AMERICA'S HEALTH RANKINGS®

United Health Foundation

The United Health Foundation provides reliable information to support health and medical decisions that lead to better health outcomes and healthier communities. The Foundation also supports activities that expand access to quality health care services for those in challenging circumstances and partners with others to improve the well being of communities.

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DECEMBER 2011

Our Partners:

American Public Health Association

Partnership for Prevention
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AMERICA'S HEALTH RANKINGS 2011 EDITION

AMERICA'S HEALTH RANKINGS®

United Health Foundation

A Call to Action
for Individuals & Their Communities

2011 EDITION

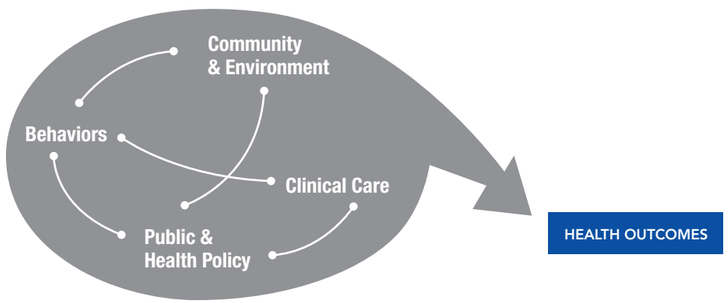
Components of Health

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

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

- Our behaviors.
- The environment and the community in which we live.
- The public and health policies and practices of our health care and prevention systems.
- The clinical care we receive.

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



A Call to Action for Individuals and Their Communities

Visit www.americashealthrankings.org to get informed, take action and improve the health of your state.

Visit Facebook at www.facebook.com/AmericasHealthRankings and take your pledge for a healthier life.

Learn about your state and how it compares to other states on over 40 different measures.

AMERICA'S
HEALTH RANKINGS®

United Health Foundation®

A Call to Action for Individuals & Their Communities

2011 Edition

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America's Health Rankings®— 2011 Edition is a joint effort of United Health Foundation (www.unitedhealthfoundation.org), the American Public Health Association (www.apha.org) and Partnership for Prevention (www.prevent.org). It is funded entirely by United Health Foundation, a recognized 501(c)(3) organization.

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

U.S. Department of Health and Human Services
- Centers for Disease Control and Prevention
- National Center for Health Statistics

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

U.S. Department of Education
- National Center for Education Statistics

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

U.S. Environmental Protection Agency
American Medical Association
The Dartmouth Atlas Project
Trust for America's Health
World Health Organization

This project was conducted for and in cooperation with United Health Foundation, the American Public Health Association and Partnership for Prevention by Arundel Street Consulting, Inc., St. Paul, Minn.

Design by Aldrich Design, St. Paul, Minn.

Questions and comments on the report should be directed to United Health Foundation at info@unitedhealthfoundation.org.

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Acknowledgement

We at United Health Foundation, along with our partners at the American Public Health Association and Partnership for Prevention are pleased to present the 22nd Edition of *America's Health Rankings®: A Call to Action for Individuals and Their Communities.* First published in 1990, America's Health Rankings provides the longest-running state-by-state analysis of our country's health and the factors that affect it.

The news, overall, is mixed. We are encouraged that through concerted multi-disciplinary efforts, our nation experienced modest improvements in areas such as smoking and violent crime. According to figures recently released by the Centers for Disease Control and Prevention, coronary heart disease has also decreased. Unfortunately, we continue to struggle with worsening rates of obesity and diabetes and no improvements in other chronic health conditions. We recognize that private employers, federal and state governments and individuals are increasingly challenged by escalating health care costs. With chronic disease affecting 130 million Americans and accounting for nearly 75% of these costs, we owe it to ourselves and future generations to act more urgently and creatively to confront these issues.

We invite you to share proven or innovative programs that have made a difference in your communities.

When it comes to challenges of this magnitude, it's important to realize that "we're all in this together." Government leadership is essential, but government cannot do it alone. The private sector, philanthropy and community-based organizations all need to join in a data-driven process to determine priorities and then recruit the broad range of assets necessary to address these priorities.

The subtitle of this report remains *A Call to Action for Individuals and Their Communities.* These are not just words but an urgent plea for comprehensive, innovative and sustained engagement. Whether it's making a personal change like quitting smoking or exercising; supporting community initiatives that create safe and healthy environments in which to live and work; or creating health enhancing policies or programs, the point is that too much is at stake to leave these issues unaddressed. Now is the time!

We invite you to share proven or innovative programs that have made a difference in your community by emailing unitedhealthfoundationinfo@uhc.com. You can also find and follow *America's Health Rankings* on Facebook at www.facebook.com/AmericasHealthRankings and Twitter at @AHR_Rankings. Let us all exchange ideas, share information and learn from each other as we work to turn the tide on the health challenges facing the nation.

As with previous editions, we are pleased to include the insights of thoughtful health leaders. Their commentaries are intended to start conversations, generate ideas and showcase innovative means for improving public health. This year's contributors include:

- Regina Benjamin, M.D., M.B.A, United States Surgeon General, who discusses the importance of prevention and promoting wellness, as chronic disease is costly to our nation in more ways than one.
- Thomas R. Frieden, M.D., M.P.H., Director, Centers for Disease Control and Prevention, who discusses that information is power, and that we must use this power to understand our country's biggest health problems, to make healthier choices, and to improve the health of the nation.
- Georges C. Benjamin, M.D., Executive Director, American Public Health Association, who discusses the importance of measuring health factors under the header of "what gets measured gets done" and goes beyond that idea to argue that the real need lies in taking action to address the challenges these measures represent.
- Andrew Webber, President and CEO, National Business Coalition on Health, who discusses the imperative for engaging employers in public-private partnerships to develop effective and creative strategies to tackle public health issues.
- Glen P. Mays, Ph.D., M.P.H. and F. Douglas Scutchfield, M.D., National Coordinating Center

for Public Health Services and Systems Research at the University of Kentucky College of Public Health, who discuss the fact that despite spending far more resources on health care than any other nation on earth, the U.S. continues to lag behind many other industrialized nations and the need to encourage and support multi-sector action to address this, and other disparities.

- Elizabeth Seaquist, M.D. and Victor Montori, M.D., representing the Decade of Discovery Program, write about the growing epidemic of diabetes and the innovative partnership between the University of Minnesota and the Mayo Clinic in launching Decade of Discovery: A Minnesota Partnership to Conquer Diabetes, a 10-year effort to prevent, optimally treat and ultimately cure type 1 and type 2 diabetes.
- Greg Vigdor, President & CEO, Washington Health Foundation and the Healthiest State in the Nation Campaign who presents the thinking behind the campaign, the 40,000 individuals involved in the campaign and their progress to date toward their goal of becoming the Healthiest State in the Nation.
- Jud Richland, M.P.H., President and CEO, Partnership for Prevention, who discusses the importance of making prevention a priority and the importance of collaboration in doing so.

We are greatly appreciative of the expertise and guidance provided by our Scientific Advisory Committee, comprised of leading public health scholars and led by Anna Schenk, Ph.D., M.S.P.H., Director, Public Health Leadership Program and North Carolina Institute for Public Health for the Gillings School of Global Public Health at the University of North Carolina at Chapel Hill. They have once again fulfilled their charge of reviewing, maintaining and continually advancing the report's methodological framework.

We also offer our gratitude and most profound respect for the dedicated efforts of our nation's public health, clinical and health policy professionals who work tirelessly every day on behalf of the people of this country.

Reed V. Tuckson, M.D.
United Health Foundation Board Member
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Jud Richland, M.P.H.
President and CEO
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Partnership for Prevention
Shaping Policies • Improving Health

The Prevention Imperative:
Protecting the Health and Well-Being of America's Families

Regina Benjamin, M.D., M.B.A. United States Surgeon General

Disease prevention is a growing national imperative, particularly as more American families struggle with the personal and financial implications of chronic illness. In 2011, the effort to promote a coordinated prevention effort reached an important milestone. As called for under the historic Affordable Care Act (ACA), the National Prevention, Health Promotion, and Public Health Council which I chair, launched the National Prevention Strategy.

Prevention can and should become a part of our everyday lives.

The National Prevention Strategy is a comprehensive blueprint to increase the number of Americans who are healthy at every stage of life. It recognizes that good health and wellbeing is determined by more than access to health care services.

As the research results in this *America's Health Rankings®* report — published annually by the United Health Foundation, the American Public Health Association and Partnership for Prevention — show, we face significant challenges in ensuring that all Americans are healthy and fit. The National Prevention Strategy now provides a roadmap to improve the health and quality of life for individuals, families and communities by moving the nation from a focus on sickness and disease to one based on prevention and wellness.

As a family physician I learned how important prevention — stopping disease before it starts — is. And that is the focus of my work as Surgeon General. Just four modifiable health risk behaviors — lack of physical activity, poor nutrition, tobacco use, and excessive alcohol consumption — are responsible for much of the illness, suffering , and early death related to chronic diseases.

Almost fifty percent of adults have at least one chronic condition, and seven out of ten deaths each year are due to chronic diseases. In 2011, more than 800,000 Americans will die of heart disease,[1] and the annual direct and overall costs resulting from cardiovascular disease are estimated at $273 billion and $444 billion, respectively.[2] Almost 600,000 Americans will die of cancer, a disease which last year cost $263.8 billion: in indirect and direct costs.[3]

Prevention can and should become a part of our everyday lives. Good health comes not just from receiving quality medical care, but also from living healthier lives that help prevent disease in the first place. Good health also comes from clean air and water, safe outdoor spaces for physical activity, safe worksites, healthy foods, violence-free environments, and healthy homes. The public and private sectors can work together to integrate prevention into all aspects of our lives, including where and how we live, learn, work, and play. Everyone — businesses, educators, health care institutions, government, communities, and every single American — can play a role in creating a healthier nation. And everyone can and will benefit from a healthier workforce and lower health care costs.

The Need for a Greater Focus on Prevention

The argument for focusing more of the nation's attention and resources on prevention is grounded

1 Roger VL, Go AS, Lloyd-Jones DM, et al. Heart disease and stroke statistics---2011 update: a report from the American Heart Association. Circulation 2011;123:e18--209.
2 Heidenreich PA, Trogdon JG, Khavjou OA, et al. Forecasting the future of cardiovascular disease in the United States: a policy statement from the American Heart Association. Circulation 2011;123:933--44.
3 Source: American Cancer Society. Cancer Facts & Figures 2011. Atlanta: American Cancer Society; 2011.
4 Source: BLS press release 10/20/11 http://www.bls.gov/news.release/wkyeng.nr0.htm

in science. Preventing chronic illness has a profound and measurable effect on our communities and economy, impacting the health and financial wellbeing of people of all ages, ethnicities, and economic strata. Consider:

- With better health, children attend school more regularly and are better able to learn. Numerous studies have found that regular physical activity supports improved learning. Student fitness levels have been associated with higher math, reading, and writing scores.
- With better health, adults are more productive and at work more days. In contrast, illnesses such as asthma, high blood pressure, smoking, and obesity each reduce annual productivity by between $200 and $440 per person. Given a U.S. labor force of 101 million full-time workers, the total cost of that productivity loss on our economy is staggering.
- With better health, seniors can maintain their independence. Support for older adults who choose to remain in their homes and communities and retain their independence ("aging in place") helps promote positive mental and emotional health.

But increasing prevention efforts in the public and private sectors and among individuals requires much more than raising awareness or creating programs piecemeal. It requires a unified plan of action and a dedicated group of leaders to champion the cause and be held accountable for delivering results.

A Plan for Better Health and Wellness

The primary objective of the National Prevention Strategy is to increase the number of Americans who are healthy at every stage of life. To advance this goal, the strategy calls for four strategic directions that are fundamental to improving the nation's health and address all sectors of society:

- Building Healthy and Safe Community Environments: Prevention of disease should start at home and in our communities. For example, businesses and employers can adopt practices to encourage their workforce to increase physical activity and reduce pollution (e.g., workplace flexibility, rideshare and vanpool programs, park-and-ride incentives, travel demand management initiatives, and telecommuting options).
- Expanding Quality Preventive Services in Both Clinical and Community Settings: Individuals who receive preventive care, including immunizations and cancer screenings, have better health and lower health care costs. To this end, clinical and community prevention efforts — such as diabetes prevention programs serving underserved groups — should be more closely aligned.
- Empowering People to Make Healthy Choices: When people have access to user-friendly, actionable information and resources, they are empowered to make healthier choices. Policies and programs should make healthy options the easy and affordable choice. For example, health care professionals can use multiple communication tools (e.g., mobile phone applications, personal health records, and credible health websites) and culturally appropriate methods to reinforce more traditional written and oral communication.
- Eliminating Health Disparities: By eliminating the disparities in achieving and maintaining health, we can help improve quality of life for all Americans. For example, health care providers can train and hire more qualified staff from underrepresented racial and ethnic minority groups and people with disabilities.

When people have access to user-friendly, actionable information they are empowered to make healthier choices.

To maximize the effectiveness of prevention efforts, the National Prevention Strategy has also identified seven priority areas focused around the leading causes of preventable death and major illness. These seven priority areas are: tobacco-free living; preventing drug abuse and excessive alcohol use; healthy eating; active living; injury and violence-free living; reproductive and sexual health; and mental and emotional well-being.

The Path Forward

To advance the National Prevention Strategy, the National Prevention Council will work together with the Advisory Group, Federal agencies, and private and public partners to help implement the Strategy at the national, state, tribal, and local levels, recognizing the need for a broad and inclusive approach to addressing the health and well-being of our communities.

The Obama Administration is already pursuing efforts to help support and achieve the goals outlined in the National Prevention Strategy. This includes efforts such as Let's Move!, My Plate, Partnership for Sustainable Communities, America's Great Outdoors Initiative, the Neighborhood Revitalization Initiative, and Executive Order 13548 to make the federal government a model employer of persons with disabilities.

And this is just the beginning — the National Prevention Council has a focused and systematic plan to enhance public and private prevention efforts and to increase prevention engagement among groups and individuals across the country.

As research has shown time and again, investing in prevention across the lifespan complements and supports treatment and care. And while protecting and saving lives, prevention policies and programs can also help reduce health care costs and enhance productivity. Ongoing initiatives to inform and engage our national leaders and local communities, such as *America's Health Rankings®,* will be critical to our success.

As your Surgeon General, I am deeply committed to ensuring that prevention and wellness are a fundamental part of our nation's health care efforts, and I urge all those in the private and public sectors to do your part to promote change. With rising chronic disease rates and increasing health care costs, our need for prevention is as urgent as it has ever been. With the National Prevention Strategy, the United States now has a strong and thoughtful plan in place to meet these challenges — and new hope for a healthier future.

For more information on the National Prevention Strategy, please visit:
http://www.healthcare.gov/prevention/nphpphc/index.html

Information is Power

Thomas R. Frieden, M.D., M.P.H.
Director, Centers for Disease Control and Prevention

With publication of this latest edition of *America's Health Rankings* comes acknowledgment that information is power. Power to know where our biggest health problems lie. Power to make healthier choices. Power to improve the health of our nation.

But with that power comes responsibility. Responsibility to figure out which interventions and programs will have the greatest impact. Responsibility to use resources wisely. Responsibility to take action at all levels of society. For if we don't take these responsibilities, all of the information and knowledge in the world will not help us make the improvement we need to keep people healthy and our nation strong.

We are making progress using better information more effectively for decision-making and action. At the CDC, surveillance and epidemiology have always been core functions. We and others use this information to improve health here at home and around the world.

Much of our data and those of other entities are reflected here in *America's Health Rankings.* The information presented here provides a detailed snapshot of our nation's current health status and trends over time, indicates where more effort is needed, and gives us a good idea of where we will likely be headed in the future.

This latest look at the health of our nation shows that we are making significant improvements in some areas, but are not making progress in others. Declines in smoking rates have slowed. Reducing obesity remains one of our biggest challenges. Although health insurance coverage rates among children are increasing, the number of Americans without health insurance continues to rise. However, recently implemented provisions in the Affordable Care Act for insuring young adults through age 26 have increased coverage levels in this group, and even more Americans will gain access to coverage by 2014. These rankings also reveal the often sharp disparities in health status among states.

CDC
Centers for Disease Control and Prevention

We are making significant improvements in some areas, but are not making progress in others.

All segments of our society — the public health and health care communities, government agencies at all levels, nonprofit organizations, the business community, educational institutions, community groups, and individuals — must join together to implement programs to improve health. It is ever more critical that coalitions of groups that have a stake in improving health come together to devise and implement solutions that will work.

Strengthening our efforts against cardiovascular disease — a key measure in *America's Health Rankings* — is crucially important. Cardiovascular disease kills 865,000 Americans each year and remains our nation's leading cause of death. CDC, in partnership with the Centers for Medicare and Medicaid Services (CMS), other federal

agencies, and clinical, community, and other partners, has launched a Million Hearts initiative to prevent a million heart attacks and strokes in the next five years. Million Hearts will reduce the number of people who need treatment through prevention and improve management of the ABCS — aspirin, blood pressure control, cholesterol management, and smoking cessation — which have the greatest potential to save lives of any clinical interventions.

Currently, less than half of Americans at highest risk of cardiovascular disease take daily aspirin, less than half with hypertension have it adequately controlled, only a third with high cholesterol have adequate treatment, and less than a quarter of smokers get help to quit. Focusing on the ABCS, advances in information technology, particularly expanded use of prevention-oriented electronic health records, and increased use of team-based care will help clinicians make progress in the ABCS.

Tobacco is the leading preventable cause of death, killing more than 440,000 Americans each year.

Blood pressure control in clinical practice may be the most important of these interventions, with the potential to save the most lives. Active partnerships can enhance clinical interventions. Clinicians need to check patients' blood pressure at each visit and prescribe or adjust anti-hypertensive medications promptly as indicated. Pharmacists can monitor medication refill patterns to ensure that drugs are being taken as prescribed and more actively engage doctors and patients in blood pressure management. Home monitoring can help people know if their medications are effective. Senior centers and other community organizations can help ensure blood pressure awareness and control and improve medication adherence. With many partners working together, it becomes much easier for people to keep their blood pressure controlled and prevent heart attacks and strokes.

At CDC, we are also focusing on "winnable battles." Although we are not de-emphasizing work in other key areas, the winnable battles are health problems that present a large burden as a leading cause of illness, injury, disability, and death, and for which there are evidence-based, scalable interventions that we know will work and that we can apply today. Our efforts can make a difference and achieve measurable results within just a few years, although success will not be easy and will require substantial effort by all segments of our society.

CDC has identified these six areas, all of which *America's Health Rankings* measure either directly or indirectly, as key winnable battles for improving our nation's health:

- Tobacco control.
- Nutrition, physical activity, obesity, and food safety.
- Healthcare-associated infections.
- Teen pregnancy.
- Motor vehicle injuries.
- HIV.

Tobacco is the leading preventable cause of death, killing more than 440,000 Americans each year — nearly 1 in 5 of all deaths — or more than a thousand people every day. About 46 million American adults still smoke, which costs us nearly $200 billion annually in medical expenses and lost productivity. After 40 years of steady progress in reducing smoking since the first Surgeon General's report on the harms of

tobacco was released, the decline in adult smoking rates has slowed since 2004.

More than two thirds of smokers want to quit. Many of them try, often multiple times, but need support to succeed. There are proven strategies we can use to reduce tobacco use, which form the basis of the World Health Organization's MPOWER strategy: Monitoring tobacco use and prevention policies; Protecting people from tobacco smoke; Offering help to quit tobacco use; Warning about the dangers of tobacco; Enforcing bans on tobacco advertising, promotion, and sponsorship; and Raising taxes on tobacco.

Strengthening tobacco control will reduce smoking by discouraging smoking initiation and encouraging cessation. We are making important progress, both nationally and at the state and local levels, to implement proven tobacco control policies. The number of Americans protected by comprehensive smoke-free laws is growing each year. Tobacco tax increases at the federal level as well as by some states and localities are encouraging people to quit smoking or not start in the first place. New graphic health warning labels mandated by the Food and Drug Administration pursuant to new federal legislation will be introduced next year, as will expanded use of anti-smoking mass media campaigns. The Centers for Medicare and Medicaid Services is taking steps to increase the coverage of smoking cessation services in public and private insurance programs. Progress shows that success is possible wherever tobacco control is made a priority.

Obesity is one of the few health problems that continues to worsen. Since the 1960s, obesity rates have doubled for adults and tripled for children, so that now more than 1 in 3 adults and 1 in 6 children are obese. We are still working to develop effective interventions to reduce obesity. Among these include policies to increase the availability of healthier foods and beverages and to reduce less healthy food in schools, government facilities, health care facilities and other places. Menu labeling guidelines for chain restaurants will encourage people to make healthier choices.

Outbreaks of foodborne illness are both common and costly. Each year, there are about a thousand such outbreaks in this country, which sicken 1 out of 6 Americans and kill 3,000 people. The annual costs to our society are estimated as high as $152 billion in health care expenses and lost productivity. With passage of the Food Safety Modernization Act, the Food and Drug Administration, CDC, the Department of Agriculture and other partners at federal, state and local levels are identifying these outbreaks and stopping them more quickly, tracking trends in food-borne illness and outbreaks more closely, conducting applied research for better diagnosis and prevention, and tracking the effectiveness of policies to reduce the spread of these illnesses. PulseNet, a national network of public health and food regulatory agency laboratories that is coordinated by CDC, is central to our ability to quickly identify which of many types of bacteria caused an outbreak, facilitating more rapid response.

Each year, there are about a thousand outbreaks of foodborne illness in this country, which sicken 1 out of 6 Americans and kill 3,000 people.

About 1 in 20 patients who are hospitalized contracts a healthcare-associated infection (HAI), which kill 100,000 Americans and cost us roughly $30 billion each year. At least a third of these in-

fections can be prevented with simple tools and procedures that already exist but are currently underutilized. There has recently been a decline in some types of HAIs, in part because more than half of states now require reporting of HAIs, and nearly 5,000 health care facilities throughout the country are enrolled in the internet-based National Healthcare Safety Network (NHSN) surveillance system. The Centers for Medicare and Medicaid Services uses this NHSN surveillance data to improve the quality of hospital care, and the Partnership for Patients is a new public-private partnership to improve patient safety and reduce health care costs.

More than 400,000 of our nation's teen girls age 15-19 years give birth each year. Pregnancy can have immediate and long-term negative effects for teen parents and their children, and can perpetuate social, economic, and educational disadvantage. Although teen pregnancy rates have declined significantly over the past two decades, to the lowest levels since records started being kept, rates are still far too high. Considerable disparities persist in rates of teen pregnancy and birth among our nation's racial and ethnic groups. The public costs associated with teen pregnancy, including health care and foster care, are more than $9 billion annually. Areas that expand access to information and services can substantially reduce teen pregnancy and reduce health disparities.

Although there has recently been a sharp decline in motor vehicle deaths, crashes kill more than 33,000 people and send more than 4 million to emergency departments every year, and remain the leading cause of death among Americans between ages 5 and 34 years. Motor vehicle-related deaths cost our nation $41 billion annually in medical expenses and productivity losses. These rates could be reduced through simple, low-cost measures, and CDC is working with states to adopt and enforce laws requiring use of seat belts, helmets, and child restraints; reduce drunk driving; and introduce and improve graduated drivers licenses for teens.

Despite being preventable, HIV continues to spread among Americans, with more than 50,000 newly infected each year joining a million already living with HIV. Rates are increasing among younger men who have sex with men. We are expanding prevention programs, including testing more people for HIV, and linking those who are infected with treatment as early as possible. CDC is also working with other federal agencies to implement the National HIV/AIDS Strategy, which is designed to achieve a more coordinated national response to the HIV epidemic to reduce new HIV infections, increase access to care and improve health outcomes, and reduce HIV-related disparities and health inequities. Suppression of viral load on a community basis and in clinical practice have emerged as critical indicators of program effectiveness.

As we continue to expand and strengthen our collection and use of data, we gain greater knowledge and insight about the extent of our biggest health problems, which populations are most affected by them, and what we need to do to solve them. Information is power — and this power makes it possible for us to implement programs that fulfill our promise to keep Americans healthy and our nation strong.

Introduction

Health is a result of our behaviors, our individual genetic predisposition to disease, the environment and the community in which we live, the clinical care we receive and the policies and practices of our health care and prevention systems. Each of us — individually, as a community, and as a society — strives to optimize these health determinants, so that all of us can have a long, disease-free and robust life regardless of race, gender or socio-economic status.

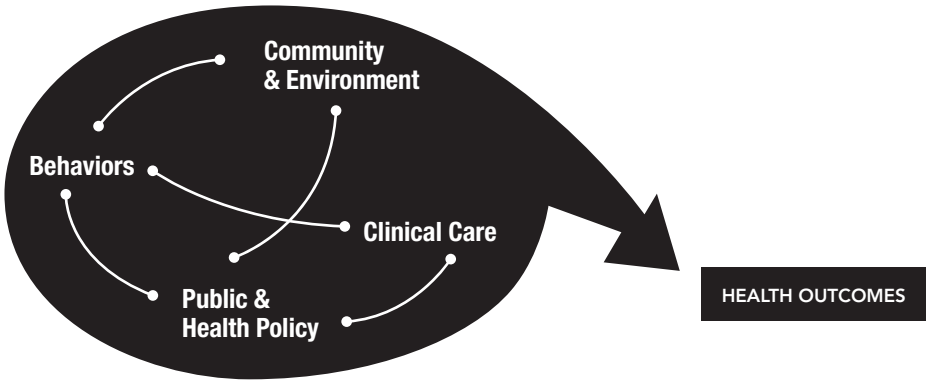
This report looks at the four groups of health determinants that can be affected:

1. Behaviors include the everyday activities we do that affect our personal health. It includes habits and practices we develop as individuals and families that have an effect on our personal health and on our utilization of health resources. These behaviors are modifiable with effort by the individual supported by community, policy and clinical interventions.
2. Community and environment reflects the reality that the daily conditions in which we live our lives have a great effect on achieving optimal individual health. These factors can be modified by a concerted effort by the community and its elected officials supported by state and federal agencies, professional associations, advocacy groups and businesses.
3. Public and health policies are indicative of the availability of resources to encourage and maintain health and the extent that public and health programs reach into the general population. Policies can have very wide reach throughout the state and promote healthy living and judicious consumption of healthcare resources.
4. Clinical care reflects the quality, appropriateness and cost of the care we receive at doctors' offices, clinics and hospitals.

All health determinants are intertwined and must work together to be optimally effective. For example, an initiative that addresses tobacco cessation requires not only efforts on the part of the individual but also support from the community in the form of public and health policies that promote non-smoking and the availability of effective counseling and care at clinics. Similarly, sound prenatal care requires individual effort, education, access to and availability of prenatal care coupled with high quality health care services. Addressing obesity, which is a health epidemic now facing this country, requires coordination among almost all sectors of the economy including food producers, distributors, restaurants, grocery

All health determinants must work together to be optimally effective.

Figure 1
Components of Health



and convenience stores, exercise facilities, parks, urban and transportation design, building design, educational institutions, community organizations, social groups, healthcare delivery and insurance to complement and augment individual actions.

America's Health Rankings® combines individual measures of each of these determinants with the resultant health outcomes into one, comprehensive view of the overall health of a state. *America's Health Rankings*® employs a unique methodology, developed and periodically reviewed by a panel of leading public health scholars, which balances the contributions of various factors, such as smoking, obesity, binge drinking, high school graduation rates, children in poverty, access to care and incidence of preventable disease, to a state's health. The report is based on data from the U.S. Departments of Health and Human Services, Commerce, Education and Labor; U.S. Environmental Protection Agency; the American Medical Association; the Dartmouth Atlas Project; and the Trust for America's Health.

The 2011 Edition of *America's Health Rankings*® is considered a benchmark of the relative health of states due to its longevity and its sound model. Numerous states incorporate this report into their annual review of programs, and several organizations use this study as a reference point when assigning goals for health improvement programs.

Purpose

The ultimate purpose of *America's Health Rankings*® is to stimulate action by individuals, elected officials, medical professionals, public health professionals, employers, educators and communities to improve the health of the population of the United States. We do this by promoting public conversation concerning health in our states, as well as providing information to facilitate citizen, community and group participation. We encourage participation in all elements: behaviors, community and environment, clinical care, and public and health policies. Each person individually, and in their capacity as an employee, employer, educator, voter, community volunteer, medical professional, public health official or elected official, can contribute to the advancement of the healthiness of their state. Proven, effective and innovative actions can improve the health of people in every state whether the state is first or 50th.

The ultimate purpose of *America's Health Rankings*® is to stimulate action.

Scientific Advisory Committee

In 2002, United Health Foundation, in concert with the American Public Health Association (APHA) and Partnership for Prevention, commissioned the School of Public Health at the University of North Carolina at Chapel Hill to undertake an ongoing review of *America's Health Rankings*®. The Scientific Advisory Committee was charged with recommending improvements that would maintain the value of the comparative, longitudinal information; reflect the evolving role and science of public health; utilize new or improved measures of health as they become available and acceptable; and incorporate new methods as feasible. Minor issues with data are always addressed immediately and incorporated into the contents of the next edition of the report. However, more significant issues, such as new measurements of health conditions, require more in-depth study and analysis.

The Scientific Advisory Committee, led by Anna Schenck, Ph.D., M.S.P.H., continues its review, and its input is reflected in this edition. The Committee emphasizes the importance of this tool as a vehicle to promote and improve the general discussion of public health and, also, to encourage balance among public health efforts to benefit the entire community.

This edition includes several suggestions discussed by the committee including:

- Inclusion of diabetes as an outcome and an indicator of the impact chronic disease has upon the health of our country
- Revision of the definition of the infectious disease measure; Infectious disease is now defined as the incidence of measles, pertussis, syphilis and hepatitis A. These four diseases reflect three major transmission routes (contact, sexual and food) and are amenable to sound and extensive public health interventions. The prior definition of infectious disease (incidence of AIDS, hepatitis A and B and tuberculosis) was no longer felt to truly represent the challenges faced in managing infectious disease.

In addition, the committee continues to work on issues concerning improved environmental health indicators, quality and availability of healthy foods, exercise and activity, methods of expressing variability within the rankings, oral health indicators, mental health indicators, improved health disparity measures, improved cost measures, quality of care measures and international benchmarking. (Some of these measures are included in the expanded detail of each state's health profile at www.americashealthrankings.org/ALL but are not included in calculating the overall state rank.)

The Committee emphasizes the importance of this tool as a vehicle to promote and improve the general discussion of public health.

The committee also stresses the importance of focusing on determinants, as improving these measures can improve the healthiness of each state and the nation. The overall ranks for combined determinants as well as outcomes are presented in each state snapshot.

The methodology review group represents a variety of stakeholders, including representatives from state health departments and the Centers for Disease Control and Prevention (CDC), members of APHA, as well as experts from many academic disciplines.

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Findings

2011 Edition Results

America's Health Rankings® — 2011 Edition shows Vermont at the top of the list of healthiest states again this year. The state has steadily risen in the rankings for the last 13 years from a ranking of 17th in 1997 and 1998. New Hampshire is ranked second this year, an improvement from ranking third last year. New Hampshire has ranked in the top 10 states every year of the index. Connecticut is number three, followed by Hawaii and Massachusetts. Mississippi is 50th and the least healthy state, while Louisiana is 49th. Oklahoma, Arkansas and Alabama complete the bottom five states.

Vermont ascended from 20th in 1990 and 1991 to the top position with sustained improvement in the last decade. Vermont's strengths include its number one position for all health determinants combined, which includes ranking in the top 10 states for a high rate of high school graduation, a low violent crime rate, a low rate of infectious disease, a high usage of early prenatal care, high per capita public health funding, a low rate of uninsured population and ready availability of primary care physicians. Vermont's challenges are low immunization coverage with 91.2 percent of children ages 19 to 35 months receiving recommended immunizations, relatively high occupational fatalities at 4.3 deaths per 100,000 workers and a high prevalence of binge drinking at 17.1 percent of the population. For further details, see Vermont's state snapshot on page 93 or visit www.americashealthrankings.org/VT.

Mississippi remains 50th this year, the same as the last ten years. It has been in the bottom three states since the 1990 Edition. The state ranks well for a low prevalence of binge drinking, a low violent crime rate and a high rate of immunization coverage. Mississippi's infectious disease rate improved from 11.9 to 10.5 cases per 100,000 population in the last year. It ranks in the bottom five states on 12 of the 23 measures including a high prevalence of obesity, a low high school graduation rate, a high percentage of children in poverty, limited availability of primary care physicians and a high rate of preventable hospitalizations. Mississippi ranks 48th for all health determinants combined, so its overall ranking is unlikely to change significantly in the near future. For further details, see Mississippi's state snapshot on page 72 or visit www.americashealthrankings.org/MS.

Table 1 (page 16) lists the score and ranking for each of the 50 states.

Scores presented in the tables indicate the weighted number of standard deviation units a state is above or below the national norm. For example, Vermont, with a score of 1.197, is slightly more than one standard deviation unit above the national norm and Mississippi, with a score of -0.822, is over three-quarters of a standard deviation unit below the national average. When comparing states from year to year, differences in score are more important than changes in ranking.

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

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

Table 2 (page 17) presents the overall rankings for the determinants, outcomes and their implications for the future. If the current trend is positive, the future overall ranking is more likely to increase; if it is neutral, the future overall ranking will probably stay the same; or if it is negative, the future overall ranking is more likely to decline.

Table 1
Overall Rankings, 2011 Edition

ALPHABETICAL BY STATE			RANK ORDER		
RANK	STATE	SCORE*	RANK	STATE	SCORE*
46	**Alabama**	-0.607	**1**	Vermont	1.197
35	**Alaska**	-0.168	**2**	New Hampshire	1.027
29	**Arizona**	0.050	**3**	Connecticut	1.010
47	**Arkansas**	-0.622	**4**	Hawaii	0.940
24	**California**	0.265	**5**	Massachusetts	0.906
9	**Colorado**	0.555	**6**	Minnesota	0.755
3	**Connecticut**	1.010	**7**	Utah	0.723
30	**Delaware**	-0.032	**8**	Maine	0.575
33	**Florida**	-0.119	**9**	Colorado	0.555
37	**Georgia**	-0.275	**10**	Rhode Island	0.549
4	**Hawaii**	0.940	**11**	New Jersey	0.495
19	**Idaho**	0.344	**12**	North Dakota	0.494
28	**Illinois**	0.098	**13**	Wisconsin	0.476
38	**Indiana**	-0.290	**14**	Oregon	0.475
17	**Iowa**	0.401	**15**	Washington	0.443
26	**Kansas**	0.128	**16**	Nebraska	0.414
43	**Kentucky**	-0.478	**17**	Iowa	0.401
49	**Louisiana**	-0.817	**18**	New York	0.392
8	**Maine**	0.575	**19**	Idaho	0.344
22	**Maryland**	0.269	**20**	Virginia	0.343
5	**Massachusetts**	0.906	**21**	Wyoming	0.311
30	**Michigan**	-0.032	**22**	Maryland	0.269
6	**Minnesota**	0.755	**23**	South Dakota	0.267
50	**Mississippi**	-0.822	**24**	California	0.265
40	**Missouri**	-0.342	**25**	Montana	0.139
25	**Montana**	0.139	**26**	Kansas	0.128
16	**Nebraska**	0.414	**26**	Pennsylvania	0.128
42	**Nevada**	-0.471	**28**	Illinois	0.098
2	**New Hampshire**	1.027	**29**	Arizona	0.050
11	**New Jersey**	0.495	**30**	Delaware	-0.032
34	**New Mexico**	-0.141	**30**	Michigan	-0.032
18	**New York**	0.392	**32**	North Carolina	-0.068
32	**North Carolina**	-0.068	**33**	Florida	-0.119
12	**North Dakota**	0.494	**34**	New Mexico	-0.141
36	**Ohio**	-0.233	**35**	Alaska	-0.168
48	**Oklahoma**	-0.669	**36**	Ohio	-0.233
14	**Oregon**	0.475	**37**	Georgia	-0.275
26	**Pennsylvania**	0.128	**38**	Indiana	-0.290
10	**Rhode Island**	0.549	**39**	Tennessee	-0.314
45	**South Carolina**	-0.521	**40**	Missouri	-0.342
23	**South Dakota**	0.267	**41**	West Virginia	-0.413
39	**Tennessee**	-0.314	**42**	Nevada	-0.471
44	**Texas**	-0.508	**43**	Kentucky	-0.478
7	**Utah**	0.723	**44**	Texas	-0.508
1	**Vermont**	1.197	**45**	South Carolina	-0.521
20	**Virginia**	0.343	**46**	Alabama	-0.607
15	**Washington**	0.443	**47**	Arkansas	-0.622
41	**West Virginia**	-0.413	**48**	Oklahoma	-0.669
13	**Wisconsin**	0.476	**49**	Louisiana	-0.817
21	**Wyoming**	0.311	**50**	Mississippi	-0.822

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

Table 2
Determinants and Outcomes, 2011 Edition

STATE	SCORE FOR ALL DETERMINANTS*	SCORE FOR ALL OUTCOMES*	INFLUENCE ON FUTURE OVERALL RANK
Alabama	-0.342	-0.265	Neutral
Alaska	-0.22	0.052	Negative
Arizona	0.016	0.035	Neutral
Arkansas	-0.473	-0.15	Negative
California	0.115	0.151	Neutral
Colorado	0.384	0.17	Positive
Connecticut	0.758	0.252	Positive
Delaware	-0.056	0.024	Neutral
Florida	-0.012	-0.108	Neutral
Georgia	-0.212	-0.063	Neutral
Hawaii	0.621	0.318	Positive
Idaho	0.185	0.159	Neutral
Illinois	0.018	0.08	Neutral
Indiana	-0.286	-0.005	Negative
Iowa	0.154	0.247	Neutral
Kansas	0.04	0.089	Neutral
Kentucky	-0.321	-0.157	Neutral
Louisiana	-0.568	-0.249	Negative
Maine	0.425	0.151	Positive
Maryland	0.253	0.016	Positive
Massachusetts	0.597	0.31	Positive
Michigan	-0.025	-0.007	Neutral
Minnesota	0.442	0.314	Neutral
Mississippi	-0.513	-0.31	Negative
Missouri	-0.285	-0.057	Negative
Montana	0.09	0.049	Neutral
Nebraska	0.233	0.181	Neutral
Nevada	-0.437	-0.034	Negative
New Hampshire	0.723	0.304	Positive
New Jersey	0.316	0.179	Neutral
New Mexico	-0.166	0.024	Neutral
New York	0.196	0.196	Neutral
North Carolina	-0.019	-0.049	Neutral
North Dakota	0.351	0.143	Positive
Ohio	-0.19	-0.043	Neutral
Oklahoma	-0.475	-0.194	Negative
Oregon	0.316	0.159	Neutral
Pennsylvania	0.099	0.029	Neutral
Rhode Island	0.397	0.153	Positive
South Carolina	-0.397	-0.124	Negative
South Dakota	0.245	0.022	Positive
Tennessee	-0.194	-0.12	Neutral
Texas	-0.539	0.032	Negative
Utah	0.47	0.253	Positive
Vermont	0.904	0.293	Positive
Virginia	0.306	0.037	Positive
Washington	0.25	0.193	Neutral
West Virginia	-0.164	-0.248	Neutral
Wisconsin	0.307	0.169	Neutral
Wyoming	0.244	0.067	Neutral

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

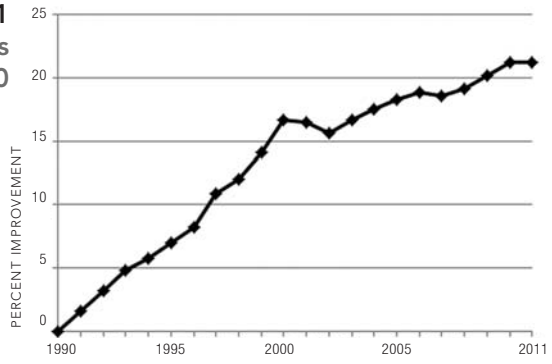
National Changes

The 22-year perspective provided by this report allows us to view health over time. During the past 22 years, this report has tracked our nation's 21.2 percent improvement in overall health (Graph 1). This national success stems from improvements in the reduction of infant mortality, infectious disease, prevalence of smoking, cardiovascular deaths and violent crime, among others (Table 3).

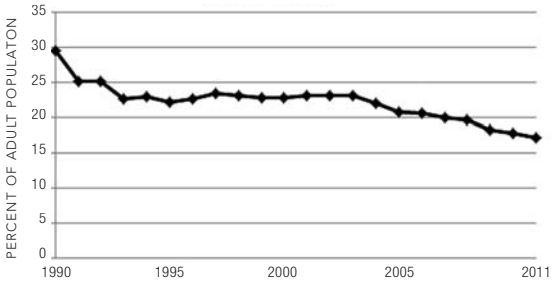
This report has tracked our nation's 21.2 percent improvement in overall health.

However, success has eluded us in several very significant measures — the rapid increase in the prevalences of obesity and diabetes and the persistently high rate of uninsured population. A dramatic increase in the percentage of children in poverty during the last five years has also suppressed faster improvement in health.

Graph 1
Improvements Since 1990



Graph 2
Prevalence of Smoking Since 1990



Graph 1 illustrates that the rate of improvement experienced in the health of the United States' population occurred in two phases. During the 1990s, improvement in national health averaged 1.6 percent per year. During this decade, the annual improvement in health has averaged 0.5 percent per year. The annual rate of growth this decade is less than one-third of the annual rate of growth during the 1990s. Special concern surrounds the decline in health determinants, as those measures point to the future health of the population.

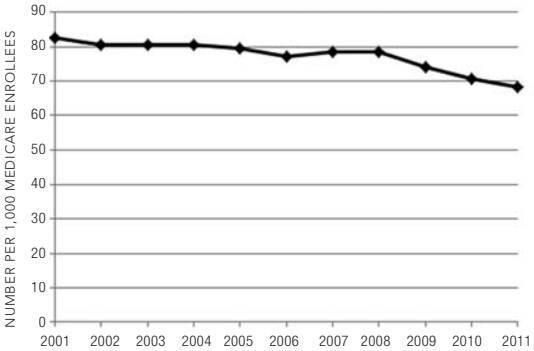
The United States has the potential to return to the rates of improvement typical in the 1990s. However, to do so, it must address the drivers of health directly by focusing on reducing important risk factors. For example, the prevalence of smoking was stagnant for many years and now is showing improvement, declining from 23.2 percent in the 2003 Edition to 17.3 percent in the 2011 Edition, the lowest level in 22 years (Graph 2). Utah has reduced its smoking rate to less than 10 percent, lower than the 12 percent goal for the nation set forth in Healthy People 2020. Seven other states (California, Connecticut, Arizona, Massachusetts, New Jersey, Hawaii and Minnesota) have driven their smoking rates to less than 15 percent, approaching the Healthy People 2020 goal. Only West Virginia has a smoking rate greater than 25 percent of the population, and 13 additional states have rates that exceed 20 percent of the adult population.

Potentially preventable hospitalizations (hospital admissions that may be preventable with high quality primary and preventive care) have declined over the last ten years from 82.5 to 68.2 admissions per 1,000 Medicare enrollees (Graph 3). Potentially preventable hospitalizations are a significant issue with regard to both quality and cost. The Agency for Healthcare Research and Quality (AHRQ) reports that in the year 2006, 4.4 million admissions to U.S. hospitals involved

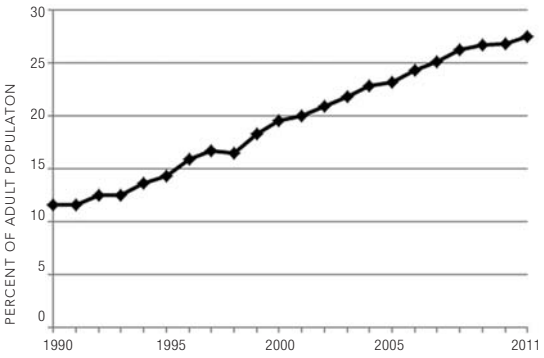
Table 3
National Successes and Challenges, 2011 Edition

MEASURE	CHANGES
SUCCESSES	
Smoking	The prevalence of smoking decreased 41 percent from 29.5 percent in the 1990 Edition to 17.3 percent of the adult population in the current edition. Smoking dropped from 17.9 percent to 17.3 percent in the last year, continuing a gradual decline over the past eight years.
Violent Crime	The violent crime rate declined 34 percent from 609 offenses in the 1990 Edition to 404 offenses per 100,000 population in the 2011 Edition. Violent crime dropped by 25 offenses per 100,000 population in the last year.
Preventable Hospitalizations	Preventable hospitalizations continue a 10-year decline. In the 2001 Edition, there were 82.5 discharges; in this edition, there were 68.2 discharges per 1,000 Medicare enrollees.
Occupational Fatalities	Occupational fatalities have declined slightly in the last five years from 5.3 deaths in the 2007 Edition to 4.0 deaths per 100,000 workers in the 2011 Edition. Rates are the lowest in 22 years.
Air Pollution	The average amount of fine particulate in the air continues to decline from 13.2 micrograms in the 2003 Edition to 10.8 micrograms per cubic meter in 2011.
Infectious Disease	Infectious disease has dropped from 19.7 cases in the 1998 Edition to 10.3 cases per 100,000 population in the 2011 Edition. However, the incidence is above the rate of 9.0 cases achieved in 2009 and 2010.
Infant Mortality	The infant mortality rate decreased 33 percent from 10.2 deaths in the 1990 Edition to 6.7 deaths per 1,000 live births in 2011. Improvements have slowed dramatically in the last 10 years as compared to the 1990s.
Premature Death	Years of potential life lost before age 75 per 100,000 population declined 16 percent from 8,716 in the1990 Edition to 7,279 years of potential life lost before age 75 per 100,000 population in 2011. Premature deaths, like several other metrics, have leveled off in the last decade compared to gains in the 1990s.
CHALLENGES	
Obesity	The prevalence of obesity increased 137 percent from 11.6 percent in the 1990 Edition to 27.5 percent of the population in the 2011 Edition.
Diabetes	Diabetes has almost doubled in prevalence since the 1996 Edition, rising from 4.4 percent to 8.7 percent of the adult population. This continued 0.3 percent annual increase does not show signs of abating in the near term.
Children in Poverty	The percentage of children in poverty has increased for the last four editions and, at 21.5 percent of persons under age 18, is approaching the 22-year historical high of 22.7 percent in the 1994 Edition. This is far above the 22-year low of 15.8 percent in the 2002 Edition.
Lack of Health Insurance	The rate of uninsured population has increased 17 percent from 13.9 percent in the 2001 Edition to 16.2 percent in 2011. The rate of uninsured population has slowly but steadily increased during the last 10 years.
Binge Drinking	The percent of adults who report binge drinking remains above 15 percent of the population.
High School Graduation Rate	Over the last seven years, the high school graduation rate remains locked in the range of 73 percent to 75 percent of incoming ninth graders who graduate in four years.

Graph 3
Preventable Hospitalizations Since 2001



Graph 4
Prevalence of Obesity Since 1990



Unprecedented and still unchecked growth in the prevalence of obesity dramatically affects the overall health of the United States.

treatment for one or more potentially preventable conditions, with a resulting cost of more than $30.8 billion.[1] Furthermore, AHRQ states that "While some hospitalizations were likely inevitable, many might have been prevented if individuals had received high quality primary and preventive care. Identifying and reducing such avoidable hospitalizations could help alleviate the economic burden placed on the U.S. health care system. Assuming an average cost of $5,300 per admission, even a 5 percent decrease in the rate of potentially avoidable hospitalizations could result in a cost savings of more than $1.3 billion."[2]

Preventable hospitalizations are also a window into the disparities that exist in the healthcare delivery system. In a study of 2003 data by Russo, C. Allison et. al.,[3] racial and ethnic disparities existed in the rates of preventable hospitalizations, with blacks generally having the highest rates and Hispanics the second highest rates. In particular, disparities were greatest for hospitalizations related to chronic health conditions such as diabetes, hypertension, and asthma. Compared with non-Hispanic whites, rates of admission for these conditions were about three to five times greater among blacks, and approximately two to three times greater among Hispanics.

Unprecedented and still unchecked growth in the prevalence of obesity dramatically affects the overall health of the United States. The prevalence of obesity has increased 137 percent, from 11.6 percent of the population in the 1990 Edition to 27.5 percent of the population in the 2011 Edition. Now, more than one in four people in the U.S. is considered obese — a category that the CDC reserves for those who are significantly over the suggested body weight given their height. This alarming rate of increase shows little evidence of slowing or abating (Graph 4).

Because this data relies on self-reported height and weight, actual obesity rates, as measured by

1. Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, www.hcup-us.ahrq.gov/reports/statbriefs/sb72.jsp accessed on Nov 8, 2011.
2. Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, http://archive.ahrq.gov/data/hcup/factbk5/ accessed Oct 27, 2011.
3. Russo, C Allison; Andrews, Roxanne M; and Coffey, Rosanna M, Healthcare Cost and Utilization Project (HCUP) Statistical Brief #10, Rockville (MD), 2006, http://www.ncbi.nlm.nih.gov/books/NBK63497/#sb10.s2 accessed on Oct 27, 2011.

health professionals, may be up to 10 percent higher, meaning that over one-third of the population is likely to be obese.[4] In fact, the National Health and Nutritional Examination Survey (NHANES) study, which physically measures height and weight, indicates that the national obesity level is 33.8 percent of adults.[5]

Obesity is known to contribute to a variety of diseases, including heart disease, diabetes and general poor health.

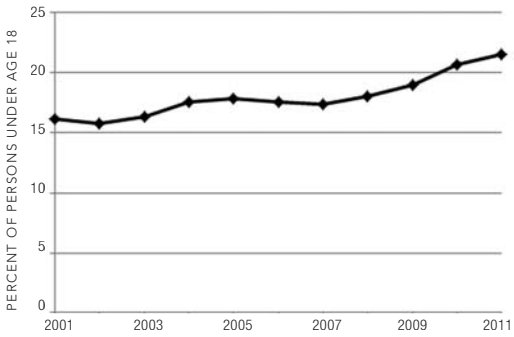
The current economic climate also increases the challenge of maintaining a healthy population. Graph 5 depicts the continuing increase in the percentage of children in poverty, increasing from 17.4 percent of children in the 2007 Edition to 21.5 percent of children in the 2011 Edition. In the 2002 Edition, the child poverty rate was at a historic low of 15.8 percent of persons under age 18.

Children in Poverty is an indication of the lack of access to health care, including preventive care, for this vulnerable population.

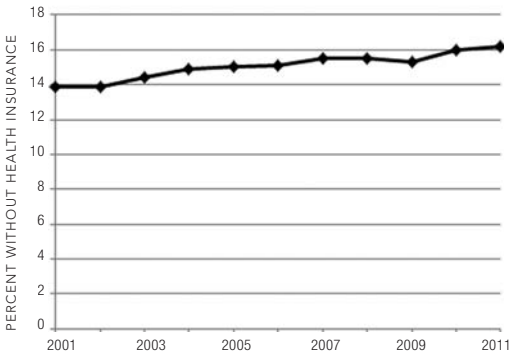
Lack of health insurance coverage increased from 13.9 percent in the 2001 Edition to 16.2 percent of the population in the 2011 Edition (Graph 6). Lack of health insurance not only inhibits people from getting the proper care when needed but also reduces access to necessary preventive care to curtail or minimize future illnesses.

Massachusetts, with lack of health insurance at 5.0 percent of the population, is substantially better than all other states and less than one third of the national average. Texas has a rate five times that of Massachusetts. Changes in national health care laws have the potential to dramatically affect this metric over the next few years.

In addition to these setbacks, high school graduation, binge drinking, poor mental health days and poor physical health days have shown minimal improvement in the last decade and impede more significant improvements in general population health.



Graph 5
Children in Poverty Since 2001



Graph 6
Lack of Health Insurance Since 2001

4. Yun, S., et. al. *A comparison of national estimates of obesity prevalence from the behavioral risk factor surveillance system and the national health and nutrition examination survey,* International Journal of Obesity (2006) 30, 164–170.
5. National Health and Nutritional Examination Survey, National Center for Health Statistics, CDC, http://wwwn.cdc.gov/nchs/nhanes/bibliography/key_statistics.aspx accessed Oct 30, 2011.

Health Disparities within States

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

The statewide measures used in *America's Health Rankings*® reflect the condition of the "average" resident. However, when those measures are examined more closely and race, gender, geographic location and/or economic status are considered, startling differences can exist within a state.

The National Healthcare Disparities Report (http://www.ahrq.gov/qual/qrdr10.htm), released each year by the Agency for Healthcare Research and Quality, highlights disparities in healthcare delivery at a national level. The report analyzes numerous measures and indicates that disparities exist for many groups, including women, children, the elderly, rural residents, and among racial and socio-economic groups. The report also indicates that such disparities affect all aspects of health and health care delivery, including preventive care, acute care and chronic disease management. They also affect many modes of delivery including primary care, home health care, hospice, emergency care, hospitals and nursing homes.

The report highlights several key themes this year, including:

- Health care quality and access are suboptimal, especially for minority and low-income groups.
- Even though overall quality is improving; access and disparities are not improving.
- All eight national priority areas —
  1. Palliative and End-of-Life Care,
  2. Patient and Family Engagement,
  3. Population Health,
  4. Safety,
  5. Access,
  6. Care Coordination,
  7. Overuse, and
  8. Health System Infrastructure — showed disparities related to race, ethnicity, and socioeconomic status.
- Urgent attention is warranted with respect to certain services, geographic areas, and populations, including:
  - Cancer screening and management of diabetes.
  - States in the central part of the country.
  - Residents of inner-city and rural areas.
  - Disparities in preventive services and access to care.

While each state has unique issues that contribute to disparities, states that have been successful in reducing disparities in health indicators while retaining high overall health can serve as models for other states.

America's Health Rankings® contains an explicit metric for disparities — Geographic Disparity. This indicator reflects the range of age-adjusted mortality rates that exist within a state at the county level. State data is available at www.americashealthrankings.org/all/Disparity. This overall disparity metric provides a broad view of the challenges facing a state, but a few specific behavioral measures shed more light on the extent of the disparity.

Tables 4 through 6 show how the prevalences of smoking, obesity and diabetes vary by race/ethnicity within the states. These tables illustrate that disparities are a local issue; in some states, there is a wide difference among racial/ethnic groups whereas among other types of groups, the difference is much less pronounced. This type of analysis, especially when expanded to encompass a broad range of social, economic and health indicators, allows communities, their organizations and public health officials to target programs to address the biggest areas of concern.

Disparities also exist in the prevalence of diseases, especially chronic disease. Table 6 shows how diabetes affects the various racial/ethnic groups in each state. It is notable that diabetes is consistently higher among non-Hispanic blacks than among either non-Hispanic whites or Hispanics.

Kalkarni et. al.[6] further accent the disparities that exist by calculating the extensive difference in life expectancy by race and gender in counties throughout the United States. Using their methods, they showed that although the overall U.S. life expectancy for men and women averaged 75.6 and 80.8 years respectively in 2007, county-by-county life expectancy ranged from 65.9 to 81.1 years for men and 73.5 to 86.0 years for women. If viewed from a racial disparity perspective, life expectancy at birth ranges from 59.4 to 77.2 years for black men and 69.6 to 82.6 years for black women.

6. Karlarni, Sandeep C., Levin-Rector, Alixon, Ezzati, Majid, and Murray, Chirstopher JL, Falling behind: life expectancy in US counties from 2000-2007 in an international context, Population Health Metrics, 2011, 9:16, http://www.pophealthmetrics.com/content/9/1/16.

Table 4
Prevalence of Smoking by Race/ Ethnicity and State (percent of adult population), 2011 Edition

	NON-HISPANIC WHITE	NON-HISPANIC BLACK	HISPANIC	NON-HISPANIC ASIAN	NON-HISPANIC HAWAIIAN / PACIFIC ISLANDER	NON-HISPANIC AMERICAN INDIAN OR ALASKAN NATIVE	NON-HISPANIC MULTIRACIAL
Alabama	22.4%	21.5%	26.9%	NA	NA	28.6%	16.4%
Alaska	17.6%	NA	20.2%	11.8%	NA	37.6%	36.7%
Arizona	15.0%	16.4%	15.1%	9.5%	NA	17.4%	29.9%
Arkansas	21.7%	24.3%	18.5%	NA	NA	29.4%	43.2%
California	13.3%	20.2%	12.5%	6.4%	17.0%	28.2%	22.3%
Colorado	15.8%	20.6%	19.4%	12.9%	NA	30.4%	26.1%
Connecticut	14.5%	16.1%	17.4%	10.3%	NA	NA	30.3%
Delaware	18.2%	15.9%	22.9%	3.1%	NA	NA	23.9%
Florida	19.0%	14.7%	12.5%	7.1%	NA	37.1%	29.7%
Georgia	19.3%	16.1%	13.8%	11.1%	NA	32.0%	22.4%
Hawaii	13.7%	17.2%	21.4%	10.6%	22.7%	NA	20.3%
Idaho	16.1%	NA	15.9%	NA	NA	29.1%	23.4%
Illinois	17.9%	23.3%	19.9%	8.4%	NA	NA	26.8%
Indiana	22.4%	31.6%	25.9%	9.0%	NA	45.3%	33.6%
Iowa	17.0%	31.6%	17.0%	NA	NA	NA	NA
Kansas	17.0%	23.8%	17.5%	7.6%	NA	39.4%	30.0%
Kentucky	24.9%	27.4%	23.2%	NA	NA	40.6%	35.5%
Louisiana	21.9%	20.7%	22.3%	NA	NA	23.8%	24.4%
Maine	17.6%	NA	23.2%	NA	NA	46.7%	28.2%
Maryland	15.4%	16.8%	9.5%	6.0%	NA	26.2%	21.6%
Massachusetts	15.0%	17.0%	14.8%	5.9%	NA	35.0%	22.9%
Michigan	18.8%	21.1%	24.7%	11.2%	NA	30.4%	31.9%
Minnesota	15.9%	21.3%	20.8%	7.0%	NA	50.4%	NA
Mississippi	22.9%	23.0%	22.4%	NA	NA	37.4%	29.4%
Missouri	22.6%	25.0%	21.9%	NA	NA	29.0%	32.3%
Montana	16.1%	NA	27.9%	NA	NA	44.5%	41.7%
Nebraska	16.8%	24.0%	17.1%	14.0%	NA	44.6%	34.6%
Nevada	21.7%	21.2%	19.6%	22.1%	NA	29.1%	32.0%
New Hampshire	16.2%	NA	16.7%	3.6%	NA	52.0%	34.3%
New Jersey	15.9%	17.0%	13.2%	7.3%	NA	13.5%	21.3%
New Mexico	17.1%	26.1%	19.9%	16.0%	NA	18.5%	29.1%
New York	17.1%	17.3%	16.1%	9.6%	NA	27.3%	30.4%
North Carolina	20.4%	21.3%	13.8%	15.1%	NA	33.8%	31.2%
North Dakota	16.3%	NA	25.4%	NA	NA	46.5%	NA
Ohio	20.4%	23.2%	29.1%	5.4%	NA	51.6%	33.7%
Oklahoma	23.4%	31.5%	21.2%	9.0%	NA	31.5%	29.4%
Oregon	15.5%	NA	14.9%	9.5%	NA	36.6%	26.7%
Pennsylvania	19.1%	27.2%	19.7%	9.5%	NA	46.8%	36.2%
Rhode Island	16.2%	14.4%	12.2%	8.6%	NA	25.7%	30.3%
South Carolina	20.8%	19.1%	15.3%	17.8%	NA	40.1%	32.6%
South Dakota	14.9%	NA	19.2%	NA	NA	48.4%	26.8%
Tennessee	22.3%	20.2%	20.2%	NA	NA	NA	15.4%
Texas	18.3%	18.6%	16.0%	10.0%	NA	30.2%	23.0%
Utah	9.1%	NA	12.2%	6.0%	NA	18.1%	18.3%
Vermont	16.0%	NA	19.4%	NA	NA	43.6%	25.0%
Virginia	17.6%	18.3%	22.0%	8.8%	NA	50.5%	22.5%
Washington	15.1%	21.3%	11.9%	4.8%	15.1%	31.8%	27.3%
West Virginia	26.3%	27.0%	25.0%	NA	NA	NA	31.0%
Wisconsin	18.2%	28.3%	29.4%	NA	NA	34.5%	32.2%
Wyoming	18.5%	NA	24.5%	NA	NA	49.1%	23.2%
United States	18.1%	19.9%	14.8%	8.4%	21.2%	32.6%	27.2%
District of Columbia	9.4%	21.6%	15.1%	5.8%	NA	NA	21.1%

Source: Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2008-2010. NA indicates data is not available for this subgroup. Note: Differences between groups may be more or less than shown because the reliability of self-report data varies by ethnic and racial groups.

Table 5
Prevalence of Obesity by Race/ Ethnicity and State (percent of adult population), 2011 Edition

	NON-HISPANIC WHITE	NON-HISPANIC BLACK	HISPANIC	NON-HISPANIC ASIAN	NON-HISPANIC HAWAIIAN / PACIFIC ISLANDER	NON-HISPANIC AMERICAN INDIAN OR ALASKAN NATIVE	NON-HISPANIC MULTIRACIAL
Alabama	29.0%	42.4%	30.7%	NA	NA	31.5%	24.0%
Alaska	24.3%	NA	28.6%	11.6%	NA	33.9%	30.1%
Arizona	23.3%	35.9%	32.3%	8.2%	NA	40.8%	30.8%
Arkansas	29.8%	41.5%	30.1%	NA	NA	33.0%	31.9%
California	21.8%	35.8%	30.6%	8.4%	21.7%	30.5%	23.7%
Colorado	18.3%	27.9%	24.8%	7.6%	NA	32.7%	28.8%
Connecticut	20.8%	39.5%	29.0%	7.3%	NA	NA	32.5%
Delaware	26.0%	42.5%	31.5%	5.3%	NA	NA	34.3%
Florida	24.1%	38.8%	28.7%	10.8%	NA	26.0%	29.5%
Georgia	25.6%	38.1%	32.7%	7.9%	NA	31.0%	27.1%
Hawaii	19.3%	35.3%	27.0%	13.7%	56.8%	NA	34.6%
Idaho	25.1%	NA	29.6%	NA	NA	41.1%	35.2%
Illinois	25.5%	39.5%	31.5%	10.8%	NA	NA	27.5%
Indiana	28.8%	37.0%	28.4%	8.9%	NA	27.1%	26.8%
Iowa	28.1%	33.0%	29.5%	NA	NA	NA	NA
Kansas	28.4%	41.8%	34.7%	4.9%	NA	31.9%	31.8%
Kentucky	31.0%	43.2%	33.1%	NA	NA	27.8%	32.5%
Louisiana	28.4%	39.5%	29.3%	NA	NA	33.9%	38.5%
Maine	26.7%	NA	21.0%	NA	NA	29.0%	35.8%
Maryland	24.3%	36.3%	27.4%	10.2%	NA	23.8%	31.6%
Massachusetts	21.8%	30.5%	29.1%	8.0%	NA	26.1%	25.3%
Michigan	29.1%	41.1%	32.9%	7.5%	NA	41.5%	38.5%
Minnesota	25.2%	28.2%	27.1%	17.4%	NA	34.8%	NA
Mississippi	30.4%	42.6%	35.4%	NA	NA	32.2%	26.2%
Missouri	29.5%	38.2%	29.0%	NA	NA	36.9%	33.5%
Montana	22.9%	NA	22.9%	NA	NA	42.3%	32.3%
Nebraska	27.0%	39.6%	31.8%	8.4%	NA	43.6%	36.9%
Nevada	24.1%	28.5%	26.5%	17.2%	NA	35.2%	34.1%
New Hampshire	25.8%	NA	24.0%	3.0%	NA	29.1%	27.5%
New Jersey	23.1%	35.9%	26.8%	7.6%	NA	21.9%	26.5%
New Mexico	20.8%	31.7%	30.7%	8.5%	NA	37.0%	22.5%
New York	24.1%	31.4%	27.2%	8.6%	NA	36.4%	27.0%
North Carolina	26.7%	42.4%	26.0%	5.1%	NA	34.5%	39.9%
North Dakota	27.4%	NA	37.7%	NA	NA	43.5%	NA
Ohio	28.7%	40.8%	32.5%	8.2%	NA	34.9%	31.6%
Oklahoma	29.7%	41.3%	30.3%	8.0%	NA	40.0%	35.0%
Oregon	25.3%	NA	25.4%	5.1%	NA	NA	29.3%
Pennsylvania	27.7%	39.4%	34.5%	5.6%	NA	32.7%	29.2%
Rhode Island	23.3%	35.6%	30.9%	13.0%	NA	NA	23.2%
South Carolina	27.4%	40.3%	38.2%	4.4%	NA	38.1%	26.1%
South Dakota	28.1%	NA	29.2%	NA	NA	39.4%	37.6%
Tennessee	30.5%	40.9%	30.3%	NA	NA	NA	31.2%
Texas	26.7%	38.5%	36.0%	9.1%	NA	33.1%	32.0%
Utah	23.0%	NA	27.4%	9.0%	NA	30.2%	22.6%
Vermont	23.6%	NA	20.8%	NA	NA	33.2%	28.2%
Virginia	25.2%	37.2%	25.1%	6.9%	NA	25.2%	28.6%
Washington	26.2%	33.8%	30.4%	7.4%	29.6%	40.7%	32.2%
West Virginia	32.1%	39.5%	29.7%	NA	NA	NA	41.8%
Wisconsin	26.5%	45.8%	21.1%	NA	NA	44.2%	39.1%
Wyoming	24.6%	NA	32.0%	NA	NA	42.4%	32.6%
United States	25.8%	38.2%	30.4%	9.0%	24.5%	35.1%	30.5%
District of Columbia	9.3%	34.4%	18.1%	8.2%	NA	NA	27.9%

Source: Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2008-2010. NA indicates data is not available for this subgroup. Note: Differences between groups may be more or less than shown because the reliability of self-report data varies by ethnic and racial groups.

Table 6
Prevalence of Diabetes by Race/ Ethnicity and State (percent of adult population), 2011 Edition

	NON-HISPANIC WHITE	NON-HISPANIC BLACK	HISPANIC	NON-HISPANIC ASIAN	NON-HISPANIC HAWAIIAN / PACIFIC ISLANDER	NON-HISPANIC AMERICAN INDIAN OR ALASKAN NATIVE	NON-HISPANIC MULTIRACIAL
Alabama	10.9%	15.3%	16.0%	NA	NA	18.0%	15.0%
Alaska	5.7%	NA	8.2%	5.0%	NA	5.7%	4.9%
Arizona	8.6%	12.4%	10.7%	8.4%	NA	15.4%	9.8%
Arkansas	9.3%	12.3%	8.8%	NA	NA	13.9%	14.8%
California	7.0%	14.1%	10.1%	7.9%	10.0%	14.3%	8.0%
Colorado	5.0%	10.3%	8.4%	5.4%	NA	9.6%	5.7%
Connecticut	6.7%	11.5%	6.2%	6.7%	NA	NA	5.4%
Delaware	7.9%	11.0%	7.1%	6.5%	NA	NA	8.8%
District of Columbia	2.8%	15.4%	4.5%	4.8%	NA	NA	8.5%
Florida	9.5%	13.4%	9.3%	8.1%	NA	15.3%	11.7%
Georgia	8.4%	12.8%	9.0%	12.7%	NA	10.7%	7.5%
Hawaii	4.7%	8.7%	9.4%	9.6%	10.1%	NA	9.1%
Idaho	7.5%	NA	7.7%	NA	NA	12.0%	9.0%
Illinois	7.4%	13.4%	8.2%	7.6%	NA	NA	10.4%
Indiana	9.1%	14.8%	9.4%	5.1%	NA	11.8%	13.7%
Iowa	7.4%	12.6%	4.6%	NA	NA	NA	NA
Kansas	8.1%	12.2%	9.0%	2.5%	NA	20.2%	9.8%
Kentucky	10.1%	14.9%	6.3%	NA	NA	20.3%	13.4%
Louisiana	9.4%	13.4%	9.5%	NA	NA	11.7%	13.4%
Maine	8.3%	NA	7.0%	NA	NA	18.1%	13.1%
Maryland	8.0%	12.8%	5.5%	7.3%	NA	11.2%	9.2%
Massachusetts	7.1%	11.1%	9.3%	6.4%	NA	11.7%	6.7%
Michigan	8.6%	13.8%	10.7%	7.7%	NA	13.4%	13.4%
Minnesota	6.3%	3.4%	7.4%	3.6%	NA	10.2%	NA
Mississippi	10.4%	14.5%	8.7%	NA	NA	11.5%	10.7%
Missouri	8.3%	13.2%	7.0%	NA	NA	10.0%	14.5%
Montana	6.4%	NA	4.3%	NA	NA	14.4%	10.0%
Nebraska	7.5%	11.7%	8.5%	4.7%	NA	9.8%	6.1%
Nevada	8.2%	11.7%	6.6%	10.8%	NA	7.4%	9.6%
New Hampshire	7.3%	NA	7.2%	6.7%	NA	7.8%	8.9%
New Jersey	7.8%	13.7%	8.5%	7.6%	NA	18.8%	7.4%
New Mexico	6.6%	12.9%	10.2%	2.9%	NA	9.7%	10.1%
New York	7.9%	12.8%	8.2%	7.4%	NA	16.4%	11.4%
North Carolina	8.7%	15.3%	4.9%	2.5%	NA	12.1%	9.5%
North Dakota	7.1%	NA	6.5%	NA	NA	14.7%	NA
Ohio	9.4%	15.3%	12.6%	6.7%	NA	14.4%	9.3%
Oklahoma	9.4%	14.7%	9.7%	8.1%	NA	15.1%	13.6%
Oregon	7.3%	NA	6.6%	3.9%	NA	10.3%	10.5%
Pennsylvania	8.9%	15.7%	6.6%	5.8%	NA	12.4%	10.1%
Rhode Island	7.3%	10.9%	7.6%	3.4%	NA	13.9%	7.4%
South Carolina	8.9%	13.4%	10.0%	5.3%	NA	14.9%	9.1%
South Dakota	6.6%	NA	6.4%	NA	NA	12.4%	9.9%
Tennessee	10.5%	12.2%	6.3%	NA	NA	NA	13.4%
Texas	8.1%	14.8%	10.6%	5.2%	NA	17.6%	8.3%
Utah	6.2%	NA	5.8%	4.1%	NA	9.8%	7.2%
Vermont	6.3%	NA	7.0%	NA	NA	11.4%	12.4%
Virginia	8.0%	13.0%	3.7%	4.9%	NA	9.2%	5.5%
Washington	7.4%	12.8%	6.8%	5.7%	7.0%	10.3%	8.9%
West Virginia	11.8%	15.2%	11.7%	NA	NA	NA	18.5%
Wisconsin	7.4%	12.4%	NA	NA	NA	15.8%	NA
Wyoming	NA	NA	NA	NA	NA	NA	NA
United States	8.2%	13.6%	9.7%	7.2%	8.3%	13.3%	10.0%

Source: Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2008-2010. NA indicates data is not available for this subgroup.
Note: Differences between groups may be more or less than shown because the reliability of self-report data varies by ethnic and racial groups.

Comparison to Other Nations

When health in the United States is compared to health in other countries, the picture is disappointing. The World Health Organization, in its annual *World Health Statistics 2011,* compares the United States to the nations of the world on a large variety of measures. While the U.S. does exceed many countries, it is far from the best in many of the common measures used to gauge healthiness, and it lags behind its peers in other developed countries.

Life expectancy is a measure that indicates the number of years that a newborn can expect to live. Japan is the perennial leader in this measure, with a life expectancy of 86 years on average for females and 80 years for males (San Marino men have a longer life expectancy at 82 years). With a life expectancy of 81 years for women, the United States is 32nd among the 193 reporting nations of the World Health Organization and at 76 years for men, the United States is 34th among nations. Table 7 lists a few other countries for comparison purposes. U.S. male life expectancy rates are on par with Chile, Cuba and Slovenia and U.S. female life expectancy rates are on par with Costa Rica and Denmark.

The infant mortality rate for the U.S. in 2009 was seven deaths per 1,000 live births, ranking the United States 43rd among WHO nations.

If you view life expectancy at a more granular level, i.e. at the county level, and compare it to other leading nations, U.S. life expectancy rates appear even worse.[7] While many U.S. counties (33 counties for men and eight counties for women) exceed the average life expectancy of the 10 leading nations, by far the majority of U.S. counties lag behind these leading nations. In fact, 92 U.S. counties for men and two U.S. counties for women have life expectancy rates similar to rates leading nations experienced in 1957 or earlier. The authors also show that life expectancy rates in 1,406 U.S. counties for males and 2,054 U.S. counties for females are now further behind those of developing nations than they were seven years earlier.

One of the underlying causes for these differences is the gap in infant mortality rates between the United States and many other countries (Table 7). The infant mortality rate for the U.S. in 2009 was seven deaths per 1,000 live births, ranking the United States 43rd among WHO nations. Rates for Sweden, Spain, Italy, Germany, France, Czech Republic, Slovenia and Iceland are all half of the United States rate. These countries also have considerably lower infant mortality rates than those of non-Hispanic whites in the United States, the ethnic/racial group with the lowest rates in the United States.

Differences in life expectancy are also impacted by the effectiveness of treating disease, especially diseases that are amenable to care, including bacterial infections, treatable cancers, diabetes, cardiovascular and cerebrovascular disease, some ischemic heart disease and complications from common surgical procedures. The age-adjusted amenable mortality rate before age 75 for the United States was 95.5 deaths per 100,000 population in 2006 to 2007. This is a considerable improvement from 120.2 deaths per 100,000 population in 1997 to 1998, but the rate of improvement was much slower than in other Organization for Economic Cooperation and Development (OECD) nations studied. The rate in the U.S. remains 50 percent higher than the rate in Australia, France, Japan and Italy. This study estimated that if the United States achieved rates on par with comparative counties, between 59,500 and 84,300 deaths before age 75 would have been saved.[8]

Per capita healthcare spending in the United States continues to lead the world. The median expenditure among OECD countries is $2,995 per person; in the United States, it is $7,538 per person. The annual growth rate of spend-

7. Ibid.
8. Nolte, Ellen and McKee, Martin, Variations in amenable mortality – Trends in 16 high-income nations, Health Policy 103 (2011), 47-52, http://www.sciencedirect.com/science/article/pii/S016885101100159X .
9. Squires, David A., The U.S. Health System in Perspective: A Comparison of Twelve Industrialized Nations, Issues in International Health Policy, The Commonwealth Fund, July 2011.
10. Ibid

Table 7
International Comparisons

	INFANT MORTALITY RATE		LIFE EXPECTANCY (YEARS AT BIRTH)				HEALTH EXPENDITURE (%)*
	DEATHS PER 1,000 LIVE BIRTHS	RANK**	MALE	RANK**	FEMALE	RANK**	
Australia	4	21	80	2	84	7	8.5
Austria	4	21	78	14	83	11	10.5
Belgium	4	21	77	27	83	11	11.1
Canada	5	30	79	7	83	11	9.8
Chile	7	43	76	34	82	26	7.5
China	17	89	72	53	76	76	4.3
Costa Rica	10	54	77	27	81	32	9.4
Cuba	5	30	76	34	80	35	12.0
Czech Republic	3	8	74	40	80	35	7.1
Denmark	3	8	77	27	81	32	9.9
Finland	3	8	77	27	83	11	8.8
France	3	8	78	14	85	2	11.2
Germany	3	8	78	14	83	11	10.5
Greece	3	8	78	14	83	11	10.1
Hungary	5	30	70	80	78	52	7.2
Ireland	3	8	77	27	82	26	8.7
Israel	4	21	80	2	83	11	7.6
Italy	3	8	79	7	84	7	8.7
Japan	2	3	80	2	86	1	8.3
Mexico	15	80	73	44	78	52	5.9
Netherlands	4	21	78	14	83	11	9.9
New Zealand	4	21	79	7	83	11	9.7
Norway	3	8	79	7	83	11	8.5
Poland	5	30	71	66	80	35	7
Portugal	4	21	76	34	82	26	10.6
Slovenia	2	3	76	34	82	26	8.3
Spain	3	8	78	14	85	2	9
Sweden	2	3	79	7	83	11	9.4
Switzerland	4	21	80	2	84	7	10.7
United Kingdom	5	30	78	14	82	26	8.7
United States of America	7	43	76	34	81	32	15.2

*Total expenditure on health as % of gross domestic product
**Rank among 193 member countries of WHO

ing in the United States from 1998 through 2008 was 3.6 percent, slightly under the median of 3.9 percent among OECD countries.[9] Utilization of healthcare in the United States exceeds other OECD countries with 25 percent of adults taking at least four prescriptions regularly compared to a median of 17 percent among studied countries and United States patients receiving 91 MRI exams per 100,000 population compared to fewer than 50 exams per 100,000 population in the other five reporting countries.[10]

The results of these studies should be a wake-up call to everyone in the United States to strive to improve all aspects of our health system however possible, including education, safety, prevention and clinical care. Other countries have improved their overall health, indicating that we too can do the same.

Methodology

The methodology underlying *America's Health Rankings*® reflects the evolving expectations and role of health in our society and our ability to measure various aspects of health. For each measure the raw data, as obtained from the stated sources and adjusted for age as appropriate, is presented and referred to as "value." For several measures, such as Infant Mortality and Infectious Disease, data from multiple years are combined to provide sufficient sample size to be meaningful.

All age-adjusted data utilizes the population profile for the middle year of data. For example, if the data is from 2006 to 2008, the standard population is set at 2007.

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

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

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

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

The overall score was calculated by adding the scores of each measure multiplied by its weight or the percent of total overall ranking. (Note: Scores reported for individual measures may not add up to the overall scores due to the rounding of numbers.)

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

Overall comparisons to prior years are based upon the relative change in the values of a measure compared to the national average for each measure. The overall result is the weighted sum of these variations. The change between years is the summation of all changes between those years for the components included in the models used for the years of interest.

To calculate the overall change in health, the rate of change in years 1990-1999 was averaged and compared to the average rate of change in 2000-2011. The overall change is based on the slopes of the linear regression fit of these two periods of time.

The 2011 Edition uses the improved methodology introduced in the 2009 Edition to calculate state ranks. Rankings presented in this edition are comparable to rankings published in the 2010 and 2009 Editions, but they are not comparable to the rankings published in the earlier, printed editions. However, all prior rankings, including 1990 through 2008, have been recalculated using the improved method; they are available at www.americashealthrankings.org, and can be compared to the rankings in this print edition. All historical comparisons discussed in this report are to rankings calculated using the improved method.

Weighting of Measures

Three criteria were considered when assigning weights to measures.

1. What effect does a measure have on overall health?
2. Is the effect measured solely by this measure or is it included in other measures?
3. How reliable is the data supporting a measure?

The final weights, presented in Table 8, are based on input from experts in 1990 and 1991, and the Scientific Advisory Committee and its continuing methodological review (page 13). The weights of the measures total 100 percent. Determinants account for 75 percent of the overall ranking and outcomes account for 25 percent, a shift from the 50/50 balance in the original 1990 index. This reflects the importance and growing availability of determinant data. The column labeled "% of Total" indicates the weight of each measure in determining the overall ranking. For example, prevalence of smoking is 7.5 percent of the *America's Health Rankings*®. The column labeled "Effect on Score" presents how each measure positively or negatively relates to the overall ranking. For example, a high prevalence of smoking has a negative effect on score and will lower the ranking of a state. An increase in the percent of high school graduates has a positive effect on score and will increase the overall ranking of a state.

Table 8
Weight of Individual Measures, 2011 Edition

NAME OF MEASURE	% OF TOTAL	EFFECT ON SCORE
DETERMIINANTS		
BEHAVIORS		
Prevalence of Smoking	7.5	Negative
Prevalence of Binge Drinking	5.0	Negative
Prevalence of Obesity	7.5	Negative
COMMUNITY AND ENVIRONMENT		
High School Graduation	5.0	Positive
Violent Crime	5.0	Negative
Occupational Fatalities	2.5	Negative
Infectious Disease	5.0	Negative
Children in Poverty	5.0	Negative
Air Pollution	5.0	Negative
PUBLIC AND HEALTH POLICIES		
Lack of Health Insurance	5.0	Negative
Public Health Funding	2.5	Positive
Immunization Coverage	5.0	Positive
CLINICAL CARE		
Early Prenatal Care	5.0	Positive
Primary Care Physicians	5.0	Positive
Preventable Hospitalizations	5.0	Negative
OUTCOMES		
Diabetes	2.0	Negative
Poor Mental Health Days	2.0	Negative
Poor Physical Health Days	2.0	Negative
Geographic Disparity	5.0	Negative
Infant Mortality	5.0	Negative
Cardiovascular Deaths	2.0	Negative
Cancer Deaths	2.0	Negative
Premature Death	5.0	Negative
OVERALL HEALTH RANKING	100	—

Measures

Selection of Measures

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

1. The overall rankings had to represent a broad range of issues that affect a population's health,
2. Individual measures needed to use common health measurement criteria,
3. Data had to be available at a state level, and
4. Data had to be current and updated periodically.

While not perfect, the measures selected are believed to be the best available indicators of the various aspects of healthiness at this time and are consistent with past reports.

For *America's Health Rankings*® to continue to meet its objectives, it must evolve and incorporate new information as it becomes available. The Scientific Advisory Committee provides guidance for the evolution of the rankings, balancing the need to change with the desire for longitudinal comparability. Over the last few years, change is being driven by: 1) the acknowledgement that health is more than years lived but also includes the quality of those years; 2) data about the quality and cost of health care delivery are becoming available on a comparative basis; and 3) measurement of the additional determinants of health are being initiated and/or improved. The Committee also emphasizes that the real impact on health will be made by addressing the determinants, and making improvements on these items will affect the long-term health of the population. The determinants are the predictors of our future health.

In this edition, diabetes has been changed from a supplemental measure to an outcome measure to account for the impact of treating and managing chronic diseases in the United States.

The definition of infectious disease was also changed from the combined incidence rate of tuberculosis (TB), AIDS and hepatitis A and B to the combined incidence of measles, pertussis, hepatitis A and syphilis. These diseases were chosen to be representative of various modes of transmission. Measles and pertussis are spread by direct contact or airborne droplets from infected individuals. Hepatitis A is spread by the fecal-oral route and outbreaks are often associated with contaminated water or food. Syphilis is spread through sexual contact with an infected person. These new measures are meant to be more indicative of current efforts to control infectious disease since transmission of measles, pertussis and hepatitis A can be reduced with immunizations and other public health efforts and the incidence of syphilis can be reflective of state health efforts in the management and control of sexually transmitted diseases. The previous definition may have been more indicative of the advances in the treatment of HIV and changes in the nature of TB than state public health efforts to control infectious diseases.

As with all indices, the positive and negative aspects of each measure must be weighed when choosing and developing them. These aspects for consideration include: 1) the interdependence of the different measures; 2) the possibility that the overall ranking may disguise the effects of individual measures; 3) an inability to adjust all data by age and race; 4) an over-reliance on mortality data; and 5) the use of indirect measures to estimate some effects on health. These concerns cannot be addressed directly by adjusting the methodology; however, assigning weights to the individual measures can mitigate their impact (on page 28).

Determinants and Outcomes

The 23 measures that comprise *America's Health Rankings*® are of two types — determinants and outcomes. Determinants represent those actions that can affect the future health of the population, whereas outcomes represent what has already occurred, either through death, disease or missed days due to illness.

For further clarity, determinants are divided into four groups: Behaviors, Community and Environment, Public and Health Policies, and Clinical Care. These four groups of measures influence the health outcomes of the population in a state, and improving these inputs will improve outcomes over time. Most measures are actually a combination of activities in all four groups. For example, the prevalence of smoking is a behavior that is strongly influenced by the community and environment in which we live, by public policy including taxation and restrictions on smoking in public places, and by the care received to treat the chemical and behavioral addictions associated with tobacco. However, for simplicity, we placed each measure in a single category.

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

Table 2 (page 17) presents the overall scores for the determinants, outcomes and implications for the future. Table

9 displays the top 10 and bottom 10 states for determinants, while Table 10 depicts the top 10 and bottom 10 states for outcomes.

When compared to other states, Vermont, Connecticut, New Hampshire and Hawaii have a much higher score for determinants than for outcomes, showing a stronger indication they will improve over time. Texas, Nevada, Arkansas and Louisiana show a stronger indication that they will decline over time compared to other states.

Description of Measures

Table 11 summarizes each of the measures, including data source and data year, in this edition of *America's Health Rankings®*. The table includes the core measures included in the current model plus supplemental measures that can be used to further understand each state's unique situation.

A short discussion of each measure immediately follows. The data for each year are the most current data available at the time the report was compiled.

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

Table 9
2011 Determinants — Highest and Lowest Ranked States

RANK	STATE	RANK	STATE
1	Vermont	50	Louisiana
2	Connecticut	49	Texas
3	New Hampshire	48	Mississippi
4	Hawaii	47	Oklahoma
5	Massachusetts	46	Arkansas
6	Utah	45	Nevada
7	Minnesota	44	South Carolina
8	Maine	43	Alabama
9	Rhode Island	42	Kentucky
10	Colorado	41	Indiana

Table 10
2011 Outcomes — Highest and Lowest Ranked States

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

Table 11
Summary Description of Measures, 2011 Edition

CORE MEASURES

DETERMINANTS	DESCRIPTION	SOURCE	DATA YEAR(S)
BEHAVIORS			
Smoking	Percentage of population over age 18 that smokes on a regular basis.	CDC BRFSS	2010
Binge Drinking	Percentage of population over age 18 that drank excessively in the last 30 days.	CDC BRFSS	2009 - 2010
Obesity	Percentage of the population estimated to be obese, with a body mass index (BMI) of 30.0 or higher.	CDC BRFSS	2010
High School Graduation	Percentage of incoming ninth graders who graduate in four years from a high school with a regular degree.	NCES	2007 - 2008 school year
COMMUNITY AND ENVIRONMENT			
Violent Crime	The number of murders, rapes, robberies and aggravated assaults per 100,000 population.	FBI	2010
Occupational Fatalities	Number of fatalities from occupational injuries per 100,000 workers.	CFOI BLS	2008 - prelim 2010
Infectious Disease	Number of reported measles, pertussis, syphilis and hepatitis A cases per 100,000 population.	CDC MMWR	2008 - 2009
Children in Poverty	The percentage of persons under age 18 who live in households at or below the poverty threshold.	CPS, Census Bureau	2010
Air Pollution	The average exposure of the general public to particulate matter of 2.5 microns or less in size (PM2.5).	EPA, Census Bureau	2008-2010
PUBLIC AND HEALTH POLICIES			
Lack of Health Insurance	Percentage of the population that does not have health insurance privately, through their employer or the government.	CPS, Census Bureau	2009 - 2010
Public Health Funding	State funding dedicated to public health as well as federal funding directed to states by the CDC and the Health Resources and Services Administration.	TFAH	2009 - 2010
Immunization Coverage	The average percentage of children ages 19 to 35 months who have received these individual vaccinations: four or more doses of DTP, three or more doses of poliovirus vaccine, one or more doses of any measles-containing vaccine, and three or more doses of HepB vaccine.	CDC NIP	2010
CLINICAL CARE			
Early Prenatal Care	Percentage of pregnant women receiving prenatal care during the first trimester.	CDC NCHS	2008
Primary Care Physicians	Number of primary care physicians (including general practice, family practice, OB-GYN, pediatrics and internal medicine) per 100,000 population.	AMA	2009
Preventable Hospitalizations	Discharge rate among the Medicare population for diagnoses that are amenable to non-hospital based care.	Dartmouth Atlas	2009

OUTCOMES	DESCRIPTION	SOURCE	DATA YEAR(S)
Diabetes	Percentage of adults who have been told by a health professional that they had diabetes (does not include pre-diabetes or diabetes during pregnancy).	CDC BRFSS	2010
Poor Mental Health Days	Number of days in the previous 30 days when a person indicates their activities are limited due to mental health difficulties.	CDC BRFSS	2010
Poor Physical Health Days	Number of days in the previous 30 days when a person indicates their activities are limited due to physical health difficulties.	CDC BRFSS	2010
Geographic Disparity	The variation in overall mortality rates among the counties within a state.	CDC NCHS	2005 - 2007
Infant Mortality	Number of infant deaths (before age 1) per 1,000 live births.	CDC NCHS	2007 - 2008
Cardiovascular Deaths	Number of deaths due to all cardiovascular diseases, including heart disease and strokes, per 100,000 population.	CDC NCHS	2006 - 2008
Cancer Deaths	Number of deaths due to all causes of cancer per 100,000 population.	CDC NCHS	2006 - 2008
Premature Death	Number of years of potential life lost prior to age 75 per 100,000 population.	CDC NCH	2008

SUPPLEMENTAL MEASURES

(www.americashealthrankings.org/defn)

DETERMINANTS	DESCRIPTION	SOURCE	DATA YEAR(S)
Cholesterol Check	Percentage of adults who have had their blood cholesterol checked within the last five years.	CDC BRFSS	2009
Dental Visit, Annual	Percentage of adults who have visited the dentist or dental clinic within the past year for any reason.	CDC BRFSS	2010
Physical Activity	Percentage of adults who, during the past month, participated in any physical activities.	CDC BRFSS	2010
Diet, Fruit & Vegetables	Percentage of adults who consume five or more servings of vegetables and fruit a day.	CDC BRFSS	2010
Teen Birth Rate	The number of births per 1,000 mothers age 15 to 19.	CDC NVSR	2008
CHRONIC DISEASE			
Cardiac Heart Disease	Percentage of adults who have been told by a health professional that they had angina or coronary heart disease.	CDC BRFSS	2010
High Cholesterol	Percentage of adults who have had their cholesterol checked and been told that it was high.	CDC BRFSS	2009
Heart Attack	Percentage of adults who have been told by a health professional that they had a heart attack (myocardial infarction).	CDC BRFSS	2010
Stroke	Percentage of adults who have been told by a health professional that they had a stroke.	CDC BRFSS	2010
Hypertension	Percentage of adults who have been told by a health professional that they had high blood pressure.	CDC BRFSS	2009
CLINICAL CARE			
Preterm Birth	Percentage of babies born before 37 weeks gestation.	CDC NCHS	2008
Low Birthweight	Percentage of babies weighing less than 2500 grams (5 pounds, 8 ounces) at birth.	CDC NCHS	2008
ECONOMIC			
Personal Income	Per capita personal income in current dollars.	U.S. Bureau of Economic Analysis	2010
Unemployment Rate	Total unemployed as a percent of the civilian labor force (U-3 definition).	U.S. Bureau of Labor Statistics	2010
Underemployment Rate	Total unemployed, plus all marginally attached workers, plus total employed part time for economic reasons, as a percent of the civilian labor force plus all marginally attached workers (U-6 Definition)	U.S. Bureau of Labor Statistics	2010
Income Disparity (Gini coefficient)	A common measure of income inequality.	U.S. Census	2010

Health Determinants

BEHAVIORS

Four measures reflect behaviors that are potentially modifiable through a combination of personal, community and clinical interventions: smoking, obesity, binge drinking and high school graduation. These items are determinants that measure behaviors and activities having an immediate or delayed effect on health and are prominently included in these rankings.

However, the selection of these four does not imply that they are the only underlying behaviors that need to be addressed in a comprehensive public health effort. For example, the American Academy of Family Physicians suggests that to improve health, individuals should:

- Avoid any form of tobacco.
- Eat a healthy diet.
- Exercise regularly.
- Drink alcohol in moderation, if at all.
- Avoid use of illegal drugs.
- Practice safe sex.
- Use seat belts (and car seats for children) when riding in a car or truck.
- Avoid sunbathing and tanning booths.
- Keep immunizations up-to-date.
- See a doctor regularly for preventive care.

Additional suggestions for individual initiatives are in Healthy People 2020, published by the U.S. Department of Health and Human Services, Washington, D.C., available at http://www.healthypeople.gov.

The impact of changing behaviors is huge. CDC estimates that if tobacco use, poor diet and physical inactivity were eliminated, 80 percent of heart disease and stroke, 80 percent of Type 2 diabetes and 40 percent of cancer would be prevented.[11] Smoking and secondhand smoke are estimated to cause 443,000 deaths annually. Further, it is estimated that 25 million Americans who are alive today will die prematurely from smoking-related illnesses.[12]

Smoking measures the percent of the population over age 18 who smoke tobacco products regularly. It is defined as the percentage of adults who self-report smoking at least 100 cigarettes and currently smoke regularly. The 2011 ranks, based on self-report data from CDC's 2010 Behavioral Risk Factor Surveillance System (BRFSS), are at www.americashealthrankings.org/ALL/smoking.

The prevalence of smoking in the population has an adverse impact on overall health by causing increased cases of respiratory diseases, heart disease, stroke, cancer, preterm birth, low birth weight and premature death (http://www.cdc.gov/tobacco/). Tobacco use is estimated to be responsible for about one in five deaths annually, or about 443,000 deaths per year.[13] It is a lifestyle behavior that an individual can directly influence with support from the community and, as required, clinical intervention. It is an indication of known, addictive, health-adverse behavior within the population.

The national average is 17.3 percent of adults, down 0.6 percent from last year. The proportion of the population who smoke varies from a low of 9.1 percent in Utah to more than 26.8 percent in West Virginia. Due to the limits of the BRFSS, caution must be used in comparing changes in prevalence of smoking in states with small populations.

Binge Drinking measures the percentage of the population over age 18 that drank excessively in the last 30 days. It is defined as males having five or more drinks and females having four or more drinks on one occasion. The 2011 ranks, based on 2009 and 2010 BRFSS self-report data, are at www.americashealthrankings.org/ALL/bingedrinking. Binge Drinking is measured over a two-year span to increase the reliability of estimates and to allow better state-to-state comparisons.

Binge drinking has an adverse effect on health due to the impact of excessive alcohol on increased motor vehicle injuries and deaths, increased aggression, unintentional injury, fetal damage and liver diseases along with other health risks (http://www.cdc.gov/alcohol/). It is a proxy indicator for excessive drug and alcohol use within a population.

The prevalence of binge drinking varies from less than 10 percent in Tennessee, Utah and West Virginia to more than 20 percent in North Dakota and Wisconsin. The national average is 15.5 percent of adults who binge drink and has varied from 14.3 percent to 16.4 percent of adults over the last 14 years.

11. Mensah, George A., Associate Director for Medical Affairs, CDC "Global and Domestic Health Priorities: Spotlight on Chronic Disease", National Business Group on Health Webinar, May 23, 2006.
12. Centers for Disease Control, http://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/tobacco_related_mortality/index.htm, accessed Oct 30, 2011.
13. Centers for Disease Control and Prevention. Smoking-Attributable Mortality, Years of Potential Life Lost, and Productivity Losses—United States, 2000–2004. Morbidity and Mortality Weekly Report [serial online]. 2008;57(45):1226–1228.

Table 12
Top Improvements in Smoking (Percent of population who have stopped smoking)

LAST YEAR		SINCE 2006 EDITION		SINCE 2001 EDITION		SINCE 1990 EDITION	
STATE	CHANGE	STATE	CHANGE	STATE	CHANGE	STATE	CHANGE
Oregon	-2.8%	Arizona	-6.7%	New Hampshire	-8.4%	Rhode Island	-18.7%
Arizona	-2.6%	Tennessee	-6.6%	Nevada and Rhode Island (tie)	-7.7%	Connecticut	-16.4%
New York	-2.5%	Indiana	-6.1%	Iowa	-7.1%	Arizona	-16.0%
Connecticut	-2.2%	Pennsylvania	-5.2%	Connecticut	-6.7%	Vermont	-15.3%
South Dakota and Texas (tie)	-2.1%	Minnesota	-5.1%	Idaho and New Jersey (tie)	-6.6%	Michigan	-15.1%

Table 13
Least Increase in Obesity (Percent of population who have changed status)

LAST YEAR		SINCE 2006 EDITION		SINCE 2001 EDITION		SINCE 1990 EDITION	
Nevada	-3.3%	Alaska	-2.2%	Utah	+3.9%	Nevada	+10.6%
South Dakota	-2.6%	Louisiana	+0.9%	Alaska	+4.2%	Connecticut	+11.3%
Wisconsin	-2.3%	Virginia	+1.3%	California	+4.8%	Alaska	+11.8%
Louisiana	-2.2%	Nebraska and Wyoming (tie)	+1.5%	Nevada	+5.2%	Wyoming	+12.0%

*A negative number indicates a decrease in obesity rates

Obesity is the percentage of the adult population estimated to be obese, defined as having a body mass index (BMI) of 30.0 or higher. BMI, as defined by CDC, is equal to your weight in pounds divided by your height in inches squared and then multiplied by 703. CDC has a calculator for BMI at www.cdc.gov/healthyweight/assessing/bmi/. The 2011 ranks, based on self-reported weight and height from CDC's 2010 BRFSS data, are at www.americashealthrankings.org/ALL/obesity.

Obesity is known to contribute to a variety of diseases, including heart disease, diabetes, stroke, certain cancers and general poor health (http://www.cdc.gov/obesity/). The medical care costs for treating obesity and obesity-related health issues are overwhelming (http://www.cdc.gov/obesity/causes/economics.html). In 2008, it was estimated that $147 billion dollars was spent on obesity-related direct and indirect medical care costs.[14]

In the United States, 27.5 percent of the adult population are obese, up from 26.9 percent of the population in the 2010 Edition, 24.4 percent in the 2006 Edition, 20.0 percent in the 2001 Edition and substantially more than double the rate of 11.6 percent of the population in the 1990 Edition. This means that more than one-in-four are obese in the United States — that is almost 65 million adults with a body mass index of 30.0 or higher. If the population of the United States could return to the weight status of 1990, there would be more than 37 million fewer obese individuals — more than the entire population of the most populous U.S. state, California.

This is the first time in the Report's 22 year history that not a single state has a prevalence of obesity less than 20.0 percent.The prevalence of obesity ranges from 21.4 percent of the population in Colorado to over one-third of the population in Mississippi. Twenty-three states held or decreased the prevalence of obesity in the last year. Oregon reported the largest increase — an additional four percent of the population is now obese.

High School Graduation estimates the percentage of incoming ninth graders who graduate within four years and are considered regular graduates. The National Center for Education Statistics collects enrollment and completion data and estimates the graduation rate for each state. The rate is the number of graduates divided by the estimated count of freshmen four years earlier. This estimated count of freshmen is the sum of the number of 8th graders five years earlier, the number of 9th graders four years earlier and the number of 10th graders three years earlier divided by three. Enrollment counts also include a proportional distribution of students not enrolled in a specific grade. The 2011 ranks, based on 2007 to 2008 school year data are at www.americashealthrankings.org/ALL/graduation.

Education is a vital contributor to health as consumers must be able to learn about, create and maintain a healthy lifestyle, and understand and participate in their options for care.

The rate varies from over 89 percent of incoming ninth graders who graduate within four years in Wisconsin and Vermont to less than 60 percent in Nevada. The national average is 74.7 percent, compared to 73.9 percent in the 2010 Edition.

Data are not adjusted for the presence or quality of basic health and consumer health education in the curriculum, for continuing education programs nor for other non-traditional learning programs. Also, individual states are increasingly altering graduation requirements, which may affect their reported number of regular graduates, their graduation rate and the comparability of these rates across time.

Table 14
Top Improvements in High School Graduation (Increase in percentage of ninth graders who graduate within four years)

LAST YEAR		SINCE 2006 EDITION	
STATE	CHANGE	STATE	CHANGE
New Mexico	+7.7%	Tennessee	+11.5%
Nevada	+4.3%	New York	+10.0%
North Carolina	+4.2%	Massachusetts	+5.8%
South Carolina	+3.3%	Vermont	+5.7%
Oregon	+2.9%	New Hampshire	+5.1%

14. Finkelstein, EA, Trogdon, JG, Cohen, JW, and Dietz, W. Annual medical spending attributable to obesity: Payer- and service-specific estimates. Health Affairs 2009; 28(5): w822-w831.

COMMUNITY AND ENVIRONMENT

Five measures are used to represent the community and the environment: the violent crime rate, the occupational fatalities rate, the percentage of children in poverty, the incidence of infectious disease and exposure to air pollution. Measures of community and environment reflect the reality that the daily conditions in which we live our lives have a great effect on achieving optimal individual health. The presence of pollution, violence, illegal drugs, infectious disease and unsafe workplaces are detrimental. In addition, studies indicate that the general socio-economic conditions and the level of education have a significant relationship to the healthiness of a community's residents.

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

Violent Crime measures the annual number of murders, rapes, robberies and aggravated assaults per 100,000 population. The 2011 ranks, based on 2010 data (Crime in the United States: 2010. Washington, D.C., Federal Bureau of Investigation), are at www.americashealthrankings.org/ALL/crime.

The violent crime rate measures the effect criminal behavior has on the population's health, as it reflects an aspect of current U.S. lifestyle and is an indicator of health risk and death. The violent crime rate is dependent upon many factors, not just population; thus when taking action to combat crime, each state must consider its specific circumstances.

The violent crime rate varies from less than 200 offenses per 100,000 population in Maine, Vermont, New Hampshire and Wyoming to more than 600 offenses per 100,000 population in Nevada, Alaska, Delaware and Tennessee. The national average is 404 offenses per 100,000 population, down 25 offenses per 100,000 population from the prior year and down 205 offenses per 100,000 population from the 1990 Edition. Crime peaked in 1993 and 1994 at 758 offenses per 100,000 population and has since dropped by 47 percent.

Occupational Fatalities measures the combined rate of fatal injuries in the following industries: construction, manufacturing, trade, transportation, utilities, professional, and business services, as defined by the North American Industry Classification System (NAICS). Rather than using an occupational fatality rate for all workers, this industry-adjusted rate is used to account for the different industry mixes in each state in order to accurately reflect the safety differences between the states. Occupational fatalities are measured over a three-year span because of their low incidence rate. In states where occupational fatality data is not available for a specific industry, the national rate for that industry was used to calculate the state's occupational fatality rate. The 2011 ranks, based on 2008 to preliminary 2010 occupational fatality data (Census of Fatal Occupational Injuries, Bureau of Labor Statistics, U.S. Department of Labor, Washington, D.C.), are at www.americashealthrankings.org/ALL/Occupational_Fatal. The industry population data used to calculate rates was based on 2010 data collected from the Bureau of Economic Analysis.

Occupational fatalities represent the impact of hazardous jobs on the population. Occupational injuries would be a preferred measure; however, there is not a uniform reporting system used by all 50 states.

Scores vary from 2.5 deaths per 100,000 workers in Minnesota and Massachusetts to over 10 deaths per 100,000 workers in Alaska. The national rate is 4.0 deaths per 100,000 workers, down from 4.4 deaths per 100,000 workers in the 2010 Edition.

Children in Poverty measures the percentage of related persons under age 18 living in a household that is below the poverty threshold. The poverty threshold established by the U.S. Census Bureau for a household of four people which includes two children living in the lower 48 states is approximately $22,113 in household income. The 2011 ranks, based on 2010 data (Current Population Survey, 2011 Annual Social and Economic Supplement. Washington, D.C., U.S. Census Bureau), are at www.americashealthrankings.org/ALL/ChildPov.

Children living in poverty are challenged by lack of access to health care, limited availability of healthy foods, constrained choices for physical activity, limited access to appropriate educational opportunities and stressful living conditions.

The percentage of children in poverty ranged from 6.2 percent of persons under age 18 in New Hampshire to a high

Table 15
Greatest Decreases in Violent Crime (Change in number of offenses per 100,000 population)

LAST YEAR		SINCE 2006 EDITION		SINCE 2001 EDITION		SINCE 1990 EDITION	
STATE	CHANGE	STATE	CHANGE	STATE	CHANGE	STATE	CHANGE
South Carolina	-73	South Carolina	-170	Florida	-312	New York	-615
Alabama	-72	Florida	-167	Illinois	-297	Florida	-482
Louisiana	-71	Maryland	-157	South Carolina	-249	California	-477
Florida	-70	Tennessee	-144	New Mexico	-246	Illinois	-360

of more than 30 percent in Mississippi and Louisiana. The national average is 21.5 percent, an increase from 20.7 percent of children in the 2010 Edition and up 5.7 percent of children from the low of 15.8 percent of persons under age 18 reported in the 2002 Edition. That is a 36 percent increase in childhood poverty in the last ten years and is higher than the 20.6 percent reported in the 1990 Edition.

Infectious Disease measures the combined incidence of measles, pertussis, hepatitis A and syphilis per 100,000 population. Two-year averages are used to calculate the incidence rates. This is a change from the previous editions, where infectious disease was defined as the combined incidence of AIDS, TB and hepatitis A and B, and three-year averages were used. More information on this definition shift is available on pages 13 and 30. Historical data has been adjusted to fit the new definition in order to allow for comparisons, however the infectious disease rate in this edition is not comparable to infectious disease rates in previous year's print editions. The 2011 ranks, based on 2008 and 2009 data (Mortality and Morbidity Weekly Reports, Centers for Disease Control and Prevention), are at www.americas healthrankings.org/ALL/infectious diseases.

The incidence of infectious disease is an indication of the toll that infectious disease is placing on the population. Transmission of infectious diseases can often be prevented and controlled through various approaches, including immunization programs, proper handwashing, use of safe cooking practices and other public health programs.

The incidence of infectious disease per 100,000 population varies from a reported low of less than four cases per 100,000 population in West Virginia, Vermont and Connecticut to a reported high of more than 20 cases in Minnesota and Alaska. The national average is 10.3 cases per 100,000 population, down from 11.4 cases per 100,000 population in 2010.

Air Pollution measures the fine particulates in the air we breathe. It is the population-weighted average exposure to particulates 2.5 micron and smaller for each county reporting within a state. Air pollution is monitored in many counties where population density is significant and/or where there have been pollution concerns in prior years. Population weighting of the county data adjusts the information to reflect the actual number of people potentially exposed to the particulate. In counties where pollution data is not available, the population was assumed to be exposed to the background level of particulate in the air quality control region and/or state. Background levels are estimated to be the average of the lowest measures in each region or state for each of the last three years. The 2011 ranks, based on 2008 to 2010 data (U.S. Environmental Protection Agency, Washington, D.C. and the U.S. Census Bureau, Washington, D.C.), are at www.americashealthrankings.org/ALL/PM25.

Health studies have shown a significant association between exposure to fine particles and premature death from heart or lung disease. Other adverse effects on health from air pollution include decreased lung function, aggravated asthma, development of chronic bronchitis, irregular heartbeat, and nonfatal heart attacks. See www.epa.gov/air/particlepollution/health.html for more information.

Air pollution varies from a low of 5.2 micrograms of fine particulate per cubic meter in Wyoming to 15.1 micrograms of fine particulate per cubic meter in California. The national average is 10.8 micrograms of fine particulate per cubic meter, down slightly from 11.4 micrograms in the 2010 Edition and 12.5 micrograms in 2006.

PUBLIC AND HEALTH POLICIES

Three measures are used to represent public and health policies and programs: Public Health Funding, Immunization Coverage and Lack of Health Insurance. These measures are indicative of the availability of resources and the extent of the program's reach to the public.

Table 16
Greatest Decreases in Children in Poverty (Change in the percentage of children in poverty)

LAST YEAR		SINCE 2006 EDITION		SINCE 2001 EDITION		SINCE 1990 EDITION	
STATE	CHANGE	STATE	CHANGE	STATE	CHANGE	STATE	CHANGE
New Hampshire	-4.3	Iowa	-2.0	Arkansas and Montana (tie)	-5.5	Louisiana	-8.0
Massachusetts	-4.1	Wyoming	-1.7	Vermont and Wyoming (tie)	-2.6	West Virginia	-7.5
Arizona	-4.0	Connecticut and West Virginia (tie)	-1.1	New Hampshire	-1.5	Minnesota	-7.3

Table 17
Greatest Increases in Children in Poverty (Change in the percentage of children in poverty)

LAST YEAR		SINCE 2006 EDITION		SINCE 2001 EDITION		SINCE 1990 EDITION	
STATE	CHANGE	STATE	CHANGE	STATE	CHANGE	STATE	CHANGE
Louisiana	+11.0	Nevada	+10.2	Mississippi	+17.3	Nevada	+9.0
South Carolina	+8.1	North Carolina	+9.3	Indiana	+14.7	Delaware	+8.9
Nevada	+5.7	Hawaii	+8.9	Nevada	+11.7	Kansas and Oregon (tie)	+8.8

Every state has many excellent and effective public health programs, too numerous and individualized to list, that contribute to the overall health of the population but are not explicitly included in these rankings. Contact your state public health officials to obtain additional information about programs in your state that are enacted to optimize individual and community health. Each state's health department website is listed on the corresponding state snapshot. Individuals can also see the spectrum of options available to states and communities by visiting www.thecommunityguide.org, a website that provides a systemic review of programs and evidence-based recommendations for health and community officials.

Lack of Health Insurance measures the percentage of the population not covered by private or public health insurance. The 2011 ranks, based on 2009 and 2010 data (Current Population Survey, 2011 Annual Social and Economic Supplements, Washington, D.C., U.S. Census Bureau), are at www.americashealthrankings.org/ALL/healthinsurance.

Individuals without health insurance have greater difficulty accessing the health care system, frequently are not able to participate in preventive care programs, and can add substantially to the cost of health care due to delayed care and emergency department treatment.

The rate of uninsured population ranges from 5.0 percent in Massachusetts to 25.0 percent in Texas. The national average is 16.2 percent (over 50 million people) uninsured. If the United States as a whole could emulate the best state, the number of uninsured would decrease by over 35 million people.

Public Health Funding measures the dollars per person that are spent on public or population health through funding from the CDC, Health Resources Services Administration and the state. This does not include spending from other sources such as county or city governments nor does it include state spending for health that is included under other departmental spending such as education and transportation. The 2011 ranks, based on 2009 and 2010 data (Trust for America's Health, Washington, D.C.) are at www.americashealthrankings.org/ALL/PH_Spending.

High spending on public health programs are indicative of states that are proactively implementing preventive and education programs targeted at improving the health of at-risk populations within a state. Recent research has shown that an investment of $10 per person per year in proven community-based programs to increase physical activity, improve nutrition, and prevent smoking and other tobacco use could save the country more than $16 billion annually within five years. This is a return of $5.60 for every $1 invested (http://healthyamericans.org/reports/prevention08/).

Public health funding ranges from $150 or more per person in Vermont, Alaska and Hawaii to $40 per person in Wisconsin. The average funding in the United States is $95 per person, a slight increase from $94 in last year's edition.

Immunization Coverage is the average of the percentage of children ages 19 to 35 months who have received the following vaccines: Diphtheria, Tetanus, Pertussis (DTP), Poliovirus, Meningococcal conjugate vaccine (MCV) and Hepatitis B Vaccine (HepB). This measure was changed in the 2010 Edition due to the effects of a shortage of the Haemophilus Influenzae type b (Hib) vaccine, new vaccine products and a temporary recommendation on HiB vaccinations. This measure does not account for each individual receiving the full series of shots, but rather, individuals receiving individual shots. This caused immunization numbers to be higher than the previous definition used for Immunization Coverage. The 2011 ranks, based on 2010 data (National Immunization Program, Centers for Disease Control and Prevention), are at www.americashealthrankings.org/ALL/immunize.

Early childhood immunization has been shown to be a safe and cost-effective manner of controlling diseases within the population. The Guide to Community Preventive Services has numerous proven methods to increase the rate of vaccinations in a community and includes ways to increase the demand in the community, improve access and system-based or provider-based innovations. See their suggestions at http://www.thecommunityguide.org/vaccines/.

Immunization coverage ranges from over 95 percent of children ages 19 to 35 months in New Hampshire and Connecticut to less than 85 percent in Nevada and Montana. In the United States, the average immunization coverage is 90 percent of children ages 19 to 35 months, essentially the same coverage as last year and five years ago.

Table 18
Greatest Decreases in Lack of Health Insurance
(Change in percentage of people insured)

LAST YEAR		SINCE 2006 EDITION	
STATE	CHANGE	STATE	CHANGE
Colorado	-1.8%	Massachusetts	-5.3%
New Mexico	-1.4%	West Virginia	-2.9%
Alaska	-1.2%	Colorado	-2.5%

CLINICAL CARE

Preventive and curative care must be delivered in an effective, appropriate and timely manner. Three measures are included in this section: Early Prenatal Care, Primary Care Physicians and Preventable Hospitalizations. Prenatal care, in one form or another, has been included since the 1990 Edition and Primary Care Physicians and Preventable Hospitalizations were added in the 2007 Edition.

Early Prenatal Care is the percentage of pregnant women who receive care within the first trimester of pregnancy and was revised in the 2010 Edition. Early prenatal care is derived directly from the birth certificate. In 2003, CDC's National Center for Health Statistics (NCHS) introduced a revised live birth certificate, however implementation

of the new certificate has not occurred across all 50 states. Because states are using different versions of the birth certificate, a state-to-state direct comparison of prenatal care measures cannot be made, and a national average cannot be calculated. Therefore, the prenatal care measure only compares one state to another state using the same birth certificate and their scores are calculated based upon their peer group. Early prenatal care is not adjusted for frequency of care, continuation of care, age or race. The 2011 ranks, based on 2008 data (National Center for Health Statistics at http://205.207.175.93/VitalStats/ReportFolders/reportFolders.aspx), are at www.americashealthrankings.org/ALL/prenatalcare.

Prior to the 2010 Edition, a broader definition of prenatal care was used that included frequency and timeliness of prenatal care throughout the pregnancy. The 1990 through 2004 Editions of the report defined Prenatal Care using the Kessner Index and 2005 through 2009 Editions used the Kotelchuck (APCNU) index.

Prenatal care measures how early women are receiving the care they require for a healthy pregnancy and development of the fetus. Mothers who do not receive prenatal care are three times more likely to deliver a low birth weight baby than mothers who received prenatal care, and babies are five times more likely to die without the care (http://mchb.hrsa.gov/programs/womeninfants/prenatal.html). Early prenatal care allows health care providers to identify and address health conditions and behaviors that may reduce the likelihood of a healthy birth, such as smoking and drug and alcohol abuse.

Primary Care Physicians is a measure of access to primary care for the general population as measured by number of primary care physicians per 100,000 population. Primary care physicians include all those who identify themselves as Family Practice physicians, General Practitioners, Internists, Pediatricians, Obstetricians or Gynecologists. The 2011 ranks, based on 2009 data (American Medical Association, Physician Characteristics and Distribution in the United States, 2011 Edition, Chicago, Ill. Data used with permission), are at www.americashealthrankings.org/ALL/PCP.

Primary care physicians provide a combination of direct care to the patient and, as necessary, counsel the patient in the appropriate use of specialists and advance treatment locations. This measure reflects the availability of physicians to assist the population with preventative and regular care. The number of primary care physicians per 100,000 population will change because of changing state population, physician retirements, new physicians, and physicians moving between states and specialties.

Primary care physicians range from 192 physicians per 100,000 population in Massachusetts to 78 physicians per 100,000 in Idaho. The national average is 121 primary care physicians per 100,000 population, essentially unchanged in the last few years.

Preventable Hospitalizations is a measure of the discharge rate from hospitals for ambulatory care-sensitive conditions. Ambulatory care–sensitive conditions are those "for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.[15]" It is not adjusted by characteristics of the population served, such as age or health status. The 2011 ranks, based on 2009 data (The Dartmouth Atlas of Health Care, The Dartmouth Institute for Health Policy and Clinic Practice, Lebanon, N.H.), are at www.americashealthrankings.org/ALL/PrevHosp.

Preventable hospitalizations reflect how well a population uses the various delivery options for necessary care. These hospitalizations can often be reduced by strong outpatient care systems and include conditions such as adult asthma, bacterial pneumonia, congestive heart failure, chronic obstructive pulmonary disease, diabetes, low birth weight, and urinary tract infections. These discharges are also highly correlated with general admissions and reflect the tendency for a population to overuse the hospital setting as a site for care.

The rate of preventable hospitalizations ranges from a low of under 40 discharges per 1,000 Medicare enrollees in Hawaii and Utah to over 100 discharges per 1,000 Medicare enrollees in West Virginia and Kentucky. The national average is 68.2 discharges per 1,000 Medicare enrollees, down from 70.6 discharges last year and 82.5 in the 2001 Edition.

HEALTH OUTCOMES

Health outcomes include the prevalence of adults with diabetes, mortality rates, the disparity among outcomes in a state and the quality of life. These measures represent the burden placed on the overall health of a population by chronic disease, death, disparity and depressed quality of life. Measures range from counting days in which people feel their normal activities are limited due to poor health to disease-specific mortality and years of potential life lost.

Outcomes are traditionally measured using mortality measures which include premature death, infant mortality, cancer and cardiovascular mortality. While these measures overlap significantly, they do present different views of mortality outcomes of a population. Two measures of the quality of life — poor mental health days and poor physical health days — are also included and defined as the number of days in the previous 30 days when a person indicates their activities are limited due to mental or physical health difficulties. Disparity in health outcomes is now explicitly captured in the Geographic Disparity measure.

Diabetes is the percentage of adults who have been told by a health professional that they have diabetes, excluding pre-diabetes and gestational diabetes. Diabetes was changed in this edition from a supplemental measure to an outcome measure to account for the impact of treating and managing chronic diseases in the U.S. The 2011 ranks, based on self-report data from CDC's 2010 BRFSS data, are at www.americashealthrankings.org/ALL/diabetes.

15. Agency for Healthcare Research and Quality, http://www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx accessed Nov 9, 2011.

Diabetes is a long-term illness that is managed through lifestyle changes and healthcare interventions. It is a major cause of heart disease and stroke, the leading cause of kidney failure, non-traumatic lower-limb amputations, and new blindness in adults. It is also the 7th leading cause of death in the United States.[16]

Studies have indicated that the onset of type 2 diabetes can be prevented through weight loss, increased physical activity and improved dietary choices. The National Diabetes Prevention Program was created to bring evidence-based interventions to prevent diabetes to communities across the country. More information on prevention is available at http://www.cdc.gov/diabetes/projects/prevention_program.htm. Additional diabetes information is available at the National Center for Chronic Disease Prevention and Health Promotion, CDC (http://www.cdc.gov/diabetes/ and http://www.cdc.gov/chronicdisease/publications/AAG/ddt.htm) and the American Diabetes Association (http://www.diabetes.org/).

The percent of adults with diabetes ranges from over 12 percent of the population in Mississippi and Alabama to 5.3 percent in Alaska. The national average is 8.7 percent, up from 7.3 percent in the 2006 Edition.

Poor Mental Health Days is the average number of days in the previous 30 days that a person could not perform work or household tasks due to mental illness. The self-reported data relies on the accuracy of each respondent's estimate of the number of limited activity days in the previous 30 days. The 2011 ranks, based on 2010 data (Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention), are at www.americashealthrankings.org/ALL/MentalHealth.

Poor mental health days are a general indication of the population's ability to function on a day-to-day basis. It highlights the impact on overall health that occurs when mental health prohibits an individual from accomplishing everyday activities.

The number of poor mental health days in the previous 30 days ranges from an average of 2.3 days in South Dakota to 4.5 days in West Virginia. The average number of poor mental health days in the previous 30 days for the United States is 3.5 days, essentially unchanged from prior editions.

Poor Physical Health Days is the average number of days in the previous 30 days that a person could not perform work or household tasks due to physical illness. The self-reported data relies on the accuracy of each respondent's estimate of the number of limited activity days in the previous 30 days. The 2011 ranks, based on 2010 data (Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention), are at www.americashealthrankings.org/ALL/PhysicalHealth.

Poor physical health days are another general indication of the population's ability to function on a day-to-day basis. When physical health prohibits an individual from accomplishing everyday activities, overall health is influenced.

The number of poor physical health days in the previous 30 days ranges from an average of 2.6 days in Minnesota and South Dakota to over 4.9 days in West Virginia. The average number of poor physical health days in the previous 30 days for the United States is 3.7 days and has remained essentially unchanged for the last seven years.

Geographic Disparity measures the variation in the age-adjusted mortality rate among counties within a state. It is the standard deviation of the three-year average, age-adjusted all-cause mortality rate for all counties within a state divided by the three-year age-adjusted all-cause mortality rate for the state. The lower the percent, the closer each county is to the state average and the more uniform the mortality rate is across the state. For counties with fewer than 20 deaths in the three-year period (about 20 to 30 counties in the United States each year), the county was assumed to have an age-adjusted death rate equal to the state's age-adjusted death rate and thus has no effect on the geographic disparity of the state. Geographic Disparity was a new measure in the 2008 Edition. The 2011 ranks, based on 2005 to 2007 data (National Center for Health Statistics. Centers for Disease Control and Prevention), are at www.americashealthrankings.org/ALL/disparity.

Ideally, health and mortality should be equal among the populations of every county within a state and not vary based upon the physical location where a person lives. Many factors differ among counties, including natural features such as altitude, latitude, moisture and temperature and man-made features such as land use, population density,

16. Heron M. "Deaths: Leading causes for 2007." National vital statistics reports; vol 59, no 8. Hyattsville, MD: National Center for Health Statistics. 2011.

Table 19
Least Increase in Diabetes (Percent of population who report being told they have diabetes)

LAST YEAR		SINCE 2006 EDITION		SINCE 2001 EDITION		SINCE 1990 EDITION	
STATE	CHANGE	STATE	CHANGE	STATE	CHANGE	STATE	CHANGE
Kentucky	-1.5%	Delaware	+0.1%	Colorado	+0.9%	Alaska	+5.3%
Wisconsin	-1.1%	Nebraska and South Carolina (tie)	+0.4%	Wisconsin	+1.0%	Colorado	+6.0%
Oregon	-1.0%	Oregon, South Dakota and Wisconsin (tie)	+0.5%			Utah	+6.5%

*A negative number indicates a decrease in obesity rates

roads and communications. Regardless of these variations, the mortality rate should still be comparable. This measure indicates how equal the outcomes are across the state.

Geographic disparity varies from a low geographic disparity of less than 5 percent in Delaware and Vermont to a high geographic disparity of more than 25 percent in South Dakota. For the United States as a whole, the geographic disparity among all counties is 17.2 percent, essentially stabilizing after a consistently upward trend between the 2004 to the 2008 Editions.

Infant Mortality measures the number of infant deaths that occur before age 1 per 1,000 live births. The 2011 ranks, based on a two-year average using 2007 and 2008 data (National Center for Health Statistics, Washington, D.C.), are at www.americashealthrankings.org/ALL/IMR.

Infant mortality is associated with many factors surrounding birth, including but not limited to: maternal health, prenatal care, and access to quality healthcare. The nation's overall infant mortality rate is consistently higher than other developing countries and significant racial and ethnic disparities exist (http://www.cdc.gov/nchs/data/databriefs/db09.htm). Reducing infant mortality is a goal of Healthy People 2020 (http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=26).

Infant mortality varies greatly among states, from less than 5 deaths per 1,000 live births in New Hampshire, Vermont and Utah to 10 deaths per 1,000 live births in Mississippi. The national average is 6.7 deaths per 1,000 live births, stable since the 2004 Edition. States with a low number of births will experience more fluctuations in the two-year average infant mortality rate than states with a higher number of births.

Cardiovascular Deaths measures the three-year average, age-adjusted number of deaths attributed to cardiovascular diseases, including but not limited to heart disease and stroke, per 100,000 population. The 2011 ranks, based on 2006 to 2008 data (National Center for Health Statistics. Centers for Disease Control and Prevention), are at www.americashealthrankings.org/ALL/CVDDeaths.

Cardiovascular deaths are an indication of the toll cardiovascular disease places on the population. In the United States, heart disease and stroke are currently the leading and fifth most common cause of death, respectively.[17] To reduce this burden, Million Hearts, a new national initiative to prevent one million heart attacks and strokes over the next five years, was recently established.[18] Additional information on the initiative is available at http://millionhearts.hhs.gov/.

Deaths from cardiovascular disease vary from a low of 197.2 deaths per 100,000 population in Minnesota to 366.4 deaths per 100,000 population in Mississippi. The national average is 270.4 deaths per 100,000 population, down from 278.2 deaths per 100,000 population last year and 405.1 deaths per 100,000 population in 1990. The use of mortality data does not reflect the full burden of cardiovascular disease on the nation, as data indicates that despite declining cardiovascular mortality rates, more individuals are living with cardiac disease as new procedures prolong the lives of these individuals.

Cancer Deaths measures the three-year average, age-adjusted number of deaths attributed to cancer per 100,000 population. The 2011 ranks, based on 2006 to 2008 data (National Center for Health Statistics. Centers for Disease Control and Prevention), are at www.americashealthrankings.org/ALL/CancerDeaths.

Cancer is the second leading cause of death in the United States[19] and the cancer death measure is an indication of the toll it places on the population. Opportunities exist to reduce the risk of developing some cancers and to prevent others. More information on the cancer burden in the U.S. is available at http://www.cdc.gov/chronicdisease/resources/publications/AAG/dcpc.htm.

The rate varies from less than 160 cancer deaths per 100,000 population in Utah and Hawaii to 220 or more deaths per 100,000 population in West Virginia and Kentucky. The national average is 190.8 deaths per 100,000 population, a decrease of 0.7 deaths per 100,000 population from the 2010 Edition and a decrease of only 6.7 deaths per 100,000 population from the 1990 Edition. Cancer deaths peaked in 1996 when the national rate was 205.5 deaths per 100,000 population.

Premature Death measures the loss of years of life due to death before age

17. Ibid.
18. Frieden, T. R., & Berwick, D. M. (2011). The "Million Hearts" Initiative — Preventing Heart Attacks and Strokes. N Engl J Med, 365(13), e27. doi:10.1056/NEJMp1110421.
19. Heron, "Deaths: Leading Causes for 2007"

Table 20
Greatest Decreases in Infant Mortality (Change is number of fewer deaths within the first year of life per 1,000 live births)

LAST YEAR		SINCE 2006 EDITION		SINCE 2001 EDITION		SINCE 1990 EDITION	
STATE	CHANGE	STATE	CHANGE	STATE	CHANGE	STATE	CHANGE
New Hampshire	-1.0	New Hampshire	-0.9	Illinois, South Carolina, South Dakota and Vermont (tie)	-1.6	New York	-5.2
Arkansas	-0.6	Louisiana	-0.8	New Jersey and New Mexico (tie)	-1.2	Illinois	-5.0
Alaska, Idaho, Indiana, Nevada, and Vermont (tie)	-0.5	Indiana	-0.7	North Dakota	-1.1	South Carolina	-4.7

75 as defined by the CDC's Years of Potential Life Lost (YPLL-75). Thus, the death of a 25-year-old would account for 50 years of lost life, while the death of a 60-year-old would account for 15 years. The 2011 ranks, based on 2008 data (Centers for Disease Control and Prevention), are at www.americashealthrankings.org/ALL/YPLL.

Premature death is an indication of the number of useful years of life that are not available to a population due to early death. According to 2008 mortality data, cancer, unintentional injury, heart disease, suicide and deaths occurring during the perinatal period are the top five causes of premature death in the United States (National Center for Health Statistics, CDC). Often causes of early death are preventable through education, health care access and public health programs.

The age-adjusted data vary from less than 5,500 years lost per 100,000 population in Minnesota, Massachusetts and New Hampshire to more than 10,000 years lost per 100,000 population in Arkansas, Oklahoma, Mississippi, Louisiana and Alabama. The national average is 7,279 years lost before the age of 75 per 100,000 population, 97 fewer years lost than in the 2010 Edition. Premature death has slowly declined since the 2008 Edition, from 7,490 years lost before age 75 per 100,000 population to the current rate.

Supplemental Measures

The core measures used in the Rankings represent a small fraction of the measures available to the general public and to public health officials. The *America's Health Rankings®* website contains additional measures that are useful in understanding the health of your state and provide information for more in-depth analysis.

Table 11 on pages 32-33 contains a brief definition of the supplemental measures and a link to the data.

Cholesterol Check: The National Cholesterol Education Program (NCEP) recommends that adults aged 20 years or older have their cholesterol checked every five years. A simple blood test can measure total cholesterol levels, including LDL (low-density lipoprotein, or "bad" cholesterol), HDL (high-density lipoprotein, or "good" cholesterol), and triglycerides. Approximately one in six people are considered to have high cholesterol.[20] Factors that influence individuals receiving a blood cholesterol check include access, cost, education and motivation.

These data are collected through the Behavioral Risk Factor Surveillance System by the CDC. A table of the percentage of adults receiving a blood cholesterol check within the last five years is at www.americashealthrankings.org/ALL/CholesterolCheck.

In Massachusetts, Rhode Island and Maryland, over 83 percent of adults had their cholesterol checked in the last five years. In Utah and Idaho, fewer than 70 percent of adults were checked.

The National Heart, Lung and Blood Institute at the National Institutes of Health provide additional background information on cholesterol and actions you can take to manage high cholesterol at http://www.nhlbi.nih.gov/health/public/heart/index.htm.

Dental Visit, Annual: Oral health is a vital part of a comprehensive preventive health program. The Division of Oral Health at the CDC notes, "There are threats to oral health across the lifespan. Nearly one-third of all adults in the United States have untreated tooth decay. One in seven adults aged 35 to 44 years has gum disease; this increases to one in every four adults aged 65 years and older. In addition, nearly a quarter of all adults have experienced some facial pain in the past six months. Oral cancers are most common in older adults, particularly those over 55 years who smoke and are heavy drinkers."[21] Factors that influence individuals receiving dental care include access, cost, education and motivation.

These data are collected through the Behavioral Risk Factor Surveillance System by the CDC. A table of the percentage of adults visiting a dental office within the last year is at www.americashealthrankings.org/ALL/Dental_Visit.

In Connecticut and Massachusetts, over 80 percent of adults had a dental visit within the last year. In Mississippi

20. Division of Heart Disease and Stroke Prevention, Centers for Disease Control and Prevention, http://www.cdc.gov/dhdsp/ , accessed Oct 26, 2011.
21. Division of Oral Health, Centers for Disease Control and Prevention, http://www.cdc.gov/OralHealth/topics/adult.htm, accessed Oct 26, 2011.

Table 21
Greatest Decreases in Cardiovascular Deaths (Change is number of fewer deaths per 100,000 population)

LAST YEAR		SINCE 2006 EDITION		SINCE 2001 EDITION		SINCE 1990 EDITION	
STATE	CHANGE	STATE	CHANGE	STATE	CHANGE	STATE	CHANGE
Delaware	-19.5	Tennessee	-60.7	South Carolina	-106.1	South Carolina	-179.7
Louisiana	-15.9	Georgia	-60.0	New Hampshire	-91.3	Vermont	-166.6
Nevada	-15.2	Kentucky	-59.2	Georgia	-91.2	Maine	-165.9
Idaho	-12.6	South Carolina	-58.8	North Carolina	-88.4	Delaware	-160.2
South Carolina	-12.3	Texas	-58.7	Nebraska	-88.1		
Georgia	-12.2	Oklahoma	-57.5	West Virginia	-85.8		
Pennsylvania	-12.1	New Hampshire	-57.0	Virginia	-85.4		

and Oklahoma, fewer than 60 percent of adults had a visit in the last year.

Additional information on oral health can be obtained from CDC's Division of Oral Health, (http://www.cdc.gov/OralHealth) and from the American Dental Association (http://www.ada.org/365.aspx). Both websites address questions about personal oral health and community programs to improve overall oral health, such as water fluoridation.

Physical Activity: Regular physical activity is one of the most important things you can do for your health. It can help:[22]

- Control your weight.
- Reduce your risk of cardiovascular disease.
- Reduce your risk for Type 2 diabetes and metabolic syndrome.
- Reduce your risk of some cancers.
- Strengthen your bones and muscles.
- Improve your mental health and mood.
- Improve your ability to do daily activities and prevent falls, if you're an older adult.
- Increase your chances of living longer.

These data are collected through the Behavioral Risk Factor Surveillance System by the CDC. A table of the percentage of adults who have participated in any physical activities in the last 30 days is at www.americashealthrankings.org/ALL/PhysicalActivity. These physical activities range from walking to exercise programs and include activities that are accessible to almost every individual.

In Oregon, Utah, Vermont, Colorado, Washington, Minnesota, Hawaii, New Hampshire and Idaho, at least 80 percent of adults participate in physical activities. In Mississippi, West Virginia, Alabama and Louisiana fewer than 70 percent participate.

The CDC presents guidelines for physical activities for adults, children and older adults at http://www.cdc.gov/physicalactivity/everyone/guidelines/index.html.

Diet Fruit and Vegetables: According to the Dietary Guidelines for Americans published by the CDC, a healthy eating plan:

- Emphasizes fruits, vegetables, whole grains, and fat-free or low-fat milk and milk products.
- Includes lean meats, poultry, fish, beans, eggs, and nuts.
- Is low in saturated fats, trans fats, cholesterol, salt (sodium), and added sugars.
- Stays within your daily calorie needs.

Data collected for this measure focus on the consumption of vegetables and fruits at the recommended five portions per day. These data are collected through the Behavioral Risk Factor Surveillance System by the CDC. A table of the percentage of adults who consume five or more servings of vegetables and fruits a day is at www.americashealthrankings.org/ALL/diet.

Almost 30 percent of Vermont residents eat their veggies compared to less than 15 percent of Oklahoma residents.

Nutritional information is abundant and overwhelming, but two sound starting points for information are the CDC (http://www.cdc.gov/healthyweight/) resources about healthy weight and the National Heart, Lung and Blood Institute DASH nutrition plan (http://www.nhlbi.nih.gov/health/public/heart/hbp/dash/). The DASH eating plan was originally developed as an eating plan to reduce high blood pressure, i.e. hypertension. (DASH stands for Dietary Approaches to Stop Hypertension.) However, the plan also represents a

22. Centers for Disease Control and Prevention, http://www.cdc.gov/physicalactivity/everyone/health/index.html accessed Oct 26, 2011.

Table 22
Greatest Decreases in Cancer Deaths (Change is number of fewer deaths per 100,000 population)

LAST YEAR		SINCE 2006 EDITION		SINCE 2001 EDITION		SINCE 1990 EDITION	
STATE	CHANGE	STATE	CHANGE	STATE	CHANGE	STATE	CHANGE
Montana	-6.3	Louisiana	-13.3	Rhode Island	-20.3	New York	-26.5
Maine	-6.2	Nevada	-11.8	New York	-19.8	Maryland	-24.7
		Georgia	-11.1	New Jersey	-18.8	New Jersey	-20.7
						California	-20.5

Table 23
Greatest Decreases in Premature Death
(Change is number of fewer years lost before age 75 per 100,000 population)

LAST YEAR		SINCE 2006 EDITION		SINCE 2001 EDITION		SINCE 1990 EDITION	
STATE	CHANGE	STATE	CHANGE	STATE	CHANGE	STATE	CHANGE
South Carolina	-422	Arizona	-775	New York	-1218	New York	-3820
Arizona	-406	South Dakota	-758	Arizona	-929	New Jersey	-2634
Nevada	-398	Massachusetts	-702	New Jersey	-845	California	-2438
Utah	-365					Georgia	-2054
Maryland	-364						

healthy approach to eating for those who do not have a problem with hypertension.

Access to healthy food can also be a challenge. The United States Department of Agriculture identifies areas of the country that are "food deserts," areas where healthy, wholesome foods are less readily available (http://www.ers.usda.gov/data/fooddesert/).

Teen Birth Rate: Prevention of teen and unplanned pregnancy is an important part of a healthy community. The CDC notes, "In 2009, a total of 409,840 infants were born to 15–19 year olds, for a live birth rate of 39.1 per 1,000 women in this age group. Nearly two-thirds of births to women younger than age 18 and more than half of those among 18–19 year olds are unintended."[23] CDC continues on to state "Teen pregnancy accounts for more than $9 billion per year in costs to U.S. taxpayers for increased health care and foster care, increased incarceration rates among children of teen parents, and lost tax revenue because of lower educational attainment and income among teen mothers."[24] A general trend of decreasing rates has resumed with the latest data after rising a few years ago.

Data collected for this measure focus on the rate of birth to mothers age 15 through 19. These data are collected by the CDC. The birth rate for teens is at www.americashealthrankings.org/ALL/teenbirth.

Teen birth is lowest in New Hampshire at 19.8 births per 1,000 mothers age 15 to 19 and the highest in Mississippi with 65.7 births per 1,000 mothers age 15 to 19.

A valuable resource for further information about teen and unplanned pregnancy is available from The National Campaign to Prevent Teen and Unplanned Pregnancy (http://www.thenationalcampaign.org/default.aspx).

Low Birthweight: Low birthweight is the category of babies weighing less than 2,500 grams (5 pounds, 8 ounces) at birth. Low birthweight babies are more likely than babies of normal weight to have health problems during the newborn period. Serious medical problems are most common in babies born at very low birthweight and include respiratory distress syndrome; bleeding in the brain; patent ductus arteriosus, a heart problem common in premature babies; necrotizing enterocolitis, an intestinal problem that usually develops two to three weeks after birth; and retinopathy of prematurity, an abnormal growth of blood vessels in the eye that can lead to vision loss.[25]

Fewer than six percent of babies are born with low birthweight in Alaska while 10 percent or more are born with low birthweight in Mississippi, Louisiana and Alabama. Low birthweight rates are at www.americashealthrankings.org/ALL/birthweight.

Low birthweight can be addressed in multiple ways, including:[26]

- Expand access to medical and dental services, taking a lifespan approach to health care.
- Focus intensively on smoking prevention and cessation.
- Ensure that pregnant women get adequate nutrition.
- Address demographic, social, and environmental risk factors.

Preterm Birth: Preterm birth refers to the birth of a baby of less than 37 weeks gestational age. Late-preterm birth refers to babies born between 34 and 36 weeks of pregnancy. More than 70 percent of preterm babies are born at this time. While these babies are usually healthier than babies born earlier, they are three times more likely to die in the first year of life than full-term infants. They are also at increased risk of newborn health problems, including breathing and feeding problems. Some late-preterm births result from early induction of labor or cesarean delivery due to pregnancy complications. However, in some cases, early delivery may occur without good medical justification.[27]

In Alaska, New Hampshire, Minnesota, Idaho, Oregon, Vermont and Connecticut, fewer than 10 percent of babies are born preterm. In Mississippi, over 14 percent are born preterm. Preterm birth rates are at www.americashealthrankings.org/ALL/preterm.

Chronic Disease: Five diseases are included in this category: cardiac heart disease, high cholesterol, heart attack, stroke and hypertension (high blood pressure). These diseases are long-term illnesses that many individuals can manage through lifestyle changes and healthcare interventions. However, they do place a burden on many of the affected individuals by constraining options and activities available to them and can result in expensive and ongoing expenditures for health care.

All measures are self-reported by respondents to the Behavioral Risk Factor Surveillance System. Table 24 lists the national average and the highest and lowest state for these measures. The data are available at www.americashealthranking.org/ALL/CHD, www.americashealthranking.org/ALL/high_chol, www.americashealthranking.org/ALL/stroke, www.americashealthrankings.org/ALL/MI and www.americashealthranking.org/ALL/hypertension.

Resources for heart and vascular diseases are at National Heart, Lung and Blood Institute (http://www.nhlbi.nih.gov/health/public/heart/index.htm) as well as at the Division for Heart Disease

23. Centers for Disease Control and Prevention, http://www.cdc.gov/teenpregnancy/AboutTeenPreg.htm
24. Ibid
25. March of Dimes, http://www.marchofdimes.com/professionals/medicalresources_lowbirthweight.html accessed Oct 27, 2011.
26. Shore, Rima and Shore, Barbara, Preventing Low Birthweight, Annie E. Casey Foundation, July 2009 available at http://www.aecf.org/~/media/Pubs/Initiatives/KIDS%20COUNT/K/KIDSCOUNTIndicatorBriefPreventingLowBirthWeig/PreventingLowBirthweight.pdf.
27. March of Dimes, http://www.marchofdimes.com/professionals/medicalresources_lowbirthweight.html

and Stroke Prevention, CDC (http://www.cdc.gov/DHDSP/index.htm).

Median Household Income: Median household income is the amount of income that divides the income distribution into two equal groups, half with income above that amount, and half with income below that amount. Household income reflects the ability for that household to afford aspects of a healthy lifestyle, including preventive medicine and curative care not provided to the individual through government, business, trade groups or other sources.

Data for household income is from the U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements and presented at www.americashealthrankings.org/ALL/Median_Income.

Personal Income: An individual's income reflects the ability of that individual to afford aspects of a healthy lifestyle, preventive medicine and curative care not provided to the individual through government, business, trade groups or other sources. Personal income has also been shown to be negatively correlated to morbidity and mortality, meaning that higher income individuals experience lower illness and death.[28]

Data for personal income is from the Regional Economic Information System, Bureau of Economic Analysis, U.S. Department of Commerce and presented at www.americashealthrankings.org/ALL/PerCapInc.

Per capita personal income is total personal income divided by total mid-year population.

Unemployment Rate: For many individuals, their employer is the source for their healthcare insurance. For most, employment is the source of income for sustaining a healthy life and for accessing healthcare.

The Bureau of Labor Statistics, U.S. Department of Labor releases unemployment figures monthly and annually. The official definition of the unemployment rate is "total unemployed, as a percent of the civilian labor force" and is the figure most widely published by the media.

Data for the most recent annual unemployment rate is at www.americashealthrankings.org/ALL/unemployed.

Data for the August 2011 unemployment rate is at www.americashealthrankings.org/ALL/august.

Underemployment Rate: Many suggest that the official unemployment rate does not reflect the full impact of employment on the market. The Bureau of Labor Statistics uses an expanded definition to allow for individuals who are no longer seeking employment, those employed only part-time when they desire full-time work and workers who are only marginally attached, that is persons who currently are "neither working nor looking for work but indicate that they want and are available for a job and have looked for work sometime in the recent past."

Data for the most recent annual underemployment rate is at www.americashealthrankings.org/ALL/underemployed.

Income Disparity (Gini): The Gini coefficient is a common measure of income inequality. It varies between 0, which reflects complete equality of income and 1, which indicates complete inequality (one person has all the income or consumption, all others have none). Historically, the U.S. index has varied from .386 in 1968 to .469 in 2010 (http://www.census.gov/prod/2011pubs/acsbr10-02.pdf).

There is debate among the public health and economic communities as to the effect of income disparity on the health of a population. However, that need not be resolved to acknowledge that income disparity does play a factor in how a community will develop plans and take actions to change health. As such, income disparity provides a valuable description of the environment in which health improvement programs must be implemented.

The source for the data is U.S. Census Bureau, Current Population Survey, 1978 to 2010 Annual Social and Economic Supplements and it is presented at www.americashealthrankings.org/ALL/Income_Disparity.

Most developed European nations and Canada have Gini indices between .24 and .36. (The Gini Index, which is the Gini coefficient times 100, is reported for other countries by the Central Intelligence Agency at https://www.cia.gov/library/publications/the-world-factbook/fields/2172.html).

Table 24
Supplemental Chronic Disease Measures

MEASURE	U.S. RATE	HIGHEST STATE (%)	LOWEST STATE (%)
Cardiac Heart Disease	4.1%	Arizona (6.8%)	Hawaii (2.3%)
High Cholesterol	37.5%	South Carolina (41.8%)	Tennessee (32.9%)
Heart Attack	4.2%	Arizona (6.7%)	Alaska (2.6%)
Stroke	2.7%	Alabama and Arizona (4.7%)	Colorado and Connecticut (1.7%)
Hypertension	28.6%	West Virginia (37.6%)	Minnesota (21.5%)

28. "Poverty or income inequality as predictor of mortality: longitudinal cohort study" by Fiscella, Frank and Franks, Peter; BMJ 1997;314:1724 (14 June), http://www.bmj.com/cgi/content/full/314/7096/1724.

Index of Tables, Figures and Graphs

State-By-State Snapshots

The following pages describe the overall ranking, strengths, challenges and significant changes for each state. To compare your state to other states or to other years, go to www.americashealthrankings.org/all and select the display options that you desire.

On each state's snapshot, there is a separate paragraph that describes aspects of the health disparities within that state and includes variations in smoking, obesity and diabetes. For disparity information for all states, see page 22 or go to www.americas healthrankings.org/Rankings and click on the Disparity tab.

Each snapshot also contains the current economic climate of the state. Tabular data for this information is available by going to www.americashealthrankings.org/all and selecting the desired measure/ from the drop down list.

In addition, supplemental measures of health and economic status are available for each state at www.americashealthrankings.org/all.

ALABAMA

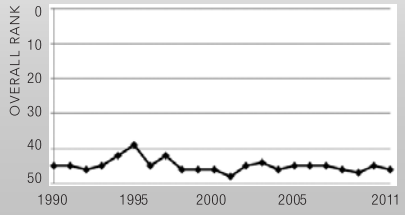
Ranking: Alabama is 46th this year; it was 45th in 2010.

Highlights:
- Over 1.2 million people in Alabama are obese, 410,000 more than 10 years ago.
- Prevalence of diabetes has doubled in the last 10 years, with 481,000 people affected.
- In the past year, prevalence of binge drinking has decreased from 11.4 percent of the population to 10.4 percent.
- In the past year, public health funding has increased from $107 per person to $116 per person.
- In the past 10 years, the rate of uninsured population increased from 12.9 percent to 15.9 percent.
- Alabama ranks higher for determinants than for outcomes, indicating that overall healthiness may improve over time.

Health Disparities:
In Alabama, obesity is more prevalent among non-Hispanic blacks at 42.4 percent than non-Hispanic whites at 29.0 percent. The prevalence of diabetes also varies by race and ethnicity in the state; 15.3 percent of non-Hispanic blacks have diabetes compared to 10.9 percent of non-Hispanic whites.

State Health Department Web Site: www.adph.org

Overall Rank: 46



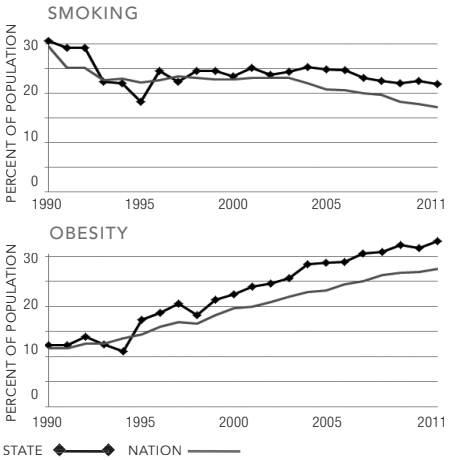
Change: ▼ 1
Determinants Rank: 43
Outcomes Rank: 49

Strengths:
- Low prevalence of binge drinking
- High per capita public health funding
- High immunization coverage

Challenges:
- High prevalence of smoking
- High prevalence of obesity
- High prevalence of diabetes

ECONOMIC ENVIRONMENT	AL	U.S.
Unemployment Rate (Aug 2011)	9.9%	8.3%
Underemployment Rate (2010)	17.3%	16.7%
Median Household Income (2010)	$40,976	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	838,000	799,000	-39,000
Obesity	794,000	1,204,000	410,000
Diabetes	246,000	481,000	235,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	**BEHAVIORS**			
	Smoking (Percent of adult population)	21.9	43	9.1
	Binge Drinking (Percent of adult population)	10.4	5	6.7
	Obesity (Percent of adult population)	33.0	49	21.4
	High School Graduation (Percent of incoming ninth graders)	69.0	43	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	378	30	122
	Occupational Fatalities (Deaths per 100,000 workers)	5.0	32	2.5
	Infectious Disease (Cases per 100,000 population)	13.6	43	2.3
	Children in Poverty (Percent of persons under age 18)	24.2	39	6.2
	Air Pollution (Micrograms of fine particulates per cubic meter)	11.5	40	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	15.9	32	5.0
	Public Health Funding (Dollars per person)	$116	10	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	92.6	11	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	78.7*	44	—
	Primary Care Physicians (per 100,000 population)	99.7	40	191.9
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	82.6	45	25.6
	ALL DETERMINANTS	-0.34	43	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	13.2	50	5.3
	Poor Mental Health Days (Days in previous 30 days)	4.1	46	2.3
	Poor Physical Health Days (Days in previous 30 days)	4.6	48	2.6
	Geographic Disparity (Relative standard deviation)	8.8	12	4.8
	Infant Mortality (Deaths per 1,000 live births)	9.7	49	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	339.0	49	197.2
	Cancer Deaths (Deaths per 100,000 population)	211.7	44	137.4
	Premature Death (Years lost per 100,000 population)	10,390	49	5481
	ALL OUTCOMES	-0.27	49	0.32
	OVERALL	-0.61	46	1.20

— indicates data not available. * See measure description for full details.

ALASKA

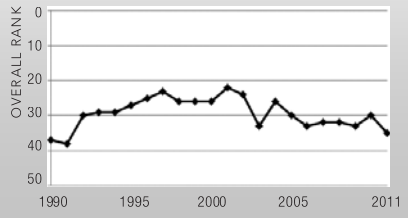
Ranking: Alaska is 35th this year; it was 30th in 2010.

Highlights:
- 132,000 adults (25.2 percent of adults) in Alaska are obese, 40,000 more than 10 years ago.
- In the past year, binge drinking increased from 16.9 percent to 19.1 percent of the adult population.
- In the past five years, smoking decreased from 24.9 percent to 20.4 percent of the adult population. However, 107,000 adults still smoke.
- In the past ten years, the percentage of children in poverty increased from 10.6 percent to 15.6 percent of persons under age 18.
- Alaska ranks lower for determinants than for outcomes, indicating that overall healthiness may decline over time.

Health Disparities:
In Alaska, smoking is more prevalent among non-Hispanic American Indians and Alaskan Natives at 37.6 percent than non-Hispanic whites at 17.6 percent.

State Health Department Web Site: health.hss.state.ak.us

Overall Rank: 35



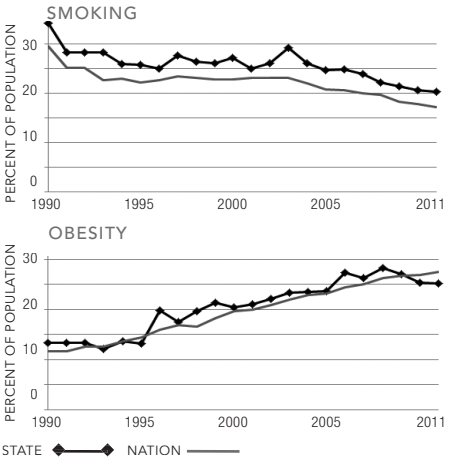
Change: ▼ 5
Determinants Rank: 39
Outcomes Rank: 24

Strengths:
- Low levels of air pollution
- High per capita public health funding
- Low prevalence of diabetes

Challenges:
- High prevalence of binge drinking
- High violent crime rate
- High incidence of infectious disease

ECONOMIC ENVIRONMENT	AK	U.S.
Unemployment Rate (Aug 2011)	7.7%	8.3%
Underemployment Rate (2010)	14.3%	16.7%
Median Household Income (2010)	$58,198	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	109,000	107,000	-2,000
Obesity	92,000	132,000	40,000
Diabetes	17,000	28,000	11,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	20.4	38	9.1
	Binge Drinking (Percent of adult population)	19.1	48	6.7
	Obesity (Percent of adult population)	25.2	13	21.4
	High School Graduation (Percent of incoming ninth graders)	69.1	42	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	639	49	122
	Occupational Fatalities (Deaths per 100,000 workers)	10.6	50	2.5
	Infectious Disease (Cases per 100,000 population)	25.1	50	2.3
	Children in Poverty (Percent of persons under age 18)	15.6	15	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	6.3	4	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	17.6	40	5.0
	Public Health Funding (Dollars per person)	$199	2	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	87.4	43	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	79.7*	39	—
	Primary Care Physicians (per 100,000 population)	111.5	28	191.9
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	55.1	11	25.6
	ALL DETERMINANTS	-0.22	39	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	5.3	1	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.0	8	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.1	11	2.6
	Geographic Disparity (Relative standard deviation)	22.2	49	4.8
	Infant Mortality (Deaths per 1,000 live births)	6.2	17	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	225.3	6	197.2
	Cancer Deaths (Deaths per 100,000 population)	192.0	24	137.4
	Premature Death (Years lost per 100,000 population)	7,786	31	5481
	ALL OUTCOMES	0.05	24	0.32
	OVERALL	-0.17	35	1.20

— indicates data not available. * See measure description for full details.

ARIZONA

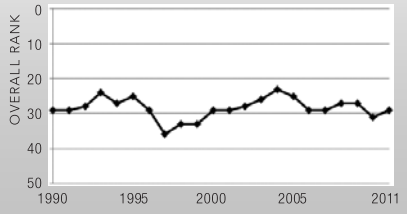
Ranking: Arizona is 29th this year; it was 31st in 2010.

Highlights:
- Nearly 1.2 million people in Arizona are obese, 453,000 more than 10 years ago.
- The number of adults with diabetes has more than doubled in the last ten years; 543,000 adults now have diabetes.
- In the past year, the percentage of children in poverty declined from 31.3 percent to 27.3 percent of persons under age 18.
- In the past five years, smoking decreased from 20.2 percent to 13.5 percent of adults; however, 643,000 adults still smoke.
- In the past ten years, the rate of deaths from cardiovascular disease decreased from 292.0 to 218.3 deaths per 100,000 population.

Health Disparities:
In Arizona, obesity is more prevalent among Hispanics and non-Hispanic American Indians at 32.3 percent and 40.8 percent, respectively, than non-Hispanic whites at 23.3 percent. Diabetes is higher among non-Hispanic blacks at 12.4 percent and non-Hispanic American Indians at 15.4 percent than among non-Hispanic whites at 8.6 percent.

State Health Department Web Site: www.azdhs.gov

Overall Rank: 29



Change: ▲ 2
Determinants Rank: 29
Outcomes Rank: 27

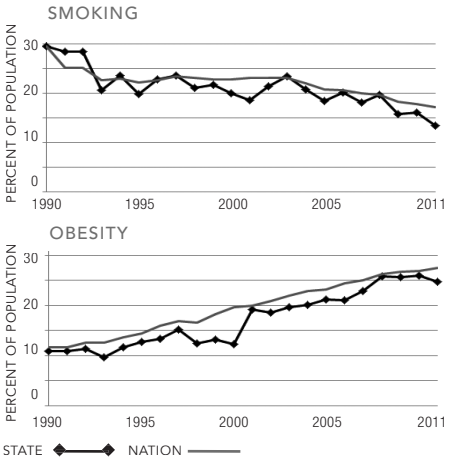
Strengths:
- Low prevalence of smoking
- Low rate of preventable hospitalizations
- Low rates of cancer deaths and cardiovascular deaths

Challenges:
- High percentage of children in poverty
- High rate of uninsured population
- Low high school graduation rate

ARIZONA

ECONOMIC ENVIRONMENT	AZ	U.S.
Unemployment Rate (Aug 2011)	9.3%	8.3%
Underemployment Rate (2010)	18.4%	16.7%
Median Household Income (2010)	$47,279	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	700,000	643,000	-57,000
Obesity	723,000	1,176,000	453,000
Diabetes	222,000	543,000	321,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	13.5	4	9.1
	Binge Drinking (Percent of adult population)	13.2	14	6.7
	Obesity (Percent of adult population)	24.7	10	21.4
	High School Graduation (Percent of incoming ninth graders)	70.7	41	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	408	33	122
	Occupational Fatalities (Deaths per 100,000 workers)	3.9	19	2.5
	Infectious Disease (Cases per 100,000 population)	9.7	34	2.3
	Children in Poverty (Percent of persons under age 18)	27.3	46	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	9.3	20	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	19.0	43	5.0
	Public Health Funding (Dollars per person)	$46	45	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	88.7	38	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	79.5*	41	—
	Primary Care Physicians (per 100,000 population)	92.6	44	191.9
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	51.7	7	25.6
	ALL DETERMINANTS	0.02	29	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	11.4	47	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.2	14	2.3
	Poor Physical Health Days (Days in previous 30 days)	4.1	41	2.6
	Geographic Disparity (Relative standard deviation)	17.1	45	4.8
	Infant Mortality (Deaths per 1,000 live births)	6.6	22	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	218.3	5	197.2
	Cancer Deaths (Deaths per 100,000 population)	166.7	4	137.4
	Premature Death (Years lost per 100,000 population)	7,086	24	5481
	ALL OUTCOMES	0.04	27	0.32
	OVERALL	0.05	29	1.20

— indicates data not available. * See measure description for full details.

ARKANSAS

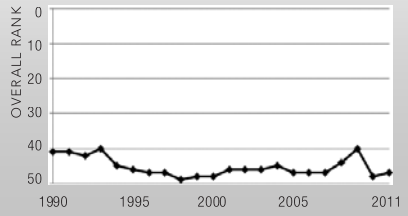
Ranking: Arkansas is 47th this year; it was 48th in 2010.

Highlights:
- There are 681,000 adults in Arkansas who are obese, 217,000 more individuals than 10 years ago.
- The number of adults with diabetes has increased by 71 percent in the last ten years, with 212,000 people now affected.
- Smoking remains high at 22.9 percent of the adult population, with 505,000 adult smokers in the state.
- In the past year, the percentage of children in poverty decreased from 25.7 percent to 21.8 percent of the population.
- In the past five years, the infant mortality rate declined from 8.1 to 7.5 deaths per 1,000 live births.
- In the past ten years, the rate of uninsured population increased from 13.7 percent to 18.9 percent.

Health Disparities:
In Arkansas, obesity is more prevalent among non-Hispanic blacks at 41.5 percent than Hispanics at 30.1 percent and non-Hispanic whites at 29.8 percent. Diabetes also varies by race and ethnicity in the state; 12.3 percent of non-Hispanic blacks have diabetes compared to 8.8 percent of Hispanics and 9.3 percent of non-Hispanic whites.

State Health Department Web Site: www.healthy.arkansas.gov

Overall Rank: 47



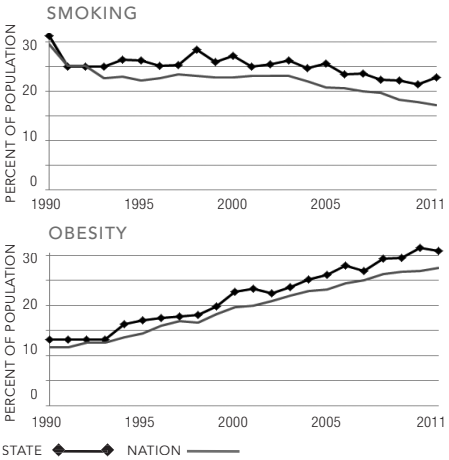
Change: ▲ 1
Determinants Rank: 46
Outcomes Rank: 44

Strengths:
- Low prevalence of binge drinking
- Moderate geographic disparity within the state

Challenges:
- High prevalence of smoking
- High incidence of infectious disease
- High rates of cancer deaths and cardiovascular deaths
- High rate of preventable hospitalizations

ECONOMIC ENVIRONMENT	AR	U.S.
Unemployment Rate (Aug 2011)	8.3%	8.3%
Underemployment Rate (2010)	14.5%	16.7%
Median Household Income (2010)	$38,571	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	500,000	505,000	5,000
Obesity	464,000	681,000	217,000
Diabetes	124,000	212,000	88,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	22.9	46	9.1
	Binge Drinking (Percent of adult population)	10.6	6	6.7
	Obesity (Percent of adult population)	30.9	39	21.4
	High School Graduation (Percent of incoming ninth graders)	76.4	25	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	505	41	122
	Occupational Fatalities (Deaths per 100,000 workers)	8.1	47	2.5
	Infectious Disease (Cases per 100,000 population)	18.8	47	2.3
	Children in Poverty (Percent of persons under age 18)	21.8	31	6.2
	Air Pollution (Micrograms of fine particulates per cubic meter)	10.9	36	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	18.9	42	5.0
	Public Health Funding (Dollars per person)	$79	24	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	89.7	33	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	78.9*	43	—
	Primary Care Physicians (per 100,000 population)	99.5	41	191.9
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	81.5	43	25.6
	ALL DETERMINANTS	-0.47	46	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	9.6	33	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.8	38	2.3
	Poor Physical Health Days (Days in previous 30 days)	4.2	44	2.6
	Geographic Disparity (Relative standard deviation)	10.8	20	4.8
	Infant Mortality (Deaths per 1,000 live births)	7.5	35	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	320.6	46	197.2
	Cancer Deaths (Deaths per 100,000 population)	212.4	45	137.4
	Premature Death (Years lost per 100,000 population)	10,017	46	5481
	ALL OUTCOMES	-0.15	44	0.32
	OVERALL	-0.62	47	1.20

— indicates data not available. * See measure description for full details.

CALIFORNIA

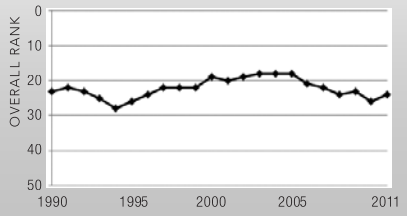
Ranking: California is 24th this year; it was 26th in 2010.

Highlights:
- Although 852,000 fewer adults smoke in California compared to 10 years ago, nearly 3.4 million adults still smoke.
- Over 6.9 million adults in California are obese, 2.0 million more adults than 10 years ago.
- In the past ten years, diabetes increased from 6.8 percent to 8.6 percent of adults. Now 2.4 million California adults have diabetes.
- In the past five years, the percentage of children in poverty increased from 18.5 percent to 23.0 percent of the population.
- California ranks lower for determinants than for outcomes, indicating that overall healthiness may decline over time.

Health Disparities:
In California, obesity is more prevalent among non-Hispanic blacks at 35.8 percent than non-Hispanic Asians at 8.4 percent or non-Hispanic whites at 21.8 percent or Hispanics at 30.6 percent. Diabetes also varies by race and ethnicity in the state; 14.1 percent of non-Hispanic blacks have diabetes compared to 7.0 percent of non-Hispanic whites and 10.1 percent of Hispanics.

State Health Department Web Site: www.cdph.ca.gov

Overall Rank: 24



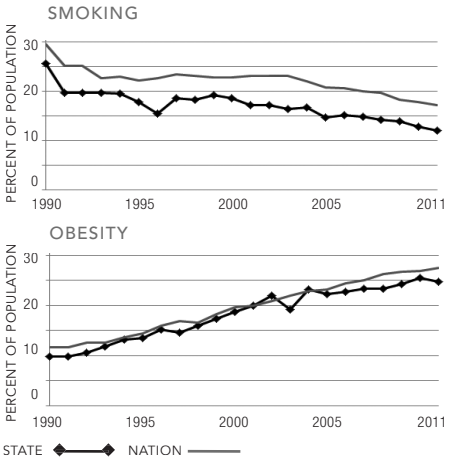
Change: ▲ 2
Determinants Rank: 24
Outcomes Rank: 18

Strengths:
- Low prevalence of smoking
- High use of early prenatal care
- Low infant mortality rate

Challenges:
- High levels of air pollution
- High rate of uninsured population
- Low immunization coverage

ECONOMIC ENVIRONMENT	CA	U.S.
Unemployment Rate (Aug 2011)	12.1%	8.3%
Underemployment Rate (2010)	22.1%	16.7%
Median Household Income (2010)	$54,459	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	4,235,000	3,383,000	-852,000
Obesity	4,900,000	6,906,000	2,006,000
Diabetes	1,674,000	2,404,000	730,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	**BEHAVIORS**			
	Smoking (Percent of adult population)	12.1	2	9.1
	Binge Drinking (Percent of adult population)	15.8	28	6.7
	Obesity (Percent of adult population)	24.7	10	21.4
	High School Graduation (Percent of incoming ninth graders)	71.2	39	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	441	35	122
	Occupational Fatalities (Deaths per 100,000 workers)	2.8	4	2.5
	Infectious Disease (Cases per 100,000 population)	8.5	26	2.3
	Children in Poverty (Percent of persons under age 18)	23.0	34	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	15.1	50	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	19.4	45	5.0
	Public Health Funding (Dollars per person)	$108	13	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	88.1	40	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	80.2	3	—
	Primary Care Physicians (per 100,000 population)	119.0	22	191.9
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	52.4	8	25.6
	ALL DETERMINANTS	0.12	24	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	8.6	24	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.7	34	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.7	29	2.6
	Geographic Disparity (Relative standard deviation)	15.1	40	4.8
	Infant Mortality (Deaths per 1,000 live births)	5.1	5	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	262.0	24	197.2
	Cancer Deaths (Deaths per 100,000 population)	173.3	6	137.4
	Premature Death (Years lost per 100,000 population)	6,015	8	5481
	ALL OUTCOMES	0.15	18	0.32
	OVERALL	0.27	24	1.20

— indicates data not available. * See measure description for full details.

COLORADO

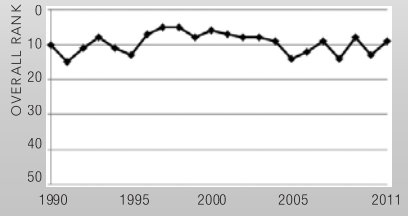
Ranking: Colorado is 9th this year; it was 13th in 2010.

Highlights:
- While Colorado has the lowest obesity rate in the U.S., 814,000 adults in Colorado are obese, an increase of 360,000 individuals in the past 10 years.
- In the past year, the rate of uninsured population decreased from 15.6 percent to 13.8 percent.
- In the past five years, smoking decreased from 19.8 percent to 16.0 percent of adults; however, 609,000 adults still smoke.
- In the past five years, diabetes increased from 4.8 percent to 6.0 percent of adults. There are now 228,000 adults with diabetes in the state.
- In the past ten years, the percentage of children in poverty increased from 10.9 percent to 18.5 percent of persons under age 18.

Health Disparities:
In Colorado, obesity is more prevalent among non-Hispanic blacks at 27.9 percent than non-Hispanic whites at 18.3 percent and Hispanics at 24.8 percent. Diabetes among non-Hispanic blacks at 10.3 percent is double the rate among non-Hispanic whites.

State Health Department Web Site: www.cdphe.state.co.us

Overall Rank: 9



Change: ▲ 4
Determinants Rank: 10
Outcomes Rank: 13

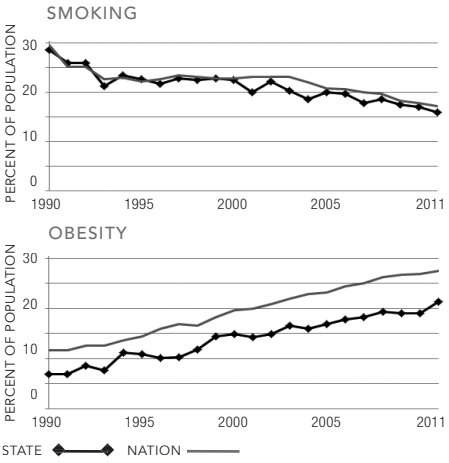
Strengths:
- Low levels of air pollution
- Lower prevalence of obesity than all other states
- Low prevalence of diabetes

Challenges:
- Low use of early prenatal care
- High geographic disparity within the state
- Low immunization coverage

COLORADO

ECONOMIC ENVIRONMENT	CO	U.S.
Unemployment Rate (Aug 2011)	8.5%	8.3%
Underemployment Rate (2010)	15.4%	16.7%
Median Household Income (2010)	$60,442	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	640,000	609,000	-31,000
Obesity	454,000	814,000	360,000
Diabetes	163,000	228,000	65,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	16.0	18	9.1
	Binge Drinking (Percent of adult population)	15.9	30	6.7
	Obesity (Percent of adult population)	21.4	1	21.4
	High School Graduation (Percent of incoming ninth graders)	75.4	30	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	321	26	122
	Occupational Fatalities (Deaths per 100,000 workers)	4.3	24	2.5
	Infectious Disease (Cases per 100,000 population)	7.3	17	2.3
	Children in Poverty (Percent of persons under age 18)	18.5	21	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	7.0	5	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	13.8	24	5.0
	Public Health Funding (Dollars per person)	$89	19	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	89.7	32	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	68.1	37	—
	Primary Care Physicians (Number per 100,000 population)	116.7	25	191.9
	Preventable Hospitalizations (per 1,000 Medicare enrollees)	48.1	6	25.6
	ALL DETERMINANTS	0.38	10	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	6.0	2	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.4	19	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.2	13	2.6
	Geographic Disparity (Relative standard deviation)	17.1	45	4.8
	Infant Mortality (Deaths per 1,000 live births)	6.2	17	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	217.0	4	197.2
	Cancer Deaths (Deaths per 100,000 population)	163.9	3	137.4
	Premature Death (Years lost per 100,000 population)	6,299	14	5481
	ALL OUTCOMES	0.17	13	0.32
	OVERALL	0.56	9	1.20

— indicates data not available. * See measure description for full details.

CONNECTICUT

Ranking: Connecticut is 3rd this year; it was 4th in 2010.

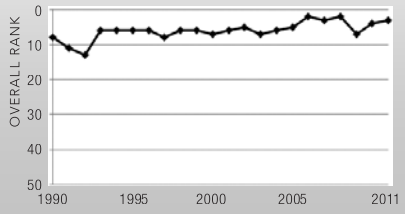
Highlights:

- While Connecticut has one of the lowest obesity rates in the U.S., 634,000 adults in Connecticut are obese, an increase of 188,000 individuals in the past 10 years.
- In the past year, smoking decreased from 15.4 percent to 13.2 percent of adults. There are 364,000 adults in Connecticut who still smoke.
- In the past year, diabetes increased from 6.6 percent to 7.3 percent of adults. There are 201,000 adults in Connecticut who have diabetes.
- In the past five years, geographic disparity within the state decreased from 8.5 percent to 5.4 percent.
- In the past five years, the infant mortality rate increased from 5.5 to 6.3 deaths per 1,000 live births.
- Compared to other health measures, the rate of preventable hospitalizations remains high in Connecticut at 63.1 discharges per 1,000 Medicare enrollees.

Health Disparities:
In Connecticut, obesity is more prevalent among non-Hispanic blacks at 39.5 percent than non-Hispanic whites at 20.8 percent. Diabetes also varies by race and ethnicity in the state; 11.5 percent of non-Hispanic blacks have diabetes compared to 6.7 percent of non-Hispanic whites.

State Health Department Web Site: www.dph.state.ct.us

Overall Rank: 3



Change: ▲ 1
Determinants Rank: 2
Outcomes Rank: 7

Strengths:

- Low prevalence of smoking
- Lower prevalence of obesity than most other states
- Low percentage of children in poverty
- High immunization coverage

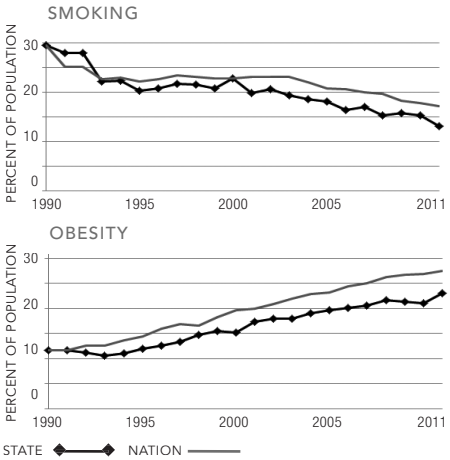
Challenges:

- High prevalence of binge drinking
- Moderate levels of air pollution

CONNECTICUT

ECONOMIC ENVIRONMENT	CT	U.S.
Unemployment Rate (Aug 2011)	9.0%	8.3%
Underemployment Rate (2010)	15.7%	16.7%
Median Household Income (2010)	$66,452	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	510,000	364,000	-146,000
Obesity	446,000	634,000	188,000
Diabetes	141,000	201,000	60,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	13.2	3	9.1
	Binge Drinking (Percent of adult population)	18.2	43	6.7
	Obesity (Percent of adult population)	23.0	2	21.4
	High School Graduation (Percent of incoming ninth graders)	82.2	12	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	281	20	122
	Occupational Fatalities (Deaths per 100,000 workers)	3.1	7	2.5
	Infectious Disease (Cases per 100,000 population)	3.6	3	2.3
	Children in Poverty (Percent of persons under age 18)	11.3	2	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	9.9	27	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	11.1	9	5.0
	Public Health Funding (Dollars per person)	$73	27	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	96.0	1	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	87.6*	4	—
	Primary Care Physicians (per 100,000 population)	164.0	6	191.9
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	63.1	21	25.6
	ALL DETERMINANTS	0.76	2	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	7.3	11	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.2	14	2.3
	Poor Physical Health Days (Days in previous 30 days)	2.8	4	2.6
	Geographic Disparity (Relative standard deviation)	5.4	4	4.8
	Infant Mortality (Deaths per 1,000 live births)	6.3	20	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	241.4	17	197.2
	Cancer Deaths (Deaths per 100,000 population)	185.7	15	137.4
	Premature Death (Years lost per 100,000 population)	5,768	4	5481
	ALL OUTCOMES	0.25	7	0.32
	OVERALL	1.01	3	1.20

— indicates data not available. * See measure description for full details.

DELAWARE

Ranking: Delaware is 30th this year; it was 32nd in 2010.

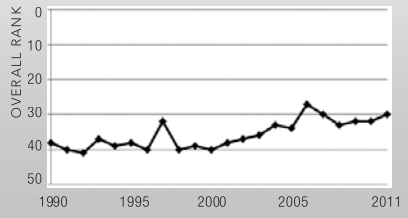
Highlights:

- There are 199,000 obese adults in Delaware, 101,000 more individuals than 10 years ago.
- In the past year, the rate of preventable hospitalizations decreased from 63.8 to 57.3 discharges per 1,000 Medicare enrollees.
- In the past ten years, the number of adults with diabetes increased by more than 50 percent, to 60,000 adults.
- In the past five years, the percentage of children in poverty increased from 14.2 percent to 17.5 percent of the population.
- In the past ten years, smoking decreased from 22.9 percent to 17.3 percent of adults; however, there are still 120,000 adults in Delaware who smoke.

Health Disparities:
In Delaware, obesity is more prevalent among non-Hispanic blacks at 42.5 percent than non-Hispanic whites at 26.0 percent and Hispanics at 31.5 percent. Diabetes also varies by race and ethnicity in the state; 11.0 percent of non-Hispanic blacks have diabetes compared to 7.1 percent of Hispanics and 7.9 percent of non-Hispanic whites.

State Health Department Web Site: www.dhss.delaware.gov/dhss

Overall Rank: 30



Change: ▲ 2
Determinants Rank: 33
Outcomes Rank: 30

Strengths:

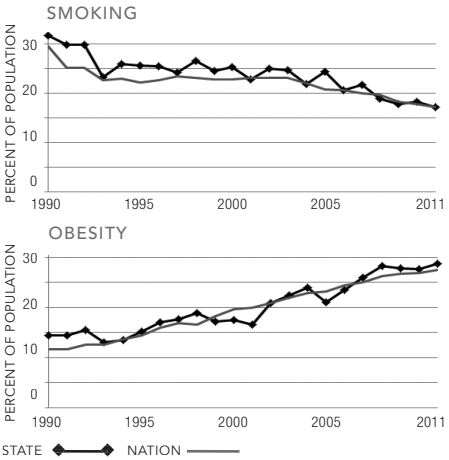
- Low incidence of infectious disease
- Low rate of uninsured population
- Low rate of preventable hospitalizations

Challenges:

- High prevalence of binge drinking
- High violent crime rate
- Low use of early prenatal care

ECONOMIC ENVIRONMENT	DE	U.S.
Unemployment Rate (Aug 2011)	8.1%	8.3%
Underemployment Rate (2010)	14.3%	16.7%
Median Household Income (2010)	$55,269	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	135,000	120,000	-15,000
Obesity	98,000	199,000	101,000
Diabetes	38,000	60,000	22,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	17.3	25	9.1
	Binge Drinking (Percent of adult population)	18.6	46	6.7
	Obesity (Percent of adult population)	28.7	31	21.4
	High School Graduation (Percent of incoming ninth graders)	72.1	37	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	621	48	122
	Occupational Fatalities (Deaths per 100,000 workers)	3.8	18	2.5
	Infectious Disease (Cases per 100,000 population)	4.9	7	2.3
	Children in Poverty (Percent of persons under age 18)	17.5	19	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	11.6	42	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	12.1	13	5.0
	Public Health Funding (Dollars per person)	$103	15	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	91.8	18	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	78.3*	46	—
	Primary Care Physicians (Number per 100,000 population)	108.2	31	191.9
	Preventable Hospitalizations (per 1,000 Medicare enrollees)	57.3	13	25.6
	ALL DETERMINANTS	-0.06	33	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	8.7	25	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.4	19	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.4	18	2.6
	Geographic Disparity (Relative standard deviation)	4.8	1	4.8
	Infant Mortality (Deaths per 1,000 live births)	7.9	41	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	262.2	25	197.2
	Cancer Deaths (Deaths per 100,000 population)	205.0	40	137.4
	Premature Death (Years lost per 100,000 population)	8,122	37	5481
	ALL OUTCOMES	0.02	30	0.32
	OVERALL	-0.03	30	1.20

— indicates data not available. * See measure description for full details.

FLORIDA

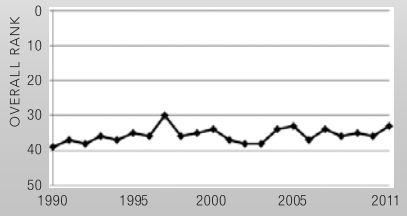
Ranking: Florida is 33rd this year; it was 36th in 2010.

Highlights:
- While smoking has decreased significantly in the past ten years, more than 2.5 million adults still smoke in Florida.
- Over 4 million adults in Florida are obese, 1.7 million more individuals than 10 years ago.
- More than 1.5 million people in Florida have diabetes, an increase of 688,000 people in the last ten years.
- In the past year, the violent crime rate decreased from 613 to 542 offenses per 100,000 population.
- In the past year, the rate of preventable hospitalizations increased from 62.5 to 64.3 discharges per 1,000 Medicare enrollees.
- Florida ranks higher for determinants than for outcomes, indicating that overall healthiness should improve over time.

Health Disparities:
In Florida, obesity is more prevalent among non-Hispanic blacks at 38.8 percent than non-Hispanic whites at 24.1 percent and Hispanics at 28.7 percent. Diabetes also varies by race and ethnicity in the state; 13.4 percent of non-Hispanic blacks have diabetes compared to 9.3 percent of Hispanics and 9.5 percent for non-Hispanic whites.

State Health Department Web Site: www.doh.state.fl.us

Overall Rank: 33



Change: ▲ 3
Determinants Rank: 30
Outcomes Rank: 41

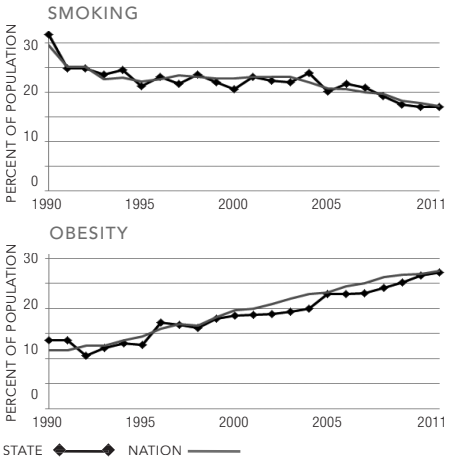
Strengths:
- Low prevalence of binge drinking
- High immunization coverage
- Low levels of air pollution

Challenges:
- High rate of uninsured population
- Low high school graduation rate
- High geographic disparity within the state

FLORIDA

ECONOMIC ENVIRONMENT	FL	U.S.
Unemployment Rate (Aug 2011)	10.7%	8.3%
Underemployment Rate (2010)	19.3%	16.7%
Median Household Income (2010)	$44,243	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	2,862,000	2,531,000	-331,00
Obesity	2,307,000	4,025,000	1,718,000
Diabetes	851,000	1,539,000	688,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	17.1	23	9.1
	Binge Drinking (Percent of adult population)	13.6	15	6.7
	Obesity (Percent of adult population)	27.2	23	21.4
	High School Graduation (Percent of incoming ninth graders)	66.9	44	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	542	42	122
	Occupational Fatalities (Deaths per 100,000 workers)	4.3	24	2.5
	Infectious Disease (Cases per 100,000 population)	8.8	28	2.3
	Children in Poverty (Percent of persons under age 18)	22.3	32	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	7.8	10	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	21.3	48	5.0
	Public Health Funding (Dollars per person)	$64	35	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	94.7	3	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	69.7	32	—
	Primary Care Physicians (per 100,000 population)	109.7	30	191.9
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	64.3	26	25.6
	ALL DETERMINANTS	-0.01	30	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	10.4	43	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.8	38	2.3
	Poor Physical Health Days (Days in previous 30 days)	4.1	41	2.6
	Geographic Disparity (Relative standard deviation)	21.9	48	4.8
	Infant Mortality (Deaths per 1,000 live births)	7.1	29	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	231.4	8	197.2
	Cancer Deaths (Deaths per 100,000 population)	182.3	11	137.4
	Premature Death (Years lost per 100,000 population)	7,964	35	5481
	ALL OUTCOMES	-0.11	41	0.32
	OVERALL	-0.12	33	1.20

— indicates data not available. * See measure description for full details.

GEORGIA

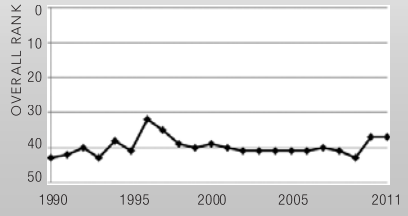
Ranking: Georgia is 37th this year, unchanged from 2010.

Highlights:
- While smoking has decreased from 22.1 percent to 17.6 percent of the adult population in the past five years, nearly 1.3 million adults still smoke in Georgia.
- Almost 2.2 million adults in Georgia are obese, 894,000 more adults than 10 years ago.
- In the past five years, the violent crime rate decreased from 446 to 403 offenses per 100,000 population.
- In the past ten years, diabetes increased from 6.8 percent to 9.7 percent of the adult population, increasing the number of adults with diabetes in the state to 698,000.
- In the past ten years, the percentage of children in poverty increased from 16.4 percent to 24.7 percent of persons under age 18.

Health Disparities:
In Georgia, obesity is more prevalent among non-Hispanic blacks at 38.1 percent than non-Hispanic whites at 25.6 percent. Diabetes also varies by race and ethnicity in the state; 12.8 percent of non-Hispanic blacks have diabetes compared to 8.4 percent of non-Hispanic whites.

State Health Department Web Site: www.health.state.ga.us

Overall Rank: 37



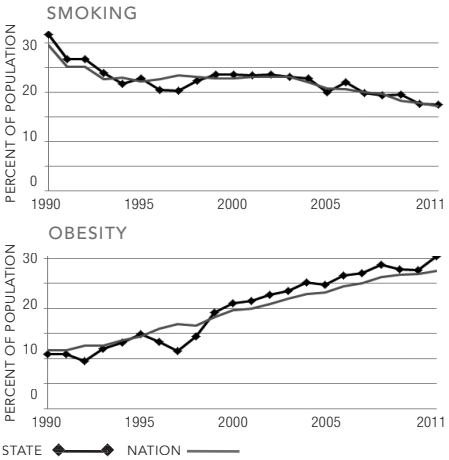
Change: no change
Determinants Rank: 38
Outcomes Rank: 40

Strengths:
- Low prevalence of binge drinking
- High immunization coverage
- Moderate use of early prenatal care

Challenges:
- Low high school graduation rate
- High levels of air pollution
- High rate of uninsured population

ECONOMIC ENVIRONMENT	GA	U.S.
Unemployment Rate (Aug 2011)	10.2%	8.3%
Underemployment Rate (2010)	17.9%	16.7%
Median Household Income (2010)	$44,108	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	1,414,000	1,267,000	-147,000
Obesity	1,294,000	2,188,000	894,000
Diabetes	409,000	698,000	289,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	17.6	27	9.1
	Binge Drinking (Percent of adult population)	11.5	7	6.7
	Obesity (Percent of adult population)	30.4	38	21.4
	High School Graduation (Percent of incoming ninth graders)	65.4	46	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	403	32	122
	Occupational Fatalities (Deaths per 100,000 workers)	4.0	21	2.5
	Infectious Disease (Cases per 100,000 population)	12.0	41	2.3
	Children in Poverty (Percent of persons under age 18)	24.7	40	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	12.0	46	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	19.9	46	5.0
	Public Health Funding (Dollars per person)	$57	38	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	92.3	14	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	72.6	17	—
	Primary Care Physicians (Number per 100,000 population)	100.2	38	191.9
	Preventable Hospitalizations (per 1,000 Medicare enrollees)	68.3	30	25.6
	ALL DETERMINANTS	-0.21	38	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	9.7	34	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.4	19	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.5	22	2.6
	Geographic Disparity (Relative standard deviation)	14.4	37	4.8
	Infant Mortality (Deaths per 1,000 live births)	8.0	43	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	292.1	40	197.2
	Cancer Deaths (Deaths per 100,000 population)	190.5	20	137.4
	Premature Death (Years lost per 100,000 population)	8,148	38	5481
	ALL OUTCOMES	-0.06	40	0.32
	OVERALL	-0.28	37	1.20

— indicates data not available. * See measure description for full details.

HAWAII

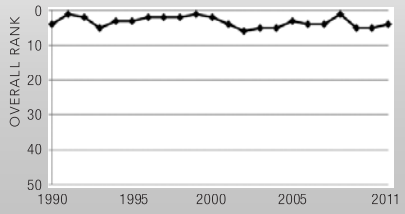
Ranking: Hawaii is 4th this year; it was 5th in 2010.

Highlights:
- While smoking has decreased from 19.7 percent in 2001 to 14.5 percent of adults in 2011, 153,000 adults still smoke in Hawaii.
- In the past year, the rate of preventable hospitalizations decreased from 28.6 to 25.6 discharges per 1,000 Medicare enrollees.
- In the past five years, obesity increased from 19.7 percent to 23.1 percent of adults. There are now 244,000 obese adults in Hawaii.
- In the past five years, diabetes increased from 7.3 percent to 8.3 percent of adults.
- In the past five years, the percentage of children in poverty increased from 10.0 percent to 18.9 percent of persons under age 18.

Health Disparities:
In Hawaii, obesity is more prevalent among non-Hispanic Hawaiian or Pacific Islanders at 56.8 percent than whites at 19.3 percent. Diabetes also varies by race and ethnicity in the state; 10.1 of non-Hispanic Hawaiian or Pacific Islanders have diabetes compared to 4.7 percent of non-Hispanic whites and 9.6 percent of non-Hispanic Asians.

State Health Department Web Site: www.hawaii.gov/health

Overall Rank: 4



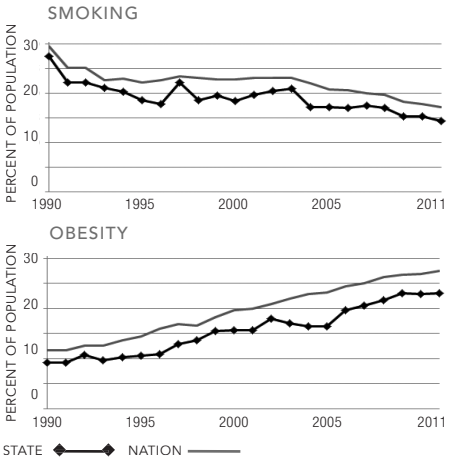
Change: ▲ 1
Determinants Rank: 4
Outcomes Rank: 1

Strengths:
- Low rate of uninsured population
- High per capita public health funding
- Low rate of preventable hospitalizations

Challenges:
- Low immunization coverage
- High prevalence of binge drinking
- Low high school graduation rate

ECONOMIC ENVIRONMENT	HI	U.S.
Unemployment Rate (Aug 2011)	6.2%	8.3%
Underemployment Rate (2010)	16.9%	16.7%
Median Household Income (2010)	$58,507	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	180,000	153,000	-27,000
Obesity	144,000	244,000	100,000
Diabetes	48,000	88,000	40,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	14.5	7	9.1
	Binge Drinking (Percent of adult population)	17.5	39	6.7
	Obesity (Percent of adult population)	23.1	4	21.4
	High School Graduation (Percent of incoming ninth graders)	76.0	28	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	263	14	122
	Occupational Fatalities (Deaths per 100,000 workers)	3.7	16	2.5
	Infectious Disease (Cases per 100,000 population)	6.2	11	2.3
	Children in Poverty (Percent of persons under age 18)	18.9	22	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	8.6	14	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	7.5	2	5.0
	Public Health Funding (Dollars per person)	$244	1	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	90.2	29	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	82.9*	21	—
	Primary Care Physicians (per 100,000 population)	148.6	7	191.9
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	25.6	1	25.6
	ALL DETERMINANTS	0.62	4	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	8.3	20	5.3
	Poor Mental Health Days (Days in previous 30 days)	2.5	3	2.3
	Poor Physical Health Days (Days in previous 30 days)	2.7	3	2.6
	Geographic Disparity (Relative standard deviation)	6.3	5	4.8
	Infant Mortality (Deaths per 1,000 live births)	6.0	15	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	214.3	2	197.2
	Cancer Deaths (Deaths per 100,000 population)	158.9	2	137.4
	Premature Death (Years lost per 100,000 population)	6,108	10	5481
	ALL OUTCOMES	0.32	1	0.32
	OVERALL	0.94	4	1.20

— indicates data not available. * See measure description for full details.

IDAHO

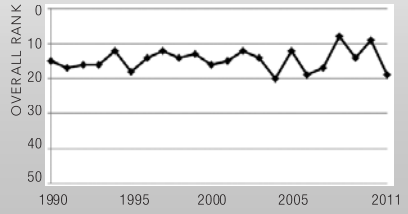
Ranking: Idaho is 19th this year; it was 9th in 2010.

Highlights:
- While smoking has decreased significantly from 22.3 percent to 15.7 percent of adults in the past ten years, 179,000 individuals still smoke in Idaho.
- There are 306,000 obese adults in Idaho, 131,000 more individuals than 10 years ago.
- In the past year, the rate of preventable hospitalizations decreased from 49.1 to 45.3 discharges per 1,000 Medicare enrollees.
- In the past five years, diabetes increased from 6.8 percent to 7.9 percent of adults. 90,000 Idaho adults now have diabetes.
- In the past five years, the percentage of children in poverty increased from 12.4 percent to 18.9 percent of persons under age 18.
- Idaho ranks lower for determinants than for outcomes, indicating that overall healthiness may decline over time.

Health Disparities:
In Idaho, smoking is more prevalent among non-Hispanic American Indians at 29.1 percent than non-Hispanic whites at 16.1 percent. Similarly, 41.1 percent of non-Hispanic American Indian adults are obese compared to 25.1 percent of non-Hispanic white adults.

State Health Department Web Site:
www.healthandwelfare.idaho.gov

Overall Rank: 19



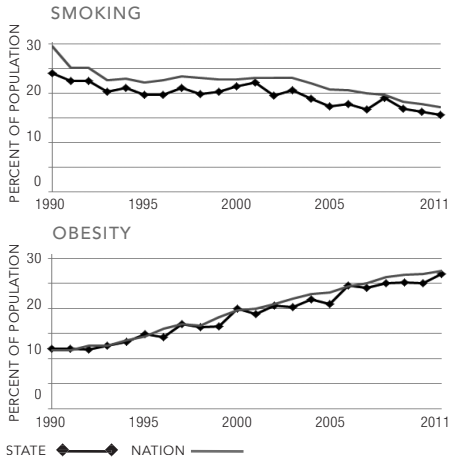
Change: ▼ 10
Determinants Rank: 22
Outcomes Rank: 15

Strengths:
- Low incidence of infectious disease
- Low rate of preventable hospitalizations
- Low violent crime rate

Challenges:
- Limited availability of primary care physicians
- Low immunization coverage
- High rate of uninsured population

ECONOMIC ENVIRONMENT	ID	U.S.
Unemployment Rate (Aug 2011)	9.2%	8.3%
Underemployment Rate (2010)	16.3%	16.7%
Median Household Income (2010)	$47,014	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	206,000	179,000	-27,000
Obesity	175,000	306,000	131,000
Diabetes	45,000	90,000	45,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	15.7	15	9.1
	Binge Drinking (Percent of adult population)	13.1	13	6.7
	Obesity (Percent of adult population)	26.9	21	21.4
	High School Graduation (Percent of incoming ninth graders)	80.1	17	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	221	7	122
	Occupational Fatalities (Deaths per 100,000 workers)	5.1	33	2.5
	Infectious Disease (Cases per 100,000 population)	5.7	9	2.3
	Children in Poverty (Percent of persons under age 18)	18.9	22	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	8.6	14	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	17.2	36	5.0
	Public Health Funding (Dollars per person)	$126	6	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	85.3	48	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	69.3	33	—
	Primary Care Physicians (Number per 100,000 population)	77.7	50	191.9
	Preventable Hospitalizations (per 1,000 Medicare enrollees)	45.3	4	25.6
	ALL DETERMINANTS	0.19	22	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	7.9	18	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.4	19	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.7	29	2.6
	Geographic Disparity (Relative standard deviation)	11.4	25	4.8
	Infant Mortality (Deaths per 1,000 live births)	6.3	20	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	238.3	15	197.2
	Cancer Deaths (Deaths per 100,000 population)	175.8	7	137.4
	Premature Death (Years lost per 100,000 population)	6,415	15	5481
	ALL OUTCOMES	0.16	15	0.32
	OVERALL	0.34	19	1.20

— indicates data not available. * See measure description for full details.

ILLINOIS

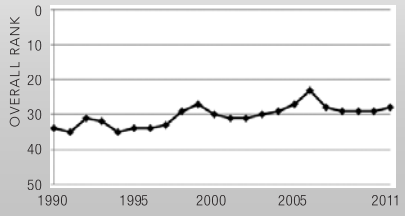
Ranking: Illinois is 28th this year; it was 29th in 2010.

Highlights:
- While smoking has decreased from 22.3 percent to 16.9 percent of adults in the past ten years, more than 1.6 million people still smoke in Illinois.
- Nearly 2.8 million adults in Illinois are obese, 793,000 more individuals than 10 years ago.
- Diabetes has increased sharply in the last 10 years from 6.2 percent to 8.7 percent of the adult population. Now, more than 844,000 Illinois adults have diabetes.
- In the past year, the violent crime rate decreased from 497 to 435 offenses per 100,000 population.
- In the past five years, the percentage of children in poverty increased from 15.6 percent to 20.6 percent of persons under age 18.
- Infectious disease, at 11.1 cases per 100,000 population, has almost returned to the level experienced in 2006 after dipping to 8.2 cases per 100,000 population last year.

Health Disparities:
In Illinois, obesity is more prevalent among non-Hispanic blacks at 39.5 percent than non-Hispanic whites at 25.5 percent and Hispanics at 31.5 percent. Diabetes also varies by race and ethnicity in the state; 13.4 percent of non-Hispanic blacks have diabetes compared to 7.4 percent of non-Hispanic whites and 8.2 percent of Hispanics.

State Health Department Web Site: www.idph.state.il.us

Overall Rank: 28



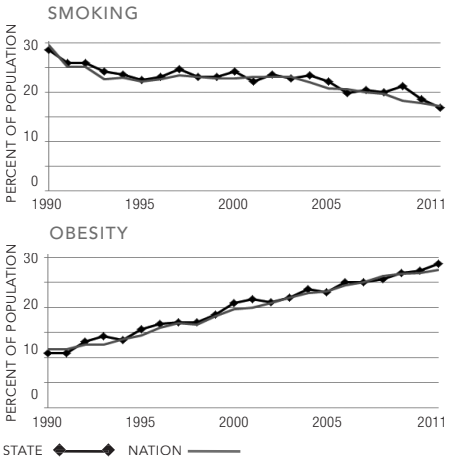
Change: ▲ 1
Determinants Rank: 28
Outcomes Rank: 22

Strengths:
- High use of early prenatal care
- Ready availability of primary care physicians
- Moderate rate of high school graduation

Challenges:
- High prevalence of binge drinking
- High levels of air pollution
- High rate of preventable hospitalizations

ECONOMIC ENVIRONMENT	IL	U.S.
Unemployment Rate (Aug 2011)	9.9%	8.3%
Underemployment Rate (2010)	17.5%	16.7%
Median Household Income (2010)	$50,761	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	2,046,000	1,640,000	-406,000
Obesity	1,991,000	2,784,000	793,000
Diabetes	569,000	844,000	275,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	16.9	20	9.1
	Binge Drinking (Percent of adult population)	17.7	40	6.7
	Obesity (Percent of adult population)	28.7	31	21.4
	High School Graduation (Percent of incoming ninth graders)	80.4	15	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	435	34	122
	Occupational Fatalities (Deaths per 100,000 workers)	3.7	16	2.5
	Infectious Disease (Cases per 100,000 population)	11.1	38	2.3
	Children in Poverty (Percent of persons under age 18)	20.6	29	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	11.8	43	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	14.5	27	5.0
	Public Health Funding (Dollars per person)	$66	33	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	91.3	21	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	86.3*	8	—
	Primary Care Physicians (per 100,000 population)	129.6	11	191.9
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	77.3	40	25.6
	ALL DETERMINANTS	0.02	28	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	8.7	25	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.4	19	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.4	18	2.6
	Geographic Disparity (Relative standard deviation)	10.1	18	4.8
	Infant Mortality (Deaths per 1,000 live births)	6.9	28	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	276.3	32	197.2
	Cancer Deaths (Deaths per 100,000 population)	199.7	33	137.4
	Premature Death (Years lost per 100,000 population)	7,049	23	5481
	ALL OUTCOMES	0.08	22	0.32
	OVERALL	0.10	28	1.20

— indicates data not available. * See measure description for full details.

INDIANA

Ranking: Indiana is 38th this year, unchanged from 2010.

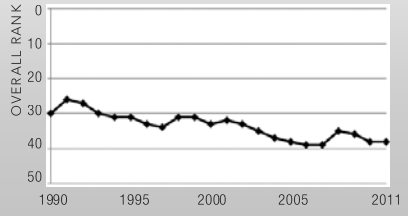
Highlights:

- While smoking has decreased from 26.9 percent to 21.2 percent of adults in the past ten years, over 1.0 million people still smoke in Indiana.
- Almost 1.5 million adults in Indiana are obese, 490,000 more individuals than 10 years ago.
- In the past year, the rate of preventable hospitalizations increased from 75.6 to 78.4 discharges per 1,000 Medicare enrollees.
- In the past year, the infant mortality rate decreased from 7.8 to 7.3 deaths per 1,000 live births.
- In the past five years, diabetes increased from 8.3 percent to 9.8 percent of the adult population. Now, 478,000 Indiana adults have diabetes.
- In the past five years, the percentage of children in poverty increased from 18.6 percent to 25.2 percent of persons under age 18.
- Infectious disease, at 7.8 cases per 100,000 population, has returned to levels experienced three years ago after dipping to 4.4 and 4.6 cases per 100,000 population in 2009 and 2010, respectively.

Health Disparities:
In Indiana, obesity is more prevalent among non-Hispanic blacks at 37.0 percent than Hispanics at 28.4 percent and non-Hispanic whites at 28.8 percent. Diabetes also varies by race and ethnicity in the state; 14.8 percent of non-Hispanic blacks have diabetes compared to 9.4 percent of Hispanics and 9.1 percent of non-Hispanic whites.

State Health Department Web Site: www.in.gov/isdh

Overall Rank: 38



Change: no change
Determinants Rank: 41
Outcomes Rank: 34

Strengths:

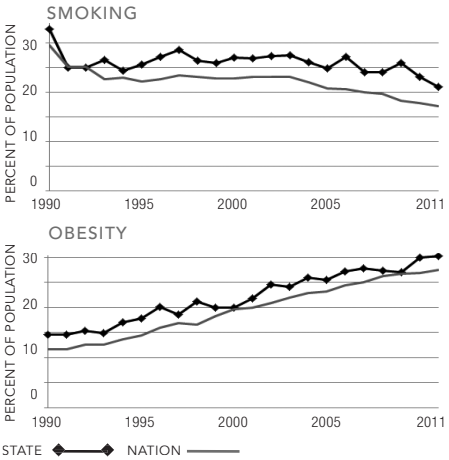
- Moderate prevalence of binge drinking
- Low geographic disparity with the state

Challenges:

- High prevalence of smoking
- High percentage of children in poverty
- Low per capita public health funding
- High levels of air pollution

ECONOMIC ENVIRONMENT	IN	U.S.
Unemployment Rate (Aug 2011)	8.7%	8.3%
Underemployment Rate (2010)	17.4%	16.7%
Median Household Income (2010)	$46,322	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	1,212,000	1,034,000	-178,000
Obesity	982,000	1,472,000	490,000
Diabetes	270,000	478,000	208,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	21.2	41	9.1
	Binge Drinking (Percent of adult population)	13.8	17	6.7
	Obesity (Percent of adult population)	30.2	37	21.4
	High School Graduation (Percent of incoming ninth graders)	74.1	34	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	315	23	122
	Occupational Fatalities (Deaths per 100,000 workers)	4.7	28	2.5
	Infectious Disease (Cases per 100,000 population)	7.8	21	2.3
	Children in Poverty (Percent of persons under age 18)	25.2	43	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	13.1	49	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	13.6	21	5.0
	Public Health Funding (Dollars per person)	$42	48	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	89.4	34	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	67.4	40	—
	Primary Care Physicians (Number per 100,000 population)	102.5	36	191.9
	Preventable Hospitalizations (per 1,000 Medicare enrollees)	78.4	42	25.6
	ALL DETERMINANTS	-0.29	41	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	9.8	36	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.7	34	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.7	29	2.6
	Geographic Disparity (Relative standard deviation)	8.7	10	4.8
	Infant Mortality (Deaths per 1,000 live births)	7.3	31	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	291.0	38	197.2
	Cancer Deaths (Deaths per 100,000 population)	208.2	41	137.4
	Premature Death (Years lost per 100,000 population)	7,917	33	5481
	ALL OUTCOMES	-0.01	34	0.32
	OVERALL	-0.29	38	1.20

— indicates data not available. * See measure description for full details.

IOWA

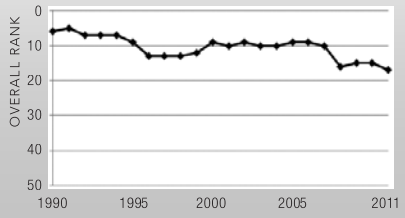
Ranking: Iowa is 17th this year; it was 15th in 2010.

Highlights:
- While smoking has decreased from 23.2 percent to 16.1 percent of adults in the past ten years, 373,000 people still smoke in Iowa.
- There are 675,000 obese adults in Iowa, 204,000 more individuals than 10 years ago.
- In the past year, the percentage of children in poverty decreased from 14.7 percent to 12.5 percent of persons under age 18.
- In the past ten years, diabetes increased from 6.1 percent to 7.5 percent of the adult population. Now 174,000 Iowa adults have diabetes.
- Iowa ranks lower for determinants than for outcomes, indicating that overall healthiness may decline over time.

Health Disparities:
In Iowa, smoking is more prevalent among non-Hispanic blacks at 31.6 percent than non-Hispanic whites at 17.0 percent. Obesity varies less dramatically by race with 33.0 percent of non-Hispanic blacks who are obese compared to 29.5 percent of Hispanics and 28.1 percent of non-Hispanic whites.

State Health Department Web Site: www.idph.state.ia.us

Overall Rank: 17



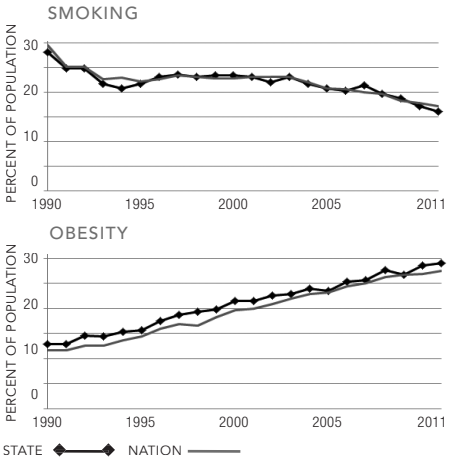
Change: ▼ 2
Determinants Rank: 23
Outcomes Rank: 8

Strengths:
- High rate of high school graduation
- Low rate of uninsured population
- Low percentage of children in poverty

Challenges:
- High prevalence of binge drinking
- Limited availability of primary care physicians
- High incidence of infectious disease

ECONOMIC ENVIRONMENT	IA	U.S.
Unemployment Rate (Aug 2011)	6.1%	8.3%
Underemployment Rate (2010)	11.6%	16.7%
Median Household Income (2010)	$49,177	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	509,000	373,000	-136,000
Obesity	471,000	675,000	204,000
Diabetes	134,000	174,000	40,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	16.1	19	9.1
	Binge Drinking (Percent of adult population)	17.7	40	6.7
	Obesity (Percent of adult population)	29.1	33	21.4
	High School Graduation (Percent of incoming ninth graders)	86.4	3	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	274	18	122
	Occupational Fatalities (Deaths per 100,000 workers)	6.0	40	2.5
	Infectious Disease (Cases per 100,000 population)	11.3	39	2.3
	Children in Poverty (Percent of persons under age 18)	12.5	5	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	10.2	29	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	11.6	10	5.0
	Public Health Funding (Dollars per person)	$58	37	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	91.9	17	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	72.5	19	—
	Primary Care Physicians (per 100,000 population)	84.2	47	191.9
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	63.4	22	25.6
	ALL DETERMINANTS	0.15	23	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	7.5	14	5.3
	Poor Mental Health Days (Days in previous 30 days)	2.5	3	2.3
	Poor Physical Health Days (Days in previous 30 days)	2.8	4	2.6
	Geographic Disparity (Relative standard deviation)	9.9	16	4.8
	Infant Mortality (Deaths per 1,000 live births)	5.6	10	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	258.3	23	197.2
	Cancer Deaths (Deaths per 100,000 population)	191.0	22	137.4
	Premature Death (Years lost per 100,000 population)	6,484	17	5481
	ALL OUTCOMES	0.25	8	0.32
	OVERALL	0.40	17	1.20

— indicates data not available. * See measure description for full details.

KANSAS

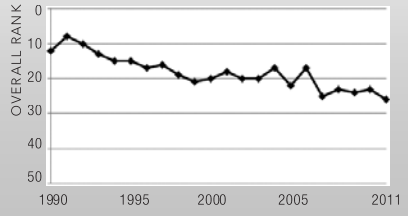
Ranking: Kansas is 26th this year; it was 23rd in 2010.

Highlights:
- While smoking has decreased from 21.0 percent to 17.0 percent of adults in the past ten years, 361,000 people still smoke in Kansas.
- There are 640,000 obese adults in Kansas, 229,000 more individuals than 10 years ago.
- In the past year, the rate of preventable hospitalizations decreased from 75.3 to 70.5 discharges per 1,000 Medicare enrollees.
- In the past year, the percentage of children in poverty increased from 18.0 percent to 23.1 percent of persons under age 18.
- In the past five years, diabetes increased from 6.9 percent to 8.4 percent of the adult population. Now, 179,000 Kansas adults have diabetes.
- The rate of deaths from cardiovascular disease has declined in the last ten years from 324.3 to 265.2 deaths per 100,000 population.

Health Disparities:
In Kansas, obesity is more prevalent among non-Hispanic blacks at 41.8 percent than non-Hispanic whites at 28.4 percent. Diabetes also varies by race and ethnicity in the state; 12.2 percent of non-Hispanic blacks have diabetes compared to 8.1 percent of non-Hispanic whites.

State Health Department Web Site: www.kdheks.gov

Overall Rank: 26



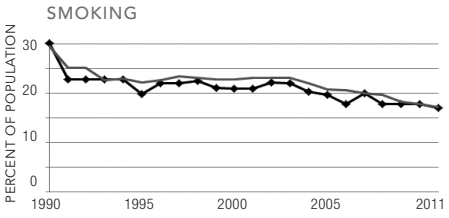
Change: ▼3
Determinants Rank: 27
Outcomes Rank: 21

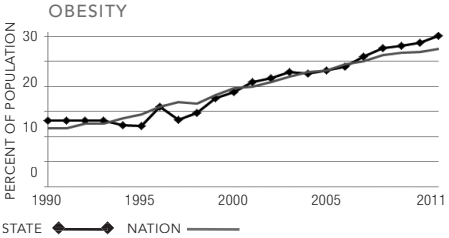
Strengths:
- Few poor mental and physical health days per month
- Moderate use of early prenatal care
- Low rate of uninsured population

Challenges:
- Low per capita public health funding
- Limited availability of primary care physicians
- High prevalence of obesity

ECONOMIC ENVIRONMENT	KS	U.S.
Unemployment Rate (Aug 2011)	6.7%	8.3%
Underemployment Rate (2010)	12.4%	16.7%
Median Household Income (2010)	$46,229	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	415,000	361,000	-54,000
Obesity	411,000	640,000	229,000
Diabetes	117,000	179,000	62,000





STATE ◆—◆ NATION

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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	17.0	22	9.1
	Binge Drinking (Percent of adult population)	14.7	20	6.7
	Obesity (Percent of adult population)	30.1	36	21.4
	High School Graduation (Percent of incoming ninth graders)	79.0	19	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	369	29	122
	Occupational Fatalities (Deaths per 100,000 workers)	5.4	36	2.5
	Infectious Disease (Cases per 100,000 population)	7.8	21	2.3
	Children in Poverty (Percent of persons under age 18)	23.1	35	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	9.3	20	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	12.8	15	5.0
	Public Health Funding (Dollars per person)	$47	44	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	91.5	19	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	73.3	15	—
	Primary Care Physicians (Number per 100,000 population)	102.4	37	191.9
	Preventable Hospitalizations (per 1,000 Medicare enrollees)	70.5	33	25.6
	ALL DETERMINANTS	0.04	27	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	8.4	21	5.3
	Poor Mental Health Days (Days in previous 30 days)	2.9	6	2.3
	Poor Physical Health Days (Days in previous 30 days)	2.9	7	2.6
	Geographic Disparity (Relative standard deviation)	11.5	26	4.8
	Infant Mortality (Deaths per 1,000 live births)	7.6	37	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	265.2	28	197.2
	Cancer Deaths (Deaths per 100,000 population)	189.6	19	137.4
	Premature Death (Years lost per 100,000 population)	7,269	25	5481
	ALL OUTCOMES	0.09	21	0.32
	OVERALL	0.13	26	1.20

— indicates data not available. * See measure description for full details.

KENTUCKY

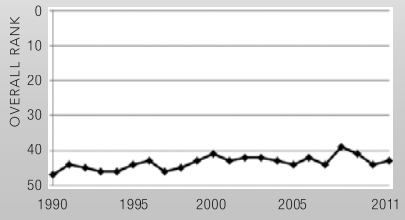
Ranking: Kentucky is 43rd this year; it was 44th in 2010.

Highlights:
- While smoking has decreased from 30.5 percent to 24.8 percent of adults in the past ten years, 822,000 people still smoke in Kentucky.
- Almost 1.1 million adults in Kentucky are obese, 353,000 more individuals than 10 years ago.
- In the past year, diabetes decreased from 11.5 percent to 10.0 percent of the population. However, there are still 332,000 adults in Kentucky with diabetes.
- In the past five years, the rate of uninsured population increased from 13.0 percent to 15.4 percent of the population.
- In the past ten years, the percentage of children in poverty increased from 15.2 percent to 24.7 percent of persons under age 18.

Health Disparities:
In Kentucky, obesity is more prevalent among non-Hispanic blacks at 43.2 percent than non-Hispanic whites at 31.0 percent. Diabetes also varies by race and ethnicity in the state; 14.9 percent of non-Hispanic blacks have diabetes compared to 10.1 percent of non-Hispanic whites.

State Health Department Web Site: www.chfs.ky.gov

Overall Rank: 43



Change: ▲ 1
Determinants Rank: 42
Outcomes Rank: 45

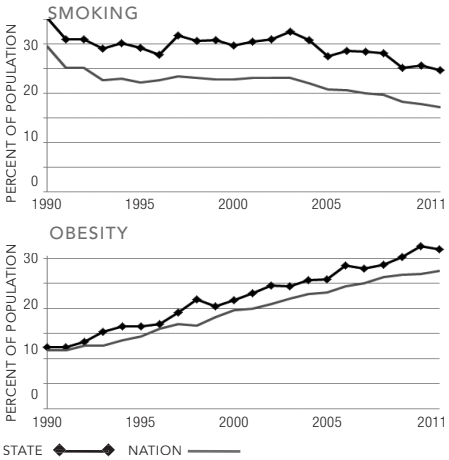
Strengths:
- Low prevalence of binge drinking
- Low violent crime rate

Challenges:
- High prevalence of smoking
- High prevalence of obesity
- High rate of preventable hospitalizations
- High rate of cancer deaths

KENTUCKY

ECONOMIC ENVIRONMENT	KY	U.S.
Unemployment Rate (Aug 2011)	9.5%	8.3%
Underemployment Rate (2010)	16.4%	16.7%
Median Household Income (2010)	$41,236	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	929,000	822,000	-107,000
Obesity	701,000	1,054,000	353,000
Diabetes	198,000	332,000	134,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	24.8	49	9.1
	Binge Drinking (Percent of adult population)	12.2	10	6.7
	Obesity (Percent of adult population)	31.8	46	21.4
	High School Graduation (Percent of incoming ninth graders)	74.4	32	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	243	10	122
	Occupational Fatalities (Deaths per 100,000 workers)	5.4	36	2.5
	Infectious Disease (Cases per 100,000 population)	7.5	19	2.3
	Children in Poverty (Percent of persons under age 18)	24.7	40	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	11.9	44	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	15.4	31	5.0
	Public Health Funding (Dollars per person)	$82	23	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	89.7	31	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	72.2	23	—
	Primary Care Physicians (per 100,000 population)	104.2	35	191.9
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	103.8	50	25.6
	ALL DETERMINANTS	-0.32	42	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	10.0	38	5.3
	Poor Mental Health Days (Days in previous 30 days)	4.3	49	2.3
	Poor Physical Health Days (Days in previous 30 days)	4.8	49	2.6
	Geographic Disparity (Relative standard deviation)	12.1	30	4.8
	Infant Mortality (Deaths per 1,000 live births)	6.8	27	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	311.5	43	197.2
	Cancer Deaths (Deaths per 100,000 population)	225.1	50	137.4
	Premature Death (Years lost per 100,000 population)	9,005	42	5481
	ALL OUTCOMES	-0.16	45	0.32
	OVERALL	-0.48	43	1.20

— indicates data not available. * See measure description for full details.

LOUISIANA

Ranking: Louisiana is 49th this year, unchanged from 2010.

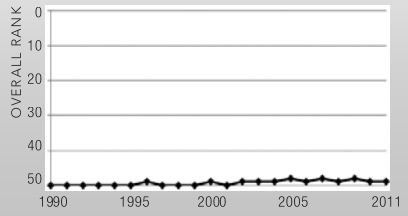
Highlights:

- While smoking has declined from 24.1 percent to 22.1 percent of adults over the last ten years, 755,000 people still smoke in Louisiana.
- Nearly 1.1 million adults in Louisiana are obese, 316,000 more individuals than 10 years ago.
- In the past year, the violent crime rate decreased from 620 to 549 offenses per 100,000 population.
- In the past year, the percentage of children in poverty increased from 19.5 percent to 30.5 percent of persons under age 18.
- In the past ten years, diabetes increased from 6.6 percent to 10.3 percent of the adult population. Now, 352,000 adults have diabetes.

Health Disparities:
In Louisiana, obesity is more prevalent among non-Hispanic blacks at 39.5 percent than non-Hispanic whites at 28.4 percent and Hispanics at 29.3 percent. Diabetes also varies by race and ethnicity in the state; 13.4 percent of non-Hispanic blacks have diabetes compared to 9.4 percent of non-Hispanic whites and 9.5 percent of Hispanics.

State Health Department Web Site: www.oph.dhh.state.la.u

Overall Rank: 49



Change: no change
Determinants Rank: 50
Outcomes Rank: 48

Strengths:

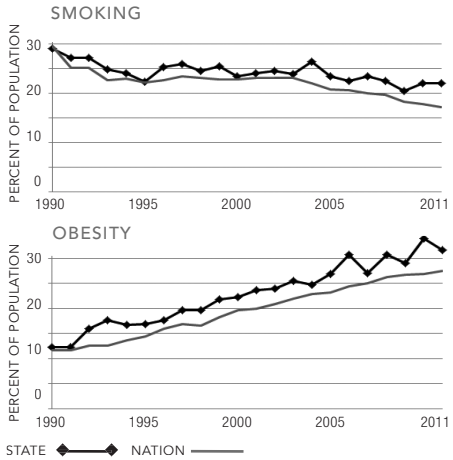
- High use of early prenatal care
- Moderate per capita public health funding

Challenges:

- Low high school graduation rate
- High percentage of children in poverty
- High rate of preventable hospitalizations
- High prevalence of smoking

ECONOMIC ENVIRONMENT	LA	U.S.
Unemployment Rate (Aug 2011)	7.2%	8.3%
Underemployment Rate (2010)	12.9%	16.7%
Median Household Income (2010)	$39,443	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	783,000	755,000	-28,000
Obesity	767,000	1,083,000	316,000
Diabetes	214,000	352,000	138,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	22.1	44	9.1
	Binge Drinking (Percent of adult population)	14.7	20	6.7
	Obesity (Percent of adult population)	31.7	42	21.4
	High School Graduation (Percent of incoming ninth graders)	63.5	48	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	549	44	122
	Occupational Fatalities (Deaths per 100,000 workers)	8.4	48	2.5
	Infectious Disease (Cases per 100,000 population)	19.6	48	2.3
	Children in Poverty (Percent of persons under age 18)	30.5	49	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	9.8	25	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	17.2	36	5.0
	Public Health Funding (Dollars per person)	$99	16	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	89.4	35	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	86.7*	7	—
	Primary Care Physicians (Number per 100,000 population)	117.9	23	191.9
	Preventable Hospitalizations (per 1,000 Medicare enrollees)	93.2	47	25.6
	ALL DETERMINANTS	-0.57	50	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	10.3	41	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.9	41	2.3
	Poor Physical Health Days (Days in previous 30 days)	4.2	44	2.6
	Geographic Disparity (Relative standard deviation)	12.1	30	4.8
	Infant Mortality (Deaths per 1,000 live births)	9.1	48	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	318.9	45	197.2
	Cancer Deaths (Deaths per 100,000 population)	215.3	47	137.4
	Premature Death (Years lost per 100,000 population)	10,331	48	5481
	ALL OUTCOMES	-0.25	48	0.32
	OVERALL	-0.82	49	1.20

— indicates data not available. * See measure description for full details.

MAINE

Ranking: Maine is 8th this year, unchanged from 2010.

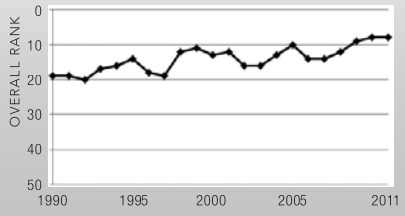
Highlights:

- While smoking has decreased from 23.8 percent to 18.2 percent of adults in the past ten years, 192,000 people still smoke in Maine.
- In the past year, geographic disparity within the state decreased from 7.8 percent to 6.7 percent.
- In the past five years, obesity increased from 22.7 percent to 27.4 percent of the population; 289,000 people in Maine are now obese.
- In the past ten years, diabetes increased from 6.0 percent to 8.7 percent of adults; 92,000 adults now have diabetes.
- In the past ten years, the percentage of children in poverty increased from 8.9 percent to 17.8 percent of persons under age 18.
- Maine ranks higher for determinants than for outcomes, indicating that overall healthiness should improve over time.

Health Disparities:
In Maine, smoking is more prevalent among Hispanics at 23.2 percent than non-Hispanic whites at 17.6 percent. Whereas, obesity is more prevalent among non-Hispanic whites at 26.7 percent than among Hispanics at 21.0 percent.

State Health Department Web Site: www.maine.gov/dhhs

Overall Rank: 8



Change: no change
Determinants Rank: 8
Outcomes Rank: 18

Strengths:

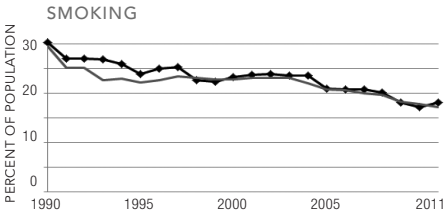
- Low violent crime rate
- Low rate of uninsured population
- High use of early prenatal care

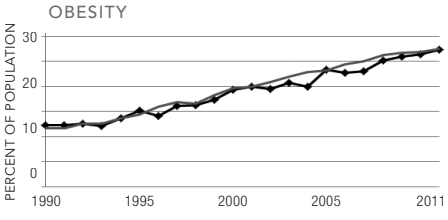
Challenges:

- Low immunization coverage
- High rate of cancer deaths
- High prevalence of smoking

ECONOMIC ENVIRONMENT	ME	U.S.
Unemployment Rate (Aug 2011)	7.6%	8.3%
Underemployment Rate (2010)	15.2%	16.7%
Median Household Income (2010)	$48,133	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	232,000	192,000	-40,000
Obesity	195,000	289,000	94,000
Diabetes	58,000	92,000	34,000





STATE ◆—◆ NATION

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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	**BEHAVIORS**			
	Smoking (Percent of adult population)	18.2	28	9.1
	Binge Drinking (Percent of adult population)	14.8	22	6.7
	Obesity (Percent of adult population)	27.4	24	21.4
	High School Graduation (Percent of incoming ninth graders)	79.1	18	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	122	1	122
	Occupational Fatalities (Deaths per 100,000 workers)	3.6	15	2.5
	Infectious Disease (Cases per 100,000 population)	6.2	11	2.3
	Children in Poverty (Percent of persons under age 18)	17.8	20	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	8.2	12	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	9.7	6	5.0
	Public Health Funding (Dollars per person)	$86	21	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	89.1	36	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	87.3*	6	—
	Primary Care Physicians (per 100,000 population)	129.3	12	191.9
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	63.0	20	25.6
	ALL DETERMINANTS	0.43	8	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	8.7	25	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.7	34	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.7	29	2.6
	Geographic Disparity (Relative standard deviation)	6.7	6	4.8
	Infant Mortality (Deaths per 1,000 live births)	5.9	12	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	242.1	20	197.2
	Cancer Deaths (Deaths per 100,000 population)	204.2	38	137.4
	Premature Death (Years lost per 100,000 population)	6,489	18	5481
	ALL OUTCOMES	0.15	18	0.32
	OVERALL	0.58	8	1.20

— indicates data not available. * See measure description for full details.

MARYLAND

Ranking: Maryland is 22nd this year; it was 21st in 2010.

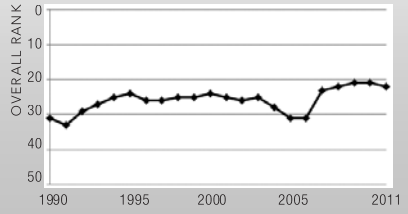
Highlights:

- While smoking has decreased from 20.5 percent to 15.2 percent of adults in the past ten years, 672,000 people still smoke in Maryland.
- More than 1.2 million adults in Maryland are obese, 437,000 more adults than 10 years ago.
- In the past year, the percentage of children in poverty increased from 12.3 percent to 13.6 percent of persons under age 18. Children in poverty was only 6.9 percent in 2001.
- In the past five years, the violent crime rate decreased from 704 to 548 offenses per 100,000 population.
- In the past ten years, diabetes increased from 6.4 percent to 9.3 percent of the adult population; 411,000 adults now have diabetes.
- Maryland ranks higher for determinants than for outcomes, indicating that overall healthiness should improve over time.

Health Disparities:
In Maryland, obesity is more prevalent among non-Hispanic blacks at 36.3 percent than non-Hispanic whites at 24.3 percent. Diabetes also varies by race and ethnicity in the state; 12.8 percent of non-Hispanic blacks have diabetes compared to 8.0 percent of non-Hispanic whites.

State Health Department Web Site:
www.dhmh.state.md.us

Overall Rank: 22



Change: ▼ 1
Determinants Rank: 16
Outcomes Rank: 33

Strengths:

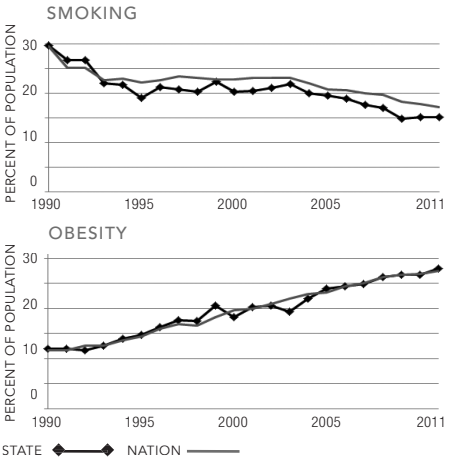
- Low prevalence of smoking
- Low percentage of children in poverty
- Ready availability of primary care physicians

Challenges:

- High violent crime rate
- High infant mortality rate
- High levels of air pollution

ECONOMIC ENVIRONMENT	MD	U.S.
Unemployment Rate (Aug 2011)	7.3%	8.3%
Underemployment Rate (2010)	13.0%	16.7%
Median Household Income (2010)	$64,025	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	808,000	672,000	-136,000
Obesity	796,000	1,233,000	437,000
Diabetes	252,000	411,000	159,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	15.2	10	9.1
	Binge Drinking (Percent of adult population)	13.7	16	6.7
	Obesity (Percent of adult population)	27.9	28	21.4
	High School Graduation (Percent of incoming ninth graders)	80.4	15	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	548	43	122
	Occupational Fatalities (Deaths per 100,000 workers)	3.5	12	2.5
	Infectious Disease (Cases per 100,000 population)	9.8	35	2.3
	Children in Poverty (Percent of persons under age 18)	13.6	11	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	11.5	40	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	13.2	18	5.0
	Public Health Funding (Dollars per person)	$105	14	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	90.1	30	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	81.3*	31	—
	Primary Care Physicians (Number per 100,000 population)	179.6	2	191.9
	Preventable Hospitalizations (per 1,000 Medicare enrollees)	65.6	27	25.6
	ALL DETERMINANTS	0.25	16	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	9.3	31	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.1	11	2.3
	Poor Physical Health Days (Days in previous 30 days)	2.9	7	2.6
	Geographic Disparity (Relative standard deviation)	12.8	33	4.8
	Infant Mortality (Deaths per 1,000 live births)	8.0	43	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	281.8	35	197.2
	Cancer Deaths (Deaths per 100,000 population)	196.4	32	137.4
	Premature Death (Years lost per 100,000 population)	7,441	27	5481
	ALL OUTCOMES	0.02	33	0.32
	OVERALL	0.27	22	1.20

— indicates data not available. * See measure description for full details.

MASSACHUSETTS

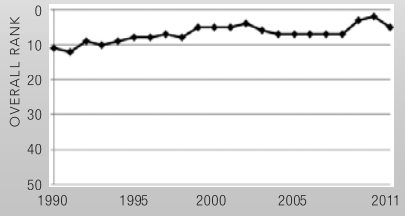
Ranking: Massachusetts is 5th this year; it was 2nd in 2010

Highlights:
- In the past year, the percentage of children in poverty decreased from 16.7 percent to 12.6 percent of persons under age 18.
- In the past ten years, diabetes increased from 5.8 percent to 7.4 percent of the adult population. There are now 380,000 adults with diabetes in the state.
- In the past ten years, obesity increased from 16.8 percent to 23.6 percent of adults, with more than 1.2 million people now obese.
- In the past five years, smoking decreased from 18.1 percent to 14.1 percent of adults. However, 723,000 adults still smoke.

Health Disparities:
In Massachusetts, obesity is more prevalent among non-Hispanic blacks at 30.5 percent than non-Hispanic whites at 21.8 percent. Diabetes also varies by race and ethnicity in the state; 11.1 percent of non-Hispanic blacks have diabetes compared to 7.1 percent of non-Hispanic whites and 9.3 percent Hispanics.

State Health Department Web Site: www.mass.gov/dph

Overall Rank: 5



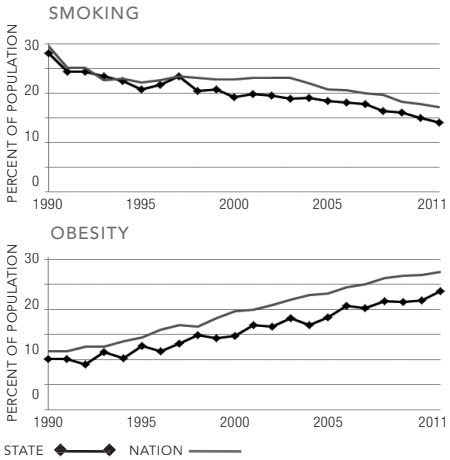
Change: ▼ 3
Determinants Rank: 5
Outcomes Rank: 3

Strengths:
- Low rate of uninsured population
- Low prevalence of smoking
- Lower prevalence of obesity than most other states
- Ready availability of primary care physicians

Challenges:
- High prevalence of binge drinking
- High rate of preventable hospitalizations

ECONOMIC ENVIRONMENT	MA	U.S.
Unemployment Rate (Aug 2011)	7.4%	8.3%
Underemployment Rate (2010)	14.3%	16.7%
Median Household Income (2010)	$61,333	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	965,000	723,000	-242,000
Obesity	815,000	1,210,000	395,000
Diabetes	281,000	380,000	99,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	14.1	5	9.1
	Binge Drinking (Percent of adult population)	17.7	40	6.7
	Obesity (Percent of adult population)	23.6	7	21.4
	High School Graduation (Percent of incoming ninth graders)	81.5	14	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	467	38	122
	Occupational Fatalities (Deaths per 100,000 workers)	2.5	1	2.5
	Infectious Disease (Cases per 100,000 population)	13.5	42	2.3
	Children in Poverty (Percent of persons under age 18)	12.6	6	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	8.9	18	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	5.0	1	5.0
	Public Health Funding (Dollars per person)	$127	5	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	93.7	5	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	87.5*	5	—
	Primary Care Physicians (per 100,000 population)	191.9	1	191.9
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	74.2	37	25.6
	ALL DETERMINANTS	0.60	5	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	7.4	12	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.0	8	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.0	10	2.6
	Geographic Disparity (Relative standard deviation)	7.4	8	4.8
	Infant Mortality (Deaths per 1,000 live births)	5.0	4	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	232.7	9	197.2
	Cancer Deaths (Deaths per 100,000 population)	192.9	29	137.4
	Premature Death (Years lost per 100,000 population)	5,481	1	5481
	ALL OUTCOMES	0.31	3	0.32
	OVERALL	0.91	5	1.20

— indicates data not available. * See measure description for full details.

MICHIGAN

Ranking: Michigan is 30th this year; it was 28th in 2010.

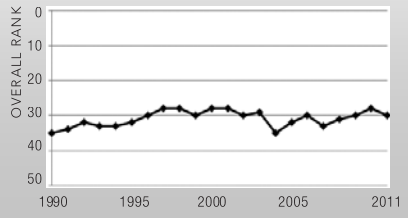
Highlights:

- While smoking has decreased from 24.1 percent to 18.9 percent of the adult population in the past ten years, more than 1.4 million adults still smoke in Michigan.
- In the past year, diabetes increased from 9.3 percent to 10.1 percent of the population; 761,000 adults now have diabetes.
- In the past five years, the violent crime rate decreased from 554 to 490 offenses per 100,000 population.
- In the past five years, obesity increased from 26.2 percent to 31.7 percent of the adult population. Now nearly 2.4 million Michigan adults are obese.
- In the past ten years, the percentage of children in poverty increased from 13.8 percent to 20.4 percent of persons u nder age 18.

Health Disparities:
In Michigan, obesity is more prevalent among non-Hispanic blacks at 41.1 percent than non-Hispanic whites at 29.1 percent. Diabetes also varies by race and ethnicity in the state; 13.8 percent of non-Hispanic blacks have diabetes compared to 8.6 percent of non-Hispanic whites and 10.7 percent Hispanics.

State Health Department Web Site: www.michigan.gov/mdch

Overall Rank: 30



Change: ▼ 2
Determinants Rank: 32
Outcomes Rank: 35

Strengths:

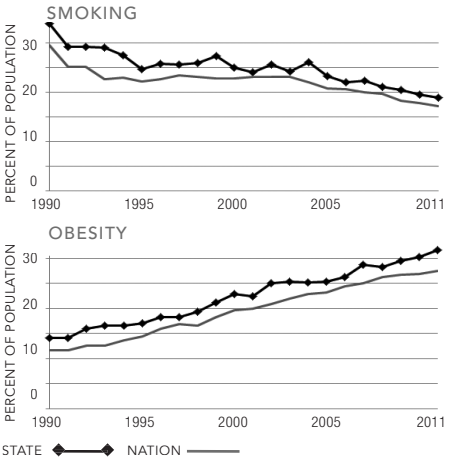
- High immunization coverage
- High use of early prenatal care
- Low occupational fatalities rate

Challenges:

- High prevalence of obesity
- High violent crime rate
- Low per capita public health funding

ECONOMIC ENVIRONMENT	MI	U.S.
Unemployment Rate (Aug 2011)	11.2%	8.3%
Underemployment Rate (2010)	21.0%	16.7%
Median Household Income (2010)	$46,441	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	1,770,000	1,425,000	-345,000
Obesity	1,645,000	2,390,000	745,000
Diabetes	514,000	761,000	247,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	18.9	33	9.1
	Binge Drinking (Percent of adult population)	16.1	32	6.7
	Obesity (Percent of adult population)	31.7	42	21.4
	High School Graduation (Percent of incoming ninth graders)	76.3	27	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	490	40	122
	Occupational Fatalities (Deaths per 100,000 workers)	3.5	12	2.5
	Infectious Disease (Cases per 100,000 population)	9.2	31	2.3
	Children in Poverty (Percent of persons under age 18)	20.4	26	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	10.1	28	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	13.0	16	5.0
	Public Health Funding (Dollars per person)	$55	40	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	92.9	9	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	77.2	9	—
	Primary Care Physicians (Number per 100,000 population)	117.8	24	191.9
	Preventable Hospitalizations (per 1,000 Medicare enrollees)	74.2	38	25.6
	ALL DETERMINANTS	-0.03	32	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	10.1	39	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.7	34	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.6	26	2.6
	Geographic Disparity (Relative standard deviation)	8.9	13	4.8
	Infant Mortality (Deaths per 1,000 live births)	7.7	39	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	306.5	42	197.2
	Cancer Deaths (Deaths per 100,000 population)	199.7	33	137.4
	Premature Death (Years lost per 100,000 population)	7,509	29	5481
	ALL OUTCOMES	-0.01	35	0.32
	OVERALL	-0.03	30	1.20

— indicates data not available. * See measure description for full details.

MINNESOTA

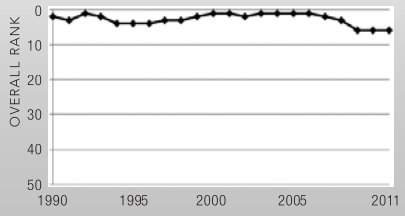
Ranking: Minnesota is 6th this year, unchanged from 2010.

Highlights:
- While smoking has decreased from 19.8 percent to 14.9 percent of adults in the past ten years, 599,000 people still smoke in Minnesota.
- In the past year, the percentage of children in poverty decreased from 17.4 percent to 13.9 percent of persons under age 18.
- In the past year, the rate of preventable hospitalizations decreased from 55.1 to 52.9 discharges per 1,000 Medicare enrollees.
- In the past ten years, obesity increased from 17.4 percent to 25.4 percent of the adult population, with more than 1.0 million obese adults in Minnesota.
- In the past ten years, diabetes increased from 4.9 percent to 6.7 percent of the population, with 269,000 adults with diabetes in the state.
- The violent crime rate decreased in the last five years from 297 to 236 offenses per 100,000 population.

Health Disparities:
In Minnesota, smoking is more prevalent among Hispanics at 20.8 percent and non-Hispanic blacks at 21.3 percent than non-Hispanic whites at 15.9 percent. Diabetes is more prevalent among non-Hispanic whites at 6.3 percent than non-Hispanic blacks at 3.4 percent but less prevalent than Hispanics at 7.4 percent of adults.

State Health Department Web Site: www.health.state.mn.us

Overall Rank: 6



Change: no change
Determinants Rank: 7
Outcomes Rank: 2

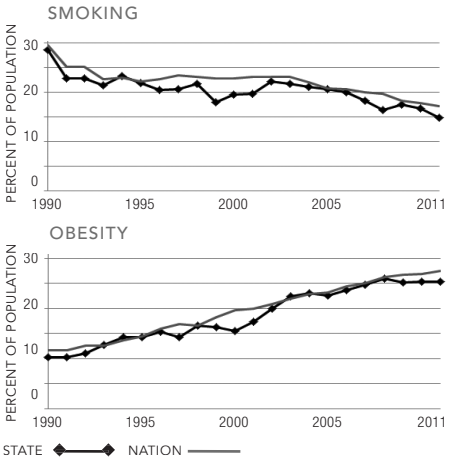
Strengths:
- Low rate of deaths from cardiovascular disease
- Low rate of uninsured population
- High rate of high school graduation

Challenges:
- High incidence of infectious disease
- Low per capita public health funding
- High prevalence of binge drinking

MINNESOTA

ECONOMIC ENVIRONMENT	MN	U.S.
Unemployment Rate (Aug 2011)	7.2%	8.3%
Underemployment Rate (2010)	13.8%	16.7%
Median Household Income (2010)	$52,554	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	719,000	599,000	-120,000
Obesity	632,000	1,021,000	389,000
Diabetes	178,000	269,000	91,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	14.9	8	9.1
	Binge Drinking (Percent of adult population)	18.4	44	6.7
	Obesity (Percent of adult population)	25.4	14	21.4
	High School Graduation (Percent of incoming ninth graders)	86.4	3	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	236	9	122
	Occupational Fatalities (Deaths per 100,000 workers)	2.5	1	2.5
	Infectious Disease (Cases per 100,000 population)	23.2	49	2.3
	Children in Poverty (Percent of persons under age 18)	13.9	12	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	8.6	14	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	8.9	3	5.0
	Public Health Funding (Dollars per person)	$45	46	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	90.9	24	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	85.7*	11	—
	Primary Care Physicians (per 100,000 population)	140.3	9	191.9
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	52.9	9	25.6
	ALL DETERMINANTS	0.44	7	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	6.7	4	5.3
	Poor Mental Health Days (Days in previous 30 days)	2.6	5	2.3
	Poor Physical Health Days (Days in previous 30 days)	2.6	1	2.6
	Geographic Disparity (Relative standard deviation)	11.3	24	4.8
	Infant Mortality (Deaths per 1,000 live births)	5.8	11	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	197.2	1	197.2
	Cancer Deaths (Deaths per 100,000 population)	182.4	12	137.4
	Premature Death (Years lost per 100,000 population)	5,499	3	5481
	ALL OUTCOMES	0.31	2	0.32
	OVERALL	0.76	6	1.20

— indicates data not available. * See measure description for full details.

MISSISSIPPI

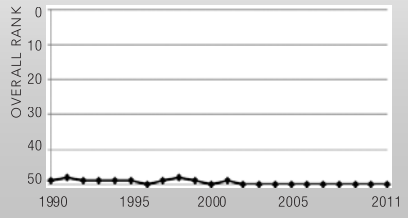
Ranking: Mississippi is 50th this year, unchanged from 2010.

Highlights:

- Smoking has decreased minimally in the last ten years from 23.5 percent to 22.9 percent of the adult population; 506,000 people still smoke in Mississippi.
- In the past year, the rate of uninsured population increased from 17.7 percent to 19.2 percent.
- In the past five years, obesity increased from 30.9 percent to 34.5 percent of the adult population, with 763,000 obese adults in the state.
- In the past five years, diabetes increased from 9.8 percent to 12.4 percent of the adult population; there are now 274,000 individuals with diabetes in the state.
- In the past ten years, the violent crime rate decreased from 349 to 270 offenses per 100,000 population.
- In the past ten years, the percentage of children in poverty increased from 16.4 percent to 33.7 percent of persons under age 18.

Health Disparities:
In Mississippi, obesity is more prevalent among non-Hispanic blacks at 42.6 percent than non-Hispanic whites at 30.4 percent and Hispanics at 35.4 percent. Diabetes also varies by race and ethnicity in the state; 14.5 percent of non-Hispanic blacks have diabetes compared to 10.4 percent of non-Hispanic whites and 8.7 percent of Hispanics.
State Health Department Web Site: www.msdh.state.ms.us

Overall Rank: 50



Change: no change
Determinants Rank: 48
Outcomes Rank: 50

Strengths:

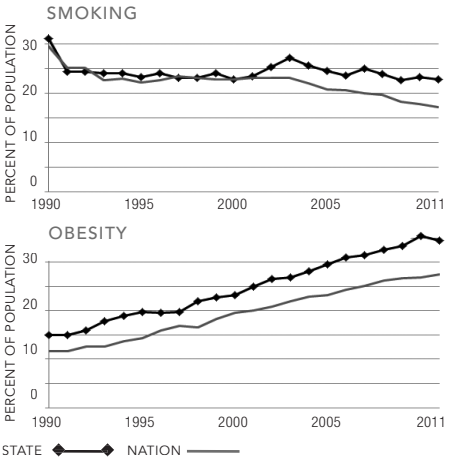
- Low prevalence of binge drinking
- High immunization coverage

Challenges:

- High prevalence of obesity
- High percentage of children in poverty
- High rate of preventable hospitalizations
- High infant mortality rate

ECONOMIC ENVIRONMENT	MS	U.S.
Unemployment Rate (Aug 2011)	10.3%	8.3%
Underemployment Rate (2010)	17.6%	16.7%
Median Household Income (2010)	$37,985	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	486,000	506,000	20,000
Obesity	517,000	763,000	246,000
Diabetes	157,000	274,000	117,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	22.9	46	9.1
	Binge Drinking (Percent of adult population)	10.0	4	6.7
	Obesity (Percent of adult population)	34.5	50	21.4
	High School Graduation (Percent of incoming ninth graders)	63.9	47	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	270	16	122
	Occupational Fatalities (Deaths per 100,000 workers)	7.2	43	2.5
	Infectious Disease (Cases per 100,000 population)	10.5	37	2.3
	Children in Poverty (Percent of persons under age 18)	33.7	50	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	10.3	31	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	19.2	44	5.0
	Public Health Funding (Dollars per person)	$73	28	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	92.7	10	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	82.3*	24	—
	Primary Care Physicians (Number per 100,000 population)	82.2	48	191.9
	Preventable Hospitalizations (per 1,000 Medicare enrollees)	95.0	48	25.6
	ALL DETERMINANTS	-0.51	48	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	12.4	49	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.9	41	2.3
	Poor Physical Health Days (Days in previous 30 days)	4.3	46	2.6
	Geographic Disparity (Relative standard deviation)	13.5	35	4.8
	Infant Mortality (Deaths per 1,000 live births)	10.0	50	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	366.4	50	197.2
	Cancer Deaths (Deaths per 100,000 population)	218.3	48	137.4
	Premature Death (Years lost per 100,000 population)	10,976	50	5481
	ALL OUTCOMES	-0.31	50	0.32
	OVERALL	-0.82	50	1.20

— indicates data not available. * See measure description for full details.

MISSOURI

Ranking: Missouri is 40th this year; it was 39th in 2010.

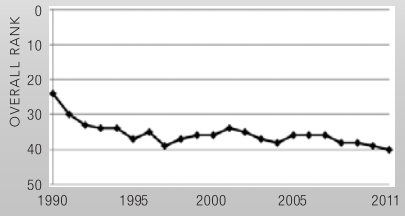
Highlights:

- In the past ten years, smoking decreased from 27.2 percent to 21.1 percent of the adult population; however, there are still 963,000 adults in Missouri who smoke.
- In the past year, the percentage of children in poverty decreased from 23.8 percent to 20.5 percent of persons under age 18. Children in poverty was 10.6 percent in 2001.
- In the past year, diabetes increased from 7.9 percent to 9.4 percent of the adult population; 429,000 adults now have diabetes.
- In the past five years, obesity increased from 26.9 percent to 31.4 percent of the adult population. There are now more than 1.4 million obese adults in the state.
- The rate of deaths from cardiovascular disease has decreased by 21 percent in the last ten years, from 381.1 to 301.9 deaths per 100,000 population.

Health Disparities:
In Missouri, obesity is more prevalent among non-Hispanic blacks at 38.2 percent than non-Hispanic whites at 29.5 percent and Hispanics at 29.0 percent. Diabetes also varies by race and ethnicity in the state; 13.2 percent of non-Hispanic blacks have diabetes compared to 8.3 percent of non-Hispanic whites and 7.0 percent of Hispanics.

State Health Department Web Site: www.dhss.mo.gov

Overall Rank: 40



Change: ▼1
Determinants Rank: 40
Outcomes Rank: 39

Strengths:

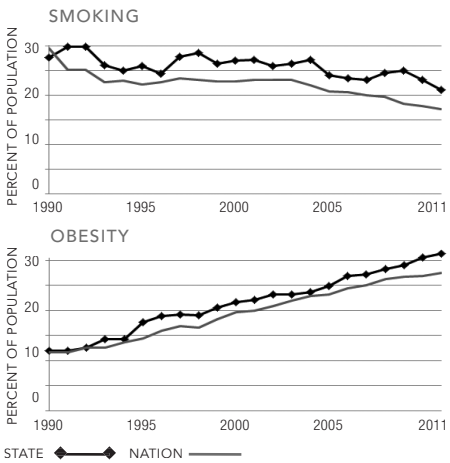
- High rate of high school graduation
- High use of early prenatal care

Challenges:

- High prevalence of smoking
- High incidence of infectious disease
- High preventable hospitalizations
- Low immunization coverage

ECONOMIC ENVIRONMENT	MO	U.S.
Unemployment Rate (Aug 2011)	8.8%	8.3%
Underemployment Rate (2010)	15.8%	16.7%
Median Household Income (2010)	$46,184	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	1,134,000	963,000	-171,000
Obesity	921,000	1,433,000	512,000
Diabetes	279,000	429,000	150,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	21.1	40	9.1
	Binge Drinking (Percent of adult population)	16.4	33	6.7
	Obesity (Percent of adult population)	31.4	41	21.4
	High School Graduation (Percent of incoming ninth graders)	82.4	11	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	455	37	122
	Occupational Fatalities (Deaths per 100,000 workers)	4.8	29	2.5
	Infectious Disease (Cases per 100,000 population)	17.3	45	2.3
	Children in Poverty (Percent of persons under age 18)	20.5	28	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	10.9	36	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	14.3	26	5.0
	Public Health Funding (Dollars per person)	$47	43	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	87.5	42	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	85.8*	10	—
	Primary Care Physicians (per 100,000 population)	106.8	33	191.9
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	75.0	39	25.6
	ALL DETERMINANTS	-0.29	40	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	9.4	32	5.3
	Poor Mental Health Days (Days in previous 30 days)	4.0	45	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.6	26	2.6
	Geographic Disparity (Relative standard deviation)	11.5	26	4.8
	Infant Mortality (Deaths per 1,000 live births)	7.4	33	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	301.9	41	197.2
	Cancer Deaths (Deaths per 100,000 population)	204.2	38	137.4
	Premature Death (Years lost per 100,000 population)	8,258	40	5481
	ALL OUTCOMES	-0.06	39	0.32
	OVERALL	-0.34	40	1.20

— indicates data not available. * See measure description for full details.

MONTANA

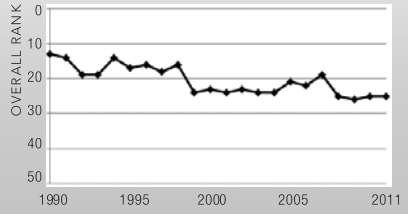
Ranking: Montana is 25th this year, unchanged from 2010.

Highlights:
- Smoking has remained unchanged in the last ten years at 18.8 percent of adults; 144,000 adults still smoke in Montana.
- In the past year, the rate of preventable hospitalizations decreased from 67.0 to 60.8 discharges per 1,000 Medicare enrollees.
- In the past year, the percentage of children in poverty decreased from 21.0 percent to 19.2 percent of persons under age 18.
- In the past five years, diabetes increased from 5.7 percent to 7.0 percent of the adult population; 54,000 adults now have diabetes.
- In the past ten years, obesity increased from 15.9 percent to 23.5 percent of the population. There are 180,000 obese adults in the state.

Health Disparities:
In Montana, obesity is more prevalent among non-Hispanic American Indians at 42.3 percent than non-Hispanic whites and Hispanics, both at 22.9 percent. Diabetes also varies by race and ethnicity in the state; 14.4 percent of non-Hispanic American Indians have diabetes compared to 6.4 percent of non-Hispanic whites and 4.3 percent of Hispanics.

State Health Department Web Site: www.dphhs.mt.gov

Overall Rank: 25



Change: no change
Determinants Rank: 26
Outcomes Rank: 25

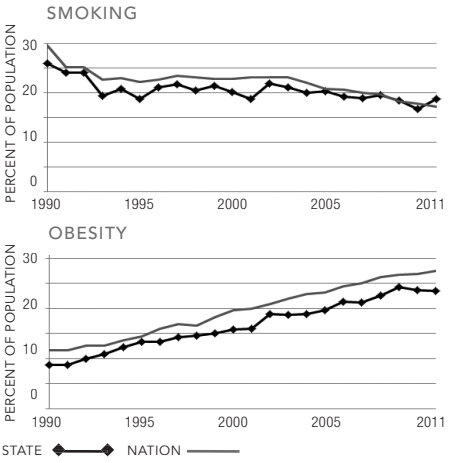
Strengths:
- Lower prevalence of obesity than most other states
- Low levels of air pollution
- Low prevalence of diabetes

Challenges:
- Low immunization coverage
- High occupational fatalities rate
- High geographic disparity within the state

MONTANA

ECONOMIC ENVIRONMENT	MT	U.S.
Unemployment Rate (Aug 2011)	7.8%	8.3%
Underemployment Rate (2010)	14.9%	16.7%
Median Household Income (2010)	$41,467	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	126,000	144,000	18,000
Obesity	107,000	180,000	73,000
Diabetes	33,000	54,000	21,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	18.8	32	9.1
	Binge Drinking (Percent of adult population)	17.2	36	6.7
	Obesity (Percent of adult population)	23.5	6	21.4
	High School Graduation (Percent of incoming ninth graders)	82.0	13	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	272	17	122
	Occupational Fatalities (Deaths per 100,000 workers)	8.0	46	2.5
	Infectious Disease (Cases per 100,000 population)	8.5	26	2.3
	Children in Poverty (Percent of persons under age 18)	19.2	24	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	7.7	9	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	16.6	34	5.0
	Public Health Funding (Dollars per person)	$93	17	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	83.3	50	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	73.4	14	—
	Primary Care Physicians (Number per 100,000 population)	100.1	39	191.9
	Preventable Hospitalizations (per 1,000 Medicare enrollees)	60.8	18	25.6
	ALL DETERMINANTS	0.09	26	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	7.0	7	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.3	17	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.7	29	2.6
	Geographic Disparity (Relative standard deviation)	16.7	43	4.8
	Infant Mortality (Deaths per 1,000 live births)	6.6	22	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	237.6	14	197.2
	Cancer Deaths (Deaths per 100,000 population)	184.4	14	137.4
	Premature Death (Years lost per 100,000 population)	7,700	30	5481
	ALL OUTCOMES	0.05	25	0.32
	OVERALL	0.14	25	1.20

— indicates data not available. * See measure description for full details.

NEBRASKA

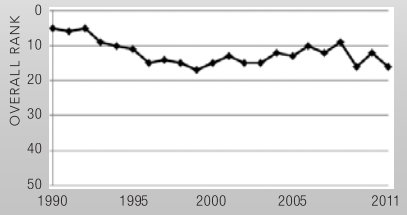
Ranking: Nebraska is 16th this year; it was 12th in 2010.

Highlights:
- While smoking decreased from 21.2 percent to 17.2 percent of adults in the last ten years, 235,000 adults still smoke in Nebraska.
- In the past year, the rate of preventable hospitalizations decreased from 69.1 to 65.7 discharges per 1,000 Medicare enrollees.
- In the past ten years, obesity increased from 21.1 percent to 27.5 percent of adults, with 376,000 obese adults in the state.
- In the past ten years, diabetes increased from 4.9 percent to 7.7 percent of adults. Now 105,000 Nebraska adults have diabetes.
- In the past ten years, the violent crime rate decreased from 430 to 280 offenses per 100,000 population.
- The incidence of infectious disease increased 18 percent in the last year, from 12.0 to 14.1 cases per 100,000 population.

Health Disparities:
In Nebraska, obesity is more prevalent among non-Hispanic blacks at 39.6 percent than non-Hispanic whites at 27.0 percent and Hispanics at 31.8 percent. Diabetes also varies by race and ethnicity in the state; 11.7 percent of non-Hispanic blacks have diabetes compared to 7.5 percent of non-Hispanic whites and 8.5 percent of Hispanics.

State Health Department Web Site: www.hhs.state.ne.us

Overall Rank: 16



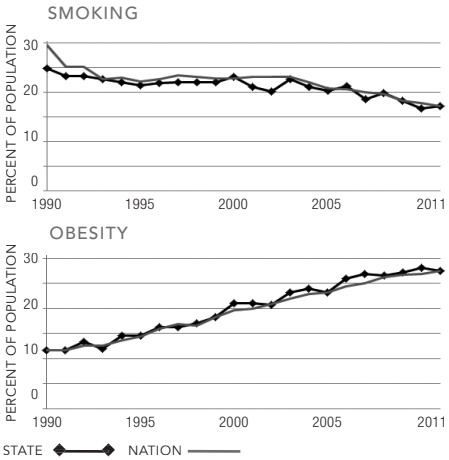
Change: ▼4
Determinants Rank: 20
Outcomes Rank: 11

Strengths:
- High rate of high school graduation
- Few poor mental and physical health days per month
- Low percentage of children in poverty
- Low rate of uninsured population

Challenges:
- High prevalence of binge drinking
- High incidence of infectious disease

ECONOMIC ENVIRONMENT	NE	U.S.
Unemployment Rate (Aug 2011)	4.2%	8.3%
Underemployment Rate (2010)	8.6%	16.7%
Median Household Income (2010)	$52,728	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	267,000	235,000	-32,000
Obesity	266,000	376,000	110,000
Diabetes	62,000	105,000	43,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	17.2	24	9.1
	Binge Drinking (Percent of adult population)	18.7	47	6.7
	Obesity (Percent of adult population)	27.5	25	21.4
	High School Graduation (Percent of incoming ninth graders)	83.8	7	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	280	19	122
	Occupational Fatalities (Deaths per 100,000 workers)	5.8	39	2.5
	Infectious Disease (Cases per 100,000 population)	14.1	44	2.3
	Children in Poverty (Percent of persons under age 18)	13.9	12	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	8.2	12	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	12.2	14	5.0
	Public Health Funding (Dollars per person)	$79	25	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	92.4	12	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	73.9	13	—
	Primary Care Physicians (per 100,000 population)	119.6	21	191.9
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	65.7	28	25.6
	ALL DETERMINANTS	0.23	20	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	7.7	16	5.3
	Poor Mental Health Days (Days in previous 30 days)	2.9	6	2.3
	Poor Physical Health Days (Days in previous 30 days)	2.9	7	2.6
	Geographic Disparity (Relative standard deviation)	13.5	35	4.8
	Infant Mortality (Deaths per 1,000 live births)	6.1	16	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	241.6	18	197.2
	Cancer Deaths (Deaths per 100,000 population)	187.2	18	137.4
	Premature Death (Years lost per 100,000 population)	6,418	16	5481
	ALL OUTCOMES	0.18	11	0.32
	OVERALL	0.41	16	1.20

— indicates data not available. * See measure description for full details.

NEVADA

Ranking: Nevada is 42nd this year; it was 47th in 2010.

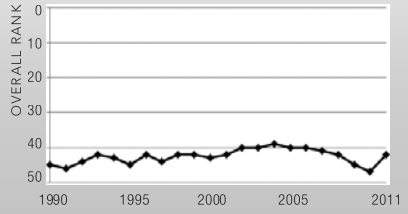
Highlights:

- While smoking has decreased from 29.0 percent to 21.3 percent of the adult population in the last ten years, 434,000 adults still smoke in Nevada.
- In the past year, the percentage of children in poverty increased from 17.9 percent to 23.6 percent of persons under age 18.
- In the past five years, diabetes increased from 7.1 percent to 8.5 percent of the adult population. There are now 173,000 Nevada adults with diabetes.
- In the past ten years, obesity increased from 17.9 percent to 23.1 percent of the adult population. There are now 470,000 obese adults in the state.
- The high school graduation rate declined in the last five years from a reported 72.3 percent to 56.3 percent of ninth graders who graduate within four years.

Health Disparities:
In Nevada, obesity is more prevalent among non-Hispanic blacks at 28.5 percent and Hispanics at 26.5 percent than non-Hispanic whites at 24.1 percent of adults. Diabetes also varies by race and ethnicity in the state; 11.7 percent of non-Hispanic blacks and 8.2 percent of non-Hispanic whites have diabetes compared to 6.6 percent of Hispanics.

State Health Department Web Site: health.nv.gov

Overall Rank: 42



Change: ▲ 5
Determinants Rank: 45
Outcomes Rank: 36

Strengths:

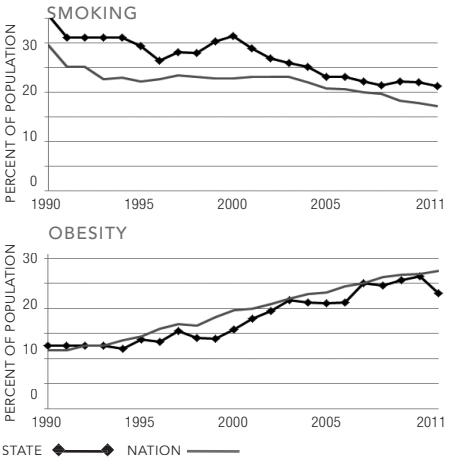
- Lower prevalence of obesity than other states
- Low incidence of infectious disease
- Low rate of preventable hospitalizations

Challenges:

- Low high school graduation rate
- High violent crime rate
- Low immunization coverage

ECONOMIC ENVIRONMENT	NV	U.S.
Unemployment Rate (Aug 2011)	13.4%	8.3%
Underemployment Rate (2010)	23.6%	16.7%
Median Household Income (2010)	$51,525	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	431,000	434,000	3,000
Obesity	266,000	470,000	204,000
Diabetes	101,000	173,000	72,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	21.3	42	9.1
	Binge Drinking (Percent of adult population)	17.3	38	6.7
	Obesity (Percent of adult population)	23.1	4	21.4
	High School Graduation (Percent of incoming ninth graders)	56.3	50	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	661	50	122
	Occupational Fatalities (Deaths per 100,000 workers)	3.5	12	2.5
	Infectious Disease (Cases per 100,000 population)	4.8	4	2.3
	Children in Poverty (Percent of persons under age 18)	23.6	36	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	8.9	18	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	21.0	47	5.0
	Public Health Funding (Dollars per person)	$41	49	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	84.6	49	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	75.4*	49	—
	Primary Care Physicians (Number per 100,000 population)	85.5	46	191.9
	Preventable Hospitalizations (per 1,000 Medicare enrollees)	58.6	15	25.6
	ALL DETERMINANTS	-0.44	45	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	8.5	22	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.8	38	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.8	36	2.6
	Geographic Disparity (Relative standard deviation)	19.1	47	4.8
	Infant Mortality (Deaths per 1,000 live births)	5.9	12	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	283.8	36	197.2
	Cancer Deaths (Deaths per 100,000 population)	192.7	27	137.4
	Premature Death (Years lost per 100,000 population)	7,956	34	5481
	ALL OUTCOMES	-0.03	36	0.32
	OVERALL	-0.47	42	1.20

— indicates data not available. * See measure description for full details.

NEW HAMPSHIRE

Ranking: New Hampshire is 2nd this year; it was 3rd in 2010.

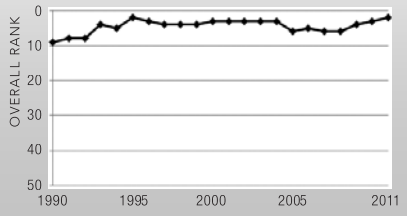
Highlights:

- While smoking has decreased from 25.3 percent to 16.9 percent of the adult population in the last ten years, 174,000 adults still smoke in New Hampshire.
- In the past year, the percentage of children in poverty decreased from 10.5 percent to 6.2 percent of persons under age 18.
- In the past year, diabetes increased from 7.1 percent to 7.9 percent of the adult population. There are now 81,000 New Hampshire adults with diabetes.
- In the past ten years, obesity increased from 18.1 percent to 25.5 percent of the adult population, with 262,000 obese adults in the state.
- Since 1990, the infant mortality rate decreased from 8.4 to 4.7 deaths per 1,000 live births and is the lowest among all states.

Health Disparities:
In New Hampshire, obesity is more prevalent among non-Hispanic whites at 25.8 percent than Hispanics at 24.0 percent.

State Health Department Web Site: www.dhhs.state.nh.us

Overall Rank: 2



Change: ▲ 1
Determinants Rank: 3
Outcomes Rank: 4

Strengths:

- Low percentage of children in poverty
- Low violent crime rate
- High use of early prenatal care
- High immunization coverage

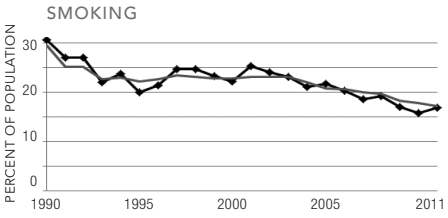
Challenges:

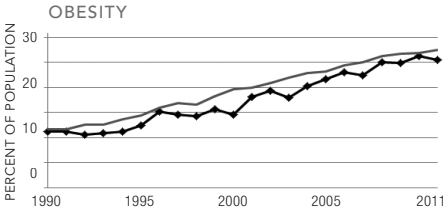
- Moderate per capita public health funding
- Moderate prevalence of binge drinking

NEW HAMPSHIRE

ECONOMIC ENVIRONMENT	NH	U.S.
Unemployment Rate (Aug 2011)	5.3%	8.3%
Underemployment Rate (2010)	11.8%	16.7%
Median Household Income (2010)	$66,707	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	234,000	174,000	-60,000
Obesity	168,000	262,000	94,000
Diabetes	41,000	81,000	40,000





STATE ◆—◆ NATION —

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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	16.9	20	9.1
	Binge Drinking (Percent of adult population)	15.4	27	6.7
	Obesity (Percent of adult population)	25.5	15	21.4
	High School Graduation (Percent of incoming ninth graders)	83.3	9	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	167	3	122
	Occupational Fatalities (Deaths per 100,000 workers)	3.4	10	2.5
	Infectious Disease (Cases per 100,000 population)	6.8	14	2.3
	Children in Poverty (Percent of persons under age 18)	6.2	1	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	7.8	10	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	10.1	7	5.0
	Public Health Funding (Dollars per person)	$64	34	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	95.7	2	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	82.1	2	—
	Primary Care Physicians (per 100,000 population)	131.7	10	191.9
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	59.2	16	25.6
	ALL DETERMINANTS	0.72	3	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	7.9	18	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.1	11	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.2	13	2.6
	Geographic Disparity (Relative standard deviation)	5.2	3	4.8
	Infant Mortality (Deaths per 1,000 live births)	4.7	1	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	235.2	11	197.2
	Cancer Deaths (Deaths per 100,000 population)	191.9	23	137.4
	Premature Death (Years lost per 100,000 population)	5,481	1	5481
	ALL OUTCOMES	0.30	4	0.32
	OVERALL	1.03	2	1.20

— indicates data not available. * See measure description for full details.

NEW JERSEY

Ranking: New Jersey is 11th this year; it was 17th in 2010.

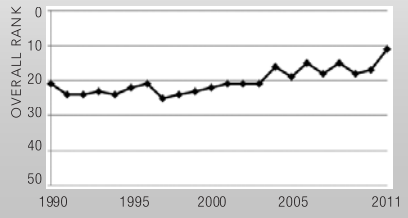
Highlights:

- While smoking has decreased from 21.0 percent to 14.4 percent of the adult population in the last ten years, 969,000 adults still smoke in New Jersey.
- In the past year, the rate of preventable hospitalizations decreased from 76.2 to 71.6 discharges per 1,000 Medicare enrollees.
- In the past five years, diabetes increased from 7.7 percent to 9.2 percent of the adult population. There are now 619,000 New Jersey adults with diabetes.
- In the past ten years, obesity increased from 18.5 percent to 24.8 percent of the population, with nearly 1.7 million obese adults in the state.

Health Disparities:
In New Jersey, obesity is more prevalent among non-Hispanic blacks at 35.9 percent than non-Hispanic whites at 23.1 percent and Hispanics at 26.8 percent. Diabetes also varies by race and ethnicity in the state; 13.7 percent of non-Hispanic blacks have diabetes compared to 7.8 percent of non-Hispanic whites and 8.5 percent of Hispanics.

State Health Department Web Site: www.state.nj.us/health

Overall Rank: 11



Change: ▲6
Determinants Rank: 12
Outcomes Rank: 12

Strengths:

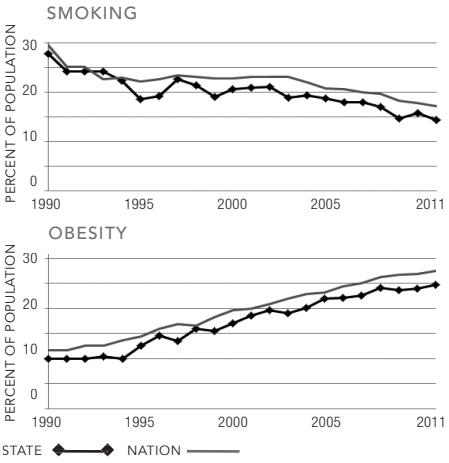
- High rate of high school graduation
- Low percentage of children in poverty
- Ready availability of primary care physicians

Challenges:

- Low use of early prenatal care
- Low immunization coverage
- Moderate rate of preventable hospitalizations

ECONOMIC ENVIRONMENT	NJ	U.S.
Unemployment Rate (Aug 2011)	9.4%	8.3%
Underemployment Rate (2010)	15.7%	16.7%
Median Household Income (2010)	$63,540	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	1,329,000	969,000	-360,000
Obesity	1,170,000	1,668,000	498,000
Diabetes	367,000	619,000	252,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	14.4	6	9.1
	Binge Drinking (Percent of adult population)	14.1	18	6.7
	Obesity (Percent of adult population)	24.8	12	21.4
	High School Graduation (Percent of incoming ninth graders)	84.6	5	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	308	21	122
	Occupational Fatalities (Deaths per 100,000 workers)	3.2	8	2.5
	Infectious Disease (Cases per 100,000 population)	6.3	13	2.3
	Children in Poverty (Percent of persons under age 18)	12.8	8	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	9.8	25	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	15.0	30	5.0
	Public Health Funding (Dollars per person)	$69	30	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	86.9	45	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	78.5*	45	—
	Primary Care Physicians (Number per 100,000 population)	142.8	8	191.9
	Preventable Hospitalizations (per 1,000 Medicare enrollees)	71.6	34	25.6
	ALL DETERMINANTS	0.32	12	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	9.2	30	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.4	19	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.2	13	2.6
	Geographic Disparity (Relative standard deviation)	11.1	22	4.8
	Infant Mortality (Deaths per 1,000 live births)	5.4	7	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	263.2	26	197.2
	Cancer Deaths (Deaths per 100,000 population)	193.0	30	137.4
	Premature Death (Years lost per 100,000 population)	6,089	9	5481
	ALL OUTCOMES	0.18	12	0.32
	OVERALL	0.50	11	1.20

— indicates data not available. * See measure description for full details.

NEW MEXICO

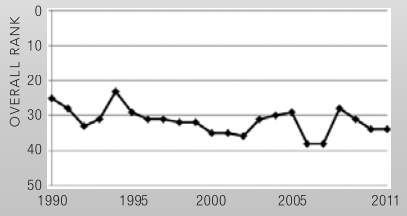
Ranking: New Mexico is 34th this year, unchanged from 2010.

Highlights:
- In the past year, the rate of preventable hospitalizations decreased from 58.6 to 56.3 discharges per 1,000 Medicare enrollees.
- In the past five years, the violent crime rate declined from 646 to 589 offenses per 100,000 population.
- In the past five years, diabetes increased from 7.3 percent to 8.5 percent of adults. There are now 131,000 adults with diabetes in the state.
- In the past ten years, obesity increased from 19.3 percent to 25.6 percent of adults; there are now 394,000 obese adults in the state.
- In the past ten years, smoking decreased from 23.6 percent to 18.5 percent of adults. However, 285,000 adults still smoke.

Health Disparities:
In New Mexico, obesity is more prevalent among non-Hispanic American Indians at 37.0 percent than non-Hispanic whites at 20.8 percent and Hispanics at 30.7 percent. Diabetes also varies by race and ethnicity in the state; 12.9 percent of non-Hispanic blacks have diabetes compared to 10.2 percent of Hispanics, 9.7 percent of non-Hispanic American Indians and 6.6 percent of non-Hispanic whites.

State Health Department Web Site: www.health.state.nm.us

Overall Rank: 34



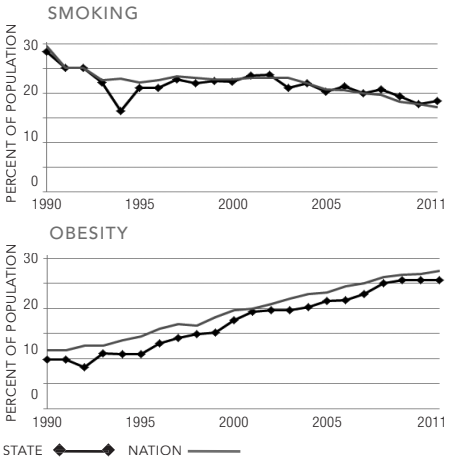
Change: no change
Determinants Rank: 35
Outcomes Rank: 30

Strengths:
- Low prevalence of binge drinking
- Low rate of cardiovascular and cancer deaths
- Low levels of air pollution

Challenges:
- High rate of uninsured population
- High percentage of children in poverty
- Low use of early prenatal care

ECONOMIC ENVIRONMENT	NM	U.S.
Unemployment Rate (Aug 2011)	6.6%	8.3%
Underemployment Rate (2010)	15.6%	16.7%
Median Household Income (2010)	$45,098	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	309,000	285,000	-24,000
Obesity	253,000	394,000	141,000
Diabetes	85,000	131,000	46,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	18.5	30	9.1
	Binge Drinking (Percent of adult population)	12.1	9	6.7
	Obesity (Percent of adult population)	25.6	16	21.4
	High School Graduation (Percent of incoming ninth graders)	66.8	45	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	589	45	122
	Occupational Fatalities (Deaths per 100,000 workers)	6.3	42	2.5
	Infectious Disease (Cases per 100,000 population)	7.9	23	2.3
	Children in Poverty (Percent of persons under age 18)	27.6	47	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	5.8	3	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	21.3	48	5.0
	Public Health Funding (Dollars per person)	$125	7	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	87.4	44	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	62.2	48	—
	Primary Care Physicians (per 100,000 population)	113.9	27	191.9
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	56.3	12	25.6
	ALL DETERMINANTS	-0.17	35	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	8.5	22	5.3
	Poor Mental Health Days (Days in previous 30 days)	4.1	46	2.3
	Poor Physical Health Days (Days in previous 30 days)	4.0	39	2.6
	Geographic Disparity (Relative standard deviation)	14.5	38	4.8
	Infant Mortality (Deaths per 1,000 live births)	5.9	12	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	229.8	7	197.2
	Cancer Deaths (Deaths per 100,000 population)	170.0	5	137.4
	Premature Death (Years lost per 100,000 population)	8,790	41	5481
	ALL OUTCOMES	0.02	30	0.32
	OVERALL	-0.14	34	1.20

— indicates data not available. * See measure description for full details.

NEW YORK

Ranking: New York is 18th this year; it was 24th in 2010.

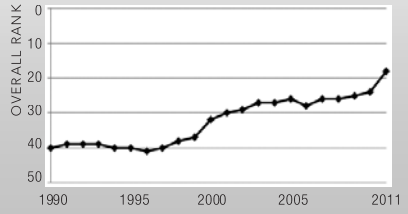
Highlights:

- In the past year, the rate of preventable hospitalizations decreased from 73.0 to 69.0 discharges per 1,000 Medicare enrollees.
- In the past five years, the violent crime rate declined from 444 to 392 offenses per 100,000 population.
- In the past five years, smoking decreased from 20.5 percent to 15.5 percent of adults. However, more than 2.3 million adults still smoke.
- In the past ten years, diabetes increased from 6.3 percent to 8.9 percent of adults. There are now more than 1.3 million adults with diabetes in the state.
- In the past ten years, obesity increased from 17.7 percent to 24.5 percent of adults; now, nearly 3.7 million adults are obese in New York.

Health Disparities:
In New York, obesity is more prevalent among non-Hispanic blacks at 31.4 percent than non-Hispanic whites at 24.1 percent and Hispanics at 27.2 percent. Diabetes also varies by race and ethnicity in the state; 12.8 percent of non-Hispanic blacks have diabetes compared to 7.9 percent of non-Hispanic whites and 8.2 percent of Hispanics.

State Health Department Web Site: www.health.state.ny.us

Overall Rank: 18



Change: ▲6
Determinants Rank: 21
Outcomes Rank: 9

Strengths:

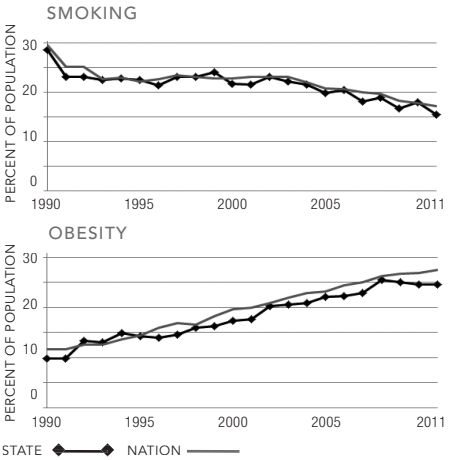
- Ready availability of primary care physicians
- Low rates of cancer deaths
- Lower prevalence of obesity than other states

Challenges:

- Low high school graduation rate
- High percentage of children in poverty
- Low immunization coverage

ECONOMIC ENVIRONMENT	NY	U.S.
Unemployment Rate (Aug 2011)	8.0%	8.3%
Underemployment Rate (2010)	14.8%	16.7%
Median Household Income (2010)	$49,826	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	3,086,000	2,333,000	-753,000
Obesity	2,529,000	3,688,000	1,159,000
Diabetes	900,000	1,340,000	440,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	15.5	14	9.1
	Binge Drinking (Percent of adult population)	15.9	30	6.7
	Obesity (Percent of adult population)	24.5	9	21.4
	High School Graduation (Percent of incoming ninth graders)	70.9	40	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	392	31	122
	Occupational Fatalities (Deaths per 100,000 workers)	2.9	5	2.5
	Infectious Disease (Cases per 100,000 population)	9.5	32	2.3
	Children in Poverty (Percent of persons under age 18)	24.1	38	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	9.7	24	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	14.5	27	5.0
	Public Health Funding (Dollars per person)	$123	8	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	87.8	41	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	72.4	21	—
	Primary Care Physicians (Number per 100,000 population)	167.0	5	191.9
	Preventable Hospitalizations (per 1,000 Medicare enrollees)	69.0	31	25.6
	ALL DETERMINANTS	0.20	21	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	8.9	29	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.6	30	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.5	22	2.6
	Geographic Disparity (Relative standard deviation)	8.7	10	4.8
	Infant Mortality (Deaths per 1,000 live births)	5.5	8	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	289.6	37	197.2
	Cancer Deaths (Deaths per 100,000 population)	177.6	8	137.4
	Premature Death (Years lost per 100,000 population)	5,934	6	5481
	ALL OUTCOMES	0.20	9	0.32
	OVERALL	0.39	18	1.20

— indicates data not available. * See measure description for full details.

NORTH CAROLINA

Ranking: North Carolina is 32nd this year; it was 35th in 2010.

Highlights:

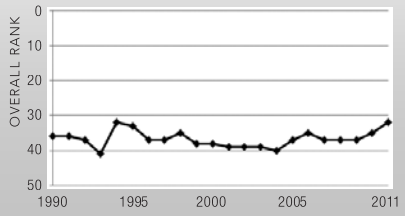
- In the past five years, the percentage of children in poverty increased from 18.3 percent to 27.6 percent of persons under age 18.
- In the past ten years, diabetes increased from 6.4 percent to 9.8 percent of adults. There are now 711,000 adults with diabetes in the state.
- In the past ten years, obesity increased from 21.8 percent to 28.6 percent of adults; now, there are nearly 2.1 million obese adults in North Carolina.
- While smoking has decreased from 26.1 percent to 19.8 percent of adults in the past ten years, more than 1.4 million adults still smoke in the state.

Health Disparities:

In North Carolina, obesity is more prevalent among non-Hispanic blacks at 42.4 percent than non-Hispanic whites at 26.7 percent and Hispanics at 26.0 percent. Diabetes also varies by race and ethnicity in the state; 15.3 percent of non-Hispanic blacks have diabetes compared to 8.7 percent of non-Hispanic whites and 4.9 percent of Hispanics.

State Health Department Web Site: www.dhhs.state.nc.us

Overall Rank: 32



Change: ▲3
Determinants Rank: 31
Outcomes Rank: 38

Strengths:

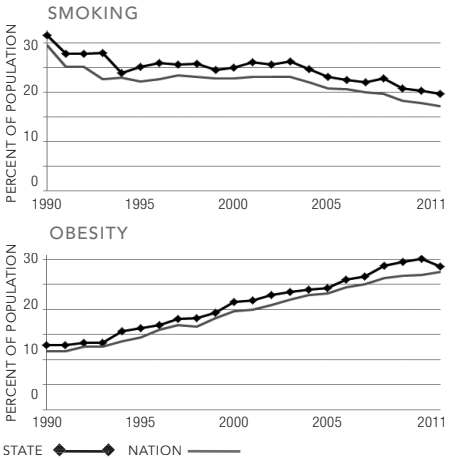
- Low prevalence of binge drinking
- Low incidence of infectious disease
- High immunization coverage

Challenges:

- Low per capita public health funding
- High percentage of children in poverty
- High infant mortality rate

ECONOMIC ENVIRONMENT	NC	U.S.
Unemployment Rate (Aug 2011)	10.4%	8.3%
Underemployment Rate (2010)	17.4%	16.7%
Median Household Income (2010)	$43,753	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	1,588,000	1,436,000	-152,000
Obesity	1,327,000	2,075,000	748,000
Diabetes	389,000	711,000	322,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	19.8	36	9.1
	Binge Drinking (Percent of adult population)	12.0	8	6.7
	Obesity (Percent of adult population)	28.6	30	21.4
	High School Graduation (Percent of incoming ninth graders)	72.8	36	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	363	27	122
	Occupational Fatalities (Deaths per 100,000 workers)	4.1	22	2.5
	Infectious Disease (Cases per 100,000 population)	7.0	15	2.3
	Children in Poverty (Percent of persons under age 18)	27.6	47	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	10.8	35	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	17.4	38	5.0
	Public Health Funding (Dollars per person)	$53	42	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	93.2	6	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	83.0*	18	—
	Primary Care Physicians (per 100,000 population)	115.6	26	191.9
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	63.7	24	25.6
	ALL DETERMINANTS	-0.02	31	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	9.8	36	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.6	30	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.6	26	2.6
	Geographic Disparity (Relative standard deviation)	10.8	20	4.8
	Infant Mortality (Deaths per 1,000 live births)	8.3	46	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	275.2	31	197.2
	Cancer Deaths (Deaths per 100,000 population)	199.8	35	137.4
	Premature Death (Years lost per 100,000 population)	8,116	36	5481
	ALL OUTCOMES	-0.05	38	0.32
	OVERALL	-0.07	32	1.20

— indicates data not available. * See measure description for full details.

NORTH DAKOTA

Ranking: North Dakota is 12th this year; it was 16th in 2010.

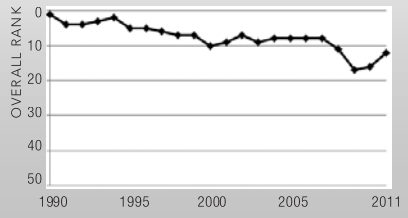
Highlights:

- In the past year, the rate of preventable hospitalizations decreased from 69.0 to 64.1 discharges per 1,000 Medicare enrollees.
- In the past year, the percentage of children in poverty increased from 14.4 percent to 16.1 percent of persons under age 18.
- In the past ten years, diabetes increased from 5.2 percent to 7.4 percent of adults. There are now 39,000 adults with diabetes in the state.
- In the past ten years, obesity increased from 20.4 percent to 27.9 percent of adults; now, there are 146,000 obese adults in North Dakota.
- While smoking has decreased from 23.2 percent to 17.4 percent of adults in the past ten years, 91,000 adults still smoke in the state.

Health Disparities:
In North Dakota, obesity is more prevalent among non-Hispanic American Indians at 43.5 percent than non-Hispanic whites at 27.4 percent and Hispanics at 37.7 percent. Diabetes also varies by race and ethnicity in the state; 14.7 percent of non-Hispanic American Indians have diabetes compared to 7.1 percent of non-Hispanic whites and 6.5 percent of Hispanics.

State Health Department Web Site: www.ndhealth.gov

Overall Rank: 12



Change: ▲ 4
Determinants Rank: 11
Outcomes Rank: 20

Strengths:

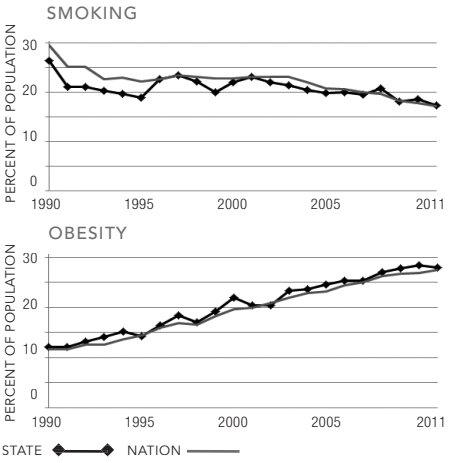
- Low violent crime rate
- High rate of high school graduation
- High immunization coverage
- Low levels of air pollution

Challenges:

- High prevalence of binge drinking
- High geographic disparity within the state

ECONOMIC ENVIRONMENT	ND	U.S.
Unemployment Rate (Aug 2011)	3.5%	8.3%
Underemployment Rate (2010)	7.4%	16.7%
Median Household Income (2010)	$51,380	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	112,000	91,000	-21,000
Obesity	98,000	146,000	48,000
Diabetes	25,000	39,000	14,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	17.4	26	9.1
	Binge Drinking (Percent of adult population)	20.1	49	6.7
	Obesity (Percent of adult population)	27.9	28	21.4
	High School Graduation (Percent of incoming ninth graders)	83.8	7	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	225	8	122
	Occupational Fatalities (Deaths per 100,000 workers)	5.7	38	2.5
	Infectious Disease (Cases per 100,000 population)	4.9	7	2.3
	Children in Poverty (Percent of persons under age 18)	16.1	16	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	5.7	2	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	11.7	11	5.0
	Public Health Funding (Dollars per person)	$77	26	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	93.1	7	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	72.4	19	—
	Primary Care Physicians (Number per 100,000 population)	126.9	14	191.9
	Preventable Hospitalizations (per 1,000 Medicare enrollees)	64.1	25	25.6
	ALL DETERMINANTS	0.35	11	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	7.4	12	5.3
	Poor Mental Health Days (Days in previous 30 days)	2.4	2	2.3
	Poor Physical Health Days (Days in previous 30 days)	2.8	4	2.6
	Geographic Disparity (Relative standard deviation)	16.8	44	4.8
	Infant Mortality (Deaths per 1,000 live births)	6.6	22	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	240.1	16	197.2
	Cancer Deaths (Deaths per 100,000 population)	186.6	16	137.4
	Premature Death (Years lost per 100,000 population)	6,564	20	5481
	ALL OUTCOMES	0.14	20	0.32
	OVERALL	0.49	12	1.20

— indicates data not available. * See measure description for full details.

OHIO

Ranking: Ohio is 36th this year; it was 33rd in 2010.

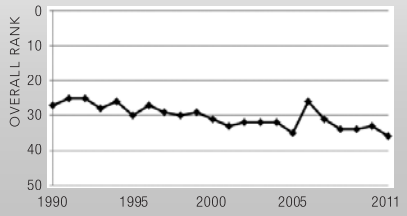
Highlights:

- In the past year, smoking increased from 20.3 percent to 22.5 percent of the adult population, with nearly 2.0 million adults who still smoke.
- In the past year, the percentage of children in poverty increased from 18.7 percent to 22.9 percent of persons under age 18.
- In the past five years, the rate of uninsured population increased from 11.0 percent to 13.7 percent.
- In the past five years, diabetes increased from 7.7 percent to 10.1 percent of adults. There are now 889,000 adults with diabetes in Ohio.
- In the past ten years, obesity increased from 21.5 percent to 29.7 percent of adults, with more than 2.6 million adults in the state who are now obese.

Health Disparities:
In Ohio, obesity is more prevalent among non-Hispanic blacks at 40.8 percent than non-Hispanic whites at 28.7 percent and Hispanics at 32.5 percent. Diabetes also varies by race and ethnicity in the state; 15.3 percent of non-Hispanic blacks have diabetes compared to 12.6 percent of Hispanics and 9.4 percent of non-Hispanic whites.

State Health Department Web Site: www.odh.ohio.gov

Overall Rank: 36



Change: ▼3
Determinants Rank: 36
Outcomes Rank: 37

Strengths:

- High immunization coverage
- Low occupational fatalities rate
- Moderate rate of high school graduation

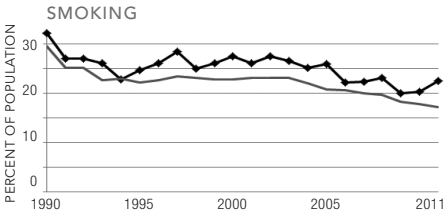
Challenges:

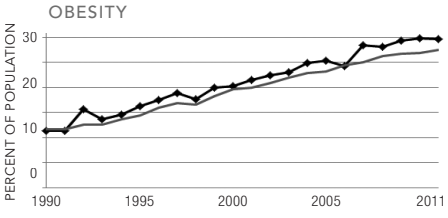
- High prevalence of smoking
- High levels of air pollution
- Low per capita public health funding

OHIO

ECONOMIC ENVIRONMENT	OH	U.S.
Unemployment Rate (Aug 2011)	9.1%	8.3%
Underemployment Rate (2010)	16.9%	16.7%
Median Household Income (2010)	$46,093	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	2,218,000	1,981,000	-237,000
Obesity	1,820,000	2,615,000	795,000
Diabetes	542,000	889,000	347,000





STATE ◆—◆ NATION —

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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	22.5	45	9.1
	Binge Drinking (Percent of adult population)	16.7	34	6.7
	Obesity (Percent of adult population)	29.7	35	21.4
	High School Graduation (Percent of incoming ninth graders)	79.0	19	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	315	25	122
	Occupational Fatalities (Deaths per 100,000 workers)	3.2	8	2.5
	Infectious Disease (Cases per 100,000 population)	11.9	40	2.3
	Children in Poverty (Percent of persons under age 18)	22.9	33	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	12.5	48	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	13.7	23	5.0
	Public Health Funding (Dollars per person)	$45	47	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	91.9	16	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	70.6	29	—
	Primary Care Physicians (per 100,000 population)	121.2	19	191.9
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	78.1	41	25.6
	ALL DETERMINANTS	-0.19	36	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	10.1	39	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.9	41	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.8	36	2.6
	Geographic Disparity (Relative standard deviation)	9.5	14	4.8
	Infant Mortality (Deaths per 1,000 live births)	7.7	39	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	291.8	39	197.2
	Cancer Deaths (Deaths per 100,000 population)	208.7	43	137.4
	Premature Death (Years lost per 100,000 population)	7,831	32	5481
	ALL OUTCOMES	-0.04	37	0.32
	OVERALL	-0.23	36	1.20

— indicates data not available. * See measure description for full details.

OKLAHOMA

Ranking: Oklahoma is 48th this year; it was 46th in 2010.

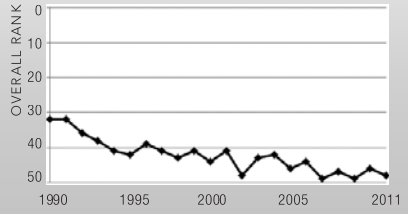
Highlights:

- In the past five years, smoking decreased six percent from 25.1 percent to 23.7 percent of adults; 669,000 adults still smoke in Oklahoma.
- In the past year, the rate of preventable hospitalizations decreased from 88.7 to 81.8 discharges per 1,000 Medicare enrollees.
- In the past year, the percentage of children in poverty increased from 20.3 percent to 25.0 percent of persons under age 18.
- In the past five years, diabetes increased from 8.9 percent to 10.4 percent of adults. Now 293,000 Oklahoma adults have diabetes.
- In the past ten years, obesity increased from 19.7 percent to 31.3 percent of adults, with 883,000 obese adults in Oklahoma.

Health Disparities:
In Oklahoma, obesity is more prevalent among non-Hispanic American Indians at 40.0 percent and non-Hispanic blacks at 41.3 percent than among non-Hispanic whites at 29.7 percent and Hispanics at 30.3 percent. Diabetes also varies by race and ethnicity in the state; 15.1 percent of non-Hispanic American Indians have diabetes compared to 9.4 percent of non-Hispanic whites.

State Health Department Web Site: www.ok.gov/health

Overall Rank: 48



Change: ▼ 2
Determinants Rank: 47
Outcomes Rank: 46

Strengths:

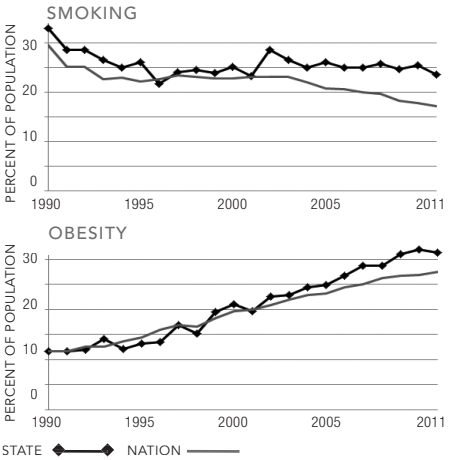
- Low prevalence of binge drinking
- High per capita public health funding
- Low incidence of infectious disease

Challenges:

- High prevalence of smoking and obesity
- Limited availability of primary care physicians
- Low use of prenatal care

ECONOMIC ENVIRONMENT	OK	U.S.
Unemployment Rate (Aug 2011)	5.6%	8.3%
Underemployment Rate (2010)	11.4%	16.7%
Median Household Income (2010)	$43,400	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	657,000	669,000	12,000
Obesity	504,000	883,000	379,000
Diabetes	141,000	293,000	152,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	23.7	48	9.1
	Binge Drinking (Percent of adult population)	13.0	12	6.7
	Obesity (Percent of adult population)	31.3	40	21.4
	High School Graduation (Percent of incoming ninth graders)	78.0	21	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	480	39	122
	Occupational Fatalities (Deaths per 100,000 workers)	7.3	44	2.5
	Infectious Disease (Cases per 100,000 population)	5.8	10	2.3
	Children in Poverty (Percent of persons under age 18)	25.0	42	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	10.2	29	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	17.5	39	5.0
	Public Health Funding (Dollars per person)	$113	11	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	86.6	46	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	76.5*	47	—
	Primary Care Physicians (Number per 100,000 population)	81.7	49	191.9
	Preventable Hospitalizations (per 1,000 Medicare enrollees)	81.8	44	25.6
	ALL DETERMINANTS	-0.48	47	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	10.4	43	5.3
	Poor Mental Health Days (Days in previous 30 days)	4.2	48	2.3
	Poor Physical Health Days (Days in previous 30 days)	4.3	46	2.6
	Geographic Disparity (Relative standard deviation)	10.3	19	4.8
	Infant Mortality (Deaths per 1,000 live births)	7.9	41	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	336.1	48	197.2
	Cancer Deaths (Deaths per 100,000 population)	208.5	42	137.4
	Premature Death (Years lost per 100,000 population)	10,042	47	5481
	ALL OUTCOMES	-0.19	46	0.32
	OVERALL	-0.67	48	1.20

— indicates data not available. * See measure description for full details.

OREGON

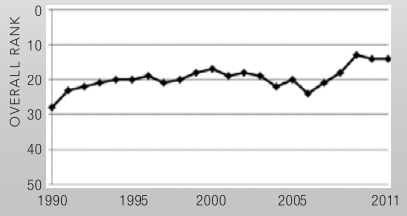
Ranking: Oregon is 14th this year, unchanged from 2010.

Highlights:
- While smoking decreased from 20.7 percent to 15.1 percent of adults in the last ten years, 448,000 adults still smoke in Oregon.
- In the past year, the rate of preventable hospitalizations decreased from 46.1 to 42.0 discharges per 1,000 Medicare enrollees.
- In the past year, obesity increased from 23.6 percent to 27.6 percent of adults, with 818,000 obese adults in the state.
- In the past five years, diabetes increased from 6.7 percent to 7.2 percent of adults. Now 213,000 Oregon adults have diabetes.
- In the past ten years, the rate of uninsured population increased from 12.7 percent to 16.8 percent.

Health Disparities:
Diabetes varies by race and ethnicity in the state; 7.3 percent of non-Hispanic whites have diabetes compared to 6.6 percent of Hispanics. Hispanics and non-Hispanic whites have approximately the same prevalence of obesity at 25.4 percent and 25.3 percent, respectively.

State Health Department Web Site: www.oregon.gov/dhs/ph

Overall Rank: 14



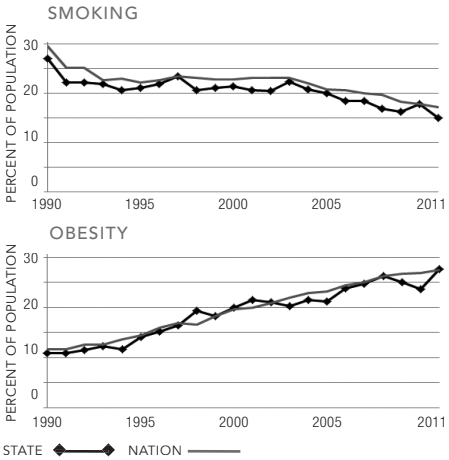
Change: no change
Determinants Rank: 12
Outcomes Rank: 15

Strengths:
- Low prevalence of smoking
- Low rate of preventable hospitalizations
- Low levels of air pollution

Challenges:
- High rate of uninsured population
- Low per capita public health funding
- High percentage of children in poverty

ECONOMIC ENVIRONMENT	OR	U.S.
Unemployment Rate (Aug 2011)	9.6%	8.3%
Underemployment Rate (2010)	20.0%	16.7%
Median Household Income (2010)	$50,526	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	533,000	448,000	-85,000
Obesity	554,000	818,000	264,000
Diabetes	154,000	213,000	59,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	**BEHAVIORS**			
	Smoking (Percent of adult population)	15.1	9	9.1
	Binge Drinking (Percent of adult population)	14.6	19	6.7
	Obesity (Percent of adult population)	27.6	26	21.4
	High School Graduation (Percent of incoming ninth graders)	76.7	24	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	252	12	122
	Occupational Fatalities (Deaths per 100,000 workers)	3.4	10	2.5
	Infectious Disease (Cases per 100,000 population)	7.4	18	2.3
	Children in Poverty (Percent of persons under age 18)	21.2	30	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	7.3	8	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	16.8	35	5.0
	Public Health Funding (Dollars per person)	$59	36	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	90.3	27	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	71.1	25	—
	Primary Care Physicians (per 100,000 population)	126.9	14	191.9
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	42.0	3	25.6
	ALL DETERMINANTS	0.32	12	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	7.2	9	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.6	30	2.3
	Poor Physical Health Days (Days in previous 30 days)	4.0	39	2.6
	Geographic Disparity (Relative standard deviation)	11.5	26	4.8
	Infant Mortality (Deaths per 1,000 live births)	5.5	8	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	235.6	12	197.2
	Cancer Deaths (Deaths per 100,000 population)	192.8	28	137.4
	Premature Death (Years lost per 100,000 population)	6,489	18	5481
	ALL OUTCOMES	0.16	15	0.32
	OVERALL	0.48	14	1.20

— indicates data not available. * See measure description for full details.

PENNSYLVANIA

Ranking: Pennsylvania is 26th this year; it was 27th in 2010.

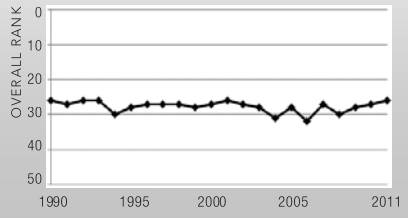
Highlights:

- In the past year, diabetes increased from 9.0 percent to 10.3 percent of the population. Now more than 1.0 million Pennsylvania adults have diabetes.
- In the past year, the percentage of children in poverty increased from 14.5 percent to 16.4 percent of persons under age 18.
- In the past ten years, obesity increased from 21.2 percent to 29.2 percent of adults, with nearly 2.9 million obese adults in the state.
- While smoking decreased from 24.3 percent to 18.4 percent of adults in the last ten years, more than 1.8 million adults still smoke in Pennsylvania.

Health Disparities:
In Pennsylvania, obesity is more prevalent among non-Hispanic blacks at 39.4 percent than Hispanics at 34.5 percent and non-Hispanic whites at 27.7 percent. Diabetes also varies by race and ethnicity in the state; 15.7 percent of non-Hispanic blacks have diabetes compared to 8.9 percent of non-Hispanic whites and 6.6 percent of Hispanics.

State Health Department Web Site: www.health.state.pa.us

Overall Rank: 26



Change: ▲ 1
Determinants Rank: 25
Outcomes Rank: 29

Strengths:

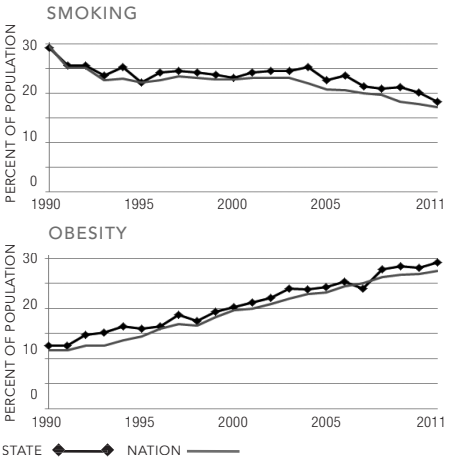
- Low rate of uninsured population
- High rate of high school graduation
- Ready availability of primary care physicians

Challenges:

- High levels of air pollution
- Low per capita public health funding
- High prevalence of diabetes

ECONOMIC ENVIRONMENT	PA	U.S.
Unemployment Rate (Aug 2011)	8.2%	8.3%
Underemployment Rate (2010)	14.7%	16.7%
Median Household Income (2010)	$48,460	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	2,274,000	1,823,000	-451,000
Obesity	1,984,000	2,894,000	910,000
Diabetes	664,000	1,021,000	357,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	18.4	29	9.1
	Binge Drinking (Percent of adult population)	15.8	28	6.7
	Obesity (Percent of adult population)	29.2	34	21.4
	High School Graduation (Percent of incoming ninth graders)	82.7	10	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	366	28	122
	Occupational Fatalities (Deaths per 100,000 workers)	4.5	27	2.5
	Infectious Disease (Cases per 100,000 population)	7.5	19	2.3
	Children in Poverty (Percent of persons under age 18)	16.4	18	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	12.4	47	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	11.0	8	5.0
	Public Health Funding (Dollars per person)	$55	41	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	92.3	13	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	70.8	28	—
	Primary Care Physicians (Number per 100,000 population)	127.8	13	191.9
	Preventable Hospitalizations (per 1,000 Medicare enrollees)	72.0	35	25.6
	ALL DETERMINANTS	0.10	25	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	10.3	41	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.5	28	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.7	29	2.6
	Geographic Disparity (Relative standard deviation)	7.9	9	4.8
	Infant Mortality (Deaths per 1,000 live births)	7.5	35	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	276.6	33	197.2
	Cancer Deaths (Deaths per 100,000 population)	200.5	36	137.4
	Premature Death (Years lost per 100,000 population)	7,410	26	5481
	ALL OUTCOMES	0.03	29	0.32
	OVERALL	0.13	26	1.20

— indicates data not available. * See measure description for full details.

RHODE ISLAND

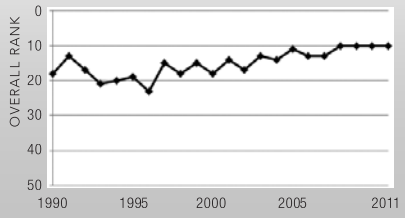
Ranking: Rhode Island is 10th this year, unchanged from 2010.

Highlights:
- In the past year, the rate of preventable hospitalizations decreased from 74.1 to 70.0 discharges per 1,000 Medicare enrollees.
- In the past year, diabetes increased from 7.0 percent to 7.8 percent of adults. Now 65,000 Rhode Island adults have diabetes.
- In the past year, the percentage of children in poverty decreased from 22.2 percent to 20.4 percent of persons under age 18.
- In the past ten years, obesity increased from 17.1 percent to 26.0 percent of adults, with 215,000 obese adults in the state.
- While smoking decreased from 23.4 percent to 15.7 percent of adults in the last ten years, 130,000 adults still smoke in Rhode Island.

Health Disparities:
In Rhode Island, obesity is more prevalent among non-Hispanic blacks at 35.6 percent and Hispanics at 30.9 percent than non-Hispanic whites at 23.3 percent. Diabetes also varies by race and ethnicity in the state; 10.9 percent of non-Hispanic blacks have diabetes compared to 7.3 percent of non-Hispanic whites and 7.6 percent Hispanics.

State Health Department Web Site: www.health.state.ri.us

Overall Rank: 10



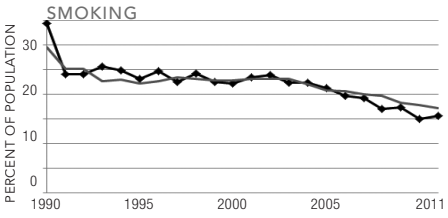
Change: no change
Determinants Rank: 9
Outcomes Rank: 17

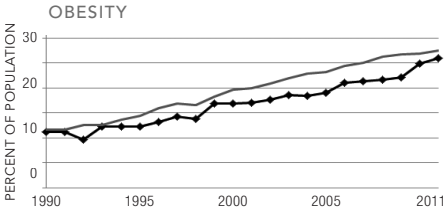
Strengths:
- High immunization coverage
- Low rate of uninsured population
- Ready availability of primary care physicians

Challenges:
- High prevalence of binge drinking
- High percentage of children in poverty
- High rate of preventable hospitalizations

ECONOMIC ENVIRONMENT	RI	U.S.
Unemployment Rate (Aug 2011)	10.6%	8.3%
Underemployment Rate (2010)	19.2%	16.7%
Median Household Income (2010)	$51,914	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	187,000	130,000	-57,000
Obesity	137,000	215,000	78,000
Diabetes	48,000	65,000	17,000





STATE ◆—◆ NATION —

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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	15.7	15	9.1
	Binge Drinking (Percent of adult population)	17.2	36	6.7
	Obesity (Percent of adult population)	26.0	18	21.4
	High School Graduation (Percent of incoming ninth graders)	76.4	25	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	257	13	122
	Occupational Fatalities (Deaths per 100,000 workers)	4.2	23	2.5
	Infectious Disease (Cases per 100,000 population)	9.1	29	2.3
	Children in Poverty (Percent of persons under age 18)	20.4	26	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	8.7	17	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	11.7	11	5.0
	Public Health Funding (Dollars per person)	$111	12	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	94.4	4	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	81.9*	27	—
	Primary Care Physicians (per 100,000 population)	168.2	4	191.9
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	70.0	32	25.6
	ALL DETERMINANTS	0.40	9	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	7.8	17	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.6	30	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.5	22	2.6
	Geographic Disparity (Relative standard deviation)	6.7	6	4.8
	Infant Mortality (Deaths per 1,000 live births)	6.6	22	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	266.0	29	197.2
	Cancer Deaths (Deaths per 100,000 population)	192.5	25	137.4
	Premature Death (Years lost per 100,000 population)	6,280	12	5481
	ALL OUTCOMES	0.15	17	0.32
	OVERALL	0.55	10	1.20

— indicates data not available. * See measure description for full details.

SOUTH CAROLINA

Ranking: South Carolina is 45th this year; it was 41st in 2010.

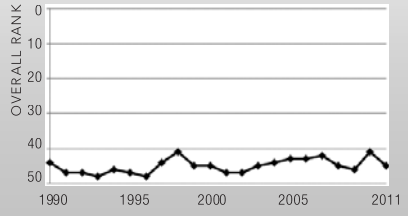
Highlights:

- In the past year, the percentage of children in poverty increased from 17.6 percent to 25.7 percent of persons under age 18.
- In the past year, the rate of uninsured population increased from 16.4 percent to 18.7 percent.
- In the past ten years, obesity increased from 22.0 percent to 32.0 percent of adults, with more than 1.1 million obese adults in the state.
- In the past ten years, diabetes increased from 7.1 percent to 10.7 percent of adults. Now 379,000 South Carolina adults have diabetes.
- While smoking decreased from 24.9 percent to 21.0 percent of adults in the last ten years, 744,000 adults still smoke in South Carolina.

Health Disparities:
In South Carolina, obesity is more prevalent among non-Hispanic blacks at 40.3 percent and Hispanics at 38.2 percent than non-Hispanic whites at 27.4 percent. Diabetes also varies by race and ethnicity in the state; 13.4 percent of non-Hispanic blacks have diabetes compared to 8.9 percent of non-Hispanic whites and 10.0 percent of Hispanics.

State Health Department Web Site: www.scdhec.net

Overall Rank: 45



Change: ▼ 4
Determinants Rank: 44
Outcomes Rank: 43

Strengths:

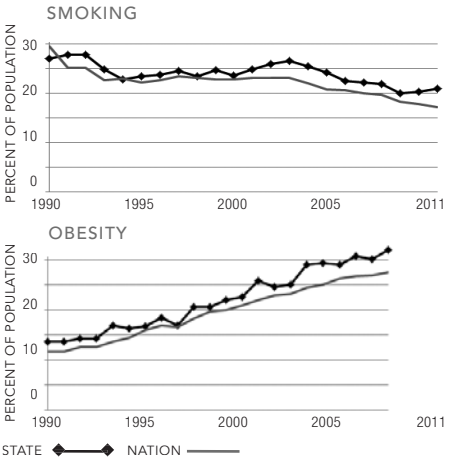
- Low prevalence of binge drinking
- High immunization coverage

Challenges:

- High prevalence of obesity
- Low high school graduation rate
- High percentage of children in poverty
- High prevalence of diabetes

ECONOMIC ENVIRONMENT	SC	U.S.
Unemployment Rate (Aug 2011)	11.1%	8.3%
Underemployment Rate (2010)	18.1%	16.7%
Median Household Income (2010)	$41,709	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	748,000	744,000	-4,000
Obesity	661,000	1,134,000	473,000
Diabetes	213,000	379,000	166,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	21.0	39	9.1
	Binge Drinking (Percent of adult population)	12.5	11	6.7
	Obesity (Percent of adult population)	32.0	47	21.4
	High School Graduation (Percent of incoming ninth graders)	62.2	49	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	598	46	122
	Occupational Fatalities (Deaths per 100,000 workers)	4.9	30	2.5
	Infectious Disease (Cases per 100,000 population)	8.0	24	2.3
	Children in Poverty (Percent of persons under age 18)	25.7	44	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	11.0	38	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	18.7	41	5.0
	Public Health Funding (Dollars per person)	$72	29	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	92.0	15	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	66.5	42	—
	Primary Care Physicians (Number per 100,000 population)	104.6	34	191.9
	Preventable Hospitalizations (per 1,000 Medicare enrollees)	63.6	23	25.6
	ALL DETERMINANTS	-0.40	44	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	10.7	45	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.9	41	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.7	29	2.6
	Geographic Disparity (Relative standard deviation)	11.8	29	4.8
	Infant Mortality (Deaths per 1,000 live births)	8.3	46	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	279.2	34	197.2
	Cancer Deaths (Deaths per 100,000 population)	201.4	37	137.4
	Premature Death (Years lost per 100,000 population)	9,099	43	5481
	ALL OUTCOMES	-0.12	43	0.32
	OVERALL	-0.52	45	1.20

— indicates data not available. * See measure description for full details.

SOUTH DAKOTA

Ranking: South Dakota is 23rd this year; it was 20th in 2010.

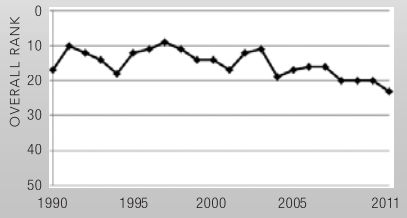
Highlights:

- In the past year, the percentage of children in poverty decreased from 18.4 percent to 15.5 percent of persons under age 18.
- In the past year, the infant mortality rate increased from 6.7 to 7.4 deaths per 1,000 live births after three years of steady decline.
- In the past ten years, obesity increased from 19.8 percent to 27.7 percent of adults, with 169,000 obese adults in the state.
- In the past ten years, diabetes increased from 5.7 percent to 6.9 percent of adults. Now 42,000 South Dakota adults have diabetes.
- While smoking decreased from 21.9 percent to 15.4 percent of adults in the last ten years, 94,000 adults still smoke in South Dakota.

Health Disparities:
In South Dakota, obesity is more prevalent among non-Hispanic American Indians at 39.4 percent than non-Hispanic whites at 28.1 percent and Hispanics at 29.2 percent. Diabetes also varies by race and ethnicity in the state; 12.4 percent of non-Hispanic American Indians have diabetes compared to 6.6 percent of non-Hispanic whites and 6.4 percent of Hispanics.

State Health Department Web Site: doh.sd.gov

Overall Rank: 23



Change: ▼ 3
Determinants Rank: 18
Outcomes Rank: 32

Strengths:

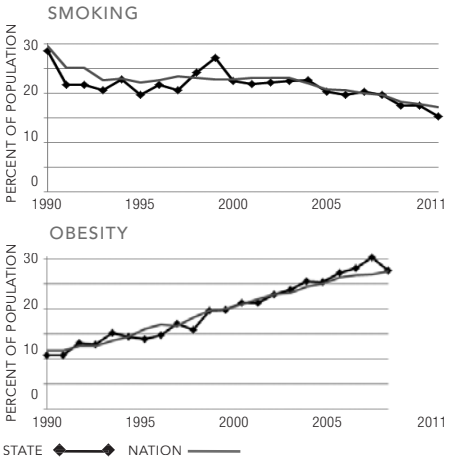
- High rate of high school graduation
- Few poor mental and physical health days per month
- Low prevalence of diabetes

Challenges:

- High prevalence of binge drinking
- High occupational fatalities rate
- High geographic disparity within the state

ECONOMIC ENVIRONMENT	SD	U.S.
Unemployment Rate (Aug 2011)	4.7%	8.3%
Underemployment Rate (2010)	9.7%	16.7%
Median Household Income (2010)	$45,669	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	121,000	94,000	-27,000
Obesity	109,000	169,000	60,000
Diabetes	31,000	42,000	11,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	15.4	12	9.1
	Binge Drinking (Percent of adult population)	18.5	45	6.7
	Obesity (Percent of adult population)	27.7	27	21.4
	High School Graduation (Percent of incoming ninth graders)	84.4	6	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	269	15	122
	Occupational Fatalities (Deaths per 100,000 workers)	6.0	40	2.5
	Infectious Disease (Cases per 100,000 population)	8.3	25	2.3
	Children in Poverty (Percent of persons under age 18)	15.5	14	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	7.1	6	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	13.1	17	5.0
	Public Health Funding (Dollars per person)	$88	20	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	90.7	26	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	0.7	33	—
	Primary Care Physicians (per 100,000 population)	110.5	29	191.9
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	67.5	29	25.6
	ALL DETERMINANTS	0.25	18	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	6.9	6	5.3
	Poor Mental Health Days (Days in previous 30 days)	2.3	1	2.3
	Poor Physical Health Days (Days in previous 30 days)	2.6	1	2.6
	Geographic Disparity (Relative standard deviation)	25.7	50	4.8
	Infant Mortality (Deaths per 1,000 live births)	7.4	33	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	236.8	13	197.2
	Cancer Deaths (Deaths per 100,000 population)	180.8	9	137.4
	Premature Death (Years lost per 100,000 population)	6,895	21	5481
	ALL OUTCOMES	0.02	32	0.32
	OVERALL	0.27	23	1.20

— indicates data not available. * See measure description for full details.

TENNESSEE

Ranking: Tennessee is 39th this year; it was 42nd in 2010.

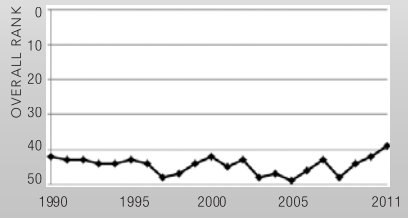
Highlights:

- In the past year, the violent crime rate decreased from 668 to 613 offenses per 100,000 population.
- In the past five years, diabetes increased from 9.1 percent to 11.3 percent of adults. Now 548,000 Tennessee adults have diabetes.
- While smoking decreased from 26.7 percent to 20.1 percent of adults in the last five years, 975,000 adults still smoke in Tennessee.
- In the past ten years, obesity increased from 22.9 percent to 31.7 percent of adults, with more than 1.5 million obese adults in the state.
- In the past ten years, the rate of uninsured population increased from 9.9 percent to 14.9 percent.

Health Disparities:
In Tennessee, obesity is more prevalent among non-Hispanic blacks at 40.9 percent than non-Hispanic whites at 30.5 percent and Hispanics at 30.3 percent. Diabetes also varies by race and ethnicity in the state; 12.2 percent of non-Hispanic blacks have diabetes compared to 10.5 percent of non-Hispanic whites and only 6.3 percent of Hispanics.

State Health Department Web Site: health.state.tn.us

Overall Rank: 39



Change: ▲ 3
Determinants Rank: 37
Outcomes Rank: 42

Strengths:

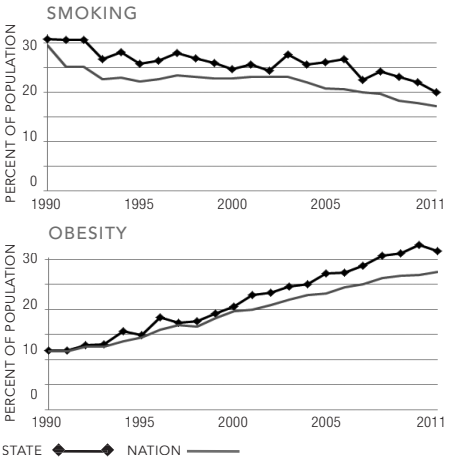
- Low prevalence of binge drinking
- High immunization coverage
- Ready availability of primary care physicians

Challenges:

- High prevalence of obesity
- High prevalence of diabetes
- High violent crime rate

ECONOMIC ENVIRONMENT	TN	U.S.
Unemployment Rate (Aug 2011)	9.7%	8.3%
Underemployment Rate (2010)	16.6%	16.7%
Median Household Income (2010)	$38,686	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	1,103,000	975,000	-128,000
Obesity	983,000	1,537,000	554,000
Diabetes	309,000	548,000	239,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	20.1	37	9.1
	Binge Drinking (Percent of adult population)	6.7	1	6.7
	Obesity (Percent of adult population)	31.7	42	21.4
	High School Graduation (Percent of incoming ninth graders)	74.9	31	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	613	47	122
	Occupational Fatalities (Deaths per 100,000 workers)	5.3	34	2.5
	Infectious Disease (Cases per 100,000 population)	9.5	32	2.3
	Children in Poverty (Percent of persons under age 18)	23.6	36	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	11.1	39	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	14.9	29	5.0
	Public Health Funding (Dollars per person)	$83	22	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	93.1	8	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	0.7	38	—
	Primary Care Physicians (Number per 100,000 population)	122.4	18	191.9
	Preventable Hospitalizations (per 1,000 Medicare enrollees)	85.8	46	25.6
	ALL DETERMINANTS	-0.19	37	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	11.3	46	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.1	11	2.3
	Poor Physical Health Days (Days in previous 30 days)	4.1	41	2.6
	Geographic Disparity (Relative standard deviation)	9.5	14	4.8
	Infant Mortality (Deaths per 1,000 live births)	8.2	45	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	315.7	44	197.2
	Cancer Deaths (Deaths per 100,000 population)	212.5	46	137.4
	Premature Death (Years lost per 100,000 population)	9,194	44	5481
	ALL OUTCOMES	-0.12	42	0.32
	OVERALL	-0.31	39	1.20

— indicates data not available. * See measure description for full details.

TEXAS

Ranking: Texas is 44th this year; it was 40th in 2010.

Highlights:

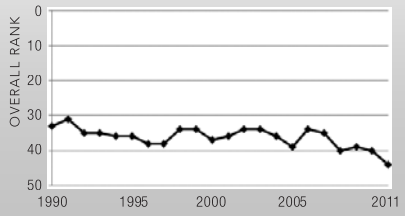
- In the past year, the incidence of infectious disease increased from 13.1 to 18.4 cases per 100,000 population.
- In the past year, the rate of preventable hospitalizations decreased from 78.7 to 72.8 discharges per 1,000 Medicare enrollees.
- In the past five years, the percentage of children in poverty increased from 22.0 percent to 26.5 percent of persons under age 18.
- While smoking decreased from 21.9 percent to 15.8 percent of adults in the last ten years, nearly 2.9 million adults still smoke in Texas.
- In the past ten years, obesity increased from 23.1 percent to 31.7 percent of adults, with nearly 5.8 million obese adults in the state.
- In the past ten years, diabetes increased from 6.2 percent to 9.7 percent of adults. Now nearly 1.8 million Texas adults have diabetes.

Health Disparities:

In Texas, obesity is more prevalent among Hispanics at 36.0 percent and non-Hispanic blacks at 38.5 percent than non-Hispanic whites at 26.7 percent. Diabetes also varies by race and ethnicity in the state; 14.8 percent of non-Hispanic blacks and 10.6 percent of Hispanics have diabetes compared to 8.1 percent of non-Hispanic whites.

State Health Department Web Site: www.dshs.state.tx.us

Overall Rank: 44



Change: ▼ 4
Determinants Rank: 49
Outcomes Rank: 28

Strengths:

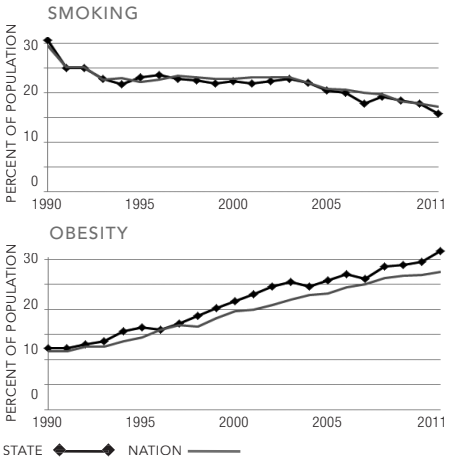
- Low prevalence of smoking
- Moderate infant mortality rate
- Low rate of cancer deaths

Challenges:

- High rate of uninsured population
- Low use of early prenatal care
- High incidence of infectious disease

ECONOMIC ENVIRONMENT	TX	U.S.
Unemployment Rate (Aug 2011)	8.5%	8.3%
Underemployment Rate (2010)	14.4%	16.7%
Median Household Income (2010)	$47,464	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	3,277,000	2,888,000	-389,000
Obesity	3,457,000	5,795,000	2,338,000
Diabetes	928,000	1,773,000	845,000



For a more detailed look at this data, visit **www.americashealthrankings.org**/TX

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	15.8	17	9.1
	Binge Drinking (Percent of adult population)	14.8	22	6.7
	Obesity (Percent of adult population)	31.7	42	21.4
	High School Graduation (Percent of incoming ninth graders)	73.1	35	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	450	36	122
	Occupational Fatalities (Deaths per 100,000 workers)	5.3	34	2.5
	Infectious Disease (Cases per 100,000 population)	18.4	46	2.3
	Children in Poverty (Percent of persons under age 18)	26.5	45	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	10.4	32	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	25.0	50	5.0
	Public Health Funding (Dollars per person)	$56	39	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	89.0	37	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	59.3	50	—
	Primary Care Physicians (per 100,000 population)	95.6	42	191.9
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	72.8	36	25.6
	ALL DETERMINANTS	-0.54	49	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	9.7	34	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.5	28	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.8	36	2.6
	Geographic Disparity (Relative standard deviation)	14.9	39	4.8
	Infant Mortality (Deaths per 1,000 live births)	6.2	17	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	272.2	30	197.2
	Cancer Deaths (Deaths per 100,000 population)	182.8	13	137.4
	Premature Death (Years lost per 100,000 population)	7,492	28	5481
	ALL OUTCOMES	0.03	28	0.32
	OVERALL	-0.51	44	1.20

— indicates data not available. * See measure description for full details.

UTAH

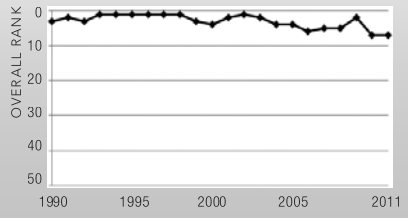
Ranking: Utah is 7th this year, unchanged from 2010.

Highlights:
- In the past year, the rate of preventable hospitalizations decreased from 39.9 to 36.7 discharges per 1,000 Medicare enrollees.
- In the past five years, diabetes increased from 5.5 percent to 6.5 percent of adults. Now 123,000 Utah adults have diabetes.
- While smoking decreased from 12.9 percent to 9.1 percent of adults in the last ten years, 172,000 adults still smoke in Utah.
- In the past ten years, obesity increased from 19.1 percent to 23.0 percent of adults, with 435,000 obese adults in the state.

Health Disparities:
In Utah, smoking is more prevalent among Hispanics at 12.2 percent than non-Hispanic whites at 9.1 percent. Obesity is more prevalent among Hispanics at 27.4 percent than non-Hispanic whites at 23.0 percent.

State Health Department Web Site: www.health.utah.gov

Overall Rank: 7



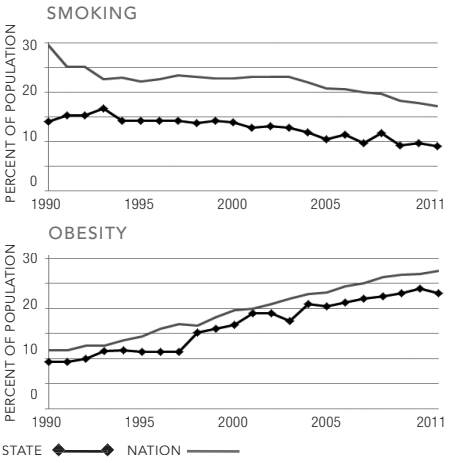
Change: no change
Determinants Rank: 6
Outcomes Rank: 6

Strengths:
- Lower prevalences of smoking, binge drinking and obesity than other states
- Low rate of preventable hospitalizations
- Low rate of cancer deaths

Challenges:
- Limited availability of primary care physicians
- Low immunization coverage
- High geographic disparity within the state

ECONOMIC ENVIRONMENT	UT	U.S.
Unemployment Rate (Aug 2011)	7.6%	8.3%
Underemployment Rate (2010)	15.1%	16.7%
Median Household Income (2010)	$56,787	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	195,000	172,000	-23,000
Obesity	289,000	435,000	146,000
Diabetes	82,000	123,000	41,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	9.1	1	9.1
	Binge Drinking (Percent of adult population)	8.8	2	6.7
	Obesity (Percent of adult population)	23.0	2	21.4
	High School Graduation (Percent of incoming ninth graders)	74.3	33	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	213	5	122
	Occupational Fatalities (Deaths per 100,000 workers)	4.9	30	2.5
	Infectious Disease (Cases per 100,000 population)	10.0	36	2.3
	Children in Poverty (Percent of persons under age 18)	12.9	9	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	9.6	22	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	13.9	25	5.0
	Public Health Funding (Dollars per person)	$67	32	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	86.6	47	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	80.4*	35	—
	Primary Care Physicians (Number per 100,000 population)	88.4	45	191.9
	Preventable Hospitalizations (per 1,000 Medicare enrollees)	36.7	2	25.6
	ALL DETERMINANTS	0.47	6	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	6.5	3	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.4	19	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.1	11	2.6
	Geographic Disparity (Relative standard deviation)	16.0	42	4.8
	Infant Mortality (Deaths per 1,000 live births)	4.9	3	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	215.2	3	197.2
	Cancer Deaths (Deaths per 100,000 population)	137.4	1	137.4
	Premature Death (Years lost per 100,000 population)	5,960	7	5481
	ALL OUTCOMES	0.25	6	0.32
	OVERALL	0.72	7	1.20

— indicates data not available. * See measure description for full details.

VERMONT

Ranking: Vermont is 1st this year, unchanged from 2010.

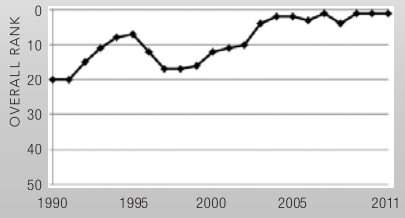
Highlights:

- In the past year, the incidence of infectious disease decreased from 8.5 to 3.1 cases per 100,000 population.
- In the past five years, the percentage of children in poverty increased from 7.4 percent to 13.5 percent of persons under age 18.
- While smoking decreased from 21.5 percent to 15.4 percent of adults in the last ten years, 76,000 adults still smoke in Vermont.
- In the past ten years, obesity increased from 18.2 percent to 23.9 percent of adults, with 119,000 obese adults in the state.
- In the past ten years, diabetes increased from 4.4 percent to 6.8 percent of adults. Now 34,000 Vermont adults have diabetes.

Health Disparities:
In Vermont, smoking is more prevalent among Hispanics at 19.4 percent than non-Hispanic whites at 16.0 percent, however obesity is more prevalent among non-Hispanic whites at 23.6 percent than Hispanics at 20.8 percent.

State Health Department Web Site: www.healthvermont.gov

Overall Rank: 1



Change: no change
Determinants Rank: 1
Outcomes Rank: 5

Strengths:

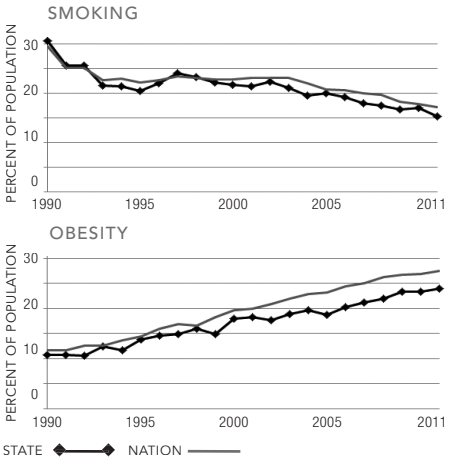
- High rate of high school graduation
- Low incidence of infectious disease
- High use of early prenatal care
- Low violent crime rate

Challenges:

- High prevalence of binge drinking
- Moderate immunization coverage

ECONOMIC ENVIRONMENT	VT	U.S.
Unemployment Rate (Aug 2011)	5.9%	8.3%
Underemployment Rate (2010)	12.5%	16.7%
Median Household Income (2010)	$55,942	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	99,000	76,000	-23,000
Obesity	89,000	119,000	35,000
Diabetes	20,000	34,000	14,000



For a more detailed look at this data, visit **www.americashealthrankings.org**/VT

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	15.4	12	9.1
	Binge Drinking (Percent of adult population)	17.1	35	6.7
	Obesity (Percent of adult population)	23.9	8	21.4
	High School Graduation (Percent of incoming ninth graders)	89.3	2	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	130	2	122
	Occupational Fatalities (Deaths per 100,000 workers)	4.3	24	2.5
	Infectious Disease (Cases per 100,000 population)	3.1	2	2.3
	Children in Poverty (Percent of persons under age 18)	13.5	10	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	7.1	6	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	9.5	5	5.0
	Public Health Funding (Dollars per person)	$154	3	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	91.2	22	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	82.6	1	—
	Primary Care Physicians (per 100,000 population)	170.3	3	191.9
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	54.7	10	25.6
	ALL DETERMINANTS	0.90	1	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	6.8	5	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.3	17	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.2	13	2.6
	Geographic Disparity (Relative standard deviation)	4.8	1	4.8
	Infant Mortality (Deaths per 1,000 live births)	4.8	2	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	235.1	10	197.2
	Cancer Deaths (Deaths per 100,000 population)	190.6	21	137.4
	Premature Death (Years lost per 100,000 population)	5,862	5	5481
	ALL OUTCOMES	0.29	5	0.32
	OVERALL	1.20	1	1.20

— indicates data not available. * See measure description for full details.

VIRGINIA

Ranking: Virginia is 20th this year; it was 22nd in 2010.

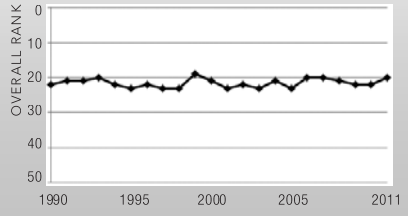
Highlights:

- In the past year, the percentage of children in poverty decreased from 14.8 percent to 12.3 percent of persons under age 18.
- In the past year, binge drinking increased from 13.6 percent to 15.3 percent of adults.
- In the past five years, diabetes increased from 6.9 percent to 8.7 percent of the population. Now 535,000 Virginia adults have diabetes.
- In the past ten years, obesity increased from 18.2 percent to 26.4 percent of adults, with more than 1.6 million obese adults in the state.
- While smoking decreased from 21.4 percent to 18.5 percent of adults in the last ten years, this is a much smaller reduction than other states and more than 1.1 million adults still smoke in Virginia.

Health Disparities:
In Virginia, obesity is more prevalent among non-Hispanic blacks at 37.2 percent than non-Hispanic whites at 25.2 percent and Hispanics at 25.1 percent. Diabetes also varies by race and ethnicity in the state; 13.0 percent of non-Hispanic blacks have diabetes compared to 8.0 percent of non-Hispanic whites and only 3.7 percent of Hispanics.

State Health Department Web Site: www.vdh.state.va.us

Overall Rank: 20



Change: ▲ 2
Determinants Rank: 15
Outcomes Rank: 26

Strengths:

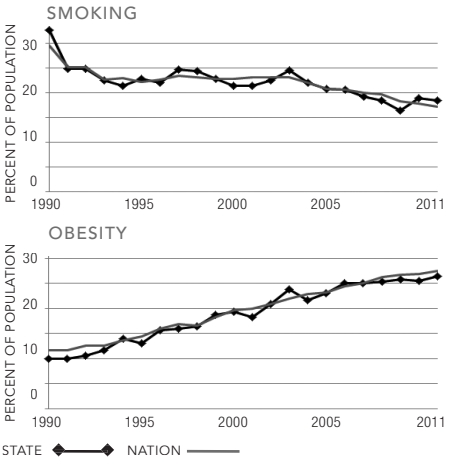
- Low violent crime rate
- High use of early prenatal care
- Low percentage of children in poverty

Challenges:

- Moderate immunization coverage
- High levels of air pollution
- High prevalence of smoking

ECONOMIC ENVIRONMENT	VA	U.S.
Unemployment Rate (Aug 2011)	6.3%	8.3%
Underemployment Rate (2010)	12.9%	16.7%
Median Household Income (2010)	$60,363	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	1,143,000	1,137,000	-6,000
Obesity	972,000	1,623,000	651,000
Diabetes	331,000	535,000	204,000



For a more detailed look at this data, visit **www.americashealthrankings.org**/VA

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	18.5	30	9.1
	Binge Drinking (Percent of adult population)	15.3	25	6.7
	Obesity (Percent of adult population)	26.4	20	21.4
	High School Graduation (Percent of incoming ninth graders)	77.0	23	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	214	6	122
	Occupational Fatalities (Deaths per 100,000 workers)	3.9	19	2.5
	Infectious Disease (Cases per 100,000 population)	7.0	15	2.3
	Children in Poverty (Percent of persons under age 18)	12.3	4	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	10.4	32	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	13.4	20	5.0
	Public Health Funding (Dollars per person)	$69	31	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	90.3	28	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	85.0*	12	—
	Primary Care Physicians (Number per 100,000 population)	126.8	16	191.9
	Preventable Hospitalizations (per 1,000 Medicare enrollees)	59.9	17	25.6
	ALL DETERMINANTS	0.31	15	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	8.7	25	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.2	14	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.3	17	2.6
	Geographic Disparity (Relative standard deviation)	15.1	40	4.8
	Infant Mortality (Deaths per 1,000 live births)	7.3	31	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	264.9	27	197.2
	Cancer Deaths (Deaths per 100,000 population)	195.5	31	137.4
	Premature Death (Years lost per 100,000 population)	6,897	22	5481
	ALL OUTCOMES	0.04	26	0.32
	OVERALL	0.34	20	1.20

— indicates data not available. * See measure description for full details.

WASHINGTON

Ranking: Washington is 15th this year; it was 11th in 2010.

Highlights:

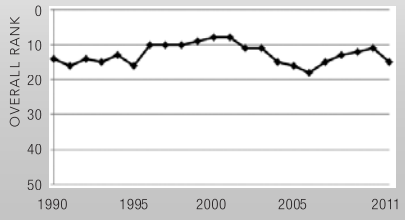
- In the past year, the percentage of children in poverty decreased from 18.0 percent to 16.1 percent of persons under age 18.
- In the past five years, diabetes increased from 6.3 percent to 7.6 percent of the population. Now 391,000 Washington adults have diabetes.
- While smoking decreased from 20.7 percent to 15.2 percent of adults in the last ten years, 782,000 adults still smoke in Washington. Smoking was 14.9 percent last year.
- In the past ten years, obesity increased from 18.8 percent to 26.2 percent of adults, with more than 1.3 million obese adults in the state.
- High school graduation is the lowest in seven years, at 71.9 percent of incoming ninth graders who graduate in four years.

Health Disparities:

In Washington, obesity is more prevalent among non-Hispanic blacks at 33.8 percent and Hispanics at 30.4 percent than non-Hispanic whites at 26.2 percent and non-Hispanic Asians at 7.4 percent. Diabetes also varies by race and ethnicity in the state; 12.8 percent of non-Hispanic blacks have diabetes compared to 5.7 percent of non-Hispanic Asians, 6.8 percent of Hispanics and 7.4 percent of non-Hispanic whites.

State Health Department Web Site: www.doh.wa.gov

Overall Rank: 15



Change: ▼4
Determinants Rank: 17
Outcomes Rank: 10

Strengths:

- Low prevalence of smoking
- Low rate of preventable hospitalizations
- Lower prevalence of diabetes than other states

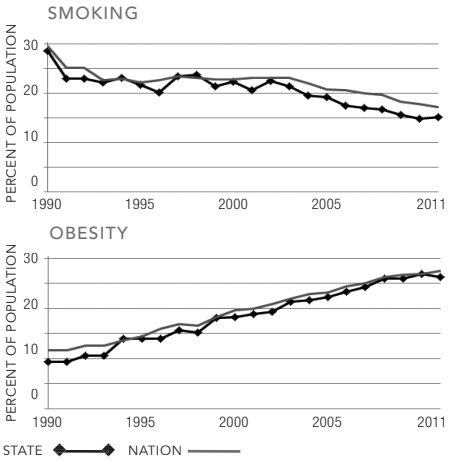
Challenges:

- Low immunization coverage
- Low use of early prenatal care
- Low high school graduation rate

WASHINGTON

ECONOMIC ENVIRONMENT	WA	U.S.
Unemployment Rate (Aug 2011)	9.3%	8.3%
Underemployment Rate (2010)	18.4%	16.7%
Median Household Income (2010)	$56,253	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	907,000	782,000	-125,000
Obesity	823,000	1,348,000	525,000
Diabetes	241,000	391,000	150,000



For a more detailed look at this data, visit **www.americashealthrankings.org**/WA

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	15.2	10	9.1
	Binge Drinking (Percent of adult population)	15.3	25	6.7
	Obesity (Percent of adult population)	26.2	19	21.4
	High School Graduation (Percent of incoming ninth graders)	71.9	38	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	314	22	122
	Occupational Fatalities (Deaths per 100,000 workers)	2.9	5	2.5
	Infectious Disease (Cases per 100,000 population)	9.1	29	2.3
	Children in Poverty (Percent of persons under age 18)	16.1	16	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	9.6	22	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	13.2	18	5.0
	Public Health Funding (Dollars per person)	$91	18	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	88.6	39	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	68.5	36	—
	Primary Care Physicians (per 100,000 population)	124.6	17	191.9
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	46.4	5	25.6
	ALL DETERMINANTS	0.25	17	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	7.6	15	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.4	19	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.4	18	2.6
	Geographic Disparity (Relative standard deviation)	13.4	34	4.8
	Infant Mortality (Deaths per 1,000 live births)	5.1	5	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	241.7	19	197.2
	Cancer Deaths (Deaths per 100,000 population)	187.0	17	137.4
	Premature Death (Years lost per 100,000 population)	6,163	11	5481
	ALL OUTCOMES	0.19	10	0.32
	OVERALL	0.44	15	1.20

— indicates data not available. * See measure description for full details.

WEST VIRGINIA

Ranking: West Virginia is 41st this year; it was 43rd in 2010.

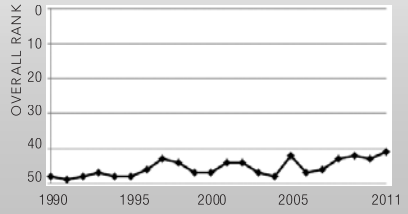
Highlights:

- In the past year, the rate of preventable hospitalizations decreased from 105.4 to 100.7 discharges per 1,000 Medicare enrollees.
- Unlike other states, smoking has not declined in the last ten years; 393,000 adults still smoke in West Virginia.
- In the past ten years, obesity increased from 23.2 percent to 32.9 percent of adults, with 482,000 obese adults in the state.
- In the past ten years, diabetes increased from 7.6 percent to 11.7 percent of the population. Now 171,000 West Virginia adults have diabetes.

Health Disparities:
In West Virginia, obesity is more prevalent among non-Hispanic blacks at 39.5 percent than non-Hispanic whites at 32.1 percent and Hispanics at 29.7 percent. Diabetes also varies by race and ethnicity in the state; 15.2 percent of non-Hispanic blacks have diabetes compared to 11.8 percent of non-Hispanic whites and 11.7 percent of Hispanics.

State Health Department Web Site: www.wvdhhr.org

Overall Rank: 41



Change: ▲ 2
Determinants Rank: 34
Outcomes Rank: 47

Strengths:

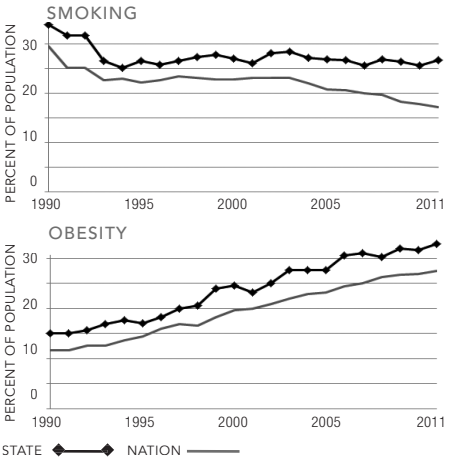
- Low prevalence of binge drinking
- High per capita public health funding
- Low incidence of infectious disease

Challenges:

- High prevalences of smoking, obesity and diabetes
- High rate of preventable hospitalizations
- Many poor mental and physical health days per month

ECONOMIC ENVIRONMENT	WV	U.S.
Unemployment Rate (Aug 2011)	8.1%	8.3%
Underemployment Rate (2010)	14.0%	16.7%
Median Household Income (2010)	$42,839	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	367,000	393,000	26,000
Obesity	326,000	482,000	156,000
Diabetes	107,000	171,000	64,000



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

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	26.8	50	9.1
	Binge Drinking (Percent of adult population)	9.1	3	6.7
	Obesity (Percent of adult population)	32.9	48	21.4
	High School Graduation (Percent of incoming ninth graders)	77.3	22	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	315	24	122
	Occupational Fatalities (Deaths per 100,000 workers)	7.7	45	2.5
	Infectious Disease (Cases per 100,000 population)	2.3	1	2.3
	Children in Poverty (Percent of persons under age 18)	20.3	25	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	11.9	44	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	13.6	21	5.0
	Public Health Funding (Dollars per person)	$144	4	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	91.0	23	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	82.0*	26	—
	Primary Care Physicians (Number per 100,000 population)	107.2	32	191.9
	Preventable Hospitalizations (per 1,000 Medicare enrollees)	100.7	49	25.6
	ALL DETERMINANTS	-0.16	34	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	11.7	48	5.3
	Poor Mental Health Days (Days in previous 30 days)	4.5	50	2.3
	Poor Physical Health Days (Days in previous 30 days)	4.9	50	2.6
	Geographic Disparity (Relative standard deviation)	12.2	32	4.8
	Infant Mortality (Deaths per 1,000 live births)	7.6	37	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	321.2	47	197.2
	Cancer Deaths (Deaths per 100,000 population)	220.0	49	137.4
	Premature Death (Years lost per 100,000 population)	9,865	45	5481
	ALL OUTCOMES	-0.25	47	0.32
	OVERALL	-0.41	41	1.20

— indicates data not available. * See measure description for full details.

WISCONSIN

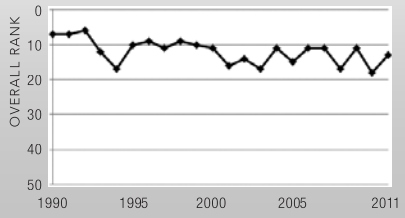
Ranking: Wisconsin is 13th this year; it was 18th in 2010.

Highlights:
- In the past year, the percentage of children in poverty decreased from 15.5 percent to 12.7 percent of persons under age 18.
- In the past year, diabetes decreased from 8.2 percent to 7.1 percent of the population; 309,000 Wisconsin adults have diabetes.
- While smoking decreased from 24.1 percent to 19.1 percent of adults in the last ten years, 830,000 adults still smoke in Wisconsin.
- In the past ten years, obesity increased from 20.0 percent to 26.9 percent of adults, with nearly 1.2 million obese adults in the state.

Health Disparities:
In Wisconsin, obesity is more prevalent among non-Hispanic blacks at 45.8 percent than non-Hispanic whites at 26.5 percent and Hispanics at 21.1 percent. Diabetes also varies by race and ethnicity in the state; 12.4 percent of non-Hispanic blacks have diabetes compared to 7.4 percent of non-Hispanic whites.

State Health Department Web Site: www.dhs.wisconsin.gov

Overall Rank: 13



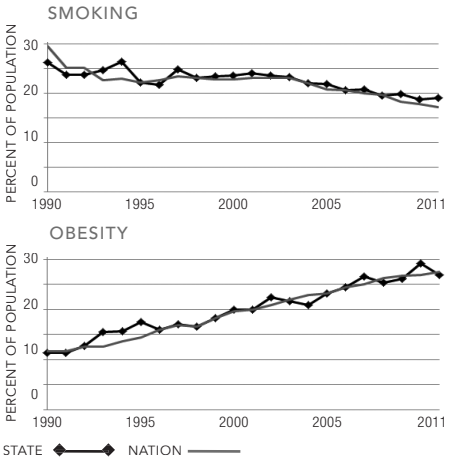
Change: ▲ 5
Determinants Rank: 14
Outcomes Rank: 14

Strengths:
- High rate of high school graduation
- Low rate of uninsured population
- Low incidence of infectious disease
- Low percentage of children in poverty

Challenges:
- High prevalence of binge drinking
- Low per capita public health funding

ECONOMIC ENVIRONMENT	WI	U.S.
Unemployment Rate (Aug 2011)	7.9%	8.3%
Underemployment Rate (2010)	14.8%	16.7%
Median Household Income (2010)	$50,522	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	963,000	830,000	-133,000
Obesity	799,000	1,169,000	370,000
Diabetes	244,000	309,000	65,000



For a more detailed look at this data, visit **www.americashealthrankings.org**/WI

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	19.1	34	9.1
	Binge Drinking (Percent of adult population)	22.8	50	6.7
	Obesity (Percent of adult population)	26.9	21	21.4
	High School Graduation (Percent of incoming ninth graders)	89.6	1	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	249	11	122
	Occupational Fatalities (Deaths per 100,000 workers)	2.7	3	2.5
	Infectious Disease (Cases per 100,000 population)	4.8	4	2.3
	Children in Poverty (Percent of persons under age 18)	12.7	7	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	10.5	34	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	9.2	4	5.0
	Public Health Funding (Dollars per person)	$40	50	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	91.4	20	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	83.3*	16	—
	Primary Care Physicians (per 100,000 population)	121.0	20	191.9
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	58.5	14	25.6
	ALL DETERMINANTS	0.31	14	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	7.1	8	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.0	8	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.5	22	2.6
	Geographic Disparity (Relative standard deviation)	10.0	17	4.8
	Infant Mortality (Deaths per 1,000 live births)	6.7	26	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	250.5	21	197.2
	Cancer Deaths (Deaths per 100,000 population)	192.5	25	137.4
	Premature Death (Years lost per 100,000 population)	6,295	13	5481
	ALL OUTCOMES	0.17	14	0.32
	OVERALL	0.48	13	1.20

— indicates data not available. * See measure description for full details.

WYOMING

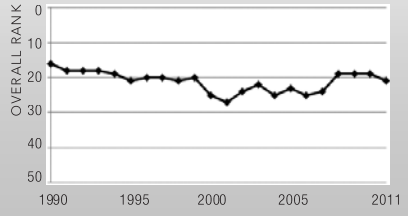
Ranking: Wyoming is 21st this year; it was 19th in 2010.

Highlights:
- In the past year, the violent crime rate decreased from 228 to 196 offenses per 100,000 population.
- In the past year, geographic disparity within the state increased from 9.3 percent to 11.1 percent.
- In the past five years, the rate of uninsured population increased from 13.8 percent to 16.3 percent.
- In the past ten years, obesity increased from 18.0 percent to 25.7 percent of adults, with 110,000 obese adults in the state.
- In the past ten years, diabetes increased from 5.0 percent to 7.2 percent of adults. Now 31,000 Wyoming adults have diabetes.
- While smoking decreased from 23.8 percent to 19.5 percent of adults in the last ten years, 84,000 adults still smoke in Wyoming.

Health Disparities:
In Wyoming, smoking is more prevalent among non-Hispanic American Indians at 49.1 percent than non-Hispanic whites at 18.5 percent and Hispanics at 24.5 percent. Similarly, obesity is highest among non-Hispanic American Indians at 42.4 percent when compared to non-Hispanic whites at 24.6 percent and Hispanics at 32.0 percent.

State Health Department Web Site: http://www.health.wyo.gov

Overall Rank: 21



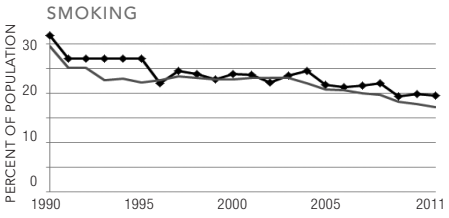
Change: ▼ 2
Determinants Rank: 19
Outcomes Rank: 23

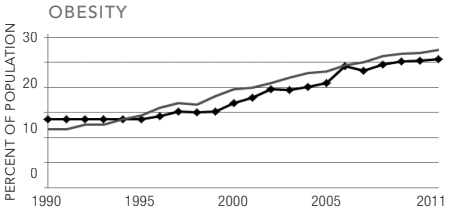
Strengths:
- Low incidence of infectious disease
- Low percentage of children in poverty
- Low levels of air pollution
- Low violent crime rate

Challenges:
- Limited availability of primary care physicians
- High occupational fatalities rate

ECONOMIC ENVIRONMENT	WY	U.S.
Unemployment Rate (Aug 2011)	5.8%	8.3%
Underemployment Rate (2010)	11.5%	16.7%
Median Household Income (2010)	$52,359	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	87,000	84,000	-3,000
Obesity	66,000	110,000	44,000
Diabetes	18,000	31,000	13,000





For a more detailed look at this data, visit **www.americashealthrankings.org**/WY

		2011 VALUE	2011 RANK	NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	19.5	35	9.1
	Binge Drinking (Percent of adult population)	15.2	24	6.7
	Obesity (Percent of adult population)	25.7	17	21.4
	High School Graduation (Percent of incoming ninth graders)	76.0	28	89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	196	4	122
	Occupational Fatalities (Deaths per 100,000 workers)	8.4	48	2.5
	Infectious Disease (Cases per 100,000 population)	4.8	4	2.3
	Children in Poverty (Percent of persons under age 18)	12.0	3	6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	5.2	1	5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	16.3	33	5.0
	Public Health Funding (Dollars per person)	$117	9	$244
	Immunization Coverage (Percent of children ages 19 to 35 months)	90.7	25	96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	70.1	30	—
	Primary Care Physicians (Number per 100,000 population)	93.7	43	191.9
	Preventable Hospitalizations (per 1,000 Medicare enrollees)	62.9	19	25.6
	ALL DETERMINANTS	0.24	19	0.90
OUTCOMES				
	Diabetes (Percent of adult population)	7.2	9	5.3
	Poor Mental Health Days (Days in previous 30 days)	3.4	19	2.3
	Poor Physical Health Days (Days in previous 30 days)	3.4	18	2.6
	Geographic Disparity (Relative standard deviation)	11.1	22	4.8
	Infant Mortality (Deaths per 1,000 live births)	7.2	30	4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	254.2	22	197.2
	Cancer Deaths (Deaths per 100,000 population)	182.2	10	137.4
	Premature Death (Years lost per 100,000 population)	8,220	39	5481
	ALL OUTCOMES	0.07	23	0.32
	OVERALL	0.31	21	1.20

— indicates data not available. * See measure description for full details.

DISTRICT OF COLUMBIA

Ranking: The District of Columbia is not included in the ranking of states, as it is a unique governmental entity and is considerably more urban than the states.

Highlights:

- In the past year, the rate of preventable hospitalizations decreased from 55.3 to 52.8 discharges per 1,000 Medicare enrollees.
- In the past year, diabetes increased from 7.5 percent to 10.9 percent of adults. Now 55,000 District of Columbia adults have diabetes.
- In the past year, the rate of uninsured population increased from 11.2 percent to 12.4 percent.
- While smoking decreased from 20.0 percent to 14.8 percent of adults in the last five years, 74,000 adults still smoke in the District of Columbia.
- Unlike most states, the level of obesity has remained steady over the past ten years, with 114,000 obese adults in the district.

State Health Department Web Site: www.dchealth.dc.gov

District is not ranked.

Strengths:

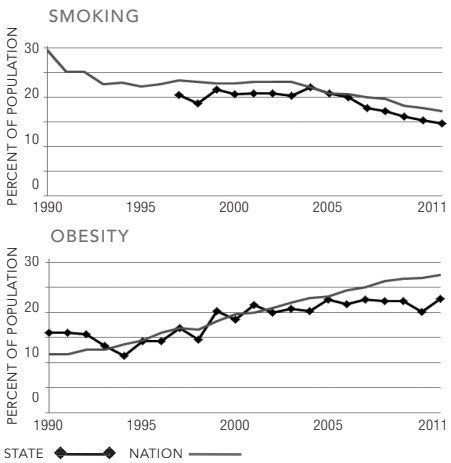
- Low prevalence of smoking
- Lower prevalence of obesity than most states
- Low rate of uninsured population

Challenges:

- High violent crime rate
- High percentage of children in poverty
- High incidence of infectious disease

ECONOMIC ENVIRONMENT	DC	U.S.
Unemployment Rate (Aug 2011)	11.1%	8.3%
Underemployment Rate (2010)	14.0%	16.7%
Median Household Income (2010)	$55,528	$49,445

MEASURE	ADULT POPULATION AFFECTED 2001	2011	10-YR CHANGE
Smoking	96,000	74,000	-22,000
Obesity	98,000	114,000	16,000
Diabetes	33,000	55,000	22,000



		2011 VALUE		NO. 1 STATE
DETERMINANTS	BEHAVIORS			
	Smoking (Percent of adult population)	14.8		9.1
	Binge Drinking (Percent of adult population)	16.4		6.7
	Obesity (Percent of adult population)	22.7		21.4
	High School Graduation (Percent of incoming ninth graders)	56.0		89.6
	COMMUNITY & ENVIRONMENT			
	Violent Crime (Offenses per 100,000 population)	1330		122
	Infectious Disease (Cases per 100,000 population)	27.5		2.3
	Children in Poverty (Percent of persons under age 18)	33.5		6.2
	Air Pollution (Micrograms of fine particles per cubic meter)	11.4		5.2
	PUBLIC & HEALTH POLICIES			
	Lack of Health Insurance (Percent without health insurance)	12.4		5.0
	Immunization Coverage (Percent of children ages 19 to 35 months)	92.4		96.0
	CLINICAL CARE			
	Early Prenatal Care (Percent with visit during first trimester)	78.3*		—
	Primary Care Physicians (per 100,000 population)	330.2		191.9
	Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	52.8		25.6
OUTCOMES				
	Diabetes (Percent of adult population)	10.9		5.3
	Poor Mental Health Days (Days in previous 30 days)	2.8		2.3
	Poor Physical Health Days (Days in previous 30 days)	3.1		2.6
	Infant Mortality (Deaths per 1,000 live births)	11.9		4.7
	Cardiovascular Deaths (Deaths per 100,000 population)	328.7		197.2
	Cancer Deaths (Deaths per 100,000 population)	212.8		137.4
	Premature Death (Years lost per 100,000 population)	11,166		5481

— indicates data not available. * See measure description for full details.

For a more detailed look at this data, visit **www.americashealthrankings.org**/DC

What Gets Measured Gets Done: But Only if We Act

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Non-communicable diseases are a growing national problem. Today they are responsible for more than 70 percent of premature deaths in the United States and cost billions of dollars to address. In fact these non-communicable diseases have become such a global phenomenon that the United Nations recently convened, for only the second time in history, a summit to address a health issue; this time, instead of an infectious disease such as HIV/AIDS, they focused on the top non-communicable diseases that are cutting lives short and diminishing quality of life: cardiovascular disease, cancer, chronic lung disease, and diabetes. And in America, as it is globally, addressing the leading causes of these largely preventable diseases is essential if we are going to reduce the demand for health care services and improve the population's health.

America's Health Rankings, now entering its 22nd year, gives us a tool to gauge how well those interventions are working and what areas need our most immediate attention. The famous quote that states "what gets measured, gets done" is a central tenet behind America's Health Rankings and should drive us to action. The numbers are compelling but the question is how?

One solution, is to find ways to "make the healthy choice the easy choice;" by finding easier ways to encourage more physical activity, healthier diets and less tobacco use. This approach should be the mantra not just for the public health community but for everyone involved in shaping policy, whether elected officials, community activists, health providers or urban planners. We need interventions on the ground level, in the very neighborhoods where the problems are most entrenched, where dangerous streets make walking difficult if not impossible, where fresh produce and affordable foods cannot be found, where fast food restaurants and liquor stores crowd the landscape, but safe places to play are in short supply. In short, we need a health-in-all-policies approach.

Since the last rankings were released, the opportunity to spotlight prevention became reality with the passage of the Affordable Care Act and its extraordinary emphasis on prevention. The law's new "Prevention and Public Health Fund" has given the nation new resources to spark some much-needed innovation in community-level interventions that will put the population on a healthier track. Such interventions include creating and maintaining safe and accessible sidewalks, walking paths and biking lanes; accelerating locally led action to improve the nutritional content of foods available in schools and child care environments; and increasing efforts to ensure children can exercise both at school and at child care centers. The work includes policy initiatives that support policy-maker education on the benefits of smoke-free environments, policy initiatives that reduce tobacco use and increased support for tobacco cessation programs.

One area where communities are taking the lead is in addressing food deserts through economic incentives for supermarkets in underserved areas and healthy corner store initiatives. The Food Trust in Pennsylvania, with a mission to ensure everyone has access to affordable, nutritious foods, supports such projects as the Fresh Food Financing Initiative, which has provided funding for 88 fresh food retail projects in 34 Pennsylvania counties, improving access to healthy food choices for more than 500,000 people. In New York, where grabbing a hot dog or pizza slice has been the norm for decades, the NYC Green Cart initiative offers permits for mobile food carts that offer fresh pro-

duce in city neighborhoods. Vendors with a Green Cart license can sell raw fruits and vegetables such as whole carrots, bananas, apples and berries. The Healthy in a Hurry Corner Store initiative has brought not only produce but other healthy food options such as whole grain cereals and lower-fat dairy products to convenience stores in some areas where such options had been non-existent and where local residents are disproportionately poor and suffering from chronic health conditions. These are the types of innovative efforts that show community-level interventions can indeed make a difference.

Communities Putting Prevention to Work, an effort by the federal government through the Centers for Disease Control and Prevention (CDC) offers more than $400 million in grants to address physical inactivity, poor nutrition and tobacco use. The goal is to address several of the root causes of the most prevalent non-communicable diseases. Projects include an effort by the Cherokee Nation Health Services Group to promote healthy food and beverage choices, implement farm-to-school programs and menu labeling, adopt quality physical education in schools and expand activity groups in workplaces, community gathering spots, parks and neighborhoods. About half of the project's $2.1 million is earmarked for anti-obesity efforts, with the other half funding anti-tobacco initiatives, including the elimination of free samples of tobacco and price discounts at Cherokee Nation businesses and events. The Boston Public Health Commission's $12.5 million project is also split about evenly between anti-obesity and anti-tobacco programs such as a bike share program, expanded backyard gardens, a smoke-free homes initiative and a plan to embed smoking cessation referral systems in electronic health records and provide training and support for health care professionals to allow access to health insurance reimbursement for smoking cessation services.

The wide range of programs being funded by Communities Putting Prevention to Work illustrate that intervention need not be complex to be evidence-based and effective. In Georgia, for example, the DeKalb County Board of Health is working to create a Master Active Living Plan. The goals of the plan include instituting a policy giving neighborhood residents access to school recreational facilities and to establish community vegetable gardens in local parks. The Jefferson County Department of Health in Alabama is planning focused interventions such as support for mixed-use land development, expanded greenways to increase opportunities for and access to physical activity and the establishment of neighborhood walking groups in low-income communities.

Improving health and putting a halt to the startling increase in preventable diseases in America begins also with smart transportation policies. The American Public Health Association, along with its healthy transportation advocacy partners, recently developed 10 public health and equity principles for transportation that are an important piece of the puzzle. Those principles underscore the need to develop transportation policies that are developed with health and equity in mind. Transportation and land-use planning policies must support healthy communities. We need performance measures to promote safe, affordable and equitable public transit and alternative modes of transportation such as walking and cycling. For daily commuters, once again, the healthy choice should be the easy choice.

Improving health and putting a halt to the startling increase in preventable diseases in America begins also with smart transportation policies.

Physical activity outreach is robust and ongoing. In Iowa, a recent conference emphasized how to better address obesity in school, clinical and community settings. The Los Angeles Department of Public Health is working to expand effective physical education policies in schools. In Montana, Missoula County sixth graders were offered a free year-long membership to the local YMCA and also linked with college students to lead them as active role models. This program called ACTIVE 6 was so well received that a third of the county's sixth graders applied for the free memberships. And a University of Montana survey of program participants found a significant

decrease in screen time, something most of our nation's youth could benefit from, as well as higher levels of physical activity and increased knowledge about healthy snacks.

A survey on Americans' walking habits conducted by America Walks confirmed what may seem obvious but what all of us who care about health must continue to strive to achieve. Neighborhoods that are more walkable, where places of interest are within easy walking distance and sidewalks are well-maintained, are home to a higher number of people who walk frequently. The survey also found that population density does not equal walkability. In other words, walkable neighborhoods, and those less conducive to walking, can be found in rural areas, towns, cities and suburbs. As researcher Peter Tuckel, PhD, of the Department of Sociology at Hunter College, said during a recent webinar about the walkability survey results, "Here we have a wonderful product — walking — but we need to work more on the successful execution of this product."

What gets measured gets done, but only if we do something proactive to address the challenges these measures represent and get everyone across the societal spectrum involved.

How do we do that? How do we reverse the trend that has led to opportunities to be physically active being engineered out of daily life in many of our communities, especially communities of color? How do we encourage smoke-free workplaces and make healthy choices, from meals to daily activity levels, the easy choices? We take an important tool – America's Health Rankings — that clearly illustrates the need for evidence-based solutions, get the community talking about solutions then implement them with the community. Then, follow the results, recalibrate, innovate with community assistance and reengage.

Other examples include first lady Michelle Obama's Let's Move campaign and its outreach on both physical activity and healthy food choices, which focuses on primary prevention, as well as the Million Hearts Campaign, a national initiative that aims to prevent 1 million heart attacks and strokes over the next five years, which is an example of a primary and secondary prevention program that integrates public health and clinical care. It is an example of strong collaboration between communities, health systems, nonprofit organizations, federal agencies and private-sector partners nationwide. The campaign focuses on the fact that "over 2 million people have heart attacks or stroke in the United States annually and over 800,000 die." (Heidenreich, PA, Trogdon, JD, Khavjou, OA, et al. Forecasting the future of cardiovascular disease in the United States: a policy statement from the American Heart Association. Circulation 2011;123:933-944). Yet many safe, effective clinical interventions such as the use of aspirin therapy, blood pressure control, cholesterol management and smoking cessation are both "underprovided and underused," (CDC, MMWR, September 16th) This effort is designed to show that clinical prevention coupled with community-based prevention is a real winner and can save lives.

What gets measured gets done, but only if we do something proactive to address the challenges these measures represent and get everyone across the societal spectrum involved. America's Health Rankings is a tool that gives us a sense of where we are and where we need to go. Programs like Pennsylvania's Fresh Food Financing Initiative, Communities Putting Prevention to Work, the Million Hearts Campaign and the New York City Green Carts are examples of wonderful programs that put us on a glide path to make substantial differences in the health of the population. After all, improving health is the business we are in; the measurement is just a tool.

Coalitions Catalyzing Community Health Promotion

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The health of our economy is dependent on the health and productivity of our workforce. High health care costs and poor outcomes in the United States when compared to other countries are impacting America's ability to remain competitive in a global market. Increasingly, employers understand the importance of not only investing in the health of their employees, but also, they are now looking beyond the worksite to the communities in which they draw their current and future workforce. An employer can implement all the right strategies with respect to keeping its employees healthy and well at the worksite. However, if those same employees leave work and return home to unhealthy communities, employer efforts and investments will invariably be compromised.

Improving health and health care is a local enterprise influenced by multiple and complex determinants. While improvements to the health care delivery system are undeniably necessary, if our ultimate goal is improved health, our solutions must extend beyond health care to other critical determinants of health such as individual behavior and environmental and socio-economic influences. In the end, health care is a relatively small influencer of health status.

Costly chronic health conditions such as obesity, diabetes, cardiovascular disease and asthma are compounded by unhealthy environments. Too much of our population live in neighborhoods void of safe places to walk or ride bikes, communities where it is easier to purchase fast food rather than fresh produce or other healthy options, and environments with heavy concentrations of air pollution. Facing this all too common reality, it has become a business imperative for employers to put "some skin in the game" and invest in the health of their communities.

Members of the National Business Coalition on Health (NBCH) embrace this notion. A non-profit, membership organization of 54 purchaser-led business and health coalitions, NBCH represents over 7,000 employers and 25 million employees and their dependents across the United States. Coalitions can understand the critical link between healthy workforces and healthy communities and are playing an important role in convening key stakeholders to address population health issues and implement evidence-based intervention strategies.

In considering this broader perspective, businesses have a strong incentive to support community health strategies with the understanding that individual employers do not often have the necessary leverage on their own to influence community health and health care. Instead, employers increasingly recognize that they must work collectively with other community stakeholders to make an impact. Such collaboration is at the center of many business and health coalitions. These coalitions provide leadership and help employers make the business case for building healthy communities by creating public-private partnerships and multi-stakeholder leadership teams that influence commitment, cooperation and community-based problem solving.

Community Health Partnerships

Now more than ever, NBCH coalitions and their employer members are becoming influential leaders within community-wide population health projects. Such activity is further supported through our partnership with the Centers for Disease Control and Prevention (CDC) called Community Health Partnerships. In the fall of 2007 as part of a five-year grant from the CDC, NBCH and its non-profit affiliate organization, the Community Coalitions Health Institute (CCHI), initiated the development

of an ongoing partnership with the Association for State and Territorial Health Officials (ASTHO) and the National Association of County and City Health Officials (NACCHO). The focus is on strengthening existing relationships and catalyzing new partnerships between NBCH member coalitions and state and local public health agencies across the United States. Key deliverables include the availability of community resources and policies to mobilize the community to meet the needs of employees, families and retirees.

In 2010, the United Health Foundation helped to support the influence of Community Health Partnerships by providing seed grants to four member coalitions through CCHI. The coalitions awarded Community Health Partnerships grants to the Memphis Business Group on Health of Memphis; Northeast Business Group on Health of New York City; Rockford, Ill.; Employers' Coalition on Health; and the New Jersey Health Care Quality Institute in West Trenton, New Jersey.

Improving health and healthcare is a local enterprise.

The funding enabled business-led coalitions to partner with public health and other stakeholders to improve population health indicators in their communities. NBCH recognizes these opportunities as emerging generations of public-private partnerships wherein relationship building and the creation of dialogue are necessary first steps before interventions can be implemented. The challenge over time will be to foster the development of evidence-based strategies with impactful outcomes. Albeit modest, the effort to date is certainly significant.

Going to School in Rockford

The Employers' Coalition on Health (ECOH) implemented an initiative to reduce childhood obesity in Rockford, IL focused on the students at Charles Beyer Elementary School in Winnebago County—an area facing many difficult health factors including excessive mental health days, low birth weight, high rates of adult smoking, teen birth, adult obesity, violent crime, unemployment and poverty. ECOH partnered with the YMCA to bring the Youth Fit for Life program to the school, and ECOH employer members organized volunteers to help staff program activities with the children.

Through the program, 68 children received their first-ever biometric screening (30% of Beyer Elementary enrollees). They were measured at baseline followed by 12-week intervals during 2010 for body mass index, blood pressure, strength, cardiovascular capacity and flexibility. The program featured academics and homework, physical activity, nutrition and a healthy snack. By reducing barriers and increasing support for healthy living in the school, momentum and support for these types of programs are growing.

Community Health Planning

The following year, United Health Foundaton supported an additional round of grants in response to the increasing incidence of debilitating and expensive preventable chronic diseases as highlighted in the Foundation's 2010 America's Health Rankings®. These seed grants were focused primarily on the significance of population data collection and strategic planning efforts prior to programmatic implementation. Six member coalitions were awarded community health planning grants to address priority public health challenges in their communities.

The coalitions awarded the grants to the Chicago-based Midwest Business Group on Health; Indiana Employers Quality Health Alliance in Indianapolis; Memphis Business Group on Health.; Employers' Coalition on Health; Savannah Business Group of Savannah, Ga.; and the St. Louis Area Business Health Coalition.

The funds enabled the grantees to launch or advance existing "community summits" with local business leaders, non-profit organizations, public health professionals, and other community health advocates. Summit attendees analyzed available community health data and prioritized community health issues. With multi-stakeholder consensus and collaboration, the communities then worked to develop action plans with concrete strategies

to address local health challenges, mobilize public and private resources and create programs that could be implemented in the near future.

Better Nutrition and Exercise in Memphis

The Memphis Business Group on Health used its grant to supplement existing community health planning activities within the Let's CHANGE (Commit to Healthy Activity and Nutrition Goals Every Day) initiative. Multi-stakeholder partners at the coalition-convened summit agreed to community health improvement strategies to combat obesity that are low cost, easily implemented and have the potential for broad impact. The group identified 12 strategies for better nutrition and exercise centered on where Memphians live, work, play, learn and heal — in both health care as well as faith settings. The rationale for targeting "low-hanging fruit" is to achieve success within the next couple of years and then build on that momentum to tackle larger community health issues.

Preventing early elective deliveries in Illinois

The result of the Midwest Business Group on Health's (MBGH) summit was a focus on maternal health — preventing early elective deliveries. The Illinois Regional Rollout Organization for the Leapfrog Group and MBGH obtained and released data from Illinois hospital surveys showing that 5-40% of deliveries in Illinois hospitals were conducted prior to 39 weeks gestation with many induced early for the convenience of doctors or patients. Data from the March of Dimes, Illinois Department of Public Health and other sources also confirmed Illinois' major problem with low-weight, early term deliveries resulting in high neonatal intensive care unit costs, morbidity and mortality for these infants. With the data known, the multi-stakeholder summit addressed the problem by determining gaps as well as opportunities for new activities that could supplement existing programs. Work is in progress to develop and to implement a community action plan such as educating patients and their physicians, implementing policy and influencing hospitals to reduce this preventable problem.

As employers grounded in the community, we can and should lend our expertise to solve problems that go beyond business. By focusing more upstream on prevention and health promotion, coalitions and businesses can together impact population health through investments in community health intervention strategies. By working together, we can build healthier, more prosperous communities for people to live, work, play, and pray.

Making the Business Case for Employers

Incentives for employers investing in building healthy communities include:

- Improved health status, and therefore productivity, of an employer's current and future workforce.
- More controlled direct (health care) and indirect (absenteeism, disability, presenteeism) costs to the employer.
- Healthier community aids in recruitment and retention of workforce.
- Increased buying power and consumption level for business products, in particular non-medical goods and services, by improving the health and wealth of a community.
- Strengthened brand and recognition in the community.
- Established public-private partnerships and multi-stakeholder leadership teams can become catalysts for other issues affecting the business community, such as economic development and education.

Commentary

Addressing Unwarranted Variation in Population Health Strategies: Mobilizing Multi-Sector Action and Evidence

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Achieving an effective, efficient, and equitable health system has proven to be an elusive goal for health policy-makers in the United States. Despite spending far more resources on health care than any other nation on earth, the U.S. continues to lag behind many other industrialized nations in population health outcomes ranging from life expectancy at birth and infant mortality to the incidence of preventable chronic diseases.[1] Equally disconcerting are the wide differences in resource use, health care practices, and health outcomes that exist within the U.S. — differences that are evident across states as profiled in America's Health Rankings, and also across individual communities and population subgroups — which collectively reveal inequities within the health system.[2] Also apparent in the Rankings, the rate of improvement in population health has slowed over time in the U.S. and now lags the progress being made in many other countries, raising concerns about the nation's global competitiveness and wellbeing over the long run.[3]

The Dartmouth Atlas of Health Care and a large body of related studies in health services research suggest that improving the nation's health system requires efforts to reduce unwarranted variation in medical care delivery by curbing the institutional structures, financing mechanisms, and professional practices that lead to over-use, under-use, and misuse of medical services.[4-6] However, a predominant focus on reducing medical care variation is unlikely to address the full array of health system challenges and improvement opportunities profiled in *America's Health Rankings.* We argue that addressing unwarranted variation in population health strategies also merits attention, requiring a broader set of actions and actors.

Population Health Strategies and Multi-Sector Action

While there are many factors that contribute to the gap between investments and outcomes in the U.S. health system, one explanation involves the limited resources and attention that Americans devote to population health strategies — the activities that are designed to promote health and prevent disease and disability on a population-wide basis.[7-9] These activities include efforts to monitor and report on community health status, investigate and control disease outbreaks, educate the public about health risks and prevention strategies, develop and enforce laws and regulations to protect health, and inspect and assure the safety and quality of water, food, air and other resources necessary for health.[10] The vast majority of the $2.7 trillion in annual health spending in the U.S. supports the organization, financing, and delivery of medical care services, with less than 3 percent allocated to population-based public health strategies.[11,12] Meanwhile, the nation's health research enterprise focuses primarily on discovering new medical interventions and better ways of delivering these interventions to

patients, with comparatively little attention given to uncovering new and better ways of preventing disease through public health.[13]

A preponderance of evidence and experience indicates that preventing disease and disability on a population-wide basis requires investments in multi-sector actions that fall far outside the boundaries of the medical care delivery system.[14] These actions include efforts to improve the physical and nutritional environments in which people live, work, study, and play in order to empower people to make choices that support good health. Schools, worksites, transportation planners, business developers, agriculture and food industry stakeholders, and many other actors need to be engaged in developing and implementing solutions to improve health. This thesis is echoed by the U.S. government's National Prevention Strategy released earlier this year.[15]

Unfortunately, successful multi-sector health initiatives — like all collective action problems — rarely emerge spontaneously.[16,17] Economic theory and practical experience suggest that initiating and sustaining collective action is difficult because the interests held in common by multiple organizations often do not align directly with the self-interests that motivate each organization individually.[18] In some cases, the decision-makers and their interests may be so heterogeneous so as to preclude the identification of shared objectives that are sufficiently powerful to motivate collective action — a problem known as incentive incompatibility. This problem is particularly prevalent when collective action requires alignment among diverse health-related stakeholders such as medical care providers that focus on delivery of care for individual patients, health insurers that focus on financing care and gaining market share among employer groups, employers that focus on labor costs and productivity among their employees, and governmental public health agencies that focus on population-wide risks and prevention strategies. In other cases, the opportunity to shirk contributions to collective actions and still benefit from these actions — the problem known as free-riding — can erode incentives for cooperation. Public health programs and services are particularly vulnerable to these collective action problems because they are public goods that produce benefits for broad segments of the population, including those who do not engage in producing or consuming the goods.

Concepts from the growing field of behavioral economics suggest that collective actions may falter even when participation incentives are well-aligned. Group decisions reached among multiple organizations may run counter to the collective interests of the group and society at large due to biases and bounded rationality in decision-making. Organizations often fail to value accurately the expected gains from collective action due to a range of common decision errors, including information gaps, risk aversion, mistrust, preference for short-run benefits, and tendencies to favor the status quo.[16] Recognizing these barriers to collective action, a fundamental challenge for public health professionals lies in fostering a clearer understanding of the expected value of partnerships among key stakeholders, and using policy and leadership strategies to enhance the incentives and blunt the barriers for participation.

Public health agencies also struggle with fundamental uncertainties regarding how best to invest in and deliver population health strategies to the populations that can benefit most from them.

Building Public Health Capacity to Catalyze Multi-Sector Actions

Promoting collective action in population health improvement requires a host of catalyzing functions, like producing and disseminating information on population health needs and risks; community-wide planning to identify the resources, roles and responsibilities of multiple stakeholders; mobilization and coordination activities through coalitions, partnerships and alliances; and measurement and evaluation activities to chart progress toward collective goals and ensure accountability for results. While America's Health Rankings contributes significantly to these catalyzing functions through comparative measurement and

reporting, the primary responsibility for carrying out these functions on a day-to-day basis often falls to state and local public health agencies in the U.S. These agencies also carry out policy development and enforcement functions that help to create incentives for collective action.

Unfortunately, many public health agencies are woefully unprepared and under-resourced to perform catalytic functions optimally. The funds that flow to U.S. public health agencies primarily support the direct delivery of clinical preventive services and community prevention interventions, rather than the cross-cutting skills and information infrastructure that are needed to mobilize, target and coordinate actions to improve health. Will health care reform drive agencies to redirect their efforts from health care delivery toward expanded information and mobilization functions? What health and economic returns, including medical cost offsets, can society expect from greater investments in these catalytic functions? Continued experimentation and evaluation will be required to answer these questions.

Will health care reform drive agencies to redirect their efforts from health care delivery toward expanded information and mobilization functons?

Expanding the Evidence Base on Population Health Strategies

Public health agencies also struggle with fundamental uncertainties regarding how best to invest in and deliver population health strategies to the populations that can benefit most from them. The nation's local, state, and federal public health agencies — together with their peers and partners in the private and public sectors — represent a vast yet diffuse delivery system charged to greater or lesser degrees with implementing these strategies.[17,19] Unfortunately, evidence about the most effective and efficient ways of organizing, financing, and deploying population health strategies across this delivery system is extremely limited.[20,21] Public health leaders have few research-tested guidelines, protocols, and decision supports to inform their choices regarding how to fund, staff, and manage population health activities. Similarly, policy leaders have relatively little empirical guidance on how to exercise taxing, spending, and regulatory authorities most effectively in public health. This dearth of evidence promotes wide variation in population health strategies across communities.[22]

The field of public health services and systems research has grown rapidly in recent years to

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address these information needs and build the evidence needed for improved policy and administrative decision-making in public health. This field of research examines the organization, financing, and delivery of public health services at local, state, and national levels, and the impact of these services on population health.[23] These studies seek to answer a wide range of questions involving how best to deliver evidence-tested health interventions in real-world practice settings, including:

- What organizational, human, technological, and information resources are required to produce public health interventions, and what means can be used to assure the availability of these resources;
- Who should pay for the delivery of public health interventions, using what types of financing mechanisms and payment methods;
- What factors influence the accessibility, reach, fidelity, quality and cost of these interventions;
- What are the health and economic effects of the interventions when delivered in real-world settings, and
- How and why do the effects of interventions vary across population subgroups and practice settings.

As such, these studies seek to produce evidence on which strategies work best, in which institutional and community contexts, for which population groups, and why. Important steps have been taken by the philanthropic sector and the federal government in recent years to advance this field of research, including development of a national consensus research agenda, development and coordination of data sources to facilitate this research, and the formation of practice-based research networks (PBRNs) that bring together public health agencies and public health scientists to collaborate on research conducted in real-world practice settings.[21, 24]

The current policy discourse around health reform increasingly reflects the need for greater emphasis on prevention as part of the pathway toward a higher-performing health system. This objective will require more and better information about how to deliver effective prevention strategies to the populations that can benefit most from them. This evidence, along with comparative measurement and reporting of the type provided by *America's Health Rankings,* promises to guide policy makers, public health practitioners, and their partners toward informed actions that protect and promote health at the population level. The result will allow the public health system to move in tandem with the medical care system toward greater impact, value, equity, and accountability.

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Minnesota's Partnership to Conquer Diabetes

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The United States is in the grip of a rapidly expanding epidemic. According to the Centers for Disease Control and Prevention (CDC), 1 in 10 adults have diabetes, affecting 25.8 million people or 8.3 percent of the U.S. population. It is estimated that as of 2010, 79 million American adults aged 20 years or older had prediabetes. Already an alarming state of health in 2011, it will be dramatically worse if current trends continue, leading to nearly a third of U.S. adults managing diabetes by 2050.

Consider the health and financial ripple effects of diabetes:

- The seventh leading cause of death in the U.S.
- A major cause of heart disease and stroke
- The leading cause of kidney failure, non-traumatic lower-limb amputations and new cases of blindness among adults
- Medical expenses for people diagnosed with diabetes are more than twice the amount than those without the disease
- In 2007, the estimated total cost of diabetes related to medical expenses was $174 billion of which $116 billion were direct medical expenses
- 1 in 3 Medicare dollars is spent on diabetes

Just imagine what 1 in 3 people suffering from diabetes will mean to the health and financial well being of our country. Diabetes is an epidemic that must be stopped.

Decade of Discovery: A Minnesota Partnership to Conquer Diabetes

How can we stop this epidemic? It will require broad implementation of proven strategies for managing the disease as well as discovery of new methods to prevent, treat and cure diabetes. This is the approach University of Minnesota and Mayo Clinic had in mind when, in 2010, we launched Decade of Discovery: A Minnesota Partnership to Conquer Diabetes. Decade of Discovery is a 10-year effort to prevent, optimally treat and ultimately cure type 1 and type 2 diabetes.

Declaring a "cure" as the goal is ambitious, which is why we did not embark on this without careful consideration and evaluation of our institutions' and Minnesota's abilities. Decade of Discovery emerged from the work of an eight-year partnership between Mayo Clinic and the University of Minnesota, called the Minnesota Partnership for Biotechnology and Medical Genomics. The partnership was formed with the explicit purpose of enhancing and maximizing the research potential of these two institutions through a high-powered collaboration. It has worked as the Partnership has become a globally-recognized model of collaboration in biomedical research.

After establishing a track record of success, Partnership leaders were asked to raise the bar

on what they could do to tackle a major disease. Based on a thorough review of the University's and Mayo's past work in diabetes, unique research strengths among the two institutions and work being done by other potential partners in the state, diabetes was identified as the research area that offered the greatest promise for a major breakthrough.

In addition to the substantial portfolio of diabetes research grants Mayo and the University of Minnesota offer, there are several other factors that provide the foundation to conquer this devastating disease:

- Mayo Clinic is ranked number one in endocrinology/diabetes research
- The University of Minnesota has invested significantly in the science of regeneration, a necessary element of improved treatment and cure
- Both organizations have active programs in islet transplantation, artificial pancreas creation and stem cell biology
- Minnesota has a well-established track record in population-based prevention and wellness initiatives
- A number of the nation's leading health care providers are in Minnesota
- Minnesota is home to recognized experts in diabetes research

Given these offerings, the question was not "Should we publicly pursue a cure for diabetes?" it was "How can we not take up this ambitious goal?"

The Pathway to Success

The ultimate success for Decade of Discovery is a cure for diabetes, but it's going to take time to reach that goal. We view Decade of Discovery as a transformational change in how researchers, providers, policy makers and communities address chronic disease. It needs to be broad, inclusive and collaborative. Success will require bold leadership and engagement from organizations and institutions outside of the University and Mayo Clinic interested in advancing diabetes research, prevention, treatment and cure in Minnesota and elsewhere.

With sustained commitment from the Partnership and its collaborating partners along with funding support from public and private entities, the pathway to success will look like this:

- In the short term, we will build knowledge, information-sharing infrastructure and the strategic partnerships necessary to guide population-wide changes. We will also focus on targeted scientific breakthroughs and viable clinical trials.
- In the mid term, we will implement population-wide changes and translate the basic research findings into effective treatment and care-delivery strategies.
- In the long term, a successful preventive strategy will be developed and implemented in those at greatest risk for the disease and new therapies will bring us closer to a cure.

The nature of diabetes demands equal attention to tackling the factors and behaviors that contribute to or cause diabetes.

To follow this pathway, Decade of Discovery will involve more than 150 researchers at the two institutions already involved in diabetes research, recruit additional scientists and engage other health provider, public health and community-based partners. The work will focus on two core areas: Prevention and Care Delivery and Discovery and Translation. While a critical element of curing the disease lies in basic research and discoveries, the nature of diabetes demands equal attention to tackling the factors and behaviors that contribute to or cause diabetes. Stopping the epidemic must include intensive, simultaneous work on both tracks.

Prevention and Care Delivery. This work focuses on conducting the public health research necessary

to improve the implementation of optimal prevention and care strategies. In many cases, we know the actions and interventions that can prevent diabetes but they are not always implemented consistently. We will work to enhance the penetration of best practices through:

- Forming a broad-based alliance of those involved in funding and delivering chronic care to diabetes patients.
- Developing the Minnesota Diabetes Atlas that will provide the alliance with baseline data on the state of diabetes in Minnesota and targets for focused improvement. It will also serve as a measure of the alliance's success.
- Developing and maintaining a catalogue of all diabetes-related initiatives, organizations, and activities across the state to identify synergies, avoid waste and duplication and broaden the impact of prevention initiatives.
- Maintaining a knowledge repository of the best scientific evidence supporting practice redesign toward improved care.
- Executing the vision of prevention and optimal treatment of diabetes through the alliance. This alliance, informed by the best available research evidence as well as the Diabetes Atlas, will advance diabetes care across the state by designing, promoting, and executing high-risk, innovative initiatives and broad-scale and cross-sector projects.

Our expectation is that Decade of Discovery will serve as a convening force to bring ideas and best practices together.

Discovery and Translation. This work focuses on developing new methods to manage and treat diabetes while exploring new approaches to replace the mechanisms in the body that fail to defend against diabetes. Generally, scientists know the what and the why of diabetes. Decade of Discovery will figure out how to change it through the following approaches:

- Basic research into genomics, proteomics, islet cells, stem cells
- Clinical trials based on discoveries in those areas
- Identifying better research methodologies to understand diabetes complications
- Establishing new scientific infrastructure for generating new treatment approaches

As the program advances, these are the indicators that will measure our progress:

- A 50% decrease in the incidence of preventable diabetes as we work toward a cure
- A 30% improvement in the quality of life for people with diabetes
- A 60% decrease in the burden and rate of complications with abolition of end-stage blindness, renal failure, and amputations due to diabetes
- A 50% reduction in the disparities of care and outcomes across gender, race, geography and socioeconomic status
- A 30% decrease in the treatment burden to patients and caregivers
- A 30% improvement in the patient care experience

Beyond the Laboratory

Mayo Clinic and the University of Minnesota can't do this work alone. The problem is bigger than us so the solution needs to come from an even bigger and broader partnership. The discoveries generated from our laboratories are a critical foundation for this work but achieving Decade of Discovery's goal demands the involvement of health care providers, health organization, businesses, public health, IT innovators and policymakers.

Our expectation is that Decade of Discovery will serve as a convening force to bring ideas and best practices together. We want to create an environment that encourages information-sharing, shared success and measurable progress. This sense

of collaboration is so important to the success of Decade of Discovery that a significant element of the early work is focused on identifying partners who offer the expertise to effectively and efficiently implement the plan. To prevent and optimally treat diabetes, we seek to create change and improvement through a broad-based alliance comprised of the major organizations involved with diabetes-related work in designing, paying for and delivering care for people at risk and with diabetes.

Minnesota as Testing Ground

The driving forces behind this initiative are Minnesota's capabilities and expertise in diabetes research and the successful collaboration between the University of Minnesota and Mayo Clinic. Decade of Discovery represents a commitment of Minnesota resources, Minnesota institutions, Minnesota talent and the engagement of Minnesotans in an aggressive effort to fight diabetes. However, the results and impact will extend far beyond Minnesota.

Although Minnesota will serve as a statewide laboratory in the battle against diabetes, testing and research that begins in Minnesota will be shared and implemented by providers across the United States and even globally. Using Minnesota's assets, the scaled approach will establish a testing ground for innovative approaches to be applied more broadly.

Bold But Achievable...and Necessary

The goal of Decade of Discovery is bold, but we are well equipped to succeed. The University of Minnesota and Mayo Clinic have already made significant breakthroughs in basic and clinical research on diabetes. Minnesota has been an international leader in diabetes and metabolism-related conditions for generations. Now it's our obligation as a state and as a recognized leader in biomedical science to elevate that work toward a cure.

Curing a disease isn't easy and it isn't cheap. We estimate that a sustained investment of $250 million to $350 million over 10 years will be necessary to build more robust research capabilities, advance the IT infrastructure, implement population-wide changes and fully integrate recognized best practices into clinical practice. These funds will be sought from a range of sources including state and federal government, industry and private donors.

With the additional investment to the focus and collaboration brought by Decade of Discovery, we believe we can conquer diabetes in the coming decade. Our ability to accomplish this goal will have far-reaching impacts beyond the health and financial benefits of finding a cure for the diabetes epidemic — it will change how we address chronic disease moving forward.

Can "We The People" Fix American Health And Health Care?

GREG VIGDOR
President & CEO
Washington Health Foundation and the Healthiest State in the Nation Campaign

Individuality. It is woven through the DNA of our American heritage. We believe that all of us, individually, can make a difference — and that all of us, collectively….matter.

Today — that belief is spreading. Not since the 1700's and the Age of Reason has there been such a powerful sense building across the globe that people matter. From the calls for freedom in theocratic societies in the Middle East, to our ability and willingness to express ourselves outside the boundaries of conventional print and television through blogs, Facebook posts, and tweets, to political movements in this country emanating from fear that societal institutions from finance to government have forgotten the interests of the people.

Yet, the potential of personal empowerment and fulfillment remain largely absent from the conversations and solution templates as they relate to our nation's health care problems. Some argue that we are now in the age of health care reform, but how can that be when the solutions seem to have much more to do with the system and the players within it than the people it is supposed to serve?

We spent our money and staff time designing fun and creative ways to involve people in our Campaign.

Our Healthiest State in the Nation Campaign was created to drive change around a powerful grassroots movement that not only involved people, but also was dependent on them to succeed. We launched the Campaign in 2004 — about the time the United Health Foundation released its "America's Health Rankings Report" that put our state health rank at #15. The Report also traced our decline from the Top Ten of states in the 1990s and provided some useful metrics on social determinants of health and what our major health problems were as a state.

The United Health Foundation Report was also important in that it allowed us to focus our resources not on data but on finding practical, fun, and creative ways to engage people around improving health. We believed (as we still do today) that as helpful as the data was in providing a snapshot of our state's health, it would take something more to forge a path to major health improvement and change. The Healthiest State in the Nation Campaign became our vehicle to drive that change.

The backbone of our engagement strategy was to develop our Campaign in a context of optimism and hope. For too long, health and health care has been dominated by a sense of crisis and pessimism, and we felt that aspiration toward a better future would be a welcome change from standard change campaigns. That idea clearly struck a chord with people in our state as we now have 40,000 individuals, 1,400 organizations and 400 schools actively engaged in our Healthiest State Campaign.

The incredible success of our Campaign can be traced to our belief that people and organizations will engage with you if you provide them with simple and practical ways to take action to improve health. For themselves or their communities. In big ways and small ways. The scale of the action, or its scientifically tested evaluation, was far less important than the simple act of just doing something. And virtually everything we offered was "free", without some underlying fundraising or advertising agenda attached, to both remove barriers to act and build trust with the champions of our movement.

We spent our money and staff time designing fun and creative ways to involve people in our Campaign through innovations such as the Governor's Health Bowl (an annual six-week health competition across the state), a series of web-based trackers (for people to set and reach health goals and log miles), health events targeting schools and businesses, a free employee wellness program, and much more. These investments worked beyond our wildest dreams as our Campaign has today grown to become the largest civic engagement project for health in state history (and maybe the Nation)!

The rewards have been apparent, beyond just the joy of engaging so many people who care about health. We are now the 10th Healthiest State in the Nation, and we have seen major improvement in some of the very issue areas that we set as our priorities eight years ago. The state rank has held over the last few years, even in the wake of the Great Recession and the near-catastrophic reduction of our state government's budget and action commitments to health and health care.

But we still have a long way to go to reach our goal of becoming the Healthiest State in the Nation. Our Campaign was built to become #1, and we remain far short of that aspiration. While we have witnessed tremendous progress on key social determinants of health, underlying problems within our health care and public health systems remain. And even as we supported National Health Reform as a platform to seek major change, we were disappointed that the law did not do more to change the system to better serve people and promote health.

We re-focused our Campaign in 2009 by examining one of our 18 key action areas adopted in 2004 as part of our initial Campaign. This was the notion of a "Health HoME", which was a new term we created to describe a health care system that is fundamentally oriented around people and not providers, insurers or government. For most of our early years of the Campaign it remained just that - a generalized concept and call to action.

Many tried to convince us that our concept of putting people in charge of their own health was a waste of time, energy and money. Their argument was that government and the medical care system were already doing everything that needed to be done for people. Yet, our concept started to stick, in part because of our efforts, in part because it made sense and, perhaps in large part — because it rode the wave of a growing call for personal empowerment in broader society.

The medical care system and government have started to acknowledge that the patient should be at the center of the system's efforts. We are beginning to see more primary care practitioners who are willing to get behind this idea. We are also seeing more patient-centered medical homes, better electronic patient records, the development of client eligibility systems and a host of new "Accountable Care Organizations."

Truth be told, we see these developments as good news. Our core strategy was to introduce a new way of thinking through our term of Health HoME and use this context shift as a way to get the health care system to adopt a much stronger platform around people. There is no doubt we are seeing improvement; but we still have a long way to go to fulfill the dream of a true person-centered system.

Putting people in charge of their own health is now the cornerstone of the Healthiest State Campaign's efforts to create big change.

Putting people in charge of their own health is now the cornerstone of the Healthiest State Campaign's efforts to create big change in the health system. To us, Health HoME can only become real when the projects and changes are sufficient to build confidence by people that we are in a system that knows who we are, that sees us as the priority and that doesn't lose that priority whenever any complication arises.

So, we have been trying to seed the need for bigger change toward this end over the past two years by sharpening what we mean by Health HoMe. Today, we talk less about defining it (to help distinguish it from other terms, such as

medical home), and more about expressing the fundamental principle that it is about a person-centered health system. And that the most likely health partner to connect someone with the system is not their medical provider, health plan or government, but a spouse, parent, friend or acquaintance that can help them better understand and deal with the health system.

The most likely health partner to connect someone with the system is a spouse, parent, friend or acquaintance.

As we continued to sharpen our Health HoME idea, we also developed a set of principles that would characterize a person-centered health system. We like to call it "Health 3.0." It is a movement that allows us to re-imagine not only healthcare but also well-being. It's about exploring new and different health ideas. We started a blog and held an innovator's conference to deepen our own understanding of the concept. This work has drawn national and even international attention.

Groundbreaking stuff, yet our Campaign's greatest strength continues to be our ability to get regular people to test our health improvement ideas at a more practical and useful level. For Health HoME, this entailed developing a series of "practical tools" that allows people to take control over their own health.

In addition — we recently introduced an innovative approach to provide Washingtonians with a personal escort to help them better understand and harness the power of personal empowerment. Officially — it's known as the Healthiest State xChange, but we like to call it....our Personal Health Advocate service! Our Personal Health Advocates can help individuals, small business owners and others take control of their health insurance, health care and Health HoME needs.

It is too early to tell whether our latest Campaign effort will bear the same positive fruit that we saw from the first eight years of our Healthiest State Campaign. But we are committed to taking this idea to its full potential.

Time will tell. But when in doubt, we will bank on the creativity and wherewithal of the American people. "Of the people, by the people, and for the people" is a core phrase embodying our national identity. It is often used to explain what is unique about our country. Maybe it's time we applied this ideal to one of our most personal, expensive, and struggling American sub-systems….. health care.

Making Prevention A Priority

Jud Richland, M.P.H.
President and CEO
Partnership for Prevention

Public health professionals increasingly recognize that their role goes beyond preventing and controlling disease. As enunciated by the World Health Organization (WHO) over 60 years ago, health "is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." This has enormous implications for how those committed to improving health go about their work, for the goals our leaders establish, for the policies we advocate, and even for the way we train our future health professionals.

Public health has taken a leadership role in helping our citizens and leaders understand that the physical, social, and economic environments play a pre-eminent role in shaping the health and well-being of communities and individuals. Only by shaping these determinants of health can we achieve health envisioned by the WHO. Only by shaping these determinants of health can we create a culture of health and prevention in America.

Healthy citizens are essential to America's productivity, innovation, and well-being. When individuals are healthy, they are more capable of giving support to their friends and families, more productive in their school or workplace, and better able to thrive in their communities. *America's Health Rankings* helps us understand the successes we have achieved in moving toward a culture of prevention. The rankings also illuminate the challenges we face in ensuring that all Americans have the opportunity to live long and healthy lives and to achieve their maximum potential.

A Call to Action

We have all heard the discouraging statistics demonstrating that America ranks below many countries in life expectancy, infant mortality, and other important health indicators. It is common knowledge that we have received far too little in improved health as a return on the nation's investment in public health and health care.

Our challenges are best demonstrated by the fact that so many of our most urgent health problems are preventable. To make prevention a priority in America, the Affordable Care Act of 2010 called for the development of the National Prevention Strategy. The strategy consists of four major directions: (1) Healthy and Safe Community Environment; (2) Clinical and Community Preventive Services; (3) Empowered People; and (4) Elimination of Health Disparities.

Partnership for Prevention
Shaping Policies • Improving Health

To move forward in these areas, the strategy recognizes the importance of engaging partners across diverse disciplines. Only through a synergistic partnership of leading organizations and agencies making prevention a priority will we make substantial progress toward a healthier America.

Growing recognition that the most significant changes in health and well-being will come about by influencing the underlying determinants of health is redefining the role of health leaders. Improving the delivery of health care and developing new community programs will always be important. But health leaders must be willing to engage on issues where they have traditionally been only marginally involved.

One example is the future of our economy. Projections that our national debt will triple or quadruple in the next thirty years should concern health leaders. Make no mistake that health and well-being will be harmed in an economy in which growth is slow or non-existent. Health leaders need to make sure their voice is heard on this

issue. That means working toward policies to reduce the national debt and promote economic growth, while ensuring that the solutions do not undermine efforts to improve health.

Health leaders must now be skilled in the policy change arena. That means being sophisticated in coalition-building, advocacy, social marketing, and many other areas that may take health professionals outside their comfort zone. But it is these skills — along with courage, passion, and persistence — which will move us toward achieving the goals of the National Prevention Strategy and shaping the determinants of health.

Health leaders must now be skilled in the policy change arena.

Collaboration to Create Change

The influence of individual public and private institutions may be limited, but when added together can yield significant change. The National Prevention Strategy identifies a wide variety of policies and initiatives that key sectors across our society can implement to achieve prevention goals:

State and Local Governments

- Include health criteria as a component of decision making across diverse sectors including housing, transportation, energy, education, and labor
- Conduct comprehensive community health assessments and use data to implement programs that address the highest priority needs
- Develop state and community health improvement plans
- Apply evidence-based prevention policies

Businesses and Employers

- Provide opportunities for workplace prevention activities, including counseling, screenings, and immunizations
- Eliminate safety hazards in the workplace and perform regular maintenance
- Adopt policies to increase physical activity and reduce stress
- Create green building solutions to improve the environment and population health

Health Care Systems

- Assume a leadership role in population-based approaches to improving the health of communities
- Screen for smoking status and other health indicators and report these on each patient's electronic health record
- Provide prevention focused services such as counseling for smoking cessation and nutrition
- Serve surrounding communities by promoting prevention and educating citizens about healthy lifestyles

Community and Faith-based Organizations

- Bring various sectors together to participate in planning, implementing, and evaluating community health efforts
- Provide needed health education and screening services to community members
- Ensure that services are culturally and linguistically appropriate and that they match the community's literacy skills

Academic Institutions

- Integrate public health competencies into school curricula and encourage collaboration across disciplines
- Conduct research to identify effective health policy and program solutions
- Implement campus policies that promote health such as going tobacco-free

Making Prevention a Priority

We have the ability to change physical, social, and economic environments through broad-based policy changes. Common ground is necessary to engage in discussion, be informed of scientific innovation and invest in new research. We must not be satisfied with our current progress. Every sector in society influences public health and every sector can benefit from improved health. Partnerships enable us to leverage the exchange of ideas, solutions and strategies to improve individual and community well-being.

America's leaders must realize the consequences of overlooking prevention — human suffering and lives lost. Only through national dialogues and active partnerships seeking policy change can we answer *America's Health Rankings* call to action and progress toward an America leading the world in health and wellness.