

Kansas Health Statistics Report

Kansas Department of Health and Environment – Center for Health and Environmental Statistics – No 24 – February 2005

HealthyKansas Initiative Unveiled

Governor Kathleen Sebelius and Insurance Commissioner Sandy Praeger have launched an initiative to contain runaway health care costs, streamline the health care system, and make health insurance and prescription drugs more affordable for thousands of children, working parents and small businesses.

The HealthyKansas reform initiative is a continuation of a reform agenda that Governor Sebelius began when she was insurance commissioner, which culminated in her blocking the takeover of Blue Cross Blue Shield of Kansas by a multi-billion dollar, out-of-state insurance company that planned to raise rates to increase its profits.

As the largest purchaser of health care services, the state of Kansas can play a major role in reforming the health care system. To ensure the reform initiative is coordinated and sustained, the governor ordered all of the state's major health care programs be streamlined into a new business division called the Division of Health Care Policy and Finance.

The transfer of the Medicaid program from the Department of Social and Rehabilitation Services to the division will improve efficiency and allow the state to push for real reforms in the health care system.

Kansans spend approximately \$12 billion a year on health care. About 30 percent of that total - \$3.5 billion - goes to cover administrative costs, including claims processing and mountains of paperwork.

To further address the problem of soaring costs, the initiative establishes a Kansas Health Care Cost Containment Commission, to be headed by Lt. Governor John Moore. The commission will work to cut unnecessary administrative costs, improve patient care, and help providers expand the use of health care information technology. (*Editor's note: see related article on page 4.*)

In addition to administrative costs, unpaid bills are a major cause of rising health care costs. It's estimated that 16 percent of every dollar that Kansans pay for health insurance goes to cover the cost of emergency room and other care provided to the uninsured. In 2003, Kansas hospitals alone reported more than \$320 million in unpaid bills.

Nearly 300,000 Kansans can't afford health insurance, and the number is growing. Most of the uninsured – about 95 percent – either work or live in a family where at least one person works full time. Two-thirds of uninsured Kansans work for small businesses that can't afford to provide coverage to their employees.

As part of the initiative, the Kansas Department of Health and Environment will have several roles.

- To reduce the incidence of obesity and other preventable, chronic health conditions, KDHE will work with business, education, and community leaders to develop and implement programs to assist Kansans in a variety of ways to take more responsibility for their own health. The program will be called HealthyKansas: Taking Steps Together.
- The Department will also continue to serve as the health care data repository or warehouse, aggregating health care data from disparate sources in the state. Administration of the Health Care Data Governing Board, which sets policy direction for health data collection, will be coordinated by the new division.

Funding for the \$50 million reform initiative will come from a health care assessment on cigarettes and tobacco products. Both Sebelius and Praeger noted the potential payoff in reduced administrative costs, saved lives, and avoided health care costs far exceed the cost of the initiative.

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Kansas Vital Statistics Implements New Reporting System

On January 1, the Center for Health and Environmental Statistics (CHES) implemented a web-enabled Vital Statistics data system. Entitled Vital Statistics Integrated Information System (VSIS), the new software moves the Center a major step forward in electronically recording vital events such as births, deaths, marriages, divorces, and abortions.

Implementation of the new system marks the culmination of a two year planning effort by CHES to update its data system and incorporate new business processes into the administration of vital records in Kansas.

The VSIS approach uses a secure web portal called VRV Web to allow hospitals, physicians, court clerks, and other authorized users to enter and submit vital record information electronically. While CHES has electronically recorded births for several years, the PC-based approach was antiquated and not directly networked with the state.

Hospitals began using the new system to record births within hours of the new year starting. Birth clerks accessed the secure web server and began entering birth data in real time. Once birth clerks completed data entry, the server checked the information for unacceptable answers. The hospital completed the process by printing a paper copy of the completed birth record. Once received by the state the paper copy is electronically linked to the previously entered data.

Funeral directors, the first step in the two-part process of recording deaths, also began using VSIS for reporting fact of death information within days of the new system going live. Full implementation of the mortality reporting component is a few years away, as the system will need to inte-



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grate cause of death information from physicians and coroners.

The new VSIS system has a number of advantages. Reporting vital events in a more timely fashion will reduce the potential for fraud. Families will be able to get birth and death certificates faster. Information entered into the system will be more accurate, as automated proofing reduces errors.

The new system incorporates information from recently revised birth and death certificates. The new certificates ask additional medical questions, enabling researchers to better gauge health issues and identify disparities among racial and ethnic subgroups in the population.

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Alzheimer's Disease in Kansas 1999 - 2003

Alzheimer's Disease (AD) is an irreversible brain disorder that is characterized by memory loss, language deterioration, poor judgment, confusion, restlessness, and mood swings. Eventually AD destroys cognition, personality, and the ability to function. Early symptoms of AD, which include forgetfulness and loss of concentration, are often missed because they resemble signs of ordinary aging. The most common cause of death in AD patients is infection. AD, the most widely known and most common member of a group of disorders termed dementias, accounts for as much as 50 to 80 percent of the total demented population.

AD is usually diagnosed in persons over the age of 60, although as many as 10 percent of all AD cases nationwide began much earlier. This so-called early onset (familial) AD is the result of genetic mutations that were present at birth. Adult-onset AD is a progressive, neurodegenerative disease with no cure and no way to slow the degeneration¹.

At present there are approximately four million AD cases in the United States. It's estimated AD affects one of every three families. Approximately one American out of five between the ages of 75 and 84, and almost half of those 85 years old and over, currently suffer from AD. If current population trends continue and no major breakthrough in AD treatment occurs, it's likely one out of two baby boomers will develop AD as they reach their senior years².

When the total AD burden in the United States is measured, including costs of care in addition to lost wages, the annual estimated cost to society is \$100 billion. The cost burden falls largely on individuals. Medicare and most health insurance plans do not provide coverage for many of the expenses associated with AD patient care³.

The Center for Health and Environmental Statistics reviewed five years of the Kansas resident hospital discharge data⁴ using diagnostic groups based on Clinical Classification Software (CCS). The review showed Senility and Other Organic Mental Disorders accounted for 1.5 percent of all discharges ages 65 and above for the years 1999 - 2003. Senility ranked 17th out of 230 CSS groups in the number of elderly discharges.

Within the group, Senility, Alzheimer's disease was the most common primary diagnosis, accounting for 30.1 percent of all discharges. In the Inpatient data a given discharge can have up to nine secondary diagnoses in addition to the primary diagnosis. Counting primary diagnoses alone, AD accounted for 2,952 discharges. Counting all diagnoses, AD accounted for 22,445 discharges, or 0.5 percent of all elderly discharges.

Among AD patients ages 65 and above and including secondary AD diagnoses, the mean age was 83.3 years and the mean Length of Stay (LOS) was 6.2 days. The values for mean age and mean LOS exhibited little change from 1999 to 2003.

For all discharges combined where the diagnosis at any level – primary through secondary diagnosis level 9 – was AD, the

most frequent primary procedure was Partial Hip Replacement. The next most frequent was Open Reduction with Insertion of Fractured Femur. These two principle procedures accounted for 5.7 percent of all discharges involving AD. Sixty-six percent of discharges involving AD listed no procedure. It appears that AD patients are often hospitalized for conditions commonly found among the elderly.

Hospitalization rates (discharges per 10,000 population)⁵ for AD for persons age 65 or above rose from 115.0 in 1999 to 137.8 in 2003, an increase of 19.9 percent (Table 1). The increase for males was 10.6 percent, and for females was 25.3 percent.

Table 1. Alzheimer's Hospitalization Rates for Elderly Kansans by Year and Gender

Both Sexes Age Group	1999	2000	2001	2002	2003	5 Yr Avg	Percent Change
65-69	12.8	13.3	16.1	14.8	12.2	13.8	-4.6%
70-74	43.8	40.1	44.5	43.4	44.2	43.2	0.9%
75-79	93.8	99.4	105.0	119.2	120.9	107.7	28.9%
80-84	214.0	213.1	217.0	233.3	236.4	222.8	10.4%
85 and up	341.6	373.9	367.9	386.0	400.6	374.0	17.3%
Totals	115.0	120.8	125.1	134.1	137.8	126.6	19.9%
Female Age Groups							
65-69	14.4	13.9	16.6	14.7	11.5	14.2	-19.9%
70-74	45.6	39.5	42.4	45.5	47.5	44.1	4.0%
75-79	92.4	104.9	109.3	129.7	124.7	112.2	34.9%
80-84	210.5	222.7	213.5	236.0	245.8	225.7	16.8%
85 and up	335.8	372.2	367.1	394.3	411.3	376.1	22.5%
Totals	124.4	135.8	137.2	151.4	155.9	140.9	25.3%
Male Age Groups							
65-69	11.0	12.5	15.5	14.9	13.1	13.4	18.8%
70-74	41.7	40.8	47.2	40.7	40.2	42.1	-3.4%
75-79	95.9	91.7	99.1	105.0	116.0	101.5	21.0%
80-84	220.0	196.6	223.0	228.9	220.9	217.9	0.4%
85 and up	355.2	378.3	369.7	365.9	375.3	368.9	5.7%
Totals	101.5	99.2	107.7	109.3	112.3	106.0	10.6%

Rates per 10,000 Population

Among the elderly, the largest percentage increase was among females ages 75 - 79 (34.9%). The largest percentage increase for males occurred in the group ages 75 - 79, which experienced an increase of 21.0 percent.

Rates did not increase for all age groups. The decline in hospitalization rates for women ages 65 - 69 of 19.9 percent was notably different from the increase of 18.8 percent for males of the same age. The increase in rates for males ages 80 and up was modest compared to the rates for females of the same age groups.

AD is a small proportion of total elderly hospital discharges. The data show an increase in the rate of hospitalization for AD patients between 1999 and 2003, particularly among females. The mean age and LOS appear to be relatively stable over this time period. The higher female rates compared to males suggests the need for further study of this debilitating condition.

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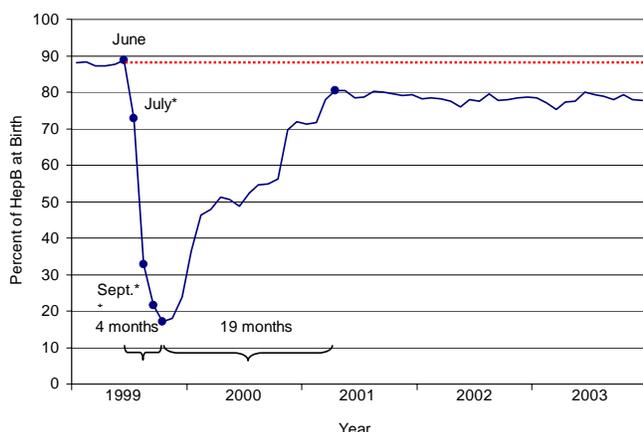
Hepatitis B Vaccination Tracked

Hepatitis B is the most frequently reported vaccine-preventable disease in the United States. Approximately 22,000 infants are born to hepatitis B infected mothers each year. Without prophylaxis, 6,000 of these infants would develop chronic hepatitis B.

In November 1991, the Advisory Committee on Immunization Practices (ACIP) stated a preference for administering the first dose of hepatitis B vaccine (HepB) before the infant leaves the hospital, for those born to mothers without hepatitis B infection (HBV)¹. Otherwise, for these infants the first dose should be administered no later than 2 months of age.

Since 1991, the Kansas Immunization Program has provided the birth dose of HepB free of charge to all Kansas born infants regardless of insurance coverage.

Figure 1. Percentage of Kansas Children Receiving the Hepatitis B Birthdose by Month, 1999-2003



*July 7, 1999 – AAP with PHS recommend suspending the hepatitis B birthdose for infants born to mothers without HBV

**September 13, 1999 – Single-antigen, thimerosal-free hepatitis B vaccine available for distribution.

Data Source: KDHE, Center for Health and Environmental Statistics

Due to thimerosal in vaccines, on, July 7, 1999, the American Academy of Pediatrics (AAP) with the US Public Health Service (PHS) published a statement recommending suspension of the HepB birth dose for infants born to mothers without HBV. Before July 7, almost 90 percent of Kansas infants received the first dose of hepatitis B vaccine by hospital discharge. Within four months, the percentage of children receiving HepB at birth dropped to 17 percent (Figure 1). While thimerosal-free vaccine became available on September 13, 1999, the portion of children receiving a HepB birth dose has yet to return to 90 percent.

Each year approximately 1,000 children develop HBV as a result of misidentification of mothers' HBV status and improper prophylaxis of infants. Currently, ACIP recommends that all infants receive the first dose of HepB soon after birth but before hospital discharge².

References

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- MMWR, 2005; 53(51); Q1-Q3

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Prevalence of Current Asthma Among Adult Kansans: Results from the 2003 BRFSS.

Asthma is a chronic disease of the airways characterized by repeated episodes of wheezing, breathlessness, tightness of the chest, and coughing. Risk factors for asthma include genetic predisposition and environmental exposures such as dust mites, animal allergens, cockroach antigens, fungi, and environmental tobacco smoke¹.

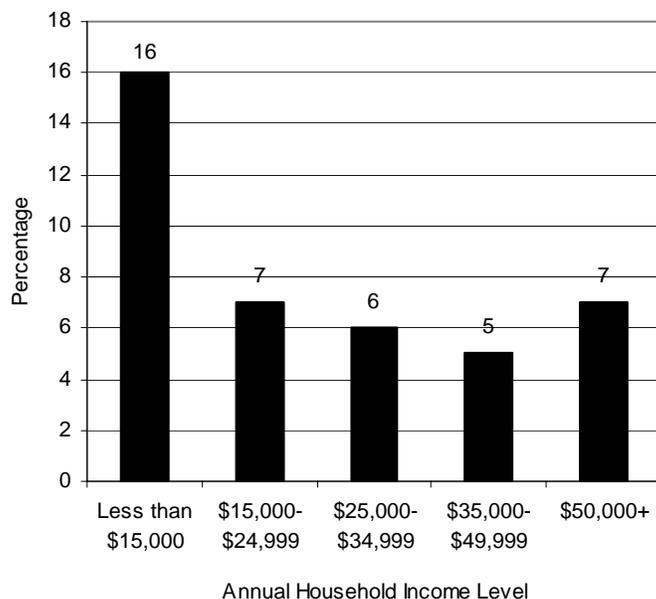
Rates of asthma are generally higher among children, females, non-whites, individuals in lower socioeconomic levels, and individuals living in urban areas. Data from the 2003 Kansas BRFSS was utilized to continue the surveillance of this public health burden.

The Behavioral Risk Factor Surveillance System (BRFSS) is a state based random digit dial telephone survey among non-institutionalized adults 18 years and older. The survey collects information on risk factors and certain health conditions.

In 2003, respondents were asked asthma questions regarding diagnosis, frequency of emergency room and physician visits, activity limitation, and medication usage. Respondents also answered questions regarding asthma among children in their household.

According to the data from the 2003 Kansas BRFSS, approximately eight percent of adults and seven percent of children under age 18 currently have asthma. The prevalence of current asthma was significantly higher among females than males (10

Figure 2. Percentage of Adults with Current Asthma by Annual Household Income Level, Kansas 2003

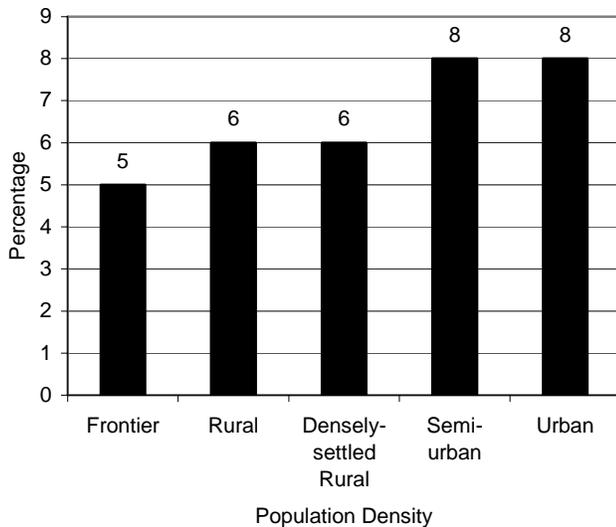


percent compared with five percent respectively).

The prevalence of current asthma was substantially higher among adults with an annual household income less than \$15,000 (16%) compared with the other income groups. Among adults with annual household income greater than \$15,000, the prevalence ranged from five percent to seven percent (Figure 2).

Regarding population density, there was a gradual increase in the percentage of adults with current asthma as the population density increased. The prevalence of current asthma ranged from five percent in frontier counties to eight percent in urban counties (Figure 3).

Figure 3. Percentage of Adults with Current Asthma by Population Density, Kansas 2003



The prevalence of asthma in Kansas is similar to the nation as a whole. The 2003 Kansas BRFSS identified females and individuals with an annual household income level less than \$15,000 as high-risk groups with current asthma. There was an overall trend with population density and the prevalence of current asthma. When developing asthma control programs in Kansas, steps should be taken to target these high-risk groups.

References

- Centers for Disease Control and Prevention. U.S. Department of Health and Human Services (2004). Basic Facts about Asthma <http://www.cdc.gov/asthma/faqs.htm>

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Prenatal Care Index Improves

The Adequacy of Prenatal Care Utilization (APNCU) Index for 2003 Kansas resident births improved by almost a percentage point from the previous year. Of 38,861 births for which an index value could be calculated, 81.2 percent of the births (31,539) had either adequate or adequate plus values. This compares to 80.4 percent in 2002, or 31,216 of 38,806 births for which a value could be calculated.

Most of the improvement is due to a decrease in the number of births in which APNCU was considered inadequate. Rates fell from 8.7 percent of the evaluated 2002 births to 8.0 percent of the evaluated 2003 births.

Adequacy of prenatal care utilization is a calculated value based on when a woman enters prenatal care and the proportion

of the recommended number of visits to her physician received from the time prenatal care began to delivery.

- Adequate Plus – prenatal care begun by the 4th month and 110 percent or more of recommended visits received.
- Adequate – prenatal care begun by the 4th month and 80-109 percent of recommended visits received.
- Intermediate – prenatal care begun by the 4th month and 50-79 percent of recommended visits received.
- Inadequate – prenatal care begun after the 4th month and less than 50 percent of recommended visits received.

In 2003, births to minority women continued to be over-represented in the APNCU categories of intermediate or inadequate. While 13.5 percent of the evaluated births were to Hispanic women, 25.0 percent of the births with intermediate or inadequate APNCU occurred to Hispanic women. Births to Black women accounted for seven percent of the evaluated births. Eleven percent of the births with either intermediate or inadequate APNCU occurred to Black women. Births to White women accounted for 88.4 percent of the births evaluated but accounted for just 84 percent of the births in the intermediate or inadequate categories.

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Containment Commission Begins Work

To combat climbing health care costs, the state's Health Care Cost Containment Commission has already started its work. Governor Kathleen Sebelius created the Commission that met for the first time on December 15, 2004.

Led by Lt. Governor John Moore, the group is looking at Kansas health care system inefficiencies and will recommend improvements and cost savings. In addition, they will focus on improving the quality of care and increasing the acceptance of health care information technology.

It is estimated that health care administration accounts for 25 to 30 percent, or nearly \$3 billion, of total Kansas health care expenditures, which are approximately \$12 billion a year. Administrative costs are also among the fastest rising components of total health care costs. The actual delivery of health care accounts for only fifty percent of total expenditures.

The commission will conduct a series of community forums throughout the state to identify regional administrative issues and best practices. They will look at ways other states have successfully reduced administrative costs. The commission will work with key stakeholders in both public and private sectors to achieve health care cost reductions.

In addition to the current list of members appointed by the Governor's office, the Senate President, Minority Leader of Senate, Speaker of the House of Representatives, and Minority Leader of the House of Representatives will each appoint one legislator to serve on the commission.

Programs Shifted to Department of Labor

The Kansas Department of Health and Environment (KDHE) shifted three Office of Health Care Information (OHCI) programs to the Kansas Department of Labor (KDOL) on January 1, 2005, as part of the "right-sizing" efforts within Kansas government. Programs transferred included the Occupational Injury and Illness Statistics Program (OSHS), the Census of Fatal Occupational Injuries Program (CFOI), and the Occupational Injury and Illness Data Initiative Program (OSHA).

Some history about the three programs shows that KDHE has been involved with the OSHS program from its inception as a

result of the OSHA Act of 1970, which created the mandate for the federal government to collect occupational injury and illness statistics cooperatively with states.

In 1991 the U.S. Department of Labor, Bureau of Labor Statistics (BLS) offered another program to states participating in the OSHA program, and that program was the Census of Fatal Occupational Injuries and Illnesses (CFOI), which OHCI has conducted since 1991. This program collected information on all occupational fatalities in the state as part of a national database, which quickly expanded to all 50 states. This also is a federal-state cooperative program that complements the non-fatal data collected in the OSHA program.

In 1995, the U.S. Department of Labor, Occupational Safety and Health Administration (OSHA) came to the state agencies that were conducting the OSHA program with a request to have the state agencies collect occupational injury statistics similar to the OSHA statistics for their agency. Unlike the two other programs, the OSHA program is entirely federally funded by OSHA. It is the only way OSHA can obtain identifying information about injuries and illnesses occurring in businesses and to identify businesses needing assistance or to target businesses with high incidence rates for inspections.

KDHE conducted the program initially for the state of Kansas in the first year and then expanded to include OSHA data collection for six other states.

Questions concerning these three programs should be directed to: Orval W. Weber, Kansas Department of Labor, Labor Market Information Services, 401 SW Topeka Blvd., Topeka, Kansas 66603, Phone 785-296-0039.

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Kansas Information for Communities Updated

The Office of Health Care Information has released the 2003 Birth Information on its Kansas Information for Communities (KIC) Web site. A four-color map is also available.

The KIC site presents statistics for Kansas births, deaths, cancer, hospital discharges, disease, pregnancies, and population. KIC displays the information in tables that may be configured in many ways: by county, age group, year, etc., depending on the users needs. Four color maps are also available for many selections.

The site may be accessed from the KDHE Web site at <http://kic.kdhe.state.ks.us/kic>. From the main page, users will have the option of selecting the dataset for analysis. Other updated datasets include Kansas population, and 2003 death information.

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News Notes

Health Director Named

Dr. Howard Rodenberg, M.D., M.P.H., of Daytona Beach, Fla. has accepted the position of KDHE Division of Health Director. Rodenberg has been serving as the director of the Volusia County Health Dept. in Daytona Beach since October 2003.

In addition to providing health leadership for Volusia County, Rodenberg continued to work as an emergency physician at Halifax Medical Center in Daytona Beach. He earned his undergraduate degree in Biology from the University of Missouri-Kansas City, his medical degree from the University of Missouri-Kansas City School of Medicine, and his Master of Public Health

degree from the University of South Florida, Tampa.

Rodenberg began work with KDHE in February

KDHE Office of Public Information

National Public Health Week Partners Sought

APHA is seeking partners for its observance of National Public Health Week (NPHW) 2005, to take place April 4-10. This year NPHW will focus on empowering Americans to live stronger and longer. Today, many individuals and their families, as well as communities and policy-makers, are not taking the preventive actions necessary to keep aging Americans stronger and healthier throughout their later years.

As a result, older Americans often endure chronic physical and mental illnesses that could have been avoided or diminished if they were more proactively addressed. APHA, believes it's never too late to address these issues. During NPHW, APHA and its partners will promote the three "Ps" in adding more healthy years to life: Prevent, Protect, and Plan.

To become a local or national partner, please sign up at http://www.apha.org/nphw/sponsors/05-partner_form.cfm. There is no cost to being a partner because we know the success of NPHW will depend on the energy of our national and local partnerships. If you have any questions, please e-mail Lakitia Mayo at lakitia.mayo@apha.org or call (202) 777-2515.

Kansas Public Health Association

NCHS Studies Infant Mortality Increase

The National Center for Health Statistics (NCHS) has released a report, *Explaining the 2001–02 Infant Mortality Increase: Data From the Linked Birth/Infant Death Data Set*. In it, NCHS studies causes for the nation's increase in infant mortality between 2001 and 2002.

The U.S. infant mortality rate increased from 6.8 infant deaths per 1,000 live births in 2001 to 7.0 in 2002, the first increase in more than 40 years. From 2001 to 2002 infant mortality rates increased for very low birthweight infants as well as for preterm and very preterm infants. (*Editor's Note: Kansas was one of 20 states that reported a decrease in infant mortality from 2001 to 2002.*)

Although infant mortality rates for very low birthweight infants increased, most of the increase in the infant mortality rate from 2001 to 2002 was due to a change in the distribution of births by birthweight and, more specifically, to an increase in infants born weighing less than 750 grams (1lb 10½ oz). The majority of infants born weighing less than 750 grams die within the first year of life; thus, these births contribute disproportionately to the overall infant mortality rate.

Increases in births at less than 750 grams occurred for non-Hispanic white, non-Hispanic black, and Hispanic women. Most of the increase occurred among mothers 20–34 years of age. Although multiple births contributed disproportionately, most of the increase in births at less than 750 grams occurred among singletons.

Three hypotheses were evaluated to assess their possible impact on the increase in less than 750-gram births: first, possible changes in the reporting of births or fetal deaths; second, possible changes in the risk profile of births; and third, possible changes in medical management of pregnancy. Although each of these factors may have contributed to the increase, the relative effects of these and other factors remain unclear. More-detailed studies are needed to further explain the 2001–02 infant mortality increase.

The full report can be found at the NCHS Web site: http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_12.pdf.

National Center for Health Statistics

Cervical Cancer Screening

A Governor's proclamation marking January as Cervical Cancer Awareness Month highlighted reports that the Kansas Department of Health and Environment (KDHE) has provided cervical cancer screenings to more than 17,000 eligible women since 1995. In 2004 alone, KDHE's Early Detection Works program provided screenings for 5,100.

Early Detection Works offers free screening of cervical cancer for eligible Kansas women. Cervical cancer is the easiest gynecologic cancer to prevent through screening. A Pap test can detect abnormal cells before they become cancerous and treatment can be used to prevent cancer. In fact, regular screening has reduced cervical cancer by 42 percent and deaths by 70 percent.

Despite the benefits of the Pap test, many women still do not know about the Pap test or its important role in detecting cervical cancer. The majority of women with newly diagnosed invasive cervical cancer have not had a Pap test in the past five years and many have never had one at all. This explains why 12,200 cervical cancers are diagnosed in the U.S. per year and 4,100 women still die from the disease.

Although the precise cause for cervical cancer is unknown, risk factors include but are not limited to Human Papillomavirus, smoking, current or past STD infections, family history of cervical cancer, diet low in fruits and vegetables, obesity, multiple births and exposure to diethylstilbestrol, a hormonal drug prescribed during pregnancy from 1940-1971 to prevent miscarriages.

Early Detection Works, established through Centers for Disease Control and Prevention (CDC) funding, is based on the simple goal of age appropriate care and screening. To qualify for the program, women must be at 250 percent of the poverty level and between the ages of 50-64 for breast cancer screening and 40-64 for cervical cancer screening. Statewide, there are 90 providers and 200 subcontractors to provide these services.

For information, go to <http://www.preventionworkskansas.org>.
KDHE Office of Public Information

Marital Status and Health Reviewed

The National Center for Health Statistics has released a report, Marital Status and Health: United States, 1999-2002, that reviewed National Health Interview Survey (NHIS) data comparing health to marital status. Based on analysis of over 120,000 sample adult interviews, NCHS found that regardless of population subgroup (age, sex, race, Hispanic origin, education, income, or nativity) or health indicator (fair or poor health, limitations in activities, low back pain, headaches, serious psychological distress, smoking or leisure-time physical inactivity), married adults were generally found to be healthier than adults in other marital status categories.

The full report can be found on the NCHS web site:
<http://www.cdc.gov/nchs/about/major/nhis/nhisadr.htm>.

National Center for Health Statistics

The Office of Health Care Information of the Kansas Department of Health and Environment's Center for Health and Environmental Statistics produces *Kansas Health Statistics Report* to inform the public about availability and uses of health data. Material in this publication may be reproduced without permission; citation as to source, however, is appreciated. Send comments, questions, address changes and articles on health data intended for publication to: OHCI, 1000 SW Jackson, Suite 130 Topeka, KS, 66612-1354, Kansas.Health.Statistics@kdhe.state.ks.us, or 785-296-8627. Roderick L. Bremby, Secretary KDHE; Lorne A. Phillips, Ph.D., State Registrar and Director, Center for Health and Environmental Statistics; Elizabeth W. Saadi, Ph.D., Director, Office of Health Care Information; Greg Crawford, Editor.

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