RHODE ISLAND HEALTHY AGING COMMUNITY DATA PROFILE

North Providence (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		4.8%	(4.2% - 5.3%)	4.8%	(4.6% - 4.9%)
% 60+ lived at same address 25 years or more		52.2%	(46.4% - 58.0%)	48.1%	(46.8% - 49.5%)
WELLNESS and PREVENTION					
% any physical activity within last month	w	63.6%	(59.1% - 68.0%)	70.0%	(69.0% - 71.0%)
% injured by a fall within last year		13.4%	(7.2% - 19.6%)	10.0%	(8.7% - 11.3%)
% ever had a hip fracture		3.6%	(2.9% - 4.3%)	3.9%	(3.7% - 4.0%)
% with self-reported fair or poor health status		24.6%	(20.2% - 29.1%)	20.4%	(19.4% - 21.5%)
% with 15+ physically unhealthy days last month		15.8%	(12.0% - 19.6%)	13.9%	(13.0% - 14.8%)
% with physical exam/check-up in past year		92.4%	(89.7% - 95.0%)	91.9%	(91.2% - 92.6%)
% met CDC preventive health screening goals		37.4%	(31.1% - 43.6%)	39.5%	(38.0% - 41.1%)
% flu shot past year		58.2%	(52.7% - 63.6%)	59.1%	(57.8% - 60.4%)
% pneumonia vaccine		73.3%	(67.5% - 79.0%)	73.8%	(72.4% - 75.2%)
% shingles vaccine		24.1%	(17.9% - 30.4%)	30.3%	(28.7% - 31.8%)
% cholesterol screening		90.2%	(87.3% - 93.1%)	88.4%	(87.6% - 89.3%)
% mammogram within last 2 years (women)		80.8%	(75.1% - 86.4%)	81.8%	(80.4% - 83.1%)
% colorectal cancer screening		71.4%	(66.4% - 76.4%)	76.1%	(75.0% - 77.3%)
Oral Health					
% with complete tooth loss	w	37.9%	(33.6% - 42.1%)	32.4%	(31.4% - 33.4%)
% with annual dental exam	W	65.4%	(60.4% - 70.4%)	74.7%	(73.5% - 75.8%)
NUTRITION / DIET					
% with 5 or more servings of fruit or vegetables per day		21.2%	(17.1% - 25.2%)	23.0%	(21.9% - 24.1%)
% obese		28.0%	(23.2% - 32.9%)	25.4%	(24.2% - 26.5%)
% high cholesterol	W	80.2%	(78.7% - 81.7%)	78.0%	(77.7% - 78.3%)
% current smokers		9.7%	(6.9% - 12.5%)	8.9%	(8.2% - 9.7%)
% excessive drinking	B	5.4%	(3.3% - 7.5%)	8.9%	(8.1% - 9.6%)
MENTAL HEALTH					
% with 15+ days poor mental health last month		7.8%	(5.4% - 10.3%)	7.5%	(6.8% - 8.1%)
% 60+ talked with family or friends almost daily		75.7%	(70.2% - 81.3%)	75.3%	(74.1% - 76.5%)
% ever diagnosed with depression	W	33.4%	(31.7% - 35.2%)	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		13.5%	(12.2% - 14.8%)	14.4%	(14.2% - 14.7%)
% with diabetes	W	42.4%	(40.5% - 44.3%)	35.7%	(35.4% - 36.1%)
% with stroke		11.7%	(10.5% - 12.8%)	12.5%	(12.2% - 12.7%)
% with chronic obstructive pulmonary disease	W	27.7%	(26.0% - 29.3%)	24.1%	(23.8% - 24.4%)
% with asthma		14.8%	(13.5% - 16.1%)	14.0%	(13.7% - 14.2%)
% with hypertension	W	82.1%	(80.6% - 83.5%)	79.0%	(78.8% - 79.3%)
% ever had a heart attack		6.2%	(5.3% - 7.1%)	5.4%	(5.3% - 5.6%)
% with ischemic heart disease	W	48.5%	(46.5% - 50.4%)	45.9%	(45.5% - 46.2%)
% with congestive heart failure	W	27.0%	(25.3% - 28.7%)	24.8%	(24.5% - 25.1%)
% with atrial fibrillation		14.8%	(13.5% - 16.1%)	15.2%	(15.0% - 15.5%)
% with osteoarthritis/rheumatoid arthritis	W	54.5%	(52.5% - 56.5%)	52.0%	(51.6% - 52.4%)
% with osteoporosis	W	23.0%	(21.5% - 24.6%)	21.0%	(20.7% - 21.3%)
% with glaucoma		26.9%	(25.3% - 28.5%)	26.6%	(26.2% - 26.9%)
% with cataract		68.6%	(66.9% - 70.3%)	67.9%	(67.6% - 68.2%)
% women with breast cancer		12.0%	(10.4% - 13.5%)	10.7%	(10.4% - 11.0%)
% with colon cancer	W	4.1%	(3.4% - 4.8%)	3.2%	(3.1% - 3.3%)
% men with prostate cancer		14.4%	(12.4% - 16.5%)	13.8%	(13.4% - 14.1%)
% with lung cancer		1.7%	(1.2% - 2.2%)	2.1%	(2.0% - 2.2%)
% with hypothyroidism	W	23.1%	(21.5% - 24.6%)	21.1%	(20.8% - 21.4%)
% with anemia	W	58.5%	(56.7% - 60.3%)	52.2%	(51.9% - 52.6%)
% with benign prostatic hyperplasia	W	43.8%	(40.9% - 46.7%)	40.3%	(39.8% - 40.8%)
% with chronic kidney disease		24.3%	(22.6% - 25.9%)	23.3%	(23.0% - 23.6%)
Summary chronic disease measures					
% with 4+ chronic conditions	W	69.0%	(67.3% - 70.8%)	63.9%	(63.6% - 64.3%)
% with 0 chronic conditions		7.2%	(6.3% - 8.2%)	8.4%	(8.2% - 8.6%)
ACCESS TO CARE					
% with a regular doctor	b	97.9%	(97.0% - 98.8%)	96.5%	(96.2% - 96.9%)
% did not see a doctor when needed due to cost		9.5%	(5.5% - 13.4%)	6.3%	(5.6% - 6.9%)
SERVICE UTILIZATION					
Physician visits per year	*	8.8	(8.5 - 9.1)	8.0	(7.9 - 8.0)
Emergency room visits/1000 persons 65+ years per year	*	708	(648 - 767)	628	(618 - 638)
Part D monthly prescription fills per person per year		54.8	(53.7 - 56.0)	54.2	(53.9 - 54.4)
Home health visits per year		4.3	(3.6 - 4.9)	3.7	(3.6 - 3.9)
Durable medical equipment claims per year	*	2.2	(2.0 - 2.4)	2.0	(1.9 - 2.0)
Inpatient hospital stays/1000 persons 65+ years per year		303	(271 - 334)	284	(279 - 289)
Inpatient hospital readmissions (as % of admissions)	*	24.3%	(20.5% - 28.1%)	16.9%	(16.3% - 17.5%)
Skilled nursing facility stays/1000 persons 65+ years per year		112	(96 - 129)	100	(97 - 103)
COMMUNITY VARIABLE & CIVIC ENGAGEMENT					
% 60+ who are satisfied with neighborhood		75.7%	(71.1% - 80.3%)	80.0%	(78.9% - 81.1%)
% 60+ who believe local service orgs understand needs	W	32.2%	(26.6% - 37.8%)	44.1%	(42.7% - 45.6%)
% 60+ who believe he/she can make a difference	W	42.0%	(36.2% - 47.8%)	51.6%	(50.2% - 53.0%)
% 60+ who believe working together can make a difference		81.0%	(76.9% - 85.2%)	81.0%	(79.9% - 82.1%)
% 60+ who volunteer at least once per month		18.3%	(14.0% - 22.6%)	22.8%	(21.6% - 23.9%)
% 60+ who attend community events at least once per month	w	37.3%	(32.5% - 42.1%)	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.