

# Kansas Health Statistics Report

Kansas Department of Health and Environment – Center for Health and Environmental Statistics – No 22 – August 2004

## Hysterectomy Rates in Kansas 1997 – 2001

Hysterectomy is the second most frequently performed surgical procedure, after cesarean section, for women in the United States [Centers for Disease Control and Prevention. *Surveillance Summaries*, July 12, 2002. MMWR 2002:51 (No. SS-5).] About 600,000 hysterectomies were performed annually in the U.S. in the years 1994 – 1999. During these years the overall hysterectomy rate for U.S. females was 5.5 per 1,000 women. Rates were lowest in the Northeast (4.3) and highest in the South (6.5).

The KDHE Center for Health and Environmental Statistics (CHES), in partnership with the Kansas Hospital Association, reviewed hospital discharge data for 1997 – 2001. Rates are based on U.S. Census Bureau data for 1997 – 2001.

For Kansas women, the hysterectomy rate during the years 1997 – 2001 was about 6.4 per 1,000 women. There was no evidence of a trend in the frequency of hysterectomy surgery; the rate was 6.3 in 1997 and 6.5 in 2001.

The most common type of hysterectomy performed in Kansas was total abdominal hysterectomy, which accounted for 59 percent of all hysterectomies in the five year period. Vaginal hysterectomy and laparoscopically assisted vaginal hysterectomy (LAVH) accounted for virtually all the remaining cases (Table 1).

Table 1. Types of Hysterectomies, Rates per 1,000 Female Population

Type of Hysterectomy	N	Rates per 1,000 Pop	Percent of Total
Hysterectomy, total, abdominal	20,274	3.8	59.3%
Hysterectomy, vaginal, other and unspecified	8,256	1.5	24.1%
LAVH	5,307	1.0	15.5%
All others	369	0.1	1.1%
Total	34,206	6.4	100.0%

Note: Population denominator is females ages 15 & up

and Disorders of Menstruation (Table 2).

Women aged 40 – 44 had the highest rate (13.7 per 1,000),

Table 2. Diagnoses Associated with Hysterectomies

Diagnoses	N	Rates per 1,000 Pop	Percent of Total
Uterine Leiomyoma (Fibroid)	8,818	1.7	25.8%
Endometriosis	5,270	1.0	15.4%
Genital Prolapse	4,779	0.9	14.0%
Disorders of Menstruation	4,330	0.8	12.7%
Genitourinary Cancer	2,882	0.5	8.4%
Pain and other Symptoms	2,133	0.4	6.2%
All Others	5,994	1.1	17.5%
Total	34,206	6.4	100.0%

Note: Population denominator is females ages 15 & up

The diagnosis most frequently associated with hysterectomies was Uterine Leiomyoma (Fibroid), followed by Endometriosis, Genital Prolapse,

followed by women aged 45 – 54 (11.4 per 1,000) (Table 3).

Kansas' rural counties had the highest rates (7.9 per 1,000 female population), while the lowest rate (5.6) occurred in the five counties designated as urban (Table 4).

Table 3. Hysterectomy Rates by Age Group: 1997 - 2001

Age Group	N	Rates per 1,000 Pop	Percent of Total
Ages 15-24	300	0.3	0.9%
Ages 25-29	1,431	3.4	4.2%
Ages 30-34	3,111	7.1	9.1%
Ages 35-39	5,664	10.8	16.5%
Ages 40-44	7,298	13.7	21.3%
Ages 45-54	9,772	11.4	28.6%
Ages 55 and up	6,623	4.1	19.4%
Total	34,199	6.4	100.0%

Note: Population denominator is females ages 15 and up.

Table 4. Hysterectomy Rates by County Density Group 1997 - 2001

Density Group	N	Rates per 1,000 Pop	Percent of Total
Densely-Settled Rural	6,829	7.4	20.0%
Frontier	1,486	7.4	4.3%
Rural	4,685	7.9	13.7%
Semi-Urban	6,275	6.4	18.3%
Urban	14,931	5.6	43.7%
Total	34,206	6.4	100.0%

Note: Population denominator is females ages 15 and up.

The type of procedure with the greatest frequency (Hysterectomy, total, abdominal) resulted in a mean length of stay (LOS) of 3.5 days. Mean LOS for all cases was 3.0 days (Table 5).

Table 5. Mean Length of Stay (LOS) by Type of Hysterectomy, 1997 - 2001

Type of Hysterectomy	Mean LOS	N
Hysterectomy, total, abdominal	3.5	20,274
Hysterectomy, vaginal, other and unspecified	2.3	8,256
LAVH	2.0	5,307
All others	4.8	369
Total	3.0	34,206

## Conclusions

The hysterectomy rate has remained stable for the years 1997 – 2001 in Kansas and the United States.

The overall rate for Kansas (6.4) was higher than the average for the United States (5.5) and also higher than the average for the Midwest (5.4). The Kansas rate was approximately the same as that for the South (6.5).

Since the rate of

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hysterectomy in Kansas was greater than some other parts of the country and higher than the national average, continued monitoring of this procedure is warranted.

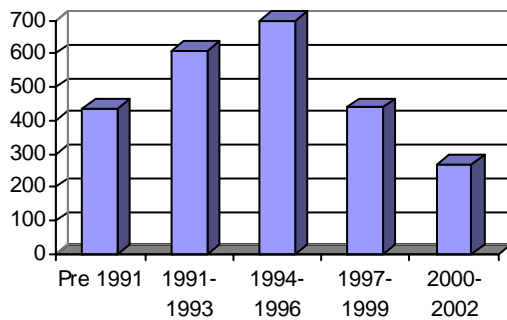
Donald Owen  
Health Care Data Analysis

## AIDS/HIV 2003 Summary Released

The KDHE Bureau of Epidemiology and Disease Prevention has published its eighth HIV/AIDS epidemiologic profile. The report defines the epidemic in Kansas and its impact on the state. The department began monitoring AIDS cases in 1983 and added HIV surveillance during 1999.

The number of AIDS cases has been declining. Between 1997-1999 and 2000-2002 the number of cases has dropped 39 percent (Figure 1).

Figure 1. AIDS Cases in Kansas



In 2002, 57 percent of new AIDS cases were diagnosed with HIV less than one year before their AIDS diagnosis. Major concerns have been raised in the past regarding the missed opportunities for prevention and control based on statistics indicating that most patients convert from HIV to AIDS within one year of their initial HIV diagnosis. This seems to indicate that most people are being tested late in the course of their infection.

Kansas is considered a low prevalence state for HIV and AIDS and therefore all percentages and rates should be interpreted cautiously. There have been 2,453 cases of AIDS reported in Kansas since 1983. Of those, 55 cases were reported in 2002. There have been 390 cases of HIV reported in Kansas since July 1, 1999. As of December 31, 2002, there were 1008 reported persons with AIDS and 382 reported persons with HIV living in Kansas. The AIDS rate for Kansas for 2000-2002 averaged 3.3 cases per 100,000 people per year.

Based on the year the case was reported, the overall trend shows a continuing decrease in the number of AIDS cases reported beginning in 1994, despite minor increases in individual years. The steep decline in the most recent year is more likely due to reporting artifacts rather than an actual decline in the burden of the disease. However, the overall decrease previously mentioned is potentially due to an improvement in therapy for newly diagnosed HIV cases. Additionally, it is possible that improvements in prevention efforts are proving to be successful.

The disproportionate effect of HIV and AIDS on men continues to exist nationwide, but simultaneously continues to decrease in magnitude. As reported in the last *Epi Profile* the number of female cases has gradually grown over the last 10 years, and in 2002 females continued to account for more than 16 percent of all Kansas AIDS cases. Even in the past three years, females accounted for nearly 15 percent of all Kansas AIDS cases compared to less than six percent of the cases diagnosed before 1991.

Black women accounted for more than 37 percent of the Kansas cases of AIDS in women from 2000 to 2002 while only

accounting for six percent of the Kansas female population. Additionally, during this time-period 26 percent of all black AIDS and HIV cases in Kansas were women. Females represented more than 20 percent of the HIV cases reported in Kansas. Again, it is difficult to draw many conclusions based on this data due to the small number of cases in Kansas.

People of color represent a disproportionate number of Kansans diagnosed with AIDS. Out of 2,453 cases of AIDS diagnosed in Kansas since 1983, 433 (18%) were Black. Blacks currently represent approximately six percent of the population in Kansas, but 26 percent of the AIDS cases diagnosed between 2000 and 2002.

This increase above the average percentage represents one area of concern. Additionally, although there has been a decrease in the rates in Kansas for all races from 2000 to 2002, the decrease among Blacks is less pronounced. The decrease may be due to the reporting artifacts rather than a decrease in the actual burden of disease.

Nearly 40 percent of AIDS cases and 42 percent of HIV cases diagnosed in Kansas between 2000 and 2002, were diagnosed in persons between the ages of 30 and 39, similar to previous reports. The mean age for people who were diagnosed with AIDS in Kansas during this time was 37, and for HIV it was 34.

Continuing to be the most prevalent mode of exposure for the contraction of HIV and AIDS, the report of male-to-male sex accounted for 46 percent and 48 percent of the risk for cases respectively. When considering the mode of exposure for men alone, the percent of HIV and AIDS cases reporting male-to-male sex accounted for 58 percent and 59 percent respectively.

These percentages indicate the spread of HIV/AIDS in Kansas to be predominantly through unprotected sex. Of course the small number of cases continues to be a factor in statistical interpretation. As the percentage of women contracting the disease increases, the number of cases reporting the mode of exposure as unprotected, risky heterosexual sex also increases. This was the leading mode of exposure in Kansas Women, appearing in 39 percent of HIV cases and 60 percent of AIDS cases.

Risk behaviors for bacterial STDs are often the same behaviors that put people at risk for HIV. Two-thirds of the HIV infections in Kansas are apparently acquired sexually. Therefore, STD statistics and trends can indicate populations that are potentially at higher risk for HIV, especially if HIV prevalence rises in those populations.

Prevention efforts targeting sexually acquired disease should lead to a reduction of HIV and AIDS as well as bacterial STDs. In Kansas, the combined number of confirmed gonorrhea and Chlamydia cases totaled nearly 10 times the number of HIV/AIDS cases in 2002, another indication of the low prevalence of HIV in the Kansas population.

As with HIV and AIDS, Blacks and Hispanics are disproportionately at increased risk for bacterial STDs when compared with Whites.

The entire report and a summary of the analytical methodology are available at [http://www.kdhe.state.ks.us/hiv-std/download/epi\\_profile2003.pdf](http://www.kdhe.state.ks.us/hiv-std/download/epi_profile2003.pdf).

Bureau of Epidemiology and Disease Prevention

## 25 Most Popular Baby Names

Emma and Jacob were the most popular names Kansas parents gave to their newborns in 2003 (Table 6). Jacob remained in first place among popular boys' names for the ninth year in a row, while other biblical names like Daniel, Gabriel, Isaac, and Noah have made way for more Celtic and English names -- such as Kaden, Aiden, Logan, and Dylan. Emma replaced Emily as the most popular girl's name.

This information was prepared by the Kansas Department of Health and Environment's Center for Health and Environmental Statistics. The lists are derived from birth certificate information which the Center's Office of Vital Statistics keeps on file.

Table 6. Most Popular Baby Names  
Kansas, 2003

Rank	Girls	Count	Boys	Count
1	Emma	284	Jacob	303
2	Madison	269	Kaden	274
3	Emily	267	Ethan	270
4	Kaitlyn	242	Aidan	249
5	Abigail	227	Andrew	217
6	Hannah	215	Michael	203
7	Olivia	202	Joshua	197
8	Hailey	191	Zachary	195
9	Alexis	184	Matthew	194
10	Brianna	174	Tyler	189
11	Lauren	174	Caleb	186
12	Elizabeth	170	Logan	185
13	Kaylee	168	Brayden	184
14	Alyssa	168	Joseph	181
15	Grace	161	William	173
16	Riley	159	Nicholas	173
17	Mackenzie	152	Christopher*	172
18	Sarah	142	Dylan	172
19	Chloe*	138	Samuel	170
20	Kylie*	131	Austin	166
21	Taylor	128	Alexander	166
22	Anna*	127	Christian*	158
23	Katherine	126	Jonathan*	155
24	Samantha*	124	Jayden*	154
25	Madeline	123	Jackson*	153

\* Names added to Most Popular Baby Names List

Dropping off the list of 25 most popular girls' names were Allison, Ashley, Makayla, and Sydney. Joining the list were Anna, Chloe, Kylie, and Samantha. Leaving the list of 25 most popular boys' names were Daniel, Gabriel, Isaac, John and Noah. Joining the list were Christian, Christopher, Jonathan, Jayden, and Jackson.

Popular baby names are one of the more regularly requested items produced by the Center's Office of Health Care Information. While the list reflects popular culture and names frequently used in the media, other information from birth certificates and other vital records stored with the Center's Office of Vital Statistics is used to gauge health trends in the state.

The popular baby names lists are available on the KDHE Web site at: <http://www.kdhe.state.ks.us/hci>

*Karen Sommer, MA  
Vital Statistics Data Analysis*

## Kansas Trauma Registry 2003 Data

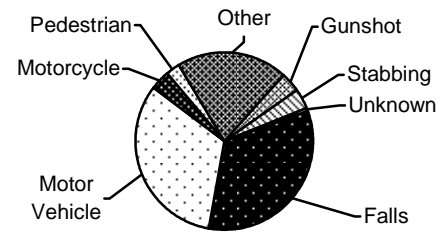
The first full year of data collection for the Kansas Trauma Registry is complete. Over 50 hospitals submitted 6,762 trauma cases in 2003. Over 70 hospitals were trained in 2003 on the state-provided registry software called "Collector." Less than 20 hospitals remain to be trained to date.

The 2003 data are provisional due to outstanding data completeness issues. Additionally, the absence of linking the trauma cases currently allows cases transferred from one facility to another to be represented in the database multiple times.

The unlinked data results for 2003 show that blunt types of injury are most prevalent in Kansas, representing over 85 percent of total cases. The most common cause of injury is falls at 33.2 percent, followed closely by motor vehicle crashes at 32.7 percent

(Figure 2). The percentage of trauma patients that died in the hospitals was 5.3 percent.

Figure 2. Cause of Injury Trauma Cases,  
Kansas, 2003



Male patients make up the majority of Kansas traumas in 2003, representing 59.3 percent of cases. Most patients are between the ages of 15 and 54 (57.8%). Patients 55 and older represent 32.9 percent, and pediatric patients less than 15 years make up 9.2 percent of total cases.

Clinical data used to score the severity of injuries and probability of survival has been submitted in the vast majority of cases, which will help the Kansas Trauma Regions make informed policy decisions to improve trauma care in Kansas.

Statistical reports can be obtained at the Trauma Program website, <http://www.kdhe.state.ks.us/olrh/TraumaRegistry.htm>.

*Susan Quinn  
Vital Statistics Data Analysis*

## Occupational Injury-Illness Rates Reported

A total of 54,700 nonfatal injuries and illnesses were reported in private industry workplaces in Kansas during 2002, resulting in a rate of 6.2 cases per 100 equivalent full-time workers (Table 7). The information is from a survey conducted by the Bureau of Labor Statistics (BLS), U.S. Department of Labor, and the KDHE Center for Health and Environmental Statistics. Among various industry divisions, incidence rates varied from a high of 8.9 cases per 100 full-time workers in construction to a low of 1.7 cases per 100 full-time workers in finance, insurance, and real estate.

The incidence rates for industry divisions in Kansas were higher than the U.S. rates in all but two categories. Those were finance, insurance, and real estate, which were tied with the U.S. rate at 1.7, and transportation and public utilities, where the Kansas rate of 4.7 was 30 percent lower than the U.S. rate, which was 6.1 per 100 full-time workers.

Table 7. Occupational Injury and Illness Incidence Rates \*, By Industry, Kansas & U.S., 2002

Industry	KS	US
Private Industry (Total)	6.2	5.3
Agriculture, Forestry & Fishing	8.3	6.4
Mining	7.4	4.0
Construction	8.9	7.1
Manufacturing	8.2	7.2
Transportation & Public Utilities	4.7	6.1
Wholesale & Retail Trade	6.1	5.3
Finance, Insurance & Real Estate Services	1.7	1.7
Services	5.6	4.6

\* Incidence rates represent number of injuries & illnesses per 100 full-time workers  
Source: Bureau of Labor Statistics, U.S. Dept of Labor, Survey of Occupational Injuries & Illnesses in cooperation with participating state agencies.

Effective January 1, 2002, the Occupational Safety and Health Administration (OSHA) revised its requirements for recording occupational injuries and illnesses. The BLS Survey of Occupational Injuries and Illnesses, the primary source for the estimates of occupational injuries and illnesses, is based on employers' records of injuries and illnesses. Due to the revised recordkeeping rule, 2002 survey estimates are not comparable with those from previous years.

Charlie Crevoiserat, MPA  
Occupational Injury Surveillance

Obesity (i), a known risk factor for diabetes, has been steadily increasing in Kansas. From 1998 to 2002 obesity had a 29 percent increase (17.7% to 22.8%) in the adult population (2). In addition, the prevalence of adults not physically active (ii) is also increasing. In 2002, about 1.2 million adult Kansans were overweight or obese, and an estimated 444,471 adults had no physical activity (2).

Henri Menager, MPH  
Office of Health Promotion

### 2003 Vital Statistics Counts Published

The KDHE Center for Health and Environmental Statistics has published its 2003 data for births, deaths, marriages, and marriage dissolutions. The data are contained in table 8 on page 5. County totals for the four vital events are listed. Population-based rates, trend data, and other analyses will be in the *Annual Summary of Vital Statistics* published later this year.

### Diabetes in Kansas: Update July 2004

From 1998 to 2002, an average of 687 Kansans died from diabetes each year (1). In 2002, diabetes was the 6th leading cause of death in Kansas accounting for 763 deaths (Figure 3). During the same year, it is estimated that about 124,000 adults, or 6.4 percent of the adult population (2), have been diagnosed with the disease. However, according to the Centers for Disease Control and Prevention (CDC), 29 percent of persons with diabetes are unaware of their condition (3).

Based on these statistics, Kansas had about 51,000 undiagnosed cases in 2002. Based on national estimates, the cost (direct and indirect cost) for diabetes care (for diagnosed diabetic patients) in Kansas in the year 2002 was estimated as approximately \$1.4 billion (4).

In addition diabetes mellitus is being increasingly diagnosed among children and adolescents (5). It is estimated that Kansas had about 1,300 cases of diabetes in 2002, or 0.19 percent of the child population, based on the CDC statistics (5).

### Definitions and Notes

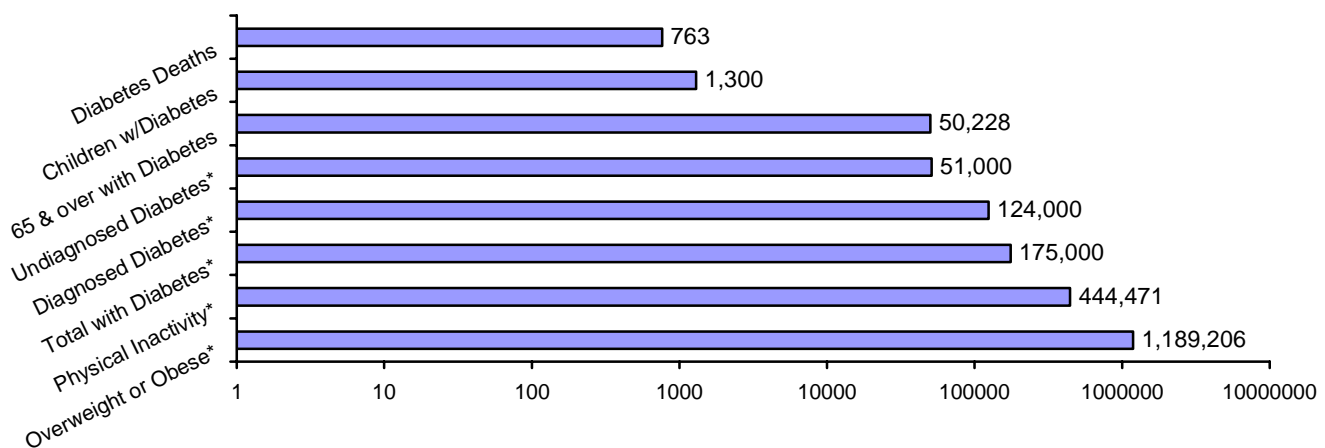
i. The weight categories are based on the National Heart, Lung, and Blood Institute Guidelines. Persons with a body mass index greater than or equal to 25 are considered overweight. Those with a body mass index greater than or equal to 30 are considered obese.

ii. According to the Behavioral Risk Factor Surveillance System, a person is physically inactive if he/she did not participate in any physical activities or exercise, other than his/her regular job, in the past 30 days.

### References

- Center for Health & Environmental Statistics, Kansas Department of Health & Environment, 2002.
- Kansas Behavioral Risk Factor Surveillance System, 2002. <http://www.kdhe.state.ks.us/brfss/index.html>
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- Economic costs of diabetics in the U.S. in 2002. *Diabetes Care*. 2003;26(3):917-913.
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Figure 3. Diabetes in Kansas, 2002: Number of Deaths, Persons with Diabetes, and Persons with Some Diabetes Known Risk Factors



\* in adults - (Note: Except for deaths, all numbers are estimated.)

## 2003 Vital Statistics Counts Published

Table 8. 2003 Kansas Vital Statistics\*

County of Residence	Live Births	Deaths	Marriages	Marriage Dissolutions	County of Residence	Live Births	Deaths	Marriages	Marriage Dissolutions
Kansas	39,353	24,417	18,722	8,644					
Allen	183	211	68	26	Lyon	557	278	230	74
Anderson	103	104	48	19	Marion	134	165	73	24
Atchison	222	175	137	62	Marshall	115	165	69	29
Barber	39	55	34	18	McPherson	342	326	223	105
Barton	371	302	212	44	Meade	68	58	27	2
Bourbon	220	181	93	72	Miami	435	257	171	32
Brown	131	131	88	32	Mitchell	57	100	37	24
Butler	704	531	395	191	Montgomery	416	459	269	139
Chase	35	44	34	3	Morris	61	88	44	23
Chautauqua	38	64	29	15	Morton	35	29	17	13
Cherokee	265	253	135	68	Nemaha	131	141	68	35
Cheyenne	22	40	14	6	Neosho	213	225	123	48
Clark	21	22	9	3	Ness	31	54	25	8
Clay	81	84	67	28	Norton	44	68	33	33
Cloud	113	170	68	31	Osage	188	183	108	57
Coffey	108	109	50	105	Osborne	37	78	14	9
Comanche	12	34	15	2	Ottawa	66	91	34	16
Cowley	461	432	286	199	Pawnee	61	86	47	44
Crawford	534	478	212	151	Phillips	61	95	44	17
Decatur	28	50	23	7	Pottawatomie	292	168	101	27
Dickinson	212	233	149	44	Pratt	105	108	66	32
Doniphan	76	90	45	24	Rawlins	17	40	19	10
Douglas	1,229	530	782	282	Reno	809	640	516	340
Edwards	41	45	19	13	Republic	44	92	35	17
Elk	22	54	21	11	Rice	119	129	53	35
Ellis	359	245	203	112	Riley	900	278	487	201
Ellsworth	45	69	41	46	Rooks	59	70	29	14
Finney	751	205	292	118	Rush	38	47	20	15
Ford	721	248	238	136	Russell	82	103	38	22
Franklin	339	228	188	106	Saline	742	502	418	237
Geary	609	197	488	194	Scott	66	52	27	24
Gove	33	48	23	8	Sedgwick	7,568	3,834	3,526	2,534
Graham	25	36	23	16	Seward	531	141	161	82
Grant	140	54	43	21	Shawnee	2,460	1,733	1,209	597
Gray	95	59	27	9	Sheridan	26	35	14	7
Greeley	6	19	7	6	Sherman	72	65	33	28
Greenwood	81	125	47	38	Smith	36	78	26	12
Hamilton	40	24	17	9	Stafford	47	46	27	11
Harper	69	106	52	16	Stanton	36	19	21	8
Harvey	432	368	236	66	Stevens	84	48	44	22
Haskell	73	25	35	4	Sumner	297	286	168	68
Hodgeman	31	17	9	5	Thomas	91	62	38	34
Jackson	194	121	89	38	Trego	31	36	25	13
Jefferson	231	148	135	44	Wabauunsee	74	65	51	10
Jewell	26	55	23	10	Wallace	21	26	12	2
Johnson	7,475	2,847	2,675	336	Washington	60	94	46	10
Kearny	62	39	15	10	Wichita	38	20	10	4
Kingman	78	111	39	21	Wilson	111	147	64	48
Kiowa	38	34	22	12	Woodson	39	60	26	9
Labette	251	296	117	99	Wyandotte	2,772	1,521	1,093	217
Lane	22	38	11	7					
Leavenworth	970	550	432	234					
Lincoln	31	66	15	7					
Linn	105	95	62	28					
Logan	31	31	26	10					

\* Residence data are presented for births and deaths  
Occurrence data are presented for marriages and marriage dissolutions

## News Notes

A new study co-funded by AHRQ shows that increasing patients' co-payments for prescription medications led to decreases in their use of eight classes of therapeutic drugs. Researchers linked pharmacy claims data representing nearly 530,000 people age 18 to 64 that had employer-sponsored health insurance with health benefit designs from 52 private health plans and 30 employers.

The study included one-tier, two-tier, three-tier, and coinsurance drug benefit plans of all types. The simulated co-payment increases were relevant for all plans but were calibrated to two-tier plans. The analysis followed study subjects for nearly 4 years.

The study, "Pharmacy Benefits and the Use of Drugs by the Chronically Ill," was led by Drs. Dana P. Goldman and Geoffrey F. Joyce and their colleagues at the RAND Corporation in Santa Monica, CA, as well as by co-authors from Merck and California Healthcare Foundation, and published May 19 in *JAMA*.

*Agency for Healthcare Research and Quality*

## Bioterrorism Preparedness Improves

After the terrorist attacks of 2001, increased funding was provided to federal, state, and local health departments to improve bioterrorism preparedness and response capacity. To evaluate the effect of this funding and to identify priority areas for allocation of resources, the Kansas Association of Local Health Departments (KALHD) contracted with the Kansas Health Institute (KHI) to perform an independent assessment of local health department preparedness in Kansas and how it changed between 2002 and 2003.

The study found that preparedness for bioterrorism improved in Kansas between 2002 and 2003. During that time, 89 of the 103 reporting counties improved their county preparedness indexes, and the statewide local preparedness index increased by 27.7 percent, from 33.9 percent to 43.3 percent.

The report provides compelling evidence that the significant investments in public health over the last few years have resulted in measurable improvement of the bioterrorism preparedness system in Kansas. The results show that local health departments (LHDs) in Kansas have implemented a wide range of activities to enhance bioterrorism preparedness and that preparedness increased in specific and measurable ways.

Overall achievements of the preparedness activities implemented in the last few years, however, must be balanced with the finding that large disparities persist among different areas of the state. Despite the progress made, many state focus area and critical capacity scores remain low. Clearly, room for improvement remains. If continued progress is a priority for policymakers, then the necessary resources must be made available. It is important to note that there are no accepted standards for what constitutes adequate preparedness for LHDs.

The indexes and thresholds used in this study to measure preparedness were created by local experts and are among the first such measures to be used to assess bioterrorism preparedness of LHDs in a quantifiable manner. It is clear that achieving a score of 100 percent for all counties is not a realistic goal, nor may it even be a desirable goal, given the resources that would have to be committed to doing so.

The report findings are at: [http://www.kdhe.state.ks.us/news/web\\_archives/2004/download/bioterrorism\\_report.pdf](http://www.kdhe.state.ks.us/news/web_archives/2004/download/bioterrorism_report.pdf).

*Kansas Health Institute*

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