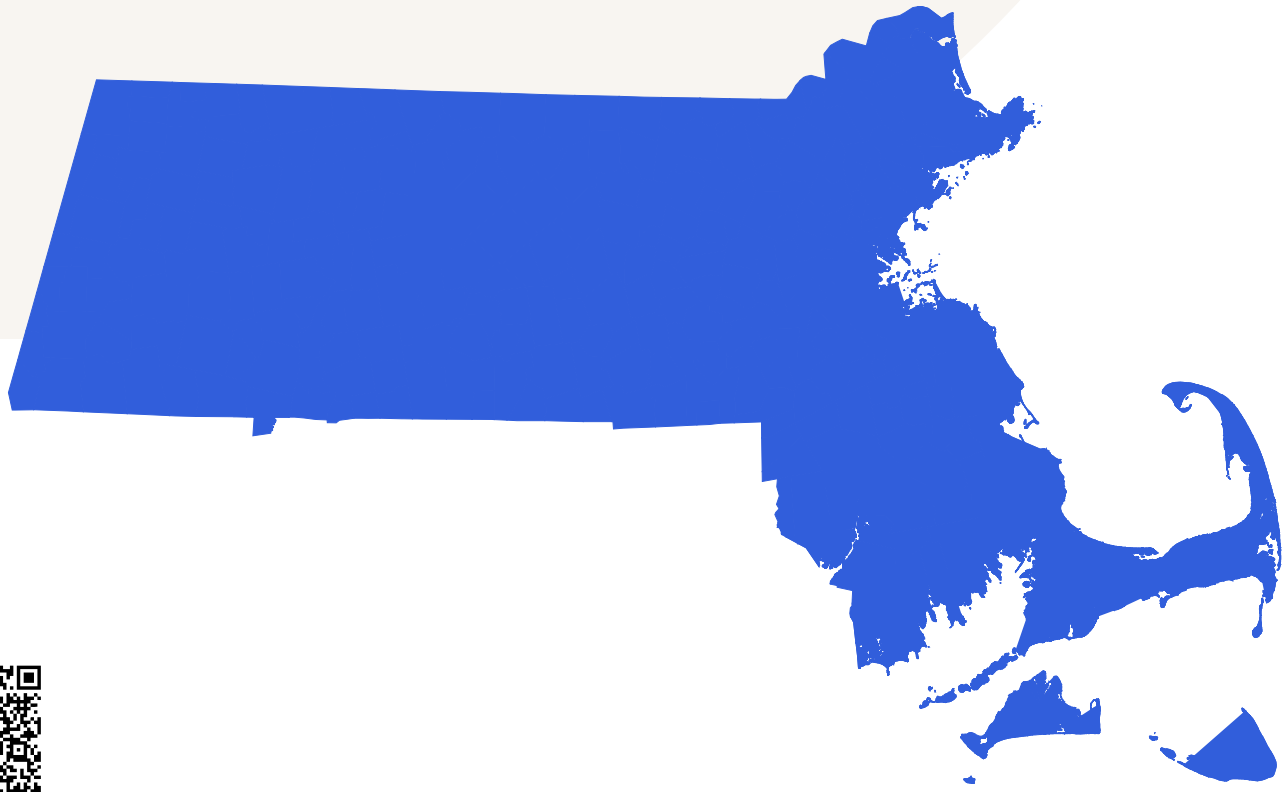
Healthy Aging Data Report

Highlights from 2025

MASSACHUSETTS



Explore more online at
HealthyAgingDataReports.org

A Message from the Funder and Principal Investigator

All of our communities can be great places to grow up and grow old. We need healthy and safe neighborhoods that work for everyone. Yet it takes effort and work to translate an aspiration into reality. Point32Health and the Foundation have given nearly $260 million to nonprofit organizations in New England since 1980. In 2024 alone, the company and Foundation gave $8 million to Massachusetts. The research team in the Gerontology Institute at UMass Boston has been working with the Foundation on Healthy Aging Data Reports since 2012 with investments from the Foundation totaling more than $2 million for 11 reports in the region. In Massachusetts alone, that translates to an investment of $564,213.

There is a recognized need for accurate, unbiased information to help pinpoint problems, mitigate harms, and promote optimal health. We are excited to release the 2025 Massachusetts Healthy Aging Data Report, a valuable tool for understanding Massachusetts's current status and to track progress in the future.

This report updates our 2018 report and builds on our previous work in other New England states. Over time we have learned some vital lessons.

- When addressing needs, don't go it alone—deliberately connect with others at the local, state, and regional levels.
- Start with small projects first. That allows you to form your network of partners, build consensus, and create momentum. As you progress, leverage your experience and expand your network to take on more challenging issues.
- Be intentional about inclusion—we all are aging and can learn from each other.
- Finally, celebrate any success! We are in this for the long run, and encouragement helps.

Thank you for your commitment to your communities and this important work.

Greg Shell
Chair, Board of Directors, Point32Health Foundation; Vice Chair, Board of Directors, Point32Health

Elizabeth Dugan, PhD
Principal Investigator, Gerontology, University of Massachusetts Boston

About the Report

The 2025 Massachusetts Healthy Aging Data Report is available online at healthyagingdatareports.org. We invite you to explore this resource to better understand the residents in your local community, the state of Massachusetts, and New England.

The 2025 Massachusetts Healthy Aging Data Report includes the following tools:

- 386 community profiles (for every city and town and some urban neighborhoods)
- 165 maps listing community rates for each indicator (organized alphabetically and ranked high to low)
- 18 interactive web maps
- Infographic summarizing key findings
- Highlights Report
- Technical documentation

The Healthy Aging Data Report team at the Gerontology Institute in the Manning School of Nursing and Health Sciences at the University of Massachusetts Boston created this resource with financial support from the Point32Health Foundation. We have been engaged in this work since 2012 and have learned from many state partners how important tools like this can be in efforts to improve healthy aging. Our goal is to help accelerate your progress in creating age-friendly, longevity-ready, healthy communities. When communities work for older people, they work for everyone!

The data reveal important patterns of disease, social determinants of health, and resources. The updated report includes maps illustrating the statewide distribution of rates highlighting areas of health inequity.

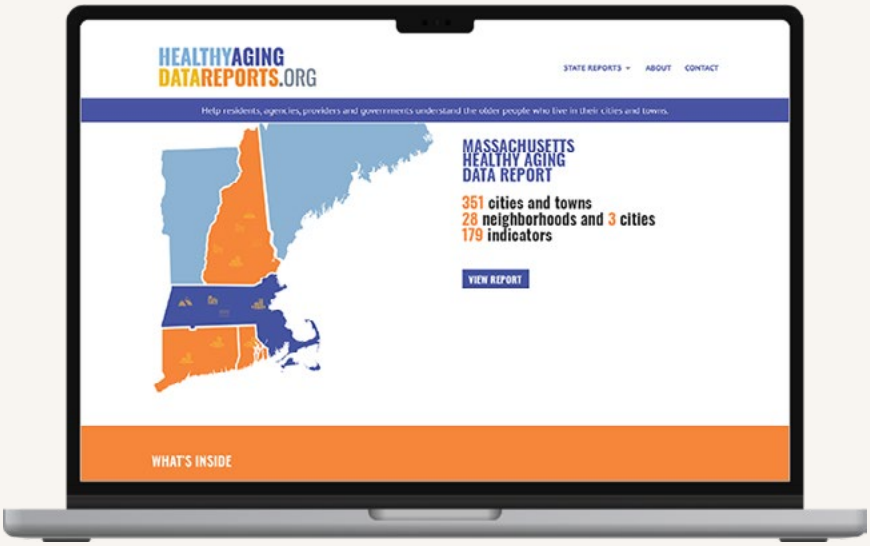


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Table of Contents

What Do Age-Friendly Communities Have in Common?

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

Contact the team for additional analyses, to share suggestions, or to request a report in your state. **Beth.dugan@umb.edu**

A Vision of Communities that Support Longevity

We are fortunate to be living in an era when advances in public health, nutrition, and medicine have contributed the most significant gains in human longevity in recorded history. Longevity coupled with declining birthrates creates population aging. Soon we will have more older adults in the United States than children 5 years or younger. These demographic changes present exciting opportunities for states and communities that prepare for the longevity economy. However, our society is still geared for the life and population age structure of a hundred years ago, when life expectancy was less than 50. This structural lag can be closed if we take thoughtful action to address the key domains of age-friendly communities: housing, communication, community supports, outdoor spaces, transportation, social participation, social inclusion, and civic participation. You are invited to join with those already working to make Massachusetts longevity-ready:

The **Massachusetts Healthy Aging Collaborative** is a network of leaders in the community, health and wellness, government, advocacy, research, business, education, and philanthropy who have come together to advance healthy aging.

AgeSpan is a Massachusetts Aging Services Access Point (ASAP), an Area Agency on Aging (AAA), and designated Protective Services Provider. Our vision is a future where everyone can choose to live and age well, in communities that support them.

Massachusetts Councils on Aging (MCOA) is a nonprofit, membership association of the 350 municipal councils on aging and senior centers. COAs are the first stop on the continuum of care. We support the 1.7 million older adults, 60 and over in Massachusetts, lead healthy, purposeful lives. We build strategic partnerships to educate, empower, and advocate for professionals who work with older adults.

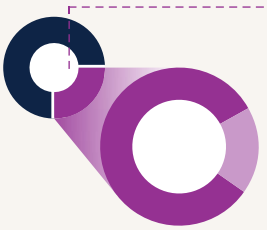
AARP Massachusetts is advocating for you. We're doing everything we can to make your neighborhoods, towns, cities, and rural areas great places to live for people of all ages. Massachusetts communities should have safe, walkable streets, age-friendly housing, transportation options, and opportunities for residents of all ages to stay active.

What's New in Aging in Massachusetts?

Massachusetts is a state bursting with potential to benefit from the gains in human longevity and the opportunities it presents. The older population is growing, more diverse, and more educated than previous generations.

MA's older population is growing

1,661,076 people in Massachusetts are 60+



23.8%
of the state is now 60 or older

17.1%
of the population is age 65 or older (1,195,589)

IMPACT OF COVID-19

According to the Centers for Disease Control, 22,579 Massachusetts residents died as a result of the COVID-19 pandemic. We expect that the reverberations of the pandemic will impact health and aging for years to come.

OTHER INDICATORS

- **Marital Status:** In terms of marital status among the population 65+, 54% are married, 21.1% widowed, 15.8% divorced/separated, and 9% never married.
- **Chronic Conditions:** Compared to the other New England states, older residents of Massachusetts have the highest rates of chronic kidney disease, HIV/AIDS, lung cancer, and have the lowest rates of people reporting no chronic conditions.
- **HIV/AIDS:** The rate of adults 65+ with HIV/AIDS increased from 0.17% in 2014–2015 to 0.30% in 2020–2021. This trend was consistent across New England. Maine, Connecticut, and Massachusetts had the largest % increases.

MA's older population is changing

AGE

The age structure of the older population has shifted younger as the baby boom generation enters later life.

58.5%
Age 65-74

28.1%
Age 75-84

13.4%
Age 85+

MORE DIVERSE

The population of adults 65 or older is increasingly diverse.

86.3% White, 4.8% Hispanic, 4% Asian, 4.4% African American/Black, 5.3% Other Race(s)

3,537
Adults 55+ are Native American

16%
Adults 65+ report speaking a language other than English at home

MORE EDUCATED

The population of adults 65 or older is more educated.

18.9%
Graduate or professional degree

50.3%
College degree

12.7%
of the 65+ population are veterans of military service

28.1%
of Massachusetts older adults live alone

Understanding the Data

There is a lot of information in the report, and it is not unusual for people to feel a little overwhelmed by it all. This Highlights Report provides a framework for understanding the status of your state. The online community profiles allow you to focus more sharply on your community.

As researchers we are often asked to identify the healthiest and/or most burdened communities in a state. Policymakers, service providers, and funders routinely have to make tough decisions on where to put resources, and many strive to be guided by data or evidence. There are several ways we try to answer that question. For example, we can compare communities by contrasting those with the healthiest rates on various conditions and those with the unhealthiest. This approach is helpful because it shows the wide range of rates for important conditions related to healthy aging. Table 1 below contrasts rates for 13 conditions.

Table 1. Best and Worst Rates on Selected Indicators

	Best Rates	Worst Rates
Alzheimer's disease and related dementias	**6.69%** Becket, Washington	**25.54%** Worcester Downtown
Any physical activity	**87.20%** Brookline, Needham, Newton, Wellesley, Weston	**53.47%** Avon and Brockton
Depression	**21.90%** Richmond	**54.46%** Brightwood, Metro Center, Memorial Square, Six Corners, and South End Neighborhood of Springfield
Diabetes	**15.00%** Manchester	**48.98%** Lawrence
Flu shot in past year	**77.19%** Arlington, Belmont, Cambridge, Waltham, Watertown	**57.49%** Acushnet, Fairhaven
Getting recommended sleep	**69.69%** Ashburnham, Ashby, Ayer, Chelmsford, Dunstable, Groton, Littleton, Pepperell, Shirley, Townsend, Tyngsborough, Westford	**46.82%** Chelsea, Revere, Winthrop
Hypertension	**54.01%** Carlisle	**84.46%** Fall River
Ischemic heart disease	**22.77%** Leverett, New Salem, Shutesbury, Sunderland	**49.38%** Ayer

Table 1. Continued

	Best Rates	Worst Rates
Obesity	**16.33%** Acton, Bedford, Boxborough, Carlisle, Concord, Harvard, Lexington, Lincoln, Maynard, Stow, Winchester	**43.29%** Avon, Brockton, New Bedford
Stroke	**6.53%** Princeton	**18.48%** Downtown Worcester
4+ chronic conditions	**42.52%** Carlisle	**74.72%** Fall River
No chronic conditions	**15.57%** Cummington, Goshen, Plainfield	**3.45%** Mattapoisett, Somerset

Another approach to describe the health of Massachusetts residents is to count how many indicators are "better" compared to the state average. Communities that are healthier than state average may have some resources (e.g., parks, walking paths, engaged senior center, or public library) in place that may be replicable in communities that are less healthy than average.

Towns with 14+ better rates (blue in the map) *Acton, Amherst, Andover, Arlington, Ashburnham, Ashby, Ashfield, Barnstable, Barre, Becket, Bedford, Belchertown, Belmont, Bernardston, Blandford, Bolton, Boxborough, Boxford, Boylston, Brewster, Brookline, Buckland, Cambridge, Carlisle, Charlemont, Chatham, Cheshire, Chester, Chesterfield, Chilmark, Cohasset, Colrain, Concord, Conway, Cummington, Deerfield, Dennis, Dover, Duxbury, Eastham, Easthampton, Edgartown, Erving, Essex, Falmouth, Aquinnah, Georgetown, Gill, Gloucester, Goshen, Gosnold, Granville, Groton, Hadley, Hamilton, Hardwick, Harvard, Harwich, Hatfield, Hawley, Heath, Hinsdale, Holden, Holliston, Hopkinton, Hull, Huntington, Ipswich, Lee, Leverett, Lexington, Leyden, Lincoln, Littleton, Lynnfield, Manchester, Marblehead, Marion, Marshfield, Mattapoisett, Maynard, Medfield, Mendon, Middlefield, Millis, Millville, Milton, Monroe, Nantucket, Natick, Needham, New Braintree, New Salem, Newbury, Newburyport, Newton, Norfolk, North Reading, Northampton, Northborough, Northfield, Norwell, Oak Bluffs, Oakham, Orleans, Pelham, Pepperell, Peru, Plainfield, Plymouth, Princeton, Provincetown, Reading, Rehoboth, Richmond, Rockport, Rowe, Russell, Sandwich, Scituate, Sharon, Shelburne, Sherborn, Shutesbury, Southampton, Southborough, Southwick, Sterling, Stockbridge, Stow, Sudbury, Sunderland, Sutton, Swampscott, Tisbury, Tolland, Topsfield, Townsend, Truro, Washington, Watertown, Wayland, Wellesley, Wellfleet, Wendell, Wenham, West Newbury, West Stockbridge, West Tisbury, Westford, Westhampton, Westminster, Weston, Whately, Wilbraham, Williamsburg, Williamstown, Winchester, Windsor, Worthington, Back Bay, Beacon Hill, Dorchester, Jamaica Plain, Mattapan*

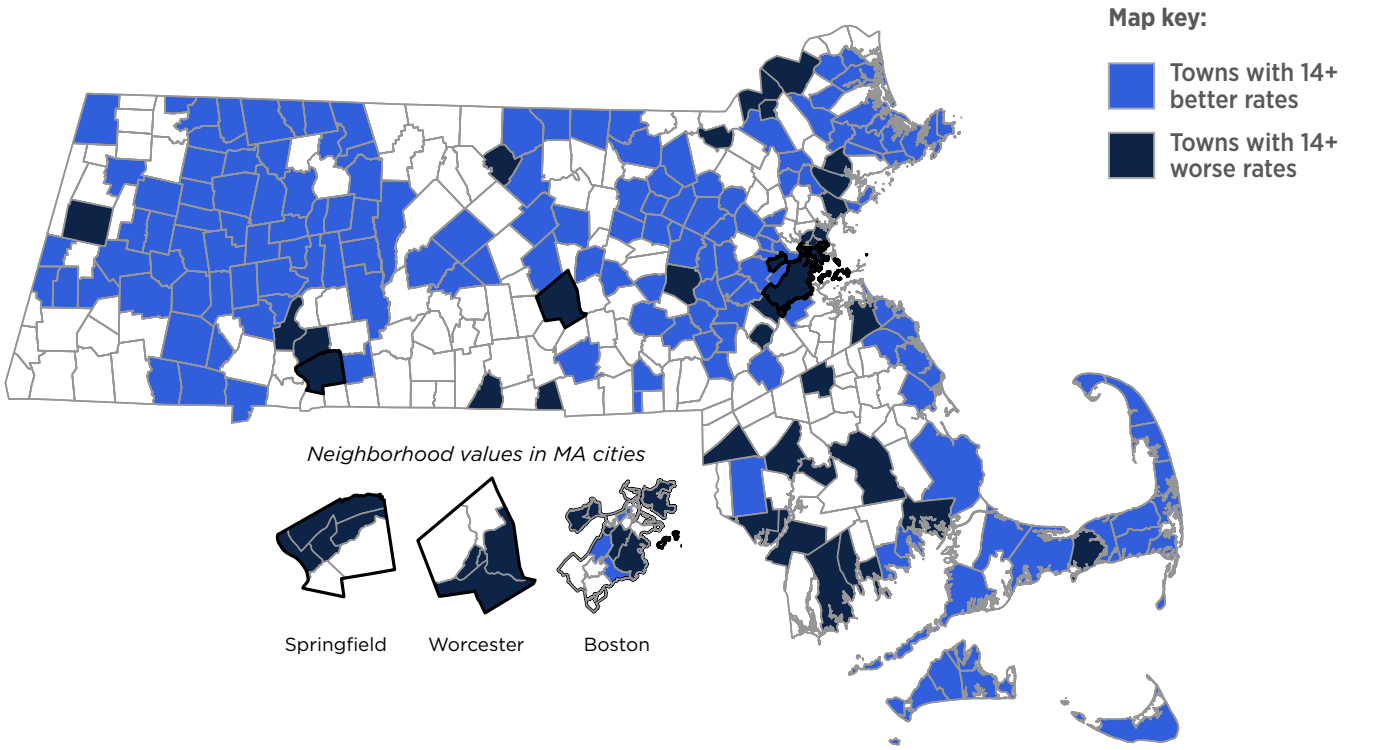
Similarly, to highlight communities with many rates "worse" than the state average may speed resources and programs to help. Investments in preventive interventions in these communities could improve healthy aging for future generations.

Towns with 14+ worse rates (navy in the map) *Attleboro, Boston, Brockton, Chelsea, Chicopee, Danvers, Dartmouth, Dedham, Everett, Fairhaven, Fall River, Framingham, Gardner, Haverhill, Hingham, Holyoke, Lawrence, Lowell, Lynn, Methuen, Middleborough, New Bedford, Norwood, Peabody, Pittsfield, Revere, Somerset, Southbridge, Springfield, Swansea, Taunton, Wareham, Webster, Worcester, Yarmouth, Allston, Brighton, Dorchester, East Boston, Mission Hill, Roxbury, the neighborhoods Bay, McKnight, Old Hill, and Upper Hill, Brightwood, Metro Center, Memorial Square, Six Corners, and South End, East Springfield, Indian Orchard, and Liberty Heights,*

Boston Road, Pine Point, East Forest Park and Sixteen Acres of Springfield, the Downtown, Central City, East Worcester, South Worcester neighborhoods of Worcester.

We recognize that communities don't become healthier or more burdened spontaneously or without cause. These differences may be the result of systemic disparities in access to education, adequate housing, safe employment, and healthy, walkable environments. We don't identify these communities to make value judgments about the residents.

In fact, we highlight differences to illuminate disparities that are hidden in reports that only describe rates at the state level. When resources are limited, it can be helpful to know which communities are most in need of investments. **Using this approach, we'd advise philanthropy, policymakers, and others to prioritize health investments for the communities shaded navy on the map.**



Note: in the comparisons that follow (trends, gender, race, state differences) only statistically significant differences are reported.

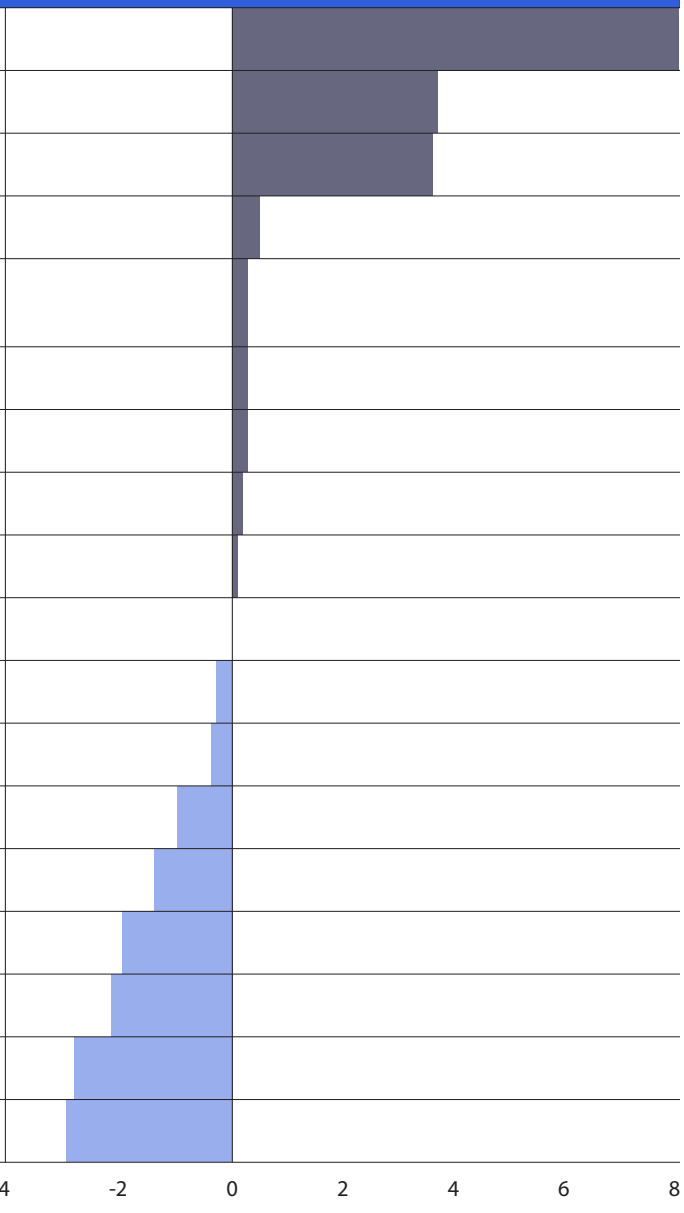
What Has Changed Over Time in Massachusetts?

We analyzed Medicare data to identify changes from 2014 – 2021. We found both positive and negative changes. As seen in Table 2, Medicare managed care enrollment increased from 23.1% at Time 1 (2014 – 2015) to 30.5% at Time 3 (2020 – 2021). Nearly one-third of the 65+ population in Massachusetts are now in a Medicare managed care plan. Rate increases were also observed for depression, arthritis, and heart attack. Alzheimer's disease and related disorders increased from Time 1 to Time 2 (2016 – 2017) but then declined slightly for Time 3.

Declines in rates were observed in stroke, colon cancer, ischemic heart disease, COPD, diabetes, and hypertension.

Table 2. Change Over Time (2014–2021) in Massachusetts

Indicators (%)	Change from T1 to T3 (%)
% 65+ Medicare managed care enrollees	7.4%
% 65+ with osteoarthritis or rheumatoid arthritis	3.7%
% 65+ with depression	3.6%
% 65+ with 4+ (out of 15) chronic conditions	0.5%
% Medicare inpatient hospital readmissions (as % of admissions)	0.3%
% 65+ dually-eligible for Medicare and Medicaid	0.3%
% 65+ with Alzheimer's disease or related dementias	0.3%
% 65+ ever had a heart attack	0.2%
% 65+ with lung cancer	0.1%
Age-sex adjusted 1-year mortality rate	0.0%
% 65+ with stroke	-0.3%
% 65+ with colon cancer	-0.4%
% 65+ with asthma	-1.0%
% 65+ getting Medicaid long term services and supports	-1.4%
% 65+ with chronic obstructive pulmonary disease	-2.0%
% 65+ with ischemic heart disease	-2.2%
% 65+ with diabetes	-2.8%
% 65+ with hypertension	-3.0%



How Does Gender Impact Healthy Aging?

Another way to understand healthy aging in Massachusetts is to contrast the experience of women and men.

The results in Table 3 show that compared to men, women have higher rates of conditions related to bone health (osteoporosis, arthritis, hip fracture), brain and mental health (anxiety, depression, Alzheimer's disease, schizophrenia, PTSD), vision (cataract, glaucoma), and pain (migraine, fibromyalgia). Interventions and programs to promote bone health and mental health should include and specifically target older women.

WOMEN	MEN
56.2% 65+	**43.8%** 65+
66.6% 85+	**33.4%** 85+

Compared to men however, women have better access to care (physician visits per year, dually-eligible Medicare and Medicaid, hospice use, and enrolling in Medicare Advantage). While greater access to health care is desirable, this may be related to the fact that many women tend to marry older spouses and may outlive a spousal caregiver, thus necessitating formal care long term care and end-of-life arrangements.

Table 3. Gender Differences: Women

Women Have Higher Rates Than Men	Female	Male	Difference Between Female and Male
% 65+ with osteoporosis	32.0%	4.3%	**22.7%**
% 65+ with anxiety disorder	39.3%	24.7%	**14.6%**
% 65+ with depression	40.0%	27.7%	**12.3%**
% 65+ with cataract	68.4%	59.4%	**9.0%**
% 65+ with osteoarthritis or rheumatoid arthritis	59.4%	50.5%	**9.0%**
% 65+ with fibromyalgia, chronic pain, and fatigue	40.0%	33.5%	**6.5%**
% 65+ with migraine	10.9%	4.5%	**6.3%**
% 65+ with asthma	16.4%	10.7%	**5.7%**
% 65+ with glaucoma	26.8%	23.5%	**3.4%**
% 65+ had hip fracture	4.0%	2.0%	**1.9%**
% 65+ with post-traumatic stress disorder	3.5%	2.4%	**1.0%**
% 65+ with Alzheimer's disease or related dementias	13.0%	12.6%	**0.4%**

Table 3. Continued

Women Have Higher Rates Than Men	Female	Male	Difference Between Female and Male
% 65+ with schizophrenia	4.2%	3.8%	**0.4%**
% 65+ with lung cancer	2.2%	2.1%	**0.1%**
% 65+ Medicare managed care enrollees	31.5%	29.3%	**2.2%**
% 65+ dually-eligible for Medicare and Medicaid	19.1%	14.5%	**4.7%**
% 65+ hospice users as % of decedents	47.7%	39.5%	**8.3%**
% 65+ getting Medicaid long term services and supports	4.2%	2.5%	**1.7%**
# physician visits per year	7.4	7.2	**0.2**

Table 4 illustrates that compared to women, older men have higher rates of conditions related to cardiovascular health (ischemic heart disease, atrial fibrillation, congestive heart failure, hypertension, heart attack, peripheral vascular disease, stroke, COPD), diabetes, harmful health behaviors (substance use disorder, tobacco use disorder), infectious disease (cancer, HIV), and higher use of emergency rooms and hospital stays. Interventions and programs to promote cardiovascular health (nutrition, exercise, smoking cessation, stress management) that target older men are needed.

Table 4. Gender Differences: Men

Men Have Higher Rates Than Women	Male	Female	Difference Between Male and Female
% 65+ with ischemic heart disease	44.8%	31.0%	**13.8%**
% 65+ with chronic kidney disease	39.4%	30.3%	**9.1%**
% 65+ with diabetes	32.9%	25.2%	**7.7%**
% 65+ with atrial fibrillation	19.2%	12.1%	**7.2%**
% 65+ with hypertension	76.2%	70.0%	**6.3%**
% 65+ with substance use disorder	12.1%	7.1%	**5.1%**
% 65+ with congestive heart failure	22.4%	17.4%	**5.0%**
% 65+ with peripheral vascular disease	20.3%	16.3%	**4.0%**
% 65+ with tobacco use disorder	14.3%	10.7%	**3.6%**
% 65+ with high cholesterol	77.4%	74.5%	**2.9%**
% 65+ ever had a heart attack	6.2%	3.5%	**2.8%**
% 65+ with stroke	12.2%	10.5%	**1.7%**
% 65+ with anemia	44.1%	42.4%	**1.7%**

Table 4. Continued

Men Have Higher Rates Than Women	Male	Female	Difference Between Male and Female
% 65+ with 4+ (out of 15) chronic conditions	61.2%	59.7%	**1.5%**
% 65+ with pressure ulcer or chronic ulcer	8.4%	7.2%	**1.2%**
% 65+ with 0 chronic conditions	7.7%	6.7%	**0.9%**
% 65+ with liver disease	12.6%	11.9%	**0.7%**
% 65+ with chronic obstructive pulmonary disease	19.4%	18.8%	**0.7%**
% 65+ with colon cancer	2.6%	2.2%	**0.5%**
% 65+ with HIV/AIDS	0.5%	0.1%	**0.4%**
% Medicare inpatient hospital readmissions (as % of admissions)	19.4%	17.2%	**2.2%**
Age-sex adjusted 1-year mortality rate	4.6%	3.5%	**1.1%**
# inpatient hospital stays/1000 persons 65+ annually	277	232	**46**
# emergency room visits/1000 persons 65+ annually	583	539	**44**
# Medicare Part D monthly prescription fills per enrollee annually	54	53	**1**

There are several public health initiatives that might be considered for statewide action. These include increasing screening for high cholesterol and hypertension in older men and women. In addition, supporting gender-specific programs to address lifestyle behaviors, such as smoking cessation for older men, and muscle strengthening and fall prevention for older women, are measures that can promote healthy aging.

KEY TAKEAWAYS

WOMEN

Bone health

- 8x higher osteoporosis
- 9% higher arthritis
- 2% higher chronic pain & migraine

Mental health

- 15% higher rates of anxiety
- 12% higher depression rates

MEN

Heart & metabolic diseases

- 14% higher ischemic heart disease
- 8% higher rates of hypertension
- 6% higher diabetes rates

Emergency room usage & hospital stays

- 44 more visits to ER annually than older MA women
- 46 more hospital stays annually than older MA women

How Do Race and Ethnicity Impact Healthy Aging?

Another way to understand the health of older adults in Massachusetts is to contrast racial and ethnic differences on indicator rates. In Tables 5-11 we report the disparities detected.

When analyzing Medicare data, we recognize that some groups may be less apt to get healthcare and thus appear "healthier" in our report, when in reality, the racial or ethnic group members have undiagnosed or untreated conditions because of a lack of health care. In addition, observed health differences may arise from the stressful burdens of structural racism. Understanding the why of rate disparities is a challenge in this type of research. Below we report the what (that is, the rate differences).

Compared to Black adults, White adults have higher rates in certain health conditions. The most significant differences are in the rates of cataracts (12% higher), hospice usage as a percentage of decedents (11.5%), anxiety disorders (11%), osteoporosis (8.2%), benign prostatic hyperplasia among men (7.1%), atrial fibrillation (6.9%), and osteoarthritis or rheumatoid arthritis (5.8%). White adults also visit healthcare providers for physical exams more often than Black individuals.

86.3% White 65+

4.4% Black 65+

4.0% Asian 65+

4.8% Hispanic 65+

5.3% Other Race(s) 65+

3,537 Native American/ Alaskan 55+

Table 5. Racial Differences Between White and Black Older Adults

White Adults Have Higher Rates Than Black Adults	White	Black	Difference Between White and Black
% 65+ with cataract	65.8%	53.8%	**12.0%**
% 65+ hospice users as % of decedents	45.7%	34.2%	**11.5%**
% 65+ with anxiety disorder	34.2%	23.2%	**11.0%**
% 65+ with osteoporosis	20.7%	12.5%	**8.2%**
% 65+ with benign prostatic hyperplasia (men)	43.7%	36.6%	**7.1%**
% 65+ with atrial fibrillation	16.1%	9.2%	**6.9%**
% 65+ with high cholesterol	76.6%	69.8%	**6.8%**
% 65+ with osteoarthritis or rheumatoid arthritis	56.9%	51.1%	**5.8%**
% 65+ with depression	35.2%	31.5%	**3.7%**

Table 5. Continued

White Adults Have Higher Rates Than Black Adults	White	Black	Difference Between White and Black
% 65+ with chronic obstructive pulmonary disease	19.9%	16.3%	**3.6%**
% 65+ with breast cancer (women)	12.0%	8.8%	**3.1%**
% 65+ had hip fracture	3.5%	1.5%	**2.0%**
% 65+ with migraine and other chronic headache	8.2%	6.8%	**1.4%**
% 65+ with peripheral vascular disease	18.8%	17.8%	**1.1%**
% 65+ hospice users	3.0%	2.1%	**0.8%**
% 65+ with endometrial cancer (women)	2.3%	1.5%	**0.8%**
% 65+ with lung cancer	2.3%	1.8%	**0.5%**
# physician visits per year	8	6	**2**

In Massachusetts, Black older adults have significantly higher rates compared to White older adults in a number of indicators. The rate for dually eligible for Medicare and Medicaid is 25.6% higher for Black older adults. Similarly, the rates for diabetes (20.7%), chronic kidney disease (13.8%), Medicare managed care enrollees (12.1%), hypertension (9.2%), glaucoma (10.1%), anemia (7.4%), prostate cancer (5.8%), Alzheimer's disease (3.8%), and tobacco use disorder (3.2%) were all higher in Black adults. In terms of health utilization, Black older adults had higher inpatient hospital readmissions, were more likely to get Medicaid long term services and supports and had more visits to the emergency room for care.

Table 6. Racial Differences Between Black and White Older Adults

Black Adults Have Higher Rates Than White Adults	Black	White	Difference Between Black and White
% 65+ dually-eligible for Medicare and Medicaid	37.4%	11.8%	**25.6%**
% 65+ with diabetes	47.8%	27.1%	**20.7%**
% 65+ with chronic kidney disease	47.8%	34.0%	**13.8%**
% 65+ Medicare managed care enrollees	40.0%	27.9%	**12.1%**
% 65+ with glaucoma	35.3%	25.2%	**10.1%**
% 65+ with hypertension	82.1%	72.9%	**9.2%**
% 65+ with anemia	51.0%	43.6%	**7.4%**
% 65+ with prostate cancer (men)	19.5%	13.7%	**5.8%**

Table 6. Continued

Black Adults Have Higher Rates Than White Adults	Black	White	Difference Between Black and White
% 65+ with Alzheimer's disease or related dementias	16.9%	13.1%	**3.8%**
% 65+ with 4+ chronic conditions	64.5%	61.1%	**3.3%**
% 65+ with tobacco use disorder	15.7%	12.5%	**3.2%**
% 65+ with congestive heart failure	22.8%	20.1%	**2.7%**
% 65+ with substance use disorder	12.1%	9.5%	**2.6%**
% 65+ with schizophrenia	6.5%	4.0%	**2.5%**
% 65+ with asthma	16.0%	13.9%	**2.1%**
% 65+ with stroke	13.2%	11.4%	**1.8%**
% 65+ with HIV/AIDS	1.8%	0.2%	**1.6%**
% 65+ with fibromyalgia, chronic pain, and fatigue	39.0%	37.6%	**1.4%**
% 65+ with 0 chronic conditions	8.0%	6.8%	**1.2%**
% 65+ with post-traumatic stress disorder	3.5%	2.9%	**0.6%**
% Medicare inpatient hospital readmissions (as % of admissions)	21.1%	18.1%	**3.0%**
% 65+ getting Medicaid long term services and supports	6.5%	3.3%	**3.2%**
# emergency room visits/1000 persons 65+ annually	726	562	**163**
# inpatient hospital stays/1000 persons 65+ annually	302	257	**45**
# skilled nursing facility stays/1000 persons 65+ annually	87	76	**11**
# Medicare Part D monthly prescription fills per enrollee annually	60	53	**8**

The overall pattern of health disparities between Hispanic and White older adults follows a similar pattern. Older Hispanic adults have much higher rates for dually eligible for Medicare and Medicaid, and higher rates of Medicare Advantage enrollment compared to White non-Hispanic adults. Hispanic older adults had higher rates for diabetes, chronic kidney disease, depression, hypertension, asthma, having 4+ chronic conditions, liver disease, and Alzheimer's disease. Older Hispanic adults had more prescription refills and more emergency room visits annually.

Table 7. Racial/Ethnic Differences: Hispanic and White Older Adults

Hispanic Adults Have Higher Rates Than White Adults	Hispanic	White	Difference Between Hispanic and White
% 65+ dually-eligible for Medicare and Medicaid	60.0%	11.8%	**48.2%**
% 65+ Medicare managed care enrollees	51.1%	27.9%	**23.2%**
% 65+ with diabetes	46.2%	27.1%	**19.1%**
% 65+ with chronic kidney disease	41.5%	34.0%	**7.5%**
% 65+ with depression	41.4%	35.2%	**6.1%**
% 65+ with hypertension	77.9%	72.9%	**5.0%**
% 65+ with asthma	18.7%	13.9%	**4.8%**
% 65+ with 4+ (out of 15) chronic conditions	64.9%	61.1%	**3.8%**
% 65+ with liver disease	15.0%	12.2%	**2.8%**
% 65+ with schizophrenia & other psychotic disorder	6.2%	4.0%	**2.2%**
% 65+ getting Medicaid long term services and supports	5.3%	3.3%	**2.0%**
% 65+ with Alzheimer's disease or related dementias	15.0%	13.1%	**1.9%**
% 65+ with post-traumatic stress disorder	4.2%	2.9%	**1.3%**
% 65+ with fibromyalgia, chronic pain, and fatigue	38.8%	37.6%	**1.2%**
% 65+ with glaucoma	26.2%	25.2%	**1.1%**
% 65+ with migraine and other chronic headache	9.2%	8.2%	**1.0%**
% 65+ with 0 chronic conditions	7.6%	6.8%	**0.8%**
% 65+ with HIV/AIDS	1.0%	0.2%	**0.8%**
% 65+ with tobacco use disorder	13.1%	12.5%	**0.7%**
# emergency room visits/1000 persons 65+ annually	679	562	**116**
# Medicare Part D monthly prescription fills per enrollee annually	67	53	**14**

Older White adults have higher rates of cataracts, atrial fibrillation, arthritis, BPH, COPD, peripheral vascular disease, pressure ulcer, osteoporosis, hip fracture, and cancers (prostate, breast, lung, endometrial, and colon). In terms of health services utilization, older White adults have higher rates compared to Hispanic older adults of hospice use, nursing home stays, and physician visits.

Table 8: Racial/Ethnic Differences Between White and Hispanic Older Adults

White Adults Have Higher Rates Than Hispanic Adults	White	Hispanic	Difference Between White and Hispanic
% 65+ with cataract	65.8%	56.2%	**9.6%**
% 65+ with atrial fibrillation	16.1%	10.0%	**6.1%**
% 65+ with osteoarthritis or rheumatoid arthritis	56.9%	51.4%	**5.5%**
% 65+ with benign prostatic hyperplasia (men)	43.7%	39.5%	**4.2%**
% 65+ with breast cancer (women)	12.0%	8.4%	**3.5%**
% 65+ with COPD	19.9%	17.7%	**2.2%**
% 65+ with peripheral vascular disease	18.8%	16.6%	**2.2%**
% 65+ with pressure ulcer or chronic ulcer	8.1%	6.4%	**1.7%**
% 65+ with osteoporosis	20.7%	19.1%	**1.7%**
% 65+ had hip fracture	3.5%	1.9%	**1.6%**
% 65+ with prostate cancer (men)	13.7%	12.2%	**1.5%**
% 65+ with high cholesterol	76.6%	75.3%	**1.4%**
% 65+ with anxiety disorder	34.2%	33.0%	**1.1%**
% 65+ hospice users	3.0%	1.9%	**1.0%**
% 65+ with lung cancer	2.3%	1.4%	**0.9%**
% 65+ with ischemic heart disease	37.9%	37.1%	**0.8%**
% 65+ with endometrial cancer (women)	2.3%	1.8%	**0.5%**
% 65+ with colon cancer	2.5%	2.1%	**0.4%**
% 65+ hospice users as % of decedents	45.7%	35.7%	**10.0%**
# skilled nursing facility stays/1000 persons 65+ annually	76	56	**20**
# physician visits per year	8	6	**2**

Older Asian adults have higher rates for being dually eligible for Medicare and Medicaid, and higher rates of enrollment in Medicare managed care. However, the only chronic conditions with higher rates compared to older White adults are diabetes and osteoporosis. Older Asian adults have a much higher rate of reporting no chronic conditions compared to older White adults.

Table 9: Racial/Ethnic Differences: Asian and White Older Adults

Asian Adults Have Higher Rates Than White Adults	Asian	White	Difference Between Asian and White
% 65+ dually eligible for Medicare/Medicaid	50.0%	11.8%	**38.1%**
% 65+ Medicare managed care enrollees	51.7%	27.9%	**23.8%**
% 65+ with diabetes	38.3%	27.1%	**11.2%**
% 65+ with 0 chronic conditions	12.5%	6.8%	**5.7%**
% 65+ with osteoporosis	22.1%	20.7%	**1.4%**

As shown in Table 10, there are many indicators where older White adults have rates that are higher compared to older Asian adults. Higher rates are found for: bone health (arthritis, hip fracture), brain and mental health (anxiety, depression, Alzheimer's disease, schizophrenia), behavioral health (substance use and tobacco use disorders), and cardiovascular health (ischemic heart disease, peripheral vascular disease, COPD, atrial fibrillation, congestive heart failure, stroke, heart attack). Rates for hospice use and being dually-eligible for Medicare and Medicaid are higher for older White adults compared to older Asians.

Table 10: Racial/Ethnic Differences: White Older Adults and Asian Older Adults

White Adults Have Higher Rates Than Asian Adults	White	Asian	Difference Between White and Asian
% 65+ with osteoarthritis or rheumatoid arthritis	56.9%	35.1%	**21.8%**
% 65+ with anxiety disorder	34.2%	15.8%	**18.4%**
% 65+ with depression	35.2%	20.0%	**15.2%**
% 65+ with fibromyalgia, chronic pain, and fatigue	37.6%	25.0%	**12.6%**
% 65+ with cataract	65.8%	53.7%	**12.2%**
% 65+ with benign prostatic hyperplasia (men)	43.7%	31.9%	**11.8%**
% 65+ with 4+ (out of 15) chronic conditions	61.1%	49.7%	**11.4%**
% 65+ with ischemic heart disease	37.9%	27.2%	**10.7%**
% 65+ with peripheral vascular disease	18.8%	8.6%	**10.2%**

Table 10. Continued

White Adults Have Higher Rates Than Asian Adults	White	Asian	Difference Between White and Asian
% 65+ with chronic obstructive pulmonary disease	19.9%	10.6%	**9.3%**
% 65+ with atrial fibrillation	16.1%	7.6%	**8.5%**
% 65+ with congestive heart failure	20.1%	12.6%	**7.5%**
% 65+ with high cholesterol	76.6%	69.3%	**7.4%**
% 65+ with prostate cancer (men)	13.7%	6.9%	**6.7%**
% 65+ with substance use disorder	9.5%	3.0%	**6.5%**
% 65+ with tobacco use disorder	12.5%	7.3%	**5.2%**
% 65+ with anemia	43.6%	38.5%	**5.1%**
% 65+ with pressure ulcer or chronic ulcer	8.1%	3.3%	**4.8%**
% 65+ with hypertension	72.9%	68.1%	**4.8%**
% 65+ with asthma	13.9%	9.4%	**4.5%**
% 65+ with breast cancer (women)	12.0%	7.7%	**4.3%**
% 65+ with migraine and other chronic headache	8.2%	4.2%	**4.0%**
% 65+ with Alzheimer's disease or related dementias	13.1%	10.0%	**3.1%**
% 65+ with stroke	11.4%	9.3%	**2.1%**
% 65+ had hip fracture	3.5%	1.5%	**2.0%**
% 65+ ever had a heart attack	4.8%	3.1%	**1.7%**
% 65+ with schizophrenia & other psychotic disorder	4.0%	2.5%	**1.5%**
% 65+ hospice users	3.0%	1.6%	**1.4%**
% 65+ with glaucoma	25.2%	23.9%	**1.3%**
% 65+ with lung cancer	2.3%	1.4%	**0.8%**
% 65+ with HIV/AIDS	0.2%	0.1%	**0.1%**
% 65+ getting Medicaid long term services and supports	3.3%	2.6%	**0.6%**
Age sex adjusted 1 year mortality rate	4.0%	2.8%	**1.2%**
% 65+ hospice users as % of decedents	45.7%	36.6%	**9.1%**
# emergency room visits/1000 persons 65+ annually	562	345	**218**
# inpatient hospital stays/1000 persons 65+ annually	257	163	**93**

The data to make comparisons between older Native American adults and older White adults was limited because of privacy requirements. Nevertheless, we were able to identify a few disparities. The most pronounced differences include higher rates for Native American adults in dually eligible for Medicare and Medicaid (25.1%), tobacco use disorder (11.2%), diabetes (10.2%), having four or more chronic conditions (8.6%), and substance use disorder (8.3%). White adults have a 20.9% higher rate of the hospice users as percentage of decedents as compared to Native American adults. These findings emphasize the significant chronic disease burden in Native American communities, and they indicate notable differences in access to healthcare.

RACIAL DISPARITIES IN MASSACHUSETTS

HIGHEST REPORTED CHRONIC CONDITIONS FOR 65+ BY RACIAL/ETHNIC GROUP

White Older Adults

- Hip fracture
- Colon cancer
- Lung cancer

Black Older Adults

- Alzheimer's disease
- Diabetes
- Congestive heart failure

Hispanic Older Adults

- Depression

Asian Older Adults

- Osteoporosis

Native American Older Adults

- COPD
- Ischemic heart disease
- Stroke

Other Race Older Adults

- High cholesterol
- Benign prostatic hyperplasic (in men)
- Cataract

Mental Health: Trends in Depression

We examined community depression rates in New England at three points in time: 2014–2015 (time 1), 2016–2017 (time 2), and 2020–2021 (time 3). Rates increased across New England at time 2 and at time 3. The largest increase in depression rates was in 2020–2021, which coincides with the COVID-19 pandemic. We then looked at the interaction between socioeconomic status and community depression rates. New England communities with higher rates and the largest increase in depression rates in 2020–2021 had lower socioeconomic status, higher chronic disease burdens, and were urban or suburban locations.

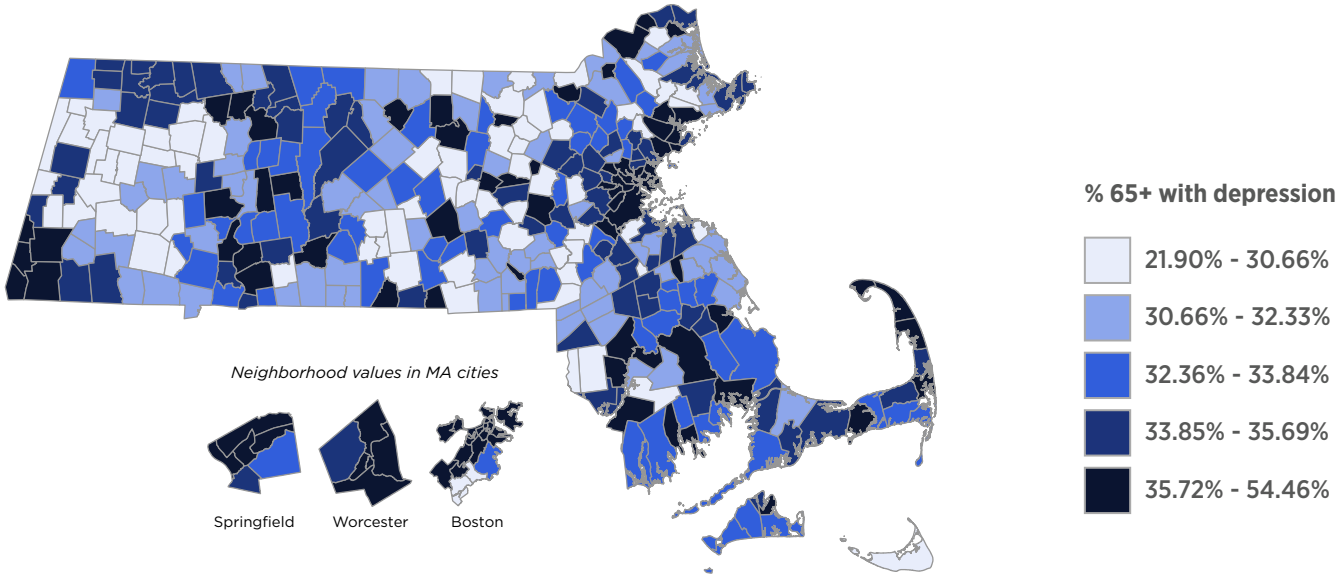
In our Massachusetts-specific analysis, we found that lower rates of depression were associated with a larger total population, higher percentage of married adults 65+, and higher community socioeconomic status. Higher community rates of depression were associated with higher percentage of residents who are 65+, higher percentage of residents who are Hispanic, more nursing homes, higher % of inter-county moves among 60+ population, higher mortality, and higher burden of chronic disease.

We think efforts to promote social connections and inclusion is a key part of promoting healthy aging. While higher rates of depression are to be expected during a pandemic, depression is not a normal part of aging. Longevity research shows that our social health is as important to our overall well-being as physical or financial health. Raising awareness about depression, increasing screening for it, and educating us all about the variety of effective treatments available are all needed.

Other behavioral health concerns among adults 65+ include state rates of 9.4% for substance use disorder and 12.3% for tobacco use disorders.

Community Behavioral Health Centers are one-stop shops for mental health and substance use services and treatment, including 24/7 in-person crisis support. The network includes 26 centers across Massachusetts. Find your CBHC here (https://www.mass.gov/info-details/find-a-cbhc).

Another resource is the Massachusetts Coalition to End Loneliness (https://www.endlonelinessma.com/). Their mission is to ensure all residents of the Commonwealth feel connected to their community and enjoy a strong sense of social health.



How Does Massachusetts Compare to Other New England States?

Massachusetts has the highest rates in New England for chronic kidney disease and prostate cancer, and the lowest rates for having no chronic conditions.

In terms of health services utilization, Massachusetts has the highest number of inpatient hospital stays and hospital readmissions.

Table 11. Comparing New England State Rates

Indicators	MA	CT	ME	NH	RI	VT
% 65+ had hip fracture	3.2%	**3.5%**	3.1%	**2.8%**	3.1%	3.1%
% 65+ with high cholesterol	75.9%	77.9%	69.5%	72.0%	**79.3%**	**63.9%**
% 65+ with Alzheimer's disease or related dementias	12.9%	**13.9%**	11.0%	10.7%	12.0%	**9.6%**
% 65+ with BPH (men)	42.6%	**44.0%**	35.2%	36.9%	43.3%	**35.1%**
% 65+ with breast cancer (women)	11.6%	**11.8%**	**9.6%**	10.2%	11.5%	**9.6%**
% 65+ with chronic kidney disease	**34.3%**	32.8%	29.4%	28.0%	34.0%	**25.1%**
% 65+ with congestive heart failure	19.6%	**21.0%**	18.1%	16.7%	20.0%	**14.9%**
% 65+ with diabetes	28.6%	31.8%	26.2%	25.2%	**32.4%**	**23.6%**
% 65+ with HIV/AIDS	**0.3%**	**0.3%**	0.2%	**0.1%**	0.2%	**0.1%**
% 65+ with hypertension	72.9%	74.2%	67.1%	67.3%	**75.8%**	**64.7%**
% 65+ with ischemic heart disease	37.1%	39.1%	35.3%	32.9%	**39.4%**	**32.8%**
% 65+ with lung cancer	**2.1%**	2.0%	1.8%	1.6%	2.0%	**1.5%**
% 65+ with osteoporosis	20.1%	**20.2%**	15.7%	16.3%	18.9%	**14.4%**

Chart key: = highest rate = lowest rate

Table 11. Continued

Indicators	MA	CT	ME	NH	RI	VT
% 65+ with peripheral vascular disease	18.1%	19.1%	15.3%	13.6%	**23.1%**	**11.5%**
% 65+ with pressure ulcer	7.8%	**9.1%**	6.8%	6.2%	7.7%	**5.7%**
% 65+ with prostate cancer (men)	**13.6%**	13.4%	10.3%	11.6%	13.4%	**10.8%**
% 65+ with stroke	11.2%	11.5%	10.0%	10.0%	**11.6%**	**9.2%**
% 65+ with 4+ chronic conditions	60.4%	61.6%	55.5%	53.9%	**63.0%**	**50.7%**
% 65+ with 0 chronic conditions	**7.2%**	7.7%	**12.4%**	10.2%	**7.2%**	11.0%
% 65+ with depression	34.6%	32.3%	**34.8%**	**30.5%**	34.5%	32.5%
% 65+ with anxiety disorder	33.0%	30.9%	30.7%	28.0%	**34.3%**	**25.8%**
% 65+ dually-eligible for Medicare and Medicaid	17.1%	**22.5%**	18.7%	**6.6%**	15.0%	12.5%
% 65+ Medicare managed care enrollees	30.5%	50.1%	50.3%	26.5%	**51.4%**	**21.1%**
# inpatient hospital stays/1,000 persons 65+ years annually	**252**	242	**170**	188	231	176
% Medicare inpatient hospital readmissions (as % of admissions)	**18.2%**	17.6%	**14.3%**	16.2%	17.1%	15.6%
# skilled nursing facility stays/1000 persons 65+ years annually	73	**90**	**43**	45	76	47
% 65+ getting Medicaid long term services and supports	3.4%	**4.4%**	**2.1%**	2.7%	4.0%	3.4%
% 65+ hospice users as % of decedents	44.0%	**42.4%**	49.7%	47.1%	**50.7%**	43.0%

Chart key: = highest rate = lowest rate

Call to Action

We are all aging and all have a role to play in making Massachusetts a great place to grow up and grow older. This report highlights the growth of the state's older population, its increasing diversity, the unequal distribution of chronic conditions within it, and the impact of the pandemic on mental health. While there is impressive momentum to build a healthy, age-friendly state, **this is no time to let up**. Identify the areas in your community where existing services for older adults can be expanded and new ones established. And see the growing older population as a valuable resource. Find and scale up opportunities for the older residents of Massachusetts to contribute to the health and well-being of all. Meaningful service contributions from older adults will benefit the volunteers themselves, their communities, and the state as a whole.

UNDERSTAND

- Download your community profile at healthyagingdatareports.org.
- Educate yourself and others about the indicators in your community.
- Compare your community rates to state rates.

ENGAGE

- Encourage participation in the age-friendly movement.
- Bring people together to talk about the data.
- Think about what your community needs to promote health for all ages.

ACT

1. Get involved! Contact Massachusetts Healthy Aging Collaborative.
2. Use data to inform your work.
3. Identify and build on what's working.

How Have Others Used the Data Reports?

- In 2014, Massachusetts advocates from the MA Councils on Aging printed community profiles and went to the state capitol to advocate for more investments in programming to promote healthy aging. They shared the community profiles to show legislators the status of healthy aging of older people in their districts. As a result of this outreach, an additional million dollars was appropriated to support evidence-based programming to enhance healthy aging.
- A geriatrician was competing for a training grant to expand fellowship training of geriatricians in western Massachusetts. She was able to use the data report to demonstrate the need for additional fellowship-trained doctors to treat the older population and was awarded a 5-year multimillion dollar grant to support a training program.
- The Alzheimer's Association was surprised to learn that the rates for Alzheimer's disease and related dementias were elevated in the southwest part of New Hampshire, an area where they had no respite or support groups in place. In response they created supports to help families taking care of persons with dementia.
- In Mississippi, the state Department of Health convened an Age-Friendly summit. They printed the entire report and mailed it to every mayor in the state. Counties along the Mississippi Delta had many rates higher than the state average. To address this concern, they convened a second special briefing for the mayors from along the Mississippi Delta to share ideas on health promotion interventions.
- In Wyoming, the Healthy Aging Data Report was released at a conference at the University of Wyoming. Media outreach around the state led to visibility and awareness of health challenges in rural and frontier counties. Networking and collaboration among interested partners are taking off.
- In New Hampshire, a legislative breakfast was held to share the New Hampshire Data Report. Graduate students showed legislators the website and how to navigate to information important to their districts. Senior Ambassadors were trained to interpret and explain community profiles and the statewide maps to legislators during the event.
- Educators in several states use the Healthy Aging Data Reports in health, statistics, and community health courses.

In all states with a Healthy Aging Data Report available, our stakeholders have been able to submit more competitive grant applications for support to address healthy aging. Whether applying to a local foundation or a federal funder, the stakeholders are able to build more convincing rationales for their requests because they can cite data and include maps that document local concerns.

Use the data in this report to help identify healthy aging priorities in your community.

Explore how to get involved:

Massachusetts Healthy Aging Collaborative

What are the Indicators and Data Sources?

POPULATION CHARACTERISTICS

Total population, population 60+ as % of total population, total population 60+, population 65+ as % of total population, total population 65+ and (% 65-74, % 75-84, and % 85+), % 65+ who are female, % 85+ who are female, Race and ethnicity of population 65+ (% White, % African American, % Asian, % Other Race(s), % Hispanic), # 55+ who are Native American/Alaskan, Marital status 65+ (% married, % divorced/separated, % widowed, % never married), Education of the population 65+ (% less than high school, % with high school or some college, % with a college degree, % with a graduate or professional degree), % 65+ who speak only English at home, % 65+ who are veterans of military service, % 60+ who are LGBT).

The U.S. Census Bureau (American Community Survey (ACS)) 2018–2022; Massachusetts Department of Public Health (MDPH) (Behavioral Risk Factor Surveillance Survey (BRFSS)), 2010–2022.

HOUSING

% 65+ population who live alone, average household size all ages, median house value (all ages), % 60+ who own home, % 60+ homeowners who have mortgage, % 65+ households (renter) who spend more than 35% of income on housing, % 65+ households (owner) spending more than 35% of income on housing, % of grandparents who live with grandchildren, # of assisted living sites.

The US Census Bureau (American Community Survey 2018–2022); Mass.gov, 2023.

SOCIAL DETERMINANTS OF HEALTH

COST OF LIVING (ELDERINDEX.ORG)

Elder Index for 65+: Single, homeowner without mortgage, good health; Single, renter, good health; Couple, homeowner without mortgage, good health; Couple, renter, good health.

Elderindex.org, 2023; Center for Social and Demographic Research on Aging at the University of Massachusetts Boston.

ECONOMIC

% 60+ receiving food benefits in past year, % 65+ employed in past year, % 65+ with income below the poverty line in past year, Median annual income for households with a householder 65+.

The US Census Bureau (American Community Survey 2018–2022)

WELLNESS

% 60+ getting the recommended hours of sleep, % 60+ doing any physical activity in the past month, % 60+ who met CDC guidelines for muscle-strengthening activity, % 60+ who met CDC guidelines for aerobic physical activity, % 60+ with fair or poor self-reported health status, % 60+ with 15 or more physically unhealthy days in last month.

BRFSS, 2010–2022.

COMMUNITY

Annual # of unhealthy days due to air pollution for 65+, AARP age-friendly communities, Dementia Friendly Communities, # public universities and community colleges, # of public libraries, # of Councils on Aging (COAs), # of Osher Lifelong Learning Institutes, % of households with a smartphone (all ages), % of households with only a smart phone to access internet (all ages), % households without a computer (all ages), % households with access to Broadband (all ages), % households without access to the Internet (all ages), % 60+ who used Internet in past month, voter participation rate in 2020 election (18+), homicide rate/100,000 person, # firearm fatalities (all ages), #65+ deaths by suicide, age-sex adjusted 1-year mortality rate.

AARP, 2023; ACS, 2018–2022; BRFSS, 2010–2022; CDC WONDER, 2016–2020; The CMS Master Beneficiary Summary File ABCD/Other (CMS), 2020–2021; Dementia Friendly Massachusetts, 2023; Massachusetts Executive Office of Elder Affairs (EOEA), 2023; NECHE, 2023; OLLI, 2023; MA State Library, 2023; MA Secretary of State, 2023; U.S. EPA Air Compare, 2023.

TRANSPORTATION

% householders 65+ who own a motor vehicle, % 60+ who always drive or ride wearing a seatbelt, % 60+ drove under the influence, # fatal crashes involving adults age 60+, AllTransit Score.

The US Census Bureau (American Community Survey 2018–2022); AllTransit, 2023; BRFSS 2010–2022; NHTSA, 2018–2022.

HEALTH OUTCOMES

FALLS

% 60+ who fell in past year, % 60+ who were injured by a fall in past year, % 65+ with hip fracture.

BRFSS 2010–2022; CMS, 2020–2021.

PREVENTION

% 60+ with check-up in past year, % 60+ flu shot in past year, % 60+ with pneumonia vaccine, % 60+ with shingles vaccine, % 60+ women with mammogram in past 2 years, % 60+ had colorectal cancer screening, % 60+ with optimal preventive health.

BRFSS 2010–2022.

NUTRITION AND DIET

% 60+ with 5 or more servings of fruit or vegetables per day, % 60+ self-reported obese, % 65+ with high cholesterol, % 60+ with high cholesterol screening.

BRFSS 2010–2022; CMS 2020–2021.

ORAL HEALTH

% 60+ with annual dental exam, # dentists per 100,000 persons (all ages), % 60+ with loss of 6 or more teeth.

BRFSS 2010–2022; HRSA, 2023.

CHRONIC DISEASE RATES AMONG MEDICARE BENEFICIARIES 65+

Alzheimer's disease or related dementias, anemia, arthritis, asthma, atrial fibrillation, BPH (men), breast cancer (women), cataract, chronic kidney disease, chronic obstructive pulmonary disease, colon cancer, congestive heart failure, diabetes, endometrial cancer (women), fibromyalgia/chronic pain/fatigue, glaucoma, heart attack, HIV/AIDS, hypertension, ischemic heart disease, liver disease, lung cancer, migraine, osteoporosis, peripheral vascular disease, pressure ulcer, prostate cancer (men), stroke, 4 or more chronic conditions, zero chronic conditions.

CMS 2020–2021.

BEHAVIORAL HEALTH

drug overdoses deaths (all ages), % 65+ with substance use disorder, % 60+ with excessive drinking, % 65+ tobacco use disorder, % 60+ current smokers.

BRFSS 2010–2022; CDC Wonder 2016–2020; CMS 2020–2021.

MENTAL HEALTH

% 60+ with 15 or more days of poor mental health in past month, % 65+ with depression, % 65+ with anxiety disorder, % 65+ with post-traumatic stress disorder, % 65+ with schizophrenia.

BRFSS 2010–2022; CMS 2020–2021.

DISABILITY RATES AMONG ADULTS 65+

Hearing difficulty, vision difficulty, cognition difficulty, ambulatory difficulty, self-care difficulty, and independent living difficulty.

American Community Survey 2018–2022.

CAREGIVING

of Alzheimer's support groups, % grandparents raising grandchildren.

American Community Survey 2018–2022; Alzheimer's Association, 2023.

ACCESS TO CARE

% 65+ dually eligible for Medicare and Medicaid, % 65+ Medicare managed care enrollees, % 60+ with a regular doctor, % 60+ who did not see a doctor when needed due to cost, # of CMS-certified (primary care providers hospitals, home health agencies, skilled nursing facilities, hospice agencies), # of HRSA community health centers, # of adult day health centers.

BRFSS 2010–2022; CMS 2020–2021; HRSA 2023; Medicare.gov, 2023; Massachusetts Executive Office of Health and Human Services (HHS), 2023.

SERVICE UTILIZATION

of physician visits per year, # of emergency room visits/1000 65+ annually, # Part D monthly prescription fills per person annually, # home health visits annually, # durable medical equipment claims annually, # inpatient hospital stays/1000 person 65+ annually, % Medicare inpatient hospital readmissions (as % of admissions), # skilled nursing facility stays/1000 person 65+ annually, # skilled nursing home Medicare beds/1000 person 65+, % 65+ getting Medicaid long term services and supports, % 65+ hospice users, % 65+ hospice uses as % of decedents.

CMS 2020–2021.

TECHNICAL COMMENT

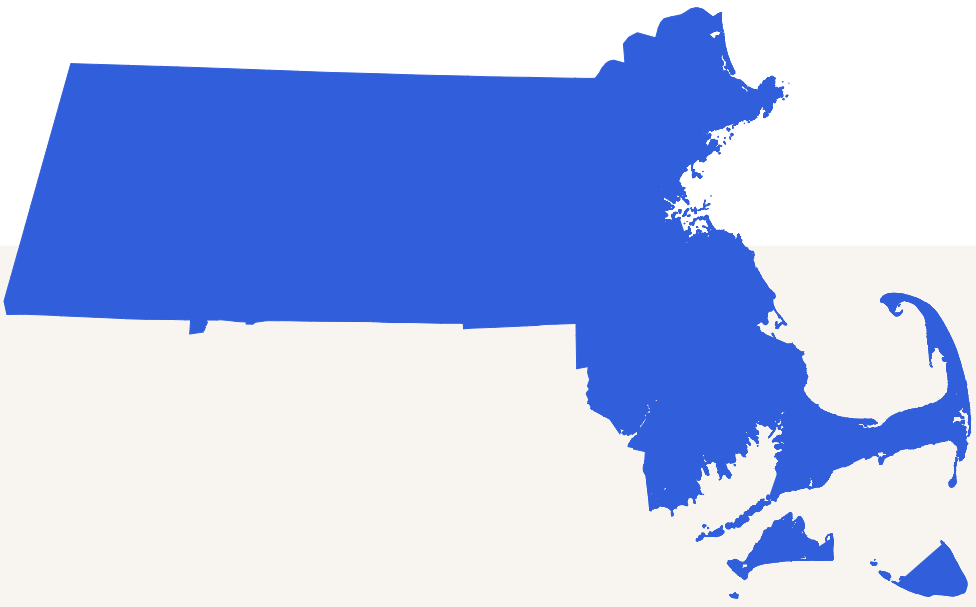
While we collect and analyze data from dozens of entities, we rely on three main sources:

- The Behavioral Risk Factor Surveillance System (BRFSS), which we obtain from the Massachusetts Department of Public Health,
- The American Community Survey (ACS), obtained from the US Census Bureau, and
- The Centers for Medicare and Medicaid Services (CMS), which provides data on chronic disease, health care utilization, and access to care for all Medicare enrollees 65+ in the fee-for-service insurance. We do not yet have data for the managed care enrollees who are 30.5% of the total Medicare population in Massachusetts. This is a limitation we acknowledge.

TECHNICAL NOTES

Our documentation on www.healthyagingdatareports.org provides comprehensive information about the indicators, data sources, geographic units, statistical approach, and resources. For most indicators, the reported community and state values are estimates calculated from sample data. Thus, it is possible that some of the differences between community and state estimates may be due to chance associated with population sampling. We use the terms “better” and “worse” to highlight the 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 health. When the implication is unclear we use an asterisk. All differences reported in the comparison tables (gender, race/ethnicity, and across states) are statistically significant at the 95% confidence level. Note that the terms better or worse do not convey or imply a value judgment on the part of the researchers or funders. After careful and in-depth conversations with a range of stakeholders, we believe the better/worse label is the simplest way to communicate what the rates mean.

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 every city/town and for neighborhoods in three cities in Massachusetts (Boston, Springfield, and Worcester). For example, the population characteristics and information from the US Census were reported for all 386 geographic units. For highly prevalent chronic conditions we report for 323 geographic units, while for less prevalent conditions we report for 214 geographic units. For the BRFSS data we report for 42 geographic units, and for the least prevalent conditions we report for 17 geographic units. The same age/sex adjusted estimate is reported for all the towns/cities in the aggregated geographic areas. Maps of the different geographic groups and the rationale behind the groupings are in the Technical Documentation online.



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"When we talk about old age, each of us is talking about his or her own future. We must ask ourselves if we are willing to settle for mere survival when so much more is possible."

DR. ROBERT N. BUTLER

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

MARGARET J. WHEATLEY

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