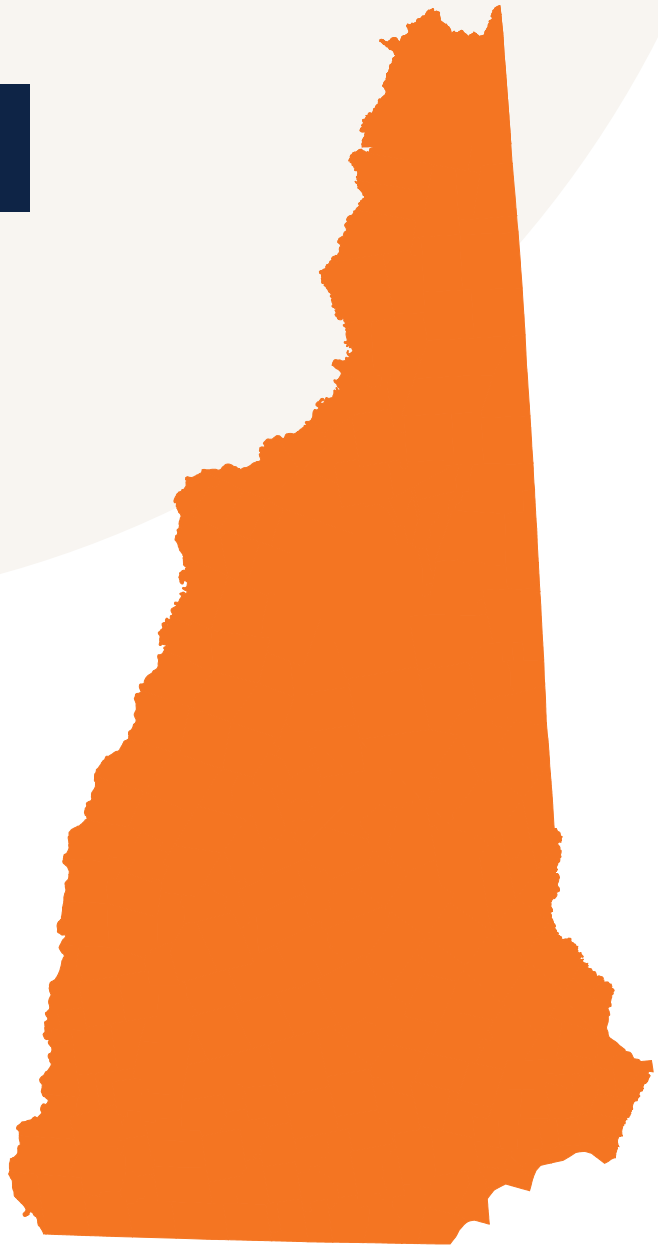
Healthy Aging Data Report

Highlights from 2025

NEW HAMPSHIRE



Explore more online at
HealthyAgingDataReports.org

A Message from the Funder and Principal Investigator

All of our communities can be great places to grow up and grow old. We need healthy and safe neighborhoods that work for everyone. Yet it takes effort and work to translate an aspiration into reality. Point32Health and the Foundation have given nearly $260 million to nonprofit organizations in New England since 1980. In 2024 alone, the company and Foundation gave $1.3 million to support healthy communities in New Hampshire. The research team in the Gerontology Institute at UMass Boston has been working with the Foundation on Healthy Aging Data Reports since 2012 with investments from the Foundation totaling more than $2 million for 11 reports in the region. In N.H. alone, that translates to an investment of $353,709.

There is a recognized need for accurate, unbiased information to help pinpoint problems, mitigate harms, and promote optimal health. We are excited to release the 2025 New Hampshire Healthy Aging Data Report, a valuable tool for understanding New Hampshire's current status and to track progress in the future.

This report updates our previous New Hampshire Healthy Aging Data Report and builds on the work we've done for more than a decade in other New England states. Over time we have learned some vital lessons.

- When addressing needs, don't go it alone — deliberately connect with others at the local, state, and regional levels.
- Start with small projects first. That allows you to form your network of partners, build consensus, and create momentum. As you progress, leverage your experience and expand your network to take on more challenging issues.
- Be intentional about inclusion — we all are aging and can learn from each other.
- Finally, celebrate any success! 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

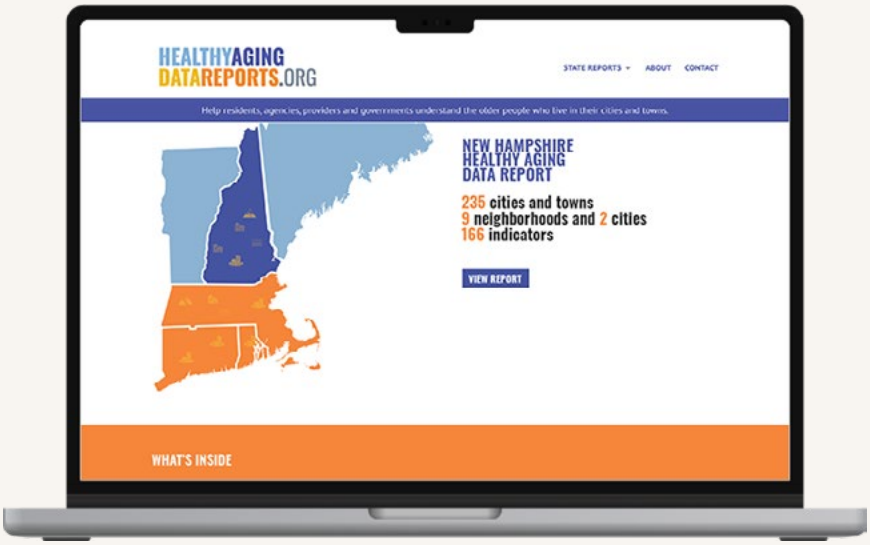
The 2025 New Hampshire Healthy Aging Data Report is available online at healthyagingdatareports.org. We invite you to explore this resource to better understand the residents in your local community, the Granite state, and New England.

The 2025 New Hampshire Healthy Aging Data Report includes the following tools:

- 244 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 you and our other 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.



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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

We are living in the midst of 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 to prepare for the longevity economy. However, our society is still geared for the life and population age structure of a hundred years ago, when average 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 New Hampshire age-friendly.

NHAHA
NEW HAMPSHIRE ALLIANCE FOR HEALTHY AGING

The New Hampshire Alliance for Healthy Aging (NHAHA) is a statewide coalition of more than 500 stakeholders focused on the health and well-being of older adults. Founded in 2016 to promote a shared vision of communities that advance culture, policies, and services which support older adults and their families and provide a range of choices that advance health, independence, and dignity. See nhaha.info

AARP New Hampshire

AARP New Hampshire works to improve the lives of people 50 and older and their families. This involves advocating for strong public policies, providing valuable educational resources and information, helping to build and strengthen communities, and facilitating volunteer involvement in all aspects of the organization's work. See states.aarp.org/new-hampshire/contact-aarp-new-hampshire

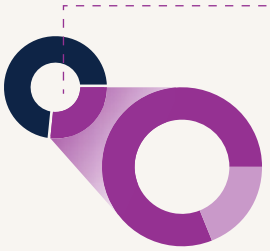
newfutures
SOLVING PROBLEMS THROUGH POLICY CHANGE

New Futures provides nonpartisan, evidence-based solutions to New Hampshire's health challenges. New Futures builds bridges among policymakers. Through policy change, they help ensure that social service programs and statewide systems work for everyone—especially the populations they are designed to serve. New Futures supports the advocacy efforts of NHAHA. See new-futures.org

Aging in New Hampshire

New Hampshire 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.

NH's older population is growing



26.7%
of the state is now 60 or older (368,151)

19%
of the population is age 65 or older (261,749)

IMPACT OF COVID-19

According to data from the Centers for Disease Control, 3,640 New Hampshire residents died as a result of the COVID-19 pandemic. We expect that the reverberations of the pandemic will impact health and aging for years to come.

OTHER INDICATORS

- **Marital Status:** In terms of marital status among the population 65+, 58.5% are married, 20% widowed, 16.5% divorced/separated, and 5.1% never married.
- **Chronic Conditions:** Compared to other New England states, older residents of New Hampshire have the lowest rates for hip fracture (2.8%) and depression (30.5%).
- **HIV/AIDS:** The rate of adults 65+ with HIV/AIDS increased from 0.05% in 2014–2015 to 0.10% in 2020–2021.

NH's older population is changing

AGE

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

60.7%
Age 65-74

28%
Age 75-84

11.3%
Age 85+

MORE DIVERSE

The population of adults 65 or older is increasingly diverse.

95.7% White, 1.1% Hispanic, 1.3% Asian, 0.6% African American/Black, 2.3% Other Race(s)

549
Adults 55+ are Native American

6%
Report speaking a language other than English at home

MORE EDUCATED

The population of adults 65 or older is more educated.

16%
Graduate or professional degree

19.6%
College Degree

56.3%
High school degree or some college

8.1%
Less than a high school education

18%
of the 65+ population are veterans of military service

25.5%
of NH residents age 65+ live alone

Understanding the Data

This Highlights Report provides a framework for understanding the status of your state. The community profiles allow you to focus more deeply on your community. The maps show the statewide distribution of rates for every indicator, and the interactive web maps allow you to see rates across New England for 18 chronic conditions. 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 convey rates at the state level.

They want to know what the topline findings are. We understand that policymakers, service providers, and funders routinely have to make tough decisions on where to allocate resources and many want to be guided by data. There are several ways we try to answer that question. For example, we can contrast communities with the healthiest rates on various conditions and those with the unhealthiest. This approach shows the wide range of rates for health outcomes. For example, rates of Alzheimer's Disease and related dementias range from a low of about 5.41% in Lincoln, Waterville Valley to a high rate of 21.16% in Westmoreland.

Table 1 below contrasts rates for 13 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	**5.41%** Lincoln, Waterville Valley	**21.16%** Westmoreland
Depression	**20.01%** Dummer, Errol, Milan	**38.08%** Boscawen, Concord, Webster
Diabetes	**14.51%** Hanover	**33.35%** Rochester
Hypertension	**53.04%** Hancock	**75.73%** Seabrook
Independent living difficulty	**0.74%** Sharon	**38.21%** Goshen
Ischemic heart disease	**20.82%** Easton, Franconia, Sugar Hill	**40.00%** Seabrook
Stroke	**5.13%** Effingham, Wakefield	**14.88%** Berlin
4+ chronic conditions	**38.81%** Bethlehem	**62.57%** Central Manchester
No chronic conditions	**20.83%** Bethlehem	**6.25%** Salem
	High	**Low**
Receiving Medicaid long term services and supports	**0.57%** New London, Springfield, Wilmot	**6.71%** Boscawen, Concord, Webster
Inpatient hospital readmission rate	**3.70%** Eaton, Freedom	**29.80%** Moultonborough, Sandwich
Dually eligible for Medicare and Medicaid	**1.36%** New London	**16.61%** Berlin

Another approach to describe the health of New Hampshire communities is to count how many indicators are statistically "better" compared to the state average. Communities that are healthier than state average may have some resources (e.g., park or walking paths, engaged senior center, or public library) in place that could be replicated in communities with "worse" rates.

Towns with 14+ indicator rates better than state rates (orange in map)

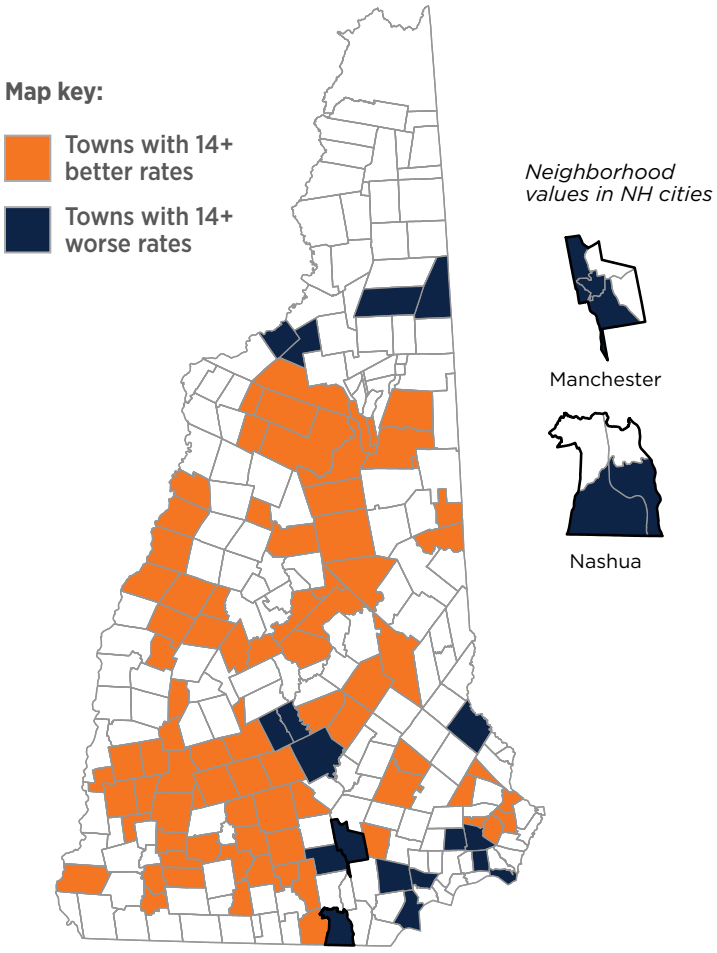
Acworth, Alstead, Alton, Amherst, Auburn, Bartlett, Bethlehem, Bradford, Campton, Canaan, Canterbury, Center Harbor, Chesterfield, Danbury, Deerfield, Deering, Dublin, Dunbarton, Easton, Eaton, Ellsworth, Enfield, Francestown, Franconia, Freedom, Gilmanton, Gilsum, Goshen, Grafton, Grantham, Greenfield, Greenland, Hadley's Purchase, Hale's Location, Hancock, Hanover, Harrisville, Hart's Location, Henniker, Hill, Hillsborough, Hollis, Hopkinton, Jackson, Langdon, Lee, Lempster, Lincoln, Livermore, Loudon, Lyme, Lyndeborough, Madbury, Marlborough, Marlow, Meredith, Mont Vernon, Moultonborough, Nelson, New Boston, New Hampton, Newfields, Newington, Northwood, Orange, Orford, Piermont, Sanbornton, Sandwich, Stoddard, Stratham, Sugar Hill, Sunapee, Temple, Troy, Warner, Washington, Waterville Valley, Weare, Windsor

Towns with 14+ indicator rates worse than state rates (navy in map)

Bedford, Berlin, Boscawen, Brentwood, Concord, Dalton, Derry, Exeter, Hampstead, Kensington, Manchester, Nashua, Rochester, Salem, Seabrook, Success, Webster, Whitefield, Central Manchester, West Manchester, South Manchester, Southeast and Southwest neighborhoods of Nashua.

We recognize that communities don't become healthier or more burdened spontaneously or without cause. These differences may be the result of systemic disparities in access to education, adequate housing, safe employment, and healthy, walkable environments.

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



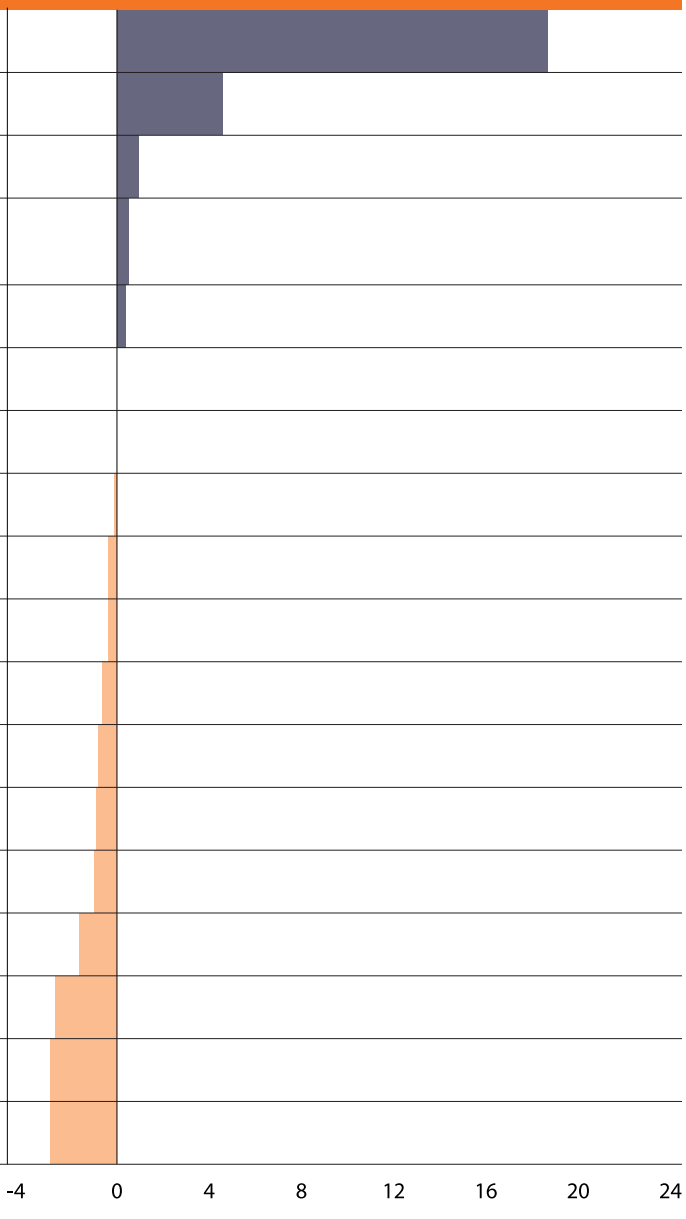
What Has Changed Over Time in New Hampshire?

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 New Hampshire. We found both positive and negative changes. As seen in Table 2, Medicare managed care enrollment increased from 7.9% at Time 1 to 26.5% at Time 3. More than a quarter of the 65+ population in New Hampshire is now in a Medicare managed care plan. Rate increases were also observed for arthritis, depression, heart attack, and the rate of inpatient hospital readmissions.

There have been declines in rates of ischemic heart disease, colon cancer, stroke, Alzheimer's disease, hypertension, diabetes, and COPD. In terms of access and utilization, declines were found in being dually-eligible for Medicare and Medicaid, and getting Medicaid long term services and supports.

Table 2. Change Over Time

Indicators (%)	Change from T1 to T3 (%)
% 65+ Medicare managed care enrollees	18.6%
% 65+ with osteoarthritis or rheumatoid arthritis	4.5%
% 65+ with depression	1.9%
% Medicare inpatient hospital readmissions (as % of admissions)	0.4%
% 65+ ever had a heart attack	0.3%
Age-sex adjusted 1-year mortality rate	0.0%
% 65+ with lung cancer	0.0%
% 65+ with 4+ (out of 15) chronic conditions	-0.1%
% 65+ with colon cancer	-0.4%
% 65+ with stroke	-0.4%
% 65+ with Alzheimer's disease or related dementias	-0.6%
% 65+ with ischemic heart disease	-0.8%
% 65+ dually-eligible for Medicare and Medicaid	-0.9%
% 65+ getting Medicaid long term services and supports	-1.0%
% 65+ with asthma	-1.6%
% 65+ with hypertension	-2.7%
% 65+ with diabetes	-2.9%
% 65+ with chronic obstructive pulmonary disease	-2.9%



How Does Gender Impact Healthy Aging?

Another way to understand healthy aging in New Hampshire is to contrast the experience of women and men. 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 (depression, Alzheimer's disease, schizophrenia, 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 have better access to care (physician visits annually, dually-eligible Medicare and Medicaid, getting long term services and supports, 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 care long term care (skilled nursing facility stays, getting Medicaid long term services and supports).

WOMEN	MEN
53.9% 65+	**46.1%** 65+
64% 85+	**36%** 85+

Table 3. Gender Differences: Women

Women Have Higher Rates Than Men	Female	Male	Difference Between Female and Male
% 65+ with osteoporosis	27.0%	3.3%	**23.7%**
% 65+ with anxiety disorder	35.2%	19.6%	**15.5%**
% 65+ with depression	36.9%	23.0%	**13.9%**
% 65+ with cataract	65.2%	54.8%	**10.4%**
% 65+ with osteoarthritis or rheumatoid arthritis	57.2%	48.5%	**8.7%**
% 65+ hospice users as % of decedents	50.6%	43.2%	**7.4%**
% 65+ with fibromyalgia, chronic pain, and fatigue	36.0%	29.2%	**6.8%**
% 65+ with asthma	14.1%	8.3%	**5.7%**
% 65+ with migraine and other chronic headache	9.5%	3.9%	**5.6%**
% 65+ with glaucoma	24.4%	20.5%	**3.9%**
% 65+ dually-eligible for Medicare and Medicaid	8.1%	5.0%	**3.1%**

Table 3. Continued

Women Have Higher Rates Than Men	Female	Male	Difference Between Female and Male
% 65+ had hip fracture	3.6%	1.7%	**1.8%**
% 65+ getting Medicaid long term services and supports	3.5%	1.8%	**1.7%**
% 65+ Medicare managed care enrollees	27.2%	25.7%	**1.6%**
% 65+ with Alzheimer's disease or related dementias	11.2%	10.0%	**1.2%**
% 65+ with post-traumatic stress disorder	2.9%	1.8%	**1.1%**
% 65+ with schizophrenia & other psychotic disorder	3.2%	2.3%	**0.9%**
# skilled nursing facility stays/1000 persons 65+ annually	47	42	**5**
# physician visits per year	6.3	5.9	**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), HIV/AIDS, higher use of inpatient hospital stays, and more numerous durable medical equipment claims. 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	39.8%	27.0%	**12.8%**
% 65+ with atrial fibrillation	17.6%	10.9%	**6.7%**
% 65+ with diabetes	28.6%	22.1%	**6.5%**
% 65+ with chronic kidney disease	31.5%	25.1%	**6.3%**
% 65+ with hypertension	70.5%	64.4%	**6.1%**
% 65+ with congestive heart failure	18.7%	14.9%	**3.8%**
% 65+ with peripheral vascular disease	15.3%	12.1%	**3.2%**
% 65+ with substance use disorder	9.3%	6.2%	**3.2%**
% 65+ with tobacco use disorder	13.2%	10.4%	**2.7%**

Table 4. Continued

Men Have Higher Rates Than Women	Male	Female	Difference Between Male and Female
% 65+ ever had a heart attack	6.0%	3.4%	**2.6%**
% 65+ with high cholesterol	73.1%	70.9%	**2.2%**
% 65+ with 0 chronic conditions	10.9%	9.5%	**1.5%**
% 65+ with pressure ulcer or chronic ulcer	6.8%	5.7%	**1.1%**
% 65+ with stroke	10.6%	9.5%	**1.1%**
Age-sex adjusted 1-year mortality rate	4.4%	3.4%	**0.9%**
% 65+ with anemia	35.5%	34.6%	**0.9%**
% 65+ with colon cancer	2.1%	1.9%	**0.2%**
% 65+ with HIV/AIDS	0.2%	0.0%	**0.1%**
# inpatient hospital stays/1000 persons 65+ annually	203	174	**29**
# Medicare Part D monthly prescription fills per enrollee annually	49.7	48.6	**1.0**
# durable medical equipment claims annually	2.1	1.7	**0.4**

Overall, there are several public health initiatives that might be considered for statewide action. For example, New Hampshire might implement programs to address lifestyle behaviors among older men such as smoking cessation, healthy nutrition, physical activity, and mindfulness. For older women, the state might target muscle strengthening, fall prevention, and efforts to promote economic security. All of these would go a long way to support healthy aging.

KEY TAKEAWAYS

WOMEN

Bone health

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

Mental health

- 16% higher rates of anxiety
- 14% higher depression rates

MEN

Heart & metabolic diseases

- 13% higher ischemic heart disease
- 6% higher rates of hypertension
- 7% higher diabetes rates

Emergency room usage & hospital stays

- 29 more hospital stays annually than older NH women

Comparing Urban, Suburban, and Rural Community Health

This report defined rurality using the United States Department of Agriculture (USDA) 2023 Rural Urban Continuum Codes (RUCC). We defined urban counties as “metro” counties, or codes 1 to 3. Suburban counties were defined as “nonmetro” counties adjacent to a metro area (codes 4, 6, 8). Rural counties were defined as “nonmetro” counties not adjacent to metro areas (codes 5, 7, 9).

Another way to understand the experience of aging in New Hampshire is to contrast the experience of people living in urban, suburban, and rural communities. Table 5 shows the indicators where urban rates are highest. Compared to rural or suburban residents, older urban residents are more diverse and have a higher percentage of residents with college degrees and in higher income categories. The burden of housing costs are higher, too, with the highest rates of both renters and owners spending more than 35% of income on housing. In terms of health outcomes, urban residents have higher rates of conditions related to bone health (osteoporosis, arthritis), mental health (depression, anxiety), and cancer (breast, prostate).

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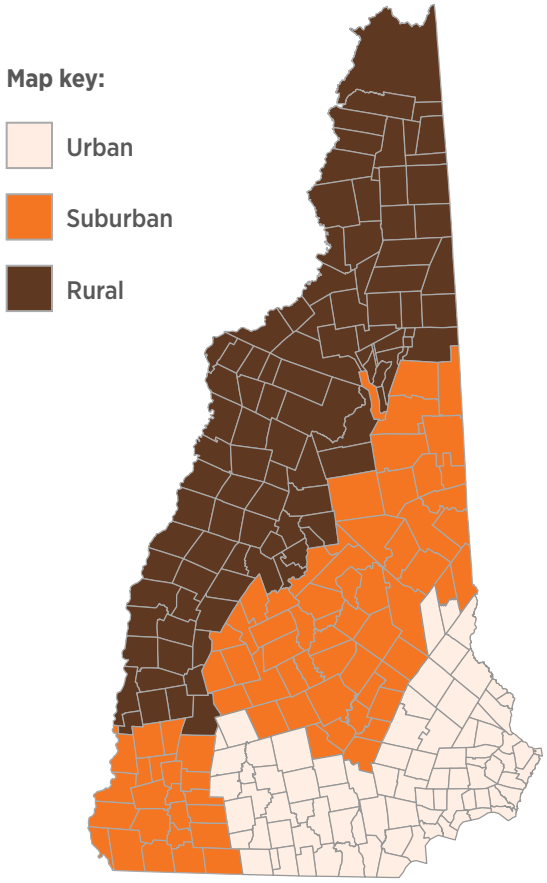


URBAN

81 Towns
(31.3% of NH communities in HADR)

58.3% of NH 60+ Residents

Counties: Hillsborough, Rockingham, Strafford

SUBURBAN

80 Towns
(30.9% of NH communities in HADR)

27.9% of NH 60+ Residents

Counties: Belnap, Carroll, Cheshire, Merrimack

RURAL

98 Towns
(37.8% of NH communities in HADR)

13.8% of NH 60+ Residents

Counties: Coos, Grafton, Sullivan

Table 5. Indicators Where Urban Rates are Highest

	Urban	Suburban	Rural
Socio-demographics Characteristics			
% females 65+	**52.6%**	50.8%	50.2%
% 65+ who are Asian	**1.4%**	0.4%	1.1%
% 65+ who are Hispanic	**1.3%**	0.6%	0.4%
% 65+ who are African American	**0.7%**	0.2%	0.2%
% 65+ who are other race(s)	**2.5%**	1.9%	2.3%
% 65+ who are widowed	**18.3%**	15.5%	18.0%
% 65+ who are veterans of military service	**18.8%**	17.1%	18.2%
% 65+ with college degree	**20.1%**	19.7%	17.9%
% of households with access to broadband (all ages)	**92.6%**	89.9%	85.0%
% of households with a smartphone (all ages)	**88.8%**	83.8%	77.2%
% of grandparents who live with grandchildren	**2.5%**	2.4%	2.2%
Economic			
% 65+ who spend more than 35% of income on housing (renters)	**45.4%**	28.2%	31.1%
% 65+ who spend more than 35% of income on housing (owners)	**26.0%**	23.3%	21.1%
% 60+ with mortgage on homes	**46.1%**	40.3%	32.5%
% 65+ with annual income between $50,000 to $99,999	**33.1%**	30.1%	33.0%
% 65+ with annual income above $100,000	**31.7%**	29.1%	22.8%
% 65+ employed in past year	**22.7%**	22.1%	21.3%
Preventive Health Screenings			
% 18+ with annual dental exam (county)	**71.3%**	67.1%	62.2%
% 18+ with cholesterol screening (county)	**86.5%**	86.2%	84.9%
% 18+ with physical exam/check-up in past year (county)	**73.8%**	71.5%	72.3%
Health Outcomes			
% 65+ with high cholesterol	**72.9%**	67.3%	67.1%
% 65+ with hypertension	**66.5%**	64.2%	65.7%

Table 5. Continued

	Urban	Suburban	Rural
% 65+ with 4+ (out of 15) chronic conditions	**53.0%**	49.8%	50.8%
% 65+ with osteoarthritis or rheumatoid arthritis	**52.7%**	52.4%	50.0%
% 65+ with anemia	**34.5%**	31.4%	31.5%
% 65+ with ischemic heart disease	**32.2%**	30.7%	29.9%
% 65+ with depression	**29.3%**	29.0%	27.2%
% 65+ with chronic kidney disease	**28.1%**	24.2%	24.3%
% 65+ with anxiety disorder	**27.7%**	25.3%	22.9%
% 65+ with glaucoma	**22.7%**	22.1%	20.2%
% 65+ with chronic obstructive pulmonary disease	**16.8%**	16.1%	15.5%
% 65+ with osteoporosis	**16.0%**	14.6%	13.9%
% 65+ with asthma	**11.3%**	10.1%	10.4%
% 65+ with liver disease	**10.4%**	8.6%	8.8%
% 65+ with prostate cancer (men)	**11.6%**	11.3%	10.4%
% 65+ with breast cancer (women)	**10.3%**	9.7%	8.7%

Table 6 shows the indicators where suburban communities have the highest rates. Older New Hampshire residents living in the suburbs are more likely to be White, only speak English at home, own their home, and be highly educated. Cataracts and Alzheimer's disease rates are highest among suburban residents. Rates for enrolling in Medicare Advantage are highest among suburban older adults.

Table 6. Indicators Where Suburban Rates are Highest

	Suburban	Urban	Rural
% 65+ who are White	**97.5%**	95.4%	96.4%
% 65+ who speak only english at home	**96.3%**	93.9%	93.9%
% 65+ who own a motor vehicle	**95.8%**	94.1%	92.8%
% 60+ who own home	**87.9%**	85.8%	87.3%
% 65+ who are married	**63.0%**	62.3%	60.8%
% 65+ with cataract	**60.2%**	58.6%	59.1%

Table 6. Continued

	Suburban	Urban	Rural
% 65+ with high school or some college education	**57.0%**	56.1%	56.2%
% 65+ enrolled in managed care	**27.8%**	26.2%	25.5%
% 65+ who live alone	**23.5%**	22.1%	21.6%
% 65+ with graduate or professional degree	**16.8%**	16.4%	16.0%
Inpatient hospital readmissions as a % of admissions for 65+	**16.4%**	16.1%	14.9%
% 65+ who are divorced or separated	**16.7%**	14.8%	14.8%
% 65+ with Alzheimer's disease or related dementias	**10.0%**	9.8%	9.4%
% of households with only a smartphone to access the internet (all ages)	**5.5%**	4.2%	4.5%

As shown in Table 7, rural residents have the highest rates on many indicators. They are more likely to be older, never married, and live alone. Financially, rural residents have more people financially struggling (receiving food benefits, income less than $20,000, income below the poverty line). Rural communities have the highest rates of grandparents raising grandchildren, and grandparents living with grandchildren; the highest rates of households without computers, and without access to the internet. Smoking, obesity, and substance use disorder rates are highest in rural communities. Rates indicating poor mental health (PTSD, schizophrenia) and poor overall health are highest in the rural communities.

Table 7. Indicators Where Rural Rates are Highest

	Rural	Urban	Suburban
Social Demographics			
% 60+ in total population	**37.9%**	26.4%	33.0%
% 65+ in total population	**28.5%**	18.3%	24.1%
% 65+ with less than high school education	**9.9%**	7.4%	6.5%
% 65+ who never married	**6.3%**	4.6%	4.8%
% 60+ receiving food benefits in past year	**5.6%**	3.8%	4.2%
% 65+ with income below the poverty line in past year	**9.0%**	6.2%	6.7%
% 65+ with annual income less than $20,000	**14.2%**	10.1%	11.5%
% 65+ with annual income between $20,000 to $49,999	**30.0%**	25.0%	29.4%

Table 7. Continued

	Rural	Urban	Suburban
% of grandparents raising grandchildren	**0.9%**	0.7%	0.8%
% of households without a computer (all ages)	**8.6%**	3.7%	5.4%
% of households without access to the internet (all ages)	**14.3%**	7.1%	9.6%
Health Behaviors			
% 18+ who are current smokers (county)	**15.4%**	13.1%	13.5%
% 18+ with less than 7 hours sleep (county)	**31.9%**	31.2%	31.6%
Chronic Disease			
% 65+ with zero chronic conditions	**12.3%**	10.4%	11.2%
% 65+ with complete tooth loss (county)	**11.1%**	8.5%	9.4%
% 18+ with self-reported fair or poor health (county)	**14.9%**	12.1%	13.2%
% 18+ who had 14+ days with poor mental health (county)	**14.7%**	14.0%	14.0%
% 18+ with obesity (county)	**32.4%**	31.5%	30.7%
% 65+ with diabetes	**24.9%**	24.4%	22.9%
% 65+ with congestive heart failure	**16.8%**	16.0%	15.5%
% 65+ who ever had a heart attack	**5.1%**	4.4%	4.2%
% 65+ with stroke	**9.6%**	9.5%	8.9%
% 65+ with substance use disorder	**7.7%**	7.4%	7.1%
% 65+ with post–traumatic stress disorder	**2.8%**	2.2%	2.2%
% 65+ with schizophrenia or other psychotic disorders	**2.9%**	2.5%	2.3%
Utilization			
One-year mortality rate for 65+, adjusted for age-sex	**3.9%**	3.8%	3.8%
% 65+ getting medicaid long term services and supports	**3.5%**	2.2%	2.4%
% 65+ who are dually eligible for Medicare and Medicaid	**7.2%**	5.3%	5.9%

Rural areas can be home to a shortage of health care workers, facilities, and challenging infrastructure by reducing accessibility to needed care, transportation, and even broadband access. To address health disparities in rural areas, community programming focused on drawing upon the strengths of rural culture are needed. Community leaders could work together to provide evidence-based programming to address rural older adult health needs, by building upon existing programming and infrastructure. For instance, programs funded through the through the Older Americans Act, like Chronic Disease Self-Management Programs, Matter of Balance, or Bingocize could be offered at local libraries, faith-based organizations, parks, YMCAs, American Legions, or VFW halls in rural areas.

Many rural communities would benefit from joining age-friendly initiatives. The National Rural Age-Friendly Initiative, a joint effort between the National Rural Health Association and The John A. Hartford Foundation, is a tailored program to assist rural communities on becoming age-friendly.

KEY TAKEAWAYS

HIGHEST REPORTED CHRONIC CONDITIONS FOR 65+ BY COMMUNITY

Urban

- COPD
- Depression
- Asthma
- Prostate cancer (in men)
- Breast cancer (in women)

Suburban

- Alzheimer's disease or related dementias

Rural

- Diabetes
- Congestive heart failure
- Heart attack
- Stroke

How Do Race and Ethnicity Impact Healthy Aging?

Another way to understand the health of older New Hampshire residents is to contrast racial and ethnic differences on indicator rates.

When analyzing Medicare data, we recognize that some groups may be less apt to get healthcare 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. We are not able to report why we see the differences detected, but are able to report the what (that is, the rate differences).

In New Hampshire, compared to older White adults Black older adults have significantly higher rates of diabetes (13.5% higher), chronic kidney disease (12.0%), dual eligibility for Medicare and Medicaid (7.6%), Medicare inpatient hospital readmissions (7.2%), Medicare managed care enrollment (6.5%), anemia (6.0%), glaucoma (6.0%), and having no chronic conditions (5.3%) compared to Whites adults. In terms of healthcare utilization, Black older adults have significantly more inpatient hospital stays, with 263 stays per 1,000 persons aged 65 and older annually compared to 191 for Whites. These disparities highlight the increased burden of chronic diseases and healthcare access challenges faced by Black older adults. Conversely, White adults have higher rates in several areas, most notably in hospice usage as a percentage of decedents (17.6% higher), cataracts (13.6%), anxiety disorders (9.2%), osteoporosis (8.4%), and osteoarthritis or rheumatoid arthritis (6.8%).

Compared to older White adults, Hispanic older adults show higher rates in a number of significant

95.7% White 65+

0.6% Black 65+

1.3% Asian 65+

1.1% Hispanic 65+

2.3% Other Race(s) 65+

549 Native American/ Alaskan 55+

health indicators. The most pronounced disparity is in dual eligibility for Medicare and Medicaid, where Hispanic older adults have a 15.4% higher rate than Whites. Hispanic older adults also have higher rates of diabetes (10.3%) and Medicare managed care enrollment (6.4%). White older adults have higher rates of certain conditions, such as cataracts (10.4% higher), osteoarthritis or rheumatoid arthritis (8.5%), benign prostatic hyperplasia among men (5.2%), and atrial fibrillation (5.0%). White older adults have slightly more physician visits per year (1 more visit on average).

Asian older adults have higher rates than Whites in a few indicators. The most notable difference is in dual eligibility for Medicare and Medicaid, with a 6.2% higher rate among Asians. Asians also have higher rates of having no chronic conditions (5.9% higher) and diabetes (5.2%). Whites have higher rates in several health measures, indicating a greater burden of certain chronic conditions. The largest disparities are observed in osteoarthritis or rheumatoid arthritis (15.9% higher in Whites), depression (14.9%), cataracts (14.3%), anxiety disorders (12.5%), and having four or more chronic conditions (12.0%).

Native Americans exhibit notably higher rates of chronic health conditions. The most pronounced disparities include chronic obstructive pulmonary disease (24.4% higher in Native Americans than in Whites), asthma (22.4%), fibromyalgia, chronic pain, and fatigue (22.2%), depression (20.8%), and having

four or more chronic conditions (20.5%). Additionally, Native Americans have higher rates of anemia (18.8%) and anxiety disorder (15.6%). These differences highlight a substantial burden of chronic and mental health conditions among Native American older adults compared to White older adults.

RACIAL DISPARITIES IN NEW HAMPSHIRE

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

White Older Adults

- Hip fracture (in women)
- Breast cancer (in women)

Black Older Adults

- Alzheimer's disease or related dementias
- Diabetes
- Hypertension

Native American Older Adults

- COPD
- Congestive heart failure
- Depression
- Having 4+ chronic conditions

Other Race Older Adults

- Heart attack
- Liver disease
- Lung cancer
- Stroke

Asian Older Adults Have LOWEST Rates of:

- Arthritis
- Depression
- Anxiety disorder

Hispanic Older Adults Have LOWEST Rates of:

- Breast cancer (in women)

Mental Health: Trends in Depression

We examined community depression rates across the New England states 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 Time 3 (2020–2021), which coincides with the COVID-19 pandemic.

New England communities with higher rates and the largest increase in depression rates in 2020–2021 had lower socioeconomic status, higher chronic disease burdens, and were urban or suburban locations.

We then investigated depression in New Hampshire. We found that lower depression rates were associated with a higher percentage of married residents 65+, greater broadband access, higher community socioeconomic status, and the presence of a community library. Higher depression rates were associated with more nursing homes, higher mortality rate, and higher chronic disease burdens. While New Hampshire has the lowest rate of depression across New England, a state rate of more than 30% indicates room for improvement. Other behavioral health concerns include the 7.6% state rate for adults 65+ with substance use disorder. County rates of binge drinking among adults of all ages in New Hampshire ranged from 13.10% to 18%.

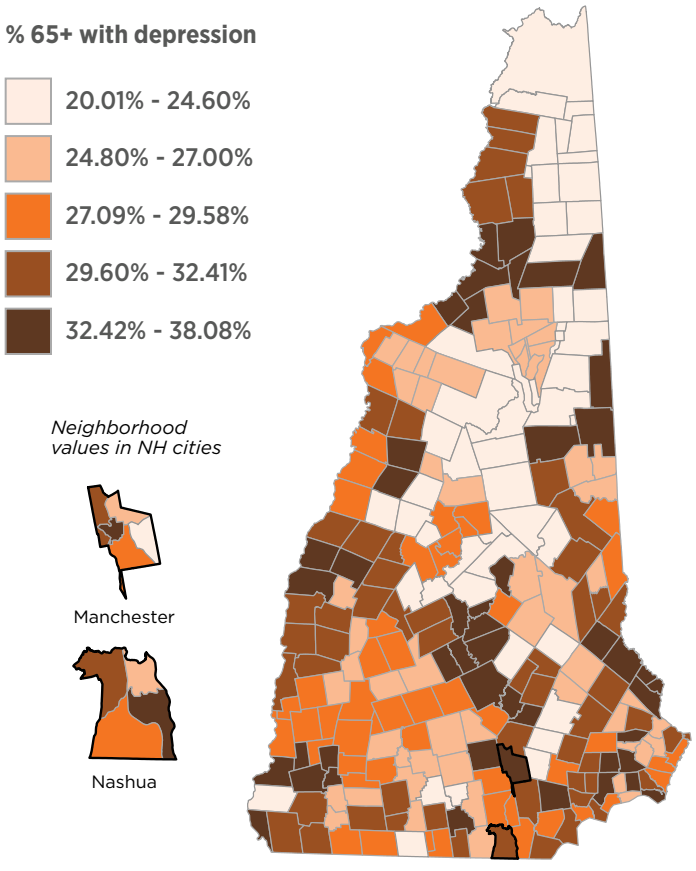
PROMOTING MENTAL HEALTH

We think increasing efforts to promote social connection and well-being are part of the solution. While higher rates of depression or anxiety are to be expected during a pandemic, depression is not a normal part of aging. Longevity research shows that our social health is as important to our overall well-being as physical or financial health.

Leaders in promoting mental health in New Hampshire are ready to help. Each would benefit from greater federal, state and/or philanthropic investments to expand services and support.

NAMI New Hampshire (https://www.naminh.org/) is a grassroots organization working to improve the quality of life for all by providing support, education, and advocacy for people affected by mental illness and suicide. Comprised of a network of affiliate chapters, support groups, staff, and volunteers, NAMI NH offers a safe and comfortable setting in which to share each other's pain and promote hope.

Community Mental Health Centers provide a wide range of services from emergency-response professionals for psychiatric emergencies to support of children and adults living with severe mental illness and substance misuse challenges.
dhhs.nh.gov/programs-services/mental-health



How Does New Hampshire Compare to Other New England States?

New Hampshire has the lowest rate among New England states for hip fracture and depression. There are no indicators where New Hampshire rates worse than the other New England states, and New Hampshire appears quite healthy in comparison to its neighboring states.

Table 8. New Hampshire rates compared to New England States

Indicators	NH	ME	CT	MA	RI	VT
% 65+ had hip fracture	**2.8%**	3.1%	**3.5%**	3.2%	3.1%	3.1%
% 65+ with high cholesterol	72.0%	69.5%	77.9%	75.9%	**79.3%**	**63.9%**
% 65+ with Alzheimer's disease or related dementias	10.7%	11.0%	**13.9%**	12.9%	12.0%	**9.6%**
% 65+ with benign prostatic hyperplasia	36.9%	35.2%	**44.0%**	42.6%	43.3%	**35.1%**
% 65+ with breast cancer (women)	10.2%	**9.6%**	**11.8%**	11.6%	11.5%	**9.6%**
% 65+ with chronic kidney disease	28.0%	29.4%	32.8%	**34.3%**	34.0%	**25.1%**
% 65+ with congestive heart failure	16.7%	18.1%	**21.0%**	19.6%	20.0%	**14.9%**
% 65+ with diabetes	25.2%	26.2%	31.8%	28.6%	**32.4%**	**23.6%**
% 65+ with HIV/AIDS	**0.1%**	0.2%	**0.3%**	**0.3%**	0.2%	**0.1%**
% 65+ with hypertension	67.3%	67.1%	74.2%	72.9%	**75.8%**	**64.7%**
% 65+ with ischemic heart disease	32.9%	35.3%	39.1%	37.1%	**39.4%**	**32.8%**
% 65+ with lung cancer	1.6%	1.8%	2.0%	**2.1%**	2.0%	**1.5%**
% 65+ with osteoporosis	16.3%	15.7%	**20.2%**	20.1%	18.9%	**14.4%**

Chart key: = highest rate = lowest rate

Table 8. Continued

Indicators	NH	ME	CT	MA	RI	VT
% 65+ with peripheral vascular disease	13.6%	15.3%	19.1%	18.1%	**23.1%**	**11.5%**
% 65+ with pressure ulcer	6.2%	6.8%	**9.1%**	7.8%	7.7%	**5.7%**
% 65+ with prostate cancer	11.6%	**10.3%**	**13.4%**	13.6%	**13.4%**	10.8%
% 65+ with stroke	10.0%	10.0%	11.5%	11.2%	**11.6%**	**9.2%**
% 65+ with 4+ chronic conditions	53.9%	55.5%	61.6%	60.4%	**63.0%**	**50.7%**
% 65+ with 0 chronic conditions	10.2%	**12.4%**	7.7%	**7.2%**	**7.2%**	11.0%
% 65+ with depression	**30.5%**	**34.8%**	32.3%	34.6%	34.5%	32.5%
% 65+ with anxiety disorder	28.0%	30.7%	30.9%	33.0%	**34.3%**	**25.8%**
% 65+ with PTSD	2.3%	**3.9%**	**2.0%**	3.0%	2.2%	2.8%
% 65+ dually-eligible for Medicare and Medicaid	**6.6%**	18.7%	**22.5%**	17.1%	15.0%	12.5%
% 65+ Medicare managed care enrollees	26.5%	50.3%	50.1%	30.5%	**51.4%**	**21.1%**
# inpatient hospital stays/1,000 persons 65+ annually	188	**170**	242	**252**	231	176
% Medicare inpatient hospital readmissions (as % of admissions)	16.2%	**14.3%**	17.6%	**18.2%**	17.1%	15.6%
# skilled nursing facility stays/1000 persons 65+ annually	45	**43**	**90**	73	76	47
% 65+ getting Medicaid long term services and supports	2.7%	**2.1%**	**4.4%**	3.4%	4.0%	3.4%
% 65+ hospice users as % of decedents	47.1%	49.7%	**42.4%**	44.0%	**50.7%**	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 of the state's older population, its increasing diversity, the unequal distribution of chronic conditions within it, and the impact of the pandemic on mental health. While there is impressive momentum to build a healthy, age-friendly state, **this is no time to let up**. Identify the areas in your community where existing services for older adults can be expanded and new ones established. And see the growing older population as a valuable resource. Find and scale up opportunities for the older residents of New Hampshire to contribute to the health and well-being of all. Meaningful service contributions from older adults will benefit the volunteers themselves, their communities, and the state as a whole. We can all play a role in making New Hampshire a great place to grow up and a great place to grow older in.

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 participation 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 New Hampshire Alliance for Healthy Aging.
2. Use data to inform your work.
3. Identify and build on what's working.

How Have States Used the Data Reports?

- In New Hampshire, a 2019 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 information important to their districts. AARP/NHAHA Senior Ambassadors were trained to interpret and explain community profiles and the statewide maps to legislators during the event.
- In 2014, Massachusetts advocates from the MA Councils on Aging printed out community profiles and went to the state capitol 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 large multi-year grant to support a training program.
- The Alzheimer's Association was surprised to learn that the rates for Alzheimer's disease and related dementias were 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. Counties along the Mississippi Delta had many rates higher than the state average. To address this concern, they convened a second 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. Networking and collaboration among interested partners are taking off.
- Educators in several states 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:

NHAHA - New Hampshire Alliance For Healthy Aging

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.

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) who spend 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.

The US Census Bureau (American Community Survey 2018–2022); New Hampshire Home Care Association (NHHCA), 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.

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+.

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.

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 smartphone (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.

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

TRANSPORTATION

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

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

HEALTH OUTCOMES

FALLS

% 65+ with hip fracture.

CMS, 2020–2021.

PREVENTION

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

CDC BRFSS 2020–2021.

NUTRITION AND DIET

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

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.

CDC BRFSS 2020–2021; HRSA, 2023.

CHRONIC DISEASE RATES AMONG MEDICARE BENEFICIARIES 65+

Alzheimer's disease or related dementias, anemia, arthritis, 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, osteoporosis, peripheral vascular disease, pressure ulcer, prostate cancer (men), stroke, 4 or more chronic conditions, zero chronic conditions.

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.

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.

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.

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.

CDC BRFSS 2020–2021; CMS 2020–2021; HRSA 2023; Medicare.gov, 2023.

SERVICE UTILIZATION

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

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 CDC,
- 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 27% of the total Medicare population in New Hampshire. 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. There are 24 unincorporated places in NH that we do not report data for. Excluding the unincorporated places, we report estimates for every city/town and neighborhoods of Nashua and Manchester (N=244). For example, the population characteristics and information from the US Census were reported for 244 geographic units. For highly prevalent chronic conditions we report for 154 geographic units, for less prevalent conditions we report for 69 geographic units. For the BRFSS data we report for 10 geographic units, and for the least prevalent conditions we report for 4 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.

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"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

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https://healthyagingdatareports.org/