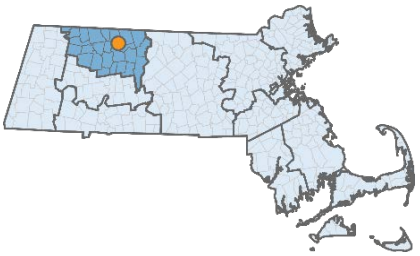
# Gill (Franklin)

Gill is a rural town in western Massachusetts with 245 residents aged 65 and older. The transit score suggests that there is minimal transit available (0/10). Compared to state averages, older residents of Gill do better on several healthy aging indicators with lower rates of hip fracture, high cholesterol, anxiety disorders, bipolar disorders, schizophrenia/other psychotic disorders, tobacco use disorders, Alzheimer's disease, diabetes chronic obstructive pulmonary disease, asthma, hypertension, heart attack, ischemic heart disease, peripheral vascular disease, osteoarthritis/rheumatoid arthritis, osteoporosis, leukemias/lymphomas, prostate cancer, benign prostatic hyperplasia, anemia, traumatic brain injury, ulcers, hearing impairment and visual impairment. Community resources to promote healthy aging include a Council on Aging and a recreation department.



| POPULATION CHARACTERISTICS | BETTER / WORSE STATE RATE[1] | COMMUNITY ESTIMATE | STATE ESTIMATE |
|---|---|---|---|
| Total population all ages | | 1,656 | 6,742,143 |
| Population 60 years or older as % of total population | | 24.7% | 21.2% |
| Total population 60 years or older | | 409 | 1,428,144 |
| Population 65 years or older as % of total population | | 14.8% | 15.1% |
| Total population 65 years or older | | 245 | 1,016,679 |
| % 65-74 years | | 60.0% | 55.3% |
| % 75-84 years | | 34.3% | 29.4% |
| % 85 years or older | | 5.7% | 15.2% |
| Gender (65+ population) | | | |
| % female | | 51.0% | 57.2% |
| Race/Ethnicity (65+ population) | | | |
| % White | | 100.0% | 90.0% |
| % African American | | 0.0% | 4.3% |
| % Asian | | 0.0% | 3.2% |
| % Other | | 0.0% | 2.5% |
| % Hispanic/Latino | | 1.6% | 3.8% |
| Marital Status (65+ population) | | | |
| % married | | 67.3% | 52.5% |
| % divorced/separated | | 6.9% | 14.0% |
| % widowed | | 18.0% | 25.5% |
| % never married | | 7.8% | 8.0% |
| Education (65+ population) | | | |
| % with less than high school education | | 2.9% | 16.5% |
| % with high school or some college | | 58.4% | 52.6% |
| % with college degree | | 38.8% | 30.9% |
| % of 60+ LGBT (county) | | N/A | 3.2% |
| % of 65+ population living alone | | 29.8% | 30.2% |
| % of 65+ population who speak only English at home | | 98.4% | 83.3% |
| % of 65+ population who are veterans of military service | | 29.0% | 18.8% |
| Age-sex adjusted 1-year mortality rate | | 4.8% | 4.2% |

| HEALTHY AGING INDICATORS | BETTER / WORSE STATE RATE[1] | COMMUNITY ESTIMATE | STATE ESTIMATE |
|---|---|---|---|
| Geographic Migration (65+ population) in the past 12 months | | | |
| % moved within same county | | 1.2% | 3.6% |
| % moved from different county in Massachusetts | | 0.0% | 1.1% |
| % moved from different state | | 0.0% | 0.8% |
| **WELLNESS & PREVENTION** | | | |
| % 60+ with any physical activity within last month | | 76.9% | 73.3% |
| % 60+ met CDC guidelines for muscle-strengthening activity | | 24.7% | 27.7% |
| % 60+ met CDC guidelines for aerobic physical activity | | 58.3% | 56.8% |
| % 60+ met CDC guidelines for both types of physical activities | | 21.6% | 20.8% |
| % 60+ getting recommended hours of sleep | | 60.9% | 62.7% |
| % 60+ injured in a fall within last 12 months | | 14.5% | 10.6% |
| % 65+ had hip fracture | B | 2.8% | 3.7% |
| % 60+ with self-reported fair or poor health status | | 14.0% | 18.0% |
| % 60+ with 15+ physically unhealthy days last month | | 8.8% | 12.7% |
| % 60+ with physical exam/check-up in past year | | 86.9% | 89.3% |
| % 60+ met CDC preventive health screening goals | | 34.6% | 35.0% |
| % 60+ flu shot past year | | 60.2% | 60.8% |
| % 65+ with pneumonia vaccine | | 69.3% | 72.0% |
| % 60+ with shingles vaccine | | 44.8% | 39.7% |
| % 60+ with cholesterol screening | | 93.4% | 95.7% |
| % 60+ women with a mammogram within last 2 years | | 83.8% | 84.8% |
| % 60+ with colorectal cancer screening | | 59.0% | 63.3% |
| % 60+ with HIV test | | 18.5% | 15.6% |
| % 60+ current smokers | | 12.2% | 8.5% |
| % 60+ living in a home where smoking is not allowed | | 81.8% | 84.7% |
| Oral Health | | | |
| % 60+ with loss of 6 or more teeth | | 39.1% | 32.5% |
| % 60+ with annual dental exam | | 73.1% | 77.5% |
| # of dentists per 100,000 persons (all ages) | | 0 | 84 |
| **NUTRITION/DIET** | | | |
| % 60+ with 5 or more servings of fruit or vegetables per day | | 18.8% | 21.5% |
| % 60+ self-reported obese | | 24.4% | 23.1% |
| % 65+ clinically diagnosed obese | | 21.2% | 19.0% |
| % 65+ with high cholesterol | B | 65.4% | 75.0% |
| % 60+ excessive drinking | | 8.5% | 9.3% |
| % 65+ with poor supermarket access | | 0.0% | 29.3% |

| HEALTHY AGING INDICATORS | BETTER / WORSE STATE RATE[1] | COMMUNITY ESTIMATE | STATE ESTIMATE |
|---|---|---|---|
| **BEHAVIORAL HEALTH** | | | |
| % 60+ with 15+ days poor mental health last month | | 7.6% | 7.0% |
| % 65+ with depression | | 28.5% | 31.5% |
| % 65+ with anxiety disorders | B | 18.7% | 25.4% |
| % 65+ with bipolar disorders | B | 2.9% | 4.5% |
| % 65+ with post-traumatic stress disorder | | 2.3% | 1.8% |
| % 65+ with schizophrenia & other psychotic disorders | B | 3.3% | 5.9% |
| % 65+ with personality disorders | | 1.0% | 1.4% |
| # opioid deaths (all ages) | | 0 | 1,873 |
| % 65+ with substance use disorders (drug use +/or alcohol abuse) | | 6.2% | 6.6% |
| % 65+ with tobacco use disorders | B | 7.4% | 10.2% |
| **CHRONIC DISEASE** | | | |
| % 65+ with Alzheimer's disease or related dementias | B | 10.5% | 13.6% |
| % 65+ with diabetes | B | 25.9% | 31.7% |
| % 65+ with stroke | | 10.1% | 12.0% |
| % 65+ with chronic obstructive pulmonary disease | B | 18.1% | 21.5% |
| % 65+ with asthma | B | 12.3% | 15.0% |
| % 65+ with hypertension | B | 67.4% | 76.2% |
| % 65+ ever had a heart attack | B | 3.3% | 4.6% |
| % 65+ with ischemic heart disease | B | 32.5% | 40.2% |
| % 65+ with congestive heart failure | | 20.6% | 22.4% |
| % 65+ with atrial fibrillation | | 14.3% | 15.9% |
| % 65+ with peripheral vascular disease | B | 14.2% | 19.4% |
| % 65+ with osteoarthritis/rheumatoid arthritis | B | 45.9% | 52.4% |
| % 65+ with osteoporosis | B | 13.2% | 20.7% |
| % 65+ with leukemias and lymphomas | B | 1.6% | 2.3% |
| % 65+ with lung cancer | | 1.7% | 2.1% |
| % 65+ with colon cancer | | 2.5% | 2.9% |
| % 65+ women with breast cancer | | 8.6% | 10.9% |
| % 65+ women with endometrial cancer | | 2.7% | 1.9% |
| % 65+ men with prostate cancer | B | 9.3% | 13.8% |
| % 65+ with benign prostatic hyperplasia | B | 35.0% | 40.9% |
| % 65+ with HIV/AIDS | * | 0.1% | 0.2% |
| % 65+ with hypothyroidism | | 20.6% | 21.1% |
| % 65+ with anemia | B | 39.9% | 46.6% |
| % 65+ with chronic kidney disease | | 25.4% | 27.3% |
| % 65+ with liver diseases | | 7.6% | 8.6% |
| % 65+ with fibromyalgia, chronic pain and fatigue | | 18.3% | 19.8% |

| HEALTHY AGING INDICATORS | BETTER / WORSE STATE RATE[1] | COMMUNITY ESTIMATE | STATE ESTIMATE |
|---|---|---|---|
| % 65+ with migraine and other chronic headache | | 5.1% | 4.6% |
| % 65+ with epilepsy | | 2.3% | 2.9% |
| % 65+ with traumatic brain injury | B | 0.6% | 1.5% |
| % 65+ with autism spectrum disorders | | 0.1% | 0.1% |
| % 65+ with glaucoma | | 25.6% | 25.7% |
| % 65+ with cataract | | 65.4% | 65.4% |
| % 65+ with pressure ulcer or chronic ulcer | B | 5.8% | 8.5% |
| % 65+ with 4+ (out of 15) chronic conditions | B | 49.5% | 60.7% |
| % 65+ with 0 chronic conditions | B | 11.8% | 7.3% |
| **LIVING WITH DISABILITY** | | | |
| % 65+ with self-reported hearing difficulty | | 13.1% | 14.2% |
| % 65+ with clinical diagnosis of deafness or hearing impairment | B | 9.4% | 16.1% |
| % 65+ with self-reported vision difficulty | | 1.2% | 5.8% |
| % 65+ with clinical diagnosis of blindness or visual impairment | B | 0.9% | 1.5% |
| % 65+ with self-reported cognition difficulty | | 9.4% | 8.3% |
| % 65+ with self-reported ambulatory difficulty | | 15.5% | 20.2% |
| % 65+ with clinical diagnosis of mobility impairments | | 3.2% | 3.9% |
| % 65+ with self-reported self-care difficulty | | 6.9% | 7.9% |
| % 65+ with self-reported independent living difficulty | | 17.1% | 14.3% |
| **ACCESS TO CARE** | | | |
| Medicare (65+ population) | | | |
| % Medicare managed care enrollees | | 21.7% | 23.1% |
| % dually eligible for Medicare and Medicaid | * | 12.3% | 16.7% |
| % 60+ with a regular doctor | | 96.1% | 96.4% |
| % 60+ who did not see doctor when needed due to cost | | 3.7% | 4.1% |
| # of primary care providers within 5 miles | | 0 | 10,333 |
| # of hospitals within 5 miles | | 0 | 66 |
| # of nursing homes within 5 miles | | 1 | 399 |
| # of home health agencies | | 3 | 299 |
| # of community health centers | | 0 | 116 |
| # of adult day health centers | | 0 | 131 |
| # of memory cafes | | 0 | 95 |
| # of dementia-related support groups | | 0 | 136 |
| **SERVICE UTILIZATION** | | | |
| Physician visits per year | * | 6.6 | 7.8 |
| Emergency room visits/1000 persons 65+ years per year | * | 543 | 639 |

| HEALTHY AGING INDICATORS | BETTER / WORSE STATE RATE[1] | COMMUNITY ESTIMATE | STATE ESTIMATE |
|---|---|---|---|
| Part D monthly prescription fills per person per year | * | 42.8 | 52.4 |
| Home health visits per year | * | 2.3 | 4.0 |
| Durable medical equipment claims per year | | 1.8 | 1.9 |
| Inpatient hospital stays/1000 persons 65+ years per year | * | 239 | 294 |
| Medicare inpatient hospital readmissions (as % of admissions) | | 15.8% | 17.9% |
| # skilled nursing facility stays/1000 persons 65+ years per year | * | 68 | 106 |
| # skilled nursing home Medicare beds/1000 persons 65+ years | | 0 | 43 |
| % 65+ getting Medicaid long term services and supports | * | 3.1% | 4.9% |
| **COMMUNITY VARIABLES & CIVIC ENGAGEMENT** | | | |
| Age-friendly efforts in community | | Not yet | Yes |
| Air pollution: annual # of unhealthy days for 65+ (county) | | 3 | N/A |
| Open space in community | | 7.2% | 18.0% |
| Walkability score of community (0-100) | | 11 | N/A |
| % of grandparents raising grandchildren | | 0.0% | 0.8% |
| % of grandparents who live with grandchildren | | 1.1% | 2.9% |
| # of assisted living sites | | 0 | 238 |
| % of vacant homes in community | | 7.6% | 9.8% |
| # of universities and community colleges | | 0 | 163 |
| # of public libraries | | 1 | 470 |
| # of YMCAs | | 0 | 83 |
| % in county with access to broadband (all ages) | | 78.0% | 97.0% |
| % 60+ who used Internet in last month | | 71.0% | 71.3% |
| Voter participation rate in 2016 presidential election (age 18+) | | 81.1% | 71.3% |
| **SAFETY & TRANSPORTATION** | | | |
| Violent crime rate /100,000 persons | | 67 | 396 |
| Homicide rate /100,000 persons (county) | | 0 | 2 |
| # firearm fatalities (county) | | 16 | 1,126 |
| Property crime rate /100,000 persons | | 798 | 1,825 |
| % of licensed drivers who are age 61+ | | 38.2% | 28.7% |
| % 65+ who own a motor vehicle | | 89.8% | 82.4% |
| % 60+ who always drive wearing a seatbelt | | 84.5% | 86.3% |
| # of fatal crashes involving adult age 60+/town | | 0 | 529 |
| # of fatal crashes involving adult age 60+/county | | 11 | 529 |
| Total # of all crashes involving adult age 60+/town | | 6 | 132,351 |
| # of senior transportation providers | | 0 | 324 |
| # of medical transportation services for older people | | 0 | 268 |
| # of nonmedical transportation services for older people | | 0 | 252 |
| Summary transportation performance score | | 0.1 | N/A |

| HEALTHY AGING INDICATORS | BETTER / WORSE STATE RATE[1] | COMMUNITY ESTIMATE | STATE ESTIMATE |
|---|---|---|---|
| **ECONOMIC & HOUSING VARIABLES** | | | |
| % 65+ with income below the poverty line past year | | 2.4% | 8.7% |
| % 60+ receiving food stamps past year | | 7.8% | 12.3% |
| % 65+ employed past year | | 36.7% | 24.3% |
| Household income (65+ householder) | | | |
| % households with annual income < $20,000 | | 19.8% | 23.6% |
| % households with annual income $20,000-$49,999 | | 22.2% | 32.5% |
| % households with annual income > $50,000 | | 58.1% | 43.9% |
| % 60+ own home | | 84.0% | 72.7% |
| % 60+ have mortgage on home | | 38.0% | 34.1% |
| % 65+ households spend >35% of income on housing (renter) | | 10.2% | 11.6% |
| % 65+ households spend >35% of income on housing (owner) | | 10.2% | 20.4% |

| COST OF LIVING | $ COUNTY ESTIMATE | $ STATE ESTIMATE | RATIO (COUNTY/STATE) |
|---|---|---|---|
| Elder Economic Security Standard Index | | | |
| Single, homeowner without mortgage, good health | $23,892 | $24,636 | 0.97 |
| Single, renter, good health | $25,788 | $28,248 | 0.91 |
| Couple, homeowner without mortgage, good health | $36,276 | $36,168 | 1.00 |
| Couple, renter, good health | $38,172 | $39,780 | 0.96 |

*TECHNICAL NOTES*

**See our technical report (online at http://mahealthyagingcollaborative.org/data-report/explore-the-profiles/data-sources-and-methods/#technical) for comprehensive information on data sources, measures, methodology, and margin of errors.*

*For most indicators the reported community and state values are both estimates derived from sample data. Thus, it is possible that some of the differences between state and community estimates may be due to chance associated with population sampling. We use the terms "better" and "worse" to highlight 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 the health of older people, and when the implication is unclear we use an *.*

*General Notes*

*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 379 geographic units (i.e., every Massachusetts city/town and 16 Boston neighborhoods, 6 Worcester neighborhoods, and 6 Springfield neighborhoods). For example, the population characteristics and information from the US Census were reported for all 379 units. For other data (i.e., highly prevalent chronic disease, health services utilization) we could report for 310 geographic units. For less prevalent conditions we report for 201 geographic units. For the BRFSS data we report for 41 geographic units, and for the lowest prevalence conditions (e.g., HIV) we report for 18 geographic units. The same estimate is reported for all cities/towns within aggregated geographic areas. Maps of the different geographic groupings and the rationale behind the groupings are in the Technical Report.*

*Data Sources. The Technical Report describes the all of the data sources for the report, but three to note are: (1) the American Community Survey (2012-2016); (2) Centers for Medicare and Medicaid Services Master Beneficiary Summary File (2014-2015); and (3) The Behavioral Risk Factor Surveillance System (2010-2015).*

*Healthy Aging Data Report Team. Many people contributed to this research. The 2018 research team: Beth Dugan PhD, Frank Porell PhD, Nina Silverstein PhD, Chae Man Lee PhD, Shuang Shuang Wang PhD, Bon Kim, Natalie Pitheckoff, Haowei Wang, Sae Hwang Han, Richard Chunga, & Shiva Prisad from the Gerontology Institute in the McCormack Graduate School of Policy and Global Studies at the University of Massachusetts Boston. The Tufts Health Plan Foundation supported the research and provided important guidance. We thank our Advisory Committee members for contributing ideas and advice on how to make the Data Report best address the needs of Massachusetts. We thank our colleagues at JSI for their continued partnership. Questions or suggestions? Beth.dugan@umb.edu*