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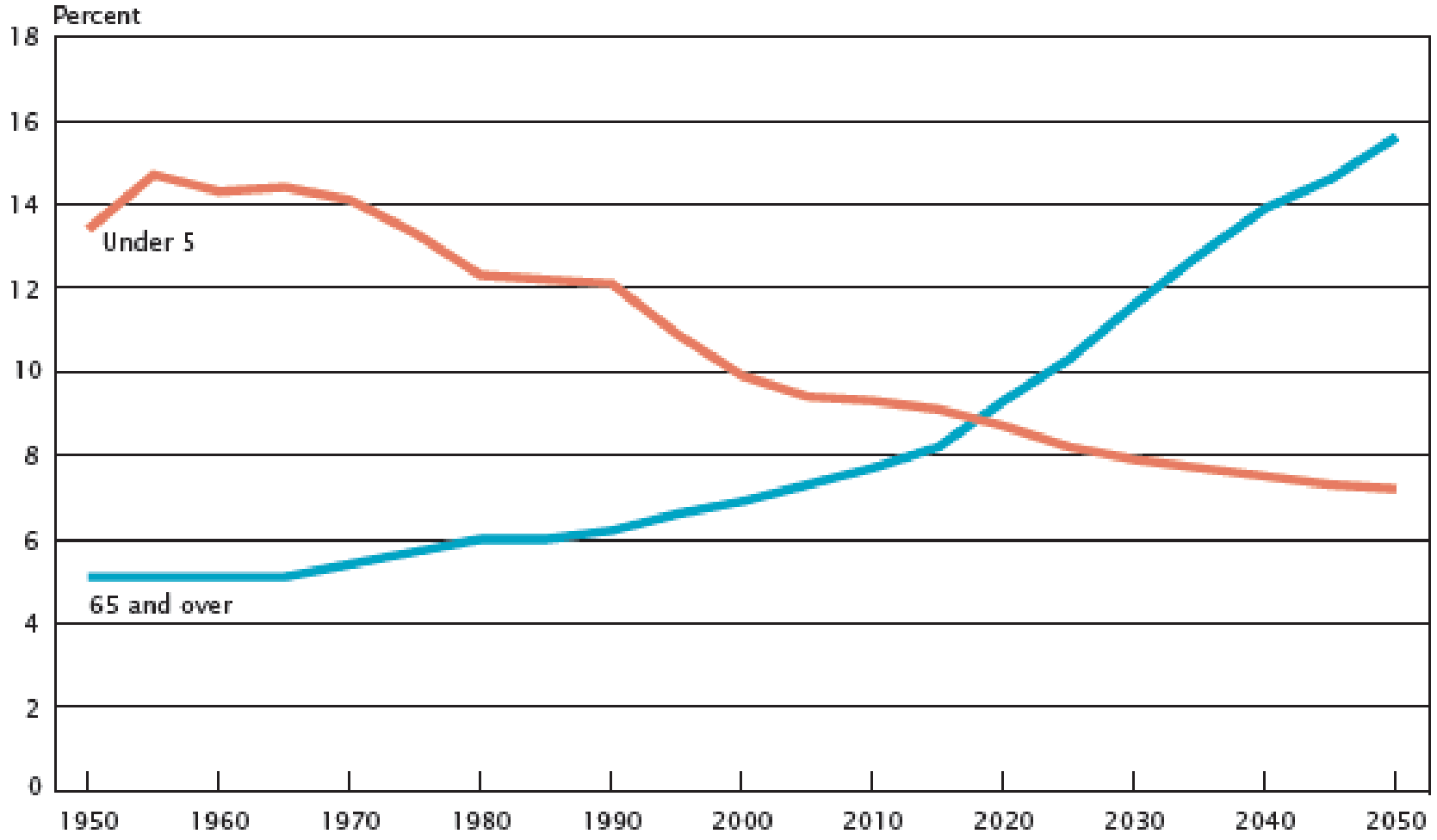
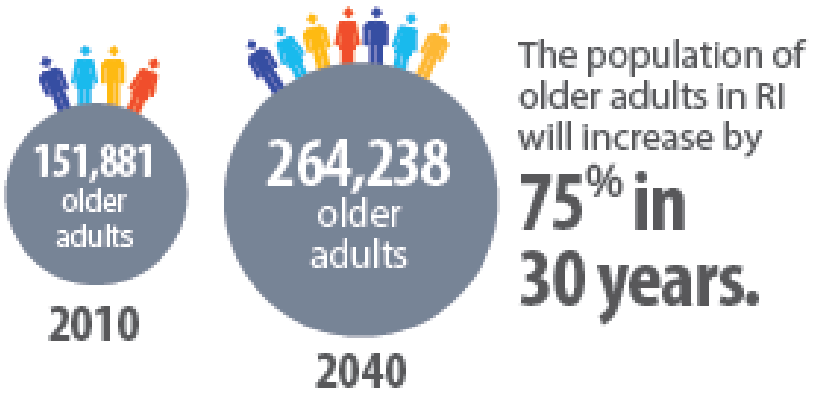
Figure 2-3.

Young Children and Older People as a Percentage of Global Population: 1950 to 2050

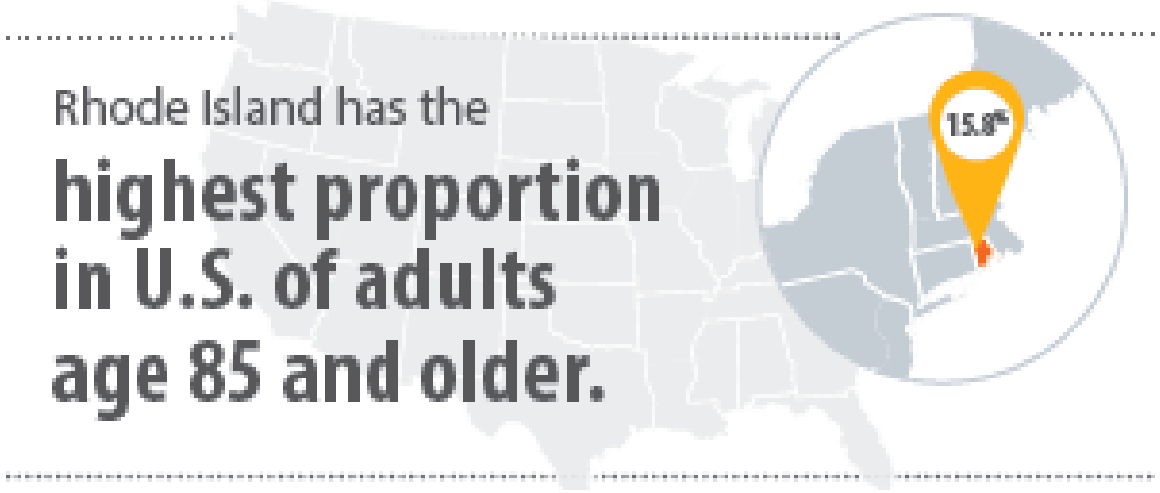


Source: United Nations, 2013.

10,000 US adults turn 65 **every day**



In 14 years **23%** of RI will be 65+



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A look inside . . .

Visit HealthyAgingDataReports.org

How healthy are older adults in Rhode Island?

In a national comparison, Rhode Island looks great! (was ranked the 11th healthiest for older adults). But regional comparisons tell another story.

RI has **highest rates in New England states** for older adults having ever been diagnosed with

- 79% HYPERTENSION
- 78% HIGH CHOLESTEROL
- 46% ISCHEMIC HEART DISEASE
- 36% DIABETES
- 64% 4 OR MORE CHRONIC CONDITIONS

Visit HealthyAgingDataReports.org

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Q: How can the Healthy Aging Data Report help you to prioritize need?

TABLE 3. COUNTS OF HEALTH INDICATORS WITH RATES BETTER/WORSE THAN STATE AVERAGE FOR CITIES AND TOWNS

TOWN	HEALTH INDICATORS **BETTER** THAN STATE AVERAGE	HEALTH INDICATORS **WORSE** THAN STATE AVERAGE	LOWER THAN AVERAGE MEDICARE SERVICE USE	HIGHER THAN AVERAGE MEDICARE SERVICE USE
MOST INDICATORS BETTER THAN STATE AVERAGE				
Jamestown	34	1	7	0
Newport	26	2	4	0
Portsmouth	26	1	4	0
Charlestown	25	0	6	0
North Kingstown	25	0	6	0
Providence NE	25	3	5	0
New Shoreham	24	0	7	0
Little Compton	24	1	2	0
MOST INDICATORS WORSE THAN STATE AVERAGE				
Providence other	9	29	1	4
Woonsocket	2	23	0	5
Central Falls	3	21	1	4
North Providence	2	20	0	4
Johnston	2	20	0	2
Pawtucket	6	18	0	2

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Q: How can the Healthy Aging Data Report help you to prioritize need?

Best and Worst Rates on Indicators

TABLE 2. BEST AND WORST RATES ON SELECT INDICATORS

INDICATOR	BEST RATES	WORST RATES
MORTALITY RATE	West Greenwich	Charlestown
	Woonsocket	Warren
	Coventry	Bristol
ANY PHYSICAL ACTIVITY IN PAST MONTH	Providence NE	Providence Other
	East Greenwich	Woonsocket
	North Kingstown	Pawtucket
CDC PREVENTIVE SCREENINGS	Providence NE	Providence Other
	Cranston	Scituate
	Charlestown	Gloucester
OBESITY	Providence NC	Providence Other
	North Kingstown	Central Falls
	East Greenwich	Pawtucket
DEPRESSION	Exeter	Central Falls
	New Shoreham	Providence
	Jamestown	Providence Other
ALZHEIMER'S & RELATED DEMENTIAS	Exeter	Central Falls
	Jamestown	Westerly
	New Shoreham	Providence Other

ABOUT CONTACT

HEALTHYAGING DATAREPORTS.ORG

Helping residents, agencies, providers and governments understand the older adults who live in their cities and towns

I want to read the report for: Massachusetts // Rhode Island

MASSACHUSSETTS HEALTHY AGING DATA REPORT

351 cities and towns
16 neighborhoods of Boston
121 indicators

HOW IS YOUR COMMUNITY AGING?

RHODE ISLAND HEALTHY AGING DATA REPORT

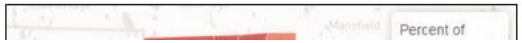
41 cities and towns
20 zip codes in **7** core cities
120 indicators

HOW IS YOUR COMMUNITY AGING?

WHAT'S INSIDE

HEALTHY AGING INDICATORS

INTERACTIVE MAPS



COMMUNITY PROFILES

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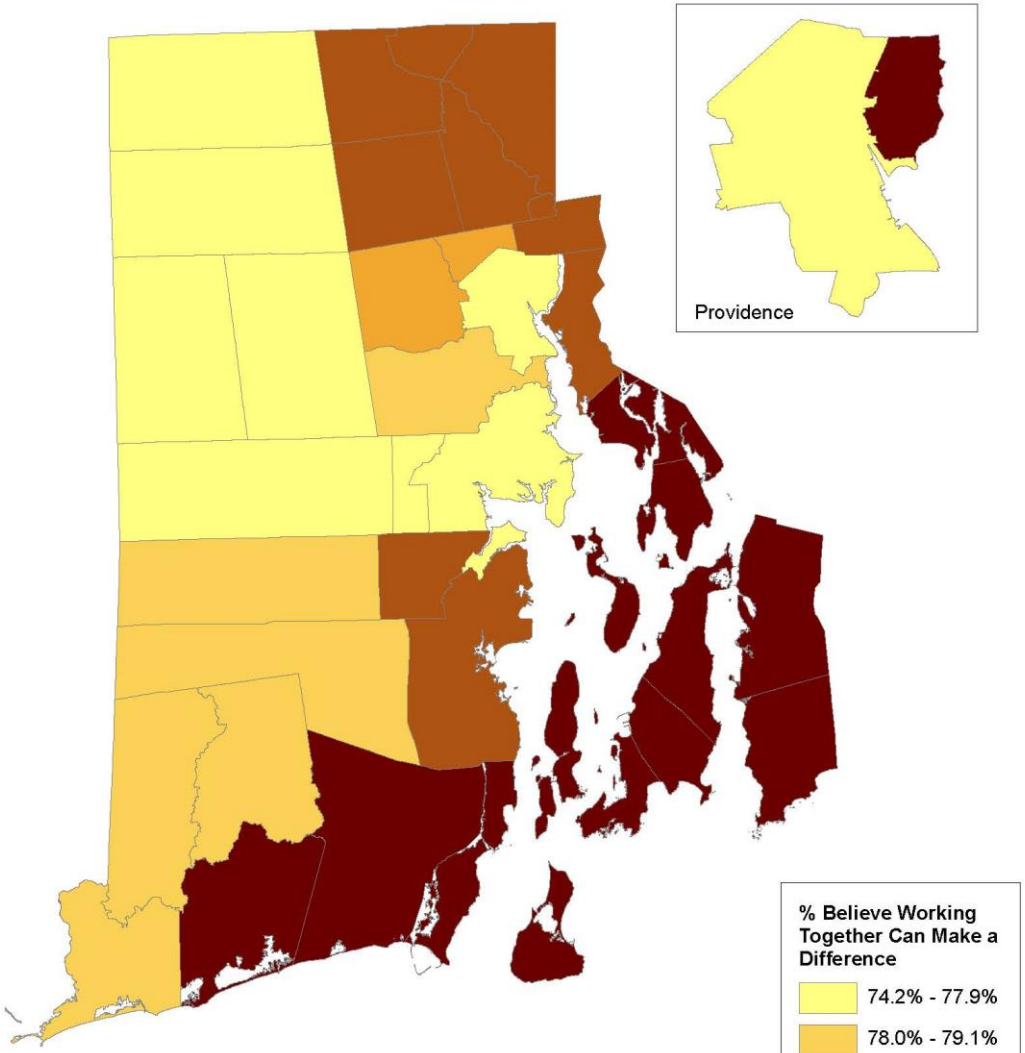
Map 111

Percentage of Persons Age 60+ Years Who Believe Working Together Can Make a Difference



RI % of Persons Age 60+ Years
Who Believe Working Together Can Make a Difference: 81.0%

Source: BRFSS, 2012-2014

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Cranston (Providence)

Cranston is a city in Providence County with 80,387 residents, and about 15% (12,029) are age 65 or older. While Cranston older adults fare better than state estimates by engaging in more preventive screening and less excessive drinking, they fare worse on several health indicators: hypertension, congestive heart failure, osteoporosis, anemia, benign prostatic hyperplasia, and chronic kidney disease. More than 66% are living with 4 or more chronic diseases. Age-friendly community resources include the library, YMCA, senior center, and Senior Services of Cranston. The senior center offers programs, such as health and wellness classes, bingo, painting, computer classes, RSVP, weekday meal program, and book club. The Transvan program offers seniors daily transportation throughout town for a monthly fee of $25. Tri-Town Community Action agency provides case management for seniors receiving state-funded home and community services. Notably, significantly fewer adults age 60 and older in Cranston when compared to state estimates, believe that local service organizations understand their needs.

POPULATION CHARACTERISTICS	COMMUNITY ESTIMATE	STATE ESTIMATE
Total population all ages	80,387	1,052,567
Population 60 years or older as % of total population	20.8%	20.6%
Total population 60 years or older	16,759	217,066
Population 65 years or older as % of total population	14.9%	14.8%
Total population 65 years or older	12,029	155,558
% 65-74 years	47.7%	50.4%
% 75-84 years	33.1%	32.0%
% 85 years or older	19.3%	17.6%
Gender (65+ population)		
% female	59.5%	58.4%
Race/Ethnicity (65+ population)		
% White	94.0%	93.0%
% African American	1.3%	2.6%
% Asian	2.4%	1.3%
% Other	2.3%	3.2%
% Hispanic/Latino	4.3%	3.7%
Marital Status (65+ population)		
% married	50.5%	50.1%
% divorced/separated	12.7%	12.6%
% widowed	29.8%	30.8%
% never married	6.9%	6.4%
Education (65+ population)		
% with less than high school education	26.4%	26.8%
% with high school or some college	56.9%	50.7%
% with college degree	16.7%	22.5%
% of 60+ LGBT	2.1%	2.0%
% of 65+ population living alone	30.7%	30.4%
% of 65+ population who speak only English at home	82.0%	81.7%
% of 65+ population who are veterans of military service	22.4%	22.7%
Age-sex adjusted 1-year mortality rate	4.5%	4.8%

How many?

What is the age distribution?

Race/ethnicity?
Build on cultural strengths, tailor svc

Living alone?

Health behaviors and disease prevention

Chronic disease

HEALTHY AGING INDICATORS	BETTER / WORSE STATE RATE[1]	COMMUNITY ESTIMATE[2]	STATE ESTIMATE[2]
Geographic Migration (65+ population)			
% moved within same county		2.6%	3.5%
% moved from different county in Rhode Island		0.8%	0.8%
% moved from different state		0.1%	1.1%
% 60+ lived at same address 25 years or more	*	57.3%	48.1%
WELLNESS and PREVENTION			
% any physical activity within last month		70.4%	70.0%
% injured by a fall within last year		7.2%	10.0%
% ever had a hip fracture		4.2%	3.9%
% with self-reported fair or poor health status		21.2%	20.4%
% with 15+ physically unhealthy days last month		13.5%	13.9%
% with physical exam/check-up in past year		93.6%	91.9%
% met CDC preventive health screening goals	B	47.4%	39.5%
% flu shot past year		59.0%	59.1%
% pneumonia vaccine		73.7%	73.8%
% shingles vaccine		30.0%	30.3%
% cholesterol screening		89.9%	88.4%
% mammogram within last 2 years (women)		85.2%	81.8%
% colorectal cancer screening		78.8%	76.1%
Oral Health			
% with complete tooth loss		32.9%	32.4%
% with annual dental exam		76.1%	74.7%
# dentists per 100,000 persons (all ages)		73	58
NUTRITION/DIET			
% with 5 or more servings of fruit or vegetables per day		21.8%	23.0%
% obese		26.2%	25.4%
% high cholesterol		78.9%	78.0%
% current smokers		7.7%	8.9%
% excessive drinking	B	5.0%	8.9%
MENTAL HEALTH			
% with 15+ days poor mental health last month		8.3%	7.5%
% 60+ talked with family or friends almost daily		78.1%	75.3%
% ever diagnosed with depression		30.9%	30.0%
CHRONIC DISEASE			
% with Alzheimer's disease or related dementias		14.0%	14.4%
% with diabetes		36.9%	35.7%
% with stroke		12.1%	12.5%
% with chronic obstructive pulmonary disease		25.0%	24.1%
% with asthma		14.1%	14.0%

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Chronic disease

Disability

HEALTHY AGING INDICATORS	BETTER / WORSE STATE RATE[1]	COMMUNITY ESTIMATE[2]	STATE ESTIMATE[2]
% with hypertension	W	80.4%	79.0%
% ever had a heart attack		5.0%	5.4%
% with ischemic heart disease		46.4%	45.9%
% with congestive heart failure	W	26.5%	24.8%
% with atrial fibrillation		14.1%	15.2%
% with osteoarthritis/rheumatoid arthritis		53.2%	52.0%
% with osteoporosis	W	22.4%	21.0%
% with glaucoma		26.9%	26.6%
% with cataract		67.0%	67.9%
% women with breast cancer		11.3%	10.7%
% with colon cancer		3.5%	3.2%
% men with prostate cancer		13.5%	13.8%
% with lung cancer		2.4%	2.1%
% with hypothyroidism		21.0%	21.1%
% with anemia	W	54.7%	52.2%
% with benign prostatic hyperplasia	W	43.0%	40.3%
% with chronic kidney disease	W	25.9%	23.3%
Summary chronic disease measures			
% with 4+ chronic conditions	W	66.3%	63.9%
% with 0 chronic conditions		8.1%	8.4%
LIVING WITH DISABILITY			
% 65+ with hearing difficulty		13.6%	13.8%
% 65+ with vision difficulty		5.5%	5.2%
% 65+ with cognition difficulty		6.0%	7.8%
% 65+ with ambulatory difficulty		20.2%	19.9%
% 65+ with self-care difficulty		6.7%	6.6%
% 65+ with independent living difficulty		12.2%	13.7%
ACCESS TO CARE			
Medicare (65+ population)			
% Medicare managed care enrollees	*	43.3%	39.4%
% dually eligible for Medicare and Medicaid	*	13.8%	14.6%
% with a regular doctor		96.4%	96.5%
% did not see a doctor when needed due to cost		5.1%	6.3%
# of primary care providers (within 5 miles)		380	1,566
# of hospitals (within 5 miles)		4	11
# of nursing homes (within 5 miles)		11	84
# of home health agencies (in same town)		25	38

HEALTHY AGING INDICATORS	BETTER / WORSE STATE RATE[1]	COMMUNITY ESTIMATE[2]	STATE ESTIMATE[2]
SERVICE UTILIZATION			
Physician visits per year	*	8.6	8.0
Emergency room visits/1000 persons 65+ years per year		627	628
Part D monthly prescription fills per person per year	*	52.6	54.2
Home health visits per year	*	4.6	3.7
Durable medical equipment claims per year		2.1	2.0
Inpatient hospital stays/1000 persons 65+ years per year		307	284
Inpatient hospital readmissions (as % of admissions)		17.7%	16.9%
Skilled nursing facility stays/1000 persons 65+ years per year		110	100
Total skilled nursing home Medicare beds/1000 persons 65+ years		20	52
% 65+ getting Medicaid long term services and supports		5.5%	6.2%
COMMUNITY VARIABLES & CIVIC ENGAGEMENT			
Air Pollution/Air Quality Index			
Annual # of unhealthy days for older adults		1	NA
Walkability of Community			
Walkability score (0-100)		83	NA
% of vacant housing units in community		6.7%	11.3%
% 60+ who are satisfied with neighborhood		76.5%	80.0%
# of registered voters (age 18+)		54,262	725,309
Voter participation rate in 2012 presidential election (age 18+)		64.4%	61.5%
% 60+ who believe local service orgs understand needs	w	37.7%	44.1%
% 60+ who believe he/she can make a difference		47.6%	51.6%
% 60+ who believe working together can make a difference		79.1%	81.0%
% 60+ who volunteer at least once per month		20.0%	22.8%
% 60+ who attend community events (e.g., church, club) at least once per month		39.3%	44.2%
SAFETY AND TRANSPORTATION			
Violent crime rate / 100,000 persons		187	253
Property crime rate / 100,000 persons		2,174	2,394
# of motor vehicle fatalities involving adult age 60+/town		5	90
# of motor vehicle fatalities involving adult age 60+/county		40	90
# of alternative transportation programs by county		26	43
Municipal senior transportation available		Yes	NA
Volunteer driver programs available		NA	NA

Walkability

Crime

Transportation

Q: Many challenges are ahead for the health safety net and those that access it.

How can funders play a role in protecting those who will be most impacted by those changes and ensure those who need it most will continue to get access to quality health care services in RI?

Poverty, food stamps?

HEALTHY AGING INDICATORS		COMMUNITY ESTIMATE[2]	STATE ESTIMATE[2]
ECONOMIC AND FINANCIAL			
Poverty (65+ Population)			
% with income below the poverty level past year		8.3%	8.6%
% 60+ receiving food stamps past year		11.3%	11.9%
% 65+ working past year		16.9%	16.3%
Household income (65+ householder)			
% households with annual income < $20,000		27.9%	28.0%
% households with annual income $20,000-49,999		36.0%	34.2%
% households with annual income ≥ $50,000		36.1%	37.7%
% 60+ own home		44.8%	43.9%
% 60+ homeowners with mortgage		40.9%	45.3%
COST OF LIVING	**$ COUNTY ESTIMATE**	**$ STATE ESTIMATE**	**RATIO OF COUNTY TO STATE**
Elder Economic Security Standard Index			
Single, homeowner without mortgage, good health	$21,732	$22,188	0.98
Single, renter, good health	$23,352	$23,544	0.99
Couple, homeowner without mortgage, good health	$31,896	$32,352	0.99
Couple, renter, good health	$33,516	$33,708	0.99

TECHNICAL NOTES: Read our technical report for information on data sources and methodology at http://healthyagingdatareports.org/ri/technicalreport.
*[1] For most indicators the community and state values are both statistical 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. When an upper case letter is used the 95% confidence intervals were used, the lowercase indicates a 90% confidence interval. When the implication for healthy aging is unclear we use an *.*
[2] "C" indicates that the community rate is censored due to inadequate sample size and "NA" indicates that the data were not available.

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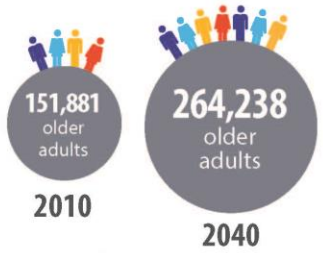
Rhode Island Healthy Aging Data Report

*120 health risk indicators in 39 communities**

KEY FINDINGS



The population of older adults in RI will increase by **75% in 30 years.**

Rhode Island has the **highest proportion in U.S. of adults age 85 and older.**

RI has **highest rates in New England states** for older adults having ever been diagnosed with

- **79%** HYPERTENSION
- **78%** HIGH CHOLESTEROL
- **46%** ISCHEMIC HEART DISEASE
- **36%** DIABETES
- **64%** 4 OR MORE CHRONIC CONDITIONS

HEALTH DISPARITIES

When it comes to healthy aging, resources matter. The map below shows the variability of healthy aging throughout the state.

RECOMMENDATIONS

UNDERSTAND AND ENGAGE.

Download your Community Profile. Explore the Highlights Report. Bring people together to discuss what the data mean and what can be done to address opportunities and challenges in your community.

PLAN AND ACT.

Use data to prioritize needs and identify interventions. Start with winnable battles. Develop relevant statewide plans.

Identify what's working in communities that are healthier than state average. Can this be replicated in communities facing challenges in healthy aging?

Prioritize efforts that address below-average indicators for North Providence, Johnston, Central Falls, Pawtucket, Providence.

Collaborate with local leaders and communities to identify ways to become more age-friendly.

Promote opportunities for community and civic engagement for older adults.

* Data reflect health for adults age 60+ or 65+ in Rhode Island

Learn more at **healthyagingdatareports.org/rhode-island**

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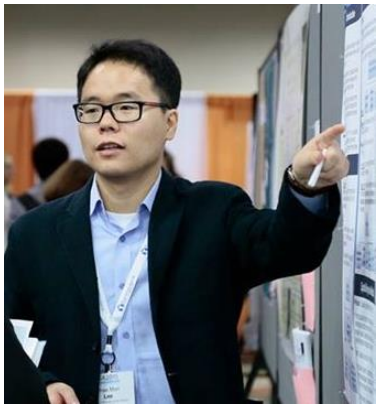
Gerontology Institute
John W. McCormack Graduate School of Policy and Global Studies
UMASS BOSTON

OCTOBER 2016

Rich resources for your work

- 41 community profiles w 120+ indicators w community and state rates.
- 20 zip code level profiles w rates by: zip code, community and state.
- 18 interactive web maps of chronic disease indicators.
- 130 pdf state maps and bar charts of the 120+ indicators.
- 1 page infographic, Highlights Report
- Technical Report on Methods/Data, Tables



Research Team: Frank Porell PhD, Nina Silverstein PhD, Chae Man Lee PhD(c), Bon Kim MS, HJ Lee PhD, and Krystal Kittle.

Q: As funders, what can you do to address healthy aging disparities?

People

- Nurture/support champions.
- Invest in programs that promote individual change.
- **Disease Management**: funding for chronic disease self-management programs.
- **Medication management**: ask the pharmacist program; identifying reasons for non-adherence; education about adverse drug reactions and polypharmacy.
- **Social Engagement**: nearly any program that promotes social interaction and the opportunity to meet and make new friends.

Q: As funders, what can you do to address healthy aging disparities?

Programs or Things

- Work to make the healthy choice the easy/default choice. Policy, environment, personal attitudes.
- **Physical Activity**: funding to add trainers to senior centers or sr housing? Benches, signage, walking trails to promote walking as transportation.
- If safety is a barrier, improve safety to improve physical activity.
- **Healthy Weight**: cooking tips; cooking show (J&W?); meal prep or delivery. Meal sharing.

Q: What are the resources and strategies that can be leveraged and scaled to address healthy aging disparities?

- The **Age-Friendly Rhode Island initiative** led by RIC and recently funded by the Tufts Health Plan Foundation.
- The **Lt. Governor** has voiced support, especially related to physical activity and healthy aging.
- The **Long-term care commission** report (Maureen Maigret).

Q: What are the resources and strategies that can be leveraged and scaled to address healthy aging disparities?

- The Health Equities Zone work *could be* leveraged to include an explicit focus on healthy aging.
- Any **pedestrian or biking safety initiatives** *could be* extended to include older pedestrians or bike riders.
- Supporting state and local leaders who recognize the importance of data driven approaches to change.
- Engaging with the RI Healthy Aging Data Report Advisory Group – they are an active group of motivated stakeholders.

Summary

- Healthy aging is important and we see **disparities in healthy aging**. One solution is to create more age-friendly communities.
- RI is *not* as healthy as it could be, there is room to improve.
- We have developed these tools to help you make a difference.

- Healthy aging is important and we see **disparities in healthy aging**. One solution is to create more age-friendly communities.
- RI is *not* as healthy as it could be, there is room to improve.
- We have developed these tools to help you make a difference.