

Kansas Maternal and Child Health

Life Course Indicators



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Kansas Maternal and Child Health
Life Course Indicators in Kansas

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Preface

The life course theory provides a framework for addressing maternal and child health issues. The Kansas Department of Health and Environment (KDHE) Bureau of Family Health and the Bureau of Epidemiology and Public Health Informatics are pleased to present Life Course Indicators data available through the 2011/2012 National Survey of Children's Health and the 2013 Behavioral Risk Factor Surveillance System. This report reflects KDHE Bureau of Family Health Title V programming efforts to view issues from a life course perspective. This report is intended to be a visualization tool to help highlight key disparities in 11 life course indicators representing the following domains: 1) childhood experiences, 2) family well-being, 3) health care access and quality, and 4) mental health. The Kansas data were examined for each indicator by their recommended modifiers from the Association of Maternal and Child Health Programs (AMCHP) Life Course project, including race, ethnicity, sex, age, education, income, peer group, federal poverty level and insurance type and consistency. The findings for children demonstrated that living near or below the federal poverty level, being non-Hispanic black or Hispanic, and lacking consistent insurance negatively impacted the likelihood of receiving evidence-based protective factors against health issues, and likewise increased the likelihood of exposure to negative factors which contribute to future health problems. This combination ultimately negatively impacts the child's health throughout their life course. Similar demographic disparities were seen among adults, because non-Hispanic black race and Hispanic ethnicity, lower education, and older age were associated with the presence of a health condition. These differences are important in understanding health disparities seen throughout the population.

Table of Contents

Introduction	1
Life Course Indicators and Title V Programming	2
Overview of the Data Sources.....	4
General Technical Notes.....	6
Summary of Findings	8
Adverse Childhood Experiences	12
Children with Special Health Care Needs.....	13
Diabetes.....	14
Hypertension.....	15
Exposure to Secondhand Smoke at Home.....	16
Obesity-Adults.....	17
Obesity-Children	18
Medical Home	19
Inability or Delay in Receiving Medical Care	20
Oral Health Preventive Visit	21
Mental Health.....	22
Appendix: Life Course Indicators Tables.....	23

Introduction

The life course theory (LCT) evolved from research documenting the long-term impact on health of various events and exposures earlier in life.¹ The LCT offers a broader viewpoint on examining health over a life span, not as disconnected stages of life (infancy, latency, adolescence, childbearing years, and elderly age), but rather as an integrated whole.² The LCT points to the importance of critical periods for interventions and the cumulative impacts of environmental factors in health.

Instead of focusing on differences in health patterns of one disease or condition at a time, LCT points to broad social, economic and environmental factors as underlying causes of persistent inequalities in health for a wide range of disease and conditions among population groups. While LCT was developed in large part from efforts to better understand and address disparities in health and disease patterns, it is also more universally applied to understand factors that can help everyone attain optimal health and developmental trajectories over a lifetime and across generations.

There are four key concepts in understanding LCT,¹ summarized as follows:

- **Timeline:** Today's experiences and exposures influence tomorrow's health.
- **Timing:** Health trajectories are particularly affected during critical or sensitive periods.
- **Environment:** The broader community environment--biologic, physical, and social, strongly affects the capacity to be healthy.
- **Equity:** While genetic make-up offers both protective and risk factors for disease conditions, inequality in health reflects more than genetics and personal choice.

As LCT became more prominent in maternal and child health (MCH) programming, a need for measurable indicators developed. In 2012, a team of seven states sponsored by the Association of Maternal and Child Health Programs (AMCHP) went through a 12 month process to narrow down a list of over 400 indicators to 59 indicators.³ This report represents a subset of the indicators available by the Behavioral Risk Factor Surveillance System (BRFSS) and National Children's Health Survey (NSCH).

This report analyzes the following 11 indicators: 1) adverse childhood experiences among children, 2) children with special health care needs, 3) diabetes, 4) exposure to secondhand smoke in the home, 5) hypertension, 6) obesity in children, 7) obesity in adults, 8) medical home, 9) inability or delay in necessary medical care or dental care, 10) oral health preventive visit for children, and 11) mental health status among adults.

References

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2. Fine A, Kotelchuck M, Adess N, Pies C. [Policy Brief. A New Agenda for MCH Policy and Programs: integrating a Life Course Perspective.](#) 2009. Martinez, CA. Contra Costa Health Services.
3. Association of Maternal and Child Health Programs. Life Course Metrics Project. <http://www.amchp.org/programsandtopics/data-assessment/Pages/LifeCourseMetricsProject.aspx> . Accessed 21 December 2015

Life Course Indicators and Title V Programming

Title V of the Social Security Act is the longest-standing public health legislation in American history that is a federal-state partnership to improve maternal and child health (MCH). The MCH Program relies on collaborative efforts and partnerships to maximize reach and promote efficiency to help assure that the diverse needs of Kansas families are met, without duplicating efforts. Kansas incorporates the life course perspective when conducting the Title V needs assessment and planning for the five-year period. As a result, the most recent action plan for the period 2016-2020 (*MCH 2020*) includes state priorities, state objectives, national performance measures, and national outcome measures which overlap with the life course indicators in this report (Table 1).

Table 1: Relationship Between Select Life Course Indicators and Title V Programming

Life Course Indicator	State Priority Need	State Objective	National Performance Measure or National Outcome Measure
Adverse Childhood Experiences	Communities and providers support physical, social and emotional health	Increase the number of adolescents aged 12 through 17 years accessing positive youth development, prevention, and intervention services and programs by 2020.	Adolescent suicide rate ages 15 through 19 per 100,000
Children with Special Health Care Needs	Services are comprehensive and coordinated across systems and providers	Develop an outreach plan to engage partners, providers, and families in the utilization of a shared resource to empower, equip, and assist families to navigate systems for optimal health outcomes by 2020.	Percent of children with and without special health care needs having a medical home
Exposure to Secondhand Smoke	Professionals have the knowledge and skills to address the needs of maternal and child health populations	Increase the proportion of smoking women referred to evidence-based cessation services to 95% or higher by 2020.	Percent of children who live in households where someone smokes

		Increase abstinence from cigarette smoking among pregnant women to 90% by 2020	
Medical Home	Services are comprehensive and coordinated across systems and providers	Increase family satisfaction with the communication among their child's doctors and other health providers to 75% by 2020.	Percent of children with and without special health care needs having a medical home
		By 2020, increase the proportion of families who received care coordination supports through cross-system collaboration by 25%.	
		Explore new and existing partnerships that promote collaboration between primary care and behavioral health providers.	
Obesity-Childhood	Services and supports promote healthy family functioning	Increase the percent of home-based child care facilities implementing daily routines involving at least 60 minutes of daily physical activity per CDC recommendation to decrease risk of obesity by 2020.	Percent of children and adolescents who are overweight or obese (BMI at or above the 85 th percentile)

Currently, Kansas is involved with several multi-sector, cross-cutting initiatives, coordinating both state and local programs to help continue to improve outcomes for all life course indicators. These programs include the following:

- Faces of Change
- Becoming a Mom (BAM)
- Infant Mortality Collaborative Improvement and Innovation Network (ColIN)
- Maternal, Infant, and Early Childhood Home Visiting (MIECHV)
- Kansas Special Supplemental Nutrition Program for Women, Infants and Children (WIC)
- Healthy Start (Delivering Change)

Overview of the Data Sources

The 2011/2012 National Survey of Children's Health (NSCH) and the 2013 Behavioral Risk Factor Surveillance System (BRFSS) are both large and complex sample telephone surveys. Both of these surveys are valuable tools in examining the burden of public health issues in a state, planning and evaluating public health programs to address these issues, public health decision making, leveraging funding opportunities, and public education.

National Survey of Children's Health

In 2011/2012, the NSCH survey was administered for the third time to continue monitoring the health in the United States. The 2011/2012 NSCH was primarily funded by the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA) and the United States Department of Health and Human Services (DHHS). Additional funding for specific questions was provided by DHHS, Office of the Assistant Secretary for Planning and Evaluation.

From February 2011 to June 2012, households with children in the 0-17 year age range were selected using a random-digit dialed sample. For the 2011/2012 NSCH, an additional independent random-digit-dial sample of cell phones was also selected. The respondents were parents or guardians with knowledge of the health and health care of the sampled child in the household. In total, 95,677 detailed child-level interviews were conducted representing an estimated 73,716,714 children nationwide. Each state and the District of Columbia conducted between 1,811 to 2,200 interviews, with Kansas conducting 1,836 interviews. The NSCH interview national completion rate was 54.1% for the land line sample and 41.2% for the cell-phone sample.¹ The Kansas interview completion rate was 60% for the land line sample and 49.3% for the cell-phone sample.

Each record of the NSCH was assigned a single sample weight to account for each state's unique population of non-institutionalized children. The sample weights were adjusted to account for non-response, households without land lines, and demographics such as age, gender and race. Sample weights allow estimates to be representative of the entire population for both on the national and state levels.

For the NSCH, the Data Resource Center (DRC) provides the recommended code for approximately 80 of the child health indicators. This report used the DRC's 2011/2012 NSCH SAS Code for Data Users as a guide for analysis of the indicators presented.²

More information regarding the NSCH can be found at the DRC website www.nschdat.org. The public use file and methodology for NSCH can be found on the State and Local Area Integrated Telephone Survey (SLAITS) website at www.cdc.gov/nchs/slaitns/nsch.htm.

Behavioral Risk Factor Surveillance System

The BRFSS, which is coordinated and partially funded by the Centers for Disease Control and Prevention (CDC), is the largest continuously conducted telephone survey in the world. It is conducted in every state, the District of Columbia and U.S. territories. In this report, the U.S. territories were excluded from the analysis. The Kansas response rate for combined landline and cellphone is 53.8%.³ The BRFSS uses a method which weights the data collected from

survey responders so that it is representative of the population as a whole. In 2013, over 500,000 BRFSS surveys were conducted nationwide, with 23,282 surveys in Kansas. More information regarding the BRFSS, as well as the downloadable file, can be found at the CDC website http://www.cdc.gov/brfss/annual_data/annual_2013.html.

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1. Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey. 2011-2012. National Survey of Children's Health Frequently Asked Questions. <http://www.cdc.gov/nchs/slait/nsch.htm>. Published 2013. Accessed January 6 2016.
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General Technical Notes

95% Confidence Intervals

95% Confidence intervals (CI) were calculated for each measure. If the confidence intervals do not overlap, there is a statistically significant difference between the estimates of interest.

All the statistical analyses were performed using SAS version 9.3.

Pairwise Comparison and Statistical Testing

Each indicator in the report was examined by potential recommended modifiers (e.g. race and ethnicity) that contain different groups (e.g. race and ethnicity: Hispanic, non-Hispanic white, non-Hispanic black, non-Hispanic other). Pair-wise comparisons were used to compare every pair combination for each modifier using a two sample t-test with a $p < 0.05$ threshold for statistical significance. In this report, significant difference can be assumed in the key highlights section unless otherwise stated.

Federal Poverty Level

Every year, the U.S. Department of Health and Human Services publishes the poverty guidelines for the household poverty status referred as federal poverty level (FPL). Poverty status is determined by two variables: household income and the number of people living in the household. For the National Survey of Children's Health (NSCH), 9.3 % of the households in the sample had an unknown value for income, household size or both, so a value was imputed based on a routine developed by the Data Resource Center (DRC). In this report, life course indicators are presented for children and adults living less than 100% below the FPL, versus those living 100-199%, 200-399% and 400% or more above the FPL.

Children with Special Health Care Needs

A child with Special Health Care Needs (CSHCN) status is determined using a validated instrument for identification of CSHCN as defined by the federal Maternal and Child Health Bureau (MCHB). The CSHCN Screener asks whether a child currently experiences a health consequence and, if so, whether that specific health consequence is due to a medical, behavioral, or other type of health condition that has lasted or is expected to last 12 months or longer.

Race and Ethnicity

For this report, race and Hispanic origin categories were combined as follows:

- non-Hispanic white;
- non-Hispanic black;
- non-Hispanic other; and
- Hispanic.

In this report non-Hispanic was abbreviated to NH in the graphs and tables.

Peer Group

Kansas is a rural state with one-third of the population living in two-thirds of its land mass. Peer groups combine counties of similar population densities to make comparisons. The following are the different peer groups in Kansas.

- Frontier (less than 6.0 persons per square mile)
- Rural (6.0 to 19.9 persons per square mile)
- Densely-settled Rural (20.0 to 39.9 persons per square mile)
- Semi-urban (40.0 to 149.9 persons per square mile)
- Urban (150.0 or more persons per square mile)

Unreliable Estimates and Relative Standard Error

The NSCH allowed for the reporting of estimates based on any cell size but required the relative standard error (RSE) be calculated when the cell count is <50. The RSE is a measure of variability of an estimate and is calculated as the standard error divided by the estimate for the measure in the particular population group. An estimate is unstable and does not meet standards for reliability and precision when the RSE is greater than 30%.

In this report, any estimate in a population subgroup that did not meet the appropriate RSE threshold was suppressed. Additionally, the asterisk (*) notation is used when the cell size was < 50 for the subgroups for both NSCH and BRFSS. Caution is needed with interpretation when there are a small number of respondents for the indicator, even if the RSE is within acceptable standards.

Comparison with the United States

Throughout this report, comparisons between Kansas data and the United States data were made. Note, the overall United States data included all 50 states and excludes territories.

Summary of Findings

Both children and adults experienced issues related to the life course. Over half of adults were considered overweight or obese based on their Body Mass Index (BMI) levels (Table 2). For children, only 60% received care within a medical home, well below the Kansas Title V target for 2020 of 83.1%.¹

For several life course indicators, the Kansas prevalence levels were statistically significant and more favorable compared to the United States (Table 2). Kansans reported less frequently to ever being diagnosed with diabetes or an inability or delay in necessary medical care for their children in the previous year. Kansans were also less likely to report that in the past month, 14 or more days their mental health was “not good”. Also, Kansas children were more likely to receive care that meets the definition of the medical home compared to the overall United States.

The biggest area for improvement is adult obesity; Kansas had a significantly higher prevalence of obesity compared to the overall United States (Table 2).

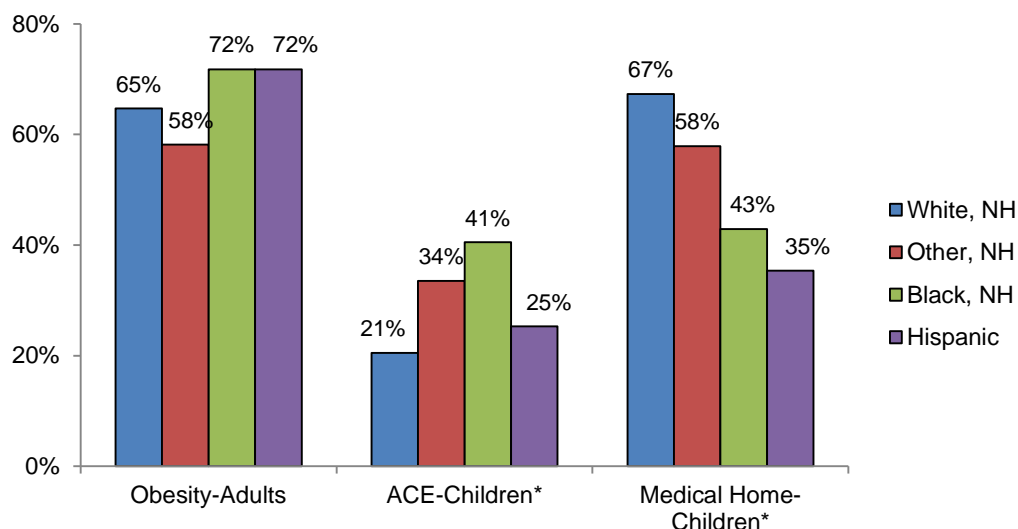
Life Course Theory (LCT) recognizes the importance of demographic disparities as a cause of health inequity. Racial and ethnic disparities were evident in the select life course indicators. In this report the following indicators had significant differences among the four race/ethnic groups evaluated:

- Hypertension
- Diabetes
- Obesity-Adults
- Mental Health
- Adverse Childhood Experiences*
- Medical Home*
- Obesity-Childhood*

* Interpret with caution: estimates are based on cell count less than 50

Figure 1 displays the disparities for select indicators. For adult obesity, non-Hispanic other adults had significantly lower rates of obesity compared to the other three race and ethnicity groups. Furthermore, non-Hispanic white adults had significantly lower rates of obesity compared to non-Hispanic black and Hispanic adults. For adverse childhood events, non-Hispanic white children were significantly less likely to have two or more adverse childhood events compared to non-Hispanic black children and non-Hispanic other children. A significantly higher proportion of non-Hispanic white children received care within a medical home setting compared to non-Hispanic black and Hispanic children. Furthermore, a significantly higher proportion of non-Hispanic other children received medical home care compared to Hispanic children.

Figure 1. Select Life Course Indicators by Race/Ethnicity, Kansas



Sources: Behavioral Risk Factor Surveillance System, 2013 and National Survey of Children's Health 2011-2012

NH is Non-Hispanic

Obesity refers to a Body Mass Index over 25.0

Adverse Childhood Experiences (ACEs) are more than two ACEs out of nine

Medical Home is defined as receiving care within a medical home, based on a composite of 19 items

Refer to Data Resource Center discussed in Overview of Data Sources

*Interpret with caution: NH black race had cell counts less than 50

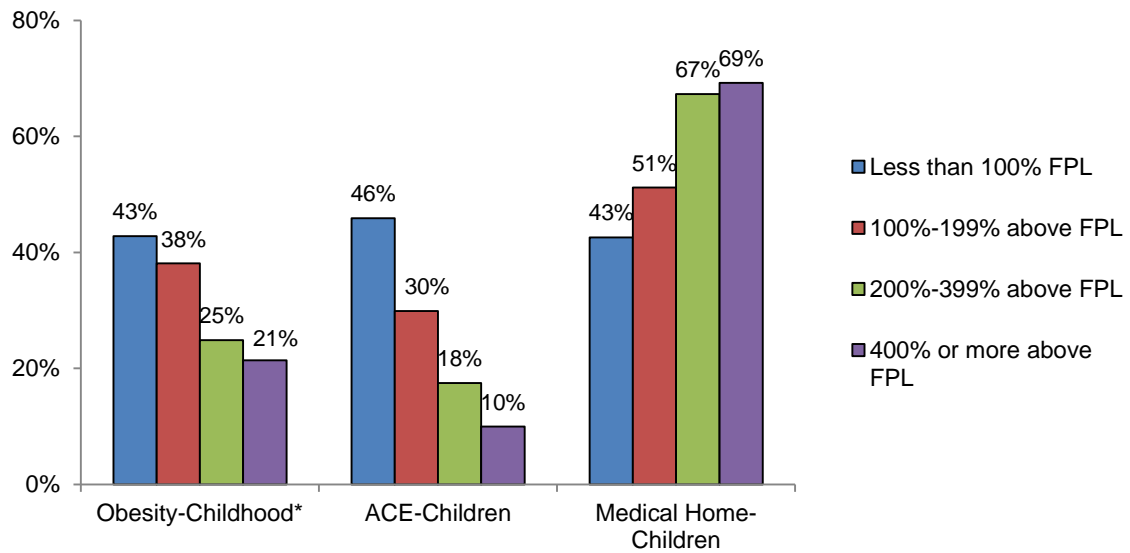
Poverty is a key disparity in health inequity. Federal Poverty Level (FPL) was imputed for indicators from the National Survey of Children's Health (See Technical Notes). In this report, the following indicators had significant differences for the different poverty levels:

- Adverse Childhood Experiences (ACE)*
- Special Health Care Needs
- Obesity-Childhood
- Medical Home
- Oral Health Preventive Visit

*Interpret with caution: estimates are based on cell count less than 50

Figure 2 displays how children living below or close to the federal poverty level are more likely to experience health inequities. For childhood obesity, children living 400% or more above the FPL had lower rates of obesity compared to children living less than 100% under the FPL or between 100%-199% above the FPL. For adverse childhood experiences, there was a significant decrease of children experiencing two or more adverse childhood experiences as each group moved away from the poverty line. For children receiving care within a medical home, children living 200% or more above the FPL were significantly more likely to receive care within a medical home compared to children living below 200% FPL.

Figure 2. Select Life Course Indicators by Federal Poverty Level, Kansas



Source: National Survey of Children's Health 2011-2012

FPL Federal Poverty Level

Obesity refers to a body-mass-index for age is 85% percentile or above

Adverse Childhood Experience (ACE) is more than two adverse childhood events out of nine

Medical Home is defined as receiving care within a medical home, based on a composite of 19 items.

*Interpret with caution: Less than 100% FPL and 100%-199% FPL both had cell counts less than 50

Reference

1. Kansas Department of Health and Environment. Maternal and Child Health Services Title V Block Grant: Kansas.

Table 2: Kansas Life Course Indicators

	Kansas %	95% CI	United States %	95% CI
Childhood Experiences				
Adverse Childhood Experiences Among Children	24.0	21.2, 26.9	22.6	22.0,23.2
Family Wellbeing				
Children with Special Health Care Needs	19.4	16.9, 21.9	19.8	19.2, 20.4
Diabetes	9.6†	9.1, 10.0	10.2	10.0, 10.4
Exposure to Secondhand Smoke in the Home	5.7	4.2, 7.2	4.9	4.6, 5.2
Hypertension	31.3†	30.6, 32.0	32.4	32.1, 32.7
Obesity-Children	30.2	25.6, 34.7	31.3	30.3, 32.4
Obesity-Adults	65.3†	64.5, 66.1	63.8	63.5, 64.1
Health Care Access and Quality				
Medical Home for Children	59.1†	55.9, 62.3	54.4	53.7,55.1
Inability or Delay in Obtaining Necessary Medical Care or Dental Care	4.9†	3.5,6.2	6.7	6.3,7.1
Oral Health Preventive Visit for Children	74.0	71.2, 76.8	72.8	72.1, 73.4
Mental Health				
Mental Health Among Adults	9.7	9.2, 10.2	11.5	11.3, 11.7
Sources: Behavioral Risk Factor Surveillance System, 2013 and National Survey of Children's Health, 2011-2012				
† Statistically significant difference between U.S and Kansas with alpha at 0.05				

Adverse Childhood Experiences

Prevalence of adverse childhood experiences among children (experiences of emotional, physical, or sexual abuse and household dysfunction)

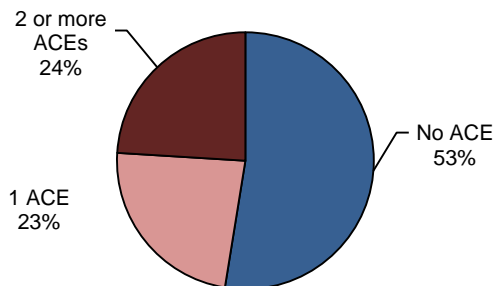
Importance

The effects of Adverse Childhood Experiences (ACEs) can last a lifetime without a proper intervention. Children who have ACEs are at **higher risk for chronic mental, physical and emotional health problems** which transcend into adulthood, such as sexual developmental issues, depression, aggression, lower income, socioeconomic status, and higher rates of health risk behaviors (e.g., risky sexual behaviors, alcohol, drug and tobacco use).¹ **ACEs include experiences of emotional, physical or sexual abuse, as well as household dysfunction** (e.g., financial difficulties and household members who are substance abusers, mentally ill, or incarcerated).

Kansas Highlights

- About **half of Kansas children** (47.4%) had an adverse childhood experience (ACE), and about a **quarter** (24%) of all children had experienced two or more, similar to the national prevalence (47.9% and 22.6%).
- The most common ACE was **financial hardship** (28%).
- Children living in households under the **federal poverty level** had higher prevalence of two or more ACEs than children living in households with higher income.
- Children with **special health care needs** (CSHCN) (9.4%) were more likely to experience two or more ACEs compared to non-CSHCN (4.8%).
- Children **living with two biological or adoptive parents** were less likely to experience two or more ACEs (10.0%).
- **Gender** did not have an effect on prevalence rates of two or more ACEs.

**Adverse Childhood Experiences
Kansas, 2011-2012**

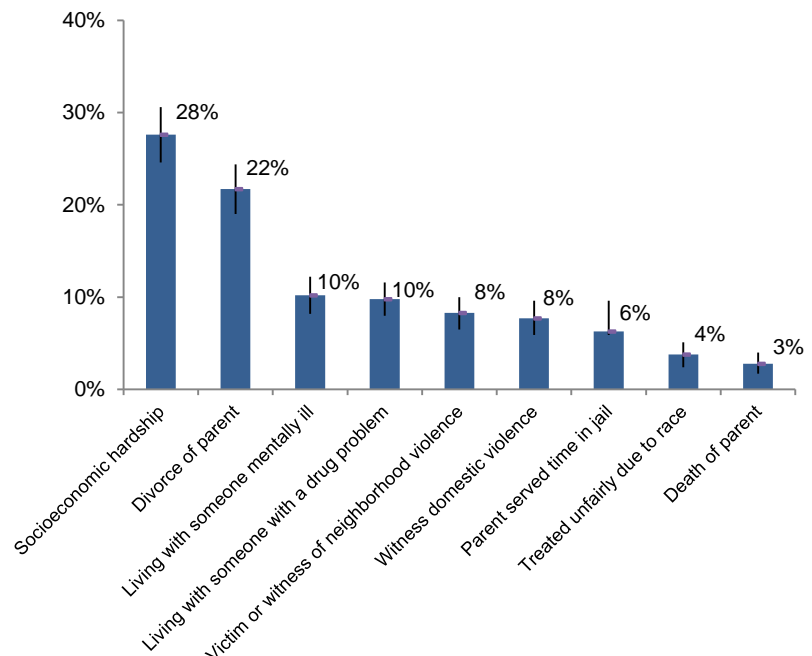


Source: National Survey of Children's Health, 2011-2012
ACE: Adverse Childhood Experience

What can be done?

- Protective factors, such as child's positive relationship with a caring adult, easy temperament of the child, and health insurance coverage can counteract the negative impact of ACEs.²
- Implement the *Lemonade for Life* ACEs screening protocol with home visiting programs.

**Type of Adverse Childhood Experiences
Kansas, 2011-2012**



Source: National Survey of Children's Health, 2011-2012
ACE: Adverse Childhood Experience

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1. Association of Maternal & Child Health Programs. Life Course Indicators: Prevalence of adverse childhood experience among children (LC-2) Washington DC
2. Wermer, E, Smith R. Overcoming the Odds: High Risk Children from Birth to Adulthood. 1992. New York: Cornell University Press

Children with Special Health Care Needs

Percent of children (0-17 years) with a special health care need

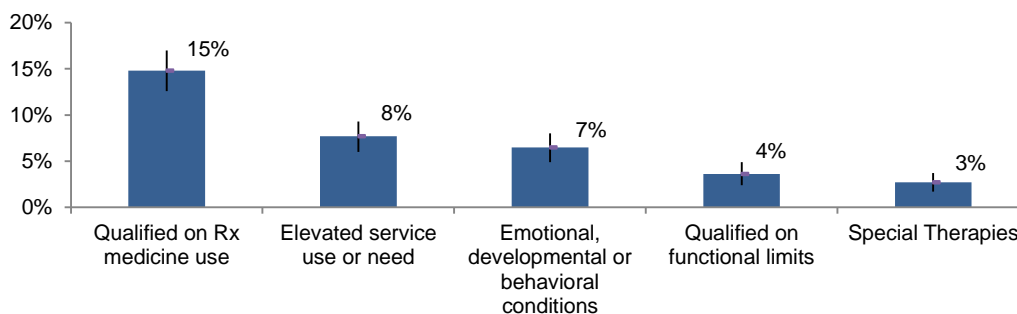
Importance

Children with Special Health Care Needs (CSHCN) and their families experience **lifetime societal barriers and disparities in healthcare access and health equity**. Poor childhood physical and mental health conditions result in poorer adult health. Furthermore, CSHCN tend to have **lower educational achievements compared to their peers and are less likely to have a job**, which could contribute to socioeconomic status and health care status in adulthood.¹ Although many conditions and illnesses CSHCN experience are not preventable, with adequate health care access, **many of the adverse side effects can be prevented** or decreased, allowing for the child to reach their full potential. CSHCN are defined as those with one or more chronic physical, developmental, behavioral or emotional condition for which they require specialized health care services.²

Kansas Highlights

- **1 in 5** (19.4%) Kansas children were classified as having a special health care need.
- Children living **under federal poverty level** (26.4%) had a higher proportion of CSHCN compared to children living above the poverty level.
- CSHCN were more likely to have **public insurance** (25.7%) versus private insurance (17.1%).
- **School-aged children** (6-11 and 12-17 years) were more likely to have a special health care need compared to children aged 0-5.
- Race and ethnicity do not significantly impact special health care needs status.

Type of Special Health Care Needs
Kansas, 2011-2012

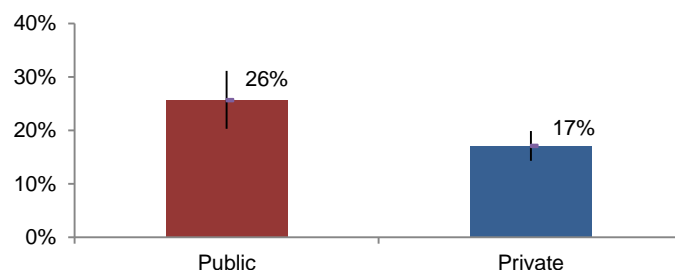


Source: National Survey of Children's Health, 2011-2012

What can be done?

- Encourage families and providers to use the *Charting the LifeCourse Tool*.³
- Promote the Special Bequest Program among providers to help assist with financial burden.
- Align local schools, public health entities and pediatric providers to avoid redundancy in screening the same child for the same conditions.

Children with Special Health Care Needs and Insurance Type
Kansas, 2011-2012



Source: National Survey of Children's Health, 2011-2012

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1. Forrest, C et.al. School Outcomes of Children with Special Health Care Needs. *Pediatrics*. 2011. 128 (2)
2. Child and Adolescent Health Measurement Initiative. "Who Are Children with Special Health Care Needs (CSHCN)." Data Resource Center, supported by Cooperative Agreement 1-U59-MC06980-01 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). www.childhealthdata.org. Revised April 2 2012. Accessed January 6, 2016.
3. Missouri Family to Family. *Charting the Life Course: A Guide for Individuals, Families and Professionals*. 2015. Kansas City, MO: University of Missouri-Kansas City Institute for Human Development, University Center for Excellence in Developmental Disabilities

Diabetes

Percent of adults diagnosed with diabetes

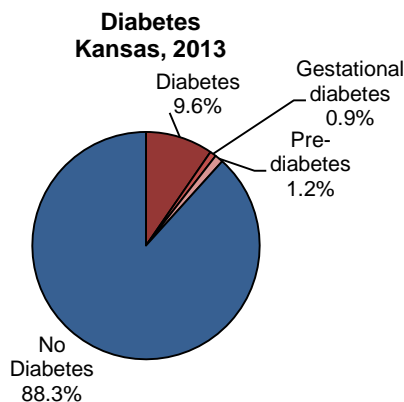
Importance

Self-reported diabetes prevalence has steadily increased in the United States over the past two decades from 4.9% in 1990 to 8.7% in 2010.¹ Approximately 28.9 million U.S. adults aged 20 and older are living with diabetes.² Type 2 diabetes is a strong risk factor for **cardiovascular disease, high blood pressure, high cholesterol, obesity and/or high triglyceride levels**. If left unmanaged, diabetes can result in blindness, lower limb amputations and end-stage renal failure. Diabetes is the **seventh** leading cause of death in Kansas.³ Furthermore, **diabetes is costly**; generally patients with diabetes incur twice the medical costs compared to those who do not have diabetes.⁴

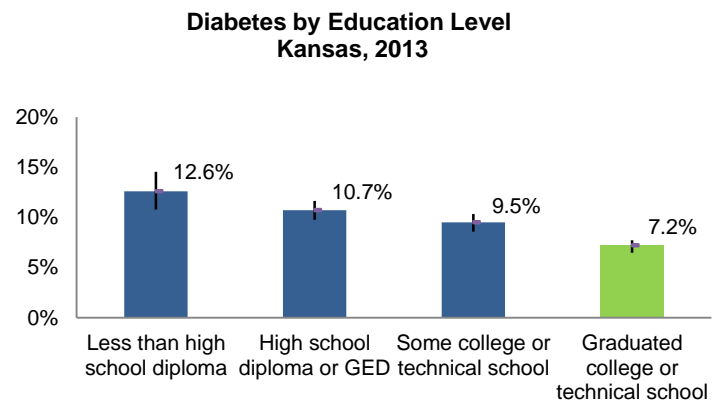
Note: since diabetes can go undetected for a long period of time, the numbers may be underreported.

Kansas Highlights

- **1 in 11 (9.6%)** Kansas adults had diabetes, similar, but significantly lower than, the national average (10.2%).
- As age group increased, diabetes prevalence increased. Approximately a **fifth of adults aged 65 and older (20.2%)** had diabetes.
- **Fewer** adult with a **college or technical degree (7.2%)** had diabetes in Kansas compared to adults without degrees.
- As income **increased**, prevalence levels **decreased**.
- **Non-Hispanic black adults (12.8%)** had **higher prevalence** levels than non-Hispanic white adults (9.4%).
- There was **no difference** in prevalence among males and females or peer groups.



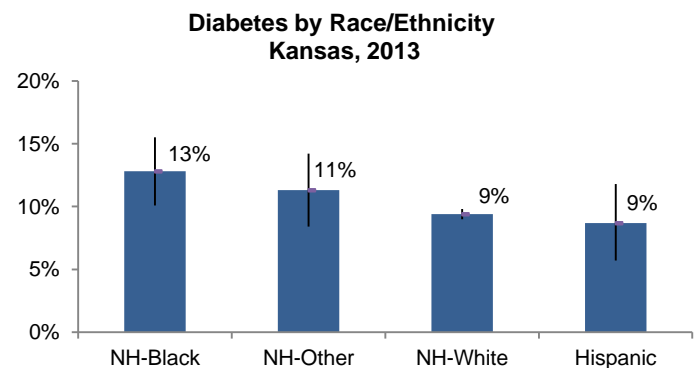
Source: Behavioral Risk Factor Surveillance System, 2013



Source: Behavioral Risk Factor Surveillance System, 2013

What can be done?

- Encourage community leaders to use the *Kansas and You - Living Free of Diabetes and Its Complications* toolkit in their community.



Source: Behavioral Risk Factor Surveillance System, 2013
Note: NH is non-Hispanic

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Hypertension

Percent of adults diagnosed with hypertension

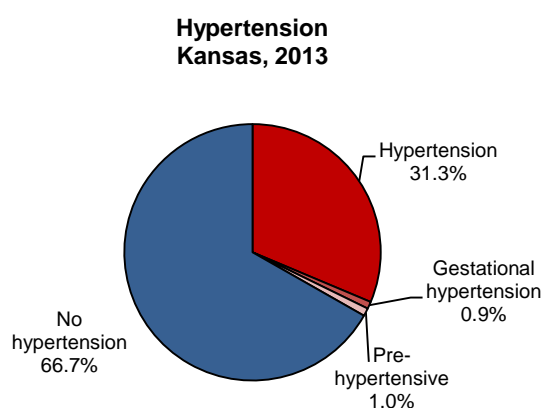
Importance

Nearly 1 in 3 American adults have hypertension and about **half do not have their hypertension under control**.^{1, 2} Hypertension **increases the risk for heart disease and stroke**, which are the leading causes of death in the United States.

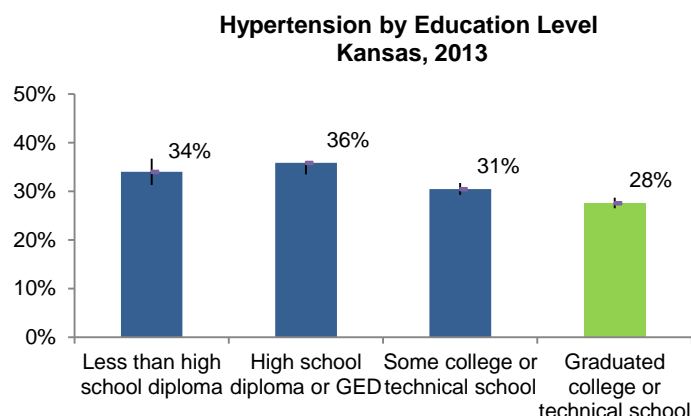
¹ Hypertension is **deadly**--it contributes to nearly 1,000 deaths per day. It is typically faced later in life but the prevalence among children is rising. Furthermore, hypertension is **costly**--medical expenditures associated with hypertension and hypertension-related morbidity has been estimated to be \$131 billion.³

Kansas Highlights

- **A third (31.3%) of Kansas** residents had hypertension, a slightly lower prevalence, but significant, than the **U.S. (32.4%)**.
- **Males (33.2%)** had a higher prevalence than females (29.5%).
- As age group **increased** so did the prevalence.
- As **income and years of education increased**, the prevalence of **hypertension decreased**.
- **Non-Hispanic black adults (40.2%)** had the highest prevalence of hypertension compared to any other race and ethnicity.



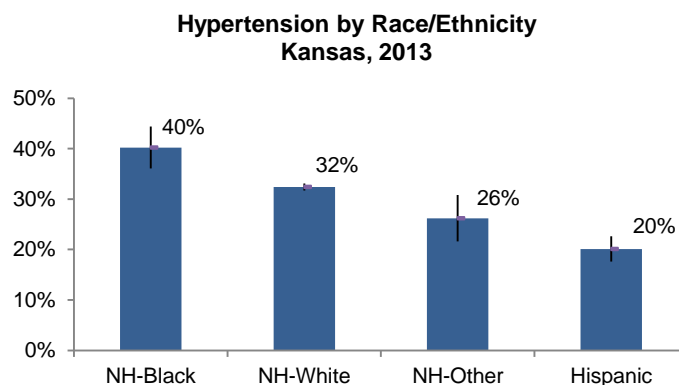
Data Source: Behavioral Risk Factor Surveillance System, 2013



Data Source: Behavioral Risk Factor Surveillance System, 2013

What can be done?

- Extend patient care and self-management initiatives through partnerships with pharmacists, nurses and health care navigators across the state.



Source: Behavioral Risk Factor Surveillance System, 2013
Note: NH is non-Hispanic

References

1. Keenan NL, Rosendorf KA. Prevalence of Hypertension and Controlled Hypertension-United States, 2005-2008. *CDC MMWR: Morbidity and Mortality Weekly Supplement*. 14 Jan 2011. Vol 60.
2. CDC, National Center for Health Statistics. Table 68. In: health, United States, 2009: with special feature on medical technology. Hyattsville, MD: U. S. Department of Health and Human Services, CDC; 2010:293-4.
3. National Center for Chronic Disease Prevention and health Promotion: Division for Heart Disease and Stroke Prevention. Vital Signs: Awareness and Treatment of Uncontrolled Hypertension Among Adults—United States, 2003-2013. 2012. 1600 Clifton Road NE, Atlanta, GA.

Exposure to Secondhand Smoke at Home

Percent of children living in a household where smoking occurs in the home

Importance

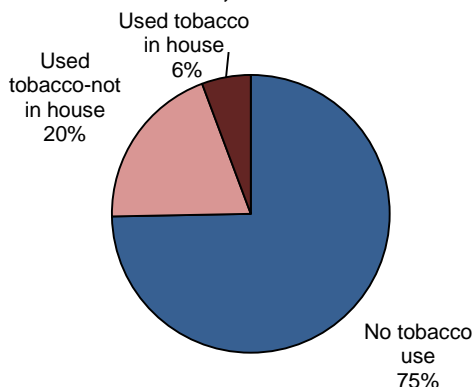
Secondhand smoke has been labeled by the U.S. Environmental Protection Agency (EPA) as a **known cancer-causing agent** and has caused over 7,500 lung cancer deaths in nonsmokers each year.¹ Children suffer from **serious health risks** due to second hand smoke exposure, including **new cases of asthma and symptoms of asthma exacerbating, Sudden Infant Death Syndrome (SIDS), pneumonia, bronchitis and middle ear infections.**^{1,2}

The National Performance Measure for Title V aims to reduce the percent of children who live in households where someone smokes by 2020.

Kansas Highlights

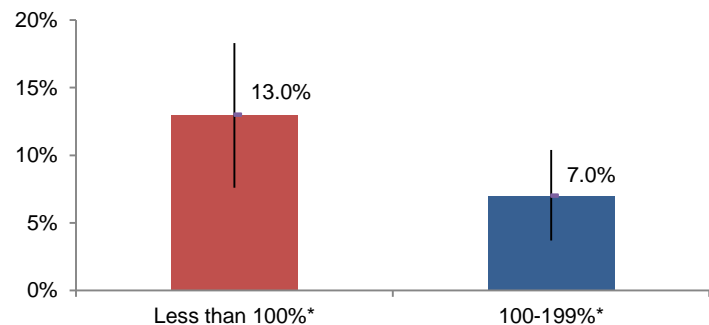
- **Kansas** (5.7%) had similar prevalence of children exposed to secondhand smoke in the home to the **U.S.** (4.9%).
- Boys and girls had roughly the **same level of exposure** to secondhand smoke at home.
- Children **living in poverty** (13.0%) were more likely to be exposed to secondhand smoke in the home than children not in poverty.
- Children with **public insurance** (11.7%) were more likely to be exposed to secondhand smoke than children with private insurance (2.7%).
- **Children with a special health care need** (9.5%) were more likely to be exposed to secondhand smoke than children without (4.8%).

Tobacco Usage Among Families with Children
Kansas, 2011-2012



Source: National Survey of Children's Health, 2011-2012

Exposed to Secondhand Smoke at Home by
Federal Poverty Level*
Kansas, 2011-2012

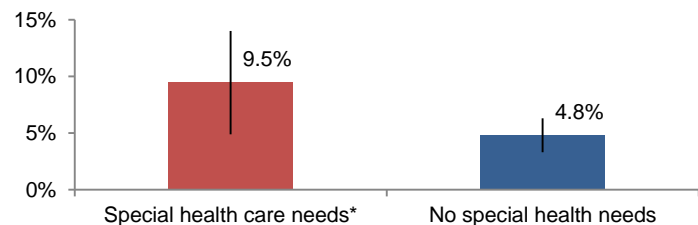


Source: National Survey of Children's Health, 2011-2012
*Interpret with caution: Estimates are based on counts less than 50. 200% -399% and greater than 400% had relative stand error greater than 30%, therefore was suppressed.

What can be done?

- Ensure healthcare providers know about Kansas Quitline as a way to assist with smoking cessation.
- Encourage Head Start Centers to use smoke-free pledges among low-income families.³

Exposed to Secondhand Smoke at Home by
Special Health Care Needs*
Kansas, 2011-2012



Source: National Survey of Children's Health, 2011-2012

References

1. U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014 [accessed 2015 Oct 14].
2. U.S. Department of Health and Human Services. A Report of the Surgeon General: How Tobacco Smoke Causes Disease: What It Means to You. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2010 [accessed 2015 Oct 14].
3. United States Environmental Protection Agency. Promoting Smoke-free Homes for Head Start Families. Washington D.C. April 4, 2014.

Obesity-Adults

Percent of adults who are overweight or obese (BMI higher than 25)

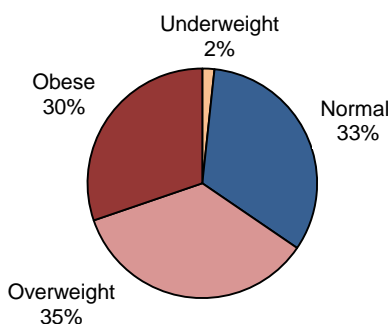
Importance

In the past 30 years, obesity **prevalence doubled** among children and adults and tripled among adolescents.¹ Obesity **increases the risk of many chronic diseases**, including diabetes, heart disease, hypertension, depression, stroke, arthritis and certain cancers.² Furthermore, an overweight parent is a risk factor for a child to become obese as an adult.³ **Obesity is expensive**—in the year 2000, the estimated cost of obesity and physical inactivity was estimated to be approximately **\$117 billion**.⁴

Kansas Highlights

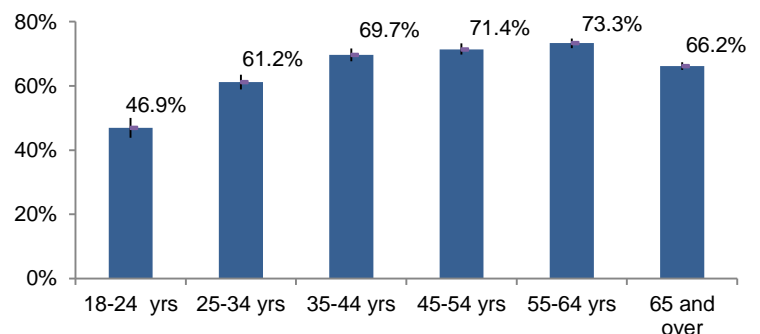
- **Two-thirds** (65.3%) of Kansas adults were considered overweight or obese, statistically higher than the national prevalence (63.8%).
- **Men** (71.2%) were more likely to be overweight or obese compared to women (59.2%).
- As **age increased**, the likelihood of being overweight or obese increased.
- Education level for men had no impact, but **higher education** is a **protective factor** for **women** against overweight or obese status.
- No differences among males for the different race/ethnicity groups, while **non-Hispanic black and Hispanic women had higher Body Mass Index** compared to non-Hispanic white and other women.
- **Rural** (69.1%) counties in Kansas had higher rates of overweight and obesity compared to **urban** (64.2%) counties.

Weight Status of Adults
Kansas, 2013



Source: Behavioral Risk Factor Surveillance System, 2013

Overweight or Obese by Age Group
Kansas, 2013

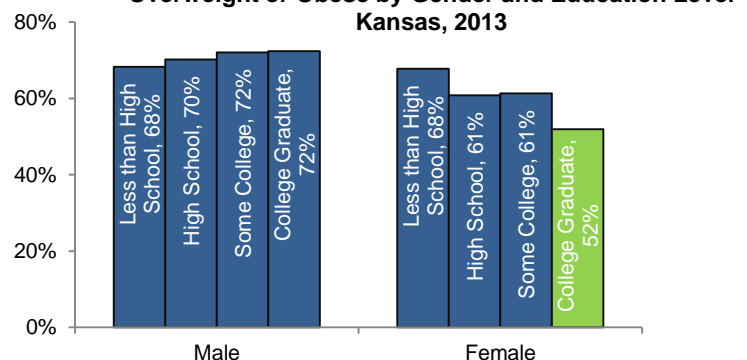


Source: Behavioral Risk Factor Surveillance System, 2013

What can be done?

- Expand on bike-share programs to encourage physical activity.
- Promote *Safe Street Laws*.
- Increase access to affordable fruits and vegetables by increasing the number of farmers markets that accept electronic benefit transfers for SNAP and WIC.

Overweight or Obese by Gender and Education Level
Kansas, 2013



Source: Behavioral Risk Factor Surveillance System, 2013

References

1. Ogden CL, Carroll MD, Kit BK, Flegal KM. Prevalence of obesity and trends in body mass index among US children and adolescents, 1999-2010. *Journal of the American Medical Association*. 2012; 307 (5): 483-490.
2. Guh DP, Zhang W, Bansback N, Amarsi Z, Birmingham CL, Anis AH. The incidence of co-morbidities related to obesity and overweight: a systematic review and meta-analysis. *BMC Public Health*. 2009; 9 (88)
3. Whitaker RC, Wright JA, Pepe MS, Seidel KD, Dietz WH. Predicating obesity in young adulthood from childhood and parental obesity. *N Engl J Med* 37. 1997; (13): 869—873
4. Office of the Surgeon General, "The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity," U.S. Department of Health and Human Service Public Health Service, 2001, p. 10.

Obesity-Children

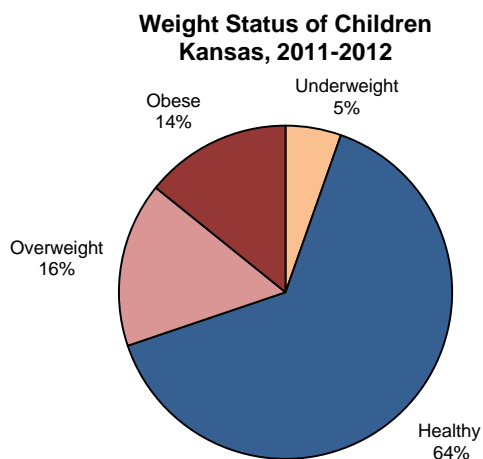
Percent of children (aged 10-17) who are overweight or obese (BMI in the 85th percentile or higher)

Importance

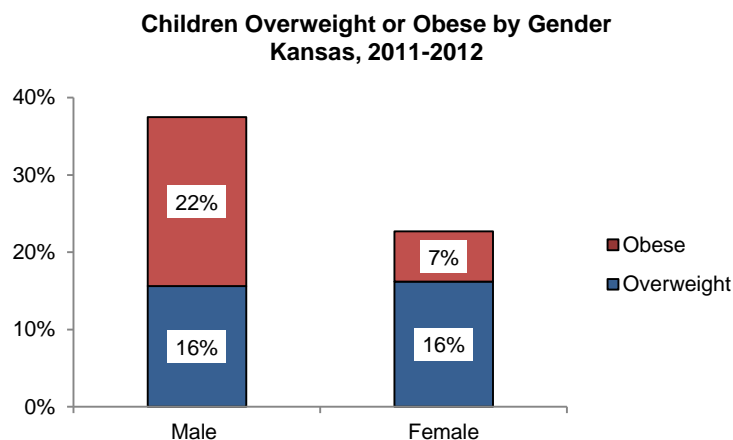
The prevalence of obesity has **more than doubled** among children and adults in the past 30 years.¹ Furthermore, overweight children are likely to become overweight or obese adults. Obesity **increases health risk** for both physical health as well as emotional health. For physical health, obesity increases risk for **shortened life expectancy** and **many chronic diseases**, including diabetes, heart disease, hypertension, stroke, arthritis and certain cancers.² In terms of emotional health, obesity can **decrease quality of life** and lead to behavioral problems, depression and withdrawal, learning problems and teasing and bullying.³

Kansas Highlights

- Almost a **third** (30.2%) of Kansas children were considered overweight or obese, similar to the national prevalence (31.3%).
- **Boys** (37.6%) were more likely to be overweight or obese compared to girls (22.7%).
- Children living in **poverty** (42.8%) were more likely to be overweight or obese compared to children 400% or more above the federal poverty level (21.4%).
- **Non-Hispanic other** (47.1%) and **Hispanic children** (54.3%) were more likely to be overweight or obese compared to non-Hispanic white children (22.4%).



Source: National Survey of Children's Health, 2011-2012

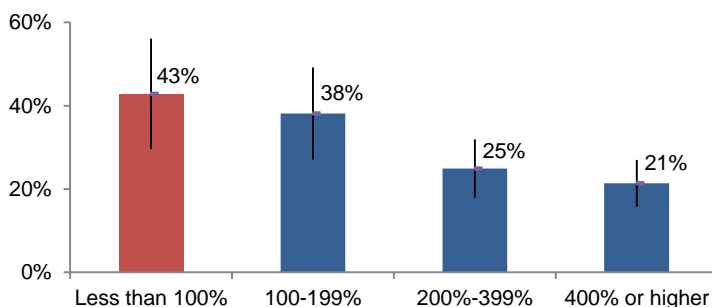


Source: National Survey of Children's Health, 2011-2012

What can be done?

- Promote the HealthierUS School Challenge and increase the number of schools that receive recognition.
- Encourage Salad Bars at schools.
- Encourage physicians to get continuing education on behavioral training for weight loss.

Children Classified as Overweight or Obese by Federal Poverty Level Kansas, 2011-2012



Source: National Survey of Children's Health, 2011-2012

References

1. Ogden CL, Carroll MD, Kit BK, Flegal KM. Prevalence of obesity and trends in body mass index among US children and adolescents, 1999-2010. *Journal of the American Medical Association*. 2012; 307 (5): 483-490.
2. Guh DP, Zhang W, Bansback N, Amarsi Z, Birmingham CL, Anis AH. The incidence of co-morbidities related to obesity and overweight: a systematic review and meta-analysis. *BMC Public Health*. 2009; 9 (88)
3. State of Connecticut Department of Public Health. Childhood Obesity in Connecticut. Hartford, CT. Fall 2013. http://www.ct.gov/dph/lib/dph/hems/nutrition/pdf/chob_fact_sheet_dec2013.pdf

Medical Home

Percent of children who receive care that meet the standards of a medical home

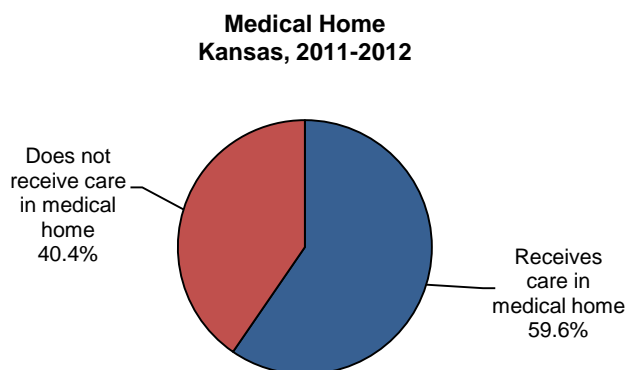
Importance

Medical home is not a physical location but rather an approach to providing **comprehensive primary care** that is now seen as the **ideal model of care** for all children.¹ This is defined as primary care that is “**accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective**”.¹ When individuals receive care within a medical home, racial/ethnic disparities in receiving timely, needed care as well as preventive care disappear.² Children with a medical home are more likely to exhibit behaviors that aid in disease prevention and increase overall wellness.³ Furthermore, the medical home can promote early detection and intervention with developmental delays.⁴

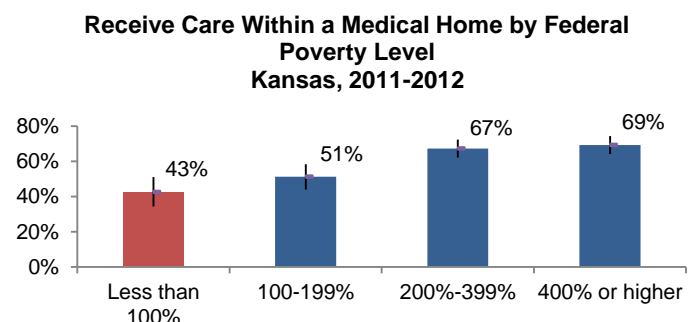
Kansas aims to have 83.1% of children in a medical home by 2020.⁵

Kansas Highlights

- **59.1% of Kansas children** received care within a medical home, statistically higher than the **U.S.** (54.4%).
- Children living **below 200% of the federal poverty level (FPL)** were less likely to receive care within a medical home compared to children living 200% or more above FPL.
- **Non-Hispanic white** children (67.3%) were **more likely** to receive care within a medical home compared to other races and ethnicities.
- The **higher the parent's education level**, the more likely the child would receive care within a medical home.
- There was **no difference** in children receiving care within a medical home based on special health care needs status.



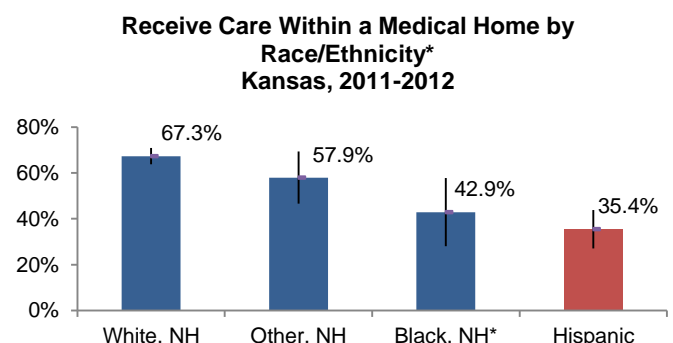
Source: National Survey of Children's Health, 2011-2012



Source: National Survey of Children's Health 2011-2012

What can be done?

- Promote readability and cultural competency in health literature so patients can advocate for their health needs.⁶



Source: National Survey of Children's Health, 2011-2012

*Note: Sample size <50: interpret with caution.

NH is non-Hispanic

References

1. American Academy of Pediatrics. National Center for Medical home Implementation (NCHMI). medicalhomeinfo.org/ Accessed January 6 2016.
2. Veal, A.C.; Doty, M.M.; Hernandez, S.E.; Shea, K.; & Davis, K. Closing the Divide: How Medical Home Promote Equity in Health Care: Results from the Commonwealth Fund 2006 Health Quality Survey. *The Commonwealth Fund*.2007.
3. Long, W.E., Bauchner,H., Sege, R.D.,Cabral, H.J., &Garg, A. The Value of the Medical Home for Children Without Special health Care Needs. *Pediatrics*. 2012; 129 (1) 87-98
4. Adams, R., & Tapia,C. Early Intervention, IDEA Part C Services, and the Medical Home: Collaboration for Best Practices and Best Outcome. *Pediatrics*, 2013; 132 (4), E1073-E1088
5. Kansas Department of Health and Environment. Maternal and Child Health Services Title V Block Grant: Kansas.
6. Patient-Centered Primary Care Collaborative. "Defining the Medical Home: A patient-centered philosophy that drives primary care excellence". 2013.

Inability or Delay in Receiving Medical Care

Percent of children who had their medical care delayed or not received

Importance

Delay in medical care during critical and sensitive periods of development (e.g., early childhood and adolescence) can **adversely affect a child's health status** and functioning both short and long term.¹ Inability to receive timely health care may result in a patient becoming more severely ill and having a **worse prognosis, possible hospitalization** and **higher costs** than would have been required initially.^{2,3}

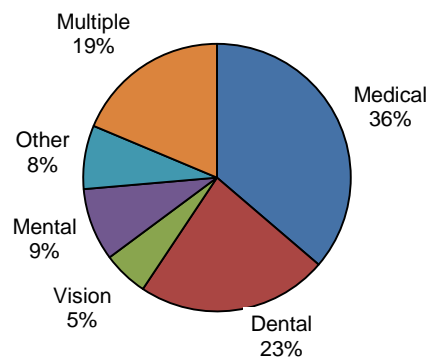
Unmet health care needs are strongly associated with poverty, race and ethnicity, and insurance status, which contribute to health inequities.¹

Kansas Highlights

- **Kansas** had a **significantly lower prevalence** of children (4.8%) than the U.S. (6.7%) who experienced delayed needed medical care or did not receive needed medical care.
- Children who experienced **periods with lack of insurance*** (19.2%) were more likely to experience delay or not receive medical care compared to children consistently insured (3.0%).
- **Children with special health care needs** (9.5%) were more likely to have medical delay than children without special health care needs (3.7%).
- There were no differences based on race and ethnicity, child age and type of insurance.
- The most common type of delay was **medical delay** (48.7%).

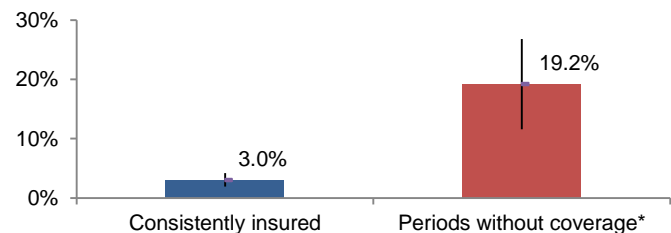
*Note: Estimates are based on counts less than 50.

Type of Inability or Delay in Medical Care
Kansas, 2011-2012



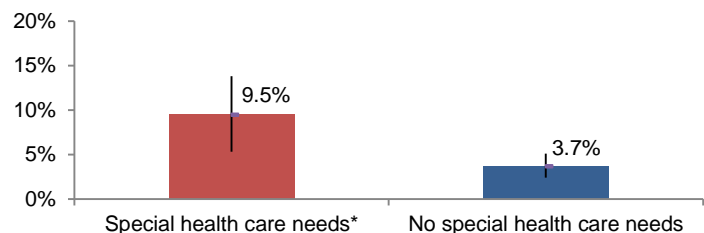
Source: National Survey of Children's Health, 2011-2012

Inability or Delay in Medical Care by Insurance
Consistency*
Kansas, 2011-2012



Source: National Survey of Children's Health, 2011-2012
*Note: Sample size <50: interpret with caution.

Inability or Delay in Medical Care by Special
Health Care Needs*
Kansas, 2011-2012



Source: National Survey of Children's Health, 2011-2012
*Note: Sample size <50: interpret with caution.

What can be done?

- Collaborate with Head Start and Early Head Start programs to educate parents on resources available.

References

1. Newacheck, P., Hughes, D., Hung, Y., Wong, S. & Stoddard, J. The unmet health needs of America's children. *Pediatrics*. 2000; 105(4 part 2), 989-997.
2. Lynch, B.A., Van Norman, C.A., Jacobson, R.M., Weaver, A.L., Juhn, Y.J. Impact of delay in asthma diagnosis on health care service use. *Allergy Asthma Proc*. 2010; 31(4): 48-52
3. Association of Maternal & Child Health Programs. Life Course Indicators; Inability or Delay in Obtaining Necessary Medical Care or Dental Care (LC-39) Washington DC

Oral Health Preventive Visits

Percent of children (aged 1-17) who received a preventive dental visit in the past 12 months

Importance

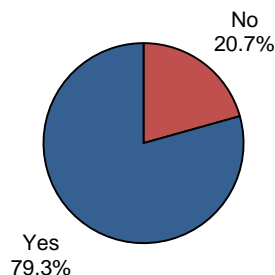
Oral health is vital for overall health and well-being. Oral health conditions can interfere with vital functions such as breathing, food selection and eating, speaking and daily living activities.¹ Furthermore, these **conditions undermine self-image and self-esteem**, discourage normal social interaction or lead to chronic pain, stress and depression.¹ Oral health can predict an individual's health and wellness. For example, evidence links poor oral health to several chronic diseases.²

Dental problems can be **costly**. Through early and regular oral health care visits, children can **avoid complex and expensive** restorative and emergency dental treatment in later years.

Kansas Highlights

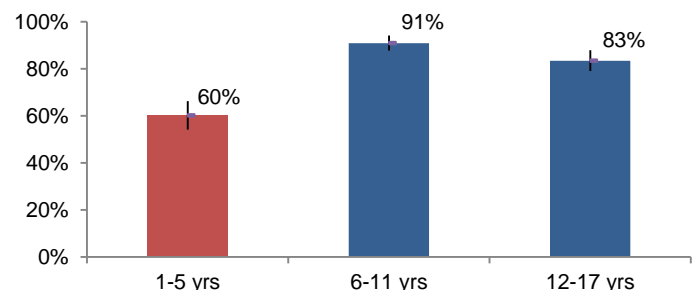
- Approximately **four out of five (79.4%)** children had received preventive dental care visit in past year, similar to the **national average (77.2%)**.
- Children whose household incomes were **200% or above federal poverty level were more likely** to receive preventive health care visits.
- Children with **special health care needs were more likely (85.7%)** to receive preventive visits than children without special needs (77.8%).
- Children **aged 1-5 years (60.2%) were less likely to have an oral health visit** compared to school aged children (6-11 years, 90.9%; 12-17 years, 83.4%).
- **No difference based on race and ethnicity** on receiving oral preventive care.

Had at Least One Oral Health Preventive Visit in Past Year
Kansas, 2011-2012



Source: National Survey of Children's Health, 2011-2012

Had at Least One Oral Health Preventive Visit in Past Years by Age Group
Kansas, 2011-2012

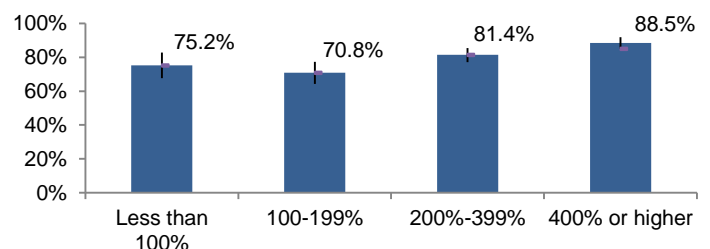


Source: National Survey of Children's Health, 2011-2012

What can be done?

- Partner with oral providers to address needs of with Medicaid population.
- Partner with pre-schools, Early Head Start Programs and oral providers to focus on delivery of oral health services as well as dissemination of the public health messages.

Had at Least One Oral Health Preventive Visit in Past Year by Federal Poverty Level
Kansas, 2011-2012



Source: National Survey of Children's Health, 2011-2012

References

1. Association of Maternal & Child Health Programs. Life Course Indicators; Oral health preventive visit for children (LC-41) Washington DC
2. US Department of Health and Human Services, Public Health Service, Office of the Surgeon General. Oral health in America: A report of the Surgeon General. Rockville, MD: National Institutes of Health, National Institute of Dental and Craniofacial Research; 2000, p. 33-59.

Mental Health

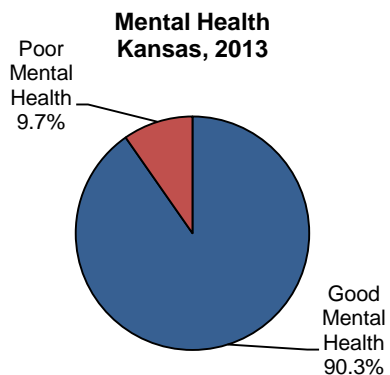
Percent of adults with poor mental health (14 or more days in the past 30 days self-reported as poor)

Importance

Poor mental health is associated with **chronic mental and physical problems**—individuals are more likely to be underweight or obese, smoke, binge drink, engage in no leisure time or physical activity, have no health insurance and have chronic health conditions.¹ Poor mental health is associated with a mental health disorder. **A quarter of adults are expected to have mental health disorder in a lifetime.**² In 2006, the mental healthcare cost was \$56 billion, equivalent to cancer.³ Improved mental health will **likely lead to expanded productivity, economic development and improved physical health.**

Kansas Highlights

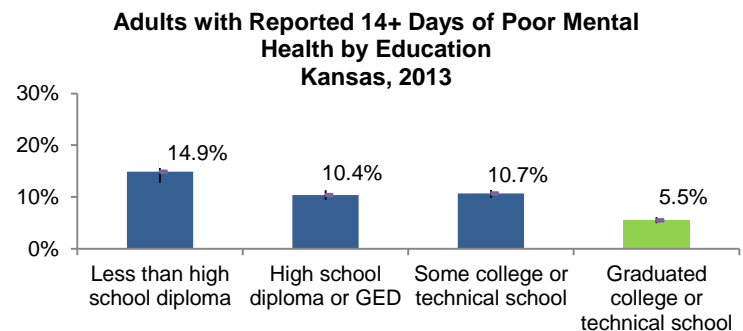
- Approximately **a tenth (9.7%)** of the Kansas population reported poor mental health; similar to the United States population (11.5%).
- **Females (11.2%)** were **more likely** to report poor mental health compared to **males (8.0%)**.
- **Non-Hispanic other and non-Hispanic black adults (11.7% and 12.8%, respectively)** were more likely to report poor mental health compared to non-Hispanic white and Hispanic adults (9.3% and 9.8%, respectively).
- **Adults ages 65 and older (5.7%)** were less likely to report poor mental health days compared to other age categories.



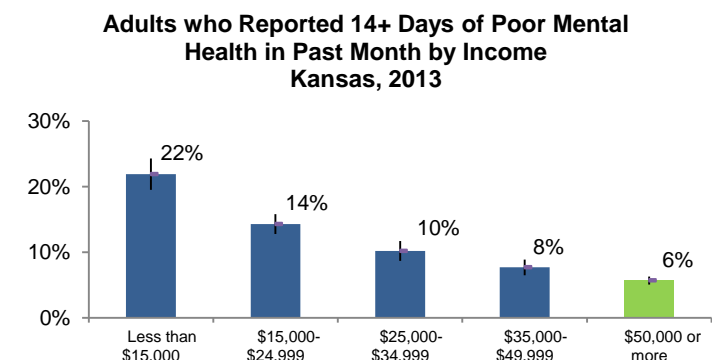
Source: Behavioral Risk Factor Surveillance System, 2013
Poor Mental Health is defined as 14+ days of self-reported poor mental health in past 30 days

What can be done?

- Utilize mental health awareness campaigns to reduce the stigma and barriers to receiving treatment.
- Raise awareness that the Affordable Care Act requires all marketplace insurance to cover mental health, including behavioral health treatment.⁴



Source: Behavioral Risk Factor Surveillance System, 2013



Source: Behavioral Risk Factor Surveillance System, 2013

References

1. Centers for Disease Control and Prevention. Health-related Quality of Life (HRQOL), Data and Statistics, Table 3. <http://www.cdc.gov/hrqol/data/tables/table3a.htm> Published March 15, 2011. Accessed October 15, 2015
2. World Health Organization . Mental disorder affects one in four people. http://www.who.int/whr/2001/media_centre/press_release/en/ Published October 4 2001. Accessed December 1, 2015
3. Insel, T. Directors's Blog: The Global Cost of Mental Illness. National Institute of Mental Health. <http://www.nimh.nih.gov/about/director/2011/the-global-cost-of-mental-illness.shtml>. Published September 28, 2011. Accessed January 6, 2006.
4. Mental Health & Substance abuse coverage. Healthcare.gov. <https://www.healthcare.gov/coverage/mental-health-substance-abuse-coverage/> Accessed January 19 2016.

Appendix: Life Course Indicators Tables

Children ages 0-17 years who had experienced two or more adverse childhood experiences (ACEs) by select demographic, Kansas and U.S., 2011-2012

	Total Respondents	Number	Weighted Number	Percent (95% CI)
Kansas	1,817	378	171,270	24.0 (21.2, 26.9)
U.S.	94,520	19115	16,430,694	22.6 (22.0, 23.2)
Child's Sex				
Female	845	165	80,178	22.9 (18.9, 27.0)
Male	970	213	91,092	25.1 (21.1, 29.2)
Child's Age				
0-5	514	56	32,004	13.2 (9.1, 17.2)
6-11	591	127	61,331	25.3 (20.3, 30.3)
12-17	712	195	77,935	34.3 (29.0, 39.6)
Household Poverty Level				
Less than 100% FPL	228	99	62,308	45.9 (37.5, 54.3)
100%-199% FPL	356	111	51,727	29.9 (23.4, 36.4)
200%-399% FPL	611	108	39,421	17.5 (13.3, 21.6)
400% or more FPL	622	60	17,814	10.0 (6.7, 13.2)
Race and Ethnicity*				
White, NH	1,334	239	96,547	20.5 (17.4, 23.6)
Black, NH	73	48	18,837	40.5 (25.7, 55.3)
Other, NH	164	51	21,873	33.5 (22.7, 44.4)
Hispanic	225	57	30,484	25.3 (17.7, 32.8)
Family Structure				
Two-parent (biological or adopted)	1,317	106	47,751	10.0 (7.5, 12.4)
Two-parent (one-step)	158	82	42,183	52.2 (42.0, 62.4)
Mother only	206	104	54,021	52.1 (42.8, 61.5)
Other	122	84	25,570	62.0 (49.1, 74.9)
Insurance type*				
Public	439	198	98,978	44.5 (38.1, 50.8)
Private	1,276	156	61,282	13.9 (11.1-16.6)
Uninsured	77	21	9,131	26.0 (14.4, 37.6)
Special health care needs*				
Yes	392	31	13,159	9.5 (4.9, 14.0)
No	1,427	63	27,424	4.8 (3.3, 6.3)
Type of ACEs				
Socioeconomic hardship	1,793	390	194,485	27.6 (24.6, 30.6)
Divorce of Parent	1,808	353	154,154	21.7 (19.0, 24.4)
Living with someone mentally ill	1,802	180	72,174	10.2 (8.2, 12.2)
Living with someone with drug problem	1,808	202	69,256	9.8 (8.0, 11.6)
Victim or witness of neighborhood violence	1,802	145	58,310	8.3 (6.5, 10.0)
Witness domestic violence	1,793	119	54,632	7.7 (5.8, 9.6)
Parent served time in jail	1,809	106	44,805	6.3 (5.9, 9.6)
Treated unfairly due to race	1,801	57	26,453	3.8 (2.4, 5.1)
Death of parent	1,813	52	20,256	2.8 (1.7, 4.0)

Source: National Survey of Children's Health (NSCH), 2011-2012

Number: Number of respondents who reported that their child experienced at least two ACEs, based on nine adverse childhood experiences developed for the NSCH.

Weighted Number: Estimated number of children aged 0-17 who experienced at least two ACEs

95% CI: 95% Confidence Interval

FPL: Federal Poverty Level

NH: Non-Hispanic

*Interpret with caution: Estimates are based on counts less than 50

Children ages 0-17 years with special health care needs, Kansas and U.S., 2011-2012

	Total Respondents	Number	Weighted Number	Percent (95% CI)
Kansas	1,836	394	139,623	19.3 (16.9, 21.9)
U.S.	95,677	19687	14,598,486	19.8 (19.2, 20.4)
Sex				
Female	853	164	56,933	16.1 (12.9, 19.4)
Male	981	230	82,690	22.5 (18.8, 26.3)
Child Age				
0-5	517	59	24,970	10.2 (6.8, 13.7)
6-11	595	139	58,367	23.9 (19.0, 28.7)
12-17	724	196	56,286	24.3 (19.9, 28.7)
Household Poverty Level				
Less than 100% FPL	230	53	36,456	26.4 (18.8, 34.0)
100%-199% FPL	361	71	24,268	13.9 (9.5, 18.3)
200%-399% FPL	617	135	46,721	20.4 (16.1, 24.9)
400% or more FPL	628	135	32,178	17.9 (14.1, 21.7)
Race and Ethnicity*				
White, NH	1,336	291	92,703	19.6 (16.8, 22.5)
Black, NH	73	16	10,394	22.2 (9.8, 34.9)
Other, NH	165	38	13,642	20.9 (11.8, 29.9)
Hispanic	225	42	18,401	15.2 (9.2, 21.3)
Insurance Type*				
Public	455	133	58,277	25.7 (20.3, 31.1)
Private	1,286	246	75,899	17.1 (14.3, 19.9)
Uninsured	80	9	4,570	*
Medical Home				
Yes	1,125	199	74,319	17.8 (14.5, 21.0)
No	671	187	63,775	22.1 (18.0, 26.1)
Type of special health care needs				
Prescription medicine	1,836	315	106,827	14.8 (12.6, 17.0)
Elevated service use or need	1,836	163	55,131	7.6 (6.0, 9.3)
Functional Limitations	1,836	70	26,169	3.6 (2.4, 4.9)
Special Therapies	1,836	56	19,570	2.7 (1.7, 3.7)
Ongoing emotional, developmental or behavioral conditions	1,836	136	46,481	6.5 (4.9, 8.0)

Source: National Survey of Children's Health (NSCH), 2011-2012

Number: Number of respondents who reported that their child has a special health care need, based on five types of special health care needs developed for the NSCH.

Weighted Number: Estimated number of children who have a special health care need.

95% CI: 95% Confidence Interval

FPL: Federal Poverty Level

NH: Non-Hispanic

*Interpret with caution: Estimates are based on counts less than 50 or the relative standard error is greater than 30%

Adults diagnosed with hypertension, Kansas and U.S., 2013

	Total Respondents	Number	Weighted Number	Percent (95% CI)
Kansas	23,219	9,309	681,387	31.3 (30.6, 32.0)
U.S.	482,478	195,348	78,548,842	32.4 (32.1, 32.7)
Sex				
Female	13,615	5,409	326,817	29.5 (28.7, 30.4)
Male	9,604	3,900	354,570	33.2 (32.1, 34.3)
Age				
18-24	2,154	90	19,211	6.3 (4.9, 7.7)
25-34	2,427	273	42,683	11.4 (10.0, 12.9)
35-44	2,787	523	64,715	18.9 (17.3, 20.6)
45-54	3,871	1,299	128,237	33.9 (32.1, 35.6)
55-64	5,006	2,345	165,867	46.8 (45.2, 48.4)
65 and over	13,818	4,733	257,265	62.7 (61.5, 64.0)
Education				
Less than high school diploma	1,562	693	83,855	34.0 (31.3, 36.7)
High school diploma or GED	6,461	2,931	209,232	35.9 (33.5, 36.2)
Some college	7,054	2,839	226,692	30.5 (29.3, 31.7)
Graduated college or technical school	8,102	2,831	160,606	27.6 (26.5, 28.7)
Income				
Less than \$15,000	1,879	871	59,306	32.6 (30.1, 35.2)
\$15,000-\$24,999	3,622	1,684	118,978	34.8 (32.9, 36.7)
\$25,000-\$34,999	2,524	1,132	81,184	34.9 (32.7, 37.1)
\$35,000-\$49,999	3,248	1,346	97,449	32.8 (30.9, 34.8)
\$50,000 or more	8,862	2,959	233,331	28.1 (27.1, 29.2)
Race and Ethnicity				
White, NH	20,043	8,131	558,323	32.4 (31.7, 33.1)
Black, NH	934	518	49,230	40.3 (36.1, 44.4)
Other, NH	899	306	28,254	26.0 (22.4, 29.6)
Hispanic	1,163	284	40,473	20.1 (17.6, 22.6)
Peer Group				
Frontier	1,283	551	38,307	36.0 (32.9, 39.1)
Rural	2,373	975	68,429	34.4 (32.2, 36.6)
Densely-Settled Rural	3,891	1,619	111,964	32.9 (31.2, 34.7)
Semi-Urban	3,666	1,512	106,502	31.9 (30.1, 33.6)
Urban	4,652	4,652	356,184	29.8 (28.8, 30.7)

Data Source: Kansas Behavioral Risk Factor Surveillance System, 2013

Number: Number of respondents who ever had a physician tell them they had high blood pressure, excludes females told only during pregnancy.

Weighted Number: Estimated number of adults with hypertension.

95% CI: 95% Confidence Interval.

NH: Non-Hispanic

Adults diagnosed with diabetes, Kansas and U.S., 2013

	Total Respondents	Number	Weighted Number	Percent (95% CI)
Kansas	23,253	2,832	207,955	9.6 (9.1, 10.0)
U.S.	483,060	60,987	24,801,338	10.2 (10.0, 10.4)
Sex				
Female	13,632	1,604	102,919	9.3 (8.7, 9.9)
Male	9,621	1,228	105,036	9.8 (9.2, 10.4)
Age*				
18-24	1,384	11	3,116	1.0 (0.2, 1.8)
25-34	2,421	47	6,650	1.8 (1.2, 2.3)
35-44	2,792	161	18,711	5.5 (4.5, 6.4)
45-54	3,873	388	38,864	10.3 (9.1, 11.4)
55-64	5,017	759	56,405	15.9 (14.7, 17.1)
65 and over	7,625	1,449	82,901	20.2 (19.1, 21.2)
Education				
Less than high school diploma	1,565	264	31,084	12.6 (10.8, 14.4)
High school diploma or GED	6,476	919	64,206	10.7 (9.9, 11.5)
Some college	7,056	886	70,290	9.5 (8.7, 10.2)
Graduated college or technical school	8,115	757	41,798	7.2 (6.6, 7.8)
Income				
Less than \$15,000	1,882	375	25,645	14.1 (12.3, 15.9)
\$15,000-\$24,999	3,622	601	42,187	12.3 (11.2, 13.5)
\$25,000-\$34,999	2,525	367	25,553	11.0 (9.6, 12.3)
\$35,000-\$49,999	3,252	393	28,691	9.7 (8.6, 10.8)
\$50,000 or more	8,867	705	56,674	6.8 (6.3, 7.4)
Race and Ethnicity				
White, NH	20,071	2,375	161,970	9.4 (9.0, 9.8)
Black, NH	934	184	15,658	12.8 (10.1, 15.5)
Other, NH	901	131	11,517	10.6 (8.3, 12.8)
Hispanic	1,162	126	17,708	8.8 (7.1, 10.6)
Peer Group				
Frontier	1,284	166	11,964	11.3 (9.3, 13.2)
Rural	2,379	281	20,449	10.3 (8.9, 11.6)
Densely-Settled Rural	3,890	480	33,190	9.8 (8.8, 10.8)
Semi-Urban	3,675	480	33,050	9.9 (8.7, 11.0)
Urban	12,025	1,425	109,301	9.1 (8.6, 9.7)

Data Source: Kansas Behavioral Risk Factor Surveillance System, 2013

Number: Number of respondents who ever had a physician tell them they had diabetes, excludes females told only during pregnancy.

Weighted Number: Estimated number of adults with diabetes

95% CI: 95% Confidence Interval

NH: Non-Hispanic

*Interpret with caution: Estimates are based on counts less than 50.

Children ages 0-17 years exposed to secondhand smoke in the home, Kansas and U.S., 2011-2012

	Total Respondents	Number	Weighted Number	Percent (95% CI)
Kansas	1,819	94	40,583	5.7 (4.2, 7.2)
U.S.	94,748	4,623	3,576,544	4.9 (4.6, 5.2)
Sex*				
Female	845	37	16,083	4.6 (2.6, 6.6)
Male	972	57	24,499	6.7 (4.6, 9.0)
Child Age				
0-5	515	11	5,255	*
6-11	592	25	12,592	5.2 (2.5, 7.8)
12-17	712	58	22,735	10.0 (6.7, 13.4)
Household Poverty Level*				
Less than 100% FPL	229	36	17,802	13.0 (7.6, 18.3)
100%-199% FPL	356	27	12,118	7.0 (3.7, 10.4)
200%-399% FPL	613	20	5,770	*
400% or more FPL	621	11	4,893	*
Race and Ethnicity*				
White, NH	1332	57	28,395	6.0 (4.1, 8.0)
Black, NH	73	8	2,476	*
Other, NH	165	14	3,819	*
Hispanic	225	13	3,766	*
Insurance Type*				
Public	441	59	26,285	11.7 (7.8, 15.7)
Private	1,277	30	12,021	2.7 (1.5, 4.0)
Uninsured	77	5	2,277	*
Insurance Consistency*				
Consistently Insured	1,637	72	31,654	5.0 (3.5, 6.6)
Periods without coverage	170	21	8,689	10.9 (5.2, 16.6)
Special health care needs*				
Yes	392	31	13,159	9.5 (4.9, 14.0)
No	1,427	63	27,424	4.8 (3.3, 6.3)

Source: National Survey of Children's Health, 2011-2012

Number: Number of respondents who reported that someone smokes tobacco in the home where their child lives.

Weighted Number: Estimated number of children aged 0-17 who was exposed to secondhand smoke in the home.

95% CI: 95% Confidence Interval

FPL: Federal Poverty Level

NH: Non-Hispanic

*Interpret with caution: Estimates are based on counts less than 50 or the relative standard error is greater than 30%

Adults who are overweight or obese, Kansas and U.S., 2013

	Total Respondents	Number	Weighted Number	Percent (95% CI)
Kansas	21,991	14,533	13,38,699	65.3 (64.5, 66.1)
U.S.	457,487	296,873	145,701,088	63.8 (63.5, 64.1)
Sex				
Female	12,535	7,591	593,405	59.2 (58.12, 60.3)
Male	9,456	6,942	745,294	71.2 (70.0, 72.3)
Age				
18-24	1,287	596	133,692	46.9 (43.8, 50.0)
25-34	2,209	1,329	208,474	61.2 (58.9, 63.5)
35-44	2,631	1,825	224,034	69.7 (67.7, 71.7)
45-54	3,693	2,604	247,452	71.4 (69.8, 73.2)
55-64	4,748	3,402	247,452	73.3 (71.8, 74.7)
65 and over	7,350	4,737	262,475	66.2 (65.0, 67.4)
Education				
Less than high school diploma	1,421	959	148,635	68.0 (65.0, 71.1)
High school diploma or GED	6,116	4,088	373,526	65.8 (64.4, 67.4)
Some college	6,706	4,570	472,203	66.6 (65.1, 68.0)
Graduated college or technical school	7,729	4,904	343,522	60.7 (60.7, 63.3)
Income				
Less than \$15,000	1,778	1,164	106,539	62.9 (60.0, 66.0)
\$15,000-\$24,999	3,424	2,262	209,666	66.2 (64.1, 68.2)
\$25,000-\$34,999	2,409	1,627	148,051	67.0 (64.5, 69.4)
\$35,000-\$49,999	3,129	2,179	198,136	69.6 (67.5, 71.6)
\$50,000 or more	8,565	5,696	527,405	65.7 (64.4, 66.9)
Race and Ethnicity				
White, NH	19,105	12,515	1,064,151	64.7 (63.9, 65.5)
Black, NH	895	667	83,724	71.8 (67.5, 76.1)
Other, NH	851	540	59,893	58.2 (53.8, 62.7)
Hispanic	990	717	121,471	71.8 (68.5, 75.1)
Peer Group				
Frontier	1,215	825	67,401	67.1 (63.7, 70.4)
Rural	2,246	1,538	128,916	69.1 (66.7, 71.4)
Densely-Settled Rural	3,669	2,493	212,653	66.8 (64.9, 68.8)
Semi-Urban	3,472	2,296	204,969	65.1 (63.0, 67.1)
Urban	11,389	4,008	724,760	64.2 (63.0, 65.3)

Data Source: Kansas Behavioral Risk Factor Surveillance System, 2013

Number: Number of respondents who are overweight or obese (body mass index greater than or equal to 25.0) based upon self-reported height and weight

Weighted Number: Estimated number of adults who were overweight or obese based on BMI

95% CI: 95% Confidence Interval

NH: Non-Hispanic

Children ages 10-17 years classified as overweight or obese, Kansas and U.S., 2011-2012

	Total Respondents	Number	Weighted Number	Percent (95% CI)
Kansas	913	239	95,210	30.2 (25.6, 34.7)
U.S.	43,864	12,788	9,935,162	31.3 (30.3, 32.4)
Sex				
Female	419	85	35,966	22.7 (16.9, 28.6)
Male	494	154	59,244	37.6 (31.0, 44.2)
Child Age				
0-5	**	**	**	**
6-11	210	58	22,338	25.1 (16.9, 33.2)
12-17	703	181	72,872	32.2 (26.8, 37.5)
Household Poverty Level*				
Less than 100% FPL	97	40	24,053	42.8 (29.6, 56.1)
100%-199% FPL	165	49	27,329	38.1 (27.1, 49.2)
200%-399% FPL	299	72	25,679	24.9 (17.9, 31.9)
400% or more FPL	352	78	18,150	21.4 (15.9, 27.0)
Race and Ethnicity*				
White, NH	688	159	48,035	22.4 (18.0, 26.7)
Black, NH	35	12	7,676	*
Other, NH	75	24	10,647	47.1 (29.6, 64.6)
Hispanic	97	41	26,559	54.3 (40.6, 67.9)
Parental Education Attainment*				
Less than high school	51	24	13,778	42.8 (24.6, 61.0)
High school graduate	106	36	20,242	37.2 (24.3, 50.0)
More than high school	738	176	58,898	26.5 (21.8, 31.3)
Special health care needs				
Yes	238	75	24,472	32.7 (23.7, 41.8)
No	675	164	70,739	29.4 (24.1, 34.6)

Data Source: National Survey of Children's Health, 2011-2012

Number: Number of respondents who reported their child was overweight or obese (body mass index-for-age is 85th percentile or above) based upon self-reported height and weight

Weighted Number: Estimated number of children who were overweight or obese based on BMI

95% CI: 95% Confidence Interval

FPL: Federal Poverty Level

NH: Non-Hispanic

*Interpret with caution: Estimates are based on counts less than 50 or the relative standard error is greater than 30%

**Data not available

Children ages 0-17 years in a medical home, Kansas and U.S., 2011-2012

	Total Respondents	Number	Weighted Number	Percent (95% CI)
Kansas	1,796	1,125	418,305	59.1 (55.9, 62.3)
U.S.	92,750	56,257	38,826,906	54.4 (53.7, 55.1)
Sex				
Female	836	533	207,748	60.0 (55.4, 64.5)
Male	958	591	210,200	58.3 (53.8, 62.7)
Child Age				
0-5	510	327	149,301	61.9 (56.3, 67.5)
6-11	583	364	142,325	59.5 (54.0, 65.0)
12-17	703	434	126,679	55.8 (50.4, 61.2)
Household Poverty Level				
Less than 100% FPL	226	101	58,418	42.6 (34.3, 51.0)
100%-199% FPL	351	190	86,413	51.2 (44.0, 58.3)
200%-399% FPL	605	408	150,461	67.3 (62.2, 72.3)
400% or more FPL	614	426	123,013	69.2 (64.1, 74.2)
Race and Ethnicity*				
White, NH	1,313	904	313,159	67.3 (63.8, 70.9)
Black, NH	72	27	19,773	42.9 (28.1, 57.8)
Other, NH	158	93	36,429	57.9 (46.6, 69.3)
Hispanic	219	84	41,944	35.4 (27.0, 43.8)
Insurance Type*				
Public	435	230	116,987	52.6 (46.2, 59.0)
Private	1,262	861	289,112	65.9 (62.2, 69.6)
Uninsured	80	27	9,722	27.0 (15.4, 38.6)
Insurance Consistency*				
Consistently Insured	1,615	1,051	389,865	62.6 (59.2, 65.9)
Periods without coverage	172	70	27,828	34.6 (25.3, 43.9)
Parental Education Attainment*				
Less than high school	99	32	22,845	33.1 (21.1, 45.2)
High school graduate	203	107	58,637	53.5 (44.3, 62.6)
More than high school	1,464	971	330,894	64.3 (60.8, 67.7)
Special health care needs				
Yes	386	199	74,319	53.8 (45.7, 61.0)
No	1,410	926	343,986	60.4 (56.8, 64.0)

Source: National Survey of Children's Health, 2011-2012

Number: Number of survey respondents who reported that their child was receiving care within a medical home, based on a composite of 19 items measuring personal doctor, usual source of care, family centered care, experience getting referrals, and care coordination.

Weighted Number: Estimated number of children aged 0-17 that received care within a medical home

95% CI: 95% Confidence Interval

FPL: Federal Poverty Level

NH: Non-Hispanic

*Interpret with caution: Estimates are based on counts less than 50

Children ages 0-17 years who had medical services delayed or not received, Kansas and U.S., 2011-2012

	Total Respondents	Number	Weighted Number	Percent (95 % CI)
Kansas	1,835	91	34,926	4.9 (3.5, 6.2)
U.S.	95,546	5,657	4,937,354	6.7 (6.3, 7.1)
Sex*				
Female	853	44	17,982	3.5 (3.0, 7.2)
Male	980	47	16,944	4.6 (2.8, 6.4)
Child Age*				
0-5	517	18	8,663	*
6-11	595	32	12,432	5.1 (2.7, 7.5)
12-17	723	41	13,831	6.0 (3.4, 8.6)
Household Poverty Level*				
Less than 100% FPL	229	13	7,525	*
100%-199% FPL	361	33	12,622	7.2 (4.0, 10.4)
200%-399% FPL	617	33	12,928	5.7 (3.0, 8.3)
400% or more FPL	628	12	1,851	*
Race and Ethnicity*				
White, NH	1,336	62	20,499	4.3 (2.8,5.9)
Black, NH	73	5	2,366	*
Other, NH	165	8	3,673	*
Hispanic	224	14	6,747	*
Insurance Type*				
Public	445	39	14,741	6.5 (3.7, 9.3)
Private	1,286	38	14,747	3.3 (1.9, 4.8)
Uninsured	80	12	5,129	*
Insurance Consistency*				
Consistently Insured	1,650	51	19,270	3.0 (1.9, 4.2)
Periods without coverage	173	39	15,506	19.2 (11.6, 26.8)
Parental Education Attainment*				
Less than high school	105	8	5,647	*
High school graduate	209	20	8,806	7.8 (3.7, 11.9)
More than high school	1,490	61	18,621	3.6 (2.3, 4.8)
Special health care needs*				
Yes	394	38	13,307	9.5 (5.3, 13.8)
No	1,441	53	21,619	3.7 (2.4, 5.1)
Type of medical delay**				
Medical	91	45	17,002	48.7 (33.8, 63.5)
Dental	91	36	13,896	39.8 (25.1, 54.5)
Mental	91	14	4,900	14.0, 2.8, 25.2)
Vision	91	12	6,112	17.5 (5.1, 29.9)
Other	91	7	2,460	7.0 (0.0, 14.2)

Source: National Survey of Children's Health, 2011-2012

Number: Number of survey respondents who reported that their child had medical services delayed or not received in the past 12 months.

Weighted Number: Estimated number of children aged 0-17 that had medical services delayed or not received

95% CI: 95% Confidence Interval

FPL: Federal Poverty Level

NH: Non-Hispanic

*Interpret with caution: Estimates are based on counts less than 50 or the relative standard error is greater than 30%

**Excludes children with no medical delay

Children ages 1-17 years who received one or more oral preventive health care visits, Kansas and U.S., 2011-2012

	Total Respondents	Number	Weighted Number	Percent (95% CI)
Kansas	1,734	1,404	532,724	79.4 (76.8, 82.1)
U.S.	90,940	72,354	53,387,835	77.2 (76.5, 77.8)
Sex				
Female	852	665	267,912	82.7 (79.2, 86.2)
Male	978	738	264,456	76.3 (72.4, 80.3)
Child Age				
1-5	516	220	116,840	60.2 (54.1, 66.2)
6-11	594	542	222,134	90.9 (87.7, 94.1)
12-17	722	642	193,484	83.4 (79.0, 87.9)
Household Poverty Level				
Less than 100% FPL	210	151	93,657	75.2 (67.7, 82.7)
100%-199% FPL	341	251	115,794	70.8 (64.2, 77.4)
200%-399% FPL	583	471	173,119	81.4 (77.2, 85.5)
400% or more FPL	600	531	149,888	88.5 (85.0, 91.9)
Race and Ethnicity				
White, NH	1,334	1,037	349,531	74.1 (70.8, 77.4)
Black, NH	73	60	35,402	76.1 (62.2, 90.0)
Other, NH	165	120	46,670	71.4 (61.0, 81.7)
Hispanic	224	162	87,916	73.0 (65.6, 80.3)
Insurance Type*				
Public	412	319	165,087	78.3 (72.9, 83.7)
Private	1,225	1,030	343,162	82.8 (79.8, 85.8)
Uninsured	75	39	17,905	50.8 (36.3, 65.2)
Insurance Consistency				
Consistently insured	1,563	1,295	482,977	81.8 (79.1, 84.5)
Periods without coverage	158	100	44,665	60.3 (50.2, 70.4)
Parental Education Attainment				
Less than high school	97	64	41,254	64.2 (52.0, 76.5)
High school graduate	198	148	81,231	77.2 (69.7, 84.7)
More than high school	1,409	1,168	397,234	81.6 (87.8, 84.5)
Special health care needs				
Yes	392	339	118,898	85.3 (80.1, 90.6)
No	1,440	1,066	413,826	71.3 (68.0, 74.5)

Source: National Survey of Children's Health, 2011-2012

Number: Number of survey respondents who reported that their child had a preventive oral health visit in the past 12 months

Weighted Number: Estimated number of children aged 1-17 that had at least one preventive oral health visit in past 12 months

95% CI: 95% Confidence Interval

FPL: Federal Poverty Level

NH: Non-Hispanic

*Interpret with caution: Estimates are based on counts less than 50 or the relative standard error is greater than 30%

Adults with poor mental health, Kansas and U.S., 2013

	Total Respondents	Number	Weighted Number	Percent (95 % CI)
Kansas	22,969	2,075	208,402	9.7 (9.2, 10.2)
U.S.	475,214	49,484	27,392,916	11.5 (11.3, 11.7)
Sex				
Female	13,426	1,358	123,210	11.2 (10.6,12.0)
Male	9,533	717	85,192	8.0 (7.4, 8.7)
Age				
18-24	1,372	154	34,056	11.2 (9.4, 13.0)
25-34	2,399	259	40,654	11.0 (9.6, 12.4)
35-44	2,765	300	34,942	10.3 (9.0, 11.5)
45-54	3,823	437	40,471	10.8 (9.79,12.0)
55-64	4,970	482	34,393	9.8 (8.8, 10.8)
65 and over	7,502	434	23,221	5.7 (5.1, 6.4)
Education				
Less than high school diploma	1,530	243	35,802	14.9 (12.8,17.0)
High school diploma or GED	6,372	652	61,766	10.4 (9.5, 11.3)
Some college	6,976	721	78,849	10.7 (9.8, 11.6)
Graduated college or technical school	8,050	457	31,900	5.5 (4.9, 6.11)
Income				
Less than \$15,000	1,846	421	39,230	21.9 (19.5, 24.3)
\$15,000-\$24,999	3,570	472	48,247	14.3 (12.8, 15.8)
\$25,000-\$34,999	2,492	227	23,414	10.2 (8.7, 11.7)
\$35,000-\$49,999	3,225	230	22,735	7.7 (6.5, 8.9)
\$50,000 or more	8,817	457	46,913	5.7 (5.1, 6.3)
Race and Ethnicity				
White, NH	19,824	1,714	158,870	9.3 (8.8, 9.8)
Black, NH	925	116	15,430	12.8 (9.9, 15.6)
Other, NH	887	105	12,650	11.7 (9.0, 14.4)
Hispanic	1,150	119	19,504	9.8(7.9, 11.7)
Peer Group				
Frontier	1,266	99	8,056	7.7 (5.9, 9.5)
Rural	2,346	226	21,674	11.0 (9.3, 12.7)
Densely-Settled Rural	3,843	359	32,643	9.7 (8.6, 10.9)
Semi-Urban	3,618	337	33,648	10.2 (8.9, 11.5)
Urban	11,896	1,054	112,382	9.5 (8.8, 10.2)

Data Source: Kansas Behavioral Risk Factor Surveillance System, 2013

Number: Number of respondents who self-reported at least 14 out of the past 30 days their mental health was not good.

Weighted Number: Estimated number of adults with poor mental health.

95% CI: 95% Confidence Interval.

NH: Non-Hispanic

