2026 Community Health Needs Assessment

BOSTON MEDICAL CENTER South

Acknowledgements & Overview

2026 Community Health Needs Assessment

Boston Medical Center - South (BMC South) is proud to share our inaugural Community Health Needs Assessment (CHNA), a comprehensive evaluation of the health needs and strengths of Metro South's communities. In October 2024, Boston Medical Center Health System (BMCHS) assumed ownership over the hospital (formerly Good Samaritan Medical Center) with the primary goal of preserving services in the region in the face of potential closure. Today, we deliver expert care close to home at our hospital in Brockton and are working to expand access to ambulatory services – including primary and specialty care – to our neighbors along the Route 24 corridor.

BMC South has several satellite locations in addition to the main hospital at 235 North Pearl St in Brockton, MA. This includes the following facilities:

Boston Medical Center – South Outpatient Care: 1 Pearl Street, Brockton, MA 02301
Boston Medical Center – South Outpatient Care: 830 Oak Street, Brockton, MA 02301
Boston Medical Center – South Outpatient Care: 15 Roche Bros Way, N Easton, MA 02356
Boston Medical Center – South Outpatient Care: 3 Washington Street, N Easton, MA 02356
BMC South Brockton Behavioral Health Center: 34 N Pearl St, Brockton, MA 02301

We engaged a third-party consultant, inHealth Strategies, to develop this CHNA. inHealth led primary and secondary data collection, analysis, and report production Their independent facilitation ensured that the assessment reflects rigorous methodology and community input. The BMCHS Office of Community Engagement & External Affairs (CE & EA) supported this work by identifying key community leaders and groups to engage in this process and supporting distribution of a community survey leveraging our community relationships. The CE & EA team's outreach to residents and community leaders ensured their voices were centered throughout the assessment process.

We extend our sincere gratitude to all community members, community leaders, partners, and organizations who contributed their time, perspectives, and expertise to this inaugural assessment. Your voices are vital in shaping our strategies and ensuring that our work is responsive to the needs of those we serve. BMC South is proud to demonstrate our commitment to advancing health outcomes and access in our communities, and we look forward to continuing to learn and build relationships in pursuit of that shared goal.

BOSTON MEDICAL CENTER – SOUTH

2026 Community Health Needs Assessment

This report reflects the BMC South CHNA service area and incorporates quantitative findings, community survey results, and focus group input collected in 2026.

PREPARED FOR BMC SOUTH BY

inHealth Strategies

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Executive Summary

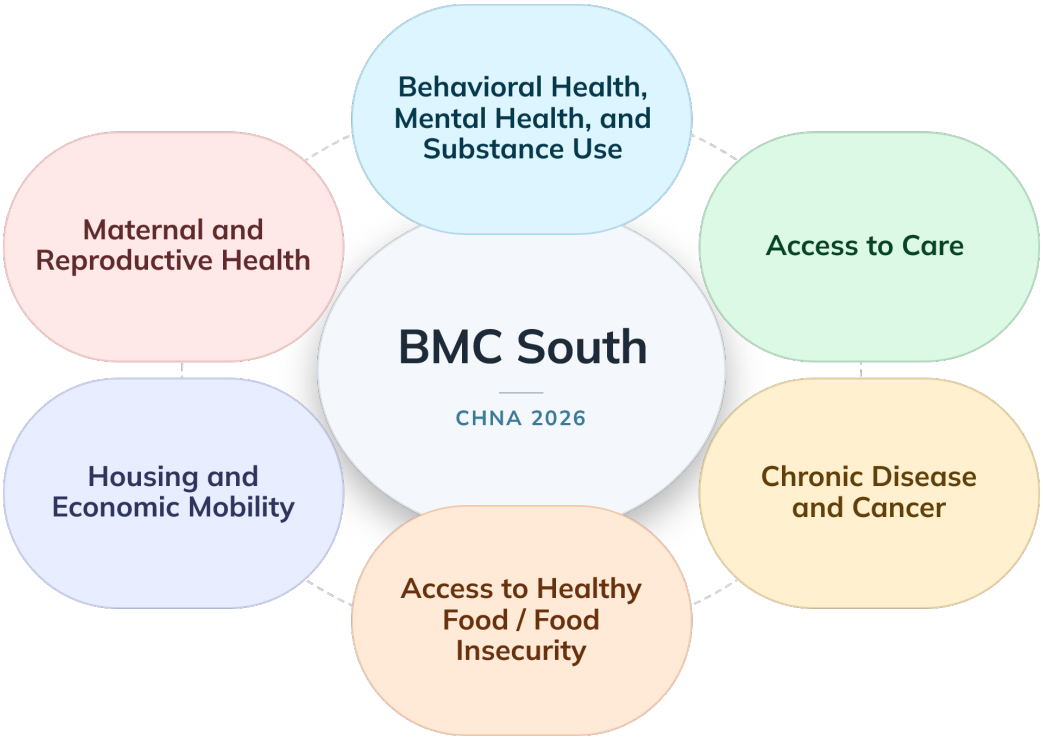
inHealth Strategies partnered with Boston Medical Center – South (BMC South) to conduct this Community Health Needs Assessment (CHNA) to better understand the health needs, strengths, barriers, and opportunities across the communities it serves. This is BMC South's first CHNA for the service area since assuming ownership in October 2024. It establishes a starting point for measuring community health improvements over time and will inform a separately published implementation strategy.

While BMC South is located in Brockton, the largest municipality experiencing some of the area's most significant health-related needs and challenges, the assessment is an analysis of all communities within the defined BMC South service area—18 municipalities and 21 ZIP codes across Plymouth, Norfolk, and Bristol counties. These communities are also referred to collectively as "Metro South."

A mixed-methods approach was used to combine quantitative data with community input. A community survey was developed and administered specifically for this CHNA to gather direct input from residents, while focus group discussions gathered perspectives from community leaders, service providers, and organizational partners.

Six priority health needs emerged through this process. These priorities are closely interconnected and reflect both quantitative findings and community perspectives. Community participants consistently emphasized that health is shaped by access to healthcare, housing stability, food security, language access, trust, mental health, economic security, and the ability to navigate trustworthy services safely.

Identified Priority Areas



Key Findings

Behavioral health, mental health, and substance use emerged as the community's highest-ranking health priority. In the service area, 17.8 percent of adults report frequent mental distress, compared with 16.2 percent in Massachusetts and 15.6 percent nationally (CDC PLACES/BRFSS, 2023). Mental health provider availability is approximately 13 percent lower in the service area than statewide (County Health Rankings, 2025). The community survey also highlighted a significant gap in access: 70 percent of respondents said they could always get medical care when needed, compared with only 42 percent who said the same about mental healthcare, and nearly one-quarter reported that they could never get the mental healthcare they needed (BMC South Community Survey, 2026). Prescription monitoring data reinforces this picture: a higher share of service area residents are prescribed opioid agonists, benzodiazepines, and stimulants than statewide, consistent with elevated behavioral health need across the region (MA PMP, 2016 – 2024).

Access to care ranked among the top priority areas, with survey respondents frequently identifying scheduling and appointment availability as barriers to care. Focus group participants described long wait times, provider turnover, confusion about navigating the healthcare system, and difficulty finding services. They emphasized that access depends on more than appointment availability—it also includes language services, culturally responsive care, affordability, transportation, and trust. The overall uninsured rate in the service area is slightly higher than the statewide rate (2.8 percent versus 2.6 percent), and Brockton's uninsured rate is nearly twice the service area average, highlighting persistent disparities in access to coverage and care (ACS, 2020 – 2024). The supply of primary care clinicians to residents is about 20 percent lower in the service area than the statewide average (HRSA AHRF, 2023). These local gaps exist within a broader statewide primary care access challenge, as more than 30 percent of Massachusetts residents report difficulty accessing primary care (CHIA Health Insurance Survey, 2025). Only one federally qualified health center serves the entire service area, located in Brockton—a municipality with federal Health Professional Shortage Area designations for primary care, mental health, and dental care (HRSA HPSA Find, 2025).

Chronic disease and cancer stood out as major health challenges, with diabetes, hypertension, obesity, heart disease, asthma, and stroke contributing to preventable illness and disability across the region. Electronic health record (EHR) data shows that the prevalence of diabetes, hypertension, and obesity is higher in the service area than statewide: diabetes affects 12.9 percent of the service area population compared with 11.4 percent across Massachusetts, hypertension affects 39.4 percent compared with 36.9 percent, and obesity affects 34.2 percent compared with 31.0 percent. Several municipalities experience an elevated burden, including Brockton, where diabetes prevalence exceeds 14 percent and hypertension affects approximately 42 percent of the population (MA DPH, 2023). Cancer incidence is also elevated across the region. Pooled across all 18 service area municipalities, overall cancer incidence was approximately 7 percent higher than the statewide expectation during 2017 – 2021, reinforcing the importance of prevention, screening, and early detection (MCR, 2017 – 2021). Focus group participants described how chronic disease and cancer are closely connected to food security, opportunities for physical activity, preventive care, health education, and access to ongoing primary care.

Access to healthy food / food insecurity were identified as significant concerns in both the quantitative data and community input. An estimated 29,620 households across the service area experience food

insecurity, representing 21.2 percent of all households—above the median rate of approximately 18 percent among Eastern Massachusetts communities included in the Greater Boston Food Bank study (Greater Boston Food Bank, 2025). The service area also faces an estimated annual meal gap of 10.46 million meals, including approximately 3.26 million meals that remain unmet after existing food distribution efforts. Supplemental Nutrition Assistance Program (SNAP) participation is 13.5 percent across the service area, compared with 12.3 percent statewide, reflecting continued economic need among many households (DTA SNAP caseload, April 2026, via Project Bread). Participants described strong food pantry networks and community partnerships but emphasized that emergency food assistance often addresses immediate hunger rather than the underlying financial pressures contributing to food insecurity.

Housing and economic mobility barriers are most pronounced in the service area's urban communities, where poverty is higher. Although the overall service area poverty rate (7.9 percent) is lower than the Massachusetts average (10.0 percent), poverty is substantially higher in Brockton (13.5 percent), reflecting concentrated economic hardship. An estimated 13.6 percent of residents in the service area report experiencing housing insecurity, compared with 11.1 percent statewide. The service area also has a relatively low housing vacancy rate (3.1 percent) compared to Massachusetts (8.2 percent) and the United States (10.1 percent), reflecting a constrained housing market that contributes to housing affordability challenges and homelessness. In Brockton, an estimated 40.4 percent of households are housing cost-burdened and 45.4 percent live in substandard housing, both well above the service area average, underscoring the cumulative impact of limited housing availability, housing affordability, poverty, housing insecurity, and poor housing conditions on residents' health and wellbeing. (Sources: ACS, 2020 – 2024; CDC PLACES/BRFSS, 2023). Participants described a growing number of older adults experiencing housing instability for the first time.

Maternal and reproductive health also ranked as a top community priority, with the service area reporting somewhat higher rates of low birth weight (9.1 percent versus 8.5 percent), preterm birth (9.3 percent versus 8.8 percent), and cesarean delivery (34.6 percent versus 31.1 percent) than Massachusetts overall (MA DPH birth data, 2013 – 2022). These averages can conceal differences between communities, with adequate prenatal care lower in Brockton (71.6 percent) and Randolph (74.4 percent) and low birth weight somewhat higher in Randolph (11.6 percent). Indicators of economic need during pregnancy are also present: approximately 42 percent of prenatal care across the service area is publicly funded through Medicaid and 34 percent of pregnant residents participate in WIC, the federally funded nutrition program for women, infants, and children. Both measures are higher in Brockton (MA DPH birth data, 2013 – 2022). Participants shared perspectives on birth trauma, trust, and whether some pregnant patients feel comfortable discussing needs related to food, housing, mental health, and substance use.

Key Themes Across Priority Areas

- Language access and culturally responsive communication influence every priority area.
- Trust, safety, and respect shape whether residents seek care, services, and support.
- Housing, food insecurity, transportation, and financial pressures often occur together and affect health across multiple areas.

- Community members described how immigration-related concerns can affect whether some residents feel comfortable accessing healthcare, community services, and other supports.
- Community organizations play a vital role in meeting community needs, although many described limited resources and the need for stronger coordination.

Introduction

Purpose of the Community Health Needs Assessment

A meaningful understanding of community health requires both quantitative data and community input. Together, these sources explain not only the extent of health needs but also how residents actually experience them. This CHNA uses public health data to describe the scale of need while drawing on focus group discussions and survey responses to provide context about the barriers residents face in their daily lives. For example, data can identify the prevalence of food insecurity, while community members explain how food insecurity is connected to housing costs, transportation, benefits access, and chronic disease.

Because this is BMC South's first CHNA, it establishes a baseline for future community health improvement efforts, documenting current health needs and the perspectives of organizations serving the community, while providing a foundation for future assessment, planning, and evaluation.

As a nonprofit hospital, BMC South conducts this CHNA to identify significant community health needs and inform strategies to advance health outcomes, increase access, and improve services responsive to community needs. Additionally, the process provides an opportunity to strengthen relationships with community organizations, better understand local strengths and challenges, and develop a shared understanding of the factors that influence health across the service area.

This report has four primary purposes:

1. Define the community served by BMC South.
2. Describe the demographic, health, social, and economic conditions across the service area.
3. Present quantitative findings alongside community survey and focus group results.
4. Identify the significant health needs that will inform BMC South's implementation strategy document (Community Health Improvement Plan, CHIP).

BMC South's CHIP will be published separately, describing the planned actions and efforts in response to the priority health needs identified in this report.

About BMC South and the Assessment Context

Boston Medical Center Health System (BMCHS) is an integrated academic healthcare system that models a new kind of excellence in healthcare where clinical and operational innovation meets health equity and access. BMCHS assumed ownership over BMC South (formerly Good Samaritan Medical Center) in October 2024 after prior owners (Steward Health Care) declared bankruptcy. BMCHS's primary goal was preserving services and jobs in the region in the face of potential closure. Today, BMC South is delivering top-tier care in the community and working to expand access to ambulatory services in the Metro South region. In addition, BMC South operates a number of outpatient clinics and BMC South - Brockton Behavioral Health Center, which provides innovative care to people with co-occurring substance use disorders and mental illness.

This CHNA was completed during a period of transition for healthcare in the Metro South region. Since this is the first CHNA conducted since the ownership transition, BMCHS and BMC South are using this assessment as a baseline to better understand the community health needs, existing strengths, and the perspectives of community organizations and residents. Throughout the focus groups, community partners expressed both optimism and opportunities for BMC South. Participants emphasized the importance of consistent local care, clear communication, reliable referral pathways, and collaboration with the many trusted organizations already serving the community. They described trust as something that is built over time through visible engagement, responsiveness, and follow-through.

Community members also highlighted the region's many strengths, including long-standing community organizations, faith communities, schools, food access partners, health centers, housing organizations, immigrant-serving organizations, and grassroots leaders. These existing assets provide an important foundation for understanding community health needs and the collaborative environment in which BMC South operates.

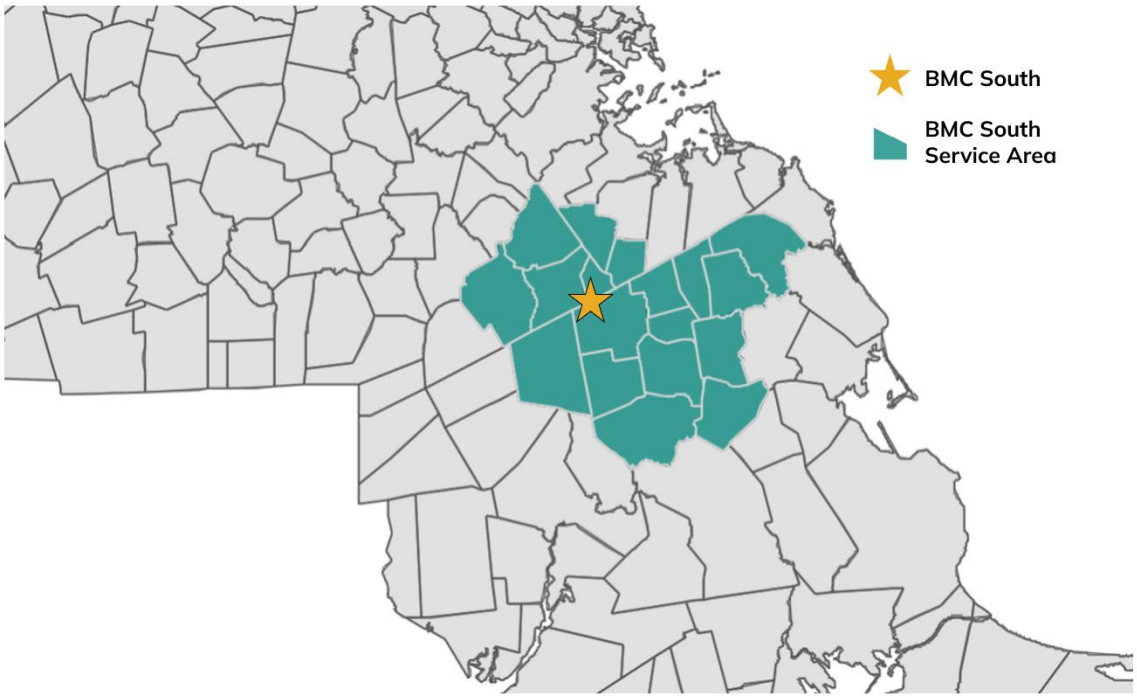
Defining the Community

The BMC South service area includes 18 municipalities and 21 ZIP codes across Plymouth, Norfolk, and Bristol counties, with an estimated population of 399,579 residents (U.S. Census Bureau, American Community Survey 2020 – 2024). The service area includes urban, suburban, and smaller towns that differ in population size, demographics, socioeconomic conditions, and health needs.

The communities in the BMC South service area differ in important ways. Population size, racial and ethnic composition, languages spoken, income, housing conditions, and other social and economic factors vary across municipalities and shape health needs and access to care. Looking at both service area and community-level data helps identify broad regional patterns while also highlighting differences that may be hidden in service area averages.

The service area includes Abington, Avon, Bridgewater, Brockton, Canton, East Bridgewater, Easton, Halifax, Hanover, Hanson, Holbrook, Norwell, Randolph, Rockland, Sharon, Stoughton, West Bridgewater, and Whitman. The corresponding ZIP codes are provided in the Appendix.

BMC South Service Area Map



Understanding the Findings

This CHNA draws on quantitative data, a community survey, and focus group discussions to provide a comprehensive picture of health across the BMC South service area. Quantitative data describes the prevalence of health conditions, comparing local outcomes with state benchmarks where available, and identifying differences across communities. Focus group discussions add context by explaining how community organizations serving the population view the needs and barriers facing those they serve. Survey responses provide direct input from residents, reflecting how they experience health needs and barriers in their daily lives.

Findings supported by more than one source provide the strongest evidence for community priorities. For example, behavioral health, mental health, and substance use emerged as a priority through quantitative data showing disparities compared to state averages—as well as geographic disparities across the service area—and presented as a key topic in community survey results and focus group discussions.

In addition to the six priority health needs, this CHNA discusses several additional topics considered through the prioritization process. Although these topics did not rank among the areas selected for focus during the current assessment cycle, they remain important to community wellbeing and are closely connected to one or more of the top standalone priorities. Including these topics provides additional context and illustrates how health needs are interconnected across BMC South's communities.

Methodology and Approach

Assessment Process

The Community Health Needs Assessment (CHNA) used a mixed-methods approach that combined quantitative analysis with community engagement to identify significant health needs across the BMC South service area. The process was designed to understand both the prevalence of health issues and the factors that influence health outcomes, providing a foundation for future community health improvement planning.

Quantitative findings were drawn from available datasets to identify measurable health needs and compare service area conditions with Massachusetts or regional benchmarks where available. Data was also analyzed on a more granular level (weighted county, municipality, and ZIP code), helping identify areas in the community that experience more elevated health needs compared to others. Different perspectives were gathered through a community survey and focus group discussions with residents, community organizations, and local leaders. These conversations provided important context by highlighting barriers that quantitative data alone cannot capture, including trust, stigma, and confusion about navigating the healthcare system, safety concerns, and challenges accessing services.

The assessment was informed by the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 framework, which emphasizes community context, health status, health equity, and collaborative action.

Key Phases of the Assessment

1. **Service area definition and data preparation.** The service area was defined using the identified municipalities and quantitative data was assembled across demographic, social, economic, health status, healthcare access, and priority-specific indicators.
2. **Community engagement.** Focus group discussions were conducted in Spring 2026 with community organizations, service providers, and local leaders.
3. **Community survey.** A survey was administered in Spring 2026 to gather residents' perspectives on health needs, barriers to care, and community concerns.
4. **Prioritization.** Health needs were evaluated using criteria that included magnitude, severity, health equity, and feasibility of impact. Final priorities were informed by both quantitative findings and community input.
5. **Report development.** Findings were synthesized into this CHNA report. A separate implementation strategy will follow the adoption of this assessment.

Focus Group Conversations

Throughout this report, qualitative engagement is collectively referred to as focus group input. This includes both larger focus groups and smaller facilitated discussions that used the same discussion guide, questions, and prompts. Participants were asked to speak from the perspective of their roles, their organizations, and the communities they serve. Discussion topics included community needs,

strengths, assets, barriers, trust, access to care, lived experiences, partnership opportunities, and changes that would have the greatest impact.

In addition to organizations representing the broad interests of the community, the focus group participants included representatives from healthcare organizations, local government, and community-based organizations serving diverse populations across the service area. These perspectives helped interpret quantitative findings, identify significant community health needs, and better understand barriers to accessing healthcare and other community services.

Because all discussions followed the same facilitation guide, findings were analyzed together as a single qualitative dataset. This approach supports consistency and avoids overstating differences based solely on group size. Smaller discussions often provided deeper insight into specific issues, while larger groups highlighted themes that resonated across multiple organizations.

A full list of organizations for the 19 participants and the primary perspectives represented is provided in Appendix B.

Community Survey

The Spring 2026 community survey was offered in five languages (English, Spanish, Haitian Creole, Cape Verdean Creole, and Portuguese) and received 215 responses, including 150 from residents of the 18 core service area municipalities and 65 from adjacent communities within the broader BMC South catchment area. Brockton accounted for 62 responses, the largest number from any municipality.

The survey included questions on community perceptions and lived experience, health status, access to care, and social and economic needs. Respondents rated their community across several dimensions, including sense of belonging, safety, availability of places to be active, and ability to access needed resources such as food, services, and care. Participants also reported on their ability to obtain medical and mental healthcare over the past year, rated their own overall health, and identified the barriers that made accessing care more difficult, such as cost, transportation, scheduling and availability, and language or communication barriers.

Respondents identified where they usually go for care or advice and were asked to select up to three of the biggest health concerns facing their community, including mental health, substance use, chronic conditions, housing instability, food insecurity, cost of living, and the health and wellbeing of youth and older adults. Open-ended questions were included asking respondents what would make it easier for them and their families to stay healthy, and whether there was anything else they wanted to share about their community or health needs, allowing respondents to elaborate in their own words on concerns.

Additionally, the survey collected demographic information, including age group, primary language spoken at home, and household income, as well as whether respondents had concerns about paying for basic needs such as food, housing, and healthcare. This demographic data allows survey findings to be considered alongside those of the focus groups and other data sources to identify patterns and disparities across different populations within the service area.

Data Collection and Analysis

The quantitative review included indicators across demographic, social, economic, clinical, and access domains. These indicators were used to identify patterns across the service area, compare local conditions with statewide benchmarks, and examine how health needs vary by municipality. When possible, findings were also examined by geography and key population characteristics, including race, ethnicity, age, primary language, and income. In some areas, disaggregated data was limited; those limitations are noted where applicable.

The analysis emphasized interpretation rather than simply reporting indicators. For example, emergency department utilization was examined alongside primary care access, care navigation, insurance stability, and transportation barriers. Food insecurity was analyzed in relation to chronic disease, SNAP enrollment, housing costs, and the availability of food assistance. Birth outcomes were considered in the context of prenatal care, maternal health equity, behavioral health, and social needs.

Data was drawn from publicly available sources, including the U.S. Census Bureau American Community Survey; the Massachusetts CARES Community Data Tool; CDC PLACES and BRFSS-modeled estimates; the Massachusetts Department of Public Health, including birth outcomes, substance use, immunization, and cancer registry data; the Center for Health Information and Analysis; the Greater Boston Food Bank; the Massachusetts Department of Transitional Assistance; County Health Rankings; and federal provider and shortage-area data from CMS and HRSA. Additional environmental, housing, and economic indicators were drawn from the U.S. Environmental Protection Agency, the U.S. Census Bureau, and related datasets. A complete list of data sources, including datasets and reference periods, appears in Appendix E. Indicators referenced in this report were selected to support the assessment's priority areas and to describe overall community health.

Municipal-level data was reviewed whenever possible to illustrate variation across communities. The report also incorporates service area summaries and statewide benchmarks when available. This approach is particularly important because BMC South’s service area spans three counties. Although county-level measures provide valuable context, municipal- and service area-level estimates were prioritized to more accurately reflect the communities served by BMC South and avoid overstating countywide findings that may not represent local conditions.

Where municipal data was available, service area figures were calculated as population-weighted averages of the 18 municipalities rather than simple averages. Each community's value was weighted by the population most relevant to the measure—total population for overall prevalence and rates, the adult population (ages 18 and older) for indicators reported among adults, and the relevant age or demographic group for age- or population-specific measures. Weighting by population ensures that larger communities such as Brockton, which is home to roughly one-quarter of service area residents, are represented in proportion to their size, and that service area estimates are not distorted by very small municipalities.

With that said, county-level data was used to fill gaps in domains where municipal estimates were not available, such as primary care physician supply and drug overdose mortality. In these cases, the three counties were combined using weights that match each county's share of the service area population rather than treating the counties equally. Because most service area residents live in Plymouth County,

followed by Norfolk County, with only one municipality (Easton) located in Bristol County, the county-weighted estimates reflect this distribution: approximately 63 percent of the weight from Plymouth County, 31 percent from Norfolk County, and 6 percent from Bristol County. This method ensures that estimates derived from county data reflect where service area residents actually live and do not overstate the influence of a county that contributes relatively few residents to the service area.

Data Limitations

This assessment relies on the best available evidence, recognizing that no single dataset fully captures the health and wellbeing of a community. Several considerations should be kept in mind when reviewing the findings. Some indicators are modeled estimates rather than direct counts and should be viewed as directional rather than exact measures. Certain datasets are available only at the county level, which may not fully reflect variation within neighborhoods or across the BMC South service area. In addition, many public datasets lag by one or more years and therefore may not capture the most current conditions. Some high-priority topics, such as severe maternal morbidity at the service area level, could not be measured directly using publicly available data.

The community survey was administered as a self-selected convenience sample. Despite being offered in five languages and distributed broadly through multiple community-based outreach channels, responses skewed toward older, English-speaking, digitally connected, and civically engaged residents. Consequently, younger adults, residents with limited English proficiency, immigrant communities, and some lower-income populations may be underrepresented.

As a result, survey findings are used to corroborate other sources of evidence and highlight residents' experiences rather than estimate population prevalence or determine priority rankings across the service area. Similarly, focus group findings reflect the perspectives of participating organizations and community leaders and should not be interpreted as representing the views of every resident.

Despite these considerations, the combination of quantitative data, community survey findings, and focus group input provides a strong foundation for identifying significant community health needs. Bringing these sources together strengthens confidence in the findings by allowing results to be compared across methods, while qualitative input helps explain issues that quantitative data alone may not fully capture.

Community Profile and Health Needs

Service Area Overview

The BMC South service area includes 18 municipalities and 21 ZIP code entries with an estimated population of approximately 399,579 residents. Brockton is the largest municipality, with 105,386 residents, followed by Randolph, Stoughton, Bridgewater, Easton, Canton, and other towns (ACS, 2020 – 2024). Brockton is also the primary source of BMC South patients, accounting for the largest share of the hospital's patient population. Because the service area spans urban, suburban, and more geographically dispersed areas, residents experience a wide range of demographic, socioeconomic, and health-related conditions.

These communities differ in population size, racial and ethnic composition, age distribution, household income, housing markets, language access needs, and healthcare access patterns. Brockton and Randolph have greater racial and ethnic diversity, larger immigrant and newcomer populations, and higher demand for culturally and linguistically appropriate services. Some other municipalities have smaller populations and higher average incomes but continue to face challenges related to transportation, housing affordability, chronic disease, social isolation, and timely access to care.

Population, Race, and Ethnicity

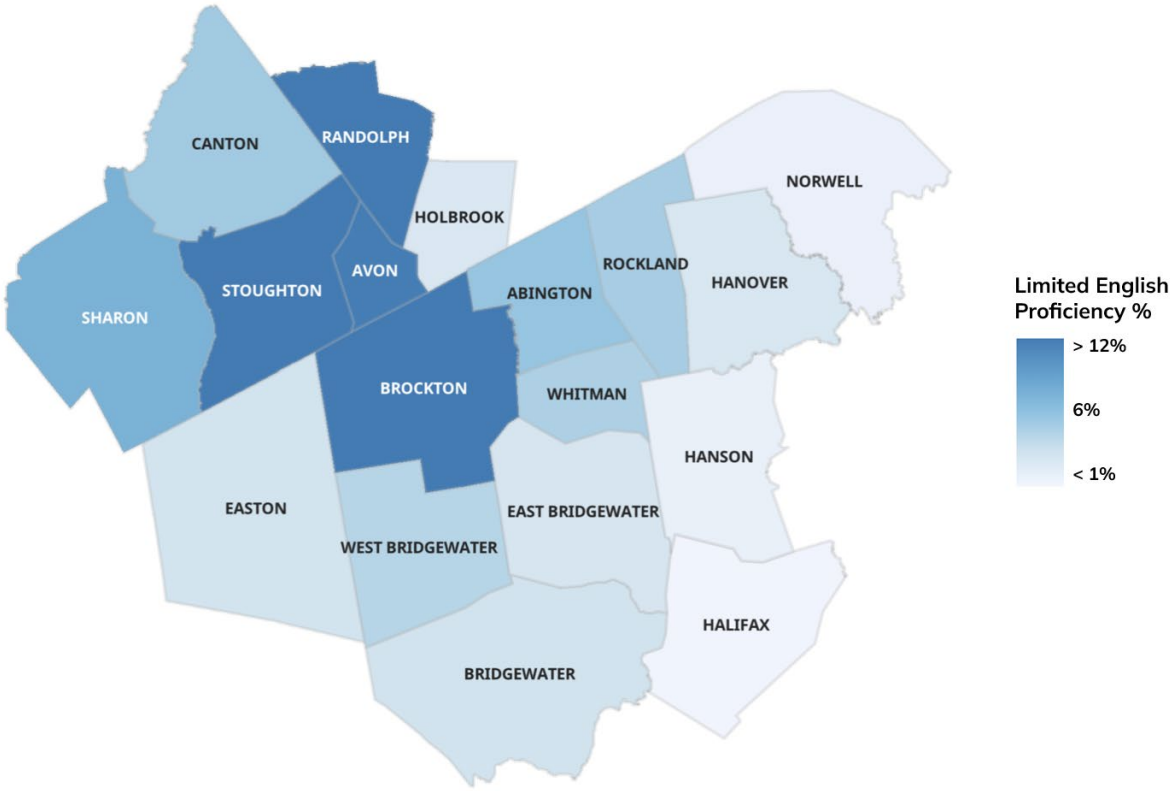
ACS, 2020 – 2024

Area	Total Population	Hispanic or Latino (any race) %	Non-Hispanic (NH) White alone %	NH Black alone %	NH Asian alone %	NH Two or More Races %	NH Other %	People of Color %*
Massachusetts	**7,044,056**	**13.3**	**66.6**	**6.4**	**7.3**	**5.1**	**1.4**	**33.4**
Service Area	**399,579**	**7.7**	**59.0**	**16.6**	**5.0**	**8.5**	**3.2**	**41.0**
Brockton	**105,386**	12.6	26.8	33.5	2.4	17.1	7.5	**73.2**
Randolph	**34,878**	14.4	27.4	39.8	12.3	5.2	0.8	**72.6**
Stoughton	**29,225**	4.8	57.2	18.4	6.6	8.2	4.8	**42.8**
Bridgewater	**28,471**	5.3	78.7	7.8	3.1	3.6	1.5	**21.3**
Easton	**25,316**	5.7	78.7	6.1	3.9	4.5	1.0	**21.3**
Canton	**24,748**	4.5	67.2	11.6	10.4	4.8	1.4	**32.8**
Sharon	**18,574**	3.3	65.6	4.2	20.3	6.5	0.1	**34.4**
Rockland	**17,701**	8.8	82.4	2.3	0.6	2.7	3.2	**17.6**
Abington	**17,053**	5.2	83.2	0.6	3.6	4.9	2.5	**16.8**
Whitman	**15,295**	5.4	82.8	1.8	0.8	7.4	1.8	**17.2**
Hanover	**14,845**	1.2	87.7	0.7	4.0	5.9	0.5	**12.3**
East Bridgewater	**14,456**	4.1	87.6	2.0	0.3	4.0	1.9	**12.4**
Holbrook	**11,380**	10.5	57.6	14.2	5.5	8.6	3.5	**42.4**
Norwell	**11,361**	2.8	90.1	0.5	3.1	3.2	0.1	**9.9**

Hanson	10,660	1.3	90.8	0.2	0.5	6.6	0.6	9.2
Halifax	7,748	1.8	89.9	—	0.3	7.6	0.3	10.1
West Bridgewater	7,708	1.0	91.0	1.0	2.0	4.4	0.6	9.0
Avon	4,774	10.6	52.3	23.9	5.8	4.8	2.5	47.7

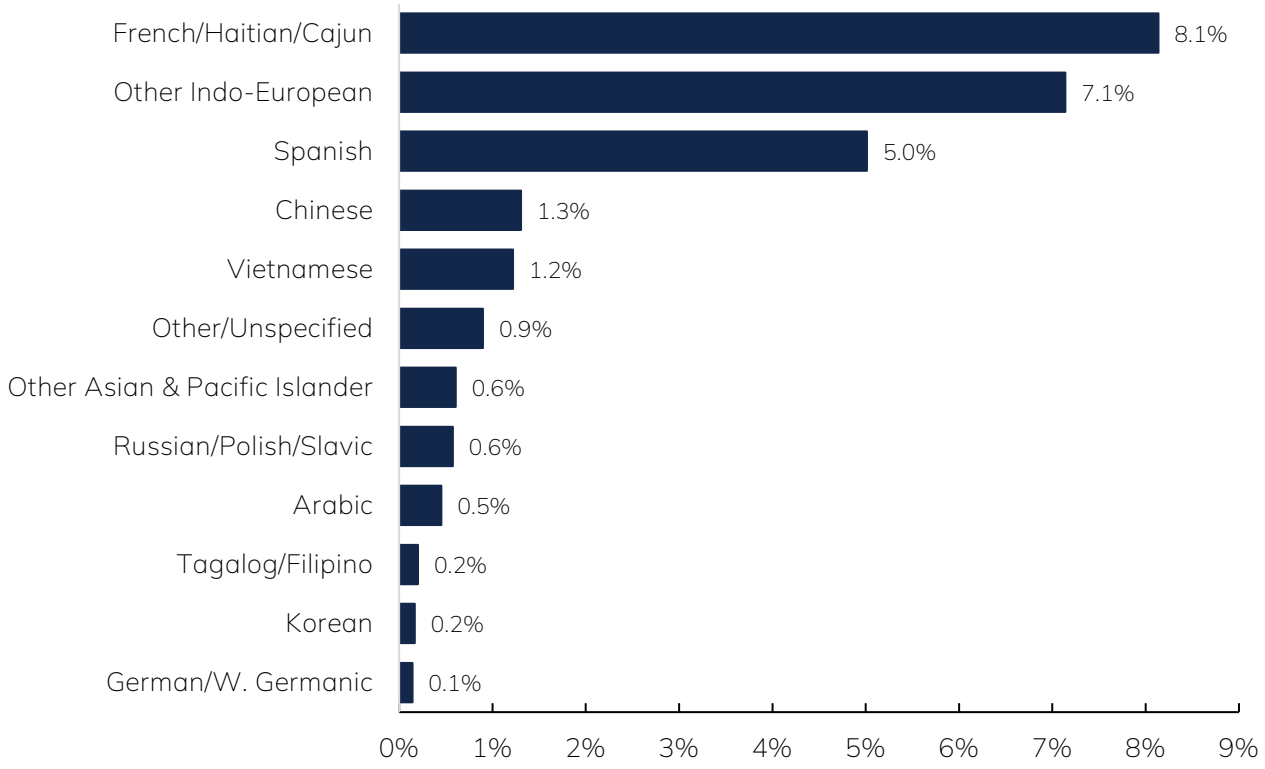
*People of color reflects all residents who do not identify as non-Hispanic White alone, including residents identifying as Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, Some other race, Two or more races, and Hispanic or Latino of any race. Calculated as total population minus non-Hispanic White alone.

Limited English Proficiency by Municipality
ACS, 2020 – 2024



Language Spoken at Home (Other than English)

ACS, 2020 – 2024



The demographic data highlights why language access and culturally responsive care are central considerations throughout this assessment. Across the service area, approximately one-quarter of residents age 5 and older speak a language other than English at home. In Brockton it is nearly half, and more than one in five residents have limited English proficiency. These patterns influence how residents receive health information, communicate with providers, navigate the healthcare system, and build trust in healthcare and community services.

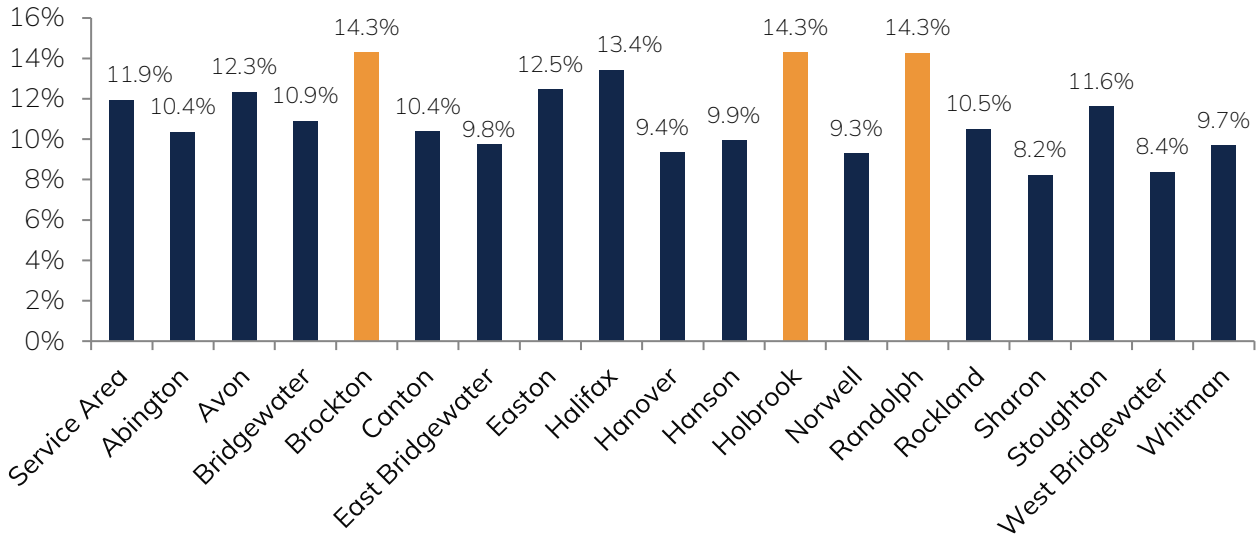
Race and ethnicity also vary considerably across the service area. Brockton and Randolph are among the most racially and ethnically diverse communities and also experience higher levels of need and greater concentrations of need across several indicators. At the same time, challenges such as chronic disease, food insecurity, and housing affordability extend beyond any single municipality.

This diversity is one reason the assessment uses a service area perspective rather than focusing on a single municipality. While some health challenges are concentrated in specific communities, others are shared across the region. Examining the service area as a whole allows the assessment to identify both localized disparities and broader regional patterns, helping ensure that implementation strategies address community-specific needs while advancing shared priorities across the BMC South service area.

The veteran population in the service area is similar to that of Massachusetts (4.6 percent versus 4.3 percent), both lower than the national average of 6.2 percent. With that said, there are towns with higher rates—Hanson with 8.2 percent and Avon with 8.0 percent (ACS, 2020 – 2024).

The disability rate in the service area is slightly lower than the statewide rate, with 11.9 percent of the population reporting a disability compared to 12.3 percent—both lower than the national average of 13.3 percent (ACS, 2020 – 2024).

Disability Rate by Municipality
ACS, 2020 – 2024



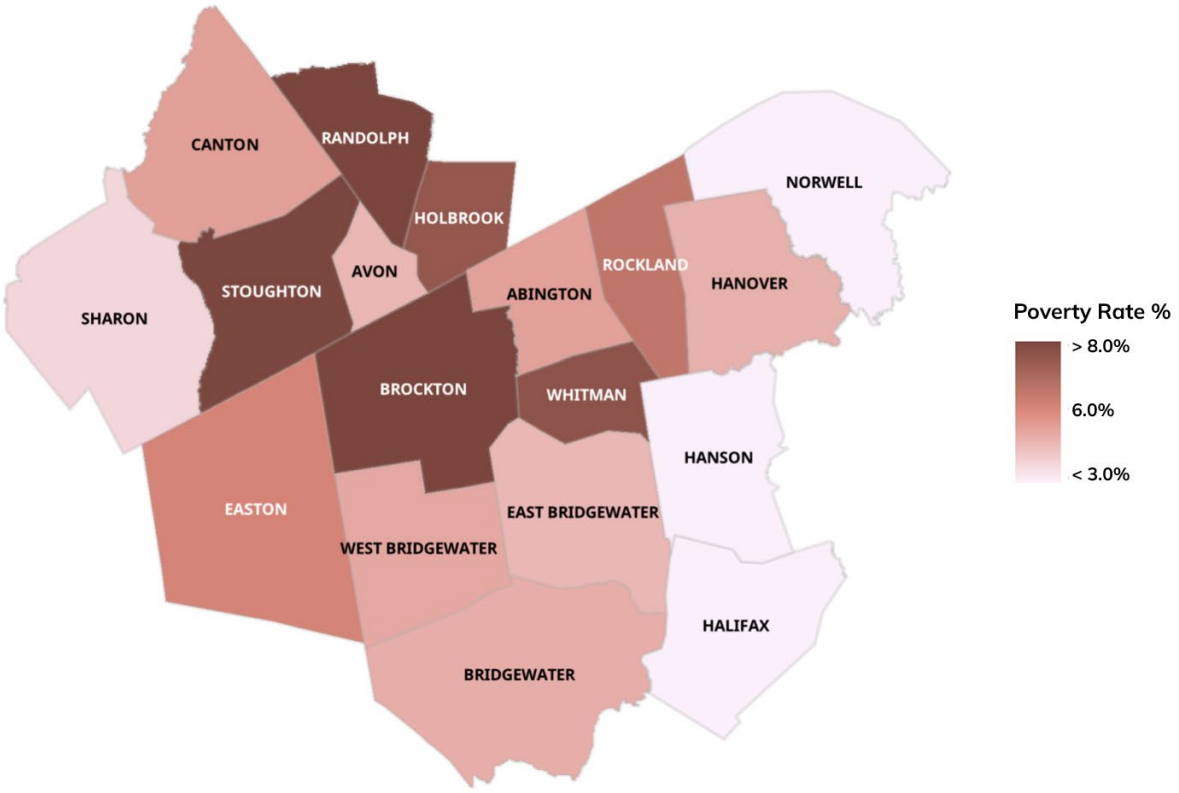
Income, Poverty, and Economic Conditions

Income and employment influence health in many ways. Families with limited financial resources may delay medical care, skip medications, rely on emergency departments, or prioritize housing and food over preventive care. Even among employed households, rising housing costs, transportation expenses, childcare costs, and medical bills can create financial strain. Focus group participants repeatedly described families working hard but still struggling to meet basic needs.

The service area poverty rate is 7.9 percent compared with 10.0 percent statewide. While this suggests the service area performs better than the state overall, important variation exists across municipalities. For example, Brockton has a poverty rate of 13.5 percent and makes up over one-quarter of the population (ACS, 2020 – 2024). Focus group participants also described many households that do not meet the federal definition of poverty but nonetheless struggle to afford rent, utilities, food, transportation, insurance premiums, and prescription medications.

Poverty Rate by Municipality

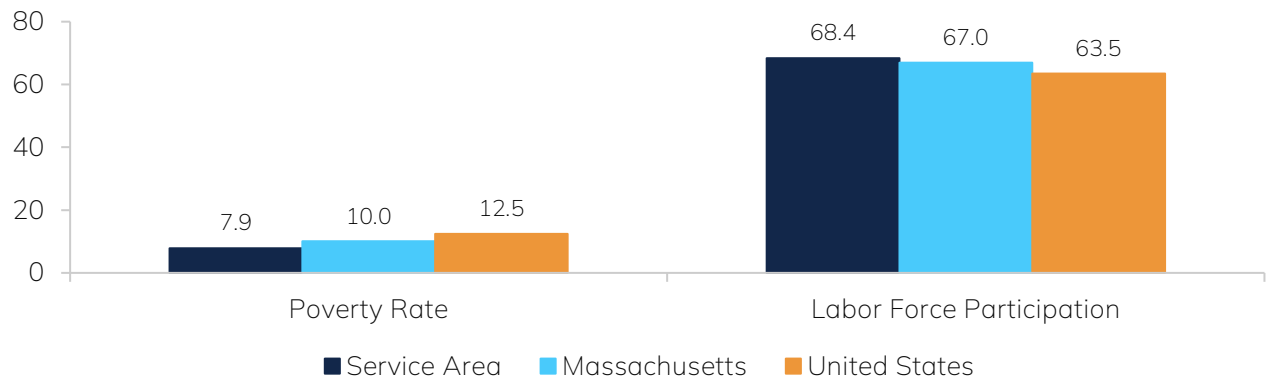
ACS, 2020 – 2024



Economic conditions influence nearly every priority area identified in this assessment. Participants described families working multiple jobs, parents unable to supervise children because of demanding work schedules, older adults on fixed incomes facing rising housing costs, and immigrant families affected by unstable employment or work authorization. These circumstances increase stress, delay care, worsen chronic disease, and make it more difficult to maintain stable housing or afford healthy food.

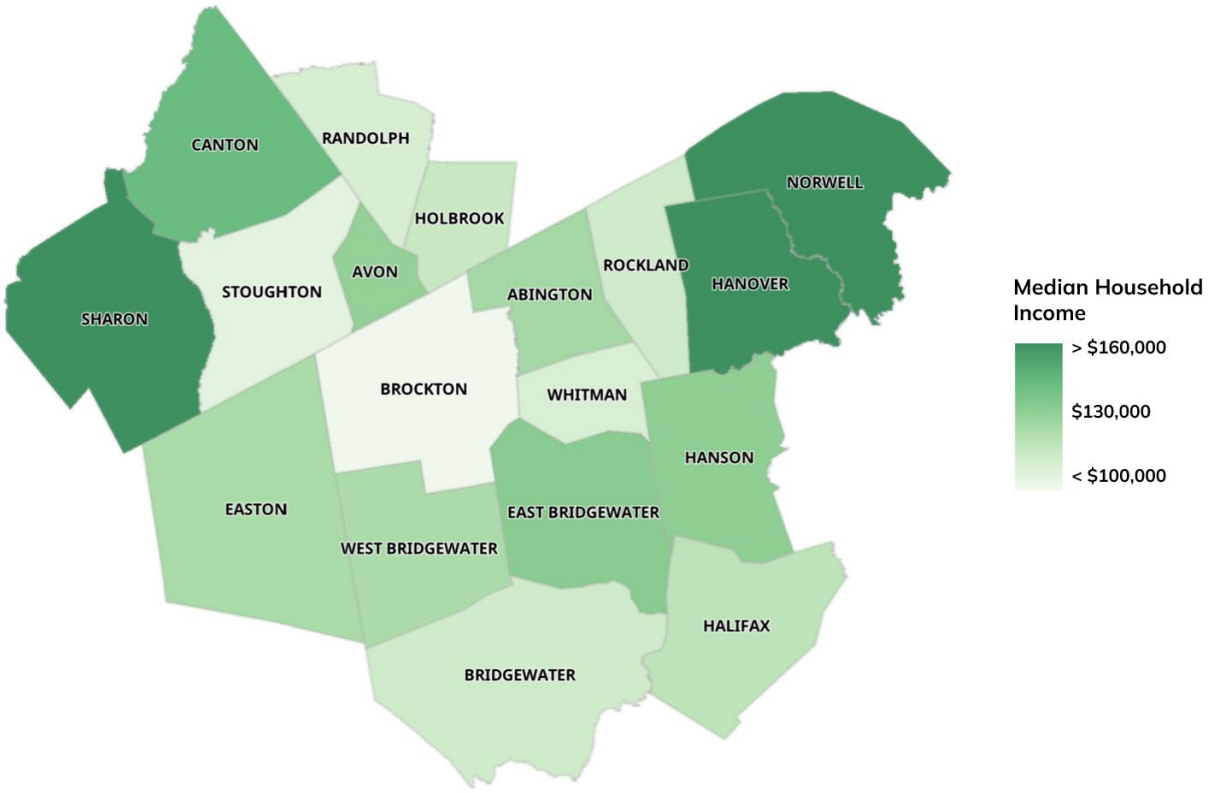
Poverty Rate and Labor Force Participation

ACS, 2020 – 2024



Community partners also described challenges recruiting and retaining bilingual and culturally responsive staff, noting that local organizations often cannot compete with Boston wages offered in Boston and other nearby labor markets. These workforce constraints affect access to care, language services, trust, and the capacity of community organizations to expand programs and meet growing community needs.

Median Household Income by Municipality
ACS, 2020 – 2024



Health Status Overview

The health status findings show that chronic disease, behavioral health, access to care, and social drivers of health are closely connected across the service area. Conditions such as depression, diabetes, hypertension, obesity, asthma, and heart disease often occur alongside challenges such as food insecurity, housing instability, transportation barriers, and limited access to healthcare. Community partners described these issues as interconnected, noting that many residents experience several of these challenges at the same time.

This community profile provides a broad overview of health across the service area. While some indicators appear favorable overall, important differences exist across municipalities and population

groups. Throughout this assessment, service area findings are complemented by town-level and population-specific data to better identify where needs are greatest.

The priority sections examine each selected health need in greater detail, integrating quantitative findings with community perspectives to describe the factors influencing health and opportunities for action.

Focus Group Findings and Community Voice

Overview of Focus Group Input

Focus group conversations were central to the CHNA process. Participants represented organizations that work directly with communities affected by health disparities, including culturally specific organizations, youth-serving organizations, food access partners, housing and homelessness organizations, adult education, health centers, economic development, and city government. (A complete list is provided in Appendix B.) The focus group input helped explain how community conditions show up in daily life and how residents experience systems of care and support.

Several themes were raised across focus groups: housing instability, mental health and trauma, language access, trust and cultural responsiveness, food insecurity, access to care, youth needs, older adult needs, community safety, and fragmentation across services. Participants consistently described these issues as interconnected. For example, a family may need food assistance because rent has increased, avoid healthcare because of cost or fear, experience stress because a parent is working multiple jobs, and struggle to find help because information is not available in the right language or through a trusted channel.

Major Themes Across Focus Groups

Housing instability emerged as a foundation for many other issues. Participants identified mental health as an urgent concern that is often overshadowed by stigma and the demands of daily life. Language access and culturally responsive communication were viewed as essential for building trust, while food insecurity remained widespread despite food pantry networks. Participants also emphasized the need for warm referral handoffs and stronger coordination among organizations.

A consistent strength across the discussions was the network of community-based organizations. Participants highlighted many organizations that are deeply committed, culturally rooted, and trusted by residents. At the same time, they noted that these organizations often operate with limited resources and fragmented systems.

Focus Group Theme	Summary of Findings
Housing Instability and Affordability	Housing was one of the most consistent themes across the discussions. Participants described rising rents, overcrowding, unsafe or informal housing arrangements, lack of formal leases, and growing housing instability among older adults. Housing was viewed not only as a social need, but also as a direct influence on mental health, chronic disease, economic stability, and access to care.
Mental Health, Trauma, and Stigma	Participants described mental health needs as urgent and closely connected to trauma, poverty, family stress, immigration-related concerns, and substance use. Stigma was identified as an important barrier in some immigrant communities and among men of color, where people may be less likely to discuss or seek care for depression, anxiety, substance use, or emotional distress.
Language Access and Communication	Language barriers were repeatedly identified as obstacles to care, trust, and service navigation. Participants emphasized the importance of interpreter services while also noting that bilingual and bicultural staff can provide greater understanding of both language and cultural context. Written materials alone may be insufficient for residents with limited digital access or English proficiency.

Focus Group Theme	Summary of Findings
Trust and Culturally Responsive Care	Participants distinguished demographic representation from meaningful cultural responsiveness. They emphasized the importance of being listened to, treated with dignity, given sufficient time, and supported by staff who understand the communities they serve. Confidentiality, privacy, consistency, and clear communication were also described as essential to building trust.
Food Insecurity and Access to Healthy Food	Food access was discussed as both an immediate basic need and an indicator of broader financial instability. Participants described strong food pantry networks and collaborative distribution efforts but noted that demand remains high and that emergency food assistance often provides only temporary relief from longer-term economic challenges.
Youth Needs, Safety, and Opportunity	Youth mental health, exposure to violence, school disengagement, vaping, and limited access to safe activities were raised across several conversations. Participants identified a need for mentorship, welcoming gathering spaces, summer programming, community gardens, tutoring, recreation, and other opportunities that help young people feel supported and connected.
Coordination and Partnership	Participants described collaboration as both an existing community strength and an area for continued improvement. While many organizations are providing important services, participants identified a need for more regular coordination, warm handoffs, shared resource navigation, and stronger connections between hospital teams and community organizations. Participants also noted that they felt collaboration was stronger before the COVID-19 pandemic. Many organizations have not fully returned to that level of coordination as they continue to manage the pandemic's lasting effects and respond to new and emerging community needs.

Community Strengths and Assets

While the focus groups identified serious needs, they also highlighted important community strengths. Participants were clear that the service area has committed organizations, culturally rooted leaders, strong informal networks, faith communities, schools, food access partners, and residents who support one another. These assets will be considered in future implementation strategies.

- A dense network of community-based organizations that understand local needs and have long-standing relationships with residents.
- Culturally specific organizations and leaders serving Haitian, Cape Verdean, Latino/a, and other immigrant communities.
- Food access partnerships, including the Brockton Area Hunger Network Cooperative and school-based pantry models.
- Schools, ESOL (English for Speakers of Other Languages) classes, churches, and community centers that function as trusted gathering places.
- Health centers and community health workers who provide trusted navigation, language support, and continuity.
- A new municipal Health and Human Services leader in Brockton whom participants viewed as a potential coordination hub.
- A strong desire among partners to work with BMC South and build a more coordinated system of support.

Community-Identified Opportunities

Focus group participants offered practical ideas that can help inform community improvement opportunities across organizations and sectors. They emphasized prevention, trust, language access, community-based outreach, and better coordination. Participants also stressed that it is important to listen first, partner with organizations already trusted by residents, and avoid duplicating services that already exist.

- Expand trusted, low-barrier access points for care and resource navigation.
- Invest in bilingual and bicultural staff, interpreters, community health workers, and liaisons.
- Use schools, churches, ESOL classes, food distribution sites, and cultural organizations as outreach channels.
- Host resource fairs with translators, insurance enrollment support, clinicians, food, and community organizations in one place.
- Support youth programming, mentoring, summer activities, tutoring, and safe gathering spaces.
- Screen for food, housing, transportation, and other social needs in clinical settings and make warm referrals to community partners.
- Support centralized resource navigation so residents and organizations know where to go for help.

COMMUNITY VOICE

"It does not matter who gets the credit, as long as we get the job done, then we can get more done."
— Focus group participant

COMMUNITY VOICE

"What kids were saying—age range from 5 up to 25 years—was positive role models and mentorship were the top priorities. Safe spaces, community connection."
— Focus group participant

Cross-Cutting Drivers of Health

Several issues influence multiple selected priorities. They do not fit neatly into a single category, but they shape whether residents can benefit from healthcare, community services, and other forms of support. These include language access, health information access, trust, safety, transportation, workforce capacity, service coordination, and the availability of community-rooted staff.

These factors often determine whether a service that exists is actually accessible. A clinic, food pantry, referral, or community program may be available, but residents may still face barriers if they cannot communicate in their preferred language, do not know where to begin, do not feel welcomed, cannot access transportation, or feel they do not have a trusted person or clear path to help them get there.

Language and Health Information Access

Language and health information access came up as one of the strongest themes in the focus groups because it affects both access to care and trust in the healthcare system. Participants described a multilingual service area where many residents speak Haitian Creole, Cape Verdean Creole, Spanish, Portuguese, or other languages at home. The data reinforces the importance of this issue: more than one-quarter of service area residents age 5 and older speak a language other than English at home, and the proportion is substantially higher in Brockton (ACS, 2020 – 2024).

Participants emphasized that language access extends beyond interpreter services. While professional interpretation is essential, residents may also need translated materials, bilingual and bicultural staff, culturally responsive outreach, and clear communication that helps them understand insurance, eligibility requirements, medications, referrals, appointment instructions, discharge information, and available community resources. They noted that written materials alone may not reach residents with lower levels of literacy, limited internet access, or limited trust in institutions.

Health information access is closely connected to these challenges. Participants described the need for education that helps residents understand preventive care, chronic disease management, mental health, available benefits, and how to advocate for themselves during healthcare encounters. They also emphasized that outreach should be delivered in ways that are accessible and culturally relevant, including through trusted community organizations, faith communities, schools, and community events rather than relying solely on websites or printed materials.

COMMUNITY VOICE

"When you are not really certain of particular words, it can easily be interpreted as what is someone trying to take from you instead of what is someone trying to give you."
— Focus group participant

COMMUNITY VOICE

"Many of our people don't have access to the internet, so available is not the same as accessible."
— Focus group participant

Trust, Safety, and Care Experience

Trust was one of the strongest themes to surface from the focus group discussions. Participants described it as something that develops through consistent relationships, respectful communication, privacy, follow-through, and a genuine understanding of the community. They emphasized that trust influences whether residents seek care, ask questions, return for follow-up, and feel comfortable discussing their health concerns.

Participants also explained that trust is closely tied to the care experience. Residents who feel rushed, dismissed, misunderstood, or uncertain that their concerns are taken seriously may be less likely to seek care in the future. Language access, cultural responsiveness, clear communication, and respectful interactions were all identified as important factors that help people feel welcomed, understood, and supported.

These issues become especially important when people are navigating sensitive concerns such as behavioral health, substance use, housing instability, food insecurity, pregnancy, or immigration-related challenges. Participants noted that worries about judgment, confidentiality, cost, or other potential consequences may discourage some residents from seeking care or sharing important information. Together, these findings highlight the importance of creating healthcare environments where residents feel safe, respected, and confident that their needs will be heard.

COMMUNITY VOICE

"Clear communication is key. A kind demeanor makes people feel warm and respected."

"When people come in the door, they want more than what they came in for, but you have to know how to draw it out of them, and that is where compassion comes in."

"How you treat people makes the difference in whether they come back and whether they are willing to disclose what is going on."

"It is very important to understand each person's background and culture so you know how to reach them."

— Focus group participants

Transportation and the Built Environment

Reliable transportation and safe community infrastructure play an important role in residents' ability to access healthcare, employment, education, food, and other essential services. During the focus group discussions, participants described both strengths and challenges within the service area. While some communities benefit from public transit and commuter rail, others face barriers related to transit routes, service schedules, walkability, and safe travel.

The discussions also highlighted how the built environment influences health and quality of life. Participants pointed to limited walkability, a lack of bike lanes, dangerous intersections, and few safe places for outdoor recreation and physical activity. These conditions can affect opportunities for exercise, social connection, youth recreation, and older adults' ability to remain active and independent.

Rather than representing a separate health priority, transportation and the built environment were consistently described as factors that shape many aspects of community health. They influence access to healthcare, healthy food, employment, housing, and other resources that support health and wellbeing across the BMC South service area.

Workforce Capacity and Community-Rooted Staff

Focus group participants consistently identified workforce capacity as an important challenge across the service area. Many community organizations reported difficulty recruiting and retaining staff because they cannot offer salaries that compete with larger employers in the Boston area. These challenges are especially significant for bilingual and bicultural staff, whose language skills and cultural knowledge help strengthen communication, build trust, and connect residents with services.

COMMUNITY VOICE

"The passion is here. The people who really care about the city are here. What is missing is the funding."

— Focus group participant

COMMUNITY VOICE

"It is not just about having staff who look like people. It is about staff who understand the community they are in."

— Focus group participant

Service Fragmentation and the Need for Warm Handoffs

The service area has many organizations doing strong work, but participants described fragmentation and a need for better coordination. Some residents may receive a list of resources but do not know which organization can help, what documents are needed, whether they are eligible, or how to follow through. A referral without navigation may not result in community members receiving the help they need.

Participants, including healthcare provider organizations, emphasized warm handoffs. This means a trusted person helps the resident connect to another trusted person or organization, rather than simply providing a phone number or website. Warm handoffs are especially important for residents with language barriers, limited digital access, mental health needs, unstable housing, or mistrust of public or social-service institutions. Participants also expressed opportunities for better collaboration and information sharing between healthcare staff and community organizations.

COMMUNITY VOICE

"Brockton has great resources and great people doing great work. We just need to come together better."

"The cross-organization meetings slowed down because we had to shift our focus to stopping the bleeding."

"I don't want to just hand out fish every day. I want to teach people to fish and help them teach others to fish too."
— Focus group participants

Prioritization of Needs

Identifying Significant Health Needs

Significant health needs were identified based on the following criteria: they affected a large number of people, they were associated with serious morbidity or mortality, they disproportionately affected groups facing health disparities, and the potential opportunity for BMC South to make an impact.

The selected priorities are not isolated categories. Behavioral health is connected to housing, food, trust, and access to care. Chronic disease and cancer are connected to primary care, food access, income, and the built environment. Maternal health is connected to access, trust, behavioral health, and social needs. The prioritization process therefore considered both topic-specific indicators and the broader systems that shape health.

Priority Scoring Criteria

Criteria	Definition
Magnitude	How many people are affected and how widespread the issue is across the service area
Severity	The level of morbidity, mortality, disability, trauma, or impact on quality of life
Health Equity	The extent to which the need disproportionately affects groups facing structural barriers and/or health disparities
Feasibility of Impact	BMC South's realistic opportunity—based on capacity, resources, and community partnerships—to implement effective responses and make meaningful progress

Each of the four criteria was scored on a scale of 0 to 6, and the four scores were added together for a maximum possible total of 24 points for each topic. The topics that scored 20 or above on the 24-point scale were elevated as priorities for this report. Those that scored below 20 are included as additional health needs assessed and remain important to community health.

Identified Priority Areas

The six areas below emerged as the health needs most strongly supported by the quantitative data and community input and were selected as the priorities for the current assessment cycle. Each was assessed using the same four criteria applied across all topics considered, and the scores shown reflect that review. Where areas received the same total, they were ordered by the consistency and strength of the supporting focus group and community survey findings.

Total (out of 24)	Priority Area	Magnitude	Severity	Equity	Feasibility
24	Behavioral Health, Mental Health, and Substance Use	6	6	6	6
		17.8% of adults report frequent mental distress (16.2% MA). Only 42% can always access mental healthcare vs. 70% for medical care; nearly 1 in 4 never can.			
22	Access to Care	6	5	6	5
		Scheduling and appointment availability were the top barriers. Uninsured rate 2.8% vs. 2.6% MA—nearly double in Brockton. Just one FQHC serves the whole area.			
22	Chronic Disease and Cancer	6	6	5	5
		Diabetes (12.9%), hypertension (39.4%), and obesity (34.2%) all exceed state rates, with Brockton carrying the heaviest burden.			
22	Access to Healthy Food / Food Insecurity	6	5	6	5
		29,620 households (21.2%) face food insecurity—an annual gap of 10.46 million meals. SNAP participation 13.5% vs. 12.3% statewide.			
21	Housing and Economic Mobility	6	5	6	4
		Brockton poverty 13.5% vs. 7.9% area-wide; housing insecurity 13.6% vs. 11.1%; 40.4% of Brockton households cost-burdened amid a tight 3.1% vacancy rate.			
21	Maternal and Reproductive Health	4	6	6	5
		Higher low birth weight (9.1% vs. 8.5%), preterm birth (9.3% vs. 8.8%), and cesarean delivery (34.6% vs. 31.1%) than Massachusetts overall.			

Consideration of Additional Health Needs Assessed

In addition to the six priority health needs, this CHNA discusses several additional topics considered through the prioritization process. Although these topics did not rank among the six selected priorities for the current assessment cycle, they remain important to community health and connect to one or more of them. Including these topics provides additional context and illustrates how health needs are interconnected across BMC South's communities.

Behavioral Health, Mental Health, and Substance Use

Behavioral health, mental health, and substance use received the highest score in the prioritization process. The issue was supported by quantitative findings, community survey results, and focus group discussions, all of which identified significant behavioral health needs and barriers to care across the BMC South service area. This priority includes mental health conditions, chronic stress, trauma, substance use, stigma, and access to prevention, treatment, and recovery services.

Data Findings

An estimated 23.6 percent of adults in the service area report experiencing depression, a rate comparable to the Massachusetts average of 23.8 percent. In addition, 17.8 percent of adults in the service area report experiencing 14 or more poor mental health days during the past month, compared with 16.2 percent statewide. Additional indicators further highlight the behavioral health needs across the service area. An estimated 35.1 percent of adults report experiencing social isolation or loneliness, slightly exceeding the Massachusetts average of 34.2 percent. Social isolation is a recognized risk factor for poor mental and physical health and may contribute to increased rates of depression, anxiety, and other adverse health outcomes (CDC PLACES/BRFSS, 2023).

The depression measure should be interpreted with some caution. CDC PLACES estimates the percentage of adults who report that a healthcare professional has ever told them they had a depressive disorder; it does not directly measure current symptoms or include residents who may be experiencing depression but have not sought care or received a diagnosis. Focus group reports of stigma and reluctance to discuss mental health provide important context and suggest that diagnosed depression may not capture the full extent of behavioral health need across the service area. However, the available data does not establish how much stigma or underdiagnosis affects the reported rate.

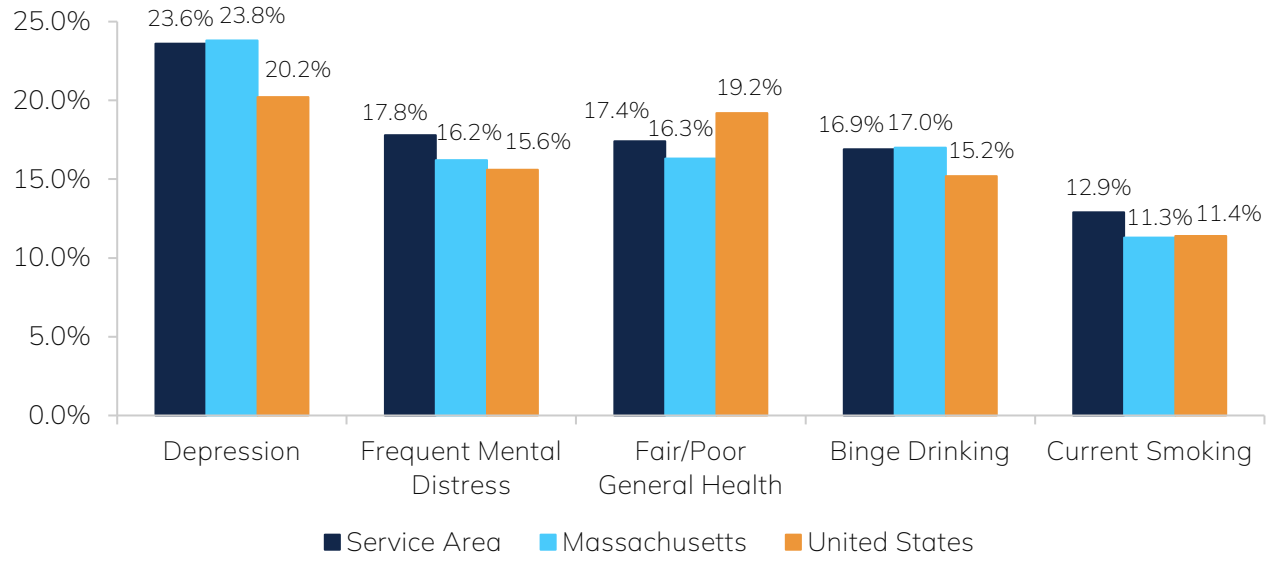
Frequent mental distress provides a complementary measure because it reflects recent experience rather than a prior clinical diagnosis. It measures the estimated percentage of adults who experienced poor mental health—including stress, depression, or emotional problems—on at least 14 of the previous 30 days. The elevated service area rate therefore supports the community reports of substantial behavioral health need, even though diagnosed depression is similar to the statewide rate.

A broader measure of health status provides additional context. Approximately 17.4 percent of service area adults report fair or poor overall health, compared with 16.3 percent statewide. Although this measure is not specific to behavioral health, it reflects the close relationship between physical health, emotional wellbeing, chronic stress, and access to care (CDC PLACES/BRFSS, 2023).

Behavioral health needs vary across the service area. Frequent mental distress ranges from 12.1 percent in Sharon to 21.5 percent in Brockton, while fair or poor overall health ranges from 10.6 percent in Sharon to 24.5 percent in Brockton. Diagnosed depression is more consistently distributed across municipalities, affecting approximately 20 to 26 percent of adults in most communities. These findings indicate that diagnosed depression is widespread, while recent frequent mental distress and poor overall health are more concentrated in higher-need communities (CDC PLACES/BRFSS, 2023).

Behavioral Health, Mental Health, and Substance Use

CDC PLACES/BRFSS, 2023. MA DPH 2023



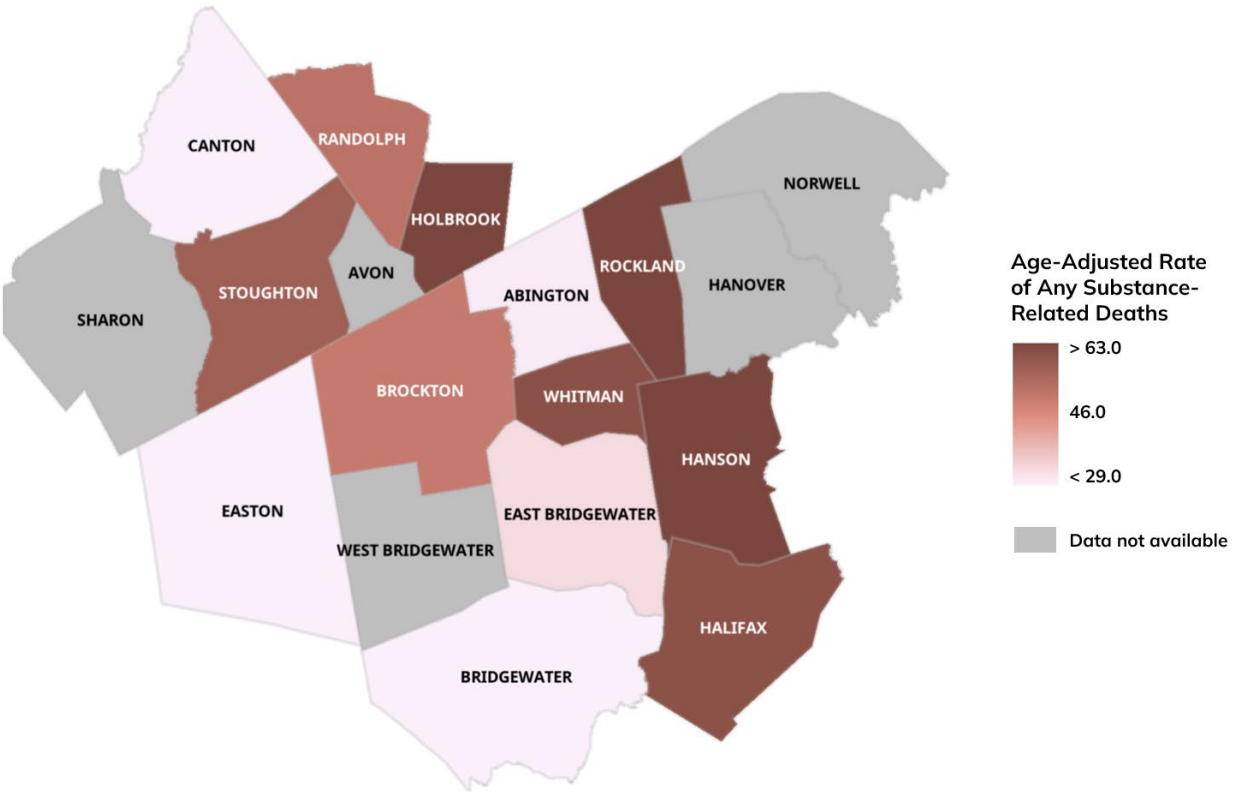
The community survey identified a substantial gap in access to mental healthcare. Mental health was the second most frequently selected community concern, identified by 45 percent of respondents and exceeded only by cost of living. However, only 42 percent of respondents reported that they could always obtain mental healthcare when needed, compared with 70 percent who could always obtain medical care. Nearly one-quarter of respondents—23 percent—said they could never obtain needed mental healthcare, compared with 2 percent for medical care (BMC South Community Survey, 2026).

Provider supply data is consistent with these access concerns. Mental health provider availability in the service area is approximately 13 percent lower than statewide (County Health Rankings, 2025).

Substance use also continues to have a serious impact. Between 2020 and 2024, there were 622 drug-related overdose deaths across the service area, representing a crude mortality rate of approximately 31.0 deaths per 100,000 residents. This rate was comparable to the Massachusetts rate of 32.9 per 100,000, but substantial variation existed across the service area. Rates within the county portions of the service area ranged from approximately 23.2 per 100,000 in the Norfolk County communities to 45.1 per 100,000 in the Bristol County portion (CDC WONDER, 2020 – 2024).

A separate source, the Massachusetts Department of Public Health Bureau of Substance Addiction Services Dashboard, provides 2024 municipal-level rates, showing several communities exceeding 60 per 100,000—Holbrook, Rockland, Hanson, and Whitman (MA DPH BSAS, 2024).

Age-Adjusted Rate of Any Substance-Related Deaths, January – December 2024
MA DPH BSAS, 2024



Prescribing patterns for controlled substances point to similar behavioral health need. A higher share of service area residents are prescribed opioid agonists, benzodiazepines, and stimulants than across Massachusetts, a pattern consistent with the region's elevated behavioral health and substance use burden (MA PMP, 2016 – 2024).

Co-occurring substance use and mental health conditions represent another significant behavioral health challenge in the Metro South region, a hospital region defined by the Massachusetts Health Policy Commission that is broader than the BMC South service area. An estimated 46.5 percent of hospitalized adult patients in Metro South had a behavioral health or substance use disorder (SUD) comorbidity in 2018 (CHIA, 2018). In state fiscal year (SFY) 2020, the region had the highest behavioral health-related readmission rate in Massachusetts, exceeding 23 percent (Massachusetts Hospital Inpatient Discharge Database, SFY 2020). These findings suggest a substantial need for integrated, dual-diagnosis treatment that addresses both mental health and substance use disorders simultaneously. While additional assessment is needed to better understand local gaps in care, the available data indicates that expanding access to coordinated behavioral health and SUD services remains an important community need.

Access to substance use treatment is also unevenly distributed across the service area. Listed SUD treatment providers are heavily concentrated in Brockton, which has far more providers relative to its

population (approximately 167 per 100,000 residents) than any other community in the service area. Several surrounding communities, including Bridgewater, Halifax, Holbrook, and Whitman, have few or no listed providers. For residents outside Brockton, particularly those without reliable transportation, this concentration of services in a single city may create additional barriers to prevention, treatment, and recovery support (CMS NPPES, 2026).

Adult smoking is another important behavioral risk indicator related to substance use. Approximately 13 percent of service area adults currently smoke, compared with about 11 percent across Massachusetts. Brockton has the highest municipal rate at almost 18 percent (CDC PLACES/BRFSS, 2023).

Provider listings reflect the location of clinicians or organizations included in the source data and do not necessarily represent current appointment availability, treatment capacity, or the number of available treatment slots.

What the Community Shared

Focus group participants described mental health needs as urgent but often hidden. They connected emotional distress with trauma, housing instability, family and financial pressures, substance use, immigration-related concerns, community violence, and the stress of meeting basic needs.

COMMUNITY VOICE

"Unfortunately, because it is also a taboo subject, most people do not want to talk about it."
— Focus group participant

Participants also described stigma as an important barrier to seeking support. This concern was raised particularly in relation to some immigrant communities and among men of color, where people may be less comfortable discussing depression, anxiety, substance use, or emotional distress.

Community members identified youth, older adults, immigrant communities, men of color, and people experiencing homelessness or housing instability as populations that may face significant behavioral health needs or barriers to care.

Substance use was also described as closely connected to trauma and instability. Participants raised concerns about opioid and polysubstance use, youth vaping, and limited access to culturally responsive prevention, treatment, and recovery services. Several participants emphasized that stable housing and consistent support can be important foundations for treatment and recovery.

COMMUNITY VOICE

"If you don't have a job, you are also dealing with mental health, because you become stressed. Everything is related."
— Focus group participant

Connections and Implications

Behavioral health is influenced by housing stability, food security, financial stress, chronic disease, access to healthcare, and community safety. These connections suggest that potential solutions should combine clinical services with prevention, stigma reduction, culturally responsive care, youth supports, recovery services, and stronger coordination with community organizations.

Related youth needs were mentioned throughout the discussions. Community members emphasized the importance of mentorship, safe spaces, recreation, tutoring, and opportunities to build a sense of belonging. Concerns about vaping and youth exposure to violence were discussed alongside broader concerns about isolation and limited opportunities for positive engagement.

COMMUNITY VOICE

"STRESS, ANXIETY, DAILY LIFE, AND NOT HAVING ANYWHERE TO LEAVE MY YOUNGEST CHILD REALLY HURT MY MENTAL HEALTH"

— Community survey response

Access to Care

Access to care ranked among the highest priority needs identified through the assessment. Quantitative findings show differences in insurance coverage, provider availability, safety-net capacity, and hospital utilization across the service area. The community survey also identified substantial barriers related to appointment availability, cost, and transportation.

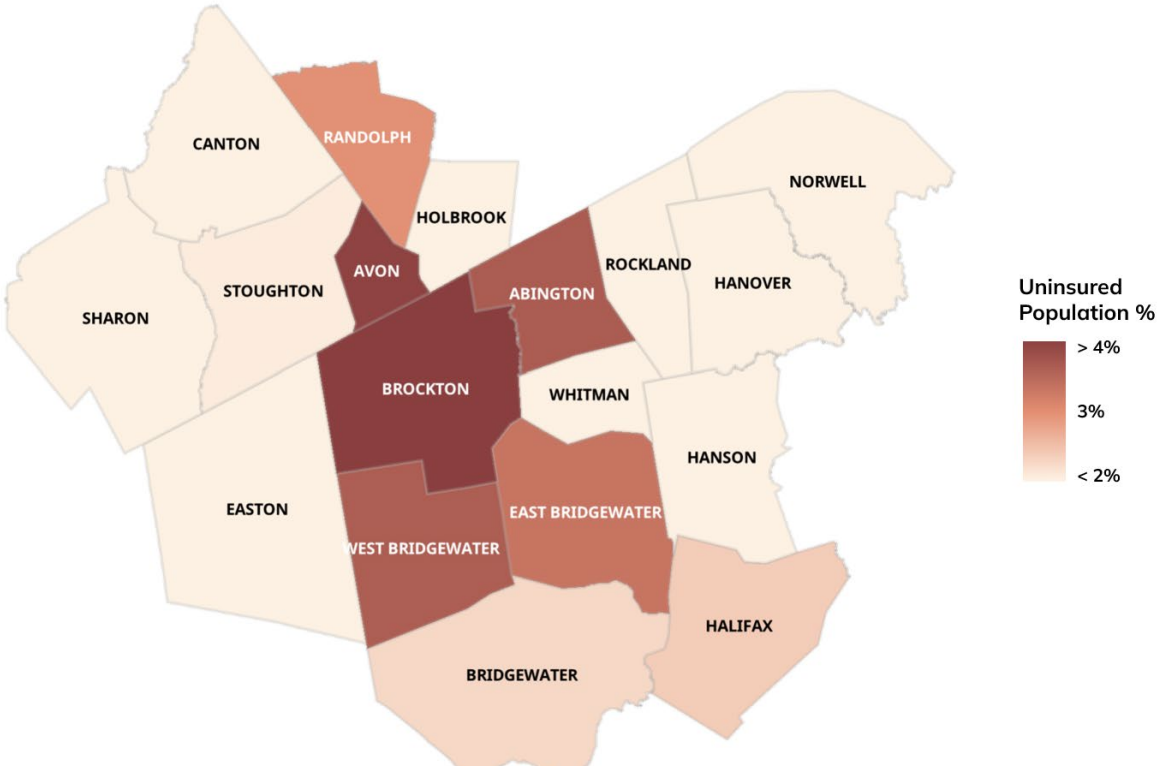
This priority includes access to primary care, specialty care, behavioral healthcare, dental care, insurance coverage, affordable services, language assistance, transportation, care navigation, and respectful, culturally responsive care.

Data Findings

Although the overall uninsured rate is relatively low, important disparities remain. Approximately 2.8 percent of service area residents are uninsured, compared with 2.6 percent statewide. Among Hispanic residents, however, the uninsured rate is 6.8 percent, compared with 5.0 percent across Massachusetts. These differences indicate that access to coverage is not experienced equally across populations (ACS, 2020 – 2024).

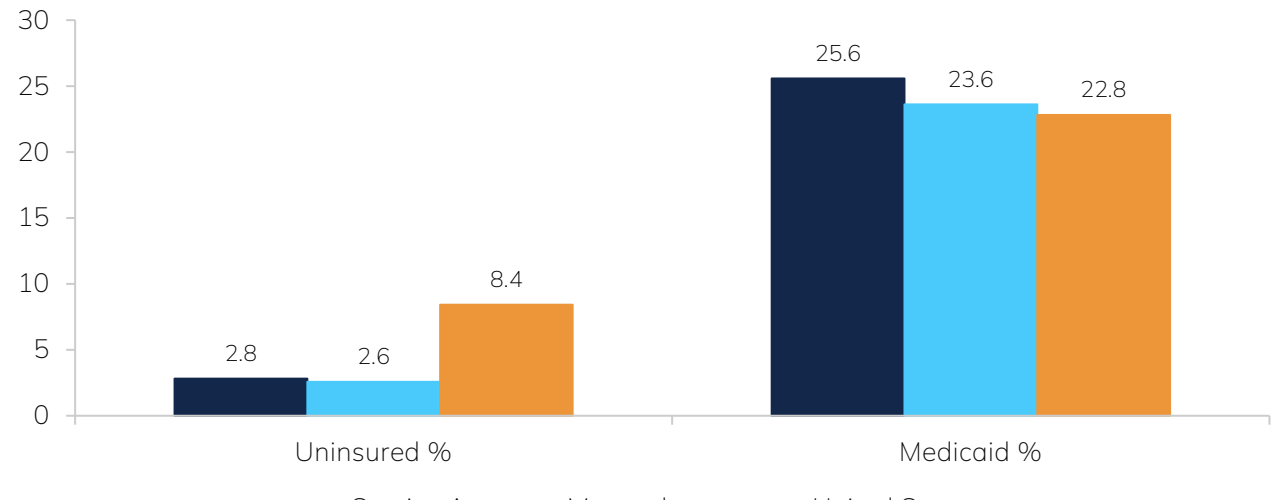
Insurance Status: Uninsured Rate

ACS, 2020 – 2024



Coverage patterns in Brockton further illustrate this variation. Approximately 4.6 percent of Brockton residents are uninsured, nearly twice the service area average. Around 47 percent of Brockton residents are covered by Medicaid, compared with approximately 26 percent across the service area and 24 percent statewide. Employer- or union-sponsored coverage accounts for approximately 48 percent of coverage in Brockton, compared with about 65 percent across the service area. These findings demonstrate Brockton's greater reliance on public coverage and its more limited access to employer-sponsored insurance (ACS, 2020 – 2024).

Insurance Coverage: Uninsured and Medicaid Rates
ACS, 2020 – 2024



Although Massachusetts has long maintained near-universal coverage, the policy environment is shifting: new Medicaid (MassHealth) work requirements and reduced Marketplace premium subsidies could make it harder for some residents to obtain or keep coverage in the coming years. These changes may weigh most heavily on communities that rely more on Medicaid, such as Brockton, with potential downstream effects on access to care.

Provider availability also presents challenges across the service area. The weighted service area primary care physician rate is roughly 20 percent lower than the state—approximately 80 physicians per 100,000 residents, compared with approximately 102 per 100,000 statewide. Plymouth County, which includes Brockton and much of the service area, has approximately 62 primary care physicians per 100,000 residents, and shortages are also evident in portions of Bristol County, at approximately 55 per 100,000 (HRSA AHRF, 2023). These local gaps exist within a broader statewide primary care access challenge: more than 30 percent of Massachusetts residents report difficulty accessing primary care (CHIA Health Insurance Survey, 2025).

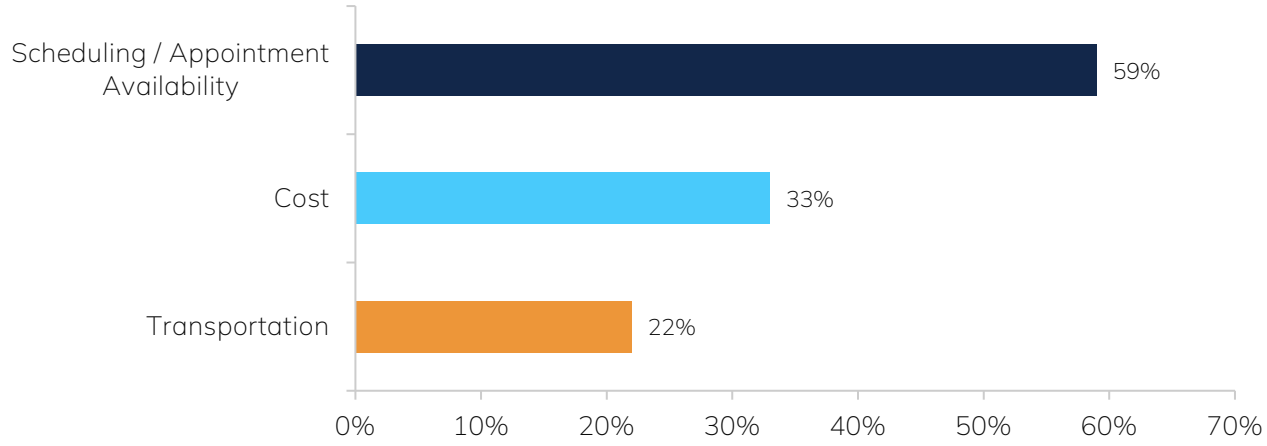
Safety-net capacity is concentrated in Brockton. One federally qualified health center serves the service area and is located in Brockton. Brockton also carries federal Health Professional Shortage Area designations for primary care, mental health, and dental services (HRSA HPSA Find, 2025).

Hospital utilization provides additional context. In 2024, the service area averaged approximately 54.6 emergency department visits per 100 residents. Brockton's rate was approximately 124 visits per 100 residents, substantially higher than rates in lower-utilization municipalities (CHIA ED, SFY 2020 – 2024).

These measures describe different aspects of healthcare access. Provider rates reflect local supply, insurance measures describe coverage, and emergency department and inpatient utilization indicate patterns of hospital use. They should be interpreted together but should not be treated as interchangeable measures or as proof that one factor directly caused another.

The community survey identified additional barriers to receiving care. Scheduling and appointment availability were selected by 59 percent of respondents, followed by cost at 33 percent and transportation at 22 percent (BMC South Community Survey, 2026).

Barriers to Care
BMC South Community Survey, 2026



What the Community Shared

Focus group participants emphasized that access to care involves more than having insurance or living near a hospital or clinic. They described long wait times, provider turnover, difficulty obtaining specialty and behavioral healthcare, uncertainty about where to seek services, and challenges navigating referrals and follow-up care. Survey comments also suggested that some residents may not be aware of the full range of specialty, pharmacy, and other healthcare services available locally, including at BMC South. Some respondents believed that certain services were available only in Boston, indicating that barriers to access may include limited awareness of where services are offered and how to obtain them, in addition to service availability itself.

Language access was one of the strongest themes across the discussions. Participants emphasized the importance of professional interpretation while also distinguishing interpreter services from care provided by bilingual and bicultural staff. They explained that direct communication and cultural understanding can help patients ask questions, understand recommendations, participate in decisions, and feel respected during care.

Participants identified low-income residents, people with limited English proficiency, immigrants and newcomers, older adults, residents without reliable transportation, and people with complex medical or social needs as populations that may experience greater barriers. Some community members described

delaying or avoiding care because they could not obtain an appointment, were concerned about cost, did not know where to go, or did not feel comfortable asking questions.

Community members also described the importance of receiving clear information about available services, referral requirements, insurance, medications, and next steps. Printed materials and websites were viewed as helpful but insufficient for some residents, particularly those facing language, literacy, digital-access, or trust-related barriers.

COMMUNITY VOICE

"It is not just about having staff who look like people. It is about staff who understand the community they are in."
— Focus group participant

COMMUNITY VOICE

"The community behavioral health centers are great resources, but they are wildly underutilized in the mental health space."
— Focus group participant

Connections and Implications

Access to care is influenced by provider supply, insurance coverage, affordability, transportation, language access, care navigation, and trust. Residents may experience several of these barriers at the same time, particularly when healthcare needs occur alongside housing instability, food insecurity, behavioral health concerns, or chronic disease.

Participants emphasized that access improves when residents receive clear information and active support navigating services. Warm handoffs, community health workers, bilingual and bicultural staff, interpreters, trusted community partners, and stronger coordination among primary care, specialty care, behavioral health, and community organizations may help residents move more successfully through the healthcare system.

Direct community feedback points to an opportunity to strengthen communication and navigation related to services that are already available locally. Increasing awareness of specialty, pharmacy, and other services offered at BMC South, along with providing clear information about referral processes and points of access, may help reduce unnecessary travel, delays in care, and the perception that certain services can only be obtained in Boston.

The findings also suggest that improving access requires attention to the care experience itself. Residents who feel rushed, dismissed, judged, or misunderstood may be less likely to return for follow-up care or share important concerns. Timely services, respectful communication, privacy, cultural responsiveness, and opportunities to ask questions are therefore important components of access in addition to insurance coverage and provider availability.

Chronic Disease and Cancer

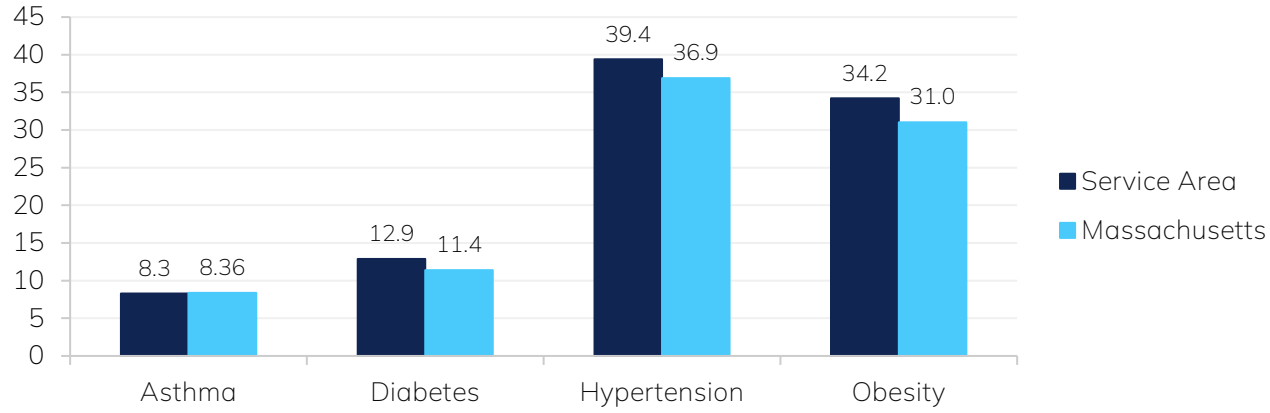
Chronic disease and cancer were identified as a priority because diabetes, hypertension, obesity, heart disease, asthma, and stroke contribute to preventable illness, disability, and healthcare utilization across the BMC South service area. Clinical data, modeled population estimates, community survey findings, and focus group discussions all point to a substantial and geographically widespread burden.

This priority includes chronic disease prevention, early detection, and ongoing management, along with the social and environmental factors that affect residents' ability to stay healthy. These factors include access to primary care, affordable healthy food, safe opportunities for physical activity, health education, and consistent follow-up care. Cancer is included within this priority because cancer incidence across the service area is measurably higher than the statewide rate, reinforcing the same needs for prevention, screening, and early detection.

Data Findings

Diabetes, hypertension, and obesity are more prevalent in the service area than across Massachusetts. Diabetes affects 12.9 percent of the service area population, compared with 11.4 percent statewide. Hypertension affects 39.4 percent, compared with 36.9 percent statewide, and obesity affects 34.2 percent, compared with 31.0 percent statewide (MA DPH, 2023).

Chronic Disease Prevalence (EHR-Based)
MA DPH, 2023 – % of Patients



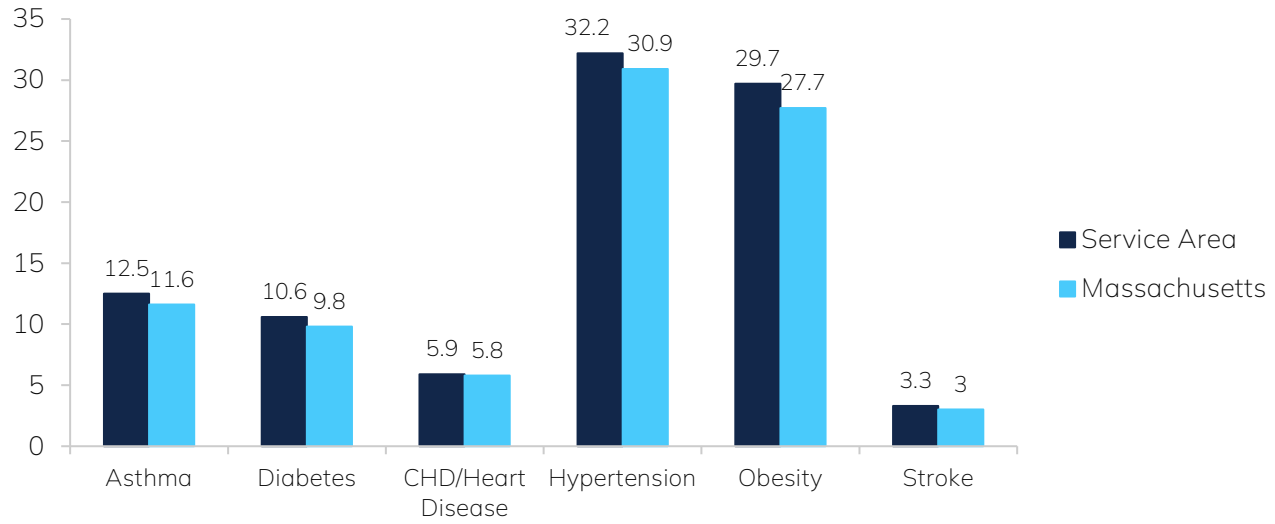
The burden is not limited to a single municipality. In the clinical data, Randolph and Holbrook report the highest diabetes prevalence in the service area, at 17.5 percent and 17.0 percent, respectively, compared with 14.2 percent in Brockton. Hypertension is highest in Stoughton at 43.3 percent, followed by Randolph at 42.2 percent, Brockton at 42.0 percent, and Holbrook at 41.7 percent. Elevated obesity is also present across several municipalities, including Halifax, Holbrook, Rockland, and Whitman. These findings indicate that chronic disease is a service area-wide concern, although the prevalence and types of conditions vary by community.

A separate source provides a similar overall picture. CDC PLACES and BRFSS-modeled estimates for adults place the service area above the Massachusetts average for:

- Diabetes: 10.6 percent compared with 9.8 percent statewide
- Hypertension: 32.2 percent compared with 30.9 percent statewide
- Obesity: 29.7 percent compared with 27.7 percent statewide
- Asthma: 12.5 percent compared with 11.6 percent statewide

Modeled estimates for heart disease and stroke are closer to statewide levels (CDC PLACES/BRFSS, 2023).

Chronic Disease Prevalence (Survey-Based)
CDC PLACES/BRFSS, 2023 – % of Patients



The clinical and modeled estimates should not be compared directly because they represent different populations and use different methods. The electronic health record data reflects documented conditions among patients and includes individuals of different ages, while the CDC PLACES estimates model prevalence among adults in the broader population. However, both sources show elevated diabetes, hypertension, and obesity, strengthening confidence that these conditions represent significant needs across the service area.

Asthma is one area where the sources differ. Modeled adult estimates place service area asthma above the Massachusetts rate—12.5 percent compared with 11.6 percent—while the clinical data places asthma near the statewide level, at 8.3 percent compared with 8.4 percent. This difference likely reflects variation in the populations, definitions, and methods used by the two sources and should be considered when interpreting the findings.

Cancer is a significant health burden in the service area. For several of the most common cancers, prevention, screening, and early detection offer meaningful opportunities to reduce its impact. To identify where the burden is greatest, cancer incidence was examined at the municipal level using the Massachusetts Cancer Registry (MCR). The registry expresses each community's incidence as a Standardized Incidence Ratio (SIR), which compares the number of cancers diagnosed locally with the number that would be expected if the community experienced the same rates as Massachusetts overall. A value of 100 equals the statewide rate; a value above 100 means more cancers than expected, and a

value below 100 means fewer. Pooled across all 18 service area municipalities, overall cancer incidence was about 7 percent higher than the statewide expectation in the most recent period (service area SIR of 107 for 2017 – 2021; 95 percent confidence interval 105 to 108), a statistically significant difference. The same elevation was present in 2012 – 2016 and has held steady rather than rising or falling, indicating a persistent rather than emerging concern (MCR, 2012 – 2016 and 2017 – 2021).

Cancers Significantly Above the Massachusetts Rate

Massachusetts Cancer Registry, MA Department of Public Health

Cancer	New Cases 2017 – 2021	Service Area SIR (MA = 100)	95% CI	Above the MA rate
All cancers combined	11,992	107	105 – 108	+7%
Stomach	197	124	107 – 142	+24%
Multiple myeloma	208	120	104 – 138	+20%
Lung & bronchus	1,707	114	108 – 119	+14%
Prostate (men)	1,627	109	104 – 115	+9%

City/Town SIR series, pooled across all 18 service area municipalities. *How to read: An SIR of 114 means 14 percent more cancers than expected if the service area matched the Massachusetts statewide rate (100). New cases = observed diagnoses, 2017 – 2021. All five rows are statistically significant—each 95 percent confidence interval excludes 100. No cancer type was significantly BELOW the statewide rate at the service area level. Full detail for all cancer types appears in the appendix.*

Four types of cancer are significantly elevated above the statewide rate across the service area: stomach (24 percent above), multiple myeloma (20 percent above), lung and bronchus (14 percent above), and prostate (9 percent above). Lung cancer is the most consistent signal, appearing significantly elevated in 11 of the 18 municipalities as well as service area-wide, pointing to tobacco use and lung cancer screening as concrete prevention and early-detection opportunities. Prostate cancer is also significantly elevated across the service area, reinforcing the importance of expanding prostate cancer awareness, screening, and timely follow-up as key strategies for early detection and improved outcomes.

As with the other chronic conditions, cancer incidence is not evenly distributed across the service area. Overall cancer incidence is significantly higher than the statewide rate in eight municipalities—Whitman, Hanson, Avon, Rockland, Abington, West Bridgewater, Holbrook, and Brockton—while Sharon is the only community with an incidence rate at or below the statewide average. Targeting screening, prevention, and outreach efforts to the highest-incidence communities is likely to have the greatest impact.

These findings should be interpreted with appropriate caution. The standardized incidence ratio (SIR) reflects diagnosed cases and may be influenced by differences in screening, access to care, and early detection, as well as underlying risk factors. In addition, estimates based on small numbers of cases are less stable, and some statistically significant findings may occur by chance when many cancer types and communities are examined. The most reliable patterns are those observed consistently across multiple municipalities and across the service area overall, particularly for lung cancer and overall cancer incidence.

County-level data provides additional regional context. Across the counties represented in the service area, the combined cancer incidence rate is approximately 460 new cases per 100,000 residents each year, compared with 432 per 100,000 statewide (U.S. Cancer Statistics, 2018 – 2022). While the data illustrates the broader regional picture, the Massachusetts Cancer Registry analysis presented above provides a more detailed assessment of the communities served by the health system.

County-level data also adds an important equity dimension to the prostate cancer findings. While the registry analysis reflects all races combined, prostate cancer incidence differs markedly by race across the three service area counties. In each of them, Black (non-Hispanic) men are diagnosed with prostate cancer at substantially higher rates than white (non-Hispanic) men: in Norfolk County, 215.4 versus 114.2 per 100,000; in Bristol County, 198.0 versus 113.7; and in Plymouth County, 153.0 versus 114.7. This gap is statistically significant in all three counties and mirrors the statewide pattern (187.0 versus 110.8 per 100,000). Because the service area includes some of the region's most racially diverse communities, particularly Brockton and Randolph, this disparity likely contributes to the elevated overall prostate incidence identified earlier and further points to prostate screening and early detection as a concrete, equity-focused prevention opportunity (State Cancer Profiles, NPCR/SEER, 2018 – 2022).

Access to primary care influences both cancer and chronic disease outcomes. The service area has approximately 80 primary care physicians per 100,000 residents, compared with approximately 102 statewide (HRSA AHRF, 2023). A lower supply of primary care providers may limit access to routine screenings, preventive care, early diagnosis, medication management, and ongoing support for chronic conditions.

Together, these findings underscore the importance of strengthening prevention, expanding access to primary care and recommended screenings, and focusing resources where the need is greatest to improve health outcomes across the service area.

What the Community Shared

Focus group participants discussed chronic disease primarily in relation to prevention, health information access, and the ability to navigate healthcare. They emphasized that residents need clear and understandable information about diagnoses, medications, appointments, referrals, and follow-up care. Participants also described the importance of helping patients feel comfortable asking questions and taking an active role in decisions about their health.

Community members connected chronic disease with access to affordable healthy food. They noted that some families have difficulty purchasing foods that support the management of diabetes, hypertension, and other diet-related conditions. Food pantry offerings may also not consistently meet the nutritional or cultural needs of residents managing chronic disease.

Participants identified lower-income residents, people experiencing food or housing insecurity, residents with limited English proficiency, older adults, and people who have difficulty establishing consistent primary care as populations that may face greater challenges preventing or managing chronic conditions.

COMMUNITY VOICE

"The health needs are pretty much awareness. The more you are aware, the more prepared you can be and the more likely you can be an advocate for yourself."

"If we are going to deal with health, the first step should be preventive health, keeping people from getting sick before they go to the hospital."

"We need wellness workshops and educational programs, just to educate us. If we are an educated community we will make better decisions whenever we have an emergency."

"When people don't have to go to Boston or Providence to get cancer care, it's really a lifesaver for many people."

"There is a real opportunity to engage the community and bring people in for various screenings and education."

— Focus group participants

Connections and Implications

Chronic disease and cancer are closely connected to access to care, food security, housing stability, behavioral health, transportation, and the built environment. Barriers in any of these areas can make it more difficult to obtain preventive services, maintain medications, attend appointments, follow recommended diets, or participate in physical activity.

The findings suggest that efforts to improve chronic disease management would benefit from combining clinical care with accessible health education, nutrition support, opportunities for physical activity, medication and referral navigation, and stronger connections between healthcare providers and community organizations. Particular attention may be needed in municipalities and populations experiencing elevated disease prevalence alongside barriers to primary care and other resources.

Clear communication and continuing support are also essential. Improving outcomes depends not only on whether services exist, but also on whether residents understand their conditions, feel comfortable asking questions, and can access the resources needed to manage their health over time.

Access to Healthy Food / Food Insecurity

Access to healthy food and food insecurity were identified as a priority because quantitative findings and community input consistently demonstrated substantial need across the BMC South service area. Food insecurity affects communities throughout the region and is closely connected to housing costs, limited income, transportation, chronic disease, maternal health, and access to public benefits.

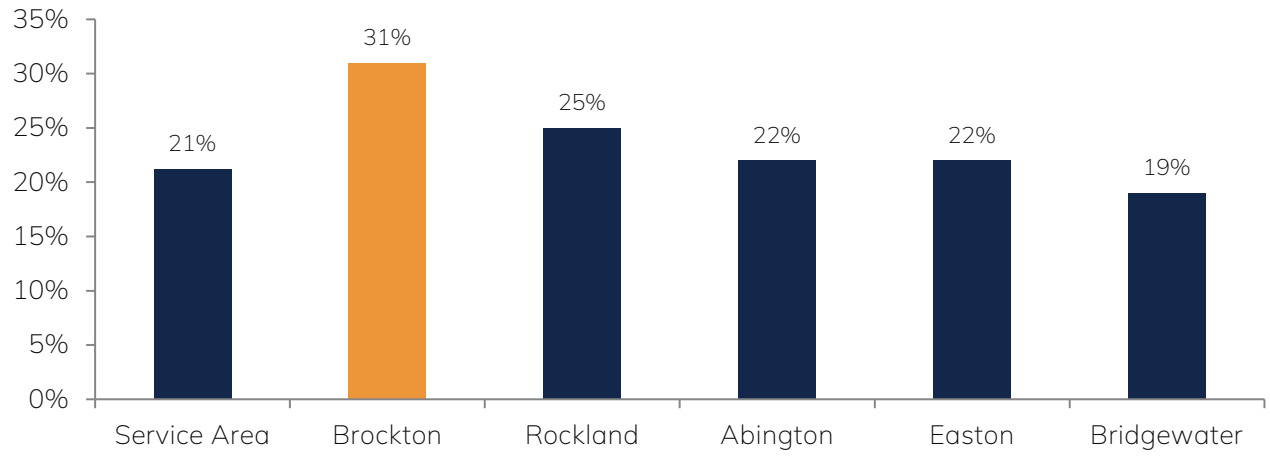
This priority includes access to affordable, nutritious, and culturally appropriate food, as well as the food assistance, benefits navigation, transportation, and community partnerships that support household food security.

Data Findings

An estimated 29,620 households experience food insecurity, representing 21.2 percent of all households across the 18 municipalities. This rate is higher than the median of approximately 18 percent among Eastern Massachusetts communities included in the Greater Boston Food Bank study (Greater Boston Food Bank, 2025). Across the service area, 13.5 percent of residents participate in SNAP, compared with 12.3 percent statewide (DTA SNAP caseload, April 2026, via Project Bread; ACS 2020 – 2024). The area also faces an estimated annual meal gap of approximately 10.46 million meals, including approximately 3.26 million meals that remain unmet after existing food distribution efforts (Greater Boston Food Bank, 2025).

These figures are modeled small-area estimates. The Greater Boston Food Bank notes that its food insecurity rates may be higher than estimates produced using federal methods; however, they provide the most detailed municipal-level food data available and align with the high demand described by community organizations.

Food Insecurity Rate
GBFB, Annual Assessment, 2024



Within the service area, Brockton carries the greatest and most visible burden. Approximately 31 percent of Brockton households experience food insecurity, compared with the service area average of 21.2 percent. The city has an estimated 10,900 food-insecure households—more than one-third of all

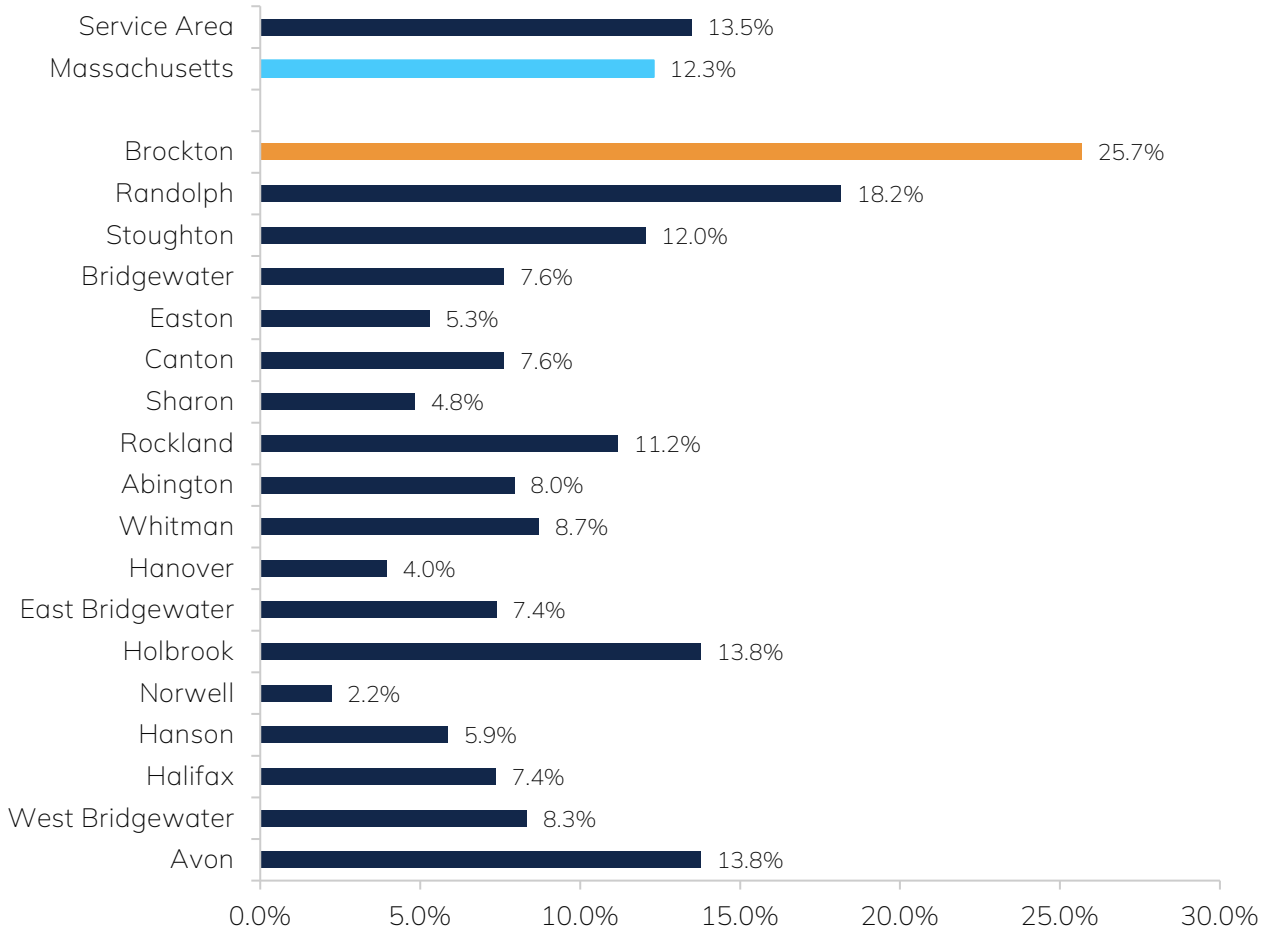
food-insecure households across the service area. Brockton also has the highest SNAP participation rate at approximately 26 percent, reflecting both a high level of need and substantial use of available nutrition assistance.

Food insecurity is not confined to Brockton. Several suburban communities have rates at or above the service area average, including Rockland and Whitman at approximately 25 percent and Abington, East Bridgewater, Easton, and Randolph at approximately 22 percent.

SNAP participation varies considerably among these communities. Easton, for example, has an estimated food insecurity rate of 22 percent and a SNAP participation rate of 5 percent, while Abington has a food insecurity rate of 22 percent and a SNAP participation rate of 8 percent. Food insecurity and SNAP participation are distinct measures with different populations and denominators and should not be interpreted as directly equivalent rates. However, these differences provide useful context and may reflect eligibility requirements, enrollment barriers, limited awareness, stigma, household income, or reliance on other forms of food assistance. They also suggest that food insecurity in some suburban communities may be less visible and that benefits navigation may be an important complement to direct food resources.

SNAP Participation Rate

MA DTA, SNAP caseload data via Project Bread, April 2026



The modeled unmet meal gap—the portion of estimated food need not addressed through current food distribution—provides additional context about the reach of existing resources. In Brockton, Avon, Halifax, and Holbrook, the estimated volume of distributed food meets or exceeds the modeled meal gap. This does not mean that food insecurity has been eliminated or that every household can access available resources. Residents may continue to experience barriers related to transportation, eligibility, program schedules, stigma, cultural appropriateness, or the nutritional quality of available food.

The largest estimated unmet meal gaps are found in suburban communities:

- Easton—approximately 519,000 meals
- Rockland—approximately 439,000 meals
- Abington—approximately 351,000 meals
- Bridgewater—approximately 344,000 meals

Based on the findings, food insecurity is a service area-wide challenge. Brockton carries the greatest concentration and volume of need, while several surrounding communities experience substantial, though sometimes less visible, food insecurity that may not be fully addressed by existing food distribution and nutrition assistance programs.

What the Community Shared

Focus group participants described high and sustained demand for food pantries and food distribution programs. They identified a strong network of community resources, including local food pantries, school-based food assistance, home delivery for older adults, and the Brockton Area Hunger Network Cooperative.

At the same time, participants emphasized that food assistance often responds to immediate hunger without addressing the underlying financial conditions contributing to food insecurity. Rising housing costs, limited income, transportation expenses, and other basic needs can leave households without sufficient resources for food even when assistance programs are available.

Participants also described food insecurity as a need that rarely occurs in isolation. Families seeking food support may also experience housing instability, chronic disease, financial stress, transportation barriers, or difficulty navigating public benefits. Access to healthy food was a particular concern for people managing diabetes, hypertension, pregnancy, and other health conditions with nutrition-related needs.

COMMUNITY VOICE

"The food that we are giving out is really a Band-Aid. How many days is it going to help you for? Then you are going to need it again."
— Focus group participant

COMMUNITY VOICE

"Food insecurity is too big for any one agency to handle alone, which is why we work together."
— Focus group participant

Connections and Implications

Food insecurity is closely connected to housing affordability, income, transportation, chronic disease, maternal health, and behavioral health. When households must prioritize rent, utilities, medications, childcare, or transportation, fewer resources may remain for food.

The findings suggest that food-access strategies should combine direct food assistance with benefits navigation, transportation support, nutrition education, and connections to other social and economic resources. Efforts should also consider whether available food meets residents' health, cultural, and dietary needs.

The municipal findings show that approaches may need to differ across communities. Brockton has both high food insecurity and substantial use of SNAP and food distribution programs, while several suburban communities have meaningful food insecurity that may be less visible and lower participation in nutrition assistance. Strengthening food access will therefore require both continued support for high-demand community networks and targeted outreach in communities where need may be harder to identify.

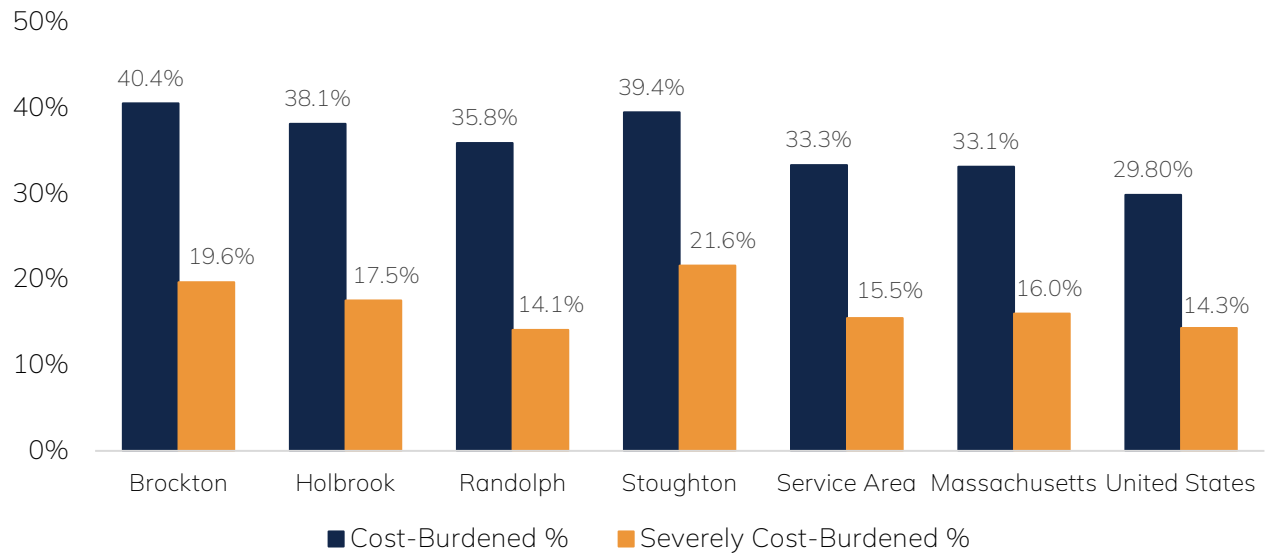
Housing and Economic Mobility

Housing and economic mobility were identified as a priority because quantitative findings and community input consistently showed that housing affordability, housing quality, homelessness, and financial strain affect health across the BMC South service area. This priority includes housing stability, income, employment, and the broader economic conditions that influence residents' ability to access healthcare, afford food and medications, manage chronic conditions, and maintain household stability.

Data Findings

Housing cost burden is common across the service area and is generally consistent with statewide levels. A household is considered housing cost-burdened if it spends 30 percent or more of its income on housing, while a household is considered severely housing cost-burdened if it spends 50 percent or more of its income on housing. Approximately 33.3 percent of service area households are housing cost-burdened, compared with 33.1 percent statewide. An estimated 15.5 percent of households are severely housing cost-burdened, compared with 16.0 percent across Massachusetts (ACS, 2020 – 2024).

Housing Cost Burden and Severe Cost Burden Rates
ACS, 2020 – 2024

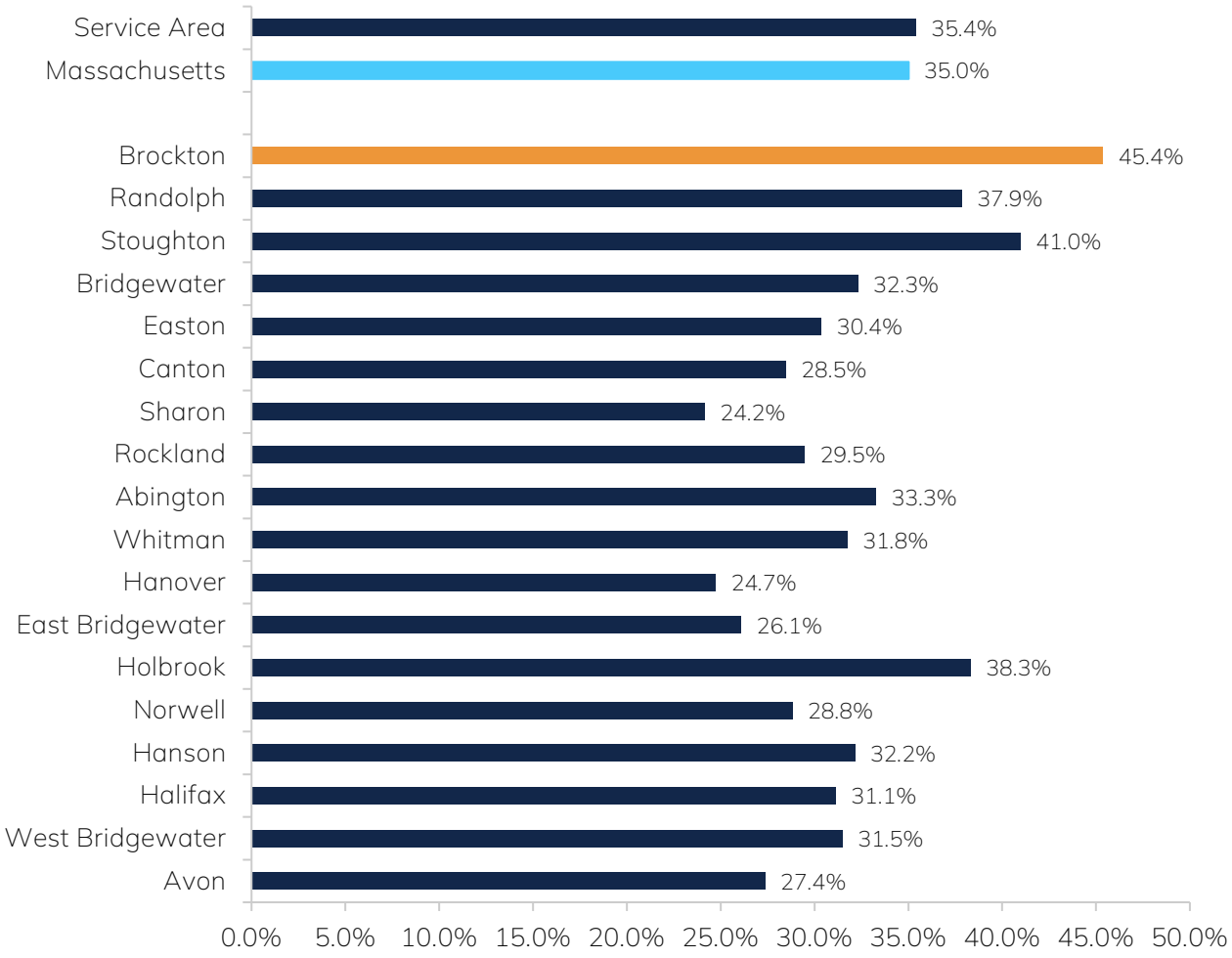


Service area averages, however, conceal substantial differences among municipalities. Cost burden is highest in Brockton at 40.4 percent, followed by Stoughton at 39.4 percent, Holbrook at 38.1 percent, and Randolph at 35.8 percent. Severe cost burden is highest in Stoughton at 21.6 percent and Brockton at 19.6 percent.

Housing quality follows a similar pattern. Approximately 35.4 percent of occupied housing units across the service area have one or more indicators of substandard housing, such as incomplete kitchen or plumbing facilities, overcrowding, or other conditions associated with inadequate housing quality (ACS, 2020 – 2024). The rate is highest in Brockton at 45.4 percent, followed by Stoughton (41.0 percent), Holbrook (38.3 percent), and Randolph (37.9 percent).

Substandard Housing Rate by Municipality

ACS, 2020 – 2024



Financial indicators also show that a relatively favorable service area average can conceal concentrated need. The service area poverty rate is 7.9 percent, below the Massachusetts rate of 10.0 percent and the national rate of 12.4 percent. Brockton's poverty rate, however, is 13.5 percent—higher than the state and national rate and nearly twice the service area average (ACS, 2020 – 2024).

Labor force participation is 68.4 percent across the service area, compared with 67.0 percent statewide. This suggests that employment alone does not eliminate economic strain, particularly when wages do not keep pace with housing, food, transportation, childcare, and healthcare costs (ACS, 2020 – 2024).

The community survey provides additional evidence of financial pressure. Cost of living was the most frequently selected community concern, identified by 49 percent of respondents. Housing instability was selected by 25 percent, and 36 percent of respondents reported concerns about paying for basic needs such as food, housing, and healthcare (BMC South Community Survey, 2026).

Historical housing patterns provide additional context. In the 1930s, the federal Home Owners' Loan Corporation (HOLC) graded neighborhoods across the country for mortgage lending in a practice known

as redlining, assigning grades from "best" to "hazardous" that shaped access to home loans and investment for decades. The lowest-graded, or "redlined," neighborhoods were those deemed hazardous and denied lending. An estimated 97.1 percent of Brockton residents live in neighborhoods that were graded through this process, far above the share statewide (26.7 percent) and nationally (14.3 percent). About 3.2 percent of Brockton residents live in neighborhoods that were specifically redlined—comparable to the statewide share (3.4 percent) but above the national rate (2.2 percent). These patterns have been associated with long-term differences in neighborhood investment, housing, and health, providing context for present-day conditions across communities (HOLC redlining grades, University of Richmond Mapping Inequality Project, via MA CARES, 2026).

The findings show that housing and economic pressure affect communities throughout the service area but are concentrated most heavily in Brockton, Stoughton, Holbrook, and Randolph. Several of these communities also experience elevated chronic disease, behavioral health, and food insecurity burdens, demonstrating how housing and economic conditions intersect with other health priorities.

What the Community Shared

Focus group participants described rising rents, overcrowding, multiple families sharing housing, unsafe or informal rental arrangements, and a shortage of affordable options. Some residents were described as living without formal leases, receipts, or other protections, making them particularly vulnerable to displacement and unsafe conditions.

Participants expressed particular concern about older adults experiencing housing instability for the first time because they can no longer maintain housing on fixed incomes. Shelter and homelessness service providers reported that first-time homelessness among older adults has roughly doubled over the past five to six years and that older adults now represent close to one-third of the population they serve through emergency shelter.

Economic mobility was also a recurring theme. Participants discussed the importance of local employment opportunities, competitive wages, workforce development, and investments that allow residents to remain in and contribute to their communities. Some noted that bilingual and bicultural professionals often leave the area for higher-paying positions elsewhere, reducing the capacity of local organizations to provide culturally and linguistically responsive services.

COMMUNITY VOICE

"We are seeing people in their 70s or even 80s first experiencing a housing crisis because of affordability."

"We see families double living, sharing one apartment among two or three families, and it keeps getting worse."

"Financial issues predominate, and that leads to all these high social needs."
— Focus group participants

Connections and Implications

Housing instability can affect health through increased stress, disrupted sleep, environmental exposures, interrupted medication use, and difficulty maintaining primary and preventive care. For children, housing instability may affect school attendance, safety, development, and family relationships. For older adults, it may contribute to shelter entry, social isolation, loss of independence, and worsening chronic disease.

Housing costs also affect the resources households have available for food, medications, transportation, childcare, and other necessities. Even residents with health insurance may delay care because of copayments, transportation expenses, lost wages, or concerns about medical bills.

The findings suggest that housing and economic mobility strategies require coordination across healthcare, housing, social services, workforce organizations, and community partners.

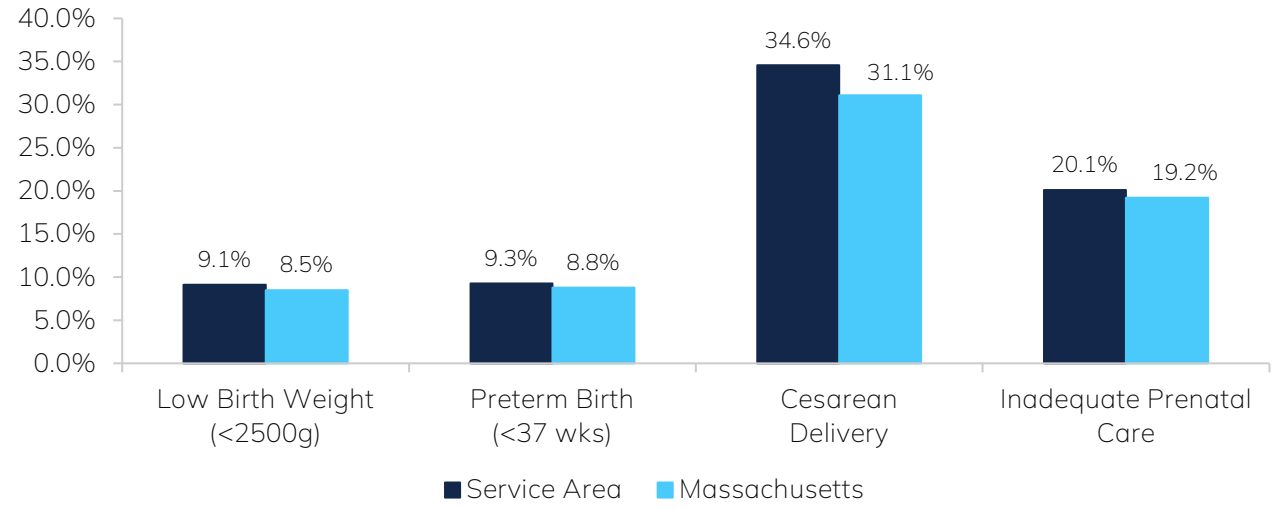
Maternal and Reproductive Health

Maternal and reproductive health was identified as a priority because quantitative findings and community input pointed to differences in birth outcomes, prenatal care, and care experiences across the BMC South service area. This priority includes prenatal care, pregnancy and birth outcomes, severe maternal morbidity, postpartum care, reproductive healthcare, and respectful, culturally responsive care.

Data Findings

Several maternal and reproductive health outcomes across the BMC South service area are less favorable than Massachusetts overall: the low birth weight rate (defined as under 2,500 grams) is 9.1 percent compared with 8.5 percent statewide, the preterm birth rate is 9.3 percent compared with 8.8 percent, and the cesarean delivery rate is 34.6 percent compared with 31.1 percent. Adequate prenatal care is slightly lower, at 79.9 percent compared with 80.8 percent statewide (MA DPH birth data, 2013 – 2022).

Birth and Maternal Outcomes
MA DPH birth data, 2013 – 2022



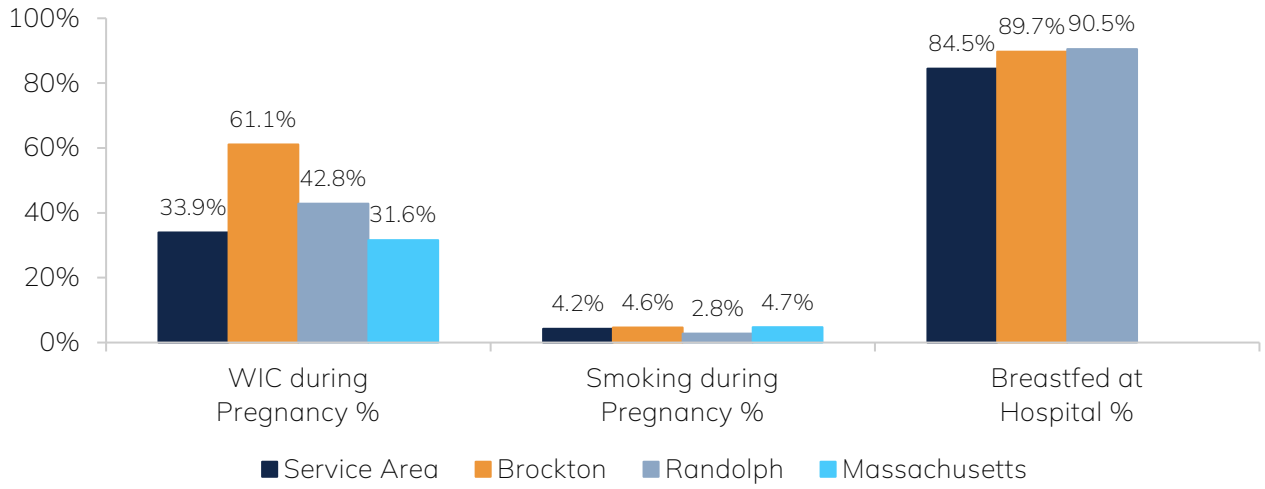
Service area averages conceal meaningful municipal differences. Adequate prenatal care is lowest in Brockton at 71.6 percent and Randolph at 74.4 percent, compared with approximately 90 percent in Hanover and Hanson. Low birth weight is highest in Randolph at 11.6 percent and Brockton at 11.0 percent and lowest in Hanover at 6.2 percent and Easton at 6.4 percent (MA DPH birth data, 2013 – 2022). Brockton and Randolph are also among the service area's most racially, ethnically, and linguistically diverse communities.

Cesarean delivery follows a different geographic pattern and should be interpreted separately. Rates are highest in Whitman at 39.2 percent and in Abington and East Bridgewater at 37.6 percent each, while Brockton and Randolph are close to the service area average. The elevated cesarean rate therefore appears across a range of communities and should not be interpreted as a disparity concentrated in the service area's highest-need municipalities.

Indicators of economic need during pregnancy provide additional context. Approximately 42 percent of prenatal care across the service area is publicly funded through Medicaid, and 34 percent of pregnant residents receive WIC. Both measures are substantially higher in Brockton—71 percent and 61 percent, respectively—and Randolph—47 percent and 43 percent (MA DPH birth data, 2013 – 2022).

WIC, Smoking, and Breastfeeding

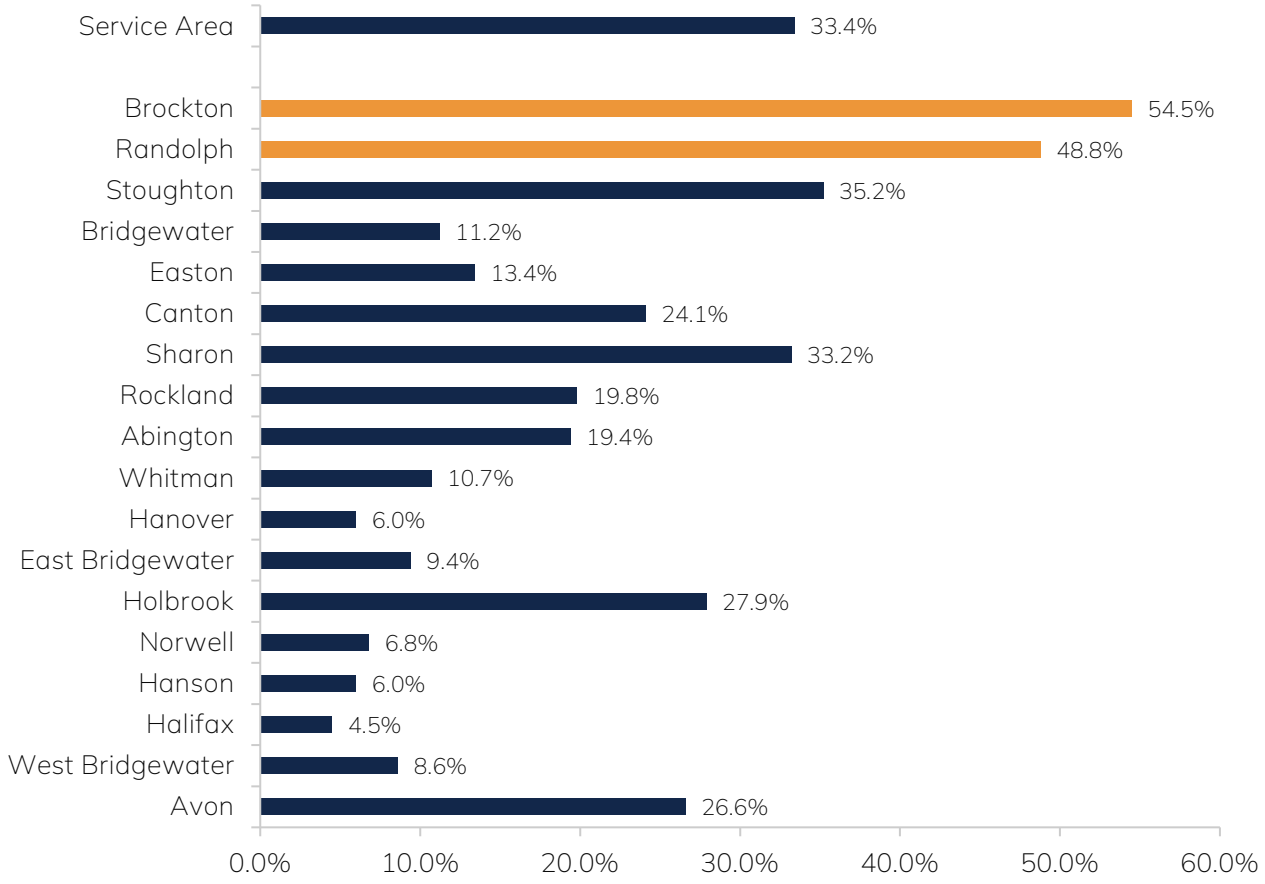
MA DPH birth data, 2013 – 2022. MA DPH PHIT, 2022 – 2023



More recent data shows that WIC enrollment among all eligible residents—including pregnant and postpartum people, infants, and children younger than age five—increased from 59.0 percent in 2022 to 64.0 percent in 2023. Enrollment reached 66.1 percent in Brockton and 70.1 percent in Randolph but was lower in several smaller suburban communities, including Norwell at 37.8 percent and Hanover at 44.7 percent. Because this measure includes a broader eligible population, it should not be directly compared with the birth-file measure of WIC participation among pregnant residents (MA DPH PHIT, WIC, 2022 – 2023).

The service area's birthing population also includes a substantial share of foreign-born residents, with approximately 33.4 percent of live births—about 14,300 births—to foreign-born women from 2013 through 2022. The proportion varied considerably by municipality, ranging from 4.5 percent in Halifax and 6.0 percent in Hanover and Hanson to 54.5 percent in Brockton and 48.8 percent in Randolph; Stoughton was also above the service area average at 35.2 percent. This variation reinforces the importance of language access, culturally responsive communication, care navigation, and trust throughout prenatal, delivery, and postpartum care (MA DPH birth data, 2013 – 2022).

Foreign-Born Share of Births by Municipality
MA DPH birth data, 2013 – 2022



Severe maternal morbidity could not be measured at the service area level using publicly available data and remains an important data gap. Statewide, severe maternal morbidity nearly doubled from 52.3 cases per 10,000 deliveries in 2011 to 100.4 per 10,000 in 2020 (MA DPH PELL, 2011 – 2020).

County-level data indicates that Plymouth, Norfolk, and Bristol counties had full maternity care access and were not classified as maternity care deserts in 2023. This designation confirms the presence of maternity services but does not show whether residents can obtain timely, affordable, culturally responsive, and respectful care within their communities (March of Dimes, 2023).

What the Community Shared

Focus group participants described maternal and reproductive health as closely connected to trust, communication, and respectful care. They raised concerns about whether pregnant patients feel comfortable discussing housing, food access, mental health, substance use, and other social needs during prenatal care.

Participants also described experiences of bias, disrespect, or poor communication that can weaken trust. They noted that Black women and other historically underserved populations may be particularly

affected. Some community members expressed concern that pregnant patients may delay care or avoid sharing important information because they fear judgment or negative consequences.

Maternal and reproductive health was not a prominent theme in the community survey. However, the survey included relatively few younger adults and people who were pregnant or recently postpartum. The survey results therefore may not fully reflect the maternal and reproductive health needs of the service area.

COMMUNITY VOICE

"There's patients who are pregnant who are afraid to access care because they don't want to get their kids taken away."
— Focus group participant

COMMUNITY VOICE

"Racial trauma and social determinants can be magnified when somebody is expecting a baby."
— Focus group participant

Connections and Implications

Maternal and reproductive health is closely connected to behavioral health, housing stability, food security, transportation, insurance coverage, and language access. These factors can influence whether patients begin prenatal care early, attend appointments, discuss their needs, and remain connected to services throughout pregnancy and the postpartum period.

The findings suggest that attention should focus on strengthening timely and adequate prenatal care in communities where participation is lower, supporting culturally and linguistically responsive services, and promoting respectful care that allows patients to discuss behavioral health and social needs without fear or judgment.

County-level data indicates that maternity care services are present across the region. However, physical availability alone does not ensure equitable access or a positive care experience. Future efforts should also address navigation, trust, affordability, communication, postpartum support, and the local data gap related to severe maternal morbidity.

Additional Health Needs Assessed

The assessment evaluated a broad range of topics, scoring each against the same four criteria using the available data and community input. This provided a consistent basis for comparing the full range of needs identified, so attention could go where the evidence was strongest while still accounting for everything that surfaced.

The topics in the table below were assessed through that same process and scored below 20 on the 24-point scale, so they did not rise to the top as the most pressing needs this cycle. These topics remain important to community health. Each connects to one or more of the selected priorities, creating natural opportunities to consider these needs as part of that work rather than treating them as wholly separate concerns.

The table summarizes the community relevance and the priorities each one can connect to, showing where these needs align with the assessment's areas of focus.

Community health needs are complex, interconnected, and continually evolving. The priorities and additional topics presented here offer a focused summary of the needs most strongly supported by the available data and community input at this time, and are not intended to represent an exhaustive list of every issue affecting residents.

Topic	Community Relevance	Connection to Selected Priorities
Older Adult Health and Wellbeing	Older adults experience intersecting challenges related to chronic disease and cancer, transportation, social isolation, fixed incomes, food insecurity, caregiver stress, and housing instability. Participants were particularly concerned about older adults entering housing crisis or shelter for the first time.	Behavioral Health, Mental Health, and Substance Use; Access to Care; Chronic Disease and Cancer; Access to Healthy Food / Food Insecurity; Housing and Economic Mobility
Violence, Safety, and Trauma	Focus group discussions raised youth and community violence, intimate partner violence, trauma, and the need for safe spaces, mentoring, prevention, and community-based support.	Behavioral Health, Mental Health, and Substance Use; Access to Care; Housing and Economic Mobility
Environmental Health and Childhood Lead	Housing quality, neighborhood conditions, air quality, environmental exposures, and the built environment can affect health, especially for children and residents living in older housing.	Access to Care; Chronic Disease and Cancer; Housing and Economic Mobility
Infectious Disease and Immunization	Vaccination and infectious disease prevention remain important for children, older adults, people living with chronic conditions, and residents who face barriers to primary care.	Access to Care; Chronic Disease and Cancer

Topic	Community Relevance	Connection to Selected Priorities
Transportation and Digital Access	Transportation, internet access, digital proficiency, and language barriers can affect residents' ability to reach services, use telehealth and patient portals, and access community resources.	Access to Care; Chronic Disease and Cancer; Access to Healthy Food / Food Insecurity; Housing and Economic Mobility
Education, Workforce, and Youth Development	Youth programs, school engagement, mentoring, workforce pathways, and the retention of bilingual and bicultural professionals support long-term health, economic stability, and community capacity.	Behavioral Health, Mental Health, and Substance Use; Access to Care; Chronic Disease and Cancer; Housing and Economic Mobility
Immigration-related Concerns	Participants also shared that immigration-related concerns can influence whether some community members feel comfortable accessing healthcare, community services, and other forms of support.	Behavioral Health, Mental Health, and Substance Use; Access to Care; Chronic Disease and Cancer; Access to Healthy Food / Food Insecurity; Housing and Economic Mobility; Maternal and Reproductive Health

Conclusion and Next Steps

This community health needs assessment identified six priority areas for the BMC South service area: behavioral health, mental health, and substance use; access to care; chronic disease and cancer; access to healthy food / food insecurity; housing and economic mobility; and maternal and reproductive health. These priorities reflect the combined findings of the quantitative data review, community survey, and focus groups.

The assessment also demonstrates that these priorities are closely connected. Housing, food security, transportation, language access, trust, and other social and economic conditions influence health across multiple areas. Community members also identified important strengths throughout the service area, including trusted community organizations, faith communities, schools, health centers, food and housing partners, cultural networks, and local leaders.

The findings in this CHNA are intended to inform future community health planning, including the development of a Community Health Improvement Plan (CHIP), community benefit activities, partnerships, and outreach. Continued engagement with residents and community organizations will help identify emerging needs, strengthen understanding of community priorities, and support planning that reflects a broad range of perspectives.

Impact Reporting

Federal requirements for nonprofit hospital Community Health Needs Assessments include consideration of the impact of actions taken to address the significant health needs identified in the previous assessment. Because this is the first CHNA completed for BMC South after BMCHS assumed ownership in October 2024, there is no previous BMC South Community Health Improvement Plan or implementation strategy to evaluate.

This CHNA therefore serves as a baseline for understanding health needs, community assets, disparities, and priorities across the BMC South service area. Quantitative data, community survey findings, and focus group discussions were considered together to identify significant health needs and provide context about the factors affecting health throughout the region.

The six priorities identified through this assessment are intended to inform the development of a separate Community Health Improvement Plan. This CHNA also establishes baseline information that can support future impact reporting, including consideration of the progress, challenges, lessons learned, and changing community needs associated with any strategies that are adopted.

Appendices

Appendix A: Focus Group Method and Prompts

Focus group conversations used a common facilitation guide. Participants were asked to share from the perspective of their role, organization, and the communities or populations they serve. The guide included questions about community needs, strengths, barriers, trust, access, experience, partnership opportunities, and changes that would make the biggest difference.

- Introductions and community connection
- Most important health and wellbeing needs
- Community strengths, resources, relationships, and assets
- Barriers affecting health, safety, stability, and support
- Community conditions or recent changes making needs better or worse
- Groups or communities having a harder time getting support
- What helps people feel comfortable, respected, and supported
- Partnership opportunities across organizations, agencies, businesses, and faith communities
- Programs or approaches that are working well
- Changes that would make the biggest difference
- Final reflections to include thoughtfully in the assessment

Prompts:

- From what you see in your work, what are some of the most important health and wellbeing needs affecting the communities you work with?
- What is working well in the community right now? What strengths, resources, relationships, or community assets are helping support people's health and wellbeing?
- What are some of the biggest barriers making it harder for people in the communities you work with to be healthy, safe, stable, and supported?
- Are there any community conditions or recent changes that are making these needs or barriers better or worse?
- Are there certain communities, neighborhoods, or groups that are being affected more than others or having a harder time getting support?
- What helps people feel comfortable, respected, and supported when they are seeking services, programs, or care?
- Where do you see opportunities for community organizations, public agencies, businesses, faith communities, and other partners to work together more effectively?
- What programs, partnerships, services, or approaches are already working well and should be continued, expanded, or better supported?

- Looking ahead, what changes would make the biggest difference for the communities you work with?
- Is there anything important from your perspective, your organization's work, or the communities you work with that we have not asked about today?

Appendix B: Organizations Represented in Focus Group Conversations

Organization / Community Partner	Primary Perspective Represented
Haitian Community Partners	Haitian community, language access, immigrant communities, community trust
MCTV / Fohadi.net	Community media, communication, health education, outreach
Old Colony YMCA	Youth, family services, food access, community programming
Sabura Youth Programs	Youth development, violence prevention, community engagement
Brockton Workers Alliance	Worker advocacy, immigrant communities, economic stability
Newhouse Charter School of Brockton	Youth, education, immigrant families, mental health
City Life/Vida Urbana	Housing justice, tenant rights, displacement, eviction
Brockton Neighborhood Health Center	Primary care, community health, language access, maternal health
Forever Young Wellness / Under One Roof Fitness Center	Health education, wellness, self-advocacy, men's health
Metro South Chamber of Commerce	Economic development, business conditions, workforce, community infrastructure
Cape Verdean Women United	Cape Verdean community, violence prevention, youth, immigrant families
My Brother's Keeper	Food assistance, furniture assistance, basic needs, regional support
The Charity Guild	Food pantry services, home delivery, school-based food access, hunger network
City of Brockton Health and Human Services	Municipal health, social needs, cross-sector coordination
Catholic Charities	Adult education, ESOL, immigrant communities, food access
Father Bill's & MainSpring	Emergency shelter, housing, older adults experiencing homelessness
Cabin Street Health Center	Community health, language access, trusted care
Cape Verdean Association	Cultural support, language access, community navigation

Appendix C: Community Survey Summary

Q1. What is your 5-digit ZIP code? Open-ended (write-in response)

Q2. City/Town – List of towns respondents could select from (each town in the survey area—e.g., Abington, Avon, Bridgewater, Brockton, Canton, East Bridgewater, Easton, etc.)

Q3. Overall, how would you rate your community? (rated on each statement below)

- I feel a sense of belonging
- My community is a good place to live
- My community feels safe
- There are places to be active (parks, sidewalks, etc.)
- I can access resources I need (food, services, care)

Scale: Agree / Neutral / Disagree

Q4. In the past year, how often were you able to get care when you needed it? (rated for each type below)

- Medical care
- Mental healthcare

Scale: Always / Sometimes / Never

Q5. How would you rate your overall health?

- Excellent
- Good
- Fair
- Poor
- Prefer not to answer

Q6. What makes it harder for you to get care? (Select all that apply)

- Cost
- Transportation
- Scheduling/availability
- Language or communication barriers
- Not feeling comfortable or welcomed
- Not sure where to go

- Other

Q7. Where do you usually go for care or advice?

- Doctor's office
- A public health clinic or community health center
- VA (Veterans Affairs) facility
- Emergency room
- Urgent care
- No regular place
- Other

Q8. What are the biggest health concerns in your community? (Select up to 3)

- Mental health
- Substance use
- Chronic conditions (diabetes, heart disease, etc.)
- Violence or safety
- Housing instability
- Food insecurity
- Cost of living
- Youth mental health
- Youth physical health
- Health and wellbeing of older adults
- Other

Q9. What would make it easier for you or your family to stay healthy? Open-ended (write-in response)

Q10. Age group

- Under 18
- 18 – 34
- 35 – 54
- 55+
- Prefer not to answer

Q11. Primary language spoken at home

- English
- Spanish
- Haitian Creole
- Cape Verdean Creole
- Portuguese
- Prefer not to answer
- Other

Q12. What is your household income?

- Less than $25,000
- $25,000 – $49,999
- $50,000 – $74,999
- $75,000 – $99,999
- $100,000+

Q13. Do you have any concerns about paying for basic needs (food, housing, healthcare, etc.)?

- Yes
- No
- Prefer not to answer

Q14. Is there anything else you would like to share about your community or health needs? Open-ended (write-in response)

Survey Measure	Finding
Total responses	215
Age 55 or older	60%
English spoken at home	88%
Worry about paying for basic needs	36%

Barriers to Care

Barrier	Share of Respondents
Scheduling/availability	59%

Barrier	Share of Respondents
Cost	33%
Transportation	22%
Not sure where to go	17%
Not feeling comfortable/welcomed	10%
Language/communication	2%

Biggest Community Health Concerns

Concern	Share of Respondents
Cost of living	49%
Mental health	45%
Chronic conditions	36%
Health and wellbeing of older adults	35%
Substance use	25%
Housing instability	25%
Food insecurity	14%
Youth mental health	14%
Violence or safety	9%
Youth physical health	4%

Appendix D: Priority Data Support Matrix

Priority	Highlighted Quantitative Support	Highlighted Focus Group Support
Behavioral Health, Mental Health, and Substance Use	Depression 23.6 percent; frequent mental distress 17.8 percent (up from 14.0 percent in 2018); 622 overdose deaths, 2020 – 2024 (approximately 31.0 per 100,000); survey access gap—42 percent could always get mental healthcare versus 70 percent for medical care (CDC PLACES/BRFSS, 2025 Release; CDC WONDER, 2020 – 2024; BMC South Community Survey, 2026)	Mental health, trauma, stigma, youth mental health, substance use, and housing-related stress
Access to Care	Scheduling/availability 59 percent; cost 33 percent; transportation 22 percent; one federally qualified health center in the service area (Brockton); primary care physician supply approximately 80 per 100,000 versus 102 statewide (BMC South Community Survey, 2026; Health Resources and Services Administration (HRSA), Area Health Resource File, 2023; HRSA HPSA Find, 2025)	Long waits, provider shortages, language access, mistrust, navigation barriers, affordability
Chronic Disease and Cancer	Service area prevalence above the state (electronic health records): diabetes 12.9 versus 11.4 percent, hypertension 39.4 versus 36.9 percent, obesity	Health information, self-advocacy, prevention, food access, primary care continuity

Priority	Highlighted Quantitative Support	Highlighted Focus Group Support
	34.2 versus 31.0 percent; highest burden in Brockton, Randolph, and Holbrook (MA DPH electronic health record data, 2023)	
Access to Healthy Food / Food Insecurity	29,620 food-insecure households (21.2 percent); 10.46 million annual meal gap, 3.26 million unmet; SNAP 13.5 versus 12.3 percent statewide, with under-enrollment in several suburban towns (Greater Boston Food Bank Food Insecurity Study; MA Department of Transitional Assistance, via Project Bread)	High pantry demand, food as temporary support, SNAP and benefits concerns, healthy food access
Housing and Economic Mobility	33.3 percent cost-burdened households; 15.5 percent severely burdened; burden concentrated in Brockton, Stoughton, Holbrook, and Randolph; 97.1 percent of Brockton residents in historically HOLC-graded areas (ACS, 2020 – 2024; University of Richmond Mapping Inequality, via MA CARES)	Rising rents, overcrowding, unsafe housing, elder homelessness, economic strain
Maternal and Reproductive Health	Low birth weight 9.1 versus 8.5 percent statewide (11.0 percent Brockton, 11.6 percent Randolph); preterm 9.3 versus 8.8 percent; adequate prenatal care 79.9 versus 80.8 percent, lowest in Brockton and Randolph (Massachusetts Department of Public Health birth files, 2013 – 2022)	Birth trauma, trust, safety, substance use disclosure, social needs in pregnancy

Appendix E: Data Sources

- U.S. Census Bureau, American Community Survey (ACS): 2020 – 2024 Five-Year Estimates
- Massachusetts CARES Community Data Tool (Conduent Healthy Communities Institute): 2026 (access point for several ACS, CDC PLACES/BRFSS, and Mapping Inequality indicators; includes the Income & Poverty Community Data Tool)
- IRS Exempt Organizations Business Master File: 2023 (nonprofit organizations per 100,000)
- CDC PLACES / Behavioral Risk Factor Surveillance System (BRFSS): 2025 release; model-based small-area estimates for adults 18 and older (underlying BRFSS data 2023, except dental visits and short sleep duration, which are 2022)
- Massachusetts Department of Public Health (MA DPH): electronic health record (EHR)-based chronic disease prevalence, 2023
- CDC National Vital Statistics System, accessed via CDC WONDER: 2020 – 2024 (mortality and injury)
- County Health Rankings & Roadmaps (University of Wisconsin Population Health Institute): 2025 release (mental health provider availability)
- MA DPH, Bureau of Substance Addiction Services (BSAS) Dashboard: 2024
- Massachusetts Prescription Monitoring Program (PMP): 2016 – 2024
- Center for Health Information and Analysis (CHIA): 2018 (behavioral health / substance use disorder comorbidity)

- Massachusetts Hospital Inpatient Discharge Database (CHIA, Acute Hospital Case Mix): SFY 2020 (July 2019 – June 2020, behavioral health readmissions); hospital regions defined by the Massachusetts Health Policy Commission
- Center for Health Information and Analysis (CHIA), Hospital Emergency Department Database (Acute Hospital Case Mix): ED utilization by ZIP code, SFY 2020 – 2024
- Center for Health Information and Analysis (CHIA), Massachusetts Health Insurance Survey: 2025
- Massachusetts Cancer Registry (MCR), MA DPH: City/Town Standardized Incidence Ratio (SIR) series, 2012 – 2016 and 2017 – 2021
- U.S. Cancer Statistics (CDC / National Cancer Institute): 2018 – 2022
- State Cancer Profiles (statecancerprofiles.cancer.gov), National Program of Cancer Registries (NPCR) and SEER: prostate cancer incidence by race and county, 2018 – 2022
- CMS National Plan and Provider Enumeration System (NPPES): 2026 (provider supply)
- Health Resources and Services Administration (HRSA), Area Health Resources Files (AHRF): 2023
- Health Resources and Services Administration (HRSA), Health Professional Shortage Area (HPSA) Find: 2025
- Greater Boston Food Bank, The Cost of Hunger in Massachusetts: 2025 (based on 2024 survey data)
- Massachusetts Department of Transitional Assistance (DTA), SNAP Caseload by ZIP Code Reports: April 2026 (municipal totals accessed via Project Bread; population denominators from ACS 2020 – 2024)
- Project Bread: SNAP enrollment and "SNAP gap" analysis
- MA DPH, Massachusetts Birth Outcomes (Resident) data: 10-year pooled 2013 – 2022
- MA DPH, Pregnancy to Early Life Longitudinal (PELL) Data System / Public Health Data Warehouse: severe maternal morbidity, 2011 – 2020
- MA DPH, Population Health Information Tool (PHIT): WIC enrollment among eligible residents, 2022 – 2023
- MA DPH, School Immunization Survey: SY2025-26
- MA DPH, Childhood Lead Poisoning Prevention Program (CLPPP): 2024 Annual Surveillance Report
- UMass Donahue Institute (UMDI): 2020 population estimate (denominator for childhood lead screening rates)
- March of Dimes: maternity care access, 2023
- University of Richmond, Digital Scholarship Lab, Mapping Inequality: Home Owners' Loan Corporation (HOLC) redlining grades (MA CARES)
- U.S. Environmental Protection Agency (EPA), AirToxScreen: respiratory hazard index, 2019
- U.S. Environmental Protection Agency (EPA), EJScreen: environmental justice indicators, 2024
- USDA / U.S. Forest Service, National Land Cover Database: tree canopy, 2023
- BMC South Community Survey: 2026 (primary data collected for this CHNA)

- Focus group conversations: conducted for the 2026 BMC South CHNA (primary data)

Appendix F: Service Area Municipalities and ZIP Codes

The following municipalities and ZIP codes define the BMC South CHNA service area used for the assessment.

ZIP Code	City / Town	County
02351	Abington	Plymouth
02322	Avon	Norfolk
02324	Bridgewater	Plymouth
02325	Bridgewater	Plymouth
02301	Brockton	Plymouth
02302	Brockton	Plymouth
02021	Canton	Norfolk
02333	East Bridgewater	Plymouth
02356	Easton	Bristol
02375	Easton	Bristol
02338	Halifax	Plymouth
02339	Hanover	Plymouth
02341	Hanson	Plymouth
02343	Holbrook	Norfolk
02061	Norwell	Plymouth
02368	Randolph	Norfolk
02370	Rockland	Plymouth
02067	Sharon	Norfolk
02072	Stoughton	Norfolk
02379	West Bridgewater	Plymouth
02382	Whitman	Plymouth

Appendix G: Additional Data

Population Age Distribution

Municipality	Total Population	Male %	Female %	Age 0 – 4 %	Age 5 – 17 %	Age 65+ %
Service Area	399,579	49.0%	51.0%	5.6%	16.6%	16.9%
Brockton	105,386	48.4%	51.6%	6.6%	18.8%	14.4%
Randolph	34,878	48.4%	51.5%	3.9%	13.3%	18.4%
Stoughton	29,225	46.4%	53.6%	4.4%	14.1%	20.8%
Bridgewater	28,471	51.6%	48.4%	4.4%	13.2%	17.3%
Easton	25,316	47.9%	52.1%	3.2%	16.5%	19.9%
Canton	24,748	50.5%	49.5%	6.8%	16.1%	18.8%
Sharon	18,574	48.9%	51.1%	5.9%	21.3%	17.6%
Rockland	17,701	50.1%	49.9%	7.0%	13.2%	15.9%
Abington	17,053	49.4%	50.6%	6.6%	15.7%	13.1%
Whitman	15,295	47.5%	52.5%	5.5%	15.6%	15.5%
Hanover	14,845	50.5%	49.5%	4.8%	21.3%	16.1%
East Bridgewater	14,456	50.0%	50.0%	5.3%	15.9%	15.8%
Holbrook	11,380	51.7%	48.3%	6.9%	14.3%	19.1%
Norwell	11,361	49.6%	50.4%	8.1%	20.4%	16.1%
Hanson	10,660	49.5%	50.5%	4.6%	17.0%	19.7%
Halifax	7,748	47.4%	52.6%	3.8%	18.4%	18.8%
West Bridgewater	7,708	50.0%	50.0%	5.8%	12.9%	19.3%
Avon	4,774	50.9%	49.1%	6.6%	15.0%	17.6%

Source: U.S. Census Bureau, American Community Survey (ACS) 2020 – 2024 Five-Year Estimates.

Other Demographic and Social Profiles

Municipality	No Computer Household %	Broadband Subscription %	Nonprofits per 100k	Insufficient Sleep %	Bachelor's+ Degree %	Less than HS Diploma %
Abington	3.1%	93.8%	362.9	34.9%	40.0%	4.6%
Avon	5.3%	95.8%	397.7	35.6%	30.6%	13.5%
Bridgewater	2.0%	97.2%	349.4	34.9%	39.5%	6.8%
Brockton	6.7%	92.9%	365.5	42.2%	22.3%	17.9%
Canton	2.6%	95.0%	558.1	31.7%	67.5%	3.5%
East Bridgewater	3.4%	96.7%	304.7	34.1%	34.2%	4.5%
Easton	4.0%	96.4%	558.7	32.0%	53.4%	3.3%

Halifax	6.6%	96.1%	258.1	33.2%	36.1%	4.3%
Hanover	4.2%	97.7%	687.7	32.4%	56.9%	4.9%
Hanson	6.8%	95.4%	338.4	33.1%	42.6%	7.4%
Holbrook	6.6%	88.9%	282.1	35.1%	34.6%	7.6%
Norwell	1.7%	98.7%	775.3	30.7%	69.6%	2.1%
Randolph	3.9%	96.0%	422.6	39.6%	35.5%	11.6%
Rockland	4.6%	89.5%	325.8	34.7%	32.7%	4.2%
Sharon	2.6%	97.1%	653.6	30.0%	76.7%	1.3%
Stoughton	5.2%	95.3%	430.1	35.7%	41.9%	9.1%
West Bridgewater	2.5%	95.7%	467.1	32.5%	43.6%	5.4%
Whitman	3.1%	92.0%	251.3	34.6%	31.3%	6.2%

Sources: Broadband, computer access, and education: U.S. Census Bureau, American Community Survey (ACS) 2020 – 2024 Five-Year Estimates. Nonprofits per 100,000: IRS Exempt Organizations Business Master File, 2023. Insufficient sleep: CDC BRFSS/PLACES, 2022.

Health Insurance Coverage

Geography	Uninsured %	Employer / Union %	Direct Purchase %	Medicare %	Medicaid %
Abington	3.7%	71.1%	9.6%	14.0%	21.8%
Avon	4.0%	63.9%	13.9%	21.4%	21.0%
Bridgewater	2.6%	71.0%	12.2%	18.1%	17.8%
Brockton	4.6%	47.9%	10.8%	15.8%	46.9%
Canton	1.7%	77.4%	11.4%	18.6%	12.1%
East Bridgewater	3.4%	71.4%	11.9%	17.3%	17.0%
Easton	1.3%	72.7%	15.2%	19.8%	14.5%
Halifax	2.7%	61.7%	23.1%	20.7%	17.4%
Hanover	2.0%	80.7%	12.8%	16.4%	10.3%
Hanson	1.0%	75.5%	11.8%	20.2%	13.1%
Holbrook	1.6%	67.3%	14.2%	20.2%	25.8%
Norwell	0.7%	82.0%	11.3%	14.3%	7.7%
Randolph	3.2%	63.8%	11.6%	19.5%	29.1%
Rockland	1.2%	69.7%	13.3%	18.0%	20.7%
Sharon	0.7%	78.4%	11.7%	17.6%	10.3%
Stoughton	2.4%	63.9%	17.1%	21.4%	19.8%
West Bridgewater	3.7%	72.0%	13.7%	19.0%	18.4%
Whitman	1.6%	70.6%	9.8%	16.4%	22.1%
Service Area	**2.8%**	**65.0%**	**12.4%**	**17.8%**	**25.6%**

Massachusetts	2.6%	64.0%	14.6%	18.8%	23.6%
United States	8.4%	59.8%	15.0%	20.1%	22.8%

Source: U.S. Census Bureau, American Community Survey (ACS) 2020 – 2024 Five-Year Estimates.

Note: Payer columns show the share of the insured population with each coverage type; categories overlap, as individuals may hold more than one. Uninsured % is shown for context.

= value notably above the service area average or state average (health-need indicators only).

Chronic Disease Prevalence, Survey-Based (Adults 18+)

Geography	Asthma %	Diabetes %	CHD / Heart Disease %	Hypertension %	Obesity %	Stroke %
Abington	12.1	9.2	5.5	29.8	29.2	2.8
Avon	12.2	10.5	6.0	33.3	27.6	3.4
Bridgewater	12.1	8.4	5.1	27.5	27.9	2.6
Brockton	14.5	13.4	6.7	35.6	36.0	4.2
Canton	10.8	8.6	5.3	30.2	23.1	2.6
East Bridgewater	12.2	9.5	5.9	30.8	29.3	3.0
Easton	12.3	8.6	5.5	29.8	28.3	2.7
Halifax	12.0	9.4	5.9	31.0	28.8	2.9
Hanover	11.7	8.9	5.6	29.9	27.4	2.8
Hanson	12.0	9.1	5.7	30.2	28.2	2.9
Holbrook	11.8	9.8	5.6	31.8	26.9	3.0
Norwell	11.3	8.3	5.2	28.9	26.3	2.5
Randolph	12.1	12.2	5.6	35.0	28.6	3.5
Rockland	12.4	9.9	6.1	31.4	29.9	3.1
Sharon	10.0	8.5	4.8	29.2	21.2	2.3
Stoughton	12.1	11.1	6.4	34.2	27.7	3.5
West Bridgewater	11.8	9.3	6.0	31.1	28.2	3.0
Whitman	12.5	9.3	5.5	29.7	30.0	2.9
Service Area	**12.5**	**10.6**	**5.9**	**32.2**	**29.7**	**3.3**
Massachusetts	**11.6**	**9.8**	**5.8**	**30.9**	**27.7**	**3.0**

Source: CDC Behavioral Risk Factor Surveillance System (BRFSS) / PLACES, 2023. Values are model-based estimates as a percentage of adults 18 and older.

= value notably above the service area average or state average (health-need indicators only).

Chronic Disease Prevalence, EHR-Based (% of Patients)

Geography	Asthma (EHR) %	Diabetes (EHR) %	Hypertension (EHR) %	Obesity (EHR) %
Abington	7.68	10.75	37.78	34.93

Avon	6.98	12.72	40.11	32.09
Bridgewater	8.50	11.13	35.46	35.98
Brockton	7.63	14.20	41.95	36.32
Canton	8.07	10.37	39.00	28.00
East Bridgewater	9.56	10.19	36.18	31.89
Easton	8.20	11.43	38.11	32.22
Halifax	8.80	11.04	39.96	38.31
Hanover	7.26	10.38	34.30	30.92
Hanson	9.83	12.51	39.25	35.12
Holbrook	8.79	16.95	41.65	38.18
Norwell	6.84	9.07	31.63	28.94
Randolph	8.44	17.48	42.20	36.26
Rockland	9.44	13.22	38.69	37.48
Sharon	7.59	10.35	35.34	23.96
Stoughton	9.10	14.41	43.26	35.42
West Bridgewater	8.13	9.85	35.79	30.90
Whitman	10.60	12.04	38.77	37.12
Service Area	**8.30**	**12.90**	**39.40**	**34.20**
Massachusetts	**8.36**	**11.40**	**36.91**	**31.04**

Source: Massachusetts Department of Public Health (MA DPH), 2023. Values reflect the percentage of patients with each condition documented in electronic health records.

= value notably above the service area average or state average (health-need indicators only).

Emergency Department Visit Rate per 100 Residents, by Year

Municipality	2020	2021	2022	2023	2024	2024 ED Visits	2024 Average LOS (hrs)
Abington	24.4	25.6	26.8	25.1	25.1	4,265	5.3
Avon	29.5	27.4	30.7	29.0	30.8	1,466	5.6
Bridgewater	39.3	44.5	45.2	43.9	46.0	11,978	6.3
Brockton	**150.4**	**131.9**	**142.2**	**130.2**	**124.3**	**130,599**	**7.2**
Canton	19.3	19.3	22.0	22.0	21.8	5,340	5.6
East Bridgewater	40.2	42.9	46.2	41.9	41.5	5,990	5.7
Easton	25.9	27.3	28.9	28.5	29.3	6,960	6.6
Halifax	20.7	22.0	21.1	21.2	21.6	1,667	4.9
Hanover	32.9	16.8	17.7	18.3	17.7	2,613	5.0
Hanson	37.1	39.4	43.2	39.8	41.5	4,340	5.3
Holbrook	31.4	29.7	32.6	30.5	30.8	3,469	5.1

Norwell	13.2	14.2	15.8	15.5	15.0	1,691	4.8
Randolph	35.1	34.4	37.6	38.6	37.5	13,009	5.3
Rockland	26.4	27.8	30.6	28.5	27.9	4,935	5.4
Sharon	13.0	12.9	14.9	15.3	15.9	2,945	5.8
Stoughton	28.1	27.8	30.0	28.6	28.9	8,412	6.3
West Bridgewater	23.8	21.9	23.1	22.5	20.2	1,548	6.3
Whitman	24.4	24.4	27.4	25.6	26.6	4,044	5.6

Source: Massachusetts Center for Health Information and Analysis (CHIA), Acute Hospital Case Mix - Hospital Emergency Department Database; ED Utilization by ZIP Code by Year, SFY 2020 – 2024. Note: Annual columns show ED visits per 100 residents. LOS = length of stay.

Cancer Incidence vs. Massachusetts, by Municipality

City / Town	Observed 2017 – 2021	Expected 2017 – 2021	SIR 2017 – 2021	95% CI 2017 – 2021	vs. State	SIR 2012 – 2016	Δ SIR ('17 – '21 vs. '12 – '16)
Whitman	512	411.5	**124**	*114 – 136*	**Higher**	109	+15
Hanson	390	318.1	**123**	*111 – 135*	**Higher**	97	+26
Avon	174	144.3	**121**	*103 – 140*	**Higher**	105	+16
Rockland	642	541.9	**118**	*109 – 128*	**Higher**	119	-1
Abington	571	491.5	**116**	*107 – 126*	**Higher**	103	+13
West Bridgewater	286	247.7	**115**	*102 – 130*	**Higher**	109	+6
Holbrook	380	329.8	**115**	*104 – 127*	**Higher**	117	-2
Halifax	269	246.6	**109**	*96 – 123*	Not sig.	119	-10
Bridgewater	779	743.0	**105**	*98 – 112*	Not sig.	106	-1
Brockton	2,726	2,593.0	**105**	*101 – 109*	**Higher**	109	-4
East Bridgewater	466	444.7	**105**	*95 – 115*	Not sig.	95	+10
Randolph	1,036	1,005.0	**103**	*97 – 110*	Not sig.	98	+5
Easton	727	705.4	**103**	*96 – 111*	Not sig.	111	-8
Hanover	457	445.0	**103**	*93 – 113*	Not sig.	102	+1
Norwell	362	349.8	**103**	*93 – 115*	Not sig.	101	+2
Canton	763	757.6	**101**	*94 – 108*	Not sig.	106	-5
Stoughton	929	921.2	**101**	*94 – 108*	Not sig.	107	-6
Sharon	523	558.5	**94**	*86 – 102*	Not sig.	93	+1

Method: SIR = 100 × Observed ÷ Expected (MA statewide = 100). Significance = 95% CI excludes 100 (Byar's). Sex-specific cancers use single-sex totals. Source: Massachusetts Cancer Registry, MA DPH - City/Town SIR series; computed from town Observed/Expected counts.

= incidence significantly higher than Massachusetts (95% confidence interval lower bound above 100).

Cancer Incidence by Site, Service Area vs. Massachusetts

Cancer Site	Observed	Expected	Service Area SIR	95% CI	Excess vs. MA	Significant vs. MA
All cancers combined	11,992	11,254.6	107	105 – 108	+737	Higher
Stomach	197	159.0	124	107 – 142	+38	Higher
Multiple Myeloma	208	173.1	120	104 – 138	+35	Higher
Lung and Bronchus	1,707	1,503.4	114	108 – 119	+204	Higher
Esophagus	151	134.8	112	95 – 131	+16	Not sig.
Larynx	81	72.8	111	88 – 138	+8	Not sig.
Prostate (male)	1,627	1,488.3	109	104 – 115	+139	Higher
Hodgkin Lymphoma	63	58.4	108	83 – 138	+5	Not sig.
Leukemia	350	325.5	108	97 – 119	+24	Not sig.
Brain and Other Nervous System	166	154.7	107	92 – 125	+11	Not sig.
Non-Hodgkin Lymphoma	507	472.1	107	98 – 117	+35	Not sig.
Kidney and Renal Pelvis	415	388.3	107	97 – 118	+27	Not sig.
Testis (male)	56	52.1	107	81 – 140	+4	Not sig.
Colon/Rectum	811	765.1	106	99 – 114	+46	Not sig.
Pancreas	376	358.8	105	94 – 116	+17	Not sig.
Oral Cavity and Pharynx	323	308.4	105	94 – 117	+15	Not sig.
Cervix Uteri (female)	55	53.0	104	78 – 135	+2	Not sig.
Liver and Intrahepatic Bile Duct	238	231.8	103	90 – 117	+6	Not sig.
Bladder, Urinary (invasive and in situ)	543	534.0	102	93 – 111	+9	Not sig.
Breast (invasive)	1,808	1,787.1	101	97 – 106	+21	Not sig.
Mesothelioma	21	21.0	100	62 – 153	0	Not sig.
Thyroid	335	337.2	99	89 – 111	-2	Not sig.
Breast (in situ)	453	460.7	98	89 – 108	-8	Not sig.
Melanoma of the Skin^	442	454.4	97	88 – 107	-12	Not sig.

Source: Massachusetts Cancer Registry (MCR), MA DPH. Standardized Incidence Ratio (SIR) compares observed cancer cases in the service area with the number expected based on statewide rates (SIR of 100 = equal to Massachusetts).

= incidence significantly higher than Massachusetts (95% confidence interval lower bound above 100).

Note: SIR above 100 indicates higher incidence than Massachusetts; below 100 indicates lower. A result is statistically significant ("Higher") only when the entire 95% confidence interval lies above 100. Excess vs. MA is the difference between observed and expected cases. ^ Melanoma may be under-reported. Sex-specific sites are noted.

Housing Affordability and Quality

Municipality	Cost-Burdened Households %	Severely Cost-Burdened %	Substandard Housing %	Vacant Housing %	% in HOLC-Graded Areas
Abington	32.9%	14.8%	33.3%	1.4%	0.0%
Avon	25.9%	13.3%	27.4%	0.4%	0.0%
Bridgewater	30.8%	12.8%	32.3%	3.5%	0.0%
Brockton	40.4%	19.6%	45.4%	4.5%	97.1%
Canton	26.8%	15.7%	28.5%	2.4%	0.0%
East Bridgewater	26.0%	10.5%	26.1%	2.3%	0.0%
Easton	29.4%	11.9%	30.4%	0.6%	0.0%
Halifax	29.9%	11.7%	31.1%	4.7%	0.0%
Hanover	24.6%	12.7%	24.7%	2.3%	0.0%
Hanson	30.6%	13.0%	32.1%	1.3%	0.0%
Holbrook	38.0%	17.5%	38.3%	0.3%	0.0%
Norwell	27.6%	14.1%	28.8%	3.7%	0.0%
Randolph	35.8%	14.1%	37.9%	2.5%	0.0%
Rockland	29.2%	13.8%	29.5%	3.4%	0.0%
Sharon	21.8%	7.7%	24.1%	3.3%	0.0%
Stoughton	39.4%	21.6%	41.0%	3.8%	0.0%
West Bridgewater	29.9%	14.8%	31.5%	1.0%	0.0%
Whitman	30.7%	12.2%	31.8%	4.0%	0.0%
Service Area	**33.3%**	**15.5%**	**35.4%**	**3.1%**	**25.7%**
Massachusetts	**33.1%**	**16.0%**	**35.0%**	**8.2%**	**26.7%**
United States	**29.8%**	**14.3%**	**32.5%**	**10.1%**	**14.3%**
Bristol County	**33.2%**	**15.9%**	**35.2%**	**4.6%**	**0.0%**
Norfolk County	**30.9%**	**14.9%**	**32.8%**	**4.0%**	**32.9%**
Plymouth County	**31.4%**	**14.7%**	**33.1%**	**6.9%**	**19.3%**

Source: U.S. Census Bureau, American Community Survey (ACS) 2020 – 2024 Five-Year Estimates. Historic redlining (HOLC) grades: University of Richmond, Mapping Inequality project.

= value notably above the service area average or state average (health-need indicators only).

Environmental Health Indicators

Municipality	Respiratory Hazard Index Score	Tree Canopy % (pop-weighted)	% in High-Burden EJ Tracts
Abington	0.22	51.8%	0.0%
Avon	0.23	47.5%	0.0%
Bridgewater	0.21	53.1%	0.0%

Brockton	0.22	29.9%	13.8%
Canton	0.25	50.4%	0.0%
East Bridgewater	0.21	58.3%	0.0%
Easton	0.22	62.9%	0.0%
Halifax	0.20	52.9%	0.0%
Hanover	0.21	63.4%	0.0%
Hanson	0.21	61.0%	0.0%
Holbrook	0.23	55.0%	0.0%
Norwell	0.21	68.0%	0.0%
Randolph	0.25	37.7%	0.0%
Rockland	0.22	49.4%	0.0%
Sharon	0.23	63.2%	0.0%
Stoughton	0.23	46.2%	18.9%
West Bridgewater	0.22	53.7%	0.0%
Whitman	0.22	47.5%	0.0%
Service Area	**0.22**	**46.8%**	**5.0%**
Massachusetts	**0.25**	**38.5%**	**16.4%**
United States	**0.31**	**21.7%**	**23.0%**
Bristol County	**0.21**	**38.0%**	**30.3%**
Norfolk County	**0.26**	**43.0%**	**2.1%**
Plymouth County	**0.21**	**47.4%**	**5.6%**

Source: Respiratory hazard index: U.S. EPA AirToxScreen, 2019. Tree canopy: USDA / U.S. Forest Service National Land Cover Database, 2023. Environmental justice tracts: U.S. EPA EJScreen, CDC, 2024.

= value notably above the service area average or state average (health-need indicators only).

Food Insecurity Rate and Meal Gap

Municipality	Households	Food-Insecure Households	Food Insecurity Rate %	Annual Meal Gap	Unmet Meals (after distribution)
Abington	6,083	1,310	22.0%	464,000	351,271
Avon	1,653	150	9.0%	52,000	0
Bridgewater	8,690	1,640	19.0%	580,000	343,726
Brockton	35,092	10,900	31.0%	3,846,000	0
Canton	9,305	1,340	14.0%	473,000	144,874
East Bridgewater	4,949	1,090	22.0%	385,000	293,281
Easton	8,993	2,010	22.0%	710,000	519,315
Halifax	2,930	300	10.0%	107,000	0
Hanover	4,744	960	20.0%	339,000	312,742

Hanson	3,920	490	13.0%	174,000	9,791
Holbrook	4,712	630	13.0%	221,000	0
Norwell	3,567	260	7.0%	91,000	88,662
Randolph	12,150	2,620	22.0%	926,000	201,646
Rockland	6,654	1,680	25.0%	592,000	438,997
Sharon	6,395	530	8.0%	187,000	65,422
Stoughton	11,277	1,870	17.0%	659,000	173,895
West Bridgewater	2,726	430	16.0%	152,000	86,058
Whitman	5,684	1,410	25.0%	497,000	234,989
Service Area	**139,524**	**29,620**	**21.2%**	**10,455,000**	**3,264,669**
GBFB Eastern-MA region - household-weighted (Boston-dominated)	**2,048,712**	**562,240**	**27.4%**	**198,355,000**	**82,348,259**
GBFB Eastern-MA region - typical community (median town)			**18.0%** (mean 19.4%)		

Source: Greater Boston Food Bank, The Cost of Hunger in Massachusetts, 2025 (based on 2024 survey data).

= value notably above the service area average or state average (health-need indicators only).

SNAP Enrollment and Participation

Municipality	SNAP Households	SNAP Clients (people)	Population (ACS, 2020 – 2024)	SNAP Participation Rate %	Share of MA SNAP Caseload %
Abington	937	1,356	17,053	8.0%	0.16%
Avon	419	658	4,774	13.8%	0.08%
Bridgewater	1,318	2,169	28,471	7.6%	0.25%
Brockton	16,703	27,069	105,386	25.7%	3.12%
Canton	1,200	1,886	24,748	7.6%	0.22%
East Bridgewater	673	1,068	14,456	7.4%	0.12%
Easton	891	1,340	25,316	5.3%	0.15%
Halifax	371	570	7,748	7.4%	0.07%
Hanover	448	587	14,845	4.0%	0.07%
Hanson	421	626	10,660	5.9%	0.07%
Holbrook	1,041	1,568	11,380	13.8%	0.18%
Norwell	190	252	11,361	2.2%	0.03%
Randolph	4,223	6,335	34,878	18.2%	0.73%
Rockland	1,251	1,980	17,701	11.2%	0.23%
Sharon	593	897	18,574	4.8%	0.10%

Stoughton	2,295	3,519	29,225	12.0%	0.41%
West Bridgewater	419	643	7,708	8.3%	0.07%
Whitman	854	1,334	15,295	8.7%	0.15%
Service Area	34,247	53,857	399,579	13.5%	6.21%
Massachusetts	546,505	867,747	7,044,056	12.3%	100.00%

Source: Massachusetts Department of Transitional Assistance (DTA), SNAP Caseload by ZIP Code Reports, April 2026 (individuals enrolled; municipal totals accessed via Project Bread). Population denominators: U.S. Census Bureau, American Community Survey (ACS) 2020 – 2024 Five-Year Estimates.

= value notably above the service area average or state average (health-need indicators only).

Birth Outcomes, Clinical and Delivery Indicators

Municipality	Live Births (2013 – 2022)	Breastfed at Hospital %	Low + Very Low Birth Weight %	Preterm (<37 wk) %	All C-Section Rate %	Elective C-Section %	Adequate Prenatal Care %
Abington	1,977	86.9	6.8	8.4	37.6	20.7	88.2
Avon	511	87.5	8.3	7.5	37.2	20.2	78.9
Bridgewater	2,350	87.0	7.0	8.1	34.8	25.1	86.2
Brockton	14,589	89.7	11.0	9.9	34.2	15.6	71.6
Canton	2,537	92.2	7.8	9.0	31.8	19.7	83.5
East Bridgewater	1,291	86.6	6.5	8.3	37.6	21.2	88.0
Easton	1,877	90.2	6.4	8.1	33.7	20.4	84.1
Halifax	674	85.6	8.6	12.5	33.1	23.7	87.7
Hanover	1,317	89.4	6.2	7.7	35.1	24.8	90.4
Hanson	930	87.6	7.9	10.7	37.3	24.8	90.0
Holbrook	1,256	87.0	10.2	9.8	34.5	15.5	85.7
Norwell	1,109	91.2	6.8	7.9	34.3	26.4	88.3
Randolph	3,757	90.5	11.6	11.3	34.3	16.3	74.4
Rockland	1,929	84.1	7.6	8.3	36.2	21.4	87.4
Sharon	1,460	93.2	6.5	7.7	27.4	23.0	84.9
Stoughton	3,047	90.3	8.8	8.8	35.4	19.6	79.6
West Bridgewater	740	89.9	7.1	8.4	34.1	16.0	86.8
Whitman	1,557	85.6	8.7	9.4	39.2	26.8	88.4
Service Area	42,908	89.2	9.1	9.3	34.6	19.2	79.9
Massachusetts	699,531	86.3	8.5	8.8	31.1	21.1	80.8

Source: Massachusetts Department of Public Health (MA DPH), Massachusetts Birth Outcomes Data of Residents; 10-year pooled data, 2013 – 2022. All indicators are percentage of live births unless otherwise noted.

= value notably above the service area average or state average (health-need indicators only).

Birth Outcomes, Prenatal Care, Behaviors, and Pregnancy Conditions

Municipality	Public Prenatal Funding %	WIC during Pregnancy %	Smoking during Pregnancy %	Alcohol during Pregnancy %	Gestational Diabetes %	Obesity Prior to Pregnancy %
Abington	27.3	17.6	5.3	2.8	7.9	24.1
Avon	33.6	25.9	4.7	2.2	7.0	24.1
Bridgewater	24.3	15.9	5.1	2.2	8.2	25.5
Brockton	70.9	61.1	4.6	1.4	7.7	27.8
Canton	15.8	11.5	1.3	4.2	6.3	15.7
East Bridgewater	24.9	17.0	5.4	2.7	8.9	28.4
Easton	17.1	12.1	2.4	3.6	5.9	18.6
Halifax	22.8	11.9	7.0	2.4	6.7	22.6
Hanover	8.7	4.5	2.2	3.2	7.3	14.8
Hanson	18.8	14.3	5.7	2.9	6.9	25.8
Holbrook	31.6	26.6	5.1	2.0	8.1	26.8
Norwell	7.0	3.4	1.4	5.2	5.7	12.1
Randolph	46.6	42.8	2.8	2.0	7.0	29.8
Rockland	35.2	26.0	8.0	2.6	7.7	25.9
Sharon	7.7	5.8	0.6	3.5	7.2	11.5
Stoughton	34.9	26.6	3.2	2.7	7.3	25.4
West Bridgewater	21.9	12.8	4.3	2.8	6.5	23.5
Whitman	30.3	20.2	7.8	2.4	7.9	26.8
Service Area	**41.6**	**33.9**	**4.2**	**2.4**	**7.4**	**24.7**
Massachusetts	**38.1**	**31.6**	**4.7**	**3.4**	**6.7**	**21.8**

Source: Massachusetts Department of Public Health (MA DPH), Massachusetts Birth Outcomes Data of Residents; 10-year pooled data, 2013 – 2022. All indicators are percentage of live births unless otherwise noted.

= value notably above the service area average or state average (health-need indicators only).

Birth Outcomes, Birthing Person Demographics

Municipality	Birthing Person under 20 %	Birthing Person 35+ %	Foreign-Born Birthing Person %	White, non-Hispanic %	Black, non-Hispanic %	Hispanic %	Asian / Pacific Islander %
Abington	1.2	25.4	19.4	80.3	6.0	8.4	3.7
Avon	2.5	25.1	26.6	59.1	24.0	9.7	5.8
Bridgewater	0.9	23.8	11.2	82.2	9.4	5.0	2.5
Brockton	4.8	22.7	54.5	19.4	59.6	15.9	2.4

Canton	0.5	36.7	24.1	68.1	12.2	6.1	12.7
East Bridgewater	1.2	23.9	9.4	88.0	5.2	3.7	2.3
Easton	0.6	29.0	13.4	79.9	8.4	6.3	4.4
Halifax	0.7	18.9	4.5	95.4	0.4	3.1	0.6
Hanover	0.3	34.0	6.0	93.0	1.4	2.4	2.8
Hanson	1.1	24.9	6.0	91.4	2.0	3.2	2.6
Holbrook	2.1	27.7	27.9	60.7	21.6	10.0	6.4
Norwell	0.3	41.1	6.8	90.6	1.4	3.9	3.3
Randolph	1.6	27.6	48.8	19.8	50.4	14.4	13.9
Rockland	1.7	21.3	19.8	80.0	5.1	10.2	2.9
Sharon	0.3	37.1	33.2	68.6	4.5	3.8	21.9
Stoughton	1.3	27.8	35.2	53.1	22.4	14.2	8.3
West Bridgewater	1.1	27.5	8.6	88.0	6.1	3.1	1.4
Whitman	1.7	21.6	10.7	85.2	6.1	4.9	2.8
Service Area	**2.4**	**26.3**	**33.4**	**52.2**	**30.1**	**10.6**	**5.4**
Massachusetts	**2.6**	**25.7**	**30.2**	**59.2**	**10.2**	**19.8**	**9.6**

Source: Massachusetts Department of Public Health (MA DPH), Massachusetts Birth Outcomes Data of Residents, 2013 – 2022. All indicators are percentage of live births unless otherwise noted.

Note: Race and ethnicity reflect the birthing person as recorded on the birth record; categories may not sum to 100% because not all categories are shown.

= value notably high for this column relative to other towns in service area.

Infectious Disease Rates

Indicator	Service Area	Massachusetts	United States	Bristol County, MA	Norfolk County, MA	Plymouth County, MA
Chlamydia Infections	**370.04**	412.70	492.20	348.55	274.92	418.64
Gonorrhea Infections	**110.22**	139.80	179.00	113.60	90.00	119.70
Population with HIV / AIDS	**250.71**	352.70	386.60	280.70	232.10	256.80
Primary and Secondary Syphilis Infections	**7.05**	10.60	15.80	7.60	4.90	8.00
TB Infections	**3.22**	3.20	2.80	3.10	3.70	3.00

Source: Massachusetts Department of Public Health (MA DPH) and U.S. Centers for Disease Control and Prevention (CDC) surveillance data. All values are rate per 100,000 population.

Immunization Coverage and Exemptions

Measure	Service Area (weighted)	Massachusetts	Bristol	Norfolk	Plymouth
A. Childcare / Preschool (ages ~3 – 5; county programs)					
DTaP (4 doses)	95.7%	96.4%	97.1%	97.4%	94.9%
Polio (3)	96.2%	97.0%	98.1%	97.7%	95.4%
MMR (1)	96.4%	97.5%	98.2%	98.3%	95.5%
Hib (3)	95.5%	96.6%	97.6%	97.7%	94.4%
Hep B (3)	95.9%	96.8%	97.9%	97.9%	94.9%
Varicella (1)	96.2%	97.1%	98.0%	98.1%	95.3%
Series complete	93.7%	94.4%	95.8%	95.9%	92.5%
Medical exemption	0.2%	0.1%	0.1%	0.1%	0.2%
Religious exemption	1.3%	1.2%	0.9%	0.9%	1.5%
Total exemption	1.4%	1.3%	1.0%	1.0%	1.7%
Un-immunized	0.8%	0.8%	0.6%	0.5%	1.0%
Non-compliance	4.8%	4.3%	3.2%	3.0%	5.8%
B. Grade 7					
MMR (2)	98.1%	98.1%	98.5%	98.9%	97.8%
Hep B (3)	98.2%	98.2%	98.6%	99.1%	97.9%
Varicella (2)	98.0%	98.0%	98.2%	99.0%	97.7%
Tdap (1)	93.3%	94.0%	94.9%	95.8%	92.0%
MenACWY (1)	92.1%	93.1%	94.5%	95.0%	90.5%
Series complete	91.0%	91.7%	93.6%	94.3%	89.3%
Medical exemption	0.2%	0.1%	0.2%	0.3%	0.1%
Religious exemption	1.1%	1.1%	1.3%	0.8%	1.3%
Total exemption	1.3%	1.3%	1.4%	1.1%	1.4%
Un-immunized	0.3%	0.3%	0.4%	0.2%	0.3%
Non-compliance	7.6%	7.0%	5.0%	4.6%	9.3%
C. Grade 12					
MMR (2)	97.5%	98.0%	98.6%	98.5%	97.1%
Hep B (3)	97.5%	97.5%	98.3%	98.5%	97.1%
Varicella (2)	97.4%	97.5%	97.9%	98.4%	97.0%
Tdap (1)	97.5%	97.6%	97.8%	98.3%	97.3%
MenACWY (1)	90.5%	90.8%	92.2%	92.1%	89.7%
Series complete	88.9%	89.2%	90.3%	90.9%	87.9%
Medical exemption	0.1%	0.2%	0.2%	0.2%	0.1%
Religious exemption	0.9%	1.1%	0.9%	0.7%	1.0%
Total exemption	1.1%	1.3%	1.1%	1.0%	1.2%
Un-immunized	0.3%	0.2%	0.2%	0.2%	0.3%
Non-compliance	9.9%	9.5%	8.6%	8.1%	10.9%

Source: Massachusetts Department of Public Health (MA DPH), School Immunization Survey, SY2025-26, by county (Childcare/Preschool, Grade 7, and Grade 12).

Note: This table compares regional and county rates rather than individual towns, so comparison columns are shown side by side. Service area figures are population-weighted county estimates (Plymouth 62.7%, Norfolk 30.9%, Bristol 6.3% of the service area population; Bristol = Easton only).

Commute, Mode of Transportation to Work

Municipality	Drove Alone %	Carpooled %	Public Transit %	Walked %	Bicycle %	Taxi / Ride-hail / Other %	Worked from Home %
Abington	72.2%	6.3%	3.6%	0.8%	0.4%	1.4%	15.1%
Avon	71.2%	8.7%	5.7%	4.0%	0.0%	0.0%	10.3%
Bridgewater	72.9%	5.8%	1.4%	5.6%	0.2%	1.4%	12.7%

Brockton	70.7%	12.5%	4.7%	1.4%	0.0%	3.9%	6.9%
Canton	57.3%	5.9%	8.4%	0.8%	0.2%	1.9%	25.7%
East Bridgewater	71.2%	6.9%	2.0%	0.9%	0.1%	1.6%	17.3%
Easton	68.2%	4.9%	3.1%	2.1%	0.0%	0.7%	21.0%
Halifax	72.6%	7.3%	1.8%	2.6%	0.0%	1.7%	13.9%
Hanover	73.8%	2.8%	2.5%	0.1%	0.4%	1.0%	19.6%
Hanson	83.1%	6.1%	0.9%	0.8%	0.2%	1.0%	7.9%
Holbrook	71.9%	6.8%	5.1%	1.6%	0.0%	2.6%	12.1%
Norwell	60.5%	5.4%	4.4%	2.1%	0.0%	0.5%	27.1%
Randolph	65.0%	7.4%	7.9%	1.0%	0.2%	3.4%	15.1%
Rockland	75.0%	6.3%	1.6%	1.0%	0.1%	1.4%	14.7%
Sharon	46.8%	5.6%	12.8%	1.6%	0.2%	1.4%	31.5%
Stoughton	67.0%	10.0%	4.3%	1.9%	0.0%	1.4%	15.4%
West Bridgewater	81.4%	5.6%	0.2%	0.5%	0.0%	0.6%	11.6%
Whitman	73.2%	8.6%	2.4%	1.6%	0.1%	3.3%	10.8%
Service Area	**68.8%**	**8.1%**	**4.5%**	**1.7%**	**0.1%**	**2.3%**	**14.6%**

Source: U.S. Census Bureau, American Community Survey (ACS) 2020 – 2024 Five-Year Estimates.

Mortality and Injury, Crude Rates per 100,000 (2020 – 2024)

Indicator	Service Area*	MA	U.S.	Bristol County	Norfolk County	Plymouth County	Notes
FIREARM DEATHS (2020 – 2024)							
Firearm Deaths - Crude Rate per 100k	~3.9	3.8	14.0	4.6	2.4	4.6	5-yr total: 78 deaths in service area
Firearm Deaths - Male Rate per 100k	-	7.0	24.2	8.5	4.4	8.7	
Firearm Deaths - Female Rate per 100k	-	0.8	3.9	0.8	No data	No data	
Firearm Deaths - Black Rate per 100k	-	11.6	32.3	11.5	7.6	11.5	
Firearm Deaths - White Rate per 100k	-	3.1	13.1	4.0	1.9	3.7	
HOMICIDE DEATHS (2020 – 2024)							
Homicide - Crude Rate per 100k	~2.3	2.4	7.1	2.6	1.3	2.7	5-yr total: 46 deaths in service area
SUICIDE DEATHS (2020 – 2024)							
Suicide - Crude Rate per 100k	~10.0	9.0	14.5	11.2	7.9	10.9	5-yr total: 200 deaths in service area
Suicide - Male Rate per 100k	-	14.1	23.3	18.4	12.5	16.7	
Suicide - Female Rate per 100k	-	4.1	5.9	4.3	3.5	5.3	
DRUG OVERDOSE DEATHS (2020 – 2024)							
Drug Overdose - Crude Rate per 100k	~31.0	32.9	29.4	45.1	23.2	33.4	5-yr total: 622 deaths in service area; Bristol Co. notably elevated
Drug Overdose - Male Rate per 100k	-	48.1	41.5	66.3	33.9	48.6	
Drug Overdose - Female Rate per 100k	-	18.4	17.5	24.9	13.2	19.0	

Indicator	Service Area*	MA	U.S.	Bristol County	Norfolk County	Plymouth County	Notes
Drug Overdose - Black Rate per 100k	-	46.2	43.7	49.4	23.6	32.9	
Drug Overdose - White Rate per 100k	-	33.3	31.9	45.0	27.8	35.0	
MV CRASH DEATHS (2020 – 2024)							
MV Crash - Crude Rate per 100k	~6.9	6.1	12.9	8.6	5.1	7.5	5-yr total: 137 deaths in service area
UNINTENTIONAL INJURY DEATHS (2020 – 2024)							
Unintentional Injury - Crude Rate per 100k	~61.5	62.3	64.3	76.0	52.2	64.6	5-yr total: 1,232 deaths; includes overdose, crashes, falls
DEATHS OF DESPAIR (2020 – 2024)							
Deaths of Despair - Crude Rate per 100k	~53.1	54.4	59.2	74.2	41.4	56.6	Deaths of Despair = Suicide + Drug poisoning + Alcohol poisoning; 5-yr total: 1,063

Source: CDC National Vital Statistics System, accessed via CDC WONDER, 2020 – 2024. *Note: This table compares regional, state, and county rates rather than individual towns, so comparison columns are shown side by side. Town-level mortality data is suppressed for most indicators due to small numbers.*

**Service area figures are approximate aggregates. "Deaths of Despair" = suicide + drug poisoning + alcohol poisoning.*

Childhood Lead Screening and Blood Lead Prevalence by Town, CY2024

Municipality	Population 9 – 47 months	Children Screened	% Screened	Elevated ≥5 µg/dL (% screened)	Lead Poisoning ≥10 µg/dL (% screened)	% Pre-1978 Housing
Abington	615	563	92%	NS	0.0%	62%
Avon	156	149	96%	NS	0.0%	79%
Bridgewater	814	729	90%	NS	NS	42%
Brockton	4,700	3,444	73%	3.9%	0.9%	79%
Canton	806	737	91%	0.0%	0.0%	49%
East Bridgewater	481	340	71%	NS	NS	52%
Easton	699	606	87%	NS	NS	47%
Halifax	252	224	89%	0.0%	0.0%	45%
Hanover	493	404	82%	NS	NS	55%
Hanson	294	248	84%	0.0%	0.0%	54%
Holbrook	371	296	80%	NS	0.0%	78%
Norwell	410	397	97%	NS	0.0%	64%
Randolph	1,211	845	70%	NS	0.0%	67%
Rockland	648	507	78%	NS	NS	68%
Sharon	657	455	69%	NS	0.0%	59%
Stoughton	937	777	83%	0.9%	NS	68%
West Bridgewater	232	199	86%	NS	0.0%	64%
Whitman	553	419	76%	2.0%	NS	72%
Service Area	14,329	11,339	79%	see note	see note	—

Massachusetts	232,249	171,171	74%	1.2%	0.3%	66%

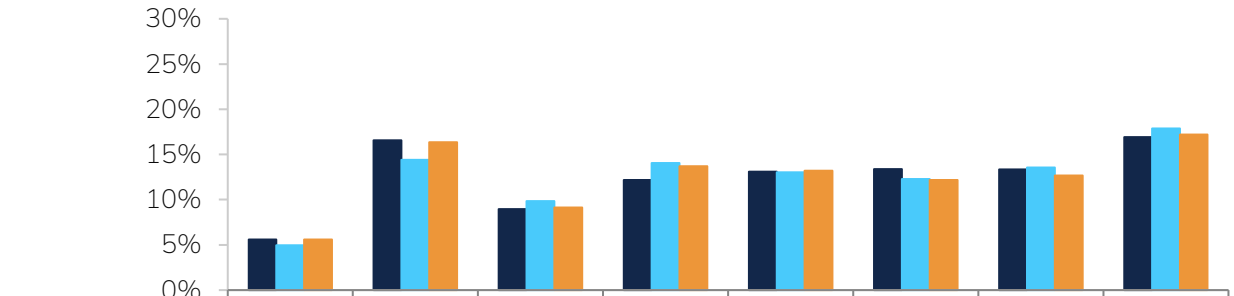
Source: 2024 Annual Childhood Lead Poisoning Surveillance Report, MA DPH Childhood Lead Poisoning Prevention Program (CLPPP), Appendix II (town-level screening and prevalence) and Appendix I (high-risk communities). Children 9 – 47 months of age, calendar year 2024.

= worse than Massachusetts (screening below 74%, or elevated/poisoning prevalence above the state rate).

Measures: % Screened = children 9 – 47 months screened divided by population (UMDI 2020 estimate). Elevated ≥5 µg/dL = estimated confirmed blood lead level of concern; Lead poisoning ≥10 µg/dL = confirmed. Prevalence is shown as a percent of those screened. An exact service area prevalence cannot be summed because most small towns are suppressed (NS) with 1 – 5 cases.

Age Distribution

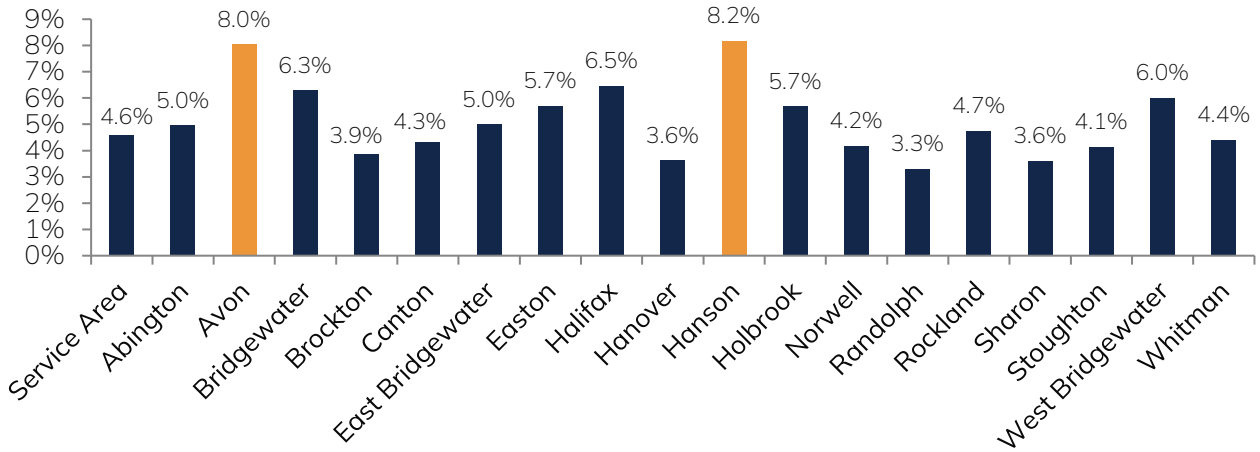
ACS, 2020 – 2024



	0 – 4	5 – 17	18 – 24	25 – 34	35 – 44	45 – 54	55 – 64	65+
Service Area	5.6%	16.6%	9.0%	12.2%	13.1%	13.4%	13.3%	16.9%
Massachusetts	5.0%	14.4%	9.8%	14.1%	13.0%	12.3%	13.6%	17.9%
United States	5.6%	16.3%	9.1%	13.7%	13.2%	12.2%	12.7%	17.2%

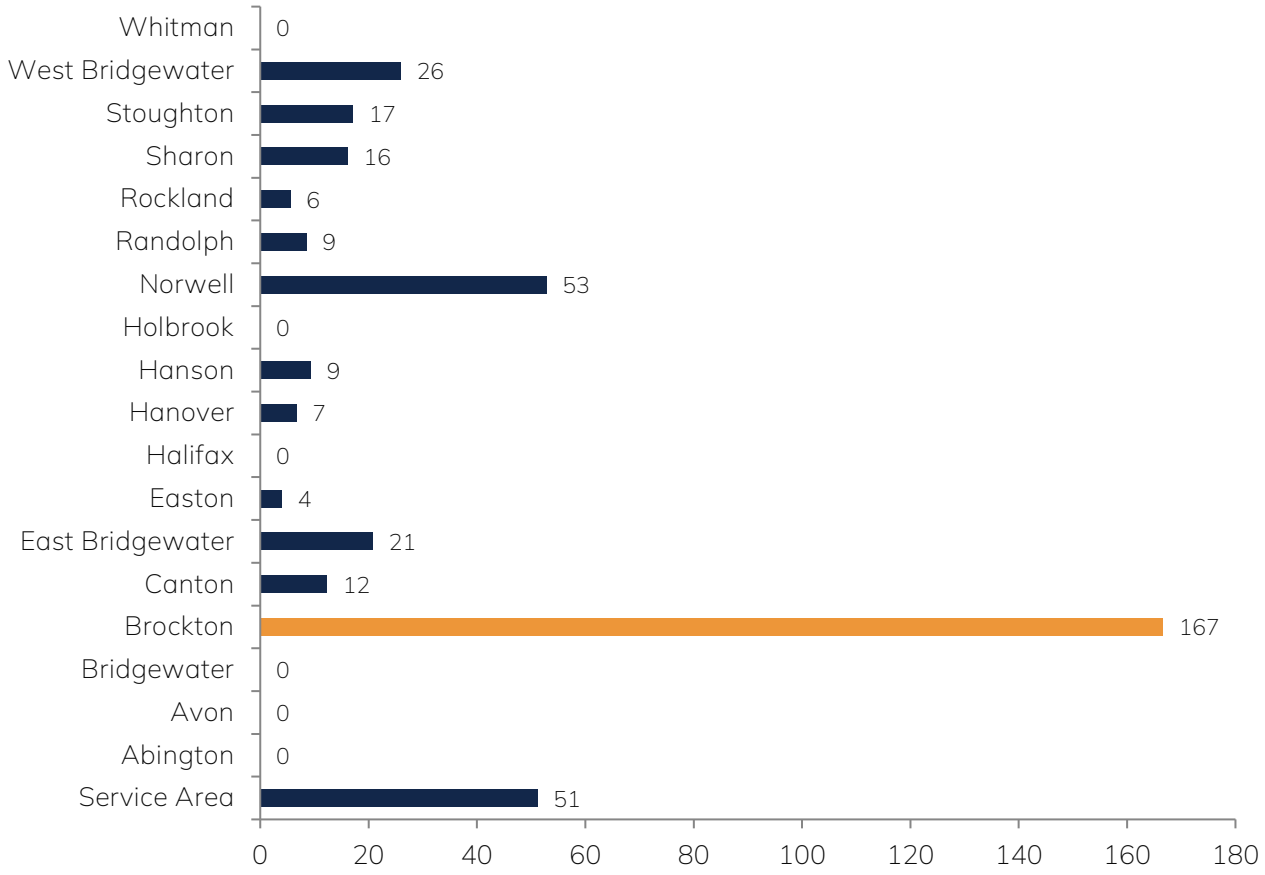
Veteran Population

ACS, 2020 – 2024



SUD Providers per 100,000

CMS National Plan and Provider Enumeration System (NPPES), March 2026



Owner vs. Renter Occupied Housing

ACS, 2020 – 2024