AMERICA'S HEALTH RANKINGS®
UNITED HEALTH FOUNDATION

2026 Senior Report

Supporting Healthy People 2030

Healthy People 2030 is an initiative led by the Office of Disease Prevention and Health Promotion within the U.S. Department of Health and Human Services (HHS) that sets data-driven national objectives for the nation's health and well-being over the next decade, with a key focus on addressing the social determinants of health. For nearly five decades, Healthy People's national-level objectives have served as valuable benchmarks for advancing health and well-being at the state level. It also provides data to track the nation's progress toward achieving those goals, as well as tools that help guide individuals, organizations and communities to do so.

As a long-standing champion of public health and the HHS Healthy People 2030 goals, the United Health Foundation is honored to be recognized as a Healthy People 2030 Champion.

Healthy People 2030 Champion badge is a service mark of the U.S. Department of Health and Human Services.
Used with permission. Participation by United Health Foundation does not imply endorsement by HHS/ODPHP.

Contents

Call to Action

Data show noteworthy progress to build on — and opportunities to address persistent challenges

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® 2026 Senior Report*, which provides a comprehensive look at the health of older adults nationwide and on a state-by-state basis.

This year's report highlights improvements in preventive health behaviors, growth in the workforce caring for older adults and a continued decrease in the early death rate. Despite these successes, older adults continued to face challenges such as increases in drug deaths, excessive drinking, suicide and food insecurity.

The *2026 Senior Report* finds that the number of geriatric clinicians and home health care workers both increased. Meanwhile, the early death rate decreased for the third consecutive year, continuing to approach the 2019 level. Physical inactivity and cancer screenings both improved.

Between 2023 and 2024, the population of adults age 65 and older in the United States increased by more than 1.9 million individuals. In 2024, there were more than 61 million adults age 65 and older in the U.S., making up 18.0% of the population. The proportion of older adults will continue to rise as 2030 approaches and the last of the baby boomers turn 65 years old.[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.

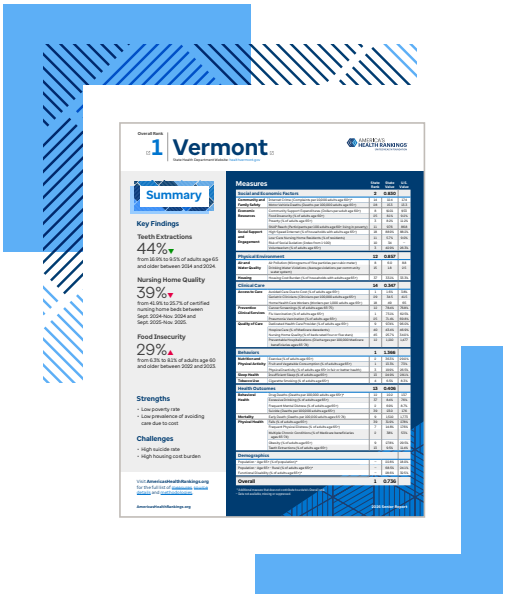
This year's report highlights important differences in the health of older adults by metropolitan status. On average, residents of rural areas are older than their urban counterparts, and older adults living in rural areas face unique challenges to staying healthy.[2,3] Rural populations vary significantly by state, meaning that these factors impact communities across the U.S. differently. These differences highlight how geographic location and access to resources can shape health.

The report also analyzes the health of older adults on a state-by-state basis. Older adults comprise a larger share of the population in some states compared with others. In 2024, Maine had the largest proportion of residents age 65 and older (23.5%), followed by Vermont (22.8%) and West Virginia (21.9%). Utah had the smallest proportion (12.4%), followed by the District of Columbia (13.0%), Texas (13.9%) and Alaska (14.8%). Strengths and challenges were present in every state, no matter the size of the older adult population.

We encourage communities and leaders nationwide to leverage these insights — and detailed state-level and demographic group data available across *America's Health Rankings* — to amplify progress, confront ongoing challenges and promote the health and well-being of all older adults.

State Summaries

State Summaries provide tailored data and insights about the demographics and health of older adults in specific states to guide local action. Visit State Summaries to explore the data.



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 *2026 Senior Report* is based on:

- **Fifty-six measures.** These include 36 ranking and 20 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 26).
- **Five categories of health.** These are comprised of Health Outcomes and four categories of health drivers: Social and Economic Factors, Physical Environment, Behaviors and Clinical Care.
- **Twenty-five 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.

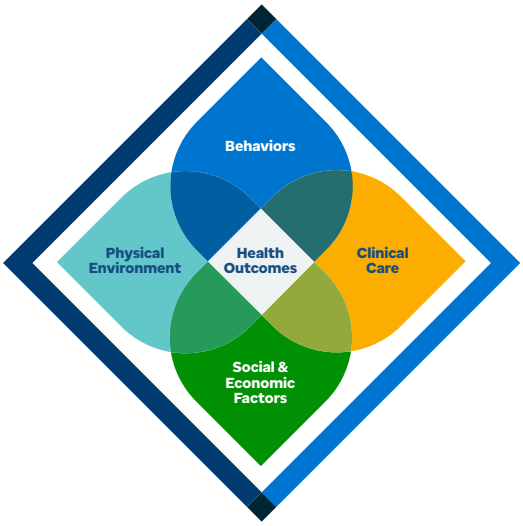
The *America's Health Rankings Senior Report* aims to improve population health by:

- **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 drivers 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."[4]

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

Drug Deaths*
38% ▲
increase from 9.9 to 13.7 deaths per 100,000 adults age 65 and older between 2019-2021 and 2022-2024.

Excessive Drinking**
10% ▲
increase from 6.9% to 7.6% of adults age 65 and older between 2023 and 2024.

Suicide*
4% ▲
increase from 16.9 to 17.6 deaths per 100,000 adults age 65 and older between 2019-2021 and 2022-2024.

Social and Economic Factors

Internet Crime†
55% ▲
increase from 11.2 to 17.4 complaints per 10,000 adults age 60 and older between 2023 and 2024.

Food Insecurity††
6% ▲
increase from 8.7% to 9.2% of adults age 60 and older between 2022 and 2023.

SNAP Reach‡
5% ▲
increase from 82.8 to 86.8 participants per 100 adults age 60 and older living in poverty between 2022 and 2023.

Clinical Care

Home Health Care Workers‡‡
5% ▲
increase from 62 to 65 workers per 1,000 adults age 65 and older between 2023 and 2024.

Geriatric Clinicians§
4% ▲
increase from 39.9 to 41.5 clinicians per 100,000 adults age 65 and older between September 2024 and September 2025.

Cancer Screenings**
4% ▲
increase from 74.1% to 76.8% of adults ages 65-75 between 2022 and 2024.

Behaviors

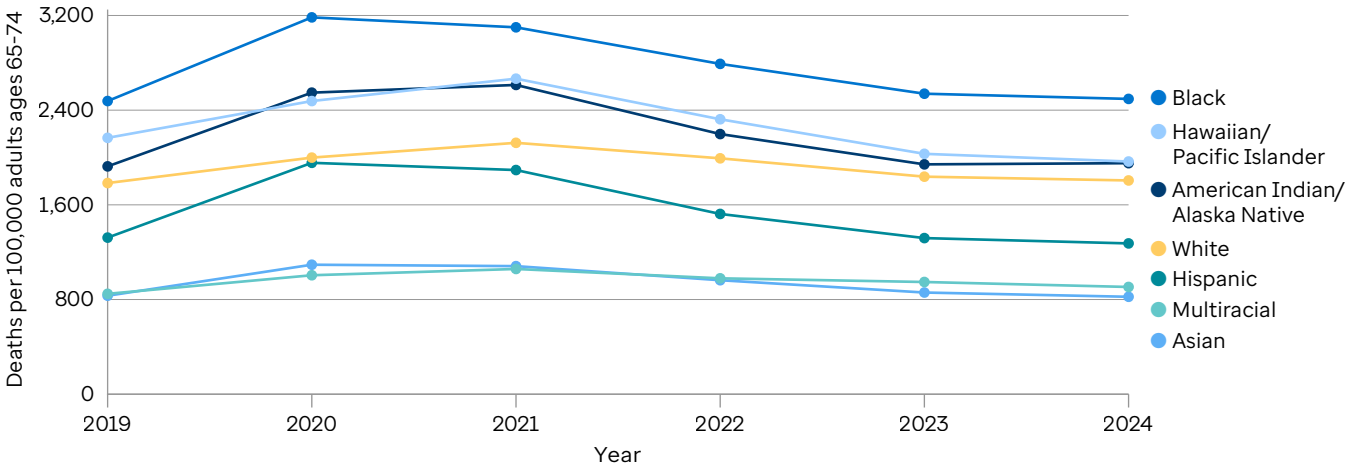
Physical Inactivity**
16% ▼
decrease from 31.7% to 26.5% of adults age 65 and older in fair or better health between 2023 and 2024.

* Source: U.S. HHS, Multiple Cause of Death Files via CDC WONDER.
** Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System.
† Source: U.S. DOJ, FBI, Internet Crime Complaint Center Annual Reports.
†† Source: Feeding America, Food Insecurity Among Seniors and Older Adults Report Series.
‡ Source: USDA, Characteristics of Supplemental Nutrition Assistance Program Households Report Series.
‡‡ Source: U.S. DOL, Bureau of Labor Statistics, Occupational Employment and Wage Statistics Program.
§ Source: U.S. HHS, CMS, National Plan and Provider Enumeration System.

Findings

Early Death

By Race/Ethnicity



Source: U.S. HHS, Multiple Cause of Death Files via CDC WONDER, 2019-2024.

HEALTH OUTCOMES | MORTALITY

Early Death

The average 65-year-old in the U.S. can expect to live another 19.7 years based on 2024 calculations.[5] However, many older adults do not live to see their 75th birthday. The leading causes of death among adults ages 65-74 in the U.S. in 2024 were cancer, heart disease, chronic lower respiratory disease, cerebrovascular disease and diabetes, according to data from the Centers for Disease Control and Prevention (CDC).[6] Unintentional injuries remain the sixth-leading cause of death, led by falls, poisonings (including drug deaths) and motor vehicle crashes.[7]

Changes over time. Nationally, the early death rate decreased 2% from 1,810 to 1,773 deaths per 100,000 adults ages 65-74 between 2023 and 2024, nearly back to the 2019 rate (1,765). In 2024, there were approximately 628,400 deaths among adults ages 65-74, 740 fewer than in 2023.

Between 2023 and 2024, the early death rate among adults ages 65-74 significantly decreased:

- 4% among Asian (859 to 823 deaths per 100,000 adults ages 65-74), 3% among Hispanic (1,319 to 1,274) and 2% among both Black (2,539 to 2,495) and white (1,838 to 1,806) older adults.
- 2% among both women (1,452 to 1,425) and men (2,212 to 2,164).

During the same time, the early death rate significantly decreased in seven states: 4% in both California (1,520 to 1,462 deaths per 100,000 adults ages 65-74) and Massachusetts (1,474 to 1,413); 3% in Florida (1,674 to 1,629), Georgia (2,049 to 1,992); New York (1,479 to 1,440) and Pennsylvania (1,827 to 1,772); and 2% in Texas (1,907 to 1,861).

Differences. In 2024, the early death rate significantly varied by race/ethnicity, geography and gender. The rate among adults ages 65-74 was:

- 3.0 times higher among Black (2,495 deaths per 100,000) compared with Asian (823) adults.
- 1.9 times higher in Mississippi (2,613) than in New Jersey (1,389).
- 1.5 times higher among men (2,164) than women (1,425).

Drug Deaths

America's Health Rankings data indicate that older adults were the only population that experienced a significant increase in drug-related deaths between 2022 and 2023, while rates decreased among younger populations.[8] According to *The Journals of Gerontology*, drug abuse can be particularly hazardous for older adults because age-related changes in the liver reduce the ability to metabolize medications.[9] Additionally, many older adults take one or more prescription medications, which can increase the risk of dangerous interactions.[10]

Changes over time. Despite staying below the United States Department of Health and Human Services' Healthy People 2030 target of 20.7 drug overdose deaths per 100,000 population, the national drug death rate increased 38% from 9.9 to 13.7 deaths due to drug injury (unintentional, suicide, homicide or undetermined) per 100,000 adults age 65 and older between 2019-2021 and 2022-2024.[11] This represents approximately 24,500 drug deaths among older adults in 2022-2024, 8,100 more than in 2019-2021.

Between 2019-2021 and 2022-2024, the drug death rate among adults age 65 and older significantly increased:

- 88% among American Indian/Alaska Native (9.1 to 17.1 deaths per 100,000), 53% among Black (24.8 to 38.0), 49% among Hispanic (7.0 to 10.4) and 31% among white (8.7 to 11.4) adults.
- 45% among older men (14.3 to 20.8) and 27% among older women (6.3 to 8.0).

During this time frame, the drug death rate significantly increased in 35 states. The largest increases were: 116% in Alaska (9.8 to 21.2 deaths per 100,000 adults age 65 and older), 87% in Washington (11.7 to 21.9) and 78% in Maine (6.7 to 11.9).

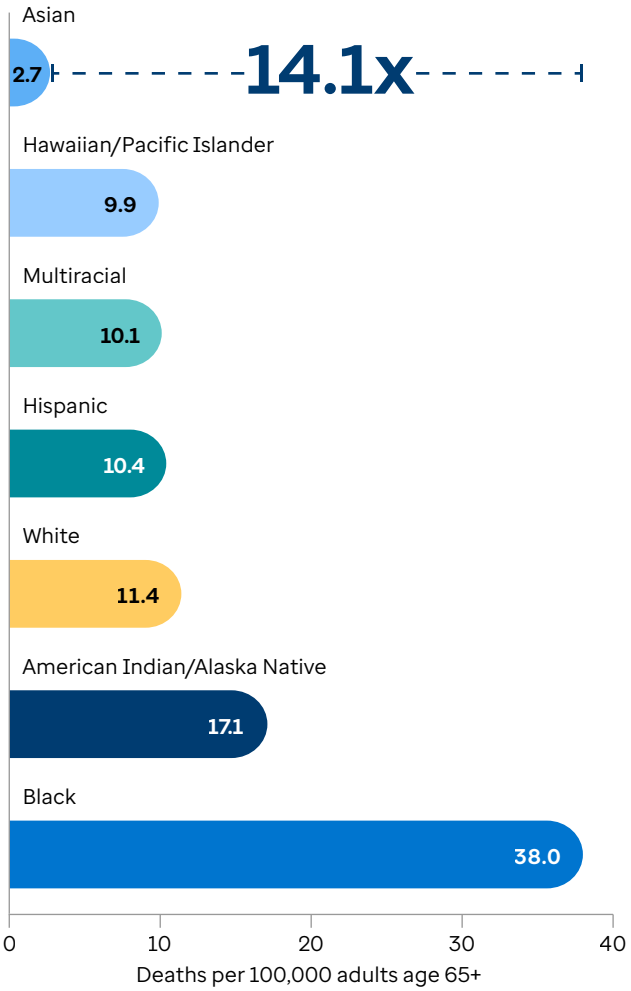
Differences. In 2022-2024, the drug death rate varied significantly by geography, race/ethnicity and gender. The rate among adults age 65 and older was:

- 16.0 times higher in the District of Columbia (86.5 deaths per 100,000) and 4.6 times higher in Nevada (24.9) than in Nebraska (5.4).
- 14.1 times higher among Black (38.0) compared with Asian (2.7) adults.
- 2.6 times higher among men (20.8) compared with women (8.0).

Note: No data were available for North Dakota and South Dakota in 2019-2021 and 2022-2024.

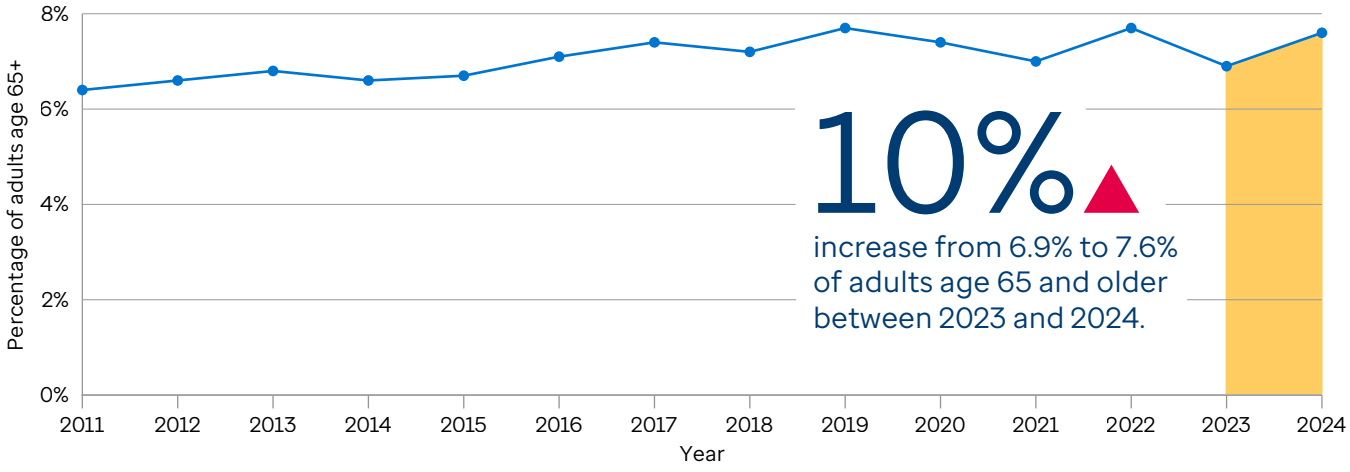
Drug Deaths

By Race/Ethnicity in 2022-2024



Source: U.S. HHS, Multiple Cause of Death Files via CDC WONDER, 2022-2024.
Note: No data were available for North Dakota and South Dakota in 2022-2024.

Excessive Drinking



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2011-2024.
Note: No data were available for Tennessee in 2024, Kentucky and Pennsylvania in 2023, Florida in 2021 and New Jersey in 2019.

Excessive Drinking

In 2022-2023, 40.9% of alcohol-attributable deaths occurred among people age 65 and older.[12] Alcohol-induced death rates for adults ages 65-74 reached record highs in 2021 and remained elevated through 2023.[13] Older adults face heightened risks because alcohol tolerance typically decreases with age – a sensitivity that is frequently compounded by the widespread use of prescription medications.[14]

Changes over time. Nationally, excessive drinking – 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) – increased 10% from 6.9% to 7.6% between 2023 and 2024.

Between 2023 and 2024, the prevalence of excessive drinking among adults age 65 and older significantly increased:

- 50% among Black (4.6% to 6.9%) and 10% among white (7.3% to 8.0%) adults.
- 12% among straight adults (6.8% to 7.6%).

During the same time period, the prevalence significantly increased 76% in Missouri (5.1% to 9.0%) and 50% in Kansas (4.8% to 7.2%).

Differences. Excessive drinking significantly varied by geography, race/ethnicity, gender, income and disability status. In 2024, the prevalence among adults age 65 and older was:

- 2.7 times higher in Alaska (11.1%) than in Utah (4.1%).
- 2.7 times higher among white (8.0%) compared with Asian (3.0%) adults.
- 1.7 times higher among men (9.7%) compared with women (5.8%).
- 1.6 times higher among those with an annual household income of $150,000 or more (10.8%) compared with those with an income less than $25,000 (6.9%).
- 1.5 times higher among those without a disability (8.3%) than those with independent living difficulty (5.5%).

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023. Differences highlighted the groups with the highest and lowest values. However, the values for certain race/ethnicity, income and disability groups may not differ significantly based on overlapping 95% confidence intervals. For more information, view excessive drinking data for older adults on the *America's Health Rankings* website.

Suicide

Suicide is a troubling public health issue that can leave a lasting impact on families and communities.[15] Suicide attempts by older adults are more likely to be fatal than suicide attempts by younger people.[16]

Changes over time. Nationally, the suicide rate increased 4% from 16.9 to 17.6 deaths due to intentional self-harm per 100,000 adults age 65 and older between 2019-2021 and 2022-2024. This remains higher than the Healthy People 2030 target to reduce suicide deaths among all ages to 12.8 per 100,000 population.[17] In 2022-2024, there were approximately 31,400 suicide deaths among adults age 65 and older, 3,400 more than in 2019-2021.

Between 2019-2021 and 2022-2024, the suicide rate among adults age 65 and older significantly increased:

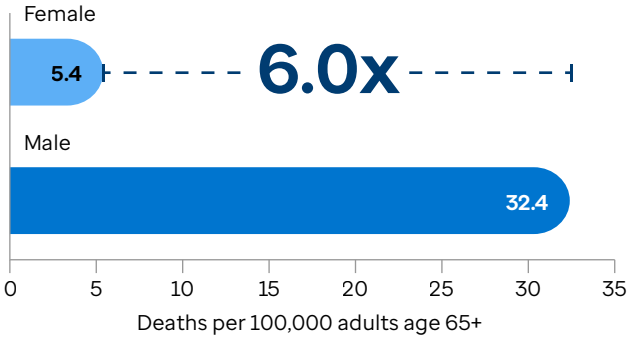
- 5% among white adults (20.3 to 21.4 deaths per 100,000).
- 3% among men (31.5 to 32.4).
- 3% among adults ages 65-74 (15.1 to 15.6).

The suicide rate among older adults significantly increased 21% in Missouri (18.0 to 21.8 deaths per 100,000 adults age 65 and older) between 2019-2021 and 2022-2024.

Differences. In 2022-2024, the suicide rate significantly varied by gender, race/ethnicity, geography and age group. The rate among adults age 65 and older was:

Suicide

By Gender in 2022-2024



Source: U.S. HHS, Multiple Cause of Death Files via CDC WONDER, 2022-2024.

- 6.0 times higher among men (32.4 deaths per 100,000) compared with women (5.4).
- 4.5 times higher among white (21.4) compared with Black (4.8) adults.
- 4.2 times higher in Montana (31.6) than in the District of Columbia (7.5), and 3.2 times higher in Montana than in New York (9.8).
- 1.4 times higher among adults age 85 and older (22.4) than those ages 65-74 (15.6).

Note: Differences highlighted the groups with the highest and lowest values. However, the values for certain race/ethnicity groups may not differ significantly based on overlapping 95% confidence intervals. For more information, view suicide data for older adults on the *America's Health Rankings* website.

SOCIAL AND ECONOMIC FACTORS | COMMUNITY AND FAMILY SAFETY

Firearm Deaths

Firearms are the most common method of suicide in the U.S., accounting for more than 50% of all suicide deaths.[18] This issue is of particular concern for older adults, who have higher overall suicide rates and are significantly more likely to commit suicide by firearm.[19]

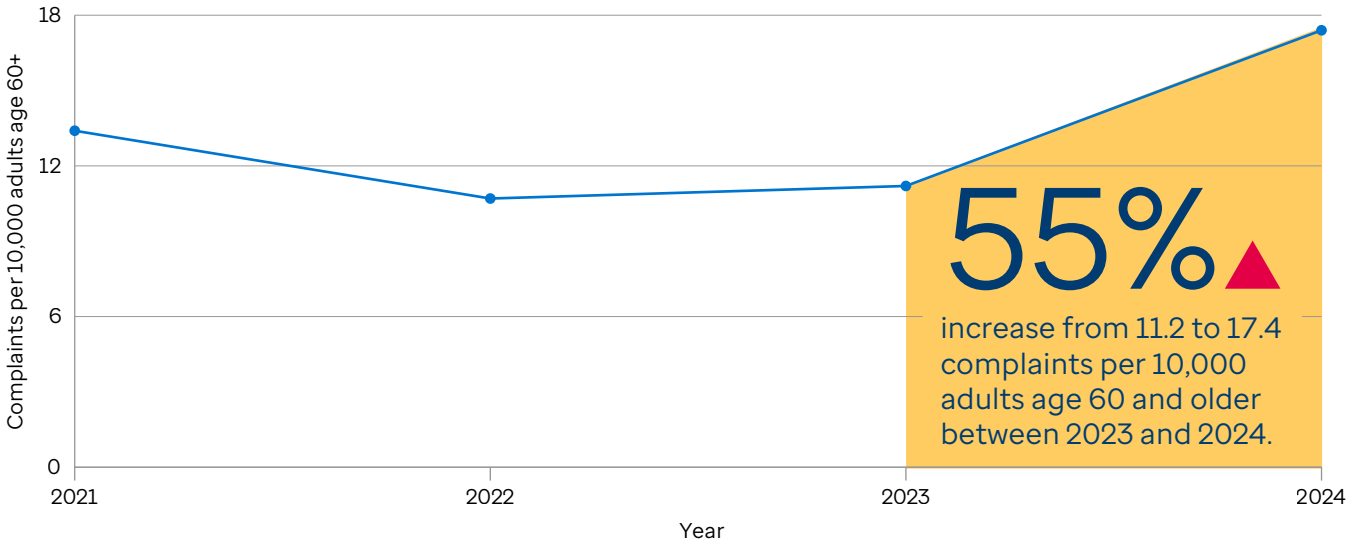
Changes over time. Nationally, the firearm death rate increased 5% from 13.1 to 13.7 deaths due to firearm injury of any intent (unintentional, suicide, homicide or undetermined) per 100,000 adults age 65 and older between 2019-2021 and 2022-2024. The majority of firearm deaths among older adults in 2022-2024 were suicides (12.5 deaths per 100,000 adults age 65 and older). There were 24,500 firearm deaths among adults age 65 and older in 2022-2024, 2,700 more than in 2019-2021. This rate is higher than the Healthy People 2030 target to reduce firearm-related deaths to 10.7 per 100,000 population.[20]

Between 2019-2021 and 2022-2024, the firearm death rate increased in two states: 22% in Missouri (16.0 to 19.5 per 100,000 adults age 65 and older) and 10% in Florida (14.7 to 16.2).

Differences. In 2022-2024, the firearm death rate significantly varied by gender, geography, race/ethnicity and age group. The rate among adults age 65 and older was:

- 9.6 times higher among men (27.0 deaths per 100,000) compared with women (2.8).
- 8.5 times higher in Montana (27.3) than in Massachusetts (3.2).
- 7.6 times higher among white (16.8) compared with Asian (2.2) adults.
- 1.5 times higher among adults age 85 and older (17.8) compared with those ages 65-74 (11.7).

Internet Crime



Source: U.S. DOJ, FBI, Internet Crime Complaint Center Annual Reports, 2021-2024.

Internet Crime

Older adults are frequent victims of fraud for many reasons, including having higher average net worth than other age groups and being vulnerable due to age-related cognitive decline.[21-23] The most common internet scams affecting older adults in 2024 were phishing/spoofing, tech support and extortion.[24] That same year, victims age 60 and older in the U.S. cumulatively lost nearly $4.9 billion to internet fraud.[24]

Changes over time. Nationally, the number of internet crime victim complaints increased 55% from 11.2 to 17.4 per 10,000 adults age 60 and older between 2023 and 2024. Nearly 143,200 internet crime victim complaints were reported among adults age 60 and older in 2024, 52,300 more than in 2023.

During this time, internet crime increased 55% or more in 17 states. The largest increases were: 315% in Indiana (7.8 to 32.4 complaints per 10,000 adults age 60 and older) and 108% in both Pennsylvania (8.6 to 17.9) and Illinois (9.5 to 19.8).

Differences. In 2024, the internet crime rate among adults age 60 and older was 4.1 times higher in Arizona (34.4 complaints per 10,000) than in Mississippi (8.4).

Food Insecurity

6% ▲

increase from 8.7% to 9.2% of adults age 60 and older between 2022 and 2023. 7.4 million older adults experienced food insecurity in 2023.

Source: Feeding America, Food Insecurity Among Seniors and Older Adults Report Series, 2022-2023.

SNAP Reach

5% ▲

increase from 82.8 to 86.8 participants per 100 adults age 60 and older living in poverty between 2022 and 2023. 7.8 million older adults received SNAP benefits in 2023.

Source: USDA, Characteristics of Supplemental Nutrition Assistance Program Households Report Series, 2022-2023.

SOCIAL AND ECONOMIC FACTORS | ECONOMIC RESOURCES

Food Insecurity

Food insecurity is an economic and social condition characterized by limited or uncertain regular access to food.[25] It differs from hunger, which is a physiological feeling. Many older adults face barriers to food access, such as affordability, limited reliable transportation and health constraints.[26]

Changes over time. Nationally, the percentage of adults age 60 and older who lack access to enough food for an active and healthy life due to limited financial resources increased 6% from 8.7% to 9.2% between 2022 and 2023. In 2023, 7.4 million adults age 60 and older experienced food insecurity, 500,000 more than in 2022.

Between 2022 and 2023, food insecurity among adults age 60 and older increased 6% or more in 33 states and the District of Columbia. The largest increases were: 56% in Kentucky (7.7% to 12.0%), 49% in New Hampshire (3.5% to 5.2%) and 47% in Minnesota (3.4% to 5.0%). During the same time, food insecurity decreased 6% or more in 10 states. The largest decreases were: 25% in Utah (7.6% to 5.7%), 22% in Delaware (7.2% to 5.6%) and 19% in Missouri (7.8% to 6.3%).

Differences. In 2023, food insecurity among adults age 60 and older was 3.6 times higher in Texas (13.6%) than in North Dakota (3.8%).

SNAP Reach

The Supplemental Nutrition Assistance Program (SNAP) is an anti-hunger program in the U.S. that helps millions of low-income Americans access food and improve their economic security and health outcomes.[27,28] In 2023, older adults who lived alone received an average of $162 a month in SNAP benefits.[29]

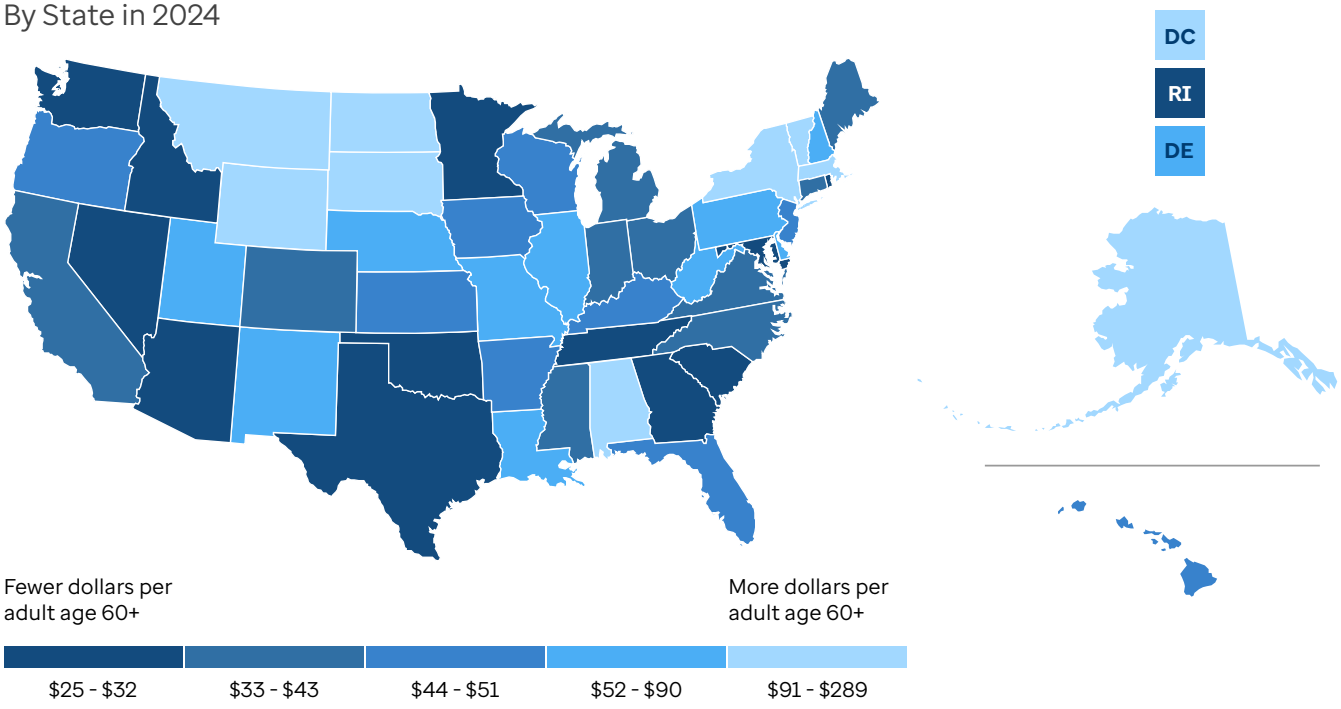
Changes over time. Nationally, SNAP reach – the number of adults age 60 and older who participated in SNAP per 100 adults age 60 and older living in poverty – increased 5% from 82.8 to 86.8 between 2022 and 2023. In 2023, 7.8 million adults age 60 and older received SNAP benefits, 626,000 more than in 2022.

Between 2022 and 2023, SNAP reach among adults age 60 and older increased 5% or more in 13 states. The largest increases were: 23% in Louisiana (63.1 to 77.5 participants per 100 adults age 60 and older living in poverty), 22% in Maryland (67.9 to 82.7) and 20% in South Dakota (38.3 to 45.9). During the same time, SNAP reach decreased 5% or more in 11 states. The largest decreases were: 35% in New Jersey (91.5 to 59.1), 32% in Indiana (51.9 to 35.5) and 31% in Wyoming (21.4 to 14.8).

Differences. In 2023, SNAP reach was 6.8 times higher in eight states (California, Connecticut, Illinois, Massachusetts, New York, Oregon, Pennsylvania and Rhode Island, all at 100 participants per 100 adults age 60 and older living in poverty) than in Wyoming (14.8).

Community Support Expenditures

By State in 2024



Source: U.S. HHS, Administration for Community Living, State Program Reports, 2024.

Community Support Expenditures

Several federal and state programs support older adults in remaining independent at home, ultimately saving money for both individuals and the federal programs that fund nursing home care.[30] In fiscal year 2023, $145.9 billion in Medicaid long-term services and supports spending went toward home- and community-based services such as home health aides, adult day care, meal programs, in-home modifications and assistive equipment.[31,32]

Changes over time. Nationally, community support expenditures – measured in dollars per adult age 60 and older of Older Americans Act Title III funding spent on support services for older adults and caregivers, including congregate meals, home-delivered meals and senior centers – decreased 7% from $57 to $53 between 2019 and 2024. While community support expenditures rose to a high of $62 in 2021, they have since dropped back below 2019 levels.

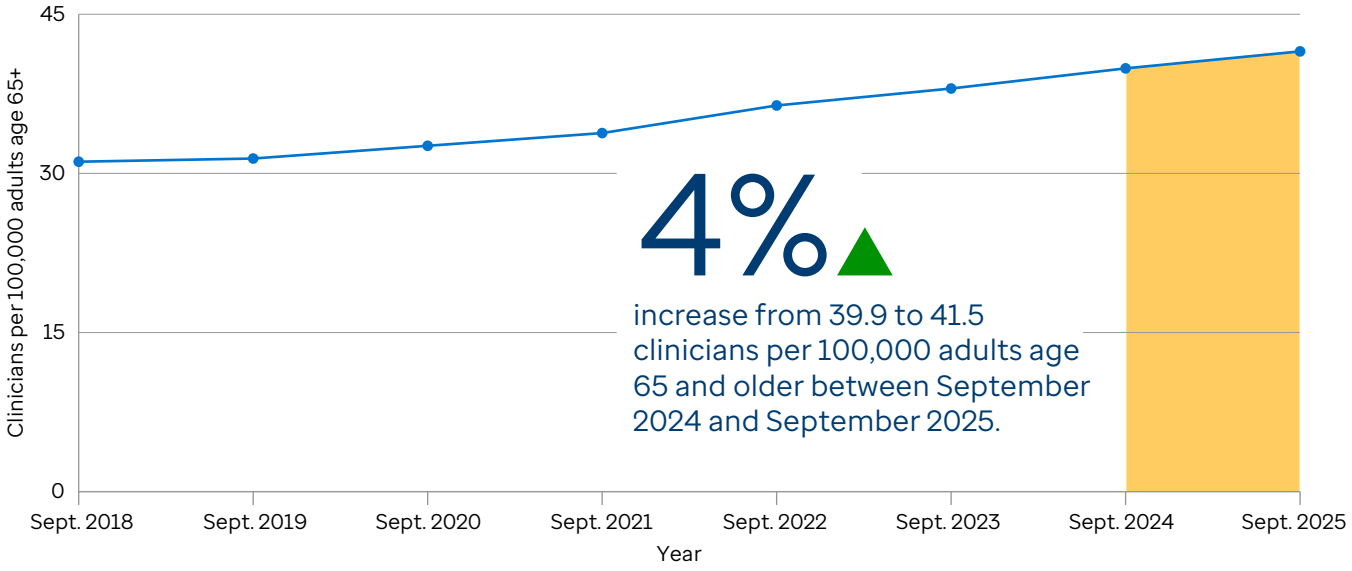
Congregate meals decreased 15% from 2.0 to 1.7 persons served per 100 adults age 60 and older between 2019 and 2024, and senior centers receiving Older Americans Act Title III funding decreased 11% from 7.9 to 7.0 senior centers per 100,000 adults age 60 and older during the same time period. However, home-delivered meals increased 27% from 8.9 to 11.3 persons served per 100 adults age 60 and older with independent living difficulty between 2019 and 2024.

Between 2019 and 2024, community support expenditures decreased 7% or more in eight states. The largest decreases were: 73% in Florida ($166 to $45 per adult age 60 and older), 37% in Pennsylvania ($94 to $59) and 17% in Massachusetts ($267 to $222).

During the same time, community support expenditures increased 7% or more in 40 states. The largest increases were 69% in North Dakota ($84 to $142 per adult age 60 and older), Kentucky ($26 to $44) and Illinois ($35 to $59).

Differences. In 2024, community support expenditures were 11.6 times higher in the District of Columbia ($289 per adult age 60 and older) and 8.9 times higher in Massachusetts ($222) than in Arizona or Georgia (both $25).

Geriatric Clinicians



Source: U.S. HHS, CMS, National Plan and Provider Enumeration System, September 2018-September 2025.

CLINICAL CARE | ACCESS TO CARE

Geriatric Clinicians

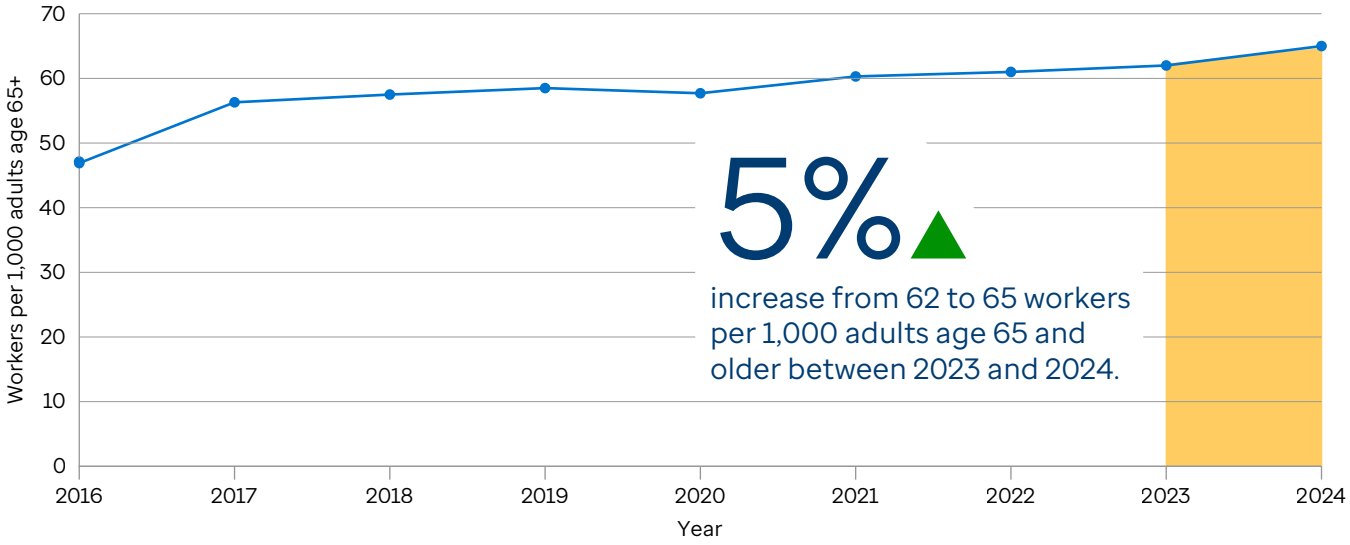
Geriatricians and geriatric nurse practitioners are trained to meet the unique needs of older adults.[33,34] Care from a geriatrician can be helpful when an older person is coping with multiple chronic conditions or managing multiple medications, as some drugs may have adverse side effects or harmful interactions with one another. [35]

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 4% from 39.9 to 41.5 between September 2024 and September 2025. In September 2025, there were approximately 25,400 geriatric clinicians across the country, roughly 1,700 more than in September 2024.

During this time frame, the number of geriatric clinicians increased 4% or more in 26 states, led by: 34% in Maine (34.9 to 46.6 clinicians per 100,000 adults age 65 and older), 13% in Tennessee (37.1 to 42.1) and 9% in Oregon (32.6 to 35.4). At the same time, geriatric clinicians decreased 6% in the District of Columbia (100.3 to 94.5) and 4% in New Hampshire (43.9 to 42.2).

Differences. In September 2024, the number of geriatric clinicians per 100,000 adults age 65 and older was 5.5 times higher in the District of Columbia (94.5 clinicians per 100,000 adults age 65 and older) and 4.3 times higher in Rhode Island (74.1) than in South Dakota (17.3).

Home Health Care Workers



Source: U.S. DOL, Bureau of Labor Statistics, Occupational Employment and Wage Statistics Program, 2016-2024.

Home Health Care Workers

Home health and personal care aides help older adults remain in their homes as they age, a preferred care option for many.[36-38] These aides provide short-term skilled nursing services such as supporting recovery from surgery, as well as long-term care for those with disabilities, functional decline or chronic illness.[39] The Department of Labor estimates that 739,800 job openings in home health care will be added between 2024 and 2034 as the older adult population grows.[40]

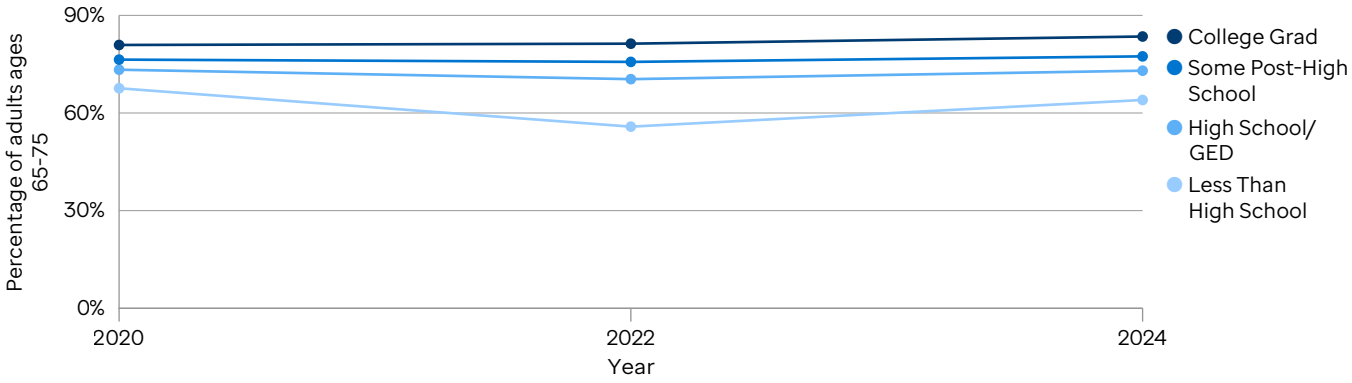
Changes over time. Nationally, the number of personal care and home health aides per 1,000 adults age 65 and older increased 5% from 62 to 65 between 2023 and 2024, and 38% since 2016.

Between 2023 and 2024, the supply of home health care workers increased 5% or more in 25 states, led by: 24% in Washington (59 to 73 aides per 1,000 adults age 65 and older), 21% in Maryland (29 to 35) and 18% in Indiana (38 to 45). At the same time, home health care workers decreased 5% or more in eight states, with the largest decreases being 13% in Hawaii (23 to 20) and 8% in both Massachusetts (88 to 81) and West Virginia (52 to 48).

Differences. In 2024, the supply of home health care workers was 9.8 times higher in New York (166 aides per 1,000 adults age 65 and older) than in Florida (17).

Cancer Screenings

By Educational Attainment



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2020-2024.
Note: No data were available for Tennessee in 2024.

CLINICAL CARE | PREVENTIVE CLINICAL SERVICES

Cancer Screenings

Cancer has been one of the top two leading causes of death in the U.S. for more than 75 years.[41] Older adults have the highest incidence of cancer – in 2025, 88% of cancer diagnoses occurred among adults age 50 and older.[42] Breast and colorectal cancers, which are among the most prevalent forms of cancer, are most commonly diagnosed between the ages of 65 and 74.[43-45]

Changes over time. Nationally, cancer screenings – the percentage of females ages 65-74 who reported having a mammogram in the past two years and the percentage of adults ages 65-75 who reported having a colorectal cancer screening within the recommended time period – increased 4% from 74.1% to 76.8% between 2022 and 2024.

Between 2022 and 2024, the prevalence of cancer screenings among adults ages 65-75 significantly increased:

- 15% among those with less than a high school education (55.8% to 64.0%) and 3% among college graduates (81.3% to 83.5%).
- 8% among those with an annual household income less than $25,000 (60.0% to 65.1%).
- 5% among women (67.5% to 71.1%).
- 3% among those living in metropolitan areas (75.1% to 77.6%).

During this time frame, cancer screenings significantly increased in four states: 11% in both New Jersey (71.6% to 79.8%) and Delaware (74.2% to 82.2%), 8% in Massachusetts (76.9% to 83.3%) and 5% in Minnesota (78.1% to 82.2%).

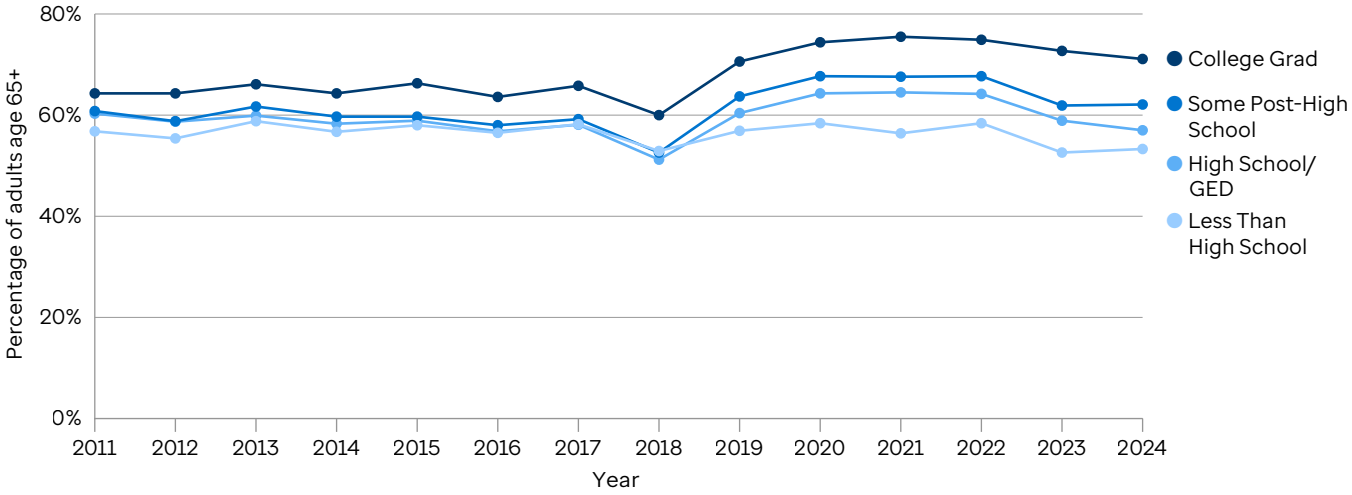
Differences. In 2024, cancer screenings significantly varied by geography, educational attainment, household income, gender, race/ethnicity and metropolitan status. The prevalence among adults ages 65-75 and older was:

- 1.3 times higher in Rhode Island (85.0%) than in Wyoming (65.0%).
- 1.3 times higher among college graduates (83.5%) compared with those with less than a high school education (64.0%).
- 1.3 times higher among those with an annual household income of $150,000 or more (86.6%) compared with those with an income less than $25,000 (65.1%).
- 1.2 times higher among men (82.6%) compared with women (71.1%).
- 1.2 times higher among Black (80.4%) compared with Asian (65.6%) adults.
- 1.1 times higher among those living in metropolitan areas (77.6%) compared with those in nonmetropolitan areas (72.8%).

Note: No data were available for Tennessee in 2024. Differences highlighted the groups with the highest and lowest values. However, the values for certain income and race/ethnicity groups may not differ significantly based on overlapping 95% confidence intervals. For more information, view cancer screenings data for older adults on the *America's Health Rankings* website.

Flu Vaccination

By Educational Attainment



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2011-2024.
Note: No data were available for Tennessee in 2024, Kentucky and Pennsylvania in 2023, Florida in 2021 and New Jersey in 2019.

Flu Vaccination

During the 2023-2024 flu season, flu vaccinations prevented nearly 6,000 influenza-related deaths among adults age 65 and older in the U.S., as well as approximately 780,000 illnesses, 436,000 medical visits and 64,000 hospitalizations.[46]

Changes over time. Nationally, the percentage of adults age 65 and older who reported receiving a seasonal flu vaccine in the past 12 months did not significantly change between 2023 and 2024 (63.4% to 62.5%) and remains lower than the Healthy People 2030 target to increase the proportion of people of all ages who get the flu vaccine every year to 70%.[47]

Differences. In 2024, the prevalence of flu vaccination significantly varied by geography, race/ethnicity, educational attainment, household income, metropolitan status and gender. The prevalence among adults age 65 and older was:

- 1.4 times higher in Vermont (73.1%) than in Alaska (52.0%).
- 1.3 times higher among white (64.8%) than American Indian/Alaska Native (51.3%) adults.
- 1.3 times higher among college graduates (71.1%) compared with those with less than a high school education (53.3%).
- 1.3 times higher among those with an annual household income of $100,000 to $149,999 and those with an income of $150,000 or more (both 71.6%) compared with those with an income less than $25,000 (54.7%).
- 1.1 times higher among adults living in metropolitan areas (63.8%) compared with those in nonmetropolitan areas (57.7%).
- 1.04 times higher among women (63.7%) compared with men (61.1%).

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023. Differences highlighted the groups with the highest and lowest values. However, the values for certain race/ethnicity, education and income groups may not differ significantly based on overlapping 95% confidence intervals. For more information, view flu vaccination data for older adults on the *America's Health Rankings* website.

Pneumonia Vaccination

Every year, approximately 900,000 individuals in the U.S. are diagnosed with pneumonia, 150,000 of whom are hospitalized and 41,000 of whom die from pneumonia or its complications.[48] Hospitalization and death rates from pneumococcal infections are highest among older adults.[49,50]

Changes over time. Nationally, the percentage of adults age 65 and older who reported ever receiving a pneumonia (pneumococcal) vaccine did not change significantly between 2023 and 2024 (70.2% to 69.8%).

Differences. In 2024, the prevalence of pneumonia vaccination significantly varied by race/ethnicity, educational attainment, geography, household income, gender, metropolitan status, disability status and veteran status. The prevalence among adults age 65 and older was:

- 1.6 times higher among white (73.0%) compared with Hawaiian/Pacific Islander (46.8%) adults.
- 1.4 times higher among college graduates (75.9%) compared with those with less than a high school education (55.9%).
- 1.2 times higher in New Hampshire (76.4%) than in Hawaii (63.2%).
- 1.2 times higher among those with an annual household income of $100,000 to $149,999 (76.3%) compared with those with an income less than $25,000 (62.1%).
- 1.1 times higher among women (73.3%) compared with men (65.7%).
- 1.1 times higher among those living in metropolitan areas (70.9%) compared with those in nonmetropolitan areas (67.3%).
- 1.1 times higher among those with difficulty hearing (74.4%) than those who have difficulty with cognition (66.6%).
- 1.1 times higher among those who have served in the U.S. armed forces (73.2%) compared with those who have not served (69.2%).

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023. Differences highlighted the groups with the highest and lowest values. However, the values for certain race/ethnicity, income and disability groups may not differ significantly based on overlapping 95% confidence intervals. For more information, view pneumonia vaccination data for older adults on the *America's Health Rankings* website.

Nursing Home Quality

In 2025, the number of people living in nursing homes across the U.S. increased to 1.2 million, while the number of nursing home facilities decreased to just 15,000.[51,52] Nursing home quality varies across the United States, impacted by differences in ownership, staffing stability, staff training and environment.[53-55] Using the Five-Star Quality Rating System, the Centers for Medicare & Medicaid Services evaluates nursing homes in measures of staffing, health inspections and quality and works to improve standards.[56]

Changes over time. Nationally, the percentage of nursing home beds rated four or five stars increased 9% from 31.1% to 34.0% between September 2024-November 2024 and September 2025-November 2025.

Between 2024 and 2025, the prevalence of nursing home beds rated four or five stars increased 9% or more in 26 states, led by: 45% in West Virginia (18.5% to 26.9%), 33% in Tennessee (25.1% to 33.5%) and 31% in both Maine (34.0% to 44.6%) and Georgia (20.9% to 27.3%). During the same time period, the prevalence decreased 9% or more in four states and the District of Columbia: 39% in Vermont (41.9% to 25.7%), 35% in Hawaii (59.7% to 38.9%), 18% in Nevada (27.6% to 22.5%), 17% in Idaho (51.3% to 42.7%) and 15% in District of Columbia (21.6% to 18.4%).

Differences. In 2025, nursing home quality was 2.6 times higher in North Dakota (49.1%) than in Louisiana (18.6%).

Physical Inactivity

Between 2023 and 2024, the percentage of adults age 65 and older in fair or better health who reported physical inactivity improved across all education groups.

21%▼

decrease from 50.3% to 39.5% among those with **less than a high school education**.

16%▼

decrease from 30.7% to 25.9% among those with **some post-high school education**.

14%▼

decrease from 40.3% to 34.5% among **high school graduates**.

11%▼

decrease from 18.2% to 16.2% among **college graduates**.

Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2023-2024.
Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023.

BEHAVIORS | NUTRITION AND PHYSICAL ACTIVITY

Physical Inactivity

Physical inactivity can increase the risk of negative health outcomes such as cardiovascular disease, cancer incidence and cancer mortality, Type 2 diabetes and premature death.[57-61] Older adults tend to be less active than younger people, increasing their susceptibility to diseases associated with physical inactivity.[62]

Changes over time. Nationally, the 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 decreased 16% from 31.7% to 26.5% between 2023 and 2024.

Between 2023 and 2024, the percentage of adults age 65 and older in fair or better health who reported physical inactivity decreased:

- 33% among multiracial (32.3% to 21.8%), 17% among white (30.3% to 25.3%), 16% among Hispanic (39.8% to 33.6%) and 15% among Black (36.9% to 31.2%) adults.
- 21% among those with less than a high school education (50.3% to 39.5%), 16% among those with some post-high school education (30.7% to 25.9%), 14% among high school graduates (40.3% to 34.5%) and 11% among college graduates (18.2% to 16.2%).
- 21% among those with difficulty hearing (39.3% to 31.2%), those with difficulty seeing (46.8% to 37.0%) and those who have difficulty with cognition (49.8% to 39.1%); 15% among those with independent living difficulty (61.9% to 52.7%); 14% among those who have difficulty with self-care (65.4% to 56.3%); 13% among those who have difficulty with mobility (54.8% to 47.5%); and 12% among those without a disability (21.2% to 18.7%).
- 20% among those living in nonmetropolitan areas (37.2% to 29.7%) and 16% among those in metropolitan areas (30.5% to 25.7%).
- 18% among men (28.3% to 23.1%) and 15% among women (34.5% to 29.3%).
- 17% among both those with an annual household income less than $25,000 (45.6% to 37.7%) and those with an income of $25,000 to $49,999 (37.3% to 31.1%), and 14% among those with an income of $50,000 to $74,999 (28.3% to 24.2%).

- 17% among straight adults (31.4% to 26.1%).
- 17% among those who have not served in the U.S. armed forces (31.9% to 26.6%) and 15% among those who have served (30.7% to 26.0%).

During this time frame, the prevalence of physical inactivity decreased in 28 states, led by: 34% in Massachusetts (30.4% to 20.1%), and 28% in both Alabama (41.0% to 29.7%) and Minnesota (28.9% to 20.7%).

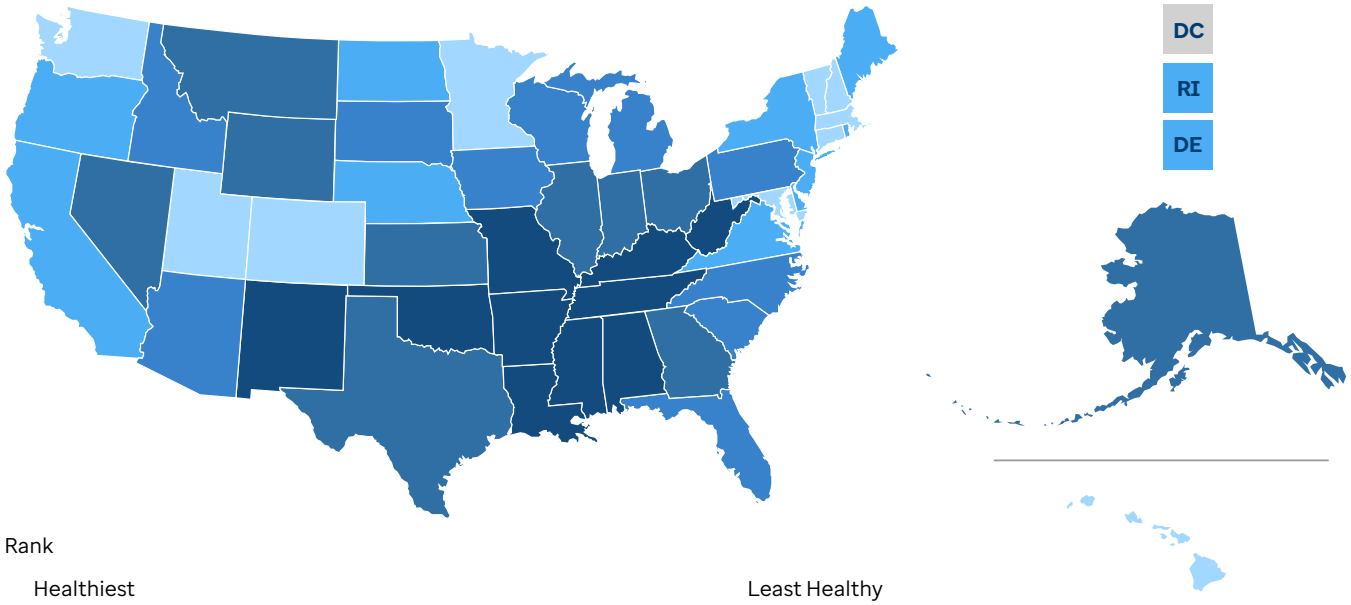
Differences. The prevalence of physical inactivity varied significantly by income, disability status, educational attainment, race/ethnicity, geography, gender and metropolitan status in 2024. The prevalence among adults age 65 and older in fair or better health was:

- 3.1 times higher among those with an annual household income less than $25,000 (37.7%) compared with those who have an income of $150,000 or more (12.0%).
- 3.0 times higher among those who have difficulty with self-care (56.3%) compared with those without a disability (18.7%).
- 2.4 times higher among those with less than a high school education (39.5%) compared with college graduates (16.2%).
- 2.0 times higher among Hispanic (33.6%) compared with Hawaiian/Pacific Islander (16.7%) adults.
- 2.0 times higher in West Virginia and Kentucky (both 35.4%) than in Colorado (17.8%).
- 1.3 times higher among women (29.3%) compared with men (23.1%).
- 1.2 times higher among those living in nonmetropolitan areas (29.7%) compared with those in metropolitan areas (25.7%).

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023. Differences highlighted the groups with the highest and lowest values. However, the values for certain disability and race/ethnicity groups may not differ significantly based on overlapping 95% confidence intervals. For more information, view physical inactivity data for older adults on the *America's Health Rankings* website.

State Rankings

2026 Senior Report State Rankings



Source: *America's Health Rankings* composite measure, 2026.
Note: District of Columbia does not have a rank or score = "Not ranked".

State Rankings

The overall state rankings are based on 36 measures across five categories of health: Social and Economic Factors, Physical Environment, Behaviors, Clinical Care and Health Outcomes. The Methodology section (page 32) of the Appendix describes how overall ranks were calculated. Additional information can be found on the *America's Health Rankings* Methodology page.

Vermont Ranks No. 1

For the second consecutive year, Vermont ranked the healthiest state for older adults in the nation. It ranked among the top five states in Behaviors (No. 1) and Social and Economic Factors (No. 2). Vermont ranked No. 12 in Physical Environment, No. 13 in Health Outcomes and No. 14 in Clinical Care.

Strengths: Low poverty rate, low prevalence of avoiding care due to cost and low prevalence of physical inactivity.

Challenges: High suicide rate, high housing cost burden and low hospice care use.

Rounding out the top five healthiest states are Utah (No. 2), New Hampshire (No. 3), Minnesota (No. 4) and Colorado (No. 5).

Louisiana Ranks No. 50

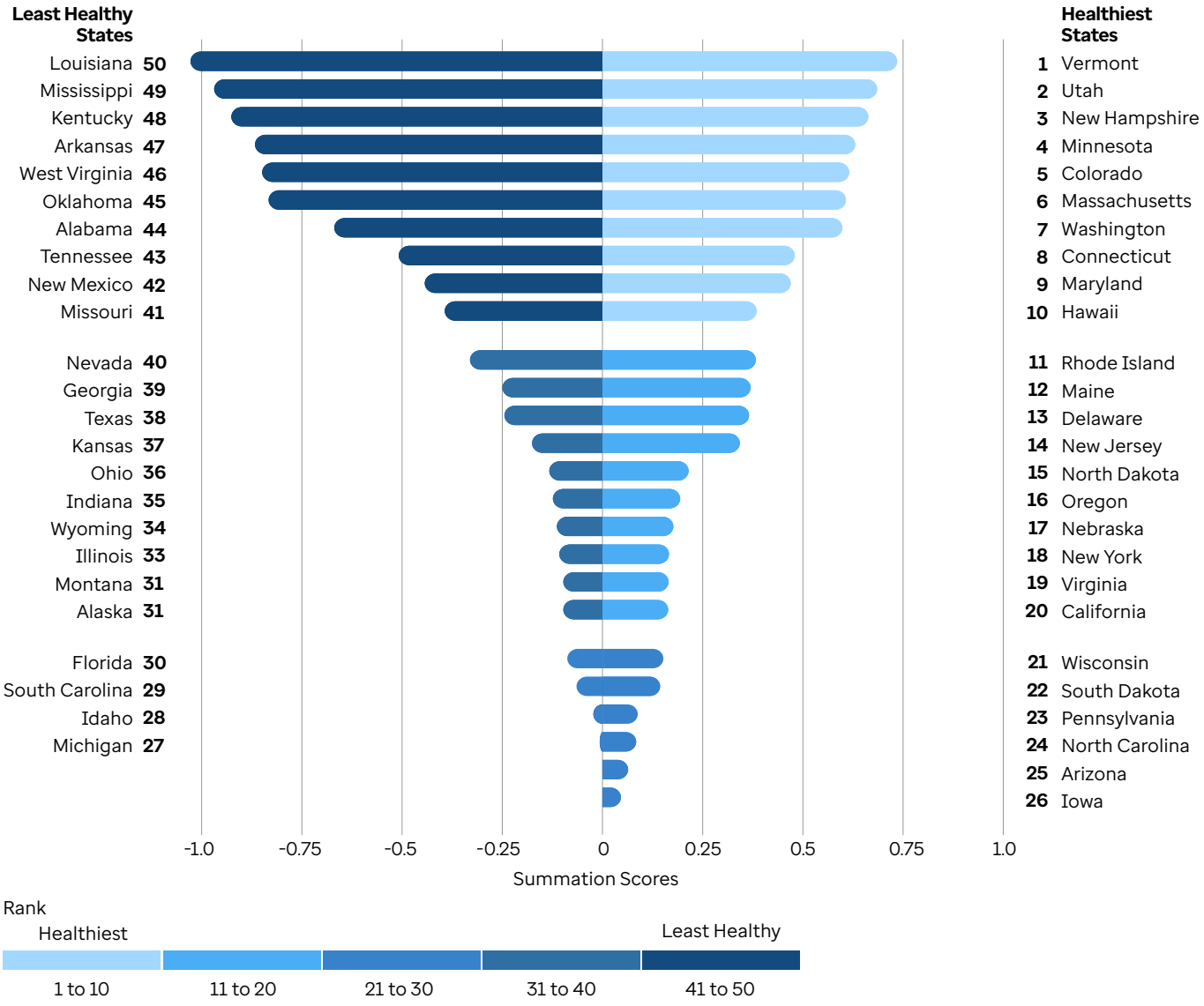
Louisiana was the least healthy state in this year's report, falling one place since last year. The state ranked in the bottom five in Behaviors (No. 47), Health Outcomes (No. 48), Social and Economic Factors (No. 48), and Clinical Care (No. 49). Louisiana was No. 45 in Physical Environment.

Strengths: Low suicide rate, high level of community support expenditures and high number of home health care workers per 1,000 older adults.

Challenges: High prevalence of frequent mental distress, high poverty rate and high prevalence of cigarette smoking.

Mississippi (No. 49), Kentucky (No. 48), Arkansas (No. 47) and West Virginia (No. 46) completed the five least healthy states.

2026 Senior Report State Rankings and Scores*



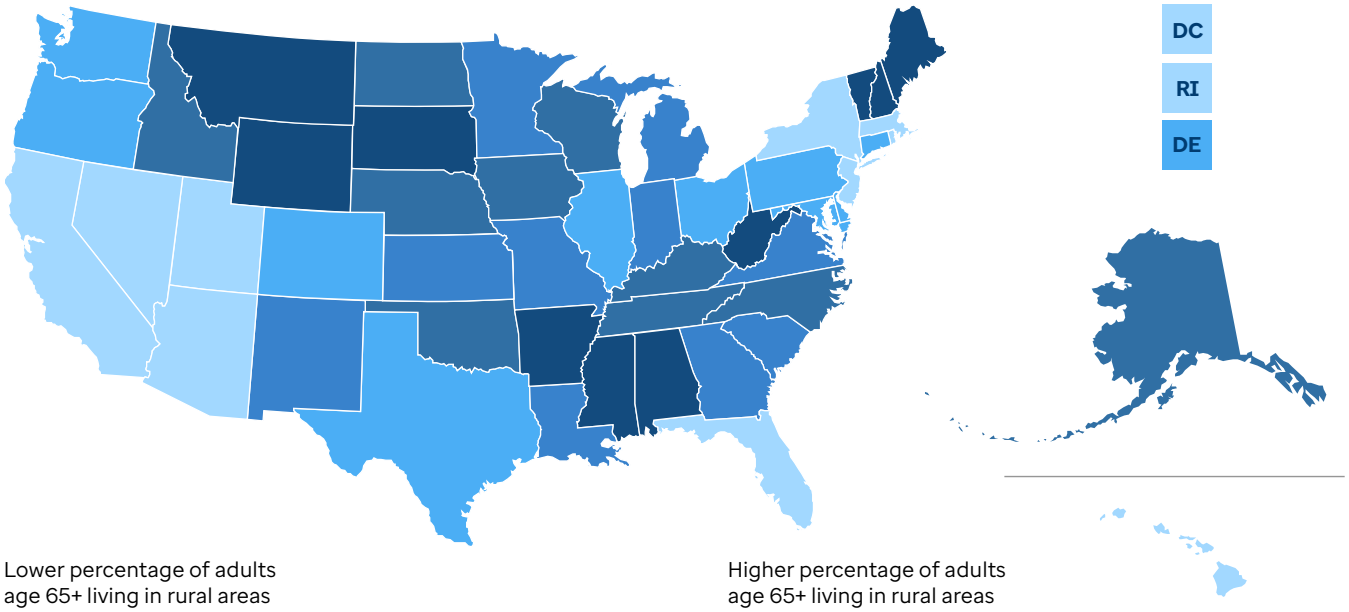
Source: *America's Health Rankings* composite measure, 2026.
*Scores are the sum of weighted z-scores of all weighted measures.

The graph above displays state scores and ranks, with the least healthy states on the left and the healthiest on the right. The distance between bars shows the difference between state scores. For example, Alabama (No. 44) and Oklahoma (No. 45), while close in ranking, had a sizable difference in score, meaning Oklahoma would need to improve in several measures to move up in the rankings. There was also a large gap in score between Tennessee (No. 43) and Alabama (No. 44). To further explore state-level data, see Explore Data.

The website features downloadable State Summaries for each state and the District of Columbia. Each summary describes state-specific strengths, challenges, key findings and rankings for individual measures, allowing users to identify which measures positively or negatively influenced each state's overall rank. This can be visualized by selecting a state in the Explore Data section. Disparity ratios, which show the relative difference between two groups within a demographic, are available for select measures in the website's State Summaries. The website also features an Adjust My Rank tool that allows users to explore how progress and challenges across key measures can impact a state's overall rank.

Rural Population Age 65 and Older

By Percentage in 2024



Lower percentage of adults age 65+ living in rural areas

Higher percentage of adults age 65+ living in rural areas

0.0%–15.4%	15.5%–26.9%	27.0%–34.8%	34.9%–45.3%	45.4%–68.5%

Source: U.S. Census Bureau, American Community Survey, 1-Year Dataset, 2024.

Spotlight

Older Adults in Rural Communities

Data provide insights into distinct factors shaping the health of older adults in rural areas

Rural communities exist across the country, and tend to be older, on average, than metropolitan communities. The percentage of the older adult population living in rural areas varies significantly between states. However, even in states where a relatively low percentage of older adults live in rural areas, there may still be significant rural older adult populations. For example, California has the ninth-largest rural older adult population, representing more than 500,000 people, despite having the second-lowest rate (7.7%) of any state. Similarly, 15.2% of older adults in New York live in rural areas, equivalent to more than 570,000 people. It is therefore critical that state and local leaders understand the health needs of their rural older adult population.

The data show recent bright spots for older adults living in rural (nonmetropolitan) areas.

For example, in 2024:

- In Minnesota, depression was significantly lower among older adults in rural areas than those in metropolitan areas (13.7% vs. 17.9%).
- In New York, the percentage of older adults in rural areas who avoided care due to cost was significantly lower compared with their metropolitan counterparts (3.0% vs. 5.6%).
- In Alaska, excessive drinking was lower among older adults in rural areas compared with those in metropolitan areas (7.4% vs. 13.1%).

Nationwide differences persist between older adults living in rural versus metropolitan areas. In 2024, those living in rural areas had higher rates of cigarette smoking than those in metropolitan areas (10.7% vs. 7.8% of adults age 65 and older). While physical inactivity improved 20% for rural older adults between 2023 and 2024 (from 37.2% to 29.7% of adults age 65 and older in fair or better health), inactivity remained more common among those living in rural areas than those in metropolitan areas (25.7%) in 2024.

Appendix

United States

Health Department Website: hhs.gov

Summary

Key Findings

Internet Crime

55% ▲

from 11.2 to 17.4 complaints per 10,000 adults age 60 and older between 2023 and 2024.

Drug Deaths

38% ▲

from 9.9 to 13.7 deaths per 100,000 adults age 65 and older between 2019-2021 and 2022-2024.

Physical Inactivity

16% ▼

from 31.7% to 26.5% of adults age 65 and older in fair or better health between 2023 and 2024.

Food Insecurity

6% ▲

from 8.7% to 9.2% of adults age 60 and older between 2022 and 2023.

Home Health Care Workers

5% ▲

from 62 to 65 aides per 1,000 adults age 65 and older between 2023 and 2024.

Measures		U.S. Value
Social and Economic Factors		
Community and Family Safety	Internet Crime (Complaints per 10,000 adults age 60+)*	17.4
	Motor Vehicle Deaths (Deaths per 100,000 adults age 65+)	13.3
Economic Resources	Community Support Expenditures (Dollars per adult age 60+)	$53
	Food Insecurity (% of adults age 60+)	9.2%
	Poverty (% of adults age 65+)	11.2%
	SNAP Reach (Participants per 100 adults age 60+ living in poverty)	86.8
Social Support and Engagement	High-Speed Internet (% of households with adults age 65+)	88.2%
	Low-Care Nursing Home Residents (% of residents)	9.0%
	Risk of Social Isolation (Index from 1-100)	–
	Volunteerism (% of adults age 65+)	26.3%
Physical Environment		
Air and Water Quality	Air Pollution (Micrograms of fine particles per cubic meter)	8.8
	Drinking Water Violations (Average violations per community water system)	2.5
Housing	Housing Cost Burden (% of households with adults age 65+)	33.3%
Clinical Care		
Access to Care	Avoided Care Due to Cost (% of adults age 65+)	3.8%
	Geriatric Clinicians (Clinicians per 100,000 adults age 65+)	41.5
	Home Health Care Workers (Workers per 1,000 adults age 65+)	65
Preventive Clinical Services	Cancer Screenings (% of adults ages 65-75)	76.8%
	Flu Vaccination (% of adults age 65+)	62.5%
	Pneumonia Vaccination (% of adults age 65+)	69.8%
Quality of Care	Dedicated Health Care Provider (% of adults age 65+)	96.0%
	Hospice Care (% of Medicare decedents)	46.9%
	Nursing Home Quality (% of beds rated four or five stars)	34.0%
	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)	26.5%
Sleep Health	Insufficient Sleep (% of adults age 65+)	28.1%
Tobacco Use	Cigarette Smoking (% of adults age 65+)	8.3%
Health Outcomes		
Behavioral Health	Drug Deaths (Deaths per 100,000 adults age 65+)*	13.7
	Excessive Drinking (% of adults age 65+)	7.6%
	Frequent Mental Distress (% of adults age 65+)	8.7%
	Suicide (Deaths per 100,000 adults age 65+)	17.6
Mortality	Early Death (Deaths per 100,000 adults ages 65-74)	1,773
Physical Health	Falls (% of adults age 65+)	27.8%
	Frequent Physical Distress (% of adults age 65+)	17.6%
	Multiple Chronic Conditions (% of Medicare beneficiaries ages 65-74)	53%
	Obesity (% of adults age 65+)	29.5%
	Teeth Extractions (% of adults age 65+)	11.4%
Demographics		
Population - Age 65+ (% of population)*		18.0%
Population - Age 65+ - Rural (% of adults age 65+)*		24.1%
Functional Disability (% of adults age 65+)*		32.5%

* Additional 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(s)	Data Year(s)
Community and Family Safety			
Firearm Deaths*^	Number of deaths among adults 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	2022-2024
Internet Crime*	Number of internet crime victim complaints per 10,000 adults age 60 and older	U.S. DOJ, FBI, Internet Crime Complaint Center Annual Reports	2024
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	2023
Economic Resources			
Community Support Expenditures^	Dollars per adult age 60 and older of Older Americans Act Title III 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	2024
Food Insecurity	Percentage of adults age 60 and older who lack 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	2023
Poverty	Percentage of adults age 65 and older living below the poverty level	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2024
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, 1-Year Dataset	2024
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	2023
Education			
College Graduate*	Percentage of adults age 65 and older who have a college degree	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2024
Social Support and Engagement			
High-Speed Internet	Percentage of households with one or more adults age 65 and older that have a broadband internet subscription and a computer, smartphone or tablet	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2024
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	2023
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, 5-Year Dataset	2020-2024

* Unweighted measure, excluded from the Overall and category composite measures.

^ Multicomponent measure. Data for each subcomponent are published on their respective measure pages, which can be found through the Explore Data section.

Social Support and Engagement (cont.)			
Unpaid Older Adult 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	2023-2024
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 percentages of U.S. citizens age 65 and older who voted in the last presidential and the last midterm elections	U.S. Census Bureau, Current Population Survey, Voting and Registration Supplement	2022/2024
Voter Participation (Midterm)*	Percentage of U.S. citizens age 65 and older who voted in the last midterm election	U.S. Census Bureau, Current Population Survey, Voting and Registration Supplement	2022†
Voter Participation (Presidential)*	Percentage of U.S. citizens age 65 and older who voted in the last presidential election	U.S. Census Bureau, Current Population Survey, Voting and Registration Supplement	2024

Physical Environment

Measure	Description	Source(s)	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	2022-2024
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	2024
Smoke-Free Policies*	Percentage of the population covered by 100% smoke-free laws for restaurants, bars and nonhospitality workplaces	American Nonsmokers' Rights Foundation	2026
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 accounting 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, 1-Year Dataset	2024
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	2018-2022

Clinical Care

Measure	Description	Source(s)	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	2024
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 2025
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	2024

* Unweighted measure, excluded from the Overall and category composite measures.

† Data in this edition were repeated from the last edition.

Preventive Clinical Services			
Cancer Screenings	Percentage of females 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	2024
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	2024
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	2024
RSV Vaccination*	Percentage of adults age 60 and older who reported ever receiving a respiratory syncytial virus (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	2024
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	2021†
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 2025 -November 2025
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(s)	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	2024
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			
Cigarette 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	2024

* Unweighted measure, excluded from the Overall and category composite measures.

^ Multicomponent measure. Data for each subcomponent are published on their respective measure pages, which can be found through the Explore Data section.

† Data in this edition were repeated from the last edition.

Health Outcomes

Measure	Description	Source(s)	Data Year(s)
Behavioral Health			
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	2024
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	2022-2024
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	2024
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	2024
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	2022-2024
Mortality			
Early Death	Number of deaths per 100,000 adults ages 65-74	U.S. HHS, Multiple Cause of Death Files via CDC WONDER	2024
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	2024
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	2024
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	2024
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	2024
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	2024

Demographics

Functional Disability*^	Percentage of adults age 65 and older who reported having a cognitive, visual, auditory, ambulatory, self-care and/or independent living difficulty disability	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2024
Population - Age 65+*	Percentage of the population that is age 65 and older	U.S. Census Bureau, Single-Race Population Estimates via CDC WONDER	2024
Population - Age 65+ - Rural*	Percentage of adults age 65 and older who live in a rural area	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2024

* Unweighted measure, excluded from the Overall and category composite measures.

^ Multicomponent measure. Data for each subcomponent are published on their respective measure pages, which can be found through the Explore Data section.

† Data in this edition were repeated from the last edition.

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. The administration's State Program Reports, available through the AGing, Independence, and Disability (AGID) Data 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 national population demographics. The survey collects and produces information about social, economic, housing and demographic characteristics from the nation's civilian noninstitutionalized population each year. Data are derived from the bureau directly via its 1-year and 5-year datasets or from 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. State-level data are obtained via a special request to the organization.

The **American Time Use Survey** provides annual activity insights into how Americans spend their daily time. The survey is conducted by the Bureau of Labor Statistics, which collects and analyzes data on employment, wages and other workplace statistics for the U.S. Department of Labor. Data are obtained from the bureau's website.

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 CDC's BRFSS web page.

The **Care Compare** tool, run by the Centers for Medicare & Medicaid Services (CMS), helps users find and compare providers and services by furnishing detailed information about every Medicare- and Medicaid-certified nursing home in the country, including 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 CDC's National Center for Health Statistics on births and deaths, as well as other topics. Data are obtained from the Multiple Cause of Death, Linked Birth/Infant Death, Natality and Single-Race Population Estimates files.

Characteristics of Supplemental Nutrition Assistance Program Households reports have been published annually by the Food and Nutrition Service of the U.S. Department of Agriculture (USDA) since 1976. These reports provide information about the demographic and economic circumstances of Supplemental Nutrition Assistance Program (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 web portal.

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

The **Fatality Analysis Reporting System (FARS)** uses state data collected by the U.S. Department of Transportation's 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 FARS Encyclopedia.

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

The **Internet Crime Complaint Center (IC3)**, a division of the Federal Bureau of Investigation, publishes annual reports analyzing complaint data on internet scams and elder fraud.

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.

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

The **Mapping Medicare Disparities (MMD) Tool** is a comprehensive source of information from the CMS 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 Environmental Public Health Tracking Network (NEPHTN)** brings together health data and environmental data from national, state and city sources and provides supporting information to make the data easier to understand. Data from state and local health departments are compiled by the tracking network and accessed via their Data Explorer.

The **National Immunization Surveys (NIS)** are a set of ongoing phone surveys conducted by the CDC's National Center for Immunization and Respiratory Diseases, which focuses on the prevention of disease, disability and death through immunization and control of respiratory and related diseases among young children and adults. Data on respiratory syncytial virus (RSV) vaccinations among older adults are collected by the NIS-Adult COVID Module and accessed via the Weekly Cumulative RSV Vaccination Coverage website.

The **National Plan and Provider Enumeration System (NPPES)** is a registry developed by CMS 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 **NHPCO Facts and Figures** report is published annually by the National Hospice and Palliative Care Organization (NHPCO), now known as the National Alliance for Care at Home, the nation's largest membership organization for hospice and palliative care workers and providers. The report leverages hospice claims data from CMS to produce statistics on hospice patient characteristics, location and level of care, as well as other topics. Data are accessed via the National Alliance website.

The **Occupational Employment and Wage Statistics** program produces employment statistics and wage estimates for nearly 800 occupations at national, state and metropolitan levels. Data are collected by the U.S. Department of Labor's Bureau of Labor Statistics and obtained through the Occupational Employment and Wages Query System.

Volunteering and Civic Life Supplement data are collected by the Current Population Survey, an ongoing statistical survey sponsored jointly by the Census Bureau and the Bureau of Labor Statistics. Data are released biennially in odd years and obtained from the Census Bureau's website.

Voting and Registration Supplement data from the Current Population Survey are released by the Census Bureau every two years following national elections.

Methodology

How State Rankings Were Generated

This year, 56 measures (including 36 weighted and 20 unweighted measures) were analyzed for the *America's Health Rankings 2026 Senior Report*, using the most recent data available as of February 26, 2026. 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 Measures Table. Measure changes were based on input from the *Senior Report* Advisory Committee and are detailed on the *2026 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 missing, unavailable or suppressed. Composite scores were generated overall and by model category. The rankings show how a state compares with other states across all weighted measures.

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.

Composite scores were calculated overall and by model category 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 composite score (e.g., 2.00), reflecting better health, whereas a state that ranked No. 50 will have a lower composite score (e.g., –2.00). The overall state ranks were calculated by ranking the Overall score, which included all 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 from 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.

Report

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

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 were available. Health disparities are presented as a ratio calculated by dividing the value of the group with the highest value by the value of the group with the lowest value. Only measures with significant differences, determined by nonoverlapping 95% confidence intervals, were considered. The groups with the largest health disparities, considering relevant risk factors, were prioritized for inclusion, along with health disparities by metropolitan status, the subject of this year's report spotlight. Not all statistically significant differences are detailed in the report. Full demographic data are published on the *America's Health Rankings* website. For more information, see Disparity Measures Methodology.

State Summaries

Key Findings. These highlights feature notable trends, presented as percent changes between two time periods of interest, often capturing inflection points or describing short- or long-term trends. Only statistically significant changes, as determined by nonoverlapping 95% confidence intervals, were considered for measures with confidence intervals. Measures without confidence intervals were considered if the change between the two time periods was 5% or more. Findings were selected to include a mix of improving and worsening measures across model categories and topic areas. Measures that did not lend themselves to changes over time were excluded from the analysis.

Strengths and Challenges. These are measures with the greatest impact on a state's overall ranking (from the 36 weighted measures). Measures with newly available data spanning model categories and topic areas were given priority during selection. Unweighted measures were excluded from the ranking calculations, and the District of Columbia was 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 overall rankings, so it does not include strengths and challenges.

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 where data were available. Individual estimates were suppressed if they did not meet reliability criteria set 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 presented.

Age. Age data in this report were available for measures from the Behavioral Risk Factor Surveillance System (BRFSS), CDC WONDER and the Fatality Analysis Reporting System. BRFSS groupings included the following self-reported age ranges: 65-74, 75-84 and 85 and older. CDC WONDER 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 and the American Community Survey (ACS). BRFSS groupings were based on responses to the questions in the core disability section. Responses of yes to the question, "Are you deaf or do you have serious difficulty hearing?" were coded as difficulty hearing. Responses of yes to the question, "Are you blind or do you have serious difficulty seeing, even when wearing glasses?" were coded as difficulty seeing. Responses of yes to the question, "Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?" were coded as difficulty with cognition. Responses of yes to the question, "Do you have serious difficulty walking or climbing stairs?" were coded as difficulty with mobility. Responses of yes to the question, "Do you have difficulty dressing or bathing?" were coded as difficulty with self-care. Responses of yes to the question, "Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?" were coded as independent living difficulty. Responses of no or missing to all questions, with at least one response being no, were coded as without a disability. Disability groups are not mutually exclusive. ACS groupings were taken from Table S1810, which used the following disability groups: with a hearing difficulty (classified in this report as difficulty hearing); with a vision difficulty (classified as difficulty seeing); with a cognitive difficulty (classified as difficulty with cognition); with an ambulatory difficulty (classified as difficulty with mobility); with a self-care difficulty (classified as difficulty with self-care); and with an independent living difficulty.

Education. Education data in this report were available for measures from BRFSS, the American Time Use Survey (ATUS) 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?" Responses of grades 1 through 11, kindergarten only or never attended school were classified as less than high school. Responses of grade 12 or GED were classified as high school graduate/GED. Responses of college one year to three years (some college or technical school) were classified as some post-high school. Responses of college four years or more (college or technical school graduate) were classified as college graduate. ATUS 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?" Responses of grades below 12 or 12th grade with no diploma were summed and classified as less than high school. Responses of high school diploma or equivalent (GED) were classified as high school graduate/GED. Responses of some college but no degree were classified as some post-high school. Responses of associate degree, bachelor's degree, master's degree, professional school degree or doctoral school degree were classified as associate or higher degree.

Gender. Gender data in this report were available for measures from BRFSS, ATUS and the Volunteering and Civic Life Supplement. This report stratified gender as men and women even though not all people identified with these two 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, ATUS and the Volunteering and Civic Life Supplement. BRFSS groupings were limited to adults age 25 and older and based on responses to the question, "[What] is your annual household income from all sources?" ATUS 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)." Responses were classified as less than $25,000, $25,000 to $49,999, $50,000 to $74,999, $75,000 to $99,999, $100,000 to $149,999 and $150,000 or more.

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

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 other race. Hispanic ethnicity includes members of all racial groups. While ACS data were collected and calculated as Hispanic-inclusive (except for white, which was non-Hispanic), all other sources collected race data as non-Hispanic. Those include: BRFSS, CDC WONDER, ATUS and the Volunteering and Civic Life Supplement.

Race and ethnicity categories by source:

- ACS: American Indian and Alaska Native; Asian; Black or African American; Hispanic or Latino Origin (any race); Native Hawaiian or Other Pacific Islander; white (non-Hispanic); two or more races; and some other race.
- ATUS: American Indian/Alaska Native (non-Hispanic); Asian (non-Hispanic); Black (non-Hispanic); Hawaiian/Pacific Islander (non-Hispanic); Hispanic (any race); multiracial (non-Hispanic); and white (non-Hispanic).
- BRFSS: American Indian/Alaskan Native (non-Hispanic); Asian (non-Hispanic); Black or African American (non-Hispanic); Hispanic, Latino/a or Spanish origin (any race); Native Hawaiian or Other Pacific Islander (non-Hispanic); white (non-Hispanic); and multiracial (non-Hispanic).
- CDC WONDER: American Indian or Alaska Native (non-Hispanic); Asian (non-Hispanic); Black or African American (non-Hispanic); Hispanic (any race); Native Hawaiian or Other Pacific Islander (non-Hispanic); white (non-Hispanic); and more than one race (non-Hispanic).
- Volunteering and Civic Life Supplement: American Indian/Alaska Native (non-Hispanic); Asian (non-Hispanic); Black (non-Hispanic); Hawaiian/Pacific Islander (non-Hispanic); Hispanic (any race); multiracial (non-Hispanic); and white (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?" Responses of yes were classified as served. Responses of no were classified as not served.

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 reporting sources.

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.[63]

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, from data collection through analysis to interpretation.[64]

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 P25-1144. Washington, D.C.: U.S. Census Bureau, February 2020. https://www.census.gov/library/publications/2020/demo/p25-1144.html.

2 Centers for Disease Control and Prevention. "About Rural Health." CDC.gov, March 23, 2026. https://www.cdc.gov/rural-health/php/about/index.html.

3 Warshaw, Robin. "Health Disparities Affect Millions in Rural U.S. Communities." *AAMCNews*. AAMC, October 31, 2017. https://www.aamc.org/news/health-disparities-affect-millions-rural-us-communities.

4 World Health Organization. "Constitution of the World Health Organization." WHO.int. Accessed April 22, 2026. https://www.who.int/about/governance/constitution.

5 Xu, Jiaquan et al. *Mortality in the United States, 2024*. NCHS Data Brief, No. 548. National Center for Health Statistics, January 29, 2026. https://doi.org/10.15620/cdc/174641.

6 Centers for Disease Control and Prevention. "10 Leading Causes of Death, United States 2024: All Deaths with Drilldown to ICD Codes, All Sexes, All Races, All Ethnicities." WISQARS Leading Causes of Death Visualization Tool, CDC.gov. Accessed April 22, 2026. https://wisqars.cdc.gov/lcd/?o=LCD&y1=2024&y2=2024&ct=10&cc=ALL&g=00&s=0&r=0&ry=0&e=0&ar=lcd1age&at=custom&ag=lcd1age&a1=65&a2=74.

7 Centers for Disease Control and Prevention. "10 Leading Causes of Death, United States 2024: Unintentional Injuries, All Sexes, All Races, All Ethnicities." WISQARS Leading Causes of Death Visualization Tool, CDC.gov. Accessed April 22, 2026. https://wisqars.cdc.gov/lcd/?o=LCD&y1=2024&y2=2024&ct=10&cc=UNI&g=00&s=0&r=0&ry=0&e=0&ar=lcd1age&at=custom&ag=lcd1age&a1=65&a2=74.

8 *America's Health Rankings*. "Findings: Health Outcomes." In *America's Health Rankings® 2025 Annual Report*, 2025. https://www.americashealthrankings.org/publications/reports/2025-annual-report/findings-health-outcomes.

9 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.

10 Centers for Disease Control and Prevention. "Prescription Drug Use - Health, United States." CDC.gov, August 6, 2024. https://www.cdc.gov/nchs/hus/topics/rx-drug-use.htm.

11 Healthy People 2030. "Reduce Drug Overdose Deaths – SU 03." Objective. Accessed April 22, 2026. https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/drug-and-alcohol-use/reduce-drug-overdose-deaths-su-03.

12 National Institute on Alcohol Abuse and Alcoholism (NIAAA). "Alcohol and Older Adults Ages 65+." NIAAA.NIH.gov, August 2025. https://www.niaaa.nih.gov/alcohols-effects-health/alcohol-topics-z/alcohol-facts-and-statistics/alcohol-and-older-adults-ages-65.

13 Wong, Tony et al. "Alcohol-Induced Deaths in the United States across Age, Race, Gender, Geography, and the COVID-19 Pandemic." Edited by Parvati Singh. *PLOS Global Public Health* 5, no. 9 (September 17, 2025): e0004623. https://doi.org/10.1371/journal.pgph.0004623.

14 National Institute on Alcohol Abuse and Alcoholism (NIAAA). "Aging and Alcohol." NIAAA.NIH.gov, December 2025. https://www.niaaa.nih.gov/alcohols-effects-health/aging-and-alcohol.

15 Centers for Disease Control and Prevention. "Facts About Suicide." CDC.gov, March 26, 2025. https://www.cdc.gov/suicide/facts/index.html.

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

17 Healthy People 2030. "Reduce the Suicide Rate – MHMD 01." Objective. Accessed April 23, 2026. https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/mental-health-and-mental-disorders/reduce-suicide-rate-mhmd-01.

18 Centers for Disease Control and Prevention. "Suicide Data and Statistics." CDC.gov, March 26, 2025. https://www.cdc.gov/suicide/facts/data.html.

19 *America's Health Rankings*. "Explore Suicide in the United States." AmericasHealthRankings.org. Accessed April 23, 2026. https://www.americashealthrankings.org/explore/measures/Suicide.

20 Healthy People 2030. "Reduce Firearm-Related Deaths – IVP 13." Objective. Accessed April 23, 2026. https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/violence-prevention/reduce-firearm-related-deaths-ivp-13.

21 Federal Bureau of Investigation. "Elder Fraud." FBI.gov. Accessed April 23, 2026. https://www.fbi.gov/how-we-can-help-you/scams-and-safety/common-frauds-and-scams/elder-fraud.

22 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.

23 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.

24 Internet Crime Complaint Center. *2024 IC3 Annual Report*. U.S. Department of Justice, Federal Bureau of Investigation, April 30, 2025. https://www.ic3.gov/AnnualReport/Reports/2024_IC3Report.pdf.

25 U.S. Department of Agriculture, Economic Research Service. "Food Security in the U.S. - Definitions of Food Security." ERS.USDA.gov, March 30, 2026. https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security.

26 Aday, Ronald H. et al. "Understanding the Experiences of Food Insecurity in Older Adult Households." *Journal of Gerontological Social Work* 66, no. 2 (February 17, 2023): 239-62. https://doi.org/10.1080/01634372.2022.2098443.

27 Center on Budget and Policy Priorities. "Policy Basics: The Supplemental Nutrition Assistance Program (SNAP)." CBPP.org, November 25, 2024. https://www.cbpp.org/research/food-assistance/the-supplemental-nutrition-assistance-program-snap.

28 U.S. Department of Agriculture, Food and Nutrition Service. "What Can SNAP Buy?" FNS.USDA.gov, June 4, 2025. https://www.fns.usda.gov/snap/eligible-food-items.

29 Monkovic, Mia et al. *Characteristics of Supplemental Nutrition Assistance Program Households: Fiscal Year 2023*. Alexandria, VA: U.S. Department of Agriculture, Food and Nutrition Service, Evidence, Analysis, and Regulatory Affairs Office, April 2025. https://fns-prod.azureedge.us/sites/default/files/resource-files/snap-FY23-Characteristics-Report.pdf.

30 Administration on Aging. *FY 2018 Older Americans Act Report to Congress*. U.S. Department of Health and Human Services, Administration for Community Living, June 2021. https://acl.gov/sites/default/files/about-acl/2021-06/ACL_FY2018%20OAA%20Report%20to%20Congress.pdf.

31 Carpenter, Alexandra et al. *Medicaid Long-Term Services and Supports Users and Expenditures by Service Category, 2023*. Chicago, IL: Mathematica, October 17, 2025. https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-users-expenditures-category-brief-2023.pdf.

32 Centers for Medicare & Medicaid Services. "Home- and Community-Based Services." CMS.gov, March 10, 2026. https://www.cms.gov/training-education/partner-outreach-resources/american-indian-alaska-native/ltss-ta-center/information/ltss-models/home-and-community-based-services.

33 Cleveland Clinic. "Geriatrician/Geriatric Medicine Doctor." my.ClevelandClinic.org, May 15, 2024. https://my.clevelandclinic.org/health/articles/geriatrician.

34 American Geriatrics Society. "Training for Geriatric Nurse Practitioners." AmericanGeriatrics.org. Accessed April 23, 2026. https://www.americangeriatrics.org/geriatrics-profession/training-requirements/training-geriatric-nurse-practitioners.

35 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.

36 O*NET OnLine. "31-1121.00 - Home Health Aides." ONETOnLine.org. Accessed April 23, 2026. https://www.onetonline.org/link/summary/31-1121.00.

37 O*NET OnLine. "31-1122.00 - Personal Care Aides." ONETOnLine.org. Accessed April 23, 2026. https://www.onetonline.org/link/summary/31-1122.00.

38 *Long-Term Care in America: Americans Want to Age at Home.* Issue Brief. Associated Press-NORC Center for Public Affairs Research, May 2021. https://www.longtermcarepoll.org/wp-content/uploads/2021/04/LTC_Report_AgingatHome_final.pdf.

39 Centers for Medicare & Medicaid Services. "Home Health Services Coverage." Medicare.gov. Accessed April 23, 2026. https://www.medicare.gov/coverage/home-health-services.

40 "Home Health and Personal Care Aides." In *Occupational Outlook Handbook*. U.S. Department of Labor, Bureau of Labor Statistics. Accessed April 23, 2026. https://www.bls.gov/ooh/healthcare/home-health-aides-and-personal-care-aides.htm.

41 Centers for Disease Control and Prevention. "Cancer Deaths - Health, United States." CDC.gov, June 2023. https://www.cdc.gov/nchs/hus/topics/cancer-deaths.htm.

42 American Cancer Society. *Cancer Facts & Figures 2025*. Atlanta, GA: American Cancer Society, 2025. https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2025/2025-cancer-facts-and-figures-acs.pdf.

43 National Cancer Institute, Surveillance, Epidemiology, and End Results Program. "Cancer Stat Facts: Female Breast Cancer." SEER.Cancer.gov. Accessed April 23, 2026. https://seer.cancer.gov/statfacts/html/breast.html.

44 National Cancer Institute, Surveillance, Epidemiology, and End Results Program. "Cancer Stat Facts: Colorectal Cancer." SEER.Cancer.gov. Accessed April 23, 2026. https://seer.cancer.gov/statfacts/html/colorect.html.

45 National Cancer Institute, Surveillance, Epidemiology, and End Results Program. "Cancer Stat Facts: Common Cancer Sites." SEER.Cancer.gov. Accessed April 23, 2026. https://seer.cancer.gov/statfacts/html/common.html.

46 Centers for Disease Control and Prevention. "Flu Burden Prevented by Vaccination 2023-2024 Flu Season." CDC Archive, January 14, 2025. https://archive.cdc.gov/www_cdc_gov/flu-burden/php/data-vis-vac/2023-2024-prevented.html.

47 Healthy People 2030. "Increase the Proportion of People Who Get the Flu Vaccine Every Year – IID 09." Objective. Accessed April 23, 2026. https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/vaccination/increase-proportion-people-who-get-flu-vaccine-every-year-iid-09.

48 Zimlich, Rachael. "Pneumonia Facts and Statistics: What You Need to Know." Verywell Health, February 16, 2026. https://www.verywellhealth.com/pneumonia-facts-and-statistics-5498569.

49 Hayes, Brandon H. et al. "Burden of Pneumonia-Associated Hospitalizations: United States, 2001-2014." *Chest* 153, no. 2 (February 2018): 427-37. https://doi.org/10.1016/j.chest.2017.09.041.

50 Gierke, Ryan et al. "Chapter 11: Pneumococcal." In *Manual for the Surveillance of Vaccine-Preventable Diseases*, edited by Sandra W. Roush et al. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2025. https://www.cdc.gov/surv-manual/php/table-of-contents/chapter-11-pneumococcal.html.

51 KFF. "Total Number of Residents in Certified Nursing Facilities." KFF State Health Facts. Accessed April 23, 2026. https://www.kff.org/other-health/state-indicator/number-of-nursing-facility-residents/.

52 KFF. "Total Number of Certified Nursing Facilities." KFF State Health Facts. Accessed April 23, 2026. https://www.kff.org/other-health/state-indicator/number-of-nursing-facilities/.

53 Harrison, Jeffrey P. et al. "Evaluation of the Quality and Efficiency of Nursing Home Services in the United States Using the Nursing Home Star Rating System." *Journal of Modern Nursing Practice and Research* 6, no. 1 (January 28, 2026): 2. https://doi.org/10.53964/jmnpr.2026002.

54 Shen, Karen et al. "Health Care Staff Turnover and Quality of Care at Nursing Homes." *JAMA Internal Medicine* 183, no. 11 (November 1, 2023): 1247. https://doi.org/10.1001/jamainternmed.2023.5225.

55 Millar, Roberto J. et al. "Nursing Home Characteristics and Resident Quality of Care Outcomes: A Scoping Review." *Journal of Long-Term Care*, May 1, 2024. https://doi.org/10.31389/jltc.235.

56 Centers for Medicare & Medicaid Services. "Five-Star Quality Rating System." CMS.gov. Accessed April 23, 2026. https://www.cms.gov/medicare/health-safety-standards/certification-compliance/five-star-quality-rating-system.

57 Kim, Yeonju et al. "Association Between Various Sedentary Behaviours and All-Cause, Cardiovascular Disease and Cancer Mortality: The Multiethnic Cohort Study." *International Journal of Epidemiology* 42, no. 4 (August 2013): 1040–56. https://doi.org/10.1093/ije/dyt108.

58 Friedenreich, Christine M. et al. "Physical Activity, Obesity and Sedentary Behavior in Cancer Etiology: Epidemiologic Evidence and Biologic Mechanisms." *Molecular Oncology* 15, no. 3 (March 2021): 790–800. https://doi.org/10.1002/1878-0261.12772.

59 Gilchrist, Susan C. et al. "Association of Sedentary Behavior With Cancer Mortality in Middle-Aged and Older US Adults." *JAMA Oncology* 6, no. 8 (June 18, 2020): 1210–17. https://doi.org/10.1001/jamaoncol.2020.2045.

60 Centers for Disease Control and Prevention. "Benefits of Physical Activity." CDC.gov, December 4, 2025. https://www.cdc.gov/physical-activity-basics/benefits/index.html.

61 Carlson, Susan A. et al. "Percentage of Deaths Associated With Inadequate Physical Activity in the United States." *Preventing Chronic Disease* 15 (March 29, 2018): 170354. https://doi.org/10.5888/pcd18.170354.

62 de Rezende, Leandro Fornias Machado et al. "Sedentary Behavior and Health Outcomes Among Older Adults: A Systematic Review." *BMC Public Health* 14, no. 1 (December 2014): 333. https://doi.org/10.1186/1471-2458-14-333.

63 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. Accessed September 11, 2025. https://www.cdcfoundation.org/data-equity-principles?inline.

64 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® 2026 Senior Report* is available in its entirety at AmericasHealthRankings.org. Visit the site to request or download additional copies. The *America's Health Rankings 2026 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, with design by VML.

Questions and comments about 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 $880 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