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The University of Texas at Austin

# COVID-19 Healthcare Demand Projections: Austin, Texas

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# COVID-19 Healthcare Demand Projections: Austin, Texas

*Presented to the city of Austin and Travis County on April 6, 2020*

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## Overview

To support planning by the city of Austin and Travis County, we analyzed the Austin-Round Rock module of our *US COVID-19 Pandemic Model* to project the number of hospitalizations under different social distancing scenarios. Note that the results presented herein are based on multiple assumptions about the transmission rate and age-specific severity of COVID-19. There is still much we do not understand about the transmission dynamics of this virus, including the extent of asymptomatic infection and transmission. These results do not represent the full range of uncertainty. Rather, they are meant to serve as plausible scenarios for gauging the likely impacts of social distancing measures in the Austin-Round Rock Metropolitan Area.

We have updated our model inputs based on the daily number of COVID-19 hospitalizations in the Austin-Round Rock MSA between March 13 and April 5, 2020. The recent data suggest that the baseline epidemic growth rate (in the absence of interventions) is slightly higher than we assumed in our March 24, 2020 report but well within the range of values estimated for COVID-19 epidemics worldwide. The data further suggest that school closures and social distancing are depressing transmission.

We are posting these results prior to peer review to provide intuition for both policy makers and the public regarding both the immediate threat of COVID-19 and the extent to which early social distancing measures can mitigate that threat. Our projections indicate that the Stay Home-Work Safe order could effectively delay or avert a COVID-19 healthcare crisis in the region.

# COVID-19 projections for the five-county Austin-Round Rock MSA with school closures and social distancing

We updated the Austin-Round Rock module of our *US COVID-19 Pandemic Model* to simulate COVID-19 epidemics under various assumptions about the efficacy of Austin's *Stay Home-Work Safe* order that was enacted on March 24, 2020.

The simulations ran from March 1 through mid-August, 2020 by assuming the following initial conditions and key parameters:

- Starting condition: March 1, 2020 with 25 infected adults
- Time course of interventions
  - March 1 - March 13: No interventions
  - March 14 - Aug 17: Schools closed (1)
  - March 25 - Aug 17: *Stay Home - Work Safe* reduces transmission (beyond school closures) by an additional 0%, 50%, 75%, 80%, 90% or 95%
- $\beta = 0.032^1$  (based on fitting our model to daily COVID-19 hospitalizations in Austin-Round Rock MSA from March 13 through April 5, 2020). This corresponds to:
  - Epidemic doubling time: 2.8 days
  - Reproduction number ( $R_0$ ): 2.6
  - Serial interval: 3.6 days.
- Average incubation period (assuming 12.1% of transmission happens pre-symptomatically): 6.9 days (2)
- Proportion of cases asymptomatic (assumed 46% as infectious as symptomatic cases): 17.9% (3)

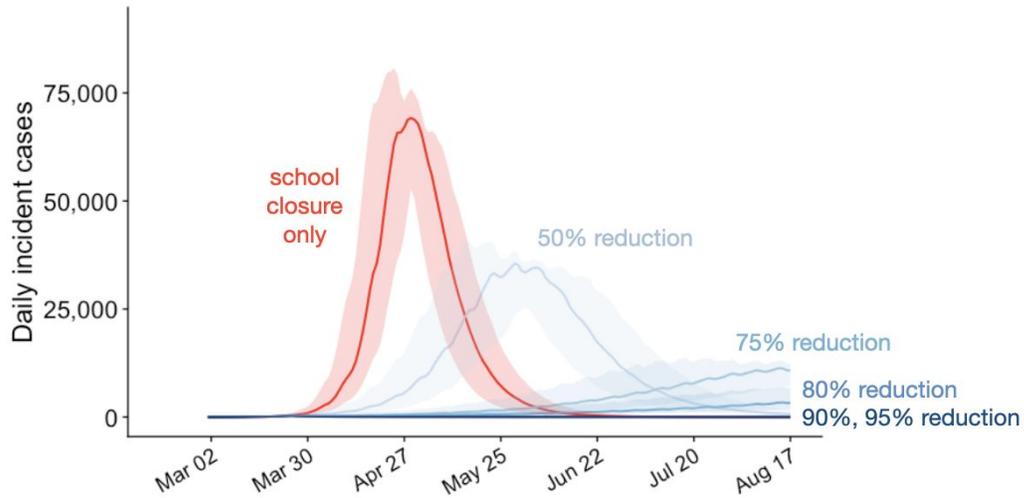
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<sup>1</sup> Note that prior projections for Austin (shared with the city on March 24, 2020) assumed  $\beta=0.026$ . This value assumed that Austin had not yet imposed social distancing measures, and was derived to produce a doubling time of 4 days and  $R_0=2.2$ .

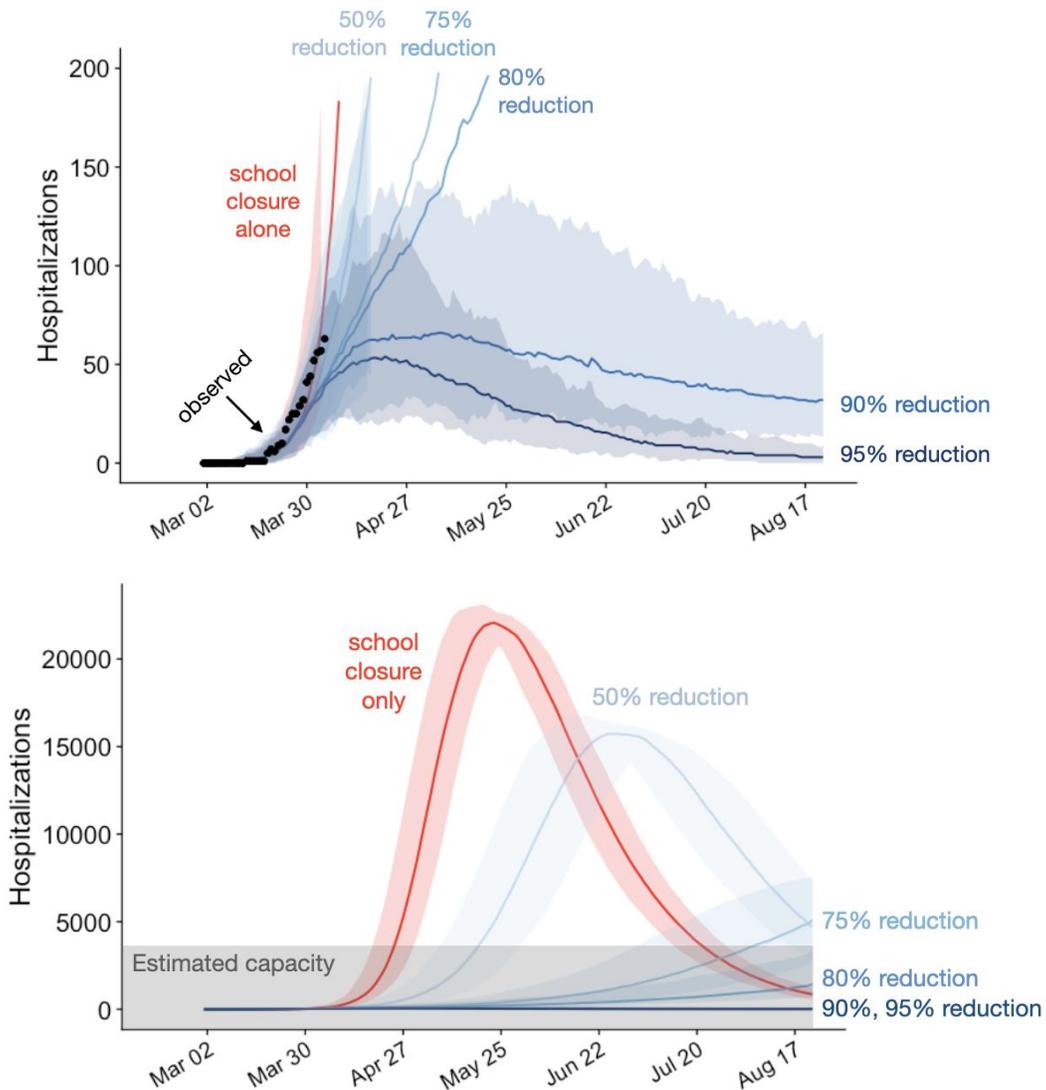
Table 1 and Figures 1-4 summarize results of COVID-19 simulations for the Austin-Round Rock MSA. Each simulation began on March 1 with 25 infectious COVID-19 cases and ended on August 17, 2020. The model structure and parameters, including age-specific hospitalization and fatality rates, are described in the Appendices below.

**Table 1. Estimated cumulative COVID-19 cases, hospitalizations, ICU cases, cases requiring mechanical ventilatory therapy, and deaths for the Austin-Round Rock MCA from March 1 through August 17, 2020.** The values are medians (with full range in parentheses) across 100 stochastic simulations based on the parameters given in Appendix 1.

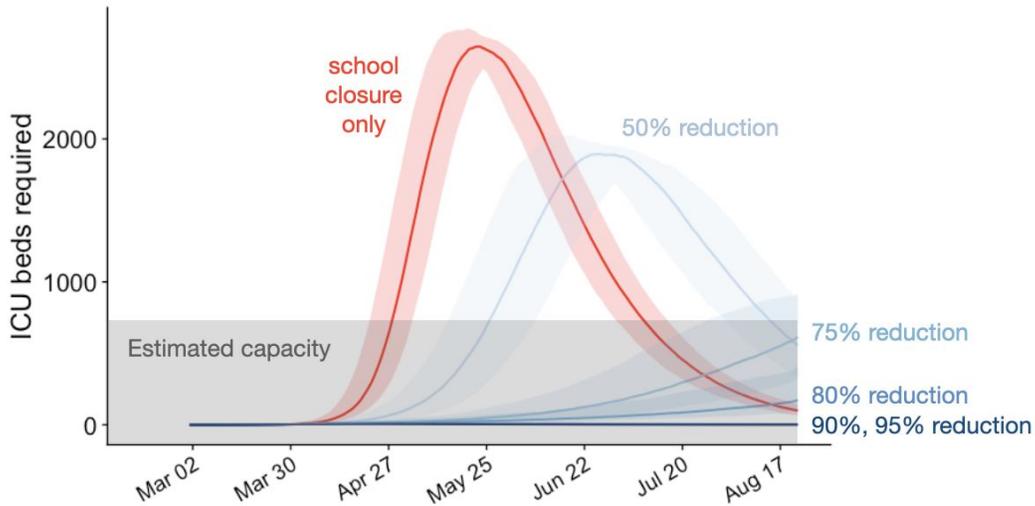
Contact reduction	Outcomes				
	Cases	Hospitalizations	ICU beds	Ventilators	Deaths
<b>School closure only</b>	1,776,101 (1,774,731-1,777,132)	89,727 (88,963-90,460)	10,730 (10,637-10,807)	7,154 (7,091-7,205)	11,408 (11,175-11,772)
<b>50%</b>	1,704,974 (1,681,832-1,719,915)	80,229 (75,922-82,823)	9,634 (9,133-9,953)	6,422 (6,088-6,636)	9,134 (8,090-9,889)
<b>75%</b>	564,969 (282,392-983,358)	17,233 (7,863-33,335)	2,083 (953-4,035)	1,389 (635-2,690)	1,333 (586-2,814)
<b>80%</b>	175,714 (95,401-422,939)	5,440 (2,909-13,435)	660 (354-1,629)	440 (236-1,086)	444 (216-1,078)
<b>90%</b>	13,403 (7,702-27,077)	542 (290-1,093)	65 (35-131)	43 (24-88)	52 (28-113)
<b>95%</b>	6,380 (3,066-12,099)	266 (124-548)	32 (15-66)	22 (10-44)	26 (6-58)



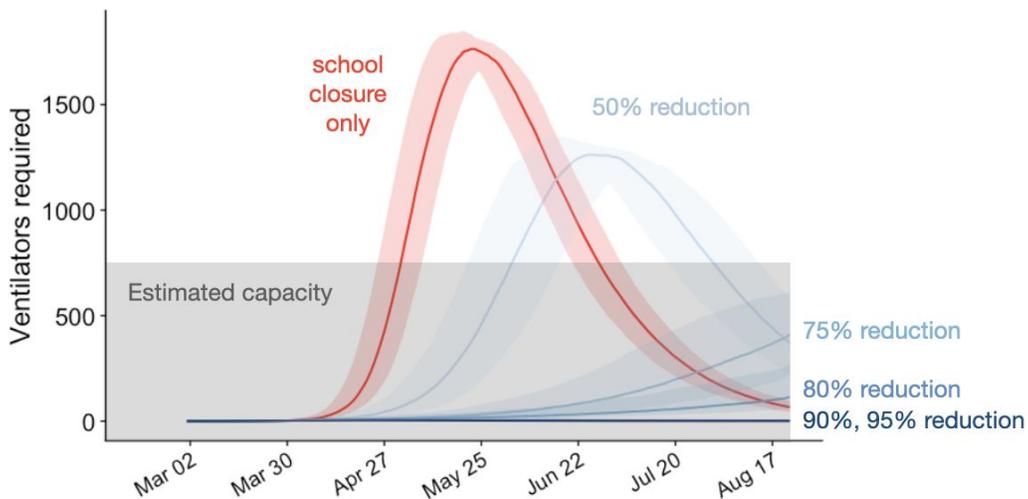
**Figure 1. Projected COVID-19 cases in the Austin-Round Rock MSA from March 1 to August 17, 2020 coupled with different degrees of social distancing following the March 24th Stay Home-Work Safe order.** The red line projects COVID-19 transmission assuming that there was no change in contact patterns (beyond school closures). The blue lines show increasing levels of social distancing efficacy, from light to dark: a 50%, 75%, 80%, 90% or 95% reduction in daily contacts. Lines and shading indicate the minimum, median and maximum values across 100 stochastic simulations.



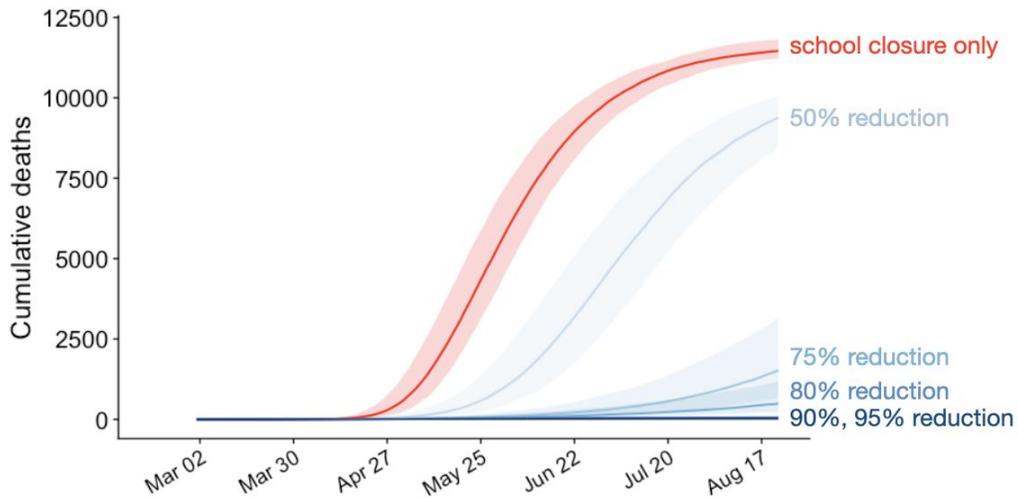
**Figure 2. Projected daily COVID-19 hospitalizations in the Austin-Round Rock MSA from March 1 to August 17, 2020 coupled with different degrees of social distancing following the March 24th Stay Home-Work Safe order.** The two graphs are identical except that the top graph only shows hospitalizations up to 200 per day and includes the reported total daily COVID-19 hospitalizations across all Austin-Round Rock MSA hospitals (black points); the bottom graph indicates local capacity via gray shading along the bottom. In both graphs, the red lines project COVID-19 transmission assuming that there was no change in contact patterns (beyond school closures). The blue lines show increasing levels of social distancing efficacy, from light to dark: a 50%, 75%, 80%, 90% or 95% reduction in daily contacts. Lines and shading indicate the minimum, median and maximum values across 100 stochastic simulations. The estimated total daily hospital capacity in the Austin-Round Rock MSA for COVID-19 patients is 80% of the 4299 total beds (3239), as indicated by gray shading along the bottom.



**Figure 3. Projected COVID-19 cases requiring ICU treatment in the Austin-Round Rock MSA from March 1 to August 17, 2020 coupled with different degrees of social distancing following the March 24th Stay Home-Work Safe order.** The red line projects COVID-19 ICU patients assuming that there was no change in contact patterns (beyond school closures). The blue lines show increasing levels of social distancing efficacy, from light to dark: 50%, 75%, 80%, 90% or 95% reduction in daily contacts. Lines and shading indicate the minimum, median and maximum values across 100 stochastic simulations. The estimated total daily ICU capacity in the Austin-Round Rock MSA for COVID-19 patients is set to the estimated number of ventilators in the region: 90% of 750 (675), as indicated by gray shading along the bottom.



**Figure 4. Projected COVID-19 cases requiring mechanical ventilation in the Austin-Round Rock MSA from March 1 to August 17, 2020 coupled with different degrees of social distancing following the March 24th Stay Home-Work Safe order.** The red line projects ventilated COVID-19 patients assuming that there was no change in contact patterns (beyond school closures). The blue lines show increasing levels of social distancing efficacy, from light to dark: 50%, 75%, 80%, 90% or 95% reduction in daily contacts. Lines and shading indicate the minimum, median and maximum values across 100 stochastic simulations. The estimated number of ventilators available for COVID-19 patients is 90% of 750 in the Austin-Round Rock MSA (675), as indicated by gray shading along the bottom.



**Figure 5. Projected cumulative COVID-19 deaths in the Austin-Round Rock MSA from March 1 to August 17, 2020 coupled with different degrees of social distancing following the March 24th Stay Home-Work Safe order.** The red line projects COVID-19 deaths assuming that there was no change in contact patterns (beyond school closures). The blue lines show increasing levels of social distancing efficacy, from light to dark: 50%, 75%, 80%, 90% or 95% reduction in daily contacts. Lines and shading indicate the minimum, median and maximum values across 100 stochastic simulations.

# Appendix

## COVID-19 Epidemic Model Structure and Parameters

The model structure is diagrammed in Figure A1 and described in the equations below.

For each age and risk group, we build a separate set of compartments to model the transitions between the states: susceptible (S), exposed (E), symptomatic infectious ( $I^Y$ ), asymptomatic infectious ( $I^A$ ), symptomatic infectious that are hospitalized ( $I^H$ ), recovered (R), and deceased (D). The symbols S, E,  $I^Y$ ,  $I^A$ ,  $I^H$ , R, and D denote the number of people in that state in the given age/risk group and the total size of the age/risk group is  $N = S + E + I^Y + I^A + I^H + R + D$ .

The model for individuals in age group  $a$  and risk group  $r$  is given by:

$$\begin{aligned} \frac{dS_{a,r}}{dt} &= - \sum_{i \in A} \sum_{j \in K} (I_{i,j}^Y \omega^Y + I_{i,j}^A \omega^A + E_{i,j} \omega^E) \beta \phi_{a,i} / N_i \\ \frac{dE_{a,r}}{dt} &= \sum_{i \in A} \sum_{j \in K} (I_{i,j}^Y \omega^Y + I_{i,j}^A \omega^A + E_{i,j} \omega^E) \beta \phi_{a,i} / N_i - \sigma E_{a,r} \\ \frac{dI_{a,r}^A}{dt} &= (1 - \tau) \sigma E_{a,r} - \gamma^A I_{a,r}^A \\ \frac{dI_{a,r}^Y}{dt} &= \tau \sigma E_{a,r} - (1 - \pi) \gamma^Y I_{a,r}^Y - \pi \eta I_{a,r}^Y \\ \frac{dI_{a,r}^H}{dt} &= \pi \eta I_{a,r}^Y - (1 - \nu) \gamma^H I_{a,r}^H - \nu \mu I_{a,r}^H \\ \frac{dR_{a,r}}{dt} &= \gamma^A I_{a,r}^A + (1 - \pi) \gamma^Y I_{a,r}^Y + (1 - \nu) \gamma^H I_{a,r}^H \\ \frac{dD_{a,r}}{dt} &= \nu \mu I_{a,r}^H \end{aligned}$$

where A and K are all possible age and risk groups,  $I^A$ ,  $I^Y$ ,  $I^H$  are relative infectiousness of the  $I^A$ ,  $I^Y$ ,  $I^H$  compartments, respectively,  $\beta$  is transmission rate,  $\phi_{a,i}$  is the mixing rate between age group  $a$ ,  $i \in A$ ,  $\omega^A$ ,  $\omega^Y$ ,  $\omega^E$  are the recovery rates for the  $I^A$ ,  $I^Y$ ,  $I^H$  compartments, respectively,  $\sigma$  is the exposed rate,  $\tau$  is the symptomatic ratio,  $\pi$  is the proportion of symptomatic individuals requiring hospitalization,  $\eta$  is rate at which hospitalized cases enter the hospital following symptom onset,  $\nu$  is mortality rate for hospitalized cases, and  $\mu$  is rate at which terminal patients die.

We model stochastic transitions between compartments using the  $\tau$ -leap method(4,5) with key parameters given in Table S1. Assuming that the events at each time-step are independent and do not impact the underlying transition rates, the numbers of each type of event should follow Poisson distributions with means equal to the rate parameters. We thus simulate the model according to the following equations:

$$\begin{aligned} S_{a,r}(t+1) - S_{a,r}(t) &= -P_1 \\ E_{a,r}(t+1) - E_{a,r}(t) &= P_1 - P_2 \\ I_{a,r}^A(t+1) - I_{a,r}^A(t) &= (1 - \tau)P_2 - P_3 \\ I_{a,r}^Y(t+1) - I_{a,r}^Y(t) &= \tau P_2 - P_4 - P_5 \\ I_{a,r}^H(t+1) - I_{a,r}^H(t) &= P_5 - P_6 - P_7 \end{aligned}$$

$$R_{a,r}(t+1) - R_{a,r}(t) = P_3 + P_4 + P_6$$

$$D_{a,r}(t+1) - D_{a,r}(t) = P_7,$$

with

$$P_1 \sim \text{Pois}(S_{a,r}(t)F_{a,r}(t))$$

$$P_2 \sim \text{Pois}(\sigma E_{a,r}(t))$$

$$P_3 \sim \text{Pois}(\gamma^A I_{a,r}^A(t))$$

$$P_4 \sim \text{Pois}((1 - \pi)\gamma^Y I_{a,r}^Y(t))$$

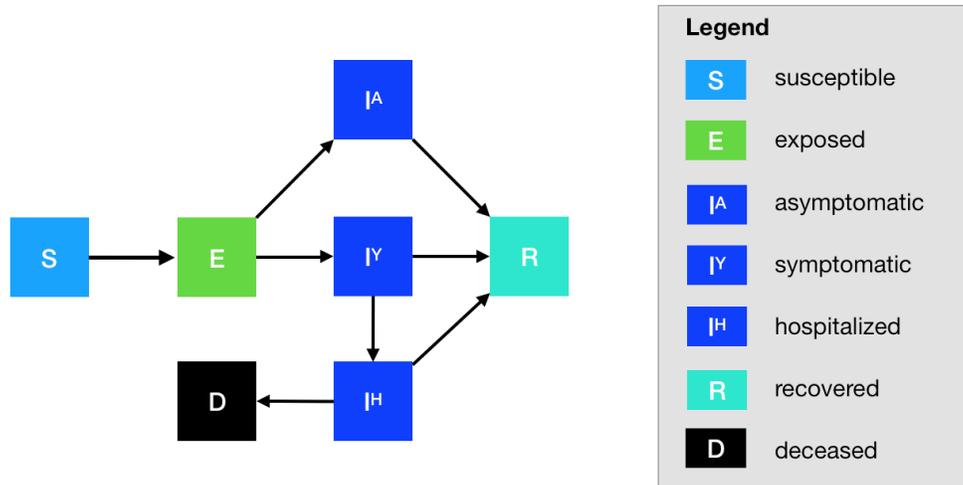
$$P_5 \sim \text{Pois}(\pi\eta I_{a,r}^Y(t))$$

$$P_6 \sim \text{Pois}((1 - \nu)\gamma^H I_a^H)$$

$$P_7 \sim \text{Pois}(\nu\mu I_{a,r}^H(t))$$

and where  $F_{a,r}$  denotes the force of infection for individuals in age group  $a$  and risk group  $r$  and is given by:

$$F_{a,r}(t) = \sum_{i \in A} \sum_{j \in K} (I_{i,r}^Y(t)\omega^Y + I_{i,r}^A(t)\omega^A + E_{i,j}(t)\omega^E)\beta_{a,i}\phi_{a,i}/N_i$$



**Figure A1. Compartmental model of COVID-19 transmission in a US city.** Each subgroup (defined by age and risk) is modeled with a separate set of compartments. Upon infection, susceptible individuals (S) progress to exposed (E) and then to either symptomatic infectious (I<sup>Y</sup>) or asymptomatic infectious (I<sup>A</sup>). All asymptomatic cases eventually progress to a recovered class where they remain protected from future infection (R); symptomatic cases are either hospitalized (I<sup>H</sup>) or recover. Mortality (D) varies by age group and risk group and is assumed to be preceded by hospitalization.

**Table A1. Initial conditions, school closures and social distancing policies**

Variable	Settings
Initial day of simulation	3/1/2020
Initial infection number in locations	25 symptomatic cases in 18-49y age group

School closure	3/14/2020 - 8/17/2020
Social distancing reduction in contacts	Six scenarios: [0, 0.5, 0.75, 0.80, 0.90, 0.95]
Age-specific and day-specific contact rates	<p>Home, work, other and school matrices provided in Tables S4.1-S4.4</p> <ul style="list-style-type: none"> <li>From 2020-03-1 to 2020-03-13  Weekday = home + school + work + other  Weekend = home + other  Weekday holiday = home + other</li> <li>From 2020-03-14 to 2020-03-24  Weekday = home + work + other  Weekend = home + other  Weekday holiday = home + other</li> <li>Since 2020-03-25  Weekday = (1-a)*(home + work + other)  Weekend = (1-a)*(home + other)  Weekday holiday = (1-a)*(home + other)</li> </ul>

**Table A2. Model parameters<sup>a</sup>**

Parameters	Best guess values (doubling time = 4 days)	Source
$R_0$ : reproduction number	2.6	Derived from fitted model
$\delta$ : doubling time	2.8 days	Derived from fitted model
$\beta$ : transmission rate	0.0324	Fitted <sup>a</sup> to daily COVID-19 hospitalizations in Austin-Round Rock MSA
$\gamma^A$ : recovery rate on asymptomatic compartment	Equal to $\gamma^Y$	
$\gamma^Y$ : recovery rate on symptomatic non-treated compartment	$\frac{1}{\gamma^Y} \sim \text{Triangular}(21.2, 22.6, 24.4)$	Verity et al. (6)

$\tau$ : symptomatic proportion (%)	82.1	Mizumoto et al.(3)
$\sigma$ : exposed rate	$\frac{1}{\sigma} \sim \text{Triangular}(5.6, 7, 8.2)$	Lauer et al.(2)
$P$ : proportion of pre-symptomatic transmission (%)	12.6	Du et al.(7)
$\omega^E$ : relative infectiousness of infectious individuals in compartment E	$\omega^E = \frac{(\frac{YHR}{\eta} + \frac{1-YHR}{\gamma^Y})\omega^Y \sigma P}{1-P}$	
$\omega^A$ : relative infectiousness of infectious individuals in compartment I <sup>A</sup>	0.4653	Set to mean of $\omega^E$
$IFR$ : infected fatality ratio, age specific (%)	Low risk: [0.0009, 0.0022, 0.0339, 0.2520, 0.6440] High risk: [0.0092, 0.0218, 0.3388, 2.5197, 6.4402]	Age adjusted from Verity et al. (6)
$YFR$ : symptomatic fatality ratio, age specific (%)	Low risk: [0.0011165, 0.0027, 0.0412, 0.3069, 0.7844] High risk: [0.0112, 0.0265, 0.4126, 3.0690, 7.8443]	$YFR = \frac{IFR}{1-\tau}$
$h$ : high-risk proportion, age specific (%)	[8.2825, 14.1121, 16.5298, 32.9912, 47.0568]	Estimated using 2015-2016 Behavioral Risk Factor Surveillance System (BRFSS) data with multilevel regression and poststratification using CDC's list of conditions that may increase the risk of serious complications from influenza(8–10)
$rr$ : relative risk for high risk people compared to low risk in their age group	10	Assumption

<sup>a</sup>Values given as five-element vectors are age-stratified with values corresponding to 0-4, 5-17, 18-49, 50-64, 65+ year age groups, respectively.

**Table A3 Hospitalization parameters**

Parameters	Value	Source
$\gamma^H$ : recovery rate in hospitalized compartment	1/14	14 day-average from admission to discharge (UT Austin Dell Med)
$YHR$ : symptomatic case hospitalization rate (%)	Low risk: [0.0279, 0.0215, 1.3215, 2.8563, 3.3873] High risk: [ 0.2791, 0.2146, 13.2154, 28.5634, 33.8733]	Age adjusted from Verity et al. (6)
$\pi$ : rate of symptomatic individuals go to hospital, age-specific	$\pi = \frac{\gamma^Y * YHR}{\eta + (\gamma^Y - \eta)YHR}$	
$\eta$ : rate from symptom onset to hospitalized	0.1695	5.9 day average from symptom onset to hospital admission Tindale et al.(11)
$\mu$ : rate from hospitalized to death	1/14	14 day-average from admission to death (UT Austin Dell Med)
$HFR$ : hospitalized fatality ratio, age specific (%)	[4, 12.365, 3.122, 10.745, 23.158]	$HFR = \frac{IFR}{YHR(1-\tau)}$
$\nu$ : death rate on hospitalized individuals, age specific	[0.0390, 0.1208, 0.0304, 0.1049, 0.2269]	$\nu = \frac{\gamma^H HFR}{\mu + (\gamma^H - \mu)HFR}$
Healthcare capacity	Hospital bed: 4299 (assume 80% available for COVID-19) ICU bed: 755 (90% available) Ventilator: 755 (90% available)	Estimates provided by each of the region's hospital systems and aggregated by regional public health leaders

<sup>a</sup> The parameter  $\beta$  is fitted through least-squares minimization in SciPy/Python.(12) Given a value of  $\beta$ , a deterministic simulation is run based on central values for each parameter, from which we can compute the total numbers of daily hospitalizations  $\bar{H}_t$ . Using a trust region method the algorithm minimizes the sum  $S(\beta)$  of squared daily differences between these estimated hospitalizations and the actual ones  $H_t$ :  

$$S(\beta) = \sum_t (H_t - \bar{H}_t)^2$$
. . The optimizing function runs until the resulting value of  $S(\beta)$  does not get any smaller.

**Table A4.1 Home contact matrix.** Daily number contacts by age group at home.

	<b>0-4y</b>	<b>5-17y</b>	<b>18-49y</b>	<b>50-64y</b>	<b>65y+</b>
<b>0-4y</b>	0.5	0.9	2.0	0.1	0.0
<b>5-17y</b>	0.2	1.7	1.9	0.2	0.0
<b>18-49y</b>	0.2	0.9	1.7	0.2	0.0
<b>50-64y</b>	0.2	0.7	1.2	1.0	0.1
<b>65y+</b>	0.1	0.7	1.0	0.3	0.6

**Table A4.2 School contact matrix.** Daily number contacts by age group at school.

	<b>0-4y</b>	<b>5-17y</b>	<b>18-49y</b>	<b>50-64y</b>	<b>65y+</b>
<b>0-4y</b>	1.0	0.5	0.4	0.1	0.0
<b>5-17y</b>	0.2	3.7	0.9	0.1	0.0
<b>18-49y</b>	0.0	0.7	0.8	0.0	0.0
<b>50-64y</b>	0.1	0.8	0.5	0.1	0.0
<b>65y+</b>	0.0	0.0	0.1	0.0	0.0

**Table A4.3 Work contact matrix.** Daily number contacts by age group at work.

	<b>0-4y</b>	<b>5-17y</b>	<b>18-49y</b>	<b>50-64y</b>	<b>65y+</b>
<b>0-4y</b>	0.0	0.0	0.0	0.0	0.0
<b>5-17y</b>	0.0	0.1	0.4	0.0	0.0
<b>18-49y</b>	0.0	0.2	4.5	0.8	0.0
<b>50-64y</b>	0.0	0.1	2.8	0.9	0.0
<b>65y+</b>	0.0	0.0	0.1	0.0	0.0

**Table A4.4 Others contact matrix.** Daily number contacts by age group at other locations.

	0-4y	5-17y	18-49y	50-64y	65y+
0-4y	0.7	0.7	1.8	0.6	0.3
5-17y	0.2	2.6	2.1	0.4	0.2
18-49y	0.1	0.7	3.3	0.6	0.2
50-64y	0.1	0.3	2.2	1.1	0.4
65y+	0.0	0.2	1.3	0.8	0.6

## Estimation of age-stratified proportion of population at high-risk for COVID-10 complications

We estimate age-specific proportions of the population at high risk of complications from COVID-19 based on data for Austin, TX and Round-Rock, TX from the CDC’s 500 cities project (Figure A2).(13) We assume that high risk conditions for COVID-19 are the same as those specified for influenza by the CDC.(8) The CDC’s 500 cities project provides city-specific estimates of prevalence for several of these conditions among adults.(14) The estimates were obtained from the 2015-2016 Behavioral Risk Factor Surveillance System (BRFSS) data using a small-area estimation methodology called multi-level regression and poststratification.(9,10) It links geocoded health surveys to high spatial resolution population demographic and socioeconomic data.(10)

**Estimating high-risk proportions for adults.** To estimate the proportion of adults at high risk for complications, we use the CDC’s 500 cities data, as well as data on the prevalence of HIV/AIDS, obesity and pregnancy among adults (Table A6).

The CDC 500 cities dataset includes the prevalence of each condition on its own, rather than the prevalence of multiple conditions (e.g., dyads or triads). Thus, we use separate co-morbidity estimates to determine overlap. Reference about chronic conditions(15) gives US estimates for the proportion of the adult population with 0, 1 or 2+ chronic conditions, per age group. Using this and the 500 cities data we can estimate the proportion of the population  $p_{HR}$  in each age group in each city with at least one chronic condition listed in the CDC 500 cities data (Table A6) putting them at high-risk for flu complications.

HIV: We use the data from table 20a in CDC HIV surveillance report(16) to estimate the population in each risk group living with HIV in the US (last column, 2015 data). Assuming independence between HIV and other chronic conditions, we increase the proportion of the

population at high-risk for influenza to account for individuals with HIV but no other underlying conditions.

**Morbid obesity:** A BMI over 40kg/m<sup>2</sup> indicates morbid obesity, and is considered high risk for influenza. The 500 Cities Project reports the prevalence of obese people in each city with BMI over 30kg/m<sup>2</sup> (not necessarily morbid obesity). We use the data from table 1 in Sturm and Hattori(17) to estimate the proportion of people with BMI>30 that actually have BMI>40 (across the US); we then apply this to the 500 Cities obesity data to estimate the proportion of people who are morbidly obese in each city. Table 1 of Morgan et al.(18) suggests that 51.2% of morbidly obese adults have at least one other high risk chronic condition, and update our high-risk population estimates accordingly to account for overlap.

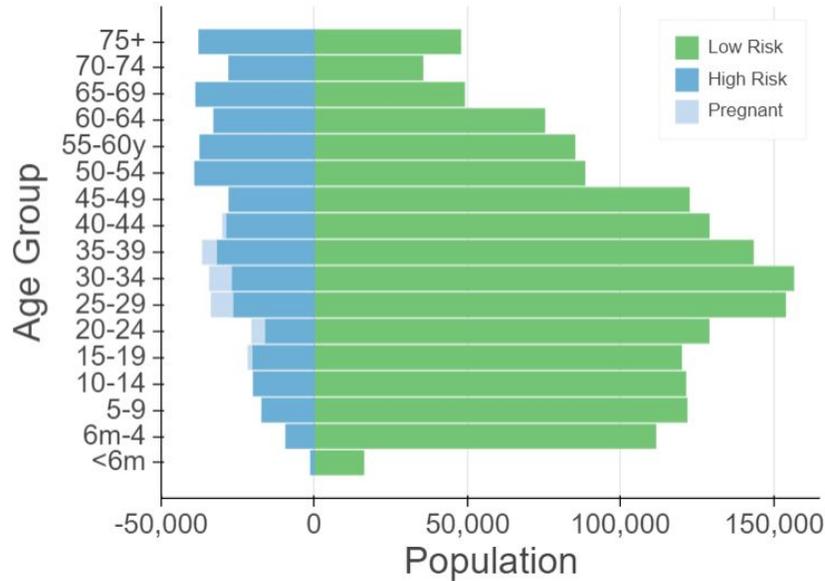
**Pregnancy:** We separately estimate the number of pregnant women in each age group and each city, following the methodology in CDC reproductive health report.(19) We assume independence between any of the high-risk factors and pregnancy, and further assume that half the population are women.

**Estimating high-risk proportions for children.** Since the 500 Cities Project only reports data for adults 18 years and older, we take a different approach to estimating the proportion of children at high risk for severe influenza. The two most prevalent risk factors for children are asthma and obesity; we also account for childhood diabetes, HIV and cancer.

From Miller et al.(20), we obtain national estimates of chronic conditions in children. For asthma, we assume that variation among cities will be similar for children and adults. Thus, we use the relative prevalences of asthma in adults to scale our estimates for children in each city. The prevalence of HIV and cancer in children are taken from CDC HIV surveillance report(16) and cancer research report,(21) respectively.

We first estimate the proportion of children having either asthma, diabetes, cancer or HIV (assuming no overlap in these conditions). We estimate city-level morbid obesity in children using the estimated morbid obesity in adults multiplied by a national constant ratio for each age group estimated from Hales et al.,(22) this ratio represents the prevalence in morbid obesity in children given the one observed in adults. From Morgan et al.,(18) we estimate that 25% of morbidly obese children have another high-risk condition and adjust our final estimates accordingly.

**Resulting estimates.** We compare our estimates for the Austin-Round Rock Metropolitan Area to published national-level estimates(23) of the proportion of each age group with underlying high risk conditions (Table A6). The biggest difference is observed in older adults, with Austin having a lower proportion at risk for complications for COVID-19 than the national average; for 25-39 year olds the high risk proportion is slightly higher than the national average.



**Figure A2. Demographic and risk composition of the Austin-Round Rock MSA.** Bars indicate age-specific population sizes, separated by low risk, high risk, and pregnant. High risk is defined as individuals with cancer, chronic kidney disease, COPD, heart disease, stroke, asthma, diabetes, HIV/AIDS, and morbid obesity, as estimated from the CDC 500 Cities Project,(13) reported HIV prevalence(16) and reported morbid obesity prevalence,(17,18) corrected for multiple conditions. The population of pregnant women is derived using the CDC’s method combining fertility, abortion and fetal loss rates.(24–26)

**Table A6. High-risk conditions for influenza and data sources for prevalence estimation**

Condition	Data source
Cancer (except skin)	CDC 500 cities(13)
Chronic kidney disease	CDC 500 cities(13)
COPD	CDC 500 cities(13)
Coronary heart disease	CDC 500 cities(13)
Stroke	CDC 500 cities(13)
Asthma	CDC 500 cities(13)
Diabetes	CDC 500 cities(13)
HIV/AIDS	CDC HIV Surveillance report(16)
Obesity	CDC 500 cities complemented with Sturm and Hattori(17) and Morgan et al.(18)
Pregnancy	National Vital Statistics Reports(24) and abortion data(25)

**Table A7: Comparison between published national estimates and Austin-Round Rock MSA estimates of the percent of the population at high-risk of influenza/COVID-19 complications.**

Age Group	National estimates(22)	Austin (excluding pregnancy)	Pregnant women (proportion of age group)
0 to 6 months	NA	6.8	-
6 months to 4 years	6.8	7.4	-
5 to 9 years	11.7	11.6	-
10 to 14 years	11.7	13.0	-
15 to 19 years	11.8	13.3	1.7
20 to 24 years	12.4	10.3	5.1
25 to 34 years	15.7	13.5	7.8
35 to 39 years	15.7	17.0	5.1
40 to 44 years	15.7	17.4	1.2
45 to 49 years	15.7	17.7	-
50 to 54 years	30.6	29.6	-
55 to 60 years	30.6	29.5	-
60 to 64 years	30.6	29.3	-
65 to 69 years	47.0	42.2	-
70 to 74 years	47.0	42.2	-
75 years and older	47.0	42.2	-

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