



Kansas Health Statistics Report

Kansas Department of Health and Environment – Division of Health
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Leading Causes of Injury-Related Hospitalizations in Kansas, 2007

In the United States an estimated 50 million persons experience injuries that require medical attention each year. In 2004, injuries nationally resulted in an estimated 1.9 million injury-related discharges from short-stay hospitals. These injuries represented six percent of all hospitalizations [1]. State morbidity data can be used to monitor temporal changes and patterns in causes of unintentional injuries, assaults, and self-harm injuries and to set priorities for planning, implementing, and evaluating the effectiveness of injury-prevention programs. The purpose of this article is to identify and rank the top five leading causes of injury-related hospitalization by age group for Kansans.

Methodology

Kansas hospital discharge data for 2007 were provided by the Kansas Hospital Association. A methodology similar to that employed by the state of Louisiana in 2001 was used [2]. Data containing ICD-9 CM primary diagnosis codes between 800-995, and any diagnoses outside the principal diagnosis code 900-995 but with a valid E-code were included in the analysis. Codes E 849.0—E 849.9, E 870.0—E 876.6, and E 996-999.9 were excluded. Data consisted of 27,492 Kansas resident injury records, of which 25,941 were E-coded. Thus, 94.4 percent of the records contained E-codes.

Injury Related Hospitalizations

Data analysis shows that in 2007, approximately eight percent of Kansas resident hospitalizations were due to injuries, and that unintentional falls were by far the most common cause of these injuries (Figure 1).

Figure 1: Leading Causes of Injury-Related Hospitalizations Kansas, 2007

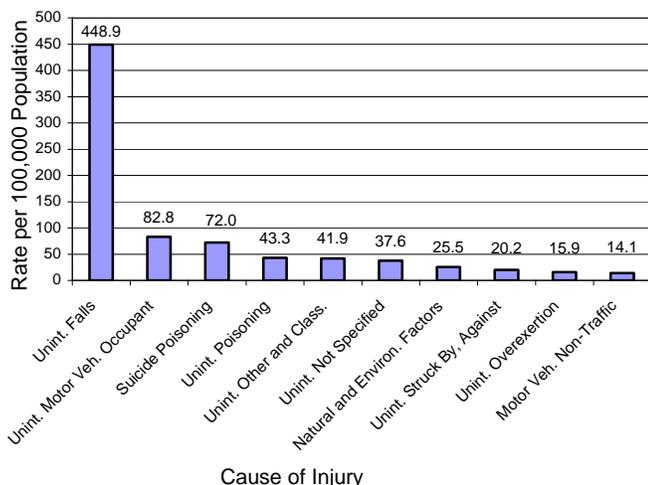


Table 1 lists the top five causes of injury related hospitalizations in Kansas by age group. Unintentional falls are the top ranking cause of injury-related hospitalization in nearly every age group, with the exception of ages less than 1, 15-24, 25-34 and 35-44. Of the other leading causes, assault and other classifiable injuries in the less than 1 age group, injuries to motor vehicle oc-

cupants in the 15-24 age group, and suicide poisoning in the 25-34 and 35-44 age groups ranked first.

Table 1 Leading Causes of Injury-Related Hospitalizations by Age Group, KHA Data, 2007*

Rank	1	2	3	4	5
Age < 1	Assault, Other & Classifiable 38 / 94.0	Unintentional Falls 36 / 89.1	Unintentional Poisoning 29 / 71.7	Unintentional Not Specified 16 / 39.6	Natural & Envir. Factors 11 / 27.2
1-4	Unintentional Falls 107 / 68.7	Unintentional Poisoning 89 / 57.2	Natural & Envir. Factors 47 / 30.2	Unintentional Burn, Hot Object 30 / 19.3	Unintentional Struck By, Against 22 / 14.1
5-14	Unintentional Falls 171 / 45.1	Unintentional MV Occupant 101 / 26.6	Natural & Envir. Factors 68 / 17.9	Unintentional Struck By, Against 57 / 15.0	Suicide Poisoning 54 / 14.2
15-24	Unintentional MV Occupant 578 / 140.7	Suicide Poisoning 513 / 124.9	Unintentional Falls 232 / 56.5	Suicide Cut/Pierce 129 / 31.4	Unint. Other & Classifiable 105 / 25.6
25-34	Suicide Poisoning 440 / 121.8	Unintentional MV Occupant 358 / 99.1	Unintentional Falls 268 / 74.2	Unint. Other & Classifiable 108 / 29.9	Unintentional Poisoning 103 / 28.5
35-44	Suicide Poisoning 466 / 126.9	Unintentional Falls 443 / 120.6	Unintentional MV Occupant 308 / 83.9	Unintentional Poisoning 149 / 40.6	Unint. Other & Classifiable 145 / 39.5
45-54	Unintentional Falls 838 / 206.6	Suicide Poisoning 384 / 94.7	Unintentional MV Occupant 349 / 86.1	Unint. Other & Classifiable 233 / 57.4	Unintentional Poisoning 220 / 54.2
55-64	Unintentional Falls 1,179 / 399.0	Unintentional MV Occupant 223 / 75.5	Unintentional Poisoning 156 / 52.8	Unint. Other & Classifiable 148 / 50.1	Unintentional Not Specified 128 / 43.3
65+	Unintentional Falls 9,129 / 2,534.3	Unintentional Not Specified 566 / 157.1	Unintentional MV Occupant 347 / 96.3	Unint. Other & Classifiable 342 / 94.9	Unintentional Poisoning 312 / 86.6
All	Unintentional Falls 12,461 / 448.9	Unintentional MV Occupant 2,298 / 82.8	Suicide Poisoning 2,000 / 72.0	Unintentional Poisoning 1,201 / 43.3	Unint. Other & Classifiable 1,164 / 41.9

*Each cell contains event frequency and rate/ per 100,000 age-group population

Unintentional Falls

Unintentional falls are a threat to life, independence, and health. One in three older adults falls each year in the United States. Every 18 seconds, an older adult is treated in an emergency department for a fall [3].

For unintentional falls, the highest hospitalization rates were among elderly females, who were hospitalized for falls at a rate of

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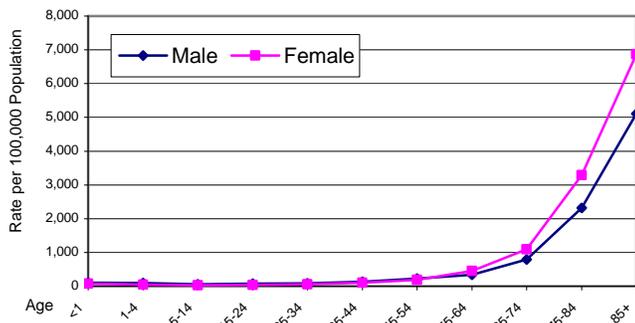
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6,873 per 100,000 population, while males in that age group were hospitalized at a rate of 5,112 (Figure 2). Females aged 85 and over were hospitalized at a significantly higher rate than their male counterparts ($P=.05$) (Figure 2).

Figure 2. Hospitalization for Unintentional Falls, Kansas, 2007

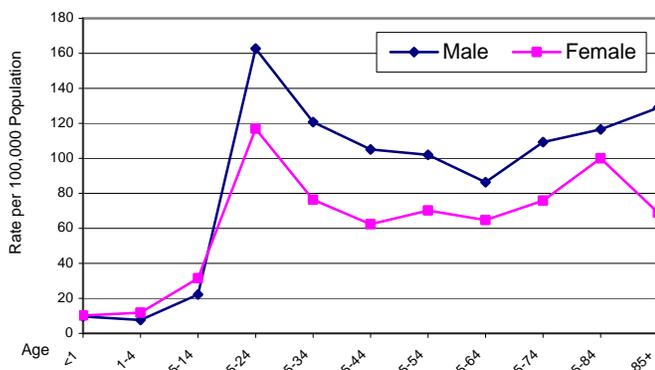


Motor Vehicle Occupant

The U.S. National Highway Traffic Safety Administration conducted a survey in 2003 related to crash injury and emergency medical services. According to the report nationally, “nearly three in 10 persons aged 16 and older reported having been injured in a vehicle crash where they required medical attention. Approximately 16 percent of the total population, aged 16 and older, has received injuries from motor vehicle crashes severe enough to prevent them from performing some of their normal activities for at least a week” [4].

Kansas individuals aged 15-24 years of age were hospitalized for injuries to motor vehicle occupants more than any other type of injury in 2007. Males in that age group were hospitalized at a rate of 163 per 100,000 population, compared to a rate of 117 for females. In fact, males were hospitalized for motor vehicle occupant injury at a significantly higher rate than females in all age groups from 15-54, spiking again in the 85 and above age group at 129 ($P=.05$) (Figure 3).

Figure 3: Hospitalization for Motor Vehicle Occupant, Kansas, 2007



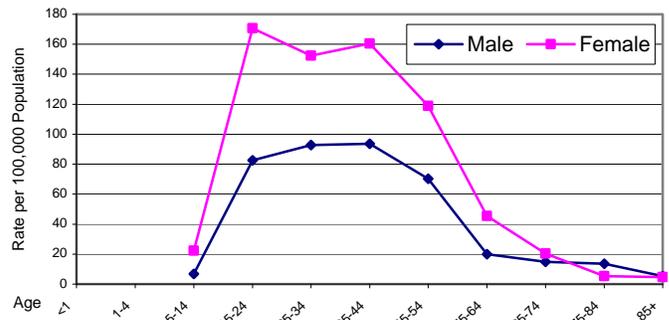
Suicide Poisoning

According to John Hopkins University, from 1999 to 2005 suicide poisoning increased in women by 57 percent [5]. “The results underscore a change in the epidemiology of suicide, with middle aged whites emerging as a new high-risk group” [6].

Kansans aged 25 to 34, and 35 to 44, were more likely to be hospitalized for suicide than for any other type of injury in 2007 (Table 1). Females had higher rates of hospitalization than males for suicide poisoning in all age groups up to age 74 (Figure 4) and overall, had higher rates of suicide poisoning than males ($p=.05$) (Figure 4). In the 15-24 year age group the rate for females was

double that for males, 171 and 83 per 100,000 population, respectively, ($P=.05$) (Figure 4).

Figure 4. Hospitalization for Suicide Poisoning, Kansas, 2007



Summary and Conclusion

This review presents Kansas injury related hospitalization trends by age group and gender for 2007. “Injuries disproportionately affect children, adolescents, young adults, and parents of young children. In the United States, injuries are the number one cause of death among persons 1 to 44 years of age and account for more years of potential life lost before age 65 than all causes of cancer and all causes of heart disease combined. According to the World Health Organization, injury ranks as a leading cause of death and disability among all age groups except (for) people 60 years of age or older” [7].

In Kansas, the leading causes of injury-related hospitalization varied. For the majority of age groups, the most common injuries were attributable to falls, but for ages 25 to 44 injury due to suicide was the most frequent cause, while motor vehicle accidents were more recurrent for younger people ages 15-24. Prevention efforts are underway to decrease injury rates in Kansas. Programs must continue to be tailored to meet the needs of specific population groups in order to reduce injury-related hospitalization.

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Automation: Key to Vital Statistics Quality Improvement

The Center for Health and Environmental Statistics produces many reports using descriptive epidemiology, as well as data tables or sets of tables supplying data for communities, state agencies, or national entities. Some of these reports and tables have many components. Examples of reports using descriptive epidemiology include the Annual Summary of Vital Statistics and the Legislative Report Card. Additionally, administration of the Kansas Information for Communities (KIC) Website requires maintenance of the databases. Accuracy of these reports and data tools depends on a strong quality assurance/quality improvement (QA/QI) process involving the center's two offices: Health Assessment (OHA) and Vital Statistics (OVS).

QA/QI of vital records has been a long-standing OVS practice. The process has taken on a more collaborative approach involving OHA staff. It involves automation of QA/QI to supplement the registration efforts of OVS staff that handle birth, death, stillbirth, marriage, and divorce certificates.

The re-engineering of the Kansas vital records process in 2005 set the stage for this enhanced QA/QI. Automation and streamlining of the registration process enabled more efficient quality assurance both in the data collection process (soft and hard edits) and data checks on the records in the vital statistics database. Fewer errors in data entry translate into fewer corrections, more accurate documents, and better service to the public.

Even with checks that prevent typos, errors can still occur. This is where analytical programs, using specialized statistical software – SAS – come into play. The use of established and tested SAS programs, Excel macros, Oracle views, and standardized Crystal Reports printouts identify possible inaccuracies and monitor reporting timeliness. Results can also be tracked and reported as part of an effort to educate the individuals providing data.

While the human eye is a good tool for spotting some errors, other mistakes may be difficult to detect. Automated checks can look for blank fields or illogical data entries.

Programs have been designed to consistently review the quality of birth, stillbirth, death, marriage and divorce data. OHA is designing SAS programming to run automatically – pulling specific observations out the various vital databases and printing out the variables necessary to understand the issue where there is a concern for accuracy or completion.

In vital records, data in legal portions of the certificate cannot be changed after the record has been registered except by an action of parents, doctors, next of kin (death), and the courts depending on the certificate. Due to this limitation in the birth data, OHA has designed a daily SAS program – the Unfinished Record Report – to check for possible errors after the birth clerks electronically enter the data for the official section and before the date when the birth event is officially registered.

This report runs automatically every weekday and prints out to an OVS printer. It checks for observations with the following issues:

- mother's age is missing or illogical,
- geographic codes are illogical or missing,
- dad is on certificate but age is missing, and
- issues related to previous live births and miscarriages.

When OVS staff confirms the error, the birth record can be electronically returned to the hospital for correction and resubmission.

Since the mother's chart is probably still available in the first week or two after the infant is born, weekly QA/QI programs check for missing, unknown, or out of range data. This task runs automatically every Monday morning at 6 am for the births registered during the previous week. Some of these checks include the following issues:

- outliers in pre- and post-pregnancy weight and height,
- age and educational level conflicts,
- number of cigarettes or packs of cigarettes smoked,
- gestational age, unknown, or illogical,
- previous live birth/pregnancy issues, and
- race category conflicts

In addition to missing information, weekly death certificate data checks address things like gender issues (e.g. was one of the pregnancy boxes checked and the decedent was a male).

Out of state births and deaths to Kansas residents are reviewed monthly. Geographic conflicts in data as well as the other checks are performed. While it may not be possible to obtain updates from the source states, corrections to geographic codes can be performed if sufficient address information is present in the submitted certificate.

Year end checks for birth and death data include evaluating frequency of specified events by county or year (Chi-square test for equal proportions) - are there more births or deaths in a specific county in one year compared to the last several years?

Additional programs perform year end checks for marriage and divorce. These files are evaluated for missing values, and dates in incorrect order. Outliers are checked as well as trends by a variety of variables such as how previous marriage ended, month married, county married, month divorced, county divorced.

Continuous vital statistics quality improvement produces a number of dividends. Coded edit checks limit the entry of bad data, regular reports identify missing or illogical responses, and corrections mean a more complete and accurate file upon which public health reports are based. Automation of these efforts with commonly available statistical software enables this activity to continue despite resource limitations.

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Who Adopts?

Key findings

Data from the National Survey of Family Growth

- People who have adopted are more likely to be men, to be over 30, to be never married, to have given birth or fathered a child, and to have ever used infertility services than people who have not adopted.
- Adoptive mothers are older than non-adoptive mothers. Eighty-one percent of adoptive mothers are 35-44 years of age compared with 52 percent of non-adoptive mothers.
- Women who have ever used infertility services are 10 times more likely to have adopted children than women who have never used infertility services.
- Men who have fathered children are more likely to have adopted children than men who have not fathered children.
- Women with incomes below 150 percent of poverty and Hispanic women are the least likely to have adopted children compared with women of other characteristics.
- The percentage of infants given up for adoption has declined from 9 percent of those born before 1973 to one percent of those born between 1996 and 2002.

If you would like to know more, the article can be found at: <http://www.cdc.gov/nchs/data/databriefs/db12.htm>

2008 Population Estimates Released

Kansas county population estimates for 2008 have been released by the U.S. Census Bureau. Shown in Table 2 are county estimates as of July 1, 2008. Kansas increased nearly one percent (0.9) in population from 2,775,997 residents in 2007 to 2,802,134 in 2008.

Table 2 Kansas County Population Estimates for July 1, 2008

County	Total	% Change from 2007	County	Total	% Change from 2007
Allen	13,319	-0.7	Linn	9,616	-1.5
Anderson	7,984	1.0	Logan	2,593	-1.3
Atchison	16,481	-0.5	Lyon	35,562	-1.2
Barber	4,674	-2.3	Marion	12,100	-1.1
Barton	27,703	-0.2	Marshall	10,178	-0.1
Bourbon	14,851	0.3	McPherson	29,044	-0.5
Brown	10,009	-0.6	Meade	4,359	-1.0
Butler	63,562	0.8	Miami	30,989	-0.3
Chase	2,804	-2.7	Mitchell	6,292	-0.2
Chautauqua	3,768	-1.0	Montgomery	34,395	-0.3
Cherokee	21,082	-1.2	Morris	6,037	1.2
Cheyenne	2,742	-2.1	Morton	2,978	-2.0
Clark	2,108	0.7	Nemaha	10,112	-0.9
Clay	8,859	2.0	Neosho	16,223	0.0
Cloud	9,453	0.8	Ness	2,945	-1.5
Coffey	8,409	-0.5	Norton	5,370	-1.0
Comanche	1,905	3.3	Osage	16,327	-0.8
Cowley	34,065	-0.5	Osborne	3,804	-1.7
Crawford	38,868	0.0	Ottawa	6,026	0.3
Decatur	2,912	-1.5	Pawnee	6,291	-1.9
Dickinson	19,328	2.0	Phillips	5,339	-0.3
Doniphan	7,753	0.0	Pottawatomie	19,695	1.5
Douglas	114,748	1.1	Pratt	9,411	-0.2
Edwards	3,082	-0.8	Rawlins	2,503	-2.2
Elk	3,047	0.2	Reno	63,427	0.4
Ellis	27,801	1.2	Republic	4,812	-1.8
Ellsworth	6,250	-1.0	Rice	10,060	-0.2
Finney	40,998	7.1	Riley	71,069	2.9
Ford	33,293	-0.1	Rooks	5,136	-0.5
Franklin	26,562	0.3	Rush	3,232	0.7
Geary	31,171	23.9	Russell	6,641	-1.4
Gove	2,548	-3.4	Saline	54,657	0.1
Graham	2,592	-0.6	Scott	4,577	0.2
Grant	7,395	-1.4	Sedgwick	482,863	1.4
Gray	5,688	0.8	Seward	23,016	-0.4
Greeley	1,266	-2.4	Shawnee	174,709	0.7
Greenwood	6,861	-1.9	Sheridan	2,501	0.7
Hamilton	2,631	0.0	Sherman	6,013	0.9
Harper	5,857	0.7	Smith	3,901	-1.3
Harvey	33,675	0.5	Stafford	4,326	-1.4
Haskell	3,919	-2.8	Stanton	2,148	-0.6
Hodgeman	1,948	-1.2	Stevens	5,056	-0.1
Jackson	13,240	-1.3	Sumner	23,616	-1.1
Jefferson	18,421	-0.2	Thomas	7,277	-0.5
Jewell	3,142	-1.8	Trego	2,882	-1.5
Johnson	534,093	1.5	Wabaunsee	6,922	0.8
Kearny	4,159	0.3	Wallace	1,404	-3.6
Kingman	7,719	-1.4	Washington	5,791	-0.8
Kiowa	2,541	-14.0	Wichita	2,148	-2.4
Labette	21,871	-0.5	Wilson	9,698	-1.1
Lane	1,743	-0.2	Woodson	3,285	-1.0
Leavenworth	74,276	0.9	Wyandotte	154,287	0.2
Lincoln	3,261	-0.7	Total	2,802,134	0.9

Source: Population Division, US Census Bureau
Release Date: March 19, 2009

You can access this table and additional Kansas estimates through the Internet at: <http://www.census.gov/popest/estimates.php>

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Abortion Report Issued

The Center for Health and Environmental Statistics released its preliminary analysis of 2008 abortion reports in late March. A total of 10,642 abortions were reported to the Center, a decrease (1.8 %) compared to 2007. In 2008, 5,131 abortions occurred in Kansas to out-of-state residents, 5,473 occurred in Kansas to in-state residents, and 38 occurred out-of-state to Kansas residents.

Fifty one percent (50.8) of all reported abortions were to women aged 15-24, 83.3 percent were unmarried and 60.0 percent were White Non-Hispanic. The number of abortions to women of Hispanic origin decreased 11.2 percent from 2007 and accounted for 10.4 percent of all abortions in 2008.

Eighty four percent (84.3) of all reported abortions were performed prior to the 13th week of gestation, while only 7.8 percent of abortions were performed after 16 weeks gestation (Table 3).

Table 3. Abortions by Selected Characteristics, Kansas, 2008

Selected Characteristics	Number	Percent
<i>Residence</i>		
Total Reported	10,642	100.0
In-state residents	5,511	51.8
Out-of-state residents	5,131	48.2
<i>Age Group</i>		
Under 15 years	58	0.5
5-19 years	1,704	16.0
20-24 years	3,698	34.8
25-29 years	2,571	24.2
30-34 years	1,502	14.1
35-39 years	847	8.0
40-44 years	236	2.2
45 years and over	25	0.2
Not Stated *	1	n.a.
<i>Population Group **</i>		
White Non-Hispanic	6,366	60.0
Black Non-Hispanic	2,360	22.2
Native American Non-Hispanic	63	0.6
Asian/Pacific Islander Non-Hispanic	379	3.6
Other Non-Hispanic ***	340	3.2
Hispanic Any Race	1,106	10.4
Not Stated *	28	n.a.
<i>Marital Status</i>		
Married	1,769	16.7
Unmarried	8,853	83.3
Not Stated *	20	n.a.
<i>Weeks Gestation</i>		
Less than 9 weeks	6,365	59.9
9-12 weeks	2,589	24.4
13-16 weeks	843	7.9
17-21 weeks	512	4.8
22 weeks & over	323	3.0
Not Stated *	10	n.a.

n.a. Not applicable

* Patient refused to provide information or information not collected by other states.

** For further explanation, see Technical Notes in the Annual Summary of Vital Statistics, 2007.

*** Includes selection of two or more races or other non-specified race.

The Center's preliminary report of 2008 abortions is available at <http://www.kdhe.state.ks.us/ches/> or by calling the Office of Health Assessment at 785-296-8627.

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2008 Most Popular Baby Names

Addison and Aiden were the most popular names given to newborns by Kansas parents in 2008. For the third consecutive year, the top name for girls and for boys is uni-gender.

Madison, Emily, Olivia and Emma join Addison in the top five most popular girls' names list. Olivia and Madeline are the only new girl's name in the top 10. New names in the top 25 were Alana, which entered the top 25 for the first time, Ella and Natalie. Kaylee is the girl's name with the most spelling variation (36).

Aiden occupies the top spot on the boys list for the fifth year running. Kaden, Ethan, Jackson and Brayden round out the top five. Kaden was the boy's name with the most spelling variation (24), and in 2008 parents preferred Kaden spelled with 'K'. The trend for Celtic and biblical boys' names continues with names such as--Aiden, Brayden, Conner, Kaden, Logan, Caleb, Daniel, Ethan, Gabriel, Isaac, Jacob, Joshua and Noah. The new boy's names in the top 10 were William and Michael, and of the four new names that entered the top 25, Wyatt was the only first timer.

The Kansas Department of Health and Environment, Division of Health's Center for Health and Environmental Statistics prepared this information. The lists are derived from birth certificate information that the Center's Office of Vital Statistics keeps on file. Our list contains names with the same pronunciation, but different spellings, to give a more accurate view of name popularity.

Popular baby names are one of the more regularly requested items produced by the Center's Office of Health Assessment. While the list reflects popular culture and names frequently used in the media, other information from birth certificates and other vital records stored with the Center's Office of Vital Statistics is used to gauge health trends in the state.

The popular baby names lists are available on the KDHE Web site at: <http://www.kdheks.gov/ches/index.html>.

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H1N1 Flu Outbreak Activities

Human cases of the 2009 H1N1 flu virus (initially known as swine flu) have been identified in Kansas as well as in additional states and internationally. This situation is of high concern for public health officials because it is a novel virus – one that we have never seen in humans before – so it is unlikely that anyone has a natural immunity to it.

The KDHE-led response partners with the Kansas Department of Emergency Management and local health departments. That response includes active laboratory and epidemiologic surveillance, advanced distribution of antiviral medications for use in widespread community outbreaks, guidance on community mitigation strategies for schools, employers and local public health departments, and a comprehensive public information effort.

KDHE is working closely with local health departments, Kansas hospitals, and the Centers for Disease Control and Prevention (CDC) to investigate the sources of exposure and monitor these cases. KDHE's goals during this public health emergency are to reduce transmission and illness severity, and provide information to assist health care providers, public health officials and the public in addressing the challenges posed by this newly identified influenza virus. Individuals who have been in contact with the patients are being interviewed and tested as appropriate.

In accordance with the Kansas Response Plan, KDHE is also monitoring and instituting recommendations from CDC for any additional influenza disease surveillance activities, reviewing plans to further enhance those activities, and advising health care providers regarding testing for persons who have symptoms consistent with H1N1 flu virus, especially if they have recently been

to areas that have confirmed cases of H1N1 flu virus, and taking other steps under the plan.

One of the surveillance activities being undertaken involves monitoring mortality patterns in the state. The CDC and KDHE have agreed to prepare daily mortality reports for submission to CDC scientists. The pattern for this follows the weekly reporting KDHE performs for CDC monitoring pneumonia and influenza mortality for the state's two largest cities, Kansas City and Wichita. The weekly reports are summarized every Friday in the CDC's publication, *Mortality and Morbidity Weekly Report* at <http://www.cdc.gov/mmwr/>. The special reports will continue until outbreak activity subsides.

The symptoms of H1N1 flu virus in humans are similar to the symptoms of seasonal flu and include:

- Fever greater than 100 degrees
- Body aches
- Coughing
- Sore throat
- Respiratory congestion
- In some cases, diarrhea and vomiting

What should I do if I have symptoms?

Individuals with the above symptoms should contact their physician, who will determine whether testing or treatment is needed.

Readers interested in more up-to-the-minute guidance and information on the outbreak can go to the KDHE Website at <http://www.kdheks.gov/H1N1/index.htm>.

KIC FastStats Updated

Several features of the Kansas Information for Communities (KIC) FastStats application have been updated with new data. The three updated features are: Agency for Healthcare Research and Quality Indicators, standard health professionals reports, and primary care health care professionals standard FTE reports.

The AHRQ report now contains 2007 Kansas information and 2006 national information for selected quality indicators. The Website is <http://kic.kdhe.state.ks.us/kic/OHA/ahrq.html>. Indicators are:

- Prevention Quality Indicators (PQIs) – are measures that can be used with hospital inpatient discharge data to identify ambulatory care sensitive conditions (ACSCs) in adult populations.
- Inpatient Quality Indicators (IQIs) – are measures that can be used with hospital inpatient discharge data to provide information on quality. Several reported IQI levels are included in this indicator.
- Patient Safety Indicators (PSIs) - screen for patient adverse events resulting from exposure to the health care system. Several reported PSI levels are included in this indicator.

The 2007 standard reports for all health professions (http://kic.kdhe.state.ks.us/kic/OHA/pro_standards.html) have been added to the information available under standard reports. These are counts of health professions based on provider residence.

The 2007 primary care provider FTE data are also online at <http://kic.kdhe.state.ks.us/kic/OHA/fte.html>. These are FTE counts and physician population ratios that detail the level of practicing primary care providers practicing in a given county.

These reports provide valuable insight into health care provider shortages and enable the state to access resources to address the shortages.

The data are now available in a different format. The data are now posted as Excel spreadsheets. Users will need Excel or an Excel viewer. However, access to the spreadsheet will enable users to create their own charts and pivot tables using the data.

Questions about these datasets and other information available from KIC can be submitted via e-mail to KDHE at Kansas.Health.Statistics@kdheks.gov.

Office of Health Assessment

Overview of Fall Traumas in Kansas

Falls are the most common cause of trauma in Kansas. In 2006, 2,721 unintentional fall-related traumas (ICD9 E-codes 880-888) were reported to the State Trauma Registry. Injury severity was minor (ISS 1-8) for approximately half (53.25%) of patients, moderate (ISS 9-14) for 31 percent of patients, and severe (ISS > 15) for 15.7 percent of patients. The average length of stay across all ages was 5.68 days. Twelve percent of patients stayed in the hospital one day, 58 percent stayed for 2-5 days, 23 percent stayed 6-10 days, and seven percent stayed for more than 10 days.

Traumas due to falls result in a significant amount of morbidity. Discharge disposition for 41.3 percent of patients was either to a skilled nursing facility, a nursing home, or rehabilitation facility (24%, 6.4%, 11% respectively). Half of patients who fell were discharged to home or to home with health care. Death was the outcome for 4.37 percent of patients.

younger (Mean = 53.8 years) than females (Mean = 71.26). Half of all male patients are older than 57 years old, whereas half of female patients are older than 79 years old.

Many falls (62.92%) included in the trauma registry occur at home. Other places where falls occur include: residential facility (8.59%), public building (7.04%), recreation (3.50%), industry (2.73%), farm (1.29%), and other/unspecified place (10.55%).

For adults greater than 55 years old and children 0-4 years old, more than half of all falls occur at home. Recreation accounts for 22.3 percent of all falls in 5-14 year olds and 17.89 percent of 15-24 year olds. For persons 85 and older, 20.96 percent of falls occur in residential facilities.

*Impact Newsletter
Kansas Trauma Program*

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