

2023 Senior Report

 AMERICA'S
HEALTH RANKINGS®
UNITED HEALTH FOUNDATION



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Improving the Health of the Older Adults in Our Lives Using Data

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We all have older adults in our lives who we admire, who lead interesting lives, teach us so much and continue to make new memories with us. As a geriatrician, I am committed to supporting health as we age and ensuring that older Americans are thriving.

Every year I look forward to the *America's Health Rankings Senior Report*, a comprehensive review of the health of our nation's older generations and a critical tool for individuals, community leaders and policymakers to guide their decision-making with solid data. I always learn something new from this report, which takes into account the measures that really matter as we age, such as the ability to be independent, the availability of community support and the level of access to health care resources provided to seniors.

In this report, we see some concerning short- and long-term trends, including in mortality. As we all know, the COVID-19 pandemic had a disproportionate impact on older Americans, which was reflected in a continued increase in the early death rate in the most recent data. But we also see longer-term mortality trends headed in the wrong direction, like drug deaths, or remaining stubbornly high, like suicide — areas that many people do not realize have impacted seniors significantly in recent years.

On the other hand, the bright spots in the data give me hope. For example, it's great to see a continued increase in access to high-speed internet, which can allow older adults to be better connected with family and friends. Although not a replacement for face-to-face interactions, anything that promotes social engagement is so important for overall health and well-being. It is also heartening to see the continued growth in the number of physicians, nurse practitioners, personal care and

home health care workers per capita, as more individuals choose careers focused on caring for older populations. I know firsthand how important and rewarding this work is — but also recognize the great need for even more dedicated people to fill these roles.

Since the inception of this report 11 years ago, we have examined disparities across the senior population. As we age, the differences in our health can become more pronounced, and we did find significant variation by race/ethnicity, gender, rural/urban geography, income and education. These disparities were particularly wide in mortality, behavioral health and physical health measures.

“With the right investments, some creativity and a desire for change, we can improve the lives of older Americans.”

From over a decade of working on these reports with the United Health Foundation, I know that when I see improvements in measures it is almost always because there was a successful coordinated effort to improve outcomes. I hope that the report will be a valuable resource for these efforts at the individual and community levels as leaders and policymakers tailor their interventions to address the most pressing challenges facing seniors today. With the right investments, some creativity and a desire for change, we can improve the lives of older Americans.

The United Health Foundation is proud to release the *America's Health Rankings® 2023 Senior Report*, which provides a portrait of the health and well-being of older adults across the United States.

The report features successes and challenges in a broad range of health measures and, because most measures include data from 2021 or later, the report highlights some of the effects that the COVID-19 pandemic had on older adults.

For the second year in a row, the early death rate continued to increase, reversing a decade-long decline. Other challenges affecting older adults included an ongoing rise in drug deaths and increases in multiple chronic conditions, frequent physical distress, physical inactivity and poverty. A new measure in this year's report shows that many older adults spent more than 30% of their income on housing. Despite these challenges, the number of geriatric providers and home health care workers per capita both increased, while food insecurity continued to decline amid increases in home-delivered meals.

As the early death rate continued to rise, the percentage of the United States population ages 65 and older declined for the first time in the 11 years of the *Senior Report*, from 16.9% to 16.8% between 2020 and 2021. However, the overall number of older adults still increased — in 2021, there were 55.8 million adults ages 65 and older in the U.S., 188,588 more than in 2020. That population is [projected](#) to continue increasing despite the pandemic's impact.¹

The demographic makeup of the older adult population has become more racially and ethnically diverse. Between 2018 and 2021, the proportion of white (83.6% to 75.1%), Asian (5.1% to 4.8%) and Black (9.9% to 9.4%) older adults decreased, while the proportion of Hispanic (8.4% to 9.0%) and multiracial (0.8% to 0.9%) older adults increased. During the same period, the proportion of American Indian/Alaska Native older adults stayed the same (0.6%).

Older adults comprise a much larger share of the population in some states than in others. In 2021, Maine had the highest proportion of adults ages 65 and older (21.7%) and Utah had the lowest (11.7%).

The demographic makeup of the older adult population has become more racially and ethnically diverse.

No matter the size of the older adult population, strengths, challenges and disparities are present in every state, as demonstrated by the findings in this report. It is essential that policymakers, community leaders and public health officials who work to safeguard and improve the health of older Americans consider these measures collectively, as each measure influences and is influenced by other measures of health as well as factors that affect older adults' everyday lives. Public health and community leaders are encouraged to use the data in this report to guide their efforts to engage older adults with resources in their communities and address these health challenges. It is particularly critical to address the unique challenges and disparities of the older adult population as it continues to diversify.

Objective

America's Health Rankings aims to inform and drive action to build healthier communities by offering credible, trusted data that can guide efforts to improve health and health care. To achieve this, a comprehensive set of measures were analyzed to assess the health of older adults across the nation. The report is based on:

- **Fifty-two measures.** These include 35 ranking and 17 non-ranking measures. New non-ranking measures in this year's report include firearm deaths, motor vehicle deaths, housing cost burden and rural population, all among adults ages 65 and older.
- **Five categories of health.** These include health outcomes and four other categories that are determinants of health: social and economic factors, physical environment, behaviors and clinical care.
- **Twenty-two data sources.** Data included in this report are from many different sources, including the Centers for Disease Control and Prevention's (CDC's) Behavioral Risk Factor Surveillance System and the Centers for Medicare & Medicaid Services' (CMS') Mapping Medicare Disparities Tool.
- **Providing a benchmark for states.** Each year the report presents trends, strengths, challenges and highlights for every state using the 11 years of data analyzed in the *America's Health Rankings Senior Report*. Public health advocates can monitor health trends over time and compare their state with neighboring states and the nation. This year, state summaries are available on the website as a separate download.
- **Stimulating action.** The report is intended to drive change and improve health by promoting data-driven discussions among individuals, community leaders, public health workers, policymakers and the media. States can incorporate the report into their annual review of programs, and many organizations use the report as a reference when assigning goals for health improvement plans.
- **Highlighting disparities.** The report shows differences in health between states and among population groups at state and national levels, with groupings based on metropolitan status, education level, income level, gender, age and race/ethnicity. These analyses often reveal differences among groups that national or state aggregate data may mask.

The *America's Health Rankings Senior Report* aims to improve population health by:

- **Presenting a holistic view of health.** This report goes beyond measures of clinical care and health behaviors by considering social, economic and physical environment measures, reflecting a growing understanding of the impact of social determinants on health.

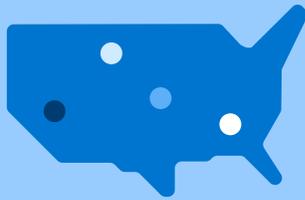
Model for Measuring America's Health

America's Health Rankings is built upon the World Health Organization's definition of health: "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."

The model was developed under the guidance of the *America's Health Rankings* advisory council and committees, with insights from other rankings and health models, namely County Health Rankings & Roadmaps and Healthy People. The model serves as a framework across all *America's Health Rankings* reports for identifying and quantifying health drivers and outcomes that impact state and national population health.

America's Health Rankings Model





Recent notable changes in key health indicators.



Drug Deaths

2.3x

higher among males than females in 2019-2021.



Geriatric Providers

3.8x

higher in Rhode Island than Idaho, though highest in the District of Columbia in 2022.

National Highlights

Health Outcomes

4%▲

Early Death

increased from 2,072 to 2,151 deaths per 100,000 adults ages 65-74 between 2020 and 2021.

CDC WONDER, Multiple Cause of Death Files.

43%▲

Drug Deaths

increased from 6.9 to 9.9 deaths per 100,000 adults ages 65+ between 2016-2018 and 2019-2021.

CDC WONDER, Multiple Cause of Death Files.

6%▼

Cognitive Difficulty

decreased from 8.3% to 7.8% of adults ages 65+ between 2019 and 2021.

U.S. Census Bureau, American Community Survey.

9%▲

Frequent Physical Distress

increased from 14.5% to 15.8% of adults ages 65+ between 2020 and 2021.

CDC, Behavioral Risk Factor Surveillance System.

13%▲

Multiple Chronic Conditions

increased from 46% to 52% of adults ages 65-74 between 2020 and 2021.

U.S. HHS, Centers for Medicare & Medicaid Services, Office of Minority Health, Mapping Medicare Disparities Tool.

Clinical Care

8%▲

Geriatric Providers

increased from 33.8 to 36.4 providers per 100,000 adults ages 65+ between 2021 and 2022.

U.S. HHS, Centers for Medicare & Medicaid Services, National Plan and Provider Enumeration System.

5%▲

Home Health Care Workers

increased from 57.7 to 60.3 workers per 1,000 adults ages 65+ between 2020 and 2021.

U.S. Department of Labor, Bureau of Labor Statistics.

8%▼

Hospice Care

decreased from 50.7% to 46.7% of Medicare decedents between 2018 and 2020.

National Hospice and Palliative Care Organization, NHPCO Facts and Figures.

Social and Economic Factors

10%▲

Poverty

increased from 9.4% to 10.3% of adults ages 65+ between 2019 and 2021.

U.S. Census Bureau, American Community Survey.

6%▼

Food Insecurity

decreased from 12.6% to 11.9% of adults ages 60+ between 2019 and 2020.

Feeding America, The State of Senior Hunger in America.

5%▲

Community Support Expenditures

increased from \$59 to \$62 per adult ages 60+ between 2020 and 2021.

U.S. HHS, Administration for Community Living, State Program Reports.

7%▲

High-Speed Internet

increased from 78.0% to 83.1% of households with adults ages 65+ between 2019 and 2021.

U.S. Census Bureau, American Community Survey.

5%▼

Senior Centers

decreased from 6.4 to 6.1 senior centers receiving OAA funds per 100,000 adults ages 60+ between 2020 and 2021.

U.S. HHS, Administration for Community Living, State Program Reports.

22%▼

Volunteerism

decreased from 28.5% to 22.1% of adults ages 65+ between 2019 and 2021.

U.S. Census Bureau, Current Population Survey, Volunteering and Civic Life Supplement.

79%▲

Home-Delivered Meals

increased from 8.9 to 15.9 adults ages 60+ served per 100 adults ages 60+ with independent living difficulty between 2019 and 2021.

U.S. HHS, Administration for Community Living, State Program Reports.

Health Behaviors

6%▲

Physical Inactivity

increased from 29.4% to 31.2% of adults ages 65+ in fair or better health between 2018 and 2021.

CDC, Behavioral Risk Factor Surveillance System.



Poverty

5.6M

adults ages 65+ were living below the poverty level in 2021.



High-Speed Internet

46

access significantly increased in 46 states between 2019 and 2021.



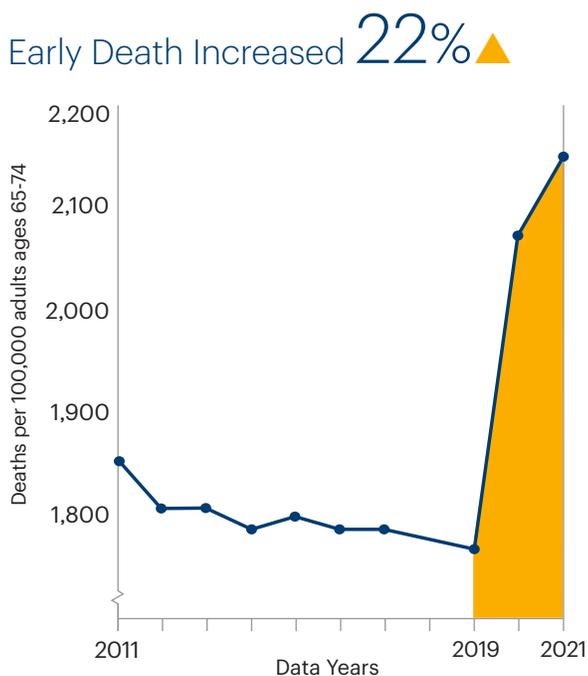
Physical Inactivity

1.9x

higher in Alabama than Colorado in 2021.

Findings

Persistent disparities were found throughout the report by gender, race/ethnicity, age, geography, education and income.



The early death rate among adults ages 65-74 significantly increased 4% between 2020 and 2021, and 22% since 2019.

Source: CDC WONDER, Multiple Cause of Death Files, 2011-2021.

HEALTH OUTCOMES | MORTALITY

Early Death

For the second year in a row, the early death rate continued to increase, reversing the trend on a decade-long decline.

In 2021, [life expectancy at age 65](#) was 18.4 additional years, and yet many older adults do not live to see their 75th birthday.² Research estimates that [48%](#) of all premature deaths are due to preventable causes.³

Changes over time. Nationally, the early death rate — deaths per 100,000 adults ages 65-74 — significantly increased 4% from 2,072 to 2,151 between 2020 and 2021 and 22% (from 1,765) since 2019. These increases reversed the nearly decade-long progress of a 4% decline in early death rates between 2011 and 2019. There were 724,266 deaths among adults ages 65-74 in 2021, nearly 50,000 more deaths than in 2020, and 169,000 more than in 2019.

The early death rate significantly increased in 25 states, led by 22% in Alaska (1,768 to 2,163 deaths per 100,000 adults ages 65-74) and 18% in West Virginia (2,589 to 3,066) between 2020 and 2021. Over the same period,

the rate significantly decreased in six states, led by 15% in New Jersey (2,036 to 1,727), 14% in New York (2,026 to 1,737) and 10% in Connecticut (1,742 to 1,570). Some racial/ethnic and gender groups experienced significant increases in the early death rate, including 6% among white older adults (1,999 to 2,124), 5% among females (1,627 to 1,716) and 2% among males (2,582 to 2,640). Over the same period, the rate significantly decreased by 3% among Black (3,184 to 3,100) and Hispanic (1,955 to 1,894) older adults.

Disparities. The early death rate was 2.0 times higher in Mississippi (3,147 deaths per 100,000 adults ages 65-74) than Hawaii (1,552), the states with the highest and lowest rates in 2021. The early death rate significantly varied by race/ethnicity and gender. The rate was:

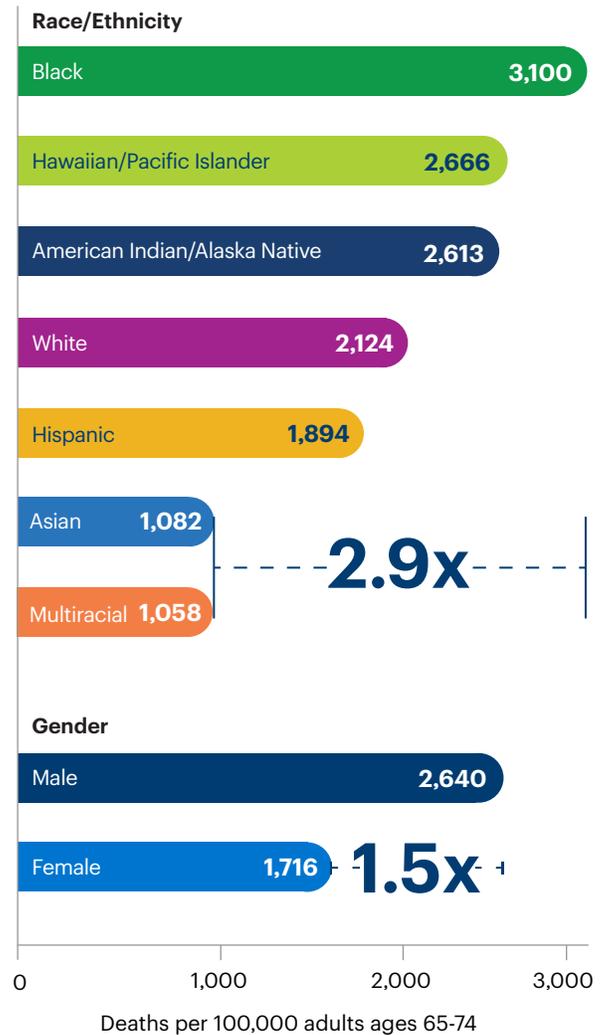
- 2.9 times higher among Black (3,100) compared with multiracial (1,058) and Asian (1,082) older adults.*
- 1.5 times higher among males (2,640) than females (1,716).

Related Measure: Suicide

While suicide among older adults has remained relatively stagnant in recent years, 27,962 older adults died by suicide in 2019-2021. Nationally, the suicide rate significantly increased 9% among those ages 85 and older (19.4 to 21.1 deaths per 100,000 ages 65 and older) and significantly decreased 4% among those ages 65-74 (15.8 to 15.1) between 2016-2018 and 2019-2021. The suicide rate significantly varied by gender, race/ethnicity and age in 2019-2021. The rate was 6.3 times higher among males (31.5) than females (5.0); 4.6 times higher among white (20.3) compared with Black† (4.4) older adults; and 1.4 times higher among those ages 85 and older compared with those ages 65-74.

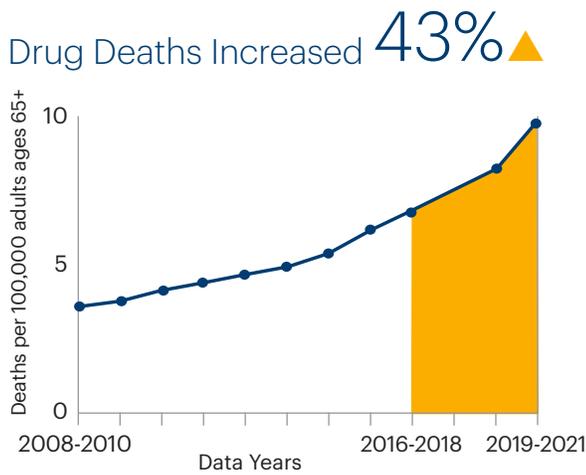
* Estimates for the two lowest groups were not significantly different from each other based on non-overlapping 95% confidence intervals.
 † Estimates for Black and multiracial (6.0) older adults were not significantly different from each other based on non-overlapping 95% confidence intervals.

Disparities in Early Death by Race/Ethnicity* and Gender



Source: CDC WONDER, Multiple Cause of Death Files, 2021.

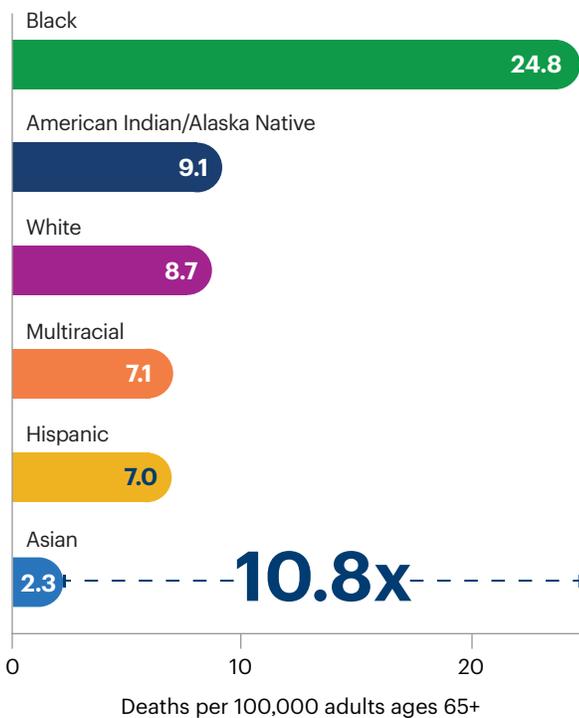
Note: All racial groups are non-Hispanic. Hispanic ethnicity includes members of all racial groups.



The drug death rate among adults ages 65 and older significantly increased 43% between 2016-2018 and 2019-2021, and 136% since 2008-2010.

Source: CDC WONDER, Multiple Cause of Death Files, 2008-2021.

Disparities in Drug Deaths by Race/Ethnicity



Source: CDC WONDER, Multiple Cause of Death Files, 2019-2021.

Note: All racial groups are non-Hispanic. Hispanic ethnicity includes members of all racial groups.

Drug Deaths

Drug overdose deaths among older adults have been on the rise the past two decades, largely due to opioids.⁴ Older adults are among those most impacted by the opioid crisis, as they are often prescribed opioids to help them cope with chronic pain or recover from surgical procedures.⁵

Changes over time. Nationally, the drug death rate — deaths due to drug injury (unintentional, suicide, homicide or undetermined) per 100,000 adults ages 65 and older — significantly increased 43% from 6.9 to 9.9 between 2016-2018 and 2019-2021 and 136% from 4.2 in 2008-2010. In 2019-2021, 16,380 older adults died from drug injury, an increase of 5,804 since 2016-2018. The drug death rate significantly increased in 30 states* and the District of Columbia, led by 94% in Hawaii (7.9 to 15.3 deaths per 100,000 adults ages 65 and older), 92% in Illinois (5.2 to 10.0) and 90% in the District of Columbia (39.6 to 75.3) between 2016-2018 and 2019-2021. By gender, the drug death rate significantly increased 61% among males (8.9 to 14.3) and 17% among females (5.4 to 6.3).

Opioids have been a major component of this rise. Opioid deaths surged more dramatically than the overall drug death rate (involving all drug types), more than doubling since 2014-2016 from 2.6 to 5.4 deaths per 100,000 adults ages 65 and older. In particular, deaths due to synthetic opioids, such as fentanyl and tramadol, increased 175% among older adults between 2016-2018 and 2019-2021.

Disparities. The drug death rate was 4.3 times higher in Maryland (16.6 deaths per 100,000 adults ages 65 and older) than Nebraska (3.9), the states* with the highest and lowest rates in 2019-2021. However, the highest rate was in the District of Columbia (75.3). The drug death rate significantly varied by race/ethnicity and gender. The rate was:

- 10.8 times higher among Black (24.8) compared with Asian (2.3) older adults. The rate was also higher among American Indian/Alaska Native (9.1), white (8.7), multiracial (7.1) and Hispanic (7.0) older adults compared with Asian older adults.
- 2.3 times higher among males (14.3) than females (6.3).

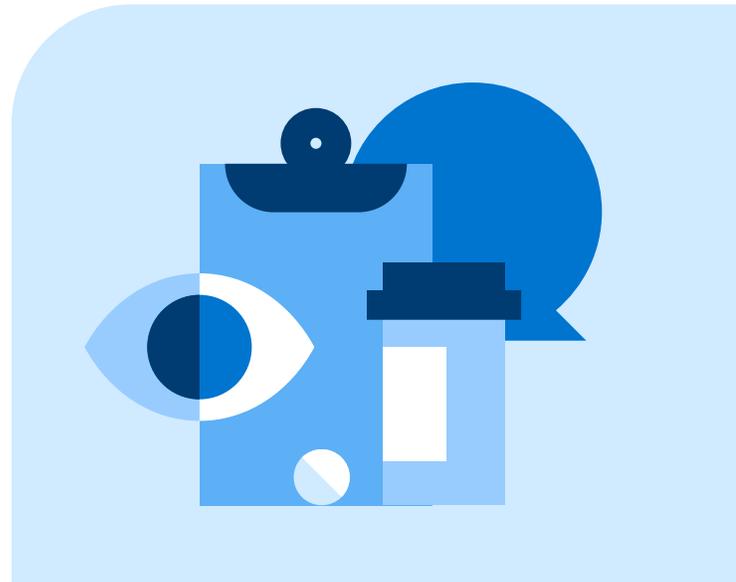
* Data not available for North Dakota and South Dakota in 2019-2021; state rankings are based on 48 states.

Cognitive Difficulty

Cognitive impairment can be [caused by](#) Alzheimer's disease, brain injury, stroke, medication side effects, vitamin B12 deficiency and depression.⁶ As the 65-and-older population increases, the number of older adults living with Alzheimer's disease is projected to reach [12.7 million](#) by 2050.⁷

Changes over time. Nationally, the percentage of adults ages 65 and older who reported having physical, mental or emotional problems or difficulty remembering, concentrating or making decisions significantly decreased 6% from 8.3% to 7.8% between 2019 and 2021. In 2021, nearly 4.3 million older adults reported cognitive difficulty, a decrease of 62,308 from 2019. Between 2019 and 2021, cognitive difficulty significantly decreased in four states: 32% in Delaware (8.7% to 5.9%), 18% in Maryland (7.6% to 6.2%), 17% in Wisconsin (6.4% to 5.3%) and 12% in Pennsylvania (7.8% to 6.9%). Over the same period, cognitive difficulty significantly increased 31% in Idaho (7.1% to 9.3%).

Disparities. Cognitive difficulty was 2.0 times higher in Mississippi (10.7%) than Wisconsin (5.3%), the states with the highest and lowest percentages in 2021.



4.3M

adults ages 65+
reported cognitive
difficulty in 2021.

Source: U.S. Census Bureau, American Community Survey, 2021.

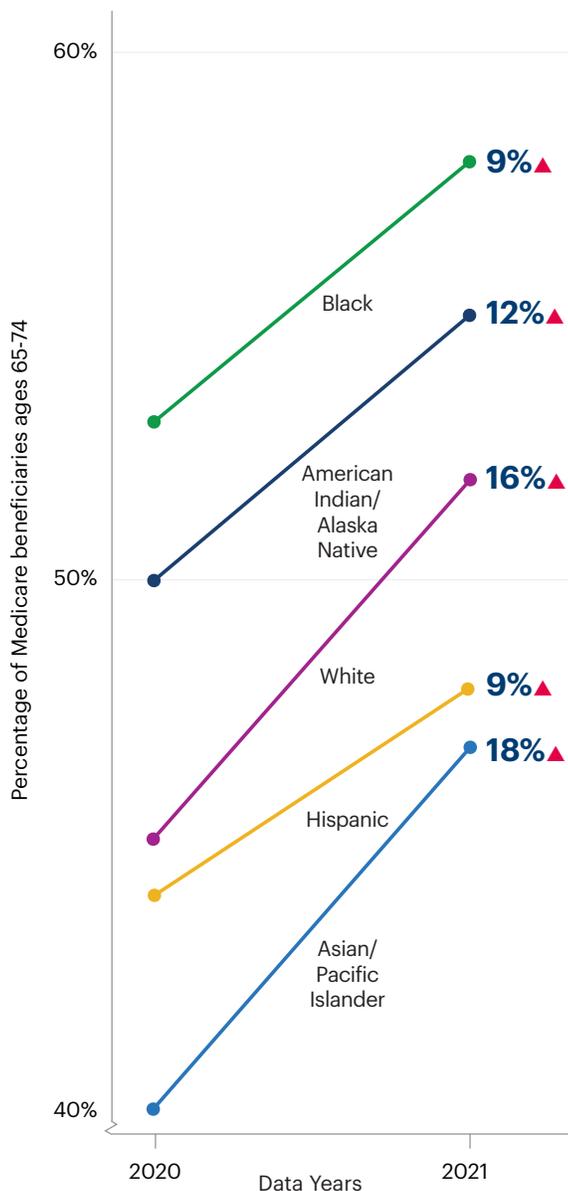
Cognitive Difficulty

2.0x

higher in Mississippi (10.7%)
than Wisconsin (5.3%) in 2021.

Source: U.S. Census Bureau, American Community Survey, 2021.

Increases in Multiple Chronic Conditions by Race/Ethnicity



Source: U.S. HHS, Centers for Medicare & Medicaid Services, Office of Minority Health, Mapping Medicare Disparities Tool, 2020, 2021.

Note: All racial groups are Hispanic-inclusive (except for white, which is non-Hispanic). Hispanic ethnicity includes members of all racial groups.

HEALTH OUTCOMES | PHYSICAL HEALTH

Multiple Chronic Conditions

[Chronic conditions](#) last more than a year and require ongoing medical attention and/or limit daily functions such as eating, bathing and mobility.⁸ Adults with multiple chronic conditions represent one of the highest-need segments of the population, as each chronic condition may require additional medication and monitoring.

Changes over time. Nationally, the percentage of Medicare beneficiaries* ages 65-74 with three or more of 21 [chronic conditions](#) identified by the Centers for Medicare & Medicaid Services (CMS) increased 13% from 46% to 52% between 2020 and 2021.⁹ Multiple chronic conditions increased by 13% or more in 34 states and the District of Columbia, led by 29% in Alaska (28% to 36%) and 27% in both Vermont (30% to 38%) and Montana (30% to 38%). All racial/ethnic and gender groups experienced increases in multiple chronic conditions. By group, increases were:

- 18% among Asian/Pacific Islander (40% to 47%), 16% among white (45% to 52%), 12% among American Indian/Alaska Native (50% to 56%), 9% among Black (53% to 58%) and 9% among Hispanic (44% to 48%) Medicare beneficiaries ages 65-74.
- 16% among female (45% to 52%) and 13% among male (46% to 52%) Medicare beneficiaries ages 65-74.

Disparities. The prevalence of multiple chronic conditions was 1.8 times higher in Alabama (64%) than in Wyoming (35%), the states with the highest and lowest prevalences in 2021. Multiple chronic conditions varied by race/ethnicity. The prevalence was 1.2 times higher among Black (58%) compared with Asian/Pacific Islander (47%) Medicare beneficiaries ages 65-74.

Frequent Physical Distress

Frequent physical distress is an indicator of [health-related quality of life](#) and the burden of physical illness in a population.¹⁰ It is associated with such chronic health conditions as diabetes, hypertension and chronic obstructive pulmonary disease as well as risk factors such as smoking, obesity and physical inactivity.

Changes over time. Nationally, the percentage of adults ages 65 and older who reported their physical health was

* Limited to Medicare beneficiaries who were enrolled in the fee-for-service program.

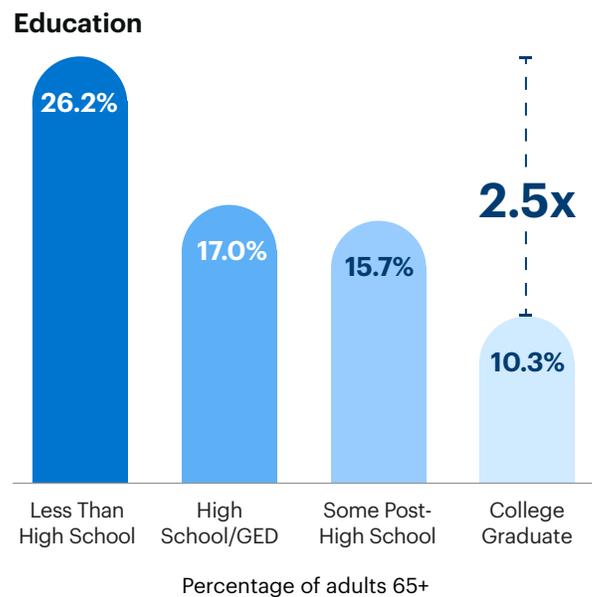
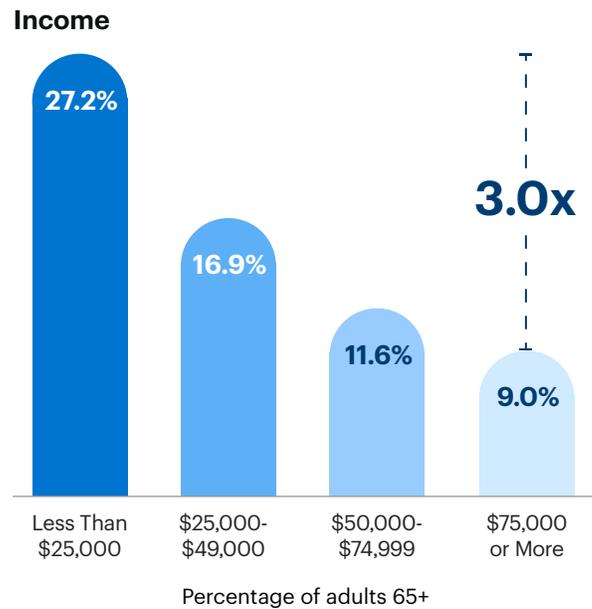
not good 14 or more days in the past 30 days increased 9% from 14.5% to 15.8% between 2020 and 2021. Despite this increase, the prevalence remains 9% lower than in 2019 (17.4%). Between 2020 and 2021, frequent physical distress increased in two states: 43% in Wyoming (11.8% to 16.9%) and 41% in New Jersey (11.6% to 16.3%). Some racial/ethnic, income, gender and metropolitan groups experienced significant increases in frequent physical distress including: 28% among Black older adults (14.2% to 18.2%); 20% among older adults with a household income less than \$25,000 (22.6% to 27.2%); 18% among older adults with an income of \$25,000-\$49,999 (14.3% to 16.9%); 15% among males (13.3% to 15.3%); and 9% among older adults living in metropolitan areas (14.1% to 15.3%).

Disparities. Frequent physical distress was 2.1 times higher in West Virginia (22.4%) than South Dakota and Connecticut (10.6%), the states with the highest and lowest percentages in 2021. Frequent physical distress varied by income, race/ethnicity, education and metropolitan status. The prevalence was:

- 3.0 times higher among older adults with a household income less than \$25,000 (27.2%) than those with an income of \$75,000 or more (9.0%).
- 2.5 times higher among American Indian/Alaska Native (23.1%) compared with Asian (9.1%) older adults. Hispanic (22.0%), multiracial (20.5%), other race (18.5%) and Black (18.2%) older adults also had a high rate. Hawaiian/Pacific Islander older adults (11.3%) also had a low rate.*
- 2.5 times higher among older adults with less than a high school education (26.2%) than college graduates (10.3%).
- 1.1 times higher among older adults living in non-metropolitan (17.4%) than metropolitan (15.3%) areas.

* Estimates within the five highest and two lowest groups were not significantly different from each other, respectively, based on non-overlapping 95% confidence intervals.

Disparities in Frequent Physical Distress by Income and Education



Source: CDC, Behavioral Risk Factor Surveillance System, 2021.



Using Data to Make the Health of American Indian Elders Visible

Carmelita Wamego Skeeter

Chief Executive Officer,
Indian Health Care Resource Center of Tulsa
Citizen Potawatomi Nation

Over my 50 years working in Tulsa, I have seen the health challenges facing American Indians continue to evolve. And while American Indians have come a long way in Oklahoma in terms of recognition and direct discrimination, we are still, in many ways, an “invisible race” that has been historically overlooked in health-related data. Resources like the *Senior Report* that use the data we do have available to highlight the challenges facing this population are critical to better understanding the health of our elders.

The data we have point to troublesome trends. We have sadly lost many of our elders to COVID-19, as underscored by the *Senior Report’s* findings around the early death rate. But COVID is not the only threat to our elders; this report shows a rise in chronic conditions like diabetes, which is a health challenge I see every day in my work, as well as disparities in drug deaths and poverty.

For American Indians, older adults hold a breadth of cultural wisdom that is critical to pass along to the next generations in our community. As we recover from these many losses, we know we must form strong intergenerational bonds to record and preserve cultural knowledge and traditions. This is something we pride ourselves on at the Indian Health Care Resource Center (IHCRC) as we aim to foster collaboration between our youth- and senior-focused programming.

We must do our best to [protect our elders](#) by investing in physical, mental and emotional health programs and a comprehensive, compassionate and understanding approach — with services ranging from transportation and home visits to social offerings — for the over 1,000 older adults from 112 federally recognized tribes in our care. These older patients, like

Barbara Williams, a grandmother and proud member of the Cherokee Nation, remember times when being a Native American did not always elicit friendly responses in health care settings, and thus they value the caring environment and respect they receive at the IHCRC.

In addition to addressing what we know are serious health challenges, we need to ensure that we have strong data to use as a starting point. The health data collection systems which we all rely on often require people to identify themselves as one race alone, but the majority of American Indians do not consider themselves as belonging to a single racial group for a variety of historical reasons. I’ve seen this challenge in action when we assisted our local elders in the COVID-19 vaccination process, which included answering demographic questions as part of the necessary documentation. I watched as many people checked the box identifying themselves as another race, even though I knew they were part American Indian. This limitation in data collection persists in other data sources that rely on self-identification, making it difficult at times to accurately assess the health challenges facing American Indians.

As we emerge from this period of great loss, preserving cultural knowledge through intergenerational connections and better understanding the health of our community will be crucial. And to do that, we need data that make American Indian communities seen and “visible” so we can find solutions to the unique health challenges facing our elders. The *Senior Report* gives us an important tool to do this. I urge my fellow community leaders to use it as a guide to improve the health challenges of our elders and thereby the overall health of both the American Indian community and the U.S. overall.

10.3%

of older adults were living below the poverty level in 2021.

Source: U.S. Census Bureau, American Community Survey, 2021.

31.8%

of older adult households were housing cost-burdened in 2021.

Source: U.S. Census Bureau, American Community Survey PUMS, 2021.

SOCIAL AND ECONOMIC FACTORS | ECONOMIC RESOURCES

Poverty

Poverty is associated with [poor health outcomes](#) and increases the risk of chronic disease and [mortality](#).^{11,12} Among older adults, poverty is linked to an increased risk of [disability](#), [homelessness](#) and [physical and cognitive decline](#).¹³⁻¹⁵ Adults ages 65 and older were the only age group to experience an increase in poverty between 2020 and 2021, according to [Census Bureau](#) data.¹⁶

Changes over time. Nationally, the percentage of adults ages 65 and older who live below the poverty level significantly increased 10% from 9.4% to 10.3% between 2019 and 2021. In 2021 this corresponded to 5.6 million older adults, an increase of 638,347 since 2019. Between 2019 and 2021, poverty significantly increased in 16 states, led by 49% in Vermont (6.1% to 9.1%), 43% in South Dakota (7.7% to 11.0%) and 38% in Idaho (6.9% to 9.5%). By race/ethnicity, the prevalence significantly increased 21% among multiracial (12.5% to 15.1%) and 12% among white (7.3% to 8.2%) older adults.

Disparities. Poverty was 2.1 times higher in Louisiana (14.1%) than Wyoming (6.7%), the states with the highest and lowest rates in 2021. Poverty significantly varied by race/ethnicity. The prevalence was twice as high among older adults who identified their race as other* (18.9%), Hispanic (17.7%), Black (17.6%), American Indian/Alaska Native (17.6%) or Hawaiian/Pacific Islander (16.5%) compared with white older adults (8.2%).

Related Measure: Housing Cost Burden

In 2021, 31.8% of households with one or more adults ages 65 and older were housing cost-burdened —

meaning housing costs were more than 30% of household income — corresponding to nearly 12.4 million households. Between 2018 and 2021, housing cost burden among older adults significantly decreased in three states: 9% in Indiana (27.4% to 24.9%), 8% in Pennsylvania (32.1% to 29.5%) and 7% in Ohio (29.7% to 27.6%). During the same period, housing cost burden significantly increased 8% in Texas (29.0% to 31.3%). Housing cost burden was 2.1 times higher in California (40.5%) than West Virginia (19.1%) in 2021.

Food Insecurity

Food insecurity is a [socioeconomic condition](#) where access to food is limited or uncertain, and it differs from hunger, which is a physiological experience.¹⁷ Food-insecure older adults have [significantly reduced](#) intakes of vital nutrients and a higher prevalence of [health problems](#).^{18,19}

Changes over time. Nationally, the percentage of adults ages 60 and older who faced the threat of hunger in the past 12 months decreased 6% from 12.6% to 11.9% between 2019 and 2020 and 11% (from 13.3%) since 2018. Food insecurity decreased by 11% or more in 21 states between 2017-2018 and 2019-2020, led by 48% in Nevada (20.9% to 10.8%), 31% in Utah (10.7% to 7.4%) and 28% in both Kansas (15.5% to 11.2%) and New Mexico (18.8% to 13.5%). Over the same period, food insecurity increased by 11% or more in seven states, led by 39% in Kentucky (14.4% to 20.0%), 31% in Rhode Island (10.5% to 13.8%) and 27% in Wyoming (9.9% to 12.6%).

Disparities. Food insecurity was 3.3 times higher in Louisiana (21.0%) than New Hampshire (6.4%), the states with the highest and lowest rates in 2019-2020.

* The estimate for the highest group was not significantly different from the American Indian/Alaska Native and Hawaiian/Pacific Islander estimates, based on non-overlapping 95% confidence intervals.



Addressing Health Challenges Holistically through Senior Centers

Kathleen Cameron, BSPHarm, MPH

Senior Director, National Council on Aging Center for Healthy Aging (NCOA)

Early in my career as a community pharmacist, most of the clients at my counter were older adults. The stories I heard about their daily health challenges continue to motivate me today. While many measures of senior health have improved over the past decades, the *2023 Senior Report* demonstrates that gaps remain across a variety of interrelated areas. It is critical that we address the health of older adults through a holistic approach — not just in the clinical setting, but also in the home and the community.

In this year's *Senior Report*, we see a range of trends we need to address. For example, millions of seniors are at risk for social isolation, poverty and physical inactivity continue to rise and volunteerism has declined. When local and national leaders use the data in this report to promote real-world solutions, they should look to senior centers as places that can effectively address many of these concerning trends.

“It is critical that we address the health of older adults through a holistic approach.”

As a hub for nutritional, financial and social support and a delivery site for wellness programs, senior centers are uniquely suited to meet older adults' multifaceted needs. Senior centers can foster social connection and physical activity through activities like book clubs, dancing and poetry classes and volunteering, while also mitigating food insecurity — providing the only warm meal some older adults will receive all day — and helping older adults apply for federal, state and local [benefits](#) and assistance programs.

At the beginning of the pandemic, senior centers were forced to shut down the in-person versions of many of these services — but they did not stop supporting older adults through home-delivered meals and virtual programming, as well as COVID-19 vaccination efforts to help seniors get back to in-person participation. As the report's findings on early death imply, centers lost to COVID-19 many of the older adults they once served. But many also adapted to reach even more older adults who may not be able to visit centers in person due to disabilities or caregiver responsibilities.

A “senior center without walls” is one model to meet older adults where they are — in person, online and/or at home — and address these pressing threats more comprehensively. While [volunteers like Dianne Tucker](#) see seniors experiencing a “great sense of joy [to be back] at the center” in-person, we must build on the progress of the past few years, including the continued increase in high-speed internet, by offering hybrid programming and digital literacy lessons.

It's clear that the biggest issues this year's *Senior Report* shows, from socioeconomic challenges to behavioral health, are intertwined and can't be addressed by any one program or health professional. As we reimagine what “modern” senior care looks like going forward, we must empower senior centers to do what they do best and bring people together, from health providers and social workers to caregivers and volunteers, to tackle these health challenges holistically. By collaborating through senior centers and other channels, we can address the challenges we see in the data and improve well-being for all older Americans.

Community Support Expenditures

Most older adults [value living in their own home](#) safely and independently.²⁰ Since the Older Americans Act (OAA) of 1965, the [Administration on Aging](#) has provided funding to states for community, social and nutritional services that assist adults ages 60 and older and their caregivers.²¹ A 2013 study found that increases in home- and community-based services for older adults — such as home-delivered meals, congregate meals or senior centers — were associated with a [decrease in the proportion of low-care residents](#) in nursing homes.²²

Changes over time. Nationally, community support expenditures — dollars captured by the Administration on Aging per adult ages 60 and older — increased 5% from \$59 to \$62 between 2020 and 2021 and 9% (from \$57) since 2019. Community support expenditures increased by 5% or more in 22 states and the District of Columbia, led by 273% in North Carolina (\$37 to \$138 per adult ages 60 and older), 30% in Maine (\$30 to \$39) and 29% in Minnesota (\$24 to \$31). Over the same period, community support expenditures decreased by 5% or more in 14 states, led by 32% in South Carolina (\$25 to \$17), 30% in Idaho (\$27 to \$19) and 26% in Delaware (\$57 to \$42).

Disparities. The rate of community support expenditures per capita was 16.0 times higher in Massachusetts (\$272 per adult ages 60 and older) than South Carolina (\$17), the states with the highest and lowest rates in 2021. However, the highest rate was in the District of Columbia (\$338).

Related Measure: Home-Delivered Meals

Nationally, the number of adults ages 60 and older served an OAA-funded home-delivered meal per 100 adults ages 60 and older with independent living difficulty increased 79% from 8.9 to 15.9 between 2019 and 2021. The rate of home-delivered meals was 14.0 times higher in North Dakota (81.3 per 100 adults ages 60 and older with independent living difficulty) than Georgia (5.8), the states with the highest and lowest rates in 2021.

Related Measure: Senior Centers

Nationally, the number of senior centers receiving OAA Title III funds per 100,000 adults ages 60 and older decreased 5% from 6.4 to 6.1 between 2020 and 2021 and 23% (from 7.9) since 2019, meaning funds were diverted from senior centers to other programs like home-delivered meals. Senior centers receiving OAA



9% ▲

increase in **community support expenditures** from \$57 to \$62 between 2019 and 2021.



79% ▲

increase in **home-delivered meals** from 8.9 to 15.9 between 2019 and 2021.



23% ▼

decrease in **senior centers** receiving OAA Title III funds from 7.9 to 6.1 between 2019 and 2021.

Source: U.S. HHS, Administration for Community Living, State Program Reports, 2019, 2021.



45.3M

households with adults ages 65 and older had high-speed internet in 2021.

Source: U.S. Census Bureau, American Community Survey, 2021.

High-Speed Internet Access

1.2x

higher in Utah (88.6%) than Mississippi (72.5%) in 2021.

Source: U.S. Census Bureau, American Community Survey, 2021.

funds decreased by 5% or more in 17 states, led by 98% in New Jersey (5.4 to 0.1 per 100,000 adults ages 60 and older), 48% in Iowa (14.5 to 7.6) and 43% in Hawaii (1.4 to 0.8). Over the same period, senior centers receiving OAA funds increased by 5% or more in seven states, led by 263% in Rhode Island (3.0 to 10.9), 122% in Oklahoma (9.8 to 21.8) and 87% in Massachusetts (4.6 to 8.6). The rate of senior centers receiving OAA funds was highest in Wyoming (45.1) and lowest in Delaware, Kansas, Montana, New Hampshire, North Dakota and West Virginia (all zero), the states with the highest and lowest rates in 2021.

High-Speed Internet

High-speed internet is an [important resource](#) for work, education and effective communication.²³ Many essential activities and services require an internet connection, including [telemedicine](#) and [telehealth](#), which became [increasingly common](#) during the COVID-19 pandemic.²⁴⁻²⁶

Changes over time. Nationally, the percentage of households with adults ages 65 and older that had a broadband internet subscription and a computer, smartphone or tablet significantly increased 7% from 78.0% to 83.1% between 2019 and 2021. In 2021 this corresponded to nearly 45.3 million households. Between 2019 and 2021, high-speed internet access significantly increased in 46 states, led by 14% in Mississippi (63.8% to 72.5%) and 10% in North Dakota (71.6% to 79.1%), New Mexico (70.8% to 78.2%), Maine (76.6% to 84.2%) and Iowa (72.3% to 79.3%).

Disparities. High-speed internet access was 1.2 times higher in Utah (88.6%) than Mississippi (72.5%), the states with the highest and lowest rates in 2021.

Risk of Social Isolation

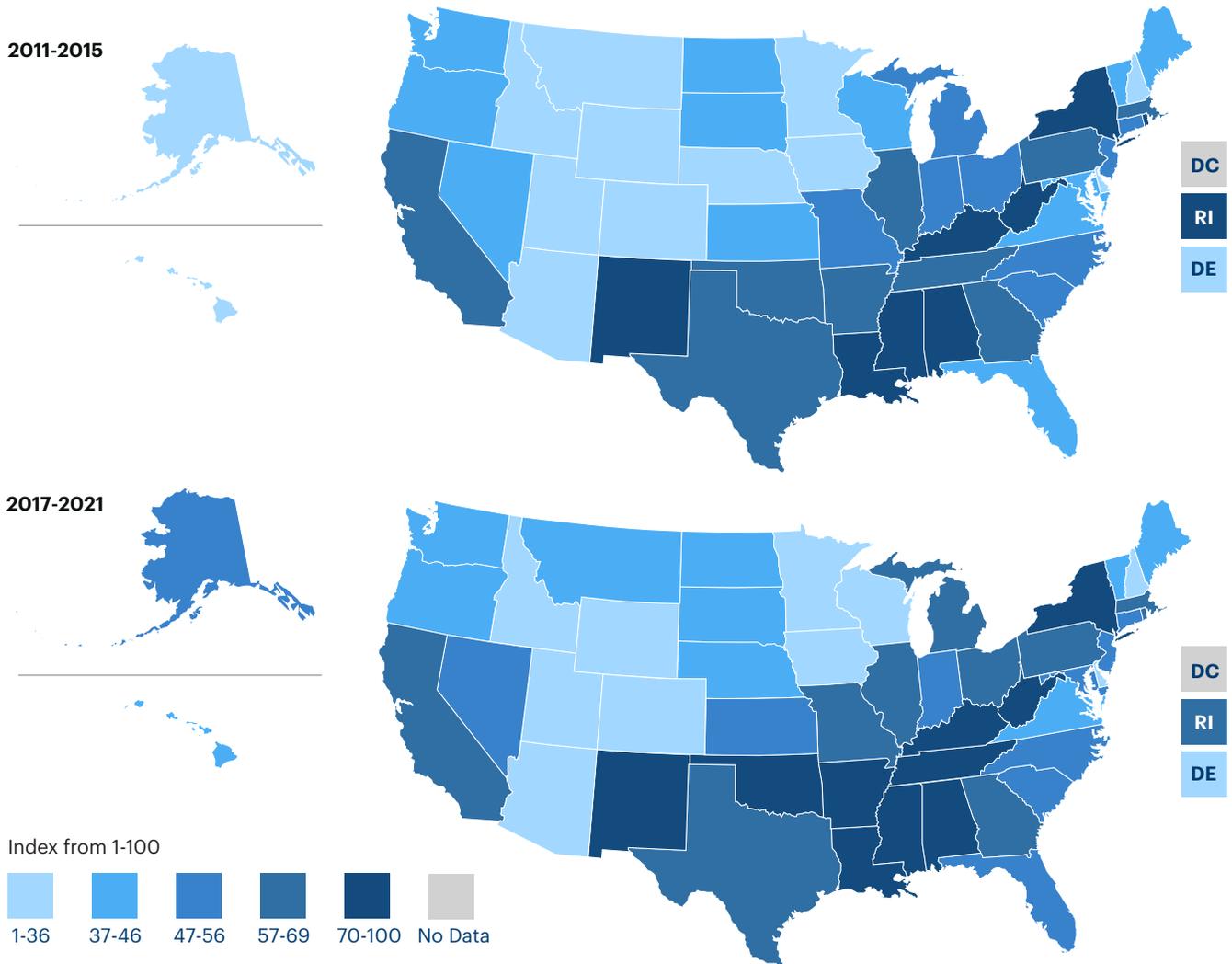
Some [research](#) has found that the percentage of adults ages 50-80 who felt isolated from others some of the time has largely improved from the height of the pandemic in 2020 but still exceeds pre-pandemic 2018 rates.²⁷ Socially isolated older adults are left further vulnerable as they go through stressful life events common to aging, such as losing a close friend or family member, or changing or losing a familiar role (i.e., retiring), without the [buffering effects of social support](#).²⁸

Risk of social isolation is an index of these social isolation risk factors: poverty; living alone; divorced, separated

or widowed; never married; disability; and independent living difficulty. This index is normalized on a scale of 1 to 100, with a higher value indicating greater risk among adults ages 65 and older. Risk of social isolation was highest in Mississippi (100) and lowest in Utah (1) in 2017-2021. Nationally, the most common risk factors were being divorced, separated or widowed (38.2%), living alone (37.0%) and having a disability (33.4%). The least common risk factor was having never married (6.1%). County-level risk of social isolation maps are available for download on the *America's Health Rankings* website.

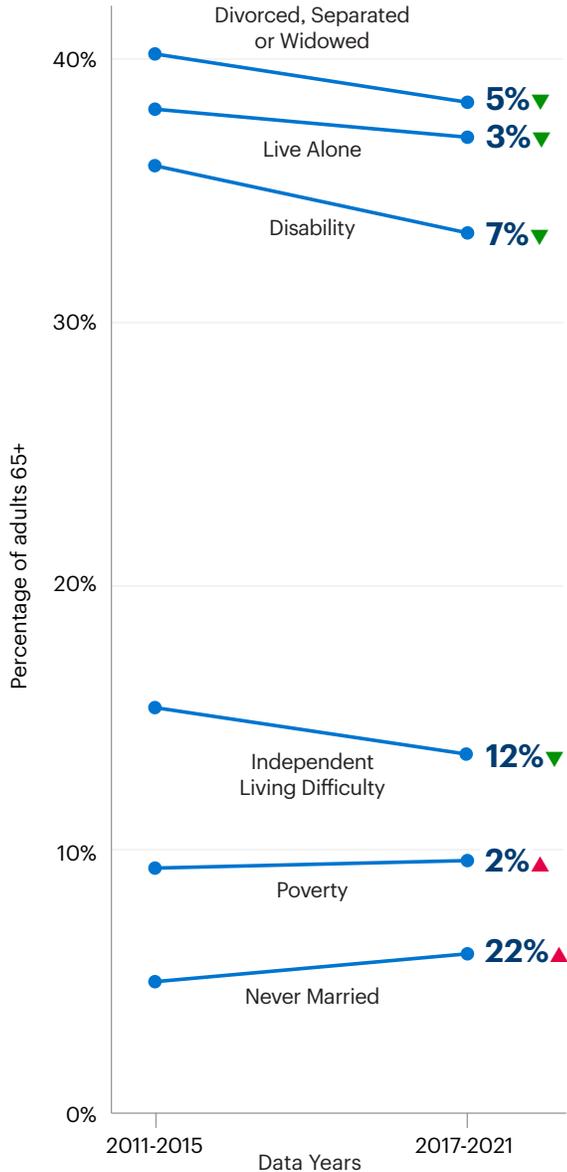
Risk of Social Isolation by State, 2011-2015 and 2017-2021

The pattern of high risk of social isolation is distinct and consistent across years.



Source: U.S. Census Bureau, American Community Survey, 2011-2015, 2017-2021.

Changes in Social Isolation Risk Factors



Source: U.S. Census Bureau, American Community Survey, 2011-2015, 2017-2021.

Changes over time. Nationally, the majority of risk factors for social isolation have significantly improved between 2011-2015 and 2017-2021:

- Independent living difficulty decreased 12% from 15.5% to 13.6%; however, the absolute number increased from 6.7 to 7.0 million older adults.
- Disability decreased 7% from 36.0% to 33.4%; however, the absolute number increased from 15.6 to 17.2 million older adults.
- Being divorced, separated or widowed decreased 5% from 40.2% to 38.2%; however, the absolute number increased from 17.9 to 20.2 million older adults.
- Living alone decreased 3% from 38.0% to 37.0%; however, the absolute number increased from 11.9 to 13.9 million older adults.

Over the same period, having never married significantly increased 22% from 5.0% to 6.1% and from 2.2 to 3.2 million older adults.

Volunteerism

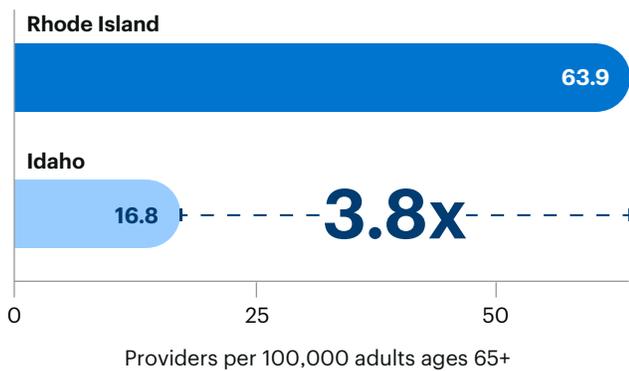
Volunteering provides a service for communities and organizations. For volunteers, it can offer [positive social interactions](#), a greater level of social support and a sense of [meaning and purpose](#).^{29,30} Volunteering also allows older adults to learn new things, promoting [cognitive function](#).³¹

Changes over time. Nationally, the percentage of adults ages 65 and older who reported volunteering in the past 12 months decreased 22% from 28.5% to 22.1% between 2019 and 2021. Volunteerism decreased by 22% or more in 22 states, led by 45% in Louisiana (26.6% to 14.7%), 39% in Alabama (27.6% to 16.9%) and 38% in Georgia (28.2% to 17.4%).

Disparities. Volunteerism was 3.0 times higher in Utah (44.2%) than Louisiana (14.7%), the states with the highest and lowest percentages in 2021.

Geriatric Providers

The rate of geriatric providers was highest in Rhode Island and lowest in Idaho.



Source: U.S. HHS, Centers for Medicare & Medicaid Services, National Plan and Provider Enumeration System, September 2022.

CLINICAL CARE | ACCESS TO CARE

Geriatric Providers

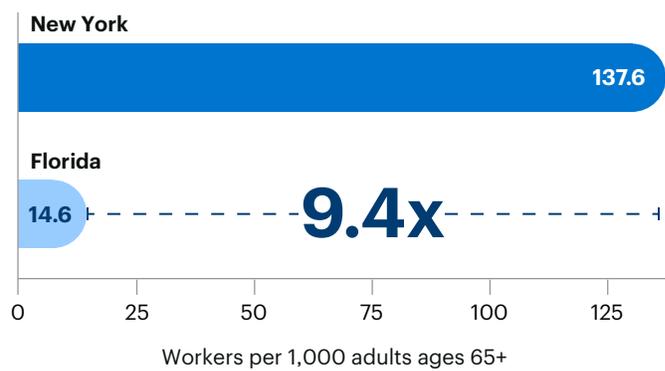
Geriatricians and geriatric nurse practitioners are [specially](#) trained to meet the unique needs of older adults.³² Specialized care can be helpful when an older person is coping with multiple chronic conditions or managing multiple medications, as some drugs may negatively interact with others or have side effects that impact well-being.

Changes over time. Nationally, the number of family medicine and internal medicine geriatricians and nurse practitioners per 100,000 adults ages 65 and older increased 8% from 33.8 to 36.4 between 2021 and 2022, and 26% (from 29.0) since 2018. There were 20,344 geriatric providers in 2022, an increase of 1,553 providers since 2021. Between 2021 and 2022, the rate of geriatric providers increased by 8% or more in 23 states and the District of Columbia, led by 67% in North Dakota (13.0 to 21.7 providers per 100,000 adults ages 65 and older), 21% in Oklahoma (17.9 to 21.7) and 18% in South Dakota (14.6 to 17.3).

Disparities. The rate of geriatric providers was 3.8 times higher in Rhode Island (63.9 providers per 100,000 adults ages 65) than Idaho (16.8), the states with the highest and lowest rates in 2022. However, the highest rate was in the District of Columbia (90.9).

Home Health Care Workers

The rate of home health care workers was highest in New York and lowest in Florida.



Source: U.S. Department of Labor, Bureau of Labor Statistics, 2021.

Home Health Care Workers

[Home health](#) and [personal care](#) aides enable older adults to remain in their homes as they age.^{33,34} These aides [provide](#) short-term skilled nursing services, such as aiding in recovery from surgery, as well as long-term care for those with disabilities, functional decline or chronic illness.³⁵ There is currently a [shortage](#) of these workers in many communities and the need is expected to increase.³⁶ The Bureau of Labor Statistics [projects](#) employment of home health and personal care aides will grow by 25% between 2021 and 2031.³⁷

Changes over time. Nationally, the number of personal care and home health aides per 1,000 adults ages 65 and older increased 5% from 57.7 to 60.3 between 2020 and 2021, and 29% (from 46.9) since 2016. In 2021 there were nearly 3.4 million home health care workers, an increase of 154,890 since 2020. Between 2020 and 2021, the rate of home health care workers increased by 5% or more in 18 states, led by 24% in New Jersey (37.5 to 46.4 workers per 1,000 adults ages 65 and older), 20% in California (100.0 to 120.4) and 15% in both Michigan (37.8 to 43.4) and Rhode Island (36.2 to 41.8). Over the same period, the rate decreased by 5% or more in 14 states, led by 29% in both Hawaii (32.8 to 23.4) and Vermont (56.5 to 40.3) and 15% in Maryland (33.1 to 28.0).

Disparities. The rate of home health care workers was 9.4 times higher in New York (137.6 workers per 1,000 adults ages 65 and older) than Florida (14.6), the states with the highest and lowest rates in 2021.



CLINICAL CARE | QUALITY OF CARE

Hospice Care

While standard medical care may focus on finding a cure, hospice care emphasizes [pain control and emotional support](#) for patients and their families.³⁸ Hospice care is provided in a patient's home — where most individuals [prefer to die](#) — or in a freestanding hospice facility, hospital or long-term care facility.³⁹

Changes over time. Nationally, the percentage of Medicare decedents who were in hospice at time of death decreased 8% from 50.7% to 46.7% between 2018 and 2020. Hospice care decreased by 8% or more in nine states and the District of Columbia, led

by 22% in the District of Columbia (33.2% to 25.8%), 18% in New York (30.0% to 24.7%), 13% in both Delaware (59.4% to 51.9%) and New Jersey (45.6% to 39.5%) and 11% in Rhode Island (57.5% to 51.2%). Over the same period, hospice care increased 32% in Alaska (22.8% to 30.1%); other states had increases but none equal to or greater than the national change.

Disparities. Hospice care was 2.5 times higher in Utah (60.7%) than New York (24.7%), the states with the highest and lowest percentages in 2020.

COVID Measures:

As of February 2023, 94.3% of adults ages 65 and older had completed a primary COVID-19 vaccination series, and 41.3% had received a bivalent booster dose; booster vaccination in this population doubled between October 2022 and February 2023. Roughly a quarter of older adults who had COVID-19, however, experienced symptoms consistent with long COVID. By age group, the prevalence of long COVID was 28.5% among those ages 60-69, 21.9% among those ages 70-79 and 24.5% among those ages 80 and older.

Physical Inactivity

Physical inactivity, or living a sedentary lifestyle, can increase the risk of several negative health outcomes, such as [cardiovascular disease](#), [cancer](#), [cancer mortality](#), Type 2 [diabetes](#) and [premature death](#).⁴⁰⁻⁴⁴ Around 10% of deaths among adults ages 40-69 and 7.8% of deaths among adults ages 70 and older can be attributed to physical inactivity.

Changes over time. Nationally, the percentage of adults ages 65 and older in fair or better health who reported doing no physical activity or exercise other than their regular job in the past 30 days significantly increased 6% from 29.4% to 31.2% between 2018 and 2021. Physical inactivity significantly increased in five states, led by 23% in both Alabama (33.7% to 41.3%) and Maine (28.6% to 35.1%) and 18% in West Virginia (34.7% to 41.0%). Some income, gender and racial/ethnic groups experienced significant increases in physical inactivity, including 12% among older adults with a household income of \$25,000-\$49,999 (31.7% to 35.5%), 8% among those with a household income less than \$25,000 (40.3% to 43.6%), 6% among females (32.2% to 34.1%) and 5% among white older adults (28.6% to 30.0%).

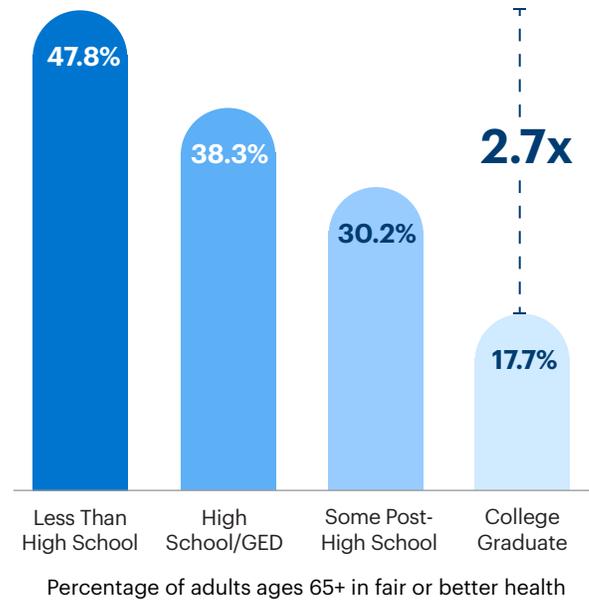
Disparities. Physical inactivity was 1.9 times higher in Alabama (41.3%) than Colorado (21.4%), the states with the highest and lowest percentages in 2021. Physical inactivity varied significantly by education, income, race/ethnicity, gender and metropolitan status. The prevalence was:

- 2.7 times higher among older adults with less than a high school education (47.8%) than college graduates (17.7%).
- 2.4 times higher among older adults with a household income less than \$25,000 (43.6%) than those with an income of \$75,000 or more (18.0%).
- 1.9 times higher among Hispanic (39.2%) compared with Asian (20.6%) older adults. American Indian/Alaska Native (38.9%), Black (37.0%) and other race (34.1%) older adults also had a high prevalence, and multiracial older adults (25.2%) also had a lower prevalence.*
- 1.2 times higher among females (34.1%) compared with males (27.7%).
- 1.2 times higher among older adults living in non-metropolitan (35.4%) than metropolitan (30.0%) areas.

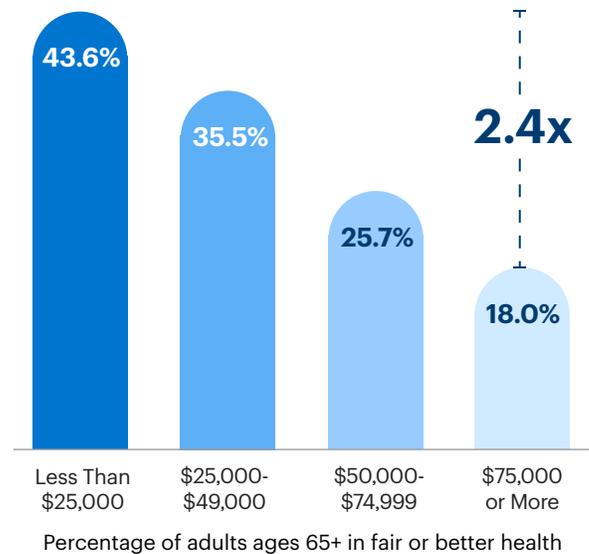
* Estimates for the four highest and two lowest groups were not significantly different from each other, respectively, based on non-overlapping 95% confidence intervals. The prevalence among Hawaiian/Pacific Islander older adults (33.7%) did not significantly differ from the highest or the lowest group.

Disparities in Physical Inactivity by Education and Income

Education



Income



Source: CDC, Behavioral Risk Factor Surveillance System, 2021.

State Rankings

Rankings included in this year's *Senior Report* are derived from 35 measures across five categories of health: social and economic factors, physical environment, behaviors, clinical care and health outcomes. For a more detailed description of how the overall rank is calculated, visit the *America's Health Rankings* [Methodology](#) page.

Utah Ranks No. 1

Utah is the healthiest state for older adults. It ranks in the top quintile across social and economic factors (No. 1), clinical care (No. 9), behaviors (No. 3) and health outcomes (No. 9).

Strengths: Low poverty rate, high volunteerism rate and high hospice care use.

Challenges: High suicide rate, low geriatric provider rate and low percentage of older adults with a dedicated health care provider.

The five healthiest states for older adults are Utah, New Hampshire, Colorado, Minnesota and Vermont.

Mississippi Ranks No. 50

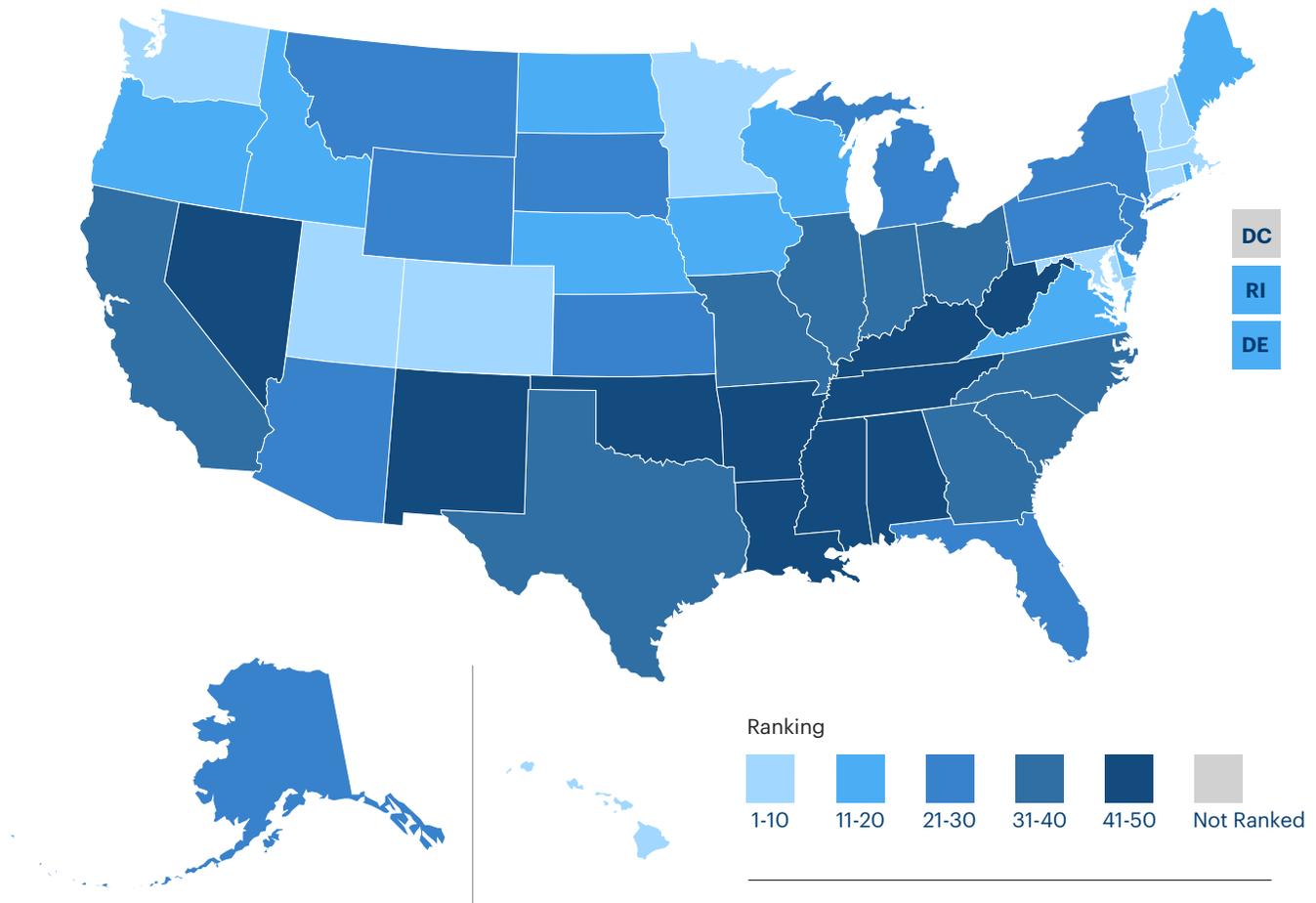
Mississippi is the least healthy state for older adults. It ranks in the bottom quintile across all model categories: social and economic factors (No. 50), physical environment (No. 42), clinical care (No. 49), behaviors (No. 47) and health outcomes (No. 43).

Strengths: Low prevalence of frequent mental distress, low prevalence of excessive drinking and low prevalence of severe housing problems.

Challenges: High early death rate, high poverty rate and high prevalence of food insecurity.

The five states with the most room to improve are Mississippi, Louisiana, Kentucky, West Virginia and Oklahoma.

2023 Senior Report State Rankings



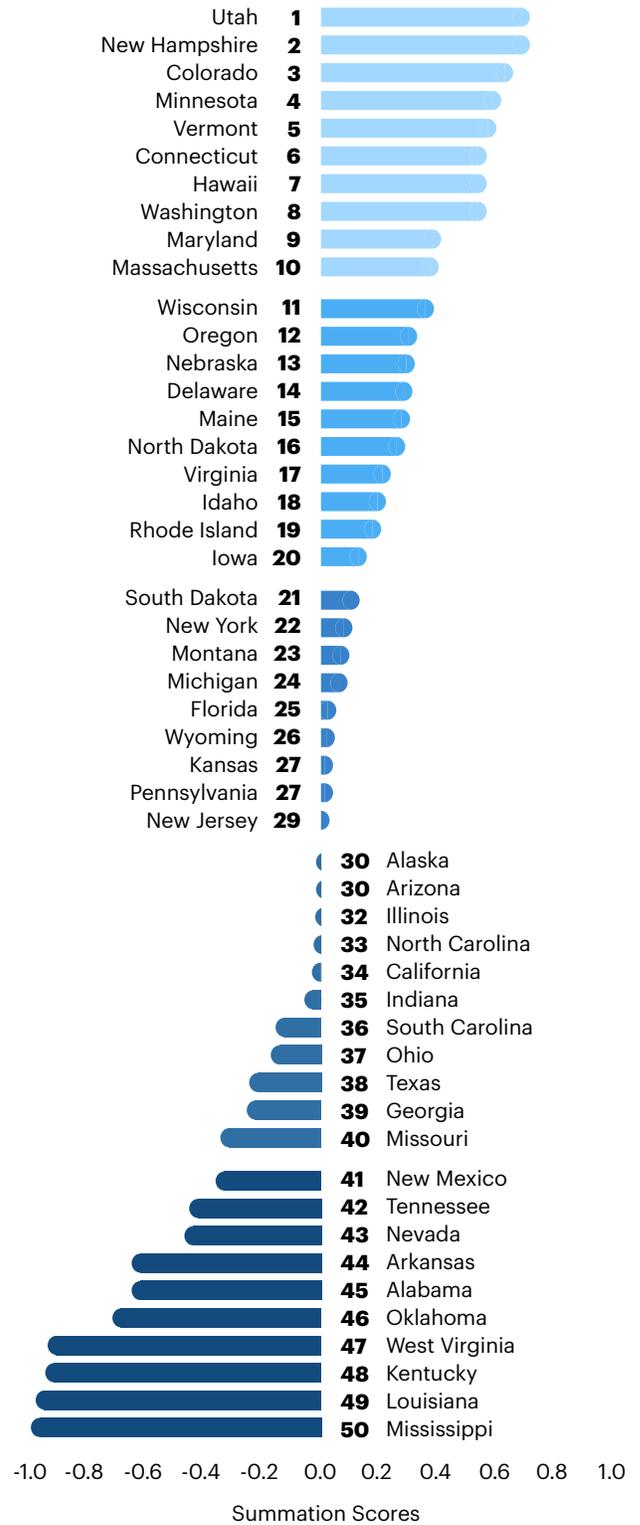
Source: *America's Health Rankings* composite measure, 2023.

Measure Impact

This graph displays the state scores in order of rank from healthiest to least healthy. The difference between the lengths of the bars indicates the difference between state scores. For example, Oklahoma (No. 46) and West Virginia (No. 47) have a large difference in score, making it more of a challenge for West Virginia to move up in the rankings. There is also a large gap in score between Nevada (No. 43) and Arkansas (No. 44).

To further explore state-level data, see [Explore Data](#). The website features downloadable State Summaries for each state as well as the District of Columbia. Each summary describes state-specific strengths, challenges, trends and rankings for individual measures, allowing users to identify which measures positively or negatively influenced their state’s overall rank. This can be visualized by selecting a state in the Explore Data section. The website also features an Adjust My Rank tool that allows users to explore how progress and challenges across key measures can impact a state’s overall rank.

2023 Senior Report State Rankings and Scores*



Source: America’s Health Rankings composite measure, 2023.

*Sum of weighted z-scores of all ranked measures

United States

Health Department Website: hhs.gov

Summary

Highlights

Drug Deaths

43% 

from 6.9 to 9.9 deaths per 100,000 adults ages 65+ between 2016-2018 and 2019-2021.

Geriatric Providers

16% 

from 31.4 to 36.4 per 100,000 adults ages 65+ between September 2019 and September 2022.

Multiple Chronic Conditions

13% 

from 46% to 52% of Medicare beneficiaries ages 65+ between 2020 and 2021.

Poverty

10% 

from 9.4% to 10.3% of adults ages 65+ between 2019 and 2021.

High-Speed Internet

7% 

from 78.0% to 83.1% of households with adults ages 65+ between 2019 and 2021.

Food Insecurity

6% 

from 12.6% to 11.9% of adults ages 60+ between 2019 and 2020.

Measures

		U.S. Value
Social & Economic Factors*		
Community and Family Safety	Firearm Deaths (deaths per 100,000 adults ages 65+)*	13.1
	Motor Vehicle Deaths (deaths per 100,000 adults ages 65+)*	11.8
Economic Resources	Food Insecurity (% of adults ages 60+)	11.9%
	Poverty (% of adults ages 65+)	10.3%
	SNAP Reach (participants per 100 adults ages 60+ in poverty)	81.0
Social Support and Engagement	Community Support Expenditures (dollars per adult ages 60+)	\$62
	High-speed Internet (% of households with adults ages 65+)	83.1%
	Low-care Nursing Home Residents (% of residents)	15.2%
	Risk of Social Isolation (index from 1-100, adults ages 65+)	—
	Volunteerism (% of adults ages 65+)	22.1%
Physical Environment*		
Air and Water Quality	Air Pollution (micrograms of fine particles per cubic meter)	7.8
	Drinking Water Violations (% of community water systems)	0.8%
Housing	Housing Cost Burden (% of households with adults ages 65+)*	31.8%
	Severe Housing Problems (% of small households with adults ages 62+)	32.3%
Clinical Care*		
Access to Care	Avoided Care Due to Cost (% of adults ages 65+)	3.4%
	Geriatric Providers (providers per 100,000 adults ages 65+)	36.4
	Home Health Care Workers (workers per 1,000 adults ages 65+)	60.3
Preventive Clinical Services	Cancer Screenings (% of adults ages 65-75)	75.9%
	Flu Vaccination (% of adults ages 65+)	67.5%
	Pneumonia Vaccination (% of adults ages 65+)	69.7%
Quality of Care	Dedicated Health Care Provider (% of adults ages 65+)	96.1%
	Hospice Care (% of Medicare decedents)	46.7%
	Nursing Home Quality (% of beds rated four or five stars)	32.6%
	Preventable Hospitalizations (discharges per 100,000 Medicare beneficiaries ages 65-74)	1,482
Behaviors*		
Nutrition and Physical Activity	Exercise (% of adults ages 65+)	23.1%
	Fruit and Vegetable Consumption (% of adults ages 65+)	7.3%
	Physical Inactivity (% of adults ages 65+ in fair or better health)	31.2%
Sleep Health	Insufficient Sleep (% of adults ages 65+)	26.0%
Tobacco Use	Smoking (% of adults ages 65+)	8.9%
Health Outcomes*		
Behavioral Health	Cognitive Difficulty (% of adults ages 65+)*	7.8%
	Drug Deaths (deaths per 100,000 adults ages 65+)*	9.9
	Excessive Drinking (% of adults ages 65+)	7.0%
	Frequent Mental Distress (% of adults ages 65+)	8.5%
	Suicide (deaths per 100,000 adults ages 65+)	16.9
Mortality	Early Death (deaths per 100,000 adults ages 65-74)	2,151
	Early Death Racial Disparity (ratio)**†	1.5
Physical Health	Falls (% of adults ages 65+)	27.1%
	Frequent Physical Distress (% of adults ages 65+)	15.8%
	Multiple Chronic Conditions (% of Medicare beneficiaries ages 65-74)	52%
	Obesity (% of adults ages 65+)	29.5%
	Teeth Extractions (% of adults ages 65+)	13.4%

* Value is a sum of weighted, ranking measure z-scores (the number of standard deviations a state value was above or below the U.S. value). Higher summation scores are better. Scores are not calculated for the District of Columbia.

** Disparity measures compare the group with the highest or lowest rate to the white rate.

† Non-ranking measure.

— Data not available, missing or suppressed.

For measure descriptions, source details and methodology, visit AmericasHealthRankings.org.

Ranks are calculated by state for each measure, ordered by the states' values, with 1 corresponding to the healthiest value and 50 the least healthy value. Ties in value are assigned equal ranks.

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