



Community Health Needs Assessment 2025

Table of Contents

Executive Summary.....	4
Previous CHNA and Prioritized Health Issues	5
Sturdy Health.....	8
Community Health Needs Assessment.....	10
Background and Purpose	10
Social Determinants of Health as a Foundational Framework.....	10
Service Area.....	11
Community Health Needs Assessment Goals	13
CHNA Methodology.....	13
Secondary Data Analysis	13
Primary Data Analysis	14
Community Demographic Profile	16
Population	16
CHNA Findings.....	22
Access to Care	23
Serving the Growing Immigrant Community	25
Chronic Disease Burden	27
Mental Behavioral Health Needs	31
Social Drivers of Health and Health-Related Social Needs.....	35
Next Steps and Recommendations	37
Appendices	40
Appendix A: Environmental Scan Data Sources	40
Appendix B: Sturdy Community Health Survey and Report	42
CHNA and Community Planning Survey.....	43
Community Survey Results Summary	45
Community Survey Detailed Results	47
Appendix C: Key Informant Response	56

Executive Summary

The Community Health Needs Assessment (CHNA) conducted by Sturdy Health from January to June 2025 aims to address the health and social needs of the community for the years 2025-2028. This assessment is the foundation for Sturdy Health's Community Benefit Program (CBP) and Community Health Improvement (CHI) projects, which are required by federal and state rules for nonprofit hospitals¹.

Key Findings:

- **Chronic Disease Burden:** The service area has high rates of chronic diseases, including high blood pressure, coronary heart disease, high cholesterol, diabetes, obesity, and chronic obstructive pulmonary disease. These conditions are often associated with obesity and smoking, and Bristol County, where there is a significant portion of Sturdy Health's service area, is less physically active and has a higher prevalence of smokers than neighboring Norfolk County.
- **Behavioral Health Needs:** There is a significant unmet need for mental health and substance use services. The service area has wide variation in access to mental health providers compared to county, state, and national benchmarks, and many residents report poor mental health status.
- **Access to Care:** Residents face variable access to primary care, and have low access to mental healthcare, drug treatment, and specialty care. The patient-to-primary care provider ratio in Bristol County is twice that of Norfolk County, and preventable emergency department utilization is high.
- **Health-Related Social Needs:** Housing affordability and food security emerged as significant concerns. More than one-third of homeowners and renters are housing cost-burdened. Many older adults live alone, and a notable number have expressed uncertainty about where to turn for help if needed.

Community Feedback:

- **Access to Care:** Survey respondents and key informants highlighted the need for more primary care providers, mental health services, and drug treatment facilities.
- **Health Education:** There is a demand for culturally responsive health education provided by community health workers and peer recovery specialists.
- **Social Isolation:** There is an ongoing crisis of social isolation, particularly among older adults, children, and youth, that could be addressed through community engagement.

Recommendations:

- **Increase Healthcare Access:** Identify opportunities to expand primary care and build on behavioral health access and resources, especially among populations with health-related social needs (HRSN), or other conditions that make them more vulnerable to adverse outcomes.

- **Support Affordable Housing:** Collaborate with local organizations to address affordable housing shortages and improve housing stability.
- **Explore Becoming an “Age-Friendly Health System”:** Consider how to orient health and human service providers to the unique needs of older adults to help address preventable emergency department utilization and other needs specific to the population.
- **Address Social Isolation:** Work with partners to fund initiatives that bring isolated individuals together, leverage local resources, and help residents understand the services and facilities available.

Previous CHNA and Prioritized Health Issues

Sturdy Health’s CHNA in 2022 evaluated the needs of the individuals in the hospital’s service area and identified the following priority health issues:

- Access to Care
- Behavioral Health and Substance Abuse
- Chronic Disease Management and Prevention
- Cancer Prevention Education and Screening

In response, Sturdy took several steps within the health system and in partnership with external partners to address community health improvement priorities. They included:

- Established the Department of Population Health.
- Addition of a director of quality and population health in ambulatory care (outpatient) services.
- Recruited 42 new clinicians and established clinical partnerships to expand access, including twenty-seven (27) primary care providers [including MDs/DOs, and APPs], five (5) cardiologists, one (1) gastroenterologist, seven (7) obstetricians, and two (2) orthopedists.
- Established external partnerships to expand access to sub-specialty services, including University Orthopedics for spine services, and Prima Care Vascular for vascular services.
- Addition of an ambulatory care clinical pharmacist to establish collaborative practices in co-management of patients with chronic diseases.
- Integration of nurse care managers in ambulatory clinics via strategic partnerships with accountable care organizations to facilitate care transitions and support patients in the community.
- Pursued and received \$15,000 in grant funding from Novo Nordisk for diabetes education and a continuous glucose monitoring program from 2022 to 2025.
- Awarded a cumulative \$45,000 from Coverys, Demoulas Foundation, and BayCoast Bank; and earned 2 grants of \$500,000 each from Community Health Systems Foundation and the Lloyd G. Balfour Foundation to advance maternal health equity and labor and delivery services.

- Integrated and standardized health-related social needs screening across health system settings (inpatient, emergency department, and outpatient/ambulatory care visits).
- Developed and implemented continuity-of-care workflows to support patient follow-up with primary care or behavioral health providers after an emergency department visit and inpatient discharge.
- Hired and embedded a Patient Navigator in the Emergency Department to assist patients with substance use disorder to facilitate access to ongoing care.
- Collaborated with the YMCA on several health and wellness programs, including chronic conditions management and nutrition education for diabetes and hypertension, including distribution of packaged food boxes with meal plans for at risk patients; and a direct referral system into the Y's LIVESTRONG cancer survivorship community program.
- Collaborated with HopeHealth to launch a Palliative Care awareness campaign.
- Awarded twelve grants to patients with Breast Cancer to support continued care through Ellie's Fund.
- Continued support of the Breathe Easy Pulmonary Clinic to provide patient education and support.
- Provided Cancer Care Navigator Services.
- Held PSA campaigns for breast cancer awareness, participating in Gloria Gemma Event, Breast Cancer Walk with employee and patient teams, webinar on proactive screenings and advertisements to promote regular screenings and mammograms.
- Coordinated four blood drives.
- Launched a Triple Aim Initiative focused on heart disease, stroke prevention, and education initiatives.
- Supported immediate basic needs of infants in the local refugee population, providing car seats, clothing, and blankets.
- Connected birthing people to a Maternal Care Navigator to assist during the perinatal period, reaching 50 patients.
- Expanded our collection of resources and databases to create comprehensive guides providing patients and their families with community resources for housing, food, financial insecurities, and behavioral health services.

Prioritized issues of the 2019 CHNA

- Access to Care
- Behavioral Health and Substance Abuse
- Chronic Disease Management and Prevention
- Cancer Prevention, Education and Screening

Major outcomes of the 2019 CHNA Priorities:

- Hired 9 providers, including four (4) primary care physicians, two (2) pulmonologists and two (2) obstetrician/gynecologists.
- Focused on access to care as related to cost of oral chemotherapy drugs. In FY 2020, through nurse navigator and social worker assistance, 23 patients were provided funding for oral chemotherapy in the amount of \$252,398.52.

- Sturdy Memorial Hospital and Associates launched telehealth services via a HIPAA approved Zoom platform in response to the COVID-19 mandated service restrictions. Over 20,000 telehealth visits were conducted.
- There were 556 substance abuse disorder patients directed to Column Health averaging 10.5 intakes per week. A total of 9,373 visits and 4,807 telehealth visits were provided for substance use disorder patients.
- *Ladies Night* - An education event related to Breast Cancer Awareness was held with over 125 women in attendance. Showcased a panel of 3 provider presenters including Drs. Latif, Whitby and Saunders.
- The program launched a Cardio-oncology program and enhanced breast imaging services through a partnership for completion of Breast MRI. Offered early detection and prevention by providing breast cancer screenings – 7,210 mammograms performed in fiscal year 2019.
- 221 outpatient orders/referrals occurred from the Sturdy Health practices into the Diabetes Management Program.

Prioritized Health Issues 2016

- | | |
|-------------------------|---------------------------------|
| ▪ Cancer | ▪ Overweight/Obesity |
| ▪ Diabetes | ▪ Substance Abuse/Alcohol Abuse |
| ▪ Mental Health/Suicide | |

Major Outcomes from the 2016 CHNA Priorities

- Held Cancer Survivors Day Event and sponsored Relay for Life events yearly.
- Developed and distributed 1,500 educational brochures in April 2017 that highlighted the dangers of opioid use, as well as provided education on alternatives available for managing pain. An additional 1,500 brochures were distributed in October 2017.
- In January 2018, the hospital began to monitor opioid prescribing patterns of providers with a 45% decrease in prescribing of opioids in the Emergency Care Center (ECC).
- Partnered with Column Health to provide outpatient addiction treatment to the community and opened a site in April 2019. As of May 31, 2019, the clinic had registered 52 patients.
- From year to date of fiscal year 2019, there were a total of 184 initial patient consults and 1,598 follow-up visits with the Sturdy Wellness Weight Management Program.
- Since the Sturdy Wellness Weight Management Program's start in May 2016, a total of 39 patients had undergone bariatric surgery

Sturdy Health

Established in 1913, Sturdy Health is an independent, nonprofit health system comprised of a 142-bed acute care hospital, 25 primary and specialty care medical practices, and an urgent care center dedicated to providing safe, high-quality, cost-efficient healthcare services to the residents and visitors of Southeastern Massachusetts and neighboring Rhode Island. In 2024, 8,490 patients received inpatient care at our hospital. There were 52,160 visits to the Emergency Department, and volunteers worked more than 42,660 hours.

Sturdy Health ensures that ample primary and specialty services are accessible to approximately 294,201 area residents in suburban communities 45 minutes from Boston and 15 minutes from Providence, RI. Currently, more than 200 highly qualified physicians and advanced practice providers deliver care across 25 locations throughout the region. With more than 2,000 employees throughout the health system, Sturdy Health is one of Attleboro's largest employers. In 2025, Sturdy Health was named by *Becker's Hospital Review* as one of their "100 Great Community Hospitals," and one of the top 150 places to work in healthcare. Sturdy Health strives to be an organization that not only employs but also empowers its employees to hold themselves accountable for their actions, while developing a sense of ownership and pride in what they do each day. Employees who represent ownership do what needs to be done because they expect it of themselves. This is reflected in Sturdy Health's mantra, "I Am Sturdy."

The hospital provides leadership while working in cooperation with public and private healthcare organizations to avoid costly duplication of services and civic and business organizations to meet the healthcare needs of area communities. Sturdy Health is licensed by the State of Massachusetts to provide acute care hospital services and has earned a reputation as a high-quality institution offering the finest standards of care. It is nationally accredited by DNV-GL Healthcare and meets or exceeds patient safety standards set forth by the Centers for Medicaid and Medicare Services (CMS) and has received an "A" Leapfrog Safety Grade in 2024 and 2025, a score achieved by just 34% of hospitals across the country.

Sturdy Health has also received the American Heart Association Bronze Award and the American Stroke Association Silver Plus Achievement Award. Sturdy affiliated physicians have achieved the Harvard Pilgrim Health Honor Roll.

Our Mission

"We improve the health and well-being of the people in our communities through kindness, compassion, and convenient access to the highest quality care."

Our Vision

"We will be a trusted partner to our patients, communities, and each other — inspiring hope and enabling better health and quality of life."

Our Values

Sturdy Health's approach to comprehensive health care for our community embraces these values:

- **Courage & Caution:** We push the boundaries of what is possible, while keeping the safety of our patients and colleagues at the forefront of everything we do.
- **Improvement & Excellence:** We continuously learn, develop, and improve as we passionately pursue excellence each and every day.
- **Partnership & Independence:** We partner with people on their path to health and healing, and we honor their independence by respecting their privacy, perspectives, and preferences.
- **Connection & Community:** We build trusting and enduring relationships with our patients, communities, and each other, deepening our roots and growing our reach to meet the evolving needs of our region.
- **Listening & Communication:** We listen with empathy and communicate with clarity and kindness — creating a safer, more inclusive, and equitable environment in which to deliver and receive care.
- **Stewardship & Sustainability:** As stewards of our patients' and communities' healthcare resources, we never stop working to improve health, increase value, and forge a more sustainable future.

In line with its mission to invest in the health and wellness of the community, Sturdy is currently implementing a multi-year master space plan. The system is renovating and adding facilities that will transform the patient and care team member experience and ensure greater access to care. A \$60 million, state-of-the-art, 60,000+ square-foot medical office building, located next to the hospital, is scheduled to open in Fall 2025. And construction is underway on a \$113 million modernization and expansion of the emergency department, which will increase capacity to 38,000 square feet, including 54 patient exam rooms, a dedicated 12-bed behavioral health unit, covered parking, and a new helipad.

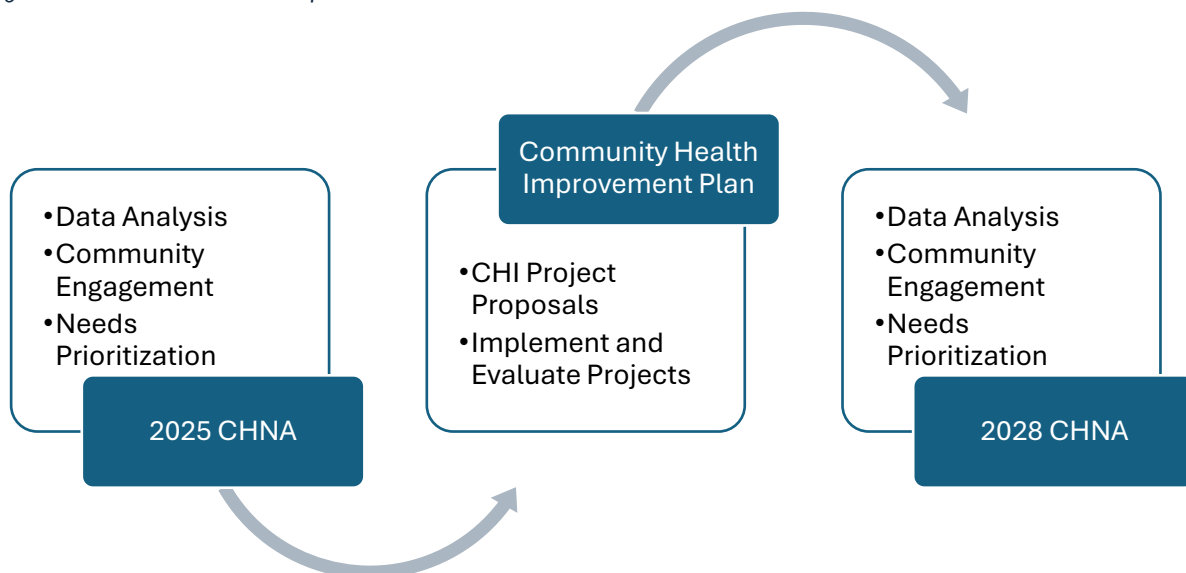
Learn more at www.sturdyhealth.org.

Community Health Needs Assessment

Background and Purpose

From January to June 2025, Sturdy Health conducted its community health needs assessment (CHNA) for the years 2025-2028. The CHNA is the foundation of Sturdy's Community Benefit Program (CBP) and Community Health Improvement (CHI) projects. The CBP and the CHI projects aim to address the health and social needs of Sturdy's community, and Federal¹ and State² rules require all nonprofit hospitals to have CBPs. The foundation for a hospital's community benefits program is a CHNA that must be conducted every three years. The CHNA examines health and community data and seeks feedback from community members to better understand the community's health needs. This information, along with input from the Community Benefit Advisory Council (CBAC), helps the health system bring the lived experiences of community members into the needs assessment process and ensures that community health improvement strategies and activities are not only data-informed but community-driven. Sturdy's CBAC includes members of the population served and is reflective of the racial, ethnic, cultural, socioeconomic, and age diversity of the community. Massachusetts requires that all nonprofit hospitals establish a CBAC. See Figure 1 for the CHNA to CHI process timeline for 2025-2028.

Figure 1 CHNA to CHI Process Map



Social Determinants of Health as a Foundational Framework

Sturdy Health recognizes that health is largely determined by conditions outside a hospital or ambulatory clinic. Access to high quality healthcare services, affordable and safe housing,

¹ Legal Requirements for Section 501(c)(3) Hospitals. (2024, April 15). <https://www.congress.gov/crs-product/R48027>

² The Attorney General's Community Benefit Guidelines for Non-Profit Hospitals (2018, February) <https://www.mass.gov/doc/updated-nonprofit-hospital-community-benefits-guidelines/>

financial security, healthy social environments, good schools, and education are critical to a person's health over their lifetime. With this in mind, the U.S. Centers for Disease Control and Prevention's Social Determinants of Health (SDOH) framework³ shown in Figure 2 was utilized to guide the development of the CBAC and the CHNA's community engagement plan.

Comprehensive and effective community benefits programs require the input of many voices. In recruiting community members to the CBAC and CHNA community engagement process, Sturdy Health worked to ensure engagement of local voices and perspectives for each domain of SDOH framework. CBAC members

Figure 2 CDC SDOH Framework



were recruited from public education, physical and behavioral healthcare providers, local government, housing, transportation, food security, services for the aging and people with disabilities, private sector employers, social services, and community and economic development.

Service Area

Sturdy Health serves any person who requires care, regardless of their place of residence. Located in the City of Attleboro in Bristol County, Massachusetts, Sturdy Health defines its community as the twelve municipalities across the primary and secondary service areas whose residents receive care from Sturdy Health.

Municipalities in the **primary service area include Attleboro, Mansfield, North Attleboro, Norton, Rehoboth, and Seekonk in Bristol County, and Foxborough, Plainville, and Wrentham in Norfolk County.** Sturdy Health's ambulatory care services also draw some patients from **Taunton** in Bristol County and **Raynham** in Norfolk County. The municipalities of **Norfolk, Sharon, and Walpole in Norfolk County make up the secondary service area.** Figures 3 & 4 show maps of Sturdy's primary and secondary service areas and Figure 5 lists associated zip codes.

³ U.S. Centers for Disease Control and Prevention (2024). Social Determinants of Health. Accessible at <https://www.cdc.gov/public-health-gateway/php/about/social-determinants-of-health.html>

Table 1 Sturdy Service Area Zip Codes

Primary Service Area		
Municipalities	Zip Code	County
Attleboro	02703	Bristol
Foxborough	02035	Norfolk
Mansfield	02048	Bristol
North Attleborough	02760	Bristol
	02761	
	02763	
Norton	02766	Bristol
Plainville	02762	Norfolk
Rehoboth	02769	Bristol
Seekonk	02771	Bristol
Wrentham	02093	Norfolk
Raynham	02767	Bristol
Taunton	02780	Bristol

Figure 3 Sturdy Primary Service Area Map

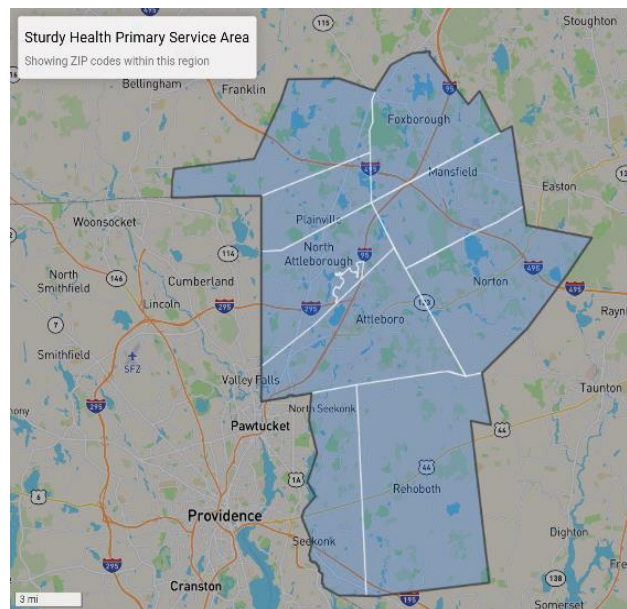
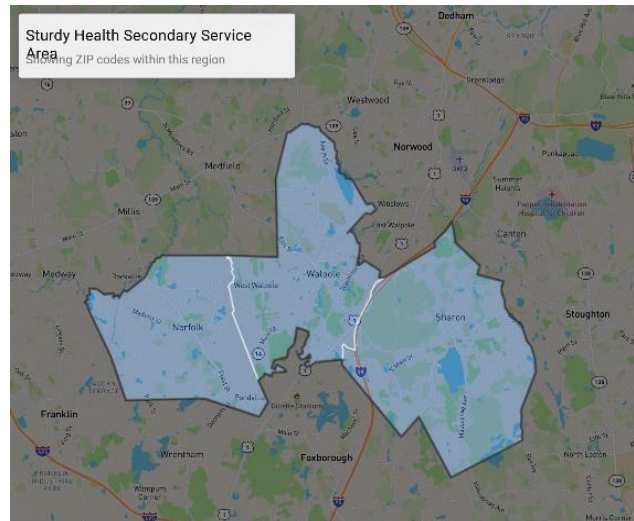


Figure 4 Sturdy Secondary Service Area Map

Secondary Service Area		
Municipalities	Zip Code	County
Norfolk Town	02056	Norfolk
Sharon Town	02067	Norfolk
Walpole Town	02081	Norfolk



Community Health Needs Assessment Goals

Sturdy Health's CHNA set out to answer these questions:

- What are the pressing health problems in the service area? What subpopulations are most at risk for these problems?
- What factors are driving those health problems?
- What resources are available to address health problems?
- What are the gaps in resources needed to meet community health needs?
- How can Sturdy Health partner with others to meet these needs?

CHNA Methodology

To understand community health needs, Sturdy Health used a mixed-methods approach that included quantitative and qualitative analysis of secondary data sources (see Appendix A) and a qualitative primary data analysis of community members' feedback.

Secondary Data Analysis

Public and internal reports, program descriptions, relevant assessments from other community organizations, and publicly available health, demographic, and economic data to identify community needs, priorities, gaps, and assets were also analyzed to further inform the CHNA. A list of these sources is available in Appendix A.

Table 2 CHNA Background Reports and Data

Internal Data	Description
Inpatient Diagnoses	List of diagnoses by volume.
Emergency Department (ED) Diagnoses and Readmissions	Top 20 diagnoses and return statistics within 72 hours.
Volume and Demographic data	Number of unduplicated patients by gender, age, language, race/ethnicity, payor.
Third Next Available Appointment (TNAA) data	For each Sturdy Health ambulatory clinic site.
Patient-centered Assessment and Plan for Advancing Risk Assessment and Referral Evaluation (PRAPARE) Data	SDoH screening tool that includes race, age, language, migrant farmer status, refugee status, house size, housing situation, housing insecurity, HRSN – childcare, clothing, food, medicine, phone, utilities, education, employment, primary insurance, transportation gap, close contact, stress level, emotional safety.
Mental Health and Substance Use Discharge Data w/ 30-day Follow-up	MH/SUD diagnoses with days to follow-up.

Environmental Scan of Publicly Available Reports and Data

Sturdy Health also conducted an extensive review of publicly available health, demographic, and economic data from sources including the U.S. Census American Community Survey, CDC

Behavioral Risk Factor Surveillance System, Massachusetts Department of Health Data, and County Health Rankings, among other sources. These sources assisted with understanding community demographics, social economic, environmental conditions, and health needs across the service area. A full list of data sources and measures is included in Appendix A.

Primary Data Analysis

Community Survey

Sturdy Health conducted a community survey to gather insights on community member needs, service gaps, and opportunities for improvement. The survey was hosted online and programmed utilizing Qualtrics, a specialized survey software. The survey was available between March and June of 2025. The survey was available in English, Spanish, Portuguese, Arabic, and Haitian Creole, and was made available to the community through a combination of emails to Sturdy's mailing list of patients and community members, social media posts, flyers with QR Codes posted throughout Sturdy's facilities, as well as at community partner's facilities, and through word of mouth. Community based organizations and other community partners, including the City of Attleboro government, also distributed the survey through coordinated outreach on their mailing lists and social media channels. The complete text of the survey is included in Appendix B.

Key Informant Interviews & Focus Group

Interviews with individual community clinical and social service leaders, and a focus group with community leaders on the Community Benefit Advisory Council used standardized questions. This process elicited in-depth perspectives from more than 20 community leaders on local needs, priorities, assets, and health improvement recommendations to understand real time issues not reflected in other information sources.

Research Partner

Sturdy Health engaged Health Management Associates (HMA), an independent, national research and consulting firm in the healthcare industry with expertise in community engagement and community health improvement. Headquartered in Michigan and with offices throughout the United States, HMA has over 40 years of experience providing technical assistance, resources, and decision support.

Landscape Literature & Secondary Sources

Health, demographic, and economic, data indicators and other quantitative figures came from a variety of public and private sector sources including local government, community-based organizations, state and national research and advocacy organizations. Sources included:

- CDC data
- City of Attleboro reports
- County Health Rankings
- Federal Reserve Economic Data
- Feeding America
- HRSA data
- Institute for Community Health
- Local needs assessments
- Massachusetts County Health Assessments
- Massachusetts Health Data
- Mental Health America
- U.S. Census data

Community Representation

Throughout the CHNA process, Sturdy worked to ensure community voices and input were engaged and incorporated into its findings. Sturdy sought community input through a public survey, key informant interviews, and a focus group of community leaders that included members of the Community Benefit Advisory Committee. Community partners throughout the service area, including government offices, community-based organizations, and local associations, assisted in distributing the survey.

Research Limitations

Secondary data analysis: Data was captured at the Zip-Code Tabulation area (ZCTA) level to the extent feasible and aggregated into primary and secondary service areas along Sturdy Health's definitions for each. For some health and social indicators, the most recent publicly available data was at the County level rather than ZCTA, which may present a less precise indicator of need since Sturdy's service area a) borders two counties (Bristol and Norfolk) and b) is smaller than either individual county alone. Wherever possible, numeric data is presented as an adjusted (e.g., age adjusted, population-adjusted, etc.) rate rather than a crude rate or count. Indicators will specify where the quantity given is at an adjusted rate.

Primary data analysis: Community survey data was collected via non-random sampling techniques, which presents both advantages and disadvantages. Among the advantages are ease of implementation, flexibility, practicality for increasing access to harder to reach populations to ensure engagement, and utility for gathering qualitative information from which insights can be gathered. Disadvantages include limitations on generalizability. These benefits and limitations noted, non-random sampling is still a recommended method for gathering qualitative data when the purpose of the information gathering is to generate detailed insights.⁴

⁴ Qualtrics. (n.d.). "What is Non-Probability Sampling? Everything You Need to Know." Accessible at <https://www.qualtrics.com/experience-management/research/non-probability-sampling/>

Community Demographic Profile

Population

Sturdy's service area is home to over 294,201 residents. Approximately 24% of the population is under 19 years old and 18% is over 65 years old. The median age is 42; and 50% of the community is identified as female.

Table 3 Total Population Breakdowns by Age, (U.S. Census, 2023 5-Year Estimate)

Age	US	MA	Primary Service Area	Secondary Service Area	Combined Service Area
	334,914,895	7,066,568	257,273	49,737	307,010
Under 5 years	5.70%	5.00%	4.9%	5.9%	5.06%
5 to 9 years	6.00%	5.20%	5.1%	7.2%	5.44%
10 to 14 years	6.50%	5.70%	6.4%	7.2%	6.53%
15 to 19 years	6.60%	6.50%	7.0%	7.2%	7.03%
20 to 24 years	6.50%	6.80%	5.7%	3.3%	5.31%
25 to 34 years	13.70%	14.10%	11.8%	9.5%	11.43%
35 to 44 years	13.10%	12.90%	12.5%	14.9%	12.89%
45 to 54 years	12.30%	12.60%	13.8%	14.6%	13.93%
55 to 59 years	6.40%	7.00%	7.5%	7.3%	7.47%
60 to 64 years	6.40%	6.80%	7.4%	6.7%	7.29%
65 to 74 years	10.00%	10.30%	10.8%	9.7%	10.62%
75 to 84 years	4.90%	4.90%	4.7%	4.5%	4.67%
85 years and over	1.90%	2.20%	2.5%	2.0%	2.42%
Median age (years)	38.7	40	42	42	42

89.2% of the total service area population is Non-Hispanic White; 5.8% are Asian, 5.7% are Black, 5.5% are another race, and about 4.7% are Hispanic of any race.

Table 4 Race/Ethnicity (U.S. Census, 2023 5-Year Estimate)

Race/Ethnicity	US	MA	Primary Service Area	Secondary Service Area	Combined Service Area
White	73.40%	78.90%	89.8%	86.5%	89.2%
Black or African America	14.40%	10.10%	5.8%	4.6%	5.7%
American Indian Alaska Native	2.20%	1.00%	0.4%	0.3%	0.4%
Asian	7.20%	8.30%	3.9%	9.9%	5.8%
Native Hawaiian or Pacific Islander	0.50%	0.10%	0.1%	0.2%	0.1%
Some other race	13.90%	12.20%	5.7%	4.0%	5.5%
Hispanic or Latino	19%	12.9%	4.8%	4.2%	4.7%

There are fewer persons with Limited English Proficiency (LEP) than statewide or nationally.

Table 5 Limited English Proficiency (U.S. Census 2023)

	US	MA	Primary Service Area	Secondary Service Area	Combined Service Area
LEP Residents (%)	8	10	4.73	3.88	4.59
LEP Households (%)	4	6	2.47	3.14	2.57
LEP Spanish Speaking Households (%)	3	2	0.66	0.4	0.56
LEP Spanish Speaking Residents (%)	5	4	1.30	.25	1.13
LEP Asian Languages Households (%)	1	1	0.35	1.26	0.49
LEP Asian Languages Residents (%)	2	2	0.76	1.03	0.80

Household and average family size is relatively consistent with state and national rates.

Table 6 Households by Type (U.S. Census 2023)

Household Type	US	MA	Primary Service Area	Secondary Service Area	Combined Service Area
Total Households	127,482,865	2,762,070	99,685	17,121	116,806
Average household size	2.54	2.45	2.537*	2.791*	2.574*
Average family size	3.15	3.04	3.024*	3.253*	3.058*
Married-couple household	35,014,662	788,685	50,639	11,642	62,281
Male householder, no spouse/partner present	19,839,684	455,067	15,493	1,519	17,012
Female householder, no spouse/partner present	9,806,069	231,831	25,822	3,345	29,167
Householder living alone	127,482,865	2,762,070	13,313	2,304	15,617
65 years and older living alone	60,193,570	1,275,950	7,523	1,391	8,914
Children living with grandparents (% of children)	7.91	6.28	5.98	2.38	5.21
Grandparents responsible for grandchildren (% of residents 30+)	1.06	0.64	0.473	0.22	0.419

Housing costs are consistent with state and national rates but may vary within regions.

Table 7 Housing Characteristics (U.S. Census 2023)

	US	MA	Primary Service Area	Secondary Service Area	Combined Service Area
Owner Occupied Units	82,892,037	1,728,986	8,230	4,796	13,026
Housing units with a mortgage	61%	67%	67%	71%	68.5%
Housing Units without a mortgage	39%	33%	33%	29%	31.6%
Households spending 30% + income on housing	--	--	29%	28%	28.7%
Median Value (dollars)	303,400	525,800	492,164	606,243	\$549,204 *simple average
Renter Occupied Units	44,590,828	1,033,084	3,888	1,083	4,971
Median gross rent (dollars)	1,348	1,687	1,551	1,821	1,610

There are fewer children living in poverty than statewide or national levels.

Table 8 Families/People, Income Below Poverty Level in Past 12 Months (U.S. Census 2023)

Families in Poverty	US	MA	Primary Service Area	Secondary Service Area
All families	8.7%	6.6%	2.6%	5.2%
Married couple families	4.5%	3.0%	3.1%	2.9%
Families with female householder, no spouse present	23.7%	19.1%	--	18.7%
All people	12.4%	10.0%	5.1%	5.3%
Under 18 years	16.3%	11.8%	2.6%	4.9%
18 to 64 years	11.6%	9.3%	4.7%	5.1%
65 years and over	10.4%	10.2%	8.9%	6.6%
With Food Stamp/SNAP benefits in the past 12 months	11.8%	13.8%	2.2%	5.3%

Unemployment in the primary service area is significantly lower than state/national rates.

Table 9 Employment Status, Population 16 Years and Older (U.S. Census 2023)

Occupational Group	US	MA	Primary Service Area	Secondary Service Area
Population 16 years and older in labor force	169,855,626	3,892,683	7,634	8,836
% of population in labor force	63.5%	67.2%	69.7%	67.2%
Civilian labor force	63.5%	67.1%	69.7%	67.1%
Armed forces	0.5%	0.1%	--	0.1%
% of population not in labor force	36.5%	32.8%	30.3%	32.8%
Unemployed civilian labor force	5.2%	5.1%	3.5%	5.2%

Most residents are employed in management, business, science, or the arts.

Table 10 Estimated Major Occupational Groups: Population 16 Years and Older (U.S. Census 2023)

Occupational Group	US	MA	Primary Service Area	Secondary Service Area
Management, business, science, and arts	42%	50.8%	48%	58.2%
Service	16.5%	15.6%	14.3%	9.7%
Sales and office	19.9%	17.7%	13.9%	19.7%
Natural resources, construction, and maintenance	8.6%	6.8%	13.8%	6.3%
Production, transportation, material moving	13%	9.1%	9.9%	6.1%

Residents have health insurance coverage at significantly higher rates than nationally, which is consistent with Massachusetts' statewide coverage levels.

Table 11 Health Insurance Coverage (U.S. Census 2023)

Insurance Status	US	MA	Primary Service Area	Secondary Service Area
With health insurance coverage	299,424,402	6,743,422	12,519	15,523
% population with health insurance	91.4%	97.4%	97.8%	99.2%
% With private health insurance	67.3%	73.8%	83.2%	87.5%
% With public coverage	36.3%	37.1%	26.2%	26.9%
% Population without health insurance	8.6%	2.6%	2.2%	0.8%

The ratio of resident per primary care provider is far higher in Bristol County than in Norfolk County, Statewide, and the U.S. The preventable hospital utilization rate is also higher.

Table 12 Clinical Care Rankings (County Health Rankings 2023)

Clinical Care Area	US	MA	Bristol County	Norfolk County
Uninsured (Population <65 years)	10%	3%	3%	2%
Population to primary care physician ratio	1,330:1	990:1	1,980:1	840:1
Population to dentist ratio	1,360:1	910:1	1,460:1	810:1
Population to mental health provider ratio	300:1	130:1	170:1	140:1
Preventable hospital stays per 100,000	2,666	3,196	3,755	3,065
Flu vaccinations	48%	58%	55%	61%
Mammography screening	44%	54%	58%	55%

Cancer and heart disease are the leading causes of death.

Table 13 Crude Death Rates per 100,000 for Selected Causes of Death (MA DPH 2022)

Causes of Death	MA	Bristol County	Norfolk County
Total cancer	12,424	1,223	1,259
Heart disease	12,409	1,174	1,185
Stroke	2,391	241	259
Chronic lower respiratory disease	2,374	261	224
Diabetes	1,501	158	122
Influenza & pneumonia	934	78	90
Motor vehicle	477	53	41
Homicide	172	17	7
Suicide	624	70	54
Opioid-related	2,314	273	157

Bristol County has higher lung and prostate cancer rates than Norfolk County and state averages.

Table 14 Age-Adjusted Cancer Incidence Rates by Site, per 100,000 (National Cancer Institute 2017-2021)

Cancer Type	MA	Bristol County	Norfolk County
Breast	136.2	124.2	147.4
Bladder	20.7	22.3	20.3
Colon & Rectum	31.3	32.5	33.7
Lung & Bronchus	56.6	65.8	55.7
Pancreas	13.9	15.1	14.6
Melanoma	17.7	12.2	22.3
Prostate	113.3	125.5	119
Cervix	4.8	5.7	4.1
Uterus	28.3	29.3	26.6
All sites	437.2	453.8	454.3

Bristol County's rates for both low birth weight and maternal mortality exceed state and national measures; maternal mortality for Non-Hispanic Black women in Norfolk County exceeds statewide rates but is lower than the national figure.

Table 15 Maternal/Child Health (MA DPH 2016-2022)

Maternal/Child Health Indicator	US	MA	Bristol County	Norfolk County
Infant mortality rate (per 1,000 live births)	5.6	4.0	4.0	3.0
Low birth weight %	8.4%	7.6%	8.6%	6.9%
Low birth weight, % Hispanic or Latino	7.6%	8.4%	10.2%	7.6%
Low birth weight, % Non-Hispanic Asian	8.9%	8.4%	10.5%	8.1%
Low birth weight, % Non-Hispanic American Indian/ Alaska Native	8.2%	10.6%	16.7%	No data
Low birth weight, % Non-Hispanic Black	14.3%	11%	11.7%	10.2%
Low birth weight, % Non-Hispanic Native Hawaiian/Other Pacific Islander	8.6%	No data	No data	No data
Low birth weight, % Non-Hispanic White	7%	6.4%	7.5%	5.9%

Norfolk County's Tuberculosis rate is elevated relative to State and national rates.

Table 16 Cases of Tuberculosis (TB) Disease and Incidence Rates per 100,000 (MA DPH 2022)

	US	MA	Bristol County	Norfolk County
Number of tuberculosis cases	9,633	224	18	27
Tuberculosis case rate	2.8	3.2	3.1	3.7

Opioid dispensing rates are higher in Bristol County than in Norfolk and statewide.

Table 17 Opioid Dispensing Rates per 100 Persons (CDC Overdose Prevention by year)

	US	MA	Bristol County	Norfolk County
2023	37.5	28.6	34.4	23.2
2022	39.5	30.8	36.5	23.7
2021	42.0	32.6	39.3	23.9
2020	43.2	32.9	41.1	24.2

Bristol County residents smoke, use alcohol, and are less active than those in Norfolk County, statewide, and nationally.

Table 18 Health Factors and Behaviors (County Health Rankings 2025)

	US	MA	Bristol County	Norfolk County
Adult smoking	13%	11%	15%	10%
Excessive drinking	19%	20%	24%	23%
Alcohol-impaired driving deaths	26%	30%	31%	26%
Adult obesity (BMI >30)	34%	27%	33%	27%
Food environment index	7.4	9.3	8.6	9.5
Physical inactivity	23%	21%	24%	18%
Access to exercise opportunities	84%	95%	90%	94%
Some college	68%	75%	62%	85%
High school completion	89%	91%	86%	94%

Bristol County residents have worse health, and more frequent poor physical and mental health days than those in Norfolk, statewide, and nationally.

Table 19 Quality of Life Rankings (County Health Rankings 2022)

	US	MA	Bristol County	Norfolk County
Poor or fair health	17%	13%	17%	12%
Poor physical health days	3.9	3.6	4.2	3.2
Poor mental health days	5.1	4.9	5.8	4.7

CHNA Findings

Sturdy Health conducted a scan of community health data and a stakeholder engagement to learn about factors like the levels of chronic disease, access to care, and gaps in care in the service area. The stakeholder engagement process included a survey of Sturdy patients and service area residents, key informant interviews with local healthcare leaders, and a focus group of residents and community leaders. These quantitative and qualitative processes helped inform the system's knowledge and understanding of the community's overall health care experience and perception of health needs.

Stakeholders praised Sturdy's recent efforts on population health and health equity. Several key informants and focus group participants noted that Sturdy has made considerable and positive efforts in the post-pandemic period in building relationships with the community, conducting outreach, and working to improve health literacy. Stakeholders cited the addition of staff at Sturdy to address population and community health and health equity as very positive and characterized that effort as "making a difference."

90% of CHNA survey respondents reported seeing a primary care provider in the last 12 months, and 38% of survey respondents reported no barriers to access to care. Most respondents also saw a dental provider in the last year. These findings contrast with community-level data showing high patient-to-provider ratios in Bristol County (which includes several towns in Sturdy's service area), which typically indicate provider shortages.

Findings on chronic disease burden are consistent with stakeholder feedback through surveys. Data on many communities throughout the service area showed high rates of chronic disease burden and unmet behavioral health needs, and survey respondents' perceptions of community health versus their own health were relatively poor.

At the same time, community-level data also showed significant health-related social needs like affordable housing and food security. This finding was corroborated by stakeholder engagement, especially as it related to the needs of older adults and families with children.

Respondents' Top Community Health Concerns

The top four concerns were access to healthcare; chronic health conditions; food & nutrition, and mental health. Each was selected by 60% or more of 478 survey respondents.

1. **Access to Healthcare**
2. **Chronic Health Conditions**
3. **Health related social needs (e.g., Food & Nutrition)**
4. **Mental Health**
5. Housing
6. Substance Use and Addiction
7. Employment
8. Physical Environment
9. Infectious Diseases
10. Violence
11. Social Conditions
12. Discrimination
13. K-12 Education
14. Other

The top community health concerns raised by survey respondents were access to care, chronic conditions, health-related social needs such as food and nutrition, and mental health needs. These were echoed by key informants who highlighted food and nutrition concerns and focus group members who highlighted access to care concerns.

Access to Care

Public data on population health measures in combination with community feedback paint a complex picture of access and barriers to care. County-level data suggest communities in Bristol County have an especially dire primary care workforce shortage, yet survey responses suggest good access to primary care providers. Local data shows strong adherence rates for screening and preventive care, but survey respondents report inability to get appointments, and Sturdy's own utilization data reported long wait times.

Rates of uninsurance are far lower in Sturdy's service area than national or statewide rates, suggesting that lack of insurance is a less prominent barrier to care for Sturdy's community than for other places in the state and across the country. The average uninsured rate for the overall service area is 1.55%. Nearly 2% in the primary service area are uninsured, and less than 1% in the secondary service area. In contrast, nearly 11% of U.S. residents, and 7% of Massachusetts residents, are uninsured. In contrast, most residents of Sturdy's service area have health insurance. Of those individuals who are insured, between 10.9% and 34.2% in the primary service area and 5.4 and 12.6% in the secondary service area receive Medicaid.

Primary Care Access

Quantitative data from local, state, and national health metrics suggest that residents in Sturdy Health's service area may have inadequate access to primary care, mental health care, drug treatment, and specialty care. These findings were echoed in feedback from key informants and focus group participants (see Appendix C to see how one key informant described access).

Survey responses regarding access to care were mixed and presented a mismatch with the dire picture of primary care availability expressed with county-level data. The patient-to-primary care provider ratio in Bristol County is twice that of Norfolk County, with 1,980 persons per provider vs 840:1, and a state rate of 990:1, suggesting large gaps in access. Despite these concerning proportions of provider supply to patient demand, 90% of the CHNA survey respondents reported seeing a primary care provider in the last year, and publicly available data for the service area shows screening adherence that is better than state and national benchmarks for many conditions. The rate of seniors who are up to date with preventive screenings is also equal to or better than state and national figures in most communities; however, emergency department utilization for this population is elevated. Overall emergency department utilization is elevated in three communities, Norton, Raynham, and Taunton. These communities are part of an overlapping service area with other hospitals and health systems located in and around Taunton.

At the same time, however, survey respondents reported barriers to access, and recent utilization data show significant wait times for appointments. The average time to the Third Next Available

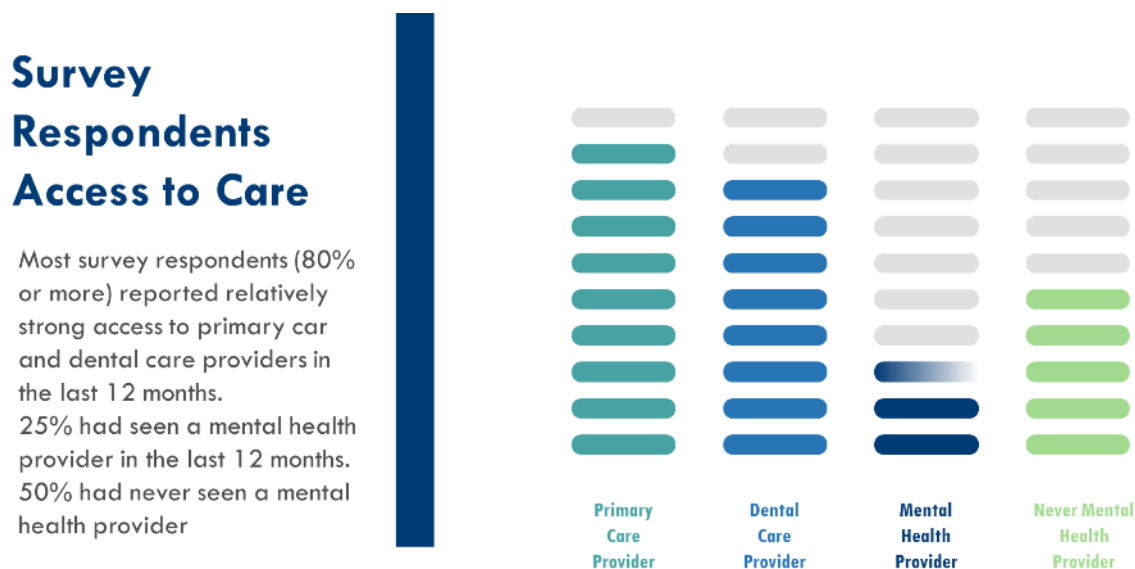
Appointment (TNAA), a measure of access, was 47 days for established patients and 88 days for new patients. Waits for appointments as long as 201 days for an established patient and 205 days for a new patient were also reported⁵.

Table 20: Access to Care, Screenings, and Utilization provide more detail on insurance coverage, screening rates, prevention measures, and emergency department utilization for both the overall population and Medicare beneficiaries (older adults, people with disabilities). One area of concern observed for older adults is the rate of emergency department utilization and preventable hospital stays by Medicare beneficiaries in Bristol and Norfolk Counties; both were significantly elevated compared to State and National measures.

Self-Reported Access to Other Services

90% of CHNA survey respondents noted they had seen a primary care provider in the last 12 months. Similarly, 80% of respondents saw a dental or oral health provider, and 25% saw a mental health provider. 50% of respondents had never seen a mental health provider (see chart in Figure 4).

Figure 4 Survey Respondents' Access to Services



SPOTLIGHT ON OLDER ADULTS

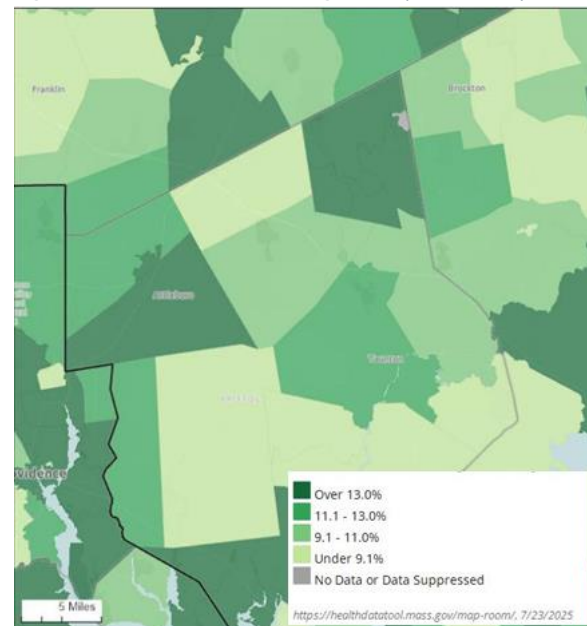
A focus group participant reported that people covered by Medicare are being forced to find providers out of state or the area, and a key informant shared that the service area has just one geriatrician and few advanced practice, nursing, and social work providers specialized in age-friendly care. These gaps in services for older adults may suggest a need for more geriatric care, which could help reduce the high rates of emergency department visits among Medicare beneficiaries in Bristol County (687.99 per 1,000). This measure, which is tracked at the County level, is significantly higher in Bristol than both Norfolk County and State figures. Similarly, Bristol

⁵ Internal report, Sturdy Health.

County has many more preventable hospitalizations among Medicare beneficiaries (3,650) than Norfolk County (3,186) in the same period. Inpatient stays are similar across both counties (Bristol 275:1,000, Norfolk 271:1,000) but higher than statewide rates (259:1,000).

Also of note, Attleboro, Foxboro, Taunton, and Walpole all have many more older adults 65+ living alone than the State or National average. This is a point of concern, given that past studies of the needs of older adults in Attleboro revealed nearly 30% didn't know who in the city to turn to if they needed help⁶. This finding was upheld in focus group and key informant discussions, which reiterated many seniors were unaware of available services, exacerbating their vulnerability.

Figure 5 Older Adults 65+ Living Alone (2019-2023)



Serving the Growing Immigrant Community

Our findings on access to care were further supported by a prior health survey conducted by Attleboro's Literacy Center in June and September 2024. The Literacy Center's survey, which examined health practices and health literacy trends in Attleboro's immigrant community, had 163 respondents. Among its findings were that 48% of respondents had gone to the ER in the past year and most of these visits were for conditions that could be managed by primary care providers; 50% did not have a primary care physician; 75% of respondents did not have a dentist; and 75% did not have access to mental health care.

Respondents to The Literacy Center's survey reported similar barriers around wait times and availability, but also reported some additional barriers, including caregiving responsibilities, getting time off work, and having reliable transportation. Respondents also shared relatively high levels of trust in the US medical system, but low understanding of co-pays, deductibles, or medication management. In addition, recent changes in immigration enforcement policies have had a chilling effect on individuals seeking care, where documented immigrants and other minority residents avoid seeking the care due to fears about Immigration and Customs Enforcement (ICE).

⁶ Center for Social and Demographic Research on Aging, University of Massachusetts, Boston (2020). Aging in the City of Attleboro: A Community Needs Assessment. Available at <https://scholarworks.umb.edu/demographyofaging/44/>

Table 20 Access to Care, Screenings, and Utilization

																Yellow: < MA; > US values Red: > both MA, US values	
Service Area	Primary												Secondary				
Town	Atl.b.	No. Atl.b.	No. Atl.b.	Plain.	Foxxb.	Mnfd.	Nort.	Seek.	Wren	Rehb.	Rayn.	Taun.	Norf.	Shar.	Walp.	MA	US
Condition	02703	02760	02763	02762	02035	02048	02766	02771	02093	02769	02767	02780	02056	02067	02081		
Uninsured	2.99	1.64	.79	2.8	1.76	1.68	1.53	1.48	0.9	2.2	0.28	2.58	0.4	0.82	1.47	2.68	8.55
Medicaid Coverage % residents	24.92	16.83	12.98	20.77	16.63	16.63	12.91	14.26	13.01	10.91	16.04	34.24	5.4	10.41	12.6	22.86	20.68
Colorectal Cancer Screen %	66.9	68.2	72.2	69.6	69.5	69.6	69.2	71.8	73	70.8	70.4	65.8	71.2	70.5	71.9	63.12	58.85
Mammography Use %	83.5	84.3	84.2	83.5	83.9	83.9	85.1	85.5	86.3	85.9	84	85.2	85.2	86.7	85.8	83.4	75.65
Pap Smear Use %	84.30	85.7	86.8	87.7	87.4	87.7	85.4	86.4	88.5	87.2	86.2	88.6	88.6	88.9	87.9	85.14	82.3
Cholesterol Screening %	88.6	89.4	90	90.1	90.3	90.7	88.4	90.9	91.5	91.2	90.3	87	90.5	92.8	91.2	87.19	83.65
Seniors up to date on preventive screening %	43.7	45.9	47	45	44	49.1	47	47.3	42.6	48.8	46.6	45.4	45.4	46.7	43.2	44.44	37.67
Visited doctor for routine checkup %	83.6	83.6	84.6	79.8	80.5	83.6	83.2	84.1	80.8	84.3	84.1	83	80.2	81.8	80.6	78.04	74.04
Emergency Department Utilization per 100	34.77	47.7	31.54	24.12	18.01	18.97	50.74	11.2	37.34	16.72	53.34	51.67	15.25	15.34	17.21	50.13	47.3
Healthcare Utilization					U.S.		MA		Bristol		Norfolk						
Preventable Hospital Stays					2,666		3,196		3,755		3,065						
Medicare Emergency Department use/1K					583.21		631.85		687		587.69						

Chronic Disease Burden

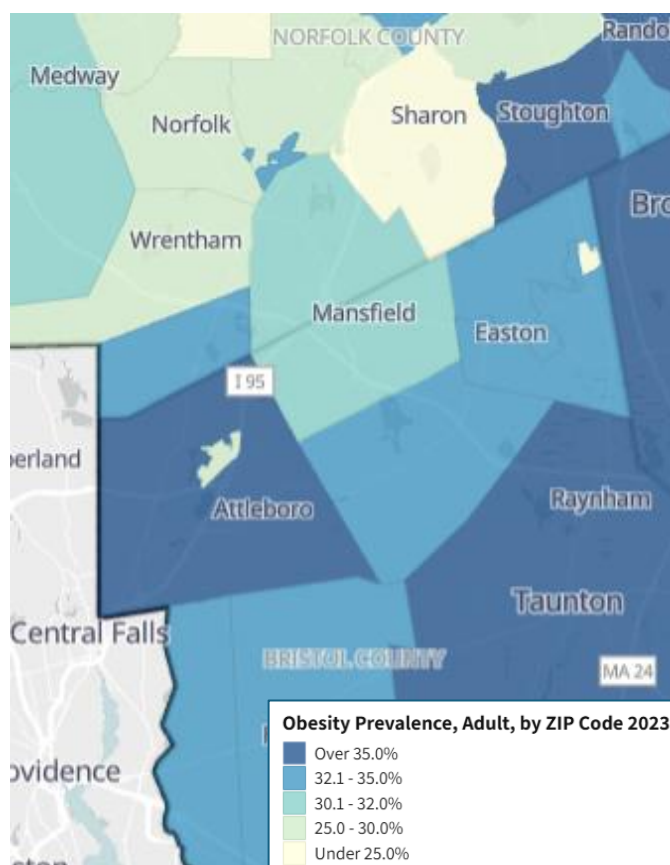
Chronic health conditions are associated with obesity and smoking. The self-reported obesity prevalence in the City of Attleboro Zip Code 02703 is 32.6% compared to 28.5% statewide. Self-reported smoking prevalence in the same Attleboro Zip Code is 13.6% compared to 9.8% in Massachusetts and 11.5% nationwide.⁷ **In fact, communities within Sturdy’s service area in Bristol County consistently fared worse than communities in Norfolk County and worse than Massachusetts-wide rates.** For example, obesity prevalence in Sturdy’s primary service area towns in Bristol County is far higher than that in Norfolk County. For more indicators, see chronic disease data in Table 8.

Coronary heart disease and high cholesterol prevalence, in nearly all communities in the service area, are worse than both the Massachusetts and United States rates. High blood pressure, obesity, and diabetes rates are elevated in many communities at rates better than the US but equal or worse than statewide rates.

The Taunton community, which is primarily served by another health system, but from which Sturdy draws some patients from the region through primary care sites, showed consistently higher prevalence of all common chronic diseases than MA or US figures. Attleboro, Seekonk, and Raynham also demonstrate higher rates across multiple conditions (see Table 20).

In publicly available data, relatively few residents across the service area reported poor physical health, despite clear challenges with high rates of high blood pressure, heart disease, and cholesterol in the same communities. Each of these conditions is referred to as a “silent killer”—a disease that often has no obvious signs or symptoms, but poses major risks for cardiovascular disease, which may be a contributing factor in the disconnect between residents’ outcomes and their perceptions of community-wide health.

Figure 6 Obesity Prevalence by Zip Code



⁷ Cornelius ME, Loretan CG, Jamal A, et al. Tobacco Product Use Among Adults – United States, 2021. MMWR Morb Mortal Wkly Rep 2023;72:475–483. DOI: <http://dx.doi.org/10.15585/mmwr.mm7218a1>.

Sturdy Health – Community Health Needs Assessment 2025

Table 21 Chronic Disease and Health Status

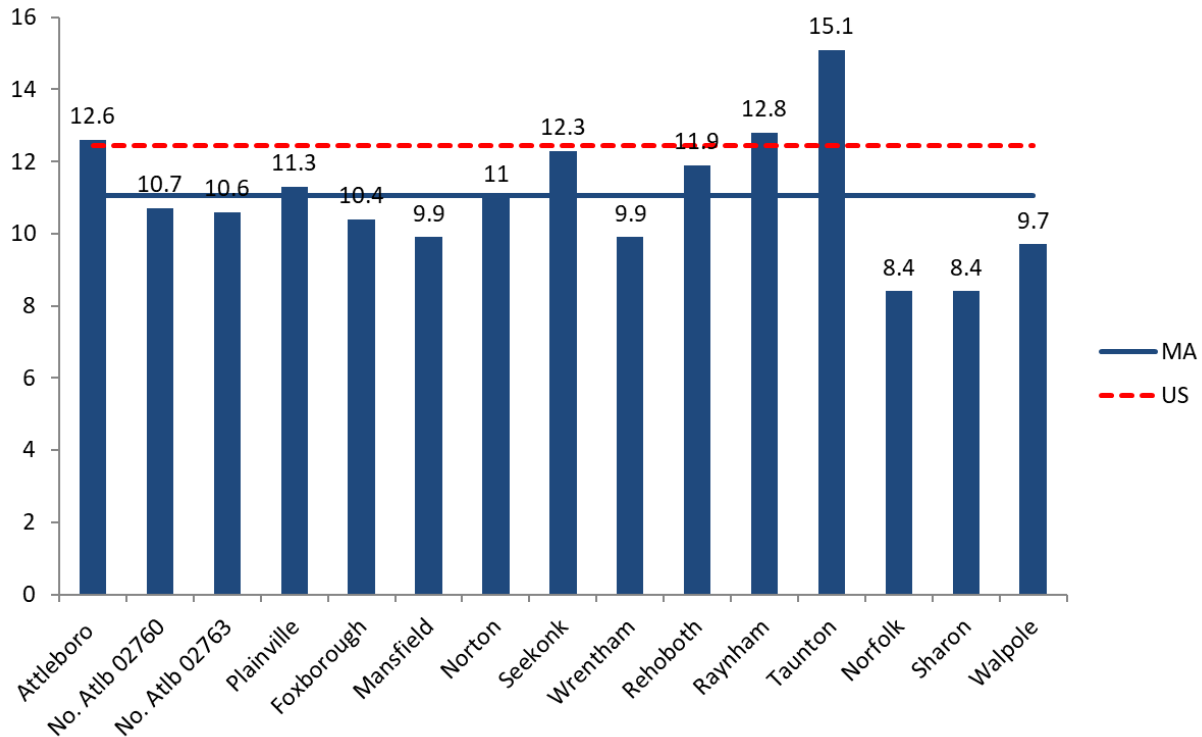
Town	Atlb.	No. Atlb.	No. Atlb.	Plain.	Foxb.	Mnfd.	Nort.	Seek.	Wren	Rehb.	Rayn.	Taun.	Norf.	Shar.	Walp.		
Condition	02703	02760	02763	02762	02035	02048	02766	02771	02093	02769	02767	02780	02056	02067	02081	MA	US
Chronic Kidney Disease %	2.7	2.5	2.3	2.4	2.3	2.5	2.3	2.8	2.6	2.5	2.7	3.1	2.3	2.4	2.8	2.6	2.9
High Blood Pressure %	31.4	28.3	29.2	30.5	28.5	27.7	28.1	30.5	28.7	31.1	31.5	33.1	28.2	26.6	28	26.23	30.32
Current Asthma %	11.9	11.4	11.5	11.9	11.3	11.2	11.8	11.9	10.9	11.8	12.1	13.2	10.2	9.8	11	11.55	10.35
Coronary Heart Disease %	6.9	6	6.4	6.6	6.5	5.4	6.1	7.4	6.4	7.1	7.4	7.8	5.3	5.5	6.2	5.55	5.82
High Cholesterol %	35.1	34.5	33.6	34.8	35.8	33.2	34.8	36.8	36.5	36.1	35.9	36.3	34.9	36.6	37	30.48	31.13
Diabetes %	10.6	9	9.3	9.1	8.9	8.3	8.3	10.3	8.7	10	10.5	11.6	7.7	8.5	8.4	8.6	10.8
COPD %	6.9	5.6	5.8	6.3	5.6	4.9	5.8	7.2	5.5	6.7	7.4	8.7	4	3.9	5.2	5.43	6.37
Obesity %	32.6	30.1	29	29.4	28.5	29.2	29.4	31	27.7	31.2	31.3	34.9	27.4	23.7	27.3	28.5	33.8
Depression %	23	22.5	21.9	23.1	21.8	22	23.8	23.4	21.1	23.2	23.4	25	19.8	18	21.2	23.9	22.5
Self-report poor physical health %	12.6	10.7	10.6	11.3	10.4	9.9	11	12.3	9.9	11.9	12.8	15.1	8.4	8.4	9.7	11.06	12.44
Self-report poor mental health %	16.7	15.3	14.1	15.8	14.4	14.8	17	16.1	13.4	15.7	16.4	19.3	12.6	11	13.7	16.84	17.35

Yellow: > MA, < US values
Red: > both MA, US values

Data sources: BRFSS 2022; CDC PLACES 2022

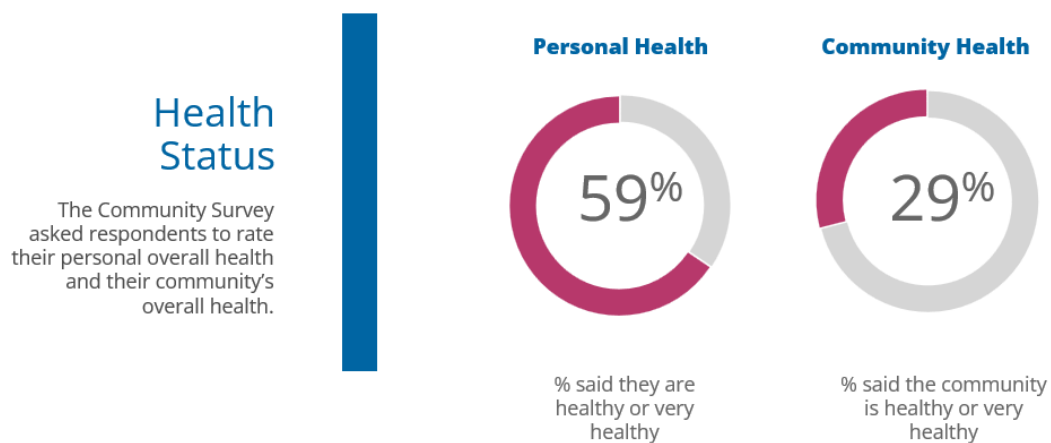
Sturdy Health – Community Health Needs Assessment 2025

Figure 7 Self-reported poor physical health. % Adults, (CDC, 2022)



This finding is consistent with those of the community stakeholder survey. Respondents tended to view their own well-being more optimistically than their community's overall condition. This discrepancy also suggests respondents' awareness of local barriers to access, or gaps in care, as well as environmental pressures and social stressors that they may not directly experience themselves, or that they do not perceive as impactful on health.

Figure 8 Perceptions of Personal vs Community Health Status



Sturdy Health – Community Health Needs Assessment 2025

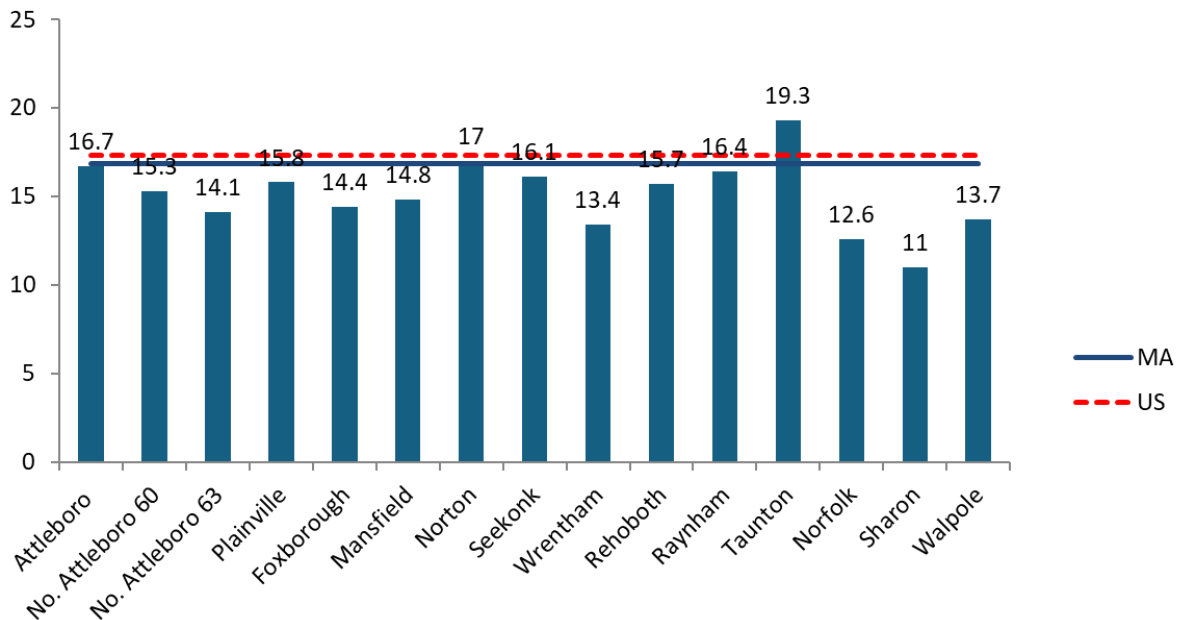
Table 22 Select Causes of Death, MA Department of Public Health, 2022

Town	Primary											Secondary				
Cause	Attlb	No. Attlb	Plain	Foxtb	Mnfd	Nort	Seek	Wrn	Rehb	Rayn	Taun	Nort	Shar	Walp	MA	US
Total deaths	489	262	74	146	178	150	128	139	120	188	647	77	134	234		
Age adjusted death rate/100K	949.90	692.50	647.70	623.70	644.30	729.10	720.20	1,023.1	900.50	1,108.6	1,013.6	464.6	531.7	643.1	691.6	798.8
Lung Cancer	34	16	5	8	4	8	5	4	5	11	30	3	2	18		
Breast Cancer	8	3	-	1	1	2	1	3	1	1	5	1	1	3		
Motor Vehicle	8	5	1	2	2	-	-	1	-	3	5	-	3	1		
Homicide	1	-	-	-	-	-	-	-	1	1	2	-	-	-		
Suicide	5	-	-	3	1	1	1	3	2	1	10	3	1	2		
Opioid Related	21	10	2	1	6	4	1	2	1	4	24	1	3	3		

Mental Behavioral Health Needs

In a 2023 MA Department of Health Community Health Equity Survey, only about 20% of respondents in Bristol County and 22% of that survey’s respondents in Norfolk County who reported having mental health concerns received care when they needed it⁸. Sturdy’s communities vary widely in people-to-provider ratios, from approximately 4 to 102 residents per provider. The ratios of people to providers for Bristol 170:1; Norfolk 140:1; MA 130:1; and U.S. 300:1.9 (See Table 5). In addition, several parts of the service area reported poor mental health status near or above state and national benchmarks. Attleboro (16.7) Norton (17) all had higher rates of poor mental health status than MA (16.84) and the U.S. (17.35). The communities of Taunton and Raynham, which is part of a shared service area with a different health system, also have notably higher rates of poor mental health status. These communities are included in the analysis because some residents use Sturdy-affiliated outpatient service sites nearby.

Figure 9 Self-reported poor mental health status, % Adults (CDC, 2022)



⁸ Massachusetts Executive Office of Health and Human Services (2023). “Community Health Equity Survey.” Available at [CHES 2023 Background & Resources | Mass.gov](https://www.mass.gov/info-details/ches-2023-background-and-resources)

⁹ Centers for Medicare & Medicaid Services (CMS): National Provider Identifier Files (NPI)

Sturdy Health – Community Health Needs Assessment 2025

Table 23 Select behavioral health indicators by Zip Code Tabulation Area or County (various sources)

Table 23 Select behavioral health indicators by Zip Code Tabulation Area or County (various sources)																	Outlier vs region	
Service Area	Primary												Secondary			Yellow: > MA < US values		
	Town	Atlb	No. Atlb.	No. Atlb.	Plain.	Foxb.	Mnfd.	Nort.	Seek.	Wren	Rehb.	Rayn*	Taun*	Norf.	Shar.	Walp.	Red: > both MA US values	
Condition	02703	02760	02763	02762	02035	02048	02766	02771	02093	02769	02767	02780	02056	02067	02081		MA	US
Opioid-related EMS incidents (count)	55	41		13	16	21	17	18	6	9	26	156	31	10	6		n/a	
Opioid related EMS incidents (%population)	0.12	0.14		.13	0.09	0.09	0.09	0.12	0.05	0.07	0.17	0.30	0.27	0.05	0.03		n/a	
Opioid deaths (2023)	17	7		5	3	4	6	2	3	1	5	35	1	1	2		n/a	
Suicides % of deaths	1.18%	0.41%		1.11%	0.68%	3.38 %	2.22 %	1.46%	0.84%	0	1.94%	1.37%	0	.097%	0.45%		2.06%	1.5%
Total Deaths all causes	489	262		74	146	178	150	128	139	120	188	647	77	134	234		n/a	
Self-report poor mental health	16.7	15.3	14.1	15.8	14.4	14.8	17	16.1	13.4	15.7	16.4	19.3	12.6	11	13.7		16.84	17.35
People per MH provider	30.91	102.6	3.91	16.23	21.86	47.53	41.65	46.94	28.31	53.87	25.96	28.38	52.23	33.14	18.85		36.98	117.33

Topic	Bristol	Norfolk	MA	US
Poor Mental Health Days per Month	5.8	4.4	4.9	5.1
Frequent Mental Distress	17.2%	15.1%	15%	16%
Alcohol and binge drinking past 30 days	21.6%	20.6%	19.8%	18.6%
Mental Health Provider Ratio	170:1	140:1	130:1	300:1

*Raynham and Taunton are included as Sturdy receives some patients from the region, however these towns are part of a shared service area with other health systems in the region.

Sources: National Provider Identifier Files; MA Department of Health; CDC Behavioral Risk Factor Surveillance System; County Health Rankings

Public data on suicide rates showed disparities in Mansfield and Norton compared to the rest of the service area. Other geographic disparities included high counts of opioid related EMS calls in Attleboro, North Attleboro, and Taunton. Adjusted for population size, there were disparities in Opioid EMS calls in Norfolk, as well as in Taunton and Raynham communities that are part of a shared service area with other area health systems. At the same time, Sturdy Health's internal data showed that, with over 1,000 encounters in 2024, suicidal ideation is one of the top three most frequent reasons for emergency department use, alongside chest pain and respiratory conditions (e.g., pneumonia, COVID, acute upper respiratory infection).

About 41% of patients with mental health conditions discharged from the emergency department saw a provider within 30 days for a follow-up appointment. For patients with a substance use disorder diagnosis, the 30-day follow-up rate was 35%, suggesting gaps in access to care in the community.

Sturdy Health – Community Health Needs Assessment 2025

Table 24 Access to Care, Screening, Utilization

Service Area	Primary												Secondary			Outlier vs region	
Town	Atlb	No. Atlb.	No. Atlb.	Plain.	Foxb.	Mnfd.	Nort.	Seek.	Wren	Rehb.	Rayn.	Taun	Norf.	Shar.	Walp.	MA	US
Condition	02703	02760	02763	02762	02035	02048	02766	OFix2771	02093	02769	02767	02780	02056	02067	02081		
Uninsured	2.99	1.64	.79	2.8	1.76	1.68	1.53	1.48	.9	2.2	.28	2.58	.4	.82	1.47	2.68	8.55
Medicaid Coverage % residents	24.92	16.83	12.98	20.77	16.63	16.63	12.91	14.26	13.01	10.91	16.04	34.24	5.4	10.41	12.6	22.86	20.68
Colorectal Cancer Screen	66.9	68.2	72.2	69.6	69.5	69.6	69.2	71.8	73	70.8	70.4	65.8	71.2	70.5	71.9	63.12	58.85
Mammography Screen	83.50	84.3	84.2	83.5	83.9	83.9	85.1	85.5	86.3	85.9	84	85.2	85.2	86.7	85.8	83.4	75.65
Pap Smear Screen	84.30	85.7	86.8	87.7	87.4	87.7	85.4	86.4	88.5	87.2	86.2	88.6	88.6	88.9	87.9	85.14	82.3
Cholesterol Screening	88.6	89.4	90	90.1	90.3	90.7	88.4	90.9	91.5	91.2	90.3	87	90.5	92.8	91.2	87.19	83.65
Seniors up to date on preventive screenings	43.7	45.9	47	45	44	49.1	47	47.3	42.6	48.8	46.6	45.4	45.4	46.7	43.2	44.44	37.67
Visited doctor for routine checkup	83.6	83.6	84.6	79.8	80.5	83.6	83.2	84.1	80.8	84.3	84.1	83	80.2	81.8	80.6	78.04	74.04
Emergency Department Utilization per 100	34.77	47.7	31.54	24.12	18.01	18.97	50.74	11.2	37.34	16.72	53.34	51.67	15.25	15.34	17.21	50.13	47.3

Topic	Bristol	Norfolk	MA	US
Preventable Hospital Stays	3,671	3,065	3,158	2,681
Medicare Emergency Department visit per 1K	687	587.63	623.7	575.6

* Raynham and Taunton are included as Sturdy receives some patients from the region, however these towns are part of a shared service area with other health systems in

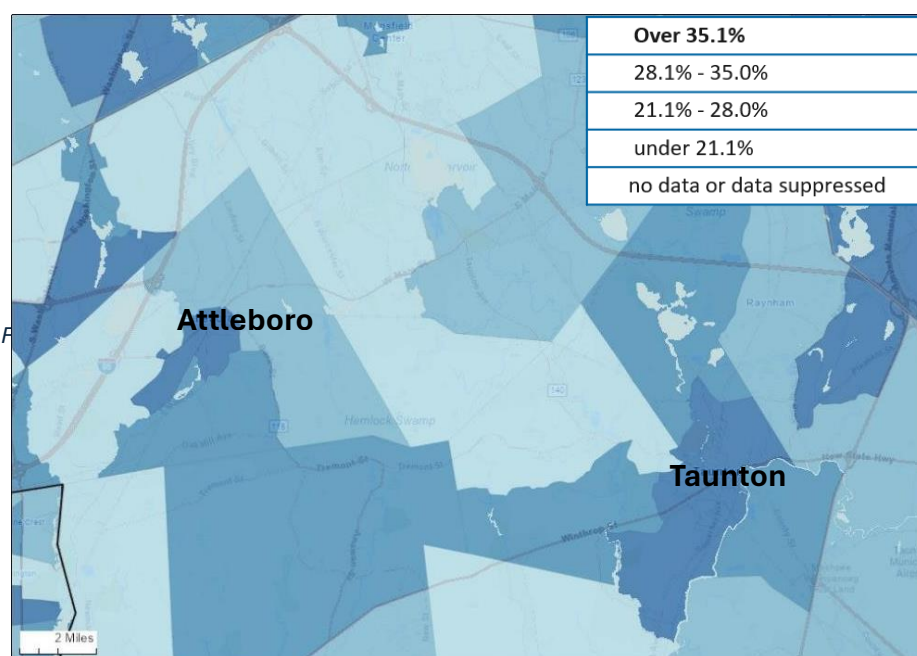
Social Drivers of Health and Health-Related Social Needs

While key informant interviews and other data sources showed that Sturdy’s service area has great parks, cultural resources, schools, and transportation assets, the Sturdy Health service area revealed a divide between the resources available to area residents, including Providence and Boston commuters and others who are long-term residents—families who have lived in the community since its heyday as one of the world’s great jewelry manufacturing centers, and those who are recent immigrants.

Housing Availability and Affordability

On average, about 30% of homeowners and renters in Sturdy’s service area are housing cost burdened, meaning they spend more than 30% of their monthly earnings on housing. As a result, they may have limited disposable income for healthy foods, prescriptions, and other needs. The highest cost burden was seen in and around Attleboro and North Attleboro and Foxboro. High-cost burden was also observed in Taunton, which is part of a shared service area from which Sturdy occasionally draws patients.

Figure 10 Cost Burdened Households by Census Tract

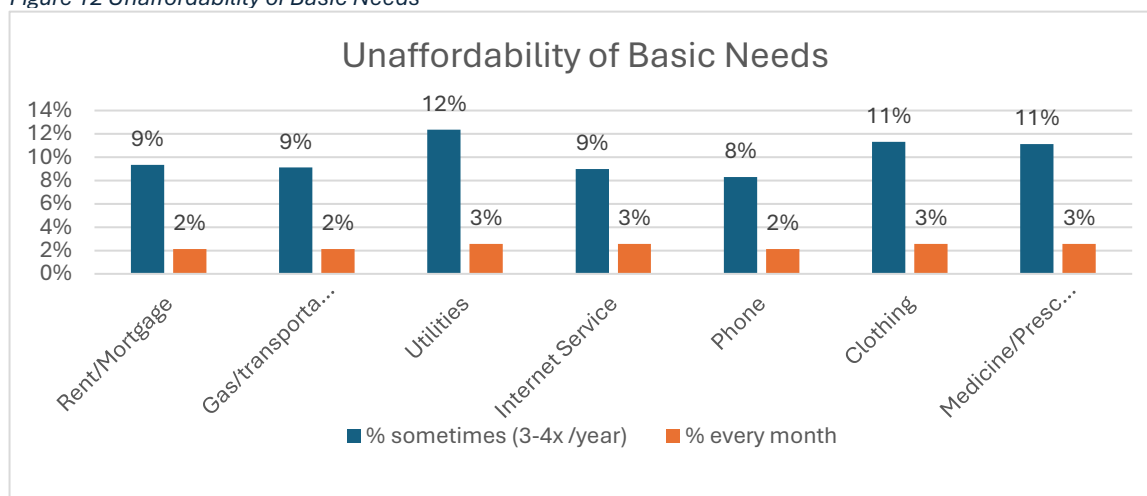


When survey respondents were asked how often they were unable to afford basic needs— rent, utilities, food, medicine, clothing, etc.— between 9% and 12% stated that they could not afford a basic need three to four times per year. Between 2 and 3% of respondents said they had difficulty affording basic needs every month. The most frequent responses were utilities, clothing, and medicine.

For context, according to U.S. Census Bureau Household Pulse Survey data from the latter half of October 2023, up to 27% of Massachusetts residents were unable to pay an energy bill in full in

the last 12 months, and 36.9% of Commonwealth residents reported it was somewhat or very difficult to pay for usual household expenses in the last 7 days.¹⁰

Figure 12 Unaffordability of Basic Needs



Food Security Concerns

One impact of high housing costs is insufficient resources to pay for utilities, insurance, food, and medical costs, especially considering rising food costs and decreased Supplemental Nutrition Assistance Program (SNAP) benefits. For example, CDC data reports more than 15% of Bristol County residents face food security concerns, and more than 21% of adults in the county, and more than 17% in Attleboro receive SNAP. This is in stark contrast to 7.3% of Norfolk County residents who face food security concerns and 8.6% who receive SNAP. For context, 804,000 people, or 11.5% of all households in Massachusetts, are reported as food insecure,¹¹ and 15% of households in the Commonwealth receive SNAP. According to U.S. Census Household Pulse Survey Data from early November 2022, 6.9% of Massachusetts residents reported food scarcity, a measure of the percent of adults in households where there was either sometimes or often not enough to eat in the last 7 days. Multiple CHNA key informants and focus group respondents reported that within Sturdy's service area, food insecurity is common among older adults and children, two groups that are particularly vulnerable to health consequences of poor nutrition.

¹⁰ U.S. Census (2022) Household Pulse Survey: Food Scarcity. Available at https://www.census.gov/data-tools/demo/hhp-weeks/#/?s_state=&measures=FOODSCARCE

¹¹ Feeding America (2023). "Food Insecurity among the Overall Population in Massachusetts." Available at <https://map.feedingamerica.org/county/2023/overall/massachusetts>

Next Steps and Recommendations

This community health needs assessment clearly identified the high burden of chronic disease and behavioral health conditions, limited access to health care and behavioral health services, and lack of affordable housing as the top community needs. Sturdy may wish to give special attention to the needs of older adults due to significant disparities in emergency department utilization. The next step is for Sturdy Health to collaborate with the Community Benefits Advisory Committee to refine and prioritize community health initiative options that could synergize existing resources and programs to meet these needs.

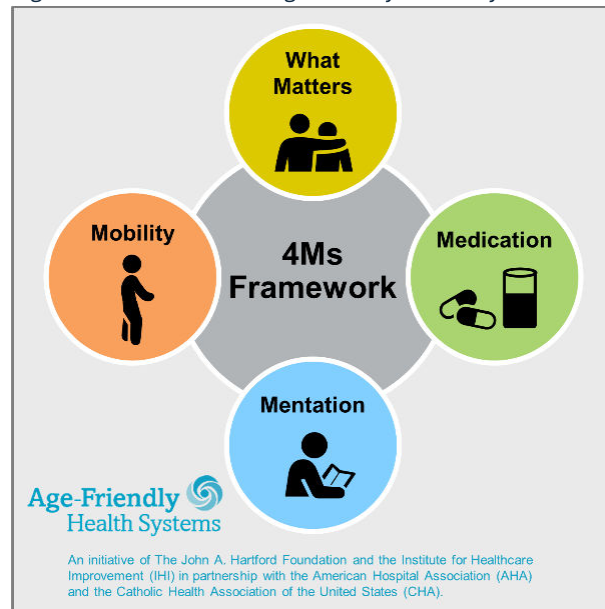
There are great opportunities to partner with other organizations in the Sturdy service area to align efforts to address community needs.

Key informant interviewees identified ways that Sturdy Health can leverage existing community initiatives and resources to increase the impact of its community benefits investments. There was a consensus that Sturdy Health could address gaps in healthcare access and community members' health-related social needs through these strategies:

- a. **Increase Healthcare Access and Health Education:** Identify opportunities to expand primary care and build on behavioral health access and resources, especially among populations with health-related social needs, or other conditions that make them more vulnerable to adverse outcomes. This could include opportunities to bolster health education by utilizing non-clinical staff and community partners to augment the health education available from primary care practitioners who are challenged by high ratios of patients due to provider shortages throughout the state and nation.
- b. **Explore Opportunities to Improve Services for Older Adults:**

Sturdy has opportunities to make an impact on the provision of care and services for older adults by examining service delivery improvement models. One example of such a model is Age Friendly Health Systems, an evidence-based framework designed to meet the needs of older adults by looking beyond acute events, engaging the whole community, and achieving better health. It provides many tools to improve patient care, safety, and outcomes; improve patient and family engagement in care; and reduce outcomes such as length of stay and readmission.

Figure 13 4-Ms Model for Age Friendly Health Systems



For related work, this graphic may be used in its entirety without requesting permission. Graphic files and guidance at ihi.org/AgeFriendly

Age Friendly Health Systems work to support the needs of older adults by focusing on four key areas: what matters, medications, mobility, and mentation — better known as the 4Ms Framework. Pursuit of an Age-Friendly Health System framework would align with new Centers for Medicare and Medicaid Services requirements, effective FY 2025, for measurement and attestation from hospitals in five domains of clinical care for patients 65 years and older. They include:

- Eliciting Patient Healthcare Goals
- Responsible Medication Management
- Frailty Screening and Intervention
- Social Vulnerability
- Age-Friendly Care Leadership

- c. **Address Top Health-Related Social Needs:** Collaborate with others in the service area to identify ways to expand access to affordable housing. Some older adults cannot afford to maintain large homes, and others cannot afford market rate housing at all. Sturdy Health may want to consider opportunities to take a more active role in supporting collective action to address affordable housing and increase housing stability.
- d. **Prevent Escalation of Mental Health Needs:** To address the ongoing crisis of social isolation among older adults, children, and youth that intensified during the COVID pandemic, Sturdy Health could work with partners to identify ways for those who are most isolated to come together, taking advantage of local parks and cultural resources, in addition to other strategies. Addressing social isolation can help prevent the exacerbation of behavioral health conditions.

Appendices

Appendix A: Environmental Scan Data Sources

	Environmental Scan Data Sources	Measures
I	Aging in the City of Attleboro Final Report 2020	This report describes research undertaken by the Center for Social & Demographic Research on Aging within the Gerontology Institute at the University of Massachusetts Boston, on behalf of the Attleboro Council on Aging. The goals of this project were to investigate the needs, interests, preferences, and opinions of Attleboro's residents aged 60 or older. The contents of this report are meant to inform the City of Attleboro, the Attleboro Council on Aging and Senior Center, and organizations that work with and on behalf of older residents of Attleboro for the purposes of planning and coordination of services. The report will also help to build awareness about issues facing Attleboro among community members at large. Aging in the City of Attleboro Final Report 2020.docx
II	Sturdy Hospital CHNA, 2022	Sturdy Memorial Hospital and Medical Associates conducted the CHNA in February 2022, in partnership with Holleran Consulting. The assessment aimed to analyze health indicators (e.g., chronic disease, healthcare access, and social determinants) using both secondary data and a key informant survey. 2022 Community Health Needs Assessment.pdf
III	Sturdy Hospital CHIP, 2022	Clinical care ranking, health outcomes, PCP patient ratio, dental care access, barriers to healthcare, leading cause of death, physical inactivity food stamps. 2022 Community Health Needs Assessment Implementation Plan.pdf
IV	Attleboro Housing Needs Assessment, 2023	The City of Attleboro conducted a Housing Needs Assessment Survey between September 20 and November 30, 2023, gathering responses from 239 participants. Attleboro Housing Needs Assessment Survey Results 2023.pdf
V	Attleboro Community Development Block Grant, 2024	The City of Attleboro's 2024–2028 Consolidated Plan outlines strategic priorities for utilizing Community Development Block Grant (CDBG) funds to enhance the well-being of low- and moderate-income residents. The plan emphasizes affordable housing, public facility improvements, social services, and administrative support. Attleboro Community Development Block Grant 2024.pdf
VI	Massachusetts Community Health Data Tool	The Massachusetts Health Data Tool includes two key platforms: the Population Health Information Tool (PHIT) and the Massachusetts Environmental Public Health Tracking (MEPHT) system. PHIT provides comprehensive health data segmented by various factors like race and ethnicity, covering topics such as cancer, asthma, and substance use, while also highlighting health disparities through equity dashboards. MEPHT combines environmental data with health statistics to explore the impact of factors like air quality and hazardous exposures on public health. Community Health Data Mass.gov
VII	Massachusetts EMS Regional Opioid Related Incident Dashboard, 2024	All opioid-related EMS events (911 calls involving opioids) — this includes acute overdoses, naloxone administrations, intoxication, withdrawal, and fatal “dead on arrival” cases. EMS Regional Opioid Related Incident Dashboard Mass.gov

Sturdy Health – Community Health Needs Assessment 2025

	Environmental Scan Data Sources	Measures
VIII	Bureau of Justice, 2023	The 2023 LEARCAT Victim Report provides a national overview of crime incidents reported to law enforcement, focusing on victims who were individual persons - count by victim type and offense category. Incidents - Victim View
IX	Feeding America, 2022	Map the Meal Gap is an annual study by Feeding America that provides detailed local-level estimates of food insecurity and meal costs across the United States. The 2025 report, based on 2023 data, reveals that hunger affects every county and congressional district in the U.S., with disparities influenced by factors such as income, race, and geography. Hunger & Poverty in the United States Map the Meal Gap
X	Citizens for Citizens Action, 2023-2024	Citizens for Citizens, Inc. is a nonprofit organization dedicated to alleviating poverty and promoting self-sufficiency in southeastern Massachusetts. CFC-Annual-Report-2023-2024.pdf
XI	Health Policy Commission, 2024	Policy recommendations
XII	Massachusetts Health Quality Partners, 2024	MHQP's Healthcare Compass MA is a public tool that helps Massachusetts residents compare primary care practices based on patient experience and clinical quality to support informed, high-quality healthcare choices. Healthcare Compass MA
XIII	Medicare, 2023	Medicare.gov Sturdy hospital ratings: overall star rating, patient survey ratings, timely and effective care. Medicare.gov
XV	Metopio, Community Health Data	County-level health, demographic and social service measures derived from multiple sources (HMA subscription)
XVI	U.S. Census	American Community Survey measures at County and Zip Code Tabulation Area levels.
XVII	County Health Rankings	County-level health outcome and risk factor measures. County Health Rankings & Roadmaps
XVIII	Medicare Disparities Tool	CMS Medicare Disparities tool. Mapping Medicare Disparities by Population CMS Data
XIV	CDC Overdose Prevention	Opioid Dispensing Rate Maps Overdose Prevention CDC

Appendix B: Sturdy Community Health Survey and Report

1. Full text of survey
2. Summary of Results
3. Detailed Response Report

Appendix B-1

CHNA and Community Planning Survey

Sturdy Health wants to hear from you about what you see as the top health and social needs in the places where we live and work. We need your input to develop programs that will meet our community's needs. We appreciate your willingness to help us by completing this anonymous short survey. We encourage you to forward this survey to others who may not have received it. If you have any questions, please contact Mel Reichelt at mreichelt@sturdyhealth.org.

1. Please rate your overall health and your community's overall health. (Rate on the scale of: Very unhealthy, Unhealthy, Somewhat health, Healthy, Very healthy)
 - My overall health: _____
 - My community's overall health: _____
2. When did you last see the following (Rate on the scale of: Within the last year, More than a year ago, I do not remember the last time, Never)
 - Regular doctor (physician, nurse practitioner, physician assistant): _____
 - Oral or dental care provider (dentist, dental hygienist): _____
 - Mental health provider (counselor, social worker, psychiatrist): _____
3. Which five (5) areas in the list below concern you the most when thinking about the health of your community? Some examples are listed in parentheses.
 - Access to Healthcare (lack of insurance, lack of conveniently located doctors' offices that take insurance, cost of healthcare, concerns about quality of healthcare)
 - Chronic Health Conditions (overweight/obesity, diabetes, heart disease, high blood pressure, asthma, cancer)
 - Discrimination (unfair treatment due to race, ethnicity, culture, age, gender)
 - Employment (low-paying jobs, lack of jobs)
 - Food & Nutrition (cost of food, lack of healthy food in certain areas, too much fast food)
 - Housing (unsafe housing, unaffordable housing, homelessness)
 - Infectious Diseases (COVID, flu, measles, sexually transmitted diseases, tuberculosis, hepatitis)
 - K-12 Education (attendance at school, quality of school, school achievement)
 - Mental Health (depression, anxiety, serious mental illness, suicide)
 - Physical Environment (air quality, unsafe water, superfund sites, extreme heat, flooding, lack of access to green space)
 - Social Conditions (social isolation, loneliness)
 - Substance Use and Addiction (tobacco, marijuana, alcohol, opioid misuse)
 - Violence (community or domestic violence, bullying, child abuse, firearm-related injuries)
 - Other (please specify)
4. Some people may experience barriers to getting healthcare services. (For example, long-distance travel can make it hard to get healthcare services.) What barrier(s) have you experienced in getting services to support your healthcare and wellness? Select all that apply.
 - Forms were too complicated (Health Insurance or doctor's office/hospital forms etc.)
 - High out-of-pocket-costs/it costs too much money.
 - I was not eligible for services.

- I could not find providers or services that understand, value and respect my culture.
 - I could not find providers that looked like me or that spoke my language.
 - I did not have health insurance.
 - I did not know what services and resources were available.
 - I do not have a mobile device to engage in my healthcare.
 - I do not have internet access or a device to use telehealth services.
 - I felt embarrassed about asking for help and/or getting services.
 - I needed evening and/or weekend hours of service.
 - I needed service not offered in my area.
 - No appointments were available, or I could not get an appointment in a reasonable amount of time.
 - Not easy to travel to appointments / I do not have transportation.
 - Poor physical access (i.e., disability accessibility)
 - I have not experienced any barriers.
5. The ability to meet basic needs influences health and well-being. Please tell us how often you couldn't pay for the following: (Rate on the scale of: Never, Sometimes (3-4 times a year), Every month)
- Food
 - Rent/Mortgage
 - Gas for a car or other transportation costs
 - Utilities (electricity, water)
 - Internet Service
 - Phone/Cell phone service
 - Clothing
 - Medicine/Prescriptions or medical supplies
6. Please review the entire list of factors below that are commonly used to define a "healthy community." What five (5) things are most important to improving the health of your community?
- Access to healthcare services (physicians, nurse practitioners, physician's assistants)
 - Access to mental health services (e.g., counselors, psychiatrists)
 - Access to treatment services for people with addictions
 - Affordable housing
 - Arts and cultural events
 - Clean water and air
 - Community safety
 - Fair treatment of all people and groups
 - Good jobs and a healthy economy
 - Healthy food and grocery stores nearby
 - Parks and green spaces
 - Reliable transportation
 - Religious or spiritual support
 - Safe, stable, and nurturing relationships within the family and community
 - Social support and connections
 - Other (please specify)

We ask for information about you to understand different experiences and identify areas for improvement at Sturdy Health. Your responses are anonymous and confidential. While optional, we appreciate your participation.

7. What is the zip code where you live?

8. How old are you?

- < 18
- 18 – 24
- 25 – 49
- 50 – 64
- 65 +

9. What is your gender?

- Male
- Female
- Prefer not to answer

10. What is your race/ethnicity? Please choose all that apply.

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latine
- Middle Eastern/North African
- Native Hawaiian or Other Pacific Islander
- White
- Other (please specify)
- Prefer not to answer

11. How or where did you get this survey?

- Community or Faith Organization
- Email
- Facebook
- Healthcare Provider
- Instagram
- Newsletter
- X (formerly Twitter)
- Other (please specify)

Appendix B-2

Community Survey Results Summary

Between April 14 and June 18, 2025, Sturdy Health fielded the survey component of the 2025 community health needs assessment (CHNA). The survey, which received approximately 500 responses, aimed to understand individual and community health status, barriers to healthcare access, and priorities for improving well-being across demographics.

Health Status

- Personal Health: Most respondents rated themselves as healthy or somewhat healthy, though a notable portion reported unhealthy or very unhealthy status.
- Community Health: Perceptions were more mixed, with many rating their community as somewhat healthy or unhealthy.
- 90% of respondents had seen a primary care provider (physician, nurse practitioner, or physician assistant) in the last year; similarly, 408 of 504 had seen a dental or oral health provider. In contrast, less than 25% had seen a mental health provider. Nearly 50% had never seen a mental

health provider, although it is unclear how many of these respondents felt they needed to see a mental health provider.

Barriers to Healthcare

The top four barriers to healthcare access included:

- No available appointments
- High out-of-pocket costs
- Needing evening or weekend service
- Not knowing what services were available

Community Health Concerns

The most frequently chosen health concerns were:

- Chronic health conditions
- Access to Health Care
- Food & Nutrition
- Mental health

Social Determinants of Health

Recurring themes included:

- Employment challenges
- Unsafe or unaffordable housing
- Limited access to healthy food
- Poor air and water quality
- Lack of green spaces and community safety

Community Priorities

Respondents emphasized the need for:

- Access to healthcare and mental health services
- Affordable housing
- Clean water and air
- Good jobs and a healthy economy
- Community safety
- Social support and connections
- Reliable transportation
- Fair treatment for all groups
- Parks and green spaces
- Arts and cultural events

Demographics

- Age: Majority were aged 25–49, followed by 50–64 and 65+.
- Gender: Predominantly female respondents.
- Race/Ethnicity: Mostly White, with representation from Asian, Black or African American, Hispanic or Latine, and Middle Eastern/North African groups.

Survey Response Sources

Respondents accessed the survey via Facebook, Email, Healthcare Providers, Community or Faith Organizations, and LinkedIn.

Appendix B-3

Community Survey Detailed Results

Q1: Please rate your overall health and your community's overall health.

- Total Responses: 485
- Response Rate: 96.6%

Heatmap, Perceived Health Status Correlations (blanks excluded)

Personal Overall Health	Very Healthy	1	26	25	3	0
	Healthy	1	86	126	17	2
	Somewhat healthy	2	23	108	23	1
	Unhealthy	0	4	13	6	3
	Very unhealthy	1	0	2	1	0
		Very Healthy	Healthy	Healthy	Unhealthy	Very Unhealthy
		Community Overall Health				

Most respondents rated their personal health as either “Healthy” or “Somewhat Healthy,” indicating that individuals generally feel positively about their own well-being. A smaller number of responses indicated “Very Healthy” or “Unhealthy,” and only a few reported “Very Unhealthy.”

When evaluating their community’s overall health, responses were more varied. While “Somewhat Healthy” was the most common rating, many also selected “Unhealthy,” and fewer rated their community as “Healthy” or “Very Healthy.” A small number indicated “Very Unhealthy,” suggesting more concern for the broader community's health than for personal well-being.

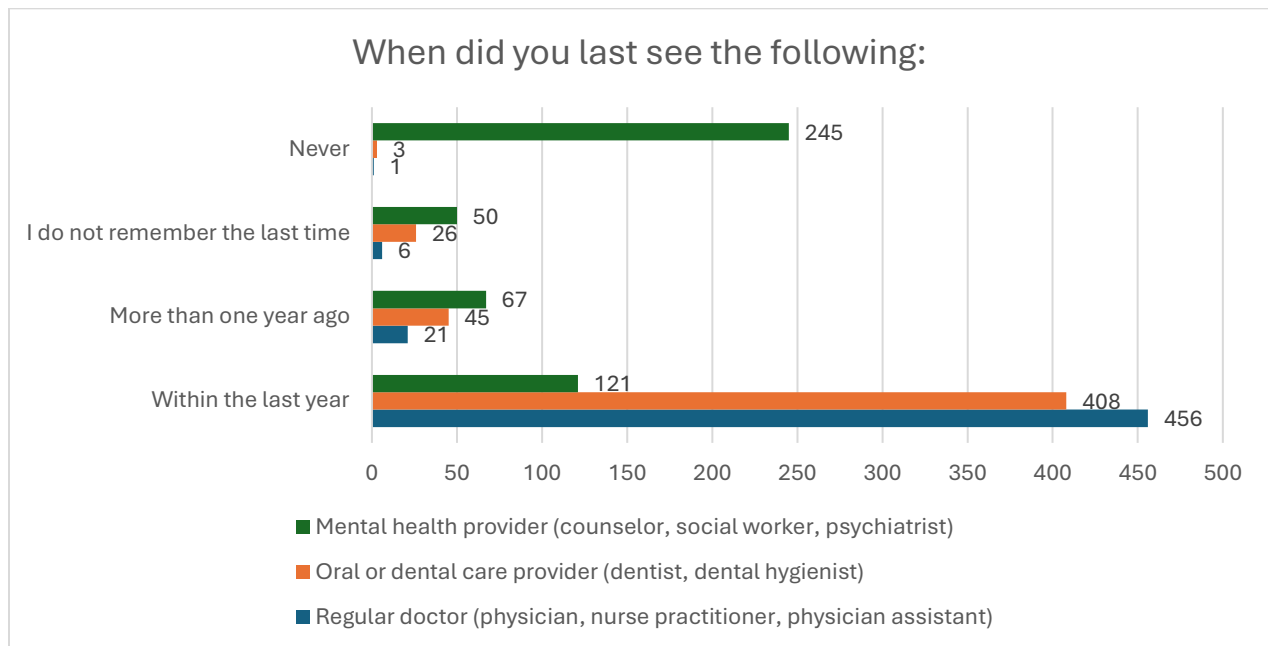
The most common pairing between personal and community health status was self-rated status of healthy with a community rated status of healthy or somewhat healthy. A very small number of very healthy individuals rated the community as unhealthy, suggesting a disconnect between personal and community perceptions of health. Unhealthy and very unhealthy self-ratings were rare, but those that did emerge were aligned with perceptions of the community as unhealthy.

Key Takeaway: personal health is largely perceived as “somewhat healthy” or “healthy” while community health is perceived less favorably, with notable concern.

Q2: *When did you last see the following:*

- Total Responses & Response Rate:
 - Regular doctor (physician, nurse practitioner, physician assistant): 484 (96.4%)
 - Oral or dental care provider (dentist, dental hygienist): 482 (96.0%)

- Mental health provider (counselor, social worker, psychiatrist): 483 (96.2%)



Regular Doctor (Physician, Nurse Practitioner, or PA): Most respondents reported seeing a regular doctor within the last year, indicating strong and recent access to general medical care. A smaller portion had not seen a doctor in over a year or did not remember their last visit. Very few selected “Never,” showing that most individuals have engaged with primary care at some point.

Oral or Dental Care Provider: Most respondents also saw a dental provider within the last year, although slightly fewer than those who saw a regular doctor. A noticeable number had not seen a dental provider in more than a year or did not remember the last visit, suggesting moderate gaps in routine dental care. A small number indicated they had never seen a dental care provider.

Mental Health Provider (Counselor, Social Worker, Psychiatrist): This category had the lowest utilization: many respondents indicated “Never” or “More than one year ago.” A considerable number selected “I do not remember,” pointing to uncertainty or infrequent engagement.

Key Takeaways:

- Among survey respondents, routine medical and dental care appear generally accessible and utilized within the past year.
- The understanding of mental health care utilization and access is far more limited or inconsistent. Most respondents report never having received services or, if they accessed services, doing so a long time ago. This could be interpreted as most respondents have never needed services, therefore it is not indicative of accessibility.

Q3: Which five (5) areas in the list below concern you the most when thinking about the health of your community?

Total Responses: 478; Response Rate: 95.2%

- | | |
|---|---|
| ■ Access to Healthcare (299 – 14.1%) | ■ K-12 Education (66 – 3.1%) |
| ■ Chronic Health Conditions (293 – 13.8%) | ■ Mental Health (282 – 13.3%) |
| ■ Discrimination (66 – 3.1%) | ■ Physical Environment (102 – 4.8%) |
| ■ Employment (109 – 5.1%) | ■ Social Conditions (70 – 3.3%) |
| ■ Food & Nutrition (287 – 13.5%) | ■ Substance Use and Addiction (147 – 6.9%) |
| ■ Housing (183 – 8.6%) | ■ Violence (82 – 3.9%) Other (please specify) |
| ■ Infectious Diseases (96 – 4.5%) | (27 – 1.3) |

The most frequently mentioned concerns were Mental Health, Chronic Health Conditions, Access to Healthcare, Food & Nutrition, and Substance Use and Addiction. Selection of Mental Health frequently occurred with selection of Substance Use and Addiction, Chronic Health Conditions, Access to Healthcare, Food & Nutrition

These data suggest that community members are most concerned about basic and foundational health and social needs, with Access to Healthcare, Chronic Health Conditions, Food & Nutrition, and Mental Health each receiving over 13% of total responses. Housing (8.6%) and Substance Use and Addiction (6.9%) were also significant concerns, pointing to broader social drivers of health outcomes. Lower response rates in areas like Discrimination, K-12 Education, and Social Conditions may not suggest these issues are unimportant, but rather that they are more difficult to name directly or may be seen as underlying factors rather than primary concerns.

The table on the following page (Q3 Heatmap, Interaction of Top Community Concerns) charts the frequency of interaction between survey respondents' areas of concern. For example, respondents whose top concern was access to care also named food and nutrition, chronic health conditions, mental health, and housing as their other priority concerns. Degree of interaction is shown on the heat map from lowest interaction (green) to highest interaction (red).

Q3 Heatmap, Interaction of Top Community Concerns

	Access to Healthcare	Chronic Health Conditions	Discrimination	Employment	Food & Nutrition	Housing	Infectious Diseases	K-12 Education	Mental Health	Other	Physical Environment	Social Conditions	Substance Use and Addiction	Violence
Access to Healthcare	0	177	46	62	186	112	53	42	169	9	58	34	81	45
Chronic Health Conditions	177	0	30	62	182	102	64	39	184	9	58	35	97	46
Discrimination	46	30	0	16	33	27	19	10	34	3	17	8	6	11
Employment	62	62	16	0	70	49	15	15	58	3	20	11	20	12
Food & Nutrition	186	182	33	70	0	116	59	47	163	8	61	40	79	45
Housing	112	102	27	49	116	0	18	24	119	5	28	24	54	24
Infectious Diseases	53	64	19	15	59	18	0	11	37	1	30	10	24	22
K-12 Education	42	39	10	15	47	24	11	0	40	2	16	11	16	11
Mental Health	169	184	34	58	163	119	37	40	0	5	38	46	106	47
Other	9	9	3	3	8	5	1	2	5	0	8	4	4	2
Physical Environment	58	58	17	20	61	28	30	16	38	8	0	15	26	17
Social Conditions	34	35	8	11	40	24	10	11	46	4	15	0	19	7
Substance Use and Addiction	81	97	6	20	79	54	24	16	106	4	26	19	0	25
Violence	45	46	11	12	45	24	22	11	47	2	17	7	25	0

Q4: Some people may experience barriers to getting healthcare services. What barrier(s) have you experienced in getting services to support your healthcare and wellness? Select all that apply.

- Total Responses: 474
- Response Rate: 94.4%

Most (181) respondents said they had no major barriers to care, however of those respondents who did note barriers, top responses were:

- Appointment availability and wait times (157)
- High out of pocket costs (137)
- Lack of evening or weekend service hours (94)
- Uncertain about available services. (72)

In addition, respondents cited eligibility for services (46), as well as accessibility of culturally (28) and linguistically accessible (8) care as concerns.

Some (33) respondents reported feeling embarrassed about seeking help, reflecting stigma or discomfort with accessing care. A small number reported digital connectivity barriers (7 had no mobile, 8 had no internet), as well as transportation barriers (27) and physical accessibility challenges (8).

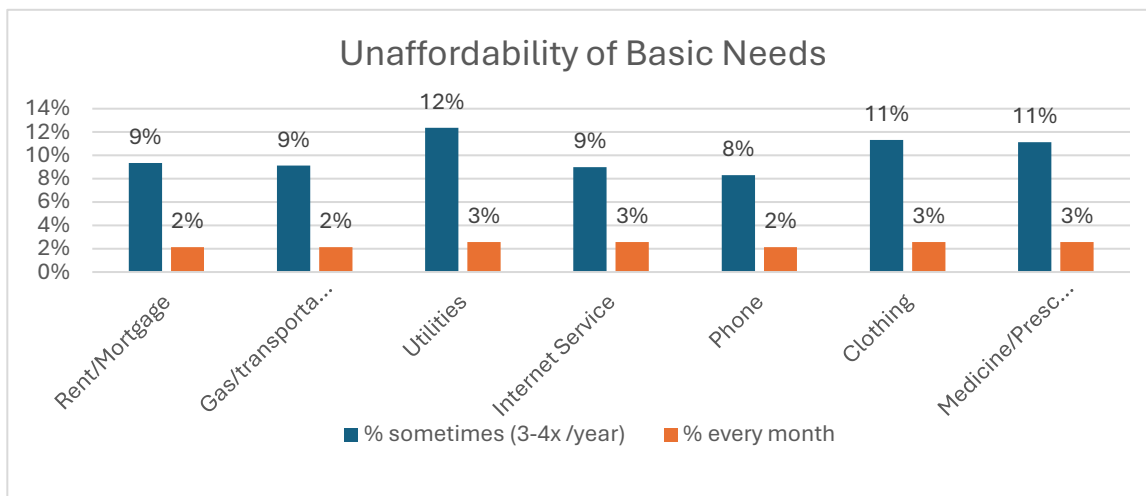
Overall, the data highlights appointment availability, cost, service hours, and awareness of resources as the most prominent barriers, while also drawing attention to cultural sensitivity, technological limitations, and stigma as contributing factors to healthcare access challenges.

Q5: Please tell us how often you couldn't pay for the following:

- | | |
|---|--|
| • Total Responses & Response Rate: | ▪ Utilities (electricity, water) (469 – 93.4%) |
| ▪ Food (470 – 93.6%) | ▪ Internet Service (467 – 93.0%) |
| ▪ Rent/Mortgage (471 – 93.8%) | ▪ Phone/Cell phone service (470 – 93.6%) |
| ▪ Gas for a car or other transportation costs (471 – 93.8%) | ▪ Clothing (468 – 93.2%) |

Between 2 and 3% of survey respondents said they had difficulty affording basic needs every month, and between 9% and 12% said they sometimes needed help affording basic needs.

Q5 How often were things unaffordable?



Q6: Please review the entire list of factors below that are commonly used to define a “healthy community.” What five (5) things are most important to improving the health of your community?

- Total Responses: 478
- Response Rate: 95.2%

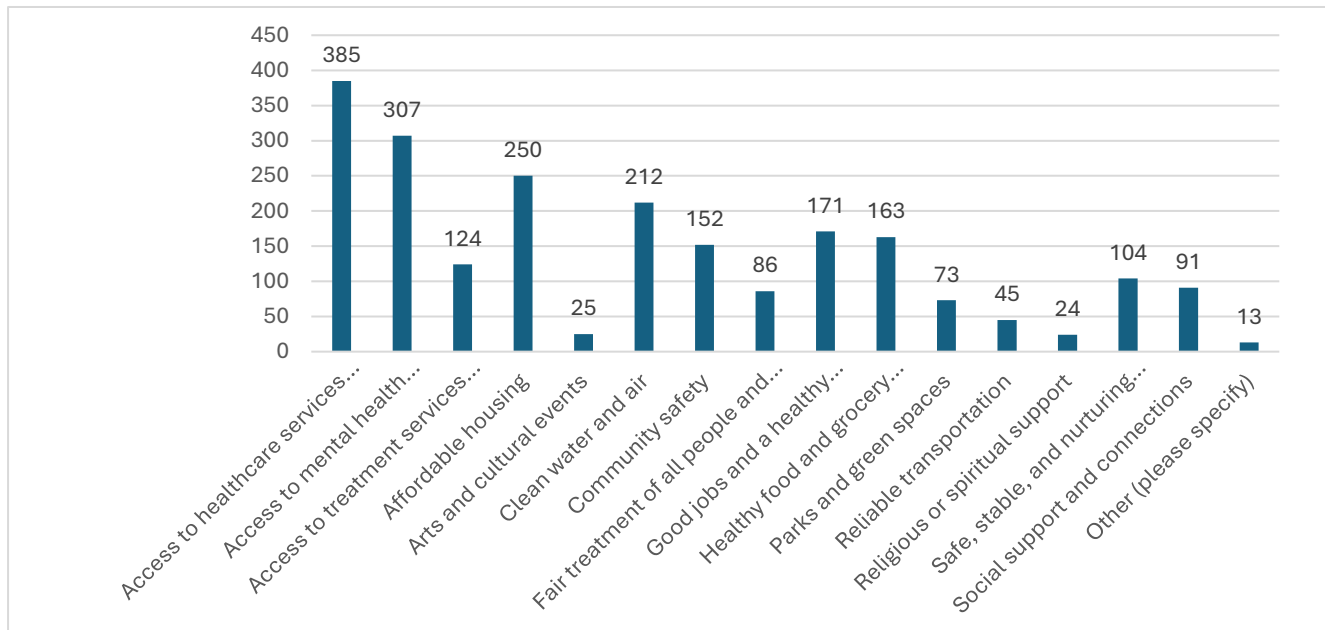
Respondents were asked to choose the five most important components of a healthy community from a comprehensive list. The most frequently selected priorities were:

- Access to healthcare services (385 responses) and mental health services (307), highlighting the community’s strong emphasis on medical and behavioral health access.
- Affordable housing (250) emerged as a critical concern, pointing to housing stability as a foundational need.
- Clean water and air (212) and good jobs/a healthy economy (171) were also highly rated, reflecting the importance of environmental quality and economic opportunity

Other notable responses included:

- Healthy food access (163),
- Community safety (152),
- Social support (91), and
- Safe, stable, and nurturing relationships (104).

Q6 Components of a Healthy Community



Fewer respondents selected arts and culture, religious support, or reliable transportation, suggesting these were viewed as less urgent priorities compared to basic health, housing, and economic needs.

Respondents who selected other provided open-ended feedback, including multiple individuals who emphasized all of the above. Themes of the open-ended responses were focused on:

- **Healthcare Quality and Coverage:** “healthcare providers who listen” and aren’t limited to standardized messaging. One respondent stressed the need for “medical coverage tailored to chronic conditions”, such as multiple sclerosis, and the availability of jobs that offer adequate insurance.
- **Education and Schools:** Respondents noted concern about outdated and deteriorating schools, calling for investments in education quality and infrastructure.
- **Fair Wages and Workforce Support:** The importance of fair wages for quality caregivers
- **Overall Health and Wellness:** There was a call for integrating physical activity into mental and physical healthcare, underscoring the value of preventive and holistic strategies.

Q7: What is the zip code where you live?

- Total Responses: 469
- Response Rate: 93.4%

Survey respondents originated from 45 different Zip Codes in the region. Eleven were in Bristol County, ten were in Norfolk County, five were from Middlesex County, and nineteen were from Rhode Island. There were respondents from nearly all municipalities in Sturdy’s Primary and Secondary service areas; the exception was Norfolk Town.

Most respondents (226 of 469 who shared a Zip Code) were from Attleboro, North Attleboro, and Plainville. The remaining respondents were primarily from Mansfield (30), Norton (20), Seekonk (10). All other Zip Codes had fewer than 10 respondents with many Zip Codes having just one respondent each.

Q8: How old are you?

- Total Responses: 482
- Response Rate: 96.0%

The age distribution of survey respondents shows that the majority were adults over the age of 25. Specifically:

- 65+ was the largest age group, with 172 respondents.
- This was followed closely by those aged 25–49 (155 respondents) and 50–64 (146 respondents).
- Very few respondents were under 25, with only 8 between 18–24 and 1 under 18

Q8: What is your gender?

- Total Responses: 482
- Response Rate: 96.0%

74% of respondents identified themselves as female. 23% identified themselves as male, 3% preferred not to answer.

Q9: What is your race/ethnicity?

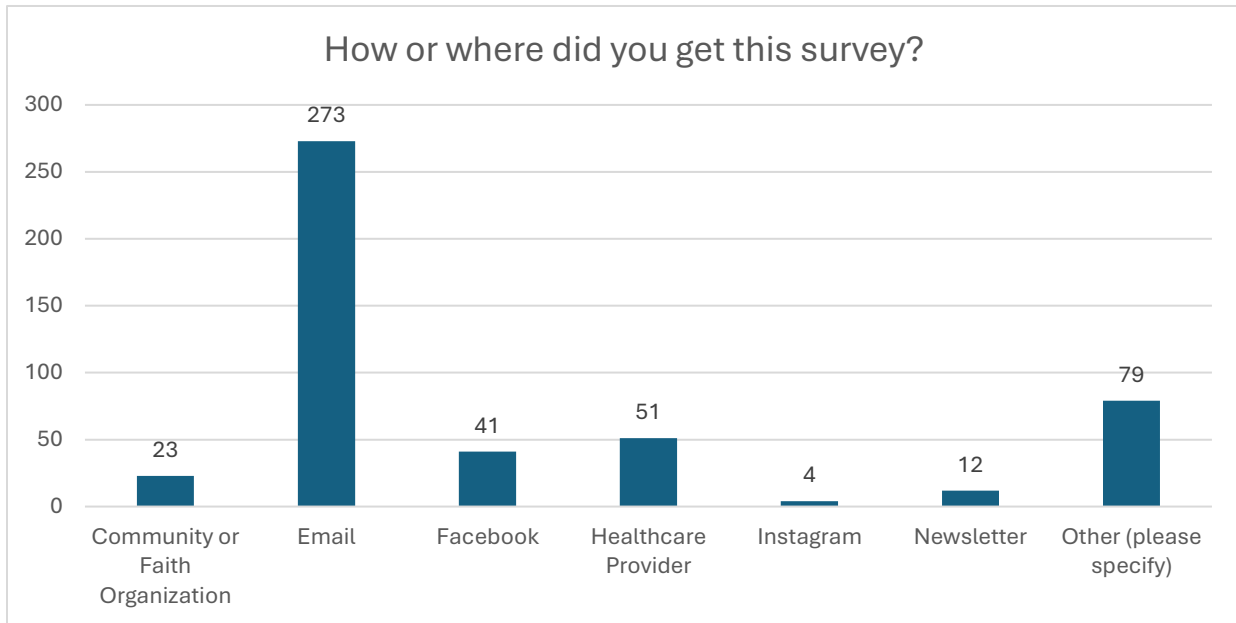
- Total Responses: 483
- Response Rate: 96.2%

89% of respondents were White, 11% Black or African American, 12% Hispanic or Latine, 4% Middle Eastern, 5% Asian, 6% other, and 16% preferred not to say. The open-ended “other” race/ethnicity responses indicate a range of identities not captured by standard categories. Respondents described themselves as: Irish American and American; Black and White; East Indian.

Q10: How or where did you get this survey?

- Total Responses: 483
- Response Rate: 96.2%

Q10 Survey Sources



Most respondents received the survey via email outreach, either from Sturdy, the City of Attleboro government, and regional chambers of commerce, among other community stakeholder organizations that assisted with distribution of the survey. Respondents who said their survey source was other reported they got the survey through their workplace. This could indicate a recipient got the survey as an employee of one of the above distribution partners or from Sturdy itself. Many participants received surveys through area schools, including school newsletters and district-wide emails, school or school system parent and family advisory councils, and through local literacy centers operated by the school district. Some respondents received the survey via direct outreach at community events and postings in the region, such as Attleboro City Hall, and still others learned of the survey through personal networks and word of mouth.

Appendix C: Key Informant Response

“There are not enough boots on the ground. There are a lot of ‘suits’ providing case management. We need teams of well-qualified people – nurses, primary care providers and social workers.”

One way to clearly illustrate what the speaker is referring to is by considering “who coordinates the coordinators”, for example, Nothelle, et al (2023), discusses co-occurring care management which occurs in silos and makes it harder for the patient and family to easily identify the involved care manager.

Consider, for example, a low-income older adult with multiple chronic conditions who is enrolled in social services with a local community-based agency. Without team-based case management they can easily be overwhelmed by co-occurring case management

In this example:

- A case manager at their primary care office
- Three different disease-specific care managers for diabetes, ESRD, and congestive heart failure
- A behavioral health case manager at the mental health clinic they visit for bipolar disorder
- A case manager at the certified home-health agency providing visiting nurse services
- A care manager from the Medicare Advantage plan because they are in a high-risk beneficiary

¹² Nothelle, S., Nkodo, A., Fiddler, K., Litman, J., Sleppy, R., Brancati, F., Boyd, C. M., & Wolff, J. L. (2023). Care manager, older adult, and caregiver perspectives on co-occurring care management among high-need older adults. *Journal of the American Geriatrics Society*, 71(11), 3424–3434. <https://doi.org/10.1111/jgs.18531>