Cambridge Health Alliance
Regional Wellbeing Report 2025

A Community Health Needs Assessment

The Main Takeaways

Cambridge Health Alliance (CHA) is pleased to present this summary of main takeaways from the 2025 CHA Regional Wellbeing Report: A Community Health Needs Assessment (CHNA). This summary provides an overview of what the report is about, how it was created, and the key findings. Visit our website for more information, resources, and data: www.challiance.org/communityhealthdata.

About the Wellbeing Report

The Wellbeing Report tells the story of health in our communities. Every three years, CHA works together with our communities to identify strengths, challenges, and priorities for improving wellbeing. This process includes a *Community Health Needs Assessment (CHNA)*, which engages community members to understand the factors that affect their health, and an *Implementation Strategy (IS)*, which is an action plan to address the community's health priorities. It covers the eight communities of CHA's service area: Cambridge, Chelsea, Everett, Malden, Medford, Revere, Somerville, and Winthrop.

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

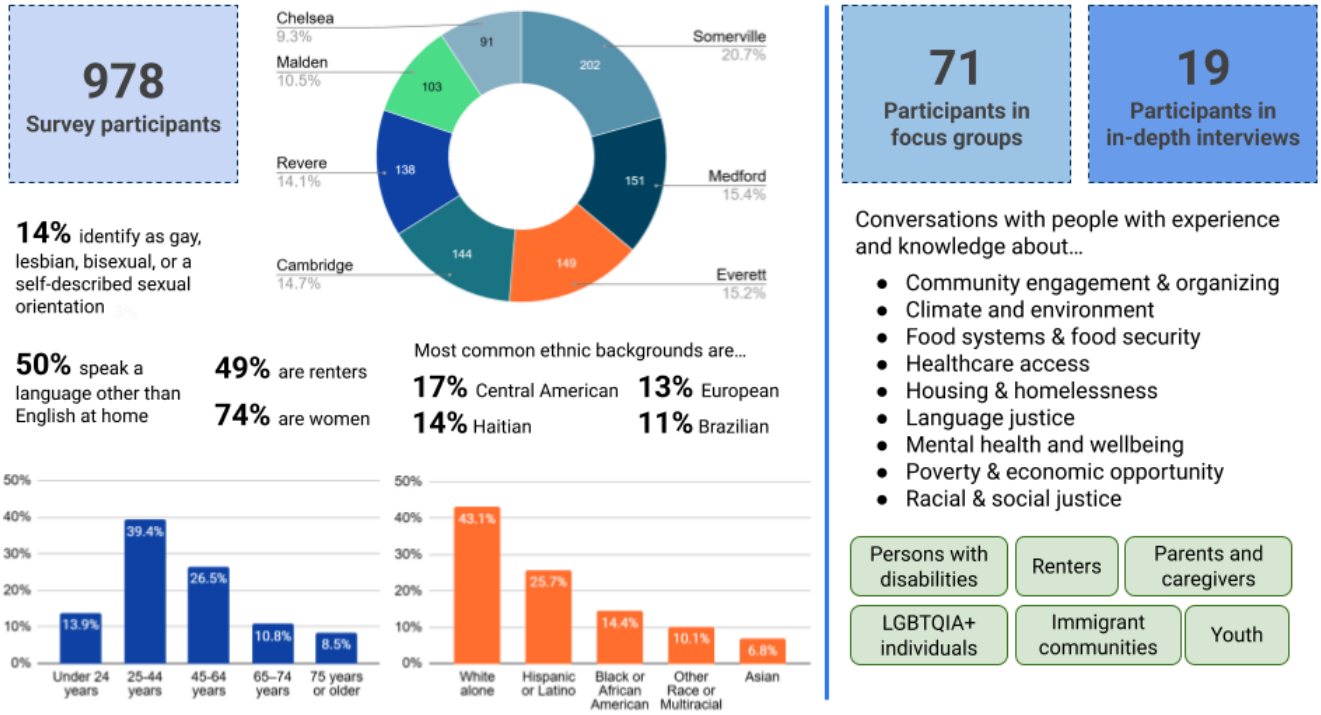
This 2025 Wellbeing Report shares the results from our latest assessment. It builds on what we learned in 2022, with a deeper focus on the priorities that came out of that assessment – like improving housing stability, strengthening families' economic security, increasing equity in access to care, and promoting environmental justice. These social, cultural, economic, political, and environmental conditions all influence people's health and wellbeing.

The report also focuses on the root causes of unfair, avoidable health differences that exist between groups – such as racism, poverty, and exclusion. Finally, it shares data about mental and physical health issues, such as heart disease, diabetes, depression and anxiety, and more.

How the Wellbeing Report was created

CHA worked with Community Researchers, community partners, and Community Health Advisory Council members to design the assessment, collect and analyze data, and identify priorities for action. This approach is called Participatory Action Research (PAR), which emphasizes community participation and leadership in all parts of an assessment. We also coordinated our efforts with several health systems and local public health partners who were carrying out CHNAs at the same time.

Community members shared their opinions and experiences through a community survey, focus groups, and interviews. By building trust, using accessible methods, and honoring lived experience, we were able to include more voices from communities of color, immigrants, LGBTQIA+ individuals, and other communities who are impacted by racism and other forms of discrimination.



Additional data were gathered from more than 40 trusted sources, including the U.S. Census Bureau, Massachusetts Department of Public Health, Centers for Disease Control and Prevention, and regional and local reports on specific health topics. We worked collaboratively with our community to understand what the data really means – and what should be done next.

While this report tells an important story of health in our communities, it's also a story that is changing. The data for this assessment was collected in the summer and fall of 2024, and this report is being written in the early summer of 2025. There have been major political, economic, social, and environmental developments this year that 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 now – if not more so. **CHA affirms our commitment to advancing health equity and centering community priorities in our work.**

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.

~ 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

Key Findings: Strengths and Challenges

Our communities and institutions have many strengths. Most people who took part in the Wellbeing Assessment feel a sense of belonging in their communities and believe their communities are good places to live, raise children, and age. At the same time, many people 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, most people said they believe we can make things better by building on the strengths we already have.

10 Key Findings stood out across all results of the Wellbeing Assessment. These findings are explored in more depth in the full Wellbeing Report. You can use these 10 Key Findings to get a sense of what matters most to people in our communities – and how we can focus our efforts to strengthen community health and wellbeing.

Key Finding #1 | A sense of community grounded in collective care is essential to wellbeing, including in the face of systemic challenges.

Across all our interviews and focus groups, community members emphasized the positive impact that **connection**, **belonging**, **shared space**, and **mutual aid** have on their physical and mental health. These themes point to a concept called **collective care**.

While collective care has many definitions, one that offers a frame for this key finding 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.

Participants in the Wellbeing Assessment spoke about collective care in two ways. First, they 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. Second, they spoke about **the need for systems and institutions to be designed in ways that are caring, accessible, and grounded in human dignity**. In fact, the most frequently cited barrier to wellbeing was the design of the very systems meant to provide support. Systems like healthcare, social services, public benefits, and housing were described as confusing, impersonal, or difficult to navigate – creating more stress rather than offering relief.

This finding challenges us to ask: how can we design systems that are not only efficient and effective, but also equitable, accessible, and caring?

"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)

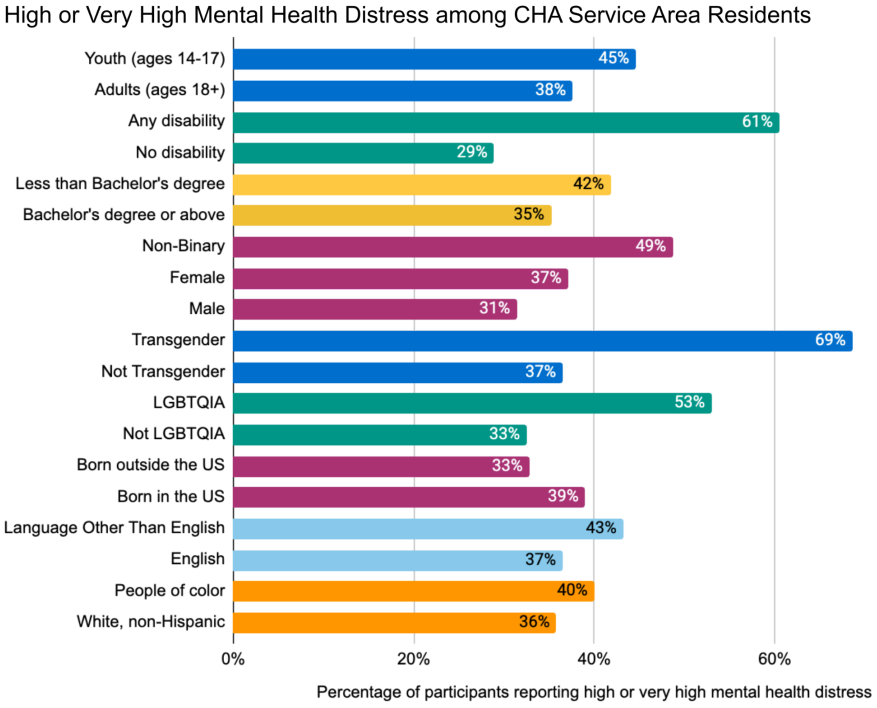
"We've seen [the community garden] has different purposes. **It's really about improving the overall wellbeing of the community by giving people the space to come together.**"

Key Finding #2 | More than 1 in 3 adults (38%) and nearly half of youth (45%) report high or very high levels of mental health distress.

Mental health is an essential part of wellbeing. However, many people in our communities are facing significant stress, anxiety, and despair.

Data Point | 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%).

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



Communities that often face discrimination are more likely to report high or very high levels of mental health distress – including people of color, people who speak languages other than English, non-binary individuals, and people with lower educational attainment.

When asked about the causes of poor mental health, community members pointed 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**. These issues require action at community and institutional 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.

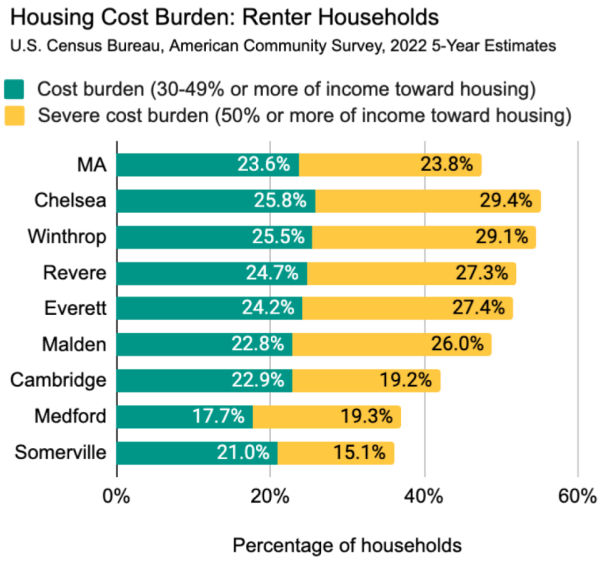
"Thinking about how are you going to pay rent, sometimes you need a car, and then you have to get a second job, **it puts more on your back, and it brings you down, it puts you in a spiral.**"

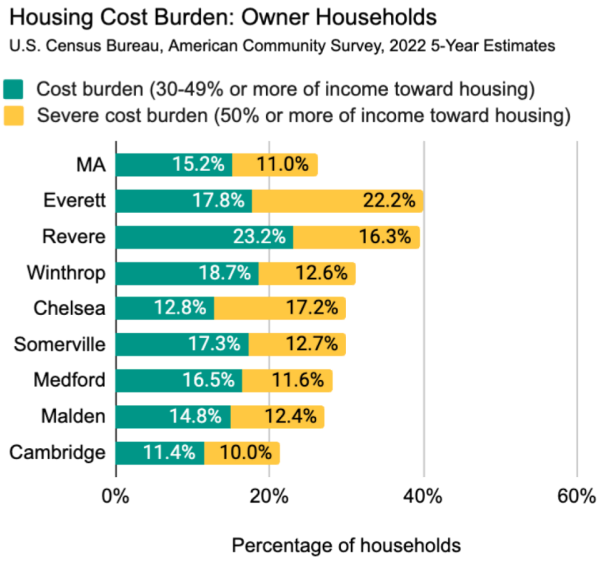
"Just knowing that climate change is happening in our environment can stress out a lot of people, affect their health, and create anxiety for the future. **Seeing how there is not much of a future creates a mindset for people.**"

Key Finding #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 insecurity and food insecurity are closely linked. When people struggle to afford the cost of housing, they face risks like eviction, overcrowding, and utility shut-off. They may prioritize paying the rent or mortgage over paying for food, healthcare, or other basic needs.

Data Point | The **percentage of households with a housing cost burden** varies by community. 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% of their income toward housing.



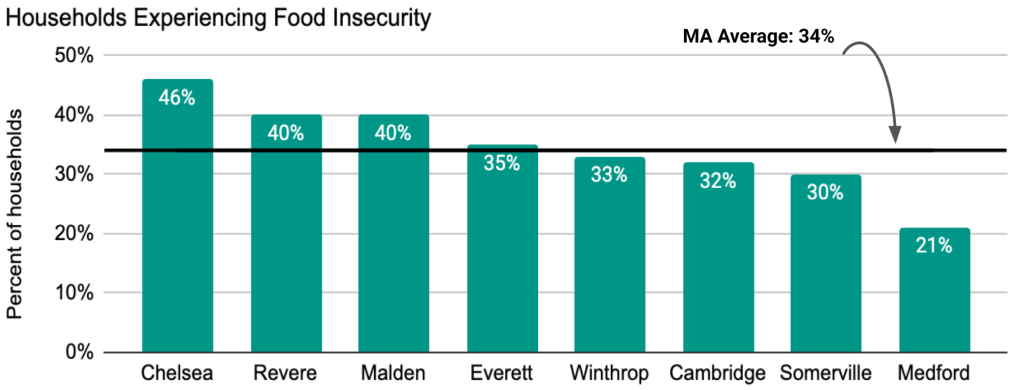


Across our communities, renter households are more likely to experience a housing cost burden compared to owner households. Housing cost burden has remained historically high for the last few years. This is especially true for renters and for Black or Latino households. At the state level, homelessness nearly doubled from 2022 to 2024 – from 15,500 to 29,360 individuals. Cambridge saw a 70% increase in the number of people experiencing homelessness during this time period.

Among participants in CHA's Community Wellbeing Survey, **more affordable housing** was the most common priority for improvement. This was consistently true regardless of age group, racial group, language, or immigration history. Overall, there is not enough housing that people can afford, and income has not kept up with rising costs of housing.

Food insecurity has risen statewide 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. The high cost of groceries, growing costs of living, 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 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

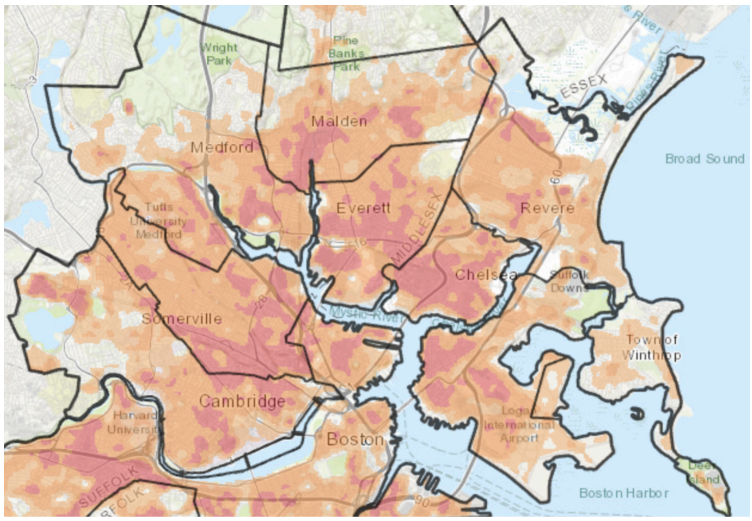
Data from the MA Department of Transitional Assistance shows enrollment in the Supplemental Nutrition Assistance Program (**SNAP)** has increased by between 13% and 41% since 2020 across our communities. It is positive that more people have access to resources to purchase food. However, according to a report from the Greater Boston Food Bank, 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.

Key Finding #4 | Environmental health issues including heat and chemical exposures are a growing focus.

Community members are increasingly concerned about environmental health issues, such as extreme heat, air pollution, water contamination, and exposure to chemicals in food and other products. Across focus groups and interviews, community members emphasized that a **pollution-free, climate resilient environment** is essential to wellbeing.

Data Mapping | Many neighborhoods in CHA's communities are considered **hot spots for extreme heat risk.** Areas of Somerville, Everett, Chelsea, and parts of Malden are especially impacted. In this map, neighborhoods shown in red and orange have a higher daytime land surface temperature compared to the area average.

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



Risk level: Very high High Moderate

Many people do not feel their environment supports their health and safety. Among participants in CHA's Community Wellbeing Survey, concerns about air quality, safe drinking water, and access to options for staying cool during extreme heat were common. More than 1 in 7 people reported not having access to options for staying cool, or having safe water to drink. More than 1 in 5 reported concerns about breathing polluted air.

14% **Do not have access to options for staying cool during extreme heat**

Black and Hispanic residents *less* likely to have options than White or Asian residents

14% **Do not agree that the water in their community is safe to drink**

Asian and Hispanic residents *less* likely than White or Black residents to say the water is safe

22% **Do not agree that the air in their community is healthy to breathe**

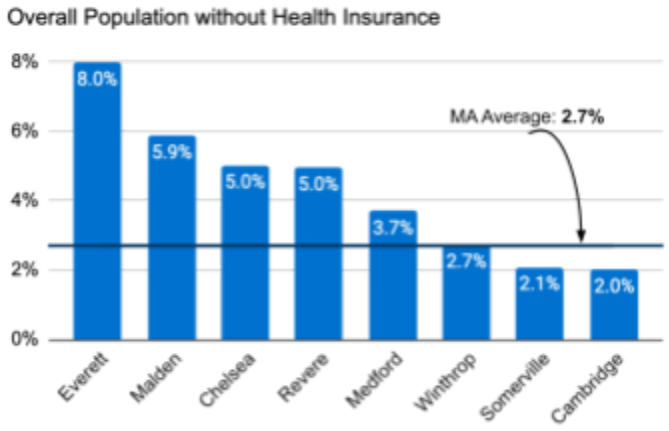
Asian, Black and Hispanic residents *more* likely than White residents to say the air *is* healthy

Key Finding #5 | Barriers to accessing physical and mental health care are worse now compared to before the COVID pandemic.

Community members and healthcare providers emphasize that **people have more complex needs** compared to before the pandemic. Some people delayed seeking healthcare during COVID, which allowed health issues to become more serious. Some people developed long COVID, which is still not well understood. Living through a pandemic that caused so much loss led to stress and grief that continue to impact people's mental health. In addition, **health systems are more under-resourced**. Policies that increased funding to hospitals and public health systems during the pandemic have ended. Some medical providers retired or changed careers. There are not enough community, organizational, and government resources to address patients' social, economic, and environmental needs. These patterns put **extra strain** on the health system, affect people's health outcomes, and contribute to health inequity.

Data Point | The **percentage of residents without health insurance** is higher than the MA state average in Everett, Malden, Chelsea, Revere, and Medford. Many people who had MassHealth lost insurance coverage after the COVID pandemic was declared over – though community outreach efforts helped to prevent disenrollment or connect people to new health insurance options.

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.

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%

There are other barriers to care besides being uninsured. Among participants in CHA's Community Wellbeing Survey, 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 were not able to access **dental care** said it was because their **insurance did not cover it.**

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

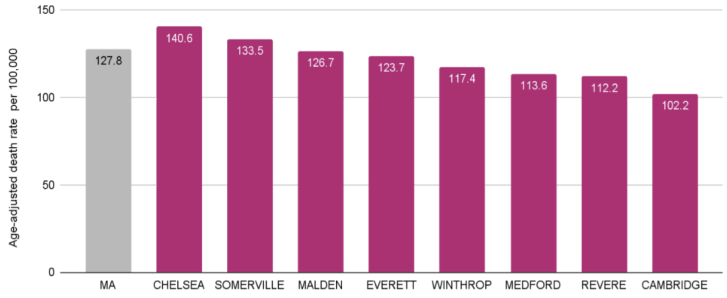
42% of people who were not able to access **emergency care for a mental health crisis** said it was because they **did not know where to go.**

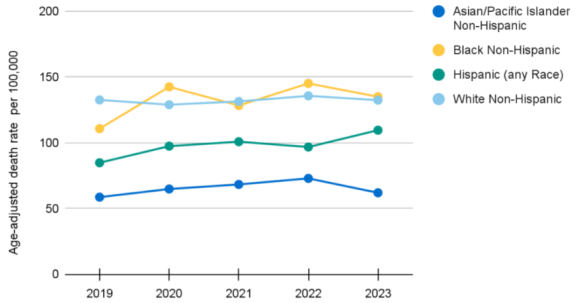
Key Finding #6 | Heart disease, cancer, diabetes, and sexually transmitted infections are major health challenges in our communities.

Heart disease, cancer, and **diabetes** continue to have a significant impact on the health of people in our communities. Heart disease and cancer are the leading causes of death in our communities – as well as state-wide and nationally. Heart disease mortality rates are higher than the MA state average in Chelsea and Somerville. Cancer mortality rates are higher than the MA state average in Malden and Chelsea. Statewide, cancer and heart disease mortality rates used to be highest among White residents – now, rates are highest among Black residents.

Heart Disease, Cancer, and Diabetes Mortality Rates

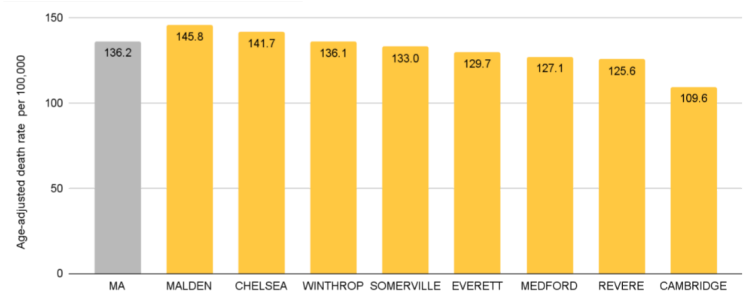
Heart Disease Mortality Rates

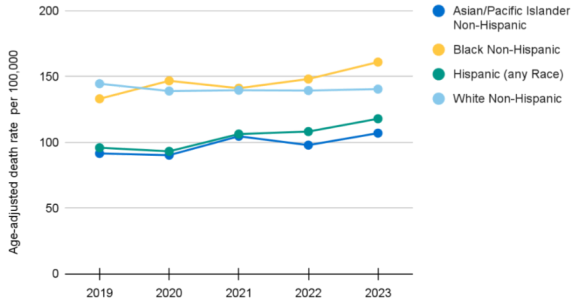




*Across MA, heart disease mortality has **increased** among Black and Hispanic residents.*

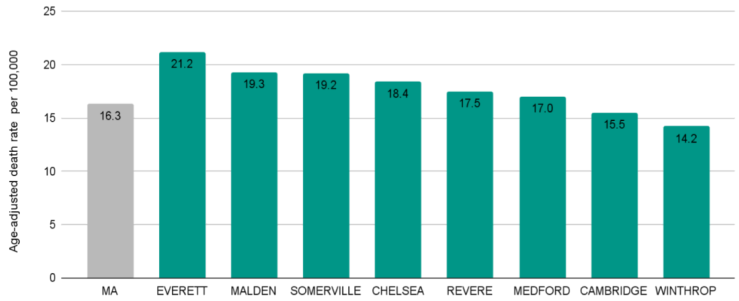
Cancer Mortality Rates

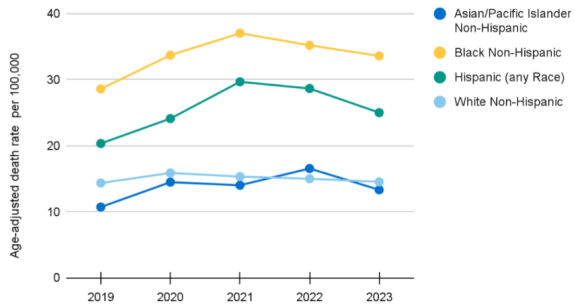




*Across MA, cancer mortality has **increased** among Asian, Black, and Hispanic residents.*

Diabetes Mortality Rates





*Across MA, diabetes mortality shows the **widest racial/ethnic disparities** of any mortality indicator.*

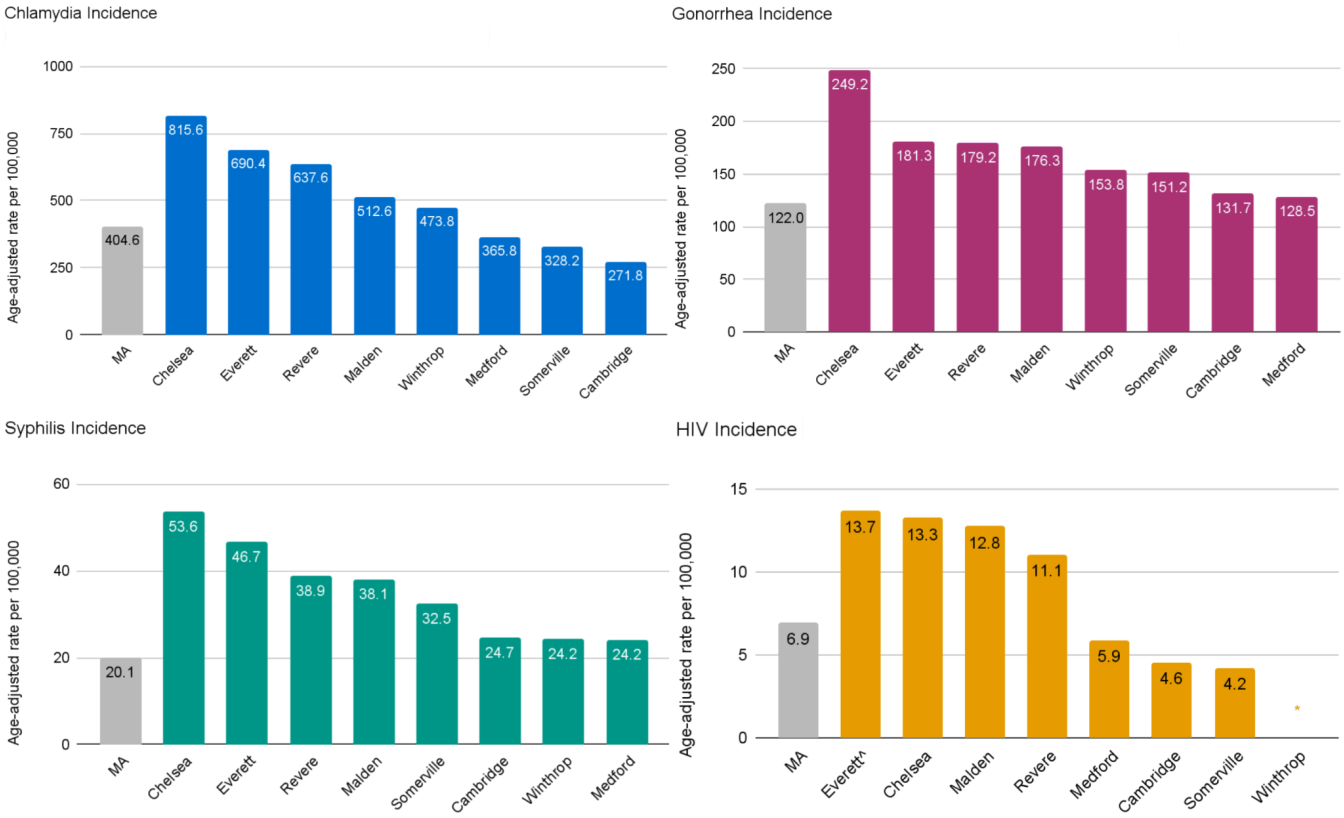
Source: MA Registry of Vital Records and Statistics, Selected Causes of Death, 2019-2023.

Diabetes mortality rates are lower overall compared to heart disease and cancer. However, rates are higher than the MA average in 6 communities: Everett, Malden, Somerville, Chelsea, Revere, and Medford. Diabetes indicators show the largest disparities between racial and ethnic groups. In all our communities, Black residents are 2 to 7 times more likely than White residents to visit the emergency room due to diabetes complications. Statewide, diabetes mortality rates are 2.2 times higher among Black residents and 1.7 times higher among Hispanic residents compared to White residents.

Chlamydia, gonorrhea, and syphilis rates have risen in our communities since 2020. While sexually transmitted infection (STI) testing has expanded, testing alone does not explain these increases. Chlamydia rates are higher than the MA average in Chelsea, Everett, Revere, Malden, and Winthrop. Gonorrhea and syphilis rates are higher than the MA average in all our communities. Racial and ethnic data are not available for chlamydia and gonorrhea, but we found that syphilis rates are significantly higher among Black and Hispanic residents compared to White and Asian residents.

New HIV diagnoses have remained stable in recent years and are lower than other STIs, but are still higher than the MA average in Everett, Chelsea, Malden, and Revere. There are wide racial and ethnic disparities, with significantly higher rates among Black and Hispanic residents compared to White and Asian residents in our communities.

Chlamydia, Gonorrhea, Syphilis, and HIV Incidence



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.

Key Finding #7 | Immigrant community members' physical and mental health is significantly impacted by social, economic, and political exclusion.

Across focus groups and interviews, immigrants described how policies and practices often threaten their communities' safety and wellbeing. The top stressors they reported include **fear of deportation**, **misinformation** about healthcare and resource eligibility, **language barriers**, **housing discrimination**, and **worker exploitation**.

> "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."

> "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)*

> "I'm a mother of two children. One is five years old and has special needs. I have to live on the third floor and carry that boy, and it's 28 steps... We're trying to get a first-floor apartment, but it's super difficult because everything is expensive, and we don't have any help. **Because, sometimes [with my] immigration status, I'm in the process, and I'm trying to avoid getting help because of that."**
>
> *(translated from Spanish)*

At the same time, immigrants who feel a sense of inclusion and have strong community connections – such as to cultural organizations, faith-based institutions, or neighbors – report positive impacts on their health.

Each of these stressors cause direct health impacts, such as anxiety, depression, or delayed access to healthcare. Participants who are undocumented shared how they fear discrimination and often do not feel safe speaking up about unsafe housing conditions or work conditions, which can lead to injury or illness.

There are indirect consequences too. Without a qualifying immigration status, undocumented adults 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. Some participants expressed fear or confusion about applying for resources that they or their children may in fact be eligible for, regardless of immigration status. Wage theft was another common concern that impacts financial stability.

Participants described how fear of deportation leads to isolation, and deters many people from seeking medical care. They also described difficulty navigating insurance and understanding healthcare options.

Several participants shared that immigrants are often blamed for problems that affect everyone – such as the housing crisis. Rather than recognizing shared struggles, this narrative creates division and resentment.

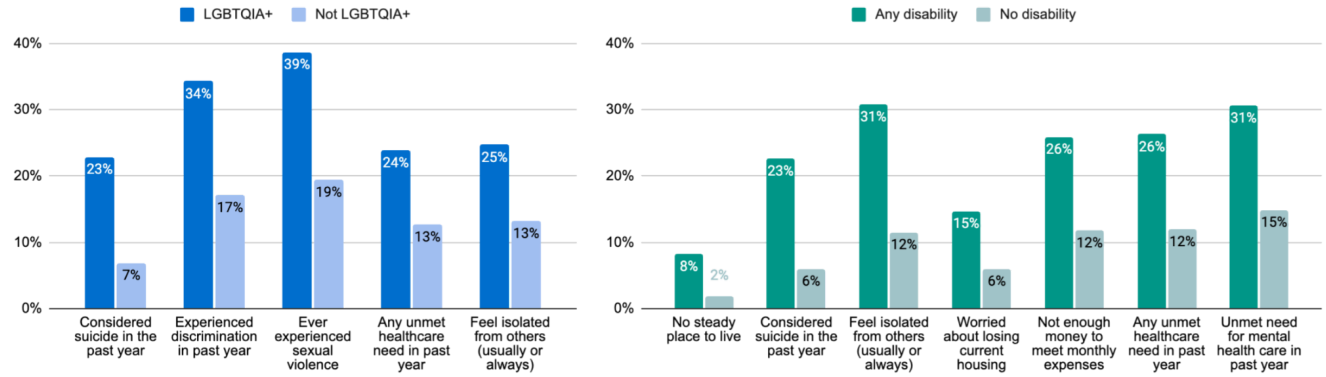
> "I see what I feel has been a failure to respond to a housing crisis. **It is an emergency that has been painted as an immigration crisis,** which is highly problematic and has contributed not only to a false narrative and backlash from neighbors, politicians, but has led to a reluctance to act better 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."**

Key Finding #8 | People with disabilities and LGBTQIA+ individuals experience disproportionate barriers to wellbeing.

There are significant differences in experiences of discrimination, violence, mental health, and access to resources when comparing LGBTQIA+ individuals and people with disabilities to their peers.

Data Point | Among residents of CHA's service area, the **biggest differences in experiences between LGBTQIA+ individuals and those who are not LGBTQIA+** were related to isolation and suicide, discrimination, sexual violence, and access to healthcare. There were even **bigger differences in experiences between people with disabilities and those without disabilities** – with the largest related to housing stability, isolation and suicide, financial stability, and access to healthcare, particularly mental healthcare.

Largest Disparities among CHA Service Area Residents



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

Notes: The selected indicators are those with at least a 1.9x difference between groups, in order from largest to smallest difference. Indicators of wellbeing barriers related to housing, basic needs, safety, discrimination, and mental health were assessed.

In focus groups and interviews, LGBTQIA+ individuals shared stories of being treated unfairly by healthcare providers and fearing violence. People with disabilities described the lack of accessible, affordable housing and reliable transportation, as well as the additional costs required to maintain quality of life, such as medical equipment. Both LGBTQIA+ individuals and people with disabilities emphasized that identities often intersect. For example, a person with a disability or who is LGBTQIA+ may also be part of a marginalized racial, ethnic, or language group. These overlapping identities can make barriers to wellbeing even greater. Overall, participants emphasized that systems can do a better job of including their voices and experiences in decision-making.

"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 health care... **It's hard trying to hide, the fear of discrimination or harassment from the people around you."**

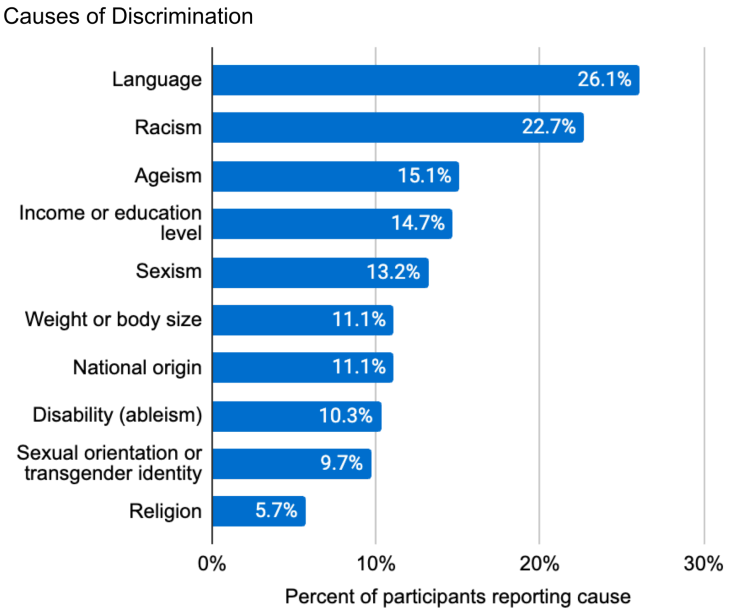
"**Cities and towns need to allow those with disabilities to be involved with decisions.** Hybrid meetings need to be a must for all so that they can attend calls and meetings and be informed about what's going on."

Key Finding #9 | Racism and language are the most frequently cited causes of discrimination.

In CHA's Community Wellbeing Survey, participants were asked if they had experienced discrimination in areas such as healthcare, housing, employment, and policing – and if so, what they believed the cause of that discrimination was. Racism and language were the most common reasons given.

Data Point | Among people who reported having experienced discrimination, the **most common reasons** given were speaking a language other than English (26%) and 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



Community members shared many examples of both structural and interpersonal discrimination – such as the legacy of racism in housing mortgage lending (known as redlining), bias against immigrants and refugees that excludes their participation on local committees, lack of attention to lead exposure among children of color, and more. As described in other key findings, people of color and immigrants often experience bigger barriers to wellbeing and worse health outcomes compared to their peers. These examples highlight the ongoing need to focus on language justice and anti-racism in all policies and practices.

"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."

"When we pressed about the need to speak English, their response was, well, it's too expensive, you have to hire interpreters, the meetings take too long, and again, we're looking for highly knowledgeable and deeply connected individuals. **And just that, this idea that our immigrants and refugees are *not* highly knowledgeable and deeply networked, when they *are*!** They're often the leaders and the forces that are driving change, moving communities."

"Linking arms and just amplifying each other's voices because again, we've got to let people know what's going on and what's at stake. **There is no safe amount of lead, period.** Can you imagine if [it were] all White students from affluent backgrounds? We would not be having this conversation."

Key Finding #10 | When community members participate in decision-making about issues that impact them, it can improve their wellbeing in direct and indirect ways.

Community members talked about how working with their neighbors, speaking up and advocating to elected officials and leaders, and getting involved in decision-making at school, work, and in the community helped their physical and mental health. When the people most affected by a problem help create and carry out solutions, those solutions are more likely to be equitable and effective.

Participants in our focus groups and interviews shared many ideas for how to strengthen wellbeing and fix problems – some of these are listed below. To solve community health challenges and advance equity, the people most affected need to be empowered and have a real voice. Meaningful involvement, accountability, and transparency are essential to improving health and wellbeing.

- ★ **Simplify and clarify housing application processes** to reduce access barriers
- ★ Invest in **housing education** and tenant workshops
- ★ Reform **zoning policies** and increase affordable, accessible housing development
- ★ Strengthen **partnerships between health care and housing agencies** to address housing as a social determinant of health
- ★ Frame housing insecurity as a systemic issue, **not an individual failing**
- ★ Expand programs to **help people navigate the healthcare system** – no matter who they are or what language they speak
- ★ **Embed health care services** in trusted community spaces
- ★ Communicate and strengthen outreach about **how climate resilience planning is built into local policy**
- ★ Address **air, soil, and water pollution sources** like trash incinerators, lead pipes and contamination, truck and bus depots, and other sources that impact environmental justice neighborhoods
- ★ Offer **mental health services tailored to climate anxiety** and people impacted by environmental disasters
- ★ Include **climate/ environmental health screenings** in medical settings
- ★ Implement policies that provide **protection against indoor extreme heat** and help people afford cooling solutions
- ★ **Include marginalized voices** from the start of decision-making processes
- ★ Provide robust **interpretation and translation** services across systems
- ★ **Raise wages and enforce labor protections**, especially in caregiving and service industries
- ★ Strengthen **community food systems** like urban farms, community gardens, food hubs, mobile markets, and culturally relevant nutrition education and cooking workshops
- ★ Expand access to **affordable childcare and caregiver support services**
- ★ Provide care and services in ways that **affirm our shared humanity**

Priorities for Collaborative Action

During the last Wellbeing Assessment in 2022, CHA and our Community Health Advisory Council developed a set of Priorities for Collaborative Action. These priorities include four focus areas and three equity principles. The focus areas define ***what*** we will work on addressing, together with CHA and community stakeholders. The equity principles guide ***how*** we will address these important issues. The findings of the 2025 assessment show that these priorities remain relevant and require continued collaboration to address.

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.

Questions or Comments?

Please visit the Cambridge Health Alliance Community Health Data & Reports webpage for more data, information, and resources: www.challiance.org/communityhealthdata

Acknowledgements

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The Health Improvement Team, part of the CHA Department of Community Health, leads the Wellbeing Assessment and Implementation Strategy process. Our team includes:

Laura McNulty, MPH, MSW
Kathleen O'Brien, MA
Jean Granick, MS
Alexis Sarpong, MPH

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Finally, we thank each interviewee, focus group participant, and survey participant. Thank you for trusting us with your stories. Your knowledge, experiences, and opinions not only inform this report – they call us to action. We are committed to stewarding your voices to strengthen health and wellbeing in the communities that Cambridge Health Alliance is proud to serve.

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