



AMERICA'S
HEALTH RANKINGS[®]
SENIOR REPORT
UNITED HEALTH FOUNDATION[®]

| A CALL TO ACTION FOR INDIVIDUALS
| AND THEIR COMMUNITIES

2013 EDITION



Components of Health

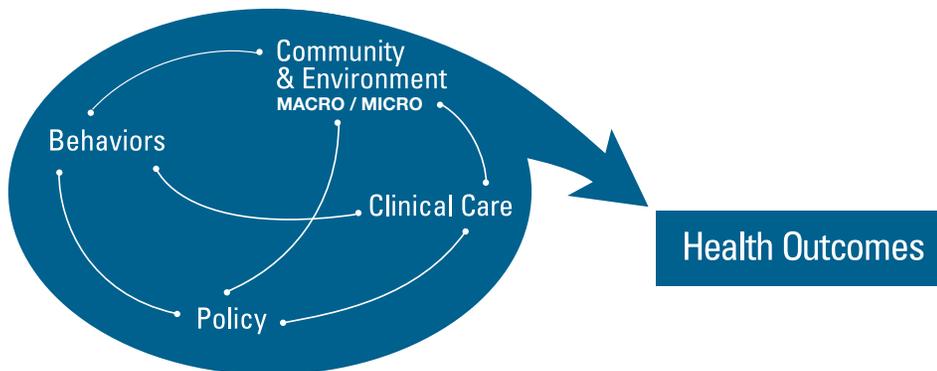
The World Health Organization defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

In addition to the contributions of our individual genetic predispositions to disease, health is the result of:

- Our behaviors.
- The environment and the community in which we live, including the larger community as well as the smaller, personal space of our home and immediate surroundings.
- The policies and practices of our health, public, and private systems.
- The clinical care we receive.

These 4 aspects interact with each other in a complex web of cause and effect, and much of this interaction is just beginning to be fully understood. Understanding these interactions is vital if we are to create the healthy outcomes we desire, including a long, disease-free, robust life for all individuals regardless of race, gender, or socio-economic status.

This report focuses on these determinants and the overall health outcomes for adults aged 65 and older, a large and expanding portion of the general population. Optimal health for older adults involves creating a healthy life that allows individuals to flourish to the best of their abilities, maintain their independence and autonomy as long as preferred, and respect their needs and desires as life draws to an end.





| A CALL TO ACTION FOR INDIVIDUALS
| AND THEIR COMMUNITIES

2013 EDITION

America's Health Rankings® Senior Report is available in its entirety at www.americashealthrankings.org. Visit the site to request or download additional copies.

America's Health Rankings® Senior Report is funded entirely by United Health Foundation, a recognized 501(c)(3) organization.

Data contained within this document was obtained from and used with permission of:

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
Agency on Aging
National Center for Health Statistics
Center for Medicare and Medicaid Services

U.S. Department of Commerce
Census Bureau
Bureau of Economic Analysis

U.S. Department of Labor
Bureau of Labor Statistics

The Dartmouth Atlas Project
National Foundation to End Senior Hunger
LTCFocUS, Alpert Medical School, Brown University
American Geriatrics Society
The Commonwealth Fund

United Health Foundation encourages the distribution of information contained in this publication for non-commercial and charitable, educational, or scientific purposes. Please acknowledge *America's Health Rankings® Senior Report* as the source and provide the following notice: ©2013 United Health Foundation. All Rights Reserved. Please acknowledge the original source of specific data as cited.

Questions and comments on the report should be directed to United Health Foundation at unitedhealthfoundationinfo@uhc.com.

Copyright ©2013 United Health Foundation

Table of Contents

Acknowledgment	2
Introduction	5
Findings	7
Health Disparities within States	13
Current Context	19
Methodology	25
Description of Measures	28
State-by-State Snapshots	46
Commentaries	
Senior Report — Working Together to Care for an Aging Nation , Jennie Chin Hansen, RN, MSN, FAAN, CEO, American Geriatrics Society	98
Preparing for the Future as Millions of Baby Boomers Continue to Age , Gail Gibson Hunt, President & CEO, National Alliance for Caregiving	102
Rx for Health—Invest in America’s Senior Centers to Promote Health and Prevent Disease , James Firman, Ed.D., President and CEO; Richard Birkel, Ph.D., Senior Vice President, National Council on Aging	104
Senior Hunger: A National Problem, A Local Problem , Enid A. Borden, Founder, President and CEO; Margaret B. Ingraham, Executive Vice President, National Foundation to End Senior Hunger	108
The Environment of Care: A Community’s Journey to Become America’s Healthiest Hometown , Elliot Sussman, MD,MBA, Chairman; Joseph Hildner, MD, Chief Medical Officer, The Villages Health; Stephen Klasko, MD, MBA, CEO, USF Health and Dean, Morsani College of Medicine	111
The Team	116
Index of Tables	117

We at United Health Foundation are pleased to present the inaugural edition of *America's Health Rankings® Senior Report: A Call to Action for Individuals & Their Communities*.

As you might recall, our 2012 Edition of *America's Health Rankings®* revealed that Americans are now living longer lives but with increased rates of preventable chronic disease among the general population. As a result of this finding—and recognizing the growing number of seniors in the United States—we believe it is time to invest in a report that takes an in-depth look at senior health.

Today, 1 in 8 Americans are aged 65 or older; in the next two decades, another 79 million baby boomers will move into this demographic. The

growing number of seniors combined with the increasing rates of obesity, diabetes, and other chronic diseases may overwhelm our ability to care for our seniors.

This report shows that the health needs of seniors are more costly, and also differ greatly from the younger population. Nearly 80 percent of seniors have been diagnosed with at least 1 chronic condition

and half have been diagnosed with at least 2.

The increased burden of chronic disease among seniors means additional visits to the doctor and medications to manage, and a negative effect on their overall well-being. Additionally, this report explores the incidence and implications of other

health factors such as limited mobility, social isolation and the need and availability of long-term care.

We want this report to be more than just an assessment of the current status of senior health. We want to promote a public discussion of the overall health of the age 65+ population that is comprehensive and balanced. We call on communities, governments, individuals and organizations to become increasingly aware of the breadth of issues facing our seniors and to learn where and how to take action to improve the health of our seniors today, and to prepare for the challenges posed by the future.

Many of the commentaries in this year's report reflect the need for multi-stakeholder solutions and action. We are honored to have commentaries from the following individuals and organizations:

- *Senior Report—Working Together to Care for an Aging Nation*, authored by Jennie Chin Hansen, RN, MSN, FAAN, CEO of the American Geriatrics Society, who discusses the importance of geriatricians and geriatric specialists in treating the multiple and complex medical needs of older adults.
- *Preparing for the Future as Millions of Baby Boomers Continue to Age*, authored by Gail Gibson Hunt, President and CEO, National Alliance for Caregiving, who discusses the important role of family caregivers in caring for seniors.
- *Rx for Health—Invest in America's Senior Centers to Promote Health and Prevent Disease*, authored by James Firman, Ed.D., President and CEO, and Richard Birkel, Ph.D., Senior Vice President, National Council on Aging, who

We want to promote a public discussion of the overall health of the age 65+ population.

recommend further investing in the capacity of senior centers to more fully leverage the role they play in improving the health of seniors.

- *Senior Hunger: A National Problem, A Local Problem*, authored by Enid A. Borden, Founder, President and CEO, and Margaret B. Ingraham, Executive Vice President, National Foundation to End Senior Hunger, who highlight the growing issue of senior hunger.
- *The Environment of Care: A Community's Journey to Become America's Healthiest Hometown*, authored by Elliot Sussman, MD, MBA, Chairman, and Joseph Hildner, MD, Chief Medical Officer, The Villages Health, and Stephen Klasko, MD, MBA, CEO, USF Health and Dean, Morsani College of Medicine, who discuss health care transformation in The Villages, a retirement community in central Florida.

We invite you to share proven or innovative programs that have made a difference in your community by emailing unitedhealthfoundationinfo@uhc.com, posting on our Facebook page at www.facebook.com/AmericasHealthRankings, or tweeting to us on Twitter at [@AHR_Rankings](https://twitter.com/AHR_Rankings). A healthy exchange of ideas allows all of us to share information, learn from one another, and work together to address our nation's—and our seniors'—health challenges and improve the lives of all.

We appreciate the efforts of our expert panel, listed in the report, in the design of this model. This group of practitioners and public health experts reviewed available models and metrics to select a set that reflects the holistic health of seniors, including behaviors, community,

environment, clinical care, policy, and outcomes.

We also want to recognize the dedicated efforts of our nation's public health, clinical and health policy professionals as well as all of the people who provide care to seniors, especially those that have compromised health. For your tireless work every day on behalf of the people of this country we offer our gratitude and respect.

Introduction

The 2012 Edition of *America's Health Rankings*[®] revealed that Americans are now living longer lives, but with increased rates of preventable chronic disease. If our nation's seniors are unhealthy, can we be healthy as a society?

Today, 1 in 8 Americans are aged 65 or older.¹ By the year 2050, this age group is projected to more than double in size, from 40.3 million to 88.5 million.² The increasing number of older adults combined with increasing rates of obesity, diabetes, and other chronic diseases are on track to overwhelm our health care system.

In no other aspect is this more true than the cost of health care. Adults aged 65 and older spend nearly twice as much as 45 to 64 year olds on health care each year. They spend 3 to 5 times more than all adults younger than 65.³ The health needs of older adults are not only more costly but also differ greatly from the younger population. Nearly 80 percent of seniors have already been diagnosed with at least 1 chronic condition and half have been diagnosed with at least 2.⁴ The increased burden of chronic disease among older adults affects not only the number of visits to a health professional and the number of medications they take, but also their overall well-being.

As seniors age, challenges such as limited mobility, social isolation, and the need for long-term care become increasingly common. These issues extend far beyond the health care system because they encompass the ability of communities to accommodate limited-mobility residents and the ability of families and communities to provide long-term care needs.

-
1. Howden LM, Meyer JM. Age and sex composition: 2010. *2010 Census Briefs*. US Census Bureau, May 2011.
 2. Vincent GK, Velkoff VA. The next four decades the older population in the United States: 2010 to 2050. *Current Population Reports*. US Census Bureau, May 2010.
 3. Centers for Disease Control and Prevention (CDC). Public health and aging: Trends in aging—United States and worldwide. *MMWR*. 2003;52(06):101-106.
 4. Centers for Disease Control and Prevention & Merck Company Foundation. *The State of Aging and Health in America 2007*.

Purpose

By assessing the current status of senior health, communities, governments, individuals, and other organizations can build awareness of the breadth of issues facing our seniors—and, by extension, our communities—and learn where and how to take action to improve the health of our current and future seniors.

Objectives

The objectives of this report are sixfold:

- 1) Be a catalyst for a comprehensive, balanced, and data-driven discussion of senior health in this country.
- 2) Provide a robust snapshot of the overall health of the population aged 65 years and older in all 50 states and the District of Columbia, including how states match up against each other and the nation as a whole.
- 3) Focus attention on the indicators that have the most potential to improve senior health and drive change in a positive direction.
- 4) Create a baseline of overall senior health to allow longitudinal comparison over time.
- 5) Produce regular updates so we can gauge the progress and challenges of senior health over time.
- 6) Provide a catalyst for action by the general public, health professionals, and policymakers.

The intent is to have *America's Health Rankings*[®] *Senior Report* assume a position in the public discussion of health that is analogous to *America's Health Rankings*[®]. In particular, it will create widespread awareness of where states stand on important public health measures and will drive action towards activities shown to improve population health.

Process

To develop *America's Health Rankings® Senior Report*, a panel of experts in senior health was charged with identifying the areas of health and well-being most pertinent to the older adult population and creating a model for assessing population health at a state level. For details on this process and a list of the panel members, see the Methodology section on page 25.

Audience

The intent is to amplify currently available public statistics and to put the flood of information into an easily digestible format for a variety of audiences, including:

- 1) The general public: Provide an easy-to-use resource that allows the general public to understand the components of overall population health for those aged 65 and older, how their state compares to other states, and what they can do to improve health.
- 2) Health professionals: Provide the information and resources that individuals and organizations need to effect positive change. This should prioritize the delivery system for senior health ("delivery system" is intended in the broadest term; this can be a mobility service in a community, a senior education provider, or a health care clinic).
- 3) Policymakers: Provide a platform for policymakers to share their successes and challenges in creating an environment where individuals, communities, businesses, and government programs can positively impact senior health. Focus on providing best practices that can be leveraged across states.
- 4) Media: Help media understand the complex issues underlying senior health and provide them with the resources to report on this story, with a particular focus on disseminating best practices and solutions.

Findings

Senior Report Results

America's Health Rankings® Senior Report shows Minnesota at the top of the list of healthiest states for older adults. Vermont is ranked second and New Hampshire is third, followed by Massachusetts and Iowa. Mississippi is ranked 50th as the least healthy state for older adults. Oklahoma, Louisiana, West Virginia, and Arkansas complete the bottom 5 states. Table 1 displays the overall ranking results alphabetically by state and by rank.

Minnesota's strengths include ranking first for all health determinants combined, which includes ranking in the top 5 states for a high rate of annual dental visits, a high percentage of volunteerism, a low percentage of marginal food insecurity, a high percentage of creditable drug coverage, and ready availability of home health care workers. Minnesota also ranks first for all health outcomes combined, including ranking in the top 5 states for a low rate of hospitalization for hip fractures, a high percentage of seniors who report very good or excellent health, a high prevalence of able-bodied seniors, a low premature death rate, a low prevalence of full-mouth tooth extractions, and few poor mental health days per month. Minnesota's challenges are low community support expenditures and a low prevalence of seniors with a dedicated health care provider. In *America's Health Rankings®—2012 Edition*, a comparison of the general health of the entire population of each state, Minnesota ranked 5th. For further details, see Minnesota's state snapshot on page 69 or visit www.americashealthrankings.org/senior/MN.

Mississippi ranks in the bottom 5 states for 14 of the 34 measures, including ranking last for a low rate of annual dental visits, a high percentage of seniors in poverty, a high percentage of marginal food insecurity, a low percentage of seniors who report very good or excellent health, a low prevalence of able-bodied seniors, and a high premature death rate. Mississippi ranks 50th for all health determinants combined, so it will be a difficult challenge for the state to improve its rank in the near future. Mississippi ranks well for a low prevalence of chronic drinking and a high prevalence of flu vaccination. Mississippi tied with Louisiana for 49th overall in *America's Health Rankings®—2012 Edition*. For further details, see Mississippi's

state snapshot on page ppp or visit www.americashealthrankings.org/senior/MS.

The next 4 highest ranked states also scored in the top 5 for all health determinants combined. These states rank among the top 10 for many individual metrics and rarely rank in the bottom 10. They are consistently among the top states for the categories of Behaviors, Community & Environment, and Outcomes. The top 5 states have different mixtures of strengths and weaknesses, indicating that they achieve their healthy state rank through a variety of approaches.

Similarly, the states that rank in the bottom 5 states for overall health also rank in the bottom 5 for all health determinants combined.

Scores presented in table 1 and table 2 indicate the weighted number of standard deviation units a state is above or below the national norm. For example, Minnesota, with a score of 0.796, is almost one standard deviation unit above the national norm. Mississippi, with a score of -0.885, is almost one standard deviation below the national average.

Determinants and Outcomes

The 34 measures that comprise *America's Health Rankings® Senior Report* are of 2 types — determinants and outcomes. Determinants represent those actions that can affect the future health of the population, whereas outcomes represent what has already occurred either through death or disease.

For a state to improve the health of its older adult population, efforts must focus on changing the determinants of health. If a state is significantly better in its score for determinants than its score for outcomes, it will likely improve its overall health ranking in the future. Conversely, if a state is worse in its score for determinants than its score for outcomes, its overall health ranking will likely decline over time.

For a state to improve the health of its older adult population, efforts must focus on changing the determinants of health.

Table 1
Overall Rankings

ALPHABETICAL BY STATE			RANK BY STATE		
RANK	STATE	SCORE*	RANK	STATE	SCORE*
44	Alabama	-0.499	1	Minnesota	0.796
40	Alaska	-0.364	2	Vermont	0.592
22	Arizona	0.116	3	New Hampshire	0.548
46	Arkansas	-0.603	4	Massachusetts	0.542
25	California	0.100	5	Iowa	0.533
8	Colorado	0.475	6	Hawaii	0.500
7	Connecticut	0.483	7	Connecticut	0.483
12	Delaware	0.309	8	Colorado	0.475
30	Florida	0.012	9	Utah	0.402
43	Georgia	-0.451	10	Maryland	0.394
6	Hawaii	0.500	11	North Dakota	0.318
24	Idaho	0.109	12	Delaware	0.309
37	Illinois	-0.217	13	Maine	0.303
32	Indiana	-0.116	14	Nebraska	0.292
5	Iowa	0.533	15	Oregon	0.245
18	Kansas	0.192	16	Washington	0.233
45	Kentucky	-0.537	17	Pennsylvania	0.229
48	Louisiana	-0.702	18	Kansas	0.192
13	Maine	0.303	19	South Dakota	0.177
10	Maryland	0.394	20	Wisconsin	0.163
4	Massachusetts	0.542	21	Virginia	0.140
26	Michigan	0.083	22	Arizona	0.116
1	Minnesota	0.796	23	New York	0.113
50	Mississippi	-0.885	24	Idaho	0.109
33	Missouri	-0.157	25	California	0.100
35	Montana	-0.178	26	Michigan	0.083
14	Nebraska	0.292	27	New Jersey	0.074
42	Nevada	-0.394	28	Ohio	0.022
3	New Hampshire	0.548	29	North Carolina	0.013
27	New Jersey	0.074	30	Florida	0.012
38	New Mexico	-0.300	31	Rhode Island	0.008
23	New York	0.113	32	Indiana	-0.116
29	North Carolina	0.013	33	Missouri	-0.157
11	North Dakota	0.318	34	Wyoming	-0.162
28	Ohio	0.022	35	Montana	-0.178
49	Oklahoma	-0.801	36	South Carolina	-0.203
15	Oregon	0.245	37	Illinois	-0.217
17	Pennsylvania	0.229	38	New Mexico	-0.300
31	Rhode Island	0.008	39	Texas	-0.302
36	South Carolina	-0.203	40	Alaska	-0.364
19	South Dakota	0.177	41	Tennessee	-0.376
41	Tennessee	-0.376	42	Nevada	-0.394
39	Texas	-0.302	43	Georgia	-0.451
9	Utah	0.402	44	Alabama	-0.499
2	Vermont	0.592	45	Kentucky	-0.537
21	Virginia	0.140	46	Arkansas	-0.603
16	Washington	0.233	47	West Virginia	-0.621
47	West Virginia	-0.621	48	Louisiana	-0.702
20	Wisconsin	0.163	49	Oklahoma	-0.801
34	Wyoming	-0.162	50	Mississippi	-0.885

*Scores presented in this table indicate the weighted number of standard deviations a state is above or below the national norm.

STATE	SCORE FOR ALL DETERMINANTS	SCORE FOR ALL OUTCOMES	INFLUENCE ON FUTURE OVERALL RANK
Alabama	-0.223	-0.276	Neutral
Alaska	-0.320	-0.044	Negative
Arizona	0.025	0.090	Neutral
Arkansas	-0.379	-0.224	Negative
California	0.034	0.065	Neutral
Colorado	0.307	0.168	Positive
Connecticut	0.249	0.233	Neutral
Delaware	0.182	0.127	Neutral
Florida	-0.014	0.027	Neutral
Georgia	-0.273	-0.178	Neutral
Hawaii	0.205	0.295	Neutral
Idaho	0.043	0.065	Neutral
Illinois	-0.145	-0.071	Neutral
Indiana	-0.042	-0.075	Neutral
Iowa	0.372	0.160	Positive
Kansas	0.179	0.013	Positive
Kentucky	-0.216	-0.321	Neutral
Louisiana	-0.489	-0.213	Negative
Maine	0.235	0.068	Positive
Maryland	0.184	0.210	Neutral
Massachusetts	0.343	0.198	Positive
Michigan	0.005	0.078	Neutral
Minnesota	0.474	0.321	Positive
Mississippi	-0.583	-0.302	Negative
Missouri	-0.063	-0.094	Neutral
Montana	-0.163	-0.015	Negative
Nebraska	0.191	0.102	Neutral
Nevada	-0.321	-0.073	Negative
New Hampshire	0.310	0.238	Neutral
New Jersey	0.024	0.050	Neutral
New Mexico	-0.245	-0.055	Negative
New York	0.007	0.107	Neutral
North Carolina	0.102	-0.089	Positive
North Dakota	0.149	0.169	Neutral
Ohio	0.087	-0.065	Positive
Oklahoma	-0.531	-0.270	Negative
Oregon	0.105	0.140	Neutral
Pennsylvania	0.234	-0.004	Positive
Rhode Island	-0.063	0.071	Negative
South Carolina	-0.056	-0.148	Neutral
South Dakota	0.048	0.129	Neutral
Tennessee	-0.183	-0.193	Neutral
Texas	-0.192	-0.110	Neutral
Utah	0.272	0.130	Positive
Vermont	0.428	0.163	Positive
Virginia	0.039	0.101	Neutral
Washington	0.085	0.148	Neutral
West Virginia	-0.335	-0.286	Neutral
Wisconsin	0.037	0.126	Neutral
Wyoming	-0.175	0.013	Negative

Table 2
Determinants
and Outcomes

*Scores presented in this table indicate the weighted number of standard deviations a state is above or below the national norm.

Table 2 presents the overall score for the determinants and outcomes, and their implications for the future. If the difference is positive, the future overall ranking is more likely to improve; if it is neutral, the future overall ranking will probably stay the same; or if it is negative, the future overall ranking is more likely to decline.

When compared to other states, Vermont, Pennsylvania, and Iowa have a much higher score for determinants than for outcomes, providing a strong indication they will improve over time. Louisiana, Alaska, and Oklahoma show a strong indication that they will decline over time compared to other states.

Determinants

There are 4 categories of health determinants: Behaviors, Community and Environment, Policy, and Clinical Care. These 4 groups of measures influence health outcomes of the older adult population in a state, and improving these inputs will improve outcomes over time.

Most measures are actually a combination of activities in all 4 categories. For example, the prevalence of smoking is a behavior strongly influenced by the community and environment in which we live, by public policy including taxation and restrictions on smoking in public places, and by the care received to treat the chemical and behavioral addictions associated with tobacco. However, for simplicity, we placed each measure into a single category.

BEHAVIORS

Behaviors are potentially modifiable through a combination of personal, community, and clinical interventions. This category includes measures for smoking, chronic drinking, obesity, underweight, physical inactivity, dental visits, and pain management. These behaviors can have both immediate and delayed effects on the health of older adults. The behaviors proved to be some of the most impactful measures in these rankings and shed light on the future health of older adults in each state. In the Senior Report, Hawaii ranks 1st for Behaviors, while Alaska ranks 50th. Table 3 presents the top and bottom 10 states for Behaviors measures.

COMMUNITY AND ENVIRONMENT— OVERALL
Measures of community and environment reflect the daily conditions that influence a healthy lifestyle. These metrics can be modified through a concerted effort by the community and its elected officials, supported by state

Table 3
Behaviors — Highest and Lowest Ranked States

RANK	STATE	RANK	STATE
1	Hawaii	50	Alaska
2	Colorado	49	West Virginia
3	California	48	Oklahoma
4	Utah	47	Louisiana
5	Minnesota	46	Mississippi
6	Vermont	45	Arkansas
7	New Hampshire	44	Alabama
8	Iowa	43	Georgia
9	Connecticut	42	Indiana
10	Maryland	41	Tennessee

Table 4
Community & Environment—Overall — Highest and Lowest Ranked States

RANK	STATE	RANK	STATE
1	Iowa	50	New Mexico
2	Wyoming	49	Mississippi
3	Minnesota	48	Nevada
4	Kansas	47	Hawaii
5	Nebraska	46	Texas
6	New Hampshire	45	California
7	Idaho	44	Louisiana
8	Vermont	43	South Carolina
9	Massachusetts	42	Georgia
10	Connecticut	41	Kentucky

and federal agencies, professional associations, advocacy groups, and businesses. Iowa ranks 1st for Community and Environment, while New Mexico ranks 50th. Table 4 presents the top 10 and bottom 10 states for overall Community and Environment measures.

In *America's Health Rankings® Senior Report*, Community and Environment is further subdivided into 2 categories: Macro and Micro. Macro Community and Environment measures the larger community context of supporting the health of older adults in a state, whereas Micro Community Environment measures the immediate, mostly in-home, support that affects the personal context of health.

COMMUNITY AND ENVIRONMENT—MACRO

The macro sub-category of Community and Environment includes poverty, volunteerism, and

Table 5
Community & Environment–Macro
— Highest and Lowest Ranked States

RANK	STATE	RANK	STATE
1	Iowa	50	New Mexico
2	Kansas	49	Louisiana
3	Nebraska	48	Florida
4	Minnesota	47	Kentucky
5	Connecticut	45	Georgia
6	Wyoming	46	Nevada
7	New Hampshire	44	Arizona
8	Wisconsin	43	New York
9	Idaho	42	Tennessee
10	Missouri	41	Texas

Table 6
Community & Environment–Micro
— Highest and Lowest Ranked States

RANK	STATE	RANK	STATE
1	Massachusetts	50	Mississippi
2	Wyoming	49	Hawaii
3	Delaware	48	Rhode Island
4	Minnesota	47	South Carolina
5	New Hampshire	46	Texas
6	Vermont	45	California
7	Idaho	44	New Mexico
8	North Dakota	43	Nevada
9	Oregon	42	Alabama
10	Nebraska	41	Arkansas

highly-rated nursing home beds. Iowa ranks 1st for Macro Community and Environment, while New Mexico ranks 50th. Table 5 presents the top 10 and bottom 10 states for Macro Community and Environment measures.

COMMUNITY AND ENVIRONMENT–MICRO

The micro sub-category of Community and Environment includes social support, food insecurity, and community support. Massachusetts ranks 1st for Micro Community and Environment, while Mississippi ranks 50th. Table 6 presents the top 10 and bottom 10 states for Micro Community and Environment measures.

POLICY

Measures included in the Policy category are indicative of policies that affect the availability of resources to support aging adults. This includes

Table 7
Policy — Highest and Lowest Ranked States

RANK	STATE	RANK	STATE
1	Hawaii	50	Wyoming
2	Pennsylvania	49	Oklahoma
3	New York	48	Montana
4	Minnesota	47	Louisiana
5	Massachusetts	46	Mississippi
6	Maine	45	Kansas
7	North Carolina	44	Illinois
8	Vermont	43	Alaska
9	North Dakota	42	Idaho
10	California	41	Wisconsin

Table 8
Clinical Care — Highest and Lowest Ranked States

RANK	STATE	RANK	STATE
1	Vermont	50	Mississippi
2	Colorado	49	West Virginia
3	Iowa	48	Kentucky
4	New Hampshire	47	Nevada
5	Minnesota	46	Wyoming
6	Utah	45	Arkansas
7	Florida	44	Alaska
8	North Carolina	43	Oklahoma
9	Maine	42	Illinois
10	Wisconsin	41	New Jersey

the percentages of low-care nursing home residents, creditable drug coverage, and geriatrician shortfall. Hawaii ranks 1st for Policy, while Wyoming ranks 50th. Table 7 presents the top 10 and bottom 10 states for Policy measures.

CLINICAL CARE

Clinical Care has the potential to enable people to live longer and healthier by treating and managing existing conditions and preventing others. Preventive and curative care must be delivered in an appropriate and timely manner in order for it to be most effective. Ten different measures are included in the Clinical Care category. These clinical care measures provide information about the availability, utilization, and efficacy of clinical care. Vermont ranks 1st for Clinical Care, while Mississippi ranks 50th. Table 8 presents the top 10 and bottom 10 states for Clinical Care measures.

Outcomes

Outcomes measures focus on quality of life and well-being among older adults. These measures represent outcomes from current or prior behaviors and clinical care, and from community, environment, and policy influences.

Minnesota ranks 1st for Outcomes measures, while Kentucky ranks 50th. Table 9 presents the top 10 and bottom 10 states for Outcomes measures.

Table 9

Outcomes — Highest and Lowest Ranked States

RANK	STATE	RANK	STATE
1	Minnesota	50	Kentucky
2	Hawaii	49	Mississippi
3	New Hampshire	48	West Virginia
4	Connecticut	47	Alabama
5	Maryland	46	Oklahoma
6	Massachusetts	45	Arkansas
7	North Dakota	44	Louisiana
8	Colorado	43	Tennessee
9	Vermont	42	Georgia
10	Iowa	41	South Carolina

Health Disparities within States

For a population to be healthy, it must minimize health disparities among segments of the population, including differences that occur by sex, race/ethnicity, education, income, disability, geographic location, or sexual orientation.

The statewide measures used in *America's Health Rankings® Senior Report* reflect the condition of the “average” older adult and can mask differences within the state. When the measures are examined by race, sex, geographic location, and/or economic status, startling differences can exist within a state.

The *Senior Report* does not contain an explicit metric for disparities; however, we have examined 4 of the individual metrics within the core metrics to illustrate how these metrics vary by race/ethnicity, education levels, income levels, sex, and urbanicity. Not all race/ethnicity differences can be examined due to limited data in states with small populations of specific races/ethnicities.

The metrics examined are Obesity, Physical Inactivity, Social Support, and Health Status among adults aged 65 and older. (Smoking would also be a logical behavior to examine. However, differences by subgroup can be masked by the markedly higher mortality rates for smoking among all older adults.)

For the United States, the mean prevalence by group for each metric are shown in table 10. For obesity and physical inactivity, a lower rate is better. For social support and health status, a higher rate is better.

Obesity among non-Hispanic Asians (9.7 percent of older adults) is dramatically lower than non-Hispanic blacks (35.7 percent), non-Hispanic American Indian/Alaskan Natives (35.2 percent), and non-Hispanic Hawaiian / Pacific Islanders (33.8 percent). Obesity is also higher among Hispanics (29.7 percent of older adults) and non-Hispanic whites (24.1 percent) compared to non-Hispanic Asians (9.7 percent). If obesity is viewed through an education lens, older adults with a college

degree are less obese (18.9 percent) than those with less than a high school degree (31.3 percent). There is also an 8.3 percent difference in obesity rates by income group.

The largest gap between subgroups with regard to physical inactivity is between older adults with less than a high school degree (41.8 percent inactive) and those with a college degree (18.4 percent inactive). The racial differences mirror the differences in obesity.

The level of social support is also strongly different by race/ethnicity, education, and income. The most notable differences are that older adults in the lowest income group and those in the lowest education group feel that they have less emotional support than those in higher income groups and education groups.

The outcomes measure, health status, is strongly divided along income lines. Almost 60 percent of older adults in the highest income group indicate that their health is very good or excellent. In contrast, only about one-quarter of those in the lowest income group feel that their health is very good or excellent. A similar dichotomy is visible between the highest and lowest education groups.

The tables on the following pages show the 2 subgroups within each state with the largest differences in each metric (tables 11–14). They illustrate the unique situation each state has in addressing health and the need to focus on certain subsegments of the population in which the differences in health are largest. For example, in Alabama the largest disparity in obesity (Table 11) is between non-Hispanic whites and non-Hispanic blacks. In Colorado, the largest difference in obesity is between college graduates and those without a high school degree.

Only about one-quarter of those in the lowest income group feel that their health is very good or excellent.

Table 10
Prevalences of Obesity, Physical Inactivity, Social Support and Excellent or Very Good Health Status in U.S. Seniors by Sex, Race/Ethnicity, Urbanicity, Education and Income (percent of seniors)

	OBESITY	PHYSICAL INACTIVITY	SOCIAL SUPPORT	HEALTH STATUS
SEX				
Male	25.4%	27.4%	77.2%	37.8%
Female	25.2%	34.0%	81.0%	38.8%
RACE/ETHNICITY				
White	24.1%	31.0%	82.5%	41.5%
Black	35.7%	33.0%	66.5%	24.1%
Hispanic	29.7%	33.1%	65.4%	22.3%
Asian	9.7%	19.9%	55.3%	36.3%
Hawaiian / Pacific Islander	33.8%	24.0%	66.5%	31.0%
American Indian / Alaskan Native	35.2%	36.6%	65.7%	25.9%
URBANICITY				
Urban residents	24.2%	29.7%	77.9%	38.5%
Suburban residents	25.1%	30.4%	80.6%	39.9%
Non-MSA residents (rural)	26.8%	35.3%	79.6%	35.4%
EDUCATION				
Less than high school	31.3%	41.8%	62.5%	20.2%
High school	26.0%	35.4%	77.2%	35.0%
Some college	25.1%	28.1%	82.0%	43.0%
College graduate	18.9%	18.4%	87.0%	55.0%
INCOME				
Income <\$25,000	28.6%	38.3%	69.4%	26.0%
Income between \$25,000 and \$50,000	26.1%	30.0%	81.1%	40.7%
Income between \$50,000 and \$75,000	25.6%	23.2%	87.2%	50.2%
Income > \$75,000	20.3%	18.0%	89.8%	59.6%

Note: All persons of Hispanic ethnicity are included in the Hispanics category regardless of race and are not included as part of the individual race categories.

	LOWEST PREVALENCE		HIGHEST PREVALENCE	
	GROUP	RATE	GROUP	RATE
Alabama	White	25.0%	Black	38.7%
Alaska	\$25,000 to \$50,000 income	19.5%	Less than \$25,000 income	35.6%
Arizona	White	20.2%	Hispanic	41.0%
Arkansas	White	23.4%	Black	43.2%
California	Asian	8.8%	Hispanic	29.3%
Colorado	College graduate	15.0%	Less than HS graduate	32.4%
Connecticut	College graduate	16.3%	Less than HS graduate	28.6%
Delaware	College graduate	25.4%	Less than HS graduate	36.8%
Florida	College graduate	18.7%	Less than HS graduate	33.0%
Georgia	More than \$75,000 income	16.7%	\$50,000 to \$75,000 income	29.0%
Hawaii	College graduate	12.0%	Less than HS graduate	24.3%
Idaho	College graduate	18.7%	Less than HS graduate	36.2%
Illinois	College graduate	19.8%	Less than HS graduate	37.3%
Indiana	White	25.9%	Black	41.2%
Iowa	More than \$75,000 income	28.0%	\$50,000 to \$75,000 income	44.3%
Kansas	White	25.9%	Black	38.5%
Kentucky	White	24.2%	Black	40.4%
Louisiana	White	26.0%	Black	41.3%
Maine	College graduate	17.2%	Less than HS graduate	35.7%
Maryland	White	22.6%	Black	38.4%
Massachusetts	Black	21.9%	Hispanic	35.3%
Michigan	White	28.7%	Black	38.6%
Minnesota	College graduate	18.4%	Less than HS graduate	29.9%
Mississippi	White	23.8%	Black	41.6%
Missouri	White	24.8%	Black	41.9%
Montana	White	21.3%	American Indian / Alaska Native	44.2%
Nebraska	White	26.8%	Black	37.6%
Nevada	Urban	14.2%	Suburban	24.6%
New Hampshire	College Grad	18.6%	Some college	28.5%
New Jersey	Hispanic	23.4%	Black	37.5%
New Mexico	White	18.3%	American Indian / Alaska Native	37.1%
New York	College graduate	18.4%	Less than HS graduate	31.2%
North Carolina	White	22.6%	Black	40.4%
North Dakota	\$50,000 to \$75,000 income	18.1%	Less than \$25,000 income	30.5%
Ohio	More than \$75,000 income	22.9%	\$50,000 to \$75,000 income	37.8%
Oklahoma	White	25.4%	American Indian / Alaska Native	33.3%
Oregon	College Grad	19.2%	Some college	27.9%
Pennsylvania	College graduate	21.6%	Less than HS graduate	35.1%
Rhode Island	College Grad	17.7%	Some college	24.1%
South Carolina	White	22.4%	Black	36.4%
South Dakota	White	22.8%	American Indian / Alaska Native	41.5%
Tennessee	White	24.6%	Black	41.8%
Texas	College graduate	17.4%	Less than HS graduate	37.1%
Utah	College graduate	21.9%	Less than HS graduate	34.3%
Vermont	College graduate	17.5%	Less than HS graduate	31.3%
Virginia	College graduate	21.1%	Less than HS graduate	33.2%
Washington	College Grad	20.5%	Some college	28.9%
West Virginia	\$50,000 to \$75,000 income	22.3%	\$25,000 to \$50,000 income	34.2%
Wisconsin	College graduate	23.0%	Less than HS graduate	37.3%
Wyoming	\$50,000 to \$75,000 income	15.4%	\$25,000 to \$50,000 income	24.7%
United States	Asian	9.7%	Black	35.7%
District of Columbia	College graduate	15.1%	High school graduate	36.8%

Table 11
Group with
Greatest Disparity
in Obesity
Prevalence by
State (percent of
seniors)

Note: See Methodology for a description of how groups are defined and selected. All persons of Hispanic ethnicity are included in the Hispanics category regardless of race and are not included as part of individual race categories.

Table 12
Group with
Greatest Disparity
in Physical Inactivity
Prevalence by State
(percent of seniors)

	LOWEST PREVALENCE		HIGHEST PREVALENCE	
	GROUP	RATE	GROUP	RATE
Alabama	College graduate	22.5%	Less than HS graduate	50.7%
Alaska	College graduate	18.9%	High school graduate	34.7%
Arizona	College graduate	16.8%	Less than HS graduate	34.1%
Arkansas	College graduate	24.0%	Less than HS graduate	46.9%
California	College graduate	14.3%	Less than HS graduate	30.7%
Colorado	College graduate	11.1%	Less than HS graduate	32.9%
Connecticut	College graduate	19.8%	Less than HS graduate	43.4%
Delaware	College graduate	18.1%	Less than HS graduate	45.5%
Florida	More than \$75,000 income	15.9%	Less than \$25,000 income	38.4%
Georgia	College graduate	22.2%	Less than HS graduate	41.6%
Hawaii	College graduate	17.2%	High school graduate	32.1%
Idaho	College graduate	16.1%	Less than HS graduate	42.9%
Illinois	College graduate	18.8%	Less than HS graduate	45.8%
Indiana	More than \$75,000 income	18.9%	Less than \$25,000 income	45.2%
Iowa	College graduate	17.4%	Less than HS graduate	40.6%
Kansas	College graduate	20.4%	Less than HS graduate	48.4%
Kentucky	More than \$75,000 income	20.2%	Less than \$25,000 income	43.3%
Louisiana	College graduate	23.7%	Less than HS graduate	52.5%
Maine	College graduate	16.7%	Less than HS graduate	40.7%
Maryland	College graduate	16.4%	Less than HS graduate	39.3%
Massachusetts	College graduate	18.8%	Less than HS graduate	39.1%
Michigan	College graduate	18.2%	Less than HS graduate	43.5%
Minnesota	College graduate	14.1%	Less than HS graduate	42.5%
Mississippi	College graduate	24.0%	Less than HS graduate	48.1%
Missouri	College graduate	19.8%	Less than HS graduate	46.8%
Montana	College graduate	18.9%	Less than HS graduate	42.3%
Nebraska	College graduate	20.8%	Less than HS graduate	44.7%
Nevada	More than \$75,000 income	11.1%	Less than \$25,000 income	37.3%
New Hampshire	College graduate	17.1%	Less than HS graduate	41.0%
New Jersey	More than \$75,000 income	19.0%	Less than \$25,000 income	40.2%
New Mexico	College graduate	17.2%	Less than HS graduate	41.2%
New York	College graduate	21.9%	Less than HS graduate	40.0%
North Carolina	College graduate	18.5%	Less than HS graduate	43.8%
North Dakota	More than \$75,000 income	20.3%	Less than \$25,000 income	42.5%
Ohio	More than \$75,000 income	16.5%	Less than \$25,000 income	39.5%
Oklahoma	College graduate	24.0%	Less than HS graduate	50.3%
Oregon	More than \$75,000 income	11.2%	Less than \$25,000 income	31.5%
Pennsylvania	College graduate	18.8%	Less than HS graduate	44.2%
Rhode Island	More than \$75,000 income	17.6%	Less than \$25,000 income	40.7%
South Carolina	College graduate	15.9%	Less than HS graduate	42.8%
South Dakota	College graduate	26.1%	Less than HS graduate	41.4%
Tennessee	College graduate	23.7%	Less than HS graduate	55.9%
Texas	More than \$75,000 income	17.9%	Less than \$25,000 income	40.7%
Utah	College graduate	16.5%	Less than HS graduate	38.9%
Vermont	College graduate	13.1%	Less than HS graduate	40.0%
Virginia	College graduate	15.9%	Less than HS graduate	46.1%
Washington	College graduate	15.8%	Less than HS graduate	38.2%
West Virginia	College graduate	22.6%	Less than HS graduate	55.5%
Wisconsin	College graduate	16.3%	Less than HS graduate	49.1%
Wyoming	College graduate	23.9%	High school graduate	42.5%
United States	College graduate	18.4%	Less than HS graduate	41.8%
District of Columbia	College graduate	14.7%	Less than HS graduate	48.0%

Note: See Methodology for a description of how groups are defined and selected. All persons of Hispanic ethnicity are included in the Hispanics category regardless of race and are not included as part of individual race categories.

	HIGHEST PREVALENCE		LOWEST PREVALENCE	
	GROUP	RATE	GROUP	RATE
Alabama	College graduate	91.0%	Less than HS graduate	63.4%
Alaska	Female	87.3%	Male	71.0%
Arizona	College graduate	87.7%	Less than HS graduate	52.6%
Arkansas	White	83.7%	Black	58.6%
California	White	84.1%	Asian	51.6%
Colorado	College graduate	87.7%	Less than HS graduate	61.5%
Connecticut	College graduate	87.9%	Less than HS graduate	50.6%
Delaware	More than \$75,000 income	95.3%	Less than \$25,000 income	76.5%
Florida	College graduate	85.6%	Less than HS graduate	58.6%
Georgia	College graduate	91.3%	Less than HS graduate	66.2%
Hawaii	College graduate	79.5%	Less than HS graduate	49.9%
Idaho	College graduate	92.1%	Less than HS graduate	70.5%
Illinois	College graduate	86.5%	Less than HS graduate	57.4%
Indiana	College graduate	88.3%	Less than HS graduate	64.2%
Iowa	College graduate	90.5%	Less than HS graduate	67.1%
Kansas	College graduate	90.2%	Less than HS graduate	69.9%
Kentucky	College graduate	89.9%	Less than HS graduate	66.3%
Louisiana	\$50,000 to \$75,000 income	89.7%	Less than \$25,000 income	69.8%
Maine	College graduate	91.9%	Less than HS graduate	62.0%
Maryland	More than \$75,000 income	89.7%	Less than \$25,000 income	66.1%
Massachusetts	More than \$75,000 income	92.3%	Less than \$25,000 income	65.2%
Michigan	College graduate	85.4%	Less than HS graduate	62.9%
Minnesota	College graduate	92.0%	Less than HS graduate	69.0%
Mississippi	More than \$75,000 income	96.3%	Less than \$25,000 income	69.1%
Missouri	College graduate	90.6%	Less than HS graduate	66.2%
Montana	White	80.3%	American Indian / Alaska Native	57.3%
Nebraska	College graduate	87.6%	Less than HS graduate	59.3%
Nevada	Some college	83.8%	Less than HS graduate	56.7%
New Hampshire	College graduate	85.6%	Less than HS graduate	57.2%
New Jersey	College graduate	85.9%	Less than HS graduate	68.0%
New Mexico	College graduate	88.6%	Less than HS graduate	63.8%
New York	College graduate	83.1%	Less than HS graduate	55.0%
North Carolina	More than \$75,000 income	95.4%	Less than \$25,000 income	72.8%
North Dakota	College graduate	91.0%	Less than HS graduate	59.7%
Ohio	College graduate	85.5%	Less than HS graduate	58.2%
Oklahoma	White	83.2%	Black	63.5%
Oregon	College graduate	91.6%	Less than HS graduate	71.8%
Pennsylvania	College graduate	87.0%	Less than HS graduate	65.3%
Rhode Island	College graduate	84.5%	Less than HS graduate	57.6%
South Carolina	College graduate	87.3%	Less than HS graduate	52.0%
South Dakota	White	81.8%	American Indian / Alaska Native	58.7%
Tennessee	College graduate	91.1%	Less than HS graduate	73.4%
Texas	College graduate	87.7%	Less than HS graduate	57.4%
Utah	College graduate	89.7%	Less than HS graduate	62.0%
Vermont	College graduate	89.3%	Less than HS graduate	64.3%
Virginia	College graduate	90.7%	Less than HS graduate	63.2%
Washington	College graduate	89.4%	Less than HS graduate	68.9%
West Virginia	Some college	89.2%	Less than HS graduate	76.7%
Wisconsin	College graduate	91.4%	Less than HS graduate	53.3%
Wyoming	College graduate	89.9%	Less than HS graduate	60.5%
United States	White	82.5%	Asian	55.3%
District of Columbia	More than \$75,000 income	89.5%	Less than \$25,000 income	54.5%

Table 13
Group with
Greatest
Disparity in
Social Support
Prevalence by
State (percent of
seniors)

Note: See Methodology for a description of how groups are defined and selected. All persons of Hispanic ethnicity are included in the Hispanics category regardless of race and are not included as part of individual race categories.

Table 14
Group with Greatest Disparity in Excellent or Very Good Health Status Prevalence by State (percent of seniors)

	HIGHEST PREVALENCE		LOWEST PREVALENCE	
	GROUP	RATE	GROUP	RATE
Alabama	More than \$75,000 income	55.3%	Less than \$25,000 income	23.5%
Alaska	More than \$75,000 income	61.2%	Less than \$25,000 income	23.5%
Arizona	College graduate	57.5%	Less than HS graduate	18.7%
Arkansas	More than \$75,000 income	58.1%	Less than \$25,000 income	21.3%
California	College graduate	56.2%	Less than HS graduate	19.2%
Colorado	College graduate	61.0%	Less than HS graduate	22.3%
Connecticut	More than \$75,000 income	61.4%	Less than \$25,000 income	28.3%
Delaware	College graduate	59.0%	Less than HS graduate	24.2%
Florida	More than \$75,000 income	59.4%	Less than \$25,000 income	25.8%
Georgia	College graduate	52.8%	Less than HS graduate	17.0%
Hawaii	White	51.6%	Hispanic	19.5%
Idaho	College graduate	57.8%	Less than HS graduate	24.5%
Illinois	College graduate	49.5%	Less than HS graduate	19.3%
Indiana	College graduate	53.0%	Less than HS graduate	16.1%
Iowa	More than \$75,000 income	61.3%	Less than \$25,000 income	29.0%
Kansas	College graduate	55.2%	Less than HS graduate	22.5%
Kentucky	College graduate	54.4%	Less than HS graduate	21.0%
Louisiana	More than \$75,000 income	56.4%	Less than \$25,000 income	20.5%
Maine	College graduate	63.4%	Less than HS graduate	24.4%
Maryland	More than \$75,000 income	59.4%	Less than \$25,000 income	26.6%
Massachusetts	College graduate	60.0%	Less than HS graduate	23.6%
Michigan	College graduate	57.6%	Less than HS graduate	22.5%
Minnesota	College graduate	61.1%	Less than HS graduate	26.9%
Mississippi	More than \$75,000 income	53.0%	Less than \$25,000 income	17.7%
Missouri	More than \$75,000 income	57.4%	Less than \$25,000 income	24.7%
Montana	College graduate	56.9%	Less than HS graduate	19.1%
Nebraska	More than \$75,000 income	59.4%	Less than \$25,000 income	28.7%
Nevada	College graduate	55.4%	Less than HS graduate	18.4%
New Hampshire	College graduate	57.3%	Less than HS graduate	24.8%
New Jersey	More than \$75,000 income	61.7%	Less than \$25,000 income	25.9%
New Mexico	More than \$75,000 income	62.3%	Less than \$25,000 income	25.6%
New York	More than \$75,000 income	57.6%	Less than \$25,000 income	21.8%
North Carolina	More than \$75,000 income	59.9%	Less than \$25,000 income	23.6%
North Dakota	College graduate	54.6%	Less than HS graduate	21.1%
Ohio	More than \$75,000 income	65.8%	Less than \$25,000 income	28.8%
Oklahoma	College graduate	49.4%	Less than HS graduate	15.8%
Oregon	College graduate	55.5%	Less than HS graduate	22.1%
Pennsylvania	College graduate	55.7%	Less than HS graduate	20.1%
Rhode Island	More than \$75,000 income	59.8%	Less than \$25,000 income	23.1%
South Carolina	More than \$75,000 income	63.2%	Less than \$25,000 income	19.7%
South Dakota	College graduate	58.9%	Less than HS graduate	23.0%
Tennessee	College graduate	52.4%	Less than HS graduate	17.5%
Texas	College graduate	55.1%	Less than HS graduate	14.8%
Utah	More than \$75,000 income	61.6%	Less than \$25,000 income	29.5%
Vermont	More than \$75,000 income	71.3%	Less than \$25,000 income	34.1%
Virginia	More than \$75,000 income	62.3%	Less than \$25,000 income	22.3%
Washington	College graduate	54.4%	Less than HS graduate	22.2%
West Virginia	College graduate	53.6%	Less than HS graduate	20.4%
Wisconsin	College graduate	55.2%	Less than HS graduate	22.9%
Wyoming	More than \$75,000 income	58.7%	Less than \$25,000 income	28.5%
United States	College graduate	55.0%	Less than HS graduate	20.2%
District of Columbia	More than \$75,000 income	64.1%	Less than \$25,000 income	19.6%

Note: See Methodology for a description of how groups are defined and selected. All persons of Hispanic ethnicity are included in the Hispanics category regardless of race and are not included as part of individual race categories.

Current Context

In 2011 the first of more than 70 million baby boomers turned 65, marking the beginning of a tremendous demographic shift in the U.S. population. Adults aged 65 and older are the largest consumers of health care as the process of aging brings upon the need for more frequent health care.⁵ The pressure that this demographic shift places on the nation is not evenly distributed among the states, with some states expecting many more aging baby boomers than others. Several supplemental measures examine the broader context of the senior population. These items have significant, and largely unchangeable, impact on the population's health but are not factored into the overall rankings.

Shifts in Aging Population

In the 2010 Census, there were 40.3 million Americans aged 65 or older, or 13 percent of the population. Between 2000 and 2010, the 60-64 age group increased 55.6 percent, followed by the 55-59 age group which increased 46.0 percent. In 2010, the median age increased from 35.3 to 37.2 years, a new high.⁶

The 15-year projected increase in state populations aged 65 and older from 2015 to 2030 are provided in Table 15. This varies from only a 29 percent increase in West Virginia to a doubling of the population in Arizona.

-
5. Alemayehu B, Warner KE. The lifetime distribution of health care costs. *Health Services Research*. 39.3 (2004): 627-642.
 6. Howden LM, Meyer JA. Age and sex composition: 2010. *2010 Census Briefs*. US Department of Commerce, Economics and Statistics Administration. US Census Bureau. (2010).

Table 15
Projected
15-Year Increases in
Population of Adults
Aged 65 and Older
by State (based
on 2015 and 2030
projections)

States in bold have the highest
15 year increase in population.

STATE	15 YEAR INCREASE	RANK OF INCREASE
U.S.	53%	
Alabama	41%	38
Alaska	70%	4
Arizona	101%	1
Arkansas	40%	39
California	59%	13
Colorado	52%	21
Connecticut	38%	42
Delaware	60%	12
District of Columbia	-6%	51
Florida	88%	3
Georgia	61%	11
Hawaii	45%	29
Idaho	64%	6
Illinois	36%	45
Indiana	36%	44
Iowa	34%	47
Kansas	41%	34
Kentucky	42%	32
Louisiana	42%	31
Maine	49%	22
Maryland	48%	25
Massachusetts	43%	30
Michigan	38%	41
Minnesota	54%	19
Mississippi	46%	27
Missouri	41%	36
Montana	55%	17
Nebraska	38%	40
Nevada	89%	2
New Hampshire	62%	8
New Jersey	41%	33
New Mexico	62%	10
New York	33%	49
North Carolina	58%	14
North Dakota	41%	35
Ohio	33%	48
Oklahoma	37%	43
Oregon	49%	23
Pennsylvania	34%	46
Rhode Island	41%	47
South Carolina	56%	16
South Dakota	45%	28
Tennessee	46%	26
Texas	67%	5
Utah	64%	7
Vermont	53%	20
Virginia	55%	18
Washington	62%	9
West Virginia	29%	50
Wisconsin	49%	24
Wyoming	56%	15

Data Source: File
2. Interim State
Projections of
Population for Five-
Year Age Groups and
Selected Age Groups
by Sex: July 1, 2004
to 2030. U.S. Census
Bureau, Population
Division, Interim
State Population
Projections, 2005.

Table 16
College Education —
Highest and Lowest Ranked States

RANK	STATE	RANK	STATE
1	Colorado	50	West Virginia
2	Vermont	49	Kentucky
3	Maryland	47	North Dakota
4	Washington	47	Arkansas
5	California	46	Indiana
5	Connecticut	45	Iowa
7	Utah	44	Mississippi
8	Massachusetts	43	Tennessee
9	New Mexico	42	Alabama
10	Virginia	41	Ohio

Table 17
Multiple Chronic Conditions —
Highest and Lowest Ranked States

RANK	STATE	RANK	STATE
1	Alaska	50	Florida
2	Wyoming	49	New Jersey
3	Montana	48	Delaware
4	Minnesota	47	New York
6	Vermont	46	Michigan
5	Oregon	45	Pennsylvania
7	Colorado	44	Ohio
8	Idaho	43	Louisiana
9	Utah	42	Texas
10	Washington	41	Kentucky

Table 18
Cognition —
Highest and Lowest Ranked States

RANK	STATE	RANK	STATE
1	Wyoming	50	Mississippi
2	Nebraska	49	Kentucky
3	Minnesota	48	Louisiana
3	North Dakota	46	West Virginia
5	Iowa	46	Alabama
5	Wisconsin	45	Tennessee
7	Delaware	44	Georgia
8	Colorado	43	Texas
8	Connecticut	41	New Mexico
8	Montana	41	Arkansas
8	South Dakota		
8	Utah		

Table 19
Diagnosis of Depression —
Highest and Lowest Ranked States

RANK	STATE	RANK	STATE
1	Hawaii	50	Alaska
2	Delaware	49	Oregon
3	Maryland	48	Maine
4	Minnesota	47	Oklahoma
5	New Jersey	46	Tennessee
5	Virginia	45	Utah
5	California	44	New Mexico
8	Iowa	43	Kentucky
9	Wisconsin	42	Vermont
10	North Dakota	41	Alabama

Supplemental Measures

EDUCATION

Educational attainment is a vital contributor to health as people must be able to learn about, create, and maintain a healthy lifestyle. It's also a strong predictor of life expectancy as well as overall health and well-being.⁷ Those with more years of education are more likely to have higher incomes, lower rates of uninsurance, and therefore increased access to health care. Increasing educational attainment has been shown to improve the health status of the population as a whole.⁸ Each additional year of education is associated with an increase in health promoting behaviors, and policies aimed at increasing education levels could have considerable impact on health in the long term.⁹ Conversely, having a less educated population puts added stress on the medical system of the state.

While obtaining a college degree after the age of 65 is unlikely and its effects on health are unknown, investments in education in early life can have great implications on health throughout life. Thus, efforts to increase educational attainment among the population will improve health through all stages of life.

The top and bottom 10 states for older adults reporting a college degree are listed in Table 16. The states with the least educated people will face additional challenges in maintaining the health of its older adult population.

MULTIPLE CHRONIC CONDITIONS

Chronic diseases have become the focus of health care, especially in older adults where the number of people with not only 1 but multiple chronic conditions is an estimated 62 percent of the senior population.¹⁰ Persons with multiple chronic conditions represent one of the neediest segments of the population as each of their chronic conditions is likely to require medication and monitoring. The economic burden of persons with multiple chronic conditions is substantial and roughly two-thirds of all Medicare spending goes towards persons with more than 5 chronic conditions.¹¹

Common chronic diseases are also largely preventable and multiple chronic conditions are often an outcome of modifiable lifestyle factors and failed prevention strategies. Tobacco use, insufficient physical activity, poor diet, and excessive alcohol consumption are major lifestyle factors that contribute significantly towards multiple chronic diseases and are modifiable.

- Molla MT, Madans JH, Wagener DK. Differentials in Adult Mortality and Activity Limitation by Years of Education in the United States at the End of the 1990s. *Population and Development Review*. 2004;30(4):625-46.
- Lleras-Muney A. The relationship between education and adult mortality in the United States. *The Review of Economic Studies*. 2005;72(1):189.
- Cutler DM, Lleras-Muney A, National Bureau of Economic Research. *Education and health: Evaluating theories and evidence*. Cambridge, MA: National Bureau of Economic Research; 2006.
- Vogeli C, et al. Multiple chronic conditions: prevalence, health consequences, and implications for quality, care management, and costs. *Journal of General Internal Medicine*. 22 (2007): 391-395.
- Partnership for Solutions. *Chronic Conditions: Making the Case for Ongoing Care*. Robert Wood Johnson Foundation; 2002.

Table 20
Comparison of
50–64 Year Olds
Reporting Very Good
or Excellent Health
Status in 1995 and
2010, by State

STATE	1995	2010	DIFFERENCE
Alabama	44.0%	39.6%	-4.4%
Alaska	59.3%	55.3%	-4.0%
Arizona	55.6%	50.5%	-5.1%
Arkansas	47.8%	44.6%	-3.2%
California	50.1%	50.2%	0.1%
Colorado	56.7%	59.1%	2.4%
Connecticut	64.3%	58.8%	-5.5%
Delaware	52.9%	55.8%	2.9%
Florida	51.2%	50.1%	-1.1%
Georgia	49.3%	47.0%	-2.3%
Hawaii	48.9%	46.1%	-2.8%
Idaho	52.6%	53.7%	1.1%
Illinois	48.5%	50.5%	2.0%
Indiana	46.1%	46.3%	0.2%
Iowa	55.6%	53.9%	-1.7%
Kansas	55.4%	56.0%	0.6%
Kentucky	41.0%	39.3%	-1.7%
Louisiana	52.9%	40.5%	-12.4%
Maine	60.2%	56.2%	-4.0%
Maryland	56.1%	55.2%	-0.9%
Massachusetts	59.4%	60.3%	0.9%
Michigan	49.5%	51.2%	1.7%
Minnesota	59.7%	60.4%	0.7%
Mississippi	41.5%	35.7%	-5.8%
Missouri	59.0%	47.8%	-11.2%
Montana	60.5%	53.8%	-6.7%
Nebraska	56.4%	53.5%	-2.9%
Nevada	57.2%	49.4%	-7.8%
New Hampshire	60.1%	60.1%	0.0%
New Jersey	50.9%	50.8%	-0.1%
New Mexico	61.4%	48.5%	-12.9%
New York	56.6%	50.6%	-6.0%
North Carolina	43.0%	47.5%	4.5%
North Dakota	53.7%	53.7%	0.0%
Ohio	50.7%	47.5%	-3.2%
Oklahoma	50.0%	42.2%	-7.8%
Oregon	56.4%	51.3%	-5.1%
Pennsylvania	48.8%	51.6%	2.8%
Rhode Island	47.6%	54.6%	7.0%
South Carolina	48.7%	46.7%	-2.0%
South Dakota	46.4%	58.4%	12.0%
Tennessee	38.1%	46.6%	8.5%
Texas	50.7%	45.2%	-5.5%
Utah	59.7%	55.0%	-4.7%
Vermont	60.8%	62.8%	2.0%
Virginia	53.0%	51.2%	-1.8%
Washington	59.1%	54.3%	-4.8%
West Virginia	40.9%	35.6%	-5.3%
Wisconsin	55.6%	55.7%	0.1%
Wyoming	57.6%	54.0%	-3.6%
United States	51.6%	49.9%	-1.7%

The top and bottom 10 states for older adults reporting multiple chronic conditions are listed in Table 17.

COGNITION

Mild cognitive impairment, which is far short of Alzheimer's disease or dementia, affects nearly 1 in 4 community dwelling seniors.¹² Alzheimer's, a severe form of cognitive impairment, affects as many as 5.1 million older adults nationwide.

Cognitive impairment (CI) has many causes, from Alzheimer's to injury or stroke, but regardless of the cause, the burden is no less significant, especially for the many family caregivers who bear the brunt of the burden. A large financial burden is associated with cognitive impairment, as those with CI report 3 times as many hospitalizations as those without.¹³

The top and bottom 10 states for older adults reporting cognitive impairment are listed in Table 18.

DEPRESSION

The rate of older adults who report depression and depressive symptoms varies from 13 to 43 percent depending upon their living situations, with those living in long-term care facilities having the highest rates.¹⁴ Depression and depressive symptoms are an outcome of poor health, lack of social support, and disabilities that affect quality of life. Seniors with depression, even mild to moderate, are less likely to seek care or services for their health conditions and consequently often have poorer outcomes, placing an added burden on the health care system.¹⁵ The number of persons experiencing or reporting depression is likely to be substantially higher than the number of persons with a diagnosis of depression.

The top and bottom 10 states for older adults reporting that they have been diagnosed with depression are listed in Table 19.

Future Context

The shift in the aging population compels us to examine the expected health of those turning 65

in the next 15 years. Health status is a summary measure of health as it is an individual's self-report of their own health rated from poor to excellent. Health status is a commonly used measure that is associated with numerous outcomes. Obesity is also a relevant measure of future health as excess weight is associated with many of the common health problems such as heart disease, diabetes, and high blood pressure that plague older adults in the nation today. By comparing the health status and obesity rates of today's older adults when they were age 50-64 to those who are currently age 50-64, we can begin to understand what to expect over the next 15 years as the next generation of older adults ages.

HEALTH STATUS

Nationally, the self-reported health status of the middle-aged population has decreased slightly from 1995 to 2010 with 1.7 percent fewer adults age 50 to 64 reporting very good or excellent health. This drop in health status is far more precipitous in some states than others, with nearly 13 percent fewer adults in Louisiana and New Mexico reporting very good or excellent health. A number of states reported an increase in health status, with the largest increase occurring in South Dakota where 12 percent more adults reported very good or excellent health.

States with greater declines can expect to face additional challenges over the coming years as a less healthy generation of adults ages. Table 20 shows the percentage of 50-64 year olds reporting very good or excellent health, by state.

Cognitive impairment has many causes, from Alzheimer's to injury or stroke.

OBESITY

The national obesity rate of the middle-aged population increased 7.5 percent from 1995 to 2010. While all but one state's obesity rates have increased, they have not done so evenly. New Jersey's rate increased the least at only 2.2 percent, while obesity rates in Alabama and Oklahoma rose 15.0 percent. In Massachusetts, the obesity rate of middle-aged adults decreased slightly at 0.5 percent over the 15-year period.

Obesity contributes to a variety of other serious diseases. States with higher obesity rates can presume further health challenges are ahead. Table 21 shows the percentage of 50-64 year olds who are obese, by state.

12. Unverzagt, FW, et al. Prevalence of cognitive impairment Data from the Indianapolis Study of Health and Aging. *Neurology*. 57.9 (2001): 1655-1662.

13. Alzheimer's Association. *Characteristics, Costs and Health Service Use for Medicare Beneficiaries with a Dementia Diagnosis: Report 1: Medicare Current Beneficiary Survey*. Chicago: Alzheimer's Association; 2009

14. Blazer DG. Epidemiology of depression: prevalence and incidence. *Principles and Practice of Geriatric Psychiatry, Second Edition*. (2002): 389-392.

15. Beekman, Aartjan TF, et al. The impact of depression on the well-being, disability and use of services in older adults: a longitudinal perspective. *Acta Psychiatrica Scandinavica*. 105.1 (2002): 20-27.

Table 21
Comparison of
Obesity Among
50–64 Year Olds
in 1995 and 2010,
by State

STATE	1995	2010	DIFFERENCE
Alabama	24.2%	39.2%	15.0%
Alaska	26.4%	31.4%	5.0%
Arizona	17.0%	28.1%	11.1%
Arkansas	23.3%	34.2%	10.9%
California	25.1%	29.2%	4.1%
Colorado	18.3%	24.4%	6.1%
Connecticut	20.4%	25.7%	5.3%
Delaware	31.2%	34.2%	3.0%
Florida	20.8%	29.7%	8.9%
Georgia	19.6%	32.8%	13.2%
Hawaii	13.3%	24.9%	11.6%
Idaho	21.2%	30.0%	8.8%
Illinois	27.4%	34.3%	6.9%
Indiana	26.8%	35.3%	8.5%
Iowa	24.2%	33.8%	9.6%
Kansas	23.8%	35.1%	11.3%
Kentucky	23.4%	37.3%	13.9%
Louisiana	28.0%	37.5%	9.5%
Maine	22.0%	30.5%	8.5%
Maryland	22.0%	31.4%	9.3%
Massachusetts	25.6%	25.0%	-0.5%
Michigan	29.8%	37.1%	7.3%
Minnesota	21.6%	28.6%	7.0%
Mississippi	25.5%	38.9%	13.4%
Missouri	28.0%	36.1%	8.1%
Montana	17.8%	29.3%	11.5%
Nebraska	25.8%	33.6%	7.8%
Nevada	19.1%	28.0%	8.9%
New Hampshire	22.9%	28.0%	5.1%
New Jersey	27.2%	29.4%	2.2%
New Mexico	21.6%	25.9%	4.3%
New York	23.4%	29.5%	6.1%
North Carolina	27.1%	31.9%	4.8%
North Dakota	22.3%	35.2%	12.9%
Ohio	28.9%	35.6%	6.7%
Oklahoma	21.7%	36.7%	15.0%
Oregon	24.4%	32.9%	8.5%
Pennsylvania	25.2%	36.2%	11.0%
Rhode Island	20.0%	29.3%	9.3%
South Carolina	25.7%	34.1%	8.4%
South Dakota	22.2%	33.3%	11.1%
Tennessee	26.7%	34.1%	7.4%
Texas	26.6%	35.3%	8.7%
Utah	21.2%	29.7%	8.5%
Vermont	21.1%	25.9%	4.8%
Virginia	21.9%	31.0%	9.1%
Washington	21.2%	30.4%	9.2%
West Virginia	23.1%	36.4%	13.3%
Wisconsin	27.4%	31.8%	4.4%
Wyoming	24.3%	30.1%	5.8%
United States	24.6%	32.1%	7.5%

Methodology

Model Development

The measures and model for *America's Health Rankings® Senior Report* were developed by a panel of experts in the field of senior health. The panel was charged with identifying the areas of health and well-being most pertinent to the older adult population and developing a model for assessing population health at a state level.

The panel convened over a series of meetings to establish the broad categories and specific determinant measures as well as the outcomes that are most relevant and amenable to change. Concurrently with the meetings, a series of surveys were sent to each panel member in order to narrow down the list of possible measures and establish the current model. The weighting of each category within the model was similarly discussed and agreed upon by the panel in order to reflect their relative importance or contribution of each category towards the health of older Americans.

Senior Health Advisory Group

The Senior Health Advisory Group members include:

Richard Birkel, PhD, MPA
Senior Vice President, Center for Healthy Aging
Director, Self-Management Alliance
National Council on Aging

Randy Brown, PhD
Director of Health Research
Mathematica Policy Research

Julie Bynum, MD, MPH
Associate Professor of The Dartmouth Institute
Associate Professor of Medicine
Associate Director, Center for
Health Policy Research
The Dartmouth Institute for Health Policy &
Clinical Practice
Geisel School of Medicine at Dartmouth

David Martin, MD
Senior Medical Director & Vice President for
Clinical Innovation
UnitedHealthcare

Rhonda Randall, DO
Chief Medical Officer & Executive Vice President
UnitedHealthcare Medicare and Retirement

Barbara Resnick, PhD, RN, CRNP, FAAN, FAANP
Professor of Nursing
Chairman of the Board, American
Geriatrics Society
Sonya Ziporkin Gershowitz Chair in Gerontology
University of Maryland

Anna Schenck, PhD, MSPH
Professor of the Practice,
Associate Dean for Practice
Director, Public Health Leadership Program and
the North Carolina Institute for Public Health
UNC Gillings School of Global Public Health
University of North Carolina at Chapel Hill

Neil Wenger, MD, MPH
Director, Assessing Care of Vulnerable
Elders Project, RAND
Professor, Division of General Internal Medicine
and Health Services Research
David Geffen School of Medicine at UCLA

Tom Eckstein, MBA
Principal
Arundel Street Consulting, Inc.

Selection of Measures

Five primary considerations drove the design of *America's Health Rankings® Senior Report* and the selection of the individual measures:

1. The overall rankings had to represent a broad range of issues that affect senior population health.
2. Individual measures needed to use common health measurement criteria.
3. Data had to be available at a state level.
4. Data had to be current and updated periodically.
5. The aspect being measured had to be amenable to change.

While imperfect, the measures selected are believed to be the best available indicators of the various aspects of senior healthiness at this time.

As with all indices, the positive and negative aspects of each measure must be weighed when choosing and developing them. These aspects for consideration include: 1) the interdependence of the different measures; 2) the possibility that the overall ranking may disguise the effects of individual measures; 3) an inability to adjust all data by age and race; and 4) the use of indirect measures to estimate some effects on health. These concerns cannot be addressed directly by adjusting the methodology; however, assigning weights to the individual measures can mitigate their impact.

Methods

For each measure the raw data, as obtained from the stated sources and adjusted for age as appropriate, is presented and referred to as "value."

The score for each state is based on the following formula. The score is stated as a decimal.

$$\text{SCORE} = \frac{\text{STATE VALUE} - \text{NATIONAL MEAN}}{\text{STANDARD DEVIATION OF ALL STATE VALUES}}$$

Often referred to as a "Z-score", this score indicates the number of standard deviations a state is above or below the national mean. This results in a score of 0.00 for a state with the same value as the national mean. States that have a higher value than the national average will have a positive score while those with a lower value will have a negative score. Scores are calculated to 3 decimal places and, to prevent an extreme value from excessively influencing a final score, the maximum score any state could receive for a measure is plus or minus 2.

Where a value for the United States overall is not available, the national mean is set at the average value of the states.

The overall score was calculated by adding the scores of each measure multiplied by its percentage

of total overall ranking and the effect it has on health (see Table 1). Note: Scores reported for individual measures may not add up to the overall scores due to the rounding of numbers.

The ranking is the ordering of each state according to value. Ties in scores are assigned equal rankings.

Weighting of Measures

The combined weights of all measures total 100 percent. Determinants account for 75 percent of the overall ranking and outcomes account for 25 percent. Rather than assigning each measure an individual weight, weights were assigned to each category in the model. Within each category, the individual measures were weighted equally.

The weights are displayed in Table 22. The column labeled "% of Total" indicates the weight of each measure in determining the overall ranking. The column labeled "Effect on Score" presents how each measure positively or negatively relates to the overall ranking. For example, a high prevalence of smoking among older adults has a negative effect on the score and will lower the ranking of a state, whereas an increase in the percentage of older adults with controlled pain management has a positive effect on score and will increase the overall ranking of a state.

Health Disparities

Four metrics derived from the Behavioral Risk Factor Surveillance System—physical inactivity, obesity, social support, and health status—were examined for health disparities. Rates were calculated by sex, race/ethnicity (6 divisions), income (4 divisions), education (4 divisions), and urbanicity (3 divisions). The largest gap within each of these categories are noted as long as at least 100 observations are present for each division and the difference in the population rate exceeds 5 percent.

Race/ethnicity groups are non-Hispanic whites, non-Hispanic blacks, Hispanics, non-Hispanic Asians, Hawaiian / Pacific Islanders, and non-Hispanic Native Americans / Native Alaskans. Income divisions are less than \$25,000 household income, \$25,000 to \$50,000 household income, \$50,000 to \$75,000 household income and more than \$75,000 household income. Education divisions are college graduates, some college study, high school graduates or equivalent and less than high school graduate. The 3 divisions within urbanicity are urban (those in a center city within a Metropolitan Statistical Area (MSA)), suburban (those outside the center city in an MSA, those in suburban MSA and those in an MSA that has no center city) and non-MSA (those in counties that are not in an MSA). All categories are determined by self-report data.

Table 22
Weight of Measures

NAME OF MEASURE	% OF TOTAL	EFFECT ON SCORE
DETERMINANTS		
BEHAVIORS	25.0	
Smoking-Seniors	3.6	Negative
Chronic Drinking-Seniors	3.6	Negative
Obesity-Seniors	3.6	Negative
Underweight-Seniors	3.6	Negative
Physical Inactivity-Seniors	3.6	Negative
Dental Visits-Seniors	3.6	Positive
Pain Management-Seniors	3.6	Positive
COMMUNITY AND ENVIRONMENT-MACRO	10.0	
Poverty-Seniors	3.3	Negative
Volunteerism-Seniors	3.3	Positive
Highly-Rated Nursing Homes	3.3	Positive
COMMUNITY AND ENVIRONMENT-MICRO	10.0	
Social Support-Seniors	3.3	Positive
Food Insecurity-Seniors	3.3	Negative
Community Support-Seniors	3.3	Positive
POLICY	15.0	
Low-Care Nursing Home Residents	5.0	Negative
Creditable Drug Coverage-Senior	5.0	Positive
Geriatrician Shortfall	5.0	Negative
CLINICAL CARE	15.0	
Dedicated Health Care Provider-Seniors	1.5	Positive
Recommended Hospital Care-Seniors	1.5	Positive
Flu Vaccine-Seniors	1.5	Positive
Health Screenings-Seniors	1.5	Positive
Diabetes Management-Seniors	1.5	Positive
Home Health Care-Seniors	1.5	Positive
Preventable Hospitalizations-Seniors	1.5	Negative
Hospital Readmissions-Seniors	1.5	Negative
Hospice Care-Seniors	1.5	Positive
Hospital Deaths-Seniors	1.5	Negative
OUTCOMES	25.0	
ICU Usage-Seniors	3.1	Negative
Falls-Seniors	3.1	Negative
Hip Fractures-Seniors	3.1	Negative
Health Status-Seniors	3.1	Positive
Able-Bodied-Seniors	3.1	Positive
Premature Death-Seniors	3.1	Negative
Teeth Extractions-Seniors	3.1	Negative
Mental Health Days-Senior	3.1	Negative
OVERALL HEALTH RANKING	100.0	

*Note—the total of the individual weights may not add up to 100% due to the rounding of numbers.

Description of Measures

Table 23 summarizes each of the core measures, including data source and data year, in *America's Health Rankings® Senior Report*. A short discussion of each measure immediately follows. The data for each year is the most current data available at the time the report was compiled.

The full data tables are available at www.americashealthrankings.org/senior/defn.

Health Determinants

BEHAVIORS

Seven measures reflect behaviors that are potentially modifiable through a combination of personal, community, and clinical interventions: smoking, chronic drinking, obesity, underweight, physical inactivity, dental visits, and pain management. These health determinants measure behaviors and activities which have an immediate or delayed effect on the health of older Americans. However, the selection of these 7 measures does not imply that they are the only underlying behaviors that need to be addressed in a comprehensive public health effort to improve the health of older adults. Additional suggestions for individual initiatives for older adults are presented in *Healthy People 2020*, published by the U.S. Department of Health and Human Services, Washington, D.C., available at www.healthypeople.gov.

Smoking-Seniors is the percentage of the population aged 65 and older who smoke tobacco products regularly. It is defined as the percentage of adults aged 65 and older who self-report smoking at least 100 cigarettes in their lifetime and who currently smoke every day or some days. The senior ranks, based on data from CDC's 2011 Behavioral Risk Factor Surveillance System (BRFSS), are at www.americashealthrankings.org/all/smoking_sr.

Smoking has a very well documented adverse impact on overall health. It is the leading cause of preventable death in the United States. Tobacco use is estimated to be responsible for about 1 in 5 deaths, or about 443,000 deaths, per year.¹⁶ Smoking damages nearly every organ in the body and causes many diseases, including respiratory disease, heart disease, stroke, cancer, and premature death.¹⁷ Among adults aged 65 or older who smoke, men are twice as likely and women are 1.5

times as likely to die from a stroke as non-smokers in the same age group.¹⁸ Smoking is estimated to cost \$96 billion in direct medical expenses and \$97 billion in lost productivity annually.¹⁹ Not only are smokers themselves at increased risk for negative health consequences, so are those who are exposed to secondhand smoke, as it has serious effects on the population causing respiratory infections in children and heart disease and lung cancer in adults.²⁰

Smoking is a lifestyle behavior that an individual can directly influence with support from the community and, as required, clinical intervention. Cessation, even in a longtime smoker, can have profound benefits on current health status as well as long term outcomes.²¹ Smoking cessation in older adults can add years of life as well as improve the quality of life.²²

A wide variety of intervention types have been found to be effective in leading to smoking cessation at the individual and community levels.²³ Many policy efforts have been tried over the past several decades including excise taxes and smoking bans. Both of these policy approaches have been shown

-
16. Adhikari B. Smoking-attributable mortality, years of potential life lost, and productivity losses—United States, 2000–2004. *MMWR*. 2008;57(45):1226.
 17. Centers for Disease Control and Prevention (CDC). *Smoking and Tobacco Use*. June 2, 2012. <http://www.cdc.gov/tobacco/>. Accessed August 3, 2012.
 18. Centers for Disease Control and Prevention (CDC). Annual smoking-Attribute mortality, years of potential life lost, and economic costs – United States, 1995–1999. *MMWR*. 2002;51(4):3003-3.
 19. Agaku I, King B, Dube SR. Current cigarette smoking among adults—United States, 2011. *MMWR*. 2012;61(44):889-894.
 20. US Department of Health and Human Services. *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General*. Atlanta, GA: Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2006.
 21. US Department of Health and Human Services. *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General*. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2004.
 22. Kerr S, Watson H, Tolson D, Lough M, & Brown M. *Developing evidence-based smoking cessation training/education initiatives in partnership with older people and health professionals*. Caledonian Nursing & Midwifery Research Centre: Glasgow 2004.
 23. Lemmens V, Oenema A, Knut IK, Brug J. Effectiveness of smoking cessation interventions among adults: A systematic review of reviews. *European Journal of Cancer Prevention*. 2008;17(6):535.

to be tremendously effective in leading to cessation, preventing non-smokers from starting, and decreasing smoking-related health problems.²⁴ ²⁵ Due to the widespread negative health effects of secondhand smoke, reducing the prevalence of smoking and creating smoke-free environments can have a profound impact on the entire community.²⁶ For more information and resources to help you quit, visit www.smokefree.gov/.

The prevalence of smoking among adults aged 65 and older varies from 4.7 percent in Utah to 13.5 percent in Nevada. Nationally, the prevalence of adults aged 65 and older who currently smoke cigarettes is 8.9 percent.

Chronic Drinking-Seniors measures the percentage of the population aged 65 and older who drank heavily in the last 30 days. It is defined as more than 60 drinks in the last 30 days for men and more than 30 drinks in the last 30 days for women. The senior ranks, based on 2011 BRFSS self-report data, are at www.americashealthrankings.org/all/chronic_drinking_sr.

Excessive alcohol consumption can lead to

accidents, liver diseases, and cardiovascular diseases along with other health risks.²⁷ Excessive alcohol consumption is the third leading cause of preventable death in the United States, with an estimated 85,000 attributable deaths in 2000.²⁸ Among the older U.S. population, chronic drinking is the most troubling alcohol-related public health issue. Chronic drinking can lead to the development of liver diseases and neurological problems, as well as certain types of cancer.²⁴ Although moderate alcohol consumption has been shown to lower all-cause mortality rates in older adults, moderate consumption is limited to 1 drink a day for women and 2 drinks a day for men.²⁹ Studies have shown that there is a general decline in alcohol consumption as age increases.³⁰ However, it has also been postulated that alcohol abuse is poorly screened in older Americans and is likely under-detected.

The prevalence of chronic drinking among adults aged 65 and older varies from less than 2.0 percent in West Virginia, Tennessee, North Dakota, Alabama, and Mississippi to 6.9 percent in Alaska. Nationally, the percent of adults aged 65 and older who are chronic drinkers is 3.9 percent.

Obesity-Seniors is the percentage of the population aged 65 and older estimated to be obese, defined as having a body mass index (BMI) of 30.0 or higher. BMI, as defined by CDC, is equal to weight in pounds divided by height in inches squared and then multiplied by 703. CDC has a calculator for BMI at www.cdc.gov/nccdphp/dnpa/bmi/calc-bmi.htm. The senior ranks, based on self-reported weight and height from CDC's 2011 BRFSS data, are at www.americashealthrankings.org/all/obesity_sr.

Obesity is one of the greatest health threats to the United States. It contributes significantly to a variety of serious diseases, including heart disease, diabetes, stroke, and certain cancers, as well as poor general health.³¹ Obesity is a leading cause of preventable death in the nation, causing an estimated 200,000 deaths annually.³² The direct medical costs for treating obesity and obesity-related health problems are overwhelming. In 2008, it was estimated that \$147 billion was spent on obesity or obesity-related health issues.³³ Obesity is more prevalent than smoking and is

-
24. Chaloupka FJ. Effectiveness of tax and price policies in tobacco control. *Tob Control*. 2011;20(3):235.
 25. Naiman A. Association of anti-smoking legislation with rates of hospital admission for cardiovascular and respiratory conditions. *CMAJ*. 2010;182(8):761.
 26. US Department of Health and Human Services. *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General*. Atlanta, GA: Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2006.
 27. Centers for Disease Control and Prevention (CDC). *Alcohol and Public Health*. July 26, 2012. <http://www.cdc.gov/alcohol/>. Accessed August 3, 2012.
 28. Mokdad, AH. Actual causes of death in the United States, 2000. *JAMA* (Chicago, Ill.). 291.10 (2004):1238.
 29. Paganini-Hill A, Kawas CH, Corrada MM. Type of alcohol consumed, changes in intake over time and mortality: the Leisure World Cohort Study. *Age Ageing*. 2007 Mar;36(2):203-9.
 30. The International Center for Alcohol Policies. Module 23: Alcohol and the elderly. *The ICAP Blue Book: Practical Guides for Alcohol Policy and Prevention Approaches*. <http://www.icap.org/LinkClick.aspx?fileticket=JrDTh3DzjMw%3d&tabid=181> Accessed March 5, 2013.
 31. Centers for Disease Control and Prevention (CDC). *Overweight and Obesity*. May 24, 2012. <http://www.cdc.gov/obesity/>. Accessed July 24, 2012.
 32. Danaei G. The preventable causes of death in the United States: Comparative risk assessment of dietary, lifestyle, and metabolic risk factors. *PLoS Medicine*. 2009;6(4).
 33. Finkelstein EA, Trogon JG, Cohen JW, Dietz W. Annual medical spending attributable to obesity: Payer- and service-specific estimates. *Health Affairs*. 2009;28(5):w822-w831.

Table 23
Summary Description of Measures

CORE MEASURES

DETERMINANTS	DESCRIPTION	SOURCE	DATA YEAR(S)
BEHAVIORS			
Smoking-Seniors	Percentage of population aged 65 and older that smokes on a regular basis (smoked at least 100 cigarettes in their lifetime and currently smoke every day or some days).	CDC BRFSS	2011
Chronic Drinking-Seniors	Percentage of population aged 65 and older that drank heavily in the last 30 days (more than 60 drinks in the last 30 days for men and more than 30 drinks in the last 30 days for women).	CDC BRFSS	2011
Obesity-Seniors	Percentage of population aged 65 and older estimated to be obese, with a body mass index (BMI) of 30.0 or higher.	CDC BRFSS	2011
Underweight-Seniors	Percentage of population aged 65 and older with reported fair or better health status estimated to be underweight, with a body mass index (BMI) of 18.5 or less.	CDC BRFSS	2011
Physical Inactivity-Seniors	Percentage of population aged 65 and older with fair or better health status who report doing no physical activity or exercise (such as running, calisthenics, golf, gardening or walking) other than their regular job in the last 30 days.	CDC BRFSS	2011
Dental Visits-Seniors	Percentage of population aged 65 and older who report having visited a dental health professional within the last 12 months.	CDC BRFSS	2010
Pain Management-Seniors	Percentage of population aged 65 and older with arthritis who report arthritis or joint pain does not limit their usual activities.	CDC BRFSS	2011
COMMUNITY AND ENVIRONMENT			
COMMUNITY AND ENVIRONMENT—MACRO			
Poverty-Seniors	Percentage of adults aged 65 and older who live in households at or below 100% of the poverty threshold.	Census Bureau ACS	2011
Volunteerism-Seniors	Percentage of adults aged 65 and older who report volunteering through or for an organization in the past 12 months.	Federal Agency for Service and Volunteering, CPS	2009-2011
Highly-Rated Nursing Homes	Number of 4 and 5-star rated nursing home beds within the state per 1,000 adults aged 75 and older.	CMS	2011
COMMUNITY AND ENVIRONMENT—MICRO			
Social Support-Seniors	Percentage of adults aged 65 and older who receive sufficient social and emotional support.	CDC BRFSS	2011
Food Insecurity-Seniors	Percentage of adults aged 60 and older who are marginally food insecure.	Meals on Wheels Research Foundation	2010
Community Support-Seniors	Total expenditures captured by the Administration on Aging divided by the number of adults aged 65 and older living in poverty.	AoA and Census Bureau	2011

DETERMINANTS	DESCRIPTION	SOURCE	DATA YEAR(S)
POLICY			
Low-Care Nursing Home Residents	Proportion of residents in all facilities in the state on the first Thursday in April who were low care, according to the broad definition. (no physical assistance required for late-loss ADLs (bed mobility, toileting, transfer and eating))	Brown University	2010
Creditable Drug Coverage-Seniors	Percent of Medicare beneficiaries with a source of creditable drug coverage	Kaiser State Health Facts / CMS	2010
Geriatrician Shortfall	Percent of currently required geriatricians not available [estimated shortfall/minimum required number]	American Geriatric Society	2012
CLINICAL CARE			
Dedicated Health Care Provider-Seniors	Percentage of adults aged 65 and older who report having a personal doctor or health care provider.	CDC BRFSS	2011
Recommended Hospital Care-Seniors	Percentage of hospitalized patients aged 65 and older who received the recommended care for heart attack, heart failure, and pneumonia.	The Commonwealth Fund	2011
Flu Vaccine-Seniors	Percentage of adults aged 65 and older who received the flu vaccine in the last year.	CDC BRFSS	2011
Health Screenings-Seniors	Percentage of adults aged 65 to 74 who have had mammograms and/or fecal occult/colonoscopy/sigmoidoscopy screens at recommended intervals	CDC BRFSS	2010
Diabetes Management-Seniors	Percentage of Medicare enrollees receiving appropriate diabetes management.	Dartmouth Atlas	2010
Home Health Care-Seniors	Number of personal, home care, and home health aide direct care workers per 1,000 population aged 75 or older.	BLS and Census	2011
Preventable Hospitalizations-Seniors	Number of discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees.	Dartmouth Atlas	2010
Hospital Readmissions-Seniors	Percentage of patients aged 65 or older that were readmitted within 30 days of discharge.	Dartmouth Atlas	2010
Hospice Care-Seniors	Percentage of decedents aged 65 and older that were enrolled in hospice during the last 6 months of life after diagnosis of condition with high probability of death.	Dartmouth Atlas	2003-2007
Hospital Deaths-Seniors	Percentage of decedents aged 65 and older that died in a hospital.	Dartmouth Atlas	2003-2007
OUTCOMES			
ICU Usage-Seniors	Percentage of decedents aged 65 and older spending 7 or more days in the ICU/CCU during the last 6 months of life.	Dartmouth Atlas	2007
Falls-Seniors	Percentage of adults aged 65 and older who report having had a fall within the last 3 months.	CDC BRFSS	2010
Hip Fractures-Seniors	Rate of hospitalization for hip fracture per 1,000 Medicare Enrollees.	Dartmouth Atlas	2007
Health Status-Seniors	Percentage of adults aged 65 and older in very good or excellent health.	CDC BRFSS	2011
Able-Bodied-Seniors	Percentage of adults aged 65 and older with no disability.	Census ACS	2011
Premature Death-Seniors	Deaths per 100,000 adults aged 65-74.	CDC NCHS	2010
Teeth Extractions-Seniors	Percentage of adults aged 65 and older with full-mouth tooth extraction.	CDC BRFSS	2010
Mental Health Days-Senior	Number of days in the previous 30 days when a person aged 65 or older indicates their activities were limited due to mental health difficulties.	CDC BRFSS	2011

highly associated with chronic conditions and overall poor physical health, similar to smoking and excessive alcohol consumption.³⁴

The causes of obesity are complex and include lifestyle and the social and physical environment, as well as genes and medical history. Older adults have an increased likelihood of having poor diet and decreased physical activity, both of which are major lifestyle contributors to obesity.³⁵ Since the 1980s, energy intake has steadily climbed and energy expenditure has declined, leading to a growing energy imbalance which closely mirrors the obesity rates.³⁶ Growing evidence illustrates the importance of the environment in the obesity epidemic and the need for environmental change in order to better facilitate changes in lifestyle.³⁷

Successful interventions targeting a wide variety of populations with various strategies exist, from school based prevention programs to treatment interventions in aging adults.^{38, 39} While obesity is associated with an increased risk of developing previously mentioned health conditions, weight loss is associated with an attenuation of those risks.⁴⁰ The CDC has put together a list of useful resources for community level interventions aimed at lowering obesity rates, available at http://www.cdc.gov/obesity/downloads/community_strategies_guide.pdf.

The prevalence of obesity among adults aged 65 and older varies from 16.9 percent in Hawaii to more than 29.0 percent in Illinois, Iowa, Alaska, and Michigan. Nationally, the percent of adults aged 65 and older who are obese is 25.3 percent. A systematic review comparing measured height and weight with self-reported height and weight found that self-report respondents tend to overestimate height and underestimate weight.⁴¹ The prevalence rates presented are likely an underestimation of the true prevalence of obesity among older adults.

Underweight-Seniors is the percentage of the population aged 65 and older with fair or better health status who are estimated to be underweight, defined as having a body mass index (BMI) of 18.5 or lower. BMI, as defined by CDC, is equal to weight in pounds divided by height in inches squared and then multiplied by 703. CDC has a calculator for BMI at www.cdc.gov/nccdphp/dnpa/bmi/calc-bmi.htm. The senior ranks, based on self-reported weight and height from CDC's 2011 BRFSS data, are at www.americashealthrankings.org/all/underweight_sr.

Social isolation, poverty, psychological disorders, physiological function, medications, and poor

oral health are all factors that put older adults at an increased risk of being undernourished.⁴² Individuals of normal weight may also suffer from undernutrition, making it difficult for physicians to diagnose and treat.⁴³ While low weight is only one potential consequence of undernutrition, it is the most relevant measure available to assess undernutrition. Undernutrition may contribute to a weakened immune system, poor wound healing, confusion, and decreased capacity for rehabilitation.⁴⁴

Little research has been done on the benefits of reversing undernutrition. However, preliminary work shows improvements in immune function, biochemical deficiencies, weight, rehabilitation times, and length of hospital stays.⁴⁵ The Nutrition Screening Initiative has created a self-assessment tool to assist older adults in determining their nutritional health, available at http://www.joblearning.com/samples/0763730629/Frank_Appendix10D.pdf.

The prevalence of underweight among adults aged 65 and older varies from less than 1.5 percent in Illinois, Michigan, Ohio, Pennsylvania, Rhode Island, Texas, and Kentucky to more than 3.0 percent in New Mexico, Oklahoma, and Hawaii. Nationally, the percent of adults aged 65 and older who are underweight is 1.8 percent.

Physical Inactivity-Seniors is the percentage of the population aged 65 and older with fair or better health status who report doing no physical activity or exercise (such as running, calisthenics, golf, gardening, or walking) other than their

-
34. Sturm R. Does obesity contribute as much to morbidity as poverty or smoking? *Public Health*. 2001;115(3):229.
 35. Elsayy B, Higgins KE. Physical activity guidelines for older adults. *Am Fam Physician*. 2010; Jan 1; 82(1): 55-59.
 36. Finkelstein EA. Economic causes and consequences of obesity. *Annu Rev Public Health*. 2005;26(1):239.
 37. Papas MA. The built environment and obesity. *Epidemiol Rev*. 2007;29(1):129.
 38. Shaya FT. School based obesity interventions: A literature review. *J Sch Health*. 2008;78(4):189.
 39. McTigue KM. Obesity in older adults: A systematic review of the evidence for diagnosis and treatment. *Obesity*. 2006;14(9):1485.
 40. Malnick SDH. The medical complications of obesity. *QJM*. 2006;99(9):565.
 41. Gorber SC, Tremblay M, Moher D, Gorber B. A comparison of direct vs. self-report measures for assessing height, weight and body mass index: A systematic review. *Obesity Reviews*. 2007;8(4):307-326. doi: 10.1111/j.1467-789X.2007.00347.x.
 42. Rauscher C. Malnutrition among the elderly. *Canadian Family Physician*. 1993;39(June):1395-1403.
 43. Ibid.
 44. Sullivan D, Patch G, Walls R, Lipschitz D. Impact of nutrition status on morbidity and mortality in a select population of geriatric rehabilitation patients. *American Journal of Clinical Nutrition*. 1990;51:749-58.
 45. Goode H, Penn N, Kelleher J, Walker B. Evidence of cellular zinc depletion in hospitalized but not in healthy elderly subjects. *Age Ageing*. 1991;20:345-48.

regular job in the last 30 days. The senior ranks, based on self-reports from CDC's 2011 BRFSS data, are at www.americashealthrankings.org/all/physical_inactivity_sr.

A natural process of aging is a decrease in muscle mass and strength, making it challenging for many older adults to continue to be active as they age. Physical inactivity increases the risk of developing cardiovascular disease, diabetes, hypertension, obesity, and premature death.^{46, 47} It is associated with many social and environmental factors as well, including low educational attainment, socioeconomic status, violent crime, and poverty.⁴⁸ Physical inactivity is responsible for an estimated \$24 billion in direct medical spending⁴⁹ and almost 200,000, or 1 in 10, deaths each year.⁵⁰

Fortunately, physical activity has been shown to increase bone density, reduce falls, and help to lessen depression in older Americans.⁵¹ Increasing physical activity, especially from a complete absence, can not only prevent numerous chronic diseases, it can also help to manage them.⁵² Even moderate increases in physical activity can greatly reduce risk for adverse health outcomes. For resources and tips on how older Americans can add physical activity to their lives, see <http://www.cdc.gov/physicalactivity/everyone/guidelines/olderadults.html>.

The prevalence of physical inactivity among adults aged 65 and older varies from 20.5 percent

in Colorado to more than 41.0 percent in West Virginia and Tennessee. Nationally, the percent of adults aged 65 and older who are physically inactive is 30.3 percent.

Dental Visit-Seniors is the percentage of the population aged 65 and older who report having visited a dental health professional within the last 12 months. The senior ranks, based on self-reports from CDC's 2010 BRFSS data, are at www.americashealthrankings.org/all/dental_visit_sr.

As we age, oral health becomes a larger contributor to overall health. Oral health naturally declines with age, and if routine care is not utilized problems can quickly arise. This fact, combined with low access to dental care for many older adults, has led to increased rates of dental diseases among this age group and a large disparity between races.⁵³ Periodontal diseases are associated with chronic disease, including cardiovascular disease, cerebrovascular disease, diabetes, and oral cancer.⁵⁴ In addition to increasing the risk for chronic disease, poor oral health can also have a large impact on quality of life, particularly the ability to chew, speak, and interact socially. The greatest dental need reported by older adults is routine oral hygiene.⁵⁵ The American Dental Association provides resources and tips on how to maintain oral health for adults over 60 at <http://www.mouthhealthy.org/en/adults-over-60/>.

The prevalence of annual dental visits among adults aged 65 and older varies from less than 51.0 percent in Mississippi and West Virginia to 79.8 percent in Connecticut. Nationally, the percent of adults aged 65 and older who visited a dental health professional within the last 12 months is 69.2 percent.

Pain Management-Seniors is the percentage of the population aged 65 and older with arthritis who report that arthritis or joint pain does not limit their usual activities. The senior ranks, based on self-reports from CDC's 2011 BRFSS data, are at www.americashealthrankings.org/all/pain_management_sr.

The leading cause of disability in the United States is arthritis, causing reduced functionality and often interfering with activities of daily living (ADL).⁵⁶ Arthritis limits activity more frequently than heart disease, cancer, and diabetes.⁵⁷ Osteoarthritis, the most prevalent form of arthritis, is a progressive degenerative joint disease that is more common in older, overweight, and obese individuals, as well as those who have a history of joint injury.⁵⁸ This form of arthritis is often

-
46. Hu FB. Sedentary lifestyle and risk of obesity and type 2 diabetes. *Lipids*. 2003;38(2):103.
 47. King AC. Environmental and policy approaches to cardiovascular disease prevention through physical activity: Issues and opportunities. *Health Education Behavior*. 1995;22(4):499.
 48. King AC. Personal and environmental factors associated with physical inactivity among different racial-ethnic groups of US middle-aged and older-aged women. *Health Psychology*. 2000;19(4):354.
 49. Colditz GA. Economic costs of obesity and inactivity. *Med Sci Sports Exerc*. 1999;31(11 Suppl):S663-7.
 50. Danaei G. The preventable causes of death in the United States: Comparative risk assessment of dietary, lifestyle, and metabolic risk factors. *PLoS Medicine*. 2009;6(4).
 51. Evans WJ. Exercise training guidelines for the elderly. *Med Sci Sports Exerc*. 1999 Jan;31(1):12-7.
 52. Weiler R, Stamatakis E, Blair S. Should health policy focus on physical activity rather than obesity? Yes. *BMJ*. 2010;340(7757):1170-1171.
 53. National Institute of Dental and Craniofacial Research. *Periodontal Disease in Seniors (Age 65 and Over)*. 2011. <http://www.nidcr.nih.gov/DataStatistics/FindDataByTopic/GumDisease/PeriodontaldiseaseSeniors65over>. Accessed January 22, 2013.
 54. American Academy of Periodontology. *Gum Disease and Other Diseases*. 2013. <http://www.perio.org/consumer/other-diseases>. Accessed January 22, 2013.
 55. Kiyak HA, Grayston MN, Crinean CL. Oral health problems and needs of nursing home residents. *Community Dentistry and Oral Epidemiology*. 1993;21(1):49-52.
 56. Arthritis Foundation. *Arthritis Foundation*. 2013. <http://www.arthritis.org/>. Accessed January 22, 2013.
 57. Ibid.
 58. Arthritis Foundation. *A National Public Health Agenda for Osteoarthritis 2010*. 2010:1-62.

associated with symptoms of pain, aches, stiffness, and swelling.⁵⁹ Osteoarthritis is preventable and manageable, though many adults associate its symptoms with normal aging and many cases go untreated.⁶⁰ For resources and tips on how to prevent and manage arthritis, see <http://www.cdc.gov/arthritis/basics/key.htm>.

The prevalence of adults aged 65 and older with arthritis who report that arthritis or joint pain does not limit their usual activities varies from 42.5 percent in Alaska to 60.7 percent in Maryland. Nationally, the percent of adults aged 65 and older with arthritis who report that arthritis or joint pain does not limit their usual activities is 51.7 percent.

Community and Environment

Measures of community and environment reflect the daily conditions influencing a healthy life. These aspects can be modified by a concerted effort by the community and its elected officials, supported by state and federal agencies, professional associations, advocacy groups, and businesses.

Community and environment is divided into 2 sub-categories: macro and micro. The macro community and environment consists of the larger, external environment impacting health: poverty, volunteerism, and nursing homes with high quality of care and services. The micro community and environment focuses on factors that directly affect the health of individuals: social support, food insecurity, and funding for community support for seniors.

These determinants measure both positive and negative aspects of the community and environment of each state and their effects on the population's health. Again, there are many additional community efforts that improve the overall health of a population but are not directly reflected in these 6 measures. Each community has its own strengths, challenges, and resources and should undertake a careful planning process to determine which action plans are best for them.

MACRO Community and Environment

Poverty-Seniors is the percentage of adults aged 65 and older who live in households at or below the poverty threshold. The poverty threshold established by the U.S. Census Bureau for a single person aged 65 and older in the lower 48 states is \$10,788 in household income. For a household with 2 individuals aged 65 and older, the income threshold is \$13,609. The senior ranks, based on 2011 data (2011 American Community Survey, Washington, D.C., U.S. Census Bureau), are at

www.americashealthrankings.org/all/poverty_sr.

The effect of poverty on health has been clearly documented with higher rates of many chronic diseases and shorter life expectancy.^{61,62} Poverty directly influences an individual's ability to meet their basic needs including lack of access to health care, limited availability of healthy foods, and constrained choices for physical activity. There are many federal, state, and local government programs and community interventions that have helped to reduce the number of older adults in poverty, yet poverty and its negative effects on health persist today. A 2011 article reported that 1 in 6 older adults live in poverty.⁶³ This number is likely higher than reported, due to the difficult nature of assessing poverty in the senior population.⁶⁴ The recent economic crisis also affected many seniors, impacting their pension incomes, retiree health benefits, and Medicaid assistance.⁶⁵ Many older adults are not aware of how to maintain economic stability, particularly when they are at increased risk for sudden high expenditures due to emergency medical care.⁶⁶

The percentage of adults aged 65 and older living at or below the poverty threshold varies from a low of 5.1 percent in Alaska to a high of 13.5 percent in Mississippi. The national average is 9.3 percent of adults aged 65 and older.

Volunteerism-Seniors is the percentage of adults aged 65 and older who report volunteering through or for an organization in the past 12 months. This data is a 3-year average of respondents from the years 2009 to 2011. The senior ranks, based on data from the 2011 Current Population Survey (CPS) fielded by the Federal Agency for Service and Volunteering and the U.S. Census Bureau, are at www.americashealthrankings.org/all/volunteerism_sr.

59. Ibid.

60. Arthritis Foundation. *Arthritis Foundation*. 2013. <http://www.arthritis.org/>. Accessed January 22, 2013.

61. Fiscella K. Poverty or income inequality as predictor of mortality: longitudinal cohort study. *BMJ*. 314.7096 (1997):1724.

62. Adler NE, Ostrove JM. Socioeconomic status and health: What we know and what we don't. *Ann N Y Acad Sci*. 1999;896(1):3-15.

63. Schwartz K. *One in six seniors lives in poverty, new analysis finds*. National Council on Aging. January 24, 2011. <http://www.ncoa.org/press-room/press-release/one-in-six-seniors-lives-in.html>. Accessed on January 29, 2013.

64. Cooper RA, Cooper MA, McGinley EL, Fan X, Rosenthal JT. Poverty, wealth, and health care utilization: a geographic assessment. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*. 2012;89(5):828-47.

65. Keller S, Brown G, Koerner J. Developing 21st century models of care for seniors in challenged urban settings. *Nurs Admin Q*. 2010;34(2):172-7.

66. Schwartz K. *One in six seniors lives in poverty, new analysis finds*. National Council on Aging. January 24, 2011. <http://www.ncoa.org/press-room/press-release/one-in-six-seniors-lives-in.html>. Accessed on January 29, 2013.

americashealthrankings.org/all/volunteerism_sr.

Retirement often provides seniors with additional free time that some choose to fill with volunteer activities. Volunteering not only provides a service for communities and organizations but also provides seniors with social interaction and altruistic feelings. Additionally, it gives retired older adults a constructive way to fill time and provides opportunities for new learning, promoting improved cognition.⁶⁷ Studies have shown that older adults who volunteer have better cognitive performance, fewer depressive symptoms, higher activity levels, and better mental well-being than seniors who do not volunteer.^{68, 69} Seniors who volunteer for multiple organizations were found to report a higher life satisfaction and perceived health over older adults who only volunteer for one organization.⁷⁰ There is also a positive relationship with the number of hours spent volunteering and reported satisfaction with life.⁷¹ To find volunteer opportunities in your interest and geographic area, visit <http://www.aarp.org/giving-back/info-09-2012/volunteer-community-service-charity.html>.

The percentage of adults aged 65 and older who volunteer varies from a high of 39.3 percent in Iowa to a low of less than 18.0 percent in Nevada and Florida. The national average is 26.0 percent of adults aged 65 and older.

Highly-Rated Nursing Homes is the number of 4 or 5-star quality nursing home beds within the state per 1,000 adults aged 75 and older. The

senior ranks, based on data from the Centers for Medicaid and Medicare Services (CMS) Nursing Home Compare program, are at www.americashealthrankings.org/all/highly_rated_nursing_homes_sr.

The Centers for Medicare and Medicaid Services created a 5-star quality rating system for nursing homes to assist older adults and their families to more easily find an appropriate facility for their needs. Nursing homes receiving 5 stars are considered to be above average quality, while those receiving 1 star are considered to have below average quality. The star rating of a nursing home is based upon the results of regular health inspections, quality measures, and staffing levels. The quality measures include numerous clinical measures and outcomes that provide an indication of how well a nursing home cares for its patients, such as the percent of residents with pressure ulcers.⁷² It is important to note not only the number of highly-rated nursing homes in a state, but also the number of beds in these high quality facilities. The Nursing Home Compare website allows users to compare nursing homes in their area to find one that will best fit their needs (<http://www.medicare.gov/NursingHomeCompare/>).

The number of 4 or 5 star-rated nursing home beds per 1,000 adults aged 75 and older varies from a high of 65.2 beds in North Dakota to a low of 15.7 beds in Alaska. The national average of 4 or 5 star nursing home beds is 41.0 beds per 1,000 adults aged 75 and older.

MICRO Community and Environment

Social Support-Seniors is the percentage of adults aged 65 and older who report receiving the social and emotional support they need on a regular basis. The senior ranks, based on self-reports from CDC's 2011 BRFSS data, are at www.americashealthrankings.org/all/social_support_sr.

Social relationships are an integral part of life, playing a large role in emotional fulfillment and cognitive function.⁷³ The number of these relationships tends to decline with age for numerous reasons, though the need for them expands with additional free time and difficult life situations. Social isolation is associated with increased overall morbidity and mortality, specifically heart disease and certain cancers.^{74, 75, 76} It also indirectly modifies health behaviors, lifestyle, stress levels, and punctual usage of health care.^{77, 78} The World Health Organization states that social isolation is associated with "increased rates of premature death, lower general well-being, more depression, and a higher level of disability from chronic diseases".⁷⁹

-
67. Schwingel A, Niti MM, Tang C, Pin Ng T. Continued work employment and volunteerism and mental well-being of older adults: Singapore longitudinal ageing studies. *Age Ageing*. 2009;38:531-7.
 68. Ibid.
 69. Van Willigen M. Differential benefits of volunteering across the life course. *Journal of Gerontology*. 2000;55B(5):S308-18.
 70. Ibid.
 71. Ibid.
 72. CMS.gov. *Five-Star Quality Rating System*. Center for Medicare & Medicaid Services. January 17, 2013. <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/FSQRS.html> Accessed February 12, 2013.
 73. Ibid.
 74. House JS, Landis KR, Umberson D. Social relationships and health. *Science*. 1988;241(4865):540-45.
 75. Knox SS, Adelman A, Ellison C, Arnett DK, Siegmund K, Weidner G, Province MA. Hostility, social support, and carotid artery atherosclerosis in the National Heart, Lung, and Blood Institute Family Heart Study. *Am J Cardiol*. 2000;86:1086-9.
 76. Price MA, Tennant CC, Butow PN, Smith RC, Kennedy SJ, Kossoff MB, Dunn SM. The role of psychosocial factors in the development of breast carcinoma: Part II. Life event stressors, social support, defense style, and emotional control and their interactions. *Cancer*. 2001;91:686-97.
 77. Cohen S, Wills TA. Stress, social support, and the buffering hypothesis. *Psychol Bull*. 1985;98:310-57.
 78. Hawkley LC, Cacioppo JT. Loneliness and pathways to disease. *Brain, Behavior, and Immunity*. 2003;17:S98-105.
 79. The social determinants of health: the solid facts-2nd edition. *World Health Organization*. 2003.

The effectiveness of social isolation intervention strategies have not been researched rigorously, though offering social activity in group formats has shown to be the most effective intervention strategy to date.⁸⁰

The prevalence of adults aged 65 and older who report that they receive the social and emotional support they need varies from a high of 85.4 percent in Oregon to a low of 65.8 percent in Hawaii. Nationally, the percent of adults aged 65 and older who report that they receive needed social support is 79.4 percent.

Food Insecurity-Seniors is the percentage of adults aged 60 and older who are marginally food insecure. Respondents that answer yes to one or more questions on the Core Food Security Module (CFSM) are considered marginally food insecure. The CFSM contains 10 to 18 questions depending on whether or not the household contains children. Each question is designed to capture some aspect of food insecurity. The senior ranks, based on 2010 data from the Meals on Wheels Research Foundation's (now National Foundation to End Senior Hunger (NFESH)) *Senior Hunger in America 2010: An Annual Report*, are at www.americashealthrankings.org/all/food_insecurity_sr. Due to data availability, this measure also includes adults aged 60-64.

Food insecurity is a rising public health issue in the United States and older adults are at an increased risk of facing hunger due to lack of income and transportation, functional limitations, or health related issues.⁸¹ Older adults require adequate nutrition to maintain health and well-being. Food insecure older adults have been found to have significantly reduced intakes of vital nutrients compared to food secure older adults, which could have tremendous implications on overall health.⁸² Older adults who face hunger may have to choose between food and other key necessities such as medical care or heat. Unfortunately, households with older adults are also less likely to receive financial support through the Supplemental Nutrition Assistance Program (SNAP).⁸³ The Feeding America group has several resources for applicable assistance programs for seniors, available at <http://feedingamerica.org/how-we-fight-hunger/programs-and-services.aspx>.

The percentage of adults aged 60 and older who are marginally food insecure varies from a low of 5.5 percent in North Dakota to a high of more than 21.0 percent in New Mexico and Mississippi. The national average of marginally food insecure seniors is 13.6 percent of adults aged 60 and older.

Community Support-Seniors is the total community expenditures per adult aged 65 and older living in poverty. This is calculated by taking the total community expenditures divided by the number of adults aged 65 and older living in poverty to represent the amount of funding that could be spent on individuals in need. The senior ranks, based on data from the 2011 Administration on Aging (AOA) and the 2011 American Community Survey Census Bureau, are at www.americashealthrankings.org/all/community_support_sr.

States receive federal grants and allocate state funds to help support older adults through home and community-based services. Specifically, they may assist in the funding of personal care, congregate meals, transportation, and nutrition education programs for seniors within their state. These programs help to provide older adults with improved access to multiple services in an effort to improve the quality of life for their seniors. Please visit your state Department of Human Services website to learn about programs and services that are funded in your area.

The total expenditures captured by the AOA vary from a high of \$8,033 per adult aged 65 and older living in poverty in Alaska to a low of \$283 per adult aged 65 and older living in poverty in Nevada. The national average community support expenditure is \$1,147 per adult aged 65 and older living in poverty.

Policy

Three measures are used to represent public health policies and programs: low-care nursing home residents, creditable drug coverage, and geriatrician shortfall. These measures are indicative of the policies that affect available resources to support aging adults.

Every state has several excellent and effective policies and public health programs that contribute to the overall health of the senior population but may not be explicitly included in these rankings. Contact your state public health officials to obtain additional information about policies and programs in your state that are enacted to optimize

80. Dickens AP, Richards SH, Greaves CJ, Campbell JL. Interventions targeting social isolation in older people: a systematic review. *BMC Public Health*. 2011;11(647):1-22.

81. Wolfe WS, Frongillo EA, Valois P. Understanding the experience of food insecurity by elders suggests ways to improve its measurement. *J Nutr*. 2003;133:2762-9.

82. Lee JS, Frongillo EA. Nutritional and health consequences are associated with food insecurity among U.S. elderly persons. *J Nutr*. 2001;131:1503-9.

83. Ziliak JP, Gunderson C. Senior hunger in the United States: differences across states and rural and urban areas. *University of Kentucky Center for Poverty Research Special Reports*. 2009.

individual senior and community health. Each state's health department website is listed in the corresponding state snapshot. Individuals can also see the spectrum of options available to states and communities by visiting www.thecommunityguide.org, a website that provides a systemic review of programs and evidence-based recommendations for health and community officials. Although it is not senior-specific, it shows what is available in different communities.

Low-Care Nursing Home Residents is the proportion of residents in all facilities in the state on the first Thursday in April who were low-care using a broad definition of no physical assistance required in any of the 4 late-loss activities of daily living (ADLs)—bed mobility, transferring, using the toilet, and eating. The senior ranks, based on 2010 data from "Shaping Long Term Care in America Project" at Brown University funded in part by the National Institute on Aging (1P01AG027296), are at www.americashealthrankings.org/all/low_care_nursing_home_residents_sr.

Low-care nursing home residents do not require the suite of services provided by nursing homes and may be able to live in a less restrictive environment with the aid of community support. Community-based services—such as Meals on Wheels, visiting home health aides, transportation programs, and technology-delivered healthcare programs—can allow older adults to age in place. A recent study found that the more states invest in home-delivered meal programs, the lower the proportion of low-care nursing home residents.⁸⁴ Several studies have found that the rate of low-care nursing home residents is related to Older Americans Act (OAA) funded programs and Medicaid expenditures on home and community-based services.^{85, 86, 87} The OAA of 1965 was directed to provide services to assist seniors in remaining independent and in their homes and

communities. Programs under the OAA provide federal funding to states for services such as in-home assistance, home-delivered meals, and preventive health services. In addition, Medicaid, which offers similar services, provides long-term care funding for those who qualify.

The percentage of low-care nursing home residents varies from a low of 1.1 percent of nursing home residents in Maine to a high of 26.7 percent in Illinois. The national average of low-care nursing home residents is 12.2 percent.

Creditable Drug Coverage-Seniors is the percentage of adults aged 65 and older who have a creditable prescription drug plan. A creditable plan must provide coverage for brand name and generic prescriptions, provide reasonable access to retail providers, pay on average at least 60 percent of participants' prescription drug expenses and must satisfy one of several other conditions established by the Centers for Medicare and Medicaid Services. The senior ranks, based on 2010 data obtained from the Kaiser Family Foundations State Health Facts, are at www.americashealthrankings.org/all/creditable_drug_coverage_sr.

Individuals may have creditable drug coverage from one of several sources: Medicare Part D, a current or former employer, or individual insurance plans. Having prescription drug coverage plays a significant impact on the overall health of older adults, allowing for less financial strain and the ability to follow their physician's treatment recommendations. The enactment of Medicare Part D in 2003 has had a positive outcome on the use of prescription medications and savings for older Americans.⁸⁸

The percentage of adults aged 65 and older with creditable drug coverage varies from a high of more than 89.0 percent in Iowa and Minnesota to a low of 78.3 percent in New Hampshire. The national average of adults aged 65 and older with creditable drug coverage is 86.5 percent.

Geriatrician Shortfall is the percentage of currently required geriatricians not available. It is calculated by taking the shortage of geriatricians in each state divided by the number needed, as determined by the American Geriatrics Society's 2012 report. The senior ranks are at www.americashealthrankings.org/all/geriatrician_shortfall_sr.

In 2012, there were 7,356 geriatricians in the United States, a number that drastically falls below the current need.⁸⁹ With an aging baby boomer generation and increases in life expectancy, the number of geriatricians needed is

-
84. Thomas KS, Mor V. The relationship between Older Americans Act Title III state expenditures and prevalence of low-care nursing home residents. *Health Serv Res.* 2012 Dec 3.
 85. Thomas KS, Mor V. The relationship between Older Americans Act Title III state expenditures and prevalence of low-care nursing home residents. *Health Serv Res.* 2012 Dec 3.
 86. Castle NG. Low-care residents in nursing homes: the impact of market characteristics. *J Health Soc Policy.* 2002;14(3):41-58.
 87. Hahn EA, Thomas KS, Hyer K, Andel R, Meng H. Predictors of low-care prevalence in Florida nursing homes: the role of Medicaid waiver programs. *Gerontologist.* 2011 Aug;51(4):495-503.
 88. Yin W, Basu A, Zhang JX, et al. The effect of the Medicare Part D prescription benefit on drug utilization and expenditures. *Ann Intern Med.* 2008;148:169-177.
 89. Projected future need for geriatricians. *American Geriatrics Society.* 2012.

going to increase dramatically in the coming years.^{90, 91} Part of the shortfall could be due to extra schooling for geriatricians and low salaries.⁹² The Institute of Medicine has laid out several strategies to help fight this shortfall. For more details, visit <http://www.iom.edu/Reports/2008/Retrofitting-for-an-Aging-America-Building-the-Health-Care-Workforce.aspx>.

The percentage of geriatrician shortfall varies from a low of 16.3 percent in Hawaii to a high of 90.4 percent in Idaho. The national average of estimated geriatrician shortfall is 65.6 percent.

Clinical Care

Clinical care has the potential to enable people to live longer and healthier by treating and managing existing conditions and preventing others. Preventive and curative care must be delivered in an appropriate and timely manner in order for it to be most effective. Clinical care is particularly important for the senior population as they are the heaviest consumers of health care. Ten measures are included in this section: dedicated health care provider, recommended hospital care, flu vaccine, health screenings, diabetes management, home health care, preventable hospitalizations, hospital readmissions, hospice care, and hospital deaths. These clinical care measures provide information about the availability, utilization, and efficacy of clinical care among the older adult population.

Dedicated Health Care Provider-Seniors is the percentage of adults aged 65 and older who report having a personal doctor or health care provider. The senior ranks, based on 2011 BRFSS self-report data, are at www.americashealthrankings.org/all/dedicated_health_care_provider_sr.

Having a usual source of care through a health care provider with whom there is an existing relationship is important for the best clinical care. With dedicated care, seniors are more easily able to receive routine care that could prevent disease, detect disease early, and manage existing conditions to help maintain health and quality of life. Individuals without usual care are more likely to have costly trips to the emergency room for non-urgent problems as well as for avoidable acute problems.⁹³ Additionally, they have been shown not to receive appropriate preventive and ambulatory care leading to poor health outcomes for many conditions, such as hypertension.^{94, 95} Older adults face numerous obstacles in obtaining a dedicated health care provider with whom they can develop a relationship, including limited

access, financial constraints, and a lack of overall knowledge of the services and providers available to them. The official U.S. government site for Medicare provides a list of Medicare-enrolled physicians and healthcare professionals in your area, at <http://www.medicare.gov/find-a-doctor/provider-search.aspx>.

The percentage of adults aged 65 and older who report having a personal doctor or health care provider ranges from 96.8 percent in Delaware to 88.1 percent in Wyoming. Nationally, 94.9 percent of older adults report having a personal doctor or health care provider.

Recommended Hospital Care-Seniors is the percentage of hospitalized patients aged 65 and older who received the recommended care for the conditions of heart attack, heart failure, pneumonia, and surgical procedures. The senior ranks, based on 2011-2012 data from The Commonwealth Fund, are at www.americashealthrankings.org/all/recommended_hospital_care_sr.

Seniors account for a disproportionate share of hospitalizations representing only around 12 percent of the population, but more than a third of hospitalizations.⁹⁶ The conditions assessed in this measure are all part of the Centers for Medicare and Medicaid service's quality initiative and were chosen due to their validity and acceptance as quality care. Failure to provide the recommended care means that patients are more likely to return to the hospital for additional treatment. Ensuring that patients receive the recommended care for these conditions not only provides better quality care, but could also lead to cost savings.

The percentage of hospitalized adults aged 65 and older receiving recommended hospital care ranges from 98.4 percent in Alabama and Vermont to 96.7 percent in New Mexico and Rhode Island. The national average is 97.6 percent.

90. Herdman R, McHugh M, Harris T, Wheatley B, Bruno M, Urmanaviciute R, Park M. Retooling for an aging America: building the health care workforce. *Institute of Medicine*. 2008.

91. *Ibid.*

92. *Ibid.*

93. Sarver JH, Cydulka RK, Baker DW. Usual Source of Care and Nonurgent Emergency Department Use. *Acad Emerg Med*. 2002; 9:916-923.

94. DeVoe JE, Fryer GE, Phillips R, Green L. Receipt of preventive care among adults: insurance status and usual source of care. *Am J Public Health*. 2003;93(5):786-91.

95. Shea S, Misra D, Ehrlich MH, Field L, Francis CK. Predisposing factors for severe, uncontrolled hypertension in an inner-city minority population. *N Engl J Med*. 1992;327:776-81.

96. Spector W, Mutter R, Owens P, et al. Transitions between Nursing Homes and Hospitals in the Elderly Population, 2009: Statistical Brief #141. 2012 Sep. In: *Healthcare Cost and Utilization Project (HCUP) Statistical Briefs*. Rockville (MD): Agency for Health Care Policy and Research (US); 2006.

Flu Vaccine-Seniors is the percentage of adults aged 65 and older who reported receiving the flu vaccine in the last year. The senior ranks, based on the CDC's 2011 BRFSS data, are at www.americashealthrankings.org/all/flu_vaccine_sr.

The flu vaccine helps protect individuals against seasonal influenza virus, a contagious respiratory illness that can cause severe illness in older adults. It is recommended that all individuals who are at least 6 months old receive a yearly flu vaccine, and older adults are strongly encouraged to get one as they are at an increased risk of contracting the virus.⁹⁷ Death is the most serious outcome from influenza and 90 percent of flu-related deaths occur in individuals aged 65 and older. Two forms of the flu vaccine are available for seniors—a regular dose shot and a higher-dose shot that was specifically designed for people aged 65 and older.⁹⁸ The higher-dose flu shot is meant to elicit a stronger immune response to better equip a senior's body to fight the flu virus.⁹⁹ Medicare covers the cost of one flu vaccine per year.¹⁰⁰ For resources and information on flu and prevention methods, visit www.flu.gov.

The percentage of adults aged 65 and older who received a flu vaccine within the past year ranges from 70.2 percent in Iowa and Louisiana to 51.8 percent in Alaska. Nationally, 60.6 percent of adults aged 65 and older received a flu vaccine within the past year.

Health Screenings-Seniors is the percentage of adults aged 65 to 74 who have had mammograms and/or fecal occult/colonoscopy/sigmoidoscopy screens all within the recommended time period. The senior ranks, based on self-reported data from CDC's 2010 Behavioral Risk Factor Surveillance System (BRFSS), are at www.americashealthrankings.org/all/health_screenings_sr.

Health screenings detect disease in its early stages when it is most effectively treated. This measure not only reveals the percent of older

adults receiving the recommended screenings, but also provides an indication of whether or not routine visits to a health professional are taking place. The U.S. Preventive Services Task Force recommends that women aged 50 to 74 years receive a breast cancer screening mammogram every 2 years and that current evidence is insufficient to assess if the benefits of mammography outweigh the harms in women 75 years and older.¹⁰¹ They also recommend that older adults receive regular screening for colorectal cancer beginning at age 50 years and continuing until age 75 years. They do not recommend routine screening in adults over the age of 75.¹⁰² Mammography and colorectal cancer screening tests have saved thousands of lives since their inception and are some of the most important weapons in the fight against cancer.¹⁰³ Although the recommendations for cancer screening have changed in recent years, health screenings are still widely accepted and are an important part of preventative medicine. Individuals may not receive these health screenings for many reasons, including access, financial resources, and fear or stigma. This measure is currently limited to cancer screening due to data availability. Health screening goes beyond cancer and includes simple things like blood pressure and cholesterol checks. Breast cancer and colorectal cancer screening guidelines are at http://www.cdc.gov/cancer/breast/basic_info/screening.htm and http://www.cdc.gov/cancer/colorectal/basic_info/screening/guidelines.htm.

The percentage of adults aged 65 to 74 who have received the recommended screenings ranges from a high of 91.7 percent in Massachusetts to a low of 77.9 percent in Oklahoma. Nationally, 86.5 percent of adults aged 65 to 74 have received the recommended screenings.

Diabetes Management-Seniors is the percentage of Medicare beneficiaries aged 65 to 75 receiving appropriate diabetes management. The senior ranks, based on 2010 data (The Dartmouth Atlas of Health Care, The Dartmouth Institute for Health Policy and Clinic Practice, Lebanon, N.H.), are at www.americashealthrankings.org/all/diabetes_management_sr.

Diabetes is often an outcome of an unhealthy lifestyle and is more than a disease itself as it increases one's risk of developing many other diseases and complications. There are 3 major types of diabetes: type 1 diabetes, type 2 diabetes, and gestational diabetes. Of these, type 2 diabetes accounts for 90 to 95 percent of all

97. Seniors. U.S. Department of Health and Human Services. Web site. www.flu.gov/at-risk/seniors/index.html#. Accessed January 23, 2013.

98. Ibid.

99. Ibid.

100. Ibid.

101. U.S. Preventive Services Task Force. *Screening for Breast Cancer*. Rockville, Maryland: Agency for Healthcare Research and Quality, 2009.

102. U.S. Preventive Services Task Force. *Screening for Colorectal Cancer: U.S. Preventive Services Task Force Recommendation Statement*. AHRQ Publication 08-05124-EF-3, October 2008. Agency for Healthcare Research and Quality, Rockville, MD.

103. Cantor I. "Controversies in Cancer Screening: Focusing on Colorectal Cancer Recommendations." *Integrative Cancer Therapies*. 9.4 (2010): 322-325.

cases and is the most common type of diabetes in the Medicare population.¹⁰⁴ Type 2 diabetes is a largely preventable progressive disease that can be managed through lifestyle modifications and health care interventions. It is a major cause of heart disease and stroke as well as the leading cause of kidney failure, non-traumatic lower limb amputations, and blindness in adults.¹⁰⁵ Overall it is the seventh leading cause of death in the United States and contributes to the first and third leading causes of death, stroke and heart disease respectively.¹⁰⁶ Direct medical costs for type 2 diabetes exceed \$100 billion and account for \$1 of every \$10 spent on medical care in the United States.¹⁰⁷ It is associated with older age, and proper management is critical in the senior population to prevent further complications. Additional diabetes information for seniors is available at the National Center for Chronic Disease Prevention and Health Promotion, CDC (www.cdc.gov/diabetes/ and www.cdc.gov/nccdphp/publications/aag/ddt.htm) and the American Diabetes Association (<http://www.diabetes.org/living-with-diabetes/seniors/>).

The percent of Medicare enrollees who receive appropriate diabetes management ranges from a high of 86.1 percent in Florida to a low of 61.0 percent in Wyoming. The national average is 80.7 percent of Medicare enrollees.

Home Health Care-Seniors is the number of personal, home care, and home health aide direct care workers per 1,000 people aged 65 or older. The senior ranks, based on 2011 data (Bureau of Labor Statistics and the Census Bureau), are at www.americashealthrankings.org/all/home_health_care_sr.

Most older adults want to stay in the homes they have lived in for years, but with aging can come a loss of function, making it more difficult to remain at home.¹⁰⁸ Home health and personal care aides play a significant role in enabling seniors to remain in their homes and can be used for either short-term periods (such as while recovering from a surgery) or for longer periods (for those suffering from chronic illnesses). They help seniors to live independently longer and include a range of assistance levels, from skilled nursing to assistance with activities of daily living.¹⁰⁹ Increases in state funding through Medicare and Medicaid over the past decade have helped to make home living more widely available to the senior population.¹¹⁰ A list of available options covered through Medicare can be found at Medicare.org.

The availability of home health care workers varies from a high of 290 workers per 1,000 adults

65 years and older in Alaska to a low of 29.1 workers per 1,000 adults aged 65 and older in Florida. The national average is 93.8 home health care workers per 1,000 adults aged 65 and older.

Preventable Hospitalizations-Seniors is a measure of the discharge rate of Medicare enrollees aged 65 to 99 with ambulatory care-sensitive conditions. Ambulatory care-sensitive conditions are those “for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.”¹¹¹ These conditions are based on ICD-9-CM diagnosis codes and include: convulsions, chronic obstructive pulmonary disease (COPD), bacterial pneumonia, asthma, congestive heart failure (CHF), hypertension, angina, cellulitis, diabetes, gastroenteritis, kidney/urinary infection, and dehydration. The senior ranks, based on 2010 data (The Dartmouth Atlas of Health Care, The Dartmouth Institute for Health Policy and Clinic Practice, Lebanon, N.H.), are at www.americashealthrankings.org/all/preventable_hospitalizations_sr.

Preventable hospitalizations reflect how efficiently a population uses the various health care delivery options for necessary care. Hospital care is expensive and makes up the largest component of health care spending in the nation, totaling over \$750 billion.¹¹² Preventable hospitalizations often occur as a result of a failure to treat conditions early in an outpatient setting due to limited availability.¹¹³ These discharges are also highly

104. Fisher ES, Goodman DC, Chandra A. Disparities in health and health care among Medicare beneficiaries: a brief report of the Dartmouth Atlas. *Dartmouth Atlas*. 2008;1-20.

105. Centers for Disease Control and Prevention (CDC). *National Diabetes Fact Sheet: National Estimates and General Information on Diabetes and Prediabetes in the United States*. 2011.

106. Heron M. Deaths: Leading causes for 2007. *National Vital Statistics Reports*; vol 59, no 8. Hyattsville, MD: National Center for Health Statistics. 2011.

107. American Diabetes Association. Economic costs of diabetes in the U.S. in 2007. *Diabetes Care*. 2008;31(3):596-615.

108. Eckert JK, Morgan LA, Swamy N. Preferences for receipt of care among community-dwelling adults. *Journal of Aging & Social Policy*. 2004;16(2):49-65.

109. Facts: Home Health Care. Administration on Aging. 2013. http://www.aoa.gov/aoaroot/Press_Room/Products_Materials/fact/pdf/Home_Health_Care. Accessed February 5, 2013.

110. Mollica R. Coordinating services across the continuum of health, housing, and supportive services. *Journal of Aging and Health*. 2003;15(1):165-88.

111. Agency for Health Care Research and Quality. Prevention quality indicators overview. <http://www.qualityindicators.ahrq.gov/>. Updated 2003. Accessed August 3, 2012.

112. The Kaiser Family Foundation. *Trends in Health Care Costs and Spending*. 2009;7692-02.

113. Billings J. Recent findings on preventable hospitalizations. *Health Aff*. 1996;15(3):239.

correlated with general admissions and reflect the tendency for a population to overuse the hospital setting as a site for care. Preventable hospitalizations place a financial burden on health care systems as they could have been avoided with earlier less costly interventions. Preventable hospitalizations are more common in those who are uninsured, which often leads to large unpaid medical bills.¹¹⁴

The rate of preventable hospitalizations ranges from a low of under 30 discharges per 1,000 Medicare enrollees in Hawaii and Utah to 103 discharges per 1,000 Medicare enrollees in Kentucky. The national average is 67 discharges per 1,000 Medicare enrollees.

Hospital Readmissions-Seniors is the percentage of patients aged 65 and older that were readmitted within 30 days of being discharged from the hospital. The senior ranks, based on 2010 data (The Dartmouth Atlas of Health Care, The Dartmouth Institute for Health Policy and Clinic Practice, Lebanon, N.H.), are at www.americashealthrankings.org/all/hospital_readmissions_sr.

Older adults utilize emergency services at increased rates and are more likely to be readmitted compared to their younger counterparts.¹¹⁵ A 2007 Medicare report found that 17.6 percent of hospital admissions resulted in readmission and \$15 billion in spending.¹¹⁶ There are numerous reasons why a patient may need to go back to the hospital, including confusion regarding prescribed medication, miscommunication of necessary information to patients, or improper follow-up care.¹¹⁷ Readmission rates differ by the reason for the initial hospitalization as well, with heart attacks and pneumonia admittance on average having

higher readmission rates than patients entering the hospital for surgery.¹¹⁸ Some readmissions may be unavoidable, but steps can be taken to greatly reduce the number of readmissions that are avoidable. Several approaches to identify seniors at an increased risk of readmission have been proposed and found to be good predictors of readmission.¹¹⁹ Dartmouth Atlas has a resource for patients with steps to take to prevent readmissions (http://www.dartmouthatlas.org/downloads/reports/Atlas_CAYC_092811.pdf).

The percent of adults aged 65 and older that were readmitted within 30 days of being discharged from a hospital varies from a low of 12.3 percent in Utah to a high of 16.9 percent in Kentucky and Rhode Island. Nationally, 15.9 percent of adults aged 65 and older are readmitted within 30 days after being discharged from a hospital.

Hospice Care-Seniors is the percentage of decedents aged 65 and older who were enrolled in hospice care during the last 6 months of life after a diagnosis with 1 of 9 chronic conditions with a high probability of death. The senior ranks, based on 2010 data (The Dartmouth Atlas of Health Care, The Dartmouth Institute for Health Policy and Clinic Practice, Lebanon, N.H.), are at www.americashealthrankings.org/all/hospice_care_sr.

Hospice care is utilized by terminally ill patients and can be provided in a health care facility or in one's home. Its emphasis is on pain control and emotional support of the patient and their family. Hospice care is available to a person of any age, though seniors made up 83.3 percent of hospice patients in 2011.¹²⁰ Most hospice care is provided in the home, and the number of individuals receiving this care has drastically increased in the past decade.¹²¹ This increase has been in part due to the increase in Medicare-certified hospices, along with the fact that Medicare is the largest payer of hospice care.¹²² There is a huge disparity among hospice users, with white patients accounting for 82.8 percent of hospice patients in 2011.¹²³ More information and resources on hospice care can be found at the National Hospice and Palliative Care Organization (<http://www.nhpco.org/>).

The percent of decedents aged 65 and older who were enrolled in hospice care in the last 6 months of life varies from a high of 54.5 percent in Arizona to a low of 15.6 percent in Alaska. Nationally, 36.7 percent of decedents aged 65 and older were enrolled in hospice care during the last 6 months of life.

114. Weissman JS. Rates of avoidable hospitalization by insurance status in Massachusetts and Maryland. *JAMA*. 1992;268(17):2388.

115. Aminzadeh F, Dalziel WB. Older adults in the emergency department: a systematic review of patterns of use, adverse outcomes, and effectiveness of interventions. *Ann Emerg Med*. 2002;39(3):238-47.

116. Medicare Payment Advisory Commission. Report to the Congress: Promoting Greater Efficiency in Medicare. *Medpac*. 2007:1-297.

117. Care about your care: Tips for patients when they leave the hospital. *Dartmouth Atlas*. 2011.

118. Ibid.

119. Graf CE, Giannelli SV, Herrmann FR, Sarasin FP, Michel JP, Zekry D, Chevalley T. Identification of older patients at risk of unplanned readmission after discharge from the emergency department: Comparison of two screening tools. *Swiss Medical Weekly*. 2012;141:1-9.

120. National Hospice and Palliative Care Organization. *Facts and Figures: Hospice Care in America*. October 2012:1-15.

121. Ibid.

122. Ibid.

123. Ibid.

Hospital Deaths-Seniors is the percent of decedents aged 65 and older who died in a hospital. The senior ranks, based on 2003-2007 data (The Dartmouth Atlas of Health Care, The Dartmouth Institute for Health Policy and Clinical Practice, Lebanon, N.H.), are at www.americashealthrankings.org/all/hospital_deaths_sr.

Most seniors would prefer to die in the comfort of their own home, with hospice care as the second most preferred location.¹²⁴ Despite the overwhelming preference for death at home, many seniors live out the last few days of life in the hospital. Death in the hospital occurs for many reasons, but in many circumstances it is avoidable and the patient could have died in a more comfortable environment. In the past decade, the percentage of Medicare patients dying in hospitals has declined, though this overall trend for the U.S. differs significantly across regions.¹²⁵

The percent of decedents aged 65 and older who died in a hospital ranges from 19.2 percent in Utah to 39 percent in New York. Nationally, 30.1 percent of decedents aged 65 and older died in a hospital.

Health Outcomes

Health outcomes are traditionally measured using mortality measures, but in this report, outcomes focus on quality of life and well-being among older adults rather than mortality. These measures represent outcomes resulting from current or prior behaviors and clinical care, and from community, environment, and policy influences. Health outcomes for older adults include ICU usage, falls, hip fractures, health status, able-bodied, premature death, teeth extractions, and mental health days.

ICU Usage-Seniors is the percentage of decedents aged 65 and older spending 7 or more days in an Intensive Care Unit (ICU) or Critical Care Unit (CCU) in their last 6 months of life. These data are derived from the Medicare Provider Analysis and Review and tabulated by the Dartmouth Atlas. Rates are adjusted for age, sex and race. The senior ranks, based on 2007 data from the Dartmouth Atlas, are at www.americashealthrankings.org/all/ICU_usage_sr.

Overuse of the critical care system is costly and often goes against the wishes of many dying patients. End-of-life care accounts for a quarter of all Medicare spending.¹²⁶ While not correlated with better outcomes or a longer life, ICU usage is correlated with the availability of ICU hospital beds. Physicians in areas with greater availability of beds are more likely to utilize ICU beds regardless

of the patients' status, illness or wishes. Research indicates that many patients receive care that they would not choose given the choice in the final days of life.¹²⁷ Areas with greater ICU usage are high use areas in other aspects as well, including physician visits and hospitalizations. Overuse places a huge amount of stress on a system already struggling to meet demands.

The percentage of decedents aged 65 and older who spent 7 or more days in the ICU/CCU in their last 6 months of life varies from a low of 5.1 percent in Vermont to a high of 24.7 percent in New Jersey. Nationally, 15.2 percent of decedents aged 65 and older spent 7 or more days in the ICU/CCU in their last 6 months of life.

Falls-Seniors is the percentage of adults aged 65 and older who report falling at least once within the last 3 months. The senior ranks, based on 2011 data from the Centers for Disease Control and Prevention's (CDC) Behavioral Risk Factor Surveillance System (BRFSS), are at www.americashealthrankings.org/all/falls_sr.

Annually, 1 in 3 adults aged 65 and older fall; 20 to 30 percent of these falls result in injuries that affect the ability to carry on with daily activities.^{128, 129} Falls and their resulting injuries may limit mobility, contribute to social isolation, and even cause premature death. Medicare's average cost of a fall is between \$9,000 and \$13,000 and the total direct medical costs of falls in 2000 were estimated at \$19 billion.¹³⁰ Falls often lead to hip fractures which are often painful, costly, and severely limit mobility for long periods of time. The risk of falls, as well as the risk of an injury, increase with age making falls particularly problematic for persons over age 75.

The percentage of adults aged 65 and older reporting a fall within the past 3 months ranges

124. Higginson IJ, Sen-Gupta GJA. Place of care in advanced cancer: A qualitative systematic literature review of patient preferences. *Journal of Palliative Medicine*. 2000;3(3):287-300.

125. Goodman DC, Esty AR, Fisher ES, Chang CH. Trends and Variation in end-of-life care for Medicare beneficiaries with severe chronic illness. *Dartmouth Atlas Project*. April 12, 2011.

126. Riley, Gerald F., and James D. Lubitz. "Long Term Trends in Medicare Payments in the Last Year of Life." *Health services research* 45.2 (2010): 565-576.

127. Lorenz, Karl A., et al. "Evidence for improving palliative care at the end of life: a systematic review." *Annals of Internal Medicine* 148.2 (2008): 147.

128. Hausdorff JM, Rios DA, Edelberg HK. Gait variability and fall risk in community-living older adults: a 1-year prospective study. *Archives of Physical Medicine and Rehabilitation*. 82.8 (2001): 1050.

129. Stevens JA, Mack KA, Paulozzi LJ, et al. Self-reported falls and fall-related injuries among persons aged ≥ 65 years—United States, 2006. *MMWR*. 2008; 57: 225–9.

130. Stevens JA, et al. The costs of fatal and non-fatal falls among older adults. *Injury Prevention*.12.5 (2006): 290-295.

from a low of 12.9 percent in Maryland to 23.9 percent in Alaska. Nationally, 16.1 percent of adults aged 65 and older report falling in the past 3 months.

Hip Fractures-Seniors is the rate of hospitalization for hip fracture per 1,000 Medicare enrollees. The senior ranks, based on 2007 Dartmouth Atlas data, are at www.americashealthrankings.org/all/hip_fractures_sr.

Hip fractures are serious injuries in older adults that often result in hospitalization, surgery, and extensive rehabilitation, often in a long term care facility. A hip fracture may signal the end of independence for many; 1 in 4 previously independent older adults remain in a long term care facility a year after injury.¹³¹ In 2007, there were over 280,000 hospitalizations nationwide for hip fractures, and as many as 1 in 5 persons with a hip fracture will die within a year of the injury.¹³² Osteoporosis, physical inactivity, poor vision, certain medications, and general frailty can all contribute towards falls and hip fractures. Individual and community-level prevention strategies are needed to minimize the risk of falls and hip fractures.

The rate of hospitalizations for hip fractures among Medicare enrollees ranges from a low of 3.0 hospitalizations per 1,000 Medicare enrollees in Hawaii to a high of 9.2 hospitalizations per 1,000 Medicare enrollees in Oklahoma. The rate nationally is 7.3 hospitalizations for hip fractures per 1,000 Medicare enrollees.

Health Status-Seniors is the percentage of adults aged 65 and older who report that their

health is very good or excellent. The senior ranks, based on 2011 data from the Centers for Disease Control and Prevention's (CDC) Behavioral Risk Factor Surveillance System (BRFSS), are at www.americashealthrankings.org/all/health_status_sr.

Self-reported health status is an indicator of the population's self-perceived health. It is a subjective measure of health that is not limited to certain health conditions or outcomes. It is influenced by life experience, the health of loved ones, and many other factors affecting one's overall well-being such as social support.^{133, 134} Research has shown that those with a poorer self-reported health status have higher rates of mortality from all causes.¹³⁵ The association between health status and mortality makes it a good predictor of not only future mortality rates, but also future health care use as persons with poor health status will likely seek care.¹³⁶

The percent of adults aged 65 and older who report very good or excellent health varies from a high of 48.9 percent in Vermont to a low of 28.5 percent in Mississippi. Nationally, 38.4 percent of adults aged 65 and older report very good or excellent health.

Able-Bodied-Seniors measures the percent of adults aged 65 and older with no disability. The senior ranks, based on 2011 data (U.S. Census Bureau's Annual Community Survey (ACS)), are at www.americashealthrankings.org/all/able-bodied_sr.

Disability can take many shapes, from physical to mental, and has many causes. It can be the outcome of lifestyle, disease, accidents, and/or aging. Over 40 percent of adults aged 65 and older report some sort of disability that interferes with their daily lives.¹³⁷ Seniors with a disability are more likely to require hospitalization and long-term care than seniors without disability.¹³⁸ While some disabilities are largely unavoidable, the extent to which they interfere with a person's life can be influenced through things at the personal level, such as exercise and the use of special equipment or aids. The burden of disability can also be influenced at the community level through programs which allow seniors the ability to remain independent, such as senior transportation programs, home-delivered meals, and those aimed at making communities more accessible for persons with a disability.

The prevalence of able-bodied adults aged 65 and older ranges from a high of 68 percent in Minnesota to a low of 54 percent in Mississippi. The prevalence nationally is 63.2 percent of adults aged 65 and older.

-
131. Magaziner J, et al. Recovery from hip fracture in eight areas of function. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences*. 55.9 (2000): M498-M507.
 132. Leibson CL, et al. Mortality, disability, and nursing home use for persons with and without hip fracture: a population-based study. *Journal of the American Geriatrics Society*. 50.10 (2002): 1644-1650.
 133. Idler E. In sickness but not in health: Self-ratings, identity, and mortality. *J Health Soc Behav*. 2004;45(3):336.
 134. Amstadter AB, et al. Prevalence and correlates of poor self-rated health in the United States: the national elder mistreatment study. *The American Journal of Geriatric Psychiatry: Official Journal of the American Association for Geriatric Psychiatry* 18.7 (2010): 615.
 135. DeSalvo KB. Mortality prediction with a single general self-rated health question. *Journal of General Internal Medicine*. 2006;21(3):267.
 136. DeSalvo KB. Predicting mortality and healthcare utilization with a single question. *Health Serv Res*. 2005;40(4):1234
 137. US Department of Health and Human Services. *The Surgeon General's Call to Action to Improve the Health and Wellness of Persons with Disabilities*. (2005).
 138. McColl MA, et al. Disentangling the effects of disability and age on health service utilisation. *Disability and Rehabilitation*. 33.13-14 (2011): 1253-1261.

Premature Death-Seniors is the number of deaths per 100,000 adults aged 65 to 74, or the number of deaths that occur within the first decade of being a senior. The senior ranks, based on 2010 data (National Center for Health Statistics, Centers for Disease Control and Prevention), are at www.americashealthrankings.org/all/premature_death_sr.

Premature death is a measure of mortality that reflects the age of death for older adults under 75 years of age. According to 2009 mortality data, cancer, heart disease, chronic lower respiratory diseases, cerebrovascular disease and diabetes are the top 5 causes of death among older adults aged 65 to 74 years in the United States.¹³⁹ Many of these causes of death are preventable through lifestyle modifications. Lung cancer is the largest contributor towards premature cancer deaths, and smoking cessation can greatly decrease the risk of lung cancer. Heart disease is tied to several modifiable risk factors such as obesity, diabetes, and physical inactivity. Diabetes is often an outcome of an unhealthy lifestyle and increases one's risk of developing many other diseases and complications. Type 2 diabetes is associated with numerous modifiable risk factors such as smoking, obesity, physical activity, and diet which make it an ideal target for prevention.¹⁴⁰ A variety of intervention strategies that encourage healthy lifestyles and preventive care can be effective in decreasing premature death in older adults.

The premature death rate varies from a low of 1,425 deaths per 100,000 adults aged 65 to 74 in Hawaii to almost twice that in Mississippi with 2,558 deaths per 100,000 adults aged 65 to 74. Nationally, the premature death rate among older adults is 1,909 deaths per 100,000 adults aged 65 to 74.

Teeth Extractions-Seniors is the percentage of adults aged 65 and older who have had all of their teeth extracted. The senior ranks, based on

self-reports from CDC's 2010 BRFSS data, are at www.americashealthrankings.org/all/teeth_extractions_sr.

Teeth extractions are performed for several reasons, including disease/decay, trauma, or crowding, with untreated dental caries and periodontal disease being the most common.¹⁴¹ The absence of natural teeth may be indicative of a poor diet or limited access to oral health care. Older adults without their natural teeth are at increased risk of heart disease and stroke.¹⁴² The percentage of older adults without their natural teeth is decreasing, likely due to improved access to oral health care, public water fluoridation programs and reduced smoking rates.¹⁴³ Currently there are 2 methods to deal with teeth extraction, dentures or implantation, though implantation preference is on the rise among dentists.¹⁴⁴

The prevalence of adults aged 65 and older with full-mouth tooth extraction ranges widely from a low of 7.4 percent in Hawaii to a high of 36.0 percent in West Virginia. The prevalence of full-mouth tooth extraction nationally is 16.5 percent of adults aged 65 and older.

Mental Health Days-Seniors is the average number of days in the previous 30 days that a

139. Heron M. Deaths: Leading causes for 2009. National vital statistics reports; vol 61 no 7. Hyattsville, MD: National Center for Health Statistics. 2012.

140. Schulze MB. Primary prevention of diabetes: What can be done and how much can be prevented? *Annu Rev Public Health*. 2005; 26(1):445.

141. U.S. Department of Health and Human Services. Oral health in America: A report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health; 2000. Available from: <http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/sgr/>.

142. Holm-Pedersen P, Schultz-Larsen K, Christiansen N, Avlund K. Tooth loss and subsequent disability and mortality in old age. *J Am Geriatr Soc* 2008;56(3):429-35.

143. National Center for Health Statistics. Health, United States, 2011: With Special Feature on Socioeconomic Status and Health. Hyattsville, MD. 2012.

144. Di Fiore PM, Tam L, Thai HT, Hittelman E, Norman RG. Retention of teeth versus extraction and implant placement: treatment preferences of dental faculty and dental students. *J Dent Educ*. 2008 Mar;72(3):352-8.

person aged 65 and older could not perform work or household tasks due to mental illness. The self-reported data relies on the accuracy of each respondent's estimate of the number of limited activity days they experienced in the previous 30 days. The senior ranks, based on 2011 data (Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention), are at www.americashealthrankings.org/all/mental_health_days_sr.

Poor mental health days provide a general indication of health related quality of life, mental distress, and the burden that more serious mental illnesses place on the older adult population. Good mental health is essential to good overall health and wellness. Poor mental health days are an assessment of the impact of poor mental health on wellness. The number of poor mental health days is also a predictor of future health as it predicts 1-month and 12-month office visits and hospitalizations.¹⁴⁵ In extreme cases, poor mental health can lead to suicide, which is the 11th leading cause of death for all ages. The medical costs of mental illness are estimated to be approximately \$100 billion annually.¹⁴⁶ Although occasional short periods of mental distress and a few poor mental health days may be unavoidable, more prolonged and serious episodes are treatable and preventable through early interventions.¹⁴⁷

The number of poor mental health days per month varies from 1.5 days in the previous 30 days in Hawaii, Iowa, and South Dakota to 3.0 days in the previous 30 days in Illinois. The national rate is 2.4 days in the previous 30 days.

145. Dominick KL, Ahern FM, Gold CH, Heller DA. Relationship of health-related quality of life to health care utilization and mortality among older adults. *Aging Clin Exp Res*. 2002;14:499-508.

146. Mark TL, Levit KR, Buck JA, Coffey RM, Vandivort-Warren R. Mental health treatment expenditure trends, 1986–2003. *Psychiatric Services*. 2007;58:1041–1048.

147. Moriarty DG. Geographic patterns of frequent mental distress: US adults, 1993–2001 and 2003–2006. *Am J Prev Med*. 2009;36(6):497.

State-By-State Snapshots

The following pages describe the overall ranking, strengths, challenges, and highlights for each state. To compare your state to other states, go to www.americashealthrankings.org.

On each state's snapshot, there is a separate paragraph that describes aspects of the health disparities among older adults within the state. The measures Obesity, Physical Inactivity, Social Support, and Health Status were examined for disparities by race/ethnicity, education levels, income levels, sex, and urbanicity. For disparity information for all states, see page 13.

Each snapshot also contains supplemental measures on education, multiple chronic conditions, cognition, and depression. These items have significant, and largely unchangeable, impact on the population's health. For a review of supplemental measures for all states, see page 21.

In addition, each snapshot looks at the 15-year projected increase in state populations aged 65 and older from 2015 to 2030. See page 20 for a review of the projected 15-year increase for all states. Each state snapshot also provides a comparison of the health status and obesity rates of today's older adults when they were aged 50 to 64 years to those who are currently aged 50 to 64, so we can begin to understand what to expect over the next 15 years as the next generation of older adults ages. See page 22 for a comparison of health status for all states and page 24 a comparison of obesity for all of the states.

ALABAMA

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	10.2	38	4.7
	Chronic Drinking (Percent of adults age 65+)	1.9	4	1.4
	Obesity (Percent of adults age 65+)	27.1	39	16.9
	Underweight (Percent of adults age 65+)	2.0	25	1.1
	Physical Inactivity (Percent of adults age 65+)	36.9	44	20.5
	Dental Visits (Percent of adults age 65+)	60.2	43	79.8
	Pain Management (Percent of adults age 65+)	50.4	33	60.7
	BEHAVIORS TOTAL	-0.118	44	
	COMMUNITY & ENVIRONMENT			
	C&E — MACRO PERSPECTIVE	-0.032	34	
	Poverty (Percent of adults age 65+)	10.8	40	5.1
	Volunteerism (Percent of adults age 65+)	20.4	39	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	51.1	12	65.2
	C&E — MICRO PERSPECTIVE	-0.056	42	
	Social Support (Percent of adults age 65+)	79.0	35	85.4
	Food Insecurity (Percent of adults age 60+)	17.3	45	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$517	40	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	-0.088	36	
	POLICY			
	Low-Care Nursing Home Residents (Percent of residents)	14.5	35	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	88.4	5	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	78.0	45	16.3
	POLICY TOTAL	-0.022	35	
	CLINICAL CARE			
	Dedicated Health Care Provider (Percent of adults age 65+)	95.4	18	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	98.4	1	98.4
	Flu Vaccine (Percent of adults age 65+)	62.6	20	70.2
	Health Screenings (Percent of adults age 65–74)	84.3	31	91.7
	Diabetes Management (Percent of Medicare enrollees)	79.7	29	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	47.2	44	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	80.1	44	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	15.3	18	12.3
	Hospice Care (Percent of decedents age 65+)	41.9	13	54.5
	Hospital Deaths (Percent of decedents age 65+)	33.5	44	19.2
	CLINICAL CARE TOTAL	0.004	23	
	ALL DETERMINANTS	-0.223	41	
	OUTCOMES			
	ICU Usage (Percent of decedents age 65+)	14.1	33	5.1
	Falls (Percent of adults age 65+)	15.6	18	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	8.8	47	3.0
	Health Status (Percent very good or excellent of adults age 65+)	31.1	47	48.9
	Able-Bodied (Percent of adults age 65+)	56.4	48	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	2,403	47	1,425
	Teeth Extractions (Percent of adults age 65+)	25.5	45	7.4
	Mental Health Days (Days in previous 30 days)	2.8	46	1.5
	ALL OUTCOMES	-0.276	47	
	OVERALL	-0.499	44	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	16.6	42	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	36.8	38	20.9
Cognition (Percent of adults age 65+)	12.0	46	5.7
Depression (Percent of adults age 65+)	15.6	41	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	44.0	39.6
Obesity (Percent obese)	24.2	39.2

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	40.5	52.7

Overall Rank: 44

Determinants Rank: 41

Outcomes Rank: 47

Strengths:

- Low prevalence of chronic drinking
- High percentage of seniors who received recommended hospital care
- High percentage of creditable drug coverage

Challenges:

- High prevalence of physical inactivity
- Low prevalence of able-bodied seniors
- High premature death rate

Ranking: Alabama is 44th in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 45th for its entire population.

Highlights:

- Alabama ranks 4th for a low prevalence of chronic drinking at 1.9 percent of adults aged 65 and older.
- Alabama has a high geriatrician shortfall at 78.0 percent of the number of geriatricians needed.
- In Alabama, 17.3 percent of adults aged 60 and older, or 114,000 seniors, are marginally food insecure.
- A high percentage of hospitalized seniors receive recommended care at 98.4 percent of hospitalized adults aged 65 and older.
- Physical inactivity is widespread in Alabama; 36.9 percent of adults aged 65 and older, or more than 240,000 seniors, are inactive.

Disparities: In Alabama, 50.7 percent of seniors with less than a high school degree are physically inactive compared to 22.5 percent of seniors with a college degree.

State Health Department Website:

www.adph.org



For a more detailed look at this data, visit www.americashealthrankings.org/senior/AL

ALASKA

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	12.4	49	4.7
	Chronic Drinking (Percent of adults age 65+)	6.9	50	1.4
	Obesity (Percent of adults age 65+)	29.3	49	16.9
	Underweight (Percent of adults age 65+)	1.7	13	1.1
	Physical Inactivity (Percent of adults age 65+)	25.9	9	20.5
	Dental Visits (Percent of adults age 65+)	66.0	33	79.8
	Pain Management (Percent of adults age 65+)	42.5	50	60.7
	BEHAVIORS TOTAL	-0.242	50	
COMMUNITY & ENVIRONMENT				
C&E — MACRO PERSPECTIVE				
	Poverty (Percent of adults age 65+)	5.1	1	5.1
	Volunteerism (Percent of adults age 65+)	31.1	11	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	15.7	50	65.2
C&E — MICRO PERSPECTIVE				
	Social Support (Percent of adults age 65+)	79.4	31	85.4
	Food Insecurity (Percent of adults age 60+)	16.0	38	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$8,033	1	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	0.074	18	
POLICY				
	Low-Care Nursing Home Residents (Percent of residents)	12.2	27	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	81.4	48	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	61.8	21	16.3
	POLICY TOTAL	-0.088	43	
CLINICAL CARE				
	Dedicated Health Care Provider (Percent of adults age 65+)	88.7	49	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.8	18	98.4
	Flu Vaccine (Percent of adults age 65+)	51.8	50	70.2
	Health Screenings (Percent of adults age 65–74)	81.7	44	91.7
	Diabetes Management (Percent of Medicare enrollees)	66.0	49	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	290.0	1	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	54.5	11	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	13.6	2	12.3
	Hospice Care (Percent of decedents age 65+)	15.6	50	54.5
	Hospital Deaths (Percent of decedents age 65+)	31.1	34	19.2
	CLINICAL CARE TOTAL	-0.064	44	
	ALL DETERMINANTS	-0.320	44	
OUTCOMES				
	ICU Usage (Percent of decedents age 65+)	8.3	12	5.1
	Falls (Percent of adults age 65+)	23.9	50	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	7.3	27	3.0
	Health Status (Percent very good or excellent of adults age 65+)	40.2	18	48.9
	Able-Bodied (Percent of adults age 65+)	57.9	43	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	1,935	33	1,425
	Teeth Extractions (Percent of adults age 65+)	16.2	21	7.4
	Mental Health Days (Days in previous 30 days)	2.3	23	1.5
	ALL OUTCOMES	-0.044	32	
	OVERALL	-0.364	40	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	24.7	11	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	20.9	1	20.9
Cognition (Percent of adults age 65+)	10.9	40	5.7
Depression (Percent of adults age 65+)	19.2	50	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	59.3	55.3
Obesity (Percent obese)	26.4	31.4

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	69.6	52.7

Overall Rank: 40

Determinants Rank: 44

Outcomes Rank: 32

Strengths:

- Low percentage of seniors living in poverty
- High community support expenditures
- Ready availability of home health care workers

Challenges:

- High prevalence of chronic drinking
- High prevalence of activity-limiting arthritis pain
- Low rate of highly-rated nursing home beds

Ranking: Alaska is 40th in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 28th for its entire population.

Highlights:

- The rate of highly-rated nursing home beds is lowest in Alaska at 15.7 beds per 100,000 adults aged 75 and older.
- A low percentage of Alaskan seniors live in poverty at 5.1 percent of adults aged 65 and older.
- Alaska has the highest rate of chronic drinking in the nation at 6.9 percent of adults aged 65 and older.
- Alaska has the highest amount of community support expenditures for older adults at \$8,033 per senior living in poverty.
- Alaska ranks 49th for both smoking and obesity with 12.4 percent adults aged 65 and older who smoke and 29.3 percent seniors who are obese.

Disparities: In Alaska, 35.6 percent of seniors with an income less than \$25,000 are obese compared to 19.5 percent of seniors with an income of \$25,000 to \$50,000.

State Health Department Website:

<http://health.hss.state.ak.us>



For a more detailed look at this data, visit www.americashealthrankings.org/senior/AK

ARIZONA

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	8.9	19	4.7
	Chronic Drinking (Percent of adults age 65+)	4.8	37	1.4
	Obesity (Percent of adults age 65+)	22.0	8	16.9
	Underweight (Percent of adults age 65+)	2.6	44	1.1
	Physical Inactivity (Percent of adults age 65+)	23.9	5	20.5
	Dental Visits (Percent of adults age 65+)	71.3	21	79.8
	Pain Management (Percent of adults age 65+)	54.8	13	60.7
	BEHAVIORS TOTAL	0.051	12	
	COMMUNITY & ENVIRONMENT			
	C&E — MACRO PERSPECTIVE	-0.074	44	
	Poverty (Percent of adults age 65+)	8.2	25	5.1
	Volunteerism (Percent of adults age 65+)	18.8	47	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	20.1	48	65.2
	C&E — MICRO PERSPECTIVE	-0.017	32	
	Social Support (Percent of adults age 65+)	78.5	38	85.4
	Food Insecurity (Percent of adults age 60+)	12.8	20	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$569	34	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	-0.091	38	
	POLICY			
	Low-Care Nursing Home Residents (Percent of residents)	10.4	21	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	87.0	20	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	67.2	29	16.3
	POLICY TOTAL	0.023	20	
	CLINICAL CARE			
	Dedicated Health Care Provider (Percent of adults age 65+)	94.3	34	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.2	39	98.4
	Flu Vaccine (Percent of adults age 65+)	57.9	35	70.2
	Health Screenings (Percent of adults age 65-74)	88.1	15	91.7
	Diabetes Management (Percent of Medicare enrollees)	75.3	39	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	92.4	19	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	52.9	10	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	15.6	23	12.3
	Hospice Care (Percent of decedents age 65+)	54.5	1	54.5
	Hospital Deaths (Percent of decedents age 65+)	21.2	2	19.2
	CLINICAL CARE TOTAL	0.043	13	
	ALL DETERMINANTS	0.025	26	
	OUTCOMES			
	ICU Usage (Percent of decedents age 65+)	15.7	38	5.1
	Falls (Percent of adults age 65+)	15.9	20	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	7.2	23	3.0
	Health Status (Percent very good or excellent of adults age 65+)	42.6	8	48.9
	Able-Bodied (Percent of adults age 65+)	66.4	8	68.0
	Premature Death (Deaths per 100,000 population age 65-74)	1,624	7	1,425
	Teeth Extractions (Percent of adults age 65+)	13.8	12	7.4
	Mental Health Days (Days in previous 30 days)	2.6	36	1.5
	ALL OUTCOMES	0.090	20	
	OVERALL	0.116	22	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	24.6	13	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	31.1	20	20.9
Cognition (Percent of adults age 65+)	8.1	14	5.7
Depression (Percent of adults age 65+)	15.4	39	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	55.6	50.5
Obesity (Percent obese)	17	28.1

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015-2030	100.7	52.7

Overall Rank: 22

Determinants Rank: 26

Outcomes Rank: 20

Strengths:

- Low prevalence of physical inactivity
- High percentage of hospice care
- Low percentage of hospital deaths

Challenges:

- High prevalence of underweight seniors
- Low percentage of volunteerism
- Low rate of highly-rated nursing home beds

Ranking: Arizona is 22nd in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 25th for its entire population.

Highlights:

- In Arizona, 54.8 percent of adults aged 65 or older with arthritis report that pain does not limit their usual activities compared to 60.7 percent nationally.
- Availability of highly-rated nursing home beds in Arizona is low at 20.1 beds per 100,000 adults aged 75 and older.
- Arizona has one of the lowest rates of volunteerism with 18.8 percent of seniors who volunteer.
- A low percentage of seniors die in the hospital at 21.2 percent of adults aged 65 and older.
- Although Arizona ranks low for obesity at 22.0 percent of adults aged 65 and older, more than 195,000 seniors are still obese.

Disparities: In Arizona, 41.0 percent of Hispanic seniors are obese compared to 20.2 percent of white seniors.

State Health Department Website:

www.azdhs.gov



For a more detailed look at this data, visit www.americashealthrankings.org/senior/AZ

ARKANSAS

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	11.6	45	4.7
	Chronic Drinking (Percent of adults age 65+)	3.0	16	1.4
	Obesity (Percent of adults age 65+)	26.1	30	16.9
	Underweight (Percent of adults age 65+)	2.0	25	1.1
	Physical Inactivity (Percent of adults age 65+)	37.4	46	20.5
	Dental Visits (Percent of adults age 65+)	59.1	44	79.8
	Pain Management (Percent of adults age 65+)	49.8	39	60.7
	BEHAVIORS TOTAL	-0.181	45	
	COMMUNITY & ENVIRONMENT			
	C&E — MACRO PERSPECTIVE	-0.013	31	
	Poverty (Percent of adults age 65+)	10.8	40	5.1
	Volunteerism (Percent of adults age 65+)	19.8	41	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	59.9	5	65.2
	C&E — MICRO PERSPECTIVE	-0.046	41	
	Social Support (Percent of adults age 65+)	81.3	16	85.4
	Food Insecurity (Percent of adults age 60+)	19.4	48	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$764	23	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	-0.059	33	
	POLICY			
	Low-Care Nursing Home Residents (Percent of residents)	17.3	43	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	86.5	25	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	68.9	33	16.3
	POLICY TOTAL	-0.058	40	
	CLINICAL CARE			
	Dedicated Health Care Provider (Percent of adults age 65+)	94.4	32	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.7	22	98.4
	Flu Vaccine (Percent of adults age 65+)	57.3	38	70.2
	Health Screenings (Percent of adults age 65–74)	83.4	37	91.7
	Diabetes Management (Percent of Medicare enrollees)	75.6	38	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	98.7	17	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	79.3	43	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	16.7	44	12.3
	Hospice Care (Percent of decedents age 65+)	32.1	33	54.5
	Hospital Deaths (Percent of decedents age 65+)	33.1	41	19.2
	CLINICAL CARE TOTAL	-0.081	45	
	ALL DETERMINANTS	-0.379	47	
	OUTCOMES			
	ICU Usage (Percent of decedents age 65+)	11.9	23	5.1
	Falls (Percent of adults age 65+)	18.0	41	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	8.5	45	3.0
	Health Status (Percent very good or excellent of adults age 65+)	31.6	46	48.9
	Able-Bodied (Percent of adults age 65+)	56.4	47	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	2,268	44	1,425
	Teeth Extractions (Percent of adults age 65+)	23.4	43	7.4
	Mental Health Days (Days in previous 30 days)	2.3	23	1.5
	ALL OUTCOMES	-0.224	45	
	OVERALL	-0.603	46	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	15.1	47	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	32.4	23	20.9
Cognition (Percent of adults age 65+)	11.0	41	5.7
Depression (Percent of adults age 65+)	13.0	23	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	47.8	44.6
Obesity (Percent obese)	23.3	34.2

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	40.3	52.7

Overall Rank: 46

Determinants Rank: 47

Outcomes Rank: 45

Strengths:

- Low prevalence of chronic drinking
- High rate of highly-rated nursing home beds
- Ready availability of home health care workers

Challenges:

- High prevalence of physical inactivity
- High percentage of low-care nursing home residents
- High prevalence of food insecurity

Ranking: Arkansas is 46th in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 48th for its entire population.

Highlights:

- Arkansas has a high rate of 4 and 5-star rated nursing home beds at 59.9 beds per 100,000 adults aged 75 and older.
- Almost 20 percent of adults aged 60 and older, or 82,000 seniors, are marginally food insecure.
- In Arkansas, almost 50,000 adults aged 65 and older smoke and more than 150,000 seniors are physically inactive.
- Arkansas has one of the lowest percentages of dental visits in the nation at 59.1 percent of adults aged 65 and older who visited the dentist in the last year.
- Arkansas has one of the highest percentages of low-care nursing home residents at 17.3 percent of nursing home residents.

Disparities: In Arkansas, 43.2 percent of black seniors are obese compared to 23.4 percent of white seniors.

State Health Department Website:

www.healthylarkansas.com



For a more detailed look at this data, visit www.americashealthrankings.org/senior/AR

CALIFORNIA

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	6.9	4	4.7
	Chronic Drinking (Percent of adults age 65+)	5.6	46	1.4
	Obesity (Percent of adults age 65+)	21.2	6	16.9
	Underweight (Percent of adults age 65+)	2.1	33	1.1
	Physical Inactivity (Percent of adults age 65+)	21.3	2	20.5
	Dental Visits (Percent of adults age 65+)	74.2	9	79.8
	Pain Management (Percent of adults age 65+)	50.5	31	60.7
	BEHAVIORS TOTAL	0.106	3	
	COMMUNITY & ENVIRONMENT			
	C&E — MACRO PERSPECTIVE	-0.060	39	
	Poverty (Percent of adults age 65+)	9.5	34	5.1
	Volunteerism (Percent of adults age 65+)	22.0	35	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	27.9	41	65.2
	C&E — MICRO PERSPECTIVE	-0.068	45	
	Social Support (Percent of adults age 65+)	77.0	45	85.4
	Food Insecurity (Percent of adults age 60+)	16.5	40	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$560	35	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	-0.127	45	
	POLICY			
	Low-Care Nursing Home Residents (Percent of residents)	11.4	24	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	88.4	5	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	59.4	18	16.3
	POLICY TOTAL	0.067	10	
	CLINICAL CARE			
	Dedicated Health Care Provider (Percent of adults age 65+)	95.0	25	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.6	26	98.4
	Flu Vaccine (Percent of adults age 65+)	57.2	39	70.2
	Health Screenings (Percent of adults age 65–74)	89.1	10	91.7
	Diabetes Management (Percent of Medicare enrollees)	80.0	27	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	53.1	42	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	51.9	9	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	15.7	27	12.3
	Hospice Care (Percent of decedents age 65+)	32.4	32	54.5
	Hospital Deaths (Percent of decedents age 65+)	32.7	40	19.2
	CLINICAL CARE TOTAL	-0.011	27	
	ALL DETERMINANTS	0.034	25	
	OUTCOMES			
	ICU Usage (Percent of decedents age 65+)	20.3	48	5.1
	Falls (Percent of adults age 65+)	16.7	28	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	6.4	5	3.0
	Health Status (Percent very good or excellent of adults age 65+)	43.7	6	48.9
	Able-Bodied (Percent of adults age 65+)	63.0	29	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	1,586	5	1,425
	Teeth Extractions (Percent of adults age 65+)	10.6	3	7.4
	Mental Health Days (Days in previous 30 days)	2.7	43	1.5
	ALL OUTCOMES	0.065	24	
	OVERALL	0.100	25	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	26.3	5	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	33.8	24	20.9
Cognition (Percent of adults age 65+)	10.7	38	5.7
Depression (Percent of adults age 65+)	10.0	7	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	50.1	50.2
Obesity (Percent obese)	25.1	29.2

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	58.5	52.7

Overall Rank: 25

Determinants Rank: 25

Outcomes Rank: 24

Strengths:

- Low prevalence of smoking
- Low prevalences of obesity & physical inactivity
- Low prevalence of teeth extractions

Challenges:

- High prevalence of chronic drinking
- High prevalence of food insecurity
- High percentage of ICU usage

Ranking: California is 25th in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 22nd for its entire population.

Highlights:

- California has one of the highest rates of chronic drinking at 5.6 percent of adults aged 65 and older.
- More than 900,000 adults aged 65 and older in California are obese and about the same number are physically inactive.
- Over 20 percent of California adults aged 65 and older have spent 7 or more days in the ICU during the last 6 months of life.
- More than 700,000 adults aged 60 and older are marginally food insecure in California.
- Although fewer adults aged 65 and older smoke in California compared to other states, almost 300,000 seniors still smoke.

Disparities: In California, 29.3 percent of Hispanic seniors are obese compared to 8.8 percent of Asian seniors and 20.3 percent of white seniors.

State Health Department Website:

www.cdph.ca.gov



For a more detailed look at this data, visit www.americashealthrankings.org/senior/CA

COLORADO

COLORADO

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	8.8	17	4.7
	Chronic Drinking (Percent of adults age 65+)	3.6	26	1.4
	Obesity (Percent of adults age 65+)	20.2	4	16.9
	Underweight (Percent of adults age 65+)	2.0	25	1.1
	Physical Inactivity (Percent of adults age 65+)	20.5	1	20.5
	Dental Visits (Percent of adults age 65+)	73.2	13	79.8
	Pain Management (Percent of adults age 65+)	52.7	19	60.7
	BEHAVIORS TOTAL	0.162	2	
COMMUNITY & ENVIRONMENT				
C&E — MACRO PERSPECTIVE				
	Poverty (Percent of adults age 65+)	8.1	22	5.1
	Volunteerism (Percent of adults age 65+)	25.8	22	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	40.8	26	65.2
C&E — MICRO PERSPECTIVE				
	Social Support (Percent of adults age 65+)	81.7	13	85.4
	Food Insecurity (Percent of adults age 60+)	11.5	14	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$651	29	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	0.051	24	
POLICY				
	Low-Care Nursing Home Residents (Percent of residents)	12.7	29	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	87.1	18	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	63.9	24	16.3
	POLICY TOTAL	0.013	22	
CLINICAL CARE				
	Dedicated Health Care Provider (Percent of adults age 65+)	94.4	32	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.8	18	98.4
	Flu Vaccine (Percent of adults age 65+)	65.9	9	70.2
	Health Screenings (Percent of adults age 65-74)	84.7	29	91.7
	Diabetes Management (Percent of Medicare enrollees)	74.6	43	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	106.5	14	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	46.6	6	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	14.8	9	12.3
	Hospice Care (Percent of decedents age 65+)	46.9	4	54.5
	Hospital Deaths (Percent of decedents age 65+)	21.8	3	19.2
	CLINICAL CARE TOTAL	0.081	2	
	ALL DETERMINANTS	0.307	6	
OUTCOMES				
	ICU Usage (Percent of decedents age 65+)	9.8	18	5.1
	Falls (Percent of adults age 65+)	17.1	32	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	7.5	31	3.0
	Health Status (Percent very good or excellent of adults age 65+)	44.9	4	48.9
	Able-Bodied (Percent of adults age 65+)	65.9	12	68.0
	Premature Death (Deaths per 100,000 population age 65-74)	1,545	2	1,425
	Teeth Extractions (Percent of adults age 65+)	13.4	9	7.4
	Mental Health Days (Days in previous 30 days)	2.1	14	1.5
	ALL OUTCOMES	0.168	8	
	OVERALL	0.475	8	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	29.8	1	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	25.7	7	20.9
Cognition (Percent of adults age 65+)	7.7	8	5.7
Depression (Percent of adults age 65+)	14.7	36	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	56.7	59.1
Obesity (Percent obese)	18.3	24.4

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015-2030	52.4	52.7

Overall Rank: 8

Determinants Rank: 6
Outcomes Rank: 8

Strengths:

- Low prevalences of obesity & physical inactivity
- Low percentage of hospital deaths
- Low premature death rate

Challenges:

- Low percentage of diabetes management
- Low prevalence of seniors with a health care provider
- High percentage of falls

Ranking: Colorado is 8th in this Senior Report. In the *America's Health Rankings®* 2012 Edition, it ranked 11th for its entire population.

Highlights:

- Colorado has the lowest prevalence of physical inactivity in the U.S. at 20.5 percent of adults aged 65 and older, or 114,000 seniors who are inactive.
- Colorado has a low prevalence of seniors with a dedicated health care provider at 94.4 percent of adults aged 65 and older.
- Although Colorado has one of the lowest obesity rates in the nation, more than 110,000 adults aged 65 and older are still obese.
- A low percentage of seniors in Colorado receive appropriate diabetes management at 74.6 percent of Medicare enrollees.
- The premature death rate for adults aged 65-74 in Colorado is one of the lowest in the U.S. at 1,545 deaths per 100,000 population.

Disparities: In Colorado, seniors with a college degree report a lower prevalence of obesity and physical inactivity, higher prevalence of social support, and better health status compared to seniors with less than a high school degree.

State Health Department Website:

www.cdphs.state.co.us



For a more detailed look at this data, visit www.americashealthrankings.org/senior/CO

CONNECTICUT

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	8.5	13	4.7
	Chronic Drinking (Percent of adults age 65+)	3.7	27	1.4
	Obesity (Percent of adults age 65+)	23.7	12	16.9
	Underweight (Percent of adults age 65+)	1.9	22	1.1
	Physical Inactivity (Percent of adults age 65+)	31.2	23	20.5
	Dental Visits (Percent of adults age 65+)	79.8	1	79.8
	Pain Management (Percent of adults age 65+)	52.0	26	60.7
	BEHAVIORS TOTAL	0.081	9	
	COMMUNITY & ENVIRONMENT			
	C&E — MACRO PERSPECTIVE	0.106	5	
	Poverty (Percent of adults age 65+)	6.5	5	5.1
	Volunteerism (Percent of adults age 65+)	29.0	14	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	56.6	7	65.2
	C&E — MICRO PERSPECTIVE	0.020	22	
	Social Support (Percent of adults age 65+)	78.8	36	85.4
	Food Insecurity (Percent of adults age 60+)	10.6	10	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$1,067	14	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	0.126	10	
	POLICY			
	Low-Care Nursing Home Residents (Percent of residents)	15.1	38	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	86.6	24	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	41.5	7	16.3
	POLICY TOTAL	0.051	15	
	CLINICAL CARE			
	Dedicated Health Care Provider (Percent of adults age 65+)	95.7	10	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.0	43	98.4
	Flu Vaccine (Percent of adults age 65+)	60.2	29	70.2
	Health Screenings (Percent of adults age 65–74)	90.7	4	91.7
	Diabetes Management (Percent of Medicare enrollees)	82.9	11	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	83.8	22	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	60.4	22	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	16.0	33	12.3
	Hospice Care (Percent of decedents age 65+)	29.4	41	54.5
	Hospital Deaths (Percent of decedents age 65+)	32.2	37	19.2
	CLINICAL CARE TOTAL	-0.008	25	
	ALL DETERMINANTS	0.249	8	
	OUTCOMES			
	ICU Usage (Percent of decedents age 65+)	12.5	27	5.1
	Falls (Percent of adults age 65+)	14.2	4	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	6.2	3	3.0
	Health Status (Percent very good or excellent of adults age 65+)	41.4	15	48.9
	Able-Bodied (Percent of adults age 65+)	67.3	2	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	1,564	3	1,425
	Teeth Extractions (Percent of adults age 65+)	9.2	2	7.4
	Mental Health Days (Days in previous 30 days)	2.2	19	1.5
	ALL OUTCOMES	0.233	4	
	OVERALL	0.483	7	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	26.3	5	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	36.6	35	20.9
Cognition (Percent of adults age 65+)	7.7	8	5.7
Depression (Percent of adults age 65+)	13.0	22	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	64.3	58.8
Obesity (Percent obese)	20.4	25.7

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	37.7	52.7

Overall Rank: 7

Determinants Rank: 8

Outcomes Rank: 4

Strengths:

- High prevalence of dental visits
- High percentage of health screenings
- Low prevalence of teeth extractions

Challenges:

- High percentage of low-care nursing home residents
- Low percentage of hospice care
- High percentage of hospital deaths

Ranking: Connecticut is 7th in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 6th for its entire population.

Highlights:

- Connecticut has more low-care nursing home residents than most other states at 15.1 percent of nursing home residents.
- A low percentage of Connecticut seniors live in poverty at 6.5 percent of adults aged 65 and older.
- A high percentage of Connecticut seniors die in the hospital at 32.2 percent of adults aged 65 and older.
- Connecticut has a higher rate of 4 and 5-star rated nursing home beds than most other states at 56.6 beds per 100,000 adults aged 75 and older.
- In Connecticut, 90.7 percent of adults aged 65 and older receive recommended health screenings.

Disparities: In Connecticut, seniors with less than a high school degree have higher prevalences of obesity and physical inactivity compared to seniors with a college degree.

State Health Department Website:

www.dph.state.ct.us



For a more detailed look at this data, visit www.americashealthrankings.org/senior/CT

DELAWARE

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	8.9	19	4.7
	Chronic Drinking (Percent of adults age 65+)	4.6	36	1.4
	Obesity (Percent of adults age 65+)	28.9	46	16.9
	Underweight (Percent of adults age 65+)	1.7	13	1.1
	Physical Inactivity (Percent of adults age 65+)	32.5	29	20.5
	Dental Visits (Percent of adults age 65+)	73.3	11	79.8
	Pain Management (Percent of adults age 65+)	58.6	3	60.7
	BEHAVIORS TOTAL	0.014	20	
COMMUNITY & ENVIRONMENT				
C&E — MACRO PERSPECTIVE				
	Poverty (Percent of adults age 65+)	6.7	6	5.1
	Volunteerism (Percent of adults age 65+)	21.3	37	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	44.5	21	65.2
C&E — MICRO PERSPECTIVE				
	Social Support (Percent of adults age 65+)	84.4	3	85.4
	Food Insecurity (Percent of adults age 60+)	8.9	5	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$1,004	17	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	0.122	11	
POLICY				
	Low-Care Nursing Home Residents (Percent of residents)	14.5	36	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	87.6	13	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	67.5	30	16.3
	POLICY TOTAL	-0.005	27	
CLINICAL CARE				
	Dedicated Health Care Provider (Percent of adults age 65+)	96.8	1	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.3	37	98.4
	Flu Vaccine (Percent of adults age 65+)	63.4	16	70.2
	Health Screenings (Percent of adults age 65–74)	90.8	3	91.7
	Diabetes Management (Percent of Medicare enrollees)	83.7	5	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	46.8	45	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	58.6	19	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	15.8	29	12.3
	Hospice Care (Percent of decedents age 65+)	42.4	12	54.5
	Hospital Deaths (Percent of decedents age 65+)	29.1	26	19.2
	CLINICAL CARE TOTAL	0.051	12	
	ALL DETERMINANTS	0.182	14	
OUTCOMES				
	ICU Usage (Percent of decedents age 65+)	16.3	42	5.1
	Falls (Percent of adults age 65+)	15.3	16	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	6.5	9	3.0
	Health Status (Percent very good or excellent of adults age 65+)	41.6	14	48.9
	Able-Bodied (Percent of adults age 65+)	66.8	5	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	1,816	22	1,425
	Teeth Extractions (Percent of adults age 65+)	16.4	23	7.4
	Mental Health Days (Days in previous 30 days)	2.0	11	1.5
	ALL OUTCOMES	0.127	15	
	OVERALL	0.309	12	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	23.1	16	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	40.1	48	20.9
Cognition (Percent of adults age 65+)	7.2	7	5.7
Depression (Percent of adults age 65+)	8.8	2	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	52.9	55.8
Obesity (Percent obese)	31.2	34.2

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	60	52.7

Overall Rank: 12

Determinants Rank: 14

Outcomes Rank: 15

Strengths:

- Low prevalence of activity-limiting arthritis pain
- High percentage of social support
- High prevalence of seniors with a health care provider

Challenges:

- High prevalence of obesity
- Limited availability of home health care workers
- Low percentage of seniors who received recommended hospital care

Ranking: Delaware is 12th in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 31st for its entire population.

Highlights:

- Delaware has one of the lowest rates of food insecurity in the nation with 8.9 percent of adults aged 60 and older who are marginally food insecure.
- A low percentage of Delaware seniors live in poverty at 6.7 percent of adults aged 65 and older.
- In Delaware, 42,000 adults aged 65 and older are physically inactive and 38,000 seniors are obese.
- A high percentage of seniors receive social support at 84.4 percent of adults aged 65 and older.
- In Delaware, 76,000 adults aged 65 and older with arthritis report that pain does not limit their usual activity, fewer than most other states.

Disparities: In Delaware, seniors with less than a high school degree have higher prevalences of obesity and physical inactivity compared to seniors with a college degree.

State Health Department Website:

www.dhss.delaware.gov/dhss



For a more detailed look at this data, visit www.americashealthrankings.org/senior/DE

FLORIDA

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	7.9	9	4.7
	Chronic Drinking (Percent of adults age 65+)	5.8	49	1.4
	Obesity (Percent of adults age 65+)	23.4	11	16.9
	Underweight (Percent of adults age 65+)	1.5	8	1.1
	Physical Inactivity (Percent of adults age 65+)	29.9	21	20.5
	Dental Visits (Percent of adults age 65+)	70.9	22	79.8
	Pain Management (Percent of adults age 65+)	48.1	45	60.7
	BEHAVIORS TOTAL	-0.009	26	
	COMMUNITY & ENVIRONMENT			
	C&E — MACRO PERSPECTIVE	-0.094	48	
	Poverty (Percent of adults age 65+)	9.9	35	5.1
	Volunteerism (Percent of adults age 65+)	17.4	50	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	27.2	42	65.2
	C&E — MICRO PERSPECTIVE	-0.016	30	
	Social Support (Percent of adults age 65+)	79.4	31	85.4
	Food Insecurity (Percent of adults age 60+)	16.6	42	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$1,649	7	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	-0.110	40	
	POLICY			
	Low-Care Nursing Home Residents (Percent of residents)	8.5	13	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	87.4	15	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	69.6	34	16.3
	POLICY TOTAL	0.040	17	
	CLINICAL CARE			
	Dedicated Health Care Provider (Percent of adults age 65+)	96.0	7	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	98.1	8	98.4
	Flu Vaccine (Percent of adults age 65+)	57.6	36	70.2
	Health Screenings (Percent of adults age 65–74)	90.1	7	91.7
	Diabetes Management (Percent of Medicare enrollees)	86.1	1	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	29.1	50	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	65.3	28	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	16.0	33	12.3
	Hospice Care (Percent of decedents age 65+)	49.5	3	54.5
	Hospital Deaths (Percent of decedents age 65+)	26.2	15	19.2
	CLINICAL CARE TOTAL	0.064	7	
	ALL DETERMINANTS	-0.014	30	
	OUTCOMES			
	ICU Usage (Percent of decedents age 65+)	23.1	49	5.1
	Falls (Percent of adults age 65+)	14.7	9	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	7.2	23	3.0
	Health Status (Percent very good or excellent of adults age 65+)	39.6	23	48.9
	Able-Bodied (Percent of adults age 65+)	65.7	14	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	1,655	9	1,425
	Teeth Extractions (Percent of adults age 65+)	13.3	8	7.4
	Mental Health Days (Days in previous 30 days)	2.7	43	1.5
	ALL OUTCOMES	0.027	27	
	OVERALL	0.012	30	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	22.5	19	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	43.5	50	20.9
Cognition (Percent of adults age 65+)	9.1	28	5.7
Depression (Percent of adults age 65+)	13.7	28	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	51.2	50.1
Obesity (Percent obese)	20.8	29.7

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	87.9	52.7

Overall Rank: 30

Determinants Rank: 30

Outcomes Rank: 27

Strengths:

- High prevalence of health screenings
- High percentage of diabetes management
- High percentage of hospice care

Challenges:

- Limited availability of home health care workers
- High prevalence of chronic drinking
- Low percentage of volunteerism

Ranking: Florida is 30th in this Senior Report. In the *America's Health Rankings®* 2012 Edition, it ranked 34th for its entire population.

Highlights:

- A high percentage of seniors in Florida receive recommended health screenings at 90.1 percent of adults aged 65 and older.
- The percentage of older adults with arthritis whose usual activity is not limited by pain is low at 48.1 percent of adults aged 65 and older.
- Florida has one of the highest chronic drinking rates in the nation at 5.8 percent of adults aged 65 and older.
- Florida has a low percentage of low-care nursing home residents at 8.5 percent of nursing home residents.
- In Florida, 23.1 percent of adults aged 65 and older spent 7 or more days in the ICU during the last 6 months of life.

Disparities: In Florida, 38.4 percent of seniors with an income less than \$25,000 are physically inactive compared to 15.9 percent of seniors with an income greater than \$75,000.

State Health Department Website:
www.doh.state.fl.us



For a more detailed look at this data, visit www.americashealthrankings.org/senior/FL

GEORGIA

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	10.8	40	4.7
	Chronic Drinking (Percent of adults age 65+)	3.0	16	1.4
	Obesity (Percent of adults age 65+)	25.4	26	16.9
	Underweight (Percent of adults age 65+)	2.4	41	1.1
	Physical Inactivity (Percent of adults age 65+)	33.6	35	20.5
	Dental Visits (Percent of adults age 65+)	66.2	32	79.8
	Pain Management (Percent of adults age 65+)	50.3	35	60.7
	BEHAVIORS TOTAL	-0.110	43	
	COMMUNITY & ENVIRONMENT			
	C&E — MACRO PERSPECTIVE	-0.091	46	
	Poverty (Percent of adults age 65+)	11.2	42	5.1
	Volunteerism (Percent of adults age 65+)	19.8	41	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	32.0	37	65.2
	C&E — MICRO PERSPECTIVE	-0.032	37	
	Social Support (Percent of adults age 65+)	81.1	20	85.4
	Food Insecurity (Percent of adults age 60+)	17.1	43	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$513	41	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	-0.124	42	
	POLICY			
	Low-Care Nursing Home Residents (Percent of residents)	10.4	22	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	85.8	32	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	72.0	36	16.3
	POLICY TOTAL	-0.019	34	
	CLINICAL CARE			
	Dedicated Health Care Provider (Percent of adults age 65+)	93.6	37	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.5	31	98.4
	Flu Vaccine (Percent of adults age 65+)	55.2	45	70.2
	Health Screenings (Percent of adults age 65–74)	87.9	16	91.7
	Diabetes Management (Percent of Medicare enrollees)	80.7	23	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	51.3	43	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	68.4	32	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	15.6	23	12.3
	Hospice Care (Percent of decedents age 65+)	42.8	9	54.5
	Hospital Deaths (Percent of decedents age 65+)	29.8	28	19.2
	CLINICAL CARE TOTAL	-0.020	30	
	ALL DETERMINANTS	-0.273	43	
	OUTCOMES			
	ICU Usage (Percent of decedents age 65+)	14.2	34	5.1
	Falls (Percent of adults age 65+)	16.7	28	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	8.5	45	3.0
	Health Status (Percent very good or excellent of adults age 65+)	32.9	45	48.9
	Able-Bodied (Percent of adults age 65+)	60.8	39	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	2,157	41	1,425
	Teeth Extractions (Percent of adults age 65+)	21.0	39	7.4
	Mental Health Days (Days in previous 30 days)	2.8	46	1.5
	ALL OUTCOMES	-0.178	42	
	OVERALL	-0.451	43	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	19.7	31	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	36.3	33	20.9
Cognition (Percent of adults age 65+)	11.2	44	5.7
Depression (Percent of adults age 65+)	12.2	16	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	49.3	47
Obesity (Percent obese)	19.6	32.8

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	60.6	52.7

Overall Rank: 43

Determinants Rank: 43

Outcomes Rank: 42

Strengths:

- Low prevalence of chronic drinking
- High percentage of hospice care
- High percentage of health screenings

Challenges:

- High prevalence of smoking
- High prevalence of underweight seniors
- High prevalence of food insecurity

Ranking: Georgia is 43rd in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 36th for its entire population.

Highlights:

- Georgia has a high percentage of seniors living in poverty at 11.2 percent of adults aged 65 and older.
- Volunteerism is low among Georgia seniors with 19.8 percent of seniors who volunteer.
- The chronic drinking rate in Georgia is 3.0 percent of adults aged 65 and older, lower than most other states.
- Georgia has a high rate of food insecurity; 17.1 percent of adults aged 60 and older, or almost 180,000 seniors, are marginally food insecure.
- In Georgia, more than 110,000 adults aged 65 and older smoke and 350,000 seniors are physically inactive.

Disparities: In Georgia, seniors with a college degree report higher health status, less physical inactivity, and greater social and emotional support than seniors with less than a high school degree.

State Health Department Website:

www.health.state.ga.us



For a more detailed look at this data, visit www.americashealthrankings.org/senior/GA

HAWAII

SENIOR HEALTH

DETERMINANTS	2013		NO 1 STATE
	VALUE	RANK	
BEHAVIORS			
Smoking (Percent of adults age 65+)	6.6	3	4.7
Chronic Drinking (Percent of adults age 65+)	4.3	34	1.4
Obesity (Percent of adults age 65+)	16.9	1	16.9
Underweight (Percent of adults age 65+)	3.5	50	1.1
Physical Inactivity (Percent of adults age 65+)	24.7	6	20.5
Dental Visits (Percent of adults age 65+)	77.6	2	79.8
Pain Management (Percent of adults age 65+)	59.4	2	60.7
BEHAVIORS TOTAL	0.195	1	
COMMUNITY & ENVIRONMENT			
C&E — MACRO PERSPECTIVE	-0.047	35	
Poverty (Percent of adults age 65+)	7.6	12	5.1
Volunteerism (Percent of adults age 65+)	19.2	45	39.3
Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	25.7	44	65.2
C&E — MICRO PERSPECTIVE	-0.096	49	
Social Support (Percent of adults age 65+)	65.8	50	85.4
Food Insecurity (Percent of adults age 60+)	15.9	37	5.5
Community Support (Dollars per adult age 65+ in poverty)	\$878	21	\$8,033
COMMUNITY & ENVIRONMENT TOTAL	-0.143	47	
POLICY			
Low-Care Nursing Home Residents (Percent of residents)	4.7	2	1.1
Creditable Drug Coverage (Percent of adults age 65+)	86.3	27	89.6
Geriatrician Shortfall (Percent of needed geriatricians)	16.3	1	16.3
POLICY TOTAL	0.166	1	
CLINICAL CARE			
Dedicated Health Care Provider (Percent of adults age 65+)	95.7	10	96.8
Recommended Hospital Care (Percent of hospitalized patients age 65+)	96.8	47	98.4
Flu Vaccine (Percent of adults age 65+)	64.7	13	70.2
Health Screenings (Percent of adults age 65-74)	85.0	28	91.7
Diabetes Management (Percent of Medicare enrollees)	83.2	9	86.1
Home Health Care (Number of workers per 1,000 adults age 75+)	68.3	38	290.0
Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	25.0	1	25.0
Hospital Readmissions (Percent of hospitalized patients age 65+)	14.2	5	12.3
Hospice Care (Percent of decedents age 65+)	21.5	49	54.5
Hospital Deaths (Percent of decedents age 65+)	38.8	49	19.2
CLINICAL CARE TOTAL	-0.013	29	
ALL DETERMINANTS	0.205	11	
OUTCOMES			
ICU Usage (Percent of decedents age 65+)	12.2	25	5.1
Falls (Percent of adults age 65+)	13.7	3	12.9
Hip Fractures (Rate per 1,000 Medicare enrollees)	3.0	1	3.0
Health Status (Percent very good or excellent of adults age 65+)	36.1	33	48.9
Able-Bodied (Percent of adults age 65+)	65.5	16	68.0
Premature Death (Deaths per 100,000 population age 65-74)	1,425	1	1,425
Teeth Extractions (Percent of adults age 65+)	7.4	1	7.4
Mental Health Days (Days in previous 30 days)	1.5	1	1.5
ALL OUTCOMES	0.295	2	
OVERALL	0.500	6	

Overall Rank: 6

Determinants Rank: 11

Outcomes Rank: 2

Strengths:

- Low prevalence of obesity
- Low prevalence of activity-limiting arthritis pain
- Low geriatrician shortfall

Challenges:

- High prevalence of underweight seniors
- Low percentage of social support
- Low percentage of hospice care

Ranking: Hawaii is 6th in this Senior Report. In the *America's Health Rankings®* 2012 Edition, it ranked 2nd for its entire population.

Highlights:

- The percentage of older adults who receive social support is lowest in Hawaii at 65.8 percent of adults aged 65 and older.
- The prevalence of obesity among older adults is lowest in Hawaii at 16.9 percent of adults aged 65 and older.
- Hawaii has the lowest rate of preventable hospitalizations in the U.S. with 25.0 discharges per 1,000 Medicare enrollees.
- Hawaii ranks 49th for both the percentage of older adults enrolled in hospice care during the last 6 months of life and the percentage of older adults who died in the hospital, at 21.5 percent and 38.8 percent of adults aged 65 and older, respectively.

Disparities: In Hawaii the percentage of older adults with less than a high school degree that receives social support is nearly 30% less than those with a college degree.

State Health Department Website:
hawaii.gov/health

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	23.8	15	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	31.3	21	20.9
Cognition (Percent of adults age 65+)	10.1	37	5.7
Depression (Percent of adults age 65+)	7.1	1	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	48.9	46.1
Obesity (Percent obese)	13.3	24.9

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015-2030	44.6	52.7



For a more detailed look at this data, visit www.americashealthrankings.org/senior/HI

IDAHO

IDAHO

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	8.4	12	4.7
	Chronic Drinking (Percent of adults age 65+)	3.7	27	1.4
	Obesity (Percent of adults age 65+)	24.3	16	16.9
	Underweight (Percent of adults age 65+)	1.8	20	1.1
	Physical Inactivity (Percent of adults age 65+)	29.8	20	20.5
	Dental Visits (Percent of adults age 65+)	67.8	29	79.8
	Pain Management (Percent of adults age 65+)	44.6	49	60.7
	BEHAVIORS TOTAL	-0.040	35	
COMMUNITY & ENVIRONMENT				
C&E — MACRO PERSPECTIVE				
	Poverty (Percent of adults age 65+)	7.5	10	5.1
	Volunteerism (Percent of adults age 65+)	36.9	3	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	36.1	32	65.2
C&E — MICRO PERSPECTIVE				
	Social Support (Percent of adults age 65+)	83.3	9	85.4
	Food Insecurity (Percent of adults age 60+)	8.1	4	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$389	46	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	0.154	7	
POLICY				
	Low-Care Nursing Home Residents (Percent of residents)	7.6	11	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	84.3	39	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	90.4	50	16.3
	POLICY TOTAL	-0.082	42	
CLINICAL CARE				
	Dedicated Health Care Provider (Percent of adults age 65+)	93.9	36	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.8	18	98.4
	Flu Vaccine (Percent of adults age 65+)	56.3	43	70.2
	Health Screenings (Percent of adults age 65–74)	80.0	48	91.7
	Diabetes Management (Percent of Medicare enrollees)	75.2	40	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	109.9	11	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	43.6	4	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	13.6	2	12.3
	Hospice Care (Percent of decedents age 65+)	33.2	29	54.5
	Hospital Deaths (Percent of decedents age 65+)	24.4	6	19.2
	CLINICAL CARE TOTAL	0.011	22	
	ALL DETERMINANTS	0.043	22	
OUTCOMES				
	ICU Usage (Percent of decedents age 65+)	5.8	3	5.1
	Falls (Percent of adults age 65+)	19.0	47	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	7.3	27	3.0
	Health Status (Percent very good or excellent of adults age 65+)	40.4	17	48.9
	Able-Bodied (Percent of adults age 65+)	61.4	38	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	1,782	20	1,425
	Teeth Extractions (Percent of adults age 65+)	15.7	20	7.4
	Mental Health Days (Days in previous 30 days)	2.0	11	1.5
	ALL OUTCOMES	0.065	24	
	OVERALL	0.109	24	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	19.8	30	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	25.8	8	20.9
Cognition (Percent of adults age 65+)	9.3	30	5.7
Depression (Percent of adults age 65+)	13.8	29	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	52.6	53.7
Obesity (Percent obese)	21.2	30.0

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	64.0	52.7

Overall Rank: 24

Determinants Rank: 22

Outcomes Rank: 24

Strengths:

- High percentage of volunteerism
- Low prevalence of food insecurity
- Low percentage of hospital readmissions

Challenges:

- High prevalence of activity-limiting arthritis pain
- High geriatrician shortfall
- Low percentage of health screenings

Ranking: Idaho is 24th in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 17th for its entire population.

Highlights:

- Idaho has a low percentage of patients readmitted to the hospital at 13.6 percent of adults aged 65 and older.
- Idaho has a low percentage of older adults who receive recommended health screenings at 80.0 percent of adults aged 65 and older.
- Idaho ranks 50th for a high percentage of estimated geriatrician shortfall at 90.4 percent of the number of geriatricians needed.
- The percentage of adults aged 65 and older with arthritis whose usual activity is not limited by pain is low at 44.6 percent.
- In Idaho, 5.8 percent of adults aged 65 and older spent 7 or more days in the ICU during the last 6 months of life.

Disparities: In Idaho, seniors with less than a high school degree have higher rates of obesity and physical inactivity as well as lower health status and social support compared to seniors with a college degree.

State Health Department Website:

www.healthandwelfare.idaho.gov



For a more detailed look at this data, visit www.americashealthrankings.org/senior/ID

ILLINOIS

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	7.6	8	4.7
	Chronic Drinking (Percent of adults age 65+)	5.1	42	1.4
	Obesity (Percent of adults age 65+)	29.1	47	16.9
	Underweight (Percent of adults age 65+)	1.1	1	1.1
	Physical Inactivity (Percent of adults age 65+)	32.7	31	20.5
	Dental Visits (Percent of adults age 65+)	65.3	37	79.8
	Pain Management (Percent of adults age 65+)	53.8	15	60.7
	BEHAVIORS TOTAL	-0.016	28	
	COMMUNITY & ENVIRONMENT			
	C&E — MACRO PERSPECTIVE	0.034	19	
	Poverty (Percent of adults age 65+)	8.3	27	5.1
	Volunteerism (Percent of adults age 65+)	25.6	23	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	48.4	16	65.2
	C&E — MICRO PERSPECTIVE	-0.036	38	
	Social Support (Percent of adults age 65+)	76.3	47	85.4
	Food Insecurity (Percent of adults age 60+)	12.5	18	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$604	31	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	-0.002	27	
	POLICY			
	Low-Care Nursing Home Residents (Percent of residents)	26.7	50	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	85.2	36	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	53.6	13	16.3
	POLICY TOTAL	-0.089	44	
	CLINICAL CARE			
	Dedicated Health Care Provider (Percent of adults age 65+)	94.9	28	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	98.0	11	98.4
	Flu Vaccine (Percent of adults age 65+)	54.7	46	70.2
	Health Screenings (Percent of adults age 65–74)	84.0	35	91.7
	Diabetes Management (Percent of Medicare enrollees)	80.9	20	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	77.7	29	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	75.0	40	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	16.8	46	12.3
	Hospice Care (Percent of decedents age 65+)	37.8	17	54.5
	Hospital Deaths (Percent of decedents age 65+)	29.3	27	19.2
	CLINICAL CARE TOTAL	-0.038	42	
	ALL DETERMINANTS	-0.145	35	
	OUTCOMES			
	ICU Usage (Percent of decedents age 65+)	19.1	46	5.1
	Falls (Percent of adults age 65+)	16.7	28	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	7.1	20	3.0
	Health Status (Percent very good or excellent of adults age 65+)	35.6	36	48.9
	Able-Bodied (Percent of adults age 65+)	64.7	21	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	1,894	29	1,425
	Teeth Extractions (Percent of adults age 65+)	15.2	17	7.4
	Mental Health Days (Days in previous 30 days)	3.0	50	1.5
	ALL OUTCOMES	-0.071	35	
	OVERALL	-0.217	37	

Overall Rank: 37

Determinants Rank: 35

Outcomes Rank: 35

Strengths:

- Low prevalence of smoking
- Low prevalence of underweight seniors
- Low geriatrician shortfall

Challenges:

- High prevalence of obesity
- Low percentage of social support
- High percentage of low-care nursing home residents

Ranking: Illinois is 37th in this Senior Report. In the *America's Health Rankings®* 2012 Edition, it ranked 30th for its entire population.

Highlights:

- Illinois has a high percentage of low-care nursing home residents at 26.7 percent of nursing home residents.
- Obesity is higher among seniors at 29.1 percent of adults aged 65 and older than among all adults in the state at 27.1 percent.
- Conversely, only 1.1 percent of adults aged 65 and older are underweight.
- Illinois ranks 50th for the number of poor mental health days per month at 3.0 days in the previous 30 days.
- The prevalence of smoking is low at 7.6 percent of adults aged 65 and older, or 123,000 older adults.

Disparities: In Illinois, seniors with less than a high school degree have higher rates of obesity and physical inactivity as well as lower health status and social support compared to seniors with a college degree.

State Health Department Website:

www.idph.state.il.us

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	19.9	29	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	36.5	34	20.9
Cognition (Percent of adults age 65+)	8.5	20	5.7
Depression (Percent of adults age 65+)	13.4	25	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	48.5	50.5
Obesity (Percent obese)	27.4	34.3

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	35.7	52.7



For a more detailed look at this data, visit www.americashealthrankings.org/senior/IL

INDIANA

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	11.5	44	4.7
	Chronic Drinking (Percent of adults age 65+)	2.8	13	1.4
	Obesity (Percent of adults age 65+)	26.6	36	16.9
	Underweight (Percent of adults age 65+)	2.1	33	1.1
	Physical Inactivity (Percent of adults age 65+)	34.8	42	20.5
	Dental Visits (Percent of adults age 65+)	65.7	34	79.8
	Pain Management (Percent of adults age 65+)	52.5	21	60.7
	BEHAVIORS TOTAL	-0.105	42	
	COMMUNITY & ENVIRONMENT			
	C&E — MACRO PERSPECTIVE	0.051	16	
	Poverty (Percent of adults age 65+)	7.4	8	5.1
	Volunteerism (Percent of adults age 65+)	25.6	23	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	48.7	15	65.2
	C&E — MICRO PERSPECTIVE	0.044	16	
	Social Support (Percent of adults age 65+)	81.0	21	85.4
	Food Insecurity (Percent of adults age 60+)	10.1	8	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$890	20	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	0.095	16	
	POLICY			
	Low-Care Nursing Home Residents (Percent of residents)	10.0	17	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	86.2	29	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	73.1	39	16.3
	POLICY TOTAL	-0.010	31	
	CLINICAL CARE			
	Dedicated Health Care Provider (Percent of adults age 65+)	95.1	22	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.5	31	98.4
	Flu Vaccine (Percent of adults age 65+)	60.6	28	70.2
	Health Screenings (Percent of adults age 65-74)	84.3	31	91.7
	Diabetes Management (Percent of Medicare enrollees)	76.4	36	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	80.2	28	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	76.0	41	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	15.5	21	12.3
	Hospice Care (Percent of decedents age 65+)	35.2	23	54.5
	Hospital Deaths (Percent of decedents age 65+)	26.7	19	19.2
	CLINICAL CARE TOTAL	-0.022	32	
	ALL DETERMINANTS	-0.042	31	
	OUTCOMES			
	ICU Usage (Percent of decedents age 65+)	13.9	32	5.1
	Falls (Percent of adults age 65+)	16.8	31	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	7.4	29	3.0
	Health Status (Percent very good or excellent of adults age 65+)	35.7	35	48.9
	Able-Bodied (Percent of adults age 65+)	62.5	31	68.0
	Premature Death (Deaths per 100,000 population age 65-74)	2,162	42	1,425
	Teeth Extractions (Percent of adults age 65+)	21.4	40	7.4
	Mental Health Days (Days in previous 30 days)	2.3	23	1.5
	ALL OUTCOMES	-0.075	37	
	OVERALL	-0.116	32	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	15.2	46	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	36.0	32	20.9
Cognition (Percent of adults age 65+)	8.3	17	5.7
Depression (Percent of adults age 65+)	15.2	38	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	46.1	46.3
Obesity (Percent obese)	26.8	35.3

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015-2030	35.9	52.7

Overall Rank: 32

Determinants Rank: 31

Outcomes Rank: 37

Strengths:

- Low prevalence of chronic drinking
- Low percentage of seniors living in poverty
- Low prevalence of food insecurity

Challenges:

- High prevalence of smoking
- High prevalence of physical inactivity
- High geriatrician shortfall

Ranking: Indiana is 32nd in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 41st for its entire population.

Highlights:

- Indiana has one of the highest prevalences of smoking with 11.5 percent of adults aged 65 and older, or 97,000 older adults, who smoke.
- Indiana has a low percentage of seniors in poverty at 7.4 percent of adults aged 65 and older.
- The death rate for adults aged 65-74 in Indiana is one of the highest in the U.S. at 2,162 deaths per 100,000 population.
- The prevalence of physical inactivity is 34.8 percent of adults aged 65 and older, higher than the prevalence among all adults in the state at 29.2 percent.
- The prevalence of chronic drinking in Indiana is low at 2.8 percent of adults aged 65 and older.

Disparities: In Indiana, 45% of seniors with annual household incomes less than \$25,000 are physically inactive compared to 19% of seniors with incomes above \$75,000.

State Health Department Website:

www.in.gov/isdh



For a more detailed look at this data, visit www.americashealthrankings.org/senior/IN

IOWA

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	7.1	5	4.7
	Chronic Drinking (Percent of adults age 65+)	3.3	23	1.4
	Obesity (Percent of adults age 65+)	29.1	47	16.9
	Underweight (Percent of adults age 65+)	1.6	9	1.1
	Physical Inactivity (Percent of adults age 65+)	31.9	26	20.5
	Dental Visits (Percent of adults age 65+)	72.6	15	79.8
	Pain Management (Percent of adults age 65+)	57.3	4	60.7
	BEHAVIORS TOTAL	0.081	8	
	COMMUNITY & ENVIRONMENT			
	C&E — MACRO PERSPECTIVE	0.166	1	
	Poverty (Percent of adults age 65+)	7.0	7	5.1
	Volunteerism (Percent of adults age 65+)	39.3	1	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	63.9	3	65.2
	C&E — MICRO PERSPECTIVE	0.052	11	
	Social Support (Percent of adults age 65+)	82.8	10	85.4
	Food Insecurity (Percent of adults age 60+)	11.2	13	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$895	19	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	0.218	1	
	POLICY			
	Low-Care Nursing Home Residents (Percent of residents)	16.9	42	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	89.3	2	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	71.7	35	16.3
	POLICY TOTAL	-0.005	29	
	CLINICAL CARE			
	Dedicated Health Care Provider (Percent of adults age 65+)	94.6	30	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.6	26	98.4
	Flu Vaccine (Percent of adults age 65+)	70.2	1	70.2
	Health Screenings (Percent of adults age 65-74)	87.1	20	91.7
	Diabetes Management (Percent of Medicare enrollees)	81.2	18	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	71.4	37	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	60.4	22	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	14.9	11	12.3
	Hospice Care (Percent of decedents age 65+)	42.8	9	54.5
	Hospital Deaths (Percent of decedents age 65+)	24.4	6	19.2
	CLINICAL CARE TOTAL	0.078	3	
	ALL DETERMINANTS	0.372	3	
	OUTCOMES			
	ICU Usage (Percent of decedents age 65+)	9.1	14	5.1
	Falls (Percent of adults age 65+)	16.6	25	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	7.2	23	3.0
	Health Status (Percent very good or excellent of adults age 65+)	42.0	13	48.9
	Able-Bodied (Percent of adults age 65+)	67.0	4	68.0
	Premature Death (Deaths per 100,000 population age 65-74)	1,862	26	1,425
	Teeth Extractions (Percent of adults age 65+)	16.9	25	7.4
	Mental Health Days (Days in previous 30 days)	1.5	1	1.5
	ALL OUTCOMES	0.160	10	
	OVERALL	0.533	5	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	15.4	45	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	30.0	15	20.9
Cognition (Percent of adults age 65+)	7.1	5	5.7
Depression (Percent of adults age 65+)	10.3	8	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	55.6	53.9
Obesity (Percent obese)	24.2	33.8

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015-2030	34.1	52.7

Overall Rank: 5

Determinants Rank: 3

Outcomes Rank: 10

Strengths:

- Low prevalence of activity-limiting arthritis pain
- High percentage of volunteerism
- High percentage of creditable drug coverage

Challenges:

- High prevalence of obesity
- Limited availability of home health care workers
- High percentage of low-care nursing home residents

Ranking: Iowa is 5th in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 20th for its entire population.

Highlights:

- Iowa has one of the lowest numbers of poor mental health days per month at 1.5 days in the previous 30 days.
- In Iowa, 29.1 percent of adults aged 65 and older, or 132,000 seniors, are obese.
- Iowa has the highest prevalence of flu vaccination in the nation, at 70.2 percent of adults aged 65 and older.
- Iowa has a high rate of 4 and 5-star rated nursing home beds at 63.9 beds per 100,000 adults aged 75 and older.
- The percentage of low-care nursing home residents is high at 16.9 percent of nursing home residents.

Disparities: In Iowa, seniors with less than a high school degree are more physically inactive and have lower social support than those with a college degree.

State Health Department Website:

<http://www.idph.state.ia.us/>



For a more detailed look at this data, visit www.americashealthrankings.org/senior/IA

KANSAS

KANSAS

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	9.5	29	4.7
	Chronic Drinking (Percent of adults age 65+)	2.2	8	1.4
	Obesity (Percent of adults age 65+)	26.3	33	16.9
	Underweight (Percent of adults age 65+)	1.7	13	1.1
	Physical Inactivity (Percent of adults age 65+)	32.6	30	20.5
	Dental Visits (Percent of adults age 65+)	70.8	23	79.8
	Pain Management (Percent of adults age 65+)	52.5	21	60.7
	BEHAVIORS TOTAL	0.029	14	
COMMUNITY & ENVIRONMENT				
C&E — MACRO PERSPECTIVE				
	Poverty (Percent of adults age 65+)	7.7	15	5.1
	Volunteerism (Percent of adults age 65+)	36.0	4	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	64.6	2	65.2
	C&E — MICRO PERSPECTIVE	0.045	14	
	Social Support (Percent of adults age 65+)	83.9	4	85.4
	Food Insecurity (Percent of adults age 60+)	12.8	20	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$762	24	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	0.189	4	
POLICY				
	Low-Care Nursing Home Residents (Percent of residents)	18.2	45	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	85.1	37	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	67.1	28	16.3
	POLICY TOTAL	-0.090	45	
CLINICAL CARE				
	Dedicated Health Care Provider (Percent of adults age 65+)	95.3	19	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	98.0	11	98.4
	Flu Vaccine (Percent of adults age 65+)	67.6	6	70.2
	Health Screenings (Percent of adults age 65–74)	85.7	25	91.7
	Diabetes Management (Percent of Medicare enrollees)	76.0	37	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	122.6	9	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	66.8	31	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	15.6	23	12.3
	Hospice Care (Percent of decedents age 65+)	40.0	15	54.5
	Hospital Deaths (Percent of decedents age 65+)	26.8	20	19.2
	CLINICAL CARE TOTAL	0.051	11	
	ALL DETERMINANTS	0.179	15	
OUTCOMES				
	ICU Usage (Percent of decedents age 65+)	9.6	17	5.1
	Falls (Percent of adults age 65+)	18.4	45	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	8.3	38	3.0
	Health Status (Percent very good or excellent of adults age 65+)	39.7	22	48.9
	Able-Bodied (Percent of adults age 65+)	62.5	30	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	1,902	30	1,425
	Teeth Extractions (Percent of adults age 65+)	17.9	30	7.4
	Mental Health Days (Days in previous 30 days)	1.8	7	1.5
	ALL OUTCOMES	0.013	28	
	OVERALL	0.192	18	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	21.0	26	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	31.9	22	20.9
Cognition (Percent of adults age 65+)	8.5	20	5.7
Depression (Percent of adults age 65+)	11.5	12	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	55.4	56
Obesity (Percent obese)	23.8	35.1

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	41.3	52.7

Overall Rank: 18

Determinants Rank: 15

Outcomes Rank: 28

Strengths:

- High percentage of volunteerism
- High rate of highly-rated nursing home beds
- High percentage of social support

Challenges:

- High percentage of low-care nursing home residents
- Low percentage of creditable drug coverage
- Low percentage of diabetes management

Ranking: Kansas is 18th in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 24th for its entire population.

Highlights:

- Kansas has a high rate of 4 and 5-star rated nursing home beds at 64.6 beds per 100,000 adults aged 75 and older.
- Kansas has a high percentage of low-care nursing home residents at 18.2 percent of nursing home residents.
- In Kansas, a high percentage of seniors volunteer at 36.0 percent of adults aged 65 and older.
- In Kansas, 18.4 percent of adults aged 65 and older fell in the last 3 months.
- A high percentage of older adults receive social support in Kansas at 83.9 percent of adults aged 65 and older.

Disparities: In Kansas, seniors with less than a high school degree have higher rates of obesity and physical inactivity as well as lower health status and social support compared to those with a college degree.

State Health Department Website:
www.kdheks.gov



For a more detailed look at this data, visit www.americashealthrankings.org/senior/KS

KENTUCKY

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	10.4	39	4.7
	Chronic Drinking (Percent of adults age 65+)	2.9	15	1.4
	Obesity (Percent of adults age 65+)	25.1	23	16.9
	Underweight (Percent of adults age 65+)	1.4	7	1.1
	Physical Inactivity (Percent of adults age 65+)	34.5	40	20.5
	Dental Visits (Percent of adults age 65+)	58.3	46	79.8
	Pain Management (Percent of adults age 65+)	55.7	10	60.7
	BEHAVIORS TOTAL	-0.025	32	
	COMMUNITY & ENVIRONMENT			
	C&E — MACRO PERSPECTIVE	-0.091	46	
	Poverty (Percent of adults age 65+)	11.9	47	5.1
	Volunteerism (Percent of adults age 65+)	20.7	38	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	34.9	34	65.2
	C&E — MICRO PERSPECTIVE	-0.023	35	
	Social Support (Percent of adults age 65+)	80.7	23	85.4
	Food Insecurity (Percent of adults age 60+)	15.3	31	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$358	47	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	-0.114	41	
	POLICY			
	Low-Care Nursing Home Residents (Percent of residents)	7.1	10	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	86.7	23	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	76.2	43	16.3
	POLICY TOTAL	0.019	21	
	CLINICAL CARE			
	Dedicated Health Care Provider (Percent of adults age 65+)	95.1	22	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.1	41	98.4
	Flu Vaccine (Percent of adults age 65+)	64.2	14	70.2
	Health Screenings (Percent of adults age 65–74)	83.3	38	91.7
	Diabetes Management (Percent of Medicare enrollees)	81.0	19	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	36.6	48	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	102.8	50	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	16.9	49	12.3
	Hospice Care (Percent of decedents age 65+)	30.8	37	54.5
	Hospital Deaths (Percent of decedents age 65+)	32.1	36	19.2
	CLINICAL CARE TOTAL	-0.095	48	
	ALL DETERMINANTS	-0.216	40	
	OUTCOMES			
	ICU Usage (Percent of decedents age 65+)	16.4	43	5.1
	Falls (Percent of adults age 65+)	18.8	46	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	8.8	47	3.0
	Health Status (Percent very good or excellent of adults age 65+)	33.4	44	48.9
	Able-Bodied (Percent of adults age 65+)	57.1	45	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	2,444	49	1,425
	Teeth Extractions (Percent of adults age 65+)	27.4	48	7.4
	Mental Health Days (Days in previous 30 days)	2.6	36	1.5
	ALL OUTCOMES	-0.321	50	
	OVERALL	-0.537	45	

Overall Rank: 45

Determinants Rank: 40

Outcomes Rank: 50

Strengths:

- Low prevalence of underweight seniors
- Low prevalence of activity-limiting arthritis pain
- Low percentage of low-care nursing home residents

Challenges:

- Low prevalence of dental visits
- High premature death rate
- High rate of preventable hospitalizations

Ranking: Kentucky is 45th in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 44th for its entire population.

Highlights:

- Community support is low in Kentucky with total community expenditures at \$358 per person aged 65 and older living in poverty.
- Kentucky has the highest rate of preventable hospitalizations in the U.S. at 102.8 discharges per 1,000 Medicare enrollees.
- Kentucky has a low prevalence of underweight seniors at 1.4 percent of adults aged 65 and older.
- The prevalence of annual dental visits is low among older adults in Kentucky at 58.3 percent of adults aged 65 and older.
- Kentucky has a low percentage of low-care nursing home residents at 7.1 percent of nursing home residents.

Disparities: In Kentucky, the prevalence of obesity among black seniors is 40% compared to 24% in white seniors.

State Health Department Website:

www.chfs.ky.gov

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	13.8	49	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	38.1	41	20.9
Cognition (Percent of adults age 65+)	12.2	49	5.7
Depression (Percent of adults age 65+)	16.1	43	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	41.0	39.3
Obesity (Percent obese)	23.4	37.3

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	41.8	52.7



For a more detailed look at this data, visit www.americashealthrankings.org/senior/KY

LOUISIANA

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	12.1	48	4.7
	Chronic Drinking (Percent of adults age 65+)	3.1	20	1.4
	Obesity (Percent of adults age 65+)	28.7	44	16.9
	Underweight (Percent of adults age 65+)	1.8	20	1.1
	Physical Inactivity (Percent of adults age 65+)	38.5	48	20.5
	Dental Visits (Percent of adults age 65+)	58.9	45	79.8
	Pain Management (Percent of adults age 65+)	51.5	27	60.7
	BEHAVIORS TOTAL	-0.204	47	
	COMMUNITY & ENVIRONMENT			
	C&E — MACRO PERSPECTIVE	-0.102	49	
	Poverty (Percent of adults age 65+)	12.2	48	5.1
	Volunteerism (Percent of adults age 65+)	18.1	48	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	38.3	29	65.2
	C&E — MICRO PERSPECTIVE	-0.024	36	
	Social Support (Percent of adults age 65+)	78.6	37	85.4
	Food Insecurity (Percent of adults age 60+)	14.0	26	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$672	28	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	-0.127	44	
	POLICY			
	Low-Care Nursing Home Residents (Percent of residents)	22.8	48	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	86.8	22	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	74.9	41	16.3
	POLICY TOTAL	-0.122	47	
	CLINICAL CARE			
	Dedicated Health Care Provider (Percent of adults age 65+)	93.4	38	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.0	43	98.4
	Flu Vaccine (Percent of adults age 65+)	70.2	1	70.2
	Health Screenings (Percent of adults age 65–74)	85.3	27	91.7
	Diabetes Management (Percent of Medicare enrollees)	78.5	34	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	126.2	7	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	92.1	48	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	16.3	38	12.3
	Hospice Care (Percent of decedents age 65+)	37.3	18	54.5
	Hospital Deaths (Percent of decedents age 65+)	31.0	33	19.2
	CLINICAL CARE TOTAL	-0.036	40	
	ALL DETERMINANTS	-0.489	48	
	OUTCOMES			
	ICU Usage (Percent of decedents age 65+)	14.4	35	5.1
	Falls (Percent of adults age 65+)	14.2	4	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	8.4	42	3.0
	Health Status (Percent very good or excellent of adults age 65+)	30.6	49	48.9
	Able-Bodied (Percent of adults age 65+)	57.1	46	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	2,363	46	1,425
	Teeth Extractions (Percent of adults age 65+)	25.6	46	7.4
	Mental Health Days (Days in previous 30 days)	2.5	32	1.5
	ALL OUTCOMES	-0.213	44	
	OVERALL	-0.702	48	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	16.9	39	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	38.6	43	20.9
Cognition (Percent of adults age 65+)	12.1	48	5.7
Depression (Percent of adults age 65+)	13.8	29	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	52.9	40.5
Obesity (Percent obese)	28.0	37.5

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	42.2	52.7

Overall Rank: 48

Determinants Rank: 48

Outcomes Rank: 44

Strengths:

- High prevalence of flu vaccination
- Ready availability of home health care workers
- Low prevalence of falls

Challenges:

- High prevalence of smoking
- High prevalences of obesity & physical inactivity
- High percentage of seniors living in poverty

Ranking: Louisiana is 48th in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 49th for its entire population.

Highlights:

- The percentage of older adults who have fallen in the last 3 months is low at 14.2 percent of adults aged 65 and older.
- The prevalence of smoking in Louisiana is high with 12.1 percent of adults aged 65 and older, or almost 70,000 seniors, who smoke.
- Louisiana has one of the highest rates of preventable hospitalizations in the U.S. at 92.1 discharges per 1,000 Medicare enrollees.
- Louisiana has a high percentage of low-care nursing home residents at 22.8 percent of nursing home residents.
- The prevalence of older adults receiving a flu vaccine is high at 70.2 percent of adults aged 65 and older.

Disparities: In Louisiana, 56.4% of seniors with a household income greater than \$75,000 report very good or excellent health compared to only 20.5% of those with incomes less than \$25,000.

State Health Department Website:

www.dhh.louisiana.gov/



For a more detailed look at this data, visit www.americashealthrankings.org/senior/LA

MAINE

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	7.9	9	4.7
	Chronic Drinking (Percent of adults age 65+)	5.7	47	1.4
	Obesity (Percent of adults age 65+)	24.5	18	16.9
	Underweight (Percent of adults age 65+)	1.6	9	1.1
	Physical Inactivity (Percent of adults age 65+)	28.0	11	20.5
	Dental Visits (Percent of adults age 65+)	68.0	27	79.8
	Pain Management (Percent of adults age 65+)	50.7	30	60.7
	BEHAVIORS TOTAL	-0.002	25	
	COMMUNITY & ENVIRONMENT			
	C&E — MACRO PERSPECTIVE	0.040	18	
	Poverty (Percent of adults age 65+)	8.6	29	5.1
	Volunteerism (Percent of adults age 65+)	28.1	20	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	47.3	18	65.2
	C&E — MICRO PERSPECTIVE	0.029	20	
	Social Support (Percent of adults age 65+)	82.4	11	85.4
	Food Insecurity (Percent of adults age 60+)	12.2	16	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$525	39	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	0.069	20	
	POLICY			
	Low-Care Nursing Home Residents (Percent of residents)	1.1	1	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	84.1	42	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	46.9	10	16.3
	POLICY TOTAL	0.109	6	
	CLINICAL CARE			
	Dedicated Health Care Provider (Percent of adults age 65+)	95.5	15	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	98.3	3	98.4
	Flu Vaccine (Percent of adults age 65+)	61.6	24	70.2
	Health Screenings (Percent of adults age 65–74)	90.3	6	91.7
	Diabetes Management (Percent of Medicare enrollees)	83.7	5	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	105.8	15	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	59.3	20	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	14.9	11	12.3
	Hospice Care (Percent of decedents age 65+)	25.3	43	54.5
	Hospital Deaths (Percent of decedents age 65+)	30.7	31	19.2
	CLINICAL CARE TOTAL	0.060	9	
	ALL DETERMINANTS	0.235	9	
	OUTCOMES			
	ICU Usage (Percent of decedents age 65+)	6.7	6	5.1
	Falls (Percent of adults age 65+)	18.2	43	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	6.9	16	3.0
	Health Status (Percent very good or excellent of adults age 65+)	44.5	5	48.9
	Able-Bodied (Percent of adults age 65+)	61.9	34	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	1,902	30	1,425
	Teeth Extractions (Percent of adults age 65+)	20.7	38	7.4
	Mental Health Days (Days in previous 30 days)	2.1	14	1.5
	ALL OUTCOMES	0.068	23	
	OVERALL	0.303	13	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	21.9	21	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	31.1	19	20.9
Cognition (Percent of adults age 65+)	9.9	36	5.7
Depression (Percent of adults age 65+)	17.8	48	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	60.2	56.2
Obesity (Percent obese)	22.0	30.5

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	49.5	52.7

Overall Rank: 13

Determinants Rank: 9

Outcomes Rank: 23

Strengths:

- Low prevalence of smoking
- Low percentage of low-care nursing home residents
- High percentage of seniors who received recommended hospital care

Challenges:

- High prevalence of chronic drinking
- Low percentage of creditable drug coverage
- High prevalence of falls

Ranking: Maine is 13th in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 9th for its entire population.

Highlights:

- The percentage of older adults who have fallen in the last 3 months is high in Maine, at 18.2 percent of adults aged 65 and older.
- In Maine, chronic drinking is high among older adults in Maine at 5.7 percent of adults aged 65 and older.
- Maine has the lowest percentage of low-care nursing home residents at 1.1 percent of nursing home residents.
- The prevalence of smoking is low at 7.9 percent of adults aged 65 and older, or 17,000 seniors, who smoke.
- A high percentage of older adults in Maine receive recommended health screenings at 90.3 percent of adults aged 65 and older.

Disparities: In Maine, seniors with less than a high school degree have higher rates of obesity and physical inactivity as well as lower health status and social support compared to those with a college degree.

State Health Department Website:

www.maine.gov/dhhs



For a more detailed look at this data, visit www.americashealthrankings.org/senior/ME

MARYLAND

MARYLAND

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	9.2	26	4.7
	Chronic Drinking (Percent of adults age 65+)	3.5	24	1.4
	Obesity (Percent of adults age 65+)	26.1	30	16.9
	Underweight (Percent of adults age 65+)	2.4	41	1.1
	Physical Inactivity (Percent of adults age 65+)	28.5	13	20.5
	Dental Visits (Percent of adults age 65+)	74.6	8	79.8
	Pain Management (Percent of adults age 65+)	60.7	1	60.7
	BEHAVIORS TOTAL	0.067	10	
COMMUNITY & ENVIRONMENT				
C&E — MACRO PERSPECTIVE				
	Poverty (Percent of adults age 65+)	7.6	12	5.1
	Volunteerism (Percent of adults age 65+)	29.5	12	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	44.1	22	65.2
	C&E — MICRO PERSPECTIVE	0.012	24	
	Social Support (Percent of adults age 65+)	81.2	19	85.4
	Food Insecurity (Percent of adults age 60+)	12.9	23	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$609	30	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	0.069	19	
POLICY				
	Low-Care Nursing Home Residents (Percent of residents)	8.2	12	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	82.8	45	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	29.4	2	16.3
	POLICY TOTAL	0.061	13	
CLINICAL CARE				
	Dedicated Health Care Provider (Percent of adults age 65+)	95.2	20	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.0	43	98.4
	Flu Vaccine (Percent of adults age 65+)	62.8	19	70.2
	Health Screenings (Percent of adults age 65–74)	89.9	8	91.7
	Diabetes Management (Percent of Medicare enrollees)	82.1	15	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	59.9	40	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	62.7	26	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	15.9	32	12.3
	Hospice Care (Percent of decedents age 65+)	32.6	31	54.5
	Hospital Deaths (Percent of decedents age 65+)	32.5	38	19.2
	CLINICAL CARE TOTAL	-0.012	28	
	ALL DETERMINANTS	0.184	13	
OUTCOMES				
	ICU Usage (Percent of decedents age 65+)	12.4	26	5.1
	Falls (Percent of adults age 65+)	12.9	1	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	6.9	16	3.0
	Health Status (Percent very good or excellent of adults age 65+)	42.5	10	48.9
	Able-Bodied (Percent of adults age 65+)	66.6	7	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	1,844	25	1,425
	Teeth Extractions (Percent of adults age 65+)	13.6	10	7.4
	Mental Health Days (Days in previous 30 days)	1.8	7	1.5
	ALL OUTCOMES	0.210	5	
	OVERALL	0.394	10	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	27.9	3	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	37.3	39	20.9
Cognition (Percent of adults age 65+)	8.4	19	5.7
Depression (Percent of adults age 65+)	9.2	3	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	56.1	55.2
Obesity (Percent obese)	22.0	31.4

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	47.6	52.7

Overall Rank: 10

Determinants Rank: 13

Outcomes Rank: 5

Strengths:

- Low prevalence of activity-limiting arthritis pain
- Low geriatrician shortfall
- Low prevalence of falls

Challenges:

- High prevalence of underweight seniors
- Low percentage of creditable drug coverage
- Limited availability of home health care workers

Ranking: Maryland is 10th in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 19th for its entire population.

Highlights:

- The estimated geriatrician shortfall in Maryland is low at 29.4 percent of the number of geriatricians needed.
- The percentage of older adults with creditable drug coverage is low at 82.8 percent of adults aged 65 and older.
- The rate of home health care workers is low in Maryland, at 59.9 per 1,000 adults aged 75 and older.
- The percentage of adults with arthritis whose usual activity is not limited by pain is lower than all other states at 60.7 percent of adults aged 65 and older.
- The percentage of older adults who have fallen in the last 3 months is lowest in Maryland, at 12.9 percent of adults aged 65 and older.

Disparities: In Maryland, seniors with household incomes less than \$25,000 have lower health status and less social support than those with incomes greater than \$75,000.

State Health Department Website:

www.dhmh.maryland.gov



For a more detailed look at this data, visit www.americashealthrankings.org/senior/MD

MASSACHUSETTS

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	9.0	23	4.7
	Chronic Drinking (Percent of adults age 65+)	5.7	47	1.4
	Obesity (Percent of adults age 65+)	22.8	10	16.9
	Underweight (Percent of adults age 65+)	2.0	25	1.1
	Physical Inactivity (Percent of adults age 65+)	29.2	19	20.5
	Dental Visits (Percent of adults age 65+)	77.0	3	79.8
	Pain Management (Percent of adults age 65+)	56.5	6	60.7
	BEHAVIORS TOTAL	0.064	11	
	COMMUNITY & ENVIRONMENT			
	C&E — MACRO PERSPECTIVE	0.028	22	
	Poverty (Percent of adults age 65+)	9.0	31	5.1
	Volunteerism (Percent of adults age 65+)	23.5	30	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	55.3	9	65.2
	C&E — MICRO PERSPECTIVE	0.107	1	
	Social Support (Percent of adults age 65+)	80.7	23	85.4
	Food Insecurity (Percent of adults age 60+)	10.5	9	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$3,620	3	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	0.135	9	
	POLICY			
	Low-Care Nursing Home Residents (Percent of residents)	10.3	20	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	87.1	18	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	40.0	6	16.3
	POLICY TOTAL	0.111	5	
	CLINICAL CARE			
	Dedicated Health Care Provider (Percent of adults age 65+)	96.3	5	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.7	22	98.4
	Flu Vaccine (Percent of adults age 65+)	66.9	7	70.2
	Health Screenings (Percent of adults age 65–74)	91.7	1	91.7
	Diabetes Management (Percent of Medicare enrollees)	83.7	5	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	84.7	21	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	72.8	38	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	16.3	38	12.3
	Hospice Care (Percent of decedents age 65+)	30.7	38	54.5
	Hospital Deaths (Percent of decedents age 65+)	31.9	35	19.2
	CLINICAL CARE TOTAL	0.033	17	
	ALL DETERMINANTS	0.343	4	
	OUTCOMES			
	ICU Usage (Percent of decedents age 65+)	9.5	16	5.1
	Falls (Percent of adults age 65+)	14.3	6	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	6.5	9	3.0
	Health Status (Percent very good or excellent of adults age 65+)	42.6	8	48.9
	Able-Bodied (Percent of adults age 65+)	66.2	10	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	1,632	8	1,425
	Teeth Extractions (Percent of adults age 65+)	15.2	17	7.4
	Mental Health Days (Days in previous 30 days)	2.3	23	1.5
	ALL OUTCOMES	0.198	6	
	OVERALL	0.542	4	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	25.4	8	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	34.2	28	20.9
Cognition (Percent of adults age 65+)	8.1	14	5.7
Depression (Percent of adults age 65+)	11.5	11	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	59.4	60.3
Obesity (Percent obese)	25.6	25

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	42.7	52.7

Overall Rank: 4

Determinants Rank: 4

Outcomes Rank: 6

Strengths:

- High prevalence of dental visits
- High community support expenditures
- High percentage of health screenings

Challenges:

- High prevalence of chronic drinking
- High rate of preventable hospitalizations
- Low percentage of hospice care

Ranking: Massachusetts is 4th in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 4th for its entire population.

Highlights:

- Massachusetts has one of the lowest percentages of estimated geriatrician shortfall at 40.0 percent of the number of geriatricians needed.
- While Massachusetts has one of the lowest obesity rates in the U.S. at 22.8 percent of adults aged 60 and older, more than 200,000 seniors are still obese in the state.
- Food insecurity is low among Massachusetts seniors; 10.5 percent of adults aged 60 and older, or 95,000 seniors, are marginally food insecure in the state.
- A low percentage of Massachusetts seniors enrolled in hospice during the last 6 months of life at 30.7 percent of adults aged 65 and older.
- Over 500,000 Massachusetts adults aged 65 and older with arthritis report that pain does not limit their usual activities.

Disparities: In Massachusetts, 60.0 percent of seniors with a college degree report excellent or very good health compared to only 23.6 percent of seniors with less than a high school degree.

State Health Department Website:

www.mass.gov/dph



For a more detailed look at this data, visit www.americashealthrankings.org/senior/MA

MICHIGAN

MICHIGAN

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	9.9	35	4.7
	Chronic Drinking (Percent of adults age 65+)	3.5	24	1.4
	Obesity (Percent of adults age 65+)	29.5	50	16.9
	Underweight (Percent of adults age 65+)	1.1	1	1.1
	Physical Inactivity (Percent of adults age 65+)	28.5	13	20.5
	Dental Visits (Percent of adults age 65+)	75.6	5	79.8
	Pain Management (Percent of adults age 65+)	51.3	28	60.7
	BEHAVIORS TOTAL	0.033	13	
COMMUNITY & ENVIRONMENT				
C&E — MACRO PERSPECTIVE				
	Poverty (Percent of adults age 65+)	8.1	22	5.1
	Volunteerism (Percent of adults age 65+)	23.1	32	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	34.4	35	65.2
	C&E — MICRO PERSPECTIVE	0.003	28	
	Social Support (Percent of adults age 65+)	80.3	26	85.4
	Food Insecurity (Percent of adults age 60+)	14.4	29	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$1,213	13	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	-0.009	29	
POLICY				
	Low-Care Nursing Home Residents (Percent of residents)	10.3	19	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	83.2	43	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	62.6	23	16.3
	POLICY TOTAL	-0.042	38	
CLINICAL CARE				
	Dedicated Health Care Provider (Percent of adults age 65+)	96.0	7	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.6	26	98.4
	Flu Vaccine (Percent of adults age 65+)	58.0	33	70.2
	Health Screenings (Percent of adults age 65–74)	88.8	11	91.7
	Diabetes Management (Percent of Medicare enrollees)	80.7	23	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	75.0	32	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	69.8	35	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	16.1	36	12.3
	Hospice Care (Percent of decedents age 65+)	43.1	8	54.5
	Hospital Deaths (Percent of decedents age 65+)	26.3	16	19.2
	CLINICAL CARE TOTAL	0.022	20	
	ALL DETERMINANTS	0.005	29	
OUTCOMES				
	ICU Usage (Percent of decedents age 65+)	13.3	30	5.1
	Falls (Percent of adults age 65+)	16.3	21	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	6.7	12	3.0
	Health Status (Percent very good or excellent of adults age 65+)	41.2	16	48.9
	Able-Bodied (Percent of adults age 65+)	63.1	28	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	1,969	35	1,425
	Teeth Extractions (Percent of adults age 65+)	13.1	7	7.4
	Mental Health Days (Days in previous 30 days)	2.2	19	1.5
	ALL OUTCOMES	0.078	21	
	OVERALL	0.083	26	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	18.2	35	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	39.3	46	20.9
Cognition (Percent of adults age 65+)	9.6	32	5.7
Depression (Percent of adults age 65+)	14.1	32	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	49.5	51.2
Obesity (Percent obese)	29.8	37.1

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	38.1	52.7

Overall Rank: 26

Determinants Rank: 29

Outcomes Rank: 21

Strengths:

- Low prevalence of underweight seniors
- High prevalence of dental visits
- Low prevalence of teeth extractions

Challenges:

- High prevalence of obesity
- Low percentage of creditable drug coverage
- High prevalence of smoking

Ranking: Michigan is 26th in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 37th for its entire population.

Highlights:

- In Michigan, more than 400,000 adults aged 65 and older are obese and almost the same number are physically inactive.
- A high prevalence of Michigan seniors have a dedicated health care provider at 96 percent of adults aged 65 and older.
- Michigan's creditable drug coverage rate is one of the lowest in the U.S. at 83.2 percent of Medicare beneficiaries.
- More than 130,000 adults aged 65 and older smoke in Michigan.
- Michigan has one of the lowest rates of teeth extraction in the nation, at 13.1 percent of adults aged 65 and older.

Disparities: In Michigan, 18.2 percent of seniors with a college degree report being physically inactive compared to 43.5 percent of seniors with less than a high school degree.

State Health Department Website:
www.michigan.gov/mdch



For a more detailed look at this data, visit www.americashealthrankings.org/senior/MI

MINNESOTA

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	8.6	14	4.7
	Chronic Drinking (Percent of adults age 65+)	4.1	32	1.4
	Obesity (Percent of adults age 65+)	23.7	12	16.9
	Underweight (Percent of adults age 65+)	1.7	13	1.1
	Physical Inactivity (Percent of adults age 65+)	28.9	16	20.5
	Dental Visits (Percent of adults age 65+)	76.5	4	79.8
	Pain Management (Percent of adults age 65+)	53.3	17	60.7
	BEHAVIORS TOTAL	0.094	5	
	COMMUNITY & ENVIRONMENT			
	C&E — MACRO PERSPECTIVE	0.111	4	
	Poverty (Percent of adults age 65+)	8.3	27	5.1
	Volunteerism (Percent of adults age 65+)	38.9	2	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	51.4	11	65.2
	C&E — MICRO PERSPECTIVE	0.086	4	
	Social Support (Percent of adults age 65+)	83.4	7	85.4
	Food Insecurity (Percent of adults age 60+)	7.4	2	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$542	37	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	0.196	3	
	POLICY			
	Low-Care Nursing Home Residents (Percent of residents)	12.9	31	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	89.6	1	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	47.4	12	16.3
	POLICY TOTAL	0.116	4	
	CLINICAL CARE			
	Dedicated Health Care Provider (Percent of adults age 65+)	92.5	43	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.4	36	98.4
	Flu Vaccine (Percent of adults age 65+)	63.6	15	70.2
	Health Screenings (Percent of adults age 65–74)	89.2	9	91.7
	Diabetes Management (Percent of Medicare enrollees)	83.0	10	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	246.1	2	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	50.6	7	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	15.2	16	12.3
	Hospice Care (Percent of decedents age 65+)	32.0	34	54.5
	Hospital Deaths (Percent of decedents age 65+)	25.4	11	19.2
	CLINICAL CARE TOTAL	0.069	5	
	ALL DETERMINANTS	0.474	1	
	OUTCOMES			
	ICU Usage (Percent of decedents age 65+)	7.4	9	5.1
	Falls (Percent of adults age 65+)	14.6	7	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	6.4	5	3.0
	Health Status (Percent very good or excellent of adults age 65+)	46.0	3	48.9
	Able-Bodied (Percent of adults age 65+)	68.0	1	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	1,585	4	1,425
	Teeth Extractions (Percent of adults age 65+)	11.2	4	7.4
	Mental Health Days (Days in previous 30 days)	1.7	5	1.5
	ALL OUTCOMES	0.321	1	
	OVERALL	0.796	1	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	21.6	23	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	24.2	4	20.9
Cognition (Percent of adults age 65+)	6.4	3	5.7
Depression (Percent of adults age 65+)	9.6	4	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	59.7	60.4
Obesity (Percent obese)	21.6	28.6

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	54.1	52.7

Overall Rank: 1

Determinants Rank: 1

Outcomes Rank: 1

Strengths:

- High percentage of volunteerism
- High percentage of creditable drug coverage
- Ready availability of home health care workers

Challenges:

- Low prevalence of dedicated health care providers
- Low community support expenditures
- High prevalence of chronic drinking

Ranking: Minnesota is 1st in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 5th for its entire population.

Highlights:

- Total community expenditures in Minnesota are lower than most states at \$542 per person aged 65 and older living in poverty.
- Minnesota has the second highest volunteer rate among seniors in the U.S. at 38.9 percent of adults aged 65 and older.
- Almost 200,000 Minnesotan adults aged 65 and older are physically inactive.
- Minnesota ranks first for combined outcomes and is among the top 5 states for 7 of the 11 outcome measures.
- Few seniors in Minnesota are marginally food insecure at 7.4 percent of adults aged 60 and older.

Disparities: In Minnesota, seniors with a college degree report lower prevalences of obesity and physical inactivity, higher prevalence of social support, and better health status compared to seniors with less than a high school degree.

State Health Department Website:

www.health.state.mn.us



For a more detailed look at this data, visit www.americashealthrankings.org/senior/MN

MISSISSIPPI

MISSISSIPPI

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	10.0	36	4.7
	Chronic Drinking (Percent of adults age 65+)	1.9	4	1.4
	Obesity (Percent of adults age 65+)	27.9	42	16.9
	Underweight (Percent of adults age 65+)	2.1	33	1.1
	Physical Inactivity (Percent of adults age 65+)	38.1	47	20.5
	Dental Visits (Percent of adults age 65+)	50.2	50	79.8
	Pain Management (Percent of adults age 65+)	46.6	47	60.7
	BEHAVIORS TOTAL	-0.198	46	
COMMUNITY & ENVIRONMENT				
C&E — MACRO PERSPECTIVE				
	Poverty (Percent of adults age 65+)	13.5	50	5.1
	Volunteerism (Percent of adults age 65+)	24.7	27	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	46.4	20	65.2
C&E — MICRO PERSPECTIVE				
	Social Support (Percent of adults age 65+)	78.0	42	85.4
	Food Insecurity (Percent of adults age 60+)	21.5	50	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$318	49	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	-0.163	49	
POLICY				
	Low-Care Nursing Home Residents (Percent of residents)	16.3	40	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	86.4	26	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	87.1	48	16.3
	POLICY TOTAL	-0.108	46	
CLINICAL CARE				
	Dedicated Health Care Provider (Percent of adults age 65+)	94.0	35	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.3	37	98.4
	Flu Vaccine (Percent of adults age 65+)	65.4	10	70.2
	Health Screenings (Percent of adults age 65–74)	80.5	47	91.7
	Diabetes Management (Percent of Medicare enrollees)	74.1	45	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	58.2	41	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	91.3	47	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	16.4	41	12.3
	Hospice Care (Percent of decedents age 65+)	35.1	24	54.5
	Hospital Deaths (Percent of decedents age 65+)	36.9	48	19.2
	CLINICAL CARE TOTAL	-0.114	50	
	ALL DETERMINANTS	-0.583	50	
OUTCOMES				
	ICU Usage (Percent of decedents age 65+)	11.2	21	5.1
	Falls (Percent of adults age 65+)	17.6	39	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	8.4	42	3.0
	Health Status (Percent very good or excellent of adults age 65+)	28.5	50	48.9
	Able-Bodied (Percent of adults age 65+)	54.0	50	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	2,558	50	1,425
	Teeth Extractions (Percent of adults age 65+)	27.2	47	7.4
	Mental Health Days (Days in previous 30 days)	2.7	43	1.5
	ALL OUTCOMES	-0.302	49	
	OVERALL	-0.885	50	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	15.7	44	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	33.8	25	20.9
Cognition (Percent of adults age 65+)	13.7	50	5.7
Depression (Percent of adults age 65+)	14.4	33	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	41.5	35.7
Obesity (Percent obese)	25.5	38.9

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	46.3	52.7

Overall Rank: 50

Determinants Rank: 50

Outcomes Rank: 49

Strengths:

- Low prevalence of chronic drinking
- High prevalence of flu vaccination
- Moderate rate of highly-rated nursing home beds

Challenges:

- High prevalence of physical inactivity
- Low prevalence of dental visits & high prevalence of teeth extractions
- High percentage of seniors living in poverty

Ranking: Mississippi is 50th in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 49th for its entire population.

Highlights:

- Mississippi has the highest rate of food insecurity in the nation with 21.5 percent of adults aged 60 and older who are marginally food insecure.
- Mississippi has one of the highest rates of physical inactivity in the U.S., with 146,000 adults aged 65 and older who are inactive.
- There is a high geriatrician shortfall in Mississippi at 87.1 percent of the number of geriatricians needed.
- Mississippi has one of the highest rates of flu vaccination at 65.4 percent of adults aged 65 and older receiving the flu vaccine.
- In Mississippi, only 46.6 percent of adults aged 65 and older with arthritis report that pain does not limit their usual activities.

Disparities: In Mississippi, 41.6 percent of black seniors are obese compared to 23.8 percent of white seniors.

State Health Department Website:

www.msdh.state.ms.us



For a more detailed look at this data, visit www.americashealthrankings.org/senior/MS

MISSOURI

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	10.1	37	4.7
	Chronic Drinking (Percent of adults age 65+)	2.7	12	1.4
	Obesity (Percent of adults age 65+)	26.2	32	16.9
	Underweight (Percent of adults age 65+)	1.6	9	1.1
	Physical Inactivity (Percent of adults age 65+)	33.6	35	20.5
	Dental Visits (Percent of adults age 65+)	57.5	47	79.8
	Pain Management (Percent of adults age 65+)	55.2	12	60.7
	BEHAVIORS TOTAL	-0.043	37	
	COMMUNITY & ENVIRONMENT			
	C&E — MACRO PERSPECTIVE	0.071	10	
	Poverty (Percent of adults age 65+)	8.6	29	5.1
	Volunteerism (Percent of adults age 65+)	29.5	12	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	56.5	8	65.2
	C&E — MICRO PERSPECTIVE	-0.016	30	
	Social Support (Percent of adults age 65+)	80.7	23	85.4
	Food Insecurity (Percent of adults age 60+)	15.5	34	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$718	26	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	0.056	23	
	POLICY			
	Low-Care Nursing Home Residents (Percent of residents)	21.1	47	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	87.3	17	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	61.3	19	16.3
	POLICY TOTAL	-0.053	39	
	CLINICAL CARE			
	Dedicated Health Care Provider (Percent of adults age 65+)	95.8	9	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.6	26	98.4
	Flu Vaccine (Percent of adults age 65+)	63.1	18	70.2
	Health Screenings (Percent of adults age 65–74)	81.6	45	91.7
	Diabetes Management (Percent of Medicare enrollees)	79.2	32	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	80.9	25	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	73.0	39	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	16.0	33	12.3
	Hospice Care (Percent of decedents age 65+)	36.7	19	54.5
	Hospital Deaths (Percent of decedents age 65+)	30.3	29	19.2
	CLINICAL CARE TOTAL	-0.023	33	
	ALL DETERMINANTS	-0.063	34	
	OUTCOMES			
	ICU Usage (Percent of decedents age 65+)	14.9	36	5.1
	Falls (Percent of adults age 65+)	17.3	34	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	8.2	36	3.0
	Health Status (Percent very good or excellent of adults age 65+)	35.0	38	48.9
	Able-Bodied (Percent of adults age 65+)	61.7	35	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	2,088	38	1,425
	Teeth Extractions (Percent of adults age 65+)	19.5	36	7.4
	Mental Health Days (Days in previous 30 days)	2.1	14	1.5
	ALL OUTCOMES	-0.094	39	
	OVERALL	-0.157	33	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	17.2	38	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	35.9	31	20.9
Cognition (Percent of adults age 65+)	8.8	26	5.7
Depression (Percent of adults age 65+)	12.1	14	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	59.0	47.8
Obesity (Percent obese)	28.0	36.1

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	41.1	52.7

Overall Rank: 33

Determinants Rank: 34

Outcomes Rank: 39

Strengths:

- Low prevalence of activity-limiting arthritis pain
- High rate of highly-rated nursing home beds
- High prevalence of seniors with a health care provider

Challenges:

- High prevalence of smoking
- Low prevalence of dental visits
- High percentage of low-care nursing home residents

Ranking: Missouri is 33rd in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 42nd for its entire population.

Highlights:

- In Missouri, 1 in 10 adults aged 65 and older smoke.
- Seniors in Missouri manage their arthritis pain better than most other states with 55.2 percent of adults aged 65 and older with arthritis reporting that pain does not limit their usual activities.
- Missouri has a high rate of 4 and 5-star rated nursing home beds at 56.5 beds per 100,000 adults aged 75 and older.
- Missouri has a high percentage of low-care nursing home residents at 21.1 percent of nursing home residents.
- Missouri has one of the lowest rates of dental visits in the U.S. at 57.5 percent of adults aged 65 and older.

Disparities: In Missouri, 41.9 percent of black seniors are obese compared to 24.8 percent of white seniors.

State Health Department Website:

www.dhss.mo.gov



For a more detailed look at this data, visit www.americashealthrankings.org/senior/MO

MONTANA

MONTANA

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	11.0	43	4.7
	Chronic Drinking (Percent of adults age 65+)	4.2	33	1.4
	Obesity (Percent of adults age 65+)	21.9	7	16.9
	Underweight (Percent of adults age 65+)	2.3	39	1.1
	Physical Inactivity (Percent of adults age 65+)	30.4	22	20.5
	Dental Visits (Percent of adults age 65+)	63.0	40	79.8
	Pain Management (Percent of adults age 65+)	56.0	8	60.7
	BEHAVIORS TOTAL	-0.036	34	
COMMUNITY & ENVIRONMENT				
C&E — MACRO PERSPECTIVE				
	Poverty (Percent of adults age 65+)	8.0	20	5.1
	Volunteerism (Percent of adults age 65+)	31.6	10	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	47.6	17	65.2
C&E — MICRO PERSPECTIVE				
	Social Support (Percent of adults age 65+)	79.4	31	85.4
	Food Insecurity (Percent of adults age 60+)	13.2	24	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$1,255	11	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	0.077	17	
POLICY				
	Low-Care Nursing Home Residents (Percent of residents)	15.3	39	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	83.0	44	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	87.3	49	16.3
	POLICY TOTAL	-0.171	48	
CLINICAL CARE				
	Dedicated Health Care Provider (Percent of adults age 65+)	89.7	47	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	98.0	11	98.4
	Flu Vaccine (Percent of adults age 65+)	55.9	44	70.2
	Health Screenings (Percent of adults age 65–74)	82.3	41	91.7
	Diabetes Management (Percent of Medicare enrollees)	71.6	47	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	105.3	16	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	56.2	15	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	14.6	7	12.3
	Hospice Care (Percent of decedents age 65+)	30.5	39	54.5
	Hospital Deaths (Percent of decedents age 65+)	23.5	4	19.2
	CLINICAL CARE TOTAL	-0.033	38	
	ALL DETERMINANTS	-0.163	36	
OUTCOMES				
	ICU Usage (Percent of decedents age 65+)	7.8	11	5.1
	Falls (Percent of adults age 65+)	20.2	49	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	7.4	29	3.0
	Health Status (Percent very good or excellent of adults age 65+)	39.8	21	48.9
	Able-Bodied (Percent of adults age 65+)	63.1	27	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	1,831	24	1,425
	Teeth Extractions (Percent of adults age 65+)	17.6	29	7.4
	Mental Health Days (Days in previous 30 days)	2.5	32	1.5
	ALL OUTCOMES	-0.015	31	
	OVERALL	-0.178	35	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	22.0	20	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	23.1	3	20.9
Cognition (Percent of adults age 65+)	7.7	8	5.7
Depression (Percent of adults age 65+)	15.6	40	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	60.5	53.8
Obesity (Percent obese)	17.8	29.3

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	55.1	52.7

Overall Rank: 35

Determinants Rank: 36

Outcomes Rank: 31

Strengths:

- Low prevalence of obesity
- Low percentage of hospital deaths
- Low prevalence of activity-limiting arthritis pain

Challenges:

- High geriatrician shortfall
- Low percentage of diabetes management
- High prevalence of falls

Ranking: Montana is 35th in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 29th for its entire population.

Highlights:

- Montana has a low prevalence of seniors with a dedicated health care provider at 89.7 percent of adults aged 65 and older.
- Montana's senior smoking rate is among the highest in the U.S. with 11.0 percent of adults aged 65 and older who smoke.
- In Montana, 56.0 percent of adults aged 65 and older with arthritis report that pain does not limit their usual activity, a higher rate than most other states.
- Montana has one of the lowest percentages of seniors with creditable drug coverage at 83.0 percent of Medicare beneficiaries.
- Compared to other states, Montana has a lower hospital readmission rate at 14.6 percent of adults aged 65 and older who are readmitted to the hospital.
- A high percentage of seniors volunteer in Montana at 31.6 percent of adults aged 65 and older.

Disparities: In Montana, 44.2 percent of American Indian seniors are obese and 57.3 percent receive emotional support compared to 21.3 percent and 80.3 percent of white seniors, respectively.

State Health Department Website:

www.dphhs.mt.gov



For a more detailed look at this data, visit www.americashealthrankings.org/senior/MT

NEBRASKA

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	8.6	14	4.7
	Chronic Drinking (Percent of adults age 65+)	3.0	16	1.4
	Obesity (Percent of adults age 65+)	27.2	40	16.9
	Underweight (Percent of adults age 65+)	1.9	22	1.1
	Physical Inactivity (Percent of adults age 65+)	33.0	32	20.5
	Dental Visits (Percent of adults age 65+)	68.0	27	79.8
	Pain Management (Percent of adults age 65+)	54.5	14	60.7
	BEHAVIORS TOTAL	0.005	23	
	COMMUNITY & ENVIRONMENT			
	C&E — MACRO PERSPECTIVE	0.127	3	
	Poverty (Percent of adults age 65+)	7.7	15	5.1
	Volunteerism (Percent of adults age 65+)	34.6	7	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	61.0	4	65.2
	C&E — MICRO PERSPECTIVE	0.056	10	
	Social Support (Percent of adults age 65+)	78.4	41	85.4
	Food Insecurity (Percent of adults age 60+)	7.7	3	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$1,552	9	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	0.183	5	
	POLICY			
	Low-Care Nursing Home Residents (Percent of residents)	12.8	30	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	88.4	5	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	72.6	37	16.3
	POLICY TOTAL	0.011	23	
	CLINICAL CARE			
	Dedicated Health Care Provider (Percent of adults age 65+)	95.7	10	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	98.2	6	98.4
	Flu Vaccine (Percent of adults age 65+)	61.8	23	70.2
	Health Screenings (Percent of adults age 65-74)	83.3	38	91.7
	Diabetes Management (Percent of Medicare enrollees)	74.7	42	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	35.1	49	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	65.4	29	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	15.6	23	12.3
	Hospice Care (Percent of decedents age 65+)	32.9	30	54.5
	Hospital Deaths (Percent of decedents age 65+)	26.5	17	19.2
	CLINICAL CARE TOTAL	-0.008	26	
	ALL DETERMINANTS	0.191	12	
	OUTCOMES			
	ICU Usage (Percent of decedents age 65+)	11.1	20	5.1
	Falls (Percent of adults age 65+)	16.4	23	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	7.5	31	3.0
	Health Status (Percent very good or excellent of adults age 65+)	40.2	18	48.9
	Able-Bodied (Percent of adults age 65+)	65.0	18	68.0
	Premature Death (Deaths per 100,000 population age 65-74)	1,819	23	1,425
	Teeth Extractions (Percent of adults age 65+)	15.2	17	7.4
	Mental Health Days (Days in previous 30 days)	1.9	9	1.5
	ALL OUTCOMES	0.102	18	
	OVERALL	0.292	14	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	17.4	37	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	29.0	14	20.9
Cognition (Percent of adults age 65+)	6.1	2	5.7
Depression (Percent of adults age 65+)	13.2	24	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	56.4	53.5
Obesity (Percent obese)	25.8	33.6

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015-2030	38.5	52.7

Overall Rank: 14

Determinants Rank: 12

Outcomes Rank: 18

Strengths:

- High percentage of volunteerism
- High rate of highly-rated nursing home beds
- Low prevalence of food insecurity

Challenges:

- Low percentage of social support
- High geriatrician shortfall
- Limited availability of home health care workers

Ranking: Nebraska is 14th in this Senior Report. In the *America's Health Rankings®* 2012 Edition, it ranked 15th for its entire population.

Highlights:

- More than 54 percent of adults aged 65 and older with arthritis report that pain does not limit their usual activities, compared to 60.7 percent nationally.
- Nebraska has a higher rate of 4 and 5-star rated nursing home beds than most other states at 61 beds per 100,000 adults aged 75 and older.
- Nebraska has a high percentage of seniors with creditable drug coverage at 88.4 percent of Medicare beneficiaries.
- In Nebraska, 67,000 adults aged 65 and older are obese and 82,000 adults aged 65 and older are physically inactive.
- Compared to most states, fewer Nebraskan seniors are marginally food insecure at 7.7 percent of adults aged 60 and older.

Disparities: In Nebraska, 87.6 percent of seniors with a college degree receive social support compared to 59.3 percent of seniors with less than a high school degree.

State Health Department Website:
www.dhhs.ne.gov/



For a more detailed look at this data, visit www.americashealthrankings.org/senior/NE

NEVADA

NEVADA

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	13.5	50	4.7
	Chronic Drinking (Percent of adults age 65+)	4.8	37	1.4
	Obesity (Percent of adults age 65+)	18.1	2	16.9
	Underweight (Percent of adults age 65+)	2.7	46	1.1
	Physical Inactivity (Percent of adults age 65+)	29.0	17	20.5
	Dental Visits (Percent of adults age 65+)	62.1	41	79.8
	Pain Management (Percent of adults age 65+)	55.8	9	60.7
	BEHAVIORS TOTAL	-0.078	39	
COMMUNITY & ENVIRONMENT				
C&E — MACRO PERSPECTIVE				
	Poverty (Percent of adults age 65+)	8.1	22	5.1
	Volunteerism (Percent of adults age 65+)	17.6	49	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	16.8	49	65.2
C&E — MICRO PERSPECTIVE				
	Social Support (Percent of adults age 65+)	78.5	38	85.4
	Food Insecurity (Percent of adults age 60+)	16.5	40	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$283	50	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	-0.147	48	
POLICY				
	Low-Care Nursing Home Residents (Percent of residents)	10.2	18	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	86.3	27	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	72.7	38	16.3
	POLICY TOTAL	-0.008	30	
CLINICAL CARE				
	Dedicated Health Care Provider (Percent of adults age 65+)	89.3	48	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.5	31	98.4
	Flu Vaccine (Percent of adults age 65+)	53.7	49	70.2
	Health Screenings (Percent of adults age 65-74)	79.5	49	91.7
	Diabetes Management (Percent of Medicare enrollees)	76.9	35	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	81.0	24	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	58.1	16	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	16.5	43	12.3
	Hospice Care (Percent of decedents age 65+)	39.7	16	54.5
	Hospital Deaths (Percent of decedents age 65+)	28.1	24	19.2
	CLINICAL CARE TOTAL	-0.089	47	
	ALL DETERMINANTS	-0.321	45	
OUTCOMES				
	ICU Usage (Percent of decedents age 65+)	19.6	47	5.1
	Falls (Percent of adults age 65+)	16.6	25	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	7.6	33	3.0
	Health Status (Percent very good or excellent of adults age 65+)	38.0	28	48.9
	Able-Bodied (Percent of adults age 65+)	66.1	11	68.0
	Premature Death (Deaths per 100,000 population age 65-74)	1,976	36	1,425
	Teeth Extractions (Percent of adults age 65+)	17.2	26	7.4
	Mental Health Days (Days in previous 30 days)	2.9	48	1.5
	ALL OUTCOMES	-0.073	36	
	OVERALL	-0.394	42	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	21.1	24	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	30.9	17	20.9
Cognition (Percent of adults age 65+)	8.0	13	5.7
Depression (Percent of adults age 65+)	12.0	13	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	57.2	49.4
Obesity (Percent obese)	19.1	28

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015-2030	89.0	52.7

Overall Rank: 42

Determinants Rank: 45

Outcomes Rank: 36

Strengths:

- Low prevalence of obesity
- Low prevalence of activity-limiting arthritis pain
- High prevalence of able-bodied seniors

Challenges:

- High prevalence of smoking
- Low percentage of volunteerism
- Low rate of highly-rated nursing home beds

Ranking: Nevada is 42nd in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 38th for its entire population.

Highlights:

- Nevada has the worst smoking rate in the nation at 13.5 percent of adults aged 65 and older.
- There is a high prevalence of seniors without disability in Nevada at 66.1 percent of adults aged 65 and older.
- Nevada has one of the lowest flu vaccination rates at 53.7 percent of adults aged 65 and older.
- While Nevada's obesity rate is the second lowest in the U.S. at 18.1 percent, almost 60,000 adults aged 65 and older are obese.
- Total community expenditures are low in Nevada at \$283 per adult aged 65 and older living in poverty.

Disparities: In Nevada, 55.4 percent of seniors with a college degree report excellent or very good health compared to only 18.4 percent of seniors with less than a high school degree.

State Health Department Website:

<http://dhhs.nv.gov/>



For a more detailed look at this data, visit www.americashealthrankings.org/senior/NV

NEW HAMPSHIRE

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	7.3	6	4.7
	Chronic Drinking (Percent of adults age 65+)	5.1	42	1.4
	Obesity (Percent of adults age 65+)	24.8	21	16.9
	Underweight (Percent of adults age 65+)	2.1	33	1.1
	Physical Inactivity (Percent of adults age 65+)	27.7	10	20.5
	Dental Visits (Percent of adults age 65+)	74.7	7	79.8
	Pain Management (Percent of adults age 65+)	57.0	5	60.7
	BEHAVIORS TOTAL	0.083	7	
COMMUNITY & ENVIRONMENT				
	C&E — MACRO PERSPECTIVE	0.088	7	
	Poverty (Percent of adults age 65+)	6.3	3	5.1
	Volunteerism (Percent of adults age 65+)	28.0	21	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	50.2	14	65.2
	C&E — MICRO PERSPECTIVE	0.083	5	
	Social Support (Percent of adults age 65+)	77.6	44	85.4
	Food Insecurity (Percent of adults age 60+)	9.2	6	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$3,483	4	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	0.171	6	
POLICY				
	Low-Care Nursing Home Residents (Percent of residents)	12.3	28	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	78.3	50	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	38.5	4	16.3
	POLICY TOTAL	-0.016	33	
CLINICAL CARE				
	Dedicated Health Care Provider (Percent of adults age 65+)	96.3	5	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	98.3	3	98.4
	Flu Vaccine (Percent of adults age 65+)	57.4	37	70.2
	Health Screenings (Percent of adults age 65-74)	90.6	5	91.7
	Diabetes Management (Percent of Medicare enrollees)	84.8	2	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	80.5	27	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	56.0	14	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	15.0	14	12.3
	Hospice Care (Percent of decedents age 65+)	30.9	36	54.5
	Hospital Deaths (Percent of decedents age 65+)	27.3	22	19.2
	CLINICAL CARE TOTAL	0.072	4	
	ALL DETERMINANTS	0.310	5	
OUTCOMES				
	ICU Usage (Percent of decedents age 65+)	6.5	5	5.1
	Falls (Percent of adults age 65+)	15.1	12	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	6.5	9	3.0
	Health Status (Percent very good or excellent of adults age 65+)	47.8	2	48.9
	Able-Bodied (Percent of adults age 65+)	66.3	9	68.0
	Premature Death (Deaths per 100,000 population age 65-74)	1,745	15	1,425
	Teeth Extractions (Percent of adults age 65+)	17.2	26	7.4
	Mental Health Days (Days in previous 30 days)	2.0	11	1.5
	ALL OUTCOMES	0.238	3	
	OVERALL	0.548	3	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	24.7	11	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	30.9	18	20.9
Cognition (Percent of adults age 65+)	8.1	14	5.7
Depression (Percent of adults age 65+)	13.6	26	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	60.1	60.1
Obesity (Percent obese)	22.9	28

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015-2030	62.2	52.7

Overall Rank: 3

Determinants Rank: 5

Outcomes Rank: 3

Strengths:

- Low percentage of seniors living in poverty
- High community support expenditures
- High percentage of diabetes management

Challenges:

- High prevalence of chronic drinking
- Low percentage of social support
- Low percentage of creditable drug coverage

Ranking: New Hampshire is 3rd in this Senior Report. In the *America's Health Rankings®* 2012 Edition, it ranked 3rd for its entire population.

Highlights:

- There is a low estimated geriatrician shortfall in New Hampshire at 38.5 percent of the geriatricians needed.
- New Hampshire has one of the highest pain management rates in the U.S. with 57.0 percent of adults aged 65 years and older with arthritis who report that pain doesn't limit their activity.
- Seniors in New Hampshire had the second highest health status with 47.8 percent of adults aged 65 and older who report very good or excellent health.
- Food insecurity among New Hampshire seniors is low with 17,000 marginally food insecure adults aged 60 and older.
- New Hampshire has a low prevalence of flu vaccination at 57.4 percent of adults aged 65 and older.

Disparities: In New Hampshire, seniors with a college degree report a lower prevalence of physical inactivity, a higher prevalence of social support, and better health status compared to seniors with less than a high school degree.

State Health Department Website:

www.dhhs.state.nh.us



For a more detailed look at this data, visit www.americashealthrankings.org/senior/NH

NEW JERSEY

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	8.9	19	4.7
	Chronic Drinking (Percent of adults age 65+)	3.9	30	1.4
	Obesity (Percent of adults age 65+)	25.0	22	16.9
	Underweight (Percent of adults age 65+)	2.0	25	1.1
	Physical Inactivity (Percent of adults age 65+)	33.2	34	20.5
	Dental Visits (Percent of adults age 65+)	74.1	10	79.8
	Pain Management (Percent of adults age 65+)	53.6	16	60.7
	BEHAVIORS TOTAL	0.015	18	
COMMUNITY & ENVIRONMENT				
C&E — MACRO PERSPECTIVE				
	Poverty (Percent of adults age 65+)	7.6	12	5.1
	Volunteerism (Percent of adults age 65+)	18.9	46	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	38.7	28	65.2
	C&E — MICRO PERSPECTIVE	0.007	26	
	Social Support (Percent of adults age 65+)	79.9	28	85.4
	Food Insecurity (Percent of adults age 60+)	12.3	17	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$729	25	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	-0.008	28	
POLICY				
	Low-Care Nursing Home Residents (Percent of residents)	13.0	32	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	85.8	32	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	41.8	8	16.3
	POLICY TOTAL	0.054	14	
CLINICAL CARE				
	Dedicated Health Care Provider (Percent of adults age 65+)	94.5	31	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	98.3	3	98.4
	Flu Vaccine (Percent of adults age 65+)	61.3	26	70.2
	Health Screenings (Percent of adults age 65–74)	82.9	40	91.7
	Diabetes Management (Percent of Medicare enrollees)	83.4	8	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	72.1	36	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	68.8	33	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	16.8	46	12.3
	Hospice Care (Percent of decedents age 65+)	33.3	28	54.5
	Hospital Deaths (Percent of decedents age 65+)	36.7	47	19.2
	CLINICAL CARE TOTAL	-0.036	41	
	ALL DETERMINANTS	0.024	27	
OUTCOMES				
	ICU Usage (Percent of decedents age 65+)	24.7	50	5.1
	Falls (Percent of adults age 65+)	15.1	12	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	6.4	5	3.0
	Health Status (Percent very good or excellent of adults age 65+)	40.0	20	48.9
	Able-Bodied (Percent of adults age 65+)	66.8	6	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	1,710	13	1,425
	Teeth Extractions (Percent of adults age 65+)	14.2	14	7.4
	Mental Health Days (Days in previous 30 days)	2.5	32	1.5
	ALL OUTCOMES	0.050	26	
	OVERALL	0.074	27	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	22.8	17	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	43.2	49	20.9
Cognition (Percent of adults age 65+)	8.6	23	5.7
Depression (Percent of adults age 65+)	10.0	5	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	50.9	50.8
Obesity (Percent obese)	27.2	29.4

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	41.5	52.7

Overall Rank: 27

Determinants Rank: 27

Outcomes Rank: 26

Strengths:

- Low geriatrician shortfall
- High prevalence of able-bodied seniors
- High prevalence of dental visits

Challenges:

- Low percentage of volunteerism
- High percentage of ICU usage
- High percentage of hospital deaths

Ranking: New Jersey is 27th in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 8th for its entire population.

Highlights:

- A low percentage of seniors volunteer in New Jersey.
- A high percentage of hospitalized New Jersey seniors receive recommended care at 98.3 percent of hospitalized patients aged 65 and older.
- In New Jersey, almost 300,000 adults aged 65 and older are obese and almost 400,000 seniors are physically inactive.
- New Jersey has one of the lowest dental visit rates in the U.S. at 74.1 percent of adults aged 65 and older.
- Hospital deaths are higher in New Jersey compared to other states at 36.7 percent of adults aged 65 and older.

Disparities: In New Jersey, 37.5 percent of black seniors are obese compared to 23.4 percent of Hispanic seniors.

State Health Department Website:

www.state.nj.us/health



For a more detailed look at this data, visit www.americashealthrankings.org/senior/NJ

NEW MEXICO

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	9.8	34	4.7
	Chronic Drinking (Percent of adults age 65+)	3.2	22	1.4
	Obesity (Percent of adults age 65+)	19.9	3	16.9
	Underweight (Percent of adults age 65+)	3.1	48	1.1
	Physical Inactivity (Percent of adults age 65+)	28.4	12	20.5
	Dental Visits (Percent of adults age 65+)	69.1	25	79.8
	Pain Management (Percent of adults age 65+)	46.6	47	60.7
	BEHAVIORS TOTAL	-0.040	36	
COMMUNITY & ENVIRONMENT				
	C&E — MACRO PERSPECTIVE	-0.121	50	
	Poverty (Percent of adults age 65+)	12.3	49	5.1
	Volunteerism (Percent of adults age 65+)	22.4	33	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	22.7	47	65.2
	C&E — MICRO PERSPECTIVE	-0.064	44	
	Social Support (Percent of adults age 65+)	80.2	27	85.4
	Food Insecurity (Percent of adults age 60+)	21.2	49	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$915	18	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	-0.185	50	
POLICY				
	Low-Care Nursing Home Residents (Percent of residents)	13.3	33	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	85.7	34	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	57.1	17	16.3
	POLICY TOTAL	0.001	25	
CLINICAL CARE				
	Dedicated Health Care Provider (Percent of adults age 65+)	90.1	46	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	96.7	49	98.4
	Flu Vaccine (Percent of adults age 65+)	58.8	32	70.2
	Health Screenings (Percent of adults age 65-74)	84.2	34	91.7
	Diabetes Management (Percent of Medicare enrollees)	67.4	48	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	207.0	3	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	54.9	12	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	14.6	7	12.3
	Hospice Care (Percent of decedents age 65+)	42.5	11	54.5
	Hospital Deaths (Percent of decedents age 65+)	26.6	18	19.2
	CLINICAL CARE TOTAL	-0.021	31	
	ALL DETERMINANTS	-0.245	42	
OUTCOMES				
	ICU Usage (Percent of decedents age 65+)	11.9	23	5.1
	Falls (Percent of adults age 65+)	17.5	38	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	8.0	35	3.0
	Health Status (Percent very good or excellent of adults age 65+)	38.2	27	48.9
	Able-Bodied (Percent of adults age 65+)	59.1	41	68.0
	Premature Death (Deaths per 100,000 population age 65-74)	1,693	11	1,425
	Teeth Extractions (Percent of adults age 65+)	18.5	33	7.4
	Mental Health Days (Days in previous 30 days)	2.5	32	1.5
	ALL OUTCOMES	-0.055	33	
	OVERALL	-0.300	38	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	24.9	9	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	27.8	12	20.9
Cognition (Percent of adults age 65+)	11.0	41	5.7
Depression (Percent of adults age 65+)	16.1	44	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	61.4	48.5
Obesity (Percent obese)	21.6	25.9

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015-2030	61.6	52.7

Overall Rank: 38

Determinants Rank: 42

Outcomes Rank: 33

Strengths:

- Low prevalence of obesity
- Ready availability of home health care workers
- Low percentage of hospital readmissions

Challenges:

- High prevalence of underweight seniors
- High prevalence of activity-limiting arthritis pain
- High percentage of seniors living in poverty

Ranking: New Mexico is 38th in this Senior Report. In the *America's Health Rankings®* 2012 Edition, it ranked 32nd for its entire population.

Highlights:

- New Mexico has one of the highest prevalences of food insecurity with 21.2 percent, or 58,000 marginally food insecure adults aged 60 and older.
- A low rate of 4 and 5-star rated nursing home beds are available in the state at 22.7 beds per 100,000 adults aged 75 and older.
- A low percentage of seniors receive appropriate diabetes management at 67.4 percent of Medicare enrollees.
- Although New Mexico has a lower rate of obesity than most other states in the U.S., there are still 55,000 obese adults aged 65 and older in the state.
- The rate of home health care workers is high at 207 per 1,000 adults age 75 and older.

Disparities: In New Mexico, seniors with less than a high school degree have a higher prevalence of physical inactivity and a lower prevalence of social and emotional support than seniors with a college degree.

State Health Department Website:

www.health.state.nm.us



For a more detailed look at this data, visit www.americashealthrankings.org/senior/NM

NEW YORK

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	8.3	11	4.7
	Chronic Drinking (Percent of adults age 65+)	3.1	20	1.4
	Obesity (Percent of adults age 65+)	25.9	29	16.9
	Underweight (Percent of adults age 65+)	2.1	33	1.1
	Physical Inactivity (Percent of adults age 65+)	31.3	24	20.5
	Dental Visits (Percent of adults age 65+)	73.3	11	79.8
	Pain Management (Percent of adults age 65+)	50.1	36	60.7
	BEHAVIORS TOTAL	0.005	22	
COMMUNITY & ENVIRONMENT				
	C&E — MACRO PERSPECTIVE	-0.072	43	
	Poverty (Percent of adults age 65+)	11.3	43	5.1
	Volunteerism (Percent of adults age 65+)	19.7	43	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	40.6	27	65.2
	C&E — MICRO PERSPECTIVE	-0.038	39	
	Social Support (Percent of adults age 65+)	75.5	48	85.4
	Food Insecurity (Percent of adults age 60+)	13.8	25	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$1,347	10	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	-0.109	39	
POLICY				
	Low-Care Nursing Home Residents (Percent of residents)	8.9	15	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	87.5	14	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	36.1	3	16.3
	POLICY TOTAL	0.145	3	
CLINICAL CARE				
	Dedicated Health Care Provider (Percent of adults age 65+)	95.7	10	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.0	43	98.4
	Flu Vaccine (Percent of adults age 65+)	60.0	30	70.2
	Health Screenings (Percent of adults age 65–74)	87.4	18	91.7
	Diabetes Management (Percent of Medicare enrollees)	84.8	2	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	198.3	4	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	66.3	30	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	16.7	44	12.3
	Hospice Care (Percent of decedents age 65+)	23.8	44	54.5
	Hospital Deaths (Percent of decedents age 65+)	39.0	50	19.2
	CLINICAL CARE TOTAL	-0.035	39	
	ALL DETERMINANTS	0.007	28	
OUTCOMES				
	ICU Usage (Percent of decedents age 65+)	12.8	28	5.1
	Falls (Percent of adults age 65+)	15.0	10	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	6.4	5	3.0
	Health Status (Percent very good or excellent of adults age 65+)	35.0	38	48.9
	Able-Bodied (Percent of adults age 65+)	65.7	13	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	1,680	10	1,425
	Teeth Extractions (Percent of adults age 65+)	14.7	15	7.4
	Mental Health Days (Days in previous 30 days)	2.3	23	1.5
	ALL OUTCOMES	0.107	17	
	OVERALL	0.113	23	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	22.6	18	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	40.0	47	20.9
Cognition (Percent of adults age 65+)	8.8	26	5.7
Depression (Percent of adults age 65+)	13.6	27	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	56.6	50.6
Obesity (Percent obese)	23.4	29.5

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	33.1	52.7

Overall Rank: 23

Determinants Rank: 28

Outcomes Rank: 17

Strengths:

- Low percentage of low-care nursing home residents
- Low geriatrician shortfall
- Ready availability of home health care workers

Challenges:

- Low percentage of social support
- Low percentage of seniors who received recommended hospital care
- High percentage of hospital deaths

Ranking: New York is 23rd in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 18th for its entire population.

Highlights:

- Volunteerism is low among New York seniors at 19.7 percent of adults aged 65 and older who volunteer.
- New York has one of the highest percentages of seniors in poverty at 11.3 percent of adults aged 65 and older.
- A high percentage of seniors receive appropriate diabetes management at 84.8 percent of Medicare enrollees.
- There are 8,700 low-care nursing home residents in New York, a lower percentage than most states.
- In New York, 680,000 adults aged 65 and older are obese, and more than 820,000 seniors are physically inactive.

Disparities: In New York, seniors with less than a high school degree have higher prevalences of obesity and physical inactivity, as well as a lower prevalence of social support compared to seniors with a college degree.

State Health Department Website:

www.health.state.ny.us



For a more detailed look at this data, visit www.americashealthrankings.org/senior/NY

NORTH CAROLINA

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	9.2	26	4.7
	Chronic Drinking (Percent of adults age 65+)	2.2	8	1.4
	Obesity (Percent of adults age 65+)	25.7	28	16.9
	Underweight (Percent of adults age 65+)	1.7	13	1.1
	Physical Inactivity (Percent of adults age 65+)	28.8	15	20.5
	Dental Visits (Percent of adults age 65+)	64.6	38	79.8
	Pain Management (Percent of adults age 65+)	50.4	33	60.7
	BEHAVIORS TOTAL	0.018	17	
	COMMUNITY & ENVIRONMENT			
	C&E — MACRO PERSPECTIVE	-0.048	37	
	Poverty (Percent of adults age 65+)	9.9	35	5.1
	Volunteerism (Percent of adults age 65+)	24.3	28	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	30.1	38	65.2
	C&E — MICRO PERSPECTIVE	-0.019	34	
	Social Support (Percent of adults age 65+)	81.0	21	85.4
	Food Insecurity (Percent of adults age 60+)	15.7	35	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$535	38	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	-0.067	34	
	POLICY			
	Low-Care Nursing Home Residents (Percent of residents)	7.0	9	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	87.9	11	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	61.4	20	16.3
	POLICY TOTAL	0.091	7	
	CLINICAL CARE			
	Dedicated Health Care Provider (Percent of adults age 65+)	95.5	15	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	98.0	11	98.4
	Flu Vaccine (Percent of adults age 65+)	66.6	8	70.2
	Health Screenings (Percent of adults age 65–74)	88.4	14	91.7
	Diabetes Management (Percent of Medicare enrollees)	82.7	12	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	125.4	8	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	62.6	25	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	15.3	18	12.3
	Hospice Care (Percent of decedents age 65+)	34.3	26	54.5
	Hospital Deaths (Percent of decedents age 65+)	32.6	39	19.2
	CLINICAL CARE TOTAL	0.061	8	
	ALL DETERMINANTS	0.102	18	
	OUTCOMES			
	ICU Usage (Percent of decedents age 65+)	13.1	29	5.1
	Falls (Percent of adults age 65+)	15.2	15	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	8.3	38	3.0
	Health Status (Percent very good or excellent of adults age 65+)	34.1	42	48.9
	Able-Bodied (Percent of adults age 65+)	61.5	37	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	2,058	37	1,425
	Teeth Extractions (Percent of adults age 65+)	21.6	41	7.4
	Mental Health Days (Days in previous 30 days)	2.4	30	1.5
	ALL OUTCOMES	-0.089	38	
	OVERALL	0.013	29	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	19.7	31	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	34.2	27	20.9
Cognition (Percent of adults age 65+)	9.8	35	5.7
Depression (Percent of adults age 65+)	14.0	31	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	43.0	47.5
Obesity (Percent obese)	27.1	31.9

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	58.1	52.7

Overall Rank: 29

Determinants Rank: 18

Outcomes Rank: 38

Strengths:

- Low prevalence of chronic drinking
- Low percentage of low-care nursing home residents
- High prevalence of flu vaccination

Challenges:

- Low community support expenditures
- High rate of hospitalization for hip fractures
- High prevalence of teeth extractions

Ranking: North Carolina is 29th in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 33rd for its entire population.

Highlights:

- The rate of 4 and 5-star rated nursing home beds in North Carolina is low at 30.1 beds per 100,000 adults aged 75 and older.
- North Carolina has one of the highest prevalences of flu vaccination at 66.6 percent of adults aged 65 and older.
- Dental visits are low among the senior population at 64.6 percent of adults aged 65 and older.
- In North Carolina, a high percentage of seniors died in the hospital at 32.6 percent of adults aged 65 and older.
- A high percentage of seniors have creditable drug coverage in the state at 87.9 percent of Medicare beneficiaries.

Disparities: In North Carolina, seniors with a household income of less than \$25,000 have lower health status and a much lower prevalence of social support than those with higher household incomes.

State Health Department Website:

www.dhhs.state.nc.us



For a more detailed look at this data, visit www.americashealthrankings.org/senior/NC

NORTH DAKOTA

NORTH DAKOTA

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	8.7	16	4.7
	Chronic Drinking (Percent of adults age 65+)	1.8	3	1.4
	Obesity (Percent of adults age 65+)	24.4	17	16.9
	Underweight (Percent of adults age 65+)	2.1	33	1.1
	Physical Inactivity (Percent of adults age 65+)	34.6	41	20.5
	Dental Visits (Percent of adults age 65+)	67.0	31	79.8
	Pain Management (Percent of adults age 65+)	50.0	37	60.7
	BEHAVIORS TOTAL	-0.010	27	
COMMUNITY & ENVIRONMENT				
C&E — MACRO PERSPECTIVE				
	Poverty (Percent of adults age 65+)	11.4	45	5.1
	Volunteerism (Percent of adults age 65+)	28.9	16	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	65.2	1	65.2
C&E — MICRO PERSPECTIVE				
	Social Support (Percent of adults age 65+)	79.8	29	85.4
	Food Insecurity (Percent of adults age 60+)	5.5	1	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$1,228	12	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	0.113	12	
POLICY				
	Low-Care Nursing Home Residents (Percent of residents)	15.1	37	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	88.6	3	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	47.3	11	16.3
	POLICY TOTAL	0.075	9	
CLINICAL CARE				
	Dedicated Health Care Provider (Percent of adults age 65+)	92.8	41	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.6	26	98.4
	Flu Vaccine (Percent of adults age 65+)	58.0	33	70.2
	Health Screenings (Percent of adults age 65–74)	83.7	36	91.7
	Diabetes Management (Percent of Medicare enrollees)	79.7	29	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	73.7	33	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	59.4	21	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	15.2	16	12.3
	Hospice Care (Percent of decedents age 65+)	23.8	44	54.5
	Hospital Deaths (Percent of decedents age 65+)	23.9	5	19.2
	CLINICAL CARE TOTAL	-0.029	36	
	ALL DETERMINANTS	0.149	16	
OUTCOMES				
	ICU Usage (Percent of decedents age 65+)	5.2	2	5.1
	Falls (Percent of adults age 65+)	15.1	12	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	6.1	2	3.0
	Health Status (Percent very good or excellent of adults age 65+)	35.1	37	48.9
	Able-Bodied (Percent of adults age 65+)	64.4	22	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	1,767	16	1,425
	Teeth Extractions (Percent of adults age 65+)	18.8	35	7.4
	Mental Health Days (Days in previous 30 days)	1.6	4	1.5
	ALL OUTCOMES	0.169	7	
	OVERALL	0.318	11	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	15.1	47	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	28.7	13	20.9
Cognition (Percent of adults age 65+)	6.4	3	5.7
Depression (Percent of adults age 65+)	10.9	10	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	53.7	53.7
Obesity (Percent obese)	22.3	35.2

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	41.2	52.7

Overall Rank: 11

Determinants Rank: 16

Outcomes Rank: 7

Strengths:

- Low prevalence of chronic drinking
- High rate of highly-rated nursing home beds
- Low prevalence of food insecurity

Challenges:

- High percentage of seniors living in poverty
- High prevalence of physical inactivity
- Low percent of hospice care

Ranking: North Dakota is 11th in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 12th for its entire population.

Highlights:

- North Dakota has a low prevalence of seniors with a dedicated health care provider at 92.8 percent of adults aged 65 and older.
- Compared to other states, North Dakota has a high percentage of seniors with creditable drug coverage at 88.6 percent of adults aged 65 and older.
- North Dakota has one of the lowest rates of hospitalization for hip fractures in the U.S. at 6.1 hospitalizations per 1,000 Medicare enrollees.
- North Dakota has one of the highest physical inactivity rates in the U.S. with 34.6 percent, or 34,000 adults aged 65 and older, who are inactive.
- A low percentage of North Dakota seniors spent 7 or more days in the ICU during the last 6 months of life at 5.2 percent of adults aged 65 and older.

Disparities: In North Dakota, seniors with a household income of less than \$25,000 have higher prevalences of obesity and physical inactivity compared to seniors with greater incomes.

State Health Department Website:

www.ndhealth.gov



For a more detailed look at this data, visit www.americashealthrankings.org/senior/ND

OHIO

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	9.7	33	4.7
	Chronic Drinking (Percent of adults age 65+)	2.6	11	1.4
	Obesity (Percent of adults age 65+)	28.7	44	16.9
	Underweight (Percent of adults age 65+)	1.3	3	1.1
	Physical Inactivity (Percent of adults age 65+)	32.4	27	20.5
	Dental Visits (Percent of adults age 65+)	67.2	30	79.8
	Pain Management (Percent of adults age 65+)	56.2	7	60.7
	BEHAVIORS TOTAL	0.027	15	
	COMMUNITY & ENVIRONMENT			
	C&E — MACRO PERSPECTIVE	0.015	24	
	Poverty (Percent of adults age 65+)	8.0	20	5.1
	Volunteerism (Percent of adults age 65+)	23.3	31	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	43.6	23	65.2
	C&E — MICRO PERSPECTIVE	-0.045	40	
	Social Support (Percent of adults age 65+)	77.9	43	85.4
	Food Insecurity (Percent of adults age 60+)	15.8	36	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$835	22	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	-0.030	30	
	POLICY			
	Low-Care Nursing Home Residents (Percent of residents)	9.2	16	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	88.4	5	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	66.1	26	16.3
	POLICY TOTAL	0.066	11	
	CLINICAL CARE			
	Dedicated Health Care Provider (Percent of adults age 65+)	95.2	20	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.9	16	98.4
	Flu Vaccine (Percent of adults age 65+)	61.4	25	70.2
	Health Screenings (Percent of adults age 65-74)	87.5	17	91.7
	Diabetes Management (Percent of Medicare enrollees)	79.2	32	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	109.4	12	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	78.5	42	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	16.3	38	12.3
	Hospice Care (Percent of decedents age 65+)	41.4	14	54.5
	Hospital Deaths (Percent of decedents age 65+)	25.9	13	19.2
	CLINICAL CARE TOTAL	0.024	19	
	ALL DETERMINANTS	0.087	19	
	OUTCOMES			
	ICU Usage (Percent of decedents age 65+)	15.8	39	5.1
	Falls (Percent of adults age 65+)	17.3	34	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	7.2	23	3.0
	Health Status (Percent very good or excellent of adults age 65+)	37.6	30	48.9
	Able-Bodied (Percent of adults age 65+)	63.5	26	68.0
	Premature Death (Deaths per 100,000 population age 65-74)	2,090	39	1,425
	Teeth Extractions (Percent of adults age 65+)	19.8	37	7.4
	Mental Health Days (Days in previous 30 days)	2.4	30	1.5
	ALL OUTCOMES	-0.065	34	
	OVERALL	0.022	28	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	16.7	41	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	38.8	44	20.9
Cognition (Percent of adults age 65+)	8.6	23	5.7
Depression (Percent of adults age 65+)	12.1	15	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	50.7	47.5
Obesity (Percent obese)	28.9	35.6

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015-2030	33.4	52.7

Overall Rank: 28

Determinants Rank: 19

Outcomes Rank: 34

Strengths:

- Low prevalence of underweight seniors
- Low prevalence of activity-limiting arthritis pain
- High percentage of creditable drug coverage

Challenges:

- High prevalence of obesity
- High rate of preventable hospitalizations
- Low percentage of social support

Ranking: Ohio is 28th in this Senior Report. In the *America's Health Rankings®* 2012 Edition, it ranked 35th for its entire population.

Highlights:

- Compared to most states, Ohio has a low percentage of low-care nursing home residents at almost 6,500 low-care nursing home residents.
- In Ohio, almost 260,000 adults aged 60 and older, or 15.9 percent of seniors, are marginally food insecure.
- The prevalence of chronic drinking, at 2.6 percent of adults aged 65 and older, is low compared to most other states.
- Ohio has one of the highest obesity rates in the U.S. with 28.7 percent, or more than 460,000 adults aged 65 and older.
- Ohio has a high percentage of seniors with creditable drug coverage at 88.4 percent of Medicare beneficiaries.

Disparities: In Ohio, seniors with an income of less than \$25,000 have a higher prevalence of physical inactivity and a lower prevalence of excellent or very good health compared to seniors with incomes greater than \$75,000.

State Health Department Website:

www.odh.ohio.gov



For a more detailed look at this data, visit www.americashealthrankings.org/senior/OH

OKLAHOMA

OKLAHOMA

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	11.7	46	4.7
	Chronic Drinking (Percent of adults age 65+)	2.0	6	1.4
	Obesity (Percent of adults age 65+)	26.3	33	16.9
	Underweight (Percent of adults age 65+)	3.1	48	1.1
	Physical Inactivity (Percent of adults age 65+)	36.9	44	20.5
	Dental Visits (Percent of adults age 65+)	57.2	48	79.8
	Pain Management (Percent of adults age 65+)	48.9	41	60.7
	BEHAVIORS TOTAL	-0.230	48	
COMMUNITY & ENVIRONMENT				
C&E — MACRO PERSPECTIVE				
	Poverty (Percent of adults age 65+)	9.3	33	5.1
	Volunteerism (Percent of adults age 65+)	22.0	35	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	40.9	25	65.2
	C&E — MICRO PERSPECTIVE	-0.018	33	
	Social Support (Percent of adults age 65+)	81.3	16	85.4
	Food Insecurity (Percent of adults age 60+)	16.0	38	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$558	36	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	-0.041	32	
POLICY				
	Low-Care Nursing Home Residents (Percent of residents)	25.0	49	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	84.2	41	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	83.0	47	16.3
	POLICY TOTAL	-0.204	49	
CLINICAL CARE				
	Dedicated Health Care Provider (Percent of adults age 65+)	95.1	22	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.5	31	98.4
	Flu Vaccine (Percent of adults age 65+)	62.4	22	70.2
	Health Screenings (Percent of adults age 65–74)	77.9	50	91.7
	Diabetes Management (Percent of Medicare enrollees)	72.6	46	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	80.9	25	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	81.0	45	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	16.1	36	12.3
	Hospice Care (Percent of decedents age 65+)	44.4	5	54.5
	Hospital Deaths (Percent of decedents age 65+)	30.3	29	19.2
	CLINICAL CARE TOTAL	-0.057	43	
	ALL DETERMINANTS	-0.531	49	
OUTCOMES				
	ICU Usage (Percent of decedents age 65+)	10.7	19	5.1
	Falls (Percent of adults age 65+)	19.3	48	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	9.2	50	3.0
	Health Status (Percent very good or excellent of adults age 65+)	34.4	41	48.9
	Able-Bodied (Percent of adults age 65+)	57.5	44	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	2,344	45	1,425
	Teeth Extractions (Percent of adults age 65+)	24.6	44	7.4
	Mental Health Days (Days in previous 30 days)	2.6	36	1.5
	ALL OUTCOMES	-0.270	46	
	OVERALL	-0.801	49	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	18.2	35	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	35.5	30	20.9
Cognition (Percent of adults age 65+)	9.7	34	5.7
Depression (Percent of adults age 65+)	17.6	47	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	50.0	42.2
Obesity (Percent obese)	21.7	36.7

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	36.8	52.7

Overall Rank: 49

Determinants Rank: 49

Outcomes Rank: 46

Strengths:

- Low prevalence of chronic drinking
- High percentage of hospice care
- High percentage of social support

Challenges:

- Low prevalence of dental visits
- Low percentage of health screenings
- High rate of hospitalization for hip fractures

Ranking: Oklahoma is 49th in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 43rd for its entire population.

Highlights:

- There is a high geriatrician shortfall in Oklahoma, with 83.0 percent of geriatricians needed.
- Oklahoma has one of the highest percentages of underweight seniors at 3.1 percent of adults aged 65 and older.
- Oklahoma has a high percentage of seniors enrolled in hospice care during the last 6 months of life at 44.4 percent of adults aged 65 and older.
- Smoking is high at 11.7 percent of adults aged 65 or older, or 60,000 seniors, in the state.
- Chronic drinking is low with 2.0 percent of seniors consuming on average more than 1 drink a day for women and 2 drinks a day for men.

Disparities: In Oklahoma, seniors with less than a high school degree have a higher prevalence of physical inactivity and a lower prevalence of excellent or very good health compared to seniors with a college degree.

State Health Department Website:

www.ok.gov/health



For a more detailed look at this data, visit www.americashealthrankings.org/senior/OK

OREGON

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	9.6	31	4.7
	Chronic Drinking (Percent of adults age 65+)	5.0	39	1.4
	Obesity (Percent of adults age 65+)	24.6	19	16.9
	Underweight (Percent of adults age 65+)	2.4	41	1.1
	Physical Inactivity (Percent of adults age 65+)	23.1	3	20.5
	Dental Visits (Percent of adults age 65+)	71.5	20	79.8
	Pain Management (Percent of adults age 65+)	50.5	31	60.7
	BEHAVIORS TOTAL	-0.023	31	
	COMMUNITY & ENVIRONMENT			
	C&E — MACRO PERSPECTIVE	-0.003	28	
	Poverty (Percent of adults age 65+)	7.9	19	5.1
	Volunteerism (Percent of adults age 65+)	29.0	14	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	23.7	46	65.2
	C&E — MICRO PERSPECTIVE	0.059	9	
	Social Support (Percent of adults age 65+)	85.4	1	85.4
	Food Insecurity (Percent of adults age 60+)	12.5	18	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$574	33	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	0.056	22	
	POLICY			
	Low-Care Nursing Home Residents (Percent of residents)	6.5	8	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	85.7	34	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	65.0	25	16.3
	POLICY TOTAL	0.039	18	
	CLINICAL CARE			
	Dedicated Health Care Provider (Percent of adults age 65+)	95.0	25	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.1	41	98.4
	Flu Vaccine (Percent of adults age 65+)	54.2	48	70.2
	Health Screenings (Percent of adults age 65-74)	84.7	29	91.7
	Diabetes Management (Percent of Medicare enrollees)	80.8	21	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	77.4	30	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	42.9	3	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	14.1	4	12.3
	Hospice Care (Percent of decedents age 65+)	43.6	7	54.5
	Hospital Deaths (Percent of decedents age 65+)	24.9	9	19.2
	CLINICAL CARE TOTAL	0.033	16	
	ALL DETERMINANTS	0.105	17	
	OUTCOMES			
	ICU Usage (Percent of decedents age 65+)	5.8	3	5.1
	Falls (Percent of adults age 65+)	16.6	25	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	6.9	16	3.0
	Health Status (Percent very good or excellent of adults age 65+)	43.1	7	48.9
	Able-Bodied (Percent of adults age 65+)	62.3	33	68.0
	Premature Death (Deaths per 100,000 population age 65-74)	1,772	18	1,425
	Teeth Extractions (Percent of adults age 65+)	13.7	11	7.4
	Mental Health Days (Days in previous 30 days)	2.2	19	1.5
	ALL OUTCOMES	0.140	12	
	OVERALL	0.245	15	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	24.4	14	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	25.2	6	20.9
Cognition (Percent of adults age 65+)	9.1	28	5.7
Depression (Percent of adults age 65+)	18.3	49	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	56.4	51.3
Obesity (Percent obese)	24.4	32.9

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015-2030	49.3	52.7

Overall Rank: 15

Determinants Rank: 17

Outcomes Rank: 12

Strengths:

- Low prevalence of physical inactivity
- Highest percentage of social support in the U.S.
- Low percentage of ICU usage

Challenges:

- High prevalence of underweight seniors
- Low rate of highly-rated nursing home beds
- Low prevalence of flu vaccination

Ranking: Oregon is 15th in this Senior Report. In the *America's Health Rankings®* 2012 Edition, it ranked 13th for its entire population.

Highlights:

- A low percentage of Oregon seniors receive the flu vaccine, at 54.2 percent of adults aged 65 and older.
- Oregon has the highest percentage of social support in the U.S. at 85.4 percent of adults aged 65 and older.
- The percentage of low-care nursing home residents is lower in Oregon than most other states at 6.5 percent, or 400 residents.
- While Oregon's physical inactivity rate is one of the lowest in the U.S., there are still almost 125,000 adults aged 65 and older in the state who are physically inactive.
- The prevalence of chronic drinking, at 5.0 percent of adults aged 65 and older, is high compared to most other states.

Disparities: In Oregon, seniors with less than a high school degree have a lower prevalence of very good or excellent health and a lower prevalence of social support compared to seniors with a college degree.

State Health Department Website:

<http://public.health.oregon.gov/>



For a more detailed look at this data, visit www.americashealthrankings.org/senior/OR

PENNSYLVANIA

PENNSYLVANIA

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	9.1	25	4.7
	Chronic Drinking (Percent of adults age 65+)	2.8	13	1.4
	Obesity (Percent of adults age 65+)	28.0	43	16.9
	Underweight (Percent of adults age 65+)	1.3	3	1.1
	Physical Inactivity (Percent of adults age 65+)	32.4	27	20.5
	Dental Visits (Percent of adults age 65+)	68.2	26	79.8
	Pain Management (Percent of adults age 65+)	52.9	18	60.7
	BEHAVIORS TOTAL	0.020	16	
COMMUNITY & ENVIRONMENT				
C&E — MACRO PERSPECTIVE				
	Poverty (Percent of adults age 65+)	8.2	25	5.1
	Volunteerism (Percent of adults age 65+)	25.2	25	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	37.0	31	65.2
C&E — MICRO PERSPECTIVE				
	Social Support (Percent of adults age 65+)	79.4	31	85.4
	Food Insecurity (Percent of adults age 60+)	14.8	30	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$2,015	6	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	0.0160	26	
POLICY				
	Low-Care Nursing Home Residents (Percent of residents)	6.0	5	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	87.4	15	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	39.4	5	16.3
	POLICY TOTAL	0.160	2	
CLINICAL CARE				
	Dedicated Health Care Provider (Percent of adults age 65+)	96.7	2	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	98.1	8	98.4
	Flu Vaccine (Percent of adults age 65+)	62.6	20	70.2
	Health Screenings (Percent of adults age 65–74)	86.7	23	91.7
	Diabetes Management (Percent of Medicare enrollees)	80.5	25	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	98.5	18	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	69.6	34	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	15.8	29	12.3
	Hospice Care (Percent of decedents age 65+)	35.3	22	54.5
	Hospital Deaths (Percent of decedents age 65+)	28.7	25	19.2
	CLINICAL CARE TOTAL	0.038	14	
	ALL DETERMINANTS	0.234	10	
OUTCOMES				
	ICU Usage (Percent of decedents age 65+)	16.7	44	5.1
	Falls (Percent of adults age 65+)	15.5	17	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	6.7	12	3.0
	Health Status (Percent very good or excellent of adults age 65+)	37.6	30	48.9
	Able-Bodied (Percent of adults age 65+)	64.4	23	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	1,958	34	1,425
	Teeth Extractions (Percent of adults age 65+)	18.0	31	7.4
	Mental Health Days (Days in previous 30 days)	2.6	36	1.5
	ALL OUTCOMES	-0.004	30	
	OVERALL	0.229	17	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	16.9	39	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	39.0	45	20.9
Cognition (Percent of adults age 65+)	8.3	17	5.7
Depression (Percent of adults age 65+)	14.5	34	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	45.2	58.2
Obesity (Percent obese)	33.2	25.1

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	34.5	52.7

Overall Rank: 17

Determinants Rank: 10

Outcomes Rank: 30

Strengths:

- Low prevalence of underweight seniors
- Low geriatrician shortfall
- High prevalence of dedicated health care providers

Challenges:

- High prevalence of obesity
- High percentage of ICU usage
- High rate of preventable hospitalizations

Ranking: Pennsylvania is 17th in this Senior Report. In the *America's Health Rankings®* 2012 Edition, it ranked 26th for its entire population.

Highlights:

- Total community expenditures are higher than most other states at \$2,015 per person aged 65 and older living in poverty.
- The chronic drinking rate in Pennsylvania is lower than most other states at 2.8 percent of adults aged 65 and older.
- Pennsylvania has a high percentage of seniors who spent 7 or more days in the ICU during the last 6 months of life at 16.7 percent of adults aged 65 and older.
- The percentage of low-care nursing home residents is lower in Pennsylvania than most other states at 6.0 percent, or 4,300 residents, in the state.
- Almost 550,000 adults aged 65 and older are obese in Pennsylvania; that is 28.0 percent of all adults aged 65 and older.

Disparities: In Pennsylvania, seniors with less than a high school degree have higher prevalences of obesity and physical inactivity and lower prevalences of excellent or very good health and social support compared to seniors with a college degree.

State Health Department Website:

www.health.state.pa.us



For a more detailed look at this data, visit www.americashealthrankings.org/senior/PA

RHODE ISLAND

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	9.3	28	4.7
	Chronic Drinking (Percent of adults age 65+)	5.4	45	1.4
	Obesity (Percent of adults age 65+)	22.2	9	16.9
	Underweight (Percent of adults age 65+)	1.3	3	1.1
	Physical Inactivity (Percent of adults age 65+)	33.1	33	20.5
	Dental Visits (Percent of adults age 65+)	72.4	16	79.8
	Pain Management (Percent of adults age 65+)	50.9	29	60.7
	BEHAVIORS TOTAL	0.011	21	
	COMMUNITY & ENVIRONMENT			
	C&E — MACRO PERSPECTIVE	-0.008	29	
	Poverty (Percent of adults age 65+)	9.1	32	5.1
	Volunteerism (Percent of adults age 65+)	19.4	44	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	51.0	13	65.2
	C&E — MICRO PERSPECTIVE	-0.083	48	
	Social Support (Percent of adults age 65+)	74.8	49	85.4
	Food Insecurity (Percent of adults age 60+)	15.3	31	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$448	44	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	-0.091	37	
	POLICY			
	Low-Care Nursing Home Residents (Percent of residents)	18.0	44	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	88.2	9	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	46.2	9	16.3
	POLICY TOTAL	0.043	16	
	CLINICAL CARE			
	Dedicated Health Care Provider (Percent of adults age 65+)	96.5	3	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	96.7	49	98.4
	Flu Vaccine (Percent of adults age 65+)	56.6	41	70.2
	Health Screenings (Percent of adults age 65-74)	91.3	2	91.7
	Diabetes Management (Percent of Medicare enrollees)	82.7	12	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	91.8	20	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	70.6	36	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	16.9	49	12.3
	Hospice Care (Percent of decedents age 65+)	36.1	20	54.5
	Hospital Deaths (Percent of decedents age 65+)	30.7	31	19.2
	CLINICAL CARE TOTAL	-0.026	34	
	ALL DETERMINANTS	-0.063	33	
	OUTCOMES			
	ICU Usage (Percent of decedents age 65+)	11.3	22	5.1
	Falls (Percent of adults age 65+)	15.6	18	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	6.2	3	3.0
	Health Status (Percent very good or excellent of adults age 65+)	36.9	32	48.9
	Able-Bodied (Percent of adults age 65+)	65.0	19	68.0
	Premature Death (Deaths per 100,000 population age 65-74)	1,798	21	1,425
	Teeth Extractions (Percent of adults age 65+)	16.5	24	7.4
	Mental Health Days (Days in previous 30 days)	2.6	36	1.5
	ALL OUTCOMES	0.071	22	
	OVERALL	0.008	31	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	20.8	27	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	36.7	36	20.9
Cognition (Percent of adults age 65+)	8.5	20	5.7
Depression (Percent of adults age 65+)	14.8	37	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	47.6	54.6
Obesity (Percent obese)	20.0	29.3

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015-2030	40.7	52.7

Overall Rank: 31

Determinants Rank: 33

Outcomes Rank: 22

Strengths:

- High prevalence of dedicated health care providers
- High percentage of health screenings
- Low rate of hospitalization for hip fractures

Challenges:

- High prevalence of chronic drinking
- Low percentage of social support
- High percentage of hospital readmissions

Ranking: Rhode Island is 31st in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 10th for its entire population.

Highlights:

- More than 1 in 5 seniors in Rhode Island are obese; this is 34,000 adults aged 65 and older.
- The percent of low-care nursing home residents in Rhode Island is one of the highest in the U.S. at 18.0 percent, or 1,300 residents.
- There are a high percentage of seniors with creditable drug coverage at 88.2 percent of Medicare beneficiaries.
- Rhode Island has a low geriatrician shortfall with 46.2 percent of the number of geriatricians needed.
- Rhode Island has one of the lowest rates of volunteerism with 19.4 percent of seniors who volunteer.

Disparities: In Rhode Island, seniors with a household income of less than \$25,000 have a prevalence of physical inactivity more than double that of seniors with an income greater than \$75,000.

State Health Department Website:

www.health.state.ri.us



For a more detailed look at this data, visit www.americashealthrankings.org/senior/RI

SOUTH CAROLINA

SOUTH CAROLINA

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	9.0	23	4.7
	Chronic Drinking (Percent of adults age 65+)	4.4	35	1.4
	Obesity (Percent of adults age 65+)	25.2	24	16.9
	Underweight (Percent of adults age 65+)	2.0	25	1.1
	Physical Inactivity (Percent of adults age 65+)	29.1	18	20.5
	Dental Visits (Percent of adults age 65+)	61.1	42	79.8
	Pain Management (Percent of adults age 65+)	55.7	10	60.7
	BEHAVIORS TOTAL	-0.020	30	
	COMMUNITY & ENVIRONMENT			
	C&E — MACRO PERSPECTIVE	-0.047	35	
	Poverty (Percent of adults age 65+)	10.3	38	5.1
	Volunteerism (Percent of adults age 65+)	22.3	34	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	37.7	30	65.2
	C&E — MICRO PERSPECTIVE	-0.079	47	
	Social Support (Percent of adults age 65+)	76.9	46	85.4
	Food Insecurity (Percent of adults age 60+)	17.1	43	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$409	45	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	-0.126	43	
	POLICY			
	Low-Care Nursing Home Residents (Percent of residents)	5.7	4	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	87.0	20	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	67.5	30	16.3
	POLICY TOTAL	0.065	12	
	CLINICAL CARE			
	Dedicated Health Care Provider (Percent of adults age 65+)	95.7	10	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	98.0	11	98.4
	Flu Vaccine (Percent of adults age 65+)	65.2	12	70.2
	Health Screenings (Percent of adults age 65–74)	87.0	21	91.7
	Diabetes Management (Percent of Medicare enrollees)	81.4	17	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	72.7	35	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	61.2	24	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	15.4	20	12.3
	Hospice Care (Percent of decedents age 65+)	35.6	21	54.5
	Hospital Deaths (Percent of decedents age 65+)	35.3	46	19.2
	CLINICAL CARE TOTAL	0.026	18	
	ALL DETERMINANTS	-0.056	32	
	OUTCOMES			
	ICU Usage (Percent of decedents age 65+)	16.0	41	5.1
	Falls (Percent of adults age 65+)	16.3	21	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	8.3	38	3.0
	Health Status (Percent very good or excellent of adults age 65+)	34.7	40	48.9
	Able-Bodied (Percent of adults age 65+)	61.6	36	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	2,121	40	1,425
	Teeth Extractions (Percent of adults age 65+)	21.6	41	7.4
	Mental Health Days (Days in previous 30 days)	2.6	36	1.5
	ALL OUTCOMES	-0.148	41	
	OVERALL	-0.203	36	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	20.7	28	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	35.0	29	20.9
Cognition (Percent of adults age 65+)	10.8	39	5.7
Depression (Percent of adults age 65+)	12.6	20	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	48.7	46.7
Obesity (Percent obese)	25.7	34.1

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	55.6	52.7

Overall Rank: 36

Determinants Rank: 32

Outcomes Rank: 41

Strengths:

- Low prevalence of activity-limiting arthritis pain
- Low percentage of low-care nursing home residents
- High prevalence of dedicated health care providers

Challenges:

- Low percentage of social support
- Low prevalence of dental visits
- High percentage of hospital deaths

Ranking: South Carolina is 36th in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 46th for its entire population.

Highlights:

- The percent of low-care nursing home residents is low at 5.7 percent, or 800 residents.
- South Carolina has one of the lowest rates of dental visits at 61.1 percent of adults aged 65 and older.
- South Carolina has a flu vaccination rate higher than most other states at 65.2 percent of adults aged 65 and older.
- In South Carolina, 17.1 percent of seniors, or almost 110,000 adults aged 60 and older, are marginally food insecure.
- The prevalence of teeth extractions is high at 21.6 percent of adults aged 65 and older who have all teeth extracted.

Disparities: Seniors with less than a high school degree have a much higher prevalence of physical inactivity and a much lower prevalence of very good or excellent health compared to seniors with a college degree.

State Health Department Website:
www.scdhec.net



For a more detailed look at this data, visit www.americashealthrankings.org/senior/SC

SOUTH DAKOTA

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	9.5	29	4.7
	Chronic Drinking (Percent of adults age 65+)	2.1	7	1.4
	Obesity (Percent of adults age 65+)	23.8	14	16.9
	Underweight (Percent of adults age 65+)	2.0	25	1.1
	Physical Inactivity (Percent of adults age 65+)	35.9	43	20.5
	Dental Visits (Percent of adults age 65+)	69.2	24	79.8
	Pain Management (Percent of adults age 65+)	52.1	25	60.7
	BEHAVIORS TOTAL	0.004	24	
	COMMUNITY & ENVIRONMENT			
	C&E — MACRO PERSPECTIVE	0.057	15	
	Poverty (Percent of adults age 65+)	11.6	46	5.1
	Volunteerism (Percent of adults age 65+)	35.4	6	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	58.6	6	65.2
	C&E — MICRO PERSPECTIVE	0.042	17	
	Social Support (Percent of adults age 65+)	81.3	16	85.4
	Food Insecurity (Percent of adults age 60+)	11.1	12	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$1,063	15	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	0.099	15	
	POLICY			
	Low-Care Nursing Home Residents (Percent of residents)	16.7	41	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	88.6	3	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	74.0	40	16.3
	POLICY TOTAL	-0.026	36	
	CLINICAL CARE			
	Dedicated Health Care Provider (Percent of adults age 65+)	92.3	44	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	96.8	47	98.4
	Flu Vaccine (Percent of adults age 65+)	68.3	4	70.2
	Health Screenings (Percent of adults age 65–74)	88.7	12	91.7
	Diabetes Management (Percent of Medicare enrollees)	74.6	43	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	38.1	47	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	63.7	27	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	14.8	9	12.3
	Hospice Care (Percent of decedents age 65+)	23.4	47	54.5
	Hospital Deaths (Percent of decedents age 65+)	24.7	8	19.2
	CLINICAL CARE TOTAL	-0.030	37	
	ALL DETERMINANTS	0.048	21	
	OUTCOMES			
	ICU Usage (Percent of decedents age 65+)	6.9	8	5.1
	Falls (Percent of adults age 65+)	16.5	24	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	7.1	20	3.0
	Health Status (Percent very good or excellent of adults age 65+)	38.0	28	48.9
	Able-Bodied (Percent of adults age 65+)	64.0	24	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	1,768	17	1,425
	Teeth Extractions (Percent of adults age 65+)	18.2	32	7.4
	Mental Health Days (Days in previous 30 days)	1.5	1	1.5
	ALL OUTCOMES	0.129	14	
	OVERALL	0.177	19	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	19.1	33	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	27.2	11	20.9
Cognition (Percent of adults age 65+)	7.7	8	5.7
Depression (Percent of adults age 65+)	12.9	21	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	46.4	58.4
Obesity (Percent obese)	22.2	33.3

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	44.6	52.7

Overall Rank: 19

Determinants Rank: 21

Outcomes Rank: 14

Strengths:

- High percentage of creditable drug coverage
- High prevalence of flu vaccination
- Few poor mental health days per month

Challenges:

- High percentage of seniors living in poverty
- Limited availability of home health care workers
- Low percentage of hospice care

Ranking: South Dakota is 19th in this Senior Report. In the *America's Health Rankings®* 2012 Edition, it ranked 27th for its entire population.

Highlights:

- South Dakota has a high percentage of seniors in poverty at 11.6 percent of adults aged 65 and older.
- A high percentage of South Dakota older adults have creditable drug coverage at 88.6 percent of Medicare beneficiaries.
- In South Dakota, 35.9 percent of adults aged 65 and older, or more than 40,000 seniors, are physically inactive. This is higher than the prevalence among all adults in the state at 27.0 percent.
- South Dakota has a high rate of volunteerism with 35.4 percent of adults aged 65 and older who volunteer.

Disparities: In South Dakota, American Indians have nearly twice the rate of obesity as white seniors at 41.5 percent of adults aged 65 and older who are obese. They also have far less social and emotional support.

State Health Department Website:

<http://doh.sd.gov>



For a more detailed look at this data, visit www.americashealthrankings.org/senior/SD

TENNESSEE

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	10.9	41	4.7
	Chronic Drinking (Percent of adults age 65+)	1.6	2	1.4
	Obesity (Percent of adults age 65+)	25.2	24	16.9
	Underweight (Percent of adults age 65+)	1.6	9	1.1
	Physical Inactivity (Percent of adults age 65+)	41.3	50	20.5
	Dental Visits (Percent of adults age 65+)	63.3	39	79.8
	Pain Management (Percent of adults age 65+)	49.3	40	60.7
	BEHAVIORS TOTAL	-0.088	41	
COMMUNITY & ENVIRONMENT				
C&E — MACRO PERSPECTIVE				
	Poverty (Percent of adults age 65+)	10.4	39	5.1
	Volunteerism (Percent of adults age 65+)	20.2	40	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	35.0	33	65.2
	C&E — MICRO PERSPECTIVE	-0.009	29	
	Social Support (Percent of adults age 65+)	83.9	4	85.4
	Food Insecurity (Percent of adults age 60+)	17.6	46	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$473	42	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	-0.076	35	
POLICY				
	Low-Care Nursing Home Residents (Percent of residents)	10.6	23	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	87.8	12	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	76.5	44	16.3
	POLICY TOTAL	0.008	24	
CLINICAL CARE				
	Dedicated Health Care Provider (Percent of adults age 65+)	95.0	25	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.7	22	98.4
	Flu Vaccine (Percent of adults age 65+)	67.7	5	70.2
	Health Screenings (Percent of adults age 65–74)	86.0	24	91.7
	Diabetes Management (Percent of Medicare enrollees)	82.1	15	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	67.2	39	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	83.4	46	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	16.4	41	12.3
	Hospice Care (Percent of decedents age 65+)	30.0	40	54.5
	Hospital Deaths (Percent of decedents age 65+)	33.7	45	19.2
	CLINICAL CARE TOTAL	-0.027	35	
	ALL DETERMINANTS	-0.183	38	
OUTCOMES				
	ICU Usage (Percent of decedents age 65+)	15.4	37	5.1
	Falls (Percent of adults age 65+)	13.5	2	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	8.8	47	3.0
	Health Status (Percent very good or excellent of adults age 65+)	33.8	43	48.9
	Able-Bodied (Percent of adults age 65+)	58.6	42	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	2,253	43	1,425
	Teeth Extractions (Percent of adults age 65+)	33.7	49	7.4
	Mental Health Days (Days in previous 30 days)	2.6	36	1.5
	ALL OUTCOMES	-0.193	43	
	OVERALL	-0.376	41	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	16.2	43	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	36.7	36	20.9
Cognition (Percent of adults age 65+)	11.8	45	5.7
Depression (Percent of adults age 65+)	17.0	46	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	38.1	46.6
Obesity (Percent obese)	26.7	34.1

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	46.3	52.7

Overall Rank: 41

Determinants Rank: 38

Outcomes Rank: 43

Strengths:

- Low prevalence of chronic drinking
- High percentage of social support
- Low prevalence of falls

Challenges:

- High prevalence of physical inactivity
- High prevalence of food insecurity
- High prevalence of teeth extractions

Ranking: Tennessee is 41st in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 39th for its entire population.

Highlights:

- The prevalence of adults aged 65 and older with all teeth extracted is 33.7 percent, one of the highest in the nation.
- More than 150,000 adults aged 60 and older in Tennessee are marginally food insecure.
- Tennessee has the highest rate of physical inactivity in the U.S.; more than 350,000 adults aged 65 and older are inactive.
- Compared to most states, Tennessee has a low prevalence of underweight seniors at 1.6 percent of adults aged 65 and older.
- A low percentage of seniors in Tennessee have fallen in the last 3 months at 13.5 percent of adults aged 65 and older.

Disparities: In Tennessee, the rate of obesity among black seniors is 41.8 percent compared to 24.6 percent among white seniors.

State Health Department Website:

<http://health.state.tn.us>



For a more detailed look at this data, visit www.americashealthrankings.org/senior/TN

TEXAS

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	8.8	17	4.7
	Chronic Drinking (Percent of adults age 65+)	4.0	31	1.4
	Obesity (Percent of adults age 65+)	26.3	33	16.9
	Underweight (Percent of adults age 65+)	1.3	3	1.1
	Physical Inactivity (Percent of adults age 65+)	31.3	24	20.5
	Dental Visits (Percent of adults age 65+)	65.5	35	79.8
	Pain Management (Percent of adults age 65+)	48.8	42	60.7
	BEHAVIORS TOTAL	-0.030	33	
	COMMUNITY & ENVIRONMENT			
	C&E — MACRO PERSPECTIVE	-0.067	41	
	Poverty (Percent of adults age 65+)	11.3	43	5.1
	Volunteerism (Percent of adults age 65+)	23.9	29	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	33.3	36	65.2
	C&E — MICRO PERSPECTIVE	-0.073	46	
	Social Support (Percent of adults age 65+)	78.5	38	85.4
	Food Insecurity (Percent of adults age 60+)	18.1	47	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$340	48	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	-0.140	46	
	POLICY			
	Low-Care Nursing Home Residents (Percent of residents)	14.3	34	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	86.2	29	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	67.9	32	16.3
	POLICY TOTAL	-0.033	37	
	CLINICAL CARE			
	Dedicated Health Care Provider (Percent of adults age 65+)	93.1	40	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.8	18	98.4
	Flu Vaccine (Percent of adults age 65+)	59.1	31	70.2
	Health Screenings (Percent of adults age 65-74)	82.3	41	91.7
	Diabetes Management (Percent of Medicare enrollees)	80.8	21	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	175.0	6	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	72.3	37	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	15.8	29	12.3
	Hospice Care (Percent of decedents age 65+)	44.4	5	54.5
	Hospital Deaths (Percent of decedents age 65+)	27.8	23	19.2
	CLINICAL CARE TOTAL	0.011	21	
	ALL DETERMINANTS	-0.192	39	
	OUTCOMES			
	ICU Usage (Percent of decedents age 65+)	18.7	45	5.1
	Falls (Percent of adults age 65+)	17.3	34	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	8.4	42	3.0
	Health Status (Percent very good or excellent of adults age 65+)	36.0	34	48.9
	Able-Bodied (Percent of adults age 65+)	59.3	40	68.0
	Premature Death (Deaths per 100,000 population age 65-74)	1,930	32	1,425
	Teeth Extractions (Percent of adults age 65+)	14.1	13	7.4
	Mental Health Days (Days in previous 30 days)	2.3	23	1.5
	ALL OUTCOMES	-0.110	40	
	OVERALL	-0.302	39	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	21.1	24	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	38.6	42	20.9
Cognition (Percent of adults age 65+)	11.1	43	5.7
Depression (Percent of adults age 65+)	14.6	35	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	50.7	45.2
Obesity (Percent obese)	26.6	35.3

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015-2030	66.6	52.7

Overall Rank: 39

Determinants Rank: 39

Outcomes Rank: 40

Strengths:

- Low prevalence of underweight seniors
- Ready availability of home health care workers
- High percentage of hospice care

Challenges:

- High prevalence of activity-limiting arthritis pain
- High prevalence of food insecurity
- Low prevalence of able-bodied seniors

Ranking: Texas is 39th in this Senior Report. In the *America's Health Rankings®* 2012 Edition, it ranked 40th for its entire population.

Highlights:

- More than 690,000 adults aged 65 and older in Texas are obese and more than 820,000 seniors are physically inactive.
- Total community expenditures are lower than most other states at \$340 per person aged 65 and older living in poverty.
- Texas has a high percentage of seniors who spent 7 or more days in the ICU during the last 6 months of life at 18.7 percent of adults aged 65 and older.
- Texas has a high rate of home health care workers at 175 per 1,000 adults aged 75 and older.
- Texas has one of the highest rates of seniors living in poverty at 11.3 percent of adults aged 65 and older.

Disparities: In Texas, seniors with less than a high school diploma have more than twice the rates of obesity and physical inactivity compared to seniors with a college degree.

State Health Department Website:

www.dshs.state.tx.us



For a more detailed look at this data, visit www.americashealthrankings.org/senior/TX

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	4.7	1	4.7
	Chronic Drinking (Percent of adults age 65+)	2.5	10	1.4
	Obesity (Percent of adults age 65+)	24.6	19	16.9
	Underweight (Percent of adults age 65+)	2.3	39	1.1
	Physical Inactivity (Percent of adults age 65+)	25.5	7	20.5
	Dental Visits (Percent of adults age 65+)	72.4	16	79.8
	Pain Management (Percent of adults age 65+)	48.4	44	60.7
	BEHAVIORS TOTAL	0.105	4	
COMMUNITY & ENVIRONMENT				
C&E — MACRO PERSPECTIVE				
	Poverty (Percent of adults age 65+)	6.2	2	5.1
	Volunteerism (Percent of adults age 65+)	35.5	5	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	24.6	45	65.2
C&E — MICRO PERSPECTIVE				
	Social Support (Percent of adults age 65+)	83.4	7	85.4
	Food Insecurity (Percent of adults age 60+)	14.2	27	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$1,569	8	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	0.113	13	
POLICY				
	Low-Care Nursing Home Residents (Percent of residents)	5.6	3	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	84.4	38	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	75.7	42	16.3
	POLICY TOTAL	-0.014	32	
CLINICAL CARE				
	Dedicated Health Care Provider (Percent of adults age 65+)	92.7	42	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	98.1	8	98.4
	Flu Vaccine (Percent of adults age 65+)	56.9	40	70.2
	Health Screenings (Percent of adults age 65–74)	84.3	31	91.7
	Diabetes Management (Percent of Medicare enrollees)	74.9	41	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	45.9	46	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	36.8	2	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	12.3	1	12.3
	Hospice Care (Percent of decedents age 65+)	53.4	2	54.5
	Hospital Deaths (Percent of decedents age 65+)	19.2	1	19.2
	CLINICAL CARE TOTAL	0.068	6	
	ALL DETERMINANTS	0.272	7	
OUTCOMES				
	ICU Usage (Percent of decedents age 65+)	7.5	10	5.1
	Falls (Percent of adults age 65+)	18.2	43	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	7.1	20	3.0
	Health Status (Percent very good or excellent of adults age 65+)	42.3	11	48.9
	Able-Bodied (Percent of adults age 65+)	65.5	15	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	1,611	6	1,425
	Teeth Extractions (Percent of adults age 65+)	12.8	6	7.4
	Mental Health Days (Days in previous 30 days)	2.3	23	1.5
	ALL OUTCOMES	0.130	13	
	OVERALL	0.402	9	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	25.7	7	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	26.0	9	20.9
Cognition (Percent of adults age 65+)	7.7	8	5.7
Depression (Percent of adults age 65+)	16.4	45	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	59.7	55
Obesity (Percent obese)	21.2	29.7

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	63.9	52.7

Overall Rank: 9

Determinants Rank: 7

Outcomes Rank: 13

Strengths:

- Low prevalences of smoking & chronic drinking
- Low percentage of seniors living in poverty
- Low percentages of hospital readmissions & hospital deaths

Challenges:

- High prevalence of activity-limiting arthritis pain
- Low rate of highly-rated nursing home beds
- Limited availability of home health care workers

Ranking: Utah is 9th in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 7th for its entire population.

Highlights:

- Utah has a low rate of home health care workers at 45.9 per 1,000 adults aged 75 and older.
- Utah has the lowest senior smoking rate in the U.S. at 4.7 percent of adults aged 65 and older. However, 12,000 older adults still smoke.
- The percentage of creditable drug coverage is lower in Utah than in most other states at 84.4 percent of Medicare beneficiaries.
- A high percentage of seniors in Utah volunteer at 35.5 percent of adults aged 65 and older.
- Utah has a low percentage of low-care nursing home residents at 5.6 percent of nursing home residents.

Disparities: In Utah, seniors with less than a high school degree have a 12.5 percent higher prevalence of obesity and a 22.5 percent higher prevalence of physical inactivity compared to seniors with a college degree.

State Health Department Website:
www.health.utah.gov

 For a more detailed look at this data, visit www.americashealthrankings.org/senior/UT

VERMONT

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	6.2	2	4.7
	Chronic Drinking (Percent of adults age 65+)	5.0	39	1.4
	Obesity (Percent of adults age 65+)	23.8	14	16.9
	Underweight (Percent of adults age 65+)	1.7	13	1.1
	Physical Inactivity (Percent of adults age 65+)	25.8	8	20.5
	Dental Visits (Percent of adults age 65+)	72.2	19	79.8
	Pain Management (Percent of adults age 65+)	50.0	37	60.7
	BEHAVIORS TOTAL	0.084	6	
	COMMUNITY & ENVIRONMENT			
	C&E — MACRO PERSPECTIVE	0.070	12	
	Poverty (Percent of adults age 65+)	7.4	8	5.1
	Volunteerism (Percent of adults age 65+)	32.3	9	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	41.5	24	65.2
	C&E — MICRO PERSPECTIVE	0.080	6	
	Social Support (Percent of adults age 65+)	81.7	13	85.4
	Food Insecurity (Percent of adults age 60+)	11.6	15	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$2,584	5	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	0.150	8	
	POLICY			
	Low-Care Nursing Home Residents (Percent of residents)	6.5	7	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	86.2	29	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	53.9	14	16.3
	POLICY TOTAL	0.085	8	
	CLINICAL CARE			
	Dedicated Health Care Provider (Percent of adults age 65+)	96.5	3	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	98.4	1	98.4
	Flu Vaccine (Percent of adults age 65+)	65.4	10	70.2
	Health Screenings (Percent of adults age 65–74)	88.7	12	91.7
	Diabetes Management (Percent of Medicare enrollees)	79.7	29	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	182.5	5	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	50.6	7	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	14.5	6	12.3
	Hospice Care (Percent of decedents age 65+)	23.5	46	54.5
	Hospital Deaths (Percent of decedents age 65+)	26.8	20	19.2
	CLINICAL CARE TOTAL	0.109	1	
	ALL DETERMINANTS	0.428	2	
	OUTCOMES			
	ICU Usage (Percent of decedents age 65+)	5.1	1	5.1
	Falls (Percent of adults age 65+)	17.3	34	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	6.9	16	3.0
	Health Status (Percent very good or excellent of adults age 65+)	48.9	1	48.9
	Able-Bodied (Percent of adults age 65+)	65.1	17	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	1,744	14	1,425
	Teeth Extractions (Percent of adults age 65+)	17.5	28	7.4
	Mental Health Days (Days in previous 30 days)	2.2	19	1.5
	ALL OUTCOMES	0.163	9	
	OVERALL	0.592	2	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	28.3	2	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	25.2	5	20.9
Cognition (Percent of adults age 65+)	8.7	25	5.7
Depression (Percent of adults age 65+)	16.0	42	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	60.8	62.8
Obesity (Percent obese)	21.1	25.9

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	53.3	52.7

Overall Rank: 2

Determinants Rank: 2

Outcomes Rank: 9

Strengths:

- Low prevalence of smoking
- High prevalence of dedicated health care providers
- Low percentage of ICU usage

Challenges:

- Low prevalence of hospice care
- High prevalence of chronic drinking
- High prevalence of falls

Ranking: Vermont is 2nd in this Senior Report. In the *America's Health Rankings®* 2012 Edition, it ranked 1st for its entire population.

Highlights:

- Vermont has a low percentage of low-care nursing home residents at 6.5 percent of nursing home residents.
- Total community expenditures are high in Vermont at \$2,584 per person aged 65 and older living in poverty.
- The percentage of seniors who spent 7 or more days in the ICU during the last 6 months of life is the lowest in Vermont at 5.1 percent of adults aged 65 and older.
- Compared to other states, Vermont has a higher rate of chronic drinking at 5.0 percent of adults aged 65 and older.
- Vermont has one of the lowest smoking rates in the nation at 6.2 percent of adults aged 65 and older, or 6,000 seniors who smoke.

Disparities: In Vermont, seniors with less than a high school diploma have a higher prevalence of obesity and physical inactivity and a lower prevalence of social and emotional support than seniors with a college degree.

State Health Department Website:

www.healthvermont.gov



For a more detailed look at this data, visit www.americashealthrankings.org/senior/VT

VIRGINIA

VIRGINIA

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	8.9	19	4.7
	Chronic Drinking (Percent of adults age 65+)	3.8	29	1.4
	Obesity (Percent of adults age 65+)	26.8	37	16.9
	Underweight (Percent of adults age 65+)	2.0	25	1.1
	Physical Inactivity (Percent of adults age 65+)	33.8	38	20.5
	Dental Visits (Percent of adults age 65+)	75.0	6	79.8
	Pain Management (Percent of adults age 65+)	52.6	20	60.7
	BEHAVIORS TOTAL	-0.016	29	
COMMUNITY & ENVIRONMENT				
C&E — MACRO PERSPECTIVE				
	Poverty (Percent of adults age 65+)	7.7	15	5.1
	Volunteerism (Percent of adults age 65+)	28.4	17	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	29.2	40	65.2
C&E — MICRO PERSPECTIVE				
	Social Support (Percent of adults age 65+)	81.5	15	85.4
	Food Insecurity (Percent of adults age 60+)	9.3	7	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$595	32	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	0.060	21	
POLICY				
	Low-Care Nursing Home Residents (Percent of residents)	8.6	14	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	84.3	39	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	61.8	21	16.3
	POLICY TOTAL	0.000	26	
CLINICAL CARE				
	Dedicated Health Care Provider (Percent of adults age 65+)	93.2	39	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.9	16	98.4
	Flu Vaccine (Percent of adults age 65+)	63.3	17	70.2
	Health Screenings (Percent of adults age 65–74)	85.5	26	91.7
	Diabetes Management (Percent of Medicare enrollees)	82.4	14	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	82.4	23	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	58.3	18	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	15.7	27	12.3
	Hospice Care (Percent of decedents age 65+)	31.7	35	54.5
	Hospital Deaths (Percent of decedents age 65+)	33.3	42	19.2
	CLINICAL CARE TOTAL	-0.005	24	
	ALL DETERMINANTS	0.039	23	
OUTCOMES				
	ICU Usage (Percent of decedents age 65+)	13.8	31	5.1
	Falls (Percent of adults age 65+)	15.0	10	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	7.7	34	3.0
	Health Status (Percent very good or excellent of adults age 65+)	38.6	26	48.9
	Able-Bodied (Percent of adults age 65+)	64.8	20	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	1,882	28	1,425
	Teeth Extractions (Percent of adults age 65+)	15.1	16	7.4
	Mental Health Days (Days in previous 30 days)	1.7	5	1.5
	ALL OUTCOMES	0.101	19	
	OVERALL	0.140	21	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	24.8	10	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	34.0	26	20.9
Cognition (Percent of adults age 65+)	9.4	31	5.7
Depression (Percent of adults age 65+)	10.0	6	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	53.0	51.2
Obesity (Percent obese)	21.9	31

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	54.5	52.7

Overall Rank: 21

Determinants Rank: 23

Outcomes Rank: 19

Strengths:

- High prevalence of dental visits
- Low prevalence of food insecurity
- Few poor mental health days per month

Challenges:

- High prevalence of physical inactivity
- Low rate of highly-rated nursing home beds
- High percentage of hospital deaths

Ranking: Virginia is 21st in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 21st for its entire population.

Highlights:

- In Virginia, 9.3 percent of adults aged 60 and older, or more than 90,000 seniors, are marginally food insecure. This rate is lower than most other states.
- Compared to most other states, Virginia has a lower percentage of creditable drug coverage at 84.3 percent of Medicare beneficiaries.
- More than 330,000 adults aged 65 and older in Virginia are physically inactive, a higher rate compared to most other states.
- Older adults in Virginia experience few poor mental health days per month at 1.7 days in the previous 30 days.
- Virginia has a low percentage of low-care nursing home residents at 8.6 percent of nursing home residents.

Disparities: In Virginia, seniors with less than a high school diploma have a higher prevalence of obesity and physical inactivity and a lower prevalence of social and emotional support than seniors with a college degree.

State Health Department Website:

www.vdh.state.va.us



For a more detailed look at this data, visit www.americashealthrankings.org/senior/VA

WASHINGTON

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	7.5	7	4.7
	Chronic Drinking (Percent of adults age 65+)	5.0	39	1.4
	Obesity (Percent of adults age 65+)	25.6	27	16.9
	Underweight (Percent of adults age 65+)	1.9	22	1.1
	Physical Inactivity (Percent of adults age 65+)	23.4	4	20.5
	Dental Visits (Percent of adults age 65+)	72.4	16	79.8
	Pain Management (Percent of adults age 65+)	47.2	46	60.7
	BEHAVIORS TOTAL	0.014	19	
	COMMUNITY & ENVIRONMENT			
	C&E — MACRO PERSPECTIVE	0.012	25	
	Poverty (Percent of adults age 65+)	7.7	15	5.1
	Volunteerism (Percent of adults age 65+)	28.4	17	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	29.3	39	65.2
	C&E — MICRO PERSPECTIVE	0.030	19	
	Social Support (Percent of adults age 65+)	84.6	2	85.4
	Food Insecurity (Percent of adults age 60+)	14.3	28	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$453	43	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	0.041	25	
	POLICY			
	Low-Care Nursing Home Residents (Percent of residents)	6.4	6	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	82.2	46	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	55.7	15	16.3
	POLICY TOTAL	-0.005	28	
	CLINICAL CARE			
	Dedicated Health Care Provider (Percent of adults age 65+)	94.7	29	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.5	31	98.4
	Flu Vaccine (Percent of adults age 65+)	60.7	27	70.2
	Health Screenings (Percent of adults age 65-74)	86.9	22	91.7
	Diabetes Management (Percent of Medicare enrollees)	80.3	26	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	73.2	34	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	46.4	5	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	14.9	11	12.3
	Hospice Care (Percent of decedents age 65+)	33.4	27	54.5
	Hospital Deaths (Percent of decedents age 65+)	25.9	13	19.2
	CLINICAL CARE TOTAL	0.034	15	
	ALL DETERMINANTS	0.085	20	
	OUTCOMES			
	ICU Usage (Percent of decedents age 65+)	9.4	15	5.1
	Falls (Percent of adults age 65+)	17.2	33	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	6.7	12	3.0
	Health Status (Percent very good or excellent of adults age 65+)	42.1	12	48.9
	Able-Bodied (Percent of adults age 65+)	62.3	32	68.0
	Premature Death (Deaths per 100,000 population age 65-74)	1,694	12	1,425
	Teeth Extractions (Percent of adults age 65+)	12.0	5	7.4
	Mental Health Days (Days in previous 30 days)	1.9	9	1.5
	ALL OUTCOMES	0.148	11	
	OVERALL	0.233	16	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	27.0	4	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	26.3	10	20.9
Cognition (Percent of adults age 65+)	9.6	32	5.7
Depression (Percent of adults age 65+)	12.6	19	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	59.1	54.3
Obesity (Percent obese)	21.2	30.4

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015-2030	62.0	52.7

Overall Rank: 16

Determinants Rank: 20

Outcomes Rank: 11

Strengths:

- Low prevalences of smoking & physical inactivity
- Low percentage of low-care nursing home residents
- High percentage of social support

Challenges:

- High prevalence of activity-limiting arthritis pain
- Low community support expenditures
- Low percentage of creditable drug coverage

Ranking: Washington is 16th in this Senior Report. In the *America's Health Rankings®* 2012 Edition, it ranked 13th for its entire population.

Highlights:

- Washington has a low percentage of seniors with creditable drug coverage at 82.2 percent of Medicare beneficiaries.
- The rate of 4 and 5-star nursing home beds is low compared to most other states at 29.3 percent of beds per 100,000 adults aged 75 and older.
- Washington has a low percentage of low-care nursing home residents at 6.4 percent of nursing home residents.
- Washington has one of the lowest physical inactivity rates in the U.S. at 23.4 percent of adults aged 65 and older who are inactive.
- There is a low geriatrician shortfall in Washington with 55.7 percent of geriatricians needed.

Disparities: In Washington, seniors with less than a high school degree have a higher prevalence of physical inactivity, lower social support, and a lower prevalence of excellent or very good health compared to those with a college degree.

State Health Department Website:

www.doh.wa.gov



For a more detailed look at this data, visit www.americashealthrankings.org/senior/WA

WEST VIRGINIA

WEST VIRGINIA

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	10.9	41	4.7
	Chronic Drinking (Percent of adults age 65+)	1.4	1	1.4
	Obesity (Percent of adults age 65+)	27.7	41	16.9
	Underweight (Percent of adults age 65+)	2.6	44	1.1
	Physical Inactivity (Percent of adults age 65+)	41.2	49	20.5
	Dental Visits (Percent of adults age 65+)	50.4	49	79.8
	Pain Management (Percent of adults age 65+)	48.5	43	60.7
	BEHAVIORS TOTAL	-0.233	49	
COMMUNITY & ENVIRONMENT				
C&E — MACRO PERSPECTIVE				
	Poverty (Percent of adults age 65+)	9.9	35	5.1
	Volunteerism (Percent of adults age 65+)	24.8	26	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	26.5	43	65.2
	C&E — MICRO PERSPECTIVE	0.016	23	
	Social Support (Percent of adults age 65+)	83.7	6	85.4
	Food Insecurity (Percent of adults age 60+)	15.4	33	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$688	27	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	-0.039	31	
POLICY				
	Low-Care Nursing Home Residents (Percent of residents)	11.7	25	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	88.0	10	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	67.0	27	16.3
	POLICY TOTAL	0.031	19	
CLINICAL CARE				
	Dedicated Health Care Provider (Percent of adults age 65+)	92.3	44	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.2	39	98.4
	Flu Vaccine (Percent of adults age 65+)	68.5	3	70.2
	Health Screenings (Percent of adults age 65–74)	81.8	43	91.7
	Diabetes Management (Percent of Medicare enrollees)	80.0	27	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	108.6	13	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	99.1	49	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	16.8	46	12.3
	Hospice Care (Percent of decedents age 65+)	27.6	42	54.5
	Hospital Deaths (Percent of decedents age 65+)	33.4	43	19.2
	CLINICAL CARE TOTAL	-0.095	49	
	ALL DETERMINANTS	-0.335	46	
OUTCOMES				
	ICU Usage (Percent of decedents age 65+)	15.8	39	5.1
	Falls (Percent of adults age 65+)	14.6	7	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	8.3	38	3.0
	Health Status (Percent very good or excellent of adults age 65+)	30.9	48	48.9
	Able-Bodied (Percent of adults age 65+)	55.7	49	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	2,423	48	1,425
	Teeth Extractions (Percent of adults age 65+)	36.0	50	7.4
	Mental Health Days (Days in previous 30 days)	2.9	48	1.5
	ALL OUTCOMES	-0.286	48	
	OVERALL	-0.621	47	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	11.4	50	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	38.0	40	20.9
Cognition (Percent of adults age 65+)	12.0	46	5.7
Depression (Percent of adults age 65+)	12.4	17	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	40.9	35.6
Obesity (Percent obese)	23.1	36.4

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	29.3	52.7

Overall Rank: 47

Determinants Rank: 46

Outcomes Rank: 48

Strengths:

- Low prevalence of chronic drinking
- High percentage of social support
- Low prevalence of falls

Challenges:

- High prevalence of physical inactivity
- Low prevalence of dental visits and high prevalence of teeth extractions
- High premature death rate

Ranking: West Virginia is 47th in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 47th for its entire population.

Highlights:

- West Virginia has a low prevalence of seniors with no disability at 55.7 percent of adults aged 65 and older.
- The state has a low percentage of seniors who have fallen in the last 3 months at 14.6 percent of adults aged 65 and older.
- West Virginia ranks in the bottom 10 states for 7 of the 8 behavior measures and ranks 49th for the Behaviors category overall.
- West Virginia has the second highest rate of physical inactivity at 41.2 percent of adults aged 65 and older, or more than 120,000 seniors, who are inactive.
- A high percentage of seniors receive the flu vaccine at 68.5 percent of adults aged 65 and older.

Disparities: In West Virginia, seniors with less than a high school degree have a higher prevalence of physical inactivity, lower social support, and a lower prevalence of very good or excellent health than those with a college degree.

State Health Department Website:

www.wvdhhr.org



For a more detailed look at this data, visit www.americashealthrankings.org/senior/WV

WISCONSIN

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	9.6	31	4.7
	Chronic Drinking (Percent of adults age 65+)	5.1	42	1.4
	Obesity (Percent of adults age 65+)	26.9	38	16.9
	Underweight (Percent of adults age 65+)	1.7	13	1.1
	Physical Inactivity (Percent of adults age 65+)	33.8	38	20.5
	Dental Visits (Percent of adults age 65+)	73.2	13	79.8
	Pain Management (Percent of adults age 65+)	52.2	23	60.7
	BEHAVIORS TOTAL	-0.061	38	
COMMUNITY & ENVIRONMENT				
	C&E — MACRO PERSPECTIVE	0.085	8	
	Poverty (Percent of adults age 65+)	7.5	10	5.1
	Volunteerism (Percent of adults age 65+)	32.8	8	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	46.9	19	65.2
	C&E — MICRO PERSPECTIVE	0.026	21	
	Social Support (Percent of adults age 65+)	79.5	30	85.4
	Food Insecurity (Percent of adults age 60+)	10.6	10	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$1,013	16	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	0.111	14	
POLICY				
	Low-Care Nursing Home Residents (Percent of residents)	11.8	26	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	80.2	49	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	56.5	16	16.3
	POLICY TOTAL	-0.068	41	
CLINICAL CARE				
	Dedicated Health Care Provider (Percent of adults age 65+)	95.5	15	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.7	22	98.4
	Flu Vaccine (Percent of adults age 65+)	56.5	42	70.2
	Health Screenings (Percent of adults age 65-74)	87.4	18	91.7
	Diabetes Management (Percent of Medicare enrollees)	84.4	4	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	120.8	10	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	55.3	13	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	15.0	14	12.3
	Hospice Care (Percent of decedents age 65+)	34.5	25	54.5
	Hospital Deaths (Percent of decedents age 65+)	25.0	10	19.2
	CLINICAL CARE TOTAL	0.055	10	
	ALL DETERMINANTS	0.037	24	
OUTCOMES				
	ICU Usage (Percent of decedents age 65+)	6.8	7	5.1
	Falls (Percent of adults age 65+)	18.0	41	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	6.7	12	3.0
	Health Status (Percent very good or excellent of adults age 65+)	39.0	25	48.9
	Able-Bodied (Percent of adults age 65+)	67.2	3	68.0
	Premature Death (Deaths per 100,000 population age 65-74)	1,780	19	1,425
	Teeth Extractions (Percent of adults age 65+)	16.3	22	7.4
	Mental Health Days (Days in previous 30 days)	2.1	14	1.5
	ALL OUTCOMES	0.126	16	
	OVERALL	0.163	20	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	18.3	34	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	30.9	16	20.9
Cognition (Percent of adults age 65+)	7.1	5	5.7
Depression (Percent of adults age 65+)	10.7	9	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	55.6	55.7
Obesity (Percent obese)	27.4	31.8

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015-2030	48.8	52.7

Overall Rank: 20

Determinants Rank: 24

Outcomes Rank: 16

Strengths:

- High percentage of diabetes management
- Low percentage of ICU usage
- High prevalence of able-bodied seniors

Challenges:

- High prevalence of chronic drinking
- High prevalence of physical inactivity
- Low percentage of creditable drug coverage

Ranking: Wisconsin is 20th in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 16th for its entire population.

Highlights:

- Wisconsin has one of the highest senior volunteer rates in the U.S. at 32.8 percent of adults aged 65 and older who volunteer.
- Wisconsin has a low percentage of seniors who spent 7 or more days in the ICU during the last 6 months of life at 6.8 percent of adults aged 65 and older.
- In Wisconsin, 210,000 adults aged 65 and older are obese and more than 260,000 seniors are physically inactive.
- Wisconsin has a low prevalence of flu vaccination at 56.5 percent of adults aged 65 and older.
- In Wisconsin, 10.6 percent of adults aged 60 and older, or more than 80,000 seniors, are marginally food insecure. This is a lower rate than most other states.

Disparities: Seniors with less than a high school degree have a higher prevalence of obesity and physical inactivity, lower social support, and a lower prevalence of very good or excellent health compared to those with a college degree.

State Health Department Website:

www.dhs.wisconsin.gov



For a more detailed look at this data, visit www.americashealthrankings.org/senior/WI

WYOMING

WYOMING

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE	RANK	
	Smoking (Percent of adults age 65+)	11.8	47	4.7
	Chronic Drinking (Percent of adults age 65+)	3.0	16	1.4
	Obesity (Percent of adults age 65+)	20.4	5	16.9
	Underweight (Percent of adults age 65+)	2.7	46	1.1
	Physical Inactivity (Percent of adults age 65+)	33.7	37	20.5
	Dental Visits (Percent of adults age 65+)	65.4	36	79.8
	Pain Management (Percent of adults age 65+)	52.2	23	60.7
	BEHAVIORS TOTAL	-0.080	40	
COMMUNITY & ENVIRONMENT				
C&E — MACRO PERSPECTIVE				
	Poverty (Percent of adults age 65+)	6.3	3	5.1
	Volunteerism (Percent of adults age 65+)	28.2	19	39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	52.5	10	65.2
C&E — MICRO PERSPECTIVE				
	Social Support (Percent of adults age 65+)	82.3	12	85.4
	Food Insecurity (Percent of adults age 60+)	12.8	20	5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$4,058	2	\$8,033
	COMMUNITY & ENVIRONMENT TOTAL	0.199	2	
POLICY				
	Low-Care Nursing Home Residents (Percent of residents)	19.2	46	1.1
	Creditable Drug Coverage (Percent of adults age 65+)	81.8	47	89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	80.0	46	16.3
	POLICY TOTAL	-0.209	50	
CLINICAL CARE				
	Dedicated Health Care Provider (Percent of adults age 65+)	88.1	50	96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	98.2	6	98.4
	Flu Vaccine (Percent of adults age 65+)	54.5	47	70.2
	Health Screenings (Percent of adults age 65–74)	81.4	46	91.7
	Diabetes Management (Percent of Medicare enrollees)	61.0	50	86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	75.2	31	290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	58.2	17	25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	15.5	21	12.3
	Hospice Care (Percent of decedents age 65+)	21.9	48	54.5
	Hospital Deaths (Percent of decedents age 65+)	25.8	12	19.2
	CLINICAL CARE TOTAL	-0.086	46	
	ALL DETERMINANTS	-0.175	37	
OUTCOMES				
	ICU Usage (Percent of decedents age 65+)	8.6	13	5.1
	Falls (Percent of adults age 65+)	17.9	40	12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	8.2	36	3.0
	Health Status (Percent very good or excellent of adults age 65+)	39.4	24	48.9
	Able-Bodied (Percent of adults age 65+)	63.6	25	68.0
	Premature Death (Deaths per 100,000 population age 65–74)	1,868	27	1,425
	Teeth Extractions (Percent of adults age 65+)	18.6	34	7.4
	Mental Health Days (Days in previous 30 days)	2.1	14	1.5
	ALL OUTCOMES	0.013	29	
	OVERALL	-0.162	34	

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE	RANK	
Education (Percent of adults age 65+)	21.7	22	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	21.5	2	20.9
Cognition (Percent of adults age 65+)	5.7	1	5.7
Depression (Percent of adults age 65+)	12.6	18	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	57.6	54
Obesity (Percent obese)	24.3	30.1

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	56.0	52.7

Overall Rank: 34

Determinants Rank: 37

Outcomes Rank: 29

Strengths:

- Low prevalence of obesity
- Low percentage of seniors living in poverty
- High community support expenditures

Challenges:

- High prevalences of smoking & underweight seniors
- Low prevalence of dedicated health care providers
- Low percentage of diabetes management

Ranking: Wyoming is 34th in this Senior Report. In the *America's Health Rankings*® 2012 Edition, it ranked 23rd for its entire population.

Highlights:

- Wyoming ranks 1st for the overall Community & Environment category.
- Wyoming ranks in the bottom 5 states for all of the policy measures and ranks 50th for the overall Policy category.
- Wyoming has a low prevalence of flu vaccination at 54.5 percent of adults aged 65 and older.
- Total community expenditures are high in Wyoming at \$4,058 per person aged 65 and older living in poverty.
- Smoking is high at 11.8 percent of adults aged 65 and older, with 8,000 seniors who smoke.

Disparities: In Wyoming, seniors with a household income less than \$25,000 have a lower prevalence of very good or excellent health status compared to seniors with household incomes greater than \$75,000.

State Health Department Website:

<http://www.health.wyo.gov>



For a more detailed look at this data, visit www.americashealthrankings.org/senior/WY

DISTRICT OF COLUMBIA

SENIOR HEALTH

DETERMINANTS	BEHAVIORS	2013		NO 1 STATE
		VALUE		
	Smoking (Percent of adults age 65+)	11.0		4.7
	Chronic Drinking (Percent of adults age 65+)	5.6		1.4
	Obesity (Percent of adults age 65+)	26.3		16.9
	Underweight (Percent of adults age 65+)	2.4		1.1
	Physical Inactivity (Percent of adults age 65+)	27.2		20.5
	Dental Visits (Percent of adults age 65+)	72.2		79.8
	Pain Management (Percent of adults age 65+)	52.1		60.7
	BEHAVIORS TOTAL			
	COMMUNITY & ENVIRONMENT			
	C&E — MACRO PERSPECTIVE			
	Poverty (Percent of adults age 65+)	13.5		5.1
	Volunteerism (Percent of adults age 65+)	22.7		39.3
	Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	37.0		65.2
	C&E — MICRO PERSPECTIVE			
	Social Support (Percent of adults age 65+)	71.5		85.4
	Food Insecurity (Percent of adults age 60+)	14.7		5.5
	Community Support (Dollars per adult age 65+ in poverty)	\$1,895		\$8,033
	COMMUNITY & ENVIRONMENT TOTAL			
	POLICY			
	Low-Care Nursing Home Residents (Percent of residents)	—		1.1
	Creditable Drug Coverage (Percent of adults age 65+)	79.1		89.6
	Geriatrician Shortfall (Percent of needed geriatricians)	32.2		16.3
	POLICY TOTAL			
	CLINICAL CARE			
	Dedicated Health Care Provider (Percent of adults age 65+)	93.2		96.8
	Recommended Hospital Care (Percent of hospitalized patients age 65+)	94.2		98.4
	Flu Vaccine (Percent of adults age 65+)	56.7		70.2
	Health Screenings (Percent of adults age 65–74)	90.7		91.7
	Diabetes Management (Percent of Medicare enrollees)	75.6		86.1
	Home Health Care (Number of workers per 1,000 adults age 75+)	160.6		290.0
	Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	53.4		25.0
	Hospital Readmissions (Percent of hospitalized patients age 65+)	15.2		12.3
	Hospice Care (Percent of decedents age 65+)	27.2		54.5
	Hospital Deaths (Percent of decedents age 65+)	37.6		19.2
	CLINICAL CARE TOTAL			
	ALL DETERMINANTS			
	OUTCOMES			
	ICU Usage (Percent of decedents age 65+)	16.3		5.1
	Falls (Percent of adults age 65+)	16.1		12.9
	Hip Fractures (Rate per 1,000 Medicare enrollees)	6.2		3.0
	Health Status (Percent very good or excellent of adults age 65+)	39.3		48.9
	Able-Bodied (Percent of adults age 65+)	64.3		68.0
	Premature Death (Deaths per 100,000 population age 65–74)	2,086		1,425
	Teeth Extractions (Percent of adults age 65+)	12.1		7.4
	Mental Health Days (Days in previous 30 days)	2.5		1.5
	ALL OUTCOMES			
	OVERALL			

SUPPLEMENTAL MEASURES

	2013		NO 1 STATE
	VALUE		
Education (Percent of adults age 65+)	36.5		36.5
Multiple Chronic Conditions (Percent of adults age 65+)	32.9		20.9
Cognition (Percent of adults age 65+)	10.4		5.7
Depression (Percent of adults age 65+)	12.9		7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	—	53.4
Obesity (Percent obese)	—	24.4

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	-5.6	52.7

footnote: — indicates data not available

District is not ranked

Strengths:

- Low prevalence of physical inactivity
- High prevalence of dental visits
- High percentage of health screenings

Challenges:

- High prevalence of smoking
- Low percentage of creditable drug coverage
- High percentage of hospital deaths

Highlights:

- In the District of Columbia, a high percentage of seniors who died in the hospital at 37.6 percent of adults aged 65 and older.
- Creditable drug coverage is low among D.C. seniors at 79.1 percent of Medicare beneficiaries.
- In the District of Columbia, 18,000 adults aged 65 and older are obese and 19,000 seniors are physically inactive.
- The rate of hospitalization for hip fractures in the District of Columbia at 6.2 hospitalizations per 1,000 Medicare enrollees is lower than the U.S. average of 7.3 hospitalizations.
- A high percentage of seniors receive recommended health screenings at 90.7 percent of adults aged 65 and older.

Disparities: Seniors with a household income of less than \$25,000 have a lower prevalence of very good or excellent health status and a lower prevalence of social support compared to those with an income greater than \$75,000.

State Health Department Website:
www.dchealth.dc.gov



For a more detailed look at this data, visit www.americashealthrankings.org/senior/DC

Senior Report — Working Together to Care for an Aging Nation



JENNIE CHIN HANSEN, RN, MSN, FAAN
CEO
American Geriatrics Society



According to the latest census data, Americans 65 years and older are the fastest-growing age group in the nation.¹ This is unprecedented.

In 1913, Americans' life expectancy at birth had yet to reach even 50 years.² But after a century of advances in public health and healthcare, more Americans are living longer than ever before.

When the youngest of the nation's 77 million Baby

Boomers turn 65 years of age in 2030, they can expect to live about 20 more years.⁴

Older Americans aren't just living longer, however. They're also living with more health problems, including complex chronic conditions such as heart disease and diabetes, and progressive diseases such as dementia. Consider these statistics:

- Roughly 80 percent of Americans 65 years and older have at least one chronic health condition.⁷
- More than 70 percent of older adults in the United States have heart disease.⁵
- Nearly 6 out of every 10 older Americans have arthritis, a leading cause of disability.³
- At least 60 percent of American seniors are former or current smokers and, as a consequence, run increased risks of chronic bronchitis and emphysema, cancer, and other diseases.¹
- One in 5 older Americans has been diagnosed with diabetes.³
- Nearly half of adults 85 years and older have Alzheimer's disease.¹⁰

- The majority of older adults in the United States have 3 or more chronic health problems.⁷

These statistics are cause for concern. Not only because they represent the toll that chronic illness can take on older adults, but also because caring for medically complex older people is both complicated and costly. Providing the unique care these older patients need is a growing challenge for our nation's healthcare system. And it's a challenge that we with the American Geriatrics Society (AGS) and others in the field are working together to address in a wide range of ways.

WHO NEEDS A GERIATRICS SPECIALIST?

Not every older adult needs specialized healthcare. Consider a couple of hypothetical patients. The first is aged 70 years and has high blood pressure and hypothyroidism— but he and his primary care provider have these conditions well under control. This patient doesn't need the care of a geriatrics specialist. The second patient is also aged 70 years, but is obese, has heart disease and high blood pressure, and has just been diagnosed with diabetes. The second patient, with his multiple and complex healthcare needs, would benefit from the care of a geriatrician.

Geriatricians are physicians who complete advanced fellowships that prepare them to care for the most medically complicated older patients. There are other geriatrics specialists as well. They include geriatric psychiatrists—physicians who complete advanced studies that prepare them to care for complex older patients with dementia and other mental health problems. And there are nurses, pharmacists, physician assistants, psychologists, social workers and other professionals who also get advanced training in eldercare.

RETOOLING FOR AN AGING AMERICA

Over the last several years, as the number of older Americans with complex and multiple health problems has begun growing markedly, so have concerns that the number of geriatrics specialists in the United States might fall considerably short of what would be needed. In response, the AGS and other eldercare organizations encouraged the Institute of Medicine (IOM) to examine this issue. As a result, in 2008, the IOM released a groundbreaking report, *Retooling for an Aging America, Building the Health Care Workforce*. This seminal study concluded that much had to be done to address this growing problem. And among other strategies, it called for initiatives to:

- Recruit and retain more geriatrics specialists and others who care for older adults—including home health aides and other “direct care” workers—by improving compensation.
- Offer loan forgiveness and other incentives to healthcare professionals pursuing advanced training in geriatrics, and increase training standards for direct care workers.
- Improve care by increasing government support for research and demonstration projects to identify and disseminate promising new models of care, including models that provide coordinated care for complex patients.⁸

Soon after the IOM report was released, AGS and nearly 30 likeminded organizations joined together to create the Elder Workforce Alliance (EWA), a coalition dedicated to advocating for the changes the report recommended. And the EWA's accomplishments to date have been significant. They include:

- Protecting funding for federal Title VII and VIII geriatrics health professions training programs from proposed federal budget cuts. These

programs provide training for geriatricians and registered nurses so they, in turn, can train primary healthcare physicians and other healthcare professionals to provide quality eldercare.

- Successfully advocating for key provisions in the Affordable Care Act that, among other things, identify core competencies for direct care workers that enhance the care they provide.
- Helping avert serious cuts in funding for National Institute on Aging research.
- Successfully advocating to have Medicare cover care-coordination services for complex, older beneficiaries when they are transitioning from inpatient to outpatient settings. Many things can go wrong when these patients are transferred between hospitals and other settings, such as nursing homes or patients' homes. Care coordination has been shown to significantly lower the likelihood of these adverse events.

These developments are improving care for older Americans in tangible ways. Among other things, they are reducing seniors' rehospitalization rates, the incidence with which patients are readmitted to the hospital within 30 days of being discharged. But unfortunately, other priorities, such

Geriatricians are physicians who complete advanced fellowships that prepare them to care for the most medically complicated older patients.

Every year, more than a third of adults 65 years and older suffer at least one serious drug side effect or other adverse drug reaction.

as ensuring that there are enough geriatricians and other geriatrics specialists to care for the most complex older patients, haven't fared as well. The relatively low compensation that Medicare offers and related payment issues are, increasingly, posing disincentives to physicians pursuing careers in the field. This is what the latest projections indicate:

- Though there were 488 openings in geriatrics fellowships in the United States in the 2010–2011 academic year, only 279 were filled.
- In 2011, there was 1 geriatrician for every 2,620 Americans 75 years or older; in 2030 there will be 1 for every 3,788.
- While there is now 1 geriatric psychiatrist for every 11,000 patients 65 years or older, the ratio will be 1 for every 12,600 older patients when the youngest Baby Boomers reach retirement age in 17 years.

FINDING NEW SOLUTIONS

In short, the ranks of geriatricians and other geriatrics specialists are declining at the same time that the population of older Americans—including many medically complex older patients—is growing dramatically. So what can we do to help provide the care these patients need? What's the solution to this problem?

The truth is that there isn't one solution. But there are *multiple solutions* that we need to pursue, with commitment and energy. And that's what we in the field are doing. Some of these solutions are new. Others are tried and true and in the process of being expanded.

Among the latter are solutions like the AGS' Geriatrics for Specialists Initiative (GSI). Launched

in the mid-1990s, this essential program helps physicians in surgical and related medical fields develop expertise in meeting the unique care needs of their aging patients. This expertise is particularly important given that a significant number of older adults treated in hospitals have adverse events while there.⁹

Among more recently launched initiatives is the Partnership for Health in Aging Workgroup on Multidisciplinary Competencies in Geriatrics (PHA). The partnership, which AGS initially convened, has developed universal entry-level geriatrics and gerontology competencies that can be used for training in all healthcare disciplines. These are invaluable.

The AGS is also making publishing, updating, and contributing to essential clinical guidelines—intended for healthcare providers in all disciplines—an even higher priority than before. Early last year, members of the society and other organizations updated and expanded one of the most-consulted guides to safe prescribing for older patients—the *Beers Criteria for Potentially Inappropriate Medication Use in Older Adults*. The guide, since renamed the *American Geriatrics Society Beers Criteria for Potentially Inappropriate Medication Use in Older Adults*, identifies medications that are potentially harmful for older people. Every year, more than a third of adults 65 years and older suffer at least one serious drug side effect or other adverse drug reaction. The criteria can help clinicians more safely prescribe for these patients.

The AGS published 2 additional guidelines last year. One focuses on older adults with multiple chronic health problems. Caring for these patients can be particularly challenging, even for specialists, because treating one health problem can sometimes exacerbate another. The other guideline—a joint undertaking of the society, the American College of Surgeons, and the John A. Hartford Foundation—is a newly updated, comprehensive guide to best practices for older

adults undergoing surgery. Americans 65 years and older account for nearly 40 percent of all surgical procedures. As this column heads to press in April, the society is at work updating another guideline for healthcare professionals regarding the diagnosis and treatment of older adults who are at high risk of diabetes or have the disease.

In a related undertaking this year, the society also joined other medical organizations in the American Board of Internal Medicine (ABIM) Foundation's *Choosing Wisely*[®] campaign. You're probably familiar with the campaign. It invites medical societies to identify 5 tests or treatments that their patients should question and discuss with their healthcare providers prior to deciding whether to undergo them. The society's "five things" are posted on the much-visited *Choosing Wisely* website, www.choosingwisely.org, as well as on the AGS website, www.americangeriatrics.org, along with many supplemental professional and public education resources.

BRINGING IT ALL TOGETHER

I'd be remiss if I didn't mention another essential effort. Recognizing the importance of ensuring that older adults and their family caregivers understand how to prevent health problems common among older adults; how to recognize signs of these problems; and what to do should they be diagnosed with them, the society's Foundation for Health in Aging recently revised and expanded its website, www.healthinaging.org. The site offers a wealth of comprehensive, expert, up-to-date, practical, information about health in later life, including all of AGS' professional guidelines rewritten to the lay public. This site is yet another solution.

So, while there isn't one solution to the challenges facing our field, there are many steps that we are taking to improve the quality and safety of care for older people. And we're committed to working together and making the most of all of them.

-
1. "The fastest-growing age group in America is 65 and over," Milken Institute slide show, Milken Institute. <http://www.milken-institute.org/presentations/slides/2923GC11.pdf>
 2. Life expectancy in the USA, 1900-98 demog.berkeley.edu/~andrew/1918/figure2.html
 3. Public Health and Aging: Trends in Aging – United States and Worldwide, February 14, 2003/ 52(06); 101-106
 4. Insight: What if baby boomers don't live forever? Reuters, <http://www.reuters.com/article/2012/08/14/us-usa-babyboomers-life-expectancy-idUSBRE87D0ZT20120814>
 5. Statistical Fact Sheet 2013 Update, Older Americans and Cardiovascular Diseases, American Heart Association
 6. Healthy Aging. Helping People To Live Long and Productive Lives and Enjoy a Good Quality Of Life, At a Glance 2011. CDC. <http://www.cdc.gov/chronicdisease/resources/publications/AAG/aging.htm>
 7. Guiding Principles for the Care of Older Adults with Multimorbidity www.americangeriatrics.org/files/documents/MCC.principles.pdf
 8. Retooling for an Aging America: Building the Health Care Workforce <http://www.iom.edu/Reports/2008/Retooling-for-an-Aging-America-Building-the-Health-Care-Workforce.aspx>
 9. Hospital Incident Reporting Systems Do Not Capture Most Patient Harm, DHHS, January 2012. <http://oig.hhs.gov/oei/reports/oei-06-09-00091.pdf>
 10. Alzheimer's Disease, CDC, <http://www.cdc.gov/aging/aginginfo/alzheimers.htm>

Preparing for the Future as Millions of Baby Boomers Continue to Age



GAIL GIBSON HUNT
President & CEO
National Alliance for Caregiving



National Alliance for Caregiving

America's Health Rankings[®] *Senior Report* aggregates knowledge to allow us to begin assessing where we stand state by state with regard to the new aging demographics. How well are we dealing today with our rapidly aging population? How prepared are we for the future as millions more Baby Boomers age?

In addition to the value of such indicators for support to seniors, there is a group whose help to seniors is invaluable but whose support often

goes unrecognized: family caregivers. According to *Caregiving in the U.S. (2009)*¹, the most recent national caregiver survey, there are 39 million family caregivers of people 65+. These caregivers include people caring for aging parents, grandparents and other relatives, as well as neighbors, friends and fictive kin. Most commonly caregivers are adult children, although as our population lives longer and longer we see more older caregivers themselves caring for the oldest old.²

Family caregivers are the backbone of the long-term care system in this country, but state by state data on caregivers' need for support and services is not yet calculated. They provide 80 percent of the care unpaid to family and friends. They spend on average 20 hours per week on caregiving tasks, and half of them are providing personal care—bathing, dressing, feeding, toileting and transferring—on top of Instrumental Activities of Daily Living, such as managing finances, transporting to doctor's appointments, and housekeeping.

Caregiving can exact a considerable emotional, financial, and physical toll as well. Many caregivers report depression and stress, and often feel isolated and unrecognized. And, of course, their most common attribute is that they do not self-identify. When corporations offer corporate eldercare services, only approximately 2 percent

of caregivers in a workplace will use the services—even though an estimated 18-20 percent of employees are caring for someone.

*The MetLife Study of Working Caregivers and Employer Health Care Costs (2007)*³, an analysis of Health Risk Appraisals of over 2,000 employed caregivers in a large multinational corporation found that those employees reported poorer health and more chronic disease than non-caregivers. There was an 8 percent differential in increased healthcare costs between caregiving and non-caregiving employees, potentially costing U.S. employers an extra \$13.4 billion a year.

We also know that family caregiving can take a toll by caregivers neglecting their own health because they are focused on their loved one. A 2006 Evercare funded study called *Caregivers in Decline (2006)*⁴ showed that 15 percent of caregivers thought their health had gotten a lot worse and another 44 percent thought it had gotten moderately worse due to caregiving responsibilities. More than half of them said that their decline in health had also affected their ability to care—an issue that could lead to their having to institutionalize their loved one, who may quickly spend down to Medicaid.

The single biggest factor for families going into bankruptcy is healthcare costs. Out-of-pocket expenses for caregiving are one financial

-
1. National Alliance for Caregiving and AARP. *Caregiving in the U.S., 2009*. (Bethesda, MD: NAC, and Washington, DC: AARP, November 2009). Funded by the MetLife Foundation.
 2. Wagner D, Takagi E. Informal Caregiving By and For Older Adults. *Health Affairs Blog*. <http://healthaffairs.org/blog/2010/02/16/informal-caregiving-by-and-for-older-adults>. Published February 16, 2010. Accessed April 23, 2013.
 3. National Alliance for Caregiving, University of Pittsburgh Institute on Aging and MetLife Mature Market Institute. *The MetLife Study of Working Caregivers and Employer Health Care Costs: New Insights and Innovations for Reducing Health Care Costs for Employers, 2010*. (Bethesda, MD: NAC, Pittsburgh, PA: University of Pittsburgh and New York, NY: MMI, February 2010). Funded by MetLife Mature Market Institute.
 4. National Alliance for Caregiving and Evercare Hospice, Inc. *Caregivers in Decline: A Close-Up Look at the Health Risks of Caring for A Loved One, 2006*. (Bethesda, MD: NAC and Eden Prairie, Minnesota, MN, September 2006). Funded by Evercare Hospice Inc.

component. Caregivers reported in *Family Caregivers—What they Spend, What They Sacrifice* (2007) that they spent an average of \$5,531 out of pocket to support the care recipient. This was more than 10 percent of the median income of the survey respondents, which was \$43,026. Besides the after-tax outlay, caregivers can take a financial “hit” at the workplace. Over half of caregivers work full or part-time and 60 percent make workplace accommodations.⁵

They come in late, leave early, take unpaid leaves of absence, drop back to part-time, pass up promotions, and even quit their jobs. Even if they have very understanding employers, caregiving can still cost them a great deal of time, money, and stress trying to balance work and family.

All the previous data have been national statistics developed from national surveys. Attempts to report family caregiving data on a state-by-state basis have been sporadic. Using data from the 2009 Caregiving in the US survey, AARP had a health economist estimate the numbers of caregivers in each state.⁶ AARP has

also published and updated a national estimate of the value of unpaid caregiving to society: \$450 billion in 2010.⁷ Using the CDC’s 2010 Behavioral Risk Factor Surveillance System (BRFSS), the Alzheimer’s Association has been able to report on Alzheimer’s caregiver surveys in 9 states that choose to fund the Caregiver Module, a series of 10 caregiver questions. This provides a population-based snapshot of Alzheimer’s caregiving in Connecticut, New Hampshire, New Jersey, New York, Tennessee, Illinois, Louisiana, Ohio, and the District of Columbia.^{8,9} Lastly, AARP has developed a state of social services state report card that includes a few proximate indicators for caregiving services along with others, such as whether there is paid family and medical leave (2 states).¹⁰

The major issue is whether support for family caregivers will begin to be seen as integral to support to older Americans. Without family caregivers, it would be necessary for someone—family, the voluntary sector, churches, government—to pay for direct care workers to help the elderly. Support to family caregivers in terms of respite, training, stipends, and the like would cost much less than direct care workers. In addition, we should be assessing the ability and willingness of caregivers to care for their older relatives and friends, as well as collecting ongoing data on caregivers’ support needs. It is certainly in the country’s best interest to do what it takes to keep older people in their own homes rather than in nursing homes on taxpayers’ dollars. That is what older people and their family caregivers want as well.

The major issue is whether support for family caregivers will begin to be seen as integral to support to older Americans.

5. National Alliance for Caregiving and Evercare Hospice, Inc. *Family Caregivers – What they Spend, What They Sacrifice: The Personal Financial Toll of Caring for a Loved One, 2007*. (Bethesda, MD: NAC and Eden Prairie, Minnesota, MN, November 2007). Funded by Evercare Hospice, Inc.
6. AARP Research & Strategic Analysis. *2012 Member Opinion Survey: State Member Profiles; Interests, Concerns, and Experiences; and Annotated Questionnaires*. AARP. <http://www.aarp.org/about-aarp/info-10-2012/member-opinion-survey-state-reports.html>. Published December, 2012. Updated January, 2013. Accessed April 2013.
7. Feinberg L, Houser A from the AARP Policy Institute. *Assessing Family Caregiver Needs: Policy and Practice Considerations*. AARP. http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/caregiver-fact-sheet-AARP-ppi-ltc.pdf. Published June, 2012. Accessed April 2013.
8. Bouldin E, Andresen E. *Caregivers of Persons with Alzheimer’s Disease or Dementia in Illinois, Louisiana, Ohio and the District of Columbia (2009)*. (Gainesville, FL: University of Florida). Funded by Alzheimer’s Association.
9. Bouldin E, Andresen E. *Caregivers of Persons with Alzheimer’s Disease or Dementia in Connecticut, New Hampshire, New Jersey, New York and Tennessee (2010)*. (Gainesville, FL: University of Florida). Funded by Alzheimer’s Association.
10. Reinhard SC, Kassner E, Houser A, Mollica R from the AARP Policy Institute. *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*. AARP. <http://www.aarp.org/home-family/caregiving/info-09-2011/lts-scorecard.html>. Published September, 2011. Accessed April 2013.

Rx for Health—Invest in America’s Senior Centers to Promote Health and Prevent Disease



JAMES FIRMAN, EdD
President and CEO



RICHARD BIRKEL, PhD
Senior Vice President for Health



The aging of the U.S. population will pose significant challenges for communities, our health care system, and our nation in coming years. Approximately 78 percent of Medicare beneficiaries today have at least 1 chronic condition, and 63 percent have 2 or more, and these rates are rising. Chronic illnesses are a major contributor to health care costs, representing 75 percent of the \$2 trillion in U.S. annual health care spending, accounting for nearly 70 percent of all deaths, and restricting daily living activities for 25 million people.¹ Beginning with the first baby boomer enrollment in Medicare in January 2011, more than 76 million Americans are projected to become beneficiaries in the next 29 years. Without improvements in the

health of these aging Americans and changes in the way we deliver health care, this near doubling of participants will seriously strain the U.S. economy. The MacArthur Foundation Research Network on an Aging Society projects that by 2030, the aggregate costs of Medicare, Medicaid, Social Security, and debt service may exceed the revenues of the U.S. Treasury.²

The onset and progression of chronic disease can be prevented or significantly delayed through preventive health services and evidence-based interventions that promote healthy behaviors. In addition, individuals with existing health conditions can learn skills and gain confidence in their ability to self-manage, resulting in a significantly improved quality of life, greater independence, and improved health status.

Promoting widespread use of evidence-based health promotion and self-management programs has been identified by the U.S. Department of Health and Human Services as a key strategy for improving care and reducing costs for people with multiple chronic conditions.³ Examples of these programs include:

- Physical activity programs, such as Enhance Fitness or Healthy Moves, which provide safe and effective low-impact aerobic exercise, strength training, and stretching.
- Falls prevention programs such as A Matter of Balance, which addresses fear of falling, and Stepping On and Tai Chi, which build muscle strength and improve balance to prevent falls.
- Nutrition programs, such as Healthy Eating, which teach older adults the value of choosing and eating healthy foods and maintaining an active lifestyle.
- Depression and/or substance abuse programs, such as PEARLS, Healthy IDEAS, and Beat the Blues, which teach older adults how to manage their mild to moderate depression.
- Stanford University Chronic Disease Self-Management Programs, which are effective in helping people with chronic conditions change their behaviors, improve their health status, and reduce their use of hospital services.⁴

As promising as these programs are, however, they currently reach only a fraction of those who could benefit. In addition, preventive services are underused, especially by racial and ethnic minority groups. Less than half of older adults are up-to-date on a core set of clinical preventive services (e.g. cancer screening and immunizations), and only 7 percent of older adults used the Welcome to Medicare Benefit in 2008.^{5,6,7}

So what is the problem? According to Wayne Giles, director of the Division of Population Health at the U.S. Centers for Disease Control and Prevention (CDC), “A key challenge in bringing evidence-based interventions to scale is lack of

an effective distribution network, especially with chronic diseases, which require more diverse efforts than the typical network of state health agencies” (http://www.ssireview.org/articles/entry/using_national_networks_to_tackle_chronic_disease).

To meet the need for an effective distribution network and to achieve the national goals for improving the health status of older Americans such as those proposed in Healthy People 2020⁸ and other national frameworks, the Institute of Medicine (IOM) has recommended enhanced collaboration of public health with community-based organizations as a way to produce better prevention and treatment outcomes for people living with chronic disease:

“There is a huge potential to leverage the infrastructure of wellness worksite programs and community-based sites like the YMCA and **senior centers** with regard to implementation of effective interventions and their sustainability” (*Living Well with Chronic Illness*, p. 251, emphasis added).

Employing resources such as senior centers to better meet the health needs of patients is also a key principle of the Chronic Care Model developed by Ed Wagner and colleagues.⁹ Wagner states: “Effective chronic illness management requires an appropriately organized delivery system **linked with** complementary community resources”¹⁰ (emphasis added). Patients are encouraged to participate in effective community programs, and health providers are encouraged to form partnerships with community organizations that provide needed interventions and services. In Wagner’s words:

“There is now considerable evidence that individual and group interventions that emphasize patient empowerment and the acquisition of self-management skills are effective in diabetes, asthma, and other chronic conditions. Most of these interventions are relatively brief and conducted **outside** of medical practice”(p. 74, emphasis added).

Partnerships between community-based organizations and health care systems not only enhance patient care, but also avoid duplication of effort, make the most of scarce resources, and ensure integration. Yet, most health systems fail to develop the needed partnerships, linkages, and collaborative relationships with community-based organizations originally envisioned in the Chronic Care Model. In 2011, the National Council on Aging (NCOA) launched the Self-Management Alliance (SMA) to address this problem and to take concrete steps to develop more effective partnerships between community organizations and health care providers with the goal of delivering effective programs close to home and in the community.

We believe that senior centers are a highly under-leveraged community resource that can add significant value to our nation’s efforts in health promotion and disease prevention. By building the capacity of senior centers to deliver evidence-based programs and services, and linking senior centers to public health systems, we will facilitate achievement of health priorities in disease prevention and health promotion for older adults by:

- Effectively distributing important public health information to seniors and their families.
- Increasing the use of clinical preventive services and health screenings.
- Increasing participation in evidence-based health promotion/disease prevention programs.
- Improving self-management skills and competencies.
- Decreasing the number of falls and fall-related injuries.
- Reducing food insecurity.
- Reducing isolation and depression.

BACKGROUND

NCOA has worked in close collaboration with senior center leaders from around the country

We believe the existing infrastructure of senior centers in the United States is an ideal vehicle for delivering health promotion and prevention services.

since 1960 and established the National Institute of Senior Centers (NISC) (<http://www.ncoa.org/nisc>) in 1970 as a national focal point and resource center to identify and meet the needs of senior centers for an array of supports. With funding from the U.S. Administration on Aging (AoA) and private foundations, NISC has developed senior center standards, training packages, curricula, and other tools to enhance the capacity of senior

centers and advance the skills and competencies of senior center staff. NISC has developed and maintains an extensive library of resources for senior center use, as well as a repository of research, surveys, and studies that support the work of researchers.

Today, NISC supports a national network of nearly 1,000 senior centers and more than 2,000 senior center professionals dedicated to excellence in senior center operations and programming, establishing a vision for the future, and promoting cutting-edge research, promising practices, and professional development. NISC offers the nation's only National

Senior Center Accreditation Program, providing official recognition that a senior center meets the highest standards of operation. NISC connects its members to a national network of professional support and innovative solutions via webinars and an online community, NCOA Crossroads.

CHARACTERISTICS OF SENIOR CENTERS

Senior centers were created for the very purpose of supporting the health and well-being of older adults and promoting independence. In 1965, Congress directed that senior centers were to be identified as preferred "focal points" for comprehensive and coordinated service delivery to older adults (Older Americans Act, Title III Regulations, 1988 Amendments). The broad term "senior center" today includes a range of facilities of varying size and organizational complexity ranging from large multipurpose service organizations with highly trained professional staff to small nutrition sites run by volunteers.

AoA reports that of the 11,400 senior centers in the United States, more than 60 percent are designated as a "Community Focal Point," defined as a "facility where comprehensive and coordinated services are provided to seniors."

CURRENT HEALTH-RELATED PROGRAMMING

The majority of senior centers already offer health-related programming, including health education, health screening, exercise programs, and nutrition programs that serve as a solid foundation for further development. In San Antonio, "One Stop" senior centers are Older Americans Act-funded nutrition sites that also offer immunizations, diabetes and osteoporosis screenings, smoking cessation counseling, and more.¹¹ In Hartford, CT, an educational intervention for health professionals and senior center workers that focused on conducting risk assessments, adjusting medications, and improving balance and gait was shown to dramatically decrease serious fall-related injuries and costs of care in people over 70 years old.¹² In New York City, a program in senior centers that focused on lifestyle changes (e.g., diet, exercise, adherence to prescribed antihypertensive medications) resulted in significant reduction in systolic blood pressure.¹³ Senior centers also have been an effective partner in delivering interventions to decrease depression, increase knowledge about depression, and enhance daily function.¹⁴

FULFILLING THE POTENTIAL

While senior centers are widely recognized by aging services and other community providers as a vital component in the aging continuum of care—and a lifeline for many vulnerable, isolated, and at-risk seniors—their potential role as a vital part of the public health system has been overlooked and neglected. Indeed, many community stakeholders lack a clear understanding of the role, relevance, and impact of senior centers. In addition, while senior centers have the ability and desire to offer a wide range of programs and services, they often lack the resources, space, equipment, and trained staff essential to ensure successful implementation. In addition, funding is inadequate and severely restricts their ability to serve as an effective public health partner in delivering health promotion and disease prevention programs.

WHAT NEEDS TO BE DONE

If senior centers are to fulfill their role as a major community focal point addressing one of today's most serious public health problems—the rising rate of multiple chronic conditions in older adults—we must re-envision their role and purpose, how they are funded, and how they are linked with public health systems. Consistent with the recent ideas of Hussein and Kerrssey,¹⁵ we believe the existing infrastructure of senior centers in the United States is an ideal vehicle for delivering health promotion and prevention services in the community and helping older adults better manage existing health conditions. With modest investments in workforce training and continuing education, the establishment of leadership academies and mentoring programs in healthy aging, development and use of technology and data management systems, and the development of formal agreements and partnerships with public health and other health systems, senior centers can play the role initially envisioned and greatly contribute to our nation's efforts to deliver prevention and health promotion interventions to vulnerable older adults.

CONCLUSION

The nation's 11,000 senior centers already offer a wide range of health, nutrition, education, recreation, volunteer, and other social interaction opportunities for their participants that enhance dignity, support independence, promote health, and encourage community involvement. Serving as many as 10 million older adults yearly, centers are also a resource for the entire community, providing services and information on aging and assisting family and friends who care for older persons. They are often the providers of Meals on Wheels and other services to homebound elders. Their full potential in community health, however, has not been achieved due to a lack of vision and investment. With modest, targeted investments designed to build the capacity of senior centers and their staff, the nation's network of senior centers can become a true partner with our public health system and an effective delivery system for health promotion and preventive interventions, services, and information to large numbers of older adults, including racial and ethnic minorities and low-income individuals. We believe the time has come to make such an investment, and we call on government, corporations, and private foundations to join us in making this vision a reality.

1. Institute of Medicine. (2012). *Living well with chronic illness: A call for public action*. Washington: National Academies Press.
2. Olshansky JS, Goldman DP, Zheng Y, Rowe JW. Aging in America in the Twenty-first Century: Demographic Forecasts from the MacArthur Foundation Research Network on an Aging Society. *Milbank Quarterly*. 2009; 87:842-862.
3. U.S. Department of Health and Human Services. *Multiple Chronic Conditions—A Strategic Framework: Optimum Health and Quality of Life for Individuals with Multiple Chronic Conditions*. Washington, DC: December 2010. Available at <http://www.hhs.gov/ash/initiatives/mcc/index.html> (accessed 4/13/13).
4. U.S. Administration on Aging, http://www.aoa.gov/AoARoot/AoA_Programs/HPW/index.aspx
5. Kramarow E, Lubitz J, Lentzner H, et al. (2007, Sep-Oct). Trends in the health of older Americans, 1970–2005. *Health Aff (Millwood)*. 26(5):1417-25.
6. Shenson D, Bolen, Adams M, Seeff L, Blackman D. (2005). Are older adults up-to-date with cancer screening and vaccinations? *Preventing Chronic Disease: Public Health Research, Practice, and Policy*; 2(3).
7. U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS). (2010, February 22). *Medicare claims data [Internet]*. Baltimore: CMS.
8. U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion. (2011). *Healthy People 2020*. Washington: U.S. Department of Health and Human Services.
9. Wagner E. "Chronic disease management: What will it take to improve care for chronic illness?" *Effective Clinical Practice*. 1998, Vol. 1, pp. 2-4.
10. Wagner E, Austin B, Davis C, Hindmarsh M, Schaefer J, and Bonomi A. "Improving Chronic Illness Care: Translating Evidence into Action." *Health Affairs*, 20(6) 64-78.
11. UCLA Center for Health Policy Research. (2013). Community Health Innovations in Prevention for Seniors (CHIPS)—"CHIPS Innovators." Retrieved March 4, 2013 from <http://healthpolicy.ucla.edu/programs/health-disparities/elder-health/Pages/CHIPS-Innovators.aspx>
12. Tinetti M, et al. (2008). Effect of Dissemination of Evidence in Reducing Injuries from Falls. *New England Journal of Medicine*; 359:252-61.
13. Fernandez, Senaida, Scales K, Pineiro J, et al. (2008, October). A senior center-based pilot trial of the effect of lifestyle intervention on blood pressure in minority elderly people with hypertension. *Journal of the American Geriatrics Society*. 56(10) 1860-1866. DOI: 10.1111/j.1532-5415.2008.01863.x
14. Gitlin LN, Harris LF, McCoy M, Chernett NL, Jutkowitz E & Pizzi L (2012) A community-integrated home based depression intervention for older African Americans: Description of the Beat the Blues randomized trial and intervention costs. *BMC Geriatrics* 2012, 12:4 (accessed online at <http://www.biomed-central.com/1471-2318/12/4>)
15. Hussein T & Kerrssey M. (2013). Using National Networks to Tackle Chronic Disease. *Stanford Social Innovation Review*, Winter.

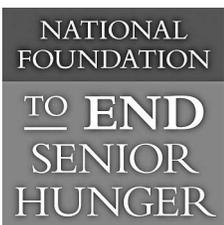
Senior Hunger: A National Problem, A Local Problem



ENID A. BORDEN
 Founder, President and CEO
 National Foundation to End Senior Hunger



MARGARET B. INGRAHAM
 Executive Vice President
 National Foundation to End Senior Hunger



INTRODUCTION

It is conventional wisdom that a problem cannot be solved unless it is first recognized. At the National Foundation to End Senior Hunger (NFESH), we regard that wisdom seriously because it simply and precisely describes the dilemma we face daily in our work—as well as explains the tragic situation in which literally millions of our nation's older adults find themselves living in and trapped in today. We are speaking about the monumental, growing and largely overlooked problem of senior hunger in America.

At the same time that conventional wisdom defines our dilemma, it also points the way toward helping us accomplish our goals as articulated in our mission statement—"Through research, education and community partnership, we will harness the

resources necessary to reverse the escalating number of seniors in the lifecycle of hunger." Much of the primary focus of our work in recent years has been in the areas of research and communications. Both are essential to ensuring that the problem we are seeking to solve is recognized for what it is. Research is the vehicle through which we quantify and analyze the issue. Communications is the channel through which we raise awareness about the facts, in order to build the public will to effect meaningful change. That means engaging other and diverse entities in the problem solving; and that begins by confronting the problem of senior hunger frankly and working to make a place for the topic in the public dialogue and debate. Senior hunger is not simply a "feeding" problem, although lack of access to nutritious food is a key

cause. It is also a health issue, which means that it has personal consequences for the individuals who are afflicted by it and that it has significant economic consequences for the nation, primarily in terms of health care spending.

A LOOK AT THE DATA

Perhaps nothing more graphically illustrates the general lack of attention to the issue of senior hunger than this fact: in 2008 our Foundation commissioned the first comprehensive national research study to look exclusively at senior hunger in America. Not Congress, not the Administration, not a federal agency, not a university, not a corporation, but our private foundation. That study, entitled "The Causes, Consequences and Future of Senior Hunger in America," was conducted by Co-Principal Investigators Dr. James P. Ziliak of the University of Kentucky and Dr. Craig Gundersen of the University of Illinois (then of Iowa State University), was heralded as groundbreaking. Dr. Eugene Smolensky, renowned economist and Professor of Public Policy at the University of California at Berkeley, reviewed the report independently and characterized it as "a first class report. . . a national study. . . which finally takes us beyond anecdote, and small partial studies, to a reliable picture of [senior] hunger nationwide."

That reliable picture was a grim one. It showed us that in 2005 in excess of 5 million individuals—11.45 percent of all seniors, or almost 1 in 9—faced the threat of hunger. This study also provided an important bench mark against which to measure our nation's progress in the fight against food insecurity among seniors. Regrettably, over the course of the last half decade, the change in the number of seniors facing the threat of hunger is more aptly characterized as regress rather than progress. By 2010, 14.85 percent of

seniors, or 8.3 million seniors were threatened. This reflects a 78 percent increase since 2001 and a 34 percent increase since the start of the Great Recession in 2007. Further, this growth cannot be explained away as a function of demographic changes, because the increases in hunger threat exceed the rate of population growth for the older cohort.¹

HOW DOES NFESH DEFINE “HUNGER”?

As we noted above, NFESH views raising public awareness about the issue, or starting the conversation as we like to say, to be absolutely critical to the success of our mission. We also understand that the manner in which we talk about issues, and the words that we use to convey our findings, are just as critical as the facts themselves. While professionals in the anti-hunger space are conversant with terms like food insecurity, most of the general public is not. And we discerned that instead of finding the nomenclature compelling, they found it confusing; instead of bringing the fact of hunger to life, such terminology put it at a distance. So together with Drs. Ziliak and Gundersen, we devised the terms “facing the threat of hunger,” “at-risk of hunger,” and “suffering from hunger” to correspond to the U.S. Department of Agriculture’s (USDA) terminology of marginally food insecure, food insecure, and very low food secure and describe the food insecurity continuum. Threat of hunger is the broadest measure, encompassing the above spectrum, and is the measure that NFESH typically uses when we quantify senior hunger. Given the characteristics of the senior population, we are convinced that the broadest measure is the most appropriate to use.

SENIORS FACE UNIQUE CHALLENGES

Why does NFESH believe it fitting to apply a different food insecurity measure to older individuals than is commonly used when discussing hunger in America? When it comes to issues related to hunger, seniors face unique challenges. As a first example, consider this fact the NFESH-commissioned research has noted. When food insecurity rates improved slightly between 2007 and 2010 in all other age cohorts and in the population as a whole, they actually grew worse among those aged 60 and older. We know that being poor or near poor puts seniors at risk of

hunger, and we also know that “poverty” should be measured differently for seniors. This is not simply an opinion on our part, and we are not alone in our view. In fact in late 2011, the U.S. Census Bureau, the federal agency charged with calculating the official U. S. poverty rate, released the Supplemental Poverty Measure (SPM). The SPM is an alternate measure to the official federal poverty index that takes into account additional factors, such as medical out-of-pocket expenses (MOOP), which affect seniors disproportionately. The SPM verified what we who work in senior hunger have long believed, namely, that there are many more poor seniors in the United States than have been recognized traditionally. According to the official poverty measure (2010), 9 percent of individuals aged 65 and older fall below poverty; but when calculated according to the SPM that number rises to 15.9 percent. So it is not surprising that the majority of seniors facing the threat of hunger have incomes above the “official” federal poverty line. More than one third have incomes between 100 percent and 200 percent of poverty, and another one fifth have incomes above 200 percent of poverty.

Additionally, the risk of hunger has a staggering negative impact on a senior’s overall quality of life. A senior at risk of hunger, for instance, has the same chance of a limitation in Activities of Daily Living (ADL) as an individual who is 14 years older. Ziliak and Gundersen found that hunger risk creates, in effect, a large disparity between actual chronological age and “physical” age, so that a 69-year-old senior suffering from hunger is likely to have the ADL limitations of an 83-year-old. This hunger-aging-ADL connection was not found to be present in any cohort of those aged 59 and younger.² As the number of seniors afflicted by hunger-related ADL limitations continues to grow, our national spending for such things as in-home caregiving, nursing home and other institutional care doubtless will increase in tandem. Seniors at

Regrettably, over the course of the last half decade, the change in the number of seniors facing the threat of hunger is more aptly characterized as regress rather than progress.

risk of hunger are also more likely than their peers to be in poor or fair health and are more likely to have lower intakes of major nutrients.

A NATIONAL PROBLEM AND A LOCAL PROBLEM

As a national Foundation, our primary focus has been on bringing national attention to a national problem in order to solve it. But we are keenly aware of the fact that national problems are also fundamentally local. They exist first and always in communities. Like most social and health problems, the incidence of the threat of senior hunger varies considerably from state to state. In order to determine just how significant the disparities were and to pinpoint states that were most severely affected, in 2009 NFESH commissioned Drs. Ziliak and Gundersen to provide a state-by-state profile, which will be updated annually. We believe that this information will be critical in assisting states and state and local hunger relief, social welfare and health care organizations in developing more effective programs and strategies to address the problem. In 2010, we saw widely discrepant rates among states. The range for the threat of hunger spanned from 5.52 percent in North Dakota to 21.53 percent in Mississippi. These rates and rankings shift from year to year.

Having the opportunity to compare state-level senior hunger data and state-level health data, such as this senior focused *America's Health Rankings*[®] easily allows, should furnish valuable new insights into the relationship between hunger and health status and assist communities, states and the nation as a whole in formulating new approaches to tackling this twin problem. NFESH is pleased to have been invited to share the findings from the research that we have commissioned in this context. The findings from this joint hunger-health perspective are not entirely new, of course, but viewed this way they do provide additional clarity about effective ways to advance our problem solving going forward.

ENGAGING ADDITIONAL PARTNERS

As noted, the correlation between good nutrition and good health is well-accepted, and the direct impact of proper nutrition on specific diseases, such as diabetes, hypertension, and certain types of cancers, is well documented. Also documented by the Centers for Disease Control and Prevention (CDC) is the fact that obese individuals are at greater risk of those and other diseases than

are adults of healthy weight. While it may seem counterintuitive that many individuals facing the threat of hunger would be obese, it is frequently the case. Obesity rates are high among those threatened with and at risk of hunger. Although the significant U.S. medical costs attributable to diseases associated with obesity have been well documented, the same attention has not been given to determining the national health care savings that could be realized by reducing the incidence of obesity through interventions designed to ensure that individuals at risk of hunger receive proper nutrition, not just food. NFESH believes it should be. We are eager to engage partners, such as hospitals and insurers, within the health care community to work with us to gather and analyze this critical information.

Similarly, the whole issue of the connection between hunger and health, between hunger and health care costs, and of the place of meal provision and nutrition education in the emerging long-term services and support system (LTSS) remains relatively unexamined. Research in this area could assist in the development of public policies intended to improve health and reduce social and economic costs to the nation. For example, projects that test the integration of nutrition services as a standard element in the LTSS system could be a first step.

A DISEASE WITH A CURE TODAY

It has long been NFESH's contention that hunger is a disease, a serious life-threatening one, in fact; but unlike so many other diseases, it is one for which we have a cure today. What seems to be lacking is a sense of national urgency to find the most effective ways of delivering the cure to all who need it. Or put another way, what seems to be lacking is a real understanding of what is at stake for all of us when we allow a curable disease to afflict a larger and larger number of vulnerable Americans each year. What is at stake, besides the quality of life experienced by those who suffer from this disease? For one thing, it is the economy that will suffer from a huge national price tag attributable to health-related costs that can be avoided. That means that we should all see ourselves as stakeholders in this winnable fight.

-
1. Ziliak JP, Gundersen CG, The state of senior hunger in America: 2010, 2012.
 2. Ziliak JP, Gundersen CG, Haist M, The causes, consequences and future of senior hunger in America, 2008.

The Environment of Care: A Community's Journey to Become America's Healthiest Hometown

ELLIOT SUSSMAN, MD, MBA
Chairman, The Villages Health

JOSEPH HILDNER, MD
Chief Medical Officer, The Villages Health

STEPHEN KLASKO, MD, MBA,
CEO, USF Health and Dean, Morsani College of Medicine



What if Walt Disney chose to focus on building a community and then embed a health system in it? Do you think that the delivery of health care in the United States might be different? Please keep the preceding 2 questions in mind as you read through the next few pages.

In 1983, The Villages was established in central Florida beginning with a few hundred manufactured homes on a few hundred acres. Over the ensuing 30 years, The Villages has grown into the largest retirement community in the United States, comprising nearly 40 square miles. More than 95,000 people from all 50 states and 14 foreign countries have moved to The Villages and now call it home. It is quite common to walk through 1 of the 3 town squares, each of which has 4 hours of live music every night of the year, and overhear someone remarking with glee, "it's Disneyworld for adults." The phrase often used to describe the vision of The Villages is the place where you can make your dreams come true.

The Villages is both a unique place and in many ways a reflection of the senior population in the United States overall despite that people have chosen to leave their original community and move to a new home. The uniqueness is characterized by novel initiatives, some of which appear counterintuitive.

Perhaps the best example of this is the creation of an educational system with a school for 2500 students (that is currently expanding to serve 3000 students) from pre-K through grade 12 in a community that specifically is designed for senior adults. How does this compute?

As a self-supporting community, some 20,000 people a day come to work at businesses based in The Villages, the gamut of employees that run from Wal-Mart to the local hospital, the daily

newspaper, national and local banks, etc. What better way to attract excellent employees of all ages and nationalities to businesses located in a senior community in Central Florida than to have a school system which rivals any private or public school in a major metropolitan area? The Villages Charter School (now regularly ranked as one of the top 10 public schools in Florida) was established 13 years ago as a work-site charter school; eligibility to attend the school is determined by whether a parent works in a business located in The Villages.

As amazing as life is for Villagers, with more than 98 percent of them saying they would recommend The Villages to friends and family, life is not perfect in our community. Meeting the need for a world class health care delivery system which matches the other world class attributes of the community has been a challenge. Much like the rest of the nation, we see a current health system where the patient often reports being confused from the outset in terms of where to turn when there is a problem (see Exhibit A).

We recall an excerpt from a conversation around health status paraphrased as follows:

"Yes, we have all our golf courses, swimming pools, softball teams, clubs and other activities available every day for our residents. But the truth is, if you don't have your health, you're not able to enjoy any of these activities."

Approximately 2 years ago, with the support



The Villages Health

of the leadership of The Villages community, the decision was made to transform the health care in The Villages. The rallying cry of making the community “America’s healthiest hometown” began to be heard.

The vision for the new health system was to provide the residents of The Villages with a clear path so they would KNOW where to go for their care (see Exhibit B).

After several months of debate and discussion the components deemed necessary to undertake this journey included:

- Commitment to the patient and the primary care physician as the foundation of the system.
- Willingness to embrace and implement the patient centered medical home philosophy and attributes.
- An integrated, aligned group of specialty physicians who are willing to function as a single group and truly partner with the primary care physicians.
- A common Information Technology (IT) platform with a seamless electronic health record (EHR) from the perspective of both patients and providers.
- An academically illuminated approach, necessitating a partnership with an academic health center to lead educational and research initiatives.
- A single insurance partner who embraces the above and will work collaboratively to rationalize financing and care delivery with a focus on Medicare.
- Community support for the effort.

Work on each of the listed components has progressed substantially in one year. The first Care Center is open and serving patients. Each Care Center will be staffed with 8 primary care physicians (PCPs). Each PCP cares for a panel of 1250 patients. Each PCP has an assigned PCP “buddy” who together lead a care team consisting of 1 physician extender and 6 other RNs and medical assistants. A Care Center, also including professionals in behavioral health, audiology and health coaching, serves the primary care needs of 10,000 patients. Each 19,000 square foot Care Center has the capability of providing blood draw and simple, stat labs, EKGs, chest and bone films and a knowledge pharmacy, a place where patients, working with providers in the Care Center, can acquire knowledge about their health and medical conditions. Two more Care Centers

COMPONENTS OF THE VILLAGES HEALTH SYSTEM

Patient Centered and Primary Care Driven

Embrace the PCMH model

Aligned, integrated specialty physicians

Single, seamless IT solution

Academically illuminated

Collaborative insurance partner

Community Support

are under construction and will open this year. The intent is to locate these throughout the community so that no Villager is more than a 15 minute golf car ride from their Care Center.

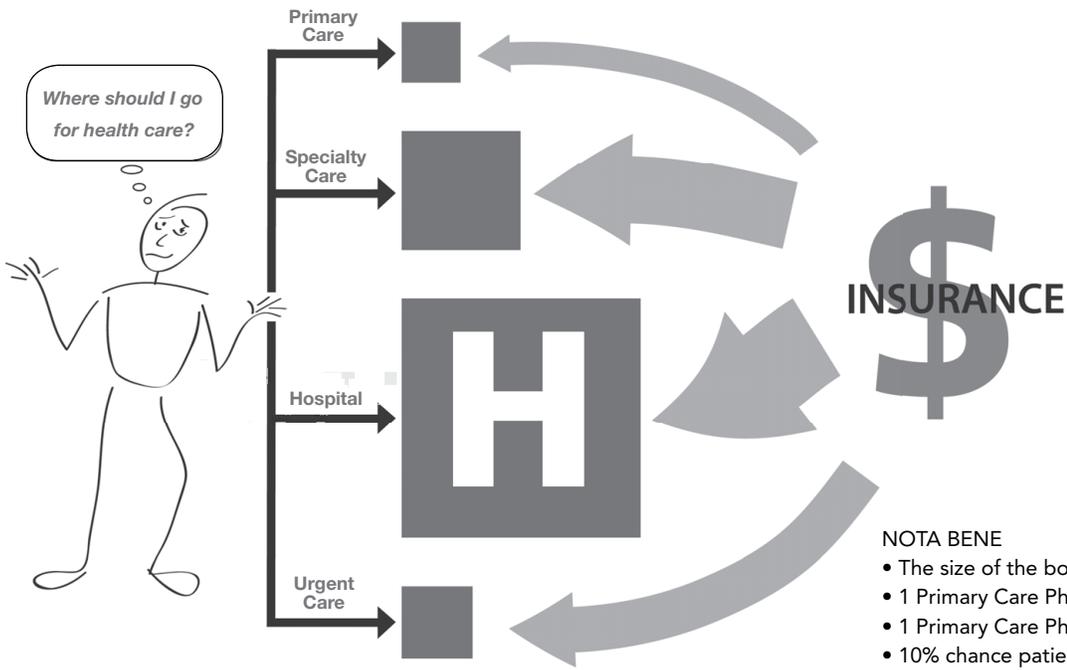
The first Specialty Care Center, operated by the University of South Florida (USF), with capacity for 20 specialist physicians, is scheduled to open this fall in a 25,000 square foot newly renovated building adjacent to the hospital. As the system grows in size and matures, the plan is to add at least one more specialty care center so that ultimately there is an approximate 1:1 ratio of primary care to specialty physicians.

The IT/EHR decision ensures that all physicians will share patient information seamlessly and securely. Patients will register once. Whether we end with a single platform for all (which would be e-Clinical Works) or a combination of e-Clinical for the PCPs and Allscripts for specialty physicians with a bi-directional interface is being actively investigated.

To help assure that our patients can take advantage of the advances in medicine, we want care to be academically illuminated. All of the PCPs, who are employed by The Villages Health, and all of the specialty physicians, who are either employed by or contracted with USF Health, are eligible for faculty appointments at the University of South Florida. It is intended that significant numbers of medical students and other health professional students will undertake studies and training in The Villages. In addition, a discussion is underway with the local hospital about starting select residencies at the hospital so that graduate medical education opportunities can also be developed as part of the initiative.

A significant number of research opportunities are being identified. To date, 8 peer reviewed abstracts and publications relating to this endeavor have been accepted for presentation and publication. The paper on the Villages/USF Health

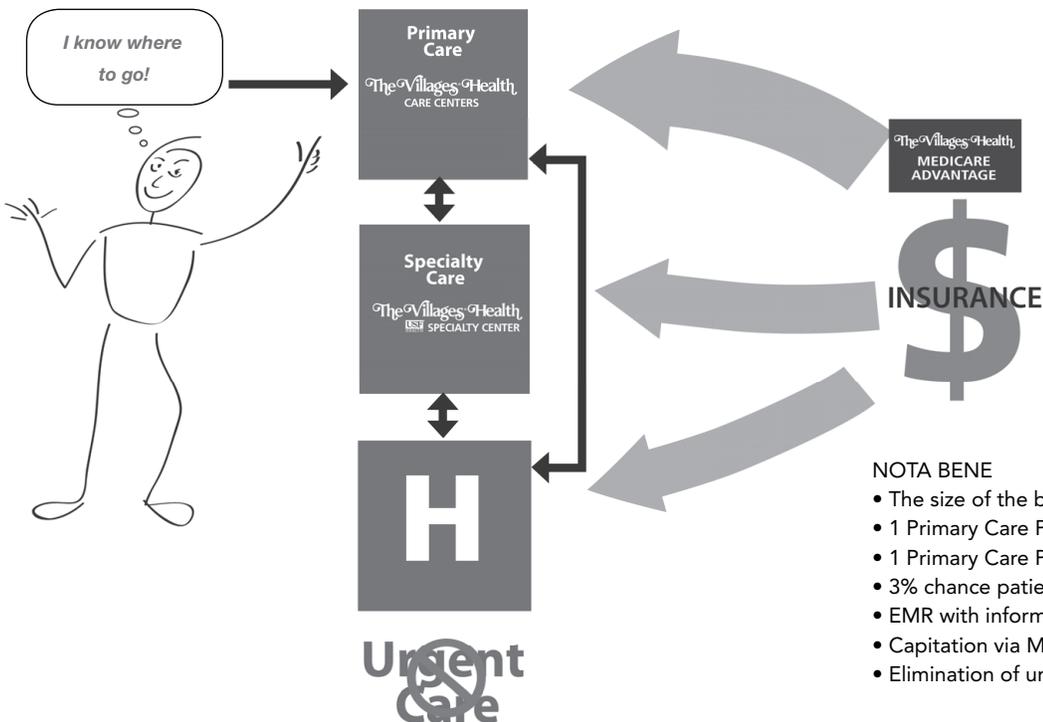
Exhibit A Health Care Today



NOTA BENE

- The size of the boxes and arrows matter
- 1 Primary Care Physician for 3,000 patients
- 1 Primary Care Physician for 4 Specialists
- 10% chance patients will be hospitalized
- No information integration or coordination
- All fee for service
- Lots of unnecessary tests and procedures

Exhibit B Health Care Tomorrow



NOTA BENE

- The size of the boxes and arrows matter
- 1 Primary Care Physician for 1,250 patients
- 1 Primary Care Physician for 1 Specialists
- 3% chance patients will be hospitalized
- EMR with information integration and coordination
- Capitation via Medicare Advantage
- Elimination of unnecessary tests and procedures

Choosing to live in The Villages, an active retirement community, encourages social cohesion and engagement.

Survey has been selected to receive the Erickson Award in Aging and Public Health by the American Public Health Association.

A 9 month process was completed to select a single insurance partner. The rationale for a single insurance partner started with the fact that almost 70 percent of the population of The Villages was eligible for Medicare. It became evident that if The Villages were to become "America's healthiest hometown," the simplest and most effective way to accomplish this was to develop a co-branded health plan that would appeal to a wide variety of Villagers. At the same time, the health system would then have the flexibility to move rapidly from a traditional fee-for-service emphasis focused on illness to a philosophy focused on health and wellness and embracing capitation.

Absolutely essential to transforming health care and improving health is the level of community engagement and social cohesion.

The results from The Villages / USF Health Survey suggest that residents of The Villages look quite similar to seniors across the United States. Probably the largest difference is the environment in which they live; The Villages encourages community which we believe is a necessary pre-requisite to "successful aging." The Villages has over 800 daily recreational activities (75 percent of Villagers report participating at least 1 time a week in moderate intensity physical activity), more than 1900 sanctioned resident clubs (75

percent of Villagers report being a member of at least 1), 38 neighborhood recreation centers, and a Lifelong Learning College that offers more than 500 courses with over 1200 sessions in which more than 26,000 Villagers participate annually. A weekly supplement to the daily newspaper, Recreation News, contains 64 pages of activities. One statistic that may provide the best snapshot of the level of activity is this: the median number of rounds of golf played daily is over 8000!

In addition, there are numerous daily opportunities to interact and connect. One revolves around the delivery of mail which is delivered to 1 of 57 neighborhood postal pickup centers usually located proximal to a community pool. The postal pickup centers are located in the neighborhood villages that together comprise The Villages. As a result, the environment is rich with

interaction, connectedness and social cohesion. The first mailed health survey undertaken in 2012 had 35,000 responses, almost a 40 percent response rate. As another example of social cohesion, more than 95 percent of Villagers report they could always or sometimes count on a neighbor to grocery shop for them if they were sick and more than 98 percent report doing favors for their neighbors and watching over their property. In fact, one of the most striking findings related to the Villages/USF Health Survey was that an overwhelming majority of Villagers felt connected to their community—a statistic not normally seen in studies of seniors in the United States.

Although residents of The Villages are similar to many other older adults in terms of the health issues they experience and are concerned with, they do differ in being better educated and having higher incomes. Also, the overall perception of their health is significantly better despite experiencing many of the same chronic illnesses, mental health concerns and mobility limitations as other, older adults. Choosing to live in The Villages, an active retirement community, encourages social cohesion and engagement, factors associated with optimism and high lifestyle satisfaction. This may help buffer the effects of the physical and mental challenges experienced nearly universally by aging adults.

The health system now being built in The Villages views itself as part of the fabric of the community. It is the responsibility of clinicians and all the other members of our system to help promote the overall health of the community. Similarly, to the extent that the community exhibits characteristics associated with a positive perception of health, the health of the community positively impacts the health of the individual. Perhaps most importantly, during a time when there is unprecedented discussion about healthcare reform, this Villages-USF Health partnership represents healthcare "transformation." What better way to define an accountable care organization than to have a patient centered medical home, an academic medical center and an insurance partner functioning as partners all working toward a common goal. As a result, the overall environment at The Villages which includes the design and operation of the health system, can lead to "America's healthiest hometown" as well as serve as a model for other communities to move toward this goal.

The Team

America's Health Rankings® Senior Report is a team effort in which all contribute a vital part to the creation and dissemination of this report. Members of this team, listed alphabetically by organization, follow:

Aldrich Design

Emily Aldrich
Jenna Brouse

RoninWare Inc.

TJ Kellie

Arundel Street Consulting, Inc.

Tom Eckstein
Kathryn Knippenberg
Sarah Milder
Amy Peterson
Nathan Wegmann

Tuckson Health Connections

Reed Tuckson

United Health Foundation

Shelly Espinosa
Lauren Mihajlov
Jessica Pappas
Jane Pennington
Ipyana Spencer

Balsera Communications

Sonia Diaz
David Duckenfield

The Glover Park Group

Carol Andes
Alex Ferrara
Cara Paley
Morgan Warners
Scott Weier
Lisa Wolford

Rockfish Interactive

Tom Black
Kayla Bond
Terra Butler
Jason Ferrara
Julie Fisk
Steven Fulfer
Teni Hallums
Scott Hamm
Steve Plunkett
Eliana Rodriguez
Matt Slaughter
Kristy Stevenson
Eric Svenson

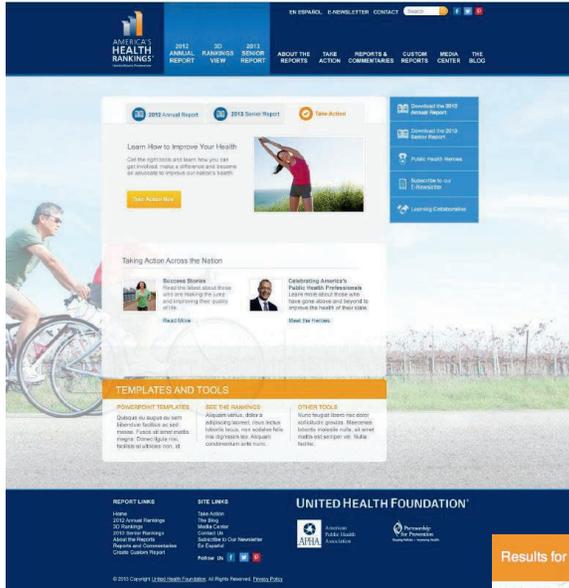
Index of Tables

	DESCRIPTION	PAGE
1	Overall Rankings	8
2	Determinants and Outcomes	9
3	Behaviors — Highest and Lowest Ranked States	10
4	Community & Environment - Overall — Highest and Lowest Ranked States	10
5	Community & Environment - Macro — Highest and Lowest Ranked States	11
6	Community & Environment - Micro — Highest and Lowest Ranked States	11
7	Policy — Highest and Lowest Ranked States	11
8	Clinical Care — Highest and Lowest Ranked States	11
9	Outcomes — Highest and Lowest Ranked States	12
10	Prevalences of Obesity, Physical Inactivity, Social Support and Excellent or Very Good Health Status in U.S. Seniors by Sex, Race/Ethnicity, Urbanicity, Education and Income	14
11	Group with Greatest Disparity in Obesity Prevalence by State	15
12	Group with Greatest Disparity in Physical Inactivity Prevalence by State	16
13	Group with Greatest Disparity in Social Support Prevalence by State	17
14	Group with Greatest Disparity in Excellent or Very Good Health Status Prevalence by State	18
15	Projected 15-Year Increases in Population of Adults Aged 65 and Older by State	20
16	College Education — Highest and Lowest Ranked States	20
17	Multiple Chronic Conditions — Highest and Lowest Ranked States	20
18	Cognition — Highest and Lowest Ranked States	21
19	Diagnosis of Depression — Highest and Lowest Ranked States	21
20	Comparison of 50-64 Year Olds Reporting Very Good or Excellent Health Status in 1995 and 2010 by State	22
21	Comparison of Obesity Among 50-64 Year Olds in 1995 and 2010 by State	24
22	Weight of Measures	27
23	Summary Description of Measures	30

TAKE ACTION

For you and your community

1. Visit americashealthrankings.org/takeaction to learn what you can do to improve your community's health.
2. Select what you want to improve and click Go.



SEARCH
TAKE ACTION

Measure:
Diabetes

Audience:
Select Audience

Action Type:
Select Action

Source Type:
Select Source

Go Reset

3. Review results and decide on the actions you can take.

Results for Diabetes, (52)

Add Healthy Heart Program to Classroom Advocacy Association
 Implement activities into lesson plans that teach children how to maintain a healthy heart. Teaching children about choices from a young age may prevent chronic disease in the future. ... | [Read More](#)

Bring Health Care to Low-Income Areas University
 The 11th Street Family Health Services Center is a nurse managed clinic of Drexel University that serves Philadelphia's 11th Street Corridor – an area that encompasses several public housing tracts and suffers from limited access to affordable, quality health care services. The Center is centrally located within one of the Philadelphia Housing Authority's residential sites and has an Advisory Board comprised of neighborhood residents to ensure that the clinic is addressing the needs of the community. The clinic focuses on primary and preventive care and has recently added a Healthy Living Center, which provides programs to help patients reduce risk factors for diseases and to manage existing conditions. The Healthy Living Center programs include diabetes education, disease self-management programs, nutrition and cooking classes, exercise programs, and behavioral health groups. In addition, the Center serves as a training and education site for nurses and other health professionals in culturally competent, community-based care. The 11th Street Family Health Services Center is an excellent model of potential for partnerships between communities and medical institutions to improve the health and well-being of the community's most vulnerable residents. ... | [Read More](#)

Bring Health Care to Low-Income Areas University
 The 11th Street Family Health Services Center is a nurse managed clinic of Drexel University that serves Philadelphia's 11th Street Corridor – an area that encompasses several public housing tracts and suffers from limited access to affordable, quality health care services. The Center is centrally located within one of the Philadelphia Housing Authority's residential sites and

At americashealthrankings.org, you can find information about the health of your state compared to other states, build custom reports to fit your needs, and download templates and graphs to share with others. Stay informed throughout the year by signing up for the newsletter and reading the AHR blog.

Keep up with *America's Health Rankings*® via Facebook and Twitter. You'll see how everyone is working in real time to help improve the health of our communities, workplaces, states, and nation.



twitter.com/AHR_Rankings



facebook.com/AmericasHealthRankings



Americashealthrankings.org/newsletter



The United Health Foundation provides reliable information to support health and medical decisions that lead to better health outcomes and healthier communities. The Foundation also supports activities that expand access to quality health care services for those in challenging circumstances and partners with others to improve the well-being of communities.

United Health Foundation
9900 Bren Road East
Minnetonka, MN 55343

www.unitedhealthfoundation.org

America's Health Rankings® Senior Report is available in its entirety at www.americashealthrankings.org. Visit the website to request or download additional copies.

MAY 2013