AMERICA'S HEALTH RANKINGS® SENIOR REPORT

UNITED HEALTH FOUNDATION®

A CALL TO ACTION FOR INDIVIDUALS AND THEIR COMMUNITIES

2013 EDITION

WISCONSIN

SENIOR HEALTH

	2013 VALUE	2013 RANK	NO 1 STATE
DETERMINANTS **BEHAVIORS**			
Smoking (Percent of adults age 65+)	9.6	31	4.7
Chronic Drinking (Percent of adults age 65+)	5.1	42	1.4
Obesity (Percent of adults age 65+)	26.9	38	16.9
Underweight (Percent of adults age 65+)	1.7	13	1.1
Physical Inactivity (Percent of adults age 65+)	33.8	38	20.5
Dental Visits (Percent of adults age 65+)	73.2	13	79.8
Pain Management (Percent of adults age 65+)	52.2	23	60.7
BEHAVIORS TOTAL	-0.061	38	
COMMUNITY & ENVIRONMENT			
C&E — MACRO PERSPECTIVE	0.085	8	
Poverty (Percent of adults age 65+)	7.5	10	5.1
Volunteerism (Percent of adults age 65+)	32.8	8	39.3
Highly-Rated Nursing Homes (Number of beds per 1,000 adults age 75+)	46.9	19	65.2
C&E — MICRO PERSPECTIVE	0.026	21	
Social Support (Percent of adults age 65+)	79.5	30	85.4
Food Insecurity (Percent of adults age 60+)	10.6	10	5.5
Community Support (Dollars per adult age 65+ in poverty)	$1,013	16	$8,033
COMMUNITY & ENVIRONMENT TOTAL	0.111	14	
POLICY			
Low-Care Nursing Home Residents (Percent of residents)	11.8	26	1.1
Creditable Drug Coverage (Percent of adults age 65+)	80.2	49	89.6
Geriatrician Shortfall (Percent of needed geriatricians)	56.5	16	16.3
POLICY TOTAL	-0.068	41	
CLINICAL CARE			
Dedicated Health Care Provider (Percent of adults age 65+)	95.5	15	96.8
Recommended Hospital Care (Percent of hospitalized patients age 65+)	97.7	22	98.4
Flu Vaccine (Percent of adults age 65+)	56.5	42	70.2
Health Screenings (Percent of adults age 65–74)	87.4	18	91.7
Diabetes Management (Percent of Medicare enrollees)	84.4	4	86.1
Home Health Care (Number of workers per 1,000 adults age 75+)	120.8	10	290.0
Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)	55.3	13	25.0
Hospital Readmissions (Percent of hospitalized patients age 65+)	15.0	14	12.3
Hospice Care (Percent of decedents age 65+)	34.5	25	54.5
Hospital Deaths (Percent of decedents age 65+)	25.0	10	19.2
CLINICAL CARE TOTAL	0.055	10	
ALL DETERMINANTS	0.037	24	
OUTCOMES			
ICU Usage (Percent of decedents age 65+)	6.8	7	5.1
Falls (Percent of adults age 65+)	18.0	41	12.9
Hip Fractures (Rate per 1,000 Medicare enrollees)	6.7	12	3.0
Health Status (Percent very good or excellent of adults age 65+)	39.0	25	48.9
Able-Bodied (Percent of adults age 65+)	67.2	3	68.0
Premature Death (Deaths per 100,000 population age 65–74)	1,780	19	1,425
Teeth Extractions (Percent of adults age 65+)	16.3	22	7.4
Mental Health Days (Days in previous 30 days)	2.1	14	1.5
ALL OUTCOMES	0.126	16	
OVERALL	0.163	20	

SUPPLEMENTAL MEASURES

	2013 VALUE	2013 RANK	NO 1 STATE
Education (Percent of adults age 65+)	18.3	34	36.5
Multiple Chronic Conditions (Percent of adults age 65+)	30.9	16	20.9
Cognition (Percent of adults age 65+)	7.1	5	5.7
Depression (Percent of adults age 65+)	10.7	9	7.1

HEALTH INDICATORS AT 50 TO 64 YEARS OF AGE	CURRENT SENIORS	FUTURE SENIORS
Health Status (Percent very good or excellent)	55.6	55.7
Obesity (Percent obese)	27.4	31.8

SENIOR POPULATION GROWTH	STATE	U.S.
Projected Increase 2015–2030	48.8	52.7

Overall Rank: 20

Determinants Rank: 24
Outcomes Rank: 16

Strengths:

- High percentage of diabetes management
- Low percentage of ICU usage
- High prevalence of able-bodied seniors

Challenges:

- High prevalence of chronic drinking
- High prevalence of physical inactivity
- Low percentage of creditable drug coverage

Ranking: Wisconsin is 20th in this Senior Report. In the *America's Health Rankings®* 2012 Edition, it ranked 16th for its entire population.

Highlights:

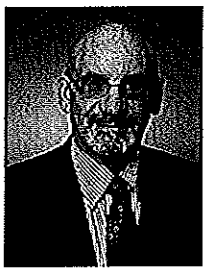
- Wisconsin has one of the highest senior volunteer rates in the U.S. at 32.8 percent of adults aged 65 and older who volunteer.
- Wisconsin has a low percentage of seniors who spent 7 or more days in the ICU during the last 6 months of life at 6.8 percent of adults aged 65 and older.
- In Wisconsin, 210,000 adults aged 65 and older are obese and more than 260,000 seniors are physically inactive.
- Wisconsin has a low prevalence of flu vaccination at 56.5 percent of adults aged 65 and older.
- In Wisconsin, 10.6 percent of adults aged 60 and older, or more than 80,000 seniors, are marginally food insecure. This is a lower rate than most other states.

Disparities: Seniors with less than a high school degree have a higher prevalence of obesity and physical inactivity, lower social support, and a lower prevalence of very good or excellent health compared to those with a college degree.

State Health Department Website:
www.dhs.wisconsin.gov

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

Rx for Health—Invest in America's Senior Centers to Promote Health and Prevent Disease



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The aging of the U.S. population will pose significant challenges for communities, our health care system, and our nation in coming years. Approximately 78 percent of Medicare beneficiaries today have at least 1 chronic condition, and 63 percent have 2 or more, and these rates are rising. Chronic illnesses are a major contributor to health care costs, representing 75 percent of the $2 trillion in U.S. annual health care spending, accounting for nearly 70 percent of all deaths, and restricting daily living activities for 25 million people.[1] Beginning with the first baby boomer enrollment in Medicare in January 2011, more than 76 million Americans are projected to become beneficiaries in the next 29 years. Without improvements in the health of these aging Americans and changes in the way we deliver health care, this near doubling of participants will seriously strain the U.S. economy. The MacArthur Foundation Research Network on an Aging Society projects that by 2030, the aggregate costs of Medicare, Medicaid, Social Security, and debt service may exceed the revenues of the U.S. Treasury.[2]

The onset and progression of chronic disease can be prevented or significantly delayed through preventive health services and evidence-based interventions that promote healthy behaviors. In addition, individuals with existing health conditions can learn skills and gain confidence in their ability to self-manage, resulting in a significantly improved quality of life, greater independence, and improved health status.

Promoting widespread use of evidence-based health promotion and self-management programs has been identified by the U.S. Department of Health and Human Services as a key strategy for improving care and reducing costs for people with multiple chronic conditions.[3] Examples of these programs include:

- Physical activity programs, such as Enhance Fitness or Healthy Moves, which provide safe and effective low-impact aerobic exercise, strength training, and stretching.
- Falls prevention programs such as A Matter of Balance, which addresses fear of falling, and Stepping On and Tai Chi, which build muscle strength and improve balance to prevent falls.
- Nutrition programs, such as Healthy Eating, which teach older adults the value of choosing and eating healthy foods and maintaining an active lifestyle.
- Depression and/or substance abuse programs, such as PEARLS, Healthy IDEAS, and Beat the Blues, which teach older adults how to manage their mild to moderate depression.
- Stanford University Chronic Disease Self-Management Programs, which are effective in helping people with chronic conditions change their behaviors, improve their health status, and reduce their use of hospital services.[4]

As promising as these programs are, however, they currently reach only a fraction of those who could benefit. In addition, preventive services are underused, especially by racial and ethnic minority groups. Less than half of older adults are up-to-date on a core set of clinical preventive services (e.g. cancer screening and immunizations), and only 7 percent of older adults used the Welcome to Medicare Benefit in 2008.[5,6,7]

So what is the problem? According to Wayne Giles, director of the Division of Population Health at the U.S. Centers for Disease Control and Prevention (CDC), "A key challenge in bringing evidence-based interventions to scale is lack of

an effective distribution network, especially with chronic diseases, which require more diverse efforts than the typical network of state health agencies" (http://www.ssireview.org/articles/entry/using_national_networks_to_tackle_chronic_disease).

To meet the need for an effective distribution network and to achieve the national goals for improving the health status of older Americans such as those proposed in Healthy People 2020[8] and other national frameworks, the Institute of Medicine (IOM) has recommended enhanced collaboration of public health with community-based organizations as a way to produce better prevention and treatment outcomes for people living with chronic disease:

"There is a huge potential to leverage the infrastructure of wellness worksite programs and community-based sites like the YMCA and senior centers with regard to implementation of effective interventions and their sustainability" (*Living Well with Chronic Illness,* p. 251, emphasis added).

Employing resources such as senior centers to better meet the health needs of patients is also a key principle of the Chronic Care Model developed by Ed Wagner and colleagues.[9] Wagner states: "Effective chronic illness management requires an appropriately organized delivery system linked with complementary community resources"[10] (emphasis added). Patients are encouraged to participate in effective community programs, and health providers are encouraged to form partnerships with community organizations that provide needed interventions and services. In Wagner's words:

"There is now considerable evidence that individual and group interventions that emphasize patient empowerment and the acquisition of self-management skills are effective in diabetes, asthma, and other chronic conditions. Most of these interventions are relatively brief and conducted outside of medical practice"(p. 74, emphasis added).

Partnerships between community-based organizations and health care systems not only enhance patient care, but also avoid duplication of effort, make the most of scarce resources, and ensure integration. Yet, most health systems fail to develop the needed partnerships, linkages, and collaborative relationships with community-based organizations originally envisioned in the Chronic Care Model. In 2011, the National Council on Aging (NCOA) launched the Self-Management Alliance (SMA) to address this problem and to take concrete steps to develop more effective partnerships between community organizations and health care providers with the goal of delivering effective programs close to home and in the community.

We believe that senior centers are a highly under-leveraged community resource that can add significant value to our nation's efforts in health promotion and disease prevention. By building the capacity of senior centers to deliver evidence-based programs and services, and linking senior centers to public health systems, we will facilitate achievement of health priorities in disease prevention and health promotion for older adults by:

- Effectively distributing important public health information to seniors and their families.
- Increasing the use of clinical preventive services and health screenings.
- Increasing participation in evidence-based health promotion/disease prevention programs.
- Improving self-management skills and competencies.
- Decreasing the number of falls and fall-related injuries.
- Reducing food insecurity.
- Reducing isolation and depression.

BACKGROUND

NCOA has worked in close collaboration with senior center leaders from around the country

since 1960 and established the National Institute of Senior Centers (NISC) (http://www.ncoa.org/nisc) in 1970 as a national focal point and resource center to identify and meet the needs of senior centers for an array of supports. With funding from the U.S. Administration on Aging (AoA) and private foundations, NISC has developed senior center standards, training packages, curricula, and other tools to enhance the capacity of senior centers and advance the skills and competencies of senior center staff. NISC has developed and maintains an extensive library of resources for senior center use, as well as a repository of research, surveys, and studies that support the work of researchers.

We believe the existing infrastructure of senior centers in the United States is an ideal vehicle for delivering health promotion and prevention services.

Today, NISC supports a national network of nearly 1,000 senior centers and more than 2,000 senior center professionals dedicated to excellence in senior center operations and programming, establishing a vision for the future, and promoting cutting-edge research, promising practices, and professional development. NISC offers the nation's only National Senior Center Accreditation Program, providing official recognition that a senior center meets the highest standards of operation. NISC connects its members to a national network of professional support and innovative solutions via webinars and an online community, NCOA Crossroads.

CHARACTERISTICS OF SENIOR CENTERS

Senior centers were created for the very purpose of supporting the health and well-being of older adults and promoting independence. In 1965, Congress directed that senior centers were to be identified as preferred "focal points" for comprehensive and coordinated service delivery to older adults (Older Americans Act, Title III Regulations, 1988 Amendments). The broad term "senior center" today includes a range of facilities of varying size and organizational complexity ranging from large multipurpose service organizations with highly trained professional staff to small nutrition sites run by volunteers. AoA reports that of the 11,400 senior centers in the United States, more than 60 percent are designated as a "Community Focal Point," defined as a "facility where comprehensive and coordinated services are provided to seniors."

CURRENT HEALTH-RELATED PROGRAMMING

The majority of senior centers already offer health-related programming, including health education, health screening, exercise programs, and nutrition programs that serve as a solid foundation for further development. In San Antonio, "One Stop" senior centers are Older Americans Act-funded nutrition sites that also offer immunizations, diabetes and osteoporosis screenings, smoking cessation counseling, and more.[11] In Hartford, CT, an educational intervention for health professionals and senior center workers that focused on conducting risk assessments, adjusting medications, and improving balance and gait was shown to dramatically decrease serious fall-related injuries and costs of care in people over 70 years old.[12] In New York City, a program in senior centers that focused on lifestyle changes (e.g., diet, exercise, adherence to prescribed antihypertensive medications) resulted in significant reduction in systolic blood pressure.[13] Senior centers also have been an effective partner in delivering interventions to decrease depression, increase knowledge about depression, and enhance daily function.[14]

FULFILLING THE POTENTIAL

While senior centers are widely recognized by aging services and other community providers as a vital component in the aging continuum of care—and a lifeline for many vulnerable, isolated, and at-risk seniors—their potential role as a vital part of the public health system has been overlooked and neglected. Indeed, many community stakeholders lack a clear understanding of the role, relevance, and impact of senior centers. In addition, while senior centers have the ability and desire to offer a wide range of programs and services, they often lack the resources, space, equipment, and trained staff essential to ensure successful implementation. In addition, funding is inadequate and severely restricts their ability to serve as an effective public health partner in delivering health promotion and disease prevention programs.

WHAT NEEDS TO BE DONE

If senior centers are to fulfill their role as a major community focal point addressing one of today's most serious public health problems—the rising rate of multiple chronic conditions in older adults—we must re-envision their role and purpose, how they are funded, and how they are linked with public health systems. Consistent with the recent ideas of Hussein and Kerrssey,[15] we believe the existing infrastructure of senior centers in the United States is an ideal vehicle for delivering health promotion and prevention services in the community and helping older adults better manage existing health conditions. With modest investments in workforce training and continuing education, the establishment of leadership academies and mentoring programs in healthy aging, development and use of technology and data management systems, and the development of formal agreements and partnerships with public health and other health systems, senior centers can play the role initially envisioned and greatly contribute to our nation's efforts to deliver prevention and health promotion interventions to vulnerable older adults.

CONCLUSION

The nation's 11,000 senior centers already offer a wide range of health, nutrition, education, recreation, volunteer, and other social interaction opportunities for their participants that enhance dignity, support independence, promote health, and encourage community involvement. Serving as many as 10 million older adults yearly, centers are also a resource for the entire community, providing services and information on aging and assisting family and friends who care for older persons. They are often the providers of Meals on Wheels and other services to homebound elders. Their full potential in community health, however, has not been achieved due to a lack of vision and investment. With modest, targeted investments designed to build the capacity of senior centers and their staff, the nation's network of senior centers can become a true partner with our public health system and an effective delivery system for health promotion and preventive interventions, services, and information to large numbers of older adults, including racial and ethnic minorities and low-income individuals. We believe the time has come to make such an investment, and we call on government, corporations, and private foundations to join us in making this vision a reality.

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