

# THE CITY OF CAMBRIDGE COMMUNITY HEALTH NEEDS ASSESSMENT



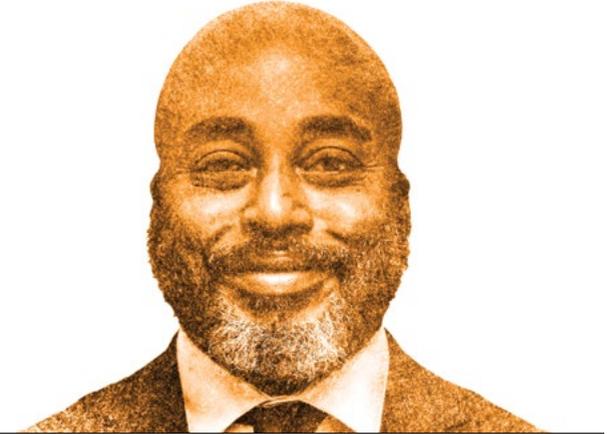
Cambridge  
Public Health  
Department

JANUARY 2025



# Derrick Neal

## CHIEF PUBLIC HEALTH OFFICER



### Hello.

Thank you for your interest in the City of Cambridge's Community Health Needs Assessment. This assessment results from the work of a Community Advisory Committee convened by the Cambridge Public Health Department (CPHD) to help guide the department over the next several years. Committee members represented city agencies and our community nonprofit partners who were invited to bring their voices and perspectives to the process that informs CPHD's programmatic priorities. I would like to offer my sincere gratitude to the members of the Committee for dedicating their time and their expertise to this important work.

The Community Advisory Committee considered a wide range of primary and secondary data sources, exploring:

- Demographics of the Population Served by CPHD;
- Health Status and Health-Related Behaviors;
- Community Assets and Resources, Utilization, and Barriers to Care;
- Social Determinants of Health; and Disparities.

The group reached conclusions about the major challenges to health equity for certain groups in the city including:

- Immigrants, Refugees, and People of Color;
- Older Adults and People with Disabilities;
- Low-Income Families/Individuals, Persons who are Unhoused, and Victims of Abuse, Neglect, and Exploitation; and
- Youth, Young Adults, and the LGBTQIA+ Community.

Based on their examination of the data, the committee identified several cross-cutting issues that, if addressed in the city's Community Health Improvement Plan (CHIP), could improve health equity for multiple populations in Cambridge. The committee members recommended that CHIP leadership examine these issues as they consider the priorities moving forward.

CPHD has embarked on its CHIP planning work. I invite you to join us as we dive into the next phase of the process.

Sincerely,

A handwritten signature in blue ink that reads "Derrick L. Neal".

Derrick Neal

# Acknowledgments

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Selena Durden, Margaret Fuller House

Michelle Godfrey, Community Engagement Team

Shameka Gregory, Transition House

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### Why earn PHAB accreditation?

PHAB supports health departments in their work to promote the health of the communities they serve through accreditation and recognition, education, technical assistance, and research and evaluation. PHAB accreditation benefits health departments in a variety of ways, including their ability to maximize existing resources and increase competitiveness for new funding; improving health department services and performance; strengthening relationships with multi-sectors partners and accountability to external stakeholders; and in planning for emergencies and to address health priorities using a health equity lens.

## 1

# Background on Assessment, Improvement Planning, and Accreditation

In 2013, the Cambridge Public Health Department (CPHD), a city department administered by the Cambridge Health Alliance, conducted its first comprehensive community health needs assessment (CHNA). This effort culminated in a clearer picture of the health needs of the community and informed the collaborative community health improvement planning (CHIP) process that followed.

In August of 2018, CPHD became nationally accredited by the Public Health Accreditation Board (PHAB), a nonprofit organization developed in 2007 with a mission to advance and transform public health practice by championing performance improvement, strong infrastructure, and innovation. CPHD is one of only three local public health departments in Massachusetts to earn PHAB accreditation.

The CHNA and CHIP, elements of the accreditation process, are conducted every five years to ensure that CPHD understands and is responsive to the needs of the community, including disparities affecting subpopulations within the city that must be addressed to achieve health equity.

CPHD completed its second CHNA in 2020, followed by a second CHIP in 2021. The 2025 Community Health Needs Assessment process is described on the next page.

Figure 1. AHA's Community Health Assessment



# A | THE 2025 COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS

Figure 1 shows the American Hospital Association’s Community Health Assessment model,<sup>1</sup> the process CPHD adapted for how partners within Cambridge would collaborate in developing the CHNA. Between May and December of 2024, CPHD completed the first five steps of the process, as described below.

## 1. Map the Development Process

The internal CPHD planning team reviewed the PHAB Standards and Measures for Reaccreditation; engaged an evaluation consultant with CHNA expertise to assist CPHD with its assessment process; reviewed feedback from PHAB; and sought input from participants from the 2020 CHNA to understand what worked well and what did not. Among the lessons learned that the planning team committed to address in the 2025 CHNA were:

- Drawing a clearer connection between secondary data and the health needs of the community
- Identifying or developing a clear list of community assets
- Assessing health care (primary/behavioral health) availability, service gaps, and emerging healthcare access issues
- Engaging mid-level and frontline staff in the CHNA’s advisory group and as data sources to ensure perspectives informing the CHNA are from those who work directly with and understand the Cambridge community and its sub-populations

## 2. Build Relationships

The CPHD internal planning team identified and engaged stakeholders for its Community Advisory Committee (see Table 1). Among the 23 members were 15 from organizations outside of governmental public health. Several members are Cambridge residents themselves and represent organizations that serve populations who are disproportionately affected by conditions that contribute to poor health outcomes (e.g., communities of color, persons with disabilities, immigrants/refugees, victims of violence). The committee members met four times (twice in person and twice virtually) in May, June, September, and November 2024. The Committee’s role was to plan the CHNA methodology,

discuss data from primary and secondary sources, draw conclusions, and develop recommendations for CPHD’s next CHIP.

## 3. Develop a Community Profile

A critical first step to understanding community health is understanding who lives within the city. The Community Advisory Committee members reviewed demographic data about the Cambridge population, including the many diverse sub-populations within it (e.g., race, ethnicity, language, income, education, employment, age, disabilities, country of origin/place of birth) and discussed implications of the findings (e.g., income inequality, unemployment, linguistic barriers) for the resources available to support good health, especially within sub-populations.

**Table 1. Organizations That Partnered With CPHD on the 2024 CHNA**

Community Advisory Committee Members	Sectors/Populations Partners Represent
Cambridge Agenda for Children Out-of-School Time	Out-of-school programs for children and youth
Cambridge Commission for Persons with Disabilities	Advocacy & resources for persons with disabilities
Cambridge Council on Aging	Services for older adults
Cambridge Data Services	Data access for all organizations & residents
Cambridge Economic Opportunity Committee	Anti-poverty programs
Cambridge Housing Authority	Housing
Cambridge Human Services	Human Services
Cambridge Office of Early Childhood	Human Services
Cambridge Public Schools Social Emotional Learning	Education - children and youth
Community Arts Center	Arts for children and youth
Community Development Department	City Planning
Community Engagement Team	Community Outreach to immigrants/refugees
Community Learning Center	Employment and Adult Education
Margaret Fuller House	Immigrants & Vulnerable Residents
Transition House	Services for survivors of domestic violence

<sup>1</sup>American Hospital Association Community Health Assessment Toolkit accessed online at: <https://www.healthycommunities.org/resources/community-health-assessment-toolkit>

#### 4. Increase Equity with Data

The Community Advisory Committee reviewed both primary and secondary data to identify major health conditions and related disparities as well as the implications of community assets, barriers to care, and the social determinants of health for health status and health equity.

#### 5. Prioritize Needs and Assets

The Community Advisory Committee adapted AHA’s suggested criteria to identify issues to recommend to CPHD for inclusion in the next CHIP. The modified criteria are:

- Magnitude of the problem or asset
- Severity of the problem
- CPHD’s (with its partners) capacity, resources, and willingness to act on the issue

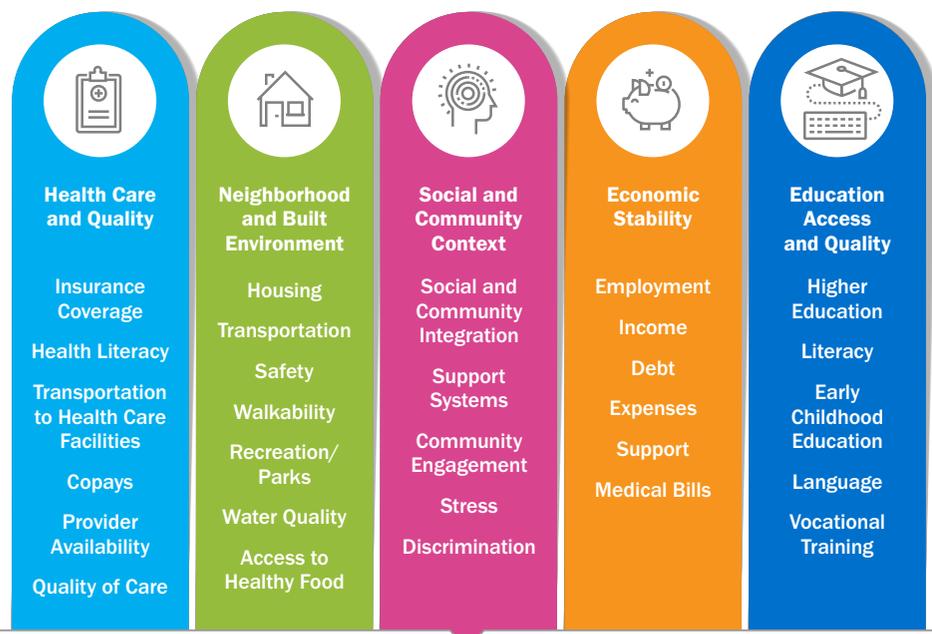
- Ability to have a measurable impact on the issue
- Whether existing interventions are focused on the issue
- Whether the issue is a root cause of other problems
- The priority the community places on the problem

The committee identified a number of issues that, if addressed, could improve health equity for multiple sub-populations within the city (see Section III). Additionally, the committee identified issues that have an impact on health equity that are outside the scope of the health department and its partners. CHNA data on these issues should be shared with city leadership for use in other forms of planning.

#### 6. Document and Communicate Results

The CHNA report describes the data reviewed by the committee as well as its conclusions about the issues affecting health equity. The report was designed for multiple audiences, including CPHD staff and community partners who will engage in planning to address the challenges to health equity and community members and leaders (e.g., the City Manager, the City Council, community organizations, business community) not directly involved in the CHNA and CHIP but who have a stake in community health. The report will be provided to PHAB and available on the CPHD website.

Figure 2. The Social Determinants of Health



## B | KEY CONCEPTS INFORMING THE CHNA

The aforementioned steps were taken with the goal of achieving **health equity**. According to the Robert Wood Johnson Foundation, health equity means that “everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.”<sup>2</sup> From the engagement of partners who work with disadvantaged populations to the data sources and indicators reviewed by the committee and the criteria used to identify issues for the CHIP, CPHD and its partners were focused on identifying, understanding, and addressing factors that prevent some groups in the community from having a fair and just opportunity to be as healthy as possible.

HEALTH, WELL-BEING, FUNCTIONING, QUALITY-OF-LIFE OUTCOMES AND RISKS

<sup>2</sup><https://www.rwjf.org/en/insights/our-research/2017/05/what-is-health-equity-.html>

The Community Advisory Committee recognized that data on health outcomes and health behaviors (and disparities in both) were essential to understanding the health-related needs and challenges in Cambridge. However, as reported by the Centers for Disease Control and Prevention, addressing differences in the **social determinants of health** (SDOH) accelerates progress toward health equity. Thus, the committee members understood the need to devote substantial time to also analyzing information about the SDOH and understanding how these factors affect the health of the city and its sub-populations. Commonly defined as the conditions in environments where people are born, live, learn, work, play, worship, and age, the SDOH have been shown to have a greater influence on health than either genetic factors or access to healthcare services.<sup>3</sup> *Figure 2* shows the five domains of the SDOH and conditions within each that affect a wide range of health, functioning, and quality-of-life outcomes and risks.<sup>4</sup> The committee explored data in all five SDOH categories as part of the assessment.

## C | METHODS

### Secondary Data

The committee reviewed and discussed quantitative data from multiple national, state, and local sources (*See Table 2*) outside of CPHD to understand:

1. The demographics of the population and sub-populations that live in Cambridge
2. The health status and health-related behaviors of Cambridge residents and disparities affecting sub-populations

3. Community assets and resources that support, promote, or improve the health of residents (overall and sub-populations), including health and behavioral health resources, and barriers to care
4. The social determinants of health, their relationship to the health of the community, and which sub-populations are affected disproportionately by the SDOH.

The committee faced some limitations in the secondary data. For example, city-level data were sometimes several years old or were not available for racial/ethnic groups. In such cases, national trends (e.g., for low birth weight, stroke, cancer) were noted when available.

### Primary Data

The Community Advisory Committee decided to utilize key informant interviews to gather qualitative information to help elucidate the findings from the secondary data. On behalf of the committee, the CHNA consultant conducted interviews with 39 community leaders/service providers who work in 36 city and community agencies (see Table 3). The key informants work in diverse sectors, including adult education, the arts, behavioral health (mental health and substance use disorders), climate/environment, community organizing, education, food access, housing, faith communities, health care (hospital and primary care), human services, oral health, and public safety. The informants also work with and represent a range of sub-populations within the city, including people with disabilities, those experiencing unstable housing and homelessness, children and youth, older adults, and populations facing systemic oppression, such as Black, Indigenous, and People of Color (BIPOC), immigrants and refugees, and LGBTQIA+ communities. The interviewees were primarily mid-level and direct

**Table 2.**



### Selected secondary data sources used in the 2024 CHNA

City of Cambridge Residents Survey  
 County Health Rankings & Roadmaps  
 Federal Bureau of Investigation Uniform Crime Reports  
 MA Department of Elementary and Secondary Education School and District Profiles  
 MA Department of Public Health Community Health Equity Survey; Vital Statistics; State Cancer Profiles  
 U.S. Center for Medicare and Medicaid Services Beneficiary Hospitalizations & ER Use; SUDs providers  
 U.S. Centers for Disease Control and Prevention: Youth Risk Behavior Survey; Behavioral Risk Factor Surveillance Survey; National Vital Statistics  
 U.S. Census Bureau, Decennial Census; American Community Survey  
 U.S. Department of Education ED Facts  
 U.S. Health Resources Services Administration Primary Care Providers  
 U.S. Internal Revenue Service, 501(c)(3) organizations

<sup>3</sup>Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>

<sup>4</sup>Graphic accessed on October 5, 2024 at <https://www.chesshealthsolutions.com/2021/09/08/what-are-social-determinants-of-health-and-why-do-they-matter/>

service staff who have direct contact with various sub-populations within the city and an understanding of the health needs and challenges those sub-populations face. The interviews employed a semi-structured interview tool and thematic analysis to explore:

1. How the community has changed over the past five years (since the last CHNA)
2. The assets and needs of the community and those the interview participants serve
3. Barriers and facilitators to health and wellness and what’s needed to address barriers (including health and behavioral health services)
4. The Community Advisory Committee discussed whether to conduct a survey of Cambridge residents. Ultimately, the group decided not to conduct its own survey as there were already three existing surveys with overlapping objectives that could be promoted and used instead. These surveys included:
  - a. The Mt. Auburn Hospital system’s CHNA. Cambridge is among the communities in the Mt. Auburn Hospital service area, and Cambridge residents were targeted to respond to the hospital’s survey to inform its CHNA. Mt. Auburn will share its survey data with CPHD when it becomes available.

- b. The Community Health Equity Survey (CHES) being conducted by the Massachusetts Department of Public Health, which includes items similar to past surveys conducted by CPHD. The CHES will allow CPHD to access Cambridge-specific data and compare it to other communities and the state overall.
- c. The City of Cambridge resident survey, which asks about quality of life, safety, community engagement, mobility, housing, and other SDOH topics.

The assessment findings are summarized in five sections below:

1. Demographics of the Population Served by CPHD
2. Health Status and Health-related Behaviors
3. Community Assets and Resources, Utilization, and Barriers to Care
4. Social Determinants of Health
5. The section, entitled “Disparities,” tells the story of individual sub-populations who are at risk for poor health outcomes due to the social determinants of health and disparities in access to care

**Table 3.**



**Organizations involved in the key informant interviews**

Access/AIDS Action	Cambridge Public Health Department, Environmental Health
Cambridge Agenda for Children in Out of School Time	Cambridge Public Schools, Social Emotional Learning
Cambridge Commission for Persons with Disabilities	Cambridge Somerville Elder Services
Cambridge Community Center	Commission on Immigrants’ Rights and Citizenship
Cambridge Community Safety Office	Community Arts Center
Cambridge Council on Aging	Community Engagement Team (CDHSP)
Cambridge Department of Human Service Programs	Community Learning Center
Cambridge Economic Opportunity Committee	Community Safety Department
Cambridge Health Alliance, Cambridge Family Health North	ENROOT
Cambridge Health Alliance, Family Care Partners	First Church Cambridge
Cambridge Health Alliance, Windsor Clinic	Food for Free
Cambridge Health Alliance, Zinberg Clinic	Green Cambridge
Cambridge Multi-Service Center	Healthcare for the Homeless
Cambridge Office of Early Childhood	Mount Auburn Hospital Community Benefits
Cambridge Office of Workforce Development	Mount Auburn Primary Care / Belmont Medical Associates
Cambridge Pediatric Dental Associates	Native American Indian Center of Boston
Cambridge Police Department, Clinical Support Services	Rindge Tenants Association
	Transition House
	WIC

# 2 Findings

The findings below were derived from the primary and secondary sources described in the methods section. The figures and tables associated with the narrative below are provided in the report's appendix. The secondary data described below is followed by a table or figure number so that the information can be easily located in the corresponding table or figure in the appendix.

The terminology across secondary data sources when referring to sub-populations sometimes differs (e.g., Asian vs. Asian/Pacific Islander vs. Asian/Native Hawaiian/Pacific Islander). Because the terms used by a given secondary source are used in the narrative below, different terms may be used to describe the same group throughout the findings section (e.g., Hispanic/Latino vs. Hispanic/Latinx vs. Hispanic).

## A | DEMOGRAPHICS OF THE POPULATION SERVED BY CPHD

CPHD's charge is to improve the quality of life for all residents of Cambridge. When one examines the demographics for the city as a whole, particularly indicators for education and income, Cambridge appears to be a community of wealthy and educated residents in comparison to the state and country. However, as one key informant explained, the story of Cambridge is "a tale of two cities." Despite the overall well-being of many residents, analyzing health indicators by demographic subgroups reveals that certain populations are struggling due to a lack of education, financial resources, or English proficiency, which are crucial for obtaining well-paying jobs, quality housing, reliable transportation, stable living conditions, and access to essential health and behavioral health care. Whenever possible, the indicators discussed in this section are provided for both the city's overall population and for sub-populations so that such disparities are identifiable.

### 1. Population Size and Distribution

According to each decennial census over the 70 years between 1950 and 2020, the City's population size was largest in 1950 at 120,740. Although it declined thereafter, dipping below 100,000 in 1980 and 1990, by 2020 the population of Cambridge was once again approaching the 70-year high. The 2018-2022

American Community Survey (ACS) provides a population estimate for Cambridge of 117,962 (*Figure 3*).

Cambridge is 7.1 square miles (6.4 square miles of land and .71 of water) and is made up of 13 neighborhoods that differ in population size and density. According to the 2018-2022 ACS, the smallest in terms of population size and density was Cambridge Highlands at 1,716 residents and 9.08 residents per acre. The largest in terms of population size was North Cambridge with 15,381 residents, while the densest was Riverside at 59.06 residents per acre (*Table 4*).

### 2. Population by Age

Based on the 2020 Census, Cambridge could be described as a young city, with 89% of the population under age 65. Those 20 to 29 years of age made up 32% of the population, whereas those aged 19 and under comprised 16% (*Figure 4*).

### 3. Race and Ethnicity of the Population

The key informants reported that, while still a majority White city, Cambridge is becoming increasingly racially/ethnically diverse, driven in part by individuals and families from around the world who have moved to Cambridge for education and work opportunities and/or because Cambridge is a progressive, welcoming community with many resources that can aid in resettlement. While there has been an increase in racial/ethnic diversity overall, several key informants indicated that Black families who have resided

in Cambridge for decades are increasingly moving out of the city primarily due to the cost of living. The Census shows that between 1950 and 2020, among all residents, the city's White population has been the largest. In 2020, the city's population was 58% White. However, the proportion of Asian, Hispanic/Latino, and "All Other" residents has increased over time. The largest growth among non-White groups was among Asians, who in 2020 comprised 19% of the population. The proportion of Black residents hit its 70-year peak in 1990. In 2020, it was 12,520 or 11% of the population. In 2020, 9% of the Cambridge population was Hispanic/Latino (*Figures 5 and 6*).

Between 1980 and 2020, among those under the age of 18, the White population was and continues to be proportionately the single largest followed by the Black population. However, the proportion of White and Black youth has decreased since 2010, whereas the proportion that are Asian, Hispanic/Latino, and Other has increased. The city's youth (under age 18) were more racially/ethnically diverse than the population overall in 2020. While 58% of the total population in 2020 was White, among youth, 58% were people of color (i.e., Hispanic/Latino and/or a race other than White) (*Figures 7 and 8*).

#### 4. Birth Rate

Between 1989 and 2021, the birth count in Cambridge was highest in 2011 (at 1,304). The City's 2021 birth count (of 966) was the lowest it has been since 1996. Thus, while the population of Cambridge grew between 2010 and 2020 (*per Figure 3*), births were not the primary driver of the population increase. In 2021, 47% of newborns were from communities of color (*Figures 9 and 10*).

#### 5. Education

According to the 2018-2022 ACS, 79.9% of the City's residents have a college degree or higher. The proportion of those with bachelor/graduate degrees was highest among Asian (92.7%) and White (83.8%) residents and lowest among Black (40.4%) residents (*Figure 11*).

#### 6. Languages Spoken

In Cambridge, between 2018 and 2022, the proportion of residents who spoke a language other than English at home was highest among the Asian (71.9%) and Hispanic/Latino (69.1%) populations. During the same time period, the majority (65.5%) of people aged 5 and over spoke English at home. Of those who spoke something other than English at home (n=38,973), 23.9% spoke English less than very well. The key informants described racial/ethnic diversity

and immigrant populations as contributing to the city's richness while also acknowledging that the diversity of languages and number of residents with no/low proficiency in English present significant challenges related to access to care and meeting the needs of the population, concepts described in more detail in Section II, parts C and E (*Figure 12 and Table 5*).

#### 7. U.S. or Foreign-Born

Between 2018 and 2022, the majority (71.2%) of the population was U.S.-born. However, the proportion of Black, Asian, and Hispanic/Latino residents who were foreign-born was double the proportion of White residents. Among Asian residents, the majority (65.6%) were foreign-born. The top three foreign places of birth were mainland China, India, and Korea (*Figure 13 and Table 6*).

#### 8. Disabilities

Between 2018 and 2022, 6.9% of the City's population had some form of disability. Among adults ages 18-64 who had a disability, 44.5% were employed (*Tables and 8*).

#### 9. Income and Poverty

The key informants explained that, because of its vibrant business community, world class universities, and excellent public schools, Cambridge has become increasingly attractive to higher income individuals and families. But they also explained there is substantial disparity in incomes. Many informants asserted that the city's residents are on one end of the economic scale or the other (i.e., very wealthy or very low income). They reported that the middle class is being "squeezed out" of Cambridge because middle class residents can't afford the cost of living in the city and are over-income for public housing and other programs. They noted that, if you look at economic indicators for the city overall, it appears to be a very wealthy community. However, they cautioned that these numbers tend to mask the poverty with which a portion of the community struggles.

Across the U.S., in Massachusetts, and in Cambridge, household median incomes in 2018-2022 were higher than in 1999. However, the increase in median income in Cambridge across the same time period was more than five times the increase for Massachusetts overall. Similarly, in Massachusetts and the U.S., family median income was higher in 2018-2022 than it was in 1999. The increase over the same time period was 41% higher in Cambridge than in Massachusetts (*Table 9*).

In the 2018-2022 time period, the mean household income of Cambridge residents in the upper income quintile was more than 23 times greater than the mean household income of those in the lowest quintile (*Figure 14*). Those who earned the top 5% of incomes in Cambridge in 2018-2022 (households earning a minimum of \$250k per year) had a mean income of \$771,319 per year.

The proportion of adults and all households living in poverty decreased from 2006-2010 to 2018-2022. The same was true for sub-groups in the city (i.e., under 18 and 65 and over; households of unrelated adults and non-family members as well as those with families; households with no working adults; families with children; single moms and single moms with kids under age 4; new moms). Although the proportion of residents living in poverty decreased over the two time periods, single mothers, particularly those with children under age 5, were most at risk for living in poverty in both time periods (*Table 10*).

While overall and in each racial/ethnic group, the proportion of families living in poverty was lower in 2018-2022 than in the previous time periods, the proportion of Black, Asian, and Hispanic/Latino families living in poverty in 2018-2022 was several times greater than White families, and the percentage was highest for Black families (*Figure 15*).

### In Summary

Cambridge is a relatively young city with 89% of residents under age 65. While the White population is still the largest racial group in Cambridge, the city is becoming increasingly racially/ethnically diverse. Over a quarter of the population was foreign-born, with higher proportions among people of color. People of color are the majority of those under age 18. While the majority of residents speak English at home, among those who do not, the majority speak English less than very well. Although over 80% of the population overall and the majority of White, Asian, and Hispanic/Latino residents have a college degree or more, this is true for only a minority of Black residents (40.4%). Household and family median incomes have climbed over time. While the percentage of residents in key groups living in poverty has decreased, 12% of the population lives in poverty, and significant disparities in income exist. Roughly 7% of the population has a disability of some kind, and unemployment among adults with disabilities (ages 18-64) is substantially higher than for those not living with a disability.

Demographically and culturally, Cambridge is a richly diverse city, but that richness is accompanied by racial/ethnic disparities in income and education and linguistic barriers to care. These factors mean that, for some of the city's diverse sub-populations, inequities exist, such as the ability to afford conditions that support health (e.g., healthy foods, stable and quality housing) and to access resources, including health and behavioral health services. Those with disabilities, while a relatively small sub-population within the city, also face inequities related to higher rates of unemployment and the economic challenges that accompany it. Section II, part E, in particular, explores these inequities and their impact on the health of sub-populations in more detail.

## B | HEALTH STATUS AND HEALTH-RELATED BEHAVIORS

Similar to the demographics section above, when one reviews data for Cambridge as a whole, it could be described as a “healthy” city. In general, life expectancy and most indicators related to health status and health behaviors are more favorable for Cambridge than the state or country. However, also like the discussion of demographics, when one drills down to examine differences among sub-populations, it becomes clear that some groups within Cambridge do not do as well in terms of their health and health-related behaviors. This section explores, whenever possible, both the data for the city's population as a whole and data on sub-populations (generally for different racial/ethnic groups). Data were not available for specific sub-populations for all indicators discussed in this section. In some cases, national trends<sup>5</sup> are discussed in relation to indicators that are widely understood to have a disproportionate impact on certain sub-populations.

### 1. Life Expectancy

For the 2010-2015 time period, the life expectancy at birth for Cambridge residents was 82.03 years, greater than Massachusetts and the U.S. (*Figure 16*). While life expectancy data were not available for individual racial/ethnic groups in the city, national trends suggest there are likely differences in life expectancy, with Black and American Indian/Alaska Native populations experiencing shorter life spans than White, Asian, and Hispanic/Latino populations.

<sup>5</sup>National Institutes of Health. (2022). Life expectancy in the U.S. increased between 2000-2019, but widespread gaps among racial and ethnic groups exist. Accessed on October 9, 2024 at <https://www.nih.gov/news-events/news-releases/life-expectancy-us-increased-between-2000-2019-widespread-gaps-among-racial-ethnic-groups-exist>

## 2. Birth Weight

During the years 2014-2020, 7% of live births of infants born to Cambridge residents were low birth weight (<2,500 grams). The rate was less than statewide and nationwide (*Figure 17*). Still, during the time period, over 470 infants born to Cambridge residents had low birth weights. While data by race/ethnicity were not available for the city, nationwide the percentage of low birthweight births is higher among American Indian/Alaska Native, Asian/Pacific Islander, Black/African American, and Hispanic/Latino populations and people of two or more races than for White populations. This was the case nationally for every year between 2016 and 2022.<sup>6</sup>

## 3. Chronic Disease

Clinicians and outreach workers among the key informants reported that several chronic diseases persist for at-risk groups. Specifically, they expressed concerns about metabolic disorders, including diabetes, heart disease, hypertension, obesity, and asthma and other respiratory conditions. They suggested that immigrant and non-English speaking populations often lack knowledge about chronic disease and prevention strategies. They reported that disproportionately, low-income individuals who are often food insecure have poor nutrition that can be directly linked to diabetes and heart disease. Additionally, they explained that low-income individuals often lack the time for and/or access to exercise opportunities. Finally, they expressed concern about the impact of asthma and childhood respiratory illness on the health, social development, and academic performance of youth, particularly low-income youth and youth of color. Secondary data were available for a number of chronic diseases and underlying conditions:

- **Hypertension:** In 2021, 19% of Cambridge adults age 18+ reported ever having been told by a medical professional that they have high blood pressure, a lower proportion than for Massachusetts and the U.S. The proportion of White and Black adults 18+ in Cambridge who reported ever being told by a medical professional that they have hypertension was higher than the rate overall and among other groups, but it was highest among Black adults (*Figures 18 and 19*).

- **Stroke:** In 2021, the rate of adults in Cambridge age 18+ who reported ever being told by a medical professional that they have had a stroke was lower than for Massachusetts and the U.S. (*Figure 20*). Although city-level data were not available by race/ethnicity, nationally the risk of having a stroke varies with race and ethnicity.<sup>7</sup> Black adults are at nearly twice the risk of having a stroke as White adults, and Black and Pacific Islander adults have the highest rates of death from stroke.<sup>8</sup>
- **Obesity:** In 2021, the proportion of Cambridge adults age 18+ who were obese (BMI  $\geq 30$  kg/m<sup>2</sup>) was 21.8%, lower than in Massachusetts and the U.S.. Rates of obesity were highest among Black and Hispanic/Latino residents at 22.8% and 20.2%, respectively (*Figures 21 and 22*).
- **Diabetes:** In Cambridge in 2021, the proportion of adults age 18+ who reported ever having been told by a medical professional that they have diabetes was lower than in Massachusetts and the U.S. at 5.2%. However, the rate among Black adults (9.8%) was at least twice the rate of diabetes among White, Asian, Hispanic/Latino, and all other adults (*Figures 23 and 24*).
- **Asthma:** In 2021, the proportion of adults 18+ in Cambridge who reported “yes” to both of these questions: “Have you ever been told by a doctor, nurse, or other health professional that you have asthma?” and “Do you still have asthma?” was 10.3%, which is lower than statewide but higher than the U.S. overall. The proportion of White residents 18+ who reported having been told by a medical professional that they have asthma or still have asthma was 7.6%, which was higher than other racial/ethnic groups (*Figures 25 and 26*).

## 4. Cancer

From 2016-2020, the age-adjusted incidence rate (cases per 100,000) of cancer in Cambridge (426.4/100,000) was lower than the rate for Massachusetts and for the U.S. (*Figure 27*). City-level cancer rates are not available by race/ethnicity. Although 2017-2021 data showed that new cancer cases nationally were higher for White populations, 2018-2022 data showed that deaths due to cancer were higher among Black and American Indian/Alaska Native populations.<sup>9</sup> Outreach workers among the key informants indicated that cancer-related deaths have increased in the immigrant communities in which they work, primarily due to a decrease in cancer-related screenings during the pandemic.

<sup>6</sup>KidsCount (2024). Low birth-weight babies by race and ethnicity in United States. Accessed on October 10, 2024 at: <https://datacenter.aecf.org/data/tables/9817-low-birth-weight-babies-by-race-and-ethnicity#detailed/1/any/false/1095,2048,574,1729,37,871,870/8223,4040,4039,2638,2597,1353,4758/19108,19109>

<sup>7</sup>Tsao CW, Aday AW, Almarzooq ZI, et al. Heart disease and stroke statistics—2023 update: a report from the American Heart Association. *Circulation*. 2023;147: e93–e621.

<sup>8</sup>National Center for Health Statistics. Multiple Cause of Death 2018–2022 on CDC WONDER Database. Accessed May 3, 2024. <https://wonder.cdc.gov/mcd.html>

<sup>9</sup>National Institutes of Health, National Cancer Institute. Cancer Stat Facts: Cancer Disparities. Accessed on October 9, 2024 at <https://seer.cancer.gov/statfacts/html/disparities.html>

## 5. Behavioral Health (Substance Use and Mental Health)

Key informant interviews suggest that mental health and substance use disorders are among the top 10 greatest challenges facing the city. The interviewees indicated that anxiety and depression are worse than they were five years ago due to a number of factors, including loss, isolation, and loneliness fueled by the COVID-19 pandemic, cumulative stress related to economic pressure, and a range of other factors (e.g., political instability, racial/law enforcement tension, the climate crisis, anti-immigrant sentiments, and gun violence). They reported that several groups have been disproportionately affected by worsening mental health:

- **Youth** suffered isolation during the pandemic, often lack consistent and supportive relationships with adults, and frequently have a fear of the future. Additionally, youth of color experienced greater losses due to deaths caused by COVID-19 and its disproportionate impact on communities of color.
- **LGBTQIA+ youth** were described as at increased risk for isolation, bullying, and mental health challenges including anxiety and depression.
- **Immigrants and refugees** were described as experiencing possible trauma in or as a result of relocating from their country of origin, and their children often face the additional stress of serving as the liaison and interpreter between non-English speaking parents and people and systems in their new city. Often immigrants have no experience with the concept of mental health, or it has negative connotations, and thus immigrants tend not to seek mental health care. There are too few mental health providers who speak languages other than English and/or who share similar life experiences with immigrant communities, which affects access to care for those who might seek it.
- **Low-income residents** are affected by long-term economic stress.

In 2021, at 20.1%, the proportion of Cambridge adults 18+ who reported binge drinking (i.e., men having 5+ drinks or women 4+ drinks on an occasion in the past 30 days) surpassed the rates for Massachusetts (16.8%) and the U.S. (15.5%) (*Figure 28*). Data for sub-populations were not available for the city.

At 133 deaths or 22.2/100,000 residents, the age-adjusted death rate due to overdose in Cambridge between 2016-2020 was lower than for Massachusetts and the U.S. (*Figure 29*). The key informants reported that use of substances has increased over the last five years (since the last CHNA), particularly opioid use. They warned that the drug supply has become contaminated with fentanyl and that there has been a shift toward smoking versus injection drug use. Despite increased use, overdose deaths have decreased, largely due to the increase

in Narcan-trained public safety personnel, business owners, and residents. However, some explained that the unhoused segment of the population that uses drugs has begun to migrate away from the more visible/public locations in Cambridge to areas of the city where it is harder for Narcan-trained responders to see and assist someone who may be overdosing. A few key informants described the provision of sharps containers in public locations as very effective, but reported that more containers are necessary, particularly in areas frequented by those who are using injection drugs. Finally, there was a sense among some key informants that self-medicating is on the rise among the city's youth to address anxiety and depression.

## 6. Tobacco Use

Compared to Massachusetts and the U.S. in 2021, at 7.6%, Cambridge had a lower proportion of adults 18+ who reported having smoked at least 100 cigarettes in their lifetime or who are currently smoking every day or some days; rates were highest among White residents (7.8%) and those who identified as "Other" races (7.2%) followed closely by rates for Hispanic/Latino and Black residents (6.4% each) (*Figures 30 and 31*). The key informants indicated that older adults have high rates of tobacco use and smoking and that Cambridge youth are increasingly vaping.

## 7. Physical Activity

The proportion of Cambridge adults over the age of 20 who reported not participating in any physical activity or exercise outside of their regular jobs in the past month (16.6%) was lower than statewide or nationwide (*Figure 32*). The key informants explained that Cambridge is a very walkable city and is fairly conducive to biking with its designated bike lanes. But for low-income individuals who may have little flexibility in their work or who may be working two jobs, or those juggling work and families, finding time to exercise and being able to afford a gym membership, bike, or other exercise equipment are barriers to exercise.

## 8. Unintentional Injury

At 39/100,000, the age-adjusted death rate per 100,000 residents in Cambridge due to unintentional injury between 2016-2020 was lower than rates for Massachusetts and the U.S. Nevertheless, roughly 258 Cambridge residents died of unintentional injury during the time period (*Figure 33*).

## 9. Violent Crime

At 118/100,000 residents, the violent crime (homicide, rape, robbery, and aggravated assault) rate in Cambridge in 2014 and 2016 was lower than statewide or nationwide. Still, there were roughly 212 violent crimes in Cambridge (*Figure 34*). The key informants described an alarming increase in the presence of ghost guns in Cambridge and a rise in gun violence, particularly involving youth and young adults.

### In Summary

The population of Cambridge overall is healthier in relation to most indicators when compared to the state and country. Specifically, Cambridge did better in terms of physical activity, low birth weight, asthma, obesity, hypertension, stroke, diabetes, cancer, violent crime, deaths due to overdose and unintentional injury, and life expectancy. However, rates of reported binge drinking among Cambridge adults were higher than statewide and nationwide.

Data for several indicators show differences by race and/or ethnicity and reveal that some sub-populations within Cambridge are not as healthy as their fellow community members. For example, Black and White residents had the highest rates of hypertension. Black residents had the highest rates of diabetes. Black and Hispanic/Latino residents had the highest rates of obesity. White and Black residents had the highest rates of asthma. White residents and other races, followed by Black and Hispanic/Latino residents, had the highest rates of tobacco use.

The key informants expressed specific concerns for the health of several sub-populations, including youth (i.e., vaping and drug use; violence; mental health due to isolation, stress, and lack of supportive adults in their lives; and the impact of asthma and respiratory illnesses on their development); immigrants and refugees (e.g., decreased screenings and increased cancer deaths, lack of knowledge about chronic disease and prevention strategies, and mental health concerns due to stress); and low-income individuals (e.g., chronic disease fueled by poor nutrition and lack of exercise and mental health due to chronic stress).

## C | COMMUNITY ASSETS AND RESOURCES, UTILIZATION, AND BARRIERS TO CARE

As with the findings shared above, Cambridge as a whole appears to be a resource-rich community, and data related to insurance and health care service utilization are better in comparison to the state. However, data for sub-populations (from both primary and secondary sources) show that there are differences in terms of access to resources needed for health and well-being and utilization of services to address health and behavioral health concerns. Note that, while “health access and quality” is one of the domains of the social determinants of health described in Section II, part D, this report includes such findings in this section because they are so closely tied to resources and barriers to care. The key informants described Cambridge as having multiple strengths or assets, most especially:

- **The diversity of the population and rich culture** created by newcomers as well as those with deeper roots in the community.
- **The resilience of the population**, particularly those who have confronted relocation from their country of origin, persistent poverty, health conditions or disabilities, and the economic fallout and isolation caused by the pandemic.
- **Positive attitudes and investment in the community** by a population that is largely welcoming to newcomers, devoted to equity, civic-minded and engaged, progressive, and entrepreneurial. Cambridge was described as having an active faith community that cares for residents in need, high rates of volunteerism, and an activist community focused on health equity and social justice.
- **Excellent organizations**, including world class higher education, excellent public schools, household-name businesses, and an invested and prevention-focused police department.
- **Effective municipal leadership** that is committed to equity and creative in their approaches to achieve it, while maintaining the good fiscal health of the city.
- **Opportunities for engagement** include the ease of getting around the city due to its walkability, bike lanes, and public transportation; excellent parks and playgrounds; many cultural events and festivals; and numerous volunteer opportunities.

- **The quality and quantity of resources and services** with committed service providers and collaboration among them, great outreach and harm reduction services, and both formal and informal support for those in need.

Findings from the 2023 Resident Opinion Survey suggest that Cambridge residents also believe that the city is a welcoming place with a sense of community and that city government is effective. Respondents indicated further that the city is a safe place to live.

Cambridge residents also benefit from *Find It Cambridge*, an online, one-stop shop, searchable resource in multiple languages that helps residents and service providers easily find activities, services, and resources in the city. By visiting <https://www.finditcambridge.org/services>, users can locate resources in multiple categories (i.e., early childhood, elementary, and middle/high school services; adult education, arts, and culture; career and college; health and safety; housing and utilities; parks, playgrounds, and pools; public benefits and community assistance; sports and recreation; and science, technology, engineering, and math (STEM)). Not only are the many resources listed with *Find It Cambridge* major assets of the city, so is this resource-rich tool.

The available secondary data provide further insights into community resources, as well as service/resource utilization and related disparities. The key informant interviews helped to elucidate these findings. Interviewees described the health system as complex and confusing. They described gaps due to workforce issues (i.e., too few doctors, nurses, medical assistants) which often cause lengthy delays in care. Clinicians among the key informants indicated that patients often “fall through the cracks” when they make referrals due to siloes and poor communication among providers. They described long wait lists and difficulty in making the “hand off” from primary to specialty care. Several populations face challenges when it comes to accessing the services they need.

- Immigrants and refugees and non-English speaking residents find the system difficult to understand and navigate due to linguistic barriers and because the system is so different from what exists in their country of origin. While telephone and web-based interpreters are available, several of the key informants indicated that more in-person medical interpreters are needed.
- While telehealth has addressed access for some, it does not work equally well for everyone. Older adults and those with limited comfort with or access to technology, for example, are less likely to use telehealth services.

- Clinicians among the key informants reported that the hours during which health care can be accessed are not amenable for working adults, especially those with limited flexibility in their jobs.
- When describing health care needs among members of the LGBTQIA+ community, a couple of the key informants indicated that the transgender community relies heavily on specialized endocrine services at Fenway Community Health Center and that comparable services are needed in Cambridge.
- A few key informants also explained that, within the health system, more training is necessary to ensure safe screening and referrals for victims of exploitation, neglect, and physical violence (e.g., children, victims of domestic violence, older adults, people with disabilities). While the health system has come a long way in understanding how abuse and neglect affect health and health care access, some key informants indicated that providers still frequently screen for these conditions in front of family members, which significantly decreases the likelihood that a victim will disclose violence and be able to access referrals for services.

### 1. Primary Care Providers

In Cambridge, there are more primary care physicians (128.31 per 100,000 residents) than statewide (103.53/100,000) and nationwide (76.38/100,000) (*Figure 35*). However, as interviewees explained, it is difficult to find primary care providers who are accepting new patients. Geriatricians are often embedded within larger practices and systems and thus difficult for older adults and their families in search of such expertise to locate.

### 2. Nonprofits

There are more nonprofit organizations (i.e., with 501(c)(3) status) in Cambridge (922.16 per 100,000) than statewide (472.34/100,000) or in the U.S. (421.5/100,000) (*Figure 36*). The key informants explained that Cambridge is rich with a range of nonprofits and those dedicated to meeting the needs of the community. There is a willingness to collaborate in service of the community. However, it can be difficult for service providers to coordinate care across agencies as they are not always aware of other programs in which clients are engaged. Thus, duplication of effort is a problem. The nonprofit sector can be challenging for those with low health and system literacy and who do not speak English to understand and navigate. That is especially true for the immigrant/refugee populations.

### 3. Substance-Related Services

As of February 2024, Cambridge had fewer providers (10.13 per 100,000 residents) who specialize in addiction or substance abuse treatment, rehabilitation, addiction medicine, or who provide methadone than statewide (30.58/100,000) or nationwide (26.94/100,000) (*Figure 37*). The key informants reported that there are fewer treatment and support resources in Cambridge and neighboring communities for those with problematic substance use than there were five years ago. It can be difficult to locate treatment resources, particularly for detox, which can mean missing the window in which a client is ready to access care. Additionally, because so few substance-related services are available within the city, residents often have to travel elsewhere for services, which can be hindered by work or school schedules, lack of childcare, lack of transportation, etc. They added that too few recovery options or pathways exist and reported that there is limited awareness of and capacity for medication-assisted treatment. As is true for the health system, the behavioral health system is difficult to understand and navigate. It is most challenging for those with low health and systems literacy, who may not understand substance use issues or the related services, and for those who do not speak English. And like the health care sector, behavioral health also lacks enough providers who share a similar culture and/or language with the many diverse residents of Cambridge who need such services.

### 4. Mental Health Services

The key informants indicated that anxiety and depression are problems for an increasing portion of the city's population. Many of the issues that make mental health services inaccessible are the same as those that make it difficult to access health care and substance use disorder services. Interviewees reported that there are too few mental health clinicians in Cambridge and even fewer who speak languages other than English and who have lived experiences similar to the city's diverse population. Clinicians typically have long waiting lists. Mental health care is confusing to most people due to the range of organizations (e.g., hospital, day programs, community mental health centers, private practices) and different kinds of practitioners (e.g., psychiatrists, psychologists, social workers, mental health clinicians). The system is especially confusing to newcomers to the U.S. and non-English speaking individuals. There are a limited number who accept MassHealth and even fewer who accept Children's Medical Security Plan, which means low-income families seeking care for the adults or children may have little or no choice. Those with

disabilities generally have a hard time finding a clinician who understands the experience of having a disability, and those with psychiatric disabilities or problems with executive functioning have difficulty advocating for themselves. Stigma around mental health is also a significant barrier to care for many populations, particularly older adults and immigrants/refugees. Accessing services outside of Cambridge is difficult for those facing issues with childcare, transportation, and physical disabilities that limit mobility.

### 5. Health Insurance

Among insured residents in Cambridge, the proportion that has private insurance (87.4%) was higher than for Massachusetts or the U.S., and the proportion with public insurance (21.4%) was lower than in Massachusetts and nationwide (*Figure 38*).

While in the 2018-2022 time period only 2% of the City's population overall lacked health insurance coverage, lack of coverage was higher among segments of the population. Lack of coverage was highest among Black residents (7.1%), those under 19 years old (6.5%), and those with household incomes under \$25k (6.5%) and living below 100% of the Poverty Rate (6.6%) (*Figure 39*).

While the uninsured rate in Cambridge overall is quite low, the key informants noted that there are segments of the population who still lack health coverage. They added that even those with health insurance often find their coverage is inadequate (e.g., does not cover oral health or mental health services or limits the options for where they can go for care).

### 6. Inpatient Stays

While the percentage of Cambridge's Medicare beneficiaries that had an inpatient stay (10.5%) in 2020 was lower than the proportion statewide and nationwide, the rate per 1,000 beneficiaries was higher in Cambridge (at 250/1,000) than nationwide (although slightly lower than statewide) (*Figures 40 and 41*).

### 7. Emergency Room Utilization

In 2020, at 550/1,000 beneficiaries, Medicare beneficiaries (65+) in Cambridge had a lower rate of emergency room (ER) visits per 1,000 beneficiaries than statewide, but higher than nationwide (*Figure 42*).

For the period of 2017 to 2021, rates of ER visits among Black/African American residents were higher than White residents for asthma (5.5 times higher), diabetes (7.5 times higher), heart disease (2.5 times higher),

substance use (more than double), and mental health (2.5 times higher). While Black/African American residents had the highest rates of ER visits for these conditions, Hispanic/Latino residents also had higher rates than White residents for asthma (nearly 4 times higher), diabetes (3.5 times higher), heart disease (double), substance use (double), and mental health (nearly double) (Figures 43-47).

The key informants noted that many of those who are unhoused in the community utilize the ER for their main source of health care. They expressed concern that, as patients of the ER, the individuals may be subjected to long wait times, stigma, and to staff who are experiencing burnout related to workforce shortages and stress carried over from the pandemic.

### In Summary

Cambridge is an asset- and resource-rich community, including more primary care and nonprofits than statewide or nationwide, although, with regard to substance-related services, Cambridge has fewer resources. Access to services, particularly primary care, mental health, and substance-related services, is limited by several factors, including workforce shortages, especially of providers who speak languages other than English and whose backgrounds reflect the diverse sub-populations in the city. Low health and systems literacy, particularly among immigrant communities and those who do not speak English, contribute to difficulties in understanding, accessing, and navigating health and behavioral health services. While there are some geriatricians in the city, they are difficult to locate due to the structure of the health system. Although most residents have insurance, uninsured rates were higher among Black residents, younger residents (<19), and those with lower SES (household incomes < \$25k/year, live below 100% of Poverty Rate). Even those with insurance often find their access and choice to be limited. Higher rates of ER use among Black and Hispanic/Latino residents for asthma, diabetes, heart disease, substance use disorders, and mental health point to underlying challenges in health prevention and promotion as well as in access to health and behavioral health services needed to manage these problems and prevent the need for and use of ER services.

## D | HEALTH STATUS AND HEALTH-RELATED BEHAVIORS

Data from multiple sources allowed the Community Advisory Committee the opportunity to look at literally hundreds of social determinants of health in determining which posed risks for the health of residents. To fuel discussions about the impact of the SDOH on the health and well-being of Cambridge residents, the Committee opted to have the internal planning team gather data from across four of the five domains (Neighborhood and Built Environment, Education Access and Quality, Social and Community Context, and Economic Stability). Data on Healthcare Access and Quality were reviewed in a separate meeting when discussing health behaviors, outcomes, and access to services. The planning team prioritized factors where disparities exist as well as a few that were of particular interest to the Committee because they perceived them to be problematic and connected to health (e.g., economic stability, housing, education). The SDOH reviewed by the Committee are described below and organized by the four SDOH domains named above.

### 1. Neighborhood and Built Environment

- **Housing Costs, Quality, and Continuity:** According to the ACS for the period of 2018-2022, there were 49,475 households in Cambridge. Just over one-third (33.6%) were owner-occupied, and there was an average of 2.08 people per household. The median owner cost with a mortgage was \$3,193 per month and median gross rent was \$2,628 per month. Thirty-five percent of households were considered cost burdened (i.e., 30% or more of income is spent on rent or mortgage). Affordable housing was the top concern expressed by Cambridge residents in the 2023 Resident Opinion Survey,<sup>11</sup> and 36% of occupied housing units had one or more substandard conditions (e.g., incomplete plumbing or kitchen, over-crowded conditions). While 72.9% of residents still lived in the same household over the past year, 27.1% did not (Table 11). The key informant interview participants pointed to housing as a major factor influencing the health of Cambridge residents. They explained that, for cost-burdened households, the occupants generally have to make difficult financial choices (e.g., between paying rent versus buying healthy food or paying for prescription medications) that ultimately impact their ability to prevent or manage poor health outcomes (e.g., obesity,

<sup>11</sup>Accessed on October 17, 2024 at: file:///C:/Users/hopew/OneDrive/Documents/Cambridge%20CHNA/secondary%20data/2023residentsurveyresults.pdf

diabetes, hypertension). Additionally, sub-standard housing, they explained, may mean residents do not have the ability to store or prepare healthy foods. Such conditions could lead to poor nutrition that would then lead to poor health outcomes. Beyond the cost of housing, finding accessible housing can be a challenge for older adults and people with disabilities who require housing that is appropriate given their physical limitations.

- **Food Access:** The key informants described the tremendous efforts that took place during the pandemic to improve food and nutrition security for Cambridge residents, including additional food pantry locations and home delivery for those unable to access food safely. However, most of the additional resources provided during the pandemic to fund expanded services have now gone away. The interviewees reported that, once again, lower-income community members face food and nutrition insecurity. In order to have the nutrition needed to prevent or control health issues (e.g., hypertension, diabetes), residents must have access to healthy foods. They described certain areas of the city as lacking sufficient opportunities for low-income residents to access healthy food. For example, according to the 2023 U.S. Department of Agriculture (*Figure 48*), Cambridge had 5.08 SNAP-authorized retailers per 10,000 residents, which is lower than the state (7.28) and U.S. (7.47).
- **Transportation:** The key informants described Cambridge as a very “walkable” city and added that bike lanes have also improved the ability of residents to commute using bicycles. Walking and biking are physical activities that can help prevent poor health (e.g., obesity, hypertension, diabetes) and are, thus, preferable modes of transportation (from a health standpoint) to motor vehicles. In Cambridge in 2022, 38.1% of middle schoolers and 27% of high school students walked to school; 5.2% (middle school) and 16% (high school) biked or used some other non-motorized (e.g., skateboard) means of getting to school. The 2018-2022 ACS showed that 26.4% of Cambridge adults bike or walk to work, which is substantially higher than in Massachusetts (5.1%) and the U.S. (2.9%). While most students and many adults get exercise during their commute, there is also some concern about accidents involving pedestrians and bicycles given the heavy automobile traffic in the city. Quarterly data show that, during the pandemic, such pedestrian and bike crashes in Cambridge dropped significantly. However, as of quarter one of fiscal year 2023, the number of crashes had climbed, and the trend lines looked more like the pre-pandemic pattern. In the most recent quarter for which data were available (FY24,

Q3), there were 33 crashes involving bikes and 25 involving pedestrians (*Figure 49-51*). While the city’s bike lanes support physical activity among the city’s residents, key informants noted that the lanes have reduced the amount of parking in the city, which creates challenges for drivers, particularly people who work in Cambridge but who live elsewhere. Among the workers who have difficulty parking are home health aides who provide care to people with disabilities who reside in Cambridge.

- **Environmental Justice:** In general, exposure to environmental hazards is known to cause or exacerbate respiratory ailments and/or contribute to cancer risk. In 2022, Cambridge residents were at greater risk for exposure to seven of 12 environmental contaminants than Massachusetts or U.S. residents overall. Specifically, Cambridge residents faced potentially greater exposure to diesel particulate matter, air toxic respiratory risk, traffic proximity, lead paint exposure risk, Risk Management Program (RMP) facility proximity, hazardous waste site proximity, and underground storage tanks. Additionally, four of the city’s 13 neighborhoods had a light or deficient tree canopy, which means they were less likely to benefit from the naturally occurring air purifying that trees offer. With risk of exposure to hazardous contaminants and an insufficient tree canopy to help mitigate risks, some Cambridge residents are at greater risk for illness, especially respiratory illness, related to environmental contaminants than others (*Figures 52 and 53*). Several key informants argued that the increase in severe weather is due to climate change and that heat and humidity exacerbate existing health conditions such as asthma and COPD. They explained that air conditioning is as critical as heat to people with such conditions but is not required under housing codes. Although strides have been made to provide AC units to older adults, people with disabilities, and lower-income residents, the cost of electricity to operate an AC unit can be prohibitive.

## 2. Education Access and Quality

- **Graduation Rates:** For the last seven years, the Cambridge Public Schools’ (CPS) four-year cohort drop-out rate is well below the state average. Roughly nine out of 10 CPS high school students graduate with a diploma in four years.
- **Absenteeism:** The key informants explained that since the pandemic, school absenteeism has remained high. They said that, upon returning to in-person attendance, teachers and administrators were flexible with regard to attendance because so many students were having a hard time adapting after such a long time without social interactions and being away from the

school environment. However, even by the fall of the 2023-2024 school year, absenteeism rates remained high. All CPS middle and high schools are state Department of Elementary and Secondary Education priorities because of chronic absenteeism (i.e., missing 10% or more of school days per year). Chronic absenteeism differs across groups. Half of CPS' American Indian/Alaskan Native students were chronically absent in 2023-2024. Roughly one-third of CPS' Hispanic/Latino students, students with disabilities, and low-income students were also chronically absent (*Figure 54*).

- **Post-Secondary Degree Attainment:** While between 57% to 70% of CPS graduating classes of 2011 through 2018 earned post-secondary degrees, degree attainment was lower for each of the eight CPS classes than for the state overall (*Figure 55*). Between 78% and 81% of the classes of 2015-2017 enrolled in college, but only 48% and 50% attained a degree (*Figure 56*). Although degree attainment among CPS' Asian and White students was lower than statewide, it was still higher than for Black, Hispanic/Latino, multi-race, low-income, and English language learner students and those with disabilities. Multi-race students and students with disabilities had some of the lowest attainment rates.

### 3. Social and Community Context

- **Social and Community Connectedness:** Overall in 2022, 51% of CPS high school students reported having at least one teacher or other adult in school to talk to about a problem. Prior to the pandemic, roughly two-thirds of CPS high school students reported such a relationship. In 2021 (pandemic era), the rate dropped to 34% and climbed to 51% a year later. Rates were higher (>50%) among special education students, those in grades 11 and 12, gender non-conforming and female students, and White and Hispanic/Latino students. Half or less of those in earlier grades (9 and 10), males, and Asian, Black, and multi-racial students report having this social support (*Figure 57*). Some of the key informants suggested that youth of color are less likely to have trusting relationships with adults in their lives than their White peers due to higher rates of incarceration among men of color and higher death rates from COVID among adults in communities of color. The key informants indicated that there are too few services for the city's young people, particularly those with learning disabilities or autism. Some also called for evidence-based strategies (e.g., multi-system therapy, violence interruption services) to increase belonging for youth while preventing their involvement in gangs and violence.

- **Unhoused Youth:** While the proportion of unhoused youth in CPS was lower than statewide or across the country, 2.5% (or 176 of the 7,091) of students in CPS in the 2019-2020 school year were unhoused (*Figure 58*). The key informants indicated that among the recent immigrants who moved to Cambridge, there are families with children who are unhoused and, thus, the number of unhoused youth is actually higher.
- **Older Adults Living Alone:** In Cambridge, Massachusetts, and across the U.S., older adults (65+) are more likely to live alone than their younger counterparts. The proportion of older adults living alone in Cambridge (roughly 40%), however, is greater than in Massachusetts and the U.S. overall (*Figure 59*). The key informants explained that, while some older adults in Cambridge may indeed be isolated, many who live alone live active, happy lives with a lot of connection to the community through senior centers, volunteerism, etc. They cautioned that living alone is not necessarily a sign of isolation.

### 4. Economic Stability

- **Income and Poverty:** The Community Advisory Committee discussed at length the economic disparities that exist in Cambridge, including the 2018-2022 data (presented as part of the city's demographic data) that showed that the mean income of those in the upper income quintile was more than 23 times greater than the mean income of those in the lowest quintile (*Figure 14*) and data about the proportion of families living in poverty overall and within each racial/ethnic group. Specifically, the data showed that poverty was lower in 2018-2022 than in 1999 and 2006-2010, and that the proportion of Black, Asian, and Hispanic/Latino families living in poverty in 2018-2022 was several times greater than for White families, and poverty was highest among Black families (*Figure 15*).
- **Unemployment:** Unemployment among Cambridge's American Indian/Alaskan Natives and Native Hawaiian/Pacific Islanders was proportionately higher than in Massachusetts and the U.S. overall but affects relatively small numbers of people (17 and 22 unemployed persons, respectively). Unemployment in Cambridge was lower than in Massachusetts for all other racial/ethnic groups. However, compared to the city's White, Asian, and Hispanic/Latino residents, unemployment among Black/African American residents and those of other races was over three times higher, and for those of multiple races, it was roughly double (*Figure 60*). Although remote access

has opened up more employment opportunities for some, people who have disabilities still experience high rates of unemployment. The key informants explained that the scarcity of affordable and quality childcare in Cambridge and difficulty in qualifying for childcare vouchers are barriers to training and education that would help unemployed and under-employed residents to get jobs and/or better pay. They reported that there are too few daycare slots in general and very few that accept childcare vouchers. Thus, those who are able to secure vouchers need to travel to other communities to access care for their children. All too often, they said, people must rely on family to provide care. Immigrant families often do not have such informal support because their families remain in their country of origin.

### In Summary

Income inequality is a major factor affecting access to the resources in Cambridge that could be used to prevent and/or address health and behavioral health issues. Black, Hispanic/Latino, and Asian families are several times more likely to live in poverty than White families, and unemployment has historically been two or three times higher among Black/African American residents and those of other and multiple races than for White and Asian residents. High housing costs mean that some residents are likely making difficult choices that affect their health and increase their risk for chronic disease (e.g., foregoing medications, eating cheaper and less healthy foods). Substandard housing that lacks cooking facilities, too few retailers that accept SNAP, and lack of transportation serve to deny some residents the ability to access and/or prepare healthy foods.

Cambridge is an active city with assets such as parks, playgrounds, pools, and designated bike lanes. However, pedestrian and bike accidents are fairly frequent occurrences, and bike lanes have reduced already limited parking in the city.

Proximity to traffic and exposure to diesel particulate matter are just two of seven environmental risk factors that are more prevalent in Cambridge than statewide or nationwide. Portions of the city also lack sufficient trees to effectively filter air pollution. Poor air quality contributes to asthma and respiratory conditions which have a significant impact on the health, social development, school attendance, and academic performance of the city's children and youth.

While high school graduation rates are high in Cambridge, chronic absenteeism is a challenge, especially among American Indian/Alaska Native, Hispanic/Latino, and low-income students and students with disabilities.

College enrollment is high at 80%, but only half of enrollees get a degree. College degree attainment is lowest for students of color, English language learners, low-income students, and those with disabilities.

Data suggest that social support and having a relationship with a trusted adult, both important to mental health, are less available to 9th and 10th graders and Asian, Black, and multi-racial students. Additionally, while the city's rate of unhoused youth is lower than Massachusetts or the U.S. overall, 176 students in the 2019-2020 school year were unhoused, considered an under-estimate by key informants due to recent immigration to the city.

## E | DISPARITIES

Data for the city overall paint a fairly positive picture in terms of health outcomes, assets, the availability of health care and other resources, and the social determinants of health. However, when analyzing these same data for different sub-populations, disparities are apparent. While Sections II, parts A through D, above offer information on disparities specific to the content in each section, this section acknowledges that many sub-populations experience multiple disparities that compound the difficulties they face in accessing what they need to support their health. Addressing disparities is essential to improving health equity. By summarizing the findings in this section, it becomes clear which sub-populations are likely most at-risk for poor health outcomes given the many disparities they face. Additionally, we believe it will be easier for CPHD and its community partners in various sectors to identify opportunities to collaborate and address disparities affecting various sub-populations in a coordinated way. Some of the issues affect the health and access to care for all of the sub-populations below (e.g., difficulty understanding and navigating the health and mental health systems) but may be more problematic for some sub-populations than others (e.g., newer residents to the U.S., non-English speaking individuals). Addressing such issues offers an opportunity to improve health equity for multiple populations.

### Immigrants and Refugees

While immigrants and refugees contribute to the rich culture and diversity of the city, language barriers present challenges to providing services and for their access to care. In addition to linguistic barriers, those from other

countries are less likely to understand the complex health system in the United States and to be able to navigate it without assistance. Understanding of preventive health behaviors and health conditions also differ. Low health and systems literacy were described as major challenges for immigrants and refugees. Additionally, more in-person interpreters are needed because online interpreters can be difficult to use for those with little experience with technology. Often the children of immigrants fulfill a difficult role of liaison between providers and their family members and may serve as interpreters. Lower screening rates, particularly during the pandemic, have led to an increase in cancer deaths in immigrant communities. While immigrants and refugees may experience mental health challenges (e.g., due to relocation, trauma in the country of origin, anti-immigrant sentiments), stigma, linguistic barriers, and lack of understanding of the complex mental health system serve as barriers to behavioral health care. There are too few health and behavioral health providers who speak languages other than English or who share culture or lived experiences similar to those of the city's immigrants and refugees. Because daycare is expensive and difficult to find, many residents rely on their family for child care. Immigrant and refugee families are often separated from extended family, which means that those with children may face additional barriers to education, job training, and employment.

### **LGBTQIA+**

One disparity that the assessment uncovered affecting the LGBTQIA+ population is that it is difficult for members of the transgender community to access appropriate endocrine services. However, for LGBTQIA+ youth, there are additional challenges such as increased risks for isolation, bullying, and mental health concerns.

### **Low-Income Families and Individuals**

There are substantial income disparities in Cambridge. High housing costs often mean that lower income individuals must make difficult choices that have implications for health (e.g., going hungry, purchasing less expensive and unhealthy foods, not exercising due to work/time constraints or lack of access to exercise facilities). These difficult choices often result in higher risk for chronic health conditions such as obesity, hypertension, and diabetes. Lower income individuals are less likely to have health insurance. Mental health problems are fueled by long-term economic stress while access to care is difficult and choices are limited, particularly for those who have Medicaid/

MassHealth or Children's Medical Security Plan. If available services are located outside of Cambridge, transportation is a barrier to care. Lower income students have higher rates of chronic absences from school and are more likely to have asthma, which impacts their social development and academic success. For low-income students who enroll in college, graduation rates are much lower than among their higher income peers.

### **Older Adults**

Eleven percent of the city's population is aged 65 or over, and 40% of these residents live alone. While some of those residing alone may experience isolation, many of the older adults in Cambridge lead active lives and are socially and civically engaged. Tobacco use and smoking are higher among the older adult population, and they face a number of potential barriers to care, including difficulty locating a geriatrician given the structure of the health system; potential issues with mobility and transportation that make getting to and from appointments difficult; and possible executive functioning issues that can result in problems making and keeping appointments, as well as communicating and understanding important health information. Stigma about mental health is a barrier to engaging in behavioral health services. Some older adults, because of mobility issues, have difficulty finding housing that is safe and navigable. Air conditioning is a vital utility for many older adults; even for those who have one, operating an AC unit can be cost prohibitive.

### **People of Color**

Cambridge is an increasingly ethnically and racially diverse community. While people of color make up 42% of the adult population, youth of color comprise 58% of the population under the age of 18. Multiple racial/ethnic groups make up the category of people of color, and each group faces distinct disparities. In general, there are not enough providers of color in the health and behavioral health systems in Cambridge, and there is lingering distrust of the health care system among many diverse populations due to historical mistreatment.

All youth, regardless of race or ethnicity, were described as at-risk for mental health problems due to social isolation during the pandemic, lack of social support from trusted adults, and/or chronic stress (e.g., due to poverty, fear for the future, violence, and/or racial tensions). However, youth of color likely face greater stress. They experienced more death and loss due to the disproportionate impact of the pandemic on communities of color and are disproportionately impacted by separation from parents due to higher rates of incarceration of

people of color. Below are challenges confronting the health and well-being of specific racial/ethnic groups in Cambridge.

### **Black Residents**

The population of Black residents peaked in 1990, and in the last Census, 11% of the city's population identified as Black. Black residents are 13% of those under age 18 and are the largest racial group behind White residents, but the numbers have been decreasing since 2010. Among Black students in CPS, 25% are chronically absent. Black high school students are less likely to have a trusted adult at school that they can talk to about a problem than White or Hispanic/Latino students. Many families with long histories in Cambridge have relocated elsewhere given the cost of living, particularly high housing costs. The Black population faces disparities in several social determinants linked to poor health status. They have higher rates of unemployment than the White population and the lowest college degree attainment of any racial/ethnic group in the city. The proportion of Black families living in poverty is higher than any other group as well. National trends show that Black individuals have shorter life expectancy than White individuals, are at higher risk for strokes and death due to stroke, have higher rates of cancer-related deaths, and have more low birth weight babies. The city's Black population has high rates of asthma, obesity, and diabetes and higher emergency room utilization for asthma, diabetes, heart disease, substance use disorders, and mental health. They are also less likely to have health insurance than any other racial/ethnic group in the city.

### **Hispanic/Latino Residents**

In the 2020 Census, Hispanic/Latino residents made up 9% of the city's population overall and 9% of youth. Among Hispanic/Latino students in CPS, 34.6% are chronically absent. Hispanic/Latino families are more likely to experience poverty than White families. The Hispanic/Latino population has higher rates of obesity than the White population and higher rates of emergency room utilization for asthma, diabetes, heart disease, substance use disorders, and mental health.

### **Native American Residents**

While the exact number of Native American residents living in Cambridge is not known, it is a relatively small sub-population within the city. However, Native American residents have the highest rate of unemployment and, among Native

American students enrolled in CPS, half are chronically absent. Because the number of Native American residents is small, the group is often not included in racial/ethnic breakdowns of data on social determinants of health or health outcomes. Thus, as a group, they may face more disparities than can be demonstrated by data available for this assessment. However, national trends indicate that Native American individuals have lower life expectancy, more deaths due to cancer, and more low birthweight infants than the White population.

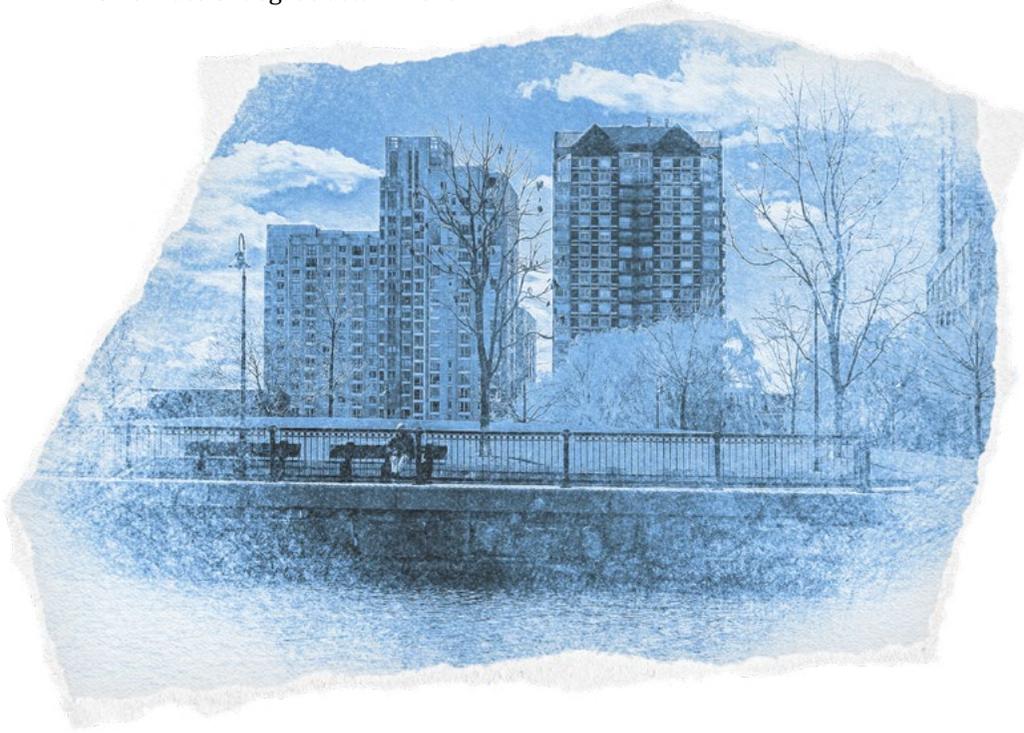
### **Asian Residents**

The Asian population accounts for 19% of the Cambridge population overall, 14% of those under age 18, and 26% of births to city residents. Unlike the White and Black populations of Cambridge, which are decreasing in size, the Asian population is growing. Nearly two-thirds of the city's Asian population was foreign-born, the largest of all foreign-born populations residing in the city. Among the top 12 foreign places of birth for Cambridge residents are China, India, Korea, Japan, and Taiwan. Nearly 72% of the Asian population speaks a language other than English at home. At 8.6%, Asian families are over 2.5 times more likely to live in poverty than White families. Asian high school students are less likely to have a trusted adult at school with whom they can discuss a problem than White or Hispanic/Latino students. Nearly 20% of Asian students in CPS are chronically absent from school.

### **Persons with Disabilities**

Just under 7% of Cambridge residents have some form of disability. Among those 18-64, 44.5% are employed, which is much lower than the employment rate for city residents in general. While remote access to work has helped many who have disabilities to secure and maintain employment, high unemployment persists. Persons with disabilities face challenges in securing housing that is safe and navigable. Air conditioning is a vital utility for persons with disabilities; even for those who have one, operating an AC unit can be cost prohibitive. People with disabilities face challenges with accessing care (e.g., home health aides who can't find parking or difficulty getting transportation to/from appointments). Too few mental health providers have experience with and understanding of disabilities. Those with psychiatric disabilities are often not able to advocate for themselves when they face barriers to care. Among youth with disabilities, there are higher rates of chronic school absenteeism. Students with Individual Education Plans often face challenges finding

accessible out-of-school time programming and, once they become adults, they age out of most services. People with disabilities who enroll in college have a lower rate of degree attainment.



### Persons Who Are Unhoused

The assessment revealed a recent increase in homelessness among newcomers (immigrants) who hope to call Cambridge home. Among them are families with children, thus increasing the number of unhoused youth in the city. Although Healthcare for the Homeless serves many of those who are unhoused in the city, others rely on the emergency room for care, which can mean being confronted with long wait times and staff attitudes that are influenced by burnout due to workplace shortages, post-COVID exhaustion, and stigma regarding those who are unhoused. Among those who are unhoused are some who are at risk for opioid overdose. Although the city has seen a decline in overdose deaths, the recent migration of some who are unhoused to more remote areas of the city could mean they will be harder to identify and assist should they overdose.

### Victims of Abuse, Neglect, and Exploitation

The one challenge the assessment revealed for those who are being victimized (e.g., elder abuse, domestic violence, abuse of persons with disabilities, child abuse) is that health care screening for abuse, neglect, and exploitation is often done in the presence of others (e.g., family member, partner), which likely means screening will be ineffective, putting victims at further risk of losing future access to healthcare as well as any referrals for services the health care provider could have provided.

### Youth

Those 19 and under make up roughly 16% of the Cambridge population. While the adult population is majority White, most of the city's youth (58%) are people of color. Youth, who were described as at risk for mental health concerns prior to the pandemic, are now at increased risk due to the isolation and loss they faced during the pandemic and stress and hopelessness related to factors that make the future look bleak (e.g., political strife, climate change, police/racial tension). Many lack a supportive adult presence in their lives. Vaping and substance use are on the rise. Absenteeism from school, which was high following the return to in-person learning, remains high. There is growing concern about violence involving youth, including gun violence and a call for interventions (e.g., out of school programming, multi-system therapy, violence interruption services). While about 80% of CPS graduates go on to college, only half graduate with a degree. Asthma has a particularly detrimental impact on the city's youth, impacting their social development and academic performance. A relatively small percentage of the city's youth is unhoused, but the population has grown with newer immigrants moving to Cambridge. Immigrant youth often straddle two worlds and serve as liaison and interpreters between their families and the people and systems in their new city. Youth of color faced more death and loss during the pandemic than their White peers and tend to have fewer supportive relationships with adults. They are also at increased risk for asthma and respiratory illness, and the limitations these conditions place on social development and academic performance. Young Adults share many of the same issues as youth but often age out of services, and they are not captured in the YRBS or teen health surveys, so their needs are not well understood.



# Conclusions and Recommendations for the Next CPHD Community Health Improvement Plan

In its fourth and final meeting, the Community Advisory Committee engaged in an exercise to review the summaries related to multiple sub-populations, consider the criteria for selecting key health equity challenges, and reach conclusions about the major challenges to health equity for the city's sub-populations. The committee members concluded that the following are integral to health equity for the city's sub-populations.

**Immigrants, Refugees, and People of Color** face significant challenges related to health literacy and often lack understanding about major health issues, especially mental health and women's health. Additionally, systems literacy or a lack of understanding about how the health and mental health systems work make it difficult to both access and navigate these systems. For communities of color, a lack of trust in health care remains. Access to care, especially primary/preventive care is necessary to address higher rates of chronic disease among people of color. Language barriers exist for those with low/no proficiency in English and pose challenges to access the array of services available in Cambridge and that one may need for good health. There are too few providers who share the culture and lived experience of the city's populations of color. For youth of color, chronic absenteeism from school and lack of a trusted adult are significant challenges.

**Older Adults and People with Disabilities** often face social isolation that can contribute to difficulty in accessing care and the ability to age in place. Isolation may also increase risk for abuse, neglect, and exploitation by caregivers. Older adults and people with disabilities often lack access to care due to transportation challenges, communication and/or language barriers, and mental health stigma; because they age into or out of services; and because of staffing shortages (i.e., PCAs) that are needed to support aging in the community. They may face difficulty navigating systems and their needs are often not adequately attended to in emergency planning.

**Low-Income Families/Individuals, Persons who are Unhoused, and Victims of Abuse, Neglect, and Exploitation** also often lack access to health care and other services due to language barriers, stigma, and the times during which services are available (e.g., during the work day). They too are challenged by difficulty understanding and navigating complex systems of care. In general, there is a lack of "whole person" recognition, which can lead to stigma and which could be combatted by better engagement of people in telling their stories and letting those stories guide our work. The group acknowledged that a community advisory board could aid in this effort. Particularly for those experiencing homelessness, mental health affects their inclusion in the community.

**Youth, Young Adults, and the LGBTQIA+ Community** often lack access to care and experience difficulty navigating systems. Their mental health is impacted by isolation/lack of connection, fear, and a lack of hope for the future. There are too few providers who share lived experience with people of color and the LGBTQIA+ communities. Housing quality/condition are factors that affect the health of young people in particular. The intersectionality of all of these factors compounds challenges to health equity for these groups.

The committee members also identified issues that are beyond the scope of CPHD and its partners (i.e., poverty, need for more good paying jobs, racism, immigration status, housing affordability) but that, nevertheless, have a major impact on health equity within Cambridge. Therefore, CHNA data on these issues should be shared with city leadership for use in other citywide planning efforts.

Based on the conclusions the committee reached about the major factors influencing health equity for these groups, they identified cross-cutting issues that, if addressed in the CHIP, could improve health equity for multiple populations. The committee members recommend that CHIP leadership consider the following in planning to improve health equity in Cambridge:

- There are multiple significant **barriers to care** that prevent access to all types of services/resources, including those posed by language, lack of trust in systems and providers (especially because increasingly providers live outside of Cambridge and aren't known or seen as part of the community or considered a trusted adult), and too few providers with similar background/lived experience as those they serve.
- There are challenges related to **health literacy**, including a need for information necessary for health promotion and to overcome stigma related to mental health.
- Multiple groups within the city face challenges with **systems literacy and navigation**, including confusion about how systems work and how to navigate complex systems.
- **Isolation and lack of strong community connection** are impacting mental health for multiple sub-populations within the city.

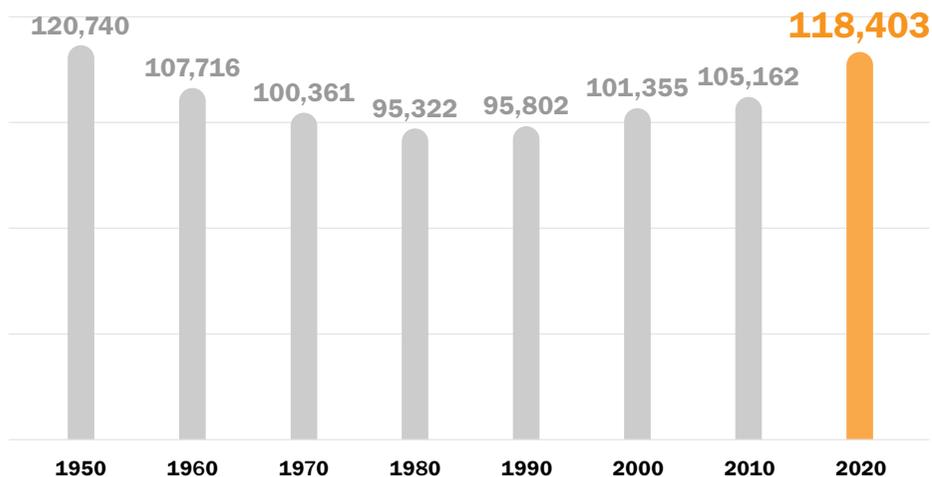
- **Absenteeism from school** is having a detrimental effect on the education of children and youth, as well as their social development and sense of connection.
- While CPHD and its partners may not be able to address housing affordability, it may be able to address issues related to **housing quality** that impact multiple populations and that have an especially detrimental impact on children's health.

The committee members noted that there is likely an important role CPHD and its partners can play in advocating for policy change to address some of the identified challenges and to amplify the voices of people with different lived experiences. Furthermore, they acknowledge that instability fueled by the political climate, xenophobia, and uncertainty about how federal-level changes will affect the city's diverse populations and the ability to serve them. The members recommended that those working on the CHIP monitor the changing landscape, engage with the community (e.g., via an advisory board, in planning for their own health, to ensure inclusion in emergency planning, to increase social connection) and exercise creativity in navigating the challenging times ahead.



# Appendix

**Figure 3. Cambridge Total Population (1950-2020)**



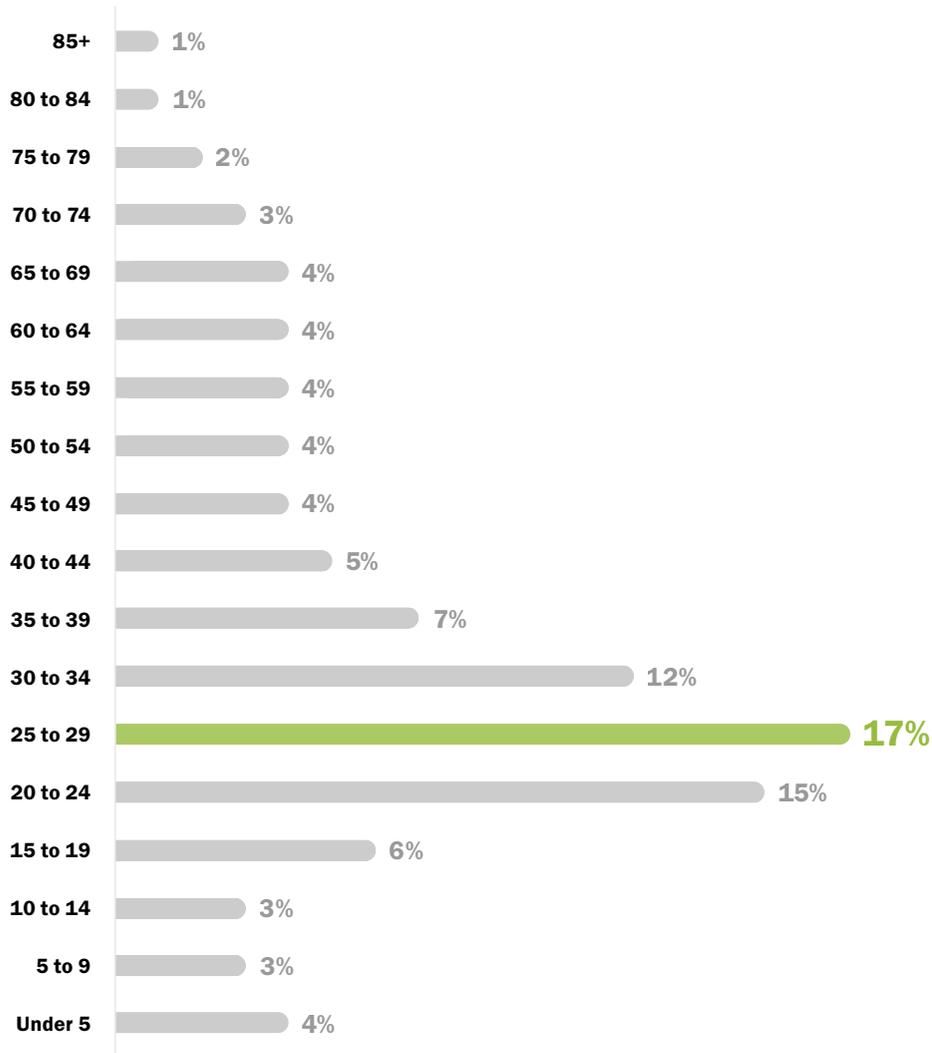
Source: U.S. Decennial Census (1950 -2020)

**Table 4. Population Size, Acreage, and Population per Acre of Cambridge Neighborhoods**

Neighborhoods	Population	Land in Acres	Population per Acre
Baldwin	5167	192	26.9
Cambridge Highlands	1716	189	9.1
Cambridgeport	13671	338	40.5
East Cambridge	12861	405	31.8
Mid-Cambridge	14494	293	49.5
MIT	4807	242	19.9
Neighborhood Nine	13088	410	31.9
North Cambridge	15381	550	28.0
Riverside	11930	202	59.1
Strawberry Hill	2627	244	10.8
The Port	6970	191	36.5
Wellington - Harrington	7026	152	46.2
West Cambridge	8224	679	12.1

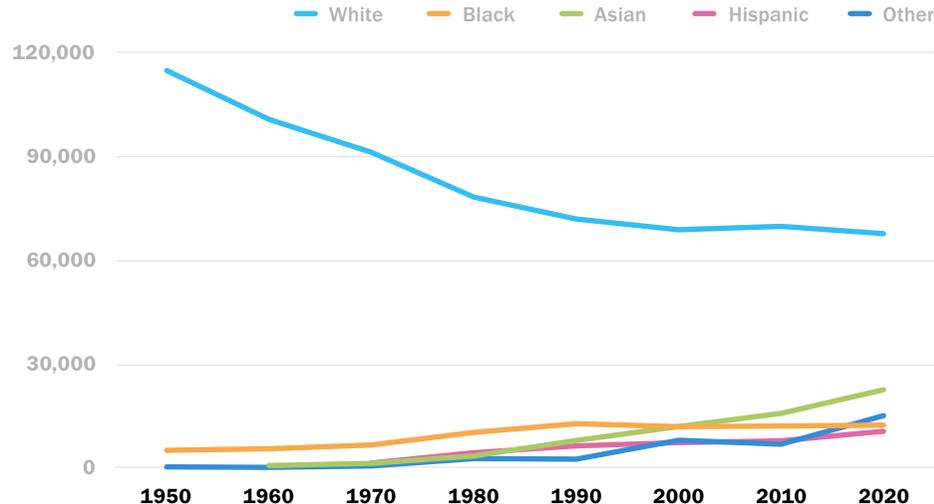
Source: American Community Survey (2018-2022)

**Figure 4. Cambridge Population by Age (2020)**



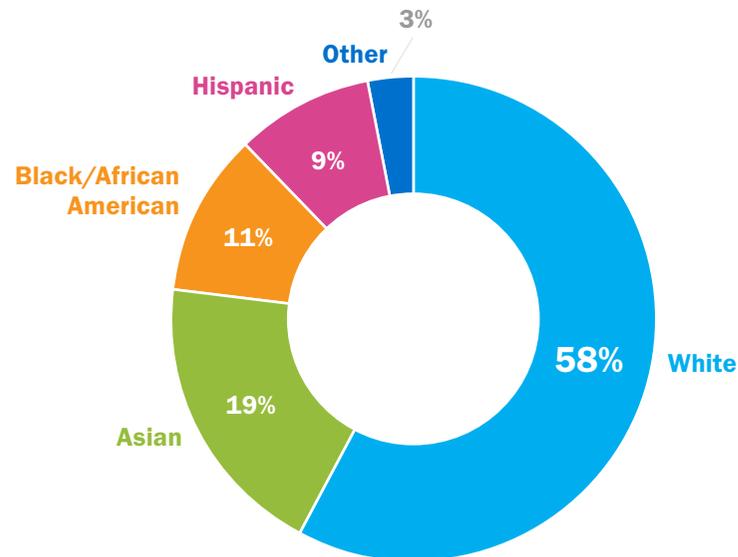
Source: U.S. Census (2020)

**Figure 5. Cambridge Population by Race/Ethnicity (1950-2020)**



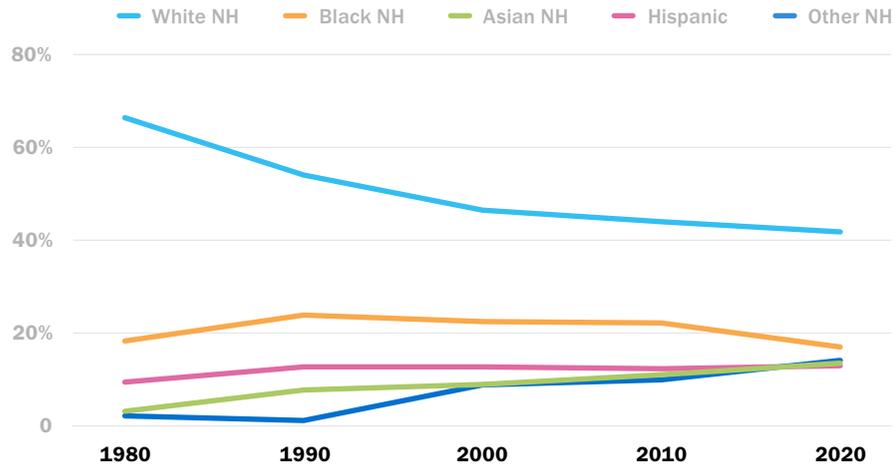
Source: U.S. Census (2020)

**Figure 6. Cambridge Proportion of Population by Race (2020)**



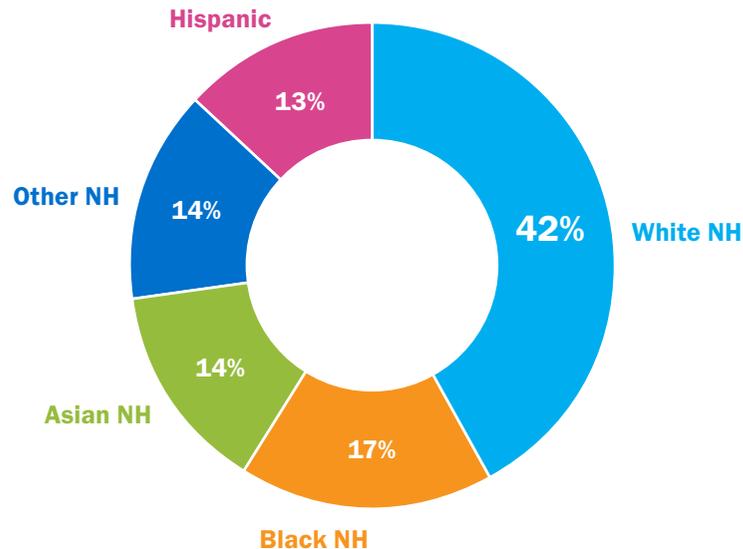
Source: U.S. Census (2020)

**Figure 7. Cambridge Population Under 18 by Race/Ethnicity (1980 - 2020)**



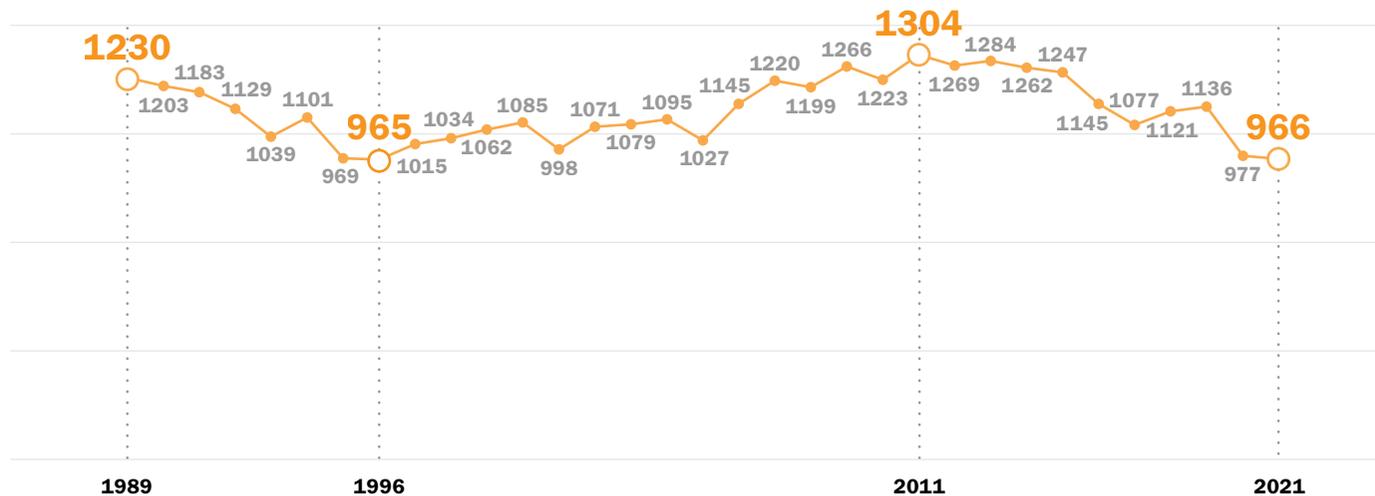
Source: U.S. Decennial Census (1980-2020)

**Figure 8. Cambridge Youth Under 18 by Race/Ethnicity (2020)**



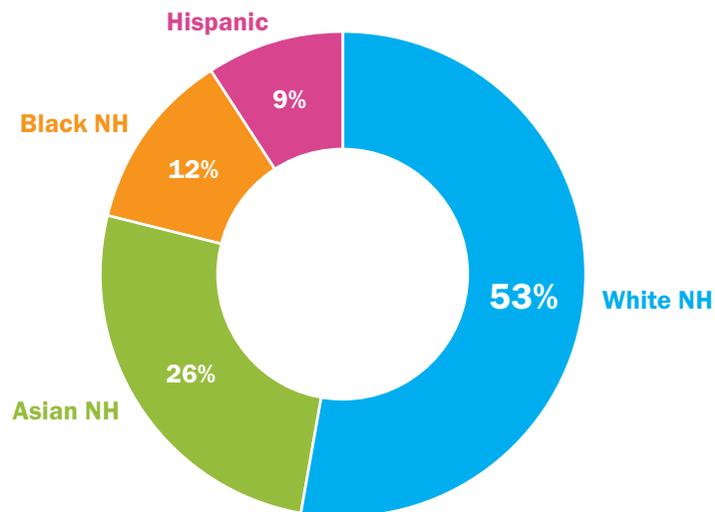
Source: U.S. Census (2020)

**Figure 9. Cambridge Birth Count (1989 - 2021)**



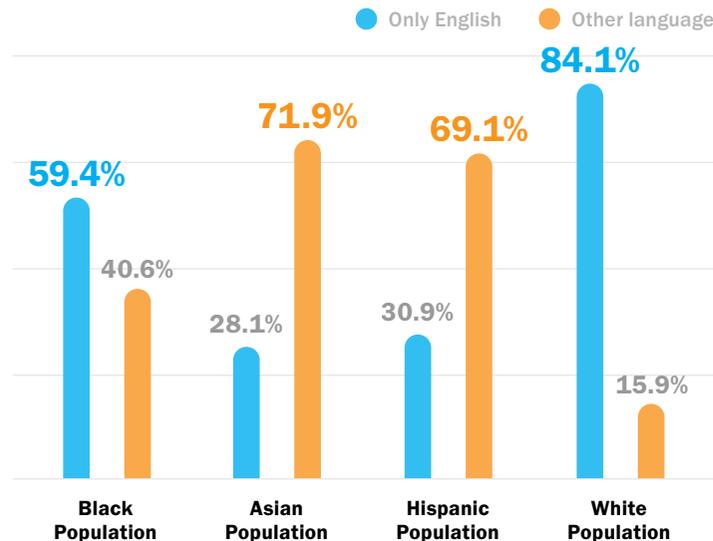
Source: MassCHIP, DPH Health Statistics Database

**Figure 10. Proportion of Births by Race/Ethnicity (2021)**



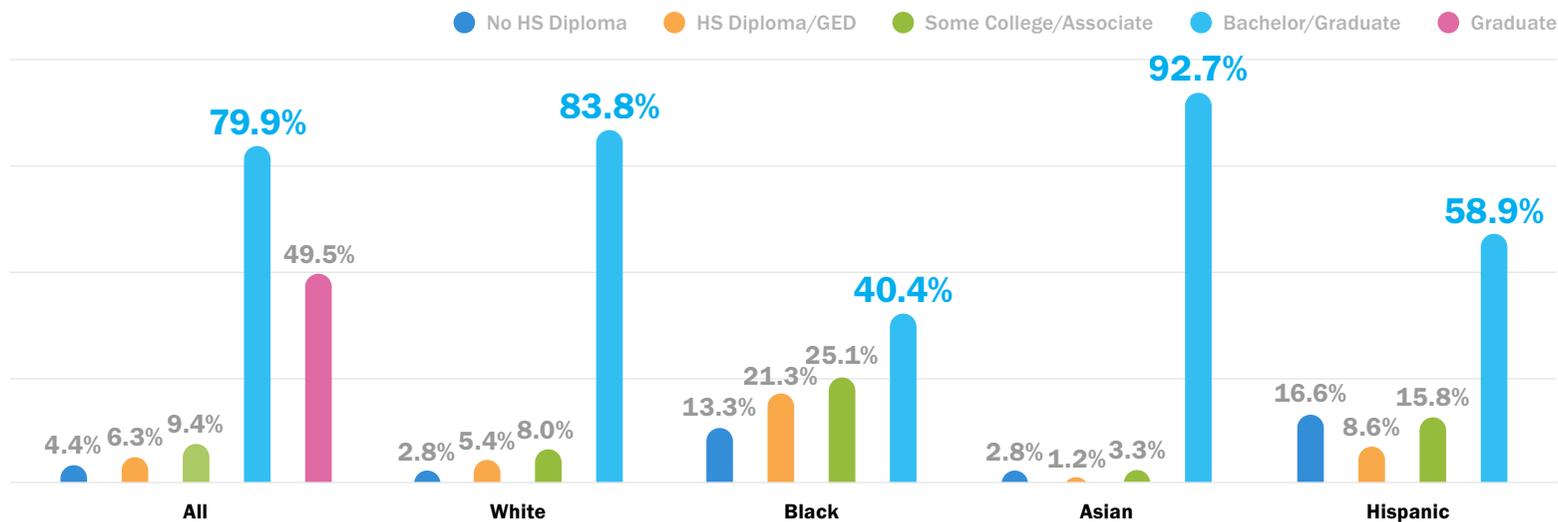
Source: MassCHIP, DPH Health Statistics Database

**Figure 12. Language Spoken at Home (2018-2022)**



Source: American Community Survey (2018-2022)

**Figure 11. Education Among Adults 25+ by Race/Ethnicity (2018-2022)**



Source: American Community Survey (2018-2022).

Note: For Cambridge overall, the total of the bars exceeds 100% because the 49.5% of adults with graduate degrees are also included in the Bachelor/Graduate category. Separate graduate degree data are not available by race/ethnicity.

**Table 5. Language Spoken at Home (2018-2020)**

Persons 5+	Population (n=113,020)	Population (%)
Speak Only English	74,047	65.5
Speak Other Language	38,973	34.5
<b>Of the 38,973 who speak another language at home...</b>		
Speak English Very Well	29,672	76.1
Speak English Less Than Very Well	9,301	23.9

Source: American Community Survey (2018-2022)

**Table 7. Disabilities in Cambridge (2019-2023)**

Disability Type	Total Population (%)
Any Disability	7.4
Hearing	1.7
Vision	0.9
Cognitive	3.5
Ambulatory	2.9
Self Care	0.8
Independent Living (population 18+)	2.9
1 Disability	4.6
2+ Disabilities	2.8

Total civilian noninstitutionalized population except where noted  
 Source: American Community Survey (2019-2023), Tables S1810 & C18108

**Table 8. Workforce Status of Cambridge Residents (Ages 18-64)**

Employment Status	Not Disabled (%)	Disabled (%)
Employed	75.5	44.5
Unemployed	2.3	6.2
Not in Labor Force	22.2	49.4

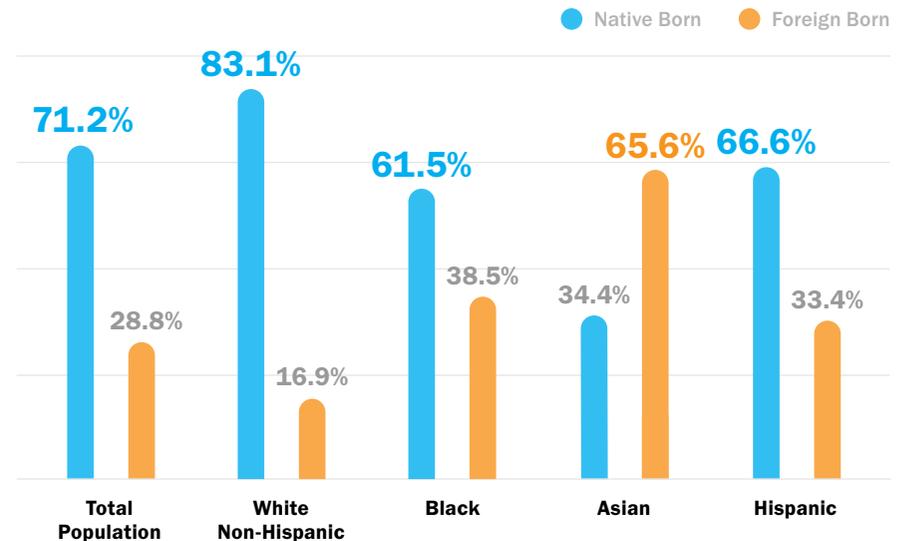
Source: American Community Survey (2018-2022)

**Table 6. Top 12 Foreign Places of Birth (2018-2022)**

Country	Population	Country	Population
1. China (mainland)	5,256	7. Japan	1,066
2. India	3,247	8. Brazil	954
3. Korea	1,746	9. Canada	920
4. Ethiopia	1,490	10. Germany	763
5. Haiti	1,402	11. Italy	697
6. France	1,076	12. Taiwan	601

Source: American Community Survey (2018-2022)

**Figure 13. Native vs. Foreign-Born (2018-2022)**



Source: American Community Survey (2018-2022)

**Table 9. Household and Family Median Income in Cambridge**

	1999*	2018-2022	Change (%)
<b>Household Median Income</b>			
United States	\$74,203	\$75,149	+1
Massachusetts	\$89,237	\$96,505	+8
Cambridge	\$84,779	\$121,539	+43
<b>Family Median Income</b>			
United States	\$88,431	\$92,646	+5
Massachusetts	\$108,960	\$122,530	+12
Cambridge	\$105,000	\$160,739	+53

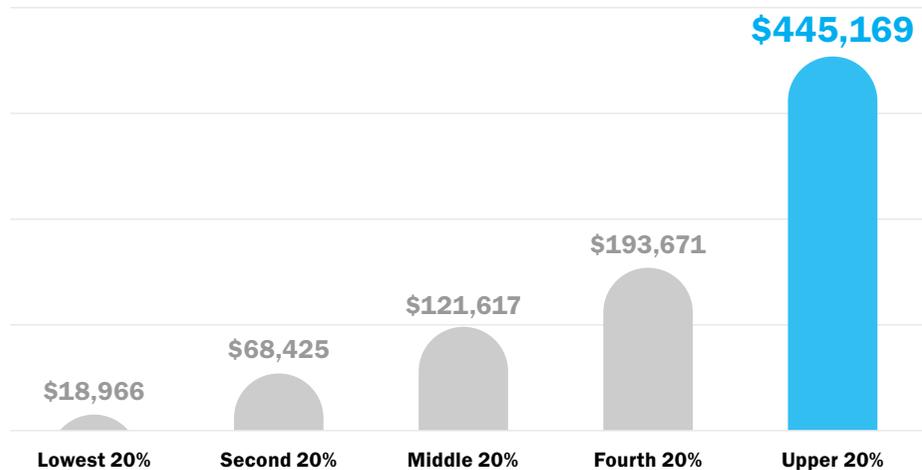
Source: American Community Survey 1999, 2018-2022  
 \*1999 incomes adjusted to 2022 dollars

**Table 10. Percent of Cambridge Population Living in Poverty**

	2006-2010	2018-2022
<b>Persons in Poverty</b>		
All	In Poverty (%) 15.0	In Poverty (%) 12.1
Under 18	17.6	12.7
65 and Over	10.9	9.6
Unrelated Persons 15+	20.3	17.7
All Households	14.3	11.5
Non-Family Households	17.6	14.9
Families	9.4	6.3
With No Working Adults	31.1	26.8
Families with Related Children	14.8	10.4
Female Single Parent	35.4	28.2
Female Single Parent w/Child Under 5	48.3	34.8
New Mothers	18.9	14.9

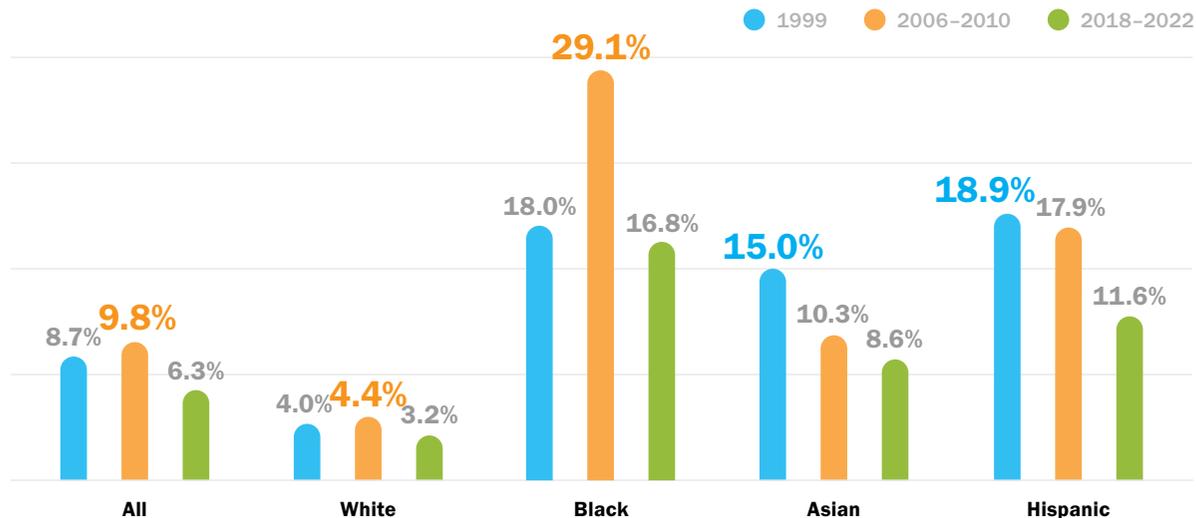
Source: American Community Survey (2006-2010, 2018-2022)

**Figure 14. Mean Incomes by Quintile in Cambridge (2018-2022)**



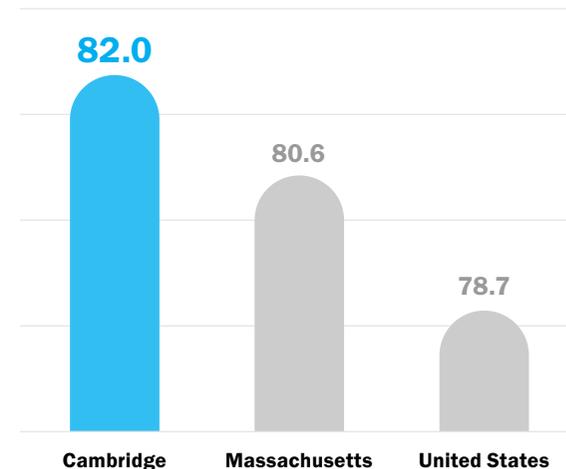
Source: American Community Survey (2018-2022)

**Figure 15. Percent of Cambridge Families in Poverty Over Time**



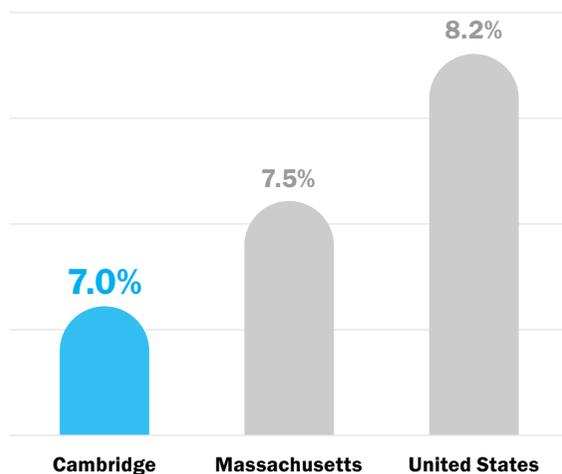
Source: American Community Survey (1999, 2006-2010, 2018-2022)

**Figure 16. Life Expectancy at Birth (2010-2015)**



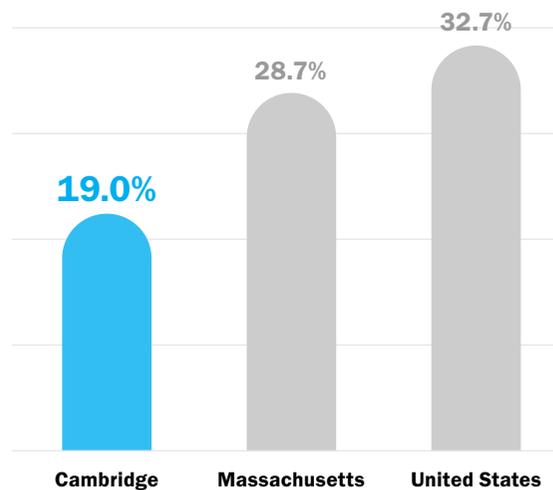
Source: CDC, National Center for Health Statistics, U.S. Small Area Life Expectancy Estimates Project (2010-2015)

**Figure 17. Low Birthweight Births (2014-2020)**



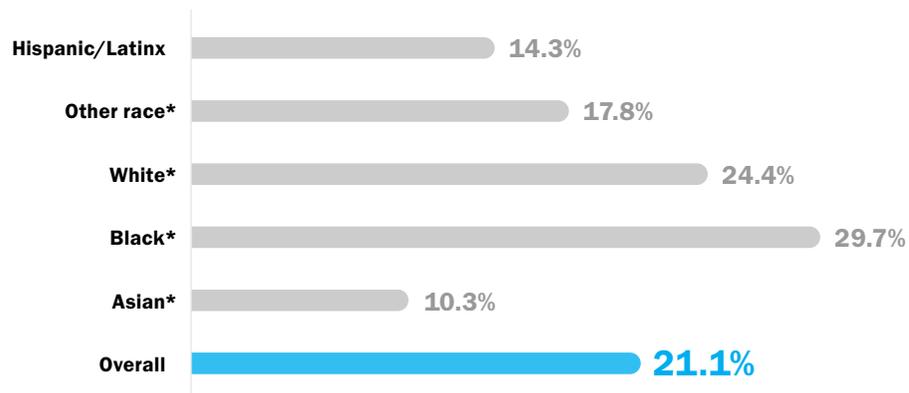
Source: National Center for Health Statistics (2014-2020) and County Health Rankings (2023)

**Figure 18. Adults Age 18+ With Hypertension (crude, 2021)**



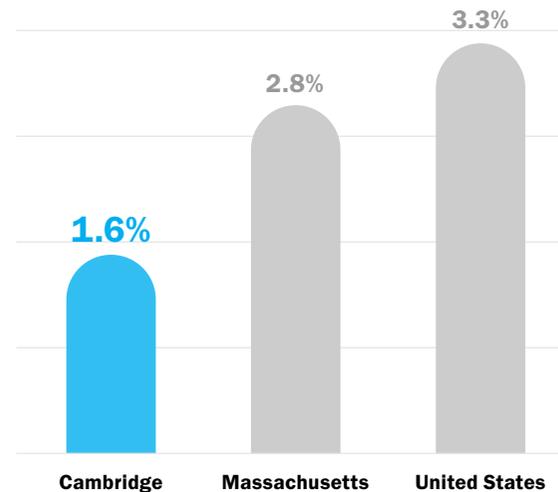
Source: CDC BRFSS (2021)  
Note: Age-adjusted rate not available for Cambridge

**Figure 19. Cambridge Adults 18+ Ever Diagnosed With Hypertension by Race/Ethnicity (crude, 2021)**



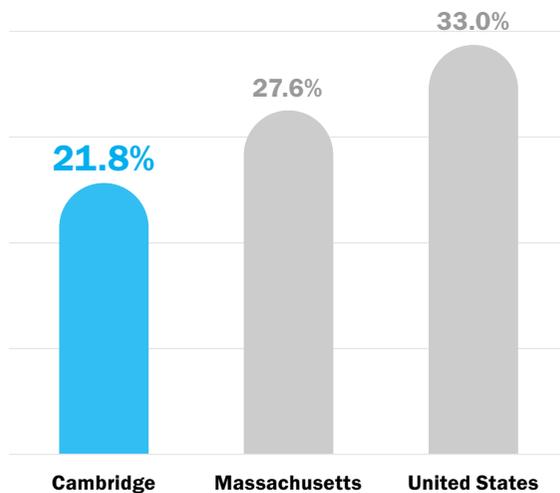
Source: MA Department of Public Health (2022)  
\*non-Hispanic/non-Latinx

**Figure 20. Adults Age 18+ Ever Having a Stroke (crude, 2021)**



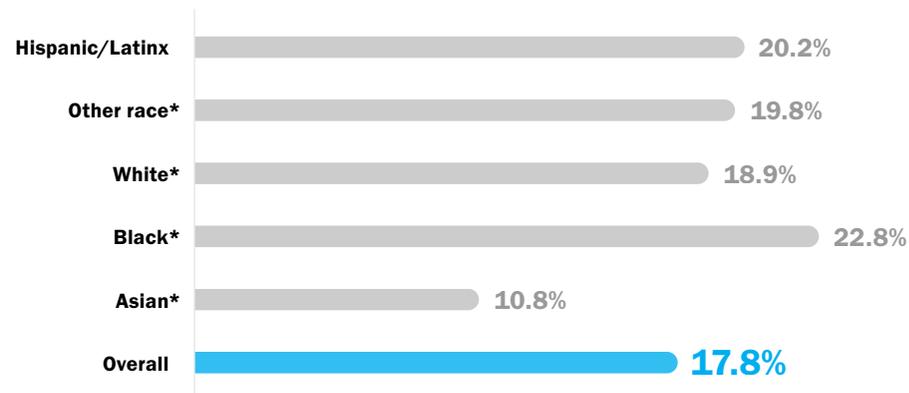
Source: CDC BRFSS (2021)  
Note: Age-adjusted data not available for Cambridge

**Figure 21. Adults Age 18+ With Obesity (crude, 2021)**



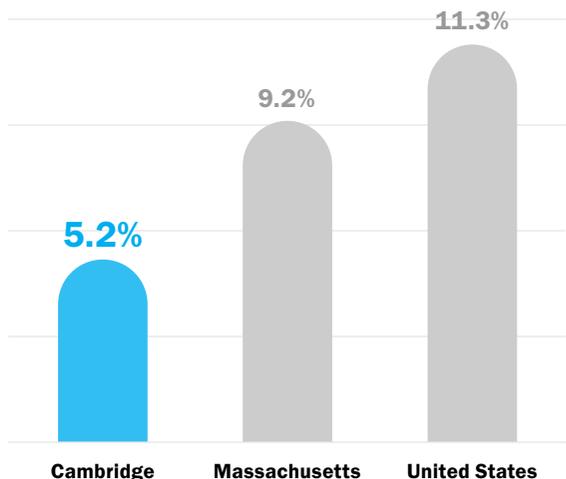
Source: CDC BRFSS (2021)  
Notes: Age-adjusted rates not available for Cambridge; BMI calculated from self-reported weight and height

**Figure 22. Cambridge Adults 18+ With Obesity by Race/Ethnicity (2021)**



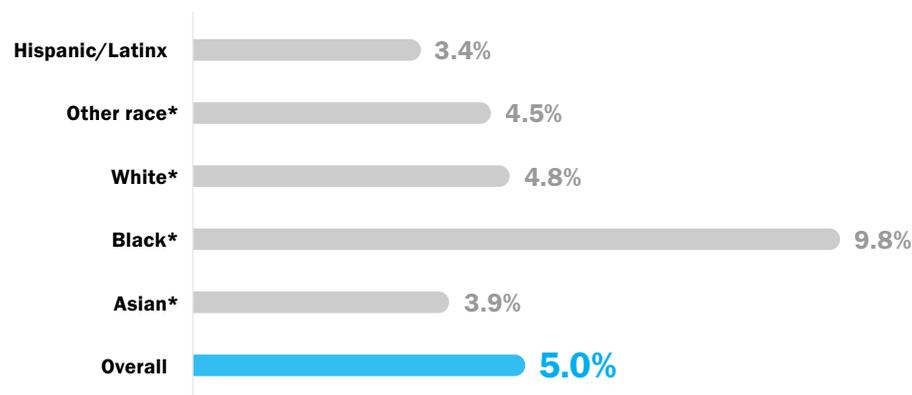
Source: MA Department of Public Health (2022)  
\*non-Hispanic/non-Latinx

**Figure 23. Adults Age 18+ Ever Diagnosed With Diabetes (crude, 2021)**



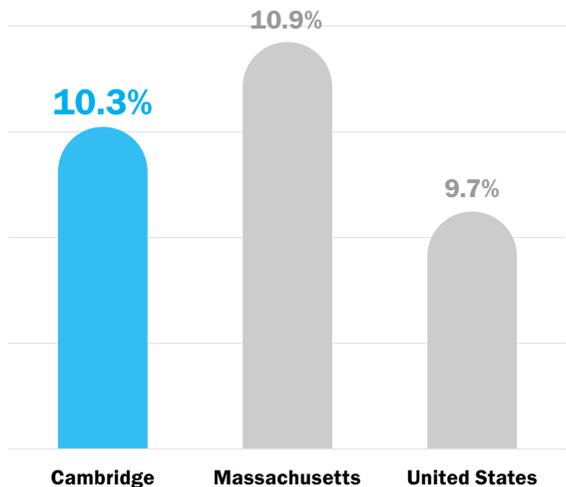
Source: CDC BRFSS (2021)  
 Note: Age-adjusted rates not available for Cambridge

**Figure 24. Cambridge Adults 18+ Ever Diagnosed With Diabetes by Race/Ethnicity (2021)**



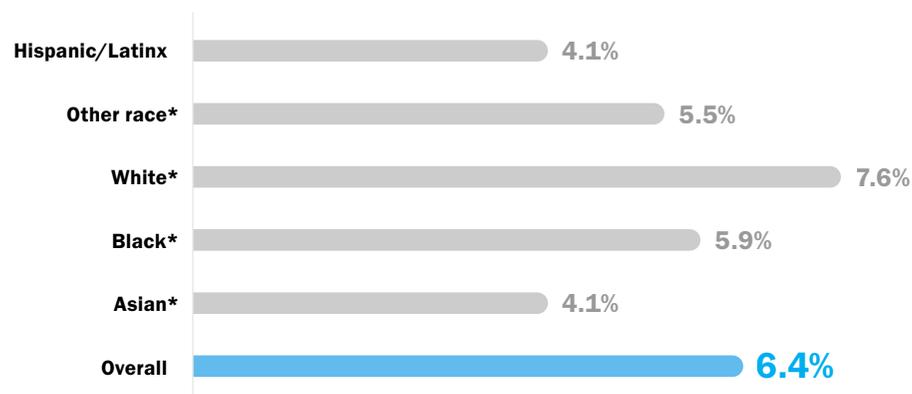
Source: MA Department of Public Health (2022)  
 \*non-Hispanic/non-Latinx

**Figure 25. Adults Age 18+ With Asthma (crude, 2021)**



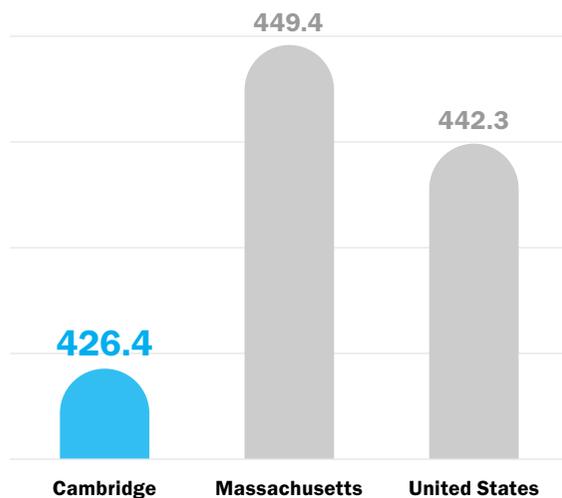
Source: CDC BRFSS (2021)  
 Note: Age-adjusted data not available for Cambridge

**Figure 26. Adults 18+ With Asthma by Race/Ethnicity (crude, 2021)**



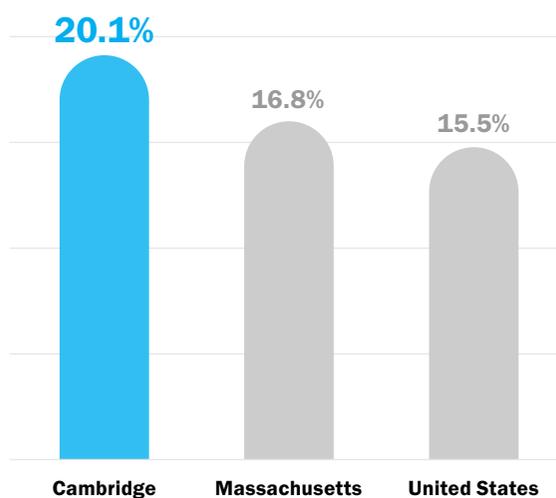
Source: MA Department of Public Health (2022)  
 \*non-Hispanic/non-Latinx

**Figure 27. Cancer Incidence:**  
Rate per 100,000 population (2016-2020)



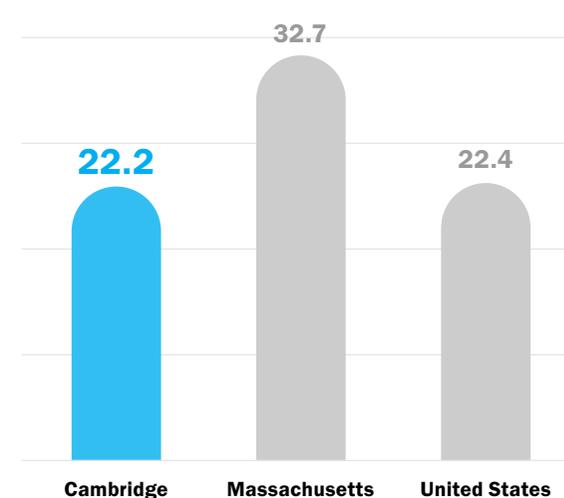
Source: State Cancer Profiles (2016-2020)

**Figure 28. Adults Age 18+ Binge Drinking In the Past 30 Days (crude, 2021)**



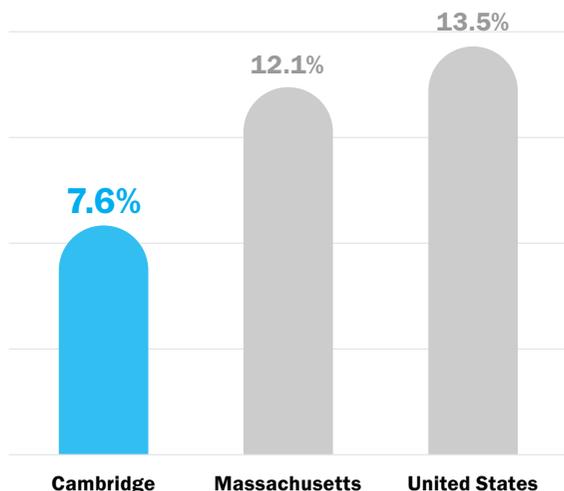
Source: Behavioral Risk Factor and Surveillance Survey (BRFSS), CDC (2021)  
Note: Age adjusted rates available for MA and US only.

**Figure 29. Age-Adjusted Death: Rate due to overdose of all substances per 100,000 population (2016-2020 five-year average rate)**



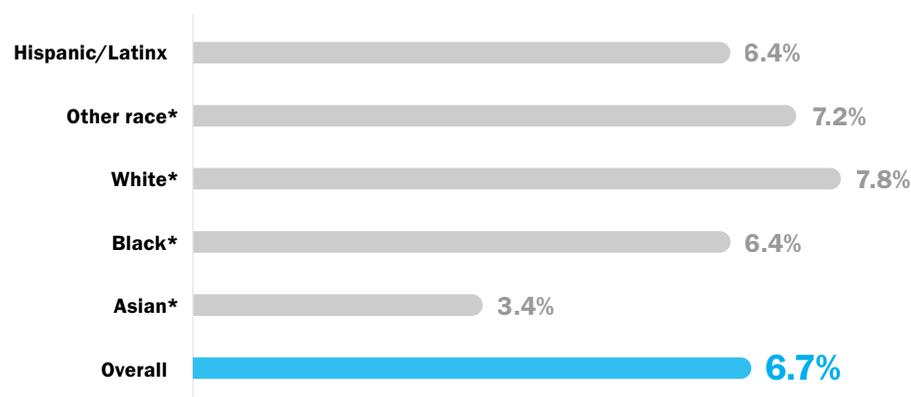
Source: CDC, National Vital Statistics System (2016-2020)

**Figure 30. Smokers Among Adults Age 18+ (crude, 2021)**



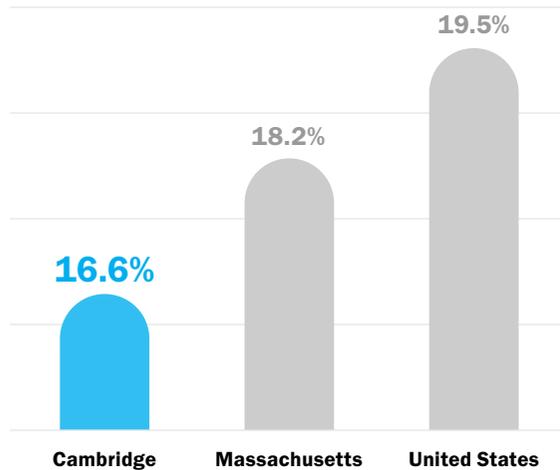
Source: BRFSS, CDC (2021)  
Note: Age-adjusted rates available for MA and US only.

**Figure 31. Smoking Among Cambridge Adults Age 18+ by Race/Ethnicity (2021)**



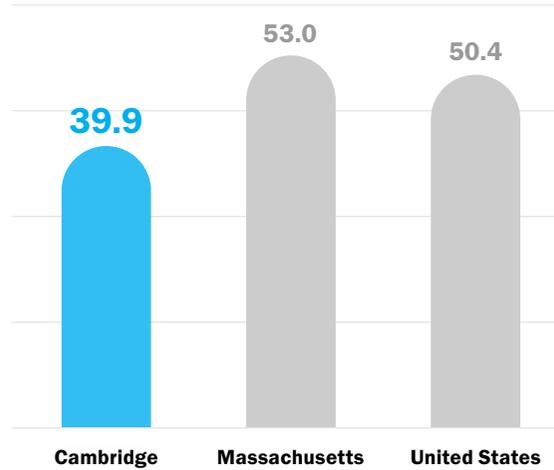
Source: MA Department of Public Health (2022)  
\*non-Hispanic/non-Latinx

**Figure 32. Adults Age 20+ with No Leisure Time Physical Activity (2021)**



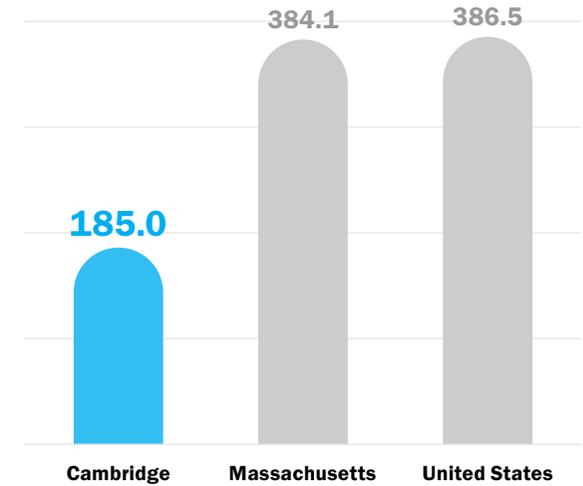
Source: U.S. Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion (2021)

**Figure 33. Age-Adjusted Death: Rate due to unintentional injury per 100,000 population (2016-2020 five-year average rate)**



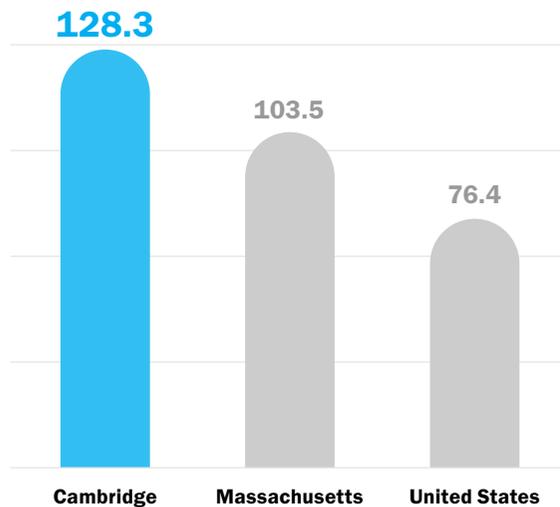
Source: CDC, National Vital Statistic System (2016-2020)

**Figure 34. Violent Crime per 100,000 Population (2014, 2016)**



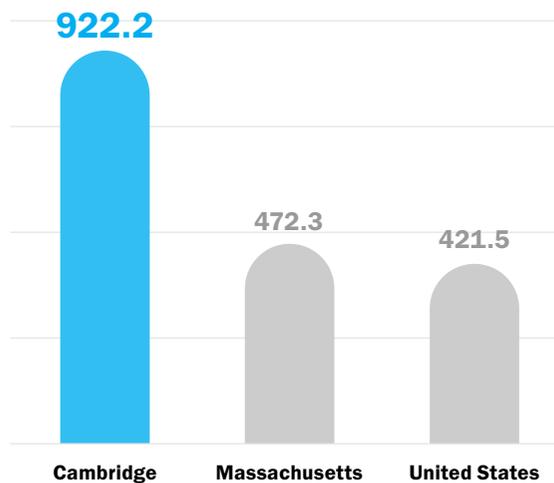
Source: 2014 and 2016 FBI Uniform Crime Reports

**Figure 35. Primary Care Physicians per 100,000 Population (2020)\***



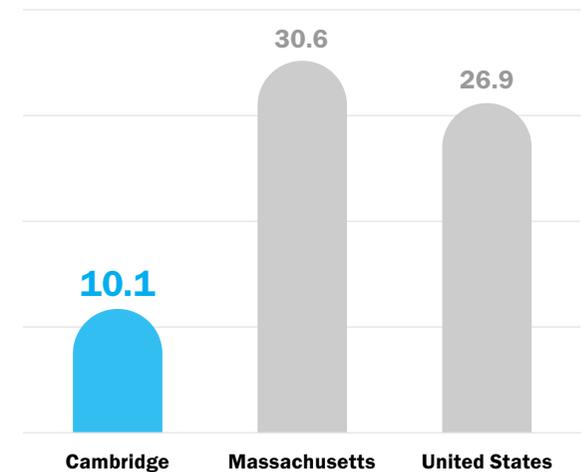
Source: US Department of Health and Human Services (USDHHS), Health Resources Services Administration (HRSA) (2020)  
 \*General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs and General Pediatrics MDs

**Figure 36. 501(c)(3) Organizations per 100,000 Population (2020)\***



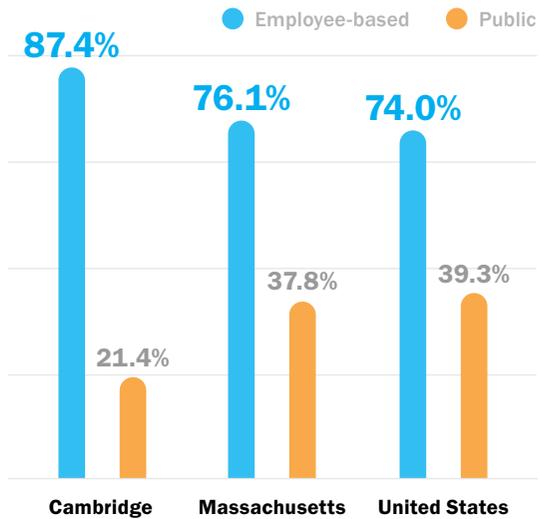
Source: Internal Revenue Service (2020)

**Figure 37. Addiction and Substance Abuse Providers per 100,000 Population (2024)**



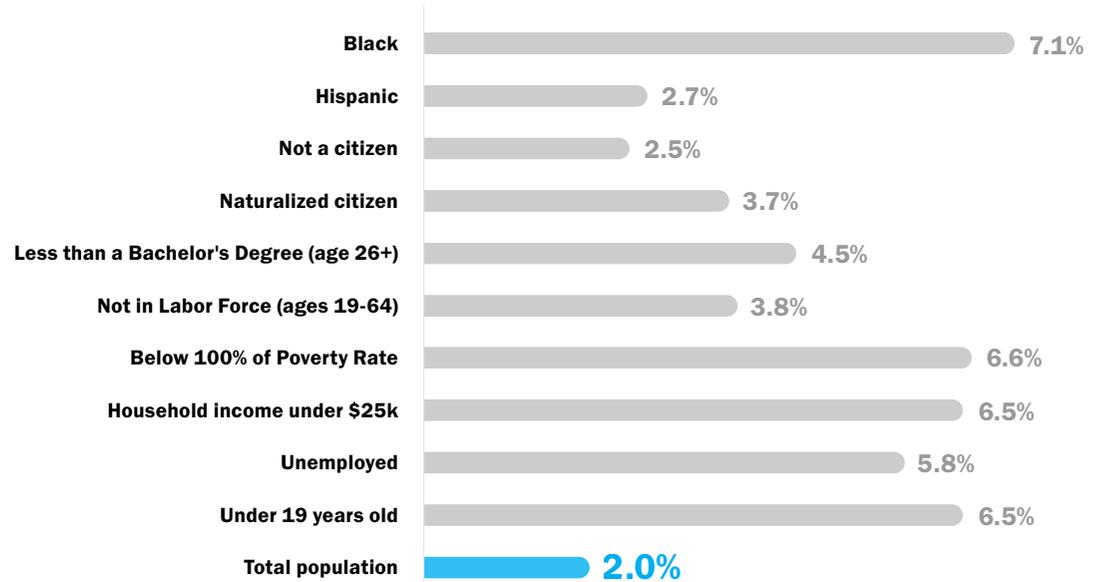
Source: Centers for Medicare and Medicaid Services (2024)

**Figure 38. Employer-Based Insurance (2018-2022)**



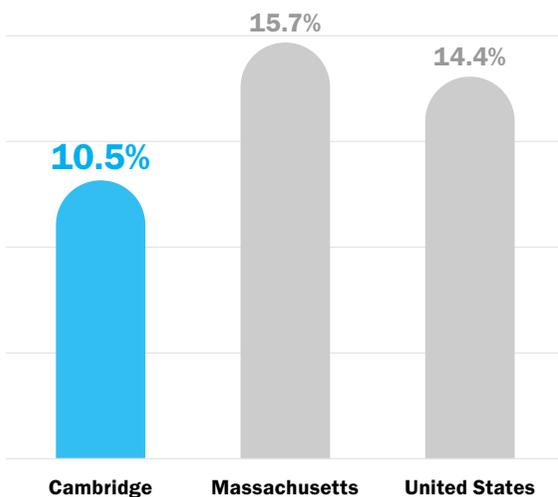
Source: American Community Survey (2018-2022)  
 Note: Total exceeds 100% as some people have more than one form of health insurance.

**Figure 39. Lacking Health Insurance Coverage in Cambridge (2018-2022)**



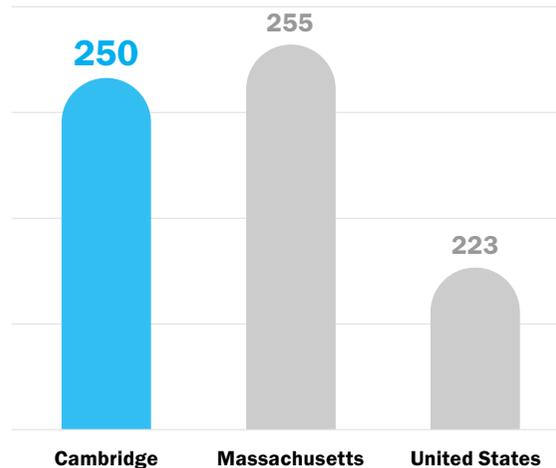
Source: American Community Survey (2018-2022)

**Figure 40. Beneficiaries with Inpatient Stays (2020)**



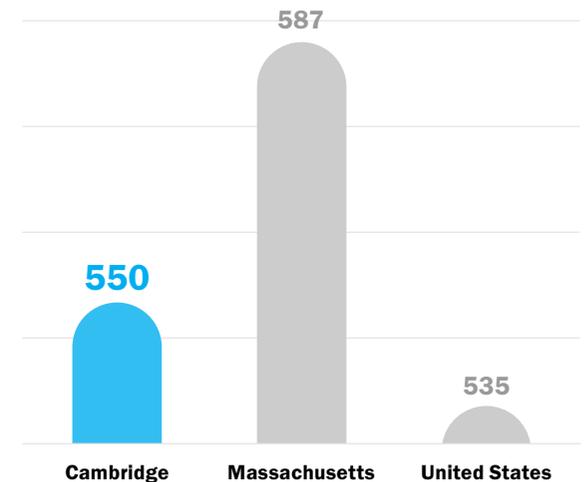
Source: Centers for Medicare and Medicaid Services (2020)

**Figure 41. Total Inpatient Stays: Rate per 1,000 beneficiaries**



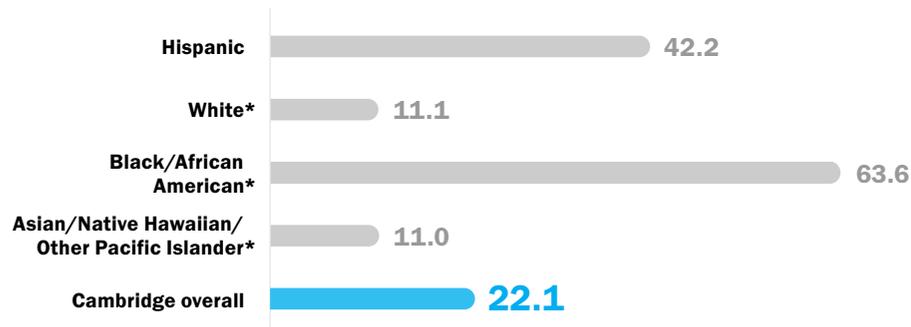
Source: Centers for Medicare and Medicaid Services (2020)

**Figure 42. Emergency Room Visits: Rate per 1,000 beneficiaries (65+)**



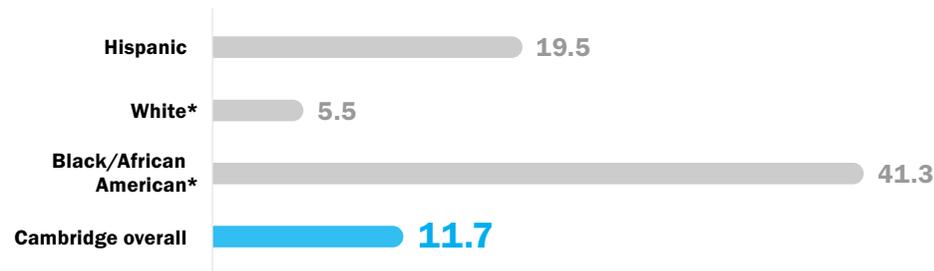
Source: Centers for Medicare and Medicaid Services (2020)

**Figure 43. ED Visits per 100,000 Due to Asthma (2017-2021)**



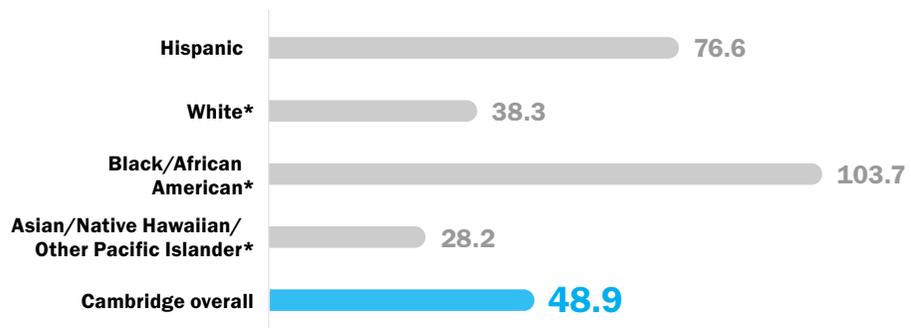
Source: MA Department of Public Health (2022)  
\*non-Hispanic/non-Latinx

**Figure 44. ED Visits per 100,000 Due to Diabetes (2017-2021)**



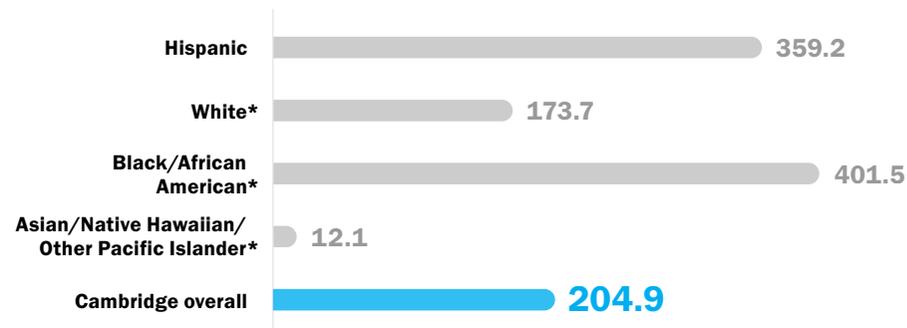
Source: MA Department of Public Health, Center for Health Information & Analytics  
\*non-Hispanic/non-Latinx. Data not available for Asian/Native Hawaiian/Pacific Islanders.

**Figure 45. ED Visits per 100,000 Due to Heart Disease (2017-2021)**



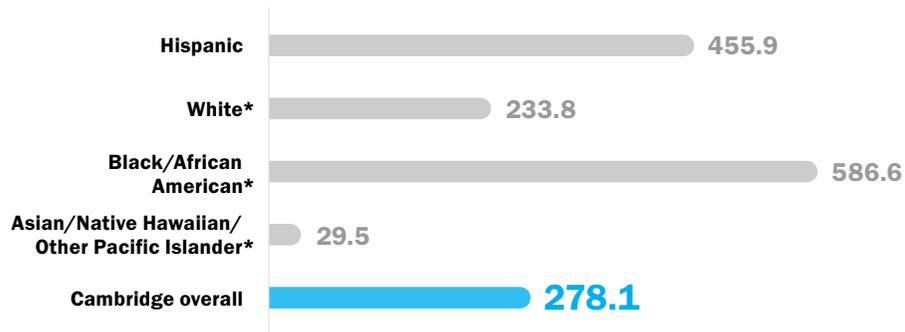
Source: MA Department of Public Health, Center for Health Information & Analytics  
\*non-Hispanic/non-Latinx

**Figure 46. ED Visits per 100,000 Due to Substance Use (2017-2021)**



Source: MA Department of Public Health, Center for Health Information & Analytics  
\*non-Hispanic/non-Latinx

**Figure 47. ED Visits per 100,000 Due to Mental Health (2017-2021)**



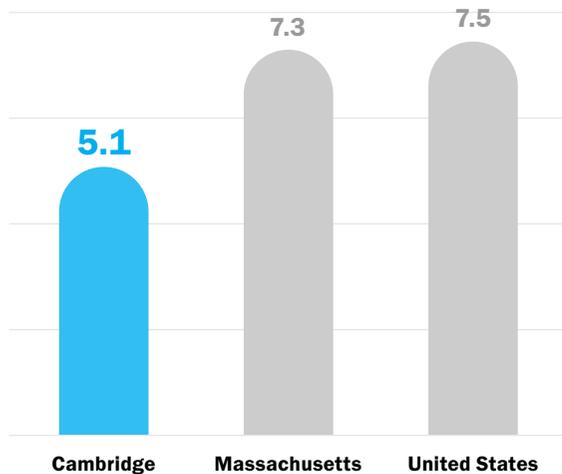
Source: MA Department of Public Health, Center for Health Information & Analytics  
 \*non-Hispanic/non-Latinx

**Table 11. Cambridge Housing Data (2018-2020)**

Description	Data
Number of households	48,475
Average number of residents per unit	2.1
Percent owner occupied housing units	33.6%
Median homeowner costs with mortgage	\$3,193
Median gross rent	\$2,628
Percent of cost burdened households (housing costs are 30% or more of income)	35%
Percent of occupied housing units with one or more substandard conditions	36%
Percent living in same house for past year	72.9%

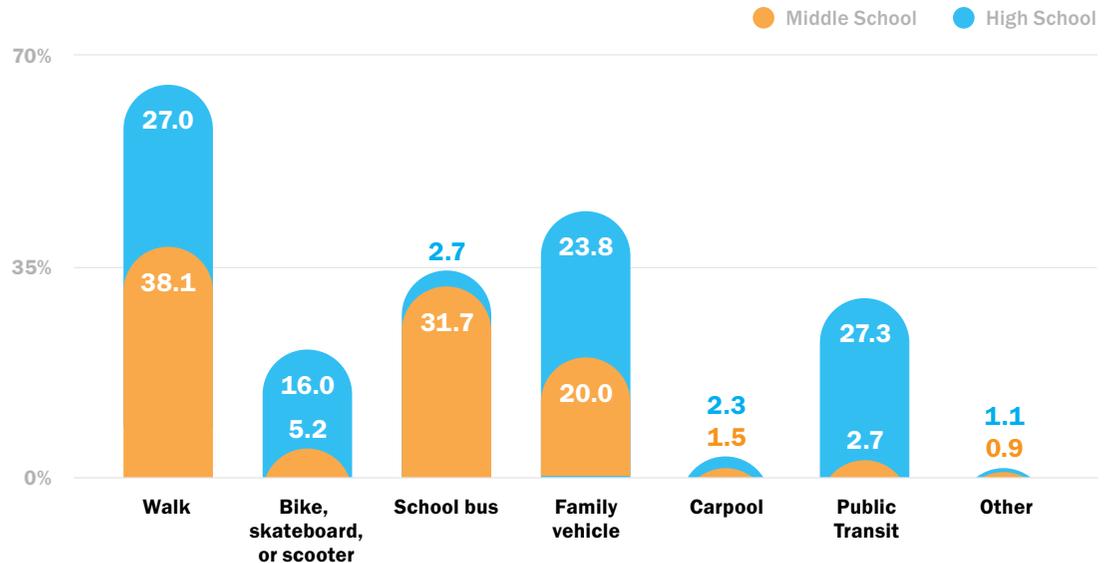
Source: American Community Survey (2018-2022)

**Figure 48. SNAP-Authorized Retailers per 10,000 Population**



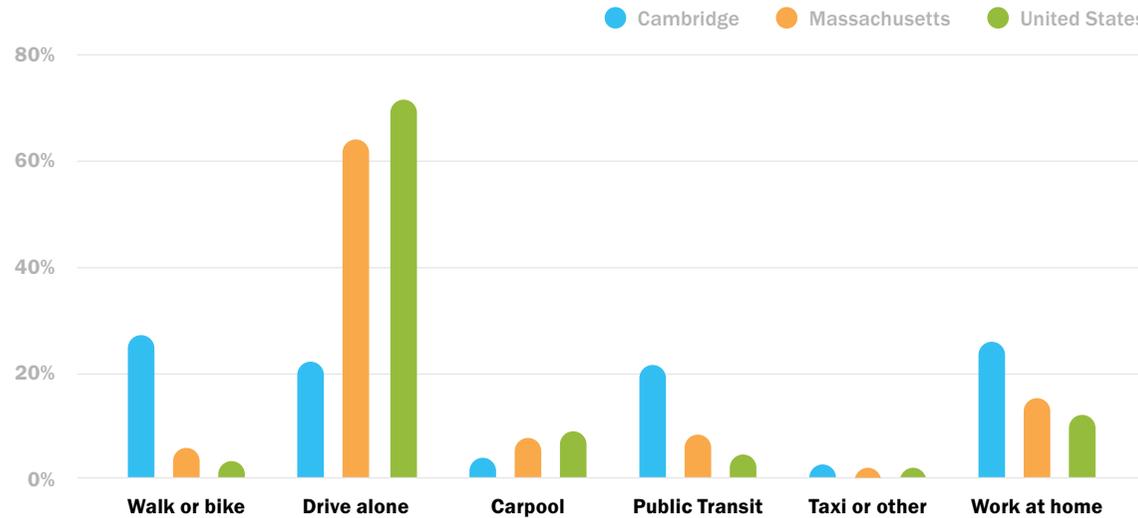
Source: U.S. Dept. of Agriculture SNAP Retailer Locator (2023)

**Figure 49. Transportation to School**



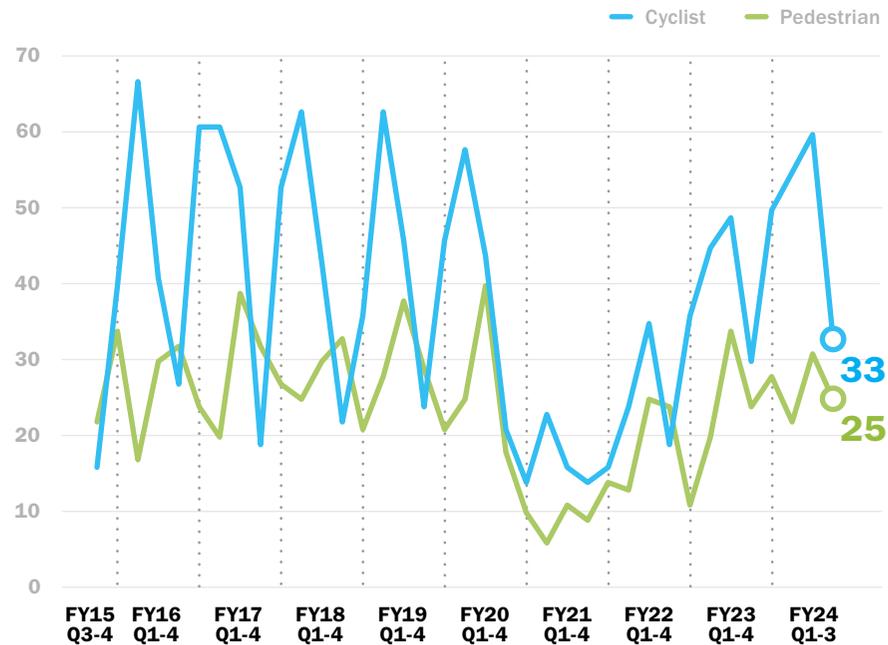
Source: Cambridge Teen Health Survey (2022)

Figure 50. Transportation to Work



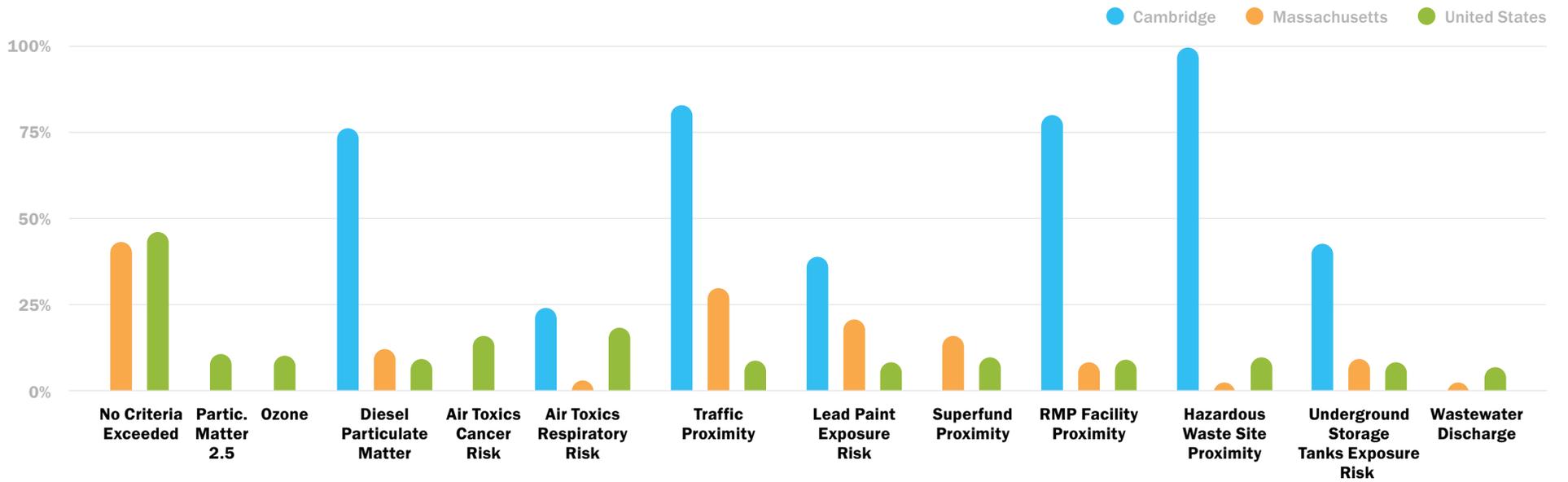
Source: American Community Survey (2018-2022)

Figure 51. Pedestrian and Bicycle Crashes in Cambridge



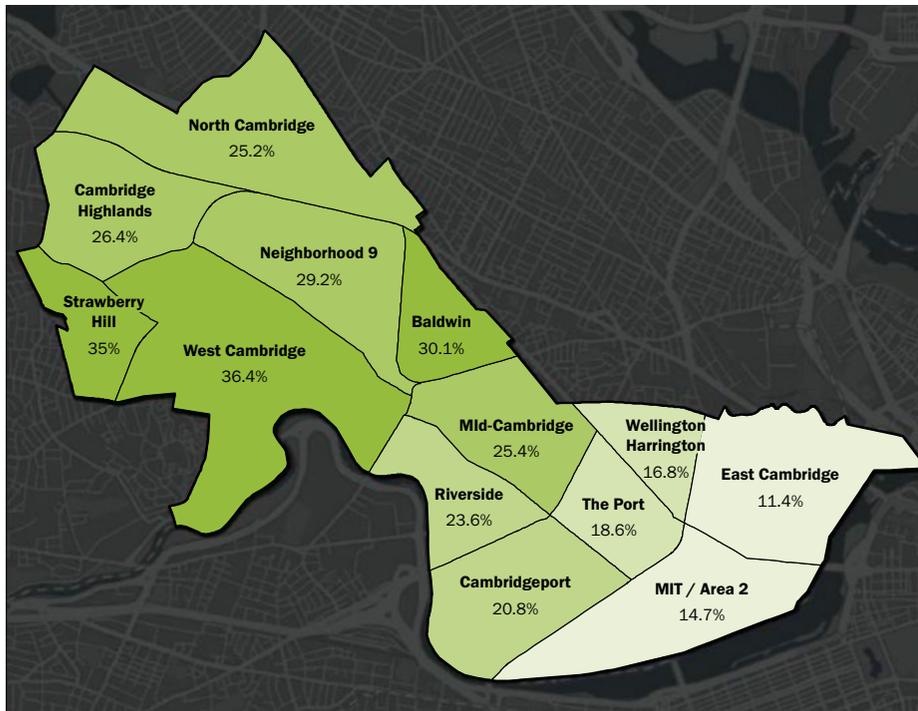
Sources: Cambridge Public Health Department Quarterly Tracking of Pedestrian and Cyclist Crashes

**Figure 52. Physical Environment Factors:** Percentage of report area's total population that rank in  $\geq 90$ th percentile (2022)



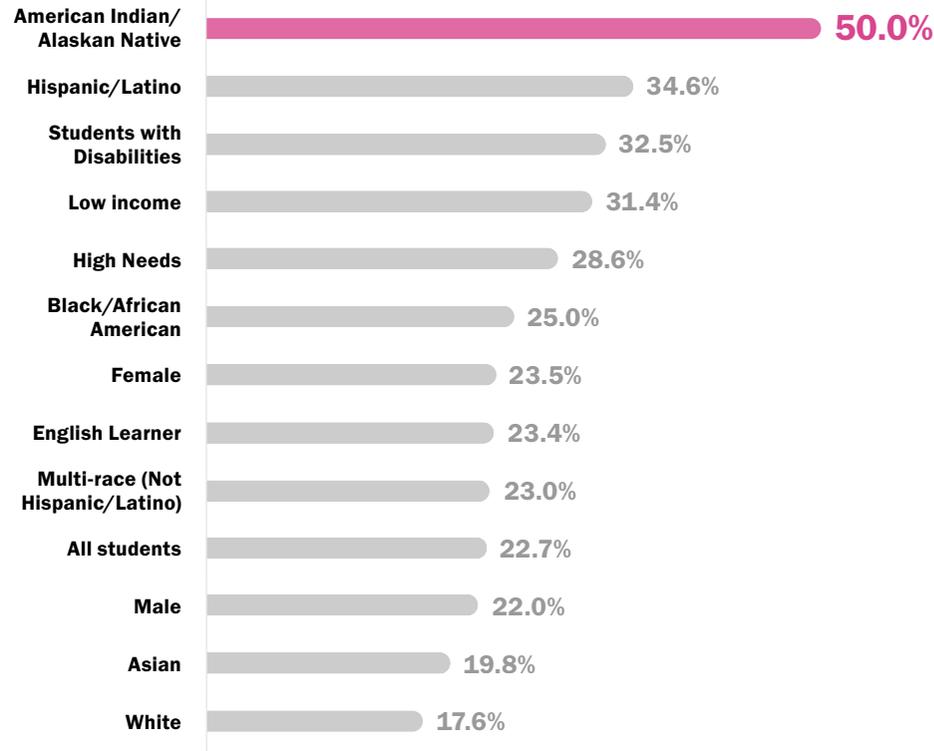
Source: Centers for Disease Control and Prevention, CDC–Agency for Toxic Substances and Disease Registry. Accessed via CDC National Environmental Public Health Tracking (2022)

**Figure 53. Comparison of Tree Canopy by Cambridge Neighborhoods (2009-2020, 2022)**



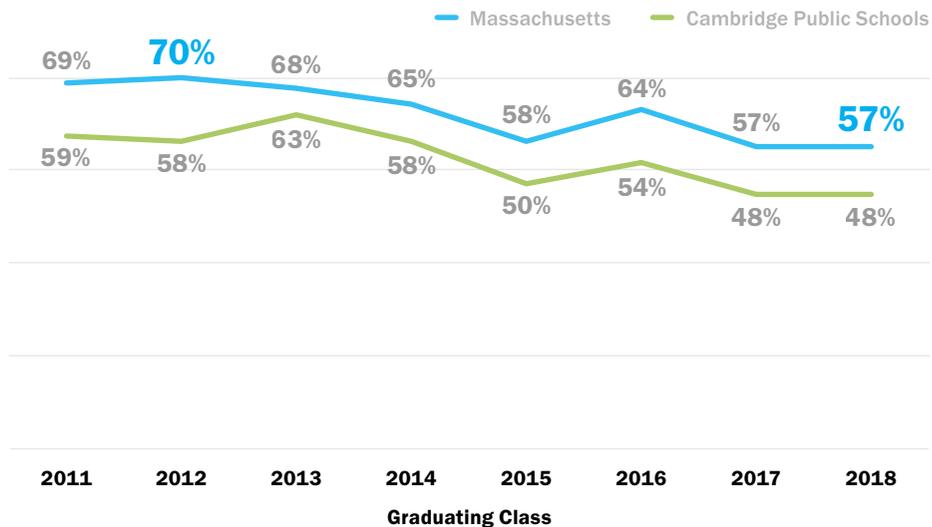
Source: Cambridge Tree Canopy Assessment (2009-2020, 2022)  
 Note: Light to dark colors represent worst to best (i.e., lightest color represents deficient tree canopy)

**Figure 54. Education Access & Quality: CPS students chronically absent (10% or more days) in the 2023-2024 school year**



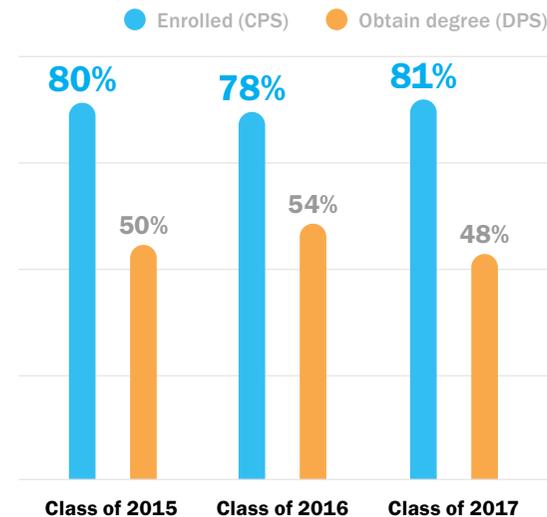
Source: MA School and District Profiles, MA Department of Elementary and Secondary Education (2024)

**Figure 55. Education Access & Quality: Post-secondary degree attainment**



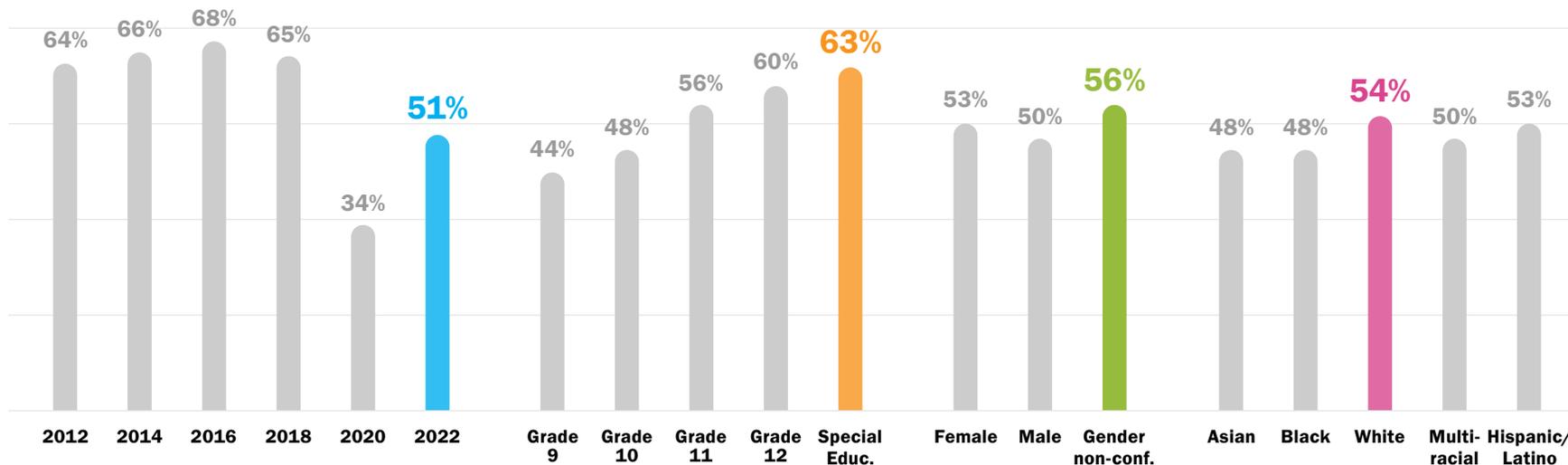
Source: Cambridge Public Schools College & Career Readiness Report, updated May 2024.

**Figure 56. Education Access & Quality: CPS college enrollment & degree attainment**



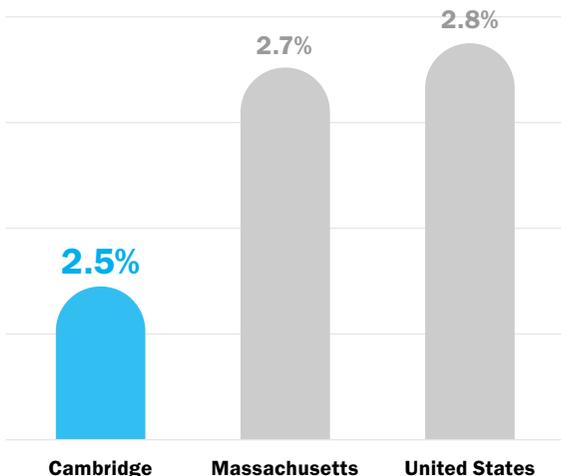
Source: Cambridge Public Schools College & Career Readiness Report, updated May 2024.

**Figure 57. Social and Community Connectedness: Percentage of high school students with at least one teacher or other adult in school to talk to about a problem (2022)**



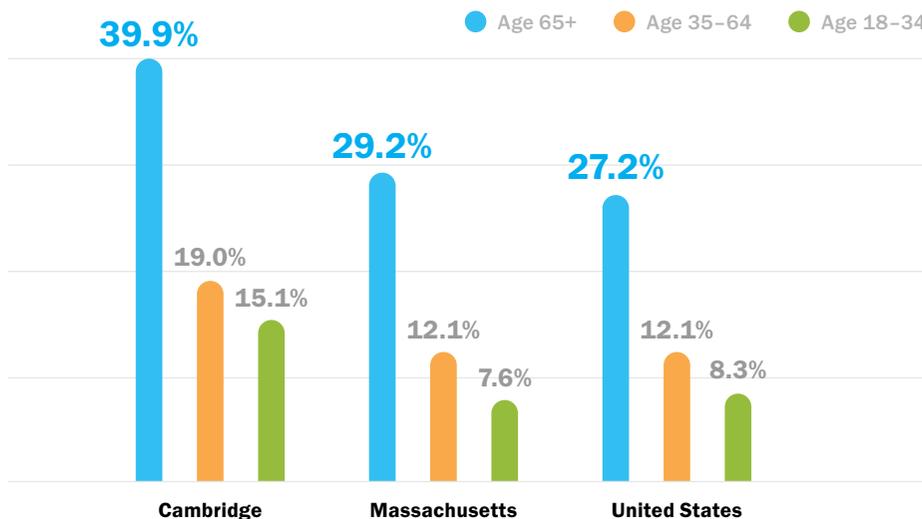
Source: Teen and Middle Grades Health Survey (2022)

**Figure 58. Social and Community Connectedness: Homeless youth by school district**



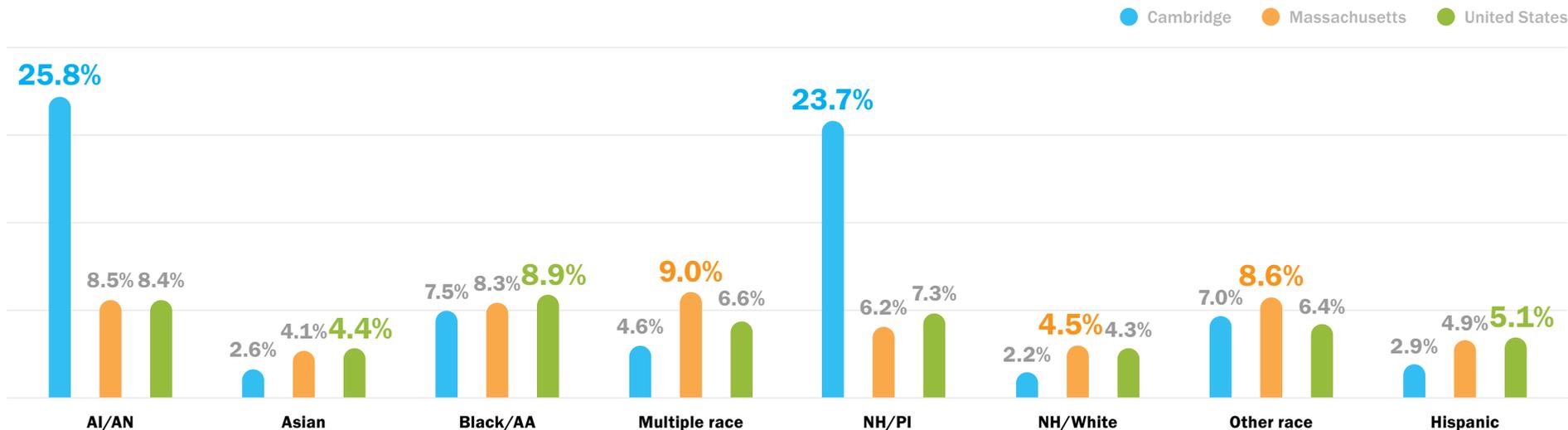
Source: U.S. Dept. of Education, EDData with additional CARES analysis (2019-2020)

**Figure 59. Social and Community Connectedness: Living alone by age group**



Source: U.S. Census, American Community Survey (2018-2022)

**Figure 60. Economic Stability: Unemployment by race/ethnicity**



Source: U.S. Census, American Community Survey (2018-2022)



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Public Health  
Department

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