Healthy Aging Data Report

Highlights from
Connecticut, 2021

A Message from the Governor

Connecticut is growing older. People are living longer than ever before. Our great state has more than 820,000 residents age 60 and older which is 23% of the state's population. Connecticut is the 7th oldest state in the nation and the most diverse in New England.

During the COVID-19 pandemic, this global health crisis highlighted inequities in our own communities and inspired innovation and upstream structural solutions. The pandemic mobilized residents of all ages to come together and support one another. There is more to be done to address these challenges and seize on these opportunities for positive change for years to come.

This *2021 Connecticut Healthy Aging Data Report* is the first of its kind for our state and is an important resource to help us shape policy, improve our programs and services as well as work collectively to engage and act. It includes community profiles for every city and town in Connecticut. I encourage municipalities to look at their community profile, compare it to the state average and think about ways to create change.

I want to take this opportunity to thank the researchers at the Gerontology Institute of the John W. McCormack Graduate School of Policy and Global Studies at the University of Massachusetts Boston, Tufts Health Plan Foundation, and advisors in Connecticut, including the Connecticut Age Well Collaborative, for their work on this important report.

The Connecticut Age Well Collaborative is a new group of public, private and philanthropic aging and community leaders with the vision of an Age-Friendly Connecticut: a great place to grow up and grow old. The Collaborative is currently preparing an analysis of aging in the state, Connecticut's history of livable community work coupled with priorities and best practices from Connecticut and other states. The *2021 Connecticut Healthy Aging Data Report* provides an important foundation for the Collaborative. I encourage you to join their movement, to create a state with inclusive, livable communities for all.

We look forward to using this valuable online resource to benefit Connecticut residents.

Ned Lamont

Governor
State of Connecticut

Letter from the Funder and Principal Investigator

We believe our communities should be great places to grow up and grow old—places with healthy economies and vibrant neighborhoods that work for everyone. This vision has been challenged over the past year as we've grappled with the COVID-19 pandemic and growing calls to dismantle systemic racism.

As community leaders begin thinking about what their cities and towns need to ensure an equitable recovery, there is a clear need for accurate, unbiased information to help pinpoint risks, mitigate harms, and improve health. The first-ever *Connecticut Healthy Aging Data Report* is a uniquely valuable tool for understanding the challenges and charting a new path.

Connecticut's demographics are changing. The state, the seventh oldest in the country, has nearly 590,000 people over age 65 and the most diverse (17.5%) older population in New England. More than 28% of people over 65 live alone and more than 66% of those over 85 are women.

This Highlights Report and the online resources include comprehensive data that can be used to identify health-related strengths, needs and opportunities in communities across the state. Unprecedented clarity and geographic details lay the groundwork for improving public health and advancing healthy aging. (Note: While most of the data analyzed for this report were collected prior to March 2020, they reveal many fundamental needs of older adults that have become critical challenges during the pandemic.)

This Connecticut report builds on our work in other New England states. We have learned some vital lessons.

- When addressing needs, don't go it alone—deliberately connect with community, especially older people and those doing the work at the local, state level and regional levels.

- Consider starting with small projects to engage more partners and build consensus and momentum. As you progress, leverage your experience and expand your network of collaborators to take on more challenging issues.

- Prioritize diverse populations. People of color are disproportionately affected by the pandemic and experience significant health disparities caused by systemic inequities.

- Be intentional about inclusion—we all are aging and have much to learn from each other. Listen to people of color, families, LGBT groups, people living with disabilities, and youth.

- Finally, celebrate successes. We are in this for the long run.

Improving community health is possible and the *Connecticut Healthy Aging Data Report* offers extensive online resources to inform your work. Use it as a roadmap to engage community leaders and local partners in the age-friendly movement. The process and ensuing outcomes will make your community a great place to grow up and grow old, stronger and better positioned to thrive.

To access the full report, go to: healthyagingdatareports.org

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

Thomas Croswell

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What Do Age-Friendly Communities Have in Common?

- Safe, affordable, and accessible public transportation options
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- 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

About the Report

Connecticut's population of older adults is the most diverse in New England in terms of race and ethnicity, and is also characterized by profound disparities which mirror the disparities in society at large. The data in this report reveal the breadth and depth of these disparities in unprecedented detail, providing both a motivation for action and a roadmap for the creation of programs and initiatives that can improve the health and well-being of all the state's residents.

The full *2021 Connecticut Healthy Aging Data Report* (www.healthyagingdatareports.org) is an easy-to-use online resource created by researchers at the Gerontology Institute of the John W. McCormack Graduate School of Policy and Global Studies at the University of Massachusetts Boston and funded by Tufts Health Plan Foundation. Our goal is to provide data to inform your efforts to create healthy, age-friendly communities. When communities work for older people, they work better for everyone.

The report includes 190 indicators providing a comprehensive picture of the health of older adults in Connecticut. The full list of indicators and our data sources appear in this report.

The data reveal important patterns of disease, health behaviors, resource distribution, and disparities in healthy aging. We have mapped the extent to which health variations differ by location to support efforts addressing the unique issues facing Connecticut cities and towns. The research team has spent years acquiring and analyzing data, talking to community members and leaders, and developing tools to inform communities about ways to make it easier for everyone to achieve their own, unique optimal health.

The measures of population health included here focus on prevention and intervention rather than on the outcomes that occur when someone gets a diagnosis in a doctor's office or enters an emergency department. Just as an ounce of prevention is worth a pound of cure on a personal level. The key to healthy aging is to invest in community-level efforts to improve access to healthcare, expand services, and support behaviors known to reduce the risks of disease and disability. These investments create opportunities to promote healthier behaviors, to support individuals making changes and developing habits, and to promote positive changes at the levels of municipal and state governments.

The online resource includes the following tools:

- 181 community profiles: one for each of the state's 169 cities and towns, plus 12 neighborhoods in Bridgeport, Hartford, New Haven, and Stamford (see page 36 for the neighborhood definitions)

- Estimates in each profile for 190 health indicators with 95% confidence intervals to help display the accuracy of individual estimates

- 188 maps listing community rates for each indicator (both ranked and alphabetical)

- 18 interactive state maps

- 18 interactive regional maps showing the distribution of rates across Connecticut, Rhode Island, Massachusetts, and New Hampshire

- Technical documentation of our data sources, methods, and statistical approaches

- An infographic summarizing key findings

- This Highlights Report

The tools can be used to inform policy, improve programs and services, and spur collective action to make Connecticut a truly age-friendly and healthier state.

Tufts Health Plan Foundation has supported Healthy Aging Data Reports in Connecticut (2021), Massachusetts (2014, 2015, 2018), New Hampshire (2019), Rhode Island (2016, 2020). Each report builds on what we have learned from our community partners in each state and previous work. We welcome your input! If you have questions or ideas, please email them to HADR@umb.edu. Your idea may help make our next Healthy Aging Data Report even better.
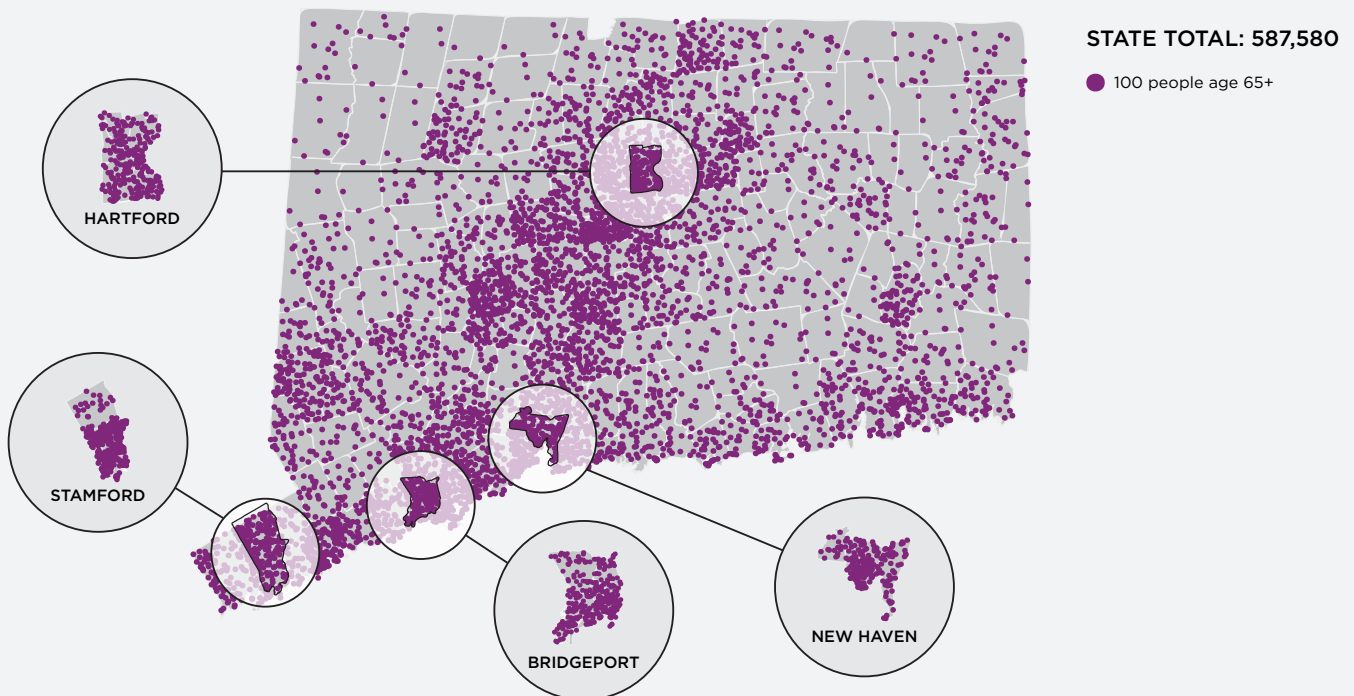
Growing Older in Connecticut

Connecticut is home to 823,529 people age 60 or older — 23% of the state's total population. Its population is the seventh-oldest in the nation, measured by median age. While Connecticut may be a small state geographically, it has tremendous resources and advantages over many larger states when you consider factors contributing to health and longevity. Connecticut is home to innovators and leaders in geriatrics, gerontology, aging services, long-term services and supports and financial services, all of which are key elements of the "longevity economy." In order to apply these resources effectively and equitably, however, it is important to know more about older people and understand how circumstances create different experiences for the state's older residents.

Population Overview

Compared to its New England neighbors, Connecticut's population of people 65+, as seen in Table 2, includes a higher percentage of Black/African American adults (6.8%), Hispanic (5.8%), and other race (2.6%). More than half (54%) of those 65+ are married, and nearly half (49%) of that group have earned a college degree (bachelors +/or graduate degree). One common statistical approach to measure how "old" the population of a state is to calculate the midpoint, or median, age. This simple measure allows comparisons across states and is a quick way of understanding population differences. The median age of females is 42.6 years, the median age for males is 39.1 years, and life expectancy at birth is 80.9 years. Approximately

Map 1. Density of Population Age 65+ Years

STATE TOTAL: 587,580

● 100 people age 65+

HARTFORD

STAMFORD

BRIDGEPORT

NEW HAVEN

16% of the overall state population is 65+, but in 5 communities (Salisbury, Sharon, Essex, Bridgewater, and Union) more than 30% of residents are 65+.

Significant Income Disparities

There are sizable disparities in the financial security of the state's older adults. At one end of the economic spectrum, 24% of the state's 65+ households have annual incomes above $100,000, and 25% of the 65+ population are still employed. At the other extreme, 7% of older people (approximately 41,130 individuals) live below the poverty level, and 11% rely on supplemental nutrition assistance for food. Keep in mind that there are likely many more older adults who qualify for assistance but are not currently receiving it due to access issues.

High Burden of Chronic Disease

As we age, the risk of experiencing chronic diseases increases. Sixty-two percent of people age 65+ have been diagnosed with four or more chronic conditions, a high burden of comorbidity that underscores the need for preventive health interventions. Connecticut rates for health conditions among people 65+ are: hypertension 76%, arthritis (osteoarthritis or rheumatoid arthritis) 54%, ischemic heart disease 41%, diabetes 34%, and depression 30%. Approximately 14% of adults age 65+ have Alzheimer's disease or a related dementia. The impact of chronic disease on older adults goes beyond those who personally suffer from a medical condition: more than 1 in 5 older adults (22%) age 60+ were caregivers of a family member or friend in the last month. By working to create healthy, age-friendly communities we can reduce the burden of disease, and allow people to live healthier, longer, and more meaningful lives.

The Toll of Social Isolation

Research suggests that loneliness and social isolation are bad for your health, possibly as bad as the impact of smoking. Several indicators allow us to estimate the prevalence of social isolation. Widowhood, for example, can contribute to isolation, and 24% of the 65+ population is widowed. Widowhood rates ranged from 37% in North Canaan to 7% in Weston. Approximately 28% of older people in Connecticut live alone, and in 21 communities the rate was more than 33%. Statewide 78% of people 60+ reported receiving adequate emotional support, but about 7% of people 60+ reported having had 15 or more days with poor mental health in the

By the Numbers

587,580
people age 65+

16.4%
of population

56.8%
of 65+ population are female

66.6%
of 85+ population are female

17.4%
of 65+ population are veterans

17.5%
are people of color, the most diverse older population in New England

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IN THE 60+ POPULATION...

75%   got any physical activity in the last month

27.6%   met CDC guidelines for muscle-strengthening activity

58%   met CDC guidelines for aerobic physical activity

Each community profile provides detailed population characteristics as well as information about community engagement, access to care, wellness and prevention, nutrition/diet, mental health, chronic disease, living with disability, and transportation and safety.

Click here to read the community profiles

last month. Rates in Orange and West Haven were nearly double the state rate (13%).

Housing Disparities

In the best circumstances our home is a place of refuge and comfort. It gives us shelter, neighbors, and a place to draw our loved ones close. Yet disparities in health and housing in Connecticut are pronounced. Although most people 65+ in Connecticut own their home (77%), the rate ranges from only 37% in Hartford to 100% in Union. Fewer than half of home-owners still have a mortgage (47%) with a range of 29% in Harwinton to 62% in Sterling. Approximately 17% of 60+ adults said they were stressed about paying their rent or mortgage in the last month (Tolland 11%–New Haven 33%). Spending more than 35% of your income on housing is considered being "housing cost burdened," and statewide 30% of homeowners and 44% of the overall population met this criterion. Owning a home is a pathway to building wealth, yet there are vast differences in who can take advantage of this option.
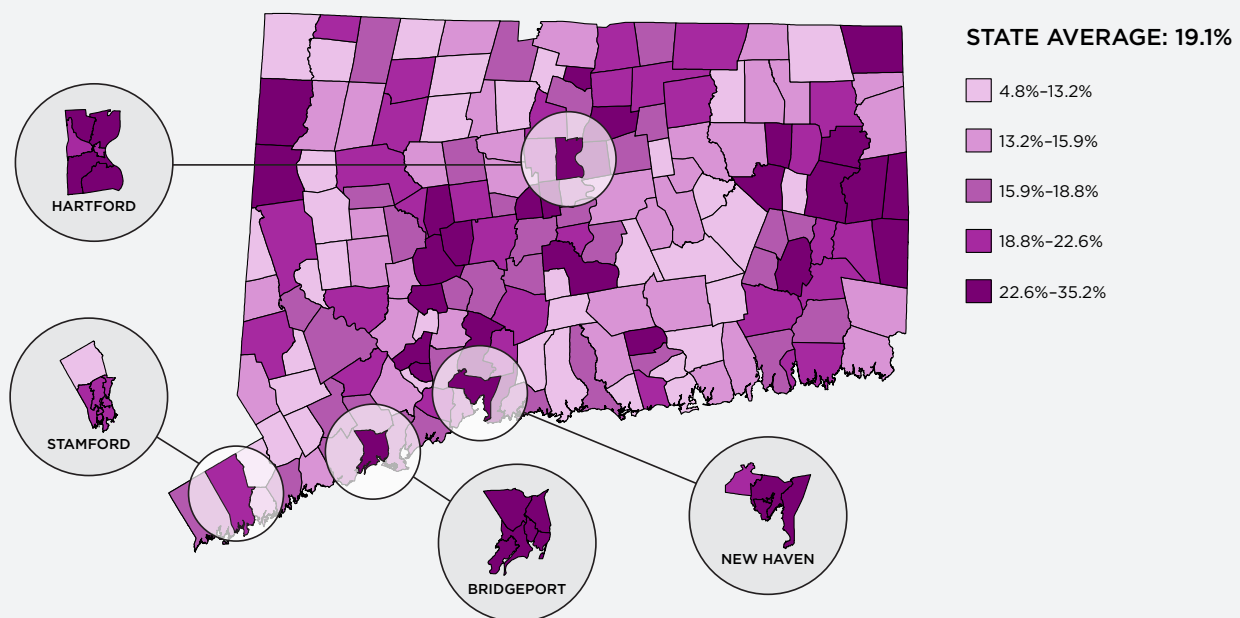
The median house value in the state was $272,700, and there was more than a million-dollar difference between the average value of a house in Waterbury ($128,000) and a house in Darien ($1,461,100).

Nutrition and Physical Health

Access to nutritious foods and healthy eating behaviors are strongly correlated with healthy aging. But statewide, only 20% of adults 60+ report eating five or more fruits and vegetables per day (West Haven 12%–Chester 24%). Nine percent of people 60+ were stressed about buying food (Winchester 4%–Bridgeport 19%). Nearly one in four (23%) were diagnosed with obesity (Westport 12%–Montville 32%). A similar percentage (24%) reported having lost six or more teeth (Farmington 12%–Hartford 42%). The statewide rate for having high cholesterol was 77% (Weston 66%–Beacon Falls 82%). Getting around on one's own two feet is difficult for 19% of people 65+ as seen in Map 2. This has implications for residents' ability to get food and sufficient exercise, to socialize, and to live independently.

Map 2. Percentage of Population Age 65+ Years with Self-Reported Ambulatory Difficulty

Source: ACS 2014–2018

STATE AVERAGE: 19.1%

- 4.8%–13.2%
- 13.2%–15.9%
- 15.9%–18.8%
- 18.8%–22.6%
- 22.6%–35.2%

HARTFORD

STAMFORD

BRIDGEPORT

NEW HAVEN

Indicators in the *Connecticut Healthy Aging Data Report*

We report 190 indicators at the local and state level and describe them below in the order they appear on the community profiles.

Population Characteristics

Total population all ages; the population age 60+ as a percentage of total population; total population 60+; population 65+ as a percentage of total population; total population 65+ that is 65–74/75–84/85+; the percentage of the 65+ population who are female; the percentage of the 85+ population who are female; the race and ethnicity of the 65+ population; the marital status of the 65+ population; the educational status of the 65+ population; the percentage of the 65+ population who only speak english at home; the percentage of the 65+ population who are veterans of military service; the percentage of the 60+ population who are LGBTQ; the median age of females; the median age of males; the life expectancy at birth; and the age-sex adjusted 1-year mortality rate.

Primary data sources: The U.S. Census Bureau, (American Community Survey, 2014–2018), The Behavioral Risk Factor Surveillance System (2012–2018), Robert Wood Johnson Foundation (2020), and the CMS Master Beneficiary Summary File ABCD/Other (2016–2017).

Wellness

The percentage of the 60+ population getting recommended hours of sleep, doing any physical activity, meeting the CDC guidelines for muscle-strengthening activity, meeting CDC guidelines for aerobic physical activity, with fair or poor health, and with 15+ physically unhealthy days in the last month.

Primary data source: The Behavioral Risk Factor Surveillance System (2012–2018).

Falls

The percentage 60+ who fell within the last year, the percentage 60+ who were injured in a fall in the last year, and the percentage 65+ who had a hip fracture.

Primary data sources: The Behavioral Risk Factor Surveillance System (2012–2018), and the CMS Master Beneficiary Summary File ABCD/Other (2016–2017).

Prevention

The percentages of the 60+ population with a physical exam, flu shot, pneumonia vaccine, shingles vaccine, women 60+ with a mammogram, colorectal cancer screening, HIV test, and the percentage who met the CDC preventive health screening goals.

Primary data source: The Behavioral Risk Factor Surveillance System (2012–2018).

Nutrition and Diet

The percentage of the 60+ population eating 5 or more servings of fruits or vegetables per day, who are stressed about buying food in the last month, who self-reported obese, and who had a high cholesterol screening. The percentage of the 65+ population with poor supermarket access, who were clinically diagnosed with obesity, and with high cholesterol.

Primary data sources: The Behavioral Risk Factor Surveillance System (2012–2018), the USDA Food Atlas (2017), and the CMS Master Beneficiary Summary File ABCD/Other (2016–2017).

Oral Health

The percentage of the 60+ population with dental insurance, with an annual dental exam, and with the loss of 6 or more teeth. The number of dentists per 100,000 (all ages).

Primary data sources: The Behavioral Risk Factor Surveillance System (2012–2018), and the CT Department of Public Health (2020).

Chronic Disease

The percentages of the 65+ population with Alzheimer's disease or related dementias, anemia, asthma, atrial fibrillation, autism, benign prostatic hyperplasia, breast cancer, cataract, chronic kidney disease, chronic obstructive pulmonary disease, colon cancer, congestive heart failure, diabetes, endometrial cancer, epilepsy, fibromyalgia, glaucoma, heart attack, HIV/AIDS, hypertension, hypothyroidism, ischemic heart disease, leukemias and lymphomas, liver disease, lung cancer, migraine, arthritis, osteoporosis, peripheral vascular disease, pressure ulcer or chronic ulcer, prostate cancer, stroke, traumatic brain injury, 4 or more (out of 15) chronic conditions, and who had no chronic conditions.

Primary data source: The CMS Master Beneficiary Summary File ABCD/Other (2016–2017).

Behavioral Health

The percentage of the 65+ population with opioid use disorder, substance use disorder, tobacco use disorder. The percentage of the 60+ population who used marijuana in the last month, who drank excessively, were current smokers, or ever used e-cigarettes. The number of drug overdose deaths (all ages).

Primary data sources: The CMS Master Beneficiary Summary File ABCD/Other (2016–2017), Behavioral Risk Factor Surveillance System (2012–2018), CDC Wonder (2014–2018), and the CT Department of Public Health (2020).

Mental Health

The percentage of the 60+ population with 15 or more days with poor mental health in the last month, and who had adequate emotional support. The percentage of the 65+ population with depressive disorder, anxiety disorder, bipolar disorder, post-traumatic stress disorder, schizophrenia or other psychotic disorder, and personality disorder.

Primary data sources: The CMS Master Beneficiary Summary File ABCD/Other (2016–2017), and Behavioral Risk Factor Surveillance System (2012–2018).

Disability

The percentage of the 65+ population with self-reported hearing difficulty, vision difficulty, cognition difficulty, ambulatory difficulty, self-care difficulty. The percentage of the 65+ population with clinical diagnosis of: hearing impairment or deafness, visual impairment or blindness, and mobility impairment.

Primary data sources: The U.S. Census Bureau, American Community Survey (2014–2018), and the CMS Master Beneficiary Summary File ABCD/Other (2016–2017).

Caregiving

The number of caregiver support groups, the number of "memory cafes," the percentage of the 60+ population who are caregivers, the percentage of grandparents raising grandchildren, the percentage of grandparents who live with grandchildren.

Primary data sources: The CT Department of Aging (2020), memorycafedirectory.com (2020), U.S. Census Bureau (American Community Survey, 2014–2018), and the Behavioral Risk Factor Surveillance System (2012–2018).

Access to Care

The percentage of the 60+ population who had a regular doctor, or who did not see a doctor when needed due to cost. The percentage of the 65+ population who were dually eligible for Medicare and Medicaid or were Medicare-managed care enrollees. The number of local primary care providers, local hospitals, home health agencies, local nursing homes, community health centers, adult day health centers, and hospice agencies.

Primary data sources: The Behavioral Risk Factor Surveillance System (2012–2018), the CMS Master Beneficiary Summary File ABCD/Other (2016–2017), Medicare.gov (September 2020), Community Health Center Association of CT (2020), and National Adult Day Services Association (2020).

Service Use

The percentage of the 65+ population who were hospice users, the percentage of hospice users as a percentage of decedents, median hospice days per hospice user (65+, deceased) and median hospice payment (Medicare + other) per hospice user. The

number of annual physician visits, per capita annual emergency room visits, Part D monthly prescription fills per person annually, annual home health visits, annual durable medical equipment claims, per capita annual inpatient hospital stays, the percentage of Medicare inpatient hospital readmissions (as a percentage of admissions), per capita skilled nursing home stays, the per capita number of skilled nursing home Medicare beds, and the percentage of 65+ getting Medicaid long-term services and supports.

Primary data sources: The CMS Master Beneficiary Summary File ABCD/Other (2016–2017), and Medicare.gov (September 2020).

Community

Measures of air pollution, age-friendly efforts in community, the number of senior centers, the number of higher education institutions, public libraries, YMCAs, the percentage of county residents with access to broadband internet, the percentage of 60+ who used internet in the last month, and voter participation rates.

Primary data sources: The US EPA Air Compare (2020), AARP (2020), CT Health and Human Services (2020), New England Commission of Higher Education (2020), CT State Library Division of Library Development (2021), CT YMCA (2020), FCC (2018), BRFSS (2012–2018), and CT Secretary of State (2020).

Safety and Crime

Homicide rates, the number of firearm fatalities, and the number of 65+ who died by suicide.

Primary data source: The CDC Wonder website (https://wonder.cdc.gov/mcd.html) (2014–2018).

Transportation

The percentage of the 65+ population who own a motor vehicle. The percentage of 60+ population who always drive or ride wearing a seatbelt, and who drove under the influence of alcohol in the last month. The number of fatal crashes involving adults 60+ (town), and the number of fatal crashes involving adults 60+ (county).

Primary data sources: The U.S. Census Bureau, American Community Survey (2014–2018), The Behavioral Risk Factor Surveillance System (2012–2018), and The National Highway Traffic Safety Administration (2014–2018).

Housing

The percentage of the 65+ population who live alone, moved within the same county in the past year, moved from a different county in the past year, and moved from a different state in the past year. The percentage of the 60+ population who own a home, have a mortgage, and are stressed about paying rent or mortgage in the past year. The average household size of all ages, median house value, number of assisted living sites, and percentage of vacant homes in community.

Primary data sources: The U.S. Census Bureau, American Community Survey (2014–2018), The Behavioral Risk Factor Surveillance System (2012–2018), and seniorcare.com/assisted-living/ (2020).

Economic Status

The percentage of 60+ population who received food benefits in past year. The percentage 65+ in past year who were employed, with income below poverty line. The percentage 65+ households with annual income less than $20,000, 20,000–$49,999, $50,000–$99,999, above $100,000.

Primary data source: The U.S. Census Bureau (American Community Survey (2014–2018).

Cost of Living

The minimum income needed to attain a modest standard of living in the community for a single homeowner without a mortgage in good health, a single renter in good health, a couple homeowner without mortgage in good health, and a couple who rent in good health.

Primary data source: The Center for Social and Demographic Research on Aging, the University of Massachusetts Boston (2019) elderindex.org.
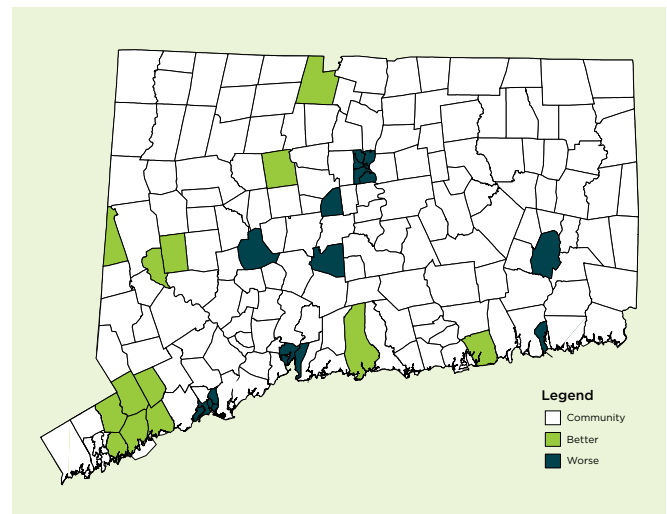
A Broader View: Communities with Rates Better or Worse than the State Average

Understanding how communities compare to state averages helps us identify which communities are doing well and consider what could be done to help communities that fall below state average. (Of course, the state average itself may, or may not, represent an optimal value for a given indicator.) We may be able to find approaches that can be replicated in areas of unmet, or poorly met, health care or social service needs. Having local data focused exclusively on older people is the foundation on which further progress can be made to create truly age-friendly communities in Connecticut.

For most indicators, the reported community and state values are estimates calculated with sample data. Thus, some differences between state and community rates may be due to chance associated with population sampling. The terms "better" or "worse" highlight differences between the community and state rates when we are confident that the difference is not due to chance. "Better" is used when a value has a positive implication for the health of older residents; "worse" is used when there is a negative implication. When the implication is unclear, we use an asterisk. (Differences noted in the tables or text of this report are all statistically significant at the 95% confidence level.)

The terms "better" or "worse" do not indicate any value judgment on the part of the researchers. After conversations with a range of stakeholders we believe using the terms "better" and "worse" is the simplest way to communicate what the rate means. The first step to addressing health disparities is to be aware of them.

Map 3. Communities with Most Rates Better or Worse than State Average Rates

Legend
- Community
- Better
- Worse

The 13 communities with the most indicators better than state averages are: Bridgewater, Burlington, Darien, Granby, Guilford, New Canaan, Norwalk, Old Lyme, Roxbury, Sherman, Weston, Westport, and Wilton. Most of these towns are characterized as higher socioeconomic status communities. The 13 Connecticut communities with the most indicators below state averages are: Bridgeport Area 2, Bridgeport Area 3, East Haven, Hartford Area 1, Hartford Area 2, Hartford Area 3, Meriden, New Britain, New Haven Area 2, New Haven Area 3, New London, Norwich, and Waterbury. These communities are all characterized as having lower socioeconomic status.

On the website, you can access 18 interactive maps or download a pdf map to view each of the indicator rates across Connecticut. These data can help stakeholders identify where resources and support are needed. For example, New London had the highest rate of depression (39.56%) and Morris and

Bethlehem had the lowest (21.51%). Better access to mental health services is needed everywhere, but policymakers working with resource constraints may decide to prioritize areas with the highest rates to address the most urgent needs.

The data in Table 1 clearly illustrate something we see in every state: that where someone lives has implications for their health.

Table 1. Communities with Best and Worse Rates on Selected Indicators

	Best Rates	Worst Rates
Alzheimer's disease	**7.9%** Oxford	**27.3%** Hartford Area 2
Any physical activity	**84.6%** Darien, New Canaan, Norwalk, Weston, Westport, Wilton	**61.0%** Hartford
Depression	**21.5%** Bethlehem, Morris	**42.5%** Hartford Area 2
Diabetes	**20.7%** Salisbury	**56.8%** Bridgeport Area 3
Flu shot in past year	**63.3%** Bridgewater, Brookfield, New Fairfield, New Milford, Newtown, Roxbury, Sherman	**45.4%** Hartford
Getting recommended sleep	**72.9%** Darien, New Canaan, Norwalk, Weston, Westport, Wilton	**53.1%** Bridgeport
Hypertension	**57.7%** Weston	**86.6%** Hartford Area 1
Independent living difficulty	**1.6%** Washington	**25.1%** Hartford Area 1
Ischemic heart disease	**29.0%** Marlborough	**51.3%** New Britain
Stroke	**7.6%** Goshen, Norfolk	**15.5%** Bridgeport Area 2
4+ chronic conditions	**47.8%** Bethlehem, Morris	**70.0%** Norwich
No chronic conditions	**12.3%** Weston	**4.1%** Bloomfield

The Impact of Race and Ethnicity on Healthy Aging

The death of George Floyd in Minneapolis in May 2020 triggered protests around the world. It brought renewed attention to the high-profile deaths of Black Americans during the past decade and renewed concerns about systemic racism, especially in the criminal justice system. The police response in some cities fueled further protests and led to widespread efforts to acknowledge the role race plays in every aspect of life, including health and healthy aging. A lifetime lived in a systematically racist society has negative consequences on health in late life. This makes the information on racial disparities in the *2021 Connecticut Healthy Aging Data Report* particularly relevant and timely.

As noted earlier and seen in Table 2, Connecticut is home to the most diverse older population in New England. The Constitution State has the highest percentage of older adult residents who are Black/African American (6.8%) and of Hispanic ethnicity (5.8%). Diversity is an asset and strength for any community or state. The data show that diverse communities often experience health disparities

There were disparities in **56** chronic disease, mental health, and health services utilization indicators. There were only four indicators (heart attack, liver disease, PTSD, and stroke) that did not have racial disparities.

Table 2. Race and Ethnicity of Older Residents in Selected States

Race and ethnicity of the 65+ population	CT	MA	NH	RI
% 65 White	88.4%	90.0%	97.7%	92.0%
% 65 Black/African American	6.8%	4.3%	0.5%	3.2%
% 65 Hispanic	5.8%	3.8%	0.9%	4.9%
% 65 Other race	2.6%	2.5%	0.9%	3.3%
% 65 Asian	2.3%	3.2%	0.9%	1.6%

because of inequitable community conditions. We sought to explore how race and ethnicity impacted healthy aging in Connecticut. The sections that follow highlight some of our findings.

Population Health

The Centers for Disease Control and Prevention (CDC) uses the term "population health" to refer to the distribution of health outcomes within a population. It includes the range of personal, social, economic, and environmental factors that influence health outcomes and the policies and interventions that affect those outcomes.

Building on our extensive, ongoing analyses of population health and healthy aging in New England, we have distilled data from 56 chronic disease, disability, and Medicare service use indicators to create a multidimensional measure of community healthy aging. Analyses revealed four distinct dimensions of population healthy aging: serious complex chronic diseases, indolent conditions, physical disability, and psychological disability.

1. **Serious complex chronic diseases** include cardiovascular, metabolic, or respiratory conditions that are disabling or life-threatening and require ongoing treatments and services across a variety of domains of care to ensure the best possible outcomes for each unique patient. This dimension of health is related to lower socioeconomic status (SES), access to affordable, healthy food, and low levels of social capital. Interestingly, when SES is statistically controlled, communities with higher concentrations of older people of color have lower rates of serious complex chronic disease.

2. **Indolent conditions** are comprised of chronic diseases that generally progress slowly, are not disabling or immediately life-threatening, and that can be effectively managed with early detection, medication, and regular visits to a medical provider. The early diagnosis and successful management of many of these medical conditions is often associated with good access to medical care. Communities with less

affluent and educated older populations have *lower rates* of indolent chronic disease.

3. **Physical disability** includes measures of reduced function in vision, walking, cognition, self-care, and/or independent living. This dimension of health is associated with older residents of lower SES, a higher percentage of residents who are Black/African American or Hispanic, a higher concentration of older persons without access to affordable, healthy food, and higher concentrations of older residents who are 85 years or older.

4. **Psychological disability** includes impairment by depression, anxiety, and other mental health disorders. This dimension of health is related to social deprivation and disorder which suggests that the social environment is a major driver affecting the mental health of older residents. Older persons are at greater risk of having diagnosed mental health disorders in communities where there are greater risks of social isolation and better access to mental health services.

Our analyses show racial/ethnic disparities are quite common among older people in Connecticut. The results demonstrate that racial/ethnic disparities in healthy aging are very common. In fact, there are only a handful of indicators that did not have significant racial differences (within a 95% confidence interval). The nature of these disparities differ depending upon the dimension of population health considered and are described below.

Serious Complex Chronic Disease Indicators

Among Medicare beneficiaries age 65+ in Connecticut, Black/African American people fared worse than White people, Hispanic people, and Asian people on indicators related to serious complex chronic disease. Asian older people generally fared much better compared to all other race/ethnic groups in this dimension.

- Relative to other race/ethnic groups, Black/African American older people have the highest rate of 4+ chronic conditions, anemia, chronic

kidney disease, diabetes, hospital and skilled nursing facility stays, hypertension, obesity, peripheral vascular disease, stroke, and tobacco use disorders. Black/African American older people have lower rates than White older people on seven indicators: anxiety disorders, COPD, endometrial cancer, fibromyalgia, heart attack, high cholesterol, and lung cancer. Relative to White older people, Black/African American older people have higher prevalence rates for 16 of 28 indicators.

- White older adults have the lowest rate of diabetes relative to other race/ethnic groups.

- There are no disparities among White, Black/African American, and Hispanic older people in rates of liver disease, ischemic heart disease, and having no chronic conditions.

- Hispanic older people have the highest rates of asthma, heart attack, and Part D prescription fills relative to other race/ethnic groups. Relative to White older people, Hispanic older people have higher rates on 15 of 28 indicators. Hispanic older people have lower rates on 9 indicators: anemia, anxiety disorders, cancer (colon, endometrial, lung), COPD, high cholesterol, one-year mortality rates, and skilled nursing facility stays. No differences were observed in rates of fibromyalgia, ischemic heart disease, peripheral vascular disease, and stroke.

- Asian older people have the highest rate of persons with no chronic conditions. They have the lowest rate among race/ethnic groups on 20 chronic conditions and Medicare service use indicators (durable medical equipment, emergency room visits, inpatient hospitalizations, Part D prescription medication fills, and skilled nursing facility stays). Relative to White older people, Asian older people have lower rates on 25 of 28 indicators. Asian older people have higher rates of diabetes than White older people with no differences in the rates of liver disease. Asian older people have lower rates on most of these same indicators relative to Hispanic and Black/African American older people. However, we recognize that some Asian cultures have a strong

traditional approach to health and medical care that may not be fully captured by the Medicare claims data we rely on for these analyses.

Indolent Chronic Disease Indicators

Although the impact of serious complex chronic disease is greatest in Black/African American and Hispanic populations, older White adults are most negatively affected by indolent chronic diseases.

- White older people have the highest rates among all race/ethnic groups on 11 indicators: arthritis, atrial fibrillation, benign prostatic hyperplasia, breast cancer, cataracts, deafness, hip fracture, hypothyroidism, leukemias, osteoporosis, and physician visits. White older people have a lower rate than Black/African American older people of prostate cancer and a lower rate of chronic migraine headaches than Hispanic older people.

- Black/African American older people have the highest rate among all race groups on only one indicator of indolent disease — prostate cancer — and the lowest rate on two indicators — hypothyroidism and osteoporosis. Relative to White older people, Black/African American older people have lower rates on 12 of 14 indolent chronic disease indicators.

- Hispanic older people have lower rates than White adults on all indolent chronic disease indicators except chronic migraine headaches.

- Relative to White older people, Asian older people have lower rates on all 14 indicators.

Physical Disability Indicators

Black/African American older people 65+ have the highest rates of physical disability indicators and Asian older people have the same or the lowest rates on these indicators compared to other race/ethnic groups.

- Black/African American older people have higher rates on all six indicators relative to White older people. The disparities are more mixed between White, Hispanic, and Asian older people.

- Hispanic older people have higher rates of visual and mobility limitations and epilepsy relative to White older people.

- Asian older people have lower rates of glaucoma, epilepsy, chronic pressure ulcers, and home health visits relative to White older people.

Psychological Disability Indicators

Asian older people have the lowest rates on 8 of these indicators relative to older people of other race/ethnic groups. Most of the disparities were substantial.

- White older people have the highest rates among all race groups on one indicator: personality disorder. Relative to Black/African American adults, White older people have higher rates on three indicators: bipolar disorder, depression, and personality disorder. They have similar rates of Post-Traumatic Stress Disorder (PTSD) relative to other race/ethnic groups.

- Hispanic older people have the highest rate among all race groups for depression and PTSD. Hispanic and Black/African American older people have the highest rates of Alzheimer's disease and Related Dementias and opioid use disorder. Hispanic older people have higher rates than White older people on 7 of 8 indicators. They have similar rates of bipolar disorder.

- Black/African American older people have the highest rate among all race groups for substance use disorder and schizophrenia. Black/African American older people have higher rates than White older people for Alzheimer's disease and related dementias, opioid use disorder, substance use disorder, and schizophrenia.

Healthy Aging Changes Over Time (2015–2017)

We examined changes in indicators over time to identify trends and potential opportunities for improvement. Focusing on the health conditions first, rates increased for Alzheimer's disease, arthritis, fibromyalgia, hearing impairment/deafness, liver disease, migraine, 4 or more chronic conditions, and obesity. Rates for several mental health conditions also increased: anxiety disorders, depression, personality disorders, substance use disorder, and

tobacco use disorder. Overall, there are 28 health indicators with statistically significant statewide increases over the two years studied.

The good news is that statewide rates for several indicators improved over time, including anemia, asthma, cataracts, colon cancer, congestive heart failure, diabetes, hypertension, ischemic heart disease, and schizophrenia. Building on this healthy momentum is key.[1]

Table 3. Change in Indicators 2015–2017

Improved	2015	2017	Change from 2015 to 2017
Colon cancer	2.92%	2.73%	**-0.19%**
Diabetes	34.20%	33.78%	**-0.41%**
Cataract	65.38%	64.88%	**-0.50%**
Schizophrenia & other psychotic disorder	5.23%	4.68%	**-0.56%**
Anemia	51.38%	50.80%	**-0.58%**
Congestive heart failure	23.69%	22.86%	**-0.83%**
Hypertension	77.11%	76.26%	**-0.84%**
Ischemic heart disease	42.31%	40.94%	**-1.37%**
Asthma	15.53%	14.09%	**-1.45%**

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[1] Statistical note: The changes are age-sex adjusted for changes in the age-sex mix of Medicare beneficiaries between 2015 and 2017. Note that the changes at the state level are based on non-overlapping 95% confidence intervals and changes at the town level are based on non-overlapping 90% confidence intervals.

Worsened	2015	2017	Change from 2015 to 2017
Fibromyalgia, chronic pain and fatigue	19.44%	26.65%	**7.21%**
Obesity	16.97%	22.39%	**5.42%**
Anxiety disorder	22.19%	25.64%	**3.44%**
Osteoarthritis or rheumatoid arthritis	52.34%	54.32%	**1.99%**
Diagnosis of deafness/hearing impairment	14.07%	15.88%	**1.81%**
Depression	28.72%	30.41%	**1.69%**
Liver disease	8.32%	9.49%	**1.17%**
Personality disorder	1.44%	2.56%	**1.13%**
Migraine and other chronic headache	4.14%	5.22%	**1.08%**
Tobacco use disorder	9.14%	10.01%	**0.88%**
Benign prostatic hyperplasia	41.99%	42.74%	**0.75%**
Substance use disorder	6.01%	6.76%	**0.75%**
Hypothyroidism	24.79%	25.28%	**0.49%**
Bipolar disorder	3.40%	3.87%	**0.47%**
4+ (out of 15) chronic conditions	61.52%	61.92%	**0.40%**
Alzheimer's disease or related dementias	14.39%	14.70%	**0.31%**
Post-traumatic stress disorder	0.96%	1.25%	**0.29%**
Leukemias and lymphomas	2.44%	2.66%	**0.22%**
Epilepsy	2.72%	2.90%	**0.18%**
Clinical diagnosis of mobility impairment	3.91%	4.06%	**0.15%**
Autism	0.10%	0.13%	**0.03%**

Changed (non-specific)	2015	2017	Change from 2015 to 2017
Average Part B physician office visit evaluation and management services received in 2017 by Medicare beneficiaries 65 years or older	49.37	50.34	**0.97**
Average home health visits in 2017 per Medicare beneficiary 65 years or older	3.82	4.15	**0.33**
Average Part B physician office visit evaluation and management services received in 2017 by Medicare beneficiaries 65 years or older	8.43	8.61	**0.18**
Average Part B durable medical equipment services received in 2017 by Medicare beneficiaries 65 years or older	2.04	1.89	**-0.14**
A count of skilled nursing facility discharges in 2017 per 1,000 Medicare beneficiaries 65 years or older	116.39	106.45	**-9.93**

State Level Changes in Chronic Disease and Service Utilization Health Indicators

These results offer a mixed message regarding the population health of older persons over the two-year period. Rising prevalence rates were much more common than falling rates. Prevalence rates for anxiety disorders, chronic fatigue, and obesity had multiple percentage point increases. While these results suggest the overall population health of Connecticut's older people is more likely to have worsened a little than improved, most of the improved indicators were related cardiovascular conditions. This result is positive given the relatively high prevalence rates of hypertension (76%) and ischemic heart disease (41%).

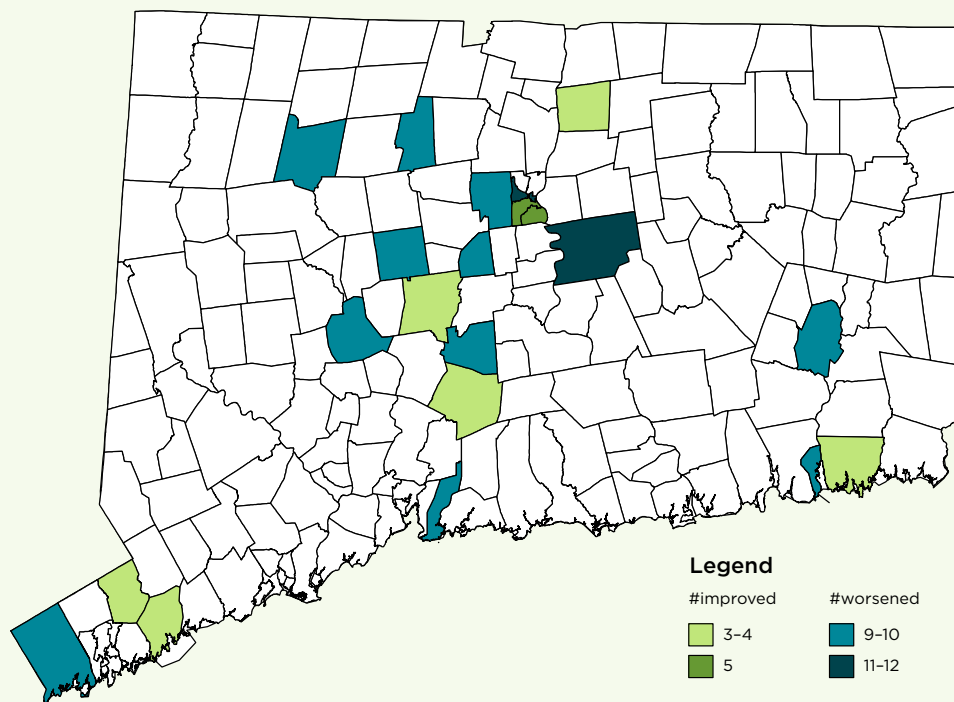## Connecticut Cities and Towns with the Most Increasing or Decreasing Rates

As seen in Table 4, nine or more indicators went up in 10 communities, which suggests worsening population health. Four of the 10 communities had no indicator that decreased, and only Waterbury had more than two indicators that improved. In general, few indicators improved in Connecticut communities over the two years. The communities with the largest counts of improved indicators are Hartford Area 3, Norwalk, Waterbury, Wallingford, Southington, East Windsor, New Canaan, and Groton.

Table 4. Communities with the Most Change in Indicators 2015–2017

	Number of Indicators That Got Worse		Number of Indicators That Got Better
Hartford area 2	13	Hartford area 3	5
Waterbury	12	Norwalk	4
Glastonbury	11	Waterbury	4

	Number of Indicators That Got Worse			Number of Indicators That Got Better
Greenwich	10		Wallingford	3
Bristol	10		Southington	3
Torrington	10		East Windsor	3
Canton	9		New Canaan	3
East Haven	9		Groton	3
Norwich	9			
West Hartford	9			

Map 4. Communities with the Most Change in Indicators Over Time 2015–2017

Legend

#improved
- 3–4
- 5

#worsened
- 9–10
- 11–12

Gender Differences in Healthy Aging

About 57% of the 65+ population in Connecticut is female, and among the 85+ population that rises to 67%. While aging is a universal human experience, men and women historically have had different opportunities, social and interpersonal roles, and experiences with health care, which affect health and lifespan.

Men tend to have more years in the work force and higher lifetime wages. Women tend to have more interruptions in labor force participation and earn less. In general, women marry spouses of the same age or older, which means women face the prospect of outliving their spouse, losing companionship and retirement income, as well assuming the responsibilities of caregiver. Research to understand disparities in healthy aging by gender can identify unique challenges and the need for additional supports and interventions.

In the analyses below, we examined rates for health, health behavior, and medical service use for older men and women. The data in Tables 5–6 confirm that men and women experience health and aging differently. All the noted disparities were statistically significant.

The positive news for older women is they have lower rates of substance and tobacco use disorders compared to older men. Women are also more likely to eat the recommended servings of fruits and vegetables and to have regular doctor's visits. However, older women have higher rates for musculoskeletal conditions (arthritis, falls, injurious falls, hip fracture, obesity, osteoporosis,) and for impaired mental health (anxiety disorders, bipolar disorder, depressive disorders, personality disorders, and schizophrenia). In addition, women have higher rates of financial insecurity (e.g., stress about buying food or paying rent/mortgage) and higher rates of Alzheimer's disease and related dementias.

Some noteworthy findings include the higher rates among men for cardiovascular conditions (atrial fibrillation, congestive heart failure, heart attack, hypertension, ischemic heart disease, peripheral vascular disease, stroke), chronic obstructive pulmonary disease, and diabetes. In terms of unhealthy behaviors, men had higher rates of driving under the influence and not wearing seatbelts. Men also have a higher mortality rate than women. The positive news for older men is that they have higher rates for all kinds of physical activity (aerobic, muscle strengthening, and engaging in any physical activity within the last month).

Table 5. Indicators with Significant Difference by Gender Among Older CT Adults — Women

Women Have Higher Rates Than Men	Female	Male	Difference Between Female and Male
% 60+ who eat 5+ servings of fruit or vegetables per day	24.2%	14.5%	9.6%
% 60+ who stressed about paying rent/mortgage in last month	20.0%	13.9%	6.1%
% 60+ who always drive or ride wearing a seatbelt	95.1%	90.4%	4.7%
% 60+ who stressed about buying food in last month	10.3%	6.4%	3.9%
% 60+ who have pneumonia vaccine	65.5%	61.7%	3.8%
% 60+ who were injured in a fall within last year	11.5%	7.8%	3.8%
% 60+ who fell within last year	28.0%	24.4%	3.7%
% 60+ who have a regular doctor	96.7%	95.3%	1.4%
% 65+ with osteoporosis	31.2%	5.3%	25.9%
% 65+ with hypothyroidism	32.8%	15.3%	17.4%
% 65+ with anxiety disorder	30.9%	18.3%	12.6%
% 65+ with depression	35.2%	23.8%	11.4%
% 65+ with arthritis	58.8%	48.2%	10.5%
% 65+ dually eligible for Medicare and Medicaid	26.0%	17.1%	8.9%
% 65+ with cataract	68.8%	60.1%	8.7%
% 65+ Hospice users as % of decedents	49.0%	41.2%	7.8%
% 65+ with fibromyalgia	29.5%	22.7%	6.8%
% 65+ with asthma	16.4%	11.2%	5.2%
% 65+ with migraine	7.1%	2.9%	4.2%
% 65+ with glaucoma	30.0%	26.1%	4.0%
% 65+ receiving Medicaid long-term services and supports	7.0%	3.7%	3.4%
% 65+ with clinically diagnosed obesity	23.6%	21.1%	2.5%

Women Have Higher Rates Than Men	Female	Male	Difference Between Female and Male
% 65+ had hip fracture	4.5%	2.3%	2.2%
% 65+ Medicare managed care enrollees	30.6%	29.0%	1.6%
% 65+ with Alzheimer's disease or related dementias	14.8%	13.5%	1.4%
% 65+ with bipolar disorder	4.4%	3.1%	1.3%
% 65+ with personality disorder	2.9%	2.0%	0.9%
% 65+ with schizophrenia & other psychotic disorder	4.9%	4.1%	0.7%
% 65+ with opioid use disorder	2.2%	2.0%	0.3%
Median hospice days per hospice user (65+, deceased)	11	9	2
# Home health visits annually	4.2	3.9	0.4
# Physician visits per year	8.8	8.5	0.2
Median payment (Medicare + other) per hospice user	$4,074	$3,334	$740

"In general, women marry spouses of the same age or older, which means women face the prospect of outliving their spouse, losing companionship and retirement income, as well assuming the responsibilities of caregiver."

Table 6. Indicators with Significant Difference by Gender Among Older CT Adults — Men

Men Have Higher Rates Than Women	Male %	Female %	Difference Between Male and Female
% 60+ who met CDC guidelines for aerobic physical activity	63.0%	54.1%	9.0%
% 60+ who met all CDC preventive health screening goals	42.8%	37.7%	5.1%
% 60+ who were doing any physical activity within last month	77.7%	72.8%	5.0%
% 60+ who met CDC guidelines for muscle-strengthening activity	30.2%	25.5%	4.8%
% 60+ who used internet in last month	77.5%	73.7%	3.8%
% 60+ who drove under the influence of drinking in last month	3.4%	0.8%	2.6%
% 65+ with ischemic heart disease	47.9%	35.0%	12.9%
% 65+ with chronic kidney disease	34.3%	26.5%	7.9%
% 65+ with atrial fibrillation	20.0%	13.1%	6.9%
% 65+ with diabetes	37.2%	31.0%	6.2%
% 65+ with congestive heart failure	25.2%	20.6%	4.6%
% 65+ with HIV test	18.3%	14.3%	4.0%
% 65+ with substance use disorder	8.7%	5.1%	3.6%
% 65+ with hypertension	77.9%	74.7%	3.3%
% 65+ with peripheral vascular disease	21.4%	18.6%	2.8%
% 65+ with tobacco use disorder	11.5%	8.9%	2.6%
% 65+ who ever had a heart attack	5.9%	3.4%	2.4%
% 65+ with clinical diagnosis of deafness/hearing impairment	16.8%	14.9%	2.0%
% 65+ with no chronic conditions	7.9%	6.6%	1.4%

Men Have Higher Rates Than Women	Male %	Female %	Difference Between Male and Female
% 65+ with stroke	12.6%	11.4%	1.2%
% 65+ with high cholesterol	77.5%	76.6%	1.0%
% 65+ with age-sex adjusted 1-year mortality rate	4.7%	3.7%	0.9%
% 65+ with leukemias and lymphomas	3.1%	2.3%	0.8%
% 65+ with chronic obstructive pulmonary disease	21.5%	20.7%	0.7%
% 65+ with clinical diagnosis of mobility impairment	4.4%	3.8%	0.6%
% 65+ with epilepsy	3.0%	2.8%	0.2%
% 65+ with HIV/AIDS	0.3%	0.1%	0.2%
% 65+ with autism spectrum disorder	0.2%	0.1%	0.1%
Medicare inpatient hospital readmissions	18.3%	16.3%	2.0%
# Inpatient hospital stays/1000 persons 65+ years annually	300.3	253.9	46.3
# Emergency room visits/1000 persons 65+ years annually	654.7	624.4	30.3
# Durable medical equipment claims annually	2.1	1.7	0.4

Comparing New England States in Healthy Aging

The health of older residents varies among New England states and is driven by differences in population density, access to care, socioeconomic factors, culture, and other issues. Looking at regional patterns of indicators of healthy aging may allow the identification of successful efforts that might be replicated in other New England states or problems that could be addressed regionally. As seen in Table 7, Connecticut has some rates that are worse and some that are better than its neighbors. We have highlighted in **bold** rates that are significantly higher (teal) or lower (green).

Table 7. Comparing Selected Indicators Among New England States

Chronic Disease Indicator	CT	RI	MA	NH	ME	VT
Post-traumatic stress disorder	**1.25%**	1.70%	2.23%	1.71%	3.08%	2.16%
Endometrial cancer	**2.03%**	1.94%	2.03%	1.79%	2.07%	1.99%
Colon cancer	**2.70%**	2.69%	2.72%	2.24%	2.39%	2.18%
Hip fracture	**3.69%**	3.39%	3.53%	3.12%	3.34%	3.18%
Age-sex adjusted 1-year mortality rate	**3.97%**	4.24%	4.01%	4.22%	4.35%	4.11%
Ever had a heart attack	**4.47%**	5.79%	4.71%	4.52%	5.94%	5.11%
0 chronic conditions	7.20%	6.96%	7.21%	10.22%	11.49%	11.07%
Pressure ulcer or chronic ulcer	**9.21%**	8.13%	8.25%	6.71%	7.31%	5.82%
Tobacco use disorder	**10.05%**	10.82%	11.21%	11.03%	13.36%	10.94%
Breast cancer (women)	**11.39%**	11.10%	11.12%	9.98%	9.27%	9.56%
Stroke	**11.91%**	11.87%	11.79%	10.52%	10.85%	9.87%
Asthma	14.08%	14.93%	13.53%	11.22%	12.25%	11.05%

Chronic Disease Indicator	CT	RI	MA	NH	ME	VT
Alzheimer's disease or related dementias	**14.37%**	13.10%	13.99%	11.68%	11.45%	10.01%
Atrial fibrillation	**16.06%**	14.97%	15.80%	14.41%	14.91%	13.84%
Osteoporosis	**20.24%**	19.57%	20.22%	16.70%	16.39%	13.75%
Obesity	22.51%	29.29%	24.06%	20.99%	23.37%	19.83%
Congestive heart failure	**22.58%**	21.63%	21.48%	17.02%	19.38%	15.79%
Hypothyroidism	**25.14%**	22.39%	21.44%	21.25%	22.43%	18.39%
Glaucoma	**28.26%**	27.01%	25.72%	22.91%	24.43%	23.98%
Diabetes	33.76%	34.65%	30.81%	27.48%	28.75%	25.09%
Ischemic heart disease	40.73%	41.76%	38.98%	33.45%	36.37%	33.68%
Benign prostatic hyperplasia	**42.75%**	42.19%	41.68%	36.90%	36.37%	35.40%
Anemia	**50.58%**	49.98%	45.53%	36.51%	39.21%	36.72%
4+ (out of 15) chronic conditions	61.78%	63.82%	60.85%	54.44%	57.15%	51.04%

Vermont, one of the region's less populated states, stands out with the best rates on numerous health indicators. The more urbanized New England states of Connecticut, Massachusetts, and Rhode Island have similar counts of the worst rates on indicators. Overall, Connecticut health indicator rates were most similar to RI.

In terms of health services use, Connecticut has the highest rate in New England for the number of home health visits, physician visits, skilled nursing facility stays, Medicaid long-term services and supports, and the percentage of older people who are dually-eligible for Medicare and Medicaid. Connecticut has the lowest median days of hospice use per decedent 65+. That may mean that older people facing the end-of-life are doing so without getting hospice care that could potentially ease their suffering and provide important support to loved ones. Research to understand the obstacles to care are needed. In Table 7 the highest or worst rates are highlighted teal, and the lowest or best rates are shaded green.

Table 8. Comparing Health Utilization and Access Indicators Among New England States

Utilization Indicator	CT	RI	MA	NH	ME	VT
# home health visits annually	4.08	3.51	3.90	2.49	2.20	2.42
# physician visits per year	8.63	8.36	7.92	6.30	5.40	5.06
# skilled nursing facility stays	104.65	98.77	94.66	69.95	67.44	66.07
# inpatient hospital stays	273.26	286.50	289.87	238.44	235.46	219.14
# emergency room visits	636.67	620.55	641.38	577.47	685.07	580.87
Hospice users	2.75%	3.54%	2.84%	2.67%	2.90%	2.42%
Hospice users as % of decedents	45.49%	53.03%	44.59%	45.88%	49.01%	41.06%
Median hospice days per hospice user (65+ deceased)	10.00	11.00	15.00	15.00	14.00	18.00
Medicaid long-term services and supports	5.54%	4.22%	4.57%	3.43%	2.58%	3.67%
Dually eligible for Medicare and Medicaid	22.07%	13.78%	16.37%	7.10%	19.54%	13.95%
Medicare managed care enrollees	29.87%	43.77%	25.33%	11.72%	32.27%	10.24%

Connecticut had the lowest rates in New England for tobacco use disorders, post-traumatic stress disorder, and mortality. However, Connecticut had the worst rates for three types of cancer (breast, colon, and endometrial), serious cardiovascular conditions (stroke, congestive heart failure, and atrial fibrillation), Alzheimer's disease, osteoporosis, hip fractures, pressure ulcers, anemia, glaucoma, hypothyroidism, and benign prostatic hyperplasia.

These results are influenced by several factors such as the mix of urban and rural populations and the level of enrollment in Medicare Advantage plans (i.e., healthier people tend to select Medicare Advantage, leaving sicker people in the fee-for-service program). The highest Medicare Advantage market shares are Rhode Island (43.8%), Maine (32.3%), Connecticut (29.9%), and Massachusetts (25.3%). Medicare Advantage market shares were much lower in Vermont (10.2%) and New Hampshire (11.7%).

Hospice and End-of-Life Care

While it might seem odd to talk about death in a report focused on healthy aging, hospice utilization and end-of-life care are important services that help create a spectrum of care for older people.
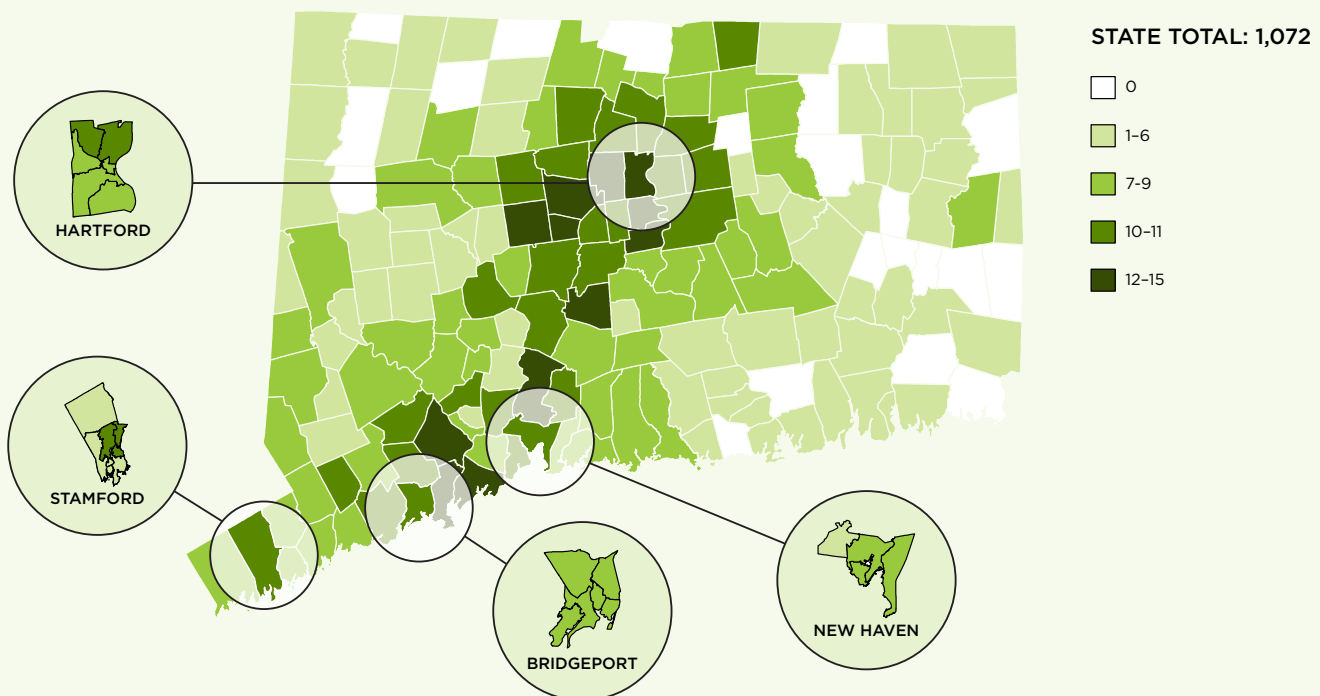
Palliative care aims to improve quality of life and to help with symptoms. Palliative care can include curative treatment and does not depend on prognosis. Palliative care aims to provide medical, social, emotional, and practical support and can occur in hospitals, nursing homes, outpatient clinics, or at home. Hospice care is a type of palliative care where attempts to cure illness are stopped and the focus shifts to comprehensive comfort care and support.

As shown in Map 5, approximately 10% of Connecticut communities do not have a hospice agency that accepts Medicare. In communities to the east and northwest there are no, or few, hospice agencies. Large urban areas tend to have higher concentrations of hospice agencies—Bristol (15), Hartford (12), Bridgeport (11), and New Haven (10).

Map 5. Number of Hospice Agencies

Source: Medicare.gov 2020

STATE TOTAL: 1,072

- 0
- 1–6
- 7–9
- 10–11
- 12–15

We also investigated what percentage of Medicare beneficiaries were hospice users in a two-year period. As seen in Map 6, 2.7% of Medicare users state-wide were hospice patients, with a high of 4.56% in Chester and a low of 1.3% in Washington. As seen in Table 7, older women used hospice at a higher rate (49%) than men (41%); on average two days longer; and, Medicare paid $740 more for their hospice care.

We found that, on average, people used hospice services for 10 days before they died. People in Salem used hospice for a median of 19 days before they died, and the median hospice use in Roxbury and Bridgewater was 6 days.

We calculated costs of hospice care. The median payment per hospice user age 65+ from all sources (Medicare + Other) was $3,741.20 statewide.
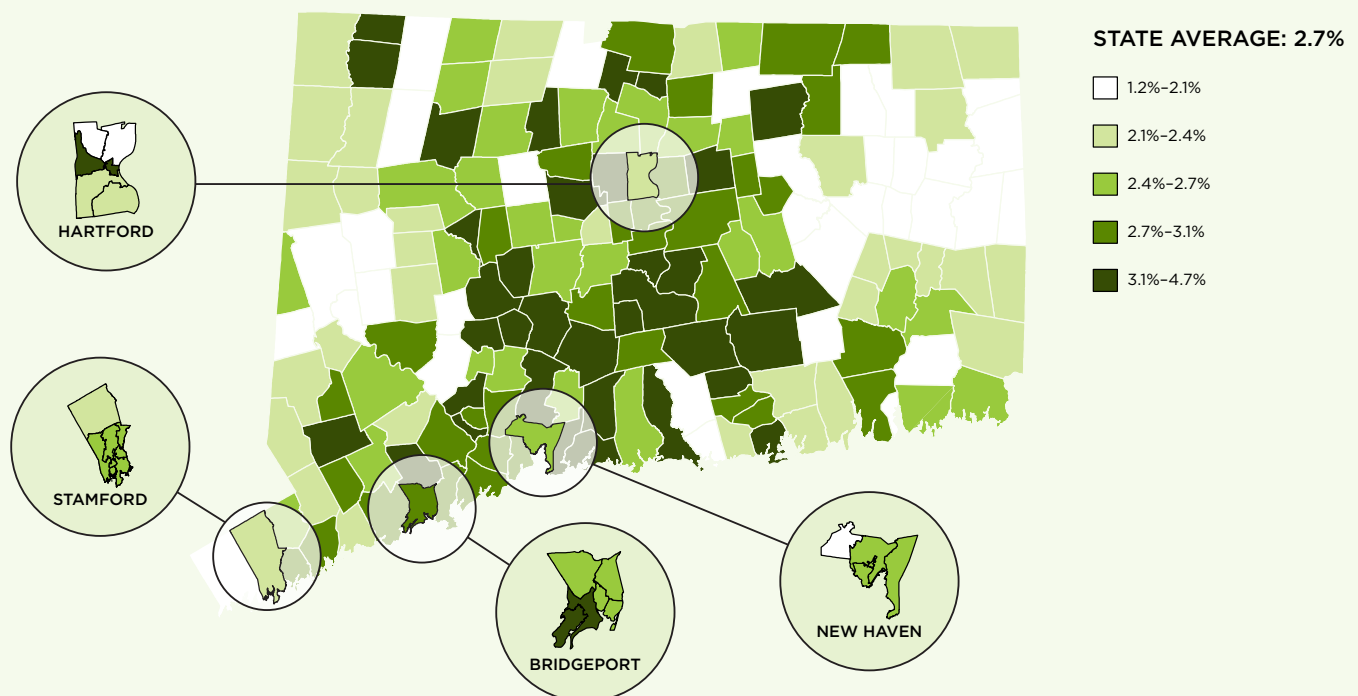
However, there were significant differences in costs based on location. North Branford had the highest per-user cost ($6,027.50) and Windham the lowest ($1,993.44).

Finally, we analyzed the ratio of hospice users to those who died during the study period to determine what percentage of decedents were hospice users. As shown in Map 7, the state average was 45.5%, which means that less than half of those dying received end-of-life hospice services. East Granby (67%) and Chester (65%) had the highest rates, while Putnamem had the lowest (20%).

These data suggest that more efforts could be made to increase access to hospice care, reduce disparities in costs, and increase use of hospice services at the end of life.
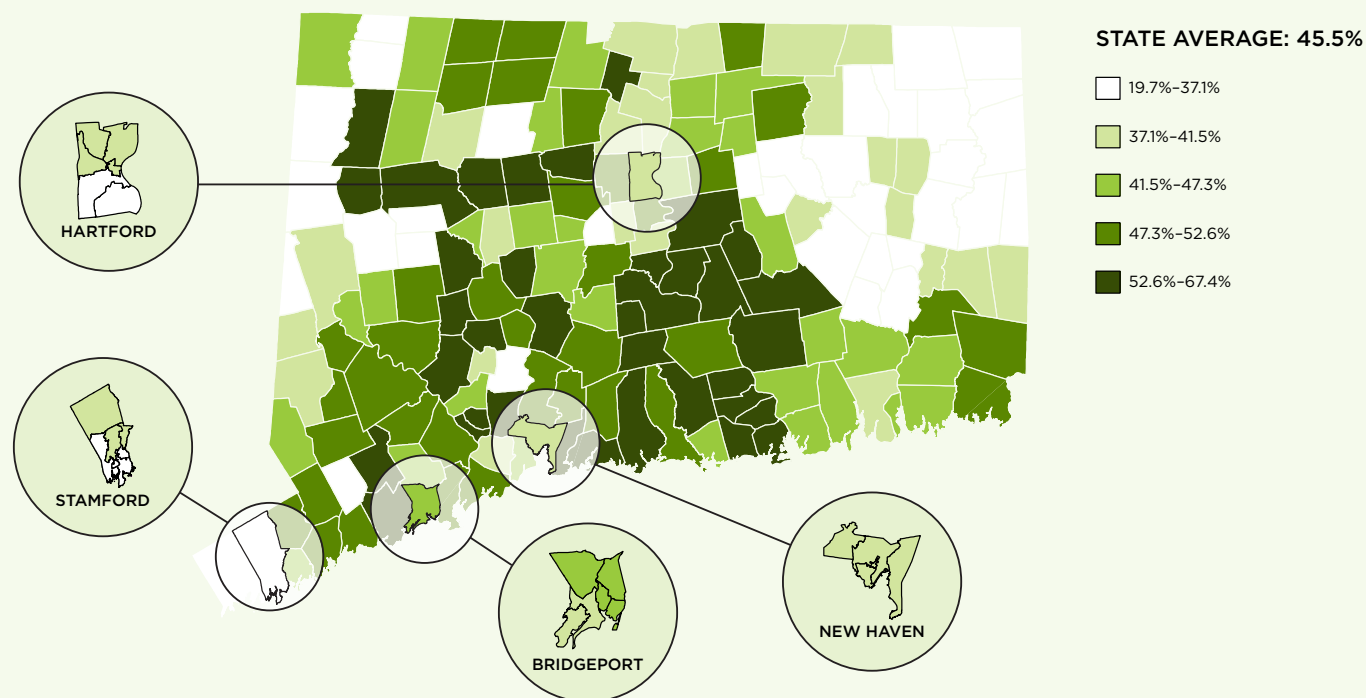
Map 6. Hospice Users as Percentage of Medicare Beneficiaries Age 65+ Years

Source: CMS 2016–2017

STATE AVERAGE: 2.7%

- 1.2%–2.1%
- 2.1%–2.4%
- 2.4%–2.7%
- 2.7%–3.1%
- 3.1%–4.7%

Map 7. Hospice Users as Percentage of Decedents

Source: CMS 2016–2017

STATE AVERAGE: 45.5%

- 19.7%–37.1%
- 37.1%–41.5%
- 41.5%–47.3%
- 47.3%–52.6%
- 52.6%–67.4%

HARTFORD

STAMFORD

BRIDGEPORT

NEW HAVEN

"Palliative care aims to improve quality of life and to help with symptoms."

Call to Action

Connecticut's population is steadily growing older, presenting challenges we must face together as well as opportunities to reap the benefits of the combined experience, wisdom, and expertise of older people. These demographic changes are prompting discussions about healthy aging and interest in what communities need to do to support healthy aging. This report is a powerful tool to inform those striving to make their communities better places to grow up and grow old together.

The path to action is clear.

Understand

Before we can solve challenges we have to understand them.

- Download your community profile at healthyagingdatareports.org to better understand your community's strengths and needs.

- Educate yourself and others about the indicators in your city, town, or neighborhood.

- Compare your community to statewide trends.

- Learn about programs and resources at myplacect.org

- Learn what makes a community age-friendly.

Engage

If you want to go fast, go alone. If you want to go far, go together.

- Encourage people you know and community leaders to engage in the age-friendly movement.

- Connect with the Age Well Collaborative www.ctagewellcollaborative.org

- Bring people together to talk about what the data mean and what can be done to address local opportunities and challenges.

- Include older people (particularly older people of color) and as many different sectors as possible, such as faith-based organizations, the business community, first responders, and public health departments.

- Share resources across organizations so that smaller and grassroots groups can fully participate.

Act

We can make the world a better place if we take action.

- Get involved in local efforts to promote healthy aging www.ctagewellcollaborative.org

- Use data to inform planning and to prioritize community needs.

- Collaborate with diverse partners.

- Create opportunities for civic engagement and social connection.

- Identify and build upon what's working.

Opportunities to act can take many forms, building on existing work and/or leveraging groups already meeting. Below are examples from communities across New England.

Advocacy

- An alliance of older people focused on healthy aging leveraged the Healthy Aging Data Report to host a series of engagement activities with elected officials, including a legislative breakfast.

- Advocates used the Healthy Aging Data Report to convince state leaders to establish a State Commission on Aging.

- Funds were appropriated to expand transportation for older people after reviewing transportation gaps.

- A state budget increase was allocated to support delivery of evidence-based health promotion programs for older people.

- Awareness was raised about mental health issues in older people, and expanded training and collaboration was provided to mental health workers and aging service providers.

Spurring Collaboration

- A group of rural communities joined together to address healthy aging issues described in their community profiles.

Economic Development

- Health insurers, developers of housing for older people, and private aging service providers used the Healthy Aging Data Reports to generate business development insights.

- A healthcare organization used one of the reports for market research on where to locate a memory assessment clinic.

Education

- Students used the reports in action research projects.

- Nonprofit organizations used the Healthy Aging Data Reports to write more competitive grant applications.

- Elected officials used the reports to better understand their communities and constituents.

Service

- A municipal senior services department expanded a tai chi program in response to learning their community had high fall rates.

- A law enforcement official used information on falls and fractures to identify communities for a program on elder abuse.

- A department of public health prioritized communities with high rates of asthma for public education campaign.

- A department of public health prioritized communities for grant funding to improve healthy aging based on factors reported in the Healthy Aging Data Reports.

Connecticut Age Well Collaborative

The Connecticut Age Well Collaborative is a partnership of public and private organizations, community groups and philanthropy with a shared vision of creating great places to grow up and grow older in Connecticut. The Collaborative focuses on providing information about priorities and best practices as well as promoting actions and policies that lead to age-friendly and dementia-friendly communities.

Visit www.ctagewellcollaborative.org to learn more. Connecticut Community Care serves as project lead.

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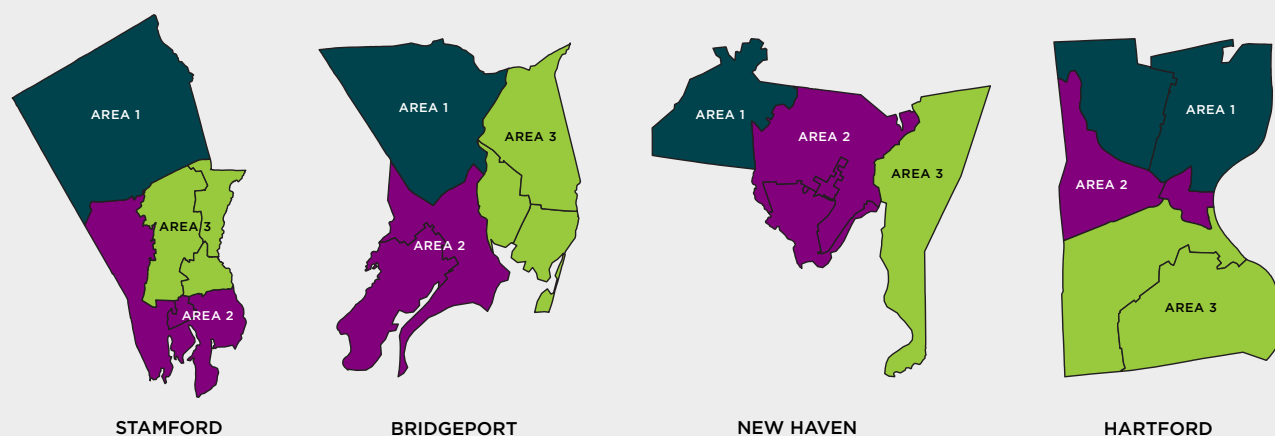Kimberly Blakemore

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Technical Notes

See our [Technical Report](#) for comprehensive information on data sources, measures, methodology, and margins of errors. For most indicators, the reported community and state values are estimates derived from sample data. Thus, it is possible that some of the differences between state and community estimates may be due to chance associated with population sampling. We use the terms "better" and "worse" to highlight differences between community and state estimates that we are confident are not due to chance. "Better" is used where a higher/lower value has positive implications for the health of older residents. "Worse" is used where a higher/lower score has negative implications for the health of older people, and when the implication is unclear, we use an asterisk. Similarly, differences noted in the tables or text are statistically significant at the 95% confidence level. The terms better or worse do not indicate any value judgement on the part of the researchers. After careful and deliberate conversations with a range of stakeholders, we believe better/worse is the simplest way to communicate what the rates mean.

In presenting the data, we balance two goals. First, we aim to report data at 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 181 geographic units (i.e., every populated city/town and three Bridgeport neighborhoods, three Hartford neighborhoods, three New Haven neighborhoods, and three Stamford neighborhoods). For example, the population characteristics and information from the US Census were reported for all 181 units. For other data (i.e., highly prevalent chronic diseases and health services use), we report for 160 geographic units. For less prevalent conditions, we report for 104 geographic units. For the Behavioral Risk Factor Surveillance System data, we report for 34 geographic units, and for the lowest prevalence conditions (e.g., HIV) we report for 10 geographic units. The same age/sex adjusted estimate is reported for all cities/towns within aggregated geographic areas. Maps of the different geographic groupings and the rationale behind the groupings are in the Technical Report.

Map 8. Connecticut Neighborhood Maps

STAMFORD   BRIDGEPORT   NEW HAVEN   HARTFORD

"

We must be impatient for change. Let us remember that our voice is a precious gift and we must use it."

CLAUDIA FLORES