Kansas Health Statistics Report

Kansas Department of Health and Environment – Center for Health and Environmental Statistics – No 30 – August 2006

Community-Associated Methicillin-resistant *Staphylococcus aureus* (CA-MRSA): A study in Northeast Kansas

"Consider the difference in size between some of the very tiniest and the very largest creatures on Earth. A small bacterium weights as little as 0.10^{-10} gram. A blue whale weighs about 100,000,000 grams. Yet a bacterium can kill a whale…Such is the adaptability and versatility of microorganisms as compared to humans and other so-called 'higher' organisms, that they will doubtless continue to colonise and alter the face of the Earth long after we and the rest of our cohabitants have left the stage forever. Microbes, not macrobes, rule the world."—Bernard Dixon, 1994 (Garrett, L. 1994, p. 411)

Staphylococcus aureus (*S. aureus*) is capable of a broad spectrum of infections, more so than any other bacteria. The introduction of antibiotics was a boon to treating infections. However, nearly as soon as antibiotics were introduced, resistance developed. The use of penicillin in the 1940s helped reduce infectious skin lesions, abscesses, pneumonia and sepsis attributed to *S. aureus*. Subsequently strains of *S. aureus* hydrolyzed penicillin, rendering penicillin useless. A semisynthetic form of penicillin, methicillin, was developed in 1959 to address resistance to penicillin. Within a few years, the first *S. aureus* resistant to methicillin was reported in several countries: the United Kingdom and other European countries, Japan, and Australia. By 1969, methicillin-resistant *S. aureus* (MRSA) was observed in the U.S.

Locations of high rates of antibiotic use, such as intensive care units of hospitals, were the first sites of MRSA outbreaks. Infection with this organism became known as "hospital-acquired" MRSA (HA-MRSA). As MRSA outbreaks occurred more generally in healthcare facilities, including acute and long-term care settings, the term was changed to more generally refer to "healthcare-associated" MRSA. MRSA continues to be an important and common resistant organism in U.S. hospitals.

Community-associated MRSA (CA-MRSA) is a strain of MRSA associated with skin and soft tissue lesions, causing infections that are less multi-drug resistant than its relative, HA-MRSA. It demonstrates high level of communicability, typically identified in more superficial skin lesions that respond favorably to a variety of antimicrobials, many of which are long-standing formulas that are less expensive. Panton-Valentine leukocidin (PVL) toxin is considered by many as a principal factor in the virulence of CA-MRSA. The toxin brings about leukocyte destruction and tissue necrosis, leading researchers to believe it enables CA-MRSA to cause disease through intact skin.

Identifying organisms is crucial to the treatment and prevention of transmission. MRSA can be identified through routine laboratory culture processes. There is continued controversy in differentiating between CA-MRSA and HA-MRSA strains. There is no simple laboratory test to exclude one from the other. Antibiograms of MRSA isolates can be helpful in monitoring sensitivity patterns but are not applicable for classifying isolates. The most scientific method for identifying isolates requires complex laboratory methods and technology is often not widely available.

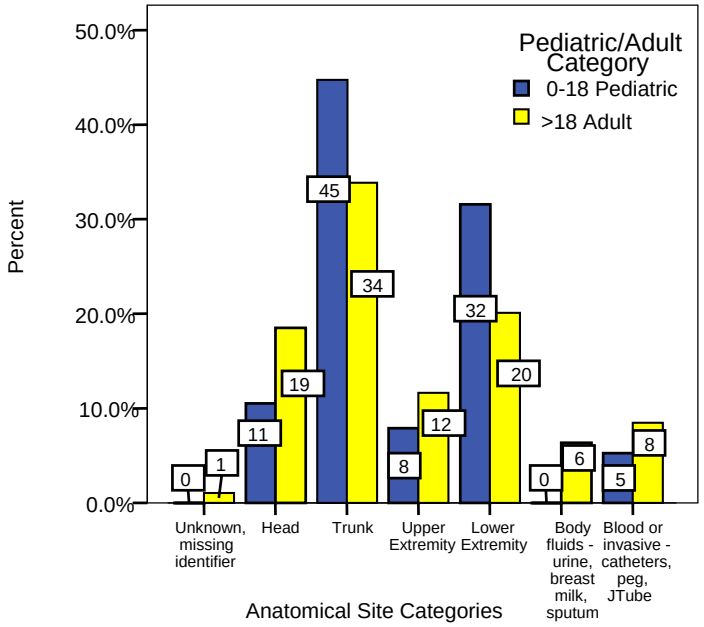


Figure 1. Anatomical Distribution - Cultured CA-MRSA and HA-MRSA

Table 1. Descriptive Statistics - CA-MRSA Study Variables by Study Population and Care Settings

	Study Population n=227	Inpatient n=101	Outpatient n=126
Patient Age in Years			
median (range)	39 (0-95)	52 (0-95)	28.5 (0-82)
mean	40.2	52.8	30.1
Pediatrics and Adults			
0 – 18 years (%)	38 (16.7%)	9 (8.9%)	29 (23%)
> 18 years (%)	189 (83.3%)	92 (91.1%)	97 (77%)
Sex			
Male (%)	118 (52.0%)	49 (49%)	69 (54.8%)
Female (%)	108 (47.6%)	52 (51%)	56 (44.4%)
Missing (%)	1 (0.4 %)		1 (0.8%)
Identified Invasiveness of Wound			
Potentially Invasive (%)	30 (13.2%)	30 (29.7%)	
Non-Invasive (%)	197 (86.8%)	71 (70.3%)	126 (100%)

Finding CA-MRSA in healthcare settings is troubling since CA-MRSA has typically been sensitive to several classes of antibiotics without the multi-drug resistance observed in HA-MRSA. Research has found that these microorganisms share characteristics, which could result in multi-drug resistance developing among CA-MRSA organisms.

Recently KDHE studied MRSA isolates from outpatient and inpatient care settings to assess MRSA in an area of northeast Kansas. The investigation assembled a convenience sample of data from a local healthcare organization. Table 1 provides the descriptive statistics for this study. Literature suggests that resistance and

Inside

sensitivities to specific antibiotics and classes of antibiotics may be predictive of CA-MRSA when drug resistance has not expanded. Another identification tool is the invasive nature of the wound from which the isolate is cultured. The more invasive wounds have typically been attributed to HA-MRSA. Other indicators such as age, sex, and behaviors broaden the informational base.

Figure 2. Age Distribution by Care Setting

In this study, sensitivity to antibiotics was found to be related to the invasiveness of wound. Additional findings include:

- Potentially invasive wounds and inpatient cases demonstrate a greater likelihood of resistance to Ciprofloxacin and Clindamycin. This finding is more typical of HA-MRSA.
- Twenty-four percent of outpatient cultures showed resistance to Ciprofloxacin and 5% showed resistance to Clindamycin. Resistance to these two antimicrobials in outpatient wounds suggests either that cases of HA-MRSA were treated in an outpatient setting, or, it may indicate an increase in drug resistance among CA-MRSA.
- Thirty-eight percent of non-invasive wound cultures demonstrate resistance to Ciprofloxacin and 24% were resistant to Clindamycin. If non-invasive wounds are more likely to be determined to be CA-MRSA, these data suggest increased resistance among CA-MRSA cases. These varied results in resistance to Clindamycin and Ciprofloxacin in outpatient and non-invasive wounds was observed in literature as well.

The theory that outpatient care and non-invasiveness in wound cultures can serve as proxy CA-MRSA indicators is mildly supported by this analysis. Assuming that CA-MRSA is the organism cultured from outpatients, the age distribution of this study aligns with other studies showing CA-MRSA affects a younger population than HA-MRSA. The greater antibiotic resistance suggests that inpatients with invasive type wounds are more likely HA-MRSA, a widely accepted characteristic of HA-MRSA

This project studied isolates from outpatient and inpatient care settings to assess MRSA in an area of northeast Kansas. Sex was not a relevant factor in this dataset because there were no statistical differences detected by care setting, pediatric/adult category, anatomical sites or invasiveness of wounds cultured, or sensitivity to antibiotics. Outpatients were significantly younger than inpatients and the overall sample population, a finding concurrent with other studies. There were proportionately more adult than pediatric cases in the sample. Significant differences were found regarding the anatomical site of wound culture, invasiveness of wound, sensitivity to antibiotics and care setting where culture was obtained. Figure 1 illustrates the differences between pediatric and adult wound locations by anatomical site. Figure 2 describes the age distribution of the two sample populations. In summary, culture and sensitivities are essential in determining appropriate treatment.

Practitioners can improve the successful treatment of CA-MRSA infections by correctly suspecting wounds to be CA-MRSA, wounds frequently described as "spider bites." Antibiotic selection should be guided by results of culture and sensitivities. Continued vigilance to culture and sensitivities and drug-resistance is vital to the prevention of a public health epidemic of highly communicable, difficult to treat infections.

Lesa Roberts, RN, MPH
Epidemology Services

Medicare Part D Enrolls One in 10 in Kansas

Some 222,494 Kansans now have prescription drug coverage through Medicare, according to final-enrollment numbers released by the federal government. This number includes those signed up for Medicare stand-alone prescription drug plans and for Medicare managed care plans that include prescription coverage.

Of Kansas' approximately 409,000 Medicare beneficiaries, about 72 percent now have some kind of drug coverage, either through a Medicare prescription drug plan or through other plans — for example, health plans provided by former employers.

Enrollment rates vary across Kansas. Statewide 10.7 percent of all Kansas residents are enrolled. Participation rates range from 5.9 percent in Finney County to 20.4 percent participation in Graham County. The full listing of participation counts and rates is available online as a special supplement to this issue, available at http//www.kdheks.gov/ches/khsnews/KHS30.pdf .

The Medicare Rx Access Network of Kansas is reminding the thousands of Kansas seniors who may be eligible but have not applied for the benefit's low-income subsidy that they can still apply between now and November 15 (when the next open-enrollment period begins) for extra help with paying for the coverage. If they qualify for the low-income subsidy, they are offered a special enrollment opportunity to enroll for coverage to begin right away and they will not be subject to a late enrollment penalty.

U.S. Department of Health and Human Services

BRFSS Estimates Kansas Health Insurance Coverage

The Behavioral Risk Factor Surveillance System (BRFSS) is a state based surveillance system among non-institutionalized adults ages 18 years and older. It allows for the continual monitoring of lifestyles and behaviors that have an impact on society. Kansas conducts the BRFSS with assistance from the Centers for Disease Control and Prevention (CDC). These results enable policymakers and other stakeholders to promote activities to improve a state or community's health status.

During 2004, BRFSS, using its random-digit-dialed telephone survey, surveyed behaviors and practices related to the Healthy People 2010 objectives. The full summary of the analysis of the data is contained in *Surveillance for Certain Health Behaviors Among States and Selected Local Areas – Behavioral Risk Factor Surveillance System, United States, 2004*, published by CDC.

Because the sample size in Kansas was 8,633, it was not possible to produce statistically reliable results for every community. However, results are available at the state level and for selected metropolitan and micropolitan statistical areas (MMSA). Those areas include: Wichita, Topeka, and Kansas City (both

Missouri and Kansas). Some results are also available for Shawnee, Johnson, Wyandotte, and Sedgwick Counties.

The estimated prevalence of adults who have health care coverage varies in those areas for which BRFSS results are available. Statewide, almost nine of 10 (87%) adult Kansans have coverage (Table 2). Among the four largest Kansas counties, rates range from 76.3 percent to 92.9 percent.

Table 2. Estimated Prevalence of Adults with Health Care Coverage in State and Selected Local Areas

	Sample Size	Percent	95% CI *
Kansas	8,633	87.0	86.1 – 88.0
Johnson	1,440	92.9	91.2 – 94.7
Sedgwick	1,245	85.8	83.3 – 88.2
Shawnee	634	84.2	80.3 – 88.1
Wyandotte	392	76.3	70.6 – 82.1
Topeka MMSA	843	85.8	81.4 – 89.9
Wichita MMSA	1631	86.1	83.9 – 88.3
Kansas City (KS-MO) MMSA	3209	88.9	87.2 – 90.6

* Confidence Interval

Source: Centers for Disease Control and Prevention

Other results are available for such topics as women's health screenings, overweight and obesity, and physical activity. For more information, visit the KDHE BRFSS Web site at http//www.kdheks.gov/brfss/index.html or the CDC site at http//www.cdc.gov/brfss/index.htm.

Morbidity and Mortality Weekly Report
Centers for Disease Control and Prevention

Behavior Change is Healthy Kansas Goal

Encouraging Kansans to make simple, but powerful changes in their personal health behaviors is the goal behind Kansas Governor Kathleen Sebelius' HealthyKansas initiative.

HealthyKansas was launched in November 2004 by Gov. Sebelius as a comprehensive effort to control health care costs, improve the quality of health care and raise awareness of the dangers of obesity in children and adults. The initiative was joined by the Kansas Department of Health and Environment (KDHE) in 2005 to support the Governor as she encouraged students in schools, adults in the workplace and seniors to increase their physical activity; eat a more nutritious diet (including five daily servings of fruits and vegetables); and to eliminate, or significantly reduce, their tobacco habit.

"Whether it's increasing physical activity each week, eating a more nutritious diet or learning about the dangers of tobacco, changing these types of behaviors results in a much healthier Kansas," Sebelius said.

KDHE has worked with the Governor to create several interesting and successful programs designed to help spread a simple message with the potential for profound personal change over a lifetime, including taking the Healthy Kansas pledge. All pledge-takers agree to follow or modify their behavior to reflect the three goals of HealthyKansas. Individuals taking the pledge receive a certificate of recognition and letter from the Governor. Pledge forms are available at http://www.healthykansas.org.

In May, KDHE Secretary Roderick L. Bremby presented 77 Kansas schools as the initial recipients of the Governor's Healthy School award with a 3 x 5-foot nylon flag.

These schools were selected based on a criteria developed by the Coordinated School Health Program, a partnership between KDHE and the Kansas Department of Education. The Governor will award more schools that designation as they qualify.

This summer Gov. Sebelius and Innovision Corporation of Lenexa launched a free personal health manager software package called CheckUp on the Healthy Kansas Web site. CheckUp is a comprehensive personal health manager that allows the user to track individual or family medical history, expenses, diet and physical activity patterns.

A statewide contest was announced in late June to solicit the best healthy tips from Kansans through the HealthyKansas Healthy Tip Postcard contest. More than 10,000 blank postcards were mailed statewide to various groups asking for a postcard creation of a tip from the three behaviors of HealthyKansas. Weekly winners will be posted to the HealthyKansas.org Web site and a grand prize winner will be selected on Sept. 14 during HealthyKansas day at the Kansas State Fair in Hutchinson.

For more information about HealthyKansas, go to http://www.healthykansas.org.

Rick Bryant
KDHE Office of Communications

Food Service Inspection Results Available

The KDHE Bureau of Consumer Health inspects directly or through local health departments over 10,300 food establishments. Now the results of those inspections are available at http://kansas.kdhe.state.ks.us/pls/certop/fssearch.

The food service establishments include restaurants, schools, senior meal sites, caterers, and mobile food units. Inspections are unannounced and only represent the conditions found in the food service establishment at the time of the inspection.

Searches can be performed based on city, county or name of an establishment. The food service inspections are a public record and this page allows the public to conduct a Web-based search to view inspection findings of food service establishments

KDHE Bureau of Consumer Health

Stroke and Heart Disease Burden Document Released

Coronary Heart Disease (CHD) and stroke are the major components of cardiovascular disease affecting Kansas' population. These are the leading causes of death and result in enormous health care expenses. The KDHE's Office of Health Promotion prepared a report, *The Burden of Coronary Heart Disease and Stroke in Kansas*, to assist public health partners, particularly those involved in the Kansas Heart Disease and Stroke Plan, in developing effective public health programs and strategies for prevention and control of cardiovascular disease. Understanding and responding to the preventable nature of these leading risk factors is key to reducing the burden of the disease among Kansans as well as preventing recurrent cardiovascular events.

To better understand the impact of CHD and stroke in Kansas, multiple data sources were used to examine various aspects of CHD and stroke and its associated risk factors.

CHD and Stroke Mortality

- CHD and stroke were the primary causes of death for Kansas residents, accounting for 4,127 CHD deaths and 1,749 stroke deaths in 2003.
- In 2003, CHD and stroke were responsible for almost a quarter of all deaths (24.1%) in Kansas, with CHD ac-

counting for 16.9 percent and stroke accounting for 7.2 percent.

- In 2003, more then half of all CHD and stroke deaths occurred before reaching a hospital, clinic or medical center and receiving appropriate clinical care (pre-transport deaths).

Risk Factors for CHD and Stroke

- High blood pressure, high blood cholesterol, cigarette smoking, diabetes, physical inactivity, overweight, obesity, and unhealthy dietary habits are known and modifiable risk factors for CHD and stroke and are described in this report.
- In 2004, nearly one in four (24.7%) adult Kansans reported being diagnosed with high blood pressure.
- In 2004, more than one-third (35.3%) of adult African Americans reported high blood pressure, the highest among all racial and ethnic groups.
- In 2004, more than one-fourth (29.4%) of adults reported being diagnosed with high blood cholesterol.
- In 2004, approximately one in five (19.8%) adults were current cigarette smokers.
- In 2002, there were 16,315 inpatient hospital discharges for CHD by primary diagnosis and 6,614 inpatient hospital discharges for stroke by primary diagnosis.
- Males had a higher age-adjusted inpatient hospital discharge rate for CHD and stroke as compared to females (78.2/10,000 population vs. 41.8/10,000 population for CHD and 25.2/10,000 population vs. 21.5/10,000 population for stroke).

Disparities

- Males and African Americans had higher mortality rates due to CHD and stroke.
- African Americans reported higher rates of high blood pressure, cigarette smoking, diagnosed diabetes and obesity than other racial and ethnic groups.
- Hispanics reported higher prevalence of not eating the recommended daily five a day fruits and vegetables than whites or African Americans.
- The recognition of signs and symptoms of a heart attack and stroke was generally lower in persons with less than a high school education.
- The recognition of signs and symptoms of a heart attack and stroke was generally lower in African Americans and Hispanics.

Although the mortality from CHD and stroke has declined in recent years, they are still the leading causes of death in Kansas. The aging of Kansas' population will further increase the burden of CHD and stroke. The prevalence of risk factors like high blood pressure, high blood cholesterol, obesity and diabetes is on the rise among the Kansas population.

The cardiovascular health of Kansans can be improved through the prevention, detection, and treatment of risk factors; early identification and treatment of heart attack and stroke; and prevention of recurrent cardiovascular events. Thus, collaborative public health efforts can achieve the goal of improved cardiovascular health for Kansans.

Farooq Ghouri, MBBS, MPH
Office of Health Promotion

References:

1. Kansas Department of Health and Environment. The Burden of Coronary Heart Disease and Stroke in Kansas. Topeka, Kansas: Office of Health Promotion; December 2005.

2005 Population Estimates Released

Kansas county and city population estimates for 2005 have been released by the U.S. Census Bureau. Table 3 shows county estimates as of July 1, 2005. Kansas increased slightly (0.3 percent) in population from 2,735,502 residents in 2004 to 2,744,687 in 2005.

Three of the state's 10 largest cities decreased in population between 2004 and 2005 (Table 4). The July 1, 2005 estimates were released by the U.S. Census Bureau.

Table 3 Kansas County Population Estimates for July 1, 2005

County	Total	County	Total
Total	2,744,687		
Allen	13,787	Linn	9,914
Anderson	8,182	Logan	2,794
Atchison	16,804	Lyon	35,609
Barber	4,958	Marion	12,952
Barton	28,105	Marshall	10,405
Bourbon	14,997	McPherson	29,523
Brown	10,239	Meade	4,625
Butler	62,354	Miami	30,496
Chase	3,081	Mitchell	6,420
Chautauqua	4,109	Montgomery	34,570
Cherokee	21,555	Morris	6,049
Cheyenne	2,946	Morton	3,196
Clark	2,283	Nemaha	10,443
Clay	8,629	Neosho	16,529
Cloud	9,759	Ness	3,009
Coffey	8,683	Norton	5,664
Comanche	1,935	Osage	17,150
Cowley	35,298	Osborne	4,050
Crawford	38,222	Ottawa	6,123
Decatur	3,191	Pawnee	6,739
Dickinson	19,209	Phillips	5,504
Doniphan	7,816	Pottawatomie	19,129
Douglas	102,914	Pratt	9,496
Edwards	3,292	Rawlins	2,672
Elk	3,075	Reno	63,558
Ellis	26,767	Republic	5,164
Ellsworth	6,343	Rice	10,452
Finney	38,988	Riley	62,826
Ford	33,751	Rooks	5,351
Franklin	26,247	Rush	3,406
Geary	24,585	Russell	6,845
Gove	2,763	Saline	53,919
Graham	2,721	Scott	4,600
Grant	7,530	Sedgwick	466,061
Gray	5,861	Seward	23,274
Greeley	1,349	Shawnee	172,365
Greenwood	7,338	Sheridan	2,591
Hamilton	2,604	Sherman	6,153
Harper	6,081	Smith	4,121
Harvey	33,843	Stafford	4,488
Haskell	4,232	Stanton	2,245
Hodgeman	2,110	Stevens	5,412
Jackson	13,535	Sumner	24,797
Jefferson	19,106	Thomas	7,639
Jewell	3,352	Trego	3,050
Johnson	506,562	Wabaunsee	6,919
Kearny	4,516	Wallace	1,573
Kingman	8,165	Washington	6,009
Kiowa	2,984	Wichita	2,309
Labette	22,169	Wilson	9,834
Lane	1,894	Woodson	3,572
Leavenworth	73,113	Wyandotte	155,750
Lincoln	3,411		

Source: Population Division, US Census Bureau
Release Date: March 16, 2006

Wichita ranked 51st nationally in population size as of July 1, 2005 and 115th in population growth rate from July 1, 2004 to July 1, 2005. Wichita contains more than 75 percent of Sedgwick County's population.

Overland Park and Olathe are in Johnson County, south of Kansas City. Overland Park ranked 137th nationally in population size as of July 1, 2005 and 64th in population growth rate from July 1, 2004 to July 1, 2005. Olathe ranked 216th in the U.S. in population size and 33rd in population growth rate from July 1, 2004 to July 1, 2005.

Kansas City contains more than 90 percent of the county's population. Kansas City ranked 158th in population size as of July 1, 2005 and ranked 174th in population growth rate from July 1, 2004 to July 1, 2005.

Topeka ranked 194th nationally in population size as of July 1, 2005 and 127th in population growth.

Table 4. Population Estimates for the 10 Largest Cities in Kansas as of July 1, 2005

		Population estimates		Change 2004 to 2005	
Rank	Geographic Area	July 1, 2005	July 1, 2004	Number	Percent Change
1	Wichita	354,865	353,562	1,303	0.4
2	Overland Park	164,811	162,795	2,016	1.2
3	Kansas City	144,210	144,536	-326	-0.2
4	Topeka	121,946	121,691	255	0.2
5	Olathe	111,334	108,440	2,894	2.7
6	Lawrence	81,816	81,842	-26	0.0
7	Shawnee	57,628	56,201	1,427	2.5
8	Manhattan	48,668	47,915	753	1.6
9	Salina	45,956	45,964	-8	0.0
10	Lenexa	43,434	42,632	802	1.9

Source: Population Division, US Census Bureau
Release Date: June 21, 2006

These and other Kansas estimates can be accessed through the Internet at: http://www.census.gov/popest/estimates.php.

U.S. Census Bureau

Medicare Hospital Payment Information Now Available

Medicare has posted the costs it pays hospitals for 30 common elective procedures and other hospital admissions. The information is categorized by state and county and includes a range of prices, the national average payment for the procedure, and the number of cases the hospital has handled.

The U.S. Department of Health and Human Services (HHS) is working closely with national and local organizations to develop more comprehensive and personalized information on quality and cost. In addition to the information posted today, Centers for Medicare and Medicaid Studies (CMS) will post payment information for common elective procedures of ambulatory surgery centers later this summer and common hospital outpatient and physician services this fall.

"Top 30 Elective Inpatient Hospital DRGs" contains the volume and ranges of Medicare payments between the 25th and 75th percentiles for a limited set of conditions treated in states and counties. Included are the 30 conditions that had the highest utilization rates among all Diagnosis Related Groups (DRGs). Data are aggregated at the county, state, and national level. To access the data, access the CMS Website at http://www.cms.gov, then in the Search area type "Elective Procedures."

Centers for Medicare and Medicaid Studies

Hispanic Information Available in Hospital Discharge Data

Health assessments for the Hispanic population are becoming more critical to planning and resource allocation needs. According to the Census Bureau, the Hispanic population in Kansas increased approximately 10 percent between 2001 and 2004 and comprises 8.1 percent of the Kansas population.

Kansas vital statistics data have been a source of population-based health information for several years. The teenage pregnancy rate for Hispanics, ages 10-17, is 2.5 times higher than for Whites. Hispanic mothers are less likely to have adequate prenatal care and more likely to have multiple children before age 25.

Death rates for Hispanics are low in most mortality categories. However, the average age at death for Hispanics is 57.9 years of age (74.0 for all races). Interestingly, average age at death for Hispanic females is almost 10 years lower (53.2 years for females versus 63.7 years for males) while the reverse is true for those in all races (77.7 years for females and 69.8 years for males).

To better assess health issues experienced by Hispanics and other sub-populations, morbidity data will need to be used. Hospital discharge data have been made available to KDHE for use in public health assessment since 1995 in which race/ethnicity data consisted of White/Black/Other categories. However, beginning in 2003, hospitals began reporting information regarding Hispanic ethnicity of patients as well as expanded racial categories in the U.S. Office of Management and Budget (OMB) directive 15.

Unfortunately, completion of the race/ethnicity fields can be problematic. Since the expanded collection began, more than 9 percent of the race field was not completed for both 2003 and 2004; while in the Hispanic selection, over 16.4 percent of the records in 2003 and 15.2 percent in 2004 had no response.

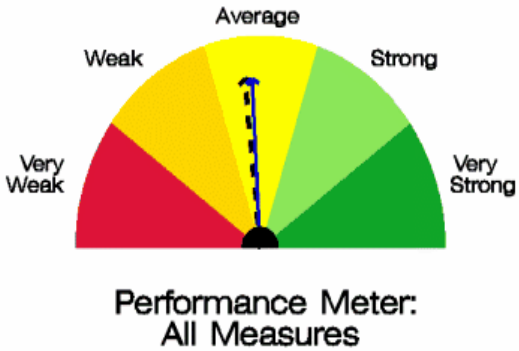
Even with the non-responses, more than half (54%) of the hospitalizations for those indicating they were Hispanic were for conditions surrounding birth. For non-Hispanics, approximately 19 percent of hospitalizations were attributed to births. Further evaluation of hospital discharge data is needed to address health issues experienced by Hispanics.

Elizabeth Saadi, PhD
Donald Owen, MA
Office of Health Care Information

Health Care Quality Report Issued

The Agency for Healthcare Research and Quality has issued the State Snapshots from the National Healthcare Quality Report (NHQR). State report breakouts are available. Kansas' score, considered average, improved slightly from 2004 (Figure 3).

Figure 3. Kansas Overall Health Care Performance, 2005



Note: The state's performance across all NHQR Quality Measures (up to 99) is shown above compared to all states in the most recent data year (solid line) and in a preceding data year (dashed line).

The 2005 State Snapshots are dashboards of health care

quality measures. The snapshots include detailed, customized tables for each state. They should help state officials and stakeholders understand health care quality in their state, including strengths, weaknesses, and opportunities for improvements.

Specifically, the 2005 State Snapshots provide:

- Performance meters that show the state's performance on summary measures of the quality of types of care, settings of care, and overall quality of health.
- State ranking tables that rank each state on 15 important measures of health care quality.
- In-depth focus on diabetes that provides information on quality, disparities, costs, and lives associated with diabetes, as well as potential savings that may result from a focused quality improvement program.

Strongest measures are those in which the state performed better than the all-state average. The best result for each measure can be either the highest or lowest value. The measure's direction representing best is noted in parenthesis.

Kansas' Strongest Measures

- Smoking cessation advice during hospital stay for heart attack: Percent of Medicare AMI (acute myocardial infarction) patients given smoking cessation counseling while hospitalized, by state, 2002 and 2003 (best = highest)
- Nursing home residents -- with too much weight loss: Chronic care: Percent of residents who lose too much weight, by state, 2004 (best = lowest).
- Diabetes hemoglobin A1c tests: Percent of adults age 18 and over with diabetes who had a hemoglobin A1c measurement at least once in the past year, by state, 2001 and 2003 (best = highest).

Weakest measures are those in which the state performed worse than the all-state average. The best result for each measure can be either the highest or lowest value; the worst result is in the opposite direction.

Kansas' Weakest Measures

- ACE (angiotensin converting enzyme) inhibitor prescribed at discharge for heart attack with dysfunction: Percent of Medicare AMI patients with left ventricular systolic dysfunction prescribed ACE inhibitor at discharge, by state, 2002 and 2003 (best = highest) .
- Pneumonia vaccinations -- age 65 plus: Percent of adults age 65 and over who ever received a pneumococcal vaccination, by state, 2001 and 2003 (best = highest).
- Antibiotic regimen within 24 hours of pneumonia admission: Percent of Medicare immunocompetent pneumonia patients (either ICU or non-ICU) who received the recommended empirical antibiotic regimen during the first 24 hours that is consistent with current guidelines, by state, 2002 and 2003 (best = highest).

National Healthcare Quality Report
Agency for Healthcare Research and Quality

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264-39
Office of Health Care Information
Center for Health and Environmental Statistics
Kansas Dept. of Health & Environment
1000 SW Jackson, Suite 130
Topeka, KS 66612-1354