



# Healthy Aging Data Report

Highlights from  
Rhode Island, 2020

Research and Analysis by



JOHN W. McCORMACK GRADUATE SCHOOL  
OF POLICY AND GLOBAL STUDIES  
UNIVERSITY OF MASSACHUSETTS BOSTON

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# A Message from the Governor

Rhode Island's older population is growing dramatically. Today, more than 240,000 Rhode Island residents are age 60 or older — that's 23% of the population. By 2040 that figure is expected to rise to almost 265,000, an increase of nearly 75% over 30 years. In addition, we have one of the highest proportions of adults age 85 and older of any state in the nation, ranking first in New England.

The *2020 Rhode Island Healthy Aging Data Report* offers a unique opportunity to address this demographic reality with state, regional, and local leaders. The *2020 Rhode Island Healthy Aging Data Report* can help guide program and policy decisions to support healthy aging and build vibrant, healthier communities.

While we are fortunate to have programs in place — Rhode Island was one of the first states to implement an adult immunization program, offering nearly all CDC recommended vaccines, the Office of Healthy Aging's CareBreaks Program was recognized as an Innovative & Exemplary Respite Program by the ARCH National Respite Network and Rhode Island was one of the first states in the nation to offer paid leave for family caregivers — there is still much work to be done.

This report includes comprehensive community profiles for every city and town, key comparisons from community to community, and recommendations to guide future efforts. I encourage everyone who cares about making Rhode Island a healthy place to grow up and grow old to use the report to inform your work.

My thanks to the community leaders who served on the Advisory Council for this report, Tufts Health Plan Foundation for its generous funding support, and the team at the Gerontology Institute of the John W. McCormack Graduate School of Policy and Global Studies at the University of Massachusetts Boston for delivering such a valuable tool.



**Gina M. Raimondo**

Governor  
State of Rhode Island

# A Message from the Rhode Island Office of Healthy Aging

Rhode Island is growing older. We are among the states with the highest share of adults age 85 and over, and by 2040, one in four residents will be an older adult. At the Rhode Island Office of Healthy Aging (OHA), our mission is to empower older Rhode Islanders, adults living with disabilities, and family caregivers to age strong. Our work is centered in providing the information and resources needed to live an inspired life of one's choosing. And it's grounded in the belief that people's needs and preferences are diverse and multi-dimensional as they age. Our focus remains on promoting agency and equity.

This year, our work took on heightened importance as we faced a global pandemic that disproportionately impacted those we serve. This public health and economic crisis levied unprecedented hardship and tragic loss, leaving many families and lives forever changed. It highlighted persistent and new challenges for older adults that will require our collective and urgent action to address. It also created fertile ground for innovation and working across sectors to support Rhode Islanders in need.

As we move forward, the *2020 Rhode Island Healthy Aging Data Report* will serve as a valuable tool in our work to shape policy and programs that benefit older adults and continue to shift the narrative and experience in aging in Rhode Island. Among its many insights, the report reinforces the deep and historic inequities that plague our state. The data is clear: where you live and your access to resources have a very real effect on your health and quality of life. As we move through this pandemic and plan for a brighter tomorrow, priority must be placed on creating meaningful opportunities for our LGBTQIA+ neighbors and our communities of color — and investing in neighborhoods with concentrated disadvantage.

At the same time, we must continue to be nimble in our service delivery and work collaboratively across

government, industry and community to make needed investments, create opportunity, and stamp out the ageist and ableist views that marginalize a vital and growing segment of our population. At OHA, we are proud to be part of a much broader healthy aging village in Rhode Island and nationally, and we are grateful to our many partners and constituents who stepped forward during this pandemic to support their neighbors in need. We must remain vigilant.

COVID-19, and its ripple effects, will be with us for some time. We must commit ourselves to addressing the disparities highlighted in this report — and magnified during this pandemic. We must continue to deliver new and existing programs and services that help meet people's basic needs, preserve social connections, and keep those we love safe from harm. This year introduced all of us to the crippling effects of social isolation, which many older adults have long faced, and the limitless potential of technology in connecting us to each other, and to support. We have an opportunity now to accelerate efforts to remove the barriers nearly one quarter of older Rhode Islanders face in participating fully in this digital age.

We are incredibly grateful to Tufts Health Plan Foundation and the Gerontology Institute of the John W. McCormack Graduate School of Policy and Global Studies at the University of Massachusetts Boston for preparing this invaluable report — and to the many advisors who assisted with this project. Thank you for your partnership and leadership. We are all united on this aging journey. We all benefit from an age-friendly, more equitable Rhode Island.



**Rosamaria Amoros Jones**

Director, Rhode Island Office of Healthy Aging

# A Message from the Funder and Principal Investigator

We are living in remarkable and unprecedented times. Rhode Islanders and others around the world have been affected by the ongoing COVID-19 pandemic. Never has accurate data on health outcomes for older adults been more important.

The *2020 Rhode Island Healthy Aging Data Report* is a roadmap for identifying health-related strengths and needs in communities across the state. The report updates and expands the information in the 2016 report. It also provides unprecedented clarity and geographic details essential for all efforts to improve public health.

As Rhode Island residents and health professionals work hard to contain the spread of COVID-19, many opportunities exist for making our communities better places to grow up and grow old. Each community must chart its own course towards better health, honoring its people, history, and culture.

We have listened to those engaging in this work and have learned some valuable lessons. First, connect with those leading the way at the state level and/or in your local community. Don't go it alone. Second, consider starting small and building consensus and momentum. As you progress, shift to more challenging issues and engage a wider circle of collaborators. Third, engage organizations serving diverse populations — people of color have been disproportionately affected by the pandemic. Still don't stop there. Include youth, families, the LGBT community and people living with disabilities. Fourth, celebrate successes. As you make progress, and/or expand your collaboration, remember to recognize the positive impact you are having and that of those making change.

Improving community health is possible. We hope you use this Highlights Report and the full online database to inform your work. Set priorities, create and strengthen partnerships, allocate resources, and focus services based on data specific to your communities.

To access the full report, go to [HealthyAgingDataReports.org](https://HealthyAgingDataReports.org).

Stay safe and thank you for your commitment to your communities and this important work.



**Thomas Crowell**

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Board of Directors, Tufts Health Plan Foundation



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President, Tufts Health Plan Foundation  
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# About the Report

The full *2020 Rhode Island Healthy Aging Data Report* (available online at [www.healthyagingdatareports.org](http://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 as you create age-friendly communities. When communities work for older people, they work better for everyone!

The report, which expands and updates the 2016 report, includes 197 indicators (up from 120 indicators) providing a comprehensive picture of the health of older adults in Rhode Island. Included are 41 community profiles — one for every city and town in the state, plus two neighborhoods in Providence — with new data to inform policy, planning, and practice. We also provide a snapshot of 20 core cities in Rhode Island.

The data reveal important patterns of disease, health behaviors, resources, 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 Rhode Island 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.

Population health measures focus on prevention and intervention rather than waiting for someone to get a diagnosis in a doctor's office or enter an emergency department. 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:

- 41 community profiles, and an additional 20 community profiles by ZIP code for the core cities in Rhode Island
- 194 maps listing community rates for each indicator (both ranked and alphabetized)
- 41 community profiles with estimates of indicators with confidence intervals, and technical documentation
- 18 interactive web maps
- An infographic summarizing key findings
- Highlights Report

The tools can be used to inform policy, improve programs and services, and spur collective action to make Rhode Island a truly age-friendly, and healthier, state. Tufts Health Plan Foundation has supported Healthy Aging Data Reports in Rhode Island (2016, 2020), Massachusetts (2014, 2015, 2018), New Hampshire (2019), and Connecticut (2021). Each report builds on what we have learned from previous work and our community partners in each state. We welcome your input! If you have questions or suggestions, please email them to [beth.dugan@umb.edu](mailto:beth.dugan@umb.edu). Your idea may help make the next Rhode Island report even better.

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## What Do Age-Friendly Communities Have in Common?

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

# Growing Older in Age-Friendly Rhode Island

Rhode Island holds a special place in the history of this country's efforts to provide services for older people. In 1965, the year that Medicare and Medicaid became law, R.I. Congressman John E. Fogarty introduced and won passage of the Older Americans Act (OAA), the first federal initiative to provide comprehensive services to older adults.

Today, Rhode Island policies relating to older people are developed and coordinated by the Long Term Care Coordinating Council, which works to preserve older adults' quality of life in all settings and all populations, including adults with chronic disabilities and illnesses. Another state asset is [Age-Friendly Rhode Island](#) an initiative of Rhode Island College, which brings together community and state agencies, healthcare and social service providers, individuals of all ages, advocacy and faith-based organizations, businesses, academic institutions, and municipal leaders committed to healthy aging. In recognition of how important the issue of aging has become, the Division of Elderly Affairs in 2019 was renamed the Office of Healthy Aging, with a cabinet-level director appointed by, and reporting to, the Governor.

The data presented in this report give advocates and decision makers the “why” needed to create new opportunities for engaging older residents and other key stakeholders. The gains in human longevity mean older people have more chances for leading high quality, fulfilling lives. Most of us want more than extra years of life. We want healthier years of life. And although Rhode Island, overall, compares well to other states on measures of health, this hides significant variations and disparities within the state, which this report explores. Put simply, where you live matters to your health.

Communities that nurture healthy aging support older people and also enrich the lives of everyone else in the community. One example of this is how adding curb cuts to sidewalks or walking paths to make navigation easy for those using a walker or a wheelchair, also benefits young parents pushing baby strollers.

## Age Friendly Rhode Island

Based at Rhode Island College, Age-Friendly Rhode Island is a coalition of community and state agencies, healthcare and social service providers, individuals of all ages, advocacy and faith-based organizations, businesses, academic institutions and municipal leaders who are committed to healthy aging. The organization's vision is to build a community that enables older Rhode Islanders to live independently with the care, support and resources needed to foster health, well-being, social connectedness and a meaningful life. Learn more at [agefriendlyri.org](http://agefriendlyri.org).

# What's New in Aging in Rhode Island?

Since the release of the first Rhode Island Healthy Aging Data Report in 2016, new data have been collected that show how Rhode Island is changing. The population of adults aged 60 or older has grown from roughly 217,000 to 243,523, representing 23% of the state's total population (up from 20%). At the same time, as the baby boom cohort enters the 65+ group, the percentage of that group who are in the youngest age category (65-74) increased from 50% in 2013 to 56% in 2018, and the percentage of adults aged 85 or older declined from 18% to 15.5%. The overall mortality rate in Rhode Island improved from 4.8% in 2016 to 4.4%. The economic situation seems to have worsened, however, even before the profound impacts of the COVID-19 pandemic. The percentage of adults aged 65+ with income below the poverty line increased from 8.6% to 9.5%; the percentage of adults aged 60+ who received food benefits increased from 11.9% to 15%. The percentage of adults aged 65+ working in the past year climbed from 16.3% to 21.9%. The Elder Index Measure of Economic Security (a measure of the income that older adults need to meet basic needs) shows that the annual cost of living increased since our last report (see Table 1).

**Table 1. Changes in Annual Cost of Living Between 2016 and 2020**

Cost of Living Categories for 2020	2016	2020	Change From 2020 to 2016
Single, homeowner without mortgage, good health	\$22,188	\$23,484	+\$1,296
Single, renter, good health	\$23,544	\$25,560	+\$2,016
Couple, homeowner without mortgage, good health	\$32,252	\$33,984	+\$1,732
Couple, renter, good health	\$33,708	\$36,060	+\$2,252

Source: Elder Index Measure of Economic Security

## The Population of Adults Aged 60+ Has Increased

**23%** of the state's population (up from 20%)

### 60+ POPULATION IN RHODE ISLAND

2016	2020
<b>217,000</b>	<b>243,523</b>

### Older Population Is Getting Younger

#### AGE 65-74 POPULATION INCREASED

2013	2018
<b>50%</b>	<b>56%</b>

#### AGED 85+ POPULATION DECREASED

2013	2018
<b>18%</b>	<b>15.5%</b>

#### MORTALITY RATE IN RHODE ISLAND

2016	2020
<b>4.8%</b>	<b>4.4%</b>



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](#)

# New Indicators Offer More Complete Picture

The *Community Profiles* now include 197 indicators, including more than 70 additional measures since the 2016 report. The new indicators increase our understanding of the following aspects of community health.

## Population Characteristics

Added the median age of females and males, the percentage of the 85+ population who are female and expanded the education measure by reporting the percentage of people in a community with a graduate or professional degree. We continue to report: the total population, the population 60+ as a percentage of total population, the total population 60+, the population 65+ as percentage of total population, the total population 65+, the total population 65+ that is 65-74/75-84/85+, the race and ethnicity of the 65+ population, the marital status of the population 65+, the education of the population 65+, the percentage of the 65+ population that speaks only English at home, the percentage 60+ who are LGBT, and the age-sex adjusted mortality rate.

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

## Wellness

New measures report the percentage of the 60+ population getting recommended levels of sleep and meeting guidelines from the Centers for Disease Control and Prevention (CDC) for physical activity (muscle-strengthening and aerobic physical activity). We continue to report the percentage of people age 60 and older getting any physical activity, with fair or poor health status, and the percentage with 15 or more physically unhealthy days in the last month.

Primary data source: The Behavioral Risk Factor Surveillance System (2012–2017).

## Falls

A new indicator reports the percentage of those aged 60 and older who fell in the last year. We continue to report 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 (2012–2017) and CMS Master Beneficiary Summary File ABCD/Other (2016–2017).

## Prevention

The percentage of those aged 60 and older tested for HIV are now in the community profiles. We continue to report the percentage of 60+ with a physical exam in the last year, flu shot, pneumonia vaccine, shingles vaccine, women with a mammogram in the last two years, with colorectal cancer screening, and who met CDC preventive health screening goals.

Primary data source: The Behavioral Risk Factor Surveillance System (2012–2017).

## Nutrition and Diet

New measures note how many people have poor supermarket access, were stressed about buying food in the last month, and who were diagnosed with obesity. We continue to report the percentage of 60+ who ate 5+ servings of fruits and vegetables per day, were obese, and obtained cholesterol screening. We also continue to report the percentage of people 65+ clinically diagnosed as obese and with high cholesterol.

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

## Oral Health

The percentage of those aged 60 and older with dental insurance and access to dental care was added. We continue to report the percentage of people 60+ with an annual dental exam, with the loss of 6+ teeth, and access to dentists (per 100,000 all ages).

Primary data source: The Behavioral Risk Factor Surveillance System (2012–2017).

## Chronic Disease

Indicators now include prevalence rates for: autism spectrum disorder, endometrial cancer, epilepsy, fibromyalgia, chronic pain and fatigue, HIV/AIDS, leukemias and lymphomas, liver disease, migraine and other chronic headache, peripheral vascular disease, pressure ulcer, and traumatic brain injury. We continue to report indicators of: Alzheimer’s disease or related dementias, anemia, arthritis, asthma, atrial fibrillation, benign prostatic hyperplasia, breast cancer, cataract, chronic kidney disease, COPD, colon cancer, congestive heart failure, diabetes, glaucoma, heart attack, hypothyroidism, ischemic heart disease, lung cancer, osteoporosis, prostate cancer, stroke, multiple chronic conditions (4 or more out of 15), and zero chronic conditions.

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

## Behavioral Health

Added data on deaths related to opioids, and prevalence rates of opioid use disorder, substance use disorder, marijuana use, and e-cigarette use. We continue to report indicators of excessive drinking, tobacco use disorder, and current smokers.

Primary data sources: The Behavioral Risk Factor Surveillance System (2012–2017), CMS Master Beneficiary Summary File ABCD/Other (2016–2017), and CDC Wonder website (2016–2020).

## Mental Health

New indicators of mental health include: emotional support; life satisfaction; and prevalence rates of anxiety disorder, bipolar disorder, personality disorder,

post-traumatic stress disorder (PTSD), and schizophrenia/other psychotic disorders. We continue to report depression and the percentage with 15 or more poor mental health days in the last month.

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

## Disability

Rates of clinically diagnosed deafness or hearing impairment, blindness or visual impairment, or mobility impairment are now reported. We continue to report self-reported hearing difficulty, vision difficulty, cognition difficulty, ambulatory difficulty, self-care difficulty, and independent living difficulty.

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

## Caregiving

This is a new section of the community profile. The report contains new indicators: Alzheimer’s disease support groups, memory cafes, caregiving in the last month, grandparents raising grandchildren, and grandparents who live with grandchildren.

Primary data sources: The Behavioral Risk Factor Surveillance System (2012–2017), [memorycaresdirectory.com](http://memorycaresdirectory.com) (2020), the Alzheimer’s Association (May 2018), the U.S. Census Bureau American Community Survey (2014–2018).

## Access to Care

To take a broader look at access to care, the report includes the numbers of community health centers, adult day health centers, and hospice agencies. We continue to report the percentage dually eligible for Medicare and Medicaid, Medicare managed care enrollees, the percentage with a regular doctor, the percentage who did not see a doctor due to cost, and the number of primary care providers/hospitals/nursing homes within five miles.

Primary data sources: R.I. Health Center Association (2020), R.I. Department of Health, [Medicare.gov](http://Medicare.gov), and The CMS Master Beneficiary Summary File ABCD/Other (2016–2017).

## Service Utilization

To better understand end-of-life care we have added: indicators for hospice use, hospice use as a percentage of decedents (people who have died), median hospice days per user, and median hospice payment per hospice user. We continue to report the following health services indicators: the number of physician visits per year, emergency room visits (per 1000 persons 65+ annually), Part D prescription refills, home health visits, durable medical equipment claims, inpatient hospital stays (per 1000 persons 65+ annually), inpatient hospital readmissions (as percentage of admissions), skilled nursing facility stays (per 1000 persons 65+ annually), skilled nursing home Medicare beds per 1000 persons 65+, and the percentage of 65+ getting Medicaid long term services and supports.

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

## Community

New indicators measure community use of, or access to, key health-related services including: senior centers, universities and colleges, public libraries, YMCAs, broadband internet service. We continue to report: air pollution, age-friendly efforts, voter participation, attitudes toward local service organizations, capacity to make a difference, volunteerism, and attending community events.

Primary data sources: The Behavioral Risk Factor Surveillance System (2012–2017), AARP (2020), New England Commission of Higher Education (2020), Institute of Museum and Library Services (2017), and the Federal Communications Commission (FCC) (2018).

## Safety and Crime

New indicators report death by suicide, firearm fatalities, and homicides. We continue to report property and violent crime.

Primary data sources: U.S. Department of Justice, Federal Bureau of Investigation (FBI) (2017–2018) and County Health Rankings (2016–2020).

## Transportation

New measures include: motor vehicle ownership, seatbelt use, and rates of arrest for driving while intoxicated in the last month. We continue to report fatal crashes.

Primary data sources: the U.S. Census Bureau American Community Survey (2014–2018) and the Behavioral Risk Factor Surveillance System (2012–2017).

## Housing

New indicators describing people's living situation include: average household size (all ages), median house value, percentage of those stressed about paying mortgage/rent in the last month, percentage of renters spending more than 35% of their income on housing, percentage of home owners spending more than 35% of their income on housing, assisted living sites, and percentage of vacant homes in the community. We continue to report homeownership, homeowners with a mortgage, migration, assisted living facilities, and vacant homes.

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

## Economic Status

Two new economic indicators: median household income, and the percentage of 65+ households with annual income above \$100,000. We continue to report the percentage receiving food benefits, employed, income below the poverty line, and the annual income of households.

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

## Cost of Living

We continue to report the Elder Index, which is a measure of the income older adults need to live independently.

Primary data source: [elderindex.org](http://elderindex.org), by the Center for Social and Demographic Research on Aging at the University of Massachusetts Boston (2019).

# Communities with Rates Better or Worse Than the State Average

Understanding how communities compare to state averages helps us identify what communities are doing well and consider what could be done to help communities that fall below the 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 accurate, local data focused exclusively on older people is the foundation on which further progress can be made to create truly age-friendly communities in Rhode Island.

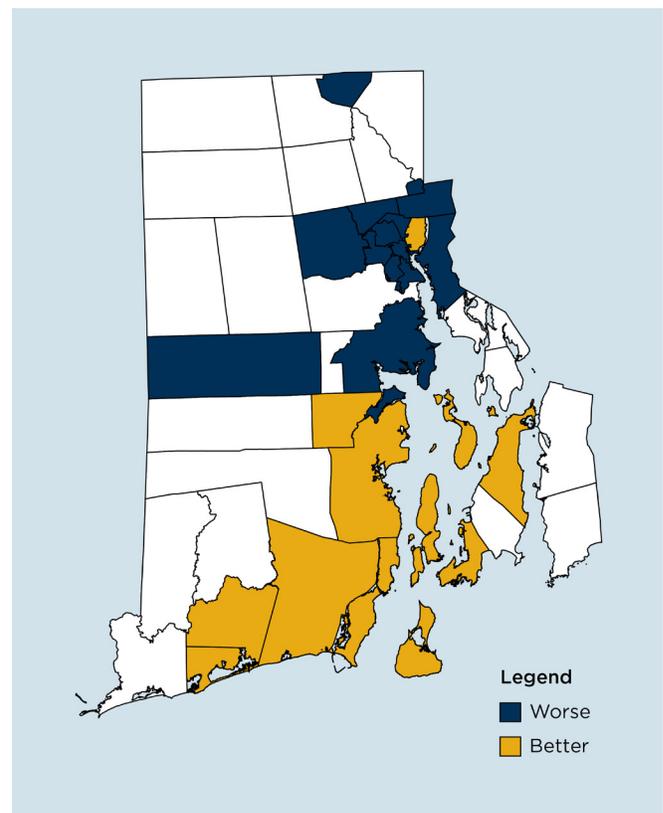
For most indicators, the reported community and state values are estimates calculated with sample data. Thus, some differences between state and community rates may be due to chance associated with population sampling. The terms “better” or “worse” highlight differences between the community and state 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 wide range of community stakeholders we believe using the terms “better” and “worse” is the simplest way to communicate what the rates mean. The first step to addressing health disparities is to be aware of them.

Map 1 identifies communities with the most rates better or worse than the state average. Highlighted in blue are communities with the most health indicators that are **better** than the state average: Charlestown, East Greenwich, Jamestown,

Narragansett, New Shoreham, Newport, North Kingstown, Providence NE, Portsmouth, and South Kingstown. Highlighted in orange are communities with the most rates **worse** than the state average: Central Falls, Coventry, East Providence, Johnston, North Providence, Pawtucket, Providence Other, Warwick, and Woonsocket.

**Map 1. Communities with Most Rates Better or Worse Than State Average**



Another way to explore health disparities is to examine variations in rates for selected indicators across communities (see Table 2). For example, the prevalence of Alzheimer’s disease and related dementias (ADRD) was highest in Central Falls (20.1%) while Jamestown had the lowest rate

(6.9%). Thus, resources to support people with memory impairment and their caregivers should be readily available in Central Falls and other communities with high ADRD rates.

On the [website](#), you can access 18 interactive maps or download a pdf map to view each of the indicator rates across Rhode Island. These data can help stakeholders identify where resources and support are needed. For example, Providence Northeast had the highest rate of depression (38.6%) and New

Shoreham had the lowest (23.7%). 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 2 clearly illustrate something we see in every state: That where someone lives has implications for their health.

**Table 2. Best and Worst Rates on Selected Indicators**

	Best Rates	Worst Rates
Alzheimer’s disease and related dementias	6.9% Jamestown	20.1% Central Falls
Any physical activity	78.6% East Greenwich and North Kingstown	60.3% Pawtucket and Woonsocket
Depression	23.7% New Shoreham	38.6% Providence NE
Diabetes	17.7% Jamestown	48.5% Central Falls
Flu shot in past year	64.1% East Greenwich and North Kingstown	57.2% Scituate, Glocester, Foster, Burrillville
Getting recommended sleep	73.6% East Greenwich and North Kingstown	49.5% Providence Other
High life satisfaction	97.3% Charlestown, Narragansett, New Shoreham, South Kingstown	91.8% Woonsocket
Hypertension	61.3% Jamestown	83.3% Johnston
Ischemic heart disease	30.4% Jamestown	52.2% Woonsocket
Stroke	6.0% Foster	13.7% North Smithfield
4+ chronic conditions	45.7% New Shoreham	70.6% Woonsocket
No chronic conditions	10.9% Jamestown	4.8% Westerly

# Changes in Healthy Aging Since the 2016 Rhode Island Healthy Aging Data Report

**Statewide changes:** An increase in the number of people with multiple comorbidities and a decline in those with no chronic conditions, suggest that morbidity (the condition of being diseased) increased over the past four years. The percentage of people age 60 and older who identify as LGBT increased. In addition, more people are enrolling in Medicare Advantage (Medicare’s managed care plan), and fewer are dually eligible for Medicare and Medicaid.

**The good news: statewide rates for several chronic disease indicators and for some service utilization measures improved significantly.** Rates improved for: anemia, colorectal cancer, congestive heart failure, diabetes, ischemic heart disease, prescription refills, and durable medical equipment claims.

There were increased rates of physician office visits, physical exams, and vaccinations for shingles and pneumonia. The percentage of those with tooth loss declined.

**The bad news: more chronic disease measures and indicators of medical service utilization got worse than got better.** Rates worsened for: arthritis, asthma, benign prostatic hyperplasia, breast cancer, cataracts, chronic kidney disease, depression, glaucoma, heart attack, high cholesterol, hypothyroidism, having 4+ chronic conditions, and number of hospital stays. The percentage of people reporting no chronic conditions declined as did the percentage of those eating 5+ servings of fruits and vegetables each day.

**Table 3. Statewide Indicators with Significant Changes Between 2020 and 2016**

Improved	2016	2020	Change From 2016 to 2020
% 65+ with pneumonia vaccine	73.8%	79.6%	5.8%
% 60+ with shingles vaccine	30.3%	35.3%	5.0%
% 60+ with physical exam	91.9%	93.1%	1.2%
% 60+ with colorectal cancer	3.2%	2.8%	-0.4%
% 65+ with diabetes	35.7%	35.0%	-0.7%
% 65+ with anemia	52.2%	51.3%	-0.9%
% 65+ with congestive heart failure	24.8%	22.7%	-2.1%
% 60+ with loss of 6+ teeth	32.4%	30.1%	-2.3%
% 65+ with ischemic heart disease	45.9%	42.9%	-2.9%

Worsened	2016	2020	Change From 2016 to 2020
% 65+ with chronic kidney disease	23.3%	31.5%	8.1%
% 65+ with osteoarthritis/rheumatoid arthritis	52.0%	57.2%	5.2%
% 65+ with depression	30.0%	33.4%	3.4%
% 65+ with benign prostatic hyperplasia (men)	40.3%	43.0%	2.7%
% 65+ with hypothyroidism	21.1%	23.0%	1.8%
% 65+ with high cholesterol	78.0%	79.6%	1.6%
% 65+ with glaucoma	26.6%	27.7%	1.2%
% 65+ with 4+ (out of 15) chronic conditions	63.9%	65.1%	1.2%
% 65+ with asthma	14.0%	15.1%	1.1%
% 65+ with cataract	67.9%	68.6%	0.7%
% 65+ ever had a heart attack	5.4%	6.1%	0.6%
% 65+ with breast cancer (women)	10.7%	11.3%	0.6%
% 65+ with no chronic conditions	8.4%	6.7%	-1.7%
% 60+ eating 5+ servings of fruit or vegetables per day	23.0%	18.1%	-4.9%
Changed (non-specific)	2016	2020	Change From 2016 to 2020
% 60+ Who are LGBT	2.0%	2.7%	0.7%
% Dually eligible for Medicare and Medicaid	14.6%	13.8%	-0.8%
Inpatient hospital stays/1000 persons 65+ years per year	284.1	295.2	11.1
Physician visits per year	8.0	8.4	0.4
Part D monthly prescription fills per person per year	2.0	1.7	-0.3
Durable medical equipment claims per year	54.2	54.2	-1.6

Values in this table are rounded. See [Technical Report](#) for full documentation.

## Community-Level Improvement Varied

**Communities with improved health indicators were:** Newport, North Providence, and Providence Other.

**Communities with worsening indicators included:** Cranston, Cumberland, East Providence, Johnston, Lincoln, Pawtucket, Scituate, and Warwick.

**Community level changes:** We determined which indicator rates had the most widespread change.

Community rates for arthritis increased in more than half (25) of Rhode Island communities. Perhaps reflecting the stress of the times or greater awareness and declining stigma, community rates for depression increased in 16 communities. Thirteen communities saw a drop in the number of the healthiest older adults — those reporting no chronic conditions. Ischemic heart disease rates increased in 12 communities.

# COVID-19 in Rhode Island

2020 has been a year unlike any in recent history due, in part, to the COVID-19 pandemic. This infectious disease has caused widespread illness, death, and economic havoc. In Rhode Island, as elsewhere, the prevalence of COVID-19 varies by community.

Map 2 illustrates the distribution of COVID-19 cases (all ages), with Providence bearing the heaviest burden (as of 7/31/2020).

Since the emergence of COVID-19, researchers have worked to understand this new disease, to identify risks for poor outcomes, and to find better treatments and vaccines. The Centers for Disease Control and Prevention (CDC), in a summary of

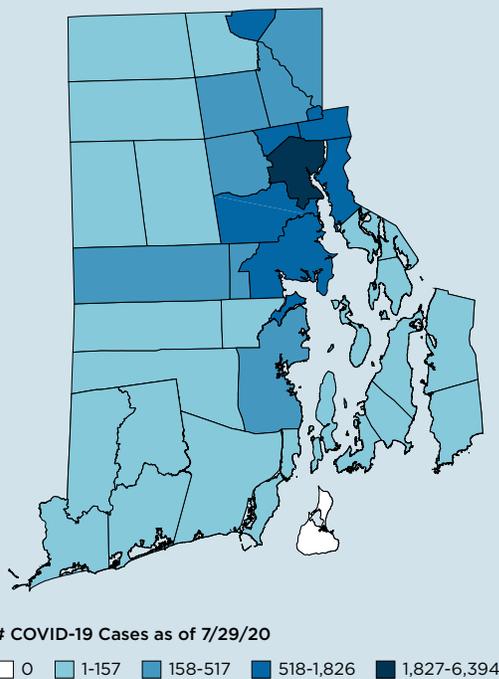
recent research, identified a number of chronic conditions (chronic obstructive pulmonary disease [COPD], diabetes, heart disease, kidney disease, and obesity) that appear to increase the risk of severe or fatal outcomes related to COVID-19.

## Comorbidities

Map 3 shows communities in Rhode Island with high rates of the comorbidities just mentioned.

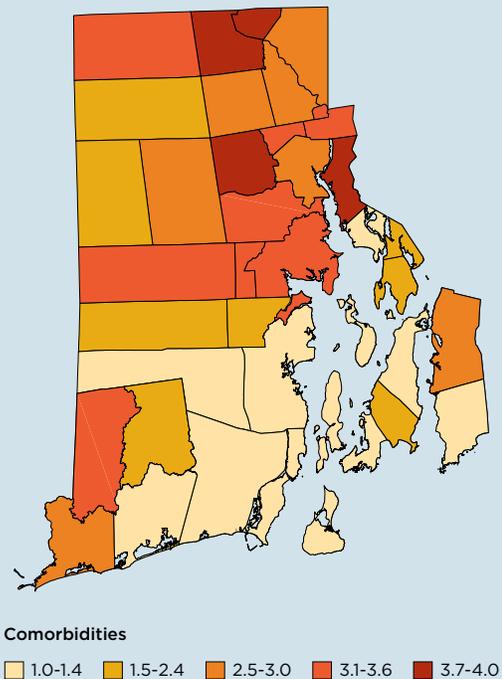
Communities with the highest incidence of comorbidities should be especially vigilant about implementing public health safeguards to prevent COVID-19 outbreaks.

**Map 2. COVID-19 Cases in Rhode Island**



Source: Rhode Island Department of Health  
[health.ri.gov/diseases/ncov2019](https://health.ri.gov/diseases/ncov2019)

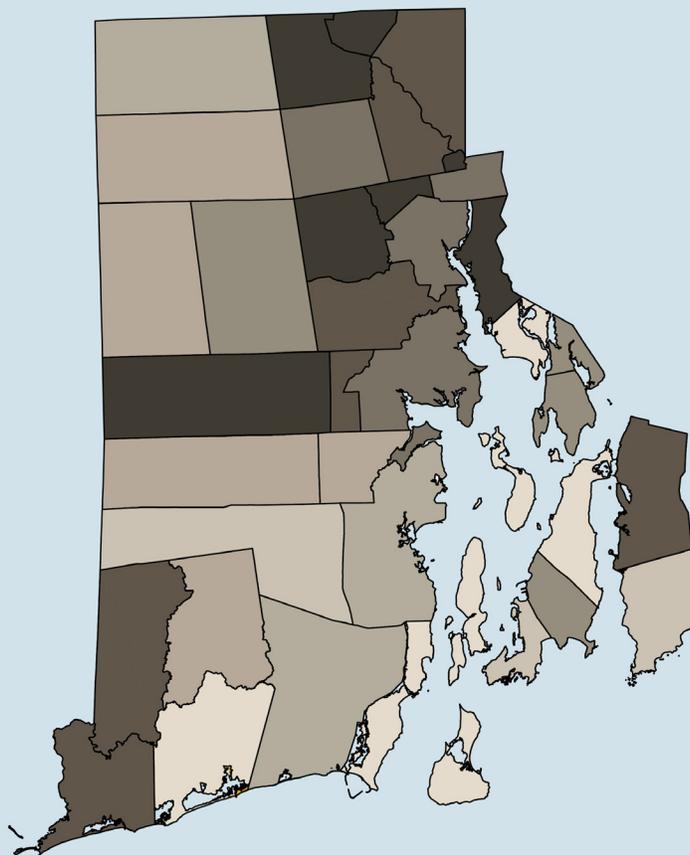
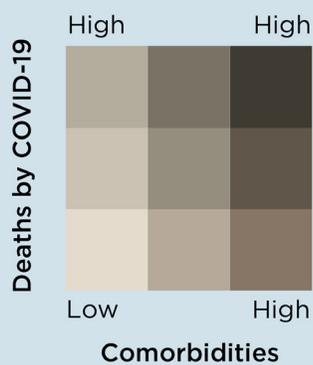
**Map 3. Community Burden of High-Risk Comorbidities in Age 65+ (COPD, Diabetes, Obesity, Heart Disease, Chronic Kidney Disease)**



Source: Rhode Island Department of Health  
[health.ri.gov/diseases/ncov2019](https://health.ri.gov/diseases/ncov2019)

#### Map 4. Community Burden of High-Risk Comorbidities in Age 65+ and Deaths Due to COVID-19 as of 7/29/2020

Source: Rhode Island Department of Health  
[health.ri.gov/diseases/ncov2019](https://health.ri.gov/diseases/ncov2019)



Map 4 shows communities ranking high on both comorbidity scores and rates of death by COVID-19. As expected, communities with higher rates of

COPD, diabetes, heart disease, kidney disease, and obesity are also communities with more deaths due to COVID-19.

# Race and Health Equity in Rhode Island

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 has fueled further protests and led to widespread efforts to acknowledge the role race plays in every aspect of life, including health and healthy aging. This makes the information on racial disparities in the *2020 Rhode Island Healthy Aging Data Report* particularly relevant and timely.

## Statewide Racial/Ethnic Disparities in Medicare Indicators

The 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 the distribution of health outcomes, and the policies and interventions that affect those factors.

Building on our extensive analyses of population health/healthy aging in New England, we have distilled the data on community rates across the region. The analyses revealed three unique dimensions of population healthy aging: serious and complex chronic disease, indolent conditions, and physical and mental disability. We use these dimensions as an organizing framework for examining racial/ethnic disparities in prevalence rates for 56 chronic disease and Medicare service utilization indicators.

Our analyses show racial/ethnic disparities are quite common among older people in Rhode Island. There were disparities in 52 health indicators. The only indicators without statistically significant differences were heart attack, liver disease, PTSD, and stroke. The nature of these disparities differ depending upon the dimension of population health considered.

## Serious and Complex Chronic Disease Indicators

The serious, complex chronic disease dimension of health includes indicators on cardiovascular and metabolic disease, mortality, and the use of expensive medical treatments.

### In the Rhode Island Population 65+ the Race/Ethnicity Breakdown is:

(Range Low to High)

WHITE

**92%**

(Providence **68%**–Little Compton **100%**)

HISPANIC/LATINX

**4.9%**

(Foster **0%**–Central Falls **29.63%**)

OTHER RACE(S)

**3.3%**

(Bristol **0%**–Central Falls **15.87%**)

AFRICAN AMERICAN/BLACK

**3.2%**

(West Greenwich **0%**–Providence **14.62%**)

ASIAN

**1.6%**

(Burrillville **0%**–Hopkinton **4.66%**)

There were racial/ethnic disparities in **52** health indicators.

In general, Black adults fared worse than white adults, Hispanic adults, and Asian adults for 25 indicators. Black adults have the highest rates of chronic kidney disease and tobacco use disorders among all racial/ethnic groups, while white adults have the lowest rates of diabetes and persons with none of 14 major chronic conditions. Asian adults have the lowest prevalence rates on 11 indicators: asthma, congestive heart failure, COPD, durable medical equipment claims, 4+ chronic conditions, emergency room visits, hypertension, ischemic heart disease, obesity, Part D prescription fills, and peripheral vascular disease. Communities with the lowest rates tend to have older populations with more education and higher incomes. There were no significant racial/ethnic disparities for only three of 28 indicators: heart attack, liver disease, and stroke.

Relative to white adults, Black adults have higher rates for seven indicators: asthma, diabetes, emergency room visits, hypertension, obesity, Part D refills, and tobacco use, and lower rates on three indicators: endometrial cancer, high cholesterol, and zero chronic conditions.

Relative to white adults, Hispanic adults have higher rates of chronic kidney disease, diabetes, Part D fills, and zero chronic conditions, and lower rates on 11 indicators: anemia, colon cancer, COPD, fibromyalgia, ischemic heart disease, lung cancer, mortality, pressure ulcer, stays in skilled nursing facilities, and tobacco use disorders.

Relative to white adults, Asian Medicare beneficiaries had lower rates on 21 of 28 indicators classified as serious and complex chronic disease. The only two exceptions are having no chronic conditions and diabetes.

### **Indolent chronic disease**

This dimension of population health includes indicators of indolent diseases (i.e., those causing little or no pain) or chronic disorders that tend to progress slowly. Most can be managed with medication and regular healthcare visits. The diagnosis of these diseases is often associated

with good access to medical care. Older residents in communities with the highest scores tend to have more education and higher incomes. Higher prevalence rates may be due, in part, to better diagnosis of those diseases in communities with good access to care. The racial disparities among the 15 indicators classified as indolent chronic disease differed from those found for the other two dimensions of population health.

White adults fared worse than other racial/ethnic groups with high rates of arthritis, atrial fibrillation, cataracts, deafness, hip fracture, and hypothyroidism. Black adults had the highest rate of prostate cancer and the lowest rate of osteoporosis among racial/ethnic groups. Asian adults generally fared best on indicators of indolent chronic disease, with the lowest rates of arthritis, physician visits, and prostate cancer, and generally low rates on other indicators.

### **Physical and psychological disability**

This dimension of population health includes assessments related to vision, cognition, ambulation, self-care, and impairments in independent living. It also encompasses Alzheimer's disease and behavioral health conditions such as alcohol use disorder, bipolar disorder, depression, personality disorders, and schizophrenia. A mix of racial disparities are found for these indicators. Black adults have the highest rates of substance use disorders and glaucoma among all race/ethnic groups. White adults have the highest rates of anxiety and personality disorders, and Hispanic adults have the highest rate of depression. Similar to the other dimensions of population health, Asian adults fared best among racial/ethnic groups, particularly on indicators of mental health—they had the lowest rates of bipolar disorder, depression, personality disorders, and schizophrenia.

# Gender Differences in Healthy Aging

While aging is a universal human experience, men and women historically have had different aging-related opportunities, expected roles, and experiences with health care. Understanding 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 demographic, health, and medical service use for older men and women. The data in Table 4 confirm men and women experience health and aging differently.

**Table 4A. Indicators With Significant Difference by Gender Among Older R.I. Adults – Women**

Women Have Higher Rates Than Men	Female	Male	Difference Between Female and Male
% 85 years or older	18.9%	10.9%	8.0%
population 60 years or older as % of total population	25.0%	21.0%	3.9%
population 65 years or older as % of total population	18.3%	14.5%	3.8%
% 60+ with 5+ servings of fruit or vegetables per day	21.3%	14.4%	6.9%
% 60+ who fell within last year	29.4%	22.9%	6.5%
% 60+ who always drive or ride wearing a seatbelt	94%	89%	5%
% 60+ who were injured in a fall within last year	12.4%	7.9%	4.5%
% 60+ stressed about buying food in last month	15.1%	10.8%	4.3%
% 60+ with a regular doctor	97.1%	96.2%	0.9%
% 65+ with osteoporosis	30.4%	4.4%	26.0%
% 65+ population who are widowed	35.3%	11.2%	24.1%
% 65+ with hypothyroidism	29.9%	12.5%	17.4%
% 65+ with anxiety disorder	36.3%	21.2%	15.1%
% 65+ with depression	38.9%	25.1%	13.9%
% 65+ with osteoarthritis or rheumatoid arthritis	61.2%	49.7%	11.5%
% 65+ population with high school or some college	57.1%	47.2%	9.9%

<b>Women Have Higher Rates Than Men</b>	<b>Female</b>	<b>Male</b>	<b>Difference Between Female and Male</b>
% 65+ with cataract	71.6%	62.5%	<b>9.1%</b>
% 65+ with fibromyalgia, chronic pain and fatigue	28.4%	21.5%	<b>7.0%</b>
% 65+ with asthma	17.9%	11.2%	<b>6.7%</b>
% 65+ with self-reported ambulatory difficulty	23.6%	17.6%	<b>5.9%</b>
% 65+ with self-reported independent living difficulty	16.7%	11.2%	<b>5.6%</b>
% 65+ with migraine and other chronic headache	8.6%	3.0%	<b>5.6%</b>
% 65+ with glaucoma	28.9%	24.7%	<b>4.2%</b>
% 65+ population who are divorced/separated	16.9%	14.0%	<b>2.9%</b>
% 65+ had hip fracture	4.3%	1.9%	<b>2.4%</b>
% 65+ with Alzheimer's disease or related dementias	13.6%	12.1%	<b>1.6%</b>
% 65+ with self-reported self-care difficulty	8.6%	7.0%	<b>1.6%</b>
% 65+ dually eligible for Medicare and Medicaid	16.7%	10.0%	<b>6.8%</b>
% 65+ Medicare managed care enrollees	46.2%	40.6%	<b>5.6%</b>
% 65+ with income below the poverty line in last year	11%	7%	<b>4%</b>
% 65+ receiving Medicaid long term services and supports	5.5%	2.5%	<b>3.0%</b>
# skilled nursing facility stays/1000 persons 65+ years annually	101.6	94.8	<b>6.8</b>
# Part D monthly prescription refills per person annually	52.7	51.4	<b>1.3</b>
% 65+ hospice users as % of decedents	56.7%	48.5%	<b>8.2%</b>
median hospice days per hospice user (65+, deceased)	12	10	<b>2</b>
median payment (Medicare + other) per hospice user	\$4,097.22	\$3,427.63	<b>\$669.59</b>

**Table 4B. Indicators With Significant Difference by Gender Among Older R.I. Adults — Men**

<b>Men Have Higher Rates Than Women</b>	<b>Male</b>	<b>Female</b>	<b>Difference Between Male and Female</b>
% 65-74 years	60.6%	51.8%	<b>8.7%</b>
% 60+ met CDC guidelines for aerobic physical activity	59.0%	50.7%	<b>8.4%</b>
% 60+ met all CDC preventive health screening goals	44.2%	36.2%	<b>8.0%</b>
% 60+ met CDC guidelines for muscle-strengthening activity	28.3%	22.8%	<b>5.5%</b>
% 60+ doing any physical activity within last month	73.9%	68.9%	<b>5.0%</b>
% 60+ with HIV test	18.4%	13.7%	<b>4.8%</b>
% 60+ with colorectal cancer screening	80.6%	76.2%	<b>4.3%</b>
% 60+ who used internet in last month	73.9%	70.5%	<b>3.4%</b>
% 60+ with dental insurance	58.2%	54.9%	<b>3.3%</b>
% 60+ with fair or poor health status	21.2%	18.3%	<b>2.9%</b>
% 60+ excessive drinking	10.6%	8.2%	<b>2.3%</b>
% 65+ with ischemic heart disease	49.1%	36.0%	<b>13.1%</b>
% 65+ with chronic kidney disease	35.6%	27.0%	<b>8.6%</b>
% 65+ with diabetes	38.2%	31.9%	<b>6.3%</b>
% 65+ with atrial fibrillation	18.5%	12.3%	<b>6.2%</b>
% 65+ with congestive heart failure	24.0%	19.7%	<b>4.3%</b>
% 65+ with self-reported hearing difficulty	16.3%	12.1%	<b>4.2%</b>
% 65+ with substance use disorder	9.1%	5.2%	<b>3.8%</b>
% 65+ ever had a heart attack	7.3%	4.7%	<b>2.7%</b>
% 65+ with tobacco use disorder	12.2%	9.7%	<b>2.5%</b>
% 65+ with hypertension	79.2%	76.9%	<b>2.3%</b>

<b>Men Have Higher Rates Than Women</b>	<b>Male</b>	<b>Female</b>	<b>Difference Between Male and Female</b>
% 65+ with 0 chronic conditions	8.2%	5.9%	<b>2.3%</b>
% 65+ with stroke	12.6%	11.3%	<b>1.3%</b>
% 65+ population who are veterans of military service	43.1%	1.0%	<b>42.2%</b>
% 65+ employed in last year	28.5%	16.9%	<b>11.6%</b>
% 65+ population with college degree	17.9%	11.4%	<b>6.5%</b>
% 65+ population with graduate or professional degree	16.8%	11.7%	<b>5.0%</b>
# inpatient hospital stays/1000 persons 65+ years annually	310.2	269.6	<b>40.6</b>
# emergency room visits/1000 persons 65+ years annually	641.6	605.2	<b>36.4</b>
% Medicare inpatient hospital readmissions	18.8%	16.3%	<b>2.5%</b>
age-sex adjusted 1-year mortality rate	5.0%	3.9%	<b>1.1%</b>

# Comparing New England States in Healthy Aging

The health of older residents varies in New England states and is driven by differences in population density, access to health care, socioeconomic factors, 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 5, Rhode Island has rates that are better and worse than its neighbors. We have

highlighted in **bold** rates that are significantly higher (blue shading) or lower (gold shading). We note Rhode Island had the lowest, or there was no difference between R.I. and another state with the lowest rate, for: autism, fatigue, traumatic brain injury, opioid use disorder, and tobacco use disorder. Rhode Island’s innovative efforts to address opioid or tobacco use could be instructive for neighboring states.

**Table 5. Comparing Selected Disease Indicators Among New England States**

Indicators	RI	CT	MA	NH	ME	VT
HIV/AIDS	0.1%	0.2%	0.2%	0.1%	0.1%	0.1%
traumatic brain injury	<b>1.0%</b>	1.3%	1.5%	1.1%	1.5%	1.0%
opioid use disorder	<b>1.9%</b>	2.2%	2.4%	2.2%	2.3%	2.0%
hip fracture	3.4%	3.7%	3.5%	3.1%	3.3%	3.2%
ever had a heart attack	5.8%	4.5%	4.7%	4.5%	5.9%	5.1%
age-sex adjusted 1-year mortality rate	4.2%	4.0%	4.0%	4.2%	4.3%	4.1%
substance use disorder	7.0%	6.8%	7.7%	6.5%	7.4%	6.4%
0 chronic conditions	7.0%	7.2%	7.2%	10.2%	11.5%	11.1%
tobacco use disorder	<b>10.8%</b>	10.1%	11.2%	11.0%	13.4%	10.9%
stroke	11.9%	11.9%	11.8%	10.5%	10.9%	9.9%
Alzheimer’s disease or related dementias	13.1%	14.4%	14.0%	11.7%	11.4%	10.0%
asthma	<b>14.9%</b>	14.1%	13.5%	11.2%	12.2%	11.1%

Indicators	RI	CT	MA	NH	ME	VT
atrial fibrillation	15.0%	16.1%	15.8%	14.4%	14.9%	13.8%
congestive heart failure	21.6%	22.6%	21.5%	17.0%	19.4%	15.8%
COPD	<b>22.9%</b>	21.0%	21.0%	19.9%	23.7%	18.5%
fibromyalgia, chronic pain and fatigue	25.4%	26.6%	27.7%	25.2%	28.3%	25.6%
obesity	<b>29.3%</b>	22.5%	24.1%	21.0%	23.4%	19.8%
depression	32.9%	30.3%	33.1%	29.8%	34.6%	31.2%
diabetes	<b>34.7%</b>	33.8%	30.8%	27.5%	28.7%	25.1%
ischemic heart disease	<b>41.8%</b>	40.7%	39.0%	33.4%	36.4%	33.7%
4+ (out of 15) chronic conditions	<b>63.8%</b>	61.8%	60.9%	54.4%	57.1%	51.0%
cataract	<b>67.5%</b>	64.8%	65.7%	61.7%	63.9%	61.9%
hypertension	<b>78.0%</b>	76.2%	75.2%	69.3%	70.0%	66.4%
high cholesterol	<b>79.1%</b>	77.0%	74.9%	71.9%	71.1%	64.3%

**Table 6. Comparing Health Service Utilization Indicators Among New England States**

Indicators	RI	CT	MA	NH	ME	VT
dually eligible for Medicare and Medicaid	13.8%	22.1%	16.4%	7.1%	19.5%	14.0%
Medicare managed care enrollees	43.8%	29.9%	25.3%	11.7%	32.3%	10.2%
# physician visits per year	8.4	8.6	7.9	6.3	5.4	5.1
# emergency room visits	620.6	636.7	641.4	577.5	685.1	580.9
# Part D monthly prescription fills per person annually	52.2	50.3	52.8	49.0	49.9	47.0
# home health visits annually	3.5	4.1	3.9	2.5	2.2	2.4

Indicators	RI	CT	MA	NH	ME	VT
# durable medical equipment claims annually	1.7	1.9	1.7	1.8	2.0	1.7
# inpatient hospital stays	286.5	273.3	289.9	238.4	235.5	219.1
% Medicare inpatient hospital readmissions	17.4%	17.2%	18.2%	16.1%	15.5%	15.1%
# skilled nursing facility stays	98.8	104.7	94.7	69.9	67.4	66.1
Medicaid long term services and supports	4.2%	5.5%	4.6%	3.4%	2.6%	3.7%
hospice users	3.5%	2.7%	2.8%	2.7%	2.9%	2.4%
hospice users as % of decedents	53.0%	45.5%	44.6%	45.9%	49.0%	41.1%
median hospice days per hospice user (65+ deceased)	11	10	15	15	14	18
median payment (Medicare + other) per hospice user	\$3,870.97	\$3,741.18	\$3,918.80	\$3,818.60	\$3,547.09	\$3,944.02

# Call to Action

Rhode Island'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 have prompted new discussions about healthy aging and the kind of communities needed to support healthy aging in the state. This report is a powerful tool to inform those striving to make their communities better places for everyone to grow up and grow old together.

The path to action is clear.

## Understand

- Download your Community Profile at [Healthy AgingDataReports.org](https://HealthyAgingDataReports.org), to better understand your community's strengths and needs.
- Educate yourself and others about the indicators for your city or town.
- Compare your community to statewide averages.
- Learn about programs and resources:
  - Call The POINT at 401-462-4444.
  - Visit the Rhode Island Office of Healthy Aging at [www.oha.ri.gov](http://www.oha.ri.gov).

## Engage

- Encourage people you know and community leaders to engage in the age-friendly movement.
- Connect with Age-Friendly Rhode Island at [www.agefriendly.org](http://www.agefriendly.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 and as many different sectors as possible, such as faith-based organizations, the business community, law enforcement, and public health departments.
- More established organizations looking to collaborate with grassroots groups should be intentional in sharing resources.
- Recommend changes for healthy aging.

## Act

- 1 Get involved in local efforts to promote healthy aging.
- 2 Use data to prioritize community needs.
- 3 Collaborate with diverse partners.
- 4 Create opportunities for civic engagement and social connection.
- 5 Identify and build upon what's working.

## Advocacy

Here are a few examples of what advocates in other New England states have accomplished with their *Healthy Aging Data Reports*.

- 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.

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

- 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 data on transportation gaps.
- A state budget was increased to deliver 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.

## Collaboration

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

## Economic development

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

- A health care organization used one of the *Healthy Aging Data Reports* for market research on where to locate a memory assessment clinic.

## Education

- Students used *Healthy Aging Data Reports* in class research.
- Nonprofit organizations used *Healthy Aging Data Reports* to write more competitive grant applications.
- Elected officials used *Healthy Aging Data Reports* to better understand their communities and constituents.

## Service

- A municipal senior services department expanded a tai chi program in response to high fall rates.
- A District Attorney 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 a public education campaign.

### Resources for Age-Friendly Communities

[Age-Friendly Rhode Island](#)

[Aging in Community Plans and Progress](#)

[2023 Rhode Island State Plan on Aging](#)

### Resources and Programs for Older People

[Age-Friendly Rhode Island Virtual Community Center](#)

[The POINT](#) or call 401-462-4444

[Rhode Island Elder Info](#)

[Rhode Island Office of Healthy Aging](#)



# Thanks and Acknowledgments

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# Technical Notes

See our [Technical Report](#) for comprehensive information on data sources, measures, methodology and margin 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% or 90% 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.

## Data Sources:

- Population Characteristics: The U.S. Census Bureau (American Community Survey 2014–2018).
- Wellness, Falls, Prevention, Nutrition/Diet, Oral Health: The Behavioral Risk Factor Surveillance System (2012–2017), the USDA Food Atlas (2017), CMS (2016–2017).
- Chronic Disease: The CMS Master Beneficiary Summary File ABCD/Other (2016–2017).
- Behavioral Health, Mental Health: BRFSS (2012–2017), CMS (2016–2017), CDC Wonder website (2016–2020).
- Living with Disability: CMS (2016–2017) and ACS (2014–2018).
- Caregiving: BRFSS (2012–2017), [memorycaresdirectory.com](#) (2020), and the Alzheimer’s Assoc. (May 2018).
- Access to Care: BRFSS (2012–2017), CMS (2017), [Medicare.gov](#) (May 2020), and R.I. Health Center Association (2020), and R.I. Department of Health.
- Service Utilization: CMS (2017), and Medicare Nursing Home Compare (May 2020).
- Community: BRFSS (2012–2017), AARP (2020 update; [www.aarp.org/livable-communities/network-age-friendly-communities/info-2014/member-list.html](#)), New England Commission of Higher Education (2020), Institute of Museum and Library Services (2017), U.S. Environmental Protection Agency Air Compare (2018), R.I. YMCA (May 2020), the Federal Communications Commission (2018), and BRFSS (2012–2017).
- Safety & Crime: U.S. Department of Justice Federal Bureau of Investigation (2017–2018), the County Health Rankings (2016–2020).
- Transportation: BRFSS (2012–2017), ACS (2014–2018), and the National Highway Traffic Safety Administration (2014–2018).
- Housing & Economic: BRFSS (2012–2017), ACS (2014–2018).
- Cost of Living: [elderindex.org](#), by the Center for Social and Demographic Research on Aging at the University of Massachusetts Boston (2019).

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 41 geographic units (i.e., every populated city/town and two Providence neighborhoods). For example, the population characteristics and information from the US Census were reported for all 41 units. For other data (i.e., highly prevalent chronic diseases and health services utilization), we report for 37 geographic units. For less prevalent conditions, we report for 28 geographic units. For the BRFSS data, we report for 15 geographic units, and for the lowest prevalence conditions (e.g., HIV) we report only the state rate. 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.



How far you go in life depends on your being tender with the young, compassionate with the aged, sympathetic with the striving, and tolerant of the weak and strong. Because someday in your life you will have been all of these.”

**GEORGE WASHINGTON CARVER**

