

Kansas Health Statistics Report

Kansas Department of Health and Environment – Center for Health and Environmental Statistics – No 21 – May - 2004

Overweight Among Adolescents in Kansas: A First Look

Background

Numerous government reports and the medical literature have documented the increase in the prevalence of overweight and obesity among both adults and children in the United States over the past two decades. Data from the National Health and Nutrition Examination Survey (NHANES) indicate that the prevalence of obesity (body mass index (BMI) greater than or equal to 30) among adults (ages 20 years and older) has increased significantly in recent years, from 23 percent in 1994 to 31 percent in 2000 (Centers for Disease Control and Prevention, 2003).

The prevalence of overweight (defined as BMI-for-age at or above the 95th percentile of the CDC Growth Charts) among children (6–11 years of age) increased from four percent in 1965 to 13 percent in 1999. The percentage of overweight among adolescents (12–19 years of age) increased from five percent in 1970 to 14 percent in 1999 (Centers for Disease Control and Prevention, 2002). This is of particular concern because older children who are overweight are at greater risk of becoming overweight or obese adults.

State-based estimates in the trends in health status and health behaviors, including the prevalence of overweight and obesity, are derived primarily from the Behavioral Risk Factor Surveillance System (BRFSS) for adults and the Youth Risk Behavior Surveillance System (YRBSS) for adolescents in grades 9–12. Kansas has participated in the adult BRFSS since 1992, and has therefore successfully documented the increase in the prevalence of obesity among adults in Kansas, from 13.1 percent in 1992 to 21.6 percent in 2001. However, reliable statewide estimates from the Kansas YRBSS have been limited due to small sample sizes.

In an effort to assess the prevalence of overweight among adolescents in Kansas, questions on self-reported height and weight from the YRBSS were added to the Kansas Youth Tobacco Survey (KYTS), a statewide survey of youth attitudes, beliefs, and behaviors related to tobacco, during the 2002-2003 school year. This report summarizes results from the statewide survey.

Methods

The methods of the Youth Tobacco Survey were similar to the Youth Risk Behavior Surveillance System. A stratified, two-stage cluster sampling technique was utilized. In the first stage, 50 schools containing grades 6-8 and 50 schools containing grades 9-12 were randomly selected from all public and private schools in Kansas. In the second stage, two to four classes were selected randomly from all participating schools. All students in selected classes were invited to participate in the survey. A standardized, self-administered questionnaire was conducted in the classroom.

Data Analyses

Sample weights were applied to the data to account for the complex sample design and non-response bias such that results represent the population of Kansas adolescents in grades six

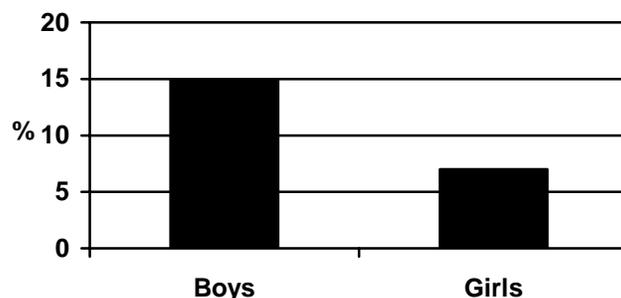
through 12 as a whole. Prevalence estimates and 95 percent confidence intervals were derived using SUDAAN software. All results presented in this report are weighted.

Body mass index (BMI) was calculated from self-reported height and weight (BMI = weight in kilograms divided by height in meters squared). The BMI is widely used in population health studies and has been shown to correlate well with adiposity. Overweight was defined as BMI-for-age at or above the 95th percentile of the CDC Growth Charts. At risk for overweight was defined as BMI-for-age at or above the 85th percentile, but below the 95th percentile of the CDC Growth Charts.

Results

At the middle school level, 37 of 50 schools selected agreed to participate (74%) and 1,489 students out of 1,711 selected agreed to participate (87%), for an overall response rate of 64.4%. At the high school level, 41 of 49 schools selected agreed to participate (83.7%) and 1,517 of 1,811 students selected agreed to participate (83.8%), for an overall response rate of 70.1%. Overall response rates were calculated by multiplying the percentage of schools participating by the percentage of students in those schools that participated.

Figure 1. Percentage of Adolescents who are Overweight, by Sex, Kansas, 2002-2003



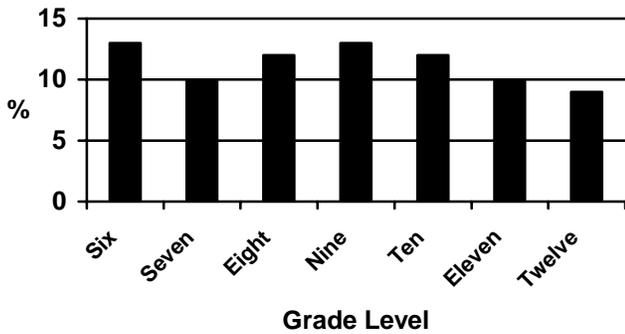
Overall, 11 percent of adolescents in grades six to 12 were overweight and 13.6% were at risk for overweight. This is comparable to the national estimates of overweight and at risk for overweight among adolescents in grades 9-12 reported from the YRBSS (10.5% and 13.6%, respectively).

As shown in Figure 1, the prevalence of overweight was 2.1 times higher among boys than among girls (15% compared to 7%, respectively). Although the prevalence of overweight varied by grade level, there did not appear to be a consistent trend by grade level (Figure 2).

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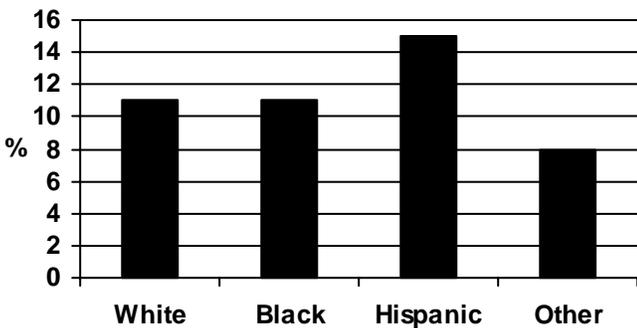
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Figure 2. Percentage of Adolescents Who are Overweight, by Grade Level, Kansas, 2002-2003



The prevalence of overweight adolescents was substantially higher among Hispanics than among other race/ethnic groups, as shown in Figure 3. (Note: Hispanic ethnicity was not collected separately from race.)

Figure 3. Percent of Adolescents who are Overweight, by Race/Ethnicity, Kansas, 2002-2003



Discussion

These data suggest that the prevalence of overweight among adolescents in Kansas is similar to the prevalence in the U.S. as a whole. Although historical data are not available in Kansas, it is reasonable to assume that the substantial increases in the prevalence of overweight that has occurred among adolescents in the U.S. has also occurred in Kansas.

Additional data on overweight and associated factors, for both children and adults, are needed in Kansas to guide public health planning efforts at both the state and local levels. The Office of Health Promotion is currently planning a statewide child health study that will provide a comprehensive assessment of nutritional behaviors, physical activity, and overweight among children in kindergarten through grade 12. The Kansas Child Health Assessment and Monitoring Project (K-CHAMP) will provide data important to public health planning and policy development, establish a model and infrastructure for comprehensive child health assessment, and establish baseline data to enhance and expand future funding opportunities to address overweight and obesity in Kansas.

Funding for K-CHAMP is provided by the Sunflower Foundation: Health Care for Kansans, a Topeka-based philanthropic organization with the mission to serve as a catalyst for improving the health of Kansans.

References

Centers for Disease Control and Prevention, U.S. Department of Health and Human Services (2002). Overweight among U.S. Children and Adolescents. National Health and Nutrition Examination Survey Data Brief. Hyattsville, MD: Author.

Centers for Disease Control and Prevention, U.S. Department of Health and Human Services (2003). Healthy weight, overweight, and obesity among U.S. adults. National Health and Nutrition Examination Survey Data Brief. Hyattsville, MD: Author.

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Occupational Fatalities, How Kansas Compares to Surrounding States

From the 1995-1998 reporting period to the 1999-2002 reporting period, work related fatalities in Kansas declined by over four percent, while surrounding states reported both larger and smaller decreases in occupationally-related mortality (Table 1). The data are contained in a report based on survey efforts by the Center for Health and Environmental Statistics. The Center's occupational injury surveillance section collects fatality data as part of the Census of Fatal Occupational Injury Program (CFOI). Data collection is conducted in cooperation with the U.S. Department of Labor, Bureau of Labor Statistics (BLS).

Among the six surrounding states, the change in mortality between reporting periods ranged from a 25.0 percent increase to a 16.7 percent decrease. The report compares occupational fatalities from two four-year periods 1995-1998 and 1999-2002.

Table 1. Fatal Occupational Injuries For Selected States, 1995-1998 and 1999-2002

State	1995-1998	1999-2002	Percent Change
Nebraska	212	265	+ 25.0
Colorado	399	485	+ 21.6
Missouri	533	633	+ 18.8
Iowa	272	269	- 1.1
Kansas	371	355	- 4.3
Arkansas	368	330	- 10.3
Oklahoma	466	388	- 16.7

Source: U.S. Department of Labor, Bureau of Labor Statistics, in cooperation with State and Federal agencies, Census of Fatal Occupational Injuries.

Three states (Nebraska, Colorado, and Missouri) in the seven states examined had double-digit increases between the two four year periods, and two states (Arkansas and Oklahoma) had double-digit decreases. Nebraska had the greatest increase when the two four-year periods were examined with a 25 percent increase in deaths. Oklahoma was at the opposite extreme with the largest decrease of the seven states at -16.7 percent. Iowa and Kansas experienced the least change of the seven states, with decreases of 1.1 percent and 4.3 percent, respectively.

Additional details about fatal occupational injuries in Kansas can be obtained by contacting: Office of Health Care Information, Occupational Injury Surveillance Section at 785-296-1058. Data for the U.S. or other states may be obtained by accessing the BLS Web site at <http://www.bls.gov>.

Two publications recently released by BLS are *Fatal Occupational Injuries in the United States, 1995-1999*, a chart book, Report 965, and *Fatal Workplace Injuries in 2001: A collection of Data and Analysis, Report 970*. Both of these documents can be obtained by contacting BLS at: Bureau of Labor Statistics Information Unit, 1100 Main St., Ste. 600, Kansas City, MO 64105-2112, Phone 816-426-2481.

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Occupational Injury Surveillance

Report Finds Kansas' Law Still Leaves Many Riding at Risk

In a report released in observance of Child Passenger Safety Week, the National SAFE KIDS Campaign announced that Kansas is among the half of the states in the country whose child occupant protection laws, leave many children unprotected while riding in motor vehicles. The report *Closing the Gaps Across the Map: A Progress Report on SAFE KIDS' Efforts to Improve Child Occupant Protection Laws* reviews improvements in laws since 2001 and summarizes gaps that have yet to be bridged.

In its 2001 report, *A National Rating of Child Occupant Protection Laws*, SAFE KIDS stringently measured child occupant protection laws in all 50 states and the District of Columbia against a model law that requires correct restraint of all children, in all seating positions, in the care of all drivers. In the report, Kansas received a failing grade in part because children aged 4-8 who should be in booster seats were allowed under Kansas law to be buckled in an adult safety belt alone. Other gaps included inadequate penalties and failure to cover children over the age of 13.

Since then, Kansas SAFE KIDS and its partners have been working to upgrade the Kansas law. Legislation considered by the 2004 Kansas legislature would have closed many of the gaps in Kansas' current law by:

- Requiring appropriate child restraints for children until they are age 8 or 4'9" or 80 lbs,
- Requiring children ages 8 -18 to wear seat belts at all times,
- Increasing the fine, and
- Including a one-year phase-in period for new requirements to allow for appropriate public education.

Motor vehicle crashes are the leading cause of death for Kansas children ages one through 17. Observational surveys conducted in 2002-2003 found that while 79 percent of Kansas children ages 0-4 were in child seats, only 45 percent of children ages 5-9 and 44 percent of children ages 10-14 were protected by a booster seat or seat belt.

Seventy-two percent of Kansas children ages 0-14 killed in motor vehicle crashes in 2002 were not using safety belts or child safety seats. For information on child safety seats or loaner programs, call the Kansas SAFE KIDS hotline at 1-800-332-6262. The entire SAFE KIDS report, *Closing the Gaps Across the Map: A Progress Report on SAFE KIDS' Efforts to Improve Child Occupant Protection Laws*, along with booster seat crash test footage, can also be accessed at <http://www.safekids.org>.

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2003 Preliminary Abortion Report Issued

Total reported Kansas abortions were 11,697 in 2003 (Table 2). The figure represents a 1.2 percent decrease from the 2002 total of 11,844. Kansas residents obtained 6,163 abortions, 135 (2.1%) fewer than the prior year. Out-of-state residents obtained 5,534 abortions, 12 (0.2%) less than the prior year.

Fifty eight (58.4) percent of all reported abortions were to women aged 20-29, 81.1 percent were unmarried and 71.5 percent were white. The number of abortions to women of Hispanic origin increased six (5.9) percent from 2002 and accounted for 7.4 percent of all abortions in 2003.

Eighty five (84.6) percent of all reported abortions were performed prior to the 13th week of gestation, while only 8.1 percent of abortions were performed after 16 weeks gestation. The number of procedures performed to women at 22 weeks gestation or greater, decreased by 73 (12.9%) to 491 in 2003. Procedures

performed at 22 weeks or greater accounted for less than five (4.2) percent of all reported abortions.

No partial birth procedures were performed in 2003. Procedures involving Digoxin/Induction decreased by 64 (12.1%) to 464 in 2003. The use of methotrexate (medical procedure II) decreased by 34 (11.0%) to 276. The number of procedures using mifepristone (RU 486 – medical procedure I) increased by 22 (3.3%) to 689.

Table 2. Abortions in Kansas by Selected Characteristics, 2003

Selected Statistics	N	Percent
<i>Residence</i>		
Total Reported	11,697	100.0
Number of in-state residents	6,163	52.7
Number of out-of-state residents	5,534	47.3
<i>Age Group of Patient:</i>		
Under 15 years	78	0.7
15-19 years	2,005	17.1
20-24 years	4,217	36.0
25-29 years	2,615	22.4
30-34 years	1,579	13.5
35-39 years	869	7.4
40-44 years	312	2.7
45 years and over	22	0.2
<i>Race of Patient:</i>		
White	8,342	71.5
Black	2,708	23.1
Native American	118	1.0
Chinese	76	0.6
Japanese	7	0.1
Hawaiian	3	0.0
Filipino	18	0.2
Other Asian or Pacific Islander	325	2.8
Other Nonwhite	76	0.7
Not Stated	24	n.a.
<i>Hispanic Origin 1</i>		
Hispanic	870	7.4
Non-hispanic	10,827	92.6
<i>Marital Status of Patient:</i>		
Married	2,202	18.9
Unmarried	9,462	81.1
Not Stated 2	33	n.a.
<i>Weeks Gestation:</i>		
Less than 9 weeks	7,077	60.6
9-12 weeks	2,806	24.0
13-16 weeks	854	7.3
17-21 weeks	455	3.9
22 weeks & over	491	4.2
Not Stated 3	14	n.a.
<i>Method of Abortion:</i>		
Suction curettage	9,320	79.7
Sharp curettage	11	0.1
Dilation & Evacuation	933	8.0
Medical Procedure I	689	5.9
Medical Procedure II	276	2.3
Intra-uterine prosta-glandin instillation	1	0.0
Hysterotomy	2	0.0
Hysterectomy	1	0.0
Digoxin/Induction	464	4.0
"Partial Birth" Procedure	0	0.0
Other	0	0.0

1 Hispanic origin may be of any race.

2 Patient (s) refused to provide information

3 Information not collected by other states

The number of physician certifications reported in 2003 was 11,969.

The report is available at <http://www.kdhe.state.ks.us/hci/absumm.html>.

Office of Health Care Information

2003 Population Estimates Released

Kansas county population estimates for 2003 have been released by the U.S. Census Bureau. Shown in Table 3 are county estimates as of July 1, 2003. Kansas increased slightly (0.3 percent) in population from 2,715,884 residents in 2002 to 2,723,507 in 2003.

Table 3. Kansas County Population Estimates
July 1, 2003

County	Total	County	Total
Total	2,723,507		
Allen	13,907	Linn	9,722
Anderson	8,208	Logan	2,855
Atchison	16,741	Lyon	35,805
Barber	5,034	Marion	13,299
Barton	27,467	Marshall	10,589
Bourbon	15,086	McPherson	29,346
Brown	10,442	Meade	4,662
Butler	61,127	Miami	29,187
Chase	3,107	Mitchell	6,707
Chautauqua	4,185	Montgomery	34,934
Cherokee	21,815	Morris	5,995
Cheyenne	2,955	Morton	3,317
Clark	2,333	Nemaha	10,500
Clay	8,573	Neosho	16,580
Cloud	9,859	Ness	3,158
Coffey	8,815	Norton	5,796
Comanche	1,915	Osage	16,784
Cowley	35,860	Osborne	4,179
Crawford	38,398	Ottawa	6,177
Decatur	3,295	Pawnee	6,796
Dickinson	19,255	Phillips	5,657
Doniphan	8,149	Pottawatomie	18,714
Douglas	102,983	Pratt	9,437
Edwards	3,275	Rawlins	2,843
Elk	3,167	Reno	63,832
Ellis	27,212	Republic	5,307
Ellsworth	6,347	Rice	10,412
Finney	39,176	Riley	62,291
Ford	33,012	Rooks	5,417
Franklin	25,540	Rush	3,418
Geary	26,313	Russell	6,907
Gove	2,910	Saline	53,737
Graham	2,808	Scott	4,806
Grant	7,745	Sedgwick	462,896
Gray	6,063	Seward	23,091
Greeley	1,420	Shawnee	170,902
Greenwood	7,485	Sheridan	2,662
Hamilton	2,666	Sherman	6,277
Harper	6,206	Smith	4,181
Harvey	33,502	Stafford	4,589
Haskell	4,246	Stanton	2,404
Hodgeman	2,151	Stevens	5,389
Jackson	13,017	Sumner	25,256
Jefferson	18,798	Thomas	7,933
Jewell	3,433	Trego	3,103
Johnson	486,515	Wabaunsee	6,767
Kearny	4,591	Wallace	1,621
Kingman	8,382	Washington	6,131
Kiowa	3,152	Wichita	2,447
Labette	22,259	Wilson	10,080
Lane	1,946	Woodson	3,631
Leavenworth	71,546	Wyandotte	157,091
Lincoln	3,498		

Source: Population Division, US Census Bureau
Release Date: April 9, 2004

You can access this table and additional Kansas estimates through the Internet at: <http://www.census.gov/>.

US Census Bureau

Hospital Performance in the Kansas City Region: A Quality Initiative

Kansas City area hospitals, local employers, managed care organizations, and others evaluated nationally recognized quality of care indicators to provide patients, employees, and the general public with information about the quality of care provided by these hospitals. By collecting quality performance data and reporting it to the public, hospitals in the Kansas City metropolitan area will be able to inform the public about health care quality and, over time, improve patient care by identifying specific areas for improvement.

The full report, covering quality performance measures on patients discharged from April 1 through September 30, 2003, examines how often heart attack, heart failure, and pneumonia patients were given the recommended care based on current guidelines. The initiative is a first step for Kansas to make health care facility performance information available to the public.

Currently recommended care for heart attack patients:

- giving an aspirin and a drug called a beta-blocker within 24 hours of arrival at the hospital, if they are appropriate for the patient,
- giving a medication to reduce the workload of the heart, if the function of the heart has been impaired, and
- giving a prescription for aspirin and a drug called a beta-blocker when the patient leaves the hospital, if they are appropriate for the patient.

Currently recommended care for heart failure patients:

- performing a diagnostic test to determine if the heart's function is impaired, if the test has not been done previously, and
- giving a medication to reduce the workload of the heart, if the heart's function has been impaired.

Currently recommended care for pneumonia patients:

- giving the patient an antibiotic within four hours of arrival at the hospital,
- performing a diagnostic test to determine if the patient is receiving enough oxygen, and
- screening pneumonia patients to determine if they had previously received a pneumonia vaccine and providing the vaccine to the patient if there are no contraindications.

The report is available at <http://www.healthykansascity.org/cms/>.

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Hospital Discharge Differences Among Female Age Groups

Concern exists whether younger women experience more pregnancy-related conditions than older women. An analysis looked at average length of stay (LOS) differences to determine whether young women were more adversely affected by complications in the birth process.

The analysis reviewed seven years of data from the Kansas Hospital Discharge dataset (1). It looked at all discharges vs. discharges for complications of pregnancy, childbirth, and puerperium. The period of time covered was 1995 to 2001. The analysis was conducted using Clinical Classification Software (CCS) (2).

Average LOS for selected hospitalizations for women did not differ statistically between females aged 12-19 and females aged 20-44. For all discharges involving females, the difference in average LOS between younger and older females was 1.16 days

(4.42 – 3.26) (Table 4). However, within the diagnostic category pertaining to childbirth complications the difference in average LOS was merely 0.06 (2.17 – 2.11).

Table 4. Average Length of Stay Among Selected Female Age Groups, Kansas Residents, 1995-2001

	N of Discharges	Mean LOS
<i>All Diagnoses</i>		
All Discharges	2,078,063	4.42
Females 12-19	1,665,170	4.70
Females 20-44	412,893	3.26
<i>Complications of Pregnancy, Childbirth and Puerperium</i>		
All Discharges	256,930	2.16
Females 12-19	228,172	2.17
Females 20-44	28,509	2.11

Kansas Hospital Association Discharge Dataset

When the category “Complications of pregnancy, childbirth, and puerperium” is broken down into its components (CCS Level 2 Diagnostic Categories) differences in average LOS begin to appear. The greatest difference between the two female age groups was “hemorrhage during pregnancy,” (0.86) (Table 5). The least difference was for “Hypertension complicating pregnancy” and “Malposition” (0).

Table 5. Average Length of Stay CCS Level 2 Diagnostic Categories Among Selected Female Age Groups, Kansas Residents, 1995-2001

Level 2 Diagnostic Groups	Females 20-44	Females 12-19	Difference
Hemorrhage during pregnancy - abruptio placenta- placenta previa	3.46	2.60	0.86
Postabortion complications	2.84	2.14	0.70
Induced abortion	1.81	1.28	0.53
Early or threatened labor	2.73	2.39	0.34
Polyhydramnios and other problems of amniotic cavity	3.11	2.83	0.28
Ectopic pregnancy	2.16	1.88	0.28
Previous C-section	2.51	2.31	0.19
Spontaneous abortion	1.25	1.07	0.18
Other complications of birth - puerperium affecting management of mother	2.08	2.02	0.06
Normal pregnancy and/or delivery	1.62	1.58	0.04
Other complications of pregnancy	2.22	2.19	0.03
Forceps delivery	1.73	1.71	0.02
Hypertension complicating pregnancy- childbirth and the puerperium	2.98	2.98	0.00
Malposition - malpresentation	2.79	2.79	0.00
Trauma to perineum and vulva	1.66	1.68	-0.02
Umbilical cord complication	1.65	1.68	-0.03
Fetal distress and abnormal forces of labor	2.22	2.34	-0.13
Fetopelvic disproportion - obstruction	2.77	2.91	-0.14
Prolonged pregnancy	1.99	2.13	-0.15
Diabetes or abnormal glucose tolerance complicating pregnancy- childbirth- or the puerperium	2.31	2.77	-0.46
Contraceptive and procreative management	1.75	NA	NA

From this cursory review it can't be substantiated from the data that any adverse effects are noted. Further study related to

outpatient conditions and the impact of socio-economic factors is warranted.

References

1. Kansas Hospital Discharge dataset, Kansas Hospital Association and Health Care Data Governing Board.
2. Clinical Classification Software Factsheet, Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/data/hcup/ccsfact.html>

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Office of Health Care Information

News Notes

Health Insurance and Children

Between 1996 and 2002 the percentage of uninsured children nationally declined from 15.7 percent to 12.9 percent. The findings, from the Medical Expenditure Panel Survey's (MEPS) *Health Insurance Status of Children in America: 1996-2002, Estimates for the Non-institutionalized Population under Age 18*, also showed the percentage of children covered by public only health insurance increased over the same period, from 21.3 percent to 25.3 percent.

Younger children and Black children were more likely to be covered by public only health insurance. Almost half (47.0%) of children with poor or fair health status were covered by public only health insurance.

While the MEPS report doesn't break out Kansas-specific results, a September 2003 Kansas Health Institute Research Brief *Findings from the HealthWave Evaluation Project*, offers insight into the makeup of children enrolling in the State Children's Health Insurance Program (also known as HealthWave).

Eighty-seven percent of HealthWave enrollees had at least one employed parent. Medicaid enrollees' parents were less likely to be employed. KHI found that two-thirds (68%) of Medicaid children had at least one working parent.

Other findings included:

- HealthWave participants lived in households whose head attained higher education levels,
- HealthWave households were more likely to have family incomes above the poverty level,
- Medicaid tended to enroll more young children because of guidelines that allow for a higher income for families with younger children, and
- HealthWave served children of low-income working families while Medicaid served a younger population with greater economic needs.

More details can be obtained from the Institute at <http://www.khi.org>.

Kansas Health Institute

National Healthcare Quality Measurement Report

The National Healthcare Quality Report, developed by the Agency for Healthcare Research and Quality (AHRQ) is the first national comprehensive effort to measure the quality of health care in America. The report includes a broad set of performance measures that can serve as baseline views of the quality of health care.

The report presents data on the quality of services for seven clinical conditions, including cancer, diabetes, end-stage renal disease, heart disease, HIV and AIDS, mental health, and respiratory disease. It also includes data on maternal and child health, nursing home and home health care, and patient safety. For a

prepublication copy of the report see
<http://www.ahrq.gov/qual/measurix.htm>.

Agency for Healthcare Research and Quality

Kansas Population and Housing Counts Available

Kansas: 2000 Population and Housing Unit Counts (PHC-3-18), published by the U.S. Census Bureau provides detailed information on changes in the geography, population and housing units of Kansas communities. Changes from the 1980 and 1990 census figures are also included in the publication. In addition to population and housing units, the publication includes averages per square mile and the land area for each community. The reports can be obtained as a PDF file from the Census Bureau's web site: <http://www.census.gov/census2000/pubs/phc-3.html>.

U.S. Census Bureau

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