

Community & Hospital Letter

Health Department First in Nation to Receive Voluntary Accreditation

On the 5th of August, Mayor Kay Barnes, the City Council, the City Manager, and the Missouri Department of Health and Senior Services joined together to recognize and celebrate the Kansas City Health Department for becoming the first local health department in Missouri and in the nation to receive voluntary accreditation. The 3-year comprehensive accreditation by the Missouri Institute for Community Health (MICH) is a seal of approval given to the agency's delivery of public health services.

To reach this milestone, the Health Department completed a comprehensive self-assessment to determine its readiness to provide the highest quality of services to Kansas City residents. MICH's

on-site review team then determined whether the Health Department was meeting 68 performance standards that measure the degree to which the community is protected from the spread of communicable diseases, plans are in place to deal with emergency situations, and Kansas Citians are safe from environmental hazards. In addition, the team looked at core staffing and training standards to ensure the staff had the necessary educational preparation, along with leadership skills, technical skills, and competencies. Seeking accreditation from MICH is voluntary.

Missouri is the first state in the nation to initiate a voluntary accreditation program for local health departments.

Patient Choice Cesarean Section Rates

A patient choice Cesarean section is a preplanned first-time C-section performed on a woman who has not labored, has no prior history of C-section and has no accepted medical indication to warrant a C-section. In 2003, HealthGrades

(www.healthgrades.com) released a landmark study that identified national, state, and individual hospital rates of first-time preplanned C-sections without medical indication. That study, which looked at more than 1,900 hospitals, coincided with

Epidemiology: Think Globally, Act Locally

Office of Epidemiology & Community Health Monitoring
Gerald L. Hoff, Ph.D., F.A.C.E., Editor

August 2004
Vol. 25 # 1

heated debate in the medical community about the appropriateness of patient choice C-sections. Subsequently, the American College of Obstetricians and Gynecologists released an updated opinion on the ethics of patient choice C-section (www.acog.org) that supports C-section by patient choice, so long as the patient is fully informed of the risks and benefits of this procedure over vaginal delivery.

In July 2004, HealthGrades issued a more detailed report on patient choice C-sections. There was a 25% increase in patient choice C-sections between 2000 and 2002. In 2002, this type of C-section accounted for 2.21% of all deliveries. The majority of patient choice C-sections were performed on younger mothers, however women >40 y old had

the highest rate, 2.94% which was 75% higher than that of women ≤ 30 y old. The overall national complication rate associated with patient choice C-sections was lower than that associated with vaginal delivery (8.43% vs 12.39%, respectively). HealthGrades' 2004 report did not include data for Missouri or Kansas.

According to the National Center for Health Statistics, overall C-sections rose to 26.1% of all births in 2002, the highest rate on record. The Yr 2010 national objective is that the C-section rate for 1st time mothers not exceed 15%. In Kansas City, the overall rate for C-sections in 2002 was 23.4%, while that among 1st time mothers was 24.3% (Table 1).

Table 1 Method of birth delivery, Kansas City, MO, 1998-2002

| | Year | Vaginal | Delivery method | | | All others | Total births |
|-----------------|-----------------------------|----------------|----------------------------|-----------------------------|------------------|-------------|--------------|
| | | | Primary elective C-section | Primary emergency C-section | Repeat C-section | | |
| All live births | 1998 | 5,795 80.5% | 279 3.9% | 628 8.7% | 363 5.0% | 132 1.8% | 7,195 |
| | 1999 | 5,824 79.9% | 253 3.5% | 654 9.0% | 420 5.8% | 142 1.9% | 7,293 |
| | 2000 | 5,761 78.6% | 284 3.9% | 738 10.1% | 419 5.7% | 127 1.7% | 7,329 |
| | 2001 | 5,705 77.7% | 401 5.5% | 655 8.9% | 483 6.6% | 103 1.4% | 7,347 |
| | 2002 | 5,554 75.5% | 505 6.9% | 636 8.6% | 578 7.9% | 82 1.1% | 7,355 |
| | 1 st time births | 1998 | 2,248 77.4% | 180 6.2% | 400 13.8% | | 77 2.7% |
| 1999 | | 2,263 77.0% | 163 5.5% | 431 14.7% | | 82 2.8% | 2,939 |
| 2000 | | 2,295 75.8% | 179 5.9% | 480 15.8% | | 75 2.5% | 3,029 |
| 2001 | | 2,229 76.1% | 243 8.3% | 399 13.6% | | 58 2.0% | 2,929 |
| 2002 | | 2,161 73.8% | 317 10.8% | 396 13.5% | | 56 1.9% | 2,930 |

The data above does not distinguish patient choice C-sections from other primary elective C-sections. However, it should be noted that there were distinct increases between 2000 and 2002 (77% overall, 85% for 1st time mothers); these increases correspond with the years noted by HealthGrades for rapidly rising rates in patient choice C-sections. It can be inferred that patient choice C-sections have contributed significantly to this phenomenon in Kansas City. The increasing rate of primary elective C-section was mirrored by a decline in vaginal

births. While the percentage of primary elective C-sections increased for 1st time mothers in all age groups over the five year period, the greatest increase was among women ≥ 35 y of age (Fig 1). For 1998-2002, blacks and Hispanics had the lowest percentages of primary elective C-sections, 5.2% and 5.7% respectively, while the percentages for whites and Asians were similar, 9.0% and 8.8% respectively. For the small number of first time births among Native Americans over the 5 year period, the primary elective C-section rate was

7.8%. Among whites, blacks and Hispanics, the rates rose across over the years (Fig 2).

Figure 1 Primary elective C-section for first time births, Kansas City, MO

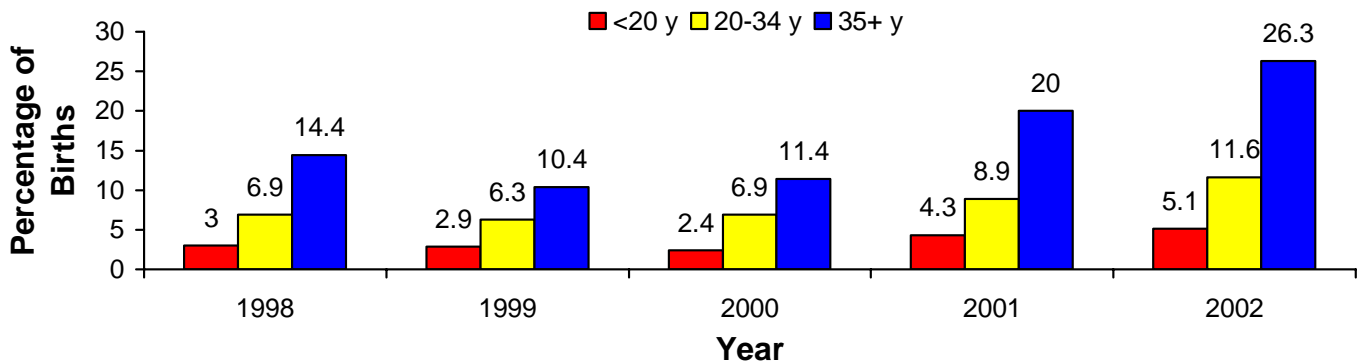
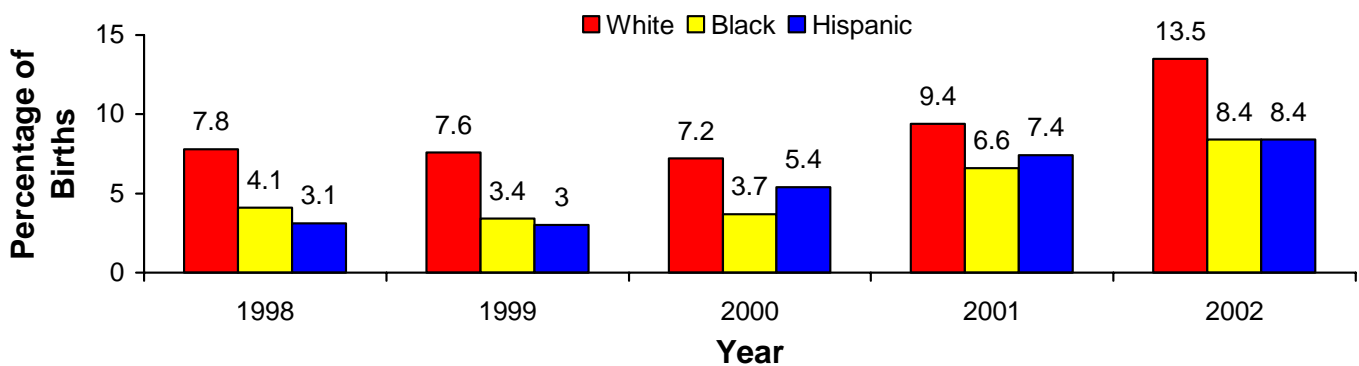


Figure 2 Primary elective C-section for first time births, by race and ethnicity, Kansas City, MO



Potpourri

Is the nasal, live attenuated influenza vaccine, FluMist, a flop? That is the question that remains to be answered. Last year 5 million doses were manufactured, but 80% went unsold and had to be destroyed (Intern Med News 37(11), 2004). The vaccine took some 36 years from the time the technique for making it was first reported to the time it entered the market, and development cost anywhere from \$750 million to \$1 billion.

A British study found that, over 9 seasons of varying influenza activity, influenza vaccinations among persons >64 y of age resulted in 21% fewer hospitalizations for respiratory diseases (J Infect Dis 190:1, 2004). Similarly, influenza vaccination

reduced the risk of death due to respiratory disease by 12%.

The danger of vaccinating against influenza, if the vaccine is not a perfect match for the disease strain, was highlighted by a study of influenza in horses (Proc Royal Soc B 271:1547, 2004). The data suggest that the infectious period, the risk of becoming infected, and the probability of excreting virus are increased when the vaccine strain is mismatched to the prevailing influenza strain. Mathematically, the risk of large outbreaks after using a mismatched vaccine was up to 1,000 times higher than after a well-matched vaccination.

The reemergence of H5N1 influenza in Asia poultry again is raising concerns that this virus will be successful in crossing into the human population. Twenty-four people died earlier this year when the virus was active. How fast could a new influenza strain spread in the human population? That depends on a number of factors, but if the virus is adapted for efficient human-to-human transmission then it would most likely spread so quickly over long distances that homogeneous global mixing will occur before the epidemic builds up within infected areas. This rapid type of spread has been

documented for normal human influenza strains (Proc Royal Soc B 265:2421, 1998).

T yphoid fever (*Salmonella typhi*) in the United States is largely a disease that is brought back from foreign countries (Clin Infect Dis 39:186, 2004). The Centers for Disease Control and Prevention (CDC) reported that between 1994 and 1999, among recent international travelers only 4% of those who developed typhoid had been vaccinated prior to their trip. India, Pakistan,

Mexico, Bangladesh, the Philippines, and Haiti accounted for the source of 76% of the travel related cases. CDC now recommends vaccination for persons planning short-term travel to high risk areas. Increasing antimicrobial resistance has complicated the treatment of typhoid fever. Typhoid fever is rarely reported in Kansas City.

Gov. Holden recently signed into law a bill requiring Missouri hospitals to report on their hospital acquired infections; the details of this reporting remain to be determined. Meanwhile, CDC has reported that hospital acquired

Clostridium difficile infections, the leading cause of hospital acquired diarrhea, in US hospitals doubled between 1993 and 2002 (Intern Med News 37(13), 2004). In 2002, about 170,000 hospitalized patients were discharged after having been diagnosed with *C difficile*. Infection results in a 3.6 day increase in length of stay at an average cost of \$3,669 per case. It is hypothesized that antibiotics, such as fluoroquinolones that are excreted in the stool, are largely responsible for this increase in disease (Emerg Infect Dis 9:730, 2003). *C difficile* can kill as witnessed by 100 deaths over the last 18 months at University Hospital in Sherbrooke, Quebec (early release, www.cmaj.ca on 8/4/04).



Office of Epidemiology & Community Health Monitoring
2330 501025
Kansas City Health Department
2400 Troost, Suite 4000
Kansas City MO 64108