



Yakima Health District BULLETIN

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Chronic Disease Mortality and Behavioral Risk Factors

The leading causes of death in Yakima County continue to be (1) heart disease, (2) cancer, (3) stroke, (4) chronic lung disease, and (5) unintentional injuries. Recent mortality data for leading chronic diseases are summarized in Table 1.

Key findings include the following:

- Heart disease remains the leading cause of death in Yakima County; however, cancer deaths have surpassed heart disease for the state of Washington as a whole.
- Heart disease mortality in Yakima County is about 25% higher than for Washington State but is still lower than national rates. The steepest decline in mortality over the past five years has been in stroke mortality, possibly due to amplified efforts at early recognition and treatment, along with advances in thrombolytic therapy for acute ischemic stroke.
- Alzheimer's dementia mortality is increasing and has surpassed diabetes as the fifth leading cause of chronic disease mortality.
- Unintentional injury (39/100K) remains the fifth leading *overall* cause of death, but is not listed in this chronic disease table.

Obesity, physical inactivity, smoking, diabetes, hypertension and hypercholesterolemia remain the dominant modifiable risk factors for chronic disease

mortality. Lack of access to health care limits one's ability to engage in medical interventions that reduce risk and may also be a surrogate marker for additional risk factors (e.g., chronic stress). The Centers for Disease Control and Prevention's (CDC's) Behavioral Risk Factor Surveillance System (BRFSS) conducts annual random-digit-dialed telephone-based surveys of the adult population. BRFSS data indicate that Yakima County's self-reported rates of obesity, diabetes, and lack of health insurance are among the worst in Washington and the nation (Tables 2&3). Physical inactivity is also a significant problem, although to a lesser extent. Daily tobacco smoking is at or below the state and national medians. Data on hypertension and serum cholesterol awareness was not available from BRFSS.

Fortunately, among survey respondents ≥ 65 years of age, vaccination against influenza (74%) and pneumococcus (68%) was the best in the state and was well above the median for the nation (pneumonia and influenza collectively are the eighth leading cause of death). Secondary prevention (early detection and management of risk factors) and tertiary prevention (management of and rehabilitation from disease) can and should continue to play a major role in the community's efforts to mitigate suffering and premature mortality from chronic disease. These interventions are predominantly clinical in nature and highlight the

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Table 1. Age-Adjusted Rates for Major Causes of Chronic Disease Mortality¹

Cause	Yakima Co. ¹			Washington			United States		
	1990	2000	2006	1990	2000	2006	1990	2000	2004
Heart	275	208	204	274	209	166	282	258	222
Cancer	191	198	162	207	196	176	186	201	187
Stroke	72	74	46	68	69	43	69	61	51
COPD ²	53	51	45	45	49	43	29	44	42
Alzheimer's	11	21	28	11	33	38	--	18	23
Diabetes	23	34	26	18	25	25	22	25	25

¹Deaths per 100,000 population per year

²Chronic obstructive pulmonary disease

Source: Center for Health Statistics, Washington State Department of Health; National Center for Health Statistics, USDHHS

Table 2. Summary of Self-Reported Risk Factors, Yakima Metropolitan Statistical Area

	Obese ¹	Inactive ²	Smoking ³	Diabetic ⁴	Uninsured ⁵
2003	23%	28%	16%	8%	21%
2006	30%	25%	12%	10%	22%
National range	14-45%	14-31%	5-24%	5-13%	6-39%
National rank (N=180; 2006)	11	37	106	9	9
Percentile	94	79	41	95	95

¹ BMI \geq 30 as calculated from self-reported height and weight

² Answered "no" to "During the past month have you participated in any physical activity?"

³ Answered "every day" to "How often do you smoke?"

⁴ Answered "yes" to "Has a doctor ever told you that you have diabetes?" (excludes gestational diabetes)

⁵ Answered "no" to "Do you have any kind of health coverage?"

Source: CDC, Behavioral Risk Factor Surveillance System

Table 3. Intra-state Comparisons for Self-reported Behavioral Risk Factors

2006 Intra-state Comparisons					
MMSA ¹	Obese (%)	Inactive (%)	Smoking (%)	Diabetic (%)	Uninsured (%)
Yakima	30.1	24.6	12.2	10.1	22.1
Spokane	24.6	18.1	18.9	8.7	16.6
Wenatchee	22.9	22.8	11.3	10.1	27.2
Tri-Cities	26.3	21.6	11.9	7.3	14.2
Tacoma	28.1	19.6	14.3	7.5	16.4
Seattle	21.2	15.0	9.6	6.8	12.7
Olympia	24.3	14.6	16.4	10.1	12.0

¹ Metro- or micro-politan statistical area

Source: CDC, Behavioral Risk Factor Surveillance System

value of enhancing access to health care and ensuring appropriate and timely utilization of preventive and therapeutic services. However, more significant long term gains are probably better derived through primary prevention-- identifying and addressing those individual choices and societal influences which contribute to smoking, physical inactivity, obesity, diabetes, hypertension, and hypercholesterolemia.

Efforts to prevent smoking initiation among youth (e.g., education, enforcement of prohibition of sales to minors) have been underway for many years and declining smoking rates would seem to indicate they are having an impact. YHD aims to work with the community to identify measures that will lead to similar improvements in obesity, physical inactivity, and diabetes.

Resources:

Body mass index calculator <http://nhlbisupport.com/bmi/>

Gateway to Washington BRFSS and mortality data <http://www.doh.wa.gov/Data/data.htm>

CDC BRFSS website <http://www.cdc.gov/brfss/>

Childhood Obesity Prevention Grant

The Yakima Health District has received a grant to address childhood obesity in Yakima County. The Washington State Department of Health has awarded the Yakima Health District almost \$50,000 per year for three years to address the obesity epidemic.

The funded project, titled *Rev it Up!...with healthy choices* will be funded 2008 through 2010.

Yakima County consistently has higher rates of chronic diseases, such as heart disease and diabetes, which are associated with obesity. Many of these health issues can be prevented by intervention and support during childhood years by schools and families. The goal of this project is to assist school districts in Yakima County in developing and implementing effective wellness policies by providing them opportunities to increase nutrition and physical activity programs in schools and for families. This project will also create a community resource for physical activity and nutrition information.

Many agencies throughout Yakima County have dedicated their support and participation in this project. These partner agencies include Children's Village, Yakima Valley Farmworkers Clinic, Northwest Community Action Center, Yakima Valley Memorial Hospital, Educational School District (ESD) #105, The YMCA of Yakima, and Yakima Pediatrics/Dr. Kerry Harthcock.

Several partner agencies are currently hard at work to address the childhood obesity problem in our community. Through this project, agencies will have an avenue to share and spread their work throughout Yakima County and provide education that will help to make our county a healthier place to live.

For more information about *Rev it Up!...with healthy choices* please visit the Yakima Health District web site, www.yakimapublichealth.org. You may also contact Jessica Brown, *Rev it Up!...with healthy choices* Project Coordinator at 509-249-6516 or jessica.johnson@co.yakima.wa.us.

Counting HIV/AIDS Cases in Washington State

The state and federal governments use HIV/AIDS surveillance data to determine funding levels for prevention, care and surveillance. A person with a new HIV diagnosis gets counted as an HIV case in the county in which the individual is living at the time of his/her diagnosis. When that person progresses to AIDS, he/she will get counted as an AIDS case in the county in which he/she is living at the time of the AIDS diagnosis and will cease to be counted as an HIV case. Therefore, in any given month, each case is only counted once: either as an HIV case or as an AIDS case, but not both. The official count for funding decisions reflects the state's number of cases based on its complete case reports as of the end of each calendar year. In contrast, the data reports that the state distributes typically reflect cases by date of diagnosis, not date of case completion. As a result, the cumulative number of cases diagnosed in any given year may change from month to month as counties report additional cases. For example, according to the state's end of the month report in December 2006, there were 626 new cases of HIV or AIDS diagnosed in Washington State in 2006. However, because new cases that were diagnosed in 2006 continued to be discovered during 2007, that figure climbed to **762** by the end of 2007. The number of cumulative living cases in any given county may also change from month to month as deaths are reported and as the state receives updated information from other states that may affect in which state a case gets counted.

This article was provided courtesy of Tom Jaenicke, MPH (Assessment Unit, Office of Infectious Diseases and Reproductive Health, Washington State Department of Health) in response to queries about fluctuations and seeming inconsistencies in month-to-month and year-to-year counts of HIV and AIDS cases.

RSV and Influenza Surveillance

Laboratory surveillance indicates that respiratory syncytial virus activity came to Yakima County in late October-early November and peaked during mid-January, although there is still considerable ongoing activity. Influenza cases were first noted in mid-December and incidence is still high, although the peak of activity appears to have been passed during the end of January.

In Washington State as a whole, influenza activity is widespread, but not severe. No pediatric deaths have been reported this season, nor have there been any confirmed outbreaks in nursing homes. School absenteeism is at or below expected levels. As of February 2, CDC reports that widespread influenza activity continued throughout the Pacific region and the entire United States. In the Pacific region, 85% of isolates have been type A and 15% have been type B. Of the A strains that have been further sub-typed in the Pacific Region, 90% are H1N1 and 10% are H3N2. However, H3N2 is now surpassing H1N1 in the southern and eastern United

States. Further antigenic characterization of isolates shows a good match between this year's vaccine and circulating H1N1 isolates, but the match is not so good with H3N2 and B types. The dominant circulating H3N2 subtype is a variant of the vaccine strain, implying that the vaccine may still be of some efficacy, but the B subtype is more distinct. Consequently, providers may be seeing more influenza-like illness in vaccinated patients this year compared to recent years. Oseltamivir and zanamivir remain the treatment options of choice for influenza in the United States, although strains with mutations conferring resistance to oseltamivir have been detected in Norway and France. Amantadine and rimantidine resistance is now considered essentially ubiquitous in the United States and these agents should not be used for treatment or prophylaxis.

Tables and figures for influenza activity can be viewed at: <http://www.co.yakima.wa.us/health/commhealth/immproviders.htm> (local)

Interim Recommendations to Defer *Haemophilus influenzae* Type b (Hib) Booster in 12-15 Month Old Children

On December 13, 2007, Merck & Co., Inc. (West Point, Pennsylvania) announced a voluntary recall of certain lots of two *Haemophilus influenzae* type b (Hib) conjugate vaccines: PedvaxHIB[®] and Comvax[®]. The Washington State Department of Health's (DOH's) universal vaccine supply system does NOT use either of these products. However, the remaining manufacturer and DOH's supplier (Sanofi Pasteur) will not be able to immediately provide adequate Hib vaccine to vaccinate fully all children for whom the vaccine is recommended. Consequently, all involved clinical and public health bodies (e.g., YHD, DOH, CDC, AAP, AAFP) are recommending that providers temporarily defer administering the Hib vaccine booster dose routinely administered at age 12-15 months (except to children in specific groups at high risk*). Short-term deferral of the booster dose among children aged 12--15 months is not likely to result in an increased risk for Hib disease because of continued protection of children with the primary series and the low level of nasopharyngeal carriage and transmission achieved in the United States by the Hib immunization program. To maximize the amount of available vaccine, providers should order only the number of doses of vaccine required to meet immediate primary vaccination needs (i.e., a supply for up to 4 weeks) and should refrain from attempting to build an inventory of Hib vaccine. Providers should register and track children for whom the booster dose is deferred to facilitate recalling them for vaccination when supply improves.

**Certain children are at increased risk for Hib disease, including children with asplenia, sickle cell disease, human immunodeficiency virus infection and certain other immunodeficiency syndromes, and malignant neoplasms. Alaskan or Native American children are also considered high risk.*

Adapted from CDC. *MMWR* 2007;56(dispatch):1-2 <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm56d1219a1.htm>

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← ATTENTION! NEW ADDRESS!



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Condition (includes confirmed and probable cases)	Cases			Total Cases by Year	
	Jan-Dec	Jan-Dec	Jan-Dec	Total Cases by Year	Total Cases by Year
	2007	2006	2005	2006	2005
Campylobacteriosis	124	202	114	202	114
Cryptosporidiosis	19	7	7	7	7
Enterohemorrhagic E. coli	7	5	3	5	3
Giardiasis	48	31	28	31	28
Salmonellosis	34	34	52	34	52
Shigellosis	26	32	29	32	29
Hepatitis A acute	0	1	3	1	3
Hepatitis B acute	1	5	1	5	1
Hepatitis B chronic	11	11	14	11	14
Hepatitis C acute	1	1	2	1	2
Hepatitis C chronic	226	176	213	176	213
Meningococcal	2	1	2	1	2
Pertussis	37	21	188	21	188
Tuberculosis	11	16	14	16	14
HIV New	10	10	14	10	14
HIV Deaths	1	2	2	2	2
HIV Cumulative Living	152	142	132	142	132
Chlamydia	1168	1120	973	1120	973
Genital Herpes—Initial	46	70	99	70	99
Gonorrhea	119	166	138	166	138
Primary and Secondary Syphilis	0	3	2	3	2

**Notifiable
Conditions
Summary
Jan– Dec,
2007**