2025 South Coast Community Health Alliance

Community Health Needs Assessment

Table of Contents

Introduction

Formation of the South Coast Community Health Alliance (SoCHA):

The South Coast Community Health Alliance (SoCHA) was formed in the summer of 2024 to unite key community stakeholders committed to improving health outcomes. The Alliance conducts comprehensive health assessments that fulfill regulatory requirements while advancing shared mission goals. By working together on one coordinated assessment, members reduce duplication, strengthen collaboration, and free up more capacity to serve the community.

The SoCHA 2025 Community Health Assessment represents the first report produced by the Alliance.

SoCHA has completed this assessment in collaboration with St. Anne's Hospital—Brown Health University and looks forward to St. Anne's fully joining the alliance for our next assessment.

About the South Coast Community Health Alliance Members

Southcoast Health, founded in 1996, is the largest provider of primary and specialty care in southeastern Massachusetts and Rhode Island. The not-for-profit, charitable system includes three acute care hospitals—Charlton Memorial in Fall River, St. Luke's in New Bedford (a Level II Trauma Center), and Tobey in Wareham, Massachusetts. With a physician network of over 900 providers and more than 55 service locations, Southcoast Health is dedicated to delivering high-quality healthcare to its communities.

The New Bedford Health Department serves as the city's primary public health agency. The department is committed to promoting healthy lifestyles and health equity, preventing and responding to disease, and ensuring safe and sanitary environments that protect our diverse, multicultural community through services, outreach, and regulations. The department is led by the city's Director of Health and supported by an Assistant Director and a mix of locally and grant-funded staff.

Fall River Health Department is a vital component of the city's Division of Health and Human Services. This division encompasses several key services, including Public Health Nursing, the Council on Aging, Youth Services, and various grant-funded initiatives such as Mass in Motion.

Child & Family Services (CFS) mission is to heal and strengthen the lives of children and families by providing equitable, inclusive, and trauma-informed behavioral health care. CFS provides over 20 specialized behavioral health programs for youth, adults, and families—delivered in office, home, and community settings—to eliminate barriers and ensure equitable access to care.

Citizens for Citizens, Inc. (CFC) is a Massachusetts Community Action Agency serving over 30,000 individuals in Southeastern Massachusetts each year. Since its incorporation in 1965, CFC has provided both short- and long-term services designed to empower low-income individuals and families, equipping them with the tools necessary to overcome poverty and financial crises while fostering self-sufficiency.

People Acting in Community Endeavors (PACE) is a nonprofit organization based in New Bedford, Massachusetts, dedicated to empowering low-income individuals and families to achieve brighter futures. Established in 1982, PACE serves the Greater New Bedford area by providing a comprehensive range of services that address critical needs such as early childhood education, housing support, food security, health access, and workforce development.

New Bedford Community Health (NBCH) formerly known as the Greater New Bedford Community Health Center, is a nonprofit, federally qualified health center (FQHC) located in downtown New Bedford, Massachusetts. Established in 1981, NBCH has been providing comprehensive, patient-centered care to the community for over four decades.

HealthFirst Family Care Center, Inc., established in 1971 in Fall River, Massachusetts, is a nonprofit Federally Qualified Health Center (FQHC) committed to providing comprehensive, accessible healthcare services to individuals and families, regardless of their ability to pay. Originally founded as a Model Cities Program, it has evolved into a vital community health resource.

Stanley Street Treatment and Resources (SSTAR) is a nonprofit healthcare and social service agency located in Fall River, Massachusetts. Established in 1977, as an addiction treatment center, SSTAR expanded to provide mental health and HIV services, later opening a Federally Qualified Health Center in 1992, and has been dedicated to providing comprehensive care to individuals in the community.

Overview

The 2025 SoCHA Community Health Needs Assessment (CHNA) represents a collaborative community-wide approach that incorporates a comprehensive analysis of health data, stakeholder interviews, community focus groups and a community survey to identify and address the most pressing health needs within the South Coast region.

CHNA's are a key resource for local policymakers and community leaders. It helps guide health improvement planning, set priorities, shape programs and policies, and strengthen collaboration across the community.

Through this collaborative process, partner organizations developed a shared understanding of the community's health needs, assets, and barriers to achieving health equity. This collective insight informs priority setting, strategy development, and coordinated action aimed at reducing disparities and improving outcomes for all populations.

Conducted on a three-year cycle, the 2025 SoCHA CHNA builds on prior assessments to identify emerging health priorities, implement targeted and equity-focused strategies, and strengthen the collective impact of participating organizations on community health and well-being.

This report highlights differences by race, ethnicity, and geography to inform actions that promote equitable health outcomes across the South Coast region.

Figure 1: SoDH Wheel—CDC Social Drivers of Health (SDOH)

The Social Drivers of Health (SDoH)

Health is influenced by multiple factors beyond health care and personal behaviors. Up to **80% of health outcomes** are shaped by the conditions in which people live, work, play, and worship—known as social drivers of health (SDoH). These include access to economic opportunities, quality education, safe housing, supportive community resources, workplace safety, environmental conditions, and social relationships *(Figure 1).*

Health disparities are preventable differences in outcomes and access that disproportionately affect certain populations. **Health equity** ensures that all individuals, particularly those in vulnerable communities, have fair and just opportunities to achieve optimal health by addressing systemic and avoidable barriers.

Identifying disparities and their underlying social and environmental drivers is essential for guiding evidence-based, community-driven strategies.

Purpose & Goals of the CHNA

The 2025 SoCHA CHNA serves as a critical tool to support institutions in meeting regulatory and accreditation requirements while advancing collaborative community health improvement efforts.

Under the Affordable Care Act, non-profit hospitals are required to identify and prioritize the health needs of the populations they serve and to develop strategies to address those needs. Similarly, Federally Qualified Health Centers (FQHCs) must conduct a CHNA to maintain compliance with Health Resources and Services Administration (HRSA) standards, local health departments are required to undertake a comprehensive Community Health Assessment (CHA) as a core public health function and to maintain accreditation through the Public Health Accreditation Board, and Massachusetts Community Action Agencies are required to complete an assessment per the requirements of the Executive Office of Housing and Livable Communities (EOHLC).

The 2025 SoCHA Community Health Assessment represents the first report produced by the Alliance. The assessment serves as the foundation for a Community Health Improvement Plan (CHIP) by systematically identifying the most pressing health needs, disparities, and social determinants affecting a community through data analysis and stakeholder engagement.

In essence, a CHNA defines what the community's health challenges are, while a CHIP establishes how the community will collaboratively address them.

During the development of the 2025 SoCHA CHNA, alliance members met on a monthly basis to oversee the process of data collection, analysis, interpretation, prioritization, and the dissemination of findings.

The alliance prioritized a set of indicators for inclusion in the assessment, and outlined a consistent, inclusive, and robust community engagement strategy. The alliance leveraged the Metopio platform, a data analytic tool that transforms data into clean, actionable insights.

The CHNA aims to:

* Identify the health-related needs, strengths, and resources of the community in a systematic way to inform future planning.
* Understand the current health status of the South Coast region and its sub-populations within their broader social context.
* Engage and elevate the voices of historically marginalized and underserved communities.
* Meet regulatory requirements for institutional stakeholders, organizations, and agencies (e.g., IRS requirements for non-profit hospitals; Public Health Accreditation Board standards for health departments; Health Resources and Services Administration (HRSA) standards for FQHCs; EOHLC requirements for Community Action Agencies).
* Foster cross-sector collaboration to drive collective impact.

Findings from this report will inform the development of the next iteration of the New Bedford Community Health Improvement Plan, and set the foundation for the Fall River Community Health Improvement Plan.

The CHIP will outline goals, measurable objectives, and implementation strategies to address the region's top health priorities. In addition, partner organizations will use these findings to shape their institutional implementation plans and guide other strategic initiatives aimed at improving the health and well-being of South Coast residents.

Methodology & Data

The 2025 SoCHA CHNA employed a mixed-methods approach to engage a diverse range of South Coast residents, community organizations, and local leaders. Primary and secondary data was collected and analyzed to guide the process.

Primary Data included input from organizational partners and direct-service providers, stakeholder interviews with experts and community leaders, focus groups with residents, and a community health survey.

Stakeholder Interviews	30 Individuals
Community Focus Groups	8 Sessions
Community Survey	1,329 Respondents

Secondary data on health outcomes, health behaviors, and social drivers of health were collected from national, state, and city sources using the Metopio platform. This platform supplemented the primary data from surveys, focus groups, and interviews, providing a broader context for understanding the community's health needs.

The **stakeholder interviews** provide in-depth information through conversations, seeking individuals' views, experiences, or knowledge on specific subjects. The interviews conducted for this assessment involved **30 stakeholders** that highlighted the importance of addressing social drivers of health, such as education and affordable housing, to improve community health outcomes. Collaborative efforts and increased resource availability are seen as crucial for addressing these complex challenges.

Focus Groups consisted of small, facilitated discussions designed to gather community perspectives on health perceptions and attitudes. A total of **75 participants** took part in **eight sessions**. Participants identified several key factors that influence community health, including access to healthcare, safe and stable housing,, nutritious food, and a clean environment. They also emphasized significant health concerns such as substance use, mental health challenges, homelessness, and managing chronic diseases. Suggested strategies for improvement included expanding access to public gyms and outdoor spaces, increasing the availability of affordable housing, and strengthening mental health services.

Survey data was collected both online (via a web link or QR code) and through paper surveys. The survey was translated into English, Spanish, Portuguese, Cape Verdean Creole, Haitian Creole, and K'iche'.

Participation was voluntary, and respondents were entered into a drawing to win gift cards provided by the New Bedford Health Department as an incentive. This survey represents a convenience sample, promoted through advertisements across various social media channels and targeted outreach at community events.

Limitations with Data

As with all data collection efforts, several limitations should be acknowledged. The data sources used in this report vary in how they measure similar variables (e.g., different questions to identify race/ethnicity or differing neighborhood boundaries). Many data sources also have a time lag between collection and availability. In some cases, data are not available for certain population groups or at more granular geographic levels due to small sample sizes. It was also not always possible to look at how different parts of people's identities (such as race, income, or gender identity) overlap. In addition, some data from multiple years were aggregated to allow for more reliable estimates at smaller geographic levels or among specific groups.

The Alliance acknowledges that the findings in this report reflect only the perspectives of those who participated in these interviews, focus groups and community survey and are not fully comprehensive. Some concerns from specific community members or subgroups within the South Coast may not be represented.

It is important to note that data collection for this assessment occurred during a period of transition in the federal government. Shifts in national leadership can reshape policy priorities, funding streams, and regulatory frameworks—factors that directly affect residents' health and well-being as well as the capacity of local organizations to serve their communities. These dynamics may also influence the degree to which individuals and groups feel comfortable engaging in data collection efforts.

As federal policies continue to evolve, it remains essential to monitor and understand the assets, challenges, and priorities of the South Coast's diverse communities, particularly those experiencing a disproportionate burden of health inequities.

SoCHA is committed to building a healthier community, and your voice is essential in helping us understand the lived experiences of residents across the region. We welcome public comments on both the CHNA process and the findings. Please submit feedback to SoCHA alliance members.

Health Themes

The health themes were identified based on the insights gathered from surveys, focus groups, interviews, and Metopio data *(Figure 2).*

Socio-economic Factors

Social and economic conditions, including income, poverty, education, and employment, that influence health outcomes and equity.

Housing

Safe, stable, and affordable housing as a foundation for physical, mental, and social well-being.

Built Environment

Community infrastructure and design, including transportation, green space, and neighborhood safety, that influence health and well-being.

Food Access & Security

Availability of affordable, nutritious, and culturally appropriate foods that support healthy eating and reduce food insecurity.

Access to Care

Availability, affordability, and accessibility of healthcare services, including preventive, primary, specialty, and dental/oral health care.

Behavioral Health

Mental health and substance use, with a focus on prevention, treatment, and reducing stigma.

Chronic Disease

Prevention, management, and treatment of conditions such as diabetes, heart disease, cancer, and respiratory illnesses.

Maternal & Child Health

Health and well-being of mothers, infants, and children, including prenatal care, birth outcomes, child development, and family support.

Overall Health

General physical, mental, and social well-being, encompassing quality of life and healthy lifestyles across the lifespan.

Figure 2: Health Themes

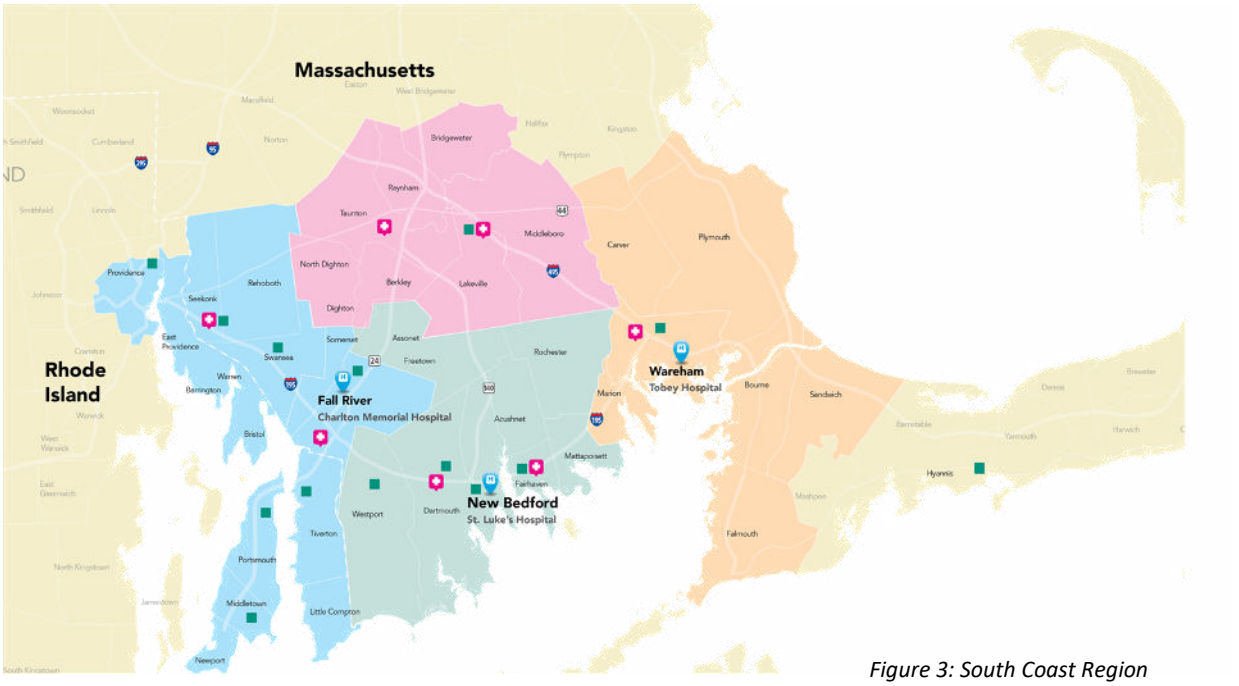


Figure 3: South Coast Region

Defining the South Coast Region of Massachusetts

The South Coast encompasses a mix of urban, suburban, and rural communities, including the cities of New Bedford and Fall River and surrounding towns. The area is home to a diverse population with rich cultural traditions, shaped by waves of immigration over time. Historically known for its fishing, textile, and manufacturing industries, the region today faces both economic challenges and opportunities for growth.

Many residents experience persistent health inequities driven by social and economic factors such as income, employment, housing, and access to care. At the same time, the South Coast is strengthened by strong community networks, cultural assets, and a shared commitment to improving health and well-being.

For the purpose of this report, the South Coast region includes the following cities and towns: Acushnet, Assonet, Fairhaven, Fall River, Freetown, Dartmouth, Lakeville, Marion, Mattapoisett, New Bedford, Rochester, Somerset, Swansea, Wareham, Westport *(Figure 3).*

Since the vast majority of the cities and towns served by SoCHA are located within Bristol County, this community analysis and profile will focus on the defined South Coast region noted above. By concentrating on this area, the report aims to provide a detailed understanding of the population characteristics, health and socioeconomic conditions, and community needs specific to the region, informing targeted strategies and interventions to promote health and well-being.

In addition, additional cities and towns within Bristol County *(Taunton, Seekonk, Dighton, Berkley, Rehoboth)* are discussed, along with Plymouth County, Nantucket County, and Norfolk County are featured in this report to support the service areas of Citizen's for Citizens and PACE.

Population Characteristics

The South Coast Region has a diverse and dynamic population, shaped by age, gender, race and ethnicity, language, immigration status, disability status, opportunity youth, and socioeconomic factors. Understanding these characteristics is essential for advancing health equity and designing inclusive, culturally competent services that meet the needs of all residents.

The South Coast Region Population

In conclusion of the most recent Census, the South Coast Region had an average population of 378,075 residents. New Bedford and Fall River serve as the largest urban centers in the region, each with significant populations across multiple zip codes. These cities anchor the region's population, contributing to its density and shaping many of its social and economic dynamics. Surrounding smaller towns add to the overall population distribution, creating a landscape that blends dense urban areas with less populated communities *(Figure 4).* This variation underscores the region's diversity and the importance of strategies that address both urban and rural needs .

Community	2020	2024	% Change from 2020 to 2024
Acushnet	10,552	10,700	1.4% increase
Berkley	46,471	47,085	1.32% increase
Dartmouth	33,914	34,139	0.66% increase
Dighton	8,103	8,275	2.12% increase
Fairhaven	15,919	16,005	0.54% increase
Fall River	93,983	94,689	0.75% increase
Freetown	9,202	9,380	1.93% increase
Lakeville	11,527	12,262	6.38% increase
Marion	5,343	5,341	-0.04% decrease
Mattapoisett	6,513	6,763	3.83% increase
New Bedford	101,079	101,318	0.24% increase
Rehoboth	12,505	13,537	8.28% increase
Rochester	5,720	5,936	3.77% increase
Seekonk	15,526	15,912	2.51% increase
Somerset	18,306	18,375	0.38% increase
Swansea	17,150	17,537	2.23% increase
Taunton	59,350	61,936	4.35% increase
Wareham	23,300	23,526	0.98% increase
Westport	16,345	16,705	2.22% increase
Massachusetts	7,033,132	7,136,171	1.48% increase
Bristol County	579,298	588,593	1.62% increase
Plymouth County	530,820	542,090	2.11% increase
Norfolk County	726,010	740,754	2.05% increase

Figure 4: South Coast Region Population

Age Characteristics

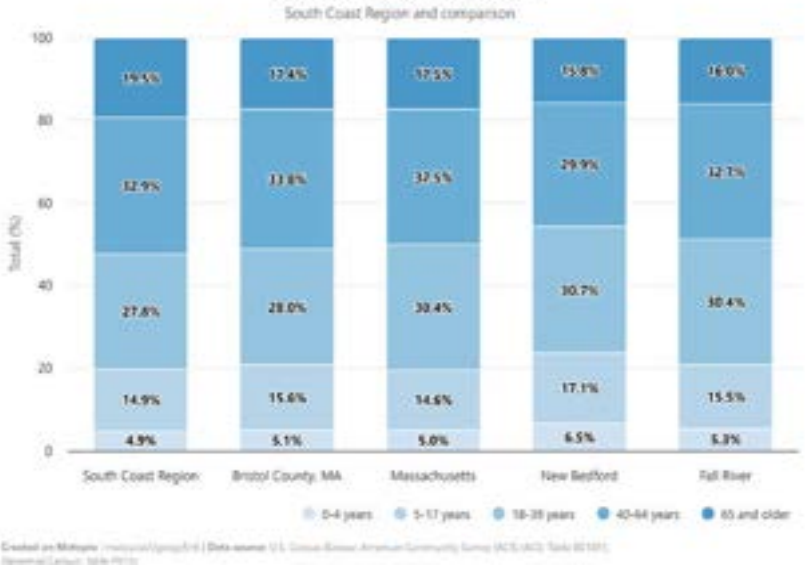
The region's age distribution reflects a mix of children, adolescents, young adults, middle-aged adults, and seniors, with a notable presence of young adults and middle-aged individuals. This demographic profile indicates a strong mix of working-age adults and younger populations, both of which are essential for maintaining a vibrant and dynamic local economy;

The significant share of young adults' points to opportunities for growth and innovation, while the concentration of middle-aged individuals underscores the need for services that support families and professionals.

When compared with Bristol County and Massachusetts overall, the South Coast shows a slightly higher proportion of young adults, while maintaining a comparable share of middle-aged and older adults *(Figure 5)*. These trends highlight the importance of tailoring healthcare, education, and economic opportunities to meet the needs of both younger and older residents.

Expanding access to quality education, employment pathways, and affordable healthcare will help foster a thriving community, while ensuring that the aging population is supported with comprehensive and accessible health services.

Figure 5 **Population by Age, 2019-2023**



Opportunity Youth

The South Coast Region has a significant population of opportunity youth—defined as young people between the ages of 16 and 24 who are not currently engaged in education, employment, or training. This group, particularly young males, faces heightened challenges in areas like New Bedford and Fall River, where the proportion of opportunity youth is notably higher than in Bristol County and Massachusetts overall.

These young individuals often encounter systemic barriers such as economic hardship, limited access to quality education, and a lack of supportive services, which can hinder their ability to transition successfully into adulthood. Addressing their needs is critical not only for their personal development but also for the long-term vitality of the region.

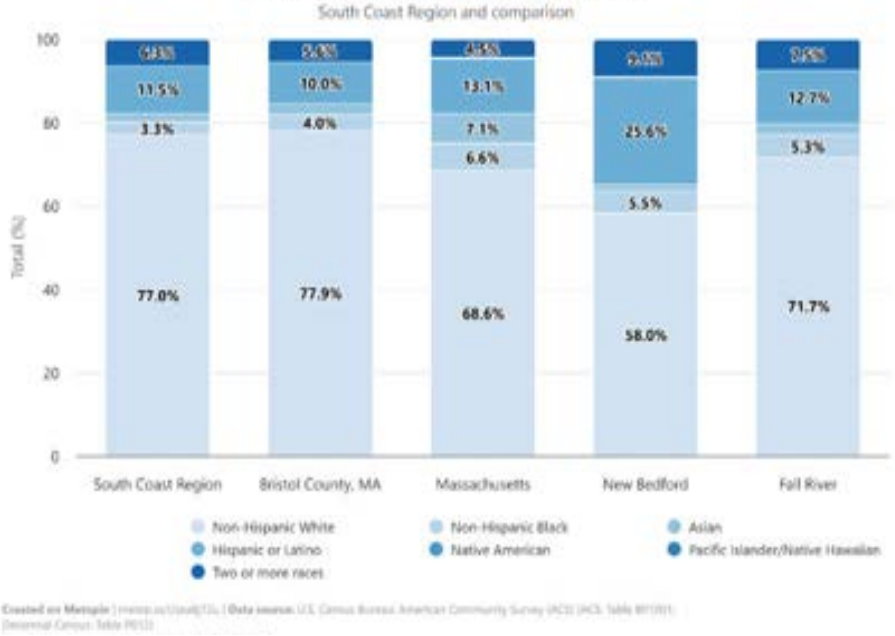
This highlights the need for targeted programs that provide education, job training, mentorship, and other youth development opportunities. By investing in the empowerment and skill-building of these young individuals, the community can foster a more resilient, engaged, and prosperous future for all residents.

The South Coast's Race & Ethnicity Profile

The South Coast region is predominantly non-Hispanic White, with significant representation of Hispanic or Latino and non-Hispanic Black residents, as well as other racial and ethnic groups. In comparison to Bristol County and Massachusetts, the South Coast Region has a higher percentage of both Non-Hispanic White and Hispanic/Latino residents *(Figure 6*).

This demographic profile highlights the importance of addressing health disparities and ensuring equitable access to healthcare services across all racial and ethnic groups. By fostering inclusivity and cultural competence within health systems and community programs, the region can advance health equity, improve outcomes, and strengthen a sense of belonging among all residents.

Figure 6 **Population by Race/Ethnicity, 2019-2023**



Immigration Status

The South Coast Region has a notable population of non-citizen immigrants, with concentrations particularly in New Bedford and Fall River. New Bedford has the highest percentage of non-citizens at 10.96%, followed by Fall River at 9.55%.

Compared with Bristol County and Massachusetts overall, the region has a higher percentage of non-citizen immigrants, highlighting the importance of providing accessible healthcare and culturally competent programs, to address the unique needs and challenges faced by immigrant communities. Ensuring these services are available promotes overall well-being, supports integration into society, and advances health across the region.

Limited English Proficiency on the South Coast

The South Coast Region has a notable share of households with limited English proficiency, particularly concentrated in New Bedford and Fall River. This linguistic diversity presents both challenges and opportunities for community health initiatives, emphasizing the need for tailored communication strategies and language assistance services to ensure that all residents can access essential health information and care.

Compared with Bristol County and Massachusetts overall, the South Coast—especially its two largest urban centers—shows a higher prevalence of limited English proficiency households. Both New Bedford and Fall River, have higher rates of such households compared to the state average. New Bedford leads with 11.2%, followed closely by Fall River at 11.03%

This underscores the importance of strengthening language support services and culturally responsive health education to bridge communication gaps and improve health literacy among non-English speaking populations. Addressing these barriers is essential for advancing health and ensuring equitable healthcare access and outcomes for all community members.

South Coast Residents with Disabilities

When compared to Bristol County and Massachusetts, the South Coast Region has a higher proportion of residents with disabilities, particularly in New Bedford and Fall River, with prevalence increasing among older adults. This demographic trend emphasizes the need for comprehensive healthcare services and support programs that address the unique needs of individuals with disabilities, ensuring access to quality medical care, rehabilitation services, and social support. Meeting these needs is critical for promoting health and enabling full participation in community life.

Gender Identities

The gender composition across the region is relatively balanced, with a slight majority identifying as women, mirroring broader regional and state trends. Applying a health equity lens, it is essential to acknowledge gender diversity and fluidity and ensure that healthcare services are inclusive, affirming, and responsive to the needs of all individuals—including women, men, non-binary, and gender-diverse people. Advancing equitable access to care across the gender spectrum is critical to reducing disparities and promoting the health and well-being of the entire community.

Population data show that the South Coast Region—including Fall River and New Bedford—has a slightly higher proportion of women (51.16%) compared to men (48.84%). Within this region, Fall River has a slightly larger female population at 51.78% compared to 48.22% male, while New Bedford has a lower female population at 49.59% and a higher male population at 50.41%. Statewide, Massachusetts has a female population of 51.14% and a male population of 48.86%.

HealthFirst & Community organizations providing educational tools for youth before the start of the 2025-2026 school year.

Health Theme: Socio-economic Factors

"Socio-economic status is huge, families often need to work multiple jobs just to meet their basic needs."

---------- COMMUNITY STAKEHOLDER

Socioeconomic conditions are a critical driver of community health, shaping individuals' ability to access basic necessities and services. Economic hardship often forces residents to prioritize immediate survival over long-term well-being, making it difficult to afford essentials such as food, healthcare, and housing. Rising costs of living, combined with limited support systems, further restrict access to critical services—particularly for low-income families, seniors, and marginalized populations. Community feedback underscores these challenges, with residents highlighting high housing costs, increasing cost of food, and limited access to affordable childcare and transportation as pressing concerns.

Economic Hardship

Socioeconomic status consistently emerged as one of the top concerns in the South Coast region. As one stakeholder observed, “socioeconomic status is a huge factor. Families are born and raised in a certain level of economy.” Another noted, “Many residents face persistent economic hardship, which affects their ability to afford healthcare, housing, nutritious food, and other basic needs. Financial instability often forces individuals to prioritize immediate survival over long-term health.” In addition, 84.2% of community survey respondents responded “yes,” when asked “In the past 12 months, have you ever struggled to pay for necessities such as housing, food or bills?”.

These perspectives illustrate how economic pressures disproportionately affect low-income families, creating barriers to stability, well-being, and long-term health.

Figure 7 **Median household income, 2019-2023**

Economic hardship remains a pressing issue in the South Coast Region. Income and poverty are central social drivers of health, shaping access to housing, food, education, and healthcare. Families with lower incomes often face limited opportunities for stability and advancement, contributing to persistent inequities in health and well-being.

The data on median household income highlights substantial economic disparities across Massachusetts, the South Coast Region, and its two major cities—Fall River and New Bedford. Massachusetts reports the highest median household income at $101,341. In comparison, the South Coast Region falls well below the state average at $79,355, approximately 22% lower. Within the region, Fall River ($57,602) and New Bedford ($56,938) have even lower incomes—about 43% below the state average and nearly 27–28% below the South Coast regional median *(figure 7).*

Poverty rates in the South Coast mirror these income disparities. While Massachusetts reports a statewide poverty rate of 9.9%, the South Coast experiences a higher rate of 12.35%. Economic hardship is particularly pronounced in urban centers—Fall River (18.21%) and New Bedford (18.73%)—where poverty levels are more than double the state average. For many households in these communities, financial instability forces difficult trade-offs between immediate needs and long-term health and stability *(figure 8).*

Figure 8 **Poverty rate, 2017-2021**

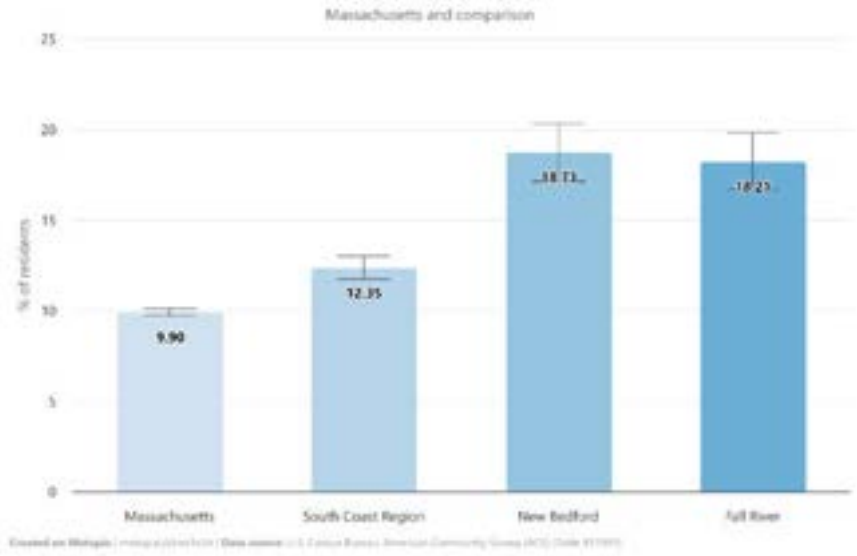
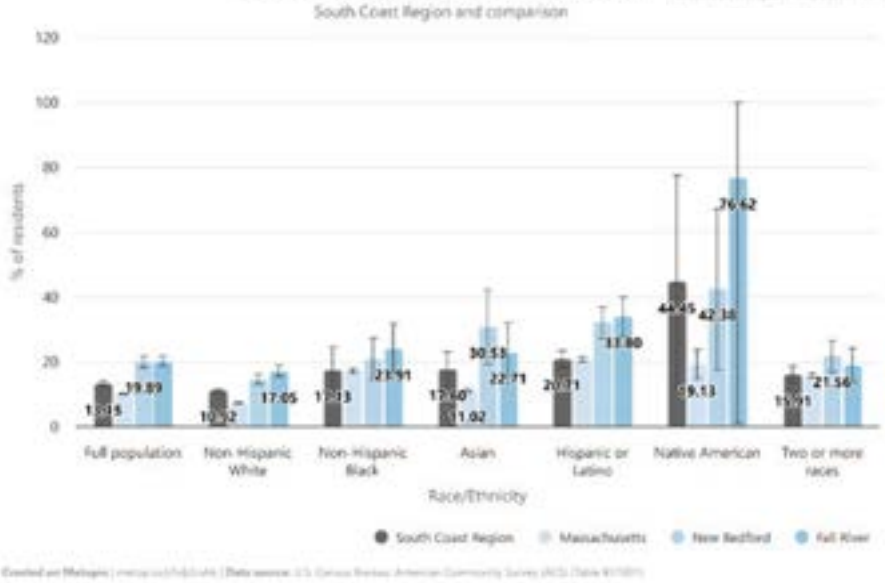


Figure 9 **Poverty rate by Race/Ethnicity, 2019-2023**



Poverty also varies significantly across racial and ethnic groups. Native American residents experience the highest poverty rates, with 44.45% living in poverty region-wide and 76.62% in Fall River. Hispanic or Latino and Non-Hispanic Black populations also experience higher-than-average poverty, while Non-Hispanic White residents have the lowest rates (10.92% region-wide; 17.05% in Fall River) (*figure 9).*

Area Deprivation Index

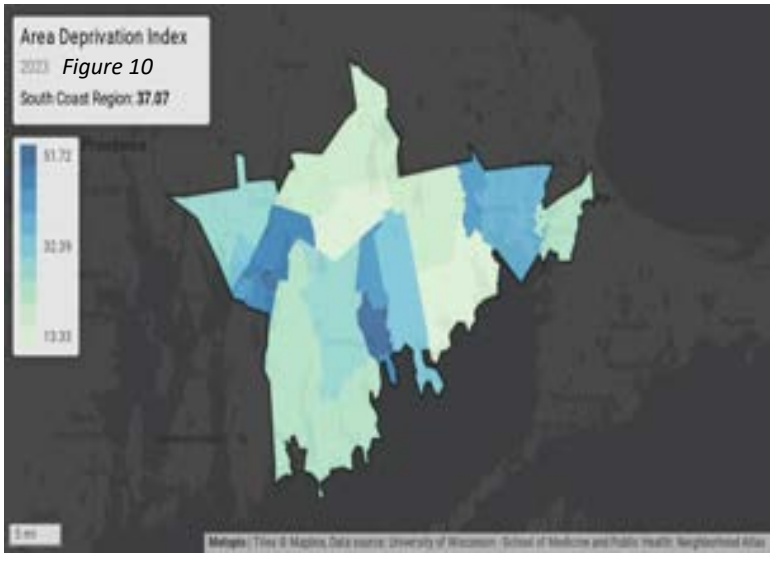


Figure 10

The **Area Deprivation Index (ADI)** ranks neighborhoods based on socioeconomic disadvantage, incorporating factors such as income, education, employment, and housing quality. Higher ADI values indicate greater levels of disadvantage.

Within the South Coast Region, ADI values vary considerably, ranging from 13.33 in Mattapoisett Center—reflecting relatively low disadvantage—to 51.72 in New Bedford, indicating significant socioeconomic challenges *(figure 10).* These differences highlight the uneven distribution of economic hardship across the region and the need for targeted interventions in more disadvantaged communities.

Education from Birth through Higher Education

Education plays a critical role in shaping health outcomes. As one stakeholder notes "lack of an education perpetuates poverty." In the South Coast Region, disparities in educational attainment can create barriers to accessing healthcare, maintaining healthy lifestyles, and achieving overall well-being.

Beginning at birth, education plays a fundamental role in shaping lifelong health and well-being. By age 5, a child's brain has already reached approximately 80% of its adult size, making early experiences, stimulation, access to quality childcare, and supportive learning environments critical for cognitive, social, and emotional development. These early foundations set the stage for future educational attainment, healthy behaviors, and overall life outcomes.

> "Educational disparities contribute to reduced health literacy and limited job opportunities. Individuals with lower levels of education may struggle to navigate the healthcare system or access preventive care."
>
> - Community Stakeholder

In the South Coast Region, disparities in **early childhood education** and developmental opportunities can have lasting effects on health and well-being.

A significant concern is the availability of early childhood education programs. As community stakeholders note, "there are more than twice as many children under the age of five as there are available childcare slots in the region." This shortage limits access to quality early learning experiences, which are critical for cognitive, social, and emotional development during a period when a child's brain is rapidly growing.

Statewide, Massachusetts has made strides in early education, with **Preschool enrollment** at 55.57%, indicating a relatively high level of early childhood education participation. However, there is a notable decline in enrollment rates within specific regions and cities. Bristol County, MA, reports a lower enrollment rate of 48.58%, and the South Coast Region further drops to 40.02%. The cities of Fall River and New Bedford exhibit the lowest rates at 38.14% and 34.77%, respectively, highlighting significant regional disparities in preschool access and participation *(figure 11)*.

Figure 11 **Preschool enrollment (3-4 years), 2019-2023**

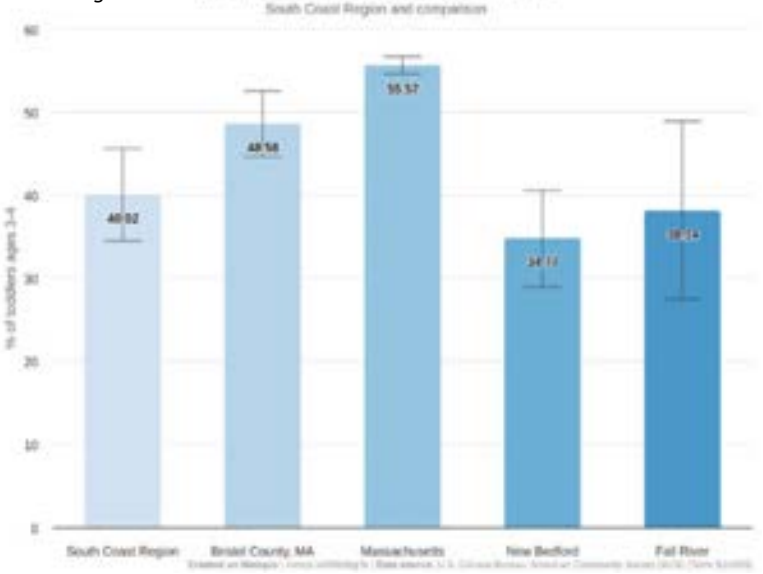
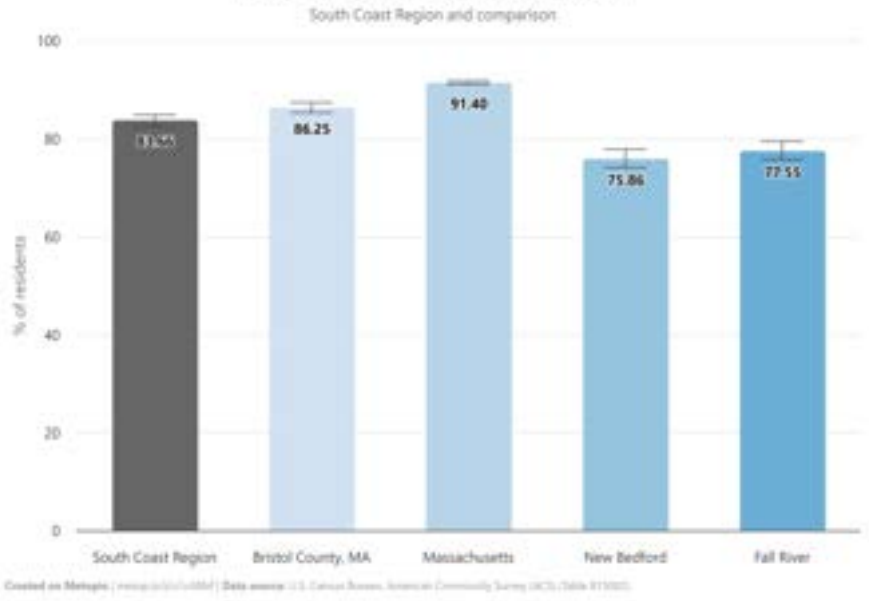


Figure 12 **High school graduation rate, 2019-2023**



High school graduation is another critical milestone with long-term implications for health, economic stability, and overall well-being. Graduating from high school is associated with higher lifetime earnings, greater employment opportunities, and increased access to healthcare and social resources.

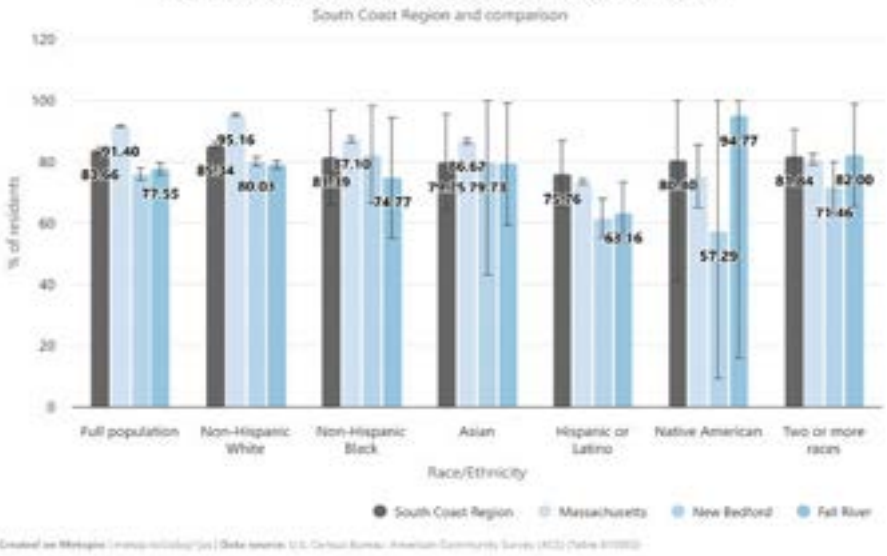
Conversely, students who do not graduate face higher risks of unemployment, poverty, and poorer health outcomes. Supporting youth to complete high school is essential for fostering resilient individuals and thriving communities, particularly in regions like the South Coast where socioeconomic disparities and opportunity gaps can create barriers to educational attainment.

The overall high school graduation rate in the South Coast Region is 83.66%, with urban centers showing lower rates—75.86% in New Bedford and 77.55% in Fall River *(figure 12).*

Graduation rates also vary significantly across racial and ethnic groups. Non-Hispanic White students have the highest graduation rate at 85.34%, while Hispanic or Latino students have the lowest at 75.76%. In New Bedford, Native American students face a particularly low graduation rate of 57.29%, and in Fall River, Hispanic or Latino students graduate at a rate of 63.16% *(figure 13).*

These disparities highlight persistent inequities in educational outcomes and underscore the need for targeted strategies to support students from historically marginalized communities.

Figure 13 **High school graduation rate by Race/Ethnicity, 2019-2023**



Higher education attainment also shows significant variation across racial and ethnic groups in the South Coast Region, as well as in New Bedford and Fall River. Asian individuals have the highest attainment rate in the South Coast at 63.84%, while Hispanic or Latino individuals have the lowest at 44.11%. In New Bedford, Asian residents lead with 72.89%, whereas Hispanic or Latino residents have the lowest rate at 23.69%. Notably, Native American individuals in Fall River achieve a higher attainment rate of 71.51% compared to other locations. These disparities underscore the need for equitable access to higher education opportunities and support for students from underrepresented communities.

Together, investments in early childhood education, support for high school completion, and equitable access to higher education are critical for fostering lifelong success, promoting health

Several colleges and universities in the South Coast region have implemented programs to reduce or eliminate tuition costs, improving accessibility for students from low- and middle-income families. Public institutions such as the **University of Massachusetts Dartmouth** and **Bridgewater State University** will waive tuition and fees for eligible in-state undergraduates beginning in Fall 2025, targeting families with incomes below $75,000 and $125,000, respectively. Community colleges, **including Bristol Community College, Massasoit Community College,** and **Cape Cod Community College,** offer free tuition and fees through initiatives like MassReconnect and MassEducate for Massachusetts residents without a bachelor's degree. While **Massachusetts Maritime Academy** provides targeted financial assistance and scholarships, private institutions such as **Stonehill College** and **Wheaton College** offer need- and merit-based aid to make their programs more affordable. These efforts collectively enhance educational access in the South Coast region, designed to help more students pursue higher education without the barrier of prohibitive costs.

Workforce Engagement & Opportunities

Workforce engagement in the region reflects these educational patterns and varies across age groups and locations. Massachusetts reports an overall workforce engagement rate of 67.21%, with Bristol County slightly lower at 65.3%. In the South Coast, engagement is lower in urban centers, with Fall River at 61.94% and New Bedford at 61.74% *(figure 14)*.

"There is a lack of jobs that pay a living wage. Wages have not kept up with cost of living."

- Community Stakeholder

Figure 14 **Labor force participation, 2019-2023**

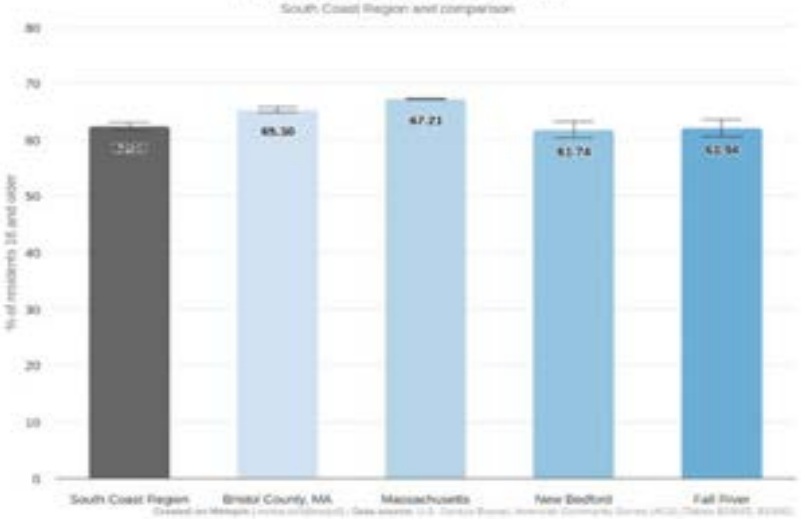
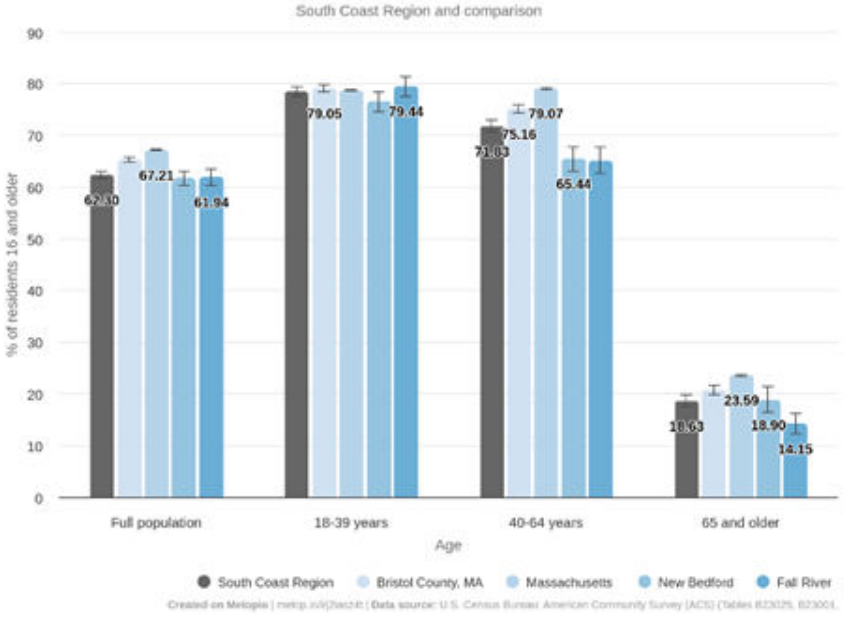


Figure 15 **Labor force participation by Age, 2019-2023**



Engagement also differs by age. Among 18–39 year-olds, the South Coast shows a rate of 78.51%, slightly below Bristol County's 79.05%. For 40–64 year-olds, Massachusetts overall has the highest engagement at 79.07%, but New Bedford and Fall River show considerably lower rates at 65.44% and 65.17%, respectively *(figure 15).* In addition, when asked the level of agreement with the statement, "there are enough well-paying jobs in my community," 41.6% of respondents selected "disagree" or "strongly disagree", while 34.9% of respondents selected "strongly agree" or "Agree."

These disparities highlight age-related and regional gaps in workforce participation, reflecting the combined influence of education, opportunity youth, and local socioeconomic conditions.

In the South Coast, organizations like **SER Jobs for Progress, Inc.** and **MassHire** play a critical role in supporting workforce development and career advancement. SER Jobs for Progress, based in Fall River, provides education, job training, and employment services to economically disadvantaged and limited-English-speaking individuals. Their programs include Adult Basic Education, GED preparation, English for Speakers of Other Languages (ESOL), youth and young parent support, and on-site childcare for participants attending daytime classes. MassHire, the statewide network of career centers overseen by the Massachusetts Department of Career Services, offers comprehensive employment services including career counseling, resume workshops, job search assistance, and access to job fairs.

Both organizations also work directly with employers to support recruitment and hiring needs. Together, these agencies provide vital resources to help South Coast residents gain the skills, education, and support necessary to achieve self-sufficiency, secure meaningful employment, and strengthen the regional workforce.

Health Theme: Socio-economic Factors Summary

Addressing these socioeconomic challenges is essential to advancing health outcomes, reducing disparities, and promoting equity across the community. As noted by community stakeholders, “families are compelled to combine incomes and pool resources to make ends meet, while limited public transportation options further restrict access to healthcare, employment, and education.” At the same time, educational disparities contribute to lower health literacy and reduced job opportunities, creating additional barriers to navigating the healthcare system and achieving economic stability. These challenges underscore the urgent need for affordable and accessible services that support working families and promote equitable opportunities for health and well-being.

Improvement Opportunities

Expand Early Childhood Education

- Increase affordable, high-quality childcare and preschool slots.
- Partner with local organizations to provide parent education and early literacy programs.

Support Educational Attainment

- Offer tutoring, mentoring, and after-school enrichment for K–12 students.
- Provide alternative pathways to high school completion (e.g., GED programs, flexible schedules for working youth).

Strengthen Workforce Development

- Build job training and career pathway programs in collaboration with local employers and vocational schools.
- Provide paid internships, apprenticeships, and skill-building opportunities for young adults.

Address Basic Needs to Support Learning and Work

- Expand access to affordable housing, transportation, and food assistance to reduce stressors that interfere with education and employment.
- Create wraparound support systems (e.g., school-based health services, counseling, financial coaching).

Foster Cross-Sector Collaboration

- Establish partnerships between schools, healthcare providers, employers, and community organizations to align resources and reduce service gaps.
- Engage residents in planning and decision-making to ensure strategies reflect lived experiences.

Addressing socioeconomic conditions is essential to improving health and well-being across the South Coast Region. By expanding access to quality education, strengthening workforce development, and reducing financial barriers to basic needs, the region can create pathways to economic stability and opportunity. Collaborative efforts that center equity and community voice can break cycles of poverty, support healthier lifestyles, and build a stronger foundation for long-term health and resilience for all residents.

The Southcoast Street Outreach team committed to supporting unsheltered residents throughout the region.

Health Theme: Housing

"Housing insecurity is affecting every age from young folks to the elderly, due to the cost of housing and lack of inventory."

---------- COMMUNITY STAKEHOLDER

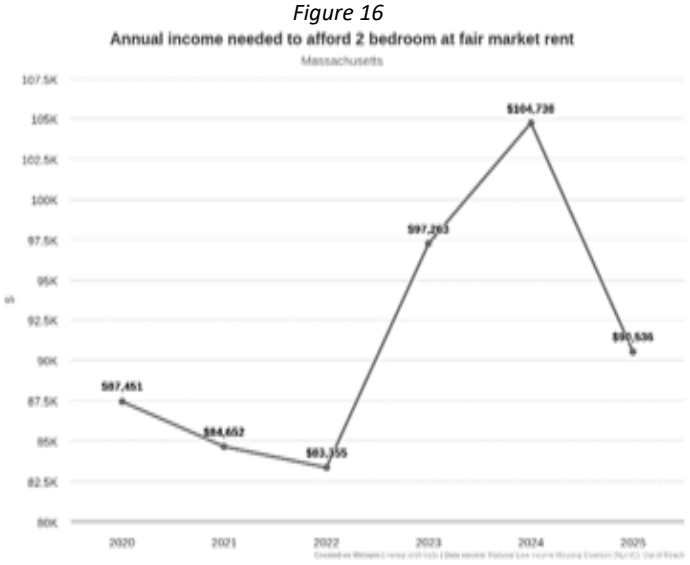
Housing quality and affordability play a crucial role in shaping health outcomes, as they directly influence multiple aspects of well-being. High housing cost burdens, eviction rates, vacant or unused housing, and crowded living conditions are closely linked to poorer socioeconomic and health outcomes, including housing instability and homelessness. Addressing these housing challenges is essential for promoting stable, healthy communities and reducing disparities in health and economic opportunity.

Housing Availability

The availability of housing fundamentally shapes affordability in the South Coast Region. Massachusetts has a total of 3,014,657 housing units, with Bristol County accounting for 244,166. The South Coast Region (including Fall River and New Bedford) holds 170,161 units, reflecting the limited housing stock in an area already facing significant affordability challenges.

Affordability pressures are clear when considering the income needed to secure housing. To afford a two-bedroom rental home at fair market rent in Massachusetts without spending more than 30% of income, a worker must earn a substantial annual income. Between 2020 and 2025, this required income fluctuated from a low of $83,355 in 2022 to a high of $104,738 in 2024—far exceeding what many South Coast households earn. This widening gap between wages and housing costs highlights the lack of affordable housing across the state and region.

Figure 16

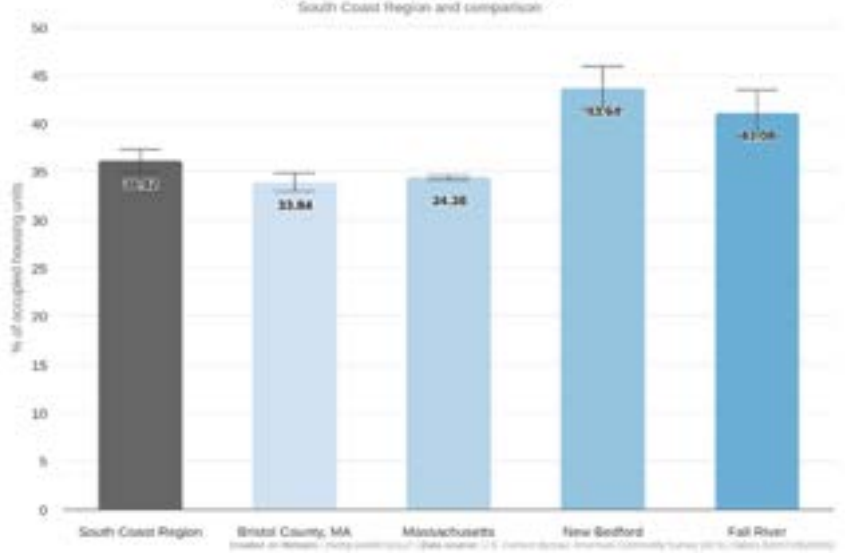


In 2025, the **Fair Market Rent (FMR)** for a 2-bedroom apartment in New Bedford is approximately $1,448 per month, while in Fall River, it is about $1,448 per month. In contrast, the Massachusetts state average for a 2-bedroom apartment is $1,957 per month *(figure 16).* Despite being lower than the state average, these rental costs still pose significant challenges for residents in the region.

Housing Cost Burden Impacts

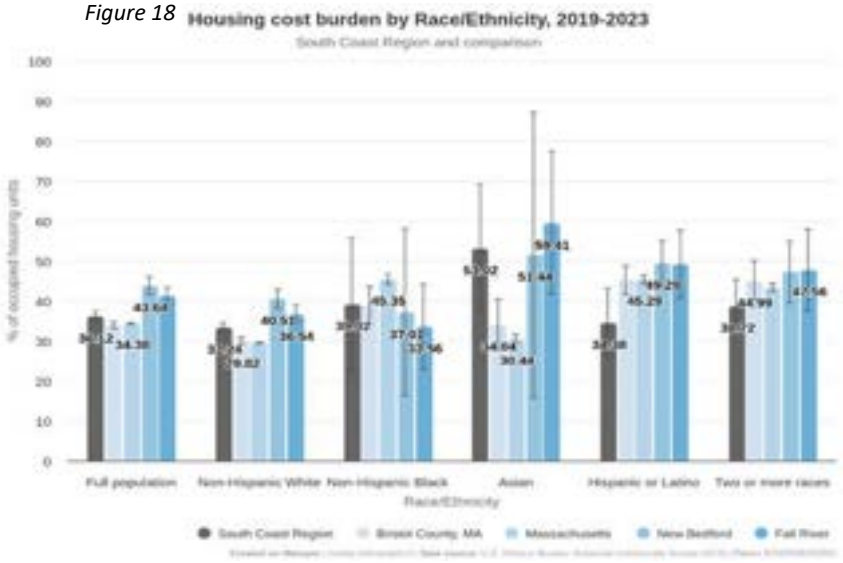
Households spending more than 30% of their income on housing are considered **housing cost burdened.** This includes both renters (rent plus any utilities or fees the renter must pay) and owners (mortgage and other owner costs, excluding insurance or building fees). Housing cost burden is a significant issue in the South Coast, with New Bedford and Fall River experiencing the highest rates at 43.64% and 41.08%, respectively *figure 17).*

Figure 17 **Housing cost burden, 2019-2023**



Housing cost burden disproportionately affects certain communities, reflecting broader structural inequities. Asian residents face the highest burden, particularly in New Bedford and Fall River, while Non-Hispanic White residents have the lowest burden overall *(figure 18).* These disparities highlight the importance of approaching housing affordability through an inclusive and equitable lens, ensuring that policies and programs address the unique needs of historically marginalized populations and promote access to stable, safe, and affordable housing for all residents.

Figure 18



For many workers and families, earning a sufficient income to secure rental housing at fair market rates is increasingly difficult. The rising cost of rent, combined with stagnant wages for many occupations, underscores the statewide shortage of affordable housing and the urgent need for policies and programs that expand housing access and support economic stability for residents across the Commonwealth.

Community survey respondents were asked their level of agreement with the statement, “there are affordable places to live in my community”, with 44.4% of respondents selecting “disagree” or “strongly disagree” and 37.4% of respondents selecting “agree” or “strongly agree.”

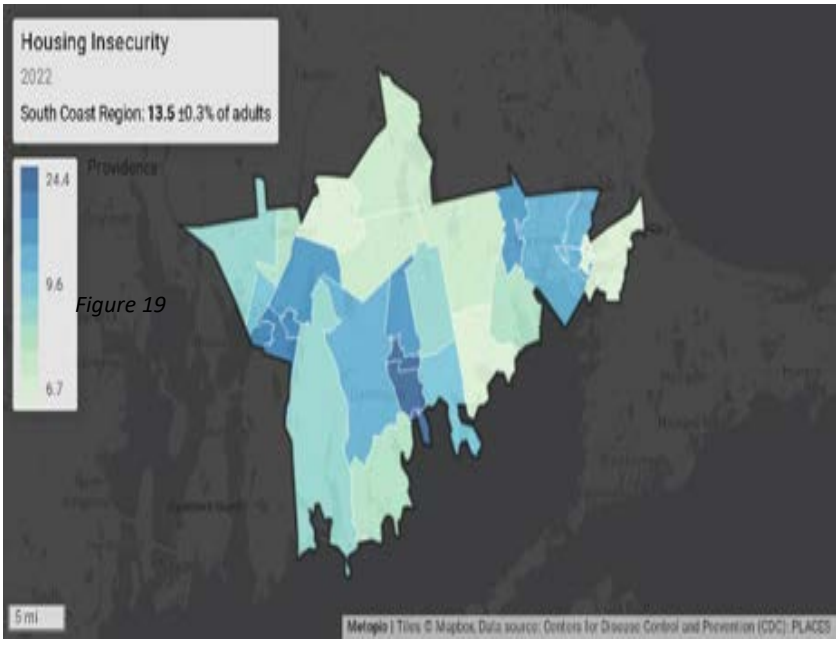


Figure 19

Housing insecurity—measured by the percentage of adults unable to pay their mortgage, rent, or utility bills in the past 12 months—is a significant concern in the South Coast. New Bedford has the highest rate at 18.97%, followed by Fall River at 16.27%, both exceeding the Massachusetts state average of 11.2% *(figure 19).* Bristol County and the South Coast overall report higher rates of housing insecurity compared to the state. As one stakeholder noted, “housing insecurity is a major issue. Rising costs and limited availability of affordable, safe housing contribute to chronic stress and health instability, and often force people to live in substandard or overcrowded conditions.”

Housing Barriers Upon Reintegration

Reentry into society after incarceration presents significant challenges, particularly in securing stable housing. Individuals with criminal records often face discrimination and legal barriers that restrict access to both public and private housing, making them disproportionately likely to experience homelessness. As stakeholders noted, "those who are incarcerated are disqualified from public housing (those who are sex offenders, committed arson, and/or have a felony). This creates long wait lists for these types of services."

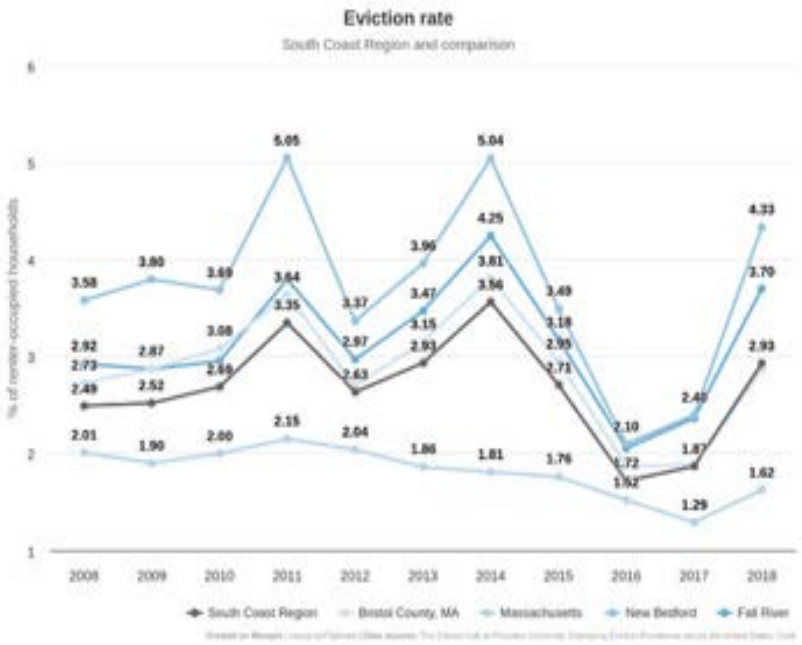
In Massachusetts, organizations such as **Justice 4 Housing**, **Redefining Reentry**, and **Brie's House** provide critical support, offering transitional housing, case management, financial literacy programs, and employment assistance to help formerly incarcerated individuals reintegrate into the community. The **Massachusetts Department of Correction** also employs Reentry Specialists to connect individuals with residential programs, shelters, and sober houses, while state-level resources like the Massachusetts Reentry Resource Directory and the Coming Home Directory provide comprehensive listings of available services.

Despite these efforts, systemic barriers—including discrimination, limited financial resources, and a shortage of affordable housing—continue to impede successful reintegration, highlighting the ongoing need for targeted support programs and policy reforms.

Evictions & Overcrowding

Individuals and households who are cost-burdened or housing insecure face an increased risk of eviction, defined as landlord-initiated involuntary moves based on court records. The **eviction rate** in the South Coast has fluctuated over the years, peaking at 3.56% in 2014. Bristol County, Fall River, and New Bedford consistently exceed state averages, with New Bedford reaching 5.05% in 2011 *(figure 20).* These trends highlight persistent housing pressures that destabilize families, disrupt employment and education, and negatively impact physical and mental health.

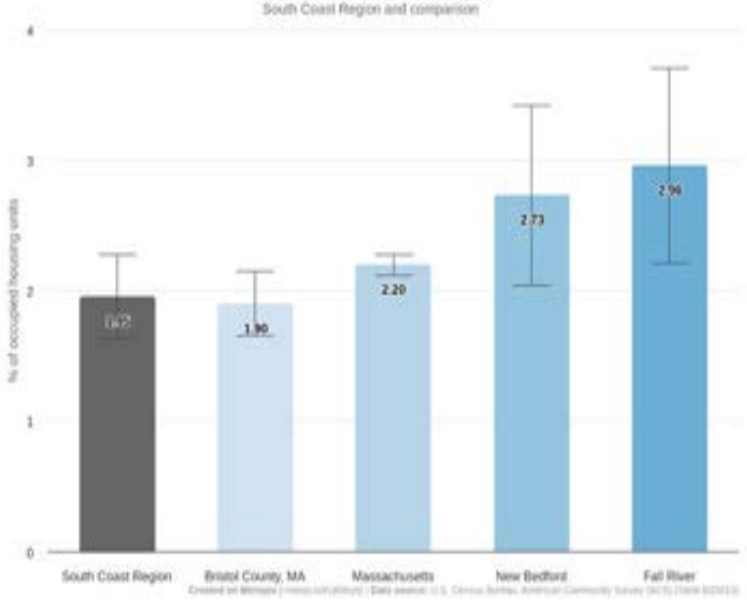
Figure 20



With rising eviction rates and the increasing cost of living, **crowded housing** is a significant concern in the South Coast region. Data indicates that Fall River and New Bedford have higher rates of crowded housing compared to the State average, while the South Coast Region and Bristol County also experience crowded conditions, though at somewhat lower rates. This suggests a regional issue that may require targeted interventions to ensure safe and adequate housing for all residents.

Crowded housing disproportionately affects certain racial and ethnic groups. Hispanic or Latino individuals experience the highest rates of crowded housing in the South Coast, particularly in New Bedford and Fall River. Individuals identifying as two or more races and Asian populations also face higher rates compared to the full population average. Non-Hispanic Black residents have notably high rates in Fall River, whereas Non-Hispanic White residents experience the lowest rates overall *(figure 21).* Addressing these disparities is critical to promoting equitable housing access and reducing associated health and social impacts.

Figure 21 **Crowded housing, 2019-2023**



Homelessness

Homelessness remains a critical public health and social issue in the South Coast region and across Massachusetts. Individuals and families experiencing homelessness face heightened vulnerability to physical and mental health challenges, including chronic illness, trauma, and substance use disorders.

In the South Coast Region, particularly in New Bedford, Fall River, and Wareham, data highlight a significant presence of people experiencing homelessness. According to the January 2023 **Point-in-Time (PIT) Counts,** New Bedford had 346 individuals experiencing homelessness, including 110 living unsheltered, 154 in emergency shelters, and 82 in transitional housing. Fall River reported 145 individuals experiencing homelessness, up from 104 the previous year, reflecting a more thorough and accurate counting process.

> "The lack of affordable housing is a growing concern, as housing instability often leads to increased stress, poor nutrition, difficulty managing chronic diseases, and reduced access to consistent healthcare."
>
> - Community Stakeholder

While the Point-in-Time (PIT) Count provides valuable data on homelessness, it has several limitations that can affect accuracy. The PIT Count captures only a single night each year, which may underrepresent individuals who are temporarily housed, staying with friends or family, or moving between locations. Unsheltered individuals can be especially difficult to locate, and participation relies on self-reporting and outreach, which can miss hidden populations. Seasonal variations, weather conditions, and resource limitations for conducting the count can also skew results. Additionally, methodological differences across cities or counties can make comparisons challenging. As a result, PIT data is considered a snapshot rather than a complete representation of homelessness, and it should be interpreted alongside other local data sources, service provider reports, and longitudinal studies to better understand housing instability and unmet needs.

Statewide, stark disparities exist those who are homeless: Non-Hispanic Black residents represent the largest group (16,011 individuals), followed by Non-Hispanic White (9,193) and Hispanic or Latino (8,885), with other groups representing fewer than 600 individuals each. These figures demonstrate the disproportionate impact of housing instability on historically marginalized populations and emphasize the need for equitable interventions that address the root causes of homelessness, including affordable housing shortages, housing insecurity, and eviction risk.

Homelessness is further compounded by systemic barriers such as discrimination, lack of affordable housing, and limited access to supportive services. Efforts to address these challenges include collaborations among local municipalities, nonprofit organizations, and state programs aimed at providing emergency shelter, permanent supportive housing, and wraparound services to help individuals and families transition to stable housing.

> "There are pockets in the city where people are putting up tents; you can't keep pushing people out and not address housing."
>
> - Community Stakeholder

Health Theme: Housing Summary

Housing is a foundational driver of health, and instability in this area contributes directly to economic hardship, stress, and poor health outcomes. In the South Coast, rising housing costs, limited affordable housing inventory, and the risk of eviction place significant strain on low-income households and communities of color. Many families are forced to spend a disproportionate share of their income on rent, leaving fewer resources for essentials like food, transportation, healthcare, and education.

Improvement Opportunities

Expand Affordable Housing Development

- Incentivize construction of affordable rental and ownership units through public-private partnerships and inclusionary zoning.
- Repurposes vacant or underutilized properties for mixed-income housing.

Increase Housing Inventory & Accessibility

- Support development of multi-family housing, accessory dwelling units (ADUs), and senior friendly housing.
- Streaming permitting process to accelerate housing production.

Prevent Evictions and Displacement

- Fund rental assistance and emergency housing support programs.
- Provide legal aid, mediation, and tenant advocacy to help residents avoid eviction.
- Implement right-to-counsel policies for tenants facing eviction.

Support Housing-insecure & Homeless Families

- Expand transitional and supportive housing with wraparound care management (mental health, employment, childcare, and healthcare services).
- Create rapid rehousing programs to help families quickly secure permanent housing.

Promote Equitable Housing Policies

- Enforce anti-discrimination laws and fair housing protections.
- Monitor & address racial and economic disparities in housing access, affordability and quality.

Foster Cross-Sector Collaboration

- Collaborate with local government, housing authorities, nonprofit developers, and healthcare system to pool resources and align strategies.
- Engage residents with lived experience in planning and decision-making to ensure solutions are responsive to community needs.

Stable, safe, and affordable housing is a cornerstone of individual and community health in the South Coast Region. By increasing affordable housing options, preventing evictions, and supporting families experiencing housing insecurity, the region can reduce health disparities and strengthen community stability. Equitable, coordinated housing strategies will create the security residents need to pursue education, employment, and wellness—laying the groundwork for healthier, more thriving communities.

The Fall River Waterfront

Health Theme: Built Environment

"The physical environment and neighborhood play a critical role in health, as outcomes often depend on the area in which you raise your family."

---------- COMMUNITY STAKEHOLDER

The built environment refers to the human-made surroundings where people live, work, and play. It includes housing, streets, parks, transportation systems, and other infrastructure, as well as exposure to environmental pollution and hazards. These aspects directly shape health outcomes by influencing opportunities for physical activity, access to essential resources such as healthy food and healthcare, and the degree of exposure to environmental risks.

Historic Communities

New Bedford's historic neighborhoods, sometimes referred to as an "Old Bedford Village" within the city, illustrate how the built environment carries both cultural value and present-day challenges.

Much like a preserved living history site, these areas reflect New Bedford's maritime and industrial heritage, with a large share of older housing stock. The Cape Verdean Creole community is a vibrant and integral part of this history, tracing its roots to the late 19th and early 20th centuries when Cape Verdeans immigrants, arrived in New Bedford aboard whaling vessels. The largest wave of immigration occurred between the 1880s and 1920s, with many finding work in the packet trade, longshoremen roles, fish processing, and as merchant seamen.

Organizations such as the Cape Verdean Association in New Bedford (CVANB), founded in 1990, have been instrumental in preserving and promoting Cape Verdean culture, maintaining a strong sense of community and identity amid the city's historic neighborhoods.

While the "Old Bedford Village" character contributes to the city's sense of place, many residents live in aging homes with heightened risks of lead paint, asbestos, inefficient heating systems, and costly maintenance needs. This juxtaposition of historic charm, cultural richness, and structural vulnerability underscores the importance of balancing preservation with investments in safe, healthy, and affordable housing.

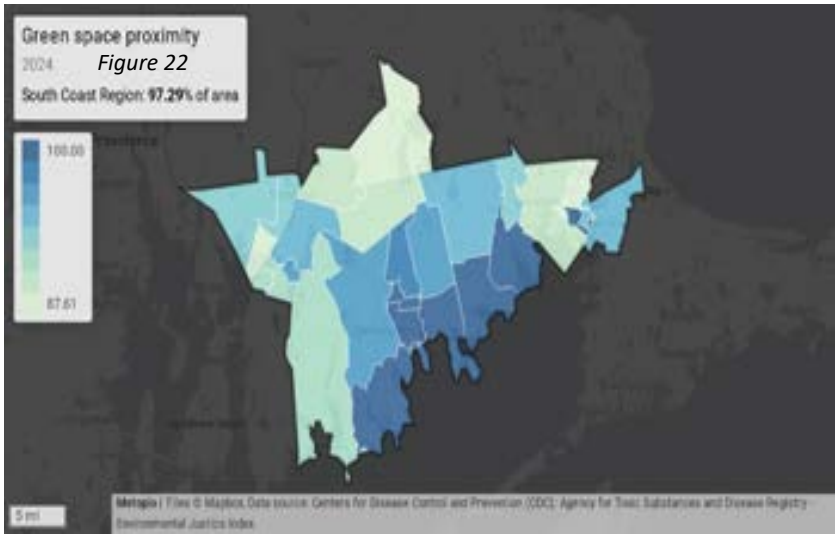


Figure 22

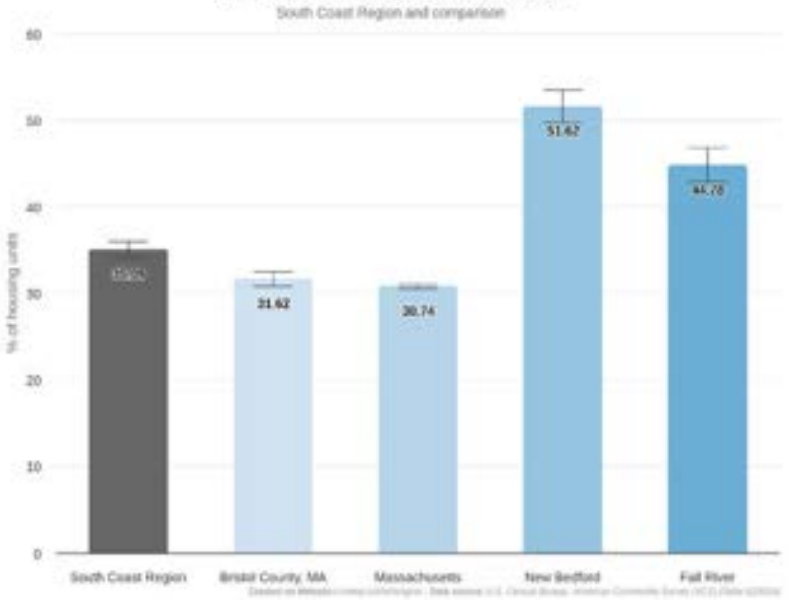
The 2024 **Environmental Burden Index** highlights disparities in exposure to harmful environmental factors such as poor air quality, pollution, and risks associated with the built environment. The South Coast Region overall has a moderate index score of 50.97; however, certain locations within the region face much higher levels of environmental burden. In New Bedford, for example, index scores reach 68.26 and 81.94, reflecting significant environmental challenges that can adversely affect community health *(figure 22).* These elevated scores underscore the uneven distribution of environmental risks and the need for targeted interventions in the most impacted areas.

Aging Housing Stock

These health risks are compounded by the city's aging housing stock. Homes built in 1939 or earlier carry several important implications—structural, financial, environmental, and public health—that can affect residents, communities, and policymakers. Within the South Coast Region, Fall River and New Bedford have some of the highest proportions of pre -1939 housing, with between 40% and over 58% of their housing stock dating to this period. This concentration is notably higher than the statewide average, where only about 30.74% of housing units were built prior to 1940 *(figure 23).* As one stakeholder observed, "individuals are often unaware of the chemicals they are exposed to in their homes," highlighting the potential health hazards associated with older housing.

The prevalence of older housing in these cities underscores the heightened potential for issues such as outdated infrastructure, increased maintenance costs, and health and safety risks compared to other parts of Massachusetts.

Figure 23 **Built 1939 or earlier (pre-war), 2019-2023**



Associated Health Risks

Lead-based paint, which was commonly used until 1978, poses a major concern in older homes, especially for children, as lead exposure can cause developmental delays and other serious health issues. New Bedford has the highest estimated rate of lead paint exposure, with 67.65% of housing units at risk, significantly exceeding the statewide rate of 47.35%. The South Coast Region overall has a moderate rate of 54.1%, suggesting that residents face greater exposure risks than the Massachusetts average *(figure 24).* Stakeholders similarly voiced their concerns stating that, "lead is in a lot of the buildings and house, specifically in paint and in the roof. When lead is on the roof, it seeps into the soil during rain."

Many of these homes also contain asbestos in insulation, flooring, or roofing materials, which can become hazardous when disturbed during renovations or deterioration. Aging electrical systems, such as knob-and-tube wiring, increase the risk of fire, while outdated plumbing can contribute to water damage, mold growth, and poor indoor air quality. In addition, older homes are typically less energy-efficient, leading to temperature instability that may exacerbate respiratory conditions and increase utility costs for residents. Collectively, these risks underscore the need for proactive housing inspections, remediation, and investment to protect the health and safety of individuals living in pre-1940 housing.

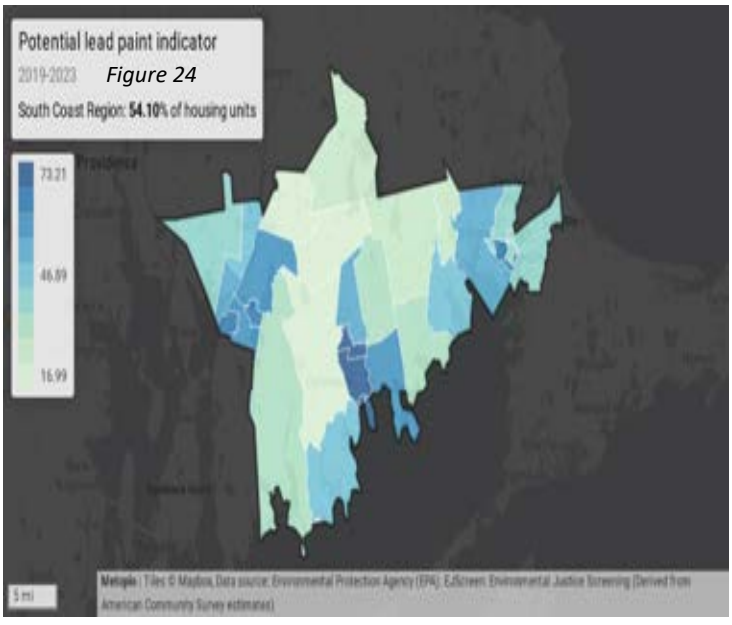


Figure 24

Infrastructure

While aging housing stock presents clear health and safety challenges, it is only one aspect of the broader built environment that shapes community well-being. Neighborhood conditions, including walkability, transportation infrastructure, access to public spaces, safety and street design, further influence residents' physical activity and quality of life.

The region's **Walkability Index** is 11.63, with higher scores in New Bedford's 02746 area (15.22) and lower scores in Fall River's 02702 and North Westport's 02790, reflecting uneven pedestrian infrastructure. In higher-walkability areas like New Bedford's 02746 ZIP code, residents may be able to meet more daily needs on foot, while in lower-walkability areas such as Fall River's 02702 and North Westport's 02790.

The **Southcoast Regional Transit Authority (SRTA)** is the primary public transportation agency serving the South Coast region. In addition, **the Greater Attleboro Taunton Regional Transit Authority (GATRA)** provides services Wareham and other cities and towns surrounding the South Coast.

Primary ridership patterns differ between the two agencies. SRTA primarily serves college-age students and low-income individuals, reflecting the region's commuter and student populations. In contrast, GATRA's primary ridership consists of elderly residents, highlighting the agency's role in providing accessible transportation for seniors and those with mobility needs. When community survey respondents were asked their level of agreement with the statement, "public transpiration is easy to use if I need it," 34.4% of respondents selected "disagree" or "strongly disagree", while 44.2% of respondents selected "agree" or "strongly agree".

Notable changes to the transportation system on the South Coast in recent years have aimed to improve accessibility, affordability, and convenience for residents. These include the increased use of on-demand services, which provide flexible, request-based transportation for areas or times not well served by fixed routes. The implementation of SRTA's fare-free program, extended through June 2026, has made bus travel more equitable and accessible, particularly for low-income residents who rely on public transit for work, errands, and medical appointments. Additionally, the introduction of a Sunday service line through SRTA has expanded transit availability, allowing residents greater mobility on weekends. Together, these changes reflect a broader commitment to enhancing public transportation infrastructure and reducing barriers to mobility in the region.

The launch of South Coast Rail represents one of the most significant transportation investments in southeastern Massachusetts in decades, with far-reaching implications for the region's economy, workforce, health, and quality of life. Many community stakeholders noted the recent opening of the South Coast Rail service as a positive addition to the South Coast, however noted some possible concerns around housing availability and rising cost.

Despite investments in local transit, a notable share of residents in the South Coast face transportation barriers that affect daily life.

In New Bedford, 13.63% of individuals reported that a lack of reliable transportation prevented them from attending medical appointments, meetings, work, or accessing necessary goods in the past 12 months, with Fall River closely behind at 11.76%. This aligns with the fact that these cities have the lowest rates in Bristol County for vehicle ownership per capita—the number of cars, passenger trucks under 1-ton capacity, and vans owned by households per 100 residents aged 18 or older.

Limited personal vehicle access, combined with uneven walkability and transit options, underscores the need for continued investment in accessible, reliable transportation to support health, employment, and quality of life in the region.

Social Conditions

In some areas, structural and environmental stressors are compounded by higher rates of community violence, which can influence both physical and mental health outcomes. Understanding the interplay between aging housing, neighborhood infrastructure, and social conditions is essential for developing comprehensive strategies to promote safe, healthy, and equitable communities.

As of 2023, New Bedford, Massachusetts, has experienced a continued decline in both violent and property crime rates. This trend aligns with broader state patterns, as Massachusetts reported a 4.4% decline in Part One crimes in 2024 compared to the previous year.

> "Neighborhood safety across the South Coast varies—some areas feel safe and well-connected, while others continue to face significant challenges."
>
> - Community Stakeholder

When community survey respondents were asked their level of agreement with the statement, “I feel safe in my own neighborhood”, 31.4% of respondents selected “disagree” or “strongly disagree” while 50.2% selected “agree” or “strongly agree”, indicating that individuals who took the survey feel comfortable in their community.

“Gang violence, specifically in New Bedford is prevalent,” stakeholders noted, and it has been a significant concern, with several high-profile incidents and ongoing challenges. As published in the **2024 Charles E. Shannon Community Safety Initiative,** there are 21 active street gangs in New Bedford, and they have identified 67 gang members between the ages of 10-24 *(figure 24).* Similarly, in Fall River they have identified 58 street gangs, with 761 total active members (*figure 25).* These gangs are involved in various criminal activities, including shootings, stabbings, and assaults. Social media platforms are often utilized for recruitment, retaliation, and to escalate tensions between rival groups.

In response to gang violence, the Cities' Police Department, in collaboration with the Shannon Program have implemented various strategies to reduce gang activity and enhance community safety.

In addition to gang violence, gun violence in New Bedford and Fall River have been a persistent concerns, with fluctuations in incidents over recent years. While overall violent crime has declined, certain months have seen spikes in shootings. “There have been a large number of youth and teenagers that have been victims of gun violence in the neighborhood,” a New Bedford resident noted. This ongoing issue highlights the need for continued community-focused prevention and intervention efforts.

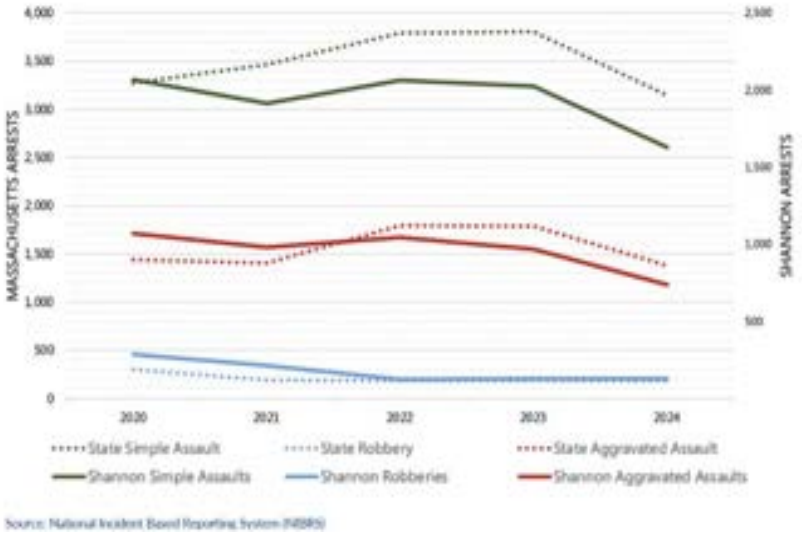


Figure 24: 5-Year Crime Trends for Offenses Committed by Youth Ages 10-24, 2020-2024—New Bedford

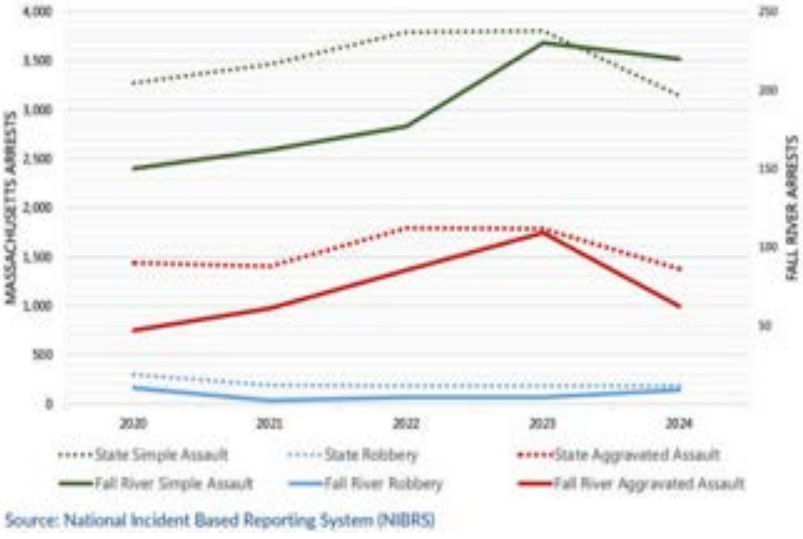


Figure 25: 5-Year Crime Trends for Offenses Committed by Youth Ages 10-24, 2020-2024—Fall River

Health Theme: Built Environment Summary

In the South Coast Region, gaps in infrastructure, limited green spaces, limited affordable transportation options, and environmental hazards contribute to health inequities. Residents in underserved areas may face unsafe walking conditions, long travel distances to grocery stores or clinics, and higher exposure to pollutants—all of which can negatively impact physical and mental health. Improving the built environment is essential for fostering active lifestyles, reducing health risks, and supporting overall community well-being.

Improvement Opportunities

Enhance Active Transportation Infrastructure

- Build and maintain sidewalks, bike lanes, and cross walks to support safe walking and biking
- Improve lighting and traffic-claiming measures to promote safety in high-traffic areas.

Expand Green and Recreational Spaces

- Increase access to parks, playgrounds, and community gardens, especially in underserved neighborhoods.
- Develop safe, well-maintained public spaces that encourage physical activity and social connection.

Improve Transpiration Access

- Expand affordable, reliable transits routes to connect residents to jobs, schools, grocery stores and healthcare.
- Provide vouchers or subsidies for low-income residents to utilize services like Uber and Lyft for transportation needs.

Address Environmental Hazards

- Monitor and remediate sites with known pollution or contamination.
- Enforce environmental regulations to reduce industrial emissions and improve air and water quality.

Integrate Health into Urban Planning

- Include health assessments in development and zoning decisions.

Foster Cross-Sector Collaboration

- Bring together planners, public health agencies, and community organizations to design healthier, more equitable environments.

Improving the built environment presents a powerful opportunity to advance health, equity, and quality of life across the South Coast Region. By investing in safe transportation networks, expanding access to green spaces, addressing environmental hazards, and ensuring equitable access to essential resources, the region can create healthier, more vibrant communities. Thoughtful planning and collaboration among local governments, community organizations, and residents can transform the places where people live, work, and play—fostering a stronger sense of connection, supporting economic growth, and building a healthier future for all.

Volunteers at Frogfoot Farm in Wareham

Health Theme: Food Access & Security

"Food costs are generally high, particularly for healthy options, and access can be limited in certain areas."

---------- COMMUNITY STAKEHOLDER

Access to nutritious food is essential for maintaining physical health, supporting growth, and preventing chronic diseases such as diabetes, heart disease, and obesity. Adequate nutrition also plays a critical role in mental health, cognitive function, and overall well-being. Without consistent access to healthy food, individuals and communities face increased health risks and long-term negative outcomes.

Food Security

Access to nutritious and affordable food remains a challenge the South Coast and Bristol County, with nearly half of County level households experiencing difficulty obtaining sufficient food.

Food insecurity is defined as the household-level economic and social condition in which individuals have limited or uncertain access to adequate, nutritious food, as documented in USDA food-security reports. While this term highlights the challenges and risks families face, the broader public health and policy conversation has shifted toward the concept of **food security**. This reframing emphasizes not just the absence of scarcity, but the presence of consistent, reliable access to safe, nutritious, and culturally appropriate foods that support an active, healthy life. By focusing on food security, we center solutions, resilience, and equity—moving from a deficit-based lens that measures need to a strengths-based perspective that prioritizes stability and well-being.

In 2023, Bristol County's food insecurity rate exceeded the state average, affecting 11.4% of the population compared to Massachusetts' overall rate of 10.2%, highlighting a clear need for targeted food assistance programs in the county *(figure 26*). These challenges are not experienced equally across populations—Non-Hispanic Black and Hispanic or Latino residents in Bristol County face disproportionately higher rates of food insecurity at 26.0%, compared to 12.8% for the overall county population. Statewide, disparities persist, with Hispanic or Latino individuals experiencing a 22.0% food insecurity rate versus the 11.5% overall state rate *(figure 27).* These figures underscore the urgent need for interventions that address both geographic and racial inequities in access to nutritious and affordable food.

Figure 26 **Food insecurity, 2022**

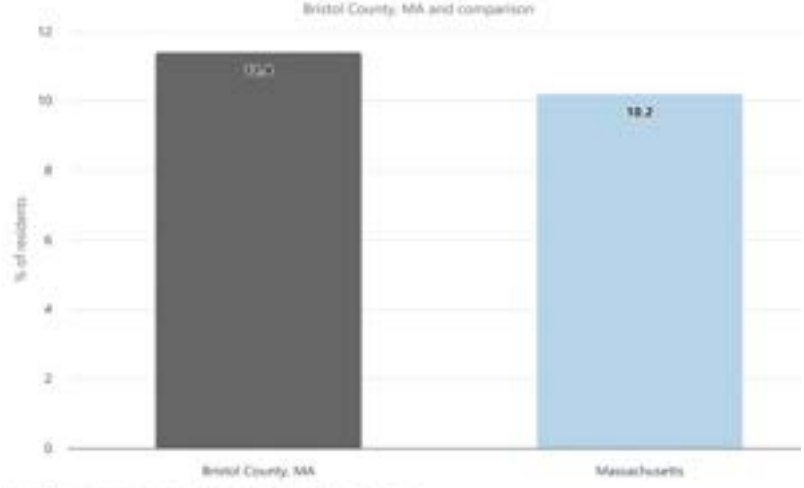
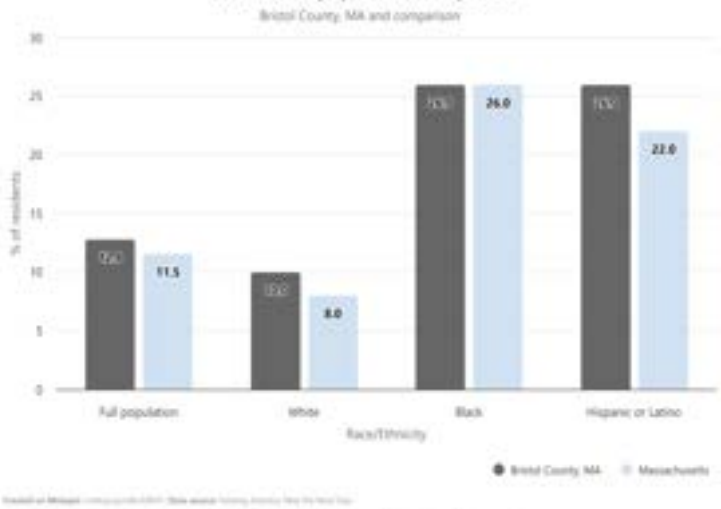


Figure 27 **Food insecurity by Race/Ethnicity, 2023**



Supplemental Nutrition Assistance Program (SNAP)

With food security remaining a pressing challenge across the South Coast, and the **Supplemental Nutrition Assistance Program (SNAP)** plays a vital role in addressing it.

The data shows the percentage of households receiving SNAP benefits across South Coast communities between 2017 and 2021. Eligibility is based on income, household size, and certain expenses *(figure 29);* however, barriers such as stigma, lack of awareness, and application challenges prevent many eligible households from enrolling. The majority of SNAP benefits currently support households that include a child, elderly adults or a person with a disability.

SNAP Eligibility Chart *Figure 28*

Household Size	Maximum Monthly Income (before taxes)	Maximum Monthly SNAP Amount*
1	$2,608	$292
2	$3,525	$536
3	$4,442	$768
4	$5,358	$975
5	$6,275	$1,158
6	$7,192	$1,390
7	$8,108	$1,536
8	$9,025	$1,756
Each additional person	+ $917	+ $220

Figure 29 **Food stamps (SNAP), 2017-2021**

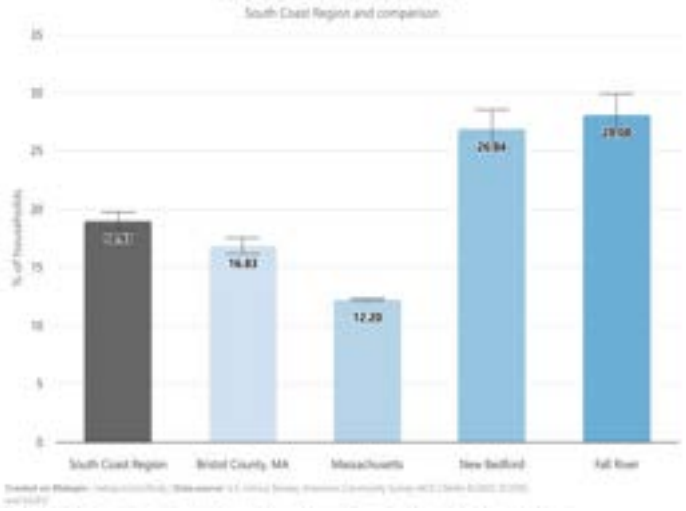
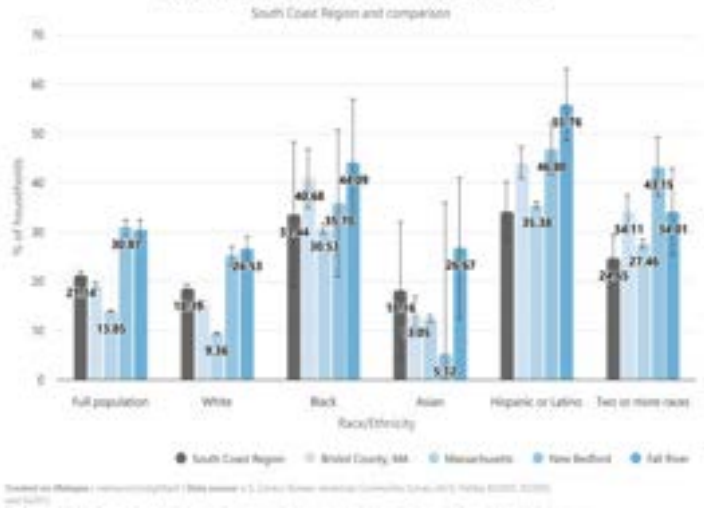


Figure 30 **Food stamps (SNAP) by Race/Ethnicity, 2019-2023**



Participation ranges from a high of 34.21% in Fall River (02721) to a low of 5.07% in Marion Center (02738), underscoring significant geographic disparities in access to food assistance. Expanding equitable access to SNAP is critical for improving food security and improving overall community health outcomes. Strategies such as culturally tailored outreach, language access services, and streamlined enrollment processes can help ensure that all eligible households are able to benefit from the program.

Participation also varies across racial and ethnic groups. Hispanic or Latino residents have the highest participation rates, particularly in New Bedford and Fall River, reflecting disproportionate levels of food insecurity. Non-Hispanic Black residents and individuals identifying with Two or More Races also show elevated participation, while Non-Hispanic White and Asian residents have lower rates overall *(figure 30).* These differences highlight the intersection of race, poverty, and access to resources, emphasizing the need for culturally responsive outreach and equitable enrollment strategies.

Access to SNAP-authorized retailers also plays a role in the effectiveness of the program. The South Coast Region has the highest average number of retailers at 10.62, followed by Fall River and New Bedford, compared with a state average of 7.88 *(figure 31).* Over the past few years, the region has made notable strides in expanding retailer inclusion, particularly at community farmers markets. While this greater availability supports access, enrollment, awareness, and other barriers continue to limit participation for many households. Despite eligibility, many households living in poverty are not receiving SNAP benefits, especially in areas such as Fall River and New Bedford, indicating gaps in food assistance accessibility *(figure 32).*

Figure 31 **SNAP retailers, 2024**

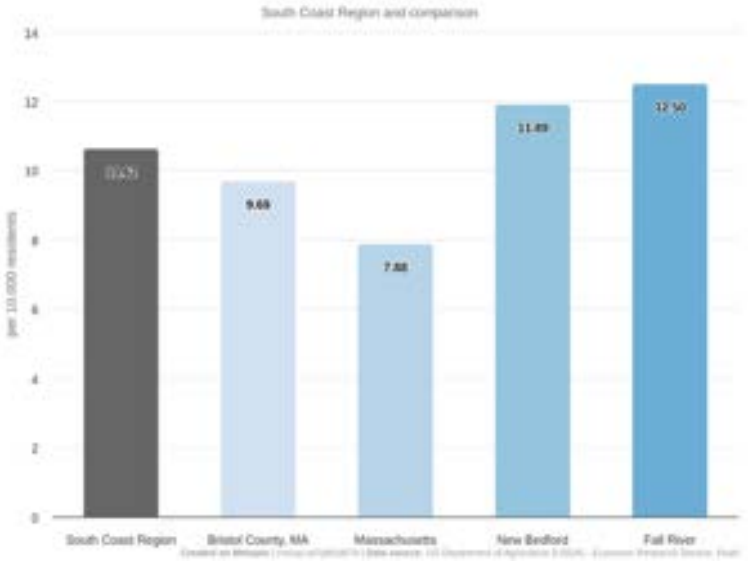
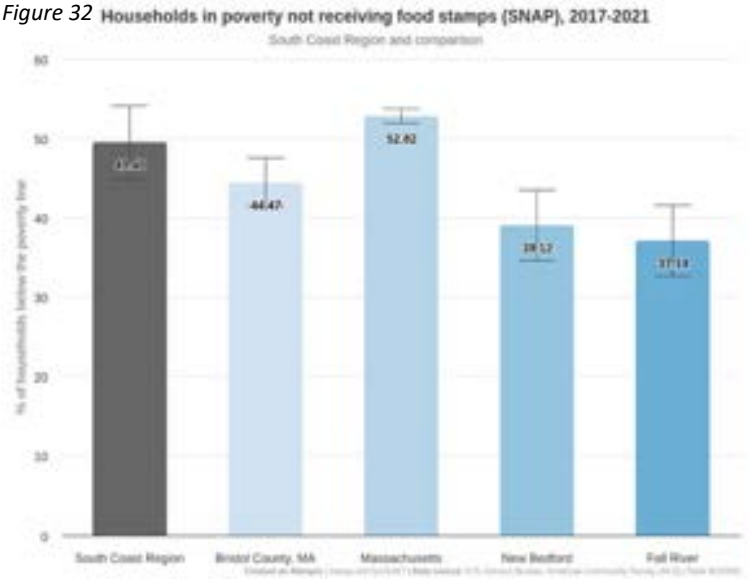


Figure 32 **Households in poverty not receiving food stamps (SNAP), 2017-2021**



Additionally, SNAP participants to the **Healthy Incentives Program (HIP)** can further enhance food security and nutrition by providing automatic monthly incentives—up to $40–$80 depending on household size—when SNAP benefits are used to purchase fresh, local fruits and vegetables from participating farmers' markets, farm stands, mobile markets, and community-supported agriculture (CSA) programs. HIP improves access to healthy foods for low-income families while also supporting local agriculture and strengthening the regional food system.

Healthy Incentives Program
Fresh. Canned. Dried. Frozen.
It's HIP to be healthy!

Health Theme: Food Access & Security Summary

Access to nutritious food is essential for maintaining physical health, supporting growth, and preventing chronic diseases such as Type 2 diabetes, Heart disease, and Obesity. Adequate nutrition also plays a critical role in mental health, cognitive function, and overall well-being. Yet, many residents in the South Coast Region experience a lack of food security.

High food costs, combined with transportation barriers and limited availability of grocery stores or markets in some neighborhoods, further restrict access. While federal nutrition programs such as Supplemental Nutrition Assistance Program (SNAP) and the Healthy Incentives Program (HIP) help offset these barriers, gaps remain in awareness, enrollment, and consistent usage. Strengthening food security is critical to reducing health disparities, supporting healthy development, and improving overall community well-being.

Improvement Opportunities

Expand Food Assistance Program Access

- Increase outreach and enrollment support for SNAP and HIP, especially in underserved communities.
- Partner with healthcare providers, schools, and community organizations to connect eligible families to benefits.

Improve Healthy Food Availability

- Support the establishment of grocery stores, farmers markets, food co-ops and mobile markets.
- Offer incentives for local retailers to stock fresh, healthy, and culturally appropriate foods.

Address Food Affordability

- Provide subsides or vouchers for fruits, vegetables and other healthy staples
- Develop community-based bulk buying or cooperative purchasing programs to lower food costs.

Strengthen Local Food System

- Support local farmers, urban agriculture, and community gardens to increase the supply of affordable produce.
- Expand farm-to-school, and farm-to-institution programs that connect local food producers to schools, hospitals and senior centers.

Promote Nutrition Education

- Implement culturally relevant nutrition and cooking education in schools, clinics and community centers.
- Provide tools and resources for families to prepare affordable, healthy meals.

Improve Transportation & Delivery Access

- Offer transpiration assistance or delivery services for residents with limited mobility or access to stores.
- Integrate healthy food delivery into existing senior services, healthcare and community health worker programs.

Expanding access to healthy, affordable food is essential for fostering health equity and improving community well-being across the South Coast Region. By strengthening food assistance programs, supporting local food systems, and reducing barriers to affordability and transportation, the region can help ensure all residents have the nourishment they need to thrive. Collaborative, equity-focused strategies will reduce food insecurity, prevent chronic disease, and lay the foundation for healthier futures for individuals and families throughout the community.

Southcoast Health Medical Professionals

Health Theme: Access to Care

"There is a shortage of doctors and medical professionals, making it difficult for people to find a new provider when one retires or leaves practice."

---------- COMMUNITY STAKEHOLDER

Access to healthcare is essential for maintaining and improving individual and community health. It enables early detection and treatment of illnesses, reduces the risk of preventable complications, and supports overall well-being. Healthcare should be accessible to everyone, ensuring that all individuals—regardless of income, race, location, or other social drivers—can obtain the care they need. Equitable access helps reduce health disparities and promotes better long-term population health outcomes.

Healthcare Delivery Across the South Coast Region

The South Coast Region, including Bristol County and cities such as New Bedford, Fall River, and Taunton, has a robust and diverse healthcare delivery system. The region is anchored by Southcoast Health System, a large integrated network that operates three hospitals and provides primary and specialty care. Additional hospitals include Saint Anne's Hospital in Fall River and Morton Hospital and Medical Center in Taunton, recently acquired by Brown Health. Behavioral health needs are served by Southcoast Behavioral Health, which provides outpatient mental health services across the region. These institutions collectively offer a full spectrum of inpatient, outpatient, specialty, and emergency care. When community survey respondents were asked their level of agreement with the statement, "I am satisfied with the healthcare systems in this community", 37.8% of respondents selected "disagree" or "strongly disagree" while 42.5% selected they "agree" or strongly agree" with the statement.

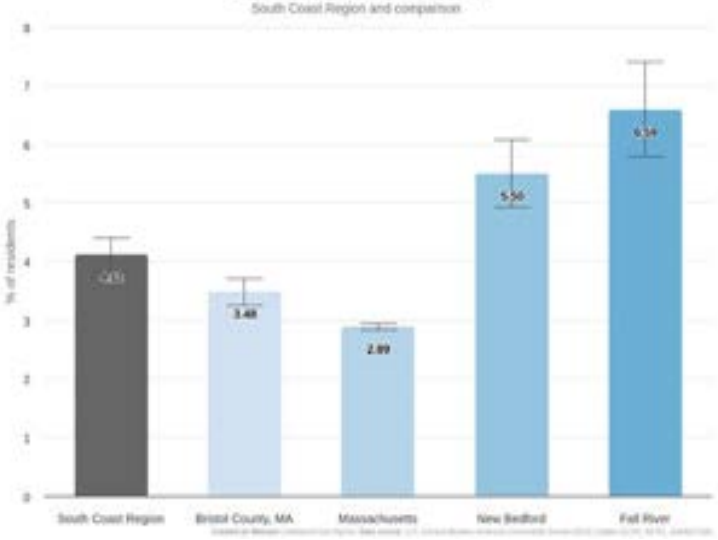
Primary care is widely available through standalone providers as well as a strong network of Federally Qualified Health Centers (FQHCs), including Manet Community Health Center, Stanley Street Treatment and Resources (SSTAR), New Bedford Community Health, and HealthFirst Family Healthcare. These centers provide comprehensive primary care, preventive services, and behavioral health support, improving access for underserved populations.

Overall, while the South Coast Region is well-equipped with hospitals, the Southcoast Health System network, primary care providers, FQHCs, and behavioral health facilities. However, access challenges remain due to geographic distribution, provider availability, insurance barriers, and other social drivers of health. Continued efforts to expand equitable access are essential to ensure that all residents can obtain the care and services they need.

Healthcare Coverage Patterns

Access to healthcare in the South Coast Region is shaped by the characteristics of the local population and insurance coverage patterns. **Dual eligible coverage**, which refers to individuals who qualify for both Medicare and Medicaid, is higher in the South Coast, including Fall River and New Bedford, compared to Massachusetts. This indicates a greater need for healthcare services among low-income and elderly populations. The payer mix, with a larger share of publicly funded coverage, has important implications for healthcare access—patients may face barriers in finding providers who accept their insurance, while providers may experience financial strain from lower reimbursement rates, ultimately affecting the availability and capacity of services *(figure 33).*

Figure 33 **Dual eligible coverage, 2019-2023**



Medicaid coverage in the region is also significantly higher than both the overall coverage in Bristol County and the state average. In New Bedford, 48.13% of residents are covered by Medicaid, while Fall River has 44.14%, compared to the state average of 22.86% *(figure 34).* This highlights a notable disparity in Medicaid coverage within the region, reflecting the greater healthcare needs of low-income populations.

Figure 34 **Medicaid coverage, 2019-2023**

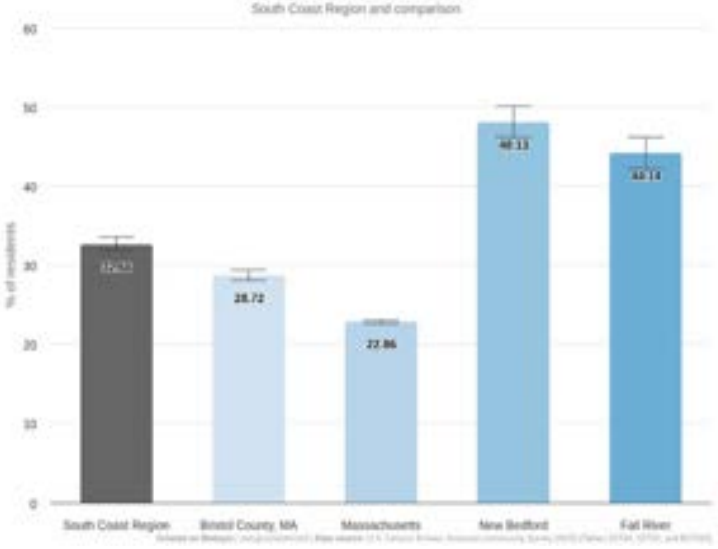
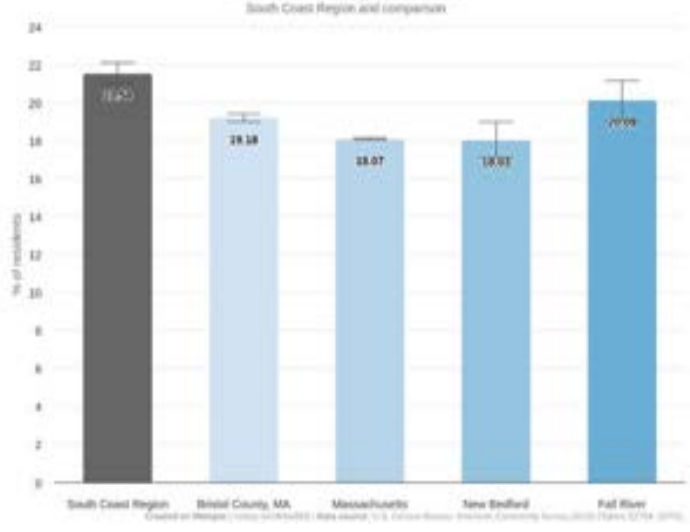


Figure 35 **Medicare coverage, 2019-2023**



Medicare coverage in the South Coast is 21.54%, with Fall River slightly lower at 20.09%. Bristol County and the state overall have coverage rates of 19.18% and 18.07%, respectively, while New Bedford has the lowest rate at 18.03% *(figure 35).* Together, these patterns of dual eligible, Medicaid, and Medicare coverage underscore both the heightened healthcare needs in the South Coast and the potential challenges residents face in accessing timely and adequate care.

Primary & Specialty Care Provider Availability

Access to healthcare providers is a critical component of a well-functioning healthcare system, supporting preventive care, early detection of illness, and management of chronic conditions. However, provider availability varies significantly across the South Coast Region. Massachusetts has a high number of primary care providers (PCPs) per capita at 135.8, compared with 64.78 in the South Coast Region, 88.12 in Fall River, and only 43.23 in New Bedford *(figure 36).* Similarly, specialist physicians per capita show disparities, with the state averaging 216.13 compared with 113.43 in the South Coast Region *(figure 37).* These gaps in both primary and specialty care highlight the need for targeted strategies to expand provider access, particularly in underserved communities, to ensure equitable healthcare for all residents.

Figure 36 **Primary care providers (PCP) per capita, 2011**

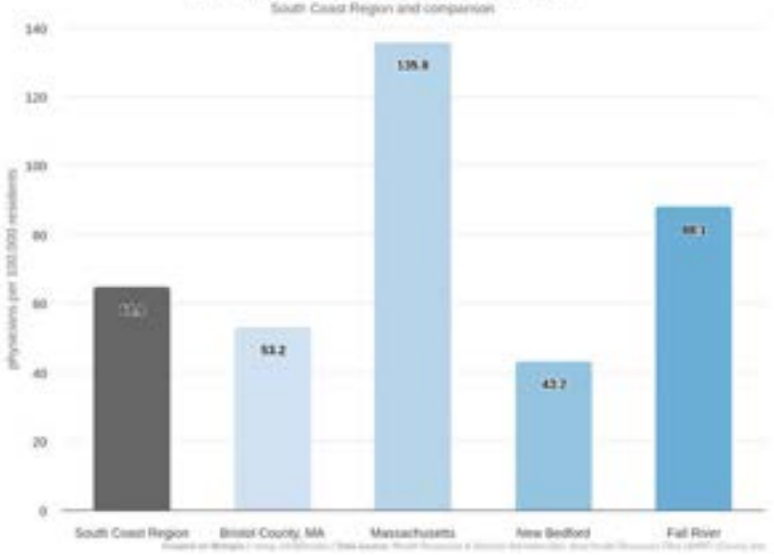
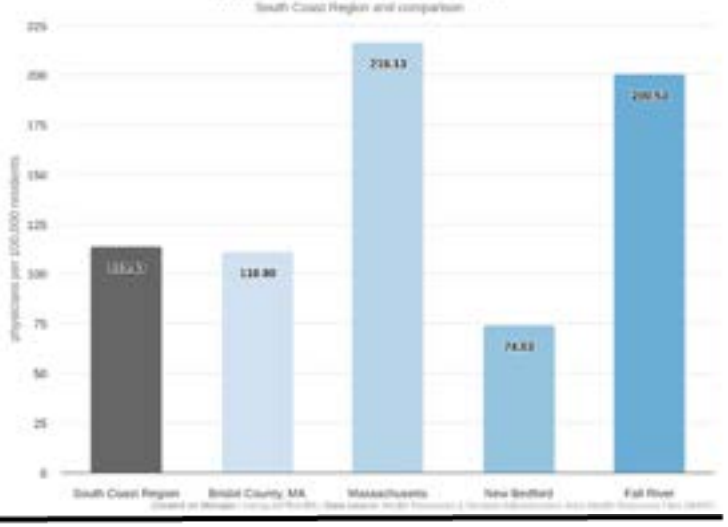


Figure 37 **Specialist physicians per capita, 2011**

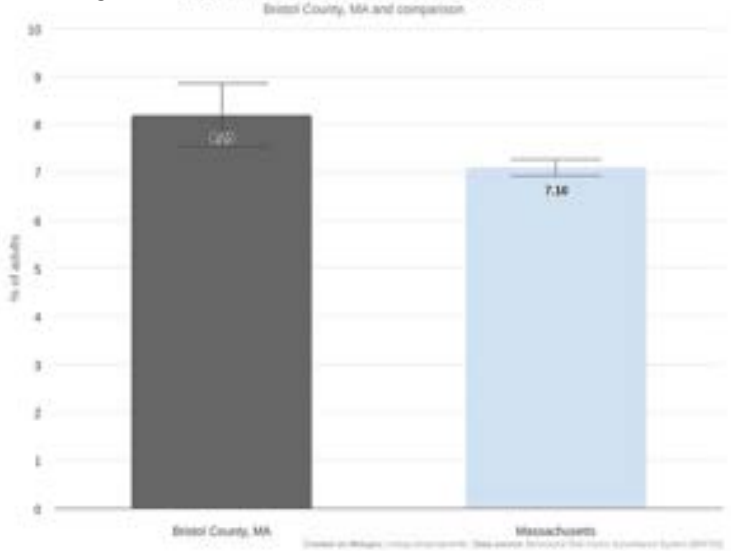


Financial Barriers to Care

Another major barrier to accessing health care is cost—whether from health insurance, co-pays, prescription medications, or transportation to a provider's office. These financial burdens can delay care, limit treatment options, and exacerbate overall health outcomes.

Delaying physician visits due to cost is a significant issue in Bristol County, where the rate is 8.2%, compared to 7.1% statewide *(figure 38).* This gap underscores the financial barriers residents face in accessing timely care, which can lead to worsening health outcomes and greater reliance on emergency services.

Figure 38 **Physician use delayed due to cost, 2006-2012**



The South Coast Region, particularly New Bedford and Fall River, has a higher percentage of individuals without health insurance compared to Massachusetts overall. In New Bedford, 8.77% of residents are uninsured, while Fall River has a rate of 6.81%, significantly above the state average of 2.9% *(figure 39).* Many individuals remain uninsured due to the high cost of health insurance premiums, deductibles, and other out-of-pocket expenses, making coverage unaffordable for low- and moderate-income households.

Lack of health insurance can lead to delayed care, reduced preventive services, and increased reliance on emergency care, which may result in more severe health outcomes and higher healthcare costs over time. It can also exacerbate existing health inequities, particularly among low-income populations and vulnerable groups who are already at greater risk for chronic conditions. Overall, these gaps in insurance coverage highlight the need for targeted policies and community-based interventions to reduce financial barriers, expand access to care, and improve health outcomes in the South Coast Region.

The data also highlights disparities in coverage across racial and ethnic groups. Hispanic or Latino individuals consistently have the highest uninsured rates in the region, with New Bedford showing a particularly high rate of 33.48% *(figure 40).* These disparities indicate systemic barriers that disproportionately affect communities of color, limiting access to timely and adequate healthcare.

Figure 39 **No health insurance, 2022**

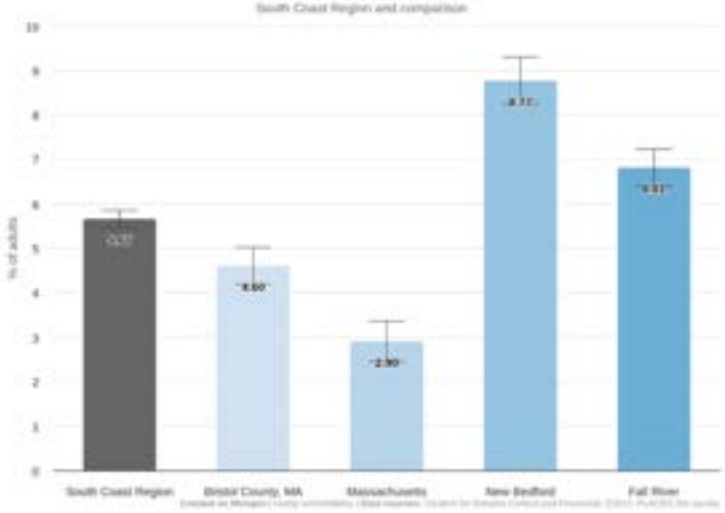
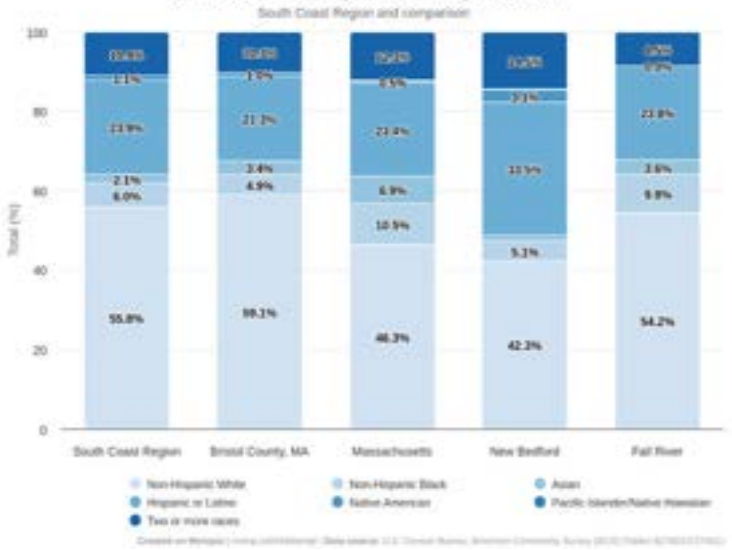


Figure 40 **Uninsured residents by Race/Ethnicity, 2019-2023**



The cost of transportation to medical appointments is another significant barrier to accessing care, which was echoed by community stakeholders and focus group participants. Many patients cannot afford travel expenses, whether for public transit, rideshares, or personal vehicles, which can lead to missed appointments and delays in treatment. This financial burden further compounds existing healthcare access challenges in the community.

In addition to transportation costs, community stakeholders noted that “the lack of flexibility in medical appointments can also cause delays in care.” Clinic hours often do not align with patients’ schedules, and many cannot afford to take time off work, limiting their ability to access timely healthcare services. This contributes to unmet health needs and can exacerbate existing health disparities.

Culturally Competent & Inclusive Care Delivery

> "As the community becomes more diverse, there is a greater need for culturally competent care and language-accessible services to ensure all populations are being reached effectively."
>
> - Community Stakeholder

Community stakeholders, focus group participants and survey respondents noted the need for more culturally competent providers who can speak the languages prevalent in the community and understand the diverse populations within the South Coast region . A lack of language-accessible and culturally responsive care can create additional barriers, preventing patients from fully understanding treatment options, following care plans, and engaging with the healthcare system.

Culturally competent health care is essential for ensuring equitable, effective, and respectful medical services for diverse populations. When health care providers understand and appreciate the cultural values, beliefs, languages, and practices of the communities they serve, they can build stronger relationships and trust with patients. This trust improves communication, encourages individuals to seek care earlier, and increases adherence to treatment plans. Without cultural competence, misunderstandings or implicit biases can lead to misdiagnoses, inadequate treatment, and health disparities that disproportionately affect minority or marginalized groups.

Educating medical professionals on cultural competence helps create a more inclusive and responsive health care system. It equips providers with the skills to recognize and address social drivers of health, reduce implicit bias, and deliver care that respects patients' cultural identities and lived experiences. This not only enhances patient satisfaction and health outcomes but also promotes equity by reducing barriers to care for underserved populations. Ultimately, culturally competent health care ensures that all patients—regardless of background—receive quality care that meets their unique needs.

Oral Health

Oral health and access to dental care emerged as a consistent theme across numerous stakeholder interviews and focus group discussions. Limited availability of dental providers, high costs, and inadequate insurance coverage were frequently cited as barriers that prevent residents from receiving timely and preventive dental care.

While Massachusetts generally has a high number of dentists per capita and Fall River and Bristol County show relatively high rates, the South Coast Region overall—and New Bedford in particular—have significantly lower rates *(figure 41).* This disparity limits access to preventive dental care, exacerbates oral health problems, and contributes to broader health disparities in the region.

Dental visit data mirrors these disparities. Massachusetts has a high overall rate of dental visits, with 72.6% of residents reporting they have seen a dentist. However, rates are lower in specific areas: Bristol County at 68.1%, the South Coast Region at 65.08%, Fall River at 59.56%, and New Bedford at 57.08% *(figure 42).*

These figures indicate that residents in the South Coast—particularly in New Bedford and Fall River—are less likely to receive regular dental care, highlighting notable geographic variations within the state.

Poor oral health is associated with several risk factors and broader health implications. Individuals who do not receive regular dental care are at higher risk for tooth decay, gum disease, and tooth loss. Additionally, poor oral health is linked to chronic conditions such as diabetes, heart disease, and adverse pregnancy outcomes. These risks underscore the importance of timely preventive care and access to dental services.

Addressing these gaps will require increasing the availability of dental providers, expanding coverage for dental services, and implementing community-based programs to promote oral health, especially for low-income and vulnerable populations.

Figure 41 **Dentists per capita, 2025**

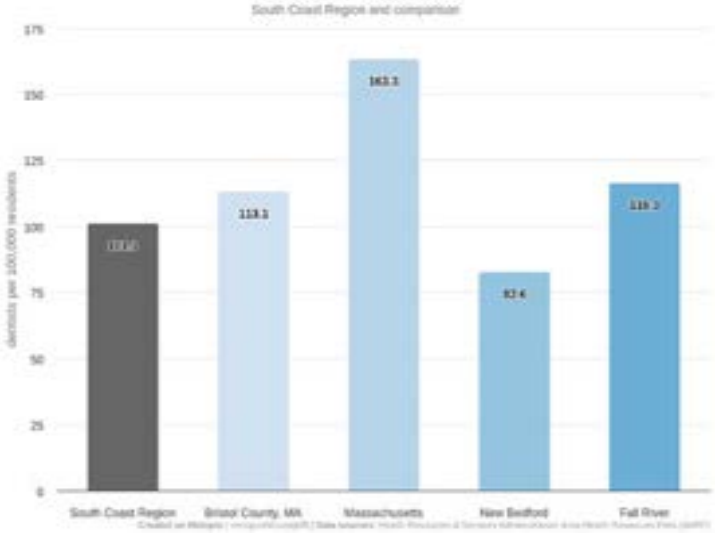
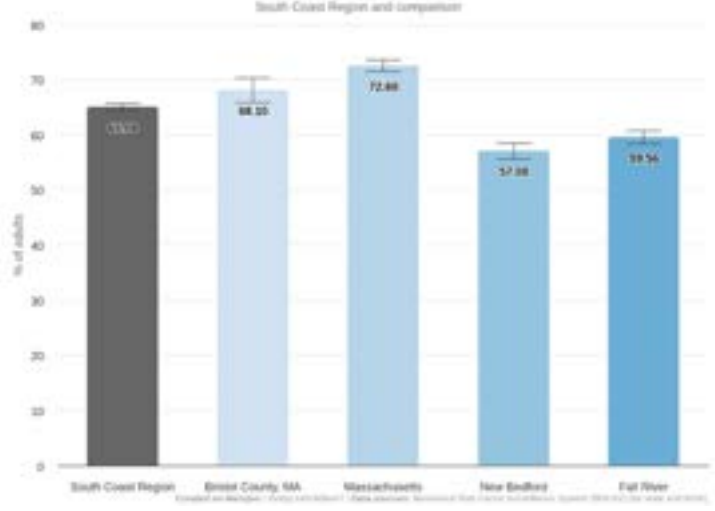


Figure 42 **Visited dentist, 2022**



Health Theme: Access to Care Summary

Overall, the South Coast Region faces multiple, interconnected barriers to healthcare and oral health access. High rates of uninsured residents, cost-related obstacles, limited appointment flexibility, and insufficient culturally competent providers restrict access to timely medical care. In addition, a shortage of primary care providers and long waitlists for appointments further delay care, contributing to unmet health needs and exacerbating chronic conditions. Dental care disparities, including lower provider availability and reduced dental visit rates, also heighten health inequities. Populations most affected include low-income residents, racial and ethnic minorities—particularly Hispanic or Latino individuals—and elderly individuals who rely on dual eligible coverage.

Improvement Opportunities

Expand Insurance Coverage & Enrollment Support

- Increase outreach to help residents enroll in Medicaid, Medicare, and marketplace plans.
- Provide community-based enrollment assistance and education to ensure awareness of avalible benefits.

Reduce Financial Barriers to Care

- Offer sliding-scale or low-cost services in clinics and health centers for patient transpiration needs.
- Expand programs that cover copays, prescriptions and preventative services for those uninsured or underinsured.

Improve Access to Culturally Competent Care

- Train healthcare providers in cultural humility, language access and implicit bias.
- Increase recruitment and retention of diverse healthcare professionals reflecting community demographics.

Strengthen Oral Health Access

- Expand community dental clinics and mobile dental services for underserved populations.
- Integrate oral health screenings and education into primary care and school-based health programs.

Enhanced Preventive and Specialty Services

- Increase availability of preventive screenings, immunizations and chronic disease management programs.
- Support telehealth and mobile health services to reach rural or transportation limited populations.

Foster Cross-Sector Partnerships

- Collaborate with schools, social service organizations, and community groups to connect residents to care.
- Integrate healthcare navigation programs to guide patients through insurance, appointments and follow-up care.

Ensuring equitable access to healthcare is vital for supporting the health and well-being of all residents in the . By expanding insurance coverage, reducing financial barriers, increasing culturally competent care, and strengthening access to preventive and oral health services, the region can promote early intervention, reduce disparities, and improve long-term health outcomes. Collaborative efforts that prioritize equity and community engagement will help ensure that every individual has the care they need to live a healthy, thriving life.

Child & Family Services Mobile Crisis Van

Health Theme: Behavioral Health

"There is a growing need for mental health services across all programs, including for youth, adults, and seniors."

---------- COMMUNITY STAKEHOLDER

Behavioral health is a broad, multifaceted field that encompasses mental health as well as substance use and overall emotional well-being. Mental health concerns are an increasing issue across the South Coast Region, affecting individuals of all ages, including youth, adults, and seniors. The region faces high prevalence rates of mental health conditions such as depression, anxiety, and other disorders, alongside challenges related to substance use, including alcohol and opioid use.

Access to behavioral health services is limited by factors such as cost, availability of providers, long waitlists, stigma, and insufficient integration with primary care. These barriers are further compounded by a lack of culturally competent providers who can effectively serve diverse populations. Addressing these challenges requires expanding access to behavioral health care, integrating services into primary care, providing community-based support programs, and implementing strategies to improve outreach, engagement, and equity in care across the South Coast Region.

Mental Health Supports in the South Coast

The South Coast Region has relatively low access to mental health facilities, with some areas lacking any facilities entirely. These facilities provide a range of services, including mental health treatment, substance use treatment, and care for co-occurring conditions—either serious mental illness in adults or serious emotional disturbances in children. The highest concentration of facilities is found in Fall River (ZIP code 02720), with 9.82 facilities per 100,000 residents, while other parts of Fall River and New Bedford have significantly fewer. This uneven distribution underscores the need to expand the availability of behavioral health services and improve equitable access across the region.

Though access remains uneven, the region has several strong mental health providers and support programs. **Southcoast Behavioral Health** in Dartmouth offers comprehensive inpatient and outpatient services for mental health and substance use disorders. **High Point Treatment Center** operates multiple facilities in the region, providing outpatient and residential behavioral health and substance use services, including therapy, medication-assisted treatment, and support for adolescents and adults. **Steppingstone Inc.** in Fall River provides outpatient therapy, trauma services, and psychotropic medication management for adults and seniors. In New Bedford**, Child & Family Services** provides community crisis stabilization and emergency counseling for individuals of all ages, while **Seven Hills Behavioral Health** offers outpatient rehabilitation and case management for people with co-occurring disorders.

As noted, despite the presence of these providers in the region, stakeholders continue to report significant access issues, including long waitlists, limited appointment availability, lack of culturally competent care, and geographic disparities in service distribution. “Mental health needs are increasing and there are not enough providers or support to meet the demand,” a stakeholder highlighted.

Substance Use Patterns and Implications for Health

Substance use, including opioids, alcohol, and tobacco, represents a significant public health concern in the South Coast Region. Opioid misuse and overdose rates have been particularly high, reflecting broader statewide trends, and contributing to increased emergency department visits, hospitalizations, and mortality. Alcohol use, including heavy and binge drinking, poses additional risks for chronic diseases, injuries, and social consequences. Tobacco use, while declining in Massachusetts overall, continues to affect certain populations in the region, increasing the risk of cancer, heart disease, and respiratory conditions.

Substance use often co-occurs with mental health conditions, creating complex behavioral health needs that require integrated, accessible care. Limited access to treatment services, long waitlists, cost barriers, and a shortage of culturally competent providers further exacerbate the impact of substance use, highlighting the importance of prevention, early intervention, and expanded treatment options in the South Coast Region.

Opioid-related overdose deaths remain a significant public health concern in Bristol County, which is inclusive of the South Coast region.

Age distribution data highlights that adults aged 40–64 are the most affected group, with a rate of 81.26 per 100,000—substantially higher than the Massachusetts state average of 58.45. Racial and ethnic disparities are also pronounced: Hispanic or Latino individuals experience the highest overdose rate at 52.71 per 100,000, while individuals identifying as Two or More Races have the lowest rate at 20.62 per 100,000. Across all populations *(figure 43).*

Figure 43 **Drug overdose mortality by Age, 2019-2023**

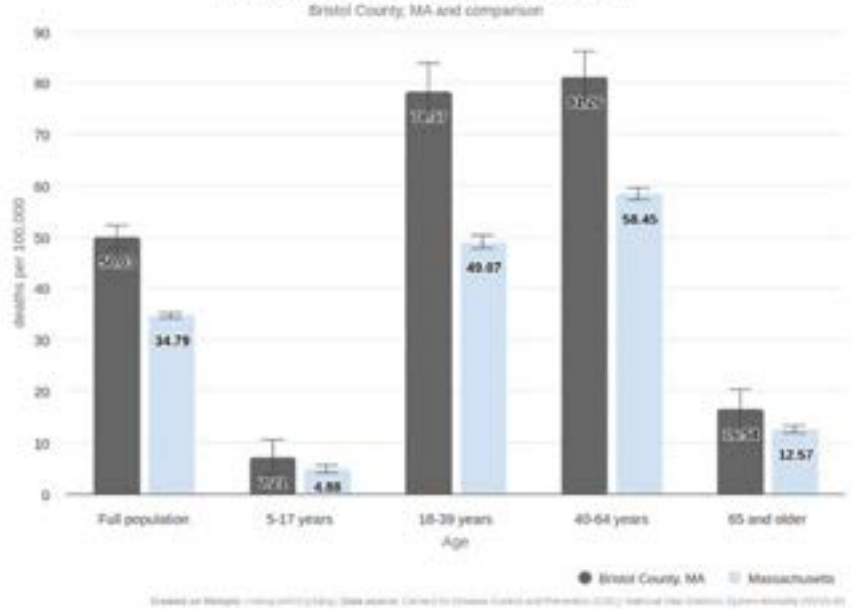
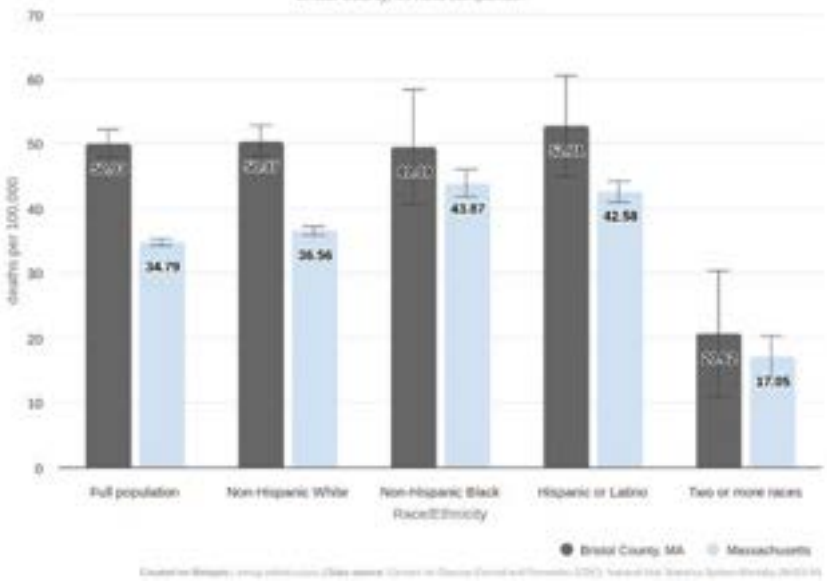


Figure 44 **Drug overdose mortality by Race/Ethnicity, 2019-2023**



Bristol County's overall overdose mortality rate is 50.03 per 100,000, compared to the statewide average of 34.78 per 100,000, highlighting a serious public health challenge *(figure 44).* These patterns underscore the need for targeted prevention, treatment, and harm reduction strategies that address both age and racial/ethnic disparities in the South Coast Region.

2025 Fall River Overdose Awareness Day

Alcohol misuse and binge drinking are significant concerns among adults in the South Coast Region, including Bristol County, where prevalence is 21.6%. Fall River and New Bedford report rates of 18.67% and 18.23%, respectively *(figure 45).* Rising rates of alcohol misuse, combined with limited access to support services and treatment options in the region, increase the risk of chronic health conditions, injuries, and social consequences. These patterns highlight the need for targeted prevention, intervention, and expanded support services to address alcohol-related harms.

Figure 45 **Binge drinking, 2022**

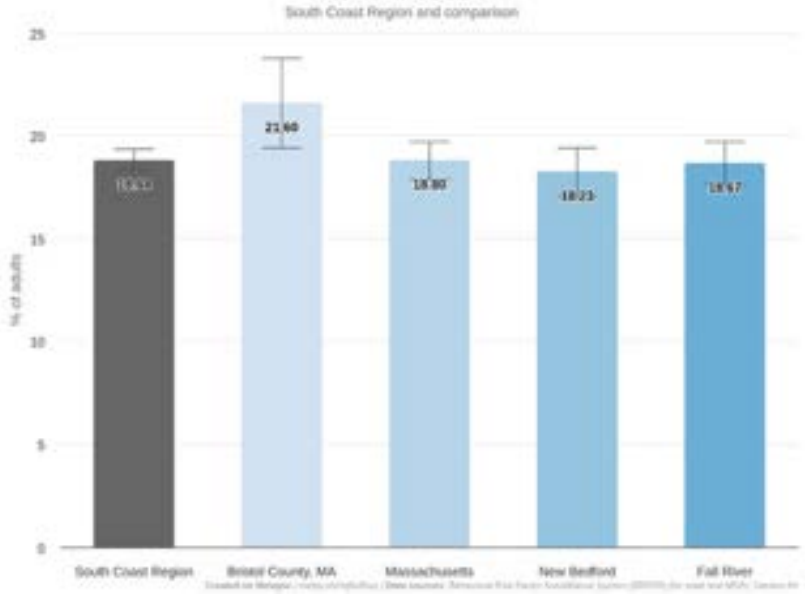
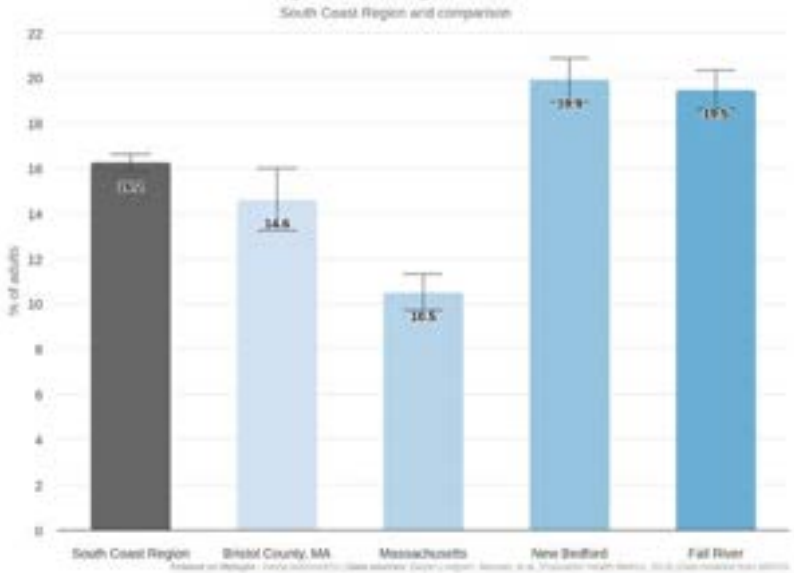


Figure 46 **Cigarette smoking rate, 2022**



In addition to alcohol misuse, **tobacco use** remains a significant public health concern in the South Coast Region, particularly in New Bedford and Fall River, where rates are notably high at 19.89% and 19.47%, respectively. The broader South Coast Region and Bristol County also show elevated rates of 16.24% and 14.6%, compared to the Massachusetts state average of 10.5% *(figure 46).* These disparities underscore the need for targeted public health interventions, prevention programs, and cessation support tailored to the communities most affected.

Substance use during pregnancy—including opioids, alcohol, and tobacco—can have serious consequences for infants and child development. Opioid use in pregnancy can lead to neonatal abstinence syndrome (NAS), where newborns experience withdrawal symptoms such as irritability, feeding difficulties, and respiratory issues. Alcohol use during pregnancy can result in fetal alcohol spectrum disorders (FASD), which affect physical growth, cognitive development, and behavioral outcomes. Tobacco use increases the risk of low birth weight, preterm birth, and long-term respiratory problems. These outcomes not only affect individual infants but also place additional strain on healthcare systems and social services. Addressing substance use among pregnant individuals through prevention, treatment, and supportive care is critical to protecting the health of both the birthing individuals and their babies in the South Coast Region.

Prevalence and Impact of Depression

Depression is a common mental health disorder characterized by persistent feelings of sadness, loss of interest or pleasure in activities, changes in appetite or sleep, fatigue, difficulty concentrating, and feelings of hopelessness or guilt.

Figure 47 **Depression, 2022**

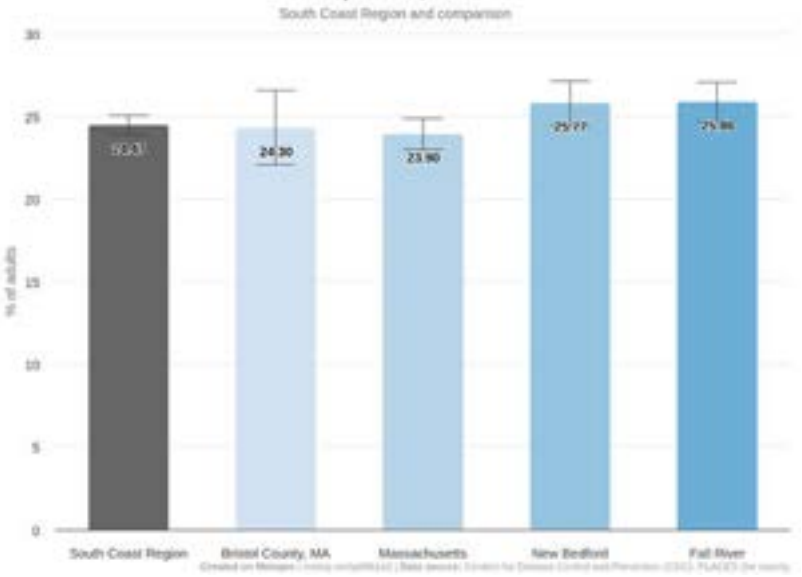
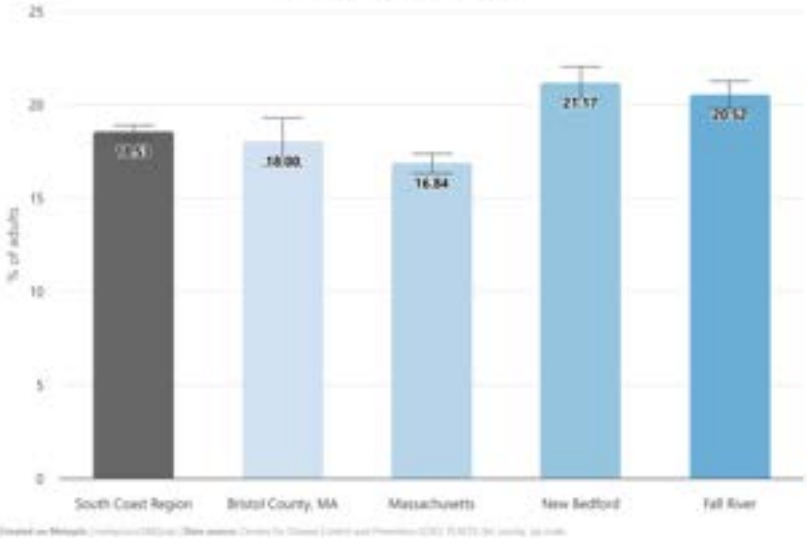


Figure 48 **Self-reported poor mental health, 2022**



Depression rates in Fall River and New Bedford are notably high, with Fall River reporting the highest rate at 25.86%. The broader South Coast Region and Bristol County also show elevated rates, indicating a significant regional impact. Massachusetts as a whole has a slightly lower, yet still substantial, depression rate of 23.9% *(figure 47).* These patterns highlight the importance of expanding access to mental health services, early intervention, and community-based supports to address depression across the region.

It should be noted that this data does not reflect the current political climate around immigration, which many stakeholders anticipate will increase the needs of the immigrant community. “There is a lot of stress and fear in our immigrant population concerning ICE,” one stakeholder noted. These concerns highlight the importance of monitoring emerging needs and providing culturally responsive supports for immigrant residents.

In addition to diagnosed depression, many residents experience **poor mental health** more broadly, as reflected in self-reported measures across the region. Self-reported poor mental health in the South Coast Region averages 18.53%, with several zip codes reporting similar levels. Notably, Fall River and New Bedford show higher rates, with Fall River’s 02724 area reporting 22.3% and New Bedford’s 02746 area reporting 23.2% *(figure 48).* These elevated rates, alongside high depression prevalence, underscore the importance of expanding access to mental health services, early intervention, and community-based supports to address behavioral health needs across the region.

Postpartum Depression

Among specific populations, such as new parents, mental health challenges can be particularly acute, with **postpartum depression (PPD)** representing a critical area of concern for both maternal and infant well-being. PPD is a mood disorder that affects parents after childbirth, characterized by persistent sadness, anxiety, irritability, changes in sleep or appetite, and difficulty bonding with the newborn. PPD can impact both mothers and fathers, and if left untreated, it may lead to long-term emotional, behavioral, and developmental challenges for both parent and child.

While statewide data indicate that approximately 1 in 7 new mothers experience PPD, localized factors in Fall River and New Bedford—such as socioeconomic stressors, limited access to mental health services, and insufficient social support networks—may increase risk. Barriers to care, including cost, transportation, and lack of culturally competent providers, further exacerbate challenges in identifying and treating postpartum depression.

Early screening, counseling, peer support programs, and integrated maternal mental health services are critical. Expanding access to these services in the South Coast Region is essential to promote the well-being of both parents and infants and to mitigate the long-term impacts of untreated postpartum depression.

Elder Isolation

In addition to challenges affecting younger and new-parent populations, older adults in the South Coast Region face unique mental health risks, with social isolation and limited access to supportive services contributing to emotional distress and poorer overall well-being. As one stakeholder shared, “there has been a noticeable increase in the need for accessible mental health services, particularly among older adults, driven by economic stress, social isolation, and post-pandemic challenges.”

Isolation can result from factors such as living alone, limited mobility, loss of social networks, and reduced access to transportation or community programs. Socially isolated seniors are at higher risk for depression, anxiety, cognitive decline, and other negative health outcomes, which can further exacerbate chronic medical conditions.

Data from the region indicate that a significant portion of older adults report feelings of loneliness or limited social connection, particularly in urban centers such as Fall River and New Bedford. Barriers to addressing elder isolation include limited availability of senior-focused mental health services, lack of culturally competent care, and financial or transportation constraints that prevent older adults from accessing support programs.

Interventions to reduce elder isolation and its mental health impacts include community engagement programs, senior centers, volunteer visitation programs, accessible mental health counseling, and integrated care models that combine physical and behavioral health services. As one focus group participant noted they’d like to see “more spaces and opportunities for elders to socialize in the community.” Strengthening these resources in the South Coast Region is critical to improving the emotional well-being and quality of life of older adults.

LGBTQIA+ Mental Health

Beyond the challenges faced by older adults, other populations—including LGBTQ+ residents—experience distinct mental health disparities that require culturally competent care and targeted support services. LGBTQ+ individuals often face unique mental health challenges due to stigma, discrimination, social exclusion, and barriers to affirming care. These experiences contribute to higher rates of depression, anxiety, substance use, and suicidal ideation compared to the general population.

In the South Coast Region, including Fall River and New Bedford, LGBTQ+ individuals may be particularly vulnerable due to limited local resources and social support networks. Mental health disparities in this population are further compounded by intersecting factors such as age, race, socioeconomic status, and housing instability. Addressing these disparities requires expanding access to culturally competent mental health services, promoting inclusive community spaces, and implementing targeted prevention and support programs that affirm LGBTQ+ identities.

Veteran Mental Health and PTSD

Veterans in the South Coast Region face elevated risk for PTSD, depression, and anxiety. PTSD may result from combat, military sexual trauma, or other service-related experiences, leading to symptoms such as flashbacks, hypervigilance, irritability, sleep disturbances, and functional impairment. Veterans also face barriers to accessing mental health care, including transportation challenges and limited local providers experienced in military-related trauma. Evidence-based treatments, peer support, and integrated care programs are essential to improve outcomes for veterans.

Adolescent Mental Health and Adverse Childhood Experiences (ACEs)

In addition to adult and population-specific mental health needs, adolescents in the South Coast Region face unique challenges, with adverse childhood experiences (ACEs) playing a significant role in shaping long-term behavioral health outcomes. Adolescence is a critical period for emotional, social, and cognitive development, and many youth experience depression, anxiety, substance use, and behavioral health challenges. ACEs—including abuse, neglect, household dysfunction, and exposure to violence or substance use—are strong predictors of poor mental health outcomes in adolescence and adulthood.

Populations in Fall River, New Bedford, and surrounding areas may face elevated ACE exposure due to socioeconomic stressors, housing instability, and community-level challenges. Addressing adolescent mental health and mitigating the impact of ACEs requires early identification, trauma-informed care, school and community programs, and family support interventions. Providing accessible and culturally competent resources helps promote resilience, healthy development, and long-term well-being for youth in the region.

Mental Health and Depression Among the Homeless Population

In addition to population-specific mental health needs, individuals experiencing homelessness face unique and compounded behavioral health challenges, including elevated rates of depression, anxiety, and co-occurring conditions. Homelessness is strongly associated with mental health challenges due to housing instability, food insecurity, exposure to violence, and limited access to healthcare.

In the South Coast Region, including Fall River and New Bedford, stakeholders report that depression and mental health concerns are pervasive among people experiencing homelessness. Limited access to primary care and behavioral health services, long waitlists, and logistical barriers such as transportation further complicate efforts to address these needs. Co-occurring conditions, such as substance use disorders, are also common and require integrated treatment approaches.

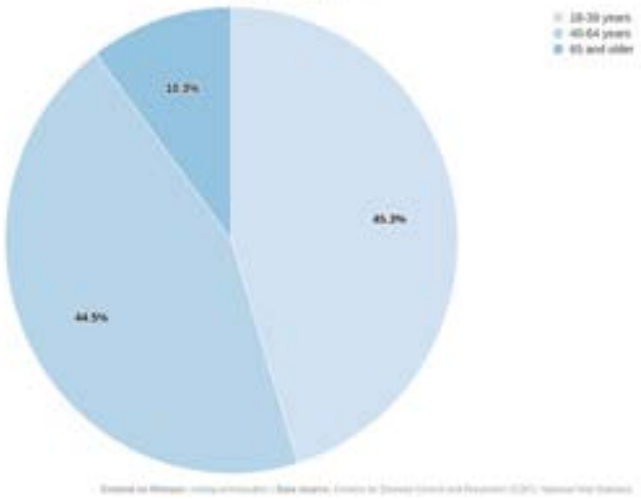
Addressing mental health among the homeless population requires trauma-informed care, accessible behavioral health services, case management, and supportive housing programs that combine mental health, substance use, and social services. Expanding these resources in the South Coast Region is critical to improving both mental health outcomes and overall quality of life for individuals experiencing homelessness.

Suicide & Suicidal Ideation

As with depression, individuals in the South Coast Region may experience thoughts of suicide or suicidal ideation, which are serious indicators of distress and require timely intervention. Suicidal ideation can be influenced by multiple factors, including mental health disorders such as depression and anxiety, substance use, social isolation, trauma, and adverse childhood experiences (ACEs). Stigma surrounding mental health and substance use can further prevent individuals from seeking help or disclosing these thoughts, exacerbating risk. Certain populations—including adolescents, older adults, veterans, LGBTQ+ residents, and individuals experiencing homelessness—may be at higher risk due to compounding social, economic, and environmental stressors.

Addressing suicidal ideation requires accessible, culturally competent mental health services, crisis intervention programs, and community education to reduce stigma and promote help-seeking behaviors across the region.

Figure 49 **Suicide deaths by Age**



Data from Bristol County, MA, highlights these risks. Suicide deaths are most prevalent among individuals aged 18–39 years, with 172 deaths reported, while the 40–64 age group also shows a significant number of deaths at 169 *(figure 49).* These trends underscore the critical need for targeted mental health interventions, suicide prevention strategies, and accessible behavioral health services to address risk across both younger and middle-aged adults in the county.

Increasing Behavioral Health Concerns with High-School Aged Youth

Another growing concern raised by numerous stakeholders is the ongoing **mental health crisis among school-aged children**, particularly middle and high school students. Rising levels of stress, anxiety, depression, and social pressures have been reported, with many students struggling to cope with academic demands, peer relationships, and the lingering effects of the COVID-19 pandemic.

Stakeholders emphasized that the region lacks sufficient mental health resources, including counselors, social workers, and specialized programs, to meet the growing demand for support among youth. This shortage of accessible services not only affects the emotional well-being of middle and high school students but also impacts their academic performance, social development, and long-term health outcomes.

Substances, particularly vaping

Early exposure to substance use was identified as another pressing concern. Substance use among individuals under 18 was described as particularly troubling, with schools reporting a sharp increase in **vaping**. The accessibility of these products is a driving factor—there are limited purchase restrictions, they are marketed as safe, relatively inexpensive, and often accessible in the home if parents use them. In addition, the rapid increase of vape and marijuana shops in the community has contributed to availability. Stakeholders also noted that vaping devices are easily concealable, can pass through metal detectors, and are therefore difficult to detect in school settings.

Social Media

In addition to limited access to mental health services for youth, stakeholders pointed to the growing influence of social media as a major factor shaping the emotional well-being of young people. While online platforms can foster connection and community, they were described as a significant source of stress, anxiety, and depression for many youths. Constant exposure to unrealistic standards, cyberbullying, and the pressure to maintain an online presence contribute to declining mental health. Stakeholders also noted that social media can normalize risky behaviors, including substance use, further compounding the challenges faced by adolescents.

Together, the combined pressures of limited mental health resources, social media influences, and increased access to substances contribute to a growing youth mental health crisis in the community. Stakeholders emphasized the need for comprehensive strategies and interventions to address these challenges, including expanding access to counselors, social workers, and youth-focused mental health programs.

Schools and community organizations can also play a role in promoting healthy social media habits and providing education on the risks of substance use. For example, **Fall River Public Schools** have implemented a no-phone policy, which has received positive feedback from students, helping to reduce distractions, social pressures, and opportunities for online harassment during the school day.

Stigma and Mental Health

Stigma remains a significant barrier to mental health care in the South Coast Region. Negative perceptions, stereotypes, and discrimination surrounding mental health conditions can prevent individuals from seeking help, delay treatment, and exacerbate symptoms. This applies across all populations, including adults, adolescents, older adults, LGBTQIA+ residents, veterans, and individuals experiencing homelessness.

Cultural and religious beliefs play a particularly important role in shaping attitudes toward mental health. In some communities, mental health challenges may be viewed as personal weakness, moral failing, or a private family matter, discouraging open discussion or help-seeking. Religious or spiritual frameworks can provide important support but may also unintentionally contribute to stigma if mental health concerns are interpreted solely through a moral or spiritual lens. These cultural and religious norms can lead to delayed treatment, underutilization of mental health services, and reliance on informal coping strategies that may not address clinical needs.

Stigma is also present in medical and healthcare settings, where individuals seeking treatment for substance use disorders may experience judgment, discrimination, or negative attitudes from providers. This can discourage patients from accessing care, adhering to treatment plans, or disclosing substance use, further exacerbating health disparities and limiting recovery opportunities.

Stakeholders have emphasized that both social and internalized stigma affect residents, with many experiencing shame, fear, or embarrassment related to mental health conditions. These challenges are compounded by structural barriers, including cost, transportation, lack of culturally competent providers, and limited-service availability.

Addressing cultural and religious stigma requires community education, mental health literacy campaigns tailored to diverse populations, and engagement with faith and community leaders. Integrating peer support, culturally responsive messaging, and inclusive mental health services can help reduce stigma, normalize help-seeking, and improve behavioral health outcomes across the South Coast Region.

> "We need more programs that de-stigmatize receiving mental health support."
>
> - Focus Group Participant

Health Theme: Behavioral Health Summary

The South Coast Region faces elevated rates of substance use, depression, and mental health concerns, compounded by disparities in age, race, ethnicity, and socioeconomic status. Across diverse populations—including older adults, LGBTQ+ residents, new parents, veterans, adolescents, and individuals experiencing homelessness—distinct behavioral health needs highlight the importance of tailored, culturally competent, and accessible services. Expanding access to prevention, early intervention, and treatment services across all populations is critical to improving overall health and well-being in the region.

Improvement Opportunities

Expand Access to Mental Health and Substance Use Services

- Increase the availability of outpatient, inpatient and telehealth behavioral health services.
- Offer flexible scheduling and mobile services to reach underserved or hard-to-reach populations.

Invest in Prevention and Early Intervention Programs

- Implement school-and community-based programs targeting youth mental health and substance use.
- Provide screening and early intervention services in community centers, primary care and workplaces.

Strengthen Culturally Competent Care

- Train providers in culturally responsive care, trauma-informed practices and LGBTQ+ health competency.
- Expand language access services and recruit diverse behavioral health professionals to reflect the community.

Support High-Risk and Vulnerable Populations

- Develop target programs for veterans, older adults, new parents, and individuals experience homelessness.
- Integrate behavioral health support into housing, employment and social services programs.

Increase Community Awareness and Education

- Reduce stigma through public campaigns, peer support networks, and community workshops.
- Educate residents on recognizing behavioral health issues and accessing avalible resources.

Foster Cross-Sector Partnerships

- Partner with schools, healthcare systems, social services agencies, and community organizations to coordinate care and support.
- Leverage data to identify gaps, monitoring outcomes, and inform resource allocation.

Strengthening behavioral health services is essential for fostering resilience, equity, and well-being across the . By expanding access to prevention, early intervention, and culturally competent treatment, and by addressing the unique needs of diverse populations, the region can reduce the impact of substance use, depression, and other mental health challenges. Collaborative, community-driven strategies will promote mental wellness, support recovery, and ensure that all residents have the resources and care they need to thrive.

New Bedford Community Health – 3D MAMMO & Lab

Health Theme: Chronic Disease

"Younger individuals are increasingly affected by a chronic disease with no family history, so are not receiving preventative screenings early enough."

---------- COMMUNITY STAKEHOLDER

Chronic diseases—such as heart disease, diabetes, cancer, and respiratory conditions—represent a significant public health challenge in the community. These conditions are long-lasting, often preventable, and can lead to substantial morbidity, reduced quality of life, and premature mortality. Risk factors for chronic disease include poor nutrition, physical inactivity, tobacco use, excessive alcohol consumption, obesity, and limited access to preventive healthcare services.

In the community, stakeholders have highlighted that disparities in socioeconomic status, access to healthcare, and education contribute to higher rates of chronic disease among certain populations. Preventive strategies, including regular screenings, health education, lifestyle interventions, and improved access to primary care, are essential to reducing the burden of chronic disease and promoting long-term health outcomes.

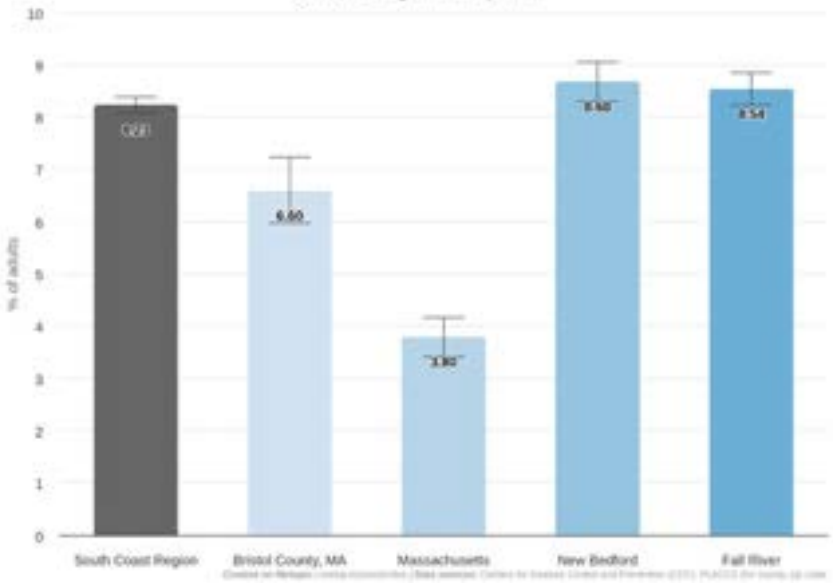
Heart Disease

Coronary heart disease (CHD), also known as coronary artery disease, is the leading cause of death in the United States and a major contributor to chronic illness in communities. CHD occurs when the coronary arteries, which supply blood to the heart muscle, become narrowed or blocked due to the buildup of plaque—a process known as atherosclerosis. This can lead to chest pain (angina), heart attacks, heart failure, and other serious complications.

Key risk factors for CHD include high blood pressure, high cholesterol, smoking, diabetes, obesity, physical inactivity, poor diet, and family history of heart disease. Social determinants of health, such as limited access to healthcare, lower socioeconomic status, and chronic stress, further contribute to the prevalence and severity of CHD.

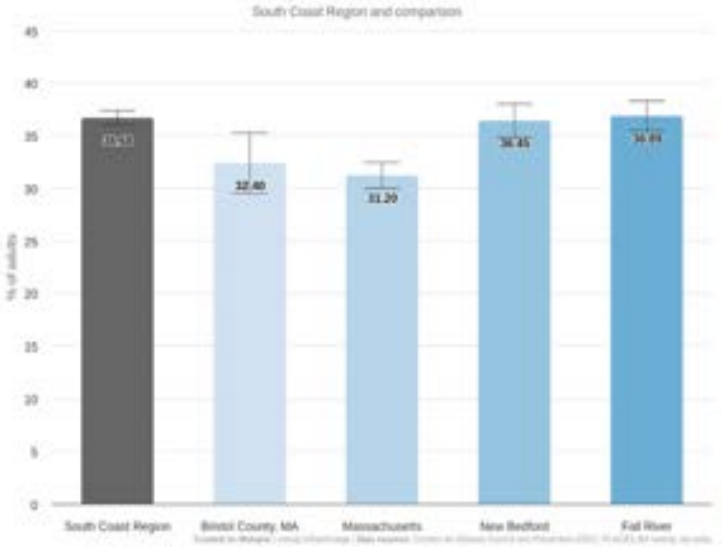
Local prevalence data highlight significant disparities within the region. New Bedford and Fall River show the highest rates at 8.68% and 8.54%, respectively, compared to lower rates in Bristol County overall (6.6%) and Massachusetts as a whole (3.8%) *(figure 50).* These elevated rates underscore the need for targeted prevention, early detection, and community-based interventions in these cities.

Figure 50 **Coronary heart disease, 2022**



Prevention and management strategies focus on lifestyle modifications—such as maintaining a heart-healthy diet, engaging in regular physical activity, avoiding tobacco, and managing stress—along with medical interventions like controlling blood pressure and cholesterol, and using medications as prescribed. Early detection through regular check-ups and health education can reduce morbidity and mortality associated with CHD.

Figure 51 **High cholesterol, 2021**



High Cholesterol

High cholesterol, or hypercholesterolemia, refers to elevated levels of cholesterol in the blood. Cholesterol is a fatty substance necessary for building cells and producing certain hormones, but excessive levels—particularly of low-density lipoprotein (LDL, or "bad" cholesterol)—can lead to the buildup of plaque in arteries. This plaque narrows and hardens the arteries, increasing the risk of heart disease, stroke, and other cardiovascular complications.

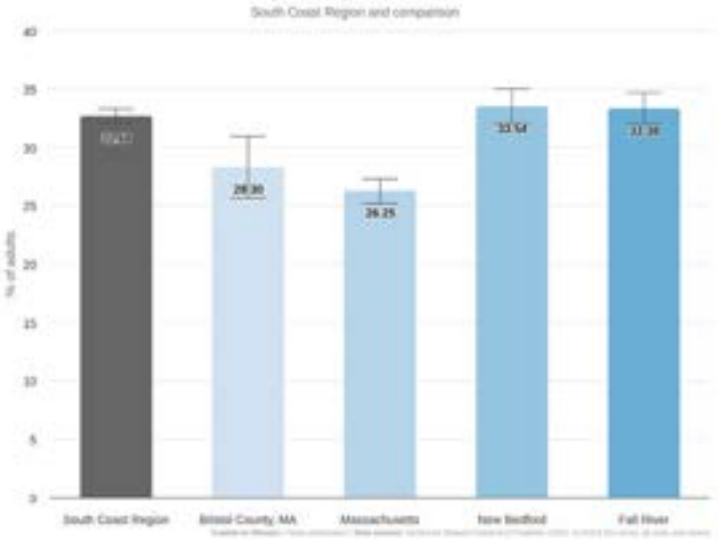
High cholesterol affects a significant portion of adults in the South Coast Region, with an overall rate of 36.68%. Specific areas such as New Bedford and Fall River report higher rates, with percentages of 36.45% and 36.89% respectively *(figure 51).* These figures highlight the need for targeted health interventions in these regions.

Prevention and management strategies focus on promoting healthy behaviors, including balanced nutrition with plenty of fruits, vegetables, whole grains, and low-sodium options; encouraging regular physical activity; and supporting healthy weight management. Community-based initiatives that reduce tobacco use, limit excessive alcohol consumption, and promote stress reduction can further protect cardiovascular health. Expanding access to preventive screenings and routine blood pressure checks in clinical and community settings allows for early detection and timely intervention, helping to prevent complications and advance health equity across the population.

High Blood Pressure

High blood pressure, or hypertension, occurs when the force of blood against the walls of the arteries is consistently too high. Over time, this increased pressure can damage blood vessels, the heart, and other organs, increasing the risk of heart disease, stroke, kidney disease, and other serious health problems. The data indicates that high blood pressure prevalence is notably higher in New Bedford and Fall River compared to the broader South Coast Region and Massachusetts. Specifically, New Bedford and Fall River have rates of 33.54% and 33.38%, respectively, which are significantly above the state average of 26.25% *(figure 52).* This suggests a localized health concern in these areas that may require targeted public health interventions.

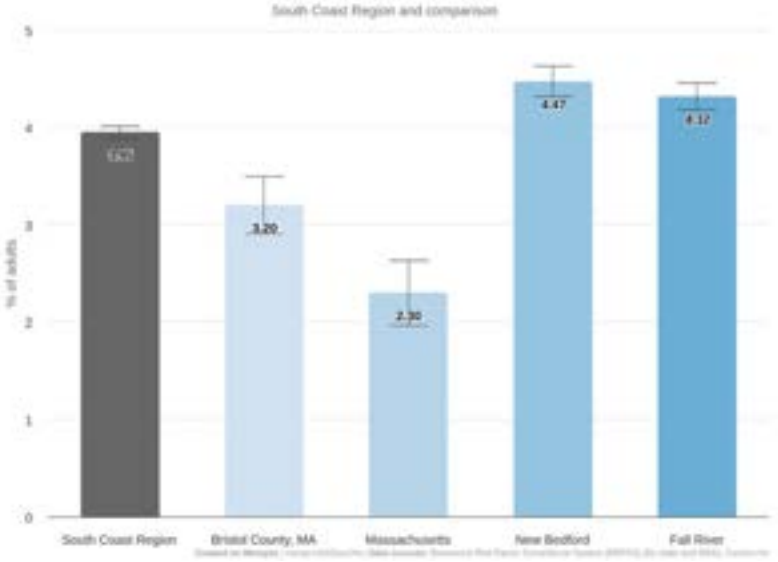
Figure 52 **High blood pressure, 2022**



If left uncontrolled, high blood pressure can significantly increase the risk of stroke, as the added strain on blood vessels can lead to blockages or ruptures in the brain. **Stroke** occurs when blood flow to the brain is interrupted or a blood vessel ruptures, depriving brain tissue of oxygen and causing potentially severe neurological damage. Local data show that New Bedford and Fall River have notably high stroke prevalence rates at 4.47% and 4.32%, respectively. The South Coast Region and Bristol County also report elevated rates, while the overall rate for Massachusetts is significantly lower at 2.3% *(figure 53).* These disparities highlight the need for targeted prevention and management strategies, including hypertension control, early detection, community education, and improved access to care.

Prevention and management strategies focus on lifestyle interventions with accessible clinical care. This includes supporting individuals in adopting heart-healthy diets; engaging in regular physical activity; maintaining a healthy weight; and avoiding tobacco use and excessive alcohol consumption. Expanding access to routine blood pressure screenings, medication management, and follow-up care—particularly in community-based and primary care settings—helps ensure early detection and consistent treatment. Culturally responsive education and support programs can also empower individuals to manage hypertension effectively, improving health outcomes and reducing disparities across the population.

Figure 53 **Diagnosed stroke, 2022**

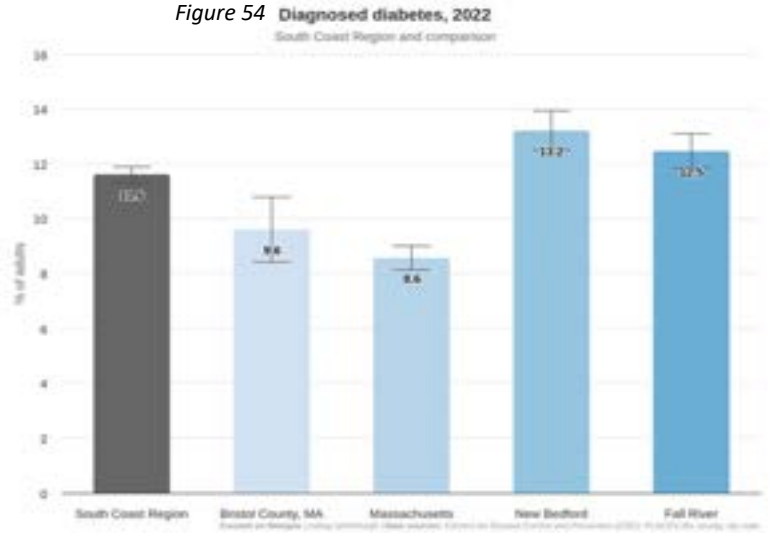


Diabetes

Diabetes is a chronic condition characterized by elevated blood glucose (sugar) levels, which can result from the body's inability to produce enough insulin (Type 1 diabetes) or the body's ineffective use of insulin (Type 2 diabetes). Over time, uncontrolled diabetes can lead to serious health complications, including heart disease, kidney disease, vision loss, nerve damage, and stroke.

The prevalence of diagnosed diabetes varies across locations in the region. The highest rates are observed in New Bedford and Fall River, with 13.22% and 12.48% respectively. The South Coast Region also shows a significant rate of 11.61%. Bristol County and Massachusetts as a whole have lower rates, at 9.6% and 8.55% respectively *(figure 54).* This indicates a higher concentration of diagnosed diabetes in specific regions compared to the state average.

Figure 54 **Diagnosed diabetes, 2022**



Prevention and management strategies focus on lifestyle modifications, including maintaining a healthy diet, engaging in regular physical activity, achieving and maintaining a healthy weight, and monitoring blood glucose levels. Medications, including insulin and other glucose-lowering therapies, may also be necessary to manage the condition effectively. Early diagnosis, education, and consistent management are essential to reducing complications and improving quality of life for individuals with diabetes.

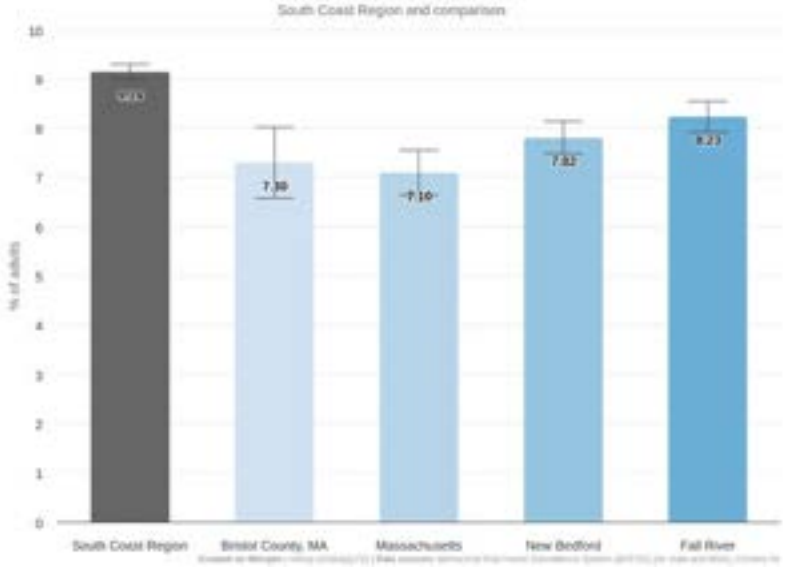
Cancer

Cancer is a leading cause of morbidity and mortality in the community, affecting individuals across all ages and backgrounds. Common types include lung, breast, colorectal, and prostate cancer, each with distinct risk factors such as tobacco use, poor diet, physical inactivity, obesity, environmental exposures, and genetic predisposition. Early detection through regular screenings—such as mammograms, colonoscopies, and Pap tests—can significantly improve outcomes, yet access to these preventive services is often limited for some populations. Disparities in cancer incidence, treatment, and survival are influenced by socioeconomic status, race and ethnicity, and geographic location.

The data indicate the prevalence of individuals who have ever been diagnosed with cancer across regions in Massachusetts. The South Coast Region has the highest rate at 9.14%, compared to the statewide rate of 7.1%. Within the region, Fall River and New Bedford report rates slightly higher than the state average, highlighting a local burden of cancer that underscores the need for prevention, early detection, and access to high-quality treatment and supportive care *(figure 55).*

Efforts to reduce cancer focus on promoting healthy lifestyles, increasing screening rates, providing public health education, and addressing health disparities to ensure equitable access to care. These strategies are essential for improving outcomes and reducing the long-term impact of cancer on the community.

Figure 55 **Have ever had cancer, 2022**



Key Cancer Types

The most prevalent cancers in the region include:

- **Lung and Bronchus Cancer**: The age-adjusted incidence rate is 65.8 per 100,000, higher than the statewide rate of 56.6 per 100,000.
- **Breast Cancer**: The age-adjusted incidence rate stands at 105.4 per 100,000 for individuals aged 50 and older, surpassing the statewide rate of 99.0 per 100,000.

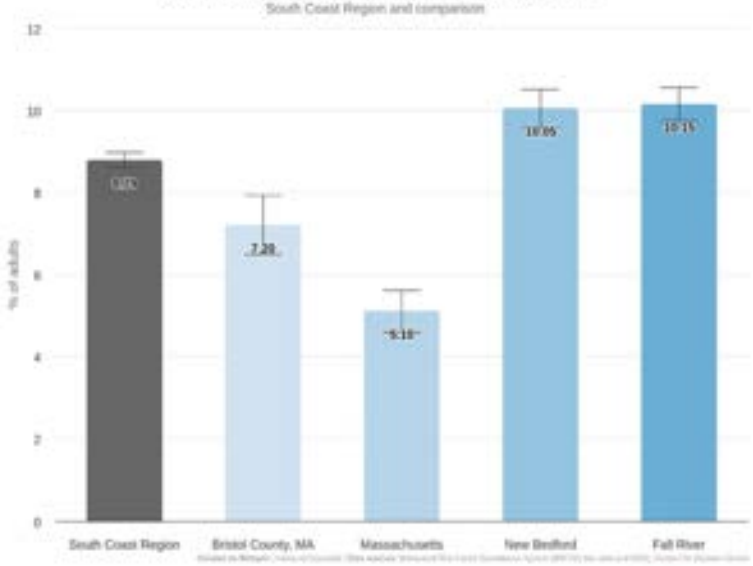
Respiratory

Chronic Obstructive Pulmonary Disease (COPD) is a progressive lung disease that makes it difficult to breathe. It includes conditions such as emphysema and chronic bronchitis, which damage the airways and air sacs in the lungs, leading to airflow obstruction. Common symptoms include chronic cough, shortness of breath, wheezing, and frequent respiratory infections.

The primary cause of COPD is long-term exposure to lung irritants, with cigarette smoking being the most significant risk factor. Other contributors include exposure to air pollution, occupational dust and chemicals, and a genetic condition called alpha-1 antitrypsin deficiency. Older age and a history of respiratory infections can also increase risk.

COPD is a leading cause of morbidity and mortality, often resulting in reduced quality of life and increased healthcare utilization. COPD affects a significant portion of adults in the South Coast region, with an average rate of 8.79%. Specific areas like Fall River and New Bedford have higher rates, reaching up to 11.6% *(figure 56).* These findings highlight the need for targeted healthcare interventions in this region.

Figure 56 **Chronic obstructive pulmonary disease (COPD), 2022**



While COPD is not fully reversible, management strategies—such as smoking cessation, medications (including bronchodilators and steroids), pulmonary rehabilitation, and vaccination against respiratory infections—can slow progression, relieve symptoms, and improve quality of life. Early detection and consistent management are essential to minimizing complications and maintaining lung function.

Asthma is a chronic respiratory condition characterized by inflammation and narrowing of the airways, which can cause wheezing, shortness of breath, chest tightness, and coughing. Asthma severity can range from mild and occasional symptoms to severe, life-threatening attacks that require immediate medical attention.

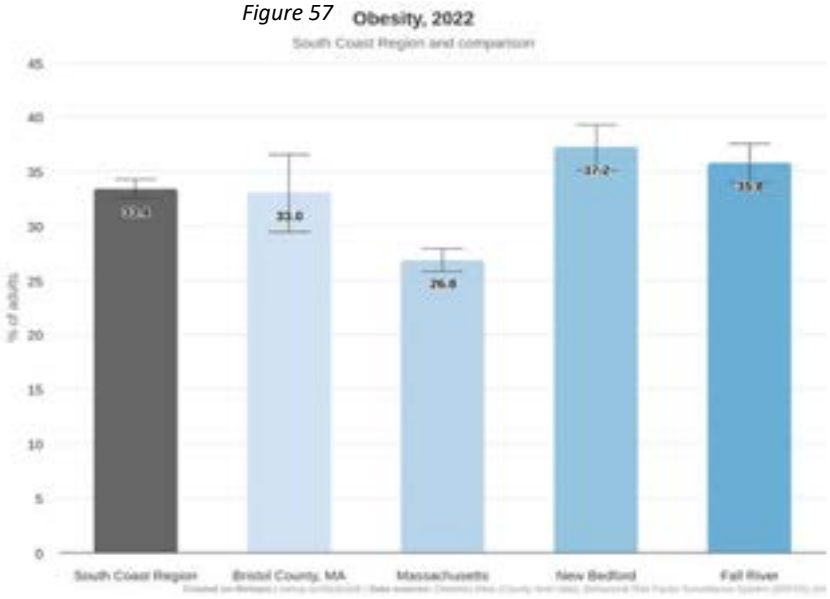
Triggers for asthma vary but often include allergens (such as pollen, mold, and pet dander), respiratory infections, air pollution, tobacco smoke, exercise, and certain medications. Genetic factors, early-life exposures, and social determinants of health—such as housing quality, access to healthcare, and environmental conditions—also influence asthma risk and severity.

The prevalence of current asthma among adults in various locations, key insights include that Fall River and New Bedford have some of the highest asthma rates, with percentages reaching up to 14.2%. These findings highlight the significant impact of asthma in these communities.

While asthma cannot be cured, it can be effectively managed with proper treatment and self-care. Management strategies include using long-term control medications (such as inhaled corticosteroids), quick-relief inhalers for acute symptoms, avoiding triggers, monitoring symptoms, and developing an asthma action plan. Effective asthma management helps reduce the frequency and severity of attacks, improves quality of life, and minimizes school or work absences.

Understanding Obesity Beyond Weight

Figure 57



Viewing obesity through an inclusive lens recognizes that it is a complex, multifactorial condition shaped by social, environmental, cultural, and structural factors—not simply individual behavior. Access to healthy foods, safe spaces for physical activity, education, and healthcare varies across communities, disproportionately affecting low-income populations, racial and ethnic minorities, and other marginalized groups.

Obesity is a condition characterized by a higher amount of body fat, often assessed using the body mass index (BMI). Adults with a BMI of 30 or higher may be classified as having obesity, while those with a BMI between 25 and 29.9 may be considered overweight. It is important to recognize that BMI is only one measure of health and does not capture overall well-being, genetic factors, or social and environmental influences on body size. In New Bedford, the obesity rate is 37.21%, the highest in the state, compared with a Massachusetts average of 26.8%, highlighting the need for targeted, inclusive health interventions that address local social, environmental, and systemic factors affecting residents' well-being *(figure 57).*

Inclusive approaches emphasize cultural sensitivity, respect for diverse dietary practices, and non-stigmatizing healthcare, ensuring that interventions are equitable and effective. By addressing systemic barriers, promoting body positivity, and engaging communities in solution-building, public health initiatives can reduce disparities in obesity prevalence and improve health outcomes for all populations.

Health Theme: Chronic Disease Summary

Chronic diseases—including heart disease, respiratory conditions, cancer, diabetes, and obesity—are prevalent in the South Coast Region. Socioeconomic disparities, limited access to healthcare, and inequities in food, housing, and physical activity opportunities contribute to elevated risk and disproportionate impacts on vulnerable populations.

Improvement Opportunities

Promote Nutrition and Healthy Eating

- Expand access to affordable, fresh and cultural appropriate foods through farmers markets and community gardens.
- Integrate nutritional education programs into schools, clinics and community centers.

Increase Opportunities for Physical Activity

- Develop and maintain safe walking paths, bike lanes and parks in underserved neighborhoods.
- Offer community-based fitness and wellness programs tailored to different ages and abilities.

Expand Access to Culturally Competent Disease Management Practices

- Expand preventive screenings, chronic disease management and telehealth services.
- Train healthcare providers in culturally responsive care and address barriers related to language, culture and trust.

Implement Community-Driven Education and Prevention Programs

- Create campaigns focused on chronic disease awareness, healthy lifestyles promotion and risk reduction strategies.
- Engage local organizations and residents in co-designing interventions that reflect community priorities.

Address Social Drivers of Health

- Link chronic disease prevention initiatives to housing stability, food security, transpiration access and workforce development.
- Support cross-sector collaboration between healthcare providers, schools, employers, and community organizations to tackle systematic barriers.

Monitor & Evaluate Impact

- Collect community-level data to identify trends, target interventions and measure outcomes.
- Use data to inform policy decisions and refine programs to ensure equity and effectiveness.

Addressing chronic disease in the South Coast Region requires inclusive, community-driven approaches that target both medical care and the social drivers of health. By expanding access to nutritious foods, safe spaces for physical activity, culturally competent healthcare, and prevention programs, the region can reduce disparities and improve long-term health outcomes. Collaborative strategies that engage residents and cross-sector partners will empower communities to take an active role in their health, fostering resilience, equity, and well-being for all.

Southcoast Health, MDC New Beginnings Program

Health Theme: Maternal & Child Health

"The community needs more resources for maternal and child health, including increased prenatal care and pediatric services."

---------- COMMUNITY STAKEHOLDER

Maternal and child health is a critical area of public health that emphasizes the well-being of mothers, infants, children, and adolescents. It encompasses key factors such as access to quality prenatal care, safe maternal health outcomes, healthy child development, and preventive measures like immunizations. Ensuring equitable access to pediatric healthcare services and early interventions supports both physical and emotional health during formative years. Strengthening maternal and child health not only improves individual outcomes but also fosters healthier families and communities across generations.

Trends in Maternal and Child Health Outcomes

From 2019 to 2023, women aged 15–50 in the South Coast Region—including Bristol County—experienced a **birth rate** of approximately 47.91 per 1,000 women, closely aligning with the Massachusetts statewide rate of 47.4 per 1,000 women aged 15–44. Within the region, birth rates vary considerably: Fall River's 02719 area recorded 35.97 per 1,000, while New Bedford's 02746 area reached 103.96 per 1,000, highlighting demographic diversity and localized birth trends. Infant and maternal health outcomes further illuminate the well-being of families in the county. The overall **infant mortality** rate in Bristol County is lower than the state average of 3.3 deaths per 1,000 live births *(see table 58),* though disparities persist: Hispanic or Latino populations experience rates above the state average, while Non-Hispanic Black populations have slightly lower rates. Maternal mortality remains rare but continues to be a critical concern, with severe maternal morbidity disproportionately affecting Black and other marginalized mothers, reflecting persistent social and health inequities.

Birth Weight

The average **birth weight** of infants in Bristol County is 3,247.8 grams, slightly lower than neighboring counties such as Barnstable (3,361.5 grams) and Plymouth (3,326.6 grams). Low birth weight—infants weighing less than 2,500 grams (5 lbs., 8 oz)—occurs in 8.4% of births in Bristol County, slightly above the Massachusetts average of 7.8%. Significant racial and ethnic disparities exist: Non-Hispanic Black infants have the highest rate at 11.1%, well above both county and state averages, while Hispanic/Latino infants also face elevated rates compared to Non-Hispanic White infants *(see table 58).*

Maternal health risk

Maternal health risks are also prevalent; 23.94% of births in Bristol County involve at least one maternal risk factor, such as chronic hypertension, eclampsia, diabetes, tobacco use, or pregnancy-associated hypertension—the highest percentage among neighboring counties, followed by Plymouth at 20.52% and Barnstable at 16.54% *(see table 58).* These patterns underscore the role of socioeconomic factors, access to prenatal care, maternal health behaviors, and systemic inequities in shaping birth outcomes. Collectively, the variations in birth rates, infant and maternal mortality, average and low birth weight, and maternal risk factors highlight the urgent need for targeted interventions, culturally responsive prenatal services, and community health initiatives to improve maternal and child health across Bristol County.

Table 58

Indicator	Bristol County	Plymouth County	Barnstable County	Massachusetts
Birth Rate (per 1,000 women 15–50)	47.91	-	-	47.4
Infant Mortality Rate (per 1,000 live births)	<3.3	-	-	3.3
Average Birth Weight (grams)	3,247.8	3,326.6	3,361.5	-
Low Birth Weight (<2,500 g) (%)	8.4	-	-	7.8
Low Birth Weight – Non-Hispanic Black (%)	11.1	-	-	9.4
Maternal Risk Factors (%)	23.94	20.25	16.54	-

Prenatal Care Overview

Building on trends observed in maternal and child health outcomes, understanding prenatal care is essential for identifying factors that influence both maternal and infant well-being. Prenatal care provides critical monitoring, education, and interventions that can reduce pregnancy complications and support healthy development. Examining access to and utilization of these services highlights disparities across communities and helps inform targeted strategies to improve health outcomes for mothers and children.

Access to Obstetric Providers and Hospitals

Massachusetts overall has a high concentration of obstetrics and gynecology physicians per capita, though Fall River falls slightly below the state average. Within Bristol County and the South Coast Region, access is notably lower, with New Bedford having the fewest providers at 12.26 physicians per capita. This disparity underscores a potential need for increased healthcare resources and targeted strategies to improve maternal health services in these communities.

Access to hospital-based obstetric care also varies across the state. In 2022, hospitals providing obstetric services per 100,000 residents were highest in Barnstable County at 0.44, followed by Bristol County at 0.35, and Plymouth County at 0.19. These regional differences in both physician availability and hospital access highlight potential gaps in prenatal care, which may influence maternal and infant health outcomes.

Prenatal Care in the First Trimester

Prenatal care during the first trimester is a critical component of maternal and child health, providing early monitoring, education, and interventions that support healthy pregnancies. Between 2020 and 2022, 80.6% of live births in Bristol County, MA, received first-trimester prenatal care, reflecting a strong emphasis on early maternal health services in the region. These data underscore the importance of timely prenatal care in promoting positive outcomes for both mothers and infants.

Examining first-trimester prenatal care alongside broader prenatal care trends provides a more complete picture of maternal health in the South Coast region. While a majority of births in Bristol County receive early prenatal care, disparities in access to obstetric providers and hospital-based services suggest that some communities may face barriers to timely care.

Understanding both the timing and overall utilization of prenatal services is essential for identifying gaps and informing strategies to improve maternal and infant health outcomes across the region.

Birthing Supports

In addition to medical prenatal care, supportive services such as **doulas, childbirth educators, and community health** workers play a vital role in promoting maternal and infant health. Doulas provide emotional, physical, and informational support throughout pregnancy, labor, and delivery, which has been associated with reduced rates of cesarean births, shorter labor, and improved birth outcomes.

Access to these supportive services can be particularly important in communities with limited obstetric providers, helping to fill gaps in care, improve patient experience, and encourage adherence to prenatal care recommendations. **In the South Coast Region, there are 13 doulas**, with the highest concentration in New Bedford, MA, particularly in the 02740 ZIP code. However, several areas, have no reported doulas, highlighting geographic disparities in access to these supportive services. Expanding the availability of doulas in underserved locations can help improve maternal experiences and birth outcomes, especially in communities facing limited obstetric provider access.

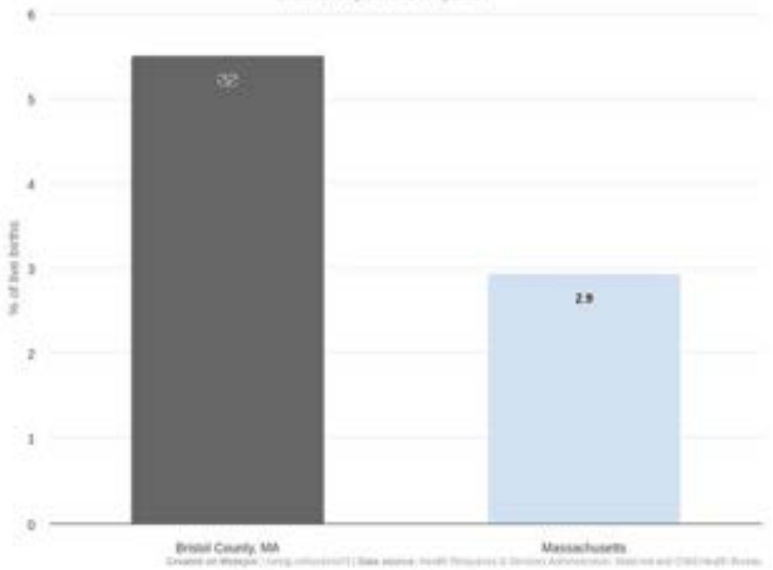
Integrating doulas and other supportive programs into prenatal care, alongside traditional medical services, can enhance maternal well-being, promote positive birth outcomes, and address disparities observed in regions like Bristol County and the South Coast, where provider access may be limited.

Prenatal Care and Smoking

Maternal smoking during pregnancy is a significant risk factor for adverse birth outcomes, including low birth weight, preterm birth, and developmental complications. Early and consistent prenatal care provides opportunities for healthcare providers to screen for tobacco use, counsel expectant mothers, and offer resources for cessation. In Bristol County, 5.5% of pregnant individuals reported smoking during pregnancy, a rate significantly higher than the Massachusetts state average of 2.93% *(figure 59).* This disparity highlights a pressing need for targeted interventions, including smoking cessation programs integrated into prenatal care, to improve maternal and infant health outcomes in the county.

Addressing smoking during pregnancy is a key component of broader efforts to ensure equitable access to prenatal care and optimize maternal and infant health outcomes across the South Coast region.

Figure 59 **Smoking during pregnancy, 2020-2022**



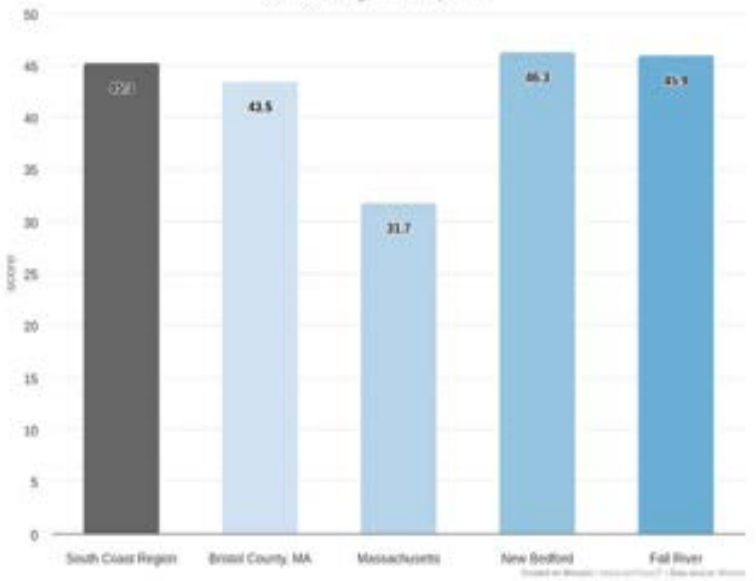
Maternal Hardship: Barriers to Health and Well-Being

The South Coast region faces significant maternal socioeconomic challenges that can impact both maternal and child health outcomes. The Maternal Hardship Index highlights disparities across Massachusetts, with New Bedford and Fall River exhibiting the highest levels at 46.26 and 45.95, respectively. Bristol County and the broader South Coast Region also show elevated indices, contrasting sharply with the state's overall lower index of 31.74 *(figure 60).* These figures underscore the need for targeted interventions to support mothers in areas experiencing the greatest hardship.

Childcare Cost Burden

Childcare costs add another significant layer of economic burden for families. In Bristol County, the childcare cost burden is 41.51%, higher than the Massachusetts state average of 39.68%. Families in the county are disproportionately affected by childcare expenses, which can limit work opportunities, savings, and access to other essential services. Addressing childcare affordability is therefore a critical component of reducing maternal hardship and promoting equitable opportunities for healthy child development.

Figure 60 **Maternal Hardship Index, 2016-2023**



Family Structure

Single-mother households are prevalent across the region, with Fall River and New Bedford showing the highest percentages at 8.32% and 8.12%, respectively. Bristol County and the South Coast Region also exhibit notable rates of 5.72% and 5.89%, above the Massachusetts state average of 4.69%. High rates of single parenthood can exacerbate economic stress, limit access to healthcare, and reduce social support, all of which can influence maternal and child well-being.

Conversely, **married-couple households** with children are less prevalent in the South Coast region compared with the state overall. In Massachusetts, 17.96% of households are married couples with children, while the South Coast region shows a lower rate of 13.47%. Within the region, New Bedford and Fall River have particularly low rates at 11.98% and 10.46%, respectively. This variation in family composition can affect economic stability, access to resources, and the availability of parental support networks.

Another important element of family structure is **grandparents raising grandchildren**. From 2019 to 2023, an average of 9.53% of children in the South Coast region lived with grandparents, though there were significant local differences. In West Wareham, 32.17% of children lived with grandparents, compared to just 1.50% in North Westport. These disparities highlight the diverse living arrangements of children across the region and suggest that support services must account for nontraditional caregiving households.

Teen pregnancy in the South Coast region appears to be very low. Data from the American Community Survey (ACS), Table B13002, indicate that the teen birth rate for females aged 15–19 was consistently 0.0 across various locations, including North Lakeville, Buzzards Bay, and White Island Shores, from 2019 to 2023. This suggests that teen pregnancy is not a significant driver of maternal hardship in these communities, although continued monitoring and access to education and support remain important.

Taken together, these socioeconomic factors—high maternal hardship, family composition disparities, teen pregnancy rates, and childcare cost burden—highlight the complex challenges faced by mothers in the South Coast region. Comprehensive policies and programs that support families before and after childbirth, enhance economic stability, and ensure access to resources are essential for improving maternal and child health outcomes and promoting long-term family well-being.

Continuity of Care: Maternal and Infant Support Services

The period following childbirth is critical for both mothers and infants, requiring consistent medical, nutritional, and social support. In the South Coast region, access to pediatric care, WIC services, and breastfeeding support serve as vital resources to strengthen maternal and child health outcomes, especially in communities facing higher socioeconomic challenges.

Pediatric Care

Pediatric care is a cornerstone of infant and child health, ensuring that developmental milestones are met, vaccinations are administered, and emerging health concerns are addressed early. Access to pediatric providers, however, can vary across the South Coast region, with some communities experiencing longer wait times or shortages of child health specialists. Strengthening pediatric services in areas with limited availability can help reduce disparities in child health outcomes.

Access to maternal care providers also influences pediatric health. Massachusetts has a high concentration of obstetrics and gynecology (OB/GYN) physicians per capita, with Fall River slightly below the state rate. However, Bristol County and the South Coast region overall have significantly lower concentrations, and New Bedford has the lowest at 12.26 physicians per capita. These disparities indicate a potential need for increased healthcare resources in maternal and pediatric care, as limited provider availability can disrupt continuity of care for both mothers and their children.

A recent development aimed at enhancing pediatric services in the region is the opening of a specialized pediatric rehabilitation facility in New Bedford by Southcoast Health. This center provides comprehensive rehabilitative care for children recovering from injuries, surgeries, or managing chronic conditions and developmental delays. By offering physical, occupational, and speech therapy in a child-focused environment, the facility helps address gaps in local pediatric specialty care. Its presence improves access for families who previously had to travel outside the South Coast region for these services, supporting earlier interventions, better care coordination, and improved long-term outcomes for children.

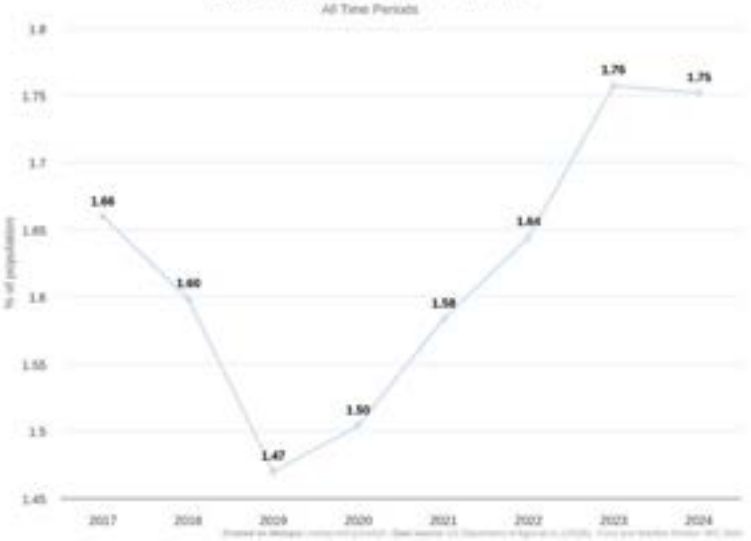
Breastfeeding Support

Breastfeeding provides infants with vital nutrients and immune protection while also promoting maternal-infant bonding. However, breastfeeding initiation and continuation can be influenced by access to lactation consultants, supportive hospital practices, and workplace accommodations. Across Massachusetts, breastfeeding initiation rates average 88.17%, but Bristol County reports a significantly lower rate of 78.3%. This gap highlights the need for enhanced breastfeeding support in the South Coast region. Expanding access to lactation consultants, peer counseling, and hospital-based lactation programs, along with community education initiatives, can help birthing individuals overcome barriers and improve infant health outcomes.

WIC Services

The Women, Infants, and Children (WIC) program provides nutrition assistance and education to eligible pregnant, postpartum, and breastfeeding women, as well as infants and children up to age five. In Massachusetts, WIC participation has shown a general upward trend from 2017 to 2024, increasing from 1.47 to 1.75. The rate peaked in 2023 at 1.76 before slightly declining in 2024 *(figure 61).* This trend indicates growing engagement with the WIC program over the past several years, reflecting the continued importance of nutrition support services for eligible populations.

Figure 61 **WIC participation rate, Massachusetts**



Childcare and Returning to the Workforce

The availability of affordable, high-quality childcare is another critical factor shaping maternal well-being and infant development, as stakeholders noted “childcare is a barrier to many families.” In the South Coast region, families face a disproportionately high childcare cost burden, and access to licensed childcare centers varies by community. As of 2023, the South Coast region reported a childcare center ratio of 11.27 (children per care center enrollment spot), reflecting significant demand relative to availability. Within the region, Fall River and New Bedford show varying ratios, indicating differences in childcare accessibility and the need for localized approaches to expand services.

Employment patterns among recent mothers further highlight the importance of accessible childcare. In Bristol County, 76.11% of recent mothers are in the labor force—a rate slightly higher than Massachusetts overall (76.1%) and the South Coast Region (75.95%). However, local disparities exist: Fall River shows a participation rate of 74.79%, while New Bedford reports a significantly lower rate of 67.42%. These figures demonstrate that while many mothers return to the workforce soon after childbirth, limited access to affordable childcare can create significant barriers, especially in communities already facing economic hardship.

Health Theme: Maternal & Child Health Summary

Maternal and child health in the South Coast region is shaped by a complex interplay of socioeconomic challenges, family structures, and access to healthcare and support services. High maternal hardship levels, elevated rates of single-mother households, and lower proportions of married-couple families with children contribute to financial and caregiving stress. Childcare costs and limited availability of childcare centers further strain families, particularly as most recent mothers return to the labor force soon after childbirth, often with limited support. At the same time, post-birth services such as pediatric care, WIC programs, and breastfeeding support remain critical resources, yet disparities—such as Bristol County's lower breastfeeding initiation rate—highlight ongoing gaps in access and utilization.

Improvement Opportunities

Expand Access to Affordable Childcare

- Increase availability of licensed childcare centers and home-based childcare programs.
- Offer subsides or sliding-scale fees to reduce financial barriers for low-income families.

Strengthen Maternal Support Services

- Enhance postpartum care, home visiting programs, and parenting education initiatives.
- Provide peer support networks and counseling for new mothers, including mental health resources.

Promote Breastfeeding and Nutrition Support

- Increase access to locational consultants and support for caregivers around feeding their babies.
- Support WIC and other nutrition programs, ensuring easy enrollment and culturally relevant resources.

Improve Access to Pediatric and Preventative Care

- Expand availability of well-child visits, immunizations, and developmental screenings.
- Offer mobile or community-based clinics to reach underserved families.

Address Socioeconomic Barriers

- Link families to housing assistance, food programs, transportation support and employment resources.
- Integrate social services with healthcare to provide coordinated, holistic support.

Enhance Health Education and Community Engagement

- Provide culturally tailored education on maternal and child health, nutrition and early development
- Involve community members in program planning to ensure services meet local needs.

Investing in maternal and child health is essential for fostering healthy families and stronger communities across the South Coast. By expanding access to affordable childcare, strengthening postpartum and pediatric services, supporting nutrition and breastfeeding programs, and addressing socioeconomic barriers, the region can ensure that mothers and children receive the care and resources they need to thrive. Collaborative, community-driven approaches will promote equitable outcomes, healthy development, and long-term well-being for families throughout the region.

SSTAR Health Van breaking down barriers to bring care into the community.

Health Theme: Overall Health

"Over the last few years since COVID, I think the health in the community has definitely decreased."

---------- COMMUNITY STAKEHOLDER

An overall assessment of health provides a broad understanding of the population's physical and mental well-being, reflecting both individual experiences and community-wide outcomes. Key indicators such as life expectancy, self-reported health status, and measures of overall quality of life offer insight into how residents are living and aging, as well as the challenges they face. These metrics capture not only the prevalence of disease but also the influence of social, economic, and environmental factors on health. By examining these overarching indicators, we gain a comprehensive picture of population health that can guide priorities for prevention, resource allocation, and long-term improvement in well-being.

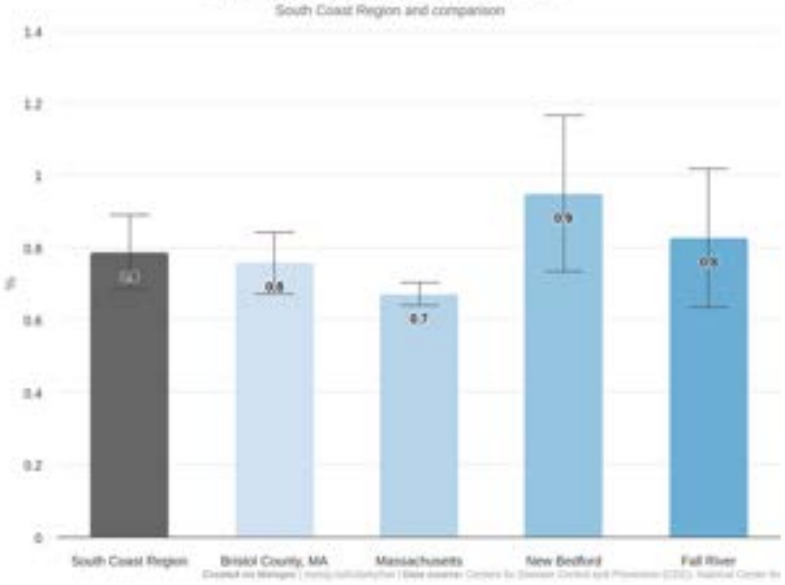
Population Health & Well-Being

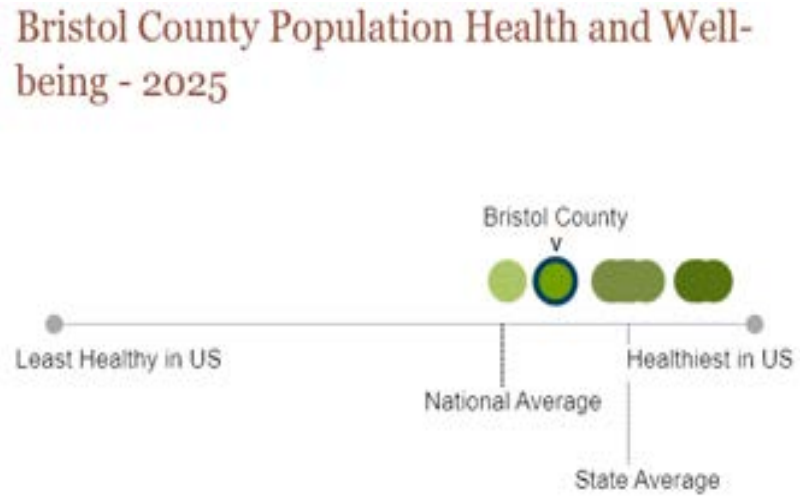
Population health encompasses the collective physical, mental, and social well-being of a defined group, considering not only the presence or absence of disease but also the broader determinants that shape health outcomes. Key indicators—such as life expectancy, self-reported health, prevalence of chronic conditions, mental health status, and quality of life measures—provide insight into how individuals experience health within their communities.

Well-being extends beyond clinical metrics to include factors such as economic stability, access to healthcare, education, safe housing, nutrition, social connectedness, and environmental conditions. Disparities in these social drivers often lead to uneven health outcomes across regions, socioeconomic groups, and racial or ethnic populations.

In the South Coast region, including the cities of New Bedford and Fall River, population health outcomes are influenced by a combination of economic challenges, higher rates of chronic disease, and disparities in access to healthcare services. Metrics such as life expectancy and all-cause mortality rates reveal these inequities, underscoring the need for targeted interventions. By monitoring both health outcomes and underlying social determinants, public health practitioners and policymakers can design strategies to improve overall well-being, promote equity, and enhance quality of life for all community members.

Figure 62 **Mortality among young adults, 2010-2015**





Life expectancy refers to the average number of years a person is expected to live, either from birth or from the beginning of a specified age bracket. It is calculated as the average age at death for all individuals born in a given place and time, or for all who survive to a particular starting age. As a population-level indicator, life expectancy provides more than a measure of longevity—it reflects the broader social, economic, and environmental conditions that shape health across the life course.

Differences in life expectancy between communities often highlight disparities in access to healthcare, nutrition, safe housing, education, and economic opportunity. Because of this, life expectancy is widely used in public health to assess overall well-being, track progress toward equity, and guide interventions aimed at improving quality of life for all populations. Mortality among young adults is a significant concern, with varying rates across different regions.

The South Coast Region, including New Bedford and Fall River, has notably higher rates compared to the overall state of Massachusetts *(figure 62).* This disparity underscores the importance of targeted health interventions to address the unique challenges facing these communities and to improve long-term population health outcomes.

From 2019 to 2023, the **all-cause mortality disparity ratio** between Black and White populations in Barnstable County, Bristol County, and Plymouth County in Massachusetts remained below 1 *(figure 63).* This indicates that, during this period, the overall mortality rate for all causes of death was lower in the Black population compared to the White population within these counties. The data, sourced from the National Vital Statistics System–Mortality (NVSS-M), provides insight into population-level mortality trends and highlights regional differences in health outcomes across racial groups.

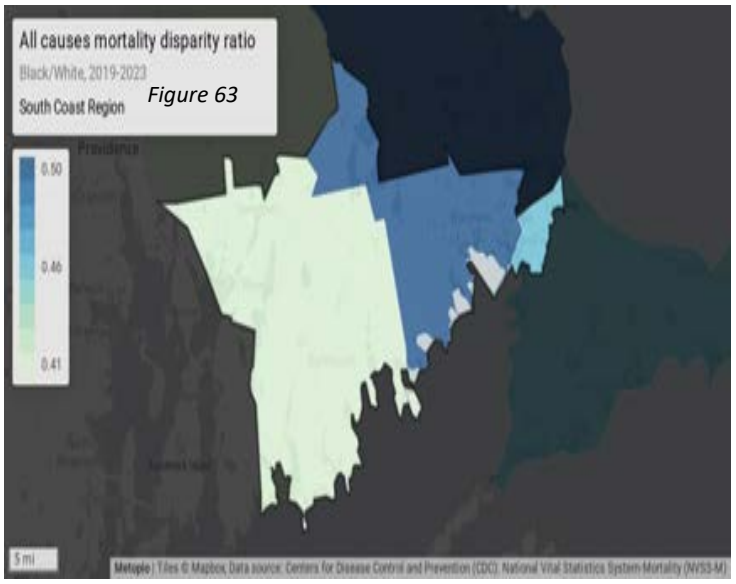


Figure 63

However, while overall mortality rates were lower among Black populations, they experienced higher rates of premature mortality, with a greater proportion of deaths occurring before age 75 *(table 64).* This suggests persistent inequities in early-life and mid-life health outcomes that are not fully captured by all-cause mortality alone.

Table 64: Premature Mortality[1] Rates by County, Massachusetts: 2022

	Bristol County	Plymouth County	Massachusetts
Number of Deaths[2]	2,642	2,233	25,291
PMR (per 100,000 population)[3]	711.8	697.1	297.7

1. Premature mortality is death before 75 years of age. 2. County deaths may not add to total due to deaths with missing ages. 3. Rates are per 100,000 population age-adjusted to the 2000 US Standard Population for persons ages 0-74 years.

In 2022, Bristol County reported a total of 6,161 deaths, with an age-adjusted death rate of 807.9 per 100,000 residents. The **leading causes of deaths** were cancer (1,223 deaths) and heart disease (1,174 deaths), followed by COVID -19 (390), lung cancer (329), and opioid-related deaths (273). Other major causes included chronic lower respiratory disease (261), stroke (241), diabetes (158), and influenza and pneumonia (78). Deaths from external causes were also notable, with 70 suicides, 53 motor vehicle-related deaths, and 17 homicides reported. Additionally, 46 deaths were attributed specifically to breast cancer (depicted in *table 65*).

Table 65: Causes of Death by County, Massachusetts: 2022

	Bristol County	Plymouth County	Massachusetts
Total Deaths	6,161	5,457	63,390
Age-Adjusted Death Rate[1]	807.9	762.3	691.6
Heart Disease	1,174	1,083	12,409
Total Cancer	1,223	1,128	12,424
Lung Cancer	329	264	2,737
Breast Cancer	46	69	718
Stroke	241	212	2,391
COPD[2]	261	229	2,374
Diabetes	158	109	1,501
Influenza & Pneumonia	78	111	934
COVID-19	390	261	3,217
Motor Vehicle	53	42	477
Homicide	17	17	172
Suicide	70	69	624
Opioids-Related[3]	273	188	2,314

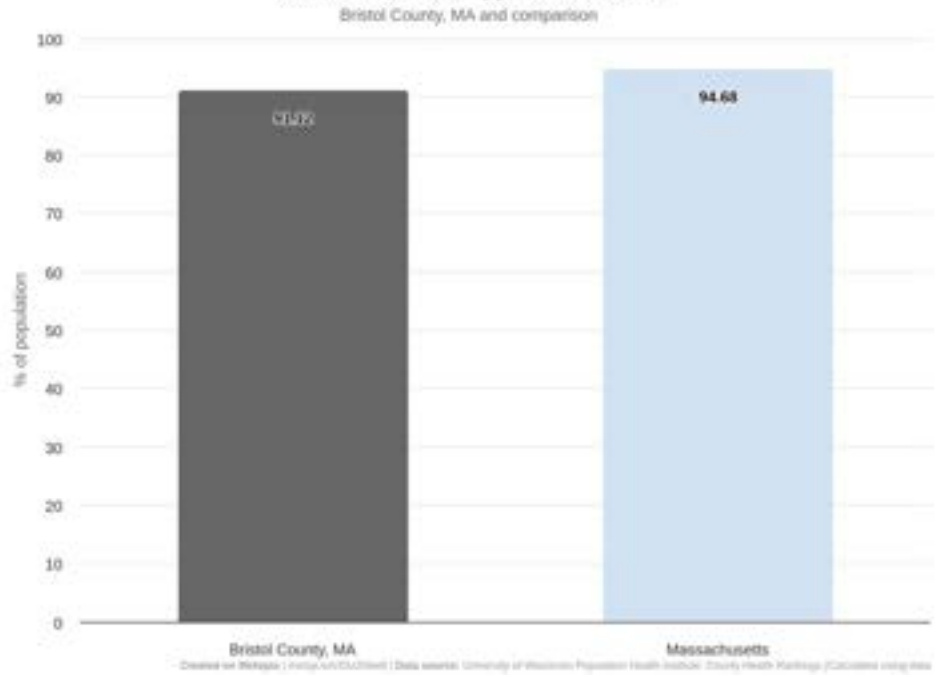
1. Rates are per 100,000 population age-adjusted to the 2000 US Standard Population and calculated using MDPH population estimates for 2020, which are the most up-to-date information available on the number of persons by age, race, and sex at the sub-state level. Data presented in this table are classified according to ICD-10. Please see Appendix for a list of ICD-10 codes used in this table. 2. Rates based on 1 to 4 deaths are not calculated. 3. The term opioid designates a class of drugs derived naturally from the opium poppy (opium, morphine, codeine), synthesized or derived from a natural opiate (heroin, oxycodone, hydrocodone), or manufactured synthetically with a chemical structure similar to opium (fentanyl, methadone). (Opioid Overdose Response Strategies in Massachusetts, MDPH, 2014). This report combines all opioid overdoses since classification of specific drugs can be difficult. For example, many deaths related to heroin cannot be specifically coded as such due to the fast metabolism of heroin into morphine, as well as the possible interaction of multiple drugs

Physical Activity

Access to exercise opportunities plays a crucial role in supporting both physical and mental health, and ensuring these opportunities are inclusive helps promote well-being for people of all body types, abilities, and backgrounds. Regular physical activity is linked to numerous health benefits, including reduced risk of chronic diseases, improved cardiovascular fitness, stronger bones and muscles, better mental health, and enhanced mood and energy levels. It can also serve as an empowering way to build confidence and reduce stress. Importantly, fostering environments where movement is celebrated for its health benefits rather than appearance helps counteract harmful body image pressures and supports a more positive relationship with physical activity.

In Massachusetts, access to exercise opportunities is notably high, with 94.68% of residents having nearby options such as parks, walking trails, fitness centers, and recreational programs. Bristol County, Massachusetts maintains a similarly strong access rate of 91.12%, reflecting a regional commitment to promoting active lifestyles. Prioritizing inclusive and affordable exercise spaces—such as community recreation centers, accessible trails, adaptive fitness classes, and culturally responsive programming—ensures that everyone can participate in physical activity without stigma or discrimination. By centering accessibility and body inclusivity, communities can encourage lifelong healthy habits and help all individuals feel welcomed and supported in their pursuit of wellness.

Figure 66 **Access to exercise opportunities, 2024**



While access to exercise opportunities is high across Massachusetts, data from the Behavioral Risk Factor Surveillance System reveal notable differences in physical health outcomes, suggesting that access alone does not guarantee improved well-being. Adults in Bristol County, Massachusetts report the highest average number of poor physical health days per month at 4.19, compared to 3.73 in Plymouth County, Massachusetts and 3.41 in Barnstable County, Massachusetts.

These findings highlight the importance of not only maintaining widespread access to physical activity opportunities, but also addressing the barriers that may prevent individuals from using them—such as cost, transportation, time constraints, health conditions, or feelings of exclusion related to body image or ability. Targeted, inclusive health interventions that actively reduce these barriers can help ensure that the benefits of physical activity reach those experiencing the greatest health challenges, ultimately reducing disparities and improving overall community health.

Supporting physical activity among high school–age students is especially important, as habits formed during adolescence often carry into adulthood and have lasting impacts on long-term health. Regular movement during the teen years contributes to healthy growth and development, supports mental well-being, reduces stress, and helps prevent chronic conditions later in life. However, many students face barriers such as limited access to safe recreational spaces, lack of inclusive programming, academic pressures, and social stigma related to body image or ability.

Creating supportive school and community environments that emphasize the joy and health benefits of movement—rather than appearance or competition—can help all students feel welcome and motivated to participate. Providing diverse options like intramural sports, dance, fitness clubs, and culturally responsive or adaptive physical education programs can foster lifelong positive attitudes toward physical activity and support healthier futures for youth.

Community Health Workers

Community Health Workers (CHWs) play a vital role in improving the overall health of a community by serving as trusted liaisons between health care systems and the populations they serve. Rooted in the communities they support, CHWs are uniquely positioned to understand cultural, social, and economic factors that influence health behaviors and access to care. They help individuals navigate complex health systems, connect them to resources such as preventive screenings, nutrition programs, or mental health services, and provide education tailored to community needs. By addressing barriers like transportation, language differences, and lack of health literacy, CHWs can reduce disparities, foster trust in health care, and encourage early engagement in preventive care. Their work not only improves individual outcomes but also strengthens the overall health infrastructure, creating healthier, more resilient communities.

In Massachusetts, the role of a CHW has continued to expand, reflecting a growing recognition of their impact on public health. The number of CHWs per capita has increased from 30.9 in 2023 to 32.9 in 2024, signaling a positive trend in the state's commitment to strengthening community-based health support.

This growth is also evident in the South Coast of Massachusetts region, where health systems, community organizations, and local health departments are increasingly integrating CHWs into their care teams to reach underserved populations and address health disparities more effectively. The rising presence of CHWs in this area not only enhances care coordination and access to resources but also reinforces community trust, positioning them as a cornerstone of efforts to improve population health and advance health equity across the region.

Health Theme: Overall Health Summary

Evaluating overall health offers a clear picture of how residents of the South Coast Region are living and thriving. Beyond measuring disease prevalence, this assessment considers life expectancy, self-reported health, and quality of life alongside social, economic, and environmental influences. These insights highlight the factors shaping well-being and help identify priority areas for intervention. .

Improvement Opportunities

Strengthen Data Collection & Monitoring

- Collect and analyze community-level health data to identify disparities, trends and emerging needs.
- Use data to inform policy, resource allocation, and program development.

Promote Health Equity Across Sectors

- Address social drivers of health, including housing, food access, education, transportation and employment.
- Implement programs that target underserved populations to reduce disparities.

Enhance Prevention and Primary Care

- Expand access to preventive screenings, vaccinations and chronic disease leveraging mobile health services.
- Support primary care services that integrate behavioral health, oral health and social services.

Engage Community in Health Planning

- Involve residents in decision-making to ensure initiatives reflect local priorities and lived experience.
- Foster partnerships among healthcare systems, local governments, schools and community organizations.

Invest in Health Promotion and Education

- Provide education campaigns on healthy behaviors, mental wellness, and community resources.
- Encourage programs that support physical activity, nutrition, and stress reduction across all age groups.

Support Policy and Environmental Changes

- Advocate for policies that improve air and water quality, housing stability, food security, and safe recreational spaces.
- Promote community environments that facilitate health choices and reduce exposure to health risks.

By taking a holistic view of population health, the region can make informed decisions to improve access to resources, reduce disparities, and support long-term community wellness through equity-focused approaches that ensure that all community members have the opportunity to live healthier, longer, and more fulfilling lives.

Health Themes & Assessment Summary

The Community Health Needs Assessment findings for the South Coast region reveal complex and interconnected health themes shaped by social, economic, and environmental conditions. The health and well-being of the South Coast Region are shaped by a complex interplay of social, economic, and environmental factors. Strengthening education, housing stability, access to nutritious food, healthcare, and behavioral health services—while promoting safe, connected communities—can reduce disparities and improve quality of life for all residents.

Socioeconomic Conditions
Economic stability and access to opportunity are at the heart of community health. In the South Coast Region, initiatives that support education, workforce participation, and financial security can help residents overcome barriers to well-being. By addressing these foundational factors and prioritizing equity, the region can create lasting improvements in health outcomes and strengthen community resilience for all populations.

Housing
Safe, affordable, and stable housing is essential for individual and community health. Expanding housing options, preventing displacement, and supporting families experiencing housing insecurity will provide the foundation residents need to thrive. When housing challenges are addressed, communities gain stronger connections, improved access to essential services, and a healthier overall population.

Built Environment
The spaces where people live, work, and play profoundly influence health and quality of life. Enhancing green spaces, improving transportation infrastructure, and reducing exposure to environmental hazards can create safer, healthier neighborhoods. Thoughtful planning that reflects community input fosters environments where residents can lead active, connected, and fulfilling lives.

Healthy Food Access
Ensuring consistent access to nutritious food is key to preventing disease and supporting well-being. Strengthening food programs, expanding local food sources, and removing barriers to healthy eating can empower residents to make choices that sustain long-term health. By tackling food insecurity through community-driven approaches, the South Coast Region can promote equity and better health outcomes for all.

Healthcare Access
Accessible, affordable, and culturally responsive healthcare is critical to preventing illness and managing chronic conditions. Expanding coverage, reducing financial barriers, and improving access to primary, preventive, and oral health services ensures that all residents can receive the care they need. Collaborative strategies that center equity help build a stronger, healthier, and more resilient community.

Behavioral Health
Mental health and substance use support are vital for individual and community well-being. By providing accessible, culturally competent services and addressing the needs of diverse populations, the region can promote recovery, resilience, and overall wellness. Community-focused, inclusive approaches ensure behavioral health resources are available to all who need them.

Chronic Disease
Reducing the burden of chronic disease requires coordinated efforts that integrate medical care with social supports. Access to healthy foods, safe physical activity options, preventive care, and culturally competent healthcare can help residents prevent and manage conditions such as heart disease, diabetes, and obesity. Engaging communities in planning and intervention strengthens outcomes and promotes lasting health improvements.

Maternal and Child Health
Supporting mothers and children is critical for lifelong health. Expanding access to affordable childcare, postpartum care, pediatric services, and nutrition programs ensures families receive the support they need. By addressing both health services and socioeconomic barriers, the region can foster equitable outcomes and promote healthy development for the next generation.

Overall Health Assessment
A broad view of population health helps guide priorities and inform effective strategies. Examining life expectancy, quality of life, and social and environmental influences highlights the opportunities and challenges facing the South Coast Region. Using these insights to drive equitable, community-centered action ensures all residents have the resources and support to live longer, healthier, and more fulfilling lives.

Strengths of the South Coast

Despite the identified health themes, the South Coast region has many qualities and resiliencies to commend. The region stands out for its diverse array of strengths that contribute to the vibrancy of the community.

Its strategic coastal location supports a robust maritime economy, including fishing, shipping, and emerging offshore wind industries, while also attracting tourism and recreation that bolster local businesses. The region benefits from a mix of urban centers and scenic rural areas, offering both economic opportunities and a high quality of life. Strong educational institutions and healthcare systems provide essential services and workforce development, while a rich cultural heritage fosters community pride and engagement.

Additionally, numerous stakeholders noted the collaborative networks of local organizations, municipalities, and community groups enable innovative approaches to regional planning, economic development, and public health, positioning the area for sustainable growth.

Over the past three years, the region has experienced notable growth and progress in several areas aimed at improving health outcomes:

- **Data-driven health planning:** Regional hospitals and public health agencies have **strengthened their use of health data from community health needs assessments (CHNAs)** to develop the first **Community Health Improvement Plan (CHIP) in New Bedford** focused on interventions where they are most needed, helping close gaps in care and outcomes.

- **Increase in Mobile Services:** Regional health systems like Southcoast Health, FQHC's such as SSTAR and HealthFirst and Child & Family Services, have **expanded mobile health clinics and telehealth services**, improving access to screenings, vaccinations, and chronic disease management, particularly for underserved populations.

- **Expanded community health workforce**: Massachusetts has seen growth in its community health worker (CHW) workforce, with the South Coast contributing to this trend, increasing outreach, care coordination, and health education capacity.

- **Maternal and child health investments**: Regional providers have strengthened **prenatal care coordination, lactation support, and postpartum home visiting programs**, aiming to lower infant mortality rates and improve maternal health outcomes.

APPENDIX

APPENDIX A: Acknowledgments; Community Stakeholders, Focus Group Hosts & Survey Distribution Partners

The Community Health Needs Assessment was made possible through the invaluable contributions and support of community members, partner organizations, and individuals who assisted with data collection and analysis. We extend our sincere gratitude to the following individuals and organizations for their dedication and collaboration. We apologize for any inadvertent omissions or errors in acknowledgment and deeply appreciate the collective effort that made this work possible.

Birth to Third Partnership
Bristol County Sherriff's Office
Child & Family Services
Citizens for Citizens
Coastline Elderly
Community Economic Development Center
Damien's Place Food Pantry
Fall River Deaconess
Fall River Health Department
Fall River Housing Authority
Fall River Police Department
Fall River Public Schools
Fishing Partnership
GATRA
GNB Allies for Health & Wellness
HealthFirst Family Health Care
HEED Coalition
HighPoint Treatment Center
Immigrants Assistance Center
Interchurch Council
LifeStream INC
Mass Hire
Minority Action Committee
My Brother's Keeper
New Bedford Community Connections Coalition
New Bedford Community Health
New Bedford Health Department
Our Sisters School
PAACA
PACE
Peer 2 Peer
Round the Bend Farm
Samaritans Southcoast
SerJobs for Hire
Southcoast Health
SRTA
SSTAR
Substance Addiction Task Force FR
The Boys & Girls Club of Greater Fall River
The Marion Institute
UIA
United Way of Greater Fall River
United Way of Greater New Bedford
Woods at Wareham
YMCA Southcoast
YWCA of SE MA

Consultant Partner: **Metopio** supported primary data collection, data analysis, synthesis, and report production, for the SoCHA Community Health Needs Assessment (CHNA). To learn

Metopio

APPENDIX B: Regional Reports

Report Name	Organization	Link
2021 Southcoast Food System Assessment	Marion Institute—Southcoast Food Policy Council	Food System Assessment - Marion Institute
Office of Housing & Development—FY25 Action Plan	New Bedford Office of Housing & Development	FINAL-CONPLAN-ACTION-PLAN-2025-2029-2.pdf
PACE Community Assessment Report 2024	PACE	Community-Assessment-Report-24-26-.pdf
CFC Community Assessment Report 2024	Citizens for Citizens	cfcinc.org/wp-content/uploads/2024/05/CARSP-2024-2026.pdf

APPENDIX C: Data Sources

The following is a list of datasets used during the analysis of secondary data. All datasets were accessed via the Metopio platform. A URL for each dataset is available upon request.

Centers for Disease Control and Prevention (CDC): Agency for Toxic Substances and Disease Registry - Environmental Justice Index
The Environmental Justice Index uses data from the U.S. Census Bureau, the U.S. Environmental Protection Agency, the U.S. Mine Safety and Health Administration, and the U.S. Centers for Disease Control and Prevention to rank the cumulative impacts of environmental injustice on health for every census tract. Census tracts are subdivisions of counties for which the Census collects statistical data. The EJI ranks each tract on 36 environmental, social, and health factors and groups them into three overarching modules and ten different domains.

Centers for Disease Control and Prevention (CDC): Agency for Toxic Substances and Disease Registry - SVI Data
The CDC/ATSDR Social Vulnerability Index (CDC/ATSDR SVI) uses 16 U.S. census variables to help local officials identify communities that may need support before, during, or after disasters.

U.S. Census Bureau: American Community Survey (ACS)
The American Community Survey (ACS) is an ongoing survey of U.S. households and residents that provides a wide variety of information. It replaces the long-form Census questionnaire and is administered to 1 in 38 U.S. households each year. Responses from multiple years can be aggregated to provide information about very small geographies.

US Department of Housing and Urban Development (HUD): Annual Homeless Assessment Report (AHAR)
The Annual Homeless Assessment Report (AHAR) is a HUD report to the U.S. Congress that provides nationwide estimates of homelessness, including information about the demographic characteristics of homeless persons, service use patterns, and the capacity to house homeless persons.

Health Resources & Services Administration: Area Health Resources Files (AHRF)
This dataset provides current as well as historic data for more than 6,000 variables for each of the nation's counties, as well as state and national data. It contains information on health facilities, health professions, measures of resource scarcity, health status, economic activity, health training programs, and socioeconomic and environmental characteristics.

Behavioral Risk Factor Surveillance System (BRFSS)
The Behavioral Risk Factor Surveillance System (BRFSS) is the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. Established in 1984 with 15 states, BRFSS now collects data in all 50 states as well as the District of Columbia and three U.S. territories. BRFSS completes more than 400,000 adult interviews each year, making it the largest continuously conducted health survey system in the world.

Chain Store Guide: Chain Store Guide
Updated November 2024.

US Department of Agriculture (USDA) - Food and Nutrition Service: Child Nutrition Tables

Environmental Protection Agency (EPA): Cleanups in My Community (CIMC)
EPA conducts and supervises investigation and cleanup actions at sites where oil or hazardous chemicals have been or may be released into the environment. Cleanup activities take place at active and abandoned waste sites, federal facilities and properties, and where any storage tanks have leaked.

Cook County Sheriff's Office of Research
The Office of Research, Operations and Innovation (ROI) was created in 2019 to improve operational efficiencies and services while reducing costs and enhancing customer experiences for all departments and agencies under Cook County government.

University of Wisconsin Population Health Institute: County Health Rankings
County Health Rankings help us understand what influences how long and how well we live. They provide measures of the current overall health (health outcomes) of each county in all 50 states and the District of Columbia.

U.S. Census Bureau: Decennial Census
The United States Census is conducted every ten years and gathers basic information about every inhabitant of the United States.

Department of Energy
The United States Department of Energy (DOE) is a federal agency that manages the country's nuclear infrastructure, energy policy, and scientific research. The DOE's mission is to ensure America's security and prosperity by addressing energy, environmental, and nuclear challenges through science and technology solutions.

Department of Transportation
The Department of Transportation serves the American people and economy through the safe, efficient, sustainable, and equitable movement of people and goods.

Diabetes Atlas
The CDC's Diabetes Atlas contains data about diabetes, obesity, and physical activity. This data is modeled using data from the Behavioral Risk Factor Surveillance System (BRFSS).

US Department of the Treasury

U.S. Census Bureau Gazetteer Files
Information about geographies in the United States.

March of Dimes: Depression (PRAMS)
Depression is a serious mental health disorder that causes frequent feelings of sadness and/or lack of interest and is associated with worsened maternal and infant outcomes. Women who experience postpartum depression have been found to have lower rates of breastfeeding initiation, poorer maternal and infant bonding and increased likelihood of developmental delays among infants. Universal screening for depression before, during and after pregnancy is recommended in order to increase identification of women at risk and ensure the appropriate referral and treatment.

Dwyer-Lindgren, Mokdad, et al. (Population Health Metrics, 2014)
Cigarette smoking prevalence in US counties: 1996-2012. Population Health Metrics, 2014, Volume 12, Number 1, Page 1

Environmental Protection Agency (EPA): EJScreen: Environmental Justice Screening
The Environmental Protection Agency's EJScreen tool provides data on measures of environmental justice.

The Eviction Lab at Princeton University: Estimating Eviction Prevalence across the United States
Gromis, Ashley, Ian Fellows, James R. Hendrickson, Lavar Edmonds, Lillian Leung, Adam Porton, and Matthew Desmond. Estimating Eviction Prevalence across the United States. Princeton University Eviction Lab. https://data-downloads.evictionlab.org/#estimating-eviction-prevalance-across-us/. Deposited May 13, 2022.

US Department of Agriculture (USDA) - Economic Research Service: Food Access Research Atlas
Presents an overview of food access indicators for low-income and other census tracts using different measures of supermarket accessibility

US Department of Agriculture (USDA) - Economic Research Service: Food and Nutrition Service

Illinois Department of Public Health (IDPH): Illinois State Cancer Registry
Department of Homeland Security (DHS): HIFLD Open Data
This site provides National foundation-level geospatial data within the open public domain that can be useful to support community preparedness, resiliency, research, and more.

US Department of Housing and Urban Development (HUD): Housing Choice Vouchers by Tract
This service provides spatial data, and information for Housing Choice Voucher (HCV) recipients.

Internal Revenue Service (IRS): Individual Income Tax Data
Numerous studies which provide statistics on income, deductions, tax, and credits reported on individual Form 1040 income tax returns and associated schedules are available in this area. Find statistics on high income tax returns, income tax rates, nonfarm sole proprietorships, data by geographic areas, and more.

Feeding America: Map the Meal Gap
Map the Meal Gap generates two types of community-level data: Local food insecurity estimates among all individuals and children by income category and local food expenditure estimates among people who are food insecure and food secure Gundersen, C., A. Dewey, E. Engelhard, M. Strayer & L. Lapinski. Map the Meal Gap 2020: A Report on County and Congressional District Food Insecurity and County Food Cost in the United States in 2018. Feeding America, 2020.

Health Resources & Services Administration: Maternal and Child Health Bureau (MCHB)

Metopio
Created by Metopio staff.

National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)
Chronic diseases like cancer, heart disease, and diabetes are the leading causes of death and disability in the United States and the leading driver of the nation's $4.5 trillion annual health care costs. CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) supports healthy behaviors and preventive medical care to help people prevent and manage chronic diseases.

National Center for Education Statistics (NCES)
The National Center for Education Statistics (NCES) is the primary federal entity for collecting and analyzing education data in the United States and other nations

Centers for Disease Control and Prevention (CDC): National Center for Health Statistics, U.S. Small-Area Life Expectancy Estimates Project (USALEEP)
The U.S. Small-area Life Expectancy Estimates Project (USALEEP) is a partnership of NCHS, the Robert Wood Johnson Foundation (RWJF), and the National Association for Public Health Statistics and Information Systems (NAPHSIS) to produce a new measure of health for where you live. The USALEEP project produced estimates of life expectancy at birth—the average number of years a person can expect to live—for most of the census tracts in the United States for the period 2010-2015.

Centers for Medicare & Medicaid Services (CMS): National Provider Identifier Files (NPI)
A National Provider Identifier is a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS). The NPI is the required identifier for Medicare services, and is also used by other payers, including commercial healthcare insurers. The NPI Registry provides information about all physicians in the country and their specialties.

University of Wisconsin - School of Medicine and Public Health: Neighborhood Atlas
The Neighborhood Atlas website was created in order to freely share measures of neighborhood disadvantage with the public, including educational institutions, health systems, not-for-profit organizations, and government agencies, in order to make these metrics available for use in research, program planning, and policy development.

State public health departments

U.S. Department of Health and Human Services

US Department of Agriculture (USDA) - Food and Nutrition Service: WIC Data Tables

Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M)
Beginning in 2021, age-adjusted rates are no longer available from the CDC at a county level. All data from 2021 onward is presented as crude rates. Please use caution when directly comparing data from before 2021 to data from 2021 onward. The National Vital Statistics System Mortality component (NVSS-M) obtains information on deaths from the registration offices of each of the 50 states, New York City, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and Northern Mariana Islands. The system is operated by the Centers for Disease Control and Prevention, National Center for Health Statistics (CDC/NCHS). This data is available from the CDC Wonder data portal.

Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Natality (NVSS-N)
In the United States, State laws require birth certificates to be completed for all births, and Federal law mandates national collection and publication of births and other vital statistics data. The National Vital Statistics System, the Federal compilation of this data, is the result of the cooperation between the National Center for Health Statistics (NCHS) and the States to provide access to statistical information from birth certificates.

Bureau of Labor Statistics (BLS): Occupational Employment and Wage Statistics (OEWS) Survey
The Occupational Employment and Wage Statistics (OEWS) program produces employment and wage estimates annually for nearly 800 occupations.

National Low Income Housing Coalition (NLIHC): Out of Reach
Out of Reach documents the significant gap between renters' wages and the cost of rental housing across the United States.

Centers for Disease Control and Prevention (CDC): PLACES
The PLACES Project is a collaboration between CDC, the Robert Wood Johnson Foundation (RWJF), and the CDC Foundation (CDCF). PLACES will allow counties, places, and local health departments regardless of population size and urban-rural status to better understand the burden and geographic distribution of health-related outcomes in their jurisdictions and assist them in planning public health interventions. PLACES is an extension of the original 500 Cities Project that provided city and census tract estimates for chronic disease risk factors, health outcomes, and clinical preventive services use for the 500 largest US cities. The PLACES Project provides model-based population-level analysis and community estimates to all counties, cities, census tracts, and ZIP codes across the United States.

Maternal and Child Health Journal: Postpartum Mental Health and Breastfeeding Practices

Centers for Medicare & Medicaid Services (CMS): Provider of Services Files
The POS file contains data on characteristics of hospitals and other types of healthcare facilities, including the name and address of the facility and the type of Medicare services the facility provides, among other information. The data are collected through the Centers for Medicare & Medicaid Services (CMS) Regional Offices. The file contains an individual record for each Medicare -approved provider and is updated quarterly. The data is an invaluable resource to a variety of stakeholders, including researchers and application developers.

Redfin: Redfin Data Center
Redfin is a real estate brokerage, meaning we have direct access to data from local multiple listing services, as well as insight from our real estate agents across the country. That's why we're able to give you the earliest and most reliable data on the state of the housing market. We publish existing industry data faster and offer additional data on tours and offers that no one else has.

National Cancer Institute (NCI): State Cancer Profiles
State Cancer Profiles characterizes the cancer burden in a standardized manner to motivate action, integrate surveillance into cancer control planning, characterize areas and demographic groups, and expose health disparities. The focus is on cancer sites with evidence-based control interventions. Interactive graphics and maps provide support for deciding where to focus cancer control efforts.

: Substance Abuse and Mental Health Services Administration (SAMHSA)
The Substance Abuse and Mental Health Services Administration (SAMHSA) works to improve substance abuse and mental health treatment services to those who are most in need of them.

National Institute of Mental Health: Suicide Statistics
Suicide is a major public health concern. Suicide is among the leading causes of death in the United States. Based on recent mortality data, suicide in some populations is on the rise.

The University of Wisconsin Population Institute
2020 County Health Rankings & Roadmaps.

UIC School of Public Health
Health risk factor score was created using several comorbidities from the Chicago Health Atlas data at the CCA level (Chicago Health Atlas, 2020).The health risk score included: the rates of heart-related death, stroke deaths, asthma, hypertension, diabetes, obesity, and smoking (CDC COVID-19 Response Team, 2020). Similar to SVI, UIC SPH performed PCA to create a risk score using the rates of these comorbidities.

Centers for Disease Control and Prevention (CDC): Youth Risk Behavior Surveillance System (YRBSS)
The Youth Risk Behavior Surveillance System (YRBSS) monitors health-related behaviors that contribute to the leading causes of death and disability among youth and adults. YRBSS is a system of surveys. It includes 1) a national school-based survey conducted by CDC and state, territorial, tribal, and 2) local surveys conducted by state, territorial, and local education and health agencies and tribal governments.

APPENDIX D: Community Stakeholder Interview Guide

COMMUNITY NEEDS ASSESSMENT 2025
STAKEHOLDER INTERVIEW GUIDE

During the summer of 2024, the Southcoast Community Health Alliance (SoCHA) was established between key organizations across the South Coast community to strengthen collective impact, reduce duplication of efforts, and improve the health throughout our region.

Each organization within SoCHA has previously completed and/or has been required to complete a Community Health Needs Assessment (CHNA/CHA). With this new alliance, the 2025 Community Health Needs Assessment will be a product of this collaboration and provide the South Coast community with one comprehensive regional assessment that will be completed every three years.

The organizations that make up SoCHA include:

- One Health System (Southcoast Health)
- Two Boards of Health (the New Bedford and Fall River Health Departments)
- Three Federally Qualified Health Centers (HealthFirst Family Health Center, New Bedford Community Health, and SSTAR)
- Two Community Action Agencies (Citizens for Citizens and People Acting in Community Endeavors (PACE).

Today we are here to learn from you. Please remember that there are no right or wrong answers. Everything you tell us is valuable. Your name/participation in this key stakeholder interview will remain anonymous. The name of your organization/entity may be included in the appendix of the final report and in sections covering themes described during this conversation. Any reports that come out of this discussion will focus on themes and ideas.

Are you okay with us recording this meeting to help with notetaking?

To start, let's talk about the work you do in the community:

- What is your organization's role in the community?
- Which communities does your organization serve geographically?
- What populations does your organization serve? (e.g., age, other demographics)
    - What are the top needs you see within this population?

1. What are your thoughts regarding the general health of the South Coast community?

2. Demographics of our community are always shifting and changing; what new needs have you seen in recent years?

3. What changes have you seen in the language needs of the communities you serve?

4. The social drivers of health are "the structural determinants and conditions in which people are born, grow, live, work and age." This includes factors such as socioeconomic status, education, transportation, the physical environment, employment, and social support networks.

   - From your perspective, which of these social drivers are the most prevalent in the community?

   The next group of questions will help us assess the impact of the social drivers of health within the South Coast region.

   - How do you think social drivers of health impact the community?
   - How does the history of this community influence the health of the community?
   - What are some challenges within the community?
   - What are some strengths within the community?
   - Which social drivers do you see most often in the people you serve?
     i. What are the barriers to addressing these drivers?
     ii. Are there resources available to address these drivers?
   - What do you feel are the top health problems facing the community?

5. What are the biggest barriers preventing residents in the community from accessing health care services?
   - What are your thoughts on the safety of neighborhoods within the South Coast region?
   - What are your thoughts on the availability of safe and clean parks within the South Coast region?
   - What are your thoughts on the affordability of food within the South Coast Region?
   - What are your thoughts related to the location and access of food within the South Coast region?
   - What are your thoughts related to the availability of healthy foods in restaurants and supermarkets within the South Coast region?
   - What are your thoughts on climate change and environmental factors impacting health in the South Coast region?

6. How do you think we can work together more effectively as a community?

7. What do you see as SoCHA's top three priorities, as we seek to capture and address community needs together?

APPENDIX E: Focus Group Question Guide

Facilitator Opening

Hello and welcome to our discussion group today. Thank you for taking the time to participate. The purpose of our discussion is to get your input on health issues that matter most to you (from your perspective as [XX] as well as your thoughts and perceptions about the health of your community. This is part of an effort by Southcoast Community Health Alliance (SoCHA) to understand the health-related needs of the community and to plan programs and services that address those needs. My name is [XX], and I will serve as the facilitator of today's discussion. My role is to introduce our topics and ask questions. I will try to make sure all the issues are touched on as fully as possible within our time frame and that everyone gets a chance to participate and express their opinion.

Introduce note takers or other facilitators.

Discussion Guidelines

1. I will ask general questions and ask for your opinions and ideas. Please remember that there are no right or wrong answers. Everything you tell us is valuable and this is a judgment free zone. You are not required to answer any question you do not feel comfortable providing a response to.
2. I want to emphasize that the discussion today will remain confidential. It's possible that some people will share personal stories or opinions. We ask all of you to refrain from sharing information from our discussion with others outside of the group. Any reports that come out of this discussion will focus on themes and ideas. Your name will not be shared or linked with anything that you say in today's focus group.
3. Today's session will go from [time of session] and we will be sure to end on time. Please silence your phones to eliminate distractions for others. You should also feel free to get up and stretch, go to the bathroom, or help yourself to refreshments.
4. Are there any questions before we begin?

General:

Our first question asks for your thoughts about community health. The term "community" can mean something different for everyone - it could mean your town or region, your friends, your ethnic group, people you work with, or however you think of your community.

1. What makes a community healthy?

Community Strengths:

1. What specific programs and/or services make people in your community healthier?

Probe: Strengths or resources in your community that help support or enhance individual, family, and community health.

Identifying Top Health and Social Issues:

1. What are the top health issues in your community?

2. Other than health and healthcare, what else impacts you or your community's wellbeing?

   Probe: *housing, economic opportunity, chronic diseases or conditions, mental health, substance abuse, violence, access to healthy food, child abuse/neglect, suicide, domestic violence, access to health care, cost of health care, poverty, stigma, prejudice, racism?*

3. We talked about [x,y,z – recite the impacts shared], are there any specific populations most impacted?

Barriers:

1. Are there significant barriers to being healthy or making healthy choices in your community?
   a. What are those barriers?

   Probe: Access to healthy food, safe, walkable streets, transportation, etc.

2. What keeps you (your family, your children) from going to the doctor or caring for your health?
   a. Are there any cost issues that keep you from caring for your health?
      Probe: (such as co-pays or high-deductible insurance plans, transportation, income, etc.)
   b. What are the challenges to obtaining health insurance?

Improving Community Health:

1. What programs, services, policies, or public spaces are missing in your community that would support health or make it easier to be healthy?

   Probe: Public space (i.e., parks, playgrounds, Libraries, etc.) in the community.

2. What else do you (your family, your children) need to keep up or improve your health and wellness?

Closing:

1. Is there anything else related to the topics we discussed today that you think I should know that I didn't ask or that you have not yet shared?

APPENDIX F: Community Survey Questions

Southcoast Community Health Alliance (SoCHA)
2025 Community Health Needs Assessment
Community Survey

ABOUT THIS SURVEY:
The Southcoast Community Health Alliance (**SoCHA**) is a team made up of local healthcare providers and groups, including:

- Southcoast Health
- SSTAR
- New Bedford Community Health
- Child & Family Services
- Brown University Health
- Health First
- PACE
- New Bedford Health Department
- Fall River Health Department
- Citizens for Citizens

We are working together to learn about the health of people living in the Southcoast area. We are doing this by asking survey questions and looking at their responses to understand what people need to live healthier lives in our community.

OUR GOALS ARE TO FIND OUT:
- How healthy are the people in our area.
- What things make it harder for people to stay healthy.
- What are the needs of our community.

YOUR CHOICE TO JOIN:
- You are being asked to complete this *Community Survey*. It will take about 15-20 minutes to complete.
- You can choose not to complete the survey at any time or to not answer any questions in the survey. Nothing negative will happen if you choose not to complete the survey.

PRIVACY:
- No one will ask for your name, phone number, or email, unless you choose to enter an optional raffle for a chance to win a gift card.
- Your answers will be kept private. Your answers will be given a random number instead of a name to keep your answers private.
- Your answers will be kept safely on a secure computer. Only the **SoCHA** team will be able to see the answers, but only in a way that does not show who you are.

CONSENT: If you understand everything that is written and want to complete this survey, select "I CONSENT to participate" below. If you do not want to complete the survey for any reason, select "I DECLINE to participate" below.

☐ I CONSENT to participate.
☐ I DECLINE to participate.

Part 1: Personal Health and Access to Care

Demographic Information

The following questions will ask about your demographic background, including race, ethnicity, preferred language, gender identity, sex assigned at birth, sexual orientation, ability status, veteran status, country of origin, marital status, age, and zip code.

Race

1. How do you describe your race? Select all that apply.
   - ☐ American Indian or Alaska Native
   - ☐ Asian or Asian American
   - ☐ Black or African American
   - ☐ Hispanic, Latino, or Spanish origin
   - ☐ Middle Eastern or North African
   - ☐ Native Hawaiian or other Pacific Islander
   - ☐ White or Caucasian
   - ☐ Don't know
   - ☐ Prefer to self-describe: _____
   - ☐ Prefer not to say

Ethnicity

2. Which of the following ethnicities do you consider yourself? Select all that apply.
   - ☐ Brazilian
   - ☐ Cape Verdean
   - ☐ Chinese
   - ☐ Dominican
   - ☐ Guatemalan
   - ☐ Haitian
   - ☐ Honduran
   - ☐ Mexican, Mexican American, or Chicano
   - ☐ Portuguese
   - ☐ Puerto Rican
   - ☐ Salvadoran
   - ☐ Don't know
   - ☐ Prefer to self-describe: _____
   - ☐ Prefer not to say

Sexual Orientation

6. Which of the following most accurately describes yourself? Choose as many as you'd like.
   - ☐ Asexual
   - ☐ Bisexual
   - ☐ Gay
   - ☐ Heterosexual or Straight
   - ☐ Lesbian
   - ☐ Pansexual
   - ☐ Queer
   - ☐ Questioning
   - ☐ Don't know
   - ☐ Prefer to self-describe: _____
   - ☐ Prefer not to say

Ability Status

7. Do you have a physical or mental health condition that makes it harder for you to do things- like walking, learning, or taking care of yourself- or that is considered a disability?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know
   - ☐ Prefer not to say

Veteran Status

8. **Have you served** in the United States military, armed forces, or uniformed services? This includes the Air Force, Army, Coast Guard, Marines, Navy, Space Force, National Guard, or Reserves or the US Public Health Service (PHS) and National Oceanic and Atmospheric Administration (NOAA).
   - ☐ Yes
   - ☐ No
   - ☐ Prefer not to say

   a. If you answered "Yes" for the previous question, are you currently serving on active duty in the United States military, armed forces, or uniformed services?
      - ☐ NOT APPLICABLE
      - ☐ Yes
      - ☐ No
      - ☐ Prefer not to say

Language

3. What language do you prefer to use at home? Select all that apply.
   - ☐ English
   - ☐ Spanish
   - ☐ Portuguese
   - ☐ Cape Verdean Creole
   - ☐ K'iche'
   - ☐ Haitian Creole
   - ☐ Prefer to self-describe: _____
   - ☐ Prefer not to say

Gender Identity

4. Which of the following most accurately describes yourself? Choose as many as you'd like.
   - ☐ Woman or Female
   - ☐ Man or Male
   - ☐ Genderqueer
   - ☐ Gender Nonconforming
   - ☐ Nonbinary
   - ☐ Transgender woman, Transfeminine, or Male-to-Female
   - ☐ Transgender man, Transmasculine, or Female-to-Male
   - ☐ Don't know
   - ☐ Prefer to self-describe: _____
   - ☐ Prefer not to say

Sex

5. What sex were you assigned at birth? Select one response.
   - ☐ Male
   - ☐ Female
   - ☐ Intersex
   - ☐ Don't know
   - ☐ Prefer not to say

9. What is your Veteran Status? Select one response.
   - ☐ NOT APPLICABLE
   - ☐ General Discharge
   - ☐ Honorable Discharge
   - ☐ Dishonorable Discharge
   - ☐ Conditional Discharge
   - ☐ Protected Veteran
   - ☐ Don't know
   - ☐ Not listed (Please describe): _____
   - ☐ Prefer not to say

10. **Has an immediate family member or member of your household** served in the United States military, armed forces, or uniformed services? This includes the Air Force, Army, Coast Guard, Marines, Navy, Space Force, National Guard, or Reserves or the US Public Health Service (PHS) and National Oceanic and Atmospheric Administration (NOAA).
    - ☐ Yes
    - ☐ No
    - ☐ Don't know
    - ☐ Prefer not to say

Country of Origin

11. What country were you born in?

    Please list: _____
    - ☐ Don't know
    - ☐ Prefer not to say

Marital Status

12. What is your current marital status? Select one response.
    - ☐ Single
    - ☐ Married
    - ☐ A member of an unmarried couple
    - ☐ Divorced
    - ☐ Separated
    - ☐ Widowed
    - ☐ Don't know
    - ☐ Prefer not to say

Age

13. What is your age in years?

    Please list: _____
    - ☐ Don't know
    - ☐ Prefer not to say

Zip Code

14. What is your home zip code?

Please list: _____
☐ Don't know
☐ Prefer not to say

Socioeconomic Information

Education

15. What is the highest level of education that you have completed? Select one response.
☐ Less than 12th grade
☐ 12th grade completed/ High school diploma/ Equivalent (GED)
☐ Vocational/ Technical diploma (vocational/technical training after high school)
☐ Some college or university
☐ Associate's degree or certificate program
☐ Bachelor's degree (such as BA, BS, etc.)
☐ Graduate work/ Graduate degree (such as MS, MEd, MSW, MD, DO, PhD, JD, etc.)
☐ Don't know
☐ Prefer not to say

16. Are you currently enrolled in school or a job training program? Select one response.
☐ Enrolled in an associate's degree program
☐ Enrolled in a MassTransfer program
☐ Enrolled in a bachelor's degree program (such as BA, BS, etc.)
☐ Enrolled in a graduate degree program (such as MS, MEd, MSW, MD, DO, PhD, JD, etc.)
☐ Enrolled in a vocational or technical degree program
☐ Not enrolled in school or a job training program
☐ Prefer not to say

Employment

17. What is your employment status? Select one response.
☐ Employed full-time (Work 35 or more hours a week)
☐ Employed part-time (Work less than 35 hours a week)
☐ Unemployed, but looking for work
☐ Unemployed, NOT looking for work
☐ Not working due to a disability
☐ Retired, not working
☐ Not old enough to work
☐ Don't know
☐ Not listed (Please describe): _____
☐ Prefer not to say

Household

18. Including yourself, how many people currently live in your household?
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6 or more
☐ Prefer not to say

19. How many children under the age of 18 live in your household? If none, select "0."
☐ 0
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6 or more
☐ Prefer not to say

a. If you selected that 1 or more children live in your household for the previous question, how many of these children are under your care?
☐ NOT APPLICABLE
☐ 0
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6 or more
☐ Prefer not to say

20. Do at least three generations of the same family live in your household (for example, grandchildren and grandparents living in the same household)?
☐ Yes
☐ No
☐ Prefer not to say

21. How much is your household income? If your household has more than 1 person, include everyone's income (use your best guess). Select one response.
☐ Less than $10,000
☐ $10,001 to $20,000
☐ $20,001 to $30,000
☐ $30,001 to $40,000
☐ $40,001 to $50,000
☐ $50,001 to $60,000
☐ $60,001 to $70,000
☐ $70,001 to $80,000
☐ $80,001 to $90,000
☐ $90,001 to $100,000
☐ $100,001 to $110,000
☐ $110,001 to $120,000
☐ $120,001 to $130,000
☐ $130,001 to $140,000
☐ $140,001 to $150,000
☐ $150,001 to $160,000
☐ $160,001 to $170,000
☐ $170,001 to $180,000
☐ $180,001 to $190,000
☐ $190,001 to $200,000
☐ More than $200,000
☐ Don't know
☐ Prefer not to say

22. I view myself as low income, regardless of the government standards in Massachusetts (At or below $67,300 for a single-headed household in New Bedford, at or below $69,200 for a single-headed household in Fall River).
☐ Yes
☐ No
☐ Don't know
☐ Prefer not to say

Basic Needs

23. In the past 12 months, have you ever struggled to pay for necessities such as housing, food or bills?
☐ Yes
☐ No
☐ Prefer not to say

24. Mark responses with an "X" or check mark. **Please rate your agreement with the following statements:**	Response Options				
	Strongly Agree	*Agree*	*Neither agree nor disagree*	*Disagree*	*Strongly Disagree*
There are affordable places to live in my community.					
I am satisfied with the healthcare systems in this community.					
Public transportation is easy to use if I need it.					
I feel safe in my own neighborhood.					
Healthy food options are available at nearby corner stores, grocery stores, or farmer's markets.					
There are enough well-paying jobs in my community.					
I have reliable internet access in my community.					

Housing

25. What is your current living situation? Select one response.

- ☐ I have a steady place to live.
- ☐ I have a place to live but I'm worried about losing it.
- ☐ I do not have a steady place to live (such as temporarily staying with others, in a hotel, in a shelter, in a car, or outside).
- ☐ Prefer not to say

30. Please tell me whether the following statement was often true, sometimes true, or never true for you in the last 12 months. **"The food that I bought just didn't last, and I didn't have money to get more."**
- ☐ Often true
- ☐ Sometimes true
- ☐ Never true
- ☐ Prefer not to say

31. Please tell me whether the following statement was often true, sometimes true, or never true for you in the last 12 months. **"I couldn't afford to eat balanced meals."**
- ☐ Often true
- ☐ Sometimes true
- ☐ Never true
- ☐ Prefer not to say

32. In the last 12 months, did you or other adults in your household ever cut the size of your meals or skip meals because there wasn't enough money for food?
- ☐ Yes
- ☐ No
- ☐ Prefer not to say

a. If you answered "Yes" for the previous question, how often did this happen?
- ☐ NOT APPLICABLE
- ☐ Almost every month
- ☐ Some months but not every month
- ☐ Only 1 or 2 months
- ☐ Prefer not to say

33. In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?
- ☐ Yes
- ☐ No
- ☐ Prefer not to say

34. In the last 12 months, were you ever hungry but didn't eat because there wasn't enough money for food?
- ☐ Yes
- ☐ No
- ☐ Prefer not to say

26. Think about the place that you live. Do you have problems with any of the following? Select all that apply.
- ☐ Pests such as bugs, ants, or mice
- ☐ Mold
- ☐ Lead paint or pipes
- ☐ Lack of heat
- ☐ Oven or stove not working
- ☐ Smoke detectors missing or not working
- ☐ Water leaks
- ☐ None of the above
- ☐ Prefer not to say

27. Please check the following statements as they apply to you. Select a response if these experiences occurred at least once within the past 12 months:
- ☐ I had difficulties paying rent.
- ☐ I couldn't pay the full amount of rent or mortgage.
- ☐ I couldn't pay the full amount of utilities (such as water, gas, or electric bills).
- ☐ I had utilities shut off due to being unable to pay for them on time.
- ☐ I moved two or more times.
- ☐ I took in a roommate in order to manage financial problems.
- ☐ I moved in with other people due to financial problems.
- ☐ I lacked a fixed, regular, safe, or adequate nighttime residence (such as being unhoused, or living in transitional housing, shelters, vehicles, or couch surfing).
- ☐ None of the above
- ☐ Prefer not to say

Food

The following questions are about the food eaten in your household in the last 12 months.

28. Which of these statements best describes the food eaten in your household in the last 12 months? Select one response.
- ☐ Enough of the kinds of food I want to eat
- ☐ Enough but not always the kinds of food I want
- ☐ Sometimes not enough to eat
- ☐ Often not enough to eat
- ☐ Prefer not to say

29. Please tell me whether the following statement was often true, sometimes true, or never true for you in the last 12 months. **"I worried whether my food would run out before I got money to buy more."**
- ☐ Often true
- ☐ Sometimes true
- ☐ Never true
- ☐ Prefer not to say

35. In the last 12 months, did you lose weight because there wasn't enough money for food?
- ☐ Yes
- ☐ No
- ☐ Prefer not to say

36. In the last 12 months, did you or other adults in your household ever not eat for a whole day because there wasn't enough money for food?
- ☐ Yes
- ☐ No
- ☐ Prefer not to say

a. If you answered "Yes" for the previous question, how often did this happen?
- ☐ NOT APPLICABLE
- ☐ Almost every month
- ☐ Some months but not every month
- ☐ Only 1 or 2 months
- ☐ Prefer not to say

Healthcare

Insurance

37. What type of medical health insurance or coverage plans do you have to cover your health care services? Select all that apply.
- ☐ Employer-sponsored
- ☐ Medicare
- ☐ Medicaid/ MassHealth
- ☐ Private
- ☐ None
- ☐ Don't know
- ☐ Other (Please describe): _____
- ☐ Prefer not to say

38. Do you have dental insurance?
- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Prefer not to say

Healthcare Utilization

39. In the past 12 months, did you receive dental care, including routine cleanings?
- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Prefer not to say

40. In the past 12 months, did you ever delay or skip care that you needed for any of the follow services? Select all that apply.
- ☐ Routine medical care (for example, physical exam, checkups, visits due to illness)
- ☐ Specialist medical care (for example, allergist)
- ☐ Dental services (including routine dental cleaning)
- ☐ Mental health services, therapy, or counseling
- ☐ Substance use counseling or treatment services
- ☐ None of the above
- ☐ Prefer not to say

41. When you are sick, where do you typically go? Select one response.
- ☐ Emergency Department (ED)
- ☐ Urgent care
- ☐ Quick clinic
- ☐ Doctor's office
- ☐ No usual place
- ☐ Don't know
- ☐ Prefer not to say

42. In the past 12 months, did you receive routine medical care (for example, physical exam, checkups, visits due to illness)?
- ☐ Yes
- ☐ No
- ☐ Prefer not to say

a. If you marked "No" for the previous question, why not? Please select the answer that most closely describes your reason.
- ☐ NOT APPLICABLE
- ☐ I did not need it
- ☐ Cost of care
- ☐ Lack of insurance coverage
- ☐ Conflict with work or caregiving
- ☐ Lack of transportation
- ☐ Difficulty scheduling appointments
- ☐ Inaccessible location
- ☐ Waiting times were too long
- ☐ Previous negative experience
- ☐ Fear of bad results
- ☐ No telehealth availability
- ☐ Lack of non-English language support
- ☐ The information given was too complicated
- ☐ The information given was in formats I could not access
- ☐ Other reason (Please describe): _____
- ☐ Prefer not to say

43. In the past 12 months, did you receive specialist medical care (for example, cardiologist or allergist)?
- ☐ Yes
- ☐ No
- ☐ Prefer not to say

a. If you marked "No" for the previous question, why not? Please select the answer that most closely describes your reason.
- ☐ NOT APPLICABLE
- ☐ I did not need it
- ☐ Cost of care
- ☐ Lack of insurance coverage
- ☐ Conflict with work or caregiving
- ☐ Lack of transportation
- ☐ Difficulty scheduling appointments
- ☐ Inaccessible location
- ☐ Waiting times were too long
- ☐ Previous negative experience
- ☐ Fear of bad results
- ☐ No telehealth availability
- ☐ Lack of non-English language support
- ☐ The information given was too complicated
- ☐ The information given was in formats I could not access
- ☐ Other reason (Please describe): _____
- ☐ Prefer not to say

44. In the past 12 months, did you receive dental services (including routine dental cleaning)?
- ☐ Yes
- ☐ No
- ☐ Prefer not to say

a. If you marked "No" for the previous question, why not? Please select the answer that most closely describes your reason.
- ☐ NOT APPLICABLE
- ☐ I did not need it
- ☐ Cost of care
- ☐ Lack of insurance coverage
- ☐ Conflict with work or caregiving
- ☐ Lack of transportation
- ☐ Difficulty scheduling appointments
- ☐ Inaccessible location
- ☐ Waiting times were too long
- ☐ Previous negative experience
- ☐ Fear of bad results
- ☐ No telehealth availability
- ☐ Lack of non-English language support
- ☐ The information given was too complicated
- ☐ The information given was in formats I could not access
- ☐ Other reason (Please describe): _____
- ☐ Prefer not to say

45. In the past 12 months, did you receive mental health services, therapy, or counseling?
- ☐ Yes
- ☐ No
- ☐ Prefer not to say

a. If you marked "No" for the previous question, why not? Please select the answer that describes your reason.
- ☐ NOT APPLICABLE
- ☐ I did not need it
- ☐ Cost of care
- ☐ Lack of insurance coverage
- ☐ Conflict with work or caregiving
- ☐ Lack of transportation
- ☐ Difficulty scheduling appointments
- ☐ Inaccessible location
- ☐ Waiting times were too long
- ☐ Previous negative experience
- ☐ Fear of bad results
- ☐ No telehealth availability
- ☐ Lack of non-English language support
- ☐ The information given was too complicated
- ☐ The information given was in formats I could not access
- ☐ Other reason (Please describe): _____
- ☐ Prefer not to say

46. In the past 12 months, did you receive substance use counseling or treatment services?
- ☐ Yes
- ☐ No
- ☐ Prefer not to say

a. If you marked "No" for the previous question, why not? Please select the answer that most closely describes your reason.
- ☐ NOT APPLICABLE
- ☐ I did not need it
- ☐ Cost of care
- ☐ Lack of insurance coverage
- ☐ Conflict with work or caregiving
- ☐ Lack of transportation
- ☐ Difficulty scheduling appointments
- ☐ Inaccessible location
- ☐ Waiting times were too long
- ☐ Previous negative experience
- ☐ Fear of bad results
- ☐ No telehealth availability
- ☐ Lack of non-English language support
- ☐ The information given was too complicated
- ☐ The information given was in formats I could not access
- ☐ Other reason (Please describe): _____
- ☐ Prefer not to say

Screenings

48. In the past 12 months, did you receive screenings for any of the following cancers? Select all that apply.
- ☐ Breast cancer (For example, mammogram)
- ☐ Cervical cancer (For example, pap smear, HPV testing)
- ☐ Colorectal cancer (For example, colonoscopy or other colorectal cancer screening test)
- ☐ Lung cancer
- ☐ Prostate cancer (For example, blood test or physical examination)
- ☐ None of the above
- ☐ Prefer not to say

49. In the past 12 months, were you screened for any of the following? Select all that apply.
- ☐ High or low blood pressure
- ☐ High or low blood sugar
- ☐ Sexually transmitted infections or diseases (For example, chlamydia, gonorrhea, syphilis)
- ☐ HIV (Human immunodeficiency virus)
- ☐ None of the above
- ☐ Prefer not to say

47. Have you been pregnant in the past 12 months?
- ☐ Yes
- ☐ No
- ☐ Prefer not to say

a. If you answered "Yes" for the previous question, during your pregnancy, did you ever delay or skip pre- or post-natal appointments or care for any of the following reasons? Select all that apply.
- ☐ NOT APPLICABLE
- ☐ I did not delay or skip pre- or post-natal appointments or care
- ☐ Cost of care
- ☐ Lack of insurance coverage
- ☐ Conflict with work or caregiving
- ☐ Lack of transportation
- ☐ Difficulty scheduling appointments
- ☐ Inaccessible location
- ☐ Waiting times were too long
- ☐ Previous negative experience
- ☐ Fear of bad results
- ☐ No telehealth availability
- ☐ Lack of non-English language support
- ☐ The information given was too complicated
- ☐ The information given was in formats I could not access
- ☐ Other reason (Please describe): _____
- ☐ Prefer not to say

Vaccines

50. Mark responses with an "X" or check mark. **Please rate your agreement with the following statements:**	Response Options				
	Strongly Agree	*Agree*	*Neither agree nor disagree*	*Disagree*	*Strongly Disagree*
It is easy to get vaccines when I need them (like a COVID or flu vaccine).					
I know where to get a vaccine in my community.					
Vaccines help keep people healthy.					
I feel safe getting vaccines for myself.					
I feel safe getting vaccines for my family.					
I trust the people who give vaccines in my community.					

51. Has anything made it hard for you or your family to get vaccines?
- ☐ Yes
- ☐ No
- ☐ Prefer not to say

a. If you selected "Yes" for the previous question, please select the answer that most closely describes your reason why.
- ☐ NOT APPLICABLE
- ☐ I didn't have a ride
- ☐ The clinic was too far away
- ☐ I couldn't get time off work or school
- ☐ I wasn't sure where to go
- ☐ I didn't trust the place offering it
- ☐ Other reason (Please describe): _____
- ☐ Prefer not to say

Health

Activity Level

52. Do you engage in at least 150 minutes of moderate-intensity activity per week? This can include bri walking, biking, dancing, or continuous housework or yardwork.
- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Prefer not to say

Mental Health

53. Over the past two weeks, how often have you felt anxious, nervous, or on edge?
- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly all the days
- ☐ Prefer not to say

54. Over the past two weeks, how often have you not been able to stop or control worrying?
- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly all the days
- ☐ Prefer not to say

Diet

55. On average, how many servings of fruits and vegetables do you eat daily? For example, a serving could equal one medium apple or a half cup of cooked broccoli. Please think about all forms of fruits and vegetables, including cooked, raw, fresh, frozen, or canned.
- ☐ 0 servings
- ☐ 1-2 servings
- ☐ 3-4 servings
- ☐ 5 or more servings
- ☐ Don't know
- ☐ Prefer not to say

Safety

Because violence and abuse happens to a lot of people and affects their health, we are asking the following questions.

56. How often does anyone, including family and friends, physically hurt you?
- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Fairly often
- ☐ Frequently
- ☐ Prefer not to say

57. How often does anyone, including family and friends, insult or talk down to you?
- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Fairly often
- ☐ Frequently
- ☐ Prefer not to say

58. How often does anyone, including family and friends, threaten you with harm?
- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Fairly often
- ☐ Frequently
- ☐ Prefer not to say

59. How often does anyone, including family and friends, scream or curse at you?
- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Fairly often
- ☐ Frequently
- ☐ Prefer not to say

60. In the past 12 months, have you ever been kicked, hit, slapped, or otherwise physically hurt by a partner or ex-partner?
- ☐ Yes
- ☐ No
- ☐ Prefer not to say

61. Please select the statement that is most true about your home.
- ☐ There are no firearms in our home.
- ☐ Firearms in our home are not locked and are easy to get to.
- ☐ Most firearms in our home are kept in a locked safe or cabinet.
- ☐ All firearms in our home are kept in a locked safe or cabinet.
- ☐ Prefer not to say

Substance Use

The following questions relate to your experience with alcohol, cigarettes, or other drugs. Some of the substances may be prescribed by a doctor (like pain medications). Only record those if you have taken them for reasons or in doses other than what is prescribed.

62. Mark responses with an "X" or check mark. **During the past 30 days, how many days did you use:**	Response Options						
	0 days	*1 or 2 days*	*3 to 5 days*	*6 to 9 days*	*10 to 19 days*	*20 to 29 days*	*All 30 days*
Cigarettes?							
Other tobacco products (cigars, cigarillos, pipe tobacco, etc.)?							
Smokeless tobacco or nicotine products (Zyn, on!, Skoal, Grizzly)?							
Nicotine electronic vapor products (vape pens, disposables, e-cigarettes, pod systems, mods/ box mods)?							
Marijuana or cannabis electronic vapor products (vape pens, disposables, e-cigarettes, pod systems, mods/ box mods)?							
Other marijuana or cannabis products (smoking, edibles, etc.)?							
Cocaine (coke, crack, etc.)?							
Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)?							
Methamphetamine (speed, crystal meth, ice, etc.)?							
Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)?							
Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)?							
Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)?							
Street opioids (heroin, opium, etc.)?							
Prescription opioids (fentanyl, oxycodone, hydrocodone, methadone, buprenorphine, etc.)?							

Alcohol Use

63. Mark responses with an "X" or check mark. **In the past 30 days, how often have you:**	Response Options						
	0 days	*1 or 2 days*	*3 to 5 days*	*6 to 9 days*	*10 to 19 days*	*20 to 29 days*	*All 30 days*
Had At least 1 drink of alcohol (beer, wine, liquor, etc.)?	☐	☐	☐	☐	☐	☐	☐
Had 5 or more drinks of alcohol in a row, that is, within a couple of hours?	☐	☐	☐	☐	☐	☐	☐

Social Support

64. Mark responses with an "X" or check mark. **Please rate your agreement with the following statements:**	Response Options				
	Strongly Agree	*Agree*	*Neither agree nor disagree*	*Disagree*	*Strongly Disagree*
I have someone to talk to when I am feeling sad or upset.					
I have someone to call or visit when I need help.					
I have people in my life that care about me.					
I belong in my neighborhood or community.					
I know people in my community that I can count on.					
There are safe places in my community where people can get together (like parks, community centers, or churches)?					
I feel welcome at community events or programs near me.					

Part 2: Community Needs

65. What do you think are the most important **community needs** that could improve the quality of life and health of people within your community? Please rate the importance of each community need listed below. Mark responses with an "X" or check mark.

Community Needs	Response Options				
	Not important	*Slightly important*	*Moderately important*	*Important*	*Very important*
Access to stable job opportunities.					
Access to jobs that pay enough to cover the cost of basic needs (food, housing, etc.)					
Access to affordable, desirable, or nutritious food.					
Availability of food assistance programs, like SNAP or WIC programs.					
Access to affordable, desirable, or safe housing.					
Availability of housing assistance, including subsidized housing.					
Resources to address homelessness.					
Access to affordable early childhood education.					
Access to affordable, desirable, or quality education.					
Access to affordable health insurance coverage.					
Health insurance coverage that covers all health care needs (medical, mental, etc.)					
Access to routine medical or dental care.					
Access to specialty medical care, such as an allergist or oral surgeon.					
Access to mental health care, including substance use services.					
Access to healthcare providers that are sensitive to cultural backgrounds.					
Access to gender affirming health care or other LGBTQ+ affirming services.					
Resources to adequately prevent or address crime.					
Please list any additional needs that you think are important:					

66. What do you think are the most important **issues** currently affecting the quality of life and health of people in your community? Please rate the importance of each issue listed below. Mark responses with an "X" or check mark.

Issues	Response Options				
	Not important	*Slightly important*	*Moderately important*	*Important*	*Very important*
Unreliable transportation for health care appointments.					
Unreliable transportation for other needs, such as for food or clothing.					
Unaffordable rent, mortgage, or utility costs.					
Forced moves, including foreclosures or evictions.					
Poor environmental conditions, such as air or water pollution.					
Rates of non-violent crimes, like theft or burglary.					
Rates of violent crimes, like assaults or homicides.					
Housing, employment, or healthcare discrimination.					
Limited language accessibility, such as a lack of translated resources.					
Limited access to routine medical care, such as general physicians (PCP).					
Exposure to traumatic events, including violence, abuse, or neglect.					
Cancers, such as breast, lung, colorectal, or prostate cancer.					
Cardiovascular disease, such as heart disease, hypertension, or stroke.					
Neurodegenerative diseases, such as Alzheimer's or dementia.					
Infectious diseases, such as flu, COVID, or tuberculosis (TB).					
Autoimmune diseases, such as multiple sclerosis, lupus, or rheumatoid arthritis.					
Poor mental health, such as depression or anxiety.					
Substance use, including overall rate of substance use or overdoses.					
Suicide.					
Please list any additional issues that you think are important:					

67. What do you think are the most important **issues for children and adolescents** that are currently affecting their quality of life and health in your community? Please rate the importance of each issue listed below. Mark responses with an "X" or check mark.

Issues Affecting Youth	Response Options				
	Not important	*Slightly important*	*Moderately important*	*Important*	*Very important*
Lack of access to safe places to play, like parks or gyms.					
Alcohol use.					
Marijuana use, including smoking, edibles, vaping, etc.					
Prescription drug abuse, such as opioids, Adderall, Xanax, etc.					
Illegal substance use, such as cocaine, heroin, methamphetamine, etc.					
Smoking cigarettes or the use of other tobacco products.					
Vaping or using e-cigarettes.					
Bullying on school property or online (cyberbullying).					
Physical abuse, verbal abuse, or neglect from caregivers.					
Poor mental health, such as depression or anxiety.					
Suicidal thoughts or attempts.					
Low physical activity or exercise.					
Poor diet or hunger.					
Negative impact of social media on mental health.					
Poor school performance or behaviors.					
Lack of caregiver involvement or supervision in youths' lives.					
Poor sleep behaviors, such as insomnia.					
Physical or sexual violence.					
Engagement in risky behaviors, such as distracted driving or unprotected sex.					
Please list any additional issues that you think are important:					

Part 3: OPTIONAL Youth Questionnaire

If you have 1 or more children that live in your household that are under your care, please complete the following questions.

68. On average, how many servings of fruits and vegetables do the children in your household eat daily? For example, a serving could equal one medium apple or a half cup of cooked broccoli. Please think about all forms of fruits and vegetables, including cooked, raw, fresh, frozen, or canned.
- ☐ 0
- ☐ 1-2
- ☐ 3-4
- ☐ 5 or more
- ☐ Don't know
- ☐ Prefer not to say

69. What type of medical health insurance or coverage plans do the children in your home have to cover their health care services? Select all that apply.
- ☐ Employer-sponsored
- ☐ Medicare
- ☐ Medicaid/MassHealth
- ☐ None
- ☐ Don't know
- ☐ Prefer not to say
- ☐ Other (Please describe): _____

70. Do the children in your household have dental insurance?
- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Prefer not to say

71. In the past 12 months, did your children receive dental care, including routine cleanings?
- ☐ Yes
- ☐ No
- ☐ Prefer not to say

72. In the past 12 months, did you ever delay or skip care your children needed for any of the following services? Select all that apply.
- ☐ Routine medical care (for example, physical exam, checkup, visits due to illness)
- ☐ Specialist medical care (for example, allergist)
- ☐ Dental services (including routine dental cleaning)
- ☐ Mental health services, therapy, or counseling
- ☐ Substance use counseling or treatment services
- ☐ None
- ☐ Prefer not to say

73. Have your children been physically active for at least 5 of the 7 past days, for at least 60 minutes each time? Examples may include any type of physical activity, like playing in parks, in neighborhoods, sports, gyms, etc.
- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Prefer not to say