Healthy Aging Data Report

Highlights from 2025

RHODE ISLAND

Explore more online at
HealthyAgingDataReports.org

A Message from the Governor

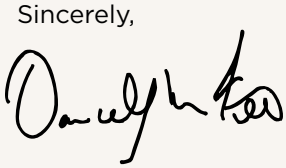
As we chart the course for a brighter future for all Rhode Islanders—one that lifts every resident, every community, and every comer of our state—we can look to the Point32Health Foundation Healthy Aging Data Report to guide our work. Healthy residents are an important component of a resilient and productive state. I am committed to fostering a holistic and comprehensive approach to health, human services, and community support that ensures every resident can succeed. I join communities across Rhode Island in the work to create environments where individuals can thrive at any age, especially with the state's population of older adults projected to reach significant proportions in the coming years. Preventing social isolation emerges as a critical factor in facilitating healthy aging, ensuring that older adults remain engaged, connected, and empowered within their neighborhoods.

I am committed to fostering healthy economies and vibrant neighborhoods, and I understand that achieving these goals requires thoughtful planning and a concerted effort from stakeholders. As laid out in my RI 2030 Plan: Charting a Course for the Future of the Ocean State, we are committed to easing the financial burden on Rhode Island's older adults by investing in workforce transition programs, increasing support for in-home care, and funding mental health and healthcare services. Our commitment to health and wellness encompasses physical and behavioral health for all Rhode Islanders. Together, these efforts are designed to create a healthier Rhode Island where every individual has the opportunity to feel good and lead a safe, fulfilling life.

As with many other states, Rhode Island's population is becoming both older and more diverse. Thoughtful planning ensures we seize the opportunities to build upon the knowledge and experience of older adults, as well as strategically respond to support all Rhode Islanders as we grow older. The Healthy Aging Data Report shows that as we age, we continue to contribute to our families and communities. We must prioritize developing supports that will help older adults access the assistance needed, ensuring that aging with dignity and maintaining independence is a priority.

This report gives us an overview of the current landscape affecting older adults. Historical data sheds light on progress made and ongoing challenges faced in the realm of social connectivity. The report highlights the necessity of collaboration across local, state, and regional levels. My administration is committed to fostering not only the well-being of Rhode Island's older population but also enhancing the overall health of the community at large. I thank the Point32Health Foundation for providing the Rhode Island Healthy Aging Data Report and I am committed to furthering the health and well-being of all Rhode Islanders.

Sincerely,



Daniel J. McKee

Governor
State of Rhode Island

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 the work Point32Health and the Foundation have given nearly $260 million to nonprofit organizations in Conn., Maine, Mass., N.H. and R.I. since 1980. In 2024 alone, the company and Foundation gave $1.7 million in Rhode Island to promote community health.

There is a clear need for accurate, unbiased information to help pinpoint risks, mitigate harms, and improve health. The 2025 Rhode Island 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 Rhode Island 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 Rhode Island Healthy Aging Data Report is available online at www.healthyagingdatareports.org. We urge you to explore this easy-to-use resource to better understand the residents in your local community, the state of Rhode Island, and New England.

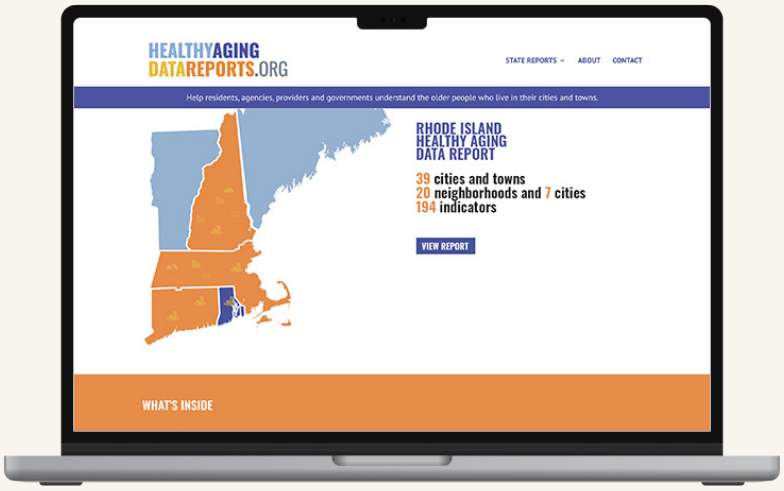
The 2025 Rhode Island Healthy Aging Data Report updates our previous reports and includes the following tools:

- 41 community profiles (for every city and town, plus two neighborhoods in Providence)
- 172 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
- Community profiles for 20 urban zip codes

The Healthy Aging Data Report team at the Gerontology Institute in the Donna M. and Robert J. Manning College of Nursing & Health Sciences at at the University of Massachusetts Boston created this resource with financial support from the Point-32Health Foundation.

We have been engaged in this work since 2012 and have learned from Rhode Islanders and other state partners about the data and tools needed to advance efforts to improve healthy aging. Our goal is to help accelerate your progress in creating age-friendly 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 Rhode Island Healthy Aging Data Report: 2025 Highlights. (https://healthyagingdatareports.org/rhode-island-healthy-aging-data-report/).

Table of Contents

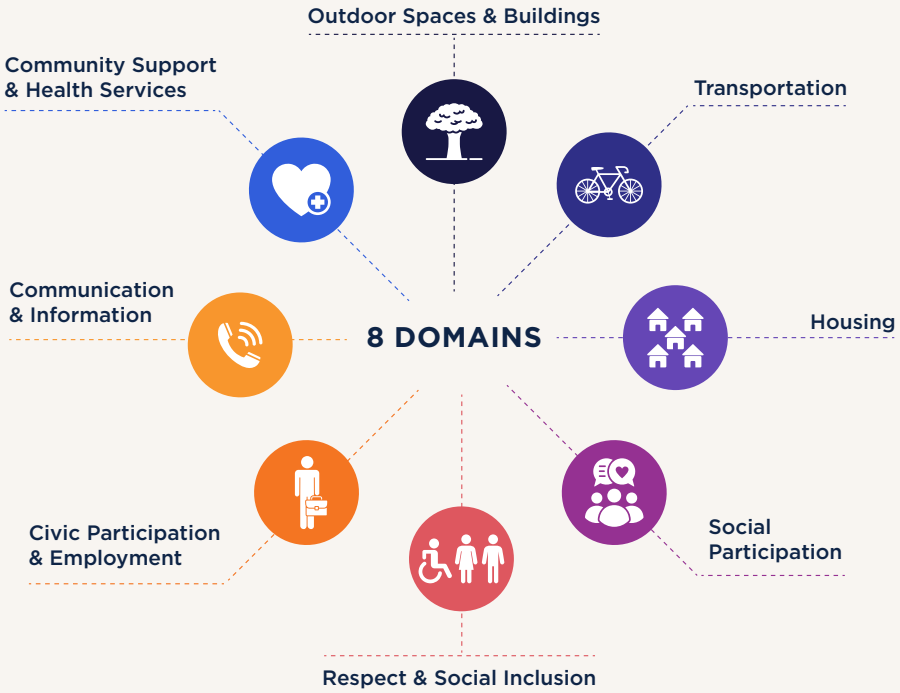
What Do Age-Friendly Communities Have in Common?

- 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

A Vision of Communities that Support Longevity

Advances in public health, nutrition, and medicine have contributed to significant gains in human longevity. Longevity coupled with declining birth-rates creates population aging. Soon we will have more older adults than children 5 or younger. These demographic changes present exciting opportunities for states and communities that prepare for the longevity economy.

Despite this demographic transformation, we exist in a society that is still geared for the life and demographics of a hundred years ago (when life expectancy was less than 50). This structural lag can be overcome if we take thoughtful action to address the 8 domains of age-friendly communities.



You are invited to join with those already working to make Rhode Island a great place to grow up and grow older. Based at Rhode Island College, Age-Friendly Rhode Island is a coalition of community and state agencies, healthcare and social service providers, individuals of all ages, advocacy and faith-based organizations, businesses, academic institutions, and municipal leaders who are committed to healthy aging. The mission of Age-friendly Rhode Island is to create partnerships, catalyze change, and build community that supports and empowers Rhode Islanders as we age. The vision of this work is to build a community that enables older Rhode Islanders to live independently with the care, support, and resources needed to foster health, well-being, social connectedness and a meaningful life.

Contact Age Friendly RI if you would like more information about becoming involved with one of their 40-plus coalition members such as AARP, Senior Fellows At Leadership Rhode Island, Sr. Agenda Coalition, or the Village Common RI, an organization with 9 villages that provides supports to help older adults remain at home and connected to their communities.

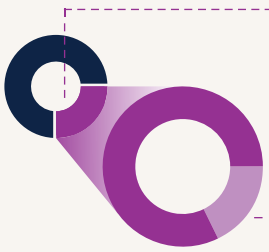
The 2025 Healthy Aging Data Report is an important resource to support Rhode Islanders committed to this mission.

Learn more at agefriendlyri.org.

What's New in Aging in Rhode Island?

Rhode Island 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 the population was in our previous 2020 Rhode Island report.

RI's older population is growing



25%
of the population is age 60 or older (273,831)
30,000 adults 60+ years old since 2020 report

18%
of the state is now 65 or older (195,378)
up from 16.5% since 2020 report

IMPACT OF COVID-19

According to the Centers for Disease Control, 4,213 Rhode Island 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.

OTHER INDICATORS

- **Marital Status:** The population 65+ saw increases in the percent divorced or separated (16.9%) and never married (9.3%), and a decline in those who were widowed (22.2%).
- **Emotional Health:** Among adults 60+, more than 3 in 4 reported receiving adequate emotional support. Yet about 35% of adults 65 or older have ever been diagnosed or treated for depression.
- **Chronic Conditions:** Compared to the other New England states Rhode Island had the highest rates for high cholesterol, hypertension, and having multiple (4+) chronic conditions
- **HIV/AIDSs:** The rate of adults 65+ with HIV/AIDS increased from 0.13% in 2014–2015 to 0.19% in 2020–2021.

RI's older population is changing

AGE

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

58% Age 65-74
29% Age 75-84
13% Age 85+

MORE DIVERSE

The population of adults 65 or older is increasingly diverse.

5.9% Hispanic
3.1% Black
6.5% Other race(s)
4.3% LGBT

MORE EDUCATED

The population of adults 65 or older is more educated.

16% Graduate or professional degree
15.9% College degree

POSITIVE PROGRESS

Rhode Island is making impressive advances in becoming more longevity ready. Five communities (Bristol, Cranston, Newport, Providence, and Westerly) have joined the **AARP Age-Friendly community movement,** and four more have made progress since we compiled the data in June, 2023 (Pawtucket, Lincoln, East Providence, Block Island).

Another positive change was the state agency focused on older adults changed its name to the **Office of Healthy Aging** to better reflect the population served.

Understanding the Data

There is a lot of information in the 2025 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.

Policymakers, service providers, and funders routinely have to make tough decisions on where to put resources, and many strive to be guided by data or evidence. As researchers, we are often asked to identify the healthiest and/or most burdened communities in a state. 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. Using this approach, we know that Central Falls has the highest rates on more indicators and Jamestown has the lowest or best rates on more indicators.

The list 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	**7.25%** Jamestown	**16.27%** Central Falls
Any physical activity in the past month	**82.76%** East Greenwich, North Kingstown	**63.10%** Central Falls, Pawtucket, Woonsocket
Depression	**28.32%** Charlestown	**40.28%** East Providence
Diabetes	**15.80%** Jamestown	**44.51%** Central Falls
Flu shot in past year	**74.73%** Charlestown, Narragansett, New Shoreham, South Kingstown	**60.29%** Central Falls, Pawtucket, Woonsocket
Getting recommended sleep	**72.63%** Barrington, Bristol, Warren	**55.50%** Providence Other
Hypertension	**63.36%** Jamestown	**81.43%** Coventry
Independent living difficulty	**2.69%** Little Compton	**21.67%** Johnston
Ischemic heart disease	**30.00%** Jamestown	**48.21%** Coventry
Obesity	**15.59%** Providence NE	**34.04%** Central Falls, Pawtucket, Woonsocket
Stroke	**8.18%** Jamestown	**13.81%** East Greenwich
4+ chronic conditions	**49.26%** Jamestown	**69.27%** Coventry
No chronic conditions	**12.10%** Providence Other	**5.25%** Smithfield

*The Providence Other neighborhood excludes the northeast portion of Providence but includes all other parts of the city.

Another approach to describe the health of Rhode Island community 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 or walking paths, very engaged senior center or public library) in place that may be models for what could help the communities with the highest rates compared to the state average.

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

Barrington, Charlestown, East Greenwich, Exeter, Jamestown, Little Compton, Middletown, Narragansett, Newport, New Shoreham, North Kingstown, Portsmouth, Providence, South Kingstown, Tiverton, West Greenwich

Similarly, to highlight communities with many rates "worse" than the state average may speed resources and programs to help. Investments in preventive interventions in these communities. This in turn could improve healthy aging for future generations.

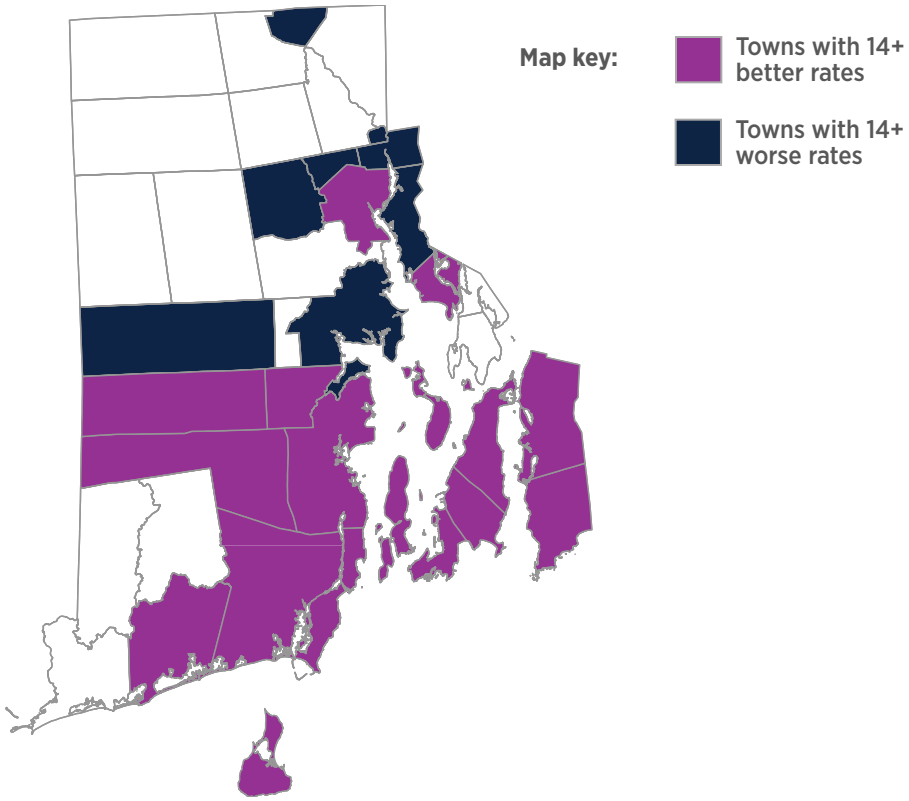
Towns with 14+ worse rates (navy in the map)

Central Falls, Coventry, East Providence, Johnston, North Providence, Pawtucket, Warwick, Woonsocket

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 Rhode Island?

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 Rhode Island. Table 2 shows that we found both positive and negative changes. Over time we observed a big increase in the percentage of older adults enrolled in Medicare managed care. More than half of the 65+ population is now in a managed care plan.

Rate increases are also observed in depression, arthritis, dually eligible for Medicare and Medicaid, and mortality.

Evidence of improvements in healthy aging are found in the declines in skilled nursing home stays, in inpatient admissions, and emergency room visits. There have also been promising declines in rates of diabetes, COPD, hypertension, and heart disease.

Table 2. Change Over Time

Indicators (%)	Change from T1 to T3 (%)
% 65+ Medicare managed care enrollees	**12.4%**
% 65+ with osteoarthritis or rheumatoid arthritis	**3.7%**
% 65+ with depression	**2.4%**
% 65+ dually-eligible for Medicare and Medicaid	**0.5%**
Age-sex adjusted 1-year mortality rate	**0.3%**
% 65+ ever had a heart attack	**0.2%**
% 65+ with lung cancer	**0%**
% 65+ with stroke	**-0.1%**
% 65+ with 4+ (out of 15) chronic conditions	**-0.1%**
% Medicare inpatient hospital readmissions (as % of admissions)	**-0.3%**
% 65+ with colon cancer	**-0.5%**
% 65+ with Alzheimer's disease or related dementias	**-0.8%**
% 65+ getting Medicaid long term services and supports	**-1.6%**
% 65+ with asthma	**-1.8%**
% 65+ with chronic obstructive pulmonary disease	**-2.3%**
% 65+ with hypertension	**-3.2%**
% 65+ with ischemic heart disease	**-3.6%**
% 65+ with diabetes	**-3.9%**

How Does Gender Impact Healthy Aging?

Another way to understand healthy aging in Rhode Island is to contrast the experience of women and men.

The results in Table 3 show that compared to men, women have higher rates on 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 have better access to care (dually-eligible Medicare and Medicaid, Long Term Services and Supports (LTSS), hospice use, and enrolling in Medicare Advantage). While greater access to health care (LTSS and hospice use) 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 and end-of-life arrangements.

WOMEN	MEN
56.3% 65+	**43.7%** 65+
67.8% 85+	**32.2%** 85+

Table 3. Gender Differences: Women

Women Have Higher Rates Than Men	Female	Male	Difference Between Female and Male
% 65+ with osteoporosis	29.9%	4.2%	**25.6%**
% 65+ with anxiety disorder	41.6%	25.1%	**16.5%**
% 65+ with depression	40.7%	26.7%	**14.0%**
% 65+ with cataract	69.5%	59.6%	**9.8%**
% 65+ with osteoarthritis or rheumatoid arthritis	61.4%	52.1%	**9.3%**
% 65+ with asthma	18.1%	11.1%	**7.0%**
% 65+ with migraine and other chronic headache	11.4%	4.4%	**7.0%**
% 65+ with fibromyalgia, chronic pain, and fatigue	36.5%	30.0%	**6.5%**
% 65+ hospice users as % of decedents	53.3%	47.5%	**5.8%**
% 65+ dually-eligible for Medicare and Medicaid	17.6%	11.9%	**5.7%**
% 65+ Medicare managed care enrollees	53.6%	48.6%	**5.0%**

Table 3. Continued

Women Have Higher Rates Than Men	Female	Male	Difference Between Female and Male
% 65+ with glaucoma	28.2%	24.1%	**4.1%**
% 65+ getting Medicaid long term services and supports	5.1%	2.7%	**2.4%**
% 65+ had hip fracture	3.9%	1.8%	**2.2%**
% 65+ with Alzheimer's disease or related dementias	12.4%	11.4%	**1.0%**
% 65+ with schizophrenia & other psychotic disorder	3.2%	2.8%	**0.5%**
% 65+ with post-traumatic stress disorder	2.4%	2.0%	**0.4%**
# physician visits per year	8.0	7.6	**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	47.4%	33.1%	**14.4%**
% 65+ with chronic kidney disease	38.4%	30.5%	**7.9%**
% 65+ with diabetes	36.4%	29.3%	**7.1%**
% 65+ with atrial fibrillation	18.2%	11.4%	**6.8%**
% 65+ with congestive heart failure	22.8%	17.9%	**4.9%**
% 65+ with hypertension	78.2%	73.7%	**4.6%**
% 65+ with substance use disorder	10.9%	6.4%	**4.5%**
% 65+ with tobacco use disorder	14.1%	10.4%	**3.6%**
% 65+ ever had a heart attack	7.0%	4.1%	**2.9%**

Table 4. Continued

Men Have Higher Rates Than Women	Male	Female	Difference Between Male and Female
% 65+ with peripheral vascular disease	24.7%	21.8%	**2.9%**
% Medicare inpatient hospital readmissions (as % of admissions)	18.5%	16.0%	**2.5%**
% 65+ with 0 chronic conditions	8.3%	6.3%	**2.0%**
% 65+ with stroke	12.6%	10.8%	**1.8%**
Age-sex adjusted 1-year mortality rate	5.0%	3.8%	**1.2%**
% 65+ with pressure ulcer or chronic ulcer	8.2%	7.2%	**1.0%**
% 65+ with colon cancer	2.5%	2.2%	**0.3%**
% 65+ with HIV/AIDS	0.3%	0.1%	**0.3%**
# emergency room visits/1000 persons 65+ years annually	530	477	**54**
# inpatient hospital stays/1000 persons 65+ years annually	258	211	**47**
# durable medical equipment claims annually	2.2	1.6	**0.5**

There are several public health initiatives that might be considered for statewide action. These include targeting older adults for screening for high cholesterol and hypertension. In addition, supporting programs to address lifestyle behaviors among older men, such as smoking cessation, and muscle strengthening and fall prevention for older women, are measures that can lead to positive outcomes to support healthy aging.

KEY TAKEAWAYS

WOMEN

Bone health

- 7x higher osteoporosis
- 9% higher arthritis
- 7% higher chronic pain & migraine

Mental health

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

MEN

Heart & metabolic diseases

- 14% higher ischemic heart disease
- 5% higher rates of hypertension
- 7% higher diabetes rates

Emergency room usage & hospital stays

- 54 more visits to ER annually than older RI women
- 47 more hospital stays annually than older RI women

How Do Race and Ethnicity Impact Healthy Aging?

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

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 cumulative burdens of structural racism. Understanding the *why* of rate disparities is a challenge in this type of research. Below we take the first step and report the what (rate differences).

88.6% White 65+

3.1% Black 65+

1.8% Asian 65+

5.9% Hispanic 65+

6.5% Other Race(s) 65+

832 Native American/ Alaskan 55+

Compared to Black adults, White adults have higher/worse rates on conditions related to bone health (arthritis, osteoporosis, hip fracture), mental health (anxiety, depression), cardiovascular health (high cholesterol, atrial fibrillation, COPD, ischemic heart disease) and other conditions (cataract, BPH, fibromyalgia, liver disease, migraine), and greater use of hospice and physician visits.

Table 5. Racial Differences Between Older White and Black Adults

White Adults Have Higher Rates Than Black Adults	White	Black	Difference Between White and Black
% 65+ with cataract	66.5%	51.6%	**14.9%**
% 65+ with benign prostatic hyperplasia (men)	44.8%	30.2%	**14.6%**
% 65+ with anxiety disorder	35.5%	22.2%	**13.3%**
% 65+ with osteoarthritis or rheumatoid arthritis	58.9%	47.4%	**11.4%**
% 65+ hospice users as % of decedents	52.3%	41.1%	**11.2%**
% 65+ with osteoporosis	19.6%	10.1%	**9.5%**
% 65+ with high cholesterol	80.3%	71.4%	**8.8%**
% 65+ with depression	35.3%	27.8%	**7.5%**
% 65+ with atrial fibrillation	15.0%	8.3%	**6.8%**
% 65+ with fibromyalgia, chronic pain, and fatigue	34.6%	28.8%	**5.8%**
% 65+ with 0 chronic conditions	6.6%	11.6%	**5.0%**

Table 5. Continued

White Adults Have Higher Rates Than Black Adults	White	Black	Difference Between White and Black
% 65+ with liver disease	13.2%	9.3%	**3.9%**
% 65+ with COPD	21.6%	18.3%	**3.3%**
% 65+ with ischemic heart disease	40.4%	37.3%	**3.1%**
% 65+ with migraine	8.5%	5.6%	**2.9%**
% 65+ had hip fracture	3.3%	1.5%	**1.8%**
% 65+ hospice users	3.6%	2.7%	**0.9%**
# physician visits per year	8	6	**2**

Compared to older White adults, older Black adults have higher rates of being dually-eligible for Medicare and Medicaid, more monthly prescription refills, conditions related to metabolic health (diabetes, kidney disease), cardiovascular health (hypertension, congestive heart failure), tobacco use disorder, prostate cancer, and schizophrenia.

Table 6. Racial Differences Between Older Black and White Adults

Black Adults Have Higher Rates Than White Adults	Black	White	Difference Between Black and White
% 65+ dually-eligible for Medicare and Medicaid	33.2%	10.9%	**22.3%**
% 65+ with diabetes	46.0%	31.8%	**14.2%**
% 65+ with chronic kidney disease	43.9%	34.0%	**9.9%**
% 65+ with prostate cancer (men)	18.6%	13.7%	**4.8%**
% 65+ Medicare managed care enrollees	55.1%	50.5%	**4.6%**
% 65+ with tobacco use disorder	16.1%	12.2%	**3.9%**
% 65+ with hypertension	79.3%	76.3%	**2.9%**
% 65+ getting Medicaid long term services and supports	6.4%	3.7%	**2.7%**
% 65+ with congestive heart failure	23.2%	20.5%	**2.7%**
% 65+ with schizophrenia & other psychotic disorder	4.9%	3.0%	**1.9%**
% 65+ with HIV/AIDS	1.1%	0.1%	**0.9%**
# Medicare Part D monthly prescription fills per enrollee annually	57	54	**3**

Compared to older Hispanic adults, older non-Hispanic White adults 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. In addition, utilization is higher for physician visits, emergency room visits, and nursing home stays.

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

White Adults Have Higher Rates Than Hispanic Adults	White	Hispanic	Difference Between White and Hispanic
% 65+ with cataract	66.5%	52.9%	**13.6%**
% 65+ with osteoarthritis or rheumatoid arthritis	58.9%	45.9%	**13.0%**
% 65+ with benign prostatic hyperplasia (men)	44.8%	36.7%	**8.1%**
% 65+ with high cholesterol	80.3%	73.1%	**7.1%**
% 65+ with anemia	48.0%	40.9%	**7.1%**
% 65+ with ischemic heart disease	40.4%	33.4%	**7.1%**
% 65+ with fibromyalgia, chronic pain, and fatigue	34.6%	28.6%	**6.0%**
% 65+ with atrial fibrillation	15.0%	9.4%	**5.7%**
% 65+ with anxiety disorder	35.5%	30.2%	**5.3%**
% 65+ with 4+ (out of 15) chronic conditions	64.1%	58.8%	**5.3%**
% 65+ with COPD	21.6%	16.7%	**4.9%**
% 65+ with breast cancer (women)	11.8%	7.0%	**4.8%**
% 65+ with glaucoma	26.8%	22.3%	**4.5%**
% 65+ with peripheral vascular disease	24.0%	20.0%	**4.0%**
% 65+ with prostate cancer (men)	13.7%	10.0%	**3.7%**
% 65+ with osteoporosis	19.6%	16.4%	**3.2%**
% 65+ with pressure ulcer or chronic ulcer	8.0%	5.6%	**2.4%**
% 65+ with congestive heart failure	20.5%	18.3%	**2.2%**
% 65+ with tobacco use disorder	12.2%	10.2%	**2.1%**
% 65+ with migraine	8.5%	6.7%	**1.8%**
% 65+ had hip fracture	3.3%	1.6%	**1.7%**

Table 7. Continued

White Adults Have Higher Rates Than Hispanic Adults	White	Hispanic	Difference Between White and Hispanic
% 65+ ever had a heart attack	5.5%	4.5%	**1.0%**
% 65+ with lung cancer	2.1%	1.4%	**0.7%**
Age-sex adjusted 1-year mortality rate	4.4%	3.7%	**0.6%**
# physician visits per year	8	5	**3**
# skilled nursing facility stays/1000 persons 65+ years annually	79	67	**12**

Compared to older White adults, older Hispanic adults have higher rates for diabetes, Alzheimer's disease, and schizophrenia. Utilization rates are higher for dually-eligible, Managed care enrollment, hospital readmission, getting Medicaid long term services, and home health visits.

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

Hispanic Adults Have Higher Rates Than White Adults	Hispanic	White	Difference Between Hispanic and White
% 65+ dually-eligible for Medicare and Medicaid	54.7%	10.9%	**43.8%**
% 65+ Medicare managed care enrollees	63.8%	50.5%	**13.2%**
% 65+ with diabetes	42.5%	31.8%	**10.7%**
% 65+ with 0 chronic conditions	12.3%	6.6%	**5.7%**
% Medicare inpatient hospital readmissions (as % of admissions)	21.4%	16.9%	**4.5%**
% 65+ getting Medicaid long term services and supports	7.6%	3.7%	**3.9%**
% 65+ with Alzheimer's disease or related dementias	14.2%	12.3%	**1.9%**
% 65+ with schizophrenia & other psychotic disorder	4.4%	3.0%	**1.4%**

White older adults had higher or worse rates on 36 chronic disease indicators and medical service utilization. The largest difference was observed in osteoarthritis or rheumatoid arthritis where approximately 59% of older White adults had the condition compared to only 36% of older Asians.

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

White Adults Have Higher Rates Than Asian Adults	White	Asian	Difference Between White and Asian
% 65+ with osteoarthritis or rheumatoid arthritis	58.9%	35.8%	**23.1%**
% 65+ with cataract	66.5%	51.3%	**15.2%**
% 65+ with anxiety disorder	35.5%	20.7%	**14.8%**
% 65+ with benign prostatic hyperplasia (men)	44.8%	30.2%	**14.6%**
% 65+ hospice users as % of decedents	52.3%	39.2%	**13.1%**
% 65+ with fibromyalgia, chronic pain, and fatigue	34.6%	21.8%	**12.7%**
% 65+ with depression	35.3%	23.2%	**12.1%**
% 65+ with 4+ (out of 15) chronic conditions	64.1%	52.4%	**11.7%**
% 65+ with peripheral vascular disease	24.0%	13.4%	**10.5%**
% 65+ with ischemic heart disease	40.4%	30.0%	**10.4%**
% 65+ with prostate cancer (men)	13.7%	5.9%	**7.9%**
% 65+ with atrial fibrillation	15.0%	7.2%	**7.8%**
% 65+ with COPD	21.6%	13.9%	**7.6%**
% 65+ with hypertension	76.3%	68.8%	**7.5%**
% 65+ with glaucoma	26.8%	21.1%	**5.7%**
% 65+ with high cholesterol	80.3%	75.2%	**5.1%**
% 65+ with pressure ulcer or chronic ulcer	8.0%	3.0%	**5.0%**
% 65+ with congestive heart failure	20.5%	15.8%	**4.8%**
% 65+ with substance use disorder	8.6%	4.9%	**3.7%**
% 65+ with migraine	8.5%	4.8%	**3.7%**
% 65+ with breast cancer (women)	11.8%	8.3%	**3.5%**
% 65+ with asthma	15.2%	11.7%	**3.5%**

Table 9. Continued

White Adults Have Higher Rates Than Asian Adults	White	Asian	Difference Between White and Asian
% 65+ with Alzheimer's disease	12.3%	9.6%	**2.7%**
% 65+ with liver disease	13.2%	10.7%	**2.5%**
% 65+ Medicare managed care enrollees	50.5%	48.2%	**2.3%**
% 65+ had hip fracture	3.3%	1.6%	**1.7%**
% 65+ with endometrial cancer (women)	2.3%	1.2%	**1.1%**
# emergency room visits/1000 persons 65+ years annually	510	397	**113**
# skilled nursing facility stays/1000 persons 65+ years annually	79	35	**44**
# Medicare Part D monthly prescription fills per enrollee annually	54	46	**8**
# physician visits per year	8	5	**3**
# home health visits annually	3	2	**1**
# durable medical equipment claims annually	2	1	**1**

Compared to older White adults, older Asian adults have higher rates for diabetes. Older Asian adults had higher rates of dually-eligible for Medicare and Medicaid, and getting Medicaid long term services. Positively, older Asian adults had higher rates of zero chronic conditions compared to older White adults.

Table 10. Racial/Ethnic Differences: Older Asian and White Adults

Asian Adults Have Higher Rates Than White Adults	Asian	White	Difference Between Asian and White
% 65+ dually-eligible for Medicare and Medicaid	36.0%	10.9%	**25.1%**
% 65+ with diabetes	41.3%	31.8%	**9.4%**
% 65+ with 0 chronic conditions	13.0%	6.6%	**6.4%**
% 65+ getting Medicaid long term services and supports	7.1%	3.7%	**3.4%**

Native American older adults have significantly higher rates for several health indicators compared to White older adults. Native elders have 16 more monthly prescription refills. Other significant differences include being dually-eligible for Medicare and Medicaid (15.6% higher), chronic kidney disease (13.1%), and diabetes (12.9%). White older adults have more physician visits per year (2 visits more on average).

The "Other" racial and ethnic group in the Medicare data had differences compared to older White adults. (Note the data reported here defines "other" race as any of the other racial categories not captured in White, Black or African American, American Indian or Alaska Native, Asian.) Notable differences include being dually-eligible for Medicare and Medicaid (14.6% higher), diabetes (9.2%), chronic kidney disease (6.7%), and Medicare managed care enrollment (6.5%). White older adults have significantly higher rates for anxiety disorder (4.7% higher) and the average number of physician visits per year (1 visit more on average).

RACIAL DISPARITIES IN RHODE ISLAND

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

White Older Adults

- Hip fracture
- High cholesterol
- Ever had a heart attack
- Anxiety disorder

Black Older Adults

- Diabetes
- HIV
- Prostate cancer (men)

Hispanic Older Adults

- Alzheimer's disease or related dementias

Alaskan Natives/American Indians Older Adults

- Congestive heart failure
- Hypertension
- Depression

Other Race(s) Older Adults

- Chronic obstructive pulmonary disease
- Stroke
- With 4+ (out of 15) chronic conditions

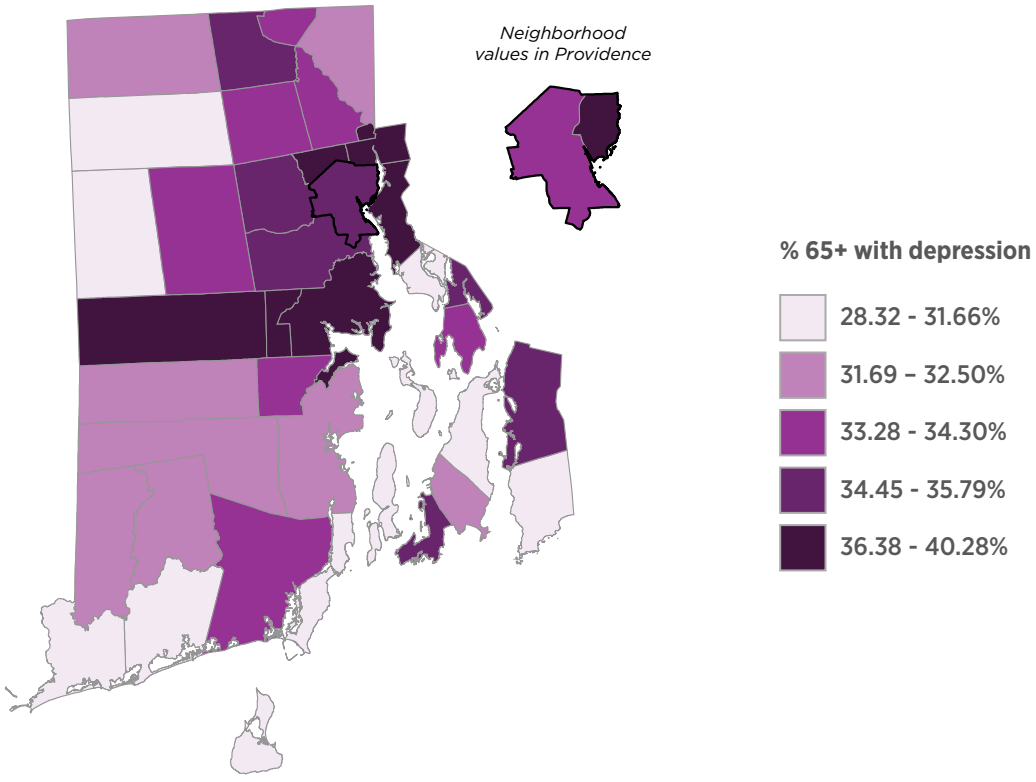
Mental Health: Trends in Depression

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 steadily increased across the 5 states of New England across the three time periods. The largest increase in depression rates was found in the Medicare data from 2020 – 2021 which coincides with the COVID-19 pandemic.

In Rhode Island-specific analyses, we found that lower community rates of depression were associated with a higher percentage of older residents who moved from other counties, a higher percentage of married older adults, greater broadband access, and a higher percentage of older Asian adults.

Higher community depression rates were associated with a higher number of nursing homes, higher mortality rate, higher percentage of older adults with 4+ chronic conditions, and a higher percentage of older Black or African American adults.

Raising awareness about depression, increasing screening for it, and educating about the variety of effective treatments available is needed. Depression is not a normal part of aging. Our social health is as important to our well-being as physical or financial health. The Mental Health Association of Rhode Island has a list of community resources available (mhari.org/resources).



How Does Rhode Island Compare to Other New England States?

Rhode Island had the highest rate among New England states for high cholesterol, diabetes, hypertension, peripheral vascular disease, stroke, multiple chronic conditions, and anxiety disorder. There are evidence-based programs related to healthy nutrition, physical activity, and mindfulness that may help prevent or manage those conditions. Rhode Island also had the highest rates of managed care enrollees and hospice users.

Table 11. Comparing Selected Disease Indicators Among New England States

Indicators	RI	CT	MA	ME	NH	VT
% 65+ had hip fracture	3.1%	**3.5%**	3.2%	3.1%	**2.8%**	3.1%
% 65+ with high cholesterol	**79.3%**	77.9%	75.9%	69.5%	72.0%	**63.9%**
% 65+ with Alzheimer's disease	12.0%	**13.9%**	12.9%	11.0%	10.7%	**9.6%**
% 65+ with BPH (men)	43.3%	**44.0%**	42.6%	35.2%	36.9%	**35.1%**
% 65+ with breast cancer (women)	11.5%	**11.8%**	11.6%	**9.6%**	10.2%	**9.6%**
% 65+ with chronic kidney disease	34.0%	32.8%	**34.3%**	29.4%	28.0%	**25.1%**
% 65+ with congestive heart failure	20.0%	**21.0%**	19.6%	18.1%	16.7%	**14.9%**
% 65+ with diabetes	**32.4%**	31.8%	28.6%	26.2%	25.2%	**23.6%**
% 65+ with HIV/AIDS	0.2%	**0.3%**	**0.3%**	0.2%	**0.1%**	**0.1%**
% 65+ with hypertension	**75.8%**	74.2%	72.9%	67.1%	67.3%	**64.7%**
% 65+ with ischemic heart disease	**39.4%**	39.1%	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	RI	CT	MA	ME	NH	VT
% 65+ with osteoporosis	18.9%	**20.2%**	20.1%	15.7%	16.3%	**14.4%**
% 65+ with peripheral vascular disease	**23.1%**	19.1%	18.1%	15.3%	13.6%	**11.5%**
% 65+ with pressure ulcer or chronic ulcer	7.7%	**9.1%**	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	**11.6%**	11.5%	11.2%	10.0%	10.0%	**9.2%**
% 65+ with 4+ chronic conditions	**63.0%**	61.6%	60.4%	55.5%	53.9%	**50.7%**
% 65+ with 0 chronic conditions	**7.2%**	7.7%	**7.2%**	**12.4%**	10.2%	11.0%
% 65+ with depression	34.5%	32.3%	34.6%	**34.8%**	**30.5%**	32.5%
% 65+ with anxiety disorder	**34.3%**	30.9%	33.0%	30.7%	28.0%	**25.8%**
% 65+ dually-eligible for Medicare and Medicaid	15.0%	**22.5%**	17.1%	18.7%	**6.6%**	12.5%
% 65+ Medicare managed care enrollees	**51.4%**	50.1%	30.5%	50.3%	26.5%	**21.1%**
# inpatient hospital stays/1,000 persons 65+ years annually	231	242	**252**	**170**	188	176
% Medicare inpatient hospital readmissions (as % of admissions)	17.1%	17.6%	**18.2%**	**14.3%**	16.2%	15.6%
# skilled nursing facility stays/1000 persons 65+ years annually	76	**90**	73	**43**	45	47
% 65+ getting Medicaid long term services and supports	4.0%	**4.4%**	3.4%	**2.1%**	2.7%	3.4%
% 65+ hospice users as % of decedents	**50.7%**	**42.4%**	44.0%	49.7%	47.1%	43.0%

Call to Action

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 Rhode Island to contribute to the health and well-being of all residents. Meaningful service contributions would benefit the state and the volunteer.

UNDERSTAND

- Download your community profile at healthyagingdatareports.org.
- Educate yourself and others about the indicators in your community.
- Compare your community rates to state rates

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! Use data to inform your work.
2. Partner with other change agents.
3. Join Age-Friendly Rhode Island. Connect with this movement at agefriendlyri.org or oha.ri.gov.

How Have States Used the Data Reports?

In 2014, 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 advocates 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 statewide 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.

Resources for Age-Friendly Communities

Age-Friendly Rhode Island

Long-term Care Coordinating Council

Providence Village RI

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, % 60+ who are LGBT.

Data sources: The US Census Bureau (American Community Survey 2018–2022); Rhode Island Department of Health BRFSS 2012–2022.

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); Rhode Island Department of Health 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 source: Elderindex.org, 2023; Center for Social and Demographic Research on Aging at the UMass Boston.

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

% 60+ getting the recommended hours of sleep, % 60+ doing any physical activity in the past month, % 60+ who met CDC guidelines for muscle-strengthening activity, % 60+ who met CDC guidelines for aerobic physical activity, % 60+ with fair or poor self-reported health status, % 60+ with 15 or more physically unhealthy days in last month, % 60+ who reported being satisfied with life.

Data sources: BRFSS, 2010–2022.

COMMUNITY

Annual # of unhealthy days due to air pollution for 65+ (county), 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), % households

without access to the Internet (all ages), % 60+ who used Internet in past month, voter participation rate in 2020 election (18+), homicide rate/100,000 person (county), # firearm fatalities (all ages) (county), #65+ deaths by suicide, age-sex adjusted 1-year mortality rate.

Data sources: AARP, 2023; ACS, 2018–2022; Age Friendly RI, 2023; BRFSS, 2010–2022; CDC WONDER, 2016–2020; The CMS Master Beneficiary Summary File ABCD/Other (CMS), 2020–2021; NECHE, 2023; OLLI, 2023; RI State Library, 2023; RI Secretary of State, 2023; U.S. EPA Air Compare, 2023.

TRANSPORTATION

% householders 65+ who own a motor vehicle, % 60+ who always drive or ride wearing a seatbelt, % 60+ drove under the influence, # fatal crashes involving adults age 60+ (county), AllTransit™ Score.

Data sources: The US Census Bureau (American Community Survey 2018–2022); AllTransit™, 2023; BRFSS 2010–2022; NHTSA, 2018–2022.

HEALTH OUTCOMES

FALLS

% 60+ who fell in past year, % 60+ who were injured by a fall in past year, % 65+ with hip fracture.

Data sources: BRFSS 2010–2022; CMS, 2020–2021.

PREVENTION

% 60+ with check-up in past year, % 60+ flu shot in past year, % 60+ with pneumonia vaccine, % 60+ with shingles vaccine, % 60+ women with mammogram in past 2 years, %60+ had colorectal cancer screening, % 60+ with HIV test, %60+ with optimal preventive health.

Data sources: BRFSS 2010–2022.

NUTRITION AND DIET

% 60+ with 5 or more servings of fruit or vegetables per day, % 60+ stressed about buying food in past month, % 60+ self-reported obese, % 65+ with high cholesterol, % 60+ with high cholesterol screening.

Data sources: BRFSS 2010–2022; CMS 2020–2021.

ORAL HEALTH

% 60+ with dental insurance, % 60+ with annual dental exam, # dentists per 100,000 persons (all ages) (county), % 60+ with loss of 6 or more teeth.

Data sources: BRFSS 2010–2022; 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) (county), %65+ with substance use disorder, % 60+ who used cannabis in the past month, % 60+ with excessive drinking, % 65+ tobacco use disorder, % 60+ current smokers, % 60+ ever used E-cigarettes in past month.

Data sources: BRFSS 2010–2022; CDC Wonder 2016–2020; CMS 2020–2021.

MENTAL HEALTH

% 60+ with adequate emotional support, % 60+ with 15 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: BRFSS 2010–2022; 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, % 60+ who provide care to a family member or friend in past month, % grandparents raising grandchildren.

Data sources: American Community Survey 2018–2022; Alzheimer's Association, 2023; BRFSS 2010–2022.

ACCESS TO CARE

% 65+ dually eligible for Medicare and Medicaid, % 65+ Medicare managed care enrollees, % 60+ with a regular doctor, % 60+ who did not see a doctor when needed due to cost, # of primary care providers, # of hospitals, # of home health agencies, # of skilled nursing facilities, # of hospice agencies, # of community health centers, # of adult day health centers.

Data sources: BRFSS 2010–2022; CMS 2020–2021; HRSA 2023; Medicare.gov, 2023; RI Adult Day Services, 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 Rhode Island 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 51.4% of the total Medicare population in Rhode Island. 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 two Providence neighborhoods (N=41). For example, the population characteristics and information from the US Census were reported for all 41 geographic units. For highly prevalent chronic conditions we report for 37 geographic units, and for less prevalent conditions we report for 28 geographic units. For the BRFSS data we report for 15 geographic units, and for the least prevalent conditions we report for 5 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

UMass Boston | Gerontology Institute

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Funded by

Point32Health Foundation

In partnership with

Harvard Pilgrim Health Care

Point32Health companies

TUFTS Health Plan

https://healthyagingdatareports.org/