Kansas Health Statistics Report

Kansas Department of Health and Environment – Division of Health
Center for Health and Environmental Statistics – No 36 – February 2008

Status of Depression among Kansas Adults

Mental health plays a vital role in a person's well-being, family and interpersonal relationships, and a person's involvement in society [1]. Depression is one of the leading mental health disorders [2]. It affects on average about 20.9 million (9.6%) of the adults, ages 18 years and older in the United States [3]. Types of depression include major depressive disorder, minor depression, dysthymia, and bipolar disorder [4].

The purpose of this article is to describe the prevalence of depression by its severity status and to report the prevalence of current depression as it relates to demographics, health behaviors, chronic diseases, access to care and disability status among adults in Kansas.

Methods

The Kansas Behavioral Risk Factor Surveillance System (BRFSS) Survey is an ongoing population-based telephone survey of non-institutionalized adults ages 18 years and older. The 2006 Survey included a module on depression and anxiety. The module included eight questions that asked respondents about their mood status and depressive symptoms. These questions were adapted and modified from the Patient Health Questionnaire (PHQ) Version 9 [2, 5] and include eight of the nine criteria for the diagnosis of depression by levels of severity (referred to as PHQ-8). PHQ-9 is a tool derived from Primary Care Evaluation of Mental Disorders (PRIME-MD) to provide assistance to general practitioners in the diagnosis and evaluation of psychiatric disorders. In the mid-1990s, Drs. Robert Spitzer and Kurt Kroenke and colleagues at Columbia University, in collaboration with researchers at the Regenstrief Institute at Indiana University, developed PRIMEMD. The questionnaire includes items corresponding to each of the nine depression criteria listed in the Diagnostic and Statistical Manual disorders, Fourth Edition Text Revision (DSM-IV-TR), and scores range from 0 to 27. Cut-points of 5, 10, 15 and 20 represent the threshold for mild, moderate, moderately severe, and severe depression. The PHQ-9 is posted online at: http://www.pfizer.com/phq-9/. The Kansas BRFSS data for the eight questions of PHQ-8 were analyzed using the severity score methodology described by the authors of PHQ-9 (available at: http://www.depressionprimarycare.org/clinicians/toolkits/materials/forms/phq9/severity_scoring/).

These eight questions asked from 4,201 BRFSS respondents about their interest or pleasure in doing things, if they felt depressed or hopeless, had trouble falling asleep or staying asleep or sleeping too much, felt tired or had little energy, had poor appetite or ate too much, felt bad about themselves or were a failure or let down for themselves or let the family down, had trouble concentrating on things and moved so slowly that other people have noted or were fidgety or restless and moved around a lot more than usual.

The respondents were asked for each of the eight questions whether, during the previous two weeks how many days they had symptoms. A depression severity scale was created by converting the number of days in response to each of the eight questions into points (Table 1).

Table 1. Depression Severity Scale

Number of days had symptoms	Points
0-1	0
2-6	1
7-11	2
12-14	3

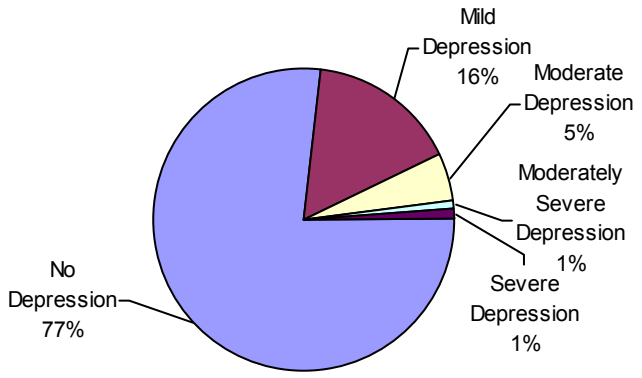
The number of points was totaled across the eight questions in order to determine the depressive symptoms' severity score. No depression was determined if the total points were 0-4, mild depression was determined if the total points across the eight questions was 5-9, moderate depression was determined if the total score was 10-14 points, moderately severe depression was determined if the total score was 15-19 points and severe depression was determined if the total score across eight questions was 20 or more points. If any of the eight questions were missing, a score was not calculated. The depression severity score was calculated for 3,797 respondents who responded to all eight questions. (Table 2)

Table 2. Depression status by depressive symptoms severity score

Points	Depression status
0-4	No depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20 +	Severe depression

The depression severity scale that was created to determine the severity of depression was dichotomized into total score of < 10 or ≥ 10 points. Current depression was defined as a score of ≥ 10 points on the depressive symptoms severity score.

Figure 1. Severity Status of Depression Among Adults in Kansas Based on PHQ-8 Questionnaire and Severity Score



Results and Discussion

About 1 in 4 (23%) respondents received a score showing some level of depression. About 1 in 6 (16%) adults had mild depression and about 5 percent of adults had moderate depression, whereas 2 percent of respondents had moderately severe or severe depression (Figure 1).

About one in fourteen (6.9% [95% CI: 5.8%-8.0%]) adults age 18 years and older had current depression. This accounts for an estimated 143,000 adult Kansans who had current depression.

About one in nine females were currently

Inside

depressed as compared to one in 20 males. The prevalence of current depression was higher among adults who had lower annual household income (< $15,000) and in adults who were unable to work as compared to adults with higher annual household income (>= $50,000) and were employed. The prevalence of current depression was also high among adults who were divorced or separated as compared to adults who were married. The prevalence of current depression was higher among adults who had less than high school education or were high school graduates as compared to adults who were college graduates (Table 3).

Table 3. Prevalence of current depression among adults age 18 years and older by selected characteristics, Kansas 2006

Characteristic	Prevalence (%)	95% Confidence Interval
Gender		
Male	4.9	3.2-6.5
Female	8.8	7.3-10.3
Education		
Less than high school	12.3	5.4-19.2
High school graduate or G.E.D	8.4	6.3-10.6
Some college	7.1	5.0-9.2
College graduate	4.2	3.1-5.3
Annual household income		
< $ 15,000	20.2	14.0-26.4
$15,000 - $24,999	10.7	7.4-13.9
$25,000 - $34,999	6.3	3.9-8.8
$35,000 - $49,999	8.9	5.8-12.1
>= $50,000	3.0	2.1-4.0
Employment status		
Employed for wages / Self-employed	5.4	4.2-6.7
Out of work (unemployed)	8.1	3.2-13.0
Homemaker / Student	11.5	6.4-16.7
Retired	4.3	2.9-5.7
Unable to work	31.1	22.3-40.0
Marital status		
Married / Member of Unmarried Couple	5.2	4.1-6.3
Divorced / Separated	13.2	9.9-16.6
Widowed	9.0	5.9-12.1
Smoking status		
Current smoker	13.4	9.8-17.1
Former smoker	5.6	3.7-7.4
Never smoker	5.1	3.9-6.4
Exercise		
Yes	5.7	4.4-7.0
No	11.1	8.8-13.4
Current asthma		
Yes	12.8	9.0-16.6
No	6.3	5.1-7.4
Stroke		
Yes	18.9	11.1-26.6
No	6.6	5.5-7.7
Health care coverage		
Yes	5.6	4.7-6.6
No	14.8	9.4-20.2
Self-rated health		
Fair or poor	20.2	16.2-24.2
Good or Excellent	4.9	3.8-6.0
Could not see doctor because of cost		
Yes	24.1	17.9-30.3
No	4.8	3.8-5.6
Disability Status		
Living with disability	18.5	15.3-21.7
Living without disability	4.0	2.9-5.1

Current depression was also high among current cigarette smokers as compared to nonsmokers. The prevalence of current depression was higher among adults who did not participate in any physical activity or exercise other than their regular job as compared to adults who participated in any physical activity or exercise.

Current depression was also high among adults with current asthma or with stroke as compared to adults without current asthma or stroke. A higher prevalence of current depression was seen among adults without health care coverage as compared to adults who had health care coverage. One in five adults who rated their health as fair or poor had current depression as compared to one in 25 who rated their health as excellent, very good or good. One in four adults who needed to see a doctor in the past 12 months but could not because of the cost had current depression. Current depression was also higher among adults living with disability as compared to adults living without disability.

Conclusion

These data provided information on the burden of depression and its relationship to demographic, health behaviors, chronic diseases, access to care and disability status among adults in Kansas. Assessing the burden of depression is an essential step towards developing effective and targeted preventive services for depressive illnesses in Kansas.

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2006 Annual Summary of Kansas Vital Statistics Released

The Kansas Department of Health and Environment (KDHE) has released the *2006 Annual Summary of Kansas Vital Statistics*. Program managers, epidemiologists, researchers and federal, state and local governments as well as the public use the annual summary to conduct studies and evaluations to guide policymaking decisions.

The tables and charts contained in the summary reflect data that is reported to KDHE regarding births, stillbirths, deaths, marriages, marriage dissolutions (divorce and annulment) and abortions. Analysis of trend data, county data and a comparison of Kansas to the nation are included in the report. Some of the highlights include:

In 2006, a total of 40,896 births were registered to Kansas residents, 1,195 more than in 2005 (Table 4). This 3 percent increase is the highest since a 3.2 percent increase between 1997 and 1998. The number of births in 2006 is the highest reported since 1981 (41,202).

In 2006, chronic lower respiratory disease became one of the top three causes of death, behind heart disease and cancer. This is noteworthy since heart disease, cancer and cerebrovascular disease have been the top three killers since 1937.

Between 1999 and 2006, the age-adjusted death rate for heart disease, the leading cause of death for Kansans, decreased 22.7 percent.

The percent of Kansas mothers receiving inadequate prenatal care increased 6.6 percent between 2005 and 2006.

Out-of-wedlock births followed national trends, increasing to a record high of 14,376 or 35.2 percent of all births.

Table 4. Selected Vital Event Rates/Ratios, Kansas, 2005-2006

Vital Event	2005	2006
Live Births		
Number	39,701	40,896
Rate [1]	14.5	14.8
Out-of-Wedlock Births		
Number	13,492	14,376
Ratio [2]	34.0	35.2
Stillbirths (S.B.)		
Number	194	192
Rate [3]	4.9	4.7
Hebdomadal Deaths (Under 7 days)		
Number	153	137
Rate [4]	3.9	3.3
Perinatal Period III Deaths (S.B. & Hebdomadal)		
Number	347	329
Rate [3]	8.7	8.0
Neonatal Deaths		
Number	196	176
Rate [4]	4.9	4.3
Infant Deaths		
Number	297	293
Rate [4]	7.5	7.2
Maternal Deaths		
Number	6	7
Rate [5]	1.5	1.7
Deaths		
Number	24,632	24,489
Rate [1]	9.0	8.9
Marriages		
Number	18,745	18,836
Rate [1]	6.8	6.8
Marriage Dissolutions		
Number	8,476	9,145
Rate[1]	3.1	3.3
Abortions		
Total Reported	10,543	11,271
Kansas Residents.	5,629	5,886
Out of State Residents	4,914	5,385

1 Rate per 1,000 population
2 Ratio per 100 live births
3 Rate per 1,000 live births + stillbirths
4 Rate per 1,000 live births
5 Rate per 10,000 live births

After a steady decline in the pregnancy rate for females ages 10-19 from 1994 to 2004, the rate increased over the following two years. In 2006, the rate (27.1 per 1,000 female age-group population) was up 1.5 percent from 2005 (26.7) and 3.8 percent from the record low (26.1) in 2004.

Almost half of the abortions performed in the state occurred to non-Kansas residents. The abortion ratio for Kansans increased 36.5 percent between 1987 (105.4 per 1,000 live births) and 2006 (143.9).

Wide discrepancies in the infant, neonatal and post neonatal death rates between white non-Hispanics and black non-Hispanics have continued. The black non-Hispanic infant death rate (17.5 per 1,000 live births) is 2.8 times higher than the rate for whites (6.2).

Marriage and marriage dissolution rates have dropped by nearly a quarter and a third, respectively, since 1987.

Madison and Aiden were the most popular names given to newborns by Kansas parents in 2006. For the first time since the state began compiling a list, the top name for both girls and boys is not gender-specific.

The Annual Summary is available at www.kdheks.gov/ches/. Requests for single copies of the annual summary can be made to the Office of Health Assessment at (785) 296-8627 or (800) 332-6262 (TDD/TT).

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Office of Health Assessment

New Birth Certificate Findings Studied

Kansas adopted a new birth certificate form and implemented a new on-line electronic reporting system effective in 2005. The new certificate resulted in a number of changes to existing data items and the addition of new questions. Data on selected characteristics were analyzed to assess data quality and comparability issues. These findings are contained in a report entitled *Selected Birth Outcome Findings from the Revised Birth Certificate 2005, Kansas.*

Selected descriptive tabulations of data reported on the 2005 Kansas birth certificates for all in-state occurrence births are presented.

During 2005, there were 40,567 Kansas occurrence births using the new birth certificate. Almost one of every five births (18.3%) occurred to women of non-white race. The primary language spoken by birth mothers was non-English in over one in 10 (10.3%) births. The percentage of women smoking during the pregnancy declined from 16.1 percent in the first trimester of the pregnancy to 14.1 percent in the third trimester.

Changes to the method of calculating the month prenatal care began affected the numbers and rates for trimester care began and Adequacy of Prenatal Care Utilization (APNCU). Resulting rates are not comparable with previous data years. Almost one in three birth mothers (31.7%) obtained WIC food for herself during the pregnancy. Medicaid was reported as the principal payment source for delivery for over one out of four births (27.3%).

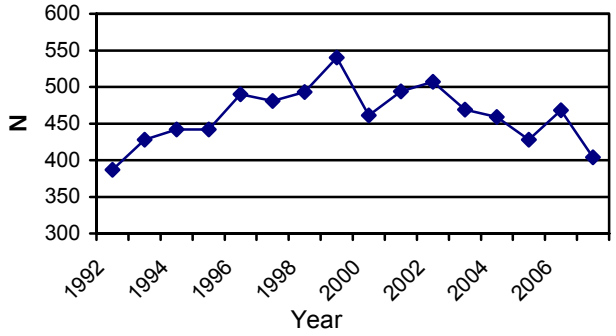
To download the entire report or more information on the findings go to http://www.kdheks.gov/ches/research.html.

Greg Crawford
Office of Health Assessment

Statewide Traffic Fatalities

Statewide traffic fatalities continued a downward trend with a 2007 tentative total of 404 reported by the Kansas Department of Transportation. The number represents a 13 percent decrease from 468 traffic fatalities in 2006 (Figure 2).

Figure 2. Fatal Traffic Accidents, 1992-2007



The number for 2007 could increase slightly with the addition of late accident reports from December 2007. KDOT said the fewer deaths last year are partly because seat belt usage by driv-

ers in the state was up to 75 percent, one of the highest reported percentages in recent years. Safety education programs involving KDOT and the Kansas Highway Patrol have contributed to lower fatality rates.

Kansas Department of Transportation
Topeka Capital Journal

Survey Reports on Physician Capacity to Provide Genetic Information/Service

The Office of Health Assessment (OHA) at the Kansas Department of Health and Environment (KDHE) has completed a report on physician capacity to provide genetically-based program services. It can be located at http://www.kdheks.gov/bcyf/download/2007_genetics_summary_report.pdf.

The report was prepared because the role of the physician in providing basic genetic medicine is growing and genetics issues are becoming increasingly important to practices. Although there are specialists in medical genetics, it is reported that there are not enough specialists to meet the growing demand for genetic guidance [1]. Physicians recognize that they have a role in explaining medical genetics to patients and discussing with them the impact of genetics on health outcomes [2], but physicians need current information in order to carry out their role.

To address the growing need for genetics information and assure adequate continuing education opportunities are available to physicians, a study was undertaken to determine current status and perceived need. KDHE sponsored the project in collaboration with the University of Kansas Medical Center (KUMC). Funding for the project was obtained through a federal grant to the Eight State Heartland Genetics Consortium at the University of Oklahoma Health Science Center.

The Office of Health Assessment conducted a survey of primary care physicians. They were asked to complete and return a questionnaire about the demand for genetics services and the need for continuing education either by mail or Internet.

Survey findings show respondents were experienced and mainly clinical primary care medical doctors licensed by the Kansas State Board of Healing Arts. Most of the physicians reported that they do not see patients with identified genetics problems or make genetically related referrals. Of those who do, an average number of three patients were referred to other medical practices by clinical primary care physicians over the last 12 months. Surveys showed that most clinical physicians are aware of genetics referral resources.

Policy implications from this study include:

- Genetics resource information should be made available to the general public and to all primary care physicians, counselors or other medical providers via circulars, program materials and on the Internet.
- Coordinated assistance should be made available to physicians so that they can include genetics service planning in their medical practices.
- Information about available services should be distributed that can be provided by genetics counselors to physicians, providers and the public via circulars, program materials and on the Internet.
- Information should be prepared on cord blood banking and made available via circulars and the Internet for physicians, providers and the public.
- Continuing education courses should be provided on "Genetics of Specific Conditions", "Basic Genetics 101", and "Ethical and Legal Issues of Genetics" via self-study training manuals, interactive CD-ROM, conveniently located one-day weekend conferences and via the Internet. .

Contact KDHE's Office of Health Assessment with any related questions.

Rachel Lindbloom, MA, LSCSW
Office of Health Assessment

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Kansas Reaches One Million Patients in Immunization Registry

The Kansas Department of Health and Environment (KDHE) reports the Kansas Immunization Registry Project, known as KSWebIZ, recently received its one-millionth patient since its inception in August 2005.

The one-millionth patient is a newborn baby girl in western Kansas who recently received her hepatitis B vaccination.

Mothers of babies born in Kansas can have a portion of their child's birth certificate entered into KSWebIZ, including documentation of the birth dose of hepatitis B vaccine. More than 97 percent of all Kansas newborns now have an immunization registry record created through this method.

KSWebIZ reached one million patients in just over two years. The registry went online in August 2005 and has 148 immunization providers in the state using the system.

All immunizations for Medicaid clients are also included in the registry, helping to assure that records are not lost, children are not vaccinated unnecessarily and funds for immunization services are maximized,.

In addition, KSWebIZ will allow the state to better assess immunization coverage, target resources to areas most in need and improve management of disease outbreaks. KDHE is also developing systems to access immunization data directly through schools and WIC clinics to further ensure good immunization coverage.

Bureau of Disease Control and Prevention

KIC System Updated

Kansas hospital discharge data for 2006 has been added to the Kansas Information for Communities (KIC), the Kansas Department of Health and Environment's Health Information Portal. The 2006 hospital discharge data, provided to the state of Kansas by the Kansas Hospital Association, represents summary results for procedures and diagnoses from over 335,000 hospital discharges to Kansas residents.

The hospital discharge dataset also includes information on the primary pay source for the discharge, length of stay, and average length of stay for these hospital episodes. Creation of population-based discharge rates and comparison to previous years is possible in KIC. Data are provided in two versions: a) without Hispanic origin for comparison of trends back to 1995 or b) with Hispanic origin from 2003, the year this important element was included in the data.

As the hospital discharge dataset is de-identified, the results may represent a duplicate count of patients – some of whom may be hospitalized more than once in a given year. The data do not include visits to the emergency room. Totals for characteristics that are unknown are not displayed. Thus, individual cells within a row or column may not sum to the row or column total respectively.

Specific questions about the hospital discharge dataset can be sent to Rachel Lindbloom at rlindblo@kdhe.state.ks.us. General KIC questions can be directed to Kansas.Health.Statistics @kdhe.state.ks.us. The URL is http://kic.kdhe.state.ks.us/kic/ for the KIC system and the URL for hospital discharge data is http://kic.kdhe.state.ks.us/kic/discharge.html.

Office of Health Assessment

Adequacy of Prenatal Care Reported

Prenatal care is defined as pregnancy-related health care services provided to a woman between conception and delivery. It is important to track because there is a strong association between prenatal care and pregnancy outcome. Pregnant women who receive inadequate care are at increased risk of bearing infants who have low birth weight, are stillborn, or die within the first year of life [1]. This data can be analyzed to suggest population groups and geographic areas in need of intervention, therefore protecting the health of these future Kansans.

The report *Adequacy of Prenatal Care Utilization Index, Kansas, 2006*, issued by the Office of Health Assessment, reviews the most recent available data to assess prenatal care.

Of the 36,832 Kansas resident live births reporting prenatal care in 2006, 78.4 percent received adequate or better prenatal care, including 33.1 percent with adequate-plus care; 21.6 percent received less than adequate prenatal care, including 14.6 percent with inadequate care.

Other findings:

- Among mothers whose prenatal care utilization was classified as inadequate (5,363), the vast majority (5,084) were due to late initiation of care. In other words, only a minority of women (279) who initiated their care within the first four months of care received inadequate care.
- Among mothers of low birth weight infants, nearly 80 (79.4) percent received adequate or better care, while 16.5 percent exhibited inadequate care.
- The proportion of mothers who received adequate or better prenatal care was highest among White Non-Hispanic (83.2 percent), followed by Asian/Pacific Islander Non-Hispanic (80.6 percent) and Other Non-Hispanic (74.8 percent). The population group with the lowest percent was Hispanic (61.5).
- The proportion of mothers with inadequate care among Black Non-Hispanic (23.8 percent), Native American Non-Hispanic (23.9 percent) and Hispanic (28.5 percent) were more than twice that of White Non-Hispanic (10.7 percent) population.

Accurate measurement of prenatal care depends on the accuracy of the index used. Beginning with 1998 data, the Kansas Department of Health and Environment (KDHE) transitioned from a modified Kessner Index to the Adequacy of Prenatal Care Utilization (APNCU) Index, (often referred to as the Kotelchuck Index). [2] This index attempts to characterize prenatal care (PNC) utilization on two independent and distinctive dimensions: adequacy of initiation of PNC and adequacy of received services (once PNC has begun).

Because of changes in the method of calculating the month prenatal care began – a key component in creating a PNC value – the new data is not comparable with that prior to 2005.

Office of Health Assessment

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State Registrar Retires

Lorne A. Phillips, Ph.D. state registrar and director of the Center for Health and Environmental Statistics, retired from the Kansas Department of Health and Environment (KDHE) on Dec. 14. As state registrar, Phillips was responsible for the agency's civil registration system and oversight of the health assessment and data analysis roles of the Center.

He became state registrar in 1987. During his tenure, he oversaw the implementation of an optical imaging system for storage and issuance of vital records, phaseout of local registrars in favor of direct registration from hospitals and funeral homes, and development of the Web-enabled electronic birth and death registration systems.

Elizabeth (Lou) W. Saadi, Ph.D., has been named acting state registrar and interim director of the Center while a national search is under way to replace Phillips. Saadi, director of the KDHE Office of Health Assessment, has been with the agency since 1988.

Teen Pregnancy Report Issued

The Office of Health Assessment has issued the *2006 Adolescent and Teenage Pregnancy Report*. The report contains a series of summary tables detailing pregnancy outcomes for women ages 10-19.

Teenage females (10-19) account for 11 percent (11.1%) of the pregnancies (46,974) in 2006. Eighty percent (80.0%) of the teenage pregnancies resulted in live birth (4,154), 19 percent in abortion (1,016) and the rest in stillbirths (22).

Other findings include:

- The pregnancy rate for females ages 10-19 was 27.1 per 1,000 women in 2006, up 1.5 percent from 2005 (26.7).
- The rates for teenage subgroups 10-14 (0.9) and 15-19 (52.2) rose 12.5 and 2.8 percent respectively between 2005 and 2006.
- The rate for teenagers, 10-17 years, remained the same (10.4).
- Despite a slight increase in the number and rate of teenage pregnancies in 2005 and 2006, there is a general downward trend. Teenage pregnancy rates (10-19) dropped 15.0 percent over-all during the past two decades 1987-2006.

The report is at http:www.kdheks.gov/hci/teenpreg.html.

Office of Health Assessment

National Report Confirms Need for Kansas Health Reform

A national study shows that the overall health of Kansans has declined over the past year. According to the 18th annual edition of America's Health Rankings, Kansas is ranked 23rd in overall health nationally, compared with last year's 17th place ranking.

According to the United Health Foundation report, Kansas' strengths included a low rate of infectious disease, few poor mental and physical health days and ready access to adequate prenatal care.

The report also showed that improving Kansas health has several challenges to overcome, including a high percentage of children in poverty, limited access to primary care and a low childhood immunization rate.

"This year's study confirms that health reform proposals need favorable consideration in order to improve Kansas health," said Roderick L. Bremby, Secretary of the Kansas Department of Health and Environment (KDHE). "Over the past year, we declined in the number of children being immunized, and saw a higher rate of uninsured Kansans as well as an increase in the

number of adult smokers. Additionally, Kansas, like the rest of the nation, continues to experience a dangerous increase in the number of adults who are overweight or obese."

The percentage of Kansans considered obese grew by 2 percent since last year's report. One in four Kansans is now considered obese, up from 13 percent in 1990.

Those factors, combined with low per-capita public health spending, a low per-capita number of primary care physicians and a high rate of preventable hospitalizations led to Kansas having the dubious distinction of being the state with the greatest overall health score decline from last year, after having the fourth highest health improvement in the 2006 report.

Kansas continues to lag behind other states in seatbelt usage. In 2006, the Kansas seatbelt rate was 73 percent, well below the national average, ranking the state 43rd in the nation. The Driving Force, a safety task force commissioned by the Kansas Department of Transportation, the Kansas Highway Patrol and KDHE, was unsuccessful in their effort to convince legislators of the need for a primary seatbelt law during last year's legislative session.

Kansas, compared to other states, continues to come up short on the amount of funds allocated for tobacco use prevention. In fiscal year 2006, Kansas collected $124 million in tobacco taxes and $48.6 million from the tobacco settlement payment, yet allocated less than $2.4 million to tobacco use prevention.

According to the United Health Foundation report, health improvement in the U.S. has been stagnant since 2000 after significant improvement throughout the 1990s. This year's decline of 0.3 percent represents the first decline in the comprehensive health of the nation in the 18-year history of the report.

A copy of the full report can be located at http://www.unitedhealthfoundation.org/ahr.html.

Office of the Secretary

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