrollees had the highest specialty care utilization (25.9%) and East Central Austin had the highest rate of utilizers with ED visits (26.5%).

63.4%	OF ENROLLEES UTILIZED SERVICES IN FY23	62.3%	OF ENROLLEES UTILIZED SERVICES IN FY23
77.6%	OF UTILIZERS VISITED A PRIMARY CARE PHYSICIAN	77.6%	OF UTILIZERS VISITED A PRIMARY CARE PHYSICIAN
21.8%	OF UTILIZERS HAD A SPECIALTY CARE VISIT	23.3%	OF UTILIZERS HAD A SPECIALTY CARE VISIT
22.6%	OF UTILIZERS HAD A VISIT IN AN EMERGENCY DEPARTMENT (ED)	21.2%	OF UTILIZERS HAD A VISIT IN AN EMERGENCY DEPARTMENT (ED)

Conclusion

- Since the last Demographic Report, there has been a marked increase in the number of affordable housing units in Travis County. Even with this increase, most areas still lack enough units to house all residents who are below 100% of the Federal Poverty Level (FPL).
- While every focus area has at least one nearby primary care provider location that is within Central Health's provider network, there is a noted centralization of health care providers in Travis County. Central Health is actively working on building health and wellness centers outside the central corridor that can help serve communities that lack nearby options for care.
- Those who are low-income and live in areas such as East Central Travis County, Manor, and Oak Hill can face difficulties traveling to access resources as public transportation in these areas is limited compared to the rest of the county.
- Public rideshare services, such as Pickup by CapMetro, cover nearly a third of focus areas and help provide a means of shuttling residents to bus stops or other nearby resources that may otherwise be inaccessible.

Central Health Enrollment & Utilization

In this report, enrollees are defined as individuals who are enrolled in Central Health's Medical Access Program (MAP), MAP Basic, local sliding fee scale (SFS) subsidy programs reimbursed by Central Health, or the Central Health Assistance Program (CHAP). MAP provides a defined benefit package to eligible residents who are at or below 100 percent of the Federal Poverty Level (FPL). MAP Basic covers uninsured residents who are at or below 200 percent of the FPL. Residents who earn up to 200% FPL may receive subsidized health care on a sliding fee scale through Central Health's network of primary care providers. CHAP is limited to individuals selected and approved by Central Health and helps cover the cost of premiums for Sendero insurance coverage.

Enrollment

Overview

In this report, enrollees are defined as individuals who are enrolled in Central Health's Medical Access Program (MAP), MAP Basic, local sliding fee scale (SFS) subsidy programs reimbursed by Central Health, or the Central Health Assistance Program (CHAP). MAP provides a defined benefit package to eligible residents who are at or below 100 percent of the Federal Poverty Level (FPL). MAP Basic covers uninsured residents who are at or below 200 percent of the FPL. Residents who earn up to 200% FPL may receive subsidized health care on a sliding fee scale through Central Health's network of primary care providers. CHAP is limited to individuals selected and approved by Central Health and helps cover the cost of premiums for Sendero insurance coverage.

The seven census tracts highlighted in the map to the right represent the areas with the highest number of enrollees in Fiscal Year (FY) 23. These areas represent 13 percent of Central Health's total enrolled population. In FY23, there were 119,103 individuals enrolled in Central Health programs. This was equivalent to more than 1 in 12 Travis County residents and represented a 7.2% increase in enrollment since FY21.

As of FY23, over half of enrollees are between the ages of 18 and 44, most speak Spanish, the majority of enrollees are female, and almost 3 out of 4 enrollees are Latino. Additionally, 8.9% of enrollees reported experiencing homelessness at least once during the fiscal year. The languages other than English and Spanish that were spoken the most by enrollees were Arabic, Vietnamese, Nepali, Sign Language, Burmese, and Mandarin.

Central Health FY23 Enrollment

119,103

ENROLLED IN CENTRAL HEALTH PROGRAMS IN FY23 [1]

[1 IN 12 TRAVIS CO. RESIDENTS]

▲ 7.2% SINCE FY21

- **52,604** ENROLLED IN MAP COVERAGE
- **77,252** ENROLLED IN MAP BASIC
- **9,963** ENROLLED IN SFS PROGRAMS
- **979** ENROLLED IN CHAP

ENROLLEE DEMOGRAPHICS

FY21 | **FY23**

AGE

	FY21	FY23
<18	**14.1%**	19.7%
18-44	49.9%	**52.6%**
45-64	26.3%	**28.1%**
65+	4.0%	**5.2%**

MEDIAN AGE: 37

HOMELESSNESS

8.9%	**91.1%**
8.1%	91.9%
Unhoused	Housed

SEX

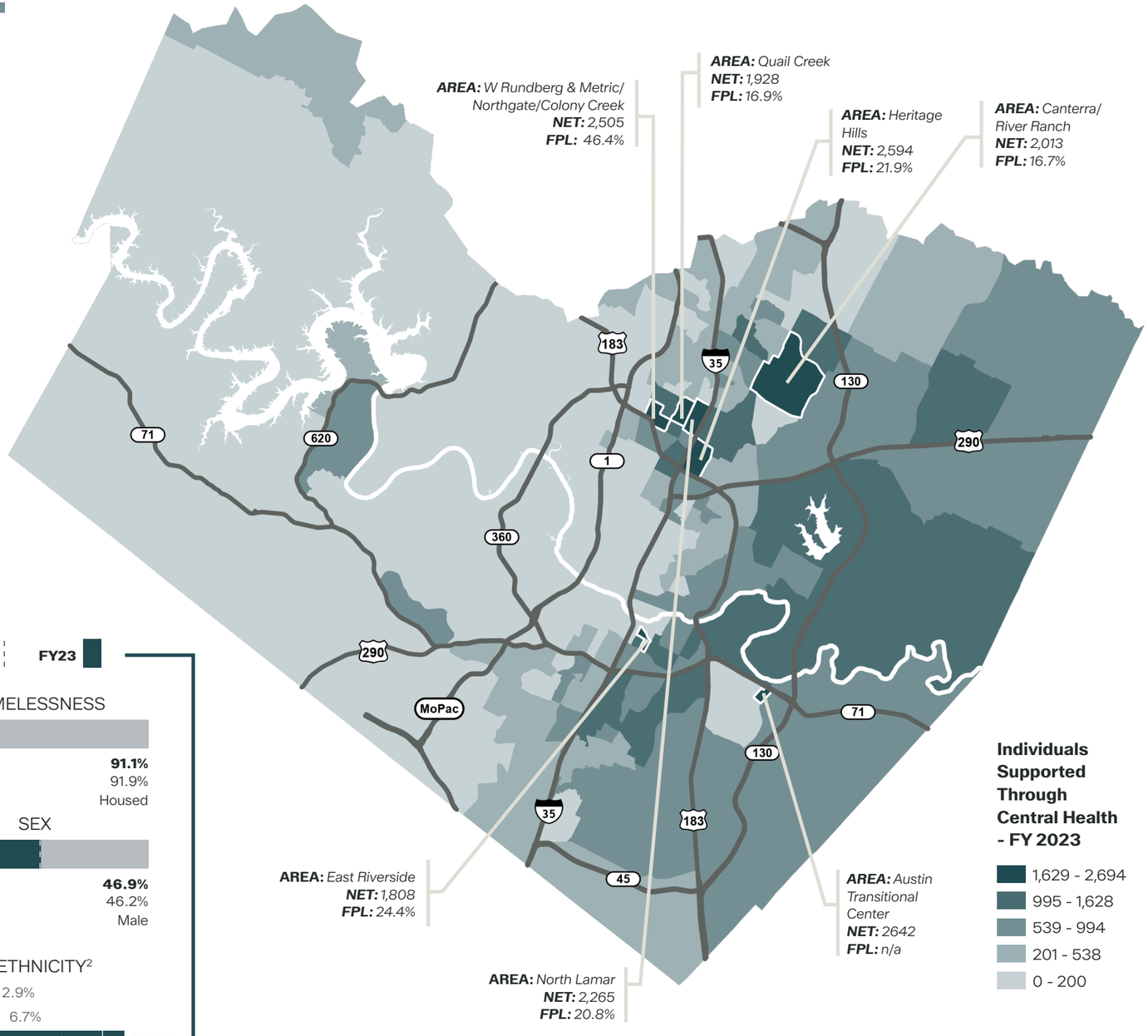
53.1%	**46.9%**
53.8%	46.2%
Female	Male

LANGUAGE

	FY21	FY23
English	**29.8%**	36.5%
Other	2.3%	**2.3%**
Spanish	51.6%	**60.0%**
Unreported	**7.9%**	9.6%

RACE/ETHNICITY[2]

	FY21	FY23
Asian	**2.3%**	2.9%
Black	**5.5%**	6.7%
Latino	67.7%	**72.9%**
Other	**6.2%**	6.9%
Unreported	**5.0%**	6.5%
White	**8.1%**	9.4%



Highlighted are the census tracts with the highest counts of enrollees

AREA: The dominant neighborhood represented in the census tract
NET: The total number of enrollees residing in the census tract in FY2023
FPL: The percent of families living below 100% of the Federal Poverty Level in 2024

[1] Total enrollment counts and demographics are based on the entire enrolled population (i.e. including non-mapped enrollees). Enrollment data shown in maps is based on the number of enrollees with addresses that could be geocoded and mapped. Total enrollment counts are deduplicated to account for those who changed programs during the year. As a result, combined enrollment by program figures do not equal deduplicated totals. [2] Ethnicity and race are combined for Central Health enrollment figures.

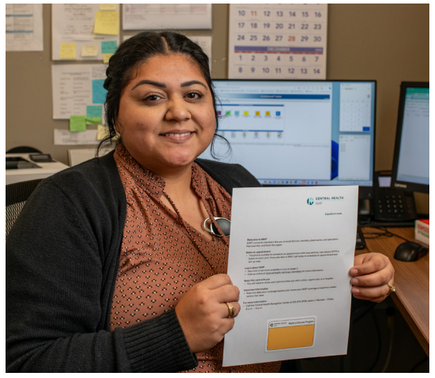
Changes in Enrollment

Between FY21 and FY23, enrollment in MAP increased by 9.9 percent and enrollment in MAP Basic increased by 26.5%. The largest demographic shifts across all enrollment programs since FY21 were a decrease in those under the age of 18 and an increase in Latino enrollees and enrollees whose preferred language is Spanish. These shifts represent changes in both the overall counts and percentages of enrollees. Additionally, the count of unhoused individuals enrolled in Central Health funded programs has increased by 14.1% since FY21.

As in previous Demographic Reports, the majority of enrollees still reside east of Mopac in FY23 – with most living around and east of the I-35 corridor. Larger pockets of enrollment in Western Travis County include Oak Hill, Leander, and Apache Shores/Hudson Bend. Over the past five years, a gradual dispersion of enrollees has started as some have moved away from the central corridor to locations that are primarily in the eastern portion of Travis County. In fact, the center of enrollee population distribution over these five years has shifted 0.7 miles east. Despite this increase in outward migration, most enrollees still live and move within the central part of the county, mainly within the City of Austin.

A client waits in line for on-site Central Health coverage program enrollment services and other health and social services at a local organization.

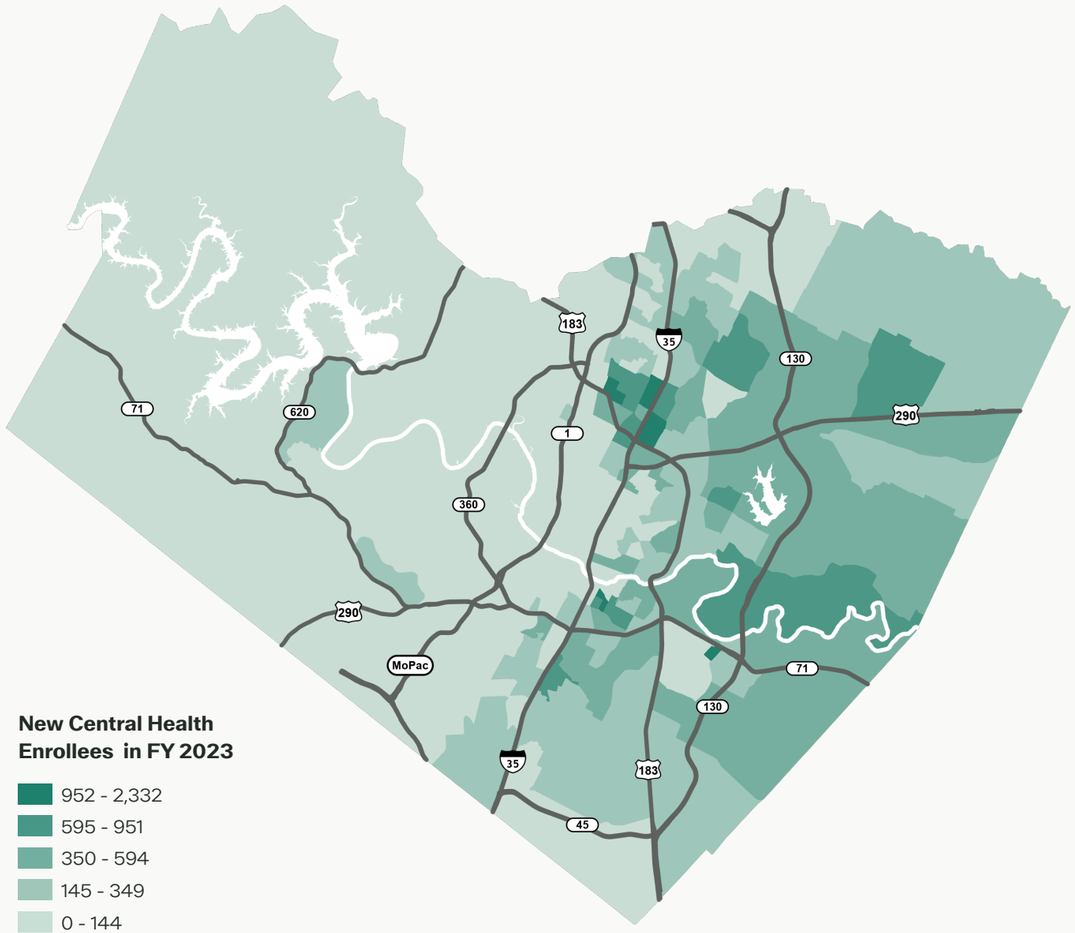
Brisa Villanueva, Eligibility and Enrollment Specialist, helps a client enroll in a Central Health coverage program



Maria Cardenas-Aguillon, Eligibility and Enrollment Specialist, shows a sample Medical Access Program card.

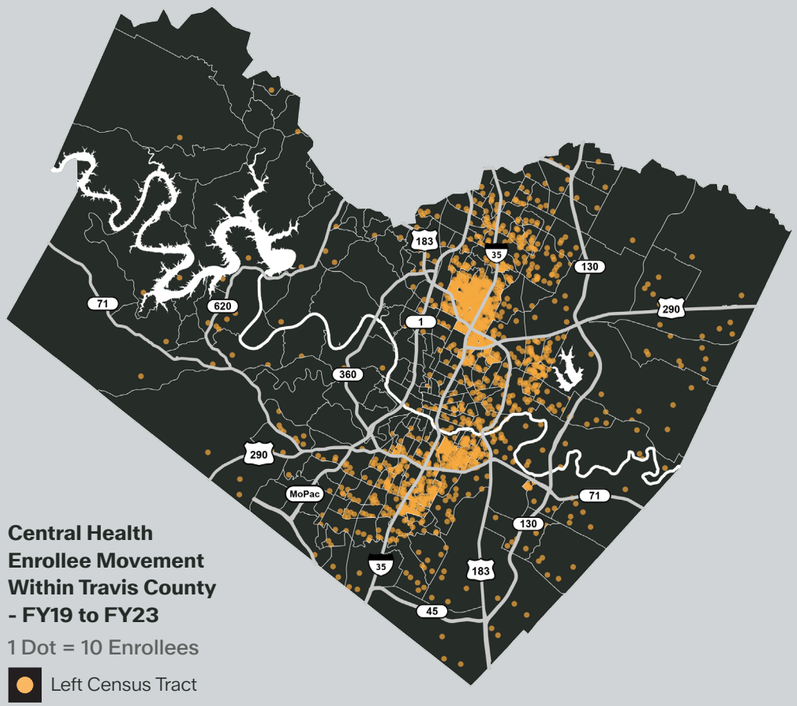
Linda Macias, Sr. Eligibility Specialist and Austin Alcon, Eligibility and Enrollment Specialist, help a client enroll in a Central Health coverage program.

FY 2023 NEW CENTRAL HEALTH ENROLLEES BY CENSUS TRACT



The above map illustrates where FY23 enrollees who were not previously enrolled in FY21 resided within Travis County. Overall the census tracts with the highest counts of new enrollees are subsets within larger regions of high enrollment. For example, while the region of Travis County that extends from Colony Park east towards Manor and Webberville and south towards Hornsby Bend all has similarly high enrollment, there are two distinct areas within that region that have a higher proportion of new enrollees. The Austin Transitional Center, located off of SH-71 in Southeast Austin, stands out as having both the highest overall enrollment and highest number of FY23 enrollees who were not previously enrolled in FY21. This is due to the fact that most enrollees in this census tract are only temporarily residing in the area.

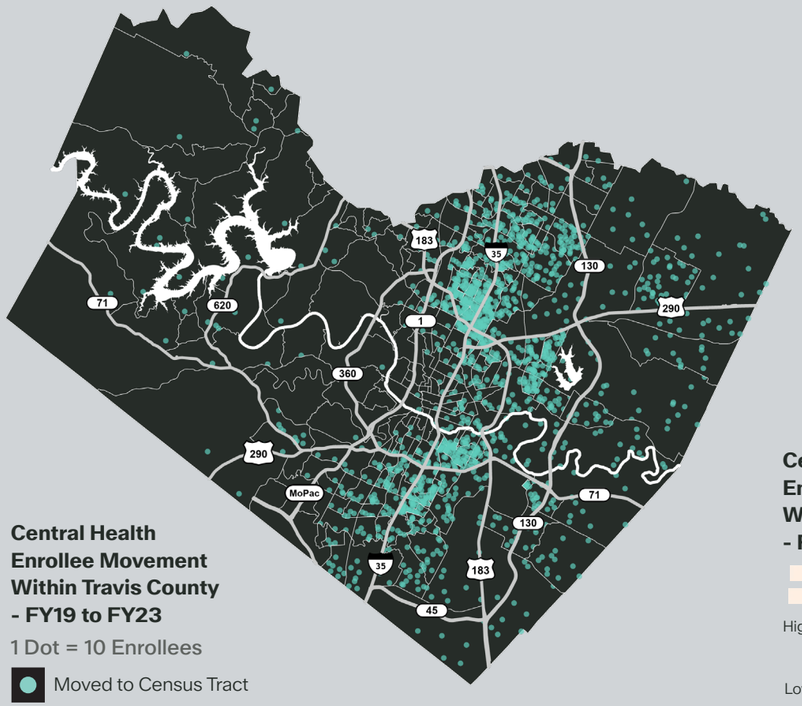
DISTRIBUTION OF CENTRAL HEALTH ENROLLEE MOVEMENT WITHIN TRAVIS COUNTY FROM FISCAL YEAR 2019 TO FISCAL YEAR 2023



Central Health Enrollee Movement Within Travis County - FY19 to FY23

1 Dot = 10 Enrollees

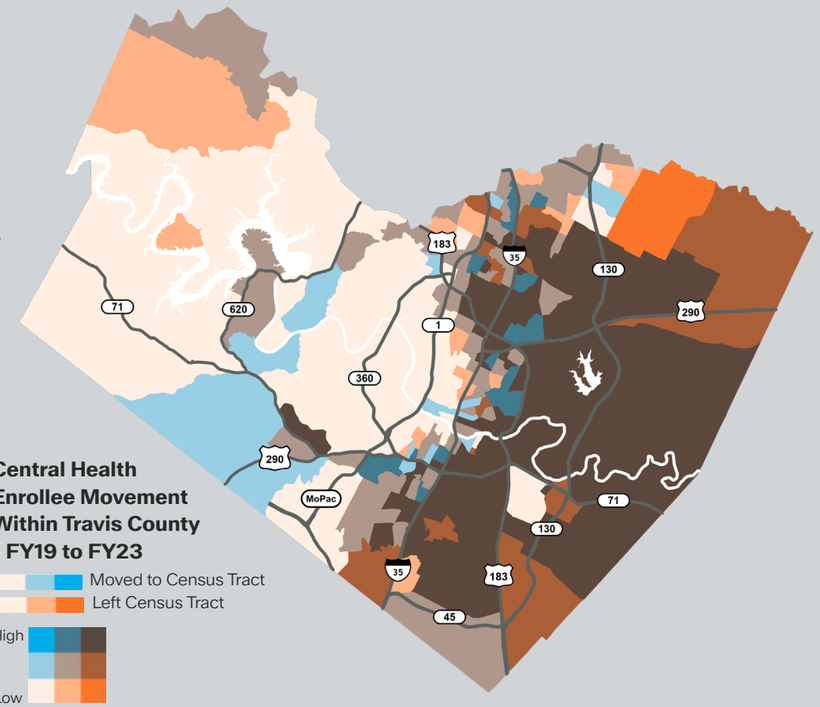
Left Census Tract



Central Health Enrollee Movement Within Travis County - FY19 to FY23

1 Dot = 10 Enrollees

Moved to Census Tract



Central Health Enrollee Movement Within Travis County - FY19 to FY23

Moved to Census Tract

Left Census Tract

High

Low

Low High

Digging Deeper: Geographic Movement of Enrollees in Travis County

The maps above show the geographic patterns of enrollee movement within the county over the past five years. Specifically, they look at where did those who were enrolled in both FY19 and FY23 move from and where did they move to if they left their census tract in that time period. Year-over-year the majority of enrollees remain residing at the same address or move somewhere nearby, but on average each year 13.2 percent of enrollees will relocate to a residence that is further away. The left and center maps above are dot density maps that show the magnitude of the shifts in where enrollees are residing. Here, each dot has been randomly generated to a place within the census tract and represents either ten enrollees that left or ten enrollees that moved to the census tract. The majority of the movement over these past five years has occurred along the I-35 corridor. There has also been more movement into far east Travis County than in western Travis County.

The map to the right is a bivariate map that compares how many enrollees left and moved to an area. The dark brown sections – that are primarily in the east - represent census tracts where there was a lot of movement overall. These are areas where enrollees were both leaving and moving to the census tracts in high numbers. The pale orange areas – that are mainly seen to the west - represent regions where movement out and movement into the census tracts was also similar, but there was little movement overall. The other shades of orange are areas where more enrollees were leaving than moving into the census tract, and the shades of blue are areas where there were more enrollees moving into the area than leaving.

Percent of Individuals Who Remained Enrolled in Central Health Programs and Moved Out of Their Census Tract of Residence Between Fiscal Years

Time Period	Percent of Enrollees That Moved
FY19 to FY20	9.6%
FY20 to FY21	18.3%
FY21 to FY22	10.7%
FY22 to FY23	14.2%
Average Year-Over-Year	**13.2%**
FY19 to FY23	**38.1%**

Utilization of Health Care

Since FY21, Central health's network of health care providers has grown 25.7% to include more than 250 locations in and around Travis County. This vast network of providers offers a diverse array of services to best address the health needs of the low-income and uninsured population. These locations include everything from small local specialty care and primary care providers to larger health and wellness centers and hospitals. In FY23:

- There were **390,897 visits**, an increase of **22.4%** since FY21
- **62.1%** of enrollees utilized services
- Out of the enrollees who utilized care, **77.0%** visited a primary care physician, **22.6%** had a specialty care visit, and **22.6%** had a visit in an Emergency Department (ED).

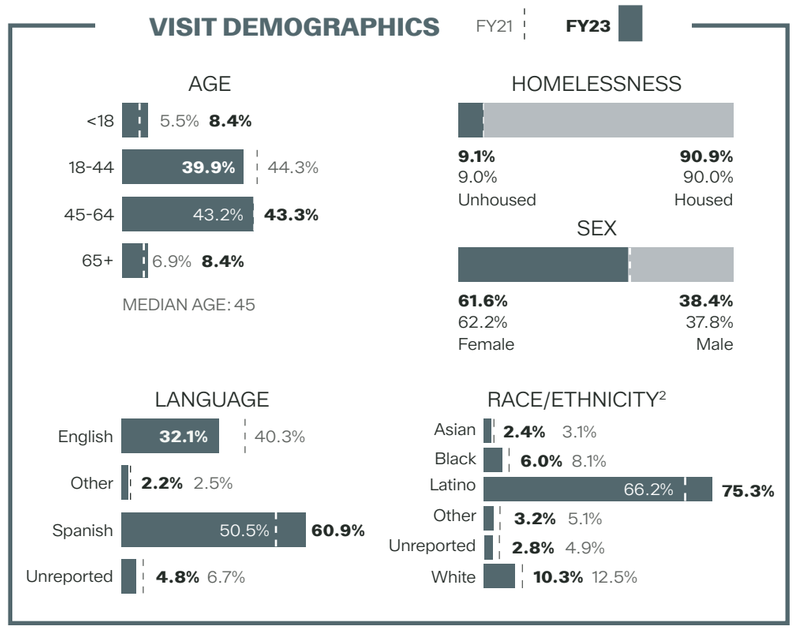
Two of the distinct geographic patterns to utilization include: 1) while enrollees will seek care at nearby providers, often the same handful of locations are among the most visited by enrollees across all geographies; and 2) the top provider location visited largely follows regional patterns.

The first pattern is evident when looking at the focus areas included in this report. In Manor, for example, CUC Manor is the third most visited location by enrollees, but CUC North Central is the top provider location. This pattern could be due to multiple factors including a greater awareness of these locations, provider preference, greater capacity and appointment availability, difference in services offered, and the proximity of these locations near work or school.

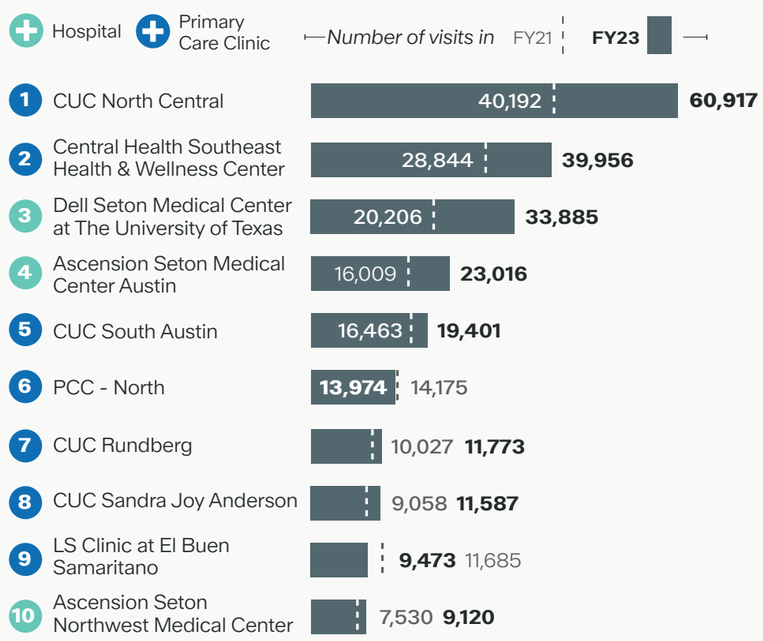
The second geographic pattern of utilization can be seen in the map below. Residents in north census tracts primarily visit CUC North Central, most southwest census tract enrollees primarily go to CUC Oak Hill, and the top provider for south central and southeast census tracts is usually CUC South Austin or Central Health Southeast Health and Wellness Center.

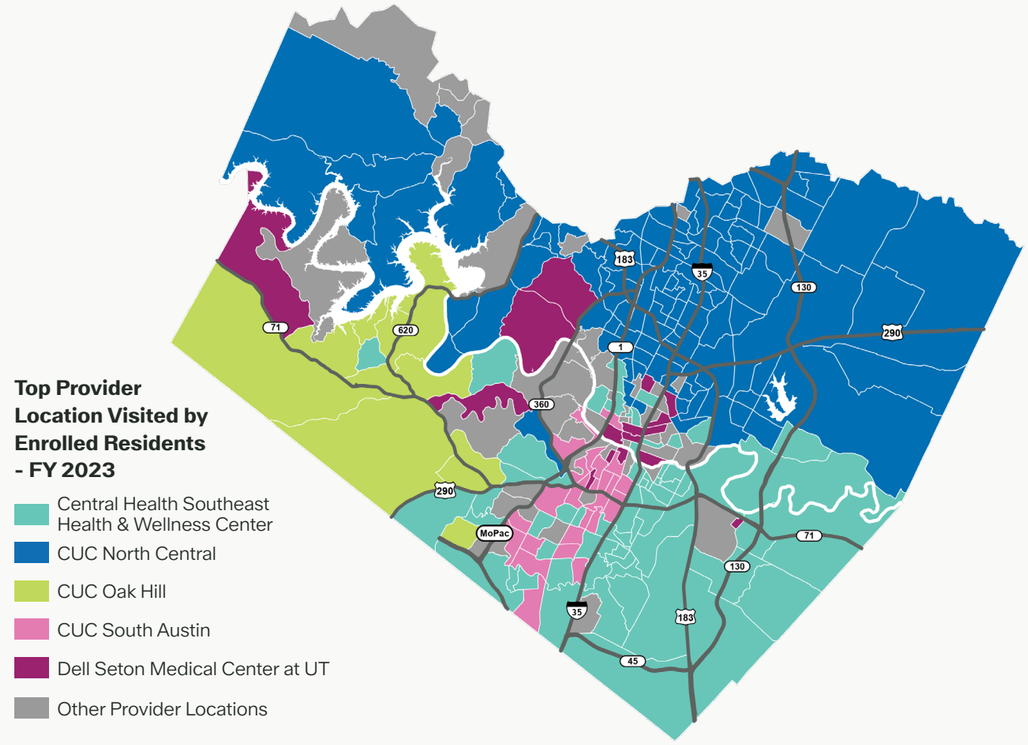
The largest differences between the demographics across all visits and the enrolled population in FY23 is that older enrollees have a higher proportion of visits than younger enrollees. Enrollees age 45 to 64 have 154% more visits than would be expected based on their enrollment levels, and the median age across all visits is eight years older than that for the total enrolled population. Higher utilization among older enrollees makes sense as younger people are generally less likely to have chronic conditions and disabilities that often result in an increased need to access health care. Additionally, there is slightly higher than expected utilization by enrollees experiencing homelessness; Asian, Black, Latino, and White enrollees; English and Spanish speakers; and female enrollees.

Between FY21 and FY23, the main shifts in the demographics of utilization include a decrease in enrollees age 18 to 44, an increase in those under 18 accessing health care, a decrease in English speakers and an increase in Spanish speakers accessing care, and an increase in Latino enrollees accessing care.



Top 10 provider locations visited by enrollees in FY23






COLLABORATION
TEAMWORK
SUPPORT
UNITY
VICTORY
UNANIMITY
CAUSE
INTENTION
OUTCOME
IDEA
GOALS
SHARING
ACCORDANCE
GROUP
POWER
COMMUNICATION
FELLOWSHIP
FUN
SYSTEM
COMBINATION


EXAMEN 20
EXAM 20
MA

Central Health Provider Network

Central Health partners with several health care providers to offer a network of primary care, specialty care, hospital, convenient/urgent care, behavioral health, dental, post-acute care, preventative screening, and other services to Travis County's low-income and uninsured populations. This allows Central Health to support patient care in a robust variety of settings.

The Travis County providers listed on pages 48 through 51 are current as of September 2024. This list is subject to change as new service locations are determined. A dashboard featuring a map of all current provider locations can be found on Central Health's website.

Central Health Provider Network

Behavioral Health

Integral Care

- Provides immediate and ongoing support services to adults and children in Travis County
- Cares for those living with mental illness, substance use disorder, and intellectual and developmental disabilities.

1. JUDGE GUY HERMAN CENTER FOR MENTAL HEALTH CRISIS CARE
2. NEXT STEP CRISIS RESPITE
3. STONEGATE
4. THE INN

Lone Star Circle of Care

- Provides behavioral health services for all ages using an integrated care model
- New patients must be referred by a LSCC primary care provider

5. LSCC BEN WHITE HEALTH CLINIC
6. LSCC SETON CIRCLE OF CARE BEHAVIORAL HEALTH

Convenient/ Urgent Care

Central Health contracts with a network of urgent and convenient care clinics offering care to patients enrolled in the Medical Access Program (MAP) and other programs supported by Central Health. These locations provide same-day options for non-emergency illnesses and injuries.

CommUnityCare Walk In

- Open 365 days per year (Hancock); closed on Sunday (Southeast)
- Walk-in appointments available on first come, first served basis
- Accepts MAP, Medicaid, Medicare, and private insurance, as well as sliding fee scale assistance for uninsured patients

7. CENTRAL HEALTH SOUTHEAST HEALTH AND WELLNESS CENTER WALK IN CLINIC
8. CUC HANCOCK WALK-IN CLINIC

NextCare Urgent Care

- Open 365 days per year
- Walk-in and online appointments available
- Accepts MAP, Medicaid, Medicare, and private insurance

9. NEXTCARE URGENT CENTER AUSTIN

Dental

Dental services offered by Central Health's provider network include dental exams, cleaning, fillings, dentures, extractions, and oral and maxillofacial surgery.

10. CENTRAL HEALTH SOUTHEAST HEALTH AND WELLNESS CENTER - DENTAL
11. CUC CAROUSEL PEDIATRICS DENTAL - RIVERSIDE
12. CUC CAROUSEL PEDIATRICS DENTAL - SPRINGDALE
13. CUC NORTH CENTRAL HEALTH CENTER - DENTAL
14. CUC PFLUGERVILLE HEALTH CENTER - DENTAL
15. LONE STAR CIRCLE OF CARE AT COLLINFIELD
16. LONE STAR CIRCLE OF CARE AT STASSNEY PEDIATRICS
17. LONESTAR ORAL AND MAXILLOFACIAL SURGERY
18. MANOS DE CRISTO DENTAL CENTER

Eligibility

Central Health operates four locations for determining eligibility and enrolling residents in the Medical Access Program (MAP). For more information, visit www.centralhealth.net/map or call (512) 978-8130.

19. NORTHEAST ELIGIBILITY OFFICE
20. NORTHEAST HEALTH AND RESOURCE CENTER
21. CENTRAL HEALTH SOUTHEAST HEALTH AND WELLNESS CENTER
22. PFLUGERVILLE ELIGIBILITY OFFICE

Hospitals

Central Health provides funding support to offset the uncompensated costs local hospitals incur treating underinsured and uninsured patients. This local network of hospitals includes Central Texas' only Level 1 trauma centers - Dell Seton Medical Center at the University of Texas and the Dell Children's Medical Center of Central Texas.

23. ASCENSION SETON MEDICAL CENTER AUSTIN
24. ASCENSION SETON SHOAL CREEK HOSPITAL
25. ASCENSION SETON SOUTHWEST HOSPITAL
26. CROSS CREEK HOSPITAL
27. DELL CHILDREN'S MEDICAL CENTER OF CENTRAL TEXAS
28. DELL SETON MEDICAL CENTER AT THE UNIVERSITY OF TEXAS
29. ST. DAVID'S MEDICAL CENTER
30. ST. DAVID'S NORTH AUSTIN MEDICAL CENTER
31. ST. DAVID'S SOUTH AUSTIN MEDICAL CENTER

Primary Care

Central Health contracts with an array of primary care providers, all of whom accept MAP coverage and/or offer sliding fee scale payment programs for uninsured patients. Each location offers a unique menu of services, which may include family medicine, women's health, pediatric care, dental care, behavioral health and more. Wrap-around services at specific locations may consist of social service referrals, case management, nutrition counseling, and legal assistance.

Additionally, Central Health is actively working to build health and wellness facilities across Travis County to provide high-quality care to the community.

Central Health

- Offer a full range of wellness programs and resources with clinic care provided by CommUnityCare
- Two locations currently open with two more in development

32. CENTRAL HEALTH AT HANCOCK (COMING SOON)
33. CENTRAL HEALTH DEL VALLE HEALTH AND WELLNESS CENTER (COMING SOON)
34. CENTRAL HEALTH HORNSBY BEND HEALTH AND WELLNESS CENTER
35. CENTRAL HEALTH SOUTHEAST HEALTH AND WELLNESS CENTER

CommUnityCare Health Centers

- Travis County's largest network of Federally Qualified Health Centers (FQHCs)
- Primary care services include medical, dental, behavioral health, and pharmacy
- Specialized clinics for patients experiencing homelessness, HIV/ AIDS treatment, women's health, and pediatrics.

36. CAROUSEL PEDIATRICS - NORTH LAMAR
37. CAROUSEL PEDIATRICS - SOUTHBROOK
38. CAROUSEL PEDIATRICS - SPRINGDALE
39. CUC ARCH
40. CUC BLACK MEN'S HEALTH CLINIC
41. CUC CARE CONNECTIONS CLINIC
42. CUC DAVID POWELL HEALTH CENTER
43. CUC EAST AUSTIN HEALTH CENTER
44. CUC MANOR HEALTH CENTER
45. CUC NORTH CENTRAL HEALTH CENTER
46. CUC OAK HILL HEALTH CENTER
47. CUC OB/GYN - SPRINGDALE
48. CUC PFLUGERVILLE HEALTH CENTER
49. CUC RUNDBERG HEALTH CENTER
50. CUC SANDRA JOY ANDERSON COMMUNITY HEALTH AND WELLNESS CENTER
51. CUC SOUTH AUSTIN HEALTH CENTER
52. CUC WILLIAM CANNON HEALTH CENTER

Lone Star Circle of Care

- Network of FQHCs throughout Central Texas
- Primary care services include behavioral health, dental, pediatrics, and pharmacy

53. LSCC ADULT MEDICINE AT ST. JOHN
54. LSCC AT BEN WHITE HEALTH CLINIC
55. LSCC AT EL BUEN SAMARITANO
56. LSCC AT JONESTOWN
57. LSCC AT PFLUGERVILLE
58. LSCC AT STASSNEY PEDIATRICS
59. LSCC OB/GYN AT OAK SPRINGS
60. LSCC PEDIATRICS AT MOPAC NORTH
61. LSCC SETON CIRCLE OF CARE FAMILY MEDICINE
62. LSCC SETON CIRCLE OF CARE PEDIATRICS
63. LSCC SETON CIRCLE OF CARE WOMEN'S HEALTH SERVICES

People's Community Clinic

- Austin-based FQHC with three locations offering wrap-around services
- Programs tailored toward women's, adolescent, and pediatric care

64. PCC AT AUSTIN CHILDREN'S CENTER
65. PCC CENTER FOR WOMEN'S HEALTH
66. PCC NORTH

Planned Parenthood

- Primary care services for women, men, and young adults
- Specializing in reproductive health care services

67. PLANNED PARENTHOOD DOWNTOWN
68. PLANNED PARENTHOOD NORTH AUSTIN
69. PLANNED PARENTHOOD SOUTH AUSTIN

University of Texas at Austin School of Nursing

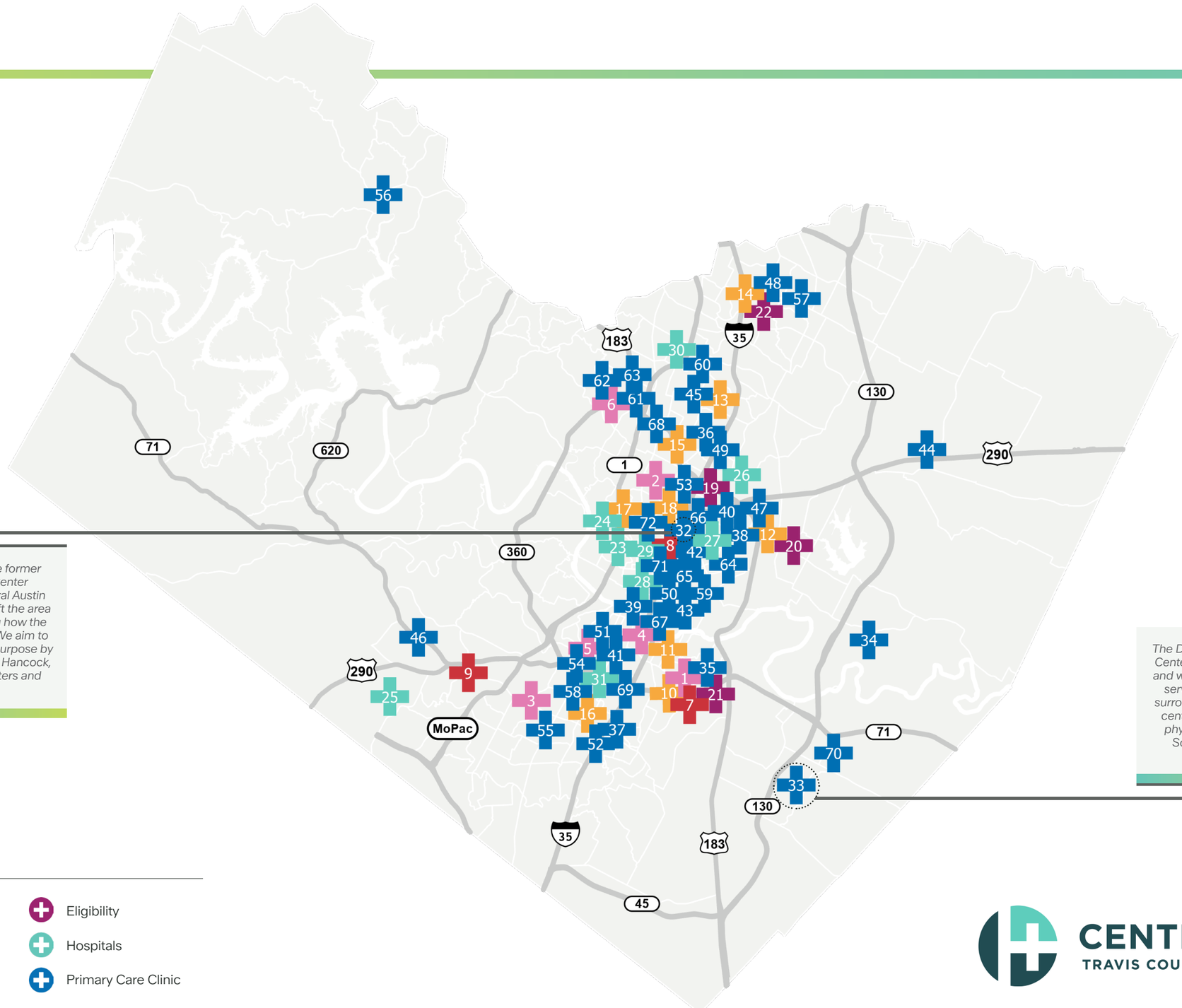
- Care provided by UT nurse practitioners
- Primary care services include women's health, pediatrics, behavioral health, and chronic disease management

70. UT SCHOOL OF NURSING CHILDREN'S WELLNESS CENTER
71. UT SCHOOL OF NURSING FAMILY WELLNESS CLINIC

Volunteer Healthcare Clinic

- Volunteer-based community clinic offering wrap-around services for uninsured Travis County residents
- Primary care services include chronic disease management, mental health, and physical therapy

72. VOLUNTEER HEALTHCARE CLINIC



When it opened in 1964, the former Sears store at Hancock Center became a fixture of the central Austin community. Its closure has left the area empty, with many wondering how the space it left would be used. We aim to give this building a renewed purpose by establishing Central Health at Hancock, an administrative headquarters and specialty center.

The Del Valle Health & Wellness Center will be opening in 2025 and will bring expanded clinical services to Del Valle and its surrounding communities. The center will foster mental and physical well-being among Southeast Travis County residents.

KEY

- Behavioral Health
- Convenient/Urgent Care Clinic
- Dental
- Eligibility
- Hospitals
- Primary Care Clinic

CENTRAL HEALTH
TRAVIS COUNTY HOSPITAL DISTRICT

Central Health Provider Network

In addition to those listed on the previous pages, Central Health contracts with dozens of providers offering specialized care, including palliative care, skilled nursing facilities, and specialty care.

Ambulatory Surgery Center

Central Health contracts with local Ambulatory Surgery Centers (ASCs) to provide same-day surgical and diagnostic care. ASCs do not offer emergency care.

73 BAILEY SQUARE AMBULATORY SURGERY CENTER
74 CENTRAL PARK SURGERY CENTER
75 NORTH AUSTIN SURGERY CENTER
76 NORTHWEST SURGERY CENTER
77 SURGICARE OF SOUTH AUSTIN

Durable Medical Equipment (DME)

Central Health's contracted Durable Medical Equipment (DME) providers offer prosthetics, orthotics, compression wear, rehabilitation, and wheelchair equipment options to patients.

78 REHAB MEDICAL OF AUSTIN
79 FOOT PAIN RELIEF STORE
80 HANGER CLINIC PROSTHETICS & ORTHOTICS - ANDERSON SQUARE
81 HANGER CLINIC PROSTHETICS & ORTHOTICS - BARBARA JORDAN
82 HANGER CLINIC PROSTHETICS & ORTHOTICS - MEDICAL ARTS (AT STRICTLY PEDIATRICS)
83 HANGER CLINIC PROSTHETICS & ORTHOTICS - WESTGATE

Post-Acute Care

Post-acute care includes services received in place of or after a stay in an acute care hospital. Settings such as skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), and home health agencies provide rehabilitation and palliative services to patients.

84 AUSTIN RETIREMENT AND NURSING CENTER AUSTIN
85 FRESH START CARE FACILITY
86 FRESH START CARE FACILITY
87 FRESH START CARE FACILITY
88 FRESH START CARE FACILITY
89 GERIATRIC POST-ACUTE SPECIALISTS
90 GRACY WOODS NURSING CENTER
91 HALCYON HOME
92 HERITAGE PARK REHABILITATION AND SKILLED NURSING CENTER
93 PFLUGERVILLE NURSING AND REHABILITATION CENTER
94 RIVERSIDE NURSING AND REHABILITATION CENTER
95 SOUTHPARK MEADOWS NURSING AND REHABILITATION CENTER
96 WINDSOR NURSING AND REHABILITATION CENTER OF DUVAL

Preventative Screening

Austin Radiological Association

- Provides radiological screening and diagnostics
- Services include MRI, CT, ultrasound, and interventional imaging

97 ARA AUSTIN CENTER BOULEVARD
98 ARA MANOR
99 ARA MEDICAL PARK TOWER
100 ARA MIDTOWN/THERANOSTICS CENTER /INTERVENTIONAL RADIOLOGY CENTER
101 ARA MUELLER
102 ARA QUARRY LAKE
103 ARA SOUTHWOOD
104 ARA VILLAGE
105 ARA WESTLAKE
106 ARA WILLIAM CANNON
107 ARA WILSON PARKE
108 ARA WOMEN'S IMAGING CENTER

Austin Retina Associates

- Provides specialized care for patients with retinal injuries and diseases

109 AUSTIN RETINA ASSOCIATES - MAIN
110 AUSTIN RETINA ASSOCIATES - SOUTH AUSTIN

Retina Consultants of Austin

- Provides specialized care for patients with retinal diseases and conditions

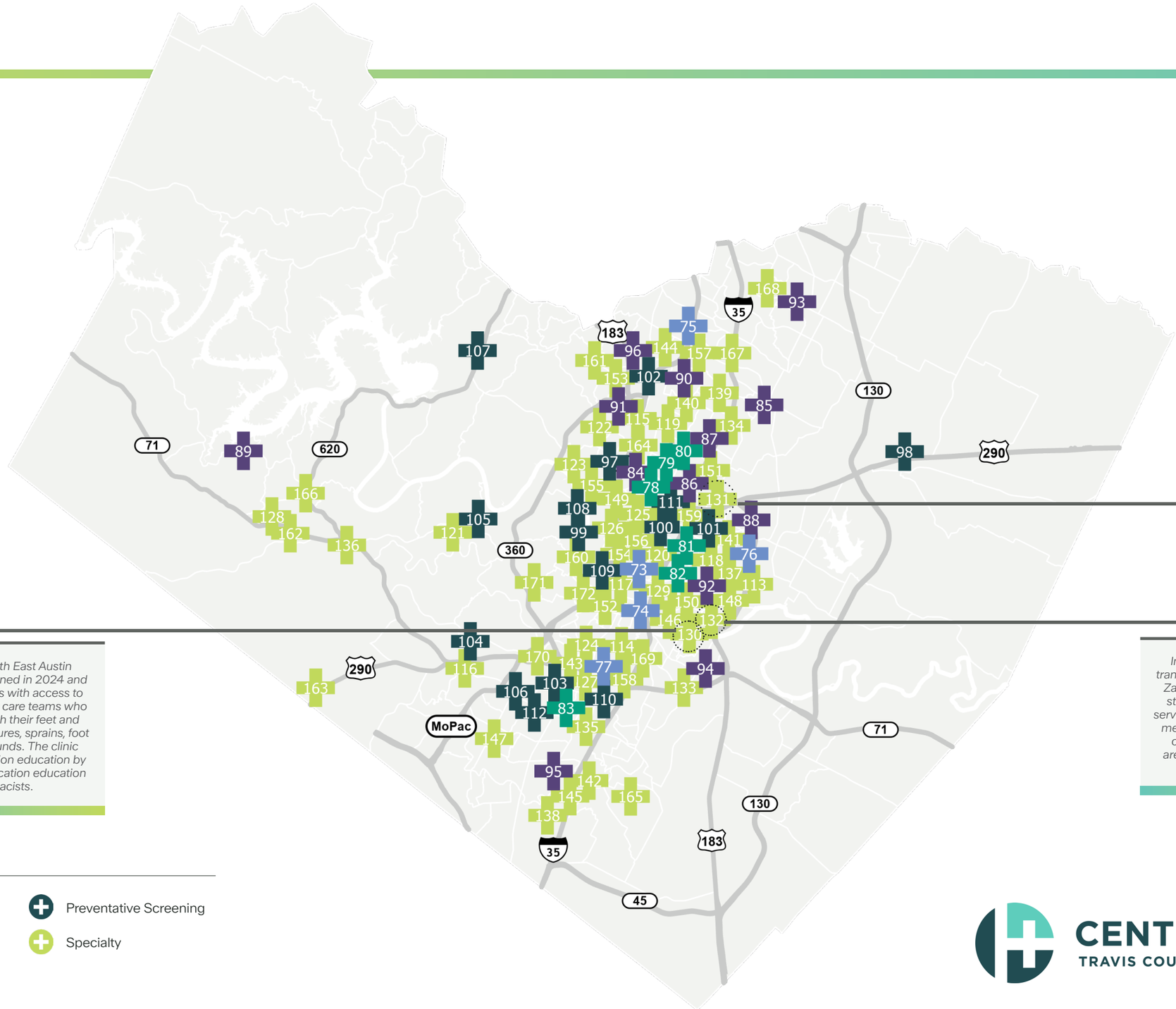
111 RCA CENTRAL
112 RCA SOUTH

Specialty

Central Health partners with a variety of specialty care providers. Some of the services offered by these providers include dermatology, dialysis, oncology, rheumatology, and physical therapy.

Additionally, there are three Central Health specialty care clinics that focus on providing care to people in the Medical Access Program (MAP). Services offered at these clinics include cardiology, gastroenterology, hepatology, nephrology, podiatry, and pulmonology.

113 A NEW ENTRY
114 ADDICTION AND PSYCHOTHERAPY SERVICES
115 ADVANCE SLEEP CENTER
116 ADVANCE SLEEP CENTER
117 ASCENSION SETON BRAIN AND SPINE INSTITUTE
118 ASCENSION SETON MCCARTHY COMMUNITY CLINIC
119 AUSTIN ACCESS CARE
120 AUSTIN CARDIOLOGY CLINIC CENTRAL
121 AUSTIN CARDIOLOGY CLINIC SATELLITE LOCATION
122 AUSTIN PALLATIVE CARE
123 AUSTIN REGIONAL CLINIC - FAR WEST
124 AUSTIN REGIONAL CLINIC - SOUTH AUSTIN
125 AUSTIN SURGEONS
126 CANCER CARE COLLABORATIVE
127 CAPITAL GASTRO - JAMES CASEY
128 CAPITAL GASTRO - LAKEWAY-BEE CAVE
129 CAPITAL GASTRO - ST. DAVID'S PLAZA
130 CENTRAL HEALTH EAST CLINIC
131 CENTRAL HEALTH MULTISPECIALTY CLINIC AT CAPITAL PLAZA
132 CENTRAL HEALTH ROSEWOOD ZARAGOSA CLINIC
133 CENTRAL HEALTH SOUTHEAST HEALTH AND WELLNESS CENTER - SPECIALTY
134 COMMUNITY MEDICAL SERVICES - AUSTIN ON FERGUSON
135 COMMUNITY MEDICAL SERVICES - AUSTIN ON WILLIAM CANNON
136 COMPREHENSIVE ENT CENTER OF TEXAS
137 COMPREHENSIVE ENT CENTER OF TEXAS
138 COMPREHENSIVE ENT CENTER OF TEXAS
139 CUC NORTH CENTRAL HEALTH CENTER - SPECIALTY
140 CVS KIDNEY CARE DIALYSIS SERVICES - METRIC
141 CVS KIDNEY CARE DIALYSIS SERVICES - MUELLER
142 CVS KIDNEY CARE DIALYSIS SERVICES - SOUTH AUSTIN
143 CVS KIDNEY CARE DIALYSIS SERVICES - SOUTHWOOD
144 CVS KIDNEY CARE DIALYSIS SERVICES - WELLBOUND AUSTIN
145 CVS KIDNEY CARE DIALYSIS SERVICES - WELLBOUND SOUTH AUSTIN
146 DELL ASCENSION SETON MEDICAL CENTER AT THE UNIVERSITY OF TEXAS - HEALTH TRANSFORMATION BUILDING
147 DR. RAJESH MEHTA
148 EAST AUSTIN ORAL SURGERY
149 EYE PHYSICIANS OF AUSTIN
150 HOSPICE AUSTIN - CHRISTOPHER HOUSE
151 LONESTAR MEDICAL TRANSPORTATION
152 SETON INSTITUTE OF RECONSTRUCTIVE PLASTIC SURGERY
153 TEXAS CANCER INSTITUTE
154 TEXAS ONCOLOGY - AUSTIN MIDTOWN
155 TEXAS ONCOLOGY - AUSTIN CENTRAL
156 TEXAS ONCOLOGY - AUSTIN MIDTOWN RADIATION ONCOLOGY
157 TEXAS ONCOLOGY - AUSTIN NORTH RADIATION ONCOLOGY
158 TEXAS ONCOLOGY - SOUTH AUSTIN
159 TEXAS PHYSICAL THERAPY SPECIALISTS - AUSTIN/MUELLER
160 TEXAS PHYSICAL THERAPY SPECIALISTS - BAILEY SQUARE
161 TEXAS PHYSICAL THERAPY SPECIALISTS - BALCONES WOODS
162 TEXAS PHYSICAL THERAPY SPECIALISTS - BEE CAVE
163 TEXAS PHYSICAL THERAPY SPECIALISTS - CEDAR VALLEY/ DRIPPING SPRINGS
164 TEXAS PHYSICAL THERAPY SPECIALISTS - FAR WEST
165 TEXAS PHYSICAL THERAPY SPECIALISTS - GOODNIGHT RANCH
166 TEXAS PHYSICAL THERAPY SPECIALISTS - LAKEWAY
167 TEXAS PHYSICAL THERAPY SPECIALISTS - NORTHEAST
168 TEXAS PHYSICAL THERAPY SPECIALISTS - PFLUGERVILLE
169 TEXAS PHYSICAL THERAPY SPECIALISTS - SOUTH CONGRESS
170 TEXAS PHYSICAL THERAPY SPECIALISTS - WESTGATE
171 TEXAS PHYSICAL THERAPY SPECIALISTS - WESTLAKE
172 UT HEALTH AUSTIN TRANSFORMATION BUILDING



Opening in 2024, the Central Health Capital Plaza Specialty Clinic helps people access lung, respiratory, and gastrointestinal care. Additionally, the clinic provides nutrition education by dietitians, medication education by pharmacists and mental health support by counselors.

The Central Health East Austin Specialty Clinic opened in 2024 and provides individuals with access to doctors and wound care teams who treat problems with their feet and lower legs, like fractures, sprains, foot pain, and foot wounds. The clinic also provides nutrition education by dietitians and medication education by pharmacists.

In 2024, Central Health finished transforming the historic Rosewood-Zaragosa health center into a new state-of-the art specialty clinic to serve Medical Access Program (MAP) members. The new multi-specialty clinic and additional physicians are expected to provide 25,000 to 40,000 visits annually.

KEY

- Ambulatory Surgery Center
- Durable Medical Equipment
- Post-Acute Care
- Preventative Screening
- Specialty

CENTRAL HEALTH
TRAVIS COUNTY HOSPITAL DISTRICT


CENTRAL HEALTH

Chronic Conditions

This section looks at the prevalence of ten chronic diseases and conditions among Central Health's patient population. These chronic conditions have been selected because they are among some of the most common and preventable health conditions in Travis County. Additionally, these conditions significantly contribute to morbidity and mortality within the community.

Chronic Conditions

Introduction

At Central Health, we're all about making a difference in the lives of low-income Travis County residents. As the county's taxpayer-funded hospital district, we are dedicated to improving health outcomes for those who needs it most. As the population in Travis County continues to grow and change, it's important that we continue to keep a close eye on how these changes impact who needs help, where the help is needed, and in what ways we best serve the people of Travis County. This section of the report explores the chronic disease diagnosis rates in our enrolled population, looking at differences in patterns of disease to help us understand the unequal burdens in communities throughout the county and across different racial, ethnic, gender, age, and language groups. Additional details on our methods and supporting tables are provided in the Appendix for the interested.

Why Chronic Conditions?

Chronic conditions are a key driver of poor health, reduced quality of life, and high health care costs. These long-term illnesses like diabetes, high blood pressure, and mental health issues affect thousands of our enrollees and are often preventable or manageable with timely care.

For vulnerable groups, including enrollees experiencing homelessness or and those in acutely underserved communities, chronic conditions can worsen existing challenges, making it even harder to access care or achieve stability. Addressing these issues is critical not only for improving individual health but also for reducing strain on the health care system and promoting health equity across populations.

- **Prevalence and Impact:** Chronic health conditions, such as diabetes, heart disease, and hypertension, are widespread and affect large portions of the population, providing insight into community health burdens.
- **Health Outcomes:** Chronic conditions significantly contribute to illness and death, influencing the life expectancy and quality of life within a community.
- **Economic Impact:** Managing chronic diseases is costly for both individuals and health care systems, leading to high health care expenditures and economic strain on communities.
- **Health Care Resource Utilization:** Chronic conditions drive health care usage, increasing demand for services like primary care, emergency care, and hospitalizations, which impacts health care infrastructure and access.
- **Risk Factors and Prevention:** Understanding the prevalence of chronic conditions highlights modifiable risk factors, such as physical inactivity and smoking, that can be targeted through population health interventions.
- **Inequities in Health:** Chronic diseases often affect vulnerable populations more, exposing and deepening health disparities within the community.
- **Community Health Planning:** Identifying and monitoring chronic conditions helps inform planning, policies, and interventions tailored to reduce disease burden and promote wellness.
- **Quality of Life:** Chronic conditions impact daily living activities, mental health, and overall well-being, emphasizing the need for supportive services in community health planning.
- **Resilience and Preparedness:** Communities with high chronic disease prevalence may be more vulnerable during public health emergencies, as chronic conditions complicate the management and recovery from events like pandemics or natural disasters.

Focusing on chronic conditions also allows us to identify patterns of inequity and tailor interventions that improve the quality of life immensely for the people we serve. For example, understanding which groups face higher rates of conditions like stroke or substance use disorders can guide the placement of resources and programs for hypertension and behavioral health with targeted support and communications. Chronic conditions are also the most likely to be influenced by prevention efforts and lifestyle modifications. By addressing chronic conditions, Central Health can focus direct clinical practice, craft health education campaigns, target interventions, and monitor the progress towards improved chronic disease self-management.

Risk for Chronic Disease or Risk for Diagnosis?

It's important to note that this analysis looked at the **relative risk of diagnosis** for a chronic condition, not the risk of disease itself. This is an important distinction – we can only identify cases of disease that have resulted in a diagnosis code in the enrollee data sets. Many cases of chronic conditions can go undetected for years or decades without proper screening. If Group A is at twice the risk of diagnosis of Group B, is that because Group A visited the doctor more often or that Group A had more contributing lifestyle and predisposing factors for that disease? These are challenging questions to answer. The best method for understanding these impacts is through the multi-variable regression analysis detailed in the Appendix; there are many factors that influence whether an individual receives a diagnosis, but first and foremost is access to care. As we discuss in the Information Gaps sections, we are aware of underdiagnosis of many of the chronic conditions. Some of these differences may be attributable to access to care issues, others to true prevalence differences, cultural and lifestyle factors such as diet, or local community factors like proximity to air pollution or lack of safe sidewalks and outdoor spaces. As such, this report should be considered a lower bound and underestimate of the chronic disease experience of our enrollees.

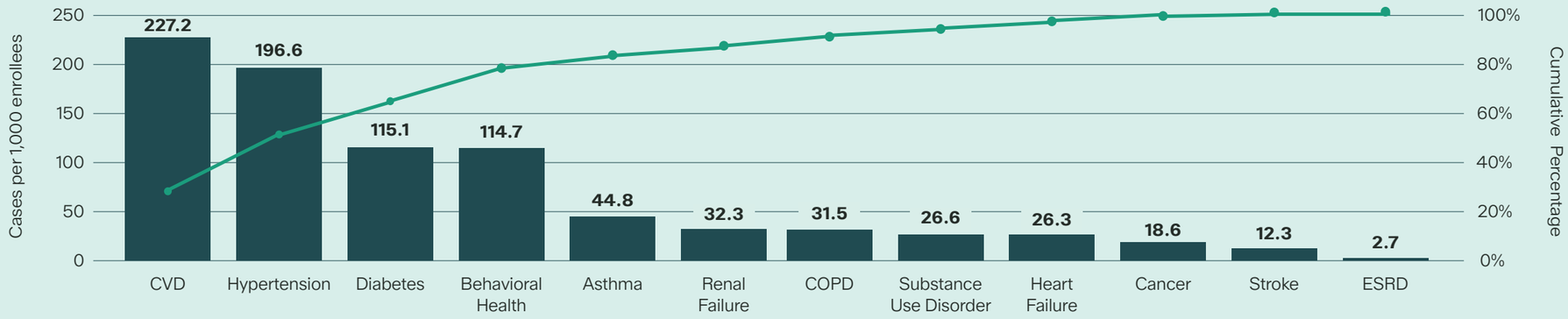
Chronic Conditions in Central Health Enrollees

The figure to the right is a Pareto chart, which displays the age-adjusted prevalence rates for each of the chronic conditions explored in this report in descending order with their cumulative contribution to the total. A Pareto chart is a combination of a bar chart and a line graph that is used to identify and prioritize issues. It is based on the Pareto Principle (also known as the 80/20 rule), which states that roughly 80% of outcomes come from 20% of causes. This makes it a useful tool for focusing on the most significant factors contributing to a problem.

These conditions were selected based on their inclusion in the 2022 Demographic Report, with the notable additions of Substance Use Disorders, End Stage Renal Disease, and Stroke for this 2024 report. These conditions were added to provide additional insights into these conditions and add specificity and context to the larger findings. Results are presented here as the number of cases of each disease per 1,000 enrollees, adjusting for differences in the age makeup of the underlying populations. Importantly, 1 in 3 enrollees (36%) had at least one chronic condition diagnosis, and for these individuals the average was 2.5 chronic conditions.

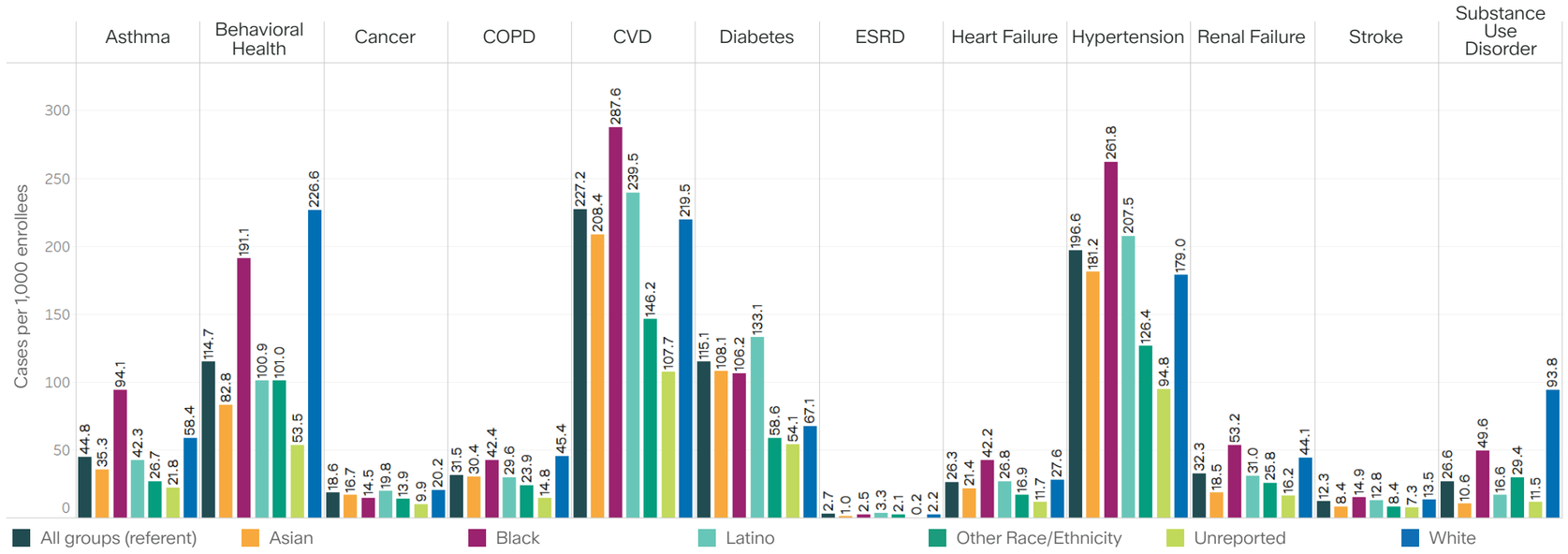
The top four conditions were cardiovascular disease (CVD), hypertension (high blood pressure), Type II diabetes, and behavioral health conditions. Combined, these four conditions account for over 80% of the diagnosed chronic conditions.

Pareto Chart of Age-adjusted Prevalence per 1,000 enrollees, by Condition (Travis County, FY23)



Matthew Dang, Operations Manager - Transitions of Care in front of Central Health's Capital Plaza Specialty Clinic that helps enrollees access lung, respiratory, and gastrointestinal care. Additionally, the clinic provides nutrition education by dietitians, medication education by pharmacists and mental health support by counselors.

Travis County FY23: Chronic Disease Age-Adjusted Prevalence Rates,by Race and Ethnicity

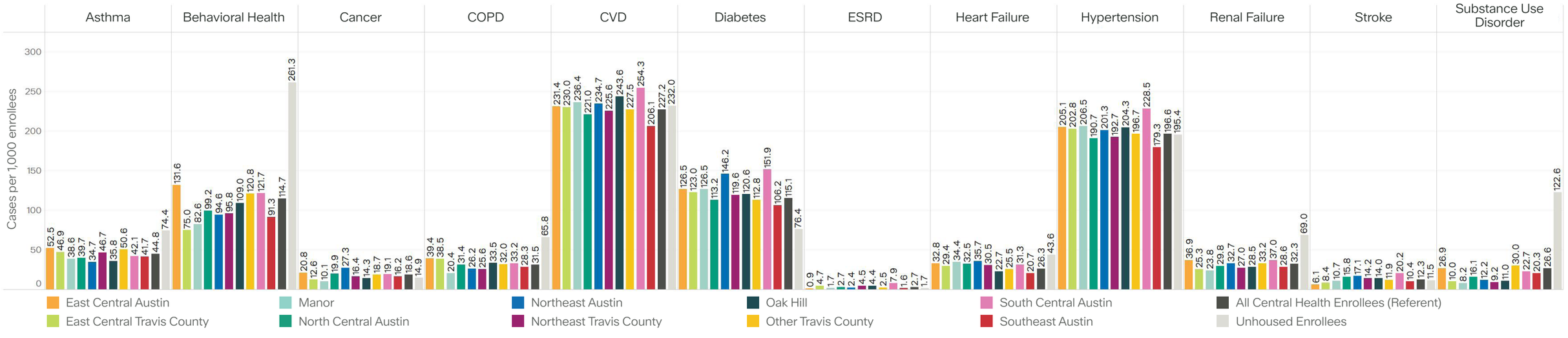


However, while comparing overall rates is useful for prioritizing which chronic conditions to address, it also obscures differences within and across the enrollee population. To address this, the overall rates are stratified and compared. First, the overall enrollee population was stratified across two dimensions – self-reported race/ethnicity and enrollee home address. The diagnosis counts for each stratum were determined, then divided by the total number of enrollees in that stratum to create what is called a "crude" rate. These crude rates were then directly standardized for age against a reference population and weighted accordingly – this created an age-adjusted rate, an "apples to apples" comparison of different subpopulations of enrollees.

In the view to the left, we can see how the rates compare across the different reported races and ethnicities. Here, disparity looks "spiky" – there is significant variability in the rates when viewed this way. The dark blue bar is the reference population of all enrollees. As you can see, the Black enrollee rates are considerably higher for asthma, behavioral health, CVD, COPD, heart failure, hypertension, renal failure, and stroke. Similarly, White enrollees have the highest rates of behavioral health, COPD, and SUD. We can also see that Asian enrollees have lower rates of diagnosis for all conditions. *Note: Due to very small enrollee numbers, Native American enrollees were combined with the Other race/ethnicity category.*

In the view below, by geography within the county, we can see that it is much less "spiky", with the notable exception of persons experiencing homelessness. The unhoused had the highest rates of diagnosis for asthma, behavioral health, COPD, heart failure, renal failure, and SUD. Some of the residents in particular focus areas also experienced unexpected excesses for disease, such as East Central Austin (behavioral health), South Central Austin (diabetes, ESRD, hypertension, stroke), and Northeast Austin (cancers, diabetes). However, to understand the relationships between these rates and to determine which differences are statistically significant, additional analytical steps are needed.

Travis County FY23: Chronic Disease Age-Adjusted Prevalence Rates, by Focus Area



CENTRAL HEALTH

Assessing Equity

The Equity Index is a rate ratio that compares the rate of a health condition for one grouping of enrollees to the all-enrollee rate for the same condition, adjusted for the most important confounder – enrollee age. For example, we would expect a group of enrollees who were 20% of the population to have roughly 20% of the heart disease, all else being equal. Here, the equity index would be 20%/20% = 1.0, a value that means the two rates are the same, suggesting no inequity.

If the value is less than 1.0, it means the group has a lower risk than expected (e.g., 0.5 means 50% lower than expected). A value higher than 1.0 means the group has a higher risk than expected (e.g., 1.5 means 50% higher than expected). The Equity Index helps us to identify which groups might face health inequities. The heat map to the right provides an overview of all the equity index values for all subgroups and chronic conditions.

In this view, risk values that are higher than expected appear in gold. Risk values that are lower than expected are purple. For both colors, the hue becomes darker the more a value varies from the expected value. A good example of this is the row for persons experiencing homelessness, where the risk value for SUD (4.6) appears in dark gold and gold values appear throughout the row, indicating a higher general level of health disparity in this subgroup. Similar disparities are seen in the Black enrollees subgroup. The table provides an overall measure of inequity – this is the average of the equity index scores for each row. We can see that there were two geographic areas at increased overall risk (South Central Austin and persons experiencing homelessness), and two race/ethnicity groups with increased overall risk of diagnosis for all conditions (Black and White enrollees).

Equity Index ***(* Denotes statistically significant result)***

Subgroup	Asthma	Behavioral Health	Cancer	CVD	COPD	Diabetes	ESRD	Heart Failure	Hypertension	Renal Failure	Stroke	SUD	Overall
Asian Enrollees	0.8	0.7	0.9	0.9	1.0	0.9	0.4	0.8	0.9	0.6	0.7	0.4	0.7
Black Enrollees	2.1	1.7	0.8	1.3	1.3	0.9	0.9	1.6	1.3	1.6	1.2	1.9	1.4
Latino Enrollees	0.9	0.9	1.1	1.1	0.9	1.2	1.2	1.0	1.1	1.0	1.0	0.6	1.0
Other Race/Ethnicity Enrollees	0.6	0.9	0.7	0.6	0.8	0.5	0.8	0.6	0.6	0.8	0.7	1.1	0.7
Unreported Race/ethnicity Enrollees	0.5	0.5	0.5 *	0.5 *	0.5	0.5	0.1	0.4	0.5	0.5	0.6	0.4	0.5
White Enrollees	1.3	2.0 *	1.1	1.0	1.4	0.6	0.8	1.0	0.9	1.4	1.1	3.5 *	1.3
East Central Austin Enrollees	1.2	1.1	1.1	1.0	1.3	1.1	0.3	1.2	1.0	1.1	0.5	1.0	1.0
East Central Travis County Enrollees	1.0	0.7	0.7	1.0	1.2	1.1	1.7	1.1	1.0	0.8	0.7	0.4	0.9
Manor Enrollees	0.9	0.7	0.5	1,0	0.7	1.1	0.6	1.3	1.1	0.7	0.9	0.3 *	0.8
North Central Austin Enrollees	0.9	0.9	1.1	1.0	1.0	1.0	1.0	1.2	1.0	0.9	1.3	0.6	1.0
Northeast Austin Enrollees	0.8	0.8	1.5	1.0	0.8	1.3	0.9	1.4	1.0	1.0	1.4	0.5	1.0
Northeast Travis County Enrollees	1.0	0.8	0.9	1.0	0.8	1.0	1.7	1.2	1.0	0.8	1.2	0.3 *	1.0
Oak Hill Enrollees	0.8	1.0	0.8	1.1	1.1	1.0	1.6	0.9	1.0	0.9	1.1	0.4	1.0
South Central Austin Enrollees	0.9	1.1	1.0	1.1	1.1	1.3	2.9	1.2	1.2 *	1.1	1.7 *	0.9	1.3
Southeast Austin Enrollees	0.9	0.8	0.9	0.9	0.9	0.9	0.6	0.8	0.9	0.9	0.9	0.8	0.8
Other Travis County Enrollees	1.1	1.1	1.0	1.0	1.0	1.0	0.9	1.0	1.0	1.0	1.0	1.1	1.0
Unhoused Enrollees	1.7	2.3 *	0.8	1.0	1.0	0.7	0.6	1.7	1.0	2.1 *	0.9	4.6 *	1.6

Digging Deeper to Understand Inequity: Regression Analysis

The Equity Index is a rate ratio that compares the rate of a health condition for one grouping of enrollees to the all-enrollee rate for the same condition, adjusted for the most important confounder – enrollee age. There is only so much information to be gained from comparing standardized rates, and these results beg the question of what factors might be driving these disparities. To gain additional insights, another analytical step was taken to create a model to explore each variable both on its own and in the context of all the other variables. This technique, known as multivariate logistic regression (MLR), is a statistical method used to understand how different factors influence the likelihood of a specific outcome. For example, it can help researchers determine what factors—like age, household size, and primary care doctor visits – affect the chances of developing a disease. The outcome being studied must be something with only two possible results, like "diagnosis: yes/no". This method not only looks at the impact of each individual factor but also accounts for the interaction between factors.

The results of this analysis show how much each factor increases or decreases the odds of diagnosis while keeping all the other factors constant. For instance, it might reveal that smoking doubles the odds of developing a disease, even after considering other factors like age and physical activity. This approach is useful in health care because it helps identify the most important factors influencing outcomes, guiding better decision-making and interventions.

National and Local Context: Understanding how Central Health Compares Rates

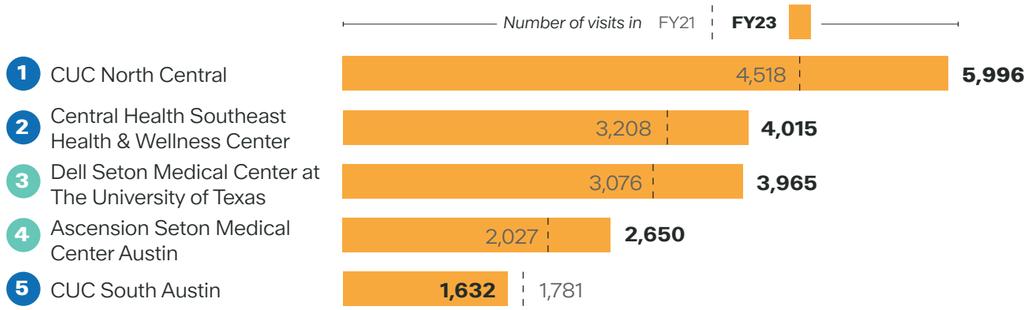
Understanding these rates in isolation is important operationally, but to see how well Central Health is performing at diagnosing enrollees we need a yardstick against which to measure. While there are many other potential data sources, all of them have their own limitations and methodological differences. As such, these comparator rates should be considered suggestive but not definitive.

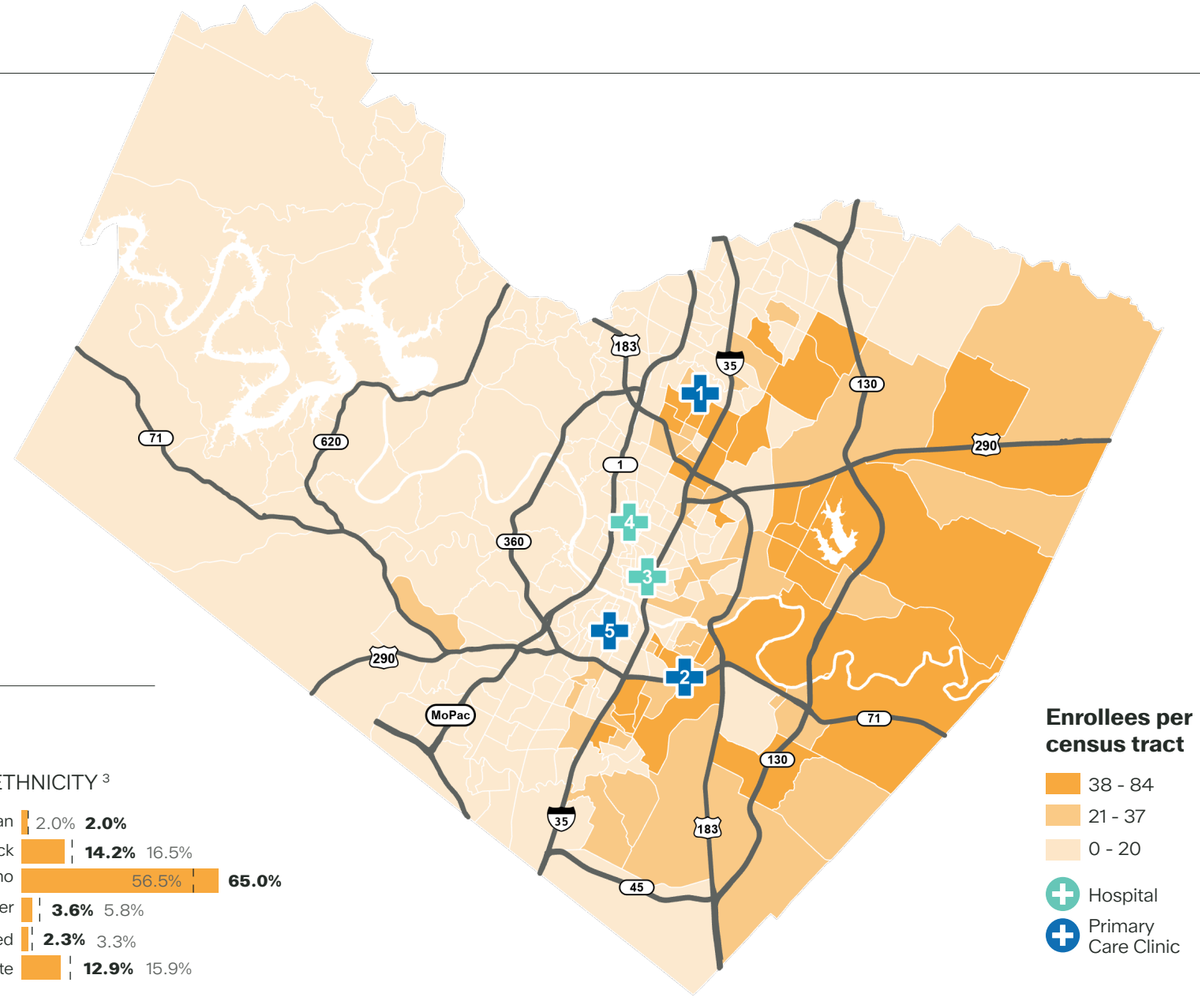
For each condition, the closest possible match to the most recently nationally validated age-adjusted prevalence rate was identified. For most conditions, this was the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), a self-reported phone survey. National comparators for behavioral health and SUD were sourced from the 2022 Adult Prevalence of Mental Illness survey. We expect our rates, which are based on diagnosis codes, to be more accurate at capturing known diagnoses, but also limited by the three-year lookback period used to determine prevalence. Additionally, Central Health sought a Most Local Number as well – be it state, metropolitan statistical area (MSA), region, or county (where available). Local comparators were not available for all conditions. Taken together, the use of a national and (where available) local comparator helped Central Health to estimate the expected prevalence and each condition and compare the observed prevalence to understand how many cases might be missing or undiagnosed in our data. Table 4 in the appendix summarizes these findings. Central Health enrollees appear to be underdiagnosed by at least half for cancers, SUD, stroke, and asthma, while "overdiagnosing" kidney issues like ESRD and renal failure through our nephrology direct practice.

Asthma

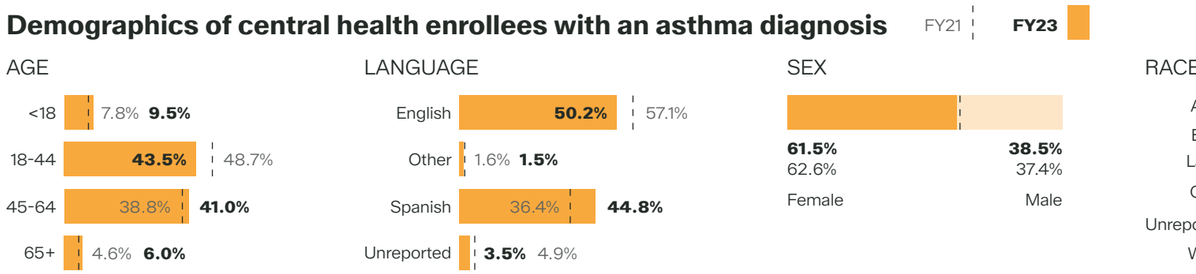
Total Central Health enrollees diagnosed[1] with chronic condition: **5,613**
(All data are from fiscal year 2023)

Top 5 provider locations visited by enrollees with an asthma diagnosis[2]





Demographics of central health enrollees with an asthma diagnosis



Asthma equity index by race/ethnicity[3] and focus area

The Equity Index is a ratio of the observed prevalence rate to the expected prevalence rate (the all-enrollee rate) among Central Health's enrollees. A value less than 1.0 indicates lower risk compared to the all-enrollee rate. A value more than 1.0 indicates higher risk compared to the all-enrollee rate. This Equity Index, as applied to these age-adjusted prevalence rates, gives us an indication of which subgroups may be experiencing a health inequity.

Asian	Black	Latino	Other	Unreported	White
0.8	2.1	0.9	0.6	0.5	1.3

East Central Austin	East Central Travis County	Manor	North Central Austin	Northeast Austin	Northeast Travis County	Oak Hill	South Central Austin	Southeast Austin
1.2	1.0	0.9	0.9	0.8	1.0	0.8	0.9	0.9

Compared to the overall Central Health population in Travis County, Black enrollees were 110% more likely to have an asthma diagnosis in FY23. White enrollees were 30% more likely and enrollees residing within East Central Austin were 20% more likely to have an asthma diagnosis compared to all Central Health enrollees.

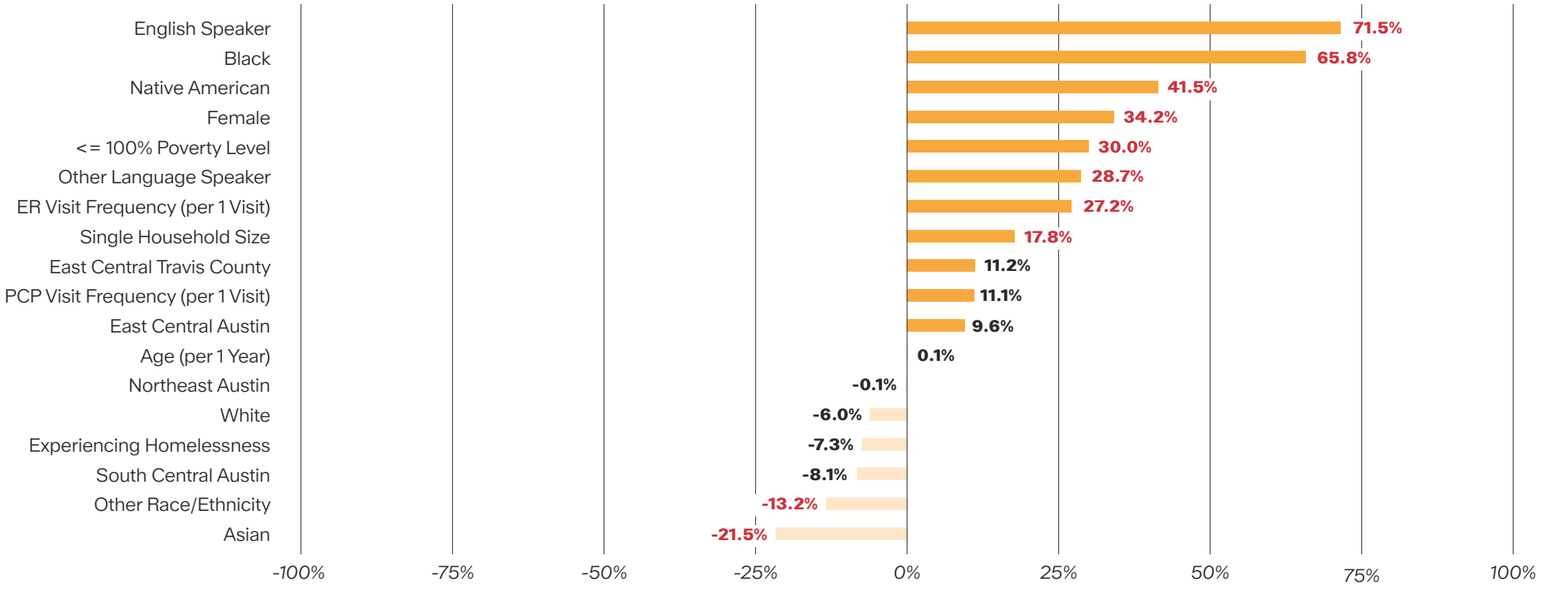
[1] Patients are identified as those who were enrolled in MAP, MAP Basic, SFS, or CHAP in FY2023 and had received a chronic condition diagnosis any time during or prior to FY2023. [2] Data were pulled from the Central Health enterprise analytics encounter database for all primary care, inpatient, and emergency department visits to Central Health provider network locations for patients identified as having the chronic conditions. [3] Central Health race and ethnicity counts are combined.

Asthma: Diagnosis and Care

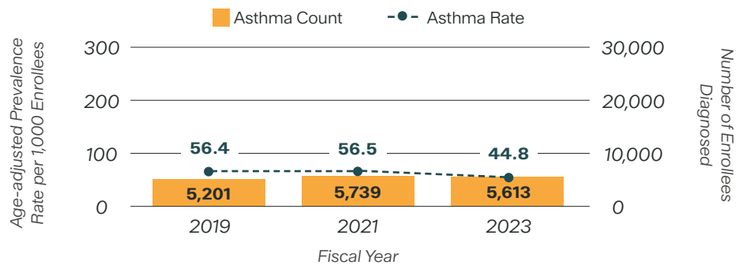
The overall age-adjusted prevalence of asthma in the Central Health enrolled population was 4.5%, or 44.8 cases per 1,000 enrollees. Advanced modeling techniques were used to explore what factors were most likely to influence an enrollee being diagnosed with a chronic condition.[1] For example, persons whose preferred language was English had a 71.5% higher probability of an asthma diagnosis. Factors that increased the probability of diagnosis have a positive percentage in the chart below, whereas factors that decrease the probability of diagnosis have a negative percentage.

Factors Linked with Asthma Diagnosis: *Demographics, Focus Area, and Utilization*

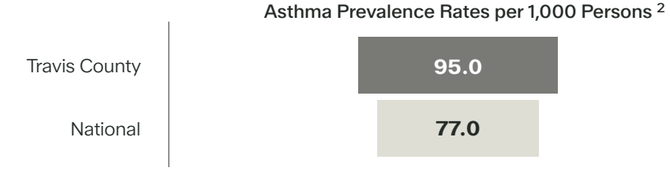
Impact of Selected Factors on Increased/Decreased Probability of Diagnosis: Asthma *(statistically significant results in **red**)*



Asthma Diagnosis Changes Over Time



In Context: Local and National Comparisons



It's important to note that data for Central Health enrollees are not directly comparable to the broader population. Central Health enrollees are by definition lower income, and differences in disease experience are documented in this report. There are also methodological differences in how Central Health calculates these rates compared to national and county calculations. For further exploration of these differences, please see the appendix.

Taking action across the continuum of care

In addition to contracting with local health care providers, Central Health launched an array of direct practice specialty services starting in FY22. Additionally, there are many cross-cutting interventions (e.g., case management) that apply to all conditions. Condition-specific interventions for asthma are listed below.

LEVERAGE POINT	SPECIFIC INTERVENTION
Preventative Care	▸ Vaccinations for respiratory conditions ▸ Smoking cessation
Community/Outpatient Care	▸ Expanded primary care options ▸ Expanded diagnostics ▸ Asthma medication coverage
Alternatives to Acute Care	▸ Expanded respiratory therapy
Acute/Hospital Care	
Post-acute care	

Information Gaps

While beyond the scope of this report, the question arises of whether enrollees are truly experiencing lower rates of asthma, or if they are under diagnosed, and why. Where we have information to inform possible sources of rate differences, they are provided for consideration.

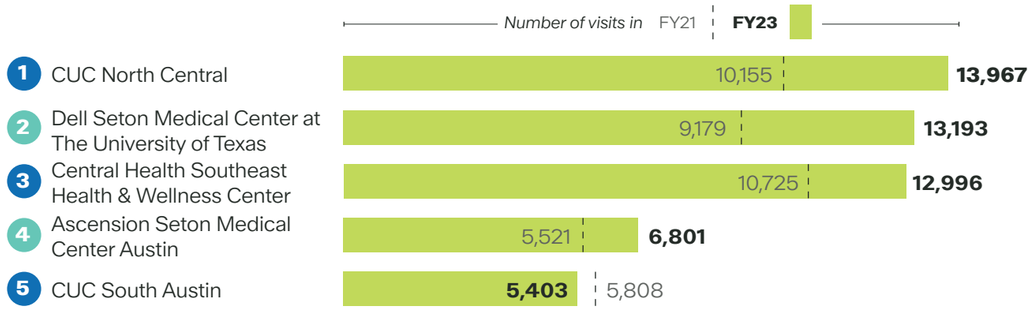
Possible sources of under diagnosis: Both comparator data sets include children diagnosed with asthma, and while our enrollee health data also include children there are fewer of them because our population does not include children enrolled in Medicaid or the Children's Health Insurance Program (CHIP). It should be noted that we applied a statistical technique called age adjustment to address this issue in our data but the difference persists. Nationally, 6.5% of children have a diagnosis of asthma. Looking specifically at people under 18 in enrollee data, we only see 3.5% with an asthma diagnosis.

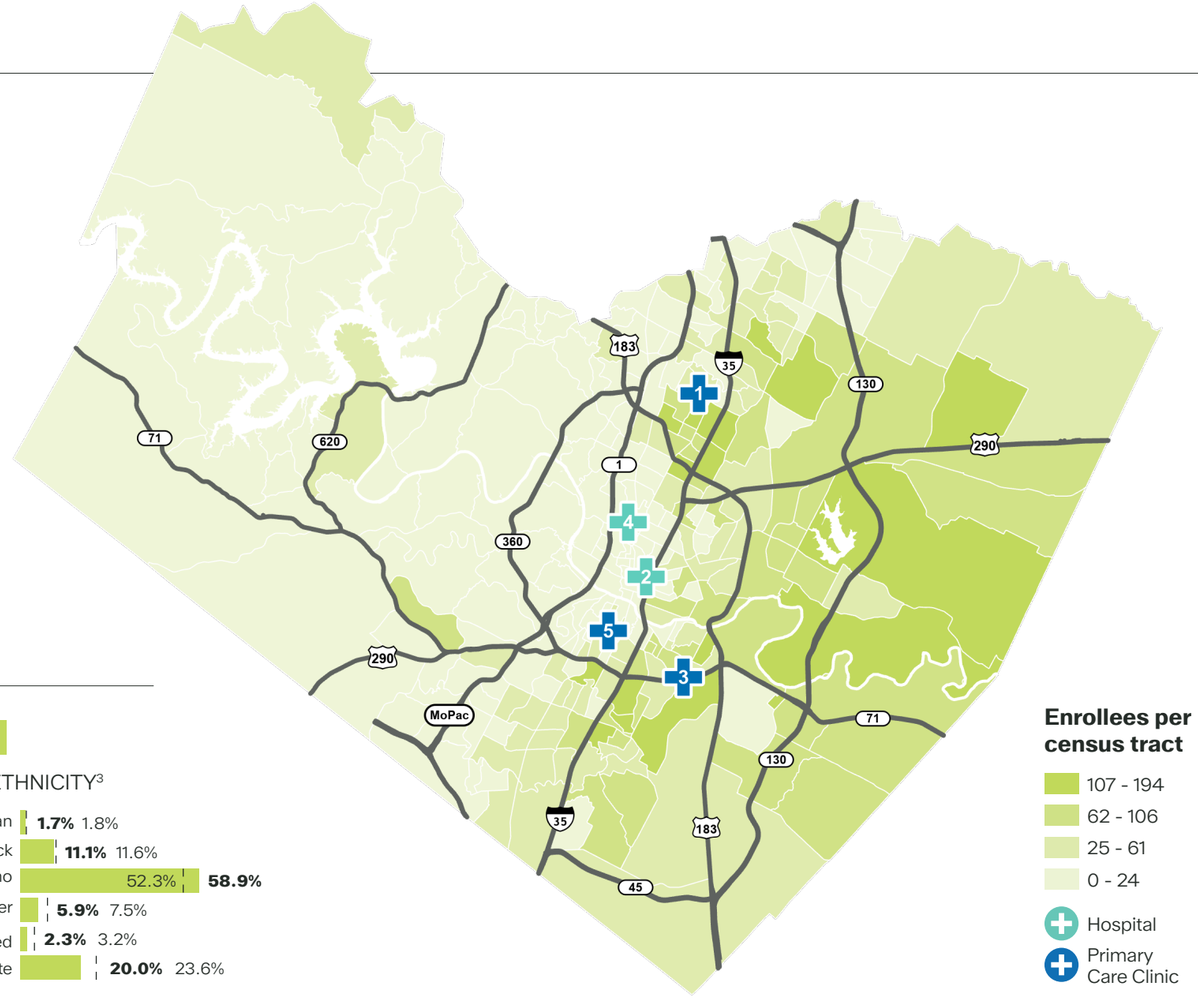
[1] For additional methodology details, see appendix. [2] Local and national data sourced from CDC BRFSS 2021

Behavioral Health

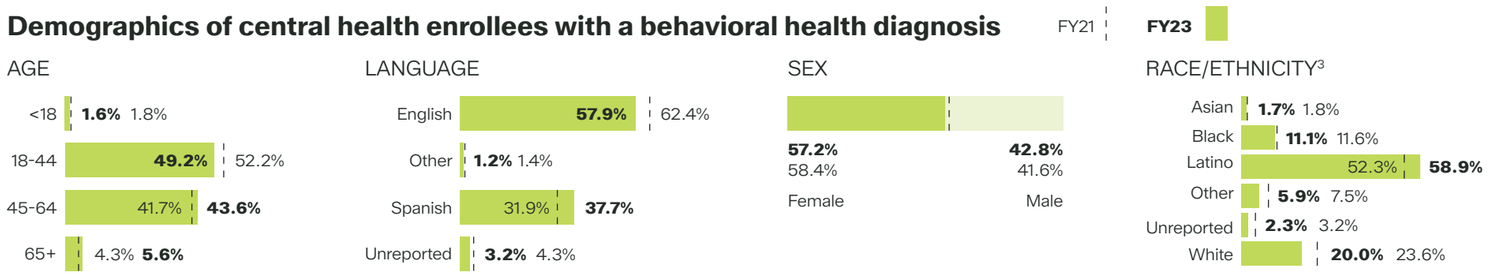
Total Central Health enrollees diagnosed[1] with chronic condition: **15,796**
(All data are from fiscal year 2023)

Top 5 provider locations visited by enrollees with a behavioral health diagnosis[2]





Demographics of central health enrollees with a behavioral health diagnosis



Behavioral health equity index by race/ethnicity[3] and focus area

The Equity Index is a ratio of the observed prevalence rate to the expected prevalence rate (the all-enrollee rate) among Central Health's enrollees. A value less than 1.0 indicates lower risk compared to the all-enrollee rate. A value more than 1.0 indicates higher risk compared to the all-enrollee rate. This Equity Index, as applied to these age-adjusted prevalence rates, gives us an indication of which subgroups may be experiencing a health inequity. Statistically significant figures have been highlighted in yellow.

Asian	Black	Latino	Other	Unreported	White
0.7	1.7	0.9	0.9	0.5	2.0

East Central Austin	East Central Travis County	Manor	North Central Austin	Northeast Austin	Northeast Travis County	Oak Hill	South Central Austin	Southeast Austin
1.1	0.7	0.7	0.9	0.8	0.8	1.0	1.1	0.8

Compared to the overall Central Health population in Travis County, Black enrollees were 70% more likely to have a behavioral health diagnosis in FY23. White enrollees were 100% more likely and East Central Austin and South Central Austin residents were 10% more likely to have a behavioral health diagnosis.

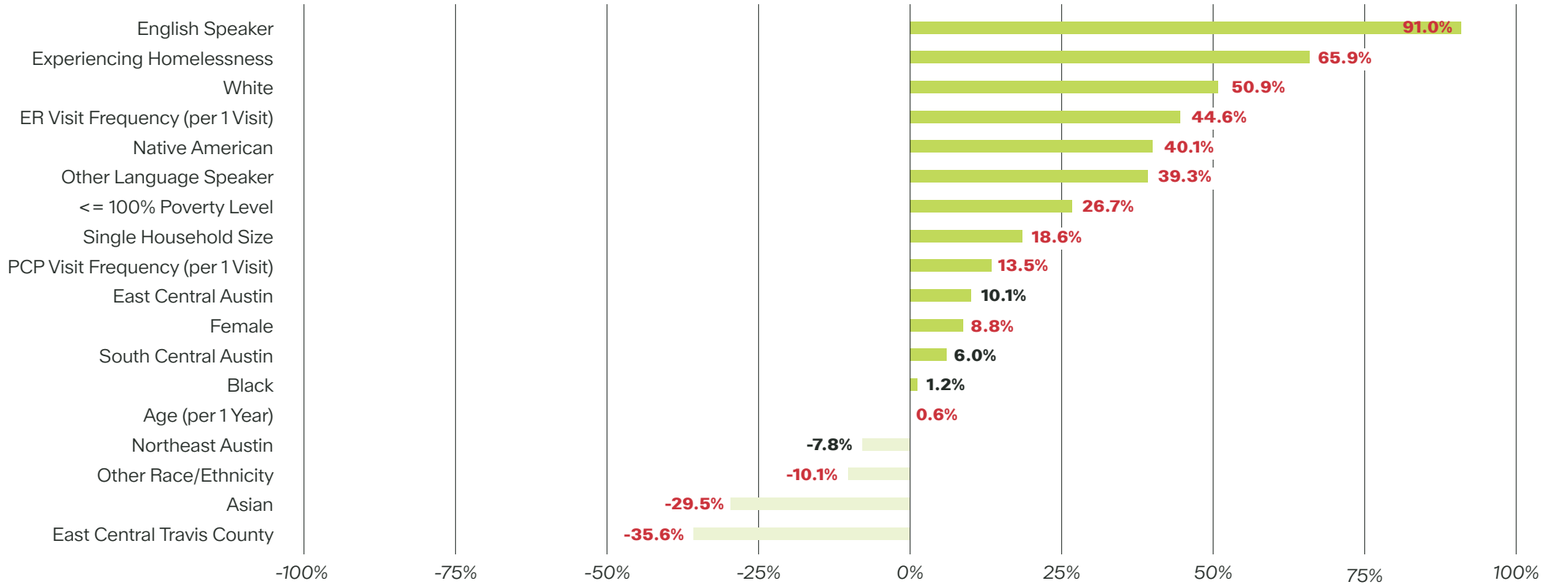
[1] Patients are identified as those who were enrolled in MAP, MAP Basic, SFS, or CHAP in FY2023 and had received a chronic condition diagnosis any time during or prior to FY2023. [2] Data were pulled from the Central Health enterprise analytics encounter database for all primary care, inpatient, and emergency department visits to Central Health provider network locations for patients identified as having the chronic conditions. [3] Central Health race and ethnicity counts are combined.

Behavioral Health: Diagnosis and Care

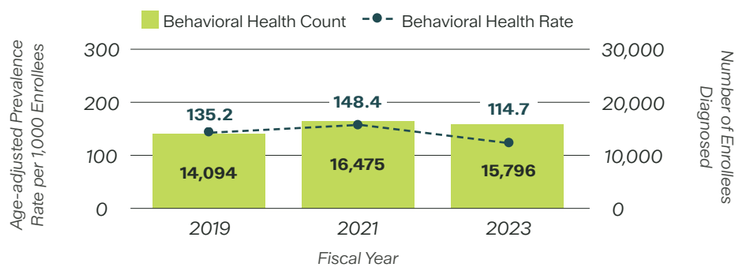
The overall age-adjusted prevalence of Behavioral Health diagnoses in this population was 11.5%, or 114.7 cases per 1,000 enrollees. Advanced modeling techniques were used to explore what factors were most likely to influence an enrollee being diagnosed with a chronic condition.[1] For example, people whose preferred language was English had a 91.0% higher probability of a behavioral health diagnosis. Factors that increased the probability of diagnosis have a positive percentage in the chart below, whereas factors that decrease the probability of diagnosis have a negative percentage.

Factors Linked with Behavioral Health Diagnosis: *Demographics, Focus Area, and Utilization*

Impact of Selected Factors on Increased/Decreased Probability of Diagnosis: Behavioral Health *(statistically significant results in **red**)*



Behavioral Health Diagnosis Changes Over Time



In Context: Local and National Comparisons

Behavioral Health Prevalence Rates per 1,000 Persons [2]

Travis County	N/A
National	199.0

It's important to note that data for Central Health enrollees are not directly comparable to the broader population. Central Health enrollees are by definition lower income, and differences in disease experience are documented in this report. There are also methodological differences in how Central Health calculates these rates compared to national and county calculations. For further exploration of these differences, please see the appendix.

Taking action across the continuum of care

In addition to contracting with local health care providers, Central Health launched an array of direct practice specialty services starting in FY22. Additionally, there are many cross-cutting interventions (e.g., case management) that apply to all conditions. Condition-specific interventions for behavioral health are listed below.

LEVERAGE POINT	SPECIFIC INTERVENTION
Preventative Care	▸ Mental health screenings
Community/Outpatient Care	▸ Direct practice counseling and psychiatric services ▸ Specific trauma recovery services
Alternatives to Acute Care	▸ Video counseling visits and telephone counseling options
Acute/Hospital Care	▸ Expanded services with Integral Care, including psychiatric emergency services
Post-acute care	▸ Austin State Hospital campus renovation plans

Information Gaps

Central Health enrollees have lower rates of behavioral health diagnoses than the national average, despite higher rates for White enrollees and persons experiencing homelessness (which exceed national rates).

Enrollees who do not identify as White are underrepresented in counts of behavioral health diagnoses. This could be an indication that this population does not seek out this care because it is stigmatized in their communities, or it could be indicative of access issues, e.g., services are not available outside of their work hours, or behavioral health prevalence among this group might not be as high because individuals might have more familial support in their day to day as they tend to live in multi-generational households.

[1] For additional methodology details, see appendix. [2] National data sourced from Adult Prevalence of Mental Illness (AMI), 2022

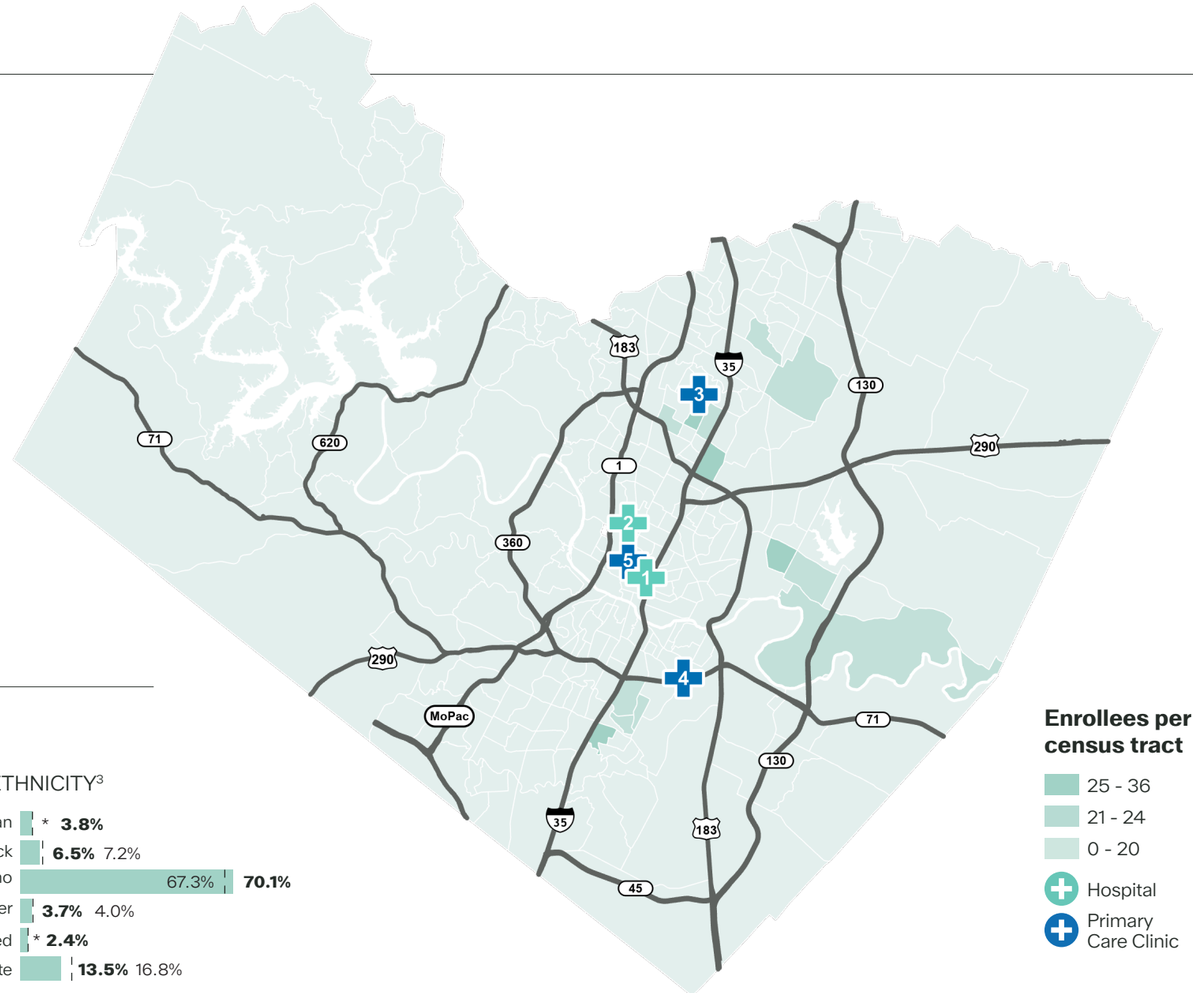
Cancer (Malignant Neoplasm)

Total Central Health enrollees diagnosed[1] with chronic condition: **1,819**

(All data are from fiscal year 2023)

Top 5 provider locations visited by enrollees with a cancer diagnosis [2]

		Number of visits in FY21	FY23
1	Dell Seton Medical Center at The University of Texas	1,810	**4,290**
2	Ascension Seton Medical Center Austin	2,652	**3,461**
3	CUC North Austin	1,571	**2,175**
4	Central Health Southeast Health & Wellness Center	1,173	**1,819**
5	Dell Medical School - Health Transformation Building	9	**1,609**



Demographics of central health enrollees with a cancer diagnosis

	FY21	FY23
AGE		
<18	*	*
18-44	**20.2%**	22.8%
45-64	**56.0%**	58.0%
65+	*	*
LANGUAGE		
English	**35.1%**	38.4%
Other	**3.7%**	3.8%
Spanish	55.9%	**59.4%**
Unreported	**1.8%**	1.9%
SEX		
	61.6%	**38.4%**
	61.0%	39.0%
	Female	Male
RACE/ETHNICITY[3]		
Asian	*	**3.8%**
Black	**6.5%**	7.2%
Latino	67.3%	**70.1%**
Other	**3.7%**	4.0%
Unreported	*	**2.4%**
White	**13.5%**	16.8%

Cancer equity index by race/ethnicity[3] and focus area

The Equity Index is a ratio of the observed prevalence rate to the expected prevalence rate (the all-enrollee rate) among Central Health's enrollees. A value less than 1.0 indicates lower risk compared to the all-enrollee rate. A value more than 1.0 indicates higher risk compared to the all-enrollee rate. This Equity Index, as applied to these age-adjusted prevalence rates, gives us an indication of which subgroups may be experiencing a health inequity. Statistically significant figures have been highlighted in yellow.

Asian	Black	Latino	Other	Unreported	White
0.9	0.8	1.1	0.7	0.5	1.1

East Central Austin	East Central Travis County	Manor	North Central Austin	Northeast Austin	Northeast Travis County	Oak Hill	South Central Austin	Southeast Austin
1.1	0.7	0.5	1.1	1.5	0.9	0.8	1.0	0.9

Compared to the overall Central Health population in Travis County, enrollees with unreported race/ethnicity and enrollees in Manor were 50% less likely to have a cancer diagnosis in FY23. Enrollees residing in Northeast Austin were 50% more likely to have a cancer diagnosis.

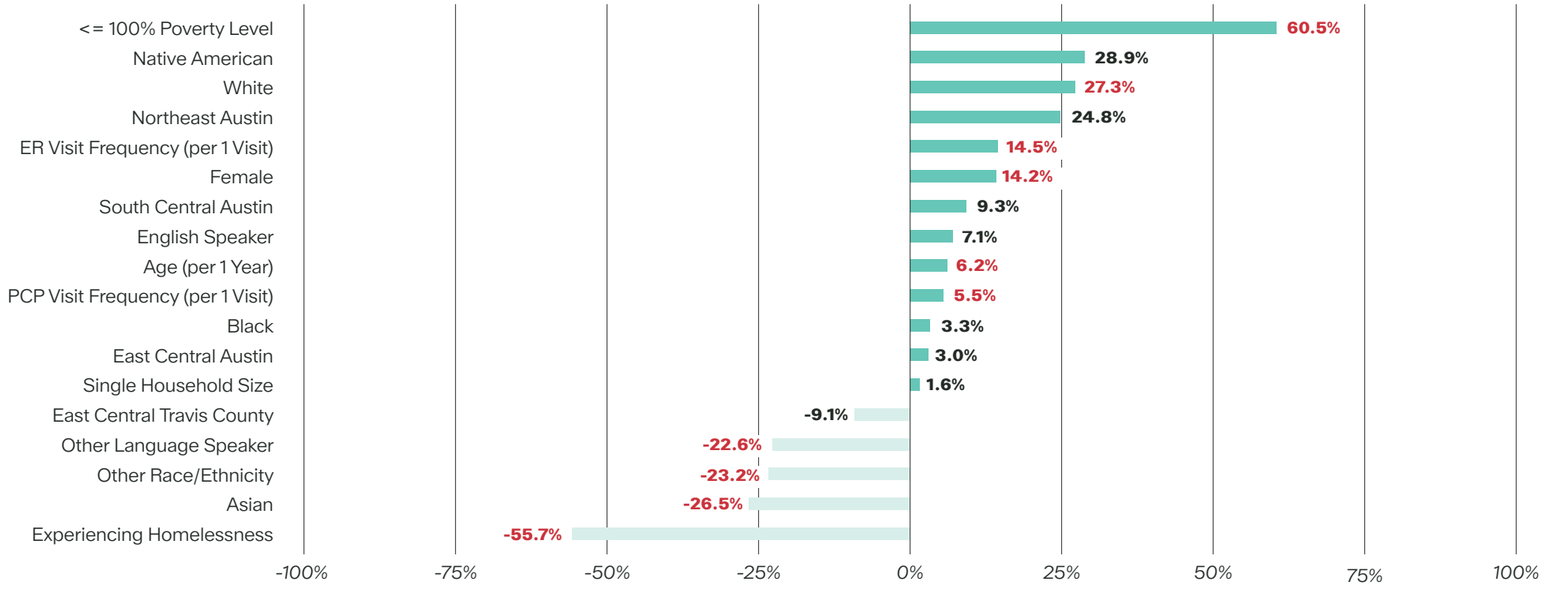
[1] Patients are identified as those who were enrolled in MAP, MAP Basic, SFS, or CHAP in FY2023 and had received a chronic condition diagnosis any time during or prior to FY2023. [2] Data were pulled from the Central Health enterprise analytics encounter database for all primary care, inpatient, and emergency department visits to Central Health provider network locations for patients identified as having the chronic conditions. [3] Central Health race and ethnicity counts are combined. * Data suppressed to maintain privacy standards.

Cancer: Diagnosis and Care

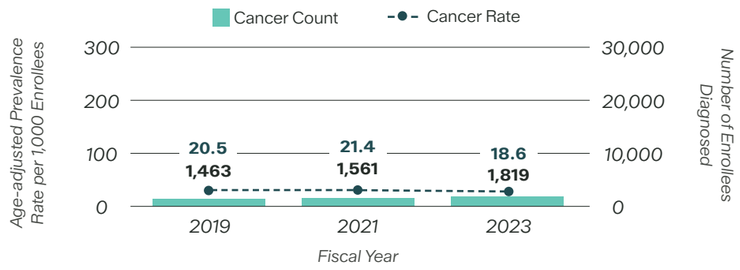
The overall age-adjusted prevalence of cancers in this population was 1.9%, or 18.6 cases per 1,000 enrollees. Advanced modeling techniques were used to explore what factors were most likely to influence an enrollee being diagnosed with a chronic condition.[1] For example, people in the lowest income group at or below 100% of the federal poverty level had a 60.5% higher probability of a cancer diagnosis. Factors that increased the probability of diagnosis have a positive percentage in the chart below, whereas factors that decrease the probability of diagnosis have a negative percentage.

Factors Linked with Cancer Diagnosis: *Demographics, Focus Area, and Utilization*

Impact of Selected Factors on Increased/Decreased Probability of Diagnosis: Cancer *(statistically significant results in **red**)*

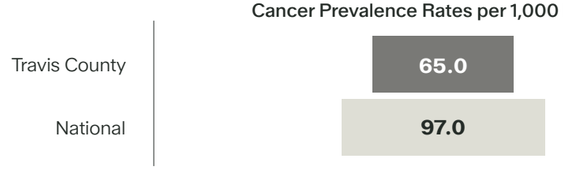


Cancer Diagnosis Changes Over Time



In Context: Local and National Comparisons

Cancer Prevalence Rates per 1,000 Persons [2]



It's important to note that data for Central Health enrollees are not directly comparable to the broader population. Central Health enrollees are by definition lower income, and differences in disease experience are documented in this report. There are also methodological differences in how Central Health calculates these rates compared to national and county calculations. For further exploration of these differences, please see the appendix.

Taking action across the continuum of care

In addition to contracting with local health care providers, Central Health launched an array of direct practice specialty services starting in FY22. Additionally, there are many cross-cutting interventions (e.g., case management) that apply to all conditions. Condition-specific interventions for cancer are listed below.

LEVERAGE POINT	SPECIFIC INTERVENTION
Preventative Care	▸ Expanded colorectal cancer screening with clinics and skilled nursing facilities
Community/Outpatient Care	▸ Expanded access to mammograms and PET scans. ▸ Low-dose CT scans for qualified smokers
Alternatives to Acute Care	
Acute/Hospital Care	▸ CAR T-cell immunotherapy and bone marrow transplants through Sendero
Post-acute care	▸ Expanded palliative care

Information Gaps

Central Health enrollees have far lower diagnosis rates for all cancers, 1/5 to 1/3 of national and Travis County prevalence. Cancers are clearly under diagnosed in our enrollee population. Further, a decision to screen is a decision to treat and cancer treatment options are limited.

Central Health is already hard at work with cancer screening initiatives, but much remains to be done. This indicates a significant fraction of cancers in our enrollee population are going undiagnosed, which greatly increases the long-term challenge and cost of treatment and reduces the probability of survival. Factors driving this under diagnosis could include a lack of access to screening and diagnostic resources.

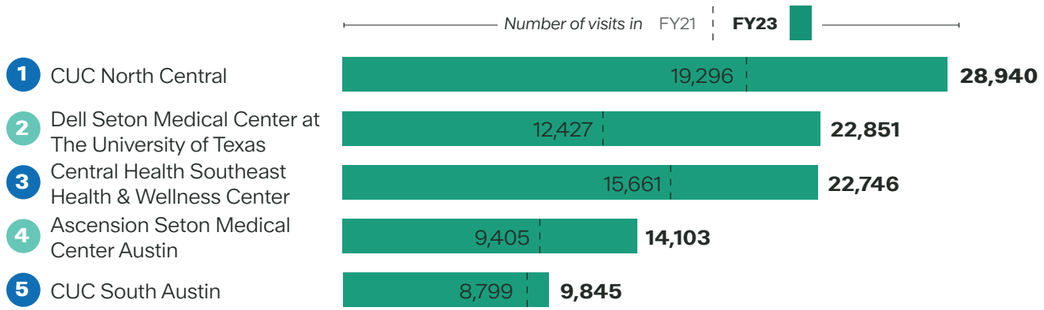
[1] *For additional methodology details, see appendix.* [2] *Local and national data sourced from CDC BRFSS 2022*

Cardiovascular Disease (CVD)

Total Central Health enrollees diagnosed[1] with chronic condition: **26,783**

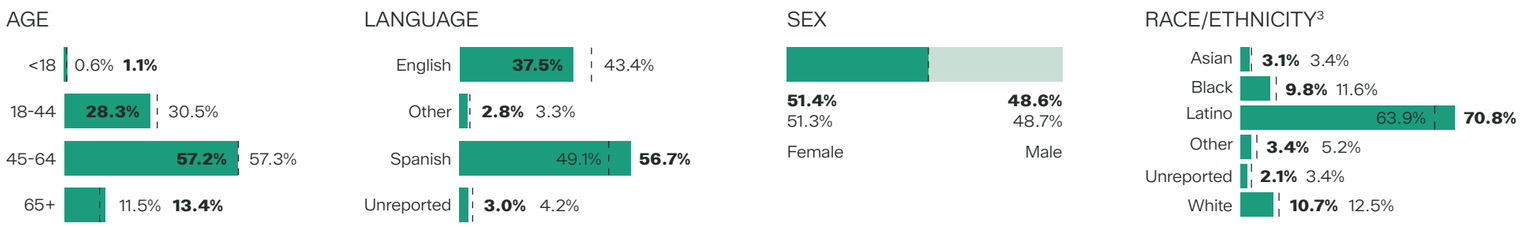
(All data are from fiscal year 2023)

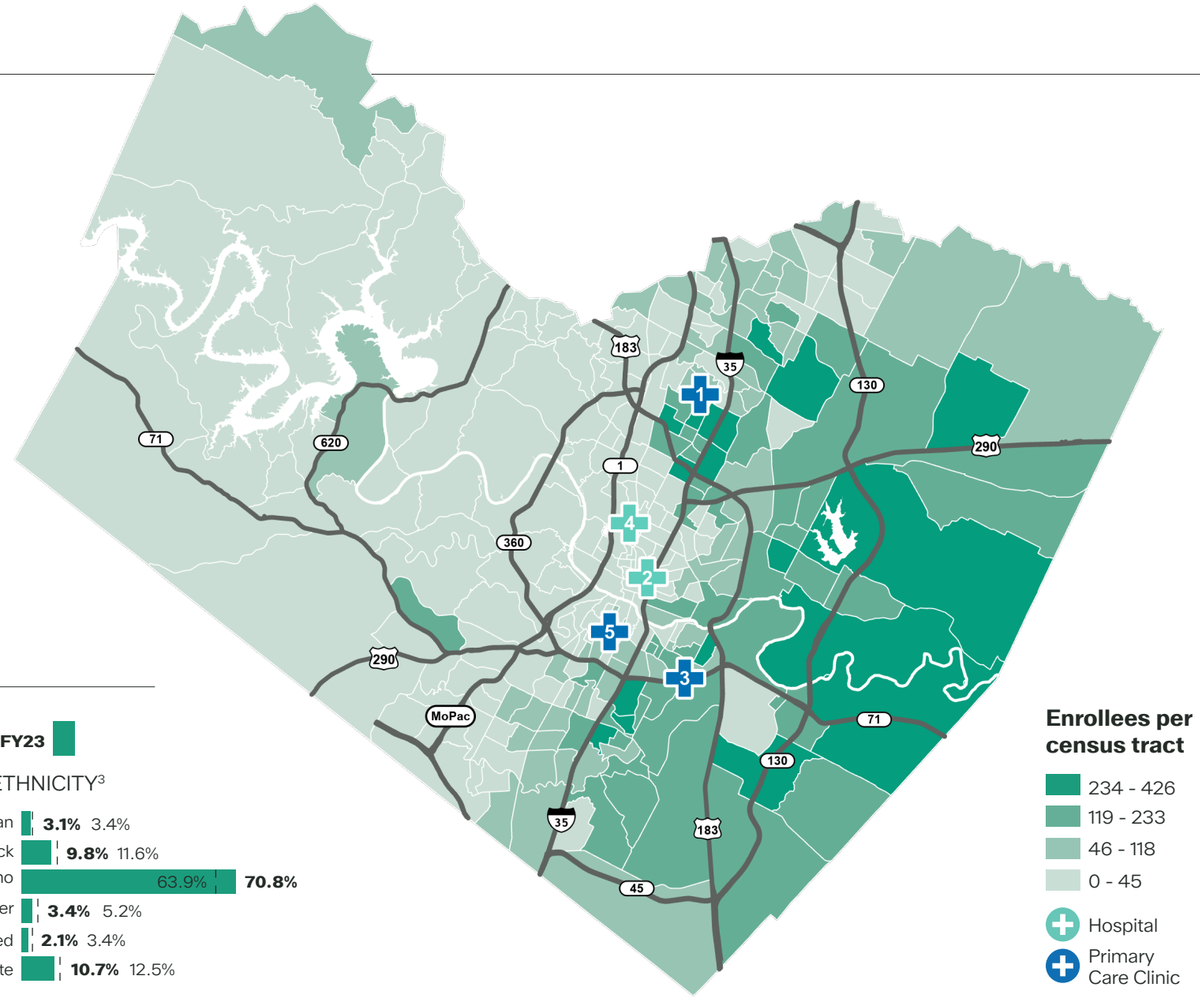
Top 5 provider locations visited by enrollees with a cardiovascular disease diagnosis [2]



Demographics of central health enrollees with a cardiovascular disease diagnosis

FY21 | **FY23**





Cardiovascular Disease equity index by race/ethnicity[3] and focus area

The Equity Index is a ratio of the observed prevalence rate to the expected prevalence rate (the all-enrollee rate) among Central Health's enrollees. A value less than 1.0 indicates lower risk compared to the all-enrollee rate. A value more than 1.0 indicates higher risk compared to the all-enrollee rate. This Equity Index, as applied to these age-adjusted prevalence rates, gives us an indication of which subgroups may be experiencing a health inequity. Statistically significant figures have been highlighted in yellow.

Asian	Black	Latino	Other	Unreported	White
0.9	1.3	1.1	0.6	0.5	1.0

East Central Austin	East Central Travis County	Manor	North Central Austin	Northeast Austin	Northeast Travis County	Oak Hill	South Central Austin	Southeast Austin
1.0	1.0	1.0	1.0	1.0	1.0	1.1	1.1	0.9

Compared to the overall Central Health population in Travis County, Black enrollees were 30% more likely to have a cardiovascular disease diagnosis in FY23. Enrollees with other and unreported race/ethnicity were 40% and 50% less likely to have a cardiovascular disease diagnosis, respectively.

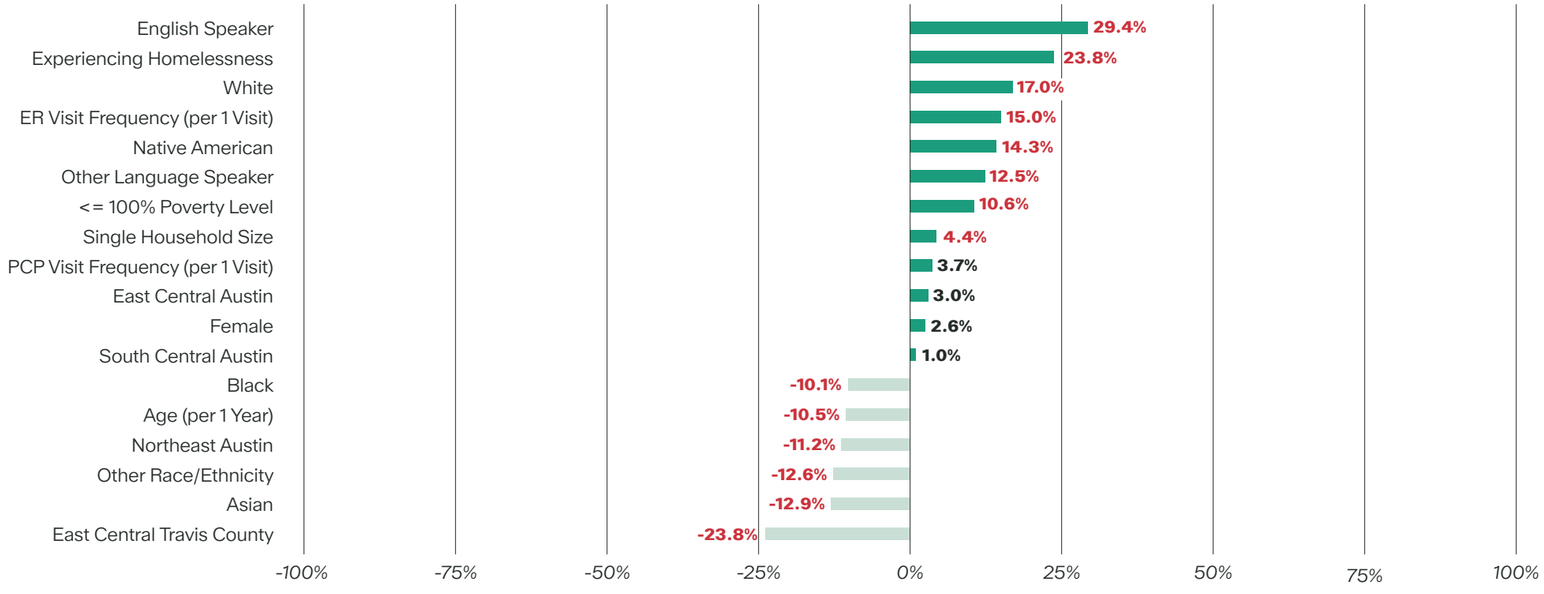
[1] Patients are identified as those who were enrolled in MAP, MAP Basic, SFS, or CHAP in FY2023 and had received a chronic condition diagnosis any time during or prior to FY2023. [2] Data were pulled from the Central Health enterprise analytics encounter database for all primary care, inpatient, and emergency department visits to Central Health provider network locations for patients identified as having the chronic conditions. [3] Central Health race and ethnicity counts are combined. * Data suppressed to maintain privacy standards.

Cardiovascular Disease (CVD): Diagnosis and Care

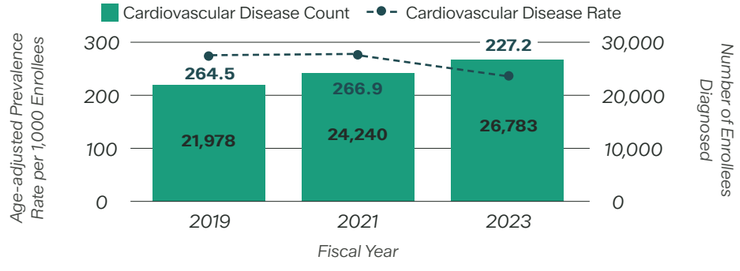
The overall age-adjusted prevalence of CVD in Central Health enrollees was 22.7%, or 227.2 cases per 1,000 enrollees. Advanced modeling techniques were used to explore what factors were most likely to influence an enrollee being diagnosed with a chronic condition.[1] For example, enrollees whose preferred language was English had a 29.4% increase in the likelihood of diagnosis of CVD. Factors that increased the probability of diagnosis have a positive percentage in the chart below, whereas factors that decrease the probability of diagnosis have a negative percentage.

Factors Linked with Cardiovascular Disease Diagnosis: *Demographics, Focus Area, and Utilization*

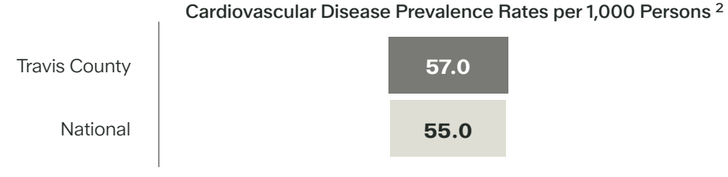
Impact of Selected Factors on Increased/Decreased Probability of Diagnosis: Cardiovascular Disease *(statistically significant results in **red**)*



Cardiovascular Disease Diagnosis Changes Over Time



In Context: Local and National Comparisons



It's important to note that data for Central Health enrollees are not directly comparable to the broader population. Central Health enrollees are by definition lower income, and differences in disease experience are documented in this report. There are also methodological differences in how Central Health calculates these rates compared to national and county calculations. For further exploration of these differences, please see the appendix.

Taking action across the continuum of care

In addition to contracting with local health care providers, Central Health launched an array of direct practice specialty services starting in FY22. Additionally, there are many cross-cutting interventions (e.g., case management) that apply to all conditions. Condition-specific interventions for cardiovascular disease are listed below.

LEVERAGE POINT	SPECIFIC INTERVENTION
Preventative Care	▸ Nutrition and Healthy Cooking classes ▸ Exercise classes (e.g., Zumba)
Community/Outpatient Care	▸ Direct practice cardiology and diagnostic testing ▸ Expanded network of providers
Alternatives to Acute Care	▸ Jail Health Cardiology access
Acute/Hospital Care	
Post-acute care	▸ Stroke recovery: Expanded access to physical therapy

Spotlight on Stroke

A stroke, sometimes called a "brain attack", is a cardiovascular medical condition that occurs when the blood supply to a part of the brain is interrupted or reduced, preventing brain tissue from getting enough oxygen and nutrients. As with a heart attack, brain cells begin to die within minutes, making a stroke a medical emergency that requires prompt treatment.

- **Total cases:** 1,201
- **Overall Prevalence:** 1.2% (12.3/1,000 persons)
- **National Prevalence:** 0.8% (7.8/1,000 persons)
- **Disparities:**
  - Black enrollees had the highest rate (1.5%), a 20% excess.
  - Residents of South Central Austin were most likely (2%), a 70% excess

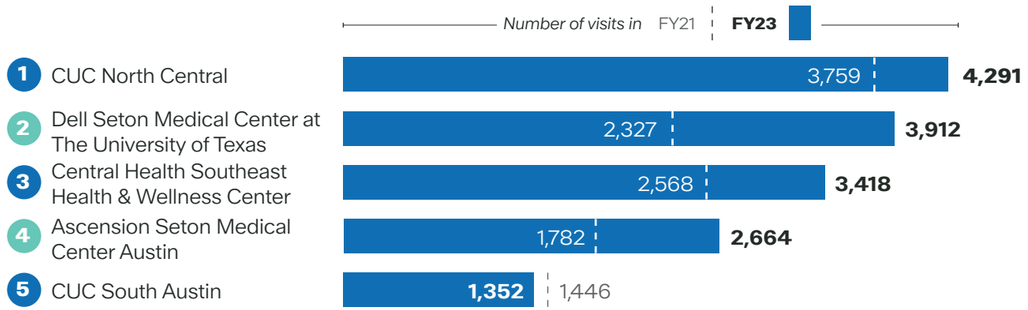
[1] *For additional methodology details, see appendix.* [2] *Local and national data sourced from CDC BRFSS 2022*

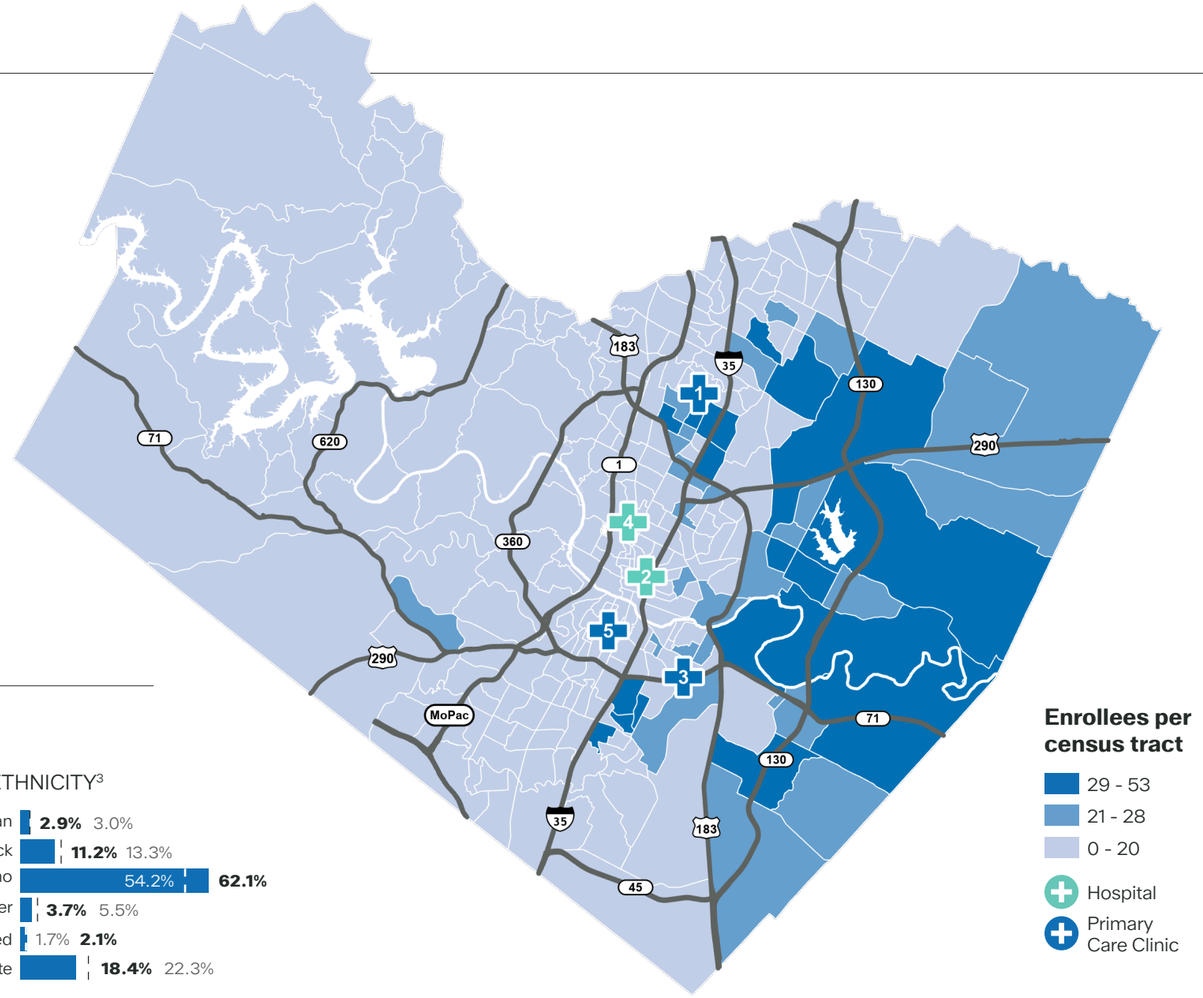
COPD (Chronic Obstructive Pulmonary Disease)

Total Central Health enrollees diagnosed[1] with chronic condition: **3,598**

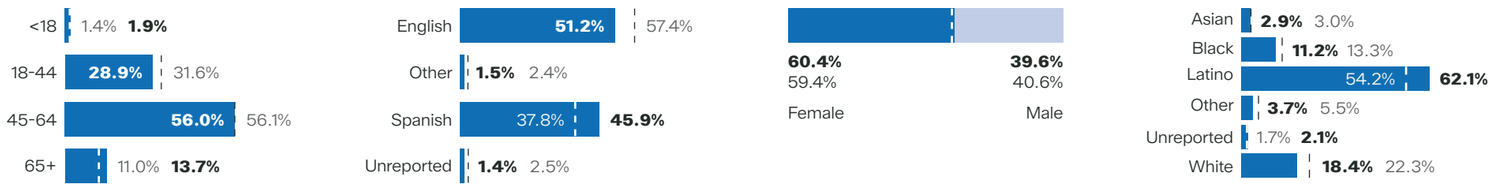
(All data are from fiscal year 2023)

Top 5 provider locations visited by enrollees with a COPD diagnosis[2]





Demographics of central health enrollees with a COPD diagnosis



COPD equity index by race/ethnicity[3] and focus area

The Equity Index is a ratio of the observed prevalence rate to the expected prevalence rate (the all-enrollee rate) among Central Health's enrollees. A value less than 1.0 indicates lower risk compared to the all-enrollee rate. A value more than 1.0 indicates higher risk compared to the all-enrollee rate. This Equity Index, as applied to these age-adjusted prevalence rates, gives us an indication of which subgroups may be experiencing a health inequity.

Asian	Black	Latino	Other	Unreported	White
1.0	1.3	0.9	0.8	0.5	1.4

East Central Austin	East Central Travis County	Manor	North Central Austin	Northeast Austin	Northeast Travis County	Oak Hill	South Central Austin	Southeast Austin
1.3	1.2	0.7	1.0	0.8	0.8	1.1	1.1	0.9

Compared to the overall Central Health population in Travis County, Black enrollees were 30% more likely and White enrollees were 40% more likely to have a COPD diagnosis in FY23. Enrollees residing in East Central Austin were 30% more likely to have a COPD diagnosis.

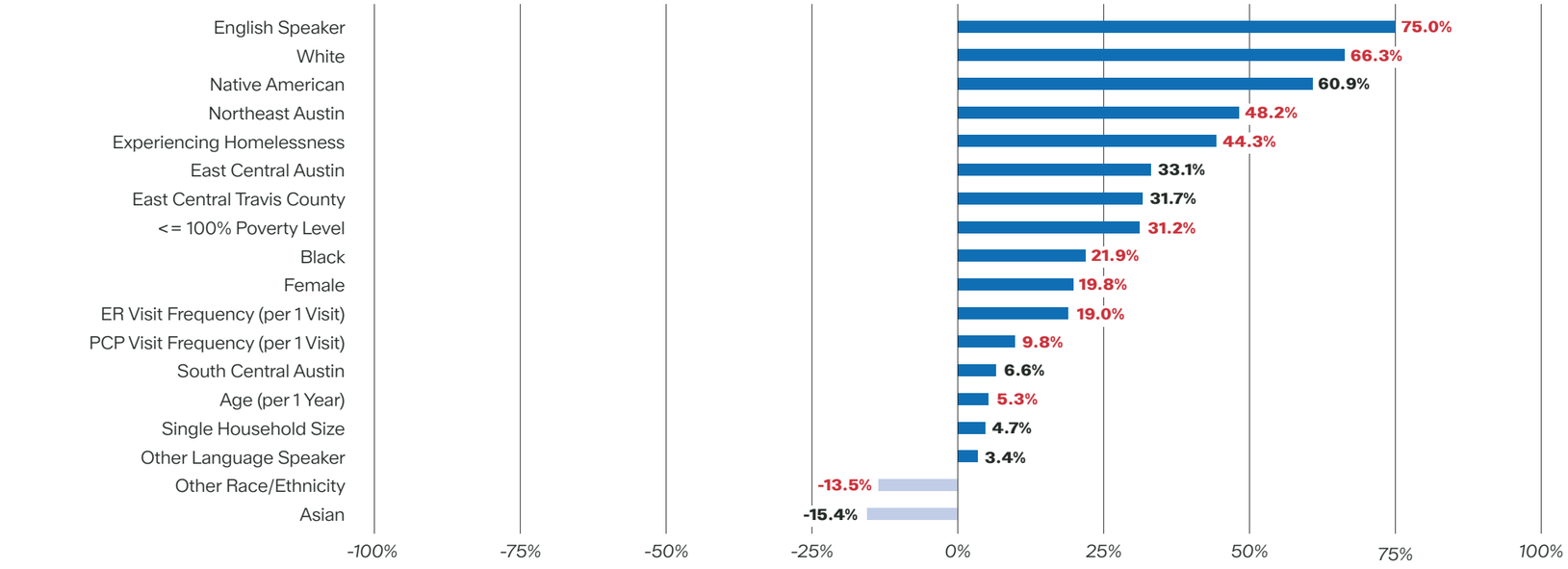
[1] Patients are identified as those who were enrolled in MAP, MAP Basic, SFS, or CHAP in FY2023 and had received a chronic condition diagnosis any time during or prior to FY2023. [2] Data were pulled from the Central Health enterprise analytics encounter database for all primary care, inpatient, and emergency department visits to Central Health provider network locations for patients identified as having the chronic conditions. [3] Central Health race and ethnicity counts are combined.

COPD: Diagnosis and Care

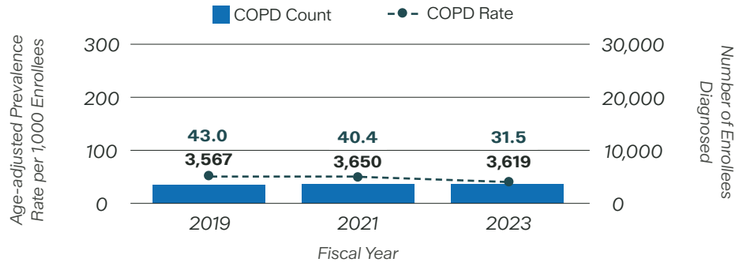
The overall age-adjusted prevalence of COPD in Central Health enrollees was 3.2%, or 31.5 cases per 1,000 enrollees. Advanced modeling techniques were used to explore what factors were most likely to influence an enrollee being diagnosed with a chronic condition.[1] For example, persons whose preferred language was English had a 75.0% higher probability of a COPD diagnosis. Factors that increased the probability of diagnosis have a positive percentage in the chart below, whereas factors that decrease the probability of diagnosis have a negative percentage.

Factors Linked with COPD Diagnosis: *Demographics, Focus Area, and Utilization*

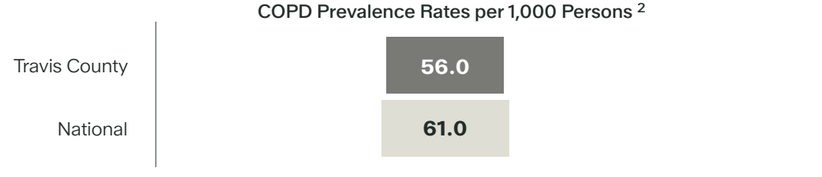
Impact of Selected Factors on Increased/Decreased Probability of Diagnosis: COPD *(statistically significant results in **red**)*



COPD Diagnosis Changes Over Time



In Context: Local and National Comparisons



It's important to note that data for Central Health enrollees are not directly comparable to the broader population. Central Health enrollees are by definition lower income, and differences in disease experience are documented in this report. There are also methodological differences in how Central Health calculates these rates compared to national and county calculations. For further exploration of these differences, please see the appendix.

Taking action across the continuum of care

In addition to contracting with local health care providers, Central Health launched an array of direct practice specialty services starting in FY22. Additionally, there are many cross-cutting interventions (e.g., case management) that apply to all conditions. Condition-specific interventions for COPD are listed below.

LEVERAGE POINT	SPECIFIC INTERVENTION
Preventative Care	▸ Smoking cessation
Community/Outpatient Care	▸ Direct practice pulmonology ▸ Expanded respiratory therapy services ▸ Expanded pulmonary testing and diagnostics
Alternatives to Acute Care	
Acute/Hospital Care	
Post-acute care	

Information Gaps

Central Health enrollees are diagnosed for COPD in roughly half the number we would expect. It's important to note that we've adjusted our rates to account for Austin's younger population, and the effects of a younger, healthier Spanish-speaking cohort of enrollees. This underdiagnosis gap remains.

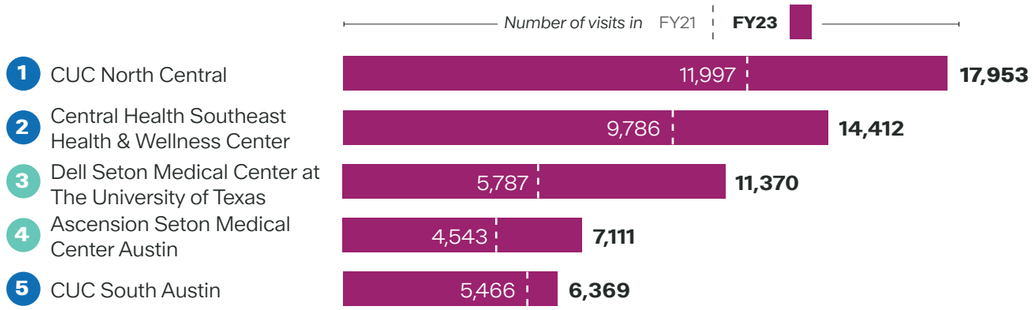
COPD is a debilitating pulmonary disease that is difficult to ignore and harder to live with. Factors that may be contributing to this underdiagnosis include fewer health care visits, lack of specialized care and equipment for diagnosis, limited awareness of symptoms, and unknown smoking prevalence.

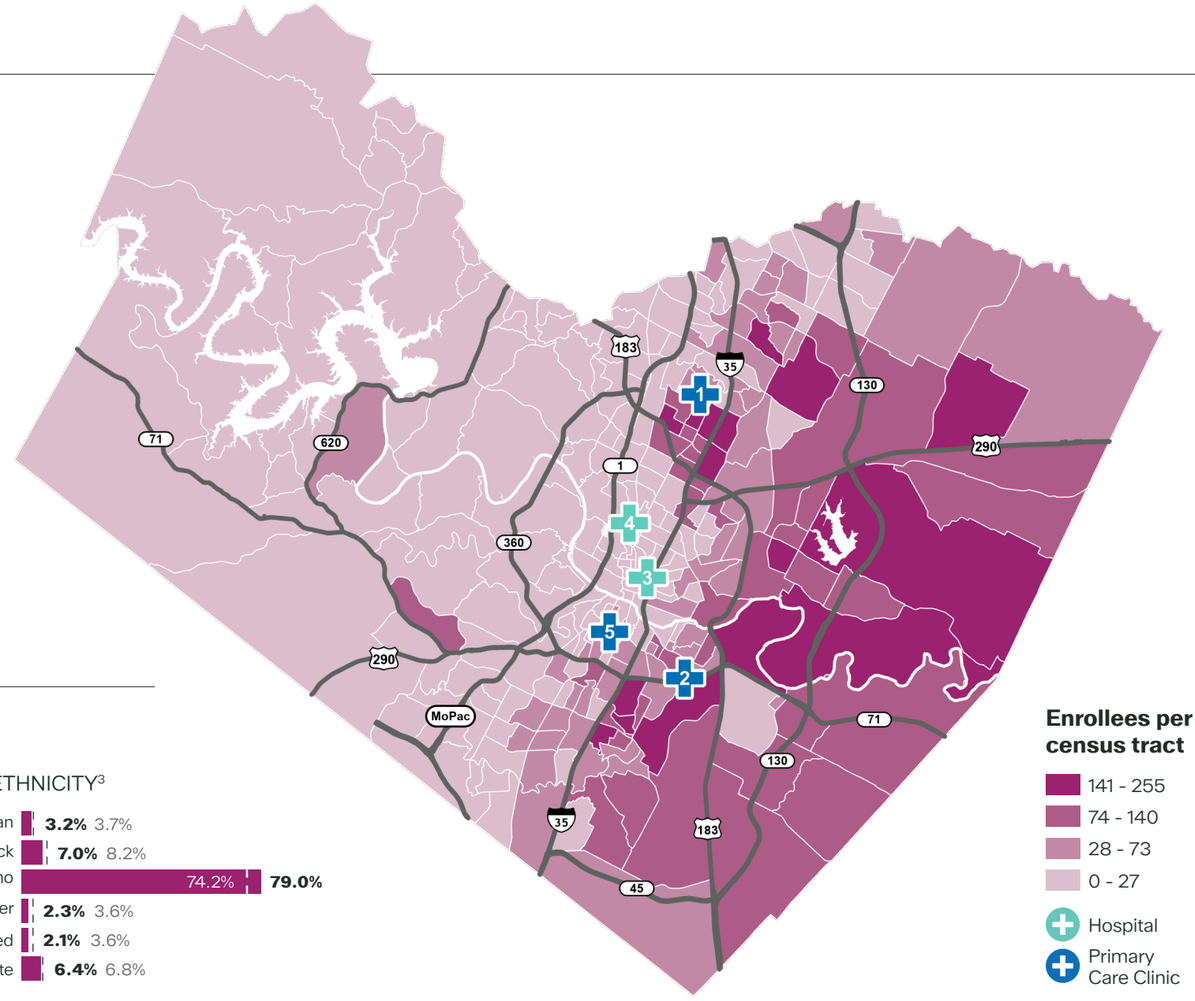
[1] For additional methodology details, see appendix. [2] Local and national data sourced from CDC BRFSS 2022

Diabetes (Type II)

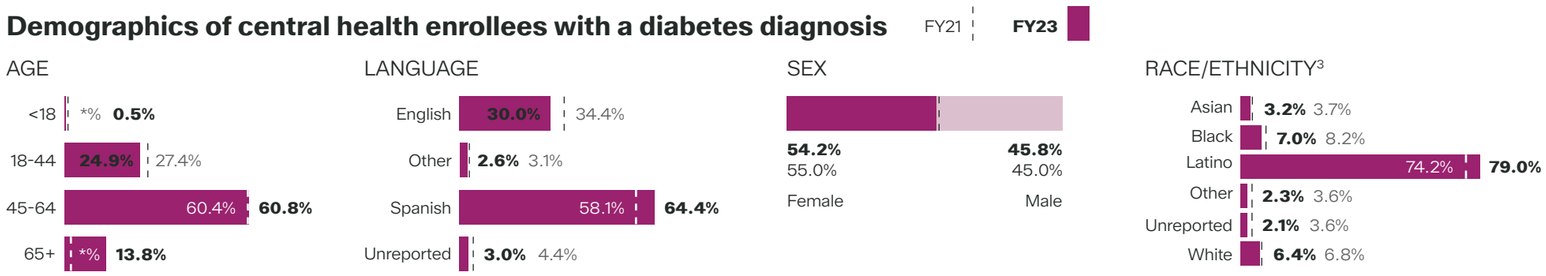
Total Central Health enrollees diagnosed[1] with chronic condition: **13,610**
(All data are from fiscal year 2023)

Top 5 provider locations visited by enrollees with a diabetes diagnosis [2]





Demographics of central health enrollees with a diabetes diagnosis



Diabetes equity index by race/ethnicity[3] and focus area

The Equity Index is a ratio of the observed prevalence rate to the expected prevalence rate (the all-enrollee rate) among Central Health's enrollees. A value less than 1.0 indicates lower risk compared to the all-enrollee rate. A value more than 1.0 indicates higher risk compared to the all-enrollee rate. This Equity Index, as applied to these age-adjusted prevalence rates, gives us an indication of which subgroups may be experiencing a health inequity.

Asian	Black	Latino	Other	Unreported	White
0.9	0.9	1.2	0.5	0.5	0.6

East Central Austin	East Central Travis County	Manor	North Central Austin	Northeast Austin	Northeast Travis County	Oak Hill	South Central Austin	Southeast Austin
1.1	1.1	1.1	1.0	1.3	1.0	1.0	1.3	0.9

Compared to the overall Central Health population in Travis County, Latino enrollees were 20% more likely to have a diabetes diagnosis in FY23.
Enrollees residing in Northeast Austin and South Central Austin were 30% more likely to have a diabetes diagnosis.

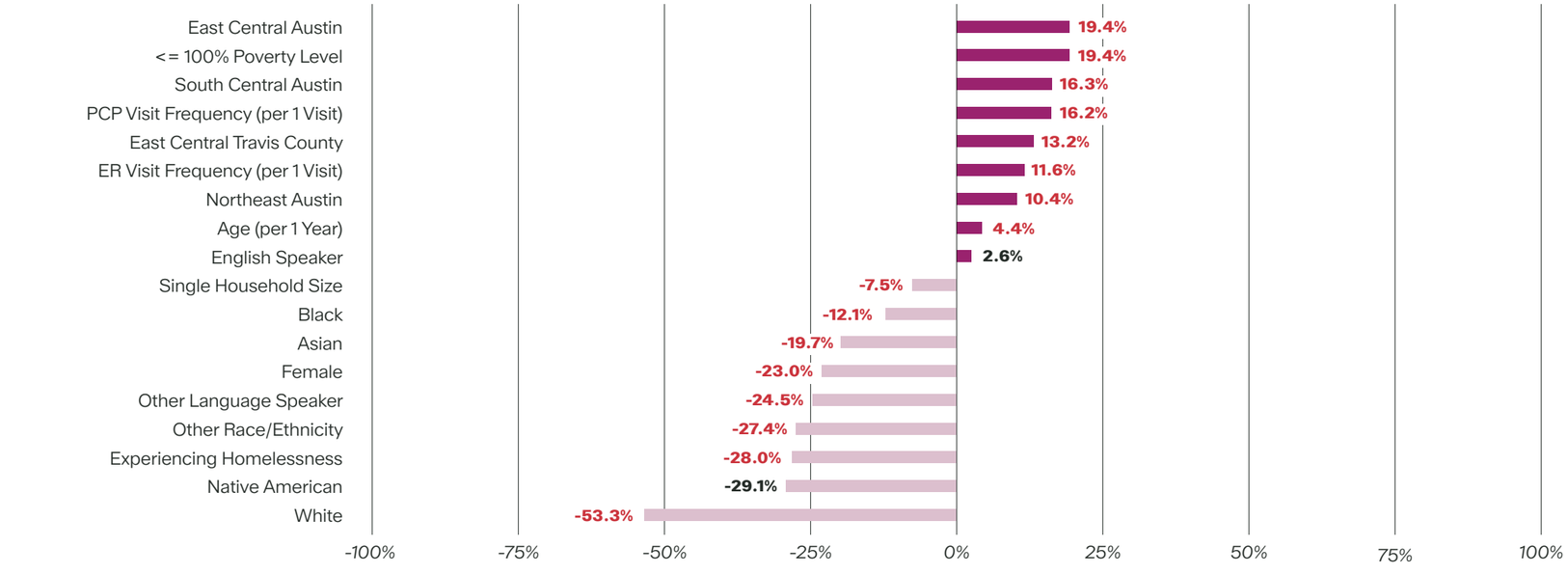
[1] Patients are identified as those who were enrolled in MAP, MAP Basic, SFS, or CHAP in FY2023 and had received a chronic condition diagnosis any time during or prior to FY2023. [2] Data were pulled from the Central Health enterprise analytics encounter database for all primary care, inpatient, and emergency department visits to Central Health provider network locations for patients identified as having the chronic conditions. [3] Central Health race and ethnicity counts are combined. * Data suppressed to maintain privacy standards.

Diabetes: Diagnosis and Care

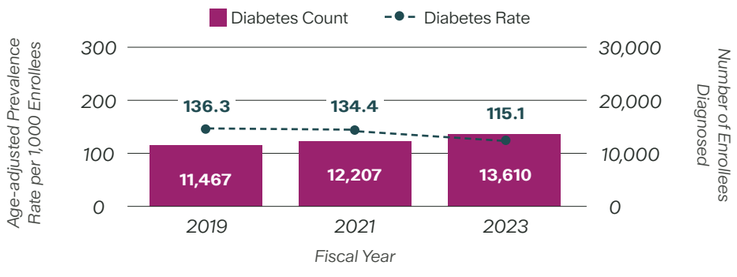
The overall age-adjusted prevalence of diabetes in Central Health enrollees population was 11.5%, or 115.1 cases per 1,000 enrollees. Advanced modeling techniques were used to explore what factors were most likely to influence an enrollee being diagnosed with a chronic condition.[1] For example, East Central Austin residents had a 19.4% higher probability of a diabetes diagnosis. Factors that increased the probability of diagnosis have a positive percentage in the chart below, whereas factors that decrease the probability of diagnosis have a negative percentage.

Factors Linked with Diabetes Diagnosis: *Demographics, Focus Area, and Utilization*

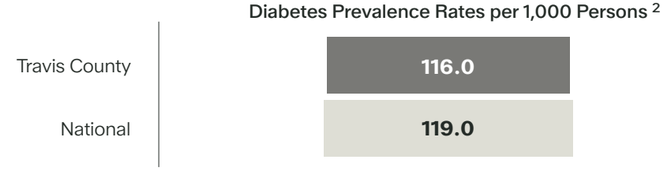
Impact of Selected Factors on Increased/Decreased Probability of Diagnosis: Diabetes *(statistically significant results in **red**)*



Diabetes Diagnosis Changes Over Time



In Context: Local and National Comparisons



It's important to note that data for Central Health enrollees are not directly comparable to the broader population. Central Health enrollees are by definition lower income, and differences in disease experience are documented in this report. There are also methodological differences in how Central Health calculates these rates compared to national and county calculations. For further exploration of these differences, please see the appendix.

Taking action across the continuum of care

In addition to contracting with local health care providers, Central Health launched an array of direct practice specialty services starting in FY22. Additionally, there are many cross-cutting interventions (e.g., case management) that apply to all conditions. Condition-specific interventions for diabetes are listed below.

LEVERAGE POINT	SPECIFIC INTERVENTION
Preventative Care	▸ Diabetic nail care
Community/Outpatient Care	▸ Direct practice podiatry and diagnostics ▸ Expanded wound and eye/ retina care ▸ Durable medical equipment for foot health
Alternatives to Acute Care	▸ Remote patient monitoring ▸ Jail Health Podiatry access
Acute/Hospital Care	
Post-acute care	

Information Gaps

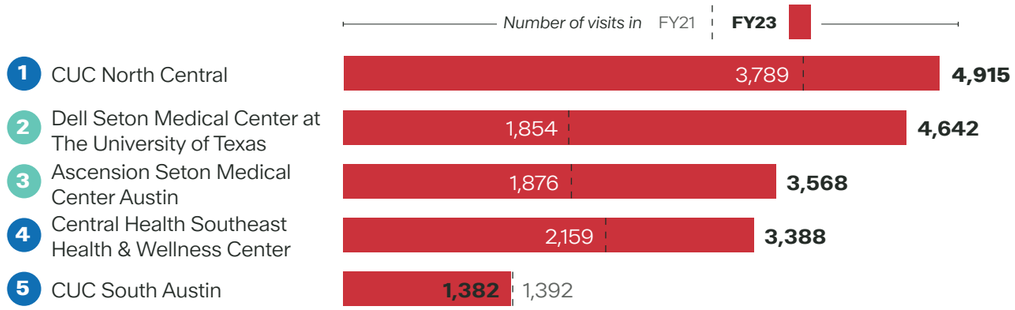
Central Health enrollees are being diagnosed for diabetes at nearly the same rate as their Travis County and National peers. There do not appear to be any significant data gaps for this condition.

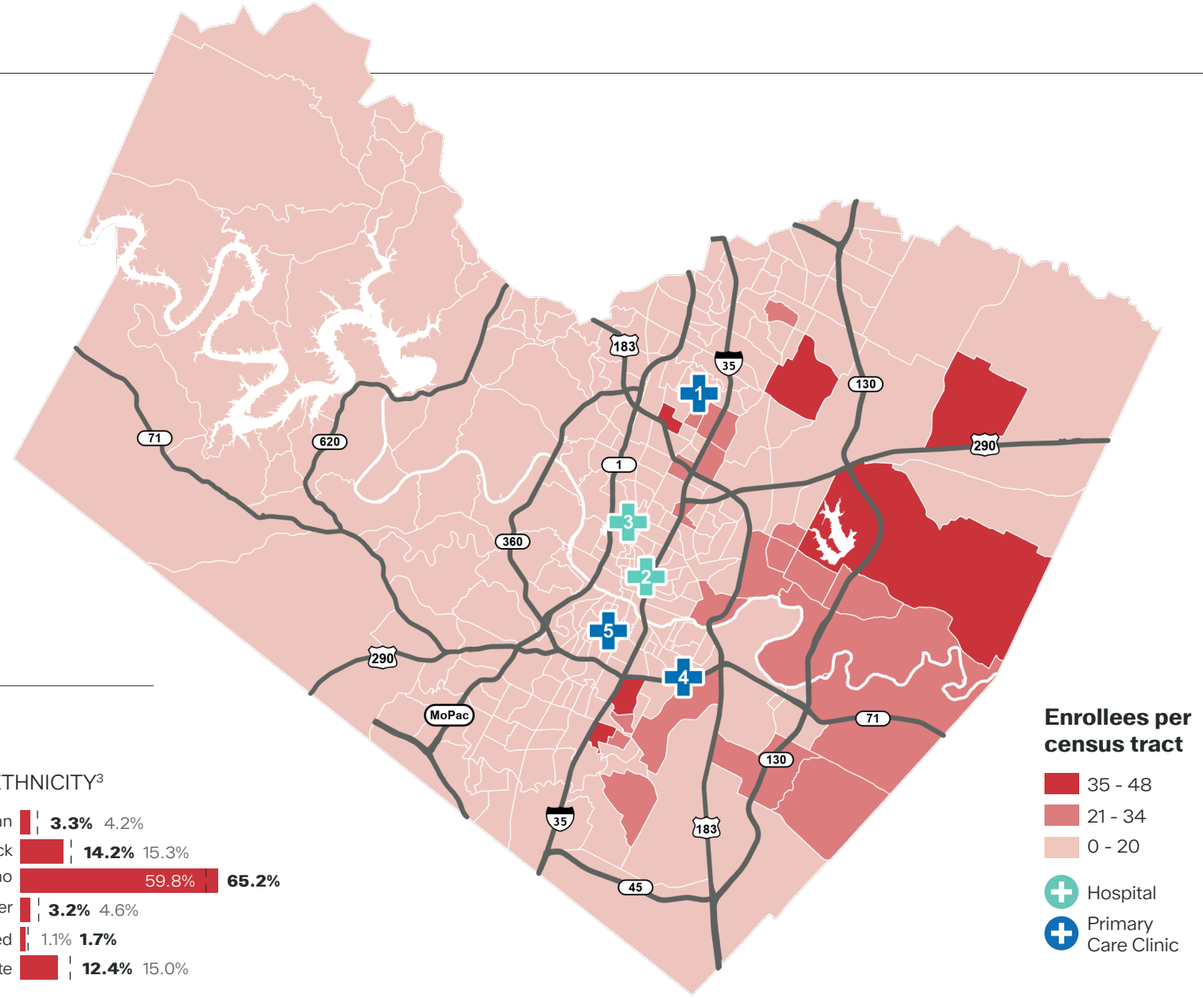
[1] *For additional methodology details, see appendix.* [2] *Local and national data sourced from CDC BRFSS 2022*

Heart Failure

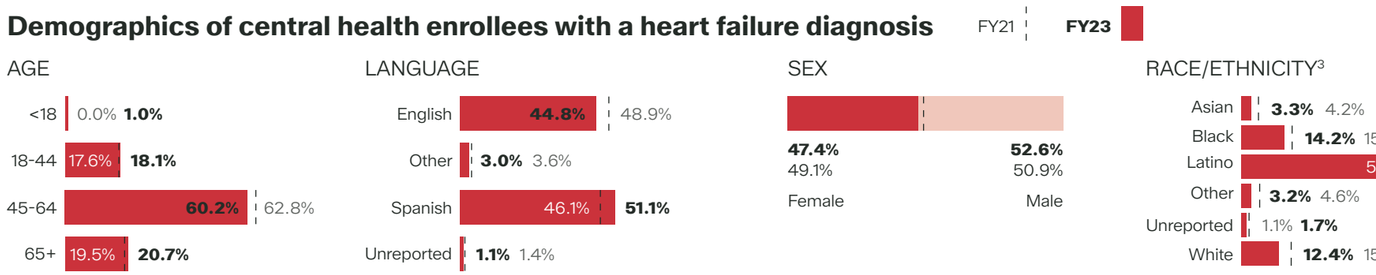
Total Central Health enrollees diagnosed[1] with chronic condition: **2,614**
(All data are from fiscal year 2023)

Top 5 provider locations visited by enrollees with a heart failure diagnosis[2]





Demographics of central health enrollees with a heart failure diagnosis



Heart failure equity index by race/ethnicity[3] and focus area

The Equity Index is a ratio of the observed prevalence rate to the expected prevalence rate (the all-enrollee rate) among Central Health's enrollees. A value less than 1.0 indicates lower risk compared to the all-enrollee rate. A value more than 1.0 indicates higher risk compared to the all-enrollee rate. This Equity Index, as applied to these age-adjusted prevalence rates, gives us an indication of which subgroups may be experiencing a health inequity.

Asian	Black	Latino	Other	Unreported	White
0.8	1.6	1.0	0.6	0.4	1.0

East Central Austin	East Central Travis County	Manor	North Central Austin	Northeast Austin	Northeast Travis County	Oak Hill	South Central Austin	Southeast Austin
1.2	1.1	1.3	1.2	1.4	1.2	0.9	1.2	0.8

Compared to the overall Central Health population in Travis County, Black enrollees were 60% more likely to have a heart failure diagnosis in FY23. Enrollees residing in Northeast Austin were 40% more likely to have a heart failure diagnosis, and Manor residents were 30% more likely to have heart failure.

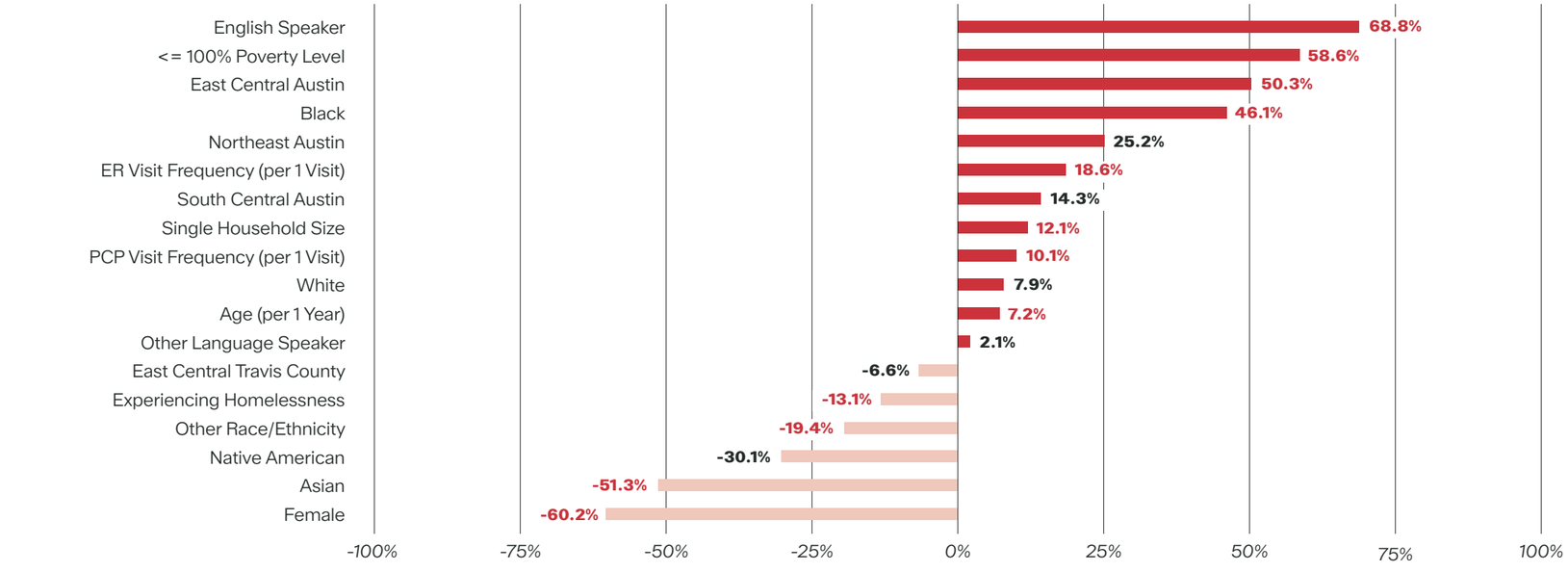
[1] Patients are identified as those who were enrolled in MAP, MAP Basic, SFS, or CHAP in FY2023 and had received a chronic condition diagnosis any time during or prior to FY2023. [2] Data were pulled from the Central Health enterprise analytics encounter database for all primary care, inpatient, and emergency department visits to Central Health provider network locations for patients identified as having the chronic conditions. [3] Central Health race and ethnicity counts are combined.

Heart Failure: Diagnosis and Care

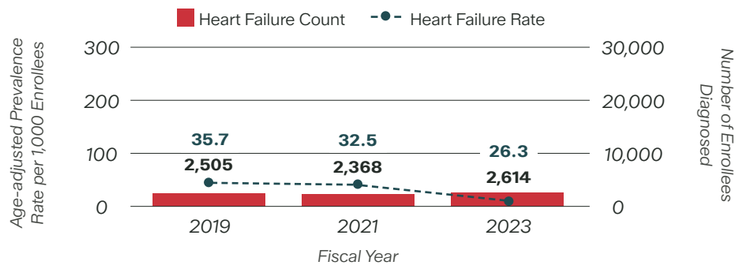
The overall age-adjusted prevalence of heart failure in Central Health enrollees population was 2.6%, or 26.3 cases per 1,000 enrollees. Advanced modeling techniques were used to explore what factors were most likely to influence an enrollee being diagnosed with a chronic condition.[1] For example, persons whose preferred language was English had a 68.8% higher probability of a heart failure diagnosis. Factors that increased the probability of diagnosis have a positive percentage in the chart below, whereas factors that decrease the probability of diagnosis have a negative percentage.

Factors Linked with Heart Failure Diagnosis: *Demographics, Focus Area, and Utilization*

Impact of Selected Factors on Increased/Decreased Probability of Diagnosis: Heart Failure *(statistically significant results in **red**)*



Heart Failure Diagnosis Changes Over Time



In Context: Local and National Comparisons

Heart Failure Prevalence Rates per 1,000 Persons [2]

Travis County	N/A
National	28.0

It's important to note that data for Central Health enrollees are not directly comparable to the broader population. Central Health enrollees are by definition lower income, and differences in disease experience are documented in this report. There are also methodological differences in how Central Health calculates these rates compared to national and county calculations. For further exploration of these differences, please see the appendix.

Taking action across the continuum of care

In addition to contracting with local health care providers, Central Health launched an array of direct practice specialty services starting in FY22. Additionally, there are many cross-cutting interventions (e.g., case management) that apply to all conditions. Condition-specific interventions for heart failure are listed below.

LEVERAGE POINT	SPECIFIC INTERVENTION
Preventative Care	▸ Nutrition and Healthy Cooking classes
Community/Outpatient Care	▸ Direct practice cardiology and diagnostic testing ▸ Expanded network of providers
Alternatives to Acute Care	▸ Jail Health Cardiology access
Acute/Hospital Care	
Post-acute care	

Information Gaps

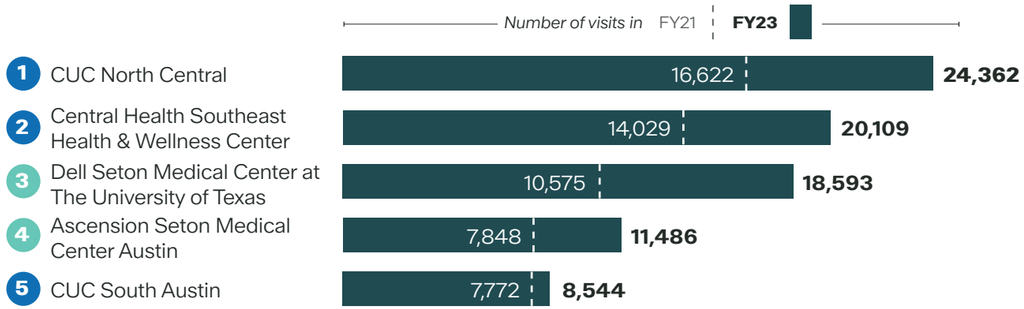
Central Health enrollees are being diagnosed with heart failure at nearly the same rate as the upper end of the estimate for the national population. Often, these diagnoses are made in the hospital.

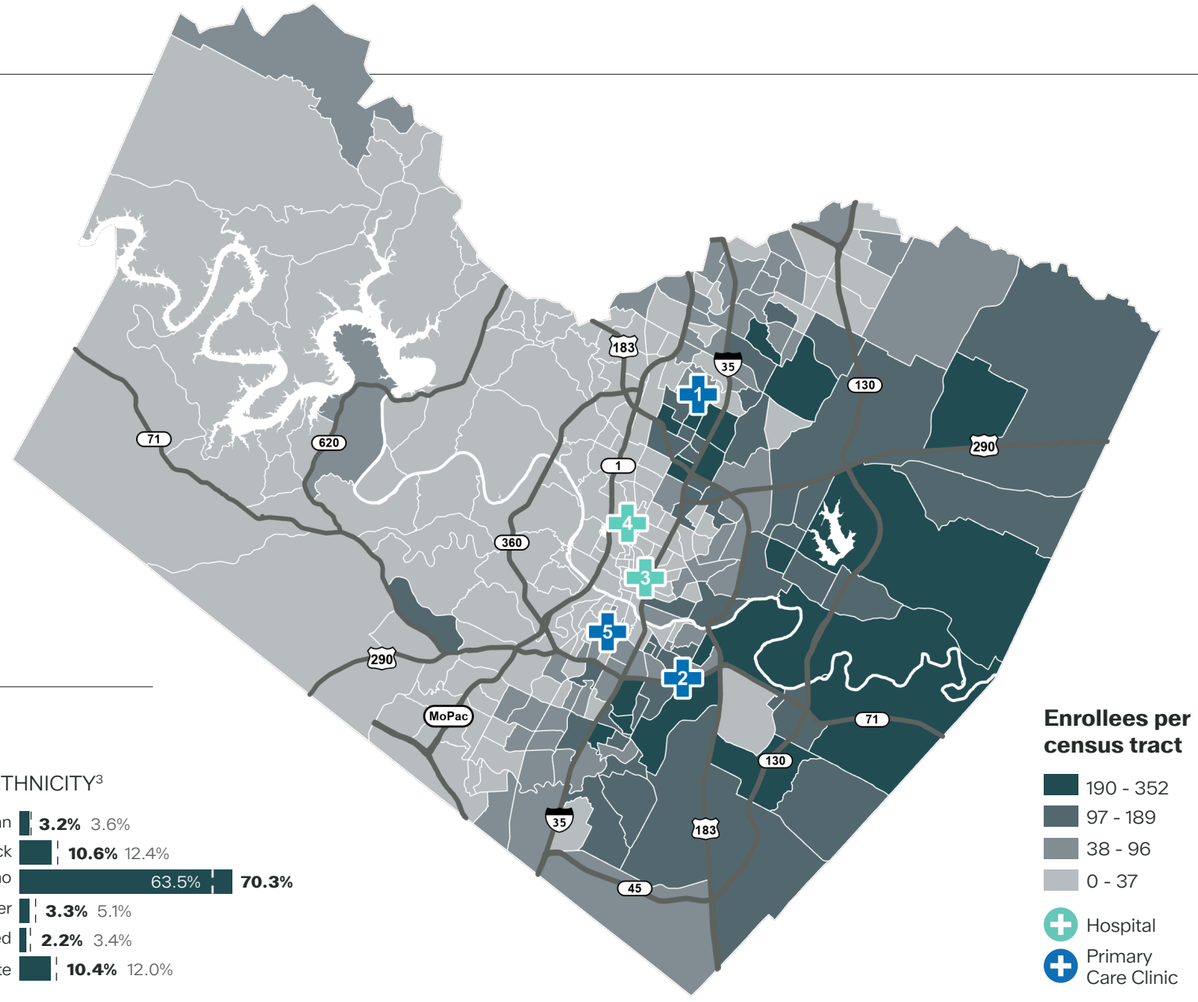
[1] *For additional methodology details, see appendix.* [2] *National data sourced from Journal of Cardiac Failure, 2024*

Hypertension (High Blood Pressure)

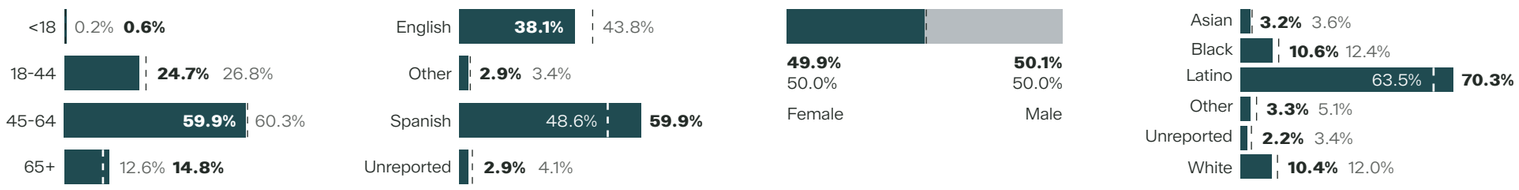
Total Central Health enrollees diagnosed[1] with chronic condition: **22,653**
(All data are from fiscal year 2023)

Top 5 provider locations visited by enrollees with a hypertension diagnosis[2]





Demographics of central health enrollees with a hypertension diagnosis



Hypertension equity index by race/ethnicity[3] and focus area

The Equity Index is a ratio of the observed prevalence rate to the expected prevalence rate (the all-enrollee rate) among Central Health's enrollees. A value less than 1.0 indicates lower risk compared to the all-enrollee rate. A value more than 1.0 indicates higher risk compared to the all-enrollee rate. This Equity Index, as applied to these age-adjusted prevalence rates, gives us an indication of which subgroups may be experiencing a health inequity. Statistically significant figures have been highlighted in yellow.

Asian	Black	Latino	Other	Unreported	White
0.9	1.3	1.1	0.6	0.5	0.9

East Central Austin	East Central Travis County	Manor	North Central Austin	Northeast Austin	Northeast Travis County	Oak Hill	South Central Austin	Southeast Austin
1.0	1.0	1.1	1.0	1.0	1.0	1.0	1.2	0.9

Compared to the overall Central Health population in Travis County, Black enrollees were 30% more likely to have a hypertension diagnosis in FY23. Enrollees that resided within the South Central Austin focus area were 20% more likely to have a hypertension diagnosis.

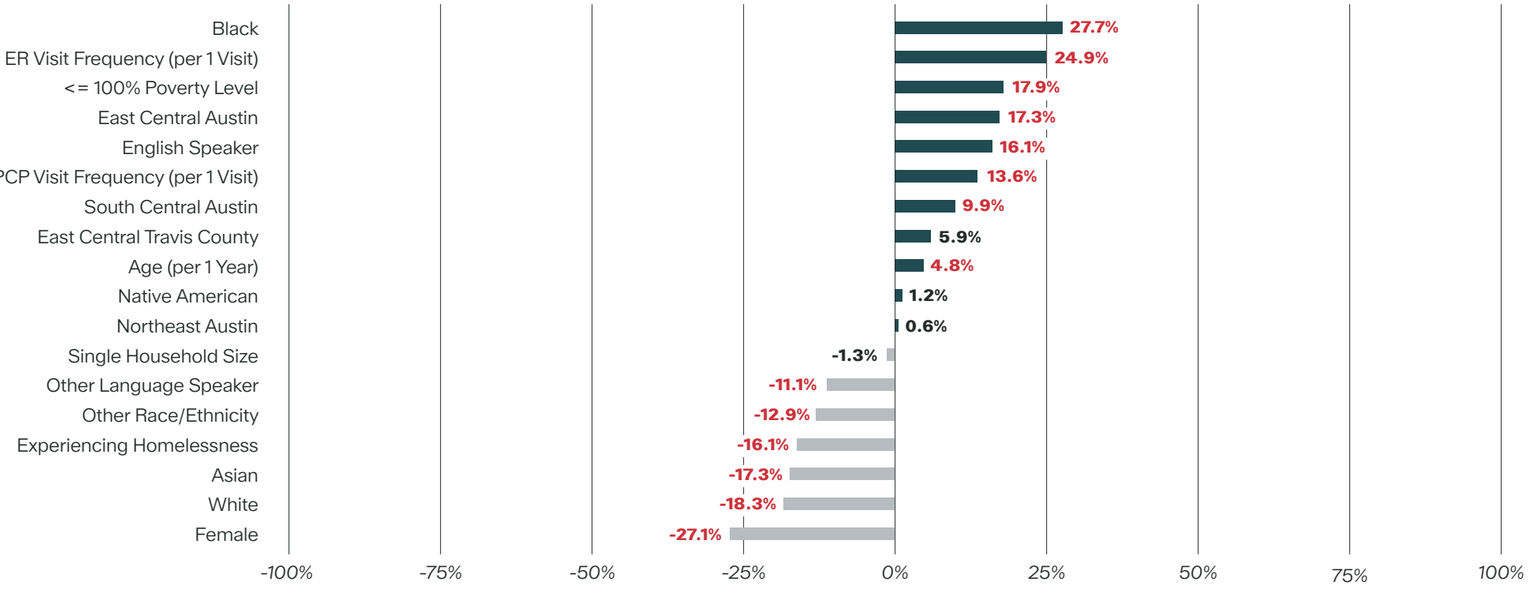
[1] Patients are identified as those who were enrolled in MAP, MAP Basic, SFS, or CHAP in FY2023 and had received a chronic condition diagnosis any time during or prior to FY2023. [2] Data were pulled from the Central Health enterprise analytics encounter database for all primary care, inpatient, and emergency department visits to Central Health provider network locations for patients identified as having the chronic conditions. [3] Central Health race and ethnicity counts are combined.

Hypertension: Diagnosis and Care

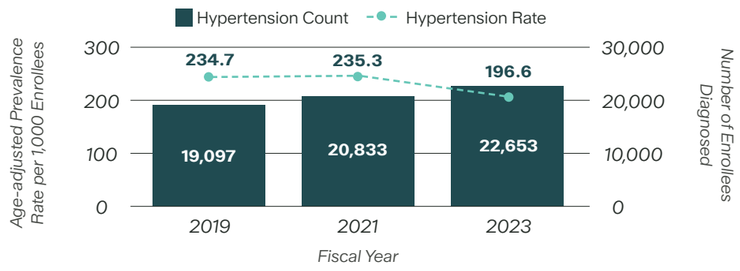
The overall age-adjusted prevalence of hypertension in Central Health enrollees was 19.7%, or 196.6 cases per 1,000 enrollees. Advanced modeling techniques were used to explore what factors were most likely to influence an enrollee being diagnosed with a chronic condition.[1] For example, Black enrollees had a 27.7% higher probability of a hypertension diagnosis. Factors that increased the probability of diagnosis have a positive percentage in the chart below, whereas factors that decrease the probability of diagnosis have a negative percentage.

Factors Linked with Hypertension Diagnosis: *Demographics, Focus Area, and Utilization*

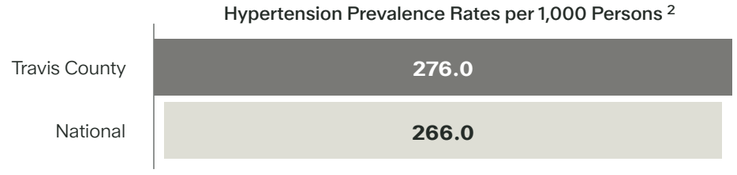
Impact of Selected Factors on Increased/Decreased Probability of Diagnosis: Hypertension *(statistically significant results in **red**)*



Hypertension Diagnosis Changes Over Time



In Context: Local and National Comparisons



It's important to note that data for Central Health enrollees are not directly comparable to the broader population. Central Health enrollees are by definition lower income, and differences in disease experience are documented in this report. There are also methodological differences in how Central Health calculates these rates compared to national and county calculations. For further exploration of these differences, please see the appendix.

Taking action across the continuum of care

In addition to contracting with local health care providers, Central Health launched an array of direct practice specialty services starting in FY22. Additionally, there are many cross-cutting interventions (e.g., case management) that apply to all conditions. Condition-specific interventions for hypertension are listed below.

LEVERAGE POINT	SPECIFIC INTERVENTION
Preventative Care	▸ Nutrition and Healthy Cooking classes
Community/Outpatient Care	▸ Medication management ▸ Blood pressure cuffs provided through clinics
Alternatives to Acute Care	▸ Remote patient monitoring
Acute/Hospital Care	
Post-acute care	

Information Gaps

Based on the Travis County prevalence for high blood pressure, we estimate that we are diagnosing 7 in 10 enrollees with that condition. This is encouraging, as managing high blood pressure is key to preventing many chronic conditions including kidney and heart problems. We know from research that the chronic stress related to poverty, housing insecurity, and food insecurity can affect both the risk of hypertension and the likelihood of seeking care.

Possible underdiagnosis factors may include access issues (e.g., clinical hours conflict with working hours), lack of active symptoms of hypertension, and low health literacy.

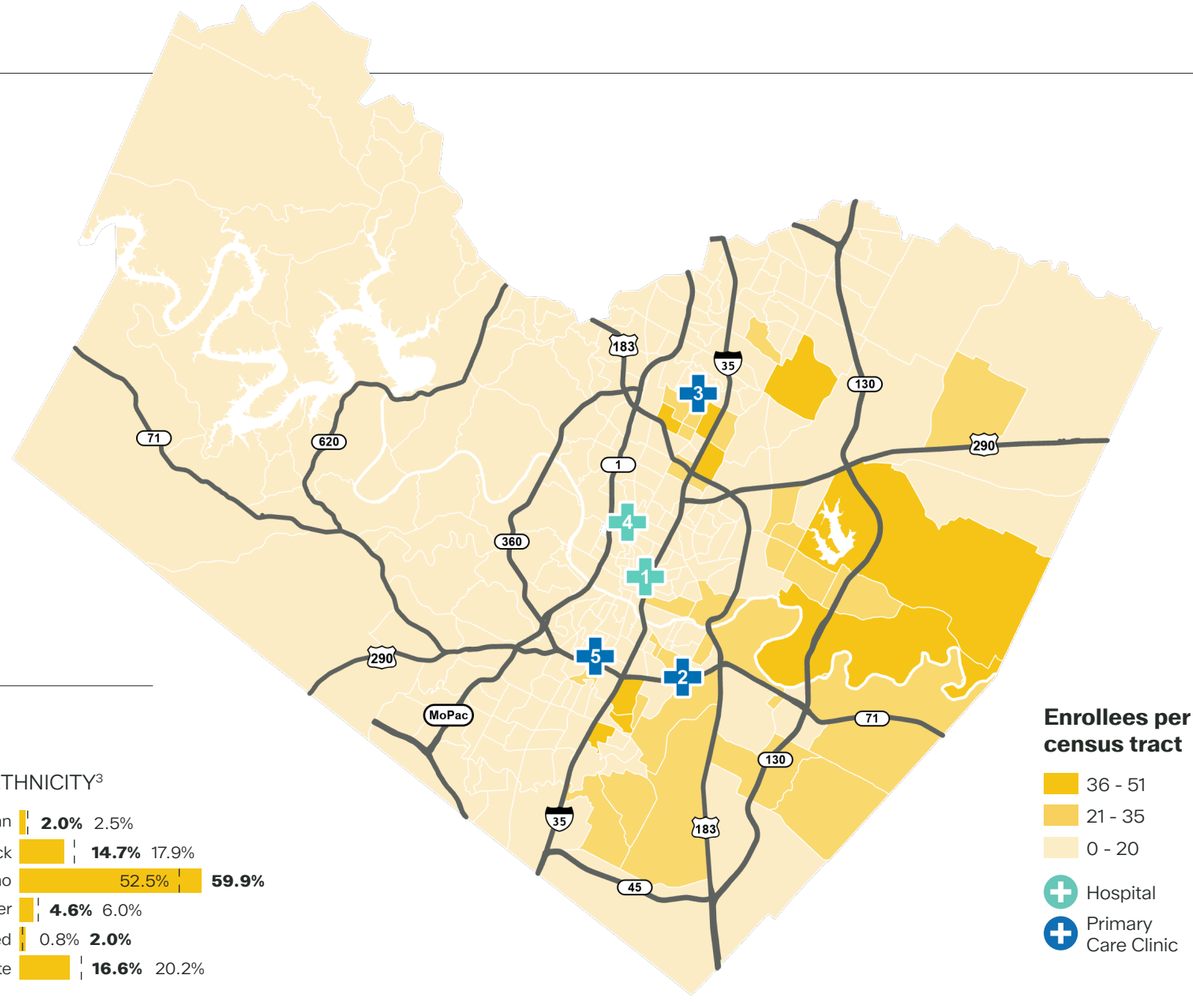
[1] *For additional methodology details, see appendix.* [2] *Local and national data sourced from CDC BRFSS 2022*

Renal Failure (Kidney Failure)

Total Central Health enrollees diagnosed[1] with chronic condition: **3,516**
(All data are from fiscal year 2023)

Top 5 provider locations visited by enrollees with a renal failure diagnosis[2]

		Number of visits in FY21	FY23
1	Dell Seton Medical Center at The University of Texas	3,268	**8,481**
2	Central Health Southeast Health & Wellness Center	2,670	**4,210**
3	CUC North Central	2,662	**3,825**
4	Ascension Seton Medical Center Austin	2,057	**3,770**
5	CUC Care Connections Clinic	1,125	**1,377**



Demographics of central health enrollees with a renal failure diagnosis

FY21 | **FY23**

AGE

	FY21	FY23
<18	*%	**1.9%**
18-44	27.6%	**28.6%**
45-64	**53.9%**	57.3%
65+	*%	**15.6%**

LANGUAGE

	FY21	FY23
English	**53.6%**	61.0%
Other	**1.3%**	2.4%
Spanish	35.1%	**42.9%**
Unreported	1.5%	**2.2%**

SEX

FY21	FY23
33.6%	**66.4%**
30.2%	69.8%
Female	Male

RACE/ETHNICITY[3]

	FY21	FY23
Asian	**2.0%**	2.5%
Black	**14.7%**	17.9%
Latino	52.5%	**59.9%**
Other	**4.6%**	6.0%
Unreported	0.8%	**2.0%**
White	**16.6%**	20.2%

Renal failure equity index by race/ethnicity[3] and focus area

The Equity Index is a ratio of the observed prevalence rate to the expected prevalence rate (the all-enrollee rate) among Central Health's enrollees. A value less than 1.0 indicates lower risk compared to the all-enrollee rate. A value more than 1.0 indicates higher risk compared to the all-enrollee rate. This Equity Index, as applied to these age-adjusted prevalence rates, gives us an indication of which subgroups may be experiencing a health inequity.

Asian	Black	Latino	Other	Unreported	White
0.6	1.6	1.0	0.8	0.5	1.4

East Central Austin	East Central Travis County	Manor	North Central Austin	Northeast Austin	Northeast Travis County	Oak Hill	South Central Austin	Southeast Austin
1.1	0.8	0.7	0.9	1.0	0.8	0.9	1.1	0.9

Compared to the overall Central Health population in Travis County, Black enrollees were 60% more likely to have a renal failure diagnosis in FY23, and White enrollees were 40% more likely. Asian and unreported race/ethnicity enrollees were 40% and 50% less likely to have a renal failure diagnosis respectively.

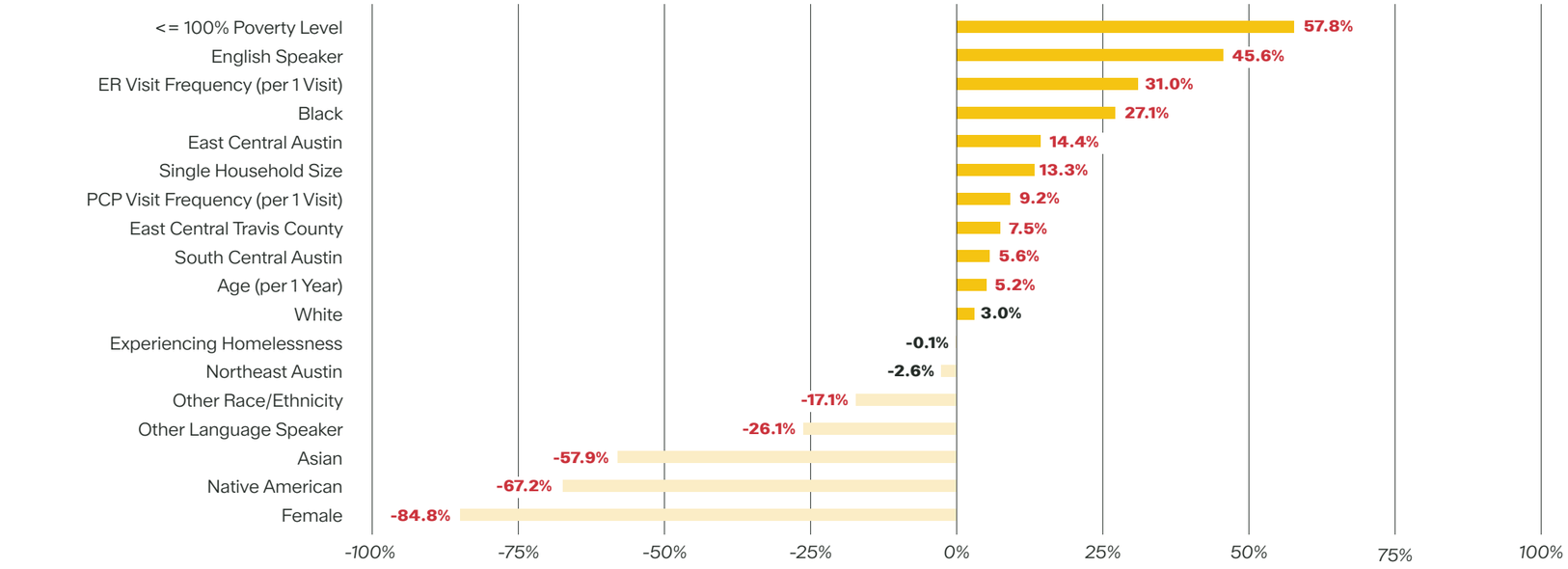
[1] Patients are identified as those who were enrolled in MAP, MAP Basic, SFS, or CHAP in FY2023 and had received a chronic condition diagnosis any time during or prior to FY2023. [2] Data were pulled from the Central Health enterprise analytics encounter database for all primary care, inpatient, and emergency department visits to Central Health provider network locations for patients identified as having the chronic conditions. [3] Central Health race and ethnicity counts are combined. * Data suppressed to maintain privacy standards.

Renal Failure: Diagnosis and Care

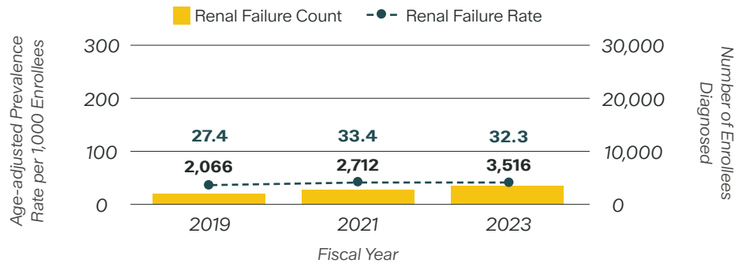
The overall age-adjusted prevalence of renal failure in Central Health enrollees was 3.2%, or 32.3 cases per 1,000 enrollees. Advanced modeling techniques were used to explore what factors were most likely to influence an enrollee being diagnosed with a chronic condition.[1] For example, people enrolled in MAP at or below 100% of the federal poverty level were 57.8% more likely to have a diagnosis of renal failure. Factors that increased the probability of diagnosis have a positive percentage in the chart below, whereas factors that decrease the probability of diagnosis have a negative percentage.

Factors Linked with Renal Failure Diagnosis: *Demographics, Focus Area, and Utilization*

Impact of Selected Factors on Increased/Decreased Probability of Diagnosis: Renal Failure *(statistically significant results in **red**)*



Renal Failure Diagnosis Changes Over Time



In Context: Local and National Comparisons

Renal Failure Prevalence Rates per 1,000 Persons [2]

Travis County	N/A
National	14.0

It's important to note that data for Central Health enrollees are not directly comparable to the broader population. Central Health enrollees are by definition lower income, and differences in disease experience are documented in this report. There are also methodological differences in how Central Health calculates these rates compared to national and county calculations. For further exploration of these differences, please see the appendix.

[1] *For additional methodology details, see appendix.* [2] *National data sourced from CDC, 2023*

Taking action across the continuum of care

In addition to contracting with local health care providers, Central Health launched an array of direct practice specialty services starting in FY22. Additionally, there are many cross-cutting interventions (e.g., case management) that apply to all conditions. Condition-specific interventions for renal failure are listed below.

LEVERAGE POINT	SPECIFIC INTERVENTION
Preventative Care	Nutrition and Healthy Cooking classes
Community/Outpatient Care	Direct practice nephrology services
Alternatives to Acute Care	Dialysis services, including peritoneal dialysis at home
Acute/Hospital Care	Kidney transplant access through Sendero Vascular access procedures for dialysis
Post-acute care	ESRD-specific palliative care

Spotlight on End Stage Renal Disease

ESRD, or End-Stage Renal Disease, is the final stage of chronic kidney disease (CKD). At this stage, the kidneys are no longer able to function adequately to meet the body's needs. ESRD typically occurs when kidney function is reduced to less than 10–15% of normal.

- **Total cases:** 310
- **Overall Prevalence:** 0.27% (2.7/1,000 persons)
- **National Prevalence: 0.23%**
- **Disparities:**
  - Residents of South Central Austin were most likely (8%), a 190% excess.
  - Latino enrollees had a 20% excess.

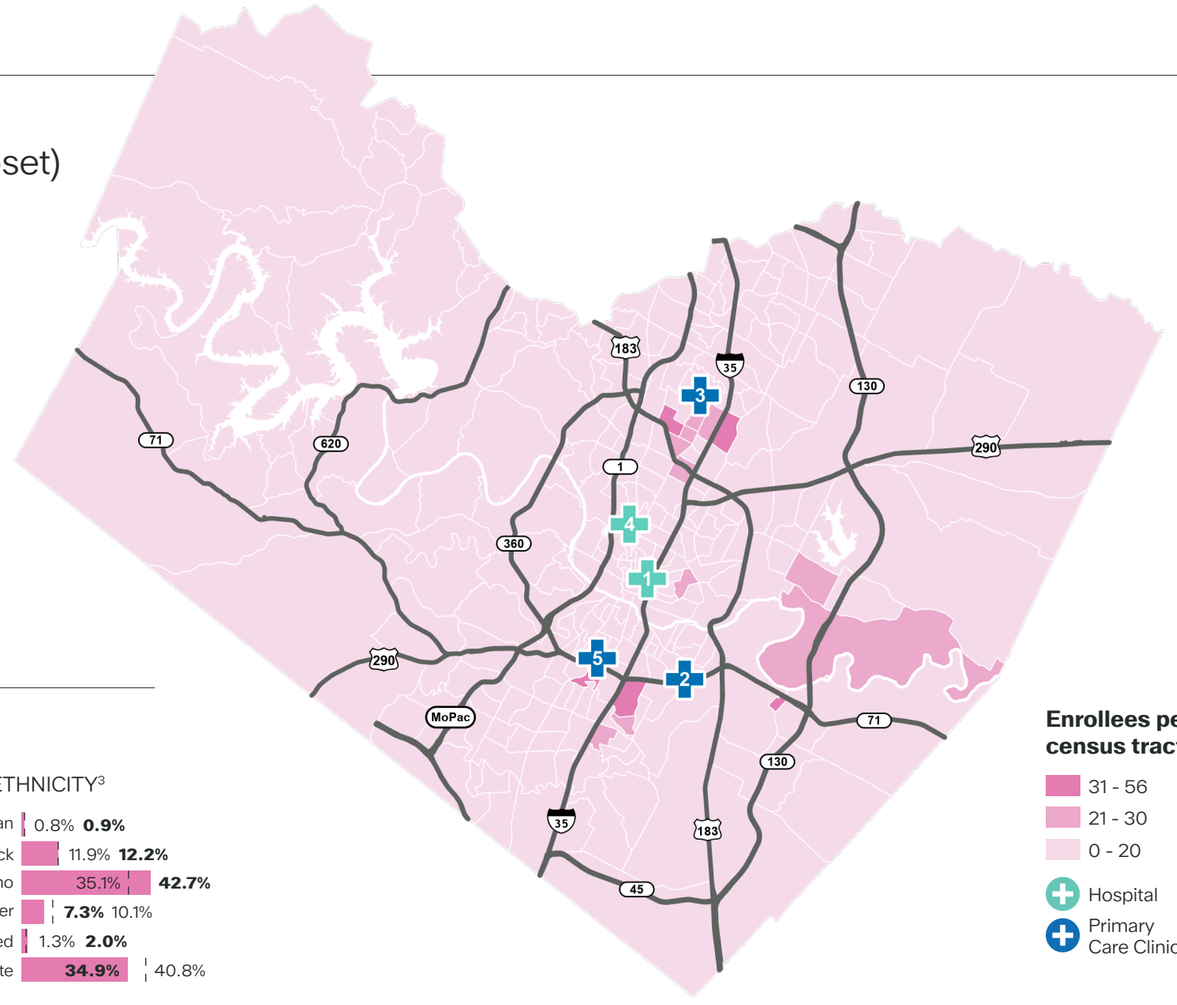
Central Health is diagnosing more than twice as many end-stage renal disease and renal failure cases than would be expected, but caution is warranted due to the very small numbers of cases. The addition of a nephrology direct care service line served to increase the number of previously undiagnosed cases.

Substance Use Disorder (Behavioral Health Subset)

Total Central Health enrollees diagnosed[1] with chronic condition: **3,972**
(All data are from fiscal year 2023)

Top 5 provider locations visited by enrollees with a SUD diagnosis[2]

		Number of visits in FY21	FY23
1	Dell Seton Medical Center at The University of Texas	3,819	**5,862**
2	Central Health Southeast Health & Wellness Center	3,751	**4,054**
3	CUC North Central	1,637	**2,095**
4	Ascension Seton Medical Center Austin	1,412	**1,785**
5	CUC Care Connections Clinic	742	**1,119**



Demographics of central health enrollees with a SUD diagnosis

FY21 | **FY23**

AGE

	FY21	FY23
<18	*%	***%**
18-44	**48.6%**	51.9%
45-64	46.2%	**47.8%**
65+	*%	***%**

LANGUAGE

	FY21	FY23
English	**80.7%**	85.3%
Other	0.4%	**0.5%**
Spanish	11.9%	**17.0%**
Unreported	**1.8%**	2.4%

SEX

FY21	FY23
33.6%	**66.4%**
31.8%	68.2%
Female	Male

RACE/ETHNICITY[3]

	FY21	FY23
Asian	0.8%	**0.9%**
Black	11.9%	**12.2%**
Latino	35.1%	**42.7%**
Other	**7.3%**	10.1%
Unreported	1.3%	**2.0%**
White	**34.9%**	40.8%

SUD equity index by race/ethnicity[3] and focus area

The Equity Index is a ratio of the observed prevalence rate to the expected prevalence rate (the all-enrollee rate) among Central Health's enrollees. A value less than 1.0 indicates lower risk compared to the all-enrollee rate. A value more than 1.0 indicates higher risk compared to the all-enrollee rate. This Equity Index, as applied to these age-adjusted prevalence rates, gives us an indication of which subgroups may be experiencing a health inequity. Statistically significant figures have been highlighted in yellow.

Asian	Black	Latino	Other	Unreported	White
0.4	1.9	0.6	1.1	0.4	3.5

East Central Austin	East Central Travis County	Manor	North Central Austin	Northeast Austin	Northeast Travis County	Oak Hill	South Central Austin	Southeast Austin
1.0	0.4	0.3	0.6	0.5	0.3	0.4	0.9	0.8

Compared to the overall Central Health population in Travis County, White enrollees were 250% more likely and Black enrollees were 90% more likely to have a SUD diagnosis in FY23. Enrollees residing in Manor and Northeast Travis County were 70% less likely to have a SUD diagnosis in FY23.

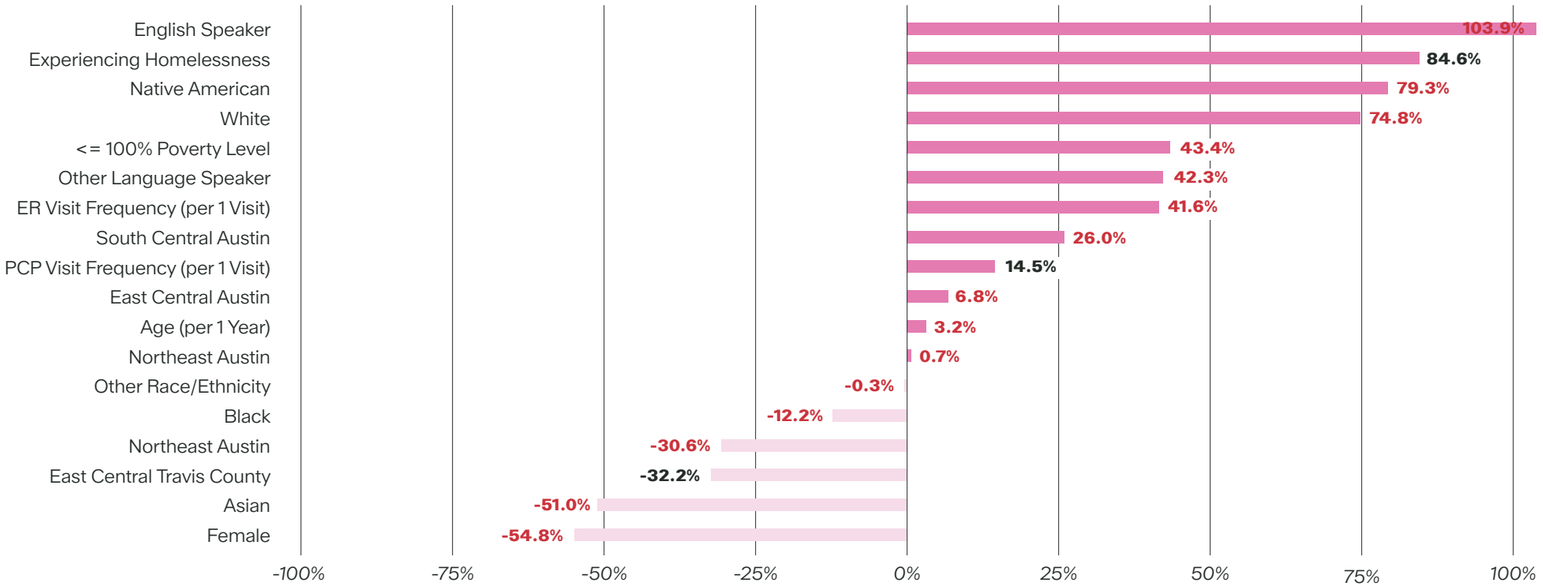
[1] Patients are identified as those who were enrolled in MAP, MAP Basic, SFS, or CHAP in FY2023 and had received a chronic condition diagnosis any time during or prior to FY2023. [2] Data were pulled from the Central Health enterprise analytics encounter database for all primary care, inpatient, and emergency department visits to Central Health provider network locations for patients identified as having the chronic conditions. [3] Central Health race and ethnicity counts are combined. * Data suppressed to maintain privacy standards.

Substance Use Disorder (SUD): Diagnosis and Care

The overall age-adjusted prevalence of substance use disorders in Central Health enrollees was 2.7%, or 26.6 cases per 1,000 enrollees. Advanced modeling techniques were used to explore what factors were most likely to influence an enrollee being diagnosed with a chronic condition.[1] For example, persons whose preferred language was English had a 103.9% higher probability of a substance use disorder diagnosis. Factors that increased the probability of diagnosis have a positive percentage in the chart below, whereas factors that decrease the probability of diagnosis have a negative percentage.

Factors Linked with Substance Use Disorder Diagnosis: *Demographics, Focus Area, and Utilization*

Impact of Selected Factors on Increased/Decreased Probability of Diagnosis: Substance Use Disorder *(statistically significant results in **red**)*



Substance Use Disorder Diagnosis Changes Over Time

2023 is the first year that SUD has been included in these analyses. Central Health will continue to monitor and report on substance use disorders and report on trends as more data become available.

In Context: Local and National Comparisons

Substance Use Disorder Prevalence Rates per 1,000 Persons [2]

Travis County	N/A
National	77.4

It's important to note that data for Central Health enrollees are not directly comparable to the broader population. Central Health enrollees are by definition lower income, and differences in disease experience are documented in this report. There are also methodological differences in how Central Health calculates these rates compared to national and county calculations. For further exploration of these differences, please see the appendix.

Taking action across the continuum of care

In addition to contracting with local health care providers, Central Health launched an array of direct practice specialty services starting in FY22. Additionally, there are many cross-cutting interventions (e.g., case management) that apply to all conditions. Condition-specific interventions for substance use disorder are listed below.

LEVERAGE POINT	SPECIFIC INTERVENTION
Preventative Care	▸ Vaccinations for respiratory conditions ▸ Smoking cessation
Community/Outpatient Care	▸ Counseling services at clinics
Alternatives to Acute Care	▸ Naloxone (Narcan) distribution and education ▸ Sobering Center partnership ▸ Medication-assisted therapy ▸ Methadone treatment
Acute/Hospital Care	
Post-acute care	▸ Medical respite

Information Gaps

Central Health enrollees are diagnosed for SUD at 1/3 the national rate. However, given the large fraction of enrollees who are Latino and the very low rates of SUD diagnoses in that population, this is not entirely unexpected. The highest rates of SUD were White enrollees and/or persons experiencing homelessness.

Factors driving this underdiagnosis include legal and social stigma to reporting substance use, persistent socioeconomic stress, and a lack of sufficient mental health providers in the county. A recent internal analysis by Central Health found that the ratio of people to mental health in Travis County was 0.0037 (equivalent to one provider for every 270 people), with a drug overdose crude death rate of 48.7/100,000 people.

[1] *For additional methodology details, see appendix.* [2] *National data sourced from Adult Prevalence of Mental Illness (AMI), 2022*

Chronic Condition Conclusions

This section provided an explanation of the in-depth analyses staff conducted to explore the chronic health conditions experience among Central Health enrollees, highlighting patterns of disease prevalence, inequity, and disparities across demographic groups and geographic focus areas. Further, we were able to identify the most important factors driving the disparities for each condition and identify areas of opportunity for the future.

Chronic conditions such as cardiovascular disease, hypertension, diabetes, behavioral health issues, and substance use disorders significantly affect a large portion of our population. Diseases of the heart are the most common, with 1 in 4 enrollees with a diagnosis of cardiovascular disease and 1 in 5 enrollees with hypertension (high blood pressure). Although Central Health has made strides in expanding care, important gaps in diagnosis and access remain, particularly for vulnerable populations. The next section summarizes the key themes and supporting findings related to chronic conditions.

Key Findings

The fiscal year 2023 analysis of chronic conditions shows big differences in health risks among Central Health's enrolled population. The following are key findings identified in this analysis:

1. **Higher Risks for Vulnerable Groups:** The results show that the unhoused populations were at increased risk for 6 of the 12 conditions studied, with 3.6 times the risk for diagnosis with substance use disorders (SUD), twice the risk of other behavioral health issues, kidney failure, and chronic obstructive pulmonary disease, plus increased risks for heart failure and asthma. Overall, the unhoused had a 20% excess of chronic conditions when compared to all enrollees. These risks for this population were much higher than the county average. Older patients were at higher risk than younger patients across all conditions, and living alone was a risk factor for all conditions except hypertension and diabetes. Black enrollees were also found to have an excess prevalence of multiple conditions, notably cardiovascular disease, hypertension, and asthma.
    - **Key Finding**: People experiencing homelessness face very high risks for SUD, Behavioral Health issues, and Kidney Failure.
    - **Key Finding**: Black enrollees had excess risks for diagnosis for most conditions studied, including 110% excess in Asthma, 70% excess for behavioral health, 90% excess for SUDs, 60% excesses for both heart and renal failure, and 30% excesses for cardiovascular disease and COPD. Black enrollees face the greatest disparities of any race/ethnicity group studied.
2. **Healthier Spanish-speaking population:** On average, enrollees who preferred Spanish were younger, healthier, more likely to visit a primary care provider, and less likely to have a hospital encounter. They had lower overall rates of chronic conditions, even after adjusting for age, utilization, and many other factors.
3. **Significant Geographic Differences Exist:** Even after adjusting for the age of the enrollees, some areas of the county still show unique health trends. South Central Austin stands out as a focus area with an overall 20% excess prevalence of chronic conditions, including statistically significant increases in stroke and end-stage renal disease (ESRD). The residents of this focus area had increased probability of diagnosis for 9 of the 12 conditions studied, including statistically significant increases in stroke (70% higher risk) and high blood pressure (20% higher risk). For end stage renal disease, residents of South Central Austin were 190% more likely to have this diagnosis. Conversely, areas like Manor and Northeast Travis County have lower rates of SUD diagnoses but higher rates of heart failure. These data show the need for health programs that focus on specific groups and areas to close health gaps and improve care for everyone in Travis County.
    - **Key Finding:** Overall, who you are mattered more than where you live. Race/ethnicity features, as well as experiencing homelessness, overall produced larger effects on the predicted probabilities of receiving diagnoses of the different condition groups than the focus areas. Only East Central Austin, South Central Austin, Northeast Austin, and East Central Travis County had statistically significant changes in probability, and only for a smaller subset of diseases.
    - **Key Finding:** East Central Austin and South Central Austin were associated with a 20-28% increase in probability for cardiovascular disease, hypertension, and diabetes.
    - **Key Finding:** Northeast Austin and East Central Travis County were associated with lower probabilities of behavioral health diagnoses.
    - **Key Finding**: South Central Austin has higher rates of Stroke and High Blood Pressure.
    - **Key Finding**: Manor and Northeast Travis County show lower SUD rates, which could offer lessons for prevention.
4. **Persistent Disparities:** Differences were greater across race/ethnicity groups than across geographic focus areas. Black enrollees were also the only racial group with an excess for 9 out of 12 conditions and faced the greatest excesses of chronic conditions high risks for conditions like Asthma, Heart Failure, and SUD. Overall, black enrollees had a 40% excess of diagnoses for chronic conditions compared to other enrollees. This remains consistent with findings in the previous demographic report. Racial and ethnic disparities point to the need for culturally tailored care to address gaps in outcomes. Addressing systemic inequities is critical for improving care for underserved groups.
    - **Key Finding**: English as preferred language was the single most predictive factor for having received a diagnosis for several conditions, including: Substance Use Disorder, Behavioral Health, Asthma, COPD, Heart Failure, and English-speaking was associated with an increased likelihood of diagnosis for all conditions, except for cancer and diabetes.

- **Key Finding**: We found that the observed decreased risk for Spanish speakers was attributable to a younger, healthier, and less socially isolated population. They also had a higher probability of seeing a primary care provider and were less likely to have an emergency room visit. Even with this utilization pattern, the decrease in risk for chronic conditions remained.
- **Key Finding**: Differences in health outcomes across racial and ethnic groups show the need for culturally appropriate care.
- **Key Finding**: Black and White enrollees overall were associated with the highest probabilities of diagnoses, but for different conditions.
    - For Black enrollees: Asthma, Heart Failure, and Renal Failure
    - For White enrollees: SUD, behavioral health and COPD
- **Key Finding:** Our enrollees in the lowest income bracket (MAP members earning less than 100% of the Federal Poverty Level) had an increased probability of diagnosis for all conditions. MAP (as opposed to MAP Basic) as the most common enrollment was associated with higher likelihood of diagnosis in all cases. Since MAP enrollment is connected to income, this higher likelihood also reflects the effect of being at the lowest income levels.
- **Key Finding:** Stark gender differences in likelihood of diagnosis were observed across different condition groups:
    - Males were more likely to have the following conditions: CVD, diabetes, heart failure, hypertension, renal failure, and substance use disorders.
    - Females were more likely to have the following conditions: Asthma, behavioral health, cancers, and COPD.

5. **Behavioral Health Disparities are the Most Significant:** Behavioral health issues and substance use disorders exhibit the most pronounced disparities. White enrollees and unhoused individuals face disproportionately higher rates of these conditions, suggesting targeted outreach and support are necessary. White enrollees show 253% higher SUD rates and 98% higher Behavioral Health rates. South Central Austin had a notable concentration of Behavioral Health cases. Enrollees experiencing homelessness face 362% higher rates of SUD and 128% higher rates of Behavioral Health issues compared to the county average.
6. **Information Gaps:** Based on comparisons with state and national data, we can estimate how much chronic disease we may be missing in our enrollee data. These data gaps help us understand how much of the proverbial "iceberg" we are seeing in the utilization and diagnosis data, and where we may be missing cases of chronic conditions that exist but have not yet been diagnosed. For example, the prevalence rate for Cancers (which notably excludes skin cancer) in Central Health enrollees is only 20-30% of what we should expect to see based on U.S. and Texas cancer prevalence rates – 18.6/1,000 for Central Health enrollees versus 65/1,000 for Travis County residents (source: CDC Behavioral Risk Factor Surveillance System, Travis County Metropolitan Statistical Area 2022). Central Health has an opportunity to enhance data collection and analysis as more clinical information becomes available. These gaps may be attributed to access issues, cultural and language barriers, and care-seeking behaviors

    - **Key Finding**: Likely significantly underdiagnosing asthma (47%), behavioral health (58%), cancers (29%), COPD (56%), strokes (42%), and substance use disorders (34%).
    - **Key Finding**: Likely somewhat underdiagnosing hypertension (71%).

Addressing disparities in chronic health conditions is essential to improving health equity, reducing health care costs, and enhancing the quality of life for Central Health enrollees. This report underscores the need for tailored, community-specific interventions that account for demographic disparities and geographic differences. Key next steps include:

1. **Expanding Access to Care:** Increasing the availability of preventive and specialty services, particularly in areas and populations with higher disease burdens, such as South Central Austin and the unhoused population.
2. **Targeted Outreach and Education**: Designing culturally tailored programs that address barriers to care for racial and ethnic minorities, particularly Black and Latino enrollees. This includes language-appropriate outreach and services that accommodate working individuals who may not be able to access care during traditional hours.
3. **Behavioral Health and SUD Focus**: Given the high disparities in behavioral health and substance use disorders, targeted investments in mental health services, counseling, and SUD prevention are critical. Collaboration with community partners and enhancing access to treatment can help address this gap.
4. **Enhancing Data Collection:** To close information gaps, Central Health should continue to strengthen data collection efforts and explore innovative ways to identify undiagnosed conditions. Regular monitoring and reporting will be critical in evaluating the impact of interventions and ensuring accountability.

In conclusion, while the FY23 analysis highlights significant disparities, it also provides a clear road map for action. By focusing on equity, enhancing access to care, and addressing information gaps, Central Health can continue its mission of improving health outcomes for Travis County's most vulnerable residents.


Monick
Administrative Supervisor

Special Populations

In fiscal year 2023, over ten-thousand Central Health enrollees reported experiencing homelessness at least once during the fiscal year. This section of the report provides additional information about the cohort of enrollees who are unhoused as well as those who are Medical Respite patients and enrollees who are part of the CHAP Expansion initiative.

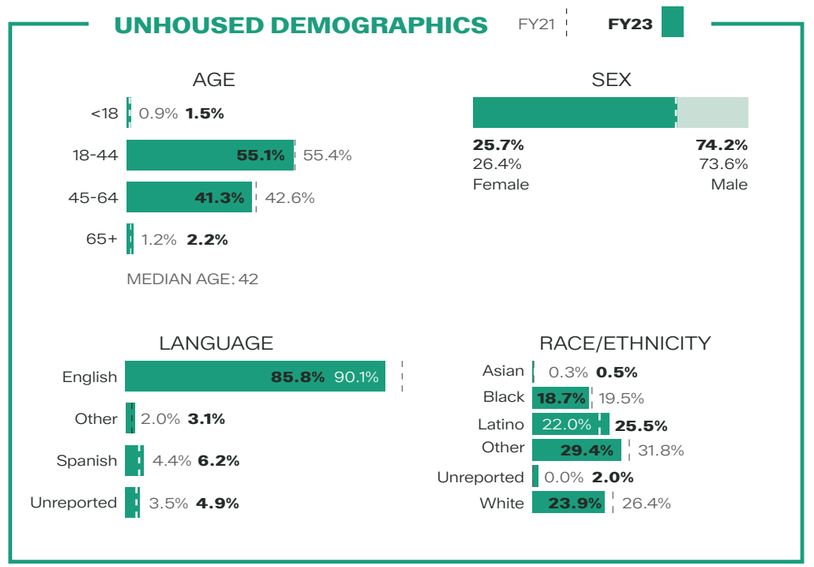
Unhoused Population

Developing an accurate assessment of how many Travis County residents are experiencing homelessness at a given time is a complex task. In Fiscal Year 2023 (FY23) Central Health enrolled 10,615 self-reported unhoused residents into its MAP and MAP Basic programs. This count can include people in sheltered or unsheltered environments, ranging from living on the streets or sleeping in cars to "couch surfing" with friends or relatives. The total measurement of need varies by source; according to the Ending Community Homelessness Coalition's (ECHO) most recent Point in Time (PIT) count in Austin, at least 6,235 people experienced homelessness on a single night in May 2024 [1]. However, the local Homelessness Response System served more than twice that number (15,007 individuals) between September 2023 and August 2024, with needs ranging from supportive services to permanent supportive housing placement for those experiencing homelessness[2]. These estimates vary by time and order of magnitude, and are likely an underestimate of the true need.

To help address this critical issue in our community, Central Health works diligently with community partners to ensure there is broad access to quality health care for Travis County residents experiencing homelessness. Of the 119,103 Central Health enrollees in FY23, 10,615 (8.9%) persons experienced homelessness at some point that year. This represents an increase of 14% from the 9,303 unhoused persons discussed in the previous version of this report (FY22).

Demographics

A total of 10,615 enrolled MAP or MAP Basic members experienced homelessness in FY23. The overwhelming majority were male (74.2%) and preferred English (85.8%). In terms of age distribution, unhoused members tended to be older overall and were less likely to be under the age of 18 or over the age of 65 years when compared to the broader population of enrollees. No single race/ethnicity category represented a majority of the population; 29.4% were 'Other' race/ethnicity, 25.6% were Latino, 23.9% were White, and 18.7% were Black. These percentages greatly exceed each group's share of the total enrolled population, with the greatest disparities in relative risk experienced by Other race/ethnicity groups (366% more likely), Black enrollees (240% more likely), White enrollees (195% more likely), and males (57% more likely). All these differences were statistically significant. These findings align with broader patterns of chronic disease disparities and highlight the disproportionate impact of homelessness among Black enrollees.



Chronic Conditions

People experiencing homelessness have higher rates of chronic disease, increased risk of premature death and often have difficulty accessing health care due to lack of transportation, lack of insurance and high costs[3]. A recent analysis of mortality data for the unhoused by ECHO (Bridging for Better Outcomes, January 2025) found that the unhoused lived 20 fewer years than did their housed counterparts.[4] Overall, enrollees experiencing homelessness were at 16% increased risk for any chronic condition, with fifty-two percent (52%) of unhoused enrollees having at least one chronic condition diagnosed in the previous three years. On average, each member experiencing homelessness had 2.7 chronic conditions diagnosed while the overall population had an average of 2.5 chronic conditions. While this difference may seem small, in practical terms it means that the unhoused are generally more medically complex and require care coordination across multiple specialties.

In FY23, the most prevalent chronic conditions among unhoused enrollees were behavioral health diagnoses followed by cardiovascular disease, hypertension, and substance use disorders.

1. **Behavioral Health** (261.3 per 1,000 persons)
2. **Cardiovascular Disease** (232.0 per 1,000 persons)
3. **Hypertension** (195.4 per 1,000 persons)
4. **Substance Use Disorders** (122.6 per 1,000 persons)

Age-adjusted prevalence of behavioral health, substance use disorders, and renal failure among enrollees experiencing homelessness are 2-4 times the rate observed among Central Health enrollees overall. Rates of chronic respiratory illness (e.g., COPD and asthma) were also higher for unhoused members – 110% higher for COPD and 70% higher for asthma. Living outdoors or in overcrowded shelters increases exposure to cold, damp, and polluted air, which can exacerbate respiratory conditions. However, prevalence rates of diabetes and cancer were 20% and 10% lower than the overall enrollee population, respectively.

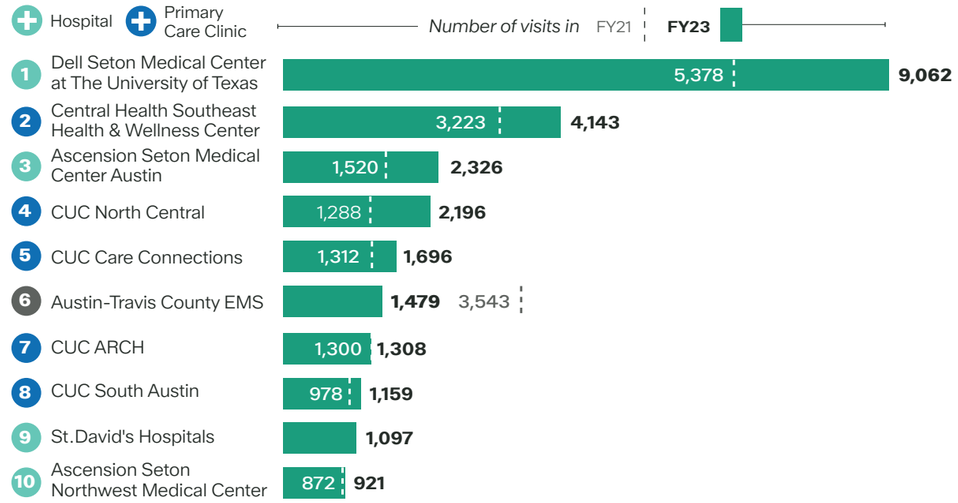
[1] Ending Community Homelessness Coalition. (n.d.). Homelessness in Austin. Austin ECHO. Retrieved February 10, 2025, from https://www.austinecho.org/about-echo/homelessness-in-austin/ [2] Ending Community Homelessness Coalition. (n.d.). Homelessness response system dashboard. Austin ECHO. Retrieved February 10, 2025, from https://echoatx.github.io/hrs-dashboard-site/ [3] National Healthcare for the Homeless Council. (2019). Homelessness & Health: What's the Connection? [Fact Sheet]. https://nhchc.org/wp-content/uploads/2019/08/homelessness-and-health.pdf [4] Fraher and Attri, 2025. ECHO, Bridging for Better Outcomes, January 2025.

Utilization

52% of enrollees experiencing homelessness sought health care in FY23, resulting in over 35,000 encounters. The average utilization per person was higher for the unhoused (i.e., 6 vs 5 average visits per person per year) and were more than twice as likely to have those encounters at a hospital and/or emergency room compared to all enrollees - 46.% vs 22.6% of utilizers with ED Visit, a relative risk of 2.03. Of the nearly 300 post-acute admissions to Skilled Nursing Facilities in FY23, 53% were for unhoused patients highlighting the medical complexity and recovery needs of this population. Unhoused patients also demonstrated high reliance on emergency services like Austin/Travis County EMS relative to the overall population (4.2% of total unhoused utilization versus 0.5% overall, relative risk: 8.3), with a smaller share of unhoused patients engaging in primary or specialty care (66% of unhoused utilizers having a primary care visit versus 77% overall; 18.6% of unhoused utilizers accessing specialty care compared to 22.6% of overall).

Top service locations of note for unhoused patients include Dell Seton Medical Center at UT in a dominating first position with over 9,000 total encounters; CommUnityCare (CUC) Care Connections Clinic and CUC ARCH facilities which provide care to unhoused patients on a walk-in basis and without need of a referral; St. Davids Hospitals with a high proportion of total encounters among unhoused patients (25% of all encounters among unhoused patients; 3.1% of total unhoused utilization versus 1.1% overall; relative risk: 2.8).

Top 10 provider locations visited by unhoused enrollees



Medical Respite Care

Medical Respite is acute and post-acute medical care for people experiencing homelessness who are too ill or frail to recover from illness or injury on the street or in a shelter. Central Health's Medical Respite program had a total of 227 admissions (197 patients) in FY 2023 and FY 2024. This program started with a capacity of 10 beds and has since expanded to 25 beds across three facility locations, with more planned in the future.

Central Health's Medical Respite program uniquely offers admission to patients at all points of care (hospital, skilled nursing facility, primary care, community partners), in contrast to most respite program models that are limited to hospital discharges only. Referral sources for Central Health's Medical Respite program have been phased in over time, starting with Skilled Nursing Facilities and later expanding to CommUnityCare (CUC) Federally-qualified health care center (FQHC) locations and Ascension Hospital locations.

Patients were admitted to Medical Respite for myriad reasons, such as recovering from skin infections or wounds, body trauma or bone fractures, after outpatient surgery, and for other complex medical needs as appropriate. In addition to the immediate concerns addressed by respite care, patients also present with high rates of co-morbid chronic conditions when compared to the unhoused population at large.

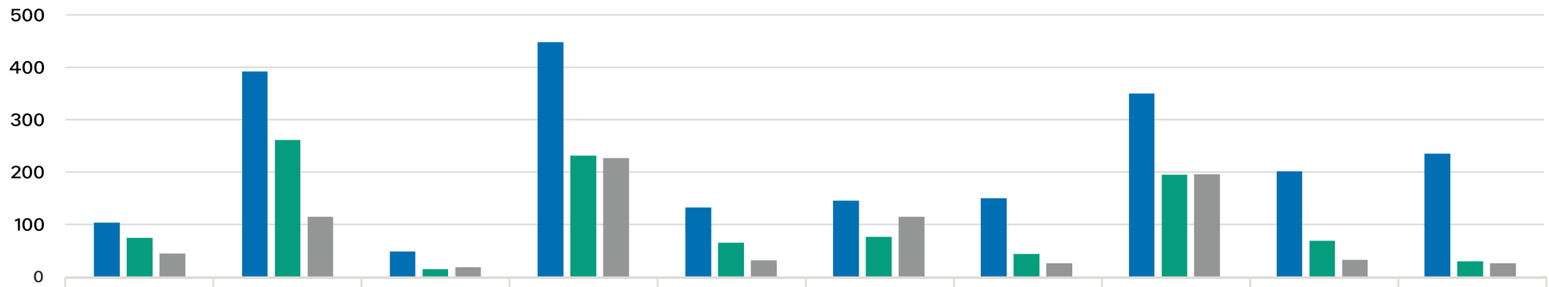
The gender distribution of respite patients mirrors that of the unhoused population, approximately 75% male and 25% female. Respite patients were notably older, with a median age 10 years greater than the broader group of unhoused enrollees. The racial and ethnic composition is similar between Black and Hispanic respite patients compared to the broader unhoused enrollee population (23.9% vs 19% Black; 25% vs 25% Hispanic). White patients are overrepresented (41% vs 24%). Of note, a significant number of individuals among the overall unhoused population categorize themselves as 'Other' race/ethnicity (29%) which may impact the accuracy of this comparison.

Greg, Central Health coverage program member and former medical respite patient

Medical Respite Chronic Conditions

The Medical Respite program illustrates Central Health's innovative approach to bridging gaps in care for unhoused individuals with acute and chronic medical needs. Patients admitted to the program exhibited significantly higher rates of chronic conditions such as cancer, cardiovascular disease, behavioral health issues, and renal failure, compared to both the overall unhoused population and the general enrollee population. With its expansion from 10 to 25 beds and the inclusion of diverse referral sources, the program provided critical recovery and care coordination services, both supporting patients and increasing access to needed services. These targeted efforts highlight the importance of sustained investment in health care access and equity for individuals experiencing homelessness.

AGE-ADJUSTED RATES OF CHRONIC CONDITIONS AMONG MEDICAL RESPITE PATIENTS, UNHOUSED ENROLLEES, AND ALL CENTRAL HEALTH ENROLLEES PER 1,000 ENROLLEES



	Asthma	Behavioral Health	Cancer	CVD	COPD	Diabetes	Heart Failure	Hypertension	Renal Failure	SUDs
Medical Respite Prevalence	103.5	392.1	48.3	448.2	132.6	145.4	150.0	350.8	201.9	235.8
Unhoused Prevalence	74.4	261.3	14.9	232.0	65.8	76.4	43.6	195.4	68.0	122.6
All Enrollees Prevalence	44.8	114.7	18.6	227.2	31.5	115.1	26.3	196.6	32.3	26.6

Unhoused Population Conclusion

These data highlight the significant health care challenges faced by Travis County residents experiencing homelessness and the critical role Central Health plays in addressing these needs. In FY23, 8.9% of individuals enrolled in MAP or MAP Basic reported being unhoused. This population, which skews older, faces disproportionate barriers to health and wellness, including high rates of chronic conditions and limited access to care. Central Health's initiatives, including partnerships with specialized facilities and the Medical Respite program, provide vital services for this vulnerable group. Despite these efforts, the data underscore persistent disparities, particularly among racial and ethnic groups, as well as the increased medical complexity of the unhoused population.

The Medical Respite program illustrates Central Health's innovative approach to bridging gaps in care for unhoused individuals with acute and chronic medical needs. Patients admitted to the program exhibited significantly higher rates of chronic conditions such as cancer, cardiovascular disease, behavioral health issues, and renal failure, compared to both the overall unhoused population and the general enrollee population. With its expansion from 10 to 25 beds and the inclusion of diverse referral sources, the program provided critical recovery and care coordination services, both supporting patients and increasing access to needed services. These targeted efforts highlight the importance of sustained investment in health care access and equity for individuals experiencing homelessness.

Key Findings

Population Characteristics: In FY23, 10,615 MAP or MAP Basic enrollees were unhoused, with males and English speakers overrepresented. Racial and ethnic disparities in persons experiencing homelessness were highest among Other Race/Ethnicity, Black, and White enrollees.

- **Chronic Conditions:** Unhoused individuals face a 60% increased risk of chronic conditions, with an average of 2.7 conditions per person. Behavioral health issues, cardiovascular disease, and substance use disorders are particularly prevalent.
- **Health Care Utilization:** The unhoused population utilized health care services at higher rates in FY23, with over 35,000 encounters. They were twice as likely to use hospital and emergency room services compared to all enrollees.
- **Medical Respite Program:** The Medical Respite program expanded to 25 beds, addressing acute recovery needs for 197 patients in FY23 and FY24. Respite patients exhibited 2-4 times higher rates of disease across all chronic conditions when compared to other unhoused enrollees.
- **Barriers to Care:** High reliance on emergency services and lower engagement with primary or specialty care highlight persistent access barriers and the need for integrated care solutions tailored to the unhoused population.

CHAP Expansion

For some of the most ill and medically complex enrollees, it is better to transition coverage from MAP/MAP BASIC to a subsidized traditional insurance plan. This small cohort is typically around 800 people. The Central Health Assistance Program (CHAP) Expansion initiative provides comprehensive insurance coverage through a platinum off-exchange insurance plan administered by Enterprise partner Sendero Health Plans. This program specifically supports eligible MAP and MAP Basic members with significant health care needs. Expansion enrollment occurs annually, with outreach to interested and qualified members taking place in November and December; coverage for the new plan year begins each January. Key enrollment insights include:

- **Enrollment Trends:** A little over ¼ of the CHAP members were new to CHAP in 2023 (26.1%), while about half had been enrolled since 2021 or earlier (52.3%). Most members joined the program before 2023.
- **Chronic Conditions:** The vast majority of CHAP-Expansion members (91.4%) live with one or more chronic conditions, with an average of 3.5 chronic conditions per member. Disease prevalence is high across all conditions with rates 2 times or more than the overall enrollee population. Substance Use Disorders were the one exception with a rate of 17.9 per 1,000 persons vs 26.6 per 1,000 persons; Relative Risk (RR): 0.67. Conditions with particularly high prevalence compared to overall enrollees include cancer (RR: 14.9), cardiovascular diseases – heart failure (RR: 4.8), stroke (RR: 6.4), and renal failure (RR: 6.2). [1]

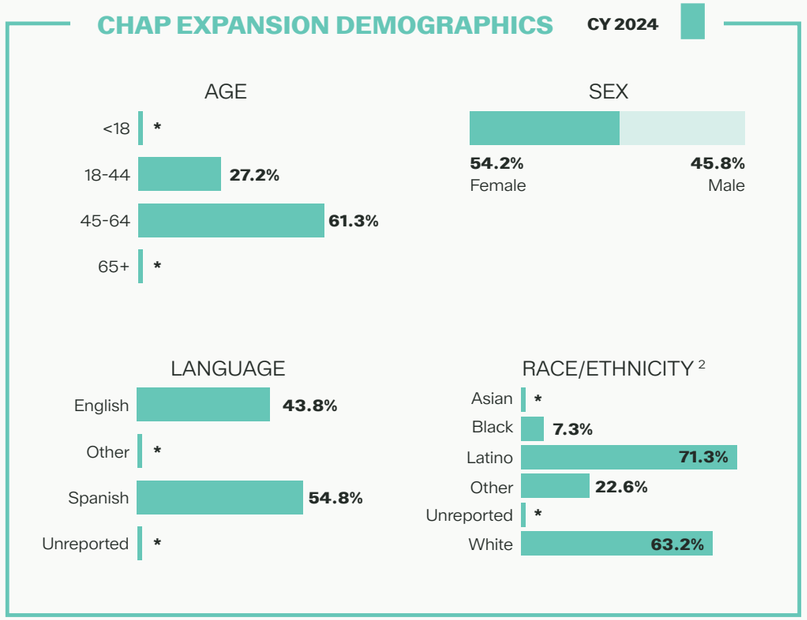
CHAP Expansion 2023 Members by Program Enrollment Year

Year	Number of Members	Percent of All Members
2019	91	11.3%
2020	179	22.2%
2021	151	18.7%
2022	174	21.6%
2023	211	26.2%
Total	806	100%

Demographics

In 2023, a total of 806 members were enrolled in the CHAP Expansion program. CHAP Expansion members represent a diverse demographic group, with notable characteristics including:

- **Age:** A majority of members are aged 45-64 years (61.3%) and members on average are older than the total enrolled population.
- **Ethnicity and Race:** A majority of members (71.3%) identify as Hispanic, Latino/a/x, or of Spanish origin. Most members identify as White (63.2%), while 22.6% identify as being of more than one racial group or some other race, and 7.3% identify as Black or African American.
- **Gender and Language:** A slightly higher proportion of members are female (54.2%), and primarily speak Spanish (54.8%).



Utilization

Members of the CHAP-Expansion program demonstrate high utilization of primary care services, driven by efforts from care management staff to connect members with trusted primary care providers (PCPs) who meet their specific needs. [3] Key findings include:

- **PCP Utilization:** In 2023, approximately 80% of members utilized primary care services, a rate that is 45% higher compared to Sendero Health Plan members not receiving subsidies from Central Health [3].
- **Primary Care Providers:** CommUnityCare Health Centers (CUC) system continues to serve the largest number and proportion of CHAP Expansion members, consistent with previous years [3].
- Hospital utilization among CHAP-Expansion members is high, reflecting the significant burden of complex diseases treated within this population.
- Life-saving transplants and related treatment are provided to members that would otherwise not have access to these services, including liver, kidney, bone marrow (stem cell), and CAR T-cell therapy. Since 2019, 157 transplant procedures have been performed for CHAP Expansion members. [4] This program supports a large unaddressed need among the Central Health population of patients -- in contrast, over the same time period, only 4 regular self-pay members from all of Sendero's other membership combined required a transplant. A total of 7 members have been evaluated and placed by their clinical teams on a transplant waiting list.

*[1] Based on historical utilization as a Sendero member [2] Ethnicity and race are two separate categories for total population counts, but have been combined in the charts [3] Sendero NCQA Population Assessment, 2023 [4] As of Q3 2024 * Data suppressed to maintain privacy standards.*


Our Mission
By caring for those who need it most, Central Health improves the health of our community.
OUTGOING USPS
STAMPED MAIL

Conclusion

Conclusion

Overview

Travis County is changing, and the population Central Health serves is changing as well. Increases in the cost of living, particularly housing, are leading to large-scale shifts in population and income distribution across the county, with concentrated areas of poverty along the I-35 corridor beginning to shift toward the western and eastern halves of the county. Through this demographic report, Central Health demonstrates its commitment to understanding how the characteristics of the safety-net population in Travis County are changing in order to meet existing and emergent needs for those Central Health is honored to serve. Focus areas are identified in this report and analyzed to compare demographics, social determinants of health, access, enrollment, utilization, and chronic conditions.

+ **THEME 1:**
  Your Background Impacts Your Health
+ **THEME 2:**
  Where You Live Impacts Your Health
+ **THEME 3:**
  Service Growth is Meeting Needs
+ **THEME 4:**
  Understand Implications and Opportunities

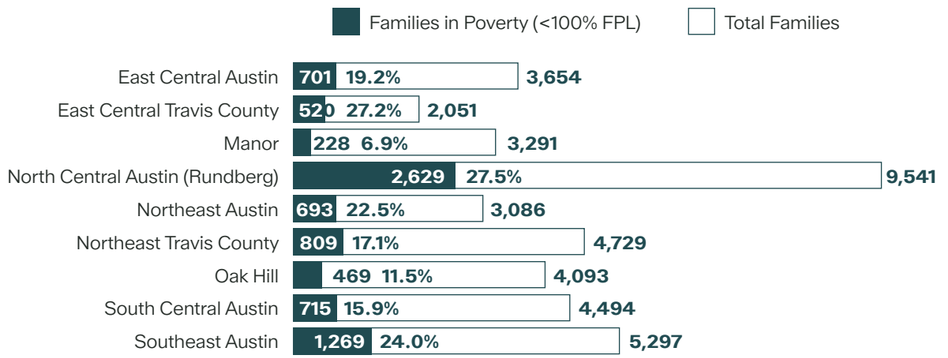
Central Health is proud to present this report to the public and is committed to the vision of Central Texas as a model healthy community. This report was developed in alignment with the Service Delivery Strategic Plan, with expanded analyses of chronic conditions and health equity; a deeper look at the needs of patients experiencing homelessness; the CHAP-Expansion program; and shared geospatial analyses at a higher level of granularity than was ever possible before. These findings will:

- Inform ongoing planning and implementation,
- Establish benchmarks for measuring improvements to care,
- Validate the effects of investments in enrollment, access to care, and emergency department utilization,
- Ensure transparency into the assessment of needs of the patient population, and
- Improve the understanding of the social determinants of health in areas projected to have high and moderately high levels of poverty in the near future.

Poverty, Enrollment, & Utilization

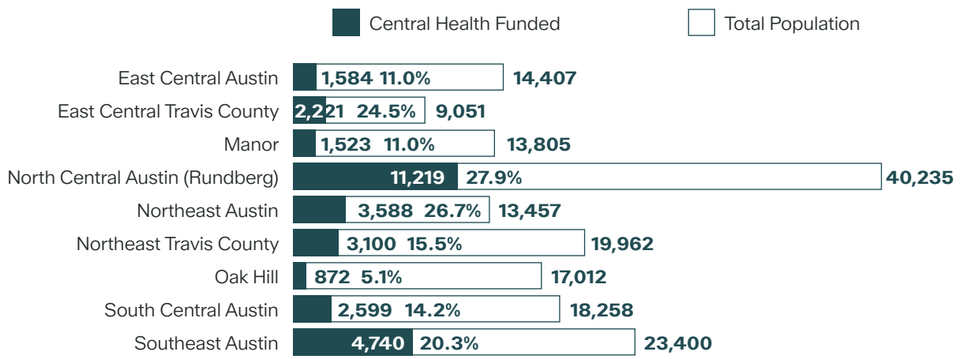
FAMILIES IN POVERTY

In 2024, there were 23,812 families in poverty in Travis County, an increase of 167 families since the 2022 report. 20% of families living in the focus areas identified in this report live at or below the poverty threshold, versus 7.4% in Travis County. North Central Austin (Rundberg) has the highest count and percentage of families living in poverty among focus areas. By 2029, it is projected that an additional 1,777 families will be living at or below 100% of the Federal Poverty Level (FPL) in Travis County.



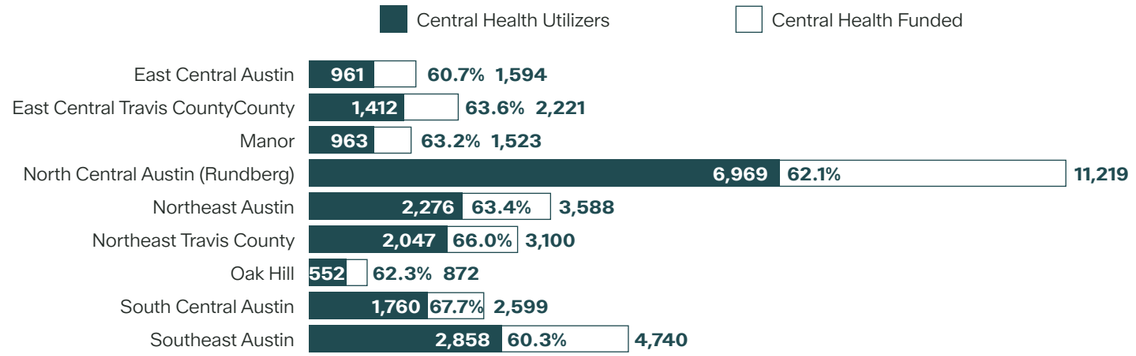
CENTRAL HEALTH ENROLLEES

In FY 2023, 1 in 12 Travis County residents were enrolled in MAP, MAP Basic, local SFS programs, or CHAP, a 7.2 percent increase since FY 2021. In contrast, more than 1 in 6 residents in the focus areas identified in this report were enrolled in Central Health-funded programs. Between FY21 and FY23, enrollment in focus areas has increased by 13.3 percent. As of FY23, over half of enrollees are between the ages of 18 and 44, most speak Spanish, the majority of enrollees are female, and almost 3 out of 4 enrollees are Latino.



CENTRAL HEALTH UTILIZERS

In Travis County, 62.3% of those who were enrolled during FY2023 utilized services, an increase of 6.3% since FY2021. This rate is slightly below the combined focus area utilization rate (63.4%). South Central Austin had the highest utilization out of all focus areas (67.7%) and the highest specialty care utilization (25.9%). Southeast Austin had the lowest utilization rate (60.3%) out of the nine focus areas. Older enrollees have a higher proportion of visits than younger enrollees. There is also slightly higher than expected utilization by enrollees experiencing homelessness; Asian, Black, Latino, and White enrollees; English and Spanish speakers; and female enrollees. Geographically, enrollees will seek care at nearby providers, but frequently the same locations show up in the top locations, which could be occurring for a variety of reasons.



Chronic Conditions

Chronic conditions are widespread and negatively impact a person's health. People living with these conditions often face challenges in managing their medical conditions, visiting specialists, and maintaining their health through medications and lifestyle changes.This analysis found that 36% of Central Health's patient population – that's 43,025 people - had a diagnosis of at least one of these conditions in the past three years. Of those with at least one of the 12 chronic condition diagnoses analyzed in this report, the average enrollee had 2.5 chronic conditions to manage. For the unhoused, the situation was worse (52.6% and 2.7 conditions per person average, and a statistically significant excess of renal failure).

Comparing age-adjusted prevalence rates for the Central Health patient population, the top four chronic conditions included in this report were cardiovascular disease (227.2 per 1,000 persons), hypertension (196.6 per 1,000 persons), diabetes (115.1 per 1,000 persons), and behavioral health (114.7 per 1,000 persons), Asthma, renal failure, COPD, SUD, heart failure, cancer, stroke, and ESRD followed. However, it should be noted that prevalence alone does not speak to the significance of any condition on those affected – for example, cancer often has serious health consequences and life disruptions, despite it being less prevalent than CVD or hypertension.

The distribution of these conditions in the population was examined across two dimensions – demography and geography. Demographic differences were generally larger than geographic differences. The rates for each race/ethnicity subgrouping were also considered and compared to the overall rate at the county level. People experiencing homelessness had a 60% excess of chronic conditions, with especially high risk for SUD, behavioral health issues, and renal failure. Black enrollees had the greatest inequities, with excesses of disease for nine of the twelve chronic conditions. Geographically, the rates for each condition were considered by focus area and compared to the overall rate for all Central Health patients in Travis County. The South Central Austin focus area in particular had 30% excess disease prevalence for nine of the twelve conditions assessed, with statistically significant increased risk of stroke (70%) and hypertension (20%). Manor and Northeast Travis County had lower rates of SUD but higher rates of heart failure.

Taken together, this information provides Central Health leadership and the community with key data on the following:

1. **The burden of disease in the community,**
2. **Measurable health inequities for enrollees with chronic conditions,**
3. **How individual factors (such as age, utilization) increase the risk of diagnosis for enrollees,**
4. **Where inequities are most acute in the areas projected to have the greatest poverty within five years, and**
5. **Where operational focus, community engagement, and outreach efforts should be directed.**

Central Health has made great strides in building up the capacity to serve these communities, particularly with the under-construction clinics in East Travis County and the renovation of the Rosewood Zaragosa site into a multi-disciplinary specialty care facility. The information and analyses in this report will help to guide continued improvements to the safety net health care system in Travis County to help ensure Central Health achieves its mission of caring for those who need it most to improve the health of our community.

Focus Areas

Focus areas – census tracts where poverty is projected to be most concentrated in 2029 – have geographically shifted since the 2022 Demographic Report, indicating that poverty is becoming more dispersed throughout the county. These areas are characterized by higher proportions of individuals identifying as Latino, Black, or Other, and lower proportions of Asian and White individuals, relative to the Travis County population.

EAST CENTRAL AUSTIN

East Central Austin's percentage of families in poverty (19.2%) is more than twice that of Travis County overall (7.4 %). Enrollees in this focus area are predominantly in the age range of 18-44 (49.1%), Spanish speaking (46.9 %), female (57.5%), and Latino (66.4%). While it has the third-lowest utilization rate (60.7%) and count of enrollees in Central Health-funded programs (1,584), between FY21 and FY23 the number of health care visits by enrollees increased by 20%, despite a 3.1% decrease in enrollees. East Central Austin had the highest rate of utilizers with ED visits (26.5%). Overall, enrollees living in this focus area were about as likely to have a diagnosis for one of more of the chronic conditions explored in this report when compared to all enrollees. Notable characteristics of East Central Austin include that it has the highest percentage of housing units without vehicles (11.3%) but also has the highest number of bus routes among focus areas (19).

EAST CENTRAL TRAVIS COUNTY

East Central Travis County's percentage of families in poverty (27.2%) is more than three times that of Travis County overall (7.4%). Enrollees in this focus area are predominantly in the age range of 18-44 (55.6%), Spanish speaking (67.8%), female (56.2%), and Latino (87.7%). One in four East Central Travis County residents were enrolled in a Central Health-funded program, with a 13.6% increase in the count of enrollees since FY21. In FY23, 63.3% of enrollees utilized services, a 39% increase from FY21. Overall, enrollees living in this focus area were 10% less likely to have a diagnosis for one or more of the chronic conditions explored in this report when compared to all enrollees. Notable characteristics of East Central Travis County include that it has lowest median home value ($173,966) which can partially be attributed to this focus area having the largest percentage of mobile homes as housing units (31.9%).

MANOR

Manor's percentage of families in poverty (6.9%) is lower than that of Travis County overall (7.4%). Enrollees in this focus are predominantly in the age range of 18-44 (50.4%) Spanish speaking (57.4%), female (57.9%) and Latino (71.3%). Enrollment in Central Health programs has increased 14.4% since FY21, with one in nine residents enrolled in FY23. Manor had the highest proportion of utilizers who visited a primary care physician (84.0%) and the lowest proportion of utilizers that had a visit in an Emergency Department (ED) (14.4%). Overall, Manor enrollees were about 20% less likely to have a diagnosis for one of the chronic conditions of and had a statistically significant 70% lower likelihood of having a substance use disorder diagnosis. Notably, when compared with the total population of other focus areas, Manor had the highest percentage of Black residents (24.6%), the highest percentage of married or cohabiting couples (75.4%) and households with children (54.3%). Manor also had the highest median rent ($1,968), but no affordable housing units or developments and zero bus routes or bus stops.

NORTH CENTRAL AUSTIN (RUNDBERG)

North Central Austin (Rundberg)'s percentage of families in poverty (27.5%) is more than three times that of Travis County overall (7.4%) and has the highest percent and count (2,629) of families in poverty among the focus areas, despite the lowest population growth since 2020. Enrollees in this focus area are predominantly in the age range of 18-44 (54.6%), Spanish speaking (79.4%), female (54.2%) and Latino (86.7%). Enrollment in Central Health programs has increased 13.9% since FY21, with one in four residents enrolled in FY23. North Central Austin (Rundberg) had the highest count (11,219) of enrollees among the focus areas. Between FY21 and FY23, health care utilization among enrollees increased by 28.1%, to 62.1%. Overall, enrollees in this focus area were about as likely to have a diagnosis of one or more chronic conditions. Compared with other focus areas, North Central Austin (Rundberg) had the lowest median household income ($48,280), the lowest median rent ($1,137), and the highest number of bus stops and transit hubs (107).

NORTHEAST AUSTIN

Northeast Austin's percentage of families in poverty (22.5%) is more than three times that of Travis County overall (7.4%). Enrollees in this focus area are predominantly in the age range of 18-44 (55.3%), Spanish speaking (80.9%), female (55.4%) and Latino (87.2%). Enrollment in Central Health programs has increased 12.8% since FY21, with one in four residents enrolled in FY23 and the third-highest count (3,588) of enrollees among focus areas. Between FY21 and FY23, health care utilization among enrollees increased by 39.7%, to 63.4%. Overall, enrollees in this focus area were about as likely as the total enrolled population to have a diagnosis of one or more chronic conditions.

Notably, about one in five people in Northeast Austin population overall work in the construction industry, and the focus area contains the Norwood Transit Center transit hub.

NORTHEAST TRAVIS COUNTY

Northeast Travis County's percentage of families in poverty (17.1%) is more than twice that of Travis County overall (7.4%). Enrollees in this focus area are predominantly in the age range of 18-44 (53%t), Spanish speaking (68.2%), female (56.5%) and Latino (79.2%). Enrollment in Central Health programs has increased 20.6% since FY21, with one in seven residents enrolled in FY23. Between FY21 and FY23, health care utilization among enrollees increased from 52%, to 66%. Enrollees in this focus area had a statistically significant 70% lower likelihood of having a substance use disorder diagnosis. Notably, Northeast Travis County's population overall had the highest percentage of Other Language speakers (17.8%) and the highest percentage of Asian residents (17.8%) when compared to other

Focus Areas

focus areas. Overall, enrollees in this focus area were about as likely as the total enrolled population to have a diagnosis of one or more chronic conditions.

OAK HILL

Oak Hill's percentage of families in poverty (11.5%) is higher than that of Travis County overall (7.4%). Enrollees in this focus area are predominantly in the age range of 18-44 (50.5 %), Spanish speaking (77.1%), female (55.4%) and Latino (85.3 %). Enrollment in Central Health programs has decreased 1.5% since FY21, with one in twenty residents enrolled in FY23 – the lowest count (872) and proportion of enrollees of all the focus areas. Between FY21 and FY23, health care utilization among enrollees increased by 22.5%, to 63.3%. Oak Hill enrollees were about as likely to have a diagnosis for one of the chronic conditions of interest. When compared to the overall populations of other focus areas, Oak Hill has the highest percentages of people ages 45-64 (26.2%) and 65+ (12.7%), residents whose preferred language was English (73.5%), and White residents (67.9%). The focus area also had the highest median household income ($120,895) and home values ($775,681). Oak Hill had the lowest percentages of Latino residents (23.7 percent), and housing units without vehicles (1.1%). For those without vehicles, there were zero bus routes or bus stops.

SOUTH CENTRAL AUSTIN

South Central Austin's percentage of families in poverty (15.9%) is more than twice as high as Travis County overall (7.4%). Enrollees in this focus area are predominantly in the age range of 18-44 (44.6%), Spanish speaking (65.7%), female (55.3%) and Latino (84%). Enrollment in Central Health programs has decreased 6.1% since FY21, with one in seven residents enrolled in FY23. Between FY21 and FY23, health care utilization among enrollees increased by 12.8%, to 67.7%, the highest percentage of enrollees utilizing services across all focus areas. South Central Austin enrollees had the highest specialty care utilization (25.9%). Overall, enrollees in South Central Austin had the highest geographic disparity, having a 30% increased probability of diagnosis for one or more of the chronic conditions. Enrollees in this focus area had a statistically significant higher likelihood of having a hypertension diagnosis.

SOUTHEAST AUSTIN

Southeast Austin's percentage of families in poverty (24%) is more than three times as high as Travis County overall (7.4%). Enrollees in this focus area are predominantly in the age range of 18-44 (57%), Spanish speaking (71.6%), female (54.2%) and Latino (82.8%). Enrollment in Central Health programs has increased 31.9% since FY21, with one in five residents enrolled in FY23. Between FY21 and FY23, health care utilization among enrollees increased by 42.6%, to 60.3%, the lowest percentage of enrollees utilizing services across all focus areas. South Central Austin enrollees had the highest specialty care utilization (25.9%). Overall, enrollees in Southeast Austin were 20% less likely to have a diagnosis for one or more of the chronic conditions. None of the chronic condition rates included in the analysis were in excess compared to the overall Central Health enrolled population. Other notable characteristics of Southeast Austin include that the overall population of the focus area, when compared to other focus areas, has the highest percentage of people ages 18-44 (57.6%) and the lowest percentage of both married or cohabiting couples (30.3%) and households with children (17.0%).

Homelessness

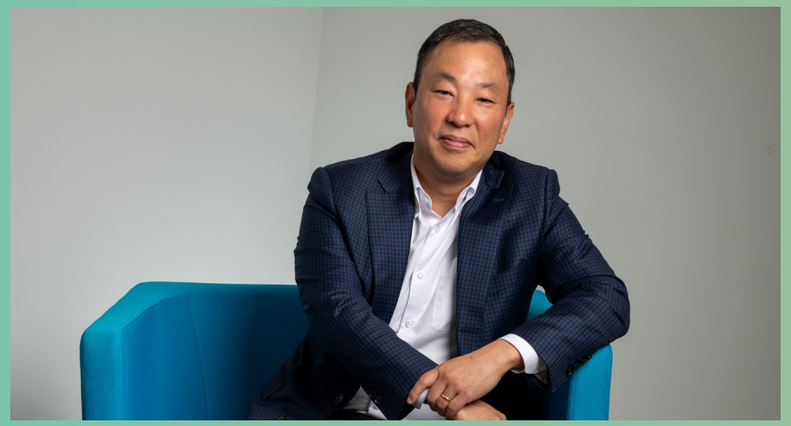
In FY2023, 8.9% of Central Health's enrolled population experienced homelessness. Homelessness increases the risk of disease and death and can make accessing health care difficult. Central Health enrollees experiencing homelessness had on average a greater number of co-morbid conditions and higher rates of chronic conditions than the overall enrolled population, including behavioral health, SUD, and renal failure. They also utilized hospital and emergency room services at twice the rate of the enrollee population at large. Unhoused utilizers also demonstrated higher rates of health care use overall with an average of six encounters per year compared to an average of five encounters for the total enrolled population. Health care for people experiencing homelessness is critical as delays or lapses in care can lead to worse health outcomes. Homelessness is disproportionately experienced by individuals identifying as Other Race/Ethnicity (4.7x more likely), Black (3.4x), or White (3.0x).

MEDICAL RESPITE

The Medical Respite program illustrates Central Health's innovative approach to bridging gaps in care for unhoused individuals with acute and chronic medical needs. Between FY 23 and FY4, the Medical Respite program expanded to 25 beds and addressed the acute recovery needs of 197 patients. Medical Respite patients exhibited significantly higher rates of chronic conditions such as cancer, cardiovascular disease, behavioral health issues, and renal failure, compared to both the overall unhoused population and the general enrollee population.

CHAP Expansion

The CHAP Expansion program serves some of the most medically complex enrollees, providing comprehensive coverage to those transitioning from MAP or MAP Basic to a subsidized platinum insurance plan through Sendero Health Plans. In 2023, 806 individuals were enrolled, with key demographic trends highlighting an aging and diverse population: over 70% are older than 45, 71.3% identify as Hispanic, Latino/a/x, or of Spanish origin, and 63.2% identify as White. The majority are female (54.2%) and primarily Spanish-speaking (54.8%). Reflecting their medical complexity, 91.4% of CHAP Expansion enrollees manage at least one chronic condition, with an average of 3.5 per member. These members demonstrate high engagement with healthcare services—primary care utilization is 45% higher than among Sendero members not receiving Central Health subsidies, with most care provided through CommUnityCare Health Centers. This program provides services that support the needs of patients including life-saving transplants and related treatment to members that would otherwise not have access.



Appendix

Appendix

Methodology 1: Chronic Condition Terminology

This section provides additional technical details underlying our analyses, as well as more detailed tables and supporting charts and figures that go beyond the narrative in the report above.

PREVALENCE RATES

Prevalence rates tell us how common a health condition is in a specific group of people. These rates are usually reported as the number of cases per 1,000 enrollees. For example, a prevalence rate of 100 per 1,000 means that 10% of the group has the condition. By comparing prevalence rates, we can see which groups or areas have higher or lower risks for certain illnesses. This information helps health organizations like Central Health focus resources where they are needed most and develop programs to prevent and treat chronic conditions.

RELATIVE RISK/RATE RATIO

Rates can be compared directly to each other to understand their relationship. A relative risk, also called a rate ratio, is the result of dividing one rate by another to see how comparable they are. For example. If Group A has a rate of 10 and Group B has a rate of 20, the rate ratio for Group A is 10 / 20 = ½, or 50%. Group A is at half the risk of Group B. Note that this says nothing about the magnitude of the risk, just the ratio. For this report, we use relative risk applied to standardized rates to help us compare the experience of our race/ethnicity and focus area groupings. The result is what we call our Equity Index.

AGE-ADJUSTMENT USING DIRECT STANDARDIZATION

Age is the single biggest confounder that modifies a person's risk of diagnosis for a chronic condition. All else being equal, a younger population will experience less chronic disease. As such, it's important when comparing the prevalence rates for any two groups that we control for the effects of differences in age distribution. To do this, we:

1. Stratified enrollees by age into ten age groups (<5 years, 5-14 yrs, 15-24 yrs, 25-34 yrs, 35-44 yrs, 45-54 yrs, 55-64 yrs, 65-74 yrs, 75-84 yrs, and 85+ yrs). This gave us a count by age group and subgroup (in this case, race/ethnicity). These were our denominators.
2. Next, we divided the number of diagnosed cases of each chronic condition in each age group bucket for each race/ethnicity group by the total number of people in that subgroup and multiply the answer by 1,000.
3. Then, we applied an adjustment factor, or weighting, to the subgroup strata rates based on some standard population. For this report, we used the U.S. Census Population from 2000 (as we have previously).
4. Finally, we added all 10 age stratum rates together to get the age-adjusted prevalence rate.
    - For populations with a greater number of older enrollees, this will adjust the rates lower.
    - For populations with a greater number of younger enrollees, this will adjust the rates higher.
        - The Latino enrollee population was significantly younger and healthier than other subgroups. Without age-adjustment, we would be underestimating the chronic disease experience of these enrollees.

Table 1: Age-adjustment table with U.S. Standard Population, by race/ethnicity.

Table 1 shows the age-adjustment that was performed with Fiscal Year 2023 enrollment data for the chronic conditions section of the Demographic Report.

Group	Age Group	U.S. 2000 Population Projection (thousands)	Weight	Asian	Black	Latino	Unreported	White	Other Race/ Ethnicity	Total
1	<5 years	18,987	0.069135	17	51	1,852	176	55	83	2,234
2	5 - 14 Years	39,977	0.145565	104	170	9,631	580	200	274	10,959
3	15 - 24 Years	38,077	0.138646	206	385	11,982	831	623	848	14,875
4	25 - 34 Years	37,233	0.135573	437	1,295	17,456	1,245	2,003	2,284	23,720
5	35 - 44 Years	44,659	0.162613	493	1,473	19,197	1,250	2,282	1,962	26,657
6	45 - 54 Years	37,030	0.134834	417	1,298	14,756	937	1,897	1,057	20,362
7	55 - 64 Years	23,961	0.087247	381	1,445	8,089	550	1,973	616	13,054
8	65 - 74 Years	18,136	0.066037	366	368	2,796	232	480	237	4,479
9	75 - 84 Years	12,315	0.044842	203	69	830	80	68	86	1,336
10	85 Years and Over	4,259	0.015508	63	11	302	16	16	19	427
				2,587	6,565	86,891	5,897	9,597	7,466	**119,103**
				2.3%	5.5%	73.0%	5.0%	8.1%	6.3%	100.0%

Methodology 2: Significance Testing

This section provides additional details about significance testing and how it is utilized in this report.

Statistical significance testing helps us decide if a result is likely due to something meaningful or just random chance. For example, if you're testing a new medication, you want to know if it genuinely works better than a placebo, not just because of random variation. At the **95% confidence level**, we are saying, "If we repeated this experiment 100 times, we'd expect the result to fall in the same range 95 times." In other words, there's a 5% chance that the observed result happened purely by chance.

Z Scores and How They Fit In: The Z score is a tool we use to measure how far a data point is from the average (mean), expressed in standard deviations. It helps us determine whether our results are statistically significant.

1. Calculating the Z Score:
    - Formula: Z = (Observed value - Expected value) / Standard error
    - The Z score tells us how many standard deviations our result is away from what we'd expect under normal conditions.

2. Using the 95% Confidence Level:
    - For a 95% confidence level, the Z score threshold is approximately ±1.96. This means:
        - If the Z score is between -1.96 and +1.96, the result is not statistically significant (it could happen by chance).
        - If the Z score is outside this range (greater than 1.96 or less than -1.96), the result is statistically significant (unlikely to be due to chance).

WHY DOES IT MATTER?

Statistical significance doesn't guarantee the result is important or practical - it just shows it's unlikely to be due to random chance. We should still consider other factors, like the size of the effect and its real-world impact, before making decisions.

In summary, testing at the 95% confidence level with Z scores is like setting a high bar for evidence. It ensures we're cautious about claiming something works unless the data strongly supports it.

Table 2: Statistically Significant Differences in Age-adjusted Prevalence Rates, descending (FY23)

Table 2 shows the enrollee subgroups and corresponding conditions that had a statistically significant likelihood of being more or less be diagnosed than the referent group in FY23.

Subgrouping	Condition	Subgroup Age-adjusted Prevalence Rate (AAPR)	County AAPR (comparison rate)	Standard Deviation from Mean	Z score	Magnitude	Direction
Unhoused	Substance Use Disorder	122.6	26.6	8.55	11.24	362%	More likely
White	Substance Use Disorder	93.8	26.6	12.45	5.40	253%	More likely
Unhoused	Behavioral Health	261.3	114.7	73.28	2.00	128%	More likely
Unhoused	Renal Failure	69.0	32.3	9.12	4.02	113%	More likely
White	Behavioral Health	226.6	114.7	56.32	1.99	98%	More likely
South Central Austin	Stroke	20.2	12.3	3.84	2.08	65%	More likely
South Central Austin	Hypertension	228.5	196.6	11.71	2.73	16%	More likely
Unreported	Cancer	9.9	18.6	3.54	(2.45)	47%	Less likely
Unreported	CVD	107.7	227.2	59.26	(2.02)	53%	Less likely
Northeast Travis County	Substance Use Disorder	9.2	26.6	8.55	(2.03)	65%	Less likely
Manor	Substance Use Disorder	8.2	26.6	8.55	(2.14)	69%	Less likely

Methodology 3: Condition Group Regression Analysis of Relevant Demographic and Utilization Factors

The equity indices were calculated separately for focus areas and for race/ethnicities. A few natural follow-up questions arise:

- When considered together, which set of factors better indicates disparities in condition groups: the geographical focus areas or race/ethnicities?
- Are there other demographic and utilization factors that are relevant or may help account for the disparities observed by focus areas and race/ethnicities?
- To what extent are condition prevalence rates impeded by enrollees' ability to be diagnosed, i.e., their health care access and utilization?

To examine these questions, further statistical modeling was conducted with an expanded set of demographic and utilizations factors. While prevalence rates were previously given with respect to focus areas and race/ethnicities, the relative risks obtained by these factors may be driven by other demographic factors. Further, as the third question highlights, because condition prevalence is measured through whether the enrollee received a diagnosis, certain groups may have higher or lower rates of diagnosis based on how often they receive medical services. Utilization factors related to visit frequency were therefore included to help account for enrollees' opportunities to receive diagnoses. The following represents a comprehensive list of demographic and utilization factors included in the statistical modeling:

1. Age (+1 Year)
2. Focus Areas
3. Race/Ethnicity
4. Gender (whether female)
5. Language (English and other non-Spanish)
6. Most frequent enrollment program (MAP or MAP Basic)
7. Single Marital Status
8. Primary Care Provider (PCP) visit count during FY 2021 - FY 2023
9. Emergency Room (ER) visit count during FY 2021 - FY 2023

Logistic regression, a statistical method for modeling "yes or no" outcomes (i.e., were they diagnosed, yes or no?), was used to measure how much each of these demographic and utilization factors was linked to whether an enrollee did or did not have each condition. For each factor, we estimated a change in probability of being diagnosed with a condition, on average, based on when the factor is present or adjusted. This change in probability is also known as the "average marginal effect," and, because some diseases like heart failure are much rarer compared to others like hypertension, it was recorded as the percent change in probability relative to the base probability for having the diagnosis out of the entire sample population. Because more factors were considered, a larger population size was used for this study, encompassing MAP and MAP Basic members enrolled any time during FY 2021 – FY 2023: a total of 158,323 unique members, with 76% utilizing within this time frame. Table 3 shows the base probabilities for each condition within the sample population.

Findings from this study for each of the chronic conditions are reported in their respective "Factors Linked with…" sections and provide actionable insights into the key drivers of health outcomes in the population. Table A3 is a compilation for the average percent change in probability due to each focus area and race/ethnicity. Factors that did not meet the 95% confidence interval, based on the Wald test of their logistic regression coefficients, are indicated by black text values (red for significant factors). Focus areas Manor, North Central Austin, Oak Hill, and Southeast Austin were not included in the models, as they were not found to be statistically significant for any of the conditions. These results must be interpreted through the lens of the baseline population: **importantly, factor probabilities reflect likelihood within the Central Health population, not the greater Travis County, Texas, or United States populations.** "Other Travis County", "Hispanic", and "Spanish-Speaking" were not included as factors, making them the baseline for the other results. For example, being in the East Central Austin focus area was associated with a 50% increased probability of receiving a heart failure diagnosis, relative to the Spanish-speaking Hispanic population not living in a focus area. The factors in the model are treated as independent from one another, meaning the effect of each factor on the outcome is assessed separately, while accounting for the presence of other factors. However, the model doesn't assume that the factors themselves are unrelated, and any interactions or correlations between them should be carefully considered when interpreting the results. Within the same heart failure example, the 50% increased probability from living in East Central Austin is the probability after accounting for age, ER and PCP utilization, gender, MAP enrollment, household size, language, race/ethnicity, and other focus areas.

Table 3 (Left): Base Probabilities of Each Condition, FY 2021-2023 MAP and MAP Basic Enrollees;

Table 4 (Right): Observed versus Expected Prevalence: Central Health versus national and local comparators

Table 3, to the left below, shows the percent of MAP and MAP Basic members who were enrolled anytime during FY 2021 - 2023 and had one of the conditions analyzed in this report. This base population includes a total of 158,323 unique enrollees, with 76% having utilized health care services covered by Central Health within this timeframe.

Table 4, to the right below, shows how well Central Health is performing at diagnosing enrollees compared to available local, state, and national data sets - all of which have their own limitations and methodological differences. As such, these comparator rates should be considered suggestive but not definitive.

For each condition, the closest possible match to the most recently nationally validated age-adjusted prevalence rate was identified. For most conditions, this was the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), a self-reported phone survey. National comparators for behavioral health and SUD were sourced from the 2022 Adult Prevalence of Mental Illness survey. We expect our rates, which are based on diagnosis codes, to be more accurate at capturing known diagnoses, but also limited by the three-year lookback period used to determine prevalence. Additionally, Central Health sought a Most Local Number as well – be it state, metropolitan statistical area (MSA), region, or county (where available). Local comparators were not available for all conditions. Taken together, the use of a national and (where available) local comparator helped Central Health to estimate the expected prevalence and each condition and compare the observed prevalence to understand how many cases might be missing or undiagnosed in our data. Table 3 in the appendix summarizes these findings. Central Health enrollees appear to be underdiagnosed by at least half for cancers, SUD, stroke, and asthma, while "overdiagnosing" kidney issues like ESRD and renal failure through our nephrology direct practice.

BASE PROBABILITIES OF EACH CONDITION, FY 2021-2023 MAP AND MAP BASIC ENROLLEES

Condition	% with Diagnosis
Asthma	3.2
Behavioral Health	9.7
Cancer	1.3
CVD	18.9
COPD	1.4
COVID-19	5.4
Diabetes	9.7
Heart Failure	1.2
Hypertension	16.2
Renal Failure	2.2
SUD	2.6

OBSERVED VERSUS EXPECTED PREVALENCE: CENTRAL HEALTH VERSUS NATIONAL AND LOCAL COMPARATORS

	Age-adjusted prevalence rates/1,000 persons				
Comparator	Central Health Enrollees	Travis County	National	Diagnosed Cases	Estimated Undiagnosed Cases
Cancer	18.6	65	97	29%	71%
Substance Use Disorder	26.6	N/A	77.4	34%	66%
Stroke	12.3	29	29	42%	58%
Asthma	44.8	95	77	47%	53%
COPD	31.5	56	61	56%	44%
Behavioral Health	114.7	N/A	199	58%	42%
Hypertension	196.6	276	266	71%	29%
Heart Failure	26.3	N/A	28	94%	6%
Diabetes	115.1	116	119	99%	1%
ESRD	2.7	N/A	2.3	119%	-19%
Renal Failure	32.3	N/A	14	231%	0%

Table 5: Average Percent Change in Probability for Diagnosis of Conditions, Expanded Set of Demographic and Utilization Factors

This heat map provides an overview of the average percentage change in probability for diagnosis of chronic conditions for an expanded set of demographic and utilization factors.

In this view, values that are higher than expected appear in gold. Values that are lower than expected are purple. For both colors, the hue becomes darker the more a value varies from the expected value. For example, for each additional visit an enrollee has to an emergency department or primary care provider, there is an increase in the likelihood of diagnosis for all chronic conditions.

(* Denotes statistically significant result)

Subgroup	Asthma	Behavioral Health	Cancer	CVD	COPD	Diabetes	Heart Failure	Hypertension	Renal Failure	SUD
Age (1+ Year)	0.1	0.6 *	6.2 *	4.4 *	5.3 *	4.4 *	7.2 *	4.8 *	5.2 *	0.7 *
ER Visit Frequency (+1 Visit)	27.2 *	44.6 *	14.5 *	29.4 *	19.0 *	11.6 *	18.6 *	24.9 *	31.0 *	41.6 *
PCP Visit Frequency (+1 Visit)	11.1 *	13.5 *	5.5 *	14.3 *	9.8 *	16.2 *	10.1 *	13.6 *	9.2 *	6.8 *
Female	34.2 *	8.8 *	14.2 *	-23.8 *	19.8 *	-23.0 *	-60.2 *	-27.1 *	-84.8 *	-54.8 *
MAP Enrollee, Most Common Program	30.0 *	26.7 *	60.5 *	17.0 *	31.2 *	19.4 *	58.6 *	17.9 *	57.8 *	43.4 *
Single Household Size	17.8 *	18.6 *	1.6	1.0	4.7	-7.5 *	12.1 *	-1.3	13.3 *	14.5 *
English-Speaker	71.5 *	91.0 *	7.1	12.5 *	75.0 *	2.6	68.8 *	16.1 *	45.6 *	103.9 *
Other Language-Speaker	28.7 *	39.3 *	-22.6 *	-10.5 *	3.4	-24.5 *	2.1	-11.1 *	-26.1 *	42.3 *
Experiencing Homelessness	-7.3	65.9 *	-55.7 *	-12.6 *	44.3 *	-28.0 *	-13.1 *	-16.1 *	-0.1	84.6 *
East Central Austin	9.6	10.1	3.0	15.0 *	33.1	19.4 *	50.3 *	17.3 *	14.4	3.2
South Central Austin	-8.1	6.0	9.3	10.6 *	6.6	16.3 *	14.3	9.9 *	5.6	26.0 *
Northeast Austin	-0.1	-7.8	24.8	3.7	48.2 *	10.4 *	25.2	0.6	-2.6	-0.3
East Central Travis County	11.2	-35.6 *	-9.1	3.0	31.7	13.2 *	-6.6	5.9	7.5	-32.2 *
Asian	-21.5 *	-29.5 *	-26.5 *	-12.9 *	-15.4	-19.7 *	-51.3 *	-17.3 *	-57.9 *	-51.0 *
Black	65.8 *	1.2	3.3	23.8 *	21.9 *	-12.1 *	46.1 *	27.7 *	27.1 *	-30.6 *
Native American	41.5	40.1 *	28.9	2.6	60.9	-29.1	-30.1	1.2	-67.2 *	79.3
White	-6.0	50.9 *	27.3 *	-11.2 *	66.3 *	-53.3 *	7.9	-18.3 *	3.0	74.8 *
Ethnicity, Other	-13.2 *	-10.1 *	-23.2 *	-10.1 *	-13.5 *	-27.4 *	-19.4 *	-12.9 *	-17.1 *	-12.2 *

Table 6: Total Population Demographics by Focus Area Census Tract for 2024

Table 6 includes 2024 demographic data for the focus areas included in this report. This data was obtained from Claritas's Pop-Facts Premier database. Language data was based on the language spoken at home by persons age 5+.

				Age				Ethnicity		Language			Race				Sex	
Census Tract	Area	Focus Area	Total Population	< 18	18-44	45-64	65+	Hispanic/ Latino	Not Hispanic/ Latino	English	Other	Spanish	Asian	Black	Other	White	Female	Male
8.02	Rosewood/Chestnut	East Central Austin	3,372	854	1,652	557	309	1,203	2,169	2,716	20	420	73	685	899	1,715	1,756	1,616
21.10	MLK-183	East Central Austin	4,352	937	2,333	722	360	1,692	2,660	2,916	89	1,102	92	1,020	1,201	2,039	2,170	2,182
21.11	Govalle/Johnston Terrace	East Central Austin	6,683	1,472	3,147	1,404	660	3,014	3,669	4,132	51	2,082	164	993	2,465	3,061	3,239	3,444
22.15	Hornsby Bend	East Central Travis County	5,598	1,735	2,481	1,092	290	3,867	1,731	1,194	323	3,709	97	871	3,239	1,391	2,799	2,799
22.21	Daffan/Decker	East Central Travis County	3,453	1,202	1,482	590	179	2,784	669	870	116	2,194	16	458	2,316	663	1,753	1,700
459.00	Manor	Manor	13,805	3,789	6,166	2,990	860	6,945	6,860	6,724	233	5,817	617	3,399	5,737	4,052	6,943	6,862
400.00	Georgian Acres/Highland/St. John's	North Central Austin (Rundberg)	6,619	1,386	3,237	1,459	537	3,297	3,322	3,543	1,130	1,526	440	729	2,942	2,508	2,966	3,653
401.00	North Lamar/Payton Gin	North Central Austin (Rundberg)	4,268	955	1,974	962	377	2,684	1,584	1,724	60	2,226	82	467	2,363	1,356	1,901	2,367
405.00	Wooten	North Central Austin (Rundberg)	5,215	1,153	2,458	1,122	482	2,568	2,647	2,293	76	2,496	112	274	2,277	2,552	2,439	2,776
407.00	W Rundberg & Metric/Northgate/Colony Creek	North Central Austin (Rundberg)	7,223	1,862	3,376	1,503	482	4,640	2,583	2,390	0	4,316	134	752	4,053	2,284	3,315	3,908
409.00	Quail Creek	North Central Austin (Rundberg)	6,473	1,587	2,962	1,335	589	4,593	1,880	3,435	91	2,499	188	331	4,011	1,943	3,058	3,415
410.00	North Lamar	North Central Austin (Rundberg)	7,195	1,940	3,257	1,519	479	5,069	2,126	2,169	1,613	2,881	587	689	4,361	1,558	3,386	3,809
432.00	Georgian Acres	North Central Austin (Rundberg)	3,242	850	1,532	637	223	2,214	1,028	1,239	134	1,639	24	394	1,893	931	1,473	1,769
21.05	Ridgetop/West Windsor Park	Northeast Austin	4,725	835	2,580	934	376	2,274	2,451	2,633	67	1,791	138	636	1,976	1,975	2,147	2,578
403.00	Heritage Hills	Northeast Austin	8,732	2,589	3,943	1,580	620	6,619	2,113	2,736	684	4,667	314	663	5,864	1,891	4,158	4,574
435.00	Walnut Creek/Pioneer Crossing	Northeast Travis County	9,538	1,886	4,929	1,942	781	2,684	6,854	4,979	2,511	1,455	1,986	1,652	2,415	3,485	4,773	4,765
449.00	Canterra/River Ranch	Northeast Travis County	10,424	2,893	4,473	2,217	841	5,986	4,438	3,820	794	5,057	1,563	1,403	5,149	2,309	5,136	5,288
19.20	West Oak Hill	Oak Hill	7,302	1,595	3,407	1,661	639	2,771	4,531	3,700	758	2,396	648	260	2,452	3,942	3,673	3,629
366.00	Barton Creek/Bee Cave/West Oak Hill	Oak Hill	9,710	2,424	2,977	2,790	1,519	1,267	8,443	8,043	187	902	440	181	1,485	7,604	4,939	4,771
24.11	Franklin Park	South Central Austin	5,588	1,554	2,300	1,241	493	4,296	1,292	1,503	51	3,649	39	563	3,496	1,490	2,644	2,944
24.12	Franklin Park	South Central Austin	4,996	1,251	1,956	1,230	559	4,084	912	1,832	35	2,816	37	176	3,291	1,492	2,426	2,570
309.00	Cherry Creek/Southwest Oaks	South Central Austin	7,674	1,265	3,470	1,806	1,133	2,291	5,383	6,035	120	1,130	225	333	1,936	5,180	3,739	3,935
23.07	Parker Lane	Southeast Austin	5,318	595	3,329	998	396	2,016	3,302	3,780	215	1,160	206	431	1,699	2,982	2,375	2,943
23.15	East Riverside/Oltorf	Southeast Austin	2,969	435	2,000	412	122	1,265	1,704	1,266	239	1,337	294	276	1,213	1,186	1,275	1,694
23.16	East Riverside	Southeast Austin	4,845	884	3,119	682	160	2,313	2,532	2,631	547	1,400	374	417	1,916	2,138	2,072	2,773
23.20	Montopolis	Southeast Austin	5,456	1,378	2,730	916	432	3,383	2,073	2,678	180	2,214	248	518	2,928	1,762	2,687	2,769
23.25	Pleasant Valley/Montopolis	Southeast Austin	4,812	1,152	2,290	889	481	3,184	1,628	2,376	159	1,986	104	473	2,684	1,551	2,552	2,260

Table 7: Enrollee Demographics by Focus Area Census Tract for FY23

Table 7 features Fiscal Year 2023 enrollee demographic data for the focus areas included in this report. Data that has been replaced with an asterisk denotes counts have been suppressed to maintain privacy standards.

				Age				Language				Race						Sex	
Census Tract	Area	Focus Area	Enrolled Population	< 18	18-44	45-64	65+	English	Other	Spanish	Unreported	Asian	Black	Latino	Other	Unreported	White	Female	Male
8.02	Rosewood/Chestnut	East Central Austin	341	*	158	149	*	243	*	85	*	*	94	181	*	*	33	213	128
21.10	MLK-183	East Central Austin	595	143	305	120	27	174	59	290	72	*	103	363	79	*	30	337	258
21.11	Govalle/Johnston Terrace	East Central Austin	648	80	315	214	39	249	*	368	*	*	64	507	*	*	41	361	287
22.15	Hornsby Bend	East Central Travis County	1,053	169	531	301	52	220	*	728	*	*	52	892	28	51	*	590	463
22.21	Daffan/Decker	East Central Travis County	1,168	209	704	228	27	146	*	923	*	*	33	1,056	*	42	*	659	509
459.00	Manor	Manor	1,523	213	767	437	106	414	91	874	144	76	129	1,086	52	121	59	882	641
400.00	Georgian Acres/Highland/St. John's	North Central Austin (Rundberg)	1,538	282	802	390	64	285	65	1064	124	65	55	1,202	53	77	86	810	728
401.00	North Lamar/Payton Gin	North Central Austin (Rundberg)	953	165	507	237	44	138	78	737	67	*	30	814	*	41	38	504	449
405.00	Wooten	North Central Austin (Rundberg)	888	167	481	208	32	77	*	736	*	*	*	784	*	35	34	500	388
407.00	W Rundberg & Metric/Northgate/Colony Creek	North Central Austin (Rundberg)	2,505	591	1426	442	46	*	*	2056	234	*	*	2,222	46	108	77	1,339	1,166
409.00	Quail Creek	North Central Austin (Rundberg)	1,928	399	1067	396	66	164	*	1621	*	*	*	1,750	39	59	50	1,081	847
410.00	North Lamar	North Central Austin (Rundberg)	2,265	471	1196	518	80	265	*	1779	*	44	59	1,945	64	87	66	1,224	1041
432.00	Georgian Acres	North Central Austin (Rundberg)	1,142	248	650	222	22	134	*	915	*	*	30	1,005	*	41	32	625	517
21.05	Ridgetop/West Windsor Park	Northeast Austin	894	172	474	210	38	179	*	616	*	*	48	699	*	64	42	476	418
403.00	Heritage Hills	Northeast Austin	2,694	593	1509	516	76	179	33	2285	197	36	35	2,429	38	100	56	1,513	1,181
435.00	Walnut Creek/Pioneer Crossing	Northeast Travis County	1,087	250	597	187	53	241	49	677	120	68	47	807	56	64	45	601	486
449.00	Canterra/River Ranch	Northeast Travis County	2,013	296	1047	567	103	335	61	1437	180	76	82	1,649	40	93	73	1,149	864
19.20	West Oak Hill	Oak Hill	795	153	407	201	34	100	*	640	*	*	*	694	*	27	41	442	353
366.00	Barton Creek/Bee Cave/West Oak Hill	Oak Hill	77	*	33	35	*	43	*	32	*	*	0	50	*	0	24	41	36
24.11	Franklin Park	South Central Austin	1,294	140	610	463	81	298	*	921	*	*	29	1,126	32	*	73	715	579
24.12	Franklin Park	South Central Austin	1,037	96	433	425	83	253	*	695	*	*	*	914	24	54	34	577	460
309.00	Cherry Creek/Southwest Oaks	South Central Austin	268	22	117	108	21	149	*	91	*	*	*	143	*	23	70	146	122
23.07	Parker Lane	Southeast Austin	566	86	289	163	28	184	*	335	*	*	25	409	*	30	76	306	260
23.15	East Riverside/Oltorf	Southeast Austin	1,150	264	705	154	27	*	*	928	105	*	*	1,004	51	26	35	594	556
23.16	East Riverside	Southeast Austin	1,808	404	1076	302	26	220	57	1416	115	30	43	1,542	75	53	65	956	852
23.20	Montopolis	Southeast Austin	616	96	333	151	36	154	*	402	*	*	*	511	25	28	31	340	276
23.25	Pleasant Valley/Montopolis	Southeast Austin	600	88	298	182	32	244	*	312	*	*	46	458	*	23	49	373	227

Table 8: Relative Risk of Central Health Enrollees Being Unhoused Based on Demographics, FY 2023

The table below shows the Relative Risk (RR) of a Central Health enrollee experiencing homelessness. The RR here is the percent of the unhoused enrolled population that is a given demographic divided by the percent of the overall Central Health enrolled population that has the same demographic characteristic. Demographics that have a RR less than one (purple in the table) mean that if an enrollee is a part of that demographic, they are less likely to be unhoused. RR values that are greater than one (yellow in the table) mean that enrollees with the demographic are more likely to be unhoused.

Grouping	Number of Unhoused	Percent of All Enrollees	Percent of Unhoused	Relative Risk
Total	10,615	8.9%	100%	N/A
Male	7,878	46.9%	74.2%	1.58
Female	2,737	53.1%	25.8%	0.48
Asian	50	2.3%	0.5%	0.2
Black	1,985	5.5%	18.7%	3.4
Latino	2,712	73.0%	25.5%	0.35
Other Race/Ethnicity	3,119	6.3%	29.4%	4.66
Unreported Race/Ethnicity	215	5.0%	2.0%	0.41
White	2,534	8.1%	23.9%	2.95

Table 9: Percentage of Skilled Nursing Facility (SNF) Admissions Among Unhoused Members, FY 2020 - FY2024

Year	SNF Admissions for Unhoused Enrollees	Total SNF Admissions	Percent of SNF Admissions by Unhoused Enrollees
FY 2020	121	207	58%
FY 2021	104	160	65%
FY 2022	109	179	61%
FY 2023	145	272	53%
FY 2024	197	334	59%

Table 10: Demographics of Central Health Medical Respite Discharges FY 2023 and FY 2024

Medical Respite is acute and post-acute medical care for people experiencing homelessness who are too ill or frail to recover from illness or injury on the street or in a shelter. Central Health's Medical Respite program had 244 total admissions in FY 2023 and FY 2024. Table 10, below, shows the breakdown of Central Health Medical Respite discharges in FY 2023 and FY2024.

Data that has been replaced with an asterisk denotes counts have undergone primary and secondary suppression to maintain privacy standards.

	Count	Percent of Total
Total Patients	197	100%
Total Discharges	227	100%
By Gender		
Male	152	77.2%
Female	*	*
Unreported	*	*
By Race/Ethnicity		
Latino	50	25.4%
White (Non-Latino)	80	40.6%
Black	47	23.9%
Other Race/Ethnicity	*	*
Unreported Race/Ethnicity	*	*
By Age in Years		
25th Percentile	43	-
Median Age	53	-
75th Percentile	58	-

Table 11: Comparison of Chronic Condition Prevalence Between All Central Health Enrollees (FY 2023) and Members of CHAP-Expansion Initiative (CY 2023)

Table 11 shows the age-adjusted prevalence rates of chronic conditions for all Central Health enrollees (FY 2023) and for CHAP-Expansion Initiative members (CY 2023). The Relative Risk (RR) here is the percent of the prevalence for chronic conditions among CHAP Expansion members divided by the prevalence of chronic conditions for the overall Central Health enrolled population. Conditions that have a RR less than one (purple in the table) mean that if an enrollee is a CHAP-Expansion member, they are less likely to have a given chronic condition. RR values that are greater than one (yellow in the table) mean that CHAP-Expansion members are more likely to have a chronic condition diagnosis.

Condition	Central Health Overall Total Age-Adjusted Prevalence Rate Per 1,000 Enrollees	CHAP Expansion Age-Adjusted Prevalence Rate Per 1,000 Enrollees	Relative Risk
Cardiovascular Disease	227.2	590.4	2.60
Hypertension	196.6	426.1	2.17
Cancer	18.6	278.7	14.98
Diabetes	115.1	250.4	2.18
Behavioral Health	114.7	242.0	2.11
Renal Failure	32.3	199.8	6.19
Asthma	44.8	166.6	3.72
Heart Failure	26.3	126.2	4.80
ESRD	2.7	100.1	37.10
Stroke	12.3	78.7	6.40
COPD	31.5	60.5	1.92
Substance Use Disorder	26.6	17.9	0.67

Table 12: CHAP - Expansion Utilization in CY 2023

Table 12 shows the number of members enrolled in the CHAP-Expansion Initiative in CY 2023 and the total number of hospital admissions members had during the calendar year. Additionally, the percent of CHAP-Expansion members that visited a Primary Care Physician (PCP) and the PCP locations that members visited the most are detailed in the table.

Enrolled Members	**806**	
Member Months - CY 2023	**9,102**	
	Total Admissions	**Admission Rate (per 1,000 Members per Year)**
Hospitalization Utilization		
IP (Acute Patient)	481	634.1
IP Rehab Facility (Non-acute)	9	28.6
Residential	7	37.3
Skilled Nursing Facility	22	38.3
ED	676	891.0
Top PCP Utilization by Provider Group	**Members**	**Percent (%)**
CommUnityCare	452	56%
Austin Regional Clinic	80	10%
Lone Star Circle of Care	47	4%
Percent with PCP Utilization		80%

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