



Data Matters

Community-Based Social Determinants of Health



Center for Social Impact

Chinese American Service League
Chicago, Illinois
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SUMMARY

In spring 2021, the Chinese American Service League, otherwise known as [CASL](#), implemented its second annual CASL Social Determinants of Health (SDoH) Assessment. Incorporating feedback from program administrators, the new version of the tool was shorter and contained simpler language. This 40-item questionnaire format was easier to distribute, could be filled out by the client independently, and offered a more targeted approach to the analysis procedure. To find out more about the initial assessment, check out [this narrative](#) released in fall 2020.

Between February 22nd and April 30th, a total of 549 assessments were collected. Several notable differences included self-administration methods (in addition to administering by phone), new analytical procedures, and identification of external variables influencing responses. The three-tiered analytical procedure considered the overall differences between samples from both years, participants with multiple entries (pre- and post-assessments), and response rates for each indicator (i.e. question or series of questions). Analysis conducted by the Center for Social Impact (CS) offers an inside look to how factors like the COVID-19 pandemic have exacerbated racial inequity in healthcare access and use.

This report covers the changes to our assessment, a glance at who was surveyed, and findings grouped by domains. Domain labels were largely retained from last year, with a few minor tweaks to ensure greater accuracy when cataloging assessment questions. We only display the most significant findings in this report, but a comprehensive look at all the indicators we cover can be found in a publicly available [supplemental folder](#). This folder containing survey distribution and administration methods, analytical chains and scripts, questions from the assessment, and high resolution, full-size dashboard images.

To offer a more comprehensive understanding of this report, we encourage you to check out our [first report](#). This will provide greater context to this initiative and how it fits into CASL's overall [strategic vision](#). The highlights from this year's collection round are included at right:

Demographics:

- *Average age: 57*
- *66.2% female, 33.8% male*
- *Most live in 4 Chicago neighborhoods*
- *97% Asian*

Place & Safety:

- *Fewer participants reported speaking English “well” or “very well” this year*
- *20% decrease in community belonging among female participants*
- *Fewer participants reported feeling safe this year*

Housing & Financial

- *More participants reported being unemployed or out-of-work this year*
- *Older participants enrolled in bank accounts less than younger participants*
- *Higher levels of English proficiency indicated greater familiarity with credit*
- *Participants who own pay more in monthly costs than renters*
- *Adults aged 45-64 reported not buying enough food*

Health Visits & Costs

- *Participants without healthcare coverage reported higher levels of self-perceived health status*
- *Participants who spoke English “very well” reported “usually” or “always” being able to receive needed health care*
- *Those who did not feel like they needed to get their teeth cleaned didn't because they thought their teeth were fine*

Health Fitness & Behaviors

- *Uninsured participants are more likely to use alternative medicine*
- *Male participants smoke more than female participants*

Data transparency and accountability matters, especially for demographic groups which have proved difficult to reach and/or assess—most of our clients identify as Asian American Pacific Islanders (AAPIs). Our aim is to use data to amplify the voices of our clients and community as a way to tell their story.

ACKNOWLEDGEMENTS

The Center for Social Impact (CSI) at CASL was launched at the beginning of 2020, thanks to CASL's Leadership and Board. Paul Luu, CEO, and Jered Pruitt, COO, were instrumental in the founding of the Center. As part of CASL's strategic plan, this project was one of many endeavors to understand the impact we have on our community. This project would not be possible without their support.

For CASL's dedicated Board of Directors, who made this project happen, their decades of industry expertise proved essential towards the oversight of this process. The Center also thanks Dr. Lee Washington, a CASL Program Committee Member and wealth of evaluative knowledge, for providing his feedback and suggestions to this report.

We would also like to take this opportunity to thank the Julian Grace Foundation for their generous support in sponsoring this endeavor. To learn more about the Julian Grace Foundation, please refer to this link [here](#). Finally, this project would not be possible without the support of dedicated CASL staff who created opportunities to connect with our clients and administer this assessment during a dynamic 2021. This report is for you.

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A NEW SEASON

CASL’s Social Determinants of Health (SDoH) Assessment entered its second annual collection round. Social Determinants of Health, as defined in last year’s [report](#), are diverse environmental conditions that contribute to one’s health. In 2021, we developed a more targeted approach to questionnaire design and distribution. This report outlines the changes to our assessment, updates to the official comparison source (Chicago Health Atlas), and key highlights by domains like health visits, built environment, and place. Our primary objective for this assessment is to amplify the voices of individuals and communities we serve—storytelling using data as a medium. Supplemental materials such as administration procedures and analytical processes can be found [here](#).

“Using DATA to tell stories”

CHANGES TO LAST YEAR’S CASL SDOH ASSESSMENT

Using the lessons taken from our initial response collection, the assessment underwent several changes. The overall length of the assessment was slightly shortened from 42 to 40 questions. Revisiting the response rates from the pilot, we paid careful attention to the wording of the questions. Did participants refuse to answer questions that seemed too confusing? A summary of what program managers thought of the new format can be seen below:

Since changes were made to the assessment...	What staff said..
Are the questions relevant to CASL’s programs?	“Yes, mostly relevant”
Were the responses relevant to the questions?	“Yes, mostly relevant”
How easy was it to understand the questions?	“Mostly easy to understand”
How much jargon was there?	“Some, but mostly okay”
How long did it take to complete?	“Somewhat long, but seems average”
What was the level of bias in the questions?	“Mostly unbiased”
What did you like most about the survey?	“Question flow, content relevance, comprehensives, well-selected indicators, not too intrusive”
What did you like least about the survey?	“No online format, somewhat wordy, a little long, should include questions on utility of services, some medical terms difficult to understand”
Any suggestions?	“Make it online-friendly, emphasize confidentiality more, make it shorter”

A thorough investigation followed, where we categorized which questions mattered. We focused on responding to the paucity of public health data on Asian American Pacific Islanders (AAPIs). Bridging these gaps in SDoH data helps us to understand how health equity and mortality are linked. Disaggregate SDoH data helps us establish targeted solutions for health problems our communities face due to inequitable conditions of living. For instance, *why does asking whether someone knows their credit score matter?* A credit score more broadly signifies financial health and spending patterns. Knowing how to look up a credit score represents awareness of local fiduciary processes and how personal money habits impact opportunity access.

“bridging these gaps in SDoH data helps us to understand how health equity and mortality are linked.”

Another change to the questionnaire this year compared with last year was the format and structure of the instrument. Last year, we had 4 domains with certain questions grouped together. A more in-depth look into the domain categories can be found in our [2020 report](#). For instance, the Place & Safety domain houses questions regarding neighborhood safety, language ability, social cohesion, and place of birth. This year, we simply changed the name of 1 domain from “Smoking” to “Health Fitness & Behaviors.” Since we wanted to capture more than just smoking habits, we wanted to discover what self-care looked like in addition to tobacco/nicotine use.

Since the redevelopment of our questionnaire, our source for our selected indicators underwent a few updates. Our questionnaire was based off of select indicators from the Chicago Health Atlas, a public health data compendium that highlights community-level needs and statistics. To learn more about why we chose the Chicago Health Atlas as the source for question items, please refer to the inaugural CASL SDoH narrative. Indicators for both rounds of response collection (2020 and 2021) were selected based on assumed relevance to current services and programs CASL offers, such as housing assistance and senior supports. The next section discusses updates from the Chicago Health Atlas and how it connects with our in-house SDoH assessment.

OFFICIAL CHANGES TO THE CHICAGO HEALTH ATLAS

On May 13, 2021, the [Chicago Health Atlas](#) announced that it would now be housed at the University of Illinois at Chicago’s School of Public Health (UIC PHAMES) instead of the City Tech Collaborative. The Chicago Health Atlas — now managed through a partnership between UIC’s School of Public Health, Metopio, and the Chicago Department of Public Health — is a free community health data resource that residents, community organizations and public health stakeholders can use to easily search, analyze and download neighborhood-level health data for Chicago’s 77 community areas.

This change enables the Atlas’ to extend its reach and impact, signifying dynamic advances in data accountability and healthcare equity. With respect to the new CASL SDoH Assessment, this meant that our comparisons could be more recent. While most of the indicators we adopted from the Health Atlas only had data up until 2019, some were updated to include more recent data. Some indicators previously available prior to the transition to UIC PHAMES were removed. This just means that those indicators are not necessarily relevant to the Health Atlas’ priorities at the moment. Since the transition became official during our data collection timeframe, we still had older Health Atlas indicators. As for what we plan to do with older indicators the Health Atlas no longer tracks, we will continue monitoring *all* indicators relevant to CASL’s services/programming.

“the Chicago health atlas is a free community health data resource that...stakeholders can use to easily search, analyze and download neighborhood-level health data for Chicago’s 77 [neighborhoods].”



As of May 13, 2021, the Chicago Health Atlas updated the following indicators:

- Limited English proficiency
- Foreign-born
- High school graduation rate
- College graduation rate
- Unemployment rate
- Rent-burdened
- Severely rent-burdened
- Median household income
- Crowded housing
- Uninsured rate

The following indicators are no longer available:

- *No high school diploma*
- *Food insecurity (due to cost)*
- *Breast cancer screening*
- *Colorectal cancer screening*
- *Visited emergency department*
- *Alternative therapy*

The following section offers a brief overview of how our methods changed between the two years of data collection.

SURVEY ADMINISTRATION & DISTRIBUTION FORMAT

The main difference for 2021 was how we collected responses. In 2020, responses were collected by phone due to the rising number of COVID-19 cases. As the situation evolved, CASL re-opened its doors to the public while observing all safety measures. This meant that assessments could be administered on paper to the client and/or participant directly. Hard copies of the assessment were collected by department staff and entered into Salesforce thereafter.

“The main difference was how we collected data...resulting in a 13% increase over last year’s total responses.”

Using a similar convenience sampling approach as last year, caution is warranted when interpreting data from this year’s sample. CASL serves nearly 5,000 clients in any given year, meaning a sizable sample of (approximately 380) was needed to offer some degree of accurate representation. In total, we had 549 responses, of which 452 had a completion rate greater than 85%. Out of all responses with a completion rate 85% or higher, this represents a 13% increase over last year’s collection round.

Although the scope of how these changes affected responses we collected, we anticipate that having a broader participant sample offers some semblance to trends among those we serve. Next, we have the opportunity to meet the participants whose stories we hope to share.



Chinese American Service League
2141 South Tan Court | Chicago, Illinois 60616 | 312.791.0418 | CASLservice.org

CASL SOCIAL DETERMINANTS OF HEALTH SURVEY

Hello and welcome to CASL! We would like to ask you some questions to better understand you as a person and any needs you may have. This information will help us determine if you are eligible for any additional benefits, programs, or services as we want to make sure that we provide the best care and services possible to meet your needs. Your responses will also help us determine if we need to add new services or programs to better care for our clients. Your information will be kept private and secure. Your decision to answer or to refuse to answer will NOT impact your ability to receive care. Please answer to the best of your ability (✓) and let us know if you have any questions, concerns, or suggestions.

PLACE AND SAFETY

We ask questions about a person’s place of birth, citizenship, and year of entry into the United States to create data about native and foreign-born populations. These statistics also help tailor services to accommodate cultural differences. We currently offer citizenship and immigration service as part of our programming.

1. Were you born in the US?
 Yes (go to 4)
 No (go to 2)
 Don't know/Not Sure

2. If you were not born in the US, which country were you born? _____

3. If you were not born in the US, what year did you move to here? _____

4. How well [do you] speak English?
 Very well
 Well
 Not well
 Not at all

5. I really feel part of my neighborhood. Would you say you _____ with this statement?
 Strongly agree
 Agree
 Neither agree nor disagree
 Disagree
 Strongly disagree
 Don't know/Not sure

6. Do you feel safe in your neighborhood?
 Yes, all of the time
 Yes, most of the time
 Sometimes
 No, mostly not
 Don't know/Not sure

Sex & Age

7. What is your sex?
 Male
 Female
 Other (specify): _____

8. What is your date of birth? MM/DD/YYYY



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华人咨询服务处社会健康因素调查表

您好，欢迎来到华咨处！我们想向您一些问题，以更好地了解您的服务需求。这些信息将不仅帮助我们确定最适合您的所有福利申请、项目和服务等，而且确保我们尽可能地为您提供最好的服务并最大程度地满足您的需求。这些信息还将帮助华咨处决定将来是否需要添加新的服务和项目以更好地为社区和您提供更多更好的服务。您的回答将被严格保密，希望您能以您所能进行回答。如果您拒绝回答任何问题，并不会影响您接受我们的服务。如果您有任何问题或建议，请告知我们。

社区与安全

以下问题有关出生地、公民身份和进入美国的年份等，用于分析移民社区的状况。这些统计数据有助于我们提供适应文化差异的服务。目前，我们的服务也包括公民入籍及移民申请等服务。

1. 您出生于美国吗？
 是 (转到第 4 题)
 否 (转到第 2 题)
 不知道/不确定

2. 如果您不是在美国出生，那么您出生在哪个国家？ _____

3. 如果您不是在美国出生，那么您是哪一年来到美国？ _____

4. 您的英语说得怎么样？
 很好
 好
 不好
 很不好

5. 我有很强的社区归属感，我和社区紧密相连。您是否同意这一说法？
 强烈同意
 同意
 既不同意也不反对
 不同意
 非常不同意
 不知道/不确定

6. 您在社区中感到安全吗？
 是的，一直都是
 大多数时候是
 有的时候是
 不，大部分时候不是
 不知道/不确定

性别与年龄

7. 您的性别是？
 男
 女
 其他
 拒绝

8. 您的出生日期是 (月/日/四位数字年份)？ / / _____

家庭状况

接下来的几个问题是关于您的家庭。这些问题是以便我们了解您和您家人的服务需求。我们有多部门和多 种针对个人及家庭的服务

9. 您的婚姻状况是？ (请只选择一项)
 已婚
 从未结婚
 未婚，有伴侣
 丧偶
 分居

10. 目前一共有多少 18 岁以下的您孩子和您住在一起 (请勾选所有合适的年龄段并写下每个年龄段里孩子的总数):
 例如: 0 岁至 5 岁 (请写出符合此年龄段的孩子的总数) 3
 0 岁至 5 岁 (请写出符合此年龄段的孩子的总数) _____
 6 岁至 10 岁 (请写出符合此年龄段的孩子的总数) _____
 11 岁至 13 岁 (请写出符合此年龄段的孩子的总数) _____
 14 岁至 18 岁 (请写出符合此年龄段的孩子的总数) _____
 没有 18 岁以下我的孩子和我住在一起

11. 目前一共有多少 18 岁以下的您的 (外) 孙子/ (外) 孙女和您住在一起 (请勾选所有合适的年龄段并写下每个年龄段里孩子的总数):
 例如: 0 岁至 5 岁 (请写出符合此年龄段的孩子的总数) 3
 0 岁至 5 岁 (请写出符合此年龄段的孩子的总数) _____
 6 岁至 10 岁 (请写出符合此年龄段的孩子的总数) _____
 11 岁至 13 岁 (请写出符合此年龄段的孩子的总数) _____
 14 岁至 18 岁 (请写出符合此年龄段的孩子的总数) _____
 没有 18 岁以下我的 (外) 孙子/ (外) 孙女和我住在一起

12. 您与多少人住在一起? 包括自己在内的总数是 _____

Adapted from [Chicago Healthy Atlas 2.0](#) Go to next page → 1

问题改编自 [Chicago Healthy Atlas 2.0](#) 请转到下一页 → 1

MEET THIS YEAR'S PARTICIPANTS

HOW OLD ARE WE?...WE ARE OF ALL AGES AND THE AVERAGE AGE IS 57.

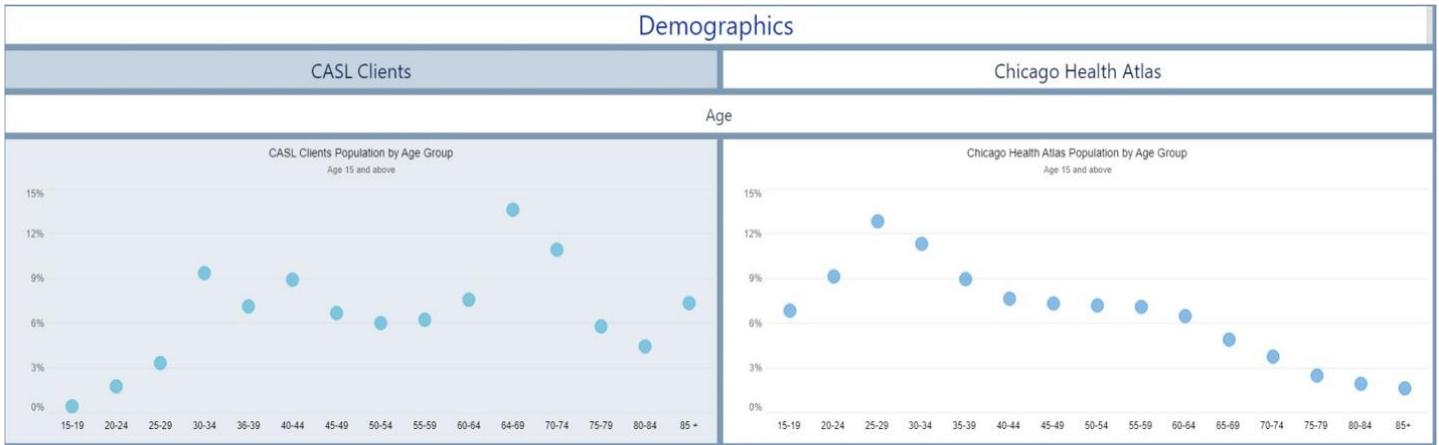


Figure 1: Click on the image for full size viewing or go to : <https://drive.google.com/file/d/15FE8Jcm6odTLclg9AYelEp2CjFhNnsqK/view?usp=sharing>

Here is a glimpse of how many of us are 18-29, 30-44, 45-64, or 65 and older compared with the Chicago Health Atlas sample. As shown here, the age group with the greatest percentage for CASL participants this year is between 64 and 69 years of age whereas the Health Atlas indicates 25-29 year olds being the largest age group. Compared with last year, we had a greater proportion of younger participants. Check out this [link](#) with a comparison between both CASL SDoH collection rounds.

SEX/GENDER?...66.2% OF PARTICIPANTS IDENTIFY AS FEMALE, 33.8% IDENTIFY AS MALE

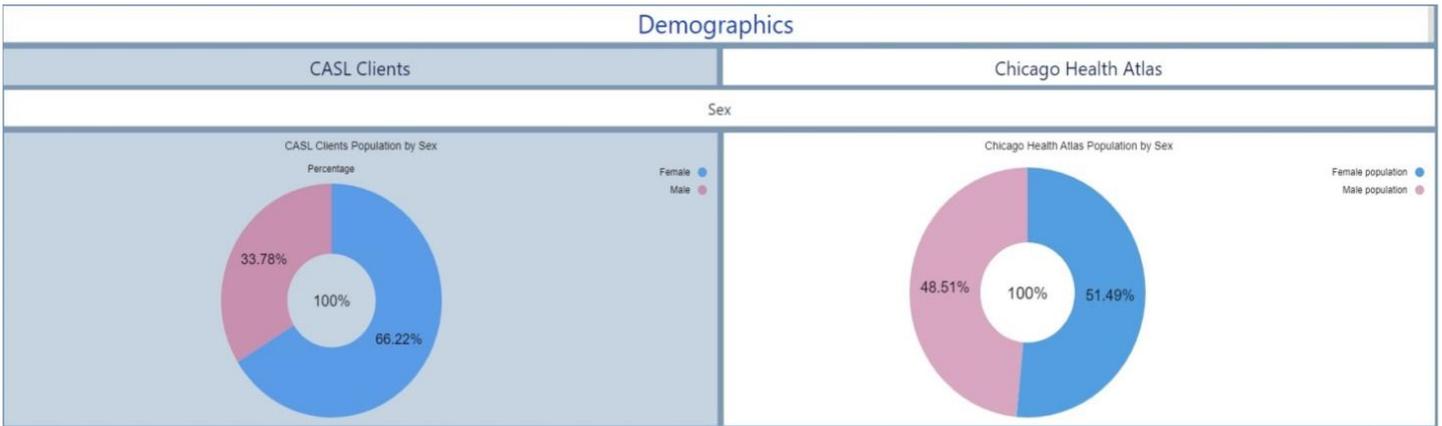


Figure 2: Click on the image for full size viewing or got to : <https://drive.google.com/file/d/1JAVuQSSqJi1pLLiqlEwz9RVnn07npeVW/view?usp=sharing>

WHERE'S HOME?...MOST OF US LIVE IN 4 CHICAGO NEIGHBORHOODS

(in order of greatest population to least):

- Armour Square
- Bridgeport
- Brighton Park
- McKinley Park

Demographics

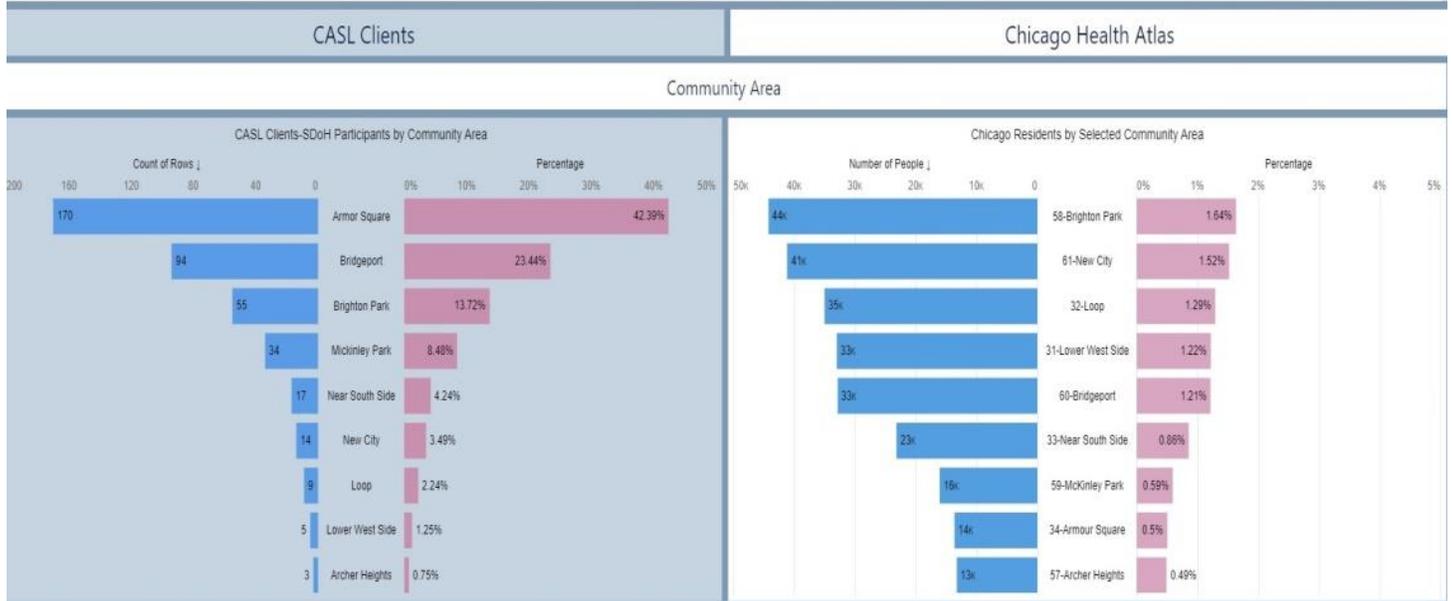
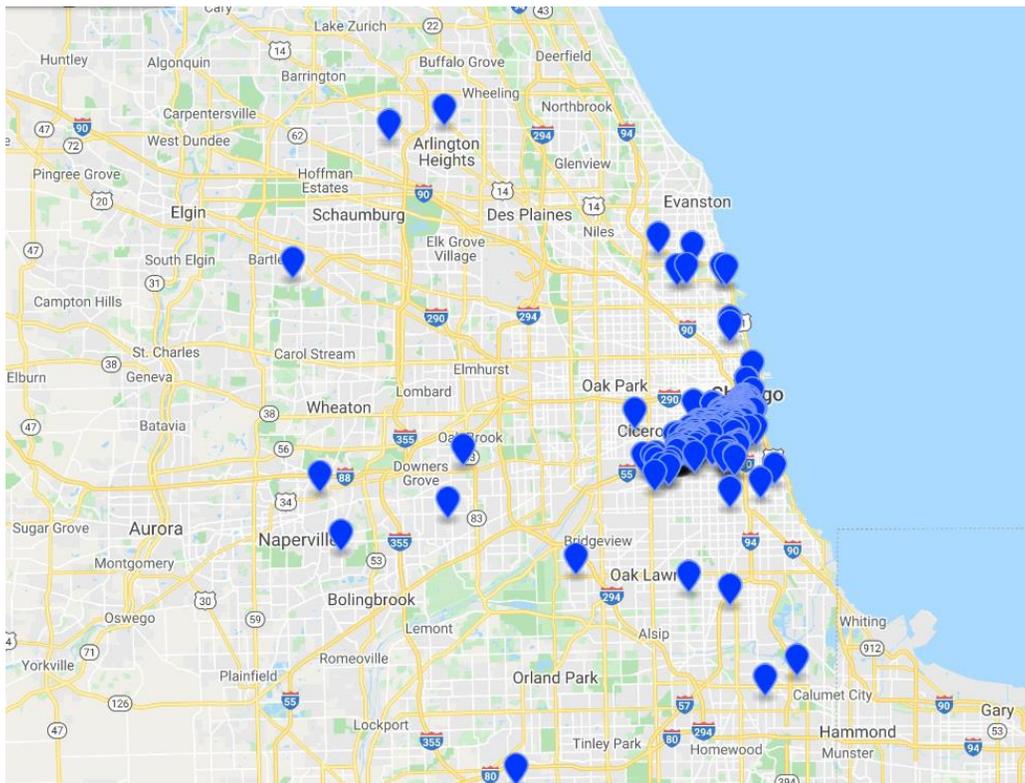


Figure 3: Click on the image for full size viewing or go to: <https://drive.google.com/file/d/1vCecvjonjS4AMtSGXv3tZIZtn3MxSAwG/view?usp=sharing>



RACE...97% OF US IDENTIFY AS ASIAN

(total sample includes participants from 2020 collection round)

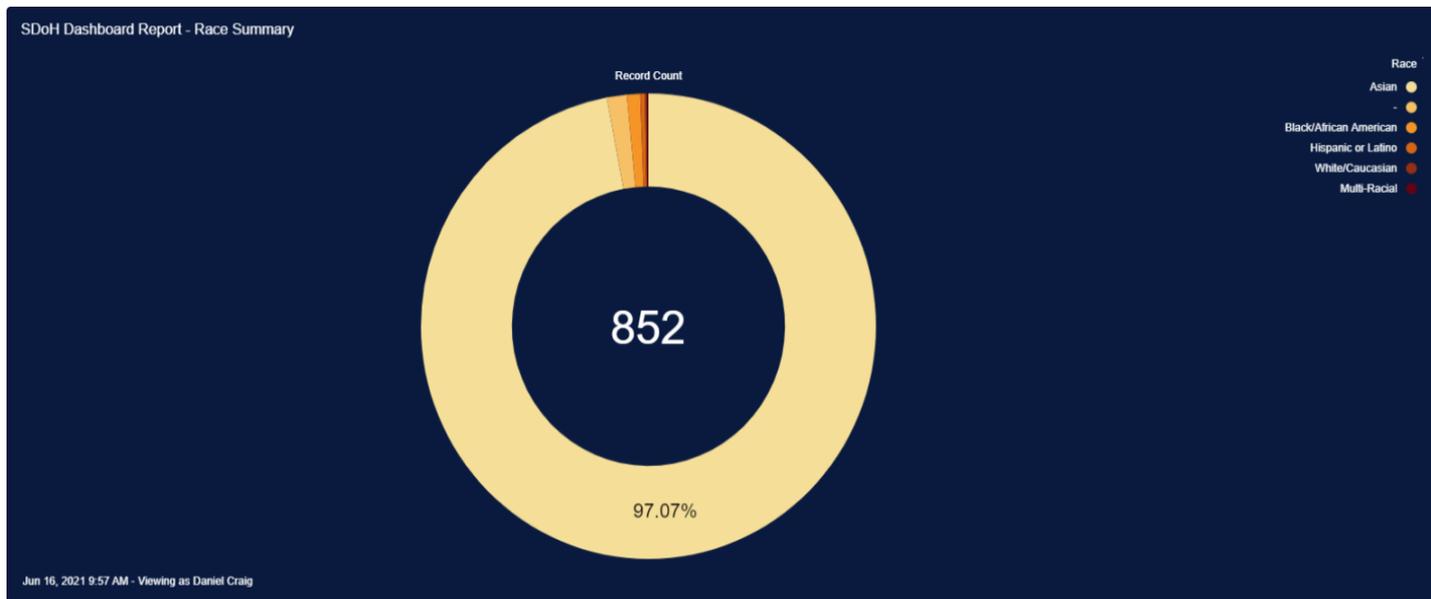


Figure 4: Click on the image for full size viewing or go to: <https://drive.google.com/file/d/10SY3UImvRNZhNqgNK0mgBWZ9Sc1oUXIB/view?usp=sharing>

Non-Hispanic Asian Pacific islanders account for 7% of Chicago's total population...

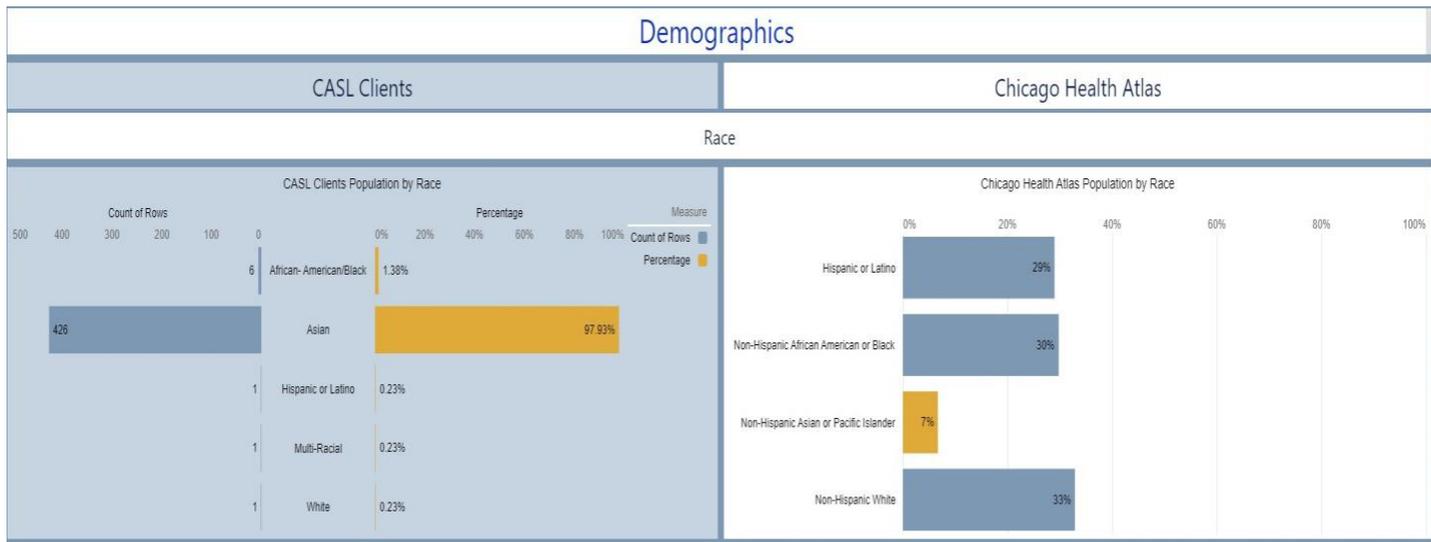


Figure 5: Click on the image for full size viewing or go to: https://drive.google.com/file/d/1FT9QjMUxaA233WS1IW_nz_XqoyepXn_H/view?usp=sharing

A comprehensive look at this year’s participant demography can be found [here](#). Now where things get interesting is what participants said this year and why it matters. When we adapted Chicago Health Atlas indicators to our own questionnaire design, we grouped them according to what we thought would best suit our constituents. We came up with four domains:

- Place & Safety, which describes personal identity
- Housing & Financial, which addresses built environment and economic security
- Health Visits & Costs, which details access and utilization of health care services
- **NEW for 2021** Health Fitness & Behaviors (formerly Smoking), which captures self-care practices

To recap, the very problem CASL’s Center for Social Impact (CSI) sought to address was the lack of disaggregate data on Asian American Pacific Islanders (AAPIs)—in the context of this assessment, bridging gaps in public health data on a community-level.

“...bridging gaps in public health data on a *community* level.”

In the next section, we explore specific highlights from this year’s participants. The conclusions our team came to were made based on a series of analytical processes, ranging from descriptive statistics to regressions between indicators. For a more exclusive look at statistical analyses conducted using *R Studio*, a statistics program, check out this [folder](#). An example of statistical analysis can be seen here.

We will be covering what each domain is comprised of and what findings were significant. Please note that since data collection was completed during the [COVID-19] pandemic, external variables cannot be ignored. We modeled our assessment off the [Chicago] Health Atlas, but some of the Atlas’ data was not updated (see [Official changes to the Chicago Health Atlas](#)). To see what highlights we found last year, please refer to the [2020 narrative](#).

CASL’s SDoH data this year may not offer the most linear comparison to Health Atlas data since that [Health Atlas] data is slightly outdated¹. Detailed comparisons between CASL participants and Health Atlas participants can be found in the supplemental [folder](#). This report primarily focuses **on internal analysis of CASL participants from 2020-2021**. This was not previously available since we did not have 2 or more points of data to reference.

```
## 2      Adult Education 100.00
## 3      Adult Employment 74.00
## 4      Alzheimer Project 100.00
## 5              CDC 93.62
## 6              CIS 100.00
## 7      CIS/PTSC 100.00
## 8              CTP 100.00
## 9      High School 100.00
## 10     Housing 93.15
## 11     INH 97.80
## 12     Middle School 100.00
## 13     PI 97.14
## 14 Pine Tree Senior Counsel 100.00
## 15     SAC 96.67
## 16     WSS 100.00
## 17     Youth 100.00

#create data sets which separate men and women

men <- (filter(placeandsafety,Gender=="Male",.preserve = FALSE))
men

## # A tibble: 261 x 8
##   `Survey Date` Division Gender `Years Since Im` `Community Area~
##   <chr>         <chr>   <chr> <chr>         <chr>
## 1 CY2021      Alzheim~ Male  10-20      Armor Square
## 2 CY2021      Pine Tr~ Male  0-5 Years  Bridgeport
## 3 CY2021      Pine Tr~ Male  0-5 Years  Near South Side
## 4 CY2021      Pine Tr~ Male  20+       Armor Square
## 5 CY2021      Alzheim~ Male  20+       Armor Square
## 6 CY2021      Alzheim~ Male  20+       Armor Square
## 7 CY2021      Pine Tr~ Male  20+       Brighton Park
## 8 CY2021      CIS      Male  10-20      Bridgeport
## 9 CY2021      WSS     Male  20+       Lower West Side
## 10 CY2021     Housing Male  20+       Brighton Park
## # ... with 251 more rows, and 3 more variables: `Foreign Born` <dbl>,
`Feels
## # part of neighborhood` <dbl>, `Feels Safe` <dbl>

Women <- (filter(placeandsafety,Gender=="Female",.preserve = FALSE))
Women

## # A tibble: 590 x 8
##   `Survey Date` Division Gender `Years Since Im` `Community Area~
##   <chr>         <chr>   <chr> <chr>         <chr>
## 1 CY2021      Alzheim~ Female 20+       Armor Square
## 2 CY2021      Alzheim~ Female 10-20     Armor Square
## 3 CY2021      Alzheim~ Female 20+       Armor Square
## 4 CY2021      CDC      Female 0-5 Years  Armor Square
## 5 CY2021      Alzheim~ Female 0-5 Years  Armor Square
## 6 CY2021      Pine Tr~ Female 0-5 Years  Brighton Park
```

Figure 6: Click on the image for full size viewing or go to: <https://drive.google.com/file/d/1j9KwVREWBXWylLil3ay4KBQ5K709W9jw/view?usp=sharing>

¹ Chicago Health Atlas data only goes to 2019 or 2014-2018, depending on the indicator selected.

*This domain includes questions about a person’s place of birth, citizenship, and year of entry into the United States. Asking for this information helps us establish trends relating to the **lived experience of native and foreign-born populations**. These statistics also help tailor services to accommodate immigrants and non-immigrants alike.*

ENGLISH PROFICIENCY

Understanding the degree to which participants are limited English proficient offers insight into which services and/or resources are available and accessible. When controlling for age, we discovered that **fewer participants reported speaking English “well” or “very well” this year** compared to 2020. However, when taking into account participants whose responses were recorded for both years (and both assessments), we observed a slight increase. Although these trends are elementary, we need to pay close attention to the length of time participants have utilized CASL's services.

- **English proficiency by age:** participants ages 18-29 reported the largest positive difference over last year. This was the only age group whose English proficiency improved.
- **English proficiency by years since immigration:** Participants who immigrated here 0-5 years ago reported English proficiency at the same or higher levels than participants immigrating over 5 years ago.
- **English proficiency and family structure:** We also observed these participants to be younger and having more children on average.

Using regression analysis, age and years since immigration were found to be significant. For instance, if the participants’ children attend public education institutions, both children and parents will most likely be required to speak English to some extent. Being able to speak English represents increased opportunity—opportunity to access services, to move and make household decisions.

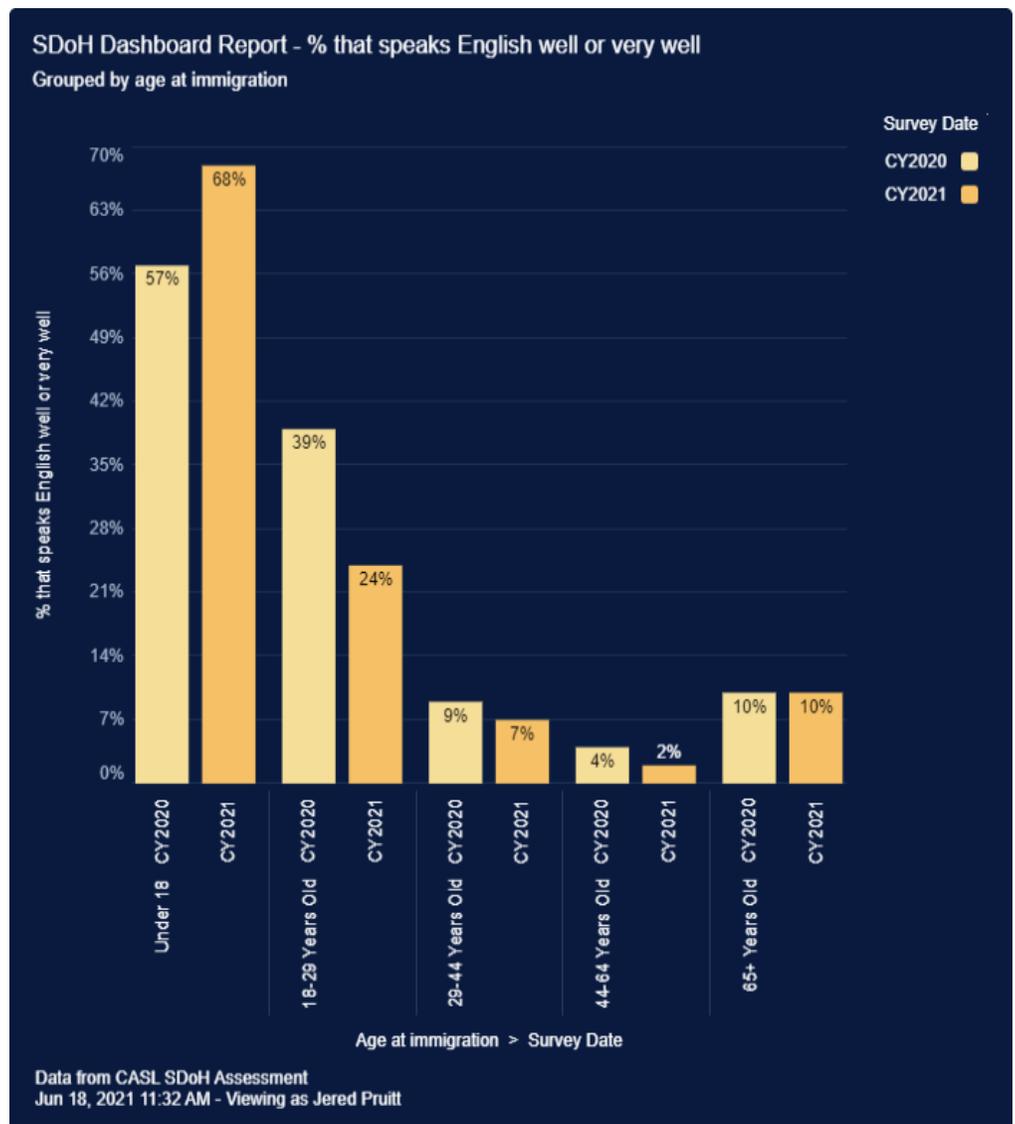


Figure 7: Click on the image for full size viewing or go to: <https://drive.google.com/file/d/1s4yOuS-YMj3r7s7yK81EDZUqN2bG1KqE/view?usp=sharing>

COMMUNITY BELONGING

Feeling like one belongs is a key to being connected to opportunity and each other. When asked how strongly participants felt being “part of their neighborhood,” we found that a lower percentage of people reported agreeing (and strongly agree) with this statement. Where over three-quarters of participants reported feeling like they belong in 2020, less than two-thirds of participants felt that way this year.

The trend continues across different neighborhoods too. Most of the participants in both years lived in the following Chicago Community Areas (CCAs) Armour Square, Bridgeport, Brighton Park, and Mckinley Park. Although we observed lower rates of community belonging across all four community areas, Armour Square—where CASL is located—reported the sharpest decline.

Something new for 2021 is how male and female participants responded:

- **Between 2020 and 2021, we observed a 20% decrease in community belonging among female participants**
- By contrast, male participants had less than one percent change (increased from 67.9% in 2020 to 69.3% in 2021).

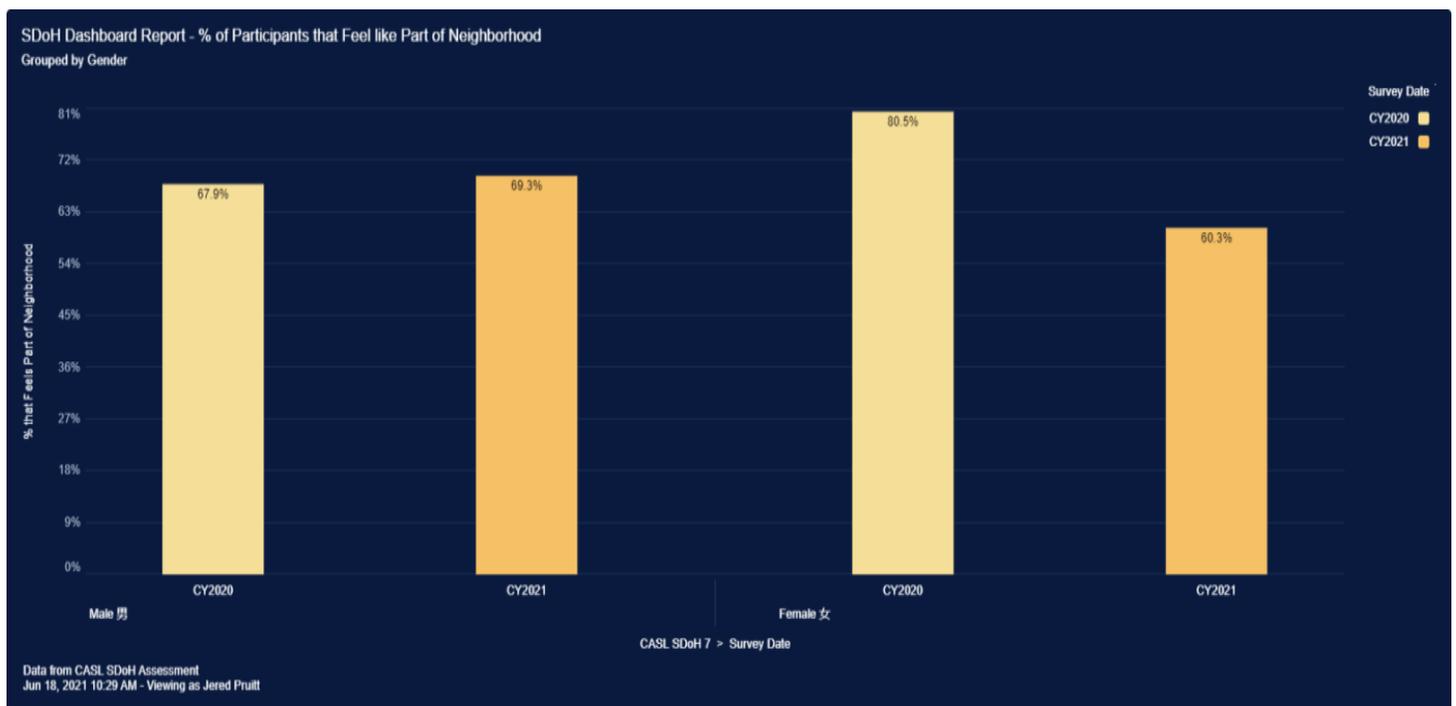


Figure 8: Click on the image for full size viewing or go to:
<https://drive.google.com/file/d/1HAmAtx4UuymXpe5a4zWxXOAvpffSXAYQ/view?usp=sharing>

Although the assessment does not allude to any reasoning for why the shift in tone, it is clear to see that environmental variables are actively at play. It may have something to do with recent events which captured national headlines, such as the murder of 6 Asian women in Atlanta-area spas and the vitriolic rhetoric tying the [COVID-19] pandemic and Asian Americans and Pacific Islanders.

CASL serves a community of immigrants and non-immigrants which contributes to Chicago’s diverse landscape. Feeling like one belongs, especially if you were not born in the United States, can be a challenge at times. Where levels of community belonging decreased from 2020 to 2021, we discovered that participants who immigrated over 20 years ago reported the largest decrease.

When grouping by years since immigration, what we want to know is whether being here longer makes one feel like they belong more. What we found was that participants who immigrated here over 5-, 10-, and even 20-years ago reported feeling less part of their neighborhoods between this year and last year. Which leads us to our final Place & Safety highlight, Neighborhood Safety.

NEIGHBORHOOD SAFETY

This leads us to our final Place & Safety highlight, Neighborhood Safety. Feeling safe where you live is crucial to being able to get around and access local services and goods. **Fewer participants reported feeling safe this year compared with last year.** Compared to 70.7% of participants who reported feeling safe in their neighborhood “all” or “most of the time” in 2020, this year, only 54.5% reported the same level of security. Across the top 4 neighborhoods participants live in, each CCA observed a noticeable drop in levels of perceived safety. Both male and female participants reported feeling less safe when compared to last year, with a larger decrease observed in females. The fact that 6 women of Asian descent were murdered in March 2021 may offer some explanation for the difference in response rates as shown here:

When grouped by the length of time participants have been living here, those who immigrated over 20 years ago saw a smaller decrease than more recent residents. This begs the question of how many actual crimes were committed during the period of our data collection. Included below are the total counts of violent crime in the top 4 neighborhoods participants live during both rounds of data collection.

Neighborhood	# Incidents of violent ² crime according to the Chicago Police Department (dates: May 11 to June 30) 2020	# Incidents of violent ³ crime according to the Chicago Police Department (dates: February 27 to April 30) 2021
Armour Square	28	23
Bridgeport	24	15
Brighton Park	46	28
McKinley Park	14	11

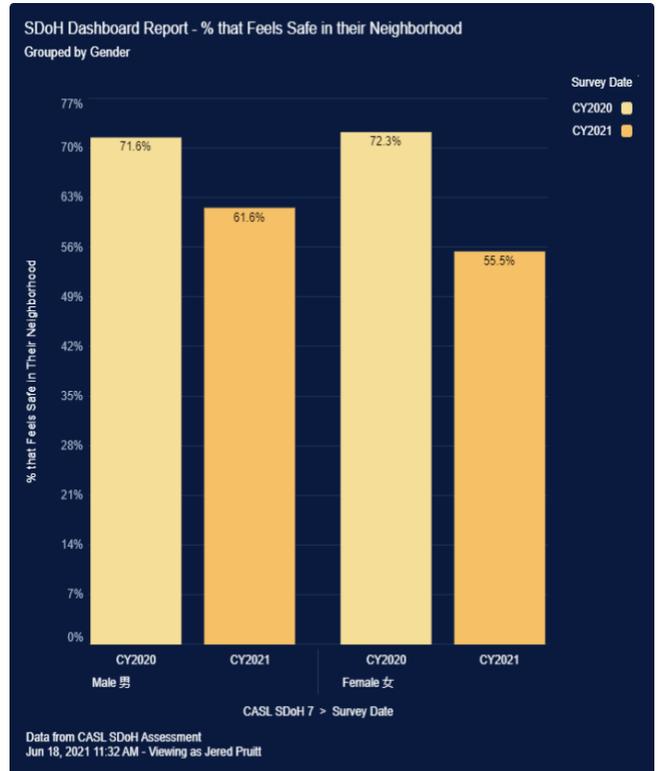


Figure 9: Click on the image for full size viewing or go to: <https://drive.google.com/file/d/1aycPuOgZx0B2JngEyhMgAylsBci4d-YG/view?usp=sharing>

As xenophobic remarks and attacks have grown with alarming frequency and intensity, something that warrants further discussion is the relationship between the data we collected and the cause for why participants felt unsafe. The data demonstrates that perceived safety changed over the past year and events (anti-Asian hate incidents, COVID-19 concerns, media coverage of violent crime, etc.) impact individuals differently. Correlation does not equal causation, but what our results do show is the need for disaggregated data telling the stories of the Asian American/Pacific Islander experience, the stories of our community.

Check out how participants from this year compared to Chicago Health Atlas samples here: [CASL vs. Chicago: Place & Safety](#)

² It is important to note that these incidents only include those reported to police and do not cite a specific intent, e.g. hate crime

³ Ibid.

HOUSING & FINANCIAL

This domain includes questions relevant to participants' housing and financial health, which helps us understand the economic needs of our community. Responses help us ensure **fair and equitable housing & employment services** both current and future.

Having a roof over one's head and stable employment is just one of the many things that contribute to our framework of health. Being healthy is being able to afford access, to have mobility, to adapt and survive. Questions ask for the highest level of education, income, credit knowledge, rent and/or mortgage amount, and food security. Many of our findings may be impacted by variables outside our control, such as the impact of the [COVID-19] pandemic on jobs, housing markets, and price of goods.

EMPLOYMENT & EDUCATION

The percentage of participants who were employed, part- or full-time, dropped nearly 4 points from last year's collection round. **More participants reported being unemployed or out-of-work this year versus last year.** When observing participants who worked full-time (40 or more hours per week) between last year and this year, we observed a negative difference of 7.1%. That is twice the overall unemployment rate we saw last year. At a time when global economies are disrupted by the [COVID-19] pandemic, more people are experiencing unemployment. Since employment and educational attainment are closely related, we found:

- 29.5% of all high school graduates reported being unemployed,
- 30.4% of those without a high school diploma report being unemployed,
- Having a college degree (including Associate's degrees) was shown to be associated with higher employment rates—this was true at least for *working age* adults, defined as being 18 to 64 years of age.

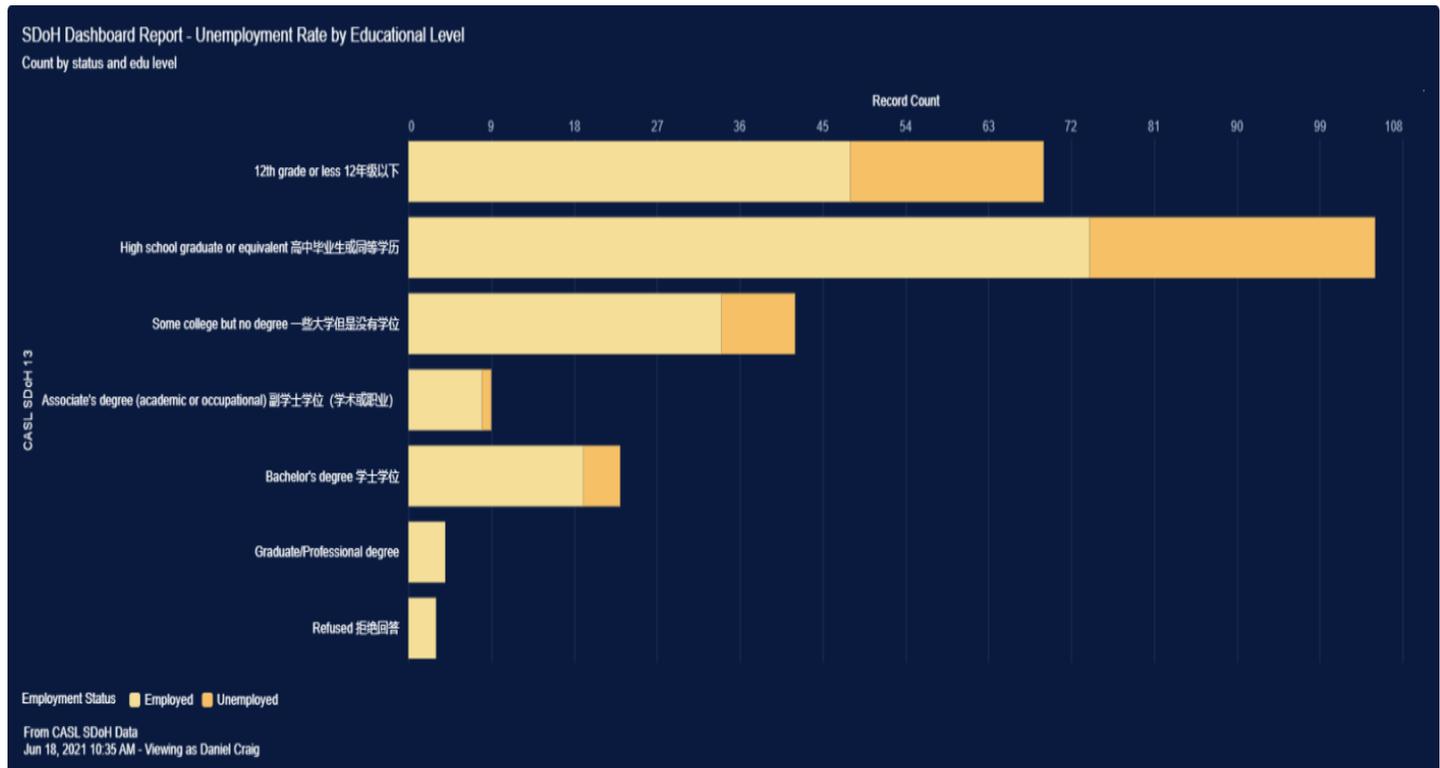


Figure 10: Click on the image for full size viewing or go to: <https://drive.google.com/file/d/1bm8xmpPaZKXuzs5Ruypl2XnqhjkFaRm/view?usp=sharing>

BANKING

Knowing how to manage one's income (saving, spending, budgeting) is a part of being fiscally responsible, which we look at through banking accounts.

*Age appears to be correlated with checking accounts. **older participants report enrolling in [checking] account at rates far less than their younger counterparts.***

See figure 11 for reference:



Figure 11: Click on the image for full size viewing or go to: <https://drive.google.com/file/d/1ibEiqle6HrlzzL-WutjWRfO5EG-ptHGj/view?usp=sharing>

CREDIT

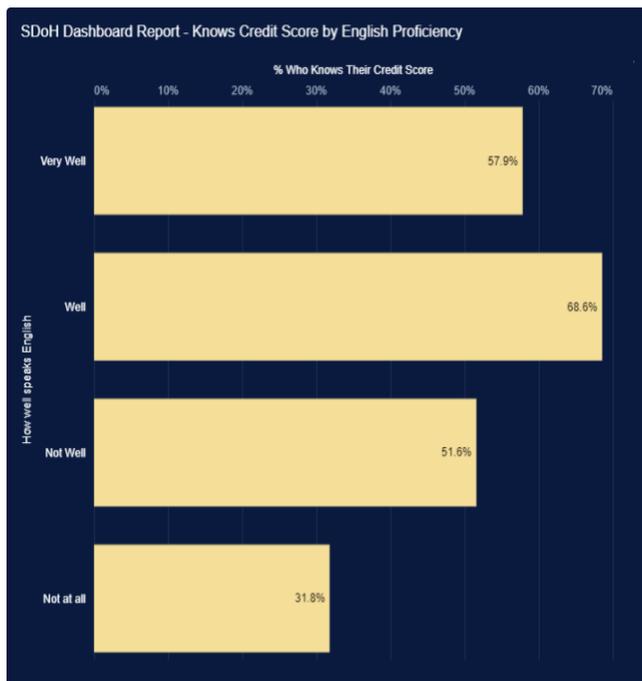


Figure 12: Click on the image for full size viewing or go to: <https://drive.google.com/file/d/1YuX8FZNUXol5BHCKAkF-WzeFBOP9LNtv/view?usp=sharing>

While our questionnaire does not ask participants for exact income or rent/mortgage amounts, the ranges offer a slightly less intrusive way of framing the question “*how much do you pay for rent/mortgage per month?*”

Speaking of money management, we found that people with **higher levels of English proficiency indicated greater familiarity with the concept of credit.** Knowledge of one's credit score often requires familiarity with local banking practices, which operates on the native language spoken. When comparing knowledge of credit scores by English proficiency, we found that participants who reported speaking English less than well also did not know their credit scores compared to their English-fluent counterparts.

As a new addition to this year's assessment, we found that only a third of participants report knowing their credit score (33.26%), with younger individuals exhibiting the highest level. Credit is a form of financial mobility, to make purchases, to save for long-term goals. Of people who make more annually, they also tend to know their credit score.⁴ We acknowledge that while knowing exactly what one's credit score is can be tricky, having a ballpark estimate is what we were attempting to gauge--how familiar are participants with this [mostly Western] concept? Check out figure 12 for a closer look at credit score by age:

⁴ Please note that participants reporting an annual income of over \$100,000 have extremely limited records (e.g. 1 or 2 people total)

HOUSING

Having a roof over your head is good, only to the extent that you can move freely and experience comfort. New to this year's assessment is an emphasis on who owns their home, who rents, and what that means for how much they pay to live there. As an example, participants under the age of 65 who live in the Armour Square neighborhood reported spending an average of \$755 per month on rent. According to apartments.com, a cursory search indicates that the average rent of a 2 bedroom apartment in Armour Square is around \$958 a month.

Another addition to this year's response collection round is asking whether people own or rent their home. Generally speaking, mortgage and rental rates can vary widely in an urban setting like ours:

- 42.3% of participants 18-29 years old report owning a home
- 52.5% of participants 45-64 years old report owning a home.

This observation also goes without saying that owners generally spend less per month than renters do, and that older residents spend less than younger ones do (e.g. subsidized housing). When comparing annual household incomes and monthly rent/mortgage rates by community area, we found that **participants who own tend to pay more in monthly costs than their renting counterparts**. For instance, participants living in McKinley Park, homeowners paid \$988.20 per month on their mortgages; renters paid \$720 per month. This indicates the need for a more accurate rendering of income diversity and housing markets. Homeownership as a proxy for residential "permanence" only gives us a partial representation of the urban housing landscape. What we are interested in understanding is how local lending programs and urban development initiatives affect our communities. Access to high quality, affordable housing is a right everyone should be able to enjoy.

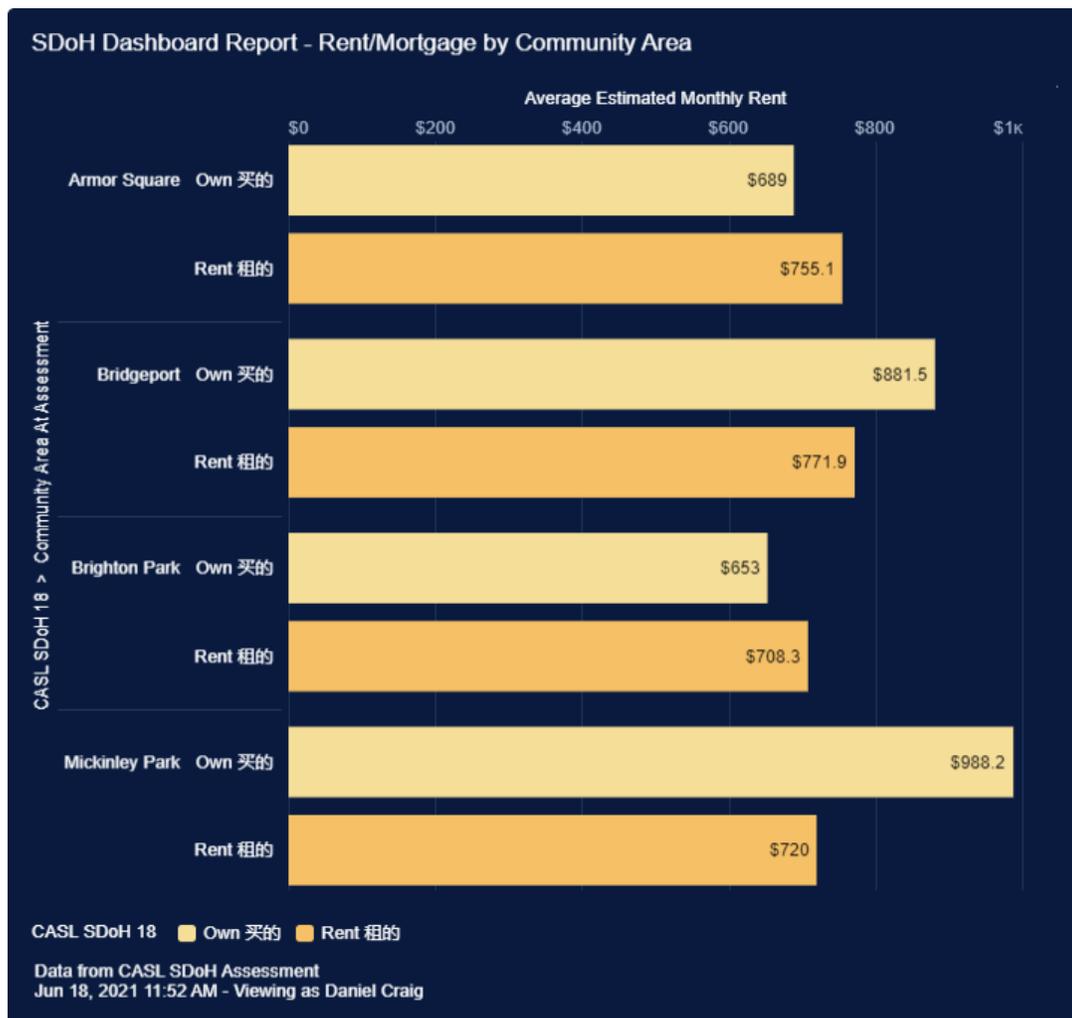


Figure 13: Click on the image for full size viewing or go to:
https://drive.google.com/file/d/1_dg5vRGdeqZv0DdddifHfkdAfTbttM/view?usp=sharing

HUNGER

“Putting food on the table,” as literal as it may be, is cost-dependent. When looking at how many participants ever went hungry in the past year due to cost, lower-income participants reported more instances of skipping meals. *When grouped by age, adults aged 45-64 reported not buying enough food in the past month.* See figure at right depicting age and having forgone food in the past year. Since CASL started a senior meal distribution program during the [COVID-19] pandemic, seniors experienced the lowest levels of hunger. This begs the question why adults 45-64⁵ are going hungry.



Figure 14: Click on the image for full size viewing or go to:
https://drive.google.com/file/d/1E1MjBCRJXQZ1osT9ESJJkPB2h_3hkia/view?usp=sharing

Furthermore, looking at income requirements for enrolling in food benefit programs, we also have an opportunity to investigate barriers to economic mobility and access to public services. Based on what we know about language access, would that impact eating habits? Over both collection rounds, on average 4% of participants went hungry at some point in the past year due to cost. Considering the total sample size for 2020—2021 was 519, this is a growing need that requires continued observation.

Check out how participants from this year compared to Chicago Health Atlas samples here: [CASL vs. Chicago: Housing & Financial](#)

⁵ These individuals are ineligible for CASL's senior meal program.

HEALTH VISITS & COSTS

*This domain ask about participants' **physical health**. We ask these questions to help understand our community's continuing health needs and how we can best meet them. If there is a possibility that we can meet individuals' health needs in the future, we will use these responses to guide our efforts. Our understanding of physical health is critical to improving the landscape of **culturally- competent healthcare** services within our communities.*

The next few questions ask about participants' physical health. We ask these questions to help understand our community's continuing health needs and how we can best meet them. Our understanding of physical health is critical to improving the landscape of culturally- competent healthcare services within our communities.

OVERALL HEALTH RATING & HEALTH COVERAGE

Would you say that in general your health is...excellent...good...fair...or poor? Just over half (55%) of our participants reported "good," "very good," or "excellent." **Participants without healthcare coverage reported higher levels of self-perceived health status.** Over two-thirds of participants without health coverage (65.5%) reported being in "good" or better health compared to 53.7% that did have coverage.

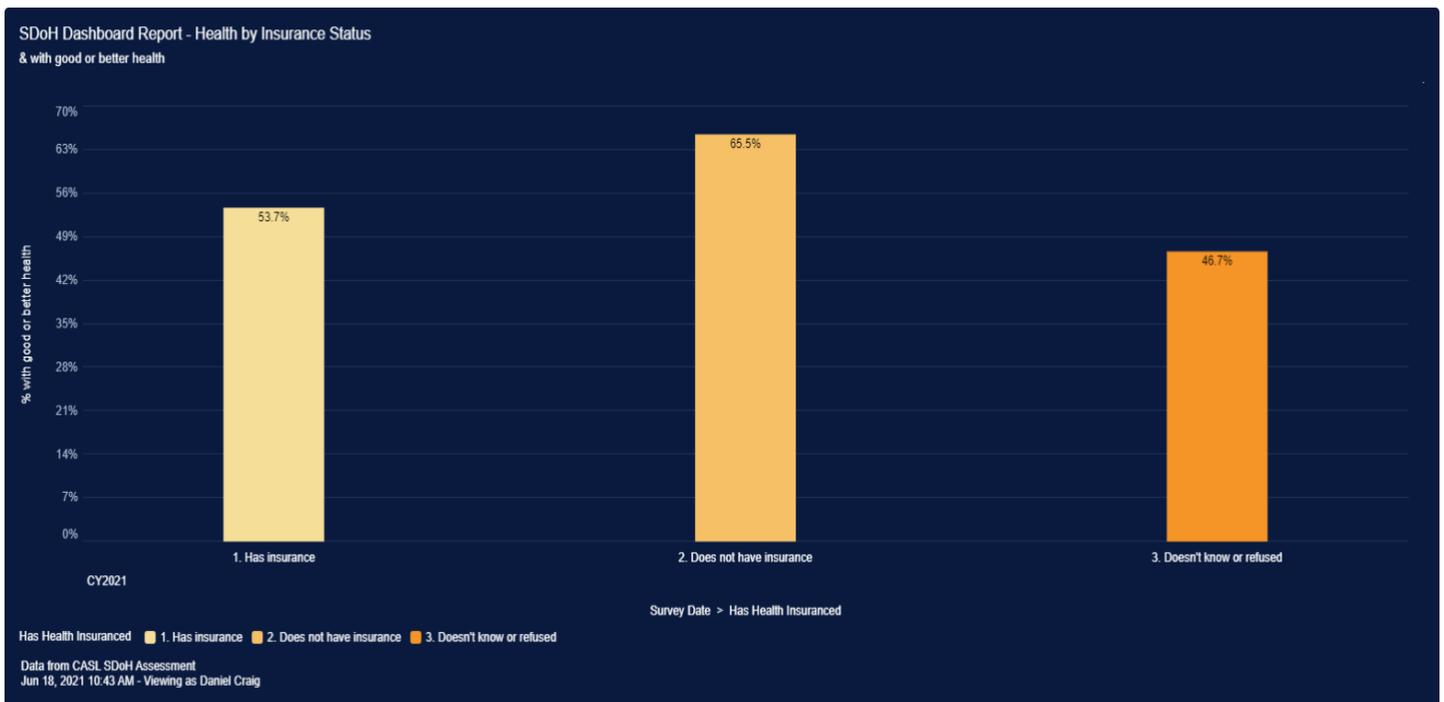


Figure 15: Click on the image for full size viewing or go to:
<https://drive.google.com/file/d/1g0NIEgYvLRHTbuqzQgZvLveH2EABYHrJ/view?usp=sharing>

Conventionally, health coverage is offered by one’s employer, but with the current scenario of people being out of work due to the pandemic and a healthcare infrastructure whose limits have been severely tested, having [health] insurance is just part of staying physically healthy.

We also found that age was positively correlated with having some sort of health care coverage, notwithstanding language ability, income, or education level. This may be due in part to federal health plans like Medicare and Social Security benefits. Other subsidized healthcare plans may offer special services limited to age.

ACCESS TO CARE AND RECEIVING CARE

Earlier, we took a look at levels of English proficiency among participants. Here is an application where language access can very well mean the difference of life and death. When looking at how well participants spoke English, we cross-referenced the level of ease in which they actually received medical care. **Participants who spoke English “very well” reported “usually” or “always” being able to receive needed health care.** *Participants who reported speaking English less than “very well” expressed having a much harder time accessing needed health services.* Compared to participants that spoke English less than very well, figures indicating the ease of accessing care was lower than half. A quarter of participants—not speaking any English—were able to access health services with relative ease. What we found further illustrates the intense need for language access by provider, coverage type, and culturally-sensitive attitudes in health care. This dashboard depicts level of English proficiency with how easy it is for them [participants] to receive needed health care.

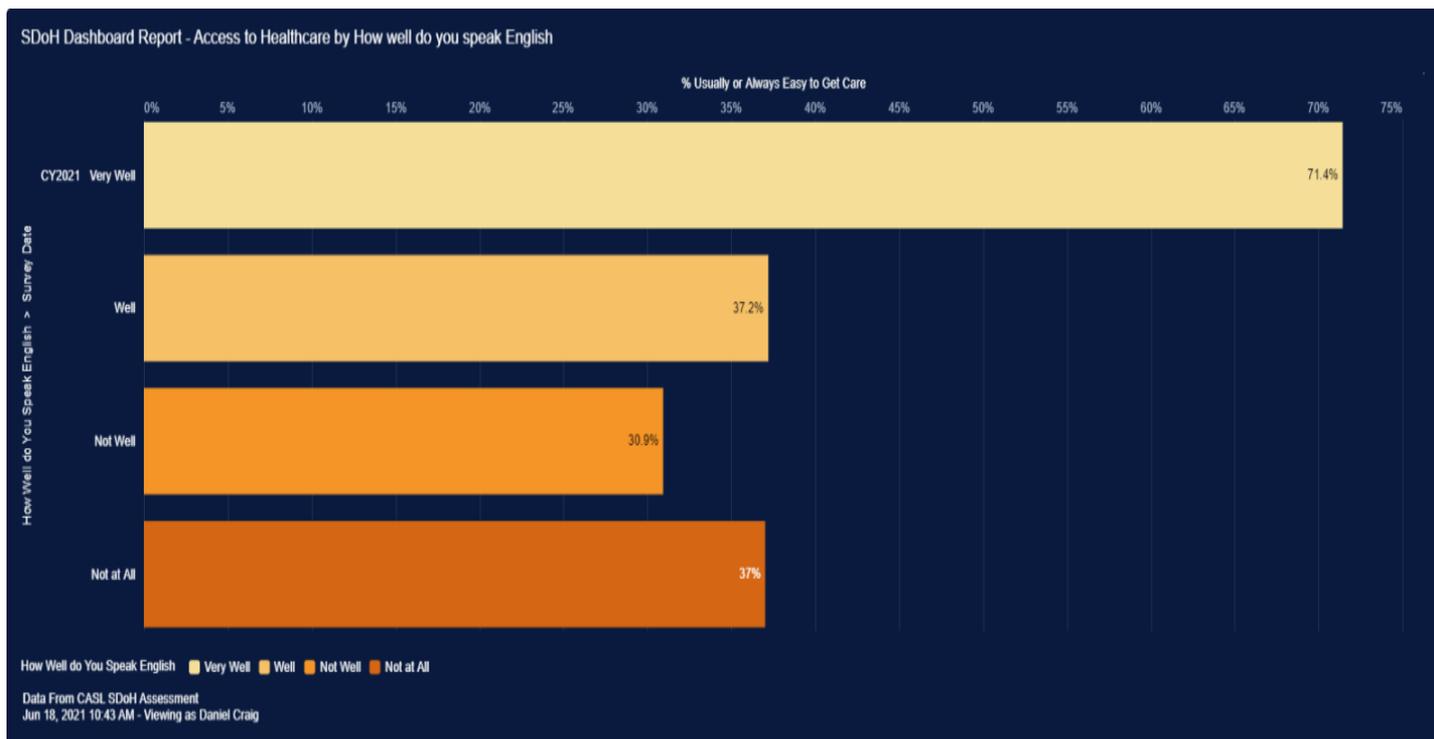


Figure 16: Click on the image for full size viewing or go to: <https://drive.google.com/file/d/13bm621vLxUDHVmSiQyxBJbTQ7vrWoQCC/view?usp=sharing>

MEDICAL PROCEDURES & ROUTINES

Taking a deeper dive into specific health services, the disparities become more noticeable. For routine procedures such as annual dental cleaning, participants varied in terms of when they last had for instance, gone to the dentist or had their teeth cleaned. Last year, we could only speak anecdotally to why participants did not get their teeth cleaned in over a year. This year, we asked participants to provide a reason for not going to the dentist or having their teeth cleaned (if it was longer than a year). Some reported that **they did not feel like they needed to get their teeth cleaned because their teeth were fine**, which confirms our previous anecdotes

Others expressed concern over costs not covered under their insurance plan, no time, or a lack of transportation. Over the course of the past 15 months that Chicago has navigated the [COVID-19] pandemic, routine procedures are not the only parts of our lives that have been affected. Similar to dental visits, participants who did not receive medical care cited the pandemic as the primary reason for not following through with appointments. This data is useful in helping us determine whether dental education is a priority we should pursue, which according to this preliminary finding suggests that it might be.

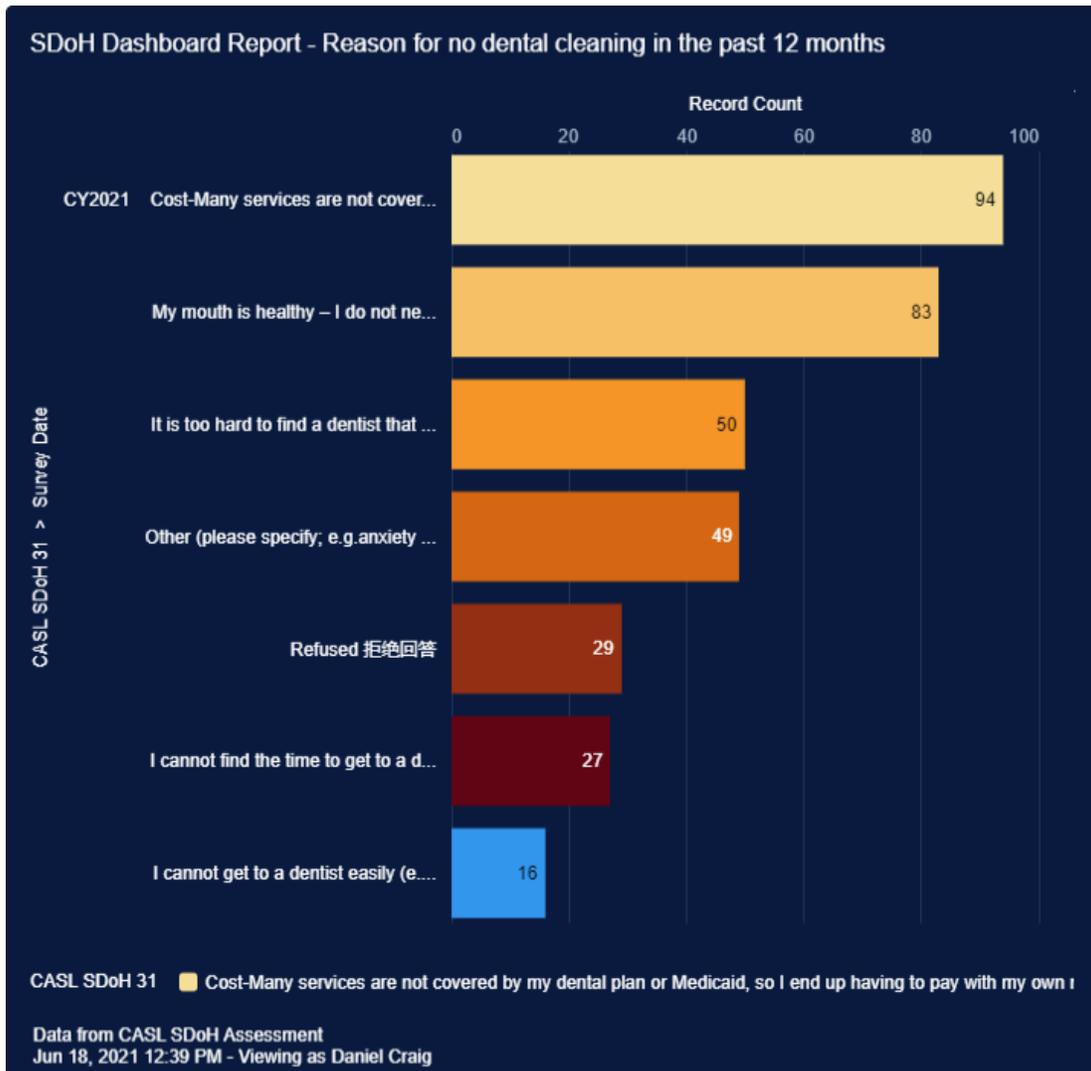


Figure 17: Click on the image for full size viewing or go to: https://drive.google.com/file/d/162zxR-ql9rtOjs88uJWyddkX7_jvIUtU/view?usp=sharing

Check out how participants from this year compared to Chicago Health Atlas samples here: [CASL vs. Chicago: Health Visits](#)

*This domain asks about alternative medicine use and unconventional therapies like herbal supplements and culturally-specific meditation. We also ask about tobacco use to understand the needs of people interested in quitting use. These questions capture **self-directed health activities and behaviors** associated with **well-being**.*

Being healthy and working to stay healthy are two different things, so we asked how participants choose to live this out. Given that most of our clients are immigrants, the U.S. healthcare system can be a bit tricky to navigate. Certain cultural implications may dissuade individuals from pursuing more socially-accepted remedies and treatments. It is an awkward question to present given what medicines and activities people consider “alternative,” so we chose to specify this as herbal supplements, medicinal teas, acupuncture, or homeopathy. Almost a fifth (19.4%) reported using such treatments, of which many were over the age of 65. These findings led us to ask a related question of what using alternative medicines has to do with traditional health coverage.



Figure 18: Seniors enrolled in CASL's Pine Tree Senior Council enjoy a fitness class

ALTERNATIVE MEDICINE

Over a quarter (28.1%) of participants without health care coverage reported using herbal supplements and the like, compared with under a fifth (18.5%) of those who were insured. **Participants who are uninsured are more likely to use alternative medicines** and the like (e.g. herbal supplements).

This appears to support our hunch of conventional health care models and its interaction with so-called alternative medicines. Whether or not this observation has anything to do with the effects of limited healthcare institutions due to the pandemic—that has yet to be fully determined. We cannot ignore the fact that individuals' self-determined health activities may help us paint a clearer picture of what determines “good” health. Check out the dashboard depicting herbal supplements by health care coverage:

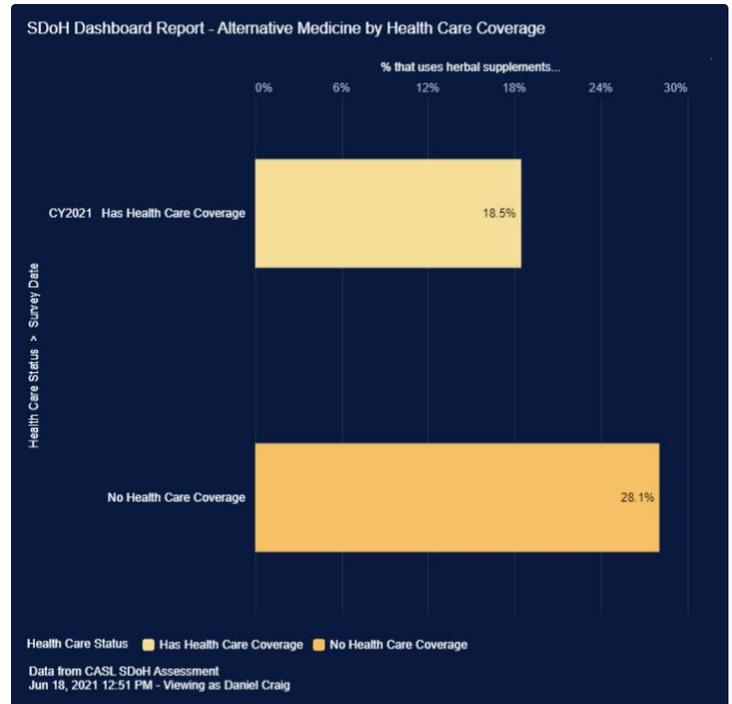
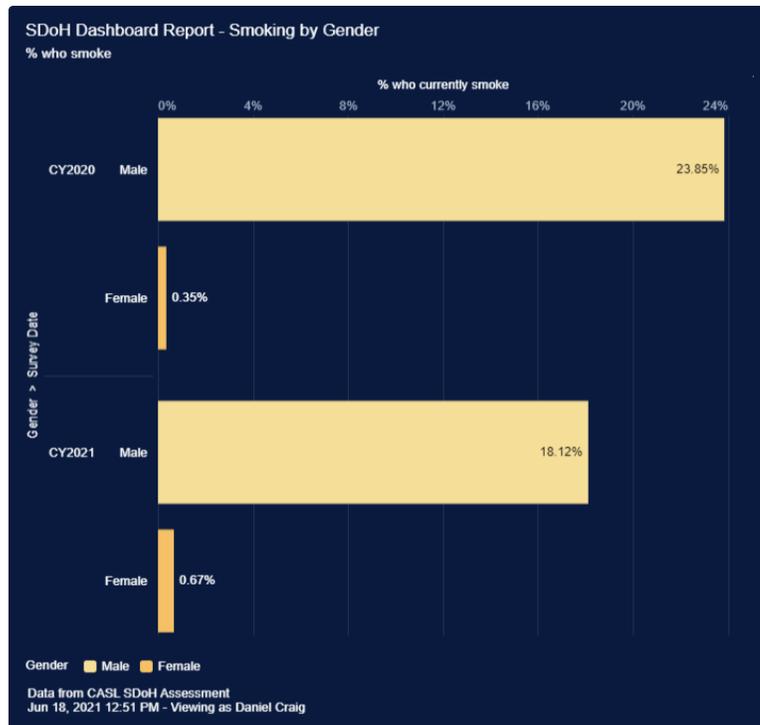


Figure 19: Click on the image for full size viewing or go to: https://drive.google.com/file/d/1xs8_c9D2We8MKBcArNBTg1fevBljGc8X/view?usp=sharing

SMOKING



Some of the questions we asked last year surrounding smoking activities have been removed. While we observed a slight decrease in overall smoking behaviors, when looking at gender, the differences are notable. **Males on average report smoking far greater than female participants.** Based on cultural assumptions and themes surrounding cigarette use among Chinese immigrants, men have been seen as “smokers” rather than women. Furthermore, the stigma towards women who do smoke appears relevant to what the data shows. CASL used to offer smoking cessation programming and these results can give us an idea of whether or not to start it up again.

Check out how participants from this year compared to Chicago Health Atlas samples here: [CASL vs. Chicago: Health Fitness & Behaviors](#)

Figure 20: Click on the image for full size viewing or go to: https://drive.google.com/file/d/1IO_DiGyxfi1YcNFYwaWJpbc1Y3apaPTJ/view?usp=sharing

FINAL THOUGHTS

Our clients come from a colorful array of backgrounds and the data we collect tells their story. The aim for assessments like this is to gauge the temperature of the room and identify where our greatest impact is and what we can add moving forward. There are needs in multiple domains, domains which correspond to the most relevant services CASL offers. After the first round of data collection and analysis, we developed an automated referral system through Salesforce, which would flag certain responses to departments that could offer useful solutions. While the total number of enrollments is not our objective for having these assessments, it is a start to understanding how our clients thrive.

This season brought about changes to our assessment, and with that, new discoveries. This exercise was inspired by the Chicago Health Atlas, which was designed for data accountability and transparency. Although the comparisons made in this report are not one-one, whereas our data is raw and the [Chicago] Health Atlas' is not, it still offers value in keeping our assessment relevant and updated.

WHAT'S NEXT

The Center for Social Impact exists to promote data-informed practice as a way for decision-makers to make the best selection on behalf of the communities we serve. The data we collect is only the beginning to understanding what our clients need and how to meet them where they are. Data has a variety of uses and we know that stories aren't told in a vacuum. This is why initiatives to understand data as a medium for storytelling are so vital to the work CASL does.

Where previous efforts to capture the Asian American Pacific Islander experience have been fraught with challenges, CASL seeks to bridge the gaps in disaggregated data for all races and ethnicities. Data matters because it gives us a roadmap of what to change, what interventions and programs work well, but most importantly, data helps us communicate the needs our clients have. Right now, our projects are principally concerned with our clients, but that could change the way we understand other AAPI communities in our city, state, nation, and world.

