

A LOCAL COMMUNITY HEALTH SURVEY: FINDINGS FROM A POPULATION-BASED SURVEY OF THE LARGEST JEWISH COMMUNITY IN CHICAGO

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Abstract: Accurate estimates of health risk factors and outcomes are difficult to obtain for certain ethnic populations. The health of Jewish individuals is particularly hard to determine because of the small group size and because health data rarely include information on religious affiliation. Furthermore, local level health information (for any population subgroup) is limited. To assess health risk factors and outcomes, as well as issues related to access to care, within a Jewish community in Chicago, a group of community agencies and researchers initiated a unique, population-based health survey. Specifically, a three-stage sampling design was used to select a representative sample of 201 adults and 58 children in the most concentrated Jewish neighborhood in the city. Nearly 500 questions were asked, covering a wide variety of demographic, socioeconomic, and health-related topics. The findings revealed that these Jewish individuals were generally as healthy (or healthier) than the average residents of Chicago and the U.S.; however, many serious health concerns still existed. In particular, health problems such as obesity, depression, disability, and domestic violence were common and, in some cases, more prevalent than in the general population. This local level information provides the first accurate estimates of key health variables for the estimated 23,000 Jewish individuals living in this community. This type of data is essential because it enables the efforts and priorities of health and social service providers to be focused on the most pressing health problems. Moreover, this project provides an example for other population subgroups (based on residence, ethnicity, religious affiliation, country of origin, or other characteristics) who would benefit from local level health information.

KEY WORDS: community health survey; ethnicity; jewish; obesity; depression.

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INTRODUCTION

The benefits of collecting local level health information are increasingly recognized in the public health and medical fields.^{1,2} One of the primary advantages of local level surveys is that they enable community leaders to pinpoint health risk factors and problems within small geographic areas, where they can be most effectively addressed by social service agencies, health care providers, schools, and other community groups.² A related advantage is that local level surveys can address a broader range of topics, including specific issues that may be of limited interest in larger populations.¹ For these reasons, local health information is most successful in building interest in survey findings and in motivating advocates within a community to confront health-related issues.

Only select health information for specific communities can be determined using vital records, communicable disease registries, and other sources, which are available by census tracts or zip codes. However, certain population subgroups are widely dispersed across geographical areas and are often minorities even in the most concentrated of neighborhoods. Thus, small sample sizes render national, state, and even city health surveys insufficient for deriving accurate estimates for these individuals.¹ Moreover, although being Jewish is often considered an ethnic identification, information classifying individuals as members of this group is not collected with the same frequency as other racial and ethnic data, possibly due to the aversion of many agencies and researchers to gathering religious information.

However, collecting data about this group is particularly important because Jewish individuals may have significantly different health profiles compared to other individuals. More specifically, both the cultural norms shared by those with a Jewish background (ethnicity) and the religious beliefs held by many Jewish individuals may influence health-related behaviors and outcomes.³ For example, many Jewish affiliations, particularly Orthodox ones, have specific rules regarding dietary choices, smoking, and other health-related behaviors. In addition, Jewish children often attend private day schools, which differ from public schools in the foods they offer, the health-related information provided in their curriculums, and the presence of physical education and extracurricular activities. Due to reasons such as these, health-related risk factors and outcomes could be expected to differ from the general population for both adults and children. This is supported by previous research that shows that Jews have

higher rates of depression and breast cancer, but lower rates of other health problems, such as alcoholism and cervical and penile cancer.⁴⁻⁷

Despite the problems attendant with using general data sources to obtain (or infer) health-related information about this group, few examples of local level data for Jewish populations were found. More importantly, the smallest area of study found for the Jewish population in Chicago came from the Metropolitan Chicago Jewish Population Survey (MCJPS), which sampled individuals living in the “Chicago metropolitan area”.⁸ This region, which encompasses six counties in northeast Illinois, is estimated to be home to over 270,000 Jews. Unfortunately, very few health-related questions were included in this survey. Furthermore, because the health problems of Jewish individuals living in affluent suburbs could be expected to differ substantially from those of Russian immigrant Jews living in poor urban neighborhoods, for example, members of the Jewish community of Chicago recognized the need to collect health-related information at the neighborhood level. In particular, a densely populated Jewish neighborhood that was perceived to have elevated health and social service needs was chosen to be the focus of the survey.

The overall purpose of this survey was to assess levels of health status and health care access for the estimated 23,000 Jewish individuals living in this Chicago community. A representative sample of over 200 individuals provided answers to nearly 500 questions on a wide variety of demographic, social, and health-related topics. It was expected that this data would provide the information (and motivation) necessary to develop effective interventions to address the health problems uncovered by the findings. It was also hoped that this survey would be used as an example for other groups who lack health-related information at the community level. The following paper will highlight several of the major health concerns revealed by this study, and will discuss the implications of these findings.

METHODS

Survey Instrument

A community-based approach was used throughout the study, from the development of the survey instrument to the dissemination of results. To design the questionnaire, a group of key stakeholders and community leaders worked with public health researchers to create an instrument that was tailored to the health issues of this community, but that also used questions from national and state surveys (to benefit from validated

questions and to allow for comparisons with other data). The questionnaire was largely based on the *Sinai Improving Community Health* survey, which was recently conducted in six Chicago community areas.⁹ Then, approximately 50 additional questions were included to focus on demographic, health, and religious issues important to the Jewish population. These questions concerned topics such as genetic screening, cancer, disability, and participation in religious activities. In total, the survey included 475 adult and 100 child questions. Examples of topic areas included in the survey are shown in Table 1.

Data Collection

The same team of community leaders and agencies mapped out the precise geographic boundaries for the community area, which is located in the northeast side of Chicago (locally known as West Rogers Park and Peterson Park). Following this, a three-stage sampling design was employed to generate a representative sample of adults and children.¹⁰ First, 45 census blocks were randomly selected from the area. In the second stage, households from the blocks were randomly sampled. Finally, one eligible respondent from each of the selected households was randomly chosen. All self-identified Jewish adults 18 years of age or older who could complete the interview in English were considered eligible. After the adult interview was completed, respondents were asked if there were any children under 13 years of age in the household. If answered affirmatively, a child was randomly selected and the adult most familiar with that child's health care was interviewed. As a token of appreciation, respondents were given \$20 for completing an adult interview and \$10 for a child interview. More information on the survey methodology is available from the author upon request.

In total, 201 adults and 58 caretakers of children (2–12 years of age) were interviewed between August 2003 and January 2004. The data were collected via face-to-face computer assisted interviews. The response rate (i.e. the proportion of eligible respondents who completed interviews) was 51% and the cooperation rate (i.e. the number of completed interviews divided by the number of completed interviews plus the number of refusals) was 75%. The survey design, sampling, and interviews were done by the University of Illinois at Chicago (UIC) Survey Research Laboratory. The study methodology was approved by the Institutional Review Boards of both the University of Illinois and Sinai Health System.

TABLE 1

Examples of Topics Included in the Jewish Community Health Survey

<i>Sociodemographic Information</i>	<i>Health Behaviors and Attitudes</i>
Education	Substance Abuse
Income	Diet and Nutrition
Marital Status	Physical Activity
Nativity	HIV/AIDS Testing
Primary Language	<i>Health Care Access and Utilization</i>
Religious Involvement	Health Insurance
<i>Physical Health Status</i>	Primary Care
Self-Rated Health	Preventive Health Care
Chronic Conditions	Alternative and Complementary
Disability	Treatments
Weight Status	Prenatal Care
<i>Mental Health Status</i>	<i>Other Health-Related Issues</i>
Quality of Life	Domestic Violence
Depression	Perceived Discrimination
Emotional Problems	Genetic Screening
Perceived Stress	
Anger Management	

Measures

Demographic and Social Factors. Demographic variables to be discussed here include age, gender, nativity, and marital status. Socioeconomic status is measured with three variables: education, income, and employment status. Coding for the demographic and socioeconomic variables is shown in Table 2.

Health Outcomes. The coding for selected health outcomes is described below. Variables not discussed here are explained in the text or tables. Body mass index, a measure of weight for height (kg/m^2), was used to determine adult weight status. The four categories of this measure are as follows: underweight ($\text{BMI} < 18.5$), normal weight ($18.5 \leq \text{BMI} < 25$), overweight ($25 \leq \text{BMI} < 30$), or obese ($\text{BMI} \geq 30$). For children, the CDC “BMI-for-age” categories were used.¹¹ The term “overweight” is used to describe children between the 85th and 95th percentile and “obese” for those greater or equal to the 95th percentile.

TABLE 2

Comparison of Demographic and Social Characteristics between the Current Survey and Other Estimates from Chicago and the U.S.^a

	<i>Current Study</i> ^b (%)	<i>U.S. (Jewish)</i> ^c (%)	<i>Chicago (All)</i> ^d (%)	<i>U.S. (All)</i> ^d (%)
<i>Age</i>				
65 years and older	20	24	14	17
<i>Gender</i>				
Female	52	56	51	51
<i>Nativity</i>				
Foreign born	20	15	22	11
<i>Marital status</i>				
Married	73	57	40	54
Divorced/separated	7	10	12	12
Widowed	7	8	7	7
Never married	13	25	41	27
<i>Education</i>				
Some college or less	35	45	74	75
College degree	38	30	16	16
Graduate degree	27	25	10	9
<i>Annual household income</i>				
Less than \$25,000	14 ^c	22	33	29
\$25,000-\$74,999	38	44	47	48
More than \$75,000	47	34	20	23
<i>Employment status</i>				
Employed	60	61	61	65

Notes: ^a Percentages may not add to 100 due to rounding.

^b Weighted data, N = 201.

^c U.S. Jewish data is from the NJPS, 2000.

^d Chicago and U.S. estimates are from the 2000 Census. Age ranges vary. Specifically, education is asked of adults ≥ 25 and employment status is asked of those ≥ 16 . All other estimates reflect adults ≥ 18 years.

^e Income categories differ for the current study. They are as follows: Less than \$30,000, \$30,000-\$69,999, and More than \$70,000.

Three different measures of depression were examined. For the first measure, respondents were asked if they had ever been told by a physician that they had depression. The second measure used a set of questions to screen for probable depression. These questions, from the

Center for Epidemiological Studies Depression (CES-D) scale, included a set of ten statements, such as “I felt depressed,” or “I felt everything was an effort”.¹² Individuals with four or more positive responses to these statements were considered likely to be depressed. Finally, individuals were asked if they were depressed in the past month.

To measure disability, individuals were asked the following question: “Including yourself, does anyone currently living in your household have a learning or physical disability diagnosed by a doctor, nurse, or other health professional?”

Access to Health Care. To measure access to care, individuals were asked whether they needed medical care or surgery in the past 12 months, but did not receive the services. They were also asked whether they needed specific types of care, but did not receive them because of the cost. The types of care included in this measure were dental care, prescription medications, mental health care, and eye care. Finally, in a series of questions regarding income sufficiency, the respondents were asked if their income was sufficient to pay for their health care needs.

Analyses

All adult frequencies were weighted to account for the probability of selection and to be representative of the Jewish population living in West Rogers Park and Peterson Park. The frequencies for children were not weighted due to the small sample size. Data were analyzed using SAS software, version 9.¹³ Unless noted, the following results pertain to the adult data.

RESULTS

Community Characteristics

Demographic, economic, and cultural characteristics are briefly discussed here, and compared to estimates from other city and national populations (see Table 2). The age distribution of this community was substantially older than the Chicago and national populations, but slightly younger than that seen for Jewish adults nationwide. The gender distribution shows that there were slightly more females than males. In terms of nativity, twenty percent were born outside of the U.S. Nearly three-quarters of adults were married, a figure that is substantially higher than that seen for other populations. As could be expected for a religiously-conservative

population, rates of divorce, separation, or never marrying were low. Also, half of the respondents lived in a household with a child under the age of 18 (not shown). Of these respondents, almost 30% had four or more children.

As historically seen for Jewish populations, individuals had relatively high levels of socioeconomic status. Notably, two-thirds had a college degree or higher, and over one-quarter had a graduate degree. This greatly exceeds the levels of education seen in the city and national Census data. Similarly, nearly half of the sample reported a household income of more than \$70,000 per year. Because of the prevalence of large families in this area, a more precise measure of income was needed to better assess the financial resources of these families. Per capita income is one such measure; it showed that only 20% of large families (6 or more individuals) earned less than \$70,000 and less than 5% reported household incomes of less than \$50,000 (not shown). In contrast, the majority of adults living alone (75%) earned \$50,000 or less.

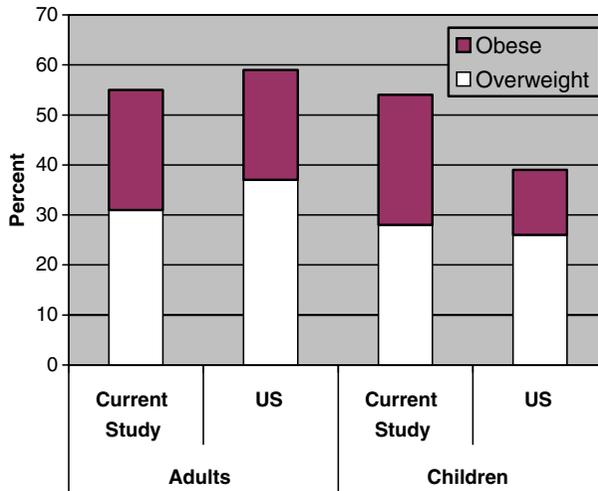
Finally, levels of religious involvement in this community were found to be exceptionally high compared to the national Jewish population. For example, the vast majority of Jewish individuals in this community reported belonging to a synagogue (81%). This can be compared to 73% in Chicago and 46% in the U.S.^{8,14} Of those who belonged to a synagogue, 82% were Orthodox. In Chicago, this percentage is only 12% and, in the U.S., 22%.^{8,14} Other indicators of religious activities also showed high levels of involvement. For example, the majority reported that they keep a Kosher home (79%) and almost all marriages were within the faith (96%). Finally, most adults reported Ashkenazi origins (82%).

Health Status

Obesity. Similar to findings from other national, regional, and local surveys, a large percentage of the individuals in this community were overweight (56%, see Figure 1), including 24% who were obese. Lowering this percentage may be particularly challenging because many overweight adults did not recognize their own weight problems. For example, 19% of overweight individuals said that they were “about the right weight,” and 30% of obese individuals said they were only “slightly overweight” (data not shown). This lack of recognition may be exacerbated by the fact that only 28% of overweight individuals and 54% of obese individuals reported being advised by their doctors to lose weight. Perhaps for these reasons,

FIGURE 1

Percent of Overweight and Obese Adults and Children in the Current Study and the U.S.¹



¹ Sources: Jewish Community Health Survey 2003 and NHANES, 1999–2000. Note: NHANES data is for children 2–11 years of age.

one-third of overweight individuals and 15% of obese individuals were NOT trying to lose weight at the time of the survey. As found in previous studies, overweight and obese individuals who reported receiving weight loss counseling from their physician were more likely to be trying to lose weight than those who did not receive counseling.^{15,16}

Obesity was also evident among children living in this Jewish community. For example, 54% of the children were overweight, including 26% who were obese. This percent of children is substantially higher than national estimates, as shown in Figure 1. Unfortunately, the main difference comes in the percentage of children who are obese. Most notably, the percentage of obese children is *twice* as high here (26%) compared to the general population (13%). The data suggest that younger children and girls were particularly at risk for weight problems, although small sample sizes limit the reliability of the estimates for age and gender groups. Similar to the adults, there was also a large discrepancy between parents' perceptions of weight status and the child's actual weight status. For example, 82%

of parents of overweight children and 70% of obese children said that their child was about the right weight or underweight. To compound the issue, only 18% of overweight children and 30% of obese children had been advised to lose weight by their doctor in the past year.

Mental Health. Within this Jewish population, a substantial number of mental health issues were discovered. For example, over half of the adults reported experiencing problems with their emotional health at some point in their lives (see Table 3). Specific questions regarding mental health in the past month revealed that over one-quarter of the adults reported that they accomplished less because of emotional problems and nearly 20% were unable to work because of these problems. Overall, over one-third had at least one day in which their emotional health was "not good."

Depression, in particular, affected a large number of adults in this community. More specifically, one in five individuals had been diagnosed with depression at some point and almost as many screened positive for probable current depression. Furthermore, nearly one-third of respondents reported that they were depressed in the past month. Both the lifetime prevalence and self-reported depression are slightly higher than

TABLE 3

Mental Health Problems in the Jewish Community Health Survey^a

	<i>Percent</i>
<i>Emotional Health</i>	
Ever had emotional health problems	53
Days in past month when emotional health was not good	
1-7 days	22
8 or more days	14
Accomplished less because of emotional problems	
Some of the time	20
All or most of the time	7
Did not work because of emotional problems	
Some of the time	16
All or most of the time	3
<i>Depression</i>	
Ever diagnosed with depression	21
Screened depressed (CESD)	17
Depressed in the past month	32

Note: ^a Weighted data; N = 201.

national estimates. For example, 21% of the current sample reported having been diagnosed with depression at some point, compared to 16% of the general population.¹⁷ More disturbingly, the percent of adults in this population who reported being depressed in the past *month* (32%) was over *four* times as high as the percent of adults in the general population who reported being depressed in the past *year*.¹⁷

Disability. Nearly one-quarter of adults lived in a household with someone with a disability. This is approximately 50% higher than the rate for all Jewish adults in Chicago. Approximately half of those who lived with someone with a disability reported that it was a learning disability, and an additional 20% reported physical disabilities. Small percentages reported other specific disabilities, such as blindness or deafness and emotional problems. Almost half of the disabled individuals were found to need some type of special care, such as a caregiver, therapist, or physical mobility aids. In addition, individuals who reported living with someone with a disability were more likely to have certain mental and physical health problems themselves. Specifically, for these individuals, rates of depression and poor self-rated health were higher. They were also more likely to report having an income that was insufficient to meet their needs.

Genetic Screening. In addition to the physical and mental outcomes discussed above, the current survey was also instrumental in exploring other health-related behaviors and experiences, such as screening for genetic diseases. Genetic screening is important for individuals of Jewish descent, especially Ashkenazi Jews, because they have a higher risk for carrying mutations for certain genetic diseases. Despite these elevated risks, over half of the adults in this community had never been screened for genetic disorders. Moreover, because a primary motivation of screening is to prevent birth defects, it is particularly important to look at rates of testing among individuals of child-bearing age. The findings showed that, within those 18–44 years of age, over half of single adults and nearly one-third of married adults had not been screened. Being told by a doctor or rabbi about genetic screening was the top motivation cited by those who had been screened. In contrast, those who had not been screened reported barriers such as not perceiving a need for testing and not knowing how or where to get tested.

Experiences with Violence. Another health-related issue identified by the survey was that a large proportion of individuals in this community had witnessed or experienced violence in their lives. For example, one-quarter

of individuals had personally witnessed domestic violence. Furthermore, nearly one-third of adults reported that they, or members of their household, had been a victim of physical, verbal, or sexual violence. The majority of these cases involved strangers, but family members were the perpetrators of the violence in 36% of the incidents. Because the reporting of violence is often well below actual levels, this could be an even more serious problem than the data shows.

Health Behaviors

Previous studies have found that Jewish individuals differ from the general public with regards to certain health behaviors, such as alcohol use.⁵ The current study confirms low rates of all measures of alcohol use (e.g. percentage of current drinkers, number of drinks per week, and presence of problem drinking). Other rates of substance use are also low. For example, only 4% of adults reported that they were current smokers. This is much lower than the national or Chicago rates, both of which are above 20%.¹⁸ Note that a social desirability bias may result in individuals underreporting their actual smoking levels. This may be particularly true in a predominantly Orthodox community where rules (and norms) prohibiting smoking exist (such as explicitly prohibiting smoking on the Sabbath). Rates of marijuana use were also low, with less than 5% of adults reporting marijuana use in the past month. Finally, respondents were questioned about their levels of physical activity. The percentages reporting moderate and vigorous activities at least three times a week (50% and 27%, respectively) were similar to estimates for other populations.

Access to Health Care

Despite the relative affluence of this population, a substantial percentage of adults reported that they needed certain health care services, but were unable to obtain them. Overall, nearly one-quarter of respondents reported not getting specific health care services when they needed them (see Table 4). Levels of unmet needs were similar across service types, ranging from 7–11%. Asked in a more general manner, over one-quarter of the respondents reported that their income was insufficient to pay for needed health care services (not shown). Although Jewish populations are generally found to have greater socioeconomic resources (for example, the nearly universal health care coverage seen in this community), the rates of unmet needs shown in Table 4 were similar to those seen in the general U.S. population.

TABLE 4

Unmet Health Care Needs in the Current Study and the U.S.

	<i>Current Study^a(%)</i>	<i>U.S.(%)</i>
Did not get care when needed (any type)	23	–
Did not get medical care or surgery	9	10 ^b
Did not get prescription medications	7	7 ^c
Did not get mental health care	10	–
Did not get dental care	11	10 ^c
Did not get eyeglasses	7	–

Notes: ^a Weighted data; N = 201.

^b BRFSS, 2000.

^c NHIS, 2001.

Vulnerable Groups

Finally, because some individuals shoulder a disproportionate amount of the burden posed by the health problems discussed above, the health status of potentially vulnerable groups is examined here. In particular, adults with large families, single parents, older adults, and Russian-speaking immigrants were all expected to have special needs. For example, families with four or more children were more likely to have insufficient funds for important needs such as health care, food, or education. More disturbingly, nearly half of all single parents lived below the poverty line (based on approximations using the 2003 federal poverty guidelines).¹⁹ In addition, over half lived in a household with someone with a disability. Perhaps for these reasons, single parents had more depressive symptoms and were more likely to report being depressed in the past month, compared to other adults.

Adults over 65 years of age were relatively advantaged financially, yet they still faced a disproportionate amount of health problems. These problems included elevated rates of high blood pressure (63%), arthritis (65%), and activity limitations (37%). Finally, there was a substantial Russian-speaking immigrant population in this Jewish community. Although this group made up only 5% of the sample, they represent an estimated 1,150 adults in the community and warrant special attention due to the disadvantages they face. For example, nearly half of the individuals in this group reported having insufficient funds to meet their health care and food needs. Health concerns were also common. For example, levels of heart disease were over twice as high as levels seen in the total sample (and

in national estimates) and these individuals were also much more likely to have weight problems.

DISCUSSION

Researchers, policy makers, and public health advocates are all beginning to recognize the benefits of collecting local level health data.^{1,2} Recent studies have shown that even city-level data do not accurately represent the health of individuals living in different community areas.^{2,9,20} Furthermore, the health-related needs of those belonging to culturally distinct groups, such as Orthodox Jews, cannot always be determined even with community area data. To address this lack of information, the current study used a population-based survey to estimate key health risk factors and outcomes for the largest Jewish community in Chicago. The findings revealed that these individuals generally are as healthy (or healthier) than the average residents of Chicago and the U.S. However, many serious health concerns still exist for both adults and children, including obesity, depression, disability, and domestic violence. In addition, despite the relatively high levels of income and education seen here (as in most Jewish populations), the number of individuals reporting insufficient funds for health care needs or going without needed medical care was surprisingly large.

Implications. Access to this type of information is critical because it allows local agencies, foundations, and other community groups to focus their efforts on the most widespread health problems within a community. It is hoped that this information will be used to develop targeted interventions and policy changes to improve individual levels of health and well-being. Efforts to make the current data available to different community groups included a series of presentations made to foundations, social service agencies, rabbis, and school administrators serving this population. In addition, a community report was written (and widely distributed) to summarize the methodology and main results of the survey for all interested individuals and agencies. This report will serve as a baseline for evaluating the impact of future health-related interventions and policy changes within this community. It is also expected that having actual prevalence rates of specific health conditions, as well as information regarding the individuals most likely to be affected, will increase the probability of receiving funding for all community groups and agencies who use the data to guide their intervention plans.

For example, one finding that has attracted a great deal of attention is the large percentage of overweight children. The number of children affected, as well as the extent of the future health problems foreshadowed by these rates, has created a sense of urgency surrounding this issue. Because the majority of Orthodox children in this community attend Jewish day schools, the private Orthodox school system was identified as the most effective location for an intervention. After presenting this data to the principals of the twenty schools in this system, every principal present volunteered to host a pilot obesity reduction intervention in their school. In addition to the child obesity rates cited here, data from the survey provided specific information on the likely causes of obesity within this population, such as levels of recreational activities, participation in sports, specific dietary intake, and hours of television viewing. This data will facilitate efforts to create a multi-faceted physical activity and nutrition intervention through the school system.

Finally, it is hoped that this study will be used as an example for other communities who wish to implement a local level health survey. In particular, this approach may be valuable for other groups for whom health estimates cannot be determined with state, city, or even community area data (especially if these groups are expected to have different health risk factors and outcomes). Several aspects of the project development may be particularly useful. For example, the collaborative process of creating a survey instrument that allowed for comparison with other data sets and used validated questions, as well as provided information on topics only (or particularly) of interest to specific population subgroups may be helpful to other community areas or groups (as may be the actual instrument itself).

Limitations. A primary limitation of the current survey is that all of the information was collected via self-reports. More accurate health information could have been determined through other methods, such as provider records, physiological testing, or insurance claims. In addition, several important topics were asked about indirectly. For example, rates of disability and domestic violence were only determined at the household level due to practical and ethical concerns. Due to this, more specific information, such as the demographic and socioeconomic correlates of these health issues, was not available. Finally, many of the subgroups of interest had very small sample sizes. In order to provide specific estimates for these individuals, a larger sample would be necessary.

CONCLUSION

This study is the first to provide in-depth health information for the largest Jewish community in Chicago. Local level data such as this is important for monitoring the health of population subgroups and for making community-level decisions and policies. Furthermore, having accurate estimates of health risk factors and outcomes increases the likelihood of community-based initiatives being developed, funded, and successfully completed. Through these means, this project has opened the door for future prevention and health education interventions at the individual and community levels.

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