

Kansas Health Statistics

Kansas Department of Health and Environment – Center for Health and Environmental Statistics – Vol. 1 No. 3 November 1999

Multiple Births Increase

The number of births in multiple deliveries for Kansans climbed to 1,081 in 1998, including 1,015 twins, 59 triplets, and 7 born in other higher order multiple deliveries. This represents a 2.0% increase in the number of multiple births from 1997, and a 22.1% increase from 1989 (Table 1).

In 1998 the multiple birth rate had grown 23.1%, from 22.9 per 1,000 live births in 1989. Over the same time period, the twin birth rate increased 19.4% (from 22.2 per 1,000 live births), and the triplet birth rate rose 114.3% (from 0.7 per 1,000 live births). There were no reported births of quadruplets or other higher order multiple births to Kansas residents from 1989-1993.

Kansas Multiple Births, 1989-1998			
	Live	Multiple	Multiple *
Year	Births (N)	Births (N)	Birth Rate
1989	38,648	885	22.9
1990	38,872	896	23.1
1991	37,630	849	22.6
1992	37,848	941	24.9
1993	37,283	908	24.4
1994	37,269	892	23.9
1995	37,087	938	25.3
1996	36,524	1,035	28.3
1997	37,191	1,060	28.5
1998	38,372	1,081	28.2

* Multiple birth rates are per 1,000 live births

Table 1

The 1998 rate of combined higher order multiple births, including triplets (*i.e.* births in greater than twin deliveries), shows an increase of 146.1% from 69.9 per 100,000 live births in 1989 (Figure 1). Put another way, one in every 581 births was a triplet or other higher level multiple in 1998, compared to one in every 1,431 births in 1989.

Nationally, there was a 52% increase in the number of twins and a 404% increase in the number of triplets and other higher order multiple births from 1980 to 1997. The higher order multiple birth rate of 173.6

per 100,000 live births in 1997

(comparable to Kansas' rate of 172.0 in 1998) was more than double the rate of 81.4 in 1991 and quadruple the rate of 37.0 in 1980

(National

Vital Statistics Report, Vol. 47, No. 18, April 29, 1999).

The trend toward greater numbers and higher rates of multiple births can be partially attributed to fertility enhancing therapies and the tendency in recent years of women to delay childbearing until later in life, when there is a greater likelihood of multiple births. For Kansas residents in 1989, births to women

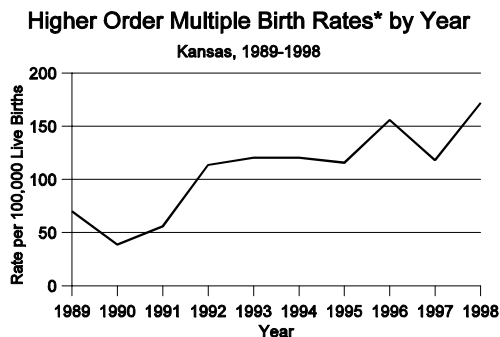


Figure 1

35 years of age or older comprised 7.2% of live births. In 1998 those births had risen to 11.4% of live births.

Material for this report was derived from summaries of birth records provided by delivering physicians to the Office of Vital Statistics. More information is available in the *Annual Summary of Vital Statistics*, a summary of health data collected by the State of Kansas on vital events.

Joy Crevoiserat
Vital Statistics Data Analysis

Breast Cancer Screenings Increase

The Centers for Disease Control and Prevention reports that Behavioral Risk Factor Surveillance System survey results show an increase in the proportion of women who have participated in breast cancer screening and a sustained high proportion of women who have participated in cervical cancer screening. The national results also indicate older women, women with low annual household income, those with a low level of education, and those without health insurance are less likely to participate in these screenings.

The total age-adjusted proportion of women aged 40 and over who reported ever having a mammogram increased from 63.9% in 1989 to 84.8% in 1997. During a period of seven survey years, over 77% of the respondents reported having received a Pap test within the past two years.

In Kansas in 1992, 74% of women aged 40 and over reported ever having a mammogram. In 1997, 80% of Kansas women aged 40 and over reported ever having a mammogram. During the six-year period from 1992 to 1997, 82% of Kansas women with a uterine cervix reported having a Pap test within the past two years.

National findings are contained in the *MMWR CDC Surveillance Summary*, Vol. 48, No. SS-6, October 8, 1999. Contact the KDHE Bureau of Health Promotion for additional information on Kansas BRFSS survey results.

Charlie Hunt
Bureau of Health Promotion

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Dental Care for Kansas Medicaid Enrolled Children

Dental care access for Kansas children is an issue of concern. According to a report funded by the United Methodist Health Ministry Fund, Medicaid dental claims records in Kansas show that of eligible enrolled children, just 29% received dental services in 1998.

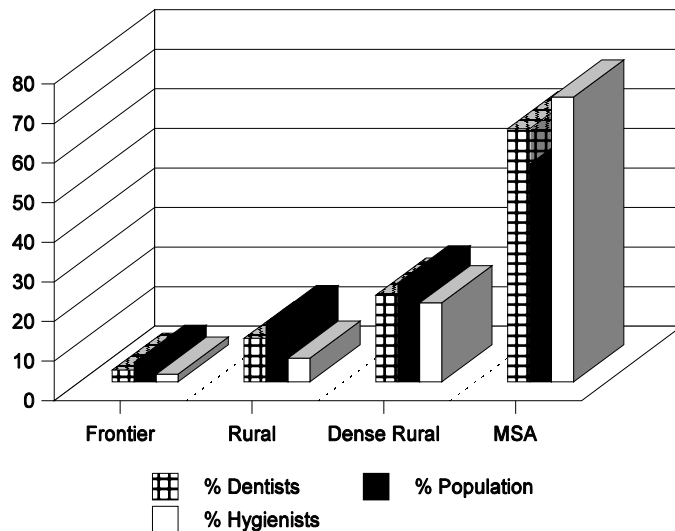
The two explanations offered for low dental use are: lack of dental providers willing to provide services to Kansas Medicaid children, and the low priority many Medicaid families place on obtaining dental care.

Recently, conferences were held in Hays and Lawrence to discuss and make plans for addressing dental access issues for Kansas children. Findings were presented in these locations from recent Kansas University studies funded by the United Methodist Health Ministry Fund. Dr. Michael Fox of the KU Health Services Research Group, Department of Health Policy and Management, also presented findings to the Health Care Data Governing Board.

Researchers found dental services to be unevenly distributed across Kansas (Figure 2). In Kansas, 3% of dentists serve 50% of all Medicaid enrollees receiving dental treatment, as few dental providers accept Medicaid. Medicaid dental providers are under-represented in areas where dental providers most often practice i.e., metropolitan areas.

Findings indicate that Medicaid reimbursement is

Dental Health Providers by Population Density, Kansas



Source: KU Health Services Research Group
Department of Health Policy & Management

Figure 2

approximately 50% of the usual, customary and reasonable rate and that the dental community finds this low reimbursement rate to be problematic. Additionally, Medicaid patients are often difficult to treat since they tend to present with extreme pain and tend to be irregular at appearing for dental appointments.

Recommendations to address the problem of dental care access for Kansas Medicaid children were gathered from policy makers, dental providers, Medicaid recipients and officials, conference participants, and others. Among improvements offered were:

- Change the delivery structure for dental services,
- Change the reimbursement methodology,
- Increase the supply of dentists and dental extenders,

- Re-engineer a new Medicaid dental program, and
- Expand dental prevention and education efforts.

It was stressed that improving dental care for Kansas Medicaid children cannot be accomplished in isolation. Recommendations should be reviewed by a panel of experts who would be responsible for recommending final options. It was indicated that dental policy action should center around prevention activities for Kansas children. Since this issue is perceived as a significant public health issue, greater cooperation among KDHE, Medicaid and the HealthWave program should be facilitated in order to improve service delivery.

Rachel Lindbloom
Health Care Data Analysis

ICD 10 to Alter Leading Causes of Death

The International Classification of Diseases makes uniform assessment of public health mortality trends possible. Underlying causes of death can be compared when ICD codes are assigned to specific causes.

Each revision – the United States implemented ICD-10 in 1999 – brings coding changes that affect data comparability with prior versions.

The National Center for Health Statistics has embarked on an ambitious effort to code 1996 deaths for ICD-10 to determine changes from ICD-9 coding (comparability ratio). NCHS reported their preliminary findings at the National Association for Public Health Statistics and Information Systems annual meeting.

ICD-10/ICD-9 Comparability Ratios	
Cause	Comparability Ratio
Diseases of heart	1.02
Malignant Neoplasms	1.00
Cerebrovascular diseases	1.04
COPD	1.03
Accidents	1.00
Pneumonia and influenza	0.37
Diabetes mellitus	1.03
HIV infection	1.05
Suicide	1.00
Chronic liver dis. & cirrhosis	1.03
Nephritis, etc.	1.40
Septicemia	1.27
Alzheimer's disease	1.69
Homicide	1.00
Atherosclerosis	0.98
Congenital anomalies	0.87
Perinatal conditions	1.03
SIDS	0.99

Table 2

Preliminary results of the non-random sample of mortality records of 14 states (Table 2) found that deaths due to pneumonia and influenza and congenital anomalies dropped. Deaths due to Alzheimer's disease, Septicemia, and Nephritis and related kidney diseases increased. The four leading causes of death – diseases of the heart, malignant neoplasms, cerebrovascular diseases, and COPD – were largely unchanged in the preliminary evaluation.

One significant change is the decrease in pneumonia and influenza deaths under ICD-10. The preliminary NCHS results indicated almost 30% of those deaths coded under ICD-9 will be coded as Nephritis, etc.; Septicemia; and Alzheimer's disease under ICD-10.

Comparability ratios will likely change some once all deaths are recoded. State-by-state results may also show some geographic variation in comparability ratios.

NCHS plans to release comparability ratios for all states once the recoding is completed. The ratios will enable public

health professionals to reassess mortality trends and program activities in light of ICD-10 coding changes.

Greg Crawford
Vital Statistics Data Analysis

Mortality Coding Over the Centuries

Recently, I came across a document that listed several causes and numbers of death for the year 1632. Thankfully, health care has come a long way and we no longer see many deaths due to "teeth", "fever", or "King's Evil" (skin disease).

Still, the need to understand why we die is ancient and terminology describing death these days is extremely complicated. Researchers must be mindful that classification systems are not consistent across the years and trend analyses must be attempted with caution.

As we enter the new realm of ICD-10, we must be mindful of the changes in terminology and classification and make sure as we compare years, we consider the inconsistencies. Under ICD-9 diabetes is 250. Under ICD-10, diabetes is E10 - E14.

Greg Crawford's article above highlights some of the changes expected from ICD-10. Some of the impact won't be known until we have a couple of years of data to review.

Before you begin analyses on 1999 vital statistics data, contact the OHCI vital statistics data analysis staff for assistance. For a copy of the year 1632 causes of death, e-mail Kansas.Health.Statistics@kdhe.state.ks.us and put "1632" in the subject line or contact Carri Carr at 785-296-8627.

Dr. Elizabeth W. Saadi
Office of Health Care Information

Teen Births Drop

The US teenage birth rate has dropped 18% since 1991. As reported in *National Vital Statistics Reports* this figure represents close to a record low. The National Center for Health Statistics, which prepared the report, said declines in teen birth rates were noted for all age, race, and Hispanic origin populations, with steepest declines recorded for black women. State-specific rates by age fell in all states; most declines were statistically significant; overall declines ranged from 9 to 32%.

The pregnancy rate for Kansas teens 15-19 dropped by 12.5% from 1991 to 1997 (Table 3). The decrease for teens 15-17 was 6.4%, which was not considered statistically significant. For Kansas teens 18-19, the decrease was 13.2%.

Teen Birth Rates, aged 15-19 by Age Group, Kansas			
Year	15-19 Years	15-17 Years	18-19 Years
1991	55.4	29.4	94.1
1997	48.5	27.5	81.7

Table 3

Live births combined with information on induced abortions and fetal deaths, enables the computation of pregnancy rates. Because of delays in obtaining some national data, pregnancy rates can only be computed for 1996. The estimated US teen pregnancy rate in 1996 was 98.7 per 1,000 women aged 15-19, down 15% from its high point of 116.5 in 1991. The 1996 rate is the lowest since 1976 when a consistent series of pregnancy rates for teenagers was started.

The Center for Health and Environmental Statistics has published its 1998 Teenage Pregnancy Package. The series of six tables address pregnancies and pregnancy rates on a county by county basis for females under 18 and females under 20. The tables are at <http://www.kdhe.state.ks.us/hci/>.

National Vital Statistics Reports
Vol. 47, No. 26, October 25, 1999

Measuring Adequacy of Prenatal Care Utilization

Prenatal care is defined as pregnancy-related health care services provided to a woman between conception and delivery. Prenatal care has long been endorsed as a major means to identify and reduce the risks of bearing infants who are low birth weight, are stillborn, or die within the first year of life.

Accurate measurement of prenatal care utilization depends on the accuracy of the index used. Two traditionally used measures of adequacy of prenatal care utilization are: trimester prenatal care began and the Kessner/Institute of Medicine Index. Both of these indices have been criticized for presenting an incomplete and inaccurate picture of prenatal care utilization.

The trimester care began does not take into account subsequent prenatal care visits nor the number of visits relative to length of gestation. While the Kessner Index does take in account the number of visits, it had been criticized for not incorporating the full length of gestation in considering the adequacy of the number of visits.

The National Healthy People objectives have been measuring the use of prenatal care by asking states to meet an objective relating to the percent of live births where the pregnant woman began her care during the first trimester. Public health officials have expressed concern that the fact that a woman enters prenatal care during the first trimester does not indicate whether she continued her care throughout the duration of the pregnancy.

Some states, such as Kansas, have been utilizing a modification of the Kessner Index, for the purpose of quasi evaluation of access and utilization of prenatal care. It is important to note, however, that such measurements do nothing to address the quality of care provided.

Beginning with the Healthy People 2010 Objectives, states will be asked to utilize the Adequacy of Prenatal Care Utilization Index (APNCU), (often referred to as the Kotelchuck Index) which attempts to characterize prenatal care (PNC) utilization on two independent and distinct dimensions: adequacy of initiation of PNC and adequacy of received services (once PNC has begun). The index uses information readily available on the standard U.S. birth certificates (number of prenatal care visits, month prenatal care began, and gestational length of pregnancy). The APNCU Index does not adjust for risk conditions of the mother. Thus, the Index is conservative and underestimates utilization adequacy.

The first dimension, "Adequacy of Initiation of Prenatal Care" measures the adequacy of the timing of initiation of PNC based on the assumption that the earlier PNC begins the better. The APNCU Index collapses the initiation months into four distinct groups: (1, 2), (3, 4), (5, 6), and (7- 9) months.

The first dimension, "Adequacy of Received Services" characterizes the adequacy of received PNC visits during the time period prenatal care is initiated until the delivery. This second indicator attempts to characterize if the woman received the appropriate number of prenatal care visits for the time period they were receiving PNC services, based on American College of Obstetricians and Gynecologists (ACOG) standards (one visit per month through 28 weeks, one visit every 2 weeks through 36 weeks, and one visit per week thereafter, adjusted for date of initiation of PNC).

The two dimensions combine into a single summary prenatal care utilization index. Figure 3 illustrates the construction of the summary APNCU Index with 1998 data and outlines the index's two factors. Local health departments have received a statistical

I. Month prenatal care began (Adequacy of Initiation of Prenatal Care)

- Adequate Plus: 1st or 2nd month
- Adequate: 3rd or 4th month
- Intermediate: 5th or 6th month
- Inadequate: 7th month or later, or no prenatal care

II. Proportion of the number of visits recommended by the American College of Obstetricians and Gynecologists (ACOG) received from the time prenatal care began until delivery (Adequacy of Received Services)

- Adequate Plus: 110% or more
- Adequate: 80% - 109%
- Intermediate: 50% - 79%
- Inadequate: less than 50%

III. Summary Adequacy of Prenatal Care Utilization Index

- Adequate Plus: Prenatal care begun by the 4th month and 110% or more of recommended visits received
- Adequate: Prenatal care begun by the 4th month and 80% - 109% of recommended visits received
- Intermediate: Prenatal care begun by the 4th month and 50% - 79% of recommended visits received
- Inadequate: Prenatal care begun after the 4th month or less than 50% of recommended visits received

Adequacy of Prenatal Utilization Index Matrix
Kansas Residence Births, 1998 n=36,372

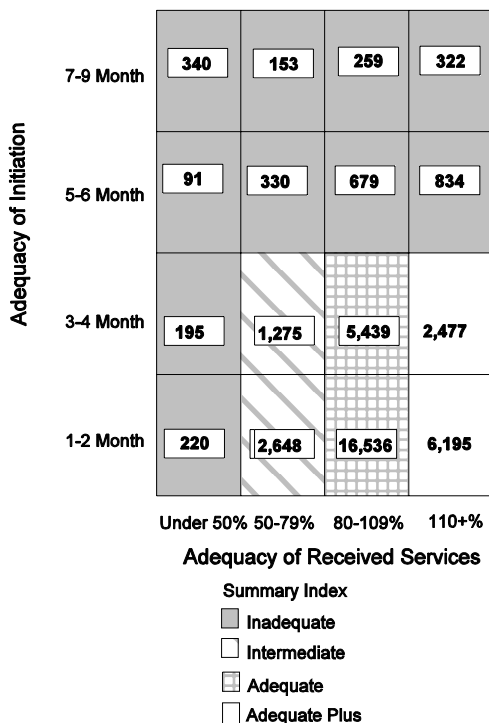


Figure 3

package and technical information regarding the implementation of this index. The bibliographic reference relating to this index is: Kotelchuck, Milton. "An Evaluation of the Kessner Adequacy of Prenatal Care Index and a Proposed Adequacy of Prenatal Care Utilization Index", *American Journal of Public Health*, 1994; 84(9): 1414-1420.

Kansas made the transition from the modified Kessner Index to the APNCU Index beginning with 1998 vital statistics data. This information is available from the Center or on the web at: <http://www.kdhe.state.ks.us/hci/>.

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Vital Statistics Data Analysis
Dr. Rita Kay Ryan
Bureau for Children, Youth, and Families

Occupational Injury & Illness Publication

In March the Center for Health and Environmental Statistics released *Occupational Injuries and Illnesses, Kansas, 1996*.

The 1996 injury and illness incidence rate for private industry in Kansas was 8.9 per 100 full time workers, slightly lower than the rate of 9.7 reported in 1995 (Table 4).

Nonfatal Occupational Injury & Illness Incidence Rates		
Industry Group	1995	1996
Private Industry	9.7	8.9
Agriculture, Forestry & Fishing	7.1	8.7
Construction	11.7	12.2
Durable Goods Mfg.	12.6	12.4
Nondurable Goods Mfg.	16.4	12.7
Transportation/Public Utilities	9.2	7.1
Wholesale Trade	8.5	7.3
Retail Trade	8.9	7.8
Finance, Insurance & Real Estate	2.8	4.0
Services	8.0	7.9

Table 4

Most major industry divisions reported lower rates in 1996 than in 1995 while three – agriculture, forestry, and fishing; construction; and finance, insurance, and real estate – reported higher rates.

The largest decrease in the rate of occupational injuries and illnesses occurred in the transportation and public utilities industry which decreased 22.8% from a rate of 9.2 injuries and illnesses per 100 full-time workers in 1995 to 7.1 in 1996.

Nondurable goods manufacturing experienced a similar decrease of 22.6% going from a rate of 16.4 injuries and illnesses per 100 full-time workers in 1995 to 12.7 in 1996.

The industry with the greatest increase was finance, insurance, and real estate which increased 42.9% from 2.8 injuries and illnesses rate in 1995 to a rate of 4.0 in 1996.

Breaking manufacturing into two categories (durable and nondurable goods), the industry division with the highest incidence rate was nondurable goods manufacturing, with a rate of 12.7 injuries and illnesses per 100 full-time workers.

Meat packing plants had the highest incidence rate within the nondurable goods manufacturing division, with a rate of 24.5 injuries and illnesses per 100 full-time workers. The other manufacturing category, durable goods, reported the next highest rate of 12.4 injuries and illnesses.

The report contains information collected through a cooperative program with the U.S. Department of Labor, Bureau of Labor Statistics, designed to collect and analyze occupational injury and illness statistics in the states as part of a national database.

Survey results help officials evaluate the effectiveness of the Occupational Safety and Health Act of 1970, in reducing work-related injuries and illnesses, and to help businesses determine where prevention measures need to be intensified.

Unpublished data show the 1997 injury and illness incidence rate for private industry in Kansas was 8.6 per 100 full-time workers, down from 8.9 in 1996 and 9.7 in 1995.

Terri O'Brate
Occupational Injury Surveillance

Epidemiologists Release 1998 Report

Kansas reported no cases of the vaccine-preventable diseases diphtheria, measles, polio, or tetanus in 1998. The Bureau of Epidemiology and Disease Prevention also reported in its *Reportable Diseases in Kansas: 1998 Summary* cases of mumps and *Haemophilus influenzae b* remained low during the year (Table 5).

Reported acute hepatitis B cases dropped slightly in 1998. Two outbreaks accounted for the majority of rubella and pertussis cases reporting during the year.

Incidence of Selected Reportable Diseases in Kansas		
Disease	1998	1997
Diphtheria	0	0
Measles	0	0
Polio	0	0
Tetanus	0	0
Mumps	2	1
<i>Haemophilus influenzae b</i>	7	0
Hepatitis B	28	32
Rubella	36	0
Pertussis	71	33
Syphilis (primary & secondary)	12	32
Gonorrhea	2,574	2,094
Chlamydia	5,446	4,698
AIDS	87	145
Tuberculosis	56	78
Salmonellosis	363	446
Shigellosis	82	133
Giardiasis	226	230
<i>E coli</i> O157:H7	39	30

Table 5

The number of primary and secondary syphilis cases decreased dramatically after an increase in 1997. The incidence of gonorrhea continued to increase last year, paralleling national trends. Like syphilis, gonorrhea is concentrated in Kansas urban areas.

Chlamydia remains the most frequently reported sexually transmitted disease in Kansas. It is more widely geographically distributed.

The number of reported Kansas AIDS cases dropped from 1997 through 1998, as did the numbers for most other states. The decrease may be due to the progress being made in prevention and new treatments that delay the onset of AIDS.

Tuberculosis cases decreased by 28% in 1998. The Kansas TB case rate is well below the national rate.

Enteric infections (salmonellosis, shigellosis, and giardiasis) continued to be reported in large numbers. Reports of *E coli* O157:H7 increased only slightly in 1998.

The Bureau of Epidemiology and Disease Prevention collects reports on 48 reportable diseases and conditions of public health importance. Reports are provided by health departments, laboratories and physicians.

Bureau staff caution public health professionals to be careful in data interpretation. Epidemiologists note that disease reporting completeness varies by disease. For example, AIDS case reporting is estimated to be 90% complete while salmonella reporting is thought to be only 3-5% complete.

The *Reportable Diseases in Kansas: 1998 Summary* is available at <http://www.kdhe.state.ks.us/epi>.

Jamie S. Kim & Dr. Gail R. Hansen
Bureau of Epidemiology and Disease Prevention

OMB Seeks Comment on Standards for Defining Statistical Areas

On October 20, the Office of Management and Budget (OMB) released the recommendations from the Metropolitan Area Standards Review Committee (MASRC) for changes to

OMB's standards for defining metropolitan and nonmetropolitan areas. This is the first major revision of these concepts since 1970, when OMB developed new areas such as Primary Metropolitan Statistical Areas (PMSA's) and Metropolitan Statistical Areas (MSA's).

MASRC has recommended a Core-Based Statistical Areas (CBSAs) classification to replace the current Metropolitan Area (MA) classification. The cores (densely settled concentrations of population) for this classification would be Census Bureau defined urbanized areas and smaller densely settled "settlement clusters."

The settlement clusters are new areas to be identified for the 2000 Census. CBSAs would be defined around these cores. This CBSA classification has three types of areas based on the total population of all cores in the CBSA: 1) Megapolitan Areas defined around cores of at least 1,000,000 population; 2) Macropolitan Areas defined around cores of 50,000 to 999,999 population; and 3) Micropolitan Areas defined around cores of 10,000 to 49,999 population.

Those counties containing the cores, should become the central counties of the CBSA's. Territory outside of Megapolitan, Macropolitan and Micropolitan Areas would be termed "Outside CBSAs." The MASRC has recommended the use of counties and equivalent entities as the building blocks for statistical areas throughout the United States and Puerto Rico, including the use of counties as the primary building blocks for statistical areas in New England. MASRC also recommended that Minor Civil Divisions (MCDs) be used as building blocks for an alternative set of statistical areas for the New England States only. A single threshold of 25% to establish qualifying linkages between outlying counties and counties containing the CBSA cores has also been recommended.

OMB has allowed sixty (60) days for comments. To ensure consideration during the final decision making process, written comments must be received no later than December 20, 1999. Comments should be sent to James D. Fitzsimmons, U.S. Bureau of the Census, IPC-Population Division, Washington, DC 20233-8860.

Final standards will be announced by April 1, 2000. Actual areas, based upon 2000 Census commuting information, will probably be available in 2003. Full release text is available at: <http://www.whitehouse.gov/OMB/fedreg/msa-recommend.pdf>.

Census Web Site Lists Population Figures

Essential to the creation of rates, which allow researchers to compare health data across geographic boundaries, is standardized population figures. The Census Bureau publishes annual population estimates for Kansas, all 105 counties, and for selected demographic characteristics on a statewide basis. The estimates are for July 1 of a given year, assuring uniformity with prior years.

These population figures can be found on the Internet at <http://www.census.gov/population/www/estimates/popest.html>. The Census Bureau has published tables back to 1900. The bureau web site also provides detailed guidance on the layout and format of the population tables.

Another table available from the Census Bureau is a detailed 1997 estimate of population by county, race, hispanic origin, and age group. This table is infrequently produced.

All of the tables are text files, which can be copied and saved as an ascii text file. Opened and parsed, as a fixed width file, in most popular spreadsheet programs, the text formats nicely into cells.

The US Census figures are crucial to the production of the *Annual Summary of Vital Statistics*. One caveat: the Census Bureau may adjust its population estimates for prior years when publishing a new year's estimate. Because the *Annual Summary* represents a fixed point in time regarding the number of vital events and population estimates, re-calculation of rates with the updated estimates is imprudent.

The Office of Health Care Information provides birth and death information to the Kansas Division of the Budget which serves as the state population census data center. The Bureau uses that and other data supplied by the state to create its estimates.

Links to the Census Bureau web site and it's population estimate pages are available at the OHCI home page <http://www.kdhe.state.ks.us/hci/>.

Greg Crawford
Vital Statistics Data Analysis

News Notes

Center Director Returns

Center Director and State Registrar Dr. Lorne A. Phillips has returned to his fulltime position, after serving as acting Director of Health. Dr. Phillips' return follows KDHE Secretary Clyde D. Graeber's appointment of Dr. Michael Moser as Health Director. We welcome Dr. Phillips back.

HIPAA Update

The August 21 deadline Congress established in the Health Insurance Portability and Accountability Act (HIPAA) to enact privacy legislation has passed and the responsibility falls to HHS to develop regulations by February 21, 2000.

According to a summary published in *Health Data Management* (October, 1999), the regulations will resemble the legislative recommendations submitted to Congress by Secretary Shalala two years ago. To review these recommendations go to <http://aspe.os.dhhs.gov/admnsimp/> and select Health Information Privacy. Stay tuned.

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* to inform the public about the availability and uses of health data. Material in this publication is in the public domain and may be reproduced without special permission. Please credit *Kansas Health Statistics*, KDHE Center for Health and Environmental Statistics. E-mail subscriptions may be obtained by sending an e-mail message to: Kansas.Health.Statistics@kdhe.state.ks.us or send comments, questions, and address changes to OHCI, 900 SW Jackson, Room 904, Topeka, KS, 66612-1220 or call 785-296-8627. Clyde D. Graeber, Secretary; Lorne A. Phillips, PhD, State Registrar & Director CHES.

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