



Kansas 2014 State Fact Sheet

Unintentional injuries and violence are the leading causes of death, hospitalization, and disability for children ages 1-18. This fact sheet provides a snapshot of data on the injury-related Maternal and Child Health Block Grant National Performance Measures and Health Status Indicators, with a special focus on disparities based on race, gender, and rural/urban residence.

The fact sheet is intended to be a helpful and easy-to-use tool for needs assessments, planning, program development, and presentations.

The Children's Safety Network (CSN) National Injury and Violence Prevention Resource Center, funded by the Maternal and Child Health (MCH) Bureau, works with states to utilize a science-based, public health approach for injury and violence prevention (IVP). CSN is available to provide information and technical assistance on injury surveillance and data; needs assessments; best practices; and the design, implementation, and evaluation of programs to prevent child and adolescent injuries.

This 2014 state fact sheet includes data that was available as of May 2014. The fact sheet will be updated as new data is made available at the federal level.

Major Causes of Injury Death

Table 1: Leading Causes and Total 5-Year Incidence of Deaths by Age Group, Kansas, 2006-2010

Rank	Age Groups					
	<1	1 - 4	5 - 9	10 - 14	15-19	20-24
1	Congenital Anomalies 346	Unintentional Injury 103	Unintentional Injury 44	Unintentional Injury 67	Unintentional Injury 310	Unintentional Injury 425
2	Short Gestation 248	Congenital Anomalies 31	Malignant Neoplasms 26	Malignant Neoplasms 29	Suicide 104	Suicide 176
3	SIDS 201	Malignant Neoplasms 16	Congenital Anomalies ****	Suicide 13	Homicide 62	Homicide 101
4	Unintentional Injury 83	Homicide 14	Homicide ****	Homicide 11	Malignant Neoplasms 32	Malignant Neoplasms 50
5	Maternal Pregnancy Comp. 78	Influenza & Pneumonia 13	Heart Disease ****	Congenital Anomalies ****	Heart Disease 22	Heart Disease 29

Note. **** = indicates that the cell values range from 1-9 and are suppressed for data confidentiality purposes.

Table 2. Leading Causes and Total 5-Year Incidence of Injury Deaths by Age Group, Kansas, 2006-2010

Age Groups							
Rank	<1	1 - 4	5 - 9		10 - 14	15-19	20-24
1	Suffocation 51	MV Traffic 29	MV Traffic 16		MV Traffic 40	MV Traffic 244	MV Traffic 292
2	Homicide 16	Drowning 22	Fire/Burn ****		Suicide 13	Suicide 104	Suicide 176
3	Fall ****	MV Traffic ****	Homicide 14	Drowning ****	Homicide ***	Homicide 11	Homicide 62
4	Other spec and; classifiable ****	Fire/Burn 13	Suffocation ****		Drowning ****	Poisoning 27	Poisoning 69
5	Natural/ environmental ****	Pedestrian, other ****	Other land transport ****		Fire/Burn ****	Drowning 10	Drowning 13

Note. All mechanisms of suicide and homicide were combined according to intent. Each listed mechanism is unintentional except those otherwise noted. **** = indicates that the cell values range from 1-9 and are suppressed for data confidentiality purposes.

Major Causes of Hospital-Admitted Injuries

These results are preliminary.

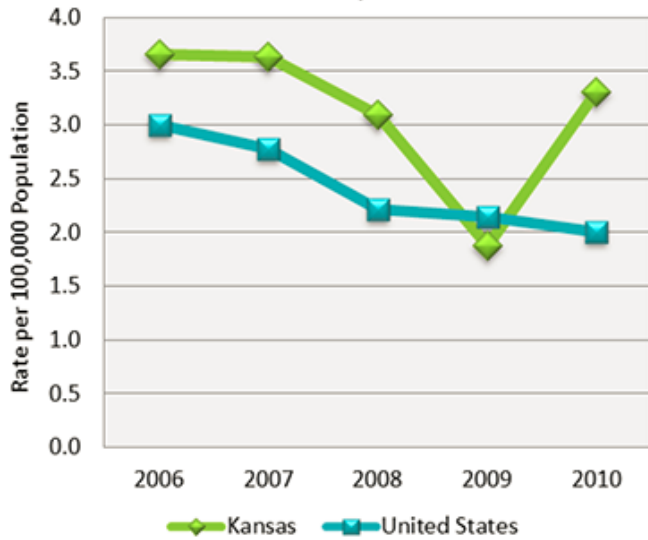
Table 3: Leading Causes and Annual Incidence of Hospital-Admitted Injuries by Age Group, Kansas Residents, 2011

Age Groups							
Rank	<1	1 - 4	5 - 9		10 - 14	15-19	20-24
1	Assault 36	Fall 61	Fall 57		Self-Inflicted 63	Self-Inflicted 311	Self-Inflicted 287
2	Fall 20	Poisoning 49	MVT 17		Fall 55	MVT 140	MVT 212
3	Other Specified, NEC 19	Fire/Burn 24	Bites & Stings 16		Struck By/ Against 29	Fall 66	Assault 125
4	Suffocation *	Other Specified, NEC 20	Other Specified, NEC 16		MVT 25	Struck By/ Against 50	Fall 84
5	Poisoning *	Fire/Burn *	Bites & Stings 19		Transport, Other *	Other Specified, NEC 17	Assault 46

Note: MVT = Motor Vehicle Traffic. NEC = Not Elsewhere Classifiable. Each listed mechanism is unintentional except those otherwise noted. * = indicates that the cell value ranges from 1 - 10 and is suppressed for data confidentiality purposes. Source: Children's Safety Network Economics and Data Analysis Resource Center (CSN EDARC), at Pacific Institute for Research and Evaluation (PIRE), Calverton, MD, January 2014. Incidence based on 2011 data from the state and obtained from the Kansas State Inpatient Databases (SID), Healthcare Cost and Utilization Project (HCUP), Agency for Healthcare Research and Quality (AHRQ), and the Kansas Hospital Association (Topeka, KS). These injuries exclude patients who were dead at the time of discharge, readmission cases, transfers (e.g., from another short or long-term care facility, different acute care hospital), medical misadventures, and/or who suffered non-acute injuries. All counts were based on the patients' state of residence.

Motor Vehicle-Related Deaths for Children 0-14 Years of Age

Figure 1: Rate of Deaths Caused by Motor Vehicle Crashes, Children Aged 0 through 14, Kansas and US, 2006-2010



Reducing unintentional motor vehicle deaths to children ages 0-14 is a Maternal and Child Health Block Grant National Performance Measure (Number 10). Motor vehicle-related deaths remain a major cause of death for this age group. Figure 1 shows the change in the rate of state motor vehicle-related deaths compared to the US rate from 2006-2010. Overall, the rate of death per 100,000 population declined steadily across the US during this period. Figure 2 provides a breakout of the fatalities by type distinguishing motor vehicle occupant deaths (of any vehicle type) from pedestrian and pedal cyclist fatalities. This information allows states to understand which types are responsible for most of the fatalities.

Figure 3 breaks out the fatalities by race and age group. There are considerable differences between races suggesting variations in social norms, safety practices, and the presence of risk factors, including child restraint system (CRS) or safety belt usage, alcohol involved crashes, and the use of helmets.

Many factors may affect this variation. Figure 4 provides a breakdown of fatalities by gender and, although there is little variability between males and females for the 10-14 age group, there is an increasing difference in the 15-24 age group. Figure 4 suggests that the female rate decreased for 20-24 year olds compared with the 15-19 year olds while male fatalities increased for 20-24 year olds.

Figure 2: Percentage Distribution of Motor Vehicle Traffic Fatalities by Type, Children Aged 0 through 14, Fig 2, Kansas, 2006-2010

65% of children ages 0 through 14 involved in a motor vehicle fatality were occupants of the vehicle.

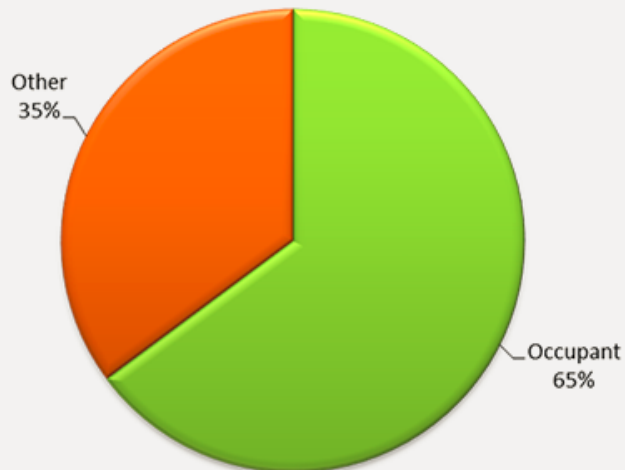


Figure 3: Motor Vehicle Traffic Fatality Rates by Race, Children and Youths Aged 0 through 24, Kansas, 2003-2007

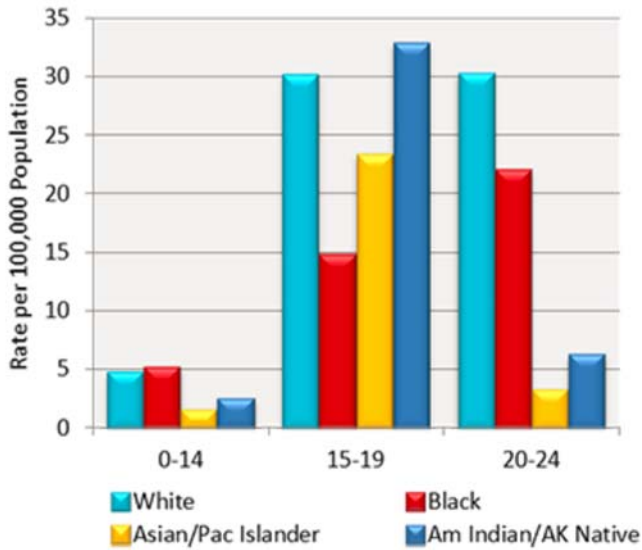
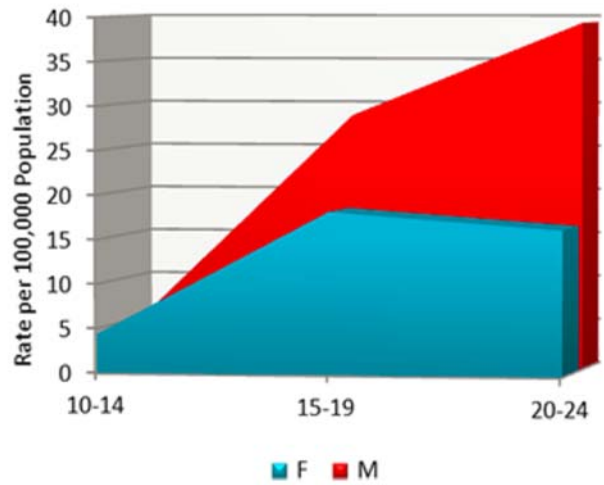
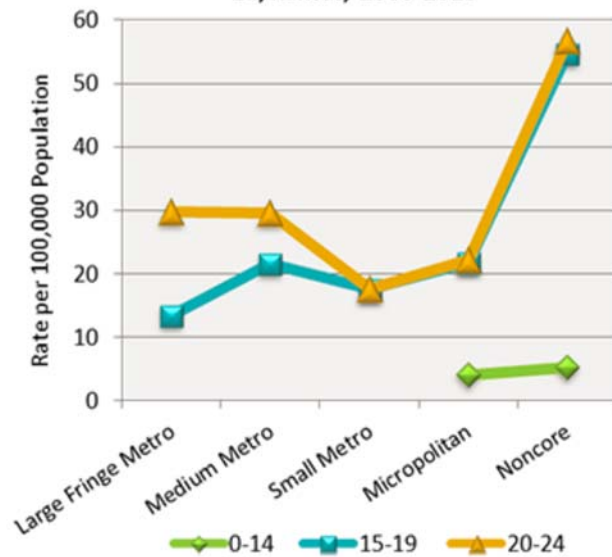


Figure 4: Motor Vehicle Traffic Fatality Rates by Gender, Children and Youths Aged 10 through 24, Kansas, 2006-2010



One way of understanding disparities is to look at the rate of injuries by place of occurrence. To show this, CSN has provided the rates for the 0– 14, 15-19 and 20-24 age groups using the urban-rural classification system developed by the National Center for Health Statistics (NCHS). To show how injury rates vary by level of urbanization, a [table based on the classification system can be found here](#) and defines six levels of urbanization: large central metro, large fringe metro, medium metro, small metro, micropolitan, and noncore. Figure 5 shows how the rate varies by age group by place of occurrence/urban-rural setting. This information allows the state to better understand any disparity that may occur between the different settings. Data are provided only for those areas in which 20 or more deaths occurred.

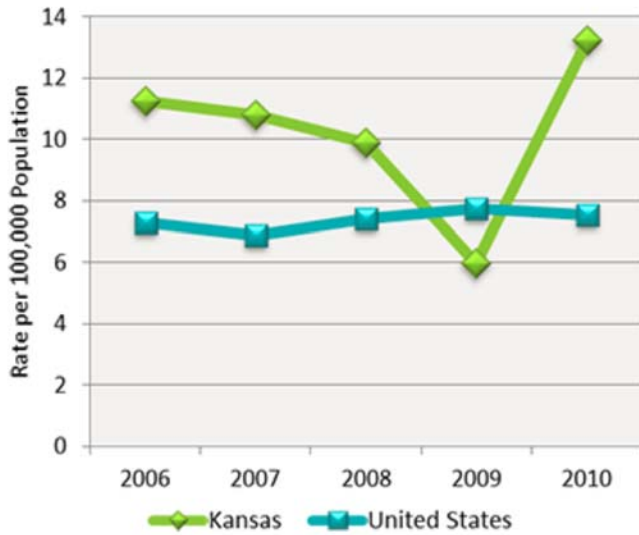
Figure 5: Motor Vehicle Traffic Fatality Rates by Urbanicity, Children and Youths Aged 0 through 24, Kansas, 2006-2010



Many of these motor vehicle related deaths can be prevented through the implementation of a broad range of evidence-informed interventions and programs. These data are intended to provide a broad overview of the magnitude of the problem and to highlight possible disparities which may exist by race, gender, and urbanicity.

Suicide Deaths for Youths 15-19 Years of Age

Figure 6: Rate of Suicide Deaths, Youths Aged 15 through 19, Kansas and US, 2006-2010



Reducing suicide deaths in youth 15 to 19 years of age is a Maternal and Child Health National Performance Measure (Number 16). Suicide is the 4th leading cause of death and the 3rd leading cause of injury-related death among US youth 10-24 years of age. According to the 2011 Youth Risk Behavior Surveillance Survey (YRBSS), 15.8% of students seriously considered attempting suicide and 7.8% of students attempted suicide one or more times in the 12 months prior to the survey. Although progress has been made over the past decade in reducing the rate of completed suicides nationally, this reduction has leveled off in the last few years. The following figures provide state-specific data related to suicide. Figure 6 shows the state rate from 2006-2010 for 15-19 year olds in comparison to the US rate for the same age group and time period. Figure 7 provides information on the means used by the 15-19 year olds for completed suicides. It is important to note that the actual number of suicides is often quite small thus resulting in considerable variation when looking at year to year rates.

Figure 7: Percentage Distribution of Completed Suicides by Means, Youths Aged 15 through 19, Kansas, 2006-2010

45% of youth ages 15 through 19 completed suicide by using suffocation.

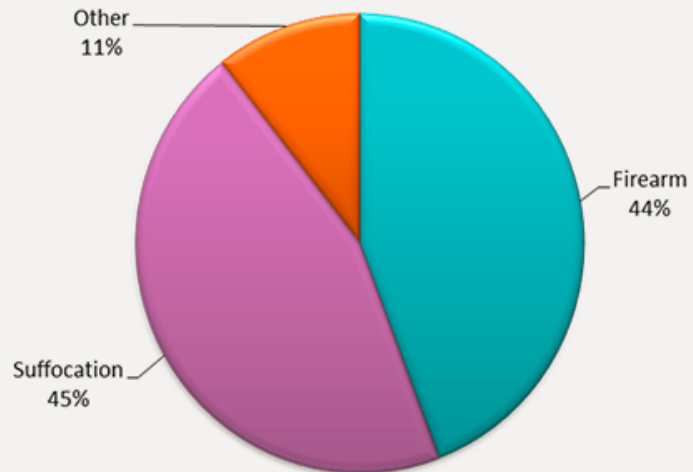


Figure 8: Percentage of High School-Aged Children with Suicide Ideation, Kansas and US, 2003-2011

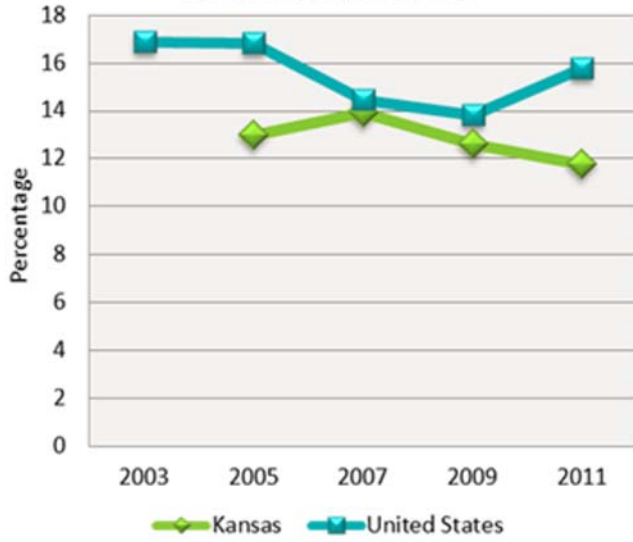


Figure 9: Percentage of High School-Aged Children Treated for Suicide Attempt, Kansas and US, 2003-2011

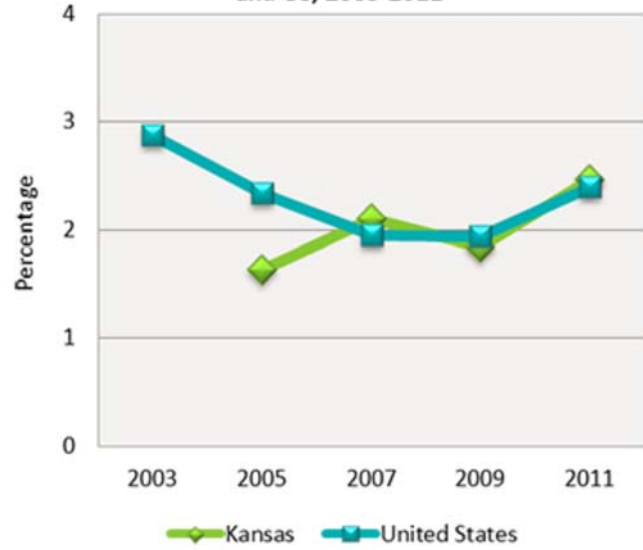


Figure 10: Rate of Completed Suicides by Race, Youths Aged 15 through 24, Kansas, 2006-2010

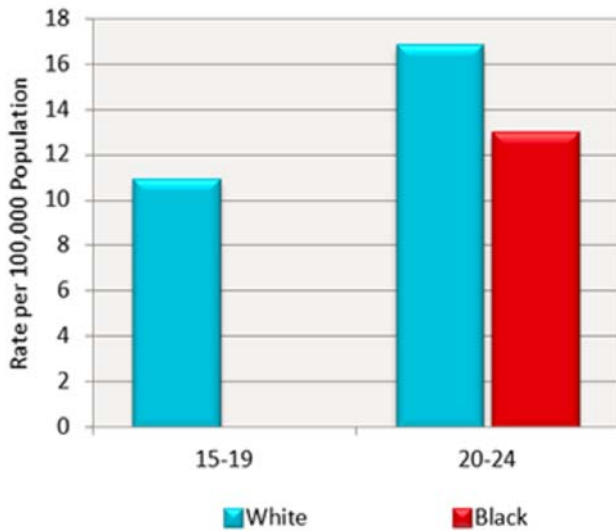
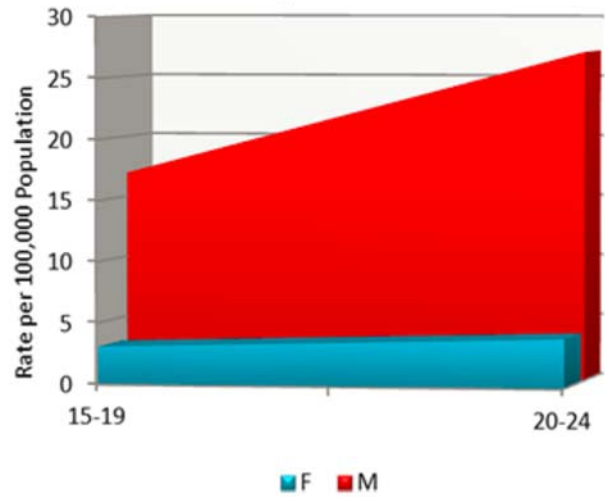


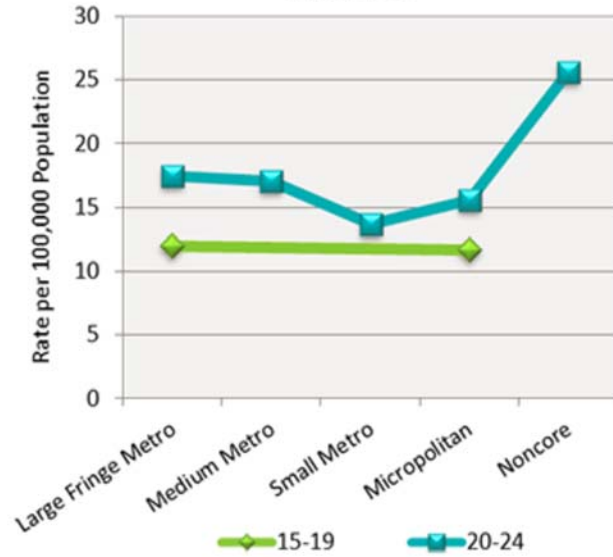
Figure 11: Rate of Completed Suicides by Gender among Youths Aged 15 through 24, Kansas, 2006-2010



The YRBSS provides information about behaviors that contribute to unintentional and intentional violence among youth. Figures 8 and 9 provide information on the percentage of high school students with suicide ideation and the percentage who reported being medically treated for a suicide attempt from 2003-2011, respectively. This information and other information available in the YRBSS can help states understand how behaviors are changing within this age group.

Figure 10 shows how the rate differs by race for 15-19 and 20-24 year olds from 2006-2010. Figure 11 shows the difference by gender for the same age group and time period with the male rate for both age groups exceeding the female rate. Figure 12 looks at the variation in rate by urbanicity for 15-24 year olds with the rate increasing as rurality increases (see definition of urbanicity in Motor Vehicle section). This information provides a better understanding of the magnitude of the problem in different parts of the state, helping the state to identify environmental risk factors and facilitate decision making on where to target its suicide prevention efforts.

Figure 12: Rate of Completed Suicides by Urbanicity, Youth Aged 15 through 24, Kansas, 2006-2010



Unintentional and Undetermined Drug Poisoning Deaths for Youths 15 -24 Years of Age

Poisoning is the 3rd leading cause of injury-related death among US youth ages 20-24 and the 5th leading cause of injury-related death among US youth ages 15-19. Drug overdose death rates among all ages in the US have more than tripled since 1990 and have never been higher. (1) Poisoning can be intentional or unintentional; poisoning cases reported here include prescription medications, illicit drugs and other, unspecified drugs. According to the national survey Monitoring the Future, in 2013 15 percent of high school seniors used a prescription drug non-medically in the past year. (2) Every day in the U S, an average of 2,000 teenagers use prescription drugs for the first time without a doctor's guidance. Youth who abuse prescription medications are also more likely to report use of other drugs. (3) Many teens falsely believe that because prescription medicines are prescribed by a physician, are inexpensive, and are widely available they are safer than illicit drugs.

Figure 15: MVT, Suicide and Drug Poisoning Fatality Rates, Youths Aged 15 through 24, Kansas, 2006-2010

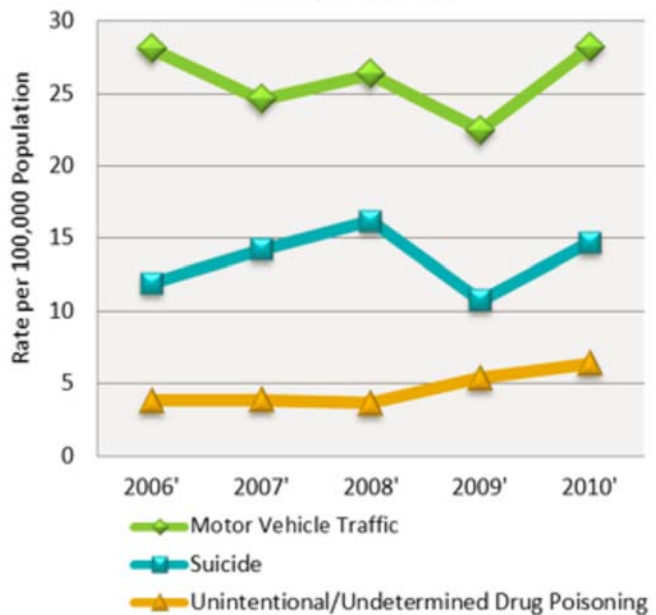


Figure 15 provides state-specific fatality rates for motor vehicle traffic, suicide, and drug poisoning for youth aged 15 through 24 for the period 2006-2010. Overall in the US, the rate of motor vehicle-related fatalities for this age group has decreased significantly from 2006 to 2010. However, the rate of fatalities for both suicide and drug poisoning has remained stable with a slight increase from 2009 to 2010. Figure 16 provides data on the rate of unintentional and undetermined drug overdoses in the state compared to the national rate. Figure 17 shows the percentage distribution of fatal unintentional and undetermined drug poisoning by drug type for the period 2006-2010.

Figure 16: Rate of Fatal Unintentional and Undetermined Drug Poisonings, Youths Aged 15 through 24, Kansas and US, 2006-2010

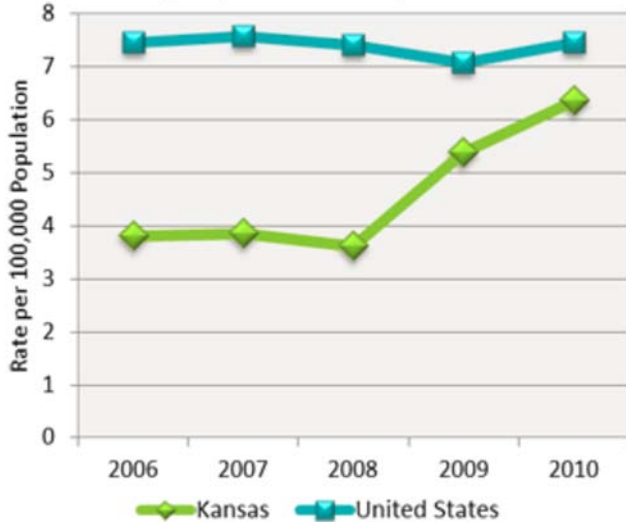
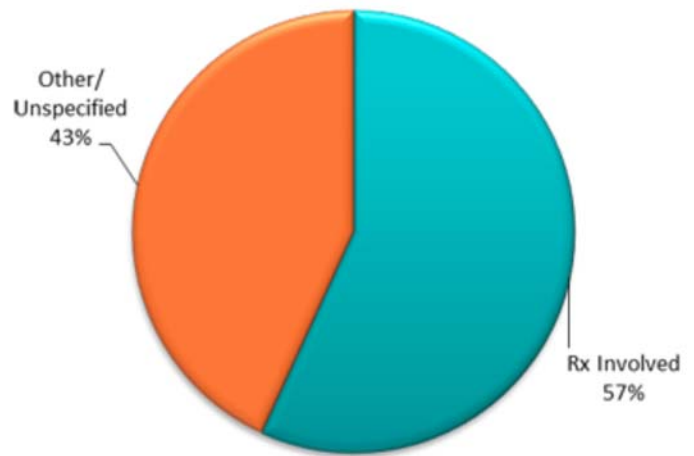


Figure 17: Percentage Distribution of Fatal Unintentional and Undetermined Drug Poisoning by Drug Type, Youths Aged 15 through 24, Kansas, 2006-2010



IVP Health Status Indicators

The Maternal and Child Health Bureau requires every state to report on 12 Health Status Indicators. Six of the indicators are related to IVP. The two figures below reflect the data reported for the IVP Health Status Indicators by the state in their Maternal and Child Health Block Grant Application Form 17, 2013.

Figure 13: Nonfatal Injury Health Status Indicators, Kansas, 2008-2012

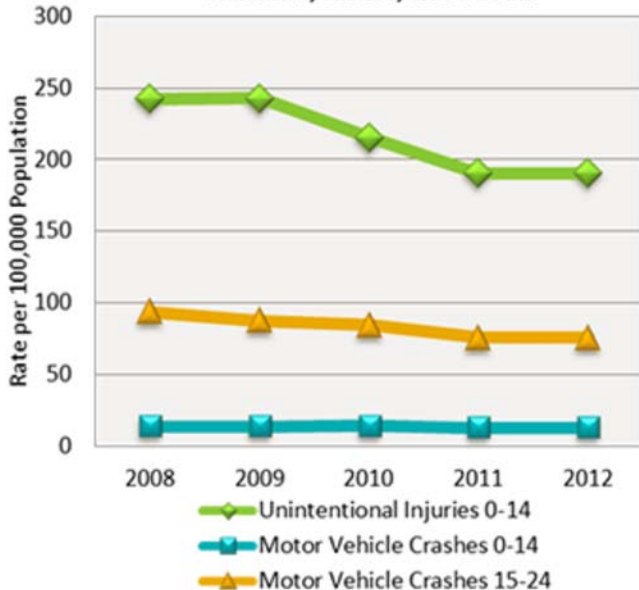
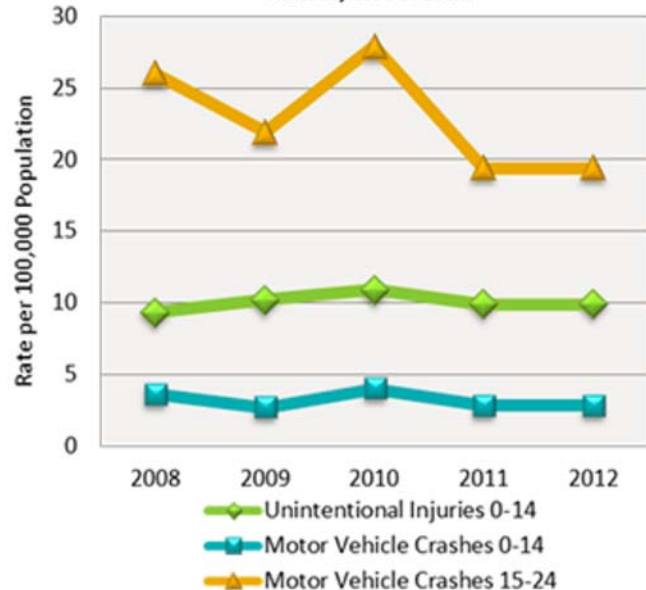


Figure 14: Fatal Injury Health Status Indicators, Kansas, 2008-2012



State Specific Performance Measures and Priority Needs

Each state develops up to 10 State Performance Measures and Priority Needs. The following provides information about the states' selected 2014 injury-related Performance Measures and Priority Needs.

Kansas does not have any injury-related State Performance Measures.

Kansas has the following injury related Priority Needs:

- The mental health and behavioral health needs of pregnant women and new mothers should be addressed.
- Child and adolescent risk behaviors relating to alcohol, tobacco, and other drugs should be reduced.

Citations and Sources

Drug Poisoning Section, 1: Centers for Disease Control and Prevention. Vital Signs: Overdoses of Prescription Opioid Pain Relievers-United States, 199-2008. MMWR 2011; 60: 1-6.

Drug Poisoning Section, 2: Monitoring the Future (sponsored by National Institute on Drug Abuse at The National Institutes of Health) www.monitoringthefuture.org/pubs/monographs/mtf-overview2013.pdf

Drug Poisoning Section, 3: NIDA Drug Facts. www.Teens.drugabuse.gov/drug-facts/prescription-drugs

Table 1 Source: WISQARS Leading Causes of Death Reports, 2006-2010

Table 2 Source: National Center for Health Statistics, Multiple Cause of Death Data, 2006-2010

Table 3 Source: Children's Safety Network Economics and Data Analysis Resource Center (CSN EDARC), at Pacific Institute for Research and Evaluation (PIRE), Calverton, MD, January 2013.

Table 4 Source: Children's Safety Network Economics and Data Analysis Resource Center (CSN EDARC), at Pacific Institute for Research and Evaluation (PIRE), Calverton, MD, January 2013.

Figure 1 Source: WISQARS Fatal Injury Reports, 2006-2010 and WISQARS Injury Mortality Reports, 2003-2007

Figure 2 Source: WISQARS Fatal Injury Reports, 2006-2010 and WISQARS Injury Mortality Reports, 2003-2007

Figure 3 Source: WISQARS Injury Mortality Reports, 2006-2010

Figure 4 Source: WISQARS Fatal Injury Reports, 2006-2010 and WISQARS Injury Mortality Reports, 2003-2007

Figure 5 Source: CDC WONDER Multiple Cause of Death data, 2006-2010 and Urban-Rural Definition Classification System The classification scheme can be found at: <http://wonder.cdc.gov/wonder/help/CMF/Urbanization-Methodology.html>. 2006 NCHS Urban-Rural Classification Scheme for Counties, by Deborah D. Ingram and Sheila Franco.

Figure 6 Source: WISQARS Fatal Injury Reports, 2006-2010 and WISQARS Injury Mortality Reports, 2003-2007

Figure 7 Source: WISQARS Fatal Injury Reports, 2006-2010 and WISQARS Injury Mortality Reports, 2003-2007

Figures 8 & 9 Source: Youth Online: High School Youth Risk Behavior Survey (YRBS), 2003-2011

Figure 10 Source: WISQARS Injury Mortality Reports, 2006-2010 and WISQARS Injury Mortality Reports, 2003-2007

Figure 11 Source: WISQARS Fatal Injury Reports, 2006-2010 and WISQARS Injury Mortality Reports, 2003-2007

Figure 12 Source: CDC WONDER Multiple Cause of Death data, 2006-2010 and Urban-Rural Definition Classification System Figures 13 & 14 Source: HRSA, Title V Information System Multi-Year Report. Some states may have changed their method of calculation.

Figures 15 & 16 Source: National Center for Health Statistics, Multiple Cause-of-Death Data, 2006-2010.

U.S. Census Bureau, Population Division (2012). Intercensal Estimates of the Resident Population by Single Year of Age and Sex for States and the United States (ST-EST00INT-AGESEX): April 1, 2000 to July 1, 2010.

Figure 17 Source: National Center for Health Statistics, Multiple Cause-of-Death Data, 2006-2010.

State Contacts

MCH Director: Rachel Berroth, Rberroth@kdheks.gov

IVP Director: Lori Haskett, Lhaskett@kdheks.gov

EMSC Contact: Lori Haskett, Lhaskett@kdheks.gov

CDR Coordinator: Angela Nordhus, angela.nordhus@ksag.org

About Children's Safety Network

The Children's Safety Network (CSN) National Injury and Violence Prevention Resource Center, funded by the Maternal and Child Health (MCH) Bureau, works with states to utilize a science-based, public health approach for injury and violence prevention (IVP). CSN is available to provide information and technical assistance on injury surveillance and data; needs assessments; best practices; and the design, implementation, and evaluation of programs to prevent child and adolescent injuries.

In this fact sheet CSN provides a cursory review of the injury morbidity and mortality data available for the state. The figures and tables in this fact sheet can help you understand the state's progress in addressing motor vehicle traffic injuries and suicide. To target and address these and other injury issues, it is critical to understand this data. CSN can assist you in conducting detailed data analyses, utilizing surveillance systems, and undertaking needs assessments. For assistance, contact the Children's Safety Network at csninfo@edc.org.

Connect with the Children's Safety Network

43 Foundry Avenue Waltham, MA 02453-8313

CSN's website: <http://www.ChildrensSafetyNetwork.org>

CSN on Facebook: <http://www.facebook.com/childrenssafetynetwork>

CSN on Twitter: <http://www.twitter.com/childrenssafety>

Register for the CSN newsletter: <http://go.edc.org/csn-newsletter>

Need TA? Have Questions? E-mail: csninfo@edc.org

CSN is funded by the Health Resources and Services Administration's Maternal and Child Health Bureau (U.S. Department of Health and Human Services). A project of the Education Development Center, Inc.

January 2014



Connect with The Children's Safety Network