



A healthier community through
collaboration, education and
the coordination of resources



Acknowledgments

The 2026 Greater Lowell Community Health Improvement Plan is a reflection of hundreds of hours of community conversation, coordination, and care. It would not exist without the generosity of the residents, frontline workers, and community organizations who gave their time and expertise to shape it.

We extend our sincere appreciation to **Dr. Hannah Tello**, author of the **2026 Greater Lowell Community Health Improvement Plan**, for her exceptional leadership, expertise, and unwavering commitment to advancing the health and well-being of our community.

Dr. Tello's in depth research, leadership, and thoughtful analysis of the **2025 Greater Lowell Community Health Needs Assessment**, combined with her strategic vision and collaborative approach, has guided the development of this plan and helped shape a shared roadmap for improving health outcomes across the Greater Lowell region. Her ability to translate community voices, data, and evidence into meaningful priorities and actionable strategies reflects her deep dedication to health equity and community partnership.

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To the community members who attended CHIP workshops in community centers and conference rooms, over lunch and after long work days, representing dozens of neighborhoods and organizations across Greater Lowell: your voices are the foundation of this plan. The goals, objectives, and activities in this document are yours. We hope they reflect the vision for Greater Lowell that you shared with us.

To our community partners and task force members: your expertise, relationships, and ongoing commitment to health equity in this region make every page of this document actionable rather than aspirational. We are grateful for your continued partnership.

To the frontline workers who participated: thank you for translating community data into lived experience, and for making clear what the numbers alone cannot convey.

Sincerely,



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This Community Health Improvement Planning process was conducted from July 2025 through May 2026. It serves as the basis of action for health improvement efforts carried out by the Greater Lowell Health Alliance of CHNA 10 and our many community partners. Built on priorities identified by the 2025 Greater Lowell Community Health Needs Assessment and developed entirely through community-driven workshops, this Community Health Improvement Plan (CHIP) identifies the goals, objectives, and recommended strategies to improve health through collaboration. Annual updates and revisions will be made available online and through public community events. **For more information please visit greaterlowellhealthalliance.org/CHIP**

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Executive Summary

The 2026 Greater Lowell Community Health Improvement Plan (CHIP) is a community-driven roadmap for collective action across Greater Lowell. Built on findings from the 2025 Greater Lowell Community Health Needs Assessment (CHNA) and developed through community workshops, it defines seven priority goals and provides organizations, municipalities, healthcare providers, and community members with a shared framework for turning data into action over the next three years.

This document builds on the momentum of the 2023 CHIP, incorporating updated community health data and new priorities that emerged from community conversations. Unlike the 2023 CHIP which was organized around eight priority domains, the 2026 CHIP consolidates those areas into seven goals that reflect where our community is today and where it wants to go.

What's New in 2026

The 2026 CHIP reflects a changed landscape in Greater Lowell and beyond. Rising costs of living have deepened pressure on residents and strained the nonprofit sector simultaneously, making Goal 1 a new and urgent priority. The 2025 CHNA confirmed that material hardship has become one of the most salient drivers of poor health outcomes in our region, and community workshop participants named it repeatedly as foundational to everything else.

The 2026 CHIP also reflects a more explicit emphasis on community-driven implementation. Rather than organizing strategies by sector, this CHIP presents objectives and a flexible activity menu that any organization, municipality, or individual can adapt to their context and capacity. Every activity in the menu was suggested by community members.

The 2026 CHIP is complemented by the 2025 Youth Community Health Improvement Plan (Youth CHIP), developed by and for young people in Greater Lowell. Through five workshops engaging 100 youth participants, in partnership with the Boys and Girls Club of Greater Lowell, Project LEARN, and UMass Lowell, young people identified their own priorities: mental health, economic mobility, safety in every space, and family health ecology, and generated activity ideas, many of which echo and reinforce the goals in this plan. The Youth CHIP is available at greaterlowellhealthalliance.org/health-priorities/hyppe/ and is a companion roadmap for youth-led action.

The 2026 Goals

The seven goals of the 2026 CHIP were identified by community members through dozens of workshops conducted across Greater Lowell in 2025. They are:

- Protect access to basic needs amid rising costs and service strain
- Improve access to affordable, high-quality, culturally-affirming healthcare
- Improve mental health through cultivating community connections, belonging and social-clinical support
- Improve chronic disease prevention and expand resources for managing lifelong conditions
- Prevent and address substance misuse, addiction, and other high-risk behaviors across the lifespan
- Strengthen services that promote healthy reproductive, perinatal and early childhood outcomes
- Create safe, accessible physical environments where all residents can gather and connect

About This CHIP

A Community Health Improvement Plan (CHIP) is a long-term, systematic effort to address public health and well-being priorities in a defined community. It is based on the results of community health assessment activities and is part of a broader cycle: assess, plan, act, evaluate, repeat. A CHIP defines a shared vision for the health of the community developed through a collaborative process and is used to coordinate effort and direct resources toward common goals. (Source: Public Health Accreditation Board)

The 2026 CHIP is linked to the 2025 Greater Lowell Community Health Needs Assessment (CHNA). The CHNA, conducted in 2024–2025, combined a community survey, focus groups, and secondary data analysis to produce a comprehensive picture of health needs across Greater Lowell. It identified priority health domains, documented disparities by race/ethnicity, income, language, and geography, and captured residents' perspectives on what matters most to their health and wellbeing. The CHNA findings provide the rationale, the baseline indicators, and the equity context that shapes how we understand each priority area. However, while the CHNA identifies need, the CHIP is built by the community to address them. These are complementary, but distinct documents.

Not every CHNA finding becomes a CHIP priority. The goals, objectives, and activities in this plan were developed in direct collaboration with hundreds of Greater Lowell community members. The result of that process is a CHIP that focuses on areas where collective, coordinated community action can have the greatest impact over three years.

Methods: How This CHIP Was Made

Between July 2025 and May 2026, the GLHA facilitated a series of community workshops across Greater Lowell. Workshops were held virtually and in person with a range of community partners to maximize reach and ensure diverse participation. Topics covered in workshops corresponded to CHNA priority areas, and facilitators used structured discussion guides to elicit input on priorities, barriers, and activity ideas within each area.

Workshop participants included residents, frontline workers, community organization staff, healthcare providers, municipal employees, faith community leaders, and others. Participation was open to all, and recruitment was conducted through GLHA's partner network, task forces, and community outreach channels. Workshop participants were offered a gift card in gratitude for their participation.

Workshop input was synthesized by GLHA staff after each session. Activity ideas were reviewed across all workshops, grouped thematically, and ideas that were duplicated across multiple workshops were noted; this cross-workshop endorsement was treated as a signal of community priority.

The goals and objectives were drafted by GLHA staff based on the pattern of community input, the CHNA findings, and the previous CHIP structure. They were reviewed by the GLHA staff and Task Force members before being adopted.

Indicators were assigned by GLHA's Director of Projects and Evaluation, with a focus on measures that are community-relevant, publicly available or internally trackable, and sensitive enough to reflect meaningful change over a three-year period. Baseline data and targets for each indicator are documented in Appendix A.

Workshop participants named specific communities experiencing disproportionate harm in nearly every goal area: immigrant residents, Cambodian and Khmer-speaking community members, Black and Hispanic residents, LGBTQ+ individuals, people experiencing housing instability, older adults, and others. In previous versions of the CHNA and CHIP, equity was highlighted as its own goal. However, in this plan, equity is not a standalone section; it is embedded in every chapter, to better reflect how community members actually talk about and experience inequities.

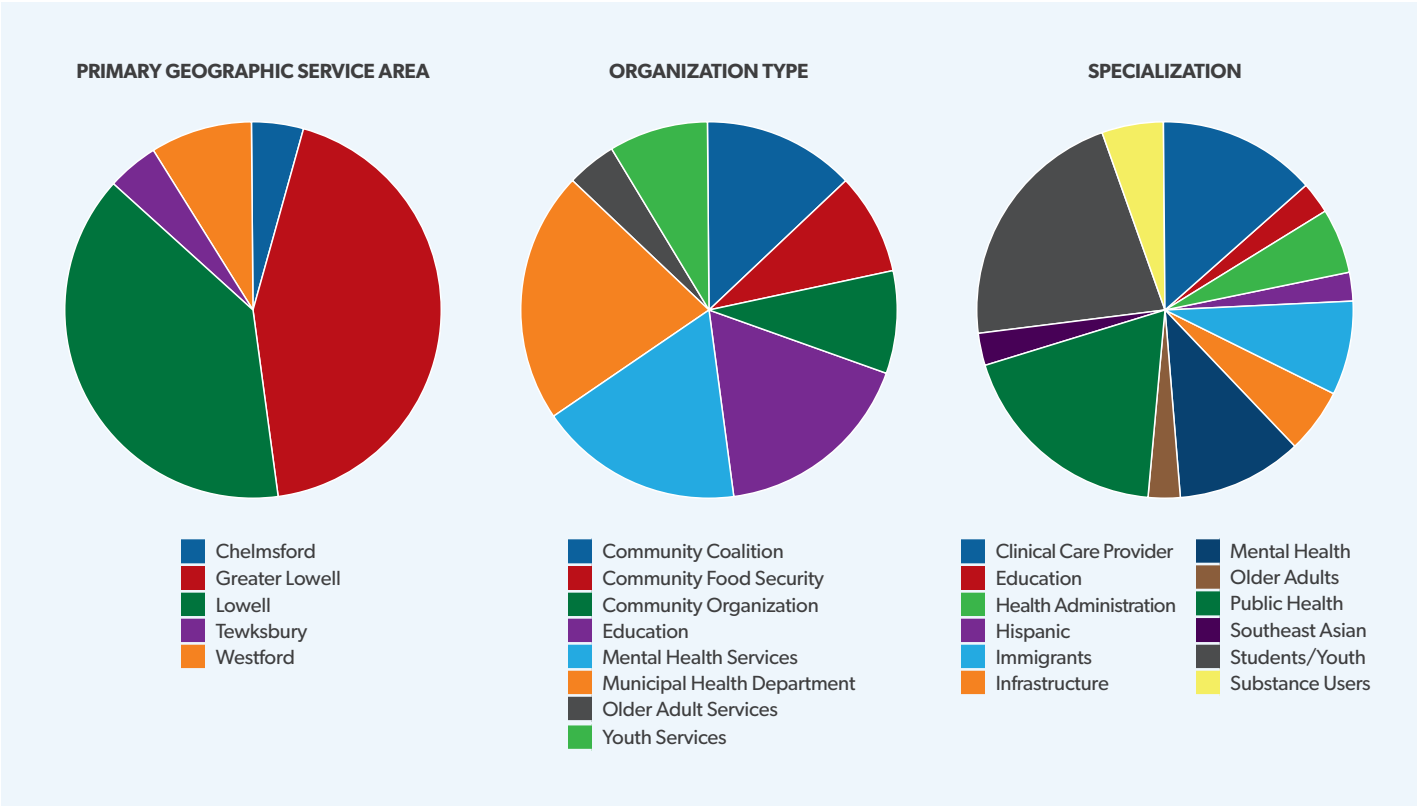
Youth and youth-serving organizations can start with the 2025 Youth CHIP, which translates priorities into youth-led projects and provides a direct on-ramp for schools, after-school programs, and career pathway initiatives.

Summary of Workshops

Between Fall 2025 and Spring 2026, GLHA conducted 23 community workshops to generate resident and stakeholder feedback about priority actions to address the priorities identified in the 2025 CHNA. Workshops were hosted in community spaces or virtually. Most workshops lasted between 60 to 90 minutes.

A majority (43%) of workshops were hosted in partnership with community agencies or groups that service residents throughout the Greater Lowell region. A variety of organization types were represented in workshops, including health departments (21.7% of all workshops), schools and educational facilities (17.4%), mental health agencies (17.4%) and community coalitions (13%).

Workshops intentionally solicited feedback from several special populations and people with professional and lived experiences. Well-represented voices included youth or students (present in 21.6% of all workshops), public health experts (18.9%), clinical healthcare providers (13.5%), and people with mental health or substance use needs (10.8% and 5.4%, respectively). Additional special populations that were intentionally recruited include infrastructure experts, immigrants, and older adults.



Formal collection of individual participant demographic information was not standardized across all workshops (due to differences in virtual versus in-person formats, participant preferences for providing demographic information, and caution in ensuring participant confidentiality). However, demographic information was collected for approximately 62% of the total 225 workshop participants.

	% of known		% of known
Women	70.5%	Middle Eastern/ North African	2.2%
Men	28.6%	Other	1.5%
LGBTQ+	13.2%	Foreign-born	26.5%
White	42.6%	Spanish speaking	16.2%
Black	21.3%	Portuguese speaking	3.7%
Asian	27.9%	Khmer speaking	17.6%
Hispanic	16.2%		

How to Use This CHIP

The 2026 CHIP is designed to function as a roadmap for collaborative action. Unlike an organizational strategic plan, which directs specific actions to be undertaken by specific entities, this CHIP summarized a shared vision for improved health at the community level, and a range of actions & strategies that will move us towards that vision together. It is not the sole responsibility of a single entity to accomplish CHIP objectives; instead, the CHIP describes ways that any entity, from a hospital to a school to a temple to a grassroots organization, could participate in improving health in our region.

But the CHIP has utility far beyond that scope as well. Here are some of the most common ways people use it:

- Aligning agency strategic plans and grant applications with priority goals
- Identifying objectives and activities that match your organization's mission and capacity, and incorporating them into program design or decision making
- Finding metrics to track for internal evaluation or external reporting
- Identifying community partners working in the same goal areas
- Informing internal priorities or staff training
- Selecting policy and advocacy priorities
- Directing philanthropic or grant funding toward community-identified needs

Chapter Structure

Each of the seven goal chapters follows the same format: a rationale grounding the goal in local data and community voice; a table pairing each objective with a menu of sample activities; and a short list of indicators that will be used to measure progress. Full baseline data, targets, and data sources for all indicators are in Appendix A.

Activity Menus

The activity menu is not a list of required projects but a sample of the dozens of good ideas that, when implemented, get us closer to the target goal. All of these good ideas were generated directly from what community members proposed in workshops. Any organization can adapt an idea, combine several, or pursue a different activity that advances the same objective. What matters is alignment with the shared goals, not the specific path taken; the activity menus are intended to spark inspiration & curiosity.

Indicators

Indicators are the pieces of evidence that we use to measure the impact of our collective work. Each chapter lists key indicators in three categories:

- Implementation indicators: what was done (e.g., number of events, number of people trained)
- CHNA indicators: changes in how residents report their own health
- Population indicators: changes in health outcomes at the population level, using publicly available data

Each of these indicators has strengths and limitations in its ability to indicate progress, but, taken together, are a reliable way to evaluate the work that was done and the impact it had. The GLHA will track and report progress toward these indicators throughout the life of the plan.



2023 CHIP: Progress Report

This section reflects our commitment to transparency and accountability to the Greater Lowell community. The 2023 CHIP established goals, objectives, and indicators across eight priority domains. The following report summarizes progress made between 2023 and 2026 toward the metrics identified in that plan. Progress is reported across implementation, CHNA, and population indicators for each domain. Where progress fell short of goals, we have tried to understand why; those lessons inform the goals and strategies of the 2026 CHIP.

Because the CHNA survey is collaboratively designed, several changes to the 2026 survey resulted in indicators being removed, so data is not reported for those indicators.

Service Navigation

INDICATOR	BASELINE	GOAL	2026 STATUS	RESULT
IMPLEMENTATION				
Implement community health fairs/clinics supported by GLHA task forces	N/A	4 fairs	9 fairs	Successful
Implement professional development trainings for healthcare workforce	N/A	3 trainings	14 trainings	Successful
CHNA				
Q26: I am able to afford the medical care I need	69.6% accurate	74.60%	59.80%	Unsuccessful
Q35: It is difficult to understand/navigate the healthcare system	12.8% agreement	9.30%	16.20%	Unsuccessful
POPULATION				
Decrease the percent of uninsured residents in disproportionately impacted communities	5.1% (Lowell)	4.00%	3.99% (Lowell)	Successful
Increase the proportion of households with a broadband internet connection	82.3% (Lowell)	86.10%	86.50%	Successful
Decrease the portion of adults reporting an unmet mental health need	6.3% (MA)	5.20%	9.90%	Unsuccessful

Mental Health

INDICATOR	BASELINE	GOAL	2026 STATUS	RESULT
IMPLEMENTATION				
Implement campaign about depression and suicide risk	N/A	1 campaign	3 trainings	Progress
Distribute resources regarding perinatal mental health and community services	N/A	Resource guide	2 resource guides, plus trainings	Successful
CHNA				
Q26: I have friends/family who help me when needed	74.1% accurate	79.10%	69.90%	Unsuccessful
Q27: My overall mental health is worse than last year	24.7% worse	18.30%	19.50%	Progress
Q34: Self-report Problems with MH	29.40%	25.60%	36.50%	Unsuccessful
Q34: Self-report Suicide/Ideation	11.20%	6.80%	16.50%	Unsuccessful
Q36: Met with therapist in the Last Year	18.40%	24.60%	26.60%	Successful
POPULATION				
Decrease the percent of adults reporting >14 days of poor mental health	12.5% (MA) 82.3% (Lowell) 12.5% (Dracut)	11.2% 11.2% 13.5%	16.2% (MA) 16.6% (Dracut) 18.0% (Lowell)	Unsuccessful
Decrease total suicides	20	11	25	Unsuccessful

Chronic Health and Wellness

INDICATOR	BASELINE	GOAL	2026 STATUS	RESULT
IMPLEMENTATION				
Implement access to cancer screenings at in-community events	N/A	2 screening events	3 events	Successful
Implement awareness campaign regarding heart and lung health data and resources	N/A	1 campaign		Unsuccessful
Expanded access to culturally-relevant health recipes	N/A	250 recipe cards	400 cards distributed	Successful
CHNA				
Q26: I have reliable access to nutritious food	89.5% Accurate	93.50%	85.10%	Unsuccessful
Q27: My overall physical health is worse than last year	22.3% Worse	18.70%	20.70%	Progress
Q36: Self-report Physical Within the Last Year	55.80%	65.80%	85.50%	Successful
POPULATION				
Reduce rate of heart disease	132.1	129.1	160.4	Unsuccessful
Decrease percent of adults with diabetes in disproportionately impacted populations	9.6% (Lowell) 9.2% (Tewksbury)	8.9% 8.9%	10.3% (Lowell) 8.7% (Tewksbury)	Progress
Increase percent of eligible households enrolled in WIC	41.5% - 59.1% (Greater Lowell)	>60%	48.3% - 60.8% (Greater Lowell)	Successful

Substance and Alcohol Misuse

INDICATOR	BASELINE	GOAL	2026 STATUS	RESULT
IMPLEMENTATION				
Distribute resource materials regarding substances other than opioids		Audience reach of 300	3 resource guides, 2 trainings	Successful
Host networking events for professionals in SUD/AUD field		4 events per year	>6 events per year	Successful
CHNA				
Q27: My relationship with substance is worse than it was a year ago	7.2% Worse	5.00%	4.00%	Successful
POPULATION				
Decrease deaths by opioid overdose	53.2 (Lowell rate per 100,000)	46	43.5 (Lowell rate per 100,000)	Successful
Decrease young adults reporting AUD	13.9% (MA)	11.10%	6.7% (MA)	Successful

Infectious Disease

INDICATOR	BASELINE	GOAL	2026 STATUS	RESULT
IMPLEMENTATION				
Implement scientific literacy educational materials or trainings		1 training OR campaign	Multiple campaigns/ materials	Successful
Implement community campaign regarding HIV in coordination with World AIDS Day activities		1 campaign	Incomplete	Unsuccessful
CHNA				
Q36: Flu shot within the last year	54.60%	66.40%	69.50%	Successful
POPULATION				
Decrease rates of new HIV diagnosis	33 (Lowell, AFAB) 40 (Lowell, IDU)	25 20	11 (Lowell, AFAB) <5 (Lowell, IDU)	Successful
Decrease HCV rate	149.7 (per 100,000, Lowell)	122	89.6 (per 100,000, Lowell)	Successful
Decrease chlamydia rate	145.4 (per 100,000, Lowell)	110	317.6 (per 100,000, Lowell)	Unsuccessful

Our vision is to create a healthier community through collaboration, education and the coordination of resources.

Reproductive and Perinatal Health

INDICATOR	BASELINE	GOAL	2026 STATUS	RESULT
IMPLEMENTATION				
Implement educational materials about contraceptive options and resources		300 audience reach	Resource guide and educator training	Successful
Implement Breastfeeding Friendly Communities toolkit		10 certified businesses	14 certifications	Successful
CHNA				
Q30: Low Priority Assignment for "Reproductive & Sexual Health"	10.40%	7.60%	6.70%	Successful
Q30: Low Priority Assignment for "Infant & Child Health"	7.40%	5.00%	3.70%	Successful
POPULATION				
Decrease the teen birth rate	13.8 (per 1,000, Lowell) 25.7 (per 1,000, Hispanic teens, Lowell) 14 (Asian teens, Lowell)	9.1 15.1 8	12.0 15.6 9	Progress
Increase proportion of WIC-enrolled infants who are breastfed	No baseline available for Greater Lowell	NA	38% (Lowell) 45% (MA)	Progress
Increase proportion of early entry into Prenatal Care (first visit in first trimester)	56.2% (LCHC patients)	64%	81.50%	Successful
Decrease proportion of LBW/VLBW infants	6.3% (LCHC patients)	5.50%	6.60%	Unsuccessful

Housing

INDICATOR	BASELINE	GOAL	2026 STATUS	RESULT
IMPLEMENTATION				
Implement distribution of Housing Policy scan		100 distribution reach	>100 reach	Successful
Implement and disseminate accessibility audit		200 distribution reach	Incomplete	Unsuccessful
CHNA				
Q26: I have a safe place to sleep every night	93.6% Accurate	95.40%	95.10%	Successful
Q26: I have a reliable way to get around	89.1% Accurate	92.90%	87.20%	Unsuccessful
Q26: There are safe, clean parks in my community	67.2% Accurate	70.80%	63.90%	Unsuccessful
POPULATION				
Decrease percent of rent burdened ELL renters	84% (Greater Lowell)	73%	Not reported	Progress
Increase the number of affordable housing units	42.8 - 45.7 (per 100 ELL households)	>49	Not reported	Progress

Safety

INDICATOR	BASELINE	GOAL	2026 STATUS	RESULT
IMPLEMENTATION				
Implement campaign to increase awareness of resources for survivors of violence		1 campaign	Incomplete	Unsuccessful
Implement violence prevention events and trainings		100 audience reach	> 100 reach	Successful
CHNA				
Q26: I feel safe in my neighborhood at night	75.4% accurate	80.60%	79.80%	Progress
Q26 My community is accepting of diversity	53.3% accurate	60.70%	60.80%	Successful
Q35: I was discriminated against by my medical team	5.60%	3.40%	9.20%	Unsuccessful
POPULATION				
Decrease sexual assault	99 (reported Greater Lowell, 2020)	40	109 (reported Greater Lowell, 2024)	Unsuccessful
Decrease overall violent crime rate	363.5 (per 100,000, Lowell)	300	537.7 (per 100,000, Lowell)	Unsuccessful



GOAL 1: PROTECT ACCESS TO BASIC NEEDS AMID RISING COSTS AND SERVICE STRAIN

RATIONALE

The 2025 CHNA highlights income inequality, housing instability, and food access challenges, while local nonprofits and other service providers are experiencing major funding cuts and reduced capacity, limiting services for vulnerable groups. Workshop participants noted untenable rises in rent, property taxes, food costs, utilities, health insurance, childcare, and out-of-pocket medical expenses as significant sources of financial strain.

This strain results in more participants seeking support from social programs and nonprofits, but funding for those services are also similarly strained, resulting in service bottlenecks or delays in access.

The health effects of financial stress are significant. Participants noted delaying, or canceling, necessary medical care, or having care unexpectedly denied due to reductions in their coverage. Many noted that they missed rent or other bill payments for the first time in the last year. Participants experienced a lack of employment stability, with many able to find only part time offerings with inconsistent hours and no benefits packages. For families, the exceptionally high cost of both childcare and eldercare were cited as the primary drivers of financial stress. For all participants, the stress of financial insecurity itself contributed to poorer health outcomes, particularly for people with chronic conditions or mental health needs.

OBJECTIVES

- 1.1: Increase the number of residents connected to food, housing, and financial assistance resources**
- 1.2: Improve capacity and coordination among local service providers to meet community needs**
- 1.3: Reduce barriers to navigating available resources**

SAMPLE ACTIVITIES

- Add enrollment resources to free little libraries to assist with food/heating/financial resources
- Pilot “social service prescription” programs with local healthcare providers
- Offer mobile enrollment services at community festivals, fairs and other events
- Digitize benefit enrollment and renewal reminders in a single application
- Pilot a mobile pantry for residents with transportation barriers
- Increase the number of affordable units required in new construction
- Improve pathways from affordable housing to market-rate homeownership
- Expand healthy meal delivery options for residents with transportation barriers
- Launch a “Too-Good-To-Go” style food rescue program to connect residents with surplus food from local businesses
- Host monthly “resource rounds” for cross sector service providers to identify bottlenecks/deploy solutions
- Pilot “specialist-on-loan” programs where agencies share expert staff (e.g. a financial counselor who does two days per week on site at a food pantry)
- Coordinate inter-sector cross-training days where staff from different agencies swap roles to learn first-hand about how their partner organizations operate and to improve collaboration between sites
- Partner with National Grid and local heating/cooling assistance programs ahead of peak seasons to connect residents to financial programs and budgeted billing plans
- Partner with Provisions Ministry and others to continue distributing clothing and other goods to nonprofits across Greater Lowell
- Make bus transit permanently fare-free or lower-income subsidized; run buses more frequently including late nights and Sundays; improve stop accessibility for people with physical disabilities
- Develop a secure process for sharing intake forms between service agencies to streamline access
- Incorporate document assistance into community events to help residents get access to photo IDs, copies of birth records, etc.
- Offer differentials to multilingual employees or candidates in service or healthcare roles

How We'll Measure Success

INDICATOR	BASELINE	GOAL	SOURCE
IMPLEMENTATION			
Facilitate community resource connections at community-based events via tabling, on-site screenings, in-person registrations, etc.	N/A	5 targeted events/year; 1500 total attendees across events	GLHA event and task force records
Incorporate information about basic needs resources (e.g. SNAP, financial assistance, etc.) into resource guides and other distributed materials	N/A	Audience reach of 500	GLHA task force and materials distribution
Host networking or professional development events for basic needs service providers to strengthen coordination and organizational capacity	N/A	2 events/year; 35 attendees per event	GLHA event and task force records
CHNA			
Increase in CHNA participants reporting agreement with "I have reliable access to nutritious food" <i>Specific targets: Older adults (baseline 94.4%), Hispanic/Latino residents (baseline 68.1%)</i>	85.5%	89.5%	CHNA 2025
Increase in CHNA participants reporting agreement with "I am able to pay my bills in full and on time" <i>Specific targets: Older adults (baseline 84.6%), Hispanic/Latino residents (baseline 48.8%)</i>	68.9%	74.4%	CHNA 2025
Decrease in CHNA participants reporting worse financial health from previous year	27.0%	21.0%	
POPULATION			
Decrease the percent of rent-burdened extremely low-income (ELI) renters in Greater Lowell	84% (Greater Lowell, 2023)	73%	CTI Community Needs Assessment 2023; EOHLC data
Decrease the percent of households reporting inability to pay monthly bills on time	36% (Greater Lowell, 2023)	31%	CTI Community Needs Assessment 2023

"Medical bills are the number one cause of bankruptcy. I have been very fortunate and always had good healthcare, but I have been appalled over the years with what I have seen happen to families."

GOAL 2: IMPROVE ACCESS TO AFFORDABLE, HIGH-QUALITY, CULTURALLY-AFFIRMING HEALTHCARE

RATIONALE

Health services are a top CHNA priority. Residents and providers note gaps in access, cost, and culturally-relevant care, as well as challenges navigating insurance, booking appointments, and expanding the clinical workforce. Healthcare providers experienced an exponential increase in the amount of labor spent negotiating or arguing with insurance providers over service denials, preauthorizations or payment refusals. These labor hours increase cost, delay care, and reduce the number of patients a provider is able to see.

Participants notably struggled to access specialized care. Unexpected or confusing changes in their insurance plans and uncertainty about financial burdens made finding appropriate care challenging and, in some cases, insurmountable. However, the region has strong existing infrastructure and resources to build on (e.g., integrated behavioral health partnerships) to address these issues effectively in the next three years.

OBJECTIVES

2.1: Increase the number of residents accessing affordable primary and preventive care

2.2: Grow a culturally concordant clinical workforce that reflects the communities served

2.3: Reduce financial, logistical, and systemic barriers to health and healthcare

SAMPLE ACTIVITIES

- Expand access to family medicine residencies to train and retain new doctors
- Increase the number of NPs, PAs, and primary care providers in the region
- Advocate for reducing specialty care waitlists
- Bring health screenings to community events or neighborhood via mobile health vans
- Expand school-based clinics for both medical and dental needs, particularly where language barriers prevent families from meeting appointments
- Partner with churches, temples and other spiritual centers to host “specialist hours” where community members can meet with medical providers for screenings and referrals
- Strengthen school-based pathways to high-level careers in healthcare through internships, career mentoring, early credentialing, and priority hiring for local talent
- Provide free or subsidized clinical upskilling, training and credentialing for existing medical interpreters and CHWs
- Expand the HYPPE program’s healthcare career pipeline through UMass Lowell and MCC*
- Develop healthcare navigation specialists dedicated to specific populations (LGBTQ+, BIPOC communities, etc.)
- Expand multilingual translation of healthcare materials and paperwork; grow the number of truly bilingual providers (not just conversational, but medically fluent)
- Engage philanthropy teams at local organizations to support a community-wide college scholarship fundraiser for youth pursuing health careers*
- Incentivize mentors in high-paying health fields to offer high engagement, long-term mentorship to youth*
- Incentivize event planners to offer free youth access tickets to donor events, annual meetings, or galas where youth could connect and network with health professionals*
- Host “Know Your Healthcare Rights” workshops covering immigration-safe care, insurance basics, and patient rights
- Increase awareness of affordable dental options and support mobile or school-based dental programs targeting children and underserved adults
- Set up evening/weekend pop-up clinics for working families
- Launch a telehealth training series to help residents navigate apps, portals, and video visits
- Connect low-income residents with manufacturer patient assistance programs, Extra Help/Low Income Subsidy, and the Massachusetts Drug Coupon Program

*Youth Community Health Improvement Plan

How We'll Measure Success

INDICATOR	BASELINE	GOAL	SOURCE
IMPLEMENTATION			
Provide professional development or training events for the healthcare workforce focused on cultural humility, equitable service access, or other emergent equity needs	N/A	3 trainings/year; 20 attendees per training	GLHA event and task force records
Enroll youth in HYPPE health careers and college pathways programming, connecting them to internships, mentorship, and healthcare career pipelines	N/A	60 youth enrolled annually across HYPPE sites	GLHA HYPPE program records
Offer professional training, certification, or upskilling for community members in health fields (e.g. doula, lactation, CHW) with a focus on cultural concordance (Cross-reference Goal 6)	13 postpartum doulas trained (2025)	25 total community members trained, certified, or MassHealth eligible by 2027	GLHA Doula Project records; BCBS Foundation grant reporting
CHNA			
Increase in CHNA participants reporting agreement with "I am able to afford the medical care I need" <i>Specific targets: Hispanic/Latino residents (baseline 39.0%), Foreign-born households (baseline 49.2%)</i>	60.4%	68.5%	CHNA 2025
Decrease in CHNA participants reporting provider discrimination and language barriers to care	9.2% 5.7%	6.0% 3.0%	
POPULATION			
Decrease the percent of uninsured residents in disproportionately impacted communities <i>Specific targets: Hispanic residents (baseline 4.9%), Other Race (baseline 5.4%)</i>	4.5% (Lowell, 2022 ACS)	3.7%	US Census Bureau ACS 5-year estimates; MA Health Data Tool
Decrease the proportion of adults reporting an unmet healthcare need due to cost <i>Specific targets: Black residents (baseline 35.8%), Hispanic residents (baseline 37.8%)</i>	28.4% (MA, 2025)	21.0%	Findings From the 2025 Massachusetts Health Insurance Survey

"I am dealing with family addicted to substances and it's been so difficult navigating that system. Finding resources, getting help, getting connected to support meetings and finding a therapist were all so challenging."

GOAL 3: IMPROVE MENTAL HEALTH THROUGH CULTIVATING COMMUNITY CONNECTIONS, BELONGING, AND SOCIAL AND CLINICAL SUPPORT

RATIONALE

The 2025 CHNA identifies high levels of loneliness and isolation, particularly among older adults, adolescents, LGBTQ+ residents, and veterans. Residents and service providers also highlighted system strain that is reducing access to clinical services.

While mental health has routinely been a top priority in previous assessments, the specific contexts in which mental health emerged in 2025 was distinct from previous years. In previous assessments, the gaps identified were distinctly clinical: a lack of specialist providers, wait times for appointments, etc. In the most recent assessment, participants more frequently discussed mental health in the context of interpersonal relationships, social connections and community identity. Workshop participants highlighted the stress of feeling isolated, disconnected from peer groups, or unable to physically share spaces with other community members. Youth noted a desire to feel more positive connections with their teachers and parents, while elders similarly expressed a desire for intergenerational connectedness.

This framing doesn't negate the need for clinical service infrastructure, but it highlights the simultaneous call for community-based interventions that don't have an explicitly clinical focus.

OBJECTIVES

3.1: Increase availability of affordable, responsive mental and behavioral health services

3.2: Strengthen social networks and physical spaces that promote connection and reduce isolation

3.3: Promote easier service navigation by reducing barriers related to cost, language access, and stigma

SAMPLE ACTIVITIES

- Support the Mental Health Task Force's efforts to expand their holiday virtual support line and mental health 'little library' project
- Fund Equine Facilitated Learning (EFL) (e.g. Ironstone Farm) particularly for veterans, people with SUD, and people with disabilities
- Expand non-talk therapy approaches (art therapy, equine facilitated learning, dance, and mindfulness) particularly for youth and trauma-affected populations
- Launch mental health first aid training for community workers, coaches, teachers, and faith leaders, including culturally specific training for providers working with Cambodian, Hispanic, LGBTQ+, and other communities
- Support replication of culturally responsive peer support groups for immigrant and refugee youth in schools
- Create a Youth Mental Health Resource Guide*
- Develop whole-family suicide prevention interventions that support parents, siblings, and others bereaved by or affected by suicide
- Host neighborhood potlucks, cultural food nights, coffee chats, game nights, and casual no-pressure hangouts in accessible places like libraries and parks
- Develop companionship programs for older adults, including transportation to game days, afternoon theater, and movie events with active outreach to older adults and caregivers
- Build or support a "human library" model where community members can share lived experiences across generations and cultures
- Train youth as Mental Health Ambassadors or Mentors*
- Support intergenerational programming that brings older adults, youth, and caregivers together*
- Offer free or low-cost outdoor community activities (movie nights, live music, storytelling circles, skill-sharing events) with a consistent, recurring schedule
- Expand availability of same-day walk-in behavioral health services
- Advocate for improved continuity of care after hospital discharge; coordinate with community providers before residents return home to prevent fall-through
- Create more and better programming for LGBTQ+ residents, including expanding Pride events and creating safer, more accessible LGBTQ+ social spaces
- Monitor and respond to federal policy changes impacting the community

*Youth Community Health Improvement Plan

How We'll Measure Success

INDICATOR	BASELINE	GOAL	SOURCE
IMPLEMENTATION			
Support community-based activities that promote social connection and reduce isolation, targeting high-isolation populations	N/A	4 events/year; 400 total attendees or distribution reach	GLHA event and task force records
Distribute resources or implement education about mental health services, peer support programs, and crisis resources	N/A	Audience reach of 300 total	GLHA event and task force records
CHNA			
Increase in CHNA participants reporting agreement with "I have friends/family who help me when I need it" <i>Specific targets: Older adults 65+ (baseline 79.2%), LGBTQ+ residents (baseline 64.7%), Veterans (baseline 67.6%)</i>	70.3%	79.0%	CHNA 2025
Decrease in CHNA participants reporting that their overall mental health is worse than last year <i>Specific targets: Under age 26 (baseline 21.9%), Hispanic/Latino residents (baseline 22.8%)</i>	19.5%	14.5%	CHNA 2025
Increase in CHNA participants reporting having met with a therapist or counselor in the last year	26.6%	35.0%	CHNA 2025
POPULATION			
Decrease the percent of adults reporting frequent mental distress	18.5% (Lowell), 16.6% (Dracut)	14.2% (MA and Dracut), 13.5% (Lowell)	CDC BRFSS PLACES Project 2023 MA Health Data Tool
Decrease total suicides in Greater Lowell	25 (Greater Lowell, 2021)	11	Registry of Vital Records and Statistics (RVRS)

"I think it is important to recognize that while mental health services are of paramount importance, difficulties with navigating so many other factors (like housing, nutrition, physical healthcare, discrimination) also impacts mental health. The mental health system is a byproduct of all of these. If we do not continue to invest in these areas, we will continue to experience mental illness."

GOAL 4: IMPROVE CHRONIC DISEASE PREVENTION AND EXPAND RESOURCES FOR MANAGING LIFELONG CONDITIONS

RATIONALE

Greater Lowell is experiencing increasing rates of chronic conditions (diabetes, hypertension, obesity) alongside an aging population. People living with lifelong conditions (including disabilities, autoimmune conditions, etc.) experience additional barriers to health and wellbeing in our region.

People living with chronic conditions felt especially concerned about financial strain, with many reporting having to forgo medication or treatments that they rely on due to cost. Increases in food costs limited the ability for people who manage conditions with diet to sustain their wellbeing. While advancements in technology-enhanced self-monitoring equipment or experimental therapies offer promise, many participants feel these options are financially or linguistically out of reach for them.

As changes in Medicare as a result of OBBBA take effect in 2026-2027, adults with chronic conditions are one of the groups most vulnerable to seeing their coverage limited or eliminated.

OBJECTIVES

- 4.1: Increase the number of residents with access to education, screenings, and resources to prevent the onset of chronic disease**
- 4.2: Increase support, tools, and care for residents living with chronic or lifelong conditions**
- 4.3: Universalize access to healthy food, physical activity, and other lifestyle supports to all residents across the lifespan**

SAMPLE ACTIVITIES

- Expand Wellness and Chronic Disease Task Force's community screening events to additional community locations
- Whole-family cooking classes, with particular focus on youth and families affected by diabetes and obesity
- Disaggregate cancer data and create culturally specific campaigns in Khmer, Spanish, and other languages
- Expand early cancer screenings (especially breast, cervical, colorectal, colon, and lung) with a focus on Asian and Hispanic communities, young women and people below the poverty line
- Advocate for insurance coverage of earlier-age screenings
- Tie preventive care to memorable moments (e.g., "schedule your checkup as a birthday gift to yourself") to normalize annual physical and screening habits
- Scale or expand the YMCA's Diabetes Prevention Program (DPP)
- Expand Mobile Market stops and subsidized produce access into neighborhoods with the highest rates of diabetes and cardiovascular disease
- Launch group medicine/group support visits for people living with chronic conditions
- Develop Alzheimer's/dementia education and early intervention programs for families and community workers, including caregiver support groups, fall prevention kits, and cognitive exercise classes
- Improve guardianship processes and HIPAA-related collaboration between agencies
- Advocate for free or subsidized access to insulin, inhalers, and other essential medications; increase awareness of patient assistance programs
- Improve air quality and environmental health: address PFAS in water, reduce pesticide exposure, regulate chemical deposits in groundwater, and pursue tree planting in EJ neighborhoods
- Expand or replicate the Healthy Eating for Cambodian Americans cookbook to include additional materials (e.g. recipe cards) or to additional cultural cuisines
- Launch a "Healthy Habits" Challenge Series, a multi-week program focusing on one habit at a time (hydration, movement, nutrition)
- Create small neighborhood walking groups for older adults

How We'll Measure Success

INDICATOR	BASELINE	GOAL	SOURCE
IMPLEMENTATION			
Implement access to chronic disease screenings (e.g., diabetes, hypertension, cancer) at in-community events	N/A	2 screening events/year; 150 total participants	GLHA task force and event records
Support activities that provide education and resources to specific communities experiencing distinct inequities in chronic conditions (e.g. SEA colon cancer inequities, disproportionate burden of specific autoimmune conditions in Black and South Asian communities, etc.)		300 resident reach total; 3 targeted initiatives yearly	GLHA task force and event records
Expand access to evidence-based chronic disease prevention programs or self-management resources for people living with lifelong conditions	N/A	At least 1 program supported per year; 50 enrollments	GLHA task force records; partner program data
CHNA			
Increase in CHNA participants reporting having had a physical exam in the last year <i>Specific targets: Hispanic/Latino residents (baseline 78.6%), Black residents (baseline 80.9%)</i>	85.5%	92.0%	CHNA 2025
Decrease in CHNA participants reporting that their overall physical health is worse than last year <i>Specific targets: Older adults 65+ (baseline 24.3%), Residents living with disability or chronic illness (baseline 28.6%)</i>	20.8%	15.5%	CHNA 2025
POPULATION			
Decrease the percent of adults with diagnosed diabetes in disproportionately impacted communities <i>Specific targets: Hispanic adults (baseline 14.8%), Black adults (baseline 16.2%)</i>	11.2% (Lowell) 15.0% (Tewksbury)	9.5% (Lowell and Tewksbury)	BRFSS via MA Health Data Tool
Reduce the rate of heart disease and stroke deaths in disproportionately impacted populations	132.1 (HD, White NH) 36.3 (Stroke, Black NH) 27.2 (Stroke, Hispanic)	129.1 (HD, White NH) 30.3 (Stroke, Black NH) 26.6 (Stroke, Hispanic)	RVRS via MA Health Data Tool
Increase the percent of residents screened for specific cancers	See 2025 CHNA, p. 72, for summary of baselines	4 - 7% point increase in all screenings	American Assoc. For Cancer Research Cancer Disparities Report

“I think everyone should be given an equal opportunity to education, health care, and environmental services.”

GOAL 5: PREVENT AND ADDRESS SUBSTANCE MISUSE, ADDICTION, AND OTHER HIGH-RISK BEHAVIORS ACROSS THE LIFESPAN

RATIONALE

While there have been significant reductions in overdose death in MA in recent years, especially in Lowell, substance use remains a major concern. Participants endorsed the policies and programs driving those improvements (e.g. Narcan access/education, MAT, outreach care), though many remained deeply concerned by the impact of fentanyl. Substance experts noted emerging concerns associated with changes in the drug supply, particularly an increase of methamphetamine as a primary substance and secondary or unexpected ingredient (i.e. methamphetamine in what is suspected to be cocaine or Adderall). Providers also noted an increase in people who intentionally inject fentanyl (as opposed to accidental exposure), though the total amount remains small.

Other risk behaviors highlighted by participants included unsafe sex, vaping, and gambling, especially online sports betting. While overall teens are engaging in less substance use and sexual behavior, their rates of vaping and gambling have increased significantly. Adults age 26-40 also have some of the highest rates of drinking alcohol, vaping, and problem gambling, especially among men.

In the next few years, stakeholders also suspect to see an increase in cigarette smoking.

OBJECTIVES

- 5.1: Equip people with the knowledge, skills and supportive environments to avoid substance misuse, vaping, gambling, STDs, and other high-risk behaviors**
- 5.2: Increase access to timely support and treatment for residents experiencing addiction**
- 5.3: Increase community capacity to respond to emergent concerns related to substance misuse, gambling, and infectious disease**

SAMPLE ACTIVITIES

- Advocate for expanded CO-OP staffing and sustained funding for street-level outreach at residences, shelters, and encampment sites
- Expand youth substance misuse prevention through Prevention Partners of Northern Middlesex/Mill City Prevention Network
- Create a sober social committee with rotating monthly events (game nights, fitness classes, coffee meetups) hosted by member organizations, building sober-friendly social infrastructure
- Expand youth-facing harm reduction approaches that frame risk in personally relatable ways (e.g., impact on sports, social life) rather than mortality statistics
- Increase outreach on treatment for HIV, Hepatitis C, and similar conditions among unhoused residents and those facing mental health or substance challenges
- Expand access to low-barrier, no-insurance-required detox and residential treatment in Lowell
- Develop co-ed detox and treatment programs that are supportive of couples
- Advocate for animal and family supports during treatment
- Incorporate gambling risk into youth and family financial literacy classes*
- Host community members with lived experience of gambling recovery to share their stories; advocate for increased funding to gambling prevention programs
- Advocate for more sober housing that doesn't cost-burden residents' full income
- Create drop-in recovery centers open 24/7 with transportation and peer support
- Build local capacity to identify and respond to problem gambling by partnering with the Massachusetts Council on Gaming and Health (MACGH) to train local SUD providers and primary care staff to screen for gambling-related harm
- Provide parent training on identifying and responding to substance use and risky behaviors in youth
- Coordinate a local SUD summit or expanded task force communications to share resources as funding tightens

How We'll Measure Success

INDICATOR	BASELINE	GOAL	SOURCE
IMPLEMENTATION			
Provide education or resources regarding various urgent/emergent substances of concern (vaping, alcohol, opioids, stimulants) with emphasis on youth and young adult audiences	N/A	Audience reach of 300	GLHA task force records
Support or implement activities that address problem gambling	N/A	Audience reach of 80	GLHA task force records
CHNA			
Decrease in CHNA participants reporting that their relationship with substances is worse than a year ago <i>Specific targets: Under age 26 (baseline 9.7%), Black residents (baseline 8.5%)</i>	4.0%	3.0%	CHNA 2025
Decrease in CHNA participants reporting current engagement in risk behaviors (vaping, smoking, gambling, etc.)	New item for 2028	Establish baseline data	CHNA 2028
POPULATION			
Decrease opioid-related overdose deaths in Lowell <i>Specific targets: Black non-Hispanic residents (baseline 60.9), Hispanic residents (baseline 40.1)</i>	32.9 per 100,000 (Lowell, 2021)	28.0 per 100,000	MA DPH Opioid-Related Deaths by City/Town; BSAS Dashboard
Decrease the percent of high school students reporting current e-cigarette use	16.0%	12.0%	MA Youth Health Survey (MYHS); MA DPH
Decrease the percent of youth reporting past-year gambling	43.6% high school students 48.4% middle school students	38.0% (high school) 42.0% (middle school)	MA Youth Health Survey; MA DPH Office of Problem Gambling Services
Decrease the rate of sexual transmitted infections in Lowell	Chlamydia: 675.9 per 100,000 Gonorrhea: 191.3 per 100,000	573.7 per 100,000 162.7 per 100,000	MA DPH Bureau of Infectious Disease; MA PHIT

“Lowell has come a long way. Resources are available [but only] if you know where to look... I am grateful for services like this that are beneficial to my friends, family, and community.”

GOAL 6: STRENGTHEN SERVICES THAT PROMOTE HEALTHY REPRODUCTIVE, PERINATAL, AND EARLY CHILDHOOD OUTCOMES

RATIONALE

Inequities in unplanned pregnancy and perinatal morbidity impact several populations in Greater Lowell. Hispanic, Black, and Southeast Asian girls and women are among the most at risk for poor perinatal outcomes. Participants noted that access to birth control and abortion services were essential for family planning, and expressed concern that this access may be under threat. Providers noted huge increases in out-of-state demand for telehealth reproductive service or services by mail.

Residents also highlighted the need for more postpartum mental health supports, early interventions, and resources for caregivers of children with special needs. Options for clinical and supportive care were described as limited and expensive; participants noted that more access to social support, like parents' groups or family-friendly drop in spaces, would be welcome supplements to the care continuum. Parents of children with autism were also highlighted a group in need of ongoing and additional school and community support.

Emerging concerns for education or school-based support for young children also were noted, with participants expressing the need for a more diverse early intervention workforce for families arriving as immigrants or refugees, especially in cases where those families are managing significant trauma or are living in shelters upon arrival.

OBJECTIVES

6.1: Increase access to affordable reproductive care before, during, and after pregnancy

6.2: Increase the number of infants and young children receiving developmental and clinical support needed to thrive

6.3: Reduce disparities in maternal and infant health outcomes across all demographics

SAMPLE ACTIVITIES

- Expand reach of the Welcome Family home visiting program
- Expand culturally/linguistically appropriate in-community lactation support
- Host community baby showers and create more peer mom groups (both prenatal and postpartum)
- Expand implementation of the CasaCare model offering postpartum residential services and wraparound support for mothers in crisis
- Explore a rotating therapist model across OB/pediatric offices to serve as a hub for identified behavioral health needs, with awareness of local referral resources
- Create robust reproductive health navigation including coverage for fertility care, expanded pap provider availability, and grief support for perinatal loss
- Expand prenatal education for teens, including sexual health, contraceptives, and pregnancy intention
- Ensure continued and expanded access to abortion services and family planning resources including Plan B; reduce stigma around reproductive care and Planned Parenthood
- Advocate for sustained and expanded federal and state funding for Head Start
- Partner with pediatric practices and housing authorities to increase early identification and timely referrals to Early Intervention home visits
- Train teachers and daycare staff to identify children who may have special needs
- Improve access to and awareness of early childcare, including options for parents working non-traditional hours and parents experiencing mental health challenges
- Develop cultural outreach specifically to Southeast Asian and Cambodian communities to increase awareness of maternal health, WIC, Early Intervention, and related services
- Universalize perinatal mental health screening, with warm handoffs to behavioral health services
- Support community-based doula programs
- Improve access to pelvic health physical therapy, postpartum care, and support for reproductive disorders (PCOS, endometriosis) particularly for young women and communities of color
- Advocate for longer/better-paid parental leave and protections for parents in jobs that don't offer paid leave
- Expand free quality childcare options, particularly for parents working non-traditional hours

How We'll Measure Success

INDICATOR	BASELINE	GOAL	SOURCE
IMPLEMENTATION			
Support activities that provide education and resources about reproductive health, family planning, and pregnancy options	N/A	Audience reach of 200	GLHA task force records
Support the perinatal workforce development program, including doula and lactation training, professional development, and mentorship (Cross-reference Goal 2)	13 postpartum doulas trained (2025)	25 community members trained/ supported toward certification	GLHA Doula Project records
Distribute resources or implement education for caregivers of children with special needs, including information about early intervention access, developmental supports, and caregiver self-care	N/A	At least 1 activity per year	GLHA task force records
CHNA			
Decrease in participants reporting pregnancy health problems	12.8%	9.8%	CHNA 2025
POPULATION			
Increase the proportion of postpartum individuals screened for depression and anxiety in Greater Lowell		80% of postpartum individuals screened across participating providers by 2028	MA DPH PPD data or Welcome Family program records
Decrease the rate of unplanned and unwanted pregnancies <i>Specific targets: Hispanic teens (baseline 25.7 per 1,000, 2021), Asian teens (baseline 14 births, 2021)</i>	Teen birth: 13.5 per 1,000 (Lowell, 2022)	9.0 per 1,000	MA Birth Report via MA Health Data Tool
Decrease the proportion of low birth weight and very low birth weight infants among LCHC patients	6.3%	5.5%	Lowell Community Health Center Uniform Data System (UDS)
Decrease the percent of sexually active youth reporting no method of contraception	10%	7%	MA YRBSS

“I think my community has done a very good job in the way of health, safety, and resources (at least from my POV) ... [we] should be putting more funds and resources into the health and safety of rural areas and cities rather than suburbs”

GOAL 7: CREATE SAFE, ACCESSIBLE PHYSICAL ENVIRONMENTS WHERE ALL RESIDENTS CAN GATHER AND CONNECT

RATIONALE

The role of participants' physical environment or community continually recurred across focus groups. The CHNA notes limited access to safe spaces and opportunities for physical activity, especially for older adults and low-income residents, but residents further identified community spaces as critical sites for fostering connections, linking to resources, and creating pro-social norms for neighborhood safety and communion.

A common refrain in focus groups was, "There is nowhere to go." Participants highlighted the importance of "third spaces": communal spaces where people can interact without having to pay money to be in the space. Youth noted being restricted or "kicked out" from parks or shopping areas. Older adults struggled to find comfortable places to sit and gather in public while still feeling safe. Parents noted struggling to find areas that were appropriate for small or school-aged children.

While organizations have attempted to take on this challenge in the past, most are operating from the perspective of health or public health providers, which limited the kinds of spaces and offerings that are provided (e.g. health fairs, drop in clinics, etc.). Participants suggested that stakeholders expand their understanding of the kinds of events, activities, interventions or spaces that can function to improve community or individual health, with a focus on casual, free, recurring social events in public or community-based spaces.

OBJECTIVES

7.1: Promote access to parks, green spaces, and community gathering places

7.2: Prioritize safety for people of all ages and abilities in community spaces

7.3: Increase access to community spaces that actively foster social connection, resource-sharing and a sense of belonging among residents

SAMPLE ACTIVITIES

- Grow the urban tree canopy and green infrastructure in heat-vulnerable neighborhoods
- Advocate for sustained public investment in park programming and maintenance beyond the ARPA period, and support community input into the next Open Space and Recreation Plan update
- Host recurring outdoor community events (movie nights, fitness classes, live music, storytelling circles, skill-sharing)
- Explore walking programs at Mill City Grows' Pawtucket Farm Wildlife Sanctuary trails, with future education spaces and food forest programming
- Support full implementation of GoLowell's ten-year corridor priorities (protected bike lanes, pedestrian safety improvements, curb extensions, and transit enhancements)
- Sustain/expand violence prevention programs, particularly public efforts that impact positive social norms
- Offer creative programming for youth in safe group settings, including practical skills like bike repair, job applications, CPR, and babysitting certification
- Install better street lighting and safety infrastructure in high-need neighborhoods; address concerns around crime and safety with community-centered approaches (not solely enforcement-based)
- Create blue light safety areas in the community (as used on college campuses); develop an anonymous help line for suspicious activity reporting
- Advocate for free public pre-K and daycare as a health and safety infrastructure issue
- Use libraries or community spaces to offer free stretching, yoga, or exercise classes, lowering barriers for people who find gyms financially or socially intimidating
- Partner with organizations serving older adults (Councils on Aging, PACE, elder housing) to bring programming directly to where people live
- Launch a neighborhood micro-grants program for community-led gathering events
- Develop a certification process for nonprofits with outdoor or community spaces to become recognized "safe spaces," with access to specialized funds for events
- Implement a Big Brother/Big Sister program or similar mentorship structure for Lowell youth

How We'll Measure Success

INDICATOR	BASELINE	GOAL	SOURCE
IMPLEMENTATION			
Support activities in public spaces that foster social connection and link residents to health and social resources	N/A	4 events or activations/year	GLHA event and task force records
Implement educational campaign or distribute resources on accessibility of parks, public spaces, and recreational opportunities	N/A	Audience reach of 150	GLHA task force records
Support activities that prevent or address physical and/or sexual violence, or provide population-specific education or resources (e.g. domestic violence resource guides for elders, resource cards for dating violence, etc.)	N/A	3 activities per year	GLHA records
CHNA			
Increase in CHNA participants reporting agreement with "There are safe, clean parks in my community"	64.6%	69.8%	CHNA 2025
Increase in CHNA participants reporting agreement with "I have a reliable way to get around" <i>Specific targets: Older adults 65+ (baseline 94.4%), Residents with a disability (baseline 81.1%), Under age 26 (baseline 80.0%)</i>	87.5%	92.3%	CHNA 2025
Increase in CHNA participants reporting agreement with "I feel safe in my neighborhood at night" <i>Specific targets: Black residents (baseline 67.1%), Hispanic residents (baseline 64.9%), Women (baseline 79.4%)</i>	80.1%	86.0%	CHNA 2025
POPULATION			
Decrease the percent of adults reporting no leisure-time physical activity in the past month	27.9%	21.2%	CDC PLACES via MA Health Data Tool
Decrease serious injuries resulting from motor vehicle collisions with pedestrians	7 (pedestrian) 9 (cyclist)	4 (pedestrian) 5 (cyclist)	MassDOT Crash Data Portal, 2021-2024
Reduce the rate of violent crime	185.0 per 100,000	162.0 per 100,000	FBI UCR via MA Community Health Tool

"All the ingredients for some really awesome things are all here; we just need go get the right mix and make them happen!"

APPENDIX: ADDITIONAL ACTIVITIES

CHIP Workshops generate far more ideas from participants that we are able to fit into each chapter. This appendix includes additional activity suggestions we collected from workshop participants. The ideas included here are intended to inspire collaborative action rather than as specific directives from GLHA.

Youth Community Health Improvement Plan Activities are included in this Appendix and recognized with an asterisk.

Goal 1: Protect Access to Basic Needs Amid Rising Costs and Service Strain

- Add home-delivery or pickup-hub options to existing food pantry partnerships for residents unable to travel to distribution sites
- Pilot a “food pharmacy” where primary care providers can write grocery-voucher prescriptions for patients with diet-related chronic conditions
- Station HIP (Healthy Incentives Program) enrollment support staff at food pantries and WIC offices
- Establish an emergency shelter/support pathway specifically for unaccompanied residents under 18
- Create a single-contact resource navigator line that connects residents to food, housing, and Medicare/insurance-gap support in one call
- Run pop-up produce stands at existing community events to raise visibility of food resources that already exist but go underused
- Host family financial health trainings via churches and temples *
- Partner with local credit unions to launch a financial mentorship program for families *
- Offer safe credit-building programs for youth and families *
- Host a Salary and Debt Transparency event where people in varying careers share their salary in the context of their educational debt via a panel or speed-dating style activity *
- Advocate for tax incentives for businesses that offer student loan forgiveness or assistance *

Goal 2: Improve Access to Affordable, High-Quality, Culturally-Affirming Healthcare

- Run pop-up primary care and screening clinics at community sites (libraries, churches, community centers) for residents who don’t regularly visit a hospital
- Recruit and station bilingual mental/behavioral health providers to match documented language gaps in the community (e.g., Quechua-speaking residents)
- Expand trauma-informed medical interpreter availability at high-volume clinics
- Train front-desk staff and community health workers specifically to help patients understand and navigate insurance coverage
- Partner with UMass Lowell and local high schools on a healthcare career pipeline (CHW, nursing, interpreter tracks) to diversify the future workforce
- Publicly track and report representation data in GLHA and partner-organization leadership annually
- Host a community-wide health career job shadow day *
- Host a “Health Careers You’ve Never Heard Of” speaker series to explore lesser-known careers in varying fields *

Goal 3: Improve Mental Health Through Cultivating Community Connections, Belonging, and Social and Clinical Support

- Deploy a mobile/on-site mental health crisis response team, co-responding with police on relevant calls
- Add recurring low-barrier drop-in social hours at community/senior centers targeted at isolated older adults
- Launch dedicated safe-space programming for LGBTQ+ youth (staffed hours, peer mentoring) in partnership with an existing LGBTQ+-serving organization
- Run a local 988 crisis-line awareness campaign through transit ads, school assemblies, and social media
- Train school staff and community leaders in Mental Health First Aid or equivalent peer check-in skills
- Fund community-garden and field-trip programming for seniors through existing senior center infrastructure, framed explicitly as isolation-reduction
- Host school and community assemblies during awareness months *
- Host a mental health storytelling or open mic event *
- Create a youth-led Suicide PSA via a podcast or social media campaign *
- Host a school-wide mental health panel with guest speakers related to mental health services *
- Host a community-wide talent show *
- Host a neighborhood “day of play” *
- Create an intergenerational mentorship program, like “Adopt a Grandparent.” *
- Launch a youth and parent intramural sports kickball league *
- Offer incentives for youth and parents to complete communication skills workshops and trainings *
- Partner with the library to create an intergenerational book club that focuses on books related to immigrant experiences, LGBTQ+ youth, etc. Partner with temples to participate in Gratitude Day
- Incentivize and provide youth-led “family days” where parents spend time with their households. *
- Host a speed networking event where families can come together to meet local health and mental health serving organizations

Goal 4: Improve Chronic Disease Prevention and Expand Resources for Managing Lifelong Conditions

- Hold free/discounted cancer-screening pop-up clinics specifically targeted to Black, Hispanic, and Puerto Rican residents
- Launch a birthday-triggered postcard or text reminder campaign prompting residents to schedule their annual checkup
- Start peer support groups for people managing diabetes, heart disease, or Alzheimer’s/dementia at community health center sites
- Pair caregiver support groups and fall-prevention kits at senior centers with a police ID-tag registry for residents with dementia
- Pilot a healthy-food stocking incentive program with corner stores/bodegas in food-desert neighborhoods
- Phase out processed food in school and hospital cafeteria contracts in favor of fresh options, starting with a pilot site
- Launch a series of hands-on workshops for youth and their families focused on planning, shopping, and preparing healthy, affordable, and delicious meals. *
- Give students an excused day off to get vaccinated with their families and enjoy a fun family outing afterward. *

Goal 5: Prevent and Address Substance Misuse, Addiction, and Other High-Risk Behaviors Across the Lifespan

- Integrate vaping, alcohol, and problem-gambling prevention content into existing middle and high school health curricula
- Install vape detectors in school restrooms/locker rooms and expand in-school NARCAN training for staff
- Expand drop-in recovery centers to include dedicated peer-support staffing
- Require ID checks and post age-verification signage at gambling retail points (lottery, sports-betting kiosks) in partnership with retailers
- Install naloxone boxes at public sites (libraries, community centers) paired with overdose-education signage
- Study feasibility of a recovery-focused high school option for youth in early recovery
- Create an after-school drop-in support group for youth struggling with gambling *
- Create a youth-focused, sober-friendly calendar of activities and incentivize youth participation *
- Engage youth in designing a public awareness campaign about the risks of sports betting *
- Host a vape trade-in day *

Goal 6: Strengthen Systems and Supports That Promote Healthy Reproductive, Perinatal, and Early Childhood Outcomes

- Expand mom's support groups (lactation support, formula teach-back method, WIC navigation) at community health center sites
- Add free, discreet STI testing sites with outreach specifically targeted to Black and Hispanic communities
- Distribute free/low-cost period products through school nurse offices, prioritizing teens
- Run a multilingual, community-leader-led childhood vaccine education campaign on social media (WhatsApp, Instagram, Facebook)
- Co-locate postpartum depression/anxiety screening within routine pediatric well-child visits
- Expand reduced-cost prenatal PT and doula program slots, prioritizing communities with the greatest documented disparities

Goal 7: Create and Sustain Safe, Accessible Physical Environments Where All Residents Can Gather, Connect, and Thrive

- Extend library and community-center after-school hours to create free, safe youth activity space in higher-crime neighborhoods
- Convert identified vacant lots into community garden or gathering spaces
- Prioritize street lighting and traffic-calming upgrades (speed bumps, flashing crosswalk signage) in areas with documented safety concerns
- Add DUI checkpoints and defensive-driving classes in partnership with local police
- Launch a Big Brother/Big Sister-style mentoring program pairing adult volunteers with youth
- Host a recurring block-party or community-safety-walk series to build neighborhood trust and connection
- Host family workshops and follow-ups on conflict resolution, communication skills, and stress management to promote healthy home environments. *
- Host a youth-led panel bringing in guest speakers who work in the field of Domestic violence. *

- Match younger youth with “big brother/ big sister” mentors to discuss healthy family dynamics. *
- Partner with local police departments and gyms to host self-defense lessons. *
- Launch a youth-led anti-bullying and safe relationships social media campaign. *
- Match younger youth with “big brother/ big sister” to plan monthly check-ins. *
- Create a youth-developed healthy romantic relationships playbook. *
- Create a community wall for youth to write notes of appreciation for their friends who supported them in any way. *
- Create monthly friendship-building bingo card competitions. *
- Train and incentivize youth leaders to participate in bystander intervention courses and act as ambassadors. *
- Partner with local gyms to refer teens who are responsible for school violence to boxing classes. *
- Pair teens responsible for school violence with mentors *
- Design and implement a youth-led safe schools podcast initiative. *
- Design a youth mural with artwork symbolizing and evoking feelings of safety *
- Create a youth-led school safety checklist that is sent to all students, parents, and teachers *
- Designate inclusive, accessible and monitored spaces in schools for youth to escape violence and peer conflict*
- Launch a series of workshops to educate youth about self-regulating social media use *
- Host monthly youth-led screen-free events or community-wide days of play *
- Implement a youth-led campaign on demystifying online beauty standards. *
- Host a series of workshops encouraging self-acceptance, identity, and trust among others, to undo the impacts of misusing social media *
- Host competitions where the teen with the least amount of screen time wins prize money or an A+ on a quiz/ assignment *
- Host an “influencer” training where teens learn how to use their platform to advocate for health, human rights, and things they are passionate about



The GLHA Needs You

The success of the Greater Lowell Health Alliance relies on the participation and engagement of individuals and organizations to enable us to inform, consult, involve, collaborate, and empower our communities. There are many ways you can become involved and support the GLHA.

JOIN A TASK FORCE

The GLHA is always looking for new community members to join task forces and to collaborate on addressing the issues our community faces. All task force meetings are open to the public – whether virtual or in person – and all are welcome.

DONATE

As the GLHA grows in both scope and impact, so does our need for resources. As a non-profit 501(C)(3), we rely on donations from organizations and individuals to sustain our mission, grow our programs, and keep our events free and accessible to everyone. **Please consider donating to the Greater Lowell Health Alliance at greaterlowellhealthalliance.org/donate.**

For more information on these initiatives and other ways to get involved with the Greater Lowell Health Alliance, visit greaterlowellhealthalliance.org.



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