



# Kansas Health Statistics Report

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## Racial Disparities in Preventable Hospitalizations for Low Birth Weight

In the United States, the incidence of low birth weight (LBW), less than 5 pounds 8 ounces (2,500 grams), has risen steadily from 6.7 percent in 1984 to the highest level recorded in the past 3 decades [1]. In 2005, the U.S. LBW was 8.2 percent, which increased from 8.1 percent the previous year [2].

In Kansas the LBW percentage increased from 7.0 in 2001 to 7.2 percent in 2006 [3]. Some of the risk factors that impact the incidence of LBW are smoking by pregnant mothers, race/ethnicity, socioeconomic status, marital status, maternal age, medical conditions, and prenatal substance use, among others [4]. Although the rise in multiple births has impacted the LBW gradient, LBW outcomes also continue to increase in single births. The purpose of this article is to summarize U.S. and Kansas trends regarding LBW and disparities in preventable hospitalization.

Kansas community hospital discharge data 2003-2006 from the Kansas Hospital Association (KHA) are used to compare preventable hospitalizations among Kansas racial/ethnic or population groups. Data for 2000-2006 are used to compare Kansas and national trends. Population groups include white non-Hispanic, black non-Hispanic, Asian/Native Hawaiian or Other Pacific Islander (NHOPI) non-Hispanic, American Indian/Alaskan Native (AI/AN) non-Hispanic, and Hispanic. Statistics for the category Other/Unknown consisting of multi-racial and individuals of unknown racial and ethnic origin, are not included due to data reporting issues and statistical unreliability.

Table 1. LBW Percents by Selected Population Groups, U.S. and Kansas, 2006\*

	US*	Kansas **
White non-Hispanic	7.3%	6.9%
Black non-Hispanic	14.0%	12.7%
Asian/NHOPI non-Hispanic	8.1%	N/A
AI/AN non-Hispanic	7.5%	N/A
Other non-Hispanic	N/A	8.1%
Hispanic	7.0%	5.7%
Total	8.3%	7.2%

Source: \* Centers for Disease Control and Prevention, National Center for Health Statistics.

\*\* KDHE Center for Health and Environmental Statistics, Kansas Information for Communities, Accessed August 12, 2008.

### Low Birth Weight

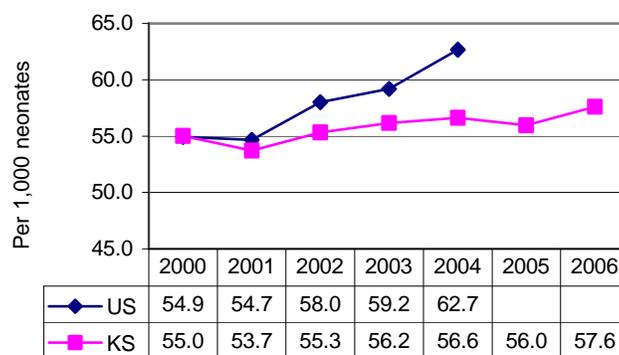
The Agency for Healthcare Research and Quality (AHRQ) indicates that adequate primary and outpatient care for selected conditions like LBW can often prevent more serious disease complications or circumvent hospitalization [5]. Since hospitalization is the most serious and expensive part of health care treatment, reducing otherwise preventable and possibly unnecessary hospitalization is critical to cost reduction and avoidance. In both the U.S. and Kansas, LBW percentages are higher among black

non-Hispanic infants than among other population segments (Table 1). In 2006, the US and Kansas LBW rates were much higher among black non-Hispanic infants (14.0 percent and 13.5 percent, respectively) than among infants of other racial/ethnic groups. Kansas percents were slightly lower than LBW percents reported nationally.

### Preventable Hospitalization

In both the US and Kansas, preventable hospitalization rates due to LBW have risen (Figure 1).

Figure 1: Preventable Hospitalizations due to Low Birth Weight, U.S. and Kansas, 2000-2006



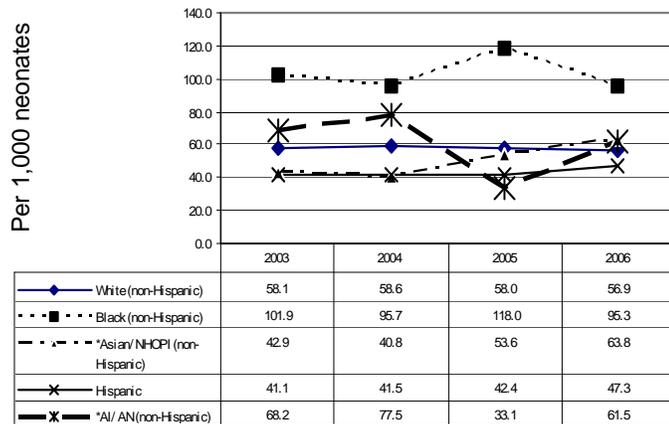
Racial differences in hospitalization rates may signify disparities in the quality of ambulatory care as well as disparities in access to timely and effective primary care for certain health conditions [5]. Among Kansans, between 2003 and 2006, black non-Hispanics had the highest preventable hospitalization rates for LBW. They were nearly twice as likely as white non-Hispanics to experience a preventable hospitalization due to LBW. On the other hand, Asian/NHOPI non-Hispanics and Hispanics had lower preventable hospitalization rates when compared to white non-Hispanics (Figure 2).

### Discussion

LBW not only affects the baby and the mother but society as a whole. There are many risk factors that impact LBW. Research has identified a number of social, medical, and behavioral risk factors that affect the incidence of LBW and some risk factors may contribute directly to racial disparities in LBW.

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Figure 2. Preventable Hospitalization Rates for Low Birth Weight by Race/Ethnicity, Kansas, 2003-2006



\*Rate based on a number of less than 30, interpret with caution

Attempts have been made to address identified risk factors like reducing smoking rates in pregnant mothers through counseling and/or pharmacotherapy; monitoring and treating chronic maternal diseases like hypertension, diabetes, and heart disease; and attending to nutritional issues, among others [6]. However, further study is warranted and may offer effective strategies for reducing LBW and helping to narrow racial disparities in LBW. For the most part, research on contributing risk factors is in its infancy [7].

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## References

- Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System. Martin JA, Hamilton BE, Sutton PD, Ventura SJ, Menacker F, Kirmeyer S, Munson ML. (2007) Births: Preliminary data for 2006. National Vital Statistics Reports, 56(7). Hyattsville, MD: National Center for Health Statistics.
- The Annie E. Casey Foundation, KIDS COUNT Data Center, Profiles by Geographic Area, [http://www.kidscount.org/datacenter/profile\\_results.jspr=1&d=1](http://www.kidscount.org/datacenter/profile_results.jspr=1&d=1), Accessed 08/04/2008.
- Kansas Annual Summary of Vital Statistics, 2001 & 2006. Office of Health Assessment, Division of Health, Center for Health & Environmental Statistics, KDHE, 2002 & 2007.
- Woodrow Wilson School of Public and International Affairs at Princeton University and the Brookings Institution, School readiness: closing racial and ethnic gaps, Low Birth Weight and School Readiness, The Future of Children, Vol15(1) SPRING 2005 [http://www.futureofchildren.org/information2827/information\)show.htm?doc\\_id256521](http://www.futureofchildren.org/information2827/information)show.htm?doc_id256521), Accessed August 5, 2008.
- Russo C, Andrews R, and Coffey R, July 2006, Racial and ethnic disparities in potentially preventable hospitalizations, 2003. HCUP Statistical Brief #10. July 2006/ Agency for Healthcare Research and Quality, Rockville, MD. <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb10.jsp>. Accessed March 3, 2008.
- Goldenberg RL and Culhane JF, Low Birth Weight in the United States, Am J Clin Nutr 2007; 85(suppl):584S-90S.
- Woodrow Wilson School of Public and International Affairs at Princeton University and the Brookings Institution, School Readiness: Closing Racial and Ethnic Gaps, Low Birth Weight and School Readiness, The Future of Children, Vol15(1) SPRING 2005 [http://www.futureofchildren.org/information2827/information\)show.htm?doc\\_id256521](http://www.futureofchildren.org/information2827/information)show.htm?doc_id256521), Accessed August 5, 2008.

## Perinatal Deaths Using Linked Death and Birth Files, Kansas, 2005 and 2006

Infant mortality, a measure used to compare the health and well-being of populations across and within countries is important both nationally and in Kansas. This measure can be drilled down to several sub-components:

- Perinatal deaths, which include fetal deaths and infant deaths less than 7 days,
- Neonatal deaths, which include infant deaths less than 28 days and
- Post-neonatal deaths, which include infant deaths from 28 days to 364 days.

This article looks at perinatal deaths. Perinatal deaths are an important sub-component of infant deaths since it is difficult at times to distinguish between an infant death that occurs near the time of birth and a late fetal death. Nationally, the perinatal death rate (perinatal period II definition) includes fetal deaths 20 weeks or more and hebdomadal deaths (infant deaths less than 7 days of age). Nationally, in 2004, the most recent year with statistics, the perinatal death rate was 10.7/1,000 hebdomadal deaths plus stillbirths. This rate according to the National Center of Health Statistics (NCHS) has declined by 18 percent from 1990 [1].

In Kansas, the definition of perinatal deaths is loosely comparable but not quite the same. Kansas collects data on "perinatal period III" deaths, which include hebdomadal deaths plus stillbirths where the fetus weighs over 350 grams.

In Kansas, in 2006, the perinatal death rate for Kansas residents was 8.0/1,000 live births plus stillbirths, a decrease of 28.6 percent from 1987 [2].

Public health caregivers need to know who is at risk for negative birth outcomes and what are the contributing factors. The linked birth and death file provides data to gain a better understanding of these issues. Additionally, starting in 2005, Kansas collected more extensive risk-related data with the revised birth certificate.

The linked birth and infant death data set (death cohort) provides important data such as:

- age at death, and underlying cause of death,
- race and Hispanic origin of the mother,
- birthweight, period of gestation,
- plurality,
- maternal age,
- socio-economic factors such as mother's education and payer of the delivery and
- medical risk factors of both mother and infant at the time of delivery.

## Methodology

For this analysis, 2005 and 2006 were combined to increase validity. Confidence intervals were calculated using NCHS methodology [1]. If confidence intervals of two rates overlap, the difference is not statistically significant at the 95 percent level.

In Kansas, during this time period, 386 fetal deaths and 290 hebdomadal deaths were registered by the file closing date. Eighty nine percent of the hebdomadal deaths were matched with birth files. Confidence intervals were calculated using NCHS methodology [1]. Unknowns were not included when calculating percents.

## Who is at Risk?

In Kansas, the 2005 and 2006, linked death - birth file includes 643 deaths, 7.9/1,000 live births plus stillbirths (total deliveries).

For this analysis, race and ethnic group (of the mother) was included where the number of perinatal deaths included at least 5 deaths. These groups included black non-Hispanic (14.5% of the deaths), white non-Hispanic (63.5%), Asian non-Hispanic (3.1%) multi non-Hispanic (1.1%), other non-Hispanic (1.3%) and Hispanic (16.5%) (Table 2).

As is shown nationally, in Kansas the perinatal death rate for black non-Hispanic mothers is over twice that of white non-Hispanic mothers [1].

Table 2. Perinatal Deaths by Mother's Population Group, Kansas, 2005 - 2006.

Mother's Race /Ethnicity	Total Deliveries	Deaths	Rate*	Confidence Intervals	
				Lower	Upper
Black non-Hispanic	5,452	92	16.9	13.6	20.7
White non-Hispanic	57,861	404	7.0	6.3	7.7
Asian non-Hispanic	2,148	20	9.3	5.7	14.4
Multi non-Hispanic	914	7	**	**	**
Other non-Hispanic	1,037	8	**	**	**
Hispanic (all races)	12,707	105	8.3	6.7	9.9
Unknown race/ethnicity	864	7	**	**	**
Totals	80,983	643	7.9	7.3	8.6

\*Rate/1,000 live births plus stillbirths.

\*\* Number of deaths is too small to calculate rate

### Maternal Age

The highest percent of perinatal deaths occurred among mothers ages 20–24 (27.7%) However, the highest rates were among mothers ages 19 and under and 35 plus (Table 3).

Table 3. Perinatal Deaths by Age of Mother, Kansas, 2005 - 2006

Age-Groups	Total Deliveries	Deaths	Rate*	Confidence Intervals	
				Lower	Upper
< 19	8,265	87	10.5	8.4	13.0
20-24	23,063	178	7.7	6.6	8.9
25-29	23,983	165	6.9	5.8	7.9
30-34	16,576	124	7.5	6.2	8.8
35 plus	9,078	88	9.7	7.8	12.0
Unknown	18	1	**	**	**

\*Rate/1,000 live births plus stillbirths.

\*\* Number of deaths is too small to calculate rate.

### Fetal, Birth Weight

Low fetal or birth weight was an important factor in perinatal deaths ranging from under 500 grams (861.9 deaths/1,000 live births plus stillborns) to 1.7 deaths/1,000 for fetuses or newborns weighing at least 2,500 grams (Table 4). The highest percent of deaths was also in the under 500 grams weight group (28.3%).

TABLE 4. Perinatal Deaths by Weight in Grams, Kansas, 2005 - 2006.

Weight (grams)	Total Deliveries	Deaths	Rate*	Confidence Intervals	
				Lower	Upper
under 500	210	181	861.9	690.6	1033.2
500-749	227	90	396.5	305.3	506.3
750-999	243	57	234.6	171.7	312.9
1000-1249	249	40	160.6	111.9	223.4
1250-1499	340	30	88.2	58.6	127.5
1500-1999	1,172	56	47.8	35.8	62.5
2000-2499	3,640	57	15.7	11.8	20.3
2500+	74,891	129	1.7	1.4	2.0
Unknown	11	3	**	**	**

\*Rate/1,000 live births plus stillbirths.

\*\* Number of deaths is too small to calculate rate.

### Delivery Payer

The payer group with the highest rate of deaths was the self-pay group, though the rate is not significantly different than the other payers listed (Table 5). The highest percent of deaths was among mothers with private insurance (48.0%).

Table 5. Perinatal Deaths by Payer of the Delivery, Kansas, 2005 - 2006

Payer	Total Deliveries	Deaths	Rate*	Confidence Intervals	
				Lower	Upper
Medicaid	21,675	186	8.6	7.3	9.8
Private Insurance	40,935	278	6.8	6.0	7.6
Self Pay	5,196	51	9.8	7.3	12.9
Indian Health Service	78	0	**	**	**
Champus/Tricare	2,997	23	7.7	4.9	11.5
Other Gov	3,726	30	8.1	5.4	11.5
Other	1,513	11	**	**	**
Unknown	4,863	64	13.2	10.1	16.8

\*Rate/1,000 live births plus stillbirths.

\*\* Number of deaths is too small to calculate rate.

### Maternal Weight Gain

The highest percent of perinatal deaths occurred among mothers who gained 10-15 pounds (21.7%) while the highest rate occurred among mothers who gained under nine pounds (Table 6). The death rates in both of these groups were significantly higher than the groups with weight gain above 15 pounds.

Table 6. Perinatal Deaths Weight Gain (Pounds) During Pregnancy, Kansas, 2005 - 2006

Weight Gain	Total Deliveries	Deaths	Rate*	Confidence Intervals	
				Lower	Upper
Under 9 lbs.	2,846	82	28.8	22.8	35.9
10-15 lbs.	5,005	112	22.4	18.2	26.6
16-21 lbs.	8,180	91	11.1	8.9	13.7
22-27 lbs.	11,805	73	6.2	4.8	7.8
28-33 lbs.	13,773	63	4.6	3.5	5.9
34-39 lbs.	11,577	35	3.0	2.1	4.2
40 + lbs.	21,952	61	2.8	2.1	3.6
Unknown	5,845	126	21.6	17.8	25.4

\*Rate/1,000 live births plus stillbirths.

### Live Birth, Pregnancy Interval

The rate of perinatal death was highest where the interval between the delivery represented here and the last delivery with a live birth was less than 18 months (11.0/1,000). The highest percent of deaths occurred among the group with no previous live birth (46.0%) (Table 7).

Table 7. Perinatal Deaths by Interval Since Last Live Birth, Kansas, 2005 - 2006

Interval (Months)	Total Deliveries	Deaths	Rate*	Confidence Intervals	
				Lower	Upper
Under 18 months	5,820	64	11.0	8.5	14.1
18-23	6,823	36	5.3	3.7	7.3
24-35	12,090	56	4.6	3.5	6.0
36 Plus	23,423	149	6.4	5.3	7.4
No previous LB	30,184	260	8.6	7.6	9.7
Unknown	2,643	78	29.5	23.3	36.9

\*Rate/1,000 live births plus stillbirths.

## Prenatal Care

No prenatal care had the highest rate of perinatal deaths - a significant difference between no prenatal care and prenatal care beginning in the first or second trimester (Table 8). The group starting prenatal care in the first trimester had the highest percent of perinatal deaths (69.6%).

Table 8. Perinatal Deaths by Prenatal Care History, Kansas, 2005 - 2006

	Total Deliveries	Deaths	Rate*	Confidence Intervals	
				Lower	Upper
None	823	44	53.5	38.5	72.3
First Trimester	56,204	385	6.9	6.2	7.5
Second Trimester	14,769	107	7.2	5.9	8.6
Third Trimester	2,697	17	**	**	**
Unknown	6,490	90	13.9	11.1	17.1

\*Rate/1,000 live births plus stillbirths.

\*\*Number is too small to calculate rate.

## Additional risk factors

Medical risk factors associated with perinatal death and at least 20 deaths included diabetes, either prepregnancy or gestational diabetes (10.2/1,000), hypertension, both prepregnancy and during pregnancy (11.4/1,000), previous preterm birth (19.0/1,000), breech presentation at delivery (43.0/1,000), birth anomalies (148.6/1,000) and of course, multiple births including twins or greater multiples (31.0/1,000).

## Conclusion

This analysis clearly shows that black non-Hispanic mothers are at risk of having a fetal or infant death along with mothers both younger and older. However, this data also shows that perinatal death is a public health concern across the other race and ethnic groups cited. Low birth weight, no prenatal care, short interval between pregnancies, no insurance, low weight gain for mom and medical risk factors along with birth anomalies are contributing risk factors, some of which are preventable or at least modifiable. Tobacco use, an important risk factor for low birth weight infants (particularly small for gestational age), will be addressed in a future article. Evaluation of who is at risk by which risk factors as well as analysis of risk factors in a more detailed manner will also be addressed more in depth in future articles. These analyses require combining additional years of data.

## References

1. MacDorman MF, Munson ML, Kirmeyer S. Fetal and perinatal mortality, United States, 2004. National vital statistics reports; vol 56 no 3. Hyattsville, MD: National Center for Health Statistics. 2007.
2. Kansas Annual Summary of Vital Statistics, 2006. Office of Health Assessment, Division of Health, Center for Health & Environmental Statistics, KDHE, 2007.

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## Childcare-related Mortality in Kansas

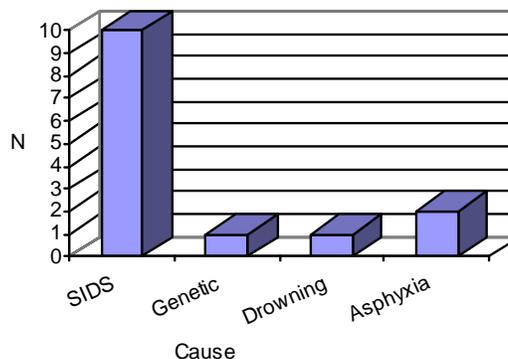
In 2006, 293 infants and 50 children aged 1-4 died in Kansas. For infants, the cause of death was due mostly to conditions originating in the perinatal period and congenital defects (67.2%). For the older children, external causes were responsible for almost half the deaths (44.7%).

Concerned about an increase in the number of deaths to infants and children in childcare settings, the KDHE Bureau of Childcare and Health Facilities (BCCHF) implemented a tracking system to gather information about childcare-related deaths. A childcare-related death was defined as a death to an individual,

age 0-17, from any cause wherein the child was in the care of a regulated provider at the time of death or at the initiation of the events that resulted in the death, regardless of the place of death.

The Center for Health and Environmental Statistics, through the Office of Vital Statistics, provides death certificate information to the tracking system. As a result, BCCHF staff identified 14 childcare-related deaths in 2007 (Figure 3).

Figure 3. 2007 Childcare Deaths by Cause



Case information collected about the deaths revealed that safe sleeping practices were not always followed. Three out of six infants placed on their backs were found unresponsive on their stomachs, two infants were found on their backs as they were initially placed, and one was found wedged (in or against bedding); one out of three infants placed on his or her side was found on his or her stomach; the unknown placement was found wedged. Infants were most often found on their stomachs, which is the found position most consistent with unresponsive infants.

Experts can't predict Sudden Infant Death Syndrome (SIDS) babies, and SIDS by definition can't be prevented. Caregivers can reduce the risks. Studies have shown that placing an infant on his or her back for sleeping reduces SIDS risk. BCCHF requires regulated providers to nap infants in approved cribs or playpens. There are no requirements presently that infants be napped on their backs.

Overall in Kansas, SIDS was responsible for 53 infant deaths in 2006. The recent trend has been an increase in SIDS deaths. As a result, KDHE is planning a media campaign to promote safe infant and childcare practices, including a focus on safe infant sleeping practices.

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## Births to Foreign-Born Mothers

The percentage of births to foreign-born mothers is increasing across the country. Nationally, this percentage has increased steadily from 15.6 percent of all births in 1990 to 24.2 percent of all births in 2004. Kansas ranked 23<sup>rd</sup> among states, with 14 percent of births to foreign-born mothers in 2004. This according to the online report *The Right Start for America's Newborns: City and State Trends* (<http://www.aecf.org/kidscount/sld.rightstart.jsp>), prepared by the

Table 9. Births to Foreign-Born Mothers By Country of Birth (Top Five), Kansas Occurrences, 2006

Rank	Country of Birth	N	%
1	Mexico	3,473	57.4
2	Vietnam	253	4.2
3	India	237	3.9
4	Germany	226	3.7
5	Guatemala	137	2.3

Annie E. Casey Foundation, based on data from the National Center for Health Statistics.

In 2006, Kansas birth certificate data showed that 14.4 percent (6,055) of births occurring in Kansas (41,918) were to foreign-born mothers. On the birth certificate a woman is identified as a foreign-born mother if she was born outside the 50 states, the District of Columbia, or U.S. territories. Over half (57.4%) of all foreign women giving birth in Kansas in 2006 were born in Mexico while around four percent each came from Vietnam, India, and Germany (Table 9). The highest concentrations of births to foreign-born Mexican mothers were in Wyandotte (26.6%), Sedgwick (23.1%), Seward (9.4%), Ford (8.3%), and Finney (7.7%) counties.

Table 10. Selected Birth Outcomes and Characteristics By Birthplace of Mother, Kansas Occurrences, 2006

Outcomes/ Characteristics	Native-Born		Foreign-Born	
	N	%	N	%
Low birth weight (<2,500 g)	2,602	7.3	354	5.8
Preterm (< 37 wks gestation)	3,413	9.5	455	7.6
Teen birth (< 20 years)	3,688	10.3	500	8.3
Less than H.S. education	4,884	13.7	2,335	39.1
College Education	10,602	29.6	1,140	19.1
Unmarried	12,482	34.8	2,064	34.1
Live birth order >= 4	4,168	11.6	985	16.3
First trimester prenatal care	26,961	78.2	3,327	60.3
No prenatal care	263	0.8	103	1.9

Not stated have been removed from totals when calculating percentages.

Maternal and newborn characteristics varied by mother's nativity for 2006 Kansas occurrence births (Table 10):

- Overall, native-born women were more likely than foreign-born women to deliver preterm (9.5% versus 7.6%) or deliver an infant with low birth weight (7.3% versus 5.8%).
- Native-born women were more likely than foreign-born women to be teenagers when they gave birth (10.3% versus 8.3%).
- In general, native-born mothers had smaller families, higher levels of educational attainment and better prenatal care.
- The percentage of foreign-born mothers who had not completed high school was nearly three (2.9) times higher than for native-born mothers.
- The percentage of foreign-born mothers who received no prenatal care was over 2 (2.4) times higher.
- Overall, the percentage of babies born to unmarried mothers was nearly identical (34.8% and 34.1%) for both groups.

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## 2007 Most Popular Baby Names

Addison and Aiden were the most popular names given to newborns by Kansas parents in 2007. For the second consecutive year, the top name for girls and for boys is uni-gender. Last year was the first time since the state began compiling a list that the top name for both girls and boys was uni-gender.

Emma, Madison, Ava and Hailey join Addison in the top five most popular girls' names list. New parents didn't stray much from past naming habits, with only one new entry in the girls' top 10: Isabella. New names in the top 25 were Avery, which entered the

top 25 for the first time, Alyssa and Chloe. Kaylee is the girl's name with the most spelling variation (31).

Aiden occupies the top spot on the boys list for the fourth year running. Jacob, in the top spot for nine years until 2004, remained at number five, behind Kaden, Ethan and Jackson. Kaden was the boy's name with the most spelling variation (28), and in 2007 parents preferred Kaden spelled with 'K'. The trend for Celtic and biblical boys' names continues with names such as--Aiden, Brayden, Conner, Gavin, Kaden, Logan, Caleb, Daniel, Ethan, Isaac, Jacob, Joshua, Joseph, Noah, and Samuel. The only new boys name in the top 10 was Christopher, and of the five new names that entered the top 25, Gavin was the only first timer.

The KDHE, Division of Health's Center for Health and Environmental Statistics prepared this information. The lists are derived from birth certificate information that the Center's Office of Vital Statistics keeps on file. The list contains names with the same pronunciation, but different spellings, to give a more accurate view of name popularity.

Popular baby names are one of the more regularly requested items produced by the Center's Office of Health Assessment. The popular baby names lists are available on the KDHE web-site at: <http://www.kdheks.gov/ches/index.html>.

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## KIC FastStats Enhanced

New data have been added to Kansas Information for Communities (KIC) FastStats' module at <http://www.dhe.state.ks.us/Kic/fs.aspx>. The site also now has an easier navigation menu. FastStats is a simple-to-use tool that allows for selection of data about Kansas counties and legislative districts.

The new features include the posting of health professionals data. New queries allow users to select health professional counts by year, county, or profession. These counts are based on health professional's county of residence. It's also possible to query for information on health professional Full Time Equivalents (FTEs). This is the count of health professionals based on their practice location. Provider per capita ratios are also available. The link to health professional data is <http://www.dhe.state.ks.us/Kic/Professionals/professionals.aspx>.

In addition, FastStats now includes comparisons of Kansas and National Quality Indicators (QIs) using an approach developed by the Agency for Healthcare Research and Quality (AHRQ). The indicators are part of an array of health care decision-making and research tools that can be used by program managers, researchers and the public.

After the Healthy People 2010 Goals were established, the KDHE published a series of health outcome indicators called Healthy Kansans 2010. FastStats now includes the 10 Leading Health Indicators which contain 19 health objectives.

Twelve of the objectives are specific to adults, six objectives are specific to children and/or adolescents and the remaining objective is an environmental objective specific to air quality. The FastStats provided at [http://www.dhe.state.ks.us/Kic/health\\_indicators.aspx](http://www.dhe.state.ks.us/Kic/health_indicators.aspx) focus solely on the adult population objectives and only those adult objectives collected by KDHE. Of the eleven KDHE-collected Kansas adult indicators, eight are measured through the Kansas Behavioral Risk Factor Surveillance System (BRFSS) and three of the objectives are measured through Kansas Vital Statistics.

This data, reported in three-year rolling periods, tracks the progress for these objectives for the state's largest counties and for the state's health preparedness regions. This was done to ensure sufficient survey results or vital event counts to produce reliable rates.

The new menu provides a simple, tiered approach to navigating the expanded Kansas Information for Communities site.

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## Population Data Available

The U.S. Census Bureau has issued its 2007 population estimates for counties by race, Hispanic origin, gender and five year age-groups. The Census Bureau provides a downloadable file through <http://www.census.gov/popest/estimates.php>. People can also obtain the data through the bureau's American Factfinder tool <http://factfinder.census.gov/home/saff/main.html?lang=en>. Another source for the data is the Missouri State Census Data Center: [http://mcdc2.missouri.edu/websas/estimate\\_reports.shtml](http://mcdc2.missouri.edu/websas/estimate_reports.shtml). At this site, the data summaries are available as downloadable PDF files.

## Youth Survey Released

The U.S. Centers for Disease Control and Prevention (CDC) has released 2007 findings from the Youth Risk Behavior Surveillance Survey (YRBSS). The YRBSS is conducted in a manner similar to the Behavior Risk Factor Surveillance Survey (BRFSS) that Kansas and most states conduct. Selected school-age youth are surveyed in YRBSS and the weighted results are then tabulated on a state and national basis. While county-level results are not available, the survey provides insight into behaviors that can contribute to morbidity and mortality among youth and adults.

Information from the report, part of CDC's Morbidity and Mortality Weekly Report, is available at <http://www.cdc.gov/HealthyYouth/yrbs/index.htm>.

Centers for Disease Control and Prevention

USA Today

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## Hospital Comparisons Possible

The Center for Medicare and Medicaid Services (CMS) has included new data on its site to enable comparison of hospitals on selected outcomes and conditions. The special site <http://hospitalcompare.com/> includes a link to compare hospitals on three conditions, <http://www.hospitalcompare.hhs.gov/hospital/mortalitytool/index.asp>. The CMS formula focuses on all deaths of heart attack, heart failure and pneumonia patients that occur within 30 days of a patient's admission to a hospital. If a patient is admitted more than once, one admission is randomly plucked out for analysis. CMS chose to include all deaths for any cause so that no death is missed that might be meaningful.

CMS picked 30-day mortality as its main benchmark of performance so it can include in the analysis patterns of deaths that might have escaped hospitals notice because the patients didn't die until several days after they were discharged.

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