RHODE ISLAND HEALTHY AGING COMMUNITY DATA PROFILE

Middletown (Newport)

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		1.2%	(0.5% - 1.9%)	2.0%	(1.6% - 2.4%)
Age-sex adjusted 1-year mortality rate		5.0%	(4.2% - 5.8%)	4.8%	(4.6% - 4.9%)
% 60+ lived at same address 25 years or more		49.2%	(44.8% - 53.6%)	48.1%	(46.8% - 49.5%)
WELLNESS and PREVENTION					
% any physical activity within last month	B	78.7%	(75.2% - 82.2%)	70.0%	(68.8% - 71.2%)
% injured by a fall within last year		10.0%	(5.9% - 14.2%)	10.0%	(8.7% - 11.3%)
% ever had a hip fracture		4.1%	(3.3% - 4.9%)	3.9%	(3.7% - 4.0%)
% with self-reported fair or poor health status	b	16.3%	(13.7% - 19.0%)	20.4%	(19.6% - 21.3%)
% with 15+ physically unhealthy days last month		11.7%	(8.9% - 14.5%)	13.9%	(13.0% - 14.8%)
% with physical exam/check-up in past year		91.7%	(89.6% - 93.9%)	91.9%	(91.2% - 92.6%)
% met CDC preventive health screening goals		41.1%	(35.9% - 46.2%)	39.5%	(38.0% - 41.1%)
% flu shot past year		60.2%	(55.9% - 64.5%)	59.1%	(57.8% - 60.4%)
% pneumonia vaccine		74.9%	(70.6% - 79.2%)	73.8%	(72.4% - 75.2%)
% shingles vaccine		35.5%	(30.2% - 40.8%)	30.3%	(28.7% - 31.8%)
% cholesterol screening		87.2%	(84.2% - 90.3%)	88.4%	(87.6% - 89.3%)
% mammogram within last 2 years (women)		77.9%	(73.0% - 82.9%)	81.8%	(80.4% - 83.1%)
% colorectal cancer screening		78.9%	(75.4% - 82.5%)	76.1%	(75.0% - 77.3%)
Oral Health					
% with complete tooth loss	B	23.9%	(20.8% - 27.1%)	32.4%	(31.4% - 33.4%)
% with annual dental exam	B	84.7%	(82.1% - 87.3%)	74.7%	(73.7% - 75.7%)
NUTRITION / DIET					
% with 5 or more servings of fruit or vegetables per day		23.9%	(20.2% - 27.7%)	23.0%	(21.9% - 24.1%)
% obese		22.1%	(18.5% - 25.6%)	25.4%	(24.2% - 26.5%)
% high cholesterol	B	74.8%	(72.8% - 76.8%)	78.0%	(77.7% - 78.3%)
% current smokers		7.3%	(5.2% - 9.4%)	8.9%	(8.2% - 9.7%)
% excessive drinking	W	13.9%	(10.9% - 16.9%)	8.9%	(8.1% - 9.6%)
MENTAL HEALTH					
% with 15+ days poor mental health last month	B	4.8%	(2.8% - 6.8%)	7.5%	(6.8% - 8.1%)
% 60+ talked with family or friends almost daily	b	79.9%	(76.9% - 82.9%)	75.3%	(74.3% - 76.3%)
% ever diagnosed with depression	B	26.5%	(24.5% - 28.5%)	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		14.7%	(13.1% - 16.3%)	14.4%	(14.2% - 14.7%)
% with diabetes	B	33.0%	(30.7% - 35.2%)	35.7%	(35.4% - 36.1%)
% with stroke		13.2%	(11.7% - 14.6%)	12.5%	(12.2% - 12.7%)
% with chronic obstructive pulmonary disease		25.2%	(23.3% - 27.1%)	24.1%	(23.8% - 24.4%)
% with asthma		13.3%	(11.8% - 14.9%)	14.0%	(13.7% - 14.2%)
% with hypertension		78.2%	(76.3% - 80.2%)	79.0%	(78.8% - 79.3%)
% ever had a heart attack		5.3%	(4.3% - 6.2%)	5.4%	(5.3% - 5.6%)
% with ischemic heart disease		43.9%	(41.4% - 46.3%)	45.9%	(45.5% - 46.2%)
% with congestive heart failure		23.0%	(21.1% - 24.9%)	24.8%	(24.5% - 25.1%)
% with atrial fibrillation		15.5%	(13.9% - 17.0%)	15.2%	(15.0% - 15.5%)
% with osteoarthritis/rheumatoid arthritis		50.2%	(47.8% - 52.7%)	52.0%	(51.6% - 52.4%)
% with osteoporosis		19.6%	(17.8% - 21.3%)	21.0%	(20.7% - 21.3%)
% with glaucoma	W	31.5%	(29.5% - 33.6%)	26.6%	(26.2% - 26.9%)
% with cataract	W	72.8%	(70.7% - 75.0%)	67.9%	(67.6% - 68.2%)
% women with breast cancer		11.4%	(9.6% - 13.3%)	10.7%	(10.4% - 11.0%)
% with colon cancer		2.9%	(2.2% - 3.7%)	3.2%	(3.1% - 3.3%)
% men with prostate cancer		16.5%	(13.9% - 19.1%)	13.8%	(13.4% - 14.1%)
% with lung cancer		1.7%	(1.2% - 2.3%)	2.1%	(2.0% - 2.2%)
% with hypothyroidism		22.2%	(20.4% - 24.1%)	21.1%	(20.8% - 21.4%)
% with anemia	B	49.0%	(46.8% - 51.3%)	52.2%	(51.9% - 52.6%)
% with benign prostatic hyperplasia		42.1%	(38.6% - 45.5%)	40.3%	(39.8% - 40.8%)
% with chronic kidney disease	B	20.6%	(18.7% - 22.4%)	23.3%	(23.0% - 23.6%)
Summary chronic disease measures					
% with 4+ chronic conditions		62.8%	(60.5% - 65.0%)	63.9%	(63.6% - 64.3%)
% with 0 chronic conditions		8.3%	(7.0% - 9.7%)	8.4%	(8.2% - 8.6%)
ACCESS TO CARE					
% with a regular doctor	B	98.2%	(97.3% - 99.2%)	96.5%	(96.1% - 97.0%)
% did not see a doctor when needed due to cost	b	4.1%	(2.7% - 5.5%)	6.3%	(5.7% - 6.8%)
SERVICE UTILIZATION					
Physician visits per year		8.2	(7.9 - 8.6)	8.0	(7.9 - 8.0)
Emergency room visits/1000 persons 65+ years per year		626	(567 - 684)	628	(618 - 638)
Part D monthly prescription fills per person per year		52.8	(50.9 - 54.7)	54.2	(53.9 - 54.4)
Home health visits per year		3.5	(2.8 - 4.2)	3.7	(3.6 - 3.9)
Durable medical equipment claims per year	*	1.6	(1.3 - 1.8)	2.0	(1.9 - 2.0)
Inpatient hospital stays/1000 persons 65+ years per year		281	(248 - 314)	284	(279 - 289)
Inpatient hospital readmissions (as % of admissions)		14.1%	(10.6% - 17.6%)	16.9%	(16.3% - 17.5%)
Skilled nursing facility stays/1000 persons 65+ years per year		109	(91 - 127)	100	(97 - 103)
COMMUNITY VARIABLE & CIVIC ENGAGEMENT					
% 60+ who are satisfied with neighborhood	B	87.0%	(84.2% - 89.8%)	80.0%	(78.9% - 81.1%)
% 60+ who believe local service orgs understand needs	B	54.1%	(49.4% - 58.7%)	44.1%	(42.7% - 45.6%)
% 60+ who believe he/she can make a difference	B	61.1%	(56.7% - 65.5%)	51.6%	(50.2% - 53.0%)
% 60+ who believe working together can make a difference		84.4%	(81.1% - 87.7%)	81.0%	(79.9% - 82.1%)
% 60+ who volunteer at least once per month	b	27.8%	(24.5% - 31.1%)	22.8%	(21.8% - 23.7%)
% 60+ who attend community events at least once per month	B	54.2%	(49.7% - 58.8%)	44.2%	(42.8% - 45.6%)

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.