

Kansas Health Statistics Report

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Kansas HIPAA Awareness Efforts Underway

A January 14-15 conference held in Topeka explored issues related to implementing in Kansas the provisions for privacy, security, and health care transactions defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). About 300 people, including health leaders, administrators, researchers, and information technology specialists from a variety of disciplines, attended the conference to learn how to bring Kansas up to speed on HIPAA compliance.



The conference, sponsored by a collaborative group called HARK (HIPAA Awareness and Readiness for Kansas), is the state's first attempt at involving a number of disciplines to address the state's needs for implementing the HIPAA provisions.

A survey distributed to health care providers and state agencies recently revealed that Kansas has a long way to go before the state is compliant with HIPAA regulations. Cathy Holmes, Internal Operations Manager for Blue Cross/Blue Shield of Kansas, reviewed the survey results and found that 44.6 percent of respondents had not yet heard of HIPAA.

Several national speakers were on hand to explain the requirements. One was Steven Lazarus, president of Boundary Information Group, a consortium of health care information and technology consulting firms, who said the health care industry needs to move faster with these regulations.

According to Lazarus, health care organizations should develop a project plan, project management, and dedicated project resources aimed at complying with HIPAA regulations.

Lazarus, who is the chairman of the Workgroup for Electronic Data Interchange board of directors, declared false several of the HIPAA myths, including:

- there will be more delays in HIPAA deadlines,
- there won't be HIPAA enforcement for many years,
- vendors will take care of HIPAA regulations,
- HIPAA is an information technology project, and
- organizations can wait until late 2002 to work on HIPAA compliance.

Lazarus recommended providers and payers work together and not delay. The deadline for compliance is 2003.

The conference presented the "world view" of HIPAA to the state and drilled down into specialties. The next steps in HARK's plans for HIPAA education and awareness are to establish workgroups on privacy, security and transactions and to foster industry-specific education programs to increase awareness about the provisions of HIPAA.

HARK is seeking participation from all elements of the health care industry in Kansas to facilitate understanding of HIPAA and implementation of its provisions. For more information on HIPAA and HARK visit <http://www.hark.info>.

*Elizabeth W. Saadi, PhD
Office of Health Care Information*

Emergency Notification of Health Care Professionals

In the event of a bioterrorism incident or disease outbreak, Kansas public health and emergency management officials need to provide information to health care professionals quickly and effectively. Given the advancements in communications technology, the capability exists to notify health care providers about how to recognize and treat health conditions related to a bioterrorism event in a matter of seconds.

The Health Care Data Governing Board recently approved an initiative to acquire electronic mail addresses and pager numbers through the Governing Board's health system inventory for maintenance in the health care database. This information would be made available to public health and emergency management officials for rapid notification purposes only.

"Issues such as professionals that do not use E-mail and rapidly changing E-mail addresses will be problematic. However, these problems can be addressed, and ultimately, this method of communication will be significantly better than the process we have now—the postal service" says Dr. Gianfranco Pezzino, State Epidemiologist. "With today's technology, we can improve the flow of information and hopefully reduce the effects of bioterrorism events."

Health care professionals will be asked to provide their E-mail addresses and pager numbers voluntarily.

*Elizabeth W. Saadi, PhD
Office of Health Care Information*

Kansas Diversity Increasing

Given the predictions about the 2000 Census, the increase in Kansas' racial and ethnic diversity in the decennial census was not a surprise. Once the census was tabulated, almost 17 percent (16.9) of the Kansas population reported themselves as a minority. This compares to only 11.6 percent of the population in the 1990 Census.

A minority was considered to be someone of Hispanic ethnicity or who was from one of the non-Hispanic subgroups of the six non-white race categories (Black/African-American, Hawaiian/Pacific Islander, American Indian/Native Alaskan, Asian, other, and multi-race). The Kansas minority population increased 58.3 percent to 454,421 from the 1990 Census to the 2000 Census.

The minority population was spread out around the state. The 35 counties having ten percent or more minority population generally occurred in a band running from the southwest to the northeast part of the state.

Outside of those 35 counties the minority population was rather small. Only 4.5 percent of the non-Hispanic Black/African-Americans and 7.3 percent of the Hispan-

What's Inside

HIPAA Summit Conference Informs 300	1
Emergency Notification of Health Care Professionals	1
Kansas Diversity Increasing	1
Kansas Workplace Injuries and Illnesses affect 70,000	2
Infectious Disease Summary Published	3
News Notes	4

ics lived outside the 35 counties.

Seward County had the highest percentage of minority population at 50.6, followed closely by Wyandotte County at 48.4 percent. Smith County had the lowest minority population at 1.6 percent.

Minority populations were not evenly spread within the 35 counties. Individuals of Hispanic origin, while living in many of the urban areas, comprised the highest share of the minority population in southwest Kansas. Individuals of non-Hispanic, Black/African-American race comprised the highest share of the minority population in 16- counties, including Wyandotte, Leavenworth, Geary, Sedgwick and Shawnee. Non-Hispanic American Indian/Alaska Natives represented the largest minority population in four counties: Jackson, Brown, Chautauqua and Cherokee.

*Greg Crawford, Office of Health Care Information
Henri Menager MPH, Bureau of Health Promotion*

Workplace Injuries & Illnesses, 2000

About 70,000 injuries and illnesses were reported in private industry workplaces in Kansas during 2000, resulting in a rate of 7.8 cases per 100 full-time workers across the state (Figure 1). This is the first time since 1993 that the incidence rate for Kansas has not decreased from the previous year, increasing 2.6% from 1999.

The manufacturing industry had the highest incidence rate in 2000, experiencing 11.3 occupational injuries and illnesses per 100 full-time workers (Figure 2). In the durable goods division of manufacturing, primary metal industries appeared to be the most dangerous industry for the state. The primary metal industries employed 3,300 people statewide, and had 1,000 reported cases, giving the industry group an incidence rate of 30.2 injuries and illnesses for every 100 employees.

Nonfatal Injury & Illness Incidence Rates Private Industry, Kansas, 1991-2000

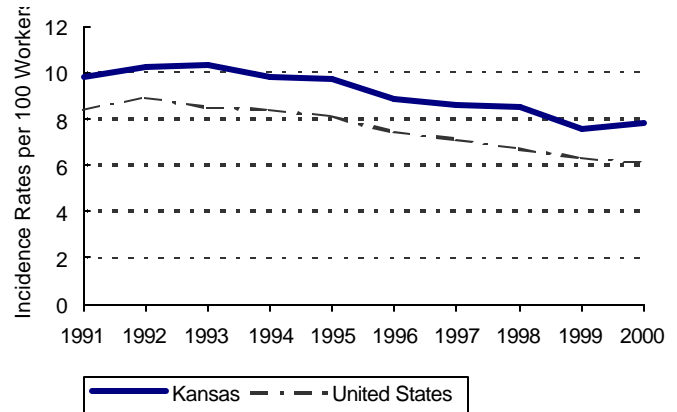


Figure 1

Private industry has been on a steady downward trend since 1994, declining from 8.4 work related injuries and illnesses in 1994, to a rate of 5.7 in 2000.

The 70,000 cases that were reported in 2000 comprised 6.4% of the estimated 1,082,600 people in the Kansas workforce. In 30,200 of the reported cases (43.1% of the total), workers actually took time off of work, or restricted their duties while working, to recover from their injury or illness. The remaining 39,800 cases were occupational injuries or illnesses that required no time away from work.

Illnesses occurred in 6,400 of the 70,000 injury and illness cases reported in the state. Those illness cases requiring days

away from work or restricted activity while working to recover totaled 3,500. Of the 3,500 cases, 1,200 actually needed days away from work to recover from their ailments. Disorders associated with repeated trauma were the leading type of illness in 2000, occurring to 56.6 of every 10,000 workers across the state.

Information on workplace injuries and illnesses are available by contacting the Office of Health Care Information at 785-296-1058. Tables for fatal occupational injury statistics can be

Nonfatal Workplace Injury & Illness Incidence Rates By Industry, Kansas, 1996-2000

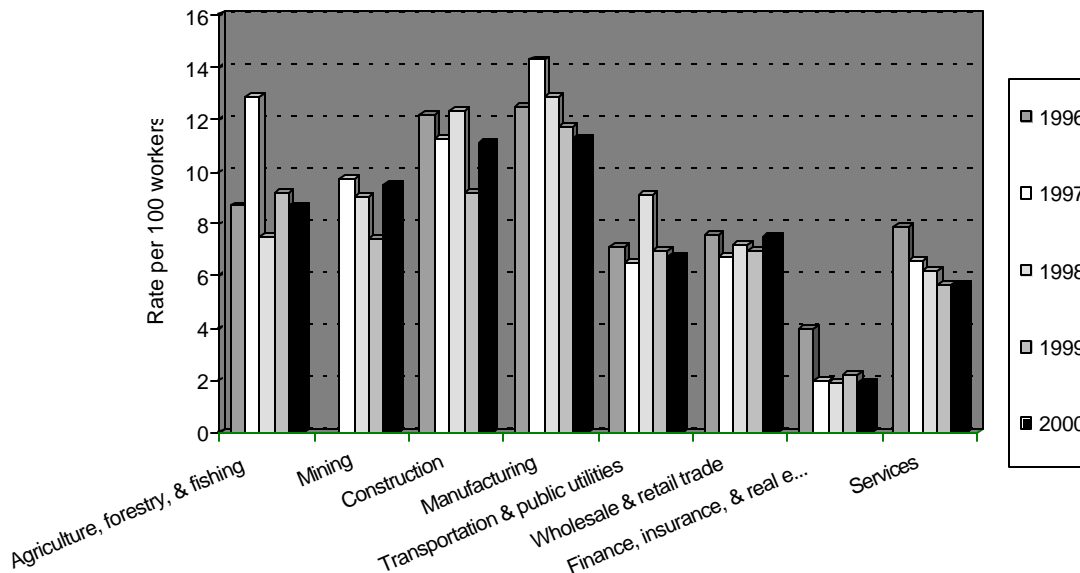


Figure 2

Both the manufacturing and the services industry continued their downward trends, decreasing the incidence rate of work related injuries and illnesses in the workplace. Since 1992, the manufacturing industry has consistently decreased the occurrence of their workplace injuries, with the one exception of 1997 where the rate increased 14.4% from the previous year. The ser-

obtained by calling the same number. National statistics can be obtained on the web at <http://www.bls.gov>.

*Charlie Sann
Occupational Injury Surveillance*

Reportable Disease Trends in Kansas

The KDHE Bureau of Epidemiology and Disease Prevention has published its 2000 *Reportable Diseases in Kansas, Annual Summary*. The report presents summaries of 33 reportable diseases or conditions of public health importance in Kansas and a summary of reportable disease cases by county for 2000.

Among vaccine-preventable diseases, there were two confirmed cases of measles in Kansas, the first since 1996; however, nationwide, measles remained at low levels. The two Kansas cases were unrelated, and were probably acquired outside our state.

The number of reported confirmed pertussis cases declined in 2000 compared to the previous 3 years, but pertussis remains the vaccine-preventable disease with the highest number of reported cases.

Tetanus remained at low levels. Reported cases of acute hepatitis B have steadily declined since 1991, when vaccine use became more widely available. There were no reported cases of diphtheria, mumps, polio, or rubella. The U.S. has been considered polio free since 1979.

The number of reported primary and secondary syphilis cases continued to decline in Kansas. In 1999, the Sexually Transmitted Disease (STD) Program received 14 reports of primary and secondary syphilis, and in 2000, the STD Program received 6 reports of primary and secondary syphilis. Syphilis cases continued to be concentrated in urban regions of the state.

Like syphilis, gonorrhea was concentrated in urban areas of the state.

Chlamydia remained the most frequently reported sexually transmitted disease in Kansas with 6,057 cases reported in 2000, a decrease from the previous year. In contrast to syphilis and gonorrhea, chlamydia was more widely distributed geographically. Over 80% of reported cases occurred among females. This gender disparity reflects the focus of chlamydia detection activities in the state which target females.

Among reported cases of these three major bacterial STDs racial and ethnic minorities were disproportionately represented, which mirrored national trends. This may reflect reporting bias (e.g., African-Americans may use public STD clinics more often for health care and be more likely to be screened or reported if positive). Both syphilis and gonorrhea infections were largely confined to the urban areas of the state, while at least one case of chlamydia occurred in 98 of 105 counties in Kansas. This distribution also reflects national trends. The majority of syphilis cases are reported from public STD clinics, whereas chlamydia and gonorrhea infections are reported from private physicians. Nearly 66% of reported bacterial STD reports are from private providers rather than publicly funded STD and family planning clinics.

The number of reported Kansas AIDS cases decreased from 1999 to 2000, as did the numbers for most other states. Male-to-male sex continues to be the leading risk behavior. Beginning July 1, 1999, positive HIV test results were also reported confidentially to the KDHE

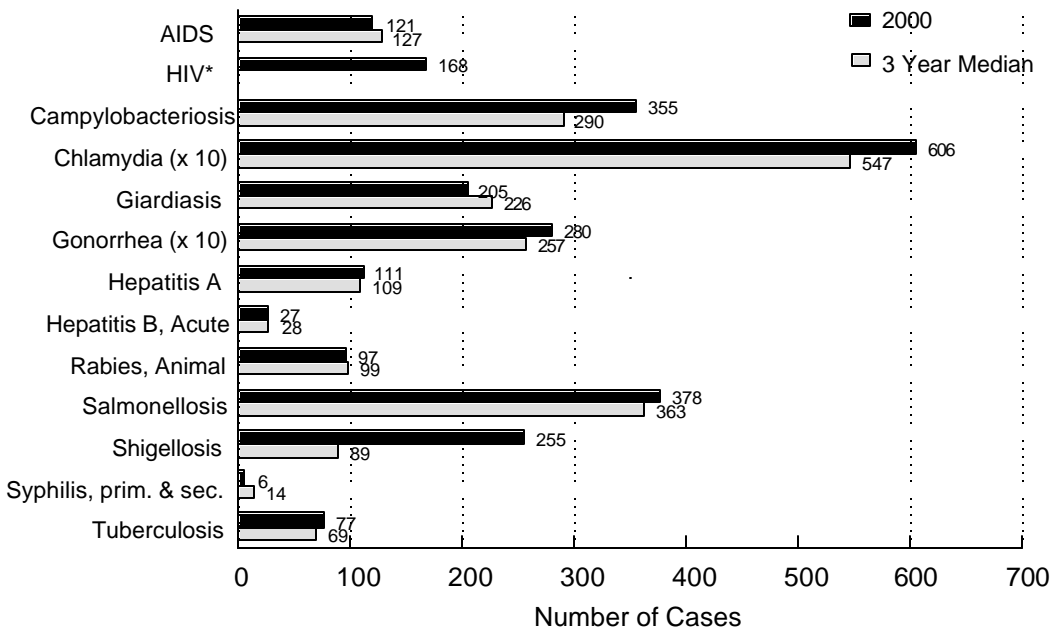
from physicians and laboratories. The percentage of cases reported with no known risk factor is higher than for AIDS cases (20% and 11% respectively in 2000), but it was not unexpected. However, many cases were reclassified into known risk categories after further investigation.

Kansas reported 77 cases of active tuberculosis (TB) disease in 2000, up from 69 cases of active TB in 1999. During 2000, the state's major metropolitan areas were home to the most reported cases of TB. Sedgwick county again reported the highest number of new cases of TB disease in 2000, with 28. Two metropolitan Kansas counties reported noteworthy increases during 2000: Johnson reported 12 cases, up from five in

1999, and Wyandotte reported 11 cases, up from four in 1999. There were two cases of TB-HIV co-infection, as compared with three cases in 1999. There were no reported cases of multi-drug resistant TB (MDR-TB) in Kansas again in 2000.

Enteric infections (salmonellosis, shigellosis and giardiasis) continued to be reported in large numbers. The number of cases of shigellosis almost tripled, primarily because of a sustained outbreak in the Kansas City area. Twelve foodborne outbreaks of

Selected Reportable Diseases in Kansas, 2000



* HIV became reportable in Kansas July 1999

Figure 3

Syphilis remains important because of its potential for elimination, its capacity for transplacental transmission to infants, and its role as a risk factor for HIV infection and transmission. In 2000, one case of congenital syphilis was reported and two reported cases of secondary syphilis were found to be infected with HIV.

The incidence of gonorrhea continued to increase, with 2,795 cases reported in 2000 paralleling national trends. Young adults aged 20-24 and adolescents aged 15-19 had higher rates of in-

gastro-intestinal illness were reported and formally investigated by Epidemiologic Services during 2000. Two of the food-related illness outbreaks were attributed to *Salmonella spp.* (serotypes Group B and *newport*), and two to norwalk-like virus. No causative agent was positively identified in the remainder of food related illness.

In 2000, all enterohemorrhagic, enteropathogenic and enteroinvasive *E. coli*, ehrlichiosis, all cases of viral hepatitis (acute and chronic), listeriosis, streptococcal invasive disease (Group A *streptococcus* or *Streptococcus pneumoniae*), and varicella (chickenpox) deaths became reportable conditions in Kansas.

When interpreting the data in this report it is important to remember that disease reporting is incomplete and often varies by disease. For example, reporting of AIDS cases is estimated to be 90% complete, whereas reporting of salmonellosis is estimated to be 3-5% complete. Absolute numbers are less meaningful than trends when interpreting the data. However, trends can be influenced by changes in case definitions, in reporting patterns, or by random fluctuations. It is also important to note that since 59% (62/105) of counties in Kansas have populations less than 10,000, it is possible to have high rates of disease in these counties even if only very few cases are reported.

The usefulness of public health surveillance data depends on its uniformity, simplicity, and timeliness. The case definitions contained in this report follow the Centers for Disease Control/Council of State and Territorial Epidemiologists surveillance definitions for disease reporting and should not be confused with clinical diagnoses. Use of additional clinical, epidemiologic, and laboratory data may enable a physician to diagnose a disease even though the formal, standardized surveillance case definition may not be met.

The full report is available at <http://www.kdhe.state.ks.us/epi>.

Jamie Kim, MPH

KDHE Bureau of Epidemiology and Disease Prevention

News Notes

The National Center for Health Statistics reports in its *Summary Health Statistics for U.S. Children: National Health Interview Survey, 1997* that most U.S. children under 18 years of age enjoyed excellent or very good health (82%). However, 13% of children had no health insurance coverage, and 6% of children had no usual place of medical care. The percent of children with unmet medical needs was twice as high in single-mother families (4%) as in two-parent families (2%). Eleven percent of children had ever been diagnosed with asthma. An estimated 8% of children 3-17 years of age had a learning disability, and an estimated 6% of children had Attention Deficit Disorder. The report is available at <http://www.cdc.gov/nchs/default.htm>.

Barbara Bloom, MPA & Luong Tonthat
National Center for Health Statistics

State Health Facts Available

The Kaiser Family Foundation has launched a new Internet resource that offers comprehensive and current health information for all 50 states, the District of Columbia and U.S. territories. State Facts Online, at <http://www.statehealthfacts.kff.org>, offers health policy information on a broad range of issues such as managed care, health insurance coverage and the uninsured, Medicaid, Medicare, women's health, minority health, and HIV/AIDS. The site allows users to view information for a single state or compare it among all 50 states and U.S. totals.

Kaiser News Update

NCHS Data Users Conference

The National Center for Health Statistics (NCHS) announces its 2002 Data Users Conference. The Conference will be held July 15 - 17, 2002, at the Omni Shoreham Hotel in Washington, DC. NCHS offers this biennial gathering of local, State, and Federal health representatives for obtaining the latest information in the field of health statistics. Complete Conference details will be posted at <http://www.cdc.gov/nchs/events.htm> in the near future.

National Center for Health Statistics

264-39
Office of Health Care Information
Center for Health and Environmental Statistics
Kansas Dept. of Health & Environment
Curtis State Office Building
1000 SW Jackson, Suite 130
Topeka, KS 66612-2221

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