Southcoast® Health

2022

Community Health Needs Assessment

SPRINGLINE RESEARCH GROUP

About Southcoast Health System

Southcoast Health is a not-for-profit, community-based health system with multiple access points, offering an integrated continuum of health services throughout southeastern Massachusetts and Rhode Island. Our system includes four hospitals — Charlton Memorial Hospital in Fall River (founded in 1885), St. Luke's Hospital in New Bedford (founded in 1884) and Tobey Hospital in Wareham (founded in 1938). These hospitals merged on June 9, 1996 to form Southcoast Hospitals Group and operate under a single hospital license, with a total of 815 beds. Southcoast Health now also includes Southcoast Behavioral Health in Dartmouth.

In addition to its hospitals and a physician network of more than 450 providers, Southcoast has more than 55 service locations across the South Coast of Massachusetts and Rhode Island. This includes more than 40 physician practices as well as urgent care centers, a Visiting Nurse Association, the Centers for Cancer Care, outpatient surgery centers, and numerous ancillary facilities. Southcoast serves more than 719,000 residents in 33 communities, covering more than 900 square miles.

Southcoast® Health

More than medicine.

The 2022 Community Health Needs Assessment was produced in collaboration with the New Bedford Health Department and the Fall River Health Department.

New Bedford Health
Prevent. Promote. Protect.

The mission of the New Bedford Health Department is to prevent disease and to promote and protect the health and well being of New Bedford's residents and visitors.

The Health Department is responsible for leading a broad public health mandate including Environmental Health (e.g. housing sanctions, childhood lead poisoning prevention, food safety, trash/nuisance, and environmental clean-up), Public Health Nursing, Substance Abuse and Violence Prevention (e.g. tobacco and alcohol), Municipal Marine Lab Testing, and Health and Wellness.

The Fall River Division of Health and Human Services is committed to equitably protecting and promoting the health of those that live, learn, work, and play in the City of Fall River. This division includes the Health Department/Public Health Nursing, the Council on Aging, Youth Services and six grant-funded programs: Mass in Motion, Tobacco Control, MassCALL3, Local Health Support for COVID-19, and Public Health Excellence Grant.

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Springline Research Group is a multidisciplinary applied research firm that specializes in projects that contribute to economic development, workforce development, public health, and community-building.

Collectively, our team has over 30 years of experience assisting public, private, and nonprofit organizations with research, technical assistance, and analytical services designed to help make our state, region, and communities better places to live, work, and do business.

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Executive Summary

Southcoast Health conducts a Community Health Needs Assessment (CHNA) every three years that identifies the region's key health issues and unmet community needs. The 2022 CHNA represents a collaborative community-wide approach that incorporates socioeconomic and health data along with community input to identify the region's top health priorities. The overarching goal of this effort is to inform data-driven goals, objectives, and strategies that can be implemented by the health system to improve the health outcomes of South Coast residents, particularly among the region's most vulnerable at-risk populations.

Key Findings

The tasks undertaken for this study show that South Coast residents and providers remained concerned about many of the same health priority issues identified in the 2019 CHNA, including mental health, substance use disorder, and health access. In addition to these longstanding issues, the effects of the COVID-19 pandemic have exposed the degree to which many individuals and households are struggling to obtain basic necessities, as evidenced by housing and food insecurity becoming much more prominent issues since the 2019 assessment.

A primary obstacle impeding better health outcomes is that for many residents, health and wellness fit within a larger framework of day-to-day needs and crises related to the social determinants of health, from issues of housing, childcare, finances, and transportation, to employment, immigration, and safety. As a result, one's health is often addressed after more immediate needs are met, if at all. As one survey respondent noted, "As a society we don't put health care first, we have other priorities like putting food on the table and finding someone to watch the kids. Financial priorities come first."

A primary obstacle impeding better health outcomes is that for many residents, health and wellness fit within a larger framework of day-to-day needs and crises related to the social determinants of health, from issues of housing, childcare, finances, and transportation, to employment, immigration, and safety.

However, this is not to overshadow the unique and focused concerns that stakeholders identified. The South Coast is faced with a myriad of health and community issues and the comments provided through this assessment underscore the breadth of the needs in our community. What the CHNA process does reveal is that the community has clear and immediate priorities that need to be addressed in the short-term. These priorities are best addressed through cooperation and collaboration. As one stakeholder noted, "Community partners have the best of intentions. However, there needs to be more collaboration rather than everyone operating in their silos. They need to be shown how to collaborate better together." Conversely, many other key community leaders noted how the community came together during the pandemic. For example, one HHSP survey respondent commented, "What I noticed is that during the pandemic and even now there is more of a willingness to collaborate. I would like to see that openness that happened during the pandemic to continue with organizations getting together to discuss the needs."

"We need a holistic approach to all dimensions of health and wellness within our region, including reconnecting marginalized groups with the resources that can improve their economic outlook, especially in terms of education.

- Stakeholder interview

Priority Health Issues

Five priority health issues were identified based on the available health data, surveys of providers and community members, and interviews with key community leaders (see **Table 1**).

Table 1. Priority Health Issues

Priority Issue	Sub-Categories
Economic Opportunity	Social Mobility, Income, Education
Behavioral Health	Mental Health, Substance Use Disorder, Youth Trauma
Housing	Affordability, Stability, Homelessness
Wellness & Chronic Disease	Unhealthy Behaviors, Health Outcomes, Prevention
Health Access & Equity	Underserved Populations, Obstacles to Care, Health Literacy

Priority Issue 1: Economic Opportunity

Economic opportunity can be defined as the ability of a person to reach their personal potential. Opportunity includes having access to resources that are essential to maintaining a good quality of life, such as education, affordable housing, healthy foods, childcare, and stable employment. Unfortunately, many economic, social, and structural barriers prevent some South Coast residents from achieving their potential. These include obstacles such as concentrated poverty, racial discrimination, low wages, unequal educational access, and lack of quality opportunities for childhood learning. Other key findings related to economic opportunity include:

- Multigenerational poverty has become a grim, unbreakable cycle for many families in Fall River and New Bedford over the last decades. For many, physical and mental health conditions prevent them from fully accessing the economic opportunities that many take for granted.
- Income levels in Fall River and New Bedford are very low: median household income is only 53.6% and 57.0% of the statewide median, respectively. Low income residents have been hit particularly hard with 2022's inflationary environment. As one survey respondent noted, "New Bedford has many people that are on fixed incomes, so they are much more vulnerable when prices rise."
- A primary obstacle to equitable economic opportunity in Fall River and New Bedford is the low-wage jobs that are prevalent in these cities. Wages in Fall River and New Bedford are 62.6% and 62.9% of the state average, respectively and this gap continues to grow, making it difficult for many individuals and families to afford basic needs, including health care.

> "Rising out of poverty is nearly impossible without education or training. The key is, how do we make that happen? The future of our region depends on finding new ways to connect disengaged residents to these resources."
>
> - Stakeholder interview

- While education is key to attaining economic stability and opportunity, many Fall River and New Bedford residents have not taken advantage of educational opportunities: the cities have some of the lowest educational attainment levels of any cities in Massachusetts, although some of the region's suburban communities have educational attainment levels below the state average as well.
- As one of the region's largest employers, Southcoast Health is in a unique position to enact change and be a leader through new implementation of progressive hiring strategies and by providing support for employees to improve their skills and climb the internal career ladder.

PRIORITY ISSUE 2: BEHAVIORAL HEALTH

Mental health emerged throughout this project as the region's most prominent health issue. In fact, results of the Health and Social Service Provider (HSSP) Survey and Community Survey show that respondents are more concerned with behavioral health issues (e.g., mental health, substance use disorder, alcohol abuse) than physical health issues and conditions. This result is supported by interviews with health providers, who strongly emphasize the connection between mental health and substance use disorder. As one might expect, COVID-19 exacerbated mental health and substance use issues significantly, with one stakeholder noting that the issue is "growing exponentially with no end in sight." Other key findings related to behavioral health include:

- Nearly all stakeholders that were interviewed identify the acute shortage of mental health professionals as a mental health priority, particularly the need for outpatient mental health workers.
- Community leaders also note that it has been challenging to find beds for patients, which is a major roadblock for patients who are willing to enter treatment but cannot do so because beds are not available.
- While mental health issues among our youth are growing exponentially, there are very few beds statewide for this age group, although adding beds does little to improve treatment outcomes if there continues to be a staffing shortage.
- Interviewees commented that a cultural stigma exists among immigrant communities and many communities of color regarding mental health issues, which keeps them from seeking treatment. In a region with high levels of poverty and a substantial immigrant population, there are many social factors that influence how residents access the mental health system, if at all.
- The diversity and linguistic abilities of mental health workers was also identified, with one community leader noting, "There are issues with the cultural linguist competence of mental health providers across the region. There is simply not enough diversity among mental health professionals both in mental health and health care as a whole."
- Substance use disorder (SUD) continues to be identified as a major challenge in the region, particularly in terms of the links between substance use disorder, other mental health issues, poverty, and homelessness. Eighty-three percent (83%) of respondents to the HHSP survey rated substance use disorder as an "extremely concerning" health issue.
- Health and social service providers increasingly report seeing patients with a dual diagnosis, that is, individuals who experience a substance use issue along with a mental health issue.
- Respondents also recognize the negative effects of alcohol use disorder; 69% of survey respondents rated alcohol use disorder as "extremely concerning." One community leader noted that, "Alcohol abuse is a big issue in the Central American community and getting support for treatment is difficult. They often don't know where to find services or don't recognize they have a problem."

> "The primary obstacle to effectively addressing mental health is the extreme lack of facilities and providers."
>
> - Survey respondent

> "Mental health issues are going to be the next pandemic. Poor mental health leads to self-medication, then to substance abuse, alcohol abuse, domestic violence, and other poor behaviors."
>
> - Survey respondent

> "Suicide ideation is on the rise, but kids and parents don't want to talk about it."
>
> - Stakeholder interview

PRIORITY ISSUE 3: HOUSING

Housing emerged as a primary issue of concern for community leaders and community members throughout the needs assessment process, with stakeholders consistently identifying housing as the social determinant that affects the largest number of the people they serve. Eighty-nine percent of respondents to the HHSP survey cite access to affordable housing as the top concern for the community they serve, followed by homelessness at sixty-two percent. Overall, stakeholders are clear that housing challenges have been made worse by COVID-19.

The region's housing issue is primarily twofold: the focus in the region's cities is largely on rising rents and its implication on the working poor and people on fixed incomes. Conversely, the issue in many of the area's suburban communities is focused on the significant increase in single-family home prices. This dynamic is creating issues for seniors who want to remain in their homes but who are "house rich, cash poor" and for younger families who leave the region because they cannot afford homes in the area. Other key findings related to housing include:

- Income and wage levels in the region are significantly lower than most of Massachusetts, so while rents are relatively inexpensive for outsiders and commuters to Greater Boston or Providence, they remain considerably high for many local residents, particularly among the working poor who generally do not qualify for housing subsidies.
- This dynamic results in many households paying housing costs that are above their means, which in turn leaves less household income available for health care and other basic needs. During the 2016–2020 period, 46.5% of renters and 30.5% of homeowners in the South Coast were housing cost burdened.
- Housing insecurity disproportionately affects low-income households, people of color, and seniors. This trend is evident in Fall River and New Bedford where White households are less likely to be burdened by housing costs than their neighbors.
- Stakeholders point to a variety of causes behind the increasing rents in the region. A confluence of improving economic conditions, the arrival of Southcoast Rail, renters being priced out of the Greater Boston market and moving south, and older homeowners selling out to investors suggests that landlords are increasingly able to raise rents.
- Community leaders identified homelessness as a significant issue in the region, which is partly an outcome of the affordable housing shortage. Mental health and substance abuse disorder, which are highly prevalent among the homeless population, are also key factors in the homelessness equation.
- There were 361 homeless individuals in Fall River and 370 in New Bedford counted during the 2022 PIT Count, with the vast majority housed in emergency shelters.
- The homeless population in New Bedford is about the same as it was in 2007, while the homeless population in Fall River more than doubled over the 2007-2021 period.

> "The cost of housing is just unbelievable … I don't know how people can afford these things."
>
> - Stakeholder interview

> "It all comes down to supply. There's just not enough rental housing available for the people that need it most."
>
> - Stakeholder interview

> "Some of the onus has to be placed on the region's suburban communities to do their share as well."
>
> - Survey respondent

Priority Issue 4: Wellness and Chronic Disease

Comments gleaned from interviews and surveys highlight the day-to-day challenges faced by residents. These responsibilities create obstacles to maintaining overall health and to adopting healthy habits that help to prevent or manage disease. Consequently, it is not surprising that the following health outcomes related to wellness and chronic disease are generally poor when compared to state and national averages. Indeed, turning these health trends around will require more than just offering treatment and preventive care; it will also require addressing the social environment that contributes to health inequities. Key findings include:

- Smoking prevalence in Fall River (23.2%) and New Bedford (22.4%) are much higher than Massachusetts (12.0%) and the country as a whole (16.0%).
- Self-reported obesity prevalence in Fall River and New Bedford are higher than the statewide and national averages (33.7%, 34.4%, 25.2%, and 32.4%, respectively).
- While substance use disorder continues to rank as one of the top health priorities, stakeholders caution that the region's health and service providers must continue to focus on alcohol abuse; 69% of HSSP survey respondents rate alcohol use disorder as an "extremely concerning" issue.
- Despite its importance, several interviewees lamented the lack of nutrition education in the schools. Further, there is a disconnect regarding perceptions of nutrition between community members and health providers; only 18% of community survey respondents reported poor nutrition and eating habits as one of the top five health concerns, while 57% of HHSP survey respondents are "extremely concerned."
- HHSP survey respondents rank food insecurity as the fourth most concerning issue among the community they serve (49%).
- Health providers caution that while educating residents on the importance of being healthy and how to achieve good health, it is equally necessary to dismantle barriers that prevent many people from accessing the supports and resources necessary to be healthy.
- Overall mortality rates in both cities have remained relatively stable over the past twenty years, although with an increase in 2019 and 2020, with COVID-19 contributing to a large portion of deaths in 2020.
- Mortality rates related to cancer and heart disease in Fall River and New Bedford have declined since 2001, with heart disease dropping to the second leading cause of death starting in 2011-2015 in New Bedford. Fall River's heart disease death rate is still higher than the cancer rate, albeit slightly.
- Heart disease remains the leading cause of death for Black & Other, Non-Hispanic residents.
- Chronic liver disease and homicide are two causes of death in New Bedford that rank among Hispanic residents but do not appear among the top ten leading causes of death for White, Non-Hispanic, and Black & Other, Non-Hispanic residents for that city.

> "Many people are supporting other households in their country, and they tend to overwork for those reasons. They get sick but don't have the time to take care of themselves."
>
> - Stakeholder interview

> "The cost of eating healthy is an issue. Many community residents have a fixed income, so they sometimes have to get unhealthier food because of cost. Fast food is cheap and accessible."
>
> - Stakeholder interview

PRIORITY AREA 5: HEALTH CARE ACCESS

Regular access to health services is essential in managing health conditions, preventing new conditions from arising, and promoting and maintaining overall good health. This includes access to a wide variety of health services such as preventive care, mental health services, and emergency services. Stakeholders described the racial and ethnic health gap that continues to afflict the region. This gap is related to a myriad of access issues such as health literacy, insurance coverage and cost, transportation, and the need for more culturally competent care. Stakeholders were clear that equity and access issues prevalent in the health care system intensified due to the pandemic. As one community leader explained, "COVID shed light on disparities we already knew existed." Other key findings related to health access include:

- Results of the community survey show that long wait for appointments (55%), lack of awareness of available services (53%), and lack of evening and weekend hours (45%) are the most significant obstacles that might prevent individuals from obtaining health services.
- There were a surprising number of open end comments related to a lack of knowledge of what services are available. Many suggested more materials are needed in Spanish, including billboards.
- Although most residents have insurance, there are extreme differences in terms of value, coverage, and cost. These factors, in turn, partly affect the degree to which residents will access the health care system, particularly as it relates to preventive care.
- Moreso than in past needs assessments, survey respondents and community leaders note that obtaining dental insurance is difficult. As one stakeholder noted, "Even for those that have it, the coverage is either poor, expensive, or both. It certainly doesn't encourage people to visit the dentist."
- Several stakeholders note that a constant struggle in community health is the ability of the health care system to effectively connect and serve certain populations with low health literacy, especially since these populations are the ones most likely to need the services.
- Even for those who have health insurance and are not overwhelmed by its cost, paying out-of-pocket expenses, finding a primary care physician, and navigating the system can be difficult, especially for non-English speakers.
- Stakeholders note that providing culturally competent care will result in more people seeking care when they need it and the care itself will be more effective. This is particularly important to Greater Fall River as the region becomes increasingly diverse.
- Transportation continues to be one of the top health access issues in the region. Key informants note that many of their clients often cannot get to appointments even when they have the desire to seek out preventive care or when they require treatment for various health issues.

"Health access and health literacy go hand in hand. You can't access something if you don't know it exists."

- Stakeholder interview

"The work schedules of most of my clients don't allow them to visit the doctor during the day. They don't work the kinds of jobs where you can just take time off. If they take time off they don't get paid."

- Stakeholder interview

"A patient needs to be aware of why it is important to eat well and exercise, but they also need information on the services available to help them become healthy. In addition, they need assistance in enrolling for insurance so they can access those services without paying out-of-pocket."

- Stakeholder interview

1 Overview

In accordance with the Massachusetts Attorney General's Community Benefits Guidelines, Southcoast Health conducts a Community Health Needs Assessment (CHNA) every three years that identifies the key health issues and unmet community needs in the South Coast region, particularly among the region's most vulnerable populations. The overarching goal of this effort is to inform data-driven goals, objectives, and strategies that can be implemented by Southcoast Health to improve the health of South Coast residents, particularly as it informs the ongoing work in developing the region's Community Health Improvement Plan (CHIP).

The 2022 CHNA identifies the region's top health priorities through a collaborative approach that incorporates socioeconomic and health data along with community input (see Figure 1). The major components of this analysis include:

1. **Socioeconomic Profile:** Understanding the community by describing its residents in terms of population, age, gender, and other demographic indicators. The analysis strives, where possible, to present these data in the context of social determinants of health by highlighting disparities in terms of income, education, and race, all of which are factors that affect health outcomes.
2. **Health Data Assessment:** Identifying major health issues and needs by presenting a variety of health indicators from sources such as the Massachusetts Department of Public Health, U.S. Centers for Disease Control and Prevention, New Bedford Health Department, Fall River Health Department, and Southcoast Health.
3. **Qualitative Activities:** Engaging community leaders and residents through surveys, interviews, and events to add context to the health data and refine our understanding of the region's primary health issues and challenges.

Figure 1. Identifying the Health Priority Issues Includes Five Primary Components

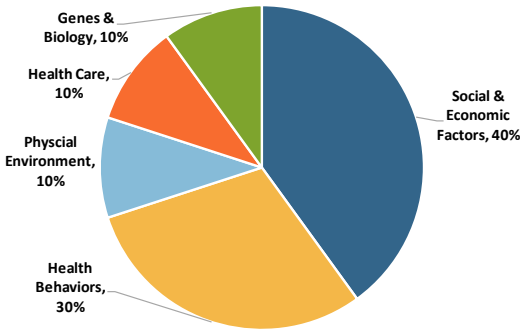
Forming Partnerships with the Region's Health Departments

Southcoast Health formally partnered with the New Bedford and Fall River health departments to assist with the needs assessment. Both health departments contributed to this report by providing health data, conducting interviews, and assisting with public outreach activities, including administering many of the Community Surveys. This partnership is intended to continue beyond the needs assessment process as Southcoast Health accelerates its work on the region's Community Health Improvement Plan.

Utilizing a Social Determinants of Health Framework

Social determinants of health, which can be described as "the conditions in which people are born, grow, work, live, age, and the wider set of forces and systems shaping the conditions of daily life,"[1] are responsible for most health inequities (see Figure 2). For example, socioeconomic factors such as income, education, race, and housing are often the best predictors of health status and health equity. Accordingly, addressing the social determinants of health is a crucial approach to achieving health equity. It is essential that Southcoast Health and its partners examine health outcomes through a socioeconomic framework and identify and focus on populations and neighborhoods with negative socioeconomic factors. (see Figure 3).[2] Social determinants of health are explored in more detail in the next section.

Figure 2. Social Determinants of Health Influence Health Outcomes the Most



Source: University of Wisconsin Public Health Institute's County Health Rankings Model

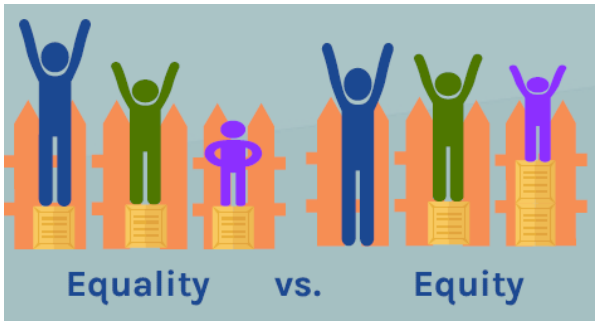
Figure 3. Social Determinants of Health

Source: Healthy People 2030

Adopting a Health Equity Lens

Health equity can be defined in many ways but is essentially a condition in which all people have the opportunity to be as healthy as possible and that no one is "disadvantaged from achieving this potential because of their social position or other socially determined circumstance."[3] Importantly, equity is not the same as equality. To equalize opportunities, those with worse health and fewer resources need more efforts expended to improve their health (see Figure 4). That is, while understanding the impact of social determinants of health within a community, it is also crucial to understand how underserved populations are disproportionately affected by social determinants.

Figure 4. Equality Versus Equity



[1] World Health Organization. Social determinants of health. 2018. See, www.who.int/social_determinants.

[2] Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. See, https://health.gov/healthypeople/objectives-and-data/social-determinants-health.

[3] Braveman, P.A., *Monitoring equity in health and health care: a conceptual framework*. Journal of health, population, and nutrition, 2003.

METHODS

SOCIOECONOMIC PROFILE

Socioeconomic data are derived from several sources. Where available, confidence intervals are included to address the levels of sampling error. The demographic profile in Section 2 and the social determinants of health in Section 3 rely primarily on data from the U.S. Census Bureau's American Community Survey five-year estimates. In order to produce estimates that are accurate for smaller geographies, the Census Bureau pools five years' worth of survey data. When these estimates are discussed in the narrative, they are referred to in terms of the last year of the five-year period, for example, the period 2015-2019 is referred to as 2019.

HEALTH DATA

Health data from national, state, and local sources are presented throughout this report and represents the latest available data. However, due to data lag, the most recent years for many of the health indicators represent pre-COVID data (i.e., 2018-2019). In addition, some of these health data are only available for the cities of Fall River and New Bedford. Comparing results based on social determinants of health categories such as race and income is not possible for many health indicators because the data is only reported for the population as a whole. In addition, the available data may underrepresent certain populations. This is particularly true for underserved populations such as the homeless, veterans, LGBTQ+ persons, and those with disabilities. In these cases, the data is supplemented, to the degree possible, with information gathered through interviews and surveys.

COMMUNITY OUTREACH

Community outreach includes four components: Community Survey, Health and Social Service Providers (HSSP) Survey, key informant interviews, and a Communities of Practice event held by the New Bedford Health Department.

Community Survey

Community surveys were conducted in cooperation with the Fall River and New Bedford health departments to determine the top health issues and obstacles among community members.[4] The surveys were primarily conducted at community events and locations that are experiencing the most acute health equity issues, with a strong emphasis on reaching out to the region's growing Hispanic and Latino community. Surveys were available in English, Portuguese, and Spanish and were completed either online using the respondent's smartphone, administered by staff via tablet, or completed on paper.

Respondents to the community survey are not representative of the South Coast population as a whole. However, the intention of the survey was to focus in on traditionally marginalized groups, in this case lower-income Hispanics and women. The survey results are helpful in exploring the nuances between the perceptions of these groups and those gathered through the H&HSP survey and key informant interviews.

A total of 1,255 surveys were completed, with the majority being completed by New Bedford residents. Over two-thirds of respondents (66.8%) are Hispanic and 68.9% are women. The age cohorts are relatively balanced. Most respondents are in the lower median income bracket, with 63.8% having a median household income below

[4] The survey questionnaire and topline results are included in Appendix A.

$25,000. Nearly twenty-nine percent (28.9%) report that they primarily speak a language other than English; 80.1% of these respondents speak Spanish.

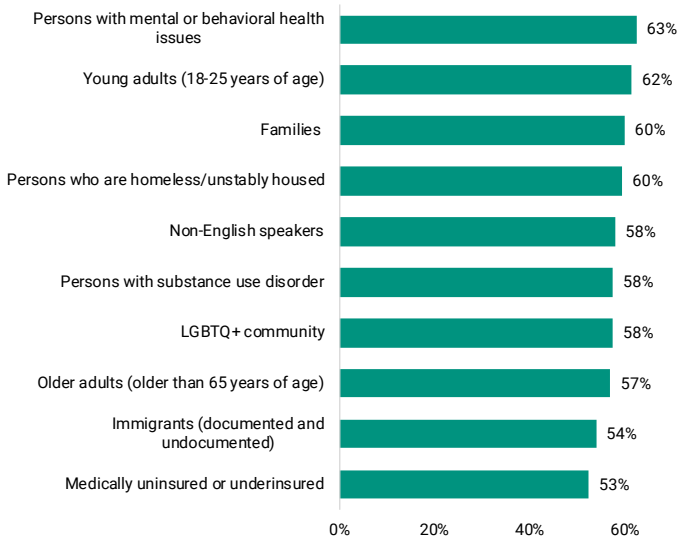
Health and Social Service Provider Survey

An online Health and Social Service Provider (HSSP) survey was conducted in conjunction with the New Bedford Health Department and the Fall River Health Department to further identify and understand the region's primary health issues and challenges.[5] A total of 200 surveys were completed. The majority of respondents are either representatives of a non-profit/social service agency (47%) or a health care provider (25%) (see Table 2). These organizations serve a wide range of communities (see Figure 5).[6]

Table 2. HSSP Survey Respondents' Organization Type

Organization Type	Number	Percent
Non-profit org. or social service agency	107	47%
Healthcare provider	57	25%
Other government agency	35	15%
Schools	15	7%
Religious organization	5	2%
Private sector/Business community	5	2%
Police/Fire/EMS	3	1%

Figure 5. Top Persons/Groups Served by HSSP Respondents



Source: Health & Social Service Provider Survey, 2022

Key Informant Interviews

Twenty in-depth interviews were conducted with community leaders to further understand the challenges and opportunities facing South Coast residents. The interviews represent a cross-section of areas, including individuals who work with the homeless, veterans, immigrants, those experiencing mental health issues, food insecure persons, and faith-based congregations.[7]

New Bedford Health Equity Communities of Practice Initiative

The New Bedford Health Department, YWCA of Southeastern Massachusetts, and Health Resources in Action hosted an event in June 2022 as part of its initiative to build a Community of Practice and strategize next steps to reach health equity in New Bedford. The event was an interactive conversation about how racism operates in New Bedford and how stakeholders can operationalize a pro-equity agenda for the Greater New Bedford community.[8]

[5] The survey questionnaire and topline results are included in Appendix B.

[6] "Other" includes businesses, children/families impacted by trauma, survivors of sexual assault, and faith based congregations.

[7] A full list of interviewees can be found in Appendix C.

[8] A thematic analysis of the event's results can be found in Appendix D.

Healthy NB Partnership

The New Bedford Health Department formed the Healthy NB Partnership to advocate and strive for a New Bedford Community Health Needs Assessment and a Community Health Improvement Plan that are community driven documents that represent the diverse community it serves. This partnership guides and informs present and all future versions of New Bedford's Community Health Needs Assessments and Community Health Improvement Plans..[9]

[9] More about the Health NB Partnership can be found in Appendix E.

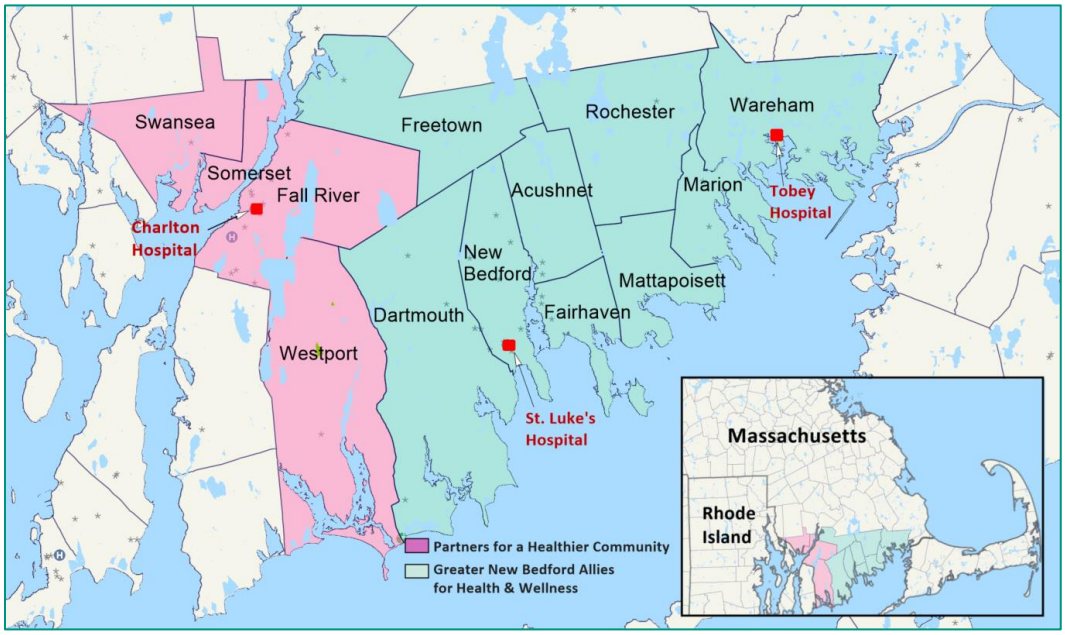
2 Overview of the South Coast Region

The South Coast region is composed of thirteen communities located in the Southeastern portion of Massachusetts. This regional definition coincides with Community Health Network Area 25, Partners for a Healthier Community, and Community Health Network Area 26, Greater New Bedford Allies for Health and Wellness (see Figure 6).[10]

To enhance the readability of this report, Partners for a Healthier Community is referred to as "Greater Fall River," while Greater New Bedford Allies for Health and Wellness is referred to as "Greater New Bedford." Also note that the "South Coast" as a region is referred to as such, while references to the health system are written as "Southcoast."

Southcoast Health has three hospitals in the region: Charlton Memorial Hospital in Fall River, St. Luke's Hospital in New Bedford, and Tobey Hospital in Wareham. Southcoast Health now also includes Southcoast Behavioral Health in Dartmouth. In addition to its hospitals and a physician network of more than 450 providers, Southcoast has more than 55 service locations across the region and Rhode Island. This includes more than 40 physician practices as well as urgent care centers, a Visiting Nurse Association, the Southcoast Health Cancer Centers, outpatient surgery centers, and numerous ancillary facilities.

Figure 6. The South Coast Region Is Comprised of Thirteen Communities and Two Community Health Network Areas



[10] A Community Health Network Area is a local coalition of public, non-profit, and private sector groups that work together to build healthier communities in Massachusetts through community-based prevention planning and health promotion.

Population Profile

The South Coast's population was 357,212 in 2020, which represents 5.1% of the state's total population. Fall River and New Bedford account for 54.6% of the region's total. The region's population increased by 4.9% from 2010 to 2020 and by 16.1% since 1970, both of which lag behind the statewide population growth rates for these periods (7.4% and 23.6% respectively) (see Table 3).

Table 3. South Coast Historical Population by Decade, 1970–2020

Community	1970	1980	1990	2000	2010	2020	% Change 1970–2020	% Change 2010–2020
Acushnet	7,767	8,704	9,554	10,161	10,303	10,559	35.9%	2.5%
Dartmouth	18,800	23,966	27,244	30,666	34,032	33,783	79.7%	-0.7%
Fairhaven	16,332	15,759	16,132	16,159	15,873	15,924	-2.5%	0.3%
Fall River	96,898	92,574	92,703	91,938	88,857	94,000	-3.0%	5.8%
Freetown	4,270	7,058	8,522	8,472	8,870	9,206	115.6%	3.8%
Marion	3,466	3,932	4,496	5,123	4,907	5,347	54.3%	9.0%
Mattapoisett	4,500	5,597	5,850	6,268	6,045	6,508	44.6%	7.7%
New Bedford	101,777	98,478	99,922	93,768	95,072	101,079	-0.7%	6.3%
Rochester	1,770	3,205	3,921	4,581	5,232	5,717	223.0%	9.3%
Somerset	18,088	18,813	17,655	18,234	18,165	18,303	1.2%	0.8%
Swansea	12,640	15,461	15,411	15,901	15,865	17,144	35.6%	8.1%
Wareham	11,492	18,457	19,232	20,335	21,822	23,303	102.8%	6.8%
Westport	9,791	13,763	13,852	14,183	15,532	16,339	66.9%	5.2%
South Coast	307,591	325,767	334,494	335,789	340,575	357,212	16.1%	4.9%
Greater FR	137,417	140,611	139,621	140,256	138,419	145,786	6.1%	5.3%
Greater NB	170,174	185,156	194,873	195,533	202,156	211,426	24.2%	4.6%
Massachusetts	5,689,170	5,737,093	6,016,425	6,349,097	6,547,629	7,029,917	23.6%	7.4%

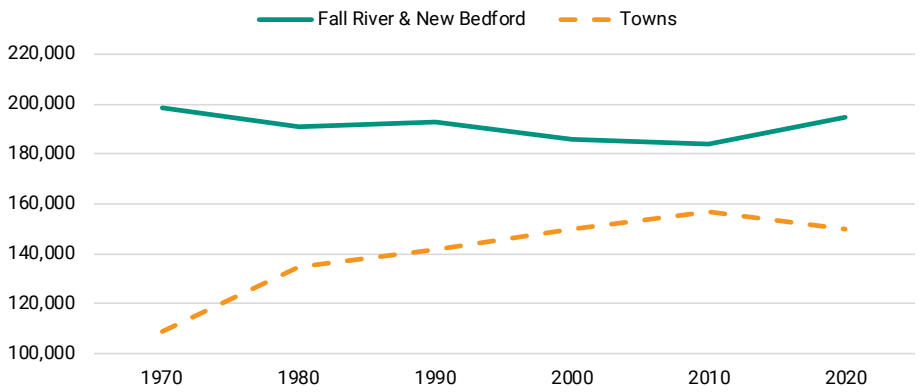
Source: Population: US Census 1970 through 2010, U.S. Census STF3 file; 2020 U.S. Census

Population Growth Has Shifted

Population growth and residential development over the past five decades have been uneven within the region, with much of the growth from 1970 to 2010 driven by population increases in the region's suburbs. For example, the population in the cities of Fall River and New Bedford declined by 14,746 residents from 1970 to 2010, while the region's suburban towns grew by 47,730 residents over this period. However, this trend has reversed in the last decade, with the region's cities experiencing a population increase of 11,150 residents from 2010 to 2020, compared with an increase of just 5,487 residents in the suburbs (see Figure 7).

Fall River and New Bedford, as they have been for decades, remain centers for immigrants arriving in the region. While Portuguese immigrants comprised the majority of the region's foreign-born residents in the last half of the 20th century, emigration from Europe to the U.S. has slowed, and now immigrants from Latin America, South America, Africa, and Asia account for increasing shares of the populations in the region. There are health care implications inherent in being a hub for immigrants, including language barriers, lack of insurance, low health literacy, and other health access issues.

Figure 7. Population Trends: Cities versus Towns

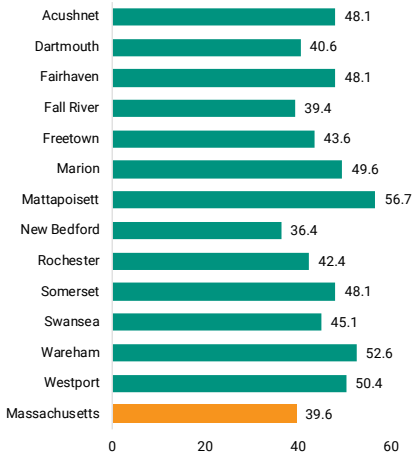


Source: 1970 through 2010, U.S. Decennial Census STF 3 File, 2012–2016, ACS 5-Year =Estimates (2007–2011, 2008–2012, 2009–2013, 2010–2014, & 2012–2017, Table DP05)

Median Age and Age Cohorts

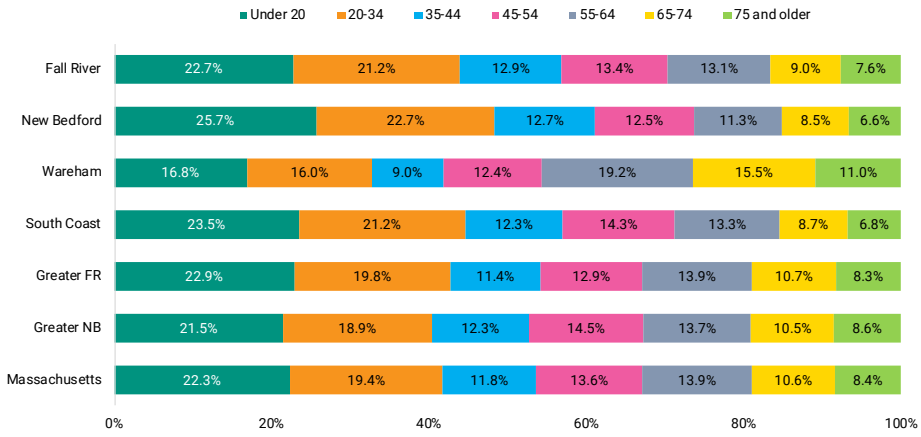
The nation's population is aging, and this trend is occurring in the South Coast as well.[11] All South Coast towns, except for Dartmouth, experienced an increase in the median age between the 2006-2010 and 2016-2020 time periods, while the statewide median age also increased over this period (see Figure 8). There are health care implications inherent in an aging population, particularly in terms of how health care systems manage chronic conditions such as cancer, dementia, falls, obesity, and diabetes. Notably, the median age of residents in Fall River and New Bedford is considerably lower than most of the other South Coast communities. The age cohorts in the South Coast generally reflect their counterparts at the state level. New Bedford, however, has a slightly higher share of residents under the age of 35 in comparison to other areas (see Figure 9).

Figure 8. Median Age by Community, 2010-–2020



Source: 2010–2014 & 2016–2020 ACS 5-Year Estimates, Table B01002

Figure 9. Age Cohorts in Selected Areas, 2016–2020



Source: ACS 5-Year Estimates, Table S010, 2013–2017

[11] For more information on the increase in the national median age, see: https://www.census.gov/newsroom/press-releases/2020/65-older-population-grows.html.

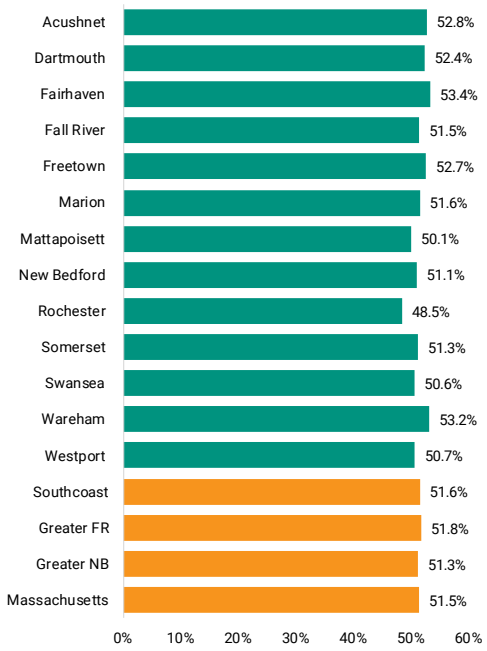
Women Are a Slight Majority of the Region's Population

Women play an essential role in maintaining family health and are more likely than men to access the health care system for their needs and the needs of their children. In addition to the unique health care needs of women related to childbirth and care, their longer life expectancies mean that women are more affected by long-term and elder care issues than are men.[12]

Women were also more likely to bear the brunt of the social and economic consequences of the pandemic in comparison to men, particularly since they are more likely to be employed in the types of lower wage occupations that experienced higher levels of layoffs during the economic shutdown. Women are also more likely than men to work in frontline positions that have few options for remote work (e.g., nurses, teachers, home health aides). The availability of childcare also became scarcer during the economic shutdown and many working mothers–particularly frontline workers–were forced to stay home to care for their children.[13]

Across the South Coast, women account for 51.6 percent of the population, compared with 51.5 percent of the population statewide. The towns of Fairhaven and Wareham have the highest shares of women. Only in Rochester do women make up less than half of the total population (see Figure 10).

Figure 10. Proportion of Women, 2016–2020



Source: ACS Survey 5-Year Estimates, Table DP05, 2016-2020

[12] Wheeler, J.B.; Foreman, M.; & Rueschhoff, A. (2013) "Improving Women's Health: Health Challenges, Access and Prevention" Improving Women's Health Series Brief No. 3. National Conference of State Legislatures, Washington D.C.

[13] It is estimated that one out of four women who reported becoming unemployed during the pandemic reported that it was due to childcare. See: Modestino, Alicia Sasser. "Coronavirus child-care crisis will set women back a generation." Washingtonpost.com, July 29, 2020, https://www.washingtonpost.com/us-policy/2020/07/29/childcare-remote-learning-women-employment/. Accessed October 1, 2021.

3 Socioeconomic Profile: Examining The Region's Social Determinants of Health

Economic Overview

Fall River and New Bedford are two of the state's many Gateway Cities, which are defined as midsize urban centers that anchor regional economies. These cities are primarily former industrial centers that were the traditional gateways for immigrants. As has been the case across most of the state's Gateway Cities, Fall River New Bedford, and many suburban areas in the South Coast region for that matter, have not experienced the benefits from the Boston metro area's knowledge economy, with many of the region's service-related jobs requiring relatively low levels of formal training or education and paying comparatively low wages. Accordingly, Fall River and New Bedford, and some of the region's suburban communities, fall below their regional counterparts and state averages on most socioeconomic metrics.

Many of the structural and health issues identified by key community leaders and community members draw a clear connection between economic struggles and health outcomes. In fact, a key theme that arose from the surveys and interviews–and in many ways is a continuation of thoughts expressed in previous needs assessments and health-related projects–is that many South Coast residents face a myriad of challenges that create obstacles to maintain overall health and to adopt healthy habits that prevent or manage disease. For many residents, health and wellness fit within a larger framework of day-to-day obligations, ranging from issues such as housing, finances, and childcare, to transportation, employment, immigration, and safety. As one community leader noted, "There are many people facing social stressors, and their health will always take a back seat. If you are worried about paying bills the last thing you are going to think about is going to a doctor." A survey respondent commented, "Social determinants of health dictate outcomes for 30-50 percent of our regional population," while another noted, "I think there needs to be more awareness around socioeconomic … even healthy people make poor choices."

Number of Southcoast Health Patients Needing Assistance is On the Rise

Notably, key informants and survey respondents make it clear that COVID-19 exacerbated the economic instability that afflicts many of the region's individuals and families and that we are only beginning to understand the degree of the impact. For example, in FY 2019 Southcoast Health implemented elements of the THRIVE tool developed by Boston Medical Center. The number of patients screened and the number of patients needing help has risen considerably since FY 2019, with 6,725 patients screened in FY21 noting that they required some type of assistance (see Table 4).[14]

Table 4. Social Determinants of Health Screening Tool

	FY 19	FY 20	FY 21
Patients Seen	164,076	161,185	166,607
Patients Screened	1,987	25,897	62,486
Patients Needing Help	313	3,508	6,725
% Patients Needing Help	15.8%	13.5%	10.8%

Source: Southcoast Health

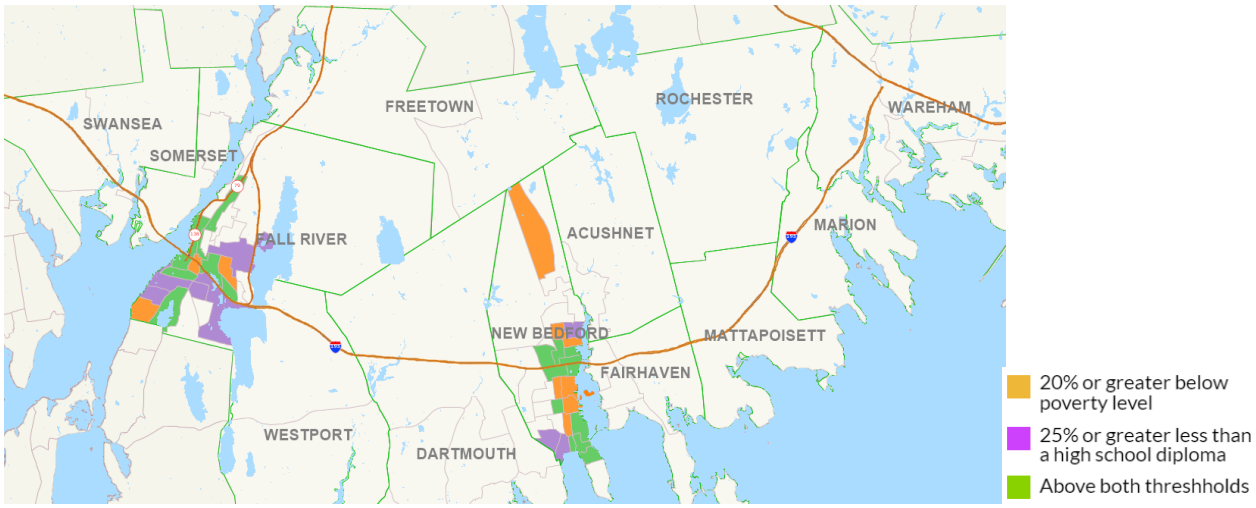
[14] Boston Medical Center implemented a social determinants of health screener for primary care patients in order to better identify and address patients' unmet social needs. The electronic health record based model, THRIVE, facilitates an automatic print out of referral information for resources when the patient asks for help with a need they have identified in the screener.

Poverty Tends to Be Concentrated in Specific Neighborhoods

Poverty is the key social determinant of health and is interconnected with most other social determinants that affect a person's economic stability, including education levels. Poverty and its interconnected conditions tend to be concentrated in certain neighborhoods, consequently, addressing the region's health conditions and outcomes requires addressing the social determinants of health that are pervasive in these areas.

Figure 11 identifies the region's Census tracts with high rates of poverty (20% of residents or greater below poverty level) and low educational attainment (25% of residents or greater with less than a high school diploma), two primary social determinants of health. By these metrics, the region's vulnerable populations reside exclusively in Fall River and New Bedford. Indeed, mapping other socioeconomic indicators such as unemployment and income would yield very similar results. The most vulnerable populations reside in the Fall River neighborhoods along Interstate 195 and the surrounding downtown area. New Bedford's most vulnerable populations are concentrated just north of downtown and in the south end. Neighborhoods in other areas of the cities are comparatively more well-off, although even most of these areas have much less economic stability compared to the neighboring towns and the state as a whole.

Figure 11. Vulnerable Population Footprint, South Coast, 2016–2020



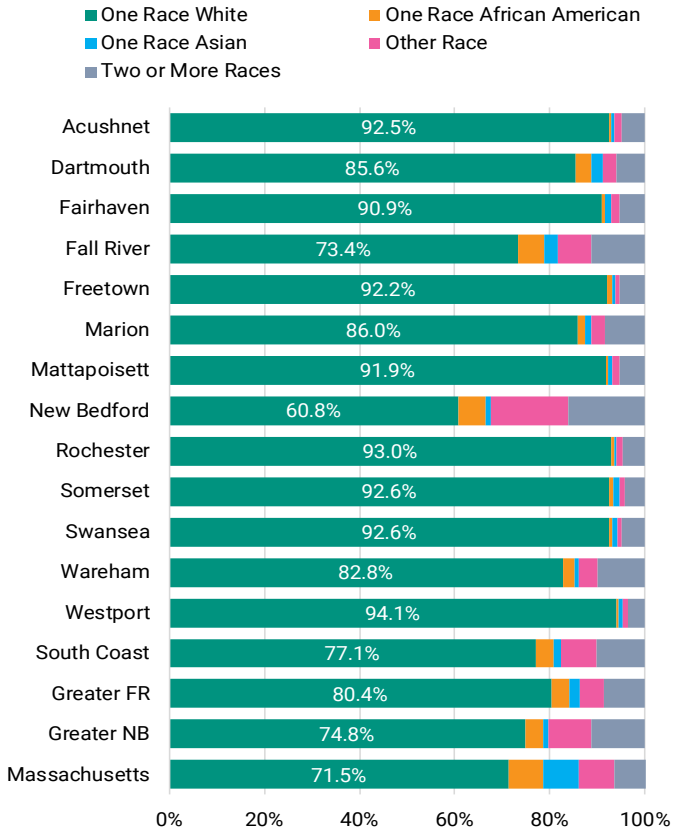
Source: United States Census American Community Survey,
2016–2020 Estimates. Mapped using data from Center for Applied Research and Engagement Systems (CARES)[15]

[15] See https://careshq.org/map-room/?action=tool_map&tool=footprint.

The Region is Less Racially Diverse Than the State As a Whole

South Coast residents are less racially diverse the Commonwealth; 77.1% are White (one race), compared with 71.5% of residents statewide (see Figure 12). However, the region's White population is not a monolith and contains ethnic and linguistic diversity, particularly among residents of Portuguese descent; Fall River and New Bedford have some of the largest populations with Portuguese ancestry in the country (see Table 5). Nearly a quarter of New Bedford residents (24.3%) identify as Hispanic, almost double the statewide percentage (12.6%).[16]

Figure 12. Race, 2020



Source: U.S. Census 2020

Table 5. Hispanic Population, 2020

Community	Number	% Total Population
Acushnet	256	2.4%
Dartmouth	1360	4.0%
Fairhaven	501	3.1%
Fall River	12,582	13.4%
Freetown	190	2.1%
Marion	225	4.2%
Mattapoisett	149	2.3%
New Bedford	24,525	24.3%
Rochester	94	1.6%
Somerset	434	2.4%
Swansea	376	2.2%
Wareham	741	3.2%
Westport	334	2.0%
South Coast	41,767	11.7%
Greater FR	13,726	9.4%
Greater NB	28,041	13.3%
Massachusetts	887,685	12.6%

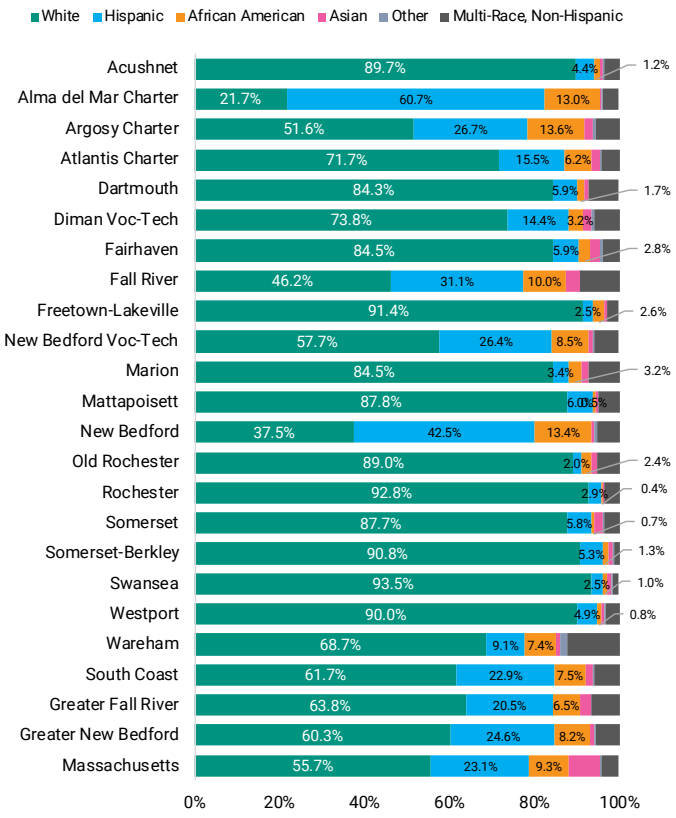
[16] Importantly, persons who identify as Hispanic can be of any race and these individuals are accounted for in the various categories. That is, the Census Bureau's data collection and classification treat race and Hispanic origin as two separate and distinct concepts. The 2020 Census allowed persons of Hispanic origin to self-report as Hispanic in a separate racial question

The Racial and Ethnic Makeup of the South Coast is Changing: Public School Students Are Much More Diverse Than the Communities As a Whole

People of color face significant disparities in access to and utilization of care. The region's health care providers must ensure that they are attuned to the needs of different racial and ethnic groups as the region's population grows increasingly more diverse. Notably, Fall River's and New Bedford's student population is much more diverse than the population as a whole, which portends that the region will become more racially diverse. For example, only 46.2% of students in the Fall River Public Schools identify as White (compared to 73.4% of all residents) and only 37.5% of students in the New Bedford students identify as White (compared to 60.8% in the city as a whole (see Figure 13).[17]

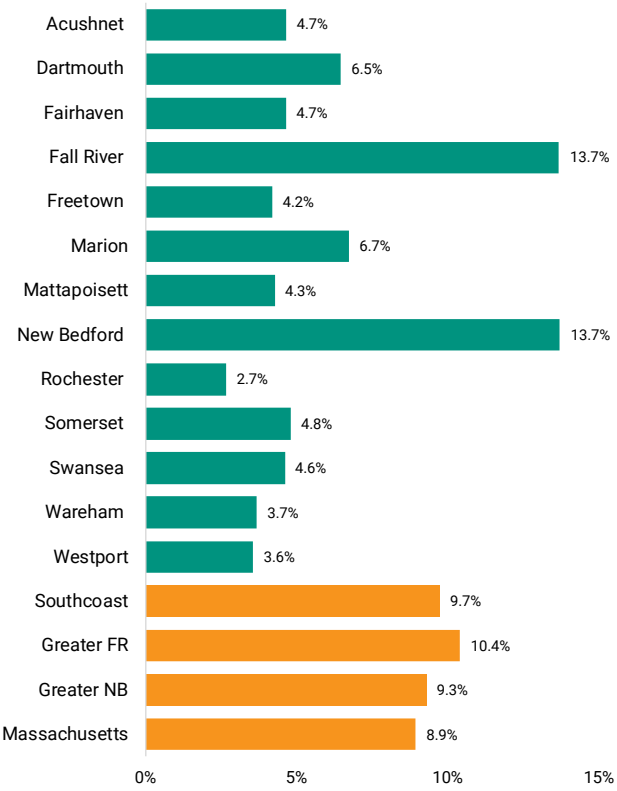
Indeed, the racial makeup of the region as a whole is changing, with the region's population increasingly comprised of groups who identify as other than White (one race) (see Figure 14). As one stakeholder noted, "Diversity is a massive asset that we have in this community. We need to harness all that energy and talent." However, another cautioned, "Looking at history from the perception from systemic racism and trauma, there is still so much racism around and the trauma that it has caused is part of the mental health issues we are seeing right now."

Figure 13. Public School Race/Ethnicity, 2021



Source: Massachusetts Department of Elementary and Secondary Education (DESE), October 1, 2021, Enrollment Report

Figure 14. Non-White Population Change, 2010–2020[18]



Source: U.S. Census Decennial 2010 & 2020

[17] Unlike the Census race categories, DESE includes Hispanic as a racial category along with the other race categories.

[18] Non-White population is defined as individuals who define their race as other than "One Race White."

The Region Has Traditionally Been a Landing Place for Immigrants

The South Coast has long been an attractive place to settle for immigrants, and as Gateway Cities, Fall River and New Bedford have been traditional destinations for new arrivals to America since the late 18th century. More than twenty-one percent (21.3%) of Fall River residents and nineteen percent (19.0%) of New Bedford residents were born outside the U.S. (see Table 6).

As emigration from Europe to the U.S. has slowed, Latin American, South American, and Asian immigrants make up increasing shares of the populations in the region. A changing immigrant population can create challenges for health service providers. Perhaps the largest obstacle is the language barrier, which was cited by many community leaders and residents as a major health equity issue.

Nearly thirty-nine percent (38.8%) of respondents to the community survey report that language problems make it difficult for them to get the health care they need. Similarly, 57% of HHSP survey respondents identified language barriers as an extremely concerning obstacle to their clients' ability to access health care. As the foreign-born population in the region continues to shift away from Lusophone countries of origin, health care providers will need to employ staff who can both engage with new arrivals in their native languages and understand cultural barriers to care.

Table 6. Foreign-Born Share of the Population, 2020

Community	Number	% Total Population
Acushnet	1,196	11.3%
Dartmouth	4,116	12.1%
Fairhaven	1,092	6.8%
Fall River	19,072	21.3%
Freetown	796	8.5%
Marion	182	3.5%
Mattapoisett	239	3.7%
New Bedford	18,151	19.0%
Rochester	236	4.2%
Somerset	1,100	6.1%
Swansea	1,848	11.1%
Wareham	803	10.1%
Westport	1,620	14.6%
South Coast	50,451	14.6%
Greater FR	23,640	16.8%
Greater NB	26,811	13.1%
Massachusetts	1,148,909	16.8%

Source: American Community Survey 2016-2020 5-year Estimates, Table B05012

Community leaders who work with undocumented immigrants and new arrivals also discussed how a learned distrust of institutions in their country of origin prevents immigrants from accessing the healthcare system once they arrive in the U.S. One interviewee noted, "Providers really need to be more grass roots, to meet these newer arrivals where they're at. This includes offering community outreach in different languages."

Affordable Quality Housing is Becoming An Increasingly Critical Issue for the Region

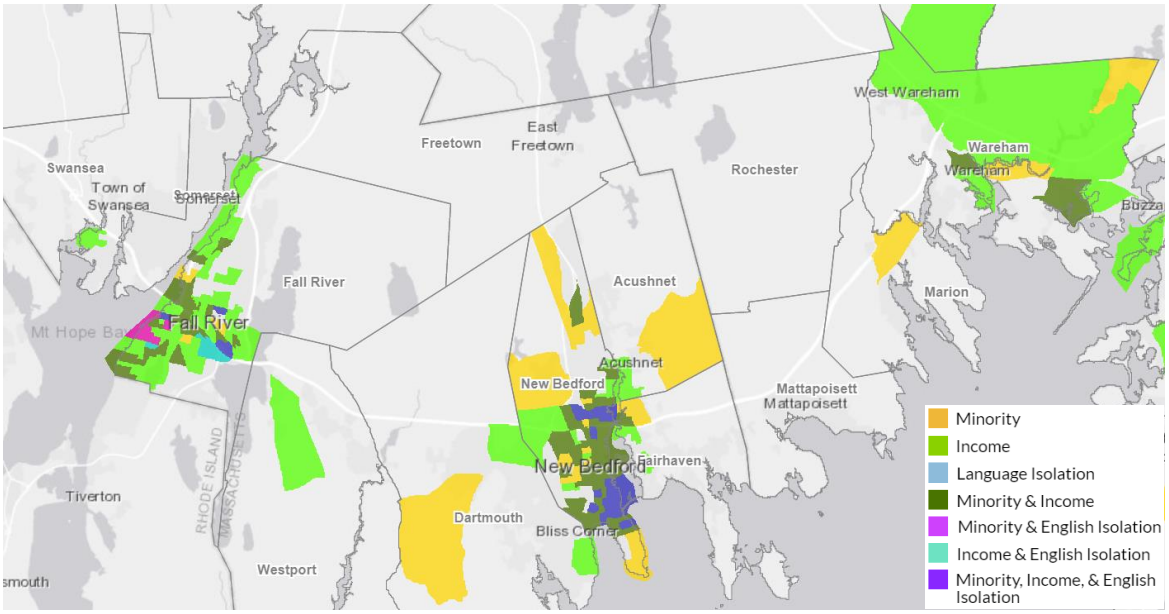
The availability of affordable, quality, and stable housing is a social determinant of health because housing stability and quality can have a great effect on health outcomes. During interviews, stakeholders consistently identified housing as a social determinant that affects the largest number of residents in their community because it is such a multifaceted issue. As one key community stakeholder noted, "How can you focus on your health when all your efforts are focused on paying the rent?" Another commented, "Putting a roof over your head comes before all else." Housing and homelessness are explored in greater detail in Section 4.

Fall River is Home to Many Neighborhoods That Meet Environmental Justice Criteria

Communities of color and low-income communities bear unequal environmental and economic burdens such as poor air and water quality, limited access to healthy food, substandard housing, and environmental contamination. The principle of environmental justice (EJ) states that all people, regardless of income or race, have the right to fair treatment and equal involvement in environmental issues, and the right to live in environmentally healthy neighborhoods.[19]

The Massachusetts Executive Office of Energy and Environmental Affairs (EOEEA) defines EJ neighborhoods as Census block groups where at least one of the following is true: 1) 25% or more of the residents are a minority; 2) 25% or more of the households have median income 65% or less than the statewide median; or 3) 25% or more of the households do not include anyone older than 14 years of age who speaks English very well. By these criteria, 77.1% of Fall River residents, 78.3% of New Bedford residents, and 48.6% of Wareham residents reside in an EJ neighborhood. Figure 15 displays environmental justice populations in the South Coast by Census tract.

Figure 15. Environmental Justice Populations, 2020



Source: Massachusetts Executive Office of Energy and Environmental Affairs

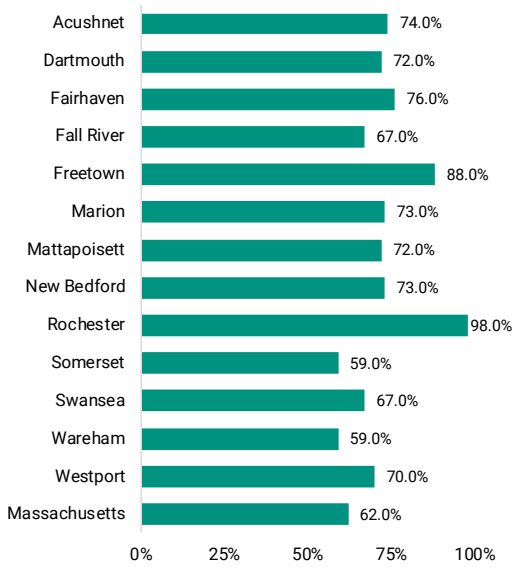
[19] Massachusetts Department of Public Health - Bureau of Environmental Health. Massachusetts Environmental Public Health Tracking. See: www.mass.gov/dph/matracking.

Lead Screening In the South Coast Is Above the Statewide Percentage

Lead poisoning is an example of an EJ factor prevalent in older neighborhoods that are often populated by people of color and low-income households. Lead paint and dust in older homes are the most common source of lead poisoning in Massachusetts. There is no safe level of lead exposure. Lead exposure can damage the brain, kidneys, and nervous system; slow growth and development; and create behavioral problems and learning disabilities in children.

The use of lead in household paint was banned in 1978. Figure 16 shows that Fall River and New Bedford children are screened for lead at rates above the state average.[20] Most South Coast communities have higher percentages of lead screening in comparison to the state as a whole.

Figure 16. Childhood Lead Poisoning Screening, 2020



Source: Massachusetts DPH 2020 Childhood Lead Poisoning Surveillance Report. Percentage of children aged 9-47 months screened for lead in 2020

The Number of Violent Crimes Is Falling, Although Some Residents Do Not Feel Safe

Crime and violence are an important public health issues that have serious short- and long-term effects on a community's health and well-being. While violence can affect people of all socioeconomic backgrounds, the risk of exposure to violent activity is greatest for people in the most socioeconomically disadvantaged groups and communities.[21] For example, the national homicide rate among young African American men, boys, and girls between the ages of 10 and 25 years old is nearly twenty times higher than the rate among white men and children in the same age group. Other historically marginalized groups such as women, persons who identify as LGBTQ+, veterans, those with a disability, and immigrants are also at a higher risk for being victims of certain kinds of violence.[22]

Apart from being directly harmed by violent acts, the health of those indirectly affected can be compromised. For example, people who live in violent neighborhoods may be more impacted by stress and mental health issues, or physical issues, because people are more apt to stay indoors and not exercise. People living in violent neighborhoods are also more likely to keep to themselves, which negatively impacts the social structure of the neighborhood and the ability to connect positively with neighbors. As one community member noted, "The safety of our neighborhood is an ongoing challenge … the community we work with is cohabiting with others that are involved with gangs and drug dealing. These people are preyed upon and are often victimized by crime."

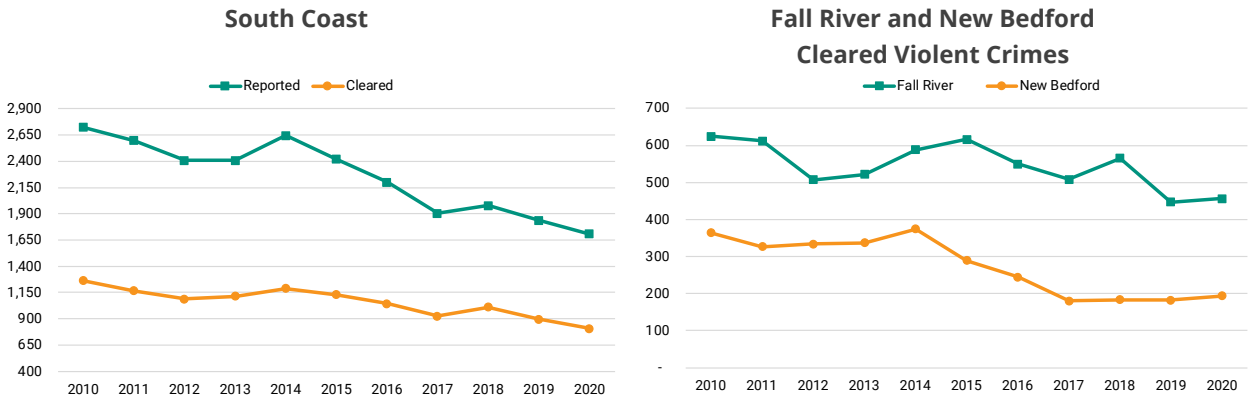
[20] Massachusetts lead regulation requires that all children be tested for blood lead between nine and twelve months, and again at ages two and three. Additionally, it is recommended that children should be tested again at age four if they live in a high-risk community.

[21] Egerton, Susan et al. 2011. *Issue Brief: Exploring The Social Determinants Of Health Violence, Social Disadvantage And Health.* University of California, San Francisco Center on Disparities in Health.

[22] American Public Health Association Policy Statement. 2018. Violence is a Public Health Issue: Public Health is Essential to Understanding and Treating Violence in the U.S. Washington DC.

The number of reported violent crimes in the South Coast declined by 37.2% from 2010 to 2020, while the number of cleared violent crimes declined by 36.0% over this period.[23] The number of cleared crimes declined by 27.0% in Fall River and 46.7% in New Bedford from 2010-2020. In total, Fall River had 456 cleared violent crimes in 2020 (out of 779 reported crimes), while New Bedford had 194 (out of 596 reported crimes) (see Figure 17).

Figure 17. Number of Reported and Cleared Violent Crimes, 2010-2020



Source: FBI Crime Data Explorer

COVID-19 Accelerated Social and Health Inequities

COVID-19 exacerbated many of the inequities related to the social determinants of health, which resulted in marginalized groups being at greater risk for contracting and dying from the virus. An analysis by the Massachusetts Office of the Attorney General found major disparities in rates of infection, hospitalization, and age-adjusted mortality between white communities and communities of color (see Figure 18and Figure 19).

Figure 18. Massachusetts COVID-19 Infection and Hospitalization Rates by Race and Ethnicity

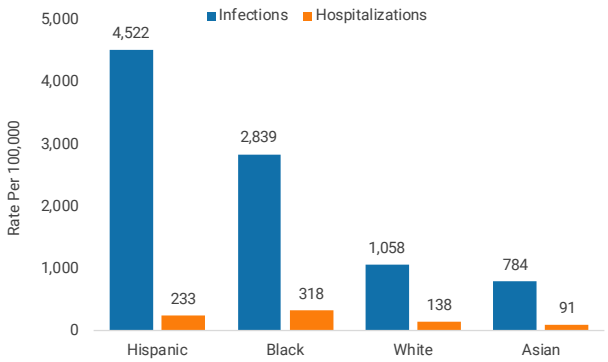
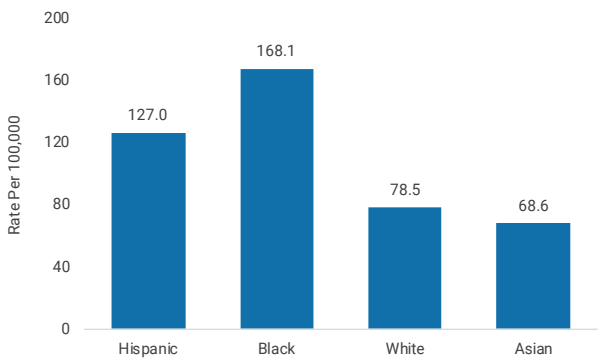


Figure 19. Massachusetts COVID-19 Age-Adjusted Mortality Rate by Race and Ethnicity



Source: Massachusetts Department of Public Health COVID-19 Dashboard. Data obtained from analysis conducted by Wolitzsky, Sandra et al.[24] Data as of November 1, 2020

[23] Cleared crimes are crimes that result in an arrest.

[24] Wolitzsky, Sandra et al. 2020. *Toward Racial Justice and Equity in Health: A Call to Action.* Massachusetts Office of the Attorney General. Boston, MA.

One of the major takeaways from our interviews is that many of the issues brought to the forefront by the pandemic are the same that existed pre-pandemic, particularly as they relate to health equity and social determinants of health. These include issues such as homelessness, immigrant health, food insecurity, health access, and mental health. In other words, the pandemic's primary effect in the South Coast was not necessarily creating new issues (although certainly new issues arose), but to exacerbate existing issues that the provider and advocacy community have worked for years to address.

Most of these issues are related in some way to health equity, which in Fall River and New Bedford—and in the region's suburban communities to a lesser extent—is driven significantly by the overall low levels of income and education as well as large pockets of newer immigrants (both documented and undocumented). A salient effect of the pandemic, particularly in the region's cities, is that a significant number of residents who are living at the edge of their means in the best of times were pushed, or will be pushed, over the edge by the ongoing health and economic crisis.

While they expressed this sentiment in many different ways, nearly all key informants said that at some point they were dealing with clients whose economic situation was tenuous. This is particularly true for providers who work with people whose income just exceeds the maximum for means-tested assistance (SNAP, MassHealth, Section 8, etc.). However, unlike in past needs assessments, community leaders noted that they are increasingly working with clients higher up on the economic ladder. As one interviewee noted, "There are people of walking through my door all the time who we would never have seen before the pandemic. Even families with two working parents with good jobs seem to be struggling more."

4 IDENTIFYING PRIORITY HEALTH ISSUES

The primary goal of the CHNA is to prioritize the region's health issues using a holistic approach that examines health data, leverages the expertise of key informants, and incorporates community views. These activities are employed to prioritize health issues based on the following criteria:

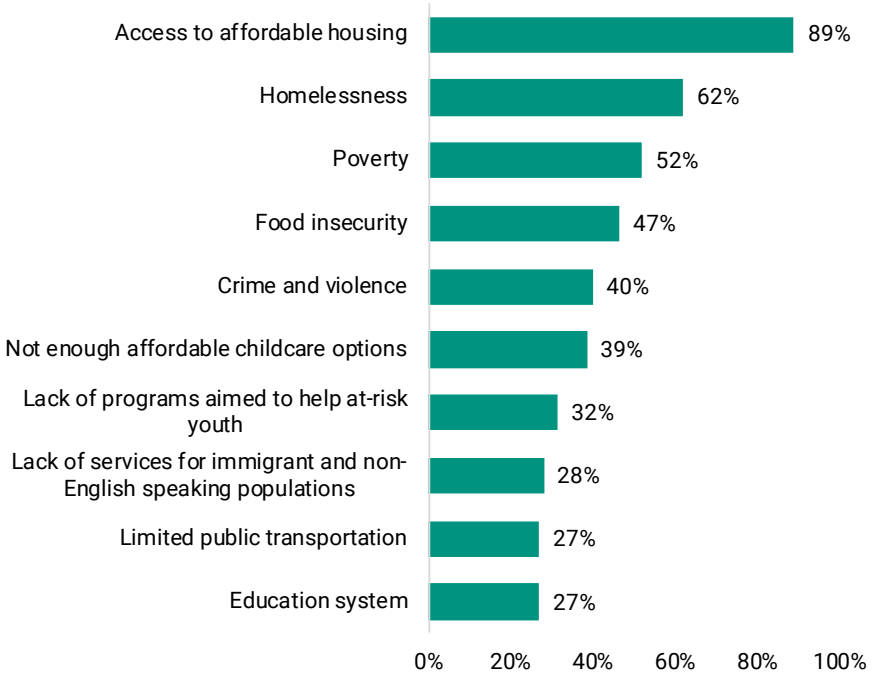
- The health issue impacts a large number or high percentage of people, particularly the region's most vulnerable at-risk populations,
- There is existing momentum to build upon and community programs are already in place,
- Addressing the health issue will substantially address health disparities or inequities, and
- Short- and long-term outcomes can be measured and tracked.

TOP ISSUES OF CONCERN

Results of the HHSP survey show that access to affordable housing, homelessness, poverty, and food insecurity are the top issues of general concern for the community they serve (see **Figure 20**). This result is strongly supported by the socioeconomic data, open end survey comments, and interviews conducted with key informants. All of these issues to some extent can be mapped to the social determinants of health.

In addition to the primary issues identified in **Figure 20**, community leaders and residents identified multiple issues related to health access, particularly with language barriers, the difficulties among immigrants in navigating the health system, and affording health care in general.

Figure 20. Please Select the Top FIVE Areas of General Concern for The Community You Serve, Not Necessarily Related to Health



Source: Health & Social Service Provider Survey, 2022

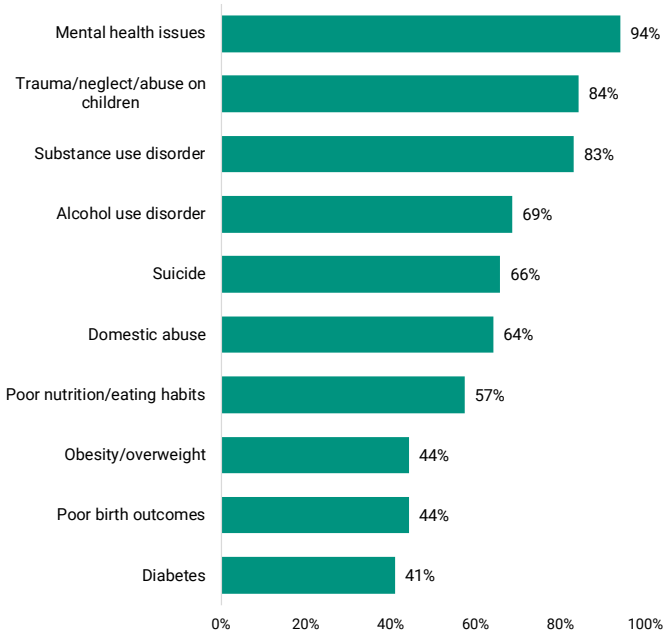
Top Health Issues

Both health and social service providers and community members were asked to rank the region's most concerning/important health issues. While results of the surveys show some differences in the ranking between the two surveys, both groups agree that mental health, substance use disorder, and alcohol abuse are among the top issues.[25] In terms of differences, community members rank diabetes higher in comparison to providers. Community members also rank dental problems seventh, which is a much higher ranking than in past community surveys (this choice is not included in HHSP survey) (see Figure 21). Many community members' open end comments reference either not having dental insurance or having insurance with poor or expensive coverage. In addition, providers rank trauma, neglect, abuse on children, and suicide higher than community members. Open end comments related to child trauma cautioned that these issues are likely to worsen as fallout from the pandemic builds.

Figure 21. Top Health Issues

HHSP Survey

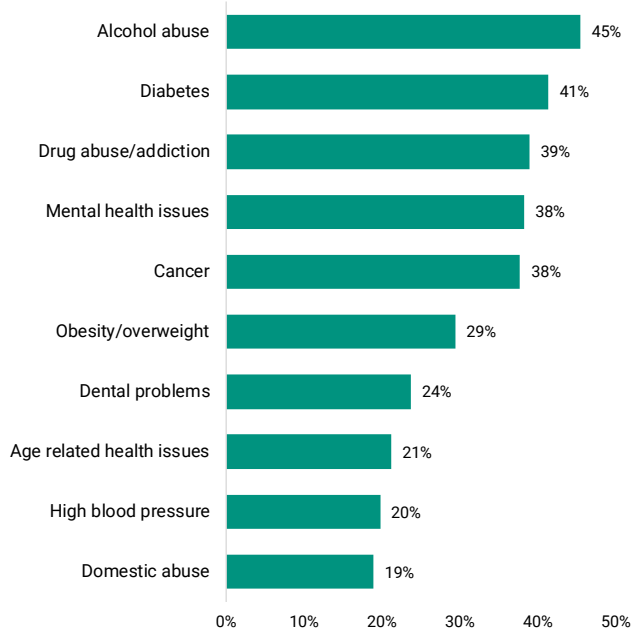
Top Levels of Concern Regarding Various Health Conditions, Percent "Very Concerned"



Source: Health & Social Service Provider Survey, 2022

Community Survey

Five Most Important Health Issues In Your Community



Source: Community Survey, 2022

In addition to the qualitative results, the available health data underscores that unhealthy behaviors among South Coast residents have resulted in comparatively poor chronic disease outcomes in comparison to state and national averages. While poor health outcomes appear to affect residents of all racial, cultural, and economic backgrounds, the available data and conversations with community leaders indicate that these issues are most acute among the poor, communities of color, and immigrants. Many key informants attribute poor health

[25] The percentages in these tables are not comparable because the question was asked differently on each survey. The charts serve only to show the priority ranking of the two groups. A full list of responses can be found in appendix A and Appendix B.

outcomes to challenges of health access including issues related to health literacy, transportation, and culturally competent care. Consequently, Wellness and Chronic Disease and Health Access were added as priority health issues based on the quantitative and qualitative analysis.

As a result of the process described above, five priority issues were identified (see Table 7). These represent issues where Southcoast Health can make significant positive impact because the system is 1) already addressing the issue and 2) has existing partnerships and collaborations with local service providers that are focused on improvement in these areas.

Table 7. Priority Health Issues

Priority Issue	Sub-Categories
Economic Opportunity	Social Mobility, Income, Education
Behavioral Health	Mental Health, Substance Use Disorder, Youth Trauma
Housing	Affordability, Stability, Homelessness
Wellness & Chronic Disease	Unhealthy Behaviors, Health Outcomes, Prevention
Health Access & Equity	Underserved Populations, Obstacles to Care, Health Literacy

5 Priority Health Issue 1: Economic Opportunity

Economic opportunity can be defined as the ability of a person to reach their personal potential. Opportunity includes having access to resources that are essential to maintaining a good quality of life, such as education, affordable housing, healthy foods, childcare, and stable employment. Unfortunately, many economic, social, and structural barriers prevent some South Coast residents from achieving their potential. These include obstacles such as concentrated poverty, racial discrimination, low wages, unequal educational access, and lack of quality opportunities for childhood learning.

Economic opportunity is an umbrella issue that encompasses many of the priority issues identified by stakeholders. Community leaders suggested the need to build stronger connections between traditionally excluded populations and the opportunities that lead to economic security, such as quality early childhood learning, paths to college success, workforce training, and quality health care. However, stakeholders caution that achieving economic opportunity for all requires overcoming structural obstacles including poverty, education, housing, racism, and employment. As one key informant noted, "We need a holistic approach to all dimensions of health and wellness within our region, including reconnecting marginalized groups with the resources that can improve their economic outlook, especially in terms of education." Another noted, "Rising out of poverty is nearly impossible without education or training. The key is, how do we make that happen? The future of our region depends on finding new ways to connect disengaged residents to these resources."

Key takeaways:

- Multigenerational poverty has become a grim, unbreakable cycle for many families in Fall River and New Bedford over the last decades. For many, physical and mental health conditions prevent them from fully accessing the economic opportunities that many take for granted.
- Median household income in Fall River is only 53.6% of the statewide median and New Bedford is only 57.0% of the statewide median. Low income residents have been hit particularly hard with 2022's inflationary environment. As one survey respondent noted, "New Bedford has many people that are on fixed incomes, so they are much more vulnerable when prices rise."
- Over twelve percent (12.6%) of the region's population and 9.8% of its families are below the poverty level. This compares to 9.8% and 6.6% statewide, respectively. The poverty rates in Fall River and New Bedford are nearly double the state average.
- More than sixty-two percent (62.2%) of the region's public school students are classified as economically disadvantaged.
- A primary obstacle to equitable economic opportunity in Fall River and New Bedford is the low-wage jobs that are pervasive in these cities. The region's annual average wage in 2021 was only 63.3% of the state average; wages in Fall River and New Bedford were 62.6% and 62.9% of the state average, respectively.
- Many Fall River and New Bedford residents have not taken advantage of educational opportunities: these communities have some of the lowest levels of educational attainment among Massachusetts cities, although some of the region's suburban communities also have educational attainment levels below the state average as well.
- High school graduation rates in Fall River and New Bedford are also well below the state average, while rates for most of the other high schools in the region are above the state average.
- Only 54% of students in Fall River and 51% of students in New Bedford plan to attend college.

Income and Poverty

Truly, poverty is the central knot of the entangled web of social determinants of health and the priority areas identified in this research. It is self-perpetuating, inheritable, and a crisis looming constantly at the edge of the households living paycheck-to-paycheck. For many in our region, health care is intimately linked with poverty because one health issue has the power to eliminate savings and suppress income. For others, physical and mental health conditions prevent them from fully accessing the economic opportunities that many of us take for granted. As detailed below, multigenerational poverty has become a grim, unbreakable cycle for many families in Fall River and New Bedford over the last decades.

Economic Opportunity begins with developing strategies for families to become economically stable so they can better support healthy children and break the cycle of poverty. Above all, it requires a coordinated effort among the many organizations working to lessen the impacts of poverty on the South Coast. As one stakeholder put it, "Poverty is linked to a range of factors—including health, housing, race, gender, family, and jobs—addressing it effectively requires better coordination among nonprofits, government agencies, philanthropic funders, and the private sector." Another lamented, "Where do you start? There are so many basic needs that are not being met consistently."

Social Mobility Is Historically Constrained In Some Neighborhoods

While the neighborhood where one grows up is not destiny, it has a profound effect on future economic opportunity, and in turn, health outcomes. To measure this effect, the Opportunity Atlas maps the childhood roots of social mobility by measuring which neighborhoods offer children the best chance to rise out of poverty. The Atlas accomplishes this by estimating the average outcomes in adulthood of people who grew up in each Census tract and were born between 1978 and 1983. That is, the Atlas shows not only where the rich and poor currently live, but whether children in a particular neighborhood grow up to become rich or poor.[26]

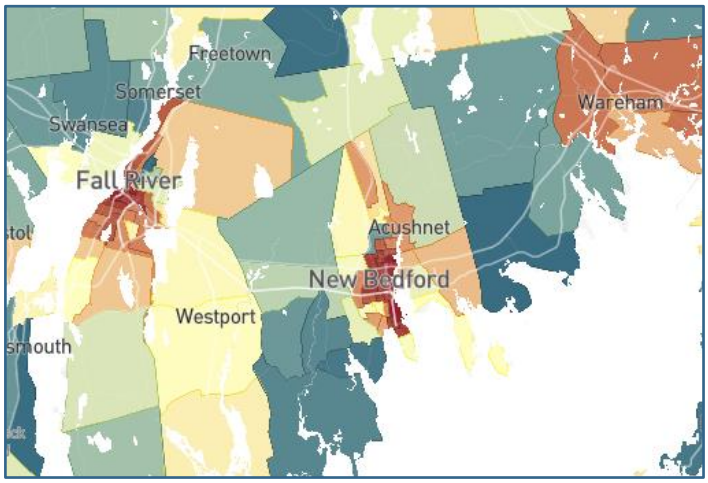
Figure 22 shows that one's childhood neighborhood is indeed destiny for many children in Fall River, New Bedford, and Wareham; average annual household income for those who grew up in these neighborhoods and are now in their 30s is the nationwide median.[27] The outcomes are even worse for non-White children and those whose parents had below average incomes.

Neighborhoods in many areas of the region not only produce poor economic outcomes but are still poor. Indeed, current data shows that poverty remains concentrated in these very same neighborhoods. Figure 23 maps median household income in the South Coast. Figure 22 and Figure 23 are remarkably similar in terms of the neighborhoods with the worse socioeconomic outcomes currently. Consequently, addressing the region's health outcomes requires addressing the social determinants of health that are pervasive in these areas.

[26] The Opportunity Atlas utilizes anonymous data following twenty million Americans from childhood to their mid-30s that trace the roots of today's affluence and poverty back to the neighborhoods where people grew up. See https://www.opportunityatlas.org/.

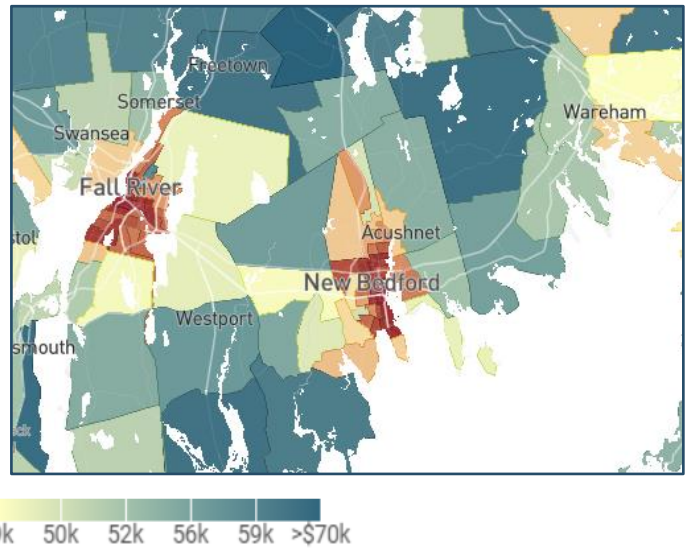
[27] Importantly, many children move to different areas in adulthood, but we always map the data by where children grew up, regardless of where they live as adults. The data provide information on the average actual outcomes of children who grew up in each area. Each estimate is specific to a selected group.

Figure 22. Average Household Income Among Individuals Born In South Coast Census Tracts Between 1978 and 1983



Source: Opportunity Atlas, All parental Income Levels
https://www.opportunityatlas.org/

Figure 23. Current Household Income by Census Tract



Source: American Community Survey 5-Year estimates, 2015–2019 Estimates

Income and Wage Stagnation Are Hindering Economic Opportunity for Many Families

When describing the obstacles to healthcare and the socioeconomic determinants of health, many stakeholders discussed the difficulty that residents experience in affording healthcare, particularly preventive care and specialists. One interviewee commented that, "A lot of our working poor just over the income guidelines and don't qualify for benefits. This group is having a hard time working low-paying jobs and trying to pay their bills with little help." Another added, "Few think about preventive health when they're worried how to get enough food on the table."

Seven South Coast communities have median incomes that are above the state average (see Table 8). Median incomes are particularly low in Fall River and New Bedford, although Acushnet, Fairhaven, Wareham, and Westport also have median incomes below the state average. Median household income in Fall River is only 53.6% of the statewide median and New Bedford is only 57.0% of the statewide median. Low income residents have been hit particularly hard with 2022's inflationary environment. As one survey respondent noted, "New Bedford has many people that are on fixed incomes, so they are much more vulnerable when prices rise."

Table 8. Median Household Income

	Median HH Income	% of State Median
Acushnet	$80,221	98.8%
Dartmouth	$84,220	103.7%
Fairhaven	$67,394	83.0%
Fall River	$43,503	53.6%
Freetown	$88,125	108.5%
Marion	$81,928	100.9%
Mattapoisett	$94,360	116.2%
New Bedford	$46,321	57.0%
Rochester	$104,041	128.1%
Somerset	$84,115	103.6%
Swansea	$86,637	106.7%
Wareham	$65,825	81.1%
Westport	$79,895	98.4%
Massachusetts	$81,215	NA

Source: Median income, ACS 5-Year Estimates, Table S1903, 2016–2020.

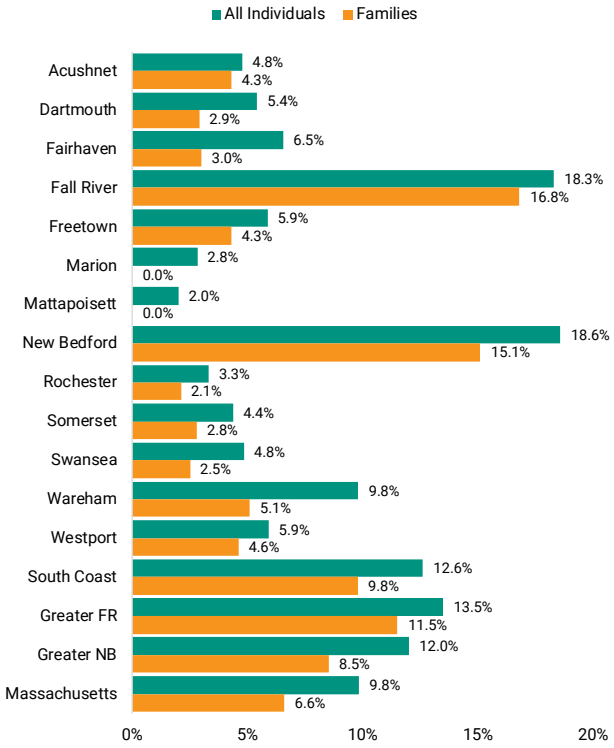
Poverty Levels are Generally Higher Than the State Average, While a Comparatively Large Percentage of the Region's Students are Economically Disadvantaged

Poverty is a major social determinant of health. Those in poverty often have less opportunity and less access to resources that can assist in improving and maintaining one's health. Resources that contribute to educational attainment, employment, housing status, health care opportunities, and social activities are all less accessible to those living in poverty.

Over twelve percent (12.6%) of the region's population and 9.8% of its families are below the poverty level. This compares to 9.8% and 6.6% statewide, respectively. The poverty rates in Fall River and New Bedford are nearly double the state average (see Figure 24).[28]

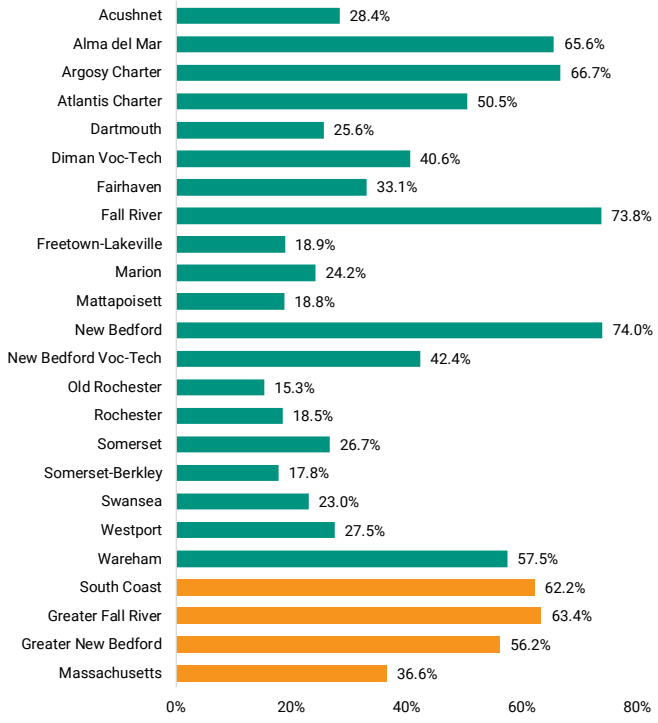
Students are often the socioeconomic bellwether of a community. More than sixty-two percent (62.2%) of the region's public school students are classified as economically disadvantaged by the Department of Elementary and Secondary Education (DESE).[29] Much like other poverty measures, the share of public school students economically disadvantaged in Fall River and New Bedford is about twice the state average (see Figure 25).

Figure 24
Share of Population Living Below Poverty Level, 2020



Source: ACS 5-Year Estimates, Table S1702, 2016–2020

Figure 25
Students Economically Disadvantaged, 2021



Source: Massachusetts Department of Elementary and Secondary Education (DESE), October 1, 2021, enrollment report

[28] Notably, the COVID-19 stimulus payments were helpful in assisting people to weather the storm during the pandemic, and even pulled some out of poverty, but the long-term effect of these payments on poverty levels is unknown.

[29] Economically disadvantaged students are defined as those who participate in one or more of the following state-administered programs: the Supplemental Nutrition Assistance Program (SNAP), the Transitional Assistance for Families with Dependent Children (TAFDC), the Department of Children and Families' (DCF) foster care program, and MassHealth (Medicaid).

Average Annual Wages in the Region Are Well Below the State Average

Having a job and earning a living wage can be critical for maintaining health. Apart from the fact that many individuals and families receive health insurance through their employer, a good-paying job makes it easier for individuals and families to live in healthier neighborhoods, send their children to better schools, and buy more nutritious food, all of which contribute to living a healthier lifestyle. Conversely, being unemployed or underpaid increases economic stresses that contribute to negative health, including higher rates of depression and stress-related conditions such as stroke and heart disease.[30]

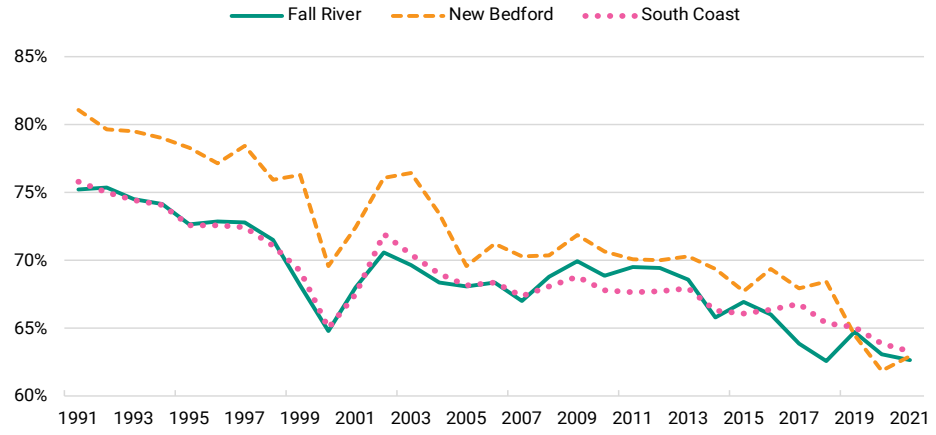
A primary obstacle to equitable economic opportunity in Fall River and New Bedford is the low-wage jobs that are pervasive in these cities, particularly as their economies have shifted from what were relatively well-paying manufacturing jobs to lower wage service jobs (see **Table 9**). The issues of affordability and economic opportunity have only grown as the wage gap with the state continues to widen. The region's annual average wage in 2021 was only 63.3% of the state average; wages in Fall River and New Bedford were 62.6% and 62.9% of the state average, respectively.[31] Figure 26 tracks this wage gap from 1991 to 2021.

Table 9. Average Annual Wage, 2021

Community	Avg. Annual Wage	% State Average
Acushnet	$60,424	68.9%
Dartmouth	$56,576	64.5%
Fairhaven	$69,628	79.4%
Fall River	$54,912	62.6%
Freetown	$66,300	75.6%
Marion	$64,272	73.3%
Mattapoisett	$49,348	56.3%
New Bedford	$55,172	62.9%
Rochester	$55,796	63.6%
Somerset	$44,460	50.7%
Swansea	$49,660	56.6%
Wareham	$51,272	58.5%
Westport	$47,528	54.2%
South Coast	$55,468	63.3%
Greater FR	$52,825	60.3%
Greater NB	$57,177	65.2%
Massachusetts	$87,672	100.0%

Source: Massachusetts Executive Office of Workforce and Labor Development, ES202 data[32]

Figure 26. Wage Gap



Source: Massachusetts Executive Office of Workforce and Labor Development, ES202 data

[30] Robert Wood Johnson Foundation. See https://www.rwjf.org/en/library/research/2012/12/how-does-employment--or-unemployment--affect-health-.html.

[31] The wage gap is defined as the average annual wage in the South Coast as a percentage of the state average annual wage.

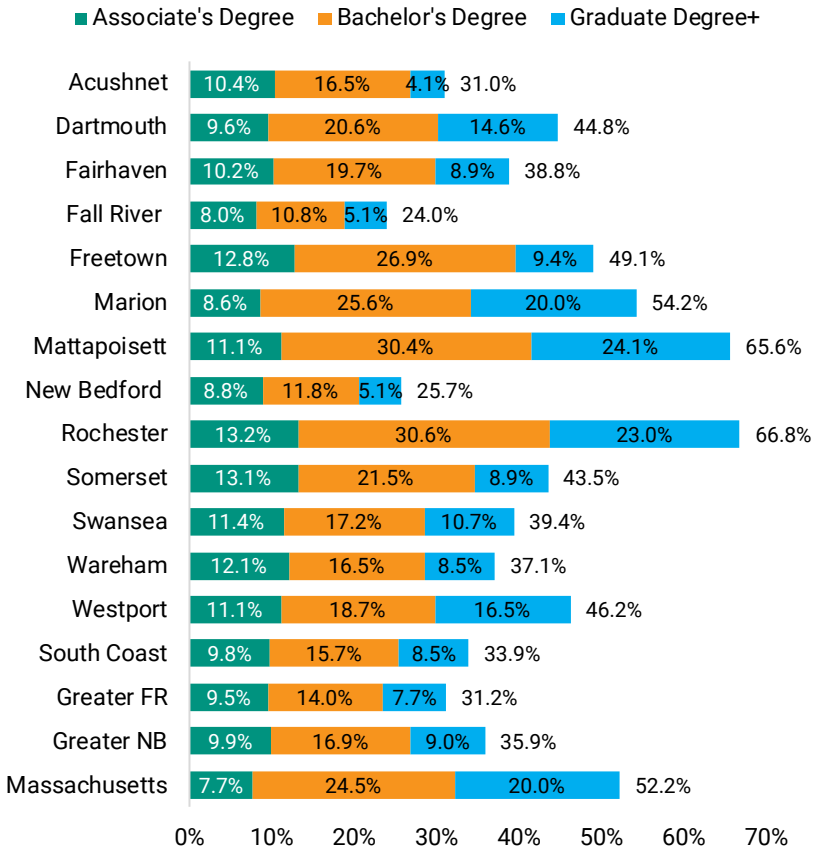
[32] The ES202 dataset reports employment and wages by place of work, not by the city or town in which employees live.

Educational Attainment Levels in Fall River Are Well Below the State Average

Economic opportunity is inexorably linked with education and the opportunities that an education affords. A college education is one of the most effective ways that families can improve their economic outlook. Unfortunately, children of parents in lower income brackets are less likely to pursue a college education in comparison to their more affluent peers, and they are even less likely to graduate even if they do attend college. And parents themselves with less education are increasingly losing ground to their more educated counterparts.

Massachusetts has the second most highly educated population in the country and one of the most well-educated populations in the world. In contrast, Fall River and New Bedford have some of the lowest levels of educational attainment levels of any cities in Massachusetts, although some of the region's suburban communities also have educational attainment levels below the state average (see Figure 27).[33]

Figure 27. Residents Aged 25 and Older with at Least an Associate Degree, 2020

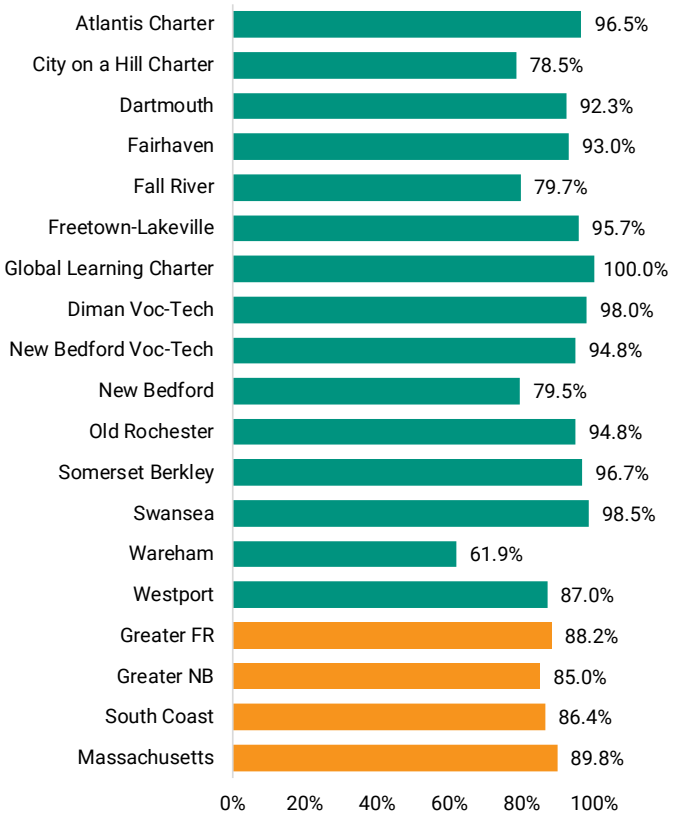


Source: American Community Survey 5-Year Estimates, Table S1501, 2016–2020

[33] High margins of error prevent any meaningful analysis of race-based educational attainment data for the region.

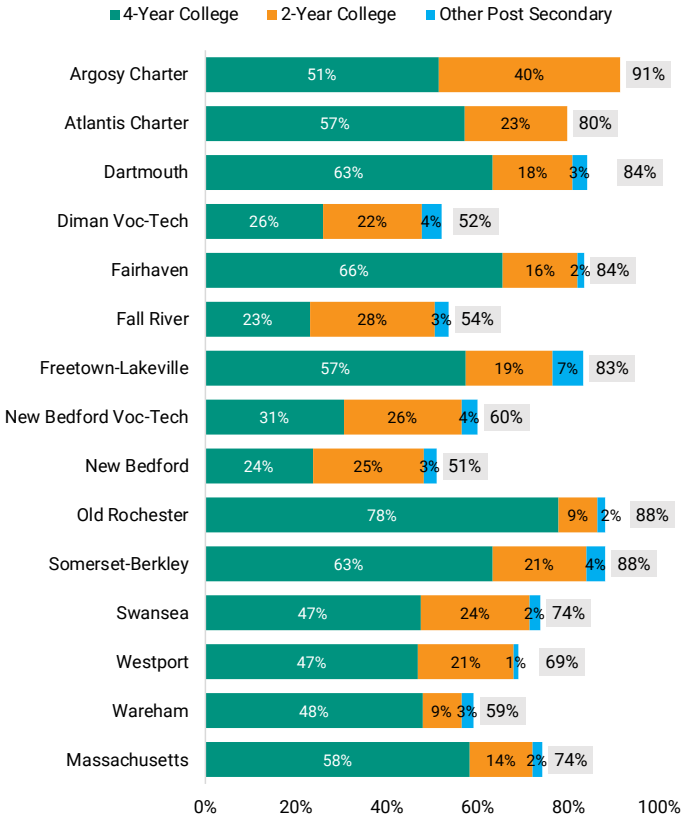
High school graduation rates in Fall River and New Bedford are also well below the state average, while rates for most of the other high schools in the region are above the state average (see Figure 28).[34] Not surprisingly, a lower percentage of students in these communities plan to attend college: only 54% of students in Fall River and 51% of students in New Bedford plan to move on to college. Notably, these percentages do not include students who already dropped out of high school. Moreover, the vocational technical schools in Fall River and New Bedford, whose mission is ostensibly to train students for vocational occupations, have high percentages of students who plan to attend college. In fact, the percentage of students who plan to attend college at New Bedford Voc-Tech (60%) is higher than for students at New Bedford High School (51%) (see Figure 29).

Figure 28. 4-Year Graduation Rate by District, SY 2021



Source: Massachusetts Department of Elementary and Secondary Education, SY 2021. Data for Argosy not available

Figure 29. Plans of High School Graduates



Source: Massachusetts Department of Elementary and Secondary Education, SY 2021. Labels highlighted in grey are totals

[34] The high school graduation rate measures the percentage of students who attain a high school diploma within a four-year period.

Ensuring Every Child Gets A Strong Start In Life Through High-Quality Early Childhood Education is Paramount

Much of the discussion among stakeholders on how to improve educational outcomes focused on early intervention strategies, such as improving access to Pre-K programs and focusing on increasing early childhood literacy rates. Research clearly demonstrates that high-quality preschool education substantially increases a child's success in school and beyond. In particular, Pre-K students get a jump start on the skills that set them up for success at the elementary school level.

Overall, the region has maintained a steady level of enrollment in Pre-K since 2013 (see Figure 30). Notably, all communities in the South Coast and across Massachusetts saw considerable declines in enrollment during the 2021 school year due to the pandemic and it appears that enrollment has recovered to near pre-pandemic levels. Figure 31 displays Pre-K enrollment as a percentage of total Pre-K through 12th grade enrollment.

Figure 30. Pre-K Enrollment in Public Schools

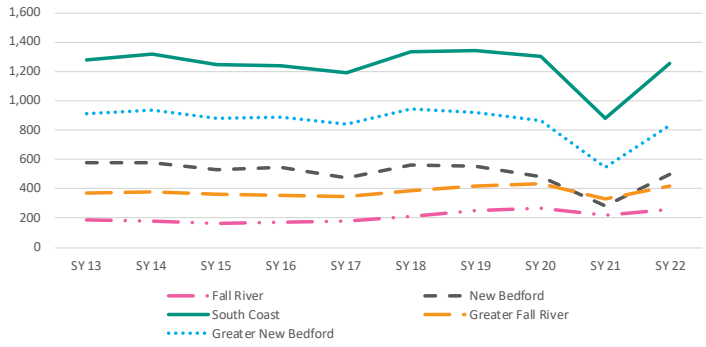
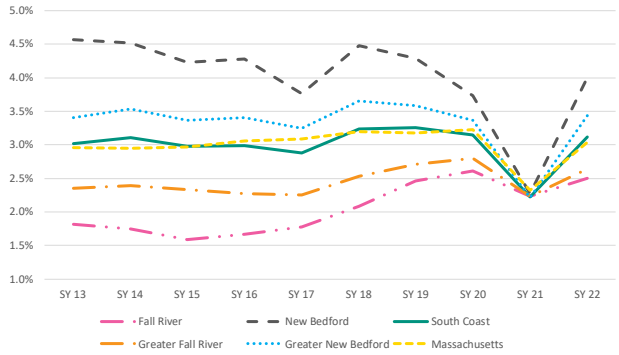


Figure 31. Pre-K Enrollment as Percentage of Total Pre-K through 12th Grade Enrollment



Source: Massachusetts Department of Elementary and Secondary Education, SY 2021

As they have in prior CHNAs, the metrics and qualitative data around economic opportunity highlight the struggle facing many residents of the South Coast, particularly in the region's cities. What is also clear is that these issues are systemic and pervasive throughout similar post-industrial cities across the state and the country. The major question raised here is what can Southcoast affect as a healthcare system? Programs like the BASICS, which guides new parents on how to approach learning and engage with their children both align with the pledge to provide "more than medicine" and attempt to tackle the educational attainment problem, which is both a root cause and symptom of the multigenerational poverty seen in Fall River and New Bedford.[35] Creative approaches such as this, which focus on a particular issue and leverage Southcoast's position as a convening entity with many regional "specialist" partners, could pay long-term dividends in improving economic opportunities over the course of the next generation. The challenge continues to be tracking and sustaining successes on a decadal scale.

Additionally, as one of the region's largest employers, Southcoast Health is in a unique position to enact change and be a leader through implementation of progressive hiring strategies and by providing support for employees to improve their skills and climb the internal career ladder. The health system's status also puts Southcoast Health in a position to advocate at the state-level for better policies around wages, educational affordability, and social services that can support people in improving their situations.

[35] See https://southcoastearlyed.org/the-basics/.

6 Priority Health Issue 2: Behavioral Health

Behavioral health examines how a person's habits affect their mental and physical well-being. This includes behaviors related to nutrition, exercise, smoking, sleep, and stress. Behavioral health is also a blanket term that includes mental health and substance use disorder. For example, people who have mental health or substance use issues may benefit from changes in their behaviors to better cope with their struggles.

Throughout this project, mental health emerged as the region's most prominent health issue. In fact, results of the HHSP survey and Community Survey show that respondents are more concerned with behavioral health issues (e.g., mental health, substance use disorder, alcohol abuse) than physical health issues and conditions. This result is supported by interviews with health providers, who strongly emphasize the connection between mental health and substance use disorder. As one might expect, COVID-19 exacerbated mental health and substance use issues significantly, with one stakeholder noting that the issue is "growing exponentially with no end in sight."

Key takeaways:

- Stakeholders clearly articulated that mental health is the most pressing health issue in the South Coast, particularly as the effects of COVID-19 on mental health are becoming more evident.
- The acute shortage of mental health professionals is the top mental health challenge, particularly the need for outpatient mental health workers.
- Community leaders note that it has been challenging to find beds for patients, which is a major roadblock for patients who are willing to enter treatment but cannot do so because beds are not available.
- While mental health issues among our youth are growing exponentially, there are very few beds statewide for this age group, although adding beds does little to improve treatment outcomes if there continues to be a staffing shortage.
- In a region with high levels of poverty and a substantial immigrant population, there are many social factors that influence how residents access the mental health system, if at all. Community leaders in particular highlighted the cultural stigma that exists among immigrant communities and communities of color regarding mental health, which keeps them from seeking treatment.
- The diversity and linguistic abilities of mental health workers was also identified, with one community leader noting, "There are issues with the cultural linguist competence of mental health providers across the region. There is simply not enough diversity among mental health professionals both in mental health and health care as a whole."
- Substance use disorder (SUD) continues to be identified as a major challenge in the region, particularly in terms of the links between substance use disorder, other mental health issues, poverty, and homelessness.
- Health and social service providers increasingly report seeing patients with a dual diagnosis, that is, individuals who experience a substance use issue along with a mental health issue. They were clear that these issues need to be addressed simultaneously.
- Respondents also recognize the negative effects of alcohol use disorder; 69% of survey respondents rated alcohol use disorder as "extremely concerning."

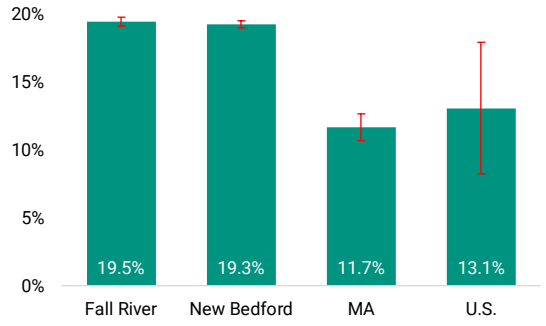
Mental Health

The 2019 Southcoast health needs assessment identified mental health as an increasingly salient issue and the work for this year's assessment confirms that mental health issues have been amplified by the pandemic. As one stakeholder commented, "The pandemic and the isolation it brought had an enormous effect on people's mental health, particularly the elderly who tend to be more isolated in the best of times." Another warned, "Mental health issues are going to be the next pandemic. Poor mental health leads to self-medication, then to substance abuse, alcohol abuse, domestic violence, and other poor behaviors." Another interviewee noted the connection between mental health and job stress: "The stresses involved with essential workers such as fish processers, construction workers, and factory workers led to ongoing heath issues and occupational issues. This also includes women working full time taking care of their families and worrying about childcare; these are all health stressors.

Another community leader notes the role racism plays in mental health, commenting "There is still so much racism around and the trauma it caused has led to many of the mental health issues we are seeing right now." One more community leader made the connection between homelessness and mental health, commenting that "Mental health issues are highly prevalent among the homeless population, where services and outreach are perhaps more lacking than elsewhere. Eliminating homelessness will help with the severity of [behavioral] cases as these folks have a hard time getting proper diagnosis and proper care."

Data show that a greater percentage of Fall River (19.5%) and New Bedford (19.3%) residents report having more than 14 days per year with poor mental health in comparison to the state (11.7%) and national (13.1%) averages (see Figure 32). In addition, data from the Youth Behavior Risk Factor Survey (YRBS) show that 43% of Durfee students and 36% of New Bedford High student felt "so sad or hopeless almost every day for two weeks or more in a row" that they stopped doing some usual activities.[36] Notably, this is 2019 data and does not reflect the effects of the pandemic.

Figure 32. Adults Reporting Poor Mental Health for at Least 14 Days, 2019



Source: CDC PLACES Project; Red bars represent confidence interval

There are three primary mental health issues stressed by community members and providers:

1) the shortage of mental health professionals,
2) the overall behavioral health system, particularly the shortage of beds, and
3) equity in mental health, including issues of access and stigma

Shortage of Mental Health Professionals

Nearly all key informants cited the acute shortage of mental health professionals as a critical issue, particularly outpatient mental health workers. The shortage has created long waitlists or deterred people from seeking treatment. As one survey responded lamented, "The primary obstacle to effectively addressing mental health is the extreme lack of facilities and providers." As discussed below, the pandemic increased the strain on this already overburdened system.

[36] Source: Durfee High School and New Bedford High School Youth Risk Behavior Survey, 2019

Community leaders note that the region faces a challenge not only in retaining mental health care workers, but hiring new ones as well, especially those who accept MassHealth. They explain that many providers have shifted to working with patients with private insurance or who are willing to pay cash. Further, it was clearly articulated that there is a stigma among some providers about accepting high needs patients, particularly those with conditions such as chronic homelessness and substance use disorder. A community leader from Wareham also cautioned that Wareham has very few options for mental health treatment, "even though we have such a great need for these services."

In addition, community leaders noted that providers outside the mental health system are often not properly trained to counsel patients or refer them to treatment services. This is especially true of primary care physicians, who are often the gatekeepers for referrals to mental health treatment. As one community leader notes, "Suicide ideation is on the rise, but kids and parents don't want to talk about it. Most kids with a mental health issue are probably talking about it with their friend, teacher, or Primary Care Physician. Most of the people in these positions are not qualified mental health professionals."

The Shortage of Beds

Community leaders and survey respondents noted that it has been challenging to find beds for patients, which is a major roadblock for patients who are willing to enter treatment but cannot do so because beds are not available. This issue is particularly troublesome for patients with acute mental health disorders who are best served by a "warm handoff" but are instead frustrated by the fact they cannot get a bed. In addition, while key informants note that mental health issues among our youth are growing exponentially, there are very few beds statewide for this age group, although adding beds does little to improve treatment outcomes if there continues to be a staffing shortage.

One health provider comments, "The ongoing shortage is a crisis. Patients in need of specialized in-patient care wait in hospital emergency departments for beds to open or do not seek help at all." Another noted a systemic issue with how mental health is covered or not covered by insurance, writing that, "Insurance should cover mental health to the same degree as physical health."

Equity in Mental Health

The importance of remedying the health inequities in the region by addressing the social determinants of health has been discussed throughout this report, and mental health care is no exception. Indeed, social inequities have been associated with increased risk of common mental health disorders, and the stigma associated with seeking treatment for mental and behavioral health issues often prevents those in need of care from seeking it. In a region with high levels of poverty and a substantial immigrant population, there are many social factors that influence how residents access the mental health system, if at all.

Interviewees and survey respondents highlighted many factors that contribute to these disparities, including language and cultural barriers for immigrant communities, lack of insurance, high out-of-pocket costs for mental health services, or simply because people are unaware that their insurance covers mental health treatment. Many people are also generally more reactive than proactive in engaging the health care system, or as one community leader noted, "You just don't talk about mental health in some cultures." Community leaders note that a cultural stigma exists among immigrant communities and many communities of color. Lack of trust of the medical system, particularly among immigrants, was also cited as an issue that affects people seeking help to address mental health issues. One community leader identified a language issue, noting that, "There are issues with the cultural linguist competence of mental health providers across the region. There is simply not enough diversity among mental health professionals both in mental health and health care as a whole."

Trust and fear among groups served by providers is also common theme throughout the interviews, particularly among the immigrant community. This includes people's fear of addressing a mental health issue, fear of doctor visits, fear that they will not be able to afford treatment, and fear in general of navigating a health care system about which they know very little. As a result, many residents only visit a mental health professional when issues get worse, and even then many will wait until life becomes unbearable, all the while hoping that eventually the symptoms will disappear. This practice applies not only to mental health, but health conditions in general.

Substance Use Disorder and Alcohol Use Disorder

Substance use disorder (SUD) continues to be identified as a major challenge in the region, particularly in terms of the links between substance use disorder, other mental health issues, poverty, and homelessness. Eighty-three percent (83%) of respondents to the HHSP survey rated substance use disorder as an "extremely concerning" health issue. Respondents also recognize the negative effects of alcohol use disorder; 69% of survey respondents rated alcohol use disorder as "extremely concerning." One community leader noted that, "Alcohol abuse is a big issue in the Central American community and getting support for treatment is difficult. They often don't know where to find services or don't recognize they have a problem." Another commented, "Alcohol abuse is an issue that I feel we don't speak enough about. It affects more people than drugs."

The region had 205 confirmed opioid-related deaths in 2021. Not only is this the greatest annual number of opioid-related deaths since 2013, but the number of deaths has increased steadily since 2013 (see **Table 10**). The number of opioid deaths in Fall River and New Bedford are disproportionate to their share of the region's population; these cities comprise 64.6% of the region's population, while they accounted for 73.2% of opioid deaths in 2021.

Table 10. Number of Opioid-Related Overdose Deaths By South Coast Communities, 2013–2021

Community	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total '13-'21
Acushnet	0	1	4	4	7	2	1	2	2	23
Dartmouth	2	7	2	9	6	4	10	5	6	51
Fairhaven	4	2	7	4	8	5	9	8	4	51
Fall River	29	38	40	64	55	55	67	75	69	492
Freetown	0	2	3	3	6	4	4	3	5	30
Marion	0	1	1	1	1	1	1	1	1	8
Mattapoisett	0	0	2	2	1	5	2	2	3	17
New Bedford	29	28	55	57	45	54	75	64	81	488
Rochester	0	1	0	0	2	1	1	1	1	7
Somerset	1	2	4	5	5	5	2	4	4	32
Swansea	4	5	0	1	5	7	6	5	7	40
Wareham	9	10	7	15	17	15	14	16	17	120
Westport	2	4	2	4	6	8	8	3	5	42
Southcoast	80	101	127	169	164	166	200	189	205	1,401
Greater FR	36	49	46	74	71	75	83	87	85	606
Greater NB	44	52	79	95	92	91	117	102	120	792
Massachusetts	961	1,362	1,747	2,110	2,006	2,013	2,005	2,090	2,234	16,528

Source: Massachusetts Department of Public Health, Current Opioid Statistics, November 2021 report
Data represents deaths by city/town of residence for the decedent

Neonatal Abstinence Syndrome (NAS)

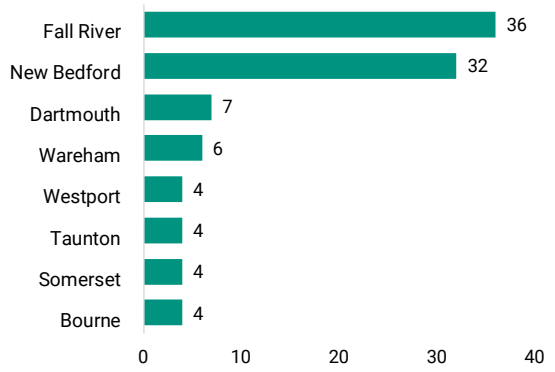
Another troubling outcome of the opioid crisis is the rate of newborns born with neonatal abstinence syndrome (NAS). NAS is a group of conditions that babies experience after being exposed to narcotics in the womb. Infants born with NAS can have low birth weight, respiratory distress, feeding difficulty, tremors, increased irritability, diarrhea, and occasionally seizures. Although data are not available at the local level, it is clear that the opioid crisis is impacting newborns in Southeast Massachusetts at a greater rate than elsewhere in the state. In 2018, the region had the highest rate of infants diagnosed with NAS, with 19.4 babies per 1,000 live births suffering from the syndrome, although this is the lowest rate since tracking began in 2011. Comparatively, 11.7 infants per 1,000 births were diagnosed with NAS statewide.[37]

Within the Southcoast Health hospital system, NAS discharges are on the decline both numerically and as a share of all births (see Table 11). Newborns with NAS accounted for 3.6 percent of all births in FY 21, compared to 5.4% in 2016. Fall River and New Bedford have the highest number of NAS infants among the region's communities, which is not surprising since these cities make up the majority of the region's population (see Figure 33).

Table 11. NAS Discharges Southcoast Hospitals as Share of All Births, FY16–FY21

Fiscal Year	All Births	NAS Discharges	NAS Share
2016	3,314	178	5.4%
2017	3,385	169	5.0%
2018	3,267	151	4.6%
2019	3,352	133	4.0%
2020	3,209	129	4.0%
2021	3,179	116	3.6%

Figure 33. Number of NAS Infants by Communities, FY21



Source: Southcoast Health

Substance Use Disorder and Behavioral Health

Health and social service providers increasingly report seeing patients with a dual diagnosis, that is, individuals who experience a substance use issue along with a mental health issue. They note the difficulty in treating patients effectively if these issues are not addressed simultaneously. This often results from an individual with a mental health issue self-medicating with alcohol or drugs in an effort to improve their mental health symptoms. However, some community members commented that there is a lack of awareness in the community of what mental health services are available in the region and where, how to get a referral for treatment, and what insurance will and will not cover.

This patient population presents a new set of challenges to health care systems, which are often not equipped to effectively care for these patients in terms of both adequate staff training and the health care settings themselves.

[37] Source: Massachusetts Department of Public Health Neonatal Abstinence Syndrome Dashboard. The Southeast region includes the counties of Bristol, Plymouth, Dukes, Barnstable, and Nantucket.

This patient population is also prone to chronic medical conditions due to, and exacerbated by, the chronic neglect of self-care such as COPD, lung cancer, hepatitis, malnutrition, Type 2 diabetes, obesity, and cancer.

Patients with comorbid behavioral health conditions are also at higher than average risk of readmission. For example, hospitalized patients in Fall River and New Bedford with any behavioral health comorbidity were more than twice as likely to be readmitted than those without a behavioral health condition. Those with a co-occurring mental and substance use disorder were nearly three times as likely to be readmitted (see **Table 12**).[38]

Table 12. Prevalence of Behavioral Health Comorbidity and Readmission Rates Among Patients in Acute Care Hospitals, FY 2018

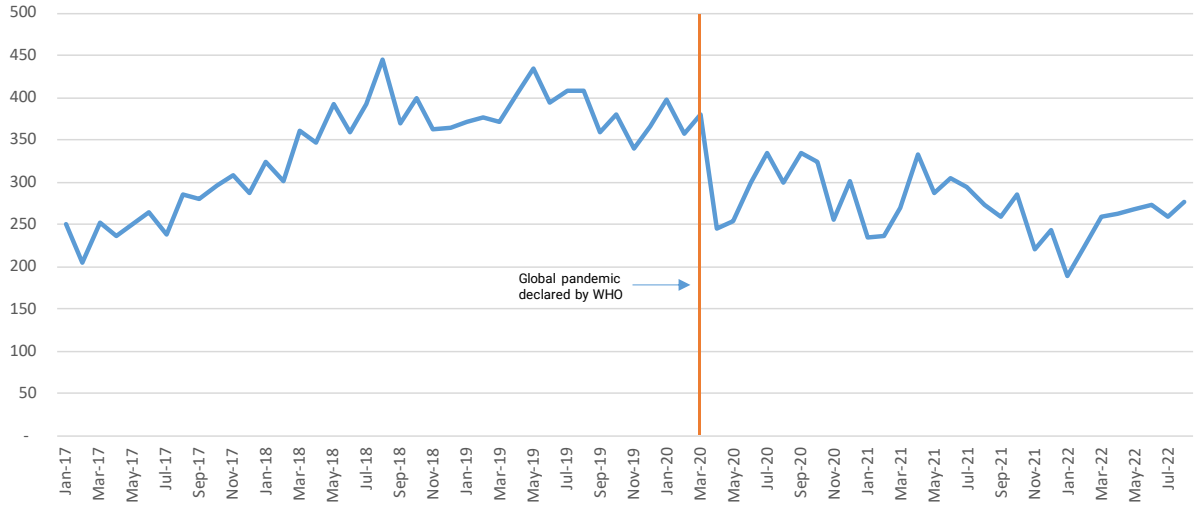
	No BH Condition	Any BH Condition	MD Alone	SUD Alone	COD Mental/SUD
Fall River	10.6%	22.8%	20.4%	16.6%	29.8%
New Bedford	12.3%	21.6%	19.9%	15.6%	28.5%
Massachusetts	10.5%	20.4%	18.0%	15.2%	26.8%

Source: Health Policy Commission Analysis of CHIA Hospital Inpatient Discharge Databases, July 2017-June 2018
Analysis by Massachusetts CHIA. Analyses include discharges for adults with any payer, excluding discharges for obstetric.
BH=Behavioral Health, MD=Mental disorders, SUD=Substance use disorders, COD=Co-occurring mental/substance use disorders.

SOUTHCOAST BEHAVIORAL HEALTH

Southcoast Behavioral Health is a 120-bed psychiatric hospital that offers inpatient treatment for patients with diagnosed mental illness from Fall River, Dartmouth, New Bedford, and Wareham. The number of inpatient admissions at Southcoast Behavioral Health declined 37.9% between the high in August 2018 and August 2022 (the most recent month available). Admissions have declined 27.1% since the pandemic officially began in March 2020, although admissions began to rebound in March 2022 as the Omicron variant began to subside (see **Figure 34**).

Figure 34. Southcoast Behavioral Health Inpatient Admissions, January 2017—August 2022



Source: Southcoast Behavioral Health

[38] Behavioral Health & Readmissions in Massachusetts Acute Care Hospitals. August 2016. Center for Health Information and Analysis (CHIA).

Youth Alcohol and Drug Use

Using drugs and alcohol at any age presents health risks; however, using these substances at a younger age can cause more severe negative health outcomes. While comprehensive local data on youth alcohol and drug use is limited, data from the Durfee High School and New Bedford high school *Youth Risk Behavior Survey* show that 20% of Durfee students and 23% of New Bedford High students reported that they consumed alcohol within a month of taking the survey. In terms of lifetime prevalence, 35% and 36% reported they tried marijuana respectively, while 35% of Durfee students and 27% of New Bedford High students vaped (see Table 13).

Table 13. Alcohol and Drug High School Students, 2019

Substance	Fall River	New Bedford
Alcohol (past 30 days)	20%	23%
Marijuana (lifetime prevalence)	35%	36%
Vaping (lifetime prevalence)	35%	27%

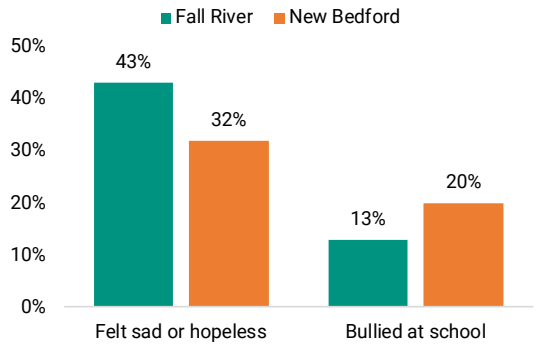
Source: Durfee High School and New Bedford High School Youth Risk Behavioral Survey, 2019

Youth Trauma

Youth trauma is a pervasive and significant public health issue. Trauma during childhood is associated with a range of physical health and emotional problems and these traumatic experiences often have serious health and social consequences into adulthood.[39] Both HHSP survey respondents and community survey respondents selected the "effects of trauma, neglect, abuse on children" as the second most concerning health and societal condition among the individuals and groups they serve (84% are "extremely concerned"). Many community leaders noted that COVID-19 exacerbated the negative mental health trends among youth and that the "where it stops is anyone's guess." Another commented," "The youth population is the most vulnerable. In our society we tend to do a lot for the elderly. The kids often fall through the cracks and then it's too late."

Apart from anecdotal evidence, comprehensive local data related to youth trauma is lacking. However, data from the Durfee High School (Fall River) Youth Behavioral Risk Factor Survey show that, in the 2019 school year, 43% of Durfee students and 32% of New Bedford students reported that during the past 12 months, they felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities. Another 13% of Durfee students and 20% of New Bedford High students reported that they were bullied at school during the past twelve months. This survey was administered pre-pandemic and mental health issues may have grown more acute since then (see Figure 35).

Figure 35.Did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities? (past 12 months)



Source: Durfee High School and New Bedford High School Youth Risk Behavioral Survey, 2019

[39] Substance Abuse and Mental Health Services Administration. 2018. *National Children's Mental Health Awareness Day Brief.* See: https://www.samhsa.gov/sites/default/files/brief_report_natl_childrens_mh_awareness_day.pdf. Accessed October 15, 2021.

7 PRIORITY HEALTH ISSUE 3: HOUSING

Housing affordability is a social determinant of health. A lack of affordable housing contributes to housing instability and homelessness, both of which are strong predictors of poor health outcomes. Housing emerged as a primary issue of concern for community leaders and community members throughout the needs assessment process, with many stakeholders consistently identifying housing as the social determinant that affects the largest number of the people they serve. Eighty-nine percent of respondents to the HHSP survey cited access to affordable housing as the top concern for the community they serve, followed by homelessness at 62%. Overall, stakeholders are clear that housing challenges have been made worse by COVID-19, although the pandemic primarily worsened existing housing issues.

The housing issue in the South Coast is primarily twofold: the focus in the region's cities is primarily on rising rents and the implications on the working poor and people on fixed incomes. Conversely, the issue in many of the area's suburban communities is focused on the significant increase in single-family home prices. This dynamic is creating issues for seniors who want to remain in their homes but who are "house rich, cash poor" and for younger families who leave the region because they cannot afford homes in the area.

Key takeaways:

- Income and wage levels in the region are significantly lower than most of Massachusetts, so while rents are relatively inexpensive for outsiders and commuters to Greater Boston or Providence, they remain considerably high for many local residents, particularly among the working poor who generally do not qualify for housing subsidies.
- This dynamic results in many households paying housing costs that are above their means, which in turn leaves less household income available for health care and other basic needs. During the 2016–2020 period, 46.5% of renters and 30.5% of homeowners in the South Coast were housing cost burdened.
- Housing insecurity disproportionately affects low-income households, people of color, and seniors. This trend is evident in Fall River and New Bedford, where White households are less likely to be housing-cost burdened in comparison to their neighbors.
- Stakeholders point to a variety of causes behind the increasing rents in the region. A confluence of improving economic conditions, the arrival of Southcoast Rail, renters being priced out of the Greater Boston market and moving south, and older homeowners selling out to investors suggests that landlords are increasingly able to raise rents.
- Community leaders identified homelessness as a significant issue in the region, which is partly an outcome of the affordable housing shortage. Mental health and substance abuse disorder, which are highly prevalent among the homeless population, are also key factors in the homelessness equation.
- There were 361 homeless individuals in Fall River and 370 in New Bedford counted during the 2022 PIT Count, with the vast majority housed in emergency shelters.
- The homeless population in New Bedford is about the same as it was in 2007, while the homeless population in Fall River more than doubled over the 2007-2021 period.
- Community leaders note that the use of the emergency department by homeless individuals is often their primary means of accessing health care.

Housing Affordability

People put down roots in a community when they buy a home, which improves neighborhood stability and people's sense of personal well-being. A home is also the single most valuable economic asset owned by most families and is one of the top ways to accrue wealth. Homeowners also have a greater stake in the local community, which leads to increased voting and higher rates of participation in community organizations.

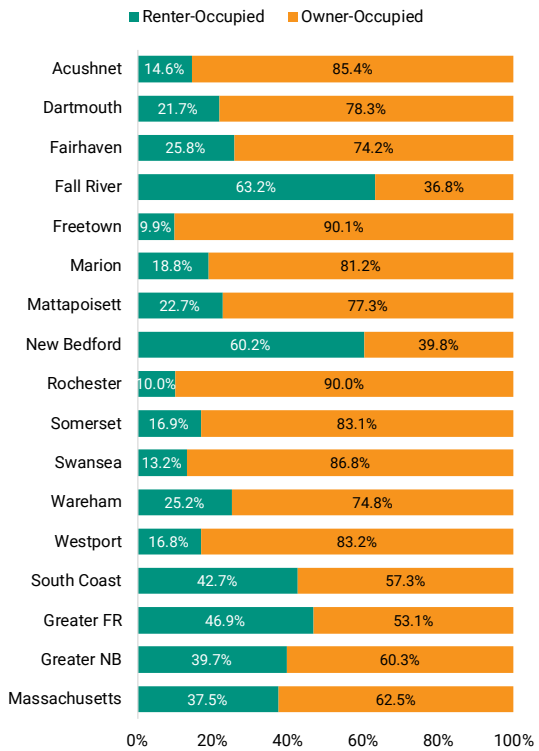
City Residents Are Primarily Renters, While Suburbanites are Homeowners

The majority of housing units in Fall River and New Bedford are renter-occupied, while the region's suburban communities are primarily owner-occupied (see Figure 36). Accordingly, affordability issues in the cities are primarily related to rising rents, while the suburbs are primarily related to homeownership. A community member commented that many of the region's seniors on fixed incomes are "house rich, cash poor," meaning that they have more equity locked in their home than cash assets.

While many seniors would like to remain in their homes, balancing the upkeep of their home, paying on increasing tax bill, and balancing health care costs and other basic needs is putting stress on many seniors. One community member stated that, "Seniors want to stay in their homes, but often times the upkeep and taxes force them to sell or to go without some of the basic necessities."

Stakeholders also noted that there are few housing options in the region for seniors who would like to downsize, so they remain in their homes even though their "homes are more than what they need in terms of the size, the cost, and the headaches." This lack of churn affects younger potential homebuyers by restricting supply. As one community leader noted, "I live in Dartmouth, and I always thought my kids would stay in the area … but now I don't think they can afford to." For families who are renting, the high cost of single-family homes does not often permit the natural transition of renters eventually purchasing homes in the region as their economic situations improve. This leads to many of the region's young and talented individuals and families leaving for places with lower housing costs.

Figure 36. Percentage of Owner-Occupied and Renter-Occupied Housing



Source: ACS 5-Year Estimates, Table DP04, 2016–2020

Rents in the South Coast Are Rising Sharply, Wages are Stagnant

Housing affordability is an issue nationwide and one that Massachusetts has been grappling with for some time. The issue encompasses a confluence of factors, but the dynamics of the South Coast rental housing market create unique issues. For example, while key informants noted that rents in Fall River and New Bedford are rising rapidly, they remain a relative bargain compared to the rents in Greater Boston. However, income and wage levels in the

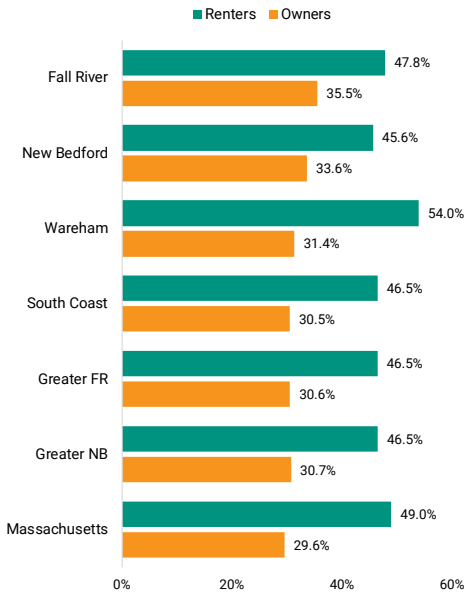
region are significantly lower than most of Massachusetts, so while rents are relatively inexpensive for outsiders and commuters to Greater Boston or Providence, they remain considerably high for many local residents, particularly among the working poor who generally do not qualify for housing subsidies.

This dynamic results in many households paying housing costs (rent or mortgage payments) that are above their means, which in turn leaves less household income available for health care and other basic needs. As one community member noted, "Rents in the private market are getting so expensive. I'm not sure what the immediate answer is because housing is not like other products you can manufacture in short period of time. Even a modest rental project can take years. Another noted, "The cost of housing is just unbelievable … I don't know how people can afford these things"

As housing costs rise faster than income, households must increasingly rent or buy above their means. During the 2016–2020 period, 46.5% of renters and 30.5% of homeowners in the South Coast were housing cost burdened (see Figure 37).[40] These figures are slightly higher for Fall River and New Bedford, while more than 54.0% of renter households in Wareham are burdened. One community leader in Wareham noted, "Especially with Wareham, the growing tourism economy and number of units transitioning to short-term rental for vacationers is driving away people who can no longer afford the rentals that remain."

The number of housing cost burdened households is likely to increase if current trends persist. Comments from two community leaders noted that some households are "doubling or even tripling up" with other family or friends to ease the housing burden, while other households have no choice but to rent in less desirable areas or to rent substandard housing that is not conducive to healthy living.

Figure 37. Housing Cost Burdened Households in Selected Areas, 2020



Source: ACS 5-Year Estimates, Table DP04, 2016–2020

Stakeholders pointed to a variety of causes behind the increasing rents in the region. A confluence of improving economic conditions, the arrival of Southcoast Rail, renters being priced out of the Greater Boston market and moving south, and older homeowners selling out to investors suggests that landlords are increasingly able to raise rents. One community member lamented," "It all comes down to supply. There's just not enough rental housing available for the people that need it most."

Key informants also noted that some owners are cashing out due to the improving housing market, with new owners immediately raising the rent, often significantly. In addition, many landlords are requiring tenants to bear upfront rental costs, including first, last, and security deposit, application fees, and CORI check fees.[41] Landlords

[40] The U.S. Department of Housing and Urban Development defines cost-burdened families as those "who pay more than 30 percent of their income for housing" and "may have difficulty affording necessities such as food, clothing, transportation, and medical care."

[41] It should be noted that in Massachusetts, it is illegal for landlords to charge for anything other than first and last month's rent, security, and changing locks.

are also performing credit checks and pulling eviction history records on prospective tenants.[42] As one key informant noted, "Even those who are fairly well off don't have that kind of upfront cash. Even if they do, the landlords have all the leverage." Another stakeholder points out that those who are evicted will have a difficult time renting in the future due to their eviction history, even if their economic outlook improves.

Clearly, the supply of affordable rental units in Fall River and New Bedford is not increasing appreciably; while some modest new projects are slated to be completed soon, community leaders note that this supply is offset by units that are taken off the market by landlords who reside in their multi-family home and "just don't want the headache of having renters living above them." Or, as another noted, "What were once relatively affordable units are being converted in condos or gutted and renovated to attract a more upscale clientele." Importantly, as one community leader points out, "Fall River and New Bedford are doing more than their share in providing housing for working-class residents. Some of the onus has to be placed on the region's suburban communities to do their share as well."

Fair Market Rents versus Market Rents

Stakeholders note that current economic realities have led landlords to "take their chances" by transitioning from accepting Section 8 vouchers to renting at market rate. In the past, landlords were likely to receive higher "fair market rents" from Section 8 than they would at market rates, but the gap is narrowing, if not already closed.[43] Moving from fair market rents to market rents means that landlords can command higher rents while not having to deal with the red tape required for subsidized housing rentals. Refusing to rent to voucher holders is an illegal practice in Massachusetts[44] and it is not the only form of housing discrimination reported by stakeholders. For example, a community member noted that some property owners discriminate against the recovery population and that raising the rent is a means to evict tenants.

Landlords, on the other hand, cannot on the whole be blamed for acting in their economic self-interest, especially since the tax, utility, mortgage, insurance, and other expenses need to be paid. In many cases, it is likely that some local landlords have experienced negative economic consequences during the pandemic, including paying legal fees. One property owner noted that, "the costs of increased taxes and utilities, either because the tax rate has increased and/or the valuation of their property has increased," makes rising rents inevitable.

In the end, however, renters increasingly struggle to find affordable housing, and these challenges are likely to grow, particularly for those on fixed incomes or working low-wage jobs. Many of these individuals and families are long-time South Coast residents who are caught up in a rental market that offers few options and seriously challenges their ability to live in the region where they have resided their entire lives. As one service provider noted, "Where else are my clients supposed to go?"

[42] Evictions court records are public and free in Massachusetts.

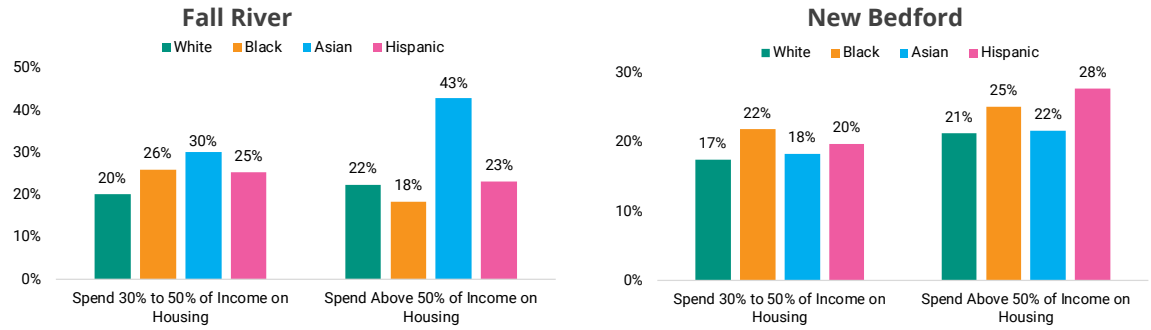
[43] HUD uses Fair Market Rents to determine payment standard amounts for Housing Choice Vouchers (Section 8). They are estimated as the "40th percentile gross rents for standard quality units within a metropolitan area or nonmetropolitan county." Because HUD incorporates Fall River in the Providence-Warwick Metro Area, some have argued in the past that the FMRs for the city are artificially high, allowing a landlord to get more from a voucher tenant than what they would have been able to charge on the open market.

[44] See https://www.mass.gov/doc/source-of-income-discrimination-faqs/download

Housing Equity

Housing insecurity disproportionately affects low-income households, people of color, and seniors. This trend is evident in Fall River and New Bedford where White households are less likely to be burdened by housing costs than their neighbors (see Figure 38).[45] Notably, lower-income households are primarily renters, and this group is more likely to have experienced a job loss during the pandemic because they are more likely to work in the industries impacted the hardest by the pandemic, either because of layoffs or the inability to work remotely.

Figure 38. Housing Cost Burden by Race in Fall River



Source: HUD 2014-2018 CHAS (CHAS: https://www.huduser.gov/portal/datasets/cp.html)

Effects of COVID-19 on Housing

Housing was cited as one of the top issues in the 2019 CHNA and COVID-19 has simply exacerbated this issue. Ideally, households will have been supported throughout the pandemic through the state's rental assistance program, Rental Assistance for Families in Transition (RAFT). Additional assistance is also provided through the federal Emergency Solutions Grant (ESG) program, although each of these programs only meets a portion of the need. However, ESG can pay only six months of arrears. RAFT can be used to "fill in" a portion of the remainder, but only until the eviction moratorium lifts. Unfortunately, there is a significant backlog in the RAFT program and in any case, landlords were beginning the eviction process early knowing that the moratorium was coming to an end. In addition, stakeholders note that federal housing funds have strict guidelines and that "spending the COVID funds related to housing is difficult due to bureaucracy. Applications cannot be processed until all required information is provided. In many cases, households simply don't have the required information or have difficulty getting it."

One stakeholder cautioned that many households not currently paying their rent believe they will get rental relief once the eviction moratorium ends. However, the stakeholder pointed out that many of these people are not aware that they do not meet income guidelines and will be in for a "rude awakening" when they apply for relief. Another stakeholder was hopeful that current safety nets will help many residents in the near term, "although the long-term consequences are difficult to predict."

Homelessness

Community leaders identified homelessness as a significant issue in the region, which is partly an outcome of the affordable housing shortage. Mental health and substance abuse disorder, which are highly prevalent among the homeless population, are also key factors in the homelessness equation. Often, experiencing homelessness in combination with these issues creates challenges for entering shelters and transitional housing. Stakeholders noted that more resources and more people are needed to support and maintain consistent engagement with

[45] As noted earlier, a household is typically considered housing cost burdened if their housing costs exceed 30 percent of their income.

homeless individuals who are experiencing mental health or substance abuse issues. This includes having resources available in the shelters, such as recovery coaches.

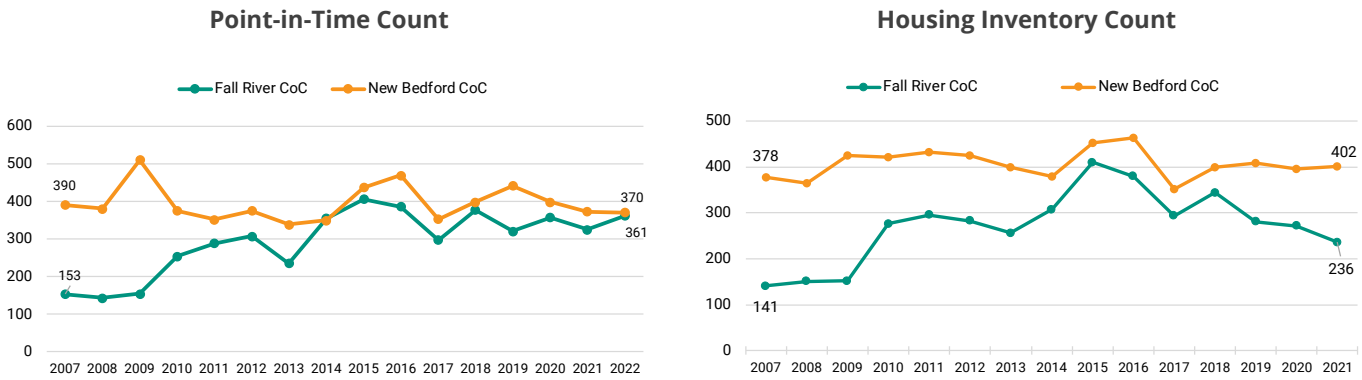
Stakeholders also noted that rapid rehousing is a key component of preventing individuals and families from becoming homeless. They suggested that the region could prevent an increase in the number of chronically homeless individuals by stabilizing people who were at-risk of becoming homeless. However, a community leader from Wareham noted that there are no shelters in Wareham and "there simply is not enough housing options for our homeless. We have organizations that do a good job assisting the homeless with finding housing, but the lack of a year-round shelter is a real impediment." Another provider noted that there is a lack of visiting nurses in Wareham to provide care to homeless veterans or veterans who cannot live on their own.

Point-in-Time and Housing Inventory Count

The U.S. Department of Housing and Urban Development's (HUD) Point-in-Time (PIT) Count is a count of sheltered and unsheltered homeless persons on a single night in January in a given service area, called a Continuum of Care (CoC).[46] Fall River and New Bedford are their own single-community CoC. The Housing Inventory Count (HIC) is an inventory of the number of beds and units available at a defined point during the last ten days in January. HIC include beds dedicated to serve persons who are homeless as well as persons in Permanent Supportive Housing.

There were 361 homeless individuals in Fall River and 370 in New Bedford counted during the 2022 PIT Count, with the vast majority housed in emergency shelters (see **Figure 39**).[47] The homeless population in New Bedford is about the same as it was in 2007, while the homeless population in Fall River more than doubled over the 2007-2021 period. The number of beds increased by 95 in Fall River and 24 in New Bedford from 2007-2021.[48] Importantly, the PIT count provides a snapshot of homelessness on one night of the year and does not necessarily reflect the nuances of the homelessness issue throughout the year. In addition, a community leader noted that the number of homeless is artificially lower than the actual number of residents having housing issues because of the number of persons and families that are doubling and tripling up.

Figure 39. Fall River and New Bedford Point-in-Time and Housing Inventory Count



Source: PIT, cities of Fall River and New Bedford; HIC, US Department of Housing and Urban Development

[46] The report notes that while the PIT counts can provide insight into homelessness in Fall River, it is important to recognize the limitations and variations of each count, including weather conditions, volunteer capacity, and statistical relevance.

[47] An emergency shelter is typically defined as temporary shelter for the general homeless population or specific subpopulation, such as women with children.

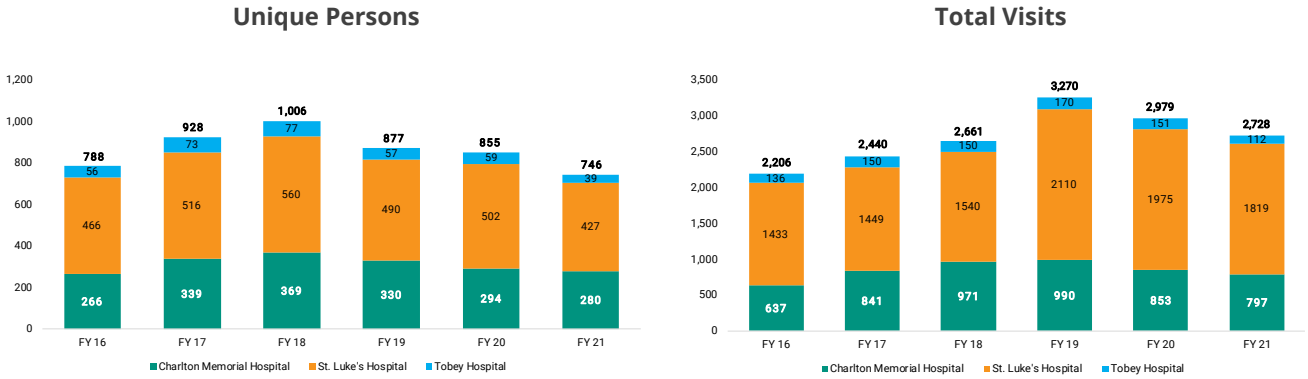
[48] HIC data for 2022 is not available.

Homeless Patients' Emergency Room Utilization

Community leaders note that the use of the emergency department by homeless individuals is often their primary means of accessing health care. In doing so, community leaders point out that the homeless only engage with the healthcare system when they are experiencing a health crisis. Thus, not only is there concern that these individuals do not receive preventive care, but also that they do not receive adequate follow-up on their health issues.

In fact, while the number of unique patients treated at Southcoast Health emergency departments decreased by 5.3% from FY16 to FY21, the number of visits by these patients increased by 23.7% over this period. In FY 21 alone, Southcoast Health treated 746 unique homeless patients who made a total of 2,979 visits to the ER (see **Figure 40**). Over thirty-eight percent (38.5%) of visits by homeless patients to one of Southcoast's emergency rooms in FY21 were related to either a psychiatric evaluation, a drug or alcohol assessment, or alcohol intoxication (see **Figure 40**).

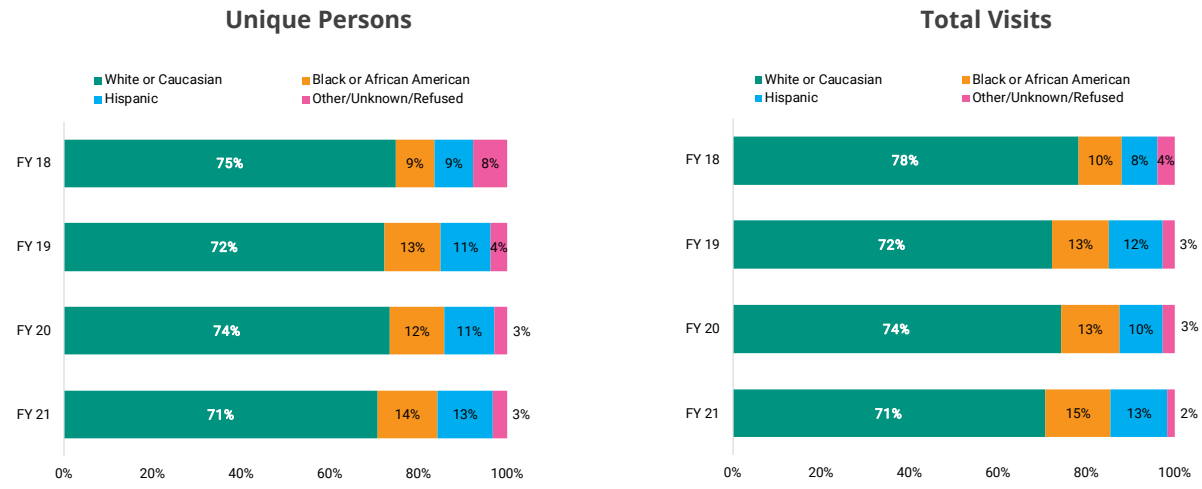
Figure 40. Total Emergency Department Unique Homeless Patient Count by Hospital, FY16–FY21



Source: Southcoast Health

Most homeless patients who visited a Southcoast health ER are White, which is not surprising considering that a majority of persons in the region identify as White, Non-Hispanic. However, the percentage of homeless persons who identify as African American or Hispanic has increased since FY18, albeit modestly (see **Figure 41**).

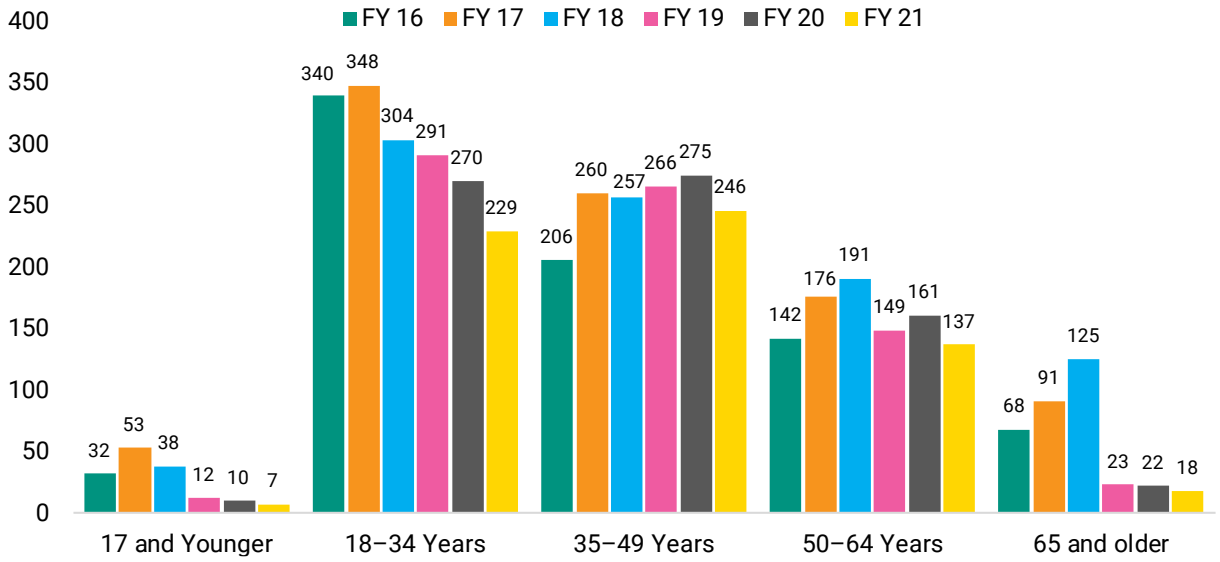
Figure 41. Total Emergency Department Unique Homeless Patient Count by Hospital By Race, FY18-FY21



Source: Southcoast Health

Most ED visits among the homeless are from persons in the 18–34 and 35–49 age range. However, the number of homeless persons in the 18–34 age cohort declined from FY16-FY21, while the number of homeless persons in the 35–49 age cohort increased over this period (see **Figure 42**).

Figure 42. Total Emergency Department Homeless Visits by Age Range, 2016–2018



Source: Southcoast Health

8 Priority Health Issue 4: Health and Wellness

As demonstrated in Section 3, there are areas of the South Coast that exhibit socioeconomic inequities. Comments gleaned from interviews and surveys highlight the day-to-day challenges faced by residents. For many, health and wellness fit within a larger framework of obligations, ranging from issues such as housing, finances, and childcare, to transportation, employment, immigration, and safety. These responsibilities create obstacles to maintaining overall health and to adopting healthy habits that help to prevent or manage disease. Health and social service providers are particularly concerned that many South Coast residents do not regularly engage in the health care system, particularly in terms of primary care and preventive care.

Consequently, it is not surprising that the following health outcomes related to wellness and chronic disease are generally poor when compared to state and national averages. Indeed, turning these health trends around will require more than just offering treatment and preventive care; it will also require addressing the social environment that contributes to health inequities. As one stakeholder noted, "It is difficult to change people's behaviors that they grew up with." Another noted, "We need more folks trained in educating people and coaching people on how to make lifestyle changes before they get sick. Those options are not available, and people are frustrated and getting sicker."

Key takeaways:

- Smoking prevalence in Fall River remains stubbornly high; 23.2% in Fall River and 22.4% in New Bedford, compared to 12.0% in Massachusetts and 16.0% for the country as a whole.
- While substance use disorder continues to rank as one of the top health priorities, stakeholders caution that alcohol abuse is also a significant issue; 69% of HSSP survey respondents rate alcohol use disorder as an "extremely concerning" issue.
- Several interviewees lamented the lack of nutrition education in the schools. Further, there is a disconnect regarding perceptions of nutrition between community members and health providers; only 18% of community survey respondents reported poor nutrition and eating habits as one of the top five health concerns, while 57% of HHSP survey respondents are "extremely concerned" about nutrition.
- HHSP survey respondents rank food insecurity as the fourth most concerning issue among the community they serve (49%).
- Health providers caution that while educating residents on the importance of being healthy and ways in which to achieve good health, it is equally necessary to dismantle barriers that prevent many people from accessing the supports and resources necessary to be healthy.
- Overall mortality rates in both cities have remained relatively stable over the past twenty years, although with an increase in 2019 and 2020, with COVID-19 contributing to a large portion of deaths in 2020.
- Mortality rates related to cancer and heart disease in Fall River and New Bedford have declined since 2001, with heart disease dropping to the second leading cause of death starting in 2011-2015 in New Bedford. Fall River's heart disease death rate is still higher than the cancer rate, albeit slightly.
- Heart disease remains the leading cause of death for Black & Other, Non-Hispanic residents.
- Chronic liver disease and homicide are two causes of death in New Bedford that rank among Hispanic residents but do not appear among the top ten leading causes of death for White, Non-Hispanic, and Black & Other, Non-Hispanic residents for that city.

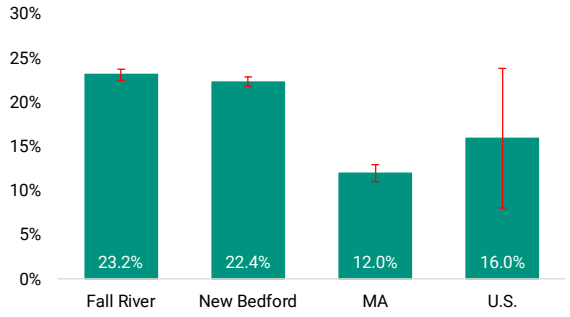
Unhealthy Behaviors

Simply put, unhealthy behaviors lead to poor health outcomes. Tobacco use, physical inactivity, and poor nutrition contribute to preventable chronic diseases such as diabetes, cancer, heart disease, and lung disease. While some chronic conditions are a result of behavior or genetics, social and environmental factors can also elevate the risk of contracting chronic diseases.

Smoking Prevalence

Smoking prevalence in Fall River (23.2%) and New Bedford (22.4%) are much higher than Massachusetts (12.0%) and the country as a whole (16.0%) (see Figure 43).[49] As one community leader noted, "Alcohol and cigarettes are issues that I feel we don't speak enough about," while another commented, "Cigarette addiction is a big problem for both our older and newer immigrant populations and these habits are the cause of a lot of poor health outcomes."

Figure 43. Self-Reported Smoking Prevalence, 2019

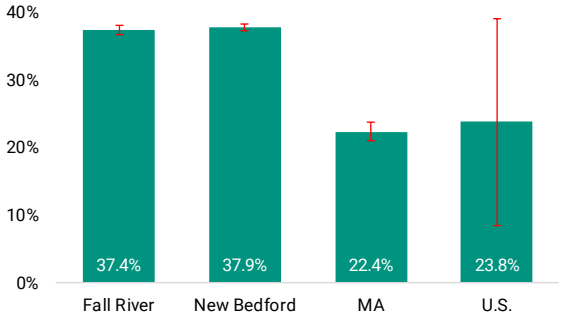


Source: Source: CDC PLACES Project, 2019 crude prevalence for adults 18+; Red bars represent confidence interval

Lack of Physical Activity

More than a third of adults in Fall River and New Bedford report that they are not physically active; 37.4% of Fall River adults and 37.9% of New Bedford adults report they have not engaged in any form of leisure time physical activity in the past month, which is greater than both the statewide (22.4%) and national percentages (23.8%) (see Figure 44).

Figure 44. Self-reported no leisure-time physical activity in past month, 2019



Source: Source: CDC PLACES Project, 2019 crude prevalence for adults 18+; Red bars represent confidence interval

[49] CDC PLACES project data provide city- and census tract-level small area estimates for chronic disease risk factors, health outcomes, and clinical preventive services use for the largest 500 cities in the US. Data by community is only available for Fall River and New Bedford.

Binge Drinking

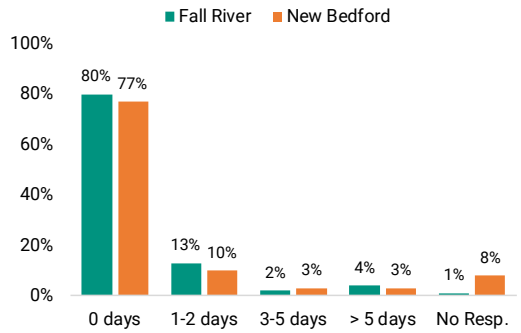
As noted earlier, stakeholders cautioned that the region's health and service providers must continue to focus on alcohol abuse; 69% of HSSP survey respondents rate alcohol use disorder as an "extremely concerning" issue. One survey respondent remarked, "People know they are not healthy, and they avoid going to the doctors because they know they have issues, such as alcoholism. They don't want to hear what the doctor has to say… to be told they need to stop drinking."

The percentage of adults in Fall River (17.8%) and New Bedford (17.4%) who report binge drinking is below the statewide percentage of 19.1%, although within the margin of error. Both these percentages are higher than the national prevalence (16.8%) (see Figure 45).[50] Results of the Youth Risk Behavior Survey show that 80% of Durfee students and 77% of New Bedford High students have not consumed alcohol in the last 30 days (see Figure 46).

Figure 45. Self-reported binge drinking prevalence among adults, 2019

Source: CDC PLACES Project, 2019 crude prevalence
Red bars represent confidence interval

Figure 46. During the past 30 days, how many days did you have at least one drink of alcohol?



Source: Durfee and New Bedford High Youth Risk Behavior Survey, School Year 2019

Nutrition

It is nearly impossible to maintain good health without a nutritious diet, even with abundant exercise. Stakeholders reiterated that nutrition is a key prevention mechanism to addressing many of the region's comparatively poor chronic health outcomes. Despite its importance, several interviewees lamented the lack of nutrition education in the schools, while others cited some of the obstacles that residents need to overcome to eat well. One interviewee noted, "The cost of eating healthy is an issue. Many community residents have a fixed income, so they sometimes have to get unhealthier food because of cost. Fast food is cheap and accessible."

There is certainly a disconnect regarding perceptions of nutrition between community members and health providers; only 18% of community survey respondents reported poor nutrition and eating habits as one of the top five health concerns, while 57% of H&HSP survey respondents are "extremely concerned" with poor nutrition and eating habits in the community they serve.

COVID-19 exacerbated issues related to nutrition, although the region responded by expanding food pantries, making home deliveries, connecting farmers with food pantries, and expanding farmers markets. Despite these efforts, some stakeholders cautioned that simply feeding residents is not sufficient; the quality and types of foods being offered should be addressed. For example, one survey comment noted that not all households have a

[50] Binge drinking, defined by the CDC as drinking five or more drinks on an occasion for adult men or four or more drinks on an occasion for adult women.

stove to prepare meals and "some immigrant households don't know how to prepare the food we give them or have diets that are very different from what we offer." However, one community leader noted that, "The sad part is people in the city would rather get pastries and bread. I've brought salads and try to push salads, but some people don't like it." Nutrition is discussed further in the Food Insecurity section.

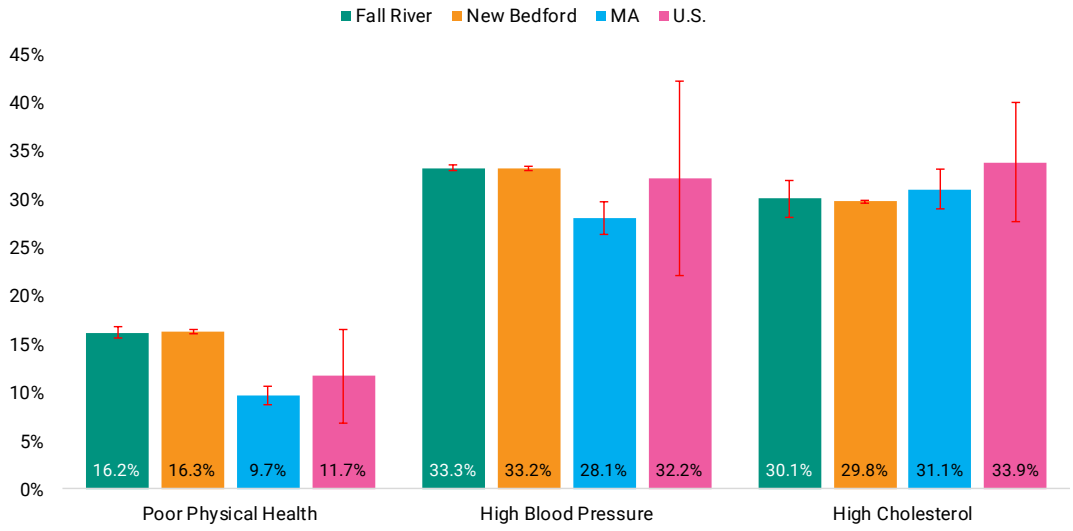
Health Outcomes

Unhealthy behaviors lead to poor health outcomes. It is therefore not surprising that comparatively high smoking prevalence, lack of exercise, binge drinking, and poor nutrition among South Coast residents have led to relatively poor health outcomes. Health providers caution that while educating residents on the importance of being healthy and ways to achieve good health, it is equally necessary to dismantle barriers that prevent many people from accessing the supports and resources necessary to be healthy.

Health Conditions

With a higher percentage of Fall River and New Bedford residents who smoke and are less physically active, it is not surprising that a higher percentage of these residents report having more than fourteen days per year with poor physical health in comparison to the state and national average. The percentage reporting high blood pressure is also higher than the state and national averages, while the percentage reporting high cholesterol is lower, although these results are within the margin of error (see Figure 47).

Figure 47. Self-Reported Health Conditions, 2019



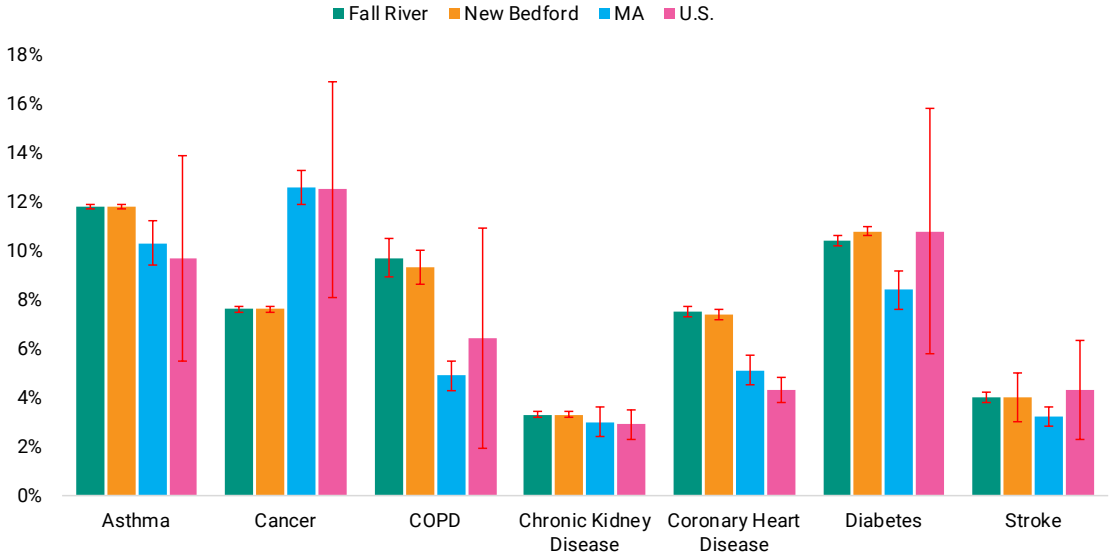
Source: CDC PLACES Project, 2019 crude prevalence. Red bars represent confidence interval

Disease Prevalence

Figure 48 compares disease prevalence for six types of diseases. In nearly each instance, the disease prevalence is higher for Fall River and New Bedford in comparison to the state and national averages.[51] Most notably, the percentage of Fall River residents who report chronic obstructive pulmonary disease (9.7%) is nearly double that of the state (4.9%).[52] Referring to the level of disease in the South Coast, one survey respondent noted that "Our numbers are just terrible across the board."

Higher disease prevalence can be linked to many of the unhealthy behaviors presented in the previous sections, including higher prevalence of smoking, poor nutrition, lack of exercise, and environmental factors. Given what we understand about the social determinants of health, it is not unexpected that socioeconomic inequities have resulted in a higher prevalence of chronic diseases in the region relative to the state and the nation. Again, these disparities speak not only to the need for preventive care and treatment of chronic diseases, but also the need to address the social determinants that contribute to health inequities in the region.

Figure 48. Self-Reported Disease Prevalence, 2019



Source: CDC PLACES Project, 2019 crude prevalence. Red bars represent confidence interval

Adult Obesity

Obesity is closely related to many other chronic diseases such as heart disease, type 2 diabetes, hypertension, and some cancers.[53] Obesity rates are on the rise; the CDC estimates that from 1999–2000 through 2017–March 2020, US obesity prevalence increased from 30.5% to 41.9%. During the same time, the prevalence of severe obesity increased from 4.7% to 9.2%.[54] Obesity affects some groups more than others; for example, non-Hispanic Black adults (49.6%) had the highest age-adjusted prevalence of obesity, followed by Hispanic adults (44.8%), non-

[51] Data for Somerset, Swansea, and Westport is not available. Note that in some instances the differences are within the margin of error.

[52] This dataset is available for the state and nation for 2019, but not individual communities.

[53] The American Medical Association designated obesity a disease in 2013.

[54] https://www.cdc.gov/nchs/nhanes/index.htm

Hispanic White adults (42.2%) and non-Hispanic Asian adults (17.4%). Alarmingly, the CDC estimates that 78.0% of people hospitalized for COVID-19 were overweight or obese.[55]

Self-reported obesity prevalence in Fall River and New Bedford are higher than the statewide and national averages (33.7%, 34.4%, 25.2%, and 32.4% respectively) (see Figure 49). Twenty-nine percent (29%) of community survey respondents reported obesity/overweight as one of the top five health concerns in the region, while 44% of H&HSP survey respondents are "extremely concerned" with obesity issues in the community they serve.

Figure 49. Self-reported obesity among adults, 2019

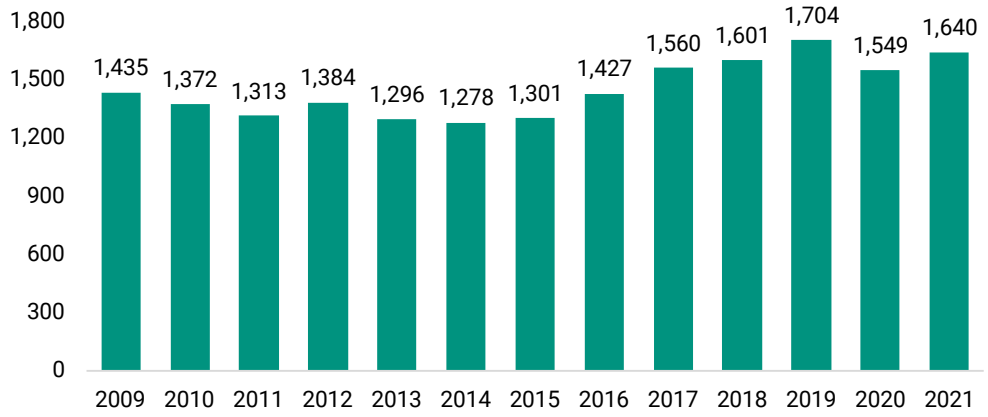
Source: CDC PLACES Project, 2019 crude prevalence
Red bars represent confidence interval

Cancer Prevalence

According to the American Cancer Society, forty-two percent of all cancers in the United States could be prevented through healthy lifestyle choices, which include avoiding smoking, cutting out high fats, and increasing physical activity. They also suggest that many types of cancer, particularly colorectal and cervical cancers, could be successfully treated if caught early through regular screenings. Over thirty seven percent (37.7%) of community survey respondents rated cancer as a top-five issue of concern in the region.

Data from Southcoast Heath reveals an increase in annual diagnoses from 2009 to 2021 among its patients (+205 cases), although this is below the high of 1,704 in 2019 (see Figure 50). However, without more analysis, it is not possible to know whether this is the result of more occurrences of cancer among the population served by Southcoast Health, the availability of better and more frequent screenings, or more people choosing Southcoast Health as their care provider.

Figure 50. Total New Cancer Diagnoses among Southcoast Health Patients, 2009–2021

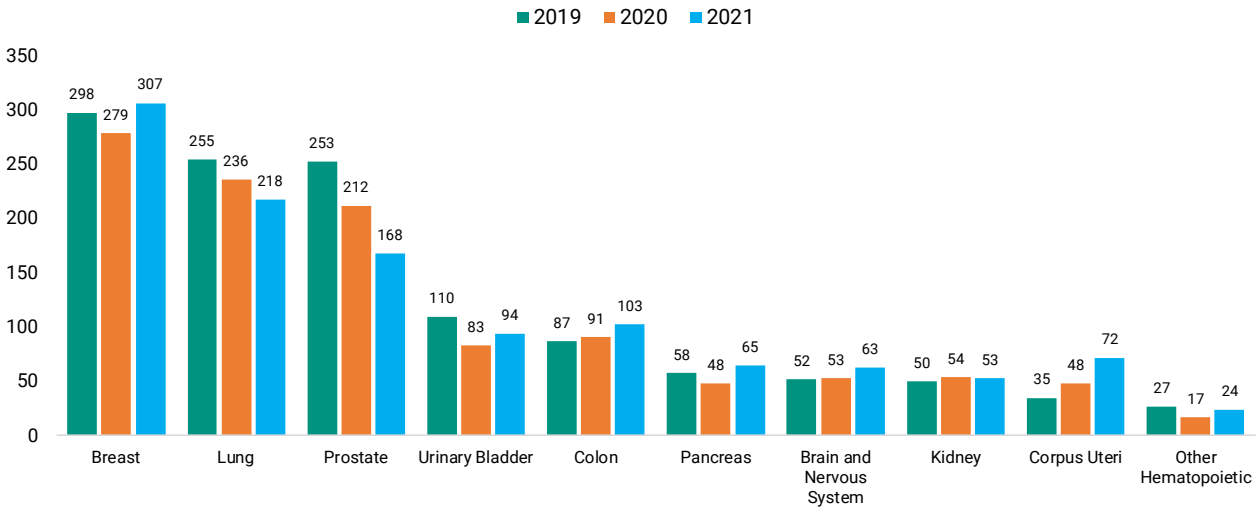


Source: Southcoast Health

[55] Kompaniyets L, Goodman AB, Belay B, et al. Body Mass Index and Risk for COVID-19–Related Hospitalization, Intensive Care Unit Admission, Invasive Mechanical Ventilation, and Death — United States, March–December 2020. MMWR Morb Mortal Wkly Rep 2021;70:355–361. DOI: http://dx.doi.org/10.15585/mmwr.mm7010e4external icon.

In terms of Southcoast Health's patient population, breast cancer was the most prevalent form of cancer in 2021, followed by lung and prostate (see Figure 51). This is generally in line with national averages.

Figure 51. Top Prevalent Cancers among Southcoast Patients, 2019 – 2021



Source: Southcoast Health

Neonatal Health Outcomes

Women who have access to adequate health resources and health information are more likely to have healthy infants and be able to successfully care for their children immediately following birth as well as later on in their child's life. Levels of neonatal care and neonatal outcomes are less favorable in Fall River and New Bedford in comparison to Massachusetts as a whole (see Table 14).

- The percentage of mothers receiving adequate prenatal care is about the same in Fall River (80.4%) in comparison to the statewide average (80.5%), but lower in New Bedford (79.8%)
- The percentage of babies born with a low birth weight is higher in Fall River (8.3%) and New Bedford (9.9%) in comparison to the statewide average (7.5%).
- The prevalence of gestational diabetes in Fall River (9.8%) and New Bedford (9.9%) is higher than the statewide average (6.5%), and these percentages have increased since 2010.

Table 14. Neonatal outcomes, 2010–2019

	Adequate Prenatal Care		Low Birthweight (<2,500 g)		Gestational Diabetes	
	2010	2019	2010	2019	2010	2019
Fall River	86.4%	80.4%	8.8%	8.3%	7.5%	9.8%
New Bedford	86.8%	79.8%	7.6%	9.9%	4.9%	9.9%
Massachusetts	81.1%	80.5%	7.8%	7.5%	4.7%	6.5%

Source: Massachusetts Birth Report

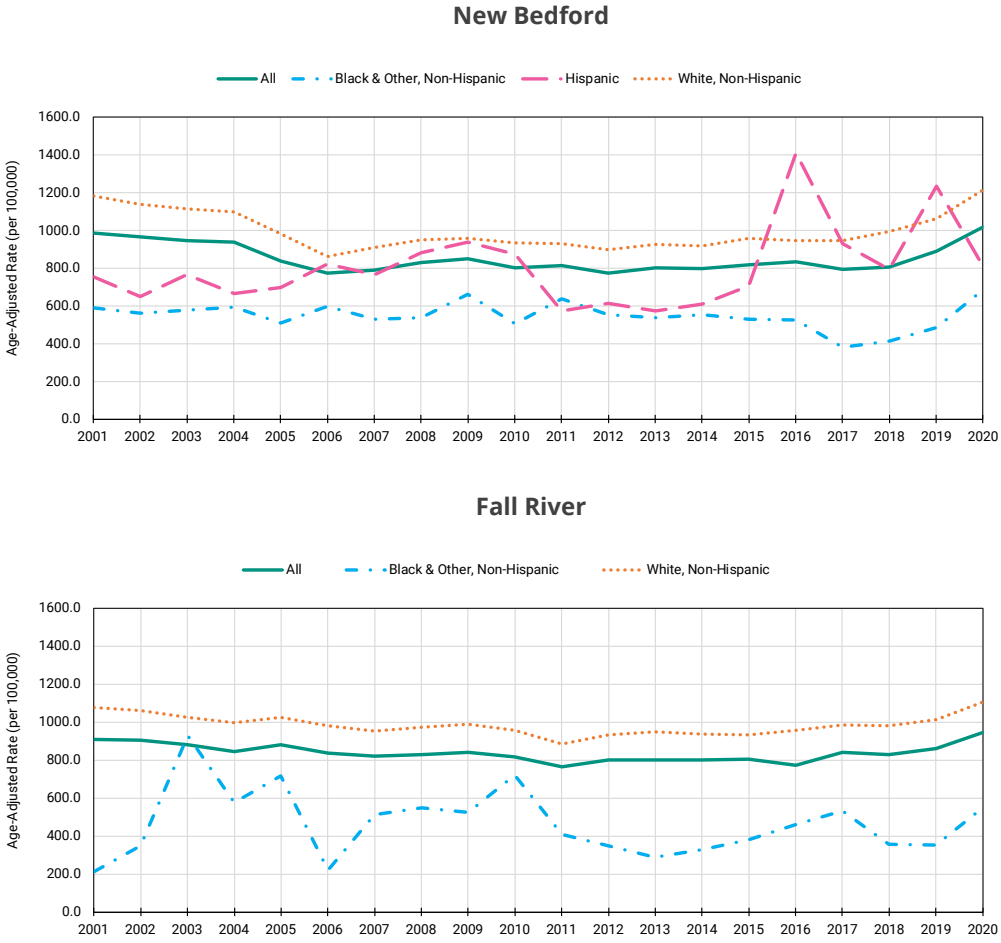
A 20-Year Review of Mortality Rates Among New Bedford and Fall River Residents

The New Bedford and Fall River Health Departments produced the following mortality analysis by examining twenty years of death records for New Bedford and Fall River residents. Data were obtained from the Massachusetts Department of Public Health's Registry of Vital Records and Statistics.

Age-adjusted Mortality Rate By Race/Ethnicity

Mortality rates overall in both cities have remained relatively stable over the past twenty years, although with an increase in 2019 and 2020, with COVID-19 contributing to a large portion of deaths in 2020 (see Figure 52). The mortality rate among white, non-Hispanic residents closely mirrors that of the overall rate as they represent the vast majority of deaths. The Hispanic and Black & Other, Non-Hispanic residents represent a smaller proportion of deaths, making their mortality rates subject to more variability overtime.[56]

Figure 52. Leading Causes of Death and Age-Adjusted Rates[1] by Race/Ethnicity[2]: 2001– 2020



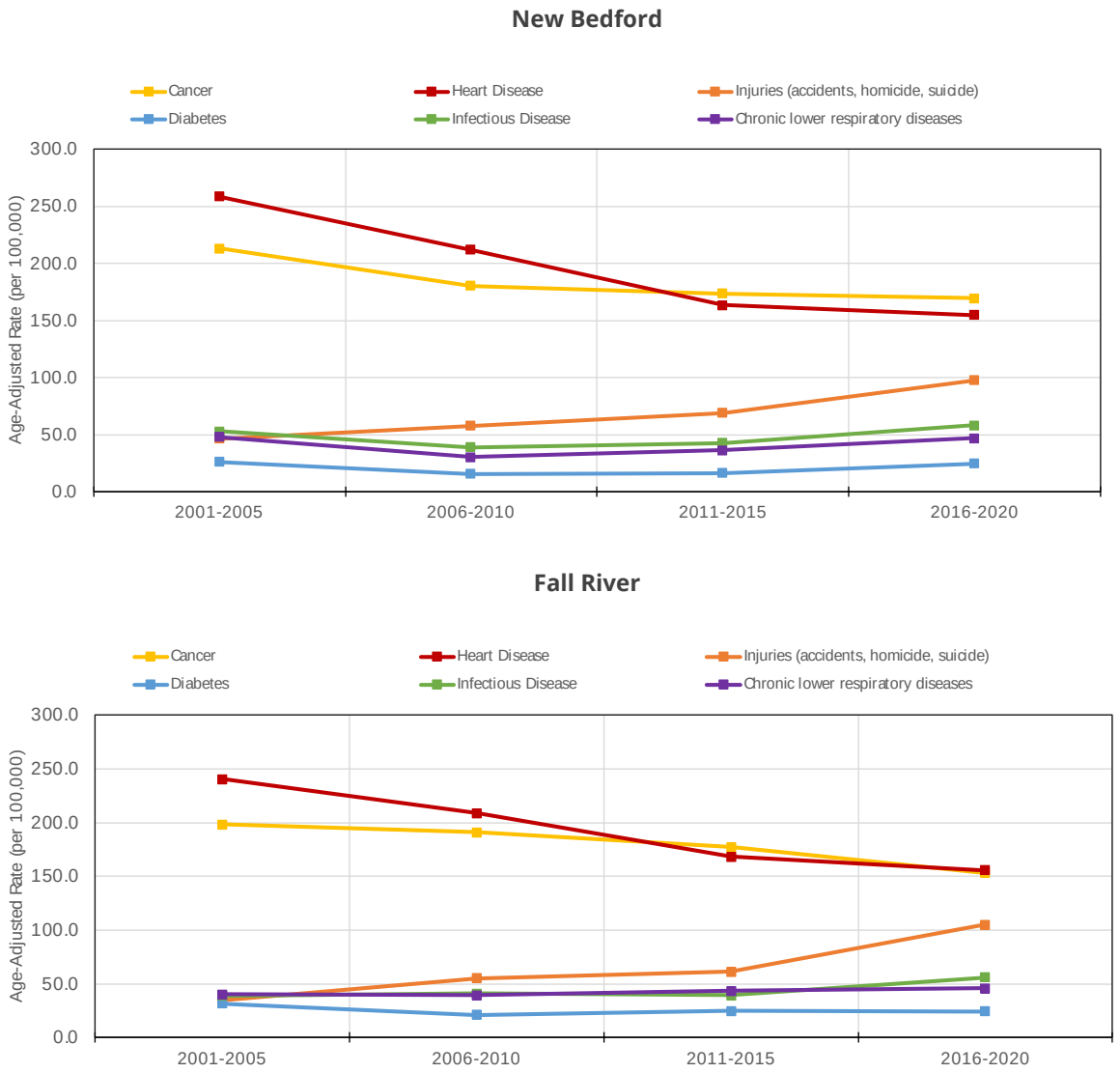
1. Rate calculations are based on resident population estimates from American Community Survey (ACS 5 Year Estimates) 2010 - 2020 and are age-adjusted per 100,000 residents using the 2000 US standard population. 2. Race and ethnicity represent mutually exclusive categories with Black/African American, Asian/Pacific Islander, American Indian, and Other, non-Hispanic numbers combined into "Black & Other, Non-Hispanic" due to small sample sizes for these populations.

[56] Hispanic data for Fall River is not included in the chart due to a high level of variance.

Age-adjusted Mortality Rate By Cause of Death

Mortality rates related to cancer and heart disease have declined since 2001, with heart disease dropping to the second leading cause of death starting in 2011-2015 in New Bedford. Fall River's heart disease death rate is still higher than the cancer rate, albeit slightly. Conversely, there has been a continued increase in deaths related to injuries in both cities, which includes but is not limited to accidents, overdoses, homicides, and suicides (see Figure 53).

Figure 53. Age-Adjusted Rates[1] by Cause of Death[2] among all New Bedford and Fall River Residents: 2001 – 2020



1. Rate calculations are based on resident population estimates from American Community Survey (ACS 5 Year Estimates) 2010 - 2020 and are age-adjusted per 100,000 residents using the 2000 US standard population. 2. Cause of death is based on the disease or injury that initiated the events leading to an individual's death or the circumstances resulting in death. These data are categorized according to ICD-10 codes identified by the National Center for Health Statistics (NCHS) for cause-of-death ranking.

Current State of Mortality among New Bedford and Fall River Residents: 2016-2020

A more in-depth review of deaths from the most recent five years (2016—2020) highlights the differences in leading causes of death by race/ethnicity to better understand the conditions with the greatest adverse impacts among New Bedford and Fall River residents (see Table 15).

The top four leading causes of death for all New Bedford and Fall River residents are the same as those identified in the Massachusetts Death 2019 report; however, the age-adjusted rates for each condition are higher among New Bedford and Fall River residents compared to Massachusetts overall – cancer (MA = 139.5), heart disease (MA = 126.9), unintentional injuries (MA = 53.7), and chronic lower respiratory diseases (MA = 31.2). Unfortunately, a 2020 death report from Massachusetts is currently unavailable so we are unable to compare the impacts of COVID-19 at the state level, but it is important to note that COVID-19 was a leading cause of death for all race/ethnicities in New Bedford and Fall River even though it only impacts one year of this five-year review. Additional difference noted by race/ethnicity include:

- Heart disease remains the leading cause of death for Black & Other, Non-Hispanic residents of New Bedford.
- Unintentional injury is the second leading cause of death among Hispanic residents in New Bedford and first in Fall River, whereas it ranks third for white, Non-Hispanic, and Black & Other, Non-Hispanic residents. This trend is mirrored in the Massachusetts Death 2019 report.
- Diabetes is the fourth leading cause of death among New Bedford Hispanic residents but is the eighth cause for White, Non-Hispanic, and Black & Other, Non-Hispanic residents.
- Chronic liver disease and homicide are two causes of death in New Bedford that rank among Hispanic residents but do not appear among the top ten leading causes of death for White, Non-Hispanic, and Black & Other, Non-Hispanic residents for that city.

Table 15. Leading Causes of Death[1] and Age-Adjusted Rates[2] by Race/Ethnicity[3], 2016 – 2020

New Bedford

All Residents		
Cause	**#**	**Rate**
Cancer	971	169.6
Heart Disease	964	155.1
Unintentional Injuries	410	84.9
Diseases	279	46.9
Alzheimer's Disease	201	27.3
Stroke	164	26.0
COVID-19	155	25.4
Diabetes	147	24.8
Influenza & Pneumonia	124	19.8
Nephritis	113	18.1

White, Non-Hispanic		
Cause	**#**	**Rate**
Cancer	801	203.7
Heart Disease	795	184.3
Unintentional Injuries	300	98.1
Diseases	245	60.4
Alzheimer's Disease	177	33.3
Stroke	124	28.3
COVID-19	124	28.5
Diabetes	118	29.5
Influenza & Pneumonia	104	23.5
Nephritis	89	20.1

Black & Other, Non-Hispanic		
Cause	**#**	**Rate**
Heart Disease	119	94.5
Cancer	107	94.1
Unintentional Injuries	55	60.4
Stroke	27	20.9
Chronic Lower Respiratory Disease	26	21.1
Alzheimer's Disease	19	13.5
COVID-19	17	13.6
Diabetes	14	11.5
Influenza & Pneumonia	14	12.2
Nephritis	12	8.9

Hispanic		
Cause	**#**	**Rate**
Cancer	63	208.5
Unintentional Injuries	55	53.8
Heart Disease	49	188.6
Diabetes	15	32.2
COVID-19	14	42.3
Stroke	13	44.8
Nephritis	12	38.3
Chronic Liver Disease	11	19.1
Homicide	10	9.2
Chronic Lower Respiratory Disease	8	8.0

Fall River

All Residents

Cause	#	Rate
Heart Disease	974	155.9
Cancer	899	153.1
Unintentional Injuries	428	93.0
Diseases	270	45.6
Alzheimer's Disease	151	21.2
Influenza & Pneumonia	150	23.3
Diabetes	146	24.3
COVID-19	141	21.6
Stroke	131	19.1
Chronic Liver Disease	97	19.3

White, Non-Hispanic

Cause	#	Rate
Heart Disease	924	189.5
Cancer	837	180.8
Unintentional Injuries	373	104.8
Diseases	262	56.3
Influenza & Pneumonia	148	29.7
Alzheimer's Disease	147	27.1
Diabetes	137	29.2
COVID-19	131	26.0
Stroke	125	23.5
Chronic Liver Disease	91	22.8

Black & Other, Non-Hispanic

Cause	#	Rate
Heart Disease	43	89.0
Cancer	36	70.7
Unintentional Injuries	24	50.4
Diabetes	7	12.6
Chronic Liver Disease	6	12.0
COVID-19	6	11.9
Suicide	6	13.9
Stroke	4	8.0
Homicide	3	5.7
Diseases	3	5.7

Hispanic

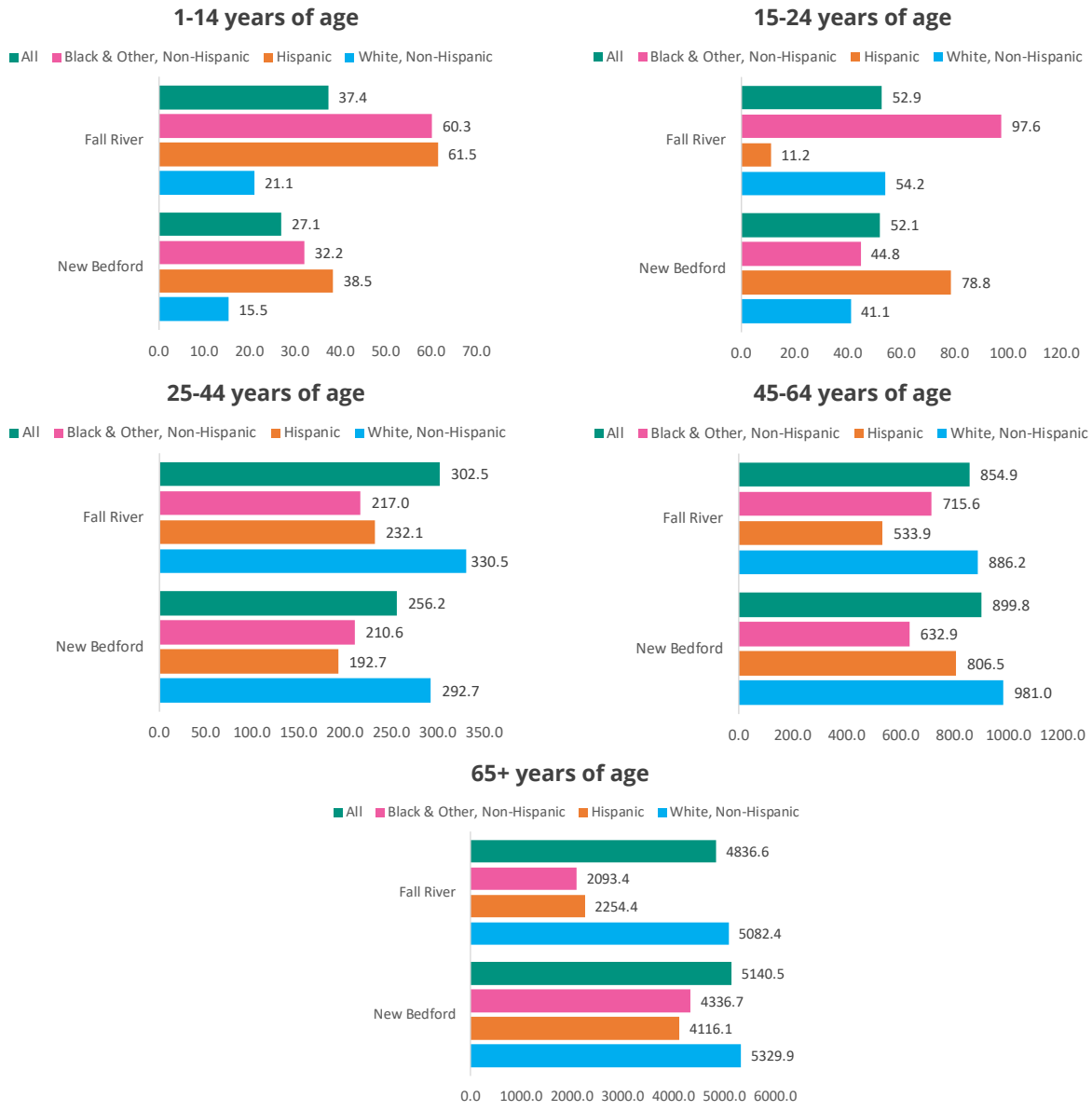
Cause	#	Rate
Unintentional Injuries	31	76.5
Cancer	25	130.1
Heart Disease	7	35.0
Diseases	5	13.4
COVID-19	4	12.8
HIV	4	8.6
Septicemia	4	8.2
Congenital abnormalities	3	4.2
Renal disease	3	19.8
Alzheimer's Disease	2	9.0

1. Cause of death is based on the disease or injury that initiated the events leading to an individual's death or the circumstances resulting in death. These data are categorized according to ICD-10 codes identified by the National Center for Health Statistics (NCHS) for cause-of-death ranking. Rankings are based on the overall number of deaths for each category. 2. Rate calculations are based on resident population estimates from American Community Survey (ACS 5 Year Estimates) 2016 - 2020 and are age-adjusted per 100,000 residents using the 2000 US standard population. 3. Race and ethnicity represent mutually exclusive categories with Black/African American, Asian/Pacific Islander, American Indian, and Other, non-Hispanic numbers combined into "Black & Other, Non- Hispanic" due to small sample sizes for these populations. Note: Rates for Black & Other, Non-Hispanic, and Hispanic population are unstable due to small sample sizes available among these populations.

Age-Specific Death Rates

As one would expect, the age-specific death rates for New Bedford and Fall River residents increase as the age cohorts increase, as older individuals are more likely to develop one or more chronic conditions and ultimately succumb to these conditions (see Figure 54). The figures also highlight the racial/ethnic disparity in deaths for younger individuals in the 1-14 and 15-24 year old cohorts. Hispanic and Black & Other, Non-Hispanic residents aged 1-14 years have more than twice the death rate compared to White, Non- Hispanic residents 1-14 years old. Furthermore, New Bedford Hispanic residents aged 15-24 have nearly twice the death rate compared to White, Non-Hispanic and Black & Other, Non-Hispanic residents. Lastly, Fall River Black & Other residents in the 15-24 year cohort have nearly twice the death rate compared to White, Non-Hispanic

Figure 54. Age-Specific Death Rate[1] by Race/Ethnicity[2], New Bedford: 2016 – 2020

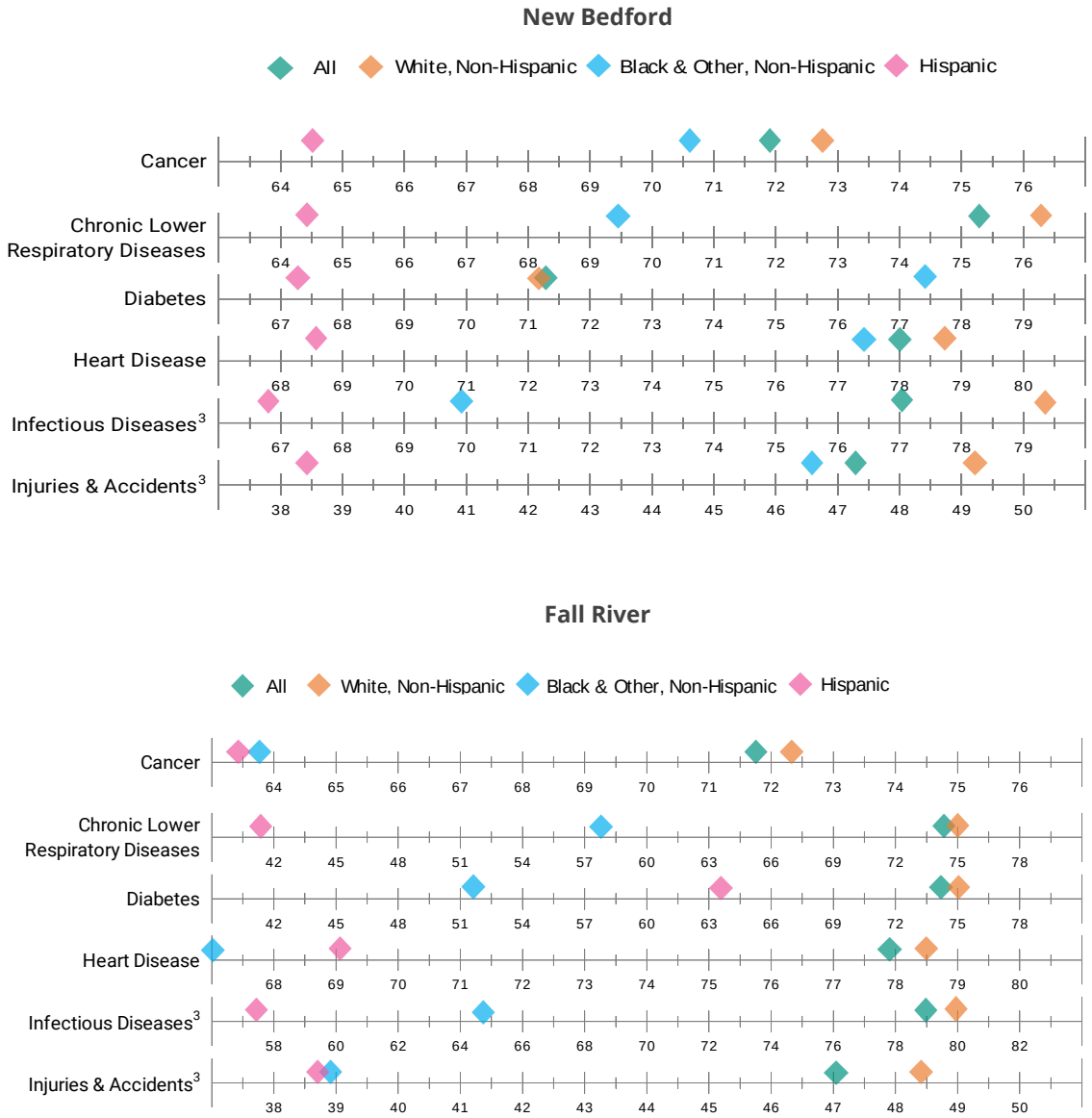


1. Rate calculations are based number of deaths per 100,000 in each age group using population estimate from American Community Survey (ACS 5 Year Estimates) 2016 - 2020. 3. Race and ethnicity represent mutually exclusive categories with Black/African American, Asian/Pacific Islander, American Indian, and Other, non-Hispanic numbers combined into "Black & Other, Non-Hispanic" due to small sample sizes for these populations. Note: Rates for Black & Other, Non-Hispanic, and Hispanic population are unstable due to small sample sizes available among these populations.

Average Age at Time of Death

A review of the average age at time of death for some of the top leading causes of death provides insight in where preventive services such as education, access to care, and care management may be lacking for different communities (see Figure 55). In almost all instances, Hispanic and Black & Other Non-Hispanic residents are succumbing to these causes at a much younger age compared to White, Non-Hispanic residents.

Figure 55. Average Age[1] at Time of Death by Cause[2] stratified by Race/Ethnicity[3], 2016 – 2020



1. The average age of the denoted population with a given condition at time of death. 2. Infectious Disease combines all cause of death categories associated with an infectious disease. Injuries & Accidents combines all cause of death categories attributed to injuries, accidents, overdoses, homicides, and suicides. 3. Race and ethnicity represent mutually exclusive categories with Black/African American, Asian/Pacific Islander, American Indian, and Other, non-Hispanic numbers combined into "Black & Other, Non-Hispanic" due to small sample sizes for these populations.

Food Insecurity

The U.S. Department of Agriculture (USDA) defines food insecurity as a lack of consistent access to enough food for an active, healthy life.[57] The USDA estimates that in 2021, 33.8 million Americans lived in food insecure households and 8.6 million adults lived in households with very low food security.[58] These rates are higher for people of African American or Hispanic descent.

People who are food insecure are at an increased risk for a variety of negative health outcomes, including obesity and other chronic diseases. Food insecurity often overlaps with many of the social determinants of health discussed throughout this report such as income, housing, race, and education. Consequently, strategies to address food insecurity must be undertaken in a social determinant context.

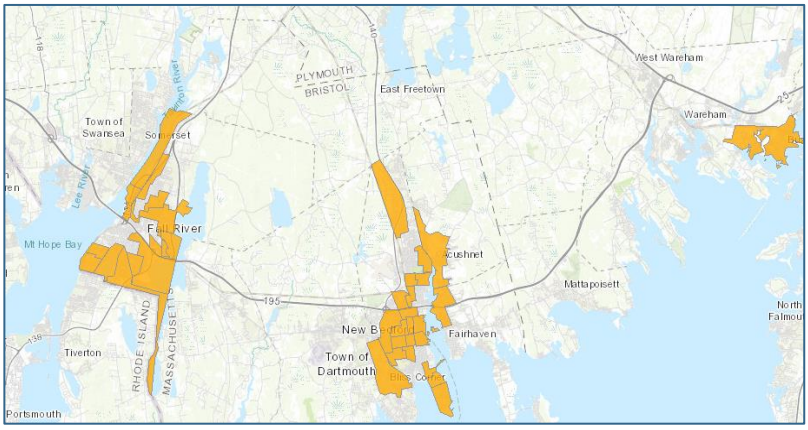
While food insecurity is closely linked to poverty, people above the poverty line can experience food insecurity, which was especially evident during the COVID-19 pandemic. HHSP survey respondents rank food insecurity as the fourth most concerning issue (49%) among the community they serve, while 13% of community survey respondents ranked food insecurity as one of the five most important health issues in the region.

Low Income, Low Access Food Areas

Interviews and survey respondents reveal that a major issue related to food insecurity is access to affordable high quality foods. Highlighted areas in Figure 56 display the region's low-income Census tracts where a significant share of residents is more than ½ mile (urban) or ten miles (rural) from the nearest supermarket. Instead, these areas tend to have more convenience stores, which generally offer more expensive and unhealthy food options. One community leader noted, "Many residents, particularly among the immigrant community, live in areas with no access to a supermarket, so they use the local corner stores with less selection of healthy foods with lack of fresh vegetables and fruits." Even with public transportation, one client commented that "…taking two buses in the rain and handling heavy bags full of food is not feasible for most of our elderly clients."

Importantly, the region's more affluent neighborhoods are located furthest from grocery stores and smaller markets, although these residents are generally able to drive to purchase food, as compared to residents in poorer neighborhoods who rely more on walking and public transportation. However, access to grocery stores is a concern among some seniors in the South Coast's suburban communities who have no car or access to public transportation. As one community member noted, "I have to rely on friend to bring me to the market."

Figure 56. Low Income, Low Access Food Areas in the South Coast, 2019



Source: US Department of Agriculture, Economic Research Service

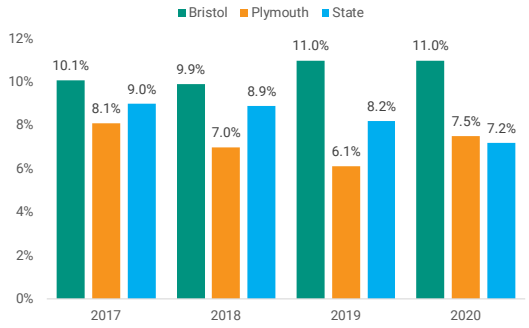
[57] US Department of Agriculture, (2019). Definitions of Food Security. Available online at: https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security.aspx

[58] Coleman-Jensen, A., et al. (2019). Household Food Security in the United States in 2018. U.S. Department of Agriculture Economic Research Service. Available online at: https://www.ers.usda.gov/webdocs/publications/94849/err-270.pdf?v=963.1

Percentage of Food Insecure Persons

In 2019, an estimated 566,930 Massachusetts residents were food insecure, or about 1 in 12 residents. This number increased by an estimated 47.1% to 834,100 residents during the COVID-19 pandemic, including over 214,000 children. In the height of the pandemic, the Census Bureau Household Pulse Survey noted that 19.6% of Massachusetts households were unsure of where they would get their next meal.[59] Bristol County, which includes Fall River and New Bedford, has one of the highest percentages of food insecurity among the state's fourteen counties; an estimated 11.0% of residents were food insecure in 2020 (see Figure 57).

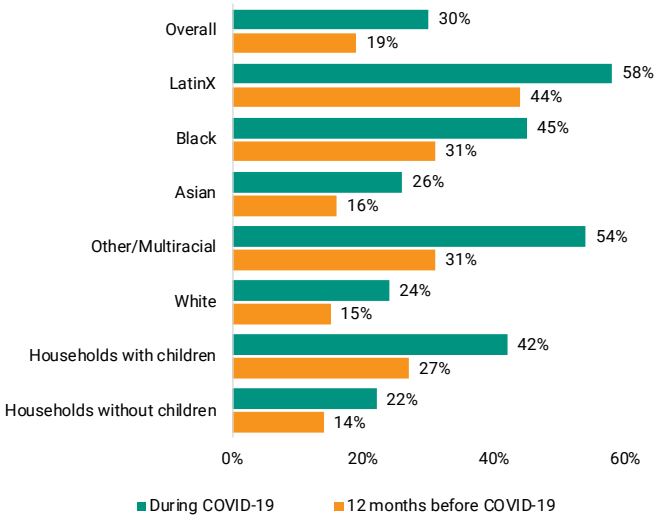
Figure 57. Percentage of Persons in Food Insecure Households by SEMass Counties and State



Source: Feeding America[60]

Food insecurity is not experienced by all groups equally. A survey conducted by The Greater Boston Food Bank in 2021 estimates that food insecurity rates among adults during the pandemic were highest among people of color and adults with children: 58% of Latinx adults, 45% of Black adults, and 26% of Asian adults. This compares to 24% of White adults (see Figure 58).[61] Among households with children, 42% reported being food insecure. Bristol and Plymouth Counties exhibit a similar pattern; nearly twice the percentage of Black and Hispanic residents were food insecure in 2020 in both counties and statewide (see Table 16).

Figure 58. Food Insecurity Rates among Massachusetts Adults



Source: The Greater Boston Food Bank

Table 16. Percentage of Persons in Food Insecure Households by Race/Ethnicity

	2019	2020
Bristol County		
All Residents	11.0%	11.0%
Black/African American	19.0%	21.0%
Hispanic	20.0%	21.0%
Plymouth County		
All Residents	6.1%	7.5%
Black/African American	16.0%	17.0%
Hispanic	14.0%	16.0%
Massachusetts		
All Residents	8.2%	7.2%
Black/African American	18.0%	20.0%
Hispanic	17.0%	19.0%

Source: Feeding America.[62] Data for 2017 & 2018 not available due to small sample size.

[59] Household Pulse Survey Public Use File. https://www.census.gov/programs-surveys/household-pulse-survey/datasets.html. Accessed July 15, 2021.

[60] Gundersen, C., M. Hake, A. Dewey, E. Engelhard (2021). The Impact of the Coronavirus on Food Insecurity in 2020 & 2021, Update March 2021 [Data file and FAQ]. Available from feedingamerica.org/.

[61] The Greater Boston Food Bank. May 2021. Gaps in Food Access During the COVID-19 Pandemic in Massachusetts. Boston, MA.

[62] Gundersen, C., M. Hake, A. Dewey, E. Engelhard (2021). The Impact of the Coronavirus on Food Insecurity in 2020 & 2021, Update March 2021 [Data file and FAQ]. Available from feedingamerica.org/.

Food Pantries, Soup Kitchens, and Mobile Markets

There are numerous food pantries, soup kitchens, and mobile markets that operate in the South Coast. These organizations ramped up during COVID-19 to meet the increased need and continue to serve a variety of foods, from drive-thru prepackaged groceries and brown bag lunches to full frozen or prepared meals. Key informants praised the ability of various organizations to marshal resources during the pandemic as well as the degree to which food scarcity became a primary focus. Community leaders noted the energy devoted to feeding residents during the pandemic, although one interviewee noted that the hours for some of the current pantries make it difficult for some working families to get to the pantry.

In terms of impact, there is no one single database that tracks the number of meals and people served. The Southcoast Food Policy Council (SFPC), a project of the Marion Institute, represents a coalition of nearly 300 stakeholders, including food producers, consumers, government representatives, public and private institutions, local industry, foundations, and social service agencies in Southeastern Massachusetts. As part of its 2021 regional food assessment, SFPC documented the collective impact of its members and partners from March 2020 to March 2021.[63] Importantly, this data represents only a portion of the collective organizational effort of SFPC members and partners from March 2020 to March 2021. Thus, the actual impact is higher than what is reported here (see Figure 59).

Figure 59. Collective Organizational Effort of Southcoast Food Policy Council Members and Partners from March 2020 to March 2021

Source: Southcoast Food Policy Council

SFPC also conducted a *Supplemental Food Providers Survey* between May and July 2020 of organizations engaged in food relief services in Southeastern Massachusetts. Survey results show that the breadth of food relief services during the pandemic was significant; supplemental food providers in the region were serving over 27,000 clients each week (more than 10,000 households). Nearly half (47.0%) of organizations stated they had the ability to serve more people in the community at their current capacity.

[63] *Southeastern Massachusetts Food Assessment 2021.* Supplemental Food Providers Survey. Marion Institute Southcoast Food Policy Council. Survey conducted May through July, 2020.

Supplemental Nutrition Assistance Program (SNAP)

The federally funded Supplemental Nutrition Assistance Program (SNAP) is the most utilized nutrition assistance program in the nation and provides low-income households funds to purchase food. In the South Coast, 84,968 residents received SNAP benefits in July 2022, which is an increase of 26.2% (17,631 recipients) from February 2020 (pre-pandemic). In fact, the number of SNAP recipients increased by 9.5% in just two months from before the pandemic (February 2020) to the time when many of the COVID-19 related restrictions were in place in April 2020 (see Table 17). One HHSP survey respondents noted that, "While New Bedford and Fall River have a lot of farmers markets, they are very expensive, even with SNAP, and sometimes it's cheaper to go to the supermarket."

Table 17. Recipients Receiving SNAP Benefits

Community	February 2020	April 2020	July 2022	Increase Feb 20 - April 20	Increase Feb 20 - Jul 22
Acushnet	805	901	1,185	11.9%	47.2%
Dartmouth	2,308	2,524	3,191	9.4%	38.3%
Fairhaven	1,498	1,691	2,123	12.9%	41.7%
Fall River	26,053	28,363	32,079	8.9%	23.1%
Freetown	540	646	771	19.6%	42.8%
Marion	260	297	417	14.2%	60.4%
Mattapoisett	216	245	306	13.4%	41.7%
New Bedford	28,693	31,143	34,963	8.5%	21.9%
Rochester	178	202	274	13.5%	53.9%
Somerset	1,274	1,425	1,729	11.9%	35.7%
Swansea	1,152	1,320	1,622	14.6%	40.8%
Wareham	3,181	3,677	4,639	15.6%	45.8%
Westport	1,179	1,287	1,669	9.2%	41.6%
Greater FR	29,658	32,395	37,099	9.2%	25.1%
Greater NB	37,679	41,326	47,869	9.7%	27.0%
South Coast	67,337	73,721	84,968	9.5%	26.2%
Massachusetts	786,749	860,204	982,480	9.3%	24.9%

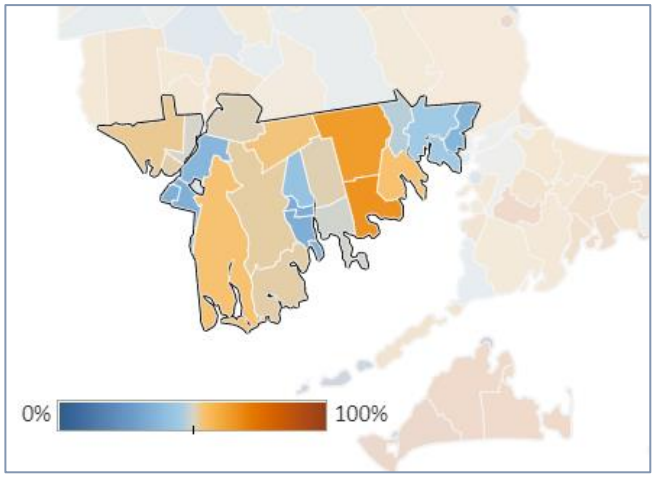
Source: Massachusetts Department of Transitional Assistance, Monthly Zip Code Catchment Reports

SNAP Gap

The SNAP Gap is defined as the difference between the number of low-income Massachusetts residents receiving MassHealth who are likely SNAP eligible and the number of people actually receiving SNAP. Despite the significant number of residents utilizing SNAP, it is estimated that over 650,000 Massachusetts residents are likely eligible for SNAP benefits but are not enrolled. A survey conducted by the MassINC Polling Group of over 10,000 K-12 parents and guardians in selected Massachusetts public school districts, including Fall River and New Bedford, concluded that under half of respondents making $25,000 or less–most all of whom likely qualified for SNAP–received SNAP benefits during the pandemic. In addition, 53.0% of households making less than $15,000, and 43.0% of households making between $15,000 and $25,000, reported not knowing how to apply for SNAP.[64]

Figure 60 displays the SNAP Gap by ZIP Code in the South Coast. The three lowest-income communities in the region—Fall River, New Bedford, and Wareham—also have the lowest SNAP Gap rates (highlighted in blue). However, these communities have a much higher number of potentially SNAP-eligible residents. For example, is estimated that 15,709 residents in Fall River, 17,851 residents in New Bedford, and 4,375 residents in Wareham are potentially eligible for SNAP benefits but are not enrolled (see Table 18).

Figure 60. Massachusetts SNAP Gap % By Zip Code



Source: The Food Bank of Western Massachusetts, via Tableau, Updated April 8, 2022

Table 18. South Coast SNAP GAP

Community	# Eligible	# Enrolled	SNAP Gap	SNAP Gap %
Acushnet	1,969	965	1,004	51.0%
Dartmouth	5,436	2,628	2,808	51.7%
Fairhaven	3,530	1,791	1,739	49.3%
Fall River	43,832	28,753	15,079	34.4%
Freetown	1,417	676	741	52.3%
Marion	734	336	398	54.2%
Mattapoisett	658	223	435	66.1%
New Bedford	49,769	31,918	17,851	35.9%
Rochester	612	222	390	63.7%
Somerset	3,599	1,714	1,885	52.4%
Swansea	2,838	1,347	1,491	52.5%
Wareham	9,627	5,252	4,375	45.4%
Westport	2,955	1,355	1,600	54.1%
South Coast	126,976	77,180	49,796	39.2%
Greater FR	53,224	33,169	20,055	37.7%
Greater NB	73,752	44,011	29,741	40.3%
Massachusetts	1,606,196	900,772	705,424	44.0%

Source: The Food Bank of Western Massachusetts, via Tableau, Updated April 8, 2021

[64] MassINC Polling Group. July 2021. Lessons from P-EBT to increase SNAP access A survey of public-school parents in targeted Mass. Boston, MA.

9 Priority Health Issue 5: Health Care Access

People who do not have access to health care are at a greater risk of having poor overall health and negative health outcomes. This includes access to a wide variety of health services such as preventive care, mental health services, and emergency services. Regular access to health services is essential in managing health conditions, preventing new conditions from arising, and promoting and maintaining overall good health.

Stakeholders described the racial and ethnic health gap that continues to afflict the region. This gap is related to a myriad of access issues such as health literacy, insurance coverage and cost, transportation, and the need for more culturally competent care. Stakeholders were clear that equity and access issues prevalent in the health care system intensified due to the pandemic. As one community leader explained, "COVID shed light on disparities we already knew existed."

Key takeaways:

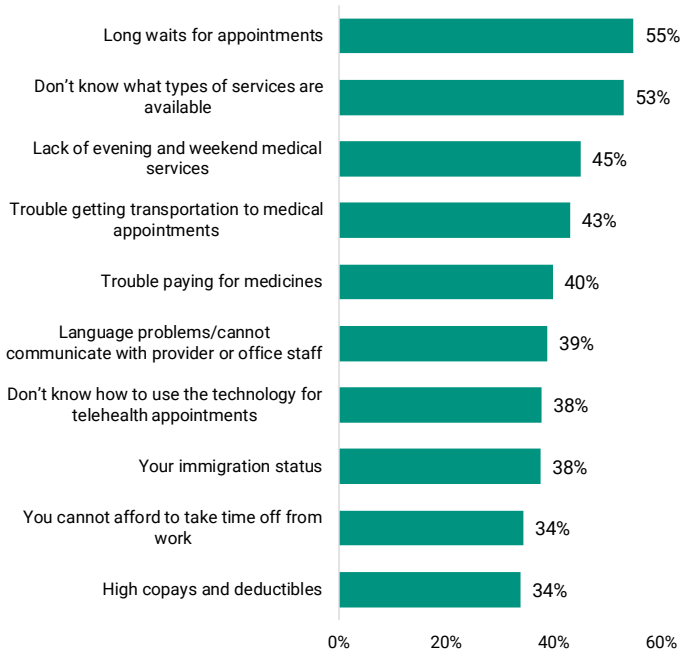
- Results of the community survey show that long wait for appointments (55%), lack of awareness of available services (53%), and lack of evening and weekend hours (45%) are the most significant obstacles that prevent individuals from obtaining health services. Conversely, providers are more concerned with issues related to mental health services and cost.
- There were a surprising number of open end comments related to a lack of knowledge of what services are available. Many suggested more materials are needed in Spanish, including billboards.
- Although most residents have insurance, there are extreme differences in terms of value, coverage, and cost. These factors, in turn, partly affect the degree to which residents will access the health care system, particularly as it relates to preventive care.
- Moreso than in past needs assessments, survey respondents and community leaders note that obtaining dental insurance is difficult. As one stakeholder noted, "Even for those that have it, the coverage is either poor, expensive, or both. It certainly doesn't encourage people to visit the dentist."
- Several stakeholders note a constant struggle in community health is the ability of the health care system to effectively connect and serve certain populations with low health literacy, especially since these populations are the ones most likely to need the services.
- Even for those who have health insurance and are not overwhelmed by its cost, out-of-pocket expenses, finding a primary care physician, and navigating the system can be difficult, especially for non-English speakers.
- Stakeholders note that providing culturally competent care will result in more people seeking care when they need it and the care itself will be more effective. This is particularly important as the region becomes increasingly diverse.
- Transportation continues to be one of the top health access issues in the region. Key informants note that many of their clients often cannot get to appointments even when they have the desire to seek out preventive care or when they require treatment for various health issues.
- The immigrant population often does not access the health system due to fear of their immigration status.

Primary Obstacles to Obtaining Health Services

The community survey asked respondents to rank the obstacles that might prevent them from obtaining health services. The top responses are primarily related to time: long wait for appointments (55%), don't know what types of services are available (53%), and lack of evening and weekend medical services (45%) (see Figure 61). Conversely, providers are more concerned with issues related to mental health services and cost (see Figure 62).[65]

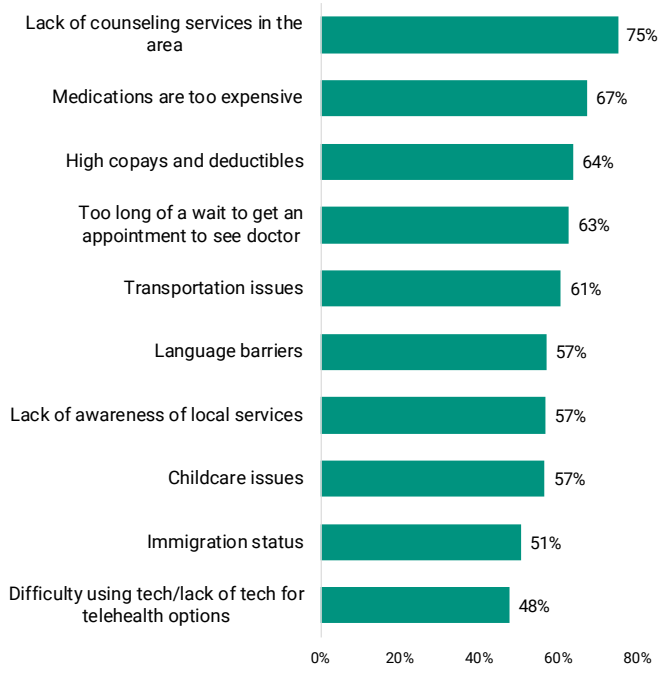
There were a surprising number of open end comments related to a lack of knowledge of what services are available. Many suggested more materials are needed in Spanish, including billboards. A community leader commented that, "The work schedules of most of my clients don't allow them to visit the doctor during the day. They don't work the kinds of jobs where you can just take time off. If they take time off they don't get paid." Still another noted specific to New Bedford's Guatemalan population, "Many people are supporting other households in their country, and they tend to overwork for those reasons. They get sick but don't have the time to take care of themselves."

Figure 61. Please check the issues below that make it difficult for you to get the health care you need.



Source: Community Survey, 2022

Figure 62. Regarding the existing obstacles to accessing health care among the community members you serve, please rank the following (percent "strong obstacle").



Source: HSSP Survey, 2022

[65] The percentages in these tables are not comparable because the question was asked differently on each survey. The charts serve only to show the priority ranking of the two groups. A full list of responses can be found in appendix A and Appendix B.

HEALTH LITERACY

Health literacy can be defined as the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions, and services needed to prevent or treat illness.[66] Health literacy is interconnected with the social determinants of health and low health literacy is more prevalent among the poor, minorities, seniors, those with a language barrier, and other marginalized groups. Though health literacy is multifaceted, five issues came to the forefront during our research:

1) Health insurance
2) Health education
3) Navigating the health care system
4) The need for culturally competent care
5) Transportation

HEALTH INSURANCE

Most residents in the South Coast have health insurance, although lack of health insurance is particularly prevalent among the undocumented. However, results of the community survey show that cost makes it difficult to get the health care they need, including the cost of insurance, medication, and copays for those who have it. One health provider noted that, " There is a fear to visit the doctor at all because my clients don't know what is covered and what is not, or what it will cost. They don't want to take the chance of getting a high medical bill."

Consequently, although most residents have insurance, there are extreme differences in terms of value, coverage, and cost. These factors, in turn, partly affect the degree to which residents will access the health care system, particularly as it relates to preventive care. As one community leader noted, "In regard to the lack of insurance and services in the area, it is more difficult based on the type of insurance families have. If on MASS Health, the options are few." Many respondents also noted in open end comments that obtaining dental insurance is difficult and among those that have it, the coverage is either poor, expensive, or both.

In addition, job losses during the pandemic left many workers without employer-sponsored health insurance, which left laid-off workers scrambling to find coverage during an extremely stressful period. The Commonwealth Fund estimates that about 42 percent of the establishments that laid off workers as a result of the pandemic continued to pay a portion of health insurance premiums for those workers, but this still resulted in a significant number of laid-off employees with no coverage.[67]

As noted earlier, many South Coast residents work lower-paid service jobs, where taking time off is not an option, even though many of these workers were deemed essential workers during the pandemic. One community member noted that one of the reasons that COVID rates were so high in Fall River and New Bedford is that a significant portion of the workforce worked throughout the pandemic.

[66] See Health Resources & Services Administration. "Health Literacy." Retrieved October 29, 20201 from: https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/index.html.

[67] The Commonwealth Fund. January 2021. *How Many Americans Have Lost Jobs with Employer Health Coverage During the Pandemic?* See: https://www.commonwealthfund.org/blog/2021/update-how-many-americans-have-lost-jobs-employer-health-coverage-during-pandemic. Accessed October 28, 2021.

Health Education

Stakeholders noted that there are two central pieces to the health education equation: learning how to be healthy in general (e.g., diet, exercise, preventive services) and knowing the resources that are available to achieve those goals (including enrolling for basic insurance). As one focus group member noted, "A patient needs to be aware of why it is important to eat well and exercise, but they also need information on the services available to help them become healthy. In addition, they need assistance in enrolling for insurance so they can access those services without paying out-of-pocket." Similarly, another focus group member commented, "Health access and health literacy go hand in hand. You can't access something if you don't know it exists." A key informant noted that a constant struggle in community health is the ability of the health care system to effectively connect and serve certain populations with low health literacy, especially since these populations are the ones most likely to need the services.

Several community leaders also made the point that nutrition education in the community is lacking, and that a basic understanding of nutrition is missing in their clients. As one community leader noted, "If we take a look at the first generation immigrant older population, Cape Verdean, Portuguese, Lebanese, they had good health habits. They had gardens and grew their food; they grew up eating meals cooked at home; they exercised by doing physical work. In the old days going to a fast food restaurant was a treat only a few times a month. Our community is so Americanized that we lost those habits."

Navigating the System

Even for those who have health insurance and are not overwhelmed by its cost, paying out-of-pocket expenses, finding a primary care physician, and navigating the system can be difficult. Above all, 53% of community survey respondents reported that they do not know what services are available, so even entering the system is difficult. As one stakeholder pointed out, "We complain that our clients don't have a PCP, yet we don't help them with how to do that. We need to do more outreach to get families connected with PCPs." Another noted, "Something that may seem simple, such as obtaining a referral, can be a struggle for someone not familiar with the system or who speaks another language."

Telehealth is also becoming more prevalent since the pandemic and focus group members noted that this can be particularly difficult for those who are not tech-savvy (particularly seniors) and for those who don't have access to technology (e.g., a laptop or smartphone) or broadband. As one community leader noted, "Many of my elderly clients are not good with technology and don't have the mean or ability to attend telehealth appointments."

Need for Culturally Competent Care

Cultural competence is generally defined as the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients.[68] Culturally competent care requires an awareness and knowledge of the issues specific to underserved populations and the ability to communicate in a way that is appropriate and effective. Properly delivered, culturally competent care results in more people seeking care when they need it and the care itself being more effective. This is particularly important to South Coast as the region becomes increasingly diverse.

Examples of culturally competent care include offering health materials in multiple languages, providing interpreter services, improving knowledge among staff about the community they serve, recruiting and training

[68] Betancourt, J. R., Green, A. R., & Carrillo, J. E. 2002. Cultural competence in health care: Emerging frameworks and practical approaches. New York: The Commonwealth Fund.

diverse team members, and becoming more aware of the needs and challenges that patients face daily. As one community member noted, "There isn't enough Spanish speaking clinicians to serve a growing non English speaking community." Another commented, "Language barrier is the largest obstacle that we have. It's critical to have people working for agencies speak other languages. Advertise in non-English, make the community aware of what Southcoast Health has to offer".

Importantly, the diversity in a population extends beyond just race, ethnic background, and language. For example, the lesbian, gay, bisexual, transgender or queer/questioning (LGBTQ+) community and the Veteran community consist of a cross-cultural range of community members. The health care needs of these groups and others require care and support that is compassionate and reflects an understanding of the unique challenges and needs of these groups. This often requires recruiting and training professionals with a variety of backgrounds or, at a minimum, training current staff to improve cultural awareness and skills. One survey respondent noted, "There is a lack of sensitivity by front office staff to mental health, language, and marginalized populations."

Transportation Options

Nearly one-in-five Fall River and New Bedford adults do not have a vehicle, and while the shares in the suburbs are smaller, it does not change the fact that a portion of South Coast residents, particularly those who are elderly, do not have a car.[69] As a result, individuals often cannot get to appointments even when they have the desire to seek out preventive care or treatment for health issues. One survey respondent noted that, increasingly, "Services that used to be provided in the city have now moved to the suburbs. It's nearly impossible for some patients to get to those places."

Many rely on public transportation, but stakeholders note that public transportation is very inconvenient, especially since "many of the health care offices are outside the city; everything is out of town." Another noted, "Transportation is a barrier to get to appointments. There's no primary care in the North end. We came to realize lack of resources in this area during the pandemic. The bus doesn't run on Sunday which is a big family visitor day at the hospital. Having to take two buses can be an obstacle." Another concurred, commenting that, "Transportation is a huge issue. I will use the food as an example; access to healthy food, getting to a Farmers Market, our clients tend to use the stores that are around. In the old days we could access the bakery, the food market in your neighborhood, the library."

[69] Source: Census ACS 2016-2020 estimates, Table S2504.

10 KEY THEMES AND CONCLUSIONS

The tasks undertaken for this study show that South Coast residents and providers remained concerned about many of the same health priority issues identified in the 2019 CHNA, including mental health, substance use disorder, and health access. In addition to these longstanding issues, the effects of the COVID-19 pandemic have exposed the degree to which many individuals and households are struggling to obtain basic necessities, as evidenced by housing and food insecurity becoming much more prominent issues since the 2019 assessment.

MENTAL HEALTH

Mental health will continue to be a priority as we emerge from the pandemic. Addressing the issue cannot be done effectively until the capacity of the system is increased, both in terms of the pipeline of mental health professionals and the facilities needed for treatment. South Coast Health and other providers must be strategic in attracting more individuals to enter the mental health profession, as well as incentivizing current mental health professionals to accept MassHealth patients. However, effectively addressing the shortage of mental health professionals will require state leaders and its largest health care providers to work in concert on the issue. This includes increasing the number of mental health outpatient beds. Unfortunately, this crisis will not be solved overnight. As one community leader noted, "The mental health system is not set up for success. There is such a high turnover with professionals and limited access. Efforts to strengthen this system would lead to relief in other areas."

SUBSTANCE USE DISORDER

Substance Use Disorder continues to afflict the region. Results from the focus groups and the key informant survey clearly show that the opioid crisis remains a top health issue, along with intertwined issues of mental health and housing. While much of the focus is on opioid abuse, stakeholders recognize that this issue extends beyond opioids to other narcotics and alcohol. In addition, stakeholders continue to recognize the ripple effect that the opioid crisis has on children and families. Parental opioid use disorder, in particular, has far-reaching effects on children. From the start of their lives, children with parents who have opioid use disorder are prone to poor birth outcomes due to prenatal opioid exposure, are more likely to accidentally ingest opioids at a young age, and may face daily trauma (e.g., neglect, abuse, domestic violence, parental incarceration) that puts them at higher risk of developing behavioral and psychosocial problems later in life.[70] Thus, treating individuals with substance use disorder is only part of the solution; strategies going forward must continue to take a holistic approach to addressing substance use disorder.

HOUSING

Surveys and interviews clearly indicate that affordable housing is a growing priority in the region. Rent is increasing faster than wages and some long-time residents have few choices other than to double-up or rent substandard housing. Even then, housing advocates point out that many households will be priced out of Fall River completely. There are many solutions that address the conditions created by the region's housing gap, but housing in the South Coast is an issue that will only truly be solved when the supply of housing at rents affordable to working families is increased.

[70] Normile, B.; Hanlon, C.; & Eichner, H. (2018). "State Strategies to Meet the Needs of Young Children and Families Affected by the Opioid Crisis." National Academy for Stat Health Policy. September 2018.

Wellness and Chronic Disease

Health and wellness compete with more immediate day-to-day priorities for many South Coast residents. In nearly each instance, the disease prevalence is higher for Fall River and New Bedford in comparison to the state and national averages. Although chronic conditions can be genetic, poor disease outcomes are partly the result of unhealthy behaviors. However, the social determinants of health identified throughout this analysis are often large contributors to health inequities. Thus, effectively remedying high disease prevalence and poor health outcomes requires addressing the social environment that contributes to health inequities. Improving economic opportunity for residents and eliminating racial constructs is not a goal that will be solved in the short-term or by one organization. It will require a collective effort that exceeds even that which was implemented during the pandemic.

Health Access

Being healthy and remaining healthy is challenging enough for those of us accustomed to accessing the health care system and doing so becomes even more difficult if one must overcome obstacles to do so. Regular access to health services is essential in managing health conditions, preventing new conditions from arising, and promoting and maintaining overall good health. However, stakeholders described the health gap that continues to afflict the region, particularly as a result of the social determinants of health. This gap consists of a myriad of access issues such as health literacy, insurance coverage and cost, transportation, and the need for more culturally competent care. In many ways, health access is an umbrella issue that spans many of the other health issues identified in this report. Thus, programs and activities that are implemented to address the region's top health issues will not be effective if certain populations cannot access them, particularly since in many cases those who would most benefit from the services have the lowest levels of access.

Going Forward

Addressing COVID-19

The full effects of COVID-19 on the health and wellness of South Coast residents are yet to be understood. In one sense, the pandemic provided an opportunity for the region's health providers, advocates, and other stakeholders to break down walls and work cooperatively with focus and purpose. These collaborative efforts, such as the Let's Talk Tuesdays weekly calls coordinated by the United Way of Greater Fall River, should be continued, and expanded to address the priority health issues identified in this report.

Addressing Historically Marginalized Populations

Health equity and the social determinants of health extend to other prevalent groups in our region. Although not an inclusive list, stakeholders referred to a number of marginalized groups who would benefit from more inclusive approaches to delivering care and a more diverse health care workforce including the LGBTQ+ community, the Veteran community, those who are homeless, and the chronically ill and disabled. Although these groups are not homogenous and consist of community members with a range of races, ethnic backgrounds, and socioeconomic status, each has unique health care challenges and needs.

However, similar to other vulnerable populations, one primary commonality is that meeting the health care needs of these groups requires understanding the challenges each experiences, communicating in a way that is appropriate and effective, and making the health care system a welcoming place for these individuals. Recruiting and extensively training a diverse team of health care providers would be a positive step toward this goal. While it was not possible to interview representatives from every marginalized group as part of this research, it stands to reason that the starting point to improve health outcomes for marginalized groups in the

South Coast is to reach out and hear their concerns and challenges in receiving care. Once providers better understand these obstacles, they can take the appropriate steps to mitigating them and creating more equitable care.

Next Steps

The goal of this Community Health Needs Assessment is to inform data-driven objectives and strategies that can be used to improve the overall health of the populations targeted as at-risk and underserved. The 2022 CHNA will serve as the blueprint for the next three annual Community Health Benefits Implementation Strategies. Southcoast Health's Community Health Benefits Advisory Committee (CBAC) will engage in an ongoing evaluation of progress made on the short and long term goals of the annual Implementation Strategy, recommending adjustments to the plan as needed to positively impact and advance the health-related needs of the populations to be served.

APPENDIX A: COMMUNITY SURVEY

QUESTIONNAIRE

Hello and thank you for participating in our survey. Your opinion about the health and wellness of your community will help us to understand the needs of our region and plan programs and services that address those needs. Please remember that there are no right or wrong answers. Everything you tell us is valuable. The responses you provide us today will be kept anonymous; we do not ask any personal information such as your name or your address.

I. OBSTACLES TO ACCESSING HEALTH CARE

1. Please check the issues below that make it difficult for you to get the health care you need.

	✓
You have no health insurance	O
Trouble paying for medicines	O
High copays and deductibles	O
Don't have a smartphone, tablet, or computer to schedule visits and/or use telehealth options	O
Don't know how to use the technology for telehealth appointments	O
Discrimination/unfriendliness of provider or office staff	O
Don't know what types of services are available	O
Fear of visiting the doctor (you're not ready to face a health problem)	O
Lack of evening and weekend medical services	O
Trouble getting transportation to medical appointments	O
Language problems/cannot communicate with provider or office staff	O
Long waits for appointments	O
You don't have a Primary Care Physician (PCP)	O
You don't feel you need to see a doctor unless you're sick or injured	O
Your immigration status	O
You cannot afford to take time off from work	O

2. Are there any other obstacles that prevent you from getting the healthcare you need? Please write in your answers here:

II. MOST IMPORTANT HEALTH ISSUES

3. What do you believe are the FIVE (5) most important health issues in your community? Please check no more than five.

- ☐ Age-related health issues (e.g., arthritis, Alzheimer's, injuries due to falls)
- ☐ Alcohol abuse
- ☐ Breathing problems/asthma
- ☐ Cancer
- ☐ Dental problems
- ☐ Diabetes
- ☐ Domestic abuse
- ☐ Drug abuse/addiction
- ☐ Effects of trauma, neglect, and abuse on children
- ☐ Elder abuse and neglect
- ☐ Food insecurity
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Mental health issues (e.g., depression, anxiety, bipolar disorder, PTSD, schizophrenia, OCD)
- ☐ Obesity/overweight
- ☐ Poor birth outcomes (baby underweight, substance exposed)
- ☐ Poor maternal health outcomes
- ☐ Poor nutrition/eating habits
- ☐ Sexually transmitted diseases
- ☐ Smoking/tobacco use
- ☐ Stroke
- ☐ Suicide
- ☐ Teenage pregnancy
- ☐ Vaping
- ☐ Violence and safety
- ☐ Other (please write in here):

III. LASTLY, WE WOULD LIKE TO ASK JUST A FEW QUESTIONS ABOUT YOURSELF

We collect this information to understand who is responding to our survey to ensure that we are reaching a diverse group of people.

4. What is your ZIP code? _____

5. To which gender do you most identify?

- ○ Woman
- ○ Man
- ○ Non-binary/Non-conforming
- ○ Prefer to self-describe _____
- ○ Prefer not to say

6. What is your age?

- ○ 18 to 24
- ○ 25 to 34
- ○ 35 to 44
- ○ 45 to 54
- ○ 55 to 64
- ○ 65 to 74
- ○ 75 and older

7. Is English the primary language spoken in your home?

○ Yes ○ No

If No, which language do you primarily speak? : _____

8. How would you describe yourself? (check all that apply)

- ○ American Indian or Alaskan Native
- ○ Asian
- ○ Black or African American
- ○ Brazilian
- ○ Cape Verdean
- ○ Haitian
- ○ Hispanic/Latino
- ○ Native Hawaiian and Other Pacific Islander
- ○ White
- ○ Multiracial
- ○ Other _____

9. What was your approximate household income in the past year?

- ○ Below $25,000
- ○ $25,000 to $50,000
- ○ $50,000 to $75,000
- ○ $75,000 to $100,000
- ○ Over $100,000

10. How many people live in your household? _____

Community Survey Topline Results

Respondent Background

Residence	Number	Percent
New Bedford	1,018	84.0%
Fall River	100	8.3%
Wareham	32	2.6%
Dartmouth	22	1.8%
Westport	16	1.3%
Freetown	6	0.5%
Somerset	6	0.5%
Fairhaven	5	0.4%
Carver	2	0.2%
Marion	2	0.2%
Rochester	2	0.2%
Middleboro	1	0.1%
Total	1,212	

Not all respondents provided their zip code

Race/Ethnicity	Number	Percent
Hispanic/Latino	757	66.8%
White	175	15.4%
Native Hawaiian and Other Pacific Islander	0	0.0%
Black or African American	53	4.7%
Multiracial	36	3.2%
Haitian	36	3.2%
Cape Verdean	30	2.6%
Brazilian	24	2.1%
American Indian/Alaskan	9	0.8%
Other	8	0.7%
Asian	6	0.5%
Total	1,134	100.0%

Age Cohort	Number	Percent
18 to 24	169	22%
25 to 34	293	33%
35 to 44	343	22%
45 to 54	209	33%
55 to 64	130	11%
65 to 74	47	22%
75 and older	29	11%
Total	**1,220**	**154%**

Gender	Number	Percent
Woman	842	68.9%
Man	374	30.6%
Non-binary/Non-conforming	3	0.2%
Prefer to self-describe	3	0.2%
Total	1,222	100%

HH Income	Number	Percent
Below $25,000	701	63.8%
$25,000 to $50,000	251	22.9%
$50,000 to $75,000	91	8.3%
$75,000 to $100,000	22	2.0%
Over $100,000	33	3.0%
Total	1,098	100.0%

Language Other Than English	Number	Percent
Cape Verdean Creole	26	3.3%
Castellano	1	0.1%
Creole	15	1.9%
Dialecto	2	0.3%
Español	634	80.1%
Portuguese	34	4.3%
Quiché	80	10.1%
Total	792	100.0%

1. Please check the issues below that make it difficult for you to get the health care you need.

	Number	% of Total Respondents
Long waits for appointments	627	54.9%
Don't know what types of services are available	606	53.0%
Lack of evening and weekend medical services	514	45.0%
Trouble getting transportation to medical appointments	492	43.0%
Trouble paying for medicines	455	39.8%
Language problems/cannot communicate with provider or office staff	444	38.8%
Don't know how to use the technology for telehealth appointments	432	37.8%
Your immigration status	430	37.6%
You cannot afford to take time off from work	393	34.4%
High copays and deductibles	387	33.9%
Discrimination/unfriendliness of provider or office staff	370	32.4%
You don't feel you need to see a doctor unless you're sick or injured	342	29.9%
You have no health insurance	325	28.4%
Don't have a smartphone, tablet, or computer to schedule visits and/or use telehealth options	282	24.7%
You don't have a Primary Care Physician (PCP)	278	24.3%
Fear of visiting the doctor (you're not ready to face a health problem)	262	22.9%

2. What do you believe are the FIVE (5) most important health issues in your community?

	Number	% of Total Respondents		Number	% of Total Respondents
Alcohol abuse	541	45.5%	Smoking/tobacco use	183	15.4%
Diabetes	492	41.3%	Violence and safety	183	15.4%
Drug abuse/addiction	463	38.9%	Heart disease	162	13.6%
Mental health issues	455	38.2%	Food insecurity	150	12.6%
Cancer	449	37.7%	Elder abuse and neglect	147	12.4%
Obesity/overweight	350	29.4%	Suicide	136	11.4%
Dental problems	282	23.7%	Teenage pregnancy	133	11.2%
Age related health issues	252	21.2%	Vaping	104	8.7%
High blood pressure	235	19.7%	Sexually transmitted diseases	89	7.5%
Domestic abuse	225	18.9%	Poor maternal health outcomes	56	4.7%
Poor nutrition/eating habits	209	17.6%	Stroke	55	4.6%
Trauma/neglect/abuse on children	196	16.5%	Poor birth outcomes	46	3.9%
Breathing problems/asthma	184	15.5%			

APPENDIX B: KEY INFORMANT SURVEY

Thank you for choosing to participate in this survey. As part of Southcoast Health's Community Health Needs Assessment, we are conducting a survey of key community members in collaboration with Springline Research Group. The results will be used to identify community health issues in the Southcoast region and to help us plan programs and services.

We assure you that all responses will be anonymous. We will share the results of our work with you and other partners in the community once we have completed the process. Thank you for your time and participation!

HEALTH AND SOCIAL SERVICE PROVIDER SURVEY TOPLINE RESULTS

1. How would you best describe the organization for which your work?

	Number	Percent
Police/Fire/EMS	3	1%
Religious organization	5	2%
Private sector/Business community	5	2%
Schools	15	7%
Other government agency	35	15%
Healthcare provider	57	25%
Non-profit org. or social service agency	107	47%

2. Please rank the top FIVE areas of general concern for the community that you serve, not necessarily related to health.

	Number	Percent
Access to affordable housing	178	89%
Homelessness	124	62%
Poverty	104	52%
Food insecurity	93	47%
Crime and violence	80	40%
Not enough affordable childcare options	77	39%
Lack of programs aimed to help at-risk youth	63	32%
Lack of services for immigrant and non-English speaking populations	56	28%
Education system	54	27%
Limited public transportation	54	27%
Racial and ethnic discrimination	44	22%
Insufficient job training opportunities	30	15%
Lack of employment opportunities	22	11%
Lack of LGBTQ+ resources and support groups	16	8%

3. Regarding the health conditions in the community you serve, please rank each of the following issues in terms of your level of concern.

	Not concerned	Somewhat concerned	Extremely concerned
Mental health issues	0%	6%	94%
Trauma/neglect/abuse on children	1%	14%	84%
Substance use disorder	0%	16%	83%
Alcohol use disorder	1%	30%	69%
Suicide	2%	32%	66%
Domestic abuse	1%	35%	64%
Poor nutrition/eating habits	5%	37%	57%
Obesity/overweight	6%	49%	44%
Poor birth outcomes	11%	44%	44%
Diabetes	10%	49%	41%
Poor maternal health outcomes	14%	47%	39%
Elder abuse and neglect	11%	51%	38%
Heart disease	12%	51%	38%
Vaping	19%	44%	37%
Age-related health issues	9%	55%	36%
Smoking/tobacco use	14%	53%	34%
High blood pressure	13%	55%	32%
Sexually transmitted diseases	11%	59%	30%
Breathing problems/asthma	10%	61%	30%

4. Are there any other health issues that you are extremely concerned about that are not mentioned above?

5. Regarding the existing obstacles to accessing health care among the community members you serve, please rank the following as not an obstacle, somewhat of an obstacle, or a strong obstacle.

	Not an obstacle	Somewhat an obstacle	Strong obstacle
Lack of counseling services in the area	4%	21%	75%
Medications are too expensive	5%	28%	67%
High copays and deductibles	6%	30%	64%
Too long of a wait to get an appointment to see doctor	7%	30%	63%
Transportation issues	7%	33%	61%
Language barriers	13%	30%	57%
Lack of awareness of local services	6%	38%	57%
Childcare issues	9%	34%	57%
Immigration status	13%	36%	51%
Difficulty using tech/lack of tech to use telehealth options	9%	43%	48%
Lack of insurance	10%	46%	44%
Very few specialists in the area, if any	16%	41%	43%
Fear (not ready to face health problem)	7%	50%	43%
No primary care physician	10%	48%	42%
Appointment time not convenient	21%	49%	30%
Cultural or religious beliefs	31%	51%	17%

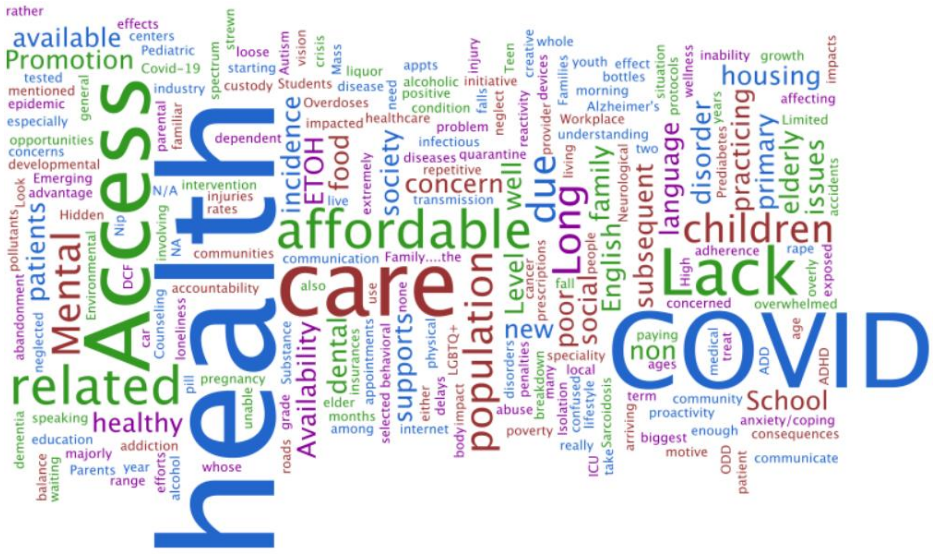
6. Any other obstacles not listed above?

SPRINGLINE RESEARCH GROUP

7. What people or groups does your organization serve?

	Number	Percent
Low-income persons	141	71%
Persons with mental or behavioral health issues	125	63%
Young adults (18-25 years of age)	123	62%
Families	120	60%
Persons who are homeless/unstably housed	119	60%
Non-English speakers	116	58%
LGBTQ+ community	115	58%
Persons with substance use disorder	115	58%
Older adults (older than 65 years of age)	114	57%
Immigrants (documented and undocumented)	108	54%
Adolescents (12-17 years of age)	105	53%
Medically uninsured or underinsured	105	53%
Persons with physical disabilities	101	51%
Persons with intellectual disabilities	97	49%
All of the above	97	49%
Infants/toddlers (0-5 years of age)	93	47%
Children (6-11 years of age)	93	47%
People with chronic disease	92	46%
Veterans	92	46%
Ethnic or racial minorities	87	44%
Persons with cancer	70	35%

8. Do you have any other comments related to the health and wellness of our region?



APPENDIX C: KEY INFORMANT INTERVIEWS

Twenty-three interviews were conducted with community leaders to further understand the challenges and opportunities facing South Coast residents. The interviews represent a cross-section of areas, including individuals who work with the homeless, veterans, immigrants, those experiencing mental health issues, food insecure persons, and faith-based congregations.

Name	Position	Organization
Ron Ponte	Member	Patient & Family Advisory Council/Community Benefits Advisory Committee
Gaelen Adam	Librarian/Editor/Senior Research Associate	Brown University
Michelle Hantman	President & CEO	United Way of Greater New Bedford
Reverend David Lima	Executive Director	Inter-Church Council of Greater New Bedford
Cheryl Bartlett	CEO	Greater New Bedford Community Health Center
Chris Everett	Wareham Service Director	Father Bill's & Main Spring
Peggy Hall	Stabilization Manager	Father Bill's & Main Spring
Maria Ferreira Bedard	Executive Director	SER Jobs for Progress
James Reid	Executive Director	Veterans Transition House
Elizabeth Wiley	Executive Director	Marion Institute
Joshua Amaral	Assistant Executive Director	People Acting in Community Endeavors (PACE)
Stanley Brajer	Director of New Bedford Community Connections Coalition	United Way of Greater New Bedford
Tess Curran	Director of Health & Human Services	Fall River Health Department
Wendy Garf-Lipp	Executive Director	United Neighbors of Fall River
Danielle Brown	Project Coordinator	Steppingstone
Helena DaSilva Hughes	Executive Director	Immigrants Assistance Center
Corinn Williams	Executive Director	Community Economic Development Center (CEDC)
Sergeant Sam Ortega	GNBOTF and GNB Human & Labor Trafficking Team	New Bedford Police Department
Haywood Barnes	Community Health Worker/Recovery Coach	Southcoast Health
Katlyn Auty	Chief Operating Officer	Southcoast Behavioral Health
Robin A Jones	Division Director of Early Intervention/Early Intervention Partnership Program	People Incorporated
David Perry	Director	SH/GFR Food Pantry
Kevin Sbardella	Executive Director	Fall River Housing Authority

Key Informant Interview Questions

I. Identifying Top Issues

1. What do you believe are the 2-3 most important issues that must be addressed to improve health and quality of life in your community? These don't necessarily have to be related to health.

   Probe [Provide some of these example as potential issues if they are not mentioned]: How about 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?

2. How have the top health issues that were mentioned affected your community?

   Probe: How has this changed in recent years? Are the issues getting better, worse, or about the same? How did COVID affect these issues; were some groups of people affected more than others and why?

II. ADDRESSING TOP HEALTH ISSUES

3. Thinking about the top health issues you mentioned, what is currently being done to address those issues for the community?

   Probe: For example, any programs or services available to help with these issues.

4. What programs, services or policies are needed in your community that would support health or make it easier to be healthy? That is, where are some of the gaps in services?

5. What do you think are some of the populations that are most underserved in the community?

III. Barriers

6. Are there significant barriers/obstacles to being healthy or making healthy choices in your community? What are those barriers?

   Probe: For example, lack of access to healthy foods, feeling unsafe in your neighborhood, lack of transportation option, stigma, prejudice, racism, lack of understanding of needs, trust.

IV. Improving Community Health

7. Thinking about the future, if you could do one thing to improve the health of people in your community, what would it be?

   Probe: What organizations are/who is already leading this effort?

8. With regard to the lessons learned during the COVID-19 pandemic, what would you recommend going forward to strengthen the community response so that similar situations in the future are addressed effectively?

9. 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 D: NEW BEDFORD HEALTH EQUITY COMMUNITIES OF PRACTICE INITIATIVE

The New Bedford Health Department, YWCA Southeastern Massachusetts, and Health Resources in Action hosted an event in June 2022 to build a Community of Practice and strategize next steps to reach health equity in New Bedford. The event was an interactive conversation about how racism operates in New Bedford and how stakeholders can operationalize a pro-equity agenda for the Greater New Bedford community.

Summary Results

Health and Healthcare

Challenges

- Infrastructure → Eurocentric medicine
- Systemic racism = groundwater, need for a shift
- Locations: do our doctors reflect the population being served
- Resources in accessibility → are they linguistically appropriate
- Less than 3% of doctors are black men (hiring process)
- Need more medical doctors in the community model that understand the culture(s)
- Funding → only certain people are receiving the funding
- Need for doulas → recognition of qualification
- Dismissive of individual needs based off racism and ethnicity
- Time to care: the time it takes individuals of color to receive care
- Paradigm shift
- Cost of healthcare → many do not seek care due to cost and bad circumstances
- Costs of medication
- Timely access to care → need to take time off work to go seek care
- Need to extend hours for medical facilities that are non-emergency
- Impatient costs
- Need to lead with data → what is measured is what is selected to be measured
- Long waits for access to doctors, especially those that represent the community
- Mental health access for those seeking representative care
- Historical trauma, for example Tulsa Tuskegee
- People often being talked down to by doctors after crossing barriers to reach that hospital/care center
- Access to insurance, especially when undocumented
- Health literacy and general literacy
- Medical billing is not transparent and is often outrageous in terms of cost
- Lack of representation of diverse populations in common core health books and beyond

Strategies:

- Hiring a diverse staff that reflects the community
- Seek out a diverse staff
- Have competitive wages to entice incentives
- Mandate all hospitals to have a certain percentage of POC staff
- Secure funding from the state that is separate from local government funding
- Open other offices or mobile clinics to decentralize healthcare
- Require policies around truth in medical billing
- Build better relationships between public schools, universities, and hospital groups
- Reparations
- Mental health integration into primary care

- More outreach workers to educate on available services
- Creating a professional development program for non-English speakers
- Community mental health service system
- Create community awareness to create advocacy and deliver policy change
- Increase the visibility of POC in education resources and literature

Education

Challenges:

- Undocumented individuals and their access to resources, internships, and co-ops
- Graduation rates, especially within low income and undocumented students
- A diploma is necessary for many jobs and the certificate of achievement often does not count
- Inequity in MCAS and standardized testing (special education, POC, non-English speakers, people with low parental support that cannot afford tutoring)
- The inequity in which students are being disciplined
- Not having many POC staff/teachers
- There is not proper support for many students in vocational schools
- The biases in the education system
- Not enough childcare
- High turnover for the staff in younger education because teachers are not paid enough
- Not enough mental health support and therapy
- Assumptions around which students will go into which programs → and how that affects what programs the guidance counselors will tell certain students about
- The domino effect of low access to early childhood education and how that eventually affects economic opportunity
- Lack of hope for many students, especially after COVID-19
- Safety in the schools, often leads to segregation
- Disparities in funding for schools
- MCACs are tied to literacy
- Financial literacy
- There are not enough classes that are bilingual
- Broken education system
- Headstart should be available to everyone who lives in New Bedford (not just a certain income)
- Curriculum should include BIPOC people and their experiences
- The school committee meetings are not diverse
- Parents should not have to sacrifice pay to attend school meetings

Strategies:

- Waive the MCAS test so people can receive their high school diplomas easier
- Recruit more POC staff/teachers → the staff should reflect the community
- Promote equitable access to trades/vocational programs
- Investing more in early development and governmental support
- Increase POC staff for mental health support
- Universal pre-K and kindergarten to help support students from a young age
- Increase social/emotional support to address trauma from COVID-19 (especially within racial inequities)
- More education and training in the classroom for teachers, especially centered around social and emotional training and cultural humility
- More outreach and working with guidance counselors in regard to which higher education programs are available
- Educations need more support with behavioral issues
- Normalize people asking for help
- Need families to have the opportunity to be more involved in their child's education

- Change the curriculum to make it more diverse
- Make sure the schools are clean and enforce smaller class sizes to each child receives more individualized attention
- More equitable funding for high schools
- Start earlier with literacy (more funding for early education)
- Higher pay for teachers
- Increase adult education
- More inner city education
- Increases the availability of classes for people who speak English as their second language
- Hire staff who speak multiple languages
- Incentivize parents to be involved in their child's education
- Allow the community to have a voice in the curriculum to help ensure that it is diverse
- Integrate DEI programming
- Implement the same opportunities for all students
- Normalize therapy and mental health help
- Give everyone access to resources to incentivize solutions
- Use lottery funds for education
- Pay attention to school committee meetings

Economic Stability

Challenges:

- Housing: rents are going up (doubling), especially in high risk areas
- Concentrated poverty + concentrated violence
- Unemployment rates + antiquated unemployment systems that create racial disparities in access to service
- Lack of assistance for working poor → face of houseless
- The elderly are not in the low income brackets
- Increase in food prices
- Not earning home equity fast enough in certain areas
- No living wage
- The development of housing is profitable which leads to shortage of housing units based on how supply and demand shifts
- POC are being pushed out of homes because rent is increasing
- Homeowner's repair cost
- Credit repair + financial literacy → funnel people to become first time buyers
- Food insecurity before COVID-19 was about 30%, now 50%
- Transportation and gas are expensive
- Often grocery stores are not located in certain neighborhoods
- Bodega's cigarette and alcohol advertisements
- Check cashing places of undocumented immigrants and low-income individuals (usually in unsafe neighborhoods)
- Access to banking
- Early cashing checks + pay day loans → the interest rates can increase
- How the racial lens affects concentrated poverty and home ownership
- Many are stuck in a system of public housing without any support for economic stability
- No access to more work opportunities, for example green jobs + training + higher education
- No training programs
- Lack of representation of POC people in high level jobs
- Not enough guidance counselors
- Environmental justice
- Unsafe and unhealthy living conditions
- Work/life balance for parents and how that affects children

Strategies:

- Modified rent control (for the individual)
- Health equity zones → conc. Poverty and violence
- Identify the pockets with less than 50% median income and also look at employment rates and tax credits
- Create a data set about closures (housing)
- Educate more about the impacts of COVID-19 on racial disparities
- Trying to increase housing prices
- Change federal programs
- Public investment in housing (not only private)
- CEDC corporation → change qualifying criteria
- Protect practices
- One time grants for homeowners
- Adjust criteria for first time homeowners
- Strategies to address food insecurity
- Community gardens
- Research + implementation of policies tried in other cities
- Increase financial literacy (K-12)
- Policy for livable wages
- Equal pay
- Advocacy for common operations
- Universal days income
- Public housing for first time home buyer pipeline
- Actively training for minorities for green jobs
- Repurpose land
- The south end has CEDC
- Mentor youth into workforce
- Child tax credit
- Teach people how to cook
- NBHD to find landlords
- Nonprofit/ government housing (proportion of homeownership)
- Incentives for New Bedford residents to purchase homes

Neighborhood and Built Environment

Challenges:

- Tree canopy
- Flooding disproportionate
- Perception of high crime
- Policing of different (violent) areas
- Access to healthy foods
- Prices as it relates to healthy and unhealthy
- Neighborhood proximity to liquor stores and bodegas etc.
- Conditions of housing (older homes with lead, poor filters, soil, air quality)
- Increase in housing costs
- Not enough voices that fully represent the community
- There is an increase in health conditions (both physical and mental)
- Inadequate or absence of signage to indicate health diagnoses
- Flood zones disparities
- Unequal access to green spaces
- Housing units + poor ventilation

- Long waitlist for sec. 8
- Large number of homeless people, need to take a deeper dive into those reasons → "pockets parks"
- Prevalence of garbage
- Hardscapes
- Lack of youth community centers → the current ones need longer hours
- Unnatural divisions in land space
- Youth violence based on location

Strategies:

- Food access → is not pop-ups, instead support the business owners
- Healthy food access points → disrupt the design
- Educational empowerment
- SNAP/HIP assistance to help support bodega owners
- Curriculum- school based for youth to understand the value of eating food
- Increase experiences that encourage curiosity
- Policy with health department for housing
- Bring even more perspectives to table
- Policies to support appropriate housing
- Warm handoffs to transition to different housing level
- Anti-stigma to address chronic homelessness
- Increase services to homeless people and substance use individuals
- Standard of physical appearance (policy in development)
- Increase collaborative process to working with certain people

Social and Community Context

Challenges:

- Civic participation
- Discrimination
- Incarceration
- Social cohesion
- Discrimination against/targeting of immigrations
- Services not provided in appropriate language
- And lack of language capacity within organization
- Undocumented people— underlying trauma
- Processes and paperwork for accessing services unclear
- Integration of different cultures is liminal, need for community mediation
- Lack of events/community orgs for the Latin population
- Lack of cultural responsiveness
- Personal biases
- Hard to prove that discrimination exists
- Existing programs/services are not relational- "toxic charity" "white saviorism"
- Segregation by racial and ethnic group, neighborhoods/groups don't mix
- Do we really value multiculturalism?
- Lack of community policing and over policing (over incarceration of POC) and racial profiling in some areas
- Do not know our neighbors- lack of trust
- Less civic engagement from young people, less spirit of volunteerism
- Lack of mentors, age group interaction
- Need for personal invitation to participate
- Lack of city appreciation for youth led initiatives

- International discrimination especially against women
- Nepotism, hiring people you know
- Deficit thinking about different groups
- Commonly held conceptions about incarceration– should "pay the price" indefinitely
- Beliefs on who is worthy of civic engagement by citizenship status
- Barriers to access for healthy and culturally appropriate foods
- Black maternal health
- Lack of belonging in the larger community
- Discrimination/racism toward certain ethnic groups/neighborhoods- "kiss me I'm Black"
- Lack of time/capacity to devote to efforts outside of work/family
- Mindset that nothing will ever change

Strategies:

- Inclusive planning communities for events
- More events → Puerto Rican festival
- Community service programs in schools
- Appoint young adults to boards and commissions
- Restorative justice programs- post incarceration and preventative/diversion
- Combat school → prison pipeline
- Build relationship trust across the board (vs. one off things)
- Elevate nonprofit collaboration over competition (for $)
- Prioritize CLAS in all federally funded agencies. Don't overlord those that have language capacity people (relationships and trust) > technology
- Equity in hiring → revise recruitment practices (job fairs), training and workforce development, public sector pay reform, incentives to keep talent in NB
- Reduce understaffing of public services
- Mindfulness to address trauma- incorporate in school, police systems
- More support for formerly incarcerated people
- Jobs open to people w records
- CORI friendly
- Database for jobs
- Health centers targeting Black women
- How to elevate healthcare access?
- Teach civic engagement in schools → parents are too busy with other demands on their time
- State and federal laws/policies
- Rent caps
- Recognize and utilize your own gifts and strengths → teach others to do this too
- Culture of open conversation in schools
- More affirming groups at schools for students and staff
- Rebuild a village mentality in communities
- City driven DEI committee

APPENDIX E: HEALTHY NB PARTNERSHIP

Contributing Organizations

The New Bedford Health Department	The LGBTQ+ Network- Southcoast	The City of New Bedford Council for Citizens with Disabilities
Southcoast Fishing Partnership	Community Economic Development Center	The New Bedford Housing Authority
Groundwork Southcoast	New Bedford Parks, Recreations, and Beaches	The Greater New Bedford Community Health Center
Seven Hills Behavioral Health	YWCA	Immigrants Assistance Center
	New Bedford Shannon Program	

Mission

This partnership works to advocate and strive for a New Bedford Community Health Needs Assessment and a Community Health Improvement Plan that are community driven documents that represent the diverse community we serve.

Vision

This partnership will guide and inform present and all future versions of New Bedford's Community Health Needs Assessments and Community Health Improvement Plans. This group of organizations will ensure community involvement and representation in these documents while also monitoring the progress of the Community Health Improvement Plans.

Summary

The Healthy NB Partnership meets regularly (monthly or more frequently as needed) via Zoom and is facilitated by the New Bedford Health Department's Accreditation Coordinator.

During initial meetings related to the Community Health Needs Assessment process, between August 5, 2022, and September 16, 2022, each participating organization assigned one representative as well as one alternate in the event the assigned individual could not attend.

The Visioning Process

The partnership begam it's work together on August 5th, 2022, with a process that focused on a collective vision for a healthy New Bedford. This vision included consideration to the CDC's 5 Social Determents of Health (https://www.cdc.gov/publichealthgateway/sdoh/index.html). Preceding the visioning activity, the partnership outlined the barriers to the collective vision of a healthy New Bedford and discussed possible strategies and contributing partners that could support the vision. Participants were placed in break out rooms on Zoom and were assigned randomly to one of the five social determinants of health to guide visioning discussions. Each group added their discussion on their group's assigned slide on a shared Google slide deck.

Data

Data sources used for the Community Health Assessment were presented to and reviewed by the Healthy NB Partnership to ensure that the data used was representative of New Bedford's diverse population. In addition to the review of archival data sources, the partnership also reviewed and offered feedback on data collection strategies and processes for all Community Health Assessment related surveys.

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