TECHNICAL DOCUMENTATION

Overview

This report contains details about the development of the 2025 Maine Healthy Aging Data report. This includes technical definitions, data sources, years of data used, and definitions of the geographic units employed for various indicators. In addition, we describe the statistical methods used to estimate indicators derived from micro-level data. Our general approach is hierarchical reporting. We report indicators at the smallest, most local level possible (i.e., neighborhood, zip code, or individual community) when data allow, and report in larger geographic units (i.e., county) when necessary.

1. Healthy Aging Indicator Definitions

Most of the indicators are derived from secondary data sources and limited to those indicators for which data are available for geographic subareas within Maine. Table A-1 contains technical definitions for most of the indicators reported in this study, except the socio-demographic variables used to describe the population composition of communities.

2. Data Sources

Multiple data sources are used in this study. Table A-2 contains a summary of all data sources, and the specific years of data used for population composition and healthy-aging indicators. Estimates of community-level indicators of physical/mental health, chronic disease prevalence, access to care, wellness and prevention health behaviors, service utilization, and nutrition and diet were derived from two major data sources: the Medicare Master Beneficiary Summary File (2020-2021) and the Behavioral Risk Factor Surveillance System (2020-2021). Population composition measures were drawn from the Five-Year American Community Survey (2018-2022) produced by the U.S. Census Bureau. These major data sources, and other data sources used for indicators representing safety, economic, and wellness variables are described below.

<u>Medicare Master Beneficiary Summary File</u>

Medicare claims data from the Centers for Medicare and Medicaid Services (CMS) are a rich source of data for measuring chronic disease prevalence and Medicare service utilization rates for individual cities and towns. The *Master Beneficiary Summary File (MBSF)* is an annual data file constructed by the Chronic Conditions Data Warehouse that includes individual records for all persons eligible for Medicare for at least one month during a calendar year. MBSF is comprised of four data files containing different types of information:

(1) The *Master Beneficiary Summary File-A/B/D (MBSF-A/B/D)* includes standard Medicare administrative data fields (e.g., sex, race, dates of birth and death), monthly variables indicating specific months of Medicare eligibility, managed care

enrollment, and Medicaid state buy-in status, as well as geographic residence identifiers (state, county, zip code) based on each beneficiary's residence address used for Social Security Administration correspondence.

(2) The *Master Beneficiary Summary File-Chronic Conditions (MBSF-CC)* includes indicators derived from Medicare algorithms applied to diagnostic codes on individual Medicare fee-for-service provider claims for 27 prevalent chronic conditions (e.g., diabetes, stroke, depression, Alzheimer's disease or related dementia, chronic obstructive pulmonary disease, hip fracture, cancer), as well as the earliest date since 1999 that the diagnostic criteria for prevalence were first met.

(3) The *Master Beneficiary Summary File- Other Chronic or Potentially Disabling Conditions (MBSF-OC)* includes indicators derived from Medicare algorithms applied to diagnostic codes on individual Medicare fee-for-service provider claims for other chronic conditions (e.g., ADHD, Alcohol Use Disorders, Anxiety Disorders, Autism Spectrum Disorders, Bipolar Disorder, Depressive Disorders, Drug Use Disorders, Epilepsy, Fibromyalgia, Chronic Pain and Fatigue, Human Immunodeficiency Virus and/or Acquired Immunodeficiency Syndrome (HIV/AIDS), Leukemias and Lymphomas, Liver Disease, Migraine and Chronic Headache, Mobility Impairments, Obesity, Peripheral Vascular Disease, Personality Disorders, Post-Traumatic Stress Disorder, Pressure and Chronic Ulcers, Schizophrenia, Sensory - Blindness and Visual Impairment, Sensory – Deafness and Hearing Impairment, Tobacco Use, Traumatic Brain Injury), as well as the earliest date since 1999 that the diagnostic criteria for prevalence were first met.

(4) The *Master Beneficiary Summary File-Cost and Use (MBSF-CAU)* contains aggregated summaries of annual service utilization and reimbursements for various types of Medicare services (e.g., inpatient hospitalizations, physician visits, home health visits, skilled nursing facility stays, emergency room visits, hospital readmissions, and filled Part D prescriptions, hospice users).

Each beneficiary record contains an encrypted individual identifier so that information from the four data files can be merged. The four MBSF data files were obtained from CMS for all Medicare beneficiaries who were age 65 years or older on January 1st of the calendar year and had a state residence code of Maine for 2020 or 2021. The data were obtained under a formal data use agreement required for privacy protection of health information contained in research-identifiable data files.

A major strength of the MBSF data is their coverage of 100% of aged Medicare beneficiaries living in Maine. This permits the estimation of health indicators for relatively small individual towns. These rates potentially can be updated annually. Additionally, the major shortcoming of MBSF data is that they are derived from claims data. Since chronic condition prevalence is identified from diagnoses on Medicare claims, rates of chronic disease prevalence and service use can only be measured for Medicare beneficiaries who receive their care from fee-for-service providers. Managed care providers such as Medicare Advantage plans do not submit claims data to

Medicare for processing. In addition, beneficiaries whose chronic condition is undiagnosed because they do not have access to a physician will not be identified as having that chronic condition. Finally, the health indicators constructed from MBSF data are limited in scope since they are based on administrative data. Nevertheless, these data are rich with respect to geographic specificity compared to other common data sources for health indicators.

Behavioral Risk Factor Surveillance System

The Behavioral Risk Factor Surveillance System (BRFSS) is a state-based system of annual health surveys established by the Centers for Disease Control and Prevention (CDC) that collects information on health risk behaviors, preventive health practices, and health care access, primarily related to chronic disease and injury. The BRFSS provides a rich source of information about individual health behaviors such as smoking, excessive drinking, obesity, and preventive health service use, which are relevant for the development of healthy aging indicators. A core set of questions about such health behaviors are included every year. The Maine Department of Health and Human Services (DHHS) is responsible for collecting BRFSS data for Maine. The ME DHHS adds questions beyond the core CDC questions on relevant topics to support health care policy planning, to guide preventive health interventions, and to assess health status and its change over time for Maine residents.

BRFSS survey data at the county level in Maine was downloaded from the Centers for Disease Control and Prevention (CDC) *PLACES: Local Data for Better Health* file. The dataset provides county level values on 37 unique indicators for 2020 and 2021 for each county in Maine. For our analysis, the crude prevalence estimates were used. No state averages were reported in the data set; thus, all state averages are listed as NA, or not available in the 2025 ME HADR products. No personal identifying information was provided. To learn more about the methodology of the PLACES dataset, visit: https://www.cdc.gov/places/index.html

U.S. Census Bureau American Community Survey

Data on population composition were downloaded from the U.S. Census Bureau Fact Finder website (https://data.census.gov/cedsci/). All census population estimates reported in the community profiles were derived from the 5-year American Community Survey data (2018-2022). Data was downloaded for all 530 individual cities and towns, and then aggregated to 265 communities.

Other Data Sources

Although most of the indicators in this data report were obtained from the CMS Beneficiary Files, the US Census Bureau ACS, and the BRFSS, additional indicators relied on additional community and county-level data sources described below:

1. Housing

a. The number of assisted living sites per town were retrieved from (https://www.mehca.org/AF_MemberDirectory.asp?version=1). Data was downloaded June 21st, 2023.

2. Community
    a. The AirNow website of the U.S. Environmental Protection Agency provides measures air quality with the Air Quality Index (AQI) with scores ranging from 0 to 500. *AirCompare* provides county-level comparisons of the number of days in a year that AQI values are between 101 and 150 (code orange) and/or exceed 150 (code red) for specific subpopulations. For the subpopulation that includes older persons without specific health concerns, the total count of days includes code red days for any pollutant and code orange days for ozone and particulate matter. Data on annual number of unhealthy days for persons age 65 and older was obtained from (https://www3.epa.gov/aircompare/#trends). The number of unhealthy days were obtained by clicking each county on the map. Data was accessed on July 30th, 2023.
    b. The number of public universities and community colleges in a community was retrieved from the New England Commission of Higher Education. Main campuses and additional affiliated campuses were included in the count. Campuses at correctional facilities or non-public facilities were not included in the count. Data was accessed on October 5th, 2023. (https://www.neche.org/roster/).
    c. The number of public libraries, main library and branch libraries, in a community were obtained from the Maine State Library Website. Libraries connected to a school were not included in our data collection. Data was accessed on June 29th, 2023. (https://www.maine.gov/msl/libs/directories/public.shtml).
    d. A list of senior centers in Maine was obtained from our stakeholders in Maine. Data was accessed on October 12th, 2023.
    e. Voter participation rates by town for 18 years and older for the 2020 Maine Presidential election were calculated based upon the ballots cast per town and the number of registered voters per town. Data was accessed from (https://www.maine.gov/sos/cec/elec/data/index.html). Data was accessed on January 30th, 2024.
    f. County-level data for homicide rate per 100,000 people, 65+ deaths by suicide, and number of firearm fatalities from 2016 to 2020 were accessed the CDC Wonder website (https://wonder.cdc.gov/mcd.html). Mortality data are coded by each state and given to the National Center for Health Statistics through the Vital Statistics Cooperative Program. See (https://wonder.cdc.gov/wonder/help/mcd.html) for additional information.
    g. The number of Osher Lifelong Learning Institutes per town were obtained from (https://www.osherfoundation.org/olli_list.html). Data was collected on October 11th, 2023.

3. Access to Care
    a. The number of primary care providers (PCPS), hospitals, home health agencies, nursing homes, and hospice agencies per town were obtained

from the data dashboard on the Medicare website (http://www.medicare.gov/). The geographic location of each provider was obtained from the data sources listed below. The addresses of the providers were then geocoded into latitude and longitudinal points to be mapped in ArcMap 10.8. The number, or count, of providers were then aggregated to the town level in ArcMap. Primary care providers (PCPs) were obtained from the Doctors and Clinicians national downloadable file (https://data.cms.gov/provider-data/dataset/mj5m-pzi6). Primary care providers were defined as physicians with the following main specialties listed in the provider file: family practice, general practice, geriatric medicine, internal medicine. In addition, physician assistants and nurse practitioners in the above specialties were also considered as PCPs. Data on PCPs was accessed on June 20th, 2023. Number of hospitals per county was obtained from the Hospital General Information data table (https://data.cms.gov/provider-data/dataset/xubh-q36u). Data on Hospitals was accessed on June 25th, 2023. Number of home health agencies per county was obtained from the Home Health Care Agencies data table (https://data.cms.gov/provider-data/dataset/6jpm-sxkc). Data on home health agencies was accessed on July 2nd, 2023. Number of nursing homes per county was obtained from the Provider Information data table (https://data.cms.gov/provider-data/dataset/4pq5-n9py). Number of hospice agencies per county was obtained from the Hospice – Provider Data table (https://data.cms.gov/provider-data/dataset/xubh-q36u). Data was accessed on June 28th, 2023.

   b. The number of community health centers were downloaded from the "Find a Health Center Tool" from the HRSA Data Warehouse. Data was accessed on July 4th, 2023. (https://findahealthcenter.hrsa.gov/?zip=Wyoming%252C%2BUSA&radius=250&incrementalsearch=false).
   c. The number of adult day health centers was obtained from Maine.gov. Data was accessed on September 25th, 2023. (https://www.pfr.maine.gov/ALMSOnline/ALMSQuery/Welcome.aspx).

4. Cost of Living
   a. Four measures of geographic comparative cost of living are reported at the county level using the Elder Index. This index contains county estimates of the minimum income needed by older households to attain a modest standard of living in the community that reflects economic security. "The Elder Index defines economic security as the financial status where elders have sufficient income (from Social Security, pensions, retirement savings, and other sources) to cover basic and necessary living expenses" (Gerontology Institute, 2012). While Elder Index estimates are available at the county-level for 18 different types of community-resident households with a head 65 years or older defined by health status (excellent, good, poor), living situation (alone, couple), housing costs (owner with mortgage, owner without mortgage, renter), we report Elder Index estimates for four types of households in good health (single renters, single owners without

mortgages, couple renters, and couple owners without mortgages). Elder indices for 2023 were obtained for all counties from the Elder Index Database (https://elderindex.org/). Data was accessed in March 2024.

5. Transportation
    a. Data on fatality related with motor vehicle crash were downloaded from the National Highway Traffic Safety Administration (NHTSA) website (http://www.nhtsa.gov/FARS). The Fatality Analysis Reporting System (FARS) is annual data on traffic crashes resulting in at least one fatality occurring within 30 days of the crash. The FARS contains data derived from a census of fatal traffic crashes within 50 states, the District of Columbus, and Puerto Rico. We selected fatal crashes with at least one death of vehicle occupants (e.g. driver or passenger) or non-motorist (e.g. pedestrian) occurring in the state only from 2018 to 2022.
    b. The AllTransit Performance Score was obtained from the AllTransit™ website on September 15th, 2023. (https://alltransit.cnt.org/). Data was reported at the Census "place" level, and the average score of each place inside a town or city was reported.
6. Oral Health
    a. The number of dentists per 100,000 persons (all ages) at the county level were obtained from the Health Resources and Services Administration (HRSA). (https://data.hrsa.gov/topics/health-workforce/ahrf). Data was accessed on June 24th, 2023.
7. Behavioral Health
    a. County-level data for number of drug overdose deaths of all ages from 2016 to 2020 were accessed the CDC Wonder website (https://wonder.cdc.gov/mcd.html). Mortality data are coded by each state and given to the National Center for Health Statistics through the Vital Statistics Cooperative Program. See (https://wonder.cdc.gov/wonder/help/mcd.html) for additional information.
8. Caregiving
    a. The number of Alzheimer's or related dementias support groups were obtained using the Community Resource finder tool by the Alzheimer's Association and AARP. In-person, "Alzheimer's support groups" within each state searched. The number of support groups per town were assigned to each community in the state. Data was collected November 2nd, 2023. (https://www.communityresourcefinder.org/ProviderSearch/Search?ProfileDefinitionId=91&location=boston%2C+ma)

Maine GIS Data

The Maine Office of GIS maintains an array of geographic services such as data development/distribution, image processing, cartography, spatial analysis, online mapping (https://maine.maps.arcgis.com/home/index.html). The shape file of city/town boundary was downloaded from the Maine Office of GIS.

3. Geographic Area Definitions of Communities

The geographic units for Maine were defined after aggregating the 530 towns provided from the Census Bureau American Community Survey. Towns were grouped together if they were next to each other, inside the same county, and were similar socioeconomically. Grouped towns had to have at least 350 people aged 65 or older. Following this criterion, a total of 265 geographic units were defined in Maine.

Geographic Areas for Medicare MBSF Indicators

Although the Medicare MSBF contains individual records for 100% of beneficiaries who are eligible for Medicare in at least one month in a calendar year, geographic aggregation of some smaller towns in Maine was necessary. Under our CMS data use agreement prevalence rates for any chronic disease or disabling condition must be censored for any geographic area if either fewer than 11 resident beneficiaries have the condition, or all but 10 beneficiaries have the condition. While censoring is not a concern for most towns and MBSF indicators, we employed a two-part strategy to substantially reduce or eliminate the need for censoring indicators. This strategy entailed: (1) spatial aggregation of less-populated towns with adjacent towns to create more-populated geographic areas, and (2) stratification of chronic diseases and disabling conditions into high prevalence, middle prevalence, low prevalence, and lowest prevalence subgroups.

Geographic Areas for High Prevalence Conditions

We classified 37 MBSF indicators as “high prevalence” conditions where the risk of censoring was more likely to be due to sparse population in a town rather than low prevalence of the condition among all aged Medicare beneficiaries. For high prevalence MBSF indicators we employed 186 geographic areas. Most of these geographic areas were individual towns with at least 200 aged Medicare beneficiary residents satisfying sample selection requirements (described below) and where there were at least 11 beneficiaries with nearly all of the conditions classified as high prevalence. Towns with fewer than 200 such beneficiaries and/or numerous censored indicators were combined with one or more adjacent towns to form an aggregate geographic area with a combined sample size of more than 200 beneficiaries and/or at least 11 beneficiaries for nearly all indicators. Combined towns had to border each other. The aggregation of specific bordering smaller towns together was guided by the following principles:

1. It is preferable to combine a smaller town with another smaller town rather than a larger town.

2. It is preferable to combine fewer towns rather than more towns together (e.g., a two-town geographic area is preferable to a three-town geographic area).

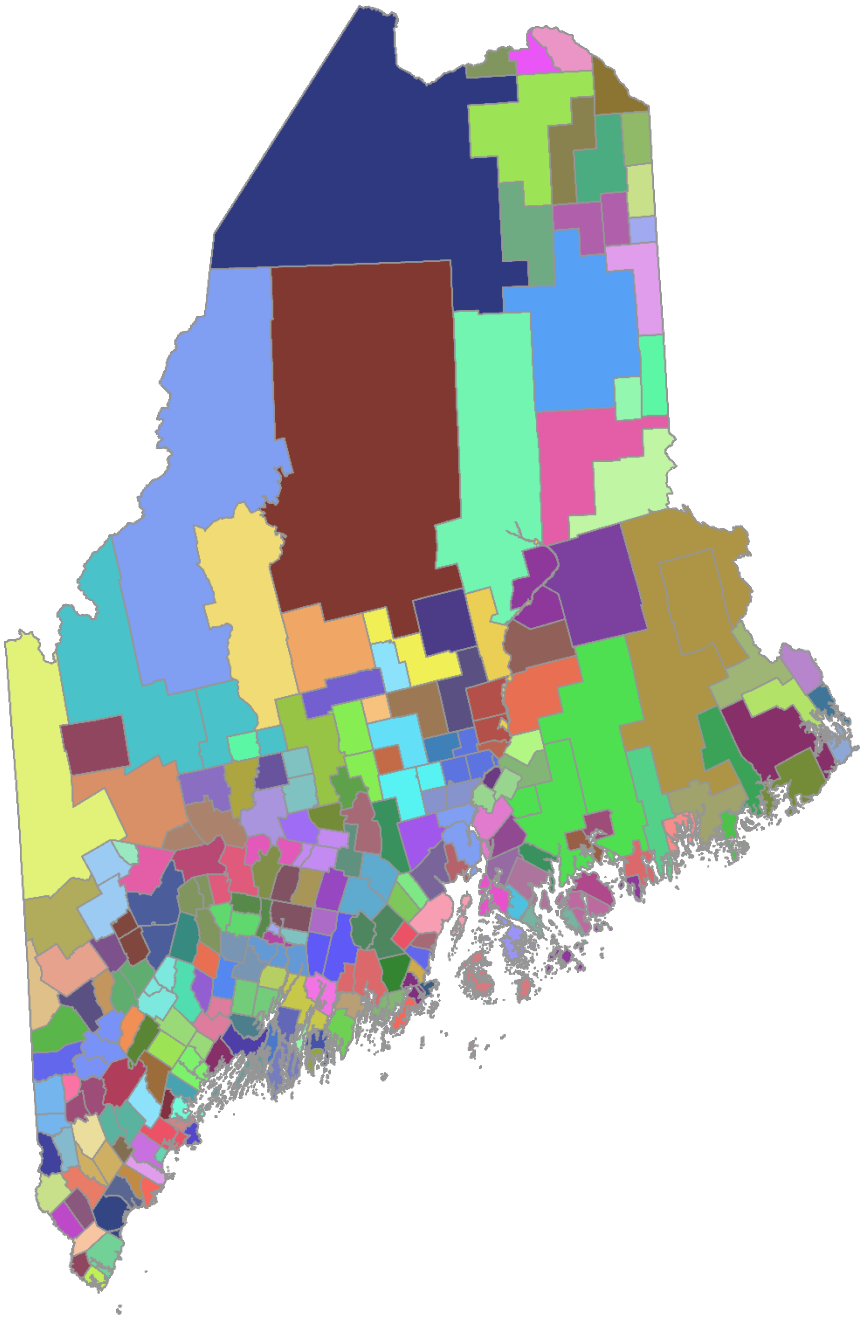
3. It is preferable to combine towns located within the same county relative to towns in different counties.

4. It is preferable to limit the number of communities with censored rates to 10 or fewer.

Using these principles as a guide, there were 186 defined geographic communities in Maine for estimating high prevalence Medicare MBSF indicators. Among these 186 communities there were 122 stand-alone individual cities or towns. There were 64 aggregated geographic areas comprised of two or more individual towns. The individual towns that were combined together to form the 64 aggregated geographic areas were: (Alfred-Lyman; Alton-Argyle-Old Town; Amherst-Central Hancock-Ellsworth-Lamoine-Mariaville-Otis-Trenton-Waltham-Aurora-East Hancock-Eastbrook-Great Pond-Northwest Hancock-Osborn-Sorrento-Sullivan-Dedham; Appleton-Union-Washington; Arrowsic-Georgetown-Phippsburg; Augusta-Sidney; Baldwin-Naples-Sebago; Bangor-Glenburn-Hermon-Veazie; Benton-Waterville-Winslow; Biddeford-Blaine-Bridgewater-Mars Hill-Monticello-Westfield; Bowdoin-Bowdoinham-Perkins; Bradford-Hudson-Lagrange-Bridgton; Buckfield-Hebron-Canton-Hartford-Sumner; Freedom-Montville-Liberty-Palermo; Buxton-Hollis; Cambridge-Ripley-St. Albans-Detroit-Palmyra; Burnham-Unity Town-Camden; Carmel-Dixmont-Etna-Plymouth; Castle Hill-Chapman-Mapleton-Presque Isle; Carrabassett Valley-Coplin-East Central Franklin-Eustis-Kingfield-North Franklin-Wyman-Central Somerset-Highland-New Portland-Pleasant Ridge-Solon; Codyville-Grand-Lake Stream-Passamaquoddy Indian Township Reservation-Princeton-Talmadge-Topsfield-Waite-Danforth-North Washington-Vanceboro; Chelsea-Cornvile-Skowhegan; Chester-Lincoln Town-Woodville-Cranberry Isles-Frenchboro-Marshall Island-Swans Island-Winter Harbor; Cumberland-North Yarmouth-Yarmouth; Clifton-Eddington-Cushing-Friendship; Clinton-Cutler-Machiasport-Whiting; Dresden-Wiscasset-Edgecomb; Holden-Orrington; Crystal-Island Falls-Penobscot Indian Island Reservation-Sherman-South Aroostook-Dixfield-Peru; Durham-Lisbon; Eliot-Rangeley; Farmingdale-Randolph; Farmington-New Sharon-Wilton; Fayette-Mount Vernon-Vienna; Dennistown-Jackman-Moose River-Northwest Somerset-Seboomook Lake-Frankfort-Prospect-Stockton Springs-Winterport; Dennysville-East Central Washington-East Machias-Freeport; Gardiner-Pittston-West Gardiner; Dover-Foxcroft-Gorham; Eagle Lake-Square Lake-Winterville-Gray; East Central Penobscot-Greenbush-Milford-Greene; Greenwood-Milton-Woodstock-Rumford; Easton-Hallowell; Hampden-Newburgh; Hibberts gore-Jefferson-Somerville-Whitefield; Embden-Hodgdon-Houlton-Littleton; Fort Fairfield-Lebanon; Fort Kent-Leeds-Livermore-Livermore Falls; Franklin-Limerick-Limington; Litchfield-Monmouth; Manchester-Readfield; Mechanic Falls-Minot-Poland; Mount Desert-Southwest Harbor; New Gloucester-Pownal; Gouldsboro-Nobleboro-Waldoboro; Ogunquit-Wells; Otisfield-Oxford; Paris-West Paris; Hiram-Porter-Rockport; Hope-Scarborough; South Thomaston-Thomaston; Kennebunkport-St. George; Wayne-Winthrop; Linneus-New Limerick-Westport Island; Newfield-Parsonsfield). The same common value for MBSF indicators is reported in the community profiles of towns that were combined to form these aggregated geographic areas. Below, the 186 grouped communities are shown in Figure 1.

Due to low sample sizes, geographic units had to be grouped together when reporting selected high prevalence conditions. Acton, Bradley, Cornish, Searsmont, Sedgwick, and Windham were reported at the “low prevalence” geographic units for % 65+ with heart attack, Acton and Searsmont reported at the “low prevalence” geographic units for % 65+ with stroke, Allagash was reported at the low prevalence units for zero chronic conditions, and Cornish and Sedgwick were reported at the low prevalence units for % 65+ with Alzheimer’s disease or related dementias, and age-sex adjusted one-year mortality.

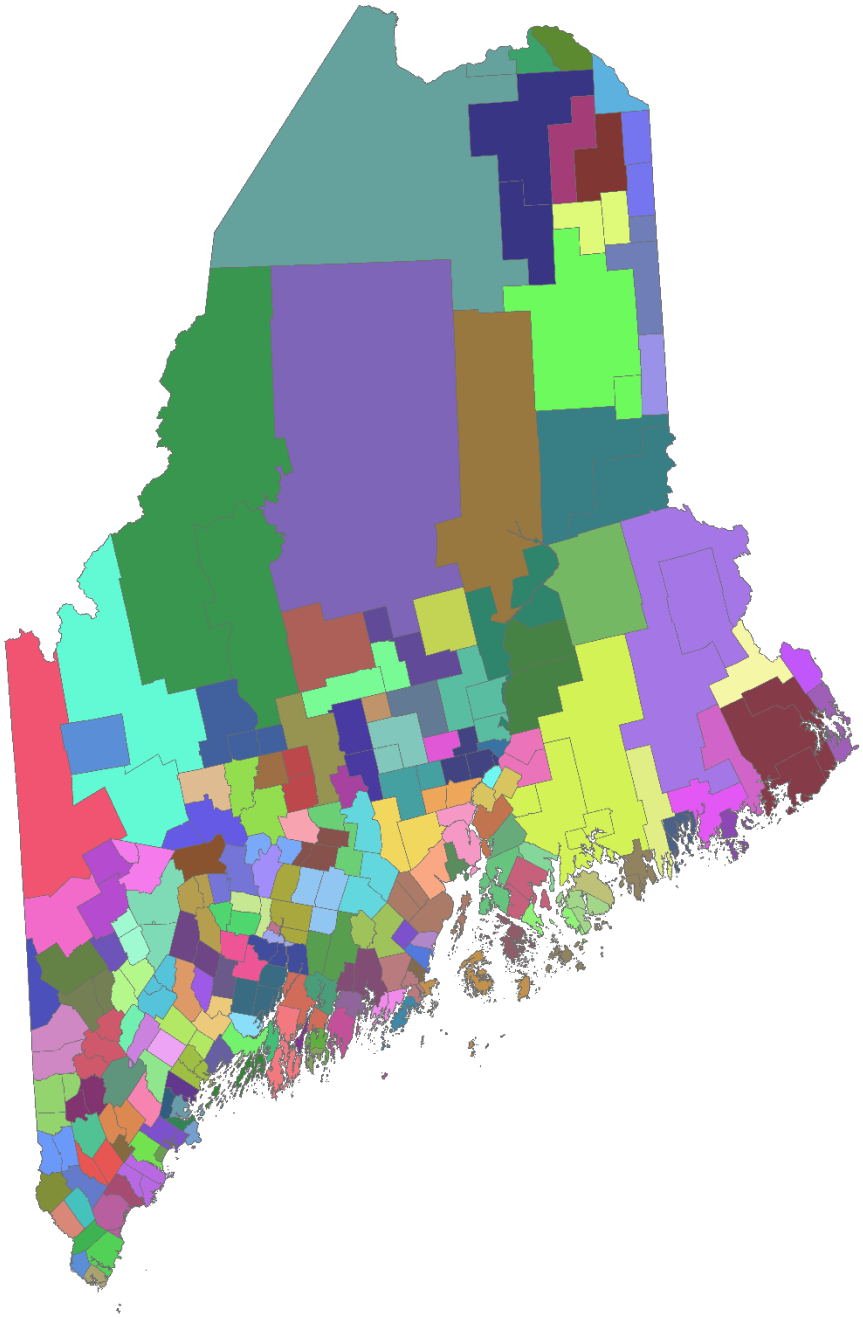
Figure 1. *Geographic Areas for High Prevalence Conditions*



Geographic Areas for Middle Prevalence Conditions

We classified 6 MBSF indicators as “middle prevalence” conditions because of the relatively high frequency of censoring required for reporting these indicators for the 186 high prevalence geographic areas described above. For middle prevalence conditions (breast cancer, liver disease, migraine/chronic headache, pressure ulcer or chronic ulcer, prostate cancer, and substance use disorder) we defined 164 larger geographic areas (see Figure 2) by selective spatial aggregation of adjacent high prevalence geographic areas. Decisions about which high prevalence areas to combine were based on the same goals which guided the spatial aggregation of individual towns into high prevalence geographic areas, namely, relatively homogeneous geographic areas with respect to population socioeconomic status and race/ethnicity. Due to the sparse population of selected middle prevalence conditions, breast cancer in (Central Aroostook, Dyer Brook, Hammond, Hersey, Ludlow, Merrill, Moro, Oakfield, Smyrna and Caribou, Connor, Washburn, Woodland was reported by the lowest prevalence area. Prostate cancer in Carroll, Drew, Kingman, Lakeville, Lee, Mattawamkeag, Prentiss, Springfield, Twombly Ridge, Webster, Whitney, Winn and Casco) was reported by the lowest prevalence areas. Migraine headaches in (Casco and Chesterville, Jay) was reported by the lowest prevalence areas. Substance disorder in (Casco and Central Aroostook, Dyer Brook, Hammond, Hersey, Ludlow, Merrill, Moro, Oakfield, Smyrna and Caribou, Connor, Washburn, Woodland) was also reported by the lowest prevalence areas. The resulting middle prevalence geographic areas are generally relatively homogeneous. However, in a few instances it was not possible to combine areas with very similar populations without violating the requirement that the combined communities be adjacent to each other, and some heterogeneity exists. The same rate is reported in community profiles of all towns or neighborhoods grouped together for low prevalence geographic areas.

Figure 2. *Geographic Areas for Middle Prevalence Conditions*

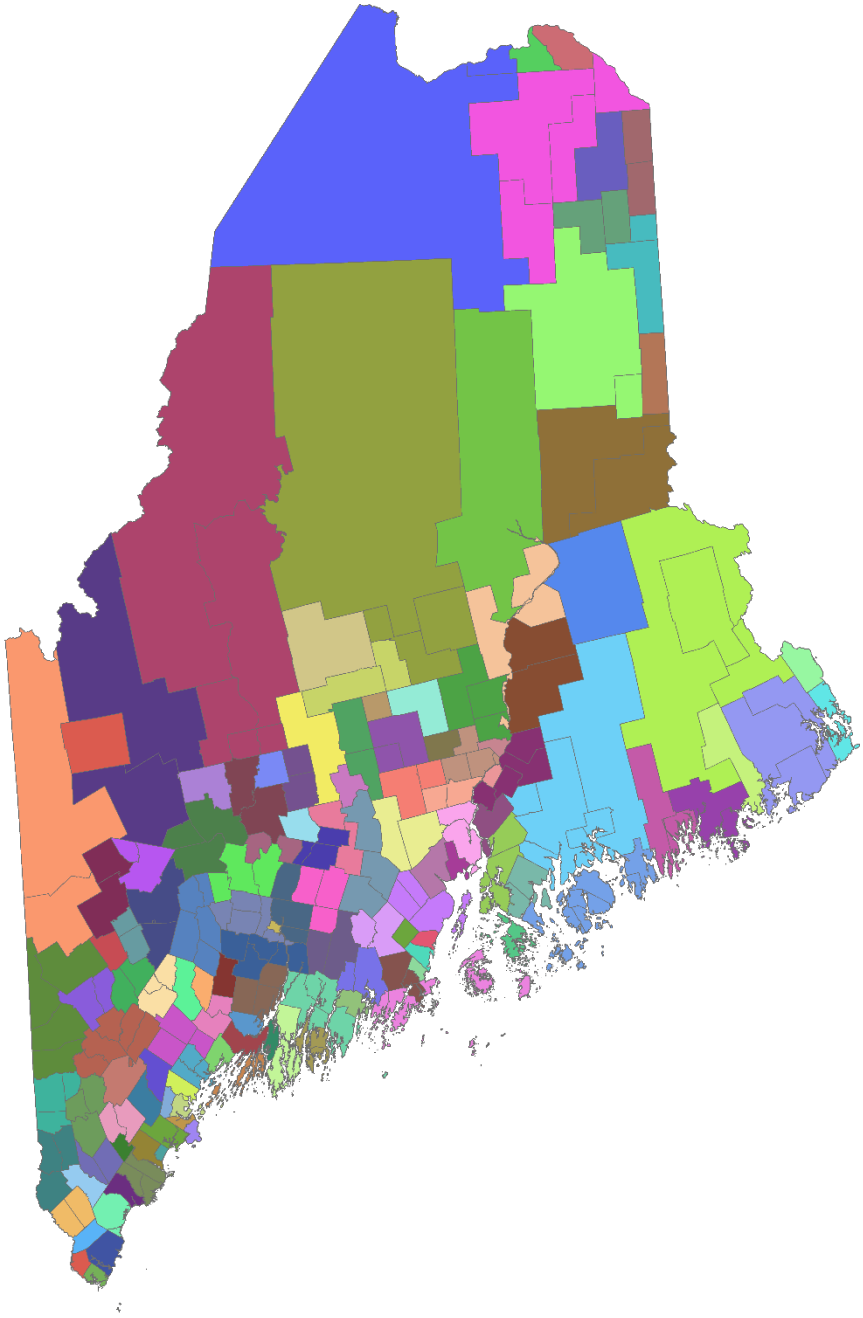


Geographic Areas for Low Prevalence Conditions

We classified 4 MBSF indicators as “low prevalence” conditions because of the relatively high frequency of censoring required for reporting these indicators for the 164 low prevalence geographic areas described above. For low prevalence conditions (hip fracture, Medicaid long-term services and supports, hospice user, and decedents of hospice user) we defined 130 larger geographic areas (see Figure 3) by selective

spatial aggregation of adjacent high prevalence geographic areas. Decisions about which high prevalence areas to combine were based on the same goals which guided the spatial aggregation of individual towns into high prevalence geographic areas, namely, relatively homogeneous geographic areas with respect to population socioeconomic status and race/ethnicity. The resulting low prevalence geographic areas are generally relatively homogeneous. However, in a few instances it was not possible to combine areas with very similar populations without violating the requirement that the combined communities be adjacent to each other, and some heterogeneity exists. The same rate is reported in community profiles of all towns or neighborhoods grouped together for low prevalence geographic areas.

Figure 3. *Geographic Areas for Low Prevalence Conditions*

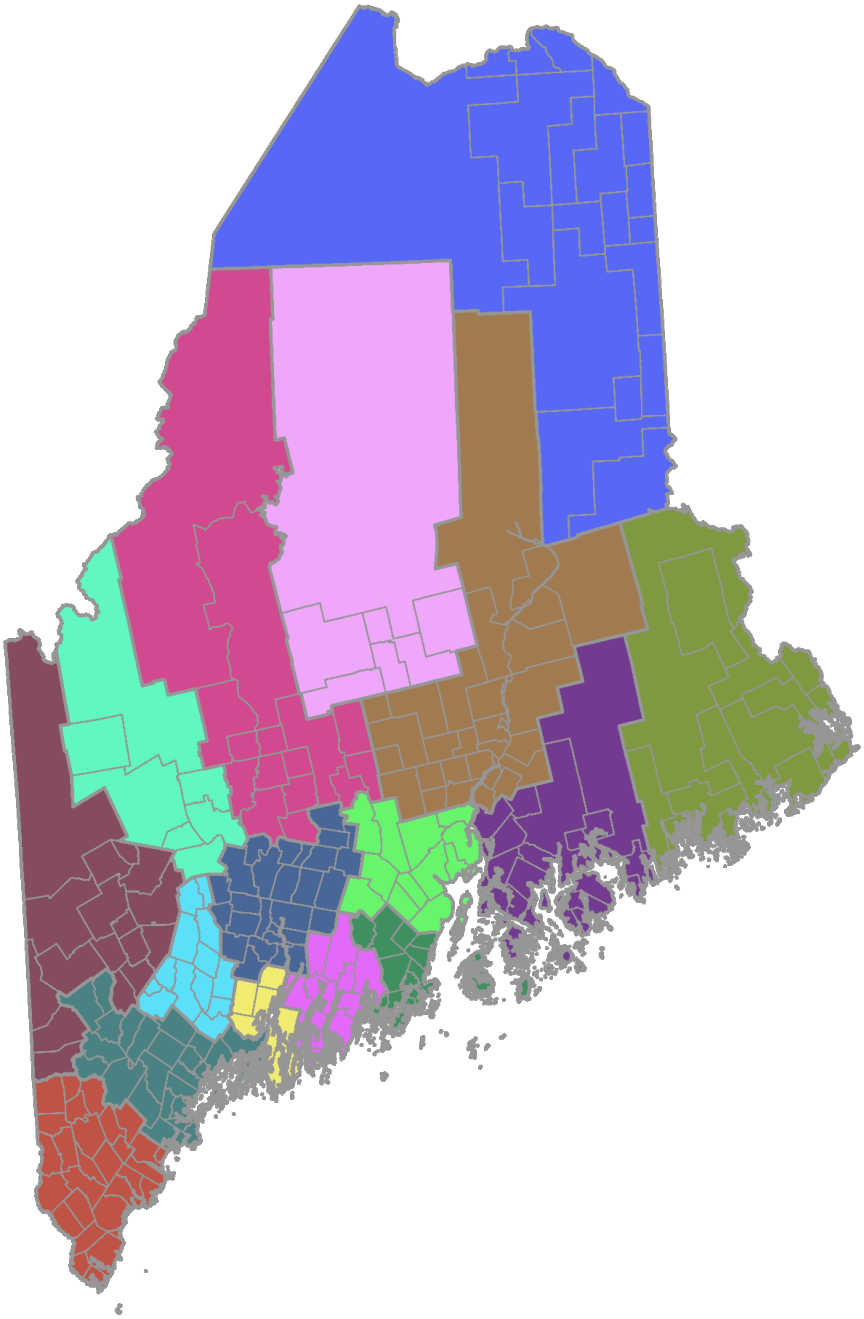


Geographic Areas for Lowest Prevalence Conditions

Six conditions (colorectal cancer, endometrial cancer, HIV/AIDS, lung cancer, post-traumatic stress disorder (PTSD), & schizophrenia and other psychotic disorders) that we report have so low prevalence rates among aged Medicare beneficiaries that rates would be censored for most of the 164 low prevalence geographic areas described above. To reduce the frequency of censoring for these lowest prevalence conditions, we combined low prevalence geographic areas together to form 16 geographic areas which

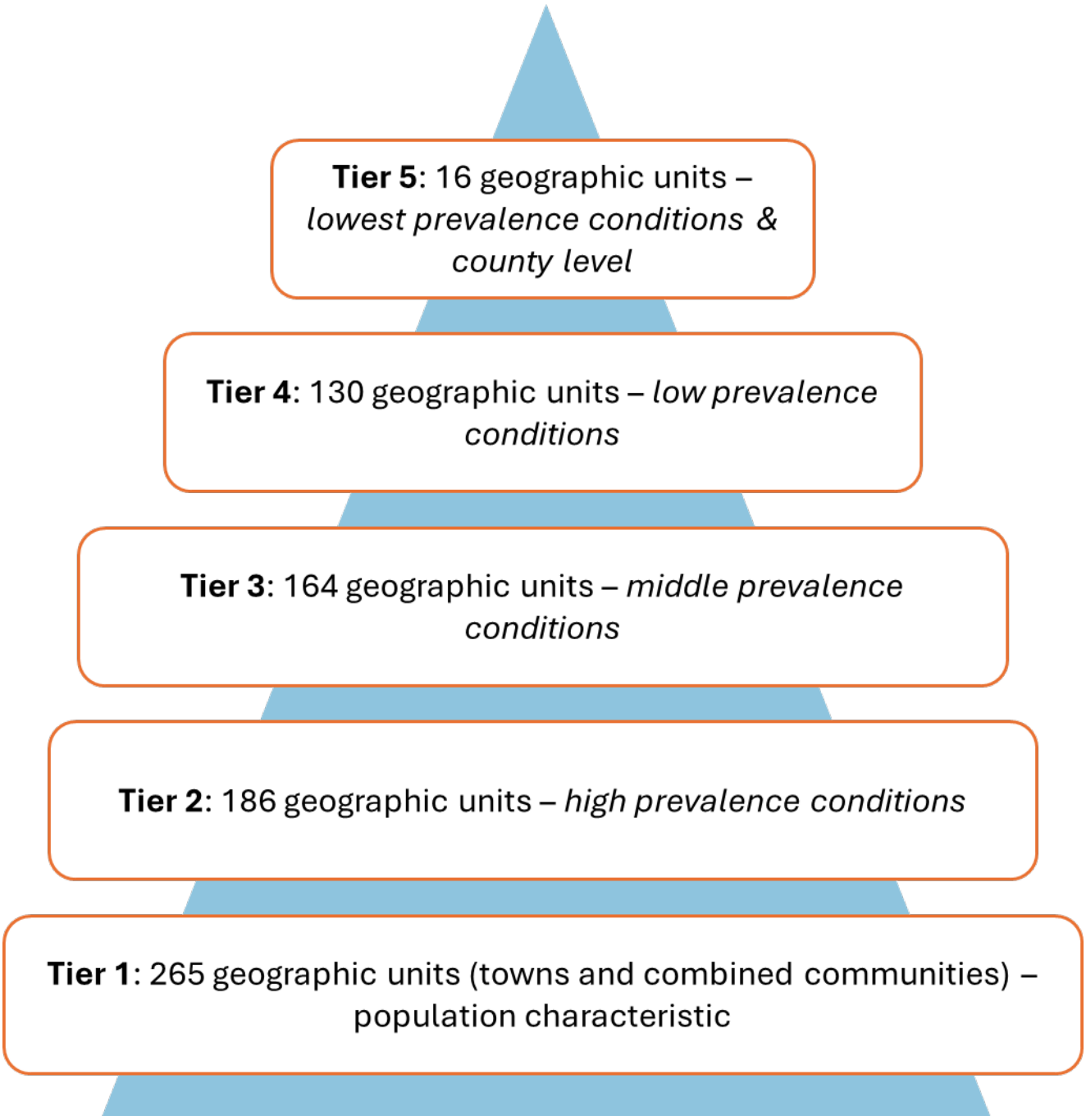
is the county level in ME for these lowest prevalence conditions (see Figure 4). Spatial aggregation decisions were guided by the same goals discussed above with adjacency strictly required. All individual cities and towns that are grouped together for the lowest prevalence conditions have the same value reported in community profiles.

Figure 4. *Geographic Areas for Lowest Prevalence Conditions*



Geographic Level of Indicators

The Healthy Aging Data Reports aim to report indicators at the community level, but some indicators are reported at the county level. Below, the indicators are organized by the geographic unit they are reported.



Town level

Population characteristics

The age distribution, race/ethnicity, marital status, and education level of the population are reported at the town level. In addition, the % of the 65+ population who speak only English at home and are veterans of military service are also reported at the town level.

Housing

The following housing indicators were reported at the town level: the % of 65+ population living alone, renter households who spend >35% of income on housing, and households who spend >35% of income on housing. Average household size of all ages, median house value, number of assisted living sites, and % of grandparents who live with grandchildren.

Cost of Living

All cost of living indicators are reported at the town level: the cost of living for a single homeowner without a mortgage in good health, the cost of living for a single renter in good health, the cost of living for a couple who are homeowners without a mortgage in good health, and the cost of living for a couple who are renters and in good health.

Economic

All economic indicators are reported at the town level: the % 60+ receiving food stamps in past year; % of 65+ employed last year, with income below the poverty level in last year, median annual income, and % of 65+ households with annual income below $20,000; between $20,000-$49,999, between $50,000-$99,999, and above $100,000.

Community

The following community indicators are reported at the town level: the age-sex adjusted 1-year mortality rate, AARP Age-Friendly Communities, senior centers, public universities and community colleges, public libraries, OLLIs; and voter participation rates in 2020 election among 18+. Moreso, the percentage of households with smartphones and access to broadband, and without a computer and access to internet are reported at the town level.

Transportation

The following transportation indicators were reported at the town level: the % of 65+ who own a motor vehicle, and the AllTransit Score.

Falls

The % of 65+ who had a hip fracture was reported at the town level.

Nutrition/Diet

The following nutrition or diet indicators were reported at the town level: % 65+ with high cholesterol.

Chronic Disease

All chronic disease indicators are reported at the town level. The HADR reports the % of 65+ with the following chronic diseases: Alzheimer's disease or related dementias, anemia, asthma, atrial fibrillation, benign prostatic hyperplasia in men, breast cancer in women, cataract, chronic kidney disease, chronic obstructive pulmonary disease, colon cancer, congestive heart failure, diabetes, endometrial cancer in women, fibromyalgia, chronic pain and fatigue; glaucoma, heart attack, HIV/AIDS, hypertension, ischemic heart disease, liver disease, lung cancer, migraine and other chronic headache, osteoarthritis or rheumatoid arthritis, osteoporosis, peripheral vascular disease, pressure ulcer or chronic ulcer, prostate cancer in men, stroke, 4+ (out of 15) chronic conditions, and no chronic conditions.

Behavioral Health

The following behavioral health indicators are reported at the town level: % 65+ with substance, and tobacco use disorders.

Mental Health

The following mental health indicators are reported at the town level: the % of 65+ with depression, anxiety, post-traumatic stress disorder, and schizophrenia and other psychotic disorders.

Living with disability

All living with disability indicators are reported at the town level: the % of 65+ with self-reported hearing, vision, cognition, ambulatory, self-care, and independent living difficulty.

Caregiving

The following caregiving indicators are reported at the town level: the number of Alzheimer's caregiver and % of grandparents raising grandchildren.

Access to Care

The following access to care indicators are reported at the town level: the % of 65+ dually eligible for Medicare and Medicaid, and Medicare managed care enrollees, and the number of primary care providers, hospitals, skilled nursing homes, home health agencies, community health centers, adult day centers, and hospice agencies.

Service Utilization

All service utilization indicators were reported at the town level: the number of physician visits per year, emergency room visits per 1,000 persons 65+ annually, part D monthly prescription fills per person annually, home health visits per year, durable medical equipment claims annually, inpatient hospital stays per 1000 persons 65+ years annually, skilled nursing facility stays per 1000 persons 65+ years annually, and skilled nursing home Medicare beds stays per 1000 persons 65+ years annually. The % of 65+ getting Medicaid long term services and supports, hospice users, hospice users as % of decedents, and the % of Medicare inpatient hospital readmissions.

County level

Wellness

All wellness indicators were reported at the county level: the percentage 18+ with less than 7 hours of sleep, fair or poor self-reported health status, 14+ physically unhealthy days, and without leisure time physical activity.

Community

The following community indicators are reported at the county level: the annual number of unhealthy days due to air pollution and all safety and crime indicators are reported at the county level: the homicide rate per 100,000 persons, the number of firearm fatalities, and number of 65+ deaths by suicide.

Transportation

The number of fatal crashes involving adults age 60+ per county were reported at the county level.

Prevention

All prevention indicators were reported at the county level: the percentage 18+ with a physical exam or check up in past year, percentage of 65+ men and women up to date on preventive services, percentage aged 50-74 women with mammogram, and percentage aged 50-74 women with fecal occult blood test, sigmoidoscopy, or colonoscopy.

Nutrition

The percentage of 18+ who are obese and reported getting a cholesterol screening were reported at the county level.

Oral Health

The percentage 18+ with annual dental exams and percentage 65+ with complete tooth loss were reported at the county level.

Behavioral Health

The number of drug overdose deaths of all ages, the percentage 18+ who report binge drinking and current smoking are reported at the county level.

Mental Health

The percentage 18+ reporting 14 or more days of poor mental health was reported at the county level.

Access to Care

The percentage 18 to 64 without health insurance was reported at the county level.

4. Geographic Data Sources

Geographic information is used in this report in a variety of ways, ranging from the creation of crosswalk tables between different geographic units (e.g., 5-digit zip code areas to towns) to the mapping of healthy-aging indicator estimates with GIS software. This section summarizes the sources of other geographic data used in the study.

Zip code shape file

A zip code shape file used for mapping of 5-digit zip code areas was obtained from the U.S. Census Bureau based on the 2020 Census. The shape file was downloaded from the Census Bureau website (https://www.census.gov/geographies/mapping-files/time-series/geo/tiger-line-file.2020.html#list-tab-790442341). ME zip code data was downloaded from (https://www.unitedstateszipcodes.org/). There are 488 zip codes in ME, 2024. The data file contains individual records for all valid 5-digit zip codes, the city/town, county, and state it is located in, and the latitude and longitude coordinates of the centroid of the zip code area. It also contains an indicator of whether the zip code value represents a standard geographic zip code area, a point zip code (e.g., post office box), or a unique zip code assigned to certain entities such as a university. The downloaded zip code database contained about 488 records for all types of 5-digit zip codes (standard, point, etc.) in Maine. The Census zip code shape file only contains 426 spatial 5-digit zip code areas. Zip code maps were used to check the validity of matches between zip codes and towns in BRFSS data and to make decisions about assignments of certain zip codes to individual towns. Some zip code areas are located in more than one town, and some small towns do not have their own zip code. Small towns without their own 5-digit zip code are aggregated together with a bordering town within the same 5-digit zip code. When multiple towns shared a 5-digit zip code, the entire zip code is assigned to the most populated town. Data from the zip code data

base and zip code shape file were combined using ArcGIS ArcMap V10.8 software (http://www.esri.com/).

5. Estimation Methods for Medicare MBSF indicators

Sample Selection Criteria

While the Medicare MBSF contains data on all Medicare beneficiaries with at least once month of Medicare Part A or B eligibility in a calendar year, estimates of chronic condition prevalence and service utilization rates can only be derived for beneficiaries who receive care from fee-for-service providers who submit claims to Medicare for reimbursement. Beneficiaries with prevalent chronic conditions are identified through algorithms applied to the diagnostic codes reported on Medicare claims over a defined surveillance period. Chronic condition prevalence is determined by the presence of one or several claims (depending on the condition) containing appropriate condition-specific diagnostic codes within surveillance period.[1] Most of these claims algorithms scan claims for both Medicare Part A and B covered services. Claims are not submitted to Medicare during any time interval in which an individual is not eligible for Medicare Part A and/or B and when a beneficiary is enrolled in a Medicare managed care plan that does not submit claims to Medicare for reimbursement. To reliably estimate chronic condition prevalence rates the sample population used for rate estimation should exclude beneficiaries for whom Medicare does not receive claims for services used. To retain such beneficiaries in the sample amounts to an implicit assumption that these beneficiaries used no Medicare covered services when they were not Medicare eligible or enrolled in a Medicare Advantage plan. Hence, rates of chronic condition prevalence and service utilization will generally be underestimated unless such beneficiaries are excluded from the estimation sample.

There are several analytic options for restricting the population sample and rate estimation under these circumstances. Pros and cons of several options for imposing restrictions on the estimation sample are discussed in CMS' *Technical Guidance for Calculating Medicare Population Statistics* (2018). The most extreme option is to require "full coverage" where the sample is restricted to beneficiaries with a full year of Medicare Part A and B eligibility and who are never enrolled in a Medicare managed care plan during the year. While requiring full coverage ensures that claims were submitted for all Medicare services used by beneficiaries in a calendar year, such a restriction can result in underestimates of chronic condition prevalence rates because some beneficiaries with partial- year coverage have Medicare claims indicating prevalent chronic conditions in those months that claims were submitted. Under the "partial coverage" option, beneficiaries with nearly a full-year of Medicare Parts A and B eligibility and care from fee-for-service providers are retained in the sample. CMS

[1] The diagnostic codes used in the algorithms used to flag Medicare beneficiaries are available from the Chronic Conditions Warehouse web site (https://www.ccwdata.org/web/guest/condition-categories).

(2018) note that “a common recommendation is to allow for a one month break in coverage per year of surveillance. This is an attractive option to avoid losing many cases with the condition of interest (i.e., known cases, as indicated in claims) due to the occurrence of only partial FFS coverage” (CMS, 2018).

In this study we chose to use this “partial-year coverage” option for estimating population-based chronic condition prevalence and service utilization rates. The sample selection criteria used to apply the partial coverage requirements differ depending on the length of the claims surveillance period employed for the chronic condition of interest. While a one-year claims surveillance period is used for most chronic conditions reported in the Medicare MBSF, for some conditions such as congestive heart failure and diabetes, the claims surveillance period is two years. The claims surveillance period is also two years for all conditions included in the MBSF Other Chronic or Potential Disabling Conditions data file. For Alzheimer’s disease or related dementias, the claims surveillance period is three years. With only two years of Medicare MBSF data (2020-2021) available to this study, we applied the two-year surveillance sample selection criteria for Alzheimer’s disease or related dementia.

Since Part A and B Medicare service utilization rates are based on single-year claims surveillance, the same sample selection criteria are employed for single-year surveillance chronic conditions and all Medicare service utilization rates except for Part D prescription drug utilization.

Determination of Chronic Condition Prevalence: Ever versus Current Year

For each beneficiary the MBSF contains two flag variables for each chronic condition that indicate whether or not the Medicare claims data diagnostic requirements were met for the condition. First, there is a variable noting whether there is claims data evidence of prevalence during the *current* surveillance period only. This variable reports whether or not full-year surveillance coverage and/or diagnostic requirements from claims data were met for the chronic condition. The four categories are: (1) neither claims diagnosis nor surveillance coverage requirements were met, (2) claims diagnosis requirements were met but surveillance coverage requirements were not met, (3) claims diagnosis requirements were not met but surveillance coverage requirements were met, (4) both claims diagnosis claims and surveillance coverage requirements were met. Current-year prevalence requires that claims diagnosis requirements are met. If partial FFS coverage is used to select beneficiaries meeting surveillance coverage requirements, then both (2) and (4) above are used to flag beneficiaries with claims data evidence of prevalence in the *current* year. For each beneficiary there is a second historical flag variable that contains earliest calendar year from 1999 onward that the CCW Medicare claims data diagnosis requirements for chronic condition prevalence were met.

Although chronic conditions can be managed effectively through medications, surgery, and/or diet and lifestyle changes, unlike acute illnesses they remain prevalent after onset. However, depending on the extent and type of a Medicare beneficiary’s service use in any particular calendar year, there may be no *current-year* claims data evidence

of chronic condition prevalence even when such claims data evidence exists in previous calendar years. While questions have been raised about the extent to which some prevalent chronic conditions may be missed for beneficiaries due to the brevity of the MBSF surveillance periods used to determine current-year prevalence[2], current-year chronic condition prevalence rates are commonly reported (e.g., see Chronic Conditions Warehouse 508 Files (https://www2.ccwdata.org/web/guest/interactive-data/ams-dashboard), Centers for Medicare and Medicaid Services, 2012).

In this report we have chosen to define chronic condition prevalence based on whether there was any CCW claims data algorithm evidence ever since 1999 rather than only current-year 2021 algorithm evidence. There are several reasons for this choice. First, self-reports of chronic conditions are typically based on questions asking whether a doctor *ever* told a respondent that he/she had a certain condition. The "ever-met" claims algorithm definition of prevalence is more similar to the "ever" time period used in self-reports. Second, while some studies have shown that for some conditions self-reports may result in underestimated prevalence rates (e.g., Porell & Miltiades, 2001), claims-based estimates based on finite surveillance time periods are more likely to understate than overstate prevalence rates (e.g., Gorina & Kramaroy, 2011).

Since prevalence rates based on any claims data surveillance evidence since 1999 will naturally include claims evidence from 2021, the prevalence rates reported in this study are higher than those based on current-year surveillance periods. (e.g., see tables on Chronic Conditions Warehouse website (https://www.ccwdata.org/web/guest/medicare-tables-reports). The reader should keep these differences in mind when comparing our reported prevalence rates, which are based on ever meeting the claims data requirements for prevalence since 1999, to rates reported elsewhere, which are commonly based on current surveillance period claims data requirements.

Specific Sample Selection Requirements

Even though chronic condition prevalence is determined on the basis of claims evidence prior to the current surveillance period, the beneficiaries selected to be

[2] Gorina and Kramaroy (2011) applied Chronic Conditions Warehouse (CCW) claims data algorithms to the Medicare claims of NHANES I Epidemiologic Follow-up Study respondents who were identified has having one or more of five chronic conditions (diabetes, ischemic heart disease, COPD, dementia, arthritis) *prior* to the claims surveillance time periods. Prior-period prevalence was determined from baseline and follow-up interview self-reports by respondents, records from baseline physical examinations conducted by physicians (including X-ray results for arthritis). In the case of dementia, baseline responses to the Mental Status Questionnaire and follow-up interview questions were used to determine prevalence prior to the claims surveillance time period. Among respondents identified as having the chronic condition prior to the claims surveillance period, application of the CCW claims algorithms over defined surveillance periods identified between 17% (arthritis) and 69% (diabetes) of respondent identified as having those conditions from survey information prior to the surveillance period. While Gorina and Kramaroy (2011) acknowledge that there may be errors in pre-surveillance prevalence status based on survey data (e.g., erroneous self-reports of chronic conditions) their empirical results suggest that the CCW chronic condition surveillance time periods are more likely to be too short to identify prevalence for those chronic conditions where there is a lesser need to regularly use Medicare services for management of the condition.

counted in the denominator for prevalence rate estimation had to meet current-year surveillance rate requirements to avoid substantial under-estimation of prevalence rates because of beneficiaries enrolled in Medicare managed care plans. Below we describe the specific partial-year surveillance coverage requirements employed in rate estimation.

Single-year surveillance chronic conditions and Parts A & B service utilization

We followed the partial-year coverage requirements recommended by CMS' *Technical Guidance for Calculating Medicare Population Statistics* (2018) that differed depending upon whether or not a beneficiary survived the full calendar year. It is important to retain beneficiaries who die during the year in the estimation sample to mitigate potential biases. If a beneficiary dies on the day when a heart attack occurs he/she cannot meet full-year coverage requirement unless the heart attack occurs on December 31st and would not be counted as experiencing a heart attack. The bias of not including beneficiaries who die during the calendar may be substantial given the high medical costs experienced in the last years of life for many beneficiaries.

For all single-year surveillance chronic conditions and for all service utilization rates except Part D prescription fills and hospital readmission rates, partial-year coverage for beneficiaries alive at the end of 2021 requires that:

- A beneficiary has at least 11 months of both Medicare Part A and B eligibility and at most one month of Medicare managed care enrollment in 2021.

Beneficiaries who died in 2021 are required to have full coverage (Medicare Part A and B eligibility and no Medicare managed care enrollment) in all months that they were alive in 2021. All beneficiaries are further required to have a valid 5-digit residence zip code recorded in the 20 Medicare MBSF for residence assignment to towns. There were 128,195 aged Medicare beneficiaries who met these one-year sample selection requirements.

For the readmission rate indicator, we naturally imposed an additional condition that a beneficiary must have been hospitalized at least once during 2021. There were 15,520 Medicare beneficiaries who met this additional sample selection requirement for hospital readmissions.

Two-year surveillance chronic conditions

For all other 2-year chronic conditions, partial-year coverage for beneficiaries alive at the end of the 2021 required that:

- A beneficiary has at least 22 months of both Medicare Part A and B eligibility and at most two months of Medicare managed care enrollment over the two calendar years 2020-2021.

Beneficiaries who died in 2021 are required to meet the partial-year coverage requirements in 2020 and meet full coverage requirements in the months they were alive in 2217. Beneficiaries are also required to have a valid 5-digit residence zip code recorded in the 2021 Medicare MBSF. There were 121,538 Medicare beneficiaries who met these sample selection requirements.

Since Maine residence requirements were applied to 2020 MBSF data, there are some beneficiaries with records in the 2021 MBSF who did not meet the two-year surveillance sample selection criteria because they did not live in Maine in 2020. Unfortunately, these beneficiaries had to be excluded from the two-year surveillance estimation sample. If Medicare beneficiaries who recently moved to Maine tend to have systematically better/worse health status than longer term resident beneficiaries, this difference will not be reflected in the town-level estimated prevalence and service utilization rates.

While beneficiaries younger than 65 years of age can be entitled to Medicare due to disability, most beneficiaries are not entitled to Medicare until they reach 65 years of age under Old Age Survivors Insurance status. Accordingly, to satisfy the one-year surveillance sample selection criteria most beneficiaries must have been 65 years old by February 1st of 2021. The two-year surveillance sample selection criteria require that such beneficiaries be 65 years old as of March 1st of 2020. While we do not make this distinction in our general descriptions of the chronic condition prevalence indicators, the prevalence rates for two-year surveillance period chronic conditions strictly pertain to an older population than the population for single-year conditions and service utilization rates. It is also possible that by employing the two-year sample selection criteria for Alzheimer's disease or related dementias (with a three-year surveillance period), this may have produced underestimates of prevalence rates for this condition.

Part D prescription drug utilization rates

In contrast to other Medicare covered services the Medicare MBSF contains summary information about Part D prescription drug utilization for both beneficiaries receiving care from fee-for-service providers and Medicare managed care enrollees. Furthermore, some Medicare beneficiaries with Parts A and B eligibility may not have opted to enroll for Part D Medicare coverage. Because of these factors, the sample selection criteria for the Part D prescription drug utilization indicator differ from that employed for other Medicare covered services.

For Part D prescription utilization, partial-year coverage for beneficiaries alive at the end of 2021 requires that:

- A beneficiary has at least 11 months of Medicare Part D coverage.

Beneficiaries who died in 2021 are required to have Medicare Part D coverage in all months they were alive in 2217. Beneficiaries are also required to have a valid 5-digit

residence zip code recorded in the 2021 Medicare MBSF. There were 229,022Medicare beneficiaries who met these sample selection requirements.

Medicaid dual eligibility and Medicare managed care status

For our estimates of Medicare managed care enrollment status, dual eligibility for Medicare and Medicaid, and Medicaid-financed use of long-term services and supports (LTSS), no additional sample selection criteria are imposed beyond the basic age and state residence requirements used to select beneficiaries contained in the MBSF data for Maine. Beneficiaries had to be 65 years or older on January 1st, 2021, eligible for Medicare for at least one month in 2021, and have a state residence code for Maine. There were 316,192 Medicare beneficiaries who met these sample selection requirements.

One-year age-sex adjusted mortality rates

Although 2021 dates of death are reported for all beneficiaries with at least one month of Medicare eligibility regardless of managed care status, additional sample selection requirements are imposed for estimates one-year mortality rates. We also require that beneficiaries reside in the same zip code in 2020 as 2021 to mitigate any potential bias associated with beneficiaries whose move to a town in 2021 may have been motivated by health concerns in their last year of life. There were 281,731 Medicare beneficiaries who met these sample selection requirements.

Single-year surveillance hospice utilization rates

For all single-year surveillance hospice utilization rates, partial-year coverage for beneficiaries alive at the end of 2021 requires that:

- A beneficiary has at least 11 months of both Medicare Part A and B eligibility and at most one month of Medicare managed care enrollment in 2021.

Beneficiaries who died in 2021 are required to have full coverage (Medicare Part A and B eligibility and at least one month of Medicare managed care enrollment) in all months that they were alive in 2021. There were 286,936 aged Medicare beneficiaries who met these one-year sample selection requirements.

Two-year surveillance hospice utilization rates among deceased beneficiaries

For all two-year surveillance hospice utilization rates, partial-year coverage for beneficiaries died at 2020 or 2021 requires that:

- A beneficiary has at least 22 months of both Medicare Part A and B eligibility and at most two months of Medicare managed care enrollment over the two calendar years 2020-2021.

Beneficiaries who died in 2020 or 2021 are required to meet the partial-year coverage requirements in 2020 and meet full coverage requirements in the months they were alive in 2021. Beneficiaries are also required to have a valid 5-digit residence zip code recorded in the 2020 and 2021 Medicare MBSF. There were 24,022 Medicare beneficiaries who met these sample selection requirements.

Post Stratification Weights

Medicare beneficiaries are assigned to towns based on their 5-digit residence zip code using a cross-walk file that we created to link all valid 5-digit zip codes to a specific city/town. Because of the sample selection criteria that are employed to ensure the potential presence of Medicare claims for all sample beneficiaries during the surveillance period, the age-sex distributions of these estimation samples in towns may differ from that of all aged Medicare beneficiaries actually residing those towns. Post stratification weights for 10 age-sex classes (males 65-69, males 70-74, males 75-79, males 80-84, males 85+, females 65-69, females 70-74, females 75-59, females 80-84, females 85+) were computed for each geographic area in the state defined for respective high prevalence, low prevalence, and lowest prevalence Medicare MBSF indicators. Individual beneficiaries in age-sex groups that are under-represented (over-represented) in the town's estimation sample relative to the total town beneficiary population are assigned post-stratification weights greater than (less than 1). These weights are computed so that when these post-stratification weights are applied, the weighted age-sex distribution of the estimation sample in each town matched the actual age-sex distribution of all Medicare beneficiaries in the town.

Different town-level post-stratification weights are computed for Medicare indicators depending upon on length of the current surveillance period (single-year versus two-year), and for Medicare Part D versus Medicare Parts A & B service utilization rates. In addition, for estimates of state-level prevalence and service utilization rates, another set of post-stratification weights were computed at the state level to ensure that the weighted age-sex distribution of the entire state estimation sample matched the actual beneficiary age-sex distribution for the state. These state-level post-stratification weights did not ensure that the age-sex distribution of the estimation sample in each town matched the town's actual beneficiary age-sex distribution. In other words, the target population for these adjustments is the state rather than the town.

The post-stratification weights for Medicare service utilization rates were applied to beneficiaries in the estimation sample after another adjustment weight was applied. This additional weight is based on the portion of the year that potential claims could have been submitted for Medicare reimbursement. This first adjustment might best be explained with an example. Beneficiary A, who was continuously entitled for Medicare Parts A and B for a full calendar year and was never enrolled in a Medicare Advantage plan, has claims over the full year showing 6 physician visits. These six visits reflect an annual physician visit rate of 6 visits per year. Consider an otherwise identical beneficiary who had six physician visits before his/her death at the end of June. The annualized rate of physician visits for this beneficiary who died before the end of the

year is actually 12 visits per year rather than 6 visits per year. However, in contrast to the former beneficiary who survived the full year, the latter beneficiary who died did was only at risk for making a physician visit for one-half of a year. Hence the decedent beneficiary contributed only ½ of a full person-year to the denominator used for calculating a mean physician visit rate for the town.

For all Medicare service utilization rate indicators, the service use reported in the MBSF for beneficiaries in the estimation sample are first annualized to reflect the expected utilization with full-year coverage (12 months). Then individual person-weights are assigned to all sample beneficiaries. These weights are equal to the fraction of the year (i.e., # months of full coverage/12) that they had full coverage. Sampled beneficiaries with full-year coverage are assigned a weight of one (12/12) and beneficiaries with less than full-year coverage are assigned a fractional weight less than one.

The post-stratification town-level weights were also computed differently for the one-year mortality rates. In this case the weights were computed so that the weighted age-sex distribution of the estimation sample in each individual town population matched the state-wide age-sex distribution of all aged Medicare beneficiaries. By computing the post-stratification weights in this manner, the one-year mortality rate in a town reflects the expected mortality rate if its age-sex beneficiary population composition matched that of the entire state.

Some caveats should be noted about what these post stratification weights do and do not do with respect to rate estimation. By applying these weights the prevalence and service utilization rate estimates are adjusted to reflect differences between the age-sex population composition of the sample and that of actual beneficiaries in the town. The age-sex distribution of all aged beneficiaries in each town contains beneficiaries who were excluded from the estimation sample because they did not have a sufficient history of fee-for-service Medicare claims. This includes the exclusion of Medicare Advantage enrollees. If such managed care enrollees are systematically younger than beneficiaries receiving care from fee-for-service providers, younger beneficiaries in the estimation sample will be assigned larger post-stratification weights to reflect their under-representation in the town estimation sample. However, application of these post-stratification weights will not adjust health indicators to reflect any systematic unmeasured health status differences between Medicare Advantage enrollees and fee-for-service beneficiaries <u>within</u> the same age-sex class. Past research has consistently found that Medicare managed care enrollees tend to be healthier than their counterparts receiving care from fee-for-service providers. A recent study suggests that this still is true in the Medicare Advantage program (Morrissey, Kilgore, Becker, Smith, & Delzell, 2013).

Also, although the post-stratification town-level weights were also computed for the hospice utilization rates, we could not apply the post-stratification town-level weights for estimation of median day of hospice utilizations and median payment of hospice utilizations due to the fact that STATA 18.0 are not allowed to add the weighting factors.

The reported healthy aging indicators derived from the Medicare MBSF strictly only reflect the health status of fee-for-service Medicare beneficiaries. For this reason we report the percentage of Medicare beneficiaries with at least two months of Medicare Advantage enrollment as a town population composition attribute. Some caution should be exercised in interpreting MBSF indicators for towns where the Medicare Advantage market penetration rate is very high.

Fixed Effects Estimation of Rates

Geographic residence dummy variables were constructed for beneficiaries in the estimation samples defined for the various MBSF indicator groups discussed above. STATA 18.0 was used to estimate separate fixed effects dummy variable ordinary least squares regressions with a suppressed constant on the full beneficiary estimation samples for each MBSF indicator noted in Tables A1 and A2. Beneficiary cases were weighted with individual population weights equal to the computed post-stratification weights for all MBSF indicators, except for Medicare service utilization rates where an additional partial-year weight adjustment was also made. The estimated dummy variable coefficients corresponding to weighted sample mean rates for towns or clusters of smaller towns. These estimated coefficients are the estimated MBSF rates reported in the main tables. Robust standard errors were estimated for the coefficient estimates. The 95% confidence intervals for these estimates are the reported margins of error for the estimates. The state-level estimates for the MBSF indicators along with their 95% confidence intervals are similarly estimated on the sample of all beneficiaries in the state estimation sample using different population weights.

The estimates for health indicators derived from Medicare MBSF data and their margins of error are reported for all towns on the community profiles with confidence intervals available for download. We took a conservative approach in distinguishing those indicators where the difference between the town rate and the state rate is statistically significant at the 5% level. We only distinguish those indicators where the 95% confidence interval of the town estimate does not overlap with the 95% confidence interval of the state estimate, as ones where the difference is estimated with enough precision so that the reported difference is unlikely to be due to chance associated with sampling variation.

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Table A1: Maine Healthy Aging Indicator Definitions

INDICATORS	DEFINITION
POPULATION CHARACTERISTICS	
Total population (all ages)	The number of all persons in the state or community.
Population 60 years or older as % of total population	The percentage of persons 60 years or older among the total population.
Total population 60 years or older	The number of persons 60 years or older.
Population 65 years or older as % of total population	The percentage of persons 65 years or older among the total population.
Total population 65 years or older	The number of persons 65 years or older.
% 65-74 years	The percentage of persons 65-74 years among population aged 65 year or older.
% 75-84 years	The percentage of persons 75-84 years among population aged 65 year or older.
% 85 years or older	The percentage of persons 85+ years among population aged 65 year or older.
% 65+ population who are female	The percentage of females 65 years or older among population aged 65 year or older.
% 85+ population who are female	The percentage of females 85 years or older among population aged 65 year or older.
65+ race/ethnicity:	
% White	The percentage of persons 65 years or older reporting their race as “White” or reporting entries such as Irish, German, Italian, Lebanese, Arab, Moroccan, or Caucasian.
% African American	The percentage of persons 65 years or older reporting their race as “Black or African American” or reporting entries such as African American, Kenyan, Nigerian, or Haitian.
% Asian	The percentage of persons 65 years or older reporting their race as “Asian Indian,” “Chinese,” Filipino,” “Korean,” “Japanese,” Vietnamese,” and “Other Asian” or provide other detailed Asian responses.
% Other race (s)	The percentage of persons 65 years or older reporting their race as “Native Hawaiian or other Pacific Islander”, or reporting entries such as Navajo, Blackfeet, Inupiat, Yup’ik, or Central American Indian groups, South American Indian groups, “Some other race”, or two or more races.
% Hispanic	The percentage of persons 65 years or older reporting their origin as “Hispanic or Latino”.
# 55+ who are Native American/Alaskan	The number of persons 55 years or older reporting their race as “American Indian or Alaska Native”
Marital status of the population 65+:	

INDICATORS	DEFINITION
% 65+ married	The percentage of persons 65 years or older reporting that they are currently married with spouse present or with spouse absent due to employment, living away from home, institutionalization, or serving away from home in the Armed Forces.
% 65+ divorced/separated	The percentage of persons 65 years or older reporting that they are legally divorced and who have not remarried, or they are legally separated or otherwise absent from their spouse because of marital discord.
% 65+ widowed	The percentage of persons 65 years or older reporting they are widows and widowers who have not remarried.
% 65+ never married	The percentage of persons 65 years or older reporting they have never been married, including people whose only marriage(s) was annulled.
Education of the population 65+:	
% 65+ with less than high school education	The percentage of persons 65 years or older reporting they have completed less than 9th grade, or 9th grade to 12th grade with no diploma.
% 65+ with high school or some college	The percentage of persons 65 years or older reporting they have graduated from high school, attended a college but did not receive a degree, or received an associate's degree.
% 65+ with college degree	The percentage of persons 65 years or older reporting they received a bachelor's degree.
% 65+ with graduate or professional degree	The percentage of persons 65 years or older reporting they received a master's, or professional or doctorate degree.
% 65+ population who speak only English at home	The percentage of persons 65 years or older reporting that no language other than English is spoken at home.
% 65+ population who are veterans of military service	The percentage of persons 65 years or older reporting to have served in the military forces for the United States (Army, Navy, Air Force, Marine Corps, or Coast Guard) in time of war or peace.
HOUSING	
% 65+ population living alone	The percentage of persons 65 years or older reporting that they live alone.
Average household size (all ages)	Average number of persons in the household.
Median house value (all ages)	The average median value of houses.
% 60+ own home	The percentage of households with a householder age 60 years or older who are homeowners.
% 60+ homeowners who have mortgage	The percentage of households with a householder age 60 years or older who have mortgage on home.
% 65+ households (renter) spend >35% of income on housing	The percentage of households with a householder age 65 years or older who spend more than 35% of income on renting a house.

INDICATORS	DEFINITION
% 65+ households (owner) spend >35% of income on housing	The percentage of households with a householder age 65 years or older who own the house and spend more than 35% of income on housing expense.
% of grandparents who live with grandchildren	The percentage of grandparents who are living with a grandchild in the household.
# of assisted living sites	The number of assisted living sites in the community
SOCIAL DETERMINANTS OF HEALTH	
COST OF LIVING	
Elder Index	
Single, homeowner without mortgage, good health (County)	Annual income needed for a single homeowner with no mortgage in good health to attain a modest standard of living in the county.
Single, renter, good health (County)	Annual income needed for a single renter in good health to attain a modest standard of living in the county.
Couple, homeowner without mortgage, good health (County)	Annual income needed for a couple who are homeowners with no mortgage in good health to attain a modest standard of living in the county.
Couple, renter, good health (County)	Annual income needed for a couple who are renters in good health to attain a modest standard of living in the county.
ECONOMIC	
% 60+ receiving food stamps in past year	The percentage of the households with a householder age 60 years or older received food stamps/Supplemental Nutrition Assistance Program (SNAP) benefits in the past 12 months.
% 65+ employed in past year	The percentage of persons 65 years or older employed in the past year.
% 65+ with income below the poverty level in past year	The percentage of households with a householder (i.e., the person (or one of the people) in whose name the housing unit is owned or rented (maintained)) age 65 years or older with an annual family income below the appropriate official poverty threshold.
Median annual income for households with a householder age 65+	The median annual income of households with a householder age 65 years or older from 2018 to 2022.
% 65+ households with annual income < $20,000	The percentage of households with a householder (i.e., the person (or one of the people) in whose name the housing unit is owned or rented (maintained)) age 65 years or older with an annual income from 2018 to 2022 less than $20,000.
% 65+ households with annual income $20,000-$49,999	The percentage of households with a householder age 65 years or older with an annual income from 2018 to 2022 between $20,000 and $49,000.
% 65+ households with annual income $50,000-$99,999	The percentage of households with a householder age 65 years or older with an annual income from 2018 to 2022 between $50,000-$99,999.

INDICATORS	DEFINITION
% 65+ households with annual income $100,000+	The percentage of households with a householder age 65 years or older with an annual income from 2018 to 2022 more than $100,000.
WELLNESS	
% 18+ with less than 7 hours sleep (County)	The percentage of persons 60 years or older reporting the recommended amount (7 or 8 hours for age 60-64 years and 7, 8, or 9 hours for age 65 years or older) of sleeping in a 24-hour period.
% 18+ without leisure-time physical activity (County)	The percentage of persons 18 years or older answering no to: “During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?”
% 18+ with fair or poor health status (County)	The percentage of persons 18 years or older reporting fair or poor to question: “Would you say that in general your health is: excellent, very good, fair, poor?”
% 18+ with 14+ physically unhealthy days in past month (County)	The percentage of persons 18 years or older reporting at least 14 days to the question- “Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?”
COMMUNITY	
Annual # of unhealthy days due to air pollution for 65+ (county)	The number of days in 2021 where there was an Air Quality Index score classified as “code red” or “code orange for ozone or particulate matter in the county.
AARP Age-friendly Communities	City/town has officially joined the AARP Network of Age-Friendly States and Communities.
# of public universities and community colleges	The number of universities or community colleges in the community.
# of public libraries	The number of public libraries in the community.
# of senior centers	The number of senior centers in the community.
# of Osher Lifelong Learning Institutes (OLLI)	The number of Osher Lifelong Learning Institutes (OLLI) in the community.
% households with a smartphone (all ages)	The percentage of households in a community with a smartphone.
% households with only a smartphone to access the internet (all ages)	The percentage of households in a community with only a smartphone to access the internet.
% households without a computer (all ages)	The percentage of households in a community without a computer.
% households with access to Broadband (all ages)	The percentage of households in a community with access to broadband.
% households without access to the Internet (all ages)	The percentage of households in a community without access to broadband or internet.
Voter participation rate in 2020 presidential election (age 18+)	The percentage of registered voters aged 18 and older who voted in the 2020 election.
Homicide rate /100,000 persons (County)	The number of deaths due to homicide per 100,000 persons from 2016 to 2020.

INDICATORS	DEFINITION
# firearm fatalities (all ages) (County)	The number of deaths due to firearms per 100,000 persons from 2016 to 2020.
# 65+ deaths by suicide (County)	The number of deaths by suicide from 2016 to 2020 among people age 65 and older.
Age-sex adjusted 1-year mortality rate	The percentage of Medicare beneficiaries 65 years or older on January 1, 2021 who lived in the same community for both 2020 and 2021 and who died in 2021 (beneficiary population is weighted to match state age-sex distribution of aged Medicare beneficiaries.
TRANSPORTATION	
% householders 65+ who own a motor vehicle	The percentage of households with a householder age 65 years or older who own one or more vehicles.
# fatal crashes involving adult age 60+ (County)	The number of motor vehicle fatalities in county involving an adult age 60 or older (driver, passenger, or pedestrian) from 2018 to 2022.
AllTransit Score	The AllTransit Performance Score was obtained from the AllTransit™ website on September 15th, 2023. (https://alltransit.cnt.org/). Data was reported at the Census “place” level, and the average score of each place inside a town or city was reported.
FALLS	
65+ hip fracture	The percentage of Medicare beneficiaries 65 years or older from 2020 to 2021 who ever met the claims-based criteria indicating a hip/pelvic fracture since 1999. These criteria are having at least 1 inpatient or skilled nursing facility Medicare claim with appropriate diagnosis codes during a 1-year period.
PREVENTION	
% 18+ with physical exam/check-up in past year (County)	The percentage of persons age 18 years or older who reporting seeing a doctor for a regular check-up within the past year.
% mammography use among women age 50-74 Years (County)	The percentage of women 50-74 years or older whose last mammogram was two years ago or less.
% 50-75 with fecal occult blood test, sigmoidoscopy, or colonoscopy (County)	Percentage of adults aged 50 to 75 who report having had a fecal occult blood test (FOBT) within the previous year; a FIT-DNA test within the previous 3 years; a sigmoidoscopy within the previous 5 years; a sigmoidoscopy within the previous 10 years with a FIT in the past year; a colonoscopy within the previous 10 years; or a CT colonography (virtual colonoscopy) within the previous 5 years.

INDICATORS	DEFINITION
% 65+ men up to date on preventive services (County)	Number of men aged 65 years or older reporting having received all of the following: an influenza vaccination in the past year; a pneumococcal vaccination (PPV) ever; and either a fecal occult blood test (FOBT/FIT) within the previous year, a FIT-DNA test within the previous 3 years, a sigmoidoscopy within the previous 5 years, a sigmoidoscopy within the previous 10 years with a FOBT in the previous year, a colonoscopy within the previous 10 years, or a CT colonography (virtual colonoscopy) within the previous 5 years.
% 65+ women up to date on preventive services (County)	Number of women aged 65 years or older reporting having received all of the following: an influenza vaccination in the past year; a pneumococcal vaccination (PPV) ever; either a fecal occult blood test (FOBT/FIT) within the previous year, a FIT-DNA test within the previous 3 years, a sigmoidoscopy within the previous 5 years, a sigmoidoscopy within the previous 10 years with a FOBT in the previous year, a colonoscopy within the previous 10 years, or a CT colonography (virtual colonoscopy) within the previous 5 years; and a mammogram in the past 2 years.
NUTRITION & DIET	
% 18+ with obesity (County)	The percentage of persons 18 years or older with a body mass index of 30 or higher.
% 65+ with high cholesterol	The percentage of Medicare beneficiaries 65 years or older from 2020 to 2021 who ever met the claims-based criteria indicating high cholesterol since 1999. These criteria are having at least one inpatient or skilled nursing facility Medicare claim, or two hospital outpatient or Part B Medicare claims with appropriate diagnosis codes during a 1-year period.
% 18+ with high cholesterol screening	The percentage of persons age 18 years or older who had their cholesterol checked within past 5 years.
ORAL HEALTH	
% 18+ with annual dental exam (County)	The percentage of persons age 18 years or older who reporting visiting a dentist or dental clinic within the past year.
# dentists per 100,000 persons (all ages) (County)	The number of professionally active dentists per 100,000 persons.
% 65+ with complete tooth loss (County)	The percentage of persons 65 years or older who report having lost all of their natural teeth due to tooth decay or gum disease.

INDICATORS	DEFINITION
CHRONIC DISEASE	
% 65+ with Alzheimer's disease or related dementias	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating Alzheimer's disease or related dementia since 1999. These criteria are having at least one inpatient, skilled nursing facility, home health, hospital outpatient or Part B Medicare claim with appropriate diagnosis codes during a 3-year period.
% 65+ with anemia	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating anemia since 1999. These criteria are having at least one inpatient, skilled nursing facility, or home health Medicare claim or at least one Part B Medicare claim with appropriate diagnosis codes during a 1-year period.
% 65+ with asthma	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating asthma since 1999. These criteria are having at least one inpatient, skilled nursing facility, or home health Medicare claim or at least 2 hospital outpatient or Part B Medicare claims with appropriate diagnosis codes during a 1-year period.
% 65+ with atrial fibrillation	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating atrial fibrillation since 1999. These criteria are having at least one inpatient Medicare claim, or at least 2 hospital outpatient or Part B Medicare claims with appropriate diagnosis codes during a 1-year period.
% 65+ with benign prostatic hyperplasia (men)	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating benign prostatic hyperplasia since 1999. These criteria are having at least one inpatient, skilled nursing facility, or home health Medicare claim or at least 2 hospital outpatient or Part B Medicare claims with appropriate diagnosis codes during a 1-year period.
% 65+ with breast cancer (women)	The percentage of female Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating breast cancer since 1999. These criteria are having at least one inpatient or skilled nursing facility Medicare claims or at least 2 hospital outpatient or Part B Medicare claims (or any combination of outpatient or Part B claims at least a day apart) with appropriate diagnosis codes during a 1-year period.
% 65+ with cataract	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating cataract since 1999. These criteria are having at least one Part B Medicare claims with appropriate diagnosis codes during a 1-year period.

INDICATORS	DEFINITION
% 65+ with chronic kidney disease	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating chronic kidney disease since 1999. These criteria are having at least one inpatient, skilled nursing facility Medicare claim or at least 2 hospital outpatient or Part B Medicare claims with appropriate diagnosis codes during a 2-year period.
% 65+ with chronic obstructive pulmonary disease	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating chronic obstructive pulmonary disease since 1999. These criteria are having at least one inpatient, skilled nursing facility, or home health Medicare claim or at least 2 hospital outpatient or Part B Medicare claims with appropriate diagnosis codes during a 1-year period.
% 65+ with colon cancer	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating colon cancer since 1999. These criteria are having at least one inpatient or skilled nursing facility Medicare claims or at least 2 hospital outpatient or Part B Medicare claims (or any combination of outpatient or Part B claims at least a day apart) with appropriate diagnosis codes during a 1-year period.
% 65+ with congestive heart failure	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating congestive heart failure since 1999. These criteria are having at least one inpatient, hospital outpatient or Part B Medicare claim with appropriate diagnosis codes during a 2-year period.
% 65+ with diabetes	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating diabetes since 1999. These criteria are having at least one inpatient, skilled nursing facility, home health Medicare claims, or at least two hospital outpatient or Part B Medicare claims with the appropriate diagnosis codes during a 2-year period.
% 65+ with endometrial cancer (women)	The percentage of female Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating endometrial cancer since 1999. These criteria are having at least one inpatient or skilled nursing facility Medicare claims or at least 2 hospital outpatient or Part B Medicare claims (or any combination of outpatient or Part B claims at least a day apart) with appropriate diagnosis codes during a 1-year period.

INDICATORS	DEFINITION
% 65+ with fibromyalgia, chronic pain and fatigue	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating fibromyalgia, chronic pain and fatigue since 1999. These criteria are having at least one inpatient or skilled nursing facility Medicare claim, or two hospital outpatient or Part B Medicare claims with appropriate diagnosis codes during a 2-year period.
% 65+ with glaucoma	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating glaucoma since 1999. These criteria are having at least one Part B Medicare claim with appropriate diagnosis codes during a 1-year period.
% 65+ ever had a heart attack	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating an acute myocardial infarction (heart attack) since 1999. These criteria are having at least one inpatient, skilled nursing facility, or home health Medicare claim or at least 2 hospital outpatient or Part B Medicare claims with appropriate diagnosis codes during a 1-year period.
% 65+ with HIV/AIDS	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating the human immunodeficiency virus and/or acquired immunodeficiency syndrome since 1999. These criteria are having at least one inpatient or skilled nursing facility Medicare claim, or two hospital outpatient or Part B Medicare claims with appropriate diagnosis codes during a 2-year period.
% 65+ with hypertension	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating hypertension since 1999. These criteria are having at least one inpatient, skilled nursing facility, or home health Medicare claim or at least 2 hospital outpatient or Part B Medicare claims with appropriate diagnosis codes during a 1-year period.
% 65+ with ischemic heart disease	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating ischemic heart disease since 1999. These criteria are having at least one inpatient, skilled nursing facility, or home health, hospital outpatient or Part B Medicare claim with appropriate diagnosis codes during a 2-year period.
% 65+ with liver disease	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating liver diseases since 1999. These criteria are having at least one inpatient or skilled nursing facility Medicare claim, or two hospital outpatient or Part B Medicare claims with appropriate diagnosis codes during a 2-year period.

INDICATORS	DEFINITION
% 65+ with lung cancer	The percentage of male Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating lung cancer since 1999. These criteria are having at least one inpatient or skilled nursing facility Medicare claims or at least 2 hospital outpatient or Part B Medicare claims (or any combination of outpatient or Part B claims at least a day apart) with appropriate diagnosis codes during a 1-year period.
% 65+ with migraine and other chronic headache	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating migraine and other chronic headache since 1999. These criteria are having at least one inpatient or skilled nursing facility Medicare claim, or two hospital outpatient or Part B Medicare claims with appropriate diagnosis codes during a 2-year period.
% 65+ with osteoarthritis or rheumatoid arthritis	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating osteoarthritis/rheumatoid arthritis since 1999. These criteria are having at least 2 inpatient, skilled nursing facility, home health, hospital outpatient, or Part B Medicare claims (or any combination of claim types at least one day apart) with appropriate diagnosis codes during a 1-year period.
% 65+ with osteoporosis	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating osteoporosis since 1999. These criteria are having at least one inpatient, skilled nursing facility, home health Medicare claims or at least 2 hospital outpatient or Part B Medicare claims with appropriate diagnosis codes during a 1-year period.
% 65+ with peripheral vascular disease	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating peripheral vascular disease since 1999. These criteria are having at least one inpatient or skilled nursing facility Medicare claim, or two hospital outpatient or Part B Medicare claims with appropriate diagnosis codes during a 2-year period.
% 65+ with pressure ulcer or chronic ulcer	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating pressure ulcer or chronic ulcer disease since 1999. These criteria are having at least one inpatient or skilled nursing facility Medicare claim, or two hospital outpatient or Part B Medicare claims with appropriate diagnosis codes during a 2-year period.

INDICATORS	DEFINITION
% 65+ with prostate cancer (men)	The percentage of male Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating prostate cancer since 1999. These criteria are having at least one inpatient or skilled nursing facility Medicare claims or at least 2 hospital outpatient or Part B Medicare claims (or any combination of outpatient or Part B claims at least a day apart) with appropriate diagnosis codes during a 1-year period.
% 65+ with stroke	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating a transient ischemic attack (stroke) since 1999. These criteria are having at least one inpatient Medicare claim or at least 2-hospital outpatient or Part B Medicare claim with appropriate diagnosis codes during a 1-year period.
% 65+ with 4+ (out of 15) chronic conditions	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating at least 4 of 15 chronic conditions since 1999. The 15 chronic conditions include Alzheimer's disease or related dementia, asthma, atrial fibrillation, cancer (breast, colorectal, lung, and prostate), chronic kidney disease, chronic obstructive pulmonary disease (COPD), depression, diabetes, congestive heart failure, hypertension, hyperlipidemia (cholesterol) ischemic heart disease, osteoporosis, osteoarthritis/rheumatoid arthritis, and stroke.
% 65+ with 0 chronic conditions	The percentage of Medicare beneficiaries 65 years or older in 2021 who never ever met the claims-based criteria indicating any of 15 chronic conditions since 1999.
BEHAVIORAL HEALTH	
# of drug overdose deaths (all ages) (County)	Number of confirmed drug overdose deaths for all intents by county of residence for the decedent among Maine residents in 2016-2020.
% 65+ with substance use disorder	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating drug use or alcohol abuse disorders since 1999. These criteria are having at least one inpatient or skilled nursing facility Medicare claim, or two hospital outpatient or Part B Medicare claims with appropriate diagnosis codes during a 2-year period.

INDICATORS	DEFINITION
% 18+ excessive drinking (County)	The percentage of persons 60 years or older reporting excessive alcoholic drinking during the past month. For men excessive drinking is defined as consuming 60 or more alcoholic drinks in the past month or consuming 5 or more alcoholic drinks on at least one occasion during the past month. For women excessive drinking is defined as consuming 30 or more alcoholic drinks in the past month or consuming 4 or more alcoholic drinks on at least one occasion during the past month. One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor.
% 65+ with tobacco use disorders	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating tobacco disorders since 1999. These criteria are having at least one inpatient or skilled nursing facility Medicare claim, or two hospital outpatient or Part B Medicare claims with appropriate diagnosis codes during a 2-year period.
% 18+ current smokers (County)	The percentage of persons 60 years or older reporting to have ever smoked at least 100 cigarettes and who now smoke on some or all days.
MENTAL HEALTH	
% 18+ with 14+ days poor mental health past month (County)	The percentage of persons 18 years or older reporting at least 14 days to the question- “Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?”
% 65+ with depression	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating tobacco disorders since 1999. These criteria are having at least one inpatient or skilled nursing facility Medicare claim, or two hospital outpatient or Part B Medicare claims with appropriate diagnosis codes during a 2-year period.
% 65+ with anxiety disorder	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating anxiety disorders since 1999. These criteria are having at least one inpatient or skilled nursing facility Medicare claim, or two hospital outpatient or Part B Medicare claims with appropriate diagnosis codes during a 2-year period.
% 65+ with post-traumatic stress disorder	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating post-traumatic stress disorders since 1999. These criteria are having at least one inpatient or skilled nursing facility Medicare claim, or two hospital outpatient or Part B Medicare claims with appropriate diagnosis codes during a 2-year period.

INDICATORS	DEFINITION
% 65+ with schizophrenia & other psychotic disorders	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating schizophrenia & other psychotic disorders since 1999. These criteria are having at least one inpatient or skilled nursing facility Medicare claim, or two hospital outpatient or Part B Medicare claims with appropriate diagnosis codes during a 2-year period.
LIVING WITH DISABILITY	
% 65+ with self-reported hearing difficulty	The percentage of persons age 65 or older reporting to be deaf or has serious difficulty hearing.
% 65+ with self-reported vision difficulty	The percentage of persons age 65 or older reporting to be blind or has serious difficulty seeing even with corrective lenses.
% 65+ with self-reported cognition difficulty	The percentage of persons age 65 or older reporting cognitive difficulties (such as learning, remembering, concentrating, or making decisions) because of a physical, mental, or emotional condition.
% 65+ with self-reported ambulatory difficulty	The percentage of persons age 65 or older reporting to have a condition that substantially limits one or more basic activities, such as walking, climbing stairs, reaching, lifting, or carrying.
% 65+ with self-reported self-care difficulty	The percentage of persons age 65 or older reporting to have a physical or mental health condition that has lasted at least 6 months and makes it difficult for them to take care of their own personal need, such as bathing, dressing, or getting around inside the home.
% 65+ with self-reported independent difficulty	The percentage of persons age 65 or older reporting to have a physical, mental, or emotional condition lasting six months or more that makes it difficult or impossible to perform basic activities outside the home alone.
CAREGIVING	
# of Alzheimer's support groups	A count of in-person support groups for caregivers of Alzheimer's disease sponsored by the Alzheimer's Association in the city/town.
% of grandparents raising grandchildren	The percentage of grandparents who are financially responsible for any or all grandchildren living in the household.
ACCESS TO CARE	
% 65+ dually eligible for Medicare and Medicaid	The percentage of Medicare beneficiaries age 65 years or older with at least one month of full or restricted Medicaid entitlement in 2021. (Beneficiaries with restricted Medicaid entitlement are only entitled to some Medicaid benefits (e.g., drug coverage only, and/or premium/copayments for services).
% 65+ Medicare managed care enrollees	The percentage of Medicare beneficiaries age 65 years or older enrolled in a Medicare managed care plan (Medicare Advantage) for at least 1 month in 2021.

INDICATORS	DEFINITION
% 18-64 who lack health insurance (County)	The percentage of adults aged 18–64 who report having no current health insurance coverage
# primary care providers	Primary care providers were defined as physicians with the following main specialties listed in the CMS provider file: family practice, general practice, geriatric medicine, internal medicine. In addition, physician assistants and nurse practitioners in the above specialties were also considered as PCPs.
# hospitals	A count of short-term CMS-certified general hospitals in the city/town.
# home health agencies	A count of CMS-certified home health agencies serving patients living in the city/town.
# skilled nursing facilities	A count of CMS-certified skilled nursing homes in the city/town.
# hospice agencies	A count of CMS-certified hospice agencies in the city/town.
# community health centers	A count of community health centers from HRSA in the city/town. For more information on HRSA regulations for community health centers, visit: https://bphc.hrsa.gov/about-health-center-program/what-health-center#:~:text=Have%20a%20governing%20board%20where,else%20the%20Compliance%20Manual%20requires
# adult day health centers	A count of adult day health centers in the city/town.
SERVICE UTILIZATION	
# physician visits per year	Average Part B physician office visit evaluation and management services received in 2021 by Medicare beneficiaries 65 years or older.
# emergency room visits/1000 persons 65+ years annually	Average number of emergency department visits (where beneficiaries were released or admitted to a hospital) in 2021 per 1,000 Medicare beneficiaries 65 years or older.
# Part D monthly prescription fills per person annually	Average number of standard 30 days supplies of a filled Part D prescription in 2021 by Medicare beneficiaries 65 years or older.
# home health visits per year	Average home health visits in 2021 per Medicare beneficiary 65 years or older.
# durable medical equipment claims annually	Average Part B durable medical equipment services received in 2021 by Medicare beneficiaries 65 years or older.
# inpatient hospital stays/1000 persons 65+ years annually	A count of inpatient hospital discharges in 2021 per 1,000 Medicare beneficiaries 65 years or older.
% Medicare inpatient hospital readmissions (as % of admissions)	The percentage of inpatient hospital discharges for Medicare beneficiaries 65 years or older which were followed by an admission to an acute care hospital for any cause within 30 days.
# skilled nursing facility stays/1000 persons 65+ years annually	A count of skilled nursing facility in 2021 per 1,000 Medicare beneficiaries 65 years or older.

INDICATORS	DEFINITION
# skilled nursing home Medicare beds/1000 persons 65+ years	The number of Medicare- certified nursing home beds in the community per 1,000 Medicare beneficiaries age 65 years or older in 2021.
% 65+ getting Medicaid long term services and supports	The percentage of Medicare beneficiaries age 65 years or older enrolled who had $0 cost-sharing for Medicare Part D for at least 1 month in 2021. (Dual-eligible beneficiaries who are either nursing home residents or who receive Medicaid-financed long term supports and services have $0 Part D cost sharing.
% 65+ hospice users	The percentage of Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating any of Medicare covered days in the hospice setting in 2021 during a 1-year period. These criteria are having at least one Part B Medicare claims with appropriate diagnosis codes or Medicare managed care plan (Medicare Advantage) for at least 1 month in 2021.
% 65+ hospice users as % of decedents	The percentage of Medicare beneficiaries 65 years or older in 2020 or Medicare beneficiaries 65 years or older in 2021 who ever met the claims-based criteria indicating any of Medicare covered days in the hospice setting in 2021, but died in 2020 or 2021. These criteria are having at least one inpatient or skilled nursing facility Medicare claim, or two hospital outpatient or Part B Medicare claims with appropriate diagnosis codes or Medicare managed care plan (Medicare Advantage) for at least 1 month during a 2-year period.

Table A2: Years and Data Sources for Community Profile Indicators

INDICATORS	SOURCES and YEAR
POPULATION CHARACTERISTICS	
Total population all ages; Population 60 years or older as % of total population; Total population 60 years or older; Population 65 years or older as % of total population; Total population 65 years and older; % 65-74 years, % 75-84 years; % 85 years or older; % 65+ population who are female; % 85+ population who are female	United States Census Bureau. "B01001: SEX BY AGE." *2018 – 2022 American Community Survey*. U.S. Census Bureau's American Community Survey Office, 2022. Accessed March 2024. *(*https://data.census.gov/cedsci/).
Race/Ethnicity: % White; % African American; % Asian; % Other race(s); % Hispanic; #55+ who are Native American/Alaskan	United States Census Bureau. "B01001A, B01001B, B01001D, B01001I: SEX BY AGE." *2018 – 2022 American Community Survey*. U.S. Census Bureau's American Community Survey Office, 2022. Accessed March 2024. *(*https://data.census.gov/cedsci/).
Marital status of the population 65+: % married; % divorced/separated; % widowed; % never married	United States Census Bureau. "B12002: SEX BY MARITAL STATUS BY AGE FOR THE POPULATION 15 YEARS AND OVER." U.S. Census Bureau's American Community Survey Office, 2022. Accessed March 2024. *(*https://data.census.gov/cedsci/).
Education of the population 65+: % with less than a high school education; % with high school or some college; % with college degree; % with graduate or professional degree	United States Census Bureau. "B15001: SEX BY AGE BY EDUCATIONAL ATTAINMENT FOR THE POPULATION 18 YEARS AND OVER." U.S. Census Bureau's American Community Survey Office, 2022. Accessed March 2024. *(*https://data.census.gov/cedsci/).
% 65+ population who speak only English at home	United States Census Bureau. "B16007: AGE BY LANGUAGE SPOKEN AT HOME BY ABILITY TO SPEAK ENGLISH FOR THE POPULATION 5 YEARS AND OVER". U.S. Census Bureau's American Community Survey Office, 2022. Accessed March 2024. *(*https://data.census.gov/cedsci/).
% 65+ population who are veterans of military service	United States Census Bureau. "B21001: SEX BY AGE BY VETERAN STATUS FOR THE CIVILIAN POPULATION 18 YEARS AND OVER". U.S. Census Bureau's American Community Survey Office, 2022. Accessed March 2024. *(*https://data.census.gov/cedsci/).

INDICATORS	SOURCES and YEAR
HOUSING	
% 65+ population who live alone	United States Census Bureau. "B09020: RELATIONSHIP BY HOUSEHOLD TYPE (INCLUDING LIVING ALONE) FOR THE POPULATION 65 YEARS AND OVER". U.S. Census Bureau's American Community Survey Office, 2022. Accessed March 2024. *(*https://data.census.gov/cedsci/).
Average household size (all ages)	United States Census Bureau. "B11016: HOUSEHOLD TYPE BY HOUSEHOLD SIZE". U.S. Census Bureau's American Community Survey Office, 2022. Accessed March 2024. *(*https://data.census.gov/cedsci/).
Median house value (all ages)	United States Census Bureau. "B25077: Median House Value". U.S. Census Bureau's American Community Survey Office, 2022. Accessed March 2024. *(*https://data.census.gov/cedsci/).
% 60+ own home	United States Census Bureau. "B25007: TENURE BY AGE HOUSEHOLDER". U.S. Census Bureau's American Community Survey Office, 2022. Accessed March 2024. *(*https://data.census.gov/cedsci/).
% 60+ homeowners who have mortgage	United States Census Bureau. "B25027: MORTGAGE STATUS BY AGE HOUSEHOLDER". U.S. Census Bureau's American Community Survey Office, 2022. Accessed March 2024. *(*https://data.census.gov/cedsci/).
% 65+ households (renter) spend >35% of income on housing	United States Census Bureau. "B25072: AGE OF HOUSEHOLDER BY GROSS RENT AS A PERCENTAGE OF HOUSEHOLD INCOME IN THE PAST 12 MONTHS". U.S. Census Bureau's American Community Survey Office, 2022. Accessed March 2024. *(*https://data.census.gov/cedsci/).
% 65+ households (owner) spend >35% of income on housing	United States Census Bureau. "B25093: AGE OF HOUSEHOLDER BY SELECTED MONTHLY OWNER COSTS AS A PERCENTAGE OF HOUSEHOLD INCOME IN THE PAST 12 MONTHS". U.S. Census Bureau's American Community Survey Office, 2022. Accessed March 2024. *(*https://data.census.gov/cedsci/).

INDICATORS	SOURCES and YEAR
% of grandparents who live with grandchildren	United States Census Bureau. "B10050: GRANDPARENTS LIVING WITH OWN GRANDCHILDREN UNDER 18 YEARS BY RESPONSIBILITY FOR OWN GRANDCHILDREN BY LENGTH OF TIME RESPONSIBLE FOR OWN GRANDCHILDREN FOR THE POPULATION 30 YEARS AND OVER". U.S. Census Bureau's American Community Survey Office, 2022. Accessed March 2024. *(*https://data.census.gov/cedsci/).
# of assisted living sites	The number of assisted living sites were retrieved on October 5th, 2023 from (https://www.mehca.org/AF_MemberDirectory.asp?version=1).
SOCIAL DETERMINANTS OF HEALTH	
COST OF LIVING	
ELDER INDEX	
Single, homeowner without mortgage, good health (County)	Elder Economic Security Index data from the University of Maine Boston Center for Social and Demographic Research on Aging, August, 2023. Accessed March 2024.
Single, renter, good health (County)	
Couple, homeowner without mortgage, good health (County)	
Couple, renter, good health (County)	
ECONOMICS	
% 60+ receiving food stamps in past year	United States Census Bureau. "B22001: RECEIPT OF FOOD STAMPS/SNAP IN THE PAST 12 MONTHS BY PRESENCE PEOPLE 60 YEARS AND OVER FOR HOUSEHOLDS". U.S. Census Bureau's American Community Survey Office, 2022. Accessed March 2024. *(*https://data.census.gov/cedsci/).
% 65+ employed in past year	United States Census Bureau. "B23004: WORK STATUS IN THE PAST 12 MONTHS BY AGE BY EMPLOYMENT STATUS FOR THE CIVILIAN POPULATION 65 YEARS AND OVER". U.S. Census Bureau's American Community Survey Office, 2022. Accessed March 2024. *(*https://data.census.gov/cedsci/).
% 65+ with income below the poverty line in past year	United States Census Bureau. "B17001: "POVERTY STATUS IN THE PAST 12 MONTHS BY SEX BY AGE". U.S. Census Bureau's American Community Survey Office, 2022. Accessed March 2024. *(*https://data.census.gov/cedsci/).

INDICATORS	SOURCES and YEAR
Median annual income for households with a householder age 65+; % 65+ households with annual income < $20,000; % 65+ households with annual income $20,000-$49,999; % 65+ households with annual income $50,000-$99,999; % 65+ households with annual income $100,000+;	United States Census Bureau. "B19037: AGE OF HOUSEHOLDER BY HOUSEHOLD INCOME IN THE PAST 12 MONTHS (IN 2023 INFLATION-ADJUSTED DOLLARS)". U.S. Census Bureau's American Community Survey Office, 2022. Accessed March 2024. (https://data.census.gov/cedsci/).
WELLNESS	
% 18+ with less than 7 hours sleep (County)	PLACES: Local Data for Better Health – County level. (2020-2021). Centers for Disease Control and Prevention. Accessed June 2024. https://www.cdc.gov/places
% 18+ without leisure-time physical activity (County)	
% 18+ with fair or poor self-reported health status (County)	
% 18+ with 14+ physically unhealthy days past month (County)	
COMMUNITY	
Annual # of unhealthy days due to air pollution for 65+ (County)	United States Environmental Protection Agency. Air Compare. Accessed July 30th, 2023. (https://www3.epa.gov/aircompare/#trends).
AARP Age-friendly Communities	Age-friendly communities were collected from the AARP livable community network. Accessed June 24th, 2023. (https://www.aarp.org/livable-communities/network-age-friendly-communities/info-2016/member-list.html).
# of public universities and community colleges	Number of public universities and community colleges in community is retrieved from New England Commission of Higher Education. Accessed October 5th, 2023. (https://www.neche.org/roster/).
# of public libraries	The number of public libraries in the community is downloaded from the ME State Library, Division of Library Development. (https://www.maine.gov/msl/libs/directories/public.shtml). Accessed June 27th, 2023.
# of senior centers	A list of senior centers in Maine was obtained from our stakeholders in Maine. Accessed July 5th, 2023.
# of Osher Lifelong Learning Institutes (OLLI)	The number of OLLI programs in community is retrieved from The Bernard Osher Foundation. Accessed October 11th, 2023. (https://www.osherfoundation.org/olli_list.html).
% households with a smartphone (all ages)	United States Census Bureau. "B28001, S2801: TYPES OF COMPUTERS AND INTERNET SUBSCRIPTIONS". U.S. Census Bureau's American Community Survey Office, 2022. Accessed March 2024. (https://data.census.gov/cedsci/).
% households with only a smartphone to access the internet (all ages)	
% household without a computer (all ages)	
% households with access to Broadband (all ages)	

INDICATORS	SOURCES and YEAR
% households without access to the Internet (all ages)	United States Census Bureau. "B28001, S2801: TYPES OF COMPUTERS AND INTERNET SUBSCRIPTIONS". U.S. Census Bureau's American Community Survey Office, 2022. Accessed March 2024. (https://data.census.gov/cedsci/).
Voter participation rate in 2020 election (age 18+)	The number of registered voters and ballots cast were obtained from the Maine Secretary of the State. (https://www.maine.gov/sos/cec/elec/data/index.html). Accessed August 13th, 2023.
Homicide rate /100,000 persons (County)	CDC Wonder, Multiple Cause of Death, 2016-2020. Accessed August 2023 (https://wonder.cdc.gov/controller/datarequest/D77;jsessionid=3AC202E57AC0BFE77BAEFB8769E8148D?stage=results&action=toggle&p=O_show_suppressed&v=true).
# firearm fatalities (all ages) (County)	
# 65+ deaths by suicide (County)	
Age-sex adjusted 1-year mortality rate	2020-2021 Master Beneficiary Summary File – A/B/C/D/Other, CMS Chronic Condition Data Warehouse. Accessed December 2023. (www.ccwdata.org).
TRANSPORTATION	
% householders 65+ who own a motor vehicle	United States Census Bureau. "B25045: TENURE BY VEHICLES AVAILABLE BY AGE OF HOUSEHOLDER". U.S. Census Bureau's American Community Survey Office, 2022. Accessed March 2024. (https://data.census.gov/cedsci/).
# fatal crashes involving adult age 60+ (County)	National Highway Traffic Safety Administration, Fatal Accident Reporting System (FARS) representing data for years 2018-2022. Downloaded from (http://www.nhtsa.gov/FARS). Accessed August 2023.
AllTransit Score	The AllTransit Performance Score was obtained from the AllTransit™ website on September 15th, 2023. (https://alltransit.cnt.org/).
HEALTH OUTCOMES	
FALLS	
% 65+ hip fracture	2020-2021 Master Beneficiary Summary File – A/B/C/D/Other, CMS Chronic Condition Data Warehouse. Accessed December 2023. (www.ccwdata.org).
PREVENTION	
% 18+ with physical exam/check-up in past year (County)	PLACES: Local Data for Better Health – County level. (2020-2021). Centers for Disease Control and Prevention. Accessed June 2024. https://www.cdc.gov/places
% mammography use among women age 50-74 Years (County)	
% 50-75 with fecal occult blood test, sigmoidoscopy, or colonoscopy (County)	

INDICATORS	SOURCES and YEAR
% 65+ men up to date on preventive services (County)	PLACES: Local Data for Better Health – County level. (2020-2021). Centers for Disease Control and Prevention. Accessed June 2024. https://www.cdc.gov/places
% 65+ women up to date on preventive services (County)	
NUTRITION/DIET	
% 18+ with obesity (County)	PLACES: Local Data for Better Health – County level. (2020-2021). Centers for Disease Control and Prevention. Accessed June 2024. https://www.cdc.gov/places
% 65+ with high Cholesterol	2020-2021 Master Beneficiary Summary File – A/B/C/D/Other, CMS Chronic Condition Data Warehouse. Accessed December 2023. (www.ccwdata.org).
% 18+ with high cholesterol screening (County)	PLACES: Local Data for Better Health – County level. (2020-2021). Centers for Disease Control and Prevention. Accessed June 2024. https://www.cdc.gov/places
ORAL HEALTH	
% 18+ with annual dental exam (County)	PLACES: Local Data for Better Health – County level. (2020-2021). Centers for Disease Control and Prevention. Accessed June 2024. https://www.cdc.gov/places
# dentists per 100,000 persons (all ages) (County)	Health Resources and Services Administration (HRSA). Accessed June 24th, 2023. (https://data.hrsa.gov/topics/health-workforce/ahrf).
% 65+ with complete tooth loss (County)	PLACES: Local Data for Better Health – County level. (2020-2021). Centers for Disease Control and Prevention. Accessed June 2024. https://www.cdc.gov/places
CHRONIC DISEASE	
% 65+ with Alzheimer's disease or related dementias	2020-2021 Master Beneficiary Summary File – A/B/C/D/Other, CMS Chronic Condition Data Warehouse. Accessed December 2023. (www.ccwdata.org).
% 65+ with anemia	
% 65+ with asthma	
% 65+ with atrial fibrillation	
% 65+ with benign prostatic hyperplasia (men)	
% 65+ with breast cancer (women)	
% 65+ with cataract	
% 65+ with chronic kidney disease	
% 65+ with chronic obstructive pulmonary disease	
% 65+ with colon cancer	
% 65+ with congestive heart failure	

INDICATORS	SOURCES and YEAR
% 65+ with diabetes	2020-2021 Master Beneficiary Summary File – A/B/C/D/Other, CMS Chronic Condition Data Warehouse. Accessed December 2023. (www.ccwdata.org).
% 65+ with endometrial cancer (women)	
% 65+ with fibromyalgia, chronic pain and fatigue	
% 65+ with glaucoma	
% 65+ ever had a heart attack	
% 65+ with HIV/AIDS	
% 65+ with hypertension	
% 65+ with ischemic heart disease	
% 65+ with liver disease	
% 65+ with lung cancer	
% 65+ with migraine and other chronic headache	
% 65+ with osteoarthritis or rheumatoid arthritis	
% 65+ with osteoporosis	
% 65+ with peripheral vascular disease	
% 65+ with pressure ulcer or chronic ulcer	
% 65+ with prostate cancer (men)	
% 65+ with stroke	
% 65+ with 4+ (out of 15) chronic conditions	
% 65+ with 0 chronic conditions	
BEHAVIORAL HEALTH	
# drug overdose deaths (all ages) (County)	CDC Wonder, Multiple Cause of Death, 2016-2020. Accessed August 2023. (https://wonder.cdc.gov/controller/datarequest/D77;jsessionid=3AC202E57AC0BFE77BAEFB8769E8148D?stage=results&action=toggle&p=O_show_suppressed&v=true).
% 65+ with substance use disorder	2020-2021 Master Beneficiary Summary File – A/B/C/D/Other, CMS Chronic Condition Data Warehouse. Accessed December 2023. (www.ccwdata.org).
% 18+ excessive drinking (County)	PLACES: Local Data for Better Health – County level. (2020-2021). Centers for Disease Control and Prevention. Accessed June 2024. https://www.cdc.gov/places
% 65+ with tobacco use disorders	2020-2021 Master Beneficiary Summary File – A/B/C/D/Other, CMS Chronic Condition Data Warehouse. Accessed December 2023. (www.ccwdata.org).

INDICATORS	SOURCES and YEAR
% 18+ current smokers (County)	PLACES: Local Data for Better Health – County level. (2020-2021). Centers for Disease Control and Prevention. Accessed June 2024. https://www.cdc.gov/places
MENTAL HEALTH	
% 18+ with 14+ days poor mental health past month	PLACES: Local Data for Better Health – County level. (2020-2021). Centers for Disease Control and Prevention. Accessed June 2024. https://www.cdc.gov/places
% 65+ with depression	2020-2021 Master Beneficiary Summary File – A/B/C/D/Other, CMS Chronic Condition Data Warehouse. Accessed December 2023. (www.ccwdata.org).
% 65+ with anxiety disorder	
% 65+ with post-traumatic stress disorder	
% 65+ with schizophrenia & other psychotic disorder	
LIVING WITH DISABILITY	
% 65+ with self-reported hearing difficulty	United States Census Bureau. "B18102: SEX BY AGE BY HEARING DIFFICULTY". U.S. Census Bureau's American Community Survey Office, 2022. Accessed March 2024. (https://data.census.gov/cedsci/).
% 65+ with self-reported vision difficulty	United States Census Bureau. "B18103: SEX BY AGE BY VISION DIFFICULTY". U.S. Census Bureau's American Community Survey Office, 2022. Accessed March 2024. (https://data.census.gov/cedsci/).
% 65+ with self-reported cognition difficulty	United States Census Bureau. "B18104: SEX BY AGE BY COGNITIVE DIFFICULTY". U.S. Census Bureau's American Community Survey Office, 2022. Accessed March 2024. (https://data.census.gov/cedsci/).
% 65+ with self-reported ambulatory difficulty	United States Census Bureau. "B18105: SEX BY AGE BY AMBULATORY DIFFICULTY". U.S. Census Bureau's American Community Survey Office, 2022. Accessed March 2024. (https://data.census.gov/cedsci/).
% 65+ with self-reported self-care difficulty	United States Census Bureau. "B18106: SEX BY AGE BY SELF-CARE DIFFICULTY". U.S. Census Bureau's American Community Survey Office, 2022. Accessed March 2024. (https://data.census.gov/cedsci/).
% 65+ with self-reported independent difficulty	United States Census Bureau. "B18107: SEX BY AGE BY INDEPENDENT DIFFICULTY". U.S. Census Bureau's American Community Survey Office, 2022. Accessed March 2024. (https://data.census.gov/cedsci/).
CAREGIVING	
# of Alzheimer's support groups	Alzheimer's Association. Community Resource finder tool. Retrieved from (https://www.communityresourcefinder.org/ProviderSearch/Search?ProfileDefinitionId=91&location=boston%2C+ma) in November, 2023.

INDICATORS	SOURCES and YEAR
% of grandparents raising grandchildren	United States Census Bureau. "B10050: GRANDPARENTS LIVING WITH OWN GRANDCHILDREN UNDER 18 YEARS BY RESPONSIBILITY FOR OWN GRANDCHILDREN BY LENGTH OF TIME RESPONSIBLE FOR OWN GRANDCHILDREN FOR THE POPULATION 30 YEARS AND OVER". U.S. Census Bureau's American Community Survey Office, 2022. Accessed March 2024. (https://data.census.gov/cedsci/).
ACCESS TO CARE	
% 65+ dually eligible for Medicare and Medicaid	2020-2021 Master Beneficiary Summary File – A/B/C/D/Other, CMS Chronic Condition Data Warehouse. Accessed December 2023. (www.ccwdata.org).
% 65+ Medicare managed care enrollees	
% 18-64 who lack health insurance (County)	PLACES: Local Data for Better Health – County level. (2020-2021). Centers for Disease Control and Prevention. Accessed June 2024. https://www.cdc.gov/places
# primary care providers	Primary care providers (PCPs) were obtained from the Doctors and Clinicians national downloadable file (https://data.cms.gov/provider-data/dataset/mj5m-pzi6) in June 2023.
# of hospitals	Number of hospitals per town was obtained from the Hospital General Information data table (https://data.cms.gov/provider-data/dataset/xubh-q36u). Data on Hospitals was accessed on June 25th, 2023.
# home health agencies	Number of home health agencies per town was obtained from the Home Health Care Agencies data table (https://data.cms.gov/provider-data/dataset/6jpm-sxkc). Data on home health agencies was accessed on July 2nd, 2023.
# skilled nursing facilities	Number of nursing homes per town was obtained from the Provider Information data table (https://data.cms.gov/provider-data/dataset/4pq5-n9py). Data on skilled nursing homes was accessed on July 2nd, 2023.
# of hospice agencies	Number of hospice agencies per town was obtained from the Hospice – Provider Data table (https://data.cms.gov/provider-data/dataset/xubh-q36u). Data was accessed on June 28th, 2023.
# community health centers	HRSA Data Warehouse. "Find a Health Center Tool". (https://findahealthcenter.hrsa.gov/). Accessed July 4th, 2023.
# adult day health centers	Maine Association of Adult Day Services. Data was accessed on October 16th, 2023. (https://www.pfr.maine.gov/ALMSOnline/ALMSQuery/Welcome.aspx).

INDICATORS	SOURCES and YEAR
SERVICE UTILIZATION	
# physician visits per year	2020-2021 Master Beneficiary Summary File – A/B/C/D/Other, CMS Chronic Condition Data Warehouse. Accessed December 2023. (www.ccwdata.org).
# emergency room visits/1000 persons 65+ years annually	
# Part D monthly prescription fills per person annually	
# home health visits annually	
# durable medical equipment claims annually	
# inpatient hospital stays/1000 persons 65+ years annually	
% Medicare inpatient hospital readmissions (as % of admissions)	
# skilled nursing facility stays/1000 persons 65+ years annually	
# skilled nursing home Medicare beds/1000 persons 65+ years	
% 65+ getting Medicaid long term services and supports	
% 65+ hospice users	
% 65+ hospice users as % of decedents	