

Community Health Assessment:
Allston-Brighton Chinese-Speaking Adults

Fall, 2015
Allston Brighton Health Collaborative
Boston, MA

Overview:

The objective of this assessment is to increase the amount of quantitative data that informs the Allston Brighton Health Collaborative (ABHC) and its member organizations on the health and wellness interests of adult non-elder Chinese-speaking residents. Nearly half of Allston/Brighton foreign-born residents are from Asia and Chinese is spoken in the home at more than twice the rate as the Boston average¹. Yet population-specific data are limited at the neighborhood level. Few Allston/Brighton organizations work specifically with the Chinese community, and more specifically with those aged 18-64. Organizations that do work with Chinese residents of any age observe that these residents leave the neighborhood for their health services, indicating that the neighborhood may not be adequately reaching out to or providing for this population.

Our long-term goal is to improve health equity and decrease chronic disease for Chinese-speaking Allston/Brighton residents of all ages. To achieve this objective, the ABHC attempted to conduct a review of existing data on the target population. The Collaborative also surveyed neighborhood Chinese-speaking residents aged 18-64. This report provides recommendations based on the assessment.

Introduction:

The ABHC set out to gather more quantitative health data on the neighborhood population of non-elder adult Chinese speakers. In Allston/Brighton, 15.5% of the nearly 75,000 residents are Asian (as defined by the U.S. Census) - roughly 11,625 people. (For the purposes of this assessment, Allston/Brighton is referred to as one neighborhood.)

¹ Boston In Context. Boston Redevelopment Authority/Research Division, 2014.
<http://www.bostonredevelopmentauthority.org/getattachment/15ddcf06-5d87-4001-a255-70e55e011f19/>

Asia is the largest region of birth for foreign-born residents, 17% higher than the Boston average. Chinese is spoken in roughly 11% of Allston/Brighton homes, compared with under 4% of Boston homes overall.²

While these general demographic data exist, more specific health indicators and their implications are illusive, which matches statewide trends. According to the Institute for Asian American Studies at UMass Boston, state and local public health data is “largely inadequate for the systematic study of health disparities faced by Asian Americans (not including Native Hawaiians or other Pacific Islanders)”³. Boston has insufficient data of Vietnamese, Chinese, and Koreans, though the city has significant populations of each ethnic subgroup.³ Additionally, many ethnic groups statistically identified as Asian American do not self-identify as Asian and therefore may not be included in health data.

It is difficult for health care providers, researchers, and community institutions to accurately and adequately provide appropriate services to neighborhoods and residents when data are generalized or non-representative. Interestingly, although there are large and growing populations of Asian ethnicities in Boston, generalizations still occur because of small sample sizes. (One possible reason is methodology, discussed more in the ‘Conclusion’ section.) Aggregated data hide differences between and among groups, including ethnicities.

² U.S. Census Bureau, 2010 Decennial Census, Summary File 1, Allston-Brighton Planning District, Boston Redevelopment Authority/Research Division, September 2011.
<http://www.bostonredevelopmentauthority.org/getattachment/05a34b1b-d8a6-4a92-b1bd-e7397264561b/>

³ Wong, Carolyn; Hosotani, Hannah; and Her, John, “Information on Small Populations with Significant Health Disparities: A Report on Data Collected on the Health of Asian Americans in Massachusetts” (2012). Institute for Asian American Studies Publications. Paper 33.
http://scholarworks.umb.edu/iaas_pubs/33

Filipino adults (27%) and Japanese adults (25%) were more likely than Chinese (17%) or Korean adults (17%) to have ever been told they had hypertension. Asian Indian adults (9%) were about two times as likely as Korean adults (4%) to have ever been told they had heart disease. Vietnamese adults (13%) and Filipino adults (11%) were more likely to suffer from migraines or severe headaches than Chinese adults (7%).³

Asian American ethnic groups demonstrate health differences that should influence and inform local outreach campaigns and engagement.

The Institute argues that data collection at the local level is important to inform place-based interventions and solutions. “Certain place-based factors affect the health of residents, including degrees of social isolation, the quality of schools, the suitability and accessibility of neighborhood-based services, viability of local markets for consumer needs (including for food and other daily supplies), and physical environmental quality³”. Multiple Boston organizations, including Asian Women for Health, Boston Public Health Commission, DotHouse Health and researchers from Tufts University, face challenges in collecting and disseminating substantial data from subsets of the Asian American Pacific Islander racial group. Data collection methodology makes it particularly difficult to share data; multiple organizations collect small pockets of data at the neighborhood level, making comparisons and aggregation difficult.

More challenges regarding existing data are discussed in the ‘Limitations’ section.

Survey Method:

A Committee convened to design the survey. Committee members included the Coordinator of the ABHC, a community organization manager, a community resident, a family physician, and members of the Boston Public Health Commission. All Committee

members identify as Chinese or Chinese American, excluding the Coordinator. Survey questions were sourced from the Behavioral Risk Factor Surveillance System 2014 Questionnaire⁴ and the North Carolina Division of Public Health Community Health Survey.⁵ The questions focused on quantitative metrics and demographics and qualitative assessments of neighborhood experience, resources, and personal and family health status. The Committee decided to exclude those questions that are included in Electronic Medical Records, with the intent of collecting those data from local health care providers. The Committee also decided to target Chinese-speaking Allston/Brighton residents age 18-64. (Nearly 70% of these Asian residents are between the ages of 20-64.¹) Elders were excluded because of the specific health needs and challenges associated with that age group. The survey, titled, “Allston/Brighton Community Health Assessment – Chinese Speaking Population, Spring 2015,” contained 42 questions and was provided in both English and Chinese.⁶ It was disseminated in 10 locations⁷ from June 22 to July 3, 2015. Two bilingual surveyors surveyed at Super 88 grocery and YMCA Brighton. Respondents were a convenient sample, targeted based on age and race. The Committee also requested comparative data from the Boston Public Health Commission, Charles River Community Health (formerly Joseph M. Smith Community Health Center), and St. Elizabeth’s Medical Center. This data could not be provided and is discussed in more detail in the ‘Limitations’ section.

⁴ Behavioral Risk Factor Surveillance System 2014 Questionnaire /Final/12.17.2013. Centers for Disease Control

⁵ North Carolina Division of Public Health Community Health Survey
publichealth.nc.gov/lhd/cha/docs/guidebook/CommunityHealthOpinionSurveyEnglish.doc

⁶ See Appendix I, *Allston/Brighton Community Health Assessment – Chinese Speaking Population, Spring 2015*

⁷ ABCD NOC, APAC, BASE, BPHC community engagement office, JMSCHC, Super 88, WIC, YMCA three Allston Chinese Restaurants and one Brighton Asian restaurant.

Results:

The total sample size was 82 observations. Below are results of note. All results are based on valid responses. See Appendix II, *Data Analysis Report*, for a detailed report.

Demographics:

- Sixty-five respondents self-identified as Chinese while others self-categorized as ‘Other’, ‘Asian’, ‘Japanese’, ‘Filipino’, ‘Korean’ and ‘Vietnamese’.

Health Status and Access:

- The vast majority of respondents – 88% - reported good health or better.
- 81.5% reported that they felt they (and their family) had good access to healthcare.
- Three quarters of valid respondents did not report that cost was a prohibiting factor in seeking medical care.
- Among the 16 respondents who could not afford to see a provider within the previous 12 months, 10 of these respondents or their family had trouble getting dental services. Eight respondents reported having trouble getting healthcare from a general practitioner/PCP.
- More respondents who had a regular check-up in the past year also reported excellent, very good and good health condition as compared with people who had a regular check-up in the past two years. There are fewer people who had a regular check-up within the past five years in excellent, very good and good health condition. That is, the more frequent someone has a regular check-up, the healthier he/she reported feeling.

Health Concerns:

- Of the 75 valid responses, half of respondents received their health-related information from friends and family. Internet has become the second most popular choice for getting information. No respondents receive health-related information via a pharmacist, their child’s school or help lines.

- Dental information, heart disease and diabetes are the health topics of most concern, and seeking dental health information is of interest to residents both with and without dependents.

Quality of Life:

- Roughly one in two people of this sample felt that they were a member of Allston/Brighton community.
- Pollution, lack of grocery stores, theft, and lack of community support are considered issues that most affect the quality of life in Allston/Brighton.
- 28 respondents noted that more affordable/better housing required most improvement. The second and third most improvement-needed services were recreational facilities (19) and transportation options (13).
- 30% of respondents reported never feeling stress about having enough money to pay the rent or mortgage in the previous 12 months. Seventeen people sometimes felt this financial stress, while eight people always felt this stress.
- Similarly, most respondents indicated that they never felt stress about having enough money to buy nutritious meals in the previous 12 months. Only one person reported always feeling stress in paying for nutritious meals.

Emergency Preparedness:

- 65 individuals reported that their household had a working smoke detector or carbon monoxide detector, or both. Among them, 31 respondents possessed both smoke and carbon monoxide, 24 respondents had a smoke detector only and 10 had a carbon monoxide detector only. Ten residents lived without either smoke or carbon monoxide detectors.
- Roughly one in two respondents reported that their families were equipped with a basic emergency supply kit.

Analysis and Discussion:

The small sample size limits our ability to analyze or discuss the results in any great detail. Below we analyze results of note. Additional analyses are included in Appendix II.

- There appears to be a trend of health conditions in the group of people who felt very satisfied with their healthcare services. Most people with the highest satisfaction were in the highest health status. After running several regressions, we found that, other things equal, a healthier resident may feel more satisfied than other residents with the healthcare services he/she received. Additionally, other things equal, a resident with more frequent regular checkups may feel more satisfied with the healthcare services he/she received than other residents.

Limitations:

This assessment faced a variety of limitations throughout the process, the largest of which was obtaining a robust sample of respondents. The Committee confined the assessment to the non-elder adult group, agreeing that the elder population should be assessed separately due to their more unique health interests and challenges. This decision resulted in targeting a smaller sample of Chinese residents who are more dispersed throughout the community. Surveyors faced challenges in locating potential survey respondents; Chinese-speaking Allston/Brighton adults aged 18-64 do not congregate in specified or consistent locations in the same way that Chinese-speaking elders do, requiring surveyors to survey small numbers of respondents at multiple community locations. The survey method, size of the survey team and budget also limited how many respondents the team was able to reach. The team considered surveying residences based on census data, but were advised against this method. The length of the survey, the challenges in securing addresses of Chinese-speaking residents, and the

workforce required to survey door-to-door all influenced the decision not to survey in this way. These design considerations yielded a convenient sample and at this point we are unable to speak to how representative it is of the population.

The team also found it challenging to engage medical providers who serve a significant Chinese-speaking population. One primary care provider collected survey responses from his patients but never returned the responses, after repeated attempts to collect. Another primary care provider declined to participate.

Our survey design also created limitations in response reliability and data analysis. For example, the question, “Which one or more of the following would you say is your race?” had overlapping response options, resulting in respondents choosing multiple options and some Chinese-speaking respondents selecting “Asian” instead. In order to get an estimate of Chinese speakers in our sample, we added the number of completed Chinese language surveys returned (30) and the number of completed English language surveys version that identified as “Chinese” in the question (35).

A final and substantial limitation was that of accessing comparative and/or supporting data. The two largest healthcare providers in the neighborhood – Charles River Community Health and St. Elizabeth’s Medical Center – were both logistically limited in their ability to access and aggregate data specific to their Allston/Brighton Asian adult patient population. The Boston Public Health Commission worked to isolate comparative data from their BRFSS but found there were too few Chinese respondents to permit valid estimates for the adult Chinese resident population.

Conclusion and Recommendations:

This assessment was unable to meet the objectives set out for a variety of reasons already established. Yet the process of designing and implementing the assessment was informative and articulated the challenges that the neighborhood faces to reach the target population. The Institute for Asian American Studies approves of the effort made to reach and gather information from Chinese-speaking adults; surveying specific ethnic populations at the neighborhood level can provide meaningful information that describes the lived experience in a community.

In states like Massachusetts where Asian Americans are not numerous but where the population grew at a remarkable rate of 46% between the years 2000 and 2010, dedicating resources to surveys of specific communities where ethnic populations are concentrated would be cost-effective, since a random household survey within such a community can obtain sizeable samples of persons of those ethnicities. It is also more effective to conduct the survey in languages spoken by respondents in the area, and to tailor questions and styles of contacting . . . to factors specific to the community.³

As people and populations become more decentralized, survey methods must become more creative, either by reaching people individually at their homes, or through social media and mobile technology. Boston organizations are now coordinating efforts to systematically reach the Asian American Pacific Islander populations and collect more representative data. An organized group hopes to identify an existing tool or develop a new tool for collectively pooling data. The ABHC supports this collaborative effort. A larger challenge remains that of funding; an effective way to collect extensive and

comprehensive data is through canvassing, an expensive undertaking. The ABHC recommends that funders at all levels and from all sectors increase funding for improved data collection methodology. The Collaborative also encourages organizations, particularly health care providers, to share Electronic Medical Records data in an effort to improve neighborhood health outcomes.

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