

HIGHLIGHTS FROM THE
MASSACHUSETTS HEALTHY
AGING DATA REPORT:

COMMUNITY PROFILES 2015



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IN COLLABORATION WITH



The **Massachusetts Healthy Aging Data Report: Community Profiles 2015** is an easy-to-use online compilation of community-specific health-related information 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 commissioned by the Tufts Health Plan Foundation.

The 2015 database significantly expands the 2014 database: it now provides custom profiles of 121 healthy aging indicators for every city and town in Massachusetts including the 16 neighborhoods of Boston (367 Community Profiles in all). It also explores these data with new analyses that provide a clearer picture of health at an unprecedented level of geographic detail. Each Community Profile is designed to help residents, agencies, providers, and governments understand the older adults who live in their cities and towns – their ages, living arrangements, health status, strengths, and vulnerabilities.

You can access this comprehensive view of healthy aging from the websites of either the [Massachusetts Healthy Aging Collaborative](#) or the [Tufts Health Plan Foundation](#).

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Building a Foundation for Community Health

Health doesn't happen in a vacuum. How well we age is tied to many factors in the communities around us.

In 1996 the World Health Organization declared that “healthy older people are a resource for their families, their communities, and the economy.” The Tufts Health Plan Foundation embraces this positive view, with a particular eye on the word “healthy.” Whether you call it “active aging,” “optimal aging,” “vibrant living,” or some other phrase, we believe that health in later life means staying involved with friends, family, and community, having purpose in life, feeling safe, eating well, drinking responsibly, staying physically active, and being proactive in managing one’s health.

Just as individuals can be more or less healthy, so can our cities and towns. A core mission of the Tufts Health Plan Foundation is to promote health at a community level—to help create “age-friendly” cities and towns in Massachusetts. A key part of our strategy has been to support the creation of an innovative way for everyone in the state to get a clearer picture of the health of their city or town.

Making a good tool even better

In 2014, we launched the Massachusetts Healthy Aging Data Report: Community Profiles. This unique online database was 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 commissioned by the Tufts Health Plan Foundation with guidance and advocacy from the Massachusetts Healthy Aging Collaborative.

The 2014 database was ground-breaking. To our knowledge it was—and is—the only public source of healthy aging indicators reported for geographic areas smaller than counties. It is also uniquely well-organized and easy-to-use. Now this tool has been significantly improved and expanded. Thirty-nine new indicators of health have been added and new ways to analyze and interpret the data have been used to create summary statistics that help users get the “big picture” about the health of citizens in each of the 351 cities and towns of Massachusetts as well as the 16 neighborhoods of Boston (367 Community Profiles in all). We have explored in depth a range of new issues, such as the impact of race and ethnicity on disparities in health, and why some cities and towns have better- or worse-than-expected health.

Key findings

The addition of new health indicators and the use of sophisticated statistical techniques to analyze the data in the 2015 Community Profiles have generated the following insights into the health of our state as it relates to older adults:

- **Income and education levels** have powerful effects on community population health. These two factors had more influence than any other variable on the variation observed across Massachusetts communities in a composite measure of chronic disease in older adults. (Communities with less educated and poorer older residents tend to have worse health.)

- **Healthy behaviors make a difference.** Older adult population health tends to be better in communities with the highest levels of good health behaviors and preventive service use, and in communities with better social environments as reflected in lower crime rates and higher voter participation rates.
- **Population health is much higher or lower than expected** in a few Massachusetts communities, despite the powerful influences of income and education levels. These communities may provide lessons about both more-effective and less-effective strategies for improving public health.
- **Major disparities between racial and ethnic groups persist** in a range of health-related outcomes. Black and Hispanic older adults report poorer health, more unhealthy days, less physical activity, and higher rates of disability, obesity, and not seeing a doctor because of cost compared to older white adults.

Look for “Winnable Battles”

The 2015 Community Profiles provide a solid foundation on which to build efforts to improve the health of individuals and communities. One way to prioritize these efforts is by using the idea of “**winnable battles**” promoted by the Centers for Disease Control and Prevention (CDC). This means targeting specific behaviors or issues, such as nutrition, physical activity, obesity, food safety, or immunizations, 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, are clearly important as well. Making progress in those long-term battles requires collaborative community efforts along with those being made in the health care field.

Importantly, improvements in health are being made, and some battles are being won. Throughout this report call-out boxes highlight ways that some Massachusetts service providers are using our Community Profiles data to create programs with clear, achievable, measurable goals to improve the health of older adults. Such efforts are gratifying. They validate our efforts to organize and present health-related information as we have done. With the 2015 expansion of this invaluable tool, we set the stage for even more exciting change in the years to come. Together, we can improve healthy aging in Massachusetts. Use the information in the Community Profiles to guide and motivate your own work and join us to make a difference in the lives of our older citizens!

*James Roosevelt Jr.
President, Tufts Health Plan Foundation
CEO, Tufts Health Plan*

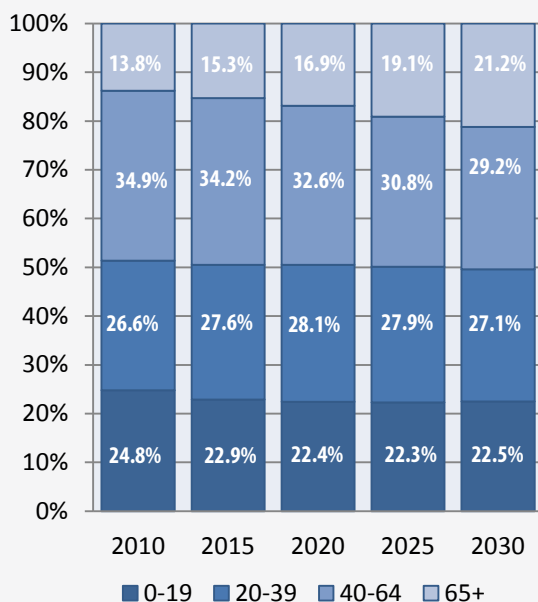
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Aging in Massachusetts

It's no secret that people are living longer. This is leading, in the United States and other developed countries, to the “greying” of the population—a shift in the percentage of the population that is age 65 or older. The CDC estimates that by 2030 about 1 of every 5 Americans will be age 65 or older—that's about 72 million people.

This trend will be mirrored in Massachusetts. It is estimated that the percentage of the state population of older adults will increase from 15% in 2015 to 21% in 2030 (Chart 1).

CHART 1: MASSACHUSETTS PROJECTED POPULATION DISTRIBUTION BY AGE GROUP 2010-2030



Source Data: U.S. Census Bureau, 2010 Census Summary File 1:
UMass Donahue Institute Population Projections 2013

The population will also become more racially and ethnically diverse. These shifts, in turn, should drive changes in the programs and services needed to support health and help overcome some of the existing disparities in health and health care use between racial and socio-economic groups.

For individuals what matters is whether the longer lifespans they can anticipate will be healthy or not. In aging, it's quality that counts for most people, not only quantity. We want to live long and well. The “ingredients” of healthy aging are summarized in Figure 1.

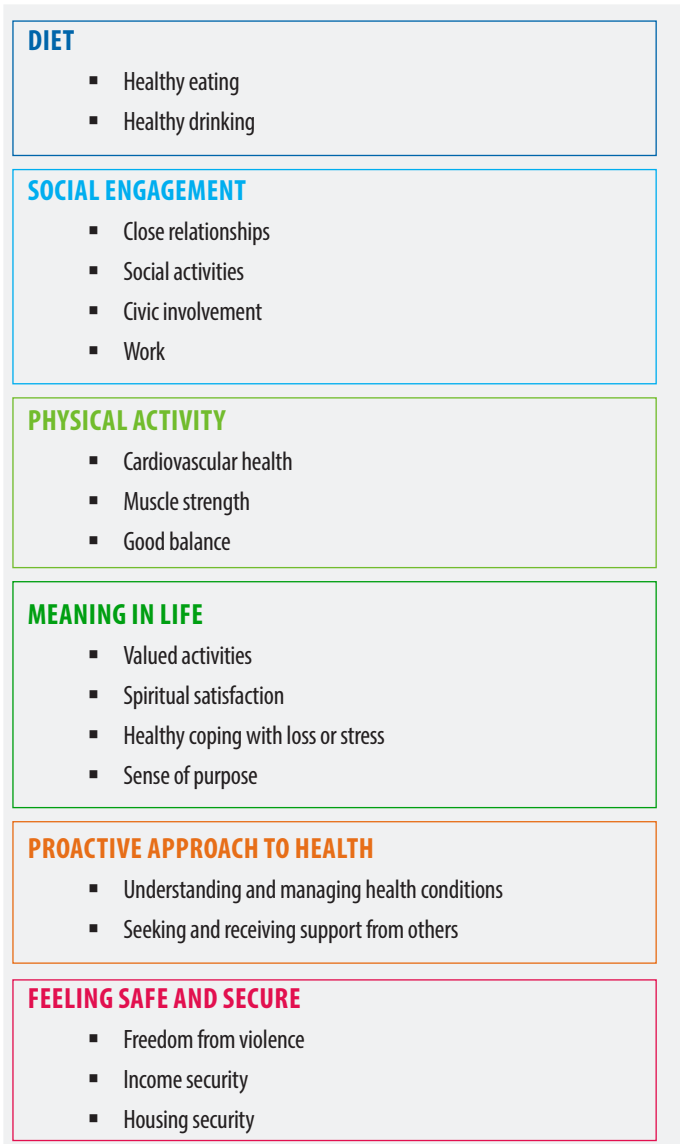
Compared to the U.S. as a whole, many in Massachusetts are achieving a healthy older age. The state is ranked 3rd-healthiest according to some reports¹, with higher-than-average education, income, access to health insurance, and rates of health care use. But averages can hide important variations.

In Massachusetts, some communities are relatively healthy, but others are much less so. And even in the healthiest communities, much progress could be made. For example, nearly 2 of every 3 older adults in Massachusetts have 4 or more chronic conditions. Although it's possible to be healthy with multiple chronic conditions if they are well-managed and well-controlled, this, still, is a sign

¹ America's Health Rankings 2014. 25th Anniversary Edition, 2014. Available at www.americashealthrankings.org.

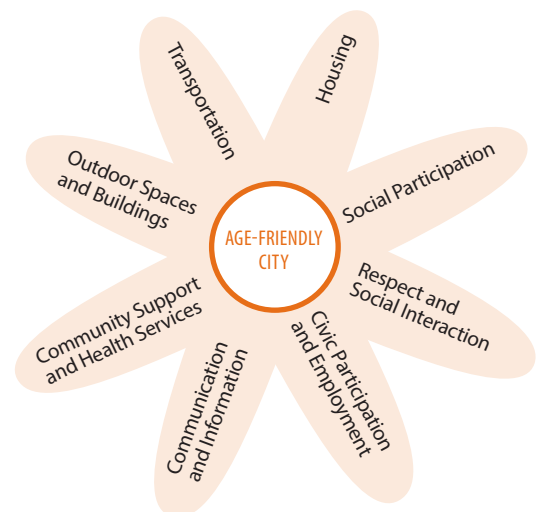
that there is room for improvement in our state's health. In addition, although Massachusetts, on average, has high education and income levels, deep pockets of poverty persist. About 1 in 3 households with an older adult has an annual income of less than

Figure 1. Ingredients of Healthy Aging



\$20,000 and more than 9% of adults age 65 and older are living in poverty. As will be clearly seen in our discussion of the key drivers of health, these figures are critically important to consider when creating targeted, realistic interventions to promote age-friendly cities and towns. Other factors important to this effort are illustrated in the World Health Organization's framework for Age-Friendly Cities (Figure 2).

Figure 2. Components of an Age-Friendly City



Adapted from: Global Age-Friendly Cities: A Guide. World Health Organization. 2007. ISBN: 978 92 4 154730 7

The New Indicators of Community Health

Thirty-nine new health indicators were added to the 2015 Community Profiles database, bringing the total number of indicators to 121. The newly-added indicators cover the following important areas, some of which are explored in more detail later in this report:

Population characteristics

New estimates for the number and percentages of people age 60 years or older were added because the federal Older Americans Act sets the eligibility requirements for local Councils on Aging and other groups at 60 and older. Other age-brackets from the previous report (e.g., the population age 65 and older) have been retained. In addition, new estimates are provided for the number of people who are non-native-English speakers, the number of veterans of military service, and for the percentage of older adults in each community who have recently moved.

Chronic disease

Eight new disease states were added as indicators: asthma; cataracts; low thyroid function (hypothyroidism); low blood iron levels (anemia); enlarged prostate (benign prostatic hyperplasia); atrial fibrillation; high cholesterol levels (hyperlipidemia); and chronic kidney disease. These new data will help guide interventions to target these relatively common conditions.

Living with disability

Estimates of the percentage of people living with six types of disability have been added—those living with impairments of: hearing; vision; thinking and memory (cognition); walking or moving (ambulation); self-care; and independent living.

Access to care

Since healthy aging can be affected by the availability of service providers, new information was gathered on the number of primary care providers, hospitals, nursing homes, and home health agencies within five miles of a geographic location.

Community

One's physical and social environment can affect health, so new estimates were added for air pollution and voter registration and participation rates (which are indicators of community or social engagement).

Safety

New data were added on traffic fatalities involving older adults.

Economics

Since financial security can have such an impact on healthy aging, new or expanded indicators about household incomes and the number of those living below the poverty level were added.

To learn more about these indicators and to view detailed maps showing the variation between communities in each indicator, visit the 2015 Community Profiles on the websites of either the [Massachusetts Healthy Aging Collaborative](#) or the [Tufts Health Plan Foundation](#).

THE DATA IN ACTION

Paula Shiner, of Coastline Elderly Services in New Bedford, is using Community Profiles data and other sources of information in her work with the local health collaborative to educate members, identify health priorities, and target interventions.

WHERE THE NUMBERS COME FROM

The data presented in both the 2014 and 2015 Community Profiles are reliable because of the extreme care used in choosing the data sources, analytical tools, and methodologies required for the project. Full details about these issues are available on the [“Data Sources and Methods”](#) page of the Massachusetts Healthy Aging Collaborative website, as well as in the technical notes that accompany each individual Community Profile. The following brief overview, however, may be helpful to understand, in order to better communicate to others where these data have come from and why they can be trusted.

Data sources

Three primary sources were used to develop the Community Profiles: U.S. census data; the Behavioral Risk Factor Surveillance Survey (BRFSS); and data from the Centers for Medicare and Medicaid Services (CMS). The BRFSS data represent community-residing respondents, while the CMS database contains information on both community-residing and institutionalized older adults. (About 5% of older Medicare beneficiaries in the state are institutionalized.)

Available data did not permit all indicators to be reported for every city and town in the state. The CMS database includes information on more than 600,000 individual Medicare beneficiaries age 65 or older in Massachusetts who received care from fee-for-service medical providers in 2011, and therefore is large enough that it can serve to estimate health indicators for all but the least-populated individual towns in the state, as well as neighborhoods within Boston. The data from the BRFSS, however, is not as extensive. This survey, although quite large, includes only about 9,000 respondents each year. These data limitations led us to stratify the indicators into three geographic tiers.

At the lowest tier, indicators derived from CMS data are reported for 310 communities, the great majority of which were individual cities or towns. The second tier of indicators, derived from BRFSS data, are computed for 33 larger areas defined by aggregating communities served by Massachusetts Aging Service Access Points (ASAPs). These indicator values are reported for each city and town within the aggregated service areas. The third tier is comprised of a few healthy aging indicators where data were only available for counties. The same

indicator values are reported for all cities and towns within a given county.

New analyses for the 2015 report

To better understand the overall population health of older adults in Massachusetts a series of multivariate analyses were conducted to:

1. Develop a single composite measure of older adult population health to simplify and reduce the data. This measure is called **Serious Complex Chronic Disease**. It was found to be strongly associated with age-sex adjusted mortality rates of Medicare beneficiaries across communities in the state, which supports its validity.
2. Identify factors (e.g., demographic, socioeconomic, health behavior, and geographic) that explain the variations in health observed in cities and towns across the state.
3. Find communities with “better” or “worse” population health than what is statistically expected, given the attributes of the older adults living in those communities.

These analyses shed valuable new light on the state of health in cities and towns across the state.

How Healthy are Massachusetts Communities?

A new composite measure of a community's health—the Serious Complex Chronic Disease measure—distills 40 individual health indicators into a single number. This measure was tested for its validity and found to be positively associated with higher mortality rates of older adults across Massachusetts communities. Communities with older adult populations that were most- and least-healthy by this measure, stratified by community size, are shown in Table 1. (Note that the cities and towns are not listed by their rank of healthiest or least healthy—they are simply examples from the top, or bottom, 20 communities.)²

TABLE 1

HEALTHIEST COMMUNITIES AS MEASURED BY SERIOUS COMPLEX CHRONIC DISEASE

SMALL	MID-SIZED	LARGE
Carlisle, West Tisbury, Sherborn, Dover	Lincoln, Harvard, Wayland, Weston, Duxbury	Back Bay-Beacon Hill, Concord, Lexington, Sudbury, Brookline, Newton, Needham

LEAST HEALTHY COMMUNITIES AS MEASURED BY SERIOUS COMPLEX CHRONIC DISEASE

SMALL	MID-SIZED	LARGE
Warren, Avon, Florida, Mendon, Holland, Phillipston	Southbridge, Carver, Palmer, Palmer, Webster, Blackstone	Fall River, New Bedford, Taunton, Chelsea, Lowell, Worcester

THE DATA IN ACTION

The high rates of falls among elders documented in the Community Profile for Middlesex County helped spur the launch of the Middlesex County Senior Health and Safety Initiative, in conjunction with Armstrong Ambulance Service, a county-wide safety and wellness initiative. Marian Ryan, the Middlesex District Attorney, also used the Community Profiles data to target special programs on elder abuse.

² The 2014 report featured tables of the 6 cities and towns with the most and least number of indicators that were better or worse than the state average. Those listings do not necessarily correlate with the cities and towns listed here because this year the serious complex chronic disease measure was used.

What Factors Drive Community Health?

Your health at any point in time is influenced by a bewildering number of factors including: genetics, lifestyle choices, healthcare, what you eat, your education and income levels, where you live, and the randomness of accidents.

Which of these factors matters most at a population level? To address this question, a number of statistical techniques were applied to the data in the 2015 Community Profiles. One of the main results of these analyses: demographic and socioeconomic factors contribute most to differences in older adult population health among communities in Massachusetts. This finding has some profound implications for health care-related decisions and for discussions about larger issues of social and economic justice in our society.

Factors associated with better population health:

- Higher levels of income and education.
- Having a more racially diverse and acculturated population, other things being equal.
- Good health behaviors and use of preventive services.

Factors associated with worse population health:

- A less-educated, poorer, and older population (suggesting that, to some extent, healthy aging is a social justice issue).
- Poorer social environments (e.g., higher crime rates, lower voter participation rates).
- Having higher percentages of older women and veterans in the population.

THE DATA IN ACTION

The Newton Department of Senior Services and Council on Aging have incorporated the information from Newton's Community Profile into its long-term strategic planning. Local thought leaders have contributed a series of articles in the local newspaper about making Newton an age-friendly community. In addition, service providers have used the profiles and a community needs assessment to identify priority target areas (e.g., housing options, transportation, depression). Community leaders now recognize that making Newton work for its oldest and youngest residents pays dividends for all.

Which Communities Are Doing Better or Worse Than Expected?

Based on the drivers of community health just described, a statistical “guess” can be made about how healthy a city or town should be. When these statistical

models are applied to actual data, some surprises emerge. Some communities are doing better than one might expect, while others are doing worse. Lessons can be learned from both types of communities. In those communities doing better than expected, something is boosting the older adult population health. Finding the “secret sauce” of these communities may lead to benefits for other communities. Communities that are doing worse than expected need to carefully assess the data for clues about what might be done to improve their situation. Table 2 highlights some communities with better- or worse-than-expected older adult population health. Interestingly, these communities are not all either very affluent or very poor. Further study is required to see what can be learned from these communities.

(As with Table 1, these cities and towns are not listed by their rank—they are examples from communities that were statistically better- or worse-than-expected.)

TABLE 2

COMMUNITIES WITH BETTER-THAN-EXPECTED POPULATION HEALTH

SMALL	MID-SIZED	LARGE
Sunderland, Monroe, Buckland, Goshen, Worthington	Adams, Boxford, Athol, Wilbraham, Nantucket	West Springfield, Back Bay-Beacon Hill, Leominster, North Dorchester, Concord

COMMUNITIES WITH WORSE-THAN-EXPECTED POPULATION HEALTH

SMALL	MID-SIZED	LARGE
Monterey, Tolland, Westhampton, Princeton, Royalston	Oxford, Holbrook, West Bridgewater, Westwood, Norfolk	Somerset, Framingham, Sharon, Bridgewater, Fall River

THE DATA IN ACTION

David Stevens, of the Massachusetts Association of Councils on Aging and Senior Centers, used Community Profiles data to help convince state legislators to add \$1,000,000 to the FY 2015 budget for the state’s Councils on Aging.

Race and Healthy Aging

To what extent might the large variations observed in healthy aging across the state be related to race? This possibility was explored in the analyses conducted for the 2015 Healthy Aging Data Report.

It turns out that determining how much race contributes to health disparities is difficult to pin down. For example, the story one draws about racial disparities in healthy aging can depend on which data you analyze. The self-report data from the BRFSS telephone survey suggest that older white persons of both genders were healthier than their non-white counterparts. In contrast, the Medicare data suggest that diagnosed rates of chronic disease are generally higher among older white persons relative to nonwhite adults.

These seemingly contradictory findings may reflect differences in access to care. Simply put, you have to access the health care system in order to be counted as having symptoms of disease. If there are race-related barriers to accessing health care, then the results of data from, for example, the Medicare system, may over-represent whites and under-represent non-whites.

Still, the researchers working on this report found ways to pool data from across the state in order to draw preliminary conclusions about racial health disparities. The results reveal important racial and ethnic differences in physical health, mental health, and in behaviors related to health:

- Older black and Hispanic men report poorer health, lower levels of emotional support, and being less likely to engage in healthy behaviors than older white men.
- Older black and Hispanic men are more likely than older white men to suffer from hypertension, diabetes, kidney disease, and glaucoma, but white men had higher rates for most other chronic conditions such as osteoporosis, hip fractures, and chronic obstructive pulmonary disease.
- Older minority women have major disparities compared to older white women. Black and Hispanic older women report poorer health, more unhealthy days, higher rates of disability and obesity, not participating in physical activity, and not seeing a doctor because of cost compared to older white women. Further, older black and Hispanic women had lower rates of adequate emotional support and engaging in healthy behaviors (e.g., getting yearly vaccinations or dental exams) compared to older white women.
- Older black and Hispanic women had higher diagnosed prevalence rates for most heart conditions (stroke, heart attacks, congestive heart failure, high blood pressure) relative to older white women.
- Older Asian adults generally appear much healthier than their non-Asian counterparts, having the lowest diagnosed prevalence rates for nearly all chronic diseases except diabetes (both men and women) and osteoporosis (women only).

One way researchers attempted to better understand these disparities was to compare statewide CMS and BRFSS data on health indicators by racial/ethnic group after statistically controlling for socio-economic status (income, education and living situation of persons age 60 and older in Massachusetts). The results were striking: the racial differences in healthy aging indicators were greatly reduced. In other words, to a large extent, it is not the color of one's skin that is driving health disparities, it is the education, income levels, and living situations of individuals that matter.

This does not mean race is irrelevant, or that physicians and health care systems are "color-blind." Much convincing research shows that, in fact, physicians can be strongly influenced by the gender, race, or perceived socio-economic status of their patients.³ The fact that wide disparities exist, regardless of their cause, is enough to warrant sustained and focused attention from policy makers to try to remedy such disparities.

THE DATA IN ACTION

Sandy Johnson at the Randolph Senior Center used the Community Profile data to win a grant from the Blue Hills Community Health Alliance aimed at reducing the level of hypertension and related heart diseases. The grant will fund heart-healthy luncheons with programs designed to promote exercise, a healthy diet, healthy weight, stress reduction, and diabetes control, among other efforts.

3 McKinlay J, Link C, Freund K, et al. 2007. "Sources of Variation in Physician Adherence with Clinical Guidelines: Results from a Factorial Experiment." *Journal of General Internal Medicine* 22:289-96.

Spotlight on Pivotal Health Indicators

In this section we highlight some of the newly-added health indicators that reveal particularly significant patterns or data. Any of the new indicators, however, may be of particular interest to health care providers, organizations, or institutions with special foci, so these should be viewed merely as examples of the kind of rich data available in the Community Profiles.

Chronic Diseases

Eight new chronic disease states were added as indicators in the 2015 report (you can find out more about these for your town or city in the Community Profiles). One of the newly-added disease states—cataracts—stands out because the percentage of adults in Massachusetts diagnosed with cataracts is 24.4%, which is significantly higher than the national average of 19.1% (Table 3). Whether this reflects an actual difference in the percentage of state residents with cataracts, or is an artifact related to the higher-than-normal availability of specialty eye care in the state and a higher rate of health care use in general is a subject for further research. Certain towns in Massachusetts have markedly high rates of cataracts such as retirement destinations on Cape Cod: Yarmouth (77%), Eastham (77%), and Orleans (76%).

The prevalence of asthma in older adults is rising and the Massachusetts rate is higher than the national rate: 5% compared with 4.2%. Urban communities with rates significantly higher than the state average include New Bedford (15.9%), Fall River (15.7%), and Springfield (15.1%)

TABLE 3: Rates of selected chronic conditions in Massachusetts and nationally

CHRONIC CONDITION	MASSACHUSETTS	NATIONAL
Asthma	5.0%	4.2%
Cataracts	24.4%	19.1%
Hypothyroidism	9.5%	9.6%
Anemia	25.5%	24.5%
Benign Prostatic Hyperplasia (Men)	17.4%	14.0%
Atrial Fibrillation	11.5%	9.1%
Hyperlipidemia/High Cholesterol	50.3%	48.0%
Chronic Kidney Disease	17.5%	15.6%

High cholesterol levels (hyperlipidemia) are a risk factor for heart disease, and more than half of the state's older adults are diagnosed with this condition—50.3%, which is somewhat higher than the national average. Communities with particularly high cholesterol rates of citizens who have ever been diagnosed with high cholesterol include Fall River (85%) and Taunton, Yarmouth, and Dartmouth, all of which had rates close to 83%.

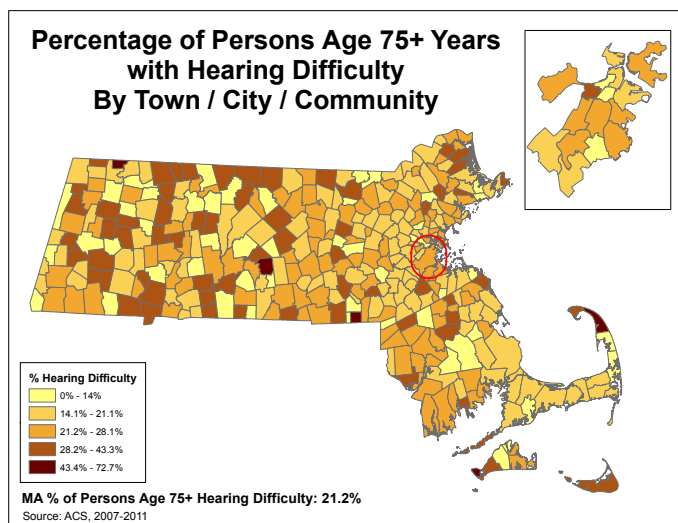
Chronic kidney disease is a condition where the kidneys are damaged and are not able to filter wastes and excess water from the blood. The state rate for adults age 65 and older with chronic kidney disease is 17.5%. Higher rates are observed in the urban communities of Roxbury, Mattapan, and Springfield.

Hearing and Vision Impairments

Hearing and vision impairments represent a good example of the kind of “winnable battles” mentioned in the introduction. These impairments are common, and yet they can often be overcome with the provision of glasses, hearing aides, or treatments to correct visual impairments (e.g., cataract surgery).

The state rate for hearing impairment among adults age 65-74 is 7% and among those age 75 and older it is 21.2% -- roughly 1 in 5 (Map 1). The rates of hearing impairment among the young-old population varied widely between communities, from a high of 46% in the small community of Ashford, to a low of 0% in 14 Massachusetts communities.

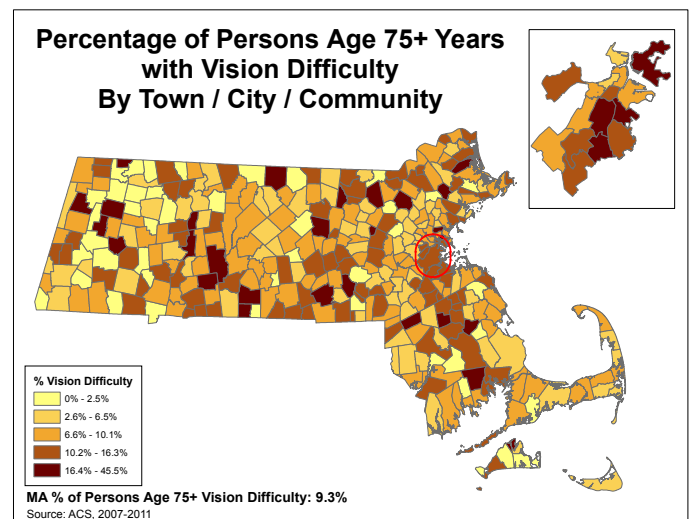
Map 1. Percentage of Persons Age 75+ with Hearing Difficulty



Disability due to vision impairment rises with age. The state rate for vision impairment among young-old adults (age 65-74) is 3.2% and among those age 75+ is 9.3% (Map 2). The communities with the highest rates of vision impairment among the “older old” were the small towns of Monroe (73%), Middlefield (36%), and Brimfield (27%). Several

larger cities, however, had significantly higher-than-average rates for this age group including Boston (13.2%), Lynn (11.9%), Springfield (11.2%), and Quincy (11.1%).

Map 2. Percentage of Persons Age 75+ with Vision Difficulty



Self-Care impairments

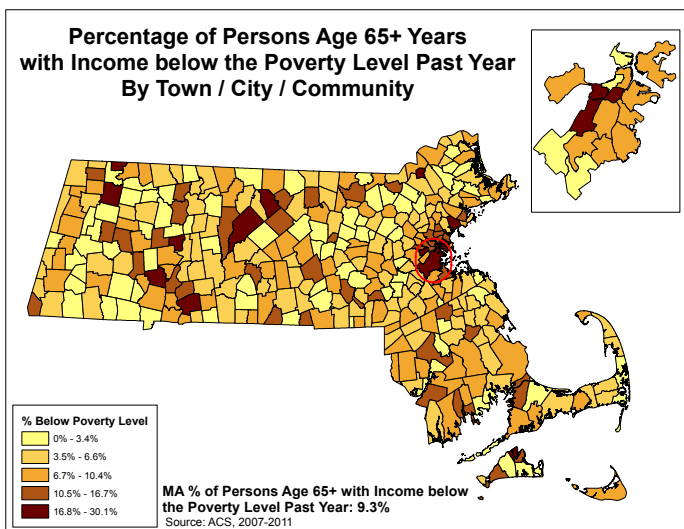
Self-care difficulty was defined as having difficulty bathing or dressing, or with basic activities of daily living. The state average for self-care difficulty was 12% for adults aged 75 and older. However, some small communities such as Monroe (46%), Aquinnah (44%), and Wales (42%) had much higher rates, while 27 communities had rates of 0%. Urban communities with higher-than-average rates include Springfield (17.4%), Brockton (16%), and Lynn (15.8%). Another important measure of community health is independent living difficulty, defined as having difficulty doing errands alone, such as visiting a doctor's office or shopping because of a physical, mental, or emotional problem. The state estimate for adults age 65-74 is 7%, but increases to 24.3% in adults 75+.

Poverty

As discussed previously, financial security has a tremendous impact on healthy aging. In general, Massachusetts is a relatively wealthy state, with only 9% of adults age 65 and older living below the poverty level. As illustrated by Map 3, however, deep pockets of poverty persist.

The poverty rate is 37% in Boston's South End, for example, and is 35% in the Fenway/Kenmore neighborhoods. Poverty isn't just an urban problem, however. Southamptton, a rural town in western Massachusetts, has a poverty rate of 30%.

Map 3. Percentage of Persons Age 65+ Years with Income below the Poverty Level Past Year

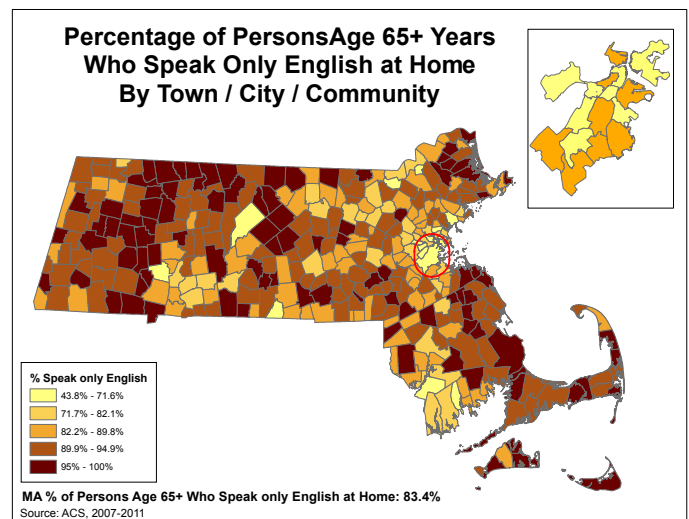


Potential language barriers

Our state's aging population is becoming more racially and ethnically diverse. This trend is important because limited ability to speak or comprehend English can make it harder for people to access community health services and other opportunities.

In Massachusetts, most older adults (83.4%) speak only English at home (in the other 16.6% a non-English language is primary). Map 4, however, illustrates the wide variation that exists in this variable, with urban areas showing markedly fewer English-only households. For example, more than half of the older adults in Allston-Brighton (56%), North Dorchester (52%), and Lawrence (52%) speak a language other than English at home. Service providers should recognize that lower rates of speaking only English at home may suggest a need for culturally sensitive outreach and provision of health services to engage and care for these populations.

Map 4. Percentage of Persons Age 65+ Years Who Speak Only English at Home



A Catalyst for Change

The Massachusetts Healthy Aging Data Report: Community Profiles 2015 significantly expands the unprecedented trove of data related to healthy aging in this state. Thirty-nine new health indicators were added, racial/ethnic differences in healthy aging were explored, a composite measure of healthy aging was developed, and a multivariate analysis allowed for a deeper exploration of the data than was previously possible. In all, there are 2680 new pages of information available in this revised online report.

These improvements came in response to suggestions made at the January 2014 Massachusetts Healthy Aging Forum, requests posted on the Massachusetts Healthy Aging Collaborative website, and direct inquiries from users. In short, we listened, we responded, and we believe the resulting data will catalyze change in communities across the state, from big-city Boston to tiny rural hamlets in the Berkshires.

By providing a free, easy-to-use source of reliable data on all 367 cities and towns within Massachusetts, we have empowered citizens, community leaders, legislators, and service providers of all kinds with the tools they need to create more focused and effective initiatives to promote healthy aging in this state. The availability of the 2015 report is helping communities understand their older adult populations and support an age-friendly cities approach. As you read the Highlights Report, we encourage you to:

1. **Understand.** Download your Community Profile and educate yourself and others in the community about the older adults who live in your city or town – their ages, living arrangements, health status, strengths, and vulnerabilities.
2. **Engage.** Bring stakeholders and community members together to start a conversation about what the data mean and what can be done to address challenges.
3. **Act.** Use the data to prioritize needs, potential interventions, new partnerships, funding sources, and allocation of resources.

As both the 2014 and 2015 reports clearly show, healthy aging is influenced by our genetics, lifestyle, behaviors, and health practices, which are in turn influenced by our community, our culture, and our differential access to care. From birth to death we are constantly adding to, or subtracting from, our capacity to age well. It is a dynamic, lifelong process. Although screening, healthy behaviors, and effective management of chronic diseases at the individual level are essential to maximizing both quality of life and longevity, changes in policies and systems that affect healthy aging are also needed, including the development of supportive social systems and physical environments. We are all in this together, and with the power of new knowledge we can work together to build age-friendly communities and improve the health of the state's older adults.

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“The first wealth is health.”

– RALPH WALDO EMERSON

