

HEALTHY AGING DATA REPORT

Highlights from Massachusetts, 2018



RESEARCH AND ANALYSIS BY



Gerontology Institute
John W. McCormack
Graduate School of
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A Message from the Funder and Principal Investigator

Building community health by creating age-friendly communities

We are living in a remarkable time. People are living longer than ever before. Many older people live healthy, productive lives, but still there are opportunities to make our communities better places to grow up and grow old.

The information in the *2018 Massachusetts Healthy Aging Data Report* can serve as a roadmap, helping to identify strengths and needs in communities across the Commonwealth. The data offer a clearer picture of the health of Massachusetts older residents—and at a finer level of geographic detail—than has ever been compiled.

Massachusetts is one of only three states in the nation to have access to such comprehensive data on healthy aging. Some clear themes emerge. When it comes to the health of older people, resources matter: 1) in wealthier communities, health indicators are generally better than the state average; 2) in less resourced, mostly urban areas, health indicators are generally worse than the state average; 3) rural areas face challenges related to access to health and aging services and transportation.

As our organizations have demonstrated in our work and engagement, we are committed to creating communities that work for people of all ages. We know it's critically important that each community chart its own course, honoring the unique attributes of the community and its people. And we've learned there are some best practices to guide those engaging in this work.

Start with winnable battles to build momentum. Focus on specific actions or changes such as improving access to nutritious foods or creating opportunities for physical activity, where significant progress can be made in improving health outcomes in a relatively short time frame—generally within one to four years. More deeply rooted challenges, such as reducing poverty rates or racial segregation, or addressing social determinants of health or other disparities, are longer term goals. To make progress with these goals will require community, regional, and state efforts—engaging all community members in healthy aging endeavors.

Learn about resources available to support your work.

State leaders, including Governor Baker and the members of the Council to Address Aging in Massachusetts, along with the Massachusetts Healthy Aging Collaborative, AARP-MA and communities throughout the Commonwealth, are committed to making ours an age-friendly state. The work emphasizes access, equity and inclusion to create more livable communities for people of all ages. One example is the Commonwealth's Community Compact Best Practices Program which offers large urban centers, midsize Gateway Cities, and smaller rural communities access to support for this work.

Use this Highlights Report and the full online database to inform your own work and join us in making Massachusetts a model for the nation. Access the data report at www.HealthyAgingDataReports.org or on the [Tufts Health Plan Foundation](http://TuftsHealthPlanFoundation.org) website.

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About the Report

The *2018 Massachusetts Healthy Aging Data Report* (available online at www.healthyagingdatareports.org) is an easy-to-use online resource created by researchers at the Gerontology Institute of the John W. McCormack Graduate School of Policy and Global Studies at the University of Massachusetts Boston and funded by Tufts Health Plan Foundation. Our ambitious goal is to use data to spur social innovation that leads to more age-friendly communities. Because when communities work for older people they work better for everyone.

A total of 179 indicators are reported to provide a comprehensive understanding of the health of older adults in Massachusetts. We provide 379 community profiles—one for every city and town in Massachusetts, plus neighborhoods in Boston, Springfield, and Worcester—with new data to inform policy, planning, and practice. The data report shows the distribution of disease, health behaviors, and the extent to which health varies by zip code across the state. Analyses show where disparities in health exist and suggest potential solutions.

The online report includes an infographic summarizing key findings, tools that make it easy to access the data and understand the status of aging in Massachusetts, and:

- 379 Community Profiles
 - 179 maps, lists of communities with rates for each indicator (179 ranked and 179 alphabetized)
 - 379 community estimates of indicators with confidence intervals, and technical documentation
 - 18 interactive web maps
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GROWING OLDER IN MASSACHUSETTS

Massachusetts residents age 60 or older are a large and valuable part of the state's population. Globally, populations are aging because people are living longer and birth rates are dropping. In the United States by 2030 roughly 72 million adults— an estimated 1 of every 5 people— will be age 65 or older. Massachusetts is no exception to this trend: more than a million residents are age 65+, about 15% of the state's population. That's more than 125,000 more than we reported just three years ago.

What do age-friendly communities have in common?

- Safe and accessible public transportation options
- Safe, affordable, and accessible housing
- Safe and pleasant parks and outdoor spaces
- Top-quality community and health services
- Plenty of employment and volunteer opportunities
- Engaging social activities and events for people of all ages
- Respect for older people and their knowledge, skills, resources, and contributions

Gains in human longevity mean that older adults have greater opportunities for high-quality, active, fulfilling lives. Communities that actively embrace older adults and facilitate healthy living not only support the older adults themselves, but enrich the lives of everyone those older adults encounter.

Massachusetts already has been proactive in its efforts to leverage the opportunity of the growing older adult population. In 2017, Gov. Charles Baker established the Council to Address Aging in Massachusetts (<https://www.mass.gov/orgs/governors-council-to-address-aging-in-massachusetts>) to support more inclusive, **age-friendly communities**. Massachusetts aims to become the Silicon Valley of innovation in aging services and opportunities. Key to that effort are reliable data on which to build policy and program initiatives. This Highlights Report summarizes the key findings of healthy aging in Massachusetts.

Overall, the older population has become younger as the "baby boom" cohort ages and enters the 65+ group. The percentage of persons 65 years or older who were between 65-74 increased from 49.8% to 55.3% between 2011-2015. We also found the population was more racially and ethnically diverse and has more education compared to our findings in 2015. There was a marked increase in the percentage of older people who were veterans, an improvement in the one-year mortality rate, and an increase in the percentage of people 65+ with annual incomes above \$50,000 (37.5% in 2011 vs 43.9% in 2015). These trends are expected to continue in the coming decades.

Massachusetts ranks among the top 10 healthiest states in the nation for people aged 60 years and over, according to the United Health Foundation. The Commonwealth benefits from higher education levels than other states, relatively higher annual incomes, state investments in community resources, and good access to health care. While on average the health of Massachusetts compares well to other states, this hides the fact that within the state the health of older adults varies significantly.

Healthy aging is about creating the environments and opportunities that enable people to be and do what they value throughout their lives.

Data also show rates for a number of health conditions that have worsened since the 2015 report, including: arthritis, asthma, chronic kidney disease, depression, having multiple (4+) chronic conditions, and lung cancer. Medical service utilization rates have increased for emergency department and physician office visits and for Medicare Part D prescription refills.

In Massachusetts communities there are wide variations in most indicators of healthy aging, many associated with social, economic, or racial determinants of health. These inequities in health are often related to the social determinants of health. The World Health Organization defines the social determinants of health as the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.

TABLE 1. NUMBER OF HEALTH INDICATORS BETTER/WORSE THAN STATE AVERAGE

Town	Health Indicators Better than State Average	Health Indicators Worse than State Average
Acton	36	0
Harvard	36	0
Ashfield	36	1
Buckland	36	1
Conway	36	1
Carlisle	36	1
Nantucket	36	1
Brookline	35	15
Newton	35	11
Rehoboth	34	7
Fall River	6	43
New Bedford	6	42
Springfield	4	41
East Worcester	3	40
Springfield	4	38
Brockton	8	37
Peabody	3	36
Lowell	9	34

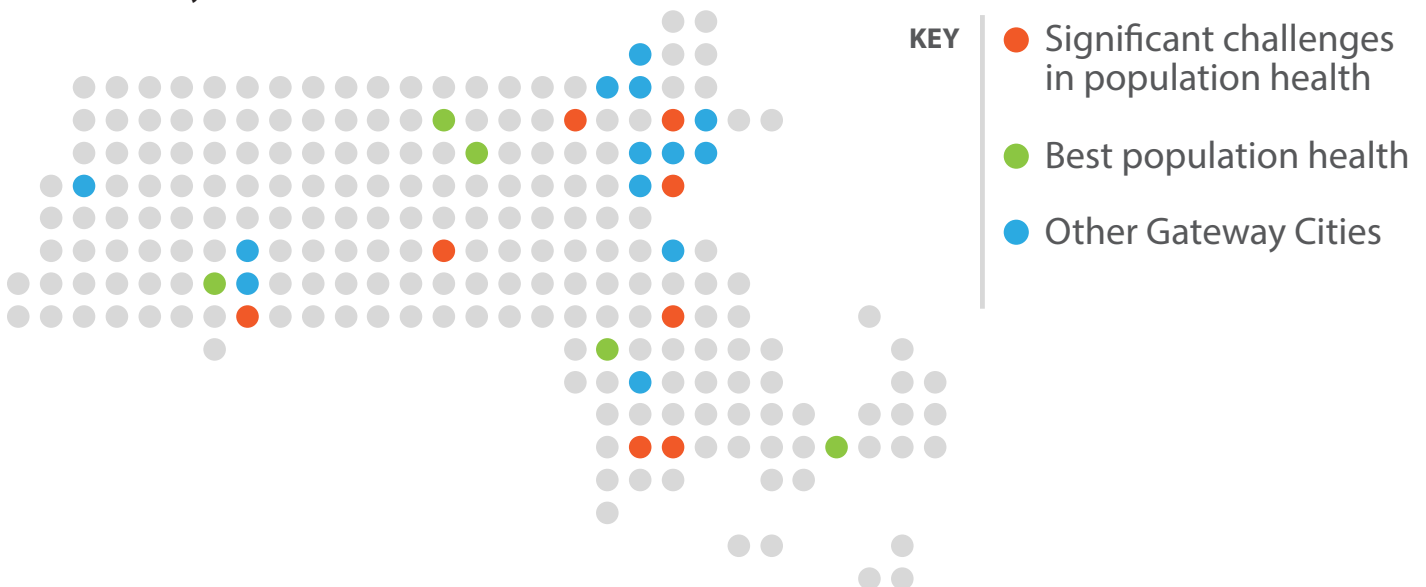
To learn more about the variations in health indicators, we looked at all communities and then took a closer look at 26 Massachusetts Gateway Cities (see sidebar for list of cities). We identified ways the health of older people in Gateway Cities differ significantly from state averages. Focusing on these communities can shed light on programs or services that seem to be working, as well as on areas of unmet, or poorly met, health care or social service needs. Having accurate, local data focused exclusively on older people is the foundation on which further progress can be made in creating truly age-friendly communities in Massachusetts.

Gateway Cities are urban hubs around the state previously known for their mills and industry. The Massachusetts Legislature defines the 26 Gateway Cities as:

- Attleboro
- Barnstable
- Brockton
- Chelsea
- Chicopee
- Everett
- Fall River
- Fitchburg
- Haverhill
- Holyoke
- Lawrence
- Leominster
- Lowell
- Lynn
- Malden
- Methuen
- New Bedford
- Peabody
- Pittsfield
- Quincy
- Revere
- Salem
- Springfield
- Taunton
- Westfield
- Worcester

The Massachusetts Healthy Aging Data Report was first produced in 2014 and updated in 2015. This 2018 edition reveals subtle population shifts since our last report.

Gateway Cities in Massachusetts



We believe the data in the *2018 Massachusetts Healthy Aging Data Report* can motivate, inform, and validate decisions that will help us realize these opportunities and can add to the momentum already building through the work of the Governor’s

Council, the Massachusetts Healthy Aging Collaborative, and the innovators, policymakers, health care providers, service providers, families, foundations, and individuals working to build age-friendly communities.

TABLE 2. BEST AND WORST RATES ON SELECT INDICATORS

Indicator	Best Rates	Worst Rates
Mortality rate	Chesterfield	Huntington
	Middlefield	Worcester Downtown
	Worthington	Worcester Central City
Any physical activity in past month	Acton	Avon
	Concord	Brockton
	Stow	New Bedford
CDC preventive screening	Marblehead	Dorchester
	Nahant	Mattapan
	Swampscott	Roxbury
Obesity	Aquinnah	Springfield (Bay, McKnight, Old Hill, Upper Hill)
	Chilmark	Springfield (Boston Road, Pine Point)
	West Tisbury	Springfield (Brightwood, Memorial Square, Metro Center, Six Corners, South End)
Depression	Dover	Worcester Central City
	Dunstable	Worcester Downtown
	Princeton	Springfield (Brightwood, Memorial Square, Metro Center, Six Corners, South End)
Alzheimer’s & related dementias	Wellfleet	Roslindale
	Mount Washington	Springfield (Brightwood, Memorial Square, Metro Center, Six Corners, South End)
	Sheffield	Worcester Center City & Downtown
	Egremont	
Stroke	Blandford	Ayer
	Boylston	Lenox
	Chester	Lowell
	Grafton	
	Russell	
Diabetes	Aquinnah	Lawrence
	Carlisle	Mattapan
	Chilmark	Roxbury
	West Tisbury	
Asthma	Boylston	Fall River
	Nantucket	Springfield (Brightwood, Memorial Square, Metro Center, Six Corners, South End)
	Richmond	Springfield (Liberty Heights, East Springfield, Indian Orchard)
Multiple comorbidities (4+)	Ashfield	East Worcester
	Buckland	Fall River
	Conway	Springfield (Brightwood, Memorial Square, Metro Center, Six Corners, South End)
Ambulatory difficulty	Aquinnah	East Boston
	Monterey	Springfield (Brightwood, Memorial Square, Metro Center, Six Corners, South End)
	Princeton	Worcester Central City

NEW INDICATORS OFFER MORE COMPLETE PICTURE

A total of 179 health indicators are reported in the 2018 Community Profiles, including 58 new measures added since the 2015 report. The new indicators help fine-tune our understanding of the following dimensions of community health:

Population Characteristics

In Massachusetts, more than 3% of adults aged 65 years and older identify as lesbian, gay, bisexual, or transgender (LGBT), so we added sexual orientation and gender identity as a new population characteristic.

Chronic Disease

Newly added are prevalence rates for 12 chronic diseases: autism spectrum disorders, endometrial cancers, epilepsy, fibromyalgia, HIV/AIDS, leukemia, liver disease, leukemias and lymphomas, migraine, peripheral vascular disease, pressure ulcers, and traumatic brain injury.

Behavioral Health

Mental health is an often-overlooked component of overall well-being. For this report, we added prevalence rates of physician-diagnosed anxiety, bipolar disorder, post-traumatic stress disorder (PTSD), and schizophrenia as indicators. We also added measures of substance and tobacco use disorders and opioid deaths, since these are often intimately tied to mental health.

Disability

Rates of deafness, blindness, and mobility impairments were included as clinical measures of disability.

Community and Civic Engagement

The local environment and an older person's engagement with it are important elements of health and well-being. We have included a number of new indicators to measure those factors. They include age-friendly efforts, open space, grandparents raising grandchildren, assisted living sites, vacant homes, universities, public libraries, YMCAs, access to broadband internet service, and internet use.

Safety and Transportation

We added indicators tracking homicide rates and firearm fatalities. New indicators also track the number of licensed drivers age 61 or older, motor vehicle ownership, seatbelt use, total automobile crashes, medical transportation, non-medical transportation, and a summary transportation score.

Economic and Housing

Indicators showing rates of food stamp receipt, employment, home-ownership, mortgage holding, and percentage of income spent on housing have been added.

Wellness

Several new indicators of wellness were added, including three measures of physical activity and measures aimed at determining sleep adequacy. In addition, indicators of overall preventative health behavior, HIV screening, and whether community residents live in a home where smoking is prohibited were also added.

Nutrition

Clinical obesity and poor access to supermarkets (e.g., food deserts) were added as indicators.

Access to Care


For older adults, “care” can come from many different sources. To reflect this, four additional indicators were added to better determine access to care: community health centers, adult day health centers, memory cafés, and dementia support groups.

Service Utilization


The number of skilled nursing home Medicare beds per capita and the prevalence of older persons receiving Medicaid long-term services and supports were added as indicators.

2018 MASSACHUSETTS HEALTHY AGING COMMUNITY PROFILE

Boston (Suffolk)



This is a summary profile for the city of Boston. Boston is the state capital and population hub for the Commonwealth of Massachusetts with 70,278 residents aged 65 or older. The transit score suggests that Boston is a “Rider’s Paradise” (9/10). Overall, healthy aging indicators for Boston are mixed. For more specific communities, please see the 16 profiles for individual Boston neighborhoods: East Boston, Charlestown, South Boston, Central Boston, Back Bay-Beacon Hill, South End, Fenway/Kenmore, Allston-Brighton, Jamaica Plain, Roxbury, North Dorchester, South Dorchester, Mattapan, Roslindale, West Roxbury and Hyde Park. Boston has been designated an Age-Friendly Community and is also considered an active Dementia-Friendly Community. To support the Dementia-Friendly initiative, five memory cafes exist.



POPULATION CHARACTERISTICS	BETTER / WORSE STATE RATE ¹	COMMUNITY ESTIMATE	STATE ESTIMATE
Total population all ages		658,279	6,742,143
Population 60 years or older as % of total population		15.3%	21.2%
Total population 60 years or older		100,694	1,428,144
Population 65 years or older as % of total population		10.7%	15.1%
Total population 65 years or older		70,278	1,016,679
% 65-74 years		55.9%	55.3%
% 75-84 years		29.5%	29.4%
% 85 years or older		14.6%	15.2%
Gender (65+ population)			
% female		58.5%	57.2%
Race/Ethnicity (65+ population)			
% White		57.7%	90.0%
% African American		26.2%	4.3%
% Asian		8.9%	3.2%
% Other		7.2%	2.5%
% Hispanic/Latino		11.0%	3.8%
Marital Status (65+ population)			
% married		39.4%	52.5%
% divorced/separated		18.7%	14.0%
% widowed		25.6%	25.5%
% never married		16.3%	8.0%
Education (65+ population)			
% with less than high school education		29.7%	16.5%
% with high school or some college		42.8%	52.6%
% with college degree		27.6%	30.9%
% of 60+ LGBT (county)		7.8%	3.2%
% of 65+ population living alone		39.8%	30.2%
% of 65+ population who speak only English at home		64.2%	83.3%
% of 65+ population who are veterans of military service		10.9%	18.8%
Age-sex adjusted 1-year mortality rate		4.0%	4.2%

Boston (Suffolk) PAGE 1

Comprehensive Community Profiles

are available for every city and town in the state. Each profile provides detailed population characteristics as well as information about community engagement, access to care, wellness and prevention, nutrition/diet, mental health, chronic disease, living with disability, and safety.

STATEWIDE CHANGES IN MASSACHUSETTS

A closer look at larger Massachusetts communities

The data show evidence of progress and reasons for concern about the health of the state's older residents. Comparing 2011 and 2015 data, some Massachusetts health indicators improved, but others worsened.

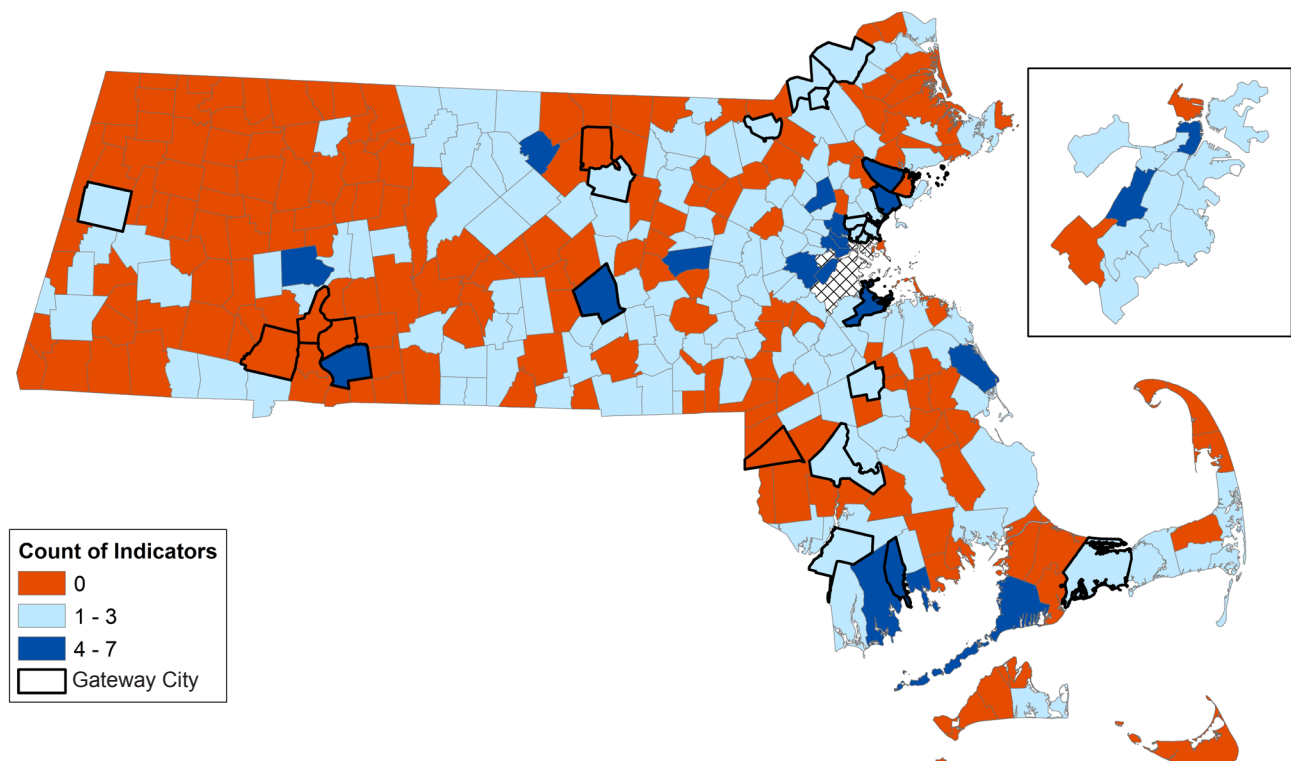
The Good News

Overall, the statewide one-year mortality rate declined and three important measures of heart health (congestive heart failure, ischemic heart disease, and heart attack) showed improvement. Rates of chronic obstructive pulmonary disease, anemia, colon cancer, and prostate cancer also were lower. Inpatient hospitalization admission, admission to skilled nursing facilities, and durable medical equipment use declined.

The Bad News

Since the previous report, higher rates were found for arthritis, asthma, atrial fibrillation, breast cancer, chronic kidney disease, depression, endometrial cancers, benign prostatic hyperplasia, high cholesterol, hypothyroidism and lung cancer. Trips to an emergency department occurred with greater frequency. We note with some concern that rates of depression significantly increased in more than 40% of communities across the Commonwealth.

Map 1. Count of CMS Indicators that Improved Comparing 2015 to 2011



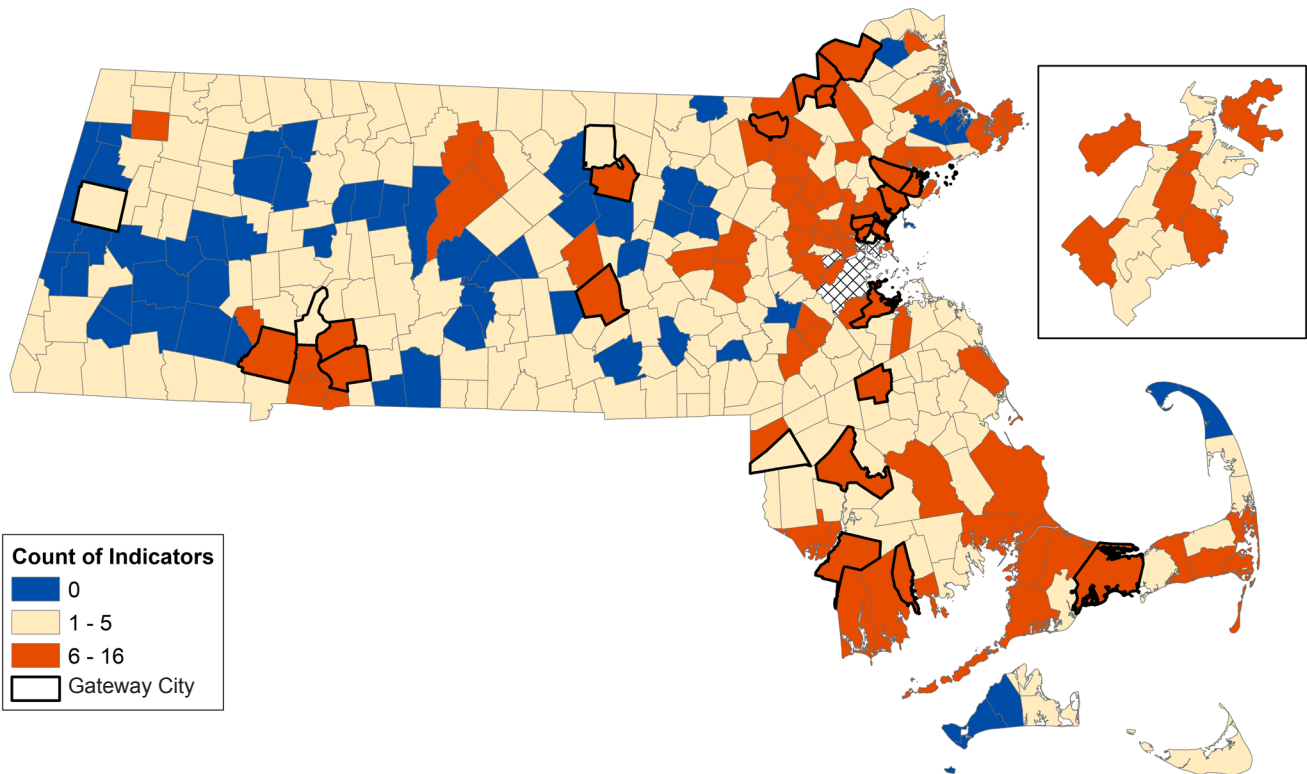
Which communities improved most?

Communities that recorded the highest number of improving indicators compared with our last report were scattered over the map, but several were located in eastern and central Massachusetts. They include Brookline, Cambridge, Dartmouth, Falmouth, Gardner, Gosnold, Lynn, Marlborough, Medford, Newton, Peabody, and Quincy. The variability among communities with at least four improving indicators included both affluent Boston suburbs and economically challenged Gateway Cities, such as Lynn, New Bedford, and Worcester (see Map 1, Count of CMS Indicators that Improved Comparing 2015 to 2011).

Which got worse results?

Overall, more communities experienced declines in health indicators than those showing improvement. The most improvement in any community was five indicators and this occurred in only four communities. In contrast, nearly 23% of communities experienced declines in five or more indicators. Communities with worsening rates for five or more indicators include Arlington, Brockton, Burlington, Fall River, Haverhill, Lawrence, New Bedford, Revere, Swansea, and Wareham. Many of the communities with larger numbers of declining indicators are in the northeastern and southeastern areas of the state (see Map 2, Count of CMS Indicators that Worsened Comparing 2015 to 2011). Most of those older populations were of average or lower socioeconomic status.

Map 2. Count of CMS Indicators that Worsened Comparing 2015 to 2011



Measuring Population Health

The Centers for Disease Control and Prevention use the term population health to refer to the distribution of health outcomes within a population. It includes the range of personal, social, economic, and environmental factors that influence the distribution of health outcomes, and the policies and interventions that affect those factors. We statistically distilled data for more than 60 chronic disease, disability, and health services utilization indicators to create a summary measure of population health for older people. The analyses revealed three key aspects of population healthy aging: serious and complex chronic disease, disability, and indolent conditions.

Serious and complex chronic disease

This dimension of health includes rates of cardiovascular disease, mortality, and use of expensive medical treatments. Communities with the lowest rates tend to have older populations with more education and higher incomes. The communities with highest rates are located across the state, but many are found in the greater Boston area and tend to be industrial areas where the older population has less education and lower incomes. Five communities with the highest rates of serious chronic disease are Gateway Cities and three more are adjacent to a Gateway City.

Disability

This aspect of community population healthy aging is determined by indicators related to physical and mental disability. Many communities with the best scores are clustered in southeast and south

central Massachusetts. Communities with the worst scores tend to be densely populated urban areas, including three neighborhoods in Boston and two in Worcester. Many of these communities have racially and ethnically diverse populations with lower income levels and less education.

Indolent disease

The third dimension of population health reflects a higher prevalence of indolent diseases, or chronic disorders that progress slowly. Most can be effectively managed with medication and regular visits to a doctor. The diagnosis of these diseases is often associated with good access to medical care. Older residents of communities with the highest scores tend to have more education and higher incomes. A higher prevalence is likely due, in part, to better diagnosis of those diseases because of good access to care. Communities with lower scores on this dimension generally have older populations with lower incomes and less education.

In an effort to identify communities with many challenges to healthy aging we conducted multiple analyses. The communities that consistently emerged as challenged, regardless of the analytic approach are communities we think should be priorities for support and are listed below.

- Brockton
- Chelsea
- Fall River
- Lawrence
- Lowell
- New Bedford
- Peabody
- Roxbury
- Springfield
- Worcester

Gateway Cities

Today, most Gateway Cities face economic and social challenges, including the health of their older residents. In general, the population health of older adults is poorer in Gateway Cities than in other Massachusetts communities. Twenty-one of the 26 Gateway Cities are below state averages on health indicators of older adults. In many cases, health indicators in individual Gateway Cities have declined since the last report. A few Gateway Cities face serious health challenges, particularly Fall River and Brockton. But several have shown modest improvement, notably Worcester, New Bedford, Springfield, and Peabody. The results suggest Gateway Cities should be a focus of population health efforts as well as economic development initiatives.

What differs among Gateway Cities?

Eight Gateway Cities have significant population health challenges, meaning they had 36 or more health indicators with rates worse than state averages, and 10 or fewer health indicators with rates better than state averages. Those eight cities are Brockton, Chelsea, Fall River, Lowell, New Bedford, Peabody, Springfield, and Worcester.

The five Gateway Cities with the best population health were: Attleboro, Barnstable, Fitchburg, Leominster, and Westfield. But these communities also had a significant number of health indicators with rates worse than the state average, suggesting even Gateway Cities with the best relative population health still struggle in comparison to all other Massachusetts communities.

How has population health changed in Gateway Cities between 2011 and 2015?

To assess whether trajectories of population health of older persons differ in Gateway Cities compared to those in other Massachusetts cities and towns, we examined changes between 2011 and 2015 in 37 indicators that were reported in both the original and newly updated Massachusetts healthy aging community profiles. Since rates on health indicators may change due to changes in the average age and gender ratio of a population, 2015 health indicator rates were adjusted to reflect the 2011 age/gender composition of communities.

Overall, we found population health disparities worsened in Gateway Cities relative to other cities, although there were also some improvements in population health measures. A greater percentage of Medicare health indicators (5.4%) improved in Gateway Cities than in other Massachusetts cities and towns (2.7%). However, declines were observed on 22% of indicators in Gateway Cities compared to declines of 9% in other Massachusetts communities. Thus, many more health indicators declined in Gateway Cities than in other Massachusetts communities. Those results suggest an increasing population health disparity between Gateway Cities and other communities.

Rural Communities

While there are more older people in urban areas, rural communities often have the highest proportion of residents who are 65+. This concentration of older people is especially notable on Cape Cod and in the

Berkshires. Residents in rural communities are often challenged by lack of access to medical care and transportation.

Behavioral Health

We investigated three key behavioral health concerns: depression, anxiety, and substance use disorders and explored community factors associated with higher or lower rates of each condition.

31% | Depression

Depression is the most commonly diagnosed mental health problem among older Americans. Statewide 31% of older people in Massachusetts have ever been diagnosed with depression and overall rates ranged from 20% in Princeton to 49% in Springfield (Brightwood, Memorial Square, Metro Center, Six Corners, South End). Increased risk for depression was associated with higher rates of older residents living alone, dealing with greater levels of chronic disease, and having access to mental health care. We worry that areas with less access to behavioral health services may have a higher prevalence of depression than we are able to detect from Medicare claims data. Statewide efforts to nurture collaboration between behavioral health, primary care, and aging service providers to optimize mental health is needed.

25% | Anxiety

There are many kinds of anxiety disorders and all of them can interfere with daily life and diminish a person's quality of life. Anxiety rates ranged from about 14% (Nantucket) to 37% (Fall River). About one of every four older people in Massachusetts has ever been diagnosed with some form of anxiety disorder and, as with depression, higher rates are associated with living alone and higher rates of chronic disease. Anxiety appeared to be more common in urban areas and communities with less access to mental health providers.

6% | Unhealthy Behaviors Related to Use of Alcohol or Drugs

More than 6% of all Massachusetts residents 65 years and older have some form of substance use disorder. But the rates vary widely in communities across the state, from less than 3% (Harvard) to about 16% (Downtown and Central Worcester). Higher rates are found in communities with relatively high levels of serious and complex chronic disease, crime, and older adults living alone. Lower rates were found in communities with higher percentages of older women of Asian descent.

Race and Health

It is difficult to determine the extent to which race contributes to health disparities within an individual community. Within racial or ethnic minority populations there is great variability in rates. Reliable and consistent access to quality care is important to maintaining good health. Residents encountering race-related barriers to health care access are less likely to be diagnosed and registered in health care systems, such as Medicare. Hence caution must be exercised in drawing firm conclusions about the causes of racial/ethnic disparities in health indicators based on Medicare service utilization.

Mindful of these potential shortcomings, we examined race and ethnic differences in 58 indicators of diagnosed chronic disease, disabling conditions, and Medicare service use. We also reviewed changes in 36 indicators between 2011 and 2015. Our analysis sheds light on several patterns of racial and ethnic differences in population health among older Massachusetts residents:

- Older adults of Asian descent appear to be in much better health than other older adults in Massachusetts. Older adult Asians have better rates than their White counterparts in all but five indicators. In contrast, health indicators were not uniformly better or worse among older White, African-American, or Hispanic older adults.
- Older Hispanic people recorded more improving health indicators between 2011 and 2015 than other older adults in Massachusetts.
- The patterns of racial and ethnic disparities in indolent chronic disease indicators were nearly opposite of those found for serious complex chronic disease and disability. (Likely due to the strong access to care component of this dimension of population health.) With relatively few exceptions older Whites had the highest rates of indolent chronic diseases such as arthritis, benign prostatic hyperplasia, hypothyroidism, and atrial fibrillation.
- In addition to higher rates of diabetes, older African-American and Hispanic adults have higher rates of obesity and hypertension than Whites. They also have higher rates than Whites of chronic kidney disease, a disease associated with hypertension and diabetes.
- White older adults are more likely than African-Americans and Hispanics to be diagnosed with a number of heart conditions, such as ischemic heart disease, peripheral vascular disease, and heart attack.
- Older White adults also have the highest prevalence of leukemia and other lymphomas, lung cancer, colorectal cancer, breast cancer, and endometrial cancer. African-American men were found to have the highest rates of prostate cancer.
- Older White adults generally fared better than their African-American and Hispanic counterparts on indicators of physical and mental disability. They had lower rates of dementia, epilepsy, glaucoma, mobility impairments, substance use disorder, and schizophrenia. A notable exception is that Whites had a higher rate of personality disorders than other racial groups.
- The relatively few health indicators where racial/ethnic disparities diminished, such as glaucoma and asthma, were due more to rising prevalence rates among Whites rather than falling rates among older adults of other races.

How Massachusetts Compares to Other New England States

When comparing key indicators across other New England states over time, we found Massachusetts had more community health indicators change (improve or worsen) than in other New England states. Fourteen indicators improved while 16 worsened.

Most of the indicators that shifted in Massachusetts moved in the same direction, for better or worse, as they did in at least three other New England states. This pattern of shifting indicators in the same

direction among New England states suggests that similar factors are influencing the population health of older adults in the region and probably isn't something specific to Massachusetts.

The only indicator that changed differently in Massachusetts than in other New England states was diabetes. It was unchanged in most New England states, but improved in Massachusetts and grew worse in Rhode Island.

TABLE 3. BEST AND WORST RATES ON SELECT INDICATORS

Table 3 shows a comparison of New England states (CT, ME, MA, NH, and VT) on selected indicators.

INDICATOR	MA	CT	ME	NH	RI	VT
Alzheimer's disease or related dementias	13.6%	14.4%	11.3%	12.0%	14.2%	10.1%
Diabetes	31.7%	34.2%	29.3%	28.2%	36.8%	25.8%
Stroke	12.0%	12.2%	11.3%	10.8%	12.4%	10.4%
Hypertension	76.2%	77.1%	71.1%	70.2%	79.7%	67.3%
Heart attack	4.6%	4.6%	6.0%	4.5%	5.5%	5.1%
Ischemic heart disease	40.2%	42.3%	37.5%	34.3%	44.4%	34.2%
Chronic kidney disease	27.3%	25.5%	23.4%	22.3%	26.5%	19.2%
Depression	31.5%	28.7%	33.7%	28.8%	32.6%	29.8%
Schizophrenia & other psychotic disorders	5.9%	5.2%	5.2%	4.9%	5.2%	3.7%
Hip fracture	3.7%	3.9%	3.5%	3.3%	3.7%	3.3%
4+ chronic conditions	60.7%	61.5%	57.4%	54.4%	64.4%	51.1%
Deafness or hearing impairment	16.1%	14.1%	12.3%	14.4%	15.4%	13.9%
Blindness or visual impairment	1.5%	1.1%	0.8%	0.9%	1.3%	0.8%

A CALL TO ACTION

This report aims to unleash the power in Massachusetts communities to achieve optimal population healthy aging. The data in this report can help guide communities to become better places to grow up and grow old.

Knowledge is power. More people are living longer lives and contributing to the economy and their communities. In many cities and towns, these demographic changes have prompted new discussions about healthy aging and age-friendly communities.

The path to action.



UNDERSTAND.

- Download your Community Profile at healthyagingdatareports.org.
- Educate yourself and others about the older people who live in your city or town.
- Compare your city or town to state averages.



ENGAGE.

- Start a conversation.
- Bring older people and community organizations together.



ACT.

- Join the age-friendly movement.
- Prioritize community needs and resources.
- Collaborate with diverse partners and funders.

TECHNICAL NOTES

See our technical report (online at <https://mahealthyagingcollaborative.org/data-report/explore-the-profiles/data-sources-and-methods/>) for comprehensive information on data sources, measures, methodology, and margin of errors.

For most indicators the reported community and state values are both estimates derived from sample data. Thus, it is possible that some of the differences between state and community estimates may be due to chance associated with population sampling. We use the terms “better” and “worse” to highlight signature differences between community and state estimates that we are confident are not due to chance. “Better” is used where a higher/lower value has positive implications for the health of older residents. “Worse” is used where a higher/lower score has negative implications for the health of older people, and when the implication is unclear we use an asterisk (*).

General Notes

We balance two goals. First, we aim to report data at very local levels because we believe change is often locally driven. Second, we vowed to protect the privacy of the people providing the information reported. Thus, given the constraints of the data analyzed we used a hierarchical approach to reporting. When possible we report estimates for 379 geographic units (i.e., every Massachusetts city/town and 16 Boston neighborhoods, 6 Worcester neighborhoods, and 6 Springfield neighborhoods). For example, the population characteristics and information from the US Census were reported for all 379 units. For other data (i.e., highly prevalent chronic disease, health services utilization) we reported for 310 geographic units. For less prevalent conditions we report for 201 geographic units. For the BRFSS data we report for 41 geographic units, and for the lowest prevalence conditions (e.g., HIV) we report for 18 geographic units. The same estimate is reported for all cities/towns within aggregated geographic areas. Maps of the different geographic groupings and the rationale behind the groupings are in the Technical Report.

Data Sources

The Technical Report describes all of the data sources for the report, but three to note are: (1) the American Community Survey (2012-2016); (2) Centers for Medicare and Medicaid Services Master Beneficiary Summary File (2014-2015); and (3) The Behavioral Risk Factor Surveillance System (2010-2015).

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Healthy Aging Data Report Team

We thank our 2018 Advisory Committee members for contributing ideas and advice on how to make the Data Report best address the needs of Massachusetts.

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“There is no power for change greater than a community discovering what it cares about.”

– – Margaret J. Wheatley

