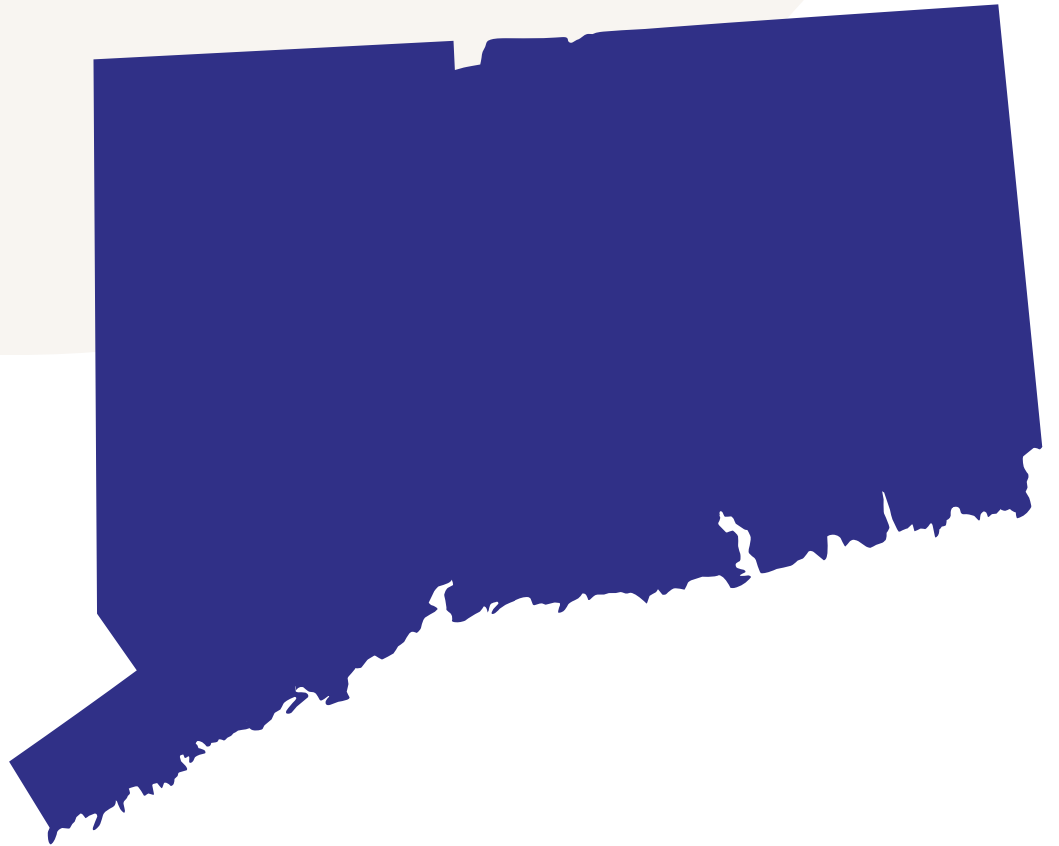




Healthy Aging Data Report

Highlights from 2025

CONNECTICUT



Explore more online at
HealthyAgingDataReports.org

A Message from the Governor



Demographic shifts are presenting exciting opportunities for Connecticut. Our great state has more than 885,046 residents aged 60 and older, which is nearly a quarter of the state's population. Connecticut's older adults are more diverse, educated, and resilient than ever before. This *2025 Connecticut Healthy Aging Data Report* offers a rich set of epidemiological trends and statistical insights that inspire age-friendly innovations and provide a roadmap for creating a more longevity-ready state.

The data in this report equips us to better respond to the changing needs of Connecticut's older residents. For example, compared to other New England states, older adults in Connecticut had the highest rates of hip fracture, Alzheimer's disease, breast and prostate cancer, osteoporosis, and other chronic health conditions. This is a call to action to develop new and improved services and focus on policies that help reverse these trends and address systemic issues. This report also highlights a population of individuals with HIV/AIDS who are aging and whose needs to which we must be prepared to respond. With over 27% of Connecticut older adults living alone, social isolation, loneliness, and mental health are also critical needs that require our thoughtful consideration. Recognizing the need to combat loneliness and social isolation, we launched a social connection campaign in Connecticut. And how can we forget the COVID-19 pandemic? The impact of the pandemic on health and aging will be felt for generations to come.

I want to extend my gratitude to the researchers at the Gerontology Institute in the Manning School of Nursing and Health Sciences at the University of Massachusetts Boston, and the Point32Health Foundation for their work on this valuable report. This resource will help inform policy, enhance our programs and services, and fuel collective action to make positive changes in local communities, municipalities, and the state.

The Connecticut Age Well Collaborative, AgingCT, and the Department of Aging & Disability Services Bureau of Aging are just a few of the many groups that are working to support livable communities across Connecticut. When our communities are livable for everyone, our state is stronger and more longevity ready. I encourage leaders in every Connecticut city and town to invest time in reading this report as well as their community profile to celebrate successes, but also identify opportunities to improve services, address social drivers of health, and support healthy aging among residents.

We look forward to working together to create a Connecticut where everyone can age with dignity, well-being, and purpose.

Ned Lamont

Governor
State of Connecticut



A Message from the Funder and Principal Investigator

All of our communities should be great places to grow up and grow old. We need healthy economies and vibrant neighborhoods that work for everyone. Yet it takes planning and intention to translate a vision into reality. To help accelerate this work the Point32Health Foundation (formerly the Tufts Health Plan Foundation and Harvard Pilgrim Foundation) has invested millions of dollars to promote community health.

There is a clear need for accurate, unbiased information to help pinpoint risks, mitigate harms, and improve health. The 2025 Connecticut Healthy Aging Data Report is a uniquely valuable tool for understanding the current status and where we have come from.

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

- When addressing needs, don't go it alone — deliberately connect with those doing the work at the local, state, and regional levels.
- Consider starting with small projects to engage more partners and build consensus and momentum. As you progress, leverage your experience and expand your network of collaborators to take on more challenging issues.
- Be intentional about inclusion — we all are aging and can learn from each other.
- Finally, celebrate successes. We are in this for the long run and encouragement helps.

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

Greg Shell

Chair, Board of Directors,
Point32Health Foundation;
Vice Chair, Board of
Directors, Point32Health

Elizabeth Dugan, PhD

Principal Investigator,
Gerontology, University of
Massachusetts Boston

About the Report

The 2025 Connecticut Healthy Aging Data Report is available online at healthyagingdatareports.org. We invite you to explore this resource to better understand the residents in your local community, the state of Connecticut, and New England.

The 2025 Connecticut Healthy Aging Data Report includes the following tools:

- 181 community profiles (for every city and town)
- 152 maps listing community rates for each indicator (organized alphabetically and ranked high to low)
- 18 interactive web maps
- Infographic summarizing key findings
- Highlights Report
- Technical documentation

The Healthy Aging Data Report team at the Gerontology Institute in the Manning School of Nursing and Health Sciences at the University of Massachusetts Boston created this resource with financial support from the Point32Health Foundation. We have been engaged in this work since 2012 and have learned from many state partners how important tools like this can be in efforts to improve healthy aging. Our goal is to help accelerate your progress in creating age-friendly, longevity-ready, healthy communities. When communities work for older people, they work for everyone!

The data reveal important patterns of disease, social determinants of health, and resources. The updated report includes maps illustrating the statewide distribution of rates highlighting areas of health inequity.



Dugan, E., Lee, CM., Jansen, T., Song, Q., Su, YJ., & Silverstein, NM. The Connecticut Healthy Aging Data Report: 2025 Highlights. (<https://healthyagingdatareports.org/connecticut-healthy-aging-data-report/>).

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What Do Age-Friendly Communities Have in Common?

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

Contact the team for additional analyses, to share suggestions, or to request a report in your state. Beth.dugan@umb.edu

A Vision of Communities that Support Longevity

How fortunate are we? We are living in an era when advances in public health, nutrition, and medicine have contributed the most significant gains in human longevity in recorded history. Longevity coupled with declining birthrates creates population aging. Soon we will have more older adults in the United States than children 5 years or younger. These demographic changes present exciting opportunities for states and communities. We exist in a society that is still geared for the life and

population age structure of a hundred years ago (when life expectancy was less than 50). This structural lag can be closed if we take thoughtful action to address the key domains of age-friendly communities: housing, communication, community supports, outdoor spaces, transportation, social participation, social inclusion, and civic participation. You are invited to join with those already working to make Connecticut longevity-ready.



The Connecticut Age Well Collaborative is a statewide, cross-sector initiative that fosters aging, dementia and disability-inclusive communities. The Collaborative is an initiative of Connecticut Community Care. Delegated by the Commission on Women, Children, Seniors, Equity & Opportunity, there leading the state's livable communities initiative (Section 17b-420a of the Connecticut General Statutes). See <https://ctagewellcollaborative.org/>



AgingCT, the voice for Connecticut's seniors, individuals with disabilities, and caregivers, combines the power of five nonprofit Area Agencies on Aging for Connecticut. As independent agencies, each works to improve the lives of Connecticut residents through advocacy, resource-sharing, and services. See <https://agingct.org/>



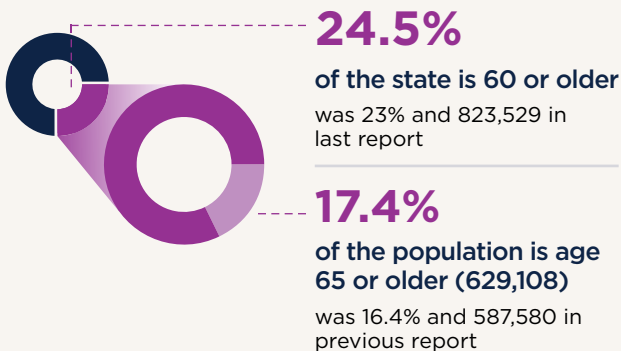
Connecticut Aging and Disability Services has the mission to maximize opportunities for independence and well-being of people with disabilities and older adults in CT. See <https://portal.ct.gov/ads>

What's New in Aging in Connecticut?

Connecticut is a state bursting with potential to benefit from the gains in human longevity and the opportunities it presents. The older population is growing, more diverse, and more educated than previous generations.

CT's older population is growing

885,046 people in Connecticut are 60+



IMPACT OF COVID-19

According to the Centers for Disease Control, 13,150 Connecticut residents died as a result of the COVID-19 pandemic. We expect that the reverberations of the pandemic may impact health and aging for years to come.



13.4% of the 65+ population are veterans of military service

CT's older population is changing



AGE

The age structure of the older population has shifted younger as the baby boom generation enters later life.

57.6% Age 65-74 **28.4%** Age 75-84 **14%** Age 85+



MORE DIVERSE

While most older residents identify as White (84.8%), 6.7% are Hispanic, 5.9% Other race(s), 2.6% are Asian, and 6.7% are African American/Black.

1,729 adults 55+ are Native American

15% report speaking a language other than English at home



27.7% of Connecticut older adults live alone

OTHER INDICATORS

- **Marital Status:** Among the population 65+, 54.5% are married, 21.2% widowed, 16.1% divorced/separated, and 8.2% never married.
- **Education:** Statewide the education levels of adults 65+ are 18.6% have a graduate or professional degree, 17% have a college degree, 52.4% have a high school degree or some college, and 11.9% have less than a high school education.
- **Chronic Conditions:** Compared to the other New England states, older residents of

Connecticut have the highest rates of hip fracture, Alzheimer's disease, benign prostatic hyperplasia, breast cancer, congestive heart failure, osteoporosis, and prostate cancer.

- **HIV/AIDS:** The rate of adults 65+ with HIV/AIDS increased from 0.18% in 2014-2015 to 0.28% in 2020-2021. This trend was consistent across New England. Maine, Connecticut, and Massachusetts had the largest % increases. Providers may be advised to prepare for a growing population of HIV/AIDS survivors.

Understanding the Data

There is a lot of information in the report, and it is not unusual for people to feel a little overwhelmed by it all. This Highlights Report provides a framework for understanding the status of your state. The online community profiles allow you to focus more sharply on your community.

As researchers we are often asked to identify the healthiest and/or most burdened communities in a state. Policymakers, service providers, and funders routinely have to make tough decisions on where to

put resources and many strive to be guided by data. There are several ways we try to answer that question. For example, we can compare communities by contrasting communities with the healthiest rates on various conditions and those with the unhealthiest. This approach is helpful because it shows the wide range of rates for important conditions related to healthy aging. Below we contrast rates for conditions that provide an indication of overall health status.

Table 1. Best and Worst Rates on Selected Indicators

	Best Rates	Worst Rates
Alzheimer’s disease and related dementias	6.90% Sherman	27.10% Central Hartford (Area 2)
Depression	23.68% Sherman	42.65% Central Hartford (Area 2)
Diabetes	18.13% Chester	54.56% Eastern Bridgeport (Area 3)
Hypertension	57.35% Weston	83.30% Northern Hartford (Area 1)
Independent living difficulty	0.80% Barkhamsted	28.21% Columbia
Ischemic heart disease	29.06% Bethany	50.57% Sharon
Stroke	7.15% Bethany	15.23% Northwest Bridgeport (Area 1)
4+ chronic conditions	49.95% Weston	70.89% Eastern New Haven (Area 3)
No chronic conditions	12.47% New Hartford	4.59% Bloomfield
	High	Low
Receiving Medicaid long term services and supports	0.90% Bridgewater, Roxbury	20.52% Central Hartford (Area 2)
Inpatient hospital readmission rate	4.84% Sharon	26.34% Southern Bridgeport (Area 2)
Dually eligible for Medicare and Medicaid	5.72% Redding	63.29% Southern Hartford (Area 3)

Another approach to describing the health of Connecticut residents is to count up how many indicators are “better” compared to the state average.

Communities that are healthier than state average may have some resources (e.g., park, walking paths, very engaged senior center, or public library) that could be replicated by less healthy communities.

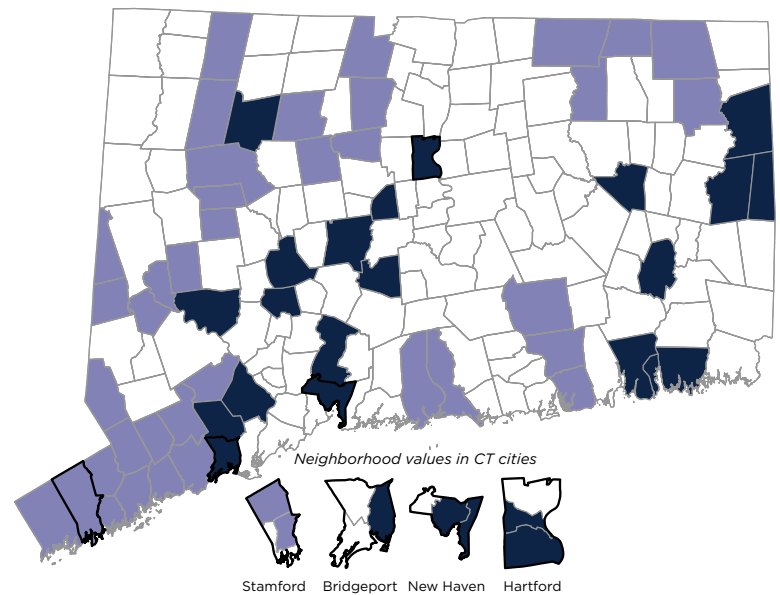
Towns with 14+ better rates (indigo in the map)

Avon, Bethlehem, Bridgewater, Brookfield, Burlington, Darien, East Haddam, Easton, Fairfield, Goshen, Granby, Greenwich, Guilford, Litchfield, Lyme, Madison, Monroe, Morris, New Canaan, New Fairfield, New Hartford, Norfolk, Norwalk, Old Lyme, Pomfret, Ridgefield, Roxbury, Sherman, Simsbury, Stafford, Stamford, Union, Weston, Westport, Willington, Wilton, Woodstock, Northern (Area 1), and Western Stamford (Area 3)

Similarly, to highlight communities with many rates “worse” than the state average may speed investments in preventive interventions in these communities. This in turn could improve healthy aging for future generations.

Towns with 14+ worse rates (navy in the map)

Bridgeport, Groton, Hamden, Hartford, Killingly, Meriden, Naugatuck, New Britain, New Haven, New London, Norwich, Plainfield, Shelton, Southbury, Southington, Sterling, Torrington, Trumbull, Waterbury, Waterford, Windham, Eastern Bridgeport (Area 3), Central (Area 2) and Southern Hartford (Area 3), Central (Area 2) and Eastern New Haven (Area 3)



Map key: Indigo square: Towns with 14+ better rates; Navy square: Towns with 14+ worse rates

We recognize that communities don’t become healthier or more burdened spontaneously or without cause. These differences may be the result of systematic disparities in access to education, adequate housing, safe employment, and healthy, walkable environments. We don’t identify these communities to make value judgments about the residents.

In fact, we highlight differences to illuminate disparities that are hidden in reports that only report rates at the state level.

Note: in the comparisons that follow (trends, gender, race, state differences) only statistically significant differences are reported.

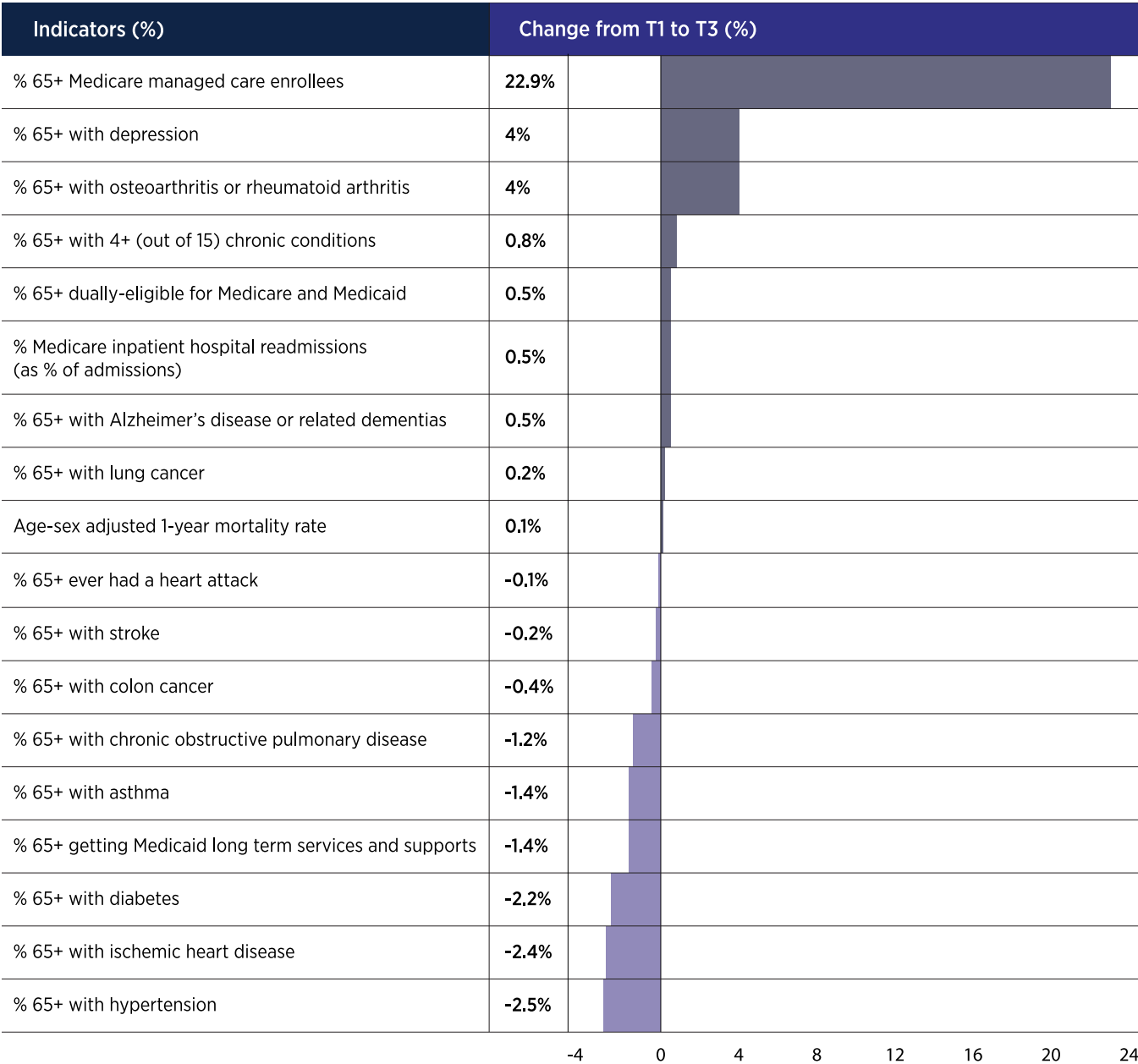
What Has Changed Over Time in Connecticut?

We were able to analyze Medicare data from 2014–2015 (Time 1), 2016–2017 (Time 2), and 2020–2021 (Time 3) to explore how health indicators have changed over time in Connecticut. We found both positive and negative changes. As seen in Table 2, Medicare managed care enrollment increased from 27.3% at Time 1 to 50.1% at Time 3. More than one-half of the 65+ population in Connecticut is now

in a Medicare managed care plan. Rate increases were also observed for depression, arthritis, having 4+ chronic conditions, dually eligible for Medicare and Medicaid, inpatient hospital readmissions, and Alzheimer’s disease.

Evidence of improvements in healthy aging are found in the declines in strokes, colon cancer, ischemic heart disease, COPD, hypertension, and diabetes.

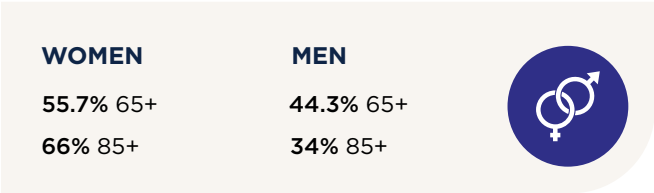
Table 2. Change Over Time



How Does Gender Impact Healthy Aging?

The results in Table 3 show that compared to men, women have higher rates of conditions related to bone health (osteoporosis, arthritis, hip fracture), mental health (anxiety, depression, Alzheimer’s disease, schizophrenia, and PTSD), vision (cataract, glaucoma), and pain (migraine, fibromyalgia). Interventions and programs to promote bone health and mental health should include and specifically target older women.

Compared to men however, women may have better access to care (physician visits per year, dually-eligible Medicare and Medicaid, hospice



use, and enrolling in Medicare Advantage). While greater access to health care is desirable, this may be related to the fact that many women tend to marry older spouses and may outlive a spousal caregiver, thus necessitating formal long term care and end-of-life arrangements.

Table 3. Gender Differences: Women

Women Have Higher Rates Than Men	Female	Male	Difference Between Female and Male
% 65+ with osteoporosis	31.8%	4.9%	26.9%
% 65+ with anxiety disorder	37.2%	22.8%	14.5%
% 65+ with depression	37.5%	25.6%	11.9%
% 65+ with osteoarthritis or rheumatoid arthritis	60.1%	50.1%	10.0%
% 65+ with cataract	65.7%	56.5%	9.2%
% 65+ hospice users as % of decedents	46.0%	38.0%	7.9%
% 65+ dually-eligible for Medicare and Medicaid	25.7%	18.5%	7.2%
% 65+ with fibromyalgia, chronic pain, and fatigue	37.9%	30.9%	7.0%
% 65+ with migraine	9.7%	3.9%	5.7%
% 65+ with asthma	16.5%	11.0%	5.6%
% 65+ with glaucoma	28.1%	24.2%	4.0%
% 65+ Medicare managed care enrollees	51.3%	48.7%	2.5%
% 65+ had hip fracture	4.3%	2.2%	2.1%
% 65+ with anemia	50.0%	48.4%	1.6%

Table 3. Continued

Women Have Higher Rates Than Men	Female	Male	Difference Between Female and Male
% 65+ with Alzheimer’s disease or related dementias	14.2%	13.3%	0.9%
% 65+ with post-traumatic stress disorder	2.2%	1.8%	0.5%
% 65+ with schizophrenia	4.3%	3.9%	0.4%
# physician visits per year	8.6	8.2	0.4

Table 4 illustrates that compared to women, older men have higher rates of conditions related to cardiovascular health (heart disease, atrial fibrillation, congestive heart failure, hypertension, heart attack, peripheral vascular disease, stroke), diabetes, harmful health behaviors (substance use disorder,

tobacco use disorder), infectious disease (cancer, HIV), and higher use of emergency rooms and hospital stays. Interventions and programs to promote cardiovascular health (nutrition, exercise, smoking cessation, stress management) that target older men are needed.

Table 4. Gender Differences: Men

Men Have Higher Rates Than Women	Male	Female	Difference Between Male and Female
% 65+ with ischemic heart disease	46.4%	33.2%	13.2%
% 65+ with chronic kidney disease	37.7%	29.0%	8.7%
% 65+ with atrial fibrillation	19.4%	12.4%	7.0%
% 65+ with diabetes	35.5%	28.8%	6.7%
% 65+ with congestive heart failure	23.8%	18.9%	4.9%
% 65+ with hypertension	76.7%	71.9%	4.8%
% 65+ with substance use disorder	10.4%	6.5%	3.9%
% 65+ with peripheral vascular disease	20.9%	17.5%	3.4%
% 65+ with tobacco use disorder	13.3%	10.1%	3.2%
% Medicare inpatient hospital readmissions (as % of admissions)	19.0%	16.4%	2.6%
% 65+ ever had a heart attack	5.7%	3.3%	2.4%
% 65+ with 0 chronic conditions	8.5%	7.0%	1.5%

Table 4. Continued

Men Have Higher Rates Than Women	Male	Female	Difference Between Male and Female
% 65+ with stroke	12.3%	10.9%	1.4%
Age-sex adjusted 1-year mortality rate	4.7%	3.5%	1.2%
% 65+ with pressure ulcer or chronic ulcer	9.7%	8.6%	1.1%
% 65+ with high cholesterol	78.3%	77.5%	0.9%
% 65+ with chronic obstructive pulmonary disease	19.9%	19.3%	0.6%
% 65+ with colon cancer	2.6%	2.3%	0.3%
% 65+ with HIV/AIDS	0.4%	0.2%	0.2%
# inpatient hospital stays/1000 persons 65+ years annually	273	218	55
# emergency room visits/1000 persons 65+ years annually	612	568	43
# Medicare Part D monthly prescription fills per enrollee annually	53	52	1
# durable medical equipment claims annually	2.3	1.8	0.5

There are several public health initiatives that might be considered for statewide action. These include increasing screening for high cholesterol and hypertension in men and women. In addition, supporting gender-specific programs to address

lifestyle behaviors among older men, such as smoking cessation, and muscle strengthening and fall prevention for older women, can help promote healthy aging.

KEY TAKEAWAYS

WOMEN

Bone health

- 7x higher osteoporosis
- 9% higher arthritis
- 2% higher hip fracture

Mental health

- 17% higher rates of anxiety
- 14% higher depression rates

MEN

Heart & metabolic diseases

- 14% higher ischemic heart disease
- 4% higher rates of hypertension
- 7% higher diabetes rates

Emergency room usage & hospital stays

- 63 more visits to ER annually than older CT women
- 47 more hospital stays annually than older CT women

How Do Race and Ethnicity Impact Healthy Aging?

Another way to understand the health of older adults in Connecticut is to contrast racial and ethnic differences on indicator rates. In Tables 5-11 we report the disparities detected.

Compared to Black adults, White adults have higher rates in certain health conditions. The most significant differences are in the rates of cataracts (11.5% higher in White adults), hospice usage as a percentage of decedents (11.1%), anxiety disorders (9.3%), osteoporosis (8.8%), benign prostatic hyperplasia among White older men (8.0%), atrial fibrillation (5.9%), and osteoarthritis or rheumatoid arthritis (5.1%). White adults also visit healthcare providers for physical exams twice as often as Black individuals. Notably, there are no significant differences between the two groups in ischemic heart disease, post-traumatic stress disorder, and liver disease.

INTERPRETING RACE & ETHNICITY DATA

When analyzing Medicare data, we recognize that some groups may be less apt to get health-care and thus appear “healthier” in our report, when in reality, the racial or ethnic group members have undiagnosed or untreated conditions because of a lack of health care. In addition, the observed health differences may arise from the stressful burdens of structural racism. Understanding the why of rate disparities is a challenge in this type of research. Below we report the what (rate differences).

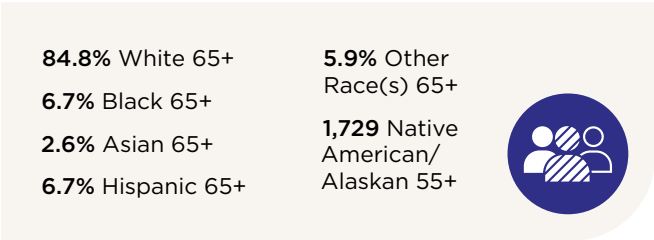


Table 5. Racial Differences Between White and Black Older Adults

White Adults Have Higher Rates Than Black Adults	White	Black	Difference Between White and Black
% 65+ with cataract	63.5%	52.0%	11.5%
% 65+ hospice users as % of decedents	44.3%	33.2%	11.1%
% 65+ with anxiety disorder	32.3%	23.0%	9.3%
% 65+ with osteoporosis	21.2%	12.4%	8.8%
% 65+ with benign prostatic hyperplasia (men)	45.5%	37.5%	8.0%
% 65+ with atrial fibrillation	16.6%	10.7%	5.9%
% 65+ with osteoarthritis or rheumatoid arthritis	57.3%	52.2%	5.1%

Table 5. Continued

White Adults Have Higher Rates Than Black Adults	White	Black	Difference Between White and Black
% 65+ with high cholesterol	78.7%	73.9%	4.8%
% 65+ with depression	33.2%	28.7%	4.5%
% 65+ with breast cancer (women)	12.3%	9.3%	3.1%
% 65+ with fibromyalgia, chronic pain, and fatigue	35.6%	32.7%	2.9%
% 65+ had hip fracture	3.8%	1.5%	2.3%
% 65+ with chronic obstructive pulmonary disease	20.4%	19.0%	1.4%
% 65+ with migraine and other chronic headache	7.3%	5.9%	1.4%
% 65+ hospice users	2.8%	2.1%	0.7%
% 65+ with endometrial cancer (women)	2.3%	1.7%	0.6%
% 65+ ever had a heart attack	4.5%	3.9%	0.6%
% 65+ with lung cancer	2.2%	1.7%	0.5%
# physician visits per year	9	7	2

In Connecticut, Black older adults have significantly higher rates compared to White older adults in several key health indicators. The most substantial difference is in the percentage of those who are dually-eligible for Medicare and Medicaid, with a 24.6% higher rate for Black older adults. Other notable disparities include diabetes (22.1%), chronic kidney disease (15.9%), Medicare managed care enrollees (13.4%), hypertension (8.8%), glaucoma (7.5%), anemia (7.0%), and congestive heart failure (6.0%). In terms of health utilization, compared to older White adults, Black older adults had 224 more emergency room visits per 1,000 individuals

annually, 86 more inpatient hospital stays per 1,000 older adults annually, 29 more stays in skilled nursing facilities, and 4.7 more Medicare Part D prescription fills per enrollee annually. Compared to older Black adults, White adults have higher rates related to cardiovascular health (high cholesterol, ischemic heart disease, atrial fibrillation, COPD, peripheral vascular disease, congestive heart failure, heart attack), vision (glaucoma, cataract), bone health (arthritis, osteoporosis, hip fracture), cancer (breast, lung, prostate), and a higher mortality rate. Utilization is higher for physician visits, emergency room visits, and nursing home stays.

Table 6. Racial Differences Between Black and White Older Adults

Black Adults Have Higher Rates Than White Adults	Black	White	Difference Between Black and White
% 65+ dually-eligible for Medicare and Medicaid	42.8%	18.2%	24.6%
% 65+ with diabetes	52.2%	30.1%	22.1%
% 65+ with chronic kidney disease	48.2%	32.4%	15.9%
% 65+ Medicare managed care enrollees	62.1%	48.7%	13.4%
% 65+ with hypertension	83.3%	74.4%	8.8%
% 65+ with glaucoma	34.0%	26.5%	7.5%
% 65+ with anemia	56.9%	49.9%	7.0%
% 65+ with congestive heart failure	27.5%	21.5%	6.0%
% 65+ with tobacco use disorder	16.4%	11.5%	4.9%
% 65+ getting Medicaid long term services and supports	8.2%	3.7%	4.5%
% 65+ with schizophrenia & other psychotic disorder	8.2%	4.0%	4.2%
% 65+ with Alzheimer's disease or related dementias	18.3%	14.2%	4.1%
% 65+ with prostate cancer (men)	17.8%	13.8%	4.0%
% 65+ with stroke	15.6%	11.7%	4.0%
% 65+ with substance use disorder	12.1%	8.2%	3.9%
% Medicare inpatient hospital readmissions (as % of admissions)	21.0%	17.1%	3.9%
% 65+ with 4+ (out of 15) chronic conditions	66.1%	62.5%	3.6%
% 65+ with peripheral vascular disease	22.5%	19.7%	2.8%
% 65+ with asthma	16.3%	14.0%	2.3%
% 65+ with pressure ulcer or chronic ulcer	11.6%	9.5%	2.1%
% 65+ with 0 chronic conditions	8.9%	7.2%	1.8%
% 65+ with HIV/AIDS	1.7%	0.2%	1.6%
Age-sex adjusted 1-year mortality rate	4.7%	4.0%	0.7%
% 65+ with colon cancer	2.9%	2.5%	0.4%
# emergency room visits/1000 persons 65+ years annually	807	583	224
# inpatient hospital stays/1000 persons 65+ years annually	329	243	86
# skilled nursing facility stays/1000 persons 65+ annually	122	93	29
# Medicare Part D monthly prescription fills annually	56.5	51.7	4.7

The overall pattern of health disparities between Hispanic and White older adults follows a similar pattern. Older Hispanic adults have an even larger disparity in dual-eligibility for Medicare and Medicaid, with a 41.1% higher rate compared to White adults. They also experience higher rates of

diabetes (17.4%), enrollment in Medicare managed care (11.7%), receipt of Medicaid long-term services and supports (8.6%), chronic kidney disease (6.0%), asthma (5.6%), liver disease, schizophrenia, and Alzheimer’s disease.

Table 7. Racial/Ethnic Differences: Hispanic and White Older Adults

Hispanic Adults Have Higher Rates Than White Adults	Hispanic	White	Difference Between Hispanic and White
% 65+ dually eligible for Medicare and Medicaid	59.3%	18.2%	41.1%
% 65+ with diabetes	47.5%	30.1%	17.4%
% 65+ Medicare managed care enrollees	60.4%	48.7%	11.7%
% 65+ getting Medicaid long term services and supports	12.2%	3.7%	8.6%
% 65+ with chronic kidney disease	38.3%	32.4%	6.0%
% 65+ with asthma	19.6%	14.0%	5.6%
% Medicare inpatient hospital readmissions (as % of admissions)	22.0%	17.1%	4.9%
% 65+ with liver disease	14.7%	11.6%	3.1%
% 65+ with schizophrenia & other psychotic disorder	7.0%	4.0%	3.0%
% 65+ with 0 chronic conditions	10.1%	7.2%	2.9%
% 65+ with Alzheimer’s disease or related dementias	16.9%	14.2%	2.7%
% 65+ with depression	35.2%	33.2%	2.0%
% 65+ with substance use disorder	9.4%	8.2%	1.2%
% 65+ with tobacco use disorder	12.6%	11.5%	1.2%
% 65+ with HIV/AIDS	1.1%	0.2%	0.9%
% 65+ with stroke	12.5%	11.7%	0.8%
% 65+ with post-traumatic stress disorder	2.8%	2.0%	0.8%
# emergency room visits/1000 persons 65+ years annually	770.8	583.4	187.4
# Medicare Part D monthly prescription fills per enrollee annually	60	52	8
# inpatient hospital stays/1000 persons 65+ years annually	266	243	23

Older White adults have higher rates of cataracts (10.4%), arthritis (7.3%), atrial fibrillation (7.0%), hospice usage as a percentage of decedents (6.9%), and benign prostatic hyperplasia (6.6%) and prostate cancer (4.5%). There are no significant differences

between the groups for having four or more chronic conditions, colon cancer, glaucoma, hypertension, heart attacks, congestive heart failure, and peripheral vascular disease.

Table 8. Racial/Ethnic Differences Between White and Hispanic Older Adults

White Adults Have Higher Rates Than Hispanic Adults	White	Hispanic	Difference Between White and Hispanic
% 65+ with cataract	63.5%	53.1%	10.4%
% 65+ with osteoarthritis or rheumatoid arthritis	57.3%	49.9%	7.3%
% 65+ with atrial fibrillation	16.6%	9.6%	7.0%
% 65+ hospice users as % of decedents	44.3%	37.3%	6.9%
% 65+ with benign prostatic hyperplasia (men)	45.5%	38.9%	6.6%
% 65+ with prostate cancer (men)	13.8%	9.3%	4.5%
% 65+ with breast cancer (women)	12.3%	8.0%	4.4%
% 65+ with high cholesterol	78.7%	75.5%	3.2%
% 65+ with anxiety disorder	32.3%	29.4%	2.9%
% 65+ with anemia	49.9%	47.8%	2.1%
% 65+ with osteoporosis	21.2%	19.3%	1.9%
% 65+ with chronic obstructive pulmonary disease	20.4%	18.5%	1.9%
% 65+ had hip fracture	3.8%	2.3%	1.6%
% 65+ with pressure ulcer or chronic ulcer	9.5%	8.3%	1.2%
% 65+ hospice users	2.8%	2.0%	0.8%
% 65+ with lung cancer	2.2%	1.5%	0.7%
% 65+ with endometrial cancer (women)	2.3%	1.9%	0.5%
# physician visits per year	8.7	6.5	2.2

Older White adults have numerous rates that are higher compared to Older Asian adults. As shown in the Table below, high rates were found for: Bone health (arthritis, osteoporosis), brain and mental health (anxiety, depression, Alzheimer’s disease), behavioral health (substance use and tobacco use disorders), and cardiovascular health (atrial fibrillation, congestive heart failure, COPD, peripheral

vascular disease, ischemic heart disease, hypertension, stroke). Rates for hospice use and being dually-eligible for Medicare and Medicaid were higher for White adults compared to older Asians. The only rate that was higher for older Asians was the rate for having no chronic conditions, which is an indicator of good health.

Table 9. Racial/Ethnic Differences: White and Asian Older Adults

White Adults Have Higher Rates Than Asian Adults	White	Asian	Difference Between White and Asian
% 65+ with osteoarthritis or rheumatoid arthritis	57.3%	39.7%	17.6%
% 65+ with depression	33.2%	17.5%	15.7%
% 65+ with anxiety disorder	32.3%	16.7%	15.6%
% 65+ dually eligible for Medicare and Medicaid	18.2%	33.1%	14.9%
% 65+ with cataract	63.5%	49.3%	14.1%
% 65+ with 4+ (out of 15) chronic conditions	62.5%	51.1%	11.5%
% 65+ with benign prostatic hyperplasia (men)	45.5%	34.3%	11.2%
% 65+ with fibromyalgia, chronic pain, and fatigue	35.6%	25.6%	10.0%
% 65+ hospice users as % of decedents	44.3%	34.4%	9.9%
% 65+ with atrial fibrillation	16.6%	8.3%	8.3%
% 65+ with peripheral vascular disease	19.7%	11.7%	8.0%
% 65+ with chronic obstructive pulmonary disease	20.4%	12.7%	7.7%
% 65+ with ischemic heart disease	39.9%	32.6%	7.3%
% 65+ with congestive heart failure	21.5%	14.2%	7.3%
% 65+ with prostate cancer (men)	13.8%	6.8%	7.0%
% 65+ with anemia	49.9%	44.1%	5.8%
% 65+ with pressure ulcer or chronic ulcer	9.5%	3.8%	5.7%
% 65+ with high cholesterol	78.7%	73.6%	5.0%
% 65+ with Alzheimer’s disease or related dementias	14.2%	9.4%	4.8%

Table 9. Continued

White Adults Have Higher Rates Than Asian Adults	White	Asian	Difference Between White and Asian
% 65+ with breast cancer (women)	12.3%	7.7%	4.6%
% 65+ with hypertension	74.4%	70.2%	4.2%
% 65+ with substance use disorder	8.2%	4.3%	3.9%
% 65+ with asthma	14.0%	10.3%	3.7%
% 65+ with tobacco use disorder	11.5%	7.8%	3.7%
% 65+ with migraine and other chronic headache	7.3%	4.0%	3.3%
% 65+ with osteoporosis	21.2%	18.0%	3.3%
% 65+ with stroke	11.7%	8.6%	3.1%

Comparing rates between older White adults and Native American adults revealed many health disparities. Older Native Americans have higher rates for diabetes (20.5%), 4+ chronic condition (16.6%), COPD (13.4%), hypertension (12.6%), tobacco use disorder (12.6%), kidney disease (11.6%), anemia (11.4%), fibromyalgia (9.9%), congestive heart failure

(7.4%), and asthma (6.6%). Utilization rates are higher for being dually-eligible for Medicare and Medicaid, getting Medicaid long term services and supports, and more monthly prescription refills. Older White adults have higher rates of Medicare Advantage enrollment.

Table 10. Native American and White Older Adult Rate Disparities

Native American Adults Have Higher Rates Than White Adults	Native American	White	Difference Between Native American and White
% 65+ with diabetes	50.6%	30.1%	20.5%
% 65+ dually-eligible for Medicare and Medicaid	36.8%	18.2%	18.6%
% 65+ with 4+ (out of 15) chronic conditions	79.2%	62.5%	16.6%
% 65+ with COPD	33.8%	20.4%	13.4%
% 65+ with hypertension	87.1%	74.4%	12.6%
% 65+ with tobacco use disorder	24.0%	11.5%	12.6%
% 65+ with chronic kidney disease	44.0%	32.4%	11.6%

Table 10. Continued

Native American Adults Have Higher Rates Than White Adults	Native American	White	Difference Between Native American and White
% 65+ with anemia	61.3%	49.9%	11.4%
% 65+ with ischemic heart disease	50.2%	39.9%	10.3%
% 65+ with fibromyalgia	45.5%	35.6%	9.9%
% 65+ with congestive heart failure	28.9%	21.5%	7.4%
% 65+ with high cholesterol	85.9%	78.7%	7.3%
% 65+ with peripheral vascular disease	26.8%	19.7%	7.1%
% 65+ with asthma	20.6%	14.0%	6.6%
% 65+ with migraine	12.9%	7.3%	5.7%
% 65+ with Medicaid long term services and supports	7.0%	3.7%	3.3%
# Medicare Part D monthly prescription fills per enrollee annually	63	52	11

RACIAL DISPARITIES IN CONNECTICUT

HIGHEST REPORTED CHRONIC CONDITIONS FOR 65+ BY RACIAL/ETHNIC GROUP

White Older Adults

- Atrial fibrillation

Black Older Adults

- Alzheimer’s disease
- Diabetes
- Stroke

Hispanic Older Adults

- PTSD

Alaskan Native/American Indian Older Adults

- COPD
- Heart Failure
- Hypertension

Other Race(s) Older Adults

- Benign prostatic hyperplasia (BPH)
- Endometrial cancer in women
- Lung cancer

Mental Health: Trends in Depression

We examined community depression rates in New England at three points in time: 2014–2015 (Time 1), 2016–2017 (Time 2), and 2020–2021 (Time 3). Rates increased across New England at Time 2 and at Time 3. The largest increase in depression rates was in 2020–2021, which coincides with the COVID-19 pandemic. We then conducted analyses to explore the interaction between social and financial status and community depression rates. Perhaps not surprisingly, the New England communities with the highest rates and the largest increase in depression rates at Time 3 (2020–2021) had lower socioeconomic status, higher chronic disease burdens, and were urban or suburban locations.

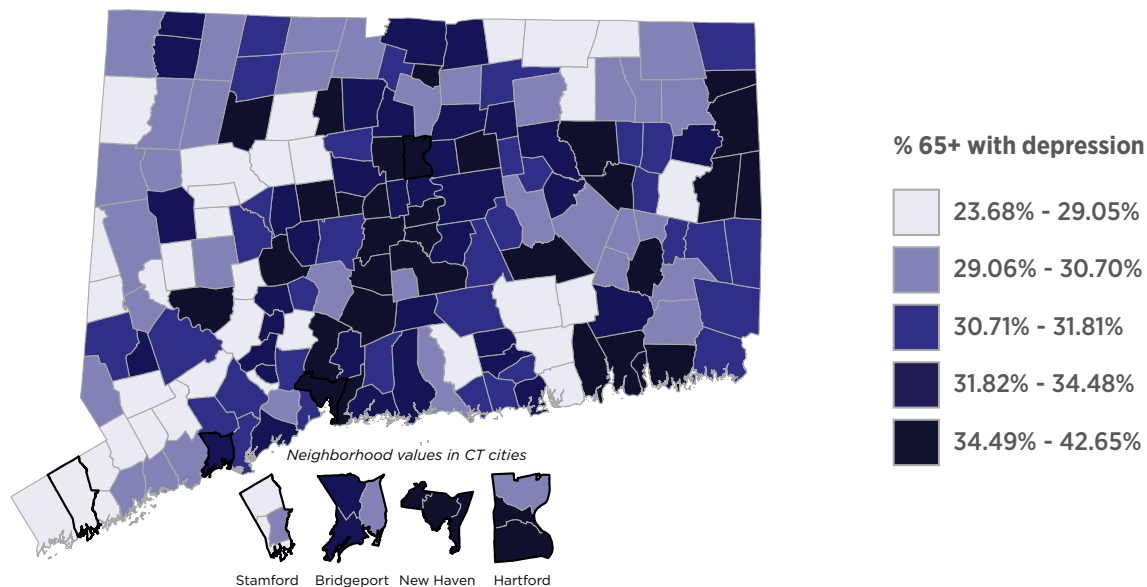
In our Connecticut-specific analysis, we found that lower rates of depression were associated with a higher percentage of married adults 65+. By contrast higher depression rates were associated with more nursing homes, residential instability (higher % of inter- and intra-county moves among 60+ population), higher mortality, and higher burden of chronic disease.

Higher rates of depression are to be expected during a pandemic. Efforts to promote social connections and inclusion are helpful. Longevity research shows that our social health is as important to our overall well-being as physical health.

Statewide rates of other behavioral health issues among adults 65+ were: substance use disorder (8.3%) and tobacco use disorder (11.5%).

211 of CT (<https://www.211ct.org/>) is a free, confidential information and referral service that connects people to essential health and human services 24 hours a day, seven days a week online and over the phone.

NAMI Connecticut (<https://namict.org/>) is a nonprofit, organization dedicated to improving the lives of all people in Connecticut affected by mental illness. NAMI works to change public attitudes about mental illness and offer support, education and advocacy programs at the state and local levels.



How Does Connecticut Compare to Other New England States?

Connecticut has the highest rates in New England for hip fracture, Alzheimer’s disease, BPH, breast cancer, congestive heart failure, HIV, lung cancer, osteoporosis, and pressure ulcer. CT also has the

highest rate of dually eligible for Medicare and Medicaid, skilled nursing facility stays, and the lowest rate of hospice users as a % of descendants.

Table 11. Comparing Selected Disease Indicators Among New England States

Indicators	CT	RI	MA	ME	NH	VT
% 65+ had hip fracture	3.5%	3.1%	3.2%	3.1%	2.8%	3.1%
% 65+ with high cholesterol	77.9%	79.3%	75.9%	69.5%	72.0%	63.9%
% 65+ with Alzheimer’s disease or related dementias	13.9%	12.0%	12.9%	11.0%	10.7%	9.6%
% 65+ with BPH (men)	44.0%	43.3%	42.6%	35.2%	36.9%	35.1%
% 65+ with breast cancer (women)	11.8%	11.5%	11.6%	9.6%	10.2%	9.6%
% 65+ with chronic kidney disease	32.8%	34.0%	34.3%	29.4%	28.0%	25.1%
% 65+ with congestive heart failure	21.0%	20.0%	19.6%	18.1%	16.7%	14.9%
% 65+ with diabetes	31.8%	32.4%	28.6%	26.2%	25.2%	23.6%
% 65+ with HIV/AIDS	0.3%	0.2%	0.3%	0.2%	0.1%	0.1%
% 65+ with hypertension	74.2%	75.8%	72.9%	67.1%	67.3%	64.7%
% 65+ with ischemic heart disease	39.1%	39.4%	37.1%	35.3%	32.9%	32.8%
% 65+ with lung cancer	2.0%	2.0%	2.1%	1.8%	1.6%	1.5%

Chart key:  = highest rate  = lowest rate

Table 11. Continued

Indicators	CT	RI	MA	ME	NH	VT
% 65+ with osteoporosis	20.2%	18.9%	20.1%	15.7%	16.3%	14.4%
% 65+ with peripheral vascular disease	19.1%	23.1%	18.1%	15.3%	13.6%	11.5%
% 65+ with pressure ulcer or chronic ulcer	9.1%	7.7%	7.8%	6.8%	6.2%	5.7%
% 65+ with prostate cancer (men)	13.4%	13.4%	13.6%	10.3%	11.6%	10.8%
% 65+ with stroke	11.5%	11.6%	11.2%	10.0%	10.0%	9.2%
% 65+ with 4+ chronic conditions	61.6%	63.0%	60.4%	55.5%	53.9%	50.7%
% 65+ with 0 chronic conditions	7.7%	7.2%	7.2%	12.4%	10.2%	11.0%
% 65+ with depression	32.3%	34.5%	34.6%	34.8%	30.5%	32.5%
% 65+ with anxiety disorder	30.9%	34.3%	33.0%	30.7%	28.0%	25.8%
% 65+ dually-eligible for Medicare and Medicaid	22.5%	15.0%	17.1%	18.7%	6.6%	12.5%
% 65+ Medicare managed care enrollees	50.1%	51.4%	30.5%	50.3%	26.5%	21.1%
# inpatient hospital stays/1,000 persons 65+ years annually	242	231	252	170	188	176
% Medicare inpatient hospital readmissions (as % of admissions)	17.6%	17.1%	18.2%	14.3%	16.2%	15.6%
# skilled nursing facility stays/1000 persons 65+ years annually	90	76	73	43	45	47
% 65+ getting Medicaid long term services and supports	4.4%	4.0%	3.4%	2.1%	2.7%	3.4%
% 65+ hospice users as % of decedents	42.4%	50.7%	44.0%	49.7%	47.1%	43.0%

Call to Action

Building communities that support older adults and their families benefits all of us. We are all aging. This report highlights the growth, increasing diversity, unequal distribution of chronic conditions, and the impact of the pandemic on mental health. While impressive momentum to build a healthy, age-friendly state exists, **this is no time to let up.** One resource for the state that is increasing and is expected to keep increasing is the older population. Find and scale up opportunities for the older residents of Connecticut to contribute to the health and well-being of residents. We can all play a meaningful role in making Connecticut a great place to grow up and grow older.



UNDERSTAND

- Download your community profile at healthyagingdatareports.org to better understand your community's strengths and needs.
- Educate yourself and others about the indicators in your community



ENGAGE

- Encourage people you know and community leaders to engage in the age-friendly movement.
- Bring people together to talk about the data
- Think about what your community needs to promote health for all ages.



ACT

1. Get involved! [Join Age-Well Collaborative.](#)
2. Use data to inform your work.
3. Identify and build on what's working.

How Have States Used the Data Reports?

- In 2014, Massachusetts advocates from the MA Councils on Aging printed out community profiles and went to the state capital to advocate for more investments in programming to promote healthy aging. They shared the community profiles to show legislators the status of healthy aging of older people in their districts. As a result of this outreach, an additional million dollars was appropriated to support evidence-based programming to enhance healthy aging.
- A geriatrician was competing for a training grant to expand fellowship training of geriatricians in western Massachusetts. She was able to use the data report to demonstrate the need for additional fellowship-trained doctors to treat the older population and was awarded a 5-year multimillion dollar grant to support the training program.
- The Alzheimer's Association was surprised to learn that the rates for Alzheimer's disease and related dementias was elevated in the southwest part of New Hampshire, an area where they had no respite or support groups in place. In response they created supports to help families taking care of persons with dementia.
- In Mississippi, the state Department of Health convened an Age-Friendly summit. They printed the entire report and mailed it to every Mayor in the state. The counties along the Mississippi Delta had many rates higher than the state average. To address this concern, they later convened a special briefing for the mayors from along the Mississippi Delta to share ideas on health promotion interventions.
- In Wyoming, the Healthy Aging Data Report was released at a conference at the University of Wyoming. Media outreach around the state led to visibility and awareness of health challenges in rural and frontier counties. The networking and collaboration among interested partners are taking off.
- In New Hampshire, a legislative breakfast was held to share the New Hampshire Data Report with each legislator. Graduate students showed legislators the website and how to navigate to various components important to their districts. Senior Ambassadors were trained to interpret and explain community profiles and the state-wide maps to legislators during the event.
- Educators use the Healthy Aging Data Reports in health, statistics, and community health courses.

In all states with a Healthy Aging Data Report available, our stakeholders have been able to submit more competitive grant applications for support to address healthy aging. Whether applying to a local foundation or a federal funder, the stakeholders are able to build more convincing rationales for the requests because they can cite data and include maps that document local concerns.



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

Explore how to get involved:

[Connecticut Age Well Collaborative](#)

What are the Indicators and Data Sources?

POPULATION CHARACTERISTICS

Total population, population 60+ as % of total population, total population 60+, population 65+ as % of total population, total population 65+ and (% 65–74, % 75–84, and % 85+), % 65+ who are female, % 85+ who are female, race and ethnicity of population 65+ (% White, % African American, % Asian, % Other Race(s), % Hispanic), # 55+ who are Native American/Alaskan, Marital status 65+ (% married, % divorced/separated, % widowed, % never married), Education of the population 65+ (% less than high school, % with high school or some college, % with a college degree, % with a graduate or professional degree), % 65+ who speak only English at home, % 65+ who are veterans of military service.

Data sources: The US Census Bureau (American Community Survey 2018–2022).

HOUSING

% 65+ population who live alone, average household size all ages, median house value (all ages), % 60+ who own home, % 60+ homeowners who have mortgage, % 65+ households (renter) spending more than 35% of income on housing, % 65+ households (owner) spending more than 35% of income on housing, % of grandparents who live with grandchildren, # of assisted living sites.

Data sources: The US Census Bureau (American Community Survey 2018–2022); CT.gov, 2023.

SOCIAL DETERMINANTS OF HEALTH

COST OF LIVING (ELDERINDEX.ORG)

Elder Index for 65+: Single, homeowner without mortgage, good health; Single, renter, good health; Couple, homeowner without mortgage, good health; Couple, renter, good health.

Data sources: Elderindex.org, 2023; UMB Center for Social and Demographic Research on Aging.

ECONOMIC

% 60+ receiving food benefits in past year, % 65+ employed in past year, % 65+ with income below the poverty line in past year, Median annual income for households with a householder 65+.

Data sources: The US Census Bureau (American Community Survey 2018–2022)

WELLNESS

% 18+ with less than 7 hours of sleep, % 18+ without leisure time physical activity, % 18+ with fair or poor self-reported health status, % 18+ with 14 or more physically unhealthy days in last month.

Data sources: CDC BRFSS, 2020–2021

COMMUNITY

Annual # of unhealthy days due to air pollution for 65+, AARP age-friendly communities, # public universities and community colleges, # of public libraries, # of senior centers, # of Osher Lifelong Learning Institutes, % of households with a smart-phone (all ages), % of households with only a smart phone to access internet (all ages), % households without a computer (all ages), % households with access to Broadband (all ages), voter participation rate in 2020 election (18+), homicide rate/100,000 person, # firearm fatalities (all ages), age-sex adjusted 1-year mortality rate.

Data sources: AARP, 2023; ACS, 2018–2022; CDC WONDER, 2016–2020; The CMS Master Beneficiary Summary File ABCD/Other (CMS), 2020–2021; CT.gov, 2023; CT State Library, 2023; CT Secretary of State, 2023; NECHE, 2023; OLLI, 2023; U.S. EPA Air Compare, 2023.

TRANSPORTATION

% householders 65+ who own a motor vehicle, # fatal crashes involving adults age 60+, AllTransit™ Score.

Data sources: The US Census Bureau (American Community Survey 2018–2022); AllTransit™, 2023; NHTSA, 2018–2022.

HEALTH OUTCOMES

FALLS

% 65+ with hip fracture.

Data sources: CMS, 2020–2021.

PREVENTION

% 18+ with physical exam/check-up in past year, % mammography use among women age 50–74 years, % 50–75 with fecula occult blood test, sigmoidoscopy, or colonoscopy, % 65+ men/women up to date on preventive services.

Data sources: CDC BRFSS 2020–2021.

NUTRITION AND DIET

% 18+ with obesity, % 65+ with high cholesterol, % 18+ with cholesterol screening.

Data sources: CDC BRFSS 2020–2021; CMS 2020–2021.

ORAL HEALTH

% 18+ with annual dental exam, # dentists per 100,000 persons (all ages), % 65+ with complete tooth loss.

Data sources: CDC BRFSS 2020–2021; HRSA, 2023.

CHRONIC DISEASE RATES AMONG MEDICARE BENEFICIARIES 65+

Alzheimer’s disease or related dementias, anemia, asthma, atrial fibrillation, BPH (men), breast cancer (women), cataract, chronic kidney disease, chronic obstructive pulmonary disease, colon cancer, congestive heart failure, diabetes, endometrial cancer (women), fibromyalgia/chronic pain/fatigue, glaucoma, heart attack, HIV/AIDS, hypertension, ischemic heart disease, liver disease, lung cancer, migraine, arthritis, osteoporosis, peripheral vascular disease, pressure ulcer, prostate cancer (men), stroke, 4 or more chronic conditions, zero chronic conditions.

Data sources: CMS 2020–2021.

BEHAVIORAL HEALTH

drug overdoses deaths (all ages), %65+ with substance use disorder, % 18+ with excessive drinking, % 65+ tobacco use disorder, % 18+ current smokers.

Data sources: CDC BRFSS 2020–2021; CDC Wonder 2016–2020; CMS 2020–2021.

MENTAL HEALTH

% 18+ with 14 or more days of poor mental health in past month, % 65+ with depression, %65+ with anxiety disorder, % 65+ with post-traumatic stress disorder, % 65+ with schizophrenia.

Data sources: CDC BRFSS 2020–2021; CMS 2020–2021.

DISABILITY RATES AMONG ADULTS 65+

Hearing difficulty, vision difficulty, cognition difficulty, ambulatory difficulty, self-care difficulty, and independent living difficulty.

Data sources: American Community Survey 2018–2022.

CAREGIVING

of Alzheimer’s support groups, % grandparents raising grandchildren.

American Community Survey 2018–2022; Alzheimer’s Association, 2023.

ACCESS TO CARE

% 65+ dually eligible for Medicare and Medicaid, % 65+ Medicare managed care enrollees, % 18–64 who lack health insurance, # of CMS-certified (primary care providers hospitals, home health agencies, skilled nursing facilities, hospice agencies), # of HRSA community health centers, # of adult day health centers.

Data sources: BRFSS, 2020–2021; CMS, 2020–2021; Connecticut Association of Adult Day Services, 2023; HRSA, 2023; Medicare.gov, 2023.

SERVICE UTILIZATION

of physician visits per year, # of emergency room visits/1000 65+ years annually, # Part D monthly prescription fills per person annually, # home health visits annually, # durable medical equipment claims annually, # inpatient hospital stays/1000 person 65+ years annually, % Medicare inpatient hospital readmissions (as % of admissions), # skilled nursing facility stays/1000 person 65+ years annually, # skilled nursing home Medicare beds/1000 person 65+ years, % 65+ getting Medicaid long term services and supports, % 65+ hospice users, % 65+ hospice uses as % of decedents.

Data sources: CMS 2020–2021.

TECHNICAL COMMENT

While we collect and analyze data from dozens of entities, we rely on three main sources:

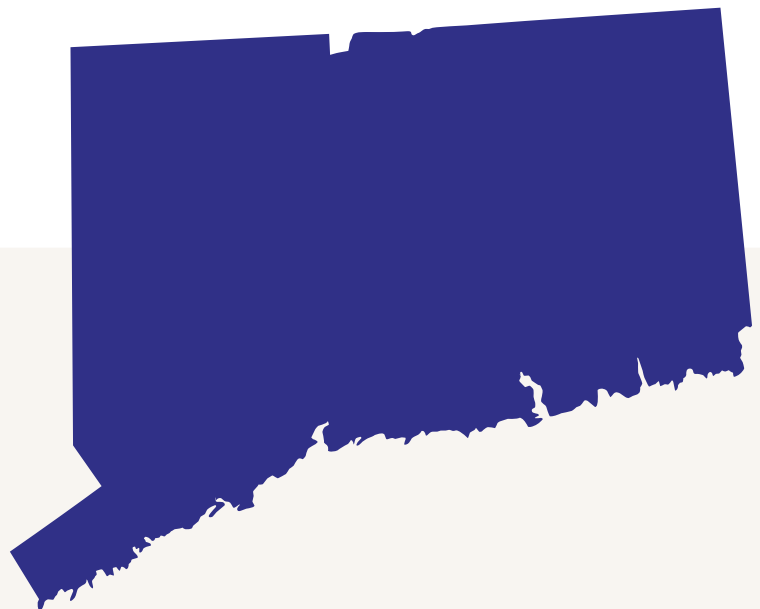
- The Behavioral Risk Factor Surveillance System (BRFSS), which we obtain from the Connecticut Department of Health,
- The American Community Survey (ACS), obtained from the US Census Bureau, and
- The Centers for Medicare and Medicaid Services (CMS), which provides data on chronic disease, health care utilization, and access to care for all Medicare enrollees 65+ in the fee-for-service insurance. We do not yet have data for the managed care enrollees who are 50.1% of the total Medicare population in Connecticut. This is a limitation we acknowledge.



TECHNICAL NOTES

Our documentation on www.healthyagingdatareports.org provides comprehensive information about the indicators, data sources, geographic units, statistical approach, and resources. For most indicators, the reported community and state values are estimates calculated from sample data. Thus, it is possible that some of the differences between community and state estimates may be due to chance associated with population sampling. We use the terms “better” and “worse” to highlight the differences between community and state estimates that we are confident are not due to chance. “Better” is used where a higher/lower value has positive implications for the health of older residents. “Worse” is used where a higher/lower score has negative implications for health. When the implication is unclear we use an asterisk. All differences reported in the comparison tables (gender, race/ethnicity, and across states) are statistically significant at the 95% confidence level. Note that the terms better or worse do not convey or imply a value judgment on the part of the researchers or funders. After careful and in-depth conversations with a range of stakeholders we believe the better/worse label is the simplest way to communicate what the rates mean.

We balance two goals. First, we aim to report data at very local levels because we believe change is often locally driven. Second, we vowed to protect the privacy of the people providing the information reported. Thus, given the constraints of the data analyzed we used a hierarchical approach to reporting. When possible, we report estimates for every city/town and three neighborhoods for four CT cities. For example, the population characteristics and information from the US Census were reported for all 181 geographic units. For highly prevalent chronic conditions we report for 160 geographic units, and for less prevalent conditions we report for 104 geographic units. For the BRFSS data we report for 8 geographic units, and for the least prevalent conditions we report for 10 geographic units. The same age/sex adjusted estimate is reported for all the towns/cities in the aggregated geographic areas. Maps of the different geographic groups and the rationale behind the groupings are in the Technical Documentation online.



Acknowledgments



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Funder

Point32Health Foundation

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Design

Report by Opus Design, Boston

Website by JSI

“When we talk about old age, each of us is talking about his or her own future. We must ask ourselves if we are willing to settle for mere survival when so much more is possible.”

DR. ROBERT N. BUTLER

“There is no power for change greater than a community discovering what it cares about.”

MARGARET J. WHEATLEY



Research and Analysis by



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Funded by

Point32Health
Foundation

In partnership with



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