Saint Anne's Hospital

2025 Community Health Needs Assessment

September 2025

About Brown University Health and the 2025 CHNA

Formed in 1994, Brown University Health is a not-for-profit health system based in Providence, Rhode Island comprising three teaching hospitals of The Warren Alpert Medical School of Brown University: Rhode Island Hospital and its Hasbro Children's; The Miriam Hospital; and Bradley Hospital, the nation's first psychiatric hospital for children; Newport Hospital, Saint Anne's Hospital, and Morton Hospital, community hospitals offering a broad range of health services; Gateway Healthcare, Rhode Island's largest provider of community behavioral healthcare; and Brown Health Medical Group, the largest multi-specialty practice in Rhode Island.

Saint Anne's Hospital joined the Brown University Health system in 2024. Founded by the Dominican Sisters of the Presentation in 1906, Saint Anne's Hospital in Fall River, Massachusetts, is a full-service, acute care Catholic hospital with 196 beds and satellites in Fall River, Attleboro, Swansea, and Dartmouth. The hospital provides nationally recognized patient- and family-centered inpatient and outpatient clinical services to patients from surrounding Massachusetts and Rhode Island communities.

Delivering health with care, Brown University Health is committed to restoring people's health and strengthening and supporting the health of the communities it serves. We are a cherished community asset, synonymous with the highest quality, most compassionate, and most patient-centered healthcare anyone needs, at any age and at any time of life. That goal extends beyond the health system into schools, workplaces, and neighborhoods. Across the system we all share a commitment to put the patient at the center of everything. That commitment is realized through investments in charity care, in-kind and subsidized health services, research, provider education, and community initiatives.

Brown University Health coordinates hundreds of programs, events, and community service activities that serve between 25,000 and 30,000 southern New Englanders annually. Programs are provided through partner hospitals and are often offered free or at a reduced cost to the community.

Brown University Health is dedicated to understanding and addressing the most pressing health and wellness concerns for the communities we serve. Brown University Health undertook a Community Health Needs Assessment (CHNA) for each of its hospitals' service areas. The goal of the CHNA is to monitor the health of community members and to identify common and unique challenges across the region. The CHNA informs the development of a Community Health Improvement Plan to address identified priority needs and align community investments with the highest needs.

Brown University Health 2025 CHNA Leadership

Kevin Bickerstaff, CPA/MST, Director of Finance, Brown University Health

Carrie Bridges, MPH, Vice President of Community Health, Brown University Health

Teresa Gerety Ibbotson, MEd, Administrative Director of Community Health Benefits, Saint Anne's Hospital, Brown University Health

Katherine Kiser, Manager of Tax Compliance, Brown University Health,

Julie Masci, Senior Director of Marketing, Community Relations & Support Services, Morton Hospital, Brown University Health

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The 2025 Community Health Needs Assessment

The goal of the CHNA was to gather data and community input to inform strategies and policies to support a healthy and thriving community and to foster collaboration among community organizations in developing and delivering services to the residents they serve.

CHNA Study Objectives:

- Compile a comprehensive profile of the factors that impact health and wellbeing for residents
- Compare community health indicators with previous CHNAs to document trends and changes
- Demonstrate the impact of Social Drivers of Health; document disparities experienced by populations and communities
- Strengthen community member engagement and partnerships; engage residents in the study process
- Define three-year priority areas and develop action planning
- Develop a community resource to monitor the progress of community health initiatives

The results of the CHNA will help us identify priorities and strategies to improve health and wellbeing in the region and promote health for all residents. Responding to the study findings and sharing data with other community-based organizations, Brown University Health aims to ensure that all residents benefit from our local resources, robust social service network, and the high-quality healthcare available in our community to help residents live their healthiest lives.

We thank you for partnering with us in this effort. We invite our community partners to learn more about the CHNA and opportunities for collaboration to address identified health needs. Please visit our website at https://www.brownhealth.org/centers-services/community-health-institute or contact Tracy Gerety Ibbotson at TGeretyIbbotson@brownhealth.org.

Research Partner

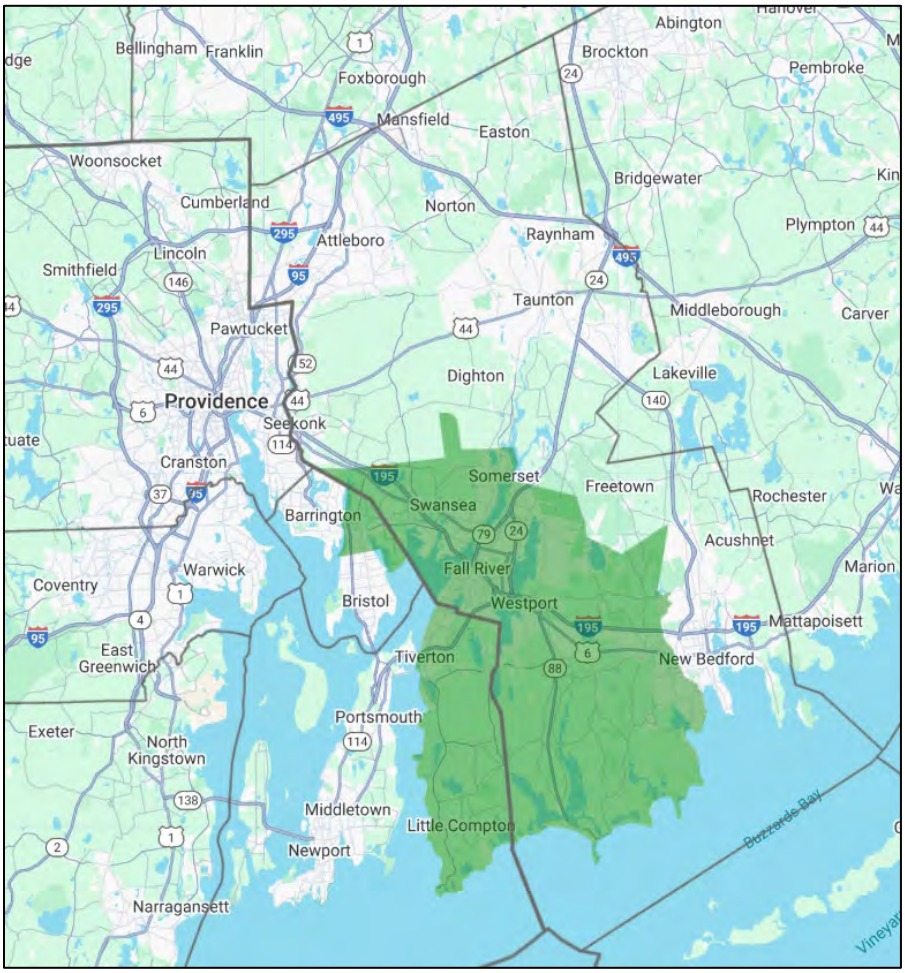
Brown University Health contracted with *Build Community* to conduct the CHNA. *Build Community* is a woman-owned business that specializes in conducting stakeholder research to illuminate disparities and transform data into practical and impactful strategies to advance access, support, and opportunities for all. An interdisciplinary team of researchers and planners, *Build Community* has worked with hundreds of healthcare and community-based organizations and their partners to reimagine policies and achieve measurable impact. Learn more about their work at buildcommunity.com.

2025 CHNA Study Area

Saint Anne's Hospital is a full-service, acute care Catholic hospital located in Fall River in Bristol County, Massachusetts along the border with Rhode Island. Saint Anne's Hospital defined its service area as the county served and used the zip codes of residence for the majority of patients seen at its hospital facility to define its primary service area. Demographics and other available indicators for zip codes and neighborhoods within the primary service area were analyzed to determine opportunities for prioritized interventions to address health and social disparities.

Saint Anne's Hospital defined its primary service area as 15 zip codes spanning the southwest portion of Bristol County and eastern portions of Bristol and Newport counties in Rhode Island. For purposes of the CHNA, the hospital focused reporting on its Massachusetts service area. Throughout the data report, findings for Fall River and all of Bristol County are highlighted in comparison to the state and nation. Secondary data also includes findings for Taunton, the location of Morton Hospital and a collaborating partner for the CHNA.

Saint Anne's Hospital Primary Service Area



Research Methods

The CHNA was conducted from October 2024 to June 2025 and included primary and secondary research methods to determine health trends and disparities.

Primary Research and Community Engagement

Community engagement was an integral part of the CHNA. Collaborating with community-based organizations across Bristol County and Massachusetts, input was invited and received from a wide array of community members with a particular focus on diverse populations, under-resourced areas, and communities that have been historically marginalized. Study participants provided perspectives on unmet health and social needs; community resources available to meet those needs; barriers to accessing services; service delivery gaps; and recommendations to improve health and wellbeing.

Key Stakeholder Survey

We conducted an online survey with 137 individuals that serve diverse communities and populations across Fall River, Bristol County, and beyond to collect input about local health needs, client experiences in receiving and accessing services, and opportunities for collective impact.

Partner Forum

We held a community meeting with 63 health and human service professionals serving Fall River and Bristol County to share CHNA data findings and collectively define challenges and meaningful strategies for health improvement. Attendees included healthcare and social services providers, educators, and community leaders, among others.

Listening Sessions

We hosted two listening sessions with long-term residents of Fall River and health and human service providers serving students and families of Fall River Public Schools. We partnered with the South Coast Community Health Alliance to hear from diverse community voices across the region. Participants discussed experiences accessing health and social services, identified available and needed community resources to support health and wellbeing, and provided community recommendations and insights on solutions.

Secondary Data Analysis

Secondary data are reported by city and county, and by zip code, as available, to demonstrate localized health needs and disparities. The most recently available data at the time of publication is used throughout the study; due to the time required to collect and analyze these data, it is typical for these data to reflect prior years rather than current year. A comprehensive list of secondary data sources is included in Appendix A.

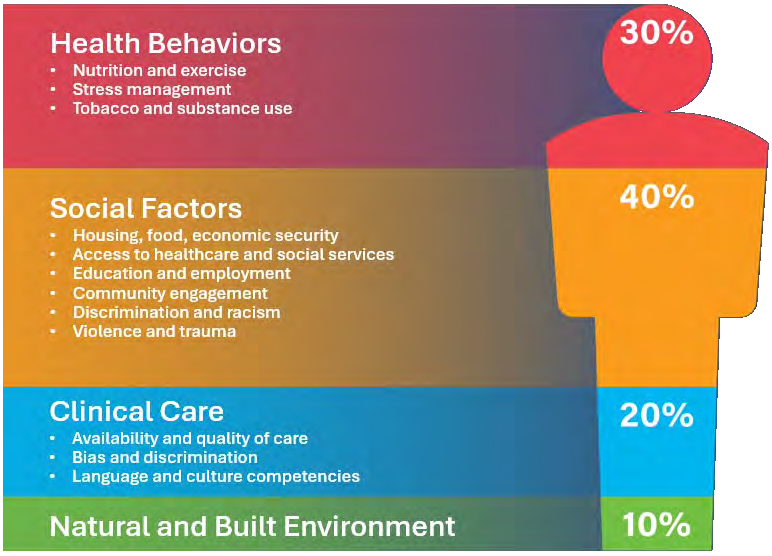
Social Drivers of Health

Where we live impacts choices available to us

The CHNA was conducted to provide deeper insights into the differences in health and wellbeing experienced between groups of people in the region. We used the Social Drivers of Health (SDoH) framework to study and document income and poverty; housing and food security; early learning and education; social factors and the environment and built community. We analyzed data across these five domains of SDoH to identify strengths and challenges in our community that impact our health and wellbeing.

Graphic Credit: U.S. Department of Health and Human Services

Social Drivers of Health are the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks.



50% of a person's health is determined by social factors and their environment.

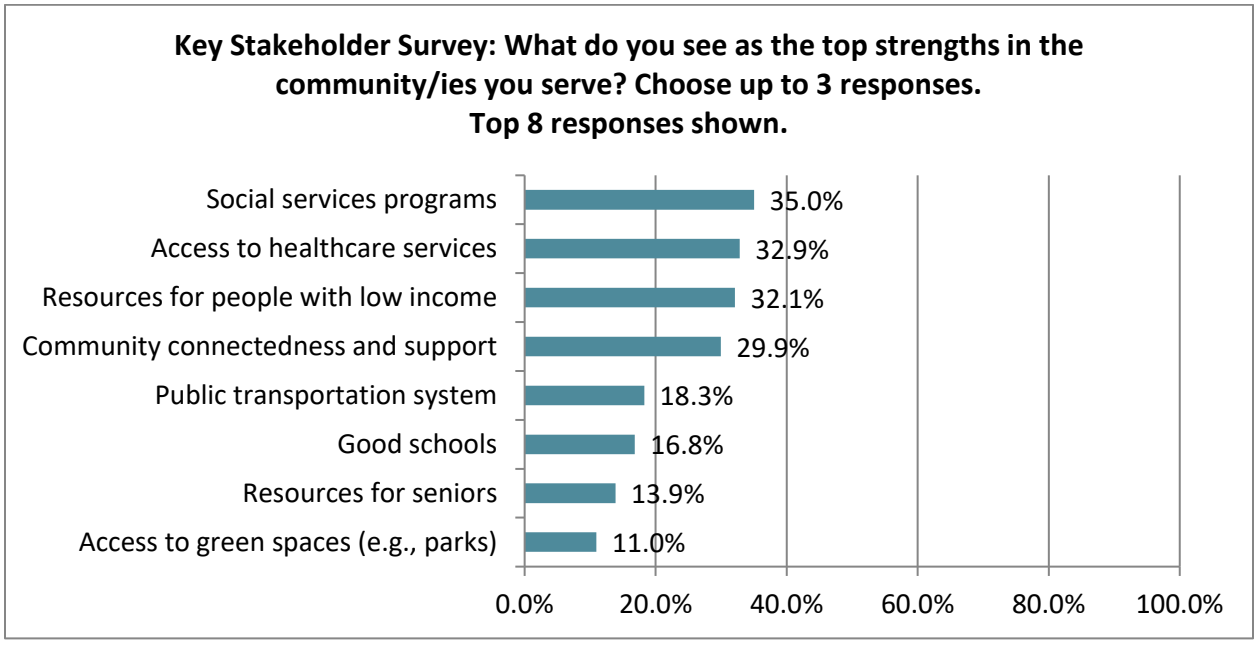
Only 20% of health outcomes are attributed to clinical care.

Examining data across SDoH domains helps us understand factors that influence differences in health status, access to healthcare, and outcomes between groups of people**.** These differences include higher prevalence of chronic diseases like diabetes, lack of health insurance, inability to afford essential medications, and shortened life expectancy. Advancing health for all residents means ensuring that all people in a community have the resources and care they need to achieve optimal health and wellbeing. To advance health for all, we need to look beyond the healthcare system to address "upstream" SDoH issues like education attainment, job opportunities, affordable housing, and safe environments.

Our Strengths and Opportunities

Massachusetts is one of the healthiest states in the nation. Residents as a whole live longer and enjoy better health while they're alive. Statewide health and healthcare policy initiatives have supported health for residents, including universal preschool and free lunches for students, near universal health insurance, and free community college tuition and financial aid for four-year public universities for certain income levels. Localized efforts have contributed to advances in socioeconomic factors, healthcare access, and health outcomes, and have included more resources for housing and food pantries, Community Health Worker (CHW) models, partnerships between high schools and universities to meet workforce needs, and greater language capacity, among others.

When asked what they see as the top strengths in the community, participants of the Key Stakeholder Survey named *social service programs*, *access to healthcare services*, *resources for people with low income*, and social cohesion factors like *community connectedness and support* among the top attributes. The region is also unique from many communities across the nation with perceived good access to *public transportation*.



In a follow-up question, Key Stakeholder Survey participants were asked to rate various SDoH factors for the region. Approximately 40% of participants rated *access to green spaces and outdoor recreation* and *healthcare access and quality* as "good" or "excellent." Over 35% of stakeholders rated *inclusion and appreciation of diversity in people and ideas*, *public transportation options*, and *childcare and early childhood education opportunities* as "good" or "excellent."

> *"It seems the infrastructure was in place to provide parks/playgrounds and public transportation for the city."*
>
> *"Fall River is lucky to have two quality hospitals located in the same city with good care and community involvement."*

"HealthFirst does an amazing job engaging the community and targeting populations that avoid the system services for the many reasons they avoid (i.e., immigration issues, addiction stereotyping, cultural choice, fear of illness, etc.)."

"[There is] free universal preschool in our public schools."

The region is supported by a strong and collaborative network of health and human service partners. The newly formed South Coast Community Health Alliance is working to unite healthcare providers in assessing and responding to the needs of residents. The Greater Fall River Partners for Healthier Community, Inc. is a network of health and human service providers that has operated for more than 30 years, acting as a catalyst for healthy eating and active living in the Greater Fall River area.

"Community collaboration is very big and a key factor towards the positive things that are coming about in our area."

"A combination of dedicated municipal resources and community organizations working together has a positive impact."

"There are leaders, movers, and shakers that work tirelessly to work with those they provide services to and a great deal of passion for what they do."

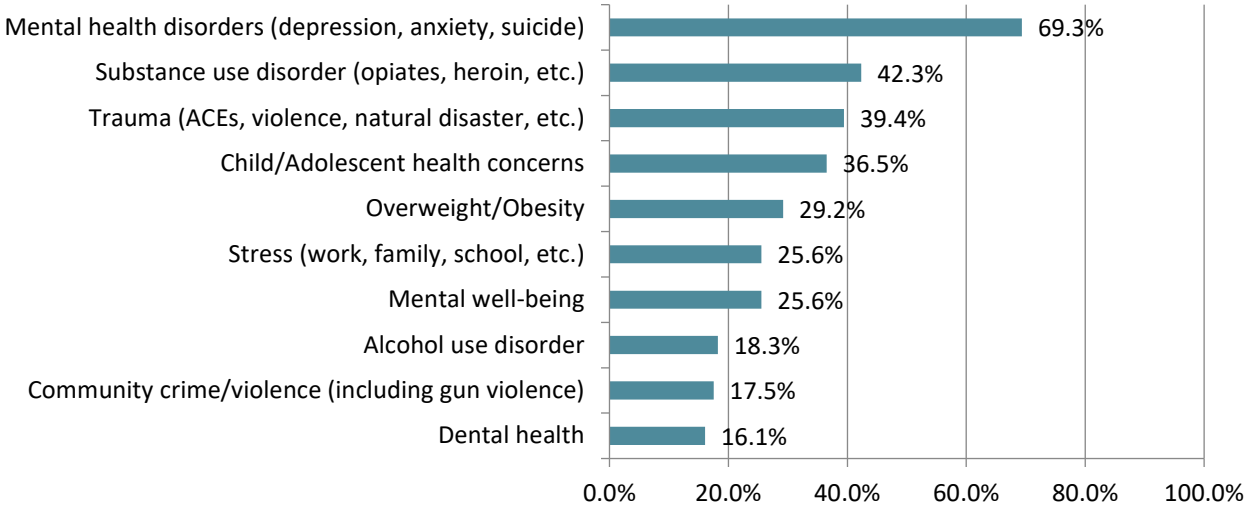
"[After the pandemic] We took off titles to work on real issues."

Community Strengths

- Commitment to access, support, and opportunities for all
- Good schools and early childhood education
- High quality healthcare services
- Local community development and infrastructure improvements
- Public transportation options
- Recreational areas and green spaces
- Sense of community
- Statewide health and healthcare policy
- Strong and collaborative social service safety net

Using these existing strengths and community assets, communities can work together to improve health. When asked to name the top health concerns affecting the people they serve, Key Stakeholder Survey responses overwhelmingly identified issues related to *behavioral health* (e.g., mental health, substance use, alcohol use disorder, trauma, stress). Other identified issues included *child/adolescent health concerns*, *overweight and obesity*, *community crime and violence*, and *dental health*. Key stakeholders' perceptions of these health concerns were in line with the secondary data statistics for the region.

Key Stakeholder Survey: What are the top health concerns of the community/ies you/your organization serve? Choose up 5 responses. Top 10 responses shown.



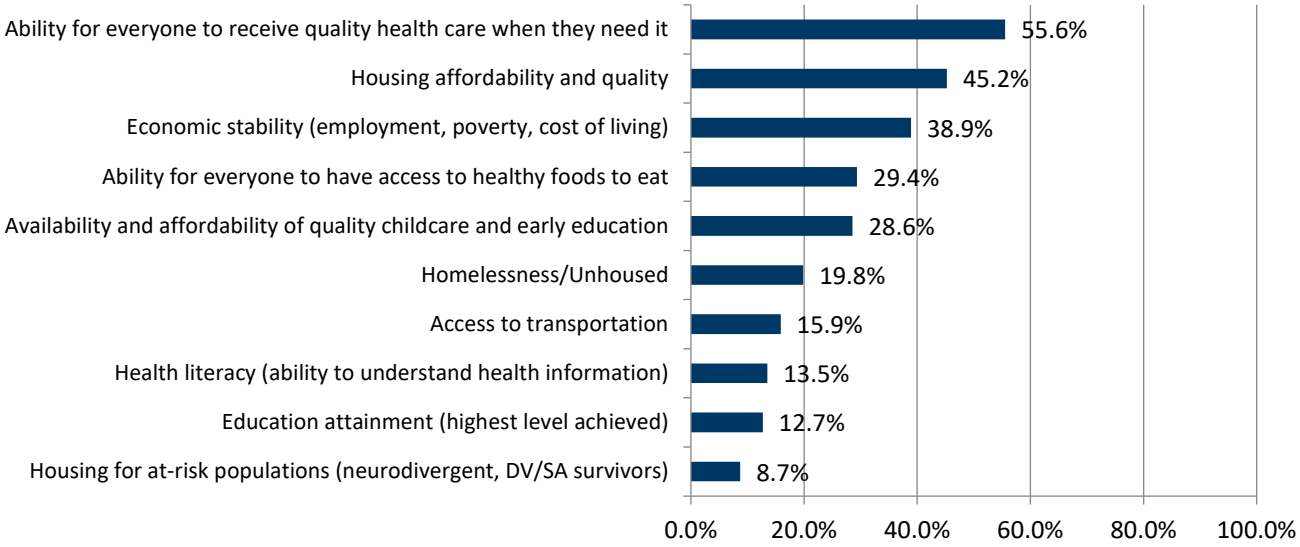
Community perception and public health data suggest that many of the identified health concerns worsened in recent years due to the lingering impact of the COVID-19 pandemic (e.g., isolation, delayed healthcare, developmental delays) and underlying SDoH factors, including rising cost of living and housing instability. Nearly 65% of Key Stakeholder Survey participants rated *housing affordability and availability* as "poor." Approximately 70% of participants rated *healthy food access and affordability* and *community safety* as "fair" or "poor." Approximately 65% of participants saw room to improve *public policies that promote health for all* and *civic participation* by residents, rating them as "fair" or "poor."

> *"Patients often tell us that access to housing, food, and healthcare are high on their list of concerns."*
>
> *"The increase of homelessness in the city. There are many children going through this currently and children cannot focus or grow in school in these kind of living conditions."*
>
> *"In terms of crime, the current response is largely reactive rather than proactive. The city's law enforcement efforts often focus on responding to crimes after they occur, perpetuating the cycle of violence and fear. A proactive approach that focuses on addressing the root causes of crime—such as poverty, lack of education, and unemployment—is critical. By investing in programs that provide support to at-risk individuals, particularly in marginalized communities, the city can help*

prevent crime before it happens. This could include increasing access to job training, educational opportunities, mental health services, and community outreach programs that engage young people and provide alternatives to criminal behavior."

When asked which SDoH to prioritize in order to have the biggest impact on the overall health of the people they serve, more than 55% of key stakeholders selected the *ability for everyone to receive quality healthcare when they need it*. *Housing affordability and quality* and *economic stability* were the next most selected factors.

Key Stakeholder Survey: Which of the following issues related to Social Drivers of Health should we prioritize to have the biggest impact on the overall health of the people you serve? Choose up to 3 responses.
Top 10 responses shown.



Community Challenges

- Access to preventive and routine healthcare
- Aging community with more health and social concerns
- Care and support for the unhoused population
- Chronic conditions prevention and management
- Community crime and violence
- Economic and health disparities for income constrained households
- Growing behavioral health concerns for adults and youth
- Prevalent experiences of poverty, food insecurity, and other socioeconomic barriers
- Rising cost of living and lack of affordable housing, childcare, food, and other basic needs

Determining Community Health Priorities

To improve community health, it is imperative to prioritize resources and activities toward the most pressing and cross-cutting health needs. In determining health priorities on which to focus its efforts over the next three-year cycle, Brown University Health and Saint Anne's Hospital leadership reviewed findings from the CHNA and sought to align with its health improvement programs and population health management strategies.

Brown University Health applied the following rationale and criteria to define priorities:

- Prevalence of disease and number of community members affected.
- Rate of disease compared to state and national benchmarks
- Health differences between community members.
- Existing programs, resources, and expertise to address the issue.
- Input from community partners and representatives.
- Alignment with concurrent public health and social service organization initiatives.

Based on the CHNA findings, Brown University Health and Saint Anne's Hospital will focus on the following priority areas, addressing underlying Social Drivers of Health and the needs of distinct population groups as cross-cutting strategies.

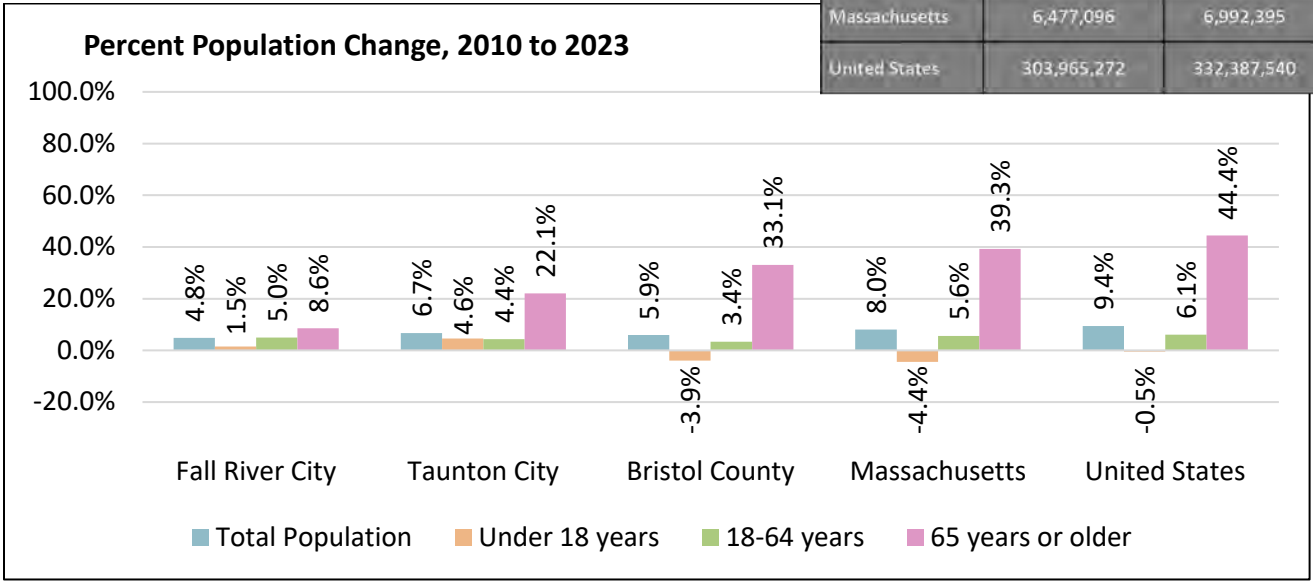
Other health issues identified as significant health needs for the region include affordable housing, maternal and child health, and older adult health and wellbeing. While these areas are not named priorities for Brown University Health due to the need to prioritize resources, the system is committed to collaborating with and supporting other community agencies focused on these needs. Brown University Health will also consider these areas and populations when developing nuanced and whole-person strategies to improve access to care, behavioral health, and chronic disease.

Our Community and Residents

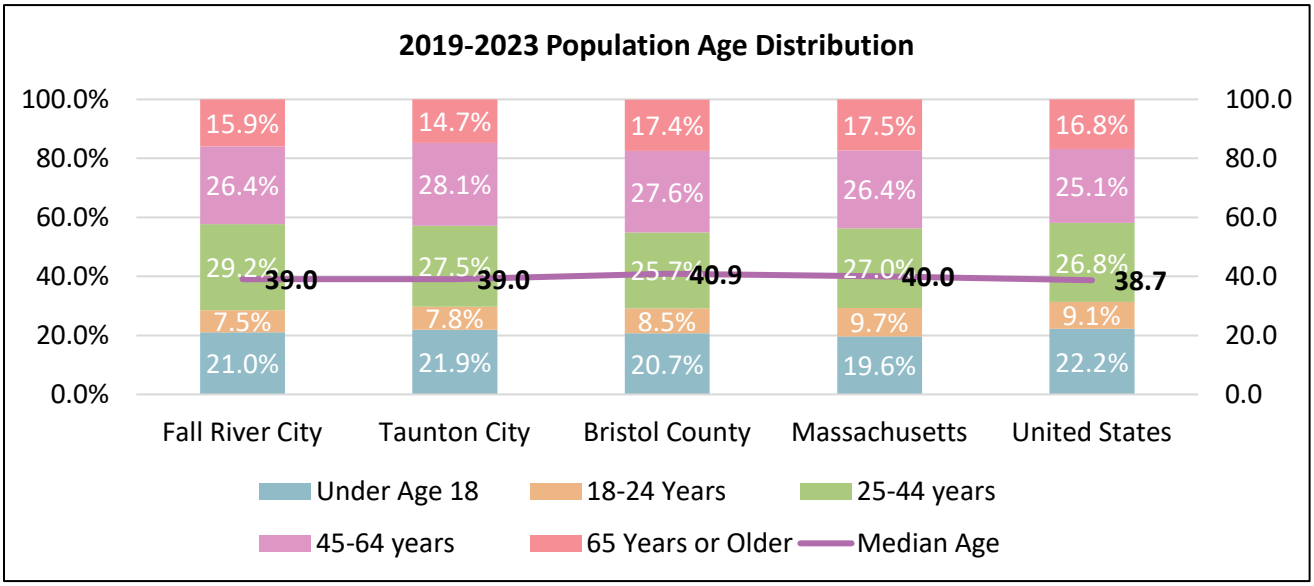
Bristol County had a total population of 578,436 people in 2023 with 93,764 people residing in Fall River. The Fall River population grew 4.8% from 2010 to 2023, slower growth than the county, state, and nation overall. Fall River is home to a slightly younger population than Bristol County, and contrary to county, state, and national trends, saw an increase in youth residents. More than 1 in 5 Fall River residents are under the age of 18. The area also saw growth in older adults, although at a slower rate than comparison geographies.

Total Population by Year

	Total Population 2010	Total Population 2023
Fall River City	89,482	93,764
Taunton City	55,954	59,719
Bristol County	546,433	578,436
Massachusetts	6,477,096	6,992,395
United States	303,965,272	332,387,540



Source: US Census Bureau, American Community Survey



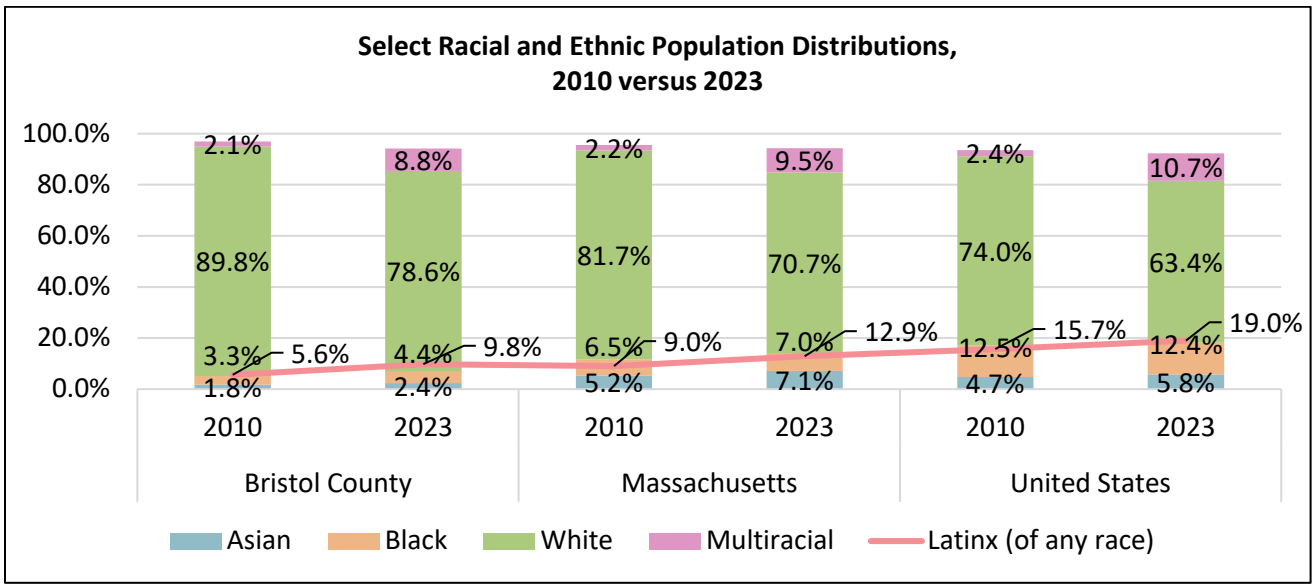
Source: US Census Bureau, American Community Survey

Disability is a physical or mental condition that limits a person's movements, senses, or activities. Approximately 20.5% of Fall River residents experience disability, a higher proportion than the county, state, and nation. Older adults are more likely to experience disability, affecting 41.7% of older adults in Fall River compared to 30.2% of adults across Massachusetts.

2019-2023 Population with a Disability

	Fall River City	Taunton City	Bristol County	Massachusetts	United States
Total population	20.5%	15.9%	14.6%	12.1%	13.0%
Youth under 18 years	7.0%	6.3%	5.5%	4.9%	4.7%
Older adults 65+ years	41.7%	34.9%	32.6%	30.2%	32.9%

Consistent with national trends, population diversity is increasing across Bristol County and Massachusetts. People of color, particularly those that identify as multiracial and/or Latinx, make up a larger portion of the population than in prior years.



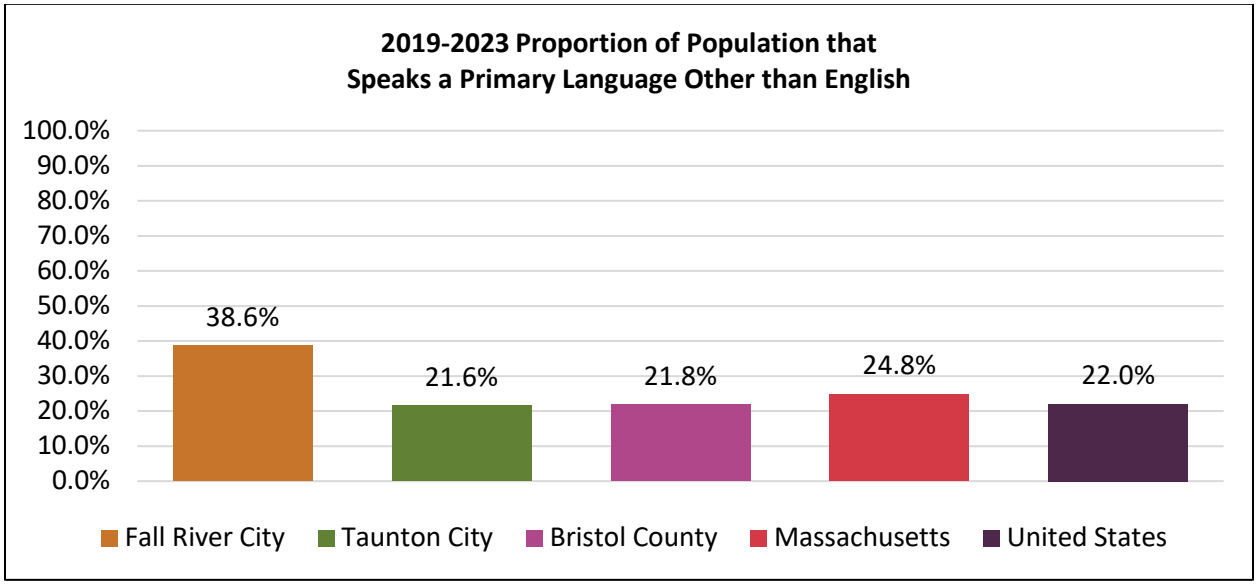
Source: US Census Bureau, American Community Survey

2019-2023 Population by Race and Ethnicity

	American Indian and/or Alaska Native	Asian	Black and/or African American	Native Hawaiian and/or Pacific Islander	White	Other Race	Two or More Races	Latinx origin (any race)
Fall River City	0.1%	2.7%	6.4%	0.1%	72.8%	7.0%	11.0%	13.2%
Taunton City	0.35	1.5%	7.1%	0.0%	74.5%	2.9%	13.7%	9.1%
Bristol County	0.2%	2.4%	4.4%	0.0%	78.6%	5.6%	8.8%	9.8%
Massachusetts	0.2%	7.1%	7.0%	0.0%	70.7%	5.4%	9.5%	12.9%
United States	0.9%	5.8%	12.4%	0.2%	63.4%	6.6%	10.7%	19.0%

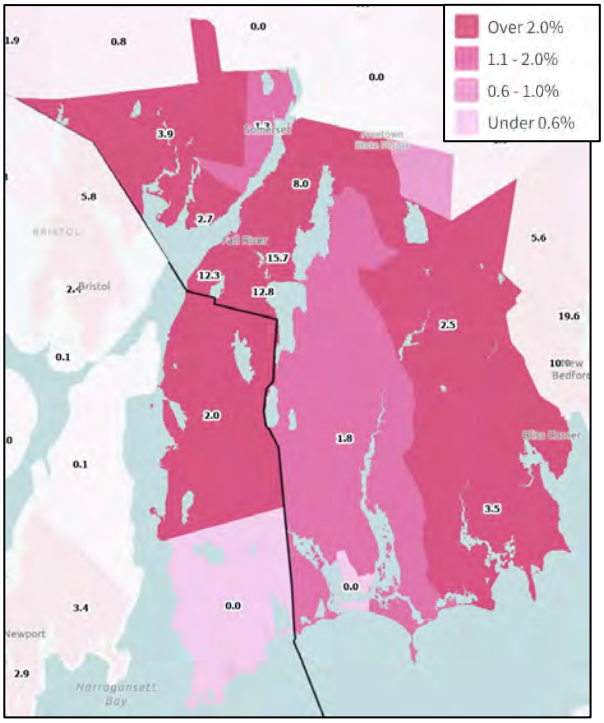
Source: US Census Bureau, American Community Survey

More than 1 in 3 Fall River residents speak a primary language other than English. In as many as 16% of households, no one aged 14 or older speaks English at least "very well" and another language is often spoken in the home. These findings inform a heightened community need for bilingual and culturally appropriate resources and workforce efforts to ensure that providers and staff reflect the communities they serve.



Source: US Census Bureau, American Community Survey

2019-2023 Linguistically Isolated Households by Zip Code^



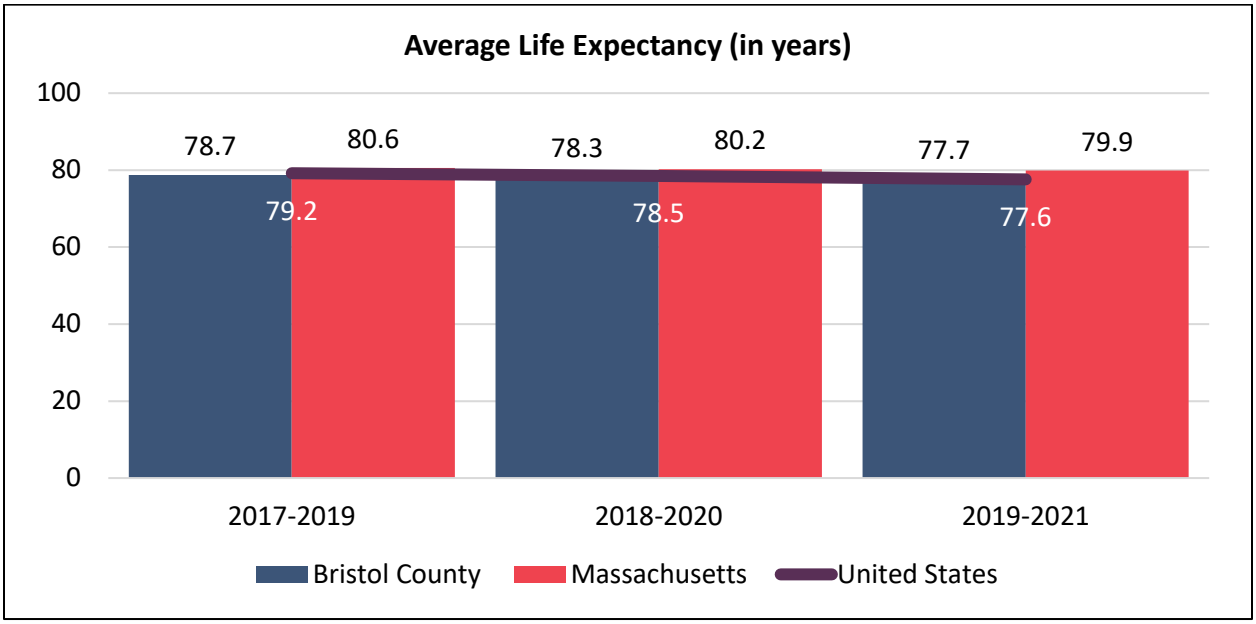
Source: US Census Bureau, American Community Survey

^Defined as households with no one aged 14 or older who speaks English "very well."

Measuring Health in Our Community

Life expectancy is a key measure of health and wellbeing within a community, often reflecting the underlying socioeconomic and environmental factors or SDoH.

Life expectancy measures how long a person can expect to live and is the culmination of living conditions, health status, economic security, and the general experience of residents within their community.



Source: Centers for Disease Control and Prevention

The Social Drivers of Health framework shows that at least 50% of a person's health profile is influenced by the socioeconomic and environmental factors that they experience. Understanding the impacts and addressing the conditions in the places where people live is essential to improving health outcomes and advancing fair access, support, and opportunities for all.

Massachusetts is one of the healthiest states in the nation, and residents report overall better health outcomes and higher average life expectancy than the national average. However, not all people across Massachusetts share these positive outcomes. Bristol County's average life expectancy is 2 years less than the state average. Looking more closely at neighborhoods and populations within Bristol County, there are clear disparities.

The Health Resources and Services Administration Unmet Need Score (UNS) helps in allocation of resources—including primary and preventive healthcare services—across communities with higher unmet need based on social, economic, and health status. The UNS evaluates zip codes using a weighted sum of 28 health and social measures with values ranging from 0 (least need) to 100 (greatest need).

In Saint Anne's Hospital's service area, there is a nearly 55-point range between zip codes with the lowest and highest UNS values demonstrating community-level health and social disparities.

Saint Anne's Hospital Service Area Zip Codes by Unmet Need Score and Select Social Drivers of Health Indicators (Years 2019-2023)^

Zip Code	Total Population in Poverty	Children in Poverty	Families with Low Income*	No High School Diploma	No Health Insurance	Unmet Need Score
02724, Fall River	24.0%	35.0%	41.4%	23.8%	5.6%	76.56
02723, Fall River	26.2%	39.4%	46.2%	25.8%	5.8%	70.78
02721, Fall River	20.4%	23.8%	34.6%	27.0%	4.5%	65.96
02720, Fall River	16.8%	26.9%	26.7%	18.6%	6.0%	58.82
02747, North Dartmouth	5.2%	3.2%	13.7%	15.4%	2.5%	40.96
02790, Westport	6.4%	8.9%	11.8%	8.9%	4.4%	35.70
02777, Swansea	2.8%	2.7%	3.4%	9.8%	2.0%	30.98
02726, Somerset	5.5%	8.0%	5.2%	7.2%	0.8%	27.76
02748, South Dartmouth	6.9%	1.4%	10.5%	10.9%	1.1%	27.51
02885, Warren	9.2%	3.5%	6.4%	9.6%	3.4%	26.65
02878, Tiverton	5.5%	2.3%	7.3%	7.4%	3.6%	24.74
02725, Somerset	1.0%	0.0%	3.6%	11.4%	1.6%	21.86
02837, Little Compton	3.0%	1.7%	6.8%	3.0%	2.2%	21.63
Bristol County	11.6%	15.9%	18.8%	13.7%	3.0%	NA
Massachusetts	10.0%	11.8%	14.5%	8.6%	2.6%	NA

Source: Health Resources & Services Administration (HRSA) & US Census Bureau, American Community Survey
^Select social drivers of health indicators are presented to illustrate measures that influence the calculation of the Unmet Need Score.
*Families with incomes at or below 185% of the Federal Poverty Level (FPL). In 2024, a family of four people at 185% of the FPL had an income of $57,720.

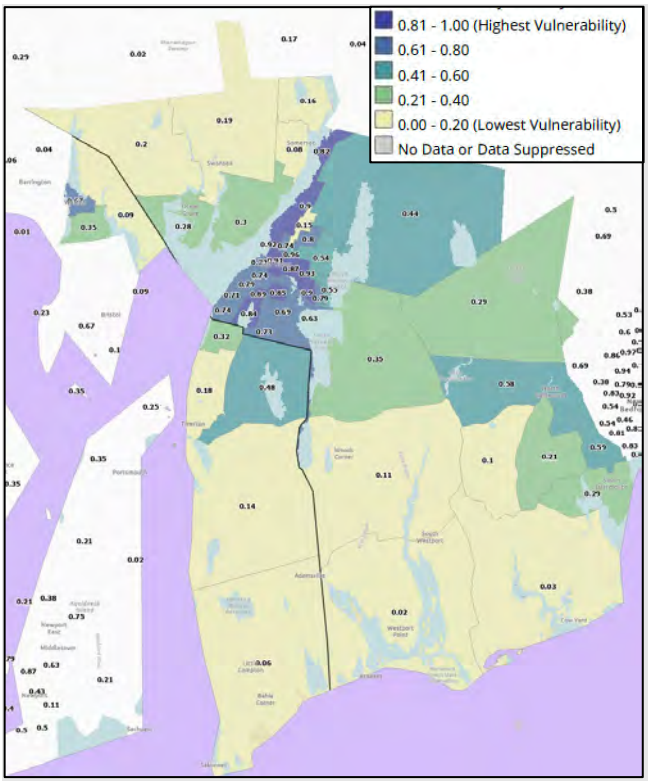
The Social Vulnerability Index (SVI) goes a level deeper than the UNS to demonstrate vulnerability to health disparities at a census tract-level.

Census tracts are small geographic regions defined for the purpose of taking a census, designed to be relatively homogeneous in terms of population characteristics, economic status, and living conditions. Census tracts cover the entire United States and typically contain between 1,500 and 8,000 people.

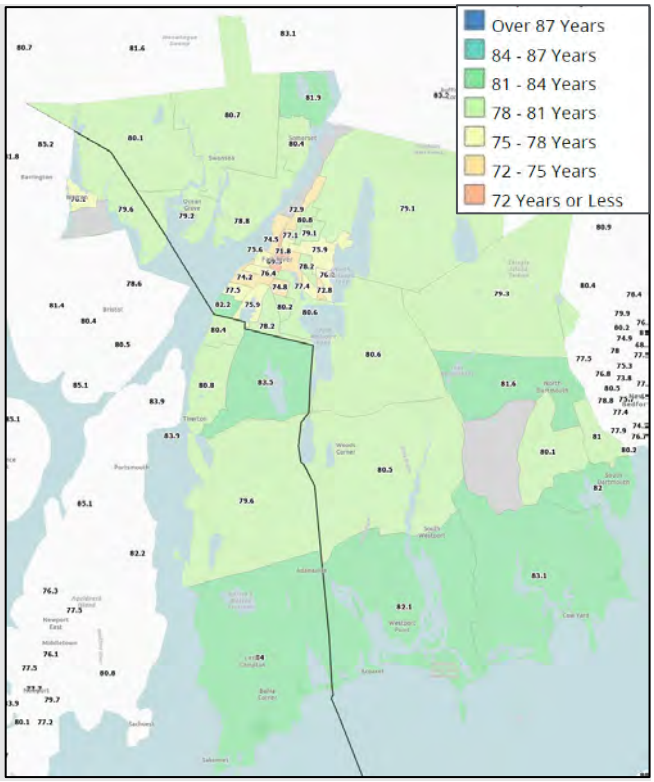
The SVI scores census tracts on a scale from 0.0 (lowest) to 1.0 (highest) vulnerability based on factors like poverty, lack of transportation, and overcrowded housing.

Examining the SVI in conjunction with average life expectancy demonstrates how SDoH impact health outcomes. Within the Saint Anne's Hospital service area, historical data indicates potential for a nearly 15-year difference in average life expectancy between Fall River and surrounding communities. Fall River also has the highest SVI values in the region of 0.9-0.96 out of a maximum score of 1.0, reported as recently as 2022.

2022 Social Vulnerability Index by Census Tract

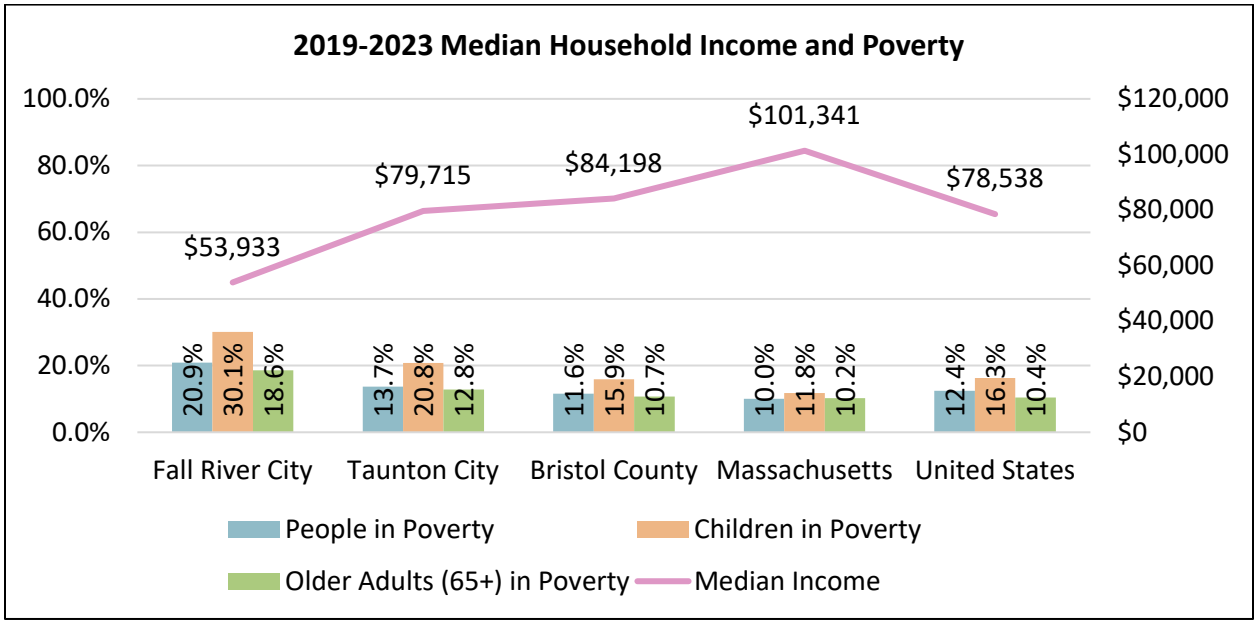


2010-2015 Life Expectancy by Census Tract

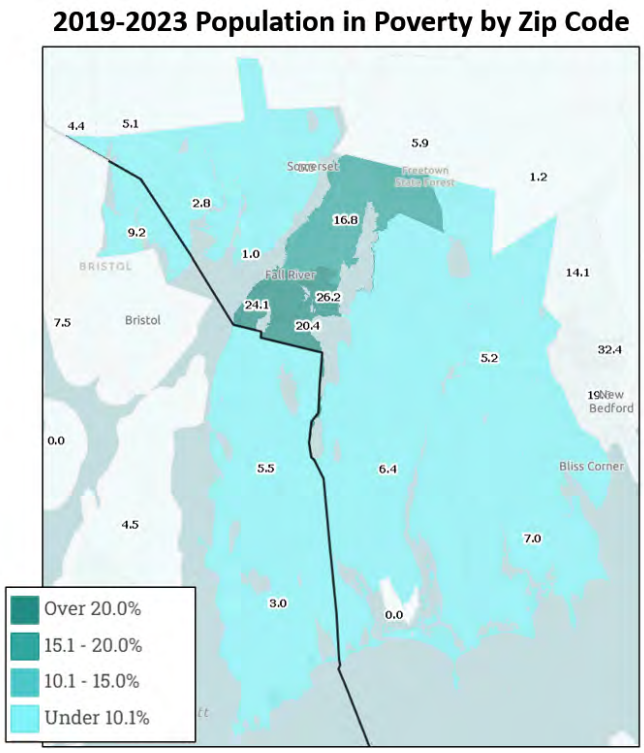


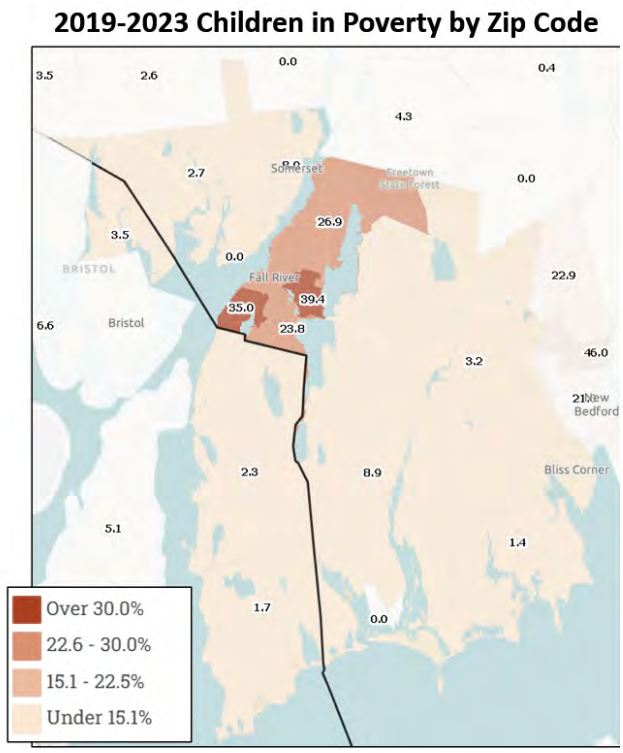
Source: Centers for Disease Control and Prevention

Disparities in life expectancy for Fall River residents reflect the impact of SDoH. More than 20% of Fall River residents and 30% of children may experience poverty compared to 12% of residents across Bristol County. Median household income ($53,933) is nearly half the state median income ($101,341).



Source: US Census Bureau, American Community Survey





Source: US Census Bureau, American Community Survey

Community Health Needs

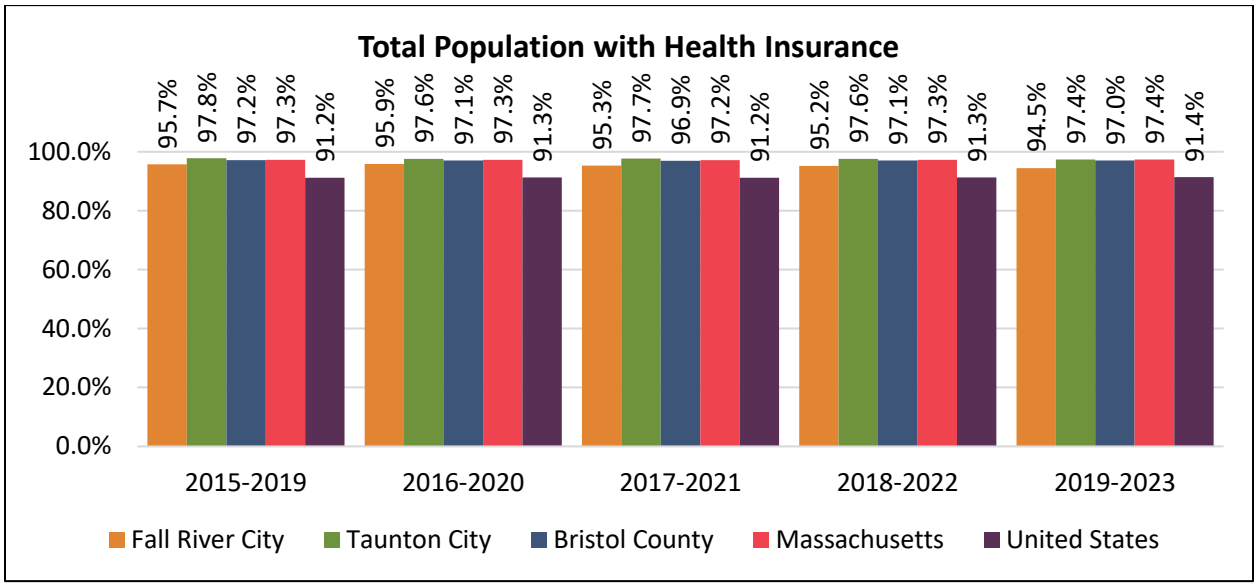
The CHNA was a comprehensive study of health and socioeconomic indicators for Fall River and Bristol County residents. The following section highlights key health and wellbeing needs as determined by secondary data statistics and community stakeholder feedback. *A full summary of secondary data findings is also provided on Brown University Health's website and available to our community partners as a resource to support their many programs and services.*

Access to Care and Services

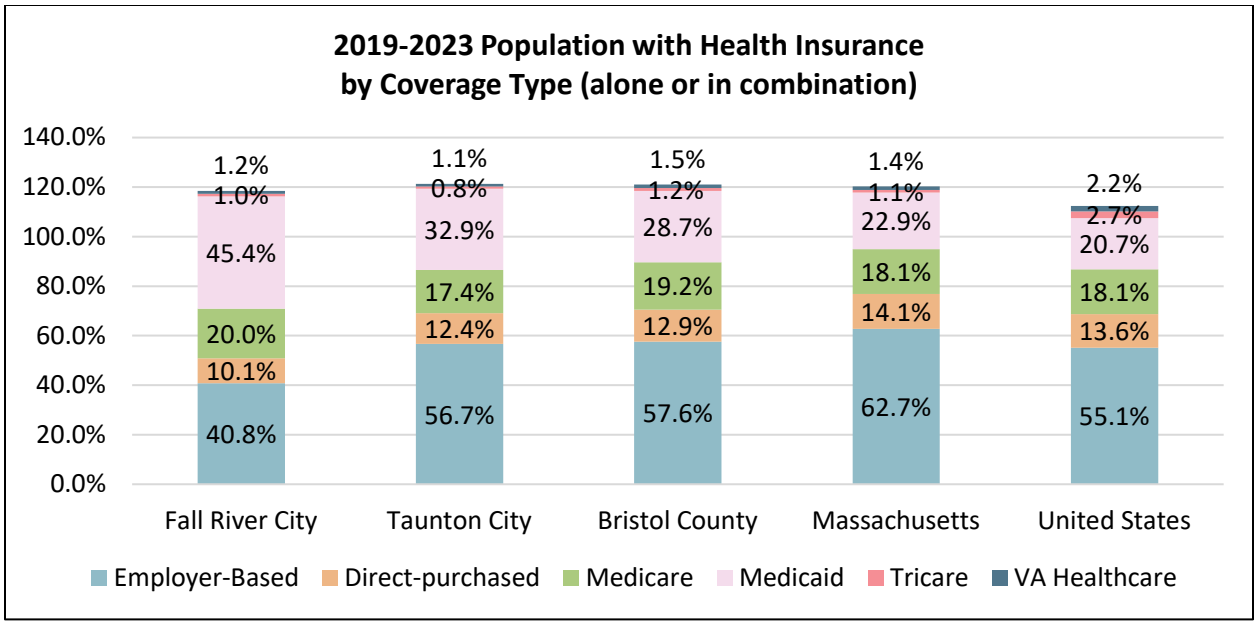
Health insurance coverage among Bristol County residents has been consistently high with 97% of residents covered in 2023 compared to 91.4% of residents nationally. A high proportion of insured residents obtain their insurance through an employer (57.6%), providing cost-sharing benefits and typically more comprehensive coverage. Approximately 82.3% of Bristol County adults received a routine primary care visit or checkup in 2022 compared to 74.2% of adults nationally.

Disparities in healthcare access are evident for Fall River residents. Residents are less likely to have health insurance (94.5%) and significantly more likely to obtain insurance through Medicaid (45.4%). Medicaid provides coverage for people with low income and has struggled with acceptance by physicians due to lower reimbursement rates, contributing to provider shortages and longer appointment wait times. These concerns may be exacerbated in Bristol County, where there are fewer primary care physicians overall than the state and nation.

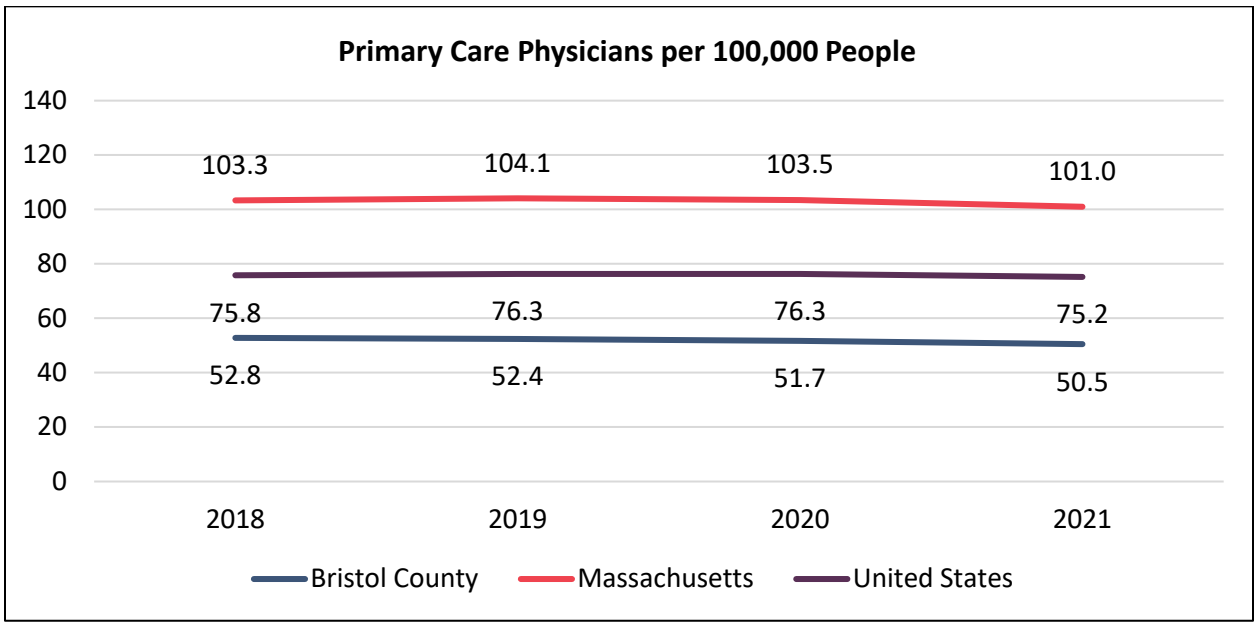
Income constraints and cost of care are key barriers for improving healthcare access for area residents. Health and human service professionals reported that patients change their own medication dosage (e.g., halving it to make it last longer) because of costs. Some patients have been disincentivized from scheduling preventive care due to unexpected costs incurred at visits – when patients present with health concerns at a wellness visit, it may be charged as a diagnostic visit versus "free" preventive visit.



Source: US Census Bureau, American Community Survey

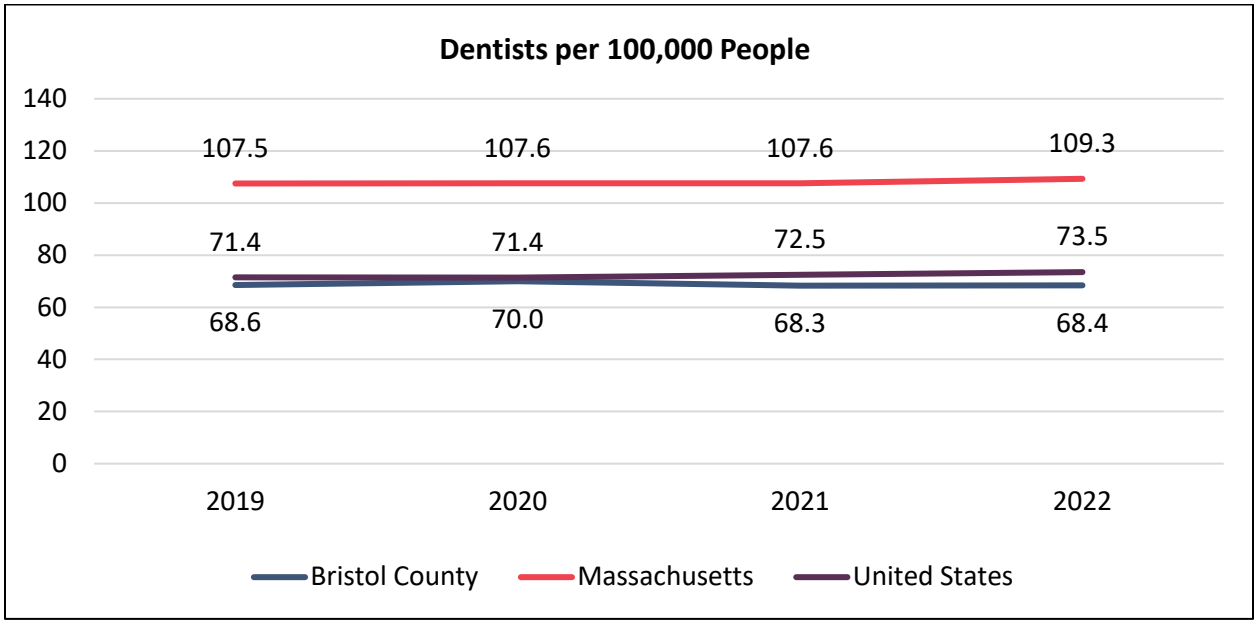


Source: US Census Bureau, American Community Survey



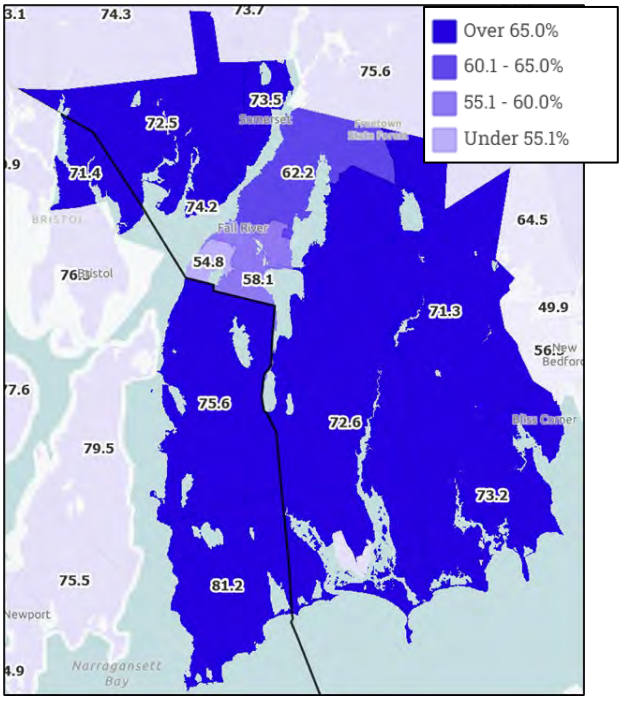
Source: Health Resources & Services Administration & Centers for Medicare and Medicaid Services

Dental care is also less available in Bristol County than in the state and nation. Approximately 68.1% of Bristol County residents received annual routine dental care compared to 72.6% of adults statewide. Within Fall River, approximately 55%-62% of adults received routine dental care compared to 72%-81% of residents in neighboring communities. Dental care and good oral health is closely linked to the prevention of various diseases and conditions, while poor oral hygiene can lead to serious health complications.



Source: Health Resources & Services Administration & Centers for Medicare and Medicaid Services

2022 Adults with a Dental Care Visit within the Past Year by Zip Code



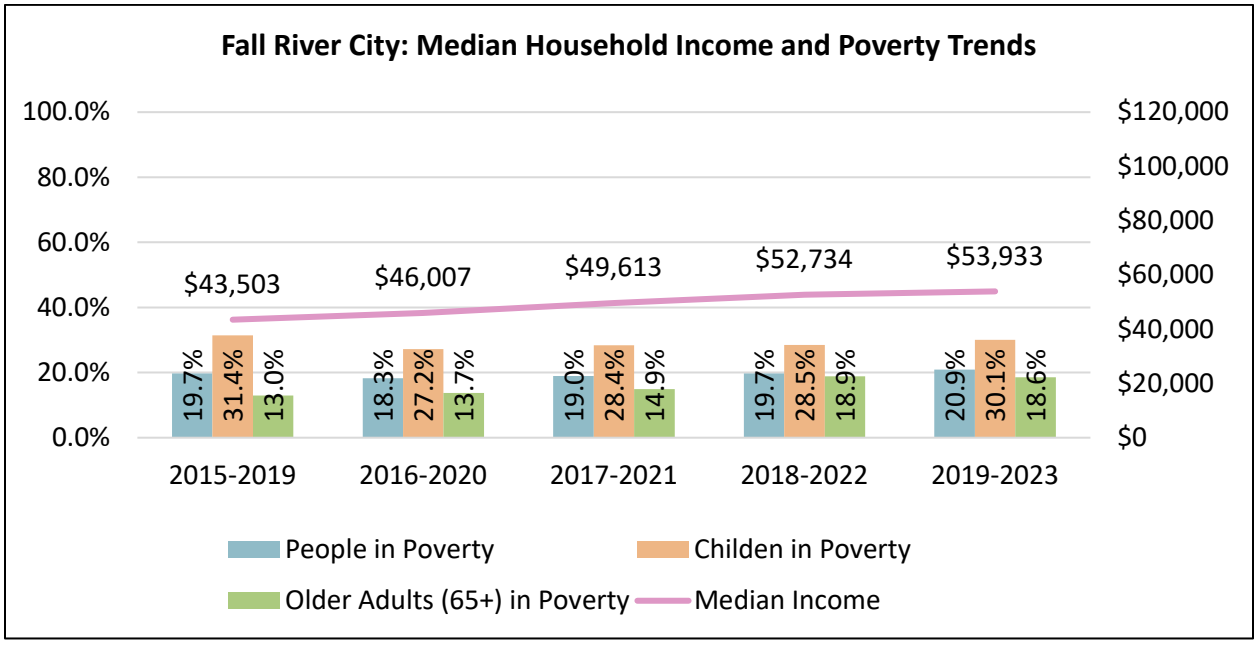
Source: Centers for Disease Control and Prevention

The rising cost of living has increased demand for social services and contributed to delays in accessing vital services. The impact has been felt across populations, but particularly for children and families. Across Bristol County, the proportion of all food insecure residents has been relatively stable at 11% but increased for children from 10.9% in 2021 to 15.8% in 2022. The cost of childcare for a household with two children in Bristol County, measured as a percentage of median household income, is 39.4%. Economic barriers disproportionately affect Fall River residents, where the proportion of children living in poverty is consistently high (30.1%) and increased since 2020.

> *"Fall River Public Schools serves a high-needs population. Students and their families deal with many inequities and these issues affect the learning and overall well-being of our students."*

> *"There are several children in this school who do not have a regular PCP or follow-up yearly. Many of our children do not see dentists often enough to prevent caries/dental disease. Mental health affects the children as well as their parents. Many children are overweight and/or obese. Several children have asthma, inhalers, and do not have a pulmonologist."*

Federal funding cuts planned for healthcare and social services are anticipated to further reduce access to community resources; cuts are expected to impact Medicaid, SNAP benefits, subsidized childcare, and low-income housing benefits.



Source: US Census Bureau, American Community Survey

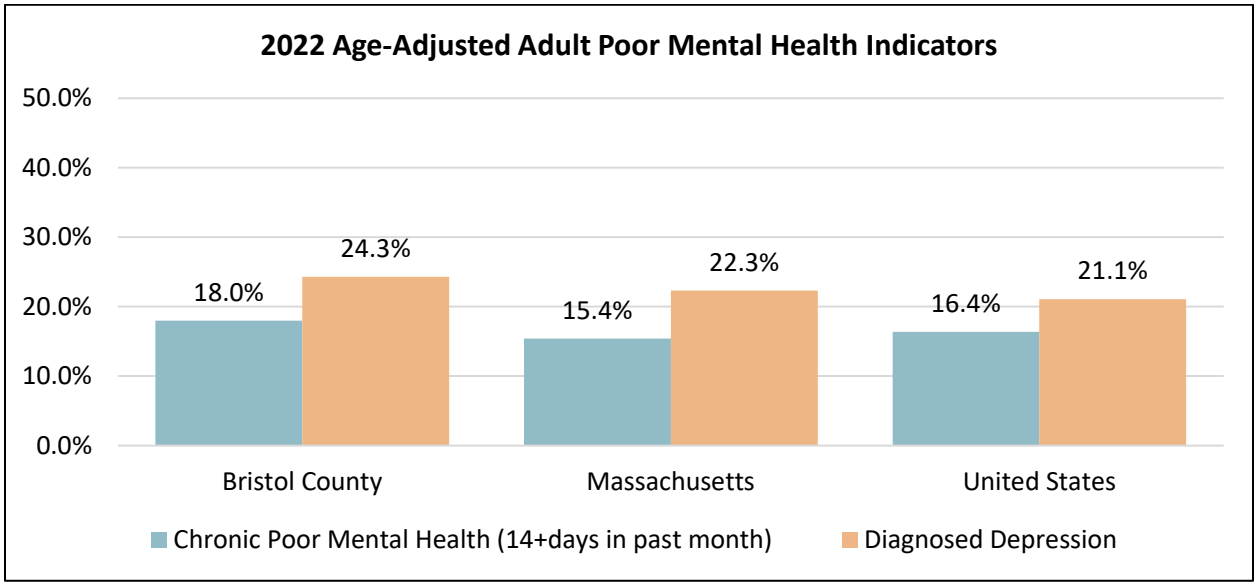
Key stakeholders recognized that groups who have been historically marginalized were more likely to experience health disparities. These underserved communities—including those that identify as people of color, immigrant, and/or people with disabilities—are more likely to face economic insecurity and have cultural and language barriers.

Stakeholders underscored the importance of staff and provider training in cultural competency and humility and increased health education materials that reflect the language and culture of communities. They advocated for the presence of people with lived experience in developing community solutions, more Community Health Workers to bridge the gap between healthcare services and the people they serve, and workforce development initiatives that encourage healthcare employment in underserved areas.

> *"Communities that struggle with equalization of opportunity and economic disparity consistently have co-occurring health struggles due to lack of healthy food, affordable housing, quality medical care, and economic mobility."*
>
> *"Many of those we serve are often suffering from trauma associated with poverty and adverse conditions in their home countries and its attendant challenges."*
>
> *"There is a dearth of medical professionals who are willing to work or specialize with people having Intellectual disabilities / Autism."*

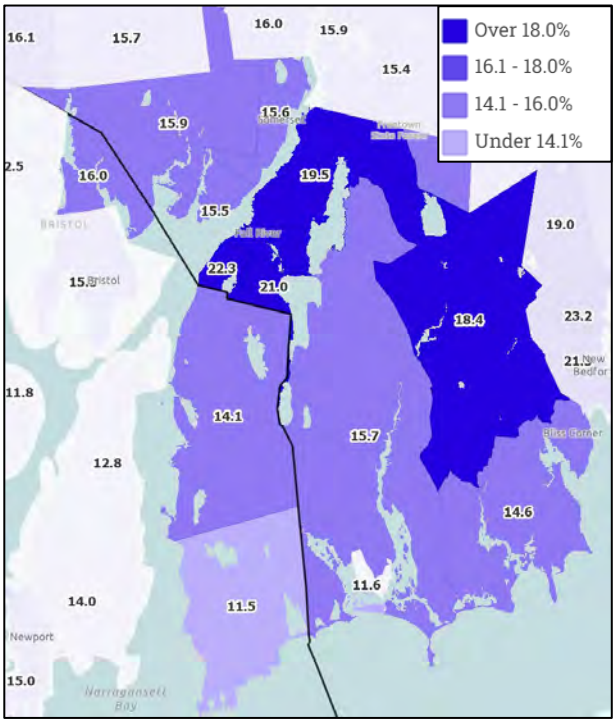
Behavioral Health

Experiences of mental distress have increased statewide and nationally. In 2022, approximately 18% of Bristol County adults reported having chronic poor mental health (14 or more days in past month) compared to 15.7% in 2020. Approximately 24.3% of adults reported being diagnosed with a depression disorder. Experiences of mental distress are more prevalent in communities experiencing socioeconomic barriers, including Fall River, where as many as 22% of adults report chronic poor mental health.



Source: Centers for Disease Control and Prevention

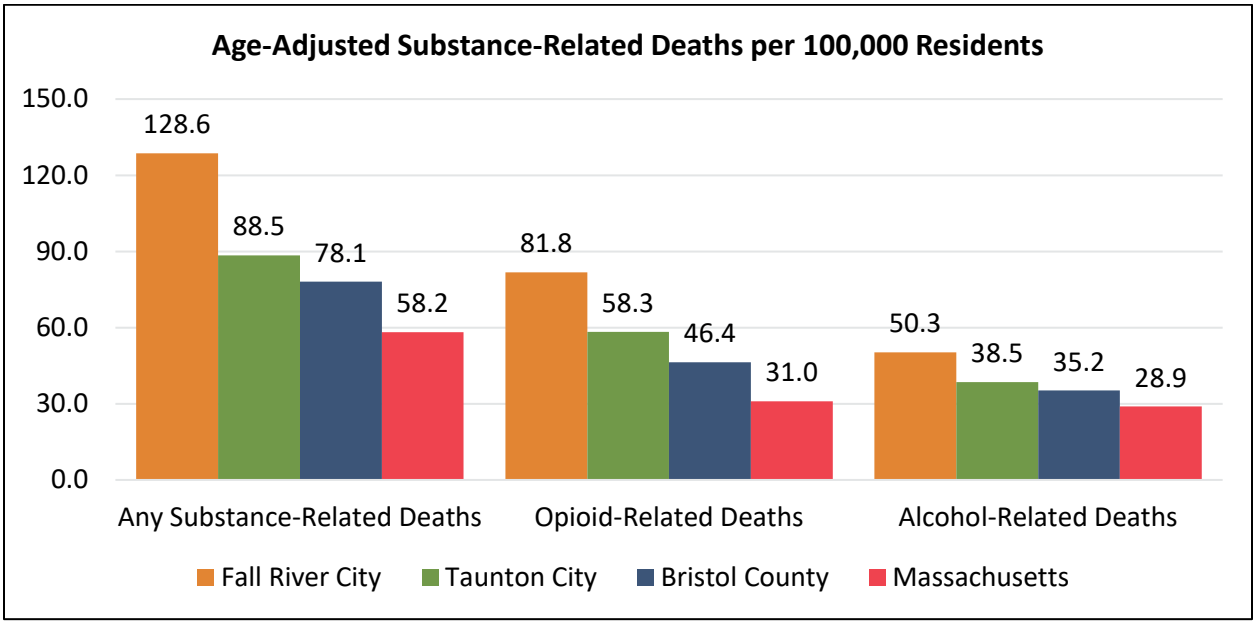
2022 Adults with Chronic Poor Mental Health by Zip Code



Source: Centers for Disease Control and Prevention

Fall River saw a 5% decrease in the number of substance-related deaths from 2022 (125) to 2023 (119), but the 2023 rate of death due to substances was still more than double the statewide rate of death. Most substance-related deaths involved opioids, followed by alcohol.

Alcohol use disorder is a growing concern nationally and for area residents. Fall River had a total of 2,917 substance-related emergency room (ER) visits in 2023, the majority involving alcohol (2,254). Emergency room visits for substance use are an indicator of burden of disease and community need for treatment services.



Source: Massachusetts Department of Public Health

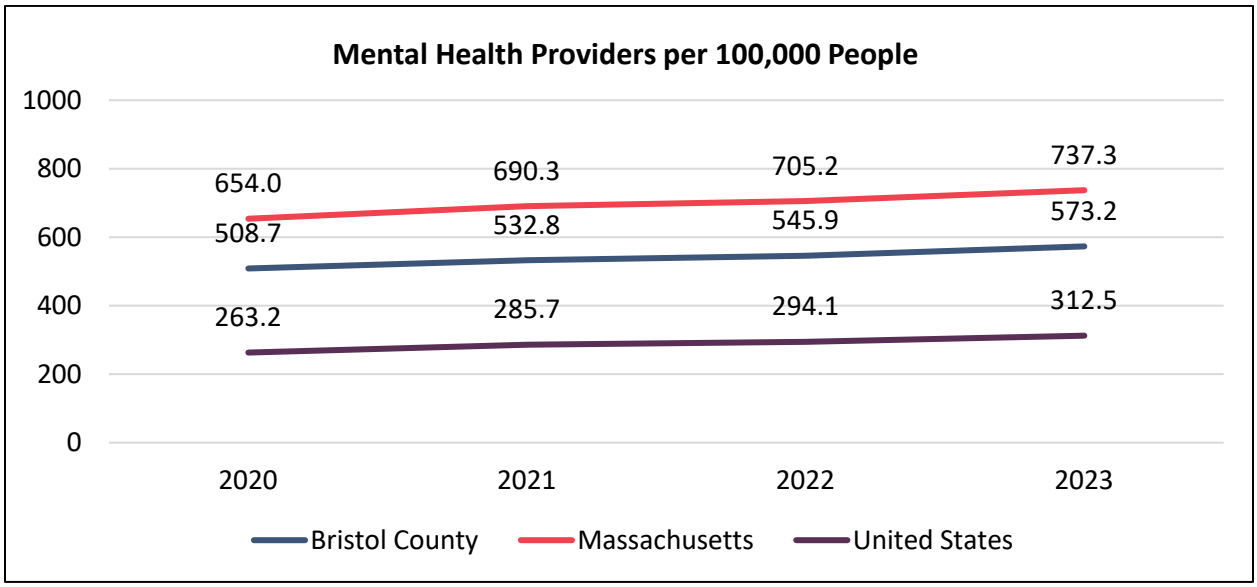
Mental health and substance use disorders are often co-occurring and directly affected by an individual's socioeconomic and community experience. Health and human service professionals reinforced that these issues are interrelated, noting that rising costs of living and social isolation contribute to mental illness and substance use, and substance use is a form of self-medicating for stress and mental illness. Community solutions require systemic and coordinated approaches.

> *"I believe it will be the decline of income levels per household, increasing prevalence of mental health disorders/ declining level of overall wellbeing."*

> *"Trauma affects many people. Who then have mental health issues and resort to using substances in order deal with their current situation, to be numb and escape their pain."*

> *"NUMEROUS people are using vapes for tobacco or cannabis in this area. Many patients disclose that they use vapes for these substances, and only some have felt that they can seriously consider quitting. This really ties in with mental wellbeing/trauma as many people use vapes/substances in general as a form of 'self-medicating' or managing their mental health/stress."*

Bristol County has a consistently higher rate of behavioral health providers compared to the national average, and the rate is increasing. Despite these trends, gaps in access to care and services persist.



Source: Centers for Medicare and Medicaid Services

*Mental health providers include those specializing in psychiatry, psychology, mental health, addiction or substance use disorders, or counselling.

Health and human service professionals reported long wait lists for services and people presenting to emergency rooms or urgent care centers in crisis due to lack of outpatient resources. Outpatient services and support are limited and costly, and insurance copays and coinsurance costs deter people from seeking treatment. Additionally, gaps in real-time data sharing between hospitals and community providers prevent them from accessing up-to-date patient information, leading to fragmented care, missed history of services, and limited collaboration among healthcare teams.

> *"Access to mental health services that do not require long waiting lists. The need to deal with crisis would be minimized if the services were given within a month, if not less..."*
>
> *"Patients will need a 'dirty UA' [urine analysis] in order to access a detox program to access care. Patients should not need to 'use' in order to seek out help."*
>
> *"Increased Strain on Emergency Services. Emergency Room Overload: Without sufficient mental health and substance abuse treatment options, individuals experiencing crises often end up in emergency rooms (ERs) or urgent care centers. This results in overcrowded ERs, where emergency room staff may not have the resources or specialized training to handle mental health crises effectively."*
>
> *"Mental Health care is not nimble in [Fall River]. Trauma is widespread. DV (domestic violence) is on the rise."*

Health and human service professionals noted an increase in mental health and substance use concerns among youth, often rooted in adverse childhood experiences (ACEs) like living in poverty and exposure to violence. Isolation and developmental delays from the COVID-19 pandemic also have had lingering impact on youth.

Schools are seeing more youth in crisis and staff generally feel under-resourced and unprepared to provide adequate support. Prevention and treatment programs for youth are limited, with professionals noting long wait times and insurance coverage barriers. Social media exposure has exacerbated issues, increasing social isolation and experiences of cyberbullying and distorting perceptions of reality and healthy relationships, among other issues.

> *"The state of children's mental health is alarming. I worry we will see an explosion of adults in mental health crisis if we do not do more to support our young people and provide them with support, opportunities, and a sense of belonging!"*
>
> *"Limited resources specific to adolescent substance misuse and wait lists for in-person trauma-informed therapy with trained clinicians continue to be lengthy."*
>
> *"Increased reports of violence reported (fights, gun related, DV, etc.) significantly impacting children/adolescents and lower income families."*

Health and human service professionals saw a need to better address behavioral health issues through a holistic care continuum that includes an open (on-demand) access model and wrap-around social services like housing to help people be successful in their treatment. Professionals also saw an opportunity to improve community engagement and sense of belonging among residents, key preventive factors that were perceived to have declined in recent years.

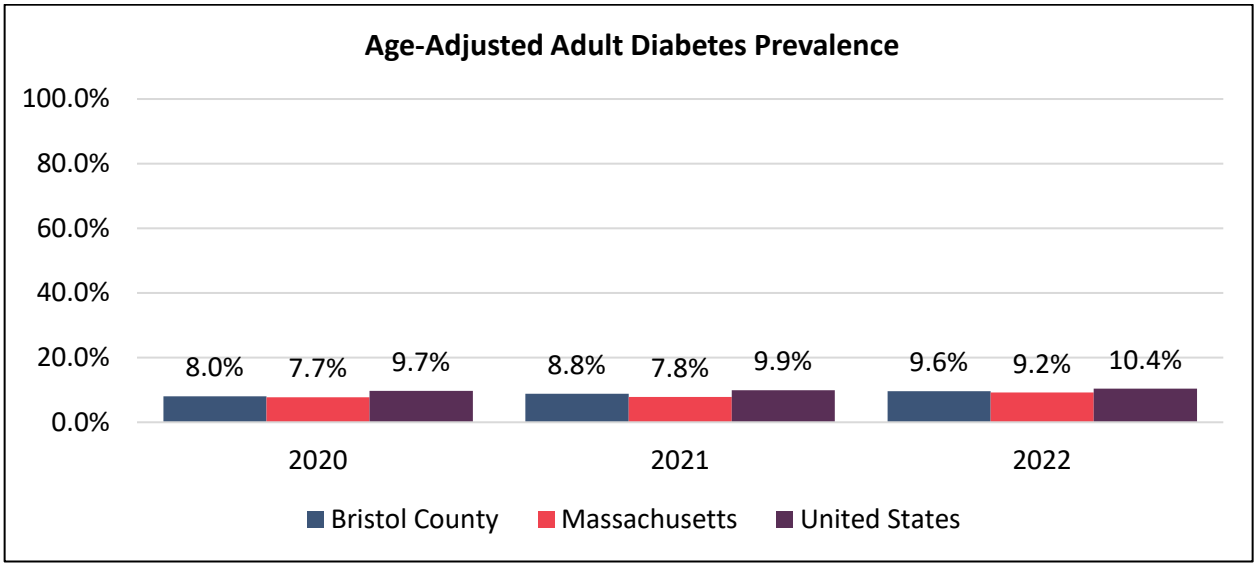
Concerted efforts to address increasing behavioral health needs have led to progress in improving community awareness and access to services. Health and human service professionals named the following successes within the region.

- More community resources and advocacy for substance use disorder
- Increased harm reduction and awareness
- Increased language capacity for some programs
- A wider variety of services available to support multiple needs of the community, including increased capacity
- Increased collaboration between behavioral health partners
- Increased programming to support trauma-informed services across the region
- Mental health awareness and stigma reduction

Chronic Diseases: Leading Causes of Death and Disease

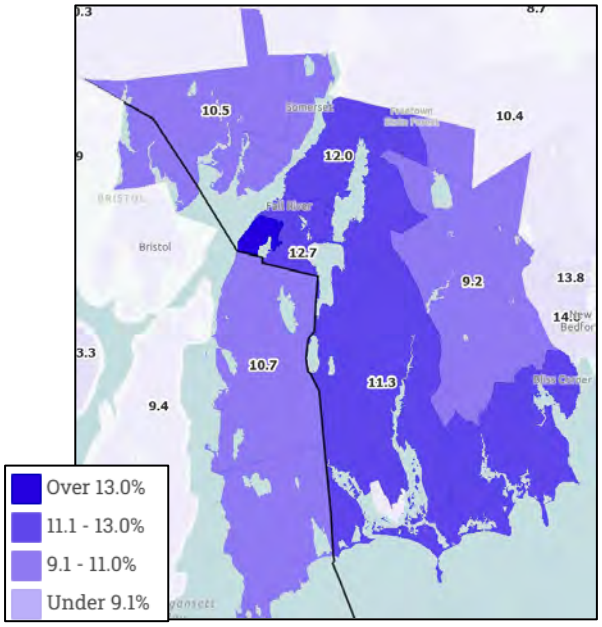
The following section focuses on the leading causes of disease burden and death, and management and prevention efforts.

Diabetes and heart disease are among the top causes of death for residents. Consistent with the state and nation, the proportion of adults aged 18 or over in Bristol County that are diagnosed with diabetes has increased since 2020 to approximately 1 in 10 adults. Diabetes prevalence is higher in and around Fall River (12%-13.5%) and along the coast (12%). Across Bristol County, 28.3% of adults have high blood pressure and 32.1% have high cholesterol.



Source: Centers for Disease Control and Prevention

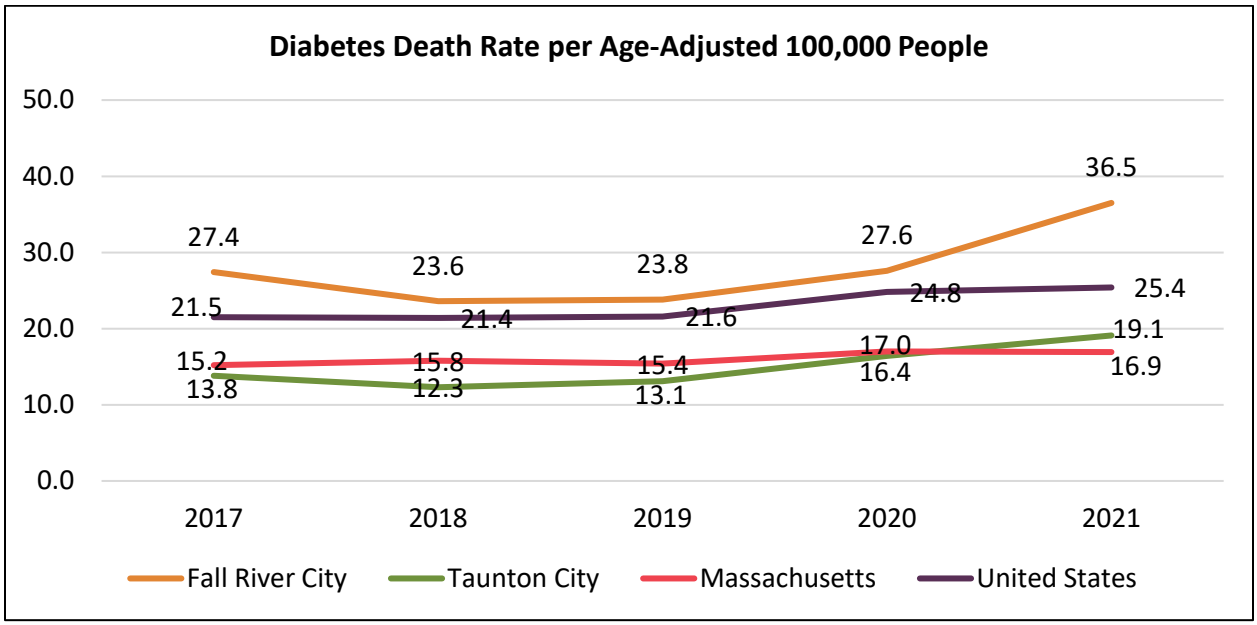
2022 Adults with Diabetes by Zip Code



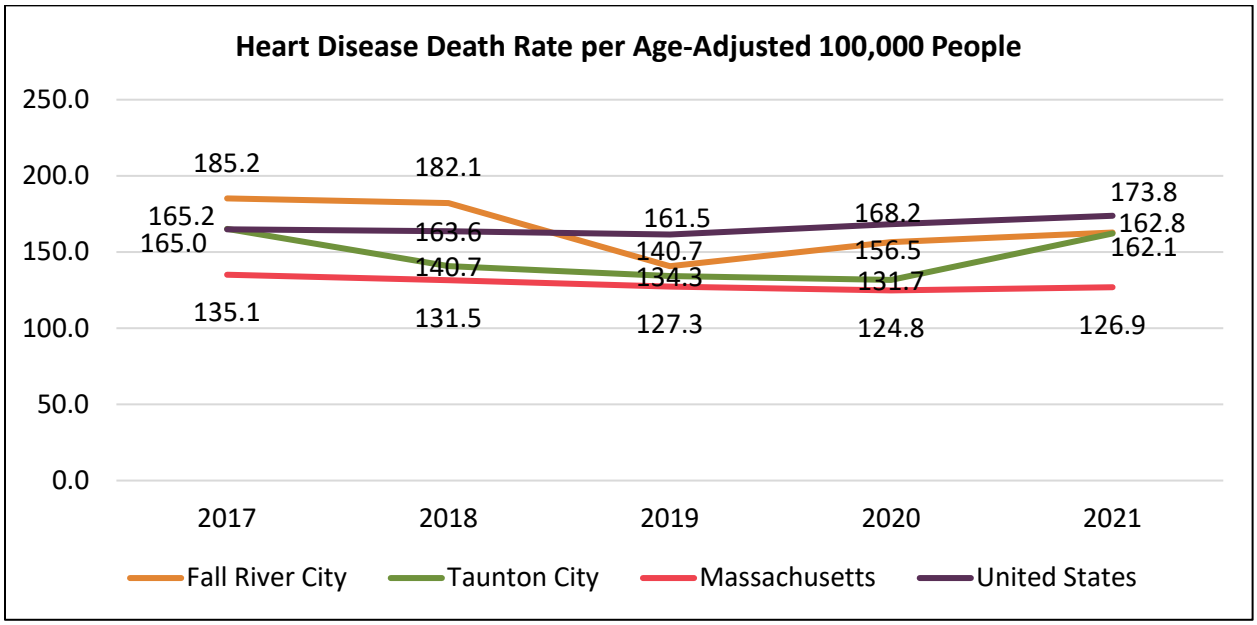
Source: Centers for Disease Control and Prevention

More Fall River residents are diagnosed with diabetes, and the diabetes death rate is historically higher in Fall River than other parts of the state and nation. Massachusetts overall saw an increase in diabetes-related death in 2020, likely due in part to gaps in timely and adequate care during the pandemic. Fall River saw a 53% increase in the diabetes death rate from 2019 to 2021.

Contrary to statewide trends, the heart disease death rate also increased in Fall River in 2020 and 2021. The rate of death due to heart disease is higher in Fall River than the state overall. These findings inform a heightened need for community chronic disease prevention and treatment efforts.

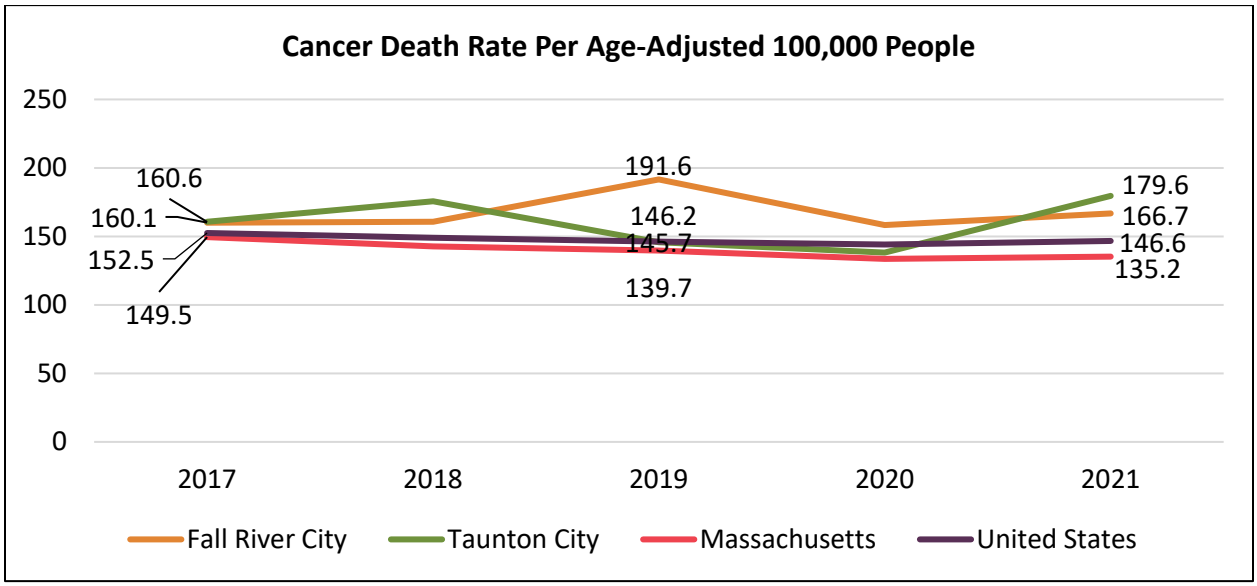


Source: Massachusetts Department of Public Health & Centers for Disease Control and Prevention

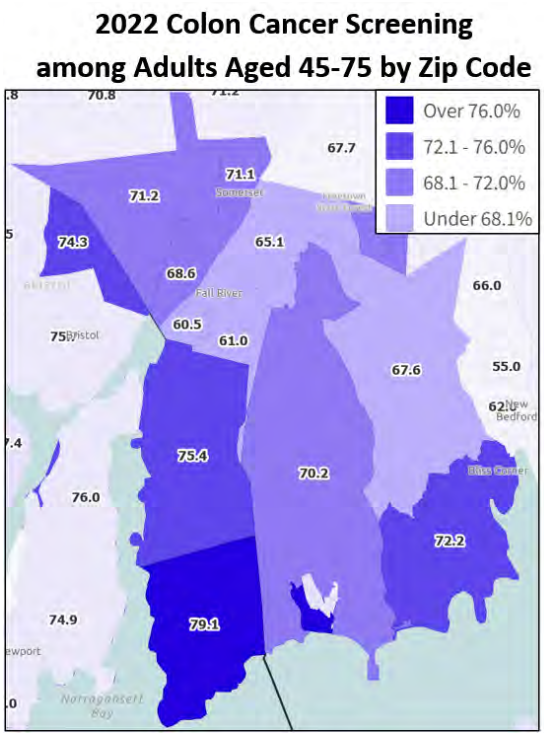


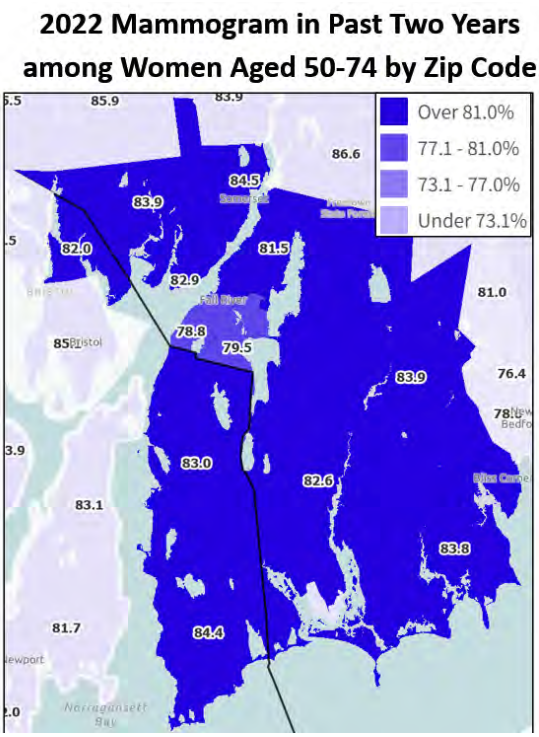
Source: Massachusetts Department of Public Health & Centers for Disease Control and Prevention

Bristol County overall has a higher incidence of cancer (any type) than the state and nation but a similar rate of death, a finding that can often indicate better screenings practices for early detection and treatment. Fall River differs from the county with a consistently higher rate of death than the state and nation and opportunity to improve screening rates. Within Fall River, approximately 60% of adults aged 45-75 received colorectal cancer screenings compared to approximately 70% of adults in neighboring communities; approximately 79% of women aged 50-74 received mammogram screenings compared to 82% or more of women in neighboring communities.



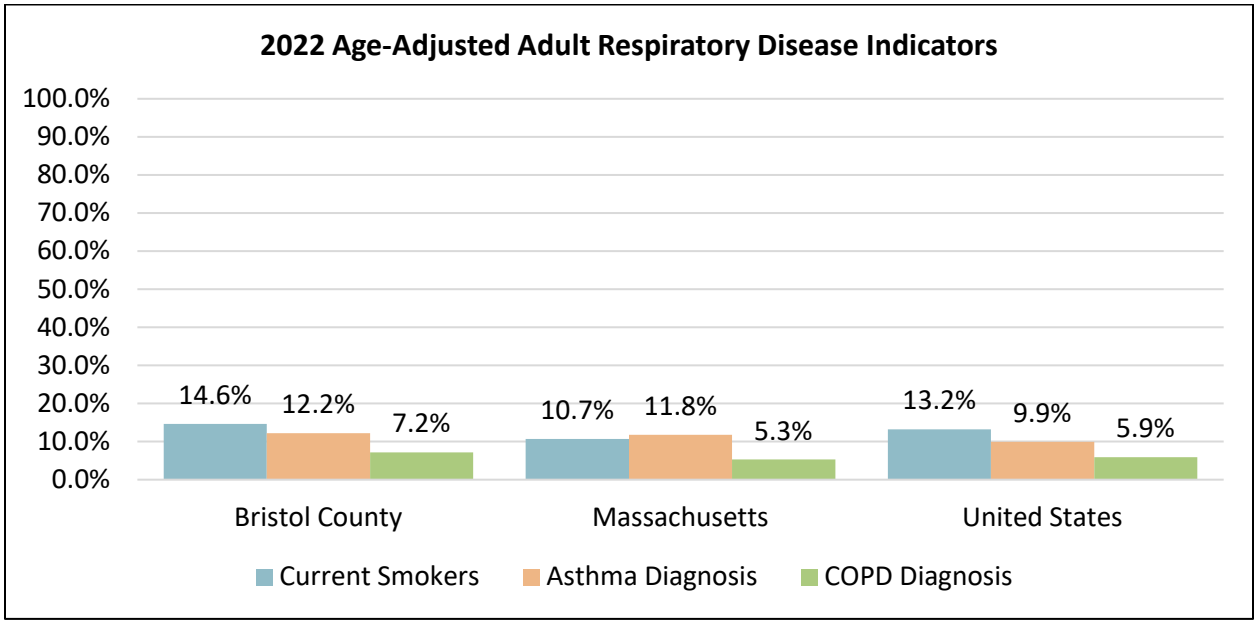
Source: Massachusetts Department of Public Health & Centers for Disease Control and Prevention





Source: Centers for Disease Control and Prevention

Traditional cigarette use (not including e-cigarettes, cigars, etc.) declined nationally over the last few decades but remains higher in Bristol County and Fall River. Approximately 18%-22% of Fall River adults reported smoking in 2022 compared to 11% of adults statewide. Tobacco use has been associated with wide-ranging negative impacts on other health and wellbeing issues, including respiratory disease. Bristol County overall has a higher prevalence of asthma and chronic obstructive pulmonary disorder (COPD) than the state and nation.



Source: Centers for Disease Control and Prevention

Challenges and Solutions as defined by health and human service professionals identified the following key drivers that impact effective chronic disease prevention and management:

- Anticipated federal cuts to Medicaid funding will move more individuals to employer plans which may have higher deductibles and copays
- High smoking rates among residents
- Lack of primary care providers available
- Limitations of routine check-ups; they do not guarantee ongoing comprehensive care and can leave gaps in long-term patient support
- Low health literacy, associated with lower general education in the population
- More vaping and cannabis use; *"Smoking no longer means cigarettes."*
- Rising food insecurity and deficit of affordable healthy food retail venues
- Stigma around using Community Health Centers and Fall River services; perception that these services are only for people with low-income or people considered "poor," which may discourage broader community use

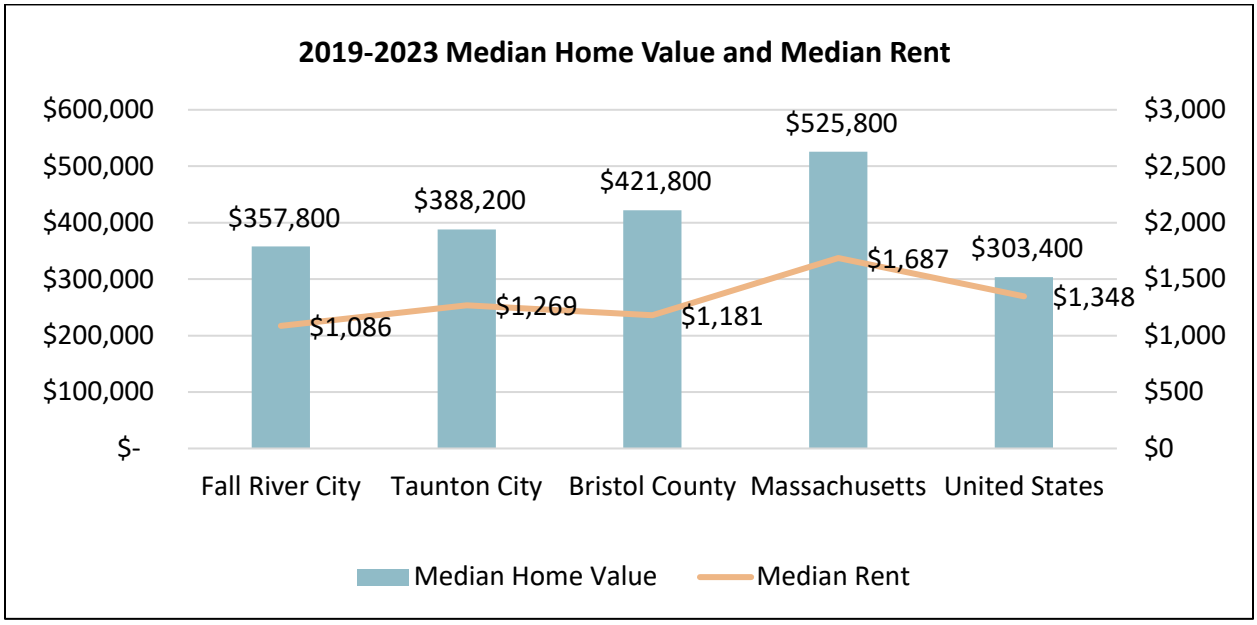
Housing

Nearly 65% of Key Stakeholder Survey participants rated housing affordability and availability as "poor." Participant feedback highlighted national concerns for rising housing prices and a shortage of affordable housing, as well as local gentrification issues. Gentrification has raised housing prices and pushed long-term residents out of what was a relatively affordable area in a high-cost state. The new South Coast Rail project that brought commuter rail service back to Fall River is anticipated to intensify these issues, increasing the area's population and demand for housing.

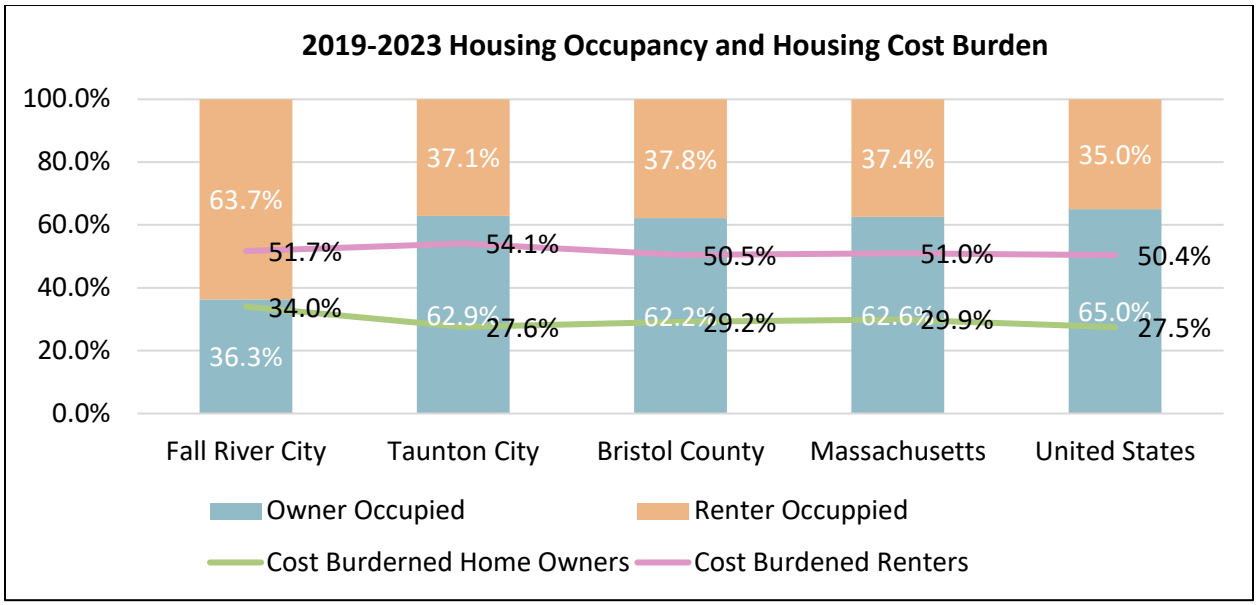
> *"Housing continues to be a challenge and will need state and federal resources to help support local city efforts."*
>
> *"Housing- there are so many abandoned buildings and malls. It would be great to get federal funds to developers to incentivize them to remodel those spaces for economically disadvantaged individuals and families."*

The impact of housing insecurity has been wide-ranging for the community. Health and human service professionals shared that households are "doubling up" to share costs, often with the consequence of overcrowded housing. More children experience homelessness and live in shelters. There are more incidents of domestic violence resulting from economic stress, as well as more foreclosures.

Housing costs have increased statewide and nationally. In Bristol County, median home value rose 24% from 2020 to 2023 and median rent rose 26%. Home prices are lower in Fall River, but residents are more likely to experience housing cost burden, spending 30% or more of their household income on mortgage or rent expenses alone. Approximately 64% of Fall River households rent their home and 52% of renters are cost-burdened by rent expenses.



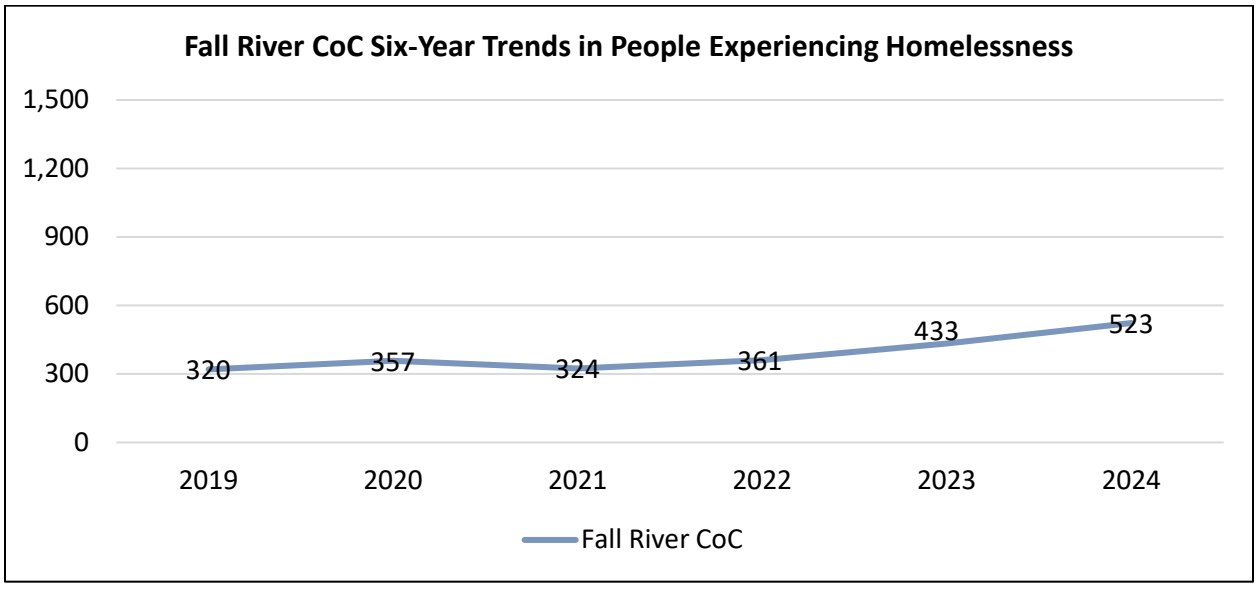
Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey

Rising housing costs have contributed to more people experiencing homelessness. The Point-in-Time (PIT) count is a nationwide count of sheltered and unsheltered people experiencing homelessness. The count is conducted by a Continuum of Care (CoC), a local planning body that coordinates housing and services for unhoused people. The most recent count conducted in 2024 found that there were more than 29,000 unhoused Massachusetts residents, a 53% increase from 2023. The Fall River CoC reported 523 unhoused people in 2024, a 21% increase from 2023.

Populations placed at risk for homelessness include households with low income, people on fixed incomes (e.g., older adults, people with disabilities), and people with behavioral health conditions. There is a need for long-term stable housing with integrated support services to assist these populations.



Source: US Department of Housing and Urban Development

Maternal and Child Health

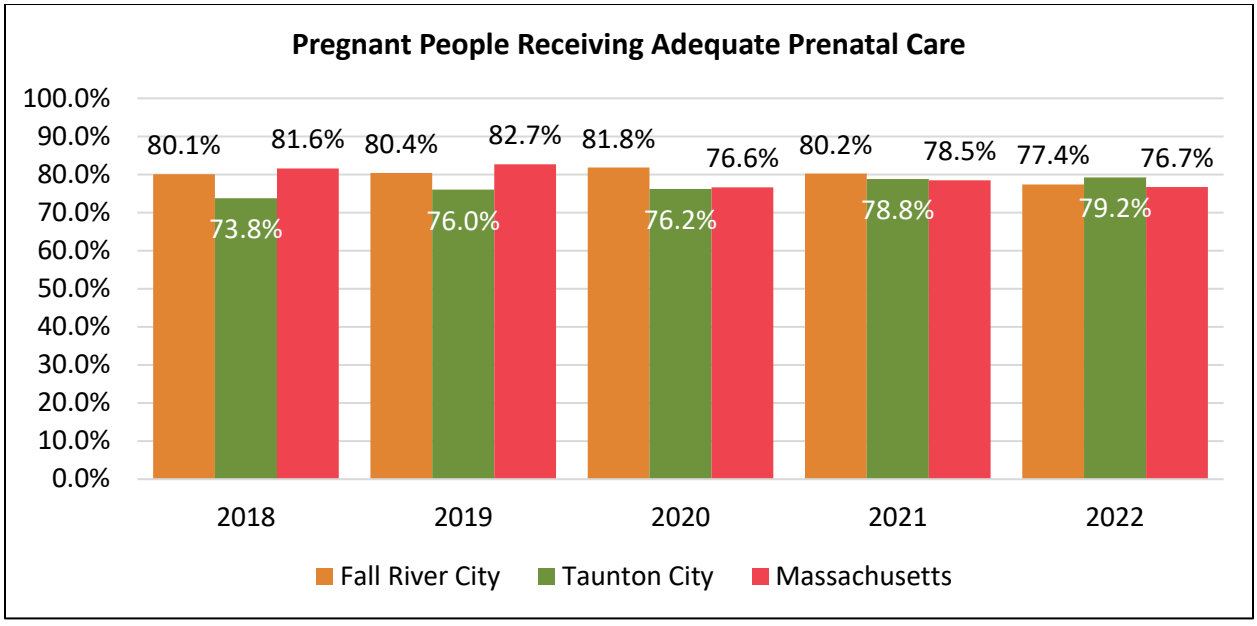
Births have declined for most of the past decade, both nationally and in Massachusetts. National research suggests that the general decline in fertility is due to women delaying childbearing and having fewer total children. Fall River differs from Massachusetts with a higher birth rate that exceeds the national birth rate. Approximately 4.2% of Fall River births in 2022 were to teenagers aged 15-19 compared to 1.9% of births statewide and 3.9% of births nationally.

2022 All Births and Birth Rate per 1,000 Females Aged 15-44 Years Old

	Count	Birth Rate per 1,000
Fall River City	1,107	58.3
Taunton City	614	52.3
Bristol County	5,652	51.1
Massachusetts	68,579	48.2
United States	3,667,758	56.0

Source: Massachusetts Department of Public Health & Centers for Disease Control and Prevention

Access to prenatal care is essential for promoting a healthy pregnancy and delivery. In 2022, approximately 77% of people in Massachusetts and Fall River received adequate and timely prenatal care, a decrease of nearly 5 percentage points from 2018.

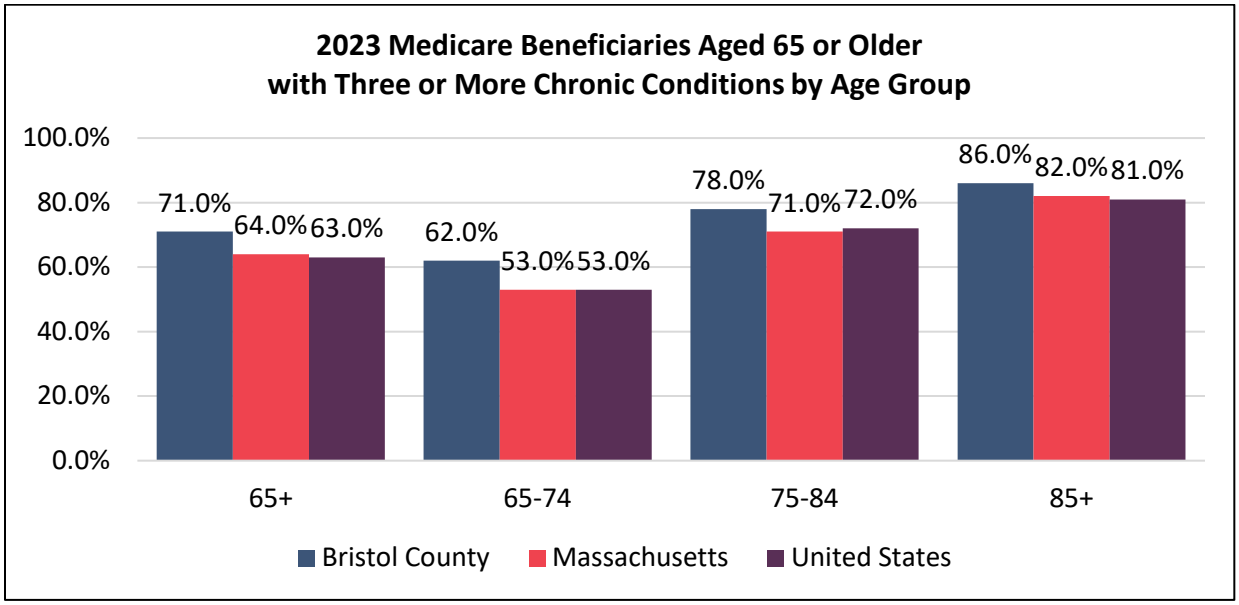


Source: Massachusetts Department of Public Health

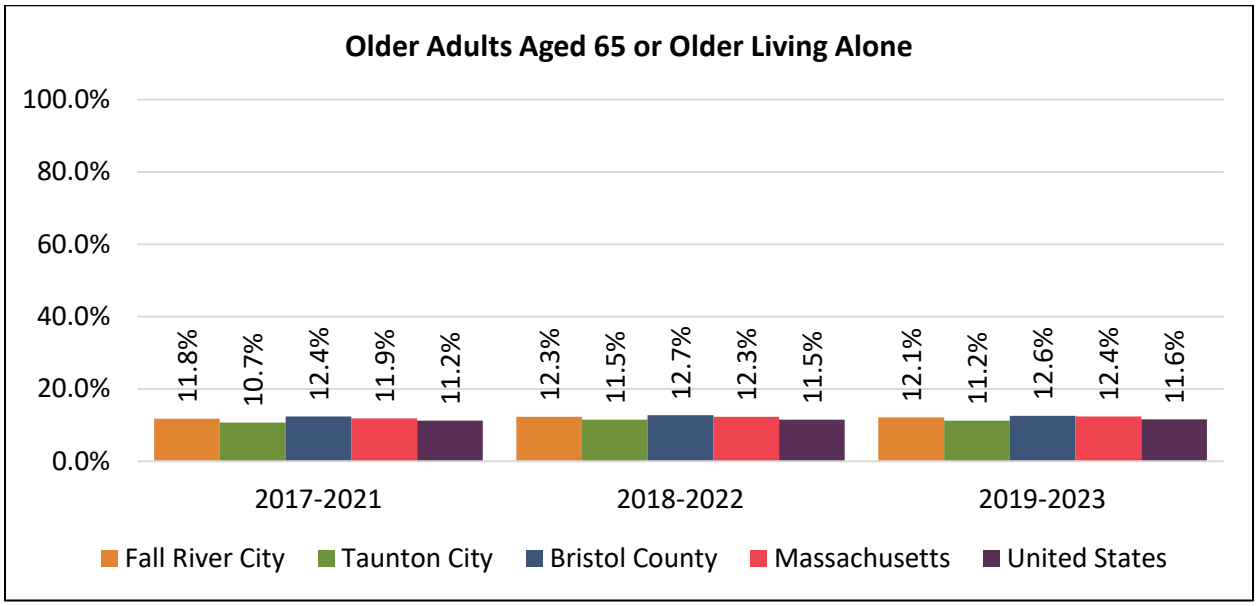
Older Adult Health and Wellbeing

Fall River is home to a younger population, but the number of older adults is increasing with reported growth of 9% from 2010 to 2023. Approximately 16% of Fall River residents are aged 65 or older.

Older adults are more at risk for chronic disease, as well as factors that impede disease management, including economic insecurity, social isolation (e.g., living alone), and access barriers (e.g., digital literacy, transportation). In 2023, 71% of Bristol County Medicare beneficiaries aged 65 or older managed three or more chronic conditions, most commonly high cholesterol (77%), high blood pressure (73%), rheumatoid arthritis (38%), diabetes (28%), and depression (21%).



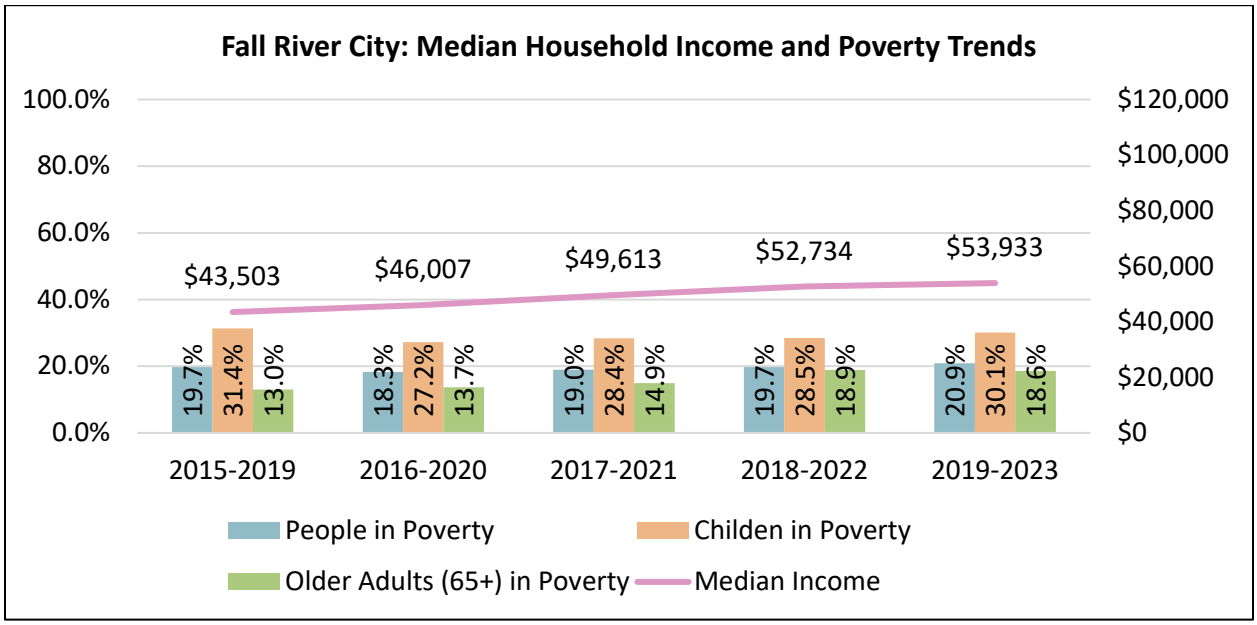
Source: Centers for Medicare and Medicaid Services



Source: US Census Bureau, American Community Survey

Older adults typically live on a fixed income and have been disproportionately affected by the rising cost of living. Nearly 20% of older adults in Fall River live in poverty, an increase from 13% in prior years. More older adults were perceived to struggle with housing, food insecurity, transportation, and medication costs, among other issues. Health and human service professionals shared concerns for lack of caregiver support for many older adults.

> *"The general population is getting older and having difficulties with food, housing, etc. Teaching young adults how to prepare for this is key."*
>
> *"Transportation to and from office visits. I'm amazed by how little the patient knows about why they are visiting a doctor, have no idea where the doctor is located, and arrives alone with no one to support them."*
>
> *"I often wonder what the elderly do when they need assistance with health problems. Who will help them navigate through their difficulties?"*



Source: US Census Bureau, American Community Survey

Our Response to The Community's Needs

In 2022, Saint Anne's Hospital conducted a similar CHNA and developed a supporting three-year Community Health Improvement Plan/community health benefits plan. Based on the CHNA findings, Saint Anne's Hospital leadership identified four priority areas:

- Access to Healthcare Services – Reducing Health Disparities
- Access to Mental and Behavioral Health/Substance Use Disorder (SUD) Services
- Chronic Disease Management and Wellness
- Health-Related Social Needs (HRSN): Food/Nutrition Insecurity and Housing and Homelessness

Saint Anne's Hospital invested in internal population health management strategies and partnered with diverse community agencies across the region to fund programs and initiatives aimed at addressing the identified priority areas. The system measured contributions and community impact from these investments, as outlined in the following sections.

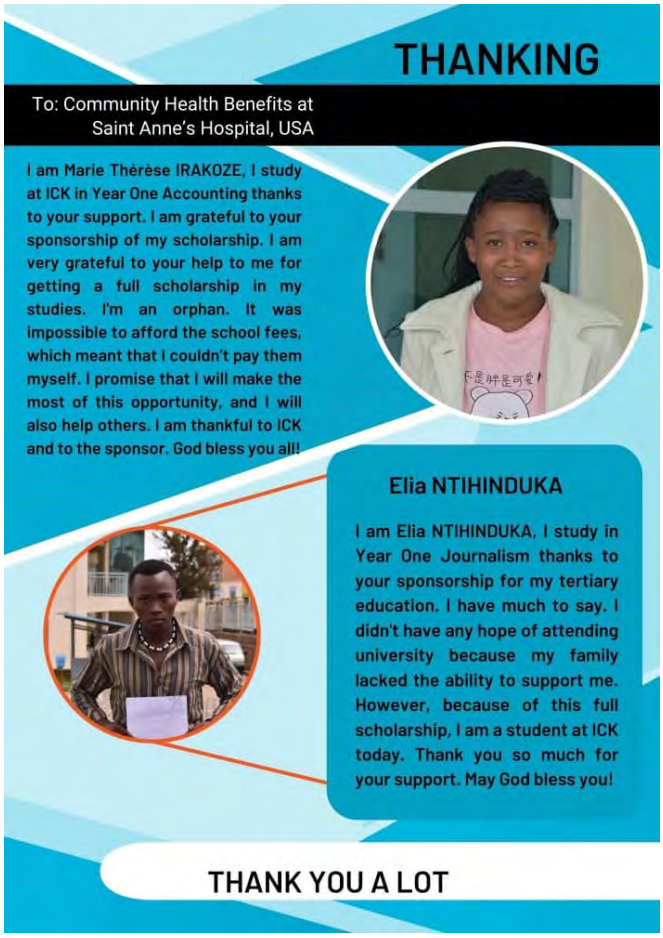
Key Accomplishments: Access to Healthcare Services – Reducing Health Disparities

- Conducted this triennial Community Health Needs Assessment (CHNA) to provide the community benefits blueprint for 2026-2028.
- Provided Financial Counselors to assist patients and community members with accessing health insurance. Provided health insurance navigation in individuals' first/preferred language.
    - Screened and/or enrolled **10,357** individuals in health insurance.

> **Testimonial:** *"She lives in a trailer on her elderly parents' property so she can look after them. She said she called so many people to assist her with applying for MassHealth and no one was able to assist her to get the coverage. By the time she left Saint Anne's Hospital she and spouse were both approved for Mass Health. She stated she is just so grateful to have met me and for all the assistance I gave them and how knowledgeable I am on these programs. I told her this is the most rewarding job anyone can have to be able to assist the community in a small way that can go very far with medical coverage for all their health needs." ~ Naomi Patricio, Supervisor, Financial Counselor*

- Provided an Oncology Financial Counselor (OFC) to assist patients with accessing treatment services, co-pay programs, and non-profit foundations that provide free and/or low-cost access to expensive oncology drugs.
    - Assisted over **3,500** unique patient requests for help, collectively saving them over **$488,000** in out-of-pocket costs for medications.
- Provided Patient Navigators in key service lines to improve continuity of care and access, helping patients overcome barriers to accessing screening or treatment services.
    - Provided breast care navigation assistance to **1,078 patients**, oncology navigation assistance to **5,804 patients**, and behavioral health navigation to **8,954 patients.**
- Provided transportation assistance for medical appointments.

  - Provided transportation to treatment appointments for **576** oncology patients.
- Provided taxi vouchers at hospital discharge for people without transportation.
  - Provided **$97,000** in funding for **6,466** taxi trips ($15/trip average) for patients without access to transportation at discharge.
- Met all performance metrics for Joint Commission National Patient Quality & Safety Goals and for participation in the MassHealth Quality & Equity Incentive Program (QEIP) to reduce disparities in patients' health status.
  - Developed patient registration and nursing assessment queries in the EMR compliant with State regulations for the collection of patients self-reported socio-demographics and health-related social needs (HRSNs).
  - Developed a data dashboard that could be sorted by patients' self-reported HRSNs and then stratified by patients self-reported socio-demographics.
  - Achieved Joint Commission Accreditation in Health Equity.
  - Achieved **100%** compliance with PY1 2023 QEIP metrics.
- Promoted student and workforce development.
  - Provided clinical training to **2,800** students from **50** colleges/universities.
  - Provided **80** students with clinical observation/shadow experiences, many submitting applications to nursing, PA, and medical programs.
  - Awarded **$1,000 scholarships** to **15** bi-lingual/bi-cultural students pursuing advanced studies in healthcare/health-related fields to increase a spectrum of identities and experiences in the healthcare workforce.
  - Provided need-based annual scholarships through graduation to two students at the Institut Catholique de Kabgayi (ICK) Rwanda. In 2024, ICK opened a Nursing School; in 2025, Saint Anne's Hospital awarded two need-based nursing scholarships and will continue to do this annually.
  - Hosted **4** annual on-site Healthcare Career Days; included multi-disciplinary career panel and presentation/ demonstration of surgical robotics for **8** area high schools.



Key Accomplishments: Access to Mental and Behavioral Health (BH)/Substance Use Disorder (SUD) Services

- Maintained dedicated and specialized behavioral health navigators (BHN) to provide assessment, resources, and referral to treatment for Emergency Department (ED) patients and inpatients with mental illness and/or SUD.
    - Provided specialized behavioral health navigation to over **8,000** patients.
    - Long-term goal to develop the "**HELP**" Hub - **Health Equity by Listening to our Patients** – a virtual resource hub for behavioral healthcare and/or health-related social needs of our patients to facilitate referrals and rapid access to low-barrier clinics and case management services.
- Provided the Certified Addiction Nurse (CARN) role to provide consultations to patients with SUD including alcohol, and in both the ED and inpatient units.
    - CARN conducted over **600** consultations with patients for SUD.
    - Provided training in stigma reduction and caring for patients with SUD/BH issues to over **600** clinicians, including virtual training to area nursing students and faculty.
    - CARN, in collaboration with SSTAR Mobile Health Unit, provided street outreach healthcare and harm reduction interventions for SUD/BH to **50** individuals per week.
- Reestablished agreement with Steppingstone's Peer2Peer Recovery Project to resume access to Recovery Coaches for patients with SUD.
    - Since launched in January 2018 through April 2023 pause, **571** patients with SUD were connected to recovery coaching services. Plan to resume program in 2026.

> **Testimonial:** *"If not for being a patient at Saint Anne's Hospital and being connected to a Recovery Coach, I might not be here today." ~ Former Peer Recovery Coaching Program Patient*

- Reduced overdose and overdose fatalities by providing access to free Narcan, an overdose reversal drug to patients and family members of patients at-risk for overdose.
    - Distributed free Narcan through the ED. Overdose deaths have decreased year-over-year, in part due to increased access to Narcan.

> **Testimonial:** *"There has been a significant decrease in the past few years in non-fatal overdoses, and we attribute this to the amount of Narcan that is getting out there and the amount of outreach being done within all the organizations. We have listed Saint Anne's Hospital as the leading pharmacy that first allowed us to distribute FREE Narcan in our reporting to SAMHSA and will continue to do so…" ~Niki Fontaine, Director of Outreach Services, City of Fall River*

- Continued to be the partnering hospital with the Fall River Fire Department's "**Safe Stations"** program, developed to expand access to treatment and allowing individuals with SUD to present at any of the City's six Fire Stations and receive immediate access to services.
    - Assisted over **175** individuals seek treatment; the majority were able to bypass an unnecessary ED visit.

Key Accomplishments: Chronic Disease Management and Wellness

- **Awarded to lead the region's Stroke Public Awareness Collaboration Project for the fourth year in a row**, including educating on the signs and symptoms of stroke, teaching individuals how to monitor their own blood pressure (BPP, and providing free BP cuffs to risk-eligible individuals.
    - Attended **31** community events, provided stroke health promotion education & BP self-monitoring to **1,080** individuals. Distributed free BP monitoring cuffs to **92** risk eligible people. Program grant-funded $6K annually.
- Delivered **40** community education events on "***Stop the Bleed,***" a program to teach bystanders how to save lives until First Responders.
- Provided free skin cancer screenings for **71** individuals and provided educational materials about skin cancer translated into Spanish and Portuguese.
- Participated in 30 community events to promote health and wellness and chronic disease management.

Key Accomplishments: Health-Related Social Needs (HRSN): Food/Nutrition Insecurity and Housing and Homelessness

- Screened patients for HRSNs and provided need-specific assistance, including referrals to community-based services and resources (e.g. copy of the Greater Fall River Resource Guide in preferred language – English, Spanish, Portuguese, Haitian-Creole).
    - **99%** of patients screened for HRSNs, positive screenings triggered Social Work consult and need-specific assistance provided to patients at/before discharge.
    - **100%** Compliance with MassHealth HQEIP Year 1 Performance Measures.
- Continued collaboration with United Neighbors of Greater Fall River (UNGFR) since 2018 to provide printed color copies of the Greater Fall River Resource Guide (The Guide). The Guide, printed in English, Spanish, Portuguese, and Haitian/Creole, provides a list of resources in the community to assist with basic needs, including a complete listing of local food pantries, soup kitchens, and agencies that provide services for mental health and addiction issues.
    - Printed over **5,000** copies of The Guide for distribution to patients & families and community partners including the Fall River Public Schools and Housing Authority.
- Supported improved Food/Nutrition Security through access to local community food pantries that provide clients with healthy, fresh, non-processed food.
    - Committed over **$80,000** in funding ($20K/annually).
- Hosted an on-site Community Farmers Market that accepts MA Healthy Incentive Program (HIP)/Supplemental Nutrition Assistance Program (SNAP) benefits and Farmers Market Nutrition Coupons (FMNC) for seniors, and Women, Infants & Children (WIC) program.
    - **85%** of total sales were made using HIP/SNAP or FMNC for seniors and WIC program participants. Sales have grown **14%** year-over-year.

Next Steps and Board Approval

Thank you to our community partners that provided guidance, expertise, and ongoing collaboration to inform the 2025 CHNA and foster collective impact in improving the health and wellbeing of Rhode Island residents.

Following approval from the Brown University Health Board of Directors, the CHNA report will be posted for public review on our website at https://www.brownhealth.org/centers-services/community-health-institute/reports-and-resources .

A full summary of secondary data findings for Rhode Island and its counties is also provided on the website and available to our community partners to serve as a resource for grant making, advocacy, and to support their many programs and services.

We value your input on our CHNA and the subsequent Community Health Improvement Plan. To contact us, please visit our website or contact Carrie Bridges, Vice President for Community Health at cbridges@brownhealth.org or 401-444-8009.

Appendix A: Secondary Data References

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Appendix B: Key Stakeholder Survey Participants

The following is a list of represented community organizations and the participants' respective title, as provided.

Organization	Title/Role
ACPE student at St. Anne Hospital, Fall River, MA	Chaplain-Student at St. Anne
Attleboro High School	Team Leader/ Early Intervention
Associates for Human Services	CEO
Associates for Human Services, Inc	Administrative Assistant
Associates of Human Services	Developmental Specialist
Bay Coast Behavioral	Clinical Director
Bay State Community Services (First Steps Together program)	Director of Admissions
Bayada Home Health Care	Sr. Marketing Manager
Boys & Girls Club of Fall River	Resource Development Director
Boys & Girls Club of Fall River	Director
Boys & Girls Club of Fall River	Executive Director
Boys & Girls Clubs of Metro South	Vice President & Chief Advancement Officer
Bristol Black Collective	Director
Bristol Community College	Adjunct Faculty
Bristol Community College	President
Bristol Elder Services Inc.	Nutrition Director
Bristol Fire Department	EMS Coordinator
C.M. Viveiros Elementary School	Nurse
Catholic Charities	Supervisor
Community Crisis Intervention Team	Coordinator
CFC Family Planning	Director of Reproductive Health Services
Child & Family Services	CEO
Child & Family Services	VP of Behavioral Health and Outreach Services
Child & Family Services, Inc.	VP of ACUTE CARE
Citizens for Citizens - Family Planning & Teen Pregnancy Prevention Programs	Health Educator/Counselor
City of Fall River	Youth Services Coordinator
City of Fall River	Head Administrative Clerk
City of Taunton	Chief of Staff
City of Taunton	City Councilor
City of Taunton	Councilor
Community Counseling of Bristol County	Director of Emergency Services
Cooperative Production	Cooperative Production
Correctional Psychiatric Services	Health Service Administrator
Cranberry Country Chamber of Commerce	Business Manager
Department of Developmental Services	Area Office Psychologist
Department of Mental Health Recovery from Addictions Program	DMH RAP
Durfee High School	Teacher/Coach
Durfee High School	Physical Education Teacher
Durfee High School	School Nurse
Durfee High School	Health/PE Teacher

Organization	Title/Role
Fall River Board of Health	Member
Fall River EMS	Chief
Fall River Housing Authority	Resident Services Coordinator
Fall River Public School Schools	School Nurse
Fall River Public Schools	PE/ Health Teacher
Fall River Public Schools	Phys Ed Teacher
Fall River Public Schools	School Nurse
Fall River Public Schools	RN
Fall River Public Schools	School Nurse
Fall River Public Schools	School Nurse
Fall River Public Schools	RN, BSN School Nurse
Fall River Public Schools	Registered Nurse
Fall River Public Schools	Nurse
Fall River Public Schools	Nurse
Fall River Public Schools	Nurse
Fall River Public Schools	School Nurse
Fall River Public Schools	Registered Nurse
Fall River Public Schools	School Nurse
Fall River Public Schools	Register Nurse
Fall River School Department	Teacher
Fall River School Department	School Nurse
Fall River Schools	School Nurse
Fall River WIC	Community & Family Support Coordinator
Family Resource Center	Program Manager
Family Service Association	Clinical Supervisor
Fall River Public Schools	Physical Education and Health Teacher
Fall River Public Schools	Co-op Coordinator -Durfee
Greater Fall River Community Food Pantry	Vice President
Greater Fall River Community Food Pantry	President
Head Start	Health Specialist
HealthFirst Family Care Center Inc.	Primary care provider- Pediatric Nurse Practitioner
HealthFirst Family Care Center Inc.	Family Nurse Practitioner
HealthFirst Family Care Center Inc.	Chief Executive Officer
HealthFirst Family Care Center Inc.	Physician
Hoye Family Medicine	Physician
John J. Doran School	School Nurse
Joseph Case High School	Director of Guidance
Justice Resource Institute	LICSW
Life Care Center of Raynham	Admissions Director
Life Care Center of West Bridgewater	Program Coordinator
Little Compton Fire Department	Little Compton FD
MA Trial Court	Specialty Court Program Coordinator
Mentor South Bay	Clinical supervisor
Morton	Board Member
Morton Hospital	Clinician
Morton Hospital MORCAP MAT	Physician Assistant
Morton Hospital/Brown Medical Group	MD

Organization	Title/Role
Nemasket Healthcare Center	Nemasket Healthcare Center
New York Life (LGBT)	Financial Professional
Old Colony YMCA - Taunton Branch	Executive Director
Parent Info Network	Ed Resource Coordinator
Pathway to Recovery LLC	Owner/PMHNP, CARN-AP, FNP
Patient and Family Advisory Council	Member
Patient and Family Advisory Council	Member
Police	Patrolman
Patient Protection Advisory Council	Patient
Regalcare at Taunton	Director of Admissions
Revere Medical	Physician
Saint Anne’s Hospital	Chaplain
Saint Anne's Hospital	Administrative Director Community Health Benefits/Equity
Saint Anne's Hospital	Spiritual Care
Saint Anne's Hospital	Member, Patient & Family Advisory Committee
Saint Vincent's Young Parent Living Program	Program Manager
Ser Jobs for Progress, Inc	Instructor
SER-Jobs	Adult Educator
Southcoast Health	Nurse
Southeastern Massachusetts SER-Jobs for Progress, Inc	Executive Director
Southeastern Massachusetts SER-JOBS for Progress, Inc.	Southeastern Massachusetts SER-JOBS for Progress, Inc.
SSTAR Addiction Treatment Center	Health Center Director
SSTAR Addiction Treatment Center	Clinical Trainer
St. Anne’s Hospital	Spiritual Care Chaplain
St. Anne’s Hospital	Chaplain
St. Anne’s Hospital	PFAC Member
St Anne's Hospital- PFAC	Patient/Family Member
Stanley Street Treatment and Resources	Assistant Director HR
Stanley Street Treatment and Resources	Program Manager
Stanley Street Treatment and Resources (SSTAR)	Prevention Coordinator
Steppingstone Inc.	Direct Care
Steppingstone Inc.	Steppingstone Inc.
Steppingstone, Inc.	Clinical Director of Behavioral Health
Taunton Area Community Table	Executive Director
Taunton Police Department	Co-response Clinician
Taunton Public School	RN
Taunton Public Schools	School Nurse (RN)
Taunton Public Schools	School Nurse, Previously Nurse at Morton Hospital
Taunton Public Schools	District Nurse Manager, Taunton Public schools
Taunton Public Schools	Director of Student Services
The Arc of Bristol County	Family Support Center Outreach Coordinator
The Children's Advocacy Center of Bristol County, a program of JRI	Co-Executive Director
The Key Program	Director of Agency Clinical Services
The Marion Institute	Program Manager
Thomas Chew Memorial Boys and Girls Club	Licensed School Age Childcare Director

Organization	Title/Role
Thomas Chew Memorial Boys and Girls Club	Teen Director
Town of Westport Board of Health	Town of Westport BOH member
Triumph, Inc. Head Start	Parent & Community Outreach Coordinator
United Neighbors	Executive Director
Women Infant and Children	Community Coordinator

Appendix C: Partner Forum Participants

The following is a list of community representatives and their respective organization, as provided.

Organization	Name
AccentCare	Skylar Ims
AccentCare	Julie Livingston
American Red Cross of Southeastern MA	Barbara Cotton
American Red Cross of Southeastern MA	Ethan Ticehurst
Bay Coast Behavioral	Matthew Millman
Bay Coast Behavioral	Olivia Parker
CAC of Bristol County, a program of JRI	Cathy Rutkowski
CAC of Bristol County, a program of JRI	Lara Stone
CFC Head Start	Cory Santos
Children's Advocacy Center of Bristol County	Elizabeth Nettikadan
Citizens for Citizens, Inc.	Lee Corrigan
Citizens for Citizens, Inc.	Nate Goncalo
City of Fall River	Christian McCloskey
City of New Bedford	Nikita Valencia
Community Development Agency	Mary Camara
Cultured Care	Nicole Nault
Fall River Deaconess Home	Hilda Moniz
Fall River HHS	Hannah Ragozzino
Greater New Bedford Community Health Center	Jenney Murphy
HealthFirst Family Care Center	Uma Jaladi
HealthFirst Family Care Center	Jenny Mello Reis
HealthFirst Family Care Center	Danielle Renzo
Office of State Representative Antonio F.D. Cabral	Alves Medeiros
Partners for a Healthier Community	Marcia Picard
People Incorporated	Mimi Larrivee
Prima CARE, PC	Martin Fogle
Saint Anne's Hospital Brown University Health	Ann Marie Couture
Saint Anne's Hospital Brown University Health	Sandra Croft
Saint Anne's Hospital Brown University Health	Teresa (Tracy) Gerety-Ibbotson
Saint Anne's Hospital Brown University Health	Mary-Louise Mancini
Saint Anne's Hospital Brown University Health	Patty McLaughlin
Saint Anne's Hospital Brown University Health	Roxanne Winsor
Saint Anne's Hospital-Fernandes Center for Children & Families	Sonya Sousa
South Coast Health	Katie Johnson
South Coastal Counties Legal Services Inc	Rob Mount
South Coastal Counties Legal Services Inc	Jeannine Schoos
Southcoast Health	Ben Jones
Southcoast Health	Sara Lapointe
Southcoast Health	Ali LeBert
Southcoast Health	Stephanie Perry
Southcoast Health	Marissa Pillai

Organization	Name
Southeast Center for Independent Living	Heidi Collins
SSTAR	Sheila Kauffmann
Steppingstone Inc.	Danielle Brown
Steppingstone Inc.	Faith Gurney
Steppingstone Inc.	Ninoska Lopez
The Greater Fall River Community Food Pantry	Richard Mancini
Steppingstone Inc.	Deborah Tanguay
The Marion Institute's Southcoast Food Policy Council	Christine Smith
The Women's Center	Amanda Miller
Thomas Chew Memorial Boys & Girls Club	Bill Kiley
THRIVE For Humanity	Laura Bradley
United Interfaith Action of Southeastern MA (UIA)	Tracy Albernaz
United Way of Greater Fall River	Patty Armstrong
United Way of Greater Fall River	Janine Pohorely
United Way of Greater Fall River	Lucy Rebelo
United Way of Greater Fall River	Kimberly Smith
University of Massachusetts Dartmouth	Gerri-Lyn Boyden
University of Massachusetts Dartmouth Community Nursing	Melissa Desroches
Veterans Transition House	Catherine Bucklye
Veterans Transition House	Dolly Mello