RHODE ISLAND HEALTHY AGING COMMUNITY DATA PROFILE

Foster (Providence)

HEALTHY AGING INDICATORS	BETTER / WORSE STATE RATE[1]	COMMUNITY ESTIMATE[3]	MARGIN OF ERROR[2]	STATE ESTIMATE	MARGIN OF ERROR[2]
POPULATION CHARACTERISTICS					
% of 60+ LGBT		2.1%	(1.3% - 2.9%)	2.0%	(1.6% - 2.4%)
Age-sex adjusted 1-year mortality rate		5.3%	(3.4% - 7.1%)	4.8%	(4.6% - 4.9%)
% 60+ lived at same address 25 years or more		51.0%	(46.0% - 56.1%)	48.1%	(46.8% - 49.5%)
WELLNESS and PREVENTION					
% any physical activity within last month		68.1%	(63.4% - 72.7%)	70.0%	(68.8% - 71.2%)
% injured by a fall within last year		13.5%	(8.3% - 18.7%)	10.0%	(8.7% - 11.3%)
% ever had a hip fracture		3.2%	(1.6% - 4.8%)	3.9%	(3.7% - 4.0%)
% with self-reported fair or poor health status		21.4%	(17.2% - 25.6%)	20.4%	(19.4% - 21.5%)
% with 15+ physically unhealthy days last month		14.9%	(11.3% - 18.4%)	13.9%	(13.0% - 14.8%)
% with physical exam/check-up in past year		90.4%	(87.3% - 93.5%)	91.9%	(91.2% - 92.6%)
% met CDC preventive health screening goals	W	30.6%	(24.9% - 36.4%)	39.5%	(38.0% - 41.1%)
% flu shot past year	w	52.9%	(48.7% - 57.1%)	59.1%	(58.0% - 60.2%)
% pneumonia vaccine		69.2%	(63.2% - 75.1%)	73.8%	(72.4% - 75.2%)
% shingles vaccine	W	23.3%	(18.2% - 28.3%)	30.3%	(28.7% - 31.8%)
% cholesterol screening		90.1%	(87.4% - 92.9%)	88.4%	(87.6% - 89.3%)
% mammogram within last 2 years (women)		80.9%	(75.7% - 86.1%)	81.8%	(80.4% - 83.1%)
% colorectal cancer screening		74.0%	(69.6% - 78.5%)	76.1%	(75.0% - 77.3%)
Oral Health					
% with complete tooth loss		35.1%	(30.3% - 39.9%)	32.4%	(31.2% - 33.6%)
% with annual dental exam		72.7%	(68.1% - 77.3%)	74.7%	(73.5% - 75.8%)
NUTRITION / DIET					
% with 5 or more servings of fruit or vegetables per day		20.3%	(16.1% - 24.4%)	23.0%	(21.9% - 24.1%)
% obese		30.1%	(25.6% - 34.7%)	25.4%	(24.2% - 26.5%)
% high cholesterol	B	73.1%	(68.6% - 77.5%)	78.0%	(77.7% - 78.3%)
% current smokers		11.1%	(7.9% - 14.2%)	8.9%	(8.2% - 9.7%)
% excessive drinking		9.0%	(5.9% - 12.2%)	8.9%	(8.1% - 9.6%)
MENTAL HEALTH					
% with 15+ days poor mental health last month		9.0%	(6.3% - 11.8%)	7.5%	(6.8% - 8.1%)
% 60+ talked with family or friends almost daily		72.3%	(67.6% - 77.0%)	75.3%	(74.1% - 76.5%)
% ever diagnosed with depression		28.3%	(23.9% - 32.8%)	30.0%	(29.7% - 30.3%)

HEALTHY AGING INDICATORS	BETTER / WORSE STATE RATE[1]	COMMUNITY ESTIMATE[3]	MARGIN OF ERROR[2]	STATE ESTIMATE	MARGIN OF ERROR[2]
CHRONIC DISEASE					
% with Alzheimer's disease or related dementias		13.9%	(10.4% - 17.3%)	14.4%	(14.2% - 14.7%)
% with diabetes	B	28.8%	(24.0% - 33.6%)	35.7%	(35.4% - 36.1%)
% with stroke	B	8.8%	(6.1% - 11.6%)	12.5%	(12.2% - 12.7%)
% with chronic obstructive pulmonary disease	B	17.9%	(14.1% - 21.7%)	24.1%	(23.8% - 24.4%)
% with asthma		13.0%	(9.7% - 16.4%)	14.0%	(13.7% - 14.2%)
% with hypertension	B	72.6%	(68.1% - 77.1%)	79.0%	(78.8% - 79.3%)
% ever had a heart attack		4.6%	(2.5% - 6.6%)	5.4%	(5.3% - 5.6%)
% with ischemic heart disease	B	38.6%	(33.4% - 43.8%)	45.9%	(45.5% - 46.2%)
% with congestive heart failure		20.7%	(16.5% - 25.0%)	24.8%	(24.5% - 25.1%)
% with atrial fibrillation		12.6%	(9.3% - 15.9%)	15.2%	(15.0% - 15.5%)
% with osteoarthritis/rheumatoid arthritis		48.1%	(42.7% - 53.5%)	52.0%	(51.6% - 52.4%)
% with osteoporosis	B	15.0%	(11.5% - 18.4%)	21.0%	(20.7% - 21.3%)
% with glaucoma		24.7%	(20.4% - 29.0%)	26.6%	(26.2% - 26.9%)
% with cataract	B	61.4%	(56.5% - 66.4%)	67.9%	(67.6% - 68.2%)
% women with breast cancer		12.7%	(8.2% - 17.1%)	10.7%	(10.4% - 11.0%)
% with colon cancer		3.8%	(1.9% - 5.7%)	3.2%	(3.1% - 3.3%)
% men with prostate cancer		9.5%	(5.2% - 13.8%)	13.8%	(13.4% - 14.1%)
% with lung cancer		2.2%	(1.2% - 3.1%)	2.1%	(2.0% - 2.2%)
% with hypothyroidism		21.3%	(17.3% - 25.3%)	21.1%	(20.8% - 21.4%)
% with anemia	B	43.6%	(38.6% - 48.5%)	52.2%	(51.9% - 52.6%)
% with benign prostatic hyperplasia		35.3%	(28.3% - 42.3%)	40.3%	(39.8% - 40.8%)
% with chronic kidney disease		20.4%	(16.2% - 24.6%)	23.3%	(23.0% - 23.6%)
Summary chronic disease measures					
% with 4+ chronic conditions	B	52.3%	(47.3% - 57.3%)	63.9%	(63.6% - 64.3%)
% with 0 chronic conditions		11.0%	(7.9% - 14.2%)	8.4%	(8.2% - 8.6%)
ACCESS TO CARE					
% with a regular doctor		96.9%	(95.2% - 98.5%)	96.5%	(96.1% - 97.0%)
% did not see a doctor when needed due to cost		6.7%	(4.1% - 9.2%)	6.3%	(5.6% - 6.9%)
SERVICE UTILIZATION					
Physician visits per year	*	6.3	(5.7 - 7.0)	8.0	(7.9 - 8.0)
Emergency room visits/1000 persons 65+ years per year		527	(411 - 644)	628	(618 - 638)
Part D monthly prescription fills per person per year	*	48.3	(45.2 - 51.4)	54.2	(53.9 - 54.4)
Home health visits per year		3.7	(2.1 - 5.3)	3.7	(3.6 - 3.9)
Durable medical equipment claims per year		1.5	(1.1 - 2.0)	2.0	(1.9 - 2.0)
Inpatient hospital stays/1000 persons 65+ years per year		257	(188 - 326)	284	(279 - 289)
Inpatient hospital readmissions (as % of admissions)		12.0%	(5.8% - 18.2%)	16.9%	(16.3% - 17.5%)
Skilled nursing facility stays/1000 persons 65+ years per year		72	(38 - 107)	100	(97 - 103)
COMMUNITY VARIABLE & CIVIC ENGAGEMENT					
% 60+ who are satisfied with neighborhood	B	86.4%	(83.1% - 89.7%)	80.0%	(78.9% - 81.1%)
% 60+ who believe local service orgs understand needs		43.6%	(38.2% - 49.0%)	44.1%	(42.7% - 45.6%)
% 60+ who believe he/she can make a difference	w	45.6%	(41.3% - 49.9%)	51.6%	(50.5% - 52.8%)
% 60+ who believe working together can make a difference		77.9%	(73.5% - 82.3%)	81.0%	(79.9% - 82.1%)
% 60+ who volunteer at least once per month	W	17.5%	(13.8% - 21.1%)	22.8%	(21.6% - 23.9%)
% 60+ who attend community events at least once per month	w	38.3%	(34.2% - 42.4%)	44.2%	(43.1% - 45.4%)

Notes. [1] Community-state differences that the margins of error do not overlap each other are noted B, b, W, w, or *.

[2] All community and state margins of error are 95% confidence intervals, except when a lower case b or w is noted in which case 90% confidence intervals are used.

[3] C indicates that the community rate is censored due to inadequate sample size.