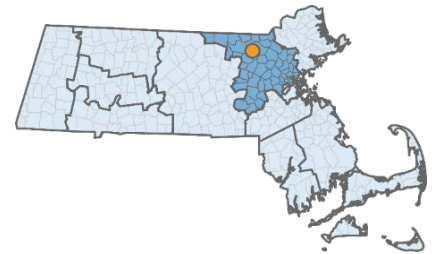


## Westford (Middlesex)

Westford is a town located approximately 35 miles northwest of Boston with 2,826 residents aged 65 or older. The transit score suggests that there is minimal transit (1/10). Compared to state averages, older residents fare better on most healthy aging indicators. Rates are lower than state averages for depression, anxiety and bipolar disorders, schizophrenia/other psychotic disorders, substance and tobacco use disorders, Alzheimer's disease, diabetes, chronic obstructive pulmonary disease, asthma, hypertension, ischemic heart disease, congestive heart failure, atrial fibrillation, peripheral vascular disease, arthritis, osteoporosis, prostate cancer, benign prostatic hyperplasia, hypothyroidism, anemia, chronic kidney disease, fibromyalgia, epilepsy, cataract, ulcers, high cholesterol, and hearing impairment. One health promoting behavior they engage in is living in a non-smoking house. However, older residents have a higher rate of excessive drinking. One community resource to promote healthy aging is the Council on Aging. Westford is designated an Age-Friendly Community.



<b>POPULATION CHARACTERISTICS</b>	<b>BETTER / WORSE STATE RATE<sup>1</sup></b>	<b>COMMUNITY ESTIMATE</b>	<b>STATE ESTIMATE</b>
Total population all ages		23,850	6,742,143
Population 60 years or older as % of total population		17.7%	21.2%
Total population 60 years or older		4,221	1,428,144
Population 65 years or older as % of total population		11.8%	15.1%
Total population 65 years or older		2,826	1,016,679
% 65-74 years		65.3%	55.3%
% 75-84 years		26.9%	29.4%
% 85 years or older		7.8%	15.2%
Gender (65+ population)			
% female		52.1%	57.2%
Race/Ethnicity (65+ population)			
% White		88.0%	90.0%
% African American		0.3%	4.3%
% Asian		11.6%	3.2%
% Other		0.0%	2.5%
% Hispanic/Latino		1.8%	3.8%
Marital Status (65+ population)			
% married		66.0%	52.5%
% divorced/separated		12.1%	14.0%
% widowed		18.7%	25.5%
% never married		3.3%	8.0%
Education (65+ population)			
% with less than high school education		7.7%	16.5%
% with high school or some college		47.6%	52.6%
% with college degree		44.7%	30.9%
% of 60+ LGBT (county)		3.1%	3.2%
% of 65+ population living alone		23.5%	30.2%
% of 65+ population who speak only English at home		83.1%	83.3%
% of 65+ population who are veterans of military service		23.0%	18.8%
Age-sex adjusted 1-year mortality rate		4.2%	4.2%

<b>HEALTHY AGING INDICATORS</b>	<b>BETTER / WORSE STATE RATE<sup>1</sup></b>	<b>COMMUNITY ESTIMATE</b>	<b>STATE ESTIMATE</b>
<b>Geographic Migration (65+ population) in the past 12 months</b>			
% moved within same county		3.4%	3.6%
% moved from different county in Massachusetts		0.4%	1.1%
% moved from different state		0.6%	0.8%
<b>WELLNESS &amp; PREVENTION</b>			
% 60+ with any physical activity within last month		79.7%	73.3%
% 60+ met CDC guidelines for muscle-strengthening activity		25.0%	27.7%
% 60+ met CDC guidelines for aerobic physical activity		61.7%	56.8%
% 60+ met CDC guidelines for both types of physical activities		21.1%	20.8%
% 60+ getting recommended hours of sleep		64.0%	62.7%
% 60+ injured in a fall within last 12 months		9.9%	10.6%
% 65+ had hip fracture		3.8%	3.7%
% 60+ with self-reported fair or poor health status		13.6%	18.0%
% 60+ with 15+ physically unhealthy days last month		8.4%	12.7%
% 60+ with physical exam/check-up in past year		91.1%	89.3%
% 60+ met CDC preventive health screening goals		37.4%	35.0%
% 60+ flu shot past year		64.4%	60.8%
% 65+ with pneumonia vaccine		78.8%	72.0%
% 60+ with shingles vaccine		46.0%	39.7%
% 60+ with cholesterol screening		95.8%	95.7%
% 60+ women with a mammogram within last 2 years		86.1%	84.8%
% 60+ with colorectal cancer screening		62.4%	63.3%
% 60+ with HIV test		15.6%	15.6%
% 60+ current smokers		6.4%	8.5%
% 60+ living in a home where smoking is not allowed	B	91.0%	84.7%
<b>Oral Health</b>			
% 60+ with loss of 6 or more teeth		28.4%	32.5%
% 60+ with annual dental exam		77.0%	77.5%
# of dentists per 100,000 persons (all ages)		184	84
<b>NUTRITION/DIET</b>			
% 60+ with 5 or more servings of fruit or vegetables per day		22.7%	21.5%
% 60+ self-reported obese		24.5%	23.1%
% 65+ clinically diagnosed obese		17.3%	19.0%
% 65+ with high cholesterol	B	67.2%	75.0%
% 60+ excessive drinking	W	15.9%	9.3%
% 65+ with poor supermarket access		80.8%	29.3%

<b>HEALTHY AGING INDICATORS</b>	<b>BETTER / WORSE STATE RATE<sup>1</sup></b>	<b>COMMUNITY ESTIMATE</b>	<b>STATE ESTIMATE</b>
<b>BEHAVIORAL HEALTH</b>			
% 60+ with 15+ days poor mental health last month		7.7%	7.0%
% 65+ with depression	B	27.1%	31.5%
% 65+ with anxiety disorders	B	22.1%	25.4%
% 65+ with bipolar disorders		4.0%	4.5%
% 65+ with post-traumatic stress disorder		1.4%	1.8%
% 65+ with schizophrenia & other psychotic disorders	B	4.8%	5.9%
% 65+ with personality disorders		1.7%	1.4%
# opioid deaths (all ages)		6	1,873
% 65+ with substance use disorders (drug use +/- alcohol abuse)	B	4.7%	6.6%
% 65+ with tobacco use disorders	B	6.2%	10.2%
<b>CHRONIC DISEASE</b>			
% 65+ with Alzheimer's disease or related dementias	B	11.6%	13.6%
% 65+ with diabetes	B	26.1%	31.7%
% 65+ with stroke		10.8%	12.0%
% 65+ with chronic obstructive pulmonary disease	B	14.5%	21.5%
% 65+ with asthma	B	12.7%	15.0%
% 65+ with hypertension	B	68.6%	76.2%
% 65+ ever had a heart attack		3.8%	4.6%
% 65+ with ischemic heart disease	B	36.6%	40.2%
% 65+ with congestive heart failure	B	17.3%	22.4%
% 65+ with atrial fibrillation	B	14.2%	15.9%
% 65+ with peripheral vascular disease	B	14.3%	19.4%
% 65+ with osteoarthritis/rheumatoid arthritis	B	48.0%	52.4%
% 65+ with osteoporosis	B	18.2%	20.7%
% 65+ with leukemias and lymphomas		2.1%	2.3%
% 65+ with lung cancer		1.9%	2.1%
% 65+ with colon cancer		2.6%	2.9%
% 65+ women with breast cancer		11.1%	10.9%
% 65+ women with endometrial cancer		2.0%	1.9%
% 65+ men with prostate cancer	B	10.5%	13.8%
% 65+ with benign prostatic hyperplasia	B	33.0%	40.9%
% 65+ with HIV/AIDS		0.1%	0.2%
% 65+ with hypothyroidism	B	18.5%	21.1%
% 65+ with anemia	B	40.4%	46.6%
% 65+ with chronic kidney disease	B	23.9%	27.3%
% 65+ with liver diseases		7.8%	8.6%
% 65+ with fibromyalgia, chronic pain and fatigue	B	16.4%	19.8%

<b>HEALTHY AGING INDICATORS</b>	<b>BETTER / WORSE STATE RATE<sup>1</sup></b>	<b>COMMUNITY ESTIMATE</b>	<b>STATE ESTIMATE</b>
% 65+ with migraine and other chronic headache		5.1%	4.6%
% 65+ with epilepsy	B	2.1%	2.9%
% 65+ with traumatic brain injury		1.4%	1.5%
% 65+ with autism spectrum disorders		0.1%	0.1%
% 65+ with glaucoma		26.8%	25.7%
% 65+ with cataract	B	60.1%	65.4%
% 65+ with pressure ulcer or chronic ulcer	B	6.4%	8.5%
% 65+ with 4+ (out of 15) chronic conditions	B	51.5%	60.7%
% 65+ with 0 chronic conditions	B	9.5%	7.3%
<b>LIVING WITH DISABILITY</b>			
% 65+ with self-reported hearing difficulty		8.3%	14.2%
% 65+ with clinical diagnosis of deafness or hearing impairment	B	11.0%	16.1%
% 65+ with self-reported vision difficulty		5.0%	5.8%
% 65+ with clinical diagnosis of blindness or visual impairment	B	1.0%	1.5%
% 65+ with self-reported cognition difficulty		5.1%	8.3%
% 65+ with self-reported ambulatory difficulty		13.6%	20.2%
% 65+ with clinical diagnosis of mobility impairments		3.3%	3.9%
% 65+ with self-reported self-care difficulty		4.2%	7.9%
% 65+ with self-reported independent living difficulty		9.6%	14.3%
<b>ACCESS TO CARE</b>			
Medicare (65+ population)			
% Medicare managed care enrollees	*	25.6%	23.1%
% dually eligible for Medicare and Medicaid	*	7.3%	16.7%
% 60+ with a regular doctor		94.5%	96.4%
% 60+ who did not see doctor when needed due to cost		3.0%	4.1%
# of primary care providers within 5 miles		33	10,333
# of hospitals within 5 miles		0	66
# of nursing homes within 5 miles		1	399
# of home health agencies		31	299
# of community health centers		0	116
# of adult day health centers		0	131
# of memory cafes		0	95
# of dementia-related support groups		0	136
<b>SERVICE UTILIZATION</b>			
Physician visits per year	*	7.2	7.8
Emergency room visits/1000 persons 65+ years per year	*	497	639

<b>HEALTHY AGING INDICATORS</b>	<b>BETTER / WORSE STATE RATE<sup>1</sup></b>	<b>COMMUNITY ESTIMATE</b>	<b>STATE ESTIMATE</b>
Part D monthly prescription fills per person per year	*	43.5	52.4
Home health visits per year	*	3.0	4.0
Durable medical equipment claims per year		1.7	1.9
Inpatient hospital stays/1000 persons 65+ years per year	*	239	294
Medicare inpatient hospital readmissions (as % of admissions)		15.3%	17.9%
# skilled nursing facility stays/1000 persons 65+ years per year	*	70	106
# skilled nursing home Medicare beds/1000 persons 65+ years		41	43
% 65+ getting Medicaid long term services and supports	*	3.3%	4.9%
<b>COMMUNITY VARIABLES &amp; CIVIC ENGAGEMENT</b>			
Age-friendly efforts in community		Yes	Yes
Air pollution: annual # of unhealthy days for 65+ (county)		0	N/A
Open space in community		11.4%	18.0%
Walkability score of community (0-100)		31	N/A
% of grandparents raising grandchildren		0.3%	0.8%
% of grandparents who live with grandchildren		2.0%	2.9%
# of assisted living sites		1	238
% of vacant homes in community		3.9%	9.8%
# of universities and community colleges		0	163
# of public libraries		1	470
# of YMCAs		0	83
% in county with access to broadband (all ages)		98.0%	97.0%
% 60+ who used Internet in last month		77.0%	71.3%
Voter participation rate in 2016 presidential election (age 18+)		78.9%	71.3%
<b>SAFETY &amp; TRANSPORTATION</b>			
Violent crime rate /100,000 persons		61	396
Homicide rate /100,000 persons (county)		1	2
# firearm fatalities (county)		145	1,126
Property crime rate /100,000 persons		495	1,825
% of licensed drivers who are age 61+		25.5%	28.7%
% 65+ who own a motor vehicle		96.4%	82.4%
% 60+ who always drive wearing a seatbelt		86.9%	86.3%
# of fatal crashes involving adult age 60+/town		2	529
# of fatal crashes involving adult age 60+/county		86	529
Total # of all crashes involving adult age 60+/town		553	132,351
# of senior transportation providers		7	324
# of medical transportation services for older people		9	268
# of nonmedical transportation services for older people		31	252
Summary transportation performance score		0.7	N/A

HEALTHY AGING INDICATORS	BETTER / WORSE STATE RATE <sup>1</sup>	COMMUNITY ESTIMATE	STATE ESTIMATE
<b>ECONOMIC &amp; HOUSING VARIABLES</b>			
% 65+ with income below the poverty line past year		5.8%	8.7%
% 60+ receiving food stamps past year		6.1%	12.3%
% 65+ employed past year		27.1%	24.3%
Household income (65+ householder)			
% households with annual income < \$20,000		15.9%	23.6%
% households with annual income \$20,000-\$49,999		26.9%	32.5%
% households with annual income > \$50,000		57.2%	43.9%
% 60+ own home		89.9%	72.7%
% 60+ have mortgage on home		43.5%	34.1%
% 65+ households spend >35% of income on housing (renter)		1.9%	11.6%
% 65+ households spend >35% of income on housing (owner)		25.0%	20.4%
<b>COST OF LIVING</b>	<b>\$ COUNTY ESTIMATE</b>	<b>\$ STATE ESTIMATE</b>	<b>RATIO (COUNTY/STATE)</b>
Elder Economic Security Standard Index			
Single, homeowner without mortgage, good health	\$25,056	\$24,636	1.02
Single, renter, good health	\$29,184	\$28,248	1.03
Couple, homeowner without mortgage, good health	\$35,688	\$36,168	0.99
Couple, renter, good health	\$39,816	\$39,780	1.00

#### TECHNICAL NOTES

\*See our technical report (online at <http://mahealthyagingcollaborative.org/data-report/explore-the-profiles/data-sources-and-methods/#technical>) 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 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 \*.

#### 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 could report 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 the 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).

**Healthy Aging Data Report Team.** Many people contributed to this research. The 2018 research team: Beth Dugan PhD, Frank Porell PhD, Nina Silverstein PhD, Chae Man Lee PhD, Shuang Shuang Wang PhD, Bon Kim, Natalie Pitheckoff, Haowei Wang, Sae Hwang Han, Richard Chunga, & Shiva Prasad from the Gerontology Institute in the McCormack Graduate School of Policy and Global Studies at the University of Massachusetts Boston. The Tufts Health Plan Foundation supported the research and provided important guidance. We thank our Advisory Committee members for contributing ideas and advice on how to make the Data Report best address the needs of Massachusetts. We thank our colleagues at JSI for their continued partnership. Questions or suggestions? [Beth.dugan@umb.edu](mailto:Beth.dugan@umb.edu)