

Kansas Health Statistics Report

Kansas Department of Health and Environment – Center for Health and Environmental Statistics – No 20 – February 2004

Annual Summary Reports Increased Suicide Rate, Decreased Teen Pregnancy Rate

Unintentional injury and violence (suicide and homicide) accounted for over six percent (6.4%) of all deaths recorded for Kansans in 2002. The 1,597 external cause deaths were among the 24,968 deaths analyzed in the 2002 *Kansas Annual Summary of Vital Statistics* published by the Center for Health and Environmental Statistics.

The most common single external cause of death in 2002 was motor-vehicle deaths (547), followed by suicide (346) and falls (170). Unintentional injury and violent deaths accounted for nearly 50 (49.2) percent of deaths for those 1-44 years of age.

The 2002 age-adjusted death rate for suicide was 12.6 per 1,000 standard U.S. 2000 population, an increase of 13.5 percent from the 2001 rate of 11.1.

Mortality data are just part of the wealth of information provided in the *Annual Summary*. The Center prepares the summary as part of Kansas Department of Health and Environment's fundamental responsibility for assessing the health of Kansas residents.

The data compiled are used by program managers and policy makers at state and local levels to address health concerns. Analysis of trend data, county data, and a comparison of Kansas to the nation are included.

Additional findings include:

There were 39,338 live births and 282 infant deaths to Kansas residents in 2002. This resulted in an infant mortality rate of 7.2 deaths per 1,000 live births and was a decrease of 1.4 percent from the infant mortality rate of 7.3 in 2001.

The teen pregnancy rate continued to decline in 2002. The pregnancy rate for females aged 10-19 decreased 18.7 percent from 34.8 pregnancies per 1,000 in 1992 to 28.3 in 2002. Teen pregnancy rates for females ages 10-17 decreased 26.6 percent during this same timeframe. Teen

pregnancies are defined as the sum of live births, fetal deaths, and abortions.

- The abortion ratio for Kansas residents in 2002 was 160.1 per 1,000 live births, a decrease of 2.7 percent from the 164.6 ratio in 1992. Ratios increased from 1991 to a high of 186.3 in 1996, and then generally declined for the next six years.
- The out-of-wedlock birth ratio has continued an upward trend over the years in both Kansas and the U.S. Out-of-wedlock births comprised 30.8 percent of all live births that occurred to Kansas residents in 2002, a 26.7 percent increase from 24.3 percent of live births in 1992. The U.S. out-of-wedlock birth ratio in 2002 was 33.8 percent. The Kansas ratio was 8.9 percent lower than the U.S. proportion.

The average age at death of Kansas residents in 2002 was 74.4 years. The average age at death for males was 70.3 years, for females 78.0. The average age at death for blacks was 64.1 years compared to 75.1 for whites.

The age-adjusted death rate for the leading cause of death, heart disease, was 219.2; and for cancer, the second leading cause of death, the age-adjusted death rate was 187.5 per 100,000 standard U.S. 2000 population. Together, these two causes accounted for almost 50 percent of all Kansas resident deaths.

Couples in Kansas had fewer marriages and divorces in 2002, continuing a general downward trend. In 2002, 19,783 marriages occurred in Kansas, a decrease of 3.3 percent from the 2001 total of 20,457. The marriage rate (7.3 per 1,000 population) decreased 16.1 percent from the 1992 rate of 8.7. A long downward trend in Kansas marriage dissolutions that began in the early 1990s continued in 2002. The 9,654 divorces and annulments represented a 2.4 percent decrease compared to the 2001 figure of 9,885 dissolutions. The marriage dissolution rate (3.6) was 26.5 percent lower than the 1992 rate of 4.9.

The 2002 *Annual Summary* is available in a PDF format at <http://www.kdhe.state.ks.us/hci/annsumm.html>

Karen Sommer
Vital Statistics Data Analysis

Table 1. Selected Vital Event Rates & Ratios, Kansas, 2001-2002

Vital Event	2001	2002
Live Births		
Number	38,832	39,338
Rate	14.4	14.5
Out-of-Wedlock Births		
Number	11,592	12,129
Ratio	29.9	30.8
Fetal Deaths		
Number	209	146
Rate	5.4	3.7
Hebdomadal Deaths (Under 7 days)		
Number	148	155
Rate	3.8	3.9
Perinatal Period III Deaths (Fetal & Hebdomadal)		
Number	357	301
Rate	9.1	7.6
Neonatal Deaths		
Number	178	192
Rate	4.6	4.9
Infant Deaths		
Number	285	282
Rate	7.3	7.2
Maternal Deaths		
Number	1	2
Rate	0.3	0.5
Deaths		
Number	24,590	24,968
Rate	9.1	9.2
Marriages		
Number	20,457	19,783
Rate	7.6	7.3
Divorces and Annulments		
Number	9,885	9,654
Rate	3.7	3.6
Abortions		
Total Reported	12,422	11,844
Kansas Residents	6,419	6,298
Out of State Residents	6,003	5,546

Residence data presented for births and deaths. Occurrence data presented for marriages, divorces, and annulments.

KIC System Updated

KIC, or Kansas Information for Communities, is the interactive web tool provided by the Center for Health and Environmental Statistics for reporting vital and other health care data online. The system is continuously being enhanced with new features and with new data as it becomes available. Recently, KIC has undergone improvements in not only new data, but also in appearance and functionality.

Currently, the KIC system provides data for the following Kansas

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events: births, deaths, hospital discharge, reportable disease, population, and pregnancy outcomes. Kansas City Metro Area deaths are also available. Data ranging up to year 2002 is available for nearly all events. New queries, such as marriages and cancer, are planned for the future.

KIC web pages have been modified in a manner to provide consistency and ease of use. Features such as navigation links, common headers/footers, structured page layouts, and a "new updates" page are just a few examples of the recent changes.

The KIC site is available at: <http://kic.kdhe.state.ks.us/kic/>

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Health Care - Who Pays the Bill

Health care expenditures are increasingly coming to the forefront. As costs creep up, insureds are being required to pay more and more of their health care bill.

Hospitalization is one of the most expensive segments of our health care system—understandably so—treating the very ill or performing the most complex of procedures requires significant amounts of expertise and resources.

Kansas hospital data maintained by the Kansas Hospital Association were recently evaluated with regard to payers of services. Table 2 summarizes the distribution of hospital discharges by payer for Kansas.

Table 2. Distribution of Discharges by Payer

Pay Source	2002	2001	2000	1999	1998	1997
Medicare	38.5%	38.4%	38.6%	40.4%	41.0%	40.7%
Medicaid	11.7%	10.8%	11.2%	10.6%	10.4%	11.3%
Private Pay	41.7%	42.5%	41.6%	39.6%	37.9%	36.1%
Self-Pay	3.7%	3.8%	4.1%	4.8%	5.1%	5.8%
Other	4.4%	4.5%	4.6%	4.8%	5.6%	6.0%

Source: Kansas Hospital Association: Stat Book 2002

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Safety Net Monitoring Initiative

A rich source of state and county level data exists in the Safety Net Monitoring Initiative, developed by the Agency for Healthcare Research and Quality (AHRQ) and the Health Resources and Services Administration (HRSA). Users can obtain on-line data addressing poverty levels to preventable/avoidable hospital discharges. In some instances data may be suppressed because of small numbers.

The health care safety net is the nation's system of providing health care to low-income and other vulnerable populations. The initiative's goal is to help local policymakers, planners, and analysts monitor the status of their local safety nets and the populations they serve. Strategies include providing baseline data and a set of tools that enable monitoring of the capacity and performance of local safety nets.

In 2000, the Institute of Medicine (IOM) released a report describing the health care safety net—the Nation's "system" of providing health care to low-income and other vulnerable populations—as "intact but endangered." In particular, the report emphasizes:

- ⚡ The precarious financial situation of many institutions that provide care to Medicaid, uninsured, and other vulnerable patients,
- ⚡ The changing financial, economic, and social environment in which these institutions operate, and
- ⚡ The highly localized, "patchwork" structure of the safety net.

One of the five key recommendations in the report is the need for data systems and measures. In response, AHRQ and HRSA established the monitoring system.

The monitoring system has four main goals:

- ⚡ Provide baseline information and an assessment of policy-makers' information needs for the safety net system and its environment,
- ⚡ Establish an early warning system to alert policymakers to changes in safety net capacity and stability,
- ⚡ Provide information to policymakers about the status of safety net providers and the populations they serve that can help in designing interventions and strategies to achieve policy objectives, and
- ⚡ Develop and implement a research agenda on safety net and access-related issues for low-income populations.

To accomplish these goals, there is a critical need to:

- ⚡ Develop clearer knowledge of what needs to be measured,
- ⚡ Identify data and measures that are currently available,
- ⚡ Identify opportunities and strategies to develop data capacity, and
- ⚡ Assess the feasibility of monitoring these areas.

The agencies involved have agreed to a three-part strategy focusing on both safety net providers and the populations they serve:

- ⚡ Creating two data books that describe baseline information on a wide variety of local safety nets. Selecting for details on measures in the data books,
- ⚡ Developing a tool kit for State and local policymakers, planners, and analysts to assist them monitor the status of their local safety nets, and
- ⚡ Identifying the data elements that would be needed to effectively monitor the capacity and performance of local safety nets.

The health care safety net consists of a wide variety of providers delivering care to low-income and other vulnerable populations, including the uninsured and those covered by Medicaid. Many of these providers have either a legal mandate or an explicit policy to provide services regardless of a patient's ability to pay.

Major safety net providers include public hospitals and community health centers as well as teaching and community hospitals, private physicians, and other providers who deliver a substantial amount of care to these populations.

For more information on the Safety Net Monitoring Initiative visit <http://www.ahrq.gov/data/safetynet/> or e-mail: safenet@ahrq.gov

Kansas Oral Health Grade Poor

An Oral Health America survey of the 50 states scored the nation and Kansas with a grade of D for oral health for older citizens. Medicaid service reimbursement rates in Kansas and 39 other states had a grade of F. Older adult private dental coverage in Kansas had a grade of C compared to the U.S. grade of D.

The survey, funded in part by the W.K Kellogg Foundation, concluded, "Limited access to oral health care poses one of the greatest crises for the health and well being of America's elderly." A copy of the full report is on the Internet and can be obtained at <http://www.oralhealthamerica.org/Report%20Card.htm>.

For more information on the Kansas Department of Health and Environment (KDHE) Oral Health Initiative, visit the KDHE web site at <http://www.kdhe.state.ks.us/ohi/index.html>.

KDHE Bureau for Children Youth and Families

U.S. Infant Mortality Increases

A National Center for Health Statistics (NCHS) report of preliminary 2002 mortality data indicates an increase in the infant mortality rate (IMR) to 7.0 deaths per 1,000 live births from 6.8 in 2001. According to NCHS this would be the first IMR increase since 1958.

Further analyses of the data are expected. The 2002 increase was concentrated in the neonatal period, particularly in the deaths occurring within seven days of birth.

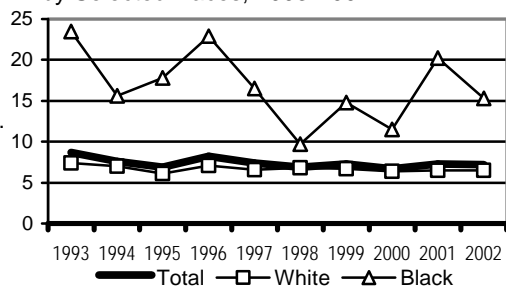
Table 3. Infant Death Rates by Race & Hispanic Ethnicity Of Mother, Kansas, 1993-2002

Year	All	White	Black	Other	Hispanic
1993	8.7	7.4	23.5	6.2	7.8
1994	7.6	7.0	15.6	5.6	5.6
1995	6.9	6.1	17.8	3.3	6.0
1996	8.2	7.1	22.9	4.5	5.6
1997	7.4	6.6	16.5	5.8	8.2
1998	6.9	6.8	9.7	0.7	6.5
1999	7.3	6.7	14.8	6.0	3.6
2000	6.7	6.4	11.5	5.1	6.7
2001	7.3	6.5	20.2	3.9	7.4
2002	7.2	6.5	15.3	5.4	8.0

Rate per 1,000 live births
Hispanic Origin may be of any race.
Residence data

Kansas' IMR dropped in 2002 to 7.2 deaths per 1,000 live births from 7.3 in 2001 (Table 3). Kansas' IMR has dropped by 17.2 percent since 1993. Disparity continues to exist in the IMR among Whites and Blacks (Figure 1).

Figure 1. Kansas Infant Mortality Rates by Selected Races, 1993-2002



Recent declines in infant mortality are attributed to improvement in birth weight and gestation-specific infant mortality rates, not prevention of preterm or low birth weight births. Credit for some of the declines has been attributed to improvements in obstetric and neonatal care, such as pulmonary surfactants for preterm infants. Kansas data is in the *Annual Summary of Vital Statistics* at <http://www.kdhe.state.ks.us/hci/as02/as2002.html>

CDC National Center for Health Statistics
KDHE Center for Health and Environmental Statistics

2002 Vital Statistics Reports Available

The Center for Health and Environmental Statistics has released 2002 reports on teenage pregnancies and adequacy of prenatal care.

The *Teenage Pregnancy Report, Kansas, 2002* summarizes data collected from vital records on fetal deaths, abortions, and live births. The report includes nine county-level tables containing pregnancy totals and rates for various age groups from 10-19.

The *Adequacy of Prenatal Care Utilization Index, Kansas, 2002* utilizes information readily available on the Kansas birth certificate (number of prenatal care visits, month prenatal care began, and gestational length of pregnancy). The index com-

bines information on the adequacy of initiation of prenatal care and the adequacy of received services for the purpose of evaluating access and utilization of prenatal care. State and county level tables are included in the report.

Both reports are available on the KDHE Website at: <http://www.kdhe.state.ks.us/ches/>. Reports for earlier years can also be found at this location.

Office of Health Care Information

Vital Statistics Upgrade in Software Development Phase

After months of work, the Center for Health and Environmental Statistics is nearing finalization of birth and death certificates that will be implemented in January 2005. The revision, the first since 1989, is accompanied by a re-engineering of the Vital Statistics system.

The current Vital Statistics process is largely paper driven. The upgrade positions the Center closer to an all electronic registration process. The new system uses a secure web-enabled process for birth registration and sets the stage for implementation of a web-enabled electronic death registration system.

The impetus for the change is the national revision of birth and death certificates. State Registrars, including Dr. Lorne A. Phillips, met with National Center for Health Statistics staff to develop standard certificates that every state would adopt for data collection and submission. This enables the collection of a uniform national dataset.

There will be little change on the issuable portion of the revised certificates. The certificate is still a civil registration document. The confidential or medical portion will be changing.

More information will be collected on tobacco use: the number of cigarettes smoked daily before and during the pregnancy and whether tobacco contributed to an individual's death. Birth certificates will collect data on payment for the birth, enabling researchers to better analyze birth outcomes by healthcare coverage. Other changes include collecting new perinatal characteristics about the birth and mother.

In keeping with the Office of Management and Budget Directive 15 on reporting race, the certificates will alter the way race data is collected. Persons will be able to check as many of the 15 available race categories as are applicable. Multiple races will be possible through this change. Expanded Hispanic ethnicity categories will also be included. The certificate will also continue to collect ancestry information. Four countries of origin will be accepted.

The department hired Man Tech Technologies, Inc., a software developer with previous experience in creating Vital Statistics data systems, to re-engineer the Kansas system. The firm has developed systems for a number of other states. Among the system's features will be a bar coding process to facilitate the matching of the paper birth certificates with data received from a hospital. To reduce problems and errors, Vital Statistics staff will be able to communicate effectively with hospitals via the web-based system.

Concurrent with the upgrade, the Center's Office of Vital Statistics is scanning birth certificates from prior to 1925 to optical disk. Once the scanning is complete, staff will be able to quickly search and issue certificates back to 1911 from optical images. Currently those records are saved to aging microfilm and in some cases referenced via old hand-written indexes.

The upgrade has been an effort involving almost everyone in the Center as well as other KDHE employees. Staff, who work with the documents daily, have provided valuable insight into how to make the process more efficient while maintaining the Center's ability to provide certified copies in a timely manner. Other KDHE

employees have commented on items to be added to the certificates and provided input on data system structure.

The Center's goal is to have the new system online and operating by January 2005.

*Greg Crawford
Center for Health and Environmental Statistics*

Specialty Hospitals Increase in Kansas

The Kansas Health Institute, in an Issue Brief called "The Growth of Specialty Hospitals in Kansas: What Effect Do They Have on Community Health Services," reviews the impact of this new kind of health care facility that provides services for a particular specialty, like cardiology or orthopedics. The institute reports that the nine specialty hospitals in five Kansas communities is more than one would expect based on the nationwide total.

Rapid growth of these facilities is fueled by their profitability and the ease of establishing new hospitals in Kansas. KHI concludes that competition from specialty hospitals threatens the revenue base that general hospitals have traditionally used to subsidize unprofitable community health services such as uncompensated care.

The growth of specialty hospitals may present some policy issues for the state. Kansas will have to weigh the desire for innovation and market-based solutions against the threat that specialty hospitals pose to community health services at general hospitals. The Institute notes that avoiding the trade-off may require a more explicit source of funding for such services.

Nationally, about 100 specialty hospitals existed as of December 2003, mostly in states like Kansas that have no Certificate of Need regulations. Certificate of Need, which requires hospitals to obtain state approval before building or expanding, ended in Kansas in 1985.

Kansas Health Institute

Governor's Office of Health Planning and Finance Underway

In October 2003, Governor Sebelius established the Governor's Office of Health Planning and Finance (OHPF) to address the approaching health care crisis with a comprehensive plan that focuses on the issues of quality, affordability, accessibility and financing. The OHPF is completely grant funded, through three leading health foundations in the state.

The purpose and charge of the office are to:

- ✍ serve as the convener of health policy initiatives that assures cross agency coordination and collaboration;
- ✍ serve as coordinator of health and health care policy initiatives brought forth by the Kansas Health and Human Services Cabinet Team members and approved by the Governor;
- ✍ coordinate public purchasing of health care by state agencies to improve quality and the cost-effectiveness of health care services; and
- ✍ bring together providers, advocates, key Cabinet officials, elected officials, and business leaders to plan a comprehensive approach to addressing the key issues of cost, quality and accessibility.

At the request of the Governor, the OHPF will develop a multi-year plan to address issues of health and health care that focuses on short, middle and long term solutions to the issues of affordability, accessibility and quality. More information on the OHPF can be found at <http://www.ksgovernor.org>, under "Policies, Initiatives & Grants."

Governor's Office of Health Planning and Finance

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