

# Senior Report 2022



# Contents

<b>Introduction</b>	2
<b>10-Year National Highlights</b>	6
<b>Findings</b>	
Mortality	7
Behavioral Health	10
Physical Health	15
Immunizations	20
Smoking and Tobacco Use	22
Social Support and Engagement	23
<b>State Rankings</b>	25
<b>National Summary</b>	27
<b>References</b>	28

# Introduction

The 10th edition of the *America's Health Rankings® Senior Report* reviews decade-long trends and provides insight into the preliminary effects of the COVID-19 pandemic on seniors' health and well-being. The majority of measures included in this report feature data from 2020 or later.

The United Health Foundation is proud to release the 10th edition of the *America's Health Rankings Senior Report*, which provides a portrait of the health and well-being of older adults in the United States. The report features long-term trends and disparities across demographic subpopulations in order to spark meaningful dialogue and action to improve senior health across the nation and on a state-by-state basis.

The 2022 *Senior Report* highlights 10 years of successes and challenges in the health and well-being of older adults. While self-reported health status and use of preventive services such as flu vaccinations improved over the past decade, behavioral health measures such as drug deaths, excessive drinking, frequent mental distress, depression and suicide have worsened. Further, a decade of progress in reducing early mortality stopped with the COVID-19 pandemic — disproportionately impacting older Americans of color.

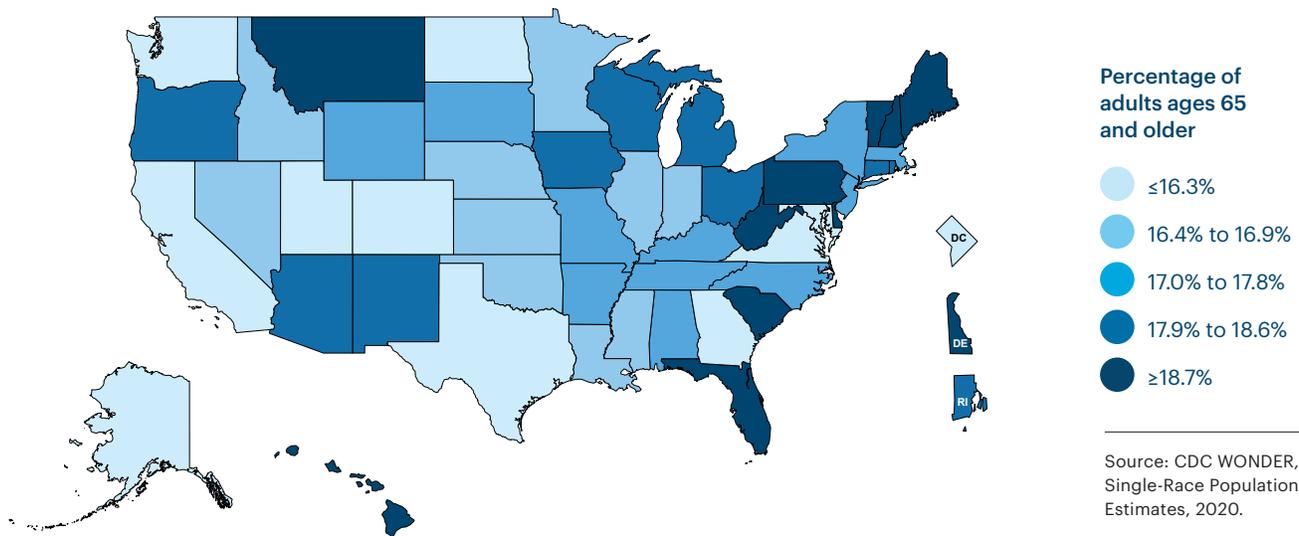
In 2020, there were more than 55.6 million adults ages 65 and older in the United States, making up approximately 16.9% of the population. This number is expected to rise to 73.1 million, or 21% of the population, by 2030 when the last of the baby boomer generation ages into older adulthood.<sup>1</sup> At that point, more than 1 in 5 people in the U.S. will be of retirement age. Thus, it is essential that policymakers, community leaders and public health officials consider how to best safeguard

and improve the health of older Americans. As the demographic makeup of the nation's older adult population continues to change, the United Health Foundation is committed to providing actionable data and insights on the health needs of older Americans.

While the older adult population is growing across the nation, they comprise a much larger share of the population in some states than in others. In 2020, Maine had the highest proportion of adults ages 65 and older (21.8%) and Utah had the lowest (11.7%). No matter the size of the senior population, strengths, challenges and disparities are present in every state, demonstrated by the findings in this report. It is important to consider the measures collectively, as each measure influences and is influenced by other measures of health as well as factors that affect seniors' everyday lives.

This year's *Senior Report* includes overall state rankings once again; rankings were excluded in 2020 and 2021 out of the shared understanding that the country is facing significant and unprecedented health challenges due to the COVID-19 pandemic. Community leaders and advocates can use this year's report to tailor and target public health efforts in their states to address issues caused or exacerbated by the pandemic and, ultimately, build healthier communities.

## Maine, Florida and West Virginia had the highest percentage of older adults in 2020.



## 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:

- **Sixty-two measures.** These include 37 ranking, 14 non-ranking and 11 subcomponent measures.
- **Five categories of health.** These include health outcomes and four categories that are determinants of health: social and economic factors, physical environment, behaviors and clinical care.
- **Twenty-one data sources.** The data included in this report are from many different sources, including the Centers for Disease Control and Prevention's (CDC) Behavioral Risk Factor Surveillance System and the Centers for Medicare & Medicaid Services' (CMS) Mapping Medicare Disparities Tool.

**While the older adult population is growing across the nation, they comprise a much larger share of the population in some states than in others.**



## Improving All Seniors' Connectedness Helps Us Thrive

Lisa Marsh Ryerson, President AARP Foundation

As someone who works with older adults, I believe it is good news that [10,000 Americans turn 65 each day](#). Older adults are living longer, healthier and more productive lives. They are a wonderful resource, contributing talent, wisdom and enormous economic value to our society.

As this report shows, we have made significant progress over the past decade towards improving senior health. However, over the past two years, older adults have lost some ground as the COVID-19 pandemic laid bare significant health inequities and the growing public health crisis of social isolation.

In many ways, the *Senior Report* reminds us of what we all already know: that who gets care, who gets sick and who dies is rooted in where we are born and raised, where we go to school, where we work and live, our race, ethnicity, gender and socioeconomic status. This is especially true during a pandemic in which longstanding inequities caused by systemic racism and discrimination are important determinants of health. Meanwhile, necessary interventions aimed at slowing the virus's spread have highlighted the importance of social connection among older adults and others and the growing public health crisis of social isolation.

Unsurprisingly, a 2020 [survey](#) by AARP Foundation and the United Health Foundation found sharp increases across age cohorts in feelings of social isolation and anxiety. It confirmed the importance of person centric approach to health that includes increasing awareness of social isolation and the solutions to combat it. AARP Foundation's [Connect2Affect](#), a consumer facing assessment tool can help by allowing older adults, their caregivers and loved ones to assess if an older adult is socially isolated. If they are, Connect2Affect

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Our communities are healthiest when everyone is a full member, with the voice, power and opportunity to contribute to their fullest potential.

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connects them to resources and support in their own communities, both increasing awareness of social isolation and lifting up possible solutions at the individual and community levels.

Social isolation has been a longstanding public health issue for older adults but with the advent of the COVID-19 pandemic, awareness of the problem has skyrocketed. We know that community engagement and digital access can increase older adults' well-being. The *Senior Report* reminds us that we should focus our talents, expertise and investments on solutions that address barriers to social connection.

To make progress in improving senior health, we must recognize that older adults are a resource to be tapped, not a problem to be solved. Our communities are healthiest when everyone is a full member, with the voice, power and opportunity to contribute to their fullest potential. With the data in the *Senior Report*, and the solutions that AARP Foundation and countless other organizations are working towards, we can strengthen the connections between older adults and their communities. By learning from their experiences and drawing on their wisdom, we will create a healthier America. Because, when older adults thrive, we all do.

# 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.

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. This reflects a growing understanding of the impact of social determinants on health.
- **Providing a benchmark for states.** Each year the report presents trends, strengths, challenges and highlights for every state. Using the 10 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 the state and national level, with groupings based on geography, education level, income level, gender, age, and race and ethnicity. These analyses often reveal differences among groups that national or state aggregate data may mask.

## 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."



# 10-Year National Highlights

## Successes

PHYSICAL HEALTH

High health status

**13%** ▲

from 38.4% to 43.5% of adults ages 65 and older between 2011 and 2020.

Source: CDC, Behavioral Risk Factor Surveillance System, 2011, 2020.

PHYSICAL HEALTH

Teeth extractions

**17%** ▼

from 16.1% to 13.4% of adults ages 65 and older between 2012 and 2020.

Source: CDC, Behavioral Risk Factor Surveillance System, 2012, 2020.

IMMUNIZATIONS

Flu vaccination

**11%** ▲

from 60.6% to 67.3% of adults ages 65 and older between 2011 and 2020.

Source: CDC, Behavioral Risk Factor Surveillance System, 2011, 2020.

## Challenges

MORTALITY

Early death

**17%** ▲

from 1,765 to 2,072 deaths per 100,000 adults ages 65-74 between 2019 and 2020 following a 4% decrease between 2011 and 2019.

Source: CDC WONDER, Multiple Cause of Death Files, 2011, 2019, 2020.

BEHAVIORAL HEALTH

Drug deaths

**100%** ▲

from 4.2 to 8.4 deaths per 100,000 adults ages 65 and older between 2008-2010 and 2018-2020.

Source: CDC WONDER, Multiple Cause of Death Files, 2008-2010, 2018-2020.

BEHAVIORAL HEALTH

Frequent mental distress

**8%** ▲

from 7.5% to 8.1% of adults ages 65 and older between 2011 and 2020.

Source: CDC, Behavioral Risk Factor Surveillance System, 2011, 2020.

BEHAVIORAL HEALTH

Depression

**9%** ▲

from 13.0% to 14.2% of adults ages 65 and older between 2011 and 2020.

Source: CDC, Behavioral Risk Factor Surveillance System, 2011, 2020.

BEHAVIORAL HEALTH

Excessive drinking

**16%** ▲

from 6.4% to 7.4% of adults ages 65 and older between 2011 and 2020.

Source: CDC, Behavioral Risk Factor Surveillance System, 2011, 2020.

BEHAVIORAL HEALTH

Suicide

**13%** ▲

from 15.0 to 16.9 deaths per 100,000 adults ages 65 and older between 2009-2011 and 2018-2020.

Source: CDC WONDER, Multiple Cause of Death Files, 2009-2011, 2018-2020.

PHYSICAL HEALTH

Obesity

**16%** ▲

from 25.3% to 29.3% of adults ages 65 and older between 2011 and 2020.

Source: CDC, Behavioral Risk Factor Surveillance System, 2011, 2020.

SMOKING AND TOBACCO USE

Smoking

◀ **unchanged** ▶

8.9% of adults ages 65 and older reported smoking in 2011 and in 2020.

Source: CDC, Behavioral Risk Factor Surveillance System, 2011, 2020.

# Findings

## MORTALITY

After almost a decade of improvement, the early death rate among adults ages 65-74 increased dramatically during the first year of the COVID-19 pandemic, disproportionately affecting older Americans of color.

### Early Death

Those who are 65 should expect to live another 18.5 years, down 1.1 years from 2019, according to 2020 life expectancy estimates.<sup>2</sup> Yet while the death rate among adults ages 65-74 — considered an early death — decreased steadily over the last decade, there was a sudden, significant increase between 2019 and 2020, and much of this increase was attributed to the COVID-19 pandemic. COVID-19 became a new top-10 cause of death in 2020 and the third-leading cause of death among older adults, causing 76,277 deaths.<sup>3</sup> There were also more deaths from cancer, heart disease, diabetes, stroke, unintentional injury, liver disease, kidney disease and influenza/pneumonia in this age group in 2020 compared with 2019.<sup>3</sup> The early death rate may continue to grow, as provisional death data revealed that more deaths due to COVID-19 occurred in 2021 than in 2020.<sup>4</sup>

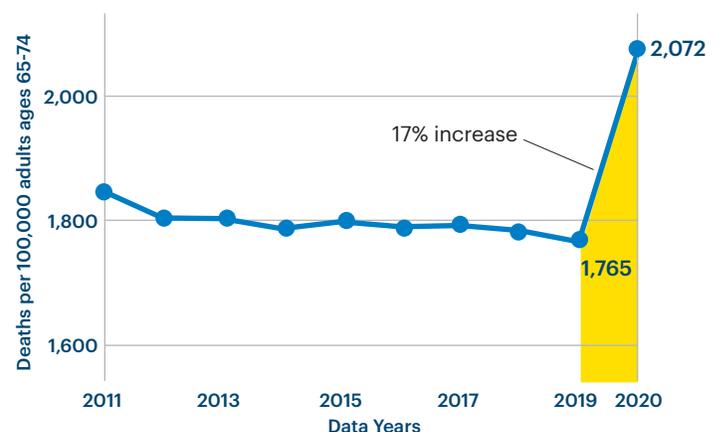
#### Between 2019 and 2020

Nationally, the number of deaths per 100,000 adults ages 65-74 significantly increased 17% from 1,765 to 2,072, corresponding to an increase of 118,948 deaths over this time. This followed a 4% decrease between 2011 and 2019. The early death rate significantly increased in 45 states and the District of Columbia, led by: 34% in the District of Columbia (1,932 to 2,593 deaths per 100,000 adults ages 65-74), 33% in New York (1,528 to 2,026), 30% in New Jersey (1,562 to 2,036) and 23% in both Arizona (1,591 to 1,962) and Louisiana (2,184 to 2,691).

All racial/ethnic and gender subpopulations experienced significant increases in the early death rate. Increases greater than the national change included: 48% among Hispanic (1,323 to 1,955 deaths per 100,000 adults ages 65-74), 32% among American

#### 10-YEAR HIGHLIGHT

**Early deaths increased sharply from 2019 to 2020, after decreasing since 2011.**



Source: CDC WONDER, Multiple Cause of Death Files, 2011-2020.

Indian/Alaska Native (1,925 to 2,548), 31% among Asian (832 to 1,094), 29% among Black (2,477 to 3,184) and 19% among multiracial (848 to 1,005) adults, as well as 18% among males (2,179 to 2,582).

#### Disparities in 2020

The COVID-19 pandemic disproportionately affected some people of color, with American Indian/Alaska Native and Black populations experiencing much higher COVID-19 mortality rates compared with non-Hispanic white and Asian populations.<sup>5</sup> According



## To Combat Health Disparities for Older Adults and Communities of Color, We Must Start with Data

Sue Peschin, MHS, President & CEO, Alliance for Aging Research

Addressing health disparities across race, ethnicity, and age has long been central to our work at the Alliance for Aging Research. The COVID-19 pandemic disproportionately impacted older adults and communities of color and has further highlighted the urgency of advancing health equity. As the data in the *Senior Report* show, the toll of the pandemic significantly increased mortality and drove down life expectancy for older adults, particularly in communities of color. While early death increased 17% nationally between 2019 and 2020, rates rose much more significantly among populations of color, including 48% among Hispanic, 32% among American Indian/Alaska Native, 31% among Asian and 29% among Black adults ages 65-74. Meanwhile, many other challenges including “deaths of despair” (i.e., drug overdoses, suicide, and alcoholic liver disease) were aggravated by the pandemic, underscoring the trade-offs inherent to policies that have an isolating effect on older adults.

As we seek to understand and address these longstanding challenges and disparities, it is critical to examine negative social determinants of health and their impact on health challenges in communities of color. Experiences with aging are shaped by many social factors such as structural racism, safety of living conditions, access to quality health care and education, and our level of financial resources. The life-changing outcomes of these social determinants of health have been thrown into sharp focus by the pandemic.

We clearly have a lot of work to do, but data collection will help with understanding just how far we need to go and where to target our efforts. That is where comprehensive, evidence-based resources like *America's Health Rankings* have an important role to play.

The COVID-19 pandemic taught us lessons about how the absence of timely access to detailed, reliable data can exacerbate health inequity. For example, initial

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Especially in a time when misinformation and disinformation of science are rampant, our policymakers need access to trusted, reliable data sources that are consistent over time.

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federal COVID-19 vaccination recommendations prioritized adults ages 75 and older, while the average age of COVID-19 deaths and cases in communities of color was several years younger — leaving those communities to wait longer to get access to limited vaccine supplies and underscoring that demographics beyond older age were critically missed in data analyses. Data sources provided early in the pandemic did not consistently provide cross-tabulations studying the intersection of COVID-19 *with both age and race/ethnicity*. While this lack of information created blinders at a vital time, we know now how valuable it is to have comprehensive subpopulation-level data over time to drive equitable public health efforts.

The pandemic revealed stark inequities in health outcomes that should be studied to inform what actions our nation’s public health system prioritizes moving forward. When collected and analyzed through an equity lens, data can better guide effective solutions for all. Especially in a time when misinformation and disinformation of science are rampant, our policymakers need access to trusted, reliable data sources that are consistent over time. I urge public health officials, community leaders and health advocates to explore, and make use of, the data available in the *Senior Report* as we work toward a healthier future for older adults across all communities.

to the CDC, inequities in the social determinants of health are driven by the negative effects of interpersonal and structural racism, placing communities of color at risk for poor health outcomes.<sup>6</sup>

The early death rate was lowest in Hawaii (1,527 deaths per 100,000 adults ages 65-74), Vermont (1,611) and New Hampshire (1,637); it was highest in Mississippi (3,024), Oklahoma (2,781) and Alabama (2,767).

The early death rate significantly varied by race/ethnicity and gender. The rate was 3.2 times higher among Black adults (3,184 deaths per 100,000 adults ages 65-74) than among multiracial adults (1,005) and 1.6 times higher among males (2,582) than among females (1,627).

## Early Death Racial Disparity

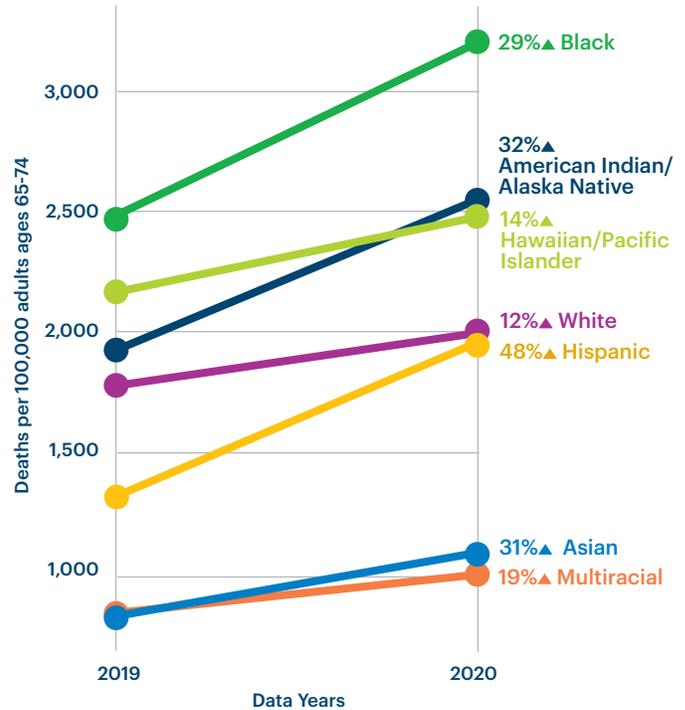
### Between 2019 and 2020

Nationally, the ratio of the early death rate among Black adults (3,184 deaths per 100,000 adults ages 65-74) compared with the rate among white adults (1,999) increased 14% from 1.4 to 1.6 between 2019 and 2020.

### Disparities in 2020

Arkansas had the largest early death racial disparity ratio at 4.4, followed by the District of Columbia (3.8), South Dakota (3.6) and North Dakota (3.5). In Arkansas, Hawaiian/Pacific Islander adults had the highest early death rate at 11,504 deaths per 100,000 adults ages 65-74, compared with 2,630 among white adults. New Hampshire had the smallest early death racial disparity ratio at 1.0, followed by Kentucky and Rhode Island (both 1.2). In New Hampshire, there was no relative difference in the early death rate between white (1,664) and Hispanic (1,109) adults. In Kentucky and Rhode Island, Black adults (3,229 and 2,228, respectively) had similar early death rates compared with white adults (2,622 and 1,845, respectively).

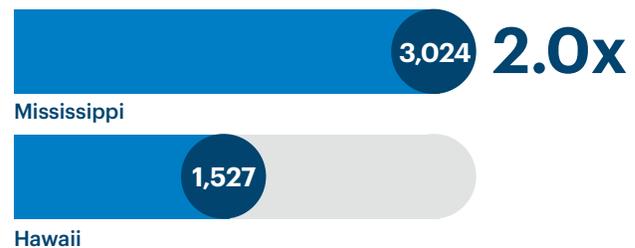
## All racial and ethnic subpopulations experienced significant increases in the early death rate.



Source: CDC WONDER, Multiple Cause of Death Files, 2019, 2020.

## Early death was higher in Mississippi than in Hawaii in 2020.

Deaths per 100,000 adults ages 65-74



Source: CDC WONDER, Multiple Cause of Death Files, 2020.

BEHAVIORAL HEALTH

## Behavioral health measures among older adults have worsened over the past decade.

### Drug Deaths

There are a variety of reasons why older adults are particularly at risk for drug overdoses. They may unintentionally misuse prescription medications like opioids, are more likely to be taking prescription medications than other populations and face other risk factors including social isolation.<sup>7,8,9</sup> Drug abuse is particularly dangerous for this population: Older adults face a reduced ability to metabolize medications due to age-related changes in the liver.<sup>10</sup>

#### Between 2008-2010 and 2018-2020

Nationally, the number of deaths due to drug injury (unintentional, suicide, homicide or undetermined) per 100,000 adults ages 65 and older significantly increased 100% from 4.2 to 8.4, corresponding to an increase of 8,620 deaths over this period. The drug death rate significantly increased in 35 states, led by: 352% in Connecticut (2.3 to 10.4 deaths per 100,000 adults ages 65 and older), 323% in Maryland (3.5 to 14.8) and 222% in New Jersey (2.7 to 8.7).

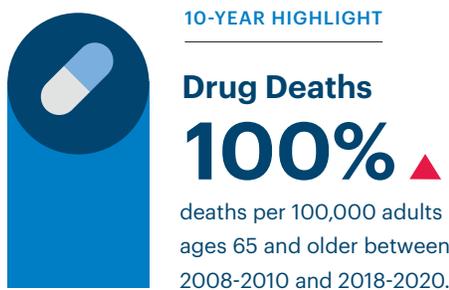
Among adults ages 65-74, drug deaths increased 147% from 4.7 to 11.6 deaths per 100,000 — the largest increase compared with all other age groups 15 and older. Both males and females experienced significant increases in the drug death rate: 172% for males (4.3 to 11.7 deaths per 100,000 adults ages 65 and older) and 38% for females (4.2 to 5.8).

#### Disparities in 2018-2020

The drug death rate was lowest in Nebraska (3.3 deaths per 100,000 adults ages 65 and older), Iowa (4.5) and Mississippi (4.8); it was highest in the District of Columbia (49.5), Nevada (15.5), Maryland (14.8) and Rhode Island (11.7).

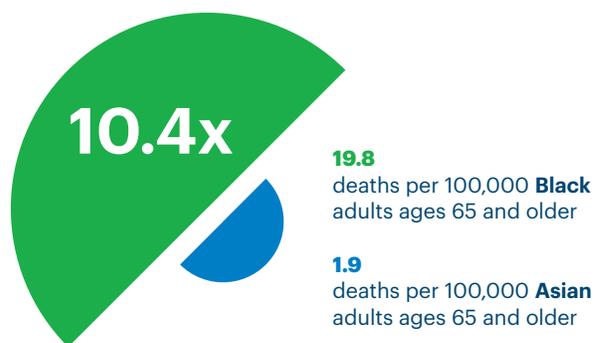
The drug death rate significantly varied by race/ethnicity and gender. The rate was 10.4 times higher among Black adults (19.8 deaths per 100,000 adults ages 65 and older) than among Asian adults (1.9) and 2.0 times higher among males (11.7) than among females (5.8).

### The rate of drug deaths doubled, resulting in 8,620 more deaths.



Source: CDC WONDER, Multiple Cause of Death Files, 2008-2010, 2018-2020.

### The rate of drug deaths among older Black adults was higher than among older Asian adults in 2018-2020.



Source: CDC WONDER, Multiple Cause of Death Files, 2018-2020.

## Frequent Mental Distress

Frequent mental distress is an indicator of health-related quality of life and the burden of mental illness in a population. Frequent mental distress is characterized by 14 or more days of self-reported poor mental health in the past month and is associated with risk factors for poor health.<sup>11,12</sup>

### Between 2011 and 2020

Nationally, the percentage of adults ages 65 and older who reported their mental health was not good 14 or more days in the past 30 days significantly increased 8% from 7.5% to 8.1%. Frequent mental distress among older adults significantly increased 81% in Hawaii (4.2% to 7.6%), 61% in Michigan (6.6% to 10.6%) and 57% in Washington (5.3% to 8.3%).

Some income, education, gender and racial/ethnic subpopulations experienced significant increases in frequent mental distress. Among adults ages 65 and older, increases greater than the national change included:

- 47% among those with an annual household income of \$50,000 to \$74,999 (4.3% to 6.3%), 41% among those with an income of \$75,000 or more (3.7% to 5.2%), 24% among those with an income of \$25,000 to \$49,999 (6.7% to 8.3%) and 15% among those with an income below \$25,000 (10.9% to 12.5%).
- 27% among those with some post-high school education (7.0% to 8.9%) and 23% among college graduates (4.4% to 5.4%).
- 16% among females (8.1% to 9.4%).
- 15% among white adults (6.8% to 7.8%).



### 10-YEAR HIGHLIGHT

## Frequent Mental Distress

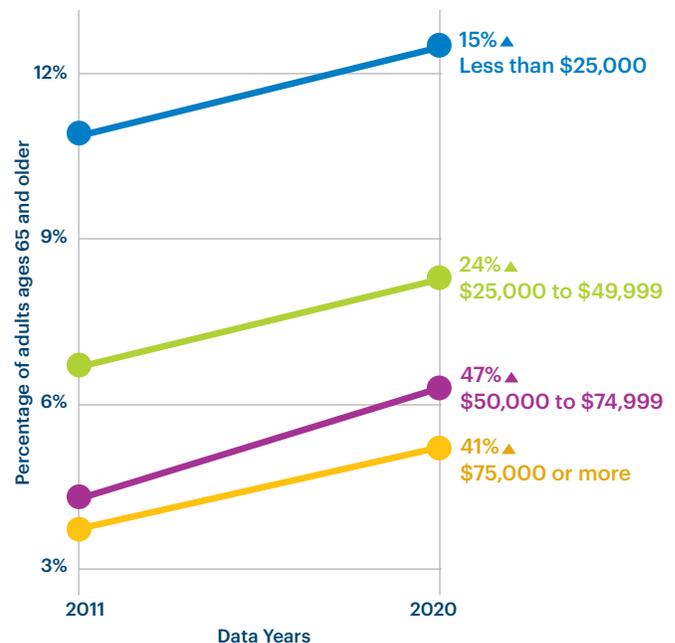
**8%** ▲

between 2011 and 2020.

Source: CDC, Behavioral Risk Factor Surveillance System, 2011, 2020.

### 10-YEAR HIGHLIGHT

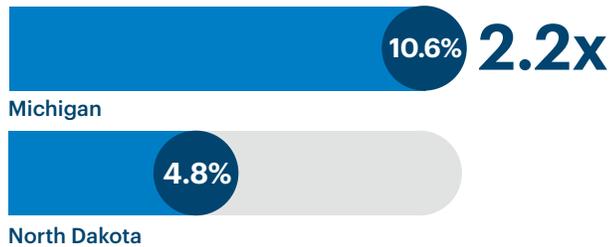
## Frequent mental distress significantly increased across all income groups.



Source: CDC, Behavioral Risk Factor Surveillance System, 2011, 2020.

## Frequent mental distress was higher in Michigan than in North Dakota in 2020.

Percentage of adults ages 65 and older



Source: CDC, Behavioral Risk Factor Surveillance System, 2020.

### Disparities in 2020

Frequent mental distress among older adults was lowest in North Dakota (4.8%), South Dakota (5.1%) and Wisconsin (5.8%); it was highest in Michigan (10.6%), the District of Columbia, Kentucky and Nevada (all 10.3%) and West Virginia (10.2%).

Frequent mental distress significantly varied by race/ethnicity, income, education and gender; differences by metropolitan status were not notable. The prevalence among adults ages 65 and older was higher among:

- American Indian/Alaska Native adults (15.6%), 4.0 times higher than among Asian adults (3.9%). The prevalence was also significantly higher among American Indian/Alaska Native adults than among Black (6.8%) and white (7.8%) adults.
- Those with an annual household income below \$25,000 (12.5%), 2.4 times higher than among those with an income of \$75,000 or more (5.2%); the prevalence was significantly lower among those with incomes of \$75,000 or more and \$50,000 to \$74,999 (6.3%) compared with all other income levels.
- Those with less than a high school education (12.0%), 2.2 times higher than among college graduates (5.4%).
- Females (9.4%) than among males (6.5%).

## Depression

### Between 2011 and 2020

Nationally, the percentage of adults ages 65 and older who reported being told by a health professional that they have a depressive disorder significantly increased 9% from 13.0% to 14.2%. Depression significantly increased in seven states, led by Washington (12.6% to 20.0%), Hawaii (7.1% to 10.9%) and West Virginia (12.4% to 19.0%). During the same period, depression significantly decreased in Alaska (19.2% to 10.4%) and Illinois (13.4% to 8.2%). All income and some education, racial/ethnic and gender subpopulations experienced significant increases in depression.

### Disparities in 2020

Depression among older adults was lowest in Illinois (8.2%) and highest in Washington (20.0%). The prevalence significantly varied by race/ethnicity, gender, income and education; differences by metropolitan status were not notable.

## Excessive Drinking

### Between 2011 and 2020

Nationally, the percentage of adults ages 65 and older who reported binge drinking (four or more drinks for females or five or more drinks for males on one occasion in the past 30 days) or heavy drinking (eight or more drinks for females or 15 or more drinks for males per week) significantly increased 16% from 6.4% to 7.4%, affecting 3.8 million older adults in 2020.

Some racial/ethnic, gender and education subpopulations experienced significant increases in excessive drinking; changes by income were not notable. Excessive drinking significantly increased in Kansas (4.0% to 5.9%), Nebraska (5.4% to 7.2%), North Carolina (4.0% to 6.4%), Ohio (4.6% to 7.8%) and West Virginia (2.1% to 4.3%).

### Disparities in 2020

Excessive drinking among older adults was lowest in Utah (2.7%) and highest in Wisconsin (11.8%). The prevalence significantly varied by income, education, race/ethnicity, gender and metropolitan status.



## Improving Primary and Mental Health Care for Seniors Lifts Us All

Dr. Jennifer Kim, President-Elect, Gerontological Advanced Practice Nurses Association (GAPNA)

The wisdom I gain from caring for seniors is what has always driven my passion for promoting the health of older adults. When I first started working as a nursing assistant in 1991, it was easy to see the gaps in health services for older adults. Over thirty years later, these challenges persist — and have only gotten worse.

Seniors and their caregivers are the salt of the earth; they work incredibly hard, yet the challenges they face are underappreciated by so many — a reality underscored by the effects of the pandemic on this population. At the Gerontological Advanced Practice Nurses Association, we believe that community advocates can use data to draw attention to the problems facing older adults to drive the public health conversation. Platforms like *America's Health Rankings* provide valuable insights that guide our work and help us engage with students, lawmakers, advocates and others.

The pandemic has highlighted the importance of primary care and mental health services among older adults; the *Senior Report* finds increases in mortality from chronic conditions like cancer and heart disease, which may have potentially been prevented earlier through primary care, as well as rising rates of depression and frequent mental distress. Many older adults avoided providers' offices in-person because of the fear of infection from COVID-19, and some may have had a difficult time navigating telehealth visits — especially those with cognitive deficits. This resulted in delays in screenings and preventive care and missed opportunities for treating chronic conditions, contributing to the significant toll the pandemic took on many seniors' emotional health and cognition.

Like the coronavirus itself, these challenges disproportionately impacted the most vulnerable

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To close gaps in senior health, we must address language barriers, teach cultural competency and prioritize equity and inclusion in both access to and provision of care.

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older adults, especially low-income individuals, people of color and those with chronic diseases. For example, while digital literacy has gone from a privilege to a necessity, many poorer older adults don't have the means to purchase a smartphone or reliable internet access, putting them at risk for experiencing isolation and losing access to essential services. Even when they can access in-person care, the lack of diversity in the health workforce serves as a barrier for patients of color who are often more comfortable working with providers who come from their own communities. To close gaps in senior health, we must address language barriers, teach cultural competency and prioritize equity and inclusion in both access to and provision of care.

As the nation's older adult population continues to grow, the *Senior Report* reminds us how important it is to be thoughtful and passionate about addressing the needs of this population. Improving access to and quality of preventive care and mental health services are just two of the many issues that policymakers should prioritize, guided by data from the *Senior Report*, to help advance health equity and improve the lives of seniors everywhere. The healthier our seniors are, the more we can learn from their wisdom and the healthier we all will be as we age.

## Suicide

Suicide is a tragic public health issue that leaves a lasting impact on families and communities. Recorded suicide attempts among older adults are usually more lethal than those among younger age groups.<sup>13</sup> Older adults may also exhibit passive self-harm behaviors that can result in death, such as refusing food, medications or liquids; these are rarely recorded as suicide attempts or deaths by suicide.<sup>14</sup>

### Between 2009-2011 and 2018-2020

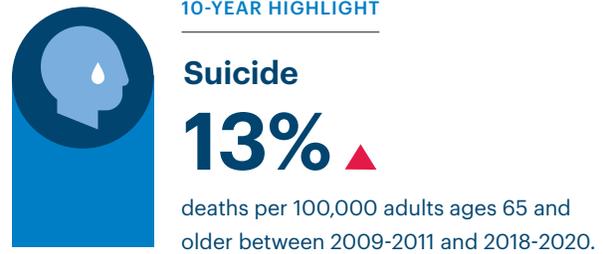
Nationally, the number of deaths due to intentional self-harm per 100,000 adults ages 65 and older significantly increased 13% from 15.0 to 16.9, corresponding to an increase of 9,239 deaths over this period. In 2018-2020, 27,412 older adults died by suicide. The suicide rate significantly increased in nine states, led by: 40% in Connecticut (9.6 to 13.4 deaths per 100,000 adults ages 65 and older), 37% in Ohio (11.9 to 16.3) and 34% in Oklahoma (16.3 to 21.8).

### Disparities in 2018-2020

The suicide rate was lowest in the District of Columbia (8.8 deaths per 100,000 adults ages 65 and older), New Jersey (9.4), New York (9.7) and Massachusetts (9.8); it was highest in Wyoming (35.5), Montana (30.7) and Nevada (30.4).

The suicide rate varied by gender, race/ethnicity and age. The rate was higher among:

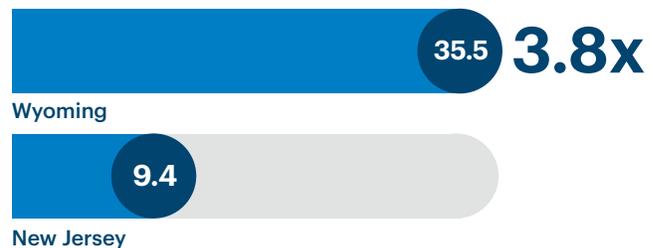
- Males (31.6 deaths per 100,000 adults ages 65 and older), 6.2 times higher than among females (5.1).
- White adults (20.2), 4.7 times higher than among Black adults (4.3). The rate was significantly higher among white adults compared with all other racial/ethnic groups.
- Adults ages 85 and older (20.0) than among adults ages 65-74 (15.4). The rate was significantly higher with each increase in age group.



Source: CDC WONDER, Multiple Cause of Death Files, 2009-2011, 2018-2020.

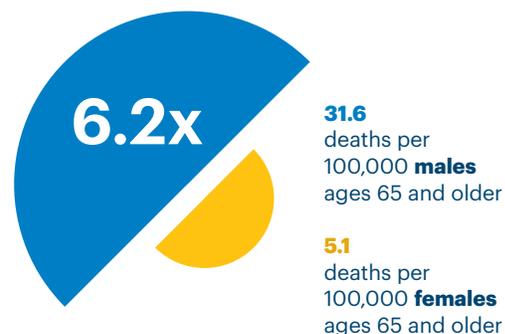
### Suicide was higher in Wyoming than in New Jersey in 2018-2020.

Deaths per 100,000 adults ages 65 and older



Source: CDC WONDER, Multiple Cause of Death Files, 2018-2020.

### Suicide was higher in males than in females in 2018-2020.



Source: CDC WONDER, Multiple Cause of Death Files, 2018-2020.

## PHYSICAL HEALTH

Self-reported high health status has improved since the inaugural *Senior Report*, and teeth extractions have decreased. However, obesity has worsened, and nearly half of older adults have multiple chronic conditions.

## High Health Status

Self-reported health status is a measure of how individuals perceive their health, rating it as excellent, very good, good, fair or poor.<sup>15</sup> Among adults ages 65 and older, self-reported health status is a good predictor of short- and long-term mortality.<sup>16</sup> It is also a good predictor of future health care use.<sup>17,18</sup>

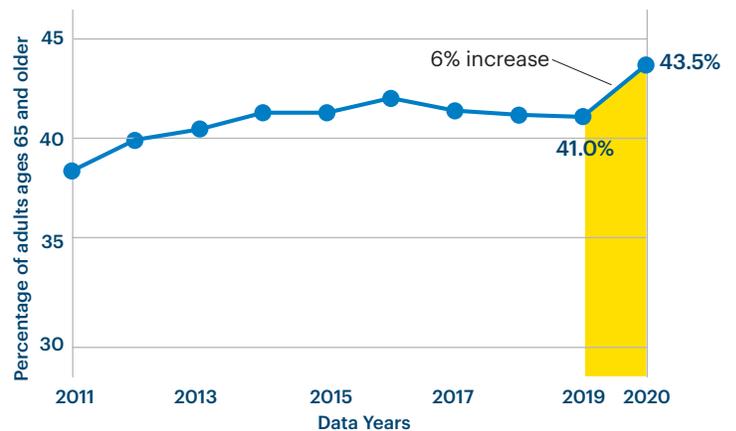
### Between 2011 and 2020

Nationally, the percentage of adults ages 65 and older who reported their health was very good or excellent significantly increased 13% from 38.4% to 43.5%. High health status has generally increased since 2011, with a large part of this change occurring in the past year, increasing 6% from 41.0% in 2019 and reaching its highest point in 2020. More than 24.5 million older adults reported that their health was very good or excellent in 2020, an increase of approximately 2.6 million older adults between 2019 and 2020. High health status among older adults significantly increased in 33 states and the District of Columbia, led by: 33% in Wisconsin (39.0% to 52.0%), 32% in Rhode Island (36.9% to 48.8%) and 30% in New York (35.0% to 45.5%).

Some racial/ethnic, gender and education subpopulations experienced significant increases in high health status; changes by income were not notable. Among adults ages 65 and older, increases greater than the national change included: 28% among Black (24.1% to 30.9%) and 14% among white (41.5% to 47.4%) adults, as well as 14% among females (38.8% to 44.3%).

### 10-YEAR HIGHLIGHT

**High health status increased sharply from 2019 to 2020, after decreasing since 2016, reaching its highest point in *Senior Report* history.**



Source: CDC, Behavioral Risk Factor Surveillance System, 2011-2020.

### Disparities in 2020

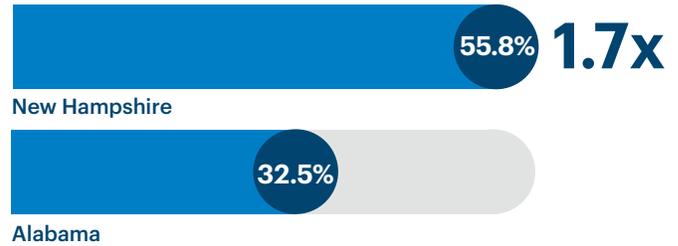
High health status among older adults was highest in New Hampshire (55.8%), Colorado (53.5%) and Vermont (53.1%); it was lowest in Alabama (32.5%), Mississippi (32.6%) and West Virginia (33.2%).

High health status significantly varied by education, income, race/ethnicity and metropolitan status; differences by gender were not notable. The prevalence among adults ages 65 and older was higher among:

- College graduates (58.7%), 2.7 times higher than among those with less than a high school education (21.5%). The prevalence was significantly higher with each increase in education level.
- Those with an annual household income of \$75,000 or more (61.3%), 2.2 times higher than among those with an income below \$25,000 (27.5%). The prevalence was significantly higher with each increase in income level.
- White adults (47.4%), 1.8 times higher than among Hispanic adults (25.7%). The prevalence was also significantly higher among white adults than among multiracial (38.4%), American Indian/Alaska Native (31.6%) and Black (30.9%) adults.
- Those living in metropolitan (44.4%) than among those living in non-metropolitan (39.7%) areas.

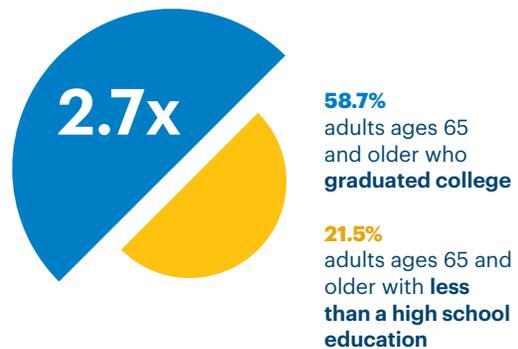
### High health status was higher in New Hampshire than in Alabama in 2020.

Percentage of adults ages 65 and older



Source: CDC, Behavioral Risk Factor Surveillance System, 2020.

### High health status was higher among college graduates than among those with less than a high school education in 2020.



Source: CDC, Behavioral Risk Factor Surveillance System, 2020.

## Teeth Extractions

Having all or some permanent teeth missing is associated with increased risk of disability, mortality and decreased daily function and quality of life.<sup>19,20</sup> Missing teeth or having dentures can also impair one’s ability to eat and speak, and is associated with poor nutrition.<sup>20</sup> Severe oral health issues that impact daily life are also associated with loneliness.<sup>21,22</sup>

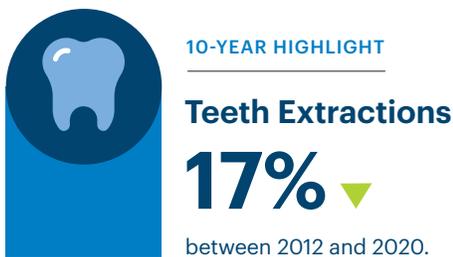
### Between 2012 and 2020

Nationally, the percentage of adults ages 65 and older who reported having all their teeth removed due to decay or gum disease significantly decreased 17% from 16.1% to 13.4%. Teeth extraction prevalence has generally decreased continuously since 2012, reaching its lowest point in 2020. Still, 7.1 million older adults reported in 2020 that they had all their teeth removed. Teeth extractions among older adults significantly decreased in 20 states, led by: 40% in Louisiana (28.7% to 17.2%), 38% in Maryland (14.5% to 9.0%) and 34% in both Kansas (18.8% to 12.4%) and West Virginia (33.7% to 22.2%).

Some education, racial/ethnic and gender subpopulations experienced significant decreases in teeth extractions; changes by income were not notable. Among adults ages 65 and older, decreases greater than the national change included:

- 21% among college graduates (4.7% to 3.7%).
- 19% among Black (24.7% to 20.1%) and 18% among white (15.4% to 12.6%) adults.
- 18% among females (16.3% to 13.4%).

**Teeth extractions have decreased since 2012, reaching its lowest prevalence in 2020.**



Source: CDC, Behavioral Risk Factor Surveillance System, 2012, 2020.

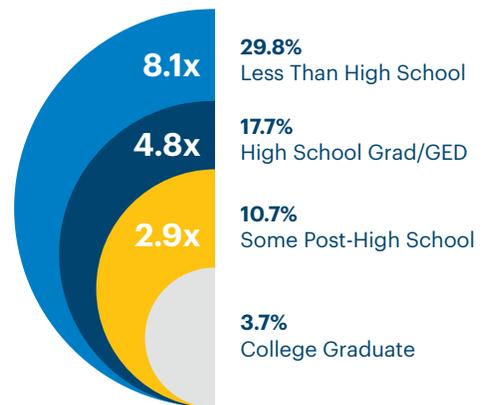
### Disparities in 2020

The percentage of teeth extractions among older adults was lowest in Hawaii (5.6%), Minnesota (8.8%), and California and Maryland (both 9.0%); it was highest in Kentucky (22.4%), West Virginia (22.2%) and Arkansas (21.5%).

Teeth extractions significantly varied by education, income, race/ethnicity and metropolitan status; differences by gender were not notable. The prevalence among adults ages 65 and older was higher among:

- Those with less than a high school education (29.8%), 8.1 times higher than among college graduates (3.7%). The prevalence was significantly higher with each decrease in education level.
- Those with an annual household income below \$25,000 (25.3%), 7.0 times higher than among those with an income of \$75,000 or more (3.6%). The prevalence was significantly higher with each decrease in income level.
- American Indian/Alaska Native adults (23.7%), 5.0 times higher than among Asian adults (4.7%). The prevalence was significantly lower among Asian adults compared with all other racial/ethnic groups.
- Those living in non-metropolitan (18.3%) than among those living in metropolitan (12.3%) areas.

**Teeth extractions among older adults significantly varied by education in 2020.**



Source: CDC, Behavioral Risk Factor Surveillance System, 2020.

## Obesity

Adults with obesity have an increased risk of developing serious health conditions such as hypertension, Type 2 diabetes, stroke, sleep apnea and breathing problems, osteoarthritis and certain cancers, as well as mental illnesses like depression and anxiety.<sup>23</sup> Some research suggests that the strength of the association between obesity and mortality risk increases with age, making obesity among older adults of particular concern.<sup>24</sup>

### Between 2011 and 2020

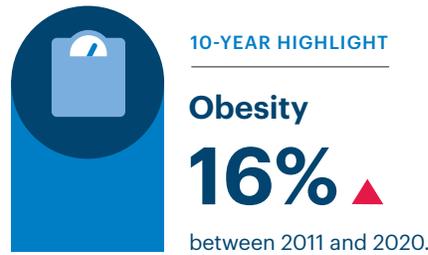
Nationally, the percentage of adults ages 65 and older with a body mass index of 30.0 or higher based on reported height and weight significantly increased 16% from 25.3% to 29.3%. Obesity among older adults significantly increased in 19 states, led by 60% in Nevada (18.1% to 28.9%), 45% in Wyoming (20.4% to 29.5%) and 36% in South Dakota (23.8% to 32.4%).

All income and some education, racial/ethnic and gender subpopulations experienced significant increases in obesity. Among adults ages 65 and older, increases greater than the national change included:

- 28% among those with an annual household income of \$75,000 or more (20.3% to 26.0%) and 20% among those with an income of \$25,000 to \$49,999 (26.1% to 31.4%).
- 24% among both those with some post-high school education (25.1% to 31.0%) and college graduates (18.9% to 23.5%) and 19% among those with a high school degree or GED diploma (26.0% to 30.9%).
- 18% among white adults (24.1% to 28.4%).

### Disparities in 2020

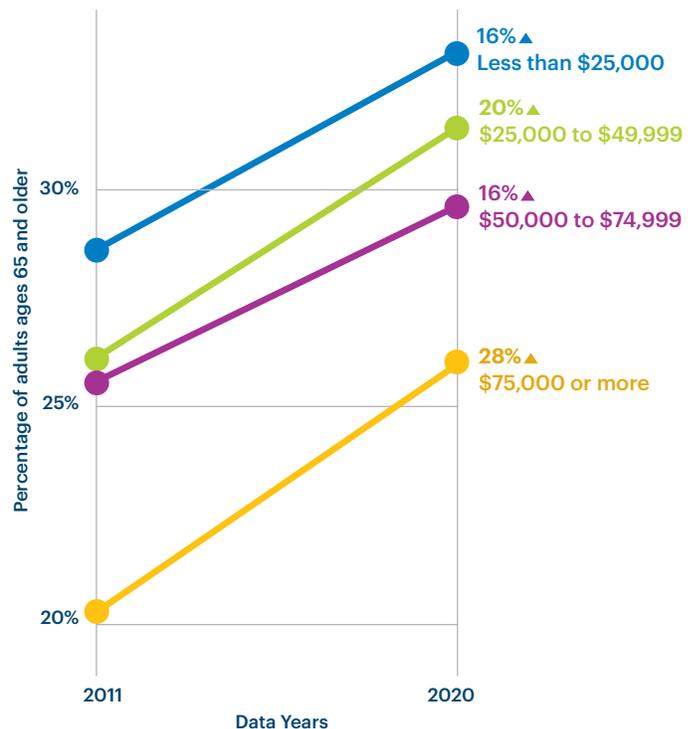
Obesity among older adults was lowest in Hawaii (18.7%), New York (23.6%) and Colorado (23.9%); it was highest in Delaware (37.6%), Louisiana (36.2%) and Michigan (35.6%).



Source: CDC, Behavioral Risk Factor Surveillance System, 2011, 2020.

### 10-YEAR HIGHLIGHT

## Obesity significantly increased across all income groups.



Source: CDC, Behavioral Risk Factor Surveillance System, 2011, 2020.

Obesity significantly varied by race/ethnicity, education, income and metropolitan status; differences by gender were not notable. The prevalence among adults ages 65 and older was higher among:

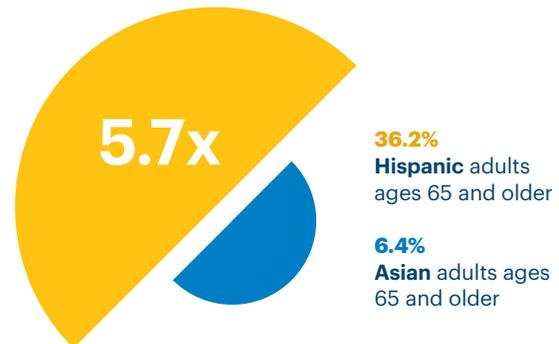
- Hispanic (36.2%), Black (36.1%) and American Indian/Alaska Native (35.7%) adults than among Asian adults (6.4%). The prevalence was significantly lower among Asian adults compared with all other racial/ethnic groups.
- Those with less than a high school education (33.7%) than among college graduates (23.5%). The prevalence was significantly lower among college graduates compared with all other education levels.
- Those with an annual household income below \$25,000 (33.1%) than among those with an income of \$75,000 or more (26.0%). The prevalence was significantly lower among those with an income of \$75,000 or more compared with all other income groups.
- Those living in non-metropolitan (31.6%) than among those living in metropolitan (28.7%) areas.

## Multiple Chronic Conditions

### 2020

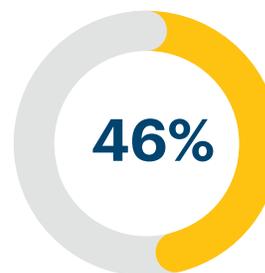
Nationally, 46% of Medicare beneficiaries ages 65-74 enrolled in the fee-for-service program had three or more of 21 chronic conditions identified by the Chronic Conditions Warehouse. The prevalence of multiple chronic conditions was lowest in Alaska and Wyoming (both 28%) as well as Montana and Vermont (both 30%); it was highest in Alabama (58%), West Virginia (55%) and Louisiana and Delaware (both 54%). Multiple chronic conditions varied by race/ethnicity; differences by gender were not notable. The prevalence was higher among Black (53%) than among Asian/Pacific Islander (40%) adults.

## Obesity was higher among older Hispanic adults than among older Asian adults in 2020.



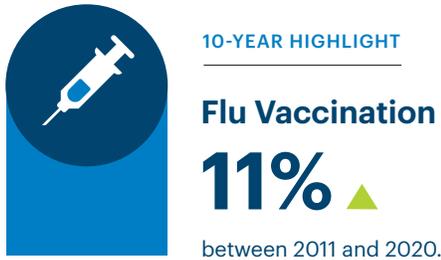
Source: CDC, Behavioral Risk Factor Surveillance System, 2020.

## Nearly half of Medicare beneficiaries ages 65-74 had multiple chronic conditions in 2020.



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

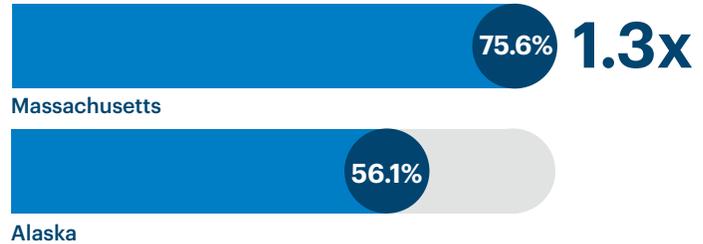
## Flu vaccination reached its highest level in 2020.



Source: CDC, Behavioral Risk Factor Surveillance System, 2011, 2020.

## Flu vaccination was higher in Massachusetts than in Alaska in 2020.

Percentage of adults ages 65 and older



Source: CDC, Behavioral Risk Factor Surveillance System, 2020.

## IMMUNIZATIONS

In the last decade, the percentage of older adults who have received flu vaccinations has improved. More recently, older adults have been receiving COVID-19 vaccinations and boosters.

### Flu Vaccination

The flu vaccine helps protect individuals against seasonal flu viruses and reduces the severity of illness for those who get sick.<sup>25</sup> As immune defense systems weaken with age, older adults are at increased risk of contracting influenza viruses and having serious health complications as a result of infection.<sup>26</sup>

#### Between 2011 and 2020

Nationally, the percentage of adults ages 65 and older who reported receiving a seasonal flu vaccine in the past 12 months significantly increased 11% from 60.6% to 67.3%, equaling about 35 million older adults in 2020. The percentage significantly increased 5% from 63.8% in 2019, reaching its highest value in 2020. Flu vaccination among older adults significantly increased in 26 states and the District of Columbia, led by: 32% in Illinois (54.7% to 72.1%), 28% in Rhode Island (56.6% to 72.7%) and 24% in both Michigan (58.0% to 71.7%) and New Hampshire (57.4% to 70.9%). During the same period, flu vaccination significantly decreased 8% in Louisiana (70.2% to 64.4%).

All income and some racial/ethnic, education and gender subpopulations experienced significant increases in flu vaccination. Among adults ages 65 and older, increases greater than the national change included:

- 26% among Asian (59.9% to 75.5%), 17% among Black (49.3% to 57.8%) and 12% among white (62.2% to 69.6%) adults.
- 18% among those with an annual household income of \$75,000 or more (63.1% to 74.2%) and 13% among those with an income of \$50,000 to \$74,999 (62.9% to 71.3%).
- 16% among college graduates (64.3% to 74.4%).
- 12% among males (60.0% to 66.9%).

#### Disparities in 2020

Flu vaccination among older adults was highest in Massachusetts (75.6%), North Carolina (74.6%) and Connecticut (74.0%); it was lowest in Alaska (56.1%), Wyoming (59.4%) and Florida (61.6%).

Flu vaccination significantly varied by race/ethnicity, education, income and metropolitan status; differences by gender were not notable. The prevalence among adults ages 65 and older was higher among:

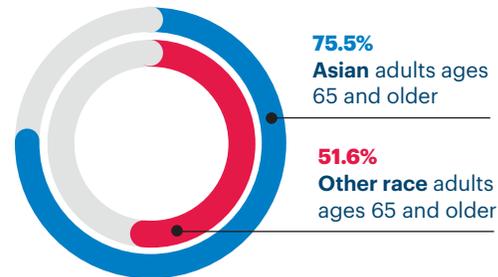
- Asian adults (75.5%), 1.5 times higher than among adults who identify as other race (51.6%). White adults (69.6%) also had a high prevalence, significantly higher than among multiracial (61.8%), Hispanic (58.6%), Black (57.8%) and American Indian/Alaska Native (55.5%) adults.
- College graduates (74.4%) than among those with less than a high school education (58.4%). The prevalence was significantly higher with each increase in education level.
- Those with an annual household income of \$75,000 or more (74.2%) than among those with an income below \$25,000 (60.6%). The prevalence was significantly higher among the top two income levels compared with the bottom two income levels.
- Those living in metropolitan (68.1%) than among those living in non-metropolitan (63.6%) areas.

### COVID-19 Vaccination

As of March 17, 2022, 88.9% of adults ages 65 and older were fully vaccinated, defined as having received the second dose in a two-dose COVID-19 vaccine series or one dose of the single-shot Johnson & Johnson/Janssen COVID-19 vaccine. The prevalence of COVID-19 vaccination was highest in Vermont, Rhode Island, Minnesota, Maine and Connecticut (all 95.0%); it was lowest in Arkansas (79.6%), Alabama (81.2%) and Georgia (82.4%).

Additionally, 66.8% of fully vaccinated adults ages 65 and older later received a booster dose of any COVID-19 vaccine. The prevalence of older adults with a COVID-19 vaccination and a booster dose was highest in Minnesota (81.5%), Wisconsin (79.9%) and Vermont (78.9%); it was lowest in New Hampshire (35.6%), North Carolina (39.5%) and Georgia (55.1%). Additional [COVID-19 data](#) are available on the website.

### Flu vaccination was higher among older Asian adults than among older adults who identify as other race in 2020.



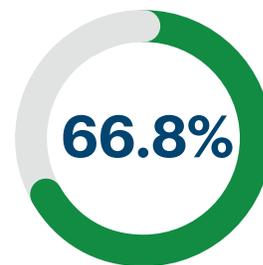
Source: CDC, Behavioral Risk Factor Surveillance System, 2020.

### Nearly 9 in 10 adults ages 65 and older were fully vaccinated against COVID-19 as of March 17, 2022.



Source: CDC, COVID Data Tracker, March 17, 2022.

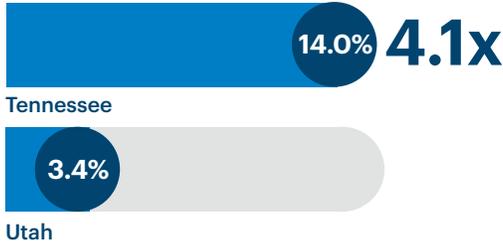
### About 2 in 3 fully vaccinated adults ages 65 and older received a booster dose of any COVID-19 vaccine as of March 17, 2022.



Source: CDC, COVID Data Tracker, March 17, 2022.

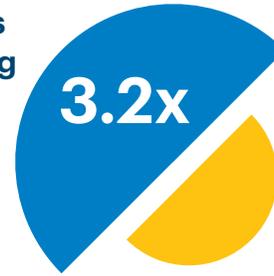
## Smoking was higher in Tennessee than in Utah in 2020.

Percentage of adults ages 65 and older



Source: CDC, Behavioral Risk Factor Surveillance System, 2020.

## Smoking was higher among those with less than a high school education than among college graduates in 2020.



**13.1%** adults ages 65 and older with less than a high school education

**4.1%** adults ages 65 and older who graduated college

Source: CDC, Behavioral Risk Factor Surveillance System, 2020.

## SMOKING AND TOBACCO USE

Despite national prevention efforts, smoking prevalence has not changed since 2011.

### Smoking

Smoking cigarettes is the leading cause of preventable death in the United States.<sup>27</sup> Even among older adults and long-term smokers, smoking cessation has been shown to improve health outcomes.<sup>28</sup>

#### Between 2011 and 2020

Nationally, the percentage of adults ages 65 and older who reported smoking at least 100 cigarettes in their lifetime and currently smoke daily or some days did not change; the prevalence was 8.9% in both 2011 and 2020. This is in contrast with a significant decrease in smoking prevalence among adults ages 18–44 and 45–64 during the past decade. Smoking among older adults did not notably change in any states during this time.

Some education and income subpopulations experienced significant changes in smoking; changes by race/ethnicity and gender were not notable. Among adults ages 65 and older, smoking decreased 20% among college graduates (5.1% to 4.1%) and increased 20% among those with an annual household income below \$25,000 (12.2% to 14.7%).

#### Disparities in 2020

Smoking among older adults was lowest in Utah (3.4%), California (5.4%) and New Jersey (6.7%); it was highest in Tennessee (14.0%), Nevada (13.4%) and Kentucky (13.0%).

Smoking varied the most by education, income and race/ethnicity, but also significantly varied by gender and metropolitan status. The prevalence in adults ages 65 and older was higher among:

- Those with less than a high school education (13.1%), 3.2 times higher than among college graduates (4.1%).
- Those with an annual household income below \$25,000 (14.7%), 3.1 times higher than among those with an income of \$75,000 or more (4.7%). The prevalence was significantly higher with each decrease in income level.
- Multiracial adults (15.0%), 1.9 times higher than among Hispanic adults (7.9%). The prevalence was also significantly higher among American Indian/Alaska Native adults (14.5%) than among white (8.5%) and Hispanic adults.

SOCIAL SUPPORT AND ENGAGEMENT

After nearly a decade of improvement, the percentage of low-care nursing home residents spiked between 2019 and 2020. Meanwhile, most social isolation risk factors improved between 2011-2015 and 2016-2020.

### Low-care Nursing Home Residents

Low-care nursing home residents — those who require no physical assistance in bed mobility, transferring, toileting or eating — may be able to live in a less-restrictive environment and receive less-intensive care through home- or community-based services or in alternative settings, such as assisted living facilities.<sup>29</sup> Aging in place has been shown to have physical, social and emotional benefits for older adults, resulting in better health outcomes.<sup>30,31</sup>

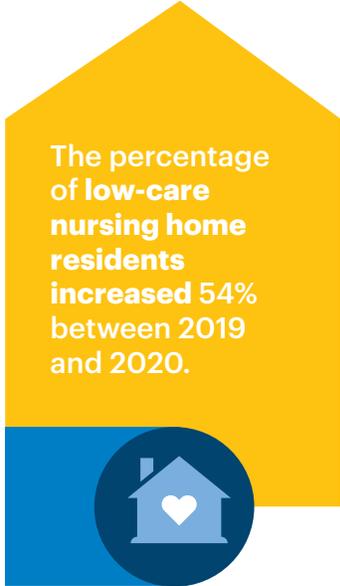
#### Between 2019 and 2020

Nationally, the percentage of nursing home residents who are considered low-care increased 54% from 9.9% to 15.2%, reaching its highest point in *Senior Report* history. Prior to the recent increase, the percentage of low-care nursing home residents decreased 19% from 12.2% to 9.9% between 2010 and 2019. The percentage of low-care nursing home residents increased in 49\* states — 44 increased 25% or more — led by: 181% in Utah (3.6% to 10.1%), 134% in Ohio (6.8% to 15.9%) and 133% in North Carolina (4.6% to 10.7%).

#### Disparities in 2020

The percentage of low-care nursing home residents was lowest in Hawaii (3.7%), Maine (4.4%) and South Carolina (7.9%); it was highest in Missouri (31.3%), Oklahoma (28.3%) and Kansas (26.0%).

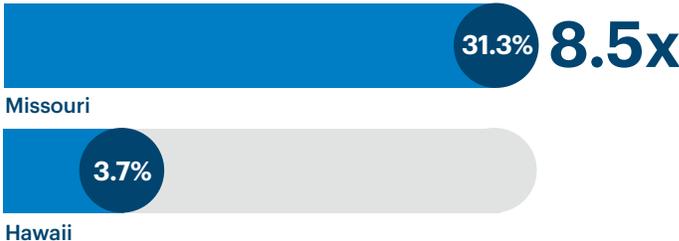
\*No data available for Alaska



Source: Brown University, Shaping Long-Term Care in America Project, 2019, 2020.

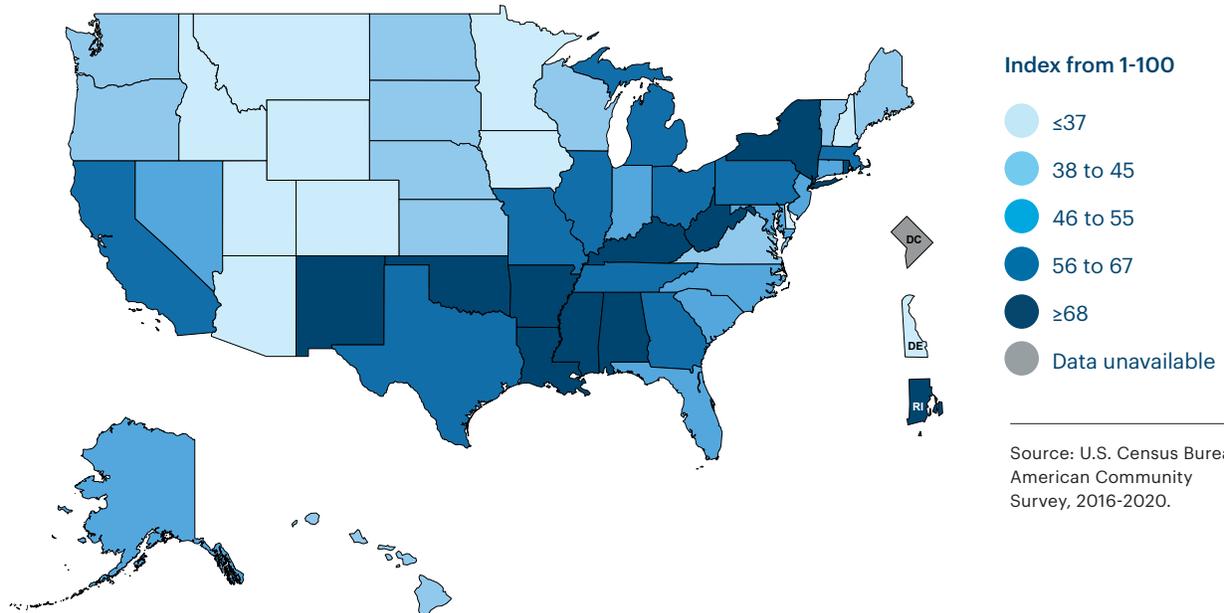
### Low-care nursing home residents was higher in Missouri than in Hawaii in 2020.

Percentage of residents



Source: Brown University, Shaping Long-Term Care in America Project, 2020.

**States throughout the West, Northeast and Midwest had the lowest risk of social isolation among older adults, while states in the South had the highest risk in 2016-2020.**



**Risk of Social Isolation**

Socially isolated older adults may not receive needed social support when experiencing stressful life events.<sup>32</sup> Strong social networks have been shown to improve the management of chronic illness and physical and cognitive health among older adults.<sup>33,34,35</sup>

**During 2016-2020**

Risk of social isolation — an index of social isolation risk factors: poverty; living alone; divorced, separated or widowed; never married; disability; and independent living difficulty — among adults ages 65 and older was highest in Mississippi (100) and lowest in Utah (1). For this analysis, risk factors were normalized on a scale of 1 to 100, with a higher value indicating greater risk. County-level risk of [social isolation maps](#) are available for download on the website.

Nationally, the most common risk factors for social isolation among older adults were being divorced, separated or widowed (38.6%) and living alone (37.4%). The least common risk factor was having never married (5.9%).

**Between 2011-2015 and 2016-2020**

Nationally, most risk factors have improved (i.e., decreased), save for having never married, which increased 18% from 5.0% to 5.9%. Changes in living alone were not notable. Significant improvements in risk factors for social isolation among adults ages 65 and older include:

- Independent living difficulty decreased 10% from 15.5% to 14.0%.
- Disability decreased 6% from 36.0% to 34.0%.
- Being divorced, separated or widowed decreased 4% from 40.2% to 38.6%.
- Poverty decreased 1% from 9.4% to 9.3%.

Risk of social isolation worsened (i.e., increased) by five or more units on the 1 to 100 scale in 18 states, led by Alaska (33 to 47), New Mexico (77 to 89) and Oklahoma (61 to 73). Three states improved (i.e., decreased) by five or more units: South Dakota (46 to 39), Delaware (26 to 20) and Idaho (26 to 21).

# State Rankings

Each state has undergone unique challenges during the COVID-19 public health crisis. The specific circumstances of each state's older adult population in the years leading up to the pandemic have shaped its impact. The rankings included in this year's *Senior Report* — the first ranking analysis conducted by *America's Health Rankings* since 2019 — are derived from 37 measures across five categories of health: social & economic factors, physical environment, behaviors, clinical care and health outcomes. For a more detailed description of how the overall rank is calculated, visit [AmericasHealthRankings.org](https://AmericasHealthRankings.org).

## Utah Ranks No. 1

Utah is the healthiest state in this year's report. It ranks in the top quintile across social and economic factors (No. 1), clinical care (No. 8), behaviors (No. 4) and health outcomes (No. 4) categories.

**Strengths:** low prevalence of excessive drinking, low risk of social isolation, low prevalence of smoking.

**Challenges:** high prevalence of falls, low SNAP participation among older adults in poverty, low geriatric provider rate.

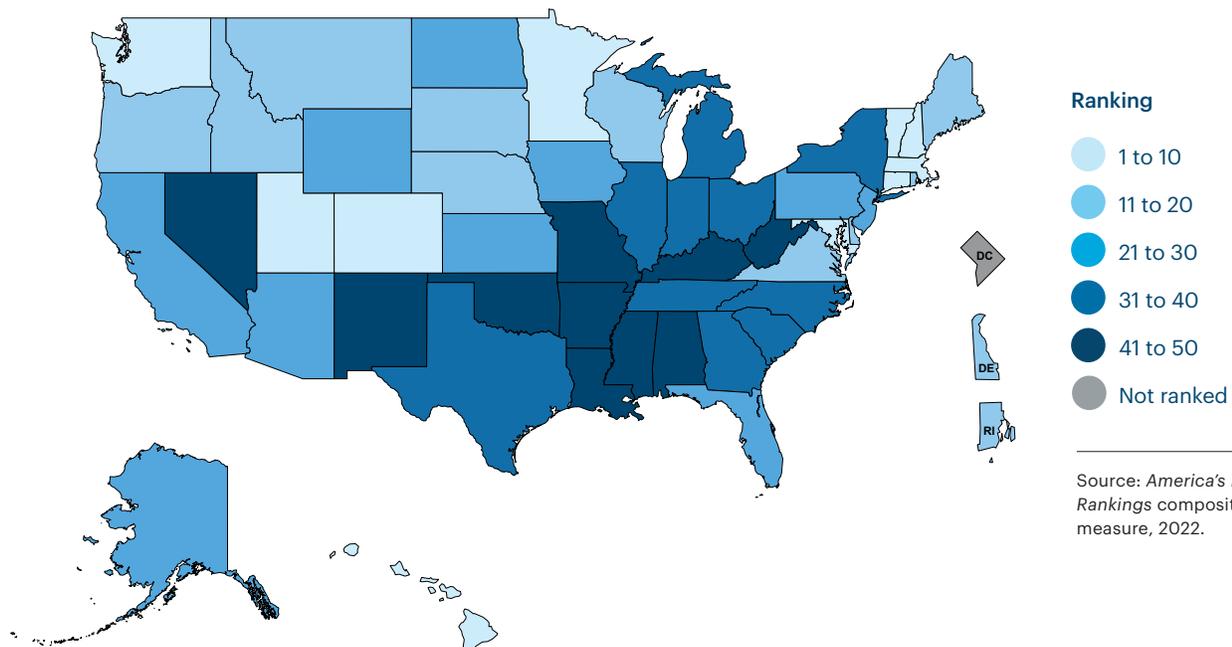
## Mississippi Ranks No. 50

Mississippi is the least healthy state, ranking in the bottom quintile across all model categories: social and economic factors (No. 50), physical environment (No. 44), clinical care (No. 49), behaviors (No. 47) and health outcomes (No. 43).

**Strengths:** low prevalence of excessive drinking, low prevalence of falls, low prevalence of severe housing problems.

**Challenges:** high early death rate, high risk of social isolation, high prevalence of physical inactivity.

## 2022 Senior Report state rankings

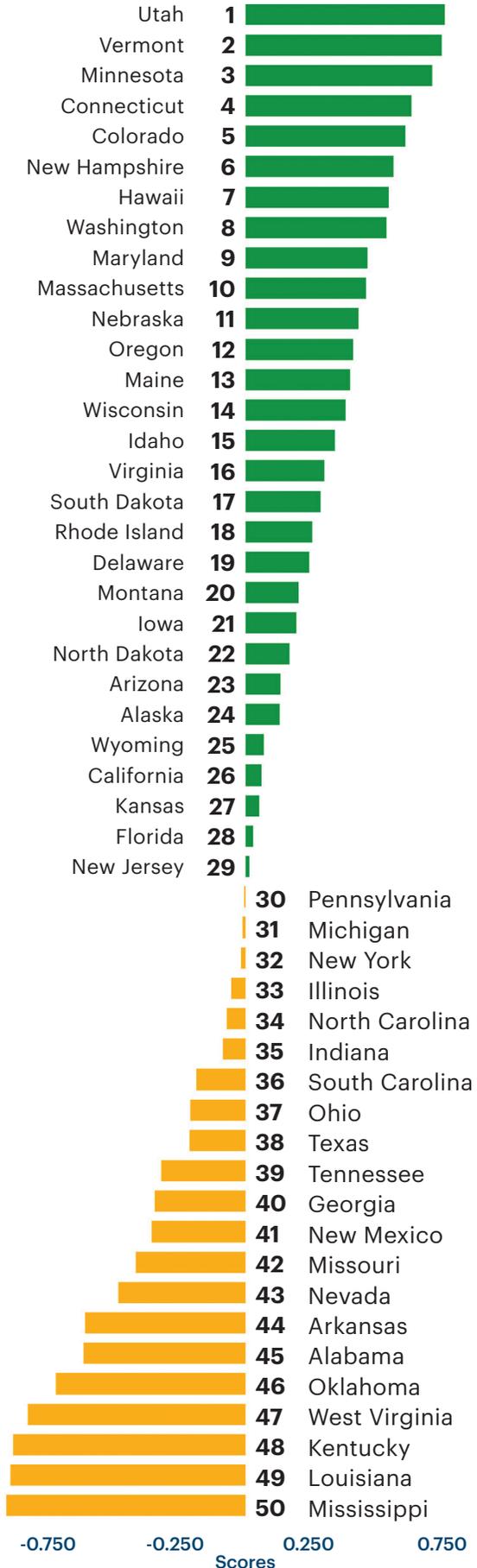


2022 Senior Report state rankings and scores\*

This graph displays the states in order of rank. The green bars represent states scoring higher (healthier), while the gold bars represent states scoring lower (less healthy).

The difference between the length of the bars indicates the difference between state scores. For example, Nevada (No. 43) and Arkansas (No. 44) have a large difference in score, making it more of a challenge for Arkansas to move up in the rankings. There is also a large gap in score between Tennessee (No. 39) and Texas (No. 38).

To further explore state-level data, visit [AmericasHealthRankings.org](https://AmericasHealthRankings.org). The website features a [state summary](#) for each state and the District of Columbia that is available for download. 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 using the Core Measure Impact graph by selecting a state in [Explore Data](#). 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.



Source: America’s Health Rankings composite measure, 2022.

\*Sum of weighted z-scores across all measures included in the rankings.

# National Summary

Health Department Website: [hhs.gov](https://hhs.gov)

## Summary

### DRUG DEATHS

**▲ 100%**

from 4.2 to 8.4 deaths per 100,000 adults ages 65+ between 2008-2010 and 2018-2020.

### EARLY DEATHS

**▲ 17%**

from 1,765 to 2,072 deaths per 100,000 adults ages 65-74 between 2019 and 2020.

### FULL-MOUTH TEETH EXTRACTIONS

**▼ 17%**

from 16.1% to 13.4% of adults ages 65+ between 2012 and 2020.

### OBESITY

**▲ 16%**

from 25.3% to 29.3% of adults ages 65+ between 2011 and 2020.

### SUICIDE

**▲ 13%**

from 15.0 to 16.9 deaths per 100,000 adults ages 65+ between 2009-2011 and 2018-2020.

### HIGH HEALTH STATUS

**▲ 13%**

from 38.4% to 43.5% of adults ages 65+ between 2011 and 2020.

### FLU VACCINATION

**▲ 11%**

from 60.6% to 67.3% of adults ages 65+ between 2011 and 2020.

### DEPRESSION

**▲ 9%**

from 13.0% to 14.2% of adults ages 65+ between 2011 and 2020.

## Measures

U.S. Value

SOCIAL & ECONOMIC FACTORS		
<b>Community and Family Safety</b>	Violent Crime (offenses per 100,000 population)	399
<b>Economic Resources</b>	Food Insecurity (% of adults ages 60+)	12.6%
	Poverty (% of adults ages 65+)	9.4%
	Poverty Racial Disparity (ratio)*	2.7
	SNAP Reach (participants per 100 adults ages 60+ in poverty)	81.0
<b>Social Support and Engagement</b>	Community Support Expenditures (dollars per adult ages 60+)	\$57
	High-speed Internet (% of households with adults ages 65+)	78.0%
	Low-care Nursing Home Residents (% of residents)	15.2%
	Risk of Social Isolation (index 1-100, adults ages 65+)	—
	Volunteerism (% of adults ages 65+)	31.6%
PHYSICAL ENVIRONMENT		
<b>Air and Water Quality</b>	Air Pollution (micrograms of fine particles per cubic meter)	8.3
	Drinking Water Violations (% of community water systems)	0.8%
<b>Housing</b>	Severe Housing Problems (% of small households with an adult ages 62+)	32.7%
CLINICAL CARE		
<b>Access to Care</b>	Avoided Care Due to Cost (% of adults ages 65+)	4.2%
	Geriatric Providers (providers per 100,000 adults ages 65+)	31.1
	Home Health Care Workers (workers per 1,000 adults ages 65+)	57.7
<b>Preventive Clinical Services</b>	Cancer Screenings (% of adults ages 65-75)	75.9%
	Flu Vaccination (% of adults ages 65+)	67.3%
	Pneumonia Vaccination (% of adults ages 65+)	70.3%
<b>Quality of Care</b>	Dedicated Health Care Provider (% of adults ages 65+)	93.5%
	Hospice Care (% of Medicare decedents)	50.7%
	Hospital Readmissions (risk-standardized readmission rate per 100 admissions)	16
	Nursing Home Quality (% of beds rated four or five stars)	41.2%
	Preventable Hospitalizations (discharges per 100,000 Medicare beneficiaries ages 65-74)	1,582
BEHAVIORS		
<b>Nutrition and Physical Activity</b>	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)	30.6%
<b>Sleep Health</b>	Insufficient Sleep (% of adults ages 65+)	26.0%
<b>Tobacco Use</b>	Smoking (% of adults ages 65+)	8.9%
HEALTH OUTCOMES		
<b>Behavioral Health</b>	Drug Deaths (deaths per 100,000 adults ages 65+)*	8.4
	Excessive Drinking (% of adults ages 65+)	7.4%
	Frequent Mental Distress (% of adults ages 65+)	8.1%
	Suicide (deaths per 100,000 adults ages 65+)	16.9
<b>Mortality</b>	Early Death (deaths per 100,000 adults ages 65-74)	2,072
	Early Death Racial Disparity (ratio)*	1.6
<b>Physical Health</b>	Falls (% of adults ages 65+)	27.1%
	Frequent Physical Distress (% of adults ages 65+)	14.5%
	High Health Status (% of adults ages 65+)*	43.5%
	Multiple Chronic Conditions (% of Medicare beneficiaries ages 65-74)	46%
	Obesity (% of adults ages 65+)	29.3%
	Teeth Extractions (% of adults ages 65+)	13.4%

\* Non-ranking measure.  
 — Indicates data missing or suppressed.  
 For measure definitions, including data sources and years, visit [AmericasHealthRankings.org](https://AmericasHealthRankings.org).

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