

Healthy Aging Data Report Massachusetts 2014



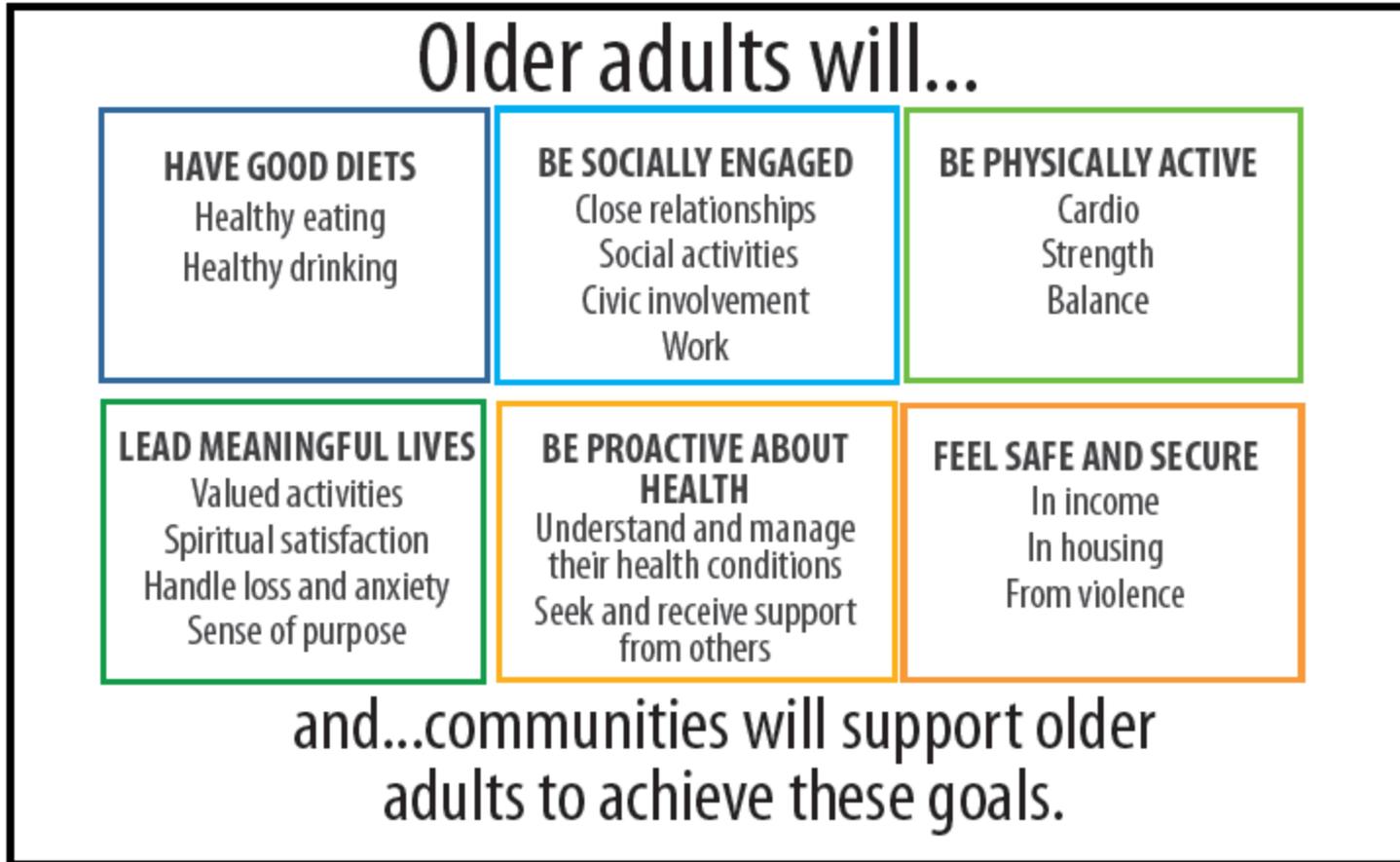
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www.mahealthyagingcollaborative.org

Defining *Healthy Aging*

FIGURE 1: INGREDIENTS OF HEALTHY AGING



Walter Leutz, PhD. Healthy Aging in the Commonwealth: Pathways to Life Long Wellness.
Presented at the 2013 Healthy Aging Forum. Newton, MA.

Healthy Aging- Adapted from World Health Organization Definition

- ▶ Supportive communities are necessary to achieve healthy aging.
- ▶ A multi-dimensional model that aligns with the World Health Organization's definition of active aging
- ▶ Supports activities that “Optimize opportunities for health, participation and security in order to enhance quality of life as people age.”



Gains in human longevity (1900=47; 2010=79).

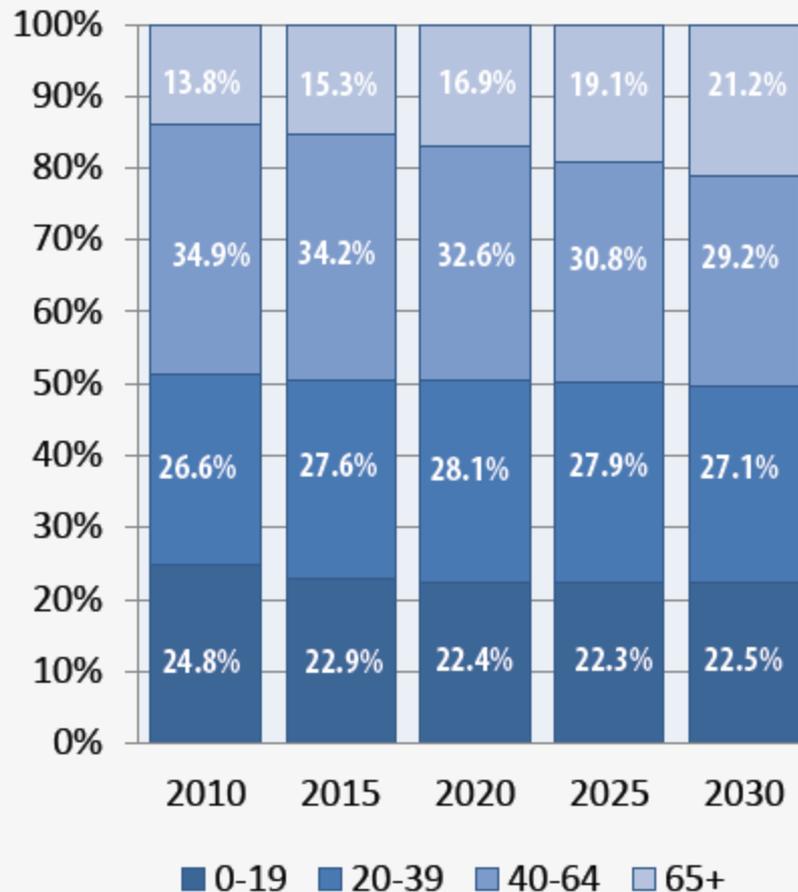
1 in 8 (13.3%) US population. 41.4 million Americans (2011);

A remarkable 8,000 adults per day turn 65!

Source: (The Administration on Aging, *Profile of Older Americans: 2012*)

Massachusetts will steadily get older.

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



The tools are all available at mahealthyagingcollaborative.org



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DATA REPORT	PROGRAMS	BROWSE TOPICS	RESOURCES	CONNECT	BLOG

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MA Healthy Aging Data Report

View the Healthy Aging Community Profile to see how your community compares to the state averages for various indicators of healthy aging.

[Learn More >](#)

STEP 1 Create an account. 	STEP 2 Find other members. 	STEP 3 Join the discussion.
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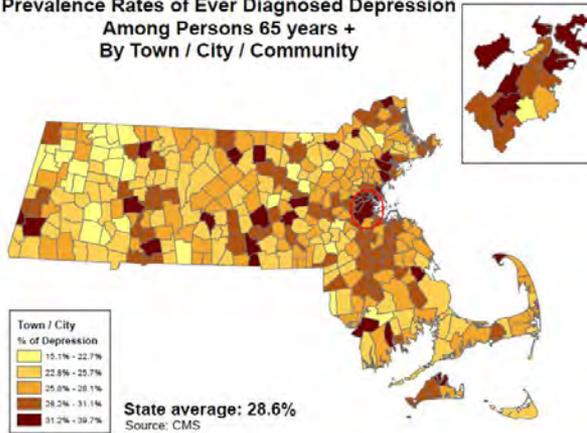


DATA REPORT	BLOG	CONNECT	
<p>HIGHLIGHTS REPORT</p> <p>Explore a snapshot of findings from the MA</p>	<p>DATA REPORT TUTORIAL</p> <p>Watch this short video tutorial to learn what's inside the MA Healthy Aging Data Report, and</p>	<p>MEET THE TEAM BEHIND THE MASSACHUSETTS HEALTHY AGING DATA REPORT</p> <p>Read More ></p> <p>VISIT THE REDESIGNED HEALTHY LIVING CENTER</p>	<p>MEMBERS</p> <p>Become a member of the community.</p>

Newly released tools for Healthy Aging toolbox

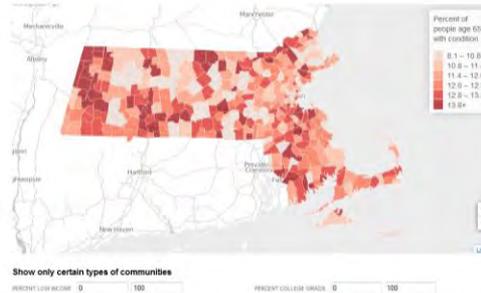


Prevalence Rates of Ever Diagnosed Depression Among Persons 65 years + By Town / City / Community



Chronic Disease Maps

- Alzheimer's disease or related dementias
- Diabetes
- Stroke**
- Chronic obstructive pulmonary disease (COPD)
- Hypertension
- Ever had a heart attack
- Ischemic heart disease
- Congestive heart failure
- Osteoarthritis
- Rheumatoid arthritis
- Ever had hip fracture
- Glaucoma
- Women with breast cancer
- Colon cancer
- Men with prostate cancer
- Lung cancer
- Osteoporosis
- 4+ chronic conditions (of 16)
- No chronic conditions (of 16)



TECHNICAL APPENDIX

Overview

This technical appendix contains details about the development of the health community profiles. It contains the technical definitions of all reported health indicators, information on all data sources and the years of data employed, the geographic units employed for different types of indicators, and the statistical methods used to estimate the indicators that were estimated from micro-level

1. Healthy aging indicator definitions

Due to resource limitations all healthy aging indicators had to be derived from secondary data sources. Healthy aging indicators were limited to those for which secondary data was available for geographic subareas within Massachusetts. Table A-1 contains technical definitions for all the healthy aging indicators reported in this study. This does not contain definitions for the socio-demographic variables used to describe the population composition of Massachusetts cities because these are basic population characteristics that do not require further explanation.

2. Data Sources

Multiple data sources were used in this study. Table A-2 contains a summary of all data sources and the specific years of data used for each population composition and healthy aging indicator. Estimates of community-level indicators of physical/mental health, chronic disease prevalence, access to care, wellness and prevention health behaviors, service utilization, and nutrition and diet were derived from two major data sources: the Medicare Master Beneficiary Summary File and the Behavioral Risk Factor

MASSACHUSETTS HEALTHY AGING COMMUNITY DATA PROFILE

Watertown (Middlesex)

Watertown is a town located approximately 10 miles west of Boston. It has 4,702 residents aged 65 or older. The walkscore indicates that this is a very walkable community (80/100). Compared to state averages older residents of Watertown do better on many healthy aging indicators with lower rates of diabetes, chronic obstructive pulmonary disease (COPD), hypertension, complete tooth loss, obesity, and annual Part D monthly prescription medications. Health promotion behaviors include physical activity, colorectal cancer screening, flu shot, shingles vaccine, annual dental exam, eating 5 or more servings of fruit or vegetables per day, and not smoking. However, older residents of Watertown do worse than state average with higher rates of depression, ischemic heart disease, breast cancer, and inpatient hospital readmissions. Community resources to promote healthy aging include: MBTA Ride, volunteer driving program, a Council on Aging, MA/NH Chapter of the Alzheimer's Association, and an arts and/or cultural department.



POPULATION COMPOSITION¹

	COMMUNITY ESTIMATE	STATE ESTIMATE
Total population all ages	31,915	6,547,629
Population 65 years or older as % of total population	14.8%	13.7%
Total population 65 years or older	4,702	891,303
% 65-74 years	48.3%	49.8%
% 75-84 years	38.1%	34.3%
% 85 years or older	13.6%	15.8%
Living Situation (65+ population)		
% living alone	28.0%	32.0%
Gender (65+ population)		
% female	60.3%	58.5%
Race/Ethnicity (65+ population)		
	95.8%	91.5%
	0.3%	3.6%
	2.2%	2.7%
	1.6%	2.1%

MASSACHUSETTS HEALTHY AGING COMMUNITY DATA PROFILE

Watertown (Plymouth)

HEALTHY AGING INDICATORS

	BETTER / WORSE STATE RATE	COMMUNITY ESTIMATE	MARGIN OF ERROR	STATE ESTIMATE	MARGIN OF ERROR
PHYSICAL/MENTAL HEALTH					
% with self-reported fair or poor health status		20.3%	(16.9% - 23.7%)	20.7%	(19.9% - 21.5%)
% injured with a fall in last 3 months		5.9%	(3.1% - 8.7%)	5.1%	(4.5% - 5.6%)
% with 15+ physically unhealthy days last month		14.4%	(11.4% - 17.3%)	14.0%	(13.3% - 14.7%)
% disabled for a year or more		32.8%	(28.8% - 36.9%)	31.0%	(30.2% - 31.9%)
Age-sex adjusted 1-year mortality rate		4.5%	(3.6% - 5.4%)	4.7%	(4.7% - 4.8%)
% with 15+ days poor mental health last month		7.2%	(5.0% - 9.3%)	6.7%	(6.2% - 7.2%)
% satisfied with life		95.3%	(93.6% - 97.0%)	95.6%	(95.5% - 96.1%)
% receiving adequate emotional support		81.9%	(78.8% - 85.0%)	80.7%	(80.0% - 81.4%)
% ever diagnosed with depression		28.3%	(26.0% - 30.6%)	28.6%	(28.5% - 28.7%)
CHRONIC DISEASE					
% with Alzheimer's disease or related dementias		13.2%	(11.5% - 15.0%)	14.4%	(14.3% - 14.5%)
% with diabetes		32.0%	(29.4% - 34.7%)	32.1%	(32.0% - 32.2%)
% with stroke		11.6%	(10.0% - 13.2%)	12.6%	(12.5% - 12.7%)
% with chronic obstructive pulmonary disease (COPD)	W	29.5%	(27.2% - 31.9%)	23.3%	(23.2% - 23.4%)

HIGHLIGHTS FROM THE
MASSACHUSETTS HEALTHY
AGING DATA REPORT:

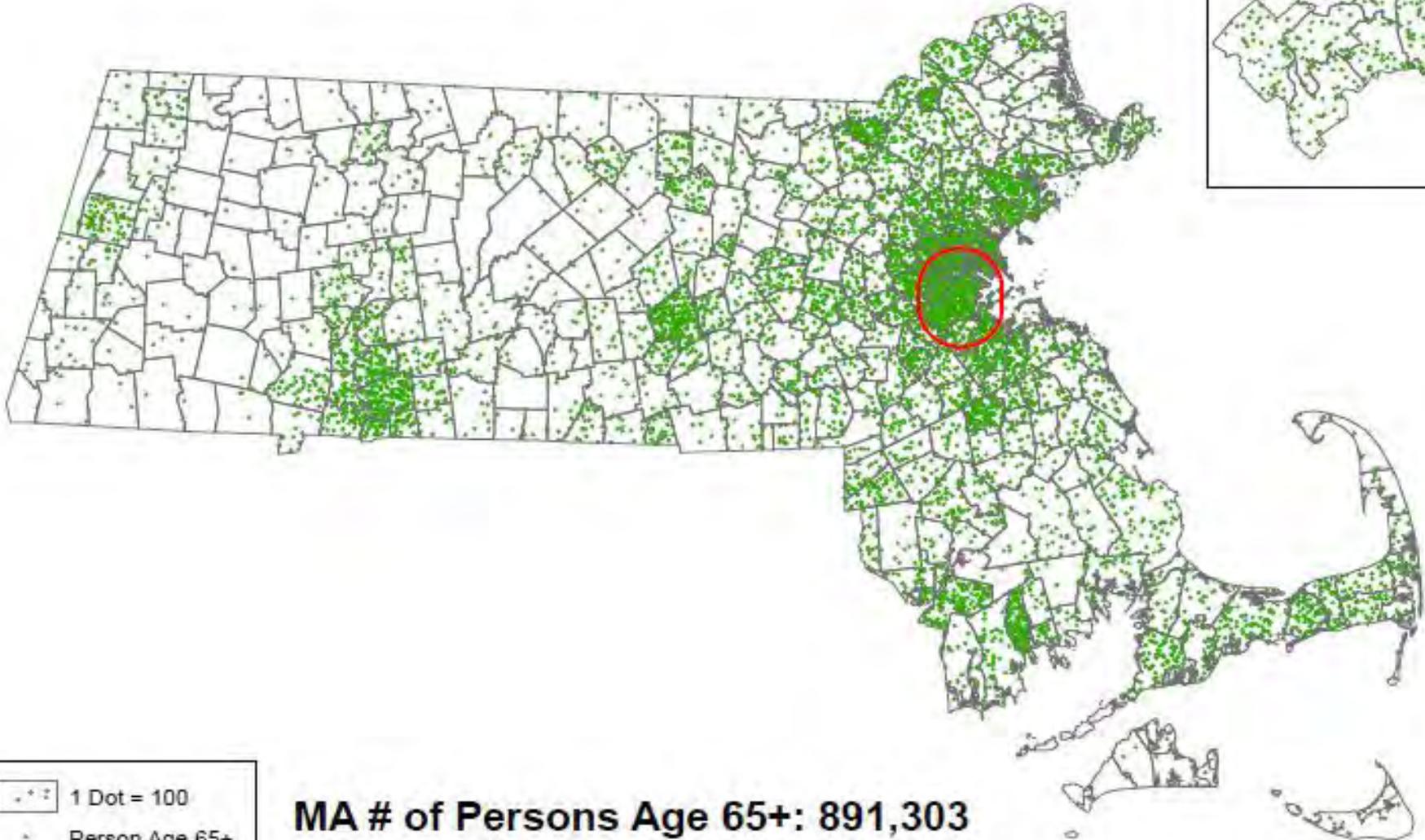
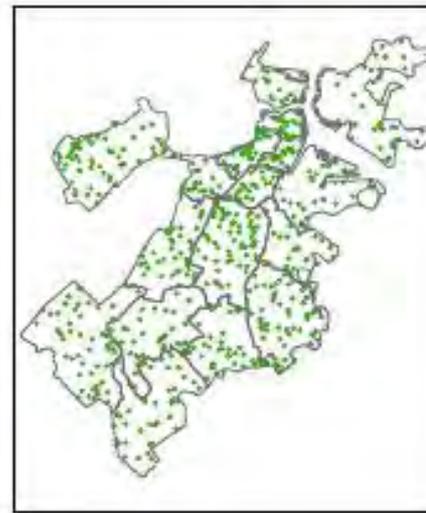
COMMUNITY PROFILES 2014



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TUFTS  Health Plan
FOUNDATION

Density of Population Age 65+ Years By Town / City / Community

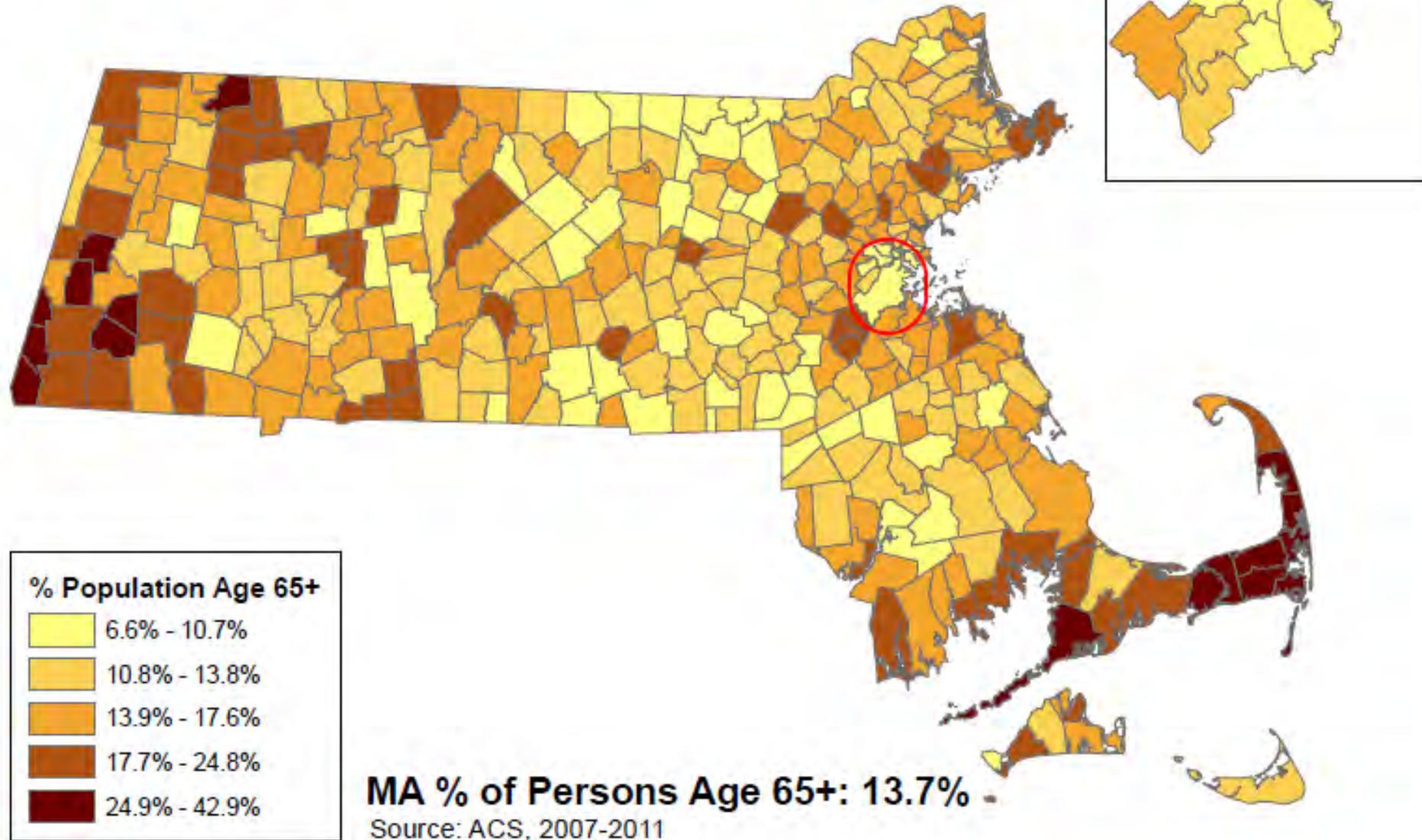


1 Dot = 100
Person Age 65+

MA # of Persons Age 65+: 891,303

Source: ACS, 2007-2011

Percentage of Population Age 65+ Years By Town / City / Community



Key Findings

- ▶ There are no clear patterns and much variability in the distribution of demographic, health and social indicators across the state.
- ▶ Multiple chronic diseases are high among older adults. State average for persons 65+ with 4 or more chronic diseases is 59%
- ▶ When compared to other states Massachusetts is advantaged in terms of average education level, income, and access to health insurance.

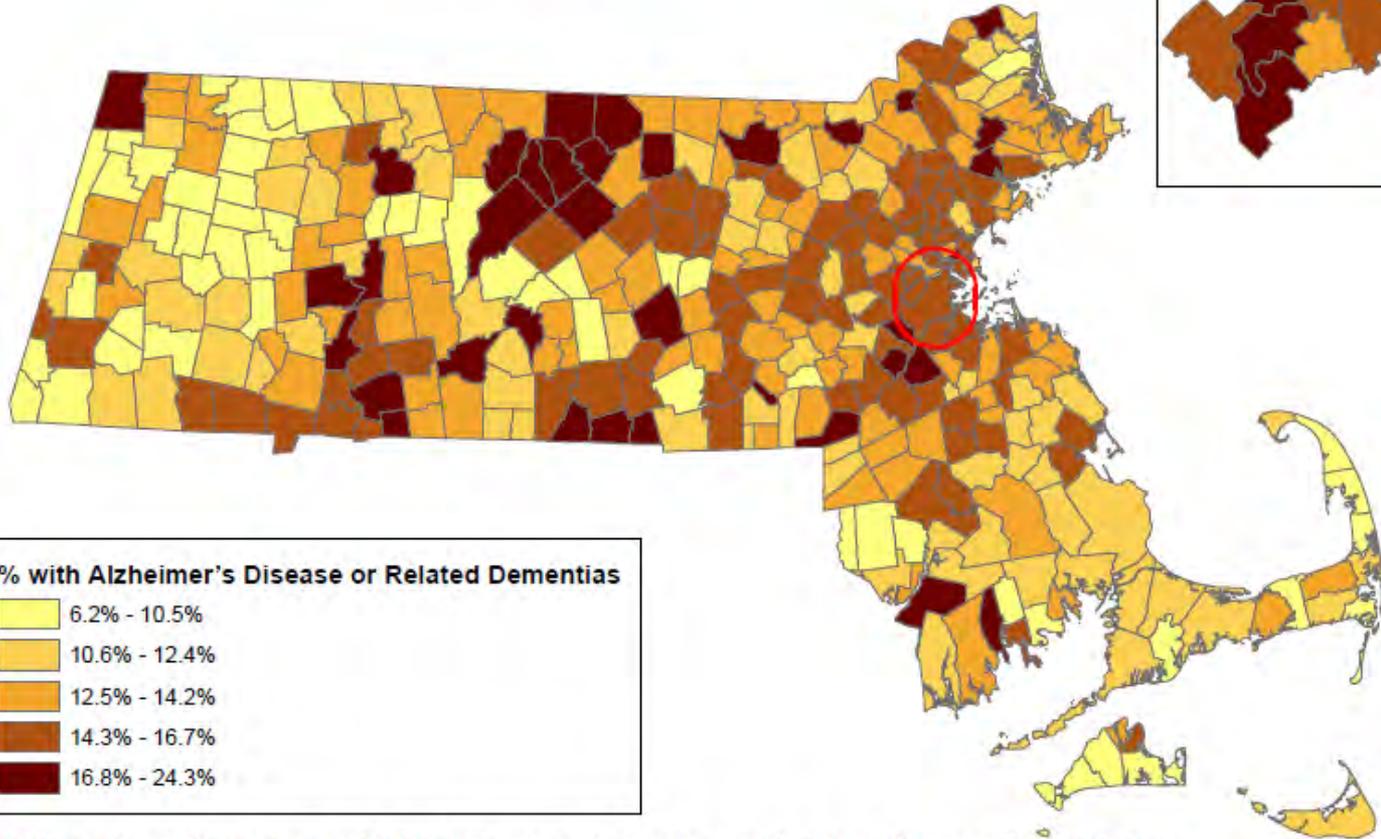
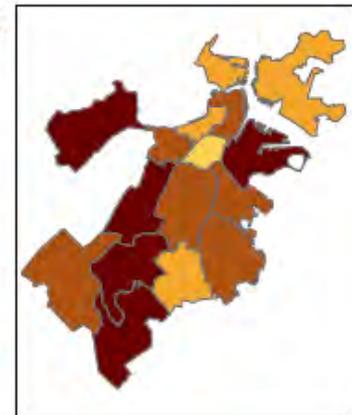
Key Findings-continued

- ▶ **Diabetes:** Nearly 1 in 3 (32%) of adults 65+ have *ever* been dx.
- ▶ **Depression** rates higher compared to national averages.
- ▶ **Hypertension** rates higher than national averages.
- ▶ **Alzheimer's disease** and related dementia rates higher than national averages.

Key Findings-continued

- ▶ **Obesity:** About 1 in 4 (23%) of adults 60+ are obese (BMI of 30).
- ▶ **Cancer:** 15% of men 65+ have prostate cancer.
- ▶ **Flu shots:** 2 out of 3 adults 60+ get a flu shot.
- ▶ **Shingles vaccine:** Only 15% have taken a shingles vaccine.

Percentage of Medicare Beneficiaries Age 65+ Years with Alzheimer's Disease or Related Dementias By Town / City / Community

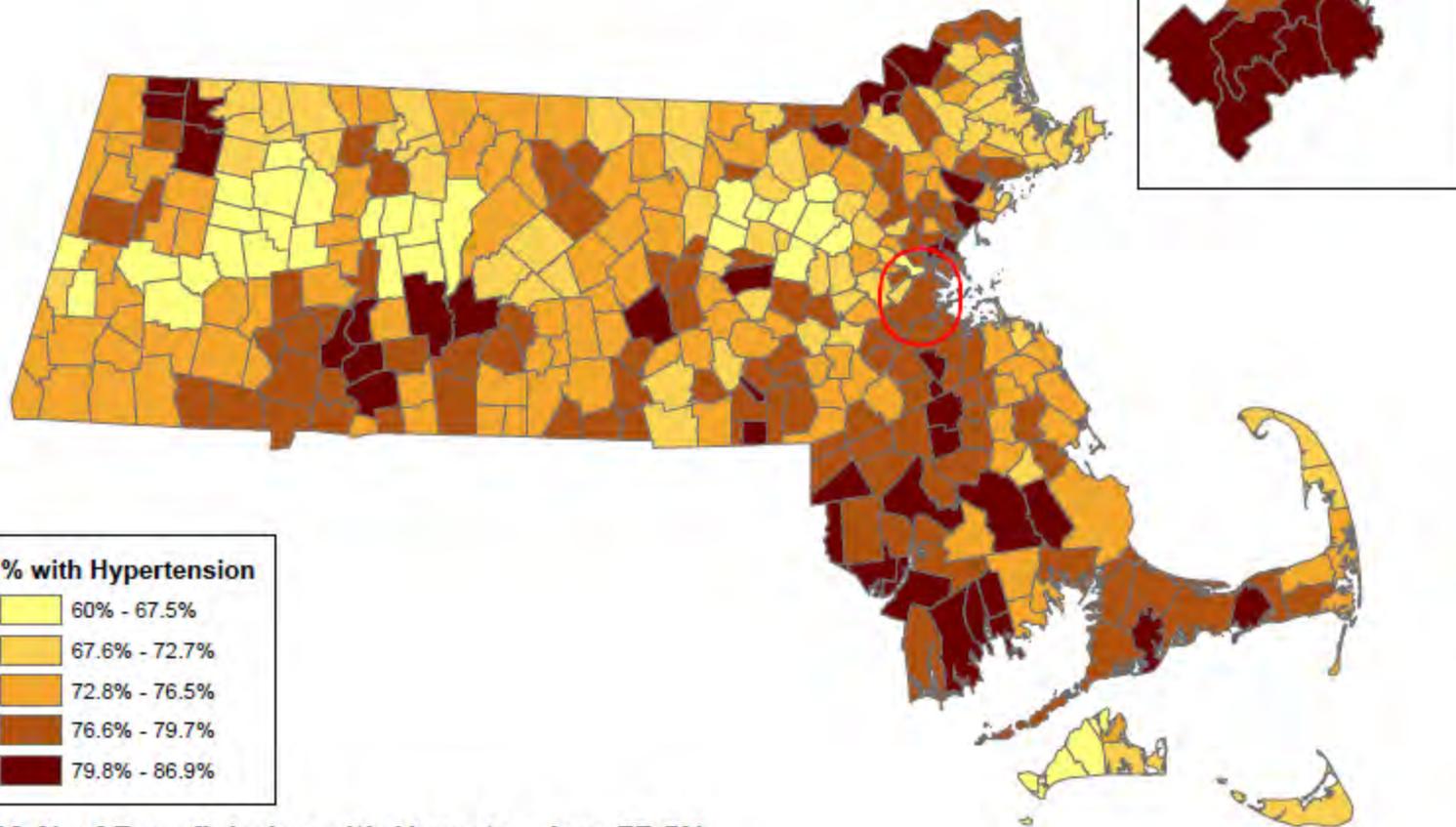


MA % of Beneficiaries with Alzheimer's Disease or Related Dementias: 14.4%

Source: CMS

Gardner 24%, Roslindale 23%, Webster 22%, Jamaica Plain 21%, Chelsea 20%

Percentage of Medicare Beneficiaries Age 65+ Years with Hypertension By Town / City / Community

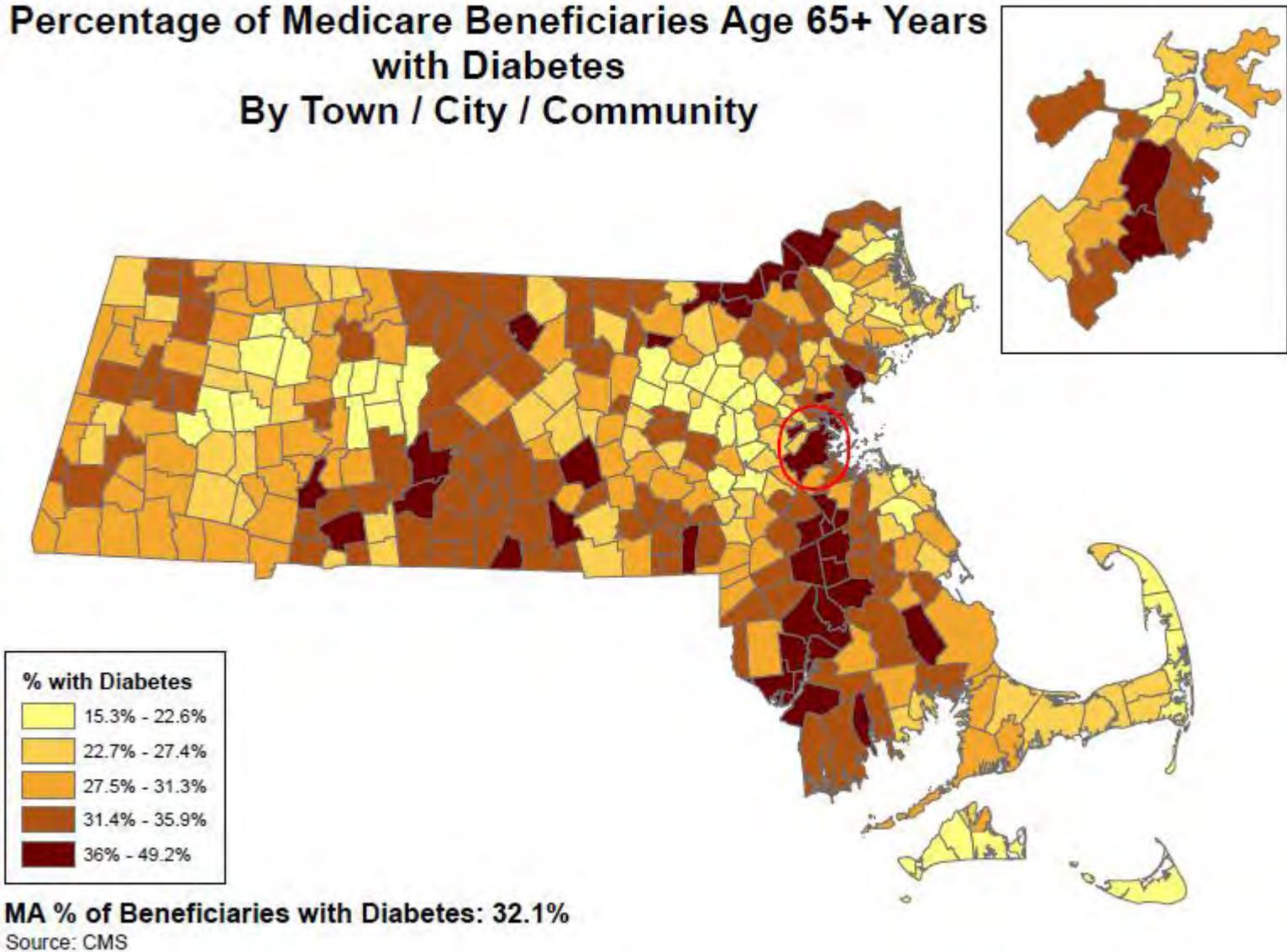


MA % of Beneficiaries with Hypertension: 77.5%

Source: CMS

Somerset 87%, Fall River 87%, Taunton 84%, Roxbury 84%, New Bedford 84%

Percentage of Medicare Beneficiaries Age 65+ Years with Diabetes By Town / City / Community

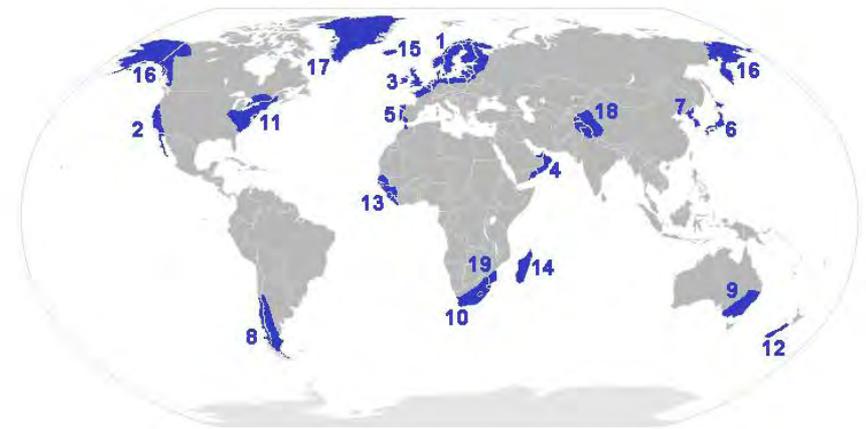


Mattapan 49%, Roxbury 47%, Fall River 45%, Lowell 44%, Lawrence 44%

Key Findings

Priority Communities	
New Bedford	-31
Springfield	-25
Fall River	-24
Worcester	-20
Lowell	-19
South Boston	-16

Key Findings



Communities With Strengths in Healthy Aging

Carlisle	+24
Wellesley	+23
Harvard	+21
Brookline	+20
Belmont	+20
Stow	+20

Somerville (Middlesex)

Somerville is a city 3 miles from Boston with 6,767 residents aged 65 or older and is considered "a walker's paradise" (walkscore: 91/100). Compared to Massachusetts state averages, older residents do better on: preventive health (not smoking, shingles vaccine, cholesterol monitoring), perceptions (self-rated physical and mental health), and a few chronic disease indicators (stroke, arthritis, prostate cancer). However, compared to state averages older residents did worse on: depression, diabetes, ischemic heart disease, congestive heart failure, hospital stays, and emergency room visits. There are many community resources directed to promoting healthy aging in Somerville, including: a MA Department of Public Health walking club, Mass in Motion community, YMCA, Council on Aging, Parks and Recreation department, lifelong learning programs, and access to the MBTA Ride and ITNGreaterBoston.



POPULATION COMPOSITION¹

	COMMUNITY ESTIMATE	STATE ESTIMATE
Total population all ages	75,754	6,547,829
Population 65 years or older as % of total population	9.0%	13.7%
Total population 65 years or older	6,787	891,303
% 65-74 years	45.9%	49.8%
% 75-84 years	39.4%	34.3%
% 85 years or older	14.8%	15.8%
<i>Living Situation (65+ population)</i>		
% living alone	37.4%	32.0%
<i>Gender (65+ population)</i>		
% female	82.0%	58.5%
<i>Race/Ethnicity (65+ population)</i>		
% White	89.5%	91.5%
% African American	4.5%	3.8%
% Asian	4.4%	2.7%
% Other	1.6%	2.1%
% Hispanic/Latino	2.7%	2.9%

HEALTHY AGING INDICATORS	BETTER / WORSE STATE RATE	COMMUNITY ESTIMATE	STATE ESTIMATE
PHYSICAL/MENTAL HEALTH²			
% with self-reported fair or poor health status	B	14.5%	20.7%
% injured with a fall in last 3 months		3.9%	5.1%
% with 15+ physically unhealthy days last month		10.5%	14.0%
% disabled for a year or more		30.6%	31.0%
Age-sex adjusted 1-year mortality rate		5.2%	4.7%
% with 15+ days poor mental health last month	B	2.6%	6.7%
% satisfied with life		95.8%	95.8%
% receiving adequate emotional support		77.4%	80.7%
% ever diagnosed with depression	W	31.5%	28.6%
CHRONIC DISEASE³			
% with Alzheimer's disease or related dementias		14.5%	14.4%
% with diabetes	W	34.9%	32.1%
% with stroke	B	11.3%	12.6%
% with chronic obstructive pulmonary disease (COPD)		23.9%	23.3%
% with hypertension		76.6%	77.5%
% ever had a heart attack		4.9%	5.0%
% with ischemic heart disease	W	46.8%	44.1%
% with congestive heart failure	W	28.8%	24.8%
% with osteoarthritis/rheumatoid arthritis	B	46.9%	50.2%
% ever had hip fracture		4.2%	3.9%
% with glaucoma		25.6%	25.1%
% women with breast cancer		9.7%	10.3%
% with colon cancer		3.6%	3.3%
% men with prostate cancer	B	12.3%	14.6%
% with lung cancer		1.8%	2.1%
% with osteoporosis		21.9%	21.7%
% with 4+ chronic conditions (of 14)		58.4%	58.6%
% with no chronic conditions (of 14)	B	10.2%	8.2%

HEALTHY AGING INDICATORS	BETTER / WORSE STATE RATE	COMMUNITY ESTIMATE	STATE ESTIMATE
ACCESS TO CARE⁵			
% with a regular doctor		97.8%	98.2%
% did not see doctor when needed due to cost		3.7%	3.7%
# dentists per 100,000 persons (all ages)		88	85
SERVICE UTILIZATION⁶			
Inpatient hospital stays/1000 persons 65+ years per year	*	396	354
Inpatient hospital readmissions (as % of admissions)		18.2%	17.8%
Skilled nursing facility stays/1000 persons 65+ years per year		104	117
Home health visits per year		4.8	4.2
Physician visits per year	*	6.7	7.8
Durable medical equipment claims per year	*	2.3	2.1
Emergency room visits/1000 persons 65+ years per year	*	735	648
Part D monthly prescription fills per person per year	*	57.0	52.7
WELLNESS and PREVENTION⁷			
% any physical activity last month		78.4%	72.4%
% mammogram within last 2 years (women)		85.3%	85.4%
% colorectal cancer screening		69.3%	65.6%
% cholesterol screening	B	98.8%	95.8%
% flu shot past year		68.9%	67.8%
% pneumonia vaccine		62.3%	60.8%
% shingles vaccine	B	26.0%	14.9%
% with physical exam in past year		89.1%	90.2%
% with annual dental exam		73.4%	76.1%
COMMUNITY VARIABLES⁸			
		COMMUNITY ESTIMATE	STATE ESTIMATE
<i>Walkability of Community</i>			
Walkability score (0-100)	Walker's Paradise	91.0	52.6

HEALTHY AGING INDICATORS

	COMMUNITY ESTIMATE	STATE ESTIMATE	
SAFETY⁹			
Violent crime rate / 100,000 persons	370	428	
Property crime rate / 100,000 persons	2,286	2,259	
ECONOMIC VARIABLES¹⁰			
<i>Household income (65+ householder)</i>			
% households with annual income < \$20,000	15.9%	28.4%	
	\$ COUNTY ESTIMATE	\$ STATE ESTIMATE	RATIO OF COUNTY TO STATE
<i>Elder Economic Security Standard Index</i>			
Single, homeowner without mortgage, good health	\$24,800	\$23,808	1.03
Single, renter, good health	\$28,956	\$27,924	1.04
Couple, homeowner without mortgage, good health	\$35,816	\$35,532	1.00
Couple, renter, good health	\$39,972	\$39,648	1.01

See our technical report for information on data sources, methodology, and margin of errors. For most indicators the reported community and state values are both estimates derived from sample data. Hence 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 should have positive implications for the health of older residents. "Worse" is used where a higher/lower score should have negative implications for the health of older residents. When the implication for healthy aging is unclear we use an *.

Explanatory Notes:

¹ Total population estimates are from the 2010 Census and are reported for individual cities/towns and subareas within Boston. Medicare managed care and dual eligible estimates are for beneficiaries 65 years or older in 2011 from the 2011 Centers for Medicare and Medicaid Services (CMS) Master Beneficiary Summary File (MBSF). For these estimates some towns with smaller populations were aggregated together resulting in 311 geographic areas in the state. The same estimate is reported for all cities/towns within the same aggregated geographic area. All other estimates are from the 2007-2011 American Community Survey (ACS) and are reported for individual cities/towns and subareas within Boston. Percentages may not add up to 100% due to rounding error.

² Mortality and depression rates were estimated from 2010-2011 CMS MBSF data for 311 geographic areas (see note 1). The 2007-2011 Behavioral Risk Factor Surveillance System (BRFSS) is the source for all other estimates. BRFSS indicators were estimated for persons 60 years or older for 33 geographic areas based on Aging Services Access Point (ASAP) geographic service areas. The same rate is reported for all cities/towns within the same ASAP service area.

³ The tooth loss rate was estimated for 33 areas from BRFSS data (see note 2). All other rates were estimated for 311 areas from CMS MBSF data (see note 1).

⁴ All rates were estimated for 33 areas from BRFSS data (see note 2).

⁵ Rates for access to doctors were estimated for 33 areas from BRFSS data (see note 2). Dentist supply estimates for 2010 were from the Area Resource File for 14 counties. The same rate is reported for all cities/towns within the same county.

⁶ All rates were estimated for 311 areas from CMS MBSF data (see note 2).

⁷ All rates were estimated for 33 areas from BRFSS data (see note 2).

Interactive Maps of Health Indicators

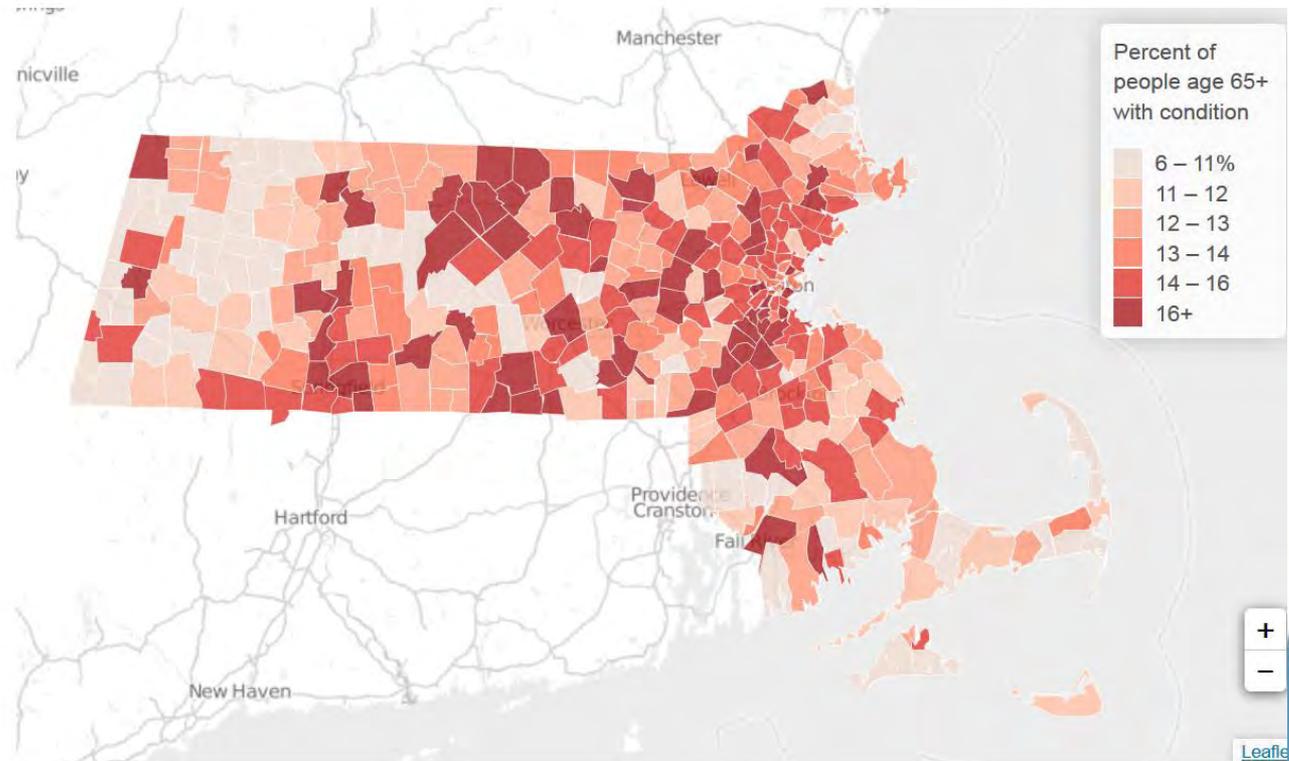
Developed by Amanda Cox, MS (NYTimes)



Chronic Disease Maps

Alzheimer's disease or related dementias

- Diabetes
- Stroke
- Chronic obstructive pulmonary disease (COPD)
- Hypertension
- Ever had a heart attack
- Ischemic heart disease
- Congestive heart failure
- Osteoarthritis/rheumatoid arthritis
- Ever had hip fracture
- Glaucoma
- Women with breast cancer
- Colon cancer
- Men with prostate cancer
- Lung cancer
- Osteoporosis
- 4+ chronic conditions (of 14)



mahealthyagingcollaborative.org

Data Sources

- ▶ Centers for Medicare and Medicaid Services for chronic disease prevalence and Medicare service utilization rates.
- ▶ US Census (2010) and the American Community Survey data pooled over five years (2007-2011).
- ▶ Behavioral Risk Factor Surveillance System for health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury.

- ▶ The Elder Economic Security Standard™ Index.
- ▶ Federal Bureau of Investigation Uniform Crime Reports.
- ▶ Area Health Resources File (2012-2013).
- ▶ Walkscore.com.

- ▶ Primary data collection on community resources.

TECHNICAL APPENDIX



Overview

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1. Healthy aging indicator definitions

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2. Data Sources

Multiple data sources were used in this study. Table A-2 contains a summary of all data sources and the specific years of data used for each population composition and healthy aging indicator. Estimates of community-level indicators of physical/mental health, chronic disease prevalence, access to care, wellness and prevention health behaviors, service utilization, and nutrition and diet were derived from two major data sources: the Medicare Master Beneficiary Summary File and the Behavioral Risk Factor

Inventory of healthy aging programs

A dynamic list of more than 150 evidenced-based and other programs from across the state.

Find and access programs. Get ideas from other cities/towns. Consider replicating or regionalizing your healthy aging efforts.

Add yours today!

How to use this data?

UNDERSTAND

- ▶ Spend some time reading the reports and looking at the maps.
- ▶ Let the reports and maps “speak” to you.
- ▶ What indicators are different from the state average?
- ▶ What challenges do you see? And what creative ideas do you have to overcome the challenges?

Now What?

ACTION

- ▶ Spread the word: Tell others about this resource.
- ▶ Form or join a work group to identify local priorities and take steps to address them. Ask what does your community need to work on to improve healthy aging?
- ▶ Try interventions or programs that help address issues in your community. *If low on fruits/vegetables organize farmers markets. *If obesity is a priority create walking clubs or other physical activities. Be creative!
- ▶ Support policymakers who want to make healthy aging a priority.

So What?

ENGAGE

- ▶ Please join the healthy aging collaborative.
- ▶ Participate on the web page.
- ▶ Give us feedback, share your ideas, make your voice heard.
- ▶ **Together we can make healthy aging a priority in Massachusetts, and in turn, become a model for the nation!**