

North Kingstown (Washington)

North Kingstown is a town in Washington County with a population of 26,486. About 14% of residents are age 65 or older. With the exception of lower than state rates of cholesterol screening and higher rates of glaucoma, North Kingstown older adults fare better or similar to state rates on most all other health indicators. Age-friendly community resources include Beechwood House, the town's senior center, offering a noon meals program, health/wellness, arts/crafts, social services and transportation for grocery shopping, medical trips in town, bank, library, pharmacy, and special trips; the West Bay Family YMCA offers Healthy Aging Evidence Based Programs (e.g., Tai Chi: Moving for Better Balance). Beechwood House is part of the Aging and Disabilities Resource Center, POINT Network, and provides older adults with informational and referral services. South County Community Action Agency provides case management for persons receiving state-funded home and community services. North Kingstown older adults are more likely than state estimates to be satisfied with their neighborhoods; believe that he or she "can make a difference" in the community; and volunteer.



| POPULATION CHARACTERISTICS | COMMUNITY ESTIMATE | STATE ESTIMATE |
|--|--------------------|----------------|
| Total population all ages | 26,486 | 1,052,567 |
| Population 60 years or older as % of total population | 21.6% | 20.6% |
| Total population 60 years or older | 5,703 | 217,066 |
| Population 65 years or older as % of total population | 14.4% | 14.8% |
| Total population 65 years or older | 3,783 | 155,558 |
| % 65-74 years | 59.9% | 50.4% |
| % 75-84 years | 26.8% | 32.0% |
| % 85 years or older | 13.2% | 17.6% |
| Gender (65+ population) | | |
| % female | 54.3% | 58.4% |
| Race/Ethnicity (65+ population) | | |
| % White | 96.9% | 93.0% |
| % African American | 0.0% | 2.6% |
| % Asian | 2.7% | 1.3% |
| % Other | 0.4% | 3.2% |
| % Hispanic/Latino | 0.1% | 3.7% |
| Marital Status (65+ population) | | |
| % married | 66.3% | 50.1% |
| % divorced/separated | 9.8% | 12.6% |
| % widowed | 20.1% | 30.8% |
| % never married | 3.8% | 6.4% |
| Education (65+ population) | | |
| % with less than high school education | 15.3% | 26.8% |
| % with high school or some college | 45.6% | 50.7% |
| % with college degree | 39.1% | 22.5% |
| % of 60+ LGBT | 2.4% | 2.0% |
| % of 65+ population living alone | 21.1% | 30.4% |
| % of 65+ population who speak only English at home | 90.2% | 81.7% |
| % of 65+ population who are veterans of military service | 29.9% | 22.7% |
| Age-sex adjusted 1-year mortality rate | 4.8% | 4.8% |

| HEALTHY AGING INDICATORS | BETTER / WORSE STATE RATE¹ | COMMUNITY ESTIMATE² | STATE ESTIMATE² |
|--|--|---|---------------------------------------|
| Geographic Migration (65+ population) | | | |
| % moved within same county | | 1.6% | 3.5% |
| % moved from different county in Rhode Island | | 2.6% | 0.8% |
| % moved from different state | | 1.2% | 1.1% |
| % 60+ lived at same address 25 years or more | | 45.4% | 48.1% |
| WELLNESS and PREVENTION | | | |
| % any physical activity within last month | B | 79.5% | 70.0% |
| % injured by a fall within last year | | C | 10.0% |
| % ever had a hip fracture | | 3.7% | 3.9% |
| % with self-reported fair or poor health status | B | 12.0% | 20.4% |
| % with 15+ physically unhealthy days last month | b | 9.7% | 13.9% |
| % with physical exam/check-up in past year | | 91.7% | 91.9% |
| % met CDC preventive health screening goals | | 42.4% | 39.5% |
| % flu shot past year | | 63.0% | 59.1% |
| % pneumonia vaccine | | 75.0% | 73.8% |
| % shingles vaccine | B | 42.1% | 30.3% |
| % cholesterol screening | w | 83.1% | 88.4% |
| % mammogram within last 2 years (women) | | 83.2% | 81.8% |
| % colorectal cancer screening | | 81.1% | 76.1% |
| Oral Health | | | |
| % with complete tooth loss | B | 20.8% | 32.4% |
| % with annual dental exam | B | 83.7% | 74.7% |
| # dentists per 100,000 persons (all ages) | | 49 | 58 |
| NUTRITION/DIET | | | |
| % with 5 or more servings of fruit or vegetables per day | | 28.8% | 23.0% |
| % obese | B | 18.7% | 25.4% |
| % high cholesterol | B | 73.9% | 78.0% |
| % current smokers | | 7.9% | 8.9% |
| % excessive drinking | | 8.5% | 8.9% |
| MENTAL HEALTH | | | |
| % with 15+ days poor mental health last month | | 5.3% | 7.5% |
| % 60+ talked with family or friends almost daily | | 74.6% | 75.3% |
| % ever diagnosed with depression | B | 26.4% | 30.0% |
| CHRONIC DISEASE | | | |
| % with Alzheimer's disease or related dementias | B | 11.4% | 14.4% |
| % with diabetes | B | 29.2% | 35.7% |
| % with stroke | | 11.1% | 12.5% |
| % with chronic obstructive pulmonary disease | B | 20.6% | 24.1% |
| % with asthma | B | 12.4% | 14.0% |

| HEALTHY AGING INDICATORS | BETTER / WORSE STATE RATE¹ | COMMUNITY ESTIMATE² | STATE ESTIMATE² |
|--|--|---|---------------------------------------|
| % with hypertension | B | 73.5% | 79.0% |
| % ever had a heart attack | | 4.8% | 5.4% |
| % with ischemic heart disease | B | 41.2% | 45.9% |
| % with congestive heart failure | B | 19.4% | 24.8% |
| % with atrial fibrillation | | 13.8% | 15.2% |
| % with osteoarthritis/rheumatoid arthritis | | 51.3% | 52.0% |
| % with osteoporosis | B | 17.0% | 21.0% |
| % with glaucoma | W | 28.8% | 26.6% |
| % with cataract | | 67.9% | 67.9% |
| % women with breast cancer | | 11.2% | 10.7% |
| % with colon cancer | | 2.8% | 3.2% |
| % men with prostate cancer | | 13.6% | 13.8% |
| % with lung cancer | | 2.0% | 2.1% |
| % with hypothyroidism | | 21.1% | 21.1% |
| % with anemia | B | 48.3% | 52.2% |
| % with benign prostatic hyperplasia | B | 36.8% | 40.3% |
| % with chronic kidney disease | B | 18.7% | 23.3% |
| Summary chronic disease measures | | | |
| % with 4+ chronic conditions | B | 55.8% | 63.9% |
| % with 0 chronic conditions | B | 10.2% | 8.4% |
| LIVING WITH DISABILITY | | | |
| % 65+ with hearing difficulty | | 8.5% | 13.8% |
| % 65+ with vision difficulty | | 4.3% | 5.2% |
| % 65+ with cognition difficulty | | 9.2% | 7.8% |
| % 65+ with ambulatory difficulty | | 12.6% | 19.9% |
| % 65+ with self-care difficulty | | 5.9% | 6.6% |
| % 65+ with independent living difficulty | | 10.7% | 13.7% |
| ACCESS TO CARE | | | |
| Medicare (65+ population) | | | |
| % Medicare managed care enrollees | * | 33.1% | 39.4% |
| % dually eligible for Medicare and Medicaid | * | 7.8% | 14.6% |
| % with a regular doctor | | C | 96.5% |
| % did not see a doctor when needed due to cost | | C | 6.3% |
| # of primary care providers (within 5 miles) | | 29 | 1,566 |
| # of hospitals (within 5 miles) | | 0 | 11 |
| # of nursing homes (within 5 miles) | | 3 | 84 |
| # of home health agencies (in same town) | | 20 | 38 |

| HEALTHY AGING INDICATORS | BETTER / WORSE STATE RATE¹ | COMMUNITY ESTIMATE² | STATE ESTIMATE² |
|--|--|---|---------------------------------------|
| SERVICE UTILIZATION | | | |
| Physician visits per year | | 8.2 | 8.0 |
| Emergency room visits/1000 persons 65+ years per year | * | 541 | 628 |
| Part D monthly prescription fills per person per year | * | 49.3 | 54.2 |
| Home health visits per year | * | 3.0 | 3.7 |
| Durable medical equipment claims per year | * | 1.5 | 2.0 |
| Inpatient hospital stays/1000 persons 65+ years per year | * | 238 | 284 |
| Inpatient hospital readmissions (as % of admissions) | * | 13.4% | 16.9% |
| Skilled nursing facility stays/1000 persons 65+ years per year | | 83 | 100 |
| Total skilled nursing home Medicare beds/1000 persons 65+ years | | 61 | 52 |
| % 65+ getting Medicaid long term services and supports | | 4.1% | 6.2% |
| COMMUNITY VARIABLES & CIVIC ENGAGEMENT | | | |
| Air Pollution/Air Quality Index | | | |
| Annual # of unhealthy days for older adults | | 0 | NA |
| Walkability of Community | | | |
| Walkability score (0-100) | | 40 | NA |
| % of vacant housing units in community | | 8.1% | 11.3% |
| % 60+ who are satisfied with neighborhood | B | 87.0% | 80.0% |
| # of registered voters (age 18+) | | 21,429 | 725,309 |
| Voter participation rate in 2012 presidential election (age 18+) | | 68.5% | 61.5% |
| % 60+ who believe local service orgs understand needs | | 50.7% | 44.1% |
| % 60+ who believe he/she can make a difference | B | 59.6% | 51.6% |
| % 60+ who believe working together can make a difference | | 82.7% | 81.0% |
| % 60+ who volunteer at least once per month | B | 29.9% | 22.8% |
| % 60+ who attend community events (e.g., church, club) at least once per month | | 48.8% | 44.2% |
| SAFETY AND TRANSPORTATION | | | |
| Violent crime rate / 100,000 persons | | 96 | 253 |
| Property crime rate / 100,000 persons | | 1,460 | 2,394 |
| # of motor vehicle fatalities involving adult age 60+/town | | 4 | 90 |
| # of motor vehicle fatalities involving adult age 60+/county | | 20 | 90 |
| # of alternative transportation programs by county | | 12 | 43 |
| Municipal senior transportation available | | Yes | NA |
| Volunteer driver programs available | | RSVP, FISH | NA |

HEALTHY AGING INDICATORS

COMMUNITY
ESTIMATE²

STATE
ESTIMATE²

ECONOMIC AND FINANCIAL

Poverty (65+ Population)

| | | |
|---|-------|-------|
| % with income below the poverty level past year | 5.8% | 8.6% |
| % 60+ receiving food stamps past year | 5.3% | 11.9% |
| % 65+ working past year | 22.3% | 16.3% |
| Household income (65+ householder) | | |
| % households with annual income < \$20,000 | 20.2% | 28.0% |
| % households with annual income \$20,000-49,999 | 23.7% | 34.2% |
| % households with annual income ≥ \$50,000 | 56.1% | 37.7% |
| % 60+ own home | 49.4% | 43.9% |
| % 60+ homeowners with mortgage | 52.1% | 45.3% |

COST OF LIVING

\$ COUNTY
ESTIMATE

\$ STATE
ESTIMATE

RATIO OF COUNTY
TO STATE

Elder Economic Security Standard Index

| | | | |
|---|----------|----------|------|
| Single, homeowner without mortgage, good health | \$22,920 | \$22,188 | 1.03 |
| Single, renter, good health | \$23,412 | \$23,544 | 0.99 |
| Couple, homeowner without mortgage, good health | \$33,096 | \$32,352 | 1.02 |
| Couple, renter, good health | \$33,588 | \$33,708 | 1.00 |

TECHNICAL NOTES: Read our technical report for information on data sources and methodology at <http://healthyagingdatareports.org/ri/technicalreport>.

¹ For most indicators the community and state values are both statistical 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. When an upper case letter is used the 95% confidence intervals were used, the lowercase indicates a 90% confidence interval. When the implication for healthy aging is unclear we use an “.”

² “C” indicates that the community rate is censored due to inadequate sample size and “NA” indicates that the data were not available.

Other notes:

- We used a hierarchical approach to reporting estimates for every city/town in Rhode Island when data allow. In other cases, we could only report indicators for aggregated areas (e.g., cities and towns with similar demographic and socioeconomic population composition were combined for some indicators and counties were used for others). The same estimate is reported for all cities/towns within aggregated geographic areas.
- Total population estimates are from the 2010 Census and are reported for the 41 geographic units. Other population characteristic estimates are from the American Community Survey (ACS) (2009-2013) and are reported for 41 geographic units. Note that % may not add up to 100% due to rounding error.
- Mortality rate, specific chronic disease, access and utilization estimates are for beneficiaries 65 years or older in 2013 from the 2012 and 2013 Centers for Medicare and Medicaid Services (CMS) Master Beneficiary Summary File (MBSF).
- The 2009-2014 Behavioral Risk Factor Surveillance System (BRFSS) is the source for wellness, health behavior, and some prevention estimates. BRFSS indicators were estimated for persons 60 years or older for 14 aggregated geographic areas derived by combining cities and towns with similar population composition. The same rate is reported for all cities/towns within the same unit.
- Access to care data pertaining to the # of primary care providers, hospitals, nursing homes, and home health agencies were obtained from the following CMS websites: <http://www.medicare.gov/nursinghomecompare/search.html>, <http://www.medicare.gov/homehealthcompare/search.html>, <http://www.medicare.gov/hospitalcompare/search.html>, <http://www.medicare.gov/physiciancompare/results.html>. The dentist data come from the RI Department of Health (<http://www.health.ri.gov/find/oralhealthservices/>).
- Walkability Estimates were downloaded from <http://www.walkscore.com/> using the finder term “city/town name, Rhode Island.”
- Air pollution/air quality estimates are from the US Environmental Protection Agency reported for 3 RI counties for older adults with no specific health concerns (2015). The same rate is reported for cities/towns within the same county.
- 2012 voter participation data from the Rhode Island Board of Elections.
- Crime estimates are from 2013 FBI Uniform Crime Reports (<http://www.fbi.gov/stats-services/crimestats>).
- Data on fatal auto (driver, passenger) and pedestrian accidents for persons age 60+ is from the Fatal Accident Reporting System of the National Highway Traffic Safety Administration (2009-2013), reported at the town and county level.
- The housing, migration, and income indicators are from the ACS (2009-2013) and are reported for individual cities/towns.
- The 2016 Elder Economic Security Standard Index estimates were obtained from researchers at the University of Massachusetts Boston Center for Social and Demographic Research on Aging.
- Our research team: Elizabeth Dugan, Frank Porell and Nina Silverstein. Graduate Student researchers included: Chae Man Lee, Hyo Jung Lee, Bon Kim, and Krystal Kittle. We thank Amanda Cox from the [NYTimes.com](http://www.nytimes.com) for data visualizations; and Maureen Maigret for sharing data on municipal senior transportation and volunteer driver programs collected by Mensel & Maigret (April, 2016). Please send your questions, comments, or ideas to beth.dugan@umb.edu. Let us know how you are using the Data Report in your community!