Cambridge Health Alliance
Regional Wellbeing Report 2025

A Community Health Needs Assessment

CHA Cambridge Health Alliance

CARE T♥ THE PEOPLE

Table of Contents

A Letter to Readers

Hello! Welcome to the Cambridge Health Alliance (CHA) 2025 Regional Wellbeing Report.

This report is the result of a collaborative, year-long assessment involving community members from across CHA's service area – Cambridge, Chelsea, Everett, Malden, Medford, Revere, Somerville, and Winthrop. Our goal was to better understand the strengths and challenges that impact community health. Importantly, the process does not end with this report – it sets the stage for action.

We are grateful to everyone whose voices and experiences are reflected in this report. In particular, we thank the CHA Community Health Advisory Council members who guided the assessment from start to finish. We also thank the Community Researchers, student interns, and partners who helped to carry out each step. Finally, we thank the CHA Department of Community Health's Health Improvement Team for leading the assessment and bringing this report to life.

We invite you to explore the Wellbeing Report. You will find data, stories, and visuals that, together, paint a picture of wellbeing in our communities. Some highlights include:

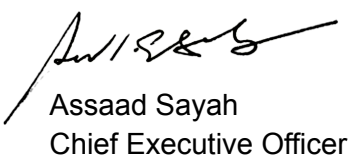
- The Health Equity section illustrates what we mean by this concept, and includes a special spotlight on the connection between stress and health.
- The Key Findings summarize ten important insights that stood out across all the data.
- There are four main chapters that share the results. Each chapter dives into the data on a different topic, summarizes recommendations from community members, and includes one or more "Health Spotlights." The four chapters are:

  Healthy Housing: Affordability, Stability, Safety
  Equitable Economy: Money, Jobs, Food, Caregiving
  Equity in Access: Care, Services, Information
  Climate Health and Environmental Justice

- While quotes and experiences of community members are woven throughout the report, you will also find a "Sharing Our Stories" section at the end of each chapter.

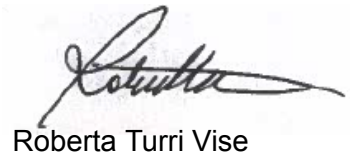
The report ends with a call to collaborative action. CHA is committed to using the priorities that emerged from the Wellbeing Assessment to help guide our work – and we invite you to join us.

Sincerely,



Assaad Sayah
Chief Executive Officer

Douglas S. Kress
Chief Community Officer



Roberta Turri Vise
Deputy Chief Community Officer

How to Use and Navigate this Report

This report is a resource for everyone who lives, works, and serves in Cambridge Health Alliance's (CHA's) service area communities. You can use this report to…

Learn about community health challenges and strengths.

Read the *Key Findings* section to see 10 takeaways from the Wellbeing Assessment process. Then, read the chapters that interest you – each one includes data, stories, and visuals to paint the picture of health in our communities.

Advocate for causes that you care about.

The report is organized in four main chapters, each focusing on a different topic that impacts community health. Find the topic that matters to you, and find the data that shows why it's important to take action. Share the data with your representatives and policy-makers.

Support your fundraising or grant proposal writing efforts.

In addition to the main chapters of the report, dig into the appendices to find detailed data from the CHA Community Wellbeing Survey, focus groups and interviews, and more data from the Census, Department of Public Health, and other secondary sources.

Ready to get started?

For readers interested in CHA's approach to conducting this assessment:

- *About the Wellbeing Report*: Learn about the purpose and design of the Wellbeing Assessment, the methods used to collect and analyze data, and the people who participated.
- Visit the *Health Equity* section to learn about the intentional equity lens of the Wellbeing Assessment process.

For readers interested in demographic data and key community health statistics:

- Visit the *Our Communities: Population Characteristics* section for demographic data that helps to describe the communities in this assessment.
- Visit Appendix F: Community Data Profiles & Visuals for statistics and charts.

For readers interested in an overview of the results of the assessment:

- Visit the *Key Findings* section for 10 takeaways that stood out across all the focus areas of the Wellbeing Assessment.

For readers interested in stories and recommendations from community members:

- Visit the *Sharing our Stories* and *Community Voices* sections of each Results chapter.

For readers interested in detailed results of the assessment:

- The results are organized into four chapters: Healthy Housing, Equitable Economy, Equity in Access, and Climate Health and Environmental Justice. Social, economic, community, and health data are integrated in each chapter.

About the Wellbeing Report

The Wellbeing Report tells the story of health in our communities.

When you hear the word “wellbeing,” what comes to mind for you? Maybe you think about a community where people care about and support each other. Maybe you think about having healthy food, enough money, and an affordable place to live. Maybe you think about an environment that’s free from pollution. Maybe you think about having access to health care services and other resources. Maybe you think about feeling a sense of belonging, safety, and possibility. All of these ideas are part of what creates wellbeing. And, if you care about community wellbeing, **this report is for you.**

Cambridge Health Alliance (CHA) works alongside communities to improve health and wellbeing. One way we do this is through the Wellbeing Assessment and Implementation Strategy. This process happens every 3 years, and includes two parts: a ***Community Health Needs Assessment (CHNA)***, which engages community members to understand what communities need and what their strengths are; and an ***Implementation Strategy (IS)***, which turns what we learn into goals and actions.

Image Source: American Hospital Association, Association for Community Health Improvement (ACHI) (2023). Community Health Assessment Toolkit.

This 2025 CHA Regional Wellbeing Report shares the results from our latest assessment. It builds on what we learned in 2022, with a deeper focus on the priorities that came out of that assessment – like improving housing security, strengthening families’ economic security, increasing access to care, and promoting environmental justice. It continues to address the ways racism, poverty, and exclusion shape differences in health between groups. We call these principles and focus areas our **Priorities for Collaborative Action**, and you will find them woven throughout this report.

Equity Principles

The “How”

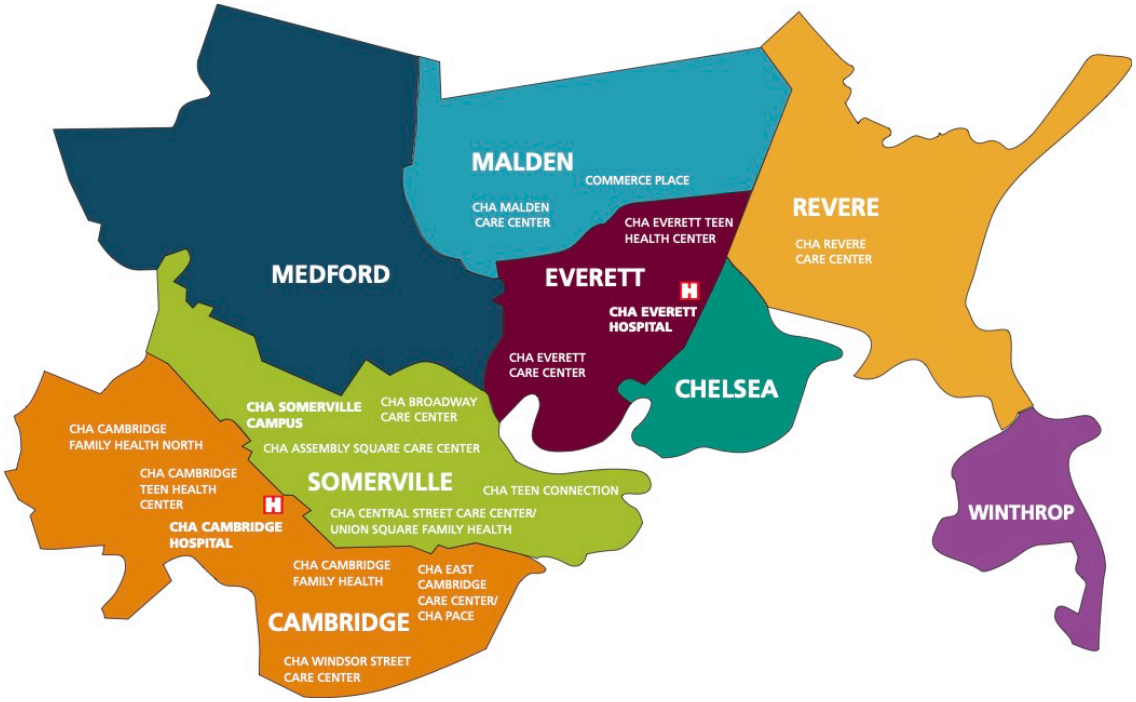
- Language justice
- Inclusion of under-represented voices in leadership and decision-making
- Environments that promote collective care and healing

Focus Areas

The “What”

- *Housing*
  Affordability, stability, safety
- *Equitable Economies*
  Money, jobs, food systems, caregiving
- *Equity in Access*
  Care, services, and information across sectors
- *Climate Health and Environmental Justice*
  Air, water, climate resilience

When we talk about “our communities,” we include people who live, work, go to school, or receive care in CHA’s primary service area. This includes the cities and towns of **Cambridge, Chelsea, Everett, Malden, Medford, Revere, Somerville, and Winthrop**. This report aims to reflect the experiences of people in our communities who are most affected by barriers to health and wellbeing.



While this report tells an important story of health in our communities, it’s also a story that is changing. The political, economic, social, and environmental landscape changed significantly between 2024, when we collected the data for this assessment, and summer 2025, when we finished writing this report. These changes continue to impact our world, country, and local communities. The data and stories you will find in this report point to conclusions that are just as relevant to health equity today – if not more so. CHA affirms our commitment to advancing health equity and centering community priorities in our work.

For more background, check out the 2022 CHA Regional Wellbeing Report on our webpage: www.challiance.org/communityhealthdata

People across our communities participated in developing this report.

People from the community helped lead the assessment – not just as participants, but as co-designers – and decide what actions to take in response to the results. This approach is called **Participatory Action Research (PAR)**. By working collaboratively and involving community members throughout the process, PAR helped us center the knowledge, lived experience, and leadership of people most affected by health inequities.

CHA's Community Health Advisory Council (CHAC) helped guide the assessment. People were invited to become CHAC members because they are deeply connected to the communities they represent and have valuable perspectives, knowledge, and forms of power. We also contracted Community Researchers to be part of our assessment team. Community Researchers and CHAC members helped shape the questions we asked, how we collected information, and how we made sense of what we heard. We also collaborated with many community partners to engage people across our communities in the assessment. **This report would not have been possible without the relationships, trust, and collaboration of our community.**

Key Terms

Community Researchers were at the heart of this assessment. These were residents trained through a two-day program in research ethics, participatory assessment methods, and community health topics. Working alongside CHA staff, student interns, and partners, they helped design tools, collect and analyze data, and build trust with community members.

Visit Appendices A and B to see the names of CHAC members and community partners.

What kinds of information did we collect? We gathered many types of data using several methods, which you can learn more about in Appendix D:

- We created a **Community Wellbeing Survey** in English, Spanish, Portuguese, Haitian Creole, and Chinese. Community members completed the survey online or on paper, and we shared it at community events, gathering places, and online channels like e-newsletters and WhatsApp. Almost 1,000 people participated in the survey.
- We held **focus groups** in partnership with community organizations to better understand people's health experiences, barriers to wellbeing, and top priorities. These small group conversations engaged over 70 community members.
- We held one-on-one **interviews** with community leaders, advocates, and content experts to better understand how policies, systems, and power impact health and wellbeing.

Key Terms

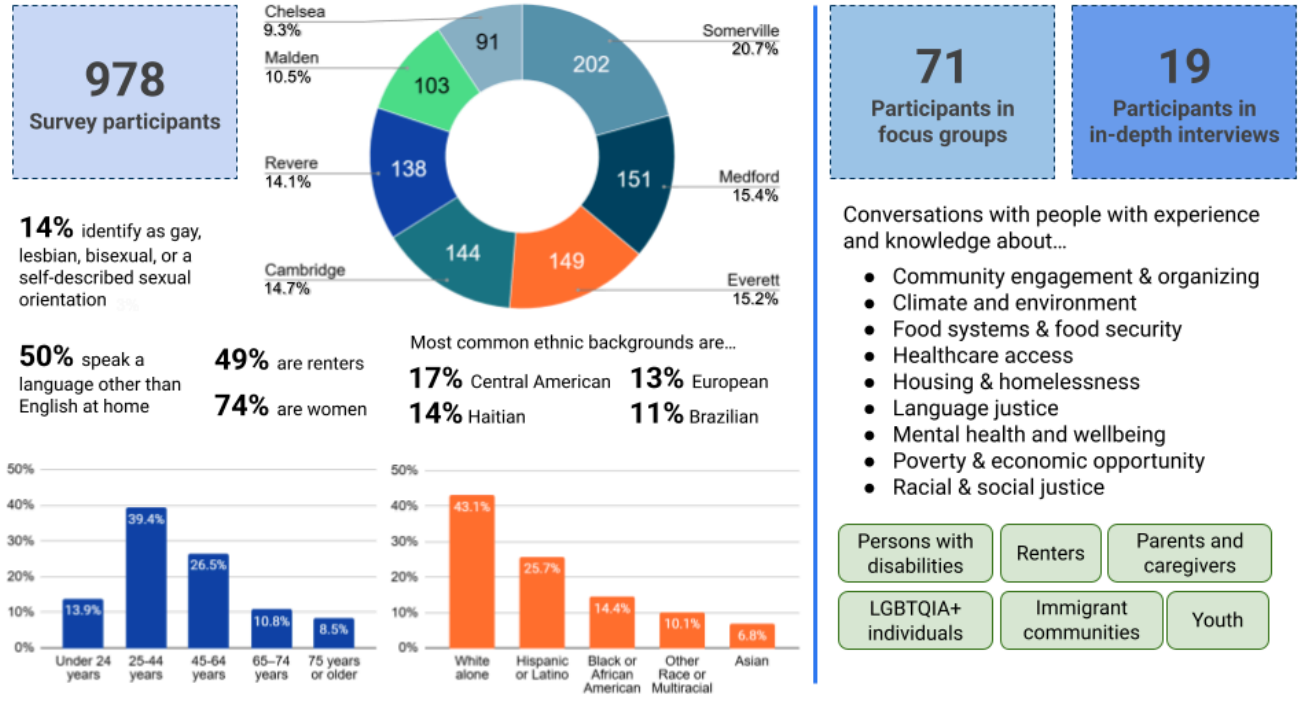
Primary data is data we collect ourselves – like surveys, focus groups, and interviews.

Secondary data is data collected by others and made available to us – like Census data, health department records, and community reports.

- We gathered **secondary data** from more than 40 trusted sources – including the U.S. Census Bureau, Massachusetts Department of Public Health, Centers for Disease Control and Prevention, and more. We looked at trends in areas like income, education, housing, chronic disease, environment, and access to care. Whenever possible, we looked at differences in the data by racial or ethnic group, income, city, and other factors to uncover patterns of inequity. We also reviewed reports from state and local agencies, researchers, and organizations to build on what's already known in our region.

Who did we hear from?

We aimed to reach people most affected by inequities – including immigrants, people of color, LGBTQIA+ individuals,[1] people with disabilities, older adults, low-income parents and caregivers, and people who speak languages other than English. Our survey and focus group data are not meant to represent the entire population, but to lift up the voices of people who are often left out of data and decision-making.



For more details about who participated in the survey, focus groups, and interviews, check out the Survey Results Frequency Tables and Qualitative Themes Report in Appendix E

How did we analyze the data?

We used a collaborative and equity-focused analysis process.

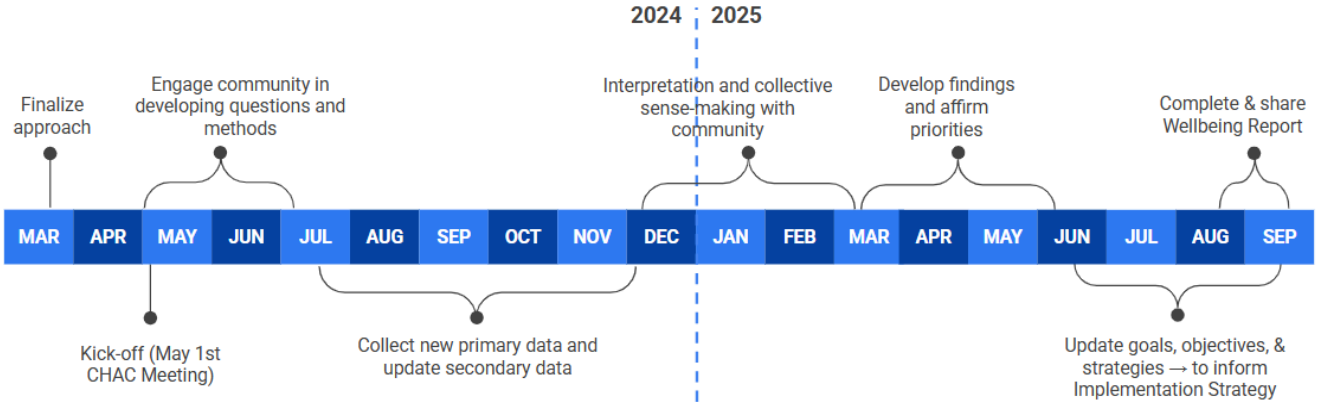
- First, the assessment team did an initial analysis to calculate survey statistics, categorize focus group and interview responses into themes, and compile secondary data – all with an equity lens to see how experiences differ between groups.
- Second, Community Researchers and Community Health Advisory Council members reviewed these initial findings. They shared what resonated, what was missing, and what deserved deeper exploration. Their input led to new data breakdowns and sharpened our analysis.

[1] LGBTQIA+ is an acronym that stands for Lesbian, Gay, Bisexual, Transgender, Queer (or Questioning), Intersex, Asexual, and other diverse sexual orientations and gender identities that fall outside of normative cisgender or heterosexual categories.

- Third, we held interactive data workshops in community settings. We created visualizations of the findings to make the data easier to understand and had conversations about how to make sense of the findings. Community members' input helped us make sure we were drawing the right conclusions from the data.

This process emphasized that numbers alone do not tell the full story. Community interpretation is essential for understanding what the data really means – and what should be done next.

When did all of this take place? The Wellbeing Assessment process began in March 2024, and concluded in August 2025. The timeline below shows each phase.



For more details about our data collection and analysis methods and tools, see Appendix D

Every assessment has its limits.

Please keep these limitations in mind as you review the Wellbeing Report.

- Our survey, focus group, and interview findings reflect the experiences of the people who participated – not the entire population. We focused on engaging people who are closest to the impact of health inequity.
- Even with intentional outreach, some groups of people remain small in number. We would need larger sample sizes to fully explore their experiences.
- We collected data in the summer and fall of 2024. What was happening in people's lives and in the world at that time may have influenced how they responded to our survey or focus group questions. Context is always changing.
- It takes time for research agencies to analyze and publish data, so some statistics like death rates, illness rates, and demographic or economic indicators may be a few years old.
- Many data sets combine unique racial, ethnic, or gender identities into single categories, which can obscure meaningful differences between groups.

Using multiple data sources together helps us balance these limitations and gain a more complete picture. Each source adds a different kind of insight – whether through stories, numbers, or patterns over time.

The Wellbeing Report is grounded in shared values.

The assessment process was grounded in a shared commitment to equity, community leadership, and accountability. The following values guided every stage of the process – from design and data collection, to analysis and action planning.

Equity. We apply an equity lens in all aspects of this work. This means asking critical questions throughout the process: *Whose experiences are included, and whose are missing? Are there differences between groups? What's missing that would reduce inequities?* We recognize the role of structural racism, economic injustice, and other forms of systemic oppression in shaping community health. Rather than focusing only on individual behaviors – such as exercise, diet, or going to the doctor – we examine the broader conditions that influence health, such as housing, income, education, the environment, and access to power and resources. A health equity lens encourages us to understand how these social and structural factors shape people's opportunities to thrive.

Inclusive Participation. We believe that people most affected by health inequities must be centered in the process of identifying priorities and shaping solutions. This includes intentionally elevating the voices of people whose experiences are often ignored or excluded – such as immigrants, people of color, LGBTQIA+ individuals, people with disabilities, older adults, low-income parents and caregivers, and people who speak languages other than English.

Strengths-Based. While it is essential to understand disparities and needs, we also focus on the strengths and assets within communities. We seek out stories of resilience, connection, and leadership. We recognize that community members hold many of the tools and knowledge needed to create change. Our role is to support and amplify that power.

Rigor and Transparency. We combine many types and sources of data to better understand both the "what" and the "why" of community health trends. Our methods are designed to be transparent, reproducible, and responsive. We draw from public health, social science, history, and community knowledge and commit to sharing findings openly and intentionally with community members.

Respect and Stewardship. We are committed to honoring people's time, knowledge, and contributions. This includes compensating participants, valuing relationships, and coordinating efforts to avoid duplication. We see the assessment not as a one-time event, but as part of a broader commitment to partnerships and shared action to improve health and wellbeing.

Health Equity

We use the term “health equity” throughout this report. What does this mean? Here is the definition[2] we have adopted at CHA:

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. To achieve this, we must remove obstacles to health — such as poverty, discrimination, and deep power imbalances — and their consequences, including lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

This definition illustrates why the Wellbeing Report focuses on housing, economic security, access to care, environmental exposures, language justice, system design, and other community conditions. All of these factors influence people’s health.

When we asked people in our focus groups and interviews what health and wellbeing mean to them, their responses showed exactly what health equity is all about. Wellbeing is influenced by multiple, interconnected factors like access to resources, stable housing, nutritious food, reliable transportation, safety, information, and other critical resources. It’s about having a strong sense of belonging, social support, and stability. Wellbeing is the ability to thrive, not just survive. It’s not just about services – it’s about creating community conditions where people feel grounded and empowered.

One way of thinking about health equity is illustrated[3] as a tree. If a tree is full of leaves, we know the soil must be rich with nutrients, and the roots, trunk, and branches must be strong. In the same way, when communities are healthy, it’s because everything that supports health is also strong – culture and beliefs, systems and institutions, conditions in the social, economic, and built environment, and people’s choices and actions.

If the leaves are sparse or not doing well, we don’t blame the leaves. We look deeper. We check the branches, the trunk, the roots, and the soil. We ask: is something blocking the tree from getting water or sunlight? Is the soil dry or polluted? Are the roots damaged?

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[2] Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. *What Is Health Equity? And What Difference Does a Definition Make?* Robert Wood Johnson Foundation, 2017.

[3] The Health EquiTREE (2022), illustration by Health Resources in Action for the Massachusetts Community Health and Healthy Aging Funds. https://mahealthfunds.org/resources/

Health equity works the same way. If some groups of people are living shorter lives or not reaching their best health, we need to look beyond individual choices. We need to ask what's happening in the deeper systems around them. Regardless of identity or circumstances, everyone should have the opportunity to achieve their best health.

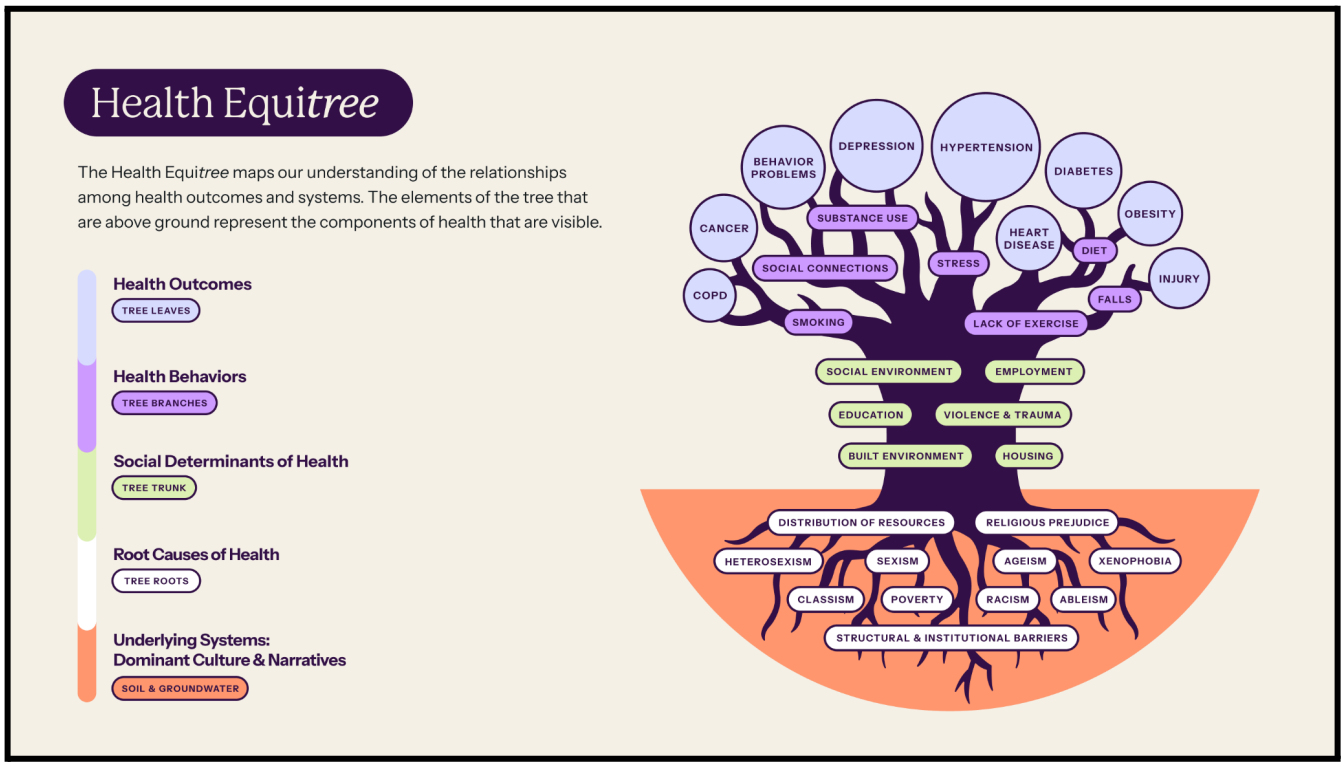

Image Source: The Health EquiTREE (2022), illustration by Health Resources in Action for the Massachusetts Community Health and Healthy Aging Funds. https://mahealthfunds.org/resources/

- **The leaves** represent health outcomes – like asthma, diabetes, or mental health challenges, as well as healthy blood pressure, physical fitness, or child developmental milestones.
- **The branches** are health behaviors – like eating, exercising, and going to the doctor, as well as smoking, misusing substances, or overusing social media.
- **The trunk** stands for the community conditions we live in – like income level, education quality, housing quality, and transportation systems – also called ***social determinants of health***.
- **The roots** are the systems and structures that shape those conditions – like racism, unfair policies, and unequal access to resources, as well as anti-discrimination, inclusive policies, and collective care.
- **The soil** is our culture and beliefs – what society values and what stories it tells about who matters and why.

For everyone to have the opportunity to achieve their best health, we have to care for the whole system, starting with the soil and roots. That's what it means to work toward health equity: not just treating the symptoms, but changing the conditions so that all people, in all communities, can thrive.

Health Spotlight: Stress and Our Health

In this report, you will read about many ways in which community conditions impact people's health and wellbeing. One important pathway that can be activated by harmful community conditions or experiences is the body's **stress response.**[4]

Stress is a normal part of life, but high levels of stress that last for a long time, or happen too often, are harmful. For people who experience poverty, racism, violence, homelessness, hunger, climate disasters, and other serious stressors, the impact of constant stress can cause health problems. Many people think of stress as a mental or emotional experience – but, stress is also a biological process.

How does stress impact health and wellbeing? Experiencing stress triggers the body to release hormones like cortisol and adrenaline. These hormones help you to react quickly in the moment, like if you need to escape danger. But if they stay high for too long, they can damage the body's blood vessels, organ systems, and metabolism.

Over time, too much stress can:

- **Raise blood pressure** and increase the risk of heart disease.
- **Weaken the immune system**, making it harder to fight off illnesses.
- **Cause inflammation**, which is linked to many chronic diseases.
- **Affect the brain**, increasing the risk of anxiety and depression.
- **Impact fertility** in both males and females and increase the risk of **pregnancy problems**.
- **Disrupt sleep, appetite, and digestion**, which affects overall health.

Stress not only affects our mood and mental health – it can lead to serious physical health issues, too. In fact, inequities in experiencing chronic stress partly explain inequities in health outcomes.[5] That's one reason why the Wellbeing Report focuses on community conditions and root causes like poverty, racism, and other forms of discrimination. The stress caused by these factors leads to health inequity.

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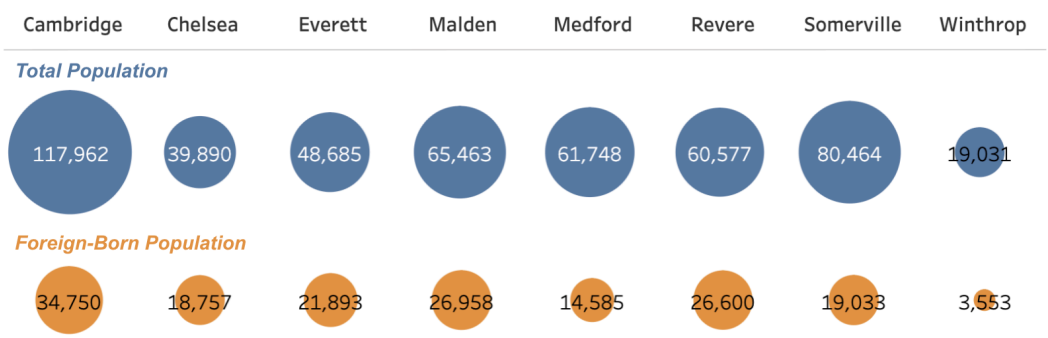
[4] For more information on the body's stress response, see **1)** American Psychological Association. Stress Effects on the Body. (October 21, 2024); **2)** Godoy LD et al. A Comprehensive Overview on Stress Neurobiology: Basic Concepts and Clinical Implications. *Frontiers in Behavioral Neuroscience.* 2018;12(127); **3)** Gianaros PJ, Wager TD. Brain-Body Pathways Linking Psychological Stress and Physical Health. *Curr Dir Psychol Sci.* 2015;24(4):313-321.

[5] For more information on stress as a causal factor of health disparities, see **1)** American Psychological Association, APA Working Group on Stress and Health Disparities. (2017). *Stress and health disparities: Contexts, mechanisms, and interventions among racial/ethnic minority and low-socioeconomic status populations*; **2)** Hines AL, Albert MA, Blair JP, et al. Neighborhood Factors, Individual Stressors, and Cardiovascular Health Among Black and White Adults in the US: The Reasons for Geographic and Racial Differences in Stroke (REGARDS) Study. *JAMA Netw Open.* 2023;6(9):e2336207; **3)** Brown TH, Hargrove TW, Homan P, Adkins DE. Racialized Health Inequities: Quantifying Socioeconomic and Stress Pathways Using Moderated Mediation. *Demography*. 2023;60(3):675-705; **4)** Latendresse G. The Interaction Between Chronic Stress and Pregnancy: Preterm Birth from A Biobehavioral Perspective. *J Midwife Womens Health*. 2009;54(1):8-17.

Our Communities

Our communities are made up of people of diverse identities, backgrounds, and experiences.[6] To explore more demographic data, check out Appendix F: Community Data Profiles and Visuals or visit CHA's Tableau Public site: https://bit.ly/CHA-Community-Health-Tableau-Public

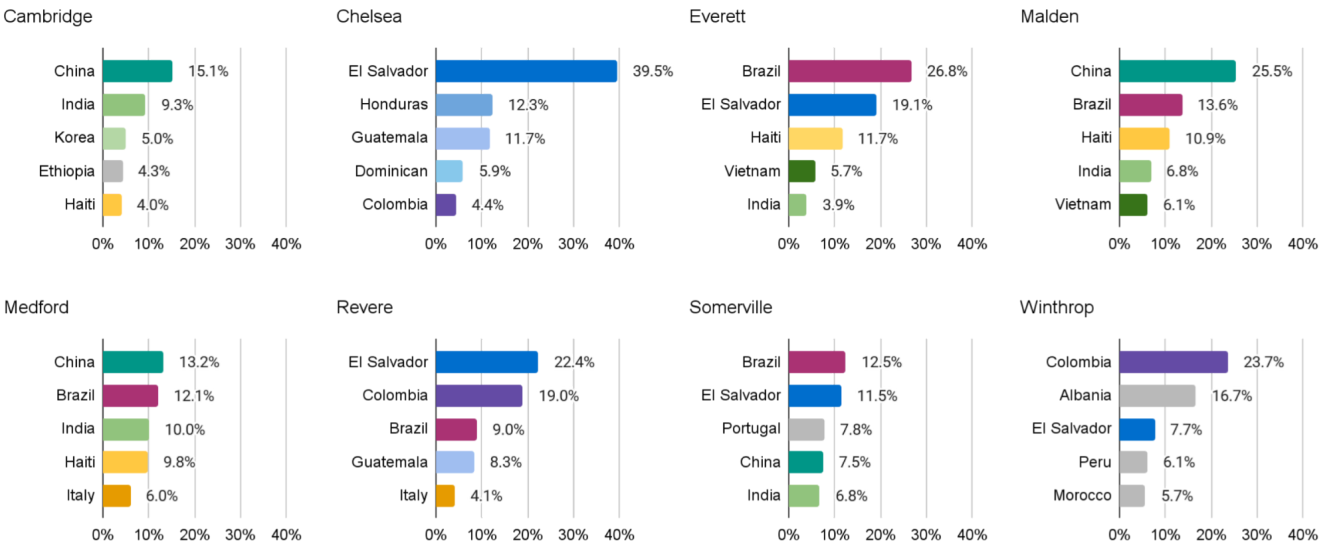
Population Size and Nativity | Cambridge and Somerville have the largest populations. Chelsea and Winthrop have the smallest. As a proportion of the total population in each community, immigrants make up the largest share in Chelsea and Everett, and the smallest share in Somerville, Medford, and Winthrop.



Countries of Origin | Across communities, countries of Central and South America and the Caribbean are among the top 5 countries of origin for immigrant populations, with large proportions of immigrants born in Brazil, El Salvador, Colombia, and Haiti. In Cambridge, Malden, Medford, and Somerville, China and India are also among the top 5 countries of origin for immigrant populations. At least 20 other countries of origin are represented among the top 10 across communities.

Top 5 Countries of Origin

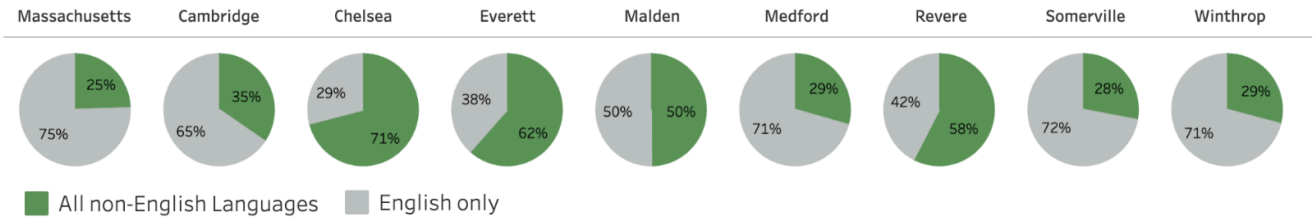
Among population born in another country



[6] Data source for all population characteristics: US Census Bureau, American Community Survey, 2018-2022 5-Year Estimates.

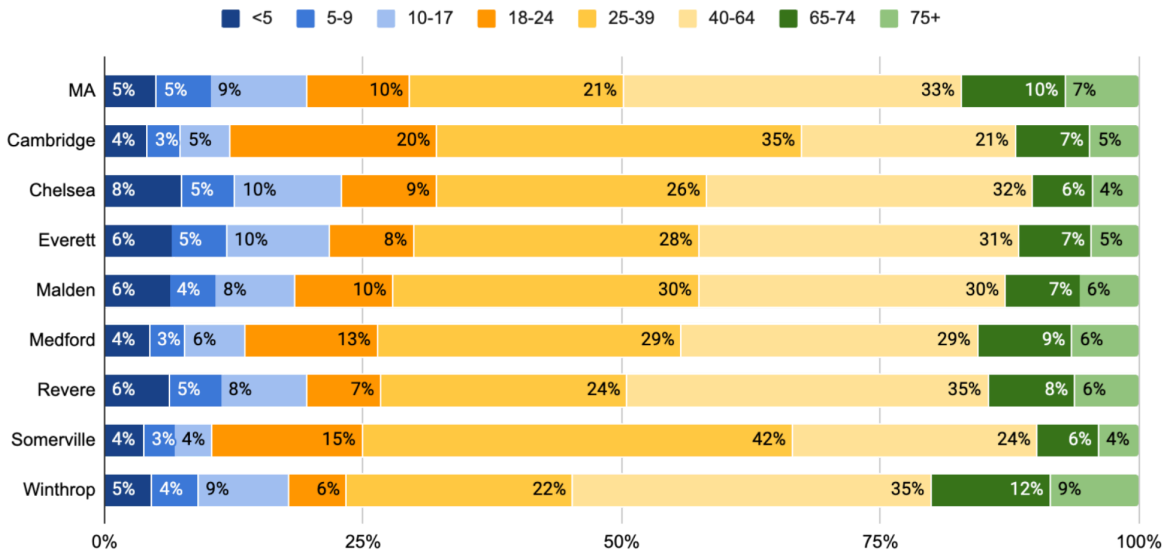
Languages Spoken | In Chelsea, Everett, Revere, and Malden, at least 50% of residents ages 5 and older speak a language other than English at home. In all 8 communities, the percentage of residents ages 5 and older who speak a language other than English at home exceeds the MA state average (25%). Dozens of languages are spoken among our communities' residents. The most common are Spanish, Chinese (including Mandarin and Cantonese), Haitian Creole, and Portuguese.[7]

Speakers of Languages Other Than English
Among population ages 5 years and older



Age Distribution | The age composition of our communities varies. In the *Population by Age Group* chart, bars in blue include children and adolescents 17 years of age and younger; orange and yellow includes adults from 18 to 64 years of age; and green includes older adults ages 65 years and older. Children and adolescents compose a greater share of the population in Chelsea, Everett, and Revere compared to other communities. Older adults compose a greater share of the population in Medford, Revere, and Winthrop compared to other communities.

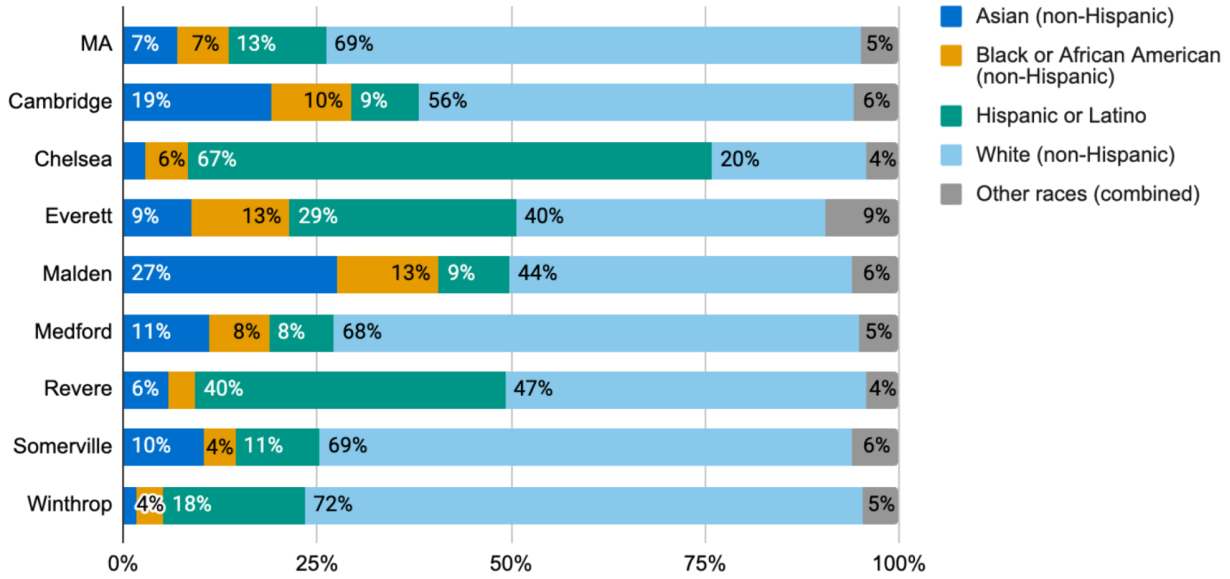
Population by Age Group
Among population ages 5 years and older



[7] The US Census Bureau's American Community Survey (ACS) only provides broad categories for certain languages at the municipal level. For example, large proportions of residents speak "French, Haitian, or Cajun" and "Other Indo-European languages." Given that the most common countries of origin among immigrants in our communities include Haiti and Brazil, it is reasonable to estimate that residents who speak Haitian Creole compose the majority of those in the "French, Haitian, or Cajun" group, and residents who speak Portuguese compose the majority of those in the "Other Indo-European languages" group. However, other languages may be represented as well.

Racial and Ethnic Groups | People of diverse racial and ethnic groups live across all of our communities. In Everett, Malden, and Revere, no single racial or ethnic group makes up more than half of the total population. In Chelsea, the majority of the population is Hispanic, while in Cambridge, Medford, Somerville, and Winthrop, the majority of the population is White.

Population by Racial or Ethnic Group



The racial and ethnic categories used by the US Census Bureau may not capture the diverse ways in which people identify. For example, many people identify as two or more races, or a race not included as a selection option. Many people identify as Hispanic or Latino,[8] but the Census considers the category "Hispanic" to be an "ethnicity" separate from "race." Also, broad racial and ethnic categories obscure meaningful differences in identity and experience within those groups, and groups that make up relatively small proportions of the population may be categorized together. For example, American Indian or Alaska Native and Native Hawaiian or Pacific Islander racial groups are included in the "Other races (combined)" category.

We consider the racial and ethnic composition of our communities because racism and discrimination have real consequences for people's health and wellbeing. ***Structural racism*** shapes the distribution of health outcomes and health equity that this report examines.

Key term

Structural racism | The policies, practices, and norms embedded in institutions and societies that privilege people of certain racial groups, and marginalize or exclude people of other racial groups

[8] We recognize that language and terminology are always evolving and are important in affirming identity. For example, "Latinx" and "Latiné" have emerged as gender-neutral and inclusive terms. In this report, the terms "Hispanic" and "Hispanic or Latino" will be used for consistency, unless a specific data source or quote uses a different term. For more information about these terms, see Noe-Bustamante, L. et al. (August 2020). *About One-in-Four U.S. Hispanics Have Heard of Latinx, but Just 3% Use It.* Pew Research Center.

Key Findings: Strengths and Challenges

Our communities and institutions have many strengths. Most people who took part in the assessment feel a sense of belonging and believe their communities are good places to live, grow, and age. At the same time, many shared concerns about big challenges like lack of social connectedness and trust, barriers to accessing resources, and unfair systems and policies. These issues affect people's health and wellbeing, especially for groups who face discrimination. Even with these challenges, people said they believe we can make things better by building on the strengths we already have. Here are **10 Key Findings** that stood out across all the focus areas of the Wellbeing Assessment:

1. **A sense of community grounded in collective care is essential to wellbeing, including in the face of systemic challenges.** Community members emphasize the physical and mental health impacts of connection, belonging, shared space, and mutual aid.

2. **More than 1 in 3 adults (38%) and nearly half of youth (45%) report high or very high levels of mental health distress.** Community members point to anxiety and stress related to housing insecurity, lack of income, climate change, lack of support for caregivers, discrimination, and harmful social and political conditions as the main causes of poor mental health.

3. **More than 1 in 3 households (39%) are paying more than 30% of their income toward housing, and around 1 in 3 people across our communities face food insecurity.** Housing and food are the most common basic needs that community members have trouble paying for.

4. **Environmental health issues including heat and chemical exposures are a growing focus.** People emphasize that a pollution-free, climate-resilient environment is essential to wellbeing.

5. **Barriers to accessing physical and mental health care are worse now compared to before the COVID pandemic.** People have more complex needs and health systems do not have enough resources.

6. **Heart disease, cancer, diabetes, and sexually transmitted infections are major health challenges in our communities.** Heart disease and cancer are the leading causes of death. Racial disparities are widest for diabetes. Chlamydia, gonorrhea, and syphilis infections exceed the state average and have increased since 2020.

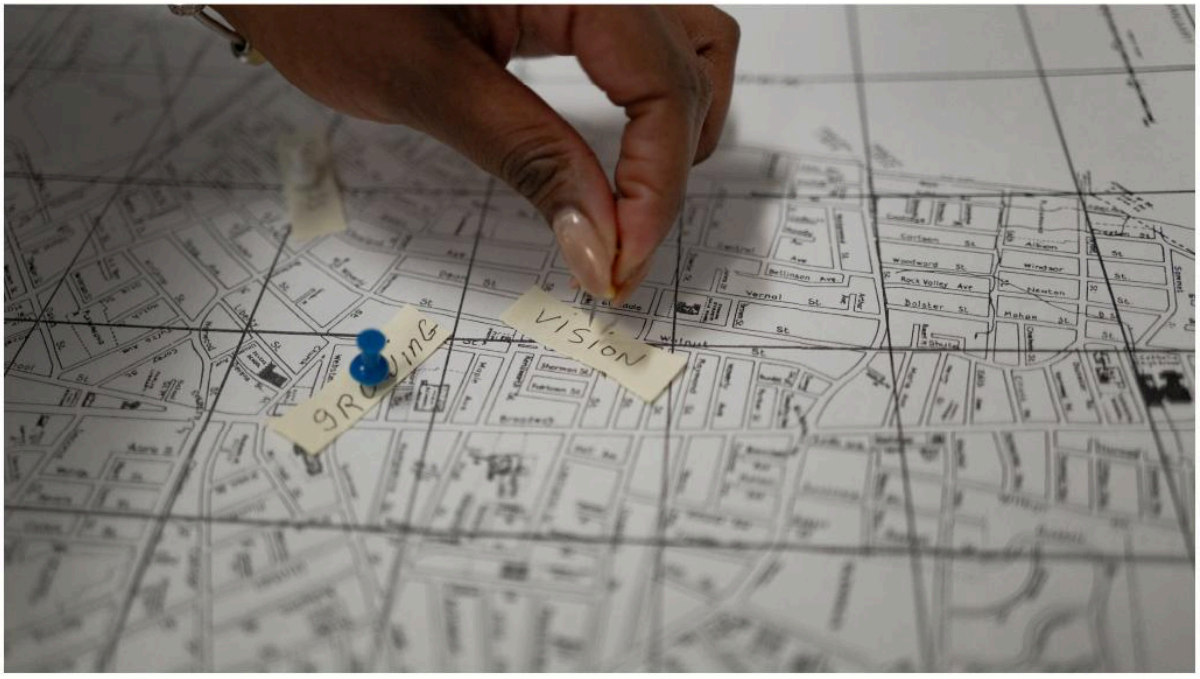
7. **Immigrant community members' physical and mental health is significantly impacted by social, economic, and political exclusion.** Fear of deportation, misinformation, language barriers, housing discrimination, and worker exploitation are among the top stressors.

8. **People with disabilities and LGBTQIA+ individuals experience disproportionate barriers to wellbeing.** It is harder to access resources and more common to face discrimination, especially for those whose identities intersect with marginalized racial, ethnic, and language groups.

9. **Racism and language are the most frequently cited causes of discrimination.** Stories of structural and interpersonal discrimination highlight the need for language justice and anti-racism.

10. **Community members who participate in decision-making about issues that impact them report direct and indirect benefits to wellbeing.** Meaningful involvement, accountability, and public transparency are necessary to advance wellbeing.

Healthy Housing



Healthy Housing: Affordability, Stability, Safety

Key Takeaway

Our communities are facing a housing crisis. More than 1 in 3 households (39%) are paying more than 30% of their income toward housing. Homelessness rates are the highest our communities have seen in recent history, particularly among youth and Black or Latino families. Housing was the most frequently raised concern among Wellbeing Assessment participants, who described the physical and mental tolls of unaffordable, overcrowded, and unsafe housing. Strategies to prevent displacement and promote housing stability in our communities are making progress, but bolder action is needed – including with meaningful involvement from the community members who are most impacted.

Housing is a health equity issue.

Housing affects our physical, mental, and emotional health, as well as our social and economic wellbeing. When people have affordable, stable, and safe housing, their health tends to be better. On the other hand, when people experience homelessness, housing instability, overcrowding, or unsafe housing, their health tends to suffer. Policies and systems – both historical and present – shape which communities are more or less likely to have the opportunity to live in healthy housing. Communities of color and low-income communities are most impacted by inequities in housing.

Deteriorating infrastructure, poor ventilation, pests and mold, lead paint, and other indoor toxins directly affect our **physical health** through **poisoning, injury, and exposure to infectious agents like bacteria and viruses.**[9, 10]	Poor housing conditions, high costs, violation of tenants' rights and instability can cause **severe stress,** which affects our **mental health.**[9]	Displacement, whether through eviction or being informally forced to move, can affect our **social networks, community cohesion, and the economic stability of our families and communities.**[11]	Directing limited income towards housing costs instead of food, health care, or education and child care can have **consequences for our nutritional health, our ability to access medical attention, and our work opportunities and children's development.** [9, 10]

Lack of affordable housing was the top community health concern among participants in the Wellbeing Assessment.

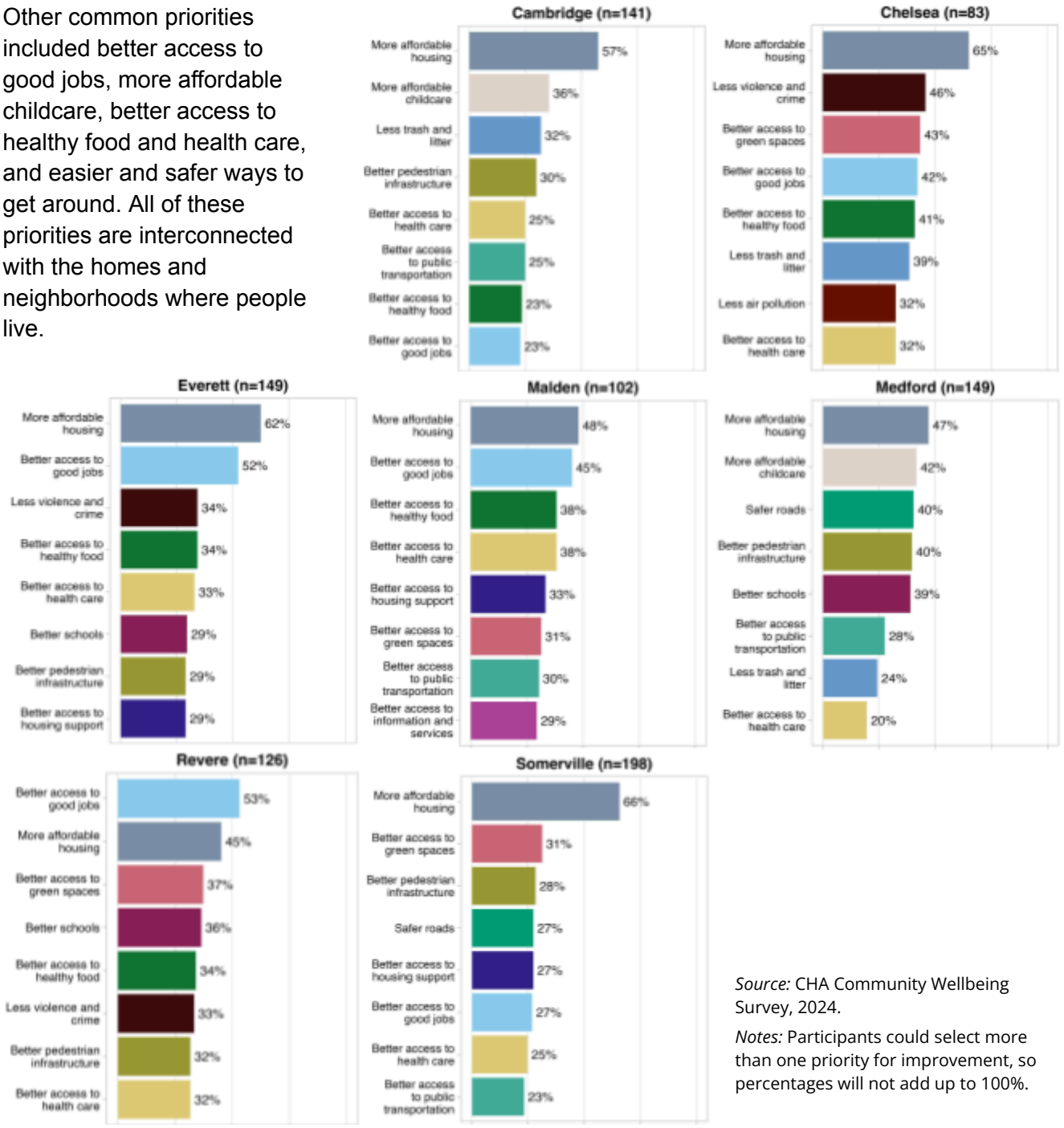
Overall, **56%** of participants in CHA's Community Wellbeing Survey said their top priority for improvement was to make housing more affordable – no other priority ranked nearly as high. Regardless of what city participants lived in, how old they were, their racial or ethnic identity, or

[9] Braveman, P. et al. (2011). *How Does Housing Affect Health?* Robert Wood Johnson Foundation.
[10] Taylor, L. (2018). Housing And Health: An Overview Of The Literature. *Health Affairs.*
[11] Bruce, C. et al. (2021). *Eviction: A Preventable Cause of Adverse Child and Family Health.* Children's HealthWatch.

whether they were renters or owners, more affordable housing generally remained the top priority for improvement.

Data Point | Participants in CHA's Community Wellbeing Survey were asked "**What are the most important things you would like to improve about your community?**" In four communities, more affordable housing was selected by over half of participants as a top priority.

Other common priorities included better access to good jobs, more affordable childcare, better access to healthy food and health care, and easier and safer ways to get around. All of these priorities are interconnected with the homes and neighborhoods where people live.



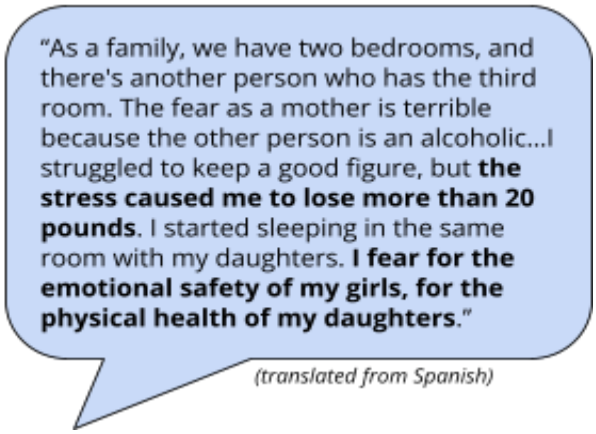
Source: CHA Community Wellbeing Survey, 2024.

Notes: Participants could select more than one priority for improvement, so percentages will not add up to 100%.

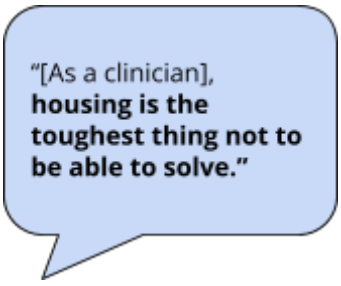
For a few groups, better access to good jobs and health care ranked higher than housing affordability as a priority for improvement. For example, the top priority for people experiencing homelessness was better access to health care – selected by 54% of participants. Better access to good jobs was the top priority for participants under age 18 (60%), Black participants (63%), Haitian Creole speaking participants (72%), and participants from the city of Revere (53%).

For more data from the Community Wellbeing Survey, focus groups, and interviews, check out the Survey Results Frequency Tables and Qualitative Themes Report in Appendix E

In focus groups and interviews, lack of access to affordable, safe, healthy housing was the most frequently expressed community health concern. Many described the emotional burden of unstable housing. Participants spoke of constant anxiety over rising rents and the threat of displacement. These pressures were especially difficult for seniors, children, and single mothers, who often had to sacrifice privacy and safety by living with others in overcrowded apartments. Participants described how this stress affected their sleep, strained relationships, and worsened physical and mental health.



Other participants described living with conditions such as mold, pests, inadequate ventilation, and broken structures that landlords neglected to address. For low-income, immigrant, or undocumented households, some decided not even to report such issues to their landlords or city officials out of fear of eviction or increased rent.



Health care providers echoed these issues, describing how unstable housing connects directly to poor health. Providers expressed a sense of frustration and despair at seeing medical treatments fail because patients continued to be exposed to mold or pests at home, could not afford medications or nutritious food on top of rent, or were unable to keep their appointments because they were facing eviction. Systemic barriers and the lack of community resources to address housing concerns weighed heavily on health care providers.

To learn more about how housing is a community health concern, check out these sections:

Sharing our Stories: Housing and Mental Health

Sharing our Stories: Falling Through the Gaps

Health Spotlight: Lead Poisoning

Housing cost burdens are historically high in the Greater Boston area, especially for renters and Black or Latino households.

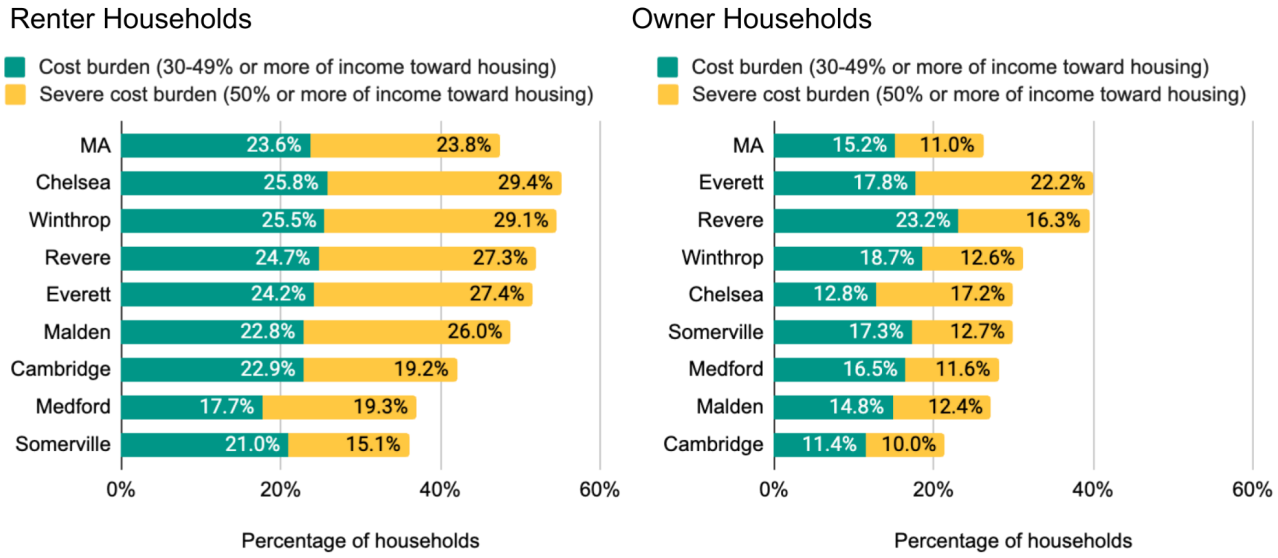
According to the 2024 Greater Boston Housing Report Card,[12] the percentage of renter households in our region who are **housing cost burdened** increased gradually from 2005 to 2017 – with larger, steadier increases among low- and moderate-income households compared to higher-income households. Since 2017, these percentages have risen rapidly among all income groups. Across renters and owners, more households are cost burdened now than at any point in the last 20 years. Patterns in our communities mirror these regional trends. Overall, between renters and owners, 39% of households are now housing cost burdened across our communities.

Key Terms

Housing Cost Burden | Paying 30% or more of income toward housing

Severe Housing Cost Burden | Paying 50% or more of income toward housing

Data Point | The **percentage of housing cost burdened households** is high in all CHA communities. Over **half** of renter households in Chelsea, Winthrop, Revere, and Everett – and more than **1 in 3** owner households in Everett and Revere – are paying 30% or more of their income toward housing.



Source: U.S. Census Bureau, American Community Survey, 2022 5-Year Estimates.

Compared to the statewide average for renters (47%), more households are cost burdened in Chelsea, Winthrop, Revere, Everett, and Malden. Compared to the statewide average for owners (26%), more households are cost burdened in all communities except Cambridge. These patterns emphasize that housing in Greater Boston – including in our communities – is increasingly unaffordable.

[12] The Boston Foundation (2024). *Greater Boston Housing Report Card*.

Across Greater Boston, Black and Latino households are more likely to be housing cost burdened compared to White and Asian households.[12] Among renters, 59% of Black households and 55% of Latino households are housing cost burdened, compared to 46% of White households and 40% of Asian households. Among owners, 32% of Black households and 27% of Latino households are cost burdened, compared to 21% of White households and 23% of Asian households. Furthermore, Black and Latino households are less likely than White households to own their homes – a pattern that is both caused by and contributes to racial wealth inequity.

Homelessness reached record highs in 2024, driven by high rents, longstanding housing shortages, and population changes.

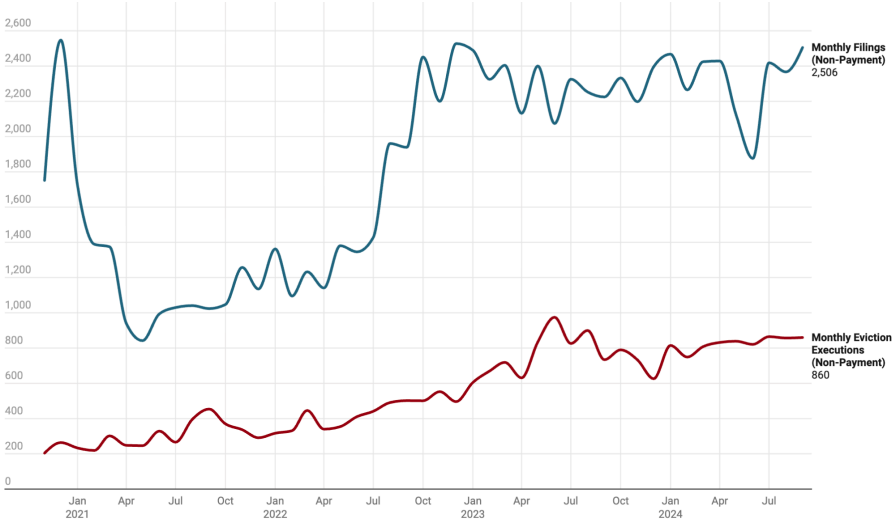
During the COVID-19 pandemic, a combination of federal and state funding and initiatives temporarily expanded housing support, stabilized many renters in the Greater Boston region, and drew attention to housing as a public health issue. For example, the federal CARES Act and American Rescue Plan Act (ARPA) provided new funding for housing security initiatives. Eviction moratorium policies prevented households from being evicted for non-payment of rent. The Eviction Diversion Initiative and expansions to emergency rental assistance funds such as RAFT (Residential Assistance for Families in Transition) helped keep Massachusetts families in their homes, even after eviction moratoria were lifted. Largely, these initiatives worked to prevent rising rates of homelessness in Greater Boston from 2020–2022.[13]

However, many of these pandemic-era protections were scaled back starting in 2022. Evictions resumed, just as inflation began to rise – meanwhile, a years-long shortage of affordable housing in our communities and across the state persisted. The rising number of households struggling to afford rent converged with an influx of migrant families fleeing political and economic crises and violence in their home countries,[14] resulting in the highest rates of homelessness our communities have seen in recent history.[13]

Data Point | Across Massachusetts, **evictions for non-payment of rent** began to rise beginning in early 2022.

Source: Massachusetts Housing Partnership, Housing Stability Monitor: Massachusetts Evictions & Foreclosures (February 2025)

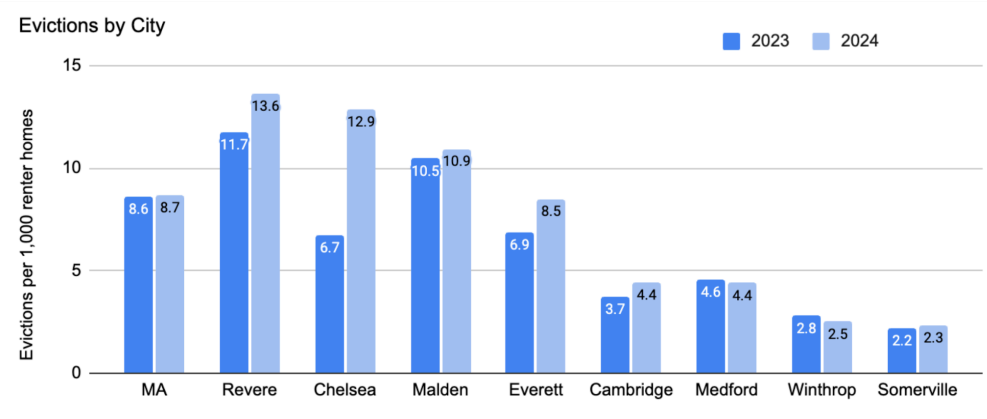
Notes: Filings refer to the start of the eviction process. Executions are the official termination of tenancy issued by a court, forcing the tenant to move out.



[13] Ciurczak P, Harrington K, Schuster L. (August 5, 2024) Homelessness in Greater Boston: Trends in the Context of our Broader Housing Crisis. *Boston Indicators.*

[14] Harrington K, Schuster L, Capote A. (February 2024). Global Greater Boston: Immigrants in a Changing Region. *Boston Indicators, Immigrant Research Initiative.*

Data Point | In our communities, Revere, Chelsea, and Malden had the highest **eviction rates** in 2024, exceeding the statewide average (8.7 per 1,000 renter households). Compared to 2023, rates increased in each of these cities (most significantly in Chelsea), as well as in Everett and Cambridge. Evictions in Cambridge, Medford, Winthrop, and Somerville remained relatively low.



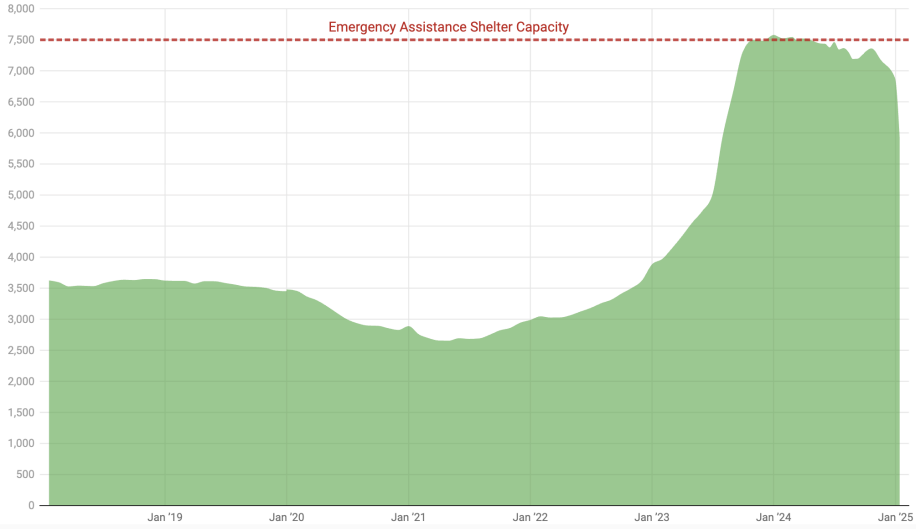
Source: Massachusetts Trial Court, Department of Research and Planning, Summary Process Executions Dashboard, 2023-2024

Notes: Number of annual evictions was pulled from Executions Issd. by Locations. Rates were calculated based on American Community Survey 2022 5-year estimates of number of renter occupied housing units.

At the state level, **homelessness**[15] nearly doubled from 2022 to 2024 – from 15,500 to 29,360 individuals. Cambridge saw a **70%** increase over this two-year period, from 440 to 747 people.[16] In Greater Boston overall, there was a **27%** increase in homelessness from 2022 to 2023, reaching 12,674 people – the highest number since the previous peak of nearly 15,000 people in 2014.[13]

Data Point | The **number of homeless families receiving emergency shelter across Massachusetts** more than doubled between 2022 and 2024.

Source: Massachusetts Housing Partnership, Housing Stability Monitor: Massachusetts Evictions & Foreclosures (December 2024, Updated February 2025)



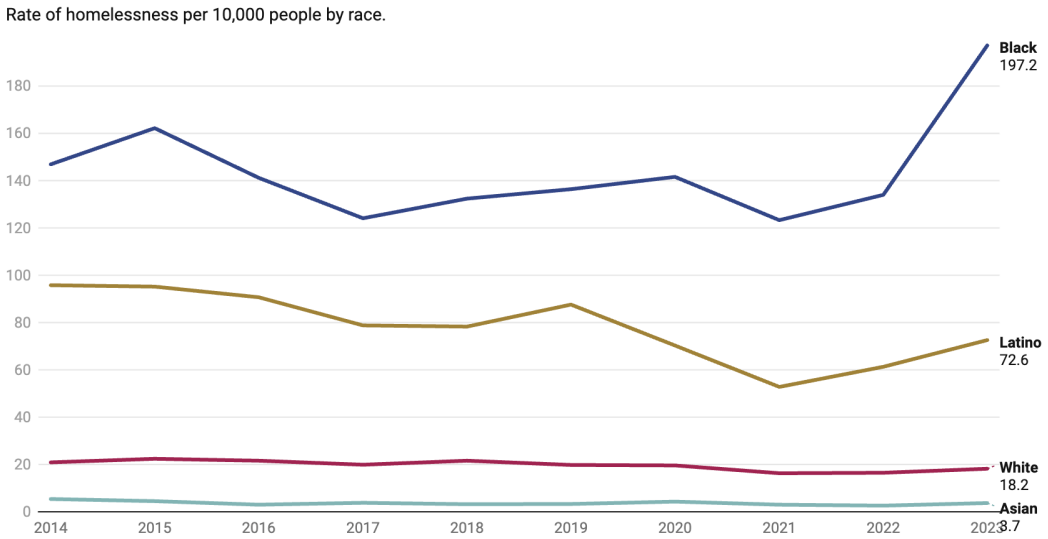
The vast majority of people experiencing homelessness in Massachusetts live in shelters, thanks in part to the state's Right To Shelter law, which guarantees emergency shelter for families with children and pregnant people who are experiencing homelessness. In Greater Boston, just 6% of people experiencing homelessness are unsheltered.[13] However, growing rates of homelessness in the last few years strained the shelter system, which increasingly relied on hotels and motels to expand its

[15] Homelessness is defined as lacking a fixed, regular, and adequate place to sleep. This includes living in places like parks or cars, emergency shelters, or sharing housing with others (living "doubled up").
[16] Massachusetts Housing Partnership, Housing Stability Monitor: Massachusetts Evictions & Foreclosures (Dec 2024, Updated Feb 2025)

capacity to house families. In 2023, a cap of 7,500 families was imposed and reforms were put in place to limit the number of days families could remain in shelter, to require proof of Massachusetts residency, and to exclude people without lawful immigration statuses, among other changes.[17]

In Greater Boston, **70% of people experiencing homelessness are in families, and 31% are youth, who experience homelessness at the highest rates of any age group**.[13] Participants in our focus groups and interviews raised concerns that changes to the emergency shelter system may push more of these groups into unsheltered homelessness – even as resources are invested in creating pathways to permanent housing, such as HomeBASE and RAFT.

Equity Lens | Compared to White and Asian residents, **rates of homelessness** have been consistently highest among Black residents, followed by Latino residents.

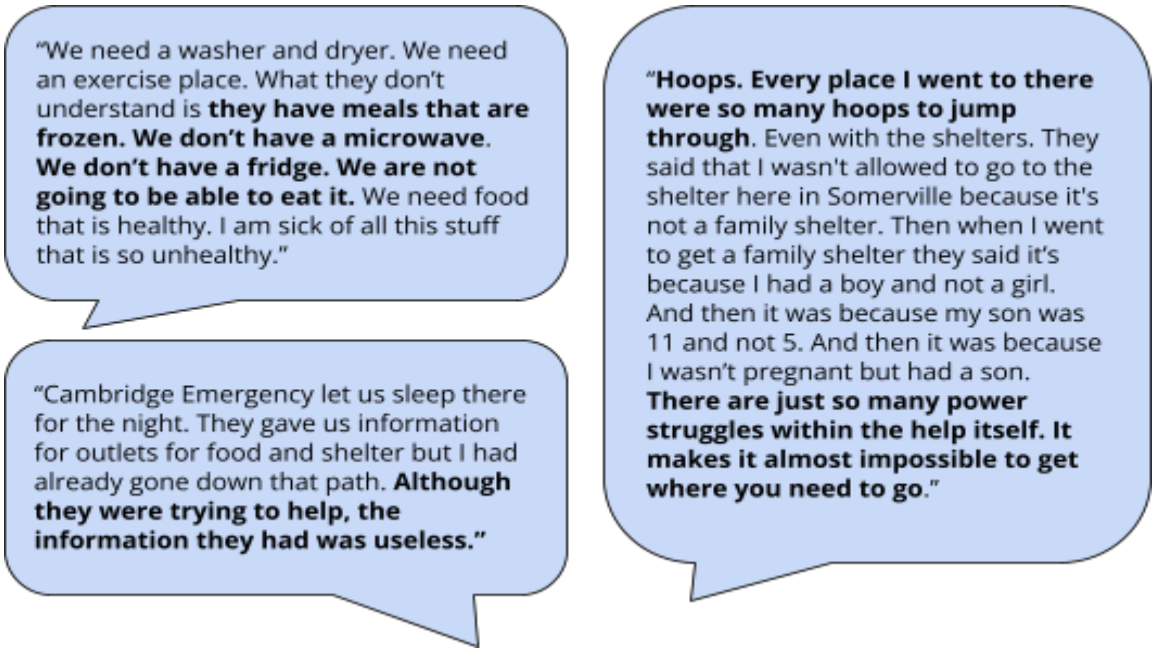


Source: Ciurczak P, Harrington K, Schuster L. (August 5, 2024) Homelessness in Greater Boston: Trends in the Context of our Broader Housing Crisis. *Boston Indicators.*

Black and Latino individuals experience homelessness at far higher rates than White individuals. These consistently high rates of homelessness reflect the impacts of structural racism on Black and Latino communities. While Black residents make up 8% of the total population of Greater Boston, they account for 52% of people experiencing homelessness. Since 2022, rates have increased further, most likely due to the increase in people from Haiti who have recently arrived with limited resources after fleeing violence in their home country.[13] People who have recently arrived from Latin American countries may also have contributed to rising rates of homelessness among Latino residents.

In focus groups and interviews, people experiencing homelessness expressed frustration with navigating complex systems that too often do not provide adequate resources. From eligibility rules to inconsistent information, participants described how the system can feel like an endless series of hurdles. In the absence of sufficient shelter beds and community resources, some participants noted turning to hospitals for support. However, these institutions are not equipped to fill the gap in resources, and while they may offer temporary help, they cannot provide long-term solutions.

[17] Executive Office of Housing and Livable Communities. Governor Healey: All Hotel Shelters to Close This Summer. Press Release, May 19, 2025.



The crisis in housing affordability and homelessness is a result of income inequality, an inadequate housing supply, and a changing population – and is exacerbated by past and present policies and structures.

According to the Greater Boston Housing Report Card, income inequality is one of the driving forces of the crisis in housing affordability. Despite high median income, Greater Boston has the third largest gap between high- and low-income households among large U.S. metro areas. The average income of the top 20% of households is nearly 20 times higher than the average income of the bottom 20%, leaving lower-income families unable to keep pace with rising housing costs.

In addition, housing production has slowed statewide over the last few years, after increasing during the 2010s. In 2015, the mayors of 15 cities and towns in Greater Boston set a goal of building 185,000 new housing units by 2030 in order to keep pace with population growth. As of 2023, permitting was only 63% of what it would need to be to keep pace with this goal. The costs of building new housing increased sharply during the COVID-19 pandemic and have remained elevated, making it difficult to deliver affordable units. Furthermore, the majority (86%) of new housing built in Greater Boston in the last nine years has been built in just six cities – Boston, Revere, Quincy, Cambridge, Everett, and Somerville – leading to imbalances in distribution across the region.

Finally, the population of Greater Boston is aging and the average household size is getting smaller. This leads to a mismatch between the type of housing people need and what is available and affordable. Combined with a rapid increase in international migration since 2020, there is increased demand for housing – without adequate supply – which leads to increasing housing costs.[12]

These dynamics are complex. In focus groups and interviews, some participants reflected on how

public perceptions about the housing crisis can be over-simplified. Several participants observed that immigrants are often blamed for problems that affect everyone – such as the housing crisis. Rather than recognizing shared struggles, these narratives create division and resentment.

"I see what I feel has been a failure to respond to a housing crisis. **It is an emergency that has been painted as an immigration crisis,** which is highly problematic and has contributed not only to a false narrative and backlash from neighbors, politicians, but has led to a reluctance to act better and more intentionally. It's "they," those ones are coming, we've already spent all the resources... **whether it's newcomers, or people who have been in MA for decades, they're all being affected by homelessness, rising costs, and different factors in our economy that are pushing people out."**

"The hottest areas of our watershed are the most renter-heavy. Not a lot of tree cover or good places to cool off... If we put a heat map on top of a redlining map, our hottest neighborhoods [were] rated D & F to get a housing mortgage [by] law a hundred years ago. **Housing, heat, health, all mixed up in one**."

The causes of the housing crisis are rooted in historical and present-day forms of housing discrimination and structural racism. Communities of color and low-income communities have faced segregation, discrimination in mortgage lending, and neighborhood disinvestment – leading to wealth inequality and inequitable access to safe, affordable, healthy housing. Consistent racial disparities in homelessness, renter cost burden, and homeownership reflect the impacts of structural racism, particularly in Black and Latino communities. In focus groups and interviews, participants emphasized how important it is to understand these intertwined and historical causes.

Equity Lens | In the 1930s, the federal Home Owners Loan Corporation (HOLC) made maps that "graded" neighborhoods based on their racial make-up. Neighborhoods where people of color lived were deemed hazardous, too risky for banks to invest in or provide mortgage loans, and were shaded red – leading to the term "redlining." Meanwhile, White homeowners took advantage of loans in areas deemed desirable – typically affluent, suburban neighborhoods, where other practices like racially restrictive deeds prevented people of color from living. Redlining denied persons of color the ability to invest in homeownership and generate wealth that could be passed down for generations. Businesses and investors followed the housing market to the suburbs, creating racially segregated inner-city communities that lacked investment.[18]

Key Term

Redlining |
The discriminatory practice of denying or limiting housing loans and financing to certain neighborhoods based on racial or ethnic composition, beginning in the 1930s and continuing until the Fair Housing Act of 1968.

Although the Fair Housing Act of 1968 outlawed redlining, this discriminatory practice has had lasting impacts on our communities. Many neighborhoods have struggled from decades of disinvestment, and residents are now ironically being displaced due to gentrification.

[18] Rothstein R. (2017). The Color of Law: A Forgotten History of How Our Government Segregated America.

Data Mapping | Studies have shown a correlation between urban heat – which can impact people's health – and historical redlining practices.[19] The **map on the left** shows that many neighborhoods in Everett, Chelsea, Malden, and Somerville are at high risk for extreme heat. The **map on the right** illustrates that these same areas were given grades of D or C by the HOLC.

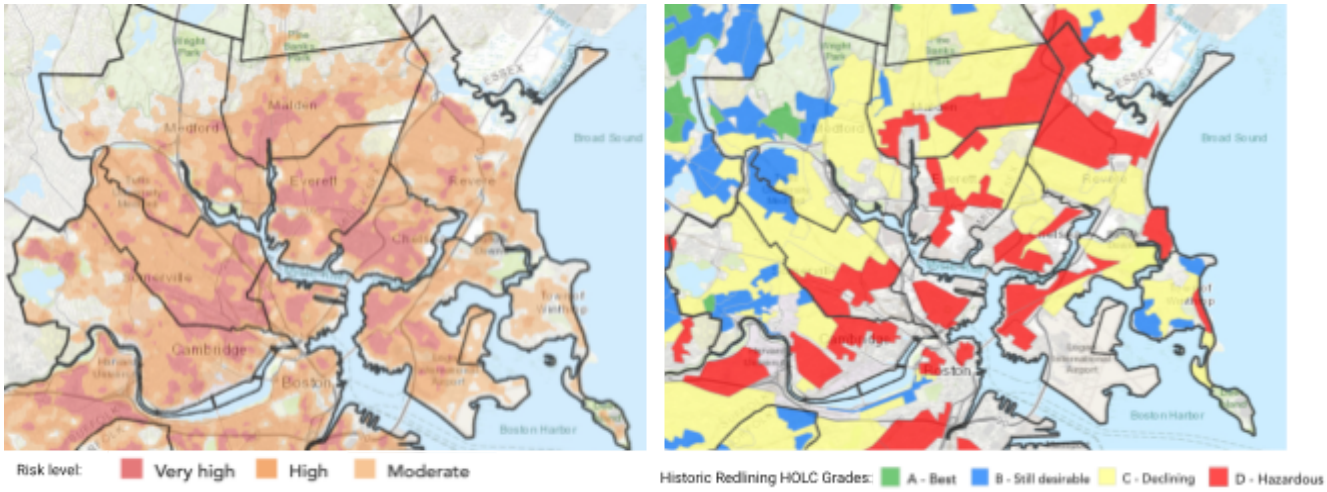


Image Source: The Trust for Public Land, Climate-Smart Cities Boston Metro Mayors Region, GIS Mapping Application.

"I wish that we could calculate rent shares based on the income the people are taking home and not their gross income. My earning is $900 a month, why am I getting charged $300? I really only take home $700, so that income should be adjusted towards it... **you're not really paying 30% of your income toward rent, if you factor in the tax piece, it's really 40-plus percent.**"

"I have been applying for low-income housing programs for the past 5-6 years and **I have never been able to receive assistance**."

In focus groups and interviews, participants also raised concerns with how "affordability" is defined for subsidized housing. Many municipalities require that a certain percentage of units within new housing developments be set aside as "affordable," based on area median income (AMI) levels that reflect averages across a broad region. However, these regional figures often fail to capture the economic realities of individual municipalities. As a result, housing classified as "affordable" may still be financially out of reach for many local residents. Participants also noted that housing subsidy calculations are based on gross income and not actual take-home pay. As a result, families are left paying more than they can realistically afford, creating financial strain.

Finally, participants described how complex systems can make it harder to maintain housing stability. Confusing applications, limited transparency, and lack of staffing can make it difficult for people to access housing support services. A consistent theme was the belief that without systemic change and coordinated efforts across multiple levels of government, the housing crisis will persist, leaving marginalized communities without the stability they need to thrive.

[19] Nowak D, Ellis A, Greenfield E.J. (2022). The disparity in tree cover and ecosystem service values among redlining classes in the United States. *Landscape and Urban Planning.*

Strategies to prevent displacement and promote housing stability are making progress, but bolder action is needed.

Community members emphasize that decision-making processes to address the housing crisis must have stronger public involvement and accountability. Between the longstanding lack of affordable housing availability, lack of adequate resources to support residents facing housing instability, and public discourse placing blame on individuals rather than broken systems, participants in focus groups and interviews emphasized that policies and resources need to be created alongside residents and providers facing these challenges firsthand.

Many promising strategies are growing across our region. As one interviewee noted, "**No one community has everything, but for every three communities there are three strengths,"** emphasizing how support and resilience come from sharing resources and lifting one another up across municipal borders. With increased collaboration between municipalities and intentional community involvement and accountability, communities can overcome barriers and build more inclusive, connected, and sustainable systems to strengthen housing stability.

Some municipalities are exploring **zoning reforms to prevent displacement** by allowing more mixed-use development and **incentivizing construction of affordable units.**	**Housing Families, Inc.** offers housing **education, street outreach, and tenant workshops,** complementing its permanent supportive housing and shelter programs.	Tenant groups, such as the **CAAS Renters Committee,** are organizing to protect neighbors from eviction and **advocate for local ordinances and state policies like rent control.**	Resident groups are exploring **Community Land Trusts** to prevent displacement by holding land in trust for community use, ensuring long-term affordability.	**Partnerships between health care and housing providers** are creating more streamlined services for people facing housing instability.

The City of Somerville's Municipal Housing Voucher Program was cited as an example of a local government stepping in to fill critical gaps left by other systems. The program prioritizes residents most at risk – those spending more than half their income on housing, who are not eligible for state or federal programs, and/or who are facing eviction or overcrowding. Special consideration is given to families caring for children enrolled in Somerville Public Schools or local daycares. The voucher ensures that rent and utility costs do not exceed 30% of a household's income, even covering security deposits and assisting families with no income. The city's Office of Housing Stability leads and coordinates the program, which is funded by the municipal budget and American Rescue Plan Act (ARPA) funds. With a focus on long-term sustainability and impact, this kind of equity-centered, hyper-local initiative offers an innovative path to housing stability.

These initiatives reflect a growing understanding that meaningful change requires coordinating efforts across sectors – and must involve policy, program, culture, community, and more. These efforts can lay the groundwork for more equitable, responsive, and sustainable solutions.

Community Voices:

Ideas for Addressing Housing Concerns

- **Expand permanent supportive housing with long-term subsidies and case management.** Residents experiencing homelessness shared stories of cycling between shelters, temporary living situations, and hospitals, which was mentally and physically exhausting. While shelters are an essential safety net, investing in permanent supportive housing that includes long-term rental subsidies and dedicated case management can help individuals transition into and maintain stable housing.
- **Advocate for revisions to current state law banning rent control, so that municipalities may implement local rent control policies.** Rent increases are forcing families to live in overcrowded, unsafe conditions or to move away entirely. Residents described spending a growing percentage of their income on rent, often leaving little for other necessities. Local rent control policies are needed to slow gentrification, protect tenants, and reduce displacement.
- **Increase support for city-run municipal housing voucher programs.** Many families are excluded from state and federal housing programs due to eligibility requirements, documentation status, or long waitlists. As demonstrated by the City of Somerville, city-run housing vouchers can be tailored to the needs of local families who lack access to state or federal assistance. Local vouchers can help cities invest in housing equity and make assistance more accessible.
- **Simplify and streamline housing application processes and account for take-home income.** Complex application systems can create barriers to housing access, even for people who qualify for assistance. Simplifying forms, eligibility requirements, and procedures can reduce barriers to housing access, in addition to investing in communication and navigation assistance. Advocating for using take-home income, rather than gross income, to calculate housing subsidies can help to ensure subsidized housing is truly affordable.
- **Expand multilingual and in-person housing application support.** Language barriers and online systems prevent many residents from completing housing applications. Providing application support in multiple languages and formats, including in-person assistance at trusted community hubs, can offer clear guidance and support throughout the process.
- **Expand housing education and tenant workshops to improve knowledge about tenants' rights and available support programs.** Residents, especially undocumented immigrants and low income tenants, shared that they are afraid to report unsafe living conditions for fear of retaliation or eviction. Offering tenant education programs and legal rights workshops in trusted spaces and multiple languages can teach residents how to document violations, understand their rights, and access housing or legal assistance.
- **Reform zoning laws on local and state levels to increase affordable, accessible housing development and redefine affordability.** Current definitions of affordable housing often do not reflect the actual incomes of local residents. Using local income data rather than regional

metrics to determine affordability can promote accessibility. Reforming zoning policies to allow for more multifamily and affordable housing developments can expand opportunities in neighborhoods that are otherwise inaccessible to low-income families.

- **Strengthen partnerships between health care and housing systems to address housing as a social determinant of health.** Health care providers are seeing firsthand how unstable housing worsens physical and mental health. Similarly, housing agencies are noticing that many people seeking housing need mental and physical health care services. Building stronger partnerships between clinics, hospitals, and housing agencies can help to ensure patients can access stable housing as a part of their care plans, and housing clients can get connected to health care. CHA's partnership with the Manning Apartments, where a CHA nurse provides on-site support to residents, is one example of a way housing and health care can work more closely together.

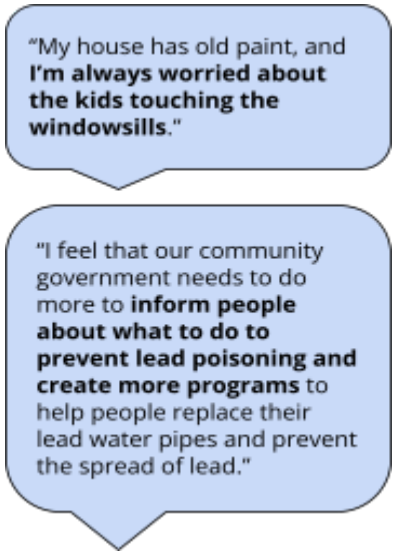
- **Involve health care providers and institutions in advocating for policies that would expand access to safe, affordable housing.** Housing advocates note that health care providers have a powerful voice in state and local government. Their timely participation in advocacy opportunities, in coordination with housing coalitions and organizers, can help to build support for important city and state action.

- **Educate and raise awareness of housing insecurity as a systemic issue, not an individual failing or a problem caused by immigrants.** Residents shared frustration about being personally blamed for rising rates of homelessness and displacement. Illustrating how the housing crisis is a result of systemic failures to build and preserve enough affordable housing in our communities – not the fault of the people impacted by these failures – can help to reduce divisiveness and build solutions. Public campaigns, community forums, and storytelling can reframe housing as a public health and human rights issue.

- **Invest in strategies to reduce exposure to lead.** As described in our Health Spotlight on Lead Poisoning, lead is a concern for many people in our communities. There are strong examples of community-based education about lead sources and risks, how to get children screened for lead exposure, and how to access resources to remove lead-based paint and replace lead water pipes. Strengthening municipal lead ordinances, developing protections for renters, and expanding resources to address the sources of lead poisoning would help to further address this housing-related public health challenge.

Health Spotlight: Lead Poisoning

Lead is a metal that can be found in old paint, dust, soil, and drinking water. It is especially harmful to young children. Even low levels of lead in the bloodstream can cause severe, irreversible damage to children's physical and mental development. It can also be dangerous for adults. Lead exposure has been linked to high blood pressure, as well as kidney, brain, and reproductive health issues.



In Massachusetts, lead paint is the main source of exposure among children. That's because 67% of housing units were built before 1978, when lead-based paint was banned.[20] In many of our communities, families are also concerned about exposure from lead-based pipes that route water from main pipes into their homes – not all of these "service lines" have been replaced with safer materials.

Key Terms

Elevated Blood Lead Level (BLL) | Lead concentration of at least 5 micrograms per deciliter of blood, abbreviated as >=5 ug/dL

Lead Poisoning | Lead concentration of at least 10 micrograms per deciliter of blood, abbreviated as >=10 ug/dL

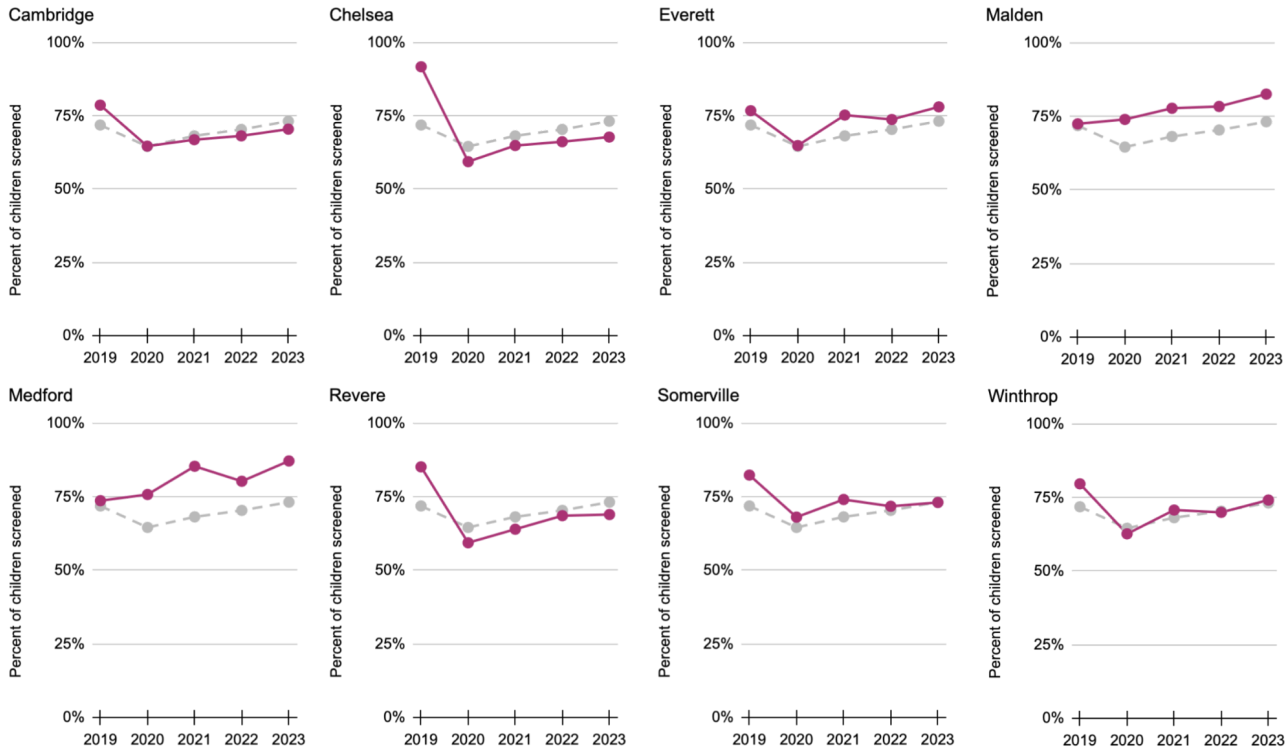
Lead exposure is a major health equity issue. The most recent Massachusetts Childhood Lead Poisoning Surveillance Report found that in 2023, children living in low-income communities were nearly 3.3 times more likely to have elevated blood lead levels (BLLs) than children in high-income communities. The good news is this disparity has been narrowing since 2020.

However, racial and ethnic disparities have not changed very much. In 2023, Hispanic children were 1.7 times more likely to have elevated BLLs compared to non-Hispanic children. Black children were 1.9 times more likely, and multi-racial children were 4.4 times more likely, to have elevated BLLs compared to White children. Past and present housing discrimination, segregation, and neighborhood disinvestment are the major reasons why communities of color and low-income communities are at an unfairly high risk of exposure to lead.

How have lead screening rates changed in our communities? The Massachusetts Lead Poisoning Prevention and Control Regulation (also called the Lead Law) requires all children to be tested regularly for lead exposure through the ages of 3 or 4. Lead testing is done using a blood test and can be done by a pediatrician or a local health department. Regular testing helps identify children with elevated blood lead levels early in order to connect them with medical care – and connect their families with resources to remove lead from their home environment.[20]

[20] Massachusetts Department of Public Health, Bureau of Climate and Environmental Health. *2023 Annual Childhood Lead Poisoning Surveillance Report*.

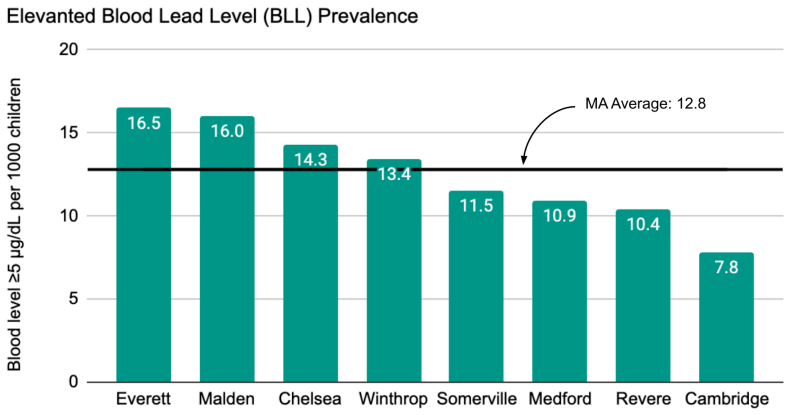
Data Point | After maintaining **lead screening rates** near or above 75% since 2012, screening declined from 2019 to 2020 in all of our communities due to the COVID-19 pandemic. Since then, rates have begun to recover. As of 2023, screening rates are higher compared to pre-pandemic in Everett, Malden, and Medford. Rates are still lower compared to pre-pandemic in Cambridge, Chelsea, Revere, Somerville, and Winthrop.

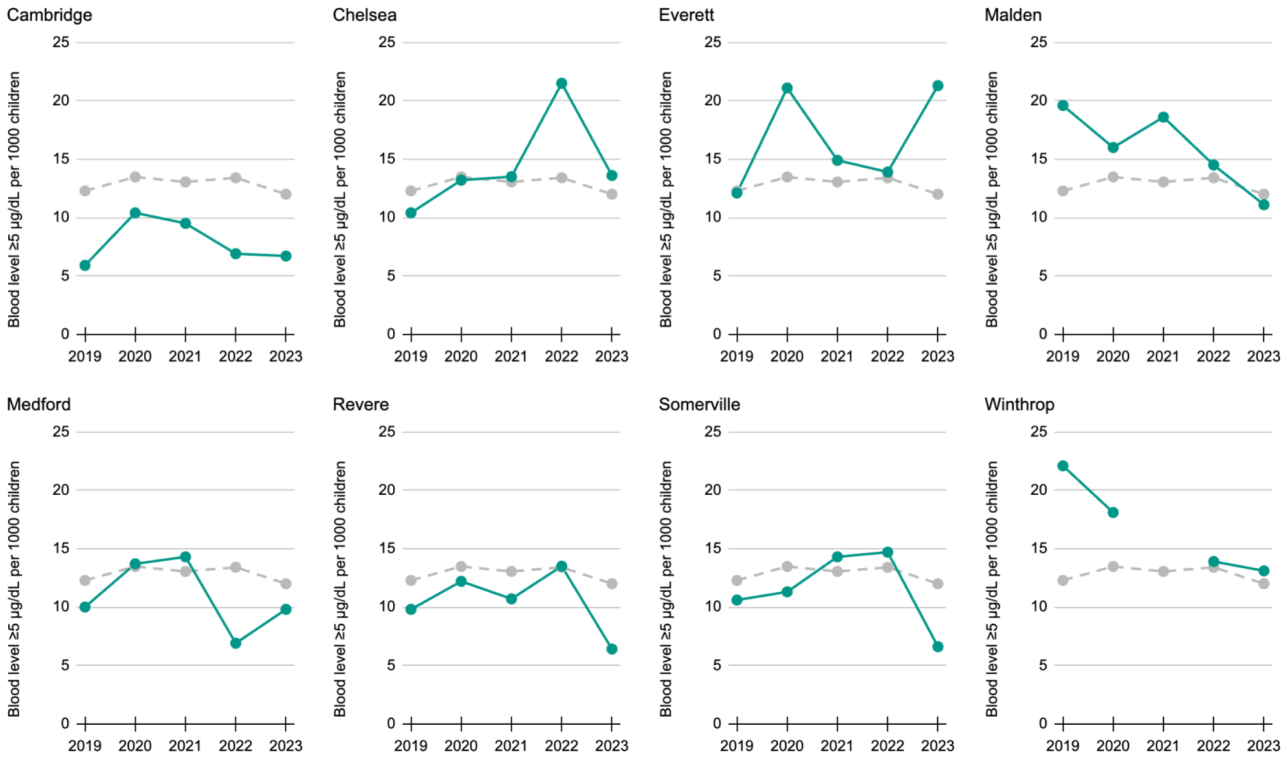


Source: Massachusetts Department of Public Health (DPH), Bureau of Climate and Environmental Health, Childhood Lead Poisoning Prevention Program (CLPPP) 2019-2023.

Notes: Screening rates are calculated as a percentage of all children between the ages of 9 months and four years old. In each chart, a gray dotted line represents the screening rate for the state of Massachusetts.

Data Point | Compared to the statewide average, the **5-year average rate of elevated blood lead levels (BLLs)** among children is higher in Everett, Malden, and Chelsea. Rates have varied by year in each community. Compared to 2019, rates in 2023 were higher in Chelsea and Everett, and lower in Malden, Revere, Somerville, and Winthrop. Rates were similar in Cambridge and Medford.



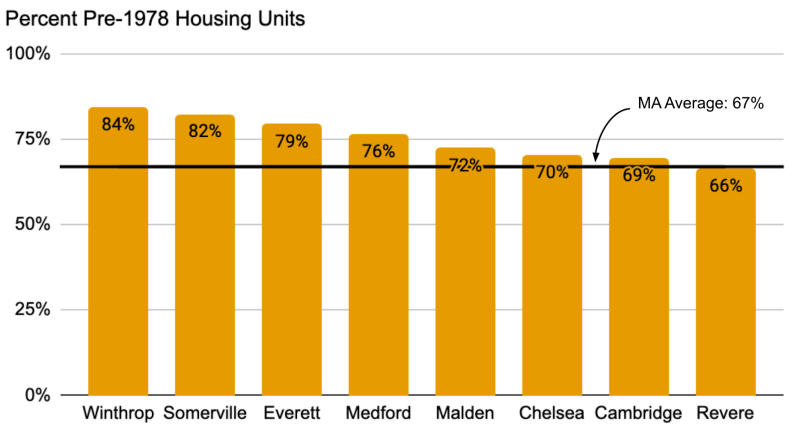


Source: Massachusetts Department of Public Health (DPH), Bureau of Climate and Environmental Health, Childhood Lead Poisoning Prevention Program (CLPPP) 2019-2023.

Notes: Elevated BLL rates are calculated per 1,000 children between the ages of 9 months and four years old, among those who had their blood screened for lead exposure. In Winthrop, fewer than 5 children had elevated BLLs in 2021, so no rate is reported; as such, the 5-year average rate is estimated. In each line chart, a gray dotted line represents the rate for the state of Massachusetts.

Which communities are most at risk for exposure to lead? The Lead Exposure Index[21] uses Census-tract data about housing age and poverty levels to calculate a score from 1 (lowest risk) to 10 (highest risk), for cities across the U.S. Among CHA communities, Chelsea and Everett have the highest lead exposure risk indices (10), nearly double the average score for all Massachusetts cities (5.5). All other cities in the CHA service area score 8 or 9, also exceeding the state average.

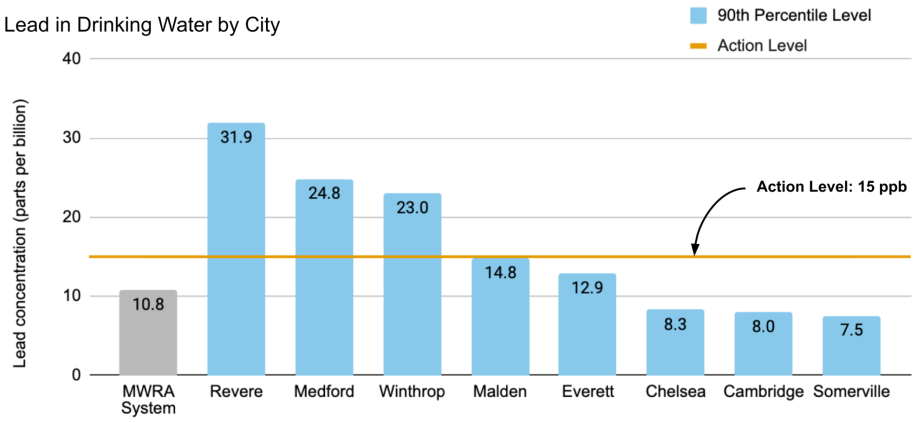
Data Point | The **percentage of housing units built before 1978** varies between communities. All except Revere exceed the statewide average (67%). Houses built before 1978 are more likely to have lead paint – especially in communities with higher poverty rates like Chelsea, Everett, and Malden.



Source: Massachusetts Department of Public Health, Bureau of Climate and Environmental Health. *2023 Annual Childhood Lead Poisoning Surveillance Report*.

In addition, the Massachusetts Water Resources Authority (MWRA) and local municipal water departments test tap water each year by collecting samples from homes that have a higher risk of lead. To meet public health standards, 9 out of 10 homes tested must have lead levels below 15 parts per billion (ppb) – called the *action level*. Each community's *90th percentile level* indicates the lead level below which 9 out of 10 homes fall.

Data Point | While drinking water is a less common source of lead exposure than paint, it remains a concern. In 2023, Revere, Medford, and Winthrop all reported **lead levels in drinking water** above the action level. Malden was close behind.



Source: Massachusetts Water Resources Authority (MWRA), Annual Drinking Water Test Results, 2023; Cambridge Water Department, Drinking Water Quality Report, 2023.

[21] NYU Langone Health. (2022). City Health Dashboard Lead Exposure Risk Index.

What actions are communities taking? With funding from the MWRA Lead Service Line Replacement Loan Program and the American Rescue Plan Act (ARPA), many of our communities have made progress in removing lead service lines that provide water to homes and businesses.[22] Participants in CHA's focus groups and interviews expressed wanting more proactive communication and transparency about these efforts and emphasized that some community members may not trust city officials to inspect their homes. In addition, many of our communities have ordinances in place to protect children from exposure to lead-based paint, but they can be difficult to enforce. Focus group and interview participants observed that renters, especially low-income and immigrant households, may fear retaliation from landlords if they raise concerns about lead paint.

Community-based organizations, municipalities, and health care organizations are collaborating to respond to these concerns. They are providing education about lead exposure, developing outreach campaigns to connect community members to resources, and increasing access to lead testing. They are advocating for stronger protections for renters and investing in removing sources of lead. Prevention is the key to progress on this important health equity priority – and that means making sure every family has the same chance to live in a safe, healthy home.

Community Lead Exposure Prevention In Action

In **Malden**, residents have organized to raise concerns about lead contaminated soil at Roosevelt Park. Located right next to a school with one of the highest proportions of students who are low-income or speak languages other than English, community members point to equity as an important reason to prioritize remediation. The park has been fenced off, but exposure concerns remain. While city officials revisit plans to address these concerns, residents have focused on raising awareness about the risks of lead exposure and how to connect kids to lead testing.

In **Chelsea**, the city's Lead Task Force is driving initiatives to raise awareness about lead, connect families to screening, and eliminate lead service lines. Since 2018, the city has replaced 200 lead lines, signed up over 100 households for service line inspections, and developed an online tool where families can check to see if their home's service line is made of lead. With 1,400 service lines still unknown, community-municipal collaboration is key. The Get The Lead Out initiative partners with trusted community-based organizations to engage residents, connect them to city resources, and increase service line replacements. In addition, the local public health department convenes a group including Clean Water Action, GreenRoots, Cambridge Health Alliance, Mass General Brigham, and community activists to develop strategies to reduce exposure to lead. Through direct outreach to families with children under the age of 5 from their medical providers, schools, and other trusted sources, the lead screening rate rose to 87% in the first quarter of 2024 – a 19 percentage point increase over the 2023 average rate.

[22] Lead service line replacement details are available in each community's Annual Drinking Water Rest Results report, available at https://www.mwra.com/water/html/awqr.htm

Sharing Our Stories: Housing & Mental Health

Across interviews and focus groups, people experiencing homelessness and housing instability shared stories of living with constant stress. The trauma of living in unsafe or overcrowded housing, worrying about paying rent, or sleeping on the street in all kinds of weather can cause chronic stress, impacting all aspects of health and wellbeing. Many people also shared how the systems meant to provide support often feel unkind and isolating. Their stories emphasize how deeply housing impacts people's mental health.

*"You walk in [to a shelter] with **fear that you are going to be thrown out**... It makes the health thing go down to zero."*

*"I was homeless with my son for a long time during the summer. It got mentally and physically draining. **My body was just hurting for no reason.**"*

*"[With paying rent] **there's always worrying, and it causes sickness.**"*

Health care providers echoed the connections between housing instability and poor mental health. Without safe, affordable housing, mental health can spiral along with physical health concerns. These providers also shared feelings of despair and frustration at being unable to fix patients' housing situations – not being able to help affects their mental health, too.

*"Therapy helps, and medication can help. But until we can get folks feeling stable and confident in their lives and feeling like they have control over their finances, jobs, food security, and **housing – over and over again, housing – it's hard to treat their mental health struggle.**"*

For people experiencing homelessness, being unhoused often means being misjudged or ignored. That judgment can mean not getting care or support when it's needed most.

*"They thought I was drunk or on drugs when I was having a seizure. **I wasn't drunk. I was having a seizure.**"*

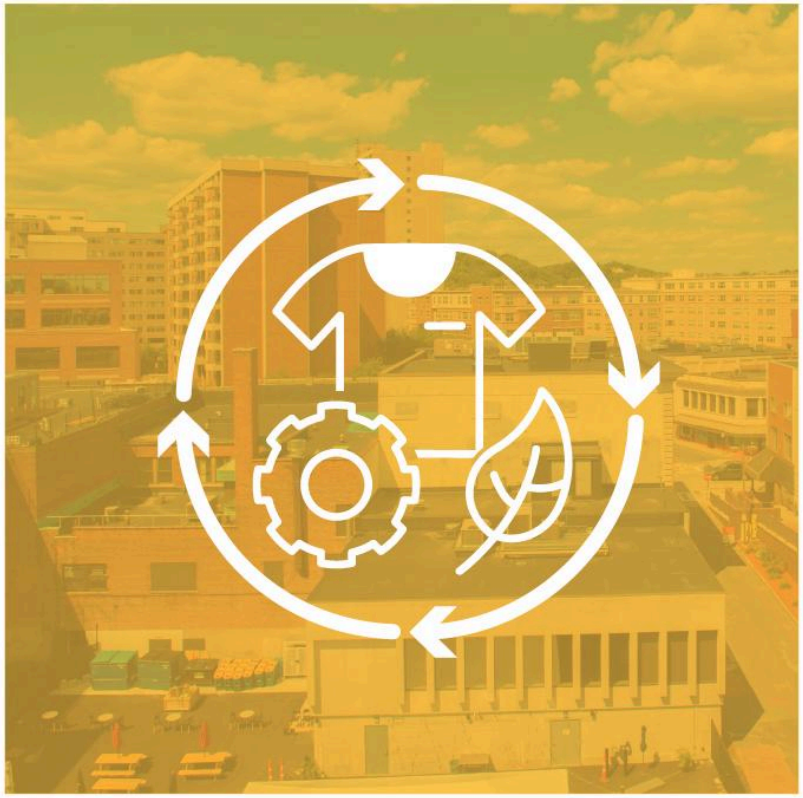
*"**People are closing their eyes and pretending this is not a thing that is happening when really we are all screaming for help because nobody wants to be here.** Nobody wants to be here. Nobody wants to be homeless. Nobody wants their kids taken away. If there is a reason for this it is because we don't have the answers and all we need is a little bit of guidance."*

Even in the most difficult situations, treating people with dignity, respect, and care can make a big difference. Clients of the Somerville Homeless Coalition described how staff members help people navigate difficult systems while making them feel seen and respected. Working together to make a plan, providing clear information, and showing care for people's wellbeing – all of these actions make people feel that they matter. Honoring people's humanity helps begin to heal our mental health.

*"You get here and they're like ok, here's a list of what we are going to do, and this is the way we are going to get it done. It's not only a place where they have answers, but they **show us how to protect ourselves, how to stand up for ourselves.**"*

*"The help that I got here just blew my mind. **I come here and I am actually a person.** Actually getting answers. It's just so nice."*

Equitable Economy



Equitable Economy: Money, Jobs, Food, Caregiving

Key Takeaway

When families cannot afford necessities like food, housing, or childcare, their physical and mental health suffers. Economic inequity disproportionately affects communities of color, immigrants, and low-income residents. Our communities face high poverty rates, food insecurity, and systemic barriers to resources, with many struggling to get help due to language barriers, low-paying jobs, and exclusion. However, communities have clear paths to building a fairer economy: increasing wages, investing in culturally rooted programs, and prioritizing the voices of the people most impacted.

Money, jobs, food, and caregiving are health equity issues.

When people do not have enough money to meet their basic needs, it takes a serious toll on their physical and mental health. Research shows that money, jobs, food security, and caregiving are closely interconnected – and differences in access to opportunity shape health disparities along lines of race, socioeconomic status, and gender.

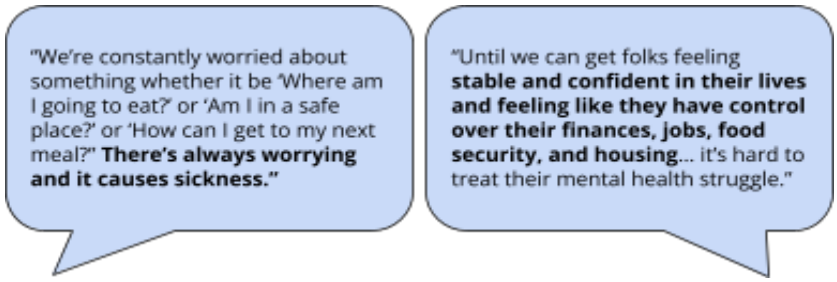
Lack of money makes it **more difficult to afford safe housing, medicine, nutritious food, and childcare,** which all have consequences for physical and mental health.[23] **Inflation** has only made it more difficult to afford basic needs.[24]

Poverty and income inequality can **impact health and wellbeing across generations.** Racial wealth inequality contributes to persistent **racial inequities in health.**[25]

Low-wage and part-time jobs often do not provide adequate health insurance – and may not provide sick leave, family leave, or retirement benefits either. **Occupational hazards** in low-wage jobs can lead to injury and disease.[26]

People experiencing **food insecurity** are more likely to experience poor health outcomes in the short- and long-term.[27] **Quality childcare** is beneficial to children's development and helps parents keep stable employment.[28]

Participants in the Wellbeing Assessment, including community members and health care providers, shared experiences that echo these research findings.



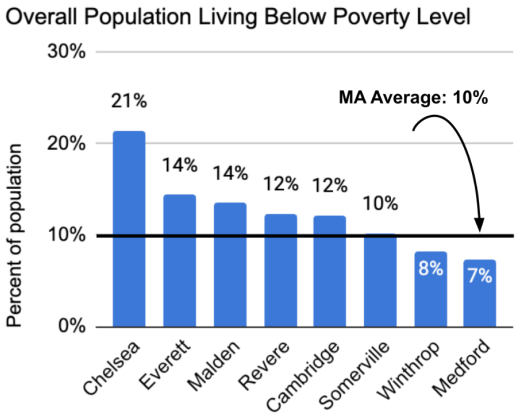
[23] Brown Weida E. et al. (2020). Financial health as a measurable social determinant of health. *PLoS One.*
[24] Fuhrer JC. (2024). The cost of being poor is rising. And it's worse for poor families of color. *Brookings Institution.*
[25] López-Cevallos DF, Rothwell DW (2025). What role does wealth play in the racial health gap in the United States? *SSM Population Health*
[26] Burgard SA, Lin KY (2013). Bad Jobs, Bad Health? How Work and Working Conditions Contribute to Health Disparities. *Am Behav Sci*
[27] Gunderson C, Ziliak JP (2015). Food Insecurity and Health Outcomes. *Health Affairs.*
[28] Chang D. (2020). Connecting The Dots: Improving Child Care Workers' Conditions Leads To Better Health, Economic Stability, And Greater Equity. *Health Affairs.*

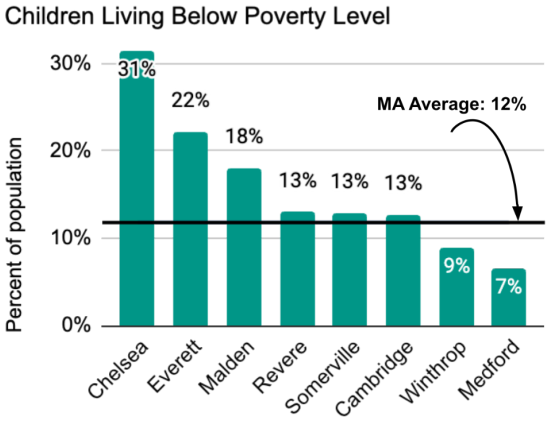
Our communities are impacted by poverty and limited access to good jobs and emphasize that lack of money is the root of many other problems.

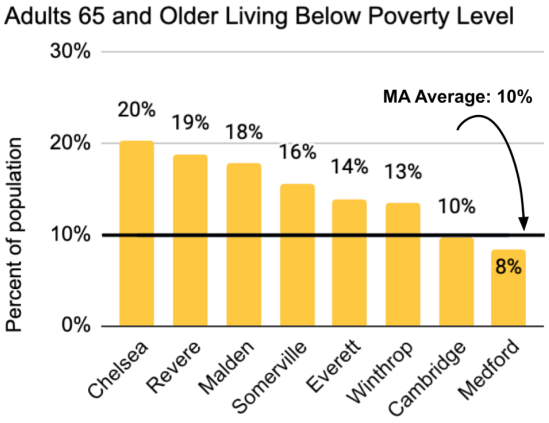
In most CHA communities, poverty rates[29] are higher than state averages. Poverty impacts people of all ages and all racial and ethnic groups. However, in most of our communities, Asian, Black and Hispanic residents tend to experience poverty at higher rates than White residents.

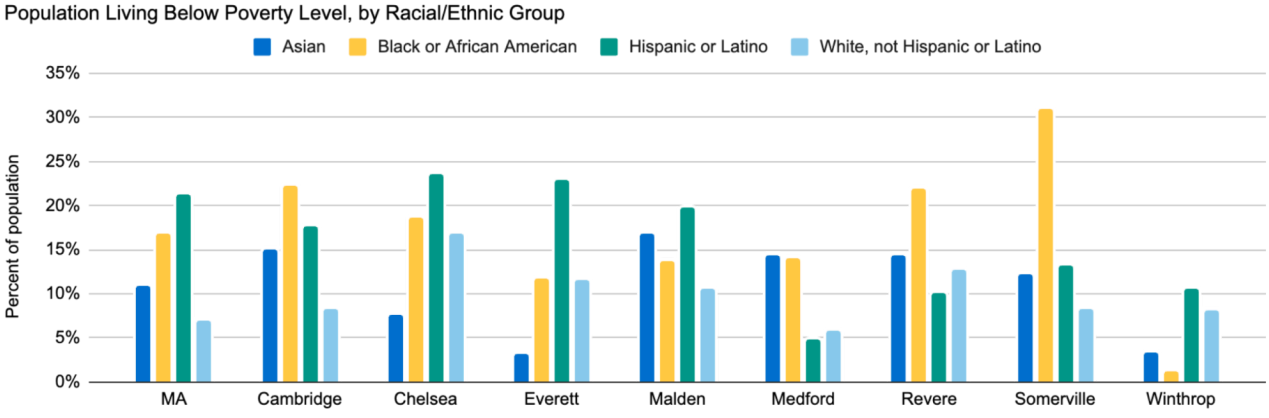
Data Point | The **overall poverty rates** in Chelsea, Everett, Malden, Revere, and Cambridge are higher than the MA average (10%). Poverty rates are notably high among **children** in Chelsea, Everett, and Malden, and among **older adults** in Chelsea, Revere, Malden, and Somerville.

Source: U.S. Census Bureau, American Community Survey, 2022 5-Year Estimates.









[29] The U.S. Census Bureau uses pre-tax income and family composition to estimate the percentage of people living in households with incomes below poverty. In 2022, the federal poverty line for a family of 4 was $29,950. See Poverty Thresholds for additional data.

In focus groups and interviews, community members described a sense of feeling trapped in poverty. Rules limit the amount of money people can earn without compromising important supplemental resources like Social Security Disability Insurance (SSDI), cash assistance, or Supplemental Nutrition Assistance Program (SNAP). Minimum wage jobs are not sufficient to make ends meet, and it is difficult to access training and workforce development programs that would open up higher-paying job opportunities.

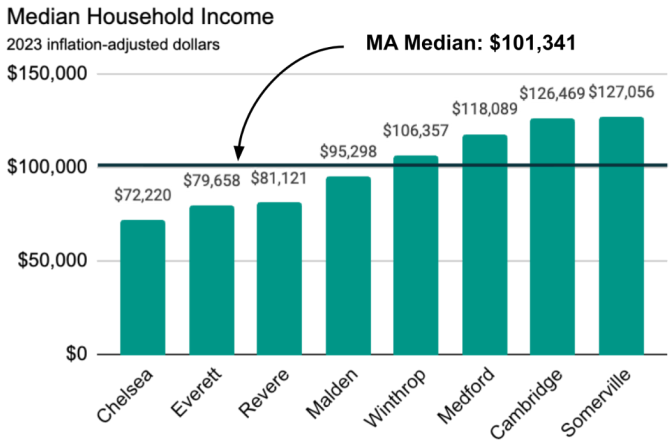
> "My biggest thing is I would love to find a job, but because I am on disability they keep a foot on my neck, so **if I go and even try to get a job they are gonna either kick me off of food stamps or cut my check down.**"

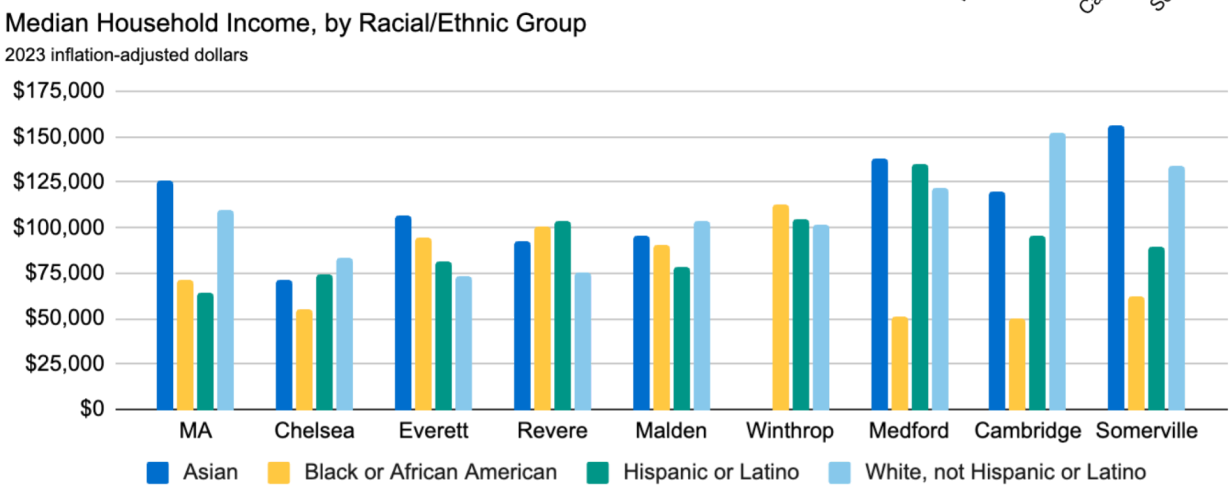
> "To actually advance and escape poverty, you need better jobs, and that requires **real job training that is not designed to just put you back in a job at minimum wage.**"

The challenge of finding good jobs is reflected in our communities' household income data. Median household income describes the middle value of the income spectrum – half of households fall below the median value, and half fall above it. As measured by the U.S. Census Bureau, household income includes wages, Social Security, unemployment compensation, disability benefits, public assistance, and income from investments and other regular sources.

Data Point | In half of CHA communities, **median household income** is lower than the state median. Cities with higher median income tend to have bigger **differences between racial and ethnic groups.** Economic systems that depress wages, especially for low-wage jobs, interact with structural racism to produce these patterns.

Source: U.S. Census Bureau, American Community Survey, 2023 5-Year Estimates.





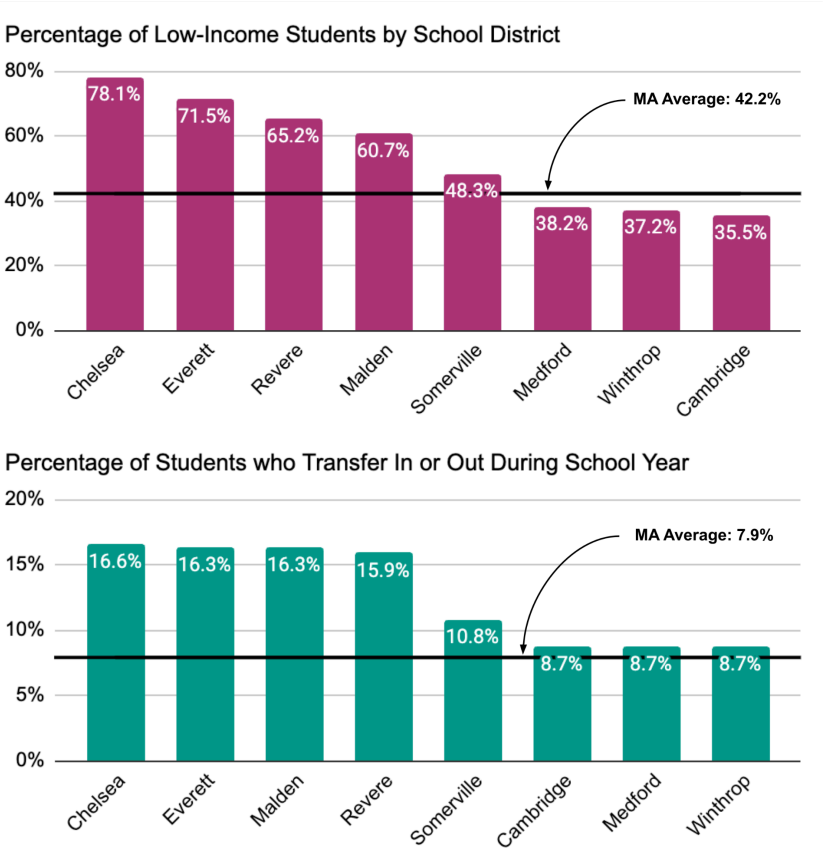
Focus group and interview participants described the impact that lack of money has on youth wellbeing and development. **In some cases, young people have to work in order to help their families make ends meet, which limits other learning and development opportunities.** In other cases, young people's learning is disrupted because their families have to move to find affordable housing or take advantage of a job opening.

> "**I have seen youth jobs increase, but I'm not sure if it's positive**... You look at other school districts, and students are doing after school activities and enrichment and not worrying about making money. It's positive that there are more opportunities for youth, but I also feel there is a political aspect of exploitation."

Data Point | In CHA communities' school districts, the **percentage of low-income students** exceeds the state average (42.2%) in Chelsea, Everett, Revere, Malden, and Somerville. In all of our communities, the **percentage of students who transfer in or out during the school year** exceeds the state average (7.9%). This is called the "churn rate" and is an indicator of family economic instability.

Source: MA Department of Elementary and Secondary Education, 2023-2024 or 2022-2023.

Notes: Low-income is calculated based on a student's participation in SNAP, TAFDC, MassHealth, or foster care, or who have been identified as experiencing homelessness.

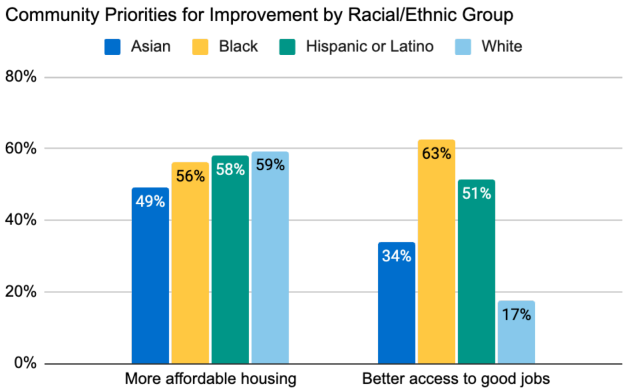


> "It causes a lot of stress if you don't find a job to pay your bills. It will cause health problems–hypertension, heart disease–if you just eat junk or processed food. And if you don't have a good job, you can't buy anything else besides that the majority of time. **So it's a cycle. One affects the other.**"

In focus groups and interviews, community members emphasized that many community health concerns boil down to a lack of money – without money, it is difficult to buy healthy food, live in healthy and safe housing, afford medication, or pay for health care. Many people work multiple, low-wage jobs in order to make ends meet – which leaves little time to cook, sleep, exercise, and participate in social and community life.

Among participants in CHA's Community Wellbeing Survey, the top two priorities for improvement were more affordable housing (56% of all participants) and better access to good jobs (35%) – both of which are tied to economic priorities.

Data Point | While people of all racial and ethnic groups prioritized **more affordable housing**, there were differences in the percentages of people who prioritized **better access to good jobs** – 63% of Black and 51% of Hispanic or Latino participants, compared to 34% of Asian and 17% of White participants.



Source: CHA Community Wellbeing Survey, 2024.

While housing is expensive for people of all racial and ethnic identities, these findings suggest **there are structural barriers to good jobs that heavily affect Black and Hispanic or Latino community members.** It is important to note that lower-income residents face significant barriers to affording housing and other basic needs – regardless of their race or ethnicity.

Food insecurity and lack of support for caregiving are growing concerns.

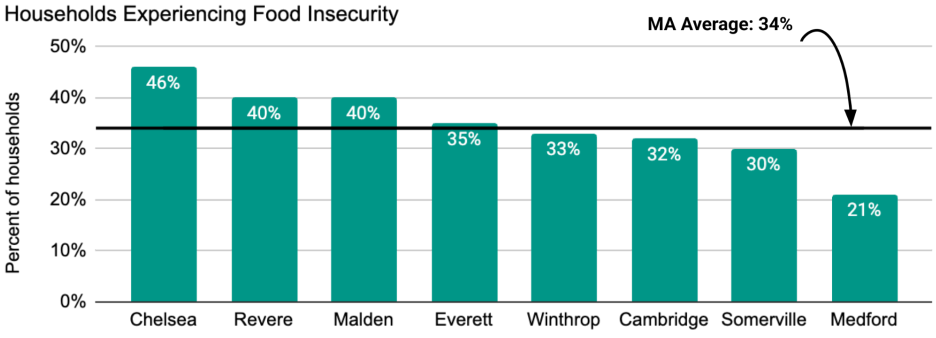
Key Terms

Food insecurity is when people do not have reliable access to adequate, safe, nutritious food.

Food security means that all people, at all times, have access to enough safe, nutritious food to live an active, healthy life.

According to the Greater Boston Food Bank, the percentage of Massachusetts households experiencing food insecurity has risen from 19% in 2019 to 34% in 2023. Now, 1 in 3 people report running out of food or not having enough money to buy food each month. Rising inflation and grocery costs, high housing costs, and the end of economic security policies created during COVID-19 have driven this trend. Food insecurity disproportionately affects American Indian (62%), Hispanic (56%), Black (51%), and LGBTQ+ (56%) households, as well as college students (44%).

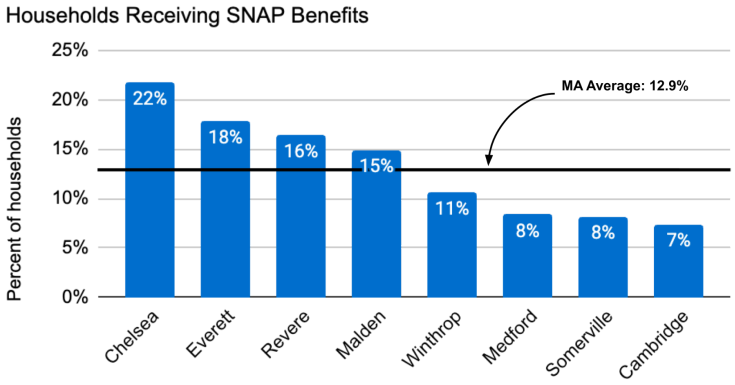
Data Point | In our communities, the **percentage of households experiencing food insecurity** exceeds the statewide average (34%) in Chelsea, Revere, Malden, and Everett.

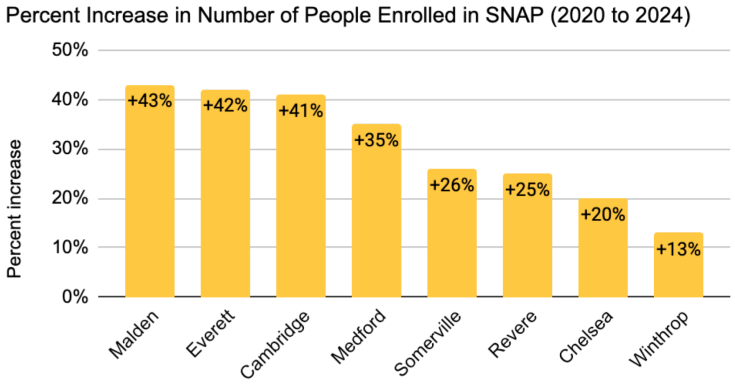


Sources: Greater Boston Food Bank (2024). *Food Equity and Access in Massachusetts: Voices and Solutions from Lived Experience*; Closing the Meal Gap, ArcGIS Map

Many people in our communities rely on the Supplemental Nutrition Assistance Program (SNAP) to help purchase groceries. More and more people are becoming eligible. Between 2020 and 2024, data from the MA Department of Transitional Assistance (DTA) shows the number of people enrolled in SNAP has increased by 32% across our communities – **from 49,844 residents to 65,695**.

Data Point | In our communities, the **percentage of households receiving SNAP benefits** exceeds the state average in Chelsea, Everett, Revere, and Malden. However, **growth in the number of people enrolled in SNAP** varies across our communities. Since 2020, the cities of Malden, Everett, and Cambridge have had the largest percent increase in SNAP enrollment.





Sources: U.S. Census Bureau, American Community Survey, 2022 5-Year Estimates; MA Department of Transitional Assistance, 2020-2024

Notes: Percent increase calculations are based on the average monthly DTA SNAP caseload for each calendar year.

It is positive that more people have access to resources to purchase food. However, according to a report from the Greater Boston Food Bank,[30] **only 34% of SNAP participants statewide say their benefits are enough to cover their monthly grocery costs**. Many people in our communities continue to experience food insecurity, even with the important help of SNAP.

In addition to food insecurity, community members in focus groups and interviews spoke about the challenges of caregiving in our current economic system – both providing care to others, and finding affordable, high-quality care when they or a loved one needs it. According to the MIT Living Wage Calculator,[31] childcare in Middlesex County costs $40,968 per year on average for a working family with two children – up from $31,333 in 2022. **In order for this expense to be considered affordable, in a household with two working adults, each adult would need to earn $40.17 per hour – 2.7 times more than the Massachusetts minimum wage of $15.00 per hour.**

[30] Greater Boston Food Bank (2024). *Food Equity and Access in Massachusetts: Voices and Solutions from Lived Experience*

[31] Massachusetts Institute of Technology. (2025) *Living Wage Calculation for Middlesex County.* https://livingwage.mit.edu/counties/25017

Community members reported there are not enough systems and supports that enable people to give and receive the care they need across their lives. In addition to being expensive, there are limited resources – not enough spots in childcare centers, not enough home health aides and personal care attendants, and not enough support for family members who take on caregiving duties full-time. In addition, people who work as caregivers described being paid minimum wage, with few benefits. **Caregiving responsibilities cause people a lot of stress because of these economic trade-offs and sense of isolation.**

"My economic situation totally changed when I became a mom. In my plan for having my first child, I never counted that I would have a son with special needs... **I had to stay home to take care of him, to be able to receive his therapy, and everything got more expensive - housing, food, everything, especially after the pandemic. I feel this has been just one more burden for all of us.** But the stress this brought on me personally has sometimes made me sick. I gained 30 pounds because I got so stressed just being at home."

(translated from Spanish)

In focus groups and interviews, women, immigrants, and people with disabilities emphasized that **changing the model of care would empower them economically.** Having access to caregiving programs would help them go back to school or pursue a career. Increasing wages for childcare providers, home health aides, and others who are employed as caregivers would attract more people to the profession. Providing financial support for family caregivers would enable people to raise their own children, care for aging parents, and support loved ones who are disabled or sick.

"**I feel like a lot of women end up being disenfranchised** because the cost of childcare is so high that most women end up opting not to work and staying home to take care of a child."

People want to participate in the economy – but policies and practices create barriers for some communities.

In focus groups and interviews, community members identified many barriers to economic stability. Government and institutional policies exclude people with certain immigration statuses from working, create reliance on low-wage jobs, limit where and how food can be grown in their communities, and limit the availability of affordable housing and caregiving services. Practices that discriminate against marginalized groups and exclude communities from decision-making tables create further barriers.

Community members described how systems and services that are only available in English make it difficult to learn about resources and participate in economic life. Worker exploitation, including wage theft, was another common concern that impacts financial stability, particularly for immigrant residents. People who do not have a qualifying immigration status cannot access many public benefits that other families in similar economic circumstances rely on to afford healthy food, safe and accessible housing, and health care.

"Personally, I don't have good DTA benefits **because I don't have a Social Security number. And because of my daughter's age, they only give me $23.** Who, in these times and with these situations, buys food with $23? **What healthy food can I give to a girl who also has a medical condition that requires specific foods with $23?"**

(translated from Spanish)

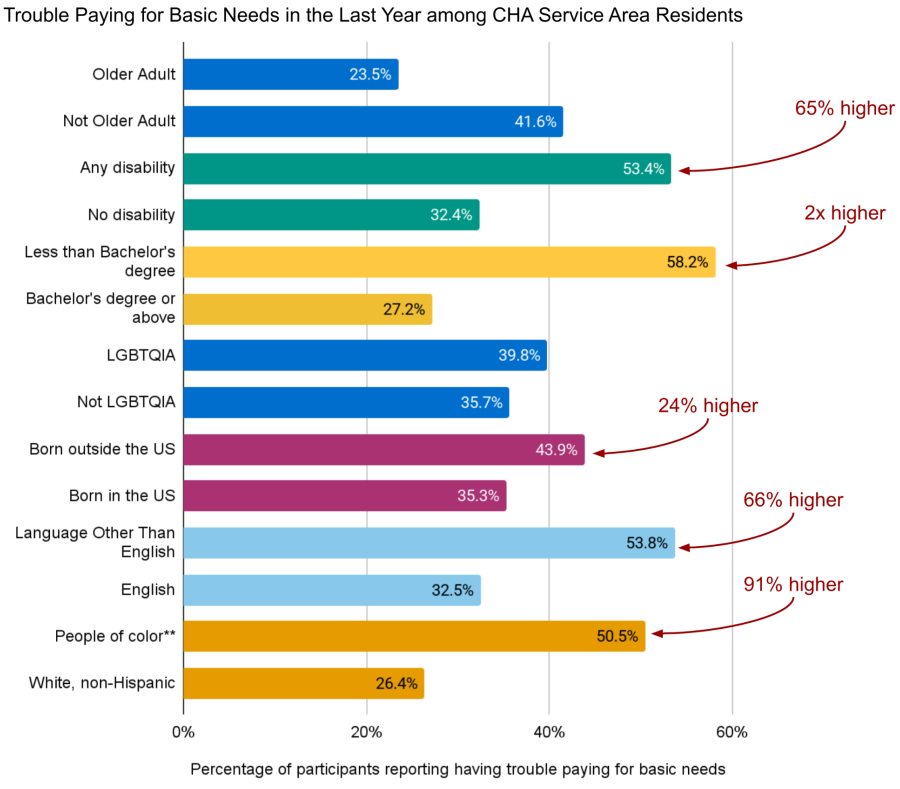
Some expressed fear or confusion about applying for resources that they or their children may in fact be eligible for, regardless of immigration status.

> "There's limited community engagement. Few attend [city council meetings], and there's often no translation available in Arabic, **making it harder to participate or share opinions**."
>
> *(translated from Arabic)*

Immigrant, disabled, and low-income community members spoke about feeling dismissed in city planning processes that affect economic opportunities – like zoning for new housing or urban agriculture, investing in workforce development, changing public transportation services, or incentivizing new businesses to come to the area. **People who already hold power are often the ones making the decisions about economic development.** One community member described a planning process where committee members were required to be "*highly educated, deeply-networked, and fluent in English [because] interpreters were too expensive and meetings would take too long*." Before even beginning, people with valuable experience, knowledge, and local connections were excluded from the process.

The impact of being excluded from economic opportunities is reflected in survey data, too. Among residents of CHA's service area communities, people who are impacted by discrimination were far more likely than their peers to report having trouble paying for basic needs, including food, health care, housing, technology, transportation, and utilities.

Data Point | Participants in DPH's Community Health Equity Survey were asked if they had **trouble paying for basic needs in the last 12 months.** In CHA's service area, people with disabilities, people without college degrees, immigrants, people who speak languages other than English, and people of color were more likely to have trouble paying for basic needs.



Source: MA Department of Public Health, Community Health Equity Survey, 2023.

Notes: ** People of color includes individuals identifying as American Indian or Alaska Native; Asian or Pacific Islander; Black or African American; Hispanic; Middle Eastern or North African; Multiracial; or Other race.

Creating a more equitable economy requires listening to residents, investing in local communities, and creating systems of collective care.

Community members were clear: **to improve health outcomes, we must create a more equitable economy that allows everyone to thrive**. Rather than more fragmented programs, residents called for investment in community-rooted models for providing good jobs, strengthening economic security, building wealth, investing in sustainable local food systems, and lifting up the value of caregiving.

Creating systems of collective care was seen as a powerful tool for advancing community wellbeing. While collective care has many definitions, one that reflects community members' perspectives states:

> *Care is our individual and common ability to provide the political, social, material, and emotional conditions that allow for the vast majority of people and living creatures on this planet to thrive — along with the planet itself.*

Rottenberg, C. and Segal, L. *What is Care?* The Care Collective.

Collective care cuts across all elements of our society – including our economy. **An economic system grounded in collective care would provide the conditions for people to have enough money and resources to care for themselves and each other.** It would prioritize language justice and would center under-represented voices in leadership and decision-making. It would value social capital, human wellbeing, and the natural environment.

Community members spoke about the value of creating spaces where people can build relationships, support one another, and reduce isolation. A sense of connection and belonging was especially important for people facing injustice and oppression – not only to protect their wellbeing and share resources, but also to organize and advocate. Moving from individual care to collective care would provide more support for caregivers – and benefit children, older adults, and people with disabilities. Beyond economic and logistical benefits, collective care would create stronger, healthier communities.

"Really embracing all the diverse communities that are there and creating more inclusion and visibility for those communities. I think that would be a good start, **so people can just help each other and support each other, just emotionally**. Maybe if you get to know another lady that lives in the neighborhood and you can rely on each other to take care of the kids. **You can start to do those things if you create that sense of community and know your neighbors.**"

"For me, it's an honor to be able to have these links and to say, you know what, this is happening in my family, and to understand that it's not only me who's living through this. It's not that I'm happy that we are all facing challenges, **but it makes me feel that I am not alone... For me, this is a forum. A little staircase to move upward and be heard.**"

(translated from Spanish)

"We've seen [the community garden] has different purposes. **It's really about improving the overall wellbeing of the community by giving people the space to come together.**"

An economy grounded in collective care would create community-driven business opportunities, culturally rooted food access, and peer-driven caregiving networks — **places where people can thrive, not just survive.**

Community Voices:

Ideas for Addressing Money, Jobs, Food, Caregiving Concerns

- **Raise wages for caregivers and reinforce labor protections across low-wage sectors.** People working in caregiving and other low-wage jobs, such as the service industry, described unfair treatment, long shifts, and low pay. These jobs are essential but often undervalued. Increasing wages and enforcing stronger labor protections would help reduce burnout, improve working conditions, and protect those who are most at risk of being exploited.
- **Expand affordable caregiving and elder support services.** Caregivers described the difficulty of balancing paid work with caring for children, aging parents, or family members with disabilities. Some shared stories of working overnight shifts and getting only a few hours of sleep before starting their caregiving responsibilities. Expanding access to affordable in-home support and respite services would ease pressure on families and promote long-term stability.
- **Implement free or reduced-cost childcare programs.** Many families said childcare is unaffordable and forces parents, especially mothers, to reduce work hours or leave the workforce. Participants stressed how essential childcare is for staying employed and maintaining financial stability. Offering free or affordable childcare programs would allow more families to access reliable care while supporting workforce participation.
- **Implement inclusive hiring practices that protect against discrimination and promote workforce diversity.** Residents facing discrimination, especially LGBTQIA+ people, immigrants, and people with disabilities, said they often cannot access good jobs or fair treatment at work. Employers should be held accountable for creating safe, inclusive workplaces. Fair hiring practices and stronger protections against discrimination would give more people a fair chance to succeed.
- **Increase access to job training and career development programs, especially for marginalized groups.** Many people said they are stuck in low-wage jobs without a clear path forward. They want opportunities to grow, learn new skills, and access better jobs. Offering free or low-cost training programs, especially for youth and people facing barriers to employment, would open doors to more stable and better-paying careers.
- **Establish guaranteed basic income initiatives and municipal housing voucher programs to reduce financial instability.** Expanding city-run housing voucher programs[32] and testing guaranteed basic income can give residents more stability and control. These programs help cover essential expenses, reduce daily financial pressure, and allow families to make choices that support their well-being.
- **Develop community food hubs and mobile markets.** In cities like Everett, where the closure of Stop & Shop left a major gap, residents have limited access to full-service grocery stores. Many must travel to other towns to shop, while local stores are more expensive and offer fewer

[32] For example, the City of Somerville's municipal housing voucher program, described in the Housing chapter.

healthy options. Community food hubs[33] and mobile markets can bring fresh, affordable groceries directly to neighborhoods that are underserved by traditional food retailers.

- **Promote urban agriculture initiatives as local, sustainable food sources.** Residents shared how urban agriculture – including small commercial or nonprofit farms, community gardens, and home gardens – offers more than just fresh produce. Many of these spaces provide job opportunities, especially for youth, and create places for people to connect. Community gardens also allow residents to grow culturally familiar foods and strengthen neighborhood ties. Urban agriculture was described as a way to improve overall wellbeing by rooting food access in community life.

- **Organize nutrition and cooking workshops that are culturally relevant and accessible.** Some residents noted that even when they have access to healthy ingredients and are encouraged to eat healthier, they do not know how to best prepare the ingredients. Others lack the time or tools to prepare balanced meals. Cooking workshops that focus on simple, affordable, and culturally relevant recipes can help families use the food they receive and improve their health. Teaching basic techniques like roasting or sautéing vegetables can make a meaningful difference.

- **Advocate for policies that support food sovereignty and long-term investment in local food systems.** Residents expressed frustration with the slow pace of policy change and the lack of long-term investment in food access. Community members called for policies that support food sovereignty by prioritizing local growing, distribution, and decision-making. Strengthening partnerships with trusted organizations can also help ensure lasting impact. Food insecurity has long been identified as a growing problem, demanding system-level solutions.

- **Support organizations that run food pantries, provide free meal services, and directly prevent hunger and food insecurity.** Organizations like Bread of Life were praised for meeting immediate needs through food pantries, free community meals, and meal deliveries for older adults. Residents emphasized the importance of investing in and providing continuous support to these groups so that they can continue serving the community.

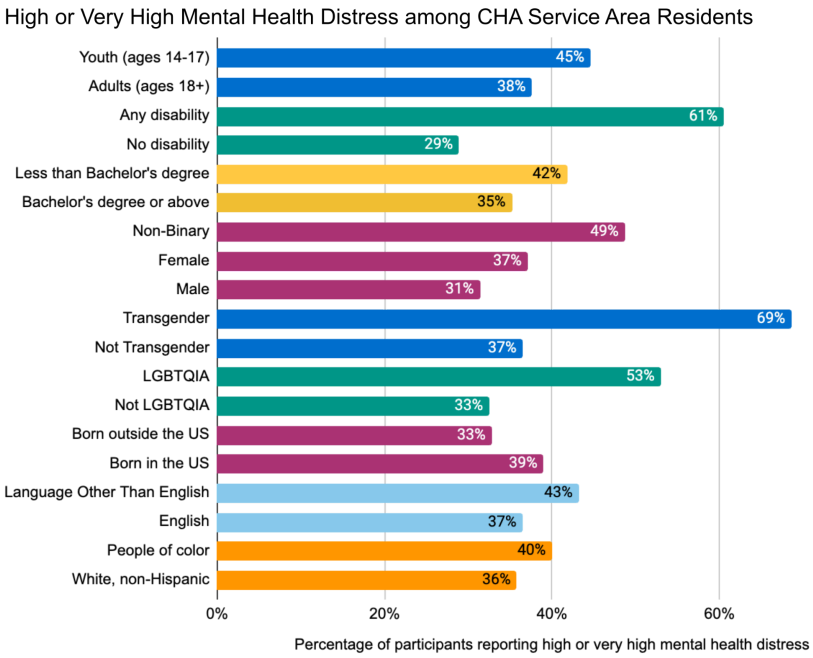
[33] A community food hub is a facility or organization that works to gather, distribute, and market local food products to meet community demand.

Health Spotlight: Mental Health

Mental health is an essential part of wellbeing. However, many people in our communities are facing significant stress, anxiety, and despair. According to the MA Department of Public Health's Community Health Equity Survey, more than 1 in 3 adults (38%) and nearly half of youth (45%) in CHA's communities report high or very high levels of mental health distress.

The COVID-19 pandemic had a severe impact on mental health. In each of our communities, the proportion of residents who reported having poor mental health was 2–3 times higher in Fall 2020 (near the height of the pandemic) compared to 2019.[34] The pandemic impacted people's mental health in many ways – the grief of losing loved ones, feelings of fear and isolation, the stress of unemployment or job changes, and increasing polarization about vaccines and public health measures. While rates of COVID-19 infection and death are now far lower than they were in 2020–2022, the impacts on mental health continue and are amplified by new stressors. Across the United States, increasing stress, social isolation, and mental health challenges among parents, youth, and the general population are driving a worsening mental health crisis that demands urgent action.[35]

Equity Lens | Among residents of CHA's service area, many people report **high or very high levels of mental health distress**, especially youth (45%), LGBTQIA+ individuals (53% overall, and 69% of transgender individuals), and people with disabilities (61%). Overall, **communities that face discrimination are more likely to report poor mental health** – including people of color, people who speak languages other than English, non-binary individuals, and people with lower educational attainment.



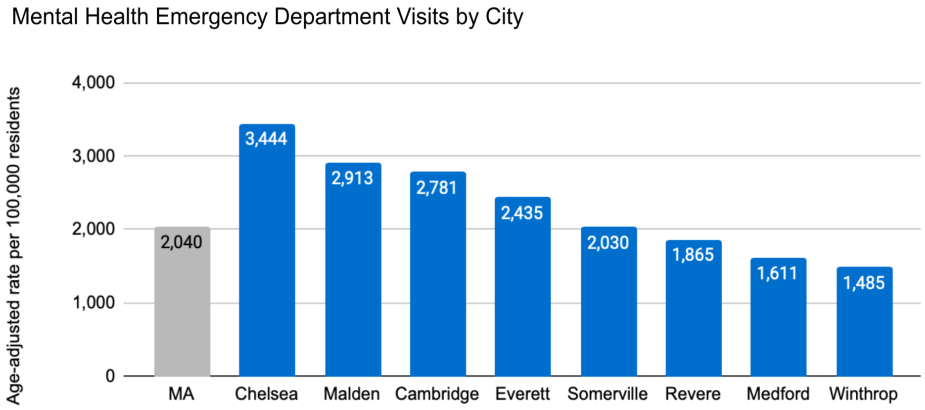
Source: MA Department of Public Health, Community Health Equity Survey, 2023

Notes: People of color include individuals identifying as American Indian or Alaska Native; Asian or Pacific Islander; Black or African American; Hispanic; Middle Eastern or North African; Multiracial; or Other race.

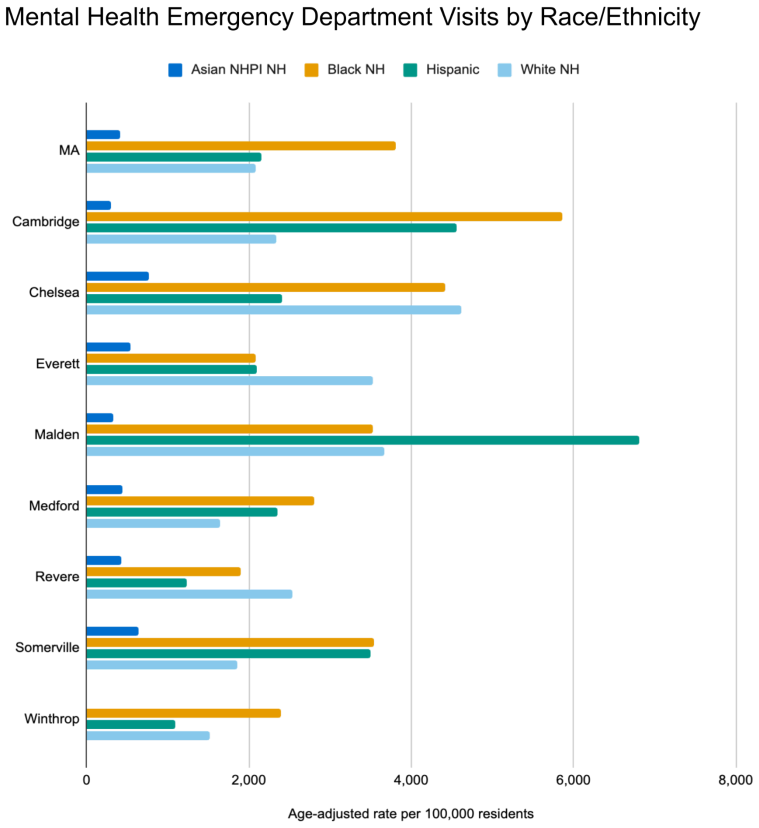
[34] Centers for Disease Control and Prevention (CDC) PLACES, 2021; Behavioral Risk Factor Surveillance System (BRFSS), 2019; Massachusetts Department of Public Health, COVID-19 Community Impact Survey (CCIS), Fall 2020.

[35] U.S. Department of Health and Human Services. (2024). Parents Under Pressure: The U.S. Surgeon General's Advisory on the Mental Health & Well-Being of Parents; U.S. Department of Health and Human Services. (2023). Our Epidemic of Loneliness and Isolation: The U.S. Surgeon General's Advisory on the Healing Effects of Social Connection and Community; U.S. Department of Health and Human Services. (2021). Protecting Youth Mental Health: The U.S. Surgeon General's Advisory.

Data Point | In Chelsea, Malden, Cambridge and Everett, the **5-year average age-adjusted rate of emergency department visits due to mental health** is higher than the state average.



Source: Center for Health Information and Analysis (CHIA), Massachusetts Acute Hospital Case Mix Database, 2017-2021 5-Year Annual Averages.



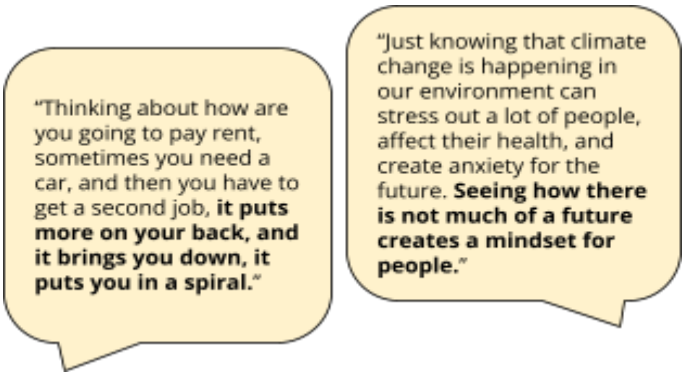
Equity Lens | The 5-year average age-adjusted rates of emergency department (ED) visits for mental health are **highest among Hispanic residents of Malden**, followed by **Black residents of Cambridge**. Rates are also notably high among **Hispanic residents of Cambridge, and White and Black residents of Chelsea**. Rates vary in comparison to state averages across our communities. In all our communities, Asian residents have the lowest ED visit rates for mental health.

Source: Center for Health Information and Analysis (CHIA), Massachusetts Acute Hospital Case Mix Database, 2017-2021 5-Year Annual Averages.

Notes: The number of average annual ED visits due to substance use was less than 10 among certain racial and ethnic groups, so rates could not be reported. NH = Non-Hispanic; NHPI = Native Hawaiian or Pacific Islander.

It is important to note that while ED visit rates provide valuable insight into the mental health of our communities, **they do not offer a complete picture of the overall need**. Barriers to accessing care persist, and many individuals may not seek help through emergency services. In fact, among participants in CHA's Community Wellbeing Survey, **30% of people who needed mental health care (routine or emergency)** were not able to get the care they needed. The most common reasons why

people were unable to access care were related to **cost, insurance coverage, inability to get an appointment, lack of trust, or knowledge barriers**. As a result, many individuals with significant mental health needs in our communities may not be captured in emergency department visit data, highlighting the gap between need and access to care.[36]



When asked about the **causes of poor mental health**, participants in focus groups and interviews pointed to anxiety and stress related to many social, economic, and environmental concerns. Many people described how **housing insecurity** and **lack of income** are primary drivers of poor mental health, with constant worrying impacting their sleep, emotional state, relationships, and overall mental health. Others, particularly youth, spoke about a sense of despair, depression, and hopelessness about a future impacted by **climate change**[37] – in addition to anxiety caused by witnessing or experiencing the human and environmental impacts of wildfires, heat waves, floods, droughts, and other events caused or exacerbated by climate change**.** Parents and caregivers emphasized how a **lack of support for caregivers** caused significant stress – including a sense of isolation and loneliness, frustration at gender norms and policies that undermine women's independence and choices, and anxiety about how to balance responsibilities and care for loved ones with minimal economic and societal support. Finally**,** many participants, especially people of color and immigrant community members, spoke about the mental health impacts of **discrimination** and **harmful social and political conditions.** Experiencing unequal treatment, being stigmatized and blamed for societal problems, and hearing dehumanizing narratives in the media and from leaders, all cause significant stress. Furthermore, people who have experienced violence and other forms of trauma, including immigrants who may have fled persecution in their home countries, described long-term mental health impacts.

These findings emphasize that poor mental health is often caused by issues that require action at community, institutional, and policy levels. While access to mental health care is important, community members' experiences show that this challenge cannot be the responsibility of mental health professionals alone to solve. Creating affordable housing for all, developing systems of collective care, promoting equitable and inclusive practices and narratives, and addressing the impacts of climate change, require collaboration across sectors – and would help to address the root causes of poor mental health in our communities.

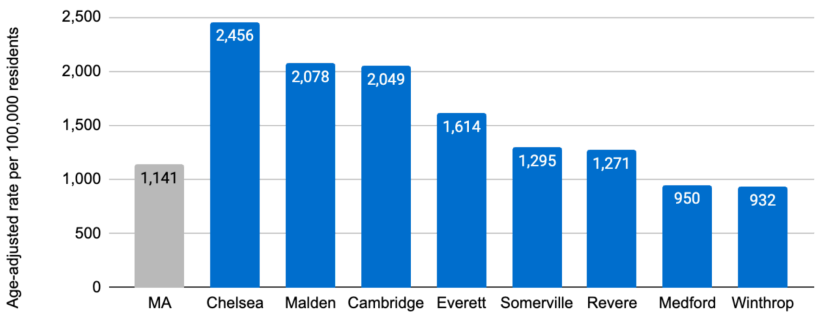
[36] For more about access to care, visit the Equity in Access chapter.
[37] For more about climate anxiety, visit the Sharing Our Stories section in the Climate Health and Environmental Justice chapter.

Health Spotlight: Substance Use

In focus groups and interviews, substance use was described as both a health challenge and a symptom of deeper structural inequities. Community members and service providers emphasized that problems with substance use are often rooted in housing instability, economic hardship, untreated trauma, caregiving burdens, and overall lack of social support and connection. Many people use substances in ways that do not interfere with their wellbeing – but, when substance use becomes intertwined with other challenges, it can become harmful. Substance use disorders are seen as serious health conditions that deserve compassionate, equitable care and treatment.

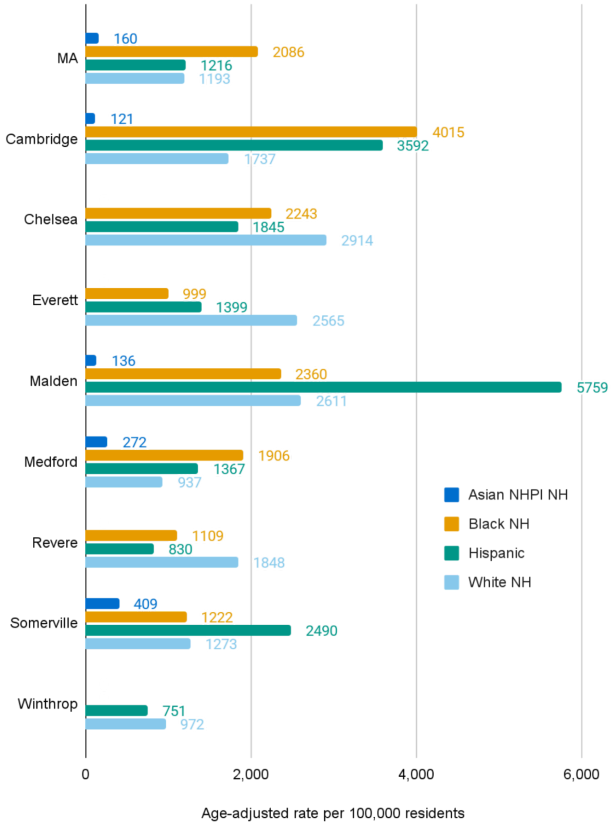
Data Point | The **5-year average age-adjusted rates of emergency department (ED) visits due to substance use** are higher than the statewide average in all of our communities except Medford and Winthrop. The rate in Chelsea is *more than* double the statewide average, and rates in Malden and Cambridge are *nearly* double the statewide average.

Substance Use Emergency Department Visits by City



Equity Lens | Across our communities, **Black, Hispanic, and White residents visit the emergency department (ED) at high rates due to substance use**. In Cambridge and Medford, rates are highest among Black residents. In Malden and Somerville, rates are highest among Hispanic residents. In Chelsea, Everett, Revere, and Winthrop, rates are highest among White residents.

Substance Use Emergency Department Visits by Race/Ethnicity



Source: Center for Health Information and Analysis (CHIA), Massachusetts Acute Hospital Case Mix Database, 2017-2021 5-Year Annual Averages.

Notes: The number of average annual ED visits due to substance use was less than 10 among certain racial and ethnic groups, so rates could not be reported. NH = Non-Hispanic; NHPI = Native Hawaiian or Pacific Islander.

The reasons for inequities in substance use-related emergency department (ED) visits are complex. In focus groups and interviews, community members recognized important

progress in expanding access to care for substance use disorders – such as community behavioral health centers, harm reduction programs, Narcan[38] distribution, and mobile treatment options. On the other hand, some community members described being unaware of available resources for crisis care or outpatient care, which may result in turning to the ED. Others described being reluctant to go to the ED for fear of being treated unfairly. ED visit rates are driven by multiple types of substance use – including alcohol, opioids, cocaine, methamphetamine, and other substances. Differences in patterns of use may partly explain why some groups experience higher ED visit rates than others. Importantly, the data points to complex, interconnected forces that shape the experiences of people of different racial and ethnic groups – such as racism, poverty, and stigma.

Deaths due to drug overdoses increased in 2020, the first year of the COVID-19 pandemic, and continued to rise through 2022. However, the trend has begun to change. In 2023, according to the U.S. Centers for Disease Control and Prevention (CDC), reported drug overdose deaths in the United States declined by 3% – and accelerated further in 2024, declining 26% compared to 2022.[39, 40] In Massachusetts, overdose deaths mirror this national trend, but with an even steeper decline in the last 2 years. The number of drug overdose deaths increased steadily from a reported 2,215 in 2019, to 2,647 in 2022, before beginning to decline. **In 2024, a reported 1,598 Massachusetts residents died of drug overdoses – a 40% decline compared to 2022**.[40] While each death is one too many, the declining numbers are promising, and reflect the impact of investments in prevention, treatment, and harm reduction efforts that help to decrease the chances of dying from overdoses.

However, many deaths due to substance use are not the result of overdoses. Other causes of death include alcohol-related liver cirrhosis, accidents while under the influence of drugs, and heart attacks caused by cocaine or methamphetamine. **In the 12 months ending June 2024, there were 3,692 substance-use related deaths in Massachusetts – a 22% decline compared to the 12 months ending June 2022.** The decline has been driven primarily by fewer deaths due to opioids, alcohol, and cocaine – which remain the top 3 causes of substance use related deaths – even as deaths due to other sedatives (including xylazine) have increased (though remain less common overall)**.**[41] Rates have begun to decline across all racial and ethnic groups, but disparities remain.[41]

Changes in the drug supply and patterns of use may also play a role in these mortality patterns. In Massachusetts, as of June 2024, fentanyl was present in 91.6% of opioid-related overdose deaths where a toxicology screen was conducted – a rate that has remained unchanged for the last 5 years. On the other hand, **xylazine was present in 16.3% of opioid-related overdose deaths – more than 2 times higher than 7.2% the year prior,** when this dangerous tranquilizer first emerged in the drug supply.[42] Cocaine has gradually risen as a proportion of other substances present in opioid-related deaths; prescription opioids and heroin have gradually declined; and alcohol, benzodiazepines, and amphetamines have remained relatively stable.[42]

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[38] Narcan (or naloxone) is a life-saving nasal spray medication that rapidly reverses the effects of an opioid overdose.

[39] CDC National Center for Health Statistics. (May 15, 2024). U.S. Overdose Deaths Decrease in 2023, First Time Since 2018.

[40] Ahmad FB, et al. (2025). *Provisional drug overdose death counts*. CDC National Center for Health Statistics.

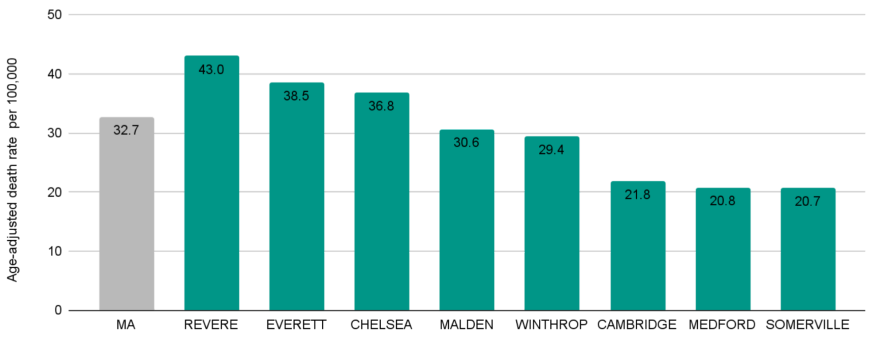
[41] Massachusetts Bureau of Substance Addiction Services Dashboard. MA Community Profile: Substance Related Deaths, June 2024.

[42] Massachusetts Bureau of Substance Addiction Services Dashboard. MA Community Profile: Opioid-Related Overdose Deaths, June 2024.

Data Point | Compared to the statewide average, **5-year average age-adjusted opioid-related overdose mortality rates** are higher in Revere, Everett, Chelsea, and lower in all other CHA communities.

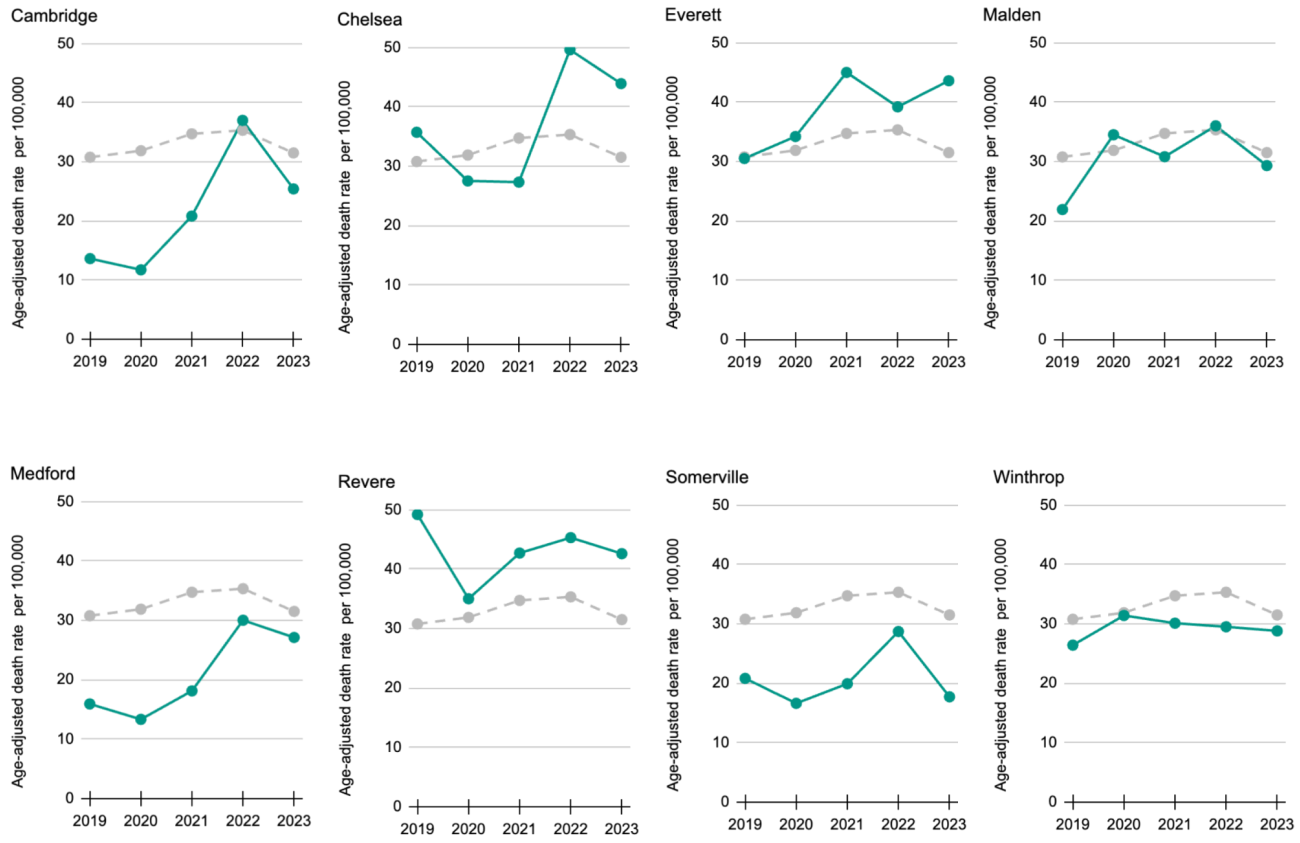
Source: MA Registry of the Vital Records, Selected Causes of Death, 2019-2023.

Opioid Death Rate by City



Between 2019 and 2023, trends in opioid-related overdose mortality rates varied across communities. The impact of the COVID-19 pandemic is clear, as most communities saw increases between 2020 and 2022 – mirroring statewide and national trends. Notably, opioid death rates rose by 80% in Chelsea, 126% in Medford, and 216% in Cambridge between 2020 and 2022. The opioid death rate declined in 2023 across all communities – except in Everett, where the mortality rate rose by 11%.

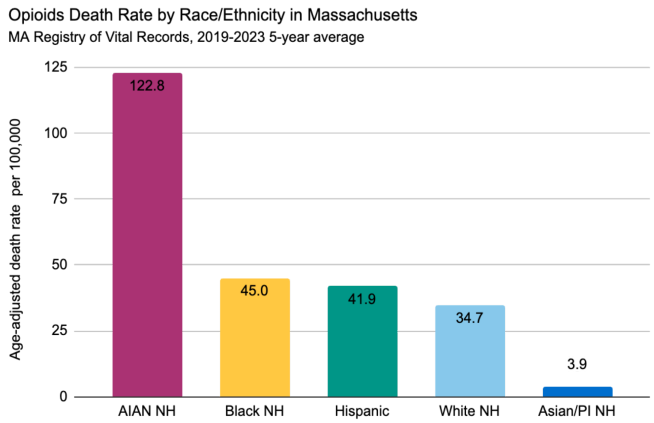
Opioid Death Rate Over Time by City

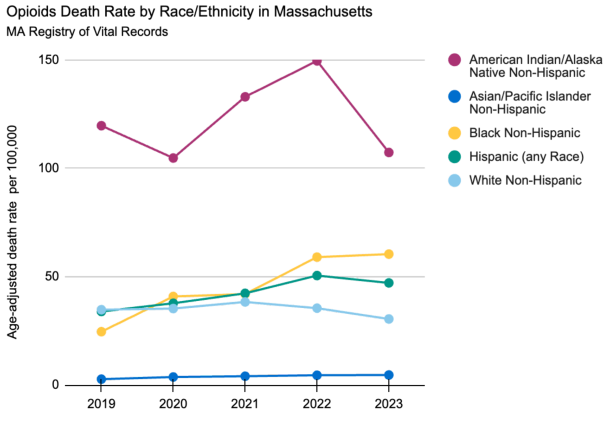


Source: MA Registry of the Vital Records, Selected Causes of Death, 2019-2023.

Notes: In each chart, a gray dotted line represents the age-adjusted rate for the state of Massachusetts.

Equity Lens | In Massachusetts overall, 5-year average age-adjusted **opioid-related overdose mortality rates are highest among American Indian/Alaska Native (AIAN) residents** – more than 2.7 times higher than any other group. Between 2019 and 2021, opioid-related overdose rates were very similar between Black, Hispanic, and White residents. However, beginning in 2022, a clear disparity emerged: **Black residents now experience higher rates of opioid-related mortality,** followed by Hispanic residents, then White residents. Opioid-related mortality rates have been consistently low among Asian/Pacific Islander residents.





Source: Massachusetts Registry of Vital Records and Statistics, Selected Causes of Death, 2019-2023.
Notes: Mortality rates by racial/ethnic group are not available at the municipal level due to small numbers. Mortality rates at the state level are not available for racial/ethnic groups other than those identified in these charts due to small numbers. The American Indian/Alaska Native group is relatively small, so small changes in the number of deaths can result in large changes in annual rates.

While overall trends in substance use and overdose related mortality are promising, it is notable that racial and ethnic disparities remain wide. In addition, while preventing death is a critical goal, many people continue to struggle with substance use disorders and lack access to comprehensive treatment and care. Substance use remains a serious and evolving public health challenge.

Sharing Our Stories: Food Justice

In the heart of Everett, the sun beats down on a vibrant urban farm. Neighbors move between planter beds, exchanging news and stories in between tending peas and potatoes. This isn't just a place where vegetables grow. It is an example of a more equitable economy and a healthier community.

Food insecurity can impact anyone. "*Another issue that I'm also hearing about is food*," shared a local teacher. "*Usually it's my students who come to me and say, 'Hey, I'm having difficulty with food. Where can I get support?' But now I'm getting staff members – people who are teaching, who have full-time jobs – and they come to us like, 'Hey, I cannot do this. I need support.'*" Struggling to afford nutritious food is a consequence of an economy where wages haven't kept pace with the rising cost of living.

Community advocates have long envisioned what a more local, accessible food system could look like. "*A few years ago, the YWCA presented on food access,*" remembered another resident. "*They spoke to the city council about food deserts in the city and access to healthy, fresh food – and they brought such good ideas. However, we neglected to move forward with forming the committee that was supposed to bring those suggestions, or that policy, into action.*" This captures a constant challenge: good ideas exist, but the political will or resources to implement them are often missing.

This is where organizations like Everett Community Growers (ECG) step in. What began as a space for growing and distributing food has grown into something much broader – a commitment to promoting food justice and food sovereignty. ECG's gardens provide a place for people facing food insecurity to grow their own food. At their farms, food is grown to donate to local food pantries and to sell at local farmstands. ECG offers training and experience in sustainable agriculture, creating new pathways to employment and engaging youth in community and economic life.

Beyond the economic benefits, the farm offers a place for people to connect, build relationships, and organize to advocate for what matters to them. "*We've seen [the community garden] has different purposes,*" one garden grower explained. "*It's really about improving the overall wellbeing of the community by giving people the space to come together.*"

Key Terms

Food Justice is a holistic and structural view of our food systems that sees healthy food as a basic human right and addresses the structural barriers that obstruct this right. These structural barriers include poverty, racial inequity, and social injustice.

Food Sovereignty is the right of individuals and communities to define and control their own food systems. This results in the production of culturally relevant foods to individual communities, while allowing these communities to build their own distribution systems that directly benefit them both socially and financially.

Source: Food Lifeline

When communities have control over their food sources, it fosters a sense of empowerment and belonging. Access to fresh, healthy food combats chronic diseases linked to poor nutrition, directly improving health outcomes. The collective act of growing food builds social capital, strengthens community ties, and reduces the isolation often experienced by those facing economic hardship. Food justice can cultivate a more resilient, equitable, and healthy community from the ground up.

Equity in Access

Equity in Access: Care, Services, Information

Key Takeaway

Across CHA's communities, people experience significant barriers to accessing care, services, and information. Over half (57%) of participants in CHA's Community Wellbeing Survey reported having trouble paying for or accessing essential resources in the last 12 months. People of color, people with disabilities, and people with less than a college education report greater barriers to access. In many communities, lack of health insurance is significantly higher among people of color and immigrants. Community members emphasize that access issues have gotten worse since the COVID-19 pandemic. Service providers, leaders, and community members all acknowledge that health care, social service, and government systems are too complicated, and community needs outnumber resources. They emphasize that investing in systems that center people's humanity – from patients to providers, from clients to staff – can increase simplicity, efficiency, and equity in access.

Access is a health equity issue.

Everyone needs resources like health care, housing, food, and transportation. And, everyone needs information about what services and opportunities are available to them. When some people have less access to care, services, and information than others, differences in health outcomes can result.[43, 44]

What does it mean to have access? According to focus group and interview participants, access requires more than the physical presence of a hospital, school, social or municipal service office. It means having people there who speak your language and understand your culture. It means the office has enough staff to see you in a timely manner and is open during hours when you are not working or caregiving. It means being able to afford the cost of transportation and the co-pay or deductible. It means considering the needs of people with disabilities. It means having information communicated to you proactively, so you know what resources are available. Importantly, it means having trust that you will be treated with respect, honesty, and quality.

Many people in our communities experience barriers to accessing the resources they need to thrive.

Among participants in CHA's Community Wellbeing Survey, **57%** reported having trouble paying for or accessing essential resources in the last 12 months. Barriers were most common for housing, which almost one-third (32.4%) of participants had trouble accessing. Many people also reported barriers to accessing food or groceries (24.2%), utilities like electricity, gas, or water (21.5%), and health care, including appointments, medicine, and insurance (21.4%).

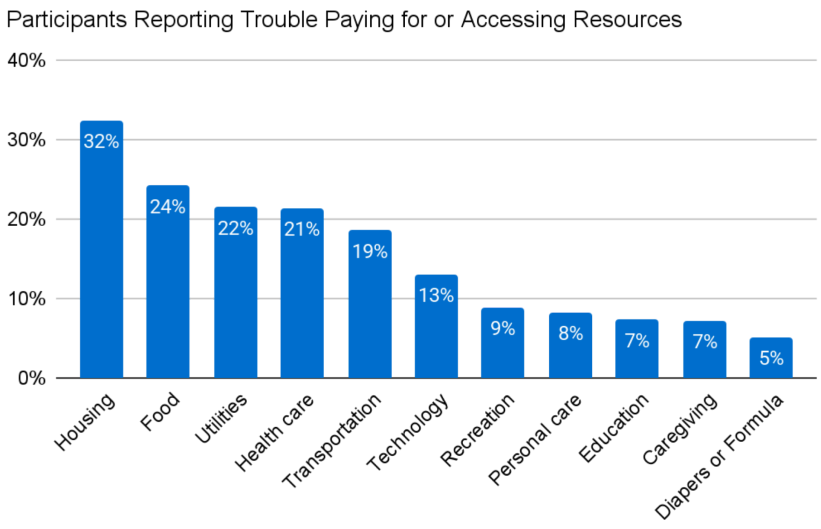
[43] Gulati I, Kilian C, Buckley C, Mulia N, Probst C. Socioeconomic disparities in healthcare access and implications for all-cause mortality among US adults: a 2000-2019 record linkage study. *Am J Epidemiol.* 2025 Feb 5;194(2):432-440. doi: 10.1093/aje/kwae202

[44] Choudhury P, Sineshaw H, Freedman R, et al. Contribution of health insurance to racial and ethnic disparities in advanced-stage diagnosis of 10 cancers, *JNCI: Journal of the National Cancer Institute*. 2025 Feb; 117(2): 338–343. https://doi.org/10.1093/jnci/djae242

Data Point | Participants in CHA's Community Wellbeing Survey were asked which **resources they had trouble paying for or accessing in the last 12 months.** Barriers were most common for housing, food, utilities, and health care.

Source: CHA Community Wellbeing Survey, 2024.

Notes: Personal care includes hygiene products like toothpaste, soap, and menstrual products.

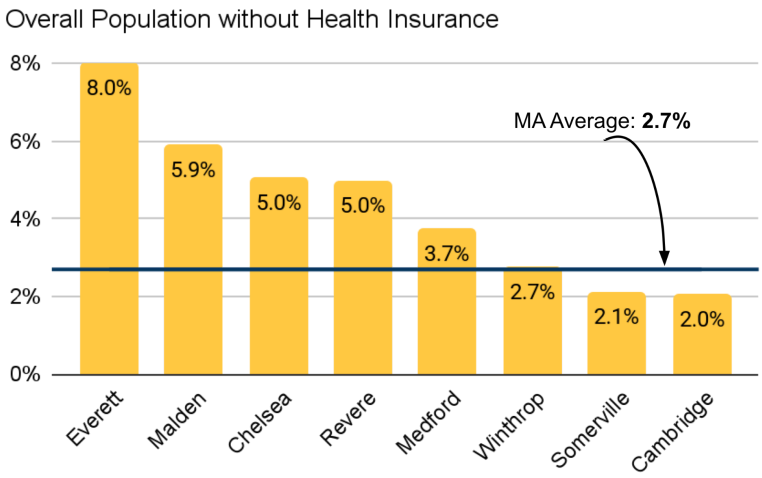


There are many reasons people have trouble accessing resources. In the Housing and Equitable Economy chapters, we explored some of the barriers to accessing resources like housing, food, and other basic needs. In this chapter, we will take a closer look at barriers to accessing health care.

Not having health insurance is a significant barrier to accessing health care. The ***uninsurance rate*** is a measure that describes the percentage of people in a population or group who do not have health insurance. In CHA's service area, five municipalities have uninsurance rates that are higher than the Massachusetts state average, according to the U.S. Census Bureau.

Data Point | The **percentage of residents without health insurance** is higher than the MA state average (2.7%) in Everett, Malden, Chelsea, Revere, and Medford.

Source: U.S. Census Bureau, American Community Survey, 2022 5-Year Estimates.



When we look *within* each community, uninsurance rates vary between groups of people who live in the same city. People who face racism and other forms of discrimination tend to be less likely to have health insurance. In our communities, immigrants are more likely to be uninsured compared to people born in the U.S. People of color are more likely to be uninsured compared to White residents.

Equity Lens | In our communities, people who face racism and other forms of discrimination tend to be less likely to have health insurance.

Compared to people born in the U.S, uninsurance among non-citizen immigrants is…

16 times higher in **Medford**
5.7 times higher in **Revere**
4.5 times higher in **Chelsea**

Hispanic residents have the highest uninsurance rates in…

Medford – 16.5%
Everett – 11.6%
Malden – 8.2%
Chelsea – 6.2%
Winthrop – 4.7%

Black residents have the highest uninsurance rates in…

Revere – 8.0%
Cambridge – 7.1%
Somerville –5.8%

While not having health insurance is a major barrier to care, even people with health insurance cannot always access the health care they need. In focus groups and interviews, community members shared experiences like going to the emergency room because they could not get a timely appointment with their medical provider, becoming locked in debt because their insurance did not cover their visit, and having difficulty finding health care providers who accept their insurance.

"I went to the emergency room. There, I received only ibuprofen, and they charged me a staggering $3,000. My insurance did not cover it. They sent me to collections and added late fees, increasing the total cost. **I was in debt for a long time.**"

(translated from Spanish)

"MassHealth has several different plan options. Often you get started on "Limited" and then it changes to a different level of coverage. **It can be hard to understand these changes and find providers that cover you through the changes."**

Equity Lens | Participants in CHA's Community Wellbeing Survey were asked if they needed various types of health care in the last 12 months, and if so, whether they could access that care.

Uninsured participants were less likely to report needing health care, compared to participants with MassHealth, Medicare, or employer-based insurance.

When **uninsured participants** *did* need care, they were **more likely** to report having **unmet needs for dental, vision, and heart health care** (such as high blood pressure).

Participants with **MassHealth** were **more likely** to report having **unmet needs for mental health care.**

More than **1 in 10 participants with MassHealth or who were uninsured** reported having **unmet needs for routine primary care.**

Among Wellbeing Survey participants, the most common types of health care needs were dental care, primary care, and vision care. We found that **30% of people who needed dental care, 11% of people who needed primary care,** and **15% of people who needed vision care** in the last 12 months could not access it. In addition, over **30% of people who needed mental health care**

(routine or emergency) or treatment for a substance use disorder were not able to get the care they needed. The most common reasons why people were unable to access care were related to cost, insurance coverage, inability to get an appointment, lack of trust, or knowledge barriers.

61% of people who could not access **dental care** said it was because their **insurance did not cover it.**

42% of people who could not access **primary care,** and **40%** of people who could not access routine **mental health care**, said it was because they **could not get an appointment.**

42% of people who could not access **emergency care for a mental health crisis** said it was because they **did not know where to go.**

Since the COVID-19 pandemic, equity in access to health care and other resources has worsened for many people in our communities – and longstanding concerns about discrimination remain.

Most people in our focus groups and interviews reported that access to care, services, and information has gotten worse in the last few years. Community members shared they are experiencing longer wait times to get appointments and more difficulty in finding providers for the physical and mental health care they need.

"As the mother of children with disabilities, we are very affected because even if we can get ABA [*applied behavior analysis therapy, used to help people with autism*], the **quality is worse because the companies are short staffed.**"

(translated from Spanish)

"My mental health has been affected, because even if you seek counseling, there's nobody available. You have to be on a list, sometimes waiting 3 years or more for therapy. **This is something that greatly affects the emotional health of the whole community.**"

(translated from Spanish)

Since the COVID-19 pandemic, the uninsurance rate increased in four communities: Malden, Medford, Everett, and Winthrop. However, not all groups within each community were equally affected. According to the U.S. Census Bureau:

In **Malden**, more Asian, Black, and Hispanic residents were **uninsured** in 2022 compared to 2019.

In **Medford**, more Asian and Hispanic residents and non-citizens were **uninsured**, while insurance **coverage increased** among Black and White residents.

In **Everett**, more Hispanic residents were **uninsured**, while insurance **coverage increased** among White residents.

In **Winthrop**, more Black and Hispanic residents and naturalized citizen immigrants were **uninsured** in 2022 compared to 2019.

On the other hand, **the uninsurance rate declined in Chelsea and Somerville.**

The decline in **Chelsea** was driven by greater proportions of Hispanic residents and non-citizens **gaining access to insurance.**

In **Somerville**, Black residents had the greatest **gains in health insurance coverage.**

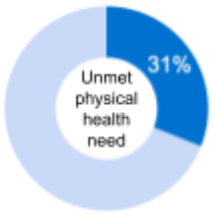
The uninsurance rate did not change much in **Cambridge** or **Revere**.

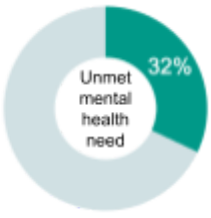
While the data does not tell us *why* uninsurance rates varied in these ways, changes in outreach, eligibility, or other factors may have impacted some groups more than others. For example, during the COVID-19 pandemic, many people in our communities and across the state became eligible for MassHealth – whether because of a job loss, the death of a family member, or other circumstances. MassHealth was not permitted to disenroll people from coverage while the pandemic emergency continued. However, after the emergency was declared over, in April 2023, MassHealth began requiring all members to certify their eligibility.[45]

- Between April 2023 and May 2024, **1.8 million people renewed** their MassHealth coverage, and **898,233 people lost** MassHealth coverage.
- Of those who lost coverage, **67% (~597,100 people) were due to "insufficient information."** Some of these people may have been eligible, but simply did not submit the right paperwork.
- **33% (~286,700 people) lost coverage because they were confirmed to be no longer eligible.** Around 133,000 (46%) enrolled in a Health Connector plan instead.
- **Children had the lowest rate of coverage loss,** due to safeguards put in place by MassHealth to maintain coverage for kids.
- **Overall, the total number of people with MassHealth decreased by 16%, or 363,000 people.** Still, as of May 2024, there were 2,039,000 people with MassHealth, which was 282,000 **more than pre-COVID**. Community outreach efforts helped significantly to prevent coverage loss and connect people to new health insurance options.

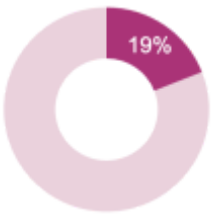
Results from CHA's Community Wellbeing Survey echo the challenge of barriers to access.

Almost one-third of survey participants report that their physical health needs (31%) or mental health needs (32%) are **not being met.**





Almost one in five (19%) report their **insurance plan is unaffordable**.



More than one in five (20%) report their **insurance does not cover the care** they need.

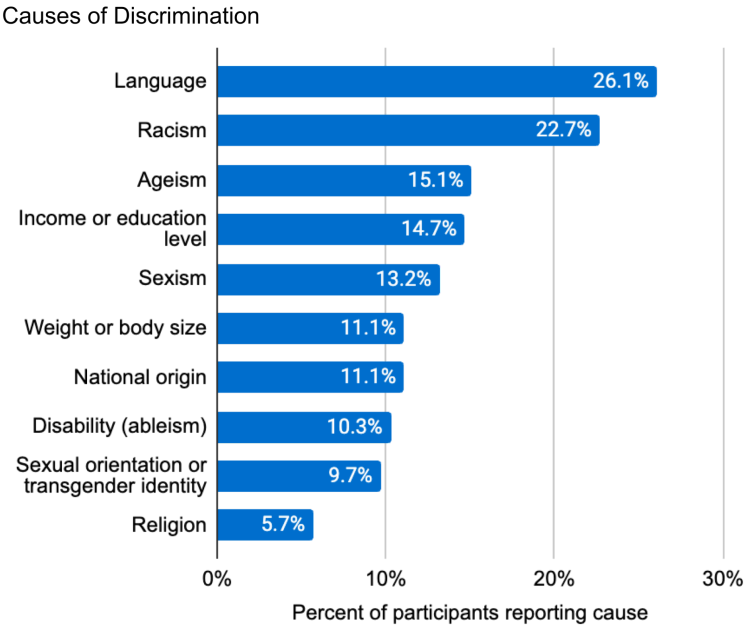
[45] Commonwealth of Massachusetts, Executive Office of Health and Human Services. Final Update on MassHealth Redeterminations. June 2024. https://www.mass.gov/doc/june-2024-redetermination-key-takeaways/download

"We have the elections coming up in a few days. **If someone gets elected who is against immigrants, this will impact so many people in the community.** People are worried about being deported. There's a lot of physical and emotional stress."

"As a non-binary individual, I've faced many challenges. Some healthcare providers do not respect my identity. I have to advocate for myself to get proper healthcare... **It's hard trying to hide, the fear of discrimination or harassment from the people around you."**

Community members also continue to experience discrimination when trying to access resources, including health care, housing, social services, jobs, and other opportunities. In focus groups and interviews, community members expressed how they feel the impact of bias and even hatred due to their identity. Experiencing racism, hearing stories of people being deported, and being treated unfairly because of one's gender, sexual orientation, or disability all have an impact on people's ability to access care, services, and information. In fact, among CHA Wellbeing Survey participants, almost 1 in 6 (15%) report experiencing discrimination from health care providers.

Data Point | Among those reporting discrimination in health care, housing, employment, policing, and other circumstances, **the most common reasons people experienced discrimination** were due to speaking a language other than English (26%) or racism (23%). Other causes of discrimination were also noted, reflecting the wide range of discrimination experiences faced by community members.



Source: CHA Community Wellbeing Survey, 2024

There are significant barriers in access to care for LGBTQIA+ community members and people with disabilities. According to MA Department of Public Health's Community Health Equity Survey, among residents of CHA's service area, 24% of LGBTQIA+ individuals and 26% of disabled individuals experienced an unmet health care need in the past year, compared to 13% of non-LGBTQIA+ individuals and 12% of non-disabled individuals – around double the rate for both groups. 31% of people with disabilities experienced an unmet need for mental health care – more than twice the percentage of non-disabled individuals. In CHA's Wellbeing Assessment focus groups and interviews, LGBTQIA+ and disabled community members emphasized the need for services and systems that are accessible, welcoming, and sensitive to their needs.

Health care, social service, and government systems are complex to navigate – and their capacity is increasingly strained.

Among interview and focus group participants in CHA's Wellbeing Assessment, **the most frequently cited barrier to wellbeing was the design of the very systems meant to provide support.**

Complicated application processes, unclear eligibility criteria, and fragmented service delivery make it difficult to access housing, health care, financial assistance, and other forms of support. Community members described how these structural barriers are especially harmful for immigrants, people with disabilities, people experiencing homelessness, and those with limited English proficiency – **people who may not have the privileges, time, and connections to navigate or work around the system.** Young people, particularly those with immigrant parents, described how the burden of navigating these complex systems can fall on their shoulders – taking on the responsibility of making appointments, navigating resources, interpreting legal or medical documents, and supporting any interactions that require English language skills. There is not enough support for orienting adults, especially immigrants and people who speak languages other than English, to understand how these complex, often confusing systems work.

> "It's the inaccessibility of the system. Anything that a patient has to apply to involves long and complicated applications, waiting in line, following up - **each of these exposes cracks that they fall through.** [...] **You're navigating a system that is designed to check boxes, but not designed to problem solve.**"

At the same time, **service providers are facing increasing levels of strain – being asked to do more with fewer resources.** In focus groups and interviews, community members and health care providers emphasized that people have more complex needs now compared to before the pandemic. Other research affirms their experiences. Some people delayed seeking health care during COVID, which allowed health issues to become more serious.[46, 47] Others developed long COVID, which is still not well understood.[48] Living through a pandemic that caused so much loss led to stress and grief that continue to impact people's mental health.[49]

Community members and health care providers emphasized that health systems do not have enough resources to address these growing, complex needs. **The lack of resources impacts patients and providers alike – and is recognized by both.** Again, other research affirms their experiences. Policies that increased funding to hospitals and public health systems during the pandemic have ended.[50] Some medical providers retired or even

> "Doctors often rush through appointments, and unless it's something really serious, they sometimes act like they just want you to leave. **Having healthcare providers who can take care of their own well-being, so they can take care of us, is a huge hurdle.**"

[46] Smith M, Vaughan Sarrazin M, Wang X, et al. Risk from delayed or missed care and non-COVID-19 outcomes for older patients with chronic conditions during the pandemic. *J Am Geriatr Soc.* 2022 May;70(5):1314-1324. doi: 10.1111/jgs.17722.

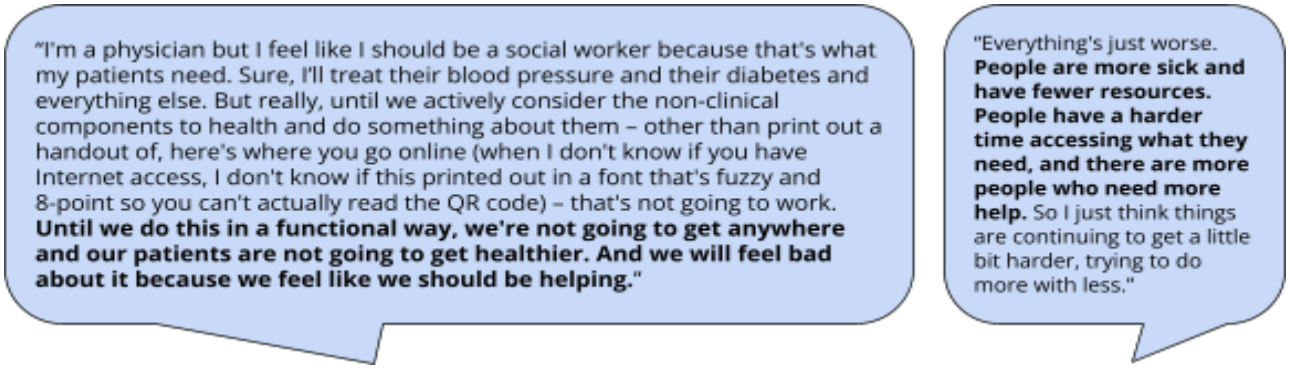
[47] Negoita S, Chen H-S, Sanchez PV, et al. Annual Report to the Nation on the Status of Cancer, part 2: early assessment of the COVID-19 pandemic's impact on cancer diagnosis. Cancer. 2024; 130(1): 117-127. doi:10.1002/cncr.35026

[48] Centers for Disease Control and Prevention. (Feb 3, 2025) CDC Science and the Public Health Approach to Long COVID.

[49] American Psychological Association. (2023) Stress in America 2023: A Nation Recovering from Collective Trauma.

[50] Kates J, Cubanski J, Cox C, Tolbert J. Timeline of End Dates for Key Health-Related Flexibilities Provided Through COVID-19 Emergency Declarations, Legislation, and Administrative Actions. *KFF*, April 28, 2023.

changed careers, as the stress of not being able to meet patients' needs led to increasing rates of burnout.[51] Staff shortages, financial stress, and barriers to providing accessible care combine with increasing burdens of poor mental health, untreated chronic disease, and delays in acute care to place enormous strain on providers' wellbeing and health system capacity.[52] In focus groups and interviews, many people described how there are not enough community, organizational, and government resources to address patients' social, economic, and environmental needs – which are often outside of health care providers' expertise in medicine. These patterns put extra strain on the health system, affect people's health outcomes, and contribute to health inequity.



Investing in systems that center people's humanity – from patients to providers, clients to staff – can increase simplicity, efficiency, and equity.

Community members described the feeling of being unseen, unsupported, and dehumanized by the very systems meant to provide care. For people seeking access to resources, being treated without kindness and respect can erode their sense of worth and hope. For people working in these systems, it is painful to know they cannot help – because of lack of resources, time, or restrictive eligibility requirements for services. Being constantly overwhelmed by needs they cannot meet can lead to a feeling of being dehumanized by the system, too. **Across focus groups and interviews, people spoke about the need for systems and institutions to be designed in ways that are caring, accessible, and grounded in human dignity.**

Even when resources and services exist, people may not be aware of them – due to language barriers, lack of outreach, or confusing communication. For example, participants in one focus group expressed a desire for a 24/7 hotline for urgent mental health needs – not knowing that CHA's community behavioral health urgent care centers offer this service. Other participants in focus groups and interviews emphasized the need for people-centered communication and outreach by going to where people are and tapping into existing communication channels, rather than expecting community members to visit a new website or sign up for an email. **This means building relationships and investing in trusted community connectors.**

[51] Ortega MV, Hidrue MK, Lehrhoff SR, et al. Patterns in Physician Burnout in a Stable-Linked Cohort. JAMA Netw Open. 2023;6(10):e2336745. doi:10.1001/jamanetworkopen.2023.36745
[52] Sullivan EE, Etz RS, Gonzalez MM, et al. Primary Care in Peril: How Clinicians View the Problems and Solutions. *NEJM Catalyst.* 2023;4(6). doi:10.1056/CAT.23.0029

Community members also emphasized that care is not only provided by health care professionals or social service professionals. People also care for one another – through mutual aid, community-rooted healing practices, connecting and coming together in shared spaces and cultural practices, investing in relationships and belonging, and simply helping one another in times of need. **Investing in people as caregivers – not just institutions – is an important element of building systems of collective care.**

One example of a caring system is CHA's Healthcare for the Homeless program. Focus group participants experiencing homelessness described how bringing health care services directly into shelters gives them the time and space to address complex health needs. They described being treated with dignity and respect, and with a true commitment to addressing their concerns.

> "Any health issues you may have, physical, mental, spiritual...**all you need to say is, "this is what is going on, this is what I need help with."** You step forward and speak up about which services you need. It doesn't matter if you are homeless or not."

> **"What would build trust? Having, not really a special treatment, but having just the same care.** Take for example, if there's a form that you fill out, with a list of gender identities. It gives me peace to see, okay, I am being recognized for who I am. It's encouraging to see, yes, I am welcomed here."

Efforts to improve systems at CHA are rooted in the goal of improving equity in access. In 2023, CHA began a process of becoming a high-reliability organization,[53] with the goal of increasing patient safety. This journey has involved streamlining systems, creating new standards, and embedding a culture of safety into all levels of the organization. CHA developed a Health Equity Strategic Plan to set specific equity goals, including to improve quality, safety, and patient experience in behavioral health, hypertension (high blood pressure), and maternal health, and to improve care for patients with disabilities and language access needs. CHA is also working to improve its facilities and expand its presence in the community, bringing care directly to people. All of these improvements involve opportunities to make systems simpler, more efficient, and more equitable – by centering the voices of the people directly impacted by these systems.

> "I had a conversation with somebody yesterday about, all right, you're not taking your blood pressure medications and haven't been for a year and a half, why? Do you understand why we care about high blood pressure? **And when I actually took the five minutes to explain this could cause a heart attack or stroke or kidney failure, she's like okay, that's important. Just taking the moment to understand where people are."**

> "I'd like to see people be kinder. Just navigating these systems, kindness goes a long way. Demonstrating an interest in understanding the person you're talking to, the problem, validating their fears and challenges, even if you can't solve the problem, **can make someone feel held and supported in a broken system."**

[53] A High-Reliability Organization (HRO) is one with culture and systems that enable it to operate in complex, high-risk environments while consistently achieving high levels of safety and performance. To learn more, visit https://psnet.ahrq.gov/primer/high-reliability

Community Voices:

Ideas for Improving Equity in Access to Care, Services, and Information

- **Expand programs to help people navigate the health care system – no matter who they are or what language they speak.** Programs that position Community Health Workers, patient navigators, health educators, and social workers to accompany people through the health care system can play a critical role in helping people access the care they need.
- **Ensure language justice across all sectors**. Equitable language access is not just a matter of convenience – it is a matter of inclusion and equity. Across our communities, services should be designed to welcome residents who speak common languages like Portuguese, Spanish, and Haitian Creole, as well as languages spoken less commonly. This includes offering high-quality interpretation and translation services, multilingual signage and materials, and staff who reflect the linguistic diversity of the population.
- **Engage in proactive outreach.** Many residents noted that even when there are resources available, many people do not know they are out there. Door-knocking campaigns, phone calls, and events in different languages can help make sure everyone knows what is available. This kind of outreach builds trust and helps connect people who might otherwise feel left out or unsure where to turn.
- **Simplify systems.** As important as it is to have support for navigating complex systems, it is equally important to make those systems as simple as possible. Having simpler processes would help to reduce confusion and delays for community members.
- **Embed services in trusted community spaces such as schools, libraries, and housing developments.** It's easier for people to get help when services are located in places they already go and feel safe. Setting up clinics, support services, or drop-in hours in community spaces helps remove barriers like transportation, time, or fear of being judged.
- **Invest in non-clinical staff and care navigators who reflect the communities they serve.** A diverse, culturally responsive workforce can strengthen the community through providing good jobs, while also improving patient experience and outcomes.
- **Strengthen partnerships between health care systems and community-based organizations to build trust and improve outreach.** Community groups often know the people they serve better than large hospitals or city offices do. When hospitals and city services work together with local groups, they can learn more, build trust, and make their programs stronger.
- **Provide care and services in ways that affirm all patients regardless of age, race or ethnicity, gender identity, sexual orientation, or housing status.** Health care providers, social service providers, municipal staff, and others must be committed to non-discrimination. Institutions must be held accountable to ensuring non-discriminatory practices and policies.

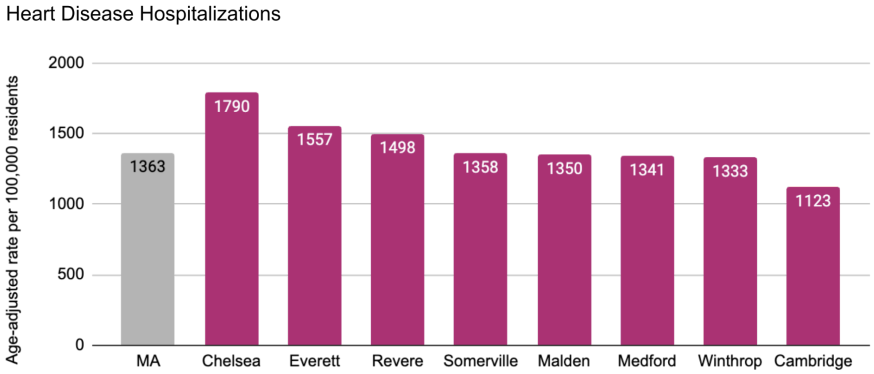
Health Spotlight: Chronic Diseases

Chronic diseases are the leading cause of preventable death and disability in the United States.[54] Conditions such as heart disease, cancer, and diabetes are common within our communities and are linked to factors such as lack of physical activity, poor nutrition, smoking, and excessive alcohol use.[55] These individual risk factors are influenced by conditions in our communities, like whether nutritious food is affordable and available, and whether we have safe places to walk and exercise.[56,57] Chronic diseases have also been associated with toxins in the environment.[58]

Equity in access to care is essential for preventing and managing chronic diseases. Regular access to primary care can help prevent people from developing common chronic diseases. Routine screenings – such as blood pressure checks, mammograms, and colonoscopies – can catch some chronic diseases early, allowing for treatment before they become more serious. However, not all chronic diseases can be prevented and some, like autoimmune disorders, long COVID, depression, and fibromyalgia, are not well understood.[59, 60] Access to primary and specialty care, medication, counseling, and treatment options can help people living with chronic diseases to enjoy a high quality of life and prevent harmful outcomes.

Heart Disease

Data Point | The 5-year average age-adjusted rates of **hospitalizations due to heart disease** are higher than the statewide average in Chelsea, Everett, and Revere. In all other communities, the heart disease hospitalization rate is similar to or lower than the state average.



Source: Center for Health Information and Analysis (CHIA), Massachusetts Acute Hospital Case Mix Database, 2017-2021 5-Year Annual Averages.

[54] Hacker K. The Burden of Chronic Disease. *Mayo Clinic Proceedings: Innovations, Quality & Outcomes.* 2024;8(1):112-119.
[55] U.S. Centers for Disease Control and Prevention. About Chronic Diseases. October 4, 2024.
[56] American Public Health Association. *Addressing Environmental Justice to Achieve Health Equity*. November 4, 2019.
[57] Munzel T, Hahad O, Sorensen M, et al. Environmental risk factors and cardiovascular diseases: a comprehensive expert review. *Cardiovascular Research.* 2022;118(14):2880-2902.
[58] National Cancer Institute. *Cancer Trends Progress Report: Chemical and Environmental Exposures*. April 2025.
[59] Global Autoimmune Institute. Breaking the Silence: Navigating Stigma and Shared Challenges in Long Covid and Autoimmune Disease. January 24, 2024.
[60] Smyth NJ, Blitshteyn S. Language Matters: What Not to Say to Patients with Long COVID, Myalgic Encephalomyelitis/Chronic Fatigue Syndrome, and Other Complex Chronic Disorders. Int J Environ Res Public Health. 2025;22(2):275.

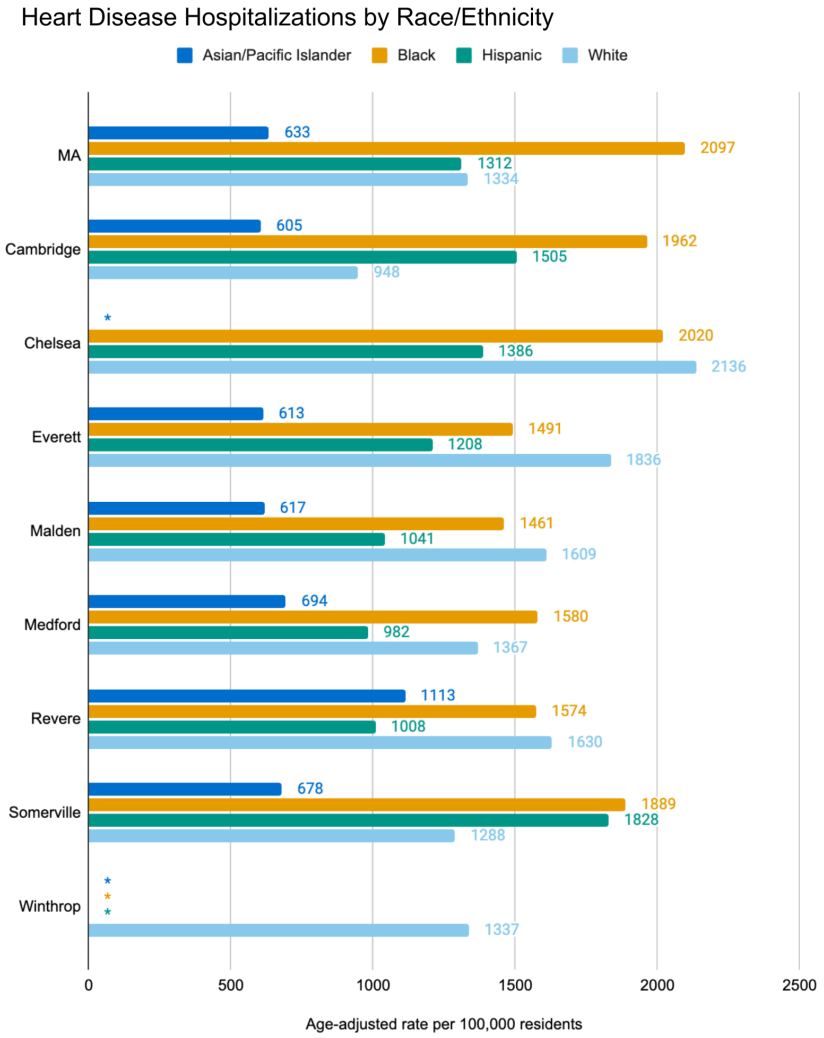
Equity Lens | People in our communities are not impacted equally by heart disease. In most of our communities, Black and White residents have higher **heart disease hospitalization** rates compared to Asian/Pacific Islander and Hispanic residents.

Source: Center for Health Information and Analysis (CHIA), Massachusetts Acute Hospital Case Mix Database, 2017-2021 5-Year Annual Averages.

Notes: * indicates there were fewer than 10 hospitalizations on average each year, so statistics could not be reported.

Among CHA patients, disparities in hypertension (high blood pressure) – a risk factor for heart disease – inspired CHA to launch a **Hypertension Initiative**.

Learn more: www.challiance.org/hypertension



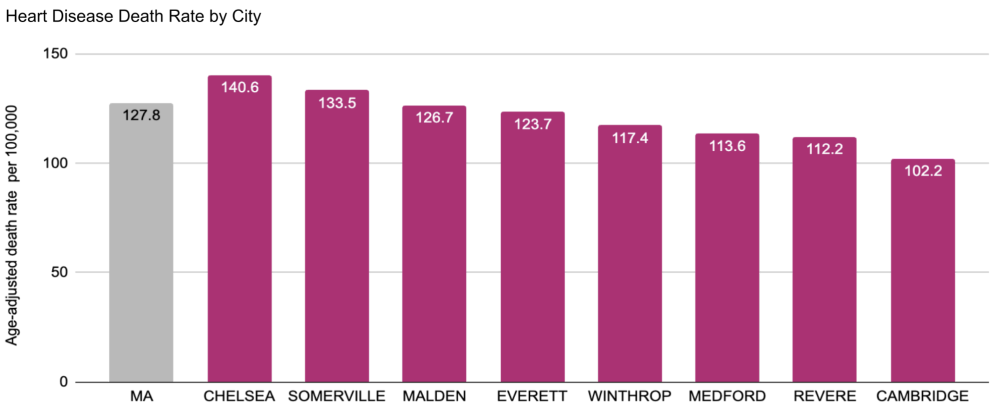
In our communities…

Black residents are hospitalized for heart disease at **higher** rates than other racial and ethnic groups residents in **Cambridge, Somerville, and Medford.** In all of our communities, Black residents are hospitalized at **lower** rates compared to Black residents of **MA** overall.

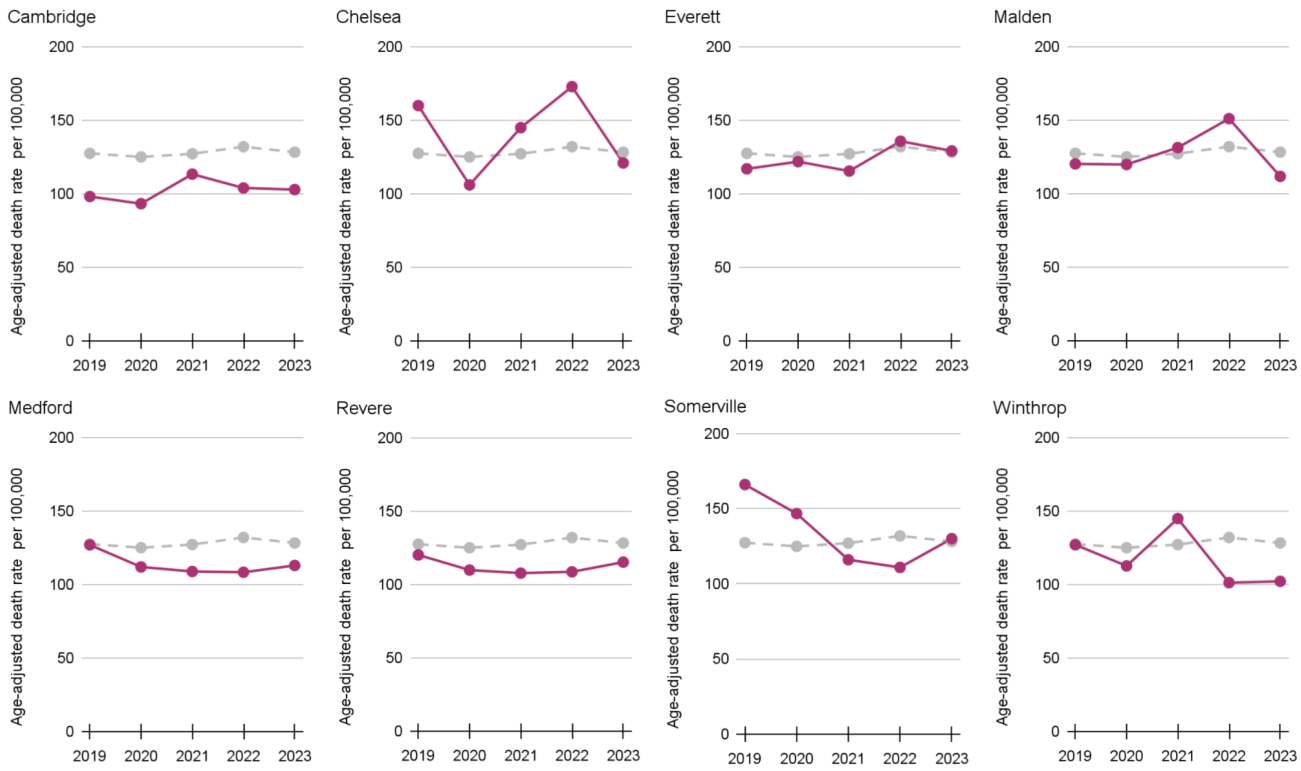
White residents are hospitalized for heart disease at **higher** rates than other racial and ethnic groups in **Chelsea, Everett, Malden, Revere, and Winthrop**. In each of these communities plus **Medford,** they are hospitalized at **higher** rates compared to White residents of **MA** overall.

Hispanic residents of **Cambridge, Chelsea, and Somerville,** and **Asian/Pacific Islander** residents of **Medford, Revere**, and **Somerville** have relatively **higher** heart disease hospitalization rates compared to **MA** averages for their same racial or ethnic group.

Data Point | Heart disease is the second leading cause of death in Massachusetts and in our communities. Compared to statewide average, 5-year average age-adjusted **heart disease mortality rates** are higher in Chelsea and Somerville. In all other communities, heart disease mortality rates are similar to or lower than the state average.

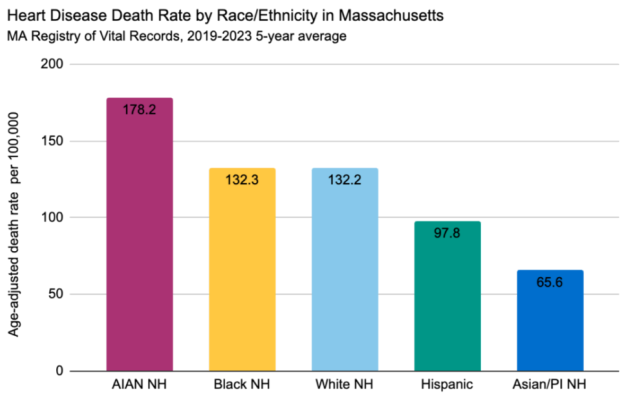


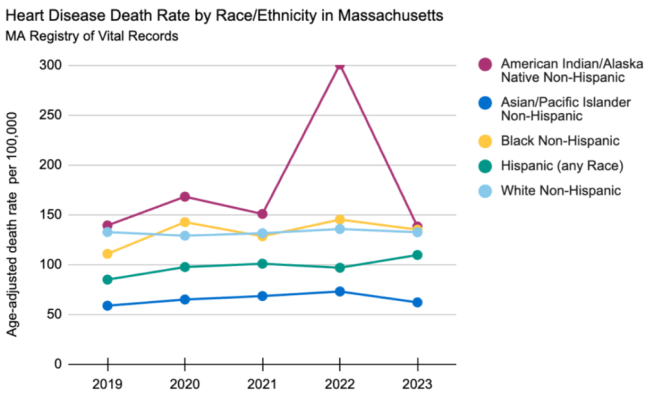
In most of our communities, heart disease mortality rates declined from 2019 to 2023. Rates increased slightly in Cambridge (by 4.8%) and more significantly in Everett (by 10%).



Source: Massachusetts Registry of Vital Records and Statistics, Selected Causes of Death, 2019-2023.
Notes: In each line chart, a gray dotted line represents the age-adjusted rate for the state of Massachusetts.

Equity Lens | In Massachusetts overall, the 5-year average **heart disease mortality rate is highest among American Indian/Alaska Native (AIAN) residents and lowest among Asian/Pacific Islander residents.** Rates did not change significantly for people of these groups from 2019 to 2023, nor for White residents. However, heart disease mortality rates **increased by 22% among Black residents** and by **29% among Hispanic residents.**





Data Source: Massachusetts Registry of Vital Records and Statistics, Selected Causes of Death, 2019-2023.

Notes: Mortality rates by racial/ethnic group are not available at the municipal level due to small numbers. Mortality rates at the state level are not available for racial/ethnic groups other than those identified in these charts due to small numbers. The American Indian/Alaska Native group is relatively small, so small changes in the number of deaths can result in large changes in annual rates.

Cancer

According to the Massachusetts Cancer Registry, more than 9,900 people across our communities were diagnosed with cancer between 2016 to 2020 – a 2.8% decline compared to 10 years ago. Among females, the most common cancers were breast cancer and lung cancer. Among males, the most common cancers were prostate cancer and lung cancer.

Key Term

Standardized Incidence Ratio (SIR) | A measure used to describe how the *observed* number of new cancer cases in a city compares to what would be *expected*. The measure is based on the city's population distribution by sex and age, and the corresponding Massachusetts statewide incidence rates for each cancer type. SIRs should only be used in comparison to the state. It is *not* valid to compare SIRs between communities.

To understand how the burden of cancer in each community compares to the statewide average, the MA Cancer Registry uses a measure called a ***Standardized Incidence Ratio (SIR)***. The tables below display the number of males and females in our communities who were diagnosed with cancer, including the six most common cancers, between 2016 and 2020. **Orange** indicates the number of diagnoses is **statistically significantly higher** than what would be expected, given statewide incidence rates**. Green** indicates it is **statistically significantly lower** than expected**. No color** indicates it is **not statistically significantly different** than expected.

Number of People Diagnosed with Six Most Common Cancers

	Cambridge	Chelsea	Everett	Malden
Females				
Cancer (all sites)	1015	365	432	718
Breast (invasive)	344	78	111	226
Lung cancer	105	52	68	112
Breast (in situ)	69	21	36	69
Uterine cancer	70	38	22	54
Colorectal cancer	56	20	26	47
Thyroid cancer	63	29	31	37
Males				
Cancer (all sites)	931	350	386	732
Prostate cancer	273	69	91	151
Lung Cancer	101	55	64	122
Colorectal cancer	66	38	31	86
Bladder cancer	62	26	23	41
Kidney cancer	35	17	22	36
Non-Hodgkin Lymphoma	41	20	21	32

	Medford	Revere	Somerville	Winthrop
Females				
Cancer (all sites)	758	794	677	335
Breast (invasive)	230	193	204	97
Lung cancer	124	162	81	50
Breast (in situ)	79	51	54	13
Uterine cancer	51	53	52	23
Colorectal cancer	47	50	44	25
Thyroid cancer	29	42	48	14
Males				
Cancer (all sites)	780	698	657	296
Prostate cancer	164	128	148	51
Lung Cancer	97	104	83	57
Colorectal cancer	68	57	53	26
Bladder cancer	49	63	51	29
Kidney cancer	42	43	28	13
Non-Hodgkin Lymphoma	42	33	32	12

Source: Massachusetts Cancer Registry, Cancer Incidence in Massachusetts, City/Town Supplement, 2016-2020.

Notes: The MA Cancer Registry reports cancer statistics by male or female sex. Statistics based on gender identity are not available. **Orange** indicates the number of diagnoses is **statistically significantly higher** than expected**. Green** indicates it is **statistically significantly lower** than expected**. No color** indicates it is **not statistically significantly different** than expected.

While many people in our communities face cancer, the number of diagnoses for most of these six common cancers is not statistically significantly different from what would be expected based on statewide rates – and in some cases, rates are better than expected. However, **uterine cancer** rates are higher than expected for females in Chelsea. **Lung cancer** rates are higher than expected for males in Malden and Winthrop, and females in Revere. **Colorectal cancer** rates are higher than expected for males in Malden. **Breast (in situ) cancer** rates are higher than expected for females in Revere.

There are a few less common cancers where the numbers of people diagnosed between 2016 and 2020 were also statistically significantly higher than expected. These are displayed in the Additional Cancers of Concern table.

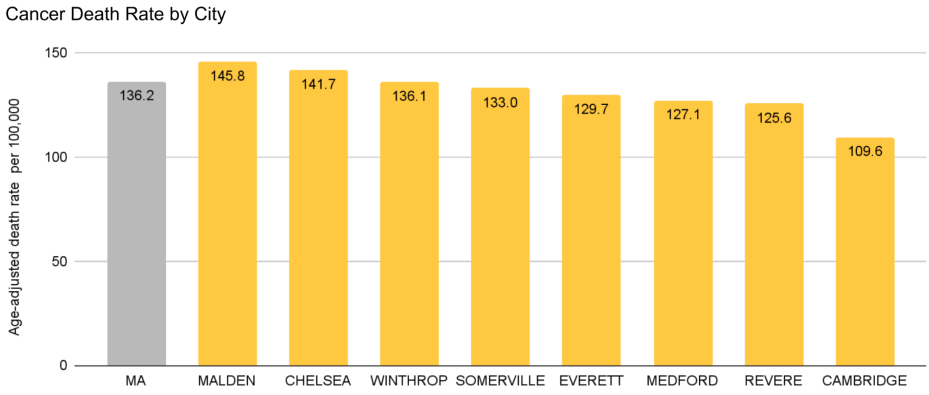
Source: Massachusetts Cancer Registry, Cancer Incidence in Massachusetts, City/Town Supplement, 2016-2020.

Notes: The MA Cancer Registry reports cancer statistics by male or female sex. Statistics based on gender identity are not available. **Orange** indicates the number of diagnoses is **statistically significantly higher** than expected.

Number of People Diagnosed with Additional Cancers of Concern

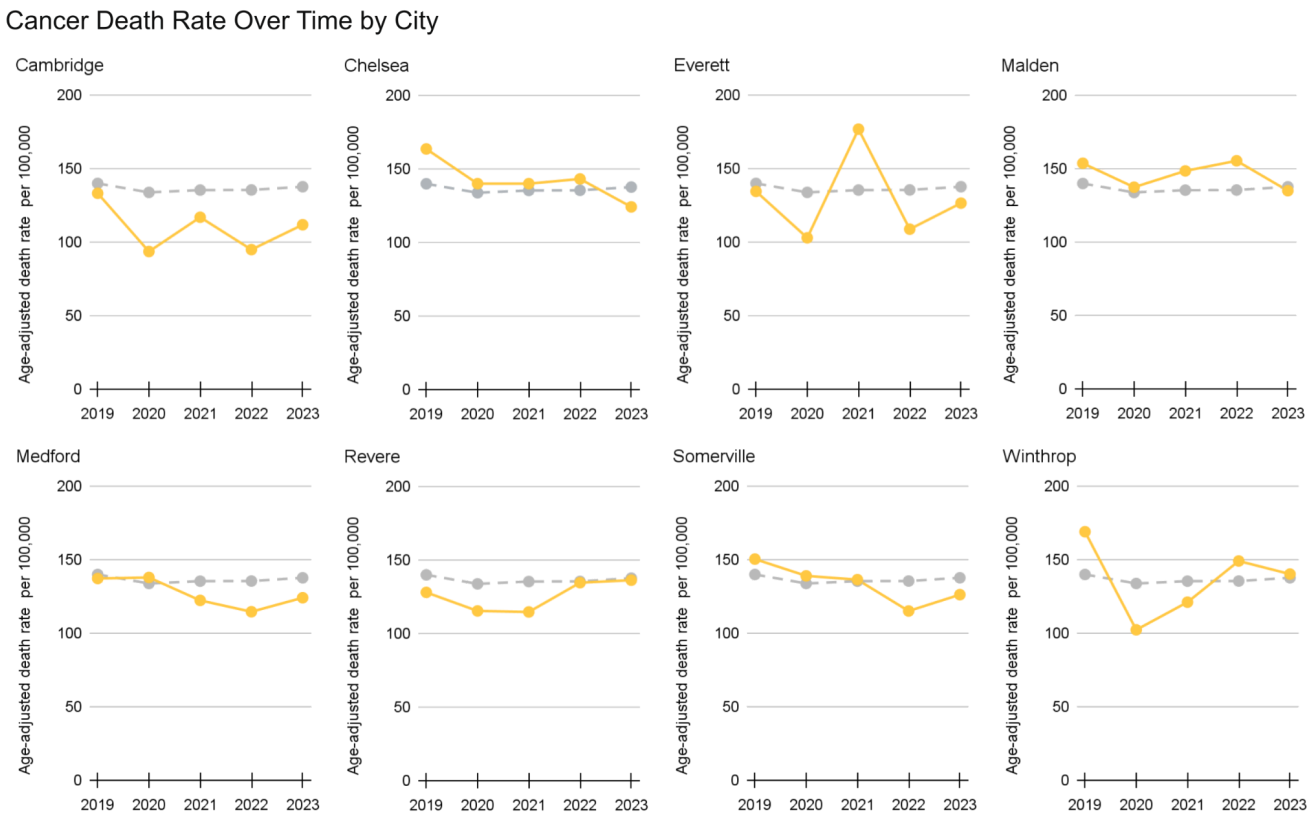
Chelsea	
Cervical cancer (Females)	13
Stomach cancer (Males)	15
Liver cancer (Males)	20
Revere	
Liver cancer (Males)	35

Data Point | Cancer is the leading cause of death in Massachusetts and in our communities. Compared to the statewide average, the 5-year average age-adjusted **cancer mortality** rate is higher in Malden and Chelsea. In all other communities, the cancer mortality rate is similar to or lower than the state average.



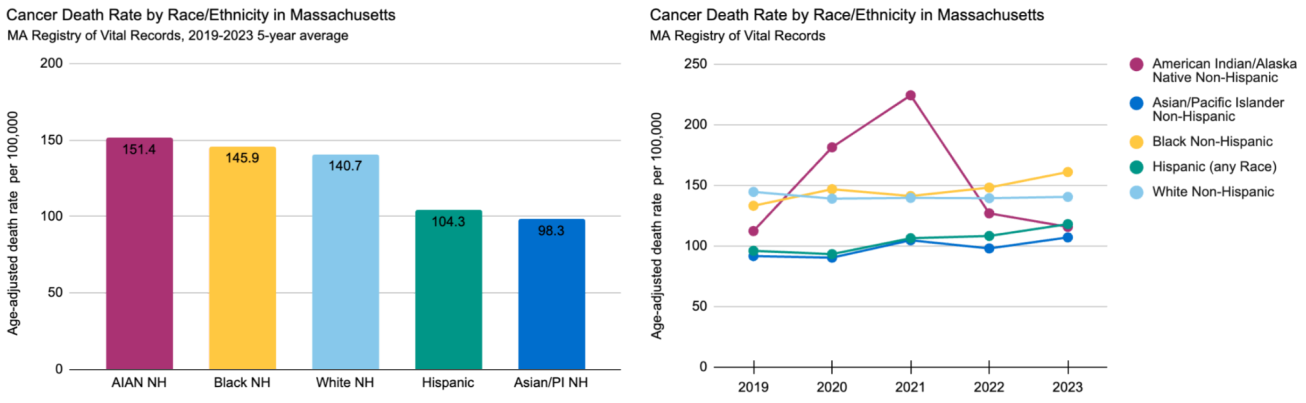
Source: Massachusetts Registry of Vital Records and Statistics, Selected Causes of Death, 2019-2023.

In most of our communities, cancer mortality rates declined from 2019 to 2023. Most notably, the cancer death rate declined by 24% in Chelsea, 17% in Winthrop, 16% in Somerville, and 12% in Malden. On the other hand, the cancer death rate increased by 6.5% in Revere over this period.



Source: Massachusetts Registry of Vital Records and Statistics, Selected Causes of Death, 2019-2023.
Notes: In each line chart, a gray dotted line represents the age-adjusted rate for the state of Massachusetts.

Equity Lens |In Massachusetts overall, the 5-year average age-adjusted **cancer mortality rate is highest among American Indian/Alaska Native (AIAN), and lowest among Asian/Pacific Islander residents.** From 2019 to 2023, cancer mortality increased among Asian/Pacific Islander residents, Hispanic residents, and Black residents. Mortality remained about the same for White residents. **As of 2023, cancer mortality is highest among Black residents.**

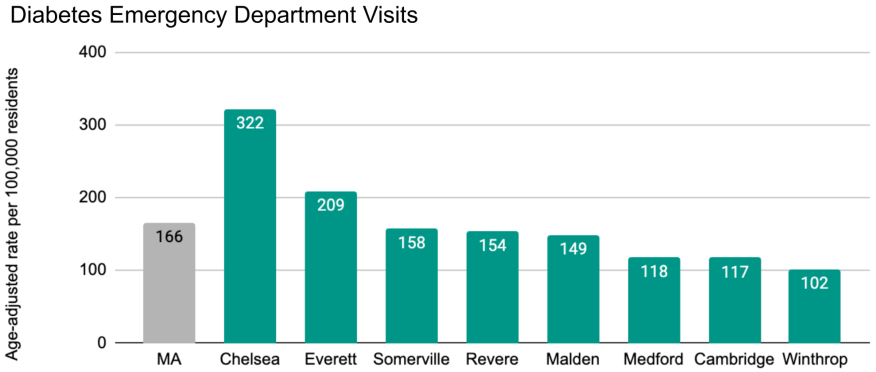


Source: Massachusetts Registry of Vital Records and Statistics, Selected Causes of Death, 2019-2023.

Notes: Mortality rates by racial/ethnic group are not available at the municipal level due to small numbers. Mortality rates at the state level are not available for racial/ethnic groups other than those identified in these charts due to small numbers. The American Indian/Alaska Native group is relatively small, so small changes in the number of deaths can result in large changes in annual rates.

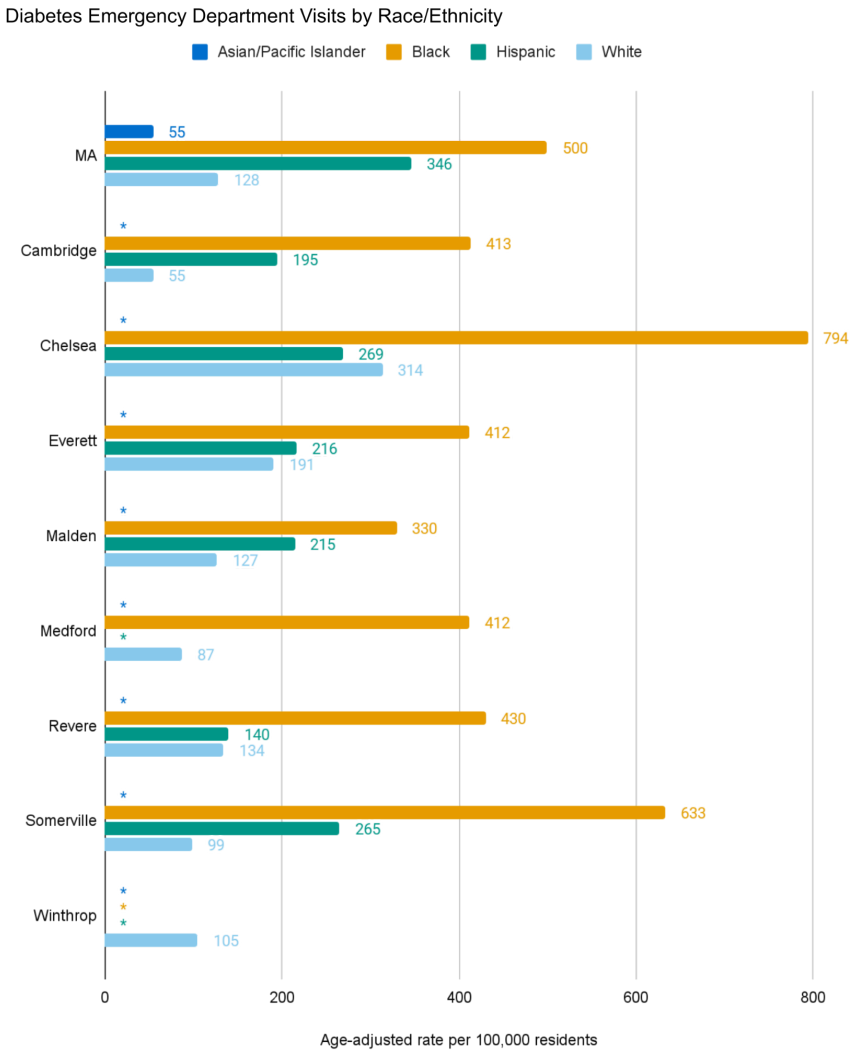
Diabetes

Data Point | Compared to the statewide average, the 5-year average age-adjusted rate of **emergency department (ED) visits due to diabetes** is higher in Chelsea and Everett. In all other communities, the diabetes hospitalization rate is similar to or lower than the state average.



Equity Lens | In most of our communities, **Black and Hispanic residents have higher diabetes emergency department visit rates** compared to White residents.

For Black residents, diabetes ED visits reflect the widest disparities of all health outcome measures we reviewed. In Cambridge and Somerville, rates are 6-7 times higher among Black residents compared to White residents. In Medford, rates are almost 5 times higher. In Revere, rates are more than 3 times higher. In Chelsea, Everett, and Malden, rates are 2-2.5 times higher.



Source: Center for Health Information and Analysis (CHIA), Massachusetts Acute Hospital Case Mix Database, 2017-2021 5-Year Annual Averages.

Notes: * indicates there were fewer than 10 ED visits on average each year, so statistics could not be reported.

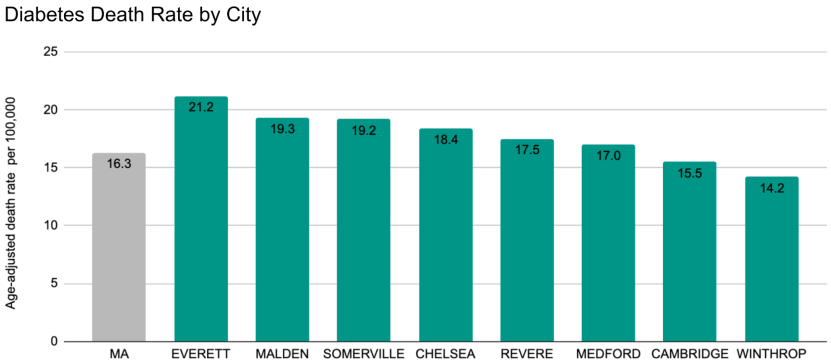
In our communities…

Black residents visit the ED for diabetes at **higher** rates than other racial and ethnic groups in **Cambridge, Chelsea, Everett, Malden, Medford, Revere and Somerville.** Rates are **lower** compared to Black residents of **MA** overall, except in Chelsea and Somerville.

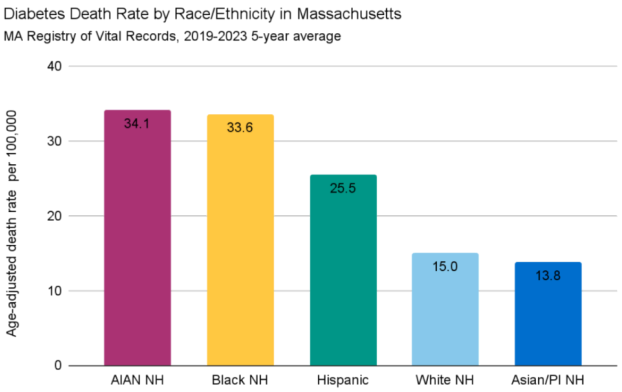
Hispanic residents visit the ED for diabetes at **higher** rates than White residents in **Cambridge**, **Everett, Malden, Revere, and Somerville**. In each of these communities**,** they visit the ED at **lower** rates compared to Hispanic residents of **MA** overall.

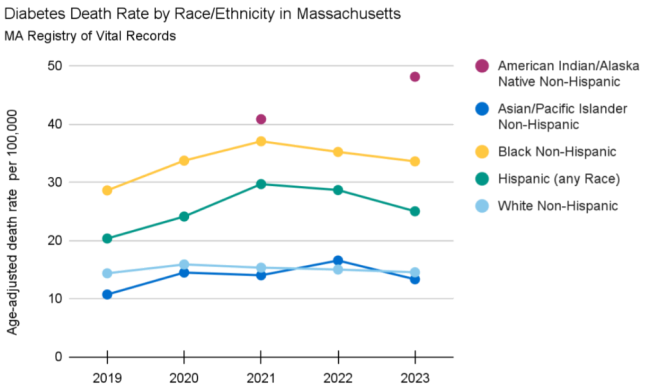
White residents of **Chelsea** visit the ED for diabetes at **higher** rates than Hispanic residents. In **Chelsea and Everett**, they visit the ED at **higher** rates compared to White residents of **MA** overall.

Data Point | The 5-year average age-adjusted **diabetes mortality** rate is lower overall compared to heart disease and cancer. However, rates are higher than the MA average in Everett, Malden, Somerville, Chelsea, Revere, and Medford.



Equity Lens | In Massachusetts overall, 5-year average **diabetes mortality rates are highest among American Indian/Alaska Native (AIAN) and Black residents**. From 2019 to 2021, **racial and ethnic disparities in diabetes mortality grew**, as rates increased among Black, Hispanic, and Asian residents and stayed stable among White residents. Even with recent declines in diabetes deaths among communities of color, diabetes mortality rates were **2.3** times higher among Black residents and **1.7** times higher among Hispanic residents compared to White residents in 2023.





Source: Massachusetts Registry of Vital Records and Statistics, Selected Causes of Death, 2019-2023.

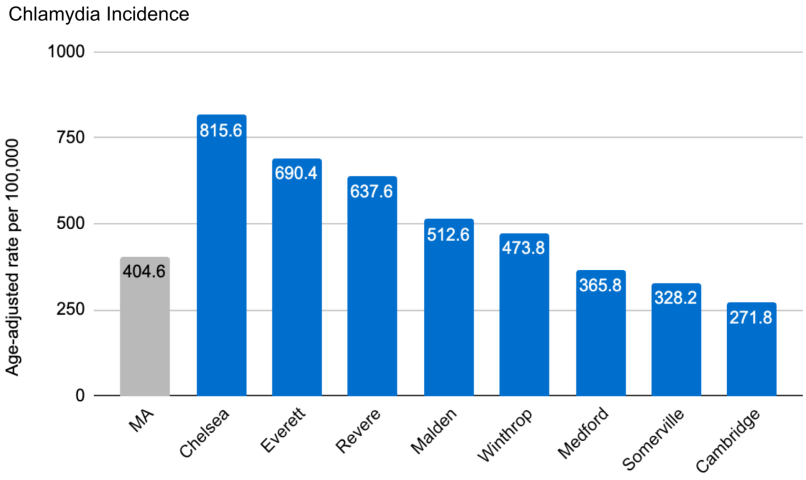
Notes: Mortality rates by racial/ethnic group are not available at the municipal level due to small numbers. Rates for the American Indian/Alaska Native group were not available for all years due to data suppression, but the 5-year average could be calculated.

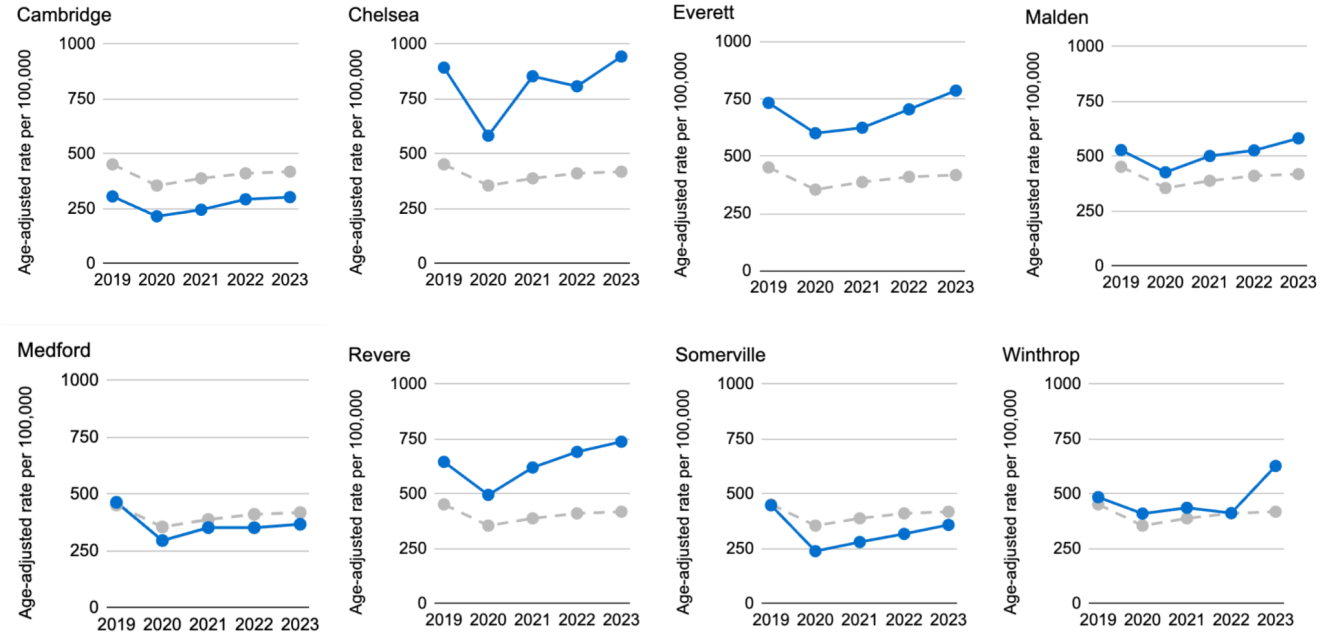
Health Spotlight: Sexually Transmitted Infections (STIs)

Chlamydia, gonorrhea, and syphilis rates have risen in our communities since 2020. In our communities and across the country, access to STI testing declined during the first year of the COVID-19 pandemic, leading to a drop in diagnosed STIs. While STI testing has expanded in the years since, increased testing alone does not fully explain the increases in diagnoses.

Overall, chlamydia is the most common STI, followed by gonorrhea. Syphilis is less common, but is an important public health concern. For all three STIs, rates have been notably higher in Chelsea compared to other communities, though Everett, Revere, and Malden also trend fairly high.

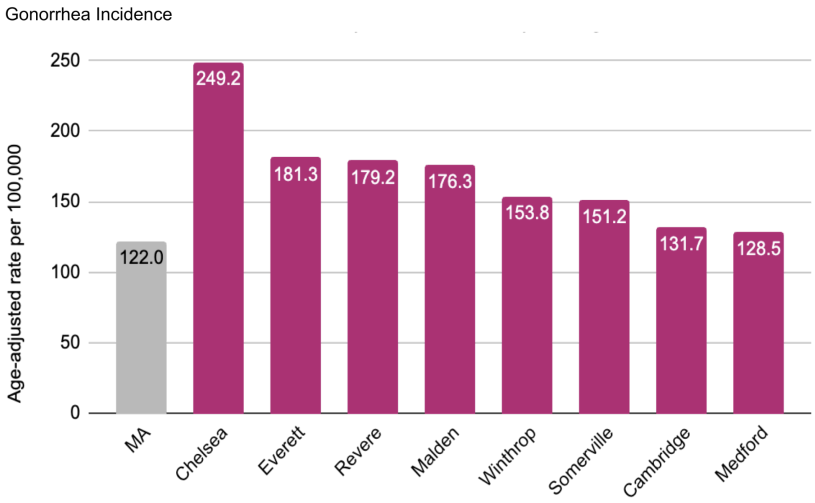
Data Point | The 5-year average age-adjusted incidence rates for **chlamydia** are higher than the statewide average in Chelsea, Everett, Revere, Malden, and Winthrop – where chlamydia diagnoses exceed pre-pandemic (2019) levels as of 2023. Rates are still lower than pre-pandemic in Cambridge, Medford, and Somerville, but have also been rising since 2020.

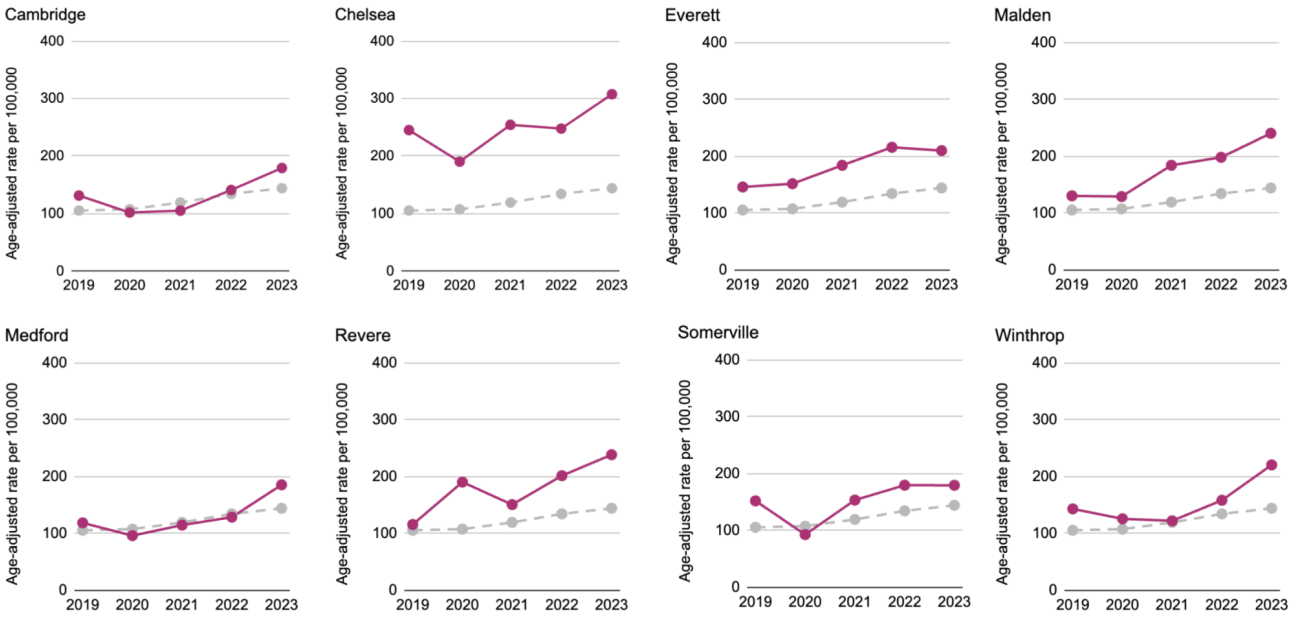




Source: MA Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, Surveillance Division, 2019-2023
Notes: In each chart, a gray dotted line represents the age-adjusted rate for the state of Massachusetts.

Data Point | The 5-year average age-adjusted incidence rates for **gonorrhea** are higher than the statewide average in all our communities. As of 2023, gonorrhea diagnoses exceed pre-pandemic (2019) levels in all of our communities – and at the state level. Rates may be leveling off in Everett and Somerville, but continue to increase in all other communities.



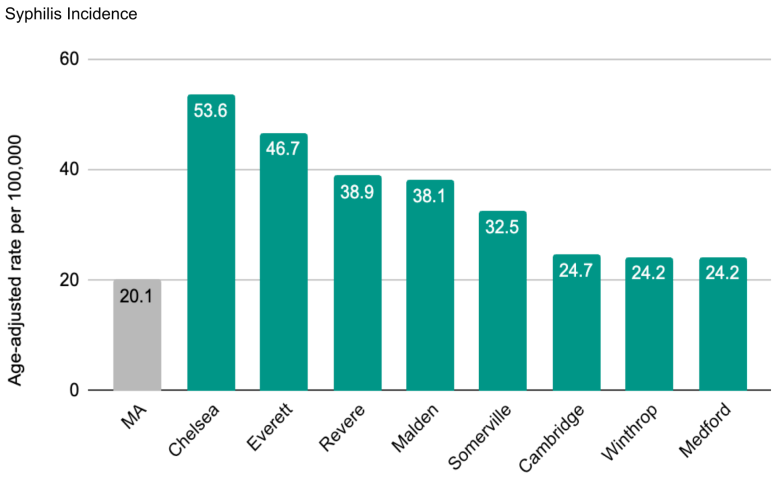


Source: MA Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, Surveillance Division, 2019-2023
Notes: In each chart, a gray dotted line represents the age-adjusted rate for the state of Massachusetts.

In Massachusetts overall, gonorrhea incidence rates are now 37% higher than pre-pandemic. In Revere, rates are now more than 2 times higher – the largest increase of any of our communities. The next largest increases were in Malden (84% higher), Medford (56% higher), and Winthrop (54% higher). Other communities saw smaller, but still notable increases: Everett (44% higher), Cambridge (37% higher), Chelsea (26% higher), and Somerville (18% higher).

Data Point | The 5-year average age-adjusted incidence rates for **syphilis** are higher than the statewide average in all of our communities. As of 2023, syphilis diagnoses now exceed pre-pandemic (2019) levels in Cambridge, Chelsea, Malden, Revere, and Somerville – as well as at the state level.

Source: MA Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, Surveillance Division, 2019-2023



In Massachusetts overall, syphilis incidence rates are now 17% higher than pre-pandemic. In Chelsea, rates are now 95% higher – the largest increase of any of our communities. The next largest increases were in Somerville (50% higher), Revere (47% higher), Malden (39% higher), and Cambridge (12% higher). Rates declined in Everett (12% lower) and Medford (13% lower).[61]

Equity Lens | While racial and ethnic data are not available for chlamydia and gonorrhea, 5-year average age-adjusted **syphilis rates are significantly higher** among Black and Hispanic residents compared to White residents in many of our communities.

Source: MA Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, Surveillance Division, 2019-2023

Notes: *Case counts less than 5 are suppressed for confidentiality purposes, so statistics cannot be calculated for Asian residents across communities, nor for Black residents of Winthrop.

Syphilis Incidence *(compared to White)*

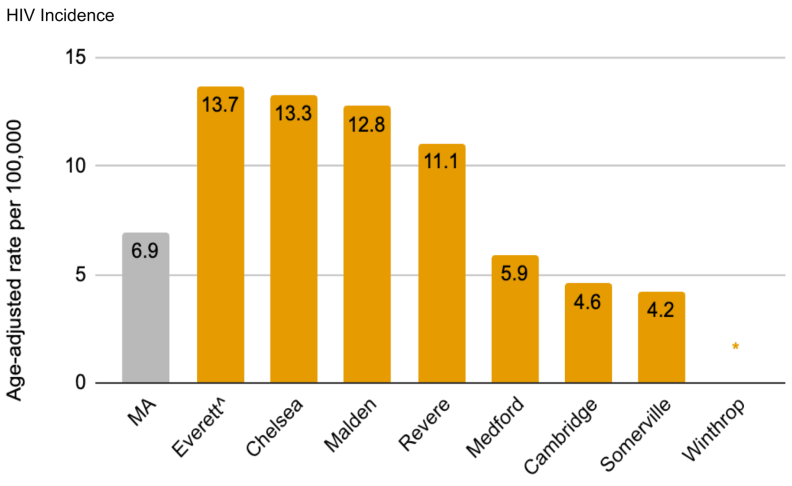
	Black	Hispanic
MA	3.8x higher	3.6x higher
Cambridge	2.6x higher	2.0x higher
Chelsea	1.8x higher	Equal
Everett	1.3x higher	3.5x higher
Malden	50% lower	4.3x higher
Medford	2.9x higher	5.5x higher
Revere	1.9x higher	1.9x higher
Somerville	2.3x higher	3.5x higher
Winthrop	*	4.6x higher

Nationally, more than 2.4 million cases of chlamydia, gonorrhea, and syphilis were reported in 2023. This included over 1.6 million cases of chlamydia, more than 600,000 cases of gonorrhea, and over 209,000 cases of syphilis. Between 2019 and 2023, national chlamydia rates decreased by 10.7% and gonorrhea by 4.4%, while syphilis rates rose sharply – by 57.8%, primarily driven by cases in women and newborn infants (called congenital syphilis).[62] In many of our communities, rates have increased for all three STIs, in contrast to national trends.

[61] A statistic could not be calculated for Winthrop, as data were suppressed for 2019 because there were fewer than 5 people diagnosed with syphilis that year.

[62] Centers for Disease Control and Prevention. Sexually Transmitted Infections Surveillance, 2023. Table 2. Trends in Reported Cases and Rates of Reported Cases for Nationally Notifiable STIs, United States. November 12, 2024.

Data Point | New HIV diagnoses are now less common than other STIs. However, **5-year average age-adjusted HIV incidence rates** are higher than the statewide average in Chelsea, Everett, Malden, and Revere. As of 2023, HIV incidence rates are lower than pre-pandemic (2019) in all of our communities except Somerville – on the other hand, rates are slightly higher at the state level compared to pre-pandemic.



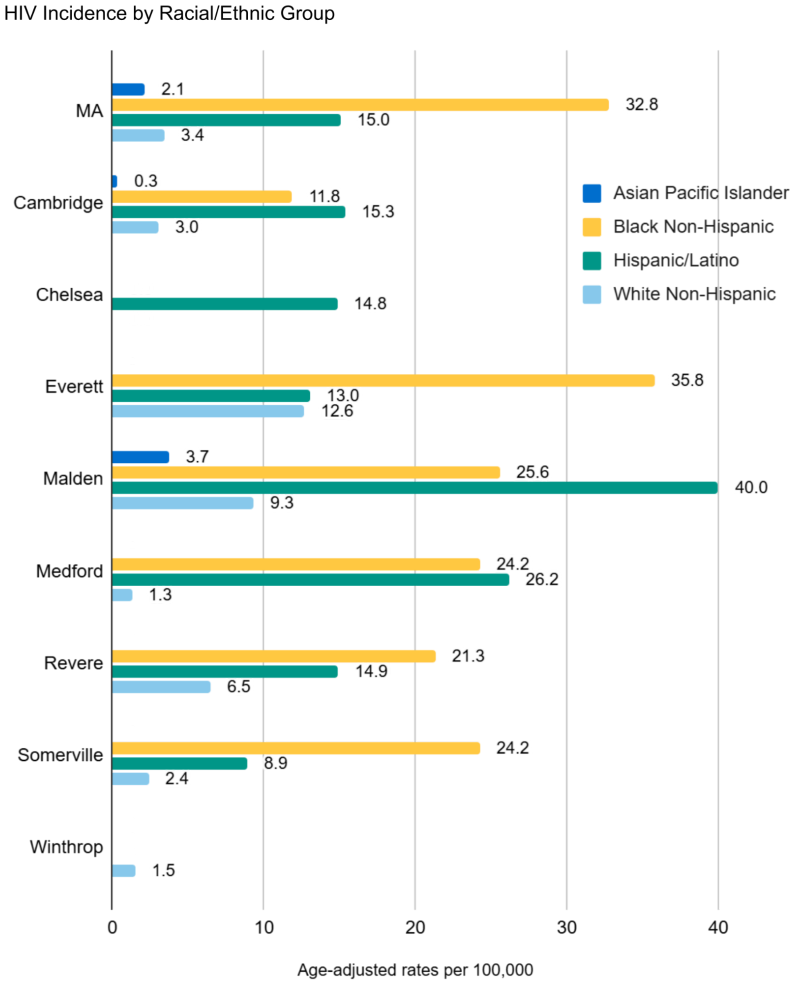
Source: MA Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, Surveillance Division, 2019-2023

Notes: The 5-year HIV incidence rate for Everett (^) may be under-estimated, as data were suppressed for 2022 because there were fewer than 5 people diagnosed with HIV that year. No statistic could be calculated for Winthrop because there were fewer than 5 people diagnosed with HIV in each year of the 5-year reporting period.

Equity Lens | There are wide **racial and ethnic disparities in HIV incidence** within our communities, with HIV rates generally higher among Black and Hispanic residents compared to White and Asian residents. This trend can be seen when looking at statewide HIV incidence rates as well. A notable exception is in Everett, where rates are also relatively high among White residents.

Source: Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, 2019-2023.

Notes: Data are suppressed for counts <5. In several communities, fewer than five diagnosed cases of HIV were reported among certain racial and ethnic groups, which is why certain rates are not shown for Chelsea, Everett, Medford, Revere, Somerville, and Winthrop.



Sharing Our Stories: Falling Through the Gaps

When access to care, services, or information is unequal, it can lead to unequal health outcomes. Many people in our interviews and focus groups shared stories of falling through the gaps in the social service and health care systems. One health care provider shared a story of a patient* whose experience illustrates the challenge of ensuring equity in access.

I have a patient right now who has lived in the US for over 20 years. He has always worked in construction. But in the last 6 months, he developed some medical conditions. He's been hospitalized several times, and the issues have become chronic. He's following up with 3-4 doctors a week. Now, he can't work. He has zero income. He has no family support and hasn't paid rent in 2 months. He has already used RAFT rental assistance funds, so he can't access that again this year. He gets SNAP benefits, so he can afford food – but he's in a rooming house and doesn't have access to a kitchen, microwave, or hot plate. A medically tailored meals program would be perfect, and he would benefit from nutrition education – but without a microwave, the program won't even enroll him.

A lack of resources is exacerbating his medical issues. He has already applied for disability, but he got denied the first time around and then had to appeal. Just waiting on hold and being denied caused him to spiral into a panic attack. One bad interaction pulled at the thread of his mental health. Now, it will be a year until he starts getting checks, if he is approved. I'm working with him to get EAEDC** income, which is temporary cash assistance, while he waits – but it's not enough to pay rent or buy food.

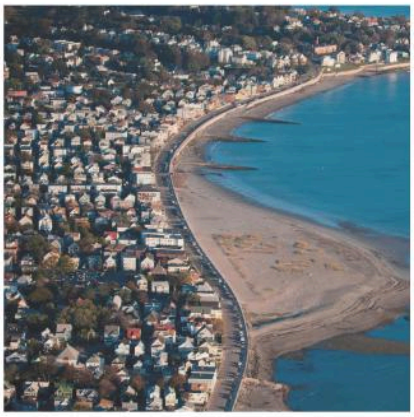
I'm watching the trajectory of his care. He's very sick, but he's very engaged in his care. He's doing a great job of following up, but the system around him is inadequate to support him. I know in the next 2-3 months he'll get evicted. His ability to follow up with his health care will fall apart right along with that. And, once he loses his housing, it's going to be really hard for him to get it back. The likelihood of finding stability is significantly lower, once he's evicted, as opposed to being able to preserve his current housing.

I think the best way to kind of describe how all of this is interconnected is to share this example. If you pull on one thread, you pull on 5 others.

This story shows how a person can do everything right – stay engaged in their care, attend appointments, follow instructions – and still fall through the cracks when the systems around them fail to meet their basic needs. It also shows how other aspects of life can unravel when just one part gives way. This story reminds us that while fixing one part of the system can help, real wellbeing and long-term stability require coordinated investment in all areas. Housing, health care, food, and income are connected to one another. Equity in access to care, services, and information requires responding to these issues as part of the same story.

* Patient details have been edited to preserve confidentiality. This quote has been lightly edited for length and clarity.
** More information about the Emergency Aid to the Elderly Disabled and Children (EAEDC) can be found on the Massachusetts Department of Transitional Assistance website.

Climate Health and Environmental Justice



Climate Health and Environmental Justice

Key Takeaway

People of color, people who speak languages other than English, and lower-income families are more likely to live in neighborhoods at higher risk of climate and environmental hazards. The Massachusetts Executive Office of Energy and Environmental Affairs classifies these neighborhoods as ***Environmental Justice*** communities.[63] Engaging those who are most impacted by extreme heat, air pollution, and exposure to other hazards is necessary to repair past harms, prevent future damage, and promote community health.

Climate change and environmental exposures are health equity issues.

Climate change is leading to more extreme weather events, like storms and droughts, longer and more frequent heat waves, colder winter days, and worsening air pollution. These shifts impact our health, especially when combined with exposure to harmful chemicals in our environment. Some communities and groups of people are more at risk of harm from climate change and environmental exposures. Low income communities, some communities of color, immigrant groups, children, pregnant people, older adults, workers in high-risk industries, persons with disabilities, and people with preexisting or chronic medical conditions are especially vulnerable to these impacts.[64] Social and economic factors make it harder for some communities to prepare for or recover from climate-related health risks.[65] Addressing unfair differences in health that result from these risks is an issue of environmental justice.

Key Terms

Environmental Justice | EJ is based on the principle that all people have a right to be protected from environmental hazards and to live in and enjoy a clean and healthful environment. It involves the equal protection and meaningful involvement of all people with respect to the development, implementation, and enforcement of environmental laws, regulations, and policies and the equitable distribution of environmental benefits.

How does the environment impact our health? Air pollution is associated with an increased risk of cardiovascular disease[66] and lung cancer,[67] and with higher COVID-19 death rates.[68] Environmental exposure to chemicals such as arsenic, benzene, PFAS, and radon can increase our risk of cancer.[69] There are more than 1,000 environmental chemicals that affect the body's hormone systems – some

[63] An Environmental Justice (EJ) community is a neighborhood where one or more of the following criteria are true: 1) the annual median household income is 65% or less of the statewide annual median household income; 2) racial minorities make up 40% or more of the population; 3) 25% or more of households identify as speaking English less than "very well"; 4) racial minorities make up 25% or more of the population and the annual median household income of the municipality in which the neighborhood is located does not exceed 150% of the statewide annual median household income: https://www.mass.gov/info-details/environmental-justice-populations-in-massachusetts

[64] U.S. Global Change Research Program. *The Impacts of Climate Change on Human Health in the United States*. 2016.

[65] U.S. Environmental Protection Agency. (2025, April 9). *Climate Change and the Health of Socially Vulnerable People*.

[66] Kaufman JD, Adar SD, Barr GR, et al. Association between air pollution and coronary artery calcification within six metropolitan areas in the USA (the Multi-Ethnic Study of Atherosclerosis and Air Pollution): A longitudinal cohort study. *The Lancet.* 2016;388(10045):696-704.

[67] Turner MC, Andersen ZJ, Baccarelli A, et al. Outdoor air pollution and cancer: An overview of the current evidence and public health recommendations. *CA Cancer J Clin.* 2020: 70: 460-479.

[68] Petroni, M. et al. (2020). Hazardous air pollutant exposure as a contributing factor to COVID-19 mortality in the United States. *Environmental Research Letters.* 2020;15(9):0940a9.

[69] National Cancer Institute. *Cancer Trends Progress Report: Chemical and Environmental Exposures*. April 2025.

of these chemicals, called endocrine disrupters, have been associated with obesity and diabetes.[70] People are exposed to these chemicals not only from outdoor pollution, but from household products like pesticides, plastics, and cleaning agents. Plus, indoor air pollution from secondhand smoke, chemicals, mold, and pests can trigger or worsen asthma and other chronic respiratory diseases.[71]

Why is climate change a health threat? Rising temperatures have been linked to serious health problems such as heart attacks, heat stroke, and worsened asthma and diabetes. The changing climate can also increase the spread of diseases carried by insects, like Lyme disease and West Nile virus, by allowing them to survive in more places and stay active for longer periods of the year. Climate events like hurricanes, wildfires, floods, and extreme heat can cause both physical harm and stress and anxiety. These health impacts are often worse for people who have less access to quality housing, clean air and water, and health care.[64]

Climate and chemical hazards are a significant threat to our communities.

The Massachusetts Climate Assessment [72] found the most urgent risks to health and welfare in the Greater Boston region are extreme heat, air pollution, and disrupted access to emergency services.

Health and Cognitive Effects from Extreme Heat	• Health impacts include heat-related illness, exacerbated chronic illness, learning loss among children, and workplace injuries. • **400+ additional heat-related deaths per year** in MA are anticipated by 2090. • Environmental Justice communities defined by language isolation are **28 percent more likely** to experience extreme heat mortality.
Health Effects from Degraded Air Quality	• Climate induced changes in particulate matter and ozone lead to premature death, increased health care costs, and missed school. • **100+ additional annual asthma diagnoses per year** in MA are anticipated by 2030. • Black individuals are **40% more likely** to live in areas with the highest projected increases in childhood asthma.
Emergency Service Response Disruptions	• Extreme storms cause delays in response time and trap residents, leading to injury and loss of life. • Consequences of flooded roads are projected to **double the effects of storms on death and injury** by 2050. • Environmental Justice communities of all classifications are projected to experience **greater impacts**.

[70] Gupta R, Kumar P, Fahmi N, et al. Endocrine disruption and obesity: A current review on environmental obesogens. *Current Research in Green and Sustainable Chemistry.* 2020: 3:100009.

[71] Hulin M, Simoni M, Viegi G, Annesi-Maesano I. Respiratory health and indoor air pollutants based on quantitative exposure assessments. *European Respiratory Journal.* 2012;40(4):1033-45.

[72] Massachusetts Climate Change Assessment. 2022.

People living in environmental justice neighborhoods are especially vulnerable to climate and chemical hazards – not because of who they are, but because of the policies and practices that have shaped the conditions in which they live. These neighborhoods are often closer to major roads, transportation hubs, and industrial facilities that release toxic chemicals and pollution. They have more limited access to green space, safe routes to walk or cycle, and places to play outside. Their water and sewer systems are more likely to be outdated and prone to flooding. Housing tends to be lower quality, and barriers to accessing care, services, and information are more common. As a result, people in environmental justice neighborhoods experience hotter temperatures, poor air quality, and exposure to more pollutants for extended periods of time. These factors can increase the risk of chronic illness and worsen mental health.

Many neighborhoods in CHA's communities are considered hot spots for extreme heat risk. Of these, many are also environmental justice communities with high concentrations of older adults, children, and people with disabilities.

Data Mapping |Urban heat islands are areas that have a higher daytime land surface temperature compared to the area average**.** The **map on the left** shows that a significant number of neighborhoods in Everett, Chelsea, Malden, and Somerville are considered urban heat islands. The **map on the right** displays environmental justice neighborhoods with high percentages of older adults, children, and/or people with disabilities. These communities are especially at risk for negative health impacts of extreme heat.

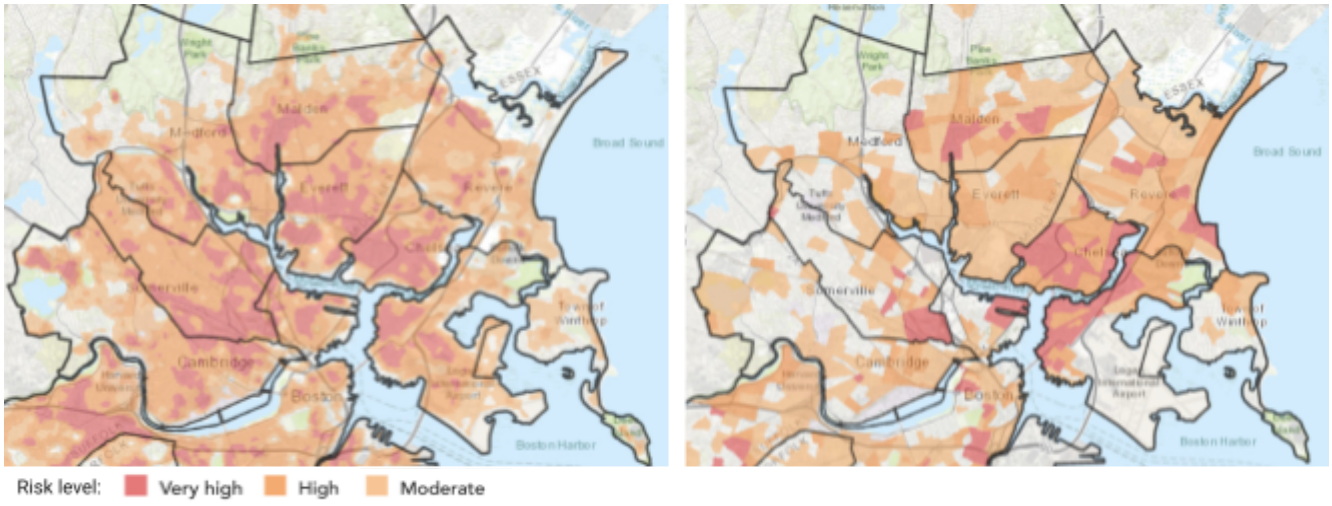


Image Source: The Trust for Public Land, Climate-Smart Cities Boston Metro Mayors Region, GIS Mapping Application.

In our communities, many people do not feel protected from the growing dangers of climate change or existing environmental hazards.

Among participants in CHA's Community Wellbeing Survey, between 1 in 7 and 1 in 4 people expressed concerns about heat, extreme weather, air quality, and water quality. Many of these concerns related to not having the resources to prepare for or cope with these issues.

14% **Do not have access to options for staying cool during extreme heat** – Black and Hispanic residents are *less* likely to have options than White or Asian residents

24% **Do not agree that their community is prepared for climate disasters** like flooding, droughts, and storms… and 26% ***do not know*** if their community is prepared

22% **Do not agree that the air in their community is healthy to breathe** – Asian, Black and Hispanic residents are *more* likely than White residents to say the air *is* healthy

14% **Do not agree that the water in their community is safe to drink** – Asian and Hispanic residents are *less* likely than White or Black residents to say the water is safe

Focus group and interview participants described the unequal environmental burdens facing low-income and marginalized communities. In many neighborhoods, extreme heat makes outdoor spaces unsafe for gathering during much of the summer. Without adequate greenery, these areas also feel isolating and disconnected. While winter heating laws exist to protect buildings, pipes, and people from extreme cold, participants noted that there are no equivalent protections for extreme heat, and high utility costs make air conditioning difficult to afford. Participants shared their experiences struggling to breathe because of poor air quality from traffic and industrial sources. They worried about children being exposed to lead through water or soil, especially in municipalities that have not yet replaced lead pipes or have not yet remediated contaminated public parks. They described how these issues impact their mental health and erode their sense of trust that environmental regulations and climate resilience plans are adequate – or being enforced.

For communities facing many stressors like high housing costs, food insecurity, and fear of discrimination and harm, it can be hard to prioritize climate change concerns.

When asked to identify the most important areas for improvement in their community, only 10% of participants in CHA's Community Wellbeing Survey said there should be more focus on climate change resilience. This was the second to last ranked item, behind 22 other priorities for improvement. The problem of climate change can feel out of reach when people have immediate, urgent needs. Still, people clearly feel its effects on their health and wellbeing.

"We could also provide help and support for climate anxiety. Something like **counseling to provide support for climate related stress, anxiety and trauma.** Especially in communities facing repeated environmental disasters. If they could be provided with mental health support, that would be great."

"And the air conditioner is even more electricity, so more costs. With the cold that we have right now, we had to turn on the heat because we have a child who has asthma. **Now we are worrying, here comes the stress about the cost of heat.**"

(translated from Spanish)

Even if advocating for policies to address climate change is not a priority community members have the luxury to work on, it *is* a priority to address the inequitable impacts of climate change. People care about having healthy air to breathe, safe water to drink, streets and homes that do not flood, and indoor and outdoor spaces that are safe during extreme heat or cold. Investing in outdoor spaces where people can enjoy nature and connect with one another was emphasized as a priority – for physical, mental, and social health and wellbeing.

"Green spaces, which include grass, trees, plants, and flowers, are not only beneficial for pulling carbon out of the atmosphere but also play a crucial role in making the air cleaner for us to breathe. It feels good to see plants and greenery. It encourages people to spend time outside. **It's an excellent way for individuals to come together and enjoy a communal space rather than staying indoors in their homes.** If everything is just concrete, it can feel isolating."

Community-based organizations, city governments, local businesses, schools, and health care systems can work together to promote resilience to climate change and protect people from environmental harms.

City governments, schools, health care systems, community organizations, and local businesses all have a role to play in building climate resilience. In CHA's Community Wellbeing Survey, residents were asked if their community is prepared for climate disasters. 26% of participants said they *did not know*. Many were also unsure whether the air or water in their community was safe. These findings point to opportunities for better outreach, communication, and trust-building.

Fortunately, there are already strong examples of local collaboration and action to build on. In Malden, community members have organized to educate and advocate for remediation and improvement of Roosevelt Park. Across the CHA service area, city governments have developed municipal climate preparedness plans, such as the City of Somerville's Climate Forward plan and Medford's Resilience Hubs. Regional organizations are also leading important work. The Mystic River Watershed Association and Resilient Mystic Collaborative are working on tree planting, water quality, flooding prevention, heat resilience, and air quality issues. Everett Community Growers has organized and empowered residents to advocate for policies that address extreme heat, health, and housing. Overall, addressing climate change and environmental hazards requires collaboration across sectors.

Community Voices:

Ideas for Addressing Climate Health and Environmental Justice Concerns

- **Expand access to green spaces and public places to stay cool.** Invest in planting trees, maintaining parks, adding public pools and public drinking fountains, shading public spaces (including but not limited to bus stops and other public transit), and indoor community spaces. These spaces can help people stay cool and create welcoming places for rest, recreation, and community connection.
- **Strengthen housing protections for extreme heat.** Improve renter protections and reduce high utility costs to help people stay safe at home. Implement policies that provide protection against indoor extreme heat, such as utility shut-off protections. Help people access programs like MassSAVE, which help people afford cooling solutions like AC and weatherization.
- **Strengthen worker protections for extreme heat.** Establish requirements for employers to maintain safe indoor temperatures. Require employers create and follow heat safety plans for outdoor workers during hot weather. Provide employers with resources and tools to maintain safe job site conditions.
- **Equip health care providers with tools and knowledge to respond to climate and environmental hazards and questions.** Patients and community members have questions about how to stay safe during heat waves, how to protect themselves from air pollution, and how to navigate and understand information about chemicals and toxins in food, water, air, and consumer products. Health care providers can be trusted messengers to share accurate, actionable information.
- **Ground climate communication in people's daily realities.** People experience climate change through everyday challenges like high utility bills, unsafe housing, air pollution, and stress. Communication should be practical and relatable.
- **Provide mental health care for those affected by climate and environmental stress.** This is especially important for communities directly impacted by heat, pollution, housing instability, and other environmental burdens.
- **Reduce air, soil, and water pollution.** Pollution from trash incinerators, industrial facilities, lead pipes and contaminated soil, roadways, and truck and bus depots disproportionately impact environmental justice neighborhoods. Prioritize these communities' health and wellbeing by preventing pollution at its source, cleaning up pollution, and providing people with information and resources about risks and options to protect themselves.
- **Invest in regional partnerships and community-led efforts.** Climate change and environmental hazards are regional problems that no single community can fully address in isolation. Support coordination across cities through networks like the Resilient Mystic Collaborative and Mystic River Watershed Association, and take direction from the work of community organizers and grassroots groups.

Health Spotlight: Reproductive Health

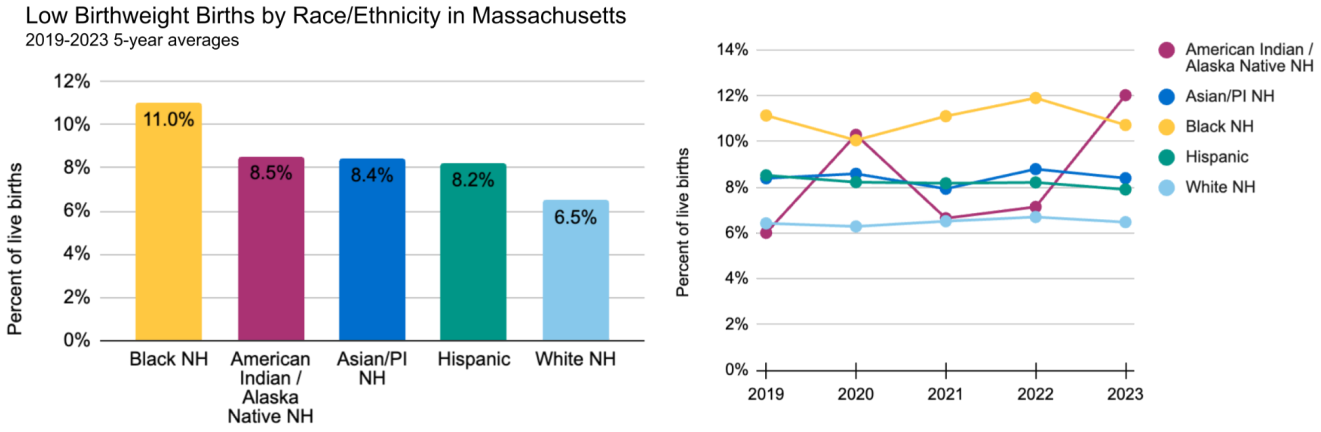
Breathing polluted air and living through extreme heat can harm reproductive health.[73] Both can make it harder to get pregnant. During pregnancy, the body works differently – blood flow increases, breathing changes, and it's harder to stay cool. These changes make pregnant people more sensitive to heat and air pollution. Pollution and high heat can also affect the developing baby, raising the risk of miscarriage, preterm birth, and low birthweight.[73]

Environmental health risks are not shared equally. Environmental justice communities – neighborhoods with high percentages of residents who are people of color, low-income, and speak languages other than English – often face the highest levels of pollution and heat. These same communities also tend to have less access to the resources needed to protect reproductive health, like quality health care, safe housing, and food security. This creates a double burden: greater exposure to harm, with fewer tools to respond.

Babies born early or underweight often need extra medical care and may face long-term health challenges. In this way, inequities in our everyday environments get passed down and shape health across generations.

In Massachusetts and in our communities, we see the impact of these overlapping inequities. Birth outcomes vary by racial/ethnic group and by city.

Equity Lens | Statewide, the **5-year average for low birthweight births** is highest among Black infants (11.0%), and lowest among White infants (6.5%). The percentage of infants born with low birthweight remained stable among most racial and ethnic groups from 2019 to 2023, but fluctuated among American Indian / Alaska Native infants – in part due to small numbers.

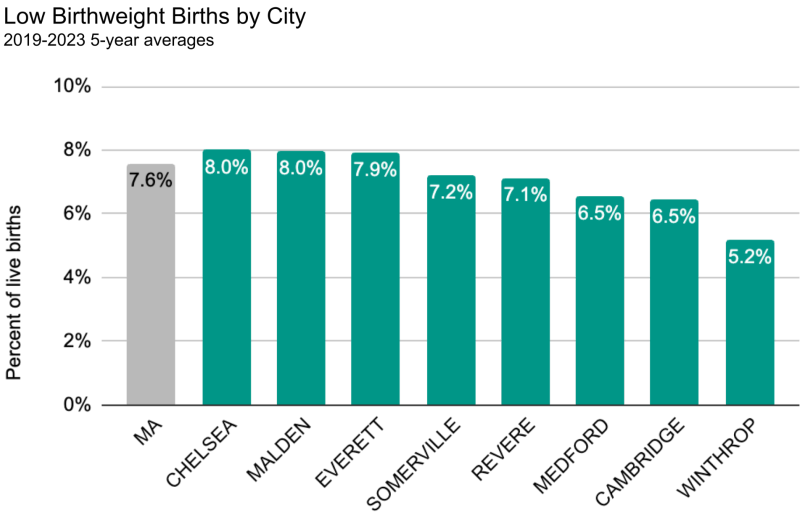


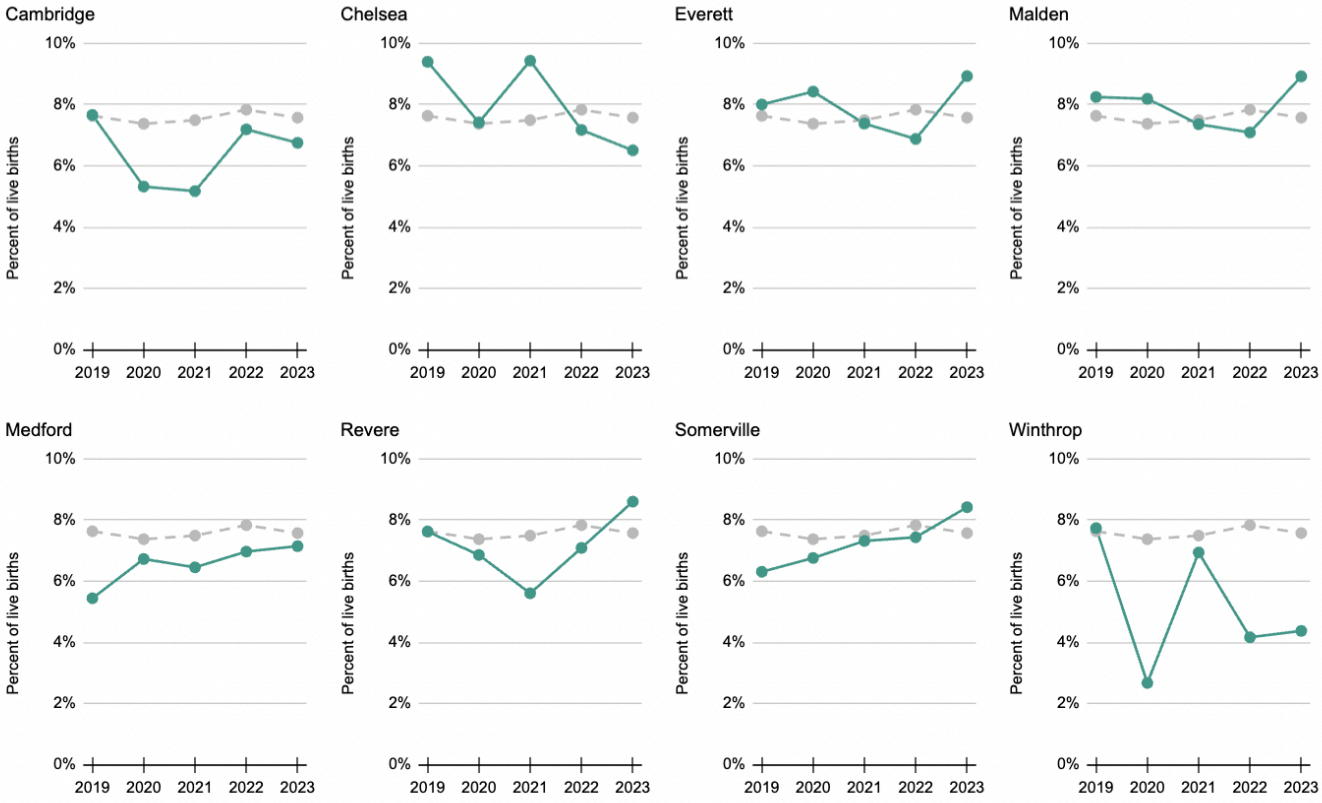
Source: Massachusetts Registry of Vital Records and Statistics, Births, 2019-2023

Notes: Low birthweight is defined as less than 2,500 grams, or 5.5 pounds. NH stands for "non-Hispanic."

[73] Bekkar B, Pacheco S, Basu R, DeNicola N. Association of Air Pollution and Heat Exposure With Preterm Birth, Low Birth Weight, and Stillbirth in the US: A Systematic Review. JAMA Netw Open. 2020;3(6):e208243.

Data Point | The **5-year average for low birthweight** births is higher than the state average in Chelsea, Everett, and Malden. Between 2019 and 2023, the percentage of babies born with low birthweight has increased in Medford and Somerville, and declined in Chelsea and Winthrop. The percentage has fluctuated in other communities.

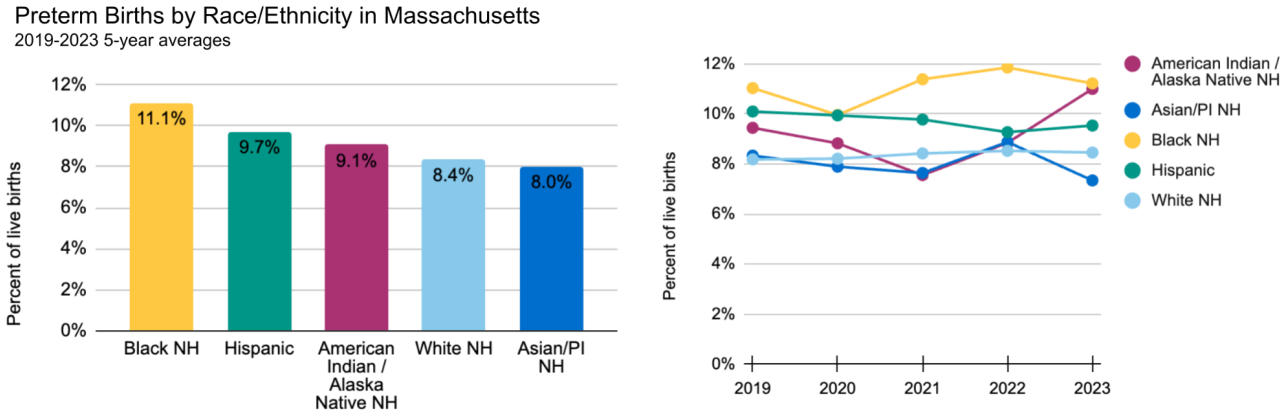




Source: Massachusetts Registry of Vital Records and Statistics, Births, 2019-2023

Notes: Low birthweight is defined as less than 2,500 grams, or 5.5 pounds. In each line chart, a gray dotted line represents the rate for the state of Massachusetts.

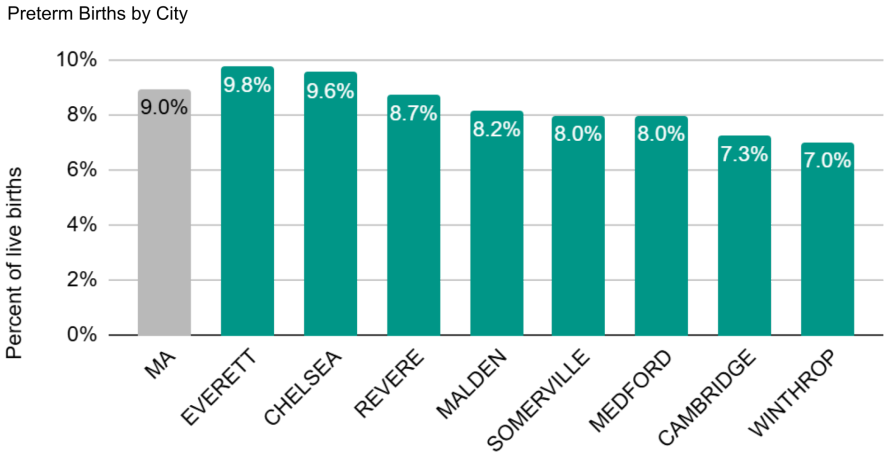
Data Point | Statewide, the **5-year average for preterm births** is highest among Black infants (11.1%) and lowest among Asian infants (8.0%). The percentage of infants born preterm remained stable among most racial and ethnic groups from 2019 to 2023, but fluctuated among American Indian / Alaska Native infants – in part due to small numbers.



Source: Massachusetts Registry of Vital Records and Statistics, Births, 2019-2023

Notes: Preterm birth is defined as less than 37 weeks gestation. NH stands for "non-Hispanic."

Data Point | In our communities, the **5-year average percentage of preterm births** is higher than the state average (9.0%) in Everett and Chelsea.



Source: Massachusetts Registry of Vital Records and Statistics, Births, 2019-2023 5-Year Averages

Notes: Preterm birth is defined as less than 37 weeks gestation.

Inequities in birth outcomes are not *always* or *only* due to inequities in exposure to heat, air pollution, or other environmental hazards. But, it is important to recognize the impact of climate health and environmental justice on the wellbeing of parents and babies.

Health Spotlight: Asthma

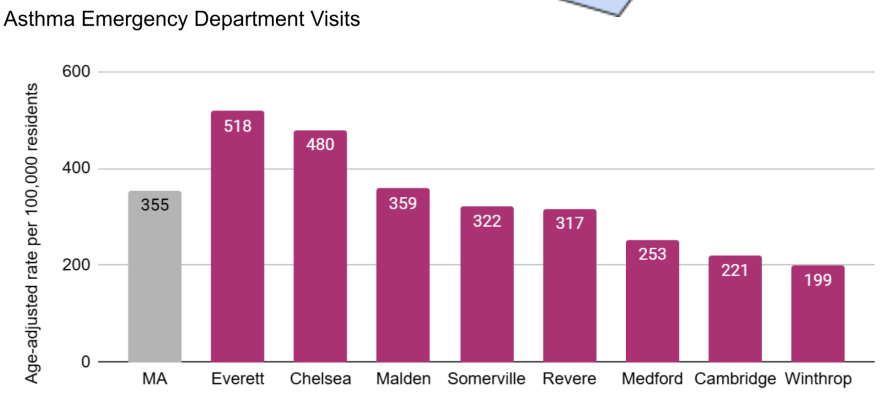
Asthma is a chronic respiratory condition that can be worsened by environmental factors like air pollution, mold, and poor housing conditions. Social determinants of health – such as income, housing quality, and access to health care – play a major role in shaping who is most vulnerable. Environmental injustice means that low-income families and communities of color often face higher exposure to asthma triggers.

> **"I can't get my asthmatic kids not to wheeze when their house is full of mold** and I don't have any place for them to go. So it's tough, it's really tough."

> **"As an asthma patient, I have to go around with my mask on.** It's a problem for my health. At some times, I have been forced indoors."

In focus groups and interviews, health care providers described the difficulty of treating asthma in patients who are living in housing conditions that make their symptoms worse. People living with asthma described how worsening air pollution – from traffic, wildfires, and extreme heat – makes their symptoms worse too.

Data Point | Among adults, the **5-year average age-adjusted rate of emergency department (ED) visits due to asthma** varies by city. Rates are higher in Everett, Chelsea, and Malden compared to the statewide average.



Source: Center for Health Information and Analysis (CHIA), Massachusetts Acute Hospital Case Mix Database, 2017-2021.

Equity Lens | Across Massachusetts, **Black residents visit the ED for asthma at four times the rate of White residents, and Hispanic residents at three times the rate.** In our communities, Black and Hispanic residents also tend to visit the ED for asthma at higher rates than White residents – but, the gaps are more narrow than at the state level, except in Cambridge.

Source: Center for Health Information and Analysis (CHIA), Massachusetts Acute Hospital Case Mix Database, 2017-2021 5-Year Annual Averages

Notes: *Case counts less than 10 are suppressed for confidentiality purposes, so statistics cannot be calculated for Asian, Black, or Hispanic residents of certain communities.

Asthma ED Visit Rates *(compared to White)*

	Asian	Black	Hispanic
MA	60% lower	4.0x higher	3.0x higher
Cambridge	Equal	5.7x higher	3.8x higher
Chelsea	*	1.8x higher	Equal
Everett	*	1.9x higher	1.2x higher
Malden	60% lower	2.4x higher	1.9x higher
Medford	*	3.3x higher	1.7x higher
Revere	*	1.9x higher	10% lower
Somerville	*	3.2x higher	2.8x higher
Winthrop	*	*	*

Data Point | Between the 2017-2018 school year and the 2023-2024 school year, the statewide **prevalence of childhood asthma** decreased by 2.2 percentage points. Most of our communities experienced a decrease as well, with Cambridge having the most significant reduction, followed by Somerville, Malden, and Everett.

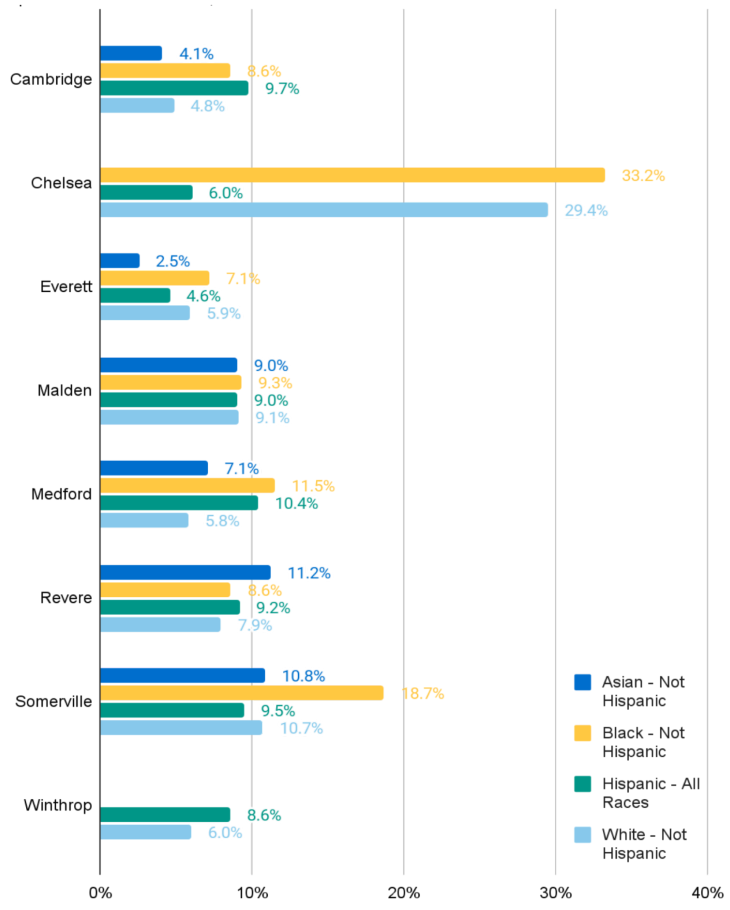
Community	2017-2018 School Year	2023-2024 School Year	Change
Chelsea	11.1%	10.9%	⇩ -0.2 percentage points
Malden	11.6%	9.9%	⇩ -1.7 percentage points
Somerville	11.9%	9.6%	⇩ -2.3 percentage points
Medford	8.6%	8.6%	0.0 percentage points
Revere	8.2%	8.2%	0.0 percentage points
Winthrop	7.9%	8.1%	⇧ 0.2 percentage points
Everett	9.0%	7.3%	⇩ -1.7 percentage points
Cambridge	10.6%	6.4%	⇩ -4.2 percentage points
MA	11.8%	9.6%	⇩ -2.2 percentage points

Source: Massachusetts Department of Public Health (DPH), Bureau of Climate and Environmental Health, Pediatric Asthma, 2017-2018 and 2023-2024

Notes: The data reflect asthma prevalence rates among children in grades K through 8 (ages 5-14) enrolled in public and charter schools, as reported annually by school nurses.

Equity Lens |Racial disparities in the prevalence of childhood asthma vary across our communities. Asthma rates are highest among Black children in Chelsea, Somerville, Medford, Malden, and Everett; among Hispanic children in Cambridge and Winthrop; and among Asian children in Revere. Across all communities, White children have the highest rates of asthma in Chelsea and Somerville. Notably, disparities are narrowest in Malden.

Percent of Students with Asthma by Racial/Ethnic Group



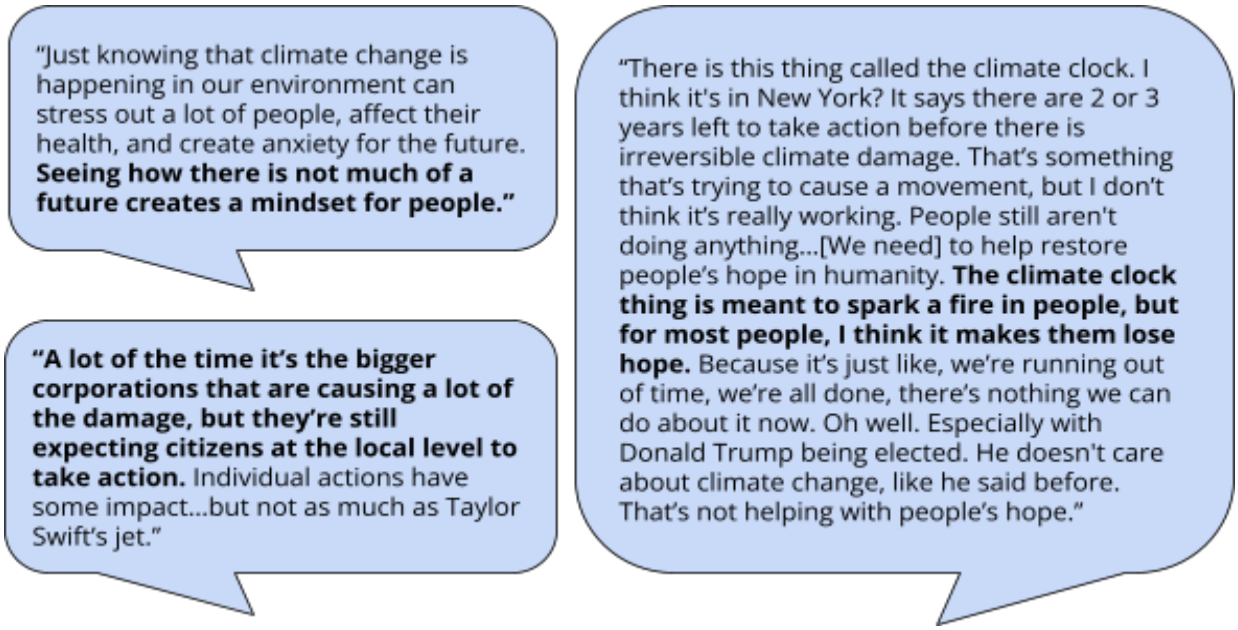
Source: Massachusetts Department of Public Health (DPH), Bureau of Climate and Environmental Health, Pediatric Asthma, 2022-2023

Notes: The data reflect asthma prevalence rates among children in grades K through 8 (ages 5-14) enrolled in public and charter schools, as reported annually by school nurses. Case counts less than 5 are suppressed for confidentiality purposes, so statistics cannot be calculated for Asian or Black residents of certain communities.

Sharing Our Stories: Climate Anxiety

People in our communities are worried about how climate change is affecting their lives and what it will bring in the future. **This worry is called climate anxiety, which involves feelings of fear, anger, grief, despair, guilt, or shame about the impacts of climate change on our planet, our health, and future generations.**[74] Even though climate anxiety is painful to experience, it is a rational reaction to the climate crisis, and in some cases can lead people to take action. However, it can also become overwhelming – especially since the solutions to the climate crisis are not always clear.

In one of our focus groups, high school students shared their perspective on the emotional toll of climate awareness and the frustration that comes with seeing little action from those in power.



These feelings aren't unique to our community. A global survey of youth ages 16 to 25 from ten countries around the world found consistently high levels of anxiety about climate change. Among U.S. youth, 46% were very or extremely worried about climate change, and 75% were at least moderately worried. Approximately one in four (26%) said their feelings about climate change negatively affected their daily lives.[74]

Even with these fears, young people in our communities are asking questions, having conversations with their families and each other, and thinking critically about how climate change is connected to power, policy, and everyday life. Beyond reflection, many are taking action – organizing to demand policy change, advocating for mental health support, and creating spaces for connection and care. These efforts reflect a deep commitment to one another and a vision for a healthier future.

[74] Hickman C, Marks E, Pihkala P, et al. Climate anxiety in children and young people and their beliefs about government responses to climate change: a global survey. *The Lancet Planetary Health*. 2021;5(12):e863-e873. doi:10.1016/S2542-5196(21)00278-3

Next Steps: Priorities for Collaborative Action

During the last Wellbeing Assessment in 2022, CHA and our Community Health Advisory Council (CHAC) developed a set of Priorities for Collaborative Action. These priorities included four focus areas and three equity principles. Over the past 3 years, the focus areas defined ***what*** we worked on addressing, together with CHA and community stakeholders. The equity principles guided ***how*** we worked to address these important issues. **The findings of the 2025 assessment show that these priorities remain relevant and require continued collaboration, strategic growth, and investment in the coming 3 years.**

Equity Principles

Our strategies will continue to be guided by the following principles:

Language justice

We will continue to apply a language justice lens in all our efforts. While many definitions of language justice exist, we follow the definition offered by Communities Creating Healthy Environments (CCHE): "*Valuing language justice means recognizing the social and political dimensions of language and language access, while working to dismantle language barriers, equalize power dynamics, and build strong communities for social and racial justice*."[75]

Inclusion of under-represented voices in leadership and decision-making

In the development, implementation, and evaluation of strategies, we will continue to center the leadership and decision-making power of those most impacted by health inequities. We will continue to remove barriers to engagement in our work and to work in solidarity with community members for more equitable access to civic engagement and public participation.

Collective care

We will continue to design strategies that embody elements of collective care. We follow a definition that states: "*Care is our individual and common ability to provide the political, social, material, and emotional conditions that allow for the vast majority of people and living creatures on this planet to thrive — along with the planet itself."*[76] As we co-develop strategies and plans of action, we will consider how our efforts can best foster caring environments. This means considering the unique stressors that impact diverse communities, and intentionally designing systems and environments that promote collective care and ability to thrive.

[75] Arguelles, P., Williams, S., Hemley-Bronstein, A. (n.d.) *Language Justice Toolkit: Multilingual Strategies for Community Organizing*. Communities Creating Healthy Environments.

[76] Rottenberg, C. and Segal, L. *What is Care?* The Care Collective

Focus Areas

The four focus areas will continue to be addressed in partnership with communities, organizations, and coalitions. CHA will continue to contribute in its role as a health care and community health institution and will continue to support and champion the leadership and expertise of partners across sectors.

Affordable, Stable, and Safe Housing

Our priority is to ensure that all people, especially those closest to the impact of historical and present-day housing discrimination, can thrive physically, mentally, and socially in healthy housing. Through programs, policies, and systems approaches, this means addressing concerns such as affordability, stability and anti-displacement, safety, accessibility (e.g. for older adults and persons with disabilities), as well as homelessness and transitions to stable housing.

Equitable Economy

Our priority is to ensure that all people have the economic resources and support they need to thrive through all stages of life. We recognize the impact of economic systems that exploit lower-income communities and communities of color for purposes that do not reflect their own priorities. Through programs, policies, and systems approaches, this means addressing concerns related to sustainable food systems, local jobs with living wages and benefits, healthy working conditions, and caregiving systems.

Equity in access to care, services, and information

Our priority is to ensure everyone can access the care, services, and information they need. This includes health care (including mental health), education, economic opportunities, financial support, legal services, and more. We will address issues such as costs, cultural and language barriers, system navigation, staffing, referral systems, transportation, digital access, quality, disability, and other aspects of accessibility.

Climate health and environmental justice

Our priority is to build community resilience to climate change, promote environmental justice, and reduce further environmental impact. This includes addressing air and water quality and climate preparedness. We recognize the health impacts of climate change and exposure to environmental hazards are disproportionately shouldered by low-income communities and communities of color. Strategies to address this priority must be developed with an equity lens.

In Fall 2025, CHA will work together with our Community Health Advisory Council to update our Implementation Strategy (IS). The IS will outline goals and strategies to address these Priorities for Collaborative Action. The recommendations and ideas shared by community members during the assessment will be incorporated into this action plan. Over the coming three years, the IS will guide our work together to strengthen community health and wellbeing.

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Laura McNulty, MPH, MSW
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Photo credits

Photographs were generously provided by the CHA Department of Community Health, CHA Marketing Department, and community partners and media contacts including:
City of Somerville / Ed Wonsek, designed By Warner Larson Landscape Architects (page 83)
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Everett Community Growers (cover, pages 18 and 38)

Glossary of Terms

Equity and inequity. *Equity* means treating people with fairness and justice by taking into consideration their unique circumstances and needs. Equity exists when everyone has the resources and opportunities they need in order to thrive. *Inequity*, on the other hand, refers to unfair and avoidable differences in how different groups of people are treated. Inequity results from the unfair distribution of power and resources in society. Applying an "equity lens" to analyses or interventions means identifying how experiences or outcomes differ between communities because of unfair and unjust systems – such as racism, poverty, or other forms of oppression – and taking intentional actions to reduce or eliminate those differences.

United Way of the National Capital Area. (2024, Oct 22). *Equity Definition*
Communities in Action: Pathways to Health Equity. (2017, Jan). *The Root Causes of Health Inequity*

Health equity and health inequity. *Health equity* means that everyone has a fair and just opportunity to be as healthy as possible. To achieve this, we must remove obstacles to health – such as poverty, discrimination, and deep power imbalances - and their consequences, including lack of access to good jobs with fair pay, quality education and housing, safe environments, and access to health care. *Health inequity,* on the other hand, refers to the existence of differences in health that result from unfair, unjust differences in opportunities.

Braveman P, et al. (2017). *What Is Health Equity? And What Difference Does a Definition Make?* Robert Wood Johnson Foundation

Social determinants of health. The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

U.S. Department of Health and Human Services. Healthy People 2030. *Social Determinants of Health*

Structural racism. A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity. It identifies dimensions of our history and culture that allow privileges associated with "whiteness" and disadvantages associated with "color" to endure and adapt over time. *Structural* and *systemic* racism are sometimes used interchangeably, but emphasize different paths through which racism operates: entire systems, and the structures that uphold them.

The Aspen Institute Roundtable on Community Change. (2004, June). *Structural Racism and Community Building*
Braveman P, et al. (2022). *Systemic And Structural Racism*, Health Affairs

Structural barriers. Obstacles that collectively affect a group disproportionately and perpetuate or maintain stark disparities in outcomes. Structural barriers can be policies, practices, and other norms that favor an advantaged group while systematically disadvantaging a marginalized group. Structural barriers can be a symptom of *systemic challenges* – problems that are deeply embedded in a system (rather than the result of individual failures) and that can only be addressed by changing, redesigning, and rebuilding the system.

Simms M.C., et al. (2015, Oct). *Structural Barriers to Racial Equity in Pittsburgh*. Urban Institute.

Appendices

Appendix A: **Community Health Advisory Council Membership**

Appendix B: **Organizations Involved in Data Collection & Analysis**

Appendix C: **CHA Regional Wellbeing Assessment & Implementation Strategy Framework**

Appendix D: **Data Collection Methods and Tools**

Includes the **CHA Community Wellbeing Survey,** the **focus group and interview guides** used during the assessment, the complete **primary data collection and analysis protocol**, and the list of **secondary data sources**.

Appendix E: **Survey, Focus Group, and Interview Results**

Includes the complete results of the CHA Community Wellbeing Survey, provided as a set of **Frequency Tables**; and the results of focus groups and interviews, provided as a **Qualitative Themes Report**.

Appendix F: **Community Data Profiles and Visuals**

Includes **Community Data Profiles** for each of the eight communities in CHA's service area, a consolidated **Wellbeing Data Book**, and a **Chart Pack** displaying selected social, economic, environmental, and health data visualizations.

The CHA Health Improvement Team Tableau Public site provides data visualizations for additional selected topics: https://bit.ly/CHA-Community-Health-Tableau-Public

Appendix G: **Presentation & Communication Tools**

Includes the **Main Takeaways** summary document (available in Arabic, Haitian Creole, English, Portuguese, Simplified Chinese, and Spanish), a **one-page summary** of the 10 Key Findings, and a **slide deck** highlighting the 10 Key Findings.