Kansas Health Statistics Report

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Kansas: Our State of Health

(Editor's Note: State Health Officer and Director of the KDHE Division of Health Dr. Howard Rodenberg delivered this State of the State's Health Report to the Kansas Legislature in January 2006. His report is reprinted in this issue of the Kansas Health Statistics Report)

There is an advertisement on television that describes Kansas as a land without limits. As people focused on progress, all of us in the room today see unlimited opportunities to help Kansans reach their full potential. As State Health Officer, it's my honor to represent the over 146,000 health care professionals within our state committed to promoting health as a means towards this goal.

We live in a time where people and communities have more information than ever before about how to achieve and maintain optimal health. Conversely, we also have more opportunities to make choices that do not contribute to good health — the use of tobacco, the excess use of alcohol, inattention to the need for a healthy diet and physical activity, the choice to not use seat belts and motorcycle helmets, and the persistence of lifestyles that foster stress and anxiety. Those of us in leadership positions within the public health and health care community have the responsibility to encourage and empower our citizens to be healthy and achieve the highest quality of life.

So how do we evaluate the health status of Kansas? As you know, states are continually compared and contrasted with one another in nearly every conceivable way. This is also true in measurements of health status, and the reports would indicate that in most ways, Kansas is remarkably "average." In the minds of national policymakers, there is really not much worth noticing about the health status of the citizens of the Sunflower State.

EVERY DAY KANSANS EXPERIENCE:

108 live births
- 11 live births to teenagers
- 8 low birth weight births
- 1 stillbirth and 1 infant death

909 hospital discharges:
- 9 hip fractures in the elderly
- 14 heart attacks
- 35 discharges due to pneumonia
- 11 discharges for diabetics

65 deaths
- 16 due to heart disease
- 14 due to cancer
- 4 due to chronic lower respiratory disease
- 1 due to motor vehicle accidents
- 1 suicide

Figure 1

I'm not satisfied with the notion that Kansas is "average." While it's true that being average (what the statisticians call being at the median) means that half the states are doing worse than you, it also means that half the states are doing better. Kansas is a great place to live, work, raise a family, and care for our elders. It's my goal to insure that we work towards Kansas being a great place for health.

Kansas Health Snapshot

Allow me to start the discussion by giving you a "snapshot" of the health of Kansas. Basic demographics, those numbers that tell us who and what we are, come first. In 2004, there were 2,735,502 Kansans. Kansas is a diverse state, evenly divided between men and women; 16 percent of us are Hispanic, African-American, Native American, or Asian.

Our population curve encompasses two extremes. Kansas ranks 8th in the nation for percent of residents in the 18-24 year age group, and 9th in the nation for those over 85. Like many states, the Kansas population has its share of baby boomers, and the population as a whole is aging. Our per capita income in 2003 was close to $30,000, ranked 26th in the nation. Nearly 89 percent of us graduated from high school, and 31 percent hold a four-year college degree.

Approximately 70 percent of Kansans live in urban areas and 30 percent in rural communities; Kansans continue to leave these open spaces at a rate of three percent each year. These factors…a graying population, a growing multi-ethnic culture, and a significant but shrinking rural presence…are all factors which influence the health status of our state. These kinds of factors are described as "social determinants" of health, those demographic and cultural characteristics of our population that affect not only health status, but also use of the health care system.

In terms of health data, our first level of evaluation is with birth and death statistics. In 2004, there were over 39,000 live births in Kansas and nearly 24,000 deaths. The leading causes of death were heart disease, cancer, stroke, respiratory conditions and unintentional injuries. It's often interesting to think about what health events happen each day in Kansas, and we've included a summary in your handout to illustrate this point (Figure 1).

In public health and health care policy, looking at raw numbers is never enough. One of our tasks is to identify those opportunities to make the biggest difference in the lives of individuals and in the overall health of society. One of our tools is to review Years of Productive Life Lost, or YPLLs. These numbers represent the impact of disease or injury on young people and those actively contributing to the workforce (Figure 2).

In Kansas, the top three causes of YPLLs are cancer, heart disease, and unintentional injury. Even a superficial turn at these numbers demonstrates that simple measures such as decreasing tobacco consumption and enhancing seat belt use can have a major impact on the lives of Kansans.

How do our numbers stack up against national norms? Let's address some of the successes first. Overall, we have much to be proud of (Table 1). The 2005 Health Care State Rankings places Kansas as 15th in the nation in overall health status. Kansas is a national leader in ensuring that women receive early prenatal care, resulting in successful pregnancies and healthier babies. The success can be credited to physicians, nurses, local health departments, and hospitals throughout the state dedicated to serve this vital need.

Kansas is also a leader in the number of hospital beds per population, especially in rural areas. This statistic demonstrates our commitment to ensuring that medical care is available and convenient, and that we recognize that staying

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close to home has a healing value all its own. Kansans also know that health care coverage is important. Only eleven percent of Kansans have no private or public health insurance coverage, as compared with a national average of 15 percent. Our rate of uninsured children is half that of the nation as a whole.

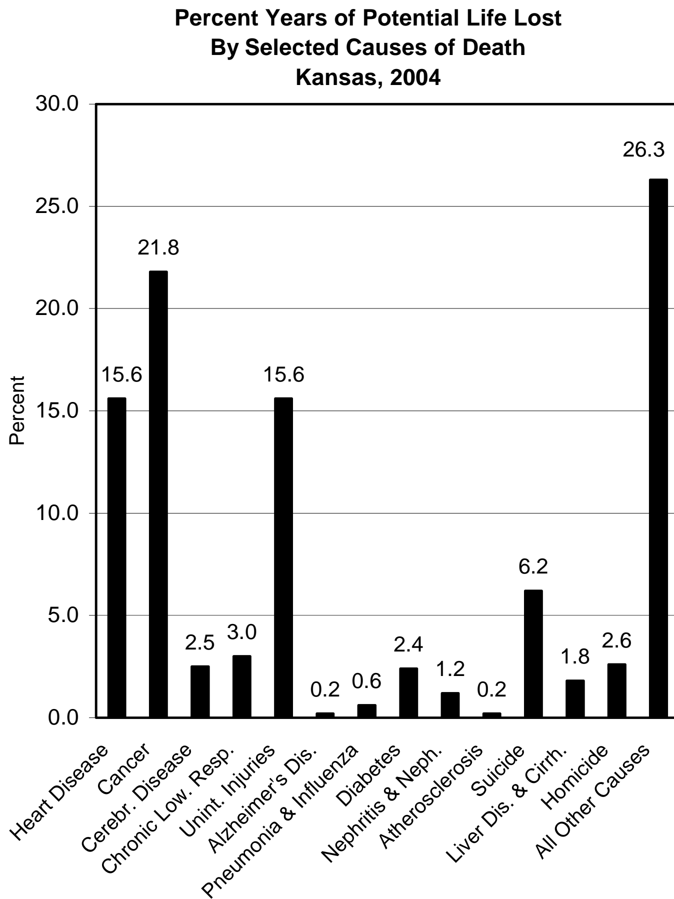

Figure 2

That being said, the prospect of even one person, and especially a child, being unable to get the health care they need because of a lack of resources is clearly one too many. Birth to five are the formative years where health setbacks can cause the greatest long-term problems and destroy what should be an exceptional future for a child in our state.

While we should all be proud of our successes and resolve to build upon them, comparison with national means also demonstrates areas that need work. In areas such as death from cancer, injury, and heart disease, our standing at or below the national average links with our known leading causes of years of productive life lost. Linking these two sets of information helps us to focus our efforts even more sharply on three major areas of work.

Tobacco Problems Remain

Tobacco use remains a significant problem in Kansas, and it is the leading cause of preventable death within the state. Despite educational efforts, smoking rates have been consistent in Kansas for several years. Twenty percent of Kansans continue to smoke cigarettes. Most concerning is that smokers who quit or die are being continually replaced by new ones.

We need to empower our citizens with more tools to achieve success in preventing tobacco use throughout the state. These efforts may encompass tools such as increased tobacco taxation, enforcement of the prohibition of sales to minors, and promoting clean indoor air. The health benefits of such efforts are real and unquestionable. A comprehensive program of tobacco use prevention will, over time, save 4,000 lives each year and up to $720 million dollars annually in smoking-related direct health care costs.

Table 1. National Indicators Kansas and U.S.

Indicator	National Statistic	Kansas Statistic	Rank in US	KS Strength	KS Weakness
Teenage birth rate	46.1	47.6	20		✔
% Mothers receiving prenatal care in 1st trimester	84.1	87.7	8	✔	
Percent of Community Hospitals in Rural Areas (2003)	44.2	79.9	10	✔	
Rate of Beds in Community Hospitals (per 100,000 population)	280	387	8	✔	
Cancer EDR (All Sites)	194.2	196.3	32		✔
Cerebrovascular Disease (Stroke) AADR	56.2	59.5	19		✔
Diabetes AADR	25.4	26.3	24		✔
Heart Disease AADR	240.8	220.6	28	✔	
Injury Death Rate AADR	54.9	58.2	23		✔
Motor Vehicle Death Rates AADR	15.7	20.3	17		✔
Suicide Deaths AADR	10.9	12.6	20		✔
Percent of Population Not Covered by Insurance	15.1	10.9	35	✔	
Percent of Children Not Covered by Insurance	11.4	6.4	44	✔	

EDR=Estimated Death Rate
AADR= Age-Adjusted Death Rate
CDR=Crude Death Rate
Source: Morgan Quitno Press

We've also learned that despite the image of the lean, weathered prairie farmer or cattle producer, Kansas ranks 8th in the nation in percent of persons who are overweight, and 23 percent of all Kansans are obese. Since 1992, our obesity rate has soared by 70%. We know that these numbers will continue to rise as long as over half of Kansans do not engage in moderate physical activity for 30 minutes daily, and 80 percent of adults fail to eat at least five servings of fruits and vegetables each day.

Obesity Rate Soars

Obesity contributes to heart disease, cancer, diabetes, and disability, and it trails only tobacco use as a cause of preventable death. Estimates indicate that over 3,700 of us will die early deaths each year from the complications of being overweight or obese, and that over $650 million dollars will be incurred annually in Kansas from obesity-related medical expenditures.

These costs, both human and financial, simply cannot be ignored. They will continue to plague us in the decades ahead if we don't act now with programs and policies designed to promote healthy nutritional habits, encourage physical activity and insure that our schools, our homes, and our communities establish these habits for life in our kids.

Injury Morbidity and Mortality

An area of personal concern to me, not only as the State Health Officer – but also as an emergency physician, is our rate of accidental injury and death. In 2005, the National Highway and Traffic Safety Administration (NHTSA) reported that Kansas ranked 45th in the nation for seatbelt usage. Only 67 percent of our citizens regularly buckle up, compared with 82 percent of motorists nationwide. Our failure to properly use seat belts means that Kansas ranks in the top 20 for motor vehicle death rates, exceeding the national average by over 30 percent.

Every year 450 Kansans die on our roads. Motor vehicle crashes are the leading cause of death for all Kansans 34 and younger, and death rates are highest for those between 15 and 24. A primary seat belt law in Kansas can raise seat belt usage and save 150 lives and $450 million dollars in health care costs each year. As one who spent the better part of a career treating the victims of motor vehicle crashes and tending to their families, these fully preventable deaths that take the youngest and most promising people from our lives are totally unacceptable.

Immunization Rates

When people look at those health measures that have been most effective within the last 200 years, they are often surprised to find that the top items include the advent of immunizations and the provision of clean and fluoridated water. Because we know so much about the benefits of vaccination, it is concerning that here again Kansas shows room for improvement.

In 2003, only 63 percent of our children had received the minimum recommended vaccinations by age two. At that time, our Governor convened a Blue Ribbon Task Force to evaluate the immunization process in Kansas. KDHE has been implementing the short-term recommendations identified in the Task Force report, moving forward with innovative programs such as developing a statewide electronic immunization registry, linking immunization to WIC services, and advancing the recommended schedule of vaccination.

These efforts have been successful even at an early stage. Our immunization rate for two year olds in 2004 was 77 percent, and over 10,000 more Kansas children had been vaccinated between 2003 and 2004. We are also proud to note that by school entry, over 95 percent of Kansas kids are "up-to-date" on their required shots. KDHE, the Kansas Health Institute (KHI), and the Kansas Health Foundation (KHF) are now engaged in a joint effort to improve these numbers even more by reviewing those processes and structures within Kansas that may assist or be barriers to us in achieving our goals.

Health Disparities

There are two pressing issues I want to bring to your attention which are not well reflected by national comparisons. An emerging issue within Kansas is that of health disparities. Put simply, health disparities are those differences in health status that exist between groups distinguished by race, ethnicity, geography, or socioeconomic status. Despite what many outsiders may think, all of us here today recognize that Kansas is becoming a diverse society. The multiple benefits of diversity also come with some challenges.

For example, we know that African-American infants die at rate more than twice that of white infants. Over 18 percent of Hispanic mothers do not receive adequate prenatal care, compared to six percent of white mothers. Native Americans have a 75 percent greater chance of dying from complications of diabetes than the rest of the population. Youth in rural areas use tobacco at twice the rate of their urban peers and are more likely to use alcohol while driving.

The magnitude of these disparities is such that, taken as a whole, the reduction of health disparities alone would allow Kansas to reach the United States Centers for Disease Control and Prevention Healthy People 2010 goals. It is our challenge to close this gap and to identify those cultural and systemic issues we must address so that every Kansan can enjoy good health. Key to this effort is an honest evaluation of cultural competency, the ability of our healthcare system to respond to the unique values and beliefs of every Kansan. At KDHE, we are moving to establish an Office of Minority Health to focus our efforts on addressing these issues and to reinforce the multiple efforts in which we're currently engaged.

Health Preparedness

The second issue I want to mention is public health emergency preparedness and specifically the prospect of influenza. Even during this year's "normal" flu season, we've seen challenges in equitable vaccine distribution across the state Many of these challenges are federal, and beyond our control.

I am gratified, however, to report to you that local health departments have done a yeoman's job in managing their supplies, and at KDHE, we've given all doses of flu vaccine we received to local health departments, state universities, and other state institutions. In the context of pandemic influenza, KDHE has issued a plan encompassing surveillance, emergency response, and communications aspects in order to help our state prepare.

We have a working group at the state level with invitations extended to representatives of the health care, business, education, law enforcement, agricultural, and emergency management communities. We are correlating our efforts with those of our federal partners to ensure coordination and cooperation.

During November and December, our State Epidemiologist, Dr. Gail Hansen and I toured 13 cities across the state presenting public forums on pandemic influenza. These forums have been focused not only on empowering Kansans to better care for themselves and their communities, but also on promoting multidisciplinary local planning efforts. We'll also be speaking with legislative committees about pandemic flu so we can all plan ahead using the same set of information. While we cannot prevent the possibility of pandemic influenza reaching our state, we can work together to lessen its impact upon our families and friends.

Where Do We Go?

In the last few minutes, I've tried to provide you with a "snapshot" of the health status of Kansas. Where do we go from here?

I see three avenues in which we as a state must move ahead. The first is in the dissemination of information just as we've done here today. Communities need information on their health status in order to prioritize local efforts and monitor their effectiveness.

We have already initiated a project at KDHE to make data such as I've shared today more accessible through our Web site, and are working to expand our information sharing even more as we acquire new data sets and new technologies for sharing. As another part of this effort, each legislator here today will receive a health profile of their own Senate or House district in comparison with state norms. The information has also been posted on our Web site. We encourage you to use this data to identify local health concerns, to share the information with your constituents, and to use this knowledge to further local efforts to promote good health.

The second action item is to take a hard look at the wide range of policy and program options available to us as we collectively work to improve the health of our state. I have previously testified to legislative interim and oversight committees that I believe one of the critical roles of KDHE and the public health community is to bring best practices in the realm of prevention to the attention of policymakers.

These may be primary preventive action designed to halt disease or injury before it happens, such as measures to increase seat belt use and limit tobacco consumption; or they may be secondary preventive measures such as promoting disease management programs and community-based elder care. As we look at our options, we should not be bound by a limited or restrictive definition of what constitutes public health programs and what does not.

We must be ready and willing to explore all avenues to improve health, be they educational, fiscal, legislative, regulatory, or environmental. And while there are many issues within health and health care that call for attention, the bottom line for all of them is the health status of our state. It's our task to ensure that

no matter what subject or nature of the policy change, we develop some measure of the impact upon health status to help judge the ultimate efficacy of these plans.

The last is to set high goals for ourselves, and to hold ourselves accountable to those goals. One of our major accomplishments this year has been the Healthy Kansans 2010 Project (Figures 3-9). The process was funded by the Kansas Health Foundation, and we're grateful to acknowledge their support.

This Healthy Kansans 2010 effort involved a series of 23 meetings involving 200 representatives from over 100 different organizations. The process began by reviewing the Kansas profile of the 10 Leading Health Indicators as identified by the CDC Healthy People 2010 Objectives for the Nation.

These ten indicators include rates of physical activity, percent of persons overweight and obese, and rates of use of tobacco and alcohol. They focus on responsible sexual behavior, the mental health of the population, and rates of death from injury and violence. They reflect environmental quality, immunization rates, and the individual's access to medical care. You will have noticed that these indicators do not reflect specific diseases, but rather more specific behaviors and societal structures. The underlying concept is that by changing behavior and enhancing access to care, we can have a significant impact on the preventable causes of death and disability.

The project began with an evaluation of the ten leading health indicators and the status of Kansas relative to these goals. The following pages describe the relationship between the current status of Kansas and the Healthy People 2010 goals. In virtually all cases, it's clear that there is work to be done. (The full table of indicators, Kansas measures, and data references is at http://www.kdheks.gov/ches/khsnews/khs28.pdf).

HK 2010: Physical Activity

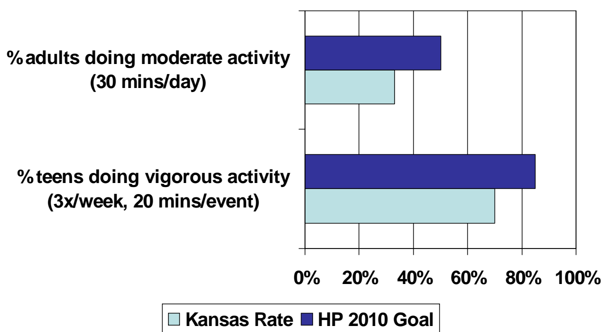

Figure 3

To reach these goals, it was important to focus our efforts. Cross-cutting themes which impacted the majority of these targets were considered targets of opportunity, areas in which a dedicated effort could show real benefit to the health of our state. These areas were noted as risk identification and disease prevention in women and children, interventions to address the social determinants of health, and the elimination of health disparities between racial and ethnic groups.

HK 2010: Overweight and Obesity

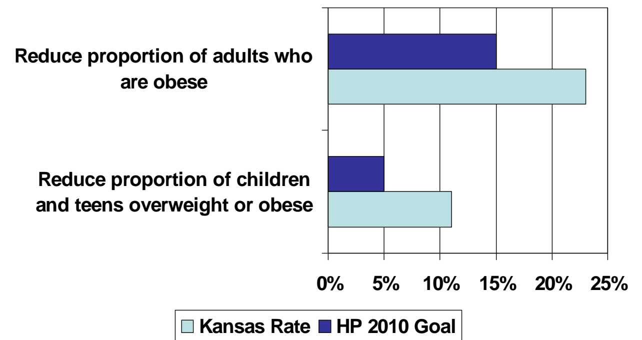

Figure 4

HK 2010: Tobacco Use

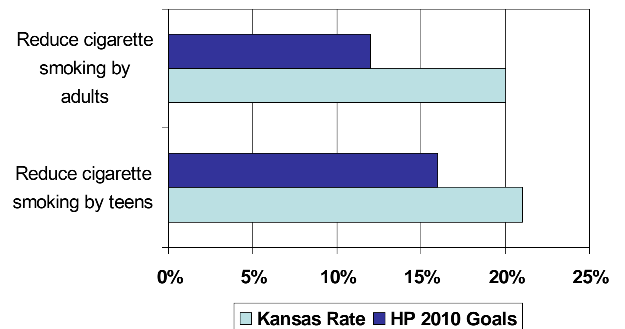

Figure 5

HK 2010: Injury and Violence

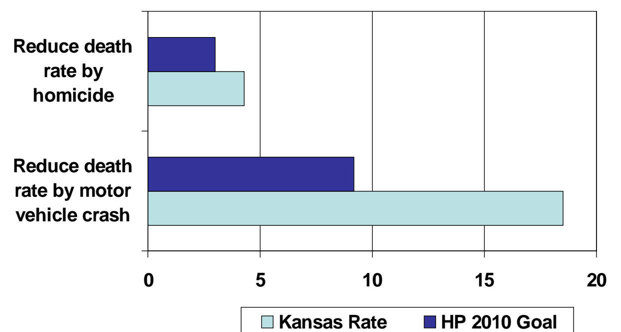

Figure 6

Workgroups have taken these themes and developed sets of action steps to enhance our efforts in these areas. Tobacco control, enhancing healthcare provider cultural competency and further characterization of health disparities were identified as the realms of activity which could have the most impact on the areas of need.

HK 2010: Access to Care

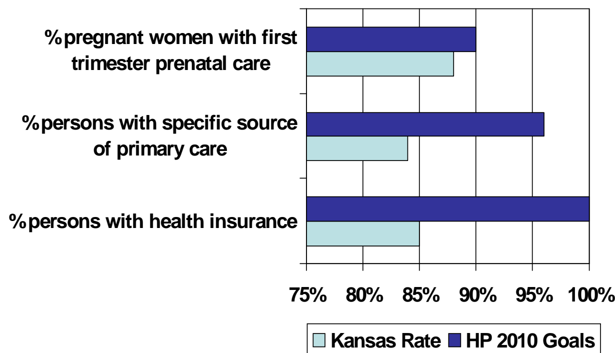

Figure 7

The counsel is wide in scope and takes full advantage of the range of public health interventions available for use. In the realm of tobacco cessation, the recommendations encompass agency, organization, local, and state tobacco control polices, funding for tobacco control efforts, and clean indoor air legislation.

HK 2010: Immunizations

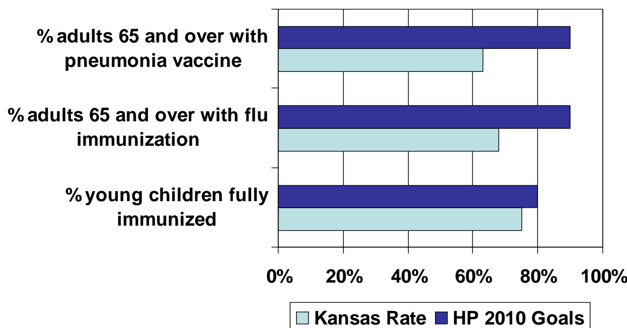

Figure 8

HK 2010: Substance Abuse

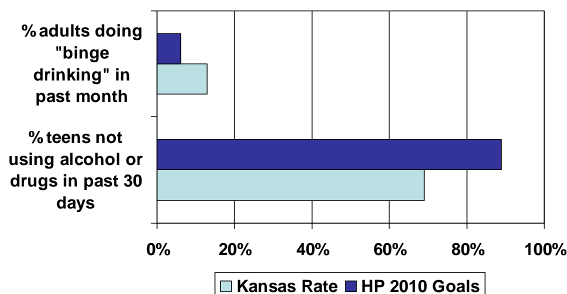

Figure 9

Comprehensive data collection systems and engaging under-represented communities in the collection process are tools used to further examine and categorize health disparities, while the establishment of an information clearinghouse and development of training courses help us to address issues of cultural competency.

As stewards of public resources and the public trust, we must ensure that we can measure the effect of these interventions in an objective fashion. While the natural history of disease means that the final impact of an action on our overall health may not be known for years…if nothing else, public health tends to be a patient science…we must identify markers. Markers are those intermediate steps that we know from experience correlate with long-term outcomes.

The markers we use will also vary by the nature of the larger issue. In the realm of tobacco control, markers of progress may include the passage of clean indoor air policies at the state and local level, compliance with laws on tobacco sales to minors, and additional tobacco taxation to pay for the health care costs of smoking. We may judge our movement towards a better understanding of health disparities by ensuring our data tools are able to capture the information we need to make informed decisions about the health of our state.

Cultural competency may be furthered through noting the number of people participating in training courses and in promoting the linguistic and cultural diversity of the public health workforce to best reflect those people we serve. We are currently developing concrete action plans to lead us towards these goals and look forward to presenting them for your consideration.

Healthy Kansas 2010 is a critical piece of the new KDHE Division of Health strategic plan. Our balanced scorecard model is based on identifying high-priority outcomes, finding ways to measure them, and formulating means to exert an impact upon those aims. Some of these goals are external and many more internal; but all are geared towards improving the health of Kansans.

I started this talk with the notion that Kansas is, in many ways, acutely average. In the last few minutes, I hope I've convinced you that average is simply not good enough. I mentioned the advertisements running on television that promote Kansas as a place of unlimited spaces. I believe that there is unlimited opportunity for the health of Kansas to improve. I also believe that the only place for Kansas as we measure the health status of our nation is in first. I bring you the assurance that all of us at KDHE, and all the health care professionals that we are privileged to call our partners, are fully engaged in making this dream a reality. We ask you to join us in this work.

Thank you for your time and your interest in this topic. I'd be delighted to entertain any questions you might have. Thank you once again.

Howard Rodenberg, MD, MPH
Director, KDHE Division of Health and State Health Officer

Nosocomial Infection Related Mortality

Nosocomial or hospital-acquired infections are considered an emerging infectious disease. Based on an assumed nosocomial infection rate of five percent, of which 10 percent are bloodstream infections, and an attributable mortality rate of 15 percent, bloodstream infections would represent the eighth leading cause of death in the U.S. (1). While vital statistics are valuable in supporting efforts to reduce chronic disease, infections, and unintentional injuries, the summaries provide little insight into how hospital infections contributed to those deaths.

Nosocomial infections are reported on the death certificate. The infections, once assigned a code under the International Classification of Diseases, 10th revision (Table 2), become contributing factors to the death.

Table 2. ICD 10 Codes for Nosocomial Infections

ICD 10 Code	Description
T80.2	Infections following infusion, transfusion and therapeutic injection
T81.4	Infection following a procedure, not elsewhere classified
T82.6	Infection and inflammatory reaction due to cardiac valve prosthesis
T82.7	Infection and inflammatory reaction due to other cardiac and vascular devices, implants, and grafts
T83.5	Infection and inflammatory reaction due to prosthetic device, implant, and graft in urinary system
T83.6	Infection and inflammatory reaction due to prosthetic device, implant, and graft in genital tract
T84.5	Infection and inflammatory reaction due to internal joint prosthesis
T84.6	Infection and inflammatory reaction due to internal fixation device (any site)
T84.7	Infection and inflammatory reaction due to other internal orthopaedic prosthetic devices, implants, and grafts
T85.7	Infection and inflammatory reaction due to other internal prosthetic devices, implants, and grafts
T86.0	Bone-marrow transplant rejection

An examination of Kansas resident deaths between 1999 and 2004 identified 252 deaths in which one or more nosocomial infections were a contributing factor in the death (Table 3). Males represented 51.2 percent of the deaths. Almost 95 percent (94.8) of the deaths occurred to persons of the white race; just two percent were Hispanic. The manner of death was natural for 97.2 percent of the deaths. The majority of deaths occurred to persons over the age of 74 (Table 4).

Table 3.Nosocomial Infection Related Deaths by Year and Sex, 1999-2004

Year	Female	Male	Total
1999	18	13	31
2000	19	26	45
2001	15	22	37
2002	20	23	43
2003	24	23	47
2004	27	22	49
Total	123	129	252

Table 4. Nosocomial Infection Related Deaths by Age-Group, 1999-2004

Age-Group	N	%
0-44 Years	21	8.3
45-74 Years	99	39.3
75-84 Years	84	33.4
85 Years Plus	48	19.0
Total	252	100.0

Since nosocomial infections can't be listed as the underlying cause of death in ICD 10, another category is listed as the underlying cause of the deaths. The most frequently reported underlying cause of death was cardiovascular diseases (I00-I78) (Table 6).

Table 5. Nosocomial Infection Related Deaths by Underlying Cause of Death, 1999-2004

Underlying Cause Group	N	%
Cardiovascular Diseases	67	26.6
Non-Motor Vehicle Crash Unintentional Injuries	41	16.3
Cancers	27	10.7
Kidney Diseases	16	6.3
Diabetes	14	5.6
All Other Causes	87	34.5
Total	252	100.0

The most frequently reported nosocomial infection was T81.4, infection following a procedure, not elsewhere classified, 140; followed by T82.7, infection and inflammatory reaction due to other cardiac and vascular devices, implants, and grafts, 50; T83.5, infection and inflammatory reaction due to device, implant, and graft in urinary system, 24; and T84.5, infection and inflammatory reaction due to internal joint prosthesis, 21. Nosocomial infections were reported a total of 254 times in the 252 deaths.

Studies have shown that effective measures to reduce and prevent nosocomial infections exist. The Centers for Disease Control and Prevention supports these efforts through the publication of guidelines to prevent these infections (2).

Greg Crawford
Vital Statistics Data Analysis

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Psychostimulant Drug Use Hospitalizations in Kansas Rising

In recent months, America's war on drugs has seemingly highlighted the impact of methamphetamine (meth) abuse on hospital emergency room admissions (1). Meth, like its sister drug, amphetamine, is known as a psychostimulant drug.

The source for much of the discussion is a report issued in January 2006 by the National Association of Counties. According to the report, meth "is the top illicit drug involved in presentations at [responding hospitals]" (2). The report's findings are the result of surveys completed by representatives of 200 hospital emergency rooms in 39 states.

This brief report will summarize the data on drug related hospital admissions in Kansas for the years 1995 – 2004. The data, which are made available to the Kansas Department of Health and Environment by the Kansas Hospital Association, consist of inpatient admissions in about 130 Kansas community hospitals; emergency room admissions are not available for this report.

Based only on primary diagnoses, 20,061 inpatient hospitalizations for drug-related diagnoses occurred during the 10-year period (Table 6).

Table 6 - Primary Hospital Inpatient Diagnoses Involving Drugs 1995 – 2004

Diagnostic Group	Count	Percent
Alcohol	7,526	37.5
Other, Mixed, Or Unspecified	6,011	30.0
Antidepressants	2,751	13.7
Cocaine	1,659	8.3
Opioids	934	4.7
Amphetamines	832	4.2
Hallucinogens	339	1.7
Tobacco Use Disorder	9	0.0
Total	20,061	100.0

Admissions due to disorders relating to alcohol use accounted for over one third of all admissions. A large group not easily classifiable made up another 30 percent. Amphetamine abuse represented only 4.2 percent of admissions.

The number of admissions increases greatly when the secondary diagnoses are included (Table 7). There are nine levels of secondary diagnoses in the source data, including E-codes.

Tobacco and alcohol related disorders are associated with a very large proportion of all drug related admissions. The largest percentage increase over the 10-year period belongs to the group

Table 7 – All Hospital Inpatient Diagnoses Involving Drugs by Year, 1995 – 2004

Diagnosis Groups	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	% Change 1995-2004
Opioids	246	259	287	315	375	454	654	758	1,024	1,123	357%
Amphetamines	307	278	386	335	359	504	559	618	661	825	169%
Tobacco Use Disorders	10,864	13,768	15,907	16,887	17,893	20,278	24,663	27,120	28,237	27,689	155%
Other, Mixed, or Un-specified	2,506	2,301	2,491	2,403	2,751	3,087	3,341	3,992	4,247	4,486	79%
Hallucinogens	1,303	1,421	1,377	1,346	1,505	1,767	1,863	1,995	2,139	2,269	74%
Alcohol	4,040	4,155	3,972	4,263	4,635	5,426	6,198	6,724	6,670	6,755	67%
Cocaine	1,201	1,257	977	1,137	1,355	1,359	1,421	1,674	1,799	1,820	52%
Antidepressants	472	492	486	438	401	494	593	559	565	640	36%
Total	20,939	23,931	25,883	27,124	29,274	33,369	39,292	43,440	45,342	45,607	118%

Drug Related Hospital Admissions: 1995 and 2004

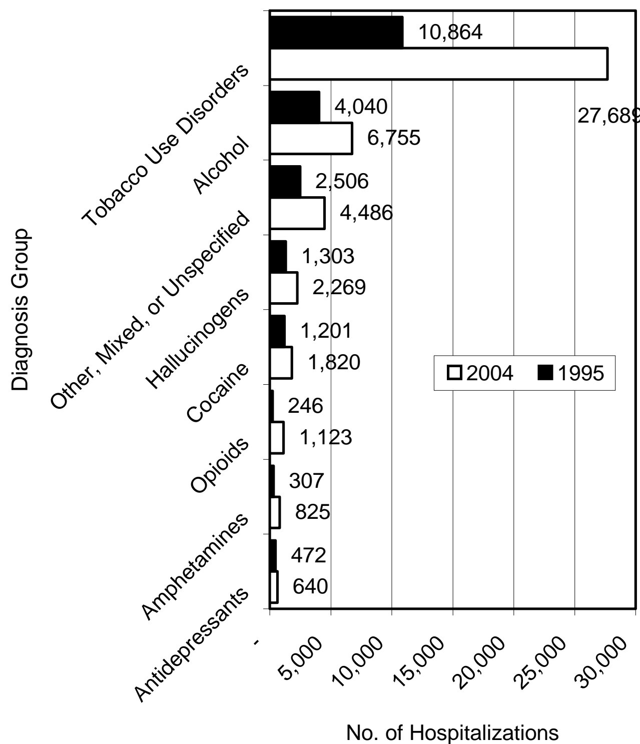

Figure 10

of drugs known as opioids, e.g., morphine, codeine, heroin, and oxycodone. The amphetamine group, which also includes methamphetamine, has increased by 169 percent. This is greater than the 118 percent increase for all drug related admissions. Amphetamines, however, remain a small part of the overall drug picture. The category named "Other, Mixed, or Unspecified" includes admissions that were coded as "Other", "Mixed" (meaning two or more drugs used in combination), or "Unspecified", and also includes admissions that have been grouped as "Other" because of small numbers of such records.

Hospital admissions for all drug categories increased between 1995 and 2004 (Figure 10). Although admissions related to use of psychostimulant drugs are evidently increasing, it appears that the real burden on hospitals from drug related incidents is primarily the result of behavior driven by tobacco, alcohol, and "Other" drugs.

Emergency room admissions, many of which do not result in hospital admissions, might be more reflective of the extent to which psychostimulant drug abuse is affecting the ability of emergency room professionals to provide adequate care.

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Health Care Data Section

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Health Disparities Conference Planned

Governor Kathleen Sebelius will provide the opening address to the 2006 Health Disparities Conference: Healthy Cultures, Healthy Kansas, sponsored for the second straight year by the Kansas Department of Health and Environment, on April 14 in Topeka. The one-day conference will be at the Maner Conference Center of the Capitol Plaza Hotel in Topeka.

Dr. David R. Williams, a nationally recognized author and researcher on social influences on health, will make a return trip to Kansas as the conference's keynote presenter. Williams, a University of Michigan Professor, is a nationally recognized author and researcher on social influences on health and is centrally interested in the trends and determinants of socioeconomic and racial differences in mental and physical health.

This year's conference will recognize a Kansan for his or her work as a community champion for the efforts to improve the public health of racial and ethnic populations across the state. Also, the conference will host a *'Taste of Cultures'* Legislative and Constituent Networking Reception on Thursday, April 13 from 6:30 – 9 p.m. as part of its conference early registration period.

Displays, presentations, networking with friends and colleagues, and making new connections are included on the agenda for the one-day conference. Health professionals and community champions from across Kansas and the Midwest will share best practices through seminars, presentations and displays to learn about new strategies and resources to improve the health of diverse racial and ethnic populations across the state.

Registration and conference materials for KDHE staff are available on the Web along with display booth exhibitor information, according to Sharon Goolsby, program coordinator for the Office of Minority Health. KDHE programs supporting staff attendance or booth displays can pay registration/exhibit fees through intra-agency vouchers.

For more conference information, e-mail: minority-health@kdhe.state.ks.us or go to http://www.minorityhealthks.org.

Sharon Goolsby
KDHE Office of Minority Health

2006 Governor's Public Health Conference

The 2006 Governor's Public Health Conference will be held April 11, 12, and 13, at the Hyatt Regency Hotel in Wichita, Kansas. This conference will focus on partnering and taking steps together to make our communities in Kansas healthier places to live and grow.

Previous spring conferences (MCH Conference, KPHA Conference, and the Public Health Nursing Conference) are combining to decrease participant time away from work, increase the variety of offerings, and create an atmosphere where people link with others to increase professional competency and reach Healthy People 2010 goals for Kansas. The 2006 Conference theme is "Public Health in Kansas - Taking Steps Together."

The goals of the conference are:

- Share best practices in public health;
- Promote partnerships at the local, regional, state, and national levels;
- Increase effectiveness of public health leadership and management roles;
- Increase public health workforce competency; and
- Discuss strategies to eliminate health disparities.

Thirty-five breakout sessions will be presented over the first day and a half covering Environmental, Public Health, Preparedness, Leadership, and Maternal Child Health topics. The last half of the conference will focus specifically on Maternal Child Health topics and training.

Participants can attend the whole conference or the half they are specifically interested in. Registration for the conference will be available around the middle of March on KS-TRAIN at: http://ks.train.org. For further information, contact: Julie Oler-Manske, jolerman@kumc.edu, (316) 293-2626, or Deborah Fromer, dfromer@kumc.edu, (316) 293-2627.

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Healthy People/Healthy Kansans 2010 – 10 Leading Health Indicators

Objective	Kansas Rate	HP2010 Goal
Physical Activity		
Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardio-respiratory fitness 3 or more days per week for 20 or more minutes per occasion.	70% (2005 KS Youth Risk Behavior Surveillance System, grades 9-12)	85% (grades 9-12)
Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day.	33% (2003 KS BRFSS)	50%
Overweight and Obesity		
Reduce the proportion of children and adolescents who are overweight or obese.	11% (ages 12-18, 2002 KS Youth Tobacco Survey)	5% (ages 12-19)
Reduce the proportion of adults who are obese.	23% (2004 KS BRFSS)	15%
Tobacco Use		
Reduce cigarette smoking by adolescents.	21% (2005 KS Youth Risk Behavior Surveillance Survey, grades 9-12)	16% (grades 9-12)
Reduce cigarette smoking by adults.	20% (2004 KS BRFSS)	12%
Substance Abuse		
Healthy People: Increase the proportion of adolescents *not* using alcohol or any illicit drugs during the past 30 days.	69% of 6th, 8th, 10th, and 12th graders reported *not* using alcohol at least once in the past 30 days 91% of 6th, 8th, 10th, and 12th graders reported *not* using marijuana at least once in the past 30 days (2005 Kansas Communities That Care Survey – Youth Survey)	89%
Reduce the proportion of adults engaging in binge drinking of alcoholic beverages during the past month.	13% (2004 KS BRFSS)	6%
Responsible Sexual Behavior		
Increase the proportion of adolescents who abstain from sexual intercourse.	55% (Abstinence only - 2005 KS Youth Risk Behavior Surveillance System, grades 9-12)	95% (Includes abstinence or condom use if sexually active)

Objective	Kansas Rate	HP2010 Goal
Mental Health		
Increase the proportion of adults with recognized depression who receive treatment.	No Kansas data available that is directly comparable to HP2010 target.	50%
Injury and Violence		
Reduce deaths caused by motor vehicle crashes.	18.5 deaths per 100,000 population (2004 Vital Statistics, KDHE)	9.2 deaths per 100,000 population
Reduce homicides.	4.3 homicides per 100,000 population (2004 KS Vital Statistics)	3.0 homicides per 100,000 population
Environmental Quality		
Reduce the proportion of persons exposed to air that does not meet the U.S. Environmental Protection Agency's health-based standards for ozone.	0% (EPA Aerometric Information Retrieval System)	0%
Immunization		
HP2010 Objective: Increase the proportion of young children who are fully immunized (4:3:1:3:3 series)	75% (4:3:1:3:3 series - 2004 National Immunization Survey)	80% (4:3:1:3:3 series)
Increase the proportion of noninstitutionalized adults aged 65 years and older who are vaccinated annually against influenza. Increase the proportion of adults aged 65 years and older ever vaccinated against pneumococcal disease.	68% (2004 KS BRFSS) 63% (2004 KS BRFSS)	90% 90%
Access to Health Care		
Increase the proportion of persons with health insurance.	85% (2004 KS BRFSS)	100%
Increase the proportion of persons who have a specific source of ongoing primary care.	84% (2004 KS BRFSS)	96%
Increase the proportion of pregnant women who begin prenatal care in the first trimester of pregnancy.	88% (2003 Vital Statistics, KDHE)	90%

Source: Division of Health, Kansas Department of Health and Environment