

Kansas Health Statistics Report

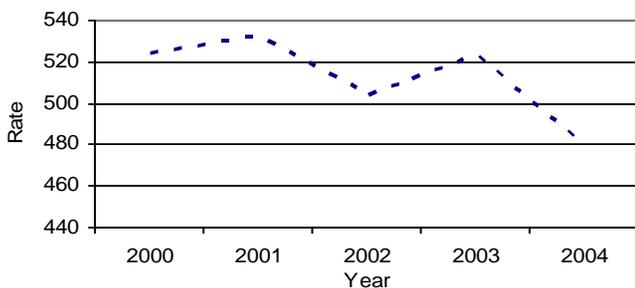
Kansas Department of Health and Environment – Center for Health and Environmental Statistics – No 31 – November 2006

CLRD Deaths and Hospitalizations Studied

Chronic Lower Respiratory Disease (CLRD) claimed the lives of 6,953 Kansas residents during the first half of the decade. CLRD deaths represented 5.7 percent of the 122,371 deaths reported to the KDHE Division of Health's Center for Health and Environmental Statistics from 2000 to 2004. Over three out of four of these deaths (78.3%) occurred to persons aged 70 or older.

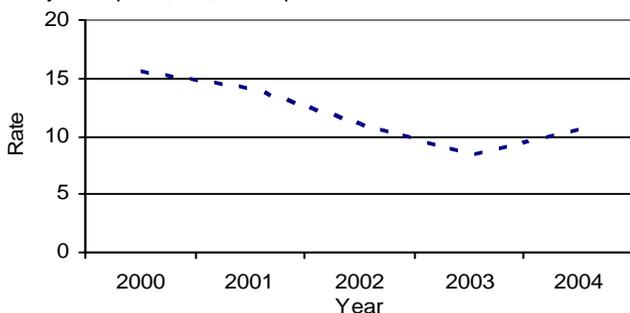
CLRD includes asthma, emphysema, chronic bronchitis, bronchiectasis and Chronic Obstructive Pulmonary Disease (COPD). These diseases are characterized by impaired lung function.

Figure 1. Kansas Resident CLRD Age-Adjusted Mortality Rate Per 1,000,000 Population



Source: Deaths - Kansas Vital Statistics
Population – U.S. Census Bureau (CC-EST2005-alldata-20)

Figure 2. Kansas Resident Asthma Age-Adjusted Mortality Rate per 1,000,000 Population



Source: Deaths - Kansas Vital Statistics
Population – U.S. Census Bureau (CC-EST2005-alldata-20)

Nationally, during 2000, about 10 million adults reported a diagnosis of COPD (CDC, 2002). About 119,000 deaths were attributed to COPD that year, making it the fourth leading cause of death in the U.S. (CDC, 2002).

Several epidemiological studies have reported associations between air pollution exposures and respiratory disease. Increases in short-term exposures to ambient air particulate matter have been associated with increased asthma mortality⁽¹⁻²⁾.

Between 2000-2004, 162 asthma deaths were reported to Kansas residents. Among CLRD deaths to persons under the age of 35, asthma is the most common cause of death, accounting for 17 of the 24 deaths (70.8%).

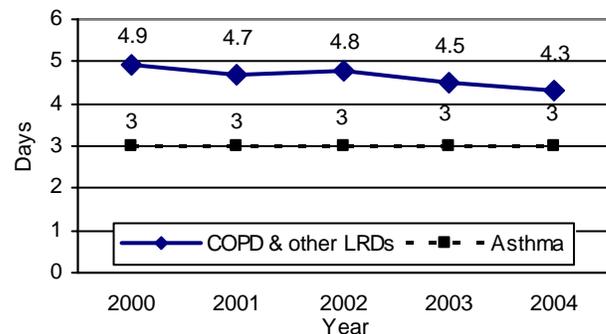
The age-adjusted mortality rate for CLRD in Kansas has declined from 524.39 deaths per 1,000,000 population in 2000 to

479.20 deaths per 1,000,000 population in 2004 (Figure 1). The age-adjusted mortality rate for CLRD declined annually an average of 10.0 per 1,000,000 population between 2000-2004.

Asthma mortality has also declined during the five year period (Figure 2). The age-adjusted mortality rate declined from 15.6 deaths per 1,000,000 population in 2000 to 10.6 in 2004. The age-adjusted asthma mortality rate declined annually an average of 1.6 per 1,000,000 population between 2000-2004.

Kansas hospital discharge data for 2000 through 2004 show an average of 9,940 hospitalizations due to selected chronic lower respiratory diseases (COPD and bronchiectasis, asthma and other lower respiratory disease). The average length of stay was approximately four days with an average 39,454 hospital days per year. Interestingly, during the five years, average days of hospitalization for asthma was 3.0 days while the other CLRD conditions exhibited decreasing numbers in lengths of stay (Figure 3).

Figure 3. Average Length of Stay, Selected Hospitalizations, 2000-2004



Disparities observed with CLRD hospitalization include:

- Blacks are three times more likely to be hospitalized for asthma than whites;
- Females are 1.5 times more likely to be hospitalized for asthma than males; and
- Individuals over 65 are five times more likely to be hospitalized for CLRD than patients under 64.

CLRD and asthma mortality data serve as baseline environmental public health indicators to enable comparison of population, spatial, and temporal trends. The use of these indicators in conjunction with ambient air monitoring data will help to better characterize at-risk populations and geographic areas.

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References

1. Ito, K (2003). Associa-

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tions of particulate matter components with daily mortality and morbidity in Detroit, Michigan. In: Revised Analysis of Time-Series Studies of Air Pollution and Health. Special Report. Boston, MA: Health Effects Institute: pp. 97-106.

2. Moolgavka, SH (2003). Air Pollution and Daily Deaths and Hospital Admissions in Los Angeles and Cook Counties. In: Revised Analysis of Time-Series Studies of Air Pollution and Health. Special Report. Boston, MA: Health Effects Institute: pp 97-106.
3. Coefficient of determination - <http://www.stat.tamu.edu/stat30x/notes/node47.html>

Office of Health Assessment Formed

KDHE's Division of Health, Center for Health and Environmental Statistics has reconfigured its health data and statistical office. The Office of Health Care Information has become the Office of Health Assessment (OHA).

During the past 13 years the office collected health profession, hospital discharge, and health insurance data on behalf of the state. That function has been transferred to the Kansas Health Policy Authority (KHPA).

"This change will enable the office to focus exclusively on public health assessment using existing datasets and to propose new ones," said Howard Rodenberg, MD, MPH, state health officer and division director.

In addition to analyzing hospital discharge data, health claims, and health professions, the office retains its traditional responsibility for primary analysis of vital statistics and trauma data, as well as maintenance and enhancement of the agency's Internet-based health information portal and query site: Kansas Information for Communities (KIC).

The Office of Health Assessment is expected to increase its information dissemination to policy makers, program managers, and the public through the creation of data linkages, routine and special publications, and geographic display of health data.

For more information, contact the Office at 785-296-8627 or visit <http://www.kdheks.gov/hci/index.html>.

Maternal and Child Health Trends in Kansas

The KDHE Bureau for Children, Youth, and Families has published the first edition of the *Kansas Maternal and Child Health (MCH) Annual Summary, 2004*. The report presents summaries of 26 important health issues in women of reproductive age, infants, children, adolescents, and children with special health care needs, and presents MCH health systems indicators in Kansas.

Women of Reproductive Age and Infants

In 2004, low birth weight (LBW) and very low birth weight (VLBW) infants contributed heavily to the total infant mortality rate in Kansas. Almost two-thirds (66.0%) of infant deaths occurred among the 7.3 percent of infants who were born at LBW. Similarly, 50.7 percent of infant deaths occurred among the 1.4 percent of infants born at VLBW. The risk of delivering a LBW infant was greater among Black mothers (all ethnicities) and differed by maternal age, with the highest risk for the youngest and oldest mothers regardless of race.

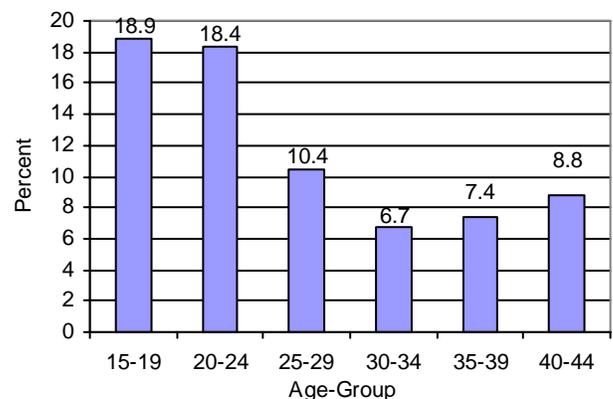
In Kansas in 1999-2004, there was an increasing trend in the percent of women ages 18-44 who lacked health insurance. About 86,307 women (16.9%) lacked health insurance in 2004. In 2004, women at greatest risk of being uninsured were Hispanic, had less than a high school education, earned less than \$15,000 a year, resided in a rural county, and were divorced or separated. The percent of Hispanic women ages 18-44 with no health insurance has increased in recent years and was about 19,223 women (41.4%) in 2004.

The percent of Kansas WIC (Special Supplemental Nutrition Program for Women, Infants, and Children) infants ever breastfed

has increased by 19.4 percent in the last 10 years from 53.5 percent in 1995 to 63.9 percent of infants in 2004. The percent breastfed at least six months has also increased to 24.4 percent of infants. However, the percent breastfed at least 12 months has decreased to 13.7 percent of infants.

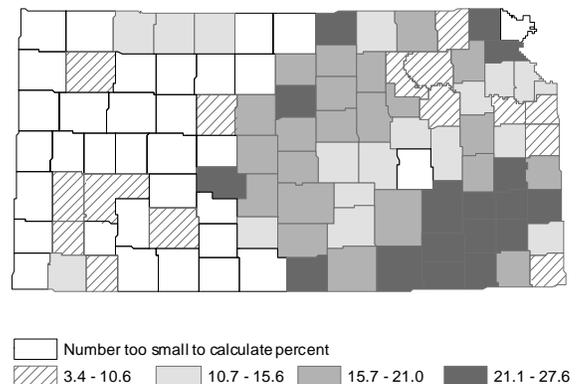
In Kansas, the percent of resident mothers who smoked during pregnancy remained essentially the same from 2000 to 2004. Kansas mothers were more likely to smoke than the national average. In 2004, the age-group with the highest percent of live births where the mother reported smoking was ages 15-19 (18.9%) followed by ages 20-24 (18.4%) (Figure 4). Asian mothers came closest to the Healthy People 2010 target of one percent. Women in Ford, Seward, and Johnson counties were least likely to report smoking during pregnancy while women in Woodson, Harper, and Atchison counties were most likely to report tobacco use during pregnancy (Figure 5).

Figure 4. Percent of Women Reporting Smoking During Pregnancy by Age-Group, Kansas, 2004



Source: Center for Health and Environmental Statistics

Figure 5. Percent of Women Reporting Smoking During Pregnancy, Kansas, 2002-2004 (combined)



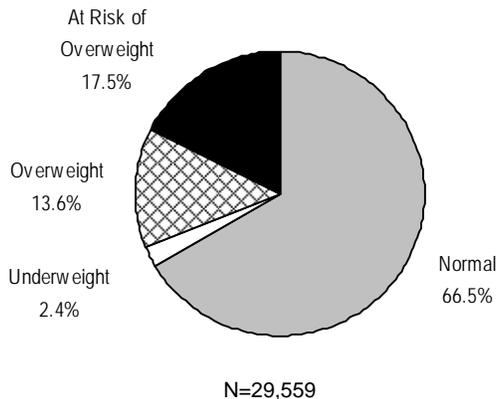
*County level data, visit KIC website: <http://kic.kdhe.state.ks.us/kic/>
Data Source: Center for Health and Environmental Statistics

Children and Adolescents

Based on the 2004 Pediatric Nutrition Surveillance System, 29,559 children ages 2-4 participated in the Kansas WIC program (below 185 percent of poverty level). Three of 10 participants were either overweight or at risk of being overweight (Figure 6). In 2004, 13.6 percent of the children were overweight compared to 14.8 percent for the U.S.; 17.5 percent of the children were at risk of overweight, which compares to 16.2 percent for the U.S.

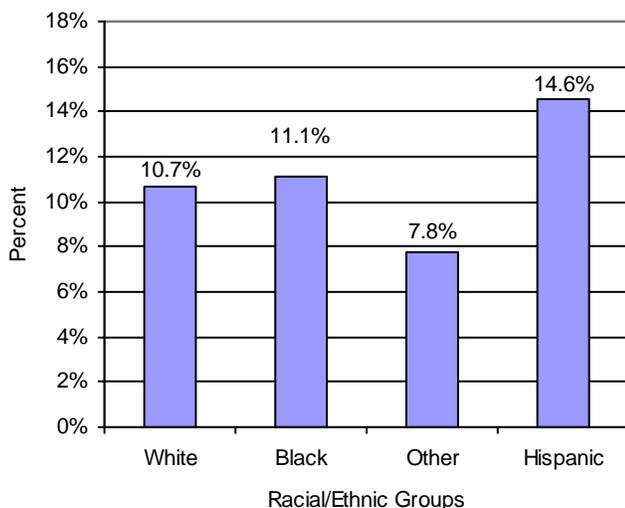
Overweight in Kansas WIC children increased from 8.1 percent in 1995 to 13.6 percent in 2004. According to the Youth Tobacco Survey, during the 2002-2003 school year, 10.9 percent of adolescents in grades 6-12 were overweight, and 13.6 percent were at risk of overweight. The prevalence of overweight was 2.1 times higher among boys (15%) compared to girls (7%). The prevalence of overweight among Hispanics (14.6%) was higher than among other racial/ethnic groups (Figure 7).

Figure 6. Percent Weight Distribution of WIC Participants (Ages 2-4), Kansas, 2004



Source: Pediatric Nutrition Surveillance System

Figure 7. Percent of Adolescents Who Were Overweight (Grads 6-12), Kansas, 2002-2003 School Year



In Kansas, among adolescents/young adults ages 15-24 (2002-2004), 86.9 percent (412) of unintentional injury deaths were caused by motor vehicle crashes, 7 percent (36) were caused by poisonings, and 3.3 percent (17) were caused by drowning. In White (non-Hispanic and Hispanic) youth, unintentional injury caused the highest percent of injury deaths; however, in Black (non-Hispanic) youth, homicides caused more deaths than unintentional injuries.

Children with Special Health Care Needs (CSHCN)

In general, Kansas CSHCN fared slightly better than U.S. CSHCN. Results from the 2001 National CSHCN Survey esti-

mated that 59 percent of Kansas CSHCN receive coordinated ongoing comprehensive care within a medical home compared to the national average of 53 percent. Seventy-one percent of Kansas CSHCN families reported that community-based service systems are organized so families can use them easily, compared to 74 percent for the U.S. An estimated 64 percent of CSHCN had adequate health insurance coverage compared to the national average of 60 percent. "Adequate" private and/or public insurance is defined as access to health services including preventive care, primary care and tertiary care. Many Kansas families have policies that cover only well visits or catastrophic care.

In Kansas, the CSHCN program estimates that only 7 percent of youth with special health care needs receive services necessary to transition to all aspects of adult life. Generally, the vocational/education transition is more comprehensive than transition to adult medical services.

For additional information, the report is at <http://www.kdheks.gov/bcyf/index.html>.

MCH Epidemiology
KDHE Bureau for Children, Youth and Families

Cancer Data added to KIC

Cancer occurrence data for 2003 has been added to the Kansas Information for Communities (KIC) query page at <http://kic.kdhe.state.ks.us/kic/cancer.html>. The data are provided by the Kansas Cancer Registry (KCR), which is operated on behalf of KDHE by the University of Kansas Medical Center.

With the provision of 2003 cases, cancer data for previous years is also updated. Thus, results of KIC queries of the new data will be different from queries made before the update.

The reason for the difference is KCR continues to receive cancer reports long after a year is over. Cases are reported by the year of diagnosis. Sometimes, a cancer case only becomes known after a person dies.

The public health value of the registry is in its completeness. That is why there is a lag time in reporting cancer totals for a given year. It takes about two years of data reporting to reach what KCR feels is 95 percent complete reporting.

The value to users of KIC is that, while up to five percent of the cases may not be reported, statistical results presented are more representative of the geographic or demographic cohort queried.

KIC users should also note that when making comparisons of cancer data, the comparisons should be based on age-adjusted rates (AA rates). AA rates remove the bias of different population sizes and different age makeup of the individuals in the two cohorts compared.

KIC can also create confidence intervals for rates which, if they overlap, mean that the difference is not statistically significant.

It should also be noted that KCR, as part of the requirements to be a cancer registry, must publish a preliminary cancer report about a year after a cancer reporting year closes. These results will obviously be different from results in KIC, which are based on the KCR's updated counts for a given year.

KDHE Office of Health Assessment

Health Risk Behaviors of Kansas Veterans Ages 18-64 Years

According to the U.S. Census, in 2005, there was an estimated 23.4 million civilian veterans ages 18 years and older in the United States and 239,000 civilian veterans in Kansas. Approximately 150,000 Kansas veterans are 18-64 years old (1). While there have been many research studies to identify the psy-

chological effects wartime has on military personnel, little is known about the general health risk behaviors of veterans compared to non-veterans. Although an estimated 15 percent of veterans receive health care from Veteran Health Administration (VHA) facilities, the majority receive health care in the private and public sectors (2).

Table 1. Health Risk Behaviors of Chronic Disease and Disability Status Among Kansas Veterans, 18-64 Years Old¹

Health Risk Behavior	Veteran Status			
	Veteran (ages 18-64 years)		Non Veteran (ages 18-64 years)	
	N	Weighted % (95% CI) ²	N	Weighted % (95% CI)
Binge drinking	83	14.4 (11.1-17.7)	629	14.6 (13.3-15.8)
Heavy alcohol consumption	31	5.4 (3.1-7.6)	167	3.4 (2.7-4.0)
Self reported fair or poor health status	108	14.4 (11.5-17.3)	646	9.9 (9.0-10.9)
14 or more days of poor mental health	58	8.6 (6.1-11.2)	570	9.6 (8.6-10.5)
No health care coverage	87	12.7 (9.7-15.6)	720	15.9(14.6-17.4)
Doctor diagnosed diabetes	63	8.7 (6.3-11.0)	310	4.5 (3.9-5.1)
Hypertension	225	30.8 (27.0-34.6)	1,142	17.2 (16.1-18.3)
Tested and diagnosed with high blood cholesterol	227	37.8 (33.4-42.2)	1,313	29.3 (27.7-30.9)
Current asthma	37	5.1 (3.3-6.9)	439	7.5 (6.7-8.4)
Doctor-diagnosed arthritis	223	31.0 (27.1-34.8)	1,385	20.5 (19.3-21.7)
Chronic joint symptoms	255	36.6 (32.5-40.6)	1,760	27.8 (26.5-29.2)
Living with a disability	181	26.1 (22.3-29.9)	985	15.0 (13.9-16.1)
Has activity limitation	174	25.1 (21.3-28.9)	939	14.28 (13.2-15.4)
Experience chronic pain	97	31.7 (25.8-37.6)	639	20.44 (18.7-22.2)
Current smoker	174	25.9 (22.0-29.8)	1,082	19.67 (18.3-21.02)
Overweight or obese (Body mass index > = 25 kg/m ²)	495	75.00 (71.1-78.9)	3,207	59.26 (57.6-61.0)
Obese (Body mass index > = 30 kg/m ²)	168	24.9 (21.2-28.6)	1,399	24.9 (23.6-26.3)
Not consuming fruits and vegetables 5 or more times per day	557	84.6 (81.3-87.8)	4,390	81.9 (80.7-83.2)
Not participating in the recommended amount of physical activity	331	48.3 (44.0-52.7)	2,747	49.3 (47.6-51.0)
Not participating in the recommended amount of vigorous physical activity	468	67.9 (63.6-72.2)	4,068	72.3 (70.8-73.9)

1 Bolded Results Statistically Significant

2 Confidence Interval

The Behavioral Risk Factor Surveillance System (BRFSS) is a random digit dial telephone survey among non-institutionalized adults ages 18 years and older. The veteran status question have

been a part of this state based surveillance system since 2003. Data from the 2005 Kansas BRFSS were utilized to examine the prevalence of health risk behaviors, chronic disease, and disability among Kansas veterans compared to non-veterans.

Statistically significant differences (bolded text) in the health risk behaviors were found between Kansas veterans and non-veterans ages 18-64 years (Table 1).

Among Kansas veterans, 14% reported their health as fair or poor compared to 10% of non-veterans who reported their health as fair or poor.

Doctor-diagnosed diabetes was higher among veterans than non-veterans (8.7% vs. 4.5% respectively).

Cardiovascular disease risk factors, including hypertension, high blood cholesterol, current smoking, and overweight or obesity were higher among Kansas veterans than non-veterans.

An estimated 31% of Kansas veterans ages 18-64 years had doctor diagnosed arthritis and 37% had chronic joint symptoms. Chronic joint symptoms is defined as symptoms of pain, aching, or stiffness in or around a joint in the past 30 days and the symptoms first began more than three months ago.

Living with a disability is defined as being limited in any activities because of physical, mental, or emotional problems or having a health problem that requires use of special equipment such as a cane, wheelchair, special bed or special phone. Approximately one out of four (26%) Kansas veterans are living with a disability compared to 15% of non-veterans living with a disability.

Nearly one out of three (32%) Kansas veterans experienced chronic pain of any type.

Results from the 2005 Kansas BRFSS indicate veterans ages 18-64 years had a higher prevalence of selected health risk behaviors, particularly cardiovascular disease risk factors, than non-veterans. Higher prevalence of certain chronic diseases such as diabetes, arthritis, and chronic joint symptoms were also seen among them. In addition, a higher percentage of veterans 18-64 years old were living with a disability compared to non-veterans 18-64 years. Strategies and interventions need to be established with VHA and other health care providers to improve the health status of Kansas veterans.

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References

1. U.S. Census. 2005 American Community Survey
2. A Proposal for 2007 BRFSS Veteran Status Core Questions. Annual BRFSS Conference, Palm Springs, CA 2006.

Kansas Teen Pregnancy Rates Continue to Drop

Teenage pregnancy rates for Kansas residents declined again in 2004, but at a slower pace than observed since the declines started in 1995. The teenage pregnancy rate for females aged 10-19 reached a low of 26.1 per 1,000 female age-group population in 2004. This was 1.1 percent lower than in 2003 (26.4), and 24.3 percent lower than the rate of 34.5 in 1995 (Figure 8). The pregnancy rate for 10-19 years olds declined annually an average of 1.0 per thousand female age-group population between 1995-2004. The rate decrease between 1995 and 2004 was statistically significant.

The rates for teenage subgroups 10-17 and 15-19 each fell 1.9 percent to 10.3 and 50.3, respectively between 2003 and 2004. The rate for the youngest teenagers, 10-14 years, remained the same (0.8).

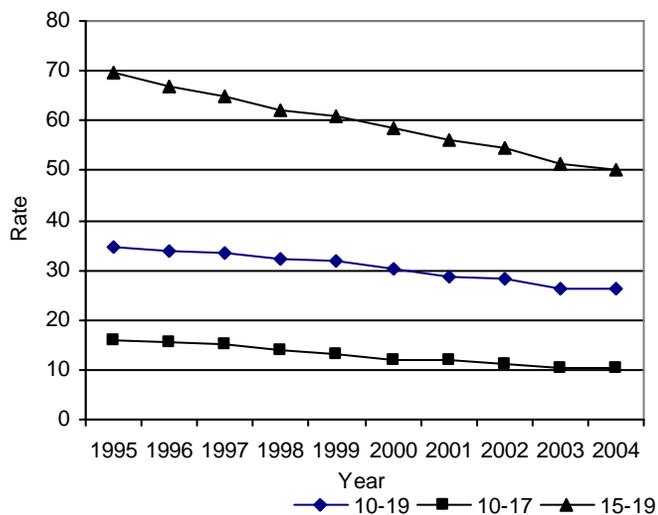
Pregnancies are comprised of live births, stillbirths, and abortions. The total of all three events is divided by the population of the appropriate age-group of women to arrive at the rate.

The five-year 2000-2004 teen pregnancy rate for Kansas resident females ages 10-19 was 28.0. Thirty-two of the state's 105 counties had five-year teen pregnancy rates greater than the state rate. The lowest five-year rate in the state was in Rawlins County, with 5.1 pregnancies per 1,000 females ages 10-19. The highest rate was in Geary County, with 56.2 per 1,000 females ages 10-19.

While the five-year average rate tends to smooth random variation in vital statistics, one should use caution when comparing rates between counties of significantly different population sizes to avoid misleading conclusions.

These and other data by county of residence are contained in

Figure 8. Teen Pregnancy Rates* for Mothers Under 20, Kansas Residents, 1995-2004



* Rate per 1,000 female age-group population

the *Teenage Pregnancy Report, 2004*, published by the Center for Health and Environmental Statistics. This report is available at: <http://www.kdheks.gov/hci/tnpreg04.pdf>. Kansas teen pregnancy reports back to 1995 are available at the KDHE Web site: <http://www.kdheks.gov/hci/teenpreg.html>. Pregnancy statistics can also be queried on the Kansas Information for Communities (KIC) web site: <http://kic.kdhe.state.ks.us/kic/>.

Karen Sommer, MA
Vital Statistics Data Analysis

Kansas Trauma Registry Issues New Reports

The Kansas Trauma Registry (KTR) is a statewide data repository for traumatic injuries occurring in Kansas and/or treated by hospitals in Kansas. KTR is a component of the Kansas Trauma Program, operated by the KDHE Office of Local and Rural Health.

One of the primary objectives of the registry is to facilitate ongoing assessment and assurance of trauma system performance and outcomes. It provides a basis for continuously improving the trauma system. To begin this process, KTR has developed a data report to be distributed to all participating hospitals on a quarterly schedule.

Participating hospitals will be able to use the report for comparing their case mix and performance on several standard trauma care indicators with their region and with the state overall. The indicators are derived from suggested audit filters published by the American College of Surgeons and other sources and have been evaluated by the Kansas Trauma Registry Subcommittee of the Advisory Committee on Trauma.

It's anticipated that the indicators will change and evolve as the Trauma Program identifies specific issues in the Kansas Trauma System and begins to implement systems for performance improvement.

Kansas Trauma Registry
KDHE Office of Health Assessment

Southern Kansas Gastrointestinal Outbreak Investigated

On June 15, staff from the Cowley and Wilson County Health Departments contacted the Kansas Department of Health and Environment's Epidemiology Services Section (ESS) about a potential gastrointestinal outbreak among participants in Biking Across Kansas (BAK). Preliminary information indicated that approximately 20 BAK participants had become ill with nausea, vomiting, and diarrhea; at least eight people were hospitalized.

With the cooperation of BAK staff, ESS initiated an outbreak investigation on June 16. The purpose of the investigation was to characterize the outbreak, to identify potential risk factors associated with illness, and to recommend and implement appropriate prevention and control measures.

Biking Across Kansas is an annual recreational cycling event that starts at the western Kansas-Colorado border and ends at the Kansas-Missouri border. BAK 2006 began on Friday, June 9 near Johnson City, KS and concluded on June 17 at Mulberry, KS. Approximately 870 persons from 33 states participated in BAK 2006. Participants ate food from a variety of venues, including meals prepared by local civic groups, food from commercial vendors, and a few meals provided by BAK coordinators. Throughout the day, support and gear (SAG) stops were located every 10 to 15 miles for cyclists to replenish food and water supplies. During the week-long event, most participants resided in camping tents or school gymnasiums.

Epidemiologic Investigation

Risk factor and illness information was collected for BAK participants, staff, and volunteers. Persons attending breakfast on June 17 were asked to complete a self-administered survey. To capture information from participants who were not present at the June 17 breakfast, a Web-based version of the survey was posted on a secure Internet site from June 21-27.

Cases were defined as persons who participated in or were associated with BAK 2006 and became ill with diarrhea (three or more loose stools within 24 hours) and/or vomiting between June 9-19, 2006. Persons who became ill after June 19 were considered secondary cases.

Eleven stool and three vomitus specimens were collected from BAK participants seeking medical care in Wilson, Cowley, and Crawford counties. Following preliminary testing at local laboratories, the specimens were forwarded to the KDHE Division of Health and Environmental Laboratories (DHLE) for additional testing.

Public Health Measures

In Wilson County, the local health department along with Emergency Medical Services (EMS) and the local hospital set up a triage unit for ill participants. Wilson County Health Department utilized the Regional Emergency Preparedness Van for communication, data collection, and triage.

In Crawford County, the local health department initiated preventive measures to minimize the spread within the county. The Crawford County Health Department alerted the Sheriff's Department, local hospitals, EMS, and food workers to the outbreak. In addition, extra handwashing and portable restrooms were organized in towns where BAK stops were scheduled.

Findings

Four hundred and ninety-three surveys (58%) were collected from the 847 listed participants. Of these 126 (25%) met the case

definition. The cases and non-cases were similar in age, participant type, and state of residence (Table 2). A higher percentage of cases were male compared to non-cases.

Table 2. Characteristics of Cases and Non-cases

	Case	Non-case
Number	126	367
Age		
Median	51	51
Range	9-76	1-77
Gender (%)		
Male	76.1	57.5
Female	22.2	39.0
Unknown	1.7	3.5
Participant Type (%) ¹		
Cyclist	95.2	87.5
BAK Staff	2.5	1.6
SAG Staff	1.6	3.5
Relative of Rider	4.9	7.0
Other	0.0	3.0
State (%)		
Kansas	77.9	73.8
Not in Kansas	22.1	26.2

Source: Epidemiologic Services

¹ Participants could check more than one type.

laboratory. None of the samples tested positive for Salmonella, Shigella, Campylobacter, Escherchia coli O157, or intestinal parasites. Nine specimens have been forwarded to the Minnesota Public Health Laboratory for further analysis; results are pending.

Data analysis of risk factors is pending. At this time, no source of the outbreak has been identified. Counties along the route have not reported any community-wide spread or other outbreaks that were linked to BAK 2006.

*Epidemiological Services
KDHE Division of Health*

American Community Survey Released

The American Community Survey (ACS) has been conducted for a number of years but the 2005 ACS is a new nationwide survey designed to provide communities a fresh look at how they are changing. It is a critical element in the Census Bureau's reengineered 2010 census plan, which calls for discontinuing the use of the long census form that one of every six Americans received in the 2000 Census.

The ACS collects information such as age, race, income, commute time to work, home value, veteran status, and other important data from U.S. households. As with the official decennial census, information about individuals will remain confidential.

The value to data users is the size of the sample, which will ultimately result in estimates being available for small communities. Many Census Bureau surveys do not produce estimates below the state level nor for counties with population below 65,000. Frequently that means the estimates are good for only the largest Kansas counties

The new ACS collects and produces population and housing information every year instead of every ten years. About three million households are surveyed each year, from across every county in the nation. Collecting data every year reduces the cost of the official decennial census, and provides more up-to-date information throughout the decade about trends in the U.S. population at the local community level.



The ACS began in 1996 and has expanded each subsequent year. Data from the 2005 ACS are available for geographic areas with a population of 65,000 or more, including 761 counties, 436 congressional districts, 602 metropolitan and micropolitan statistical areas, all 50 states, and the District of Columbia.

Within three years (by 2008), data will be available for all areas of 20,000 or more. For small areas less than 20,000, it will take five years to accumulate a large enough sample to provide estimates with accuracy similar to the decennial census. Beginning in 2010, and every year thereafter, the nation will have a five-year period estimate available, a resource that shows change over time, even for neighborhoods and rural areas.

There are several sites for obtaining ACS data or learning more about the data and its limitations. Some sites allow users to craft their own queries. The source data are at <http://www.census.gov/acs/www/>, the U.S. Census Bureau Web site. The Census Bureau query tool is American Factfinder.

The Missouri Census Data Center ACS data site is at http://mcdc2.missouri.edu/pub/data/acs2005/Ten_things_to_know.shtml. A more complex query tool at the University of California at Berkeley is <http://ucdata.berkeley.edu/ACS2005/>. The UC Berkeley site does not have much documentation.

The 2005 ACS data cover only six Kansas counties: Wyandotte, Shawnee, Sedgwick, Leavenworth, Johnson, and Douglas. Links to the ACS data, and other health data information can be found at <http://http://kic.kdhe.state.ks.us/kic/otherLinks.html>.

U.S. Census Bureau

Death and Safety Belts

Over half of the people killed in passenger vehicle crashes in 2004 were not wearing safety belts or other restraints. In the United States, 55 percent of the 31,693 persons involved in traffic fatalities were not wearing safety belts.

In Kansas, 62 percent of the 390 traffic fatalities were not restrained. The highest rate was in Mississippi, where 78 percent of the traffic fatalities were not restrained. The best rate in the country was in Oregon, where just 32 percent of the traffic fatality victims were not restrained.

National Highway Traffic Safety Administration

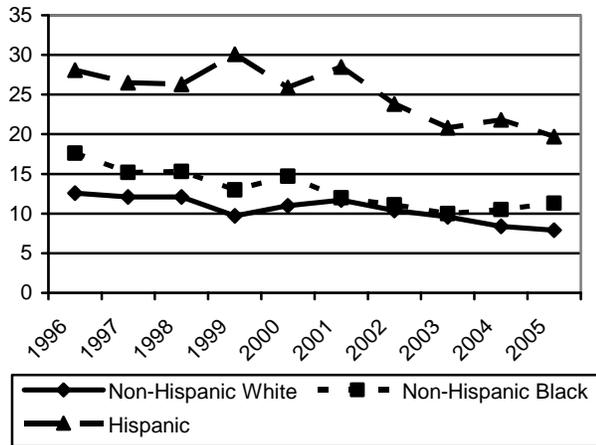
Changes in Children's Health Insurance Status Assessed

The Agency for Health Care Research and Quality has released its findings from an assessment of changes in children's health insurance status from 1996 to 2005. A statistical brief from the Medical Expenditure Panel Survey (MEPS) found that nationally, non-Hispanic white, non-Hispanic Black and Hispanic children's rates of being uninsured dropped substantially between 1996 and 2005. Non-Hispanic white children's rates of being uninsured fell from 12.6 percent to 7.9 percent while non-Hispanic Black and Hispanic children's rates fell from 17.6 percent to 11.3 percent and 28.1 percent to 19.7 percent, respectively (Figure 9).

The State Children's Health Insurance Program (SCHIP), enacted in 1997, expanded eligibility for public coverage for low-income children. Previously published MEPS findings showed that efforts to improve outreach, simplify enrollment, and retain eligible enrollees in Medicaid and SCHIP likely contributed to increases in the rate at which eligible children enrolled in public programs.

The latest evidence on trends in children's coverage by race/ethnicity status shows that continued growth in public coverage has been a major factor in improving rates of health insurance coverage for children. The changes have been particularly dramatic for minority children.

Figure 9. Percentage of U.S. Population Uninsured, by Race/Ethnicity, Under Age 18



Between 1996 and 2005 rising rates of public-only coverage offset declines in private coverage for non-Hispanic white and Hispanic children and reduced the likelihood that they would be uninsured.

*Statistical Brief #141
Agency for Healthcare Research and Quality*

West Nile Virus Reported

KDHE has reported the number of West Nile Virus (WNV) cases in the state has reached a total of 25 as of October 10. The most recent cases included adults who had the onset of symptoms in August and September.

“Although the warmer weather is now behind us, West Nile Virus season is not yet considered over,” stated Howard Rodenberg, M.D., M.P.H., state health officer and director of KDHE’s Division of Health. “West Nile cases in Kansas are most often seen in late summer or early fall, so it’s important to continue taking precautions.”

A West Nile Virus-positive horse has been identified in Harvey County, and a positive mosquito pool was recently identified in Pottawatomie County. West Nile Virus has also been detected in a mosquito pool in Finney County, and has been confirmed in animals in several counties throughout the state, including two birds in Riley County, a squirrel in Reno County, a horse in Jewell County, a horse in Logan County and a horse in Ottawa County.

As of October 10, all but nine states had reported at least one human case of West Nile Virus to the Centers for Disease Control and Prevention. Every Midwest state has reported human cases to CDC this year.

In 2005, KDHE confirmed 25 WNV cases in humans, resulting in one death. Three deaths from the virus have been reported in 2006.

West Nile Virus is spread to people by mosquitoes that first bite an infected bird, but it is not contagious from person to person or directly from birds or other animals. Symptoms range from mild (slight headache and low-grade fever) to extreme (neurological disease - swelling of the brain or brain tissue) and in rare cases death. Most people have no symptoms. Once a person contracts WNV, they are considered immune to it.

Non-neuroinvasive (WNV fever) cases involve milder symptoms of the illness, including fever, headache, rash, general muscle aches and weakness, gastrointestinal symptoms or inflammation of the lymph nodes. Since the symptoms are not specific, only special laboratory tests can confirm a diagnosis of WNV. Neuroinvasive cases (WNV meningitis, WNV encephalitis, and

WNV acute flaccid paralysis) involve more extreme symptoms including severe headache, high fever, difficulty walking and/or talking, coma, and even death. All WNV cases, neuroinvasive and non-neuroinvasive, should be reported to the health department.

KDHE recommends Kansans take the following actions to protect themselves and family members:

- Use effective insect repellent with DEET or picaridin on skin
- Wear protective clothing when practical (long sleeves and pants)
- Remove standing water (such as in clogged gutters, discarded tires, or unused swimming pools)
- Use larvicide in water that cannot be removed
- Replace water in bird baths, pet bowls, and wading pools at least every three days
- Limit outdoor activities at dawn and dusk when mosquitoes are most active

A toll-free educational West Nile Virus Hotline is available. The number is 1-877-228-2287. KDHE also has a Web site at <http://www.westnileks.com> to provide information regarding the disease.

KDHE Division of Health

Flu Season Underway

The 2006–2007 pneumonia and influenza (P&I) season began in September. As of October 13, no one had died directly from influenza. However during that period 126 Kansas resident deaths were reported as the result of pneumonia and influenza-like illnesses. During the 2005-2006 season, 1,790 residents died from pneumonia and influenza like illnesses, and 21 of those deaths were directly from influenza.

Monitoring of P&I mortality runs through May, with the number of deaths peaking during the coldest months of the winter season.

KDHE urges Kansans to practice good hygiene and get a flu shot to minimize the spread of illness and reduce the chances of getting sick.

“Each year, up to 20 percent of the population gets the flu, and about 1,000 Kansans die from flu or its complications,” said Dr. Howard Rodenberg, state health officer and director of KDHE’s division of health. “You can pick up the flu virus from other people at school or work, the grocery store or at a sporting event – virtually anywhere. Now is the time to think about protecting yourself.”

Influenza is a contagious respiratory illness caused by a virus. Symptoms of the flu include: fever, headache, extreme tiredness, dry cough, and muscle aches. Complications can include pneumonia, ear and sinus infections, dehydration, and worsening of other chronic conditions.

Each year the virus mutates into various strains and a new vaccine is created to combat the strain that is likely to emerge as the most contagious. The vaccine prepared for the 2006-2007 season will include A/New Caledonia/20/1999 (H1N1)-like, A/Wisconsin/67/2005 (H3N2)-like, and B/Malaysia/2506/2004-like antigens. For the A/Wisconsin/67/2005 (H3N2)-like antigen, manufacturers may use the antigenically equivalent A/Hiroshima/52/2005 virus; for the B/Malaysia/2506/2004-like antigen, manufacturers may use the antigenically equivalent B/Ohio/1/2005.

KDHE Division of Health

News Notes

Pandemic Flu Forums Scheduled

The last of seven statewide public forums sponsored by the KDHE to discuss influenza, including pandemic influenza, avian flu and the state's pandemic preparedness will be held in Leavenworth on November 13.

Dr. Howard Rodenberg, KDHE Division of Health Director and state health officer; and Dr. Gail Hansen, KDHE State Epidemiologist, will discuss what to expect if avian and/or pandemic influenza appears in the U.S., ways to limit the spread of avian and/or pandemic influenza, and the Kansas Pandemic Influenza Preparedness and Response Plan.

In addition, Rodenberg and Hansen will discuss guidelines on seeking medical care if one experiences influenza symptoms, the importance of vaccinations, the products available for treatment (antivirals), and the differences between various types of influenza. The upcoming flu season will also be discussed. A question and answer session will follow each presentation.

The general public, including business owners, chambers of commerce, community organizations, and local school and government officials are encouraged to attend.

The Leavenworth forum will be November 13 at 6 p.m. – Riverview Community Center, 123 S. Esplanade, in Leavenworth.

KDHE Office of Communications

Health Care Costs Increase

Health care spending per privately insured person increased 7.4 percent in 2005, marking the third year that the cost trend hovered between seven and eight, percent following double-digit trends in 2001 and 2002. Data for the first quarter of 2006 suggest continued stability.

The trend for 2005 reflected increased growth in spending for hospital and physician care, offsetting a sharp drop in spending growth for prescription drugs. Hospital utilization trends accelerated, while price trends decelerated in 2005.

In contrast to stable spending trends in 2005, premium trends continued to decline in 2006, likely reflecting the lagged effects of earlier years' slowing in cost trends and perhaps signaling a turn in the insurance underwriting cycle.

*Health Affairs
Center for Studying Health System Change*

Uncompensated Care Costs Rise

Community hospitals' uncompensated-care costs rose 7.1% in 2005 to \$28.8 billion from \$26.9 billion in 2004, the American Hospital Association said. Meanwhile, Medicare and Medicaid shortfalls at community hospitals increased 14.5% to \$25.3 billion last year from \$22.1 billion in 2004, the AHA said.

Modern Healthcare's Daily Dose

The Office of Health Assessment (OHA) of the Kansas Department of Health and Environment's Center for Health and Environmental Statistics (CHES) produces *Kansas Health Statistics Report* to inform the public about availability and uses of health data. Material in this publication may be reproduced without permission; citation as to source, however, is appreciated. Send comments, questions, address changes and articles on health data intended for publication to: OHA, 1000 SW Jackson, Suite 130 Topeka, KS, 66612-1354, Kansas.Health.Statistics@kdhe.state.ks.us, or 785-296-8627. Roderick L. Bremby, Secretary KDHE; Howard Rodenberg, MD, MPH, State Health Officer and Director, Division of Health; Lorne A. Phillips, PhD, State Registrar and Director CHES; Elizabeth W. Saadi, PhD, Director, OHA; Greg Crawford, Editor.

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