HEALTHY CHICAGO SURVEY

REQUEST FOR INFORMATION

Subject: Healthy Chicago Survey

Inquiries:

All inquiries or questions must be directed to Emily Laflamme, Epidemiologist, City of Chicago Department of Public Health, 312-745-3734, or by email at Emily.laflamme@cityofchicago.org

Questions must be received no later than 5:00 p.m. Central Time, **Wednesday, November 14**. If a determination is made that a clarification or change to the RFI document is required, a written addendum will be posted on the Department of Public Health website (www.cityofchicago.org/health). Respondents are responsible for obtaining all RFI materials.

Deadline and Procedures for Submitting Responses:

Responses must be received by CDPH via email no later than 5:00 p.m. Central Time, Wednesday, November 21. Responses must be delivered to the following email address: emily.laflamme@cityofchicago.org. Email responses must have "Healthy Chicago Survey – RFI Response" in the subject line.

Respondents to the RFI are not required to answer all questions but may instead determine the information they are most equipped to provide.

Please return this sheet with completed information below as part of your submittal documents.

Responding to this RFI is not a pre-requisite for responding to any subsequent solicitations relating to this project.

Response submitted by:

Organization Name	Authorized Officer Signature
Address	Title
City/State/Zip	Telephone Number
Date	Email

Healthy Chicago Survey
Request for Information

Introduction

The City of Chicago Department of Public Health (CDPH) is pleased to issue this Request for Information (RFI) to update the methodology and administration of the Healthy Chicago Survey (HCS). CDPH's goal for the HCS continues to be to collect reliable, timely and representative data on root causes, health behaviors and health outcomes from adults living in the City of Chicago to enable organizations to use the data to describe and take action towards improving health and health equity.

This RFI is being issued by CDPH as part of its continued efforts to enhance the HCS methodology, questionnaire design, participant outreach, administration and dissemination strategies by partnering with communities and organizations across all areas of expertise. To this end, CDPH is seeking responses from a variety of organizations, including community-based organizations, survey administrators, researchers, data scientists, communications experts and any others with related expertise. Responses to this RFI will inform CDPH's redesign of the HCS methodology – as envisioned by CDPH and its partners – to improve the quality of the data collected. This RFI does not provide funding nor will responding affect in any respect funding in the future.

HCS History

The HCS was launched in 2014 by CDPH as an annual random digit dial telephone survey of adults in Chicago. Since then, four cycles of data collection have been completed. Information from the HCS has been used to support the implementation of Healthy Chicago 2.0 and to develop public health interventions and policies to address health inequities. The questionnaire is approximately 20-25 minutes long.

Data are summarized and disseminated through reports[1] and on the Chicago Health Atlas (chicagohealthatlas.org) or shared with external partners through data use or data sharing agreements. The HCS has asked questions related to: access to health services, active transportation, adverse childhood experiences, chronic diseases, demographics, dental care, diet, experiences of discrimination, financial security, fruit and vegetable access, mental health, neighborhood conditions, physical activity, preventative cancer screenings, social cohesion, substance misuse and tobacco use, among others. The relatively large sample size (2,500-3,000 annually) has allowed CDPH to, for the first time, report these data by community area[2] and specific demographic groups.

Since 2014, the HCS has been administered in English and Spanish, and in 2017 was also administered in Korean.

In 2017, all HCS interviewers completed CDPH's Trauma 101 training.

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[1] See website for a list of CDPH publications that have used Healthy Chicago Survey data: https://www.cityofchicago.org/city/en/depts/cdph/supp_info/healthy-communities/healthy-chicago-survey.html

[2] Chicago is divided into 77 well-defined, static community areas that often encompass groups of neighborhoods.

In 2017, CDPH expanded the HCS and restructured its contract to include modules developed in partnership with internal and external stakeholders. For example, the Ann & Robert Lurie Children's Hospital of Chicago contributed a pilot module focused on children's health during the 2017-2018 data collection cycle. CDPH continues to envision the HCS as a tool to inform and support Chicago's entire public health system.

Further information, background, methodology reports and questionnaires can be found on the CDPH Healthy Chicago Survey website:

https://www.cityofchicago.org/city/en/depts/cdph/supp_info/healthy-communities/healthy-chicago-survey.html

Current Challenges

Response Rate

The HCS depends on its ability to reach and engage a representative sample of Chicago adults. Since its launch, the HCS has seen a marginal but steady decline in its response rate (Table 1) that has the potential to impact the quality of the information collected, especially if response rates decline disproportionately among certain demographic groups.

Table 1. Healthy Chicago Survey AAPOR Response Rates and Cooperation Rates[3]

	Data Collection Year			
	2014	**2015**	**2016**	**2017**
Response Rate 1 (RR1)	10.0%	8.0%	8.1%	4.0%
Response Rate 3 (RR3)	13.1%	10.8%	10.4%	8.4%
Cooperation Rate 1	18.5%	17.1%	16.9%	17.9%
Cooperation Rate 3	78.0%	73.8%	81.0%	80.6%

Response rates describe the proportion of completed surveys out of the total number of calls (answered or unanswered). Cooperation rates describe the rate of survey completion out of the total number of

[3] Response Rates and Cooperation Rates are calculated based on the American Association for Public Opinion Research (AAPOR) 2016 Standard Definitions: https://www.aapor.org/AAPOR_Main/media/publications/Standard-Definitions20169theditionfinal.pdf.
Response Rate 1: The number of complete interviews divided by the number of interviews (complete plus partial) plus the number of non-interviews (refusal and break-off plus non-contacts) plus all cases of unknown eligibility.
Response Rate 3: The number of complete interviews divided by the number of interviews (complete plus partial) plus the number of non-interviews (refusals and break-off plus non-contacts) plus all eligible cases (excludes ineligible cases).
Cooperation Rate 1: The proportion of all cases interviewed of all eligible units ever contacted.
Cooperation Rate 3: The proportion of all cases interviewed of all eligible units ever contacted, excluding those incapable of cooperating.

answered calls. Declining response rates coupled with steady cooperation rates suggests that our main challenge is making contact with potential participants.

Over the past four years, Latinx residents, Asian American residents, young adults under the age of 30 and those with lower educational attainment have been statistically underrepresented in the unweighted HCS sample during at least one round of data collection. Currently, the HCS corrects for non-response bias by calculating post-collection weights. This technique ensures that when weights are applied the data accurately represent the population of adult residents of Chicago. However, a declining response rate means that even with weights applied, statistical reliability may be impacted. Declining response rates also contribute to increased administration cost and burden every year.

This challenge is not unique to the HCS. The Department of Health and Human Services, the leader among federal agencies in the breadth and volume of the household surveys it administers, has documented declining response rates since the late 1990s, especially among telephone surveys[4]. This trend is also observed in privately administered telephone polls, like those conducted by Pew Research Center[5]. Research has suggested that declining response rates are a result of a multitude of different causes.

2020 US Census

The HCS relies on data from the US Decennial Census and annual American Community Survey to define administrative boundaries (Census Tracts and Public Use Microdata Areas) and provide demographic information used to calculate post-collection weights.

Changes to the methodology of the upcoming 2020 US Census have the potential to impact future HCS waves.

Additional information on proposed changes to the 2020 US Census can be found on the US Census Bureau website: https://www.census.gov/programs-surveys/decennial-census/2020-census.html

Administrative Burden

The HCS is also facing additional challenges related to its expansion and growth. The inclusion of external partners into our contracting structure has required increased administrative and analytics support.

[4] Czajka J.L. and Beyler A. Background Paper: Declining Response Rates in Federal Surveys: Trends and Implications. June 15, 2016. Submitted to: Office of the Assistant Secretary for Planning and Evaluation. U.S. Department of Health & Human Services

[5] Keeter S, Hatley N, Kennedy C and Lau A. What Low Response Rates Mean for Telephone Surveys. 2017. Pew Research Center

Key Program Elements

While CDPH is open to considering innovative methodologies and strategies to address these challenges, the future HCS should continue to include the following key elements:

Target Population:
The target population for the HCS will continue to be the adult (18 years and older) population of Chicago. To the greatest extent possible the HCS should reach a sample representative of the demographics of this population, especially those who have traditionally been underrepresented in the unweighted HCS sample.

Questionnaire Content:
The HCS should continue to allow for the flexibility to collect information on emerging and topical public health issues and to include modules developed in partnership with internal and external partners. Currently, the HCS is CDPH's primary source for data on: alcohol misuse, asthma, cancer screening, dental care, diabetes prevalence and management, diet, e-cigarette use, health care utilization and satisfaction, health status, obesity, mental health, perception of neighborhood safety, physical activity, prescription opiate misuse, smoking and social cohesion. In the future, CDPH will likely continue to collect data on these (and other) topics via the HCS unless other data sources are identified. CDPH does not envision collecting biological samples as part of HCS.

Community Area Data:
Currently, CDPH pools three consecutive years of HCS data together to increase sample size and enable direct community area (CA) estimates of some indicators. This approach has yielded stable estimates for the majority of the 77 community areas, with design effects by CA ranging from 1.164 to 1.622. These design effects are comparable to the overall apparent design effect of 1.43. Though direct estimates are not necessary, it remains a department priority to have data for community areas or other small geographies.

Data Dissemination:
The HCS should, at minimum, provide biennial data on a set of core public health metrics. CDPH is interested in using data collected by the HCS to: support communities in describing and advocating for their health and wellness, describe and understand health inequities among demographic groups and communities, monitor trends over time, and inform and monitor aspects of its community health improvement plan (currently *Healthy Chicago 2.0*).

Project Administration:

CDPH aims to collect high quality, actionable data while minimizing administrative burden and cost. CDPH envisions that all data collection and processing will be done by an external contractor.

Strategies and Desired Outcomes

CDPH now seeks ways to improve our data collection to better understand health and health inequities among the residents of Chicago.

We are seeking input on strategies to achieve the following goals:

Your responses are not limited to the questions listed below each goal. Please feel free to respond with any information relevant to the listed goals.

1. **Increase community participation and decision making within HCS governance and operations to ensure that community priorities are reflected, and the survey instrument is accessible and culturally relevant.**

    a. What aspects of HCS governance, administration and operations are communities most interested in participating in? (e.g. budget, questionnaire development, data dissemination, etc.)
    b. What governance structure would support increased community participation in HCS decision making?
    c. What strategies would make it easier for community residents to participate in HCS decision making and governance? (e.g. compensation, travel, child care, meeting location, etc.)
    d. How can we ensure that a diversity of community residents participate in HCS decision making and governance?

2. **Reach a sample of adult Chicago residents (18 years and older) that is representative by race, ethnicity, age, gender identity, sexual identity, ability, educational attainment, employment status, income and other key demographics.**

    a. What are current best practices or innovative survey methodologies for reaching a representative sample (random or non-random samples)?
    b. What are the most successful strategies to reach Chicago residents who have a cell phone number from outside of the Chicago region?
    c. What incentive structures are most successful at soliciting accurate and increased response rates?
    d. What additional data sources could supplement data collected by the HCS?
    e. What additional partnerships should CDPH seek to support our goal of reaching a representative sample?
    f. How should the HCS respond to changes in the US Census 2020?
    g. How can the HCS incorporate qualitative data collection?
    h. What are strategies to include populations in group living situations (e.g. jail/prison, university housing, group homes, etc.) in the HCS?

3. **Increase participation among groups that have historically been underrepresented in the Healthy Chicago Survey unweighted sample, in particular: Latinx and Asian American residents, young adults under the age of 30 and those with lower educational attainment[6].**

    a. What survey methods have been shown to be most accessible and effective in reaching:
        i. Latinx residents?
        ii. Asian American residents?
        iii. Residents under the age of 30?
        iv. Residents with lower educational attainment?
        v. Other populations?
    b. What incentive structures are most effective in engaging underrepresented populations?
    c. What strategies could be employed to reduce survey burden, especially among underrepresented populations?
    d. Are there strategies to oversample small populations or hard-to-reach populations within a broad population health survey? (e.g. transgender residents, people who use drugs, Native American residents, etc.)
    e. Are there marketing and communications strategies that would build awareness and trust surrounding the HCS and increase participation, especially in underrepresented populations?

4. **Collect actionable data that responds to current and emerging public health priorities and support a root cause approach for improving health and health equity. It is critical that data collected allow for reliable estimates for Chicago adults overall, for major demographic groups and for Chicago's 77 community areas or other small geographies. To the greatest extent possible, data should allow for prospective monitoring of trends, with minimal impact on monitoring and evaluating historical trends.**

    a. How can we better determine what community and stakeholder public health priorities should be included in the HCS questionnaire?
    b. What are ways to ensure that all community areas have sufficient representation in the HCS?
    c. What are strategies to develop and validate new questions?
    d. What are strategies to minimize the impact of a new methodology on our ability to monitor and evaluate historical trends?
    e. What are innovative statistical methods to calculate estimates for small geographies or demographic groups?

5. **Process, analyze, visualize and broadly disseminate survey findings to inform residents, researchers, policy-makers, funders and other key stakeholders.**

    a. How should key findings be disseminated to different audiences (residents, community-based organizations, public health, medical providers, academic community)?

[6] These groups were statistically underrepresented in previous unweighted Healthy Chicago Survey datasets.

b. What mechanisms could be used to streamline data processing and dissemination (e.g. automatically produced report, dashboard, upload to Chicago Health Atlas)?
c. How can community residents and organizations be involved in the process of analyzing and interpreting findings?
d. How can we ensure that data graphics and produced materials are culturally relevant and non-stigmatizing?

6. Establish a budget that appropriately reflects and weights these priorities, recognizing that CDPH seeks a sustainable funding model that minimizes the administrative burden and cost associated with conducting the survey.

a. Please supply budget information for methods that have been shown to successfully increase survey participation among groups that have historically been underrepresented in the HCS:
    i. Latino residents
    ii. Asian American residents
    iii. Residents under the age of 30?
    iv. Residents with lower educational attainment
    v. Other populations
b. What strategies can be employed to minimize year-over-year budget increases?
c. Are there opportunities for cost saving by partnering with existing surveys?
d. What strategies would you suggest for sustainability in an environment where funding is becoming increasingly scarce and competitive?
e. Are there examples of contract structures that maximize flexibility to include external partners while minimizing additional administrative burden?
f. What functions could the survey vendor assume responsibility for to minimize the burden on CDPH, both pre- and post-data collection?

CDPH is aware of the following methodologies, and is interested to learn about how these, and other potential strategies not listed here, might be applied within Chicago's local context:

- Incentive structures
- Reducing survey burden
- Address-based sampling
- Mixed modes
- Web-based surveys
- Two phase sampling
- Respondent driving sampling
- Panel surveys
- Utilizing big data and/or administrative records

Request for Information Response Guidelines

RFI Purpose

The purpose of this RFI is to gather information to inform a subsequent Request for Proposals. While the program concept is outlined above, CDPH is interested in feedback that may inform program elements and operations. **Respondents to the RFI are not required to answer all questions but may instead determine the information they are most equipped to provide.** Additionally, respondents may submit information that represents expertise of multiple partners who may represent similar or distinct roles outlined in this RFI. This document is not intended as an offering for the award of a contract or participation in any future solicitation.

CDPH reserves the right, at its sole discretion, to withdraw the RFI as well as to use the ideas or proposals submitted in any manner deemed to be in the best interest of CDPH or undertaking the prescribed work in a manner other than which is set forth herein. The issuer may contact respondents for clarification on the RFI submission.

Eligible Respondents

CDPH seeks responses from a variety of organizations, including community based organizations, survey administrators, researchers, data scientists and others with related expertise. Organizations may respond individually or as part of a team.

Submission Instructions & Timeline

As stated previously, CDPH is seeking input and feedback from interested parties on strategies and considerations for all components detailed above that would inform project planning and a Request for Proposals for the HCS. Respondents are not required answer all questions. **Please respond to questions/elements that are appropriate and on which your organization has expertise or feedback. Respondents may choose to limit the focus of their feedback to specific questions or sections.** Where applicable please provide references that describe proposed strategies.

Submissions will be reviewed by CDPH and may be shared with not-for-profit leaders, community partners and other government entities for the purpose of consultation on program design.

Responses must be delivered to the following email address: emily.laflamme@cityofchicago.org. Email responses must have “Healthy Chicago Survey – RFI Response” in the subject line. Any questions on the RFI can be directed to: Emily Laflamme, emily.laflamme@cityofchicago.org or 312.745.3734.

Information sessions about this RFI will be held on the following dates and times.

Participants are not required to attend an information session. All materials presented at information sessions will be publicly available on our website

Information Session (In-person)
Monday, October 22
10:00am – 11:30am
English and Spanish
Piotrowski Park (Little Village)

Information Session (Webinar):

Monday, October 22
1:30pm – 3:00pm
English and Spanish
Dial-in number (US): (641) 715-3580
Access code: 138390#
International dial-in numbers: https://fccdl.in/i/emily_laflamme
Online meeting ID: emily_laflamme
Join the online meeting: https://join.freeconferencecall.com/emily_laflamme
For 24/7 Customer Care, call (844) 844-1322

This webinar will be recorded and will be posted within 48 hours to:
https://www.cityofchicago.org/city/en/depts/cdph/supp_info/healthy-communities/healthy-chicago-survey.html

Glossary

Address based sampling: Address based sampling relies on selecting a sample of residential addresses from the U.S. Postal Service (USPS) Computerized Delivery Sequence File. Those sampled receive a paper-based survey by mail or an invitation to complete an in-person, telephone or online survey.

Administrative data: Refers to information collected primarily for administrative, not research, purposes. Education records, registries of births, marriages, licenses and deaths, tax returns, and crime records are examples of administrative data.

Big data: Big data usually includes data sets with sizes beyond the ability of commonly used software tools to capture, curate and manage. Big data are often unstructured. Twitter data is an example of big data.

Incentive: A monetary or other reward for individuals who complete a survey.

Mixed modes: Mixed mode (or multi-mode) surveys combine multiple data collection methods. For example, they may involve combinations of in-person, telephone, mail, online and other methodologies.

Panel survey: In a panel survey, repeated observations are derived by following a sample of persons (a panel) over time and by collecting data from a sequence of interviews (or waves). These interviews are usually conducted at fixed occasions that are regularly spaced.

Respondent driven sampling: Respondent driven sampling is a sampling method that relies on individuals to recruit others within their social network. RDS recruitment is initiated with a small, diverse and influence group of "seeds." Each seed receives a set number of recruitment coupons to recruit his/her peers who then present coupons at a fixed site to enroll in the survey. Eligible recruits who finish the survey are also given a set number of coupons to recruit additional peers.

Survey respondent burden: The degree to which a survey respondent perceives participation in a survey research project as difficult, time consuming or emotionally stressful. Interview length, cognitive complexity, required respondent efforts, frequency of being interviewed, and the stress of psychologically invasive questions all can contribute to respondent burden in survey research.

Two phase sampling: Method that collects basic information from a large sample of units and then, for a subsample of these units, collects more detailed information. The most common form of multi-phase sampling is two-phase sampling (or double sampling), but three or more phases are also possible