2025 Senior Report

AMERICA'S HEALTH RANKINGS®
UNITED HEALTH FOUNDATION

Contents

Several bright spots in older adult health highlight opportunities for leaders to build on successes and address persistent challenges.

The data in this report underscore meaningful progress in recent years, including decreases in the early death rate and strengthened social support and engagement among older adults. We encourage communities and leaders nationwide to leverage these insights – along with the detailed state-level and demographic group data available across the *America's Health Rankings* platform – to amplify progress, confront ongoing challenges and promote the health and well-being of all older adults.

Definitions, Limitations and Methodology

For details on demographic group definitions and limitations, data sources and methodology, please refer to the Appendix on page 24 and visit AmericasHealthRankings.org.

The United Health Foundation is proud to release the *America's Health Rankings® 2025 Senior Report*, which provides a portrait of the health and well-being of older adults across the United States.

This report highlights improvements in early deaths, social support and engagement measures, and the number of geriatric clinicians. Despite these successes, drug deaths, suicide and poverty increased, and flu vaccinations declined.

The *2025 Senior Report* found that the early death rate decreased for the second consecutive year. Meanwhile, the number of geriatric clinicians continued to improve nationwide, as did high-speed internet access. Volunteerism among older adults increased.

Despite these positive developments, rates of suicide, firearm deaths and drug deaths all continued to increase, with striking health differences by gender and race/ethnicity. Furthermore, older adults faced rising rates of poverty, and flu vaccinations decreased. These challenges pose significant obstacles to achieving optimal health and well-being for older Americans.

Between 2022 and 2023, the population of adults age 65 and older in the United States increased by almost 1.5 million individuals. In 2023, there were more than 59 million adults age 65 and older in the U.S., making up 17.7% of the population. The proportion of older adults will continue to rise as the last baby boomers turn 65 years old, approaching 2030.[1] As the older American population grows, it remains important to strengthen and expand initiatives that promote their health and well-being while working collaboratively to address the complex challenges they face.

This year's report further explores the health and resilience of older adults by introducing new measures tracking RSV vaccinations, state emergency management plans and direct care worker wage competitiveness. In 2024, 33.0% of older adults in the U.S. received an RSV vaccination. In 2023, nine states had a FEMA-approved enhanced state hazard mitigation plan for natural disasters, and direct care workers made $2.89 less per hour on average than other entry-level workers.

Finally, the report analyzed the health of older adults on a state-by-state basis. Older adults comprise a much larger share of the population in some states than others. In 2023, Maine had the largest proportion of residents age 65 and older (23.0%), followed by Vermont (22.1%) and Florida (21.7%). Utah had the smallest proportion (12.2%), followed by the District of Columbia (13.1%), Texas (13.7%) and Alaska (14.4%). Strengths and challenges were present in every state, no matter the size of the older adult population.

In 2023, there were more than 59 million adults age 65 and older in the U.S., making up 17.7% of the population.

The data in this report show meaningful progress in recent years, including decreases in the early death rate and strengthened social support and engagement among older adults. We encourage communities and leaders nationwide to leverage these insights — and detailed state-level and demographic group data available across the *America's Health Rankings* platform — to amplify progress, confront ongoing challenges, and promote the health and well-being of all older adults.

Objective

America's Health Rankings informs and drives action to build healthier communities by offering credible, trusted data that can guide efforts to improve population health and health care. The report is developed in collaboration with an advisory committee to determine the selection of a comprehensive set of measures. The *2025 Senior Report* is based on:

- **Fifty-five measures.** These include 36 ranking and 19 unweighted measures (not included in a state's overall rank). For a complete list of measures, definitions and source details, see the Measures Table (page 25).
- **Five categories of health.** These are comprised of Health Outcomes and four categories of health determinants: Social and Economic Factors, Physical Environment, Behaviors and Clinical Care.
- **Twenty-four sources.** Data are from many sources, including the Centers for Disease Control and Prevention's (CDC's) Behavioral Risk Factor Surveillance System (BRFSS) and the U.S. Census Bureau's American Community Survey.

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 the impact of social determinants of health.
- **Providing a benchmark for states.** Since 2013, the report has presented strengths, challenges and key findings for every state and the District of Columbia. Public health advocates can monitor health trends over time and compare their state with other states and the nation. State Summaries are available on the *America's Health Rankings* website as separate downloads.
- **Highlighting differences.** The report shows differences in health between states and among demographic groups at state and national levels, with groupings based on race/ethnicity, gender, age, education, income, metropolitan status, disability status, sexual orientation and veteran status where data are available.
- **Stimulating action.** The report aims to drive change and improve health by drawing attention to trends and promoting data-driven discussions among individuals, community leaders, public health workers, policymakers and the media. States can incorporate population insights into their annual review of programs, and many organizations use the report as a reference when assigning goals for health improvement plans.

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, particularly County Health Rankings & Roadmaps and Healthy People. The model serves as a framework across all *America's Health Rankings* reports for identifying and quantifying the drivers and outcomes that impact state and national population health.

National Snapshot

Health Outcomes

58%▲
Drug Deaths*
increase from 8.4 to 13.3 deaths per 100,000 adults age 65 and older between 2018-2020 and 2021-2023.

10%▼
Excessive Drinking**
decrease from 7.7% to 6.9% of adults age 65 and older between 2022 and 2023.

9%▼
Early Death*
decrease from 1,979 to 1,810 deaths per 100,000 adults ages 65-74 between 2022 and 2023.

5%▲
Suicide*
increase from 16.9 to 17.7 deaths per 100,000 adults age 65 and older between 2018-2020 and 2021-2023.

Social and Economic Factors

19%▲
Volunteerism†
increase from 22.1% to 26.3% of adults age 65 and older between 2021 and 2023.

6%▲
Firearm Deaths*
increase from 13.0 to 13.8 deaths per 100,000 adults age 65 and older between 2018-2020 and 2021-2023.

4%▲
Poverty††
increase from 10.9% to 11.3% of adults age 65 and older between 2022 and 2023.

2%▲
High-Speed Internet††
increase from 84.8% to 86.5% of households with adults age 65 and older between 2022 and 2023.

Flu Vaccination**
6%▼
decrease from 67.7% to 63.4% of adults age 65 and older between 2022 and 2023.

Geriatric Clinicians§
5%▲
increase from 38.0 to 39.9 clinicians per 100,000 adults age 65 and older between September 2023 and September 2024.

RSV Vaccination§§
33.0%
of adults age 60 and older reported ever receiving an RSV vaccine in 2024.

* Source: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, Multiple Cause of Death by Single Race Files via CDC WONDER Online Database.
** Source: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. (Note: No data were available for Kentucky or Pennsylvania in 2023.)
† Source: U.S. Census Bureau, Current Population Survey, Volunteering and Civic Life Supplement.
†† Source: U.S. Census Bureau, American Community Survey, 1-Year Dataset.
§ Source: U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, National Plan and Provider Enumeration System.
§§ Source: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, NIS-Adult COVID Module, January 2025.

Findings

Early deaths among adults ages 65-74 have nearly returned to 2019 levels, social support and engagement measures are improving, and the number of geriatric clinicians is on the rise. Despite these successes, drug deaths and suicides reached the highest levels in *Senior Report* history, and socioeconomic challenges persist.

HEALTH OUTCOMES | BEHAVIORAL HEALTH

Drug overdose and suicide deaths among older adults reached new highs, while excessive drinking decreased.

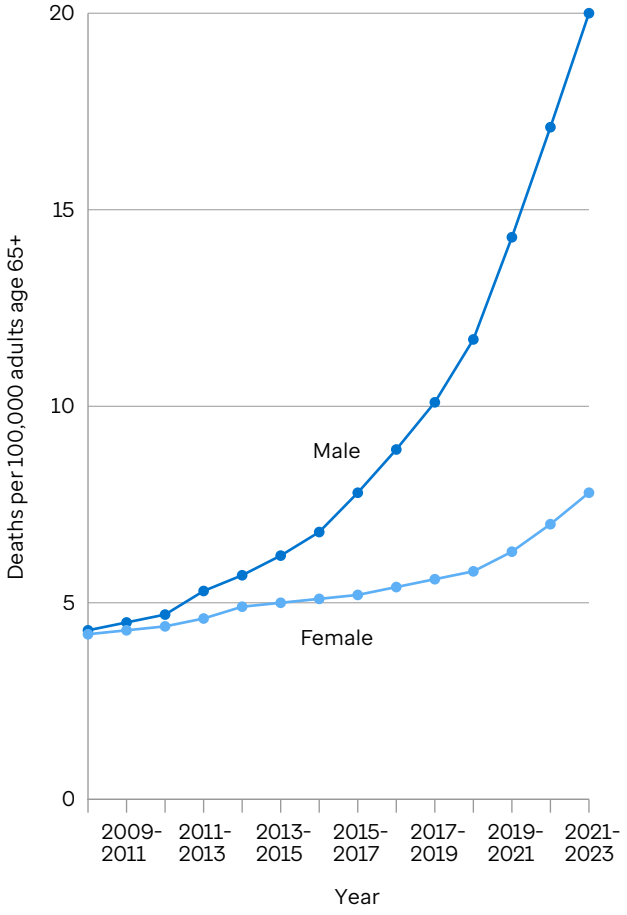
Drug Deaths

Drug overdose deaths among older adults have risen in the United States over the past two decades.[2] Drug abuse is hazardous for older adults because age-related changes in the liver reduce the ability to metabolize medications, and most older adults take one or more prescription medications.[3,4] They may also take nonprescription medications and dietary herbal supplements, which can further complicate drug interactions and lead to drug-induced death.[5,6]

Changes over time. Nationally, the drug death rate increased 58% from 8.4 to 13.3 deaths due to drug injury (unintentional, suicide, homicide or undetermined) per 100,000 adults age 65 and older between 2018-2020 and 2021-2023. There were 23,000 drug deaths among adults age 65 and older in 2021-2023, 9,350 more than in 2018-2020. While the drug death rate among older adults is below the Healthy People 2030 target to reduce drug overdose deaths for all ages to 20.7 per 100,000 population, it continues to rise in a problematic trend.[7]

Increases in Drug Deaths

By Gender



Source: U.S. HHS, Multiple Cause of Death Files via CDC WONDER, 2008-2023.

Between 2018-2020 and 2021-2023, the drug death rate among older adults significantly increased:

- 131% among American Indian/Alaska Native (6.7 to 15.5 deaths per 100,000 adults age 65), 85% among Black (19.8 to 36.7), 80% among Hispanic (5.6 to 10.1), 68% among multiracial (5.7 to 9.6) and 44% among white (7.7 to 11.1) older adults.
- 71% among men (11.7 to 20.0) and 34% among women (5.8 to 7.8).

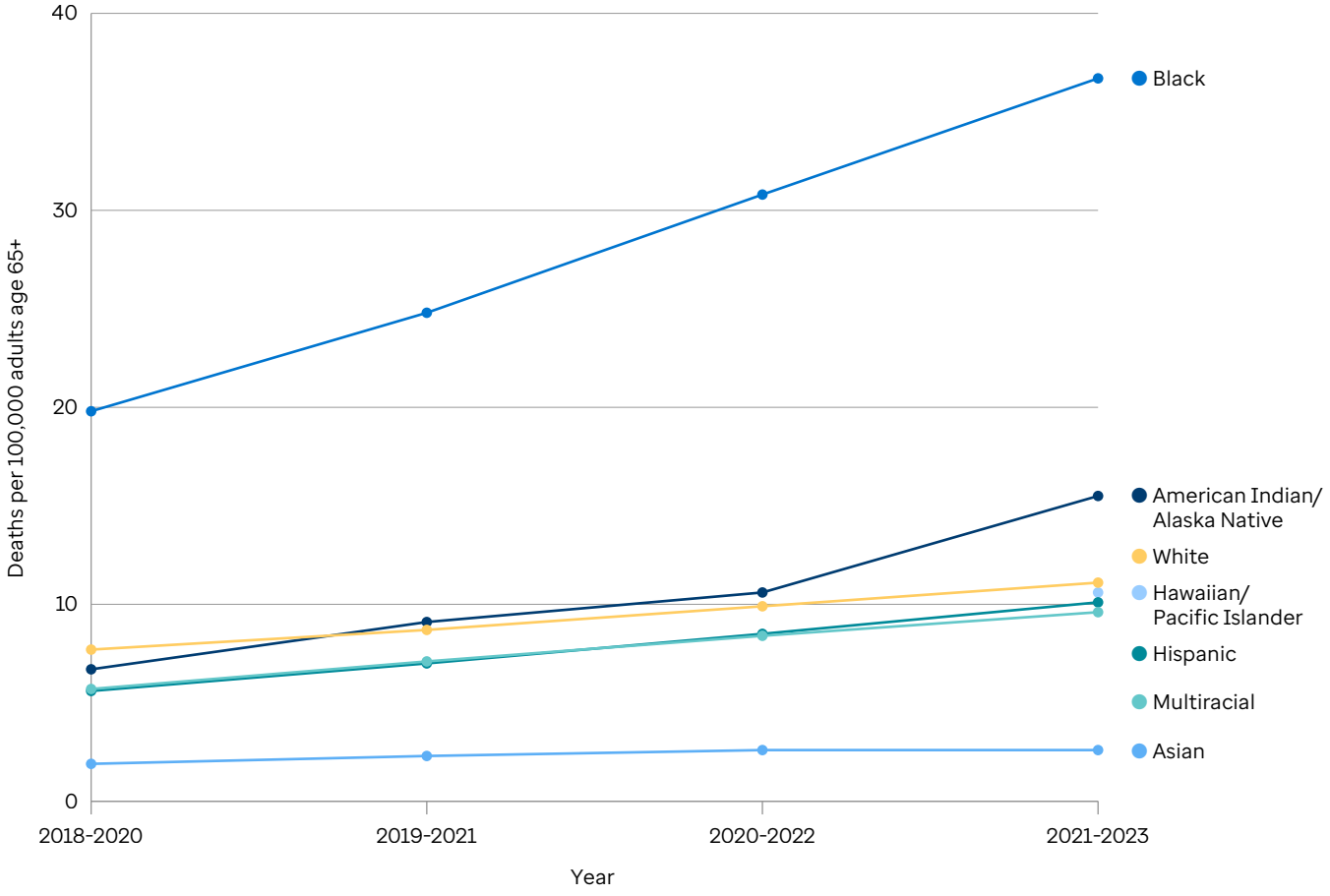
During this time frame, the drug death rate significantly increased in 37 states and the District of Columbia. The largest increases were: 120% in Kansas (5.4 to 11.9), 115% in Delaware (8.1 to 17.4) and 106% in Maine (5.3 to 10.9).

Differences. In 2021-2023, the drug death rate significantly varied by geography, race/ethnicity and gender. The rate among older adults was:

- 24.1 times higher in the District of Columbia (98.9 deaths per 100,000 adults age 65 and older), and 5.5 times higher in Nevada (22.5) than in South Dakota (4.1).
- 14.1 times higher among Black (36.7) compared with Asian (2.6) older adults.
- 2.6 times higher among men (20.0) than women (7.8).

Increases in Drug Deaths

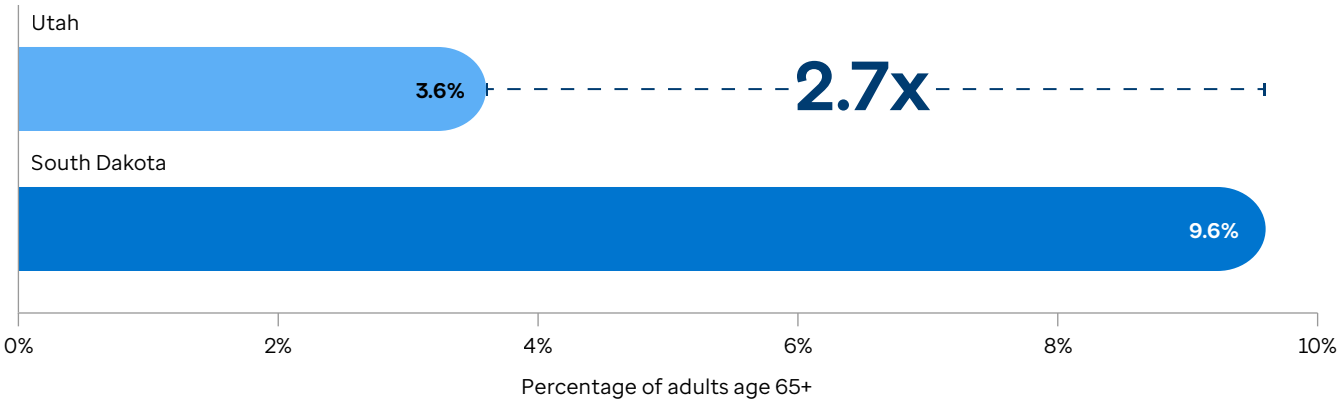
By Race/Ethnicity



Source: U.S. HHS, Multiple Cause of Death Files via CDC WONDER, 2018-2023.

Excessive Drinking

By State in 2023



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2023.

Excessive Drinking

Excessive alcohol consumption is associated with many adverse health outcomes, including unintentional injuries, cardiovascular conditions and mental health consequences.[8] Alcohol tolerance tends to decrease with age, which can make older adults more sensitive to its effects. Adults age 65 and older have a higher alcohol-attributed death rate than adults ages 25-44 due to heightened alcohol sensitivity, higher rates of health problems and greater risk for interactions with medications.[9,8]

Changes over time. Nationally, the percentage of adults age 65 and older who reported binge drinking (four or more drinks on one occasion in the past 30 days for females or five or more for males) or heavy drinking (eight or more drinks per week for females or 15 or more for males) decreased 10% from 7.7% to 6.9% of older adults between 2022 and 2023.

Between 2022 and 2023, the prevalence of excessive drinking among older adults significantly decreased:

- 12% among college graduates (8.3% to 7.3%).
- 11% among those without a disability (8.5% to 7.6%).
- 10% among those living in metropolitan areas (7.8% to 7.0%).

During this time, excessive drinking prevalence among older adults also decreased 36% in Missouri (8.0% to 5.1%), the only state with a significant change.

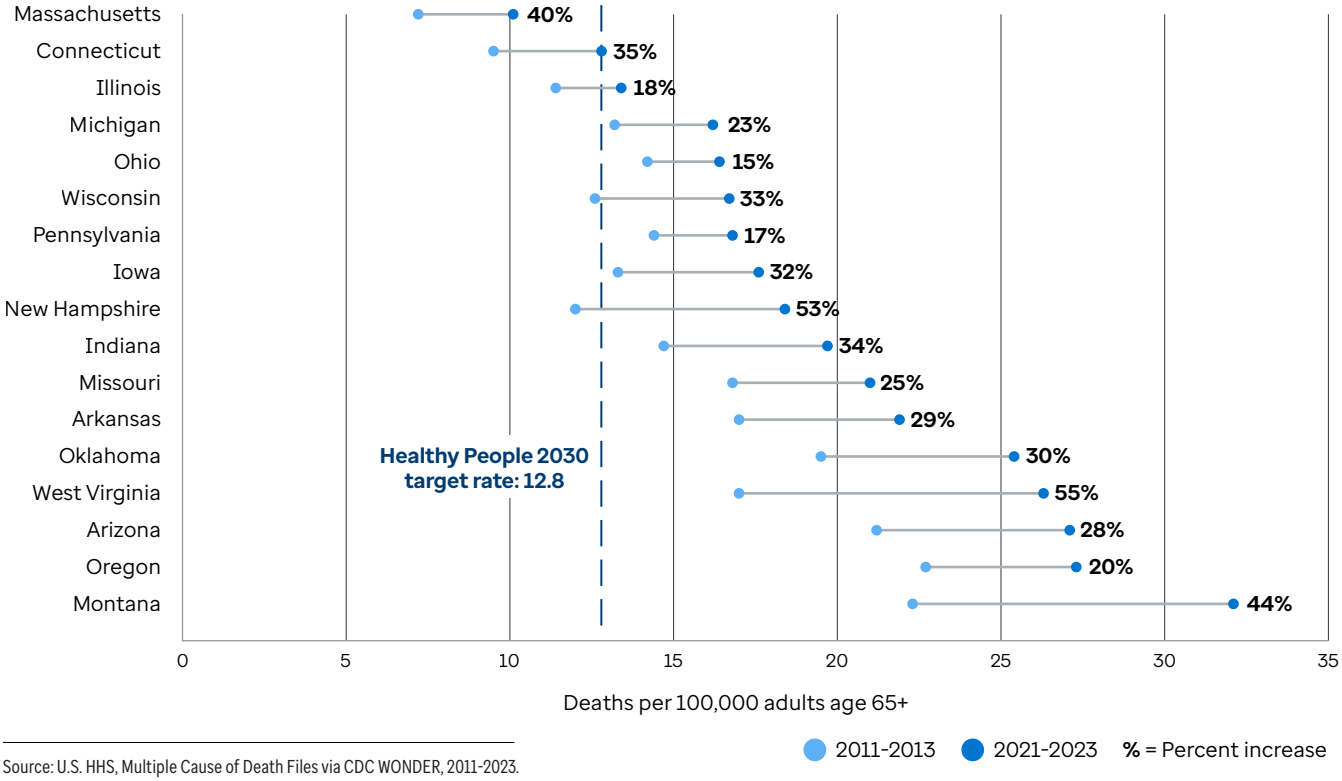
Differences. In 2023, the prevalence of excessive drinking significantly varied by geography, race/ethnicity, disability status, gender, household income and educational attainment. The prevalence among adults age 65 and older was:

- 2.7 times higher in South Dakota (9.6%) than in Utah (3.6%).
- 2.3 times higher among American Indian/Alaska Native (10.4%) compared with Black (4.6%) older adults.
- 1.7 times higher among older adults without a disability (7.6%) than those with independent living difficulty (4.6%).
- 1.6 times higher among men (8.6%) than women (5.5%).
- 1.5 times higher among older adults with an annual household income of $75,000 or more (9.2%) than those with incomes less than $25,000 (6.0%).
- 1.3 times higher among college graduates (7.3%) compared with those with less than a high school education (5.5%).

Note: No data were available for Kentucky or Pennsylvania in 2023. The values for American Indian/Alaska Native, white (7.3%), other race (7.3%), Hispanic (6.6%), multiracial (5.8%) and Asian (5.0%) older adults may not differ significantly from each other based on overlapping 95% confidence intervals. The same is true among Black, Asian (5.0%), multiracial (5.8%), Hispanic (6.6%) and other race (7.3%) older adults; among older adults without a disability, those who have difficulty with cognition (6.7%) and those with difficulty seeing (6.4%); among older adults with independent living difficulty, difficulty with mobility (5.3%), difficulty with self-care (5.6%), difficulty hearing (6.0%) and difficulty seeing (6.4%); among older adults with an annual household income less than $25,000, those with incomes of $25,000-$49,999 (6.6%) and those with incomes of $50,000-$74,999 (7.5%); among college graduates, those with some post-high school education (7.2%) and high school graduates (6.7%); and among older adults with less than a high school education, high school graduates and those with some post-high school education.

Significant Increases in Suicide

By State Between 2011-2013 and 2021-2023



Source: U.S. HHS, Multiple Cause of Death Files via CDC WONDER, 2011-2023.

Suicide

Suicide attempts among older adults are more likely to be fatal than suicide attempts among younger people.[10] Risk factors for suicide among older adults include mental illness, depression, previous suicide attempts, substance use problems, chronic pain, physical illness, declining function, disability, family discord or loss, family history of suicide and social isolation.[10,11,12] Dementia and other forms of impaired cognitive ability have also been linked to suicidal behavior in older adults.[13]

Changes over time. Nationally, the suicide rate increased 5% from 16.9 to 17.7 deaths due to intentional self-harm per 100,000 adults age 65 and older between 2018-2020 and 2021-2023. This is the highest suicide rate in *Senior Report* history, and remains higher than the Healthy People 2030 target to reduce suicide deaths among all ages to 12.8 per 100,000 population.[14] In 2021-2023, there were 30,500 suicide deaths among adults age 65 and older, 3,100 more than in 2018-2020.

Between 2018-2020 and 2021-2023, the suicide rate among older adults significantly increased:

- 14% among adults age 85 and older (20.0 to 22.7 deaths per 100,000) and 6% among adults ages 75-84 (18.6 to 19.8).
- 6% among white older adults (20.2 to 21.4).
- 6% among women (5.1 to 5.4) and 3% among men (31.6 to 32.6).

The suicide rate significantly increased in four states between 2018-2020 and 2021-2023:

- 69% in Delaware (10.2 to 17.2).
- 36% in West Virginia (19.3 to 26.3).
- 23% in Indiana (16.0 to 19.7).
- 16% in North Carolina (15.7 to 18.2).

In the past decade, the suicide rate has significantly increased in 17 states. The largest increases between 2011-2013 and 2021-2023 were:

- 55% in West Virginia (17.0 to 26.3).
- 53% in New Hampshire (12.0 to 18.4).
- 44% in Montana (22.3 to 32.1).

Differences. In 2021-2023, the suicide rate significantly varied by gender, race/ethnicity, geography and age group. The rate among older adults was:

- 6.0 times higher among men (32.6 deaths per 100,000 adults age 65 and older) compared with women (5.4).
- 4.5 times higher among white (21.4) compared with Black (4.8) older adults.
- 4.0 times higher in Montana (32.1) than in the District of Columbia (8.0), and 3.3 times higher in Montana than in New Jersey and Rhode Island (both 9.6).
- 1.4 times higher among adults age 85 and older (22.7) than those ages 65-74 (15.7).

Related Measure: Firearm Deaths

In 2021-2023, there were approximately 23,900 firearm deaths among adults age 65 and older, almost 2,800 more than in 2018-2020. Of these, 90.8% were due to suicide and 7.6% were due to homicide.

Changes over time. Nationally, the firearm death rate increased 6% from 13.0 to 13.8 deaths due to firearm injury of any intent (unintentional, suicide, homicide or undetermined) per 100,000 adults age 65 and older between 2018-2020 and 2021-2023. This rate is higher than the Healthy People 2030 target to reduce firearm-related deaths to 10.7 per 100,000 population.[15]

Between 2018-2020 and 2021-2023, the firearm death rate among older adults significantly increased:

- 16% among Black older adults (5.5 to 6.4 deaths per 100,000 adults age 65 and older) and 7% among white older adults (15.7 to 16.8).
- 16% among adults age 85 and older (15.7 to 18.2), 7% among adults ages 75-84 (15.2 to 16.2) and 4% among adults ages 65-74 (11.3 to 11.8).
- 5% among men (26.0 to 27.2).

During the same time, the firearm death rate increased in four states: 32% in West Virginia (18.4 to 24.2 deaths per 100,000 adults age 65 and older), 21% in both Indiana (14.2 to 17.2) and Illinois (8.0 to 9.7), and 17% in North Carolina (13.6 to 15.9).

Differences. In 2021-2023, the firearm death rate significantly varied by gender, geography, race/ethnicity and age group. The rate among older adults was:

- 9.7 times higher among men (27.2 deaths per 100,000 adults age 65 and older) compared with women (2.8).
- 8.4 times higher in Wyoming (27.8) than in Massachusetts (3.3).
- 7.6 times higher among white (16.8) compared with Asian (2.2) older adults.
- 1.5 times higher among adults age 85 and older (18.2) than those ages 65-74 (11.8).

Note: For the suicide measure, the values for Black and multiracial (6.3) older adults may not differ significantly from each other based on overlapping 95% confidence intervals.

HEALTH OUTCOMES | MORTALITY

Early death rates among adults ages 65-74 dropped 9% in 2023, as COVID-19 exited the top 10 causes of death.

Early Death

Based on calculations from 2023, the average 65-year-old in the U.S. should expect to live another 19.5 years.[16] However, many older adults do not live to see their 75th birthday. Research estimates that 48% of all early deaths involve behavioral and other preventable causes – among them, social isolation, which affects approximately a quarter of older adults.[17,18,12]

Changes over time. Nationally, the early death rate decreased 9% from 1,979 to 1,810 deaths per 100,000 adults ages 65-74 between 2022 and 2023, nearly back to the 2019 rate (1,765). In 2023, there were 627,700 deaths among adults ages 65-74, 40,900 fewer than in 2022. This improvement follows a sharp rise in early deaths between 2019 and 2021, when the rate reached 2,151 deaths per 100,000 adults ages 65-74. In 2023, for the first time since its emergence, COVID-19 was not among the top 10 causes of death for people ages 65-74. Chronic diseases accounted for six of the top 10 causes of death among adults ages 65-74 in 2023. The chronic conditions in the top 10 were cancer, heart diseases, chronic lower respiratory diseases, cerebrovascular diseases, diabetes and liver disease. Unintentional injury was the sixth-leading cause of death, with more than half of these cases attributed to unintentional poisonings (including drug deaths) and falls.

Between 2022 and 2023, the early death rate among adults ages 65-74 significantly decreased:

- 13% among both Hispanic (1,523 to 1,319 deaths per 100,000 adults ages 65-74) and Hawaiian/Pacific Islander (2,323 to 2,031) older adults, 12% among American Indian/Alaska Native older adults (2,198 to 1,942), 11% among Asian older adults (963 to 859), 9% among Black older adults (2,791 to 2,539) and 8% among white older adults (1,993 to 1,838).
- 9% among men (2,420 to 2,212) and 8% among women (1,586 to 1,452).

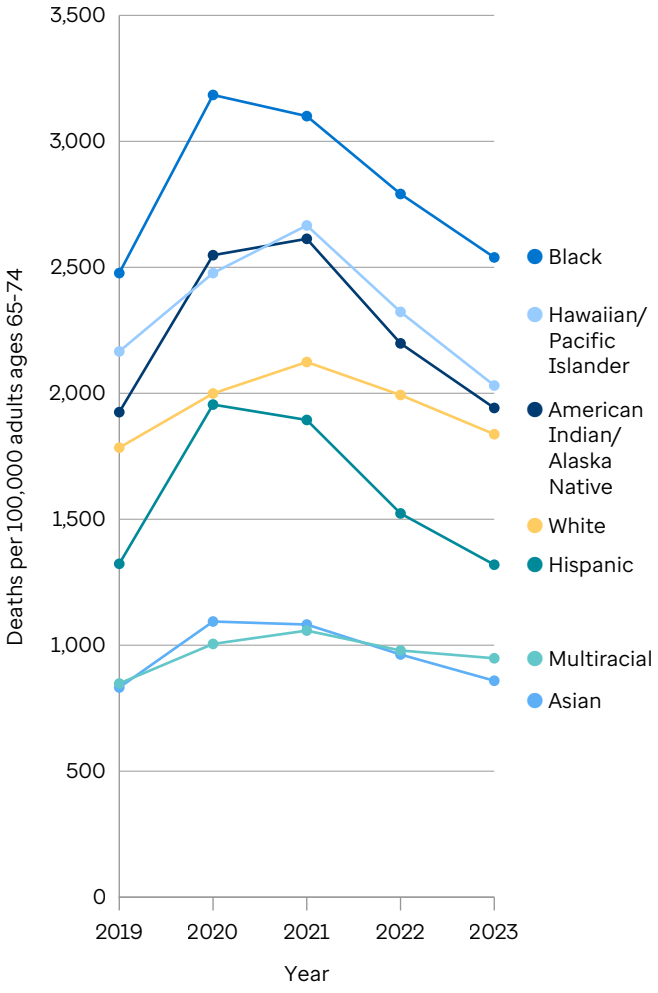
During the same time, the early death rate significantly decreased in 38 states, led by: 16% in Delaware (1,919 to 1,607), 13% in Oklahoma (2,789 to 2,432), and 12% in both Nevada (2,211 to 1,947) and New Jersey (1,625 to 1,437).

Differences. In 2023, the early death rate significantly varied by race/ethnicity, geography and gender. The rate among older adults was:

- 3.0 times higher among Black (2,539 per 100,000 adults ages 65-74) compared with Asian (859) older adults.
- 1.8 times higher in Mississippi (2,578) than in New Jersey (1,437).
- 1.5 times higher among men (2,212) than women (1,452).

Changes in Early Death

By Race/Ethnicity



Source: U.S. HHS, Multiple Cause of Death Files via CDC WONDER, 2019-2023.

HEALTH OUTCOMES | PHYSICAL HEALTH

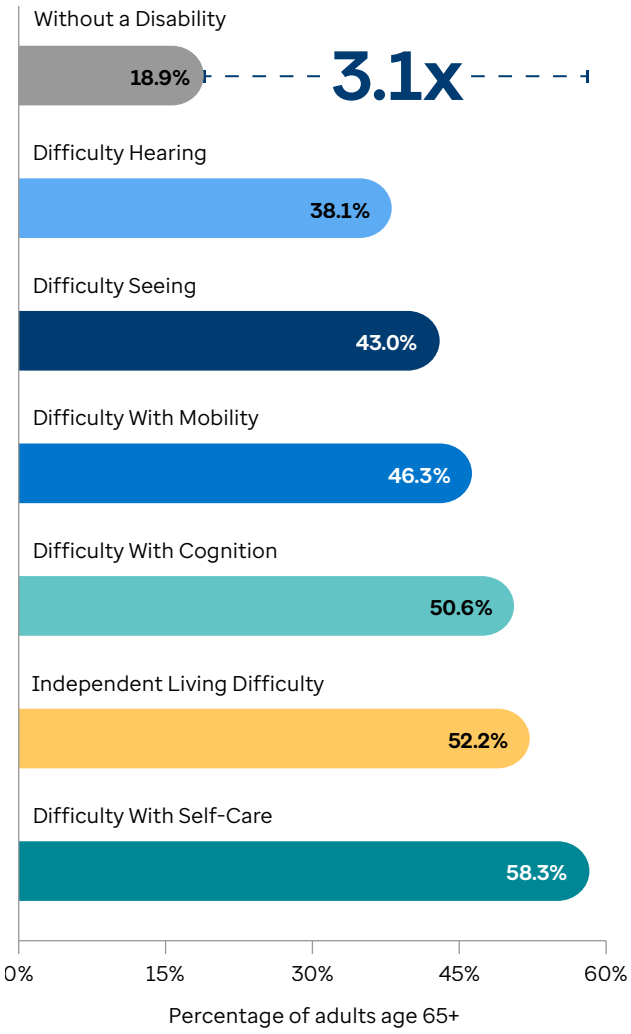
The prevalence of falls and obesity among older adults remained stable.

Falls

Falls among older adults can cause serious injuries that may lead to high medical costs and threaten their independence over time.[19] The fatality rate from falls has increased steadily over the last few decades, particularly among those age 85 and older.[20] In 2021, there were more than 38,700 deaths related to falls among older adults in the U.S.[21]

Falls

By Disability Status in 2023



Source: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2023.
Note: No data were available for Kentucky and Pennsylvania in 2023.

Changes over time. Nationally, 27.8% of adults age 65 and older reported falling in the past 12 months in 2023. The overall rate has not changed since it significantly decreased between 2016 and 2018.

Between 2020 and 2023, the prevalence of falls among adults age 65 and older significantly increased:

- 14% among those with an annual household income less than $25,000 (31.6% to 36.0%).
- 7% among those living in nonmetropolitan areas (29.6% to 31.8%).

During the same time, the prevalence of falls significantly increased in three states: 41% in Illinois (20.0% to 28.2%), 25% in Connecticut (21.3% to 26.7%) and 18% in Montana (29.9% to 35.3%).

Differences. In 2023, the prevalence of falls significantly varied by disability status, race/ethnicity, geography, household income, metropolitan status and sexual orientation. The prevalence among adults age 65 and older was:

- 3.1 times higher among those who have difficulty with self-care (58.3%) compared with those without a disability (18.9%).
- 2.5 times higher among multiracial (38.9%) compared with Asian (15.5%) older adults.
- 1.6 times higher in Montana (35.3%) than in New Jersey (22.0%).
- 1.4 times higher among older adults with an annual household income less than $25,000 (36.0%) compared with those with incomes of $75,000 or more (24.9%).
- 1.2 times higher among those living in nonmetropolitan areas (31.8%) than those in metropolitan areas (27.0%).
- 1.2 times higher among LGBQ+ (32.8%) compared with straight (27.9%) older adults.

The prevalence was also higher among older women (29.1%) than older men (26.3%), and among older adults who have served in the U.S. armed forces (29.4%) than those who have not served (27.5%).

Note: No data were available for Kentucky or Pennsylvania in 2023. The values for multiracial, American Indian/Alaska Native (34.8%) and other race (30.1%) older adults may not differ significantly from each other based on overlapping 95% confidence intervals. The same applies to Asian and Hawaiian/Pacific Islander (19.3%) older adults.

Obesity

Obesity is a complex health condition with biological, economic, environmental, individual and societal causes.[22] Research suggests that the strength of the association between obesity and mortality risk increases with age, making obesity among older adults an area of particular concern.[23]

Changes over time. Nationally, 30.2% of adults age 65 and older had a body mass index of 30.0 or higher based on reported height and weight in 2023. This prevalence has leveled off after increasing steadily between 2011 (25.3%) and 2019 (29.3%).

Between 2022 and 2023, the prevalence of obesity significantly increased in two states: 28% in Oregon (25.9% to 33.2%) and 15% in Maryland (27.9% to 32.0%). During the same time, the prevalence significantly decreased 9% among older adults with difficulty hearing (34.6% to 31.5%).

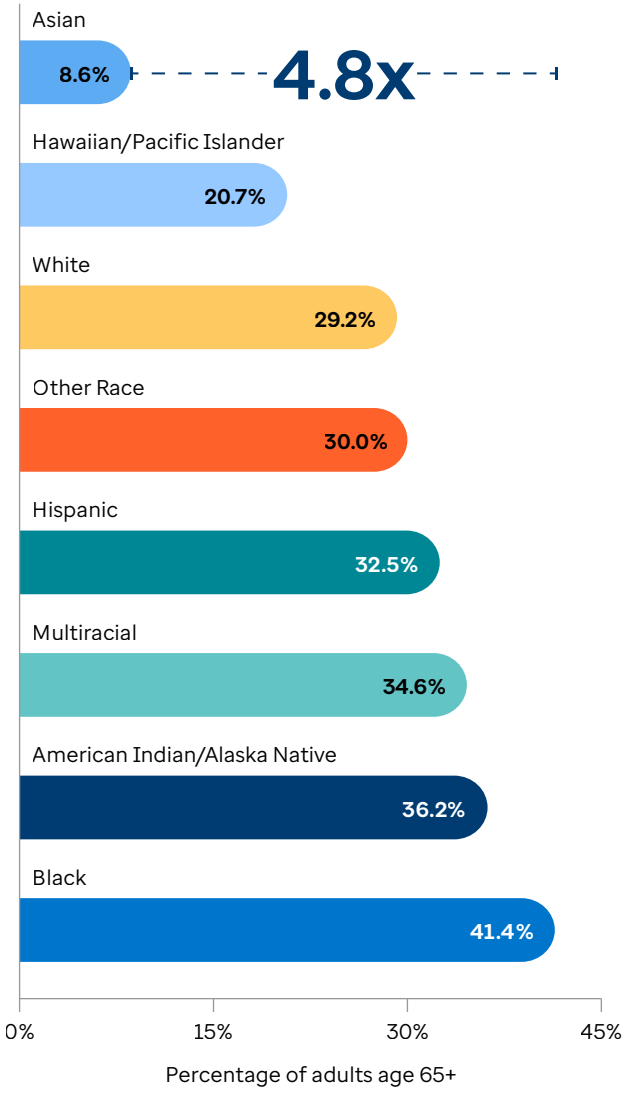
Differences. In 2023, the prevalence of obesity among older adults significantly varied by race/ethnicity, disability status, geography, educational attainment and household income. The prevalence among adults age 65 and older was:

- 4.8 times higher among Black (41.4%) than Asian (8.6%) older adults.
- 1.8 times higher among those who have difficulty with self-care (46.0%) compared with those without a disability (25.2%).
- 1.8 times higher in Louisiana (36.1%) than in Hawaii (20.5%).
- 1.5 times higher among those with less than a high school education (35.7%) compared with college graduates (24.5%).
- 1.3 times higher among those with an annual household income less than $25,000 (35.6%) than those with incomes of $75,000 or more (27.9%).

The prevalence was also higher among older adults living in nonmetropolitan areas (33.7%) than those in metropolitan areas (29.4%).

Obesity

By Race/Ethnicity in 2023



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2023.
Note: The values for Black, American Indian/Alaska Native and multiracial older adults may not differ significantly from each other based on overlapping 95% confidence intervals.

Note: No data were available for Kentucky or Pennsylvania in 2023. The values for Black, American Indian/Alaska Native (36.2%) and multiracial (34.6%) older adults may not differ significantly from each other based on overlapping 95% confidence intervals. The same is true for older adults who have difficulty with self-care and difficulty with mobility (44.5%); and among older adults with less than a high school education and high school graduates (32.6%).

Internet Crime

90,871

victim complaints reported among adults age 60 and older in 2023.

Source: U.S. DOJ, FBI, Elder Fraud Report, 2023.

SOCIAL AND ECONOMIC FACTORS | COMMUNITY AND FAMILY SAFETY

Older adults faced rising rates of internet crime.

Internet Crime

Age-related cognitive decline and higher average net worth make older adults frequent victims of fraud.[24,25,26] Fraudulent activities often inflict significant financial losses on older adults, in addition to negative emotional responses like depression, anxiety, self-blame and shame.[27] Fear of being scammed can also lead to social isolation as older adults withdraw from online activities that connect them with loved ones. In 2023, victims age 60 and older in the U.S. cumulatively lost more than $3.4 billion to internet fraud.[28]

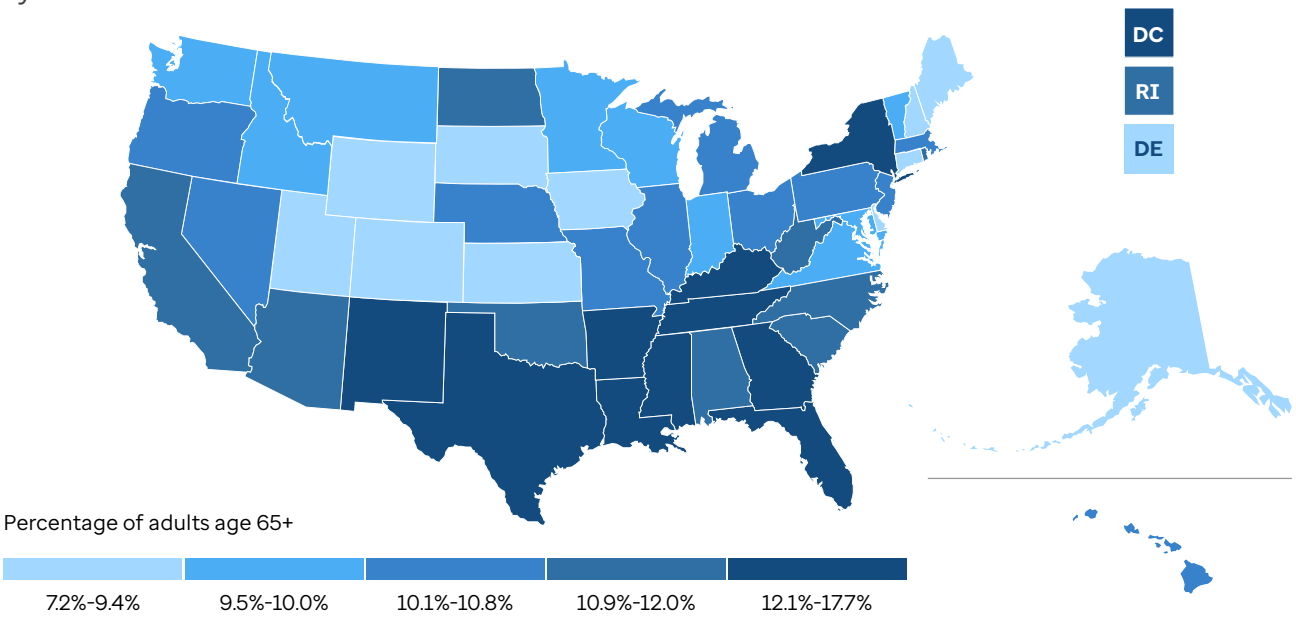
Changes over time. Nationally, the number of internet crime victim complaints increased 5% from 10.7 to 11.2 per 10,000 adults age 60 and older between 2022 and 2023. Nearly 90,900 internet crime victim complaints were reported among adults age 60 and older in 2023, almost 6,100 more than in 2022.

During this time, internet crime increased at a rate equal to or greater than the national change of 5% in 25 states. The largest increases were 36% in Arizona (19.4 to 26.3 complaints per 10,000 adults age 60 and older), 25% in Utah (13.2 to 16.5) and 22% in Rhode Island (7.8 to 9.5). The rate also decreased in 10 states by 5% or more, led by 16% in both Maine (10.9 to 9.2) and Vermont (10.0 to 8.4), 15% in New Jersey (10.6 to 9.0) and 13% in Wyoming (14.2 to 12.4).

Differences. In 2023, the internet crime rate among older adults was 4.3 times higher in Arizona (26.3 complaints per 10,000 adults age 60 and older) than in Mississippi (6.1).

Poverty

By State in 2023



Source: U.S. Census Bureau, American Community Survey, 2023.

SOCIAL AND ECONOMIC FACTORS | ECONOMIC RESOURCES

Poverty among older adults increased 4% in 2023 to another new high, with significant differences between populations.

Poverty

Poverty is associated with chronic disease, mortality and poor health outcomes.[29,30] Many older adults subsist on limited incomes and modest savings that may restrict their ability to afford basic medical care.[31] Furthermore, studies show that older adults living in poverty experience higher rates of disability, homelessness, and physical and cognitive decline.[32,33,34]

Changes over time. Nationally, the percentage of adults age 65 and older living below the poverty level significantly increased 4% from 10.9% to 11.3% between 2022 and 2023 – a new high in *Senior Report* history. Poverty among older adults remains higher than the Healthy People 2030 target to reduce the proportion of people of all ages living in poverty to 8.0%.[35] In 2023, 6.5 million older adults lived in poverty, 346,500 more than in 2022.

Between 2022 and 2023, poverty among adults age 65 and older significantly increased 3% among white older adults (8.8% to 9.1%).

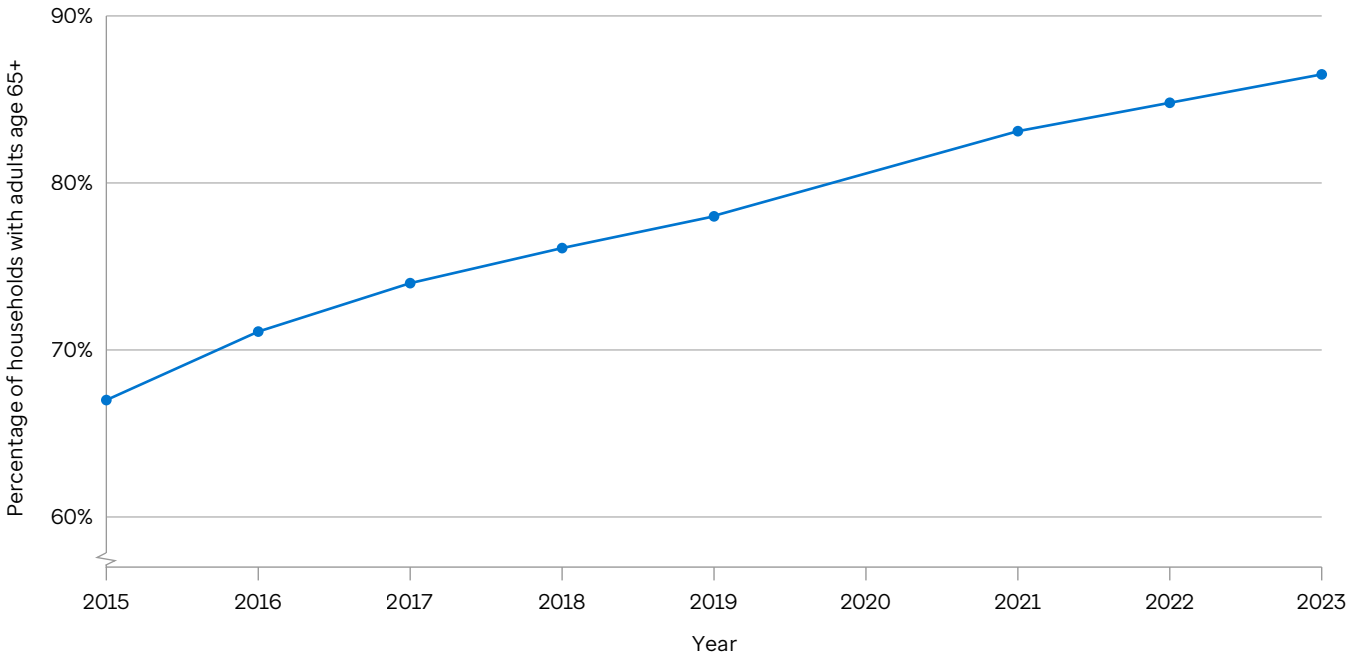
During the same time, poverty increased in two states and decreased in one. Rates increased 11% in Tennessee (11.0% to 12.2%) and 8% in New York (13.2% to 14.3%), and decreased 24% in Montana (12.5% to 9.5%).

Differences. In 2023, poverty significantly varied by geography and race/ethnicity. The prevalence among adults age 65 and older was:

- 2.2 times higher in Mississippi (15.8%) than in Alaska (7.2%).
- 2.1 times higher among other race (19.5%) and Black (19.2%) older adults compared with white older adults (9.1%).

Note: The values for other race, Black and American Indian/Alaska Native (18.3%) older adults may not differ significantly from each other based on overlapping 95% confidence intervals.

Increase in High-Speed Internet Access



Source: U.S. Census Bureau, American Community Survey, 2015-2023.

SOCIAL AND ECONOMIC FACTORS | SOCIAL SUPPORT AND ENGAGEMENT

Key social support measures improved, potentially bolstering older adults' connectivity and engagement.

High-Speed Internet

High-speed internet is a vital resource for work, education and effective communication.[36] Many essential services require an internet connection, including telemedicine and telehealth.[37,38] Older adults in particular can benefit from broadband access, as it facilitates social connectedness and enables access to news, information and essential services.[39] Some studies have found that technology such as smartphones and social networking sites may help combat loneliness among older adults.[40,41] Despite its necessity, barriers to accessing high-speed internet remain, including cost and deficient infrastructure.[42]

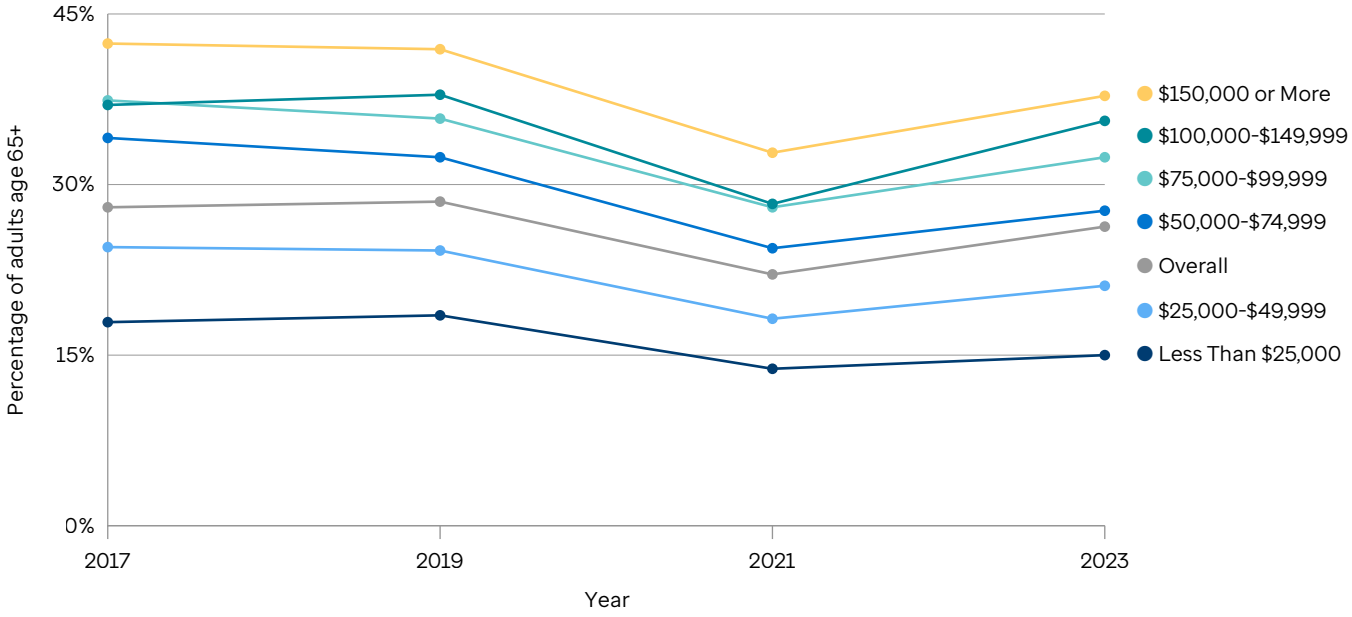
Changes over time. Nationally, the percentage of households with adults age 65 and older that have a broadband internet subscription and a computer, smartphone or tablet significantly increased 2% from 84.8% to 86.5% between 2022 and 2023, reaching another record in *Senior Report* history. In 2023, 49.8 million older adult households had high-speed internet access, 2.2 million more than in 2022.

Between 2022 and 2023, high-speed internet access increased in 28 states, led by 4% in both South Dakota (82.4% to 85.6%) and Nevada (87.7% to 90.8%).

Differences. In 2023, the prevalence of high-speed internet among households with adults age 65 and older was 1.2 times higher in Nevada (90.8%) than in West Virginia (77.6%).

Changes in Volunteerism

By Income Group



Source: U.S. Census Bureau, Current Population Survey, Volunteering and Civic Life Supplement, 2017-2023.
Note: Data released in odd years. The values among older adults with incomes of $150,000 or more, those with incomes of $100,000-$149,999 (35.6%) and those with incomes of $75,000-$99,999 (32.4%) may not differ significantly based on overlapping 95% confidence intervals.

Volunteerism

Volunteering serves the community and offers volunteers opportunities for positive social interactions, increased social support, and a sense of meaning and purpose during retirement.[43,44] Many volunteer opportunities involve active mental and physical engagement, socialization and learning, all good for cognitive function.[45] Emerging evidence shows that older adults who volunteer regularly have fewer cognitive complaints and a lower risk for dementia compared with those who do not volunteer regularly.[46]

Changes over time. Nationally, the percentage of adults age 65 and older who reported volunteering in the past 12 months increased 19% from 22.1% to 26.3% between 2021 and 2023, nearly back to the 2019 rate (28.5%).

Between 2021 and 2023, volunteerism among adults age 65 and older significantly increased:

- 23% among high school graduates (13.3% to 16.3%) and 16% among college graduates (32.5% to 37.8%).
- 22% among men (20.7% to 25.3%) and 17% among women (23.2% to 27.2%).
- 19% among white older adults (25.2% to 30.0%).

During this time, volunteerism prevalence significantly increased in four states: 74% in Tennessee (18.4% to 32.1%), 51% in Oregon (23.8% to 36.0%), 47% in Illinois (22.9% to 33.6%) and 36% in California (15.2% to 20.6%).

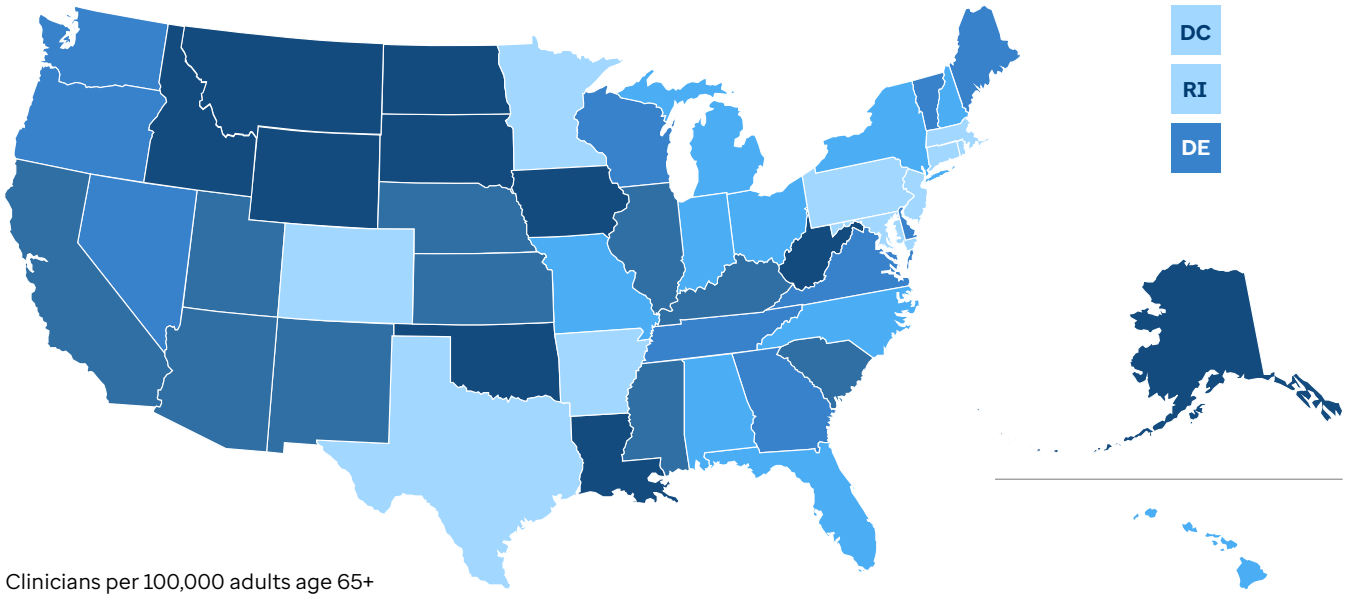
Differences. In 2023, the prevalence of volunteerism significantly varied by educational attainment, race/ethnicity, geography and household income. The prevalence among adults age 65 and older was:

- 4.4 times higher among college graduates (37.8%) than those with less than a high school education (8.5%).
- 3.1 times higher among white (30.0%) compared with Hispanic (9.6%) older adults.
- 3.5 times higher in Utah (44.6%) than in Nevada (12.9%).
- 2.5 times higher among older adults with an annual household income of $150,000 or more (37.8%) than those with incomes less than $25,000 (15.0%).

Note: The values for white and multiracial (23.6%) older adults may not differ significantly from each other based on overlapping 95% confidence intervals. The same is true among Hispanic, Asian (13.4%) and American/Indian Alaska Native (17.1%) older adults; as well as among older adults with incomes of $150,000 or more, those with incomes of $100,000-$149,999 (35.6%) and those with incomes of $75,000-$99,999 (32.4%).

Geriatric Clinicians

By State in 2024



Source: U.S. HHS, CMS, National Plan and Provider Enumeration System, 2024.
Note: Monthly data retrieved in September of each year.

CLINICAL CARE | ACCESS TO CARE

The number of geriatric clinicians per 100,000 adults age 65 and older rose 5% nationally.

Geriatric Clinicians

Geriatricians, or geriatric doctors and nurses, are medical practitioners trained to meet the unique needs of older adults. Special geriatric unit care and rehabilitative services involving a geriatrician have been shown to improve patient outcomes and lead to better functioning.[47] In primary care settings, geriatricians provide better medication management than other clinicians and are better suited to treat aging-related diseases such as dementia, incontinence and osteoporosis.[48] As the baby boomer generation reaches older adulthood and average lifespans grow longer, the demand for geriatricians is increasing more quickly than the supply.[1,49]

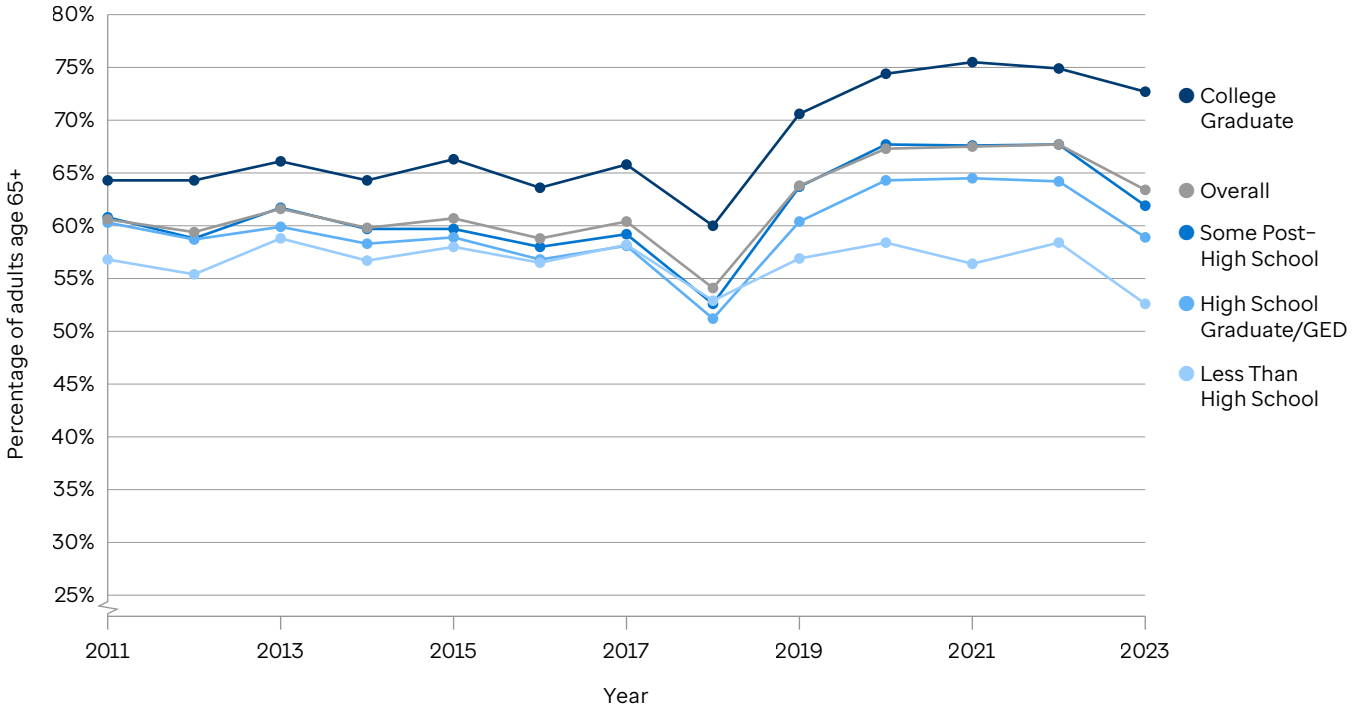
Changes over time. Nationally, the number of family medicine and internal medicine geriatricians and nurse practitioners per 100,000 adults age 65 and older increased 5% from 38.0 to 39.9 between September 2023 and September 2024. In September 2024, there were approximately 23,700 geriatric clinicians across the country, nearly 1,720 more than in September 2023.

During this time frame, the number of geriatric clinicians increased at a rate equal to or greater than the national change of 5% in 27 states, led by: 19% in New Jersey (51.6 to 61.3 clinicians per 100,000 adults age 65 and older), 15% in Tennessee (32.3 to 37.1) and 14% in Idaho (18.2 to 20.8). At the same time, geriatric clinicians decreased 5% in Vermont (33.7 to 32.1).

Differences. In September 2023, the number of geriatric clinicians per 100,000 adults age 65 and older was 5.8 times higher in the District of Columbia (100.3 clinicians per 100,000 adults age 65 and older) and 4.3 times higher in Rhode Island (73.7) than in South Dakota (17.2).

Changes in Flu Vaccination

By Educational Attainment



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2011-2023.
Note: The 2018 decrease was not confirmed by other data sources.

CLINICAL CARE | PREVENTIVE CLINICAL SERVICES

Flu vaccination rates fell among older adults between 2022 and 2023, with significant differences between populations.

Flu Vaccination

Immune defense systems weaken with age, putting older adults at increased risk of developing serious health complications from influenza (the seasonal flu).[50,51] The rate of flu-related deaths is highest among older adults.[52] About 50%-70% of seasonal flu-related hospitalizations and 70%-85% of seasonal flu-related deaths occur among those age 65 and older.[50] The influenza vaccine helps protect against the flu, lowering the risk of infection and lessening the severity of symptoms in those who get sick.[53]

Changes over time. Nationally, the percentage of adults age 65 and older who reported receiving a seasonal flu vaccine in the past 12 months decreased 6% from 67.7% to 63.4% between 2022 and 2023. Flu vaccinations among older adults remain below the Healthy People 2030 target to increase the proportion of people who get the annual flu vaccine to 70.0%.[54]

Between 2021 and 2023, flu vaccinations significantly decreased 24% among American Indian/Alaska Native older adults (60.5% to 46.2%) and 7% among white older adults (70.3% to 65.3%).

Between 2022 and 2023, flu vaccinations among adults age 65 and older significantly decreased:

- 13% among LGBQ+ older adults (70.4% to 61.4%) and 8% among straight older adults (69.9% to 64.6%).
- 11% among those who have difficulty with self-care (65.3% to 58.0%), 8% among those with independent living difficulty (66.4% to 61.0%), 8% among those who have difficulty with cognition (64.9% to 59.4%), 7% among those who have difficulty with mobility (67.4% to 62.6%), 6% among those with difficulty hearing (68.8% to 64.5%) and 5% among those without a disability (67.8% to 64.2%).

- 10% among those with less than a high school education (58.4% to 52.6%), 9% among those with some post-high school education (67.7% to 61.9%), 8% among high school graduates (64.2% to 58.9%) and 3% among college graduates (74.9% to 72.7%).
- 9% among those with an annual household income of $25,000-$49,999 (66.3% to 60.6%), 8% among those with incomes less than $25,000 (57.5% to 52.8%), 5% among those with incomes of $50,000-$74,999 (70.9% to 67.1%) and 5% among those with incomes of $75,000 or more (75.2% to 71.6%).
- 9% among those living in nonmetropolitan areas (64.1% to 58.1%) and 6% among those in metropolitan areas (68.8% to 64.5%).
- 7% among those who have not served in the U.S. armed forces (67.1% to 62.5%) and 5% among those who have served (70.8% to 67.4%).
- 7% among women (68.3% to 63.2%) and 5% among men (67.1% to 63.5%).

During this time frame, flu vaccinations significantly decreased in 27 states and the District of Columbia. The largest decreases were 18% in Louisiana (64.3% to 52.9%); 15% in Nebraska (72.8% to 61.7%); and 14% in the following states: Alaska (61.1% to 52.8%), Idaho (60.7% to 52.3%), Michigan (74.6% to 64.2%) and South Carolina (69.2% to 59.3%).

Differences. In 2023, flu vaccinations significantly varied by geography, race/ethnicity, educational attainment and household income. The prevalence among adults age 65 and older was:

- 1.4 times higher in Massachusetts (73.7%) than in Idaho (52.3%).
- 1.4 times higher among Asian (65.9%) than American Indian/Alaska Native (46.2%) older adults.
- 1.4 times higher among college graduates (72.7%) than those with less than a high school education (52.6%).
- 1.4 times higher among those with an annual household income of $75,000 or more (71.6%) compared with those who have incomes less than $25,000 (52.8%).

The prevalence was also higher among older adults living in metropolitan areas (64.5%) compared with those in nonmetropolitan areas (58.1%); among older adults with difficulty hearing (64.5%) compared with those who have difficulty with self-care (58.0%); and among older adults who have served in the U.S. armed forces (67.4%) compared with those who have not served (62.5%).

Related Measure: RSV Vaccination

Respiratory syncytial virus (RSV) is a common respiratory virus that causes cold-like symptoms and can lead to pneumonia and worsen underlying conditions such as asthma, chronic obstructive pulmonary disease (COPD) and heart failure.[55,56] While RSV tends to be mild for healthy adults and children, older adults are more likely to develop severe illness and require hospitalization.[55] Every year in the U.S., an estimated 100,000-150,000 adults age 60 and older are hospitalized for RSV.[56] In 2024, the CDC's Advisory Committee on Immunization Practices released updated recommendations that everyone age 75 and older, as well as adults ages 60–74 who are at increased risk for severe RSV disease, should receive the RSV vaccine.[57]

Nationally, the percentage of adults age 60 and older surveyed in 2024 who reported ever receiving an RSV vaccine was 33.0%. Vaccine coverage was highest in New Mexico (63.4%), Wisconsin (50.5%) and Colorado (44.0%) and lowest in Mississippi (22.6%), Alabama (25.3%) and Wyoming (26.3%).

RSV Vaccination

33.0%

of adults age 60 and older surveyed in 2024 reported having ever received an RSV vaccine.

Source: U.S. HHS, CDC, NIS-Adult COVID Module, January 2025.

Note: No data were available for Kentucky or Pennsylvania in 2023. The values for Asian, white (65.3%), Black (58.5%), Hawaiian/Pacific Islander (57.4%), Hispanic (56.7%), multiracial (55.8%) and other race (53.5%) older adults may not differ significantly from each other based on overlapping 95% confidence intervals. The same is true among American Indian/Alaska Native, other race, multiracial and Hawaiian/Pacific Islander older adults; among older adults with difficulty hearing, those without a disability (64.2%), those who have difficulty with mobility (62.6%) and those with independent living difficulty (61.0%); and among those who have difficulty with self-care, difficulty seeing (58.8%), difficulty with cognition (59.4%) and independent living difficulty (61.0%).

CLINICAL CARE | QUALITY OF CARE

More older adults reported having a dedicated provider.

Dedicated Health Care Provider

Individuals with a dedicated health care provider are better positioned to receive care that can prevent, detect and manage disease and other health conditions.[58] A regular health care provider helps patient and provider build a stable, long-term relationship with several benefits, including lower health care costs and better overall health status.[59]

Changes over time. Nationally, the percentage of adults age 65 and older who reported having a personal doctor or health care provider increased 1% from 94.8% to 95.9% between 2022 and 2023. This prevalence exceeds the Healthy People 2030 target to increase the proportion of people of all ages with a usual primary care provider to 84.0%.[60]

Between 2022 and 2023, the prevalence of dedicated health care providers among adults age 65 and older significantly increased:

- 2% among men (93.8% to 95.3%).
- 2% among those who have served in the U.S. armed forces (94.9% to 96.4%) and 1% among those who have not served (94.8% to 95.8%).
- 1% among both high school graduates (94.5% to 95.8%) and college graduates (96.4% to 97.1%).
- 1% among those living in metropolitan areas (94.9% to 96.0%) and those in nonmetropolitan areas (94.1% to 95.3%).
- 1% among those without a disability (95.0% to 96.0%).
- 1% among straight older adults (95.7% to 96.3%).

During this time frame, the prevalence of dedicated health care providers significantly increased in six states, led by: 3% in North Carolina (94.7% to 97.7%), Mississippi (94.3% to 97.2%) and Georgia (94.9% to 97.3%); 2% in New York (94.9% to 97.1%); and 1% in Washington (95.2% to 96.5%). The prevalence also decreased 2% in Nebraska (96.3% to 94.4%).

Differences. In 2023, the prevalence of dedicated health care providers among adults age 65 and older was higher in Rhode Island (98.4%) than in Wyoming (90.1%).

The prevalence also significantly varied by race/ethnicity, educational attainment, household income and gender, and was higher among:

- Black (97.0%) compared with Hispanic (91.1%) older adults.
- College graduates (97.1%) compared with those with less than a high school education (91.2%).
- Those with an annual household income of $75,000 or more (97.4%) compared with those with incomes less than $25,000 (93.4%).
- Women (96.4%) compared with men (95.3%).

Dedicated Health Care Provider

95.9%

of adults age 65+ reported having a personal doctor or health care provider in 2023.

Note: No data were available for Kentucky or Pennsylvania in 2023. The values for Black, white (96.5%), Asian (95.5%), multiracial (94.1%), other race (92.3%) and Hawaiian/Pacific Islander (92.2%) older adults may not differ significantly from each other based on overlapping 95% confidence intervals. The same is true among Hispanic, American Indian/Alaska Native (91.8%), Hawaiian/Pacific Islander, other race and multiracial older adults; among college graduates and those with some post-high school education (96.5%); and among those with an annual household income of $75,000 or more and those with incomes of $50,000-$74,999 (97.1%).

Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2023.

Direct Care Worker Wage Competitiveness

The population of adults age 65 and older in the United States is expected to increase from 57.8 million to 88.8 million between 2022 and 2060, driving up the demand for home health and caregiving services.[61] Despite this, there is a shortage of direct care workers, in part due to low pay.[62] In 2022, direct care workers had a median annual income of $25,015, leaving more than one-third of the workforce in or near poverty.[61]

Changes over time. Nationally, the shortfall between the average hourly wage rate paid for direct care jobs and the rate paid for comparable entry-level jobs increased 3% from $2.81 to $2.89 between 2019 and 2021.

During this time frame, the direct care worker wage shortfall increased (i.e., worsened) at a rate equal to or greater than the national change of 3% in 24 states and decreased in 21 states. The largest shortfall increases were: 193% in New Mexico ($1.34 to $3.93), 102% in Nevada ($1.15 to $2.32), 47% in Maryland ($2.06 to $3.02) and 39% in Indiana ($2.81 to $3.90). Of the states that had improvements, the largest shortfall reductions were: 31% in both North Dakota ($3.23 to $2.23) and Washington ($3.57 to $2.48), 30% in Hawaii ($4.67 to $3.27) and 26% in New Hampshire ($2.11 to $1.56).

Differences. In 2021, the direct care worker wage shortfall was highest in the District of Columbia ($5.03), Louisiana ($4.88), Texas ($4.33) and California ($4.19). The shortfall was lowest in New Hampshire ($1.56), Alaska ($1.58) and South Dakota ($1.65).

BEHAVIORS | NUTRITION AND PHYSICAL ACTIVITY

Fewer than 3 in 10 older adults met federal physical activity guidelines.

Exercise

Routine exercise has immediate benefits for older adults, such as improving sleep quality, reducing anxiety and improving blood pressure.[63] Exercise also helps prevent chronic diseases like dementia, heart disease, diabetes and cancer, and reduces premature death overall.[64]

Nationally, the percentage of adults age 65 and older who reported meeting the federal physical activity guidelines (150 minutes of moderate or 75 minutes of vigorous aerobic activity and two days of muscle strengthening per week) in the past 30 days was 29.0% in 2023.

Differences. In 2023, exercise among older adults significantly varied by disability status, educational attainment, geography, household income, race/ethnicity, gender and metropolitan status. The prevalence among adults age 65 and older was:

- 2.7 times higher among those without a disability (34.6%) compared with those who have difficulty with self-care (12.7%).
- 2.5 times higher among college graduates (39.1%) than those with less than a high school education (15.6%).
- 2.2 times higher in Colorado (36.7%) than in Mississippi (16.9%).
- 1.9 times higher among those with an annual household income of $75,000 or more (37.4%) than those with incomes less than $25,000 (20.0%).
- 1.7 times higher among Asian (39.1%) than Hispanic (22.4%) older adults.
- 1.2 times higher among men (31.6%) than women (26.7%).
- 1.2 times higher among those living in metropolitan areas (29.8%) compared with those in nonmetropolitan areas (25.0%).

Note: No data were available for Kentucky or Pennsylvania in 2023. The values for older adults who have difficulty with self-care and those with independent living difficulty (14.4%) may not differ significantly from each other based on overlapping 95% confidence intervals. The same is true among Asian, Hawaiian/Pacific Islander (38.6%), other race (34.4%) and multiracial (31.9%) older adults; as well as among Hispanic, American Indian/Alaska Native (26.2%), Black (26.5%) and Hawaiian/Pacific Islander older adults.

State Rankings

Rankings included in the *2025 Senior Report* are derived from 36 measures across five categories of health: Social and Economic Factors, Physical Environment, Behaviors, Clinical Care and Health Outcomes. The Methodology section (page 31) of the Appendix describes how overall ranks are calculated. Additional information can be found on the *America's Health Rankings* Methodology page.

Vermont Ranks No.1

Vermont is the healthiest state in this year's *Senior Report*, climbing two places from last year. It ranks among the top five states in model categories Social and Economic Factors (No. 2) and Behaviors (No. 1). Vermont is No. 14 in Clinical Care, No. 15 in Health Outcomes and No. 22 in Physical Environment.

Strengths: Low prevalence of multiple chronic conditions, high rate of volunteer participation and high prevalence of exercise

Challenges: High suicide rate, high prevalence of falls and low hospice care use

Differences.

- Frequent physical distress was 8.5 times higher among adults age 65 and older who have difficulty with self-care (49.9%) than those without a disability (5.9%) in 2023.
- Frequent mental distress was 5.6 times higher among adults age 65 and older with an annual household income less than $25,000 (16.1%) than those with incomes of $75,000 or more (2.9%) in 2023.
- Smoking was 4.9 times higher among adults age 65 and older with a high school degree (9.4%) than those with a college degree (1.9%) in 2023.

Colorado (No. 2), Washington (No. 3), Utah (No. 4) and Connecticut (No. 5) complete the top five healthiest states for older adults.

Mississippi Ranks No. 50

Mississippi is the least healthy state in this year's *Senior Report* for the fourth consecutive year. It ranks in the bottom five states in Social and Economic Factors (No. 50), Behaviors (No. 46) and Clinical Care (No. 50). Mississippi is No. 44 in Health Outcomes and No. 12 in Physical Environment.

Strengths: Low prevalence of excessive drinking, high percentage of older adults with a dedicated health care provider and low housing cost burden

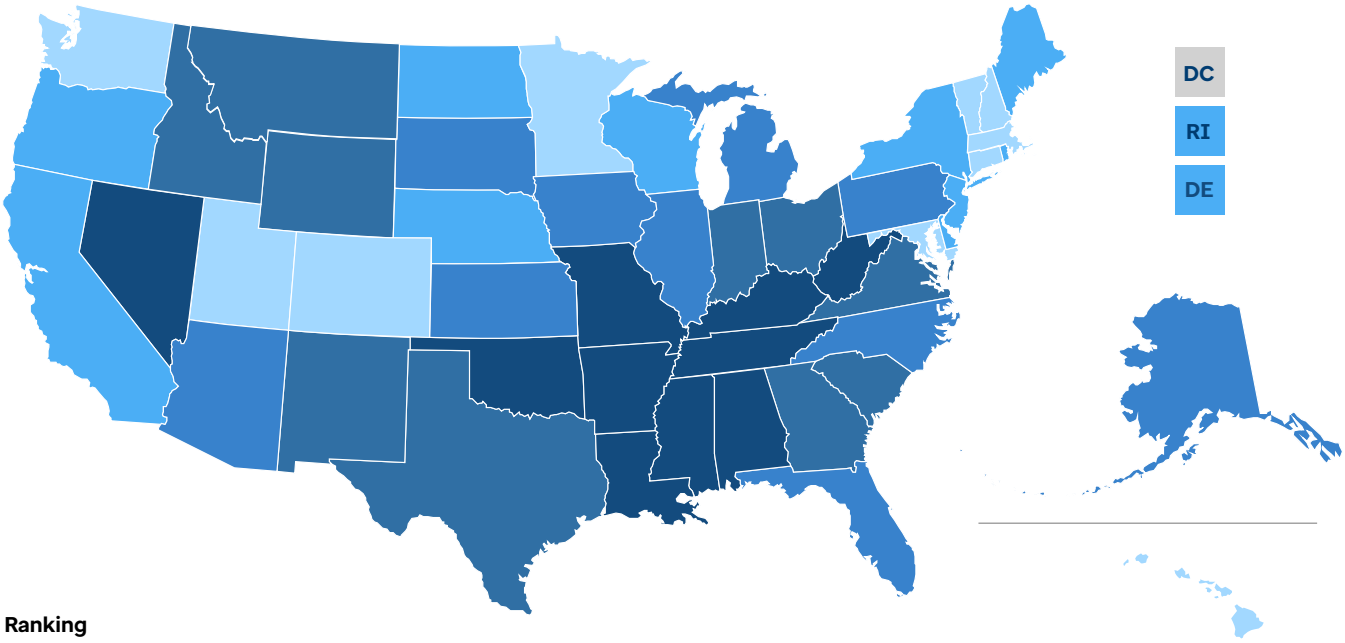
Challenges: High early death rate, high poverty rate and low prevalence of exercise

Differences.

- Avoiding care due to cost was 9.5 times higher among adults age 65 and older with less than a high school education (14.2%) than those with a college degree (1.5%) in 2023.
- Frequent physical distress was 9.3 times higher among adults age 65 and older who have difficulty with self-care (62.9%) than those without a disability (6.8%) in 2023.
- Firearm deaths per 100,000 adults age 65 and older were 7.3 times higher among men (43.2) than women (5.9) in 2021-2023.

Louisiana (No. 49), West Virginia (No. 48), Oklahoma (No. 47) and Kentucky (No. 46) complete the five least healthy states.

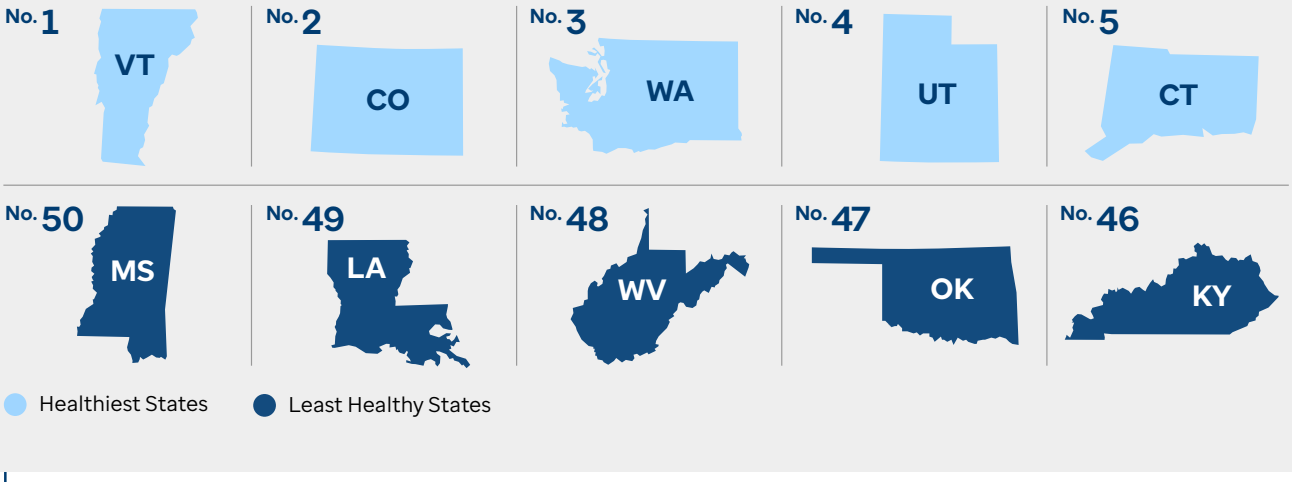
2025 Senior Report State Rankings



Source: *America's Health Rankings* composite measure, 2025.

Five Healthiest and Least Healthy States

Healthiest and least healthy states for older adults ranked across Social and Economic Factors, Physical Environment, Clinical Care, Behaviors and Health Outcomes.



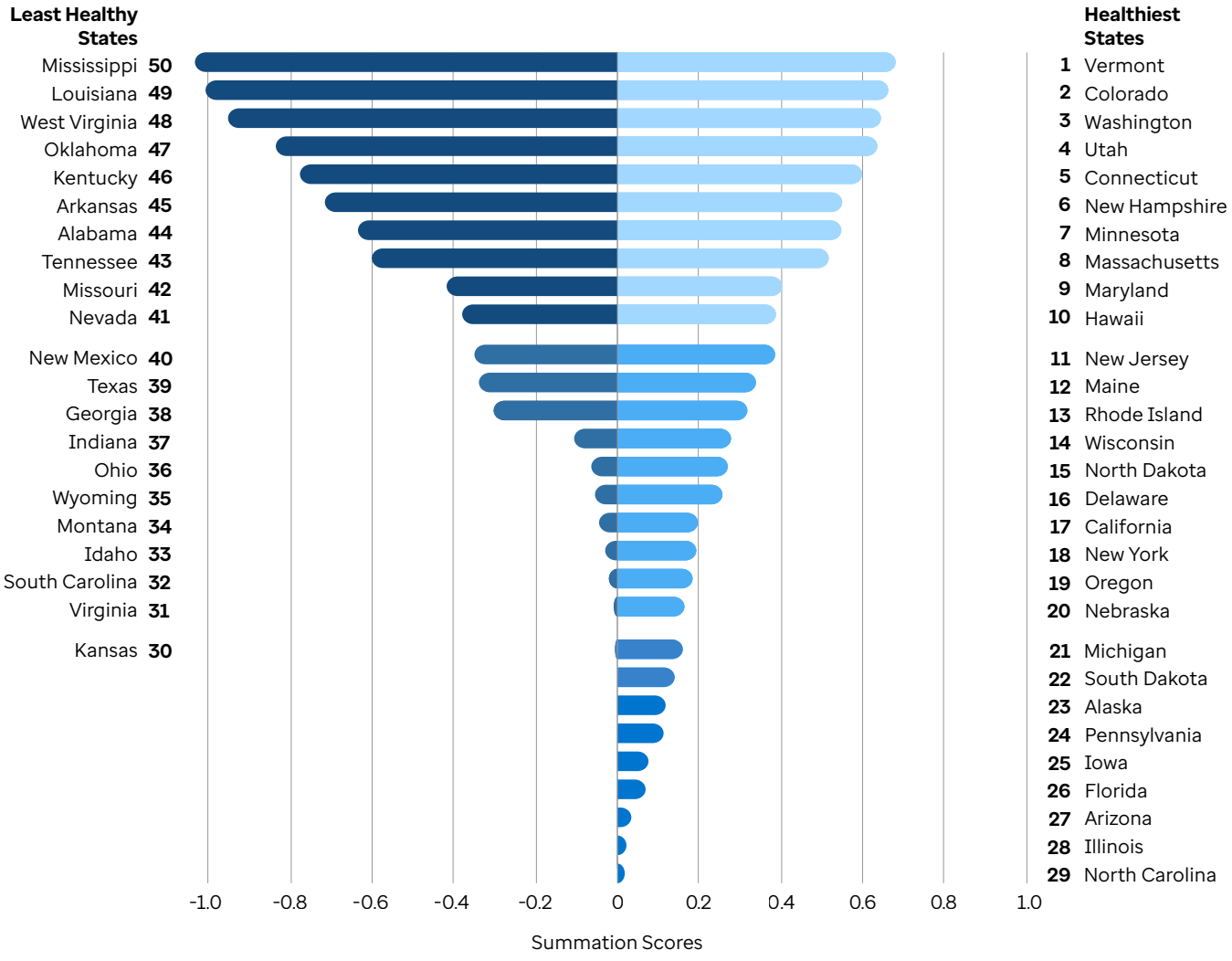
Source: *America's Health Rankings* composite measure, 2025.

Measure Impact

This graph displays the state scores in rank order, with the least healthy states on the left and the healthiest states on the right. The distance between bars shows the difference between state scores. For example, while Georgia (No. 38) and Indiana (No. 37) are close in ranking, they have a large difference in score, meaning Georgia would need to make a lot of progress to improve its score and move up in the rankings. There is also a large gap in score between Tennessee (No. 43) and Missouri (No. 42), as well as between West Virginia (No. 48) and Oklahoma (No. 47).

The website features downloadable State Summaries for each state and 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 each state's overall rank. All this information and more is also available on the View State Data pages (accessible from the Explore Data menu), which feature dynamic visualizations and an Adjust My Rank tool that allows users to explore how progress and challenges across key measures might affect a state's overall rank.

2025 Senior Report State Rankings and Scores*



Source: *America's Health Rankings* composite measure, 2025.

*Scores are the sum of weighted z-scores of all weighted measures.

United States

Health Department Website: hhs.gov

Summary

Key Findings

Drug Deaths

58%▲

from 8.4 to 13.3 deaths per 100,000 adults age 65 and older between 2018-2020 and 2021-2023.

Volunteerism

19%▲

from 22.1% to 26.3% of adults age 65 and older between 2021 and 2023.

Excessive Drinking

10%▼

from 7.7% to 6.9% of adults age 65 and older between 2022 and 2023.

Early Death

9%▼

from 1,979 to 1,810 deaths per 100,000 adults ages 65-74 between 2022 and 2023.

Flu Vaccination

6%▼

from 67.7% to 63.4% of adults age 65 and older between 2022 and 2023.

Poverty

4%▲

from 10.9% to 11.3% of adults age 65 and older between 2022 and 2023.

Measures

		U.S. Value
Social and Economic Factors		
Community and Family Safety	Motor Vehicle Deaths (Deaths per 100,000 adults age 65+)	13.8
Economic Resources	Food Insecurity (% of adults age 60+)	8.7%
	Poverty (% of adults age 65+)	11.3%
	SNAP Reach (Participants per 100 adults age 60+ living in poverty)	82.8
Social Support and Engagement	Community Support Expenditures (Dollars per adult age 60+)	$62
	High-Speed Internet (% of households with adults age 65+)	86.5%
	Low-Care Nursing Home Residents (% of residents)	8.9%
	Risk of Social Isolation (Index from 1-100)	–
	Unpaid Elder Care (% of population age 15+)*	14.1%
	Volunteerism (% of adults age 65+)	26.3%
Physical Environment		
Air and Water Quality	Air Pollution (Micrograms of fine particles per cubic meter)	8.6
	Drinking Water Violations (Average violations per community water system)	2.8
Climate and Health	Emergency Management Plan (Policy in place)*	–
Housing and Transit	Housing Cost Burden (% of households with adults age 65+)	33.5%
Clinical Care		
Access to Care	Avoided Care Due to Cost (% of adults age 65+)	3.6%
	Geriatric Clinicians (Clinicians per 100,000 adults age 65+)	39.9
	Home Health Care Workers (Workers per 1,000 adults age 65+)	62.0
Preventive Clinical Services	Cancer Screenings (% of adults ages 65-75)	74.1%
	Flu Vaccination (% of adults age 65+)	63.4%
	Pneumonia Vaccination (% of adults age 65+)	70.2%
Quality of Care	Dedicated Health Care Provider (% of adults age 65+)	95.9%
	Hospice Care (% of Medicare decedents)	46.9%
	Nursing Home Quality (% of beds rated four or five stars)	31.1%
	Preventable Hospitalizations (Discharges per 100,000 Medicare beneficiaries ages 65-74)	1,477
Behaviors		
Nutrition and Physical Activity	Exercise (% of adults age 65+)	29.0%
	Fruit and Vegetable Consumption (% of adults age 65+)	7.3%
	Physical Inactivity (% of adults age 65+ in fair or better health)	31.7%
Sleep Health	Insufficient Sleep (% of adults age 65+)	28.1%
Tobacco Use	Smoking (% of adults age 65+)	8.5%
Health Outcomes		
Behavioral Health	Drug Deaths (Deaths per 100,000 adults age 65+)*	13.3
	Excessive Drinking (% of adults age 65+)	6.9%
	Frequent Mental Distress (% of adults age 65+)	8.7%
	Suicide (Deaths per 100,000 adults age 65+)	17.7
Mortality	Early Death (Deaths per 100,000 adults ages 65-74)	1,810
Physical Health	Falls (% of adults age 65+)	27.8%
	Frequent Physical Distress (% of adults age 65+)	17.0%
	Multiple Chronic Conditions (% of Medicare beneficiaries ages 65-74)	53%
	Obesity (% of adults age 65+)	30.2%
	Teeth Extractions (% of adults age 65+)	12.1%

* Unweighted measure that does not contribute to a state's overall rank.
– Data not available, missing or suppressed.

Measures Table

Social and Economic Factors

Measure	Description	Source	Data Year(s)
Community and Family Safety			
Firearm Deaths*^	Number of deaths among individuals age 65 and older due to firearm injury of any intent (unintentional, suicide, homicide or undetermined) per 100,000 population	U.S. HHS, Multiple Cause of Death Files via CDC WONDER	2021-2023
Internet Crime*	Number of internet crime victim complaints per 10,000 adults age 60 and older	U.S. DOJ, FBI, *Elder Fraud Report*	2023
Motor Vehicle Deaths	Number of deaths due to motor vehicle traffic crashes on a public roadway per 100,000 adults age 65 and older	U.S. DOT, National Highway Traffic Safety Administration, Fatality Analysis Reporting System	2022
Economic Resources			
Food Insecurity	Percentage of adults age 60 and older who lacked access to enough food for an active and healthy life due to limited financial resources	Feeding America, *Food Insecurity Among Seniors and Older Adults* Report Series	2022[§]
Poverty	Percentage of adults age 65 and older living below the poverty level	U.S. Census Bureau, American Community Survey	2023
Poverty Racial Disparity*	Ratio of the poverty rate of the racial/ethnic group with the highest rate (varies by state) to the non-Hispanic white rate among adults age 65 and older	U.S. Census Bureau, American Community Survey	2023
SNAP Reach	Number of adults age 60 and older who participated in the Supplemental Nutrition Assistance Program (SNAP) per 100 adults age 60 and older living in poverty	USDA, *Characteristics of Supplemental Nutrition Assistance Program Households* Report Series	2022
Education			
College Graduate*	Percentage of adults age 65 and older who have a college degree	U.S. Census Bureau, American Community Survey	2023
Social Support and Engagement			
Community Support Expenditures^†	Dollars per adult age 60 and older of Older Americans Act funding spent on support services for older adults and caregivers, including congregate meals, home-delivered meals and senior centers	U.S. HHS, Administration for Community Living, State Program Reports	2021
High-Speed Internet	Percentage of households with adults age 65 and older that have a broadband internet subscription and a computer, smartphone or tablet	U.S. Census Bureau, American Community Survey	2023
Low-Care Nursing Home Residents†	Percentage of nursing home residents who do not require physical assistance for bed mobility, transferring, using the toilet or eating	Brown University School of Public Health, LTCFocus	2021
Risk of Social Isolation^	Index of social isolation risk factors (living in poverty; living alone; being divorced, separated or widowed; having never married; having a disability; and having independent living difficulty) among adults age 65 and older; normalized values are 1 to 100, with a higher value indicating greater risk	U.S. Census Bureau, American Community Survey	2019-2023
Unpaid Elder Care*	Percentage of the population age 15 and older that reported providing unpaid care or assistance to an adult age 65 or older who needed help because of a condition related to aging	U.S. DOL, Bureau of Labor Statistics, American Time Use Survey	2022-2023
Volunteerism	Percentage of adults age 65 and older who reported volunteering in the past 12 months	U.S. Census Bureau, Current Population Survey, Volunteering and Civic Life Supplement	2023
Voter Participation (Average)^*†	Average of the percentage of U.S. citizens age 65 and older who voted in the last presidential and the last midterm national elections	U.S. Census Bureau, Current Population Survey, Voting and Registration Supplement	2020/2022

Physical Environment

Measure	Description	Source	Data Year(s)
Air and Water Quality			
Air Pollution	Average exposure of the general public to particulate matter of 2.5 microns or less, measured in micrograms per cubic meter	U.S. EPA	2021-2023
Drinking Water Violations	Average number of health-based drinking water violations per community water system in a state	U.S. EPA, Safe Drinking Water Information System via ECHO	2023
Smoke-Free Policies*	Percentage of the population covered by 100% smoke-free laws for restaurants, bars and nonhospitality workplaces	American Nonsmokers' Rights Foundation	2025
Climate and Health			
Emergency Management Plan*	State has an Enhanced State Hazard Mitigation Plan approved by the Federal Emergency Management Agency that uses a social vulnerability index that accounts for older adults and people with disabilities	AARP Public Policy Institute, *LTSS State Scorecard* Report Series	2023
Housing and Transit			
Housing Cost Burden	Percentage of households with one or more adults age 65 and older for which housing costs are 30% or more of household income	U.S. Census Bureau, American Community Survey	2023
Severe Housing Problems*	Percentage of one- and two-person households inhabited by adults age 62 or older with at least one of the following problems: lack of complete kitchen facilities, lack of plumbing facilities, overcrowding or cost-burdened occupants	U.S. HUD, Comprehensive Housing Affordability Strategy	2017-2021

Clinical Care

Measure	Description	Source	Data Year(s)
Access to Care			
Avoided Care Due to Cost	Percentage of adults age 65 and older who reported a time in the past 12 months when they needed to visit a doctor but could not because of cost	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2023
Geriatric Clinicians	Number of family medicine and internal medicine geriatricians and nurse practitioners per 100,000 adults age 65 and older	U.S. HHS, CMS, National Plan and Provider Enumeration System	September 2024
Home Health Care Workers	Number of personal care and home health aides per 1,000 adults age 65 and older	U.S. DOL, Bureau of Labor Statistics, Occupational Employment and Wage Statistics Program	2023
Preventive Clinical Services			
Cancer Screenings†	Percentage of women ages 65-74 who reported receiving a mammogram in the past two years and percentage of adults ages 65-75 who reported receiving colorectal cancer screening within the recommended time period	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022
Flu Vaccination	Percentage of adults age 65 and older who reported receiving a seasonal flu vaccine in the past 12 months	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2023
Pneumonia Vaccination	Percentage of adults age 65 and older who reported ever receiving a pneumonia vaccine	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2023
RSV Vaccination*	Percentage of adults age 60 and older who reported ever receiving an RSV vaccine	U.S. HHS, CDC, NIS-Adult COVID Module	8/18/2024-1/4/2025
Quality of Care			
Dedicated Health Care Provider	Percentage of adults age 65 and older who reported having a personal doctor or health care provider	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2023
Direct Care Worker Wage Competitiveness*	Dollar amount shortfall between the average hourly wages for direct care jobs and other comparable entry-level jobs	AARP Public Policy Institute, *LTSS State Scorecard* Report Series	2023§§
Hospice Care	Percentage of Medicare decedents who were in hospice at time of death	*NHPCO Facts and Figures* Report Series	2022
Nursing Home Quality	Percentage of certified nursing home beds rated four or five stars over a three-month period	U.S. HHS, CMS, Care Compare	September–November 2024
Preventable Hospitalizations	Discharges following hospitalization for ambulatory care-sensitive conditions (PQI 90) per 100,000 Medicare beneficiaries ages 65-74 enrolled in the fee-for-service program	U.S. HHS, CMS, Mapping Medicare Disparities Tool	2023

Behaviors

Measure	Description	Source	Data Year(s)
Nutrition and Physical Activity			
Exercise	Percentage of adults age 65 and older who met the federal physical activity guidelines (150 minutes of moderate or 75 minutes of vigorous aerobic activity and two days of muscle strengthening per week) in the past 30 days	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2023
Fruit and Vegetable Consumption†	Percentage of adults age 65 and older who reported consuming two or more fruits and three or more vegetables daily	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2021
Physical Inactivity	Percentage of adults age 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	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2023
Sleep Health			
Insufficient Sleep†	Percentage of adults age 65 and older who reported sleeping, on average, less than seven hours in a 24-hour period	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022
Smoking and Tobacco Use			
Smoking	Percentage of adults age 65 and older who reported smoking at least 100 cigarettes in their lifetime and currently smoke daily or some days	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2023

Health Outcomes

Measure	Description	Source	Data Year(s)
Behavioral Health			
Cognitive Difficulty*	Percentage of adults age 65 and older who reported having difficulty remembering, concentrating or making decisions due to a physical, mental or emotional condition	U.S. Census Bureau, American Community Survey	2023
Depression*	Percentage of adults age 65 and older who reported being told by a health professional that they had a depressive disorder, including depression, major depression, minor depression or dysthymia	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2023
Drug Deaths*	Number of deaths due to drug injury (unintentional, suicide, homicide or undetermined) per 100,000 adults age 65 and older	U.S. HHS, Multiple Cause of Death Files via CDC WONDER	2021-2023
Excessive Drinking	Percentage of adults age 65 and older who reported binge drinking (four or more drinks on one occasion in the past 30 days for females or five or more for males) or heavy drinking (eight or more drinks per week for females or 15 or more for males)	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2023
Frequent Mental Distress	Percentage of adults age 65 and older who reported their mental health was not good 14 or more days in the past 30 days	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2023
Suicide	Number of deaths due to intentional self-harm per 100,000 adults age 65 and older	U.S. HHS, Multiple Cause of Death Files via CDC WONDER	2021-2023
Mortality			
Early Death	Number of deaths per 100,000 adults ages 65-74	U.S. HHS, Multiple Cause of Death Files via CDC WONDER	2023
Early Death Racial Disparity*	Ratio of the early death rate of the racial/ethnic group with the highest rate (varies by state) to the non-Hispanic white rate among adults ages 65-74	U.S. HHS, Multiple Cause of Death Files via CDC WONDER	2023

Health Outcomes (cont.)

Measure	Description	Source	Data Year(s)
Physical Health			
Falls	Percentage of adults age 65 and older who reported falling in the past 12 months	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2023
Frequent Physical Distress	Percentage of adults age 65 and older who reported their physical health was not good 14 or more days in the past 30 days	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2023
High Health Status*	Percentage of adults age 65 and older who reported their health was very good or excellent	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2023
Multiple Chronic Conditions	Percentage of Medicare beneficiaries ages 65-74 with three or more chronic conditions enrolled in the fee-for-service program	U.S. HHS, CMS, Mapping Medicare Disparities Tool	2023
Obesity	Percentage of adults age 65 and older who have a body mass index of 30.0 or higher based on reported height and weight	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2023
Teeth Extractions†	Percentage of adults age 65 and older who have had all teeth removed due to tooth decay or gum disease	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022

Demographics

Functional Disability*	Percentage of adults age 65 and older who reported having cognitive, visual, auditory, ambulatory, self-care and/or independent living difficulty disabilities	U.S. Census Bureau, American Community Survey	2023
Population – Age 65+*	Percentage of population age 65 and older	U.S. Census Bureau, Single-Race Population Estimates via CDC WONDER	2023
Rural Population – Age 65+*	Percentage of adults age 65 and older who live in a rural area	U.S. Census Bureau, American Community Survey	2023

* Unweighted measure; not included in calculating the summation measures, including the overall rankings.
† Data in this edition were repeated from the last edition of the *Senior Report*.
§ 2021-2022 data, sourced from the 2022 publication of the report.
§§ 2021 data, sourced from the 2023 edition of the scorecard.
^ Multicomponent measure. Data for each subcomponent are published on their respective measure pages, which can be found through the Explore Data section.

Data Source Descriptions

The **Administration for Community Living** is a division of the United States Department of Health and Human Services. The administration funds various community programs, social services, and training and research initiatives that help older adults and people with disabilities live independently. Its State Program Reports, available through the AGing, Independence and Disability Program Data (AGID) Portal, provide data annually on Older Americans Act services.

The **American Community Survey** is an ongoing statistical survey coordinated by the U.S. Census Bureau that provides detailed information on U.S. population demographics. Data are derived from the bureau directly via its 1-year and 5-year data sets or using the public use microdata sample (PUMS) file.

The **American Nonsmokers' Rights Foundation** is a nonprofit organization dedicated to educating the public about the adverse health effects of smoking and secondhand smoke exposure, as well as the benefits of smoke-free environments. The foundation produces lists and maps covering laws regarding clean air, e-cigarettes, marijuana and tobacco sales in pharmacies. Data are accessed via the Lists & Maps webpage.

The **American Time Use Survey** provides annual activity insights into how Americans spend their daily time. Data are obtained from the Bureau of Labor Statistics.

The **Behavioral Risk Factor Surveillance System (BRFSS)** is the nation's largest phone-based population survey. The survey, coordinated by the Centers for Disease Control and Prevention (CDC) in collaboration with state, territory and federal agencies, provides information about health-related risk behaviors, chronic health conditions and use of preventive services. Data are accessed via the BRFSS website.

The Centers for Medicare & Medicaid Services' **Care Compare** tool helps find and compare providers and services by furnishing detailed information about every Medicare- and Medicaid-certified nursing home in the country. Users can find detailed information on health inspections, staffing and various other quality measures. Data are accessed via the data archive for nursing homes, including rehab services.

CDC WONDER is a query system for analyzing public-use data from the National Center for Health Statistics on births and deaths, as well as other topics. Data are obtained from the Multiple Cause of Death and Single-Race Population Estimates files.

Characteristics of Supplemental Nutrition Assistance Program (SNAP) Households is a report put out by the U.S. Department of Agriculture's Food and Nutrition Service annually since 1976. It provides information about the demographic and economic circumstances of SNAP participants and households each fiscal year.

Comprehensive Housing Affordability Strategy (CHAS) data are produced by the U.S. Department of Housing and Urban Development's Office of Policy Development and Research, which manages specific housing data from the American Community Survey. These data demonstrate the extent of housing problems and needs, particularly for low-income households. Data are accessed via the Consolidated Planning/CHAS Data website.

The **Current Population Survey** is an ongoing statistical survey sponsored jointly by the U.S. Census Bureau and the Bureau of Labor Statistics that collects information monthly about employment, earnings and education in the nation. Voting data are obtained from their Voting and Registration Supplement, available every two years following national elections. Volunteerism data are obtained from the Volunteering and Civic Life Supplement and are released biennially in odd years.

The **Elder Fraud Report** is published annually by the Federal Bureau of Investigation's Internet Crime Complaint Center (IC3), which collects and analyzes complaints about internet scams and other cybercrimes to create the report.

The **Fatality Analysis Reporting System** uses state data collected by the National Highway Traffic Safety Administration to produce a census of public motorway accidents resulting in fatalities within 30 days of a crash. Data are obtained from the Fatality and Injury Reporting System Tool (FIRST).

Feeding America publishes an annual report on food insecurity among seniors and older adults. The report documents the prevalence of food insecurity among older adults in the U.S. and identifies the geographic sociodemographic variation in food insecurity based on data from the December supplement to the U.S. Census Bureau's Current Population Survey. Two years of data are combined to produce state-level estimates.

The ***Long-Term Services and Supports (LTSS) State Scorecard*** is published every three years by the AARP Public Policy Institute. The report details long-term services and supports for older adults, people with physical disabilities and family caregivers, aggregating data from a variety of primary sources.

The **Mapping Medicare Disparities (MMD) Tool** is a comprehensive source of information from the Centers for Medicare & Medicaid Services' Office of Minority Health, offering data on eliminating health disparities and improving the health of minority populations. This tool features health outcome measures of disease prevalence, costs, hospitalizations for 60 chronic conditions, emergency department use, readmissions rates, mortality, preventable hospitalizations and preventive services. Data are obtained from the MMD by Population website.

The **National Center for Immunization and Respiratory Diseases (NCIRD)** is a branch of the CDC that focuses on the prevention of disease, disability and death through immunization and control of respiratory and related diseases from young children to adults. Data are accessed via the Weekly Cumulative RSV Vaccination Coverage website.

The **National Hospice and Palliative Care Organization (NHPCO)** is the nation's largest membership organization for hospice and palliative care workers and providers. Their annual *NHPCO Facts and Figures* report leverages hospice claims data from the Centers for Medicare & Medicaid Services. Information provided includes hospice patient characteristics as well as location and level of care.

The **National Plan and Provider Enumeration System (NPPES)** is a registry developed by the Centers for Medicare & Medicaid Services to improve the efficiency of electronic health information transmission. NPPES assigns a unique National Provider Identifier (NPI) number to covered health care providers and health plans to conduct all administrative and financial transactions under HIPAA, the Health Insurance Portability and Accountability Act. Data are accessed via the NPI files website.

The **Occupational Employment and Wage Statistics** program produces data on employment and wage estimates for nearly 800 occupations at national, state and metropolitan levels. Data are obtained through the Occupational Employment and Wages Query System, run by the Bureau of Labor Statistics.

The **Shaping Long-Term Care in America Project** is conducted at the Brown University Center for Gerontology and Healthcare Research and is supported in part by the National Institute on Aging. The project website provides data on long-term care, including facility characteristics, resident characteristics and long-term care policies by state, county and facility.

The **U.S. Environmental Protection Agency (EPA)** performs various federal research, monitoring, standard-setting and enforcement activities to ensure environmental protection. National Safe Drinking Water Act data are reported by states and compiled from the Safe Drinking Water Information System database for public water systems (data obtained from the Enforcement and Compliance History Online website). State-level air pollution data are obtained via a special request to the agency.

Methodology

How State Rankings Were Generated

This year, 55 measures (including 36 weighted and 19 additional unweighted measures) were analyzed for the *America's Health Rankings 2025 Senior Report*, using the most recent data available as of March 3, 2025. Data years varied by measure because of the variety of data sources. Multiple data years were combined for some measures to ensure reliable state-level estimates. Measure definitions, sources and data years are available in the Appendix: Measures Table on page 25. Measure changes were based on input from the *Senior Report* Advisory Committee and are detailed on the *2025 Senior Report* Measures Selection and Changes webpage.

Each state was ranked according to its value for each measure, with a rank of No. 1 assigned to the state with the healthiest value. Ties in value were assigned equal ranks. If a state value was unavailable for a measure in this edition, it was noted as unavailable or suppressed. Summations were generated overall and by model category. Summations show how a state compares with other states for a model category, such as Social and Economic Factors or Overall.

Overall state rankings were based on 36 weighted measures that:

- Represented current population health issues.
- Had state-level data available.
- Maintained consistent measurement across all 50 states.
- Were current and regularly updated.
- Allowed for improvement over time.

The state value for each measure was normalized into a z-score, hereafter referred to as "score," using the following formula:

$$\text{Z-score} = \frac{\text{State value - National value}}{\text{Standard deviation of all state values}}$$

The score indicates the number of standard deviations a state value was above or below the U.S. value. Scores were capped at +/- 2.00 to prevent an extreme score from excessively influencing a state's overall score. If a U.S. value was unavailable from the original data source for a measure, the mean of all states and the District of Columbia was used. If a value was unavailable for a state, its value from the most recent available data year was used to generate a score.

Summation scores were calculated by adding the products of the score for each measure multiplied by that measure's assigned model weight and association with health. Measures positively associated with population health, such as volunteerism and flu vaccination, were multiplied by 1. In contrast, measures with a negative association, such as smoking and early death, were multiplied by -1. A state that ranked No. 1 will have a higher summation score (e.g., 2.00), reflecting better health, whereas a state that ranked No. 50 will have a lower summation score (e.g., -2.00). The overall state ranks were calculated by ranking the overall summation score, which included all 36 weighted measures in the model (see Measures, Weights and Direction for model and measure weights).

Scores and ranks were not calculated for the District of Columbia because of its unique status as an entirely urban population with different governing and funding mechanisms than states. While the District of Columbia was not included in the overall state rankings, its data are available in this report and on the *America's Health Rankings* website.

For additional methodology information, submit an inquiry through the *America's Health Rankings* website.

Report

Findings. Data for all measures are analyzed and considered for inclusion in the report. Measures with updated data, statistically significant national changes and new measures on emerging topics are prioritized for selection (based on nonoverlapping 95% confidence intervals, when available).

Health Disparities. Health disparities highlight significant differences within measures based on age, disability status, education, gender, income, metropolitan status, race/ethnicity, sexual orientation and veteran status where data are available. Priority goes to groups with the largest health disparities while considering relevant risk factors. Not all significant differences are detailed in the report. Full demographic data are published on the *America's Health Rankings* website. Health disparities are presented as a ratio calculated by dividing the value of one group by the value of another. For example, the value of the group with the highest value may be divided by the value of the group with the lowest value. Only measures with significant differences, determined by nonoverlapping 95% confidence intervals, are considered. For more information, see Disparity Measures Methodology.

State Summaries

Strengths and Challenges represent measures most impacting a state's overall ranking. Measures with newly available data that span model categories and topic areas are given priority during selection. Unweighted measures are excluded from the ranking calculations, and D.C. is assessed separately by comparing its values to those of the healthiest and least healthy states. The U.S. summary is a reference for calculating z-scores and the overall rankings, so it does not include strengths and challenges.

Key Findings highlight notable trends, presented as percentage changes between two time periods. Only statistically significant changes, as determined by nonoverlapping 95% confidence intervals, are considered for measures with confidence intervals. Measures without confidence intervals are considered if the change is 5% or more between the two time periods. Priorities are to include a mix of measures that are either improving or worsening across model categories and topic areas. Measures that do not lend themselves to changes over time are excluded from the analysis.

Demographic Group Definitions

Analyses were performed to illuminate health disparities by age, disability status, education, gender, income, metropolitan status, race/ethnicity, sexual orientation and veteran status. Not all groups were available for all data sources and measures. Individual estimates were suppressed if they did not meet the reliability criteria laid out by the data source or internally established criteria. Some values had wide 95% confidence intervals, meaning the true value may be far from the estimate listed.

Age. Age data in this report were available for measures from CDC WONDER and the Fatality Analysis Reporting System. Behavioral Risk Factor Surveillance System (BRFSS) groupings included the age ranges: 65-74, 75-84 and 85 and older. Fatality Analysis Reporting System groupings included the age ranges 65-74 and 75 and older.

Disability Status. Disability status data in this report were available for measures from BRFSS. Groupings were based on responses to the questions in the core disability section: "Are you deaf or do you have serious difficulty hearing?" "Are you blind or do you have serious difficulty seeing, even when wearing glasses?" "Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?" "Do you have serious difficulty walking or climbing stairs?" "Do you have difficulty dressing or bathing?" and "Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?" Responses of no or missing to all questions, with at least one response being no, were coded as without a disability.

Education. Education data in this report were available for measures from BRFSS, the American Time Use Survey and the Volunteering and Civic Life Supplement. BRFSS groupings were based on responses to the question, "What is the highest grade or year of school you completed?" American Time Use Survey and Volunteering and Civic Life Supplement groupings were based on responses to the question, "What is the highest level of school you have completed or the highest degree you have received?"

Gender. Gender data in this report were available for measures from BRFSS, the Bureau of Labor Statistics' American Time Use Survey and the Current Population Survey's Volunteering and Civic Life Supplement. This report stratified gender as men and women but acknowledges that not all people identify as belonging to one of these categories. Data did not differentiate between assigned sex at birth and current gender identity. While sex and gender influence health, the current data collection practices of some national surveys limit the ability to describe the health of transgender and nonbinary individuals, especially at the state level.

Sexual Orientation. Sexual orientation data in this report were available for measures from BRFSS. Groupings were based on responses to the question, "Which of the following best represents how you think of yourself?" Responses of lesbian or gay, gay, bisexual or something else were summed and classified as LGBQ+. Responses of straight – that is, not gay – were summed and classified as straight.

Income. Income data in this report were available for measures from BRFSS, the American Time Use Survey and the Volunteering and Civic Life Supplement. BRFSS groupings were based on responses to the question, "[What] is your annual household income from all sources?" American Time Use Survey and Volunteering and Civic Life Supplement groupings were based on responses to the question, "Which category represents your total combined income during the past 12 months (or the total combined income of all members of your family living in the household)? This includes money from jobs, net income from business, farm or rent, pensions, dividends, interest, social security payments and any other money income received by you (or by members of your family living in the household who are 15 years of age or older)."

Metropolitan Status. Metropolitan status data in this report were available for measures from BRFSS and the Volunteering and Civic Life Supplement. Groupings were coded based on respondents' residence. Identification as large central metro, large fringe metro, medium metro or small metro was classified as metropolitan, and identification as micropolitan or noncore was classified as nonmetropolitan (sometimes referred to in this report as rural). Volunteering and Civic Life Supplement groupings were based on the 2010 definitions of metropolitan statistical area as determined by the Census Bureau.

Race/Ethnicity. Data were provided where available for the following racial and ethnic groups: American Indian/Alaska Native, Asian, Black or African American (classified in this report as Black), Hispanic or Latino/a (classified as Hispanic), Native Hawaiian or Other Pacific Islander (classified as Hawaiian/Pacific Islander), white, multiracial and those who identify as other race. Hispanic ethnicity includes members of all racial groups. BRFSS, CDC WONDER, American Time Use Survey and the Volunteering and Civic Life Supplement race groupings are all non-Hispanic, while the American Community Survey and the Centers for Medicare & Medicaid Services' Mapping Medicare Disparities Tool race groupings are Hispanic-inclusive, except for white, which is non-Hispanic.

Veteran Status. Veteran status data in this report were available for measures from BRFSS and the Volunteering and Civic Life Supplement. BRFSS groupings were based on responses to the question, "Have you ever served on active duty in the United States Armed Forces, either in the regular military or in a National Guard or military reserve unit?" Volunteering and Civic Life Supplement groupings were based on responses to the question, "Did you ever serve on active duty in the U. S. Armed Forces?"

Limitations

Rankings are a relative measure of health. Not all changes in rank translate into actual declines or improvements in health. Data presented in this report were aggregated at the state level and cannot be used to make inferences at the individual level. Additionally, estimates cannot be extrapolated beyond the population upon which they were created. Values and ranks from prior years have been updated on the *America's Health Rankings* website to reflect known errors and updates from the reporting source.

Use caution when interpreting data as many measures are self-reported and rely on an individual's perception of health and behaviors. Additionally, some health outcome measures are based on respondents being told by a health care professional that they have a disease and may exclude those who have not received a diagnosis or sought or obtained treatment.

This report provides health disparity data on various demographic group characteristics alongside socioeconomic factors and environmental influences. Relying solely on health disparity data may lead to misinterpretations of health outcomes, as they do not account for the social drivers that significantly impact individuals' access to care, quality of life and overall well-being.[65]

Inclusivity in data collection is essential to documenting, analyzing and addressing the health disparities people experience. Equitable systems must accurately represent diverse populations throughout the data life cycle, including data collection, analysis and interpretation.[66]

Inadequate representation of populations may hinder the identification of trends and patterns within different demographic groups and limit the ability to tailor public health interventions and personalize care that empowers people to make better health choices.

References

1 Vespa, Jonathan et al. "Demographic Turning Points for the United States: Population Projections for 2020 to 2060." Current Population Reports. Washington, D.C.: U.S. Census Bureau, February 2020. https://www.census.gov/library/publications/2020/demo/p25-1144.html.

2 Kramarow, Ellen et al. "Drug Overdose Deaths Among Adults Aged 65 and Over: United States, 2000-2020." NCHS Data Brief No. 455. Hyattsville, MD: National Center for Health Statistics, November 30, 2022. https://doi.org/10.15620/cdc:121828.

3 McLachlan, Andrew J. et al. "Drug Metabolism in Older People—A Key Consideration in Achieving Optimal Outcomes With Medicines." *The Journals of Gerontology: Series A* 67A, no. 2 (February 1, 2012): 175-80. https://doi.org/10.1093/gerona/glr118.

4 Martin, Crescent B. et al. "Prescription Drug Use in the United States, 2015-2016." NCHS Data Brief No. 334. Hyattsville, MD: National Center for Health Statistics, 2019. https://pubmed.ncbi.nlm.nih.gov/31112126.

5 Mallet, Louise et al. "The Challenge of Managing Drug Interactions in Elderly People." *The Lancet* 370, no. 9582 (July 2007): 185-91. https://doi.org/10.1016/S0140-6736(07)61092-7.

6 Qato, Dima M. et al. "Use of Prescription and Over-the-Counter Medications and Dietary Supplements Among Older Adults in the United States." *JAMA* 300, no. 24 (December 24, 2008): 2867-78. https://doi.org/10.1001/jama.2008.892.

7 Healthy People 2030. "Reduce Drug Overdose Deaths – SU 03." Accessed April 7, 2025. https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/drug-and-alcohol-use/reduce-drug-overdose-deaths-su-03.

8 National Institute on Alcohol Abuse and Alcoholism. "Aging and Alcohol." NIAAA.NIH.gov, December 2024. https://www.niaaa.nih.gov/alcohols-effects-health/aging-and-alcohol.

9 Curtin, Sally C. et al. "*QuickStats:* Rate of Alcohol-Induced Deaths Among Persons Aged ≥25 Years, by Age Group – National Vital Statistics System, 1999-2017." *MMWR. Morbidity and Mortality Weekly Report* 68, no. 33 (August 23, 2019): 734. https://doi.org/10.15585/mmwr.mm6833a5.

10 "Older Americans Behavioral Health Issue Brief 4: Preventing Suicide in Older Adults." Substance Abuse and Mental Health Services Administration (SAMHSA), Administration on Aging, 2012. https://acl.gov/sites/default/files/programs/2016-11/Issue%20Brief%204%20Preventing%20Suicide.pdf.

11 Conwell, Yeates et al. "Suicide in Older Adults." *Psychiatric Clinics of North America*, Geriatric Psychiatry: Advances and Directions, 34, no. 2 (June 1, 2011): 451-68. https://doi.org/10.1016/j.psc.2011.02.002.

12 National Academies of Sciences, Engineering, and Medicine. *Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System.* Washington, D.C.: National Academies Press, 2020. https://doi.org/10.17226/25663.

13 Kiosses, Dimitris N. et al. "Suicide in Older Adults: The Role of Emotions and Cognition." *Current Psychiatry Reports* 16, no. 495 (September 18, 2014). https://doi.org/10.1007/s11920-014-0495-3.

14 Healthy People 2030. "Reduce the Suicide Rate – MHMD 01." Accessed April 9, 2025. https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/mental-health-and-mental-disorders/reduce-suicide-rate-mhmd-01.

15 Healthy People 2030. "Reduce Firearm-Related Deaths – IVP 13." Accessed April 9, 2025. https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/violence-prevention/reduce-firearm-related-deaths-ivp-13.

16 Murphy, Sherry L. et al. "Mortality in the United States, 2023." NCHS Data Brief No. 521. Hyattsville, MD: National Center for Health Statistics, December 19, 2024. https://doi.org/10.15620/cdc/170564.

17 Mather, Mark et al. "Up to Half of U.S. Premature Deaths Are Preventable; Behavioral Factors Key." Population Reference Bureau, September 14, 2015. https://www.prb.org/resources/up-to-half-of-u-s-premature-deaths-are-preventable-behavioral-factors-key.

18 Novotney, Amy. "The Risks of Social Isolation." *Monitor on Psychology* 50, no. 5 (May 2019): 32. https://www.apa.org/monitor/2019/05/ce-corner-isolation.

19 National Council on Aging. "Get the Facts on Falls Prevention." NCOA.org, June 1, 2024. https://www.ncoa.org/article/get-the-facts-on-falls-prevention.

20 Garnett, Matthew. "QuickStats: Death Rates from Unintentional Falls Among Persons Aged ≥65 Years, by Age Group – National Vital Statistics System, United States, 1999-2020." *MMWR. Morbidity and Mortality Weekly Report 71*, no. 38 (September 23, 2022): 1225. https://doi.org/10.15585/mmwr.mm7138a4.

21 Kakara, Ramakrishna et al. "Nonfatal and Fatal Falls Among Adults Aged ≥65 Years – United States, 2020-2021." *MMWR. Morbidity and Mortality Weekly Report* 72, no. 35 (September 1, 2023): 938-43. https://doi.org/10.15585/mmwr.mm7235a1.

22 Harvard T. H. Chan School of Public Health, Department of Nutrition. "Obesity." The Nutrition Source, June 30, 2024. https://nutritionsource.hsph.harvard.edu/obesity.

23 Masters, Ryan K. et al. "Obesity and US Mortality Risk Over the Adult Life Course." *American Journal of Epidemiology* 177, no. 5 (February 3, 2013): 431-42. https://doi.org/10.1093/aje/kws325.

24 Spreng, R. Nathan et al. "Aging and Financial Exploitation Risk." In *Aging and Money*, edited by Ronan M. Factora, 2nd ed., 55-73. Cham: Springer Press, 2021. https://doi.org/10.1007/978-3-030-67565-3_5.

25 Aladangady, Aditya et al. "Changes in U.S. Family Finances from 2019 to 2022: Evidence from the Survey of Consumer Finances." Washington, D.C.: Board of Governors of the Federal Reserve System, October 2023. https://www.federalreserve.gov/publications/files/scf23.pdf.

26 FBI. "Elder Fraud." FBI.gov. Accessed April 9, 2025. https://www.fbi.gov/how-we-can-help-you/scams-and-safety/common-frauds-and-scams/elder-fraud.

27 Shang, Yuxi et al. "The Psychology of the Internet Fraud Victimization of Older Adults: A Systematic Review." *Frontiers in Psychology* 13 (September 5, 2022): 912242. https://doi.org/10.3389/fpsyg.2022.912242.

28 Internet Crime Complaint Center. "2023 Elder Fraud Report." U.S. Department of Justice, Federal Bureau of Investigation, April 30, 2024. https://www.ic3.gov/AnnualReport/Reports/2023_IC3ElderFraudReport.pdf.

29 Lubetkin, Erica I. et al. "Burden of Disease Associated with Lower Levels of Income among US Adults Aged 65 and Older." *BMJ Open* 7, no. 1 (January 2017): e013720. https://doi.org/10.1136/bmjopen-2016-013720.

30 Adler, Nancy E. et al. "Socioeconomic Status and Health: The Challenge of the Gradient." *American Psychologist* 49, no. 1 (1994): 15-24. https://doi.org/10.1037/0003-066X.49.1.15.

31 Jacobson, Gretchen et al. "Income and Assets of Medicare Beneficiaries, 2016-2035." Issue Brief. KFF, April 21, 2017. https://www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2016-2035.

32 Minkler, Meredith et al. "Gradient of Disability across the Socioeconomic Spectrum in the United States." *New England Journal of Medicine* 355, no. 7 (August 17, 2006): 695-703. https://doi.org/10.1056/NEJMsa044316.

33 Baker, Kermit et al. "Housing America's Older Adults – Meeting the Needs of an Aging Population." Edited by Marcia Fernald. Cambridge, MA: Joint Center for Housing Studies of Harvard University, 2014. https://www.jchs.harvard.edu/sites/default/files/media/imp/jchs-housing_americas_older_adults_2014_0.pdf.

34 Steptoe, Andrew et al. "Lower Socioeconomic Status and the Acceleration of Aging: An Outcome-Wide Analysis." *Proceedings of the National Academy of Sciences* 117, no. 26 (June 30, 2020): 14911-17. https://doi.org/10.1073/pnas.1915741117.

35 Healthy People 2030. "Reduce the Proportion of People Living in Poverty – SDOH 01." Accessed April 9, 2025. https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/economic-stability/reduce-proportion-people-living-poverty-sdoh-01.

36 Early, Jody et al. "Digital Disenfranchisement and COVID-19: Broadband Internet Access as a Social Determinant of Health." *Health Promotion Practice* 22, no. 5 (September 1, 2021): 605-10. https://doi.org/10.1177/15248399211014490.

37 Julien, Howard M. et al. "Telemedicine and the Forgotten America." *Circulation* 142, no. 4 (July 28, 2020): 312-14. https://doi.org/10.1161/CIRCULATIONAHA.120.048535.

38 Suran, Melissa. "Increased Use of Medicare Telehealth During the Pandemic." *JAMA* 327, no. 4 (January 25, 2022): 313. https://doi.org/10.1001/jama.2021.23332.

39 Amundsen, Diana. "Digital Technologies as a Panacea for Social Isolation and Loneliness among Older Adults: An Intervention Model for Flourishing and Wellbeing." *Video Journal of Education and Pedagogy* 5, no. 1 (January 11, 2021): 1-14. https://doi.org/10.1163/23644583-00501008.

40 Sen, Keya et al. "The Use of Digital Technology for Social Wellbeing Reduces Social Isolation in Older Adults: A Systematic Review." *SSM - Population Health* 17 (March 1, 2022): 101020. https://doi.org/10.1016/j.ssmph.2021.101020.

41 Yu, Kexin et al. "Internet Use and Loneliness of Older Adults Over Time: The Mediating Effect of Social Contact." Edited by Deborah Carr. *The Journals of Gerontology: Series B* 76, no. 3 (February 17, 2021): 541–50. https://doi.org/10.1093/geronb/gbaa004.

42 Merschel, Michael. "High-Speed Internet Offers Key Connection to Health, but Millions Lack It." *American Heart Association News*, August 5, 2020. https://www.heart.org/en/news/2020/08/05/high-speed-internet-offers-key-connection-to-health-but-millions-lack-it.

43 Pilkington, Pamela D. et al. "Volunteering and Subjective Well-Being in Midlife and Older Adults: The Role of Supportive Social Networks." *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences* 67B, no. 2 (March 1, 2012): 249–60. https://doi.org/10.1093/geronb/gbr154.

44 Musich, Shirley et al. "Purpose in Life and Positive Health Outcomes Among Older Adults." *Population Health Management* 21, no. 2 (April 2018): 139–47. https://doi.org/10.1089/pop.2017.0063.

45 Villalonga-Olives, Ester et al. "Longitudinal Impact of Volunteering on the Cognitive Functioning of Older Adults: A Secondary Analysis from the US Health and Retirement Study." *International Journal of Nursing Sciences* 10, no. 3 (July 2023): 373–82. https://doi.org/10.1016/j.ijnss.2023.06.018.

46 Griep, Yannick et al. "Can Volunteering in Later Life Reduce the Risk of Dementia? A 5-Year Longitudinal Study among Volunteering and Non-Volunteering Retired Seniors." Edited by Gianluigi Forloni. *PLoS ONE* 12, no. 3 (March 16, 2017): e0173885. https://doi.org/10.1371/journal.pone.0173885.

47 Totten, Annette et al. "Evidence Brief: Effect of Geriatricians on Outcomes of Inpatient and Outpatient Care." VA Evidence Synthesis Program Evidence Briefs. Washington, D.C.: Department of Veterans Affairs, Health Services Research & Development Service, June 2012. https://www.ncbi.nlm.nih.gov/books/NBK98020.

48 Johns Hopkins Medicine. "Specialists in Aging – Do You Need a Geriatrician?" HopkinsMedicine.org, November 1, 2024. https://www.hopkinsmedicine.org/health/wellness-and-prevention/specialists-in-aging-do-you-need-a-geriatrician.

49 American Geriatrics Society. "Geriatrics Workforce By the Numbers." AmericanGeriatrics.org. Accessed April 10, 2025. https://www.americangeriatrics.org/geriatrics-profession/about-geriatrics/geriatrics-workforce-numbers.

50 Centers for Disease Control and Prevention. "Flu and People 65 Years and Older." CDC.gov, February 14, 2025. https://www.cdc.gov/flu/highrisk/65over.htm.

51 Centers for Disease Control and Prevention. "Signs and Symptoms of Flu." CDC.gov, January 14, 2025. https://www.cdc.gov/flu/signs-symptoms/index.html.

52 Centers for Disease Control and Prevention. "Preliminary Estimated Flu Disease Burden 2022–2023 Flu Season." CDC.gov, November 19, 2024. https://www.cdc.gov/flu-burden/php/data-vis/2022-2023.html.

53 Centers for Disease Control and Prevention. "Benefits of the Flu Vaccine." CDC.gov, August 14, 2024. https://www.cdc.gov/flu-vaccines-work/benefits/index.html.

54 Healthy People 2030. "Increase the Proportion of People Who Get the Flu Vaccine Every Year – IID 09." Accessed April 10, 2025. https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/vaccination/increase-proportion-people-who-get-flu-vaccine-every-year-iid-09.

55 Centers for Disease Control and Prevention. "About RSV." CDC.gov, August 30, 2024. https://www.cdc.gov/rsv/about/index.html.

56 Centers for Disease Control and Prevention. "RSV in Older Adults." CDC.gov, August 30, 2024. https://www.cdc.gov/rsv/older-adults/index.html.

57 Britton, Amadea et al. "Use of Respiratory Syncytial Virus Vaccines in Adults Aged ≥60 Years: Updated Recommendations of the Advisory Committee on Immunization Practices – United States, 2024." *MMWR. Morbidity and Mortality Weekly Report* 73, no. 32 (August 15, 2024): 696–702. https://doi.org/10.15585/mmwr.mm7332e1.

58 Cleveland Clinic. "Primary Care Physician (PCP): Role, Education & Where to Find." Cleveland Clinic. Accessed April 10, 2025. https://my.clevelandclinic.org/health/articles/23467-primary-care-physician.

59 Friedberg, Mark W. et al. "Primary Care: A Critical Review Of The Evidence On Quality And Costs Of Health Care." *Health Affairs* 29, no. 5 (May 1, 2010): 766–72. https://doi.org/10.1377/hlthaff.2010.0025.

60 Healthy People 2030. "Increase the Proportion of People with a Usual Primary Care Provider – AHS 07." Accessed April 10, 2025. https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality/increase-proportion-people-usual-primary-care-provider-ahs-07.

61 PHI. "Key Facts & FAQ: Understanding the Direct Care Workforce." PHINational.org. Accessed April 10, 2025. https://www.phinational.org/policy-research/key-facts-faq.

62 AARP.org. "LTSS Worker Wage Competitiveness: Long-Term Services and Supports State Scorecard." Accessed April 10, 2025. https://ltsschoices.aarp.org/scorecard-report/2023/dimensions-and-indicators/ltss-worker-wage-competitiveness.

63 Centers for Disease Control and Prevention. "Physical Activity Benefits for Adults 65 or Older." CDC.gov, November 7, 2024. https://www.cdc.gov/physical-activity-basics/health-benefits/older-adults.html.

64 Zhao, Min et al. "Recommended Physical Activity and All Cause and Cause Specific Mortality in US Adults: Prospective Cohort Study." BMJ 370 (July 1, 2020): m2031. https://doi.org/10.1136/bmj.m2031.

65 Panneton, Michelle et al. "Principles for Using Public Health Data to Drive Equity: A Guide to Embedding Equitable Practices throughout the Data Life Cycle." The CDC Foundation, n.d. https://www.cdcfoundation.org/data-equity-principles?inline.

66 Burton, Deron C. et al. "Principles of Health Equity Science for Public Health Action." *Public Health Reports* 139, no. 3 (May 2024): 277–83. https://doi.org/10.1177/00333549231213162.

The *America's Health Rankings® Senior Report* is available in its entirety at AmericasHealthRankings.org. Visit the site to request or download additional copies. The *America's Health Rankings 2025 Senior Report* is funded entirely by the United Health Foundation, a recognized 501(c)(3) organization. An advisory committee provided expertise and guidance in selecting measures and designing this report.

Data contained within this report were obtained from and used with permission of:

AARP Public Policy Institute

American Nonsmokers' Rights Foundation

Brown University, Shaping Long-Term Care in America Project

Feeding America

National Hospice and Palliative Care Organization

U.S. Census Bureau
- American Community Survey
- Current Population Survey

U.S. Department of Agriculture
- Characteristics of Supplemental Nutrition Assistance Program Households

U.S. Department of Health and Human Services
- Administration for Community Living
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services

U.S. Department of Housing and Urban Development, Comprehensive
- Housing Affordability Strategy

U.S. Department of Justice
- Federal Bureau of Investigation

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

U.S. Department of Transportation
- National Highway Traffic Safety Administration

U.S. Environmental Protection Agency
- Safe Drinking Water Information System

Data Maven of Minneapolis, Minnesota, conducted this project for and in cooperation with the United Health Foundation. Designed by VML.

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

UNITED HEALTH FOUNDATION®

About the United Health Foundation

Through collaboration with community partners, grants and outreach efforts, the United Health Foundation works to improve the health system, advance and grow the health care workforce, and enhance the well-being of local communities. The United Health Foundation was established by UnitedHealth Group in 1999 as a nonprofit, private foundation dedicated to improving health and health care. To date, the United Health Foundation has committed $845 million to programs and communities around the world, including a $100 million commitment to help support the health care workforce. To learn more, visit UnitedHealthFoundation.org.

AMERICA'S HEALTH RANKINGS®
UNITED HEALTH FOUNDATION

AmericasHealthRankings.org