



# Kansas Health Statistics Report

Kansas Department of Health and Environment – Division of Health  
Center for Health and Environmental Statistics – No. 37 – May 2008

## Disparities in Preventable Kansas Hospitalizations Reviewed

The *National Healthcare Disparities Report 2007* found that health care disparities continue among minority populations.[1] “The quality of health care has been a focal point of both past and present U.S. health care policy, but significant disparities between Whites (non-Hispanic) and minorities persist.”[2] Nearly one-tenth of Kansans belong to a racial or ethnic minority group.[3] Research shows that minorities have poorer access to medical insurance and health care than other groups.[4] However, the Agency for Healthcare Research and Quality (AHRQ) indicates that adequate primary and outpatient care for selected conditions can often prevent more serious disease complications or circumvent hospitalization.[2]

Prevention Quality Indicators (PQIs) offer an evaluative approach for determining whether hospitalizations commonly defined as preventable are being avoided. The objective of this analysis is to compare selected Kansas PQI indicators by racial/ethnic population segments and to explore related policy implications. Findings will focus on the experience of Kansas minority groups with preventable hospitalizations and offer strategies to address issues of disparity. Since hospitalization is the most serious and expensive portion of health care treatment, avoidance of unnecessary hospitalization through use of primary and outpatient care is critical to cost containment.

### Methods

Kansas community hospital discharge data 2003-2006 from the Kansas Hospital Association (KHA) are used to compare AHRQ PQIs among Kansas’ racial/ethnic population groups. Racial/ethnic groups include White (non-Hispanic), Black (non-Hispanic), Asian/Native Hawaiian or Other Pacific Islander (NHOPI) (non-Hispanic), American Indian/Alaskan Native (AI/AN) (non-Hispanic), and Hispanic. Statistics for the category Other/Unknown consisting of multi-racial and individuals of unknown racial and ethnic origin are not included due to data reporting issues and statistical unreliability. AHRQ programming methodologies are used to identify possible preventable hospitalizations found in the Kansas community hospital discharge data. Findings are reported as adjusted relative rates calculated by dividing the minority group adjusted hospitalization rates (numerator) by the White (non-Hispanic) adjusted hospitalization rate (denominator). Comparisons are made with national level hospitalization rate statistics.[2]

### Results

Although it has been reported nationally that Blacks (non-Hispanic) generally have the highest rates of preventable hospitalizations and Hispanics experience the second-highest rates,[2] findings from Kansas community hospital discharge data indicate that Blacks (non-Hispanic) most often had the highest rates of preventable hospitalization, Whites (non-Hispanic) most often had the second highest rates, and Hispanics, Asians/NHOPIs (non-Hispanic) and AI/ANs (non-Hispanic) had lower preventable hospitalization rates. Selected PQIs are categorized as preventable hospitalizations for chronic respiratory diseases, circulatory diseases, and diabetes. For the study period, findings indicate that:

- Blacks (non-Hispanic) experienced higher hospitalization rates than did Whites (non-Hispanic) on most PQIs. Blacks

(non-Hispanic) experienced higher PQI rates for uncontrolled diabetes without complications; lower extremity amputation/diabetes; diabetes, short-term complications; diabetes, long-term complications; hypertension; congestive heart failure; and adult asthma.

- All demographic population categories experienced lower PQI rates than Whites (non-Hispanic) for chronic obstructive pulmonary disease and angina without procedure.
- Hispanics had lower hospitalization rates on nearly all PQI rates compared to Whites (non-Hispanic) with the exception of uncontrolled diabetes without complications and lower extremity amputation/diabetes patients.
- AI/ANs (non-Hispanic) and Asian/NHOPI (non-Hispanic) generally had PQI rates that were similar to each other and significantly lower than rates for Whites (non-Hispanic) (Table 1).

Table 1. PQI Relative Rates by Race/Ethnicity  
Kansas, 2003-2006 §

	Black (non-Hispanic)	Asian/NHOPI (non-Hispanic)	AI/AN (non-Hispanic)	Hispanic
Adult Asthma	2.89 *	0.40 *	0.50 #	0.42 *
Chronic Obstructive Pulmonary Disease	0.68 *	0.15 *	0.40 *	0.10 *
Angina Without Procedure	0.82	0.29 *	0.21 *	0.33 *
Congestive Heart Failure	1.71 *	0.17 *	0.19 *	0.24 *
Hypertension	3.55 *	0.56 *	0.39	0.39 *
Uncontrolled Diabetes, Without Complications	3.54 *	0.39 #	0.39 #	1.04
Diabetes, Short Term Complications	3.28 *	0.34 #	0.50	0.76 *
Diabetes, Long Term Complications	3.26 *	0.33 *	0.71 *	0.69 *
Lower Extremity Amputation/ Diabetes Patients	3.05 *	0.38 #	1.21 #	1.01

§White (non-Hispanic) relative rate=1.00

#Statistically significant  $p \leq .05$  compared to White (non-Hispanic): Rate based on numbers of less than 30, interpret with caution.

\*Statistically significant  $p \leq .05$  compared to White (non-Hispanic): Rate based on numbers of 30 or greater

### Data Limitations

Review of community hospital discharge data indicates that there are significant differences in the likelihood of the occurrence of preventable hospitalizations between Whites (non-Hispanic) and minorities in Kansas. Some of the more significant limitations include:

- Rates for AI/ANs (non-Hispanic) may be affected by the absence of data from the Indian Health Service which provides services to this

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population group.

- Hospital discharge rates may be lower for Hispanics because they are healthier or younger than the general population and thus less likely to be ill or hospitalized, data coding issues or a combination of reasons.
- Patients admitted multiple times in a single year are counted as unique patients due to the lack of patient identifiers producing duplicate patient counts.
- The lack of patient identifiers limits data matching capacity and the ability to conduct statistical analysis related to the impact of socioeconomic status (SES), education, income, and other demographic factors that could improve the value of relative rate comparisons.

## Conclusions and Implications

Racial and ethnic differences in PQI rates may signify disparities in the quality of ambulatory care, as well as disparities in access to timely and effective treatment of certain conditions for specific populations.[2] The underlying causes of gaps in health care access and distribution may be due to a number of factors like discrimination either in the provision of health services or in the attainment of access to care via employment and insurance,[5] differences in ethnically based social or cultural orientation towards the health care system,[5] limited English proficiency,[1] and/or gaps in health care for the disempowered.[5] Additionally, minorities may be disproportionately exposed to environmental triggers commonly associated with asthma or may have less opportunity for diagnosis of other medical conditions.[5] Timely and routine outpatient management can reduce hospitalization rates, and thus reduce overall health care costs. Policies that address improving health insurance coverage are needed to improve access to primary health care, and in turn to reduce preventable hospitalization rates.

Review of both national and Kansas PQI trends suggest a need for continued improvement in access to quality primary health care. It is important to address preventable hospitalizations by targeting policy to address health care needs among all population groups. Equitable health insurance coverage and improvements in medical care throughout the population could reduce disparities in health care and improve health outcomes overall.[5] Increased access to primary care can improve entrée to timely diagnosis, treatment, and regular preventive screening. Trend analysis reveals that, although some PQIs are stable, other PQIs are increasing. Strategies must be developed to reduce PQI rates. Although discussion of widespread systemic health care policies and strategies are beyond the scope of this report, some practical suggestions may be apropos.

- Public health information strategies like flu immunization, non-smoking health campaigns, distribution of information relating to diet and exercise, among others, are essential in reducing the onset and seriousness of asthma, chronic obstructive pulmonary disease, diabetes and other health conditions.
- Multi-level educational programs directed to health care professionals that addresses critical knowledge gaps could lead to substantive improvements in patient care.[6]
- Patient education and reminders via follow-up phone calls and correspondence from care providers to encourage following prevention guidelines and adherence to treatment recommendations can be effective in increasing patient compliance. [7]
- Provision of information in commonly frequented locations like grocery stores, health departments, libraries, pharmacies, etc., could be used when working with minority populations.[8]
- Use of health care professionals who speak common minority languages i.e., Spanish, and who have similar cultural/racial/ethnicity characteristics could increase access to care for minority population,[8]

- Use of Internet and other newer technologies can extend education to key primary care physicians as well as the general population.[6]
- Reduction of preventable hospitalization rates is central for cost containment and enhancement of the health of Kansans. In 2006 the financial burden born in Kansas for payments of selected preventable hospitalizations totaled an estimated \$112 million, with private health insurance accounting for \$25.7 million of the full amount.[9] Continued efforts aimed at reducing the preventable hospitalization rates while improving access to primary care hold considerable promise for cost savings in the state and for improved health for Kansans.

Note: This article is a presentation summary delivered at the Kansas Department of Health and Environment's health disparities conference, "Healthy Cultures, Healthy Kansas: Moving Forward" in April 2008. A copy of the accompanying statistical brief may be obtained by request from the Office of Health Assessment by contacting Rachel Lindbloom at 785-296-8629.

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## Preliminary Abortion Report

The Center for Health and Environmental Statistics released its preliminary analysis of 2007 abortion reports in late March. A total of 10,836 abortions were reported to the Center, a decrease (3.9%) compared to 2006. In 2007, 5,162 abortions occurred in Kansas to out-of-state residents, 5,644 occurred in Kansas to in-state residents, and 30 occurred out-of-state to Kansas residents.

Fifty percent (50.4) of all reported abortions were to women ages 15-24, 83.3 percent were unmarried and 59.4 percent were White Non-Hispanic. The number of abortions to women of Hispanic origin increased 5.1 percent from 2006 and accounted for 11.5 percent of all abortions in 2007.

Table 2. Abortions by Selected Characteristics, Kansas, 2007

Selected Characteristics	N	%
<i>Residence</i>		
Total Reported	10,836	100.0
In-state residents	5,674	52.4
Out-of-state residents	5,162	47.6
<i>Age Group</i>		
Under 15 years	55	0.5
15-19 years	1,744	16.1
20-24 years	3,722	34.3
25-29 years	2,586	23.9
30-34 years	1,497	13.8
35-39 years	894	8.3
40-44 years	315	2.9
45 years and over	23	0.2
Not Stated	0	n.a.
<i>Population Group *</i>		
White Non-Hispanic	6,411	59.4
Black Non-Hispanic	2,358	21.8
Native American Non-Hispanic	86	0.8
Asian/Pacific Islander Non-Hispanic	375	3.5
Other Non-Hispanic **	326	3.0
Hispanic Any Race	1,245	11.5
Not Stated ***	35	n.a.
<i>Marital Status</i>		
Married	1,808	16.7
Unmarried	9,001	83.3
Not Stated ***	27	n.a.
<i>Gestation</i>		
Less than 9 weeks	6,836	63.1
9-12 weeks	2,422	22.4
13-16 weeks	851	7.9
17-21 weeks	426	3.9
22 weeks & over	293	2.7
Not Stated ***	8	n.a.

n.a. Not applicable

\* For further explanation, see Technical Notes in the *Annual Summary of Vital Statistics, 2006*.

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

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

Almost nine out of 10 (85.5%) of all reported abortions were performed prior to the 13<sup>th</sup> week of gestation, while only 6.6 percent of abortions were performed after 16 weeks gestation (Table 2).

The Center's preliminary report of 2007 abortions is available at <http://www.kdhe.state.ks.us/ches/> or by calling the Office of Health Assessment at 785-296-8627.

Office of Health Assessment

## Kansas Motor Vehicle Crash Mortality

### Urban vs. Non-urban

Unintentional injuries are the leading cause of death for persons ages 1-44. In 2006 unintentional injuries in Kansas were the

fifth leading cause of death for Kansas residents.[1] They accounted for 15.9 percent of all years of potential life lost before life expectancy. Among unintentional injury death categories, the largest number of deaths occur as the result of motor vehicle crashes.

The Kansas Trauma Registry, part of the Kansas Trauma Program (KTP) reports motor vehicle crashes account for more traumatic injuries treated by Kansas hospitals than any other mechanism of injury.[2] The trauma program at the Kansas Department of Health and Environment (KDHE) seeks to reduce morbidity and mortality due to traumatic injury. The registry is comprised of injuries meeting inclusion criteria. Together with mortality information, the data provides insight into the health effects of severe injuries.

Nationally, rural populations have been shown to have disproportionately high injury mortality rates, and decreasing population density is the strongest predictor of county-specific trauma death rates in the United States.[3,4] Kansas' five largest counties by population comprise the urban counties based on the Peer-group Population Density model developed by the KDHE Office of Local and Rural Health. These five counties, based on the 2006 U. S. Census Bureau Population Estimates represent 51.6 percent of Kansas' population of 2,764,075.

Table 3. Kansas Resident MVC Deaths, Mortality Rates and Confidence Interval, by Region, 1990-2006

Region	N	Age-adjusted Mortality Rate *	95 % Confidence Interval	
Urban Counties	2,773	12.6	12.2	13.1
Non Urban Counties	5,518	23.6	23.0	24.2
Kansas	8,291	18.2	17.9	18.6

\* Rate per 100,000 Population (2000 Standard Population)

Source: Kansas Information for Communities

Kansas Department of Health and Environment

During the period 1990 to 2006, 8,291 motor vehicle crash deaths, based on the International Classification of Diseases versions 9 and 10, have been reported to the Kansas Department of Health and Environment (Table 3). More than two-thirds of the deaths (67.0%) have occurred to residents of Kansas' non-urban counties.

Age-adjusted rates allow for comparison of mortality between populations of different size and age composition. The age-adjusted mortality rate for the non-urban counties is 23.6 per 100,000 population which is 87.3 percent higher than the rate for urban counties.

Comparison of confidence intervals for the mortality rates is a way to assess whether the differences are due to the chance randomness of vital events. The confidence intervals for the urban and non-urban counties do not overlap. This means the difference is considered statistically significant or not due to the randomness of vital events.

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## Varicella Outbreak Studied

In Kansas, all children enrolled in kindergarten through third grade are required to have either proof of vaccination or history of disease. In addition, individual cases of varicella (Chickenpox) became reportable to the Kansas Department of Health and Environment in 2003. In January 2008, the Office of Surveillance and Epidemiology (OSE) began collecting information on outbreaks of varicella. From Jan. 1 to April 30, 452 cases of varicella were reported to OSE and 252 (55.7%) were outbreak related.

OSE identified 14 new outbreaks after March 3. A total of 39 outbreaks have been recognized among children (daycare through high school) in 11 different counties. Half of the outbreaks were located in four large urban counties. The number of cases associated with an outbreak ranged from two to 44 cases.

Gender among the outbreak-associated cases was evenly distributed (Table 4). The majority of the cases were white. Fifty-seven percent of all cases were 'Not Hispanic/Latino' but information was missing on 27 percent of the cases. Most of the cases were ages 5 to 9, with a range of 3 months to 36 years old. Teachers were among the cases in two of the outbreaks.

For a full summary of the OSE outbreak investigation, go to: [http://www.kdheks.gov/epi/download/Outbreak\\_Report\\_varicella\\_April\\_2008.pdf](http://www.kdheks.gov/epi/download/Outbreak_Report_varicella_April_2008.pdf).

Table 4. Varicella Cases by Selected Characteristics, 2008 Outbreak, Kansas

n=252	
Gender	%
Male	46.0
Female	52.8
Unknown	1.2
Race	%
Asian	2.0
Black	4.0
White	86.5
Multiple race	1.9
Unknown	5.6
Ethnicity	%
Hispanic/Latino	15.5
Not Hispanic/Latino	57.1
Unknown	27.4
Age	
Mean	8.5 years
Range	3 months - 36 years

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## Death Certificate Race Reporting

The Office of Health Assessment has issued a report "Race and Ancestry Reporting, Revised Death Certificate, 2005 - 2006, Kansas" exploring the impacts of new race and ancestry reporting on the Kansas death certificate implemented in 2005.

This report evaluates the possible extent of under-reporting of race on Kansas death certificates, uses two alternate methods for categorizing race, and compares the effect of the resulting age-adjusted mortality rates on health disparity in Kansas.

Age-adjusted mortality rates for two race groups of Kansas residents, Blacks and American Indian/Alaska Natives, increased significantly when using the ancestry-adjusted race categorization method. Mortality rates for the two groups based on single race only, already demonstrate a disparity when compared with the single race only White population. These results may represent a clearer estimation of the mortality experience of the two race groups when compared to the white reference population.

The full report is available on the KDHE Web Site at <http://www.kdheks.gov/ches/research.html>.

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## Ovarian Cancer Concerns

Among U.S. women, ovarian cancer is the seventh most common cancer and the fifth leading cause of cancer death.[1] Annually about 20,000 women are diagnosed with ovarian cancer and about 15,000 die from the disease.[2] Among Kansas women, ovarian cancer is the eighth most common cancer [3] and the fifth

leading cause of cancer death.[4] Approximately 200 Kansas women are diagnosed every year. [2]

Types of Ovarian Cancer: Ovarian cancer is classified according to the cell type from which it originates.[2]

- Epithelial – Accounts for 90 percent of ovarian cancer cases. Seventy-five percent of epithelial tumors are diagnosed at Stage 3 or 4.[5]
- Germ cell – Develop from egg cells and accounts for about five percent of ovarian cancer cases.[5]
- Stromal - Seventy percent of the stromal carcinomas are diagnosed in Stage I and accounts for about five percent of ovarian cancer cases.[2]

## Risk Factors

The biologic events leading to ovarian cancer are unknown.[5] The female lifetime risk of developing ovarian cancer is 1.44 percent, while the risk of dying from ovarian cancer is 1.05 percent. Prospects for patients diagnosed with early-stage ovarian cancer confined to the ovaries and who receive treatment is estimated with an 80-90 percent survival rate after five years; however, for the 70 percent of patients diagnosed with advanced stage metastasized disease, survival rates decline markedly with stage at diagnosis.[6] The recurrence risk varies based on multiple factors, including the stage at diagnosis. Therapeutic improvements may be delaying or preventing ovarian cancer recurrences.[2] Several factors such as genetics, increasing age, hormonal, and environmental variables impact the risk of developing this disease.[5]

- Family history - in which multiple female family members i.e., mother, sister, daughter, grandmother or aunt had ovarian cancer can increase risk by as much as 50 percent.[5] Mutations of the BRCA1 or BRCA2 genes are attributed with 5-10 percent of all ovarian cancers. Women with hereditary non-polyposis colorectal cancer (HNPCC) or Lynch Syndrome have an estimated 12 percent lifetime risk of ovarian cancer, while women with one first degree relative i.e., mother with ovarian cancer but no genetic mutation have a lifetime risk of 5 percent.[2]
- Age - increases risk for developing ovarian cancer.[5] The median age at diagnosis is 63.[2] Women between the ages of 35 and 54 make up 25 percent of ovarian cancer deaths, while about 66 percent are women age 55 or older.[7]
- Menstrual Cycles - Risk increases in women who began to menstruate before age 12 and/or experienced menopause after age 50. Never having given birth (nulliparity) is a risk factor for the development of ovarian cancer, as is having a first child after age 30. It is thought that the protective effect of pregnancy, birth control pills, and breast-feeding are related to the suppression of ovulation. Multiple pregnancies have an increasingly protective effect.
- Contraception Pills - Women who take or have taken birth control pills have 40 to 50 percent decreased risk of ovarian cancer.[5] According to researchers of Duke Comprehensive Cancer Center, the risk of ovarian cancer is reduced by 50 percent for women taking pills containing estrogen and progestin. However, pills containing very high levels of progestin reduce risk by an additional 50 percent.[8]
- Diets high in meat and animal fats - are linked to the development of ovarian cancer. Obesity also increases the risk, especially in women who have never given birth.[5] "There is a higher rate of death from ovarian cancer in obese women. Increasingly, findings point to a link between obesity and cancer." [2]

## Symptoms

Symptoms vary and many times are vague and non-specific; consequently women and physicians blame other more common

conditions[8] such as irritable bowel syndrome (IBS), among others. Recent studies show persistent warning signs often occur in women with ovarian cancer in even early stages. Of women with ovarian cancer, 95 percent had symptoms while only 90 percent experienced symptoms with early-stage ovarian cancer.

In June 2007 the Gynecologic Cancer Foundation, the Society of Gynecologic Oncologists and the American Cancer Society, endorsed by the Ovarian Cancer National Alliance, formed a consensus statement on ovarian cancer. This is a breakthrough; it identifies indicators more likely to occur in women with ovarian cancer than women in the general public, including:[2]

- Bloating;
- Pelvic or abdominal pain;
- Difficulty eating or feeling full quickly; and
- Urinary urgency or frequency.

### Detection

There are two main barriers to early diagnosis – the lack of an ovarian cancer-screening test for all women and a lack of ovarian cancer awareness. For women experiencing ovarian cancer symptoms or who have a strong family history or genetic predisposition such as a BRCA mutation, monitoring with one or a combination of the following tests may be recommended:

- A complete pelvic exam – Experts recommend this exam be done annually;
- A transvaginal or pelvic ultrasound – Using sound waves can reveal masses on the ovaries; and
- CA-125 blood test – Tests for higher concentrations of the CA-125 protein in blood, which is indicative of cancerous cells. The test is more accurate in postmenopausal women. “However, in about 20 percent of cases of advanced stage ovarian cancer, and 50 percent of cases of early stage ovarian cancer, the CA-125 is NOT elevated, even though there is ovarian cancer present”. The CA-125 test is important to evaluate disease progress and to monitor for evidence of disease recurrence.[2]

These tests are most effective when used in combination. A CT scan or PET scan may also be used as part of the diagnostic process. The only definitive way to determine if a patient has ovarian cancer is through biopsy and/or surgery.[2]

### Treatment

“Surgery is the preferred treatment and is often needed to diagnose ovarian cancer.”[7]

“Multiple studies conducted over the past decade have shown that survival is markedly improved when surgery is performed by a gynecological oncologist.”[2] One analysis found that women whose surgery was performed by a gynecologic oncologist had a median survival time that was 50 percent longer than those whose surgery was done by a general gynecologist or other surgeons inexperienced in optimal debulking procedures.[2] Following initial treatment, it is important to have physician follow-ups to monitor and/or treat evidence of recurrent disease.[2] Chemotherapy is often given in addition to surgery to destroy cancer cells that may have been left behind, or to shrink a tumor prior to surgery if the surgeon anticipates difficulty.[9]

Table 5. Ovarian Cancer Frequencies and Rates, by Year, Kansas, 2000-2004

Year	Number	Rate *
2000	227	1.6
2001	214	1.5
2002	202	1.4
2003	191	1.3
2004	199	1.3

\*Rates per 10,000 women Age Adjusted to the 2000 U.S. Standard Population. Source: U.S. Bureau of the Census and Kansas Cancer Registry via Kansas Information for Communities

### In Kansas

Among Kansas women, the 2000 - 2004 incidence rate for ovarian cancer declined slightly with an average of 1.4 cases per 10,000 women. (Table 5)

Kansas' hospital discharge data for 2001 through 2006 show an average of 201 annual hospitalizations due to ovarian cancer (Table 6). The average length of stay was approximately 7 days with a mean of 1,398 hospital days per year. Overall, discharges appear to be on the decline.

Table 6. Ovarian Cancer Hospital Discharges and Length of Stay by Year, Kansas, 2001-2006

Year	Number	Total Length of Stay - days	Average Length of Stay - days
2001	204	1,533	7.5
2002	191	1,255	6.6
2003	191	1,248	6.5
2004	232	1,684	7.3
2005	202	1,432	7.0
2006	187	1,235	6.6
Average	201	1,398	6.9

Source: Kansas Hospital Association Community Hospital Discharge Database via Kansas Information for Communities

Kansas women ages 45 to 64 and age 65 and over were eight and 31 times, respectively, more likely to die from ovarian cancer than women ages 25 to 44. For women age 65 and over the mortality rate appears to be increasing to some extent. (Table 7)

Table 7. Resident Ovarian Cancer Deaths and Rates for Selected Age-Groups by Year, Kansas, 2001-2006

Year	Age Group							
	25 to 44		45 to 64		65 and over		All ages	
	N	Rate	N	Rate	N	Rate	N	Rate
2001	7	@	44	14.6	96	45.9	147	9.5
2002	9	@	35	11.3	104	50.0	149	9.4
2003	#	@	38	11.9	99	47.8	142	8.8
2004	#	@	47	14.3	110	53.3	159	9.7
2005	#	@	39	11.9	105	50.9	148	9.1
2006	8	@	37	10.7	110	52.9	155	9.6
Average	5.8	1.6	40	12.4	104	50.1	150	9.3

Rates Per 100,000 women. Rates for "All Ages" are Age Adjusted. Others are age group specific. Age Adjustment Uses 2000 Standard Population

# Indicates Numbers Below 6.

@ indicates numerator too small for rate calculation

Source: Kansas Hospital Association Community Hospital Discharge Database via Kansas Information for Communities

### Conclusions

The ovarian cancer incidence rate in Kansas is slowly declining, as are hospital lengths of stay. Overall, mortality rates appear stable with the exception of women age 65 and over whose death rates appear to be increasing somewhat. On the other hand, hormones associated with risk factor reduction have been found.[7] Recently, medical experts have identified a list of symptoms that are common to ovarian cancer patients. “The frequency and/or number of symptoms appear to be key factors in the diagnosis of ovarian cancer.” Then again, until a cost effective screening test is available, one of the best strategies to address ovarian cancer remains raising awareness among women and the health care community about ovarian cancer risk factors, symptoms, and state-of-the-art treatment techniques.[2]

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### Related Links:

“What Are the Symptoms of Ovarian Cancer” video at <http://www.healthline.com/adamcontent/ovarian-cancer>

## References

- Centers for Disease Control and Prevention, Division of Cancer Prevention and Control, National Center for Health Marketing [www.cdc.gov/Features/OvarianCancer/](http://www.cdc.gov/Features/OvarianCancer/)
- Ovarian Cancer National Alliance, About Ovarian Cancer. <http://www.ovariancancer.org/index.cfm?fuseaction=Page.viewPage&pagelid=764>
- Kansas Information for Communities, Center For Health and Environmental Statistics, Kansas Department of Health and Environment, [http://kic.kdhe.state.ks.us/kic/cancer\\_table.html](http://kic.kdhe.state.ks.us/kic/cancer_table.html).
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## Assessment Initiative Conference in August

The Annual Conference on Assessment Initiative, sponsored by CDC, will be Aug. 18-20, in Atlanta, Georgia. This meeting will focus on sharing information on innovative systems and methods that improve the way data are used in public health programs, services, and policies at the local and state levels. Sessions will address data dissemination, health assessment research, applied data analysis, presentation techniques, and community health-assessment processes and outcomes.

Participants will include staff from local and state health departments, federal agencies, and community organizations interested in the collection, analysis, and dissemination of data for community health assessments. Attendees can register online at <http://www.ppleventreg.com/events/HHS/index.php?id=19>; the deadline for online registration is Aug. 4, and no registration fee is charged. The deadline for making reservations with the Sheraton Atlanta Hotel – at the conference web site or by telephone, (800) 833-8624 or (404) 659-6500 – is July 14.

Abstracts for the poster session are due by July 18 and should be e-mailed to Nelson Adekoya at [nba7@cdc.gov](mailto:nba7@cdc.gov). Abstracts should be a maximum of 250 words and clearly state the purpose of the poster. Topics of interest include approaches to assessment, impact and outcome of community health assessment, systems and approaches used for data dissemination, community partnerships, and statistical methods used in assessment. A maximum of 40 abstracts will be accepted, and applicants will be notified of acceptance by Aug. 1. Additional information regarding the Assessment Initiative is available at <http://www.cdc.gov/ncphi/od/ai>.

*Nelson Adekoya  
Centers for Disease Control and Prevention*

## 2007 Population Estimates Released

Kansas county population estimates for 2007 have been released by the U.S. Census Bureau. Shown in Table 8 are county estimates as of July 1, 2007. Kansas increased slightly (0.4 percent) in population from 2,764,075 residents in 2006 to 2,775,997 in 2007. Access this table and additional Kansas estimates at: <http://www.census.gov/popest/estimates.php>.

*U.S. Census Bureau*

Table 8 Kansas County Population Estimates for July 1, 2007

County	Total	% Change from 2006	County	Total	% Change from 2006
Allen	13,414	-1.9	Linn	9,767	-2.0
Anderson	7,908	-1.8	Logan	2,628	-1.8
Atchison	16,571	-1.0	Lyon	35,981	1.7
Barber	4,786	-3.8	Marion	12,238	-4.1
Barton	27,768	0.9	Marshall	10,186	-1.6
Bourbon	14,803	-1.0	McPherson	29,196	-0.6
Brown	10,068	-1.6	Meade	4,403	-3.5
Butler	63,045	-0.2	Miami	31,078	0.6
Chase	2,882	-6.1	Mitchell	6,307	0.1
Chautauqua	3,806	-3.7	Montgomery	34,511	-0.5
Cherokee	21,337	-0.5	Morris	5,967	-1.3
Cheyenne	2,801	-3.8	Morton	3,038	-3.2
Clark	2,094	-5.1	Nemaha	10,201	-1.7
Clay	8,685	0.7	Neosho	16,228	-0.4
Cloud	9,382	-2.2	Ness	2,991	1.5
Coffey	8,454	-2.8	Norton	5,422	-2.9
Comanche	1,888	0.2	Osage	16,459	-2.9
Cowley	34,251	-1.9	Osborne	3,871	-2.7
Crawford	38,860	2.1	Ottawa	6,006	-2.6
Decatur	2,955	-5.3	Pawnee	6,415	-1.5
Dickinson	18,957	-1.9	Phillips	5,356	-1.6
Doniphan	7,756	-1.4	Pottawatomie	19,396	0.9
Douglas	113,488	1.2	Pratt	9,426	-0.1
Edwards	3,106	-1.0	Rawlins	2,558	-3.2
Elk	3,040	-1.2	Reno	63,145	-0.9
Ellis	27,464	2.0	Republic	4,901	-2.6
Ellsworth	6,310	-0.3	Rice	10,080	-2.1
Finney	38,295	-2.1	Riley	69,083	10.5
Ford	33,340	-1.3	Rooks	5,160	-2.5
Franklin	26,479	-0.1	Rush	3,211	-3.2
Geary	25,150	4.0	Russell	6,737	0.0
Gove	2,637	-3.1	Saline	54,583	0.8
Graham	2,607	-2.6	Scott	4,568	-1.6
Grant	7,497	-0.7	Sedgwick	476,026	1.1
Gray	5,641	-3.6	Seward	23,109	-1.3
Greeley	1,297	-2.6	Shawnee	173,476	0.5
Greenwood	6,993	-1.0	Sheridan	2,493	-4.1
Hamilton	2,632	1.5	Sherman	5,959	-0.4
Harper	5,819	-2.2	Smith	3,951	-1.8
Harvey	33,493	-0.4	Stafford	4,387	-1.1
Haskell	4,032	-3.3	Stanton	2,162	-3.1
Hodgeman	1,971	-4.8	Stevens	5,061	-4.3
Jackson	13,420	-0.6	Sumner	23,888	-2.3
Jefferson	18,467	-2.0	Thomas	7,314	-2.1
Jewell	3,198	-3.8	Trego	2,927	-2.2
Johnson	526,319	1.9	Wabaunsee	6,870	-0.4
Kearny	4,148	-7.2	Wallace	1,456	-6.5
Kingman	7,826	-1.9	Washington	5,840	-1.7
Kiowa	2,953	-0.5	Wichita	2,200	-3.8
Labette	21,973	-1.0	Wilson	9,807	-0.8
Lane	1,746	-2.8	Woodson	3,318	-5.4
Leavenworth	73,603	0.0	Wyandotte	153,956	-1.0
Lincoln	3,285	-3.3	Total	2,775,997	0.4

Source: Population Division, U.S. Census Bureau  
Release Date: March 20, 2008

## HCUP Indicators Released

The Agency for Health Care Research and Quality (AHRQ) continues to release 2006 state data from the Healthcare Cost and Utilization Project (HCUP). HCUP is a federal-state-industry partnership that brings together the data collection efforts of state data organizations, hospital associations, private data organiza-

tions, and the federal government to create a national information resource of encounter-level health care data.

The most recent database release includes the State Inpatient Databases (SID), State Ambulatory Surgery Databases (SASD), and State Emergency Department Databases (SEDD) of selected states. Researchers and policymakers can use these state-specific HCUP databases to investigate questions unique to one state, compare data from two or more states, conduct market area research or small area variation analyses, and identify state-specific trends in utilization, access, quality, charges, and outcomes.

These databases are available through the HCUP Central Distributor. Additional 2006 state files will be released in the next few months. For information about states already released, please visit the product release calendar on the HCUP-US Web site, [http://www.hcup-us.ahrq.gov/news/db\\_products.jsp](http://www.hcup-us.ahrq.gov/news/db_products.jsp).

AHRQ Electronic Newsletter

## AIDS and HIV Case Counts

Incident, prevalent, and cumulative AIDS and HIV (non AIDS) case counts have been released by the Bureau of Disease Control and Prevention. The information covering through Dec. 31, 2007, is available at [http://www.kdheks.gov/hiv/hiv\\_std\\_update\\_newsletter.html](http://www.kdheks.gov/hiv/hiv_std_update_newsletter.html).

Table 9. Selected Characteristics of Incident, Prevalent, and Cumulative AIDS Cases in Kansas as of December 31, 2007

	Incident AIDS Cases		Prevalent AIDS Cases		Cumulative AIDS Cases	
	N	%	N	%	N	%
<b>Adult/Adolescent</b>	126	100.0	1,330	99.6	2,808	99.5
<b>Pediatric (&lt;13 Years Old)</b>	0	0.0	6	0.4	13	0.5
<b>Total</b>	126	100.0	1,336	100.0	2,821	100.0
<b>Age</b>						
<13 Years	0	0.0	6	0.4	13	0.5
13 To 14 Years	0	0.0	2	0.1	4	0.1
15 To 24 Years	8	6.3	92	6.9	154	5.5
25 To 34 Years	33	26.2	475	35.6	1,095	38.8
35 To 44 Years	46	36.5	501	37.5	1,013	35.9
45 To 54 Years	30	23.8	203	15.2	382	13.5
55 To 64 Years	8	6.3	50	3.7	119	4.2
65 Years Or Older	1	0.8	7	0.5	41	1.5
<b>Race/Ethnicity</b>						
Hispanic	16	12.7	170	12.7	254	9.0
American-Indian Non-Hispanic	1	0.8	11	0.8	24	0.9
Asian/Pacific Islander Non-Hispanic	1	0.8	9	0.7	14	0.5
Black Non-Hispanic	37	29.4	307	23.0	540	19.1
White Non-Hispanic	71	56.3	827	61.9	1,969	69.8
Multi-Race Non-Hispanic	0	0.0	11	0.8	19	0.7
<b>Unknown Non-Hispanic</b>	0	0.0	1	0.1	1	0.0
<b>Gender</b>						
Male	107	84.9	1,117	83.6	2,473	87.7
Female	19	15.1	219	16.4	348	12.3
<b>Exposure Category</b>						
Men who have sex with men (MSM)	63	50.0	737	55.2	1,698	60.2
Injection Drug User (IDU)	9	7.1	119	8.9	262	9.3
MSM and IDU	8	6.3	122	9.1	258	9.1
Hemophilia/Coagulation Disorder or Transfusion/Transplant	0	0.0	24	1.8	91	3.2
High Risk Heterosexual Contact	15	11.9	199	14.9	300	10.6
No Identified Risk (NIR) or Other	31	24.6	125	9.4	192	6.8
Pediatric (All Risk Combined)	0	0.0	10	0.7	20	0.7
<b>TOTAL</b>	126	100.0	1,336	100.0	2,821	100.0

The data are maintained in the Kansas HIV/AIDS Reporting System (HARS). During 2007, 126 incident AIDS cases were

reported (Table 9). Another 97 HIV (non AIDS) cases were reported during 2007 (Table 10). The number of persons living with AIDS (prevalent) was 1,336 as of December 31, 2007. The prevalent number of HIV (non AIDS) individuals was 1,058. Cumulatively, the number of AIDS cases ever reported to KDHE was 2,821. The number of cumulative HIV (non AIDS) cases reported was 1,113.

Table 10. Selected Characteristics of Incident, Prevalent, and Cumulative HIV Cases in Kansas as of Dec. 31, 2007

	Incident HIV Cases		Prevalent HIV Cases		Cumulative HIV Cases	
	N	%	N	%	N	%
<b>Adult/Adolescent</b>	96	99.0	1,046	98.9	1,101	98.9
<b>Pediatric (&lt;13 Years Old)</b>	1	1.0	12	1.1	12	1.1
<b>Total</b>	97	100.0	1,058	100.0	1,113	100.0
<b>Age</b>						
<13 Years	1	1.0	12	1.1	12	1.1
13 To 14 Years	0	0.0	0	0.0	0	0.0
15 To 24 Years	24	24.7	230	21.7	235	21.1
25 To 34 Years	32	33.0	417	39.4	427	38.4
35 To 44 Years	20	20.6	274	25.9	298	26.8
45 To 54 Years	15	15.5	95	9.0	103	9.3
55 To 64 Years	4	4.1	27	2.6	31	2.8
65 Years Or Older	1	1.0	3	0.3	7	0.6
<b>Race/Ethnicity</b>						
Hispanic	16	16.5	135	12.8	139	12.5
American-Indian Non-Hispanic	1	1.0	9	0.9	9	0.8
Asian/Pacific Islander Non-Hispanic	2	2.1	7	0.7	8	0.7
Black Non-Hispanic	28	28.9	284	26.8	294	26.4
White Non-Hispanic	50	51.5	599	56.6	639	57.4
Multi-Race Non-Hispanic	0	0.0	24	2.3	24	2.2
<b>Gender</b>						
Male	72	74.2	825	78.0	868	78.0
Female	25	25.8	233	22.0	245	22.0
<b>Exposure Category</b>						
Men who have sex with men (MSM)	47	48.5	518	49.0	540	48.5
Injection Drug User (IDU)	9	9.3	103	9.7	108	9.7
MSM and IDU	3	3.1	61	5.8	67	6.0
Hemophilia/Coagulation Disorder or Transfusion/Transplant	0	0.0	4	0.4	6	0.5
High Risk Heterosexual Contact	13	13.4	141	13.3	150	13.5
No Identified Risk (NIR) or Other	24	24.7	219	20.7	230	20.7
Pediatric (All Risk Combined)	1	1.0	12	1.1	12	1.1

Bureau of Disease Control and Prevention

## Injury Deaths Decline

The accidental injury death rate of children 14 and younger has declined by 45 percent in the U.S. since 1987, yet accidental injury remains the nation's leading killer of kids, according to a new national report released by Safe Kids USA.

Entitled "Report to the Nation: Trends in Unintentional Childhood Injury Mortality and Parental Views on Child Safety", the report examines accidental injury in the U. S. and its impact on children by age, gender and race, and reviews the changes in accidental childhood injury death rates in areas such as motor vehicle occupant injuries, drownings, suffocation (which includes strangulation and choking) and more. The report also compares current data to data from 1987 and 1997.

The report unveils many findings including:

- Only 58 percent of parents with children 14 and under report their child being involved in a serious accident or getting seri-



ously injured as a major concern – a seven percentage-point drop since 1987.

- There is little change from 1987 to 2007 in the amount done by parents to ensure their child's safety – due to reasons varying from parents actually feeling the chance of their child being seriously injured is slim (especially fathers); to reporting that taking all the necessary steps are a hassle; to 20 percent of low income families (household income levels under \$25,000) saying many safety devices such as fire extinguishers and bike helmets cost too much.
- Yet when parents do take action, they are not always taking the right steps every time their child is at risk of injury. For example, 31 percent of households with children 14 and younger do not consistently ensure their children ride in the back seat of a car all the time; 24 percent do not consistently supervise their children around water all the time and 18 percent do not always ensure their children (under 10 years old) are with an adult when crossing the street.

In addition, the report demonstrates that among children ages 14 and younger accidental death rates are declining except for the childhood suffocation death rate which has increased by 21 percent. (This is partly due to a re-categorization of deaths previously attributable to Sudden Infant Death Syndrome.)

The injuries examined in the report are serious, many resulting in death or permanent disabilities. Many children survive, but live with significant physical and emotional health consequences for a lifetime. The stress on the children, their families and the health care system cannot be underestimated. In 2000, in the U.S., injuries to children ages 14 and younger cost society approximately \$58 billion in medical bills, lost wages of the children's caregivers, and more.

The four leading causes of death from accidental injuries to

children 14 and younger are: suffocation (19%); motor vehicle occupant injuries (16%); drowning (16%); and pedestrian incidents (11%). Safe Kids Kansas recommends 10 steps to parents that could have a major impact on their children's safety:

- Properly secure your children under age 13 in a back seat every time they ride in a car.
- Keep your children in the right type of car or booster seat until adult lap and shoulder belts fit them correctly.
- Make sure your children wear a helmet and other protective gear every time they bike, skate, skateboard or ride a scooter.
- Teach your children to cross streets at corners and look left, right and left again before crossing. Make sure children younger than 10 always cross the street with an adult.
- Always keep your eyes on your children when they are playing in or near water.
- Always make sure your children wear life jackets when riding on boats or playing in or near open bodies of water.
- Install smoke alarms and carbon monoxide detectors on every level of your home and outside of every sleeping area. Change the batteries once a year, and test them monthly.
- Do not place blankets, pillows or other soft items in a baby's crib. Keep small items such as toy parts, coins, buttons and beads away from children under age three.
- Keep poisonous items, such as medicines and cleaners, locked away and out of reach of children.
- Do not let your children play on stairs, furniture, balconies, roofs, or in driveways, streets or parking lots.

*Kansas Safe Kids*

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