The City of Cambridge

Community Health Assessment

A Healthy City **for All**
CAMBRIDGE COMMUNITY HEALTH ASSESSMENT

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INTRODUCTION

The health status of a community is determined by a variety of economic, social, and health-related characteristics. Understanding these characteristics is an integral part of improving a community's health and assuring a high quality of life for residents. It is also important to distinguish the strengths and assets in a community to ensure that there are sufficient services and resources to address health concerns and leverage a healthier community for all residents.

BACKGROUND ON ASSESSMENT AND IMPROVEMENT PLANNING PROCESS

In 2013, the Cambridge Public Health Department, a city department administered by the Cambridge Health Alliance, launched a major initiative to better understand the health needs of the community and develop or strengthen programs and policies to address these needs. This process included conducting a Cambridge Community Health Assessment to provide a portrait of the community's health and then developing a Community Health Improvement Plan to identify areas of action. This collaborative, participatory Community Health Assessment/Community Health Improvement Plan process had several overarching goals, including:

1. Complete a comprehensive Community Health Assessment that will identify the city's strengths and challenges in providing a healthy environment for all residents and workers
2. Develop a Community Health Improvement Plan that will serve as a blueprint for improving the health of the city over the next five years
3. Engage partners, organizations, and individuals in creating a vision for a healthy Cambridge and making that vision a reality
4. Position the Cambridge Public Health Department to become a nationally accredited health department

Following this collaborative effort, the health department became recognized as nationally accredited in 2018. Conducting a Community Health Assessment every five years is a requirement for organizations seeking or maintaining public health accreditation status through the national nonprofit Public Health Accreditation Board.

In 2018, the Cambridge Public Health Department began its most recent iteration of their Community Health Assessment to better understand and serve the Cambridge community. The most recent Community Health Assessment was conducted with the following goals in mind:

1. Understand the health needs and concerns of Cambridge
2. Assist in developing programs and policies to address those needs
3. Improve health-related programs and services
4. Provide information for city planning processes
5. Engage partners, organizations, and individuals in making the vision for a healthier Cambridge a reality

This report details the findings of the Cambridge Community Health Assessment, per the first goal of this process, which examined the current health status of Cambridge residents and explored the health-related challenges, experiences, and priorities of Cambridge residents within the social context of their community. Most of the activities in this report were conducted from April 2019 – September 2019.

It is important to note that this assessment took place before the start of the COVID-19 pandemic, which will continue to impact the health of the city for the foreseeable future. The assault of this coronavirus on the city's black and brown residents who are less likely to be able to work from home; are more likely to live in crowded housing where physical distancing is difficult; make up a large proportion of essential workers (e.g., in supermarkets or food establishments); and have higher rates of underlying disease has highlighted the urgent need to address systemic racism and the social determinants of health.

ACCREDITATION

As of August 2018, the Cambridge Public Health Department is nationally accredited by the Public Health Accreditation Board, a nonprofit organization that was developed in 2007 as a result of strategic discussions among national foundations, such as the Robert Wood Johnson Foundation, and federal agencies, such as the Centers for Disease Control and Prevention. These discussions focused on the importance of developing a set of standards, a process to measure health department performance against those standards, and recognition for those departments that meet the standards. The Cambridge Public Health Department is one of only three local public health departments in the Commonwealth that is nationally accredited.

The Community Health Assessment and Community Health Improvement Plan are essential elements of the public health accreditation process and are part of a broader initiative to strengthen agency performance, improve the quality of departmental services, and ensure that health department activities reflect the needs of the community.

Adherence to national standards benefits the Cambridge community in multiple ways, including identifying the needs of residents and how to address them, providing a framework for the health department to provide the highest quality services possible, and positioning the city for future public health funding opportunities. Accreditation provides a means for a public health department to identify performance improvement opportunities, enhance management, develop leadership, and strengthen relationships with members of the community.

DATA COLLECTION METHODS

The Cambridge Community Health Assessment aimed to gather information and data that could be used to better understand changes to the Cambridge community over the past five years as well as the community's perceptions of the city's strengths and areas for improvement. Data were collected through secondary data sources, a community-wide survey, and focus groups. The following section describes the activities and approaches used to collect the data. This section outlines the importance of integrating specific health-related concepts, the individual data collection activities, how data from the activities were analyzed, and limitations to the data collection methodology.

SOCIAL DETERMINANTS OF HEALTH FRAMEWORK

While delivering quality health care to residents is an important part of maintaining community health, it is not the only factor that allows a community to thrive. In addition to individual factors (e.g., genetic makeup and personal behaviors), community health is also influenced by economic and social factors, such as education and housing. These factors create the Social Determinants of Health framework **(FIGURE 1)** and were used to guide the discussion and development of survey questions, interview guides, and the search for secondary data indicators. For example, survey participants were asked how concerning social determinants such as housing and safety are for themselves and their families. Focus group participants were asked to discuss health-related issues such as environmental quality and access to healthy foods. Secondary data indicators incorporate factors related to transportation and poverty.

FIGURE 1: Social Determinants of Health Framework

DATA SOURCE: Health Resources in Action

HEALTH EQUITY LENS

In addition to capturing the impact of social determinants of health within a community, it is also important to understand how underserved populations in a community are disproportionately affected by social determinants. This understanding is captured by employing a health equity lens while conducting activities related to the assessment. 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."*[1] The Cambridge Public Health Department used a health equity lens to guide data collection methods by engaging populations that are typically underrepresented in data collection (e.g., individuals with disabilities, homeless youth, and immigrants).

QUANTITATIVE DATA COLLECTION METHODS

Review of Existing Data

Existing data from national, state, and local sources were reviewed to help describe the Cambridge community and create context for the strengths and concerns highlighted in the survey and focus groups. The types of data included demographics, vital statistics, public health surveillance, and self-reported health behaviors. Data sources included, but were not limited to, the U.S. Census Bureau, the Centers for Disease Control and Prevention's 500 Cities Project, and the Massachusetts Department of Public Health. Tables highlighting the key findings of the secondary data review are distributed throughout the report. More detailed summary tables of select secondary data topics can be found in the Appendix. Data included in this report represent the most recent data collected and analyzed during the time this report was written.

Community Survey

To further understand the Cambridge community, a survey was developed and administered to those who live, work, or spend time in the area. The survey explored respondents' perceptions of health, access to services, key health concerns, and areas for improvement in the future. The survey was administered online and distributed as a hardcopy at various community locations and events. It was available to the public from April through June 2019 in the nine most commonly spoken languages among Cambridge residents: English, Spanish, Portuguese, Haitian Creole, Arabic, Amharic, Chinese, Hindi, and Bengali. Hindi and Bengali were available in hardcopy versions only. To boost survey responses from typically underserved populations, surveys were also distributed through listservs and locations that serve underserved populations, such as the Community Learning Center and the Senior Center. Survey respondents who indicated that they did not live in Cambridge were excluded from the primary analyses. A total of 1,129 survey respondents who reside in Cambridge were included in the final survey sample.

TABLE 1 describes demographic data for survey respondents who indicated that they live in Cambridge and U.S. Census data on the demographics of Cambridge residents. The largest proportion of survey respondents lived in North Cambridge (18.4%), Mid-Cambridge (12.5%), and Cambridgeport (12.4%). The majority of survey respondents (74.4%) were female, and more than half (54.9%) were age 50 years or older. Less than one in five respondents (17.4%) self-identified as a minority non-Hispanic race/ethnicity, and 6.2% identified as being of Hispanic, Latinx, or Spanish origin. Roughly one in seven respondents (15.9%) indicated that they speak a language other than English in their homes. More than half (53.2%) obtained a graduate or professional degree, and more than two-thirds of respondents (69.1%) earned $50,000 or more in household income in the past 12 months.

It should be noted that while the survey data provide useful insight into resident perceptions of the Cambridge community, the survey demographics may not provide a truly representative sample of the city's residents. Though education and income categories align well with the U.S. Census data, women and individuals who identify as White were overrepresented in the survey sample, while younger age groups, individuals who identify as non-White, and non-English speakers were underrepresented.

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

TABLE 1: Demographic Characteristics of Community Health Survey Respondents, Cambridge, 2019

	Cambridge Resident Survey Respondents	Cambridge Population Based on U.S. Census
Neighborhood of Residence	(N=1,101)	
East Cambridge	11.4%	9.3%
Area 2/MIT	1.5%	4.4%
Wellington-Harrington	4.8%	5.9%
The Port	7.2%	6.4%
Cambridgeport	12.4%	11.4%
Mid-Cambridge	12.5%	12.1%
Riverside	7.3%	11.1%
Agassiz	3.3%	4.9%
Neighborhood Nine	10.5%	10.9%
West Cambridge	8.1%	7.8%
North Cambridge	18.4%	12.6%
Cambridge Highlands	0.9%	1.2%
Strawberry Hill	1.4%	2.1%
Not Sure or Do Not Know	0.3%	--
Gender	(N=1,060)	
Male	24.2%	49.1%
Female	74.4%	50.9%
Non-Binary	1.3%	--
Prefer to Self-Describe	0.1%	--
Age in Years	(N=1,073)	
Under 18	0.4%	12.2%
18 to 29	9.8%	36.5%
30 to 39	17.3%	18.9%
40 to 49	17.6%	9.3%
50 to 64	23.4%	11.8%
65 to 74	18.8%	6.6%
75 and Older	12.7%	4.7%
Race/Ethnicity	(N=1,048)	
Asian, Non-Hispanic	5.8%	15.7%

Black or African American, Non-Hispanic	9.1%	10.0%
Middle Eastern or North African, Non-Hispanic	2.5%	--
White, Non-Hispanic	70.8%	61.6%
Other, Non-Hispanic	1.4%	0.5%
Multiple Races, Non-Hispanic	4.2%	3.4%
Hispanic, Any Race	6.2%	8.8%
Primary Language Spoken at Home	(N=1,084)	
English	84.2%	63.9%
Spanish	3.0%	7.1%
Portuguese	1.3%	--
Amharic	1.0%	--
Arabic	2.0%	--
Haitian Creole	2.7%	--
Mandarin	0.6%	--
Other	5.3%	--
Educational Attainment	(N=1,060)	
Less Than High School	4.2%	5.3%
High School Graduate or Equivalent	6.2%	8.9%
Some College or Associate Degree	11.1%	9.3%
Bachelor's Degree	25.3%	29.0%
Graduate or Professional Degree	53.2%	47.4%
Income	(N=903)	
Less than $25,000	16.7%	18.1%
$25,000 to $34,000	6.5%	5.8%
$35,000 to $49,000	7.6%	7.3%
$50,000 to $74,000	12.1%	12.2%
$75,000 to $99,000	10.6%	11.9%
$100,000 to $150,000	18.5%	17.1%
$151,000 to $199,000	11.4%	11.1%
$200,000 or More	16.5%	16.5%

DATA SOURCE: Cambridge Community Health Assessment Survey, 2019; U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017.

NOTE: -- denotes the indicator is not available from the data source.

QUALITATIVE DATA COLLECTION METHODS

Focus Groups

Focus groups are a form of qualitative data that help to provide a more detailed narrative about a community that quantitative data cannot always capture. Groups typically have eight to 12 participants, and a facilitator leads participants through a semi-structured question guide. Focus groups also allow researchers to gain input from groups that are typically underrepresented in quantitative data sources, such as surveillance systems. For this assessment, six focus groups were conducted with more than 45 participants across a wide range of demographic characteristics. Groups represented commonly underrepresented populations, including homeless youth, American-born Black residents, the LGBTQ+ community, individuals with disabilities, and immigrants. Among the immigrant focus groups, a total of five languages were represented (Bengali, Haitian Creole, Arabic, Amharic, and Spanish). Participants in these groups had interpreters from the Cambridge Community Engagement Team (CET) to help translate and interpret questions and responses during the focus group.

ANALYSIS AND INTEGRATION OF DATA

Health Resources in Action (HRiA), a nonprofit public health organization, provided strategic guidance and valuable contributions to this project through the facilitation of focus groups, administration of the community health survey, analysis and synthesis of data, and summary of the findings shared in this report.

DATA LIMITATIONS

As with all research efforts, there are limitations related to the assessment's research methods that should be acknowledged. Generally speaking, data based on self-reports should be interpreted with particular caution. In some instances, respondents may overreport, underreport, or experience recall errors in reporting behaviors and illnesses based on fear of social stigma, misunderstanding the question(s) asked, or inaccurate memory.

While all secondary data sources are considered highly credible, each source may use different methods, assumptions, or time periods and may not be directly comparable to one another. Additionally, substantial data for underserved populations (e.g., people with disabilities, LGBTQ+ persons, etc.) are lacking. Therefore, available data may underrepresent certain vulnerable populations. For the community survey, a convenience sample rather than a random sample was used, meaning those who were readily available and willing to participate are included. Therefore, the sample may not be representative of the larger population or specific sub-populations of Cambridge residents. Though the survey was offered in nine languages and efforts were made to distribute the survey through community-based organizations that serve diverse populations, the survey sample tended to skew toward the higher educated, which is consistent with most online surveys. Finally, while the focus groups conducted for this assessment provided valuable perspective, the results are not statistically representative of a larger population due to the non-random recruiting techniques and a small sample size.

FINDINGS

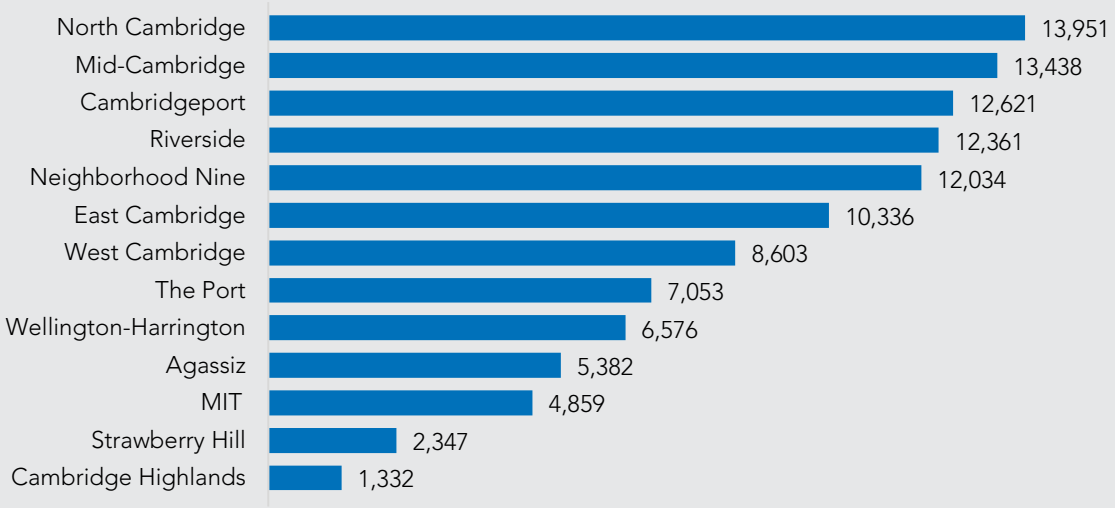
DEMOGRAPHIC CHARACTERISTICS

This section details the demographic characteristics of the Cambridge population, including population size, gender, age, racial/ethnic identity, language, and region of birth.

Population Size

The Cambridge community is comprised of 6.4 square miles of land, which includes 13 neighborhoods. According to the 2013-2017 American Community Survey, the total population of Cambridge is estimated to be over 110,000 people. The population size varies across Cambridge neighborhoods, from a low of 1,332 in Cambridge Highlands to a high of 13,951 in North Cambridge (**FIGURE 2**).

FIGURE 2: Population Count, by Neighborhood, Cambridge, 2017

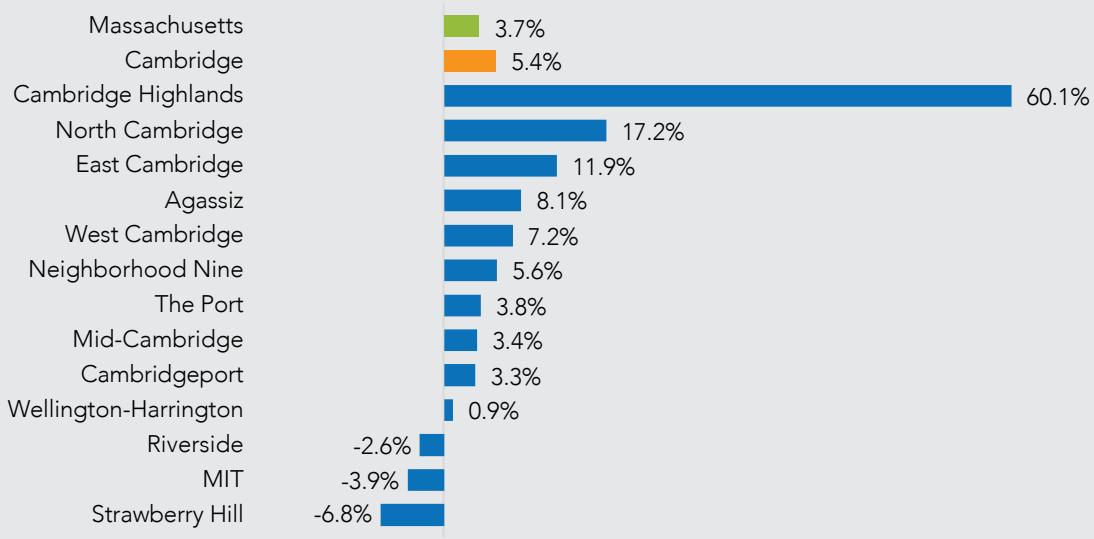


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017.

When focus group participants were asked about their view of the strengths of the Cambridge community, they identified numerous strengths, including the size and abundance of neighborhoods. One participant said that Cambridge is a *"good size"* and *"walkable,"* making it *"easier to get to know your neighbors."* Another participant said: *"I love that it has neighborhoods. It's all Cambridge, but it feels like different neighborhoods. Each has its own character. Different architecturally too, and [the Department of Public Works] has done a good job in how they approach different architecture to keep the feel."*

Cambridge experienced a population growth of 5.4% from 2010 to 2017 when compared to the 2010 population estimate of 105,162. The largest percent increases occurred in Cambridge Highlands (60.1%) and North Cambridge (17.2%). The percentage growth in Cambridge Highlands should be interpreted with caution as the population is considerably smaller than all other Cambridge neighborhoods. Decreases in population size occurred in Strawberry Hill (-6.8%), Area 2/MIT (-3.9%), and Riverside (-2.6%). Percent changes for all Cambridge neighborhoods are shown in **FIGURE 3**.

FIGURE 3: Percent Change in Total Population, Cambridge and Massachusetts, 2010 vs. 2017

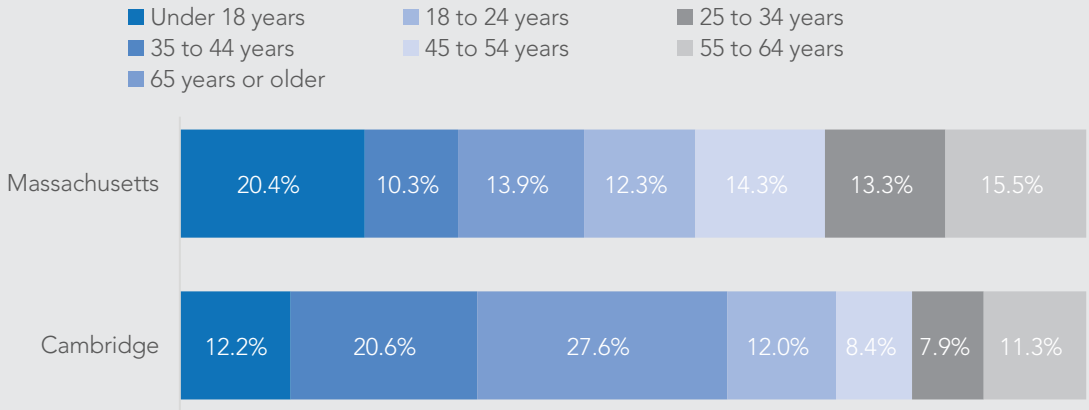


DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 2010; U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017.

Age

FIGURE 4 shows the age distribution in Cambridge as compared to Massachusetts in 2017. In Cambridge, 60.4% of the population was under age 35, with the bulk of those individuals being between the ages of 18 and 34 (48.2%). Overall, Cambridge had a considerably smaller percentage of persons under age 18 when compared to Massachusetts (12.2% vs. 20.4%, respectively).

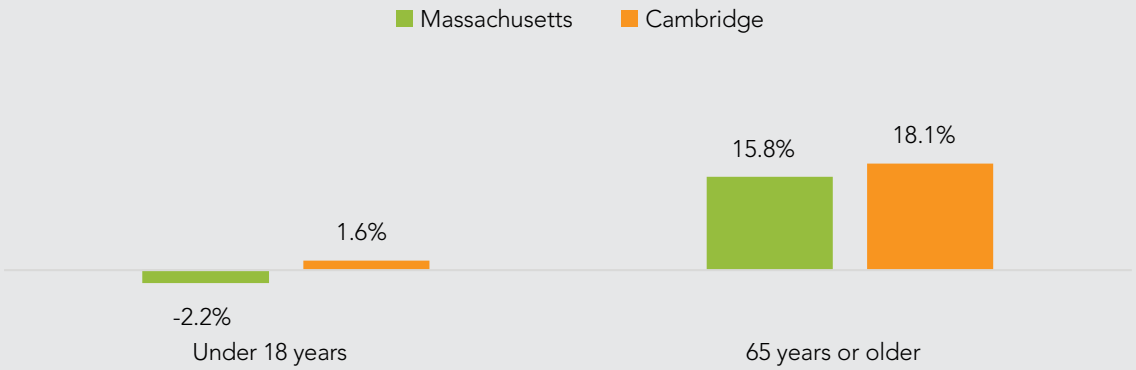
FIGURE 4: Population Age Distribution, Cambridge and Massachusetts, 2017



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017.

In 2017, Cambridge had a smaller proportion of residents aged 18 years and under compared to the state (12.2% vs. 20.4%, respectively). Between 2011 and 2017, the estimated population size among residents under 18 years remained stable (from 13,351 to 13,564). Similarly, in 2017 Cambridge had a slightly smaller proportion of residents aged 65 years and older relative to the state (11.3% vs. 15.5%, respectively). However, when examined by population size, Cambridge experienced an 18.1% increase in the number of older individuals between 2011 and 2017 (from 10,591 to 12,513) (**FIGURE 5**).

FIGURE 5: Percent Change in Population Under 18 Years and 65 Years and Older, Cambridge and Massachusetts, 2011 & 2017



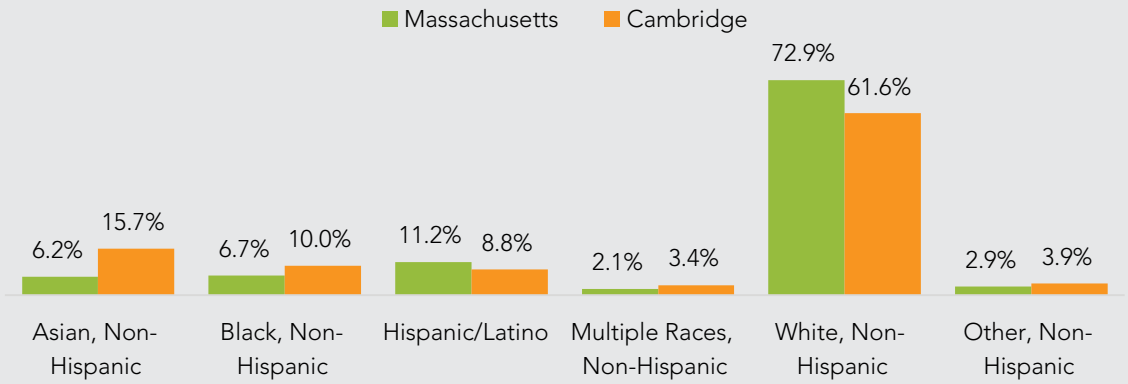
DATA SOURCE: U.S. Census Bureau, American Community Survey 3-Year Estimates, 2009-2011; U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017.

When discussing age in the focus groups, participants mentioned the challenges and implications of having an aging population. One focus group participant with disabilities noted they feel there is, *"rampant ageism in a number of agencies. Many assume you are fragile in other ways just because you are fragile in one way."*

Racial/Ethnic Diversity

Similar to Massachusetts, Cambridge has a majority White, non-Hispanic population (72.9% and 61.6%, respectively), though Cambridge is more diverse, with roughly 40% of the population identifying as non-White (**FIGURE 6**). Throughout the community focus group discussions, participants cited diversity and/or acceptance in Cambridge as one of its strongest assets. As one participant noted, *"You can meet people from all over the world."*

FIGURE 6: Population Racial/Ethnic Distribution, Cambridge and Massachusetts, 2017

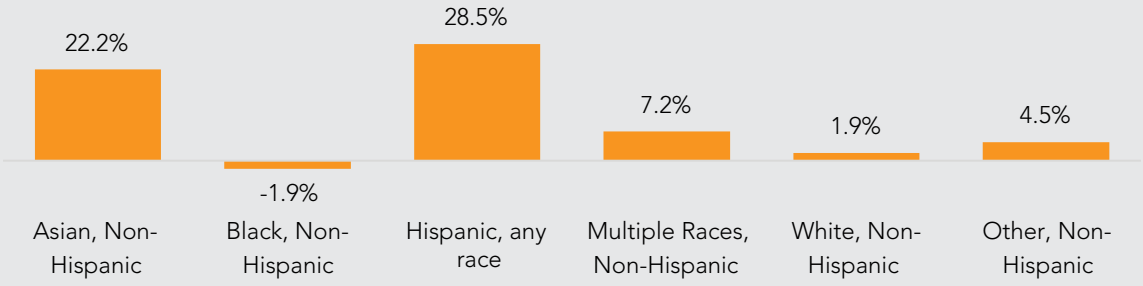


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017.

NOTE: Other includes American Indian and Alaska Native, non-Hispanic; Native Hawaiian and Other Pacific Islander, non-Hispanic; Other race, non-Hispanic; and Two or more races, non-Hispanic.

Between 2011 and 2017, Cambridge experienced an increase in its racial/ethnic diversity. Growth was particularly high among Asian, non-Hispanic residents (22.2% increase) and Hispanic residents (28.5% increase). However, the Black, non-Hispanic population decreased by 1.9% (**FIGURE 7**).

FIGURE 7: Percent Change in Population, by Racial/Ethnic Identity, Cambridge, 2011 vs. 2017



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2006-2011; U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017.

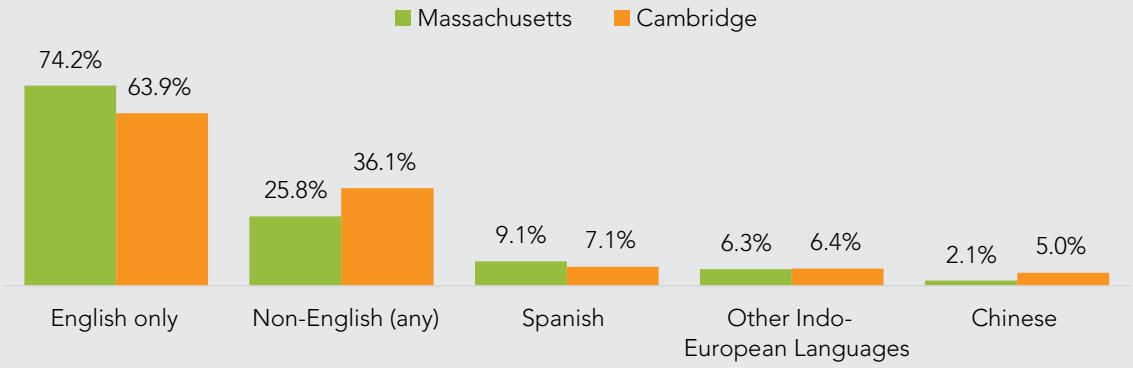
NOTE: Other includes American Indian and Alaska Native, non-Hispanic; Native Hawaiian and Other Pacific Islander, non-Hispanic; Other race, non-Hispanic; and Two or more races.

This finding echoed some of the sentiments expressed by focus group participants who discussed a perceived decrease in the number of Black residents living in the area. When noting that many families have been in Cambridge for several generations, one focus group participant said this is changing: *"You don't know everyone like you used to. Cambridge is diverse but not among the American-born Blacks. So what used to be appealing and attractive, knowing and looking out for people, you just don't [see] as much."*

Language Spoken and Foreign-Born Population

In 2017, the percentage of individuals who speak only English at home in Massachusetts and Cambridge was 74.2% and 63.9%, respectively. In Cambridge, more than one in three (36.1%) residents speak a language other than English at home. The largest proportion of these individuals spoke Spanish, followed by other Indo-European languages and Chinese. (**FIGURE 8**).

FIGURE 8: Language Spoken in Household, Cambridge and Massachusetts, 2017



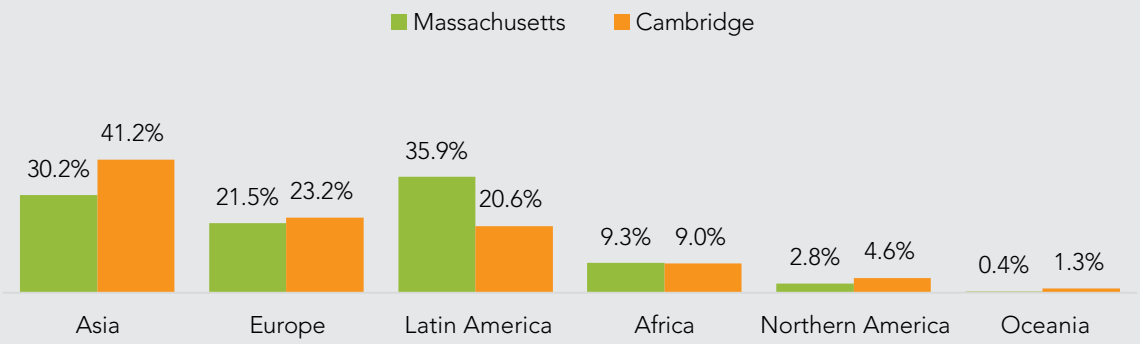
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017.

NOTE: Chinese includes Mandarin and Cantonese; A list of "Other Indo-European languages" can be found on the U.S. Census Bureau website: https://www.census.gov/topics/population/language-use/about.html.

Compared to Massachusetts residents, Cambridge had a higher overall percentage of foreign-born residents (16.2% vs. 28.2%). Similar to the discussions around race/ethnicity, focus group participants also discussed diversity as it relates to the foreign-born population. In particular, participants in the focus group with immigrants noted the importance of Cambridge being a sanctuary city, *"Especially for immigrants – they feel safe here."*

FIGURE 9 illustrates that, among Cambridge residents who are foreign-born, roughly two in five were born in Asia (41.2%), fewer than one in four was born in Europe (23.2%), one in five was born in Latin America (20.6%), and fewer than one in 10 was born in Africa (9.0%), Northern America (4.6%), or Oceania (1.3%).

FIGURE 9: Region of Birth for Foreign Born Population, Cambridge and Massachusetts, 2017



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017.

NOTE: Foreign-born does not include residents born in Puerto Rico, U.S. Island areas, or born abroad to American parent(s).

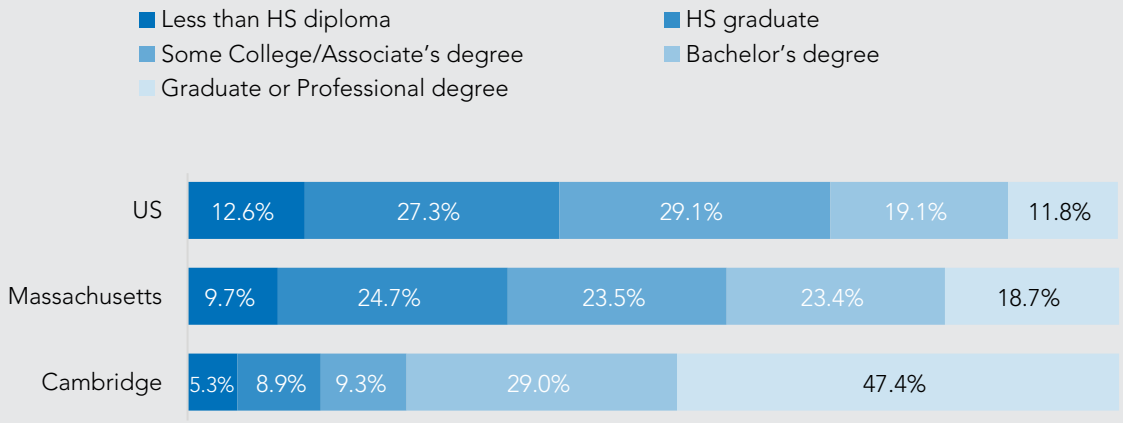
SOCIAL DETERMINANTS OF HEALTH

EDUCATION

The Cambridge public schools, city, public health department, and community partners support children's education from early childhood to college and beyond through programs such as the Birth to Grade Three Partnership and College Success Initiative. K-12 students are provided enrichment after school and during the summer through a network of out-of-school time providers, with an emphasis on science, technology, engineering, art, and math (STEAM). The Family Policy Council develops policy and program recommendations to ensure that children, teens, and their families have what they need to be successful, engaged residents who are prepared for life in our community and in the world.

Overall, Cambridge has a highly educated population (**FIGURE 10**). Compared to Massachusetts, Cambridge had a considerably larger percentage of residents with at least a bachelor's degree (42.1% vs. 76.4%, respectively) in 2017. The highest level of educational attainment for almost half of Cambridge residents was a graduate or professional degree (47.4%) while the highest level of educational attainment for roughly one in 10 (8.9%) residents was a high school diploma. The distribution of the highest level of educational attainment across Massachusetts differs, with about one in four residents holding either a high school diploma, some college/associate degree, or a bachelor's degree, while fewer than one in five (18.7%) holds a graduate or professional degree.

FIGURE 10: Educational Attainment for Population Aged 25 Years and Older, Cambridge, Massachusetts, and U.S., 2017



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017.

Education was a common topic during focus group discussions related to youth and their needs in the community. Overall, focus group participants agreed that programs and activities for youth are desired and necessary, but some pointed out that special attention should be given to transitional age youth, or individuals aged 18-26 years: *"Youth programs are great, but what about teens that have not decided they are going to college?...They are out of the youth centers, and where is there for them to go? Maybe we need more trade programs for that group."*

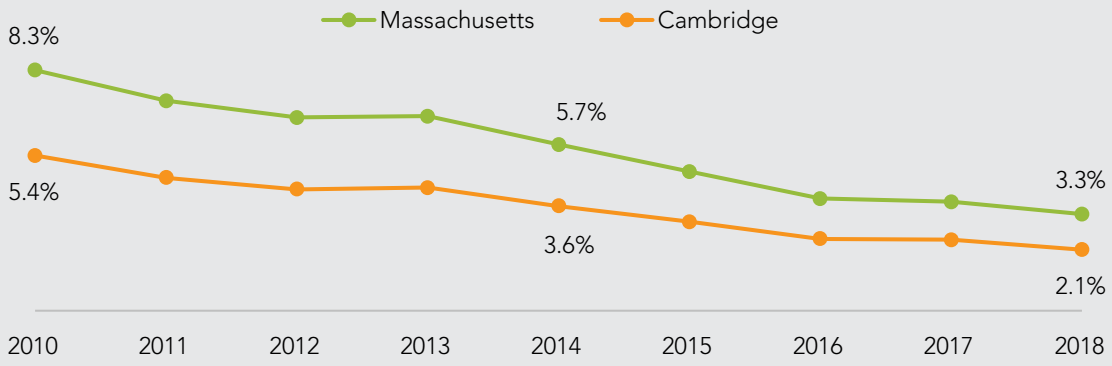
Some participants noted that programs for transitional youth exist, but the *"problem is recruiting"* and retention for these programs. One participant pointed out that another problem is that the alternatives for transitional age youth are not adequately communicated to and among youth and parents: *"High schools are providing information, but there is a lack of communication between the child and the parent. Lack of communication with parents, they need to be more involved with the schools. There are lots of opportunities that are not four-year colleges…not communicat[ed] with the parents."*

EMPLOYMENT

The City of Cambridge, through the Department of Human Service Programs Office of Workforce Development (OWD), works with community partners to offer a variety of employment-related services to adults and transitional age youth. These include job-readiness programs, career counseling and job search assistance to help residents meet their immediate needs, as well as achieve their long-term employment goals. Services for youth include summer and school year employment, work-based learning opportunities, and internships. OWD and partners recently launched the Cambridge Workforce Development Consortium to strengthen collaboration among workforce development service providers in the city.

Since 2010, the rate of unemployment in Massachusetts and in Cambridge has steadily decreased, with the rate in Cambridge consistently lower than in Massachusetts. **FIGURE 11** shows that the unemployment rates in 2018 represent the lowest rates in both Massachusetts and Cambridge since the peak of the recession in 2010 (3.3% and 2.1%, respectively).

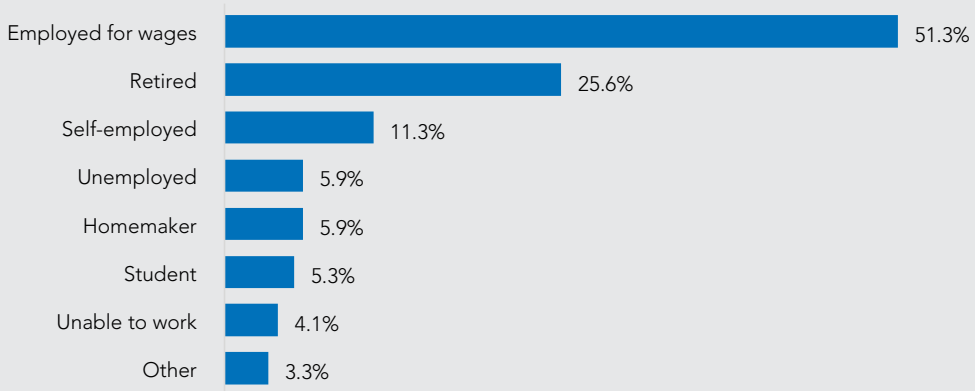
FIGURE 11: Unemployment Rate, Cambridge and Massachusetts, 2010-2018



DATA SOURCE: Bureau of Labor Statistics, Local Area Unemployment Statistics, 2010-2018.

Community survey respondents reflect a similar picture of the unemployment rate in Cambridge, with 5.9% reporting unemployment and nearly two in three respondents reporting employment to some degree (employed for wages or self-employed) (**FIGURE 12**).

FIGURE 12: Region of Birth for Foreign Born Population, Cambridge and Massachusetts, 2017



DATA SOURCE: Cambridge Community Health Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II.

The economy and employment were discussed heavily in focus groups. Participants expressed their concern for transitional age youth (described previously), as well as the impact that unemployment has on all families. One participant explained that a healthy community has *"employability for all kinds of people. If you want to work and cannot find a job, that is really the root of unhealthy living."*

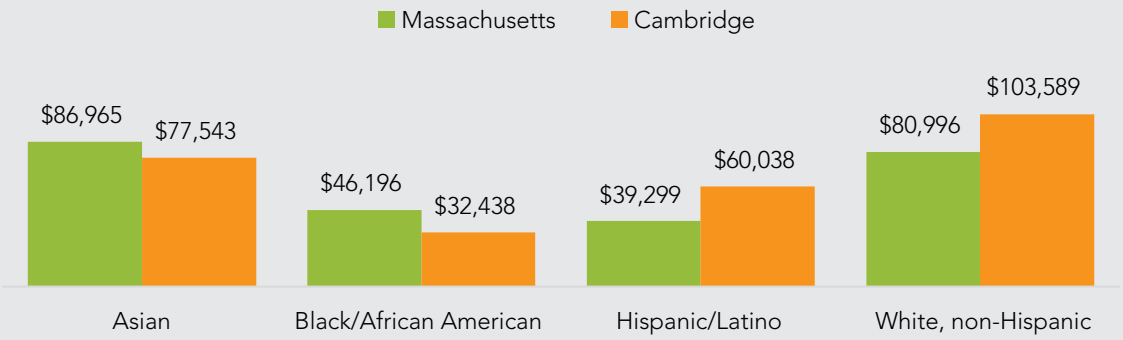
Focus group participants also described how economic opportunities impact specific groups in Cambridge. For example, participants discussed the impact of unemployment on individuals living with disabilities. One participant expressed a desire for companies to make a more deliberate effort to include individuals with disabilities in the hiring process for certain jobs, noting, *"We know that the life sciences are a major part of the Cambridge job market. I think it would be a good idea to insist that these companies set aside some jobs for people with disabilities. If you leave it up to them, it's never going to happen."* In the focus

groups with immigrants, participants described *"lack of economic opportunities"* available to them for a variety of reasons, including unaddressed trauma due to being separated from their families and, at times, limited English proficiency and lower educational attainment.

Income

In 2017, the overall median household income of Cambridge residents was $89,145, while the overall median household income of Massachusetts residents was $74,167. However, overall median incomes do not accurately reflect incomes for all racial/ethnic groups. As shown in **FIGURE 13**, in Cambridge, White, non-Hispanic residents earned the highest median income ($103,589) while Black/African American residents earned the lowest median income ($32,438). Compared to other racial/ethnic groups, Asian individuals earned median incomes that were similar in both Massachusetts and Cambridge ($86,965 vs. $77,543).

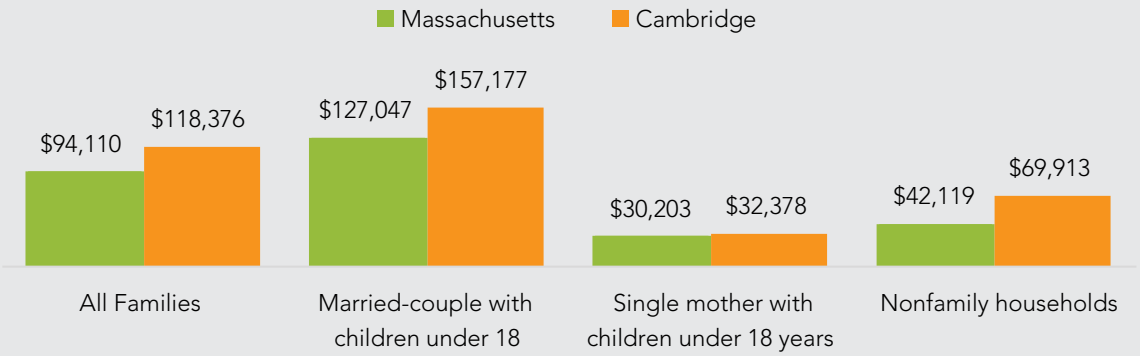
FIGURE 13: Median Household Income, by Race/Ethnicity, Cambridge and Massachusetts, 2017



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017.

FIGURE 14 details the 2017 median income of Massachusetts and Cambridge residents based on family type. Overall, Cambridge residents earned a higher median income compared to the state, regardless of family type, with married couples with children under 18 years earning the highest ($157,177) and single mothers with children under 18 years earning the lowest ($32,378). Single mothers were also the group whose earnings differed the least between Massachusetts and Cambridge ($30,203 vs. $32,378).

FIGURE 14: Median Household Income, by Family Type, Cambridge and Massachusetts, 2017

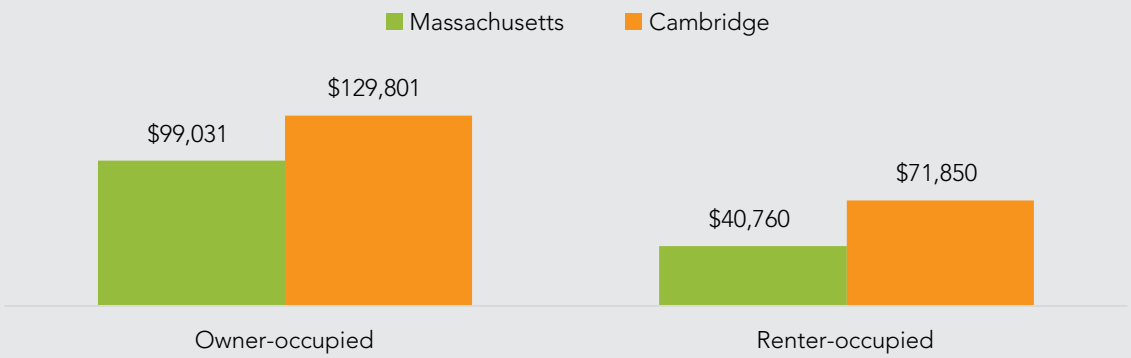


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017.

During focus group discussions, participants explicitly mentioned the *"stress"* of working to support a family. One participant described the stresses felt by single parents in particular, stating, *"When you're a working mother, it's really hard. You are a voiceless person, and the person you talk to tells you to just be happy you have a place."*

FIGURE 15 shows the 2017 median income of Cambridge residents compared to Massachusetts residents based on their owner/renter status. Overall, Cambridge residents earned a higher median income compared to the state, regardless of their household status. However, Cambridge residents in owner-occupied households earned a higher median income relative to Cambridge residents in renter-occupied households ($129,801 vs. $71,850, respectively).

FIGURE 15: Median Household Income, by Owner/Renter Status of Household, Cambridge and Massachusetts, 2017

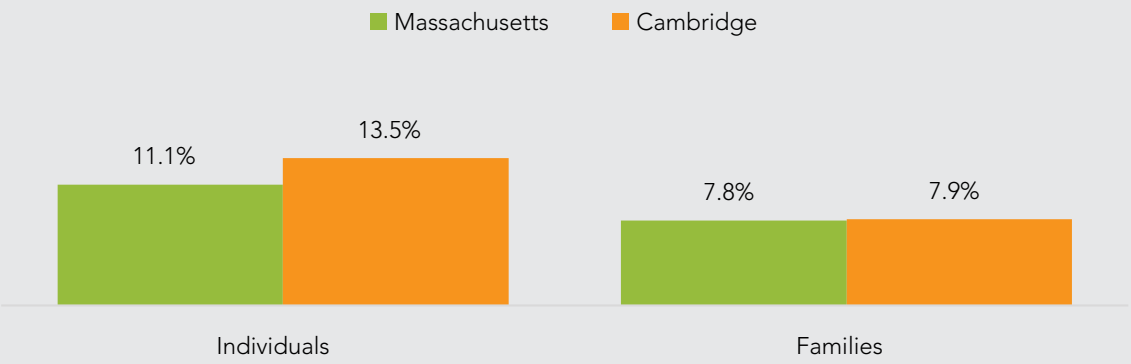


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017.

Poverty

FIGURE 16 shows the percentage of Massachusetts and Cambridge residents living below the federal poverty line in 2017. Overall, more Cambridge individuals lived below the poverty line relative to Massachusetts residents, while the percentage of Cambridge families living below the poverty line was roughly the same as in Massachusetts. In Cambridge, 13.5% of individuals and 7.9% of families lived below the poverty line, while in Massachusetts, 11.1% of individuals and 7.8% of families lived below the poverty line. It's important to note that both the number and proportion of individuals living below the poverty line may be affected by the large number of students living off-campus within the community.

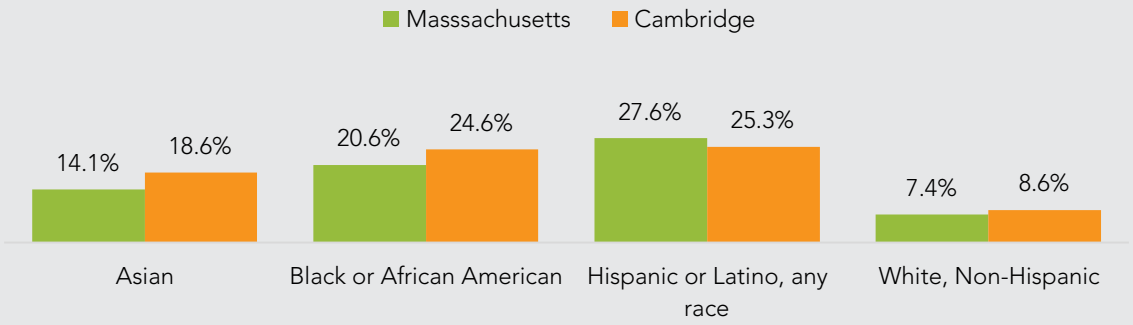
FIGURE 16: Percent of Individuals and Families Living Below the Poverty Line, Cambridge and Massachusetts, 2017



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017.

FIGURE 17 details the percent of individuals living below the poverty line in 2017 by race/ethnicity. Non-White individuals were more frequently living in poverty regardless of geography. The Hispanic population had the highest percentage of individuals living in poverty in Massachusetts and Cambridge (27.6% and 25.3%, respectively), followed by the Black/African American and Asian populations.

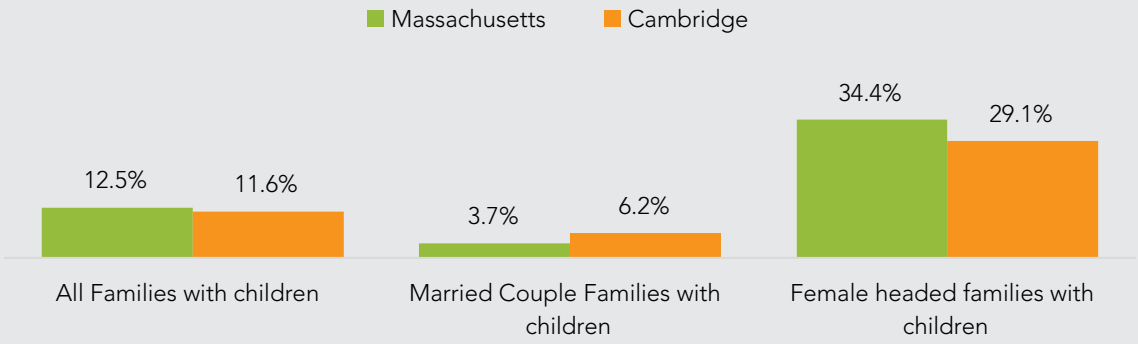
FIGURE 17: Percent of Individuals Living Below Poverty Line, by Race/Ethnicity, Cambridge and Massachusetts, 2017



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017.

When examined by family type (**FIGURE 18**), slightly more than one in 10 of all families with children lived below the poverty line in Cambridge and Massachusetts in 2017 (11.6% and 12.5%, respectively). Female-headed families with children had a much larger percentage living below the poverty line in 2017, whereas married couples with children had a much smaller percentage living below the poverty line, though the percentage was higher in Cambridge compared to Massachusetts (6.2% and 3.7%, respectively).

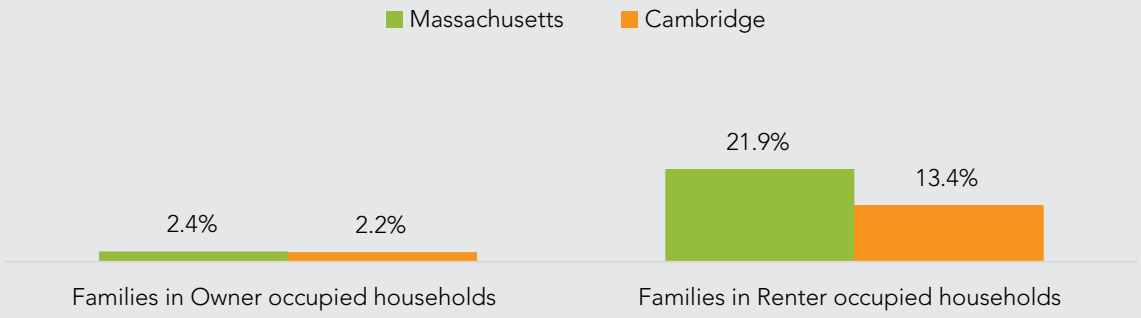
FIGURE 18: Percent of Residents Living Below Poverty Line, by Family Type, Cambridge and Massachusetts, 2017



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017.

In 2017, a substantially higher percentage of families in renter-occupied households lived below the poverty line in both Massachusetts and Cambridge (21.9% and 13.4%, respectively). Far fewer families in owner-occupied households were living below the poverty line in Massachusetts and Cambridge during that same time period (2.4% and 2.2%, respectively) (**FIGURE 19**).

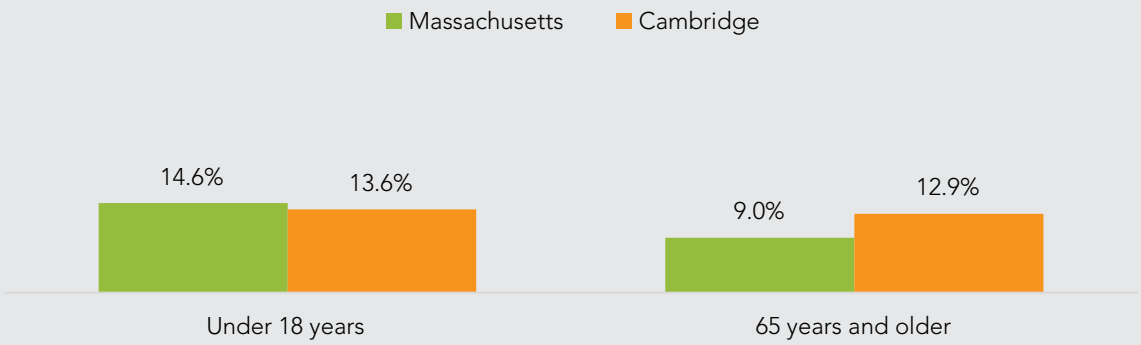
FIGURE 19: Percent of Families Living Below Poverty Line, by Owner/Renter Status, Cambridge and Massachusetts, 2017



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017.

FIGURE 20 shows the percentage of individuals under 18 years and 65 years and older who lived below the poverty line in 2017. In Cambridge and Massachusetts, the percentage of individuals under 18 years living below the poverty line was similar (13.6% vs. 14.6%), while there were more individuals 65 years and older living below the poverty line in Cambridge relative to Massachusetts (12.9% vs.9.0%).

FIGURE 20: Percent of Residents Living Below Poverty Line, by Age Group, Cambridge and Massachusetts, 2017



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017.

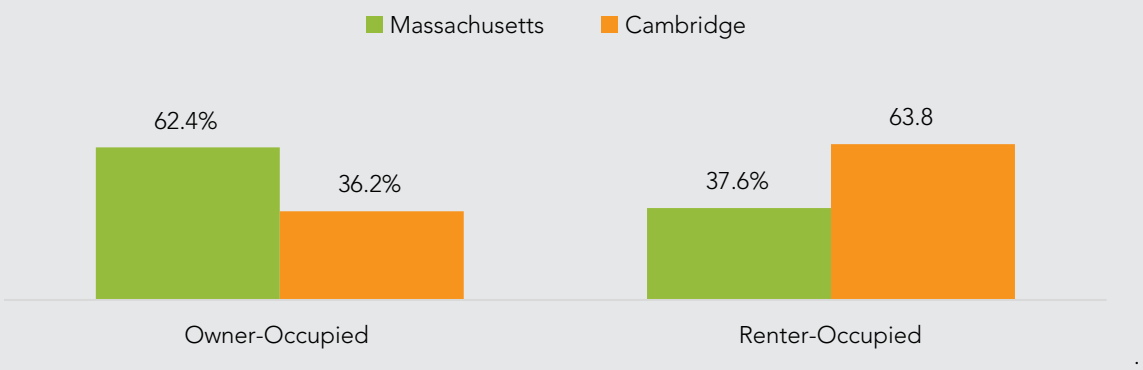
Similar to discussions about economic opportunity and income, focus group participants frequently mentioned the difficulties faced by Cambridge residents to financially support themselves and their families. Specific to poverty, one participant noted, *"I feel like there are huge income disparities here. There are some folks doing really well and many who are really poor. Poverty is very endemic among people with disabilities. I don't know how some folks are able to live here. I would love to live here, but I see this interesting combination of really nice housing and homeless folks nearby."* Another participant noted that a lack of resources, such as *"generational wealth,"* and ownership can also make it hard to support and maintain a family.

HOUSING AND HOUSING COSTS

Since the end of rent control in the 1990s, Cambridge has made substantial investments in affordable housing to ensure that the city remains socioeconomically diverse. Currently, there are more than 8,100 affordable units in Cambridge (approximately 15% of the city's housing stock) provided by the Cambridge Housing Authority, private affordable housing providers, and local affordable housing developers such as Homeowner's Rehab and the Just-A-Start Corporation. The recently completed Envision Cambridge citywide planning process developed a goal of creating an additional 3,175 affordable units by 2030. It is expected that 2,175 of these units will be created by private developers through the recently expanded inclusionary zoning and that the remaining 1000 units will be created by affordable housing developers with funding from the City.

FIGURE 21 shows the 2017 percentages of households that were owner and renter occupied in Massachusetts and Cambridge. Renter-occupied households are in the majority in Cambridge compared to Massachusetts (63.8% vs. 37.6%, respectively).

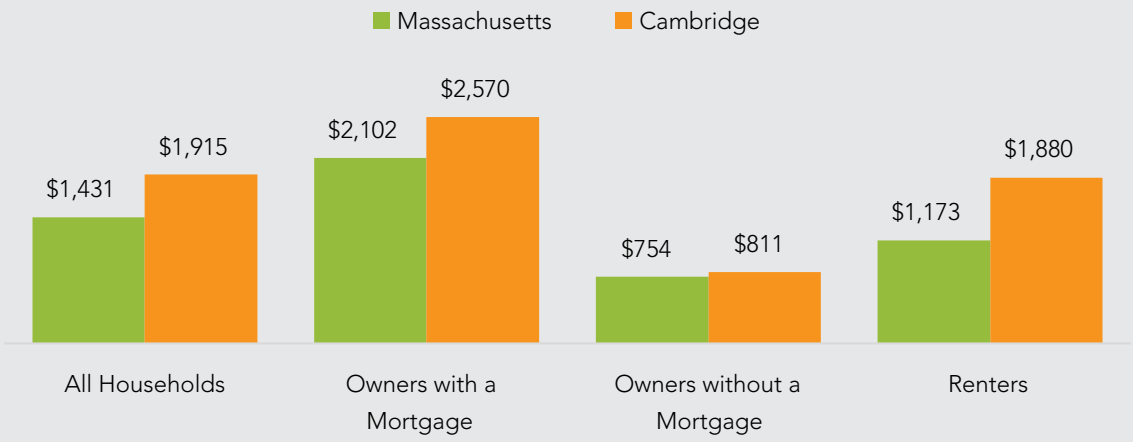
FIGURE 21: Percent of Owner- vs. Renter-Occupied Households, Cambridge and Massachusetts, 2017



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017.

FIGURE 22 details the median monthly housing costs for owners and renters in 2017. Overall, Cambridge had higher median monthly housing costs compared to Massachusetts ($1,915 vs. $1,431). When examined by owner/renter status, the biggest differences in cost existed between Massachusetts and Cambridge renters ($1,880 vs. $1,173). Cambridge owners with a mortgage experienced the highest costs overall ($2,570).

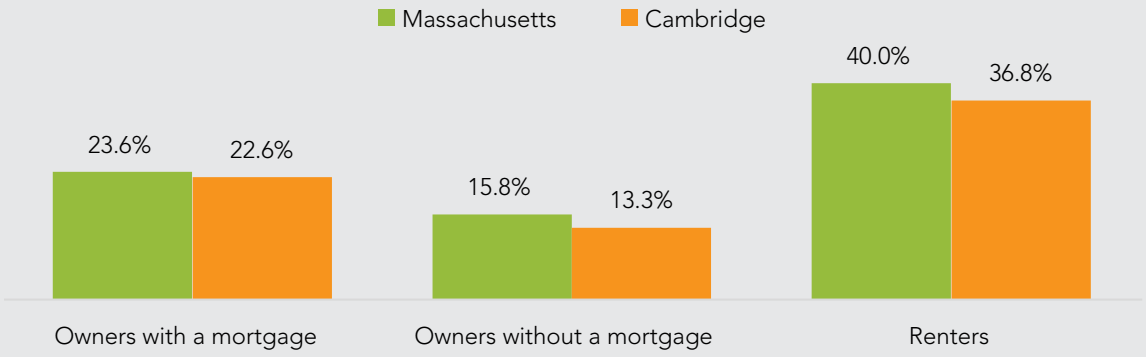
FIGURE 22: Median Monthly Housing Costs, by Owner/Renter Status, Cambridge and Massachusetts, 2017



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017.

FIGURE 23 details the percentage of households that were considered cost-burdened in 2017. Cost-burdened was defined as spending more than 35% of household income on housing using U.S. Census data estimates. Renter-occupied households in Massachusetts and Cambridge experienced the highest percentages of cost-burdened households (40% and 36.8%, respectively). Overall, Cambridge owners without a mortgage experienced the lowest percentage of cost burden (13.3%).

FIGURE 23: Percent of Cost-Burdened Households, by Owner/Renter Status, Cambridge and Massachusetts, 2017



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017.

NOTE: Cost-burdened households were defined as spending more than 35% of household income on housing.

As part of the Envision Cambridge planning process in 2017, there was extensive analysis of housing data in Cambridge. This analysis determined that "incomes required to affordably rent or purchase a home in Cambridge are higher than the maximum limits of most housing assistance programs." Data cited in the report also indicated that the income needed to affordably

rent or purchase a two-bedroom apartment was $115,280, while the Area Median Income (AMI) was $98,100.[2] In addition, the Envision Cambridge report found that "compared to households of other incomes, moderate-income households are becoming housing cost-burdened at the fastest rate in Cambridge." Furthermore, the Cambridge Housing Profile report showed that there was a total of 7,770 affordable housing units in Cambridge (defined as housing with a legal restriction limiting the occupancy or ownership to households earning at or below a specified income) in 2016, which was an increase of 224 units since 2013. However, as a proportion of total housing units, there was a decline from 15.6% in 2013 to 14.7% in 2016.[3]

Focus group participants frequently mentioned housing as an area of stress and concern either for themselves or for their fellow residents. For example, some participants pointed out the difficulties of finding housing for larger families. *"Bigger families are most affected. You can't find large apartments. I've been waiting for two years on a list for a four-bedroom…I think a lot of people are looking for bigger spaces."* Another participant expressed concern for *"elderly LGBTQ folks who may not feel safe in living situations, especially if they are lower income living in public housing…I don't know how safe they are. It would be awesome if we could have LGBTQ housing. It would also be nice if in all housing you could feel safe."* Some participants also described their concern for the indoor quality of housing, noting that in some housing developments, *"the buildings are so old and understaffed for maintenance. You don't know that they really fixed things."* Focus group participants also mentioned the high cost of housing in Cambridge. As one participant stated, *"I am very lucky to be in a rent-controlled apartment…otherwise I couldn't live here."*

Discussions about housing tended to progress into a conversation about the negative impact of housing costs, including mental health and homelessness. One participant with firsthand experience in homelessness said, *"Being on the streets is not a playground. Say nothing will be done on rent or housing cost, what is going to happen? Where will people go? It makes mental health more of an issue."* Another participant described mental health as situational. *"There is treatment for depression, but it doesn't work when the circumstance is still there. [There's] so much that could be done to solve homelessness, but it's not being done. Transitional living programs for homeless with mental health issues would be great, but no one is funding that."* Sentiments such as these also reflect the concerns shared in the 2018 Youth Voice Project. More than one in four respondents (27.4%) indicated that homelessness was a top concern.

TRANSPORTATION

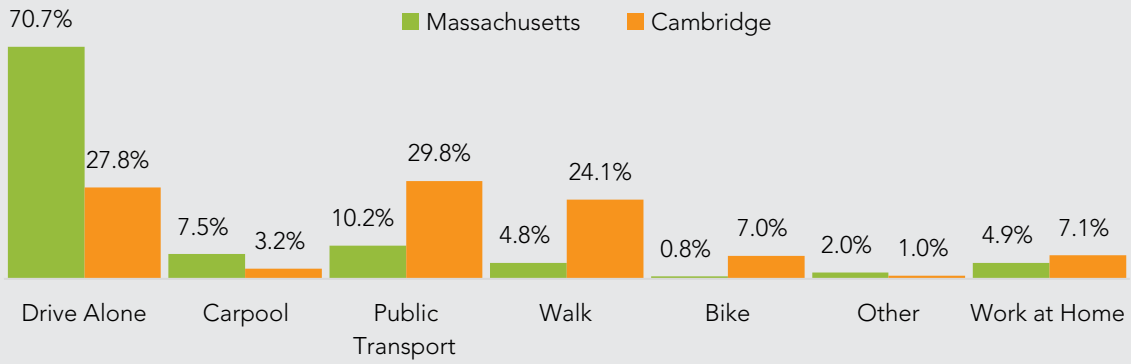
> *Cambridge has long been an innovator in active transportation, developing infrastructure and policy choices that encourage residents and visitors to travel around the city safely without driving. Cambridge has access to a range of public transportation modes, including buses, the subway, and the commuter rail. In 2016, the Cambridge City Council voted unanimously to adopt a "Complete Streets" policy, which enables safe access to streets for all users regardless of age, ability, or mode of transportation.*

FIGURE 24 details the means of transportation to work for Massachusetts and Cambridge residents in 2017. The most common form of transportation for Massachusetts residents was driving alone (70.7%); however, less than one in three Cambridge residents drives alone to work (27.8%). Among Cambridge residents, the most common forms of transportation were public transport, driving alone, walking, and biking. Rates of walking and biking to work were considerably higher in Cambridge compared to Massachusetts (24.1% vs. 4.8%, and 7.0% vs. 0.8%, respectively).

[2]Cambridge Today: An Interim report from the Envision Cambridge planning process; Cambridge Community Development Department, 2017 http://envision.cambridgema.gov/wp-content/uploads/2017/09/2017-09-20-Cambridge-Today-Pages-For-Web.pdf

[3]Cambridge Housing Profile 2016; Cambridge Community Development Department

FIGURE 24: Means of Transportation to Work, Cambridge and Massachusetts, 2017

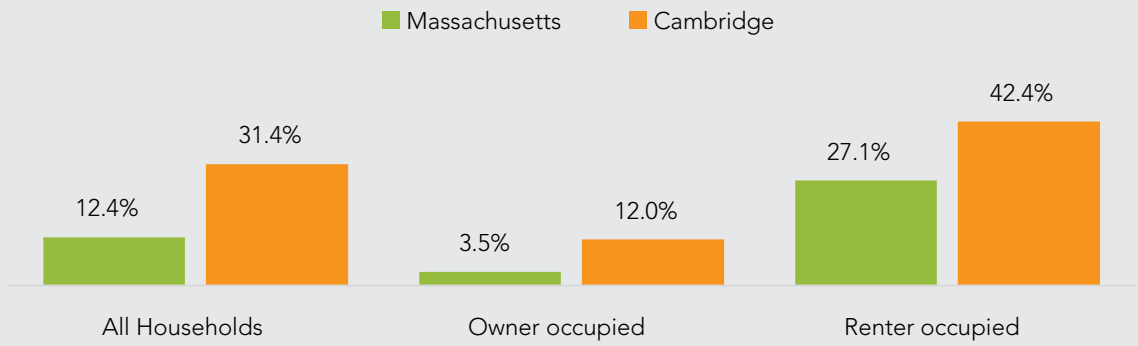


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017.

NOTE: Transportation data based on total population of workers age 16 or older.

Cambridge had a higher percentage of residents without a vehicle, regardless of household type, compared to Massachusetts in 2017 (**FIGURE 25**). The percentage was notably higher among Cambridge residents in renter-occupied housing compared to Cambridge residents in owner-occupied units (42.4% vs. 12%, respectively). This suggests that renter-occupied households are more reliant on sidewalks, bicycles, and public transportation.

FIGURE 25: Percent of Households Without Access to a Vehicle, by Household Type, Cambridge and Massachusetts, 2013-2017



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017.

Focus group participants approved of the various means of transportation in Cambridge, specifically the public transit system (trains and buses). However, many participants who live with a disability expressed dismay with rideshare applications that have become prevalent in many communities. As one participant stated, there are *"no options for people with disabilities,"* and there is a need for vehicles that sit lower and allow for more space for equipment such as walkers or wheelchairs. One focus group participant reflected that rideshare options, such as Uber, have been helpful. However, they do not provide *"options for people with disabilities, low vision, need for lower vehicle, size of vehicle. I would love to see Uber trained on how to better respond to the disabled community."*

FOOD ACCESS

Cambridge is committed to addressing food insecurity through a range of programs, including an emergency food network, food pantries, meal programs, free school markets, and a school-based weekend backpack program. In 2019, the city supported $31,000 in Supplemental Nutrition Assistance Program (SNAP) matching funds at local farmers markets, which provided participants with $62,000 worth of farm fresh food. As of January 2019, the city provides universal free school breakfast to all students. The Cambridge Summer Food Program, which offers free lunches when school is out, successfully piloted dinner meal sites in 2019 and has plans to expand them in 2020.

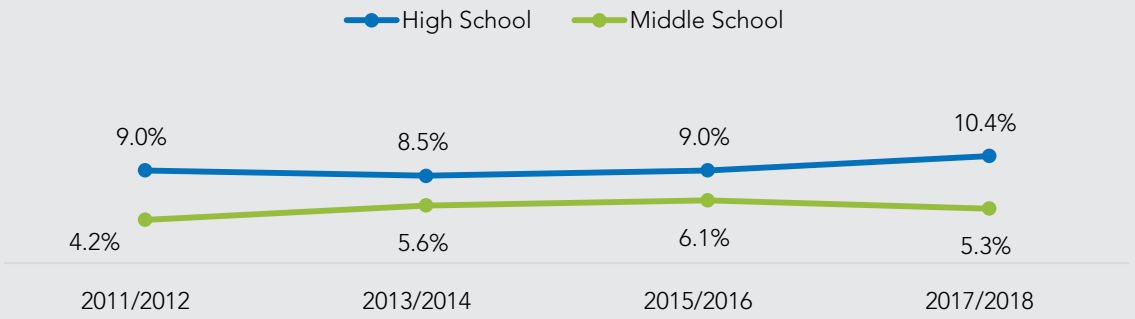
Compared to Massachusetts, Cambridge had a lower percentage of households receiving benefits through SNAP from 2013 to 2017 (**FIGURE 26**). To be eligible for SNAP in Massachusetts, beneficiaries must be a low-income citizen of the United States or a legal noncitizen.[4] While these restrictions are broad, there may be adults or families who are eligible for SNAP but do not receive the assistance, for example, because of their immigration status.

FIGURE 26: Percent of Households Receiving Snap Benefits, Cambridge and Massachusetts, 2013-2017

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017.

Between 2012 and 2018, the percentage of middle and high school students reporting hunger in the past year remained steady at approximately 15% of students overall (**FIGURE 27**). In 2018, roughly one in 10 (10.4%) Cambridge high school students and one in 20 (5.3%) Cambridge middle school students reported experiencing hunger due to lack of money to buy food.

FIGURE 27: Percent of High School and Middle School Students Reporting Hunger in Past 12 Months Because of Lack of Money to Buy Food, Cambridge, 2011-2018

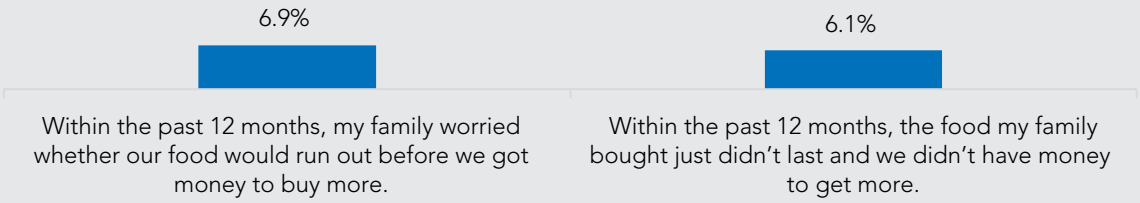


DATA SOURCE: Cambridge Middle School Health Survey, 2016-2017; Cambridge Teen Health Survey, 2017-2018.

[4]For more information see Massachusetts SNAP benefits (formerly food stamps): https://www.mass.gov/snap-benefits-formerly-food-stamps

Most respondents did not report experiencing issues related to food access in the past 12 months (93.1% and 93.9%, respectively). **FIGURE 28** shows the percentage of community health survey respondents with food access challenges in the past 12 months. Roughly 7% of respondents reported worrying about making food last, while roughly 6% reported worrying about affording food after running out.

FIGURE 28: Survey Respondents Reporting Issues With Food Access, Cambridge, 2019

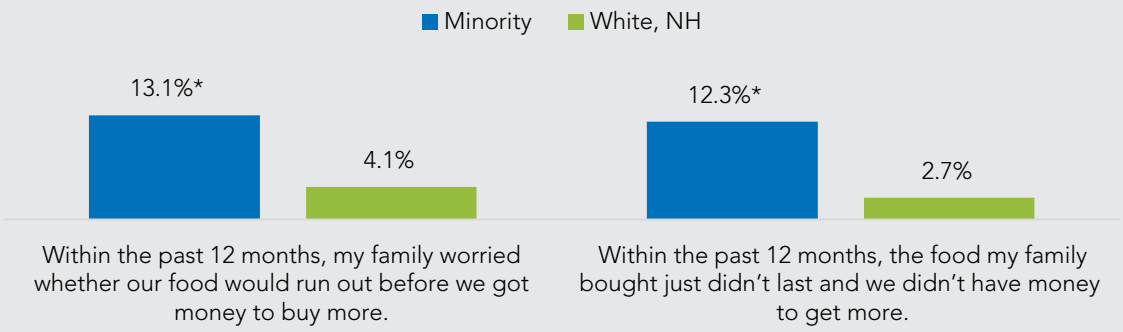


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II.

When concerns related to food access are stratified by minority status, survey respondents who identified as a racial/ethnic minority were more likely to report food access challenges and concerns compared to respondents who identify as White, non-Hispanic (**FIGURE 29**). More than one in 10 respondents who identified as a racial/ethnic minority worried about making food last before getting money to purchase more compared to less than one in 20 respondents who identified as White, non-Hispanic (13.1% vs. 4.1%, respectively). Similarly, more than one in 10 respondents who identified as a racial/ethnic minority worried about being able to afford food when they run out compared to less than one in 30 respondents who identified as White, non-Hispanic (12.3% vs. 2.7%, respectively).

FIGURE 29: Survey Respondents Who Reported Food Access Issues in Past 12 Months, Cambridge, 2019



DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II; "White, NH" represents persons who identified as White and non-Hispanic, while "Minority" represents persons who identified as any non-White category, and/or Hispanic; Asterisk (*) indicates a statistically significant difference P<0.01.

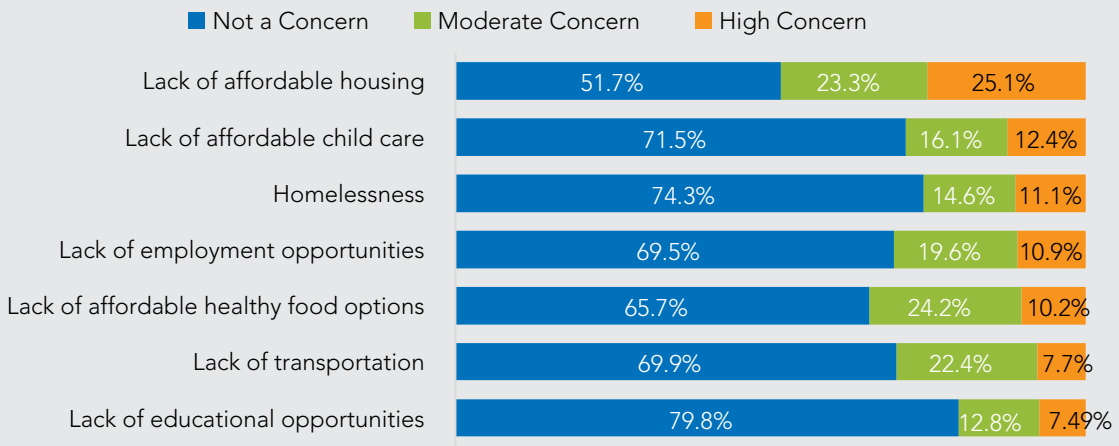
In describing what makes a healthy community, focus group participants consistently cited access to healthy and affordable food. One participant said they felt there are *"sections of Cambridge where there isn't fresh produce nearby. That is a big one I would love to see."* Participants also discussed food access in relation to employment and economic issues. Specifically, participants noted that a lack of economic opportunities directly impact a family's ability to access healthy food. One participant noted that food access is also about location, stating that an important part of food access involves, *"being able to afford healthy foods, not having to travel too far to get it – to a grocery store that is not so many miles away you have to take buses and trains to get to because it's more affordable."* Another participant said, *"Several food stores have online shopping options. But you do need money enough to do that."*

SOCIAL JUSTICE AND EQUITY

Long at the forefront of social justice and equity, Cambridge has many programs, interventions, and supports in place, including the implementation of workforce anti-bias and sexual orientation and gender identity training to build and support a municipal workforce that reflects the diversity and inclusive spirit of Cambridge. The City's commitment led to the creation of the Department of Equity and Inclusion and various training and equity and inclusion initiatives. City departments have also implemented initiatives to address equity. Cambridge Public Schools conducted an equity assessment, which led to an improved response system for student reports of racist and other inappropriate behavior by adult staff members; the creation of an office dedicated to promoting racial equity; and a review of the curriculum for cultural responsiveness, historical accuracy, and representation. The Cambridge Police Department recently formed a Family and Social Justice Section, which provides services to members of the community who would be better served through a social justice approach than through a conventional criminal justice lens. And CPD's Procedural Justice Office, believed to be the first of its kind in the country, will proactively monitor data related to police-citizen interactions for signs of possible racial profiling, racially biased policing, or use-of-force incidents.

FIGURE 30 shows the range of social concerns of survey respondents. Generally, most survey respondents did not display a high degree of concern for most of the social issues included in the survey. The largest percentage of respondents felt a high concern for the lack of affordable housing (25.1%) and the lack of affordable childcare (12.4%).

FIGURE 30: Survey Respondent Level of Concern for Social Factors, Cambridge, 2019

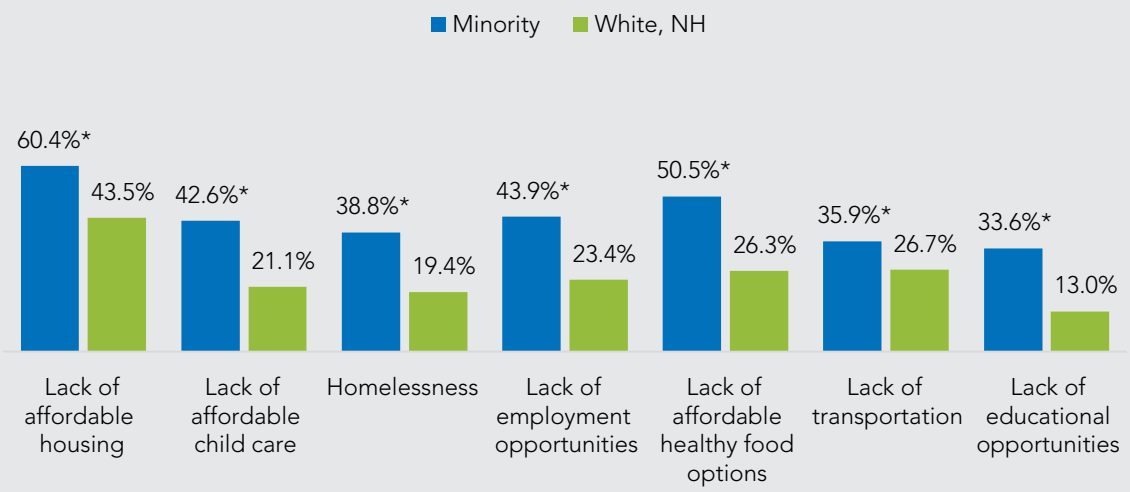


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II; Percentages <5% are not labeled within the bar chart.

FIGURE 31 shows minority and White, non-Hispanic survey respondents' moderate or high social concerns. Racial/ethnic minority respondents found all social factors to be significantly more of a moderate or high concern when compared to White, non-Hispanic respondents. More than half of minority respondents found a lack of affordable housing and a lack of affordable healthy food options to be a particularly moderate or high concern (60.4% and 50.5%, respectively). Focus group participants named multiple social justice and equity-related issues that were concerning for themselves or others. Specific to education, one participant said, *"We have some of the best education here in the city, but so many can't access it. I worry about some of the people."*

FIGURE 31: Survey Respondents Reporting Moderate or High Concern for Social Factors, by Minority Status, Cambridge, 2019

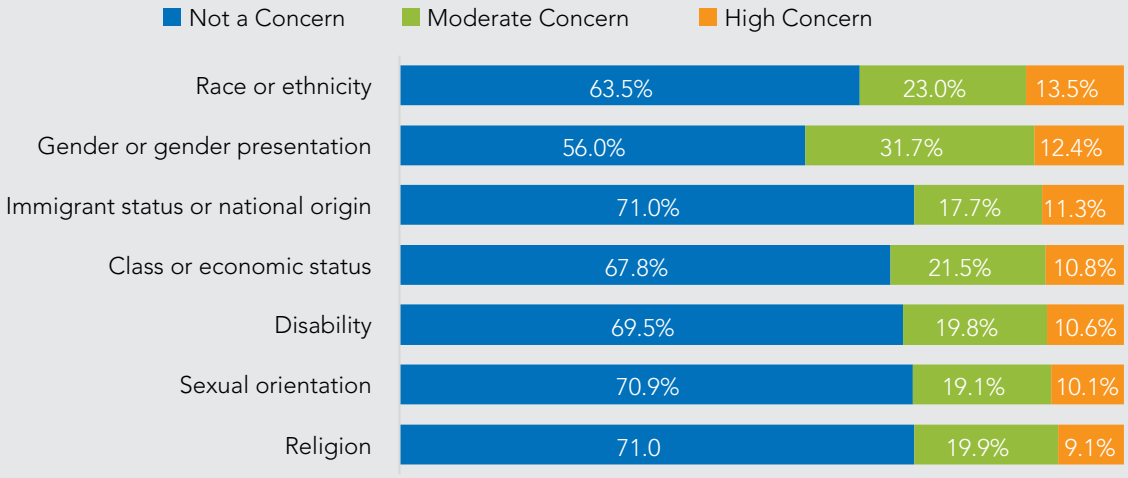


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II; "White, NH" represents persons who identified as White and non-Hispanic, while "Minority" represents persons who identified as any non-White category, and/or Hispanic; Asterisk (*) indicates a statistically significant difference P<0.01.

FIGURE 32 shows survey respondents' level of concern for discrimination and harassment. Generally, most survey respondents did not have concern for the discrimination/harassment issues included in the survey, though a larger proportion of respondents felt concern for discrimination based on race/ethnicity (13.5%) and discrimination based on gender or gender presentation (12.4%).

FIGURE 32: Survey Respondent Level of Concern for Discrimination and Harassment, Cambridge, 2019

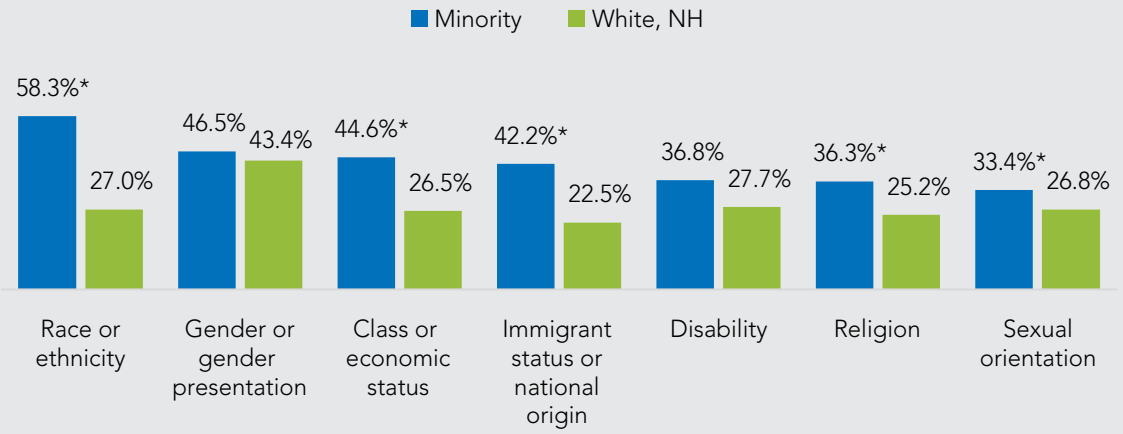


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II.

FIGURE 33 shows minority and White, non-Hispanic survey respondents moderate or high concern for discrimination and harassment. Minority respondents found all seven harassment/discrimination issues to be a higher level of concern compared to White, non-Hispanic respondents. More than half of minority respondents found discrimination or harassment based on race/ethnicity to be a moderate or high concern (58.3%).

FIGURE 33: Survey Respondents Reporting Moderate or High Concern for Discrimination and Harassment, by Minority Status, Cambridge, 2019

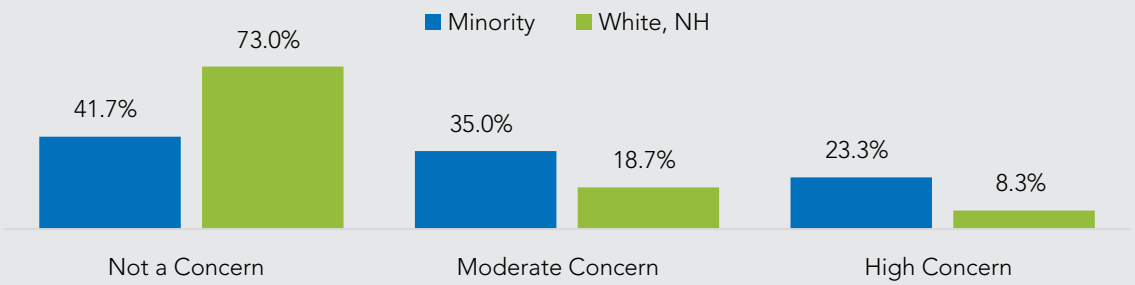


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II; "White, NH" represents persons who identified as White and non-Hispanic, while "Minority" represents persons who identified as any non-White category, and/or Hispanic; Asterisk (*) indicates a statistically significant difference P<0.01.

When stratified by minority status, the percentage of respondents who feel concern for discrimination or harassment based on race/ethnicity becomes more apparent. More than one in three (35.0%) minority respondents rated their personal concern for discrimination or harassment as moderate compared to less than one in five (18.7%) White, non-Hispanic respondents. Similarly, nearly one in four (23.3%) minority respondents rated their personal concern for discrimination or harassment as high compared to less than one in 10 (8.3%) White, non-Hispanic respondents (**FIGURE 34**).

FIGURE 34: Survey Respondent Level of Concern for Discrimination and Harassment Based on Race/Ethnicity, by Minority Status, Cambridge, 2019

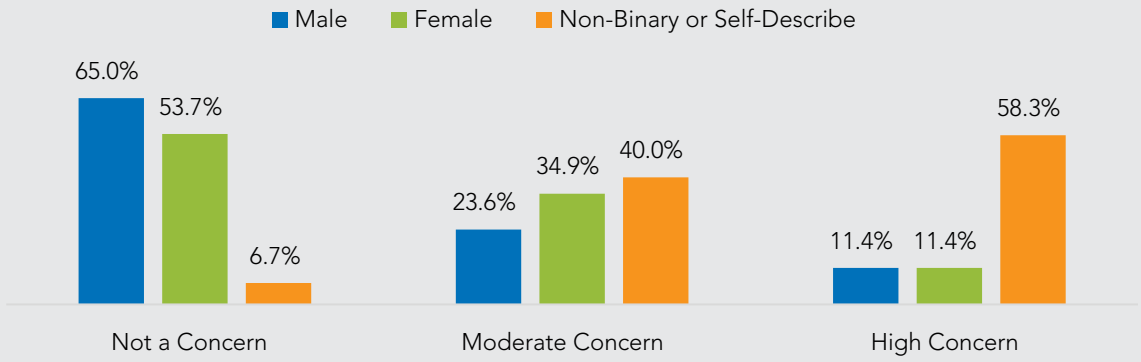


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II; "White, NH" represents persons who identified as White and non-Hispanic, while "Minority" represents persons who identified as any non-White category, and/or Hispanic.

FIGURE 35 shows the percentage of respondents who feel concern for discrimination or harassment based on gender or gender identity stratified by gender identity. About one in four (23.6%) males, one in three (34.9%) females, and two in five (40.0%) non-binary or self-describing respondents rate their level of concern as moderate. Half of respondents who identified as non-binary or self-described gender rated their personal concern for discrimination or harassment as high compared to about one in 10 respondents who identified as male or female. Data for individuals who identified as non-binary or self-describing should be interpreted with caution as the number of respondents in this category was low.

FIGURE 35: Survey Respondent Level of Concern for Discrimination and Harassment Based on Gender or Gender Identity, by Gender Identity, Cambridge, 2019

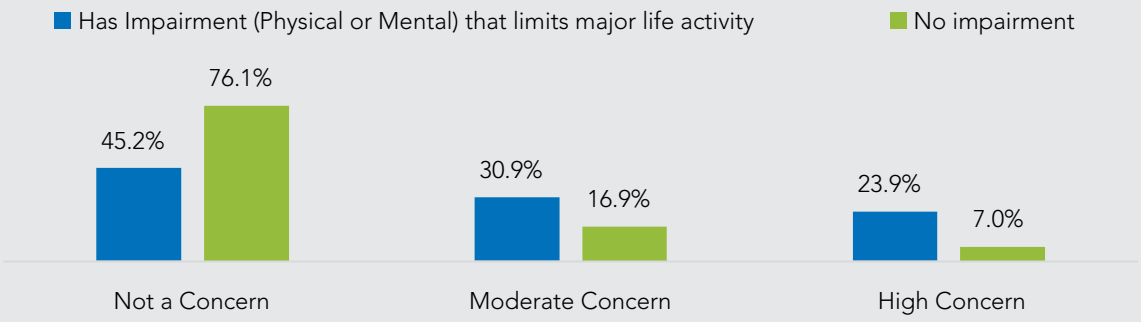


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II; sample size for those who identified as "non-binary" or chose to self-describe their gender very small (n=15) and therefore, results should be interpreted with caution.

When stratified by disability status, about one in three (30.9%) respondents who indicated having a disability rated their level of concern for discrimination or harassment as moderate compared to 16.9% of respondents who did not have an impairment. Roughly one in four (23.9%) respondents who indicated having a disability rated their level of concern for discrimination or harassment as high compared to 7.0% of respondents who did not have an impairment (**FIGURE 36**).

FIGURE 36: Survey Respondent Level of Concern for Discrimination and Harassment Based on Disability, by Disability Status, Cambridge, 2019



DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II; "Has impairment (Physical or Mental) that limits major life activity" represents persons who identified that they or a member of their family has a physical or mental impairment that substantially limits one or more major life activities.

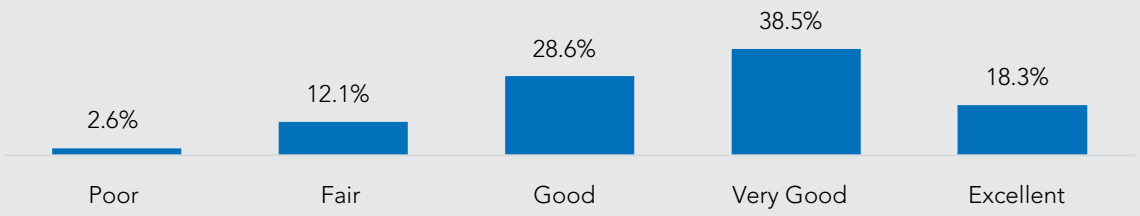
Concern for discrimination was also reflected in the 2018 Youth Voice Project, with one in four (25.1%) respondents indicating that discrimination was a significant challenge in accessing health care. During focus groups, participants noted the racism and discrimination witnessed in their schools and the lack of trust created between students and school officials when the issues are not addressed.

PHYSICAL HEALTH

Community Perceptions and Concerns

FIGURE 37 shows survey respondents' ratings of their physical health. More than half of survey respondents rated their physical and mental health as either very good or excellent.

FIGURE 37: Survey Respondents' Physical Health Self-Rating, Cambridge, 2019

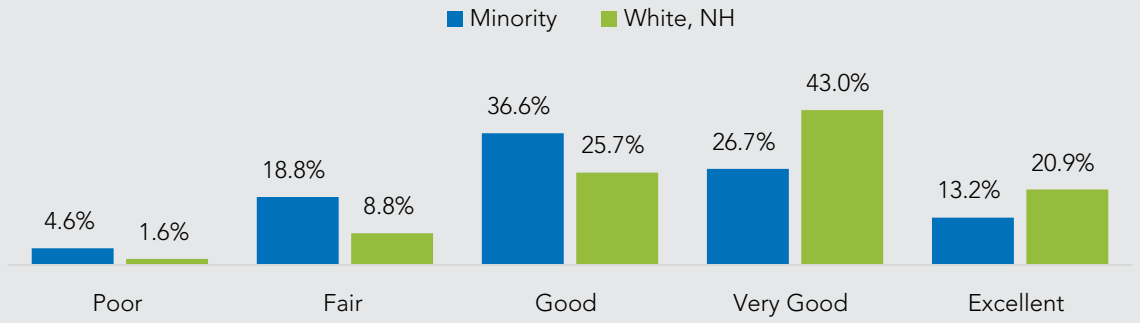


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II.

When self-ratings for physical health are stratified by minority status, respondents who identified as a racial or ethnic minority generally perceived their health to be of lesser quality when compared to White, non-Hispanic respondents. Minority respondents were less likely to report their physical health as excellent and more likely to report their health as poor (**FIGURE 38**).

FIGURE 38: Survey Respondents' Physical Health Self-Rating, by Minority Status, Cambridge, 2019

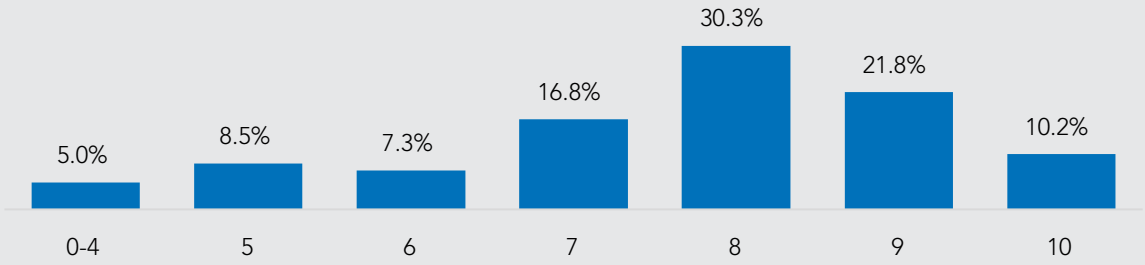


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II; "White, NH" represents persons who identified as White and non-Hispanic, while "Minority" represents persons who identified as any non-White category, and/or Hispanic.

FIGURE 39 shows how survey respondents rated their overall satisfaction with their lives on a scale of 0 (lowest) to 10 (highest). Overwhelmingly, respondents appear to be quite satisfied with their lives, with the average rating being 7.5 and more than half of respondents rating their lives at an 8 or above (62.3%). One in 10 respondents rated their lives as 10 out of 10.

FIGURE 39: Survey Respondents' Rating of Satisfaction With Life, Cambridge, 2019

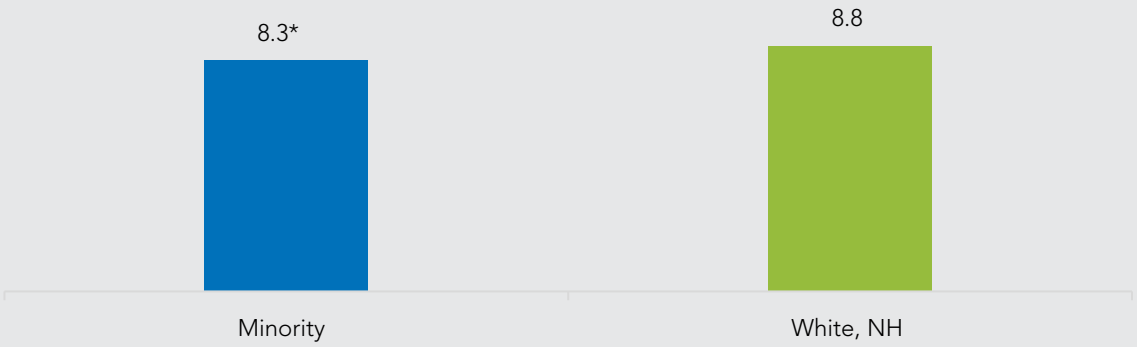


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II.

FIGURE 40 shows racial/ethnic minority and White survey respondents' average rating of life satisfaction. Generally, both minority and White, non-Hispanic respondents felt relatively high levels of satisfaction, though White, non-Hispanic respondents were more likely to rate their lives as more satisfying. While the ratings are numerically similar (8.3 vs. 8.8), minority respondents' average rating of 8.3 was statistically significantly lower than White, non-Hispanic respondents.

FIGURE 40: Survey Respondents' Average Rating of Satisfaction With Life, by Minority Status, Cambridge, 2019



DATA SOURCE: Cambridge Health Community Survey, 2019.

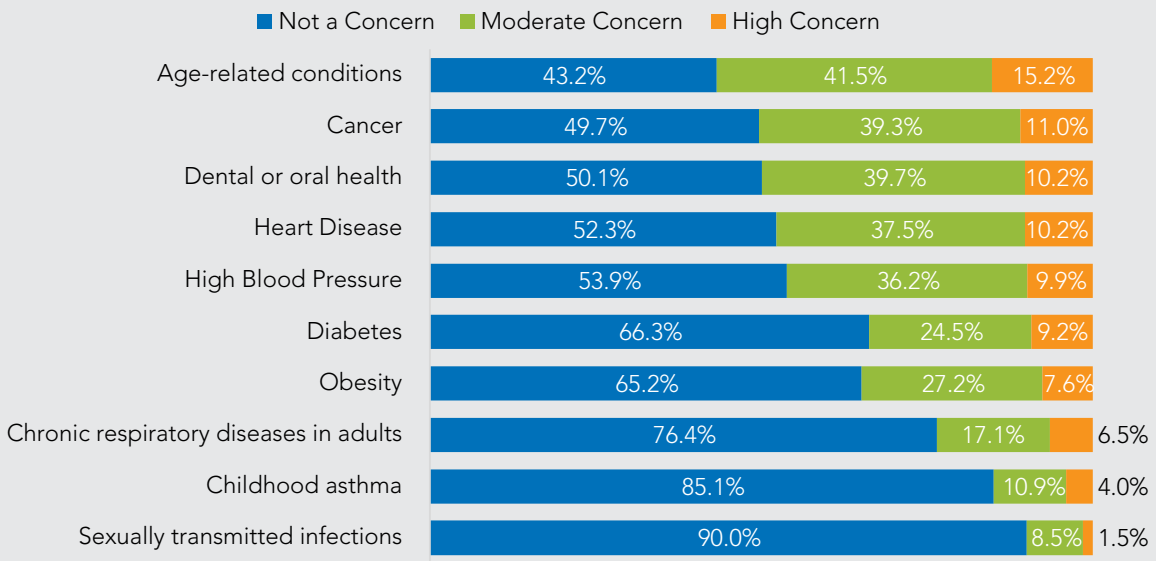
NOTE: Detailed data about the counts for each category can be found in Appendix II; "White, NH" represents persons who identified as White and non-Hispanic, while "Minority" represents persons who identified as any non-White category, and/or Hispanic; Asterisk (*) indicates a statistically significant difference P<0.01.

Overall, in focus group discussions, participants described a healthy community as more than physical health conditions and mortality. They described a healthy community as one that is safe, affordable (in terms of food, housing, health care, and social activities), and inclusive of all people. Some participants also pointed out that a healthy community is also one that is knowledgeable about health-related issues. One participant noted, *"I see being educated about health, know[ing] what to eat, what not to eat. The basic stuff that you know how your body works properly and everything. Getting checked by your doctor every few months."*

Regarding health conditions, participants primarily focused on mental health and the connection between mental health and other conditions or behaviors. The physical conditions named in some focus groups included behavioral health (e.g., smoking cigarettes and marijuana), obesity, diabetes, asthma, and cancer. Focus group participants who identified as immigrants stated that they think about safety not only in terms of physical safety but also relative to a city that is welcoming to immigrants. In both groups, participants noted that the sanctuary city status of Cambridge is very important to their perceptions of safety.

When asked to rate how much of a concern various physical health conditions were for themselves and their families, most survey respondents indicated that they had the highest level of concern for age-related conditions (15.2%), cancer (11.0%), and dental and oral health (10.2%) conditions (**FIGURE 41**).

FIGURE 41: Survey Respondents' Level of Concern for Various Physical Health Conditions, Cambridge, 2019

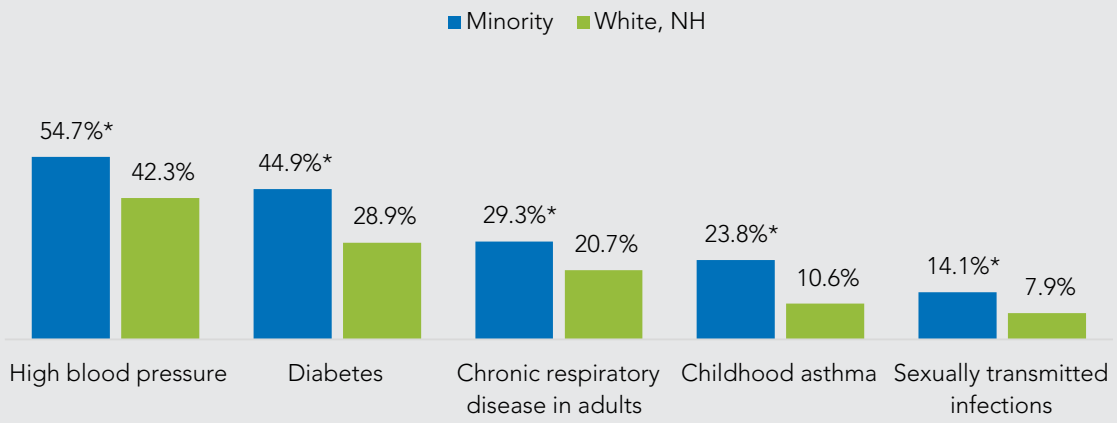


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II. Percentages <5% are not labeled within the bar chart.

When examined by minority status, a significantly larger percentage of survey respondents who identified as a racial/ethnic minority rated their personal concern as moderate or high for specific conditions compared to White, non-Hispanic respondents (**FIGURE 42**). Specific conditions included high blood pressure, diabetes, chronic respiratory disease, childhood asthma, and sexually transmitted infections.

FIGURE 42: Survey Respondents Reporting Moderate or High Concern for Various Physical Health Conditions, by Minority Status, Cambridge, 2019



DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II; "White, NH" represents persons who identified as White and non-Hispanic, while "Minority" represents persons who identified as any non-White category, and/or Hispanic; Asterisk (*) indicates a statistically significant difference P<0.01.

Overall Mortality and Leading Causes of Death

In 2015, Cambridge had a lower overall mortality rate compared to Massachusetts (591.8 per 100,000 vs. 684.6 per 100,000, respectively) (TABLE 2). Similarly, in 2016, Cambridge had a lower overall mortality rate compared to Massachusetts (554.7 per 100,000 vs. 668.9 per 100,000, respectively).

TABLE 2: Age-Adjusted Overall Mortality Rate per 100,000 Population, Cambridge and Massachusetts, 2015 and 2016

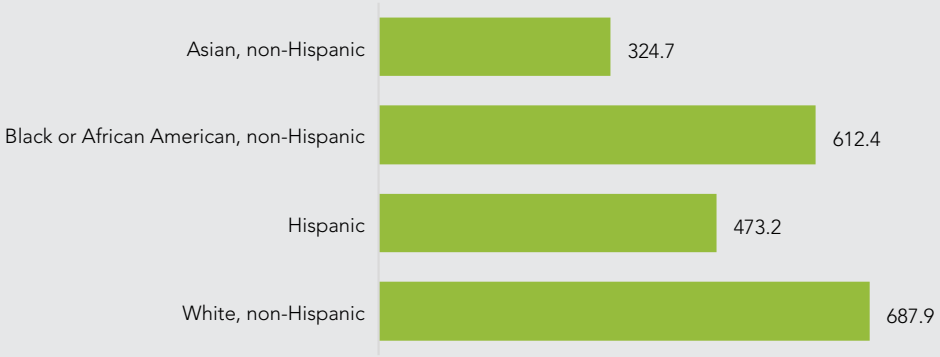
	Massachusetts		Cambridge	
	2015	2016	2015	2016
Overall	684.6	668.9	591.8	554.7

DATA SOURCE: Massachusetts Department of Public Health, Registry of Vital Records and Statistics, Massachusetts Deaths 2015, 2016.

NOTE: Rates are age-adjusted per 100,000; Data stratified by race/ethnicity not available for Cambridge.

Data were not available by race/ethnicity at the local level; however, data for Massachusetts show that White, non-Hispanic individuals experienced the highest rate of age-adjusted overall mortality per 100,000 residents (687.9), while Asian, non-Hispanic individuals experienced the lowest rate (324.7) (**FIGURE 43**).

FIGURE 43: Age-Adjusted Overall Mortality Rate per 100,000 Population, by Race/Ethnicity, Massachusetts, 2016



DATA SOURCE: Massachusetts Department of Public Health, Registry of Vital Records and Statistics, Massachusetts Deaths 2015, 2016.

NOTE: Rates are age-adjusted per 100,000; Data stratified by race/ethnicity not available for Cambridge.

In 2015, the rate of premature mortality among Cambridge residents was slightly higher than the rate in Massachusetts (282.2 per 100,000 vs. 279.6 per 100,000, respectively) (**TABLE 3**). Similarly, in 2016, the rate of premature mortality among Cambridge residents was slightly higher than the rate in Massachusetts (250.7 per 100,000 vs. 224.0 per 100,000, respectively).

TABLE 3: Age-Adjusted Premature Mortality Rate per 100,000 Population, Cambridge and Massachusetts, 2015 and 2016

	Massachusetts		Cambridge	
	2015	2016	2015	2016
Premature mortality rate	279.6	224.0	282.2	250.7

DATA SOURCE: Massachusetts Department of Public Health, Registry of Vital Records and Statistics, Massachusetts Deaths 2015, 2016.

NOTE: Rates are age-adjusted per 100,000; Premature Mortality is defined as deaths that occur before the age of 75 years.

TABLE 4 details the rates of mortality by leading cause of death in 2016. In both Massachusetts and Cambridge, the leading causes of death were cancer and heart disease. While there are some data available for Cambridge, data are not available for subpopulations. Therefore, both morbidity and mortality rates for subgroups cannot be fully described.

TABLE 4: Age-Adjusted Premature Mortality Rate per 100,000 Population, Cambridge and Massachusetts, 2015 and 2016

	Massachusetts	Cambridge
Overall	668.9	-
Cancer	**149.8**	**103.1**
Heart disease	**134.8**	**85.0**
Unintentional injuries	53.6	-

Chronic lower respiratory disease	31.5	16.3
Stroke	27.9	23.5
Alzheimer's disease	18.7	-
Diabetes	14.9	13.6
Influenza & pneumonia	14.1	-
Nephritis	13.2	-
Ill-defined conditions	10.6	-

DATA SOURCE: Massachusetts Department of Public Health, Registry of Vital Records and Statistics, Massachusetts Deaths, 2016.

NOTE: Dash mark (-) indicates that data were not available for this cause of death; Rates are age-adjusted per 100,000 for Massachusetts for 2016; however, only crude rate of deaths per 100,000 population available for Cambridge from 2015.

CANCER

Cancer was ranked as the second greatest concern among all community health survey respondents (FIGURE 42). In the 2018 Youth Voice Project, cancer was named as one of the top physical and behavioral health issues, with more than one in three respondents (36.9%) indicating it was a concern.

The 500 Cities Project data show that cancer screening rates for pap smear, mammography, and colonoscopy for Cambridge residents are slightly higher than the national average (**TABLE 5**).

TABLE 5: Self-Reported Screenings Among Adults, Cambridge and U.S., 2016

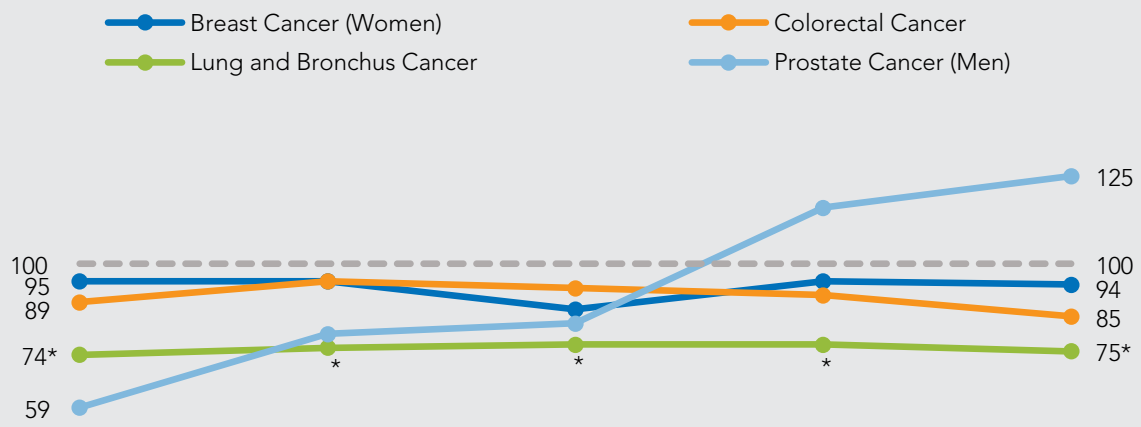
	United States	Cambridge
Pap smear (among women aged 21-65 years)	80.3%	82.1%
Mammography (among women aged 50-74 years)	77.7%	82.8%
Blood stool test or sigmoid-/colonoscopy (among adults aged 50-75 years)	64.2%	72.6%

DATA SOURCE: Centers for Disease Control and Prevention, Division of Population Health, 500 Cities Project Data, 2016.

NOTE: For percent of adults who have had a pap smear in the US, data based on states available from the 2016 BRFSS.

The most common cancers affecting Cambridge residents are breast, colorectal, lung and bronchus, and prostate. Standardized incidence ratios (SIR) allow for community-level data to be compared to state-level data. **FIGURE 44** shows the SIR for the leading types of cancer in Cambridge between 2005 and 2013. Overall, the SIR for the leading type of cancers were on par or lower than would be expected in comparison to state averages. In particular, the lung and bronchus SIR for all years shown is statistically significantly lower compared to the state. However, for prostate cancer, the SIR between 2008-2012 and 2009-2013 is higher.

FIGURE 44: Standardized Incidence Ratio (SIR) for Leading Types of Cancer, Cambridge, 2005-2009 to 2009-2013

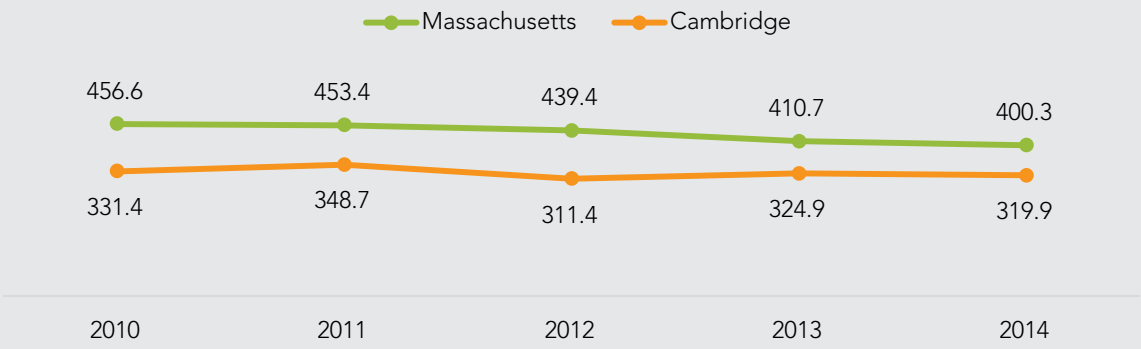


DATA SOURCE: Massachusetts Cancer Registry, 2005-2009 to 2009-2013.

NOTE: Standardized Incidence Ratio (SIR) is the ratio of the observed number of cancer diagnoses in an area to the expected number of diagnoses multiplied by 100; SIR=100 indicates incidence is equal to expected based upon statewide average, SIR>100 indicates incidence is higher than expected based upon statewide average, SIR<100 indicated incidence is lower than expected based upon statewide average; Asterisk (*) indicates SIR is statistically significantly higher or lower than expected.

Overall, Cambridge experienced a lower rate of hospitalizations due to cancer between 2010 and 2014 compared to Massachusetts (**FIGURE 45**). The rate of cancer hospitalizations in Cambridge ranged from a high of 348.7 per 100,000 in 2011 to a low of 311.4 per 100,000 in 2012, while the rate in Massachusetts ranged from a high of 456.6 per 100,000 in 2010 to a low of 400.3 per 100,000 in 2014.

FIGURE 45: Hospitalizations Due to Cancer per 100,000 Population, Cambridge and Massachusetts, 2010-2014

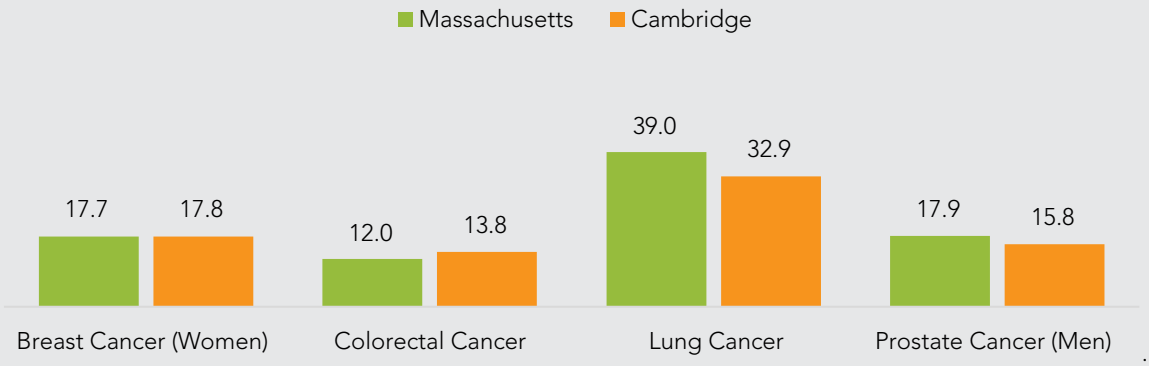


DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2010-2014.

NOTE: Rates are age-adjusted per 100,000 residents; Each chronic disease indicator is calculated by analyzing the primary diagnosis code associated with the emergency department visit or hospitalization; The following ICD-9-CM diagnosis codes were used to identify Cancer: 140-209.

FIGURE 46 shows the cancer mortality rates in Cambridge and in Massachusetts. Cambridge residents experienced lower rates of mortality for lung and prostate cancer but slightly higher rates for breast and colorectal cancer.

FIGURE 46: Cancer Mortality Rate per 100,000 Population, Cambridge and Massachusetts, 2015



DATA SOURCE: Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2015.

NOTE: Rates are age-adjusted per 100,000 residents.

Focus group participants did not discuss cancer frequently. When cancer was mentioned, most participants discussed it as a result of issues related to housing and nutrition. One participant felt that there has been an age shift for cancer diagnoses, saying, "For cancers, I'm finding a lot of younger people getting cancer, like in their forties or even younger. They are beating it, which is good, but I see people younger than me with cancer and it didn't happen in the past."

CHRONIC HEALTH CONDITIONS

TABLE 6 shows self-report data for adults participating in various preventive care services. For services related to routine doctor/dental visits, core clinical preventive services for women, cholesterol screening, and medication adherence, the percentages in Cambridge are higher than those in the United States. For services related to core preventive screenings for men, the percentage in Cambridge is slightly lower but still on par with those in the United States.

TABLE 6: Percent of Adults Participating in Preventive Care, Cambridge and U.S., 2016

	United States	Cambridge
Visit to doctor for routine checkup	69.7%	75.7%
Visit to dentist or dental clinic	65.3%	73.3%
Older adult men up to date on a core set of clinical preventive services	35.0%	34.7%
Older adult women up to date on a core set of clinical preventive services	31.5%	33.0%
Cholesterol screening	75.2%	80.5%
Taking medicine for high blood pressure control among those with high blood pressure	57.7%	61.6%

DATA SOURCE: Centers for Disease Control and Prevention, Division of Population Health, 500 Cities Project Data, 2016.

TABLE 7 shows the self-report data from the 500 Cities Project in the United States and in Cambridge. An estimated 6.0% of Cambridge residents age 18 and over have been diagnosed with some type of cancer (excluding skin), a percent similar to the United States overall (5.9%). It is important to note that many of the leading causes of disease or death, such as heart disease, diabetes, and cancer, are linked to lifestyle factors, such as diet, physical activity, and smoking. Furthermore, obesity/metabolic disease are a major and changeable contributor to chronic health conditions.

TABLE 7: Self-Reported Health Conditions Among Adults, Cambridge and U.S., 2016

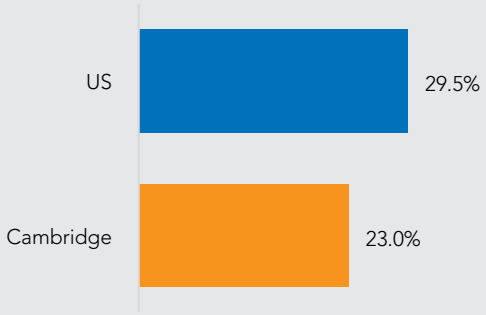
	United States	Cambridge
High cholesterol among adults who have been screened in the past 5 years	31.1%	29.7%
High blood pressure	29.4%	26.7%
Arthritis	23.0%	20.9%
Current asthma	8.8%	9.7%
Diagnosed diabetes	9.6%	7.6%
Cancer (excluding skin cancer)	5.9%	6.0%
Coronary heart disease	5.8%	4.5%
Chronic obstructive pulmonary disease	6.0%	4.2%
Chronic kidney disease	2.7%	2.3%
Stroke	2.9%	2.2%

DATA SOURCE: Centers for Disease Control and Prevention, Division of Population Health, 500 Cities Project Data, 2016.

Obesity

FIGURE 47 shows the proportion of adults in the United States and Cambridge who self-reported obesity in 2016. Almost one in three (29.5%) adults in the United States reported obesity, while less than one in four (23.0%) Cambridge adults reported obesity.

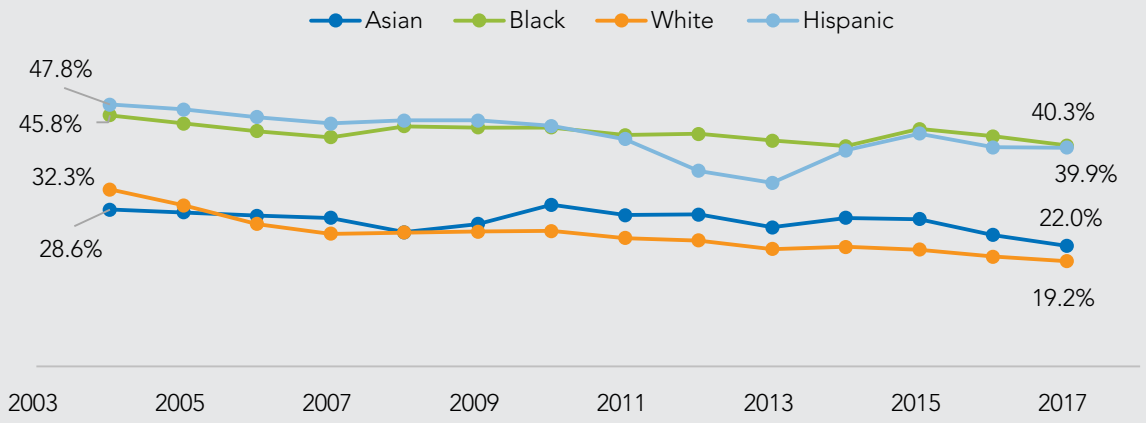
FIGURE 47: Percent of Adults With Self-Reported Obesity, Cambridge and U.S., 2016



DATA SOURCE: Centers for Disease Control and Prevention, Division of Population Health, 500 Cities Project Data, 2016.

From 2004 to 2017, the percentage of students in kindergarten to eighth grade that are overweight or obese decreased for each racial/ethnic group (**FIGURE 48**). However, racial/ethnic disparities persisted over this period, as shown by a decrease in the prevalence of overweight and obesity among White, non-Hispanic students that was two to three times that of other racial/ethnic groups.

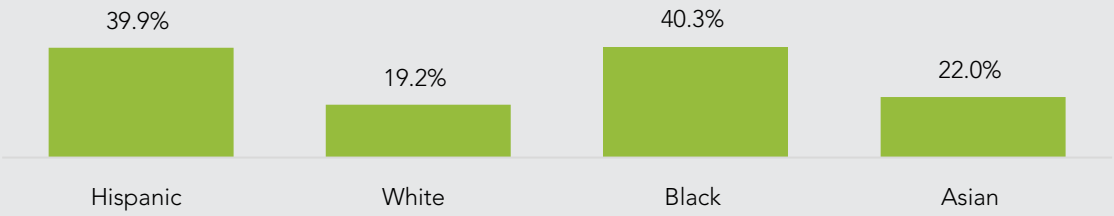
FIGURE 48: Percent of Students (K-8) That are Overweight or Obese, by Race/Ethnicity, Cambridge, 2004-2017



DATA SOURCE: Cambridge Youth Weight Surveillance Report, Grades K-8, 2003-2017.

Looking more closely, in 2017 the percentage of students in kindergarten to eighth grade that are overweight or obese was the lowest for White, non-Hispanic students and highest for Black, non-Hispanic students (19.2% vs. 40.3%) (**FIGURE 49**).

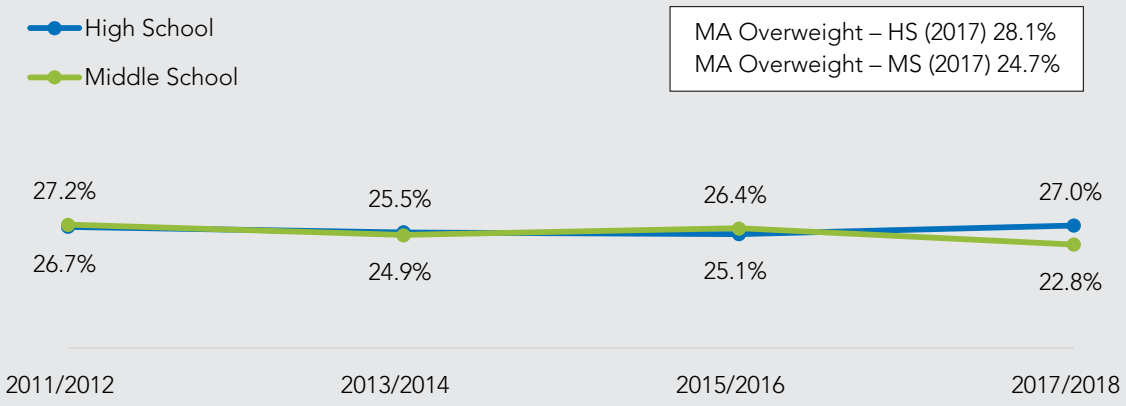
FIGURE 49: Percent of Students (K-8) That are Overweight or Obese, by Race/Ethnicity, Cambridge, 2017



DATA SOURCE: Cambridge Youth Weight Surveillance Report, Grades K-8, 2016-2017.

From 2011 to 2018, the proportion of Cambridge middle and high school students who self-described as slightly/very overweight remained relatively constant, with a high of 27.2% in 2011/2012 to a low of 22.8% in 2017/2018 (**FIGURE 50**).

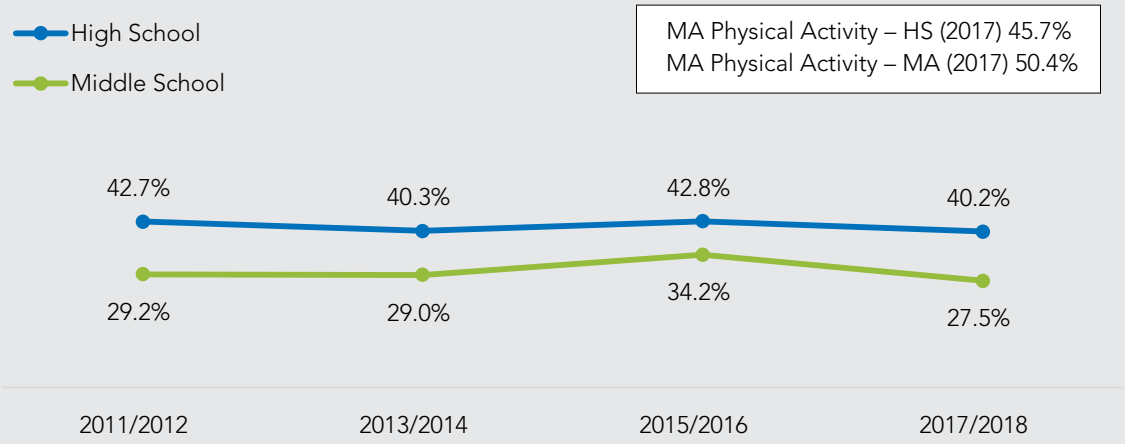
FIGURE 50: Percent of High School and Middle School Students Self-Described as Slightly/Very Overweight, Cambridge, 2011-2018



DATA SOURCE: Cambridge Middle School Health Survey, 2016-2017; Cambridge Teen Health Survey, 2017-2018; MA Youth Health Survey 2017.

From 2011 to 2018, less than 43% of Cambridge high school students and less than 35% of Cambridge middle school students reported engaging in physical activity for at least 60 minutes on five or more days of the week (**FIGURE 51**).

FIGURE 51: Percent of High School and Middle School Students Reporting Physical Activity for at Least 60 Minutes on Five or More Days per Week, Cambridge, 2011-2018



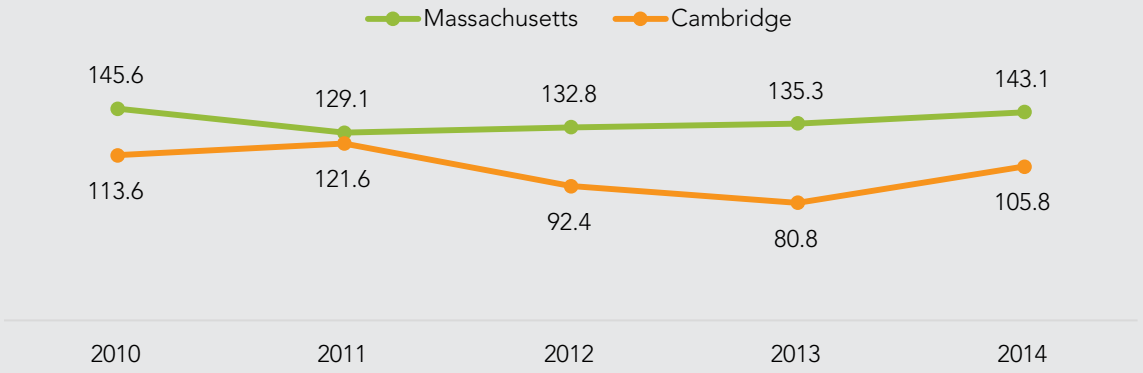
DATA SOURCE: Cambridge Middle Grades Health Survey, 2016-2017; Cambridge Teen Health Survey, 2017-2018; MA Youth Health Survey 2017.

In the 2018 Youth Voice Project, obesity was named as one of the top physical and behavioral health aspects, with about one in five respondents (20.8%) indicating it was a concern. During one youth focus group, participants noted the difficulties of healthy eating when with friends. In particular, some youth mentioned the peer pressure associated with eating poorly. *"I'd say unhealthy eating…when your friends are eating unhealthy around you, you eat that too."*

Diabetes

As shown in **FIGURE 41**, one in three (33.7%) survey respondents rated their personal level of concern for diabetes as moderate or high. Between 2010 and 2014, the rate for emergency department visits due to diabetes remained relatively constant in Massachusetts, while the rate in Cambridge fluctuated heavily during that same period (**FIGURE 52**). The rate in Massachusetts ranged from a high of 145.6 per 100,000 in 2010 to a low of 129.1 per 100,000 in 2011, then steadily increased to 143.1 per 100,000 by 2014. In contrast, the rate in Cambridge ranged from a high of 121.6 per 100,000 in 2011 to a low of 80.8 per 100,000 in 2013.

FIGURE 52: Emergency Department Visits Due to Diabetes per 100,000 Population, Cambridge and Massachusetts, 2010-2014

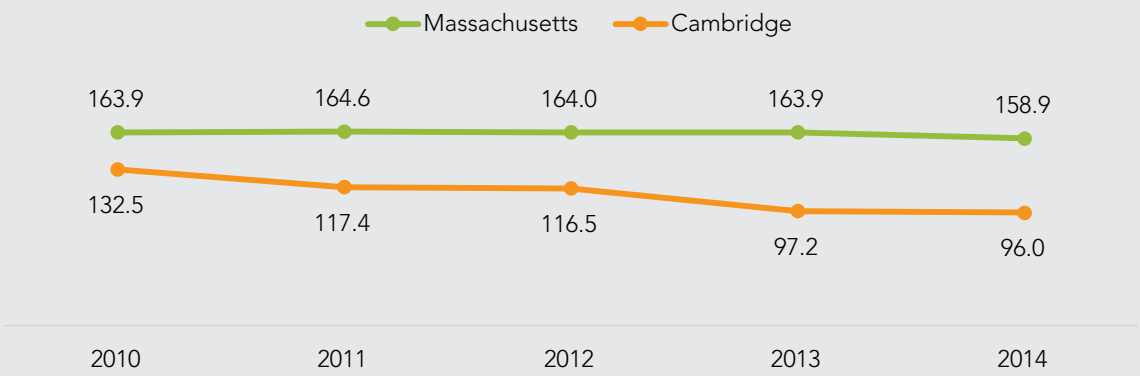


DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2010-2014.

NOTE: Each chronic disease indicator is calculated by analyzing the primary diagnosis code associated with the emergency department visit or hospitalization; The following ICD-9-CM diagnosis codes were used to identify Diabetes: 249-250; Rates are age-adjusted per 100,000.

Between 2010 and 2014, the rate of hospitalization due to diabetes experienced a steady decrease and remained consistently lower in Cambridge compared to Massachusetts (**FIGURE 53**). The rate in Cambridge ranged from a high of 132.5 per 100,000 in 2010 to a low of 96.0 per 100,000 in 2014. In contrast, the rate in Massachusetts ranged from a high of 164.6 per 100,000 in 2011 to a low of 158.9 per 100,000 in 2014.

FIGURE 53: Hospitalizations Due to Diabetes per 100,000 Population, Cambridge and Massachusetts, 2010-2014



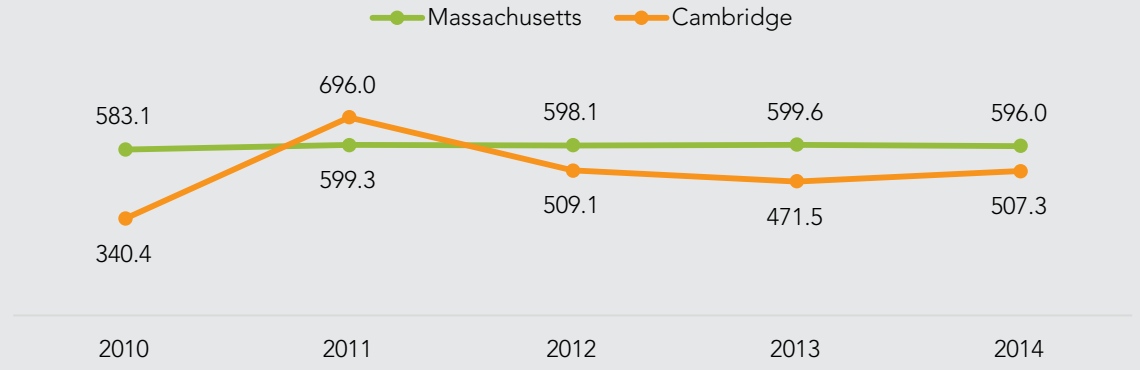
DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2010-2014.

NOTE: Each chronic disease indicator is calculated by analyzing the primary diagnosis code associated with the emergency department visit or hospitalization; The following ICD-9-CM diagnosis codes were used to identify Diabetes: 249-250; Rates are age-adjusted per 100,000.

Cardiovascular Disease

As shown in **TABLE 4**, heart disease is the second leading cause of death in Cambridge, and **FIGURE 41** shows that 47.7% of survey respondents rated their personal level of concern for heart disease as moderate or high. Between 2010 and 2014, the rate for emergency department visits due to cardiovascular disease remained relatively constant in Massachusetts, while the rate in Cambridge fluctuated during that same period (**FIGURE 54**). The rate in Massachusetts ranged from a low of 583.1 per 100,000 in 2010 to a high of 596.0 per 100,000 in 2014. In contrast, the rate in Cambridge ranged from a low of 340.4 per 100,000 in 2010 to a high of 696.0 per 100,000 in 2011, with the rate fluctuating less after 2012.

FIGURE 54: Emergency Department Visits due to Cardiovascular Disease per 100,000 Population, Cambridge and Massachusetts, 2010-2014

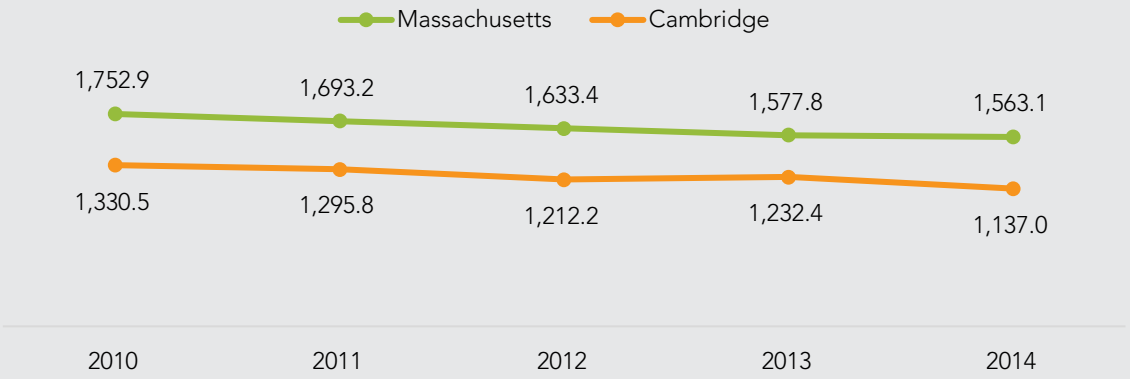


DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2010-2014.

NOTE: Each chronic disease indicator is calculated by analyzing the primary diagnosis code associated with the emergency department visit or hospitalization; The following ICD-9-CM diagnosis codes were used to identify Cardiovascular disease: 390-449, 451-459; Rates are age-adjusted per 100,000.

Between 2010 and 2014, the rate of hospitalization due to cardiovascular disease remained consistently lower in Cambridge compared to Massachusetts, and both experienced a steady decrease during the same time period (FIGURE 55). The rate in Cambridge ranged from a high of 1,330.5 per 100,000 in 2010 to a low of 1,137.0 per 100,000 in 2014. In contrast, the rate in Massachusetts ranged from a high of 1,752.9 per 100,000 in 2010 to a low of 1,563.1 per 100,000 in 2014.

FIGURE 55: Hospitalizations due to Cardiovascular Disease per 100,000 Population, Cambridge and Massachusetts, 2010-2014



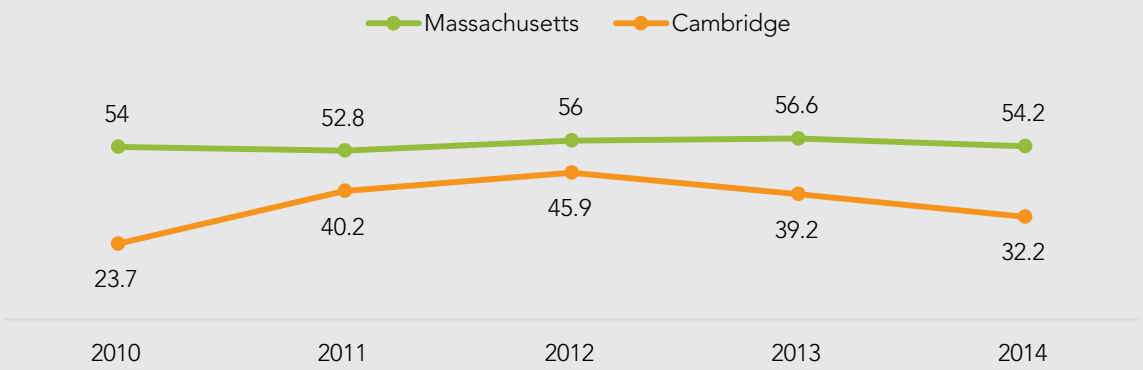
DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2010-2014.

NOTE: Each chronic disease indicator is calculated by analyzing the primary diagnosis code associated with the emergency department visit or hospitalization; The following ICD-9-CM diagnosis codes were used to identify Cardiovascular disease: 390-449, 451-459; Rates are age-adjusted per 100,000.

Stroke

Between 2010 and 2014, the rate for emergency department visits due to strokes remained relatively constant in Massachusetts, while the rate in Cambridge fluctuated during that same period (**FIGURE 56**). The rate in Massachusetts ranged from a low of 52.8 per 100,000 in 2011 to a high of 56.6 per 100,000 in 2013. In contrast, the rate in Cambridge ranged from a low of 23.7 per 100,000 in 2010 to a high of 45.9 per 100,000 in 2012.

FIGURE 56: Emergency Department Visits due to Stroke per 100,000 Population, Cambridge and Massachusetts, 2010-2014

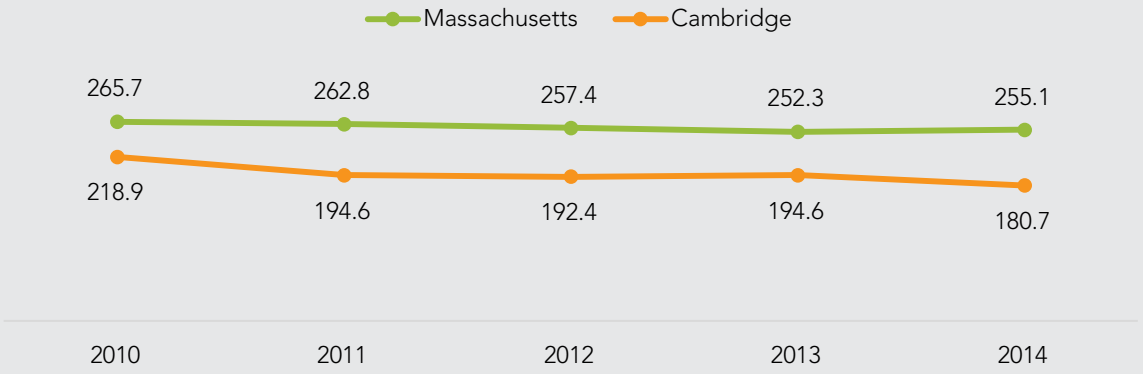


DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2010-2014.

NOTE: Each chronic disease indicator is calculated by analyzing the primary diagnosis code associated with the emergency department visit or hospitalization; The following ICD-9-CM diagnosis codes were used to identify Stroke: 430-438; Rates are age-adjusted per 100,000.

Between 2010 and 2014, the rate of hospitalization due to strokes experienced a steady decrease and remained consistently lower in Cambridge compared to Massachusetts (**FIGURE 57**). The rate in Cambridge ranged from a high of 218.9 per 100,000 in 2010 to a low of 180.7 per 100,000 in 2014. In contrast, the rate in Massachusetts ranged from a high of 265.7 per 100,000 in 2010 to a low of 252.3 per 100,000 in 2013.

FIGURE 57: Hospitalizations due to Stroke per 100,000 Population, Cambridge and Massachusetts, 2010-2014



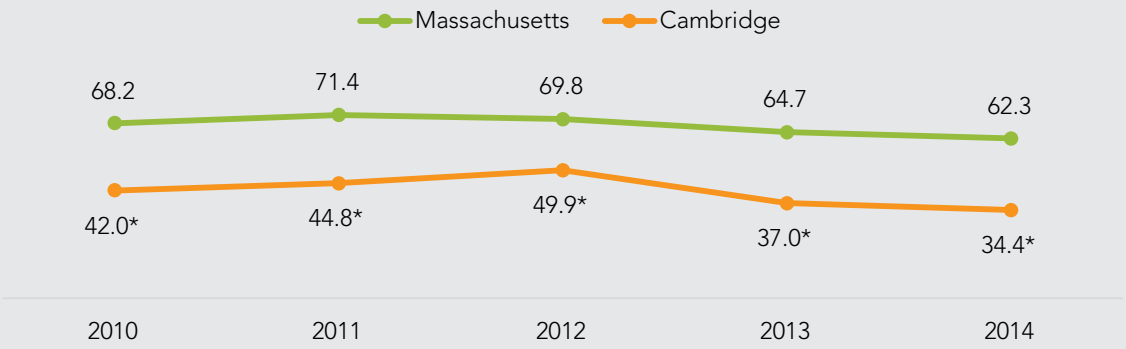
DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2010-2014.

NOTE: Each chronic disease indicator is calculated by analyzing the primary diagnosis code associated with the emergency department visit or hospitalization; The following ICD-9-CM diagnosis codes were used to identify Stroke: 430-438; Rates are age-adjusted per 100,000.

Chronic Obstructive Pulmonary Disease

Between 2010 and 2014, emergency department visits due to chronic obstructive pulmonary disease (COPD) in Massachusetts and Cambridge decreased, and the rate in Cambridge remained lower than the rate in Massachusetts during all five years. The rate for emergency department visits in Massachusetts ranged from a high of 71.4 per 10,000 in 2011 to a low of 62.3 per 10,000 in 2014, while the rate in Cambridge ranged from a high of 49.9 per 10,000 in 2012 to a low of 34.4 per 10,000 in 2014 (**FIGURE 58**).

FIGURE 58: Emergency Department Visits due to COPD per 10,000 Population, Cambridge and Massachusetts, 2010-2014

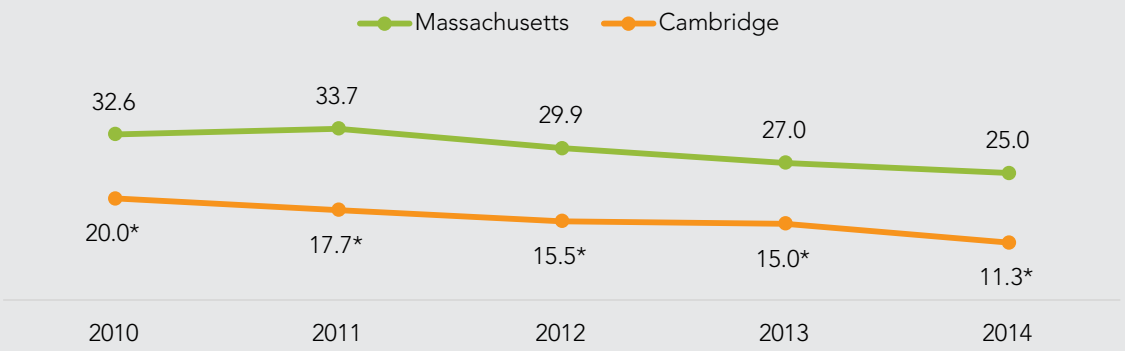


DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2010-2014.

NOTE: "COPD" means Chronic obstructive pulmonary disease; Rates are age-adjusted per 10,000; Asterisk (*) indicates a statistically significant difference.

Between 2010 and 2014, hospital admission rates due to COPD in Massachusetts and Cambridge decreased, and the rate in Cambridge remained lower than the rate in Massachusetts during all five years. The rate for hospital admissions in Massachusetts ranged from a high of 33.7 per 10,000 in 2011 to a low of 25.0 per 10,000 in 2014, while the rate in Cambridge ranged from a high of 20.0 per 10,000 in 2010 to a low of 11.3 per 10,000 in 2014 (**FIGURE 59**).

FIGURE 59: Hospitalizations due to COPD per 10,000 Population, Cambridge and Massachusetts, 2010-2014



DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2010-2014.

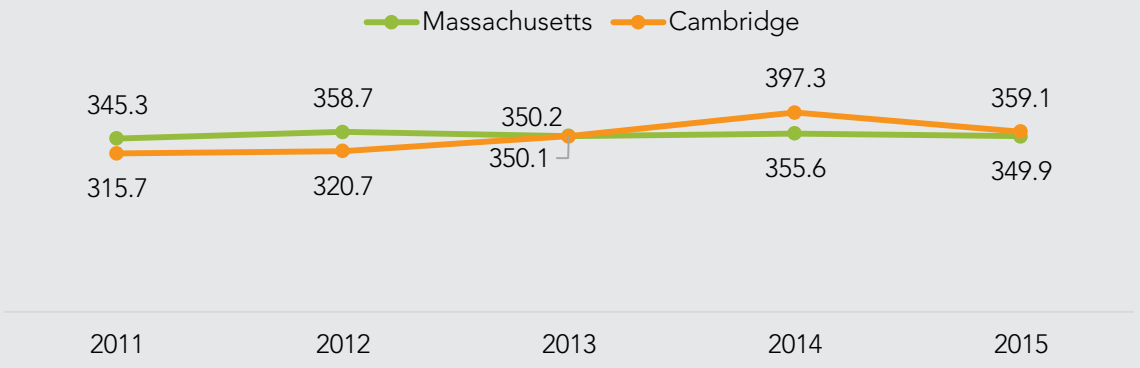
NOTE: Rates are age-adjusted per 10,000; Asterisk (*) indicates a statistically significant difference.

SEXUAL AND REPRODUCTIVE HEALTH

Infectious Disease

As shown in **FIGURE 41**, one in 10 (10.0%) survey respondents rated their personal level of concern for sexually transmitted infections as moderate or high. The crude chlamydia rates in Massachusetts and Cambridge remained steady between 2011 and 2015 (**FIGURE 60**), though the rate in Cambridge fluctuated slightly more than the state. The crude chlamydia rate in Massachusetts ranged from a low of 345.3 per 100,000 in 2011 to a high of 358.7 per 100,000 in 2012. The crude chlamydia rate in Cambridge ranged from a low of 315.7 per 100,000 in 2011 to a high of 397.3 per 100,000 in 2014.

FIGURE 60: Crude Chlamydia Rate per 100,000 Population, Cambridge and Massachusetts, 2011-2015

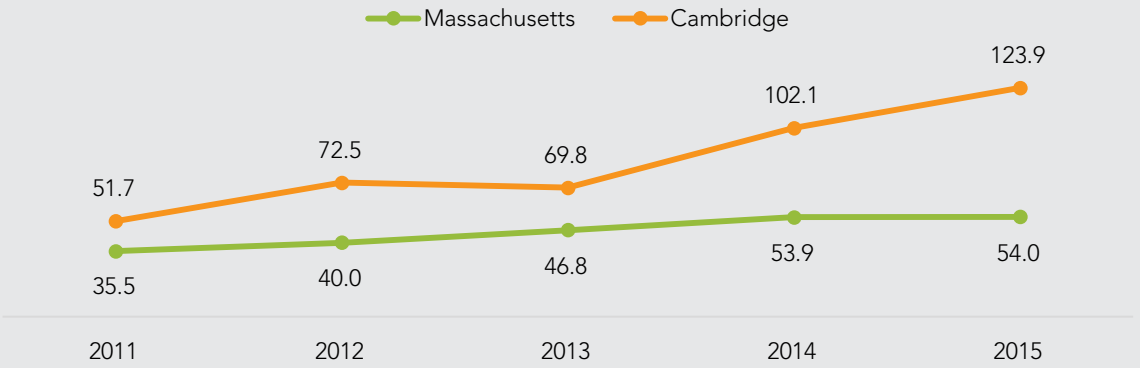


DATA SOURCE: Massachusetts Department of Public Health, Bureau of Infectious Disease, 2011-2015.

NOTE: Geography reflects residence and may not reflect location of infection.

The crude gonorrhea rate in Massachusetts increased steadily between 2011 and 2015, while the rate more than doubled in Cambridge during that same time period (**FIGURE 61**). In Massachusetts, the crude gonorrhea rate steadily increased from 35.5 per 100,000 in 2011 to 54.0 per 100,000 in 2015. In contrast, the crude gonorrhea rate in Cambridge increased from 51.7 per 100,000 in 2011 to 123.9 per 100,000 in 2015.

FIGURE 61: Crude Gonorrhea Rate per 100,000 Population, Cambridge and Massachusetts, 2011-2015

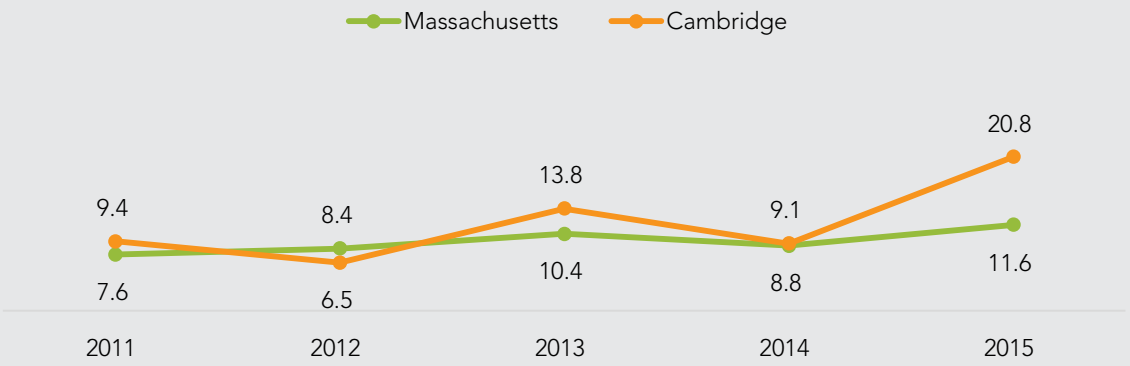


DATA SOURCE: Massachusetts Department of Public Health, Bureau of Infectious Disease, 2011-2015.

NOTE: Geography reflects residence and may not reflect location of infection.

The crude syphilis rate increased in Massachusetts and Cambridge between 2011 and 2015, though Massachusetts experienced a steadier increase compared to Cambridge (**FIGURE 62**). The crude syphilis rate in Massachusetts ranged from a low of 7.6 per 100,000 in 2011 to a high of 11.6 per 100,000 in 2015. In contrast, the crude syphilis rate in Cambridge ranged from a low of 6.5 per 100,000 in 2012 to a high of 20.8 per 100,000 in 2015, with the largest increase occurring between 2014 and 2015.

FIGURE 62: Crude Syphilis Rate per 100,000 Population, Cambridge and Massachusetts, 2011-2015



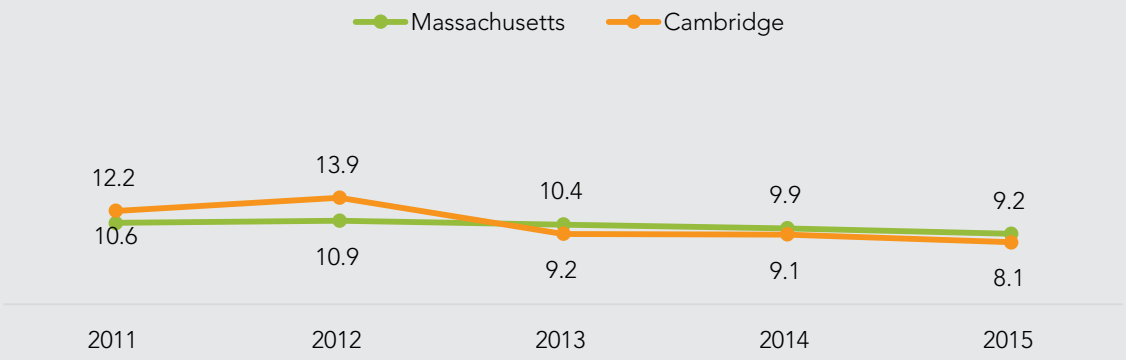
DATA SOURCE: Massachusetts Department of Public Health, Bureau of Infectious Disease, 2011-2015.

NOTE: Geography reflects residence and may not reflect location of infection.

The crude rate of human immunodeficiency virus (HIV) decreased in Massachusetts and Cambridge between 2011 and 2015, though both experienced a slight increase in 2012 (**FIGURE 63**). The crude rate of HIV in Massachusetts ranged from a high of 10.9 per 100,000 in 2012 to a low of 9.2 per 100,000 in 2015. In Cambridge, the crude rate of HIV ranged from a high of 13.9 per 100,000 in 2012 to a low of 8.1 per 100,000 in 2015. Though new infections of HIV and the mortality rate of individuals living with HIV have decreased, disparities persist among vulnerable populations statewide, including men who have sex with men, Black (non-Hispanic) and Hispanic individuals, and people who inject drugs.[5]

[5]Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences. 2018 Massachusetts HIV/AIDS Epidemiologic Profile, The Massachusetts HIV/AIDS Epidemic at a Glancehttps://www.mass.gov/lists/hivaids-epidemiologic-profiles Published September 2018.

FIGURE 63: Crude HIV Rate per 100,000 Population, Cambridge and Massachusetts, 2011-2015



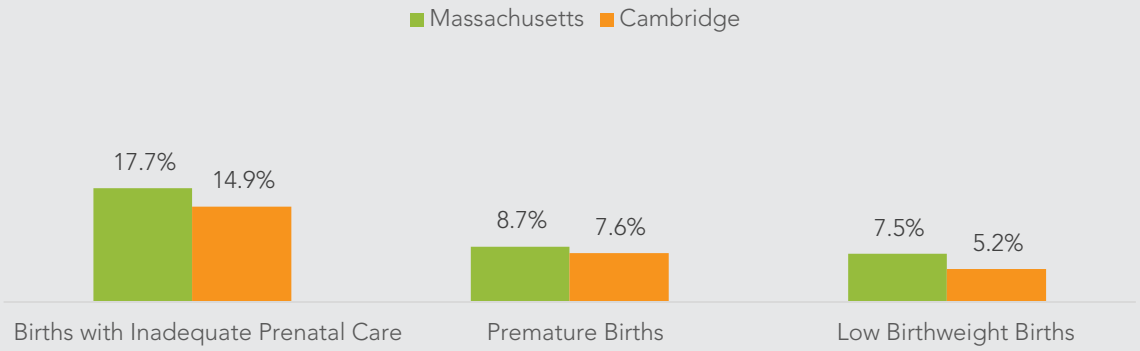
DATA SOURCE: Massachusetts Department of Public Health, Bureau of Infectious Disease, 2011-2015.

NOTE: Geography reflects residence and may not reflect location of infection.

Infant Health

Overall, Cambridge has a slightly smaller percentage of births with inadequate prenatal care, premature births, and low birthweight births when compared to Massachusetts (FIGURE 64).

FIGURE 64: Percent of Births, by Birth Type, Cambridge and Massachusetts, 2016

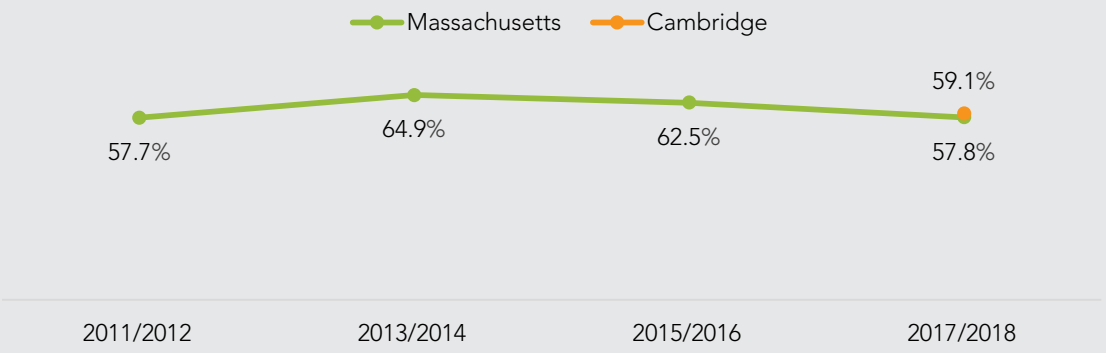


DATA SOURCE: Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2016.

Youth Sexual Activity

FIGURE 65 shows the percentage of high school students who reported use of a condom/protective barrier at last intercourse. Reported condom/protective barrier use among Massachusetts high school students remained steady from 2012-2018. Data for Cambridge are available only for 2018, but are similar to Massachusetts data, with 59.1% of Cambridge students and 57.8% of Massachusetts students reporting use of a condom/protective barrier.

FIGURE 65: Percent of High School Students Reporting Condom/Protective Barrier use at Last Intercourse, Cambridge and Massachusetts, 2012 – 2018

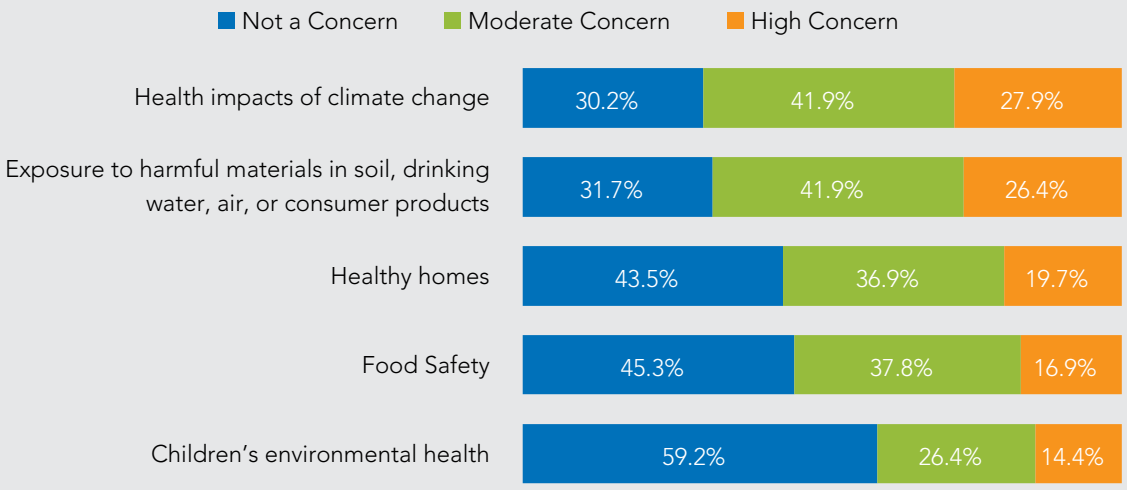


DATA SOURCE: Massachusetts Youth Health Survey 2017; Cambridge Teen Health Survey, 2017-2018.

ENVIRONMENTAL HEALTH

When asked to rate how much of a concern environmental health conditions were for themselves and their families, survey respondents indicated that they had the highest level of concern for the health impacts of climate change (27.9%), followed by exposure to harmful materials in various products (26.4%) (FIGURE 66). Relative to other concern ratings in the survey, the overall environmental health category had higher percentages of respondents rating issues as a moderate or high concern. For example, more than half of respondents felt a moderate or high concern for each environmental health factor except for children's environmental health. While survey respondents expressed concern for a variety of factors, data are lacking in many of these topic areas, and therefore it is challenging to understand the full magnitude of these issues for Cambridge residents.

FIGURE 66: Survey Respondent Level of Concern for Environmental Health Factors, Cambridge, 2019

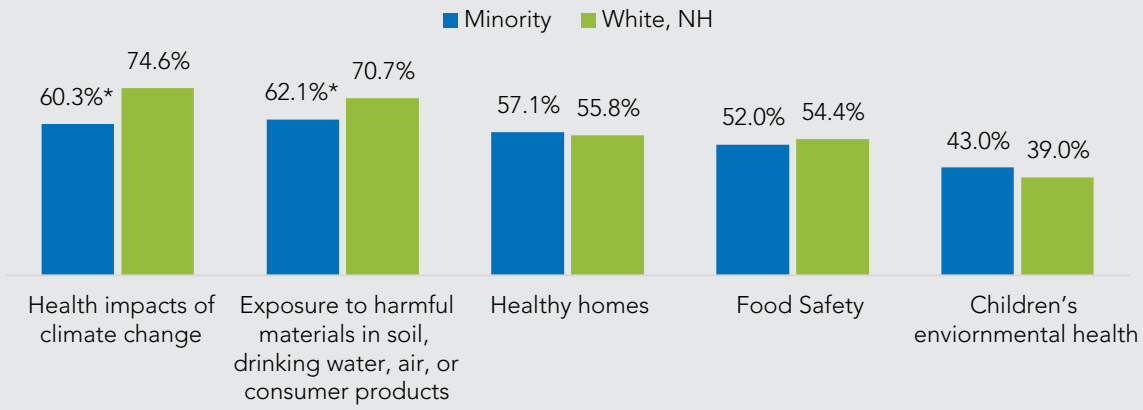


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II.

When stratified by racial/ethnic minority status, the rankings for concerning factors generally remain the same, though respondents who identify as a racial/ethnic minority were significantly less concerned about the health impacts of climate change and exposure to harmful materials. Additionally, among respondents who identify as a racial/ethnic minority, the concern for exposure to harmful materials is slightly higher compared to the health impacts of climate change (**FIGURE 67**).

FIGURE 67: Survey Respondents Reporting Moderate or High Concern for Environmental Health Factors, by Minority Status, Cambridge, 2019

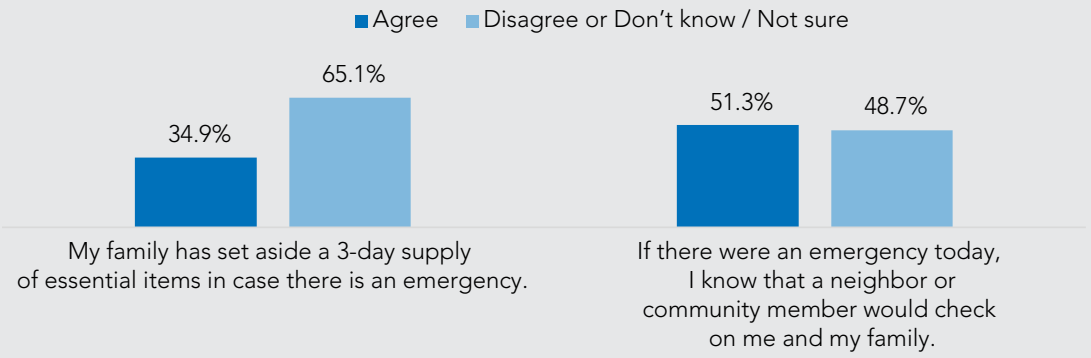


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II; "White, NH" represents persons who identified as White and non-Hispanic, while "Minority" represents persons who identified as any non-White category, and/or Hispanic.

When describing their levels of emergency preparedness, one in three (34.9%) respondents had a three-day supply of essential items set aside in case of an emergency (**FIGURE 68**). In terms of community connectedness during an emergency, roughly half of respondents (51.3%) knew that a neighbor or community member would check on them during an emergency.

FIGURE 68: Survey Respondents' Emergency Preparedness, Cambridge, 2019



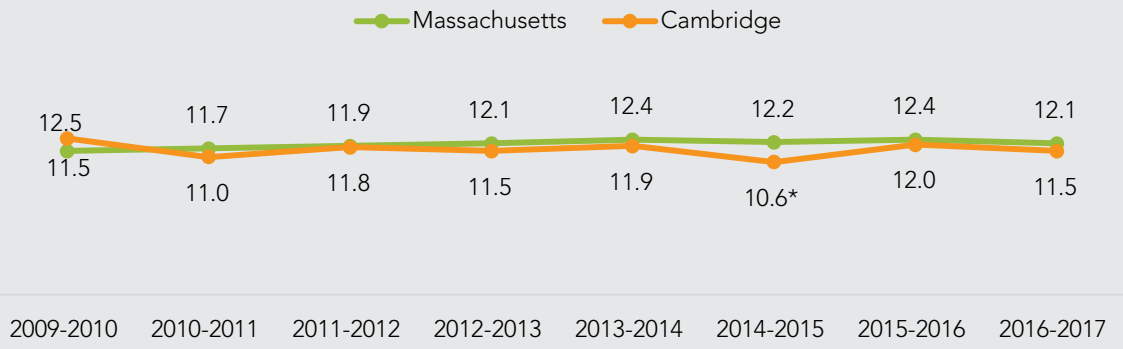
DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II.

Adults in Massachusetts had a higher prevalence of lifetime and current asthma compared to the United States. Specific to children, the prevalence of current asthma was higher among male children, children in low-income households, children living with adults with lower educational attainment, and children with disabilities.[6,7] Overall, approximately one in 10 students had a diagnosis of asthma from 2009 to 2017.

During this period, the prevalence of pediatric asthma in Massachusetts and Cambridge remained constant (**FIGURE 69**). Prevalence in Massachusetts ranged from a low of 11.5 per 100 in 2009/2010 to a high of 12.4 per 100 in 2013/2014 and 2015/2016. The prevalence in Cambridge ranged from a low of 10.6 per 100 in 2014/2015 to a high of 12.0 per 100 in 2015/2016. Though prevalence has remained stable, racial/ethnic disparities persist statewide with Hispanic and Black, non-Hispanic children experiencing much higher rates than White, non-Hispanic children.[8]

FIGURE 69: Prevalence of Pediatric Asthma per 100 Students, Cambridge and Massachusetts, 2009-2010 to 2016-2017



DATA SOURCE: Massachusetts Department of Public Health, Bureau of Environmental Health Massachusetts Department of Public Health, 2009-2010 to 2016-2017.

NOTE: Asterisk (*) indicates a statistically significant difference.

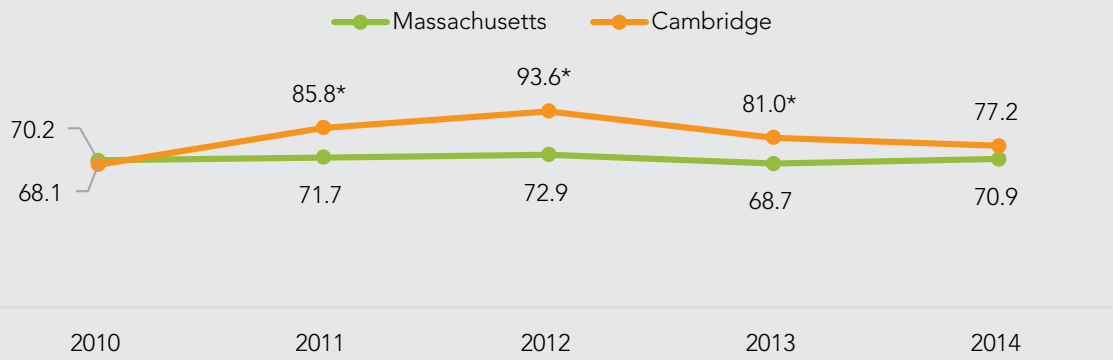
In 2015, roughly one in nine Massachusetts residents had asthma (10.2% of adults and 12.9% children).[7] From 2006–2010, roughly three in four adults (73.7%) and one in three children (66.2%) with asthma were classified as having poorly controlled asthma.[6] Between 2010 and 2014, the rate of asthma-related emergency department visits in Massachusetts remained relatively constant, though the rate in Cambridge increased slightly in 2012 (FIGURE 70). During the five-year period, the rate of emergency department visits in Massachusetts ranged from a low of 68.1 per 10,000 in 2010 to a high of 72.9 per 10,000 in 2012, while the rate of emergency department visits in Cambridge ranged from a low of 70.2 per 10,000 in 2010 to a high of 93.6 per 10,000 in 2012.

[6] For more information, see Statistics about health: https://www.mass.gov/service-details/statistics-about-asthma

[7] A Profile of Health among Massachusetts Adults, 2015: https://www.mass.gov/doc/a-profile-of-health-among-massachusetts-adults-2015/download

[8] For more information, see Asthma Among Children in Massachusetts: https://www.mass.gov/files/documents/2018/07/19/asthma-data-bulletin.pdf

FIGURE 70: Emergency Department Visits due to Asthma per 10,000 Population, Cambridge and Massachusetts, 2010-2014

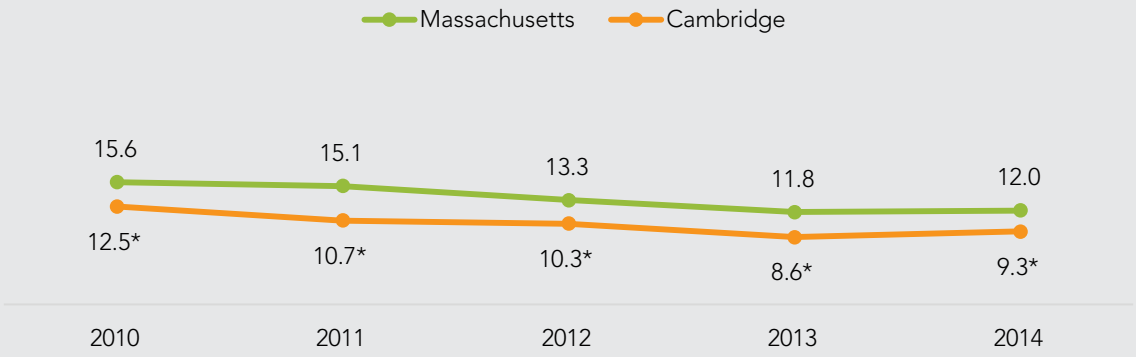


DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2010-2014.

NOTE: Rates are age-adjusted per 10,000; Asterisk (*) indicates a statistically significant difference.

Between 2010 and 2014, asthma-related hospital admissions in Massachusetts and Cambridge steadily decreased, though the rate in Cambridge remained lower than the rate in Massachusetts during all five years (**FIGURE 71**). The hospital admission rate in Massachusetts decreased from 15.6 per 10,000 in 2010 to 12.0 per 10,000 in 2014, while the hospital admission rate in Cambridge decreased from 12.5 per 10,000 in 2010 to 9.3 per 10,000 in 2014.

FIGURE 71: Hospitalizations due to Asthma per 10,000 Population, Cambridge and Massachusetts, 2010-2014

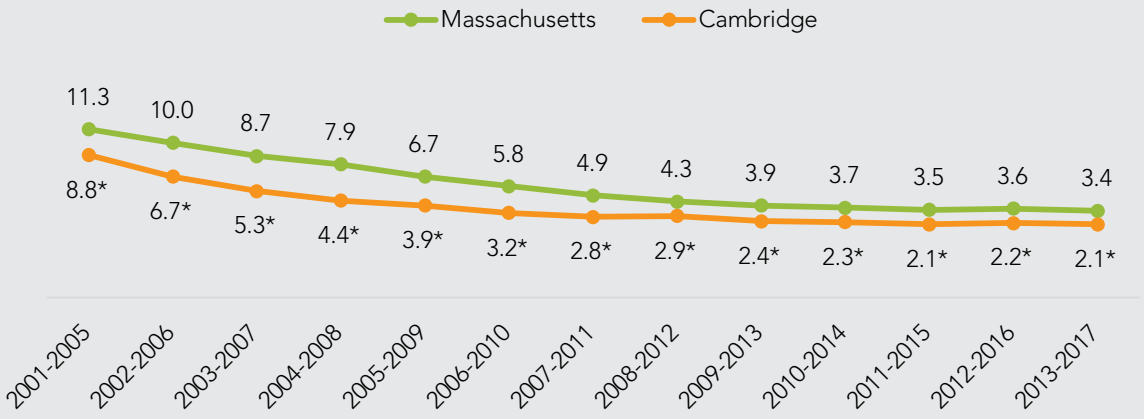


DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2010-2014.

NOTE: Rates are age-adjusted per 10,000; Asterisk (*) indicates a statistically significant difference.

Between 2001 to 2017, the average blood lead level (above 10 micrograms per deciliter) in Massachusetts and Cambridge children steadily decreased, though the rate in Cambridge remained significantly lower than the rate in Massachusetts during the entire period (**FIGURE 72**). The average blood lead level in Massachusetts decreased from 11.3 per 1,000 from 2001-2005 to 3.4 per 1,000 from 2013-2017. The average blood lead level in Cambridge decreased from 8.8 per 1,000 from 2001-2005 to 2.1 per 1,000 from 2013-2017.

FIGURE 72: Average Blood Lead Level >10 Ug/Dl, Rate per 1,000 Children 9-47 Months, Cambridge and Massachusetts, 2001-2005 to 2013-2017



DATA SOURCE: Massachusetts Department of Public Health, Bureau of Environmental Health, Childhood Lead Poisoning Prevention Program, 2001-2005 to 2013-2017.

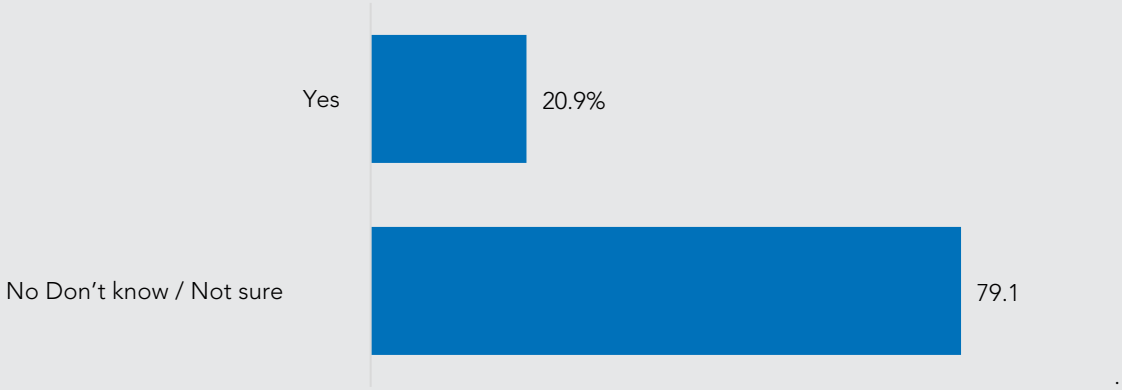
NOTE: Asterisk (*) indicates a statistically significant difference.

Similar to survey respondents, focus group participants expressed concern for many of the environmental concerns named in **FIGURE 66**. Regarding exposure to harmful materials, one participant said, *"there are a lot of toxins in the environment, and the foods we get are not local. They are stored and transported from a distance."* Another participant noted the dangers that exist in the built environment and the need for improved policies to address issues in homes. *"It could be environmental causes for asthma and cancer. [We] need a mandated system where they actually do the work needed – check air quality, check mold – specifically for older units."*

DISABILITY

One in five (20.9%) survey respondents indicated that they or a family member had a physical or mental impairment that substantially limits one or more major life activities (**FIGURE 73**).

FIGURE 73: Survey Respondents With any Physical or Mental Impairment, Cambridge, 2019

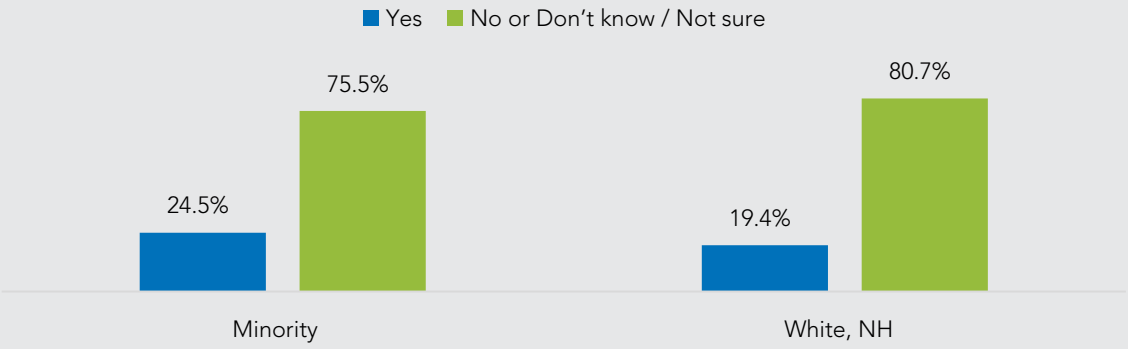


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II.

FIGURE 74 shows that when stratified by racial/ethnic minority status, a slightly higher percentage of respondents who identified as a racial/ethnic minority reported an impairment when compared to White, non-Hispanic respondents (24.5% vs. 19.4%, respectively).

FIGURE 74: Survey Respondents With any Physical or Mental Impairment, by Minority Status, Cambridge, 2019

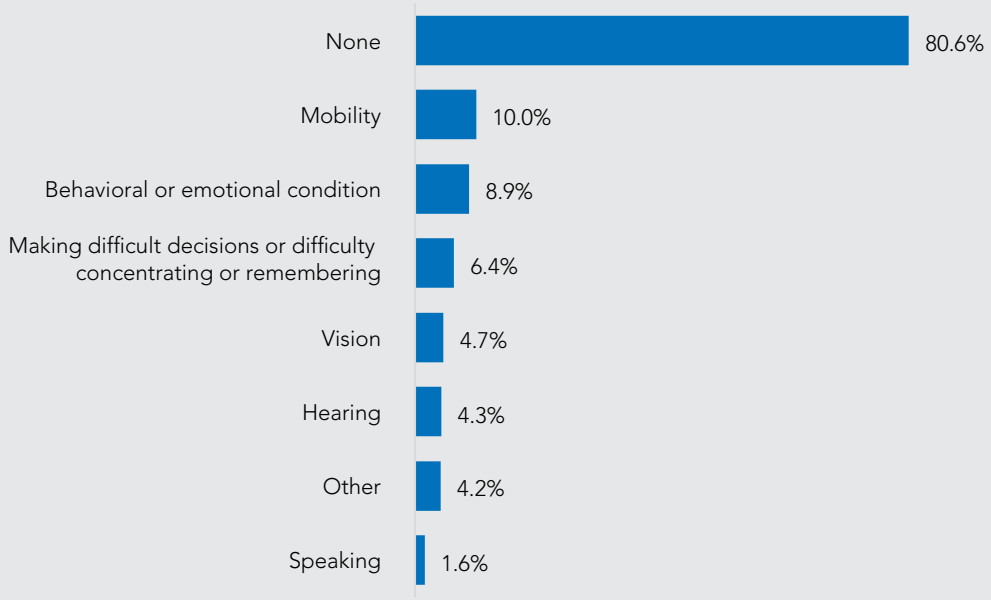


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II. "White, NH" represents persons who identified as White and non-Hispanic, while "Minority" represents persons who identified as any non-White category, and/or Hispanic.

Among survey respondents who reported the presence of a physical or mental impairment, four in five (80.6%) indicated that there were no major daily life activities impacted as a result of the impairment. Among those who indicated that major daily life activities are impacted as a result of an impairment, mobility was most often cited (10.0%), followed by behavioral or emotional conditions (8.9%) and certain cognitive functions (6.4%) (**FIGURE 75**).

FIGURE 75: Survey Respondents' Daily Life Activities Impacted by Impairment, Cambridge, 2019

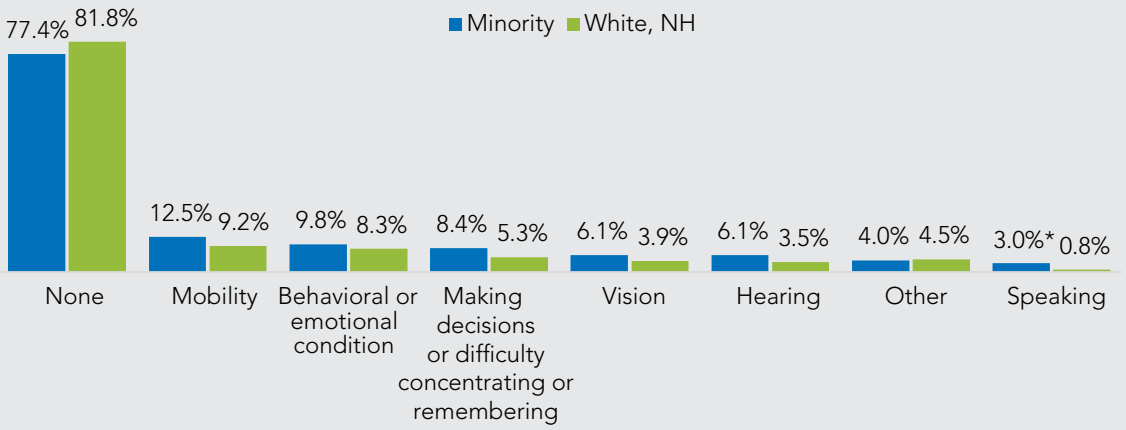


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II. Respondents were allowed to check more than one response; therefore, percentages may sum to greater than 100; Vision excludes the need for glasses or contacts; Speaking includes speech-language impairment regardless of native language spoken.

Survey respondents who reported having any physical or mental impairment were also stratified by racial/ethnic minority status (**FIGURE 76**). Overall, the majority of respondents indicated that there were no major daily life activities impacted as a result of their impairment, regardless of racial/ethnic identity (81.8% of White, non-Hispanic respondents and 77.4% of racial/ethnic minority respondents). However, among those who indicated that major daily life activities are impacted, a larger proportion of these respondents identified as a racial/ethnic minority when compared to White, non-Hispanic respondents. Mobility was most often cited (12.5% vs. 9.2%), followed by behavioral or emotional conditions (9.8% vs. 8.3%%) and certain cognitive functions (8.4% vs. 5.3%). Though a small proportion of respondents reported speech as an impacted activity, a significantly higher proportion of minority respondents reported this issue compared to White, non-Hispanic respondents (3.0% vs. 0.8%).

FIGURE 76: Survey Respondents' Daily Life Activities Impacted by Impairment, by Minority Status, Cambridge, 2019

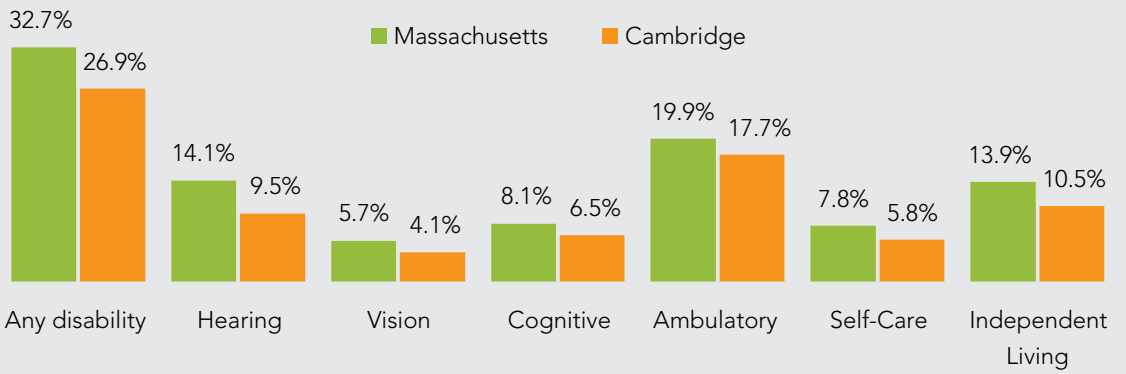


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II. Respondents were allowed to check more than one response; therefore, percentages may sum to greater than 100; Vision excludes the need for glasses or contacts; Speaking includes speech-language impairment regardless of native language spoken; "White, NH" represents persons who identified as White and non-Hispanic, while "Minority" represents persons who identified as any non-White category, and/or Hispanic. Asterisk (*) indicates a statistically significant difference. P<0.01.

FIGURE 77 shows the percentage of adults aged 65 years and older who reported having a disability in 2017, per the U.S. Census data estimates. Overall, more Massachusetts residents report having any disability compared to Cambridge residents (32.7% vs. 26.9%, respectively). When examined by disability type, both Massachusetts and Cambridge residents most frequently report having an ambulatory disability (19.9% and 17.7%, respectively) and a disability related to independent living (13.9% and 10.5%, respectively).

FIGURE 77: Disability Status of Population Age 65 Years and Over, by Disability Type, Cambridge and Massachusetts, 2017



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017.

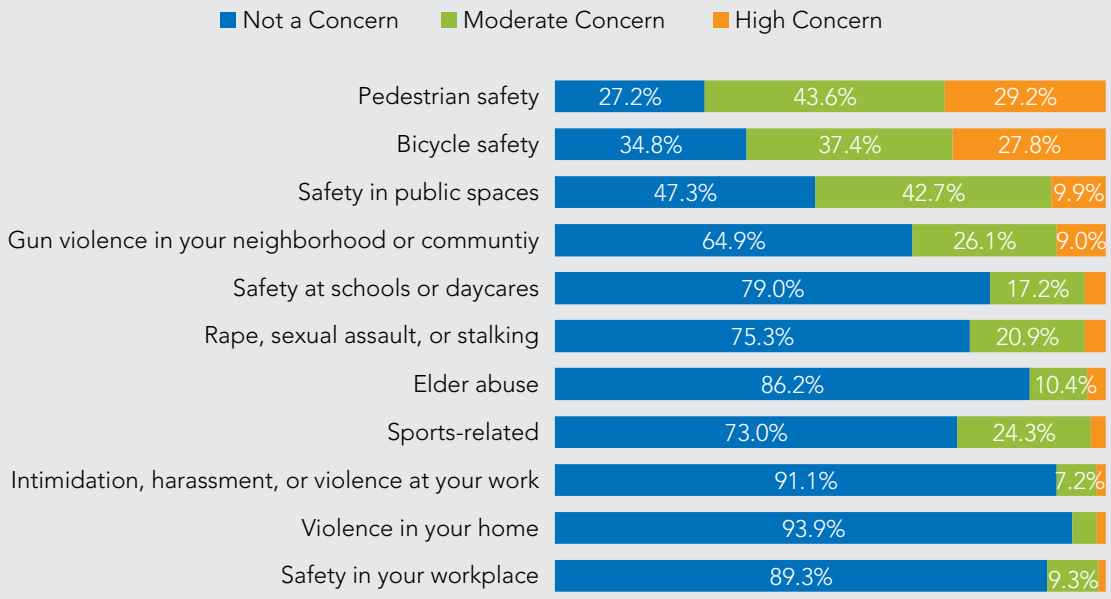
Disability status was frequently discussed in focus groups, particularly among participants with disabilities. However, the topic did not arise as a standalone subject. Rather, disability and the challenges faced by individuals with disabilities were discussed entirely in the context of social factors, such as economic opportunity (see report sections on employment, income, transportation, discrimination, and access to health care).

SAFETY AND VIOLENCE

In 2016, Cambridge adopted the Vision Zero policy, joining cities across the country and the world in a commitment to safe streets. Vision Zero calls for the elimination of all fatalities and serious injuries resulting from traffic crashes. Cambridge has gone above and beyond its goals related to speed management, committing to lowering the speed limit to 20 miles per hour on primarily local-access streets in 2020.

FIGURE 78 shows the percentage of survey respondents who rated their level of concern for various violence, safety, and injury factors. Respondents felt moderate or high concern for pedestrian safety (72.8%), bicycle safety (65.2%), and safety in public spaces (52.6%). The concern for bicycle and pedestrian safety was also reflected in focus groups, with one participant expressing concern when hearing about cyclists dying. Some participants also noted that changes to infrastructure (e.g., signage) are necessary to improve safety: *"[We] need space in the roads for safely walking and crossing streets. [We] need to have clear walking signals."*

FIGURE 78: Survey Respondent Level of Concern for Violence, Safety, and Injury Factors, Cambridge, 2019

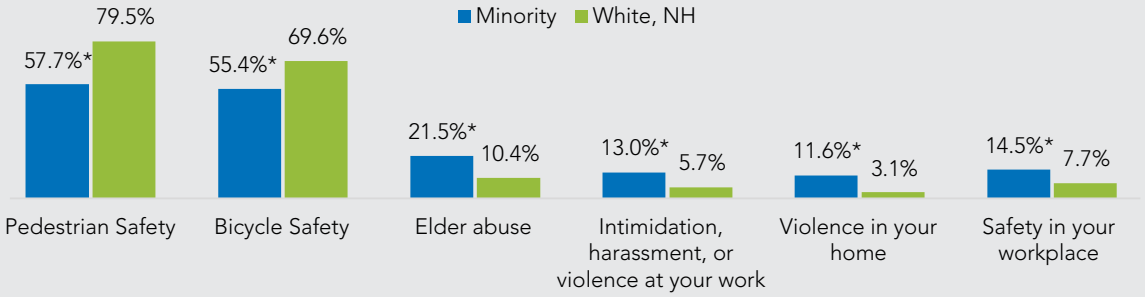


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in the Appendix II. Percentages <5% are not labeled within the bar chart.

When level of concern for various violence, safety, and injury factors are stratified by racial/ethnic minority status, pedestrian and bicycle safety remain top concerns among respondents (**FIGURE 79**). Nearly three in five (57.7%) minority respondents and nearly four in five (79.5%) White, non-Hispanic respondents rated their concern for pedestrian safety as moderate or high. Similarly, just over half (55.4%) of minority respondents and 69.6% of White, non-Hispanic respondents rated their concern for bicycle safety as moderate or high. A significantly larger percentage of survey respondents who identified as a racial/ethnic minority rated their personal concern for a range of safety issues as moderate or high. These included elder abuse, intimidation/harassment/violence at work, violence in the home, and safety in the workplace.

FIGURE 79: Survey Respondents Reporting Moderate or High Concern for Violence, Safety, and Injury Factors, by Minority Status, Cambridge, 2019

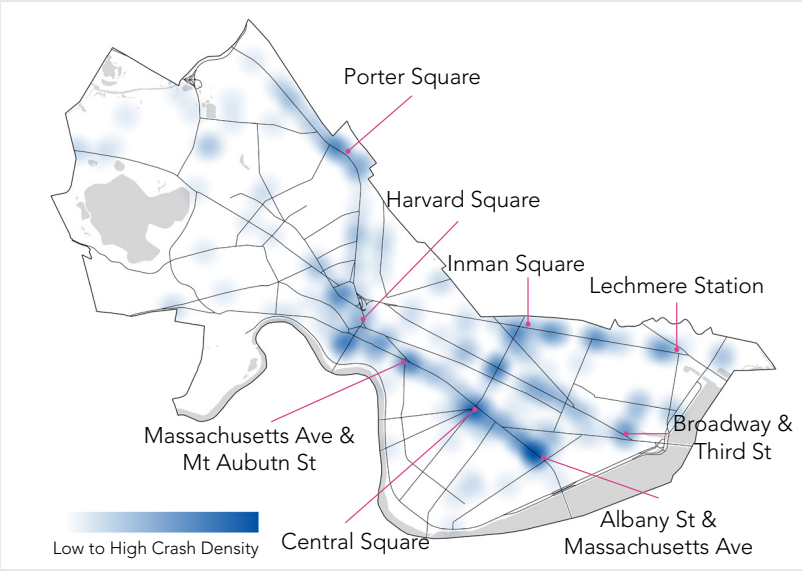


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II. "White, NH" represents persons who identified as White and non-Hispanic, while "Minority" represents persons who identified as any non-White category, and/or Hispanic. Asterisk (*) indicates a statistically significant difference. P<0.01.

FIGURE 80 shows the relative density of crashes involving non-motorists in 2019. Crashes occurred most frequently in the squares and along major thoroughfares.

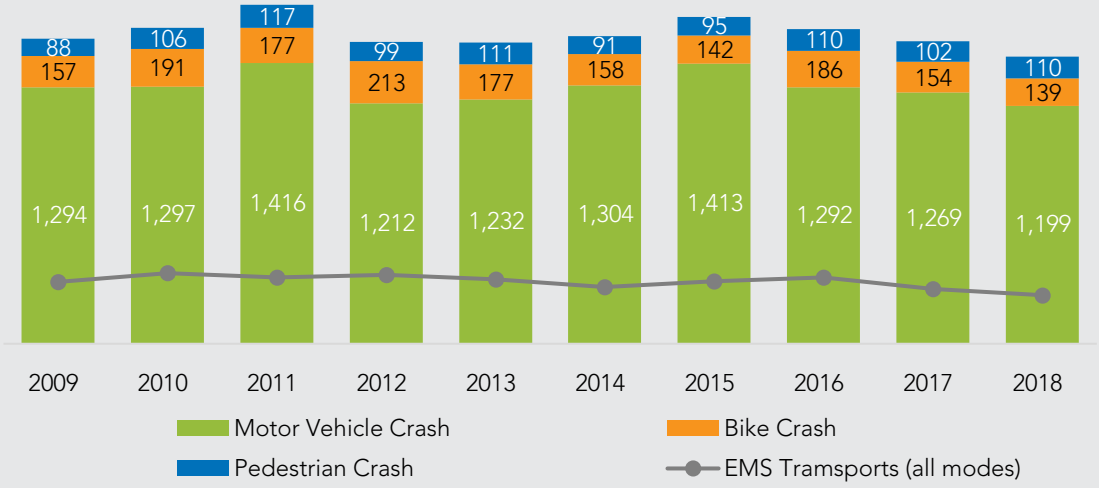
FIGURE 80: Crashes Involving Non-Motorists 2019



DATA SOURCE: Cambridge Police Department, 2019

Data monitored as part of the Cambridge Vision Zero efforts provide information on crashes occurring on Cambridge streets and the number of emergency medical service (EMS) transports due to crashes for the past 10 years (**FIGURE 81**). Pedestrian crashes have remained relatively stable over the time period, with an average of 103 crashes per year and a range from a low of 88 in 2009 to a high of 117 in 2011. Bike crashes have averaged 169 per year, with higher counts in 2010, 2012, and 2016 and lower counts in 2009, 2015, and 2018. Motor vehicle-only crashes are the most frequently occurring crash, averaging 1,292 per year. Recent years have shown a consistent decline since a peak of 1,413 crashes in 2015. EMS transports have averaged 313 per year between 2009 and 2018.

FIGURE 81: Crashes per Year by Mode and EMS Transports per Year (All Modes), Cambridge, 2009-2018

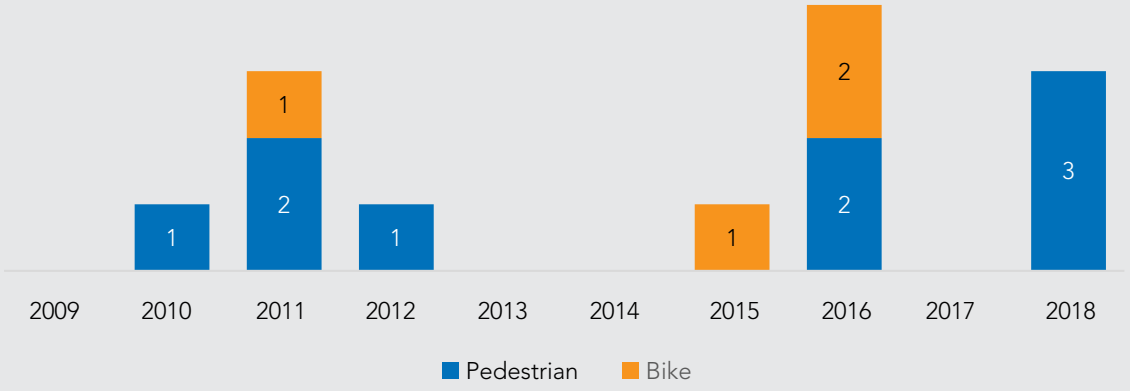


DATA SOURCE: Vision Zero Progress Report: Cambridge. Massachusetts Vision Zero Coalition in partnership with Cambridge.

NOTE: Any crash involving a pedestrian is considered a pedestrian crash. Any crash involving a bicyclist that does not also include a pedestrian is considered a bicycle crash. Any crash that only involves people in motor vehicles is considered a motor vehicle crash.

Additional data show that over the past 10 years, no one has been killed in motor vehicle crashes (**FIGURE 82**). However, nine pedestrians have been killed, and over half of these fatalities have occurred since 2016. In addition, four people have been killed in crashes while biking. While Cambridge has a low number of fatalities overall, the data clearly indicate that people are most vulnerable while walking or bicycling.

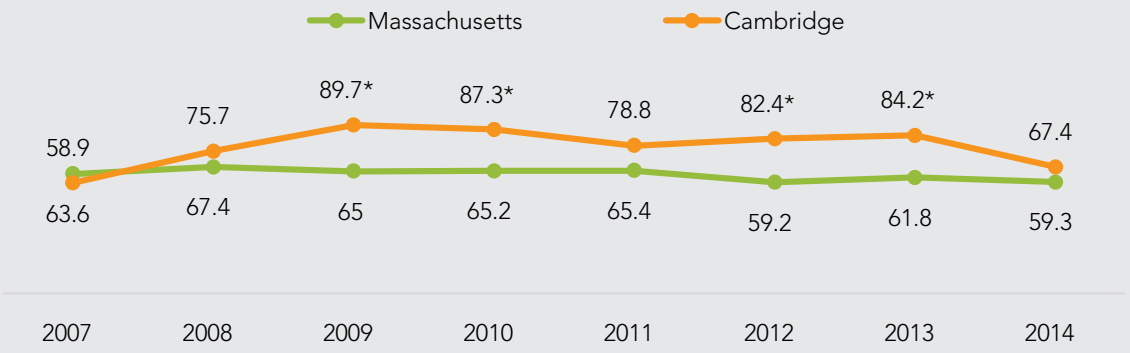
FIGURE 82: Fatalities per Year by Mode, Cambridge 2009-2018



DATA SOURCE: Vision Zero Progress Report: Cambridge. Massachusetts Vision Zero Coalition in partnership with Cambridge.

Between 2007 and 2014, rates of pedestrian hospitalizations and emergency department visits due to motor vehicle crashes remained consistent in Cambridge and Massachusetts, though the rate remained higher in Cambridge compared to Massachusetts (**FIGURE 83**). The 2014 rate of these incidents in Cambridge (67.4 per 100,000 individuals) represents approximately 80 individual pedestrians.

FIGURE 83: Hospitalizations and Emergency Department Visits due to Pedestrians Injured in Motor Vehicle Traffic-Related Incidents per 100,000 Population, Cambridge and Massachusetts, 2007-2014

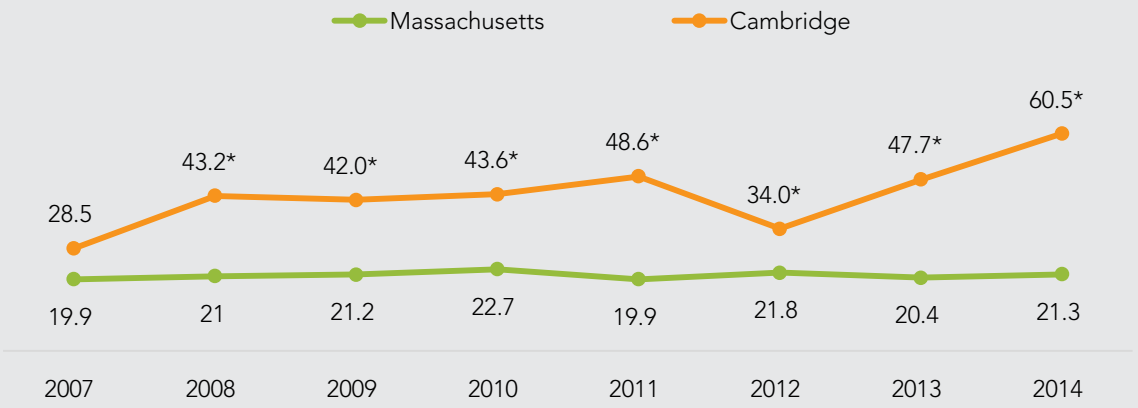


DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2007-2014.

NOTE: Asterisk (*) indicates that data are statistically significantly different from state data; Rates are age-adjusted per 100,000 population; An injury-related case is defined as having an ICD-9-CM diagnosis code of 800-909.2, 909.4, 909.9, 910-994.9, 995.5-995.59, 995.80-995.85. Cause and intent of injuries are defined by the first listed External-Cause-of-Injury code (E800 – E999).

From 2008 to 2014, the rates of bicyclist hospitalizations and emergency department visits due to motor vehicle incidents were significantly higher in Cambridge compared to Massachusetts, with a sharp increase since 2012 (**FIGURE 84**). The 2014 rate of these incidents in Cambridge (60.5 per 100,000 individuals) represents approximately 80 individual bicyclists.

FIGURE 84: Hospitalizations and Emergency Department Visits due to Bicyclists Injured in Motor Vehicle Traffic-Related Incidents per 100,000 Population, Cambridge and Massachusetts, 2007-2014

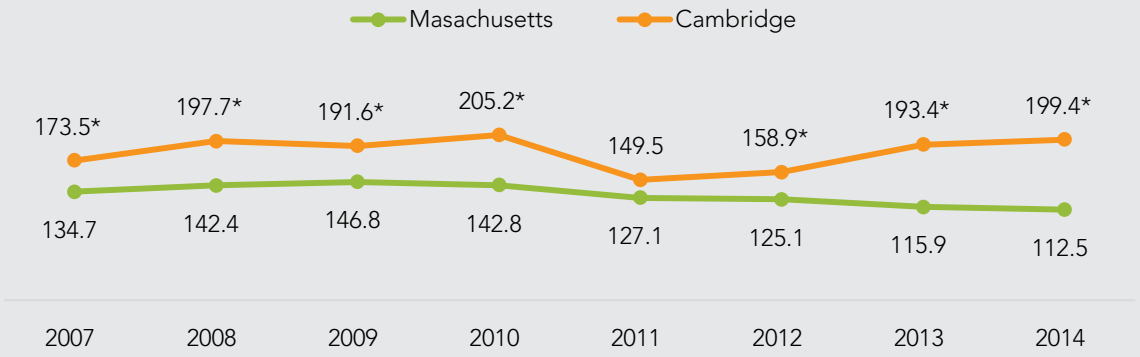


DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2007-2014.

NOTE: Asterisk (*) indicates that data are statistically significantly different than state data; Rates are age-adjusted per 100,000 population; An injury-related case is defined as having an ICD-9-CM diagnosis code of 800-909.2, 909.4, 909.9, 910-994.9, 995.5-995.59, 995.80-995.85. Cause and intent of injuries are defined by the first listed External-Cause-of-Injury code (E800 – E999).

From 2007 to 2014, the rates of bicyclist hospitalizations and emergency department visits due to non-traffic incidents remained significantly higher in Cambridge compared to Massachusetts (**FIGURE 85**). In Cambridge, the rate ranged from a low of 149.5 per 100,000 in 2011 to a high of 199.4 per 100,000 in 2014. In contrast, the rate in Massachusetts ranged from a low of 112.5 per 100,000 in 2014 to a high of 146.8 per 100,000 in 2009. Importantly, these rates are much higher than traffic-related incidents detailed above, indicating that bicyclist safety concerns are not solely related to vehicles and traffic.

FIGURE 85: Hospitalizations and Emergency Department Visits due to Bicyclists Injured in Non-Traffic-Related Incidents per 100,000 Population, Cambridge and Massachusetts, 2007-2014



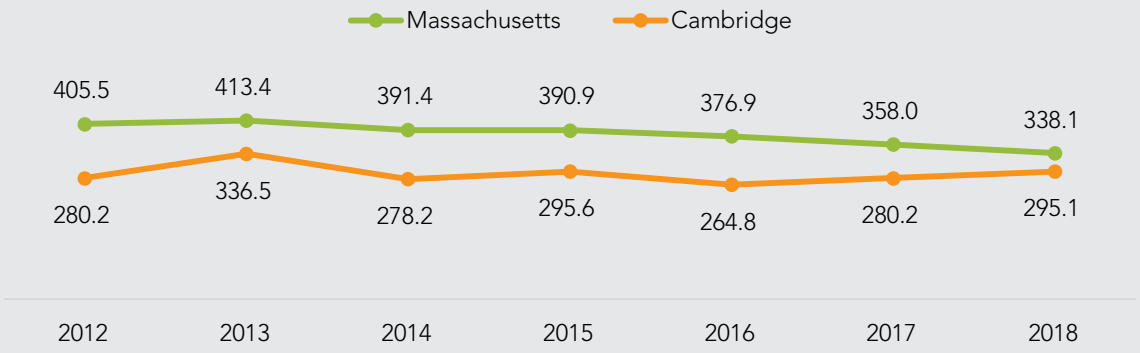
DATA SOURCE: Massachusetts Department of Public Health, Center for Health Information and Analysis (CHIA), 2007-2014.

NOTE: Asterisk (*) indicates that data was statistically significantly different than state data; Rates are age-adjusted per 100,000 population; An injury-related case is defined as having an ICD-9-CM diagnosis code of 800-909.2, 909.4, 909.9, 910-994.9, 995.5-995.59, 995.80-995.85. Cause and intent of injuries are defined by the first listed External-Cause-of-Injury code (E800 – E999).

Cambridge offers a nationally renowned and innovative Safety Net Collaborative, a partnership between the Cambridge Police Department and community partners. The Safety Net Collaborative provides physical health, mental health, and social services to youth and families in Cambridge with the goal of curtailing youth involvement in the juvenile justice system. Research studies have demonstrated that Safety Net has had a significant impact on juvenile arrests, recidivism, and service utilization and has improved youth outcomes. Additionally, the Cambridge Police Department founded the city's first Sexual Assault Response Team to review best practices and identify gaps in services to create a seamless process for survivors as they navigate their way through the criminal justice system.

The rate of violent crime in Massachusetts and Cambridge experienced a steady decline between 2012 and 2018, with the rate in Cambridge remaining consistently lower (**FIGURE 86**). In Massachusetts, the rate ranged from a high of 413.4 per 100,000 in 2013 to a low of 338.1 per 100,000 in 2018. In Cambridge, the rate ranged from a high of 336.5 per 100,000 in 2013 to a low of 264.8 per 100,000 in 2017.

FIGURE 86: Violent Crime Rate per 100,000 Population, Cambridge and Massachusetts, 2012-2017

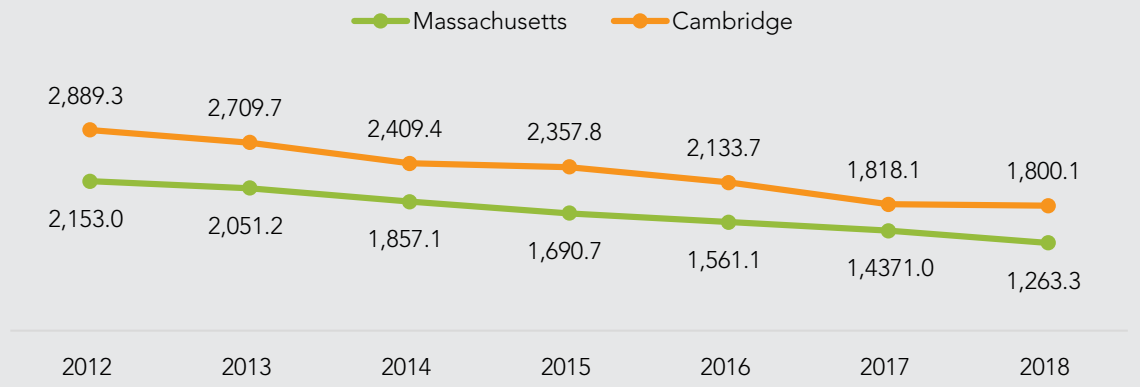


DATA SOURCE: Federal Bureau of Investigation, Uniform Crime Reports, Offenses Known to Law Enforcement, 2018.

NOTE: Data from this source may not completely match the data released annually by Cambridge Police Department due to the way reports are submitted to the state and FBI; Violent crime includes murder, rape (revised definition), robbery, and aggravated assault; Rate is per 100,000 population.

The rates of property crime in Massachusetts and Cambridge experienced a steady decline between 2012 and 2018, with the rate in Massachusetts remaining lower than the rate in Cambridge (**FIGURE 87**). In Massachusetts, the rate decreased from a high of 2,153.0 per 100,000 in 2012 to a low of 1,263.3 per 100,000 in 2018. Cambridge also experienced a steady decline from 2,889.3 per 100,000 in 2012 to 1,800.1 per 100,000 in 2018.

FIGURE 87: Property Crime Rate per 100,000 Population, Cambridge and Massachusetts, 2012-2017

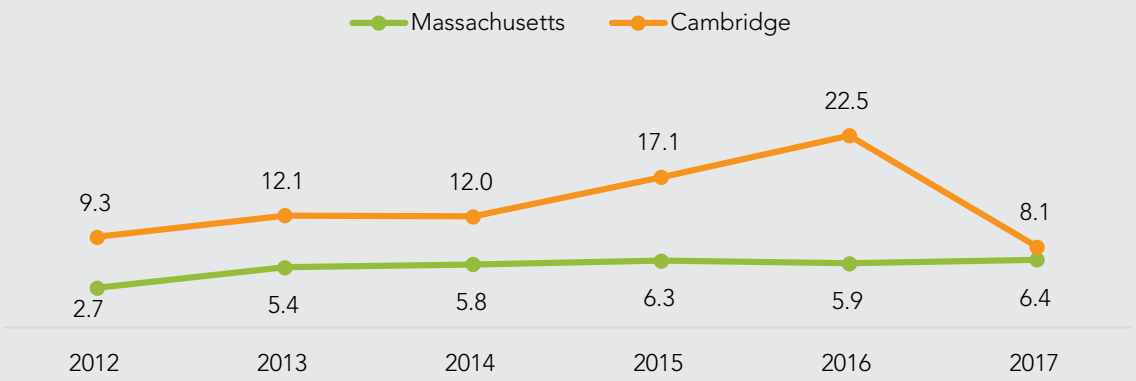


DATA SOURCE: Federal Bureau of Investigation, Uniform Crime Reports, Offenses Known to Law Enforcement, 2018.

NOTE: Data from this source may not completely match the data released annually by Cambridge Police Department due to the way reports are submitted to the state and FBI; Rate is per 100,000 population.

The rates of hate crimes in Massachusetts and Cambridge experienced a steady increase between 2012 and 2017, with the rate in Cambridge remaining consistently higher than the rate in Massachusetts (**FIGURE 88**). In Massachusetts, the rate ranged from a low of 2.7 per 100,000 in 2012 to a high of 6.4 per 100,000 in 2017. In Cambridge, the hate crime rate ranged from a low of 9.3 per 100,000 in 2012 to a high of 22.5 per 100,000 in 2016. According to data from the Federal Bureau of Investigation, the primary motivation for hate crimes in Massachusetts and Cambridge were race/ethnicity/ancestry, followed by religion, and sexual orientation.

FIGURE 88: Hate Crime Rate per 100,000 Population, Cambridge and Massachusetts, 2012-2017

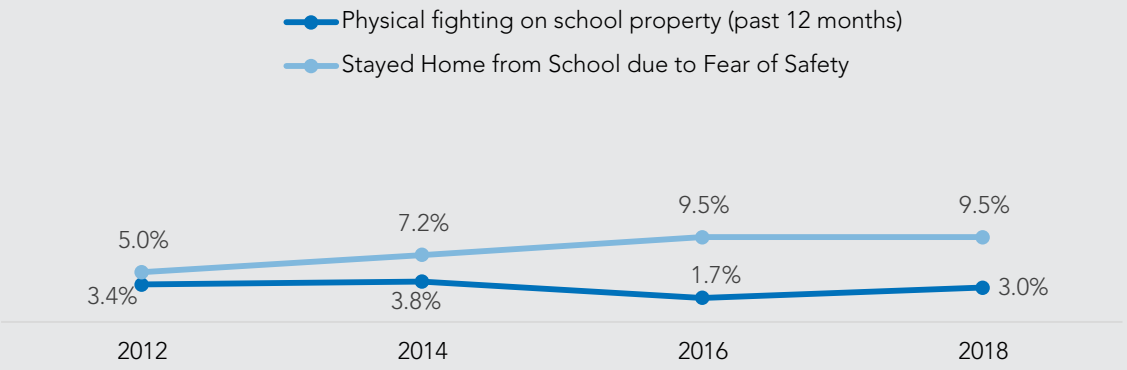


DATA SOURCE: Federal Bureau of Investigation, Uniform Crime Reports, Offenses Known to Law Enforcement, 2018.

NOTE: Data from this source may not completely match the data released annually by Cambridge Police Department due to the way reports are submitted to the state and FBI; Incidents may have more than one bias motivation; Rates for Cambridge should be interpreted with caution due to small sample size; in 2017, 9 incidents were reported in Cambridge; Rates are per 100,000 population.

Between 2012 and 2018, the proportion of high school students reporting violent behaviors remained relatively low, with fewer than 10 percent of students reporting physical fighting or staying home for fear of safety (**FIGURE 89**). However, from 2012 to 2018, the percentage of students reporting staying home from school due to fear of safety nearly doubled (5.0% vs. 9.5%, respectively).

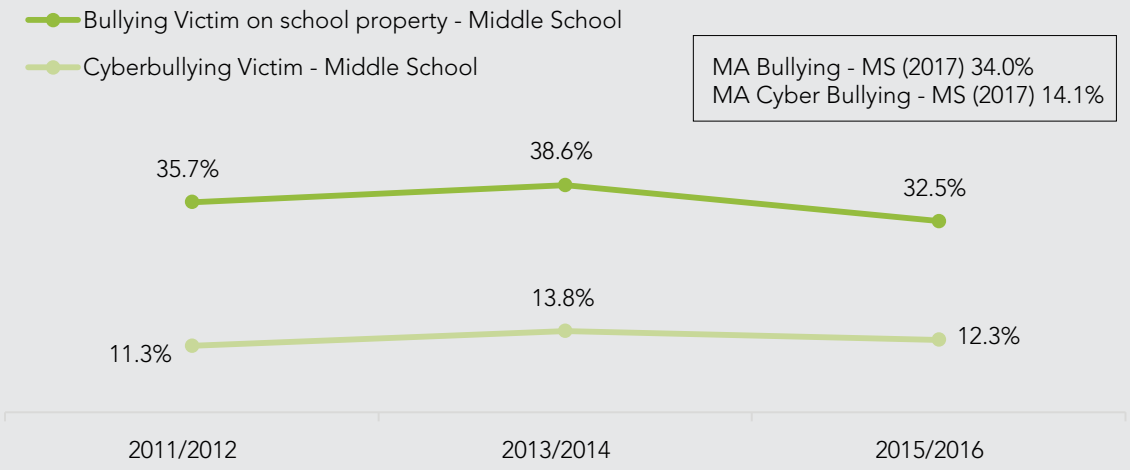
FIGURE 89: Percent of High School Students Reporting Violent Behaviors and Safety Concerns, Cambridge, 2012-2016



DATA SOURCE: Massachusetts Youth Health Surveys, 2015 & 2017; Cambridge Teen Health Survey, 2017-2018.

FIGURE 90 shows the percentage of Cambridge middle school students who reported being the victim of bullying (on school property and cyber bullying). Among middle school students, between 11.3% and 38.6% reported being the victim of bullying, with a larger proportion reporting being the victim of bullying while on school property.

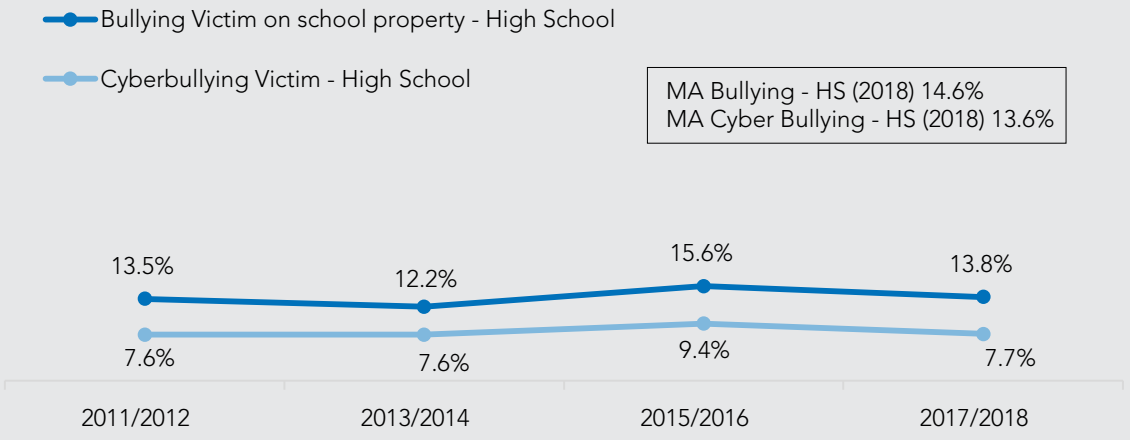
FIGURE 90: Percent of Middle School Students Reporting Bullying, Cambridge, 2012-2016



DATA SOURCE: Massachusetts Youth Health Surveys, 2015 & 2017; Cambridge Teen Health Survey, 2017-2018.

Among high school students (**FIGURE 91**), between 7.6% and 15.6% reported being the victim of bullying. Similar to middle school students, a larger proportion of high school students reported being the victim of bullying while on school property.

FIGURE 91: Percent of High School Students Reporting Bullying, Cambridge, 2012-2018



DATA SOURCE: Massachusetts Youth Health Surveys, 2015 & 2017; Cambridge Teen Health Survey, 2017-2018.

Concern for violence, safety, and injuries was also reflected in the 2018 Youth Voice Project, with two in five (40.3%) youth respondents identifying gun violence and more than one in four (28.0%) respondents identifying rape/sexual assault as top environmental health and violence and safety issues.

During Youth Voice Project focus groups, participants differed on their views of safety as it relates to bullying and sexual harassment. Some participants noted that while bullying and sexual harassment occur in schools, they feel school administrators do not take effective preventive action. *"Well, I think the real issue is that it needs to be stopped before, like instead of girls having to talk about their experiences, they should teach boys how to treat someone so that it is more preventative instead of helping them afterwards. This stops it before, and it's teaching them how to act."*

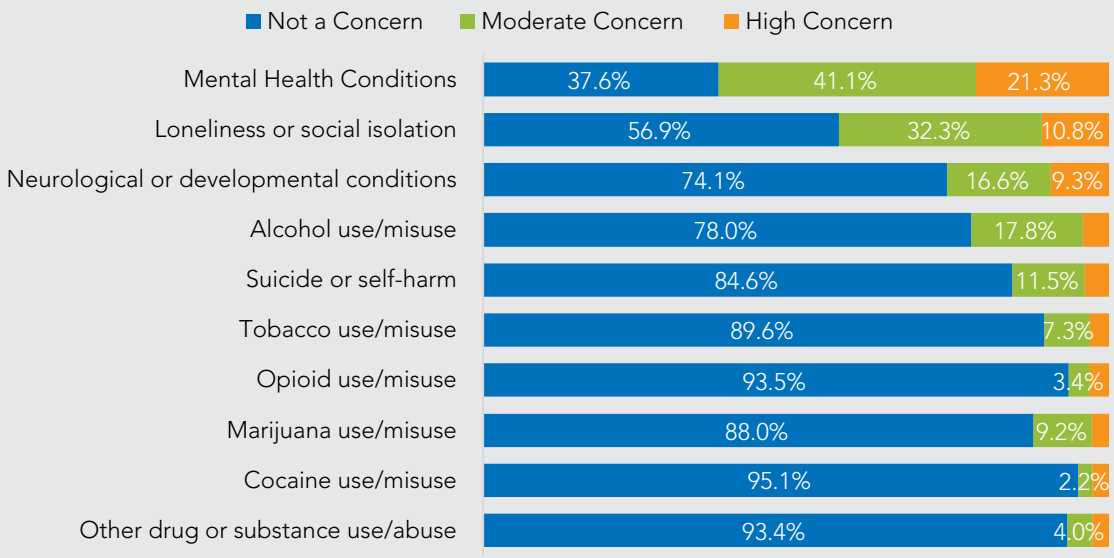
Other participants felt bullying is a way for some youth to relate to one another and is *"the way boys play around."* Regarding sexual harassment, some participants felt that *"some girls kind of like it."* Statements such as these highlight a need for more youth education around bullying and sexual harassment.

BEHAVIORAL HEALTH

Overall

FIGURE 92 shows survey respondents' personal level of concern for various behavioral health factors. Most survey respondents did not have a high degree of personal concern for the issues named in the survey. Respondents experienced the highest levels of concern for mental health conditions (e.g., depression, anxiety, bipolar disorder, etc.) (21.3%), loneliness or isolation (10.8%), and neurological or developmental conditions (e.g., ADD/ADHD, autism, etc.) (9.3%).

FIGURE 92: Survey Respondent Level of Concern for Behavioral Health Factors, Cambridge, 2019

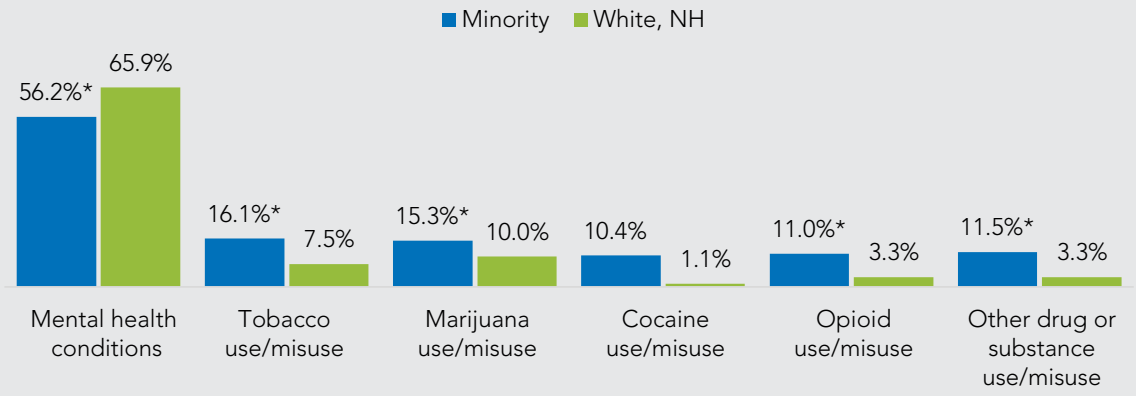


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II; Percentages <5% are not labeled within the bar chart.

FIGURE 93 shows the proportion of survey respondents who rated as moderate or high their personal concern for behavioral health factors, stratified by racial/ethnic minority status. Factors shown reflect a statistically significant difference. With the exception of mental health conditions, respondents who identified as a minority race/ethnicity were more likely to have moderate or high concern for the behavioral health issues in the survey. All other behavioral health factors were rated similarly by race/ethnicity (data not shown).

FIGURE 93: Survey Respondents Reporting Moderate or High Concern for Behavioral Health Factors, by Minority Status, Cambridge and Massachusetts, 2019



DATA SOURCE: Cambridge Health Community Survey, 2019.

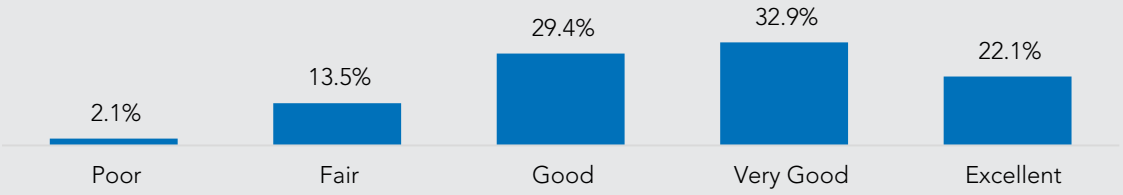
NOTE: Detailed data about the counts for each category can be found in Appendix II; "White, NH" represents persons who identified as White and non-Hispanic, while "Minority" represents persons who identified as any non-White category, and/or Hispanic; Asterisk (*) indicates a statistically significant difference P<0.01.

MENTAL HEALTH

Cambridge advances mental health and well-being through a range of supportive programs and prevention strategies. This includes an emphasis on social emotional learning at the Cambridge Public Schools; widespread training in Mental Health First Aid and Youth Mental Health First Aid; and police training on trauma-informed law enforcement. The city also has a Domestic and Gender-Based Violence Prevention Initiative and the Cambridge Community Response Network (CCRN) to help people identify resources to build resilience and better recover from a traumatic episode.

FIGURE 94 shows survey respondents' ratings of their own mental health. More than four out of five (84.4%) survey respondents rated their mental health as good or better, with over half of those respondents rating their mental health as either very good or excellent.

FIGURE 94: Survey Respondents' Mental Health Self-Rating, Cambridge, 2019

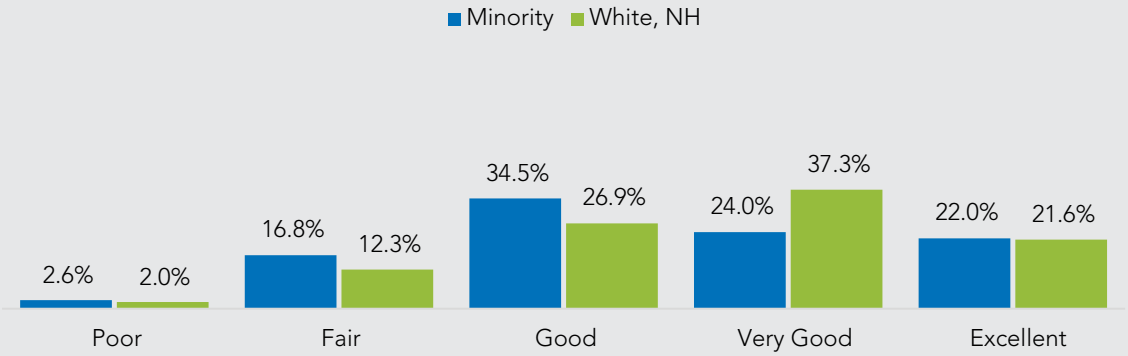


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II.

When self-ratings for mental health are stratified by racial/ethnic minority status, respondents who identified as a minority race/ethnicity generally rated their own mental health lower than White, non-Hispanic respondents. Though similar proportions of minority and White, non-Hispanic respondents reported their mental health as excellent, minority respondents were more likely to report their health as good or fair and less likely to report their physical health as very good (**FIGURE 95**).

FIGURE 95: Survey Respondents' Mental Health Self-Rating, by Minority Status, Cambridge, 2019

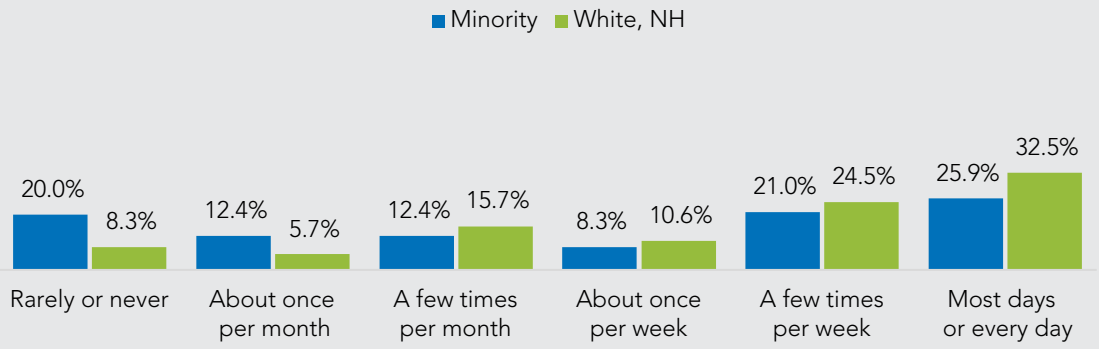


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II; "White, NH" represents persons who identified as White and non-Hispanic, while "Minority" represents persons who identified as any non-White category, and/or Hispanic.

To better understand the experience of isolation among Cambridge residents, survey respondents were asked to indicate the frequency of their interactions with their neighbors (**FIGURE 96**). Roughly two-thirds (66.5%) of respondents reported interacting with their neighbors at least once per week, but 11.4% of respondents reported interacting with their neighbors rarely or never. When data are stratified by racial/ethnic minority status, respondents who identify as a racial/ethnic minority were less likely to have frequent interactions with their neighbors and more likely to report interacting with their neighbors rarely or never compared to White, non-Hispanic respondents (20.0% vs. 8.3%, respectively).

FIGURE 96: Survey Respondents' Self-Reported Monthly Neighbor Interactions, by Minority Status, Cambridge, 2019

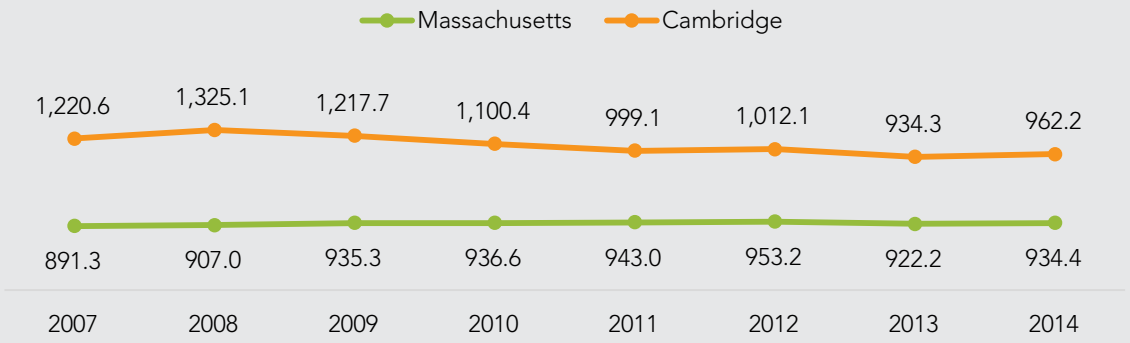


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II; "White, NH" represents persons who identified as White and non-Hispanic, while "Minority" represents persons who identified as any non-White category, and/or Hispanic.

Between 2007 to 2014, the rates of hospitalizations due to mental health conditions in Massachusetts and Cambridge remained relatively steady, though the rate in Massachusetts remained consistently lower than the rate in Cambridge. The rate of hospitalization in Massachusetts ranged from a high of 953.2 per 100,000 in 2012 to a low of 891.3 per 100,000 in 2007. The rate of hospitalization in Cambridge ranged from a high of 1,325.1 per 100,000 in 2008 to a low of 934.3 per 100,000 in 2013 (**FIGURE 97**).

FIGURE 97: Rate of Hospitalizations due to Mental Health Conditions per 100,000 Population, Cambridge and Massachusetts, 2007-2014

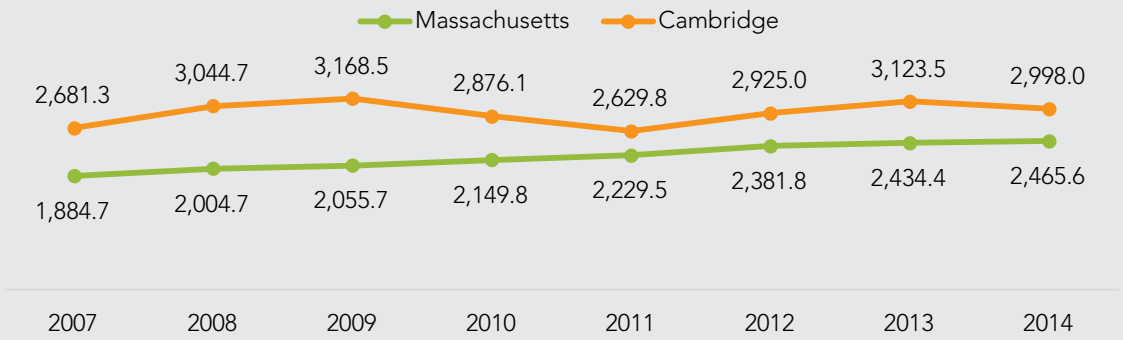


DATA SOURCE: Center for Health Information and Analysis (CHIA), 2007-2014.

NOTE: Each chronic disease indicator is calculated by analyzing the primary diagnosis code associated with the emergency department visit or hospitalization; The following ICD-9-CM diagnosis codes were used to identify Mental health: 290-319; Rate is per 100,000 population.

Between 2007 to 2014, the rate of emergency department visits due to mental health conditions remained lower in Massachusetts compared to Cambridge, though the rate in Massachusetts steadily increased during that period (**FIGURE 98**). The rate of emergency department visits in Cambridge fluctuated and ranged from a high of 3,168.5 per 100,000 in 2009 to a low of 2,629.8 per 100,000 in 2011. The rate of emergency department visits in Massachusetts increased from 1,884.7 per 100,000 in 2007 to 2,465.6 per 100,000 in 2014.

FIGURE 98: Rate of Emergency Department Visits due to Mental Health Conditions Per 100,000 Population, Cambridge and Massachusetts, 2019

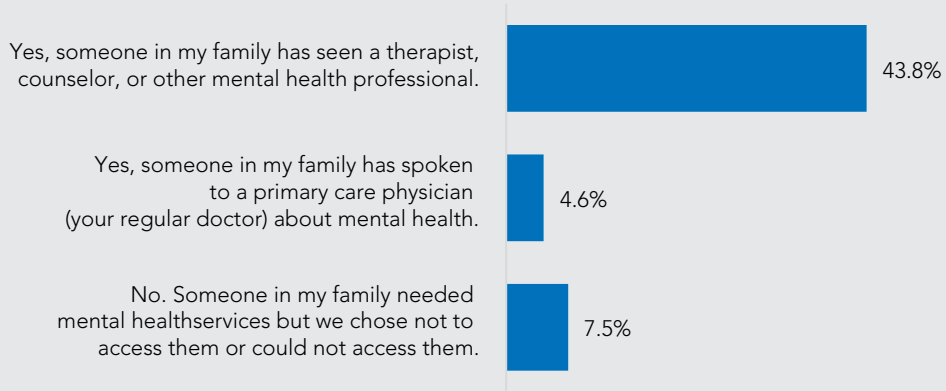


DATA SOURCE: Center for Health Information and Analysis (CHIA), 2007-2014.

NOTE: Each chronic disease indicator is calculated by analyzing the primary diagnosis code associated with the emergency department visit or hospitalization; The following ICD-9-CM diagnosis codes were used to identify Mental health: 290-319; Rates are per 100,000 population.

Among survey respondents, more than two in five (43.8%) indicated that someone in their family had accessed services from a mental health professional in the prior year, and an additional 4.6% of survey respondents indicated someone in their family had spoken to a primary care provider about their mental health. However, 7.5% of survey respondents indicated someone in their family needed mental health services in the prior year but had not accessed them. (**FIGURE 99**).

FIGURE 99: Survey Respondents' use of Mental Health Services in Past Year, Cambridge, 2019

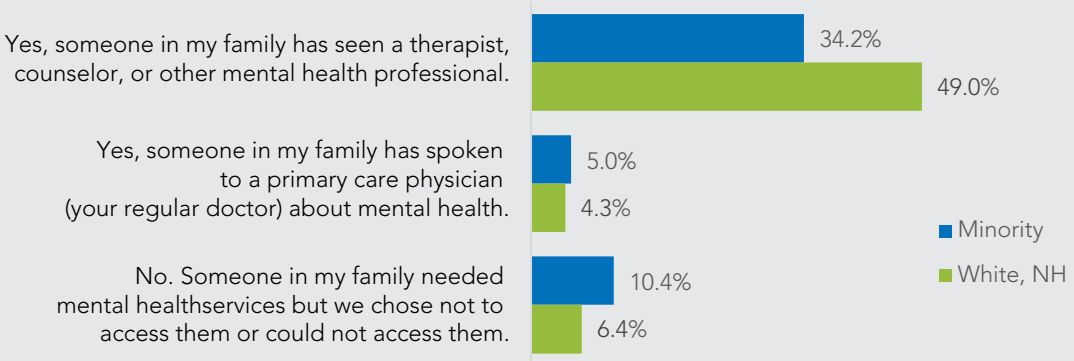


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II.

When need for and use of mental health services were stratified by racial/ethnic minority status, respondents who identified as a racial/ethnic minority were less likely to report accessing a mental health professional in the past year compared to White, non-Hispanic respondents (34.2% vs. 49.0%) (**FIGURE 100**). Similarly, respondents who identified as a racial/ethnic minority were more likely to report choosing not to access – or an inability to access – mental health services, despite having a need for the services compared to White, non-Hispanic respondents (10.4% vs. 6.4%).

FIGURE 100: Survey Respondents' use of Mental Health Services in Past Year, by Minority Status, Cambridge, 2019

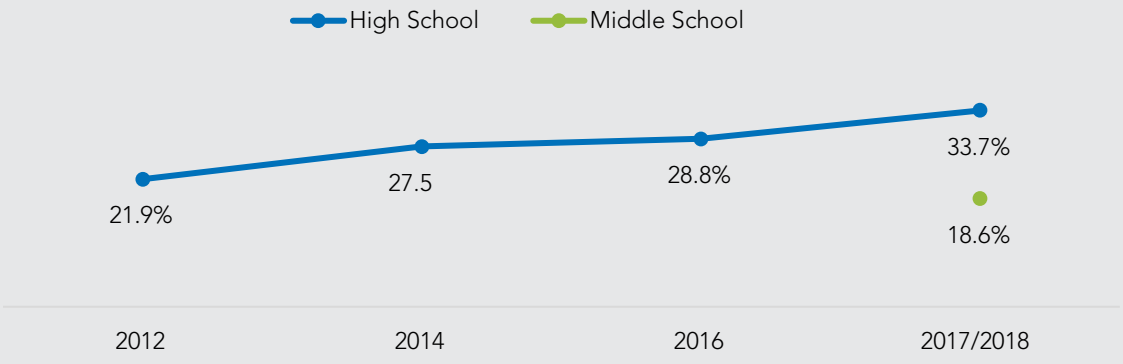


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II. "White, NH" represents persons who identified as White and non-Hispanic, while "Minority" represents persons who identified as any non-White category, and/or Hispanic.

The percentage of Cambridge high school students reporting symptoms of anxiety steadily increased from roughly one in five (21.9%) in 2012 to roughly one in three (33.7%) in 2018 (**FIGURE 101**). The question regarding anxiety symptoms was added to the Cambridge Middle Grades Health Survey in 2017. Results from this single year of data suggest that nearly 20% of Cambridge middle school students experience symptoms of anxiety (**FIGURE 101**).

FIGURE 101: Percent of High School and Middle School Students Reporting Anxiety Symptoms in Past 30 Days, Cambridge, 2012-2018

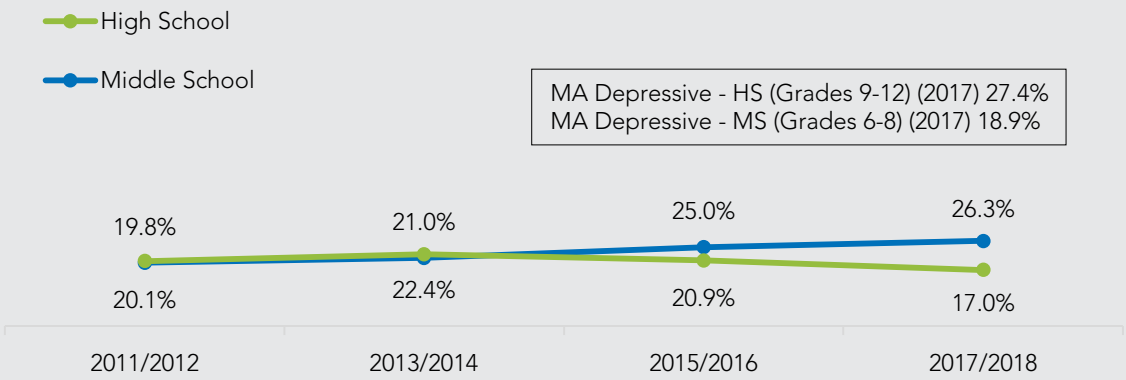


DATA SOURCE: Cambridge Middle Grades Health Survey, 2016-2017; Cambridge Teen Health Survey, 2017-2018.

NOTE: Anxiety symptoms defined as feeling tense, nervous or worried every day for two or more weeks in a row in the past 30 days; survey question asks, "During the past 30 days, did you feel tense, nervous, or worried every day for two or more weeks in a row?"

Between 2011 and 2018, the percentages of Cambridge middle and high school students reporting depressive symptoms remained similar to the percentage of Massachusetts students. However, the percentage of Cambridge middle school students reporting depressive symptoms decreased slightly, while the percentage of Cambridge high school students reporting depressive symptoms increased during the time period (**FIGURE 102**).

FIGURE 102: Percent of High School and Middle School Students Reporting Depressive Symptoms in Past 12 Months, Cambridge, 2012-2018

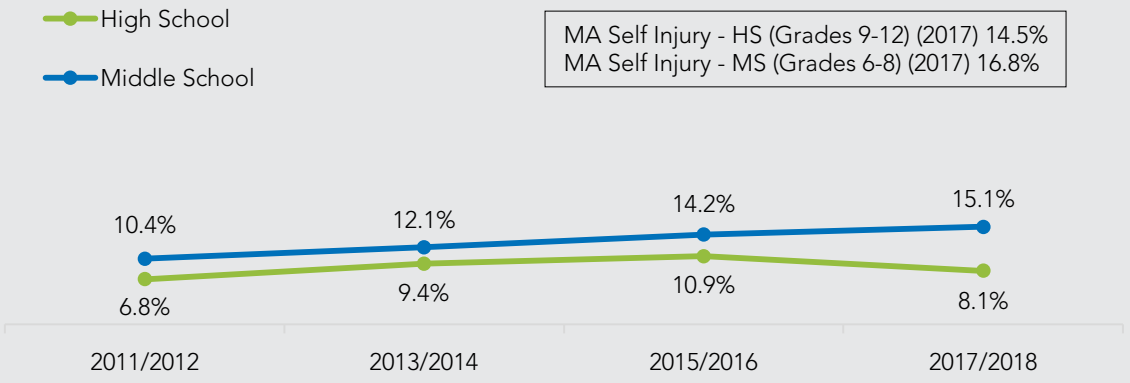


DATA SOURCE: Cambridge Middle School Health Survey, 2016-2017; Cambridge Teen Health Survey, 2017-2018; MA Youth Health Survey 2017.

NOTE: Depressive symptoms defined as feeling so sad or hopeless almost every day for two or more weeks in a row that respondent stopped doing some usual activities in last 12 months; survey question asks "During the past 12 months, did you ever feel so sad or hopeless almost every day for two or more weeks in a row that you stopped doing some usual activities?"

Between 2011 and 2018, the percentage of Cambridge high school students reporting self-injury behaviors steadily increased from 10.4% in 2011/2012 to 15.1% in 2017/2018 (**FIGURE 103**), though the rate is similar to Massachusetts in 2017 (14.5%). Between 2011 and 2018, the percentage of Cambridge middle school students reporting self-injury behaviors fluctuated from a low of 6.8% in 2011/2012 to a high of 10.9% in 2015/2016 (**FIGURE 103**). However, the proportion among Cambridge middle school students reporting self-injury behaviors is less than half the rate of Massachusetts middle school students in 2017 (16.8%).

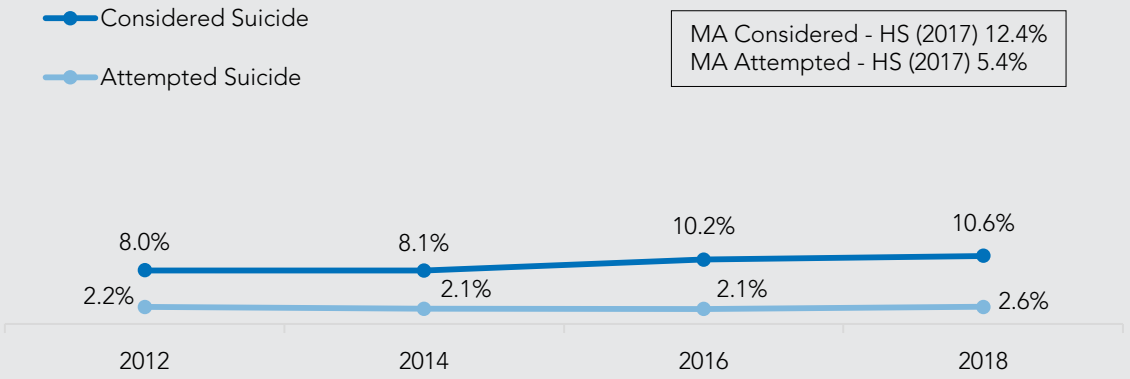
FIGURE 103: Percent of High School and Middle School Students Reporting Self-Injury Behaviors in Past 12 Months, Cambridge, 2012-2018



DATA SOURCE: Cambridge Middle Grades Health Survey, 2016-2017; Cambridge Teen Health Survey, 2017-2018; MA Youth Health Survey 2017.

Between 2012 to 2018, the percentage of Cambridge high school students who considered or attempted suicide remained consistently lower than for Massachusetts (data for all years not shown), though in Cambridge the proportions for those who considered and those who attempted suicide increased slightly during the time period (**FIGURE 104**).

FIGURE 104: Percent of High School Students Reporting Suicidal Ideation or Attempts in Past Year, Cambridge, 2012-2018



DATA SOURCE: Cambridge Teen Health Survey, 2017-2018; MA Youth Health Survey 2017.

Focus group participants discussed mental health in detail, noting the impact that social factors have on mental health. For example, one youth participant noted that their lack of stable housing directly impacts their mental health saying, *"It makes mental health more of an issue. It's an insult, my mental health only gets worked up when I'm upset."* Other participants mentioned that immigration status also impacts mental health. One individual stated, *"Immigration status affects deeply [sic] people's health and life. Depression, anxiety, and mental health – all of that. They are afraid to ask for help, afraid to go to the doctor, afraid that ICE will get them and send them back home."* Several participants, particularly in the Black/African American community, discussed the role of stigma in seeking help to address mental health. "A lot of communities have mental illness that is not recognized, [it is] not talked about, not a lot of places for them to go."

Similar sentiments were expressed in the Community Health Network Area 17's 2017 Mental Health and Racial Equity report. The report explored the connections between mental health and racial/ethnic identity among the American-born Black residents in six Massachusetts communities: Arlington, Belmont, Cambridge, Somerville, Waltham, and Watertown. Among American-born Black Cambridge residents, barriers such as a lack of resources and differences in familial or cultural values were named as reasons why many do not or cannot seek mental health care. Another common barrier was fear, particularly around the language used to describe mental health (e.g., *"having problems," "a struggle,"* or being labeled *"crazy"*). For example, one resident noted that, *"People are afraid of the word 'mental health,' so people don't get help. It has a negative connotation."* Another barrier was the complexity of the health care system, including insurance and payment schemes as well as a lack of timeliness. One resident said, *"I don't know what's out there. Even when I went to my PCP, I would've had to do the work myself to go find somebody. My PCP would just give me a list of providers at Mass General – but not narrowed down. [It] takes time and resources to narrow it down."*

Additionally, residents interviewed for the report acknowledged that both pride and stigma are associated with mental illness treatment in the American-born Black community. For example, one resident who spoke about their personal connection to the topic said, *"I think I was prideful…to an extent. Seeking mental health seemed like a sign of weakness, and I felt I was strong enough to work through my issues."* Community members also felt that there is a shortage of African American/Black mental health professionals. This was seen as problematic because many participants desired a provider who they felt would better relate to their cultural experiences. For example, when describing their own experiences seeking treatment, one resident said, *"I wanted a Black therapist who maybe could identify with me a little more better [sic] or whatever. But you know, I think they didn't have that."*

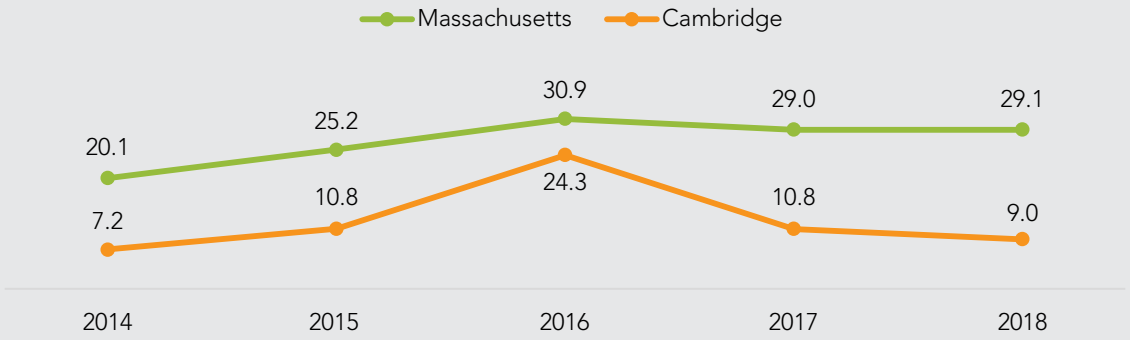
SUBSTANCE USE

The Cambridge Public Health Department partners with city agencies and community organizations to change social norms around drug and alcohol use in the community, including alcohol and drug use prevention among youth. Substance use prevention is taught in the Cambridge Public Schools' health curriculum, and school staff conduct substance use screening focused on prevention, early detection, risk assessment, counseling, and referral for treatment. Additionally, the Substance Use Advisory Committee was formed in 2019 to implement recommendations from the City Manager's Opioid Working Group. The Opioid Working Group, composed of the city's first responders, public health, and other community representatives, was formed to strengthen Cambridge's response to the opioid crisis.

Between 2014 to 2018, mortality due to opioid-related overdoses appeared to increase at the state level, ranging from a low of 20.1 per 100,000 in 2014 to a high of 30.9 per 100,000 in 2016, then slowly decreasing in the two years after (**FIGURE 105**). Similarly, the opioid-related mortality rate for Cambridge residents appears to have peaked in 2016 as well, with a more notable decline in 2017 and 2018. According to preliminary police data for 2019, as of November 2019, there were 15 fatal opioid-related overdoses in Cambridge (including both residents and non-residents), which is suggestive of further declines in opioid-related mortality among Cambridge residents in 2019 (data not shown).

One factor that may account for some of the decline in opioid-related deaths, in Massachusetts and Cambridge, is the broader availability of naloxone, a drug that reverses the effects of an opioid overdose when administered in a timely manner. The majority of naloxone administrations are done by bystanders or friends and loved ones of the overdose victim.

FIGURE 105: Estimated* Mortality Rate due to Opioid-Related Overdose per 100,000 Population, Cambridge and Massachusetts, 2014-2018



DATA SOURCE: Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2019.

*NOTE: *Rates are calculated by HRiA based upon ACS total population estimates for 2013-2017 and should be considered as unofficial estimates only; 2017 and 2018 death data are preliminary and subject to updates; Rate is per 100,000 population.*

Additional data related to the occurrence of opioid related overdoses (including fatal and non-fatal) were available from Professional Ambulance Service (Pro EMS), the sole ambulance provider in Cambridge. Pro EMS records all pick-up calls in an incident log. Suspected opioid-related overdose incidents are reported to the Cambridge Public Health Department. The health department uses a machine learning algorithm to classify EMS incidents based on the incidents' narrative text, and an epidemiologist verifies incidents that are not conclusively labeled.

Data for 2019 showed that the Harvard and Central Square areas had the highest density of opioid-related overdoses; however, ambulance pick-ups occurred in every Cambridge neighborhood. Of the 131 opioid-related overdoses recorded by Pro EMS in 2019, 75.6% occurred in a public place, such as on the street, in a public building or park, at a business, or on the Massachusetts Bay Transit Authority (MBTA) system. This represents a large increase since 2016, when 52% of all pick-ups were from a public location. This is also considerably higher than the average in Middlesex County, where an estimated 30% of individuals who fatally overdosed in 2018 were in a public place.

Cambridge residents accounted for 59.5% of opioid-related ambulance pick-ups in 2019, an increase from 44% in 2017. When the data were examined by race/ethnicity, the number of opioid-related ambulance calls increased over prior years among Black/African American individuals in Cambridge and decreased in all other race/ethnicity groups.

TABLE 8: Opioid-Related Ambulance Calls in Cambridge, by Race/Ethnicity, 2017-2019

RACE/ETHNICITY	2017	2018	2019
Asian	0%	0.6%	0.8%
Black or African American	5.8%	9.6%	15.3%

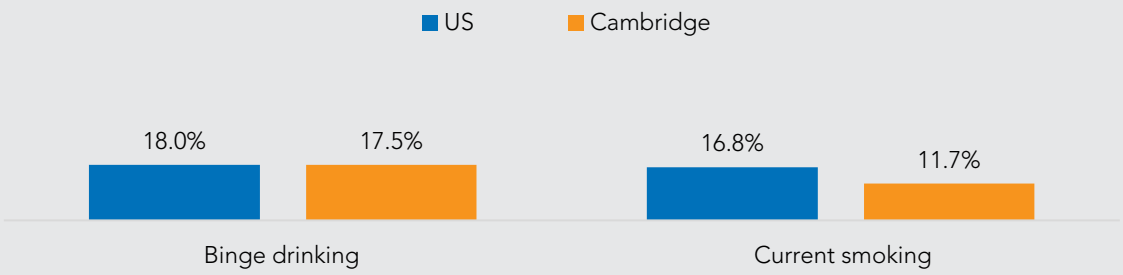
White	70.3%	69.9%	68.7%
Other (includes Latino)	13.0%	13.3%	12.2%
Unknown	10.9%	6.6%	3.1%

Data Source: Pro EMS, 2017-2019.

Note: Race and ethnicity of individuals is determined and reported by Pro EMS staff.

Data on personal use of substances among adults are sparse, particularly for illicit or prescription drug use. **FIGURE 106** shows the proportion of Cambridge and United States adults reporting current smoking and binge drinking in 2016. Roughly one in 10 (11.7%) Cambridge adults reported smoking in the past 30 days compared to roughly one in six (16.8%) adults nationally. Similar proportions of adults in Cambridge and the United States reported binge drinking in the past 30 days (17.5% vs. 18.0%, respectively).

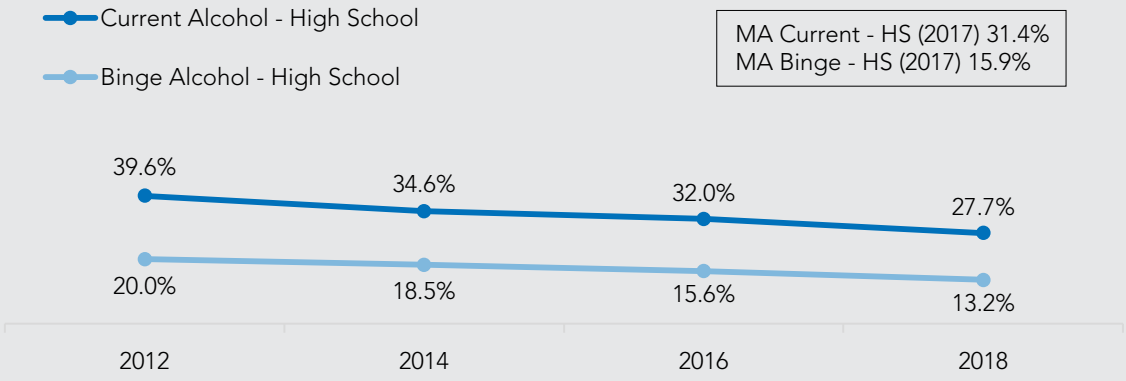
FIGURE 106: Percent of Adults Reporting Substance use in Past 30 Days, Cambridge and US, 2016



DATA SOURCE: Centers for Disease Control and Prevention, Division of Population Health, 500 Cities Project Data, 2016.

A more complete portrait of substance use is available for youth in Cambridge. From 2011 to 2018, the percentage of Cambridge high school students who reported alcohol use steadily decreased (**FIGURE 107**). The proportion of students reporting current alcohol use decreased from 39.6% in 2011/2012 to 27.7% in 2017/2018. Similarly, the proportion of students reporting binge drinking decreased from 20.0% in 2011/2012 to 13.2% in 2017/2018. Both proportions were either similar to – or lower than – Massachusetts.

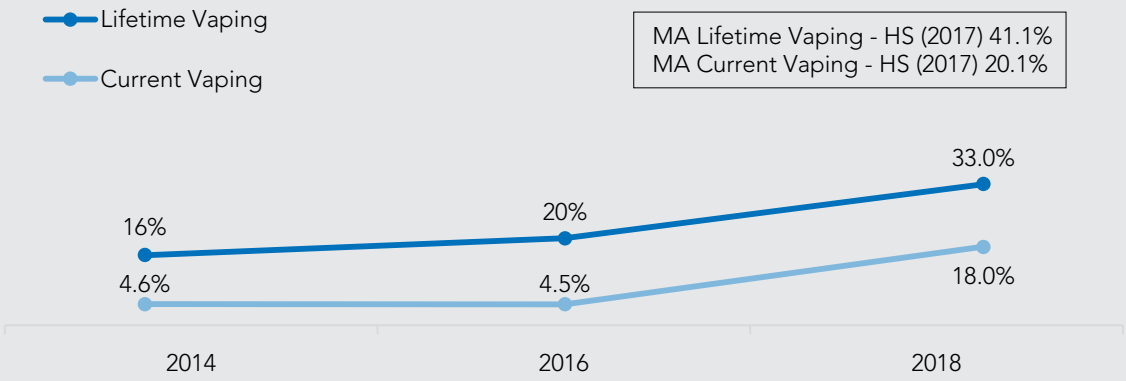
FIGURE 107: Percent of High School Students Reporting Alcohol Use, Cambridge, 2011-2018



DATA SOURCE: Cambridge Teen Health Survey, 2017-2018; MA Youth Health Survey 2017.

From 2014 to 2018, the proportion of Cambridge high school students reporting e-cigarette use/vaping more than doubled, though proportions remained consistently lower than those among Massachusetts students (**FIGURE 108**). In 2018, roughly one in three (33.0%) high school students reported e-cigarette use at some point, while roughly one in five (18.0%) reported current e-cigarette use.

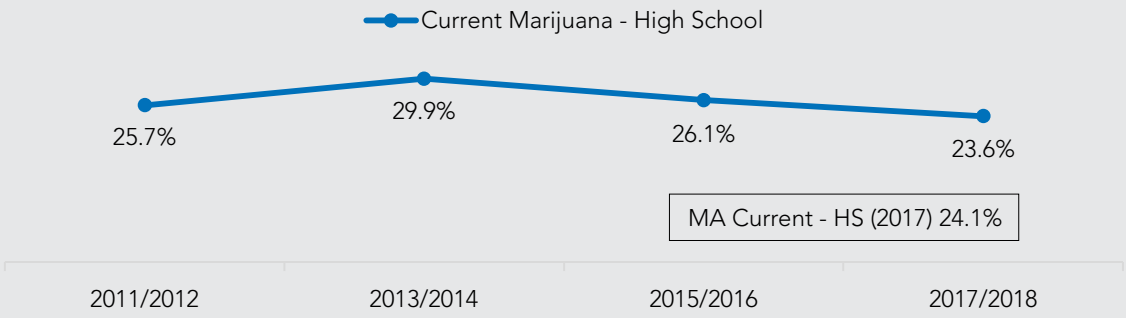
FIGURE 108: Percent of High School Students Reporting E-Cigarette Use, Cambridge, 2014-2018



DATA SOURCE: Cambridge Teen Health Survey, 2017-2018; MA Youth Health Survey 2017.

From 2011 to 2018, the proportion of Cambridge high school students reporting current marijuana use remained relatively steady (**FIGURE 109**), with about one in four students reporting current use between 2011 and 2018. This figure was on par with the proportion of Massachusetts high school students reporting marijuana use in 2017, which was 24.1%.

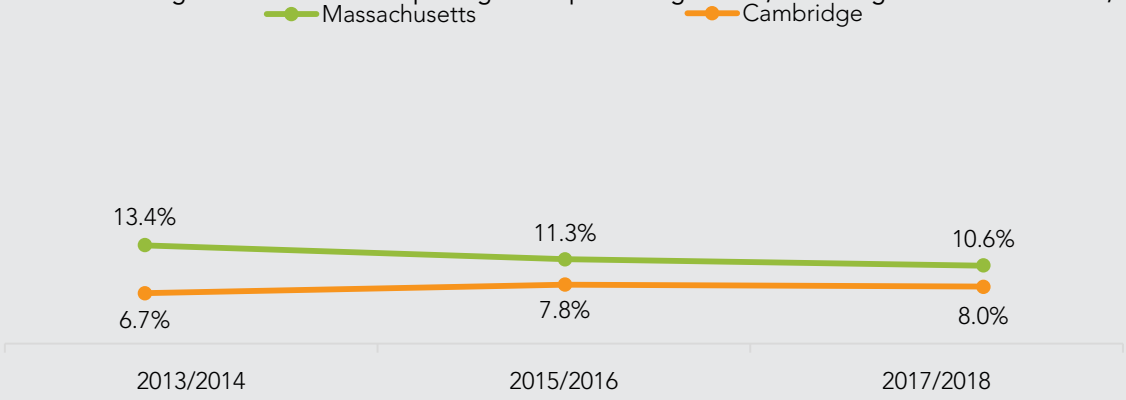
FIGURE 109: Percent of High School Students Reporting Current Marijuana Use, Cambridge, 2012-2018



DATA SOURCE: Cambridge Teen Health Survey, 2017-2018; MA Youth Health Survey 2017.

FIGURE 110 shows that from 2013 to 2018, the proportion of Massachusetts high school students reporting prescription drug misuse remained higher than for Cambridge high school students, though the percentage in Massachusetts decreased from 13.4% to 10.6%. Conversely, the proportion of Cambridge high school students reporting misuse increased slightly from 6.7% to 8.0% during the same period.

FIGURE 110: Percent of High School Students Reporting Prescription Drug Misuse, Cambridge and Massachusetts, 2013-2018



DATA SOURCE: Cambridge Teen Health Survey, 2017-2018; MA Youth Health Survey 2017.

Focus group participants discussed the topic of substance use in less depth than mental health overall. Speaking generally about substance use, one participant said, *"Substance use is a problem. It impacts decision making and having self-awareness or confidence in oneself. It slowly destroys it, and the abuse gets worse."* However, conversations related to substance use typically centered around smoking – both legalized marijuana and cigarettes. Specifically, these conversations revealed the concern that participants had for the smell of marijuana and cigarettes in their homes and in local parks. One participant said, *"Drugs and smoking – it's not good for our health in the community when they smoke next to your house."* Another participant noted, *"Here we don't have any safe place. People smoke marijuana in the park around kids. When you walk around, there is smoke. Even in your backyard you can't let your kids play by themselves…people are in your backyard smoking marijuana."*

In the 2018 Youth Voice Project, mental health conditions were named as one of the three most important physical and behavioral health aspects, with nearly two in five survey respondents (38.4%) indicating it was a concern. Concern for mental

health conditions were also reflected in the youth focus groups, with mental health emerging as a theme in all four groups. Some participants noted that programs are not well publicized and carry a stigma. For example, one youth participant said, *"I wouldn't go to [the Teen Health Center] because I might feel embarrassed. I feel like maybe if they outreach to you, that might be better."*

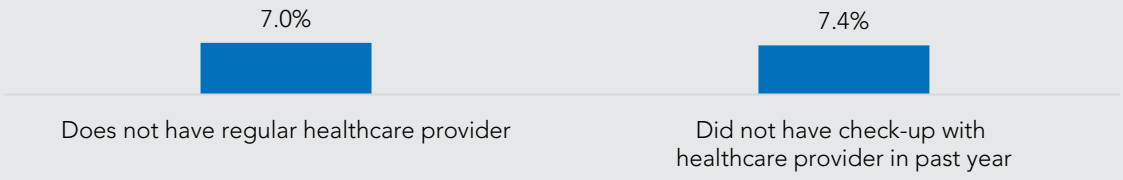
Additionally, participants mentioned that some students prefer speaking with friends/peers about mental health rather than adults due to a lack of trust and the perception that adults will apply a universal model to all youth seeking treatment rather than an individualized plan. For example, one participant said, *"…they think [mental health is] all the same, so they try to handle it all the same way,"* while another said, *"I feel like you should speak to someone who knows you because anyone can give like a standard, basic feedback, but if someone actually knows you, they can give you advice for things that actually appl[y] to you."* Regarding the lack of trust between adults and youth, one participant said, *"I have heard of kids who have gone to their guidance counselor and word gets out to deans or other administration. So instead of the guidance counselor helping out, it gets bad for the student."*

In addition to mental health, behavioral health emerged as a theme in three of the four groups conducted. Some participants viewed substance use among certain peers as a brief phase triggered by peer pressure or a desire to try drugs, while other participants perceived substance use among their peers to be a coping mechanism for mental health issues. As one participant said, *"I've seen a lot of kids and students at this school take drugs like Xanax and opioids and stuff … a lot of those kids are well known to be depressed, some kids like smoke cigarettes or marijuana or Juul."* Additionally, participants perceived drug use to be quite frequent in their schools, though it is often unaddressed by school officials. *"Well, a lot of the kids at my school vape, like some of the teachers know about it and don't do anything, but a lot of the teachers are oblivious to it."* Regarding e-cigarette use, participants expressed concern for their peers due to the health risks as well as the risk of students graduating to other substances. One participant said, *"[Juuling] is literally everywhere, and I don't want to be that snitch or whatever, I know a lot of my friends do it, but it's really bad. It's like a trend I guess, but there are so many big health risks associated with that, but it's out of control."* Another noted that their friend started smoking e-cigarettes, then began smoking cigarettes, *"so it was worse to have them in the first place."*

ACCESS TO HEALTH CARE

Most survey respondents reported having a connection to a regular health care provider, while fewer than one in 10 survey respondents indicated they (and their family) do not have a regular health care provider (7.0%). Similarly, most respondents reported accessing a health care provider within the past year for a check-up, while only 7.4% of respondents reported that they personally had not accessed a health care provider within the past year for a check-up (**FIGURE 111**). It is important to note that these data reflect the income and education levels of the survey population, which tended to include more respondents with higher income and education levels than the broader population of Cambridge residents (**TABLE 1**).

FIGURE 111: Survey Respondents' Connection to Health Care, Cambridge, 2019

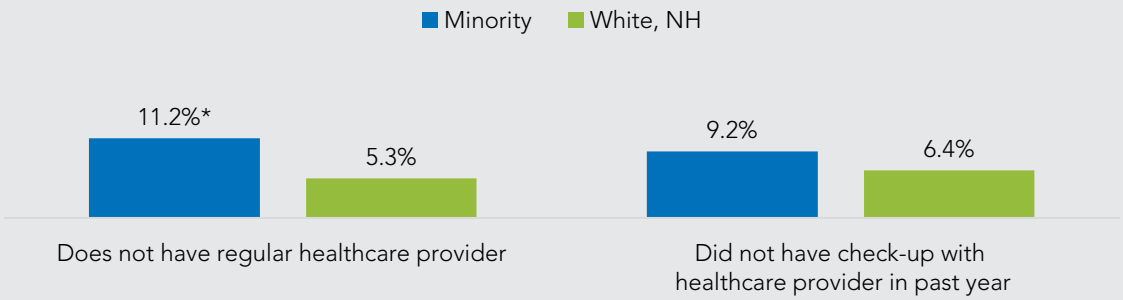


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II.

When stratified by racial/ethnic minority status, minority respondents were less likely to be connected to health care compared to White, non-Hispanic survey respondents. Specifically, roughly one in 10 minority respondents reported not having a regular health care provider (11.2%) and not accessing a health care provider within the past year for a check-up (9.2%) (**FIGURE 112**).

FIGURE 112: Survey Respondents' Connection to Health Care, by Minority Status, Cambridge, 2019

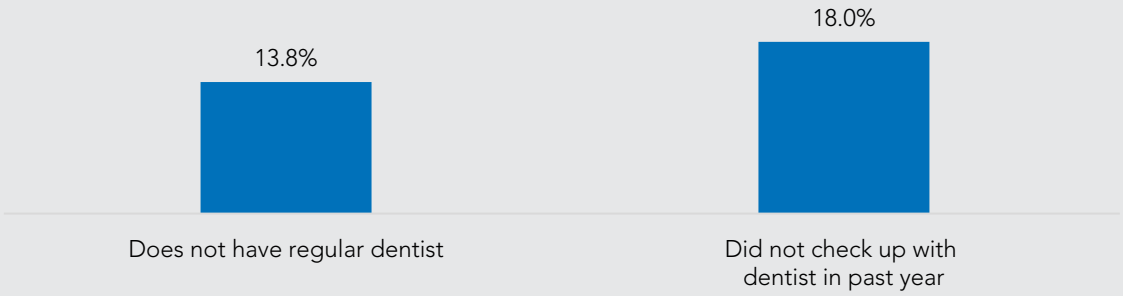


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II; Asterisk (*) indicates a statistically significant difference P<0.01.

Though many survey respondents indicated that they and their families had a regular dental care provider and had visited a dental care provider in the past year, some respondents did not share in this experience. More than one in 10 (13.8%) survey respondents did not have access to a regular dental care provider, and nearly one in five (18.0%) had not accessed a dental care provider within the past year for a check-up (**FIGURE 113**).

FIGURE 113: Survey Respondents' Connection to Dental Care, Cambridge, 2019

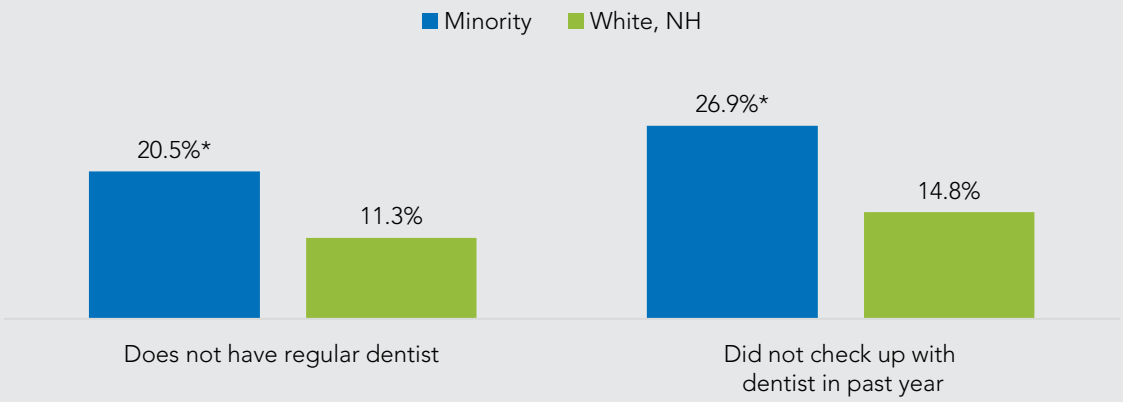


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II.

When stratified by racial/ethnic minority status, minority respondents were less likely to be connected to dental care compared to White, non-Hispanic survey respondents (**FIGURE 114**). Specifically, one in five (20.5%) minority respondents reported not having a regular dental care provider compared to about one in 10 (11.3%) White, non-Hispanic respondents. Similarly, roughly one in four (26.9%) minority respondents reported not accessing a dental care provider within the past year for a check-up, compared to about one in seven (14.8%) White, non-Hispanic respondents.

FIGURE 114: Survey Respondents' Connection to Dental Care, by Minority Status, Cambridge, 2019

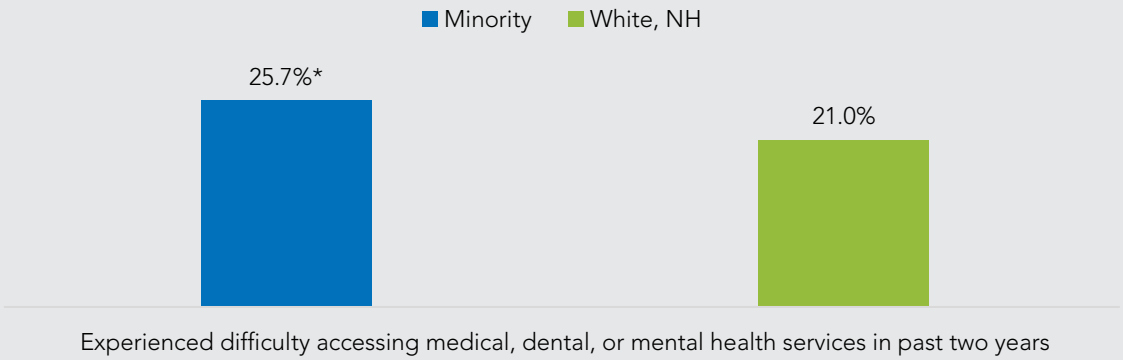


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II; Asterisk (*) indicates a statistically significant difference P<0.01.

Overall, nearly four in five survey respondents (78.5%) reported experiencing no barriers to accessing medical, dental, or mental health services in the prior two years. The remaining 21.5% of respondents reported they had experienced some type of barrier to accessing health care services. **FIGURE 115** shows the percentage of survey respondents who reported experiencing any difficulty accessing services in the prior two years, stratified by racial/ethnic minority status. Respondents who identified as a minority race/ethnicity were significantly more likely to report difficulties accessing services when compared to White, non-Hispanic respondents (25.7% vs. 21.0%, respectively).

FIGURE 115: Survey Respondents' Experiencing any Difficulty Accessing Health Services, by Minority Status, Cambridge, 2019

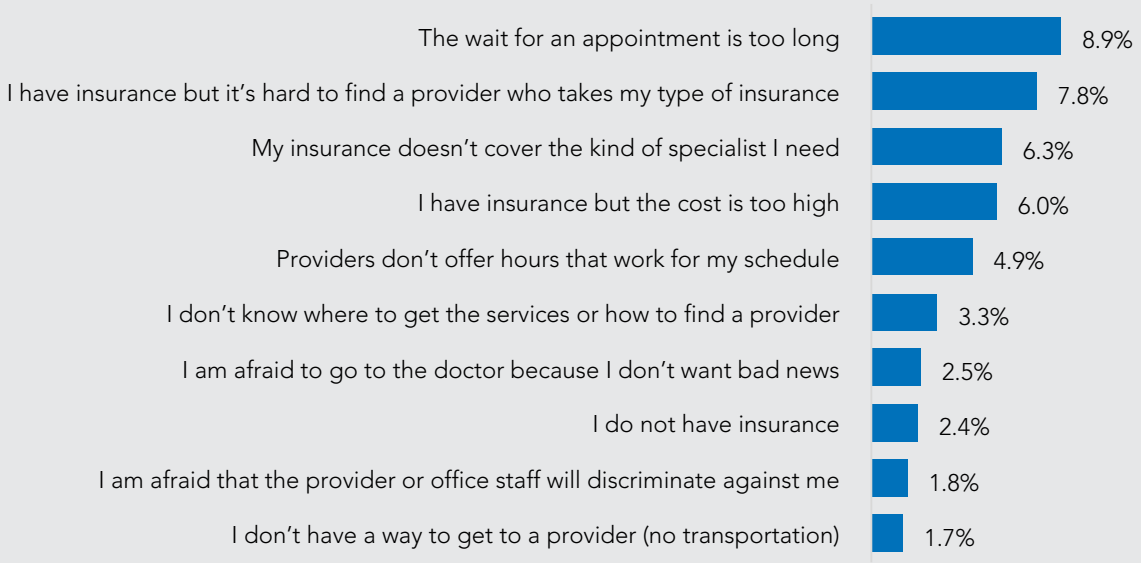


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II; Asterisk (*) indicates a statistically significant difference P<0.01.

Survey respondents were asked to indicate which barriers they had experienced when attempting to access medical, dental, or mental health care services. The most frequently identified barriers to care were long wait times (8.9%) and various insurance challenges, such as providers not taking one's insurance (7.8%) and insurance not covering specialty care (6.3%) (**FIGURE 116**).

FIGURE 116: Survey Respondents' Barriers to Health Care Access, Cambridge, 2019

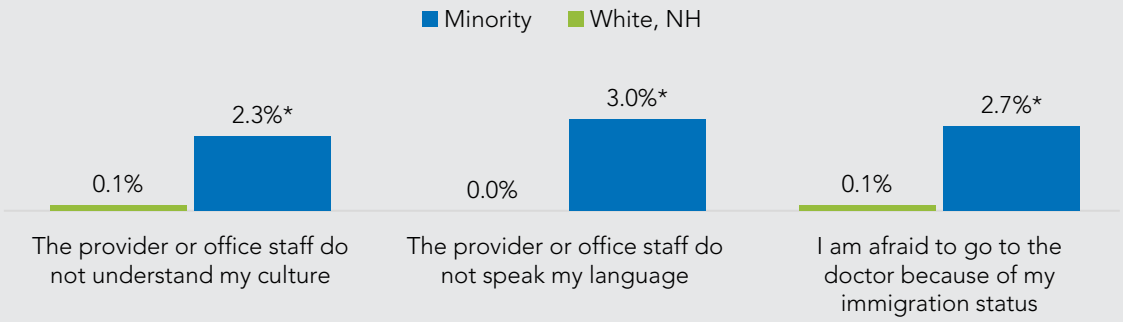


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II; Respondents could check multiple options; therefore, values may sum greater than 100%.

Several barriers to health care access were only reported among survey respondents who identified as a racial/ethnic minority (**FIGURE 117**). Specifically, these survey respondents were significantly more likely to report barriers related to cultural understanding (2.3%), language concordance (3.0%), and immigration status (2.7%) compared to White, non-Hispanic respondents.

FIGURE 117: Survey Respondents' Barriers to Health Services, by Minority Status, Cambridge, 2019

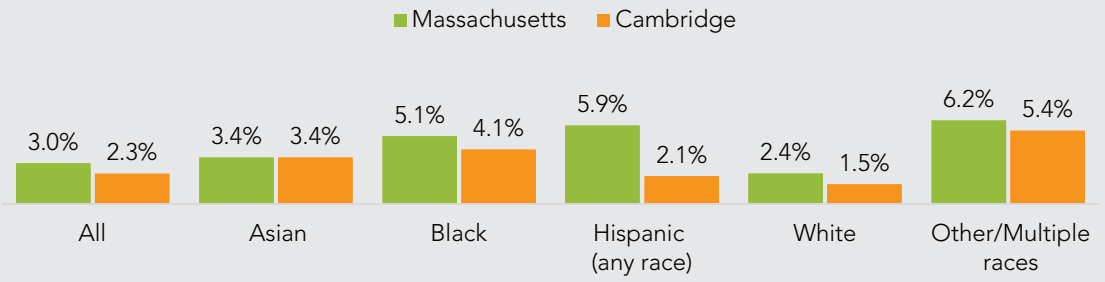


DATA SOURCE: Cambridge Health Community Survey, 2019.

NOTE: Detailed data about the counts for each category can be found in Appendix II; Asterisk (*) indicates a statistically significant difference P<0.01.

The percentage of uninsured residents in Massachusetts and Cambridge was low in 2013 and 2017, with fewer than one in 30 residents reporting being uninsured (3.0% vs. 2.3%, respectively) (**FIGURE 118**). When data were stratified by race/ethnicity, the proportions of uninsured residents differed, with non-White populations having slightly higher percentages of uninsured residents. However, the proportion of Cambridge residents who were uninsured remained equal or less than those in Massachusetts, regardless of race/ethnicity.

FIGURE 118: Percent of Population Uninsured, by Race/Ethnicity, Cambridge and Massachusetts, 2013-2017



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2013-2017.

NOTE: Other includes American Indian and Alaska Native, non-Hispanic; Native Hawaiian and Other Pacific Islander, non-Hispanic; Other race, non-Hispanic; and Two or more races, non-Hispanic.

Focus group participants discussed health care in terms of affordability and access, particularly the lack of access to dental/oral health services. As one participant noted, *"Dental is important because infections can affect the heart. I am surprised why insurers don't cover it. It's health."* Participants also expressed concern for the limitations of the health care system to meet needs for more complex conditions and underserved populations (e.g., LGBTQ+ patients). Regarding complex conditions, one participant said, *"MassHealth only covers basic stuff. As soon as you are diagnosed with a complex disease, they say you are not covered, and you need to pay for longer term treatment – most impacted people [are people] with not enough money."* Another participant said, *"It's expensive to have a disability. My health coverage doesn't cover anything for my service dog. It's expensive."* When discussing care for underserved populations, another participant described the stress they feel during doctor visits due to the fear that the provider/office staff will not understand their identity: *"Going to the doctor is always stressful because I have to remind people of the pronouns I use and how I identify. I would say that is a barrier because I have to educate people every time."*

While youth are not typically viewed as a population experiencing concerns related to health care access, data from the 2018 Youth Voice Project show that about one in three respondents (31.3%) named cost of health insurance as one of the top concerns related to access to health care and social factors.

VISION FOR THE FUTURE

The resident focus group discussions concluded with a question about the future of Cambridge. Participants were asked to imagine Cambridge in three to five years and describe their vision of a healthier city. Participants described the changes they would like to see as well as the resources that would make the biggest impact on the lives of residents in the area. Participants acknowledged that Cambridge currently offers a multitude of community resources for housing, economic opportunities, family assistance, and more. However, when describing their overall vision for the city, participants also expressed a desire for more resources to support the changing needs of residents. For example, some residents noted that while there are good programs for youth, involvement is low because the youth are not sufficiently engaged. One resident said, *"Teenagers don't like boring programs. They need some excitement to pull them in. It's not that the programs are not excellent."* Another participant suggested that youth-related resources, *"Connect [programs] to popular culture so they end up learning as they enjoy what they already do."*

Residents also described a vision for a healthy Cambridge as one that fully incorporates aspects of equity and equality. For example, one resident envisioned a Cambridge where resources are creatively deployed, *"rather than just having a table at an event,"* to reach populations that are not being served due to stigma, for example, non-White members of the LGBTQ+ community. Others envisioned a Cambridge with more gender-neutral bathrooms and bathroom signage that creates a more inclusive atmosphere. As one participant said, *"it's the little things that make a difference."*

After discussing their general vision, participants' comments often centered around the following categories: housing and homelessness, healthy eating and active living, and access to medical and dental services.

When discussing a vision for housing in Cambridge, participants frequently noted the elimination of waiting lists and more affordable housing. However, the discussion often shifted to a more disheartened description of housing in Cambridge and the fears of Cambridge becoming *"a mini New York."* One resident said, *"I think in five years we will have less low-income families able to live here. All those new buildings going in are not for low-income families."* Conversations around homelessness included a future Cambridge with more shelters, limits on rental increases, and storage space specifically for homeless persons to reduce theft and stress. As one participant said, *"I wish there was a place we could store our stuff where we would have 24-hour access to it. So, I can have what I need. Pushing and pulling stuff puts a high toll on my body, and the stress triggers health issues. Carrying my stuff around all day in the heat isn't good. I sit down and fall asleep, then I get arrested for loitering. Vicious cycle. It's exhausting."* Another participant experiencing homelessness added that they would like a *"secure place to house medication."* Similar to conversations around housing, the discussion on homelessness also shifted, with participants reflecting on their fears and frustrations. Participants noted that issues such as being arrested for sleeping on the streets, discrimination against people in recovery, and discrimination against people with developmental disabilities can be an ongoing source of stress for individuals struggling to find housing.

When discussing healthy eating and active living, participants envisioned a Cambridge with an increased number of places for residents to maintain community gardens and increased access to foods that reflect their dietary restrictions. In focus groups conducted with immigrant participants, several individuals noted the challenges that Muslim women face when trying to remain healthy. Specifically, the concept of modesty in Islam prohibits using facilities such as pools simultaneously with men, making it difficult for many Muslim women to remain physically active year-round. One participant said, *"I would like to be a woman who can use a pool. Because of my religion I cannot go to the pool."* Other participants said that some women might want a pool exclusively for women because, *"they might feel more comfortable."* In the focus group conducted with American-born Black residents, participants noted that some of the difficulties of maintaining a healthy diet included concerns about the environment and how *"the foods [they] get are not local; they are stored and transported from a distance."* Another participant noted that there was a need *"to educate [themselves] and make a change,"* particularly around food products that *"contribute to disease like cancer."*

When discussing access to medical and dental services, participants mentioned a desire for access to a variety of services, including affordable medications, an eye center, better dental coverage/care, and increased cultural competency for underserved populations. Specific to cultural competency, participants noted that it was not just important for providers to be comfortable treating LGBTQ+ patients but to be trained in a standard form of care for these patients, especially before placing a rainbow sticker in their medical office (signifying a welcoming space for LGBTQ+ patients). In addition to LGBTQ+ patients, focus group participants described the difficulties of navigating the health care system, especially for those who do not speak English. One resident said, *"It would be really great if Cambridge could push for access for folks who may feel like they have no way of advocating for themselves in a system that is set up so that the doctor is always right."*

CONCLUSIONS

The 2019 Cambridge Community Health Assessment represents the second such assessment undertaken on behalf of the Cambridge Public Health Department, with the first assessment conducted in 2014. The current assessment includes a comprehensive review of existing data, a community survey distributed in nine languages, and six focus group discussions held with a variety of underserved community members. This report of findings provides a detailed overview of the socioeconomic context and health-related needs of Cambridge residents, including populations that are typically underrepresented. Overarching themes that emerged from the synthesis of findings include the following:

Housing and economic vulnerability pose a substantial challenge for many Cambridge residents. The high cost of housing and limited availability of affordable options strain families. Cambridge residents had higher median monthly housing costs compared to Massachusetts residents, with Cambridge homeowners with a mortgage having the highest monthly housing costs. Additionally, income and opportunity disparities for some population groups persist, with Black/African American households in Cambridge earning the lowest median household incomes compared to other racial/ethnic groups. Food access is also a concern among households in Cambridge, with about one in 20 survey respondents reporting some form of food insecurity in the past year.

Chronic disease continues to be a leading physical health issue in Cambridge, with other health conditions also becoming more notable. The leading causes of mortality among Cambridge residents were "lifestyle" and aging-related conditions such as heart disease, diabetes, and high blood pressure. Additionally, sexually transmitted infections appear to be a growing issue that many residents may not be aware of. While sexually transmitted infections were a concern for less than 3% of survey respondents, crude rates of gonorrhea and syphilis in Cambridge appear to show an upward trend in recent years. Environmental health was a broad category of concern, and Cambridge residents expressed an increasing level of awareness and concern for issues ranging from food safety to climate change. However, with limited data in many areas, it is challenging to fully determine specific health-related impacts of the environment and understand the full magnitude of these issues at this time.

Safety and injury persisted as a major issue within the community. Pedestrian and bicycle safety, in particular, were perceived to be high or moderate concerns for more than two in three Cambridge residents. Though pedestrian-related crashes remained relatively constant from 2009 to 2018, and bicycle crashes have decreased in recent years, nine pedestrians have been killed, and over half of these fatalities have occurred since 2016. Motor vehicle-only crashes remained the most frequently occurring type of crash, though they have also decreased since 2015. Additionally, violence continued to be a general concern among Cambridge residents, with more than half of survey respondents noting personal concern with safety in public spaces (52.6%), gun violence (35.1%), and sexual assault/harassment (24.7%). Youth focus group participants of the Youth Voice Project also identified gun violence and sexual assault as concerns. Data from the Federal Bureau of Investigation noted that the primary motivations for hate crimes in Massachusetts and Cambridge, which increased from 2012 to 2016, were race/ethnicity/ancestry, followed by religion and sexual orientation, suggesting that intimidation and harassment are significant experiences for many Cambridge populations.

Mental health was a significant concern among Cambridge residents with extensive data supporting the need for services. Rates of hospitalizations and emergency department visits due to mental health conditions have remained consistently higher in Cambridge compared to Massachusetts. Self-report data suggest that mental health conditions, such as depression, anxiety, and stress, are experienced by adults and youth alike. In particular, Cambridge high school students experienced an increase in anxiety symptoms, depressive symptoms, and self-injury behaviors from 2012 to 2018. Social determinants of health, particularly housing and economic vulnerabilities, were viewed as key factors in poor mental health outcomes among residents.

Substance use disorder remained a leading concern among residents, though it was secondary to mental health. Though opioid mortality has plateaued within the state, and youth substance use disorder overall has declined, there are limited data available to establish a comprehensive picture of substance use and misuse among Cambridge adults. The legalization of marijuana was a notable concern of Cambridge residents, particularly because of its use in proximity to parks and playgrounds. Additionally, vaping among youth is an emerging concern, particularly with its recent connection to severe lung damage. Self-report data among teens suggest that the percentage of youth reporting e-cigarette use is increasing.

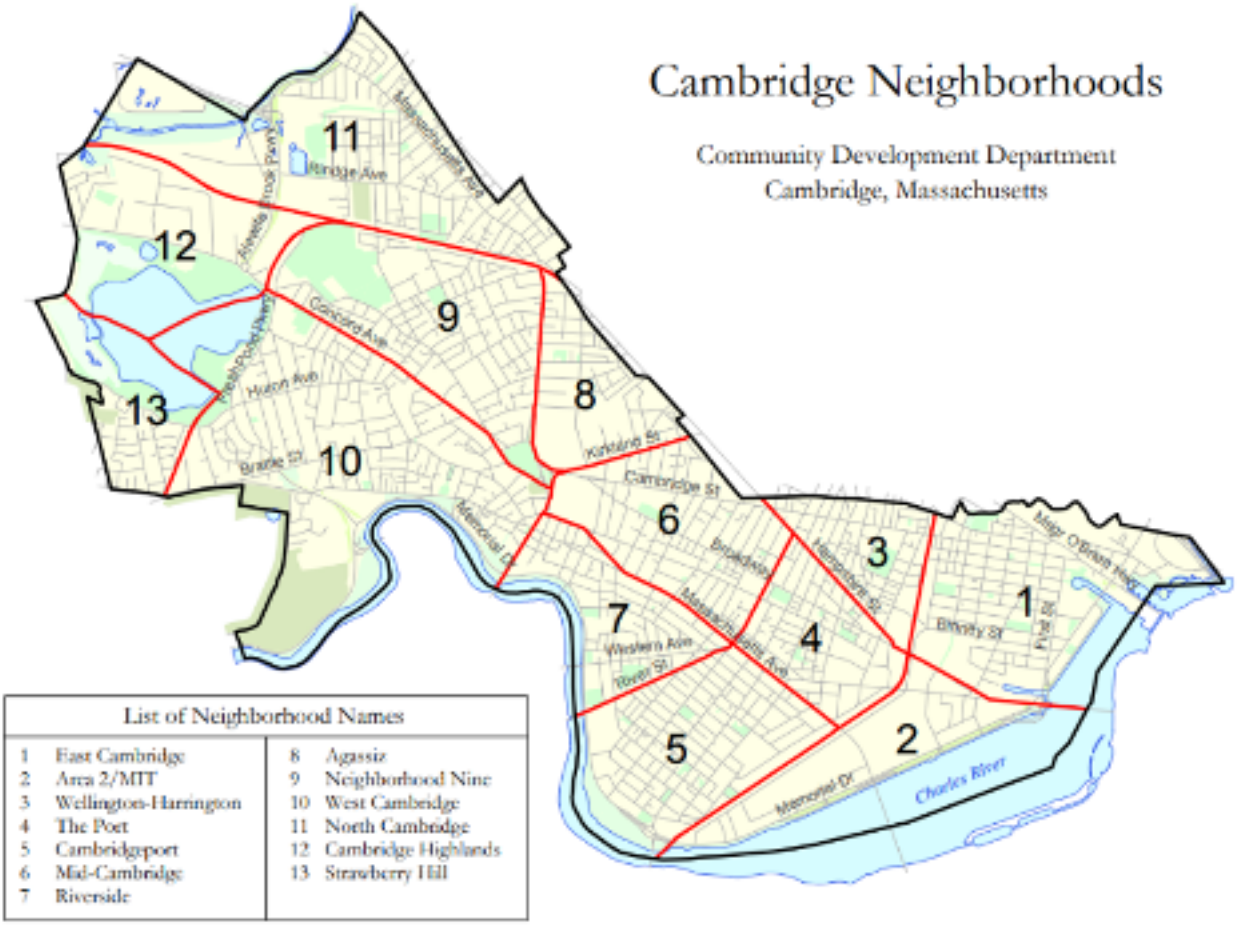
Access to health care arose as a major area of need, despite broad health insurance coverage and the high density of health care services in Cambridge. Limited access to dental care was consistently noted among Cambridge residents, particularly the high cost of care and limitations to dental coverage. Regarding the entire health care system, some groups noted concerns regarding their discomfort with providers and provider offices, ranging from cultural competence to knowledge about and respect for LGBTQ+ health needs.

The need for a more equitable and inclusive Cambridge was a consistent theme throughout the assessment. Reviews of existing data show that inequities are particularly prominent when data were stratified by racial/ethnic identity. When considering income and poverty, the median income of White households is more than three times the median household income of Black/African American households in Cambridge. As many as one in four non-White Cambridge residents live below the poverty line, whereas fewer than one in 10 White Cambridge residents live below the poverty line.

Proportions of overweight or obese Cambridge youth between kindergarten and eighth grade are nearly two times higher in Black/African American and Hispanic/Latinx children, when compared to proportions of White children. Among community survey respondents, individuals who identified as a racial/ethnic minority were more likely to experience a variety of adverse events at higher proportions, including challenges to food access, barriers to health and dental care services, and less frequent interactions with neighbors. Survey respondents who identified as a racial/ethnic minority were also more likely to rate their physical and mental health lower and to rate various factors such as affordable housing, childcare, employment opportunities, drug use, and discrimination as higher concerns when compared to respondents who identified as White, non-Hispanic. Similar sentiments were also reflected in the focus groups conducted as part of this assessment as well as those conducted through the Youth Voice Project. Participants in the assessment focus groups noted the inequities that exist in a host of social and economic factors (e.g., housing and access to health care) and how underserved populations routinely experience adverse effects due to the inequities that are perpetuated. Among youth participants, roughly one in four (25.1%) youth indicated that discrimination was one of the most important health aspects related to access to health care and social factors.

APPENDIX

I. MAP OF THE CITY OF CAMBRIDGE, MASSACHUSETTS



II. DETAILED SURVEY DATA IN TABLE FORMATS

A total of 1,129 Cambridge residents responded to the survey, with 864 (76.5%) responding online and 265 (23.5%) via hard copy. Stratified analyses were conducted for respondents comparing minority and White, non-Hispanic (White, NH) responses for the entire survey. Further stratified analyses were conducted for respondent concerns for various issues by selected age categories, gender, and housing status.

Survey Logistics

	All Respondents		Minority Status	
	n	%	Minority (%)	White, NH (%)
Language of Survey				
	N=1,129		N=306	N=742
English	1,048	92.8%	80.4%	98.5%
Spanish	8	0.7%	2.3%	0.0%
Portuguese	14	1.2%	1.0%	1.5%

Haitian Creole	17	1.5%	4.6%	0.0%
Amharic	11	1.0%	2.9%	0.0%
Mandarin	2	0.2%	0.7%	0.0%
Arabic	18	1.6%	4.6%	0.0%
Hindi	1	0.1%	0.3%	0.0%
Bengali	10	0.9%	3.3%	0.0%
Ways Respondents Heard About Survey				
	N=1,045		N=306	N=742
Email	450	43.1%	25.7%	51.3%
Social media (like Twitter or Facebook)	138	13.2%	6.6%	16.4%
Flyer or postcard	11	1.1%	1.4%	1.0%
Someone told me about it	98	9.4%	11.5%	8.2%
Other	348	33.3%	54.9%	23.2%

Minority Status

Minority Status	N=1,048	%
Minority	306	29.2%
White, NH	*742*	*70.8%*

NOTE: Minority includes "Asian, NH, Black or African American, NH, Hispanic, any race, Middle Eastern or North African, NH, Multiple Races, NH and Other, NH" race/ethnicities.

Demographics

	All Respondents		Minority Status	
	n	%	Minority (%)	White, NH (%)
Length of Residence in Cambridge				
	N=1,122		N=302	N=740
Less than one year	53	4.7%	6.3%	4.1%
At least 1 year but less than 5 years	157	14.0%	16.9%	12.4%
At least 5 years but less than 10 years	176	15.7%	19.5%	14.1%
At least 10 years but less than 15 years	127	11.3%	12.6%	10.5%
At least 15 years but less than 20 years	108	9.6%	9.6%	9.7%

	All Respondents		Minority Status	
	n	%	Minority (%)	White, NH (%)
20 years or more	501	44.7%	35.1%	49.2%
Neighborhood of Residence				
	N=1,101		N=293	N=733
East Cambridge	126	11.4%	13.3%	10.2%
Area 2/MIT	16	1.5%	4.4%	0.4%
Wellington-Harrington	53	4.8%	4.1%	4.9%
The Port	79	7.2%	8.5%	6.8%
Cambridgeport	137	12.4%	12.3%	12.8%
Mid-Cambridge	138	12.5%	11.3%	13.2%
Riverside	80	7.3%	9.9%	5.9%
Agassiz	36	3.3%	1.4%	3.7%
Neighborhood Nine	116	10.5%	3.8%	13.5%
West Cambridge	89	8.1%	6.1%	9.3%
North Cambridge	203	18.4%	20.8%	17.5%
Cambridge Highlands	10	0.9%	1.4%	0.4%
Strawberry Hill	15	1.4%	1.7%	1.4%
Not Sure or Do Not Know	3	0.3%	1.0%	0.0%
Age				
	N=1,073		N=297	N=737
Under 18 years old	4	0.4%	0.7%	0.3%
18-29 years old	105	9.8%	13.5%	8.7%
30-39 years old	186	17.3%	20.9%	16.0%
40-49 years old	189	17.6%	23.9%	14.8%
50-64 years old	251	23.4%	17.2%	26.2%
65-74 years old	202	18.8%	13.5%	20.6%
75+ years old	136	12.7%	10.4%	13.4%
Gender Identity				
	N=1,060		N=297	N=730
Female	789	74.4%	73.7%	75.5%
Male	256	24.2%	24.2%	23.4%
Non-binary	14	1.3%	1.7%	1.1%
Prefer to self-describe	1	0.1%	0.3%	0.0%

	All Respondents		Minority Status	
	n	%	Minority (%)	White, NH (%)
Transgender Identification				
	N=1,039		N=288	N=737
Yes	20	1.9%	2.4%	1.8%
No	1,039	98.1%	97.6%	98.2%
Sexual Orientation				
	N=1,001		N=269	N=707
Straight or heterosexual	871	87.0%	89.2%	85.9%
Lesbian, gay, or homosexual	58	5.8%	3.0%	7.1%
Bisexual	59	5.9%	6.0%	5.9%
Prefer to self-describe	13	1.3%	1.9%	1.1%
Hispanic, Latino, or Spanish origin				
	N=1,080		N=300	N=739
No, not of Hispanic, Latino, or Spanish origin	1,015	94.0%	78.3%	100.0%
Yes	65	6.0%	21.7%	0.0%
Race/Ethnicity				
	N=1,048			
Asian, NH	61	5.8%	-	-
Black or African American, NH	95	9.1%	-	-
Hispanic, any race	65	6.2%	-	-
Middle Eastern or North African, NH	26	2.5%	-	-
Multiple Races, NH	44	4.2%	-	-
Other, NH	15	1.4%	-	-
White, NH	742	70.8%	-	-
Total household income before taxes (past 12 months)				
	N=903		N=255	N=625
Less than $25,000	151	16.7%	31.0%	10.9%
$25,000 to $34,000	59	6.5%	10.6%	4.3%
$35,000 to $49,000	69	7.6%	10.2%	6.6%
$50,000 to $74,000	109	12.1%	15.3%	11.0%
$75,000 to $99,000	96	10.6%	7.8%	11.4%
$100,000 to $150,000	167	18.5%	11.0%	21.8%
$151,000 to $199,000	103	11.4%	6.7%	13.4%
$200,000 or more	149	16.5%	7.5%	20.6%

	All Respondents		Minority Status	
	n	%	Minority (%)	White, NH (%)
Language Spoken Most Often at Home				
	N=1,084		N=305	N=738
English	913	84.2%	55.7%	96.3%
Spanish	32	3.0%	9.8%	0.0%
Portuguese	14	1.3%	0.7%	0.0%
Amharic	11	1.0%	3.3%	0.0%
Arabic	22	2.0%	5.9%	1.6%
Haitian Creole	29	2.7%	8.9%	0.0%
Mandarin	6	0.6%	2.0%	0.0%
Other	57	5.3%	13.8%	2.0%
Highest Grade or Year Of School Completed				
	N=1,060		N=294	N=732
No schooling completed	13	1.2%	2.7%	0.7%
Grades 1-8	15	1.4%	3.4%	0.4%
Grades 9-11	16	1.5%	3.4%	0.8%
Grade 12 or GED	66	6.2%	14.3%	2.9%
College, 1 year to 3 years	93	8.8%	15.7%	5.5%
Associate's degree	25	2.4%	5.1%	1.2%
Bachelor's degree	268	25.3%	23.8%	26.5%
Master's degree	361	34.1%	20.1%	39.8%
Professional degree beyond a bachelor's degree	76	7.2%	4.1%	8.7%
Doctorate degree	127	12.0%	7.5%	13.5%
Employment Status**				
	N=1,061		N=293	N=732
Employed for wages	544	51.3%	51.9%	51.1%
Self-employed	120	11.3%	19.1%	28.1%
Unemployed	63	5.9%	7.9%	12.7%
Homemaker	63	5.9%	8.9%	5.1%
Student	56	5.3%	9.6%	4.5%
Retired	272	25.6%	8.5%	4.2%
Unable to work	43	4.1%	6.1%	3.1%
Other	35	3.3%	3.4%	3.4%

	All Respondents		Minority Status	
	n	%	Minority (%)	White, NH (%)
Business or Organization of Employment				
	N=816		N=208	N=582
Arts, entertainment, media	40	4.9%	2.9%	5.3%
Automobile maintenance and repair	3	0.4%	0.0%	0.5%
Biotechnology, pharmaceutical	30	3.7%	3.4%	3.8%
Construction and building trades	15	1.8%	4.3%	0.9%
Education	188	23.0%	19.7%	24.7%
Faith-based organizations	7	0.9%	1.4%	0.7%
Financial, accounting, insurance, real estate services	32	3.9%	3.9%	4.1%
Food Services	24	2.9%	7.2%	1.0%
Government	63	7.7%	9.6%	7.4%
Health care	89	10.9%	10.6%	10.8%
Legal services	21	2.6%	1.4%	2.8%
Manufacturing and industry	6	0.7%	0.5%	0.9%
Research and development	37	4.5%	3.9%	4.8%
Retail and wholesale	14	1.7%	1.9%	1.7%
Service occupation	14	1.7%	2.4%	1.6%
Sports and recreation	6	0.7%	0.5%	0.9%
Social and human services	53	6.5%	4.8%	7.0%
Technology, software, engineering, IT	70	8.6%	8.7%	8.6%
Transportation	5	0.6%	2.4%	0.0%
Utility, communication, internet company	6	0.7%	1.0%	0.5%
Other	93	11.4%	9.6%	12.0%

NOTE: Two asterisks (**) denote respondents who selected multiple responses, and therefore, percentages may not add up to 100%.

Housing Status

	All Respondents		Minority Status	
	n	%	Minority (%)	White, NH (%)
Current Living Situation				
	N=1,102		N=292	N=735
A house, condo, or apartment owned by me or my family	634	57.5%	34.6%	67.8%
A house, condo, or apartment rented by me or my family	433	39.3%	60.6%	29.8%
University or other school dormitory	7	0.6%	0.7%	0.7%
A shelter, motel, or other temporary housing	4	0.4%	0.7%	0.0%
A halfway house or residential program	4	0.4%	1.4%	0.0%
My family and I are staying with someone at their house/ apartment	4	0.4%	1.0%	0.1%
Other	16	1.5%	1.0%	1.6%
Best Description of Type of Home (Among Renters)				
	N=419		N=172	N=212
Affordable housing, such as public housing, Section 8, or some other income-dependent housing	151	36.0%	52.9%	20.3%
University-owned apartment rented only to students and their immediate family members	7	1.7%	1.2%	2.4%
Neither of these	261	62.3%	45.9%	77.4%

Rating of Life Satisfaction

	All Respondents		Minority Status	
	n	%	Minority (%)	White, NH (%)
Rating of Life Satisfaction				
	N=1,114		N=299	N=738
0 (Not at all satisfied)	8	0.7%	1.3%	0.4%
1	8	0.7%	0.3%	0.8%
2	7	0.6%	0.7%	0.7%
3	14	1.3%	0.7%	1.4%
4	19	1.7%	2.3%	0.9%
5 (Somewhat satisfied)	95	8.5%	16.1%	5.7%

	All Respondents		Minority Status	
	n	%	Minority (%)	White, NH (%)
6	81	7.3%	8.7%	6.1%
7	187	16.8%	18.1%	16.0%
8	338	30.3%	25.8%	32.8%
9	243	21.8%	13.7%	25.9%
10 (Completely satisfied)	114	10.2%	12.4%	9.3%
Mean Rating	-	8.57	8.25*	8.76

NOTE: Asterisk (*) indicates a statistically significant difference (P<0.01) between Minority and White, NH.

Level of Concern for Survey Respondent and Family

	All Respondents				Minority	White, NH	Minority	White, NH
	N	Not a Concern	Moderate Concern	High Concern	Not a Concern		Moderate or High Concern	
Physical Health Conditions								
Age-related conditions	1,110	43.2%	41.5%	15.2%	48.3%	40.8%	51.7%	59.2%
Cancer	1,103	49.7%	39.3%	11.0%	54.4%	48.0%	45.6%	52.0%
Childhood asthma	1,098	85.1%	10.9%	4.0%	76.2%	89.4%	23.8%*	10.6%
Chronic respiratory diseases in adults	1,112	76.4%	17.1%	6.5%	70.7%	79.3%	29.3%*	20.7%
Dental and oral health	1,106	50.1%	39.7%	10.2%	45.2%	52.5%	54.8%	47.5%
Diabetes	1,094	66.3%	24.5%	9.2%	55.1%	71.1%	44.9%*	28.9%
Heart Disease	1,107	52.3%	37.5%	10.2%	57.7%	50.3%	42.3%	49.7%
High blood pressure	1,112	53.9%	36.2%	9.9%	45.3%	57.7%	54.7%*	42.3%
Obesity	1,102	65.2%	27.2%	7.6%	59.7%	67.2%	40.3%	32.8%
Sexually transmitted infections	1,108	90.0%	8.5%	1.5%	85.9%	92.1%	14.1%*	7.9%
Behavioral Health Issues								
Alcohol use/misuse	1,109	78.0%	17.8%	4.2%	82.4%	76.5%	17.6%	23.5%
Cocaine use/misuse	1,106	95.1%	2.2%	2.7%	89.6%	98.9%	10.4%*	1.1%
Loneliness or social isolation	1,113	56.9%	32.3%	10.8%	57.5%	56.2%	42.5%	43.8%
Marijuana use/misuse	1,104	88.0%	9.2%	2.8%	84.7%	90.0%	15.3%	10.0%

	All Respondents				Minority	White, NH	Minority	White, NH
	N	Not a Concern	Moderate Concern	High Concern	Not a Concern		Moderate or High Concern	
Mental health conditions, such as depression, anxiety, bipolar disorder	1,112	37.6%	41.1%	21.3%	43.9%	34.1%	56.2%*	65.9%
Neurological or developmental conditions	1,108	74.1%	16.6%	9.3%	72.3%	75.7%	27.7%	24.3%
Opioid use/misuse	1,110	93.5%	3.4%	3.1%	89.0%	96.8%	11.0%*	3.3%
Other drug or substance use/misuse	1,102	93.4%	4.0%	2.6%	88.6%	96.7%	11.5%*	3.3%
Suicide or self-harm	1,109	84.6%	11.5%	3.9%	84.0%	84.8%	16.1%	15.2%
Tobacco use/misuse	1,108	89.6%	7.3%	3.1%	84.0%	92.5%	16.1%*	7.5%
Violence, Safety, and Injuries Issues								
Bicycle safety	1,107	34.8%	37.4%	27.8%	44.6%	30.4%	55.4%*	69.6%
Elder abuse	1,019	86.2%	10.4%	3.4%	78.5%	89.6%	21.5%*	10.4%
Gun violence in your neighborhood or community	1,103	64.9%	26.1%	9.0%	64.2%	65.9%	35.8%	34.1%
Intimidation, harassment, or violence at your work	1,108	91.1%	7.2%	1.7%	87.0%	94.3%	13.0%*	5.7%
Pedestrian safety	1,109	27.2%	43.6%	29.2%	42.3%	20.5%	57.7%*	79.5%
Rape, sexual assault, or stalking	1,105	75.3%	20.9%	3.8%	70.7%	77.6%	29.3%	22.4%
Safety at schools or daycares	1,101	79.0%	17.2%	3.8%	75.3%	81.5%	24.7%	18.5%
Safety in public spaces	1,109	47.3%	42.7%	9.9%	52.3%	45.7%	47.7%	54.4%
Safety in your workplace	1,107	89.3%	9.3%	1.4%	85.5%	92.3%	14.5%*	7.7%
Sports-related injuries	1,022	73.0%	24.3%	2.7%	75.0%	72.4%	25.0%	27.6%
Violence in your home	1,111	93.9%	4.5%	1.6%	88.4%	96.9%	11.6%*	3.1%
Environmental Health Issues								
Children's environmental health	1,104	59.2%	26.4%	14.4%	57.1%	61.0%	43.0%	39.0%
Exposure to harmful materials in soil, drinking water, air, or consumer products	1,111	31.7%	41.9%	26.4%	37.9%	29.3%	62.1%*	70.7%
Food Safety	1,107	45.3%	37.8%	16.9%	48.0%	45.6%	52.0%	54.4%
Health impacts of climate change	1,117	30.2%	41.9%	27.9%	39.7%	25.4%	60.3%*	74.6%
Healthy homes	1,109	43.5%	36.9%	19.7%	43.0%	44.2%	57.1%	55.8%
Social Factors								
Homelessness	1,108	74.3%	14.6%	11.1%	61.2%	80.6%	38.8%*	19.4%
Lack of affordable childcare	1,105	71.5%	16.1%	12.4%	57.4%	78.9%	42.6%*	21.1%

	All Respondents				Minority	White, NH	Minority	White, NH
	N	Not a Concern	Moderate Concern	High Concern	Not a Concern		Moderate or High Concern	
Lack of affordable healthy food options	1,113	65.7%	24.2%	10.2%	49.5%	73.7%	50.5%*	26.3%
Lack of affordable housing	1,109	51.7%	23.3%	25.1%	39.6%	56.5%	60.4%*	43.5%
Lack of educational opportunities	1,110	79.8%	12.8%	7.4%	66.4%	87.0%	33.6%*	13.0%
Lack of employment opportunities	1,113	69.5%	19.6%	10.9%	56.2%	76.6%	43.9%*	23.4%
Lack of transportation	1,108	69.9%	22.4%	7.7%	64.1%	73.3%	35.9%*	26.7%
Social Justice and Equity Factors: Discrimination or Harassment Based on…								
Race or ethnicity	1,113	63.5%	23.0%	13.5%	41.7%	73.0%	58.3%*	27.0%
Gender or gender presentation	1,109	56.0%	31.7%	12.4%	53.5%	56.6%	46.5%	43.4%
Sexual orientation	1,112	70.9%	19.1%	10.1%	66.6%	73.2%	33.4%	26.8%
Religion	1,111	71.0%	19.9%	9.1%	63.7%	74.8%	36.3%*	25.2%
Disability	1,110	69.5%	19.8%	10.6%	63.3%	72.3%	36.8%*	27.7%
Class or economic status	1,114	67.8%	21.5%	10.8%	55.5%	73.5%	44.6%*	26.5%
Immigrant status or national origin	1,115	71.0%	17.7%	11.3%	57.8%	77.5%	42.2%*	22.5%

NOTE: Asterisk (*) indicates a statistically significant difference (P<0.01) between Minority and White, NH; Sample size for each sub-population is noted above, however, sample sizes varied slightly by each item.

Rating of Life Satisfaction

	All Respondents	
	n	%
Different issue not listed in the previous sections of high concern (To Respondent or Respondent's Family)		
	N=1,097	
No	869	79.2%
Yes	228	20.8%

Disability Status

	All Respondents		Minority Status	
	n	%	Minority (%)	White, NH (%)
Physical or mental impairment that substantially limits one or more major life activities (respondent or respondent's family)				
	N=1,111		N=302	N=739
Yes	232	20.9%	24.5%	19.4%
No or Don't know / Not sure	879	79.1%	75.5%	80.7%
Major Activities in Daily Life that are Impacted (respondent or respondent's family) **				
	N=1,095		N=297	N=736
Vision (other than a need for glasses or contacts)	51	4.7%	6.1%	3.9%
Hearing	47	4.3%	6.1%	3.5%
Speaking (e.g. speech-language impairment regardless of native language spoken)	17	1.6%	3.0%*	0.80%
Mobility	109	10.0%	12.5%	9.2%
Making decisions or difficulty concentrating or remembering	70	6.4%	8.4%	5.3%
Behavioral or emotional condition	97	8.9%	9.8%	8.3%
Other	46	4.2%	4.0%	4.5%
None	883	80.6%	77.4%	81.8%

NOTE: Two asterisks (**) denote where respondents were allowed to select multiple responses, and therefore, percentages may not add up to 100%.

Food Related Issues (occurrence within past 12 months)

	All Respondents		Minority Status	
	n	%	Minority (%)	White, NH (%)
My family worried whether our food would run out before we got money to buy more.				
	N=1,100		N=297*	N=738
Agree	76	6.9%	13.1%	4.1%
Disagree or Don't know / Not sure	1,024	93.1%	86.9%	95.9%

	All Respondents		Minority Status	
	n	%	Minority (%)	White, NH (%)
The food my family bought just didn't last and we didn't have money to get more.				
	N=1,102		N=301*	N=738
Agree	67	6.1%	12.3%	2.7%
Disagree or Don't know / Not sure	1,035	93.9%	87.7%	97.3%

NOTE: Asterisk (*) indicates a statistically significant difference (P<0.01) between Minority and White, NH.

Emergency Preparedness

	All Respondents		Minority Status	
	n	%	Minority (%)	White, NH (%)
Family has set aside a 3-day supply of essential items in case there is an emergency.				
	N=1,106		N=302	N=740
Agree	386	34.9%	34.1%	34.7%
Disagree or Don't know / Not sure	720	65.1%	65.9%	65.3%
If there were an emergency today, a neighbor or community member would check on me and my family.				
	N=1,107		N=301	N=740
Agree	568	51.3%	52.8%	50.4%
Disagree or Don't know / Not sure	539	48.7%	47.2%	49.6%

Interaction with Neighbors or Community Members (in a typical month)

	All Respondents		Minority Status	
	n	%	Minority (%)	White, NH (%)
Frequency of interaction with neighbors or other community members				
	N=1,080		N=290	N=738
Rarely or never	123	11.4%	20.0%	8.3%
About once per month	79	7.3%	12.4%	5.7%
A few times per month	160	14.8%	12.4%	15.7%

	All Respondents		Minority Status	
	n	%	Minority (%)	White, NH (%)
About once per week	114	10.6%	8.3%	10.6%
A few times per week	254	23.5%	21.0%	24.5%
Most days or every day	350	32.4%	25.9%	35.2%

Primary Care

	All Respondents		Minority Status	
	n	%	Minority (%)	White, NH (%)
Regular health care provider for check-ups or when sick (for respondent or respondent's family)				
	N=1,100		N=304*	N=740
Yes	1,023	93.0%	88.8%	94.7%
No or Not sure	77	7.0%	11.2%	5.3%
Check-Up with health care provider in the past year				
	N=1,100		N=304	N=739
Yes	1,019	92.6%	90.8%	93.6%
No or Not sure	81	7.4%	9.2%	6.4%
Regular dentist for dental care and oral health (for respondent or respondent's family)				
	N=1,101		N=303*	N=741
Yes	949	86.2%	79.5%	88.7%
No or Not sure	152	13.8%	20.5%	11.3%
Check-up with dentist during the past year				
	N=1,103		N=305*	N=741
Yes	904	82.0%	73.1%	85.2%
No or Not sure	199	18.0%	26.9%	14.8%

NOTE: Asterisk (*) indicates a statistically significant difference (P<0.01) between Minority and White, NH.

Mental Health Care

	All Respondents		Minority Status	
	n	%	Minority (%)	White, NH (%)
Use of mental health services (by respondent or respondent's family)				
	N=1,091		N=298*	N=739
Yes, someone in my family has seen a therapist, counselor, or other mental health professional.	478	43.8%	34.2%	49.0%
Yes, someone in my family has spoken to a primary care physician (your regular doctor) about mental health.	50	4.6%	5.0%	4.3%
No. Someone in my family needed mental health services but we chose not to access them or could not access them.	82	7.5%	10.4%	6.4%
No, no one in my family needed mental health services.	481	44.1%	50.3%	40.3%

NOTE: Asterisk (*) indicates a statistically significant difference (P<0.01) between Minority and White, NH.

Barriers to Accessing Services

	All Respondents		Minority Status	
	n	%	Minority (%)	White, NH (%)
Difficulty getting medical, dental, or mental health services in past two years (for respondent of respondent's family)				
	N=1,097		N=303*	N=739
Yes	246	22.4%	25.7%	21.0%
No or Don't Know/ Not sure	851	77.6%	74.3%	79.0%
Barriers in accessing medical, dental, or mental health care service (past two years)**				
	N=1,087		N=300	N=740
I am afraid to go to the doctor because I don't want bad news	27	2.5%	4.3%	1.5%
I am afraid to go to the doctor because of my immigration status	9	0.8%	2.6%*	0.1%
I am afraid that the provider or office staff will discriminate against me because of my gender, sexual orientation, race, religion, or where I'm from	20	1.8%	2.7%	1.4%
I do not have insurance	26	2.4%	3.3%	2.0%
I have insurance but the cost is too high	65	6.0%	8.7%	5.1%
I have insurance but it's hard to find a provider who takes my type of insurance	85	7.8%	4.7%	9.2%

	All Respondents		Minority Status	
	n	%	Minority (%)	White, NH (%)
My insurance doesn't cover the kind of specialist I need	68	6.3%	7.0%	6.1%
The provider or office staff do not speak my language	9	0.8%	3.0%*	0.0%
The provider or office staff do not understand my culture	9	0.8%	2.3%*	0.1%
I don't know where to get services or how to find a provider	36	3.3%	4.3%	3.0%
The wait for an appointment is too long	97	8.9%	8.0%	9.3%
Providers don't offer hours that work for my schedule (e.g. no weekend or evening hours)	53	4.9%	4.3%	5.0%
I don't have a way to get to a provider (no transportation)	18	1.7%	1.7%	1.6%
Other (please specify)	68	6.3%	6.0%	6.6%
None	853	78.5%	76.0%	79.6%

NOTE: Asterisk (*) indicates a statistically significant difference (P<0.01) between Minority and White, NH; Two asterisks (**) denote where respondents were allowed to select multiple responses, and therefore, percentages may not add up to 100%.

Barriers to Accessing Services

	Cambridge Residents	Race/Ethnicity		Selected Age Categories		Gender			Housing Status	
	(N=1,129)	Minority (N=306)	White, NH (N=742)	18-39 years (N=295)	65+ years (N=338)	Male (N=256)	Female (N=789)	Non-Binary or Self-Describe (N=15)	Owner (N=634)	Renter (N=433)
Physical Health Conditions										
Age-related conditions	56.8%	51.7%	59.2%	33.7%	77.9%	54.2%	58.0%	53.3%	64.7%	47.3%
Cancer	50.3%	45.6%	52.0%	43.1%	51.8%	49.2%	50.5%	53.3%	55.1%	45.2%
Dental and oral health	49.9%	54.8%	47.5%	52.8%	47.6%	48.4%	50.1%	60.0%	46.0%	56.0%
Heart Disease	47.7%	42.3%	49.7%	42.0%	53.6%	48.0%	47.8%	33.3%	50.9%	43.9%
High blood pressure	46.1%	54.7%	42.3%	36.7%	55.8%	46.8%	46.2%	40.0%	47.2%	44.3%
Obesity	34.8%	40.3%	32.8%	30.5%	32.8%	30.8%	35.4%	60.0%	35.4%	35.2%
Diabetes	33.7%	44.9%	28.9%	29.1%	34.1%	30.4%	34.5%	46.7%	30.1%	38.6%
Chronic respiratory diseases in adults	23.6%	29.3%	20.7%	19.4%	24.2%	20.6%	23.7%	33.3%	22.8%	23.6%
Childhood asthma	14.9%	23.8%	10.6%	17.2%	8.0%	12.5%	14.4%	35.7%	14.0%	15.3%
Sexually transmitted infections	10.0%	14.1%	7.9%	11.8%	4.8%	9.9%	9.4%	26.7%	7.3%	11.0%
Behavioral Health Issues										
Mental health conditions	62.4%	56.2%	65.9%	72.1%	44.3%	59.2%	63.3%	93.3%	61.3%	64.6%
Loneliness or social isolation	43.1%	42.5%	43.8%	48.6%	36.1%	40.9%	43.6%	60.0%	41.0%	46.5%
Neurological or developmental conditions	25.9%	27.7%	24.3%	27.7%	15.3%	24.6%	25.2%	33.3%	24.4%	28.6%
Alcohol use/misuse	22.0%	17.6%	23.5%	24.3%	16.2%	26.0%	20.8%	26.7%	22.8%	22.0%
Suicide or self-harm	15.4%	16.1%	15.2%	19.5%	8.1%	15.0%	14.6%	40.0%	12.7%	18.8%
Marijuana use/misuse	12.0%	15.3%	10.0%	13.6%	5.7%	11.0%	12.3%	13.3%	10.7%	13.8%
Tobacco use/misuse	10.4%	16.1%	7.5%	9.8%	8.1%	9.1%	10.3%	26.7%	8.0%	12.8%
Other drug or substance use/misuse	6.6%	11.5%	3.3%	5.9%	3.3%	6.4%	5.8%	6.7%	4.2%	10.0%
Opioid use/misuse	6.5%	11.0%	3.3%	6.9%	3.3%	6.3%	5.8%	6.7%	4.1%	9.5%
Cocaine use/misuse	4.9%	10.4%	1.1%	4.5%	1.8%	2.8%	4.7%	6.7%	2.1%	8.6%

	Cambridge Residents	Race/Ethnicity		Selected Age Categories		Gender			Housing Status	
	(N=1,129)	Minority (N=306)	White, NH (N=742)	18-39 years (N=295)	65+ years (N=338)	Male (N=256)	Female (N=789)	Non-Binary or Self-Describe (N=15)	Owner (N=634)	Renter (N=433)
Violence, Safety, and Injuries Issues										
Pedestrian safety	72.8%	57.7%	79.5%	73.3%	68.5%	63.5%	76.0%	80.0%	78.4%	66.8%
Bicycle safety	65.2%	55.4%	69.6%	72.7%	52.1%	60.2%	67.4%	73.3%	69.6%	61.1%
Safety in public spaces	52.7%	47.7%	54.4%	50.2%	44.8%	41.7%	55.5%	60.0%	54.3%	51.8%
Gun violence in your neighborhood or community	35.1%	35.8%	34.1%	29.9%	34.0%	31.8%	36.1%	26.7%	37.2%	31.3%
Sports-related injuries	27.0%	25.0%	27.6%	28.5%	15.0%	25.8%	27.0%	30.8%	30.1%	22.1%
Rape, sexual assault, or stalking	24.7%	29.3%	22.4%	26.3%	14.1%	15.4%	27.0%	26.7%	22.5%	26.4%
Safety at schools or daycares	21.0%	24.7%	18.5%	23.5%	9.4%	17.8%	21.3%	26.7%	20.3%	22.0%
Elder abuse	13.8%	21.5%	10.4%	8.2%	15.7%	12.2%	13.7%	14.3%	10.8%	17.7%
Safety in your workplace	10.7%	14.5%	7.7%	11.1%	3.6%	9.8%	9.6%	13.3%	7.6%	14.3%
Intimidation, harassment, or violence at your work	8.9%	13.0%	5.7%	11.1%	3.3%	7.5%	8.6%	13.3%	5.9%	12.4%
Violence in your home	6.1%	11.6%	3.1%	5.9%	2.7%	3.5%	6.4%	6.7%	3.7%	8.8%
Environmental Health Issues										
Health impacts of climate change	69.8%	60.3%	74.6%	66.0%	66.6%	60.2%	73.1%	93.3%	74.9%	64.1%
Exposure to harmful materials in soil, drinking water, air, or consumer products	68.3%	62.1%	70.7%	62.2%	64.4%	57.9%	71.4%	86.7%	73.3%	62.4%
Healthy homes	56.5%	57.1%	55.8%	59.2%	49.0%	46.3%	58.9%	73.3%	55.5%	58.7%
Food Safety	54.7%	52.0%	54.4%	48.6%	54.2%	47.1%	56.2%	80.0%	54.6%	54.7%
Children's environmental health	40.8%	43.0%	39.0%	41.2%	33.7%	39.8%	40.0%	53.3%	42.0%	39.2%
Social Factors										
Lack of affordable housing	48.3%	60.4%	43.5%	59.3%	35.3%	47.3%	47.5%	86.7%	34.0%	67.5%
Lack of affordable healthy food options	34.3%	50.5%	26.3%	38.3%	27.1%	33.3%	33.1%	73.3%	20.8%	51.9%

	Cambridge Residents	Race/Ethnicity		Selected Age Categories		Gender			Housing Status	
	(N=1,129)	Minority (N=306)	White, NH (N=742)	18-39 years (N=295)	65+ years (N=338)	Male (N=256)	Female (N=789)	Non-Binary or Self-Describe (N=15)	Owner (N=634)	Renter (N=433)
Lack of employment opportunities	30.5%	43.9%	23.4%	24.9%	25.0%	28.6%	29.6%	53.3%	22.8%	40.8%
Lack of transportation	30.1%	35.9%	26.7%	32.1%	27.2%	26.3%	29.8%	60.0%	22.2%	40.6%
Lack of affordable childcare	28.5%	42.6%	21.1%	37.9%	16.7%	24.4%	28.2%	40.0%	23.2%	35.3%
Homelessness	25.7%	38.8%	19.4%	23.0%	22.1%	32.9%	22.6%	40.0%	19.7%	32.1%
Lack of educational opportunities	20.2%	33.6%	13.0%	15.3%	18.0%	20.2%	18.8%	33.3%	13.5%	28.9%
Social Justice and Equity Factors – Discrimination or Harassment based on the following										
Gender or gender presentation	44.0%	46.5%	43.4%	41.1%	34.7%	35.0%	46.3%	93.3%	45.2%	42.6%
Race or ethnicity	36.5%	58.3%	27.0%	32.2%	35.2%	38.8%	35.4%	46.7%	35.5%	37.0%
Class or economic status	32.2%	44.6%	26.5%	24.8%	30.1%	32.8%	31.6%	53.3%	27.1%	38.0%
Disability	30.5%	36.8%	27.7%	23.5%	30.6%	30.7%	29.7%	40.0%	28.4%	32.7%
Sexual orientation	29.1%	33.4%	26.8%	24.7%	26.4%	29.8%	27.4%	93.3%	29.3%	28.4%
Religion	29.0%	36.3%	25.2%	24.0%	26.3%	28.2%	29.2%	20.0%	28.4%	30.3%
Immigrant status or national origin	29.0%	42.2%	22.5%	26.2%	25.7%	32.0%	27.3%	40.0%	27.6%	30.5%

NOTE: Sample size for each sub population is noted above, however, sample sizes varied slightly by each item.

Cambridge
Public Health
Department

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Cambridge
Health Alliance

Cambridge Public Health Department is a city department administered
by Cambridge Health Alliance, a regional health care delivery system.

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