Kansas Department of Health and Environment

Kansas Health Statistics Report

Kansas Department of Health and Environment – Division of Health
Bureau of Epidemiology and Public Health Informatics – No 49 – May 2011

A Comparison of Primary Care Dentists, 2000 and 2010

Introduction

Kansas' primary care dentist shortage is well documented [1, 2, 3]. The Bureau of Epidemiology and Public Health Informatics (BEPHI), in coordination with the Bureau of Local and Rural Health (BLRH), recently released the "*Kansas Primary Care Dentist FTE Report by County, 2010*" [4]. This biennial update of dental FTEs (full-time equivalents) was prepared in accordance with guidelines set forth by the Code of Federal Regulations [5] used for health professional shortage area (HPSA) designation. Utilizing the "*Kansas Primary Care Dentist FTE Report by County, 2000*" [6], trends can be identified tracking the Kansas primary care dentist supply between 2000 and 2010. This comparison is highlighted below.

Methodology

License renewal data provided by the Kansas Dental Board from 2000 and 2010 submitted for the fourth quarter of the calendar year upon which the respective Primary Care Dentist FTE reports [4, 6] were based was used for preparation of the present report. Both datasets contain information provided by primary care general and pediatric dentists on their license renewal forms. This data includes their number of hours worked per week and their practice locations [7]. FTEs were adjusted for hours and age as required by federal health professional shortage regulations*. Practice hours were limited to a maximum of 40 hours per dentist for all sites. Adjusted census data for 1999 [8] and 2009 [9], with group quarters population subtracted from the Kansas total population, were used for calculation of persons per hours adjusted and age adjusted FTE dentist counts for 2000 and 2010†.

*NOTE: Full-time Equivalent. One FTE is based on a 40 hour work week. In cases where a dentist's total practice hours for all work sites exceeds 40 hours per week, the value for total hours is set to 40 and the hours are distributed across all sites in proportion to the actual practice hours. Hours per week practiced at each location are used to allocate a dentist's FTE to multiple locations.
Adjusted Full-time Equivalents. According to Federal Health Professional Shortage Area Guidelines, dentists' FTEs should be adjusted to reflect variations in productivity; one measure of dentist productivity is the number of auxiliaries employed by the dentist's office. Since that type of information was not available, an alternative measure of productivity based on age and the following values was used to compute age-adjusted FTEs, i.e., under 55 years=1.2, 55 to 59=0.9, 50 to 64=0.8 and 65+ years = 0.6. Due to the weighting, some dentists under age 55 had age-adjusted FTEs greater than 1.0; however, the theoretical maximum of 1.20 age-adjusted FTE was not exceeded [5].

†NOTE: Subtraction of group quarters population numbers for the 2000 report excludes all institutional group quarters and non-institutional group quarters Kansas population counts. Subtraction of group quarters population numbers for the 2010 report excludes all institutional group quarters and a smaller sub-set of non-institutional group quarters Kansas population counts per designation of medically underserved areas requirements by Health Resources and Services Administration [5].

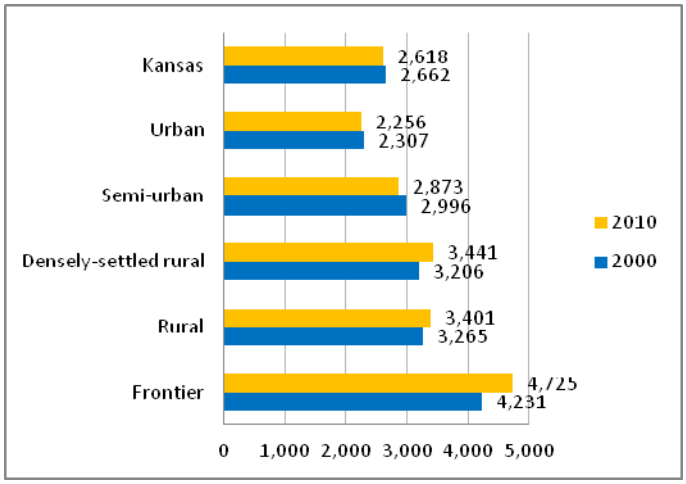
Figures and tables summarized below represent the indicated value per site, not per dentist. This is not the same as per dental office, since three dentists, for example, sharing a single office are counted as three sites and a single dentist with two offices is counted as two sites. By definition, hours reported by dentists for activities other than direct patient care (e.g., teaching, administration, research and other) are not included in primary care dentist calculations of FTEs, since primary care's focus is direct patient care [10].

Results

Comparing primary care dental FTE 2000 reports with 2010 reports indicates that:

- Rural, Densely-settled rural and Frontier peer group counties have lost population and primary care dentist FTEs. This has increased the number of persons per primary care dentist FTE over the last 10 year period.
- Semi-urban and Urban peer group counties have gained population and primary care dentist FTEs. This has reduced the number of persons per FTE primary care dentist over the same time period, since the increase in dentist FTEs has not kept pace proportionally with the population increases (Figure 1).
- Kansas overall has gained in population and primary care dentist FTEs and the number of persons per FTE primary care dentist has declined somewhat.

Figure 1. Kansas Population to Primary Care Dentist FTEs Adjusted by Hours and Age Ratio, Kansas 2000 and 2010



Inside

Table 1 provides a comparison of Kansas dentist service ratios for 2000 and 2010.

- The number of hours and age adjusted primary care FTE dentists increased by 82 between 2000 and 2010, from a total of 979 in 2000 to 1,061 in 2010 (Table 1).
- The Kansas Adjusted Population to Dentist FTE Ratio was 44 fewer in 2010 than 2000. That is, the number of people in Kansas (adjusted population) divided by the number primary care FTE dentists (hours and age adjusted) fell from 2,662 in 2000 to 2,618 persons per hours and age-adjusted primary care FTE dentist in 2010*. This means fewer persons were served by each dentist.

Table 1. Age and Hours Adjusted Primary Care Dental FTEs by Peer Group‡, Kansas 2000 and 2010

	Adjusted Population	FTE Adjusted by Hours and Age	Adjusted Population/FTE Adjusted by Hours and Age
Kansas			
2000	2,606,468	979.30	2,662
2010	2,778,506	1,061.34	2,618
Change	172,038	82	-44
Frontier			
2000	96,550	22.82	4,231
2010	85,804	18.16	4,725
Change	-10,746	-5	494
Frontier			
2000	96,550	22.82	4,231
2010	85,804	18.16	4,725
Change	-10,746	-5	494
Rural			
2000	280,944	86.04	3,265
2010	268,140	78.85	3,401
Change	-12,804	-7	136
Densely-settled rural			
2000	454,672	141.83	3,206
2010	450,535	130.93	3,441
Change	-4,137	-11	235
Semi-urban			
2000	407,034	135.86	2,996
2010	438,262	152.53	2,873
Change	31,228	17	-123
Urban			
2000	1,367,268	592.75	2,307
2010	1,535,765	680.88	2,256
Change	168,497	88	-51

The age of each dentist was calculated as of December 31, 2000 or 2010.
‡Peer groups include:
Frontier (less than 6 persons per square mile)
Rural (6 to 19.9 persons per square mile)
Densely-settled rural (20 to 39.9 persons per square mile)
Semi-urban (40 to 149.9 Persons per square mile)
Urban (150 or more persons per square mile)

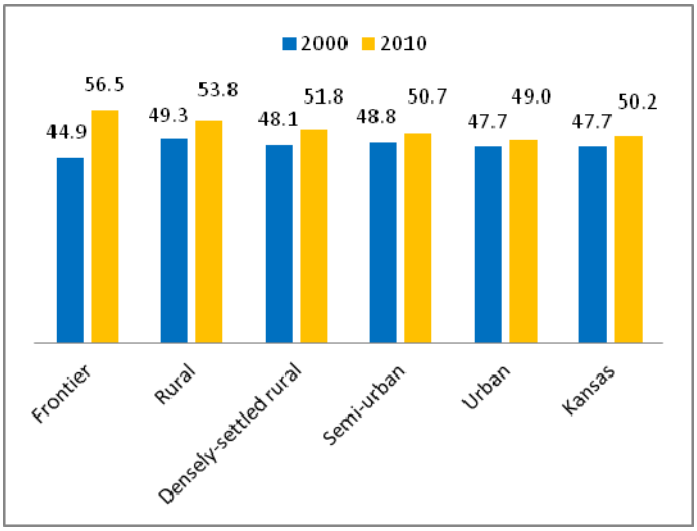
Table 2 contains information on mean age of dentists and the practice-hours-and-age-adjusted FTEs by Kansas peer groups for 2000 and 2010.

- The mean primary care dentist age rose in all peer group counties and the state between 2000 and 2010.
- The 2010 data indicated a slight trend toward younger primary care dentists practicing in more urbanized peer group areas, while older primary care dentists trended slightly toward more rural settings. Frontier counties in 2010 had the highest mean age among the peer groups for primary care dentists. The age difference was greatest for frontier counties between 2000 and 2010(Table 2 and Figure 2).
- Among more urbanized peer group primary care settings, dentists provided proportionally higher mean FTEs, while more rural peer group primary care setting dentists provided lower mean FTEs. This means that a slightly smaller average number of service hours were occurring in more rural settings, while a slightly larger average number of service hours were occurring in more urbanized settings. Mean peer group FTE distributions were similar between 2000 and 2010, while the state mean increased somewhat.

Table 2. Mean Age and Hours-and-Age-Adjusted FTEs by Peer Group, Kansas 2000 [6] and 2010 [4]

Pop Density Peer Group	2000 Mean Age	2010 Mean Age	Mean Age Diff	2000 Mean Hours/ Age-Adj FTE	2010 Mean Hours/ Age-Adj FTE
Frontier	44.9	56.5	11.6	0.71	0.73
Rural	49.3	53.8	4.5	0.77	0.74
Densely-settled rural	48.1	51.8	3.7	0.85	0.82
Semi-urban	48.8	50.7	1.9	0.86	0.83
Urban	47.7	49.0	1.3	0.85	0.86

Figure 2. Mean Primary Care Dentist Age by Peer Group, Kansas 2000 [6] and 2010 [4]



Review of primary care distribution of dental services comparing 2000 with 2010 information contained in the more the detailed reports indicates that:

- In 2000, 26 Kansas counties were better served than the state average. This number decreased to 24 in 2010 (2,662 persons per primary care dentist in 2000 vs. 2,618 persons per primary care dentist in 2010).
- The number of Kansas counties with an above average number of persons per primary care dental FTE decreased from 69 in 2000 to 67 in 2010 (had more persons per primary care dentist than the state average).

- The number of Kansas counties with less than one full primary care dentist FTE increased from 14 in 2000 to 17 counties in 2010 (Figures 3 and 4).
- The number of Kansas counties that had no primary care FTE dentist providing dental services in their county (zero FTEs) increased from 10 counties in 2000 to 14 counties in 2010 (Figures 3 and 4).

Figure 3. Distribution of Kansas Primary Care Dentist FTEs Adjusted by Hours and Age by County, 2000

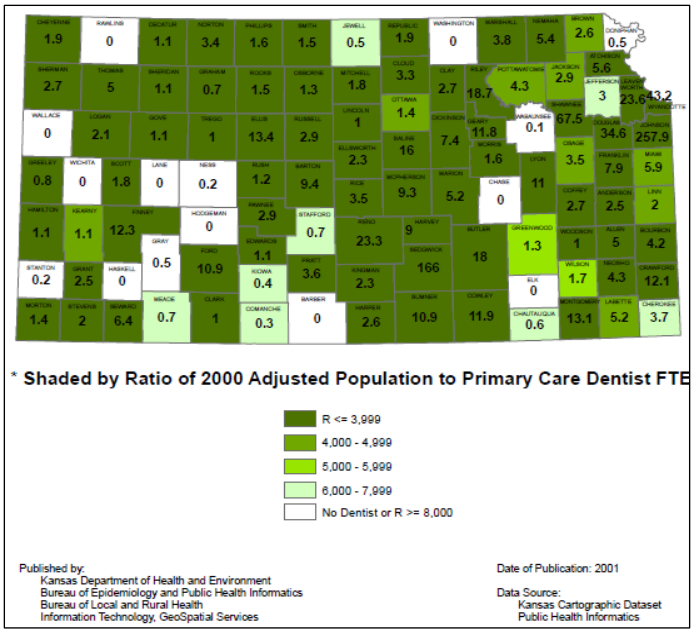
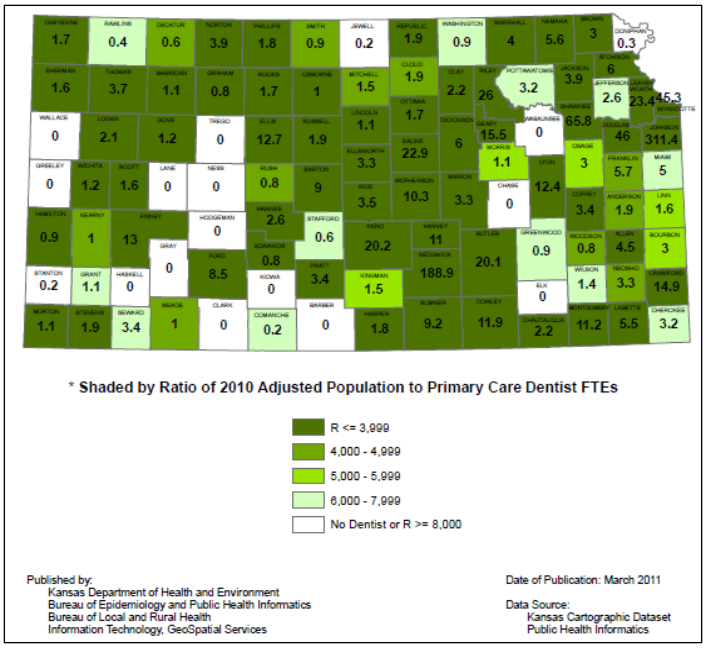


Figure 4. Distribution of Kansas Primary Care Dentist FTEs Adjusted by Hours and Age by County, 2010 †



Conclusion

Kansas dentist service ratios have changed between 2000 and 2010.

- The number of hours-and-age-adjusted primary care FTE dentists in Kansas increased by 82 between 2000 and 2010 (Table 1).
- The adjusted population number per primary care dentist FTE in Kansas improved by 44, meaning that in 2010 there was an average of 44 fewer persons per primary care dentist than in 2000 (Table 1).
- The average age of Kansas primary care dentists increased over the 10 year review period from 2000 to 2010 (Table 2).
- In 2010 in Kansas, the younger the primary care dentist, the more likely they were to be found practicing in more urbanized areas, while the reverse is seen in 2000 (Table 2).
- More urbanized Kansas service areas tend to receive higher average primary care FTE dental services (Table 2).
- The number of Kansas counties with less than one FTE increased, as did the number of counties with no FTEs, from 2000 to 2010 (Figures 1 and 2).

A comparison between the 2000 and 2010 Primary Care Dentist FTE Reports highlights a growing primary care dentist shortage, particularly in rural areas. In areas of the state where the population and dentist FTEs are declining, but dentist FTEs have a proportionally higher decline, the person to provider ratio climbs, which may in turn lead to less access to dental care. To assure that the dental needs of Kansans are met, attention must be focused on developing and implementing plans to address Kansas primary care dentist shortages.

For more information contact the BEPHI at 785-296-5281 with report questions or for additional information.

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Acknowledgement

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Enteric Disease Investigation Pilot Project

The surveillance of infectious diseases in Kansas includes the collection, analysis and dissemination of reportable disease data. In order to conduct this surveillance the Kansas Department of Health and Environment (KDHE) maintains a list of reportable infectious diseases for Kansas that can be accessed at www.kdheks.gov/epi. The data obtained through infectious disease surveillance are used to measure the burden of disease in Kansas, monitor disease trends, detect infectious disease

measures, support planning and policy efforts, prioritize the allocation of public health resources and provide a basis for epidemiologic studies. When an infectious disease is reported to KDHE the data is entered into an electronic disease surveillance system which is maintained at KDHE. The local health departments have the responsibility of monitoring this system and conducting follow-up on infectious diseases identified in their respective counties. This follow up includes collecting clinical information from the physician and case-patient as well as determining exposures that could have lead to disease transmission.

Completeness of the investigations for *Salmonella*, Shigatoxin *Escherichia coli* (STEC), *Giardia* and *Cryptosporidium* cases that were reported to KDHE and investigated by the local health departments was evaluated. During 2010, 433 cases of *Salmonella*, 104 cases of STEC, 211 cases of *Giardia*, and 141 cases of *Cryptosporidium* were reported to KDHE (Table 3). Of those, only 51 percent - 60 percent of cases were fully investigated, (Table 3).

Table 3. Number of *Salmonella*, STEC, *Giardia*, and *Cryptosporidium* cases reported in 2010 with the number and percent of cases with completed enteric supplemental forms.

Disease	Number of Cases	Number (%) with Completed Investigations
Salmonella	433	233 (54%)
STEC	104	62 (60%)
Giardia	211	108 (51%)
Cryptosporidium	141	84 (60%)

In order to determine how well the current enteric forms performed, an evaluation of the clusters of diseases was conducted. During 2010, 33 clusters of *Salmonella* and six clusters of STEC that matched by both serotype and molecular subtype were detected; however, no common exposures for any of these clusters or cases could be identified. For *Cryptosporidium* and *Giardia* no common exposures for any of these cases could be identified. The inability to discover a common transmission source for any of the clusters or cases was the result of incomplete disease investigation and a lack of specific exposure information collected with the current enteric supplemental forms used to interview cases reported to KDHE.

In order to improve the surveillance data that is collected for *Salmonella*, STEC, *Giardia*, and *Cryptosporidium* cases that are reported to KDHE, the Bureau of Epidemiology and Public Health Informatics (BEPHI) along with 31 local health departments are conducting a pilot project. The pilot project objectives are to increase the percent of questionnaires completed for *Salmonella*, STEC, *Giardia*, and *Cryptosporidium* cases that are reported and to improve the quality of the surveillance data that is collected. In order to meet these project objectives, new disease specific enteric supplemental forms were developed for *Salmonella*, STEC, *Giardia* and *Cryptosporidium*. The forms developed for *Salmonella* and STEC were a modification of a form that was developed by six states in collaboration with the Centers for Disease Control and Prevention. This form is designed to collect many additional exposures in the initial interview so that common exposures can be identified quickly and compared across states to facilitate the implementation of control and prevention measures to prevent the spread of disease. The forms developed for *Giardia* and *Cryptosporidium* are more focused on the specific activities and exposures known to be associated with the spread of these diseases.

This pilot project began on April 1, 2011 and will end on October 1, 2011. On a monthly basis during the pilot project, quality indicators that measure timeliness and completeness of the investigation will be sent to all participating counties. After the pilot ends, analysis of the new enteric supplemental form data will be conducted and feedback from the participating counties on the use of the new forms will be collected. With these results, enhancements to these four supplemental forms will be completed, and final forms will be incorporated into the disease investigation protocols for all local health departments.

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Arthritis and Overweight or Obesity as a Potential Barrier to Physical Activity among Kansas Adults

Background

Regular physical activity, including aerobic exercise and strength training, has been shown to reduce the risk of several chronic diseases [2,5] and is important for healthy aging [5]. The Kansas Behavioral Risk Factor Surveillance System (BRFSS) shows a high number of overweight and obese persons (Body Mass Index/BMI $\geq$25 kg/m^2) also having arthritis [4]. As many inactive adults with arthritis indicate fear of increased arthritis or joint pain as a barrier to physical activity [9], arthritis pain in overweight and obese patients may contribute to physical inactivity.

Objective

This study aims to examine the physical activity status among Kansans who are overweight or obese (Body Mass Index $\geq$ 25) and have arthritis, using 2009 Kansas BRFSS data [4].

Methods

2009 Kansas BRFSS data were analyzed. Kansas BRFSS is an annual population-based random digit-dial telephone survey, tracking health conditions and risk behaviors of non-institutionalized asults ages 18 years and older, residing in a private residence with a landline telephone. The sample size for the 2009 Kansas BRFSS survey was 18,912 respondents.

Respondents were considered to be overweight or obese if they had a Body Mass Index (BMI) greater than or equal to 25 kg/m^2. BMI is calculated by dividing self-reported weight in kilograms by self-reported height in meters squared. Respondents were considered to have arthritis if they responded “yes” to the question, “Have you ever been told by a doctor or other health professional that you have some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia?”

Weighted analysis of Kansas BRFSS data was performed using SAS 9.2 software to calculate population-based estimates for Kansas adults ages 18 years and older. Age- and gender-specific prevalences of arthritis among overweight or obese adults were calculated, along with physical activity status among overweight or obese adults with arthritis.

Results

In Kansas, about 24 percent of adults ages 18 years and older have doctor-diagnosed arthritis and about 65 percent of adults are overweight or obese. Among adults without arthritis, approximately 62 percent are overweight or obese, as compared to almost three-fourths (74%) of adults with arthritis (see Figure 5). Participation in recommended levels of physical activity is lower among persons who are overweight or obese (O/O), as compared to persons who are not (O/O: 45%, 95%CI: 43.9-46.4; Normal/underweight: 56.0%, 95%CI: 54.2-57.9; see Table 4). Among adults with arthritis, about 41 percent (95%CI: 39.0-42.2) participate in recommended levels of physical activity [6] as compared to 51percent of adults without arthritis (95%CI: 49.7-52.2).

Participation in recommended levels of physical activity is lower among normal weight (BMI less than 25 kg/m^2) adults with arthritis as compared to those without arthritis (Arthritis: 47%, 95% Confidence Interval (CI): 43.3-49.6; No arthritis:

recommended physical activity levels is seen among overweight or obese adults who also have arthritis. Just under half (48%, 95%CI: 46.0-49.1) of overweight or obese adults without arthritis report levels of physical activity that meet recommendations, as compared to only 39 percent (95%CI: 37.2-48.0) of overweight or obese adults with arthritis. The highest proportion of adults reporting no physical activity is also among this group. Over one-fifth (21%, 95%CI: 19.2-22.1) of overweight or obese Kansas adults with arthritis are inactive. This proportion is significantly higher than that in overweight or obese adults without arthritis (11%, 95%CI: 9.9-11.8).

Figure 5. Prevalence of Overweight & Obesity Among Adults

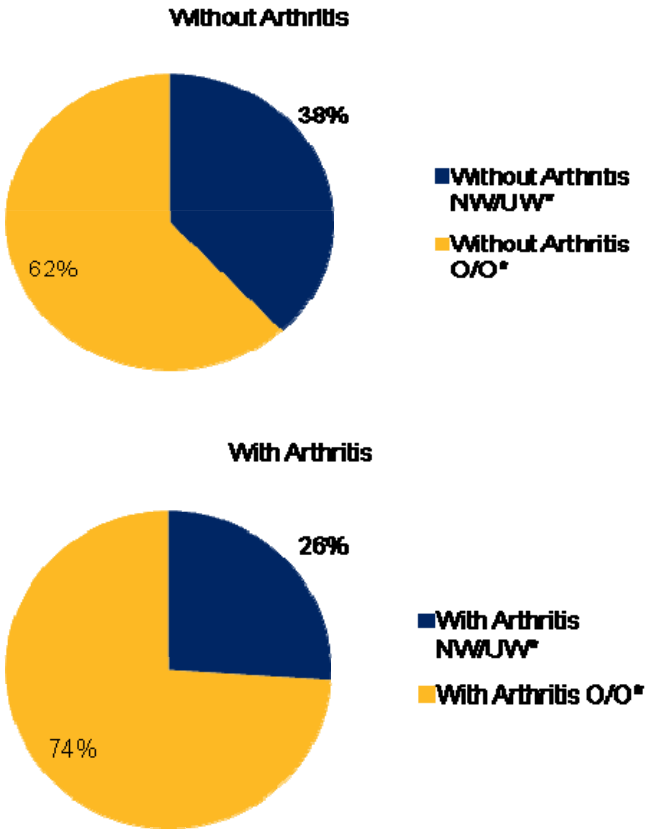

Table 4. Physical Activity Levels Among Kansas Adults with and without Arthritis

	Physical Activity Level		
	Meets Recommendations Percent (95%CI†)	Insufficient Activity Percent (95%CI†)	Inactive Percent (95%CI†)
NW/UW w/ Arthritis	46.5 (43.3-49.6)	35.9 (32.8-39.0)‡	17.6 (15.4-19.9)‡
O/O w/ Arthritis	39.0 (37.2-40.8)	40.4 (38.5-42.2)	20.6 (19.2-22.1)‡
NW/UW w/o Arthritis	58.0 (55.9-60.1)	34.0 (31.9-36.0)‡	8.0 (7.0-9.1)‡
O/O w/o Arthritis	47.5 (46.0-49.1)	41.6 (40.1-43.2)‡	10.8 (9.9-11.8)‡

*NW/UW: Normal Weight/Underweight: BMI < 25kg/m^2; O/O: Overweight/ Obese: BMI $\geq$ 25 kg/m^2
†CI: Confidence Interval
‡Significant difference within group
¶ Physical Activity Recommendations: *Meets Recommendations*: moderate physical activity at least 5 days per week for at least 30 minutes or more per day, or vigorous physical activity on at least 3 days per week for at least 20 minutes per day, or both; *Insufficient:* some activity but not enough to meet recommendations; *Inactive*: No physical activity. Physical activity includes leisure-time, household, and transportation.
Source: 2009 Kansas BRFSS, Bureau of Health Promotion

Discussion

The long-term benefits of physical activity have been established [8], yet statewide surveillance shows many Kansans do not get enough physical activity. Previous studies have shown that overweight and obese patients indicate injury, disability and/or arthritis as a barrier to becoming more physically active [1,3]. In Kansas, about three-fourths (74%) of adults who have arthritis are overweight or obese, and almost two-thirds of adults who are overweight or obese and have arthritis do not participate in recommended levels of physical activity. Health care providers should assess the arthritis status of overweight and obese patients before making recommendations for physical activity, as arthritis pain may be an additional barrier to being physically active. Providers should also be aware of programs available for persons with arthritis that help them become active without causing further damage to arthritic joints. The Kansas Arthritis Program supports the implementation of such programs, including Arthritis Foundation Exercise Program and Walk with Ease, both of which allow participants with arthritis to successfully become physically active while improving the mechanics and range of motion of arthritic joints.

This study is subject to a few limitations. Doctor-diagnosed arthritis, weight and height (for BMI), and activity level are self-reported in BRFSS; however, self-reports have been shown to be valid for surveillance purposes [7]. In addition, the findings in this report do not account for persons with undiagnosed arthritis.

The study results indicate a need for implementation of programs directed towards helping overweight or obese adults with arthritis to become physically active.

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Announcement

Abortions Decline in Kansas

There were 8,338 abortions reported in Kansas during 2010, a decrease of 12.0 percent or 1,136 fewer reports than final 2009 (9,474). Of the abortions reported in Kansas during 2010, a total of 4,188 (50.2%) occurred to Kansas residents. The number of Kansas residents obtaining abortions decreased by 12.4 percent compared to 2009.

Of the 4,150 out-of-state residents who obtained abortions in Kansas, 4,077 (98.2%) were Missouri residents.

The total number of reported abortions in 2010 was 3,989 fewer, a 32.4 percent decrease from 2000. The 2010 total was the lowest in Kansas since 1988 when 7,930 reports were made.

Women 20-24 years of age comprise the largest age-group seeking abortions (33.6%) (Table 4). The largest decline in the number of procedures from 2009 to 2010 also occurred to women 20-24 years of age, a decrease of 344 procedures (10.9%). There were 38 abortions to women under 15 reported in 2010, 11.6 percent fewer than in 2009.

White non-Hispanic women accounted for three out of five (60.0%) of the abortions reported. Hispanic women of any race accounted for about one out of 10 abortions (9.8%). Black non-Hispanic women accounted for about one out of five of abortions reported (22.0%). All three of these population groups had declines in the number of abortions reported from 2009 to 2010. The largest percentage rate decrease occurred among Black non-Hispanic women (14.1%).

Over four out of five Kansas-reported abortions occurred to unmarried women (85.2%), virtually unchanged from 2009.

Of reported abortions, almost three out of five occurred to women who reported never having a previous abortion (4,992 or 59.9%) virtually unchanged from the year before. About one in four women reported having one previous abortion (2,091 or 25.1%) A total of 160 women (1.9%) indicated they had previously had four or more abortions.

More than three out of five (64.8%) of all reported abortions occurred prior to nine completed weeks of gestational age. This is a slight increase from 2009. Only one late term abortion was reported in Kansas in 2010.

Over six out of 10 abortions (65.0%) in 2010 were performed using suction curettage. Mifepristone (RU 486) was used in over one in four reported abortions (26.4%). This represented a 5.6 percentage point increase from 2009.

The KDHE preliminary report of 2010 abortions is available at www.kdhe.ks.us/bephi/

Bureau of Epidemiology and Public Health Informatics

Table 4. Abortions by Selected Characteristics, Kansas, 2010

Selected Characteristics	Number	Percent
Residence		
Total Reported	8,338	100.0
In-state residents	4,188	50.2
Out-of-state residents	4,150	49.8
Age Group		
Under 14 years	8	0.1
14 years	30	0.4
15 years	70	0.8
16-17 years	288	3.5
18-19 years	770	9.2
20-24 years	2,805	33.6
25-29 years	2,113	25.3
30-34 years	1,277	15.3
35-39 years	725	8.7
40-44 years	240	2.9
45 years and over	12	0.1
Not Stated *	0	n.a.
Population Group **		
White Non-Hispanic	4,987	60.0
Black Non-Hispanic	1,829	22.0
Native American Non-Hispanic	61	0.7
Asian/Pacific Islander Non-Hispanic	315	3.8
Other Non-Hispanic ***	304	3.7
Hispanic Any Race	811	9.8
Not Stated *	31	n.a.
Marital Status		
Married	1,233	14.8
Unmarried	7,088	85.2
Not Stated *	17	n.a.
Weeks Gestation		
Less than 9 weeks	5,404	64.8
9-12 weeks	1,948	23.4
13-16 weeks	630	7.6
17-21 weeks	355	4.3
22 weeks & over	1	0.0
Not Stated *	0	n.a.

n.a. Not applicable

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

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

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

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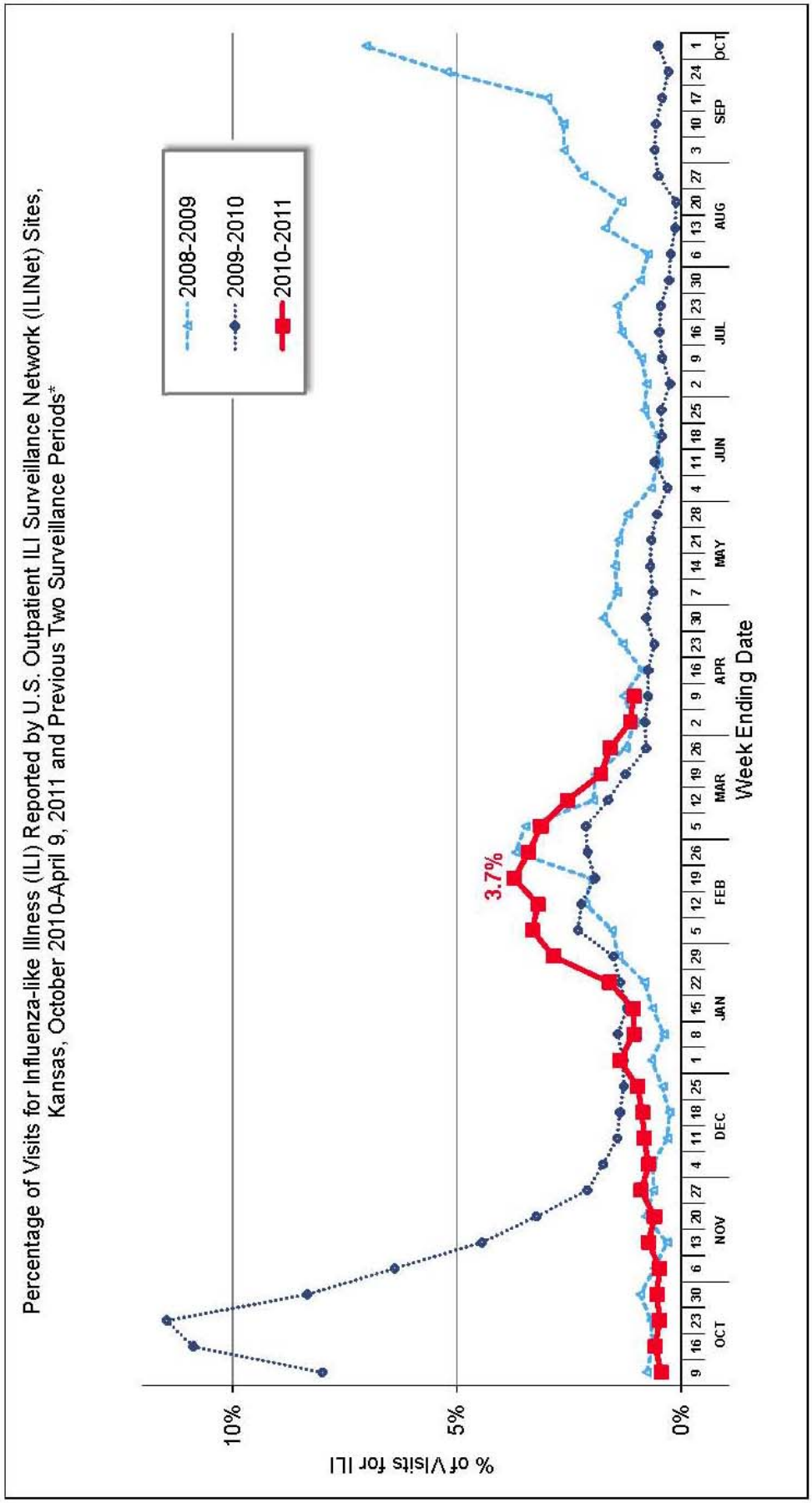
Notice to Readers

The Kansas Public Health Leadership Institute seeks applicants for the Cycle IX (2011-2012) training class, which begins in July. This nine-month competency-based training program allows participants to develop leadership skills and knowledge that are essential to public health agencies preparing for accreditation. The program is open to leaders from state and local health departments, health research, private health practice or any allied field. CEU/CNE/CME credit is available for participation. KU-MPH credit is also available for program graduates. For more information visit, www.waldcenter.org/kphli or email KPHLI assistant director Kelly Kabler at kkabler@kumc.edu



*Influenza-like Illness (ILI) is defined as fever with cough or sore throat. ILINet sites may vary in location, number, and type (student health, family practice, pediatrician, emergency medicine, etc.) each season. Data from the previous two surveillance years are plotted according to week number corresponding to the 2010-2011 week ending date; for example, week 40 of 2010 ended October 9, 2010, week 40 of 2009 ended October 10, 2009, and week 40 of 2008 ended October 4, 2008. Week 53 was unique to the 2008-2009 season; data for that week has been excluded from the chart.

The X-axis represents the week ending dates for the current surveillance year.

Data from the previous two surveillance years are plotted according to week number corresponding to the 2009-2010 week ending date.

Week 40 of 2009 ended October 10, 2009. Week 40 of 2008 ended October 4, 2008, and week 40 of 2007 ended October 6, 2007, and so on.

Week 53 was unique to the 2008-2009 season; data for that week has been excluded from the chart.

ILINet sites vary in location, number, and type (student health, family practice, etc.) each season, as new sites are enrolled and former sites are deactivated.

Influenza surveillance data collection is based on a reporting week that starts on Sunday and ends on Saturday of each week.

Each surveillance participant is requested to summarize weekly data and submit it by noon on Tuesday of the following week.

Those data are then downloaded, compiled, and analyzed.

Because the chart represents data reported by noon on Tuesday of the most recent week, the 2009-2010 data is provisional.

The chart may change as those who missed the reporting deadline submit information, or as those who reported re-submit corrected data.

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