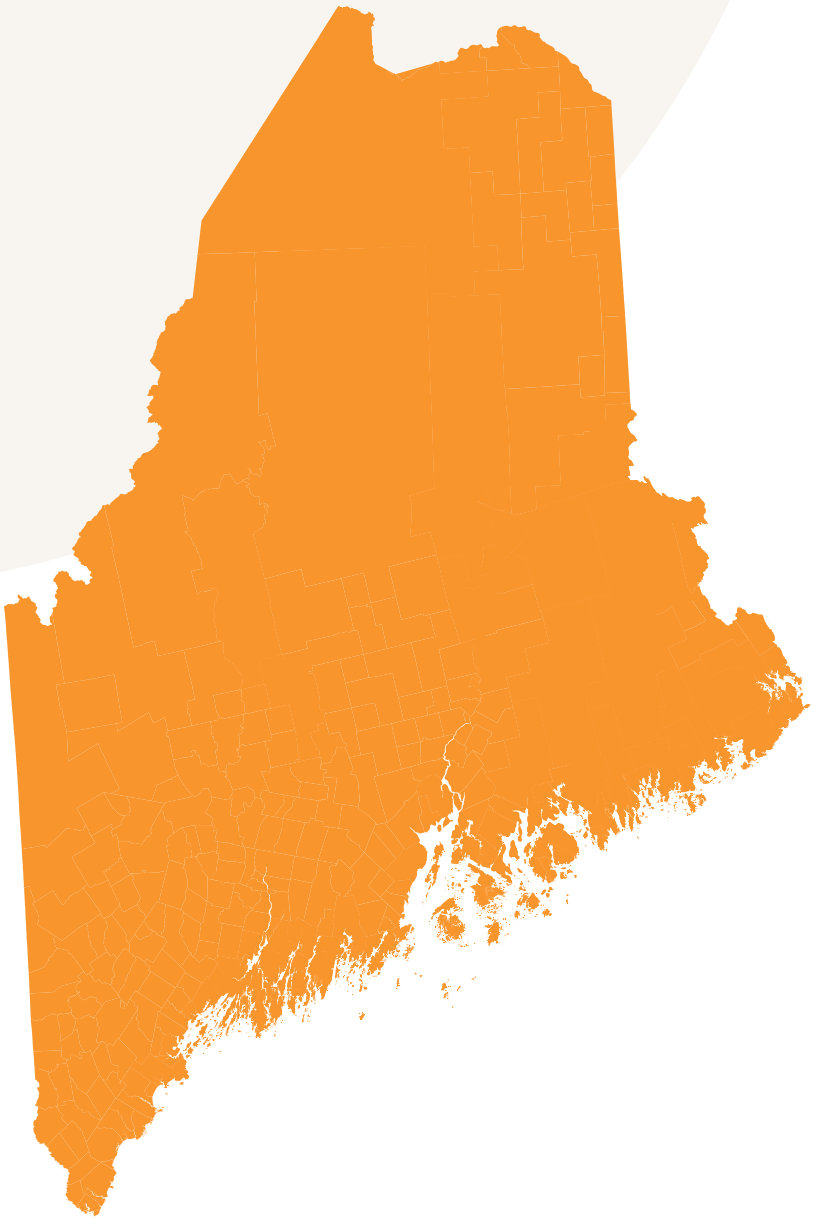
Healthy Aging Data Report

Highlights from 2025

MAINE



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 Maine. The research team at the Gerontology Institute of 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 Maine, this first-ever report has received support of $124,209.

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 inaugural 2025 Maine Healthy Aging Data Report, a valuable tool for understanding Maine's current status and to track progress in the future.

While this is our first report in Maine, it builds on our previous work 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.

Nora Moreno Cargie

President, Point32Health Foundation;
Vice President, Corporate Citizenship, Point32Health

Elizabeth Dugan, PhD

Principal Investigator, Gerontology, University of Massachusetts Boston

About the Report

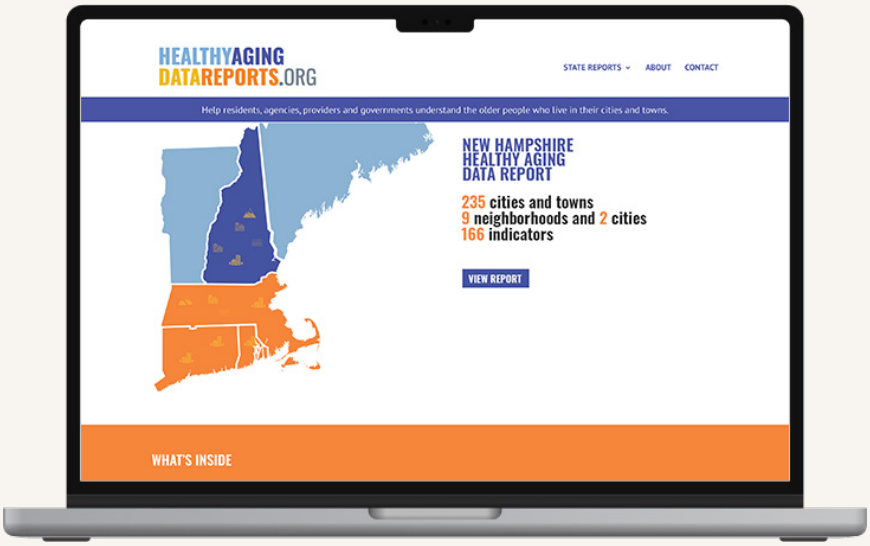
The 2025 Maine Healthy Aging Data Report is available online at www.healthyagingdatareports.org. We invite you to explore this resource to better understand the residents in your local community, the state of Maine, and New England.

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

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

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

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



Suggested Citation: Dugan, E., Lee, C.M., Jansen, T., Song, Q., Su, Y.J., & Silverstein, N.M. The Maine Healthy Aging Data Report: 2025 Highlights. (www.healthyagingdatareports.org/maine-healthy-aging-data-report/).

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What Do Age-Friendly Communities Have in Common?

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

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

A Vision of Communities that Support Longevity

We are fortunate to be living in the midst of an era when advances in public health, nutrition, and medicine have contributed to 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. However, our society is still geared for the life and population-age structure of a hundred years ago, when life expectancy was less than 50. This structural lag can be closed if we take thoughtful action to address the key domains of age-friendly communities: housing, communication, community supports, outdoor spaces, transportation, social participation, social inclusion, and civic participation. You are invited to join with those already working to make Maine longevity-ready.

MAINE COUNCIL ON AGING

The Maine Council on Aging (MCOA) believes in a Maine where we can live healthy, engaged, and secure lives with choices and opportunities as we age in our homes and communities. This vision intentionally includes diverse older people who have experienced historical bias and injustice. The MCOA draws upon wisdom, experience, and data to influence policy, educate stakeholders, and advance initiatives that move us towards our vision. We commit to including the voices, wisdom, and lived experience of diverse older people.
Learn more: https://mainecouncilonaging.org

1865 THE UNIVERSITY OF MAINE Center on Aging

The University of Maine Center on Aging's mission is to promote activities on aging in the areas of education, research and evaluation, and community service to maximize the quality of life of older citizens and their families in Maine and beyond. It coordinates Lifelong Communities initiative to create communities that are inclusive and respectful of every generation. Throughout Maine, counties, regions, cities, and towns are tapping into the wisdom and experience of older residents to develop strong communities for toddlers, centenarians, and everyone in-between.

AARP® Maine

AARP Maine devotes itself to working in Maine on issues that matter to you and your family. AARP is the nation's largest nonprofit, nonpartisan organization dedicated to empowering Americans 50 and older to choose how they live as they age. We have a membership of over 200,000 in Maine and almost 38 million nationwide. We envision a society in which everyone ages with dignity and purpose.
Learn more: https://states.aarp.org/maine

Governor Janet Mills created the Maine Cabinet on Aging to help Maine prepare for and address these demographic changes by advancing policies that will support Mainers to age safely, affordably, and in ways and settings that best serve their needs. The Cabinet will bring together state government agencies to coordinate and advance work on issue such as affordable housing and long-term services and supports; financial security and protection against fraud; access to information, broadband, and services; and engagement and employment in Maine's growing economy.
Learn more: https://www.maine.gov/future/aging

What's New in Aging in Maine?

Maine 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.

Maine's older population is growing

29%
of the state is 60 or older (402,170)

21.5%
of the population is age 65 or older (293,488)

IMPACT OF COVID-19

According to the Centers for Disease Control, 3,760 Maine 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+, 57% are married, 16.9% divorced/separated, 20.6% widowed, and 5.6% never married.
- **Mental Health:** Compared to the other New England states older residents of Maine had the highest rates for ever being diagnosed for depression (34.8%).
- **Chronic Conditions:** Positively, Mainers had the highest percentage of people reporting zero chronic diseases (12.4%) and the lowest rates for breast cancer (9.6%).
- **HIV/AIDS:** The rate of adults 65+ with HIV/AIDS increased from 0.09% in 2014–2015 to 0.17% in 2020–2021.

Maine'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% Age 65-74

29% Age 75-84

12% Age 85+

MORE DIVERSE

The population of adults 65 or older is increasingly diverse.

96.6% White, 0.7% Hispanic, 0.5% Asian, 0.3% African American/Black, 2.5% Other Race(s)

1,794
Adults 55+ are Native American

7%
Adults 65+ report speaking a language other than English at home

MORE EDUCATED

The population of adults 65 or older is more educated.

15.1%
Graduate or professional degree

18.3%
College Degree

59%
High school degree or some college

7.6%
Less than a high school education

18%
of Mainers age 65+ are veterans of military service

28.3%
of Mainers age 65+ live alone

Understanding the Data

There is a lot of information in the report, and it is not unusual for people to feel a little overwhelmed by it all. This Highlights Report provides a framework for understanding the status of your state. The 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.

Sometimes people don't have time to review the entire report and ask us to just identify the healthiest and/or most burdened communities in a state. 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 instance, we can contrast 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. To take one example, rates of Alzheimer's disease and related dementias range from a low of about 6% in the small towns of Andover, Byron, Hanover, Lincoln Plan, Magalloway, Newry, North Oxford, Roxbury, and Upton to a high rate of nearly 19% in Orono.

Table 1 below contrasts rates for indicators that provide an indication of overall health status.

Table 1. Best and Worst Rates on Selected Indicators

	Best Rates	Worst Rates
Alzheimer's disease and related dementias	**6.06%** Andover, Byron, Hanover, Lincoln Plan, Magalloway, Newry, North Oxford, Roxbury, Upton	**18.98%** Orono
Depression	**25.33%** Bowdoin, Bowdoinham, Perkins	**43.40%** Allagash, New Canada, Northwest Aroostook, St. Francis, St. John, Wallagrass
Diabetes	**15.75%** Brooksville, Castine	**38.13%** Edinburg, Howland, Maxfield, Penobscot Indian Reservation, Seboeis
Hypertension	**51.55%** Bowdoin, Bowdoinham, Perkins	**80.52%** Ashland, Garfield, Masardis, Nashville, Portage Lake
Independent living difficulty	**1.62%** Durham	**39.75%** Woolwich
Ischemic heart disease	**23.11%** Bradley	**53.59%** Allagash, New Canada, Northwest Aroostook, St. Francis, St. John, Wallagrass
Stroke	**5.68%** Sedgwick	**15.09%** Mexico
4+ chronic conditions	**38.32%** Bowdoin, Bowdoinham, Perkins	**72.37%** Grand Isle, Madawaska

Table 1. Continued

	Best Rates	Worst Rates
No chronic conditions	**25.49%** Bowdoin, Bowdoinham, Perkins	**5.24%** Grand Isle, Madawaska
Anxiety disorder	**18.68%** Carrabassett Valley, Central Somerset, Coplin, East Central Franklin, Eustis, Highland, Kingfield, New Portland, North Franklin, Pleasant Ridge, Solon, Wyman	**44.43%** Grand Isle, Madawaska
Inpatient hospital readmission rate	**0%** Anson, Starks	**32.69%** Harrison

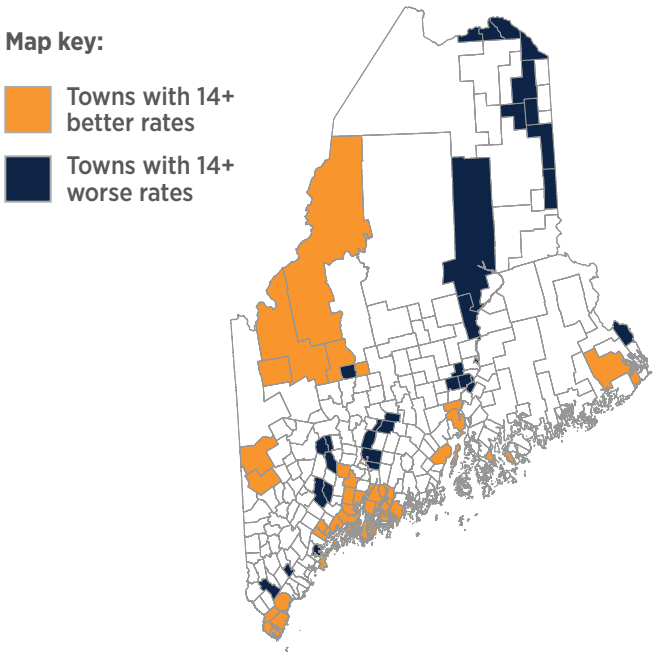
Another approach to describe the health of Maine communities is to count how many indicators are statistically "better" compared to the state average. Communities with multiple "better" indicators may be healthier than other communities. These communities may have some resources (e.g., park or walking paths, engaged senior center, public library) in place that may be replicable in less healthy communities.

Towns with 14+ better rates (yellow in the map) *Newcastle, Arrowsic, South Oxford, Boothbay, Bowdoin, Perkins, Monhegan, Brooklin, Brunswick, Cape Elizabeth, East Central Franklin, Solon, Long Island, Cumberland, Rangeley, Dresden, Dennistown, Dennysville, Edgecomb, Eliot, Stockton Springs, Freeport, Islesboro, Kittery, Litchfield, Waterford, Monmouth, North Yarmouth, Ogunquit, Phippsburg, South Berwick, Topsham, Wells, Winterport, Woolwich, Yarmouth, York*

Towns with 14+ worse rates (navy in the map) *Auburn, Augusta, Bangor, Benton, Westfield, Brewer, Robbinston, Connor, Castle Hill, Chelsea, Cyr, Dayton, Mount Chase, Penobscot Indian Island Reservation, Embden, Fort Kent, Frenchville, Glenburn, Grand Isle, Hermon, Houlton, Leeds, Lewiston, Livermore, Livermore Falls, Portland, Presque Isle, Sanford, Sidney, Veazie, Waterville, Winslow*

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. 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 describe rates at the state level. When resources are limited, it can be helpful to know which communities are most in need of investments. Using this approach, we'd advise philanthropy, policymakers, and others to prioritize health investments for the communities shaded navy on the map.



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

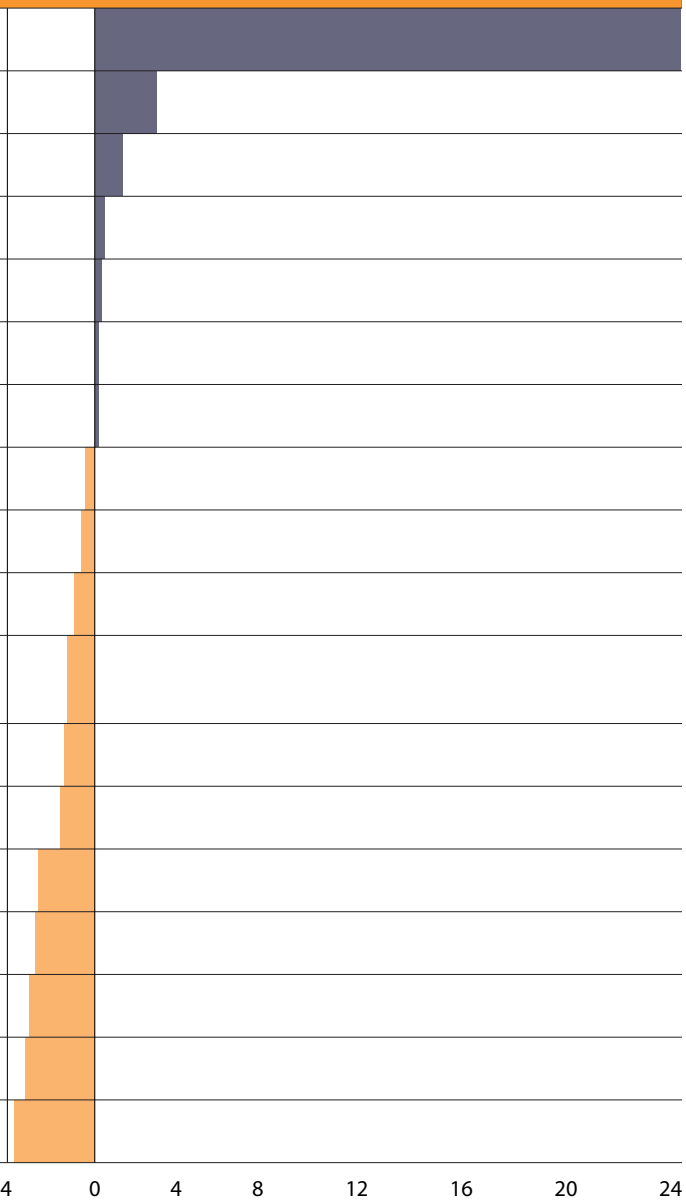
What Has Changed Over Time in Maine?

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 Maine. We found both positive and negative changes. As seen in Table 2, Medicare managed care enrollment increased from 26.9% at Time 1 to 50.3% at Time 3. That is an increase of more than 23%. More than half of the 65+ population in Maine is now in a Medicare managed care plan. Rate increases were also observed in arthritis, depression, heart attack, mortality, lung cancer, and Alzheimer's disease.

There have been declines in rates of hypertension, COPD, diabetes, having 4+ chronic conditions, heart disease, stroke, asthma, and colon cancer. In terms of access and utilization, declines were found in the use of Medicaid long term services and supports, being dually eligible for Medicare and Medicaid, and inpatient hospital readmission rate.

Table 2. Change Over Time

Indicators (%)	Change from T1 to T3 (%)
% 65+ Medicare managed care enrollees	23.4%
% 65+ with osteoarthritis or rheumatoid arthritis	3.1%
% 65+ with depression	1.4%
% 65+ with Alzheimer's disease or related dementias	0.4%
% 65+ ever had a heart attack	0.3%
Age-sex adjusted 1-year mortality rate	0.1%
% 65+ with lung cancer	0.1%
% 65+ with colon cancer	-0.4%
% 65+ getting Medicaid long term services and supports	-0.6%
% 65+ with stroke	-1%
% Medicare inpatient hospital readmissions (as % of admissions)	-1.4%
% 65+ with 4+ (out of 15) chronic conditions	-1.5%
% 65+ with ischemic heart disease	-1.6%
% 65+ dually-eligible for Medicare and Medicaid	-2.6%
% 65+ with asthma	-2.7%
% 65+ with diabetes	-3%
% 65+ with chronic obstructive pulmonary disease	-3.1%
% 65+ with hypertension	-3.7%



How Does Gender Impact Healthy Aging?

Another way to understand healthy aging in Maine 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 (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, 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
54.3% 65+	**45.7%** 65+
64.8% 85+	**35.2%** 85+

Table 3. Gender Differences: Women

Women Have Higher Rates Than Men	Female	Male	Difference Between Female and Male
% 65+ with osteoporosis	25.9%	3.2%	**22.7%**
% 65+ with anxiety disorder	37.5%	22.6%	**15.0%**
% 65+ with depression	41.0%	27.5%	**13.5%**
% 65+ with cataract	65.3%	54.9%	**10.4%**
% 65+ hospice users as % of decedents	54.2%	44.5%	**9.7%**
% 65+ with osteoarthritis or rheumatoid arthritis	55.6%	46.8%	**8.9%**
% 65+ with fibromyalgia, chronic pain, and fatigue	38.0%	31.0%	**7.0%**
% 65+ with asthma	14.5%	8.6%	**6.0%**
% 65+ dually-eligible for Medicare and Medicaid	21.3%	15.6%	**5.7%**
% 65+ with migraine and other chronic headache	9.7%	4.1%	**5.6%**
% 65+ with glaucoma	25.3%	20.9%	**4.5%**

Table 3. Continued

Women Have Higher Rates Than Men	Female	Male	Difference Between Female and Male
% 65+ Medicare managed care enrollees	51.3%	49.1%	**2.2%**
% 65+ had hip fracture	3.8%	2.0%	**1.8%**
% 65+ with Alzheimer's disease or related dementias	11.5%	10.2%	**1.3%**
% 65+ with post-traumatic stress disorder	4.5%	3.3%	**1.2%**
% 65+ getting Medicaid long term services and supports	2.7%	1.5%	**1.1%**
% 65+ with schizophrenia & other psychotic disorder	3.5%	2.9%	**0.6%**
# skilled nursing facility stays/1000 persons 65+ annually	46	39	**7**

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 higher 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	42.3%	29.4%	**12.9%**
% 65+ with atrial fibrillation	17.6%	11.5%	**6.1%**
% 65+ with chronic kidney disease	32.7%	26.7%	**6.0%**
% 65+ with diabetes	29.2%	23.6%	**5.6%**
% 65+ with congestive heart failure	20.4%	16.2%	**4.1%**
% 65+ with substance use disorder	10.8%	6.9%	**3.8%**
% 65+ with peripheral vascular disease	17.3%	13.6%	**3.7%**
% 65+ with hypertension	69.0%	65.5%	**3.5%**
% 65+ with tobacco use disorder	15.4%	12.0%	**3.4%**

Table 4. Continued

Men Have Higher Rates Than Women	Male	Female	Difference Between Male and Female
% 65+ ever had a heart attack	7.8%	4.7%	**3.1%**
% 65+ with 0 chronic conditions	13.7%	11.2%	**2.6%**
% 65+ with stroke	10.6%	9.4%	**1.3%**
% 65+ with chronic obstructive pulmonary disease	21.6%	20.3%	**1.2%**
Age-sex adjusted 1-year mortality rate	4.8%	3.7%	**1.1%**
% 65+ with pressure ulcer or chronic ulcer	7.3%	6.4%	**1.0%**
% 65+ with HIV/AIDS	0.3%	0.1%	**0.2%**
# inpatient hospital stays/1000 persons 65+ annually	182	159	**23**
# durable medical equipment claims annually	2.1	1.9	**0.2**

Overall, there are several public health initiatives that might be considered for statewide action. For example, Maine might implement new 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

- 8x higher osteoporosis
- 9% higher arthritis
- 2% higher chronic pain & migraine

Mental health

- 15% higher rates of anxiety
- 14% higher depression rates

MEN

Heart & metabolic diseases

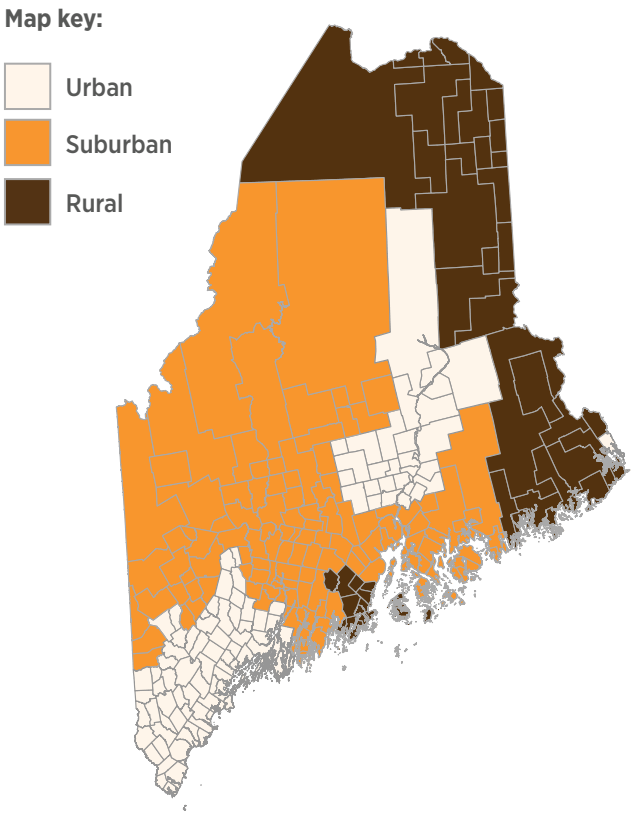
- 13% higher ischemic heart disease
- 4% higher rates of hypertension
- 6% higher diabetes rates

Emergency room usage & hospital stays

- 23 more hospital stays annually than older Maine women

Comparing Urban, Suburban, and Rural Community Health

Another way to understand the experience of aging in Maine is to contrast the experience of people living in urban, suburban, and rural communities. Table 5 shows the indicators where urban rates are highest. Urban communities have the highest rates of racial diversity and a higher percentage of older residents who are Black or Asian. Urban communities have higher education and income levels along with higher cost of housing and greater access to smartphones and broadband. Urban communities have the highest voter participation rate in 2020. Greater rates of hospice use are found in urban communities, as well as a slightly higher rate of Medicare Managed care enrollment.



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).

URBAN

104 Towns
(39% of ME communities in HADR)

60% of ME 60+ Residents

Counties: Androscoggin, Cumberland, Penobscot, Sagadahoc, Washington, York

SUBURBAN

114 Towns
(43% of ME communities in HADR)

30% of ME 60+ Residents

Counties: Franklin, Hancock, Kennebec, Lincoln, Oxford, Piscataquis, Somerset, Waldo

RURAL

47 Towns
(18% of ME communities in HADR)

10% of ME 60+ Residents

Counties: Aroostook, Knox, Washington

Table 5. Indicators Where Urban Rates are Highest

	Urban	Suburban	Rural
% 65+ who are Black or African American	**0.3%**	0.1%	0.2%
% 65+ who are Asian	**0.4%**	0.3%	0.1%
% Age 65 - 74 among people age 65+	**62.5%**	62.3%	60.8%
% 65+ who are married	**60.5%**	59.1%	59.2%
% 65+ with college degree	**17.3%**	17.2%	15.2%
% 65+ with graduate or professional degree	**14.0%**	13.5%	12.4%
% 65+ with annual income above $100,000	**21.6%**	18.4%	16.2%
% 65+ with annual income between $50,000 to $99,999	**31.1%**	30.1%	27.3%
% 65+ who spend more than 35% of income on housing (renters)	**28.2%**	26.5%	24.7%
% 65+ who spend more than 35% of income on housing (owners)	**21.3%**	17.8%	19.3%
% age 60+ with mortgage on homes	**41.9%**	37.5%	33.3%
% of households with a smartphone (all ages)	**84.2%**	80.1%	74.1%
% of households with access to broadband (all ages)	**89.3%**	85.4%	81.2%
Voter participation rate in 2020 presidential election (age 18+)	**74.8%**	73.6%	74.1%
% men 65+ who are up to date on preventive services (county)	**51.4%**	48.1%	47.0%
% 65+ with HIV/AIDS	**0.2%**	0.2%	0.1%
% 65+ with post–traumatic stress disorder	**4.1%**	3.9%	3.7%
% 18+ with excessive drinking (county)	**16.2%**	14.4%	13.5%
% 18+ with annual dental exam (county)	**66.1%**	64.1%	62.3%
Inpatient hospital readmissions as a % of admissions for 65+	**14.4%**	13.5%	13.9%
% of Medicare beneficiaries age 65+ enrolled in managed Care	**51.5%**	50.9%	43.6%
% hospice users as % of decedents	**51.9%**	50.0%	40.6%

Table 6 shows the indicators where suburban communities have the highest rates. Suburban communities have the highest percentage of White residents, and more who reported only speaking English at home. The suburbs have the highest percentage of residents who are Veterans, divorced, and employed. Car and home ownership rates are highest in the suburbs. In terms of health outcomes, substance use disorder rates, migraines, and breast cancer are highest in the suburbs and urban communities. Suburban women have the highest rates of obtaining recommended preventive services.

Table 6. Indicators Where Suburban Rates are Highest

	Suburban	Urban	Rural
% 65+ who are White	**97.2%**	96.3%	96.6%
% 65+ who speak only English at home	**96.0%**	94.3%	88.5%
% 65+ who are veterans of military service	**19.6%**	18.8%	19.1%
% 65+ who are divorced or separated	**17.2%**	15.6%	14.1%
% 65+ who own a motor vehicle	**94.1%**	93.2%	92.2%
% 60+ who own home	**86.8%**	85.2%	83.9%
% 65+ with annual income between $20,000 to $49,999	**34.9%**	32.4%	34.4%
% 65+ employed in past year	**19.8%**	18.8%	18.0%
% 65+ with substance use disorder	**8.5%**	8.5%	8.1%
% 65+ with breast cancer (women)	**9.2%**	9.2%	9.0%
% 65+ with migraine and other chronic headache	**7.0%**	7.0%	6.4%
% women 65+ up to date on preventive services (county)	**41.5%**	40.9%	38.6%

As shown in Table 7, there are many indicators where rural communities have the highest rates. We have organized the indicators in Table 7 into the following categories: social demographic, health behaviors, chronic disease, and utilization. Rural communities have the highest percentage of residents who are older adults, widowed or never married, live alone, and Hispanic. Financially, rural residents have more residents 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. Rural communities have the highest rates of household computers, access to the internet, and smartphone access to the internet. Smoking, obesity, and high cholesterol rates are highest in rural communities. Rates indicating poor mental health (depression, anxiety, schizophrenia) and poor cardiovascular health are highest in the rural communities.

Table 7. Indicators Where Rural Rates are Highest

	Rural	Urban	Suburban
Rural Social Demographic Indicators			
% of population age 60+	**36.5%**	29.1%	33.3%
% of population who are age 65+	**27.0%**	20.8%	24.3%
% age 75 - 84 among people age 65+	**28.2%**	27.5%	27.7%
% 85+ among people age 65+	**11.0%**	10.0%	10.0%
% 65+ who are widowed	**21.6%**	19.0%	19.3%
% 65+ who never married	**5.1%**	4.9%	4.5%
% 65+ who are Hispanic	**0.9%**	0.7%	0.8%
% 65+ who are other race(s)	**3.1%**	3.0%	2.4%
% 65+ with less than high school education	**10.1%**	7.3%	7.0%
% 65+ with high school or some college education	**62.3%**	61.4%	62.2%
% 65+ who live alone	**27.5%**	25.1%	26.9%
% 65+ with annual income less than $20,000	**22.1%**	14.9%	16.6%
% 60+ receiving food benefits in past year	**14.0%**	9.3%	9.6%
% 65+ with income below the poverty line in past year	**12.0%**	8.1%	8.7%
% of households without a computer (all ages)	**11.0%**	5.8%	8.2%
% without access to the internet (all ages)	**18.1%**	10.3%	14.0%
% with only a smartphone to access the internet (all ages)	**7.5%**	6.0%	7.3%
% of grandparents who live with grandchildren	**2.2%**	1.9%	1.7%

Table 7. Continued

	Rural	Urban	Suburban
% of grandparents raising grandchildren	**0.8%**	0.6%	0.5%
Rural Health Behavior Indicators			
% 65+ with tobacco use disorders	**15.2%**	13.5%	14.2%
% 18+ who are current smokers (county)	**18.6%**	15.1%	17.5%
% 18+ with obesity (county)	**35.8%**	31.9%	33.3%
Rural Chronic Disease Indicators			
% 65+ with diabetes	**28.1%**	26.6%	25.1%
% 65+ with hypertension	**70.3%**	66.7%	65.5%
% 65+ with 4+ chronic conditions	**57.7%**	54.5%	53.8%
% 65+ with osteoarthritis or rheumatoid arthritis	**51.3%**	50.4%	50.8%
% 65+ with depression	**34.3%**	33.9%	33.6%
% 18+ who had 14+ days with poor mental health (county)	**15.7%**	15.1%	15.3%
% 65+ with anxiety disorder	**30.7%**	30.3%	27.6%
% 65+ with schizophrenia or other psychotic disorders	**3.5%**	3.4%	3.1%
% 65+ with Alzheimer's disease or related dementias	**10.7%**	10.4%	10.2%
% 65+ with stroke	**10.2%**	9.5%	9.7%
% 65+ with chronic obstructive pulmonary disease	**24.3%**	19.7%	20.9%
% 65+ with complete tooth loss (county)	**15.6%**	12.2%	14.9%
% 65+ with asthma	**12.1%**	11.5%	10.8%
Rural Utilization Indicators			
One-year mortality rate for 65+, adjusted for age-sex	**4.3%**	4.2%	4.2%
% 65+ getting Medicaid long term services and supports	**2.4%**	1.8%	1.8%
% 18-64 who lack health insurance (county)	**8.7%**	7.3%	8.2%
% 65+ who are dually eligible for Medicare and Medicaid	**23.6%**	17.0%	19.8%

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

- HIV/AIDS
- PTSD

Rural

- Alzheimer's disease or related dementias
- Asthma
- COPD
- Diabetes
- Depression
- Hypertension
- Stroke

How Do Race and Ethnicity Impact Healthy Aging?

Another way to understand the status of healthy aging in Maine 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. Below we report the what (that is, the rate differences).

In Maine, Black/African American older adults have higher rates compared to White older adults in several health indicators. The most notable difference is in the percentage of those who are dually-eligible for Medicare and Medicaid, with a 16.2% difference between Black and White adults. Other significant disparities include diabetes (12.8% higher among Black older adults), chronic kidney disease (9.5%), anemia (8.0%), and glaucoma (5.0%). Conversely, White adults have higher rates compared to Black adults in certain indicators. The largest differences are found in cataract (15.6% higher among White older adults), osteoarthritis or rheumatoid arthritis (9.0%), anxiety disorder (8.6%), and atrial fibrillation (7.1%). These differences suggest varying health challenges between the two groups, with Black/African Americans experiencing higher rates of conditions related to chronic diseases and dual eligibility, and White adults having a higher prevalence of conditions related to mental health and age-related physical changes (such as cataracts and arthritis).

96.6% White 65+

0.3% Black 65+

0.5% Asian 65+

0.7% Hispanic 65+

2.5% Other Race(s) 65+

1,794 Native American/ Alaskan 55+

For Hispanic older adults, the disparities are also evident. Hispanic adults have higher rates in dually-eligible Medicare and Medicaid (10.0% higher than White older adults), and % with 0 chronic conditions (5.5%). However, Whites adults have higher rates in cataract (10.7%), high cholesterol (7.7%), osteoarthritis or rheumatoid arthritis (5.8%), and anemia (5.4%). This pattern indicates that Hispanic adults face greater challenges related to dual eligibility, whereas White adults have higher rates in cardiovascular conditions and some other chronic conditions.

Asian older adults generally show fewer disparities compared to White adults. Older Asians have a prominently higher rate of those who are dually-eligible for Medicare and Medicaid (a 15.9% difference), and have a higher rate of diabetes (7.3% greater). Conversely, White adults have higher rates in ischemic heart disease (13.5%), depression (12.3%), Medicare managed care enrollees (11.5%), osteoarthritis or rheumatoid arthritis (11.0%), cataract (10.0%), and several chronic conditions (chronic obstructive pulmonary disease and 4+ chronic conditions).

Native American older adults in Maine show substantial disparities compared to White adults, particularly in those who are dually-eligible for Medicare and Medicaid (a 27.7% difference),

diabetes (26.2%), chronic obstructive pulmonary disease (23.1%), 4+ chronic conditions (17.0%), fibromyalgia, chronic pain, and fatigue (16.2%), anemia (13.4%, glaucoma (13.4%), osteoarthritis or rheumatoid arthritis (12.2%), substance use disorder (12.0%), and other chronic conditions. Compared to Native American older adults, White adults have substantially higher rates of Medicare managed care enrollees (a 25.5% difference) and % with 0 chronic conditions (7.3%). These differences highlight significant differences related to chronic diseases and healthcare access.

RACIAL DISPARITIES IN MAINE

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

White Older Adults

- Endometrial cancer (in women)

Black Older Adults

- Prostate cancer (in men)

Hispanic Older Adults

- Migraine or other chronic headache

Native American Older Adults

- Alzheimer's disease
- Diabetes
- Heart attack
- Lung cancer
- Depression

Other Race(s) Older Adults

- Cataract

Asian Older Adults Have LOWEST Rates of:

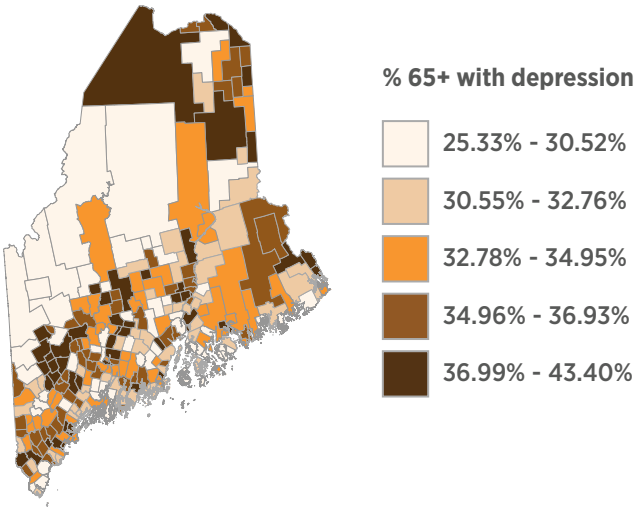
- Asthma
- Ischemic heart disease
- Depression

Mental Health

DEPRESSION

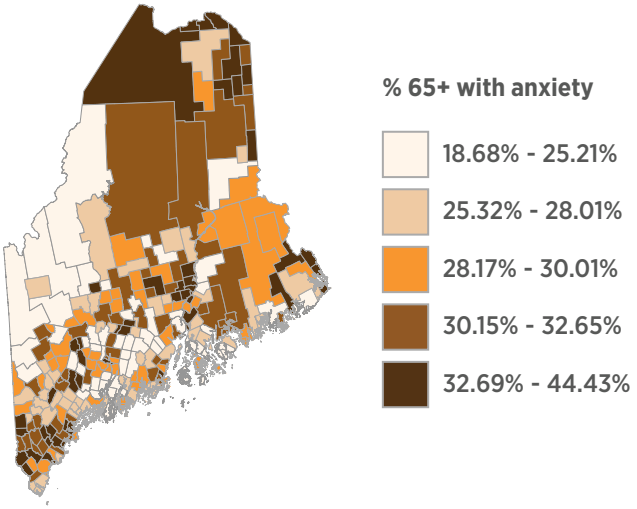
We examined community depression rates in New England at three points in time: 2014–2015 (Time 1), 2016–2017 (Time 2), and 2020–2021 (Time 3). Rates increased across New England at Time 2 and at Time 3. The largest increase in depression rates was in 2020–2021, which coincides with the COVID-19 pandemic. We then looked at the interaction between socioeconomic status and community depression rates. 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.

In Maine-specific analyses, we found that lower depression rates were associated with higher % of married residents in a community, higher community socioeconomic status, and the presence of a library in the community. Higher depression rates were associated with total community population, the number of nursing homes, higher % of inter-county moves among 60+, higher mortality rate, and a higher chronic disease burden.



ANXIETY

The state rate for ever being diagnosed for anxiety among Medicare beneficiaries 65+ is more than 30%. While some communities have rates as low as 18.68%, some have rates as high as 44.43% (Grand Isle & Madawaska).



Promoting Mental Health

We think efforts to promote social connections and inclusion are a key part of optimal health. While higher rates of depression or anxiety are to be expected during a pandemic, they are 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.

Raising awareness about mental health and educating us all about the variety of effective treatments available are needed.

How Does Maine Compare to Other New England States?

Maine has the highest rate among New England states for depression and PTSD. Maine has the lowest rates for: breast and prostate cancer, having 0 chronic conditions, inpatient hospital stays, skilled nursing facility stays, and getting Medicaid long term services and supports.

Table 12. Maine Rates Compared to New England States

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

Chart key: = highest rate = lowest rate

Table 12. Continued

Indicators	ME	CT	MA	NH	RI	VT
% 65+ with peripheral vascular disease	15.3%	19.1%	18.1%	13.6%	**23.1%**	**11.5%**
% 65+ with pressure ulcer	6.8%	**9.1%**	7.8%	6.2%	7.7%	**5.7%**
% 65+ with prostate cancer (men)	**10.3%**	**13.4%**	13.6%	11.6%	**13.4%**	10.8%
% 65+ with stroke	10.0%	11.5%	11.2%	10.0%	**11.6%**	**9.2%**
% 65+ with 4+ chronic conditions	55.5%	61.6%	60.4%	53.9%	**63.0%**	**50.7%**
% 65+ with 0 chronic conditions	**12.4%**	7.7%	**7.2%**	10.2%	**7.2%**	11.0%
% 65+ with depression	**34.8%**	32.3%	34.6%	**30.5%**	34.5%	32.5%
% 65+ with anxiety disorder	30.7%	30.9%	33.0%	28.0%	**34.3%**	**25.8%**
% 65+ with PTSD	**3.9%**	**2.0%**	3.0%	2.3%	2.2%	2.8%
% 65+ dually-eligible for Medicare and Medicaid	18.7%	**22.5%**	17.1%	**6.6%**	15.0%	12.5%
% 65+ Medicare managed care enrollees	50.3%	50.1%	30.5%	26.5%	**51.4%**	**21.1%**
# inpatient hospital stays/1,000 persons 65+ years annually	**170**	242	**252**	188	231	176
% Medicare inpatient hospital readmissions (as % of admissions)	**14.3%**	17.6%	**18.2%**	16.2%	17.1%	15.6%
# skilled nursing facility stays/1000 persons 65+ years annually	**43**	**90**	73	45	76	47
% 65+ getting Medicaid long term services and supports	**2.1%**	**4.4%**	3.4%	2.7%	4.0%	3.4%
% 65+ hospice users as % of decedents	49.7%	**42.4%**	44.0%	47.1%	**50.7%**	43.0%

Chart key: = highest rate = lowest rate

Call to Action

We are all aging and all have a role to place in making Maine a great place to grow up and grow older. 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-positive 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 Maine to contribute to the health and well-being of all.

UNDERSTAND

- Download your community profile at healthyagingdatareports.org
- Educate yourself and others about the indicators in your city or town
- Learn about services available at your local Agency on Aging mainecouncilonaging.org/support/.

ENGAGE

- Encourage participation in the age-positive movement
- Explore ways to highlight what your community needs to promote health for all ages.

ACT

1. Get involved! Join Age-Friendly Maine.
2. Host a Power in Aging Conversation.
3. Connect with your lawmaker either at the legislature or by calling them.
4. Join AARP volunteers on Tuesdays at the State House to elevate issues of older Mainers

How Have Others Used the Data Reports?

- In 2014, Massachusetts advocates from the MA Councils on Aging printed 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 out the entire report and mailed it out 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.
- In New Hampshire, a legislative breakfast was held to share the New Hampshire Data Report with each legislator. Graduate students showed legislators the website and how to navigate to information important to their districts. Senior Ambassadors were trained to interpret and explain community profiles and the statewide maps to legislators during the event.
- 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 their requests because they can cite data and include maps that documents local concerns.

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

Explore how to get involved:

Maine Council on 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).

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 (county), # firearm fatalities (all ages), age-sex adjusted 1-year mortality rate.

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

TRANSPORTATION

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

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, 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.

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

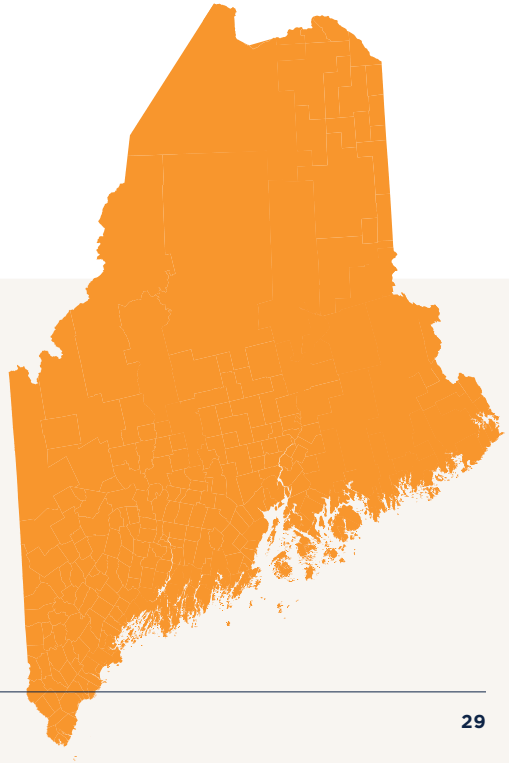
While we collect and analyze data from dozens of entities, we rely on three main sources:

- The Behavioral Risk Factor Surveillance System (BRFSS), which we obtain from the Centers for Disease Control (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 50.3% of the total Medicare population in Maine. 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. For example, the population characteristics and information from the US Census were reported for 265 geographic units. For highly prevalent chronic conditions we report for 186 geographic units, while for less prevalent conditions we report for 164 geographic units. For the BRFSS data we report for 16 geographic units, and for the least prevalent conditions we report for 16 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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Jess Mauer, *Maine Council on Aging*

Noel Bonam, *AARP Maine*

Paul Saucier, *Office of Aging and Disability Services, Maine DHHS*

Dr. Patricia Oh, *University of Maine Center on Aging*

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Design

Report by Opus Design, Boston

Website by JSI

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

DR. ROBERT N. BUTLER

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

MARGARET J. WHEATLEY

Research and Analysis by

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Funded by

Point32Health Foundation

In partnership with

Harvard Pilgrim Health Care

a Point32Health company

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