RHODE ISLAND HEALTHY AGING COMMUNITY DATA PROFILE

North Smithfield (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%	(3.9% - 5.7%)	4.8%	(4.6% - 4.9%)
% 60+ lived at same address 25 years or more		50.1%	(45.7% - 54.4%)	48.1%	(46.8% - 49.5%)
WELLNESS and PREVENTION					
% any physical activity within last month		69.5%	(65.6% - 73.5%)	70.0%	(68.8% - 71.2%)
% injured by a fall within last year		8.5%	(5.0% - 12.0%)	10.0%	(8.7% - 11.3%)
% ever had a hip fracture		4.5%	(3.3% - 5.8%)	3.9%	(3.7% - 4.0%)
% with self-reported fair or poor health status		18.2%	(15.2% - 21.3%)	20.4%	(19.4% - 21.5%)
% with 15+ physically unhealthy days last month		12.2%	(9.7% - 14.8%)	13.9%	(13.0% - 14.8%)
% with physical exam/check-up in past year		93.7%	(91.7% - 95.6%)	91.9%	(91.2% - 92.6%)
% met CDC preventive health screening goals		38.7%	(33.8% - 43.5%)	39.5%	(38.0% - 41.1%)
% flu shot past year		57.6%	(53.3% - 61.8%)	59.1%	(57.8% - 60.4%)
% pneumonia vaccine		74.3%	(69.9% - 78.7%)	73.8%	(72.4% - 75.2%)
% shingles vaccine		31.9%	(26.9% - 37.0%)	30.3%	(28.7% - 31.8%)
% cholesterol screening		89.2%	(86.7% - 91.8%)	88.4%	(87.6% - 89.3%)
% mammogram within last 2 years (women)		80.3%	(75.8% - 84.8%)	81.8%	(80.4% - 83.1%)
% colorectal cancer screening		75.7%	(72.1% - 79.3%)	76.1%	(75.0% - 77.3%)
Oral Health					
% with complete tooth loss		28.6%	(24.9% - 32.4%)	32.4%	(31.2% - 33.6%)
% with annual dental exam	B	79.3%	(75.9% - 82.7%)	74.7%	(73.5% - 75.8%)
NUTRITION / DIET					
% with 5 or more servings of fruit or vegetables per day		24.7%	(21.2% - 28.3%)	23.0%	(21.9% - 24.1%)
% obese		25.2%	(21.6% - 28.9%)	25.4%	(24.2% - 26.5%)
% high cholesterol		79.0%	(76.5% - 81.5%)	78.0%	(77.7% - 78.3%)
% current smokers		7.0%	(4.9% - 9.1%)	8.9%	(8.2% - 9.7%)
% excessive drinking		7.0%	(4.9% - 9.1%)	8.9%	(8.1% - 9.6%)
MENTAL HEALTH					
% with 15+ days poor mental health last month		6.1%	(4.3% - 8.0%)	7.5%	(6.8% - 8.1%)
% 60+ talked with family or friends almost daily		74.3%	(70.4% - 78.2%)	75.3%	(74.1% - 76.5%)
% ever diagnosed with depression		28.6%	(25.9% - 31.4%)	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%	(12.5% - 16.9%)	14.4%	(14.2% - 14.7%)
% with diabetes		37.1%	(34.0% - 40.2%)	35.7%	(35.4% - 36.1%)
% with stroke		13.5%	(11.4% - 15.5%)	12.5%	(12.2% - 12.7%)
% with chronic obstructive pulmonary disease		24.2%	(21.6% - 26.8%)	24.1%	(23.8% - 24.4%)
% with asthma		12.6%	(10.6% - 14.6%)	14.0%	(13.7% - 14.2%)
% with hypertension		81.5%	(79.1% - 83.9%)	79.0%	(78.8% - 79.3%)
% ever had a heart attack		5.0%	(3.7% - 6.3%)	5.4%	(5.3% - 5.6%)
% with ischemic heart disease	W	51.8%	(48.6% - 55.1%)	45.9%	(45.5% - 46.2%)
% with congestive heart failure	W	28.4%	(25.6% - 31.3%)	24.8%	(24.5% - 25.1%)
% with atrial fibrillation		15.7%	(13.5% - 17.8%)	15.2%	(15.0% - 15.5%)
% with osteoarthritis/rheumatoid arthritis		55.2%	(52.0% - 58.4%)	52.0%	(51.6% - 52.4%)
% with osteoporosis		23.4%	(20.8% - 25.9%)	21.0%	(20.7% - 21.3%)
% with glaucoma		27.8%	(25.1% - 30.5%)	26.6%	(26.2% - 26.9%)
% with cataract		70.9%	(68.1% - 73.7%)	67.9%	(67.6% - 68.2%)
% women with breast cancer	B	7.6%	(5.5% - 9.6%)	10.7%	(10.4% - 11.0%)
% with colon cancer		2.9%	(1.9% - 3.9%)	3.2%	(3.1% - 3.3%)
% men with prostate cancer		13.4%	(10.2% - 16.6%)	13.8%	(13.4% - 14.1%)
% with lung cancer		2.0%	(1.2% - 2.8%)	2.1%	(2.0% - 2.2%)
% with hypothyroidism		21.7%	(19.2% - 24.2%)	21.1%	(20.8% - 21.4%)
% with anemia		50.2%	(47.2% - 53.2%)	52.2%	(51.9% - 52.6%)
% with benign prostatic hyperplasia		44.2%	(39.4% - 48.9%)	40.3%	(39.8% - 40.8%)
% with chronic kidney disease	B	18.8%	(16.3% - 21.2%)	23.3%	(23.0% - 23.6%)
Summary chronic disease measures					
% with 4+ chronic conditions		65.2%	(62.3% - 68.1%)	63.9%	(63.6% - 64.3%)
% with 0 chronic conditions		8.4%	(6.7% - 10.1%)	8.4%	(8.2% - 8.6%)
ACCESS TO CARE					
% with a regular doctor		96.3%	(94.9% - 97.7%)	96.5%	(96.1% - 97.0%)
% did not see a doctor when needed due to cost		4.7%	(3.0% - 6.3%)	6.3%	(5.6% - 6.9%)
SERVICE UTILIZATION					
Physician visits per year		7.8	(7.4 - 8.3)	8.0	(7.9 - 8.0)
Emergency room visits/1000 persons 65+ years per year		587	(516 - 657)	628	(618 - 638)
Part D monthly prescription fills per person per year		56.3	(54.2 - 58.4)	54.2	(53.9 - 54.4)
Home health visits per year	*	2.4	(1.9 - 3.0)	3.7	(3.6 - 3.9)
Durable medical equipment claims per year		1.9	(1.6 - 2.2)	2.0	(1.9 - 2.0)
Inpatient hospital stays/1000 persons 65+ years per year		297	(251 - 343)	284	(279 - 289)
Inpatient hospital readmissions (as % of admissions)		17.7%	(12.4% - 22.9%)	16.9%	(16.3% - 17.5%)
Skilled nursing facility stays/1000 persons 65+ years per year		113	(85 - 141)	100	(97 - 103)
COMMUNITY VARIABLE & CIVIC ENGAGEMENT					
% 60+ who are satisfied with neighborhood	B	89.0%	(86.3% - 91.6%)	80.0%	(78.9% - 81.1%)
% 60+ who believe local service orgs understand needs		39.6%	(34.9% - 44.3%)	44.1%	(42.7% - 45.6%)
% 60+ who believe he/she can make a difference		49.8%	(45.4% - 54.3%)	51.6%	(50.2% - 53.0%)
% 60+ who believe working together can make a difference		82.2%	(78.9% - 85.5%)	81.0%	(79.9% - 82.1%)
% 60+ who volunteer at least once per month		20.5%	(17.1% - 23.8%)	22.8%	(21.6% - 23.9%)
% 60+ who attend community events at least once per month		40.0%	(35.7% - 44.2%)	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.