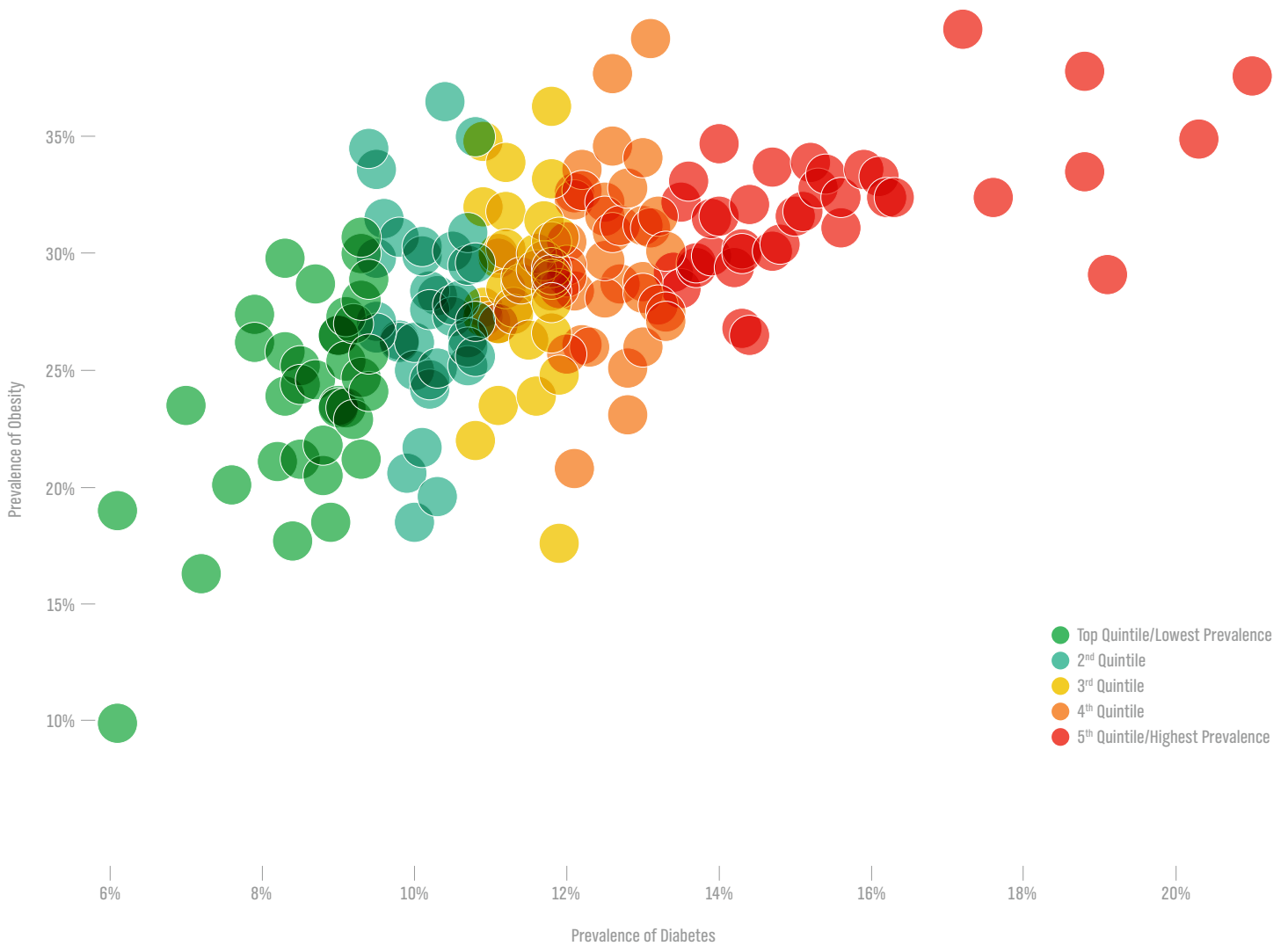


STATE OF AMERICAN WELL-BEING

2017 STATE AND COMMUNITY RANKINGS FOR THE PREVALENCE OF DIABETES



Prevalence of diabetes and obesity for 186 U.S. communities

Prevalence of Diabetes in States & Communities Across the U.S.

The continuing obesity epidemic in the U.S. continues to take a heavy toll on diabetes prevalence, with every three percentage points of added obesity resulting in about one additional percentage point of diabetes. Among states, those with a rising obesity rate are more than twice as likely to have statistically rising diabetes rates. We also know, however, that most of the states that historically are among the highest in overall well-being are the least likely to be suffering these trends, illustrating the importance of holistic well-being in combatting diabetes.

– Dan Witters
Research Director,
Gallup-Sharecare
Well-Being Index

This report, part of the Gallup-Sharecare *State of American Well-Being* series, examines the prevalence of diabetes in 186 communities nationwide and across all 50 states. The overall diabetes rate in the U.S. adult population is growing, up from 10.8% in 2008-2009 to 11.5% in 2016-2017. The rate increase has resulted in about 1.7 million more Americans with diabetes diagnoses now than would have been the case had the rate not changed since 2008-2009. Even more alarming is that obesity, a key risk factor in the development of type 2 diabetes, has climbed by 2.3 points since 2008-2009, to reach 28.3% nationally in 2016-2017.

Gallup-Sharecare data provides a unique lens through which to view the prevalence of diabetes in states and communities. Lower rates of diabetes could point to citizens of a particular state or community practicing healthier behaviors which, in turn, could lead to better health outcomes and lower prevalence of chronic conditions. But a lower rate could also signal under-diagnoses and/or an incoming tide of new diagnoses as individuals develop diabetes.

In terms of the state-by-state analysis, Alaska, Colorado, Montana, New Hampshire, Utah and Vermont have the lowest prevalence of diabetes in the nation, with less than 9% of their adult populations having been diagnosed with the disease. Colorado is the only state of these six that also saw an increase in diagnoses between 2008-2009 and 2016-2017.

On the other end of the spectrum, West Virginia has the highest diabetes prevalence, with 17.9% of its residents diagnosed with diabetes in 2016-2017 – roughly double the rate of the lowest prevalence states. Respondents for seven other states reported diabetes diagnoses of at least 14% – South Carolina, Mississippi, Kentucky, Louisiana, Arkansas, Alabama and Tennessee – all located in the southern U.S.

Among the 186 communities included in the Well-Being Index, Provo-Orem, Utah; Boulder, Colorado; Fort Collins, Colorado; and Reno, Nevada have the lowest prevalence of diabetes, at or below 7%. Conversely, residents of Fort Smith, Arkansas-Oklahoma and Kingsport-Bristol, Tennessee-Virginia report the highest rates in the nation, with more than 20% of their respective adult populations having the disease.

Prevalence of Diabetes in States & Communities Across the U.S.

Lowest Prevalence		Highest Prevalence		Lowest Prevalence		Highest Prevalence	
1. Alaska	8.4%	41. Indiana	13.0%	1. Provo-Orem, UT	5.7%	177. Spartanburg, SC	16.1%
2. Colorado	8.6%	42. Oklahoma	13.0%	2. Boulder, CO	6.1%	178. Lakeland-Winter Haven, FL	16.2%
3. Montana	8.7%	43. Tennessee	14.1%	3. Fort Collins, CO	6.1%	179. Visalia-Porterville, CA	16.3%
4. New Hampshire	8.8%	44. Alabama	14.1%	4. Reno, NV	7.0%	180. McAllen-Edinburg-Mission, TX	17.2%
5. Utah	8.9%	45. Arkansas	14.2%	5. Santa Cruz-Watsonville, CA	7.2%	181. Youngstown-Boardman, OH-PA	17.6%
6. Vermont	8.9%	46. Louisiana	14.4%	6. Burlington-South Burlington, VT	7.6%	182. Beaumont-Port Arthur, TX	18.8%
7. Massachusetts	9.0%	47. Kentucky	14.4%	7. Anchorage, AK	7.9%	183. Shreveport-Bossier City, LA	18.8%
8. Minnesota	9.4%	48. Mississippi	14.8%	8. Boise City-Nampa, ID	7.9%	184. Ocala, FL	19.1%
9. Wyoming	9.5%	49. South Carolina	15.1%	9. Oxnard-Thousand Oaks-Ventura, CA	8.2%	185. Kingsport-Bristol-Bristol, TN-VA	20.3%
10. North Dakota	9.6%	50. West Virginia	17.9%	10. Madison, WI	8.3%	186. Fort Smith, AR-OK	21.0%

Prevalence of Diabetes in States & Communities Across the U.S.

To optimize diabetes care and mitigate risk factors, such as obesity, states and communities must collaborate on a population health approach tailored for individuals. Healthcare professionals and policy makers need to create environments that give individuals the opportunity to make healthy lifestyle choices. Only with this type of encouragement will behavior change impact people with diabetes and lessen the prevalence rate and reduce rising costs associated with its treatment.

– Sheila Holcomb, RD, LD, CDE
Vice President,
Sharecare

Obesity, commonly defined as having a Body Mass Index (BMI) of 30 kg/m² or greater, is a significant risk factor for the development of type 2 diabetes. Not all people with diabetes are obese, and not all who are obese develop diabetes. Other risk factors include age, physical inactivity, race and ethnicity, and genetic predisposition. Yet, research shows that about 54% of middle aged Americans who are obese and have not yet developed diabetes will do so in their lifetime. Across most adult age groups those who are obese are at least four times more likely to have diabetes than are those who are normal weight.

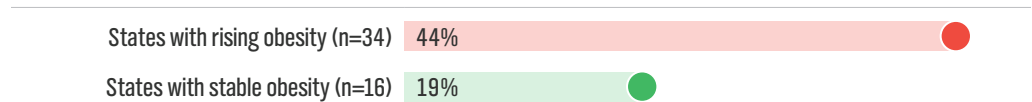
This statistic, coupled with rising obesity rates, sets the stage for rising rates of diabetes across the U.S. Additionally, some communities and regions may have populations that are currently under-diagnosed due to healthcare access issues such as lack of health insurance, lack of having a primary care doctor, and/or inconclusive patient-physician interactions.

The relationship between diabetes and obesity is of key interest to population health stakeholders and healthcare professionals supporting diabetes prevention and management initiatives within their communities. If left unchecked, the current trends of these conditions will have a significant impact on future healthcare costs, health outcomes, and the overall well-being of individuals, communities and organizations.

In the two-year period spanning 2008-2009, 26.0% of U.S. adults were obese, based on calculations of their BMI using self-reports of their height and weight. That figure rose to 28.3% in 2016-2017. This entailed increased obesity rates in 34 states, while obesity declined in none. Of the states with increased obesity, 15 of them – or 44% – also had statistically significant increases in diabetes. By contrast, diabetes increased in only three of the 16 states that did not experience significant changes in obesity, or 19%. As such, states with a rising obesity rate are about 2.3 times more likely to also be experiencing rising diabetes prevalence than are states without a rising obesity rate.

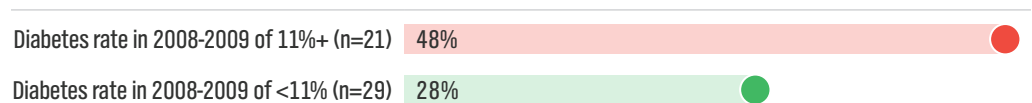
Probability of an Increasing Statewide Diabetes Rate in 2016-2017 Compared to 2008-2009

States with a rising obesity rate are 2.3 times more likely to have a rising diabetes rate than are those that have a stable obesity rate.



States with higher diabetes rates in 2008-2009 are also more likely to have experienced an increase in diabetes prevalence since that time. Among the 21 states with a diabetes rate of 11% or higher in 2008-2009, nearly half (48%) have had their rates climb still further compared to 28% of states that had rates of less than 11%. Consequently, the national diabetes rate has worsened most in states where its prevalence has historically been highest, perpetuating the problem.

Nearly half of states with a diabetes prevalence of 11% or higher in 2008-2009 have seen their rates rise less than a decade later.



Best Practices for Diabetes Management

Without a cohesive diabetes strategy, health systems are unable to effectively create and deliver value-based care models. Diabetes crosses various service lines but, historically, there has been a limited focus on the disease. The foundation of diabetes population health begins in the physician's practice and expands across inpatient and outpatient settings, allowing for the evolution of care teams and aligned payor reimbursement. By standardizing diabetes management, patient quality and safety will improve – and ultimately, hospital and patient expenditures will be reduced.

– Jeffrey Boord, MD,
Chief Quality and Safety Officer,
Board Certified Endocrinologist,
Parkview Health

Best-in-class diabetes programs have a comprehensive approach to inpatient glycemic management and outpatient self-care, education and support. This structured balance includes continuous professional education as well as robust quality and outcomes reporting. By focusing on glycemic targets, healthcare organizations can reduce the average length of inpatient hospital stays and promote coordinated care with engaged, multidisciplinary teams. Below we have identified four key elements of successfully implemented diabetes programs. Hospital and health system innovators are profiled, including results for patient engagement and clinical outcomes.

Strategic Approach

- Assess your competencies required to effectively and efficiently manage individuals with diabetes across the care continuum
- Design a comprehensive inpatient glycemic management and outpatient diabetes care program
- Position your diabetes program as a strategic service line and center of excellence
- Standardize interventions and education across your health system to scale and broaden services

Involve Physicians

- Establish standardization using systemic and concurrent interventions with guidance from physicians, specialists and diabetes resource team stakeholders
- Obtain physician “buy-in” to ensure referrals and use of the diabetes services
- Create an environment where physicians can trust their patients are hearing a consistent message throughout your health system, either while hospitalized or in the outpatient setting

Deploy Resources

- Staff accordingly to offer services beyond standard outpatient self-management education – such as medical nutrition therapy, insulin pump management, and continuous glucose monitoring
- Position advance nurse practitioners specializing in diabetes management and certified diabetes educators throughout your health system
- Make sure your program is recognized by the American Diabetes Association or accredited by the American Association of Diabetes educators to maximize billing revenue

Leverage Technology

- Utilize digital therapeutics for diabetes medication optimization for intravenous and subcutaneous therapy in adult and pediatric patients
- Deploy an outpatient reporting and tracking software to monitor, report and benchmark patient and program outcomes
- Integrate data connection interfaces with inpatient and outpatient technology to communicate with your electronic medical record

Parkview Health, Fort Wayne, IN

Parkview Health is a community-based health system that includes nine hospitals and a large network of primary care and specialty physicians serving Northeast Indiana and Northwest Ohio. With more than fifteen percent of adults in the region having diabetes, the burden of this disease is well known to have an impact on outcomes, processes, cost of care and overall health of the community. Parkview Health recognizes the threat of wide variations of diabetes care in the ambulatory, acute and post-acute care settings and through a systemwide initiative, is taking steps to identify and close these gaps across the spectrum of diabetes care.

To better align the system and prepare for value-based care initiatives, the executive leadership team has added diabetes care to the transformational roadmap and made it a strategic priority. The enterprise diabetes care support model aims to cross the continuum of care, service lines, institutes, and facilities. Historically, strategies revolve around procedural interventions, like cardiac and orthopedic surgeries, but Parkview Health is addressing diabetes as the underlying comorbid condition with a population health and a systematic approach. By leveraging key assets such as a strong primary care base, an integrated electronic health record, a dedicated diabetes patient registry, endocrinology experts and technology, Parkview can provide timely care interventions for patients living with diabetes.

Parkview Health's depth and commitment to quality and excellence includes Magnet Recognition® for nursing excellence and expansion of its ongoing relationship with Sharecare to provide glycemic management and diabetes services to its community hospitals. The goal is to ensure a strong continuum of care focused on diabetes. With continued input from executive leadership, providers and key stakeholders, the system will broaden cost-effective patient access to the appropriate level of care and services needed at the right time and in the right setting.

Our Lady of Lourdes Memorial Hospital, Binghamton, NY

Our Lady of Lourdes Memorial Hospital, Inc. located in Binghamton, NY, enhanced patient safety and quality of care by addressing the dangers of hypoglycemia (low blood glucose). Their innovative, preventative approach in hospitalized patients began by leveraging the hospital's point-of-care (POC) system to identify adult, non-pregnant patients with incidence of severe hypoglycemia, defined here as blood glucose (BG) <50 mg/dL, and establishing clinical indicator alerts.

Results revealed established risk factors (e.g. A1C, weight, renal function) did not predict hypoglycemia for this population but having a history of both diabetes and severe hypoglycemia became the triggers for a predictive alert. Since implementation, Lourdes has seen an overall 35% reduction in POC results <50 mg/dL and fewer overall patient encounters with a similar number of patient discharges from the 2015 baseline through 2017. The alert helps identify and predict those at risk for developing severe hypoglycemia and was designed to reinforce clinical guidelines and create awareness to protocols.

Additionally, the alert was carefully constructed to be clinically relevant for identified users. For nurses, this notification creates an opportunity to educate the patient on the possible signs and symptoms of hypoglycemia. In contrast, when providers review the chart, they are reminded to consider factors such as medication, dosing and increased monitoring. Outcomes of the alert include increased awareness of the hypoglycemia protocol and insulin-related risks. For over 20 years, Our Lady of Lourdes Memorial Hospital, Inc., partners with Sharecare to deliver a dedicated focus on inpatient glycemic management and outpatient diabetes care, education and support.

Addressing diabetes care and glycemic management at a system level is critical for improving quality, mitigating risk and addressing treatment disparities. At BayCare Health System, we strive to treat every patient and customer with humanity and extraordinary care.

– Joanne S. Mayers, BSN, MSN, RN,
Chief Nursing Officer and Vice
President of Patient Services,
BayCare Health System

This edition of “Voice of the Patient” features Sharecare Diabetes Solution™ Education Program Graduates at the Ascension Columbia St. Mary’s Health System. This unique program encourages sustained behaviors that can positively impact those with diabetes including diet, activity, stress management, and medication adherence, to create lifestyle changes needed to successfully manage type 2 diabetes. The diabetes program’s counselor and behavior modification specialist developed a blended method of two evidence-based interventions, Cognitive Behavioral Therapy and Motivational Interviewing, for changing diabetes self-management behavior and improving productivity. Patients that participate in one such program, Weight Mates, a group weight loss program for those with diabetes, lose an average of 20 pounds in six months and lower their A1C by 2%. Below are some experiences our patients had at Ascension Columbia St. Mary’s Health System and still attend education classes and support sessions.

In 2001, I was diagnosed with type 2 diabetes. I was on several medications including different types of insulin. As years went on my health declined further because I wasn’t taking care of myself. In June of 2015, I was sent to the diabetes center at Columbia St. Mary’s. I was 277 lbs., had an A1C of 9% and was on insulin and Metformin to control my blood sugar levels. Through the education and support provided by the diabetes team, my A1C is 6% and I am no longer taking insulin. The diabetes team is so friendly and encourage us as students – to stop, think and decide what is best for us. They really give us the tools to survive with diabetes.

– Faye S.

My doctor first referred me to the diabetes center for education around controlling my type 2 diabetes in 2002. The classes were great, I learned so much in a group setting, such as how to control my weight, glucose control, portion size and how to read labels to choose the right foods. I was also instructed on how to give myself insulin. When I started attending classes, I was 300 lbs. and my A1C was 10.6%. I currently weigh 231 lbs. and my A1C is at 7.4%. As I started losing weight, I was able to get off insulin. I feel like I am now in control of my diabetes, I even have more energy!

– Gregory T.

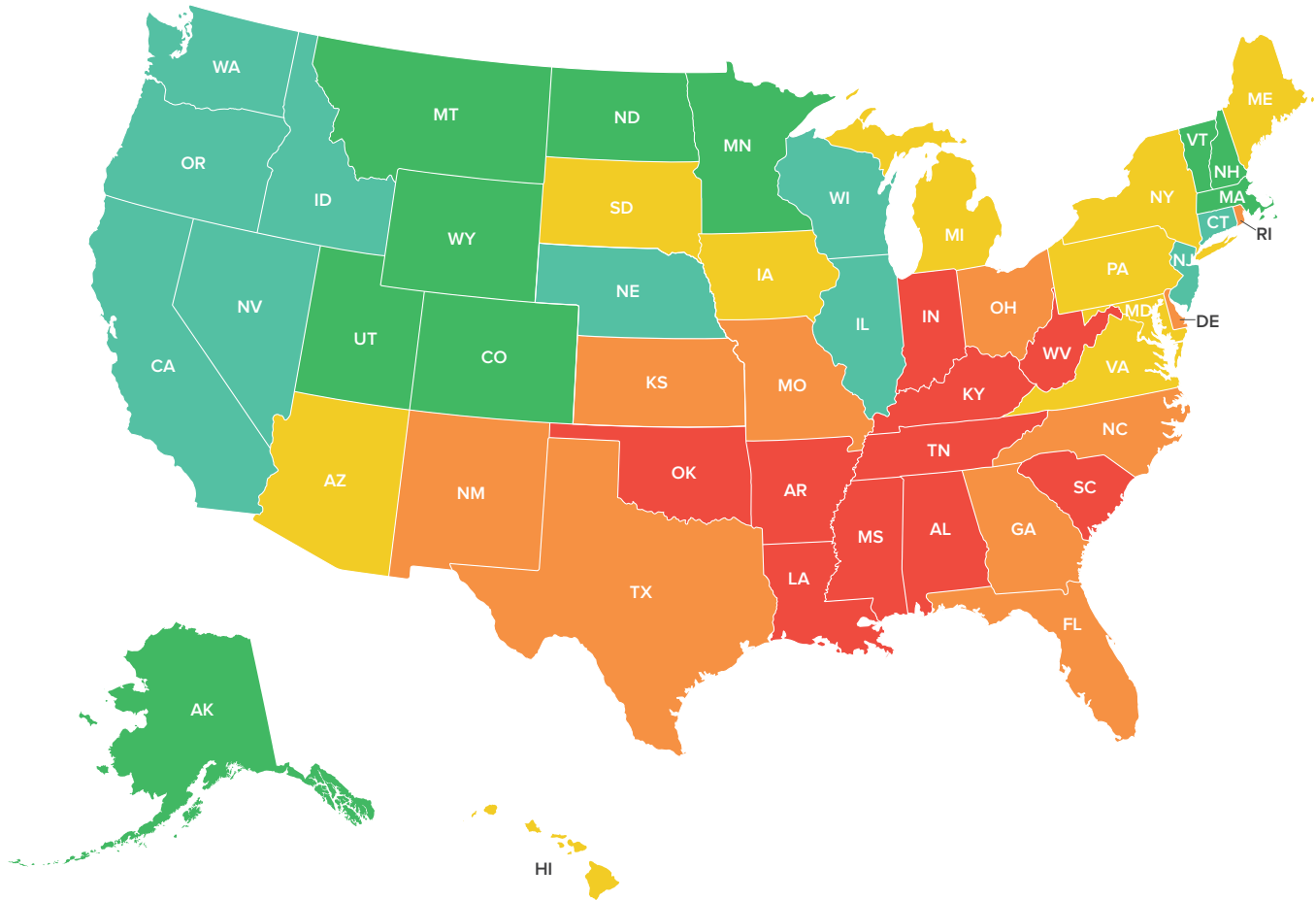
When I was diagnosed with diabetes, it wasn’t explained to me how it could impact my life. I had diabetes for quite some time, but I was in denial about the condition. Once I started taking the classes, I realized how diabetes can affect me and how to cope with it. I learned about the medicine I was taking, nutrition, exercise and so much more. At the time I started classes, my A1C was over 7% and just in 3 months, it was reduced to 6.5%. I was overweight, tired and had problems with my vision. All I was able to do was cook, eat and sleep. But after the education and support I received at the diabetes center, I have so much more energy that I can even chase after my grandbaby. I’ve lost 50 lbs. and my A1C continues to lower.

– Tanya B.

I’ve had diabetes since the mid 90’s, and I had very little education on it. I didn’t understand how to take my insulin, and I used to increase my insulin if my blood sugar was high. After participating in the diabetes education and support program, I was able to reduce the amount of insulin I take by half and decrease my A1C to 6.8%. I feel so good now! In addition, the diabetes center educators took the time to explain carbohydrate counting to me, so I’m not just adjusting my insulin. It’s very important to get the education, it cannot be done alone as diabetes needs to be understood at a deeper level. I appreciate the professionalism, honesty and guidance the diabetes center educators provide me. I hold myself accountable now, but I know the educators are there to help.

– John A.

Prevalence of Diabetes by State, 2016–2017



Top Quintile		2 nd Quintile		3 rd Quintile		4 th Quintile		5 th Quintile	
1	Alaska	11	Washington	21	Maryland	31	Texas	41	Indiana
2	Colorado	12	New Jersey	22	New York	32	New Mexico	42	Oklahoma
3	Montana	13	Idaho	23	Virginia	33	Kansas	43	Tennessee
4	New Hampshire	14	Oregon	24	Hawaii	34	Florida	44	Alabama
5	Utah	15	Connecticut	25	Iowa	35	Missouri	45	Arkansas
6	Vermont	16	Wisconsin	26	Pennsylvania	36	Georgia	46	Louisiana
7	Massachusetts	17	Nebraska	27	Michigan	37	Delaware	47	Kentucky
8	Minnesota	18	Illinois	28	Maine	38	Rhode Island	48	Mississippi
9	Wyoming	19	Nevada	29	South Dakota	39	Ohio	49	South Carolina
10	North Dakota	20	California	30	Arizona	40	North Carolina	50	West Virginia

State Rankings for Prevalence of Diabetes, 2016–2017

Rank	Diabetes			Obesity			
	2008-09	2016-17	Pct. Pt. Change	2008-09	2016-17	Pct. Pt. Change	
1.	Alaska	9.1	8.4	-0.7	27.3	28.7	1.5
2.	Colorado	7.0	8.6	1.6	18.8	20.2	1.4
3.	Montana	8.8	8.7	0.0	24.0	24.4	0.4
4.	New Hampshire	9.3	8.8	-0.6	22.2	26.3	4.1
5.	Utah	7.7	8.9	1.2	22.5	24.9	2.4
6.	Vermont	9.3	8.9	-0.3	23.5	22.4	-1.1
7.	Massachusetts	9.5	9.0	-0.6	22.1	22.5	0.4
8.	Minnesota	8.8	9.4	0.6	24.1	25.3	1.3
9.	Wyoming	8.9	9.5	0.6	25.2	27.5	2.3
10.	North Dakota	8.4	9.6	1.3	27.1	31.6	4.5
11.	Washington	9.3	9.7	0.4	24.7	25.9	1.1
12.	New Jersey	10.1	9.9	-0.2	23.5	25.1	1.6
13.	Idaho	8.4	10.1	1.7	25.2	26.1	0.9
14.	Oregon	9.7	10.2	0.5	26.0	25.3	-0.7
15.	Connecticut	10.1	10.2	0.1	23.0	25.0	2.0
16.	Wisconsin	9.5	10.3	0.8	27.2	31.9	4.8
17.	Nebraska	10.0	10.3	0.4	27.0	28.6	1.6
18.	Illinois	10.0	10.5	0.5	26.4	27.7	1.4
19.	Nevada	10.0	10.6	0.6	23.5	26.3	2.8
20.	California	9.5	10.7	1.1	23.1	23.8	0.7
21.	Maryland	11.2	10.7	-0.4	27.3	27.9	0.6
22.	New York	10.9	10.8	-0.2	24.6	25.1	0.5
23.	Virginia	10.6	11.1	0.5	25.1	27.3	2.1
24.	Hawaii	8.8	11.3	2.5	18.7	21.3	2.7
25.	Iowa	10.8	11.3	0.5	27.5	32.0	4.5
26.	Pennsylvania	11.4	11.4	0.0	27.6	29.2	1.6
27.	Michigan	11.2	11.7	0.5	27.6	30.0	2.4
28.	Maine	11.1	11.7	0.7	26.0	26.7	0.7
29.	South Dakota	10.3	11.8	1.5	26.5	28.5	2.0
30.	Arizona	9.9	11.9	1.9	23.4	27.6	4.3

Rank	Diabetes			Obesity			
	2008-09	2016-17	Pct. Pt. Change	2008-09	2016-17	Pct. Pt. Change	
31.	Texas	11.4	12.0	0.6	28.0	30.5	2.5
32.	New Mexico	10.6	12.1	1.4	23.8	28.6	4.8
33.	Kansas	10.4	12.1	1.7	25.8	28.0	2.2
34.	Florida	12.2	12.2	0.0	24.4	26.6	2.2
35.	Missouri	11.2	12.3	1.1	27.6	31.2	3.6
36.	Georgia	11.1	12.4	1.3	26.4	29.6	3.1
37.	Delaware	12.1	12.6	0.4	31.1	31.2	0.1
38.	Rhode Island	10.3	12.6	2.4	24.5	27.6	3.1
39.	Ohio	11.8	12.7	0.9	28.2	31.8	3.6
40.	North Carolina	12.1	12.7	0.6	28.0	29.2	1.2
41.	Indiana	11.7	13.0	1.3	28.6	31.1	2.4
42.	Oklahoma	12.3	13.0	0.7	28.3	33.2	4.9
43.	Tennessee	12.6	14.1	1.5	28.2	30.0	1.8
44.	Alabama	14.3	14.1	-0.2	28.9	32.8	3.9
45.	Arkansas	12.3	14.2	1.8	30.2	33.4	3.2
46.	Louisiana	11.8	14.4	2.6	31.2	32.7	1.5
47.	Kentucky	13.2	14.4	1.2	29.2	32.4	3.2
48.	Mississippi	13.5	14.8	1.2	32.1	35.8	3.7
49.	South Carolina	12.9	15.1	2.2	28.0	32.8	4.9
50.	West Virginia	14.7	17.9	3.2	30.9	34.5	3.5

■ Top Quintile/Lowest Prevalence (1 - 10)
 ■ 2nd Quintile (11 - 20)
 ■ 3rd Quintile (21 - 30)
 ■ 4th Quintile (31 - 40)
 ■ 5th Quintile/Highest Prevalence (41 - 50)

■ Statistically Significant Change (significant with 95% confidence)

Community Rankings for Prevalence of Diabetes, 2016–2017

Rank		Diabetes	Obesity	Rank		Diabetes	Obesity
1.	Provo-Orem, UT	5.7	21.8	39.	Peoria, IL	9.4	34.4
2.	Boulder, CO	6.1	9.8	40.	Stockton-Lodi, CA	9.5	33.5
3.	Fort Collins, CO	6.1	18.9	41.	Scranton-Wilkes-Barre-Hazleton, PA	9.5	27.0
4.	Reno, NV	7.0	23.4	42.	Greeley, CO	9.5	26.5
5.	Santa Cruz-Watsonville, CA	7.2	16.2	43.	Lincoln, NE	9.5	29.7
6.	Burlington-South Burlington, VT	7.6	20.0	44.	Manchester-Nashua, NH	9.6	31.4
7.	Anchorage, AK	7.9	27.3	45.	Canton-Massillon, OH	9.8	30.6
8.	Boise City-Nampa, ID	7.9	26.1	46.	Binghamton, NY	9.8	26.2
9.	Oxnard-Thousand Oaks-Ventura, CA	8.2	21.0	47.	Chicago-Naperville-Elgin, IL-IN-WI	9.8	26.1
10.	Madison, WI	8.3	25.7	48.	San Diego-Carlsbad, CA	9.9	20.5
11.	Colorado Springs, CO	8.3	23.8	49.	Santa Maria-Santa Barbara, CA	10.0	18.4
12.	Huntsville, AL	8.3	29.7	50.	Duluth, MN-WI	10.0	24.9
13.	Santa Rosa, CA	8.4	17.6	51.	Albany-Schenectady-Troy, NY	10.0	26.1
14.	Austin-Round Rock, TX	8.5	25.1	52.	Kalamazoo-Portage, MI	10.1	29.8
15.	Bridgeport-Stamford-Norwalk, CT	8.5	21.1	53.	San Luis Obispo-Paso Robles-Arroyo Grande, CA	10.1	21.6
16.	Minneapolis-St. Paul-Bloomington, MN-WI	8.5	24.3	54.	Syracuse, NY	10.1	30.2
17.	Cape Coral-Fort Myers, FL	8.7	24.5	55.	New York-Newark-Jersey City, NY-NJ-PA	10.2	24.1
18.	Tallahassee, FL	8.7	28.6	56.	Norwich-New London, CT	10.2	24.5
19.	Naples-Immokalee-Marco Island, FL	8.8	20.4	57.	Grand Rapids-Wyoming, MI	10.2	27.5
20.	Boston-Cambridge-Newton, MA-NH	8.8	21.7	58.	Savannah, GA	10.2	28.3
21.	San Francisco-Oakland-Hayward, CA	8.9	18.4	59.	Worcester, MA-CT	10.3	28.1
22.	Eugene, OR	9.0	26.4	60.	San Jose-Sunnyvale-Santa Clara, CA	10.3	19.5
23.	Raleigh, NC	9.0	26.4	61.	Ann Arbor, MI	10.3	25.0
24.	Portland-South Portland, ME	9.0	23.4	62.	York-Hanover, PA	10.4	36.4
25.	Seattle-Tacoma-Bellevue, WA	9.0	23.3	63.	Fayetteville-Springdale-Rogers, AR-MO	10.5	27.2
26.	Portland-Vancouver-Hillsboro, OR-WA	9.1	25.3	64.	Louisville-Jefferson County, KY-IN	10.5	27.7
27.	Gainesville, FL	9.1	23.3	65.	Dallas-Fort Worth-Arlington, TX	10.5	30.0
28.	Killeen-Temple, TX	9.1	27.2	66.	Omaha-Council Bluffs, NE-IA	10.6	27.9
29.	Trenton, NJ	9.2	22.8	67.	Lansing-East Lansing, MI	10.7	29.4
30.	Bremerton-Silverdale, WA	9.2	26.9	68.	Lubbock, TX	10.7	26.3
31.	Ogden-Clearfield, UT	9.3	29.9	69.	Asheville, NC	10.7	25.1
32.	Denver-Aurora-Lakewood, CO	9.3	21.1	70.	Barnstable Town, MA	10.7	25.9
33.	Des Moines-West Des Moines, IA	9.3	30.6	71.	Milwaukee-Waukesha-West Allis, WI	10.7	30.8
34.	Spokane-Spokane Valley, WA	9.3	27.9	72.	Hartford-West Hartford-East Hartford, CT	10.8	25.5
35.	Washington-Arlington-Alexandria, DC-VA-MD-WV	9.3	24.6	73.	Green Bay, WI	10.8	34.9
36.	Salt Lake City, UT	9.4	24.0	74.	Sacramento-Roseville-Arden-Arcade, CA	10.8	27.0
37.	Chico, CA	9.4	25.6	75.	Lynchburg, VA	10.8	29.5
38.	Wilmington, NC	9.4	28.8				

■ Top Quintile/Lowest Prevalence (1 - 38)
 ■ 2nd Quintile (39 - 75)
 ■ 3rd Quintile (76 - 112)
 ■ 4th Quintile (113 - 149)
 ■ 5th Quintile/Highest Prevalence (150 - 186)

Community Rankings for Prevalence of Diabetes, 2016–2017

Rank		Diabetes	Obesity	Rank		Diabetes	Obesity
76.	Charlottesville, VA	10.8	21.9	113.	Las Vegas-Henderson-Paradise, NV	11.9	28.4
77.	Evansville, IN-KY	10.9	34.7	114.	Palm Bay-Melbourne-Titusville, FL	12.0	25.6
78.	Columbus, OH	10.9	31.9	115.	Cincinnati, OH-KY-IN	12.0	29.4
79.	Rochester, NY	10.9	27.6	116.	Detroit-Warren-Dearborn, MI	12.0	28.9
80.	Atlanta-Sandy Springs-Roswell, GA	10.9	27.2	117.	Lake Havasu City-Kingman, AZ	12.0	30.4
81.	Philadelphia-Camden-Wilmington, PA-NJ-DE-MD	11.0	27.0	118.	Tampa-St. Petersburg-Clearwater, FL	12.1	28.3
82.	Durham-Chapel Hill, NC	11.1	29.7	119.	Lexington-Fayette, KY	12.1	32.5
83.	Houston-The Woodlands-Sugar Land, TX	11.1	29.9	120.	Urban Honolulu, HI	12.1	20.7
84.	Albuquerque, NM	11.1	26.9	121.	Akron, OH	12.1	32.2
85.	Los Angeles-Long Beach-Anaheim, CA	11.1	23.4	122.	Gulfport-Biloxi-Pascagoula, MS	12.2	33.5
86.	Lancaster, PA	11.1	26.9	123.	Jacksonville, FL	12.2	26.0
87.	Springfield, MO	11.2	31.7	124.	Toledo, OH	12.2	32.6
88.	Olympia, WA	11.2	30.1	125.	Providence-Warwick, RI-MA	12.3	25.9
89.	Kennewick-Richland, WA	11.2	33.8	126.	Roanoke, VA	12.5	32.1
90.	Kansas City, MO-KS	11.2	28.4	127.	Riverside-San Bernardino-Ontario, CA	12.5	28.0
91.	Springfield, MA	11.3	27.6	128.	Pensacola-Ferry Pass-Brent, FL	12.5	31.5
92.	Phoenix-Mesa-Scottsdale, AZ	11.3	27.3	129.	Baton Rouge, LA	12.5	29.6
93.	Allentown-Bethlehem-Easton, PA-NJ	11.4	28.6	130.	Harrisburg-Carlisle, PA	12.6	34.5
94.	Cleveland-Elyria, OH	11.4	28.9	131.	Clarksville, TN-KY	12.6	30.8
95.	Erie, PA	11.5	26.2	132.	Flint, MI	12.6	37.6
96.	Salem, OR	11.6	29.9	133.	Greensboro-High Point, NC	12.7	28.6
97.	Charlotte-Concord-Gastonia, NC-SC	11.6	29.2	134.	Dayton, OH	12.7	31.1
98.	Miami-Fort Lauderdale-West Palm Beach, FL	11.6	23.8	135.	Tulsa, OK	12.8	32.7
99.	Indianapolis-Carmel-Anderson, IN	11.7	29.6	136.	Medford, OR	12.8	23.0
100.	Richmond, VA	11.7	31.3	137.	North Port-Sarasota-Bradenton, FL	12.8	25.0
101.	Pittsburgh, PA	11.8	30.4	138.	Columbus, GA-AL	13.0	34.0
102.	Nashville-Davidson-Murfreesboro-Franklin, TN	11.8	29.3	139.	Little Rock-N Little Rock-Conway, AR	13.0	31.1
103.	Virginia Beach-Norfolk-Newport News, VA-NC	11.8	28.3	140.	Crestview-Fort Walton Beach-Destin, FL	13.0	25.9
104.	Jackson, MS	11.8	36.2	141.	South Bend-Mishawaka, IN-MI	13.0	28.7
105.	Charleston-North Charleston, SC	11.8	33.1	142.	Tucson, AZ	13.0	28.2
106.	Deltona-Daytona Beach-Ormond Beach, FL	11.8	26.5	143.	Montgomery, AL	13.1	39.1
107.	Baltimore-Columbia-Towson, MD	11.8	28.8	144.	Chattanooga, TN-GA	13.1	31.0
108.	New Haven-Milford, CT	11.8	29.0	145.	Wichita, KS	13.2	27.7
109.	New Orleans-Metairie, LA	11.8	27.8	146.	Fresno, CA	13.2	31.5
110.	Prescott, AZ	11.9	17.5	147.	Buffalo-Cheektowaga-Niagara Falls, NY	13.3	27.4
111.	St. Louis, MO-L	11.9	30.6	148.	Birmingham-Hoover, AL	13.3	30.0
112.	Salinas, CA	11.9	24.7	149.	Fort Wayne, IN	13.3	27.0

■ Top Quintile/Lowest Prevalence (1 - 38)
 ■ 2nd Quintile (39 - 75)
 ■ 3rd Quintile (76 - 112)
 ■ 4th Quintile (113 - 149)
 ■ 5th Quintile/Highest Prevalence (150 - 186)

Community Rankings for Prevalence of Diabetes, 2016–2017

Rank		Diabetes	Obesity
150.	Orlando-Kissimmee-Sanford, FL	13.4	29.1
151.	Salisbury, MD-DE	13.5	28.4
152.	Oklahoma City, OK	13.5	32.1
153.	Cedar Rapids, IA	13.6	33.0
154.	Greenville-Anderson-Mauldin, SC	13.7	29.3
155.	El Paso, TX	13.7	29.5
156.	Davenport-Moline-Rock Island, IA-IL	13.9	29.8
157.	San Antonio-New Braunfels, TX	13.9	31.4
158.	Bakersfield, CA	14.0	34.6
159.	Modesto, CA	14.0	31.5
160.	Winston-Salem, NC	14.2	29.3
161.	Port St. Lucie, FL	14.3	26.7
162.	Rockford, IL	14.3	30.1
163.	Knoxville, TN	14.3	29.9
164.	Augusta-Richmond County, GA-SC	14.4	32.0
165.	Vallejo-Fairfield, CA	14.4	26.4
166.	Fayetteville, NC	14.7	30.0
167.	Corpus Christi, TX	14.7	33.6
168.	Memphis, TN-MS-AR	14.8	30.3
169.	Reading, PA	15.0	31.5
170.	Mobile, AL	15.1	31.7
171.	Huntington-Ashland, WV-KY-OH	15.2	33.8
172.	Lafayette, LA	15.3	32.7
173.	Utica-Rome, NY	15.4	33.3
174.	Myrtle Beach-Conway-North Myrtle Beach, SC-NC	15.6	31.0
175.	Columbia, SC	15.6	32.3
176.	Hickory-Lenoir-Morganton, NC	15.9	33.5
177.	Spartanburg, SC	16.1	33.2
178.	Lakeland-Winter Haven, FL	16.2	32.3
179.	Visalia-Porterville, CA	16.3	32.3
180.	McAllen-Edinburg-Mission, TX	17.2	39.5
181.	Youngstown-Warren-Boardman, OH-PA	17.6	32.3
182.	Beaumont-Port Arthur, TX	18.8	37.7
183.	Shreveport-Bossier City, LA	18.8	33.4
184.	Ocala, FL	19.1	29.0
185.	Kingsport-Bristol-Bristol, TN-VA	20.3	34.8
186.	Fort Smith, AR-OK	21.0	37.5

■ Top Quintile/Lowest Prevalence (1 - 38)
 ■ 2nd Quintile (39 - 75)
 ■ 3rd Quintile (76 - 112)
 ■ 4th Quintile (113 - 149)
 ■ 5th Quintile/Highest Prevalence (150 - 186)

STATE OF AMERICAN WELL-BEING

2017 STATE AND COMMUNITY RANKINGS FOR THE PREVALENCE OF DIABETES

Methodology

Results are based on 709,183 telephone interviews conducted Jan. 2, 2008, through Dec. 30, 2009, and 337,690 interviews conducted Jan. 2, 2016, through Dec. 30, 2017, as a part of the Gallup-Sharecare Well-Being Index, with a random sample of adults, aged 18 and older, living in all 50 U.S. states and the District of Columbia. For results based on the total sample of national adults, the margin of sampling error for the diabetes rate is ± 0.2 percentage points at the 95% confidence level.

The state-level sample sizes in 2016-2017 range from 879 in Delaware to more than 33,000 in California. For most states, the margin of sampling error is ± 1 to ± 2 percentage points at the 95% confidence level, but it climbs as high as ± 3.5 percentage points for states with small populations such as North Dakota, Wyoming, Vermont and Alaska. All communities have sample sizes of at least $n=300$. All reported margins of sampling error include computed design effects for weighting. Statistical change testing is based at the 90% ($p < .10$) confidence level and includes design effect for more conservative results that incorporate the imperfectness of the randomness of the state samples.

Each sample of national adults in 2016-2017 included a minimum quota of 70% cellphone respondents and 30% landline respondents, with additional minimum quotas by time zone within region. In 2008-2009, the cellphone minimum was 15%. Landline and cellular telephone numbers are selected using random-digit-dial methods.

About the Gallup-Sharecare Well-Being Index™

The Gallup-Sharecare Well-Being Index is an ongoing measurement of well-being, with more than 2.7 million surveys fielded to date. The partnership between Gallup and Sharecare merges decades of clinical research, health care leadership and behavioral economics expertise to track and understand the key factors that drive greater well-being for individuals and populations. Gallup and Sharecare aim to create a healthier world through knowledge, information and action informed by the data and insights gathered.

The Well-Being Index is calculated on a scale of 0 to 100, where 0 represents the lowest possible well-being and 100 represents the highest possible well-being. Through ongoing nationally representative surveys, the Well-Being Index creates a composite picture of health and well-being within the U.S. To learn more, visit www.well-beingindex.com.

About Gallup

Gallup delivers forward-thinking research, analytics, and advice to help leaders solve their most pressing problems. Combining more than 75 years of experience with its global reach, Gallup knows more about the attitudes and behaviors of the world's constituents, employees, and customers than any other organization. Gallup consultants help private and public sector organizations boost organic growth through measurement tools, strategic advice, and education.

About Sharecare

Sharecare is the digital health company that helps people manage all their health in one place. The Sharecare platform provides each person – no matter where they are in their health journey – with a comprehensive and personalized health profile where they can dynamically and easily connect to the information, evidence-based programs and health professionals they need to live their healthiest, happiest and most productive life. In addition to providing individual consumers with direct access to award-winning and innovative frictionless technologies, scientifically validated clinical protocols and best-in-class coaching tools, Sharecare also helps providers, employers and health plans effectively scale outcomes-based health and wellness solutions across their entire populations. To learn more, visit www.sharecare.com.

About the Sharecare Diabetes Solution™

The Sharecare Diabetes Solution, founded on the principles of Diabetes Treatment Centers of America and established over 30 years ago, is the first and only end-to-end solution for diabetes care and glycemic management. Our solution provides evidenced-based education and comprehensive coordinated care to more than 250,000 patients and caregivers living with diabetes and prediabetes. The Sharecare Diabetes Solution delivers financial cost savings, exceeds clinical and quality measures, and yields positive satisfaction outcomes for over 125 health systems, physician practices, and large employers across the United States. For more information about the only end-to-end diabetes care program, please visit <http://sharecarediabetes.com>.

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