

Suicides among Kansas Residents, 2004-2013

Final U.S. data for 2013 showed suicide was the 10th leading cause of death, responsible for 41,149 deaths [1]. Suicide was also the 10th leading cause of death in Kansas in 2013, responsible for 426 deaths [2]. The Kansas age-adjusted suicide death rate was 14.7 per 100,000 population, which was higher than the goal set by the Healthy People 2020 project, 10.2 suicide deaths per 100,000 population [3].

Methods

All deaths for which the underlying cause of death was suicide (underlying cause of death in the range U03, X60-X84, and Y87.0) were selected from the Kansas Vital Records database. The individual codes in these groups indicate the method by which the decedent committed suicide.

Since the number of suicide deaths in any given year was fairly small, most demographic analyses were based on suicide deaths in a ten-year period, 2004–2013. The demographic categories selected for analysis included: population group, sex, age-group, and KDHE service district of residence. U.S. Census Bureau population estimates were used to calculate age-adjusted rates based on the year 2000 standard US population.

Differences in age-adjusted rates were considered to be statistically significant when the 95-percent confidence intervals did not overlap. In the rate comparisons in the rest of this report, statistical significance is assumed unless otherwise stated.

Marital status, veteran status, referral to coroner, and autopsy status had no corresponding population estimates, and thus could not be analyzed with age-adjusted rates. These categories were analyzed using percentages. Unless stated otherwise, percentages were calculated after excluding unknowns for the category from the denominator.

Results

There were 3,931 suicide deaths in Kansas during the 2004–2013 period. The age-adjusted suicide rate was 14.0 deaths per 100,000 U.S. standard population. This is higher than the goal of 10.2 deaths per 100,000 population set by the Healthy People 2020 project.

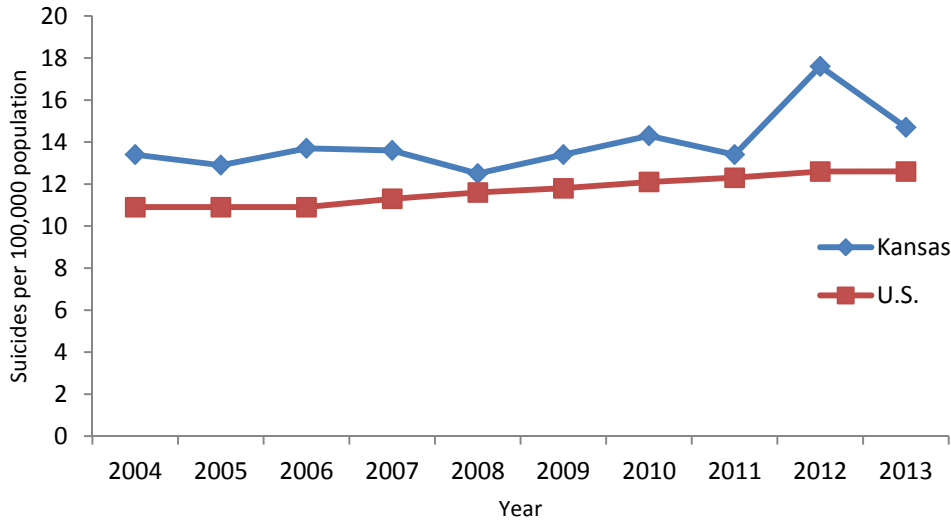
The Kansas suicide rate was higher than the national rate during each year in the 2004–2013 period. In 2013, the Kansas suicide rate (14.7 suicides per 100,000

Inside

Suicides among Kansas Residents, 2004-2013	1
Kansas Rates for Lower Extremity Amputation among Diabetes Patients.....	7
Announcements	8
STI Report Published.....	8
Preliminary Birth Report Issued.....	8
Provisional Death Statistics Available	8
Updates to Kansas Health Matters.....	9
Population Estimates Kansas Counties.....	11

population) was 16.7 percent higher than the national rate (12.6 suicides per 100,000 population) (Figure 1).

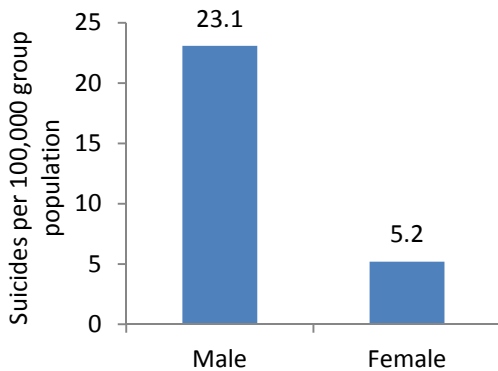
Figure 1. Age-Adjusted Suicide Rates, Kansas and U.S. 2004-2013



White non-Hispanics accounted for 88.8 percent (3,491 deaths) of Kansas resident suicides during the 2004-2013 period. The age-adjusted suicide rate for the period for White non-Hispanics was 15.1 deaths per 100,000 group population. Hispanics and Black non-Hispanics both had suicide rates of 7.4 deaths per 100,000 group population for the period, less than half the rate for White non-Hispanics.

Males accounted for 81.2 percent of suicides during the 2004-2013 period. The age-adjusted suicide rate for males was 23.1 deaths per 100,000 population, while the corresponding rate for females was 5.2 deaths per 100,000 population (Figure 2).

Figure 2. Age-Adjusted Suicide Rates by Sex, Kansas 2004-2013



The 45-54 age-group had the highest age-specific suicide rate during the 2004-2013 period (21.3 deaths per 100,000 population), followed by the 35-44 age-group (19.5 deaths per 100,000 population). The difference in rates between the two age-groups was not statistically significant.

The KDHE service districts with the highest suicide rates were Northwest Kansas (18.4 deaths per 100,000 population) and Southeast Kansas (15.2 deaths per 100,000 population). The

lowest suicide rate was reported for the Southwest Kansas district (12.4 deaths per

100,000 population). The rate differences among KDHE service districts were not statistically significant.

Among male suicide victims, a plurality (35.6%) were single (never-married), followed by married men (35.0%), divorced men (22.8%), and widowers (5.5%). Among female suicide victims, a plurality (37.4%) were married, followed by divorced women (28.3%), single women (23.5%), and widows (9.6%).

Slightly over a quarter (26.3%) of all male suicide victims were veterans, as were 3.6 percent of all female suicide victims.

For males, the method most commonly used to commit suicide was firearms (61.1%), followed by hanging or some other method of suffocation (21.7%) and poisoning (11.5%). For females, the method most commonly used to commit suicide was poisoning (40.4%), followed by firearms (31.4%) and suffocation (20.9%).

In 2005, a question whether the death had been referred to a coroner was added to the death certificate. In the period from 2005–2013, 98.1 percent of all suicide deaths were referred to a coroner. Only 0.6 percent of suicide deaths were known not to have been referred to a coroner. In the remaining cases, it was not known whether the case had been referred to a coroner.

Autopsies were performed for 76.9 percent of all suicide deaths in the 2004–2013 period. The autopsy findings were used to determine the cause of death for 70.1 percent of all suicide deaths in the period. Suicide deaths were most likely to be followed by an autopsy in cases of poisoning (80.9%) and suffocation (79.8); autopsies were slightly less likely in cases of suicide by firearm (74.6%). Unknowns were not omitted from the denominators for these percentages.

Limitations and Discussion

Official suicide statistics have long been suspected of underreporting the true suicide rate. However, most researchers have asserted that mistakes are minimal and not systematic, while a minority claims that suicide statistics are systematically biased. [4]

Separate suicide rates were not calculated for smaller population groups to avoid presenting unreliable statistics. However, national statistics by race have shown that Native American/Alaska Natives have had suicide rates similar to, but slightly lower than those of Whites, and Asian/Pacific Islanders have had rates very similar to those of Blacks and Hispanics [5].

While suicide numbers and rates have been rising slowly over the last decade, the changes have not been statistically significant. Kansas suicide rates have remained higher than national rates, even though the latter have also been rising. These changes move the state away from, rather than toward the Healthy People 2020 target of no more than 10.2 suicide deaths per 100,000 population.

References

- [1] Deaths: Final data for 2013. National vital statistics reports; vol 64 no 2 (forthcoming). Hyattsville, MD: National Center for Health Statistics. 2015. Available at www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf. Accessed January 14, 2015.
- [2] Oakley D, Crawford G, Savage C. 2013 Kansas Annual Summary of Vital Statistics. Topeka, KS: Kansas Department of Health and Environment, 2014.
- [3] Healthy People 2020 suicide targets available at www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders/objectives. Accessed January 9, 2015.
- [4] Timmermans S, Suicide Determination and the Professional Authority of Medical Examiners, American Sociological Review, Vol. 70, No. 2, Apr. 2005, pp. 311-333.
- [5] American Foundation for Suicide Prevention (AFSP). Facts and Figures. Available at www.afsp.org/understanding-suicide/facts-and-figures. Accessed February 23, 2015.

David Oakley, MA
Bureau of Epidemiology and Public Health Informatics

Kansas Rates for Lower Extremity Amputation among Diabetes Patients

Introduction

In 2008, the Centers for Disease Control and Prevention published the study “Declining Rates of Hospitalization for Nontraumatic Lower-Extremity Amputation in the Diabetic Population Aged 40 Years or Older: U.S., 1988-2008”, which reported a “substantial” decline from 1996 to 2008 in the rate of lower extremity amputations among U.S. adults with diagnosed diabetes, even though the rate of diagnosed diabetes had more than tripled from 1998 to 2008 [1].

Diabetes is the leading risk factor for non-traumatic lower extremity amputation, and falling rates of lower extremity amputation among adults with diabetes (LEA-D) may be partially due to improvement in blood sugar control, foot care and diabetes management [2]. However, even with the decline, the rate of LEA-D in 2008 remained eight times as high as the rate of amputation among adults without diabetes [1].

Objective

In a 2003 article in *Diabetes Care* which considered whether the number of amputations could be used as a measure of the prevalence of peripheral arterial disease, it was reported that “medical care and local indications for amputation versus revascularization ... vary widely”. “There is a nearly ninefold variation of major amputations in people with diabetes across the U.S.” [3]. Therefore, this article attempts to examine the incidence of lower extremity amputations among hospital patients in Kansas from 2000 to 2012, to compare Kansas numbers to the national trend and to see whether any decline in rates has continued past 2008.

Methods

Rates of LEA-D in Kansas were calculated from hospital discharge data for calendar years 2000-2012, provided to the Kansas Department of Health and Environment, Bureau of Epidemiology and Public Health Informatics by the Kansas Hospital Association. These data include up to 66 procedure code fields and up to 66 diagnosis code fields.

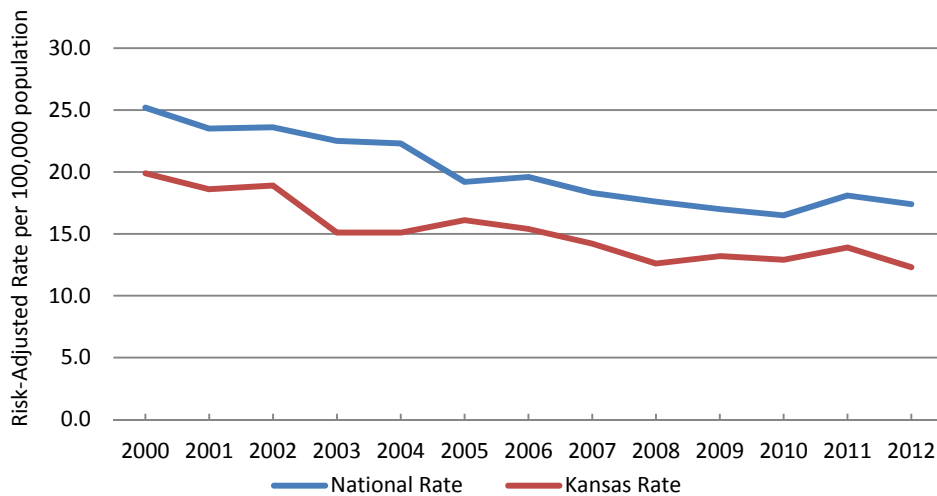
Software used for the analyses included SAS V9.3 and V4.5 of the AHRQ Prevention Quality Indicators (PQI) Software [4]. The PQI definition for Indicator 16 is “All non-maternal discharges of age 18 years and older with ICD-9-CM procedure code for lower-extremity amputation in any field and diagnosis code of diabetes in any field” per 100,000 population aged 18 years and over. Records with any diagnosis of trauma are excluded. A complete list of procedure and diagnosis codes included in, and excluded from, the analysis numerator, can be found in the AHRQ Prevention Quality Indicator PQI16 technical specifications [5].

The AHRQ programs employ covariates for risk adjustment which allowed for comparison of overall rates for Kansas to national rates [6]. Rates by age group were calculated as observed (crude) rates, and rates by race and sex were adjusted rates based on the year 2000 standard population. Differences in rates were considered to be statistically significant when the 95 percent confidence intervals did not overlap.

Results

In Kansas, the risk-adjusted rate of LEA-D per 100,000 population aged 18 years or over declined by 36.7 percent, from 19.9 in 2000 to 12.6 in 2008, then did not significantly change from 2008 to 2012. The national rate reached its lowest point in 2010, then plateaued. The Kansas rate was lower than the national rate for all years (Figure 1).

Figure 1. Lower Extremity Amputation Among Patients with Diabetes, Kansas and the U.S., 2000-2012

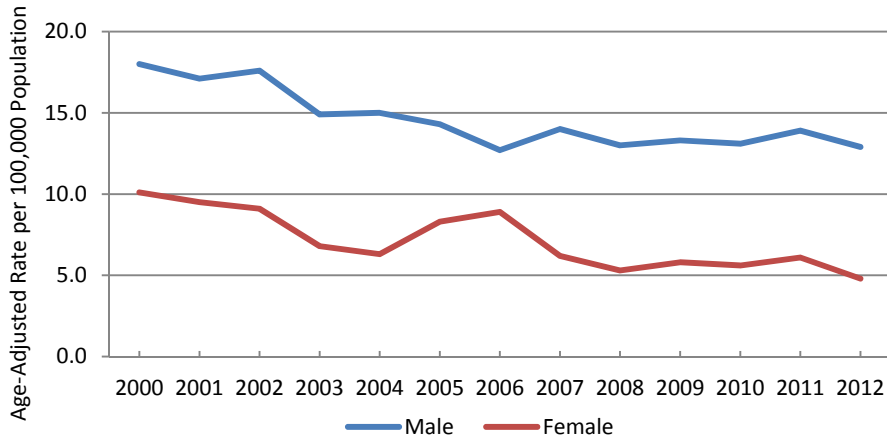


From 2000 to 2012, the Kansas age-adjusted LEA-D rate for non-Hispanic blacks fell 48.7 percent, from 56.1 to 28.8 per 100,000 year 2000 standard population. For non-

Hispanic whites, it fell 35.3 percent, from 10.2 to 6.6. The rate for non-Hispanic blacks was four to five times the rate for non-Hispanic whites in all years.

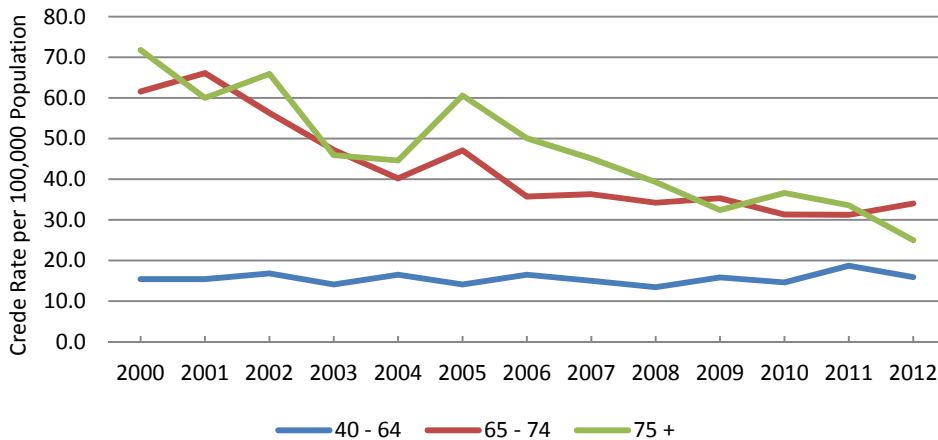
The age-adjusted rate was lower among females than among males, with the gap narrowing only temporarily in 2005 and 2006. From 2000 to 2012, the rate for females decreased 52.5 percent, while the rate for males decreased 28.3 percent (Figure 2).

Figure 2. Age-Adjusted Rates of Lower Extremity Amputation Among Patients with Diabetes, by Sex, Kansas, 2000-2012



Older patients, those aged 65 years and over, showed the greatest drop in crude rates. In 2000, the rate for patients aged 75 years and over was 4.7 times the rate for patients aged 40 to 64 years. In 2012, the rate for patients aged 75 years and over was the lowest of any year and had dropped to 1.6 times the rate for patients aged 40 to 64 years. The rate for patients aged 65 to 74 years had dropped to 2.1 times the rate for patients aged 40 to 64 years. The rate for patients aged 40 to 64 years remained virtually unchanged over the entire time period (Figure 3).

Figure 3. Rates of Lower Extremity Amputations Among Patients with Diabetes, by Age Group Kansas, 2000-2012



Discussion

Changes in rates of lower extremity amputation among patients with diabetes in Kansas mirror those seen on the national level: there was a significant decline in the rate to 2008, while men had higher rates than women, rates were higher for blacks than for whites, and rates showed the greatest decline for people aged 75 years and over.

The American Diabetes Association reports that approximately 60 percent of non-traumatic lower extremity amputations among people aged 20 years or older occur in people diagnosed with diabetes [7]. The decrease in rates of lower extremity amputation among diabetic patients is a positive development, especially considering that the rate of diabetes is increasing as the population continues to age. Since the LEA-D rate has stabilized since 2008 in Kansas, it is important to continue to monitor it and not lose any improvements made in the self-management of, and care provided to, diabetic patients. Educational efforts should be directed especially toward those most at risk: males, blacks, and the elderly.

Joy Crevoiserat, BA
Bureau of Epidemiology and Public Health Informatics

References

- [1] Li, Y., Burrows, N.R., Gregg, E.W., Albright, A., & Geiss, L.S. (2012). "Declining Rates of Hospitalizations for Nontraumatic Lower-Extremity Amputation in the Diabetes Population Aged 40 Years or Older: U.S., 1988-2008". *Diabetes Care*, 35:273-277, 2012. Accessed at: care.diabetesjournals.org/content/35/2/273.full
- [2] Grace Rattue, "Lower Limb Amputation Rates Associated With Diabetes Drop, U.S.," *Medical News Today*, December 23, 2014. Accessed at: www.medicalnewstoday.com/articles/240818.php.
- [3] Consensus Development Conference panel. "Peripheral Arterial Disease in People with Diabetes". *Diabetes Care*, vol. 26, no. 12, December 2003, 3333-3341. Accessed at: care.diabetesjournals.org/content/26/12/3333.full.
- [4] U.S. Department of Health & Human Services. Agency for Healthcare Research and Quality. Accessed at www.qualityindicators.ahrq.gov/Software/SAS.aspx.
- [5] "Lower Extremity Amputation among Patients with Diabetes Rate, Technical Specifications". Agency for Healthcare Research and Quality. Accessed at www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V44/TechSpecs/PQI%2016%20Rate%20of%20Lower-Extremity%20Amputation%20Diabetes.pdf.
- [6] HCUPnet. Agency for Healthcare Research and Quality. Accessed at hcupnet.ahrq.gov/.
- [7] Centers for Disease Control and Prevention. *National Diabetes Statistics Report: Estimates of Diabetes and Its Burden in the United States, 2014*. Atlanta, GA: U.S. Department of Health and Human Services; 2014. Accessed at: www.cdc.gov/diabetes/pubs/statsreport14/national-diabetes-report-web.pdf.

Announcements

STI Report Published

The Bureau of Disease Control and Prevention has released the annual Sexually Transmitted Infection (STI) report for calendar year (CY) 2014. A copy of the report can be found at: www.kdheks.gov/sti_hiv/download/std_reports/Kansas_STD_Report_January_December_2014.pdf. During CY2014, there were 145 cases of early (less than one year's duration) syphilis reported throughout the state of Kansas. This is a 15 case (12%) increase from CY2013. However, a larger percentage of the cases (23% versus 15%) were in women. This increase in cases among women increases the risk of experiencing congenital syphilis.

A total of 2,529 cases of gonorrhea were reported in CY2014, with the majority of cases residing in Wyandotte, Johnson, Sedgwick, and Shawnee counties. These cases represent a 353 case (16%) increase when compared to CY2013. Gonorrhea cases continue to be a priority for intervention services due to the increasing risk of anti-microbial resistance worldwide. This represents the reversal of downward trends in gonorrhea morbidity over the past ten years.

Chlamydia continues to be the most frequently reported STI in Kansas, with 11,011 cases reported during CY2014. This is a 147 case (1%) decrease when compared to CY2013. It is important to keep in mind with all STIs that the statistics released represent only reported cases. Due to the asymptomatic nature of many STIs, it is reasonable to assume that many cases may not be diagnosed due to lack of screening.

Bureau of Disease Control and Prevention

Preliminary Birth Report Issued

The Bureau of Epidemiology and Public Health Informatics has released *Preliminary Birth Report, Kansas, 2014*. As of March 25, 2015, KDHE's Office of Vital Statistics had recorded 39,201 births to Kansas resident mothers in 2014, an increase of 1.0 percent from 38,805 births in 2013. The birth rate rose from 13.4 per 1,000 population in 2013 to 13.5 in 2014. Counts and rates presented in the *Kansas Annual Summary of Vital Statistics, 2014* may be slightly higher, due to births may be reported for Kansas residents who gave birth in other states.

The full report is available at www.kdheks.gov/phi/research.html. For further inquiry about additional data needs, call (785) 296-8627.

Bureau of Epidemiology and Public Health Informatics

Provisional Death Statistics Available

Provisional death statistics for Kansas resident mortality are now available at Kansas Information for Communities, kic.kdheks.gov. This KIC feature, available at

kic.kdheks.gov/deathR12_new.php#top, provides counts and mortality rates for the most recent four calendar quarters. For example, the provisional mortality query was recently updated to report resident deaths from April 1, 2014 to March 31, 2015.

The provisional death statistics module is updated quarterly during the months of February, May, August, and November. For example the May update results in adding data for January to March of the current year following a one month lag to enable inclusion of all mortality events based on the date of death.

Population data for this module are the most currently available estimates (2013) from the U.S Census Bureau. The population estimates will be updated with 2014 as soon as they are available.

The provisional death statistics module allows users to access counts and population based rates in near real-time. Thus if there are reports of an increase of a certain cause of death, users can access the most current counts and compare a provisional mortality rate for that cause, to the mortality rate for the most recent final calendar year.

One reason for reporting a rolling four quarters of mortality data is seasonality in death occurrence. Some deaths more frequently occur during certain quarters. For example, pneumonia and influenza deaths are more frequent in the first quarter of a calendar year. Four quarters of death data removes seasonality from any comparison of rates.

There are some caveats. Even though there is a one month lag after a quarter ends and when the death data are posted, the most recent quarter may still be incomplete. Statistics may also be incomplete for infant deaths and some types of external causes like suicide or homicide. This is because of the length of time for forensic examinations to be completed and final cause of death to be reported to the Office of Vital Statistics.

Bureau of Epidemiology and Public Health Informatics

Updates to Kansas Health Matters

The Kansas Health Matters Partnership has updated the site to include new links and resources. The “Community Plans & Strategies” section of Kansas Health Matters, <http://www.kansashealthmatters.org>, now contains the most recent Community Health Needs Assessment report from participating Kansas counties. The reports can be found by selecting menu heading “Locate Resources and Funding” then select “Community Plans & Strategies”. The reports are contained within the Health group and the complete list can be viewed by clicking the “More ->” selection in the lower right hand corner of same group. Visit www.kansashealthmatters.org/index.php?module=Article&func=collection&cid=101&topic=5 for a direct link to the page.

Creating a directory of local health services and community assets provides multiple benefits to local residents, health service providers and community health organizations. A local health services and community asset directory is a requirement for certain hospital entities performing Community Health Needs Assessments. It also is required

for health departments preparing to apply for national accreditation through the Public Health Accreditation Board. The Kansas Health Matters Partnership in conjunction with K-State Research and Extension has created a Guide and a Word Template to assist hospitals, health departments and other community organizations with a local health services and community asset directory. Health services directories were created for 98 Kansas counties in 2012, and could serve as a starting point for many communities. These directories are at: www.krhw.net/ruralhsd.html.

For more information on these and other updates, visit the 'Contact Us' section of Kansas Health matters or email kansas.health.statistics@kdheks.gov.

Kansas Health Matters is a partnership for improving community health. Partners include Kansas Hospital Association, Kansas Health Institute, Kansas Health Foundation, Kansas Department of Health and Environment, Kansas Association of Local Health Departments, and Kansas Association for the Medically Underserved.

Bureau of Epidemiology and Public Health Informatics

Kansas Health Statistics Report

Population Estimates and Change by County, Kansas 2013 and 2014

Geography	Population Estimate (as of July 1)		Change 2013 to 2014	
	2013	2014	N	% [1]
Kansas	2,895,801	2,904,021	8,220	0.3
Allen	13,098	12,909	-189	-1.4
Anderson	7,858	7,883	25	0.3
Atchison	16,717	16,513	-204	-1.2
Barber	4,938	4,897	-41	-0.8
Barton	27,510	27,385	-125	-0.5
Bourbon	14,826	14,772	-54	-0.4
Brown	9,949	9,815	-134	-1.3
Butler	65,884	66,227	343	0.5
Chase	2,708	2,692	-16	-0.6
Chautauqua	3,553	3,481	-72	-2.0
Cherokee	20,933	20,787	-146	-0.7
Cheyenne	2,682	2,693	11	0.4
Clark	2,201	2,144	-57	-2.6
Clay	8,390	8,317	-73	-0.9
Cloud	9,365	9,385	20	0.2
Coffey	8,415	8,433	18	0.2
Comanche	1,924	1,954	30	1.6
Cowley	36,230	35,963	-267	-0.7
Crawford	39,330	39,290	-40	-0.1
Decatur	2,915	2,908	-7	-0.2
Dickinson	19,521	19,394	-127	-0.7
Doniphan	7,859	7,874	15	0.2
Douglas	114,803	116,585	1,782	1.6
Edwards	2,957	3,030	73	2.5
Elk	2,650	2,694	44	1.7
Ellis	29,060	29,013	-47	-0.2
Ellsworth	6,390	6,392	2	0.0
Finney	37,131	37,184	53	0.1
Ford	34,950	34,795	-155	-0.4
Franklin	25,790	25,611	-179	-0.7
Geary	36,987	36,713	-274	-0.7
Gove	2,765	2,727	-38	-1.4
Graham	2,598	2,566	-32	-1.2
Grant	7,869	7,816	-53	-0.7
Gray	6,007	6,082	75	1.2
Greeley	1,286	1,301	15	1.2
Greenwood	6,404	6,328	-76	-1.2
Hamilton	2,606	2,603	-3	-0.1
Harper	5,859	5,818	-41	-0.7
Harvey	34,803	34,820	17	0.0
Haskell	4,136	4,106	-30	-0.7
Hodgeman	1,951	1,916	-35	-1.8
Jackson	13,373	13,539	166	1.2
Jefferson	18,824	18,855	31	0.2
Jewell	3,067	3,043	-24	-0.8
Johnson	567,326	574,272	6,946	1.2
Kearny	3,904	3,915	11	0.3
Kingman	7,837	7,698	-139	-1.8
Kiowa	2,518	2,513	-5	-0.2
Labette	20,969	20,960	-9	0.0
Lane	1,720	1,687	-33	-1.9
Leavenworth	78,234	78,797	563	0.7

Geography	Population Estimate (as of July 1)		Change 2013 to 2014	
	2013	2014	N	% [1]
Lincoln	3,138	3,167	29	0.9
Linn	9,531	9,502	-29	-0.3
Logan	2,789	2,794	5	0.2
Lyon	33,522	33,212	-310	-0.9
McPherson	29,606	29,241	-365	-1.2
Marion	12,224	12,208	-16	-0.1
Marshall	10,028	10,006	-22	-0.2
Meade	4,304	4,357	53	1.2
Miami	32,839	32,822	-17	-0.1
Mitchell	6,336	6,284	-52	-0.8
Montgomery	34,396	34,065	-331	-1.0
Morris	5,717	5,698	-19	-0.3
Morton	3,150	3,110	-40	-1.3
Nemaha	10,140	10,148	8	0.1
Neosho	16,458	16,416	-42	-0.3
Ness	3,094	3,105	11	0.4
Norton	5,642	5,560	-82	-1.5
Osage	16,082	15,936	-146	-0.9
Osborne	3,806	3,756	-50	-1.3
Ottawa	6,071	6,065	-6	-0.1
Pawnee	6,946	6,916	-30	-0.4
Phillips	5,571	5,533	-38	-0.7
Pottawatomie	22,670	22,897	227	1.0
Pratt	9,844	9,850	6	0.1
Rawlins	2,603	2,584	-19	-0.7
Reno	64,155	63,794	-361	-0.6
Republic	4,810	4,803	-7	-0.1
Rice	10,010	10,015	5	0.0
Riley	75,905	75,194	-711	-0.9
Rooks	5,164	5,155	-9	-0.2
Rush	3,186	3,197	11	0.3
Russell	6,929	6,956	27	0.4
Saline	55,830	55,755	-75	-0.1
Scott	4,992	5,080	88	1.8
Sedgwick	506,121	508,803	2,682	0.5
Seward	23,470	23,465	-5	0.0
Shawnee	178,574	178,406	-168	-0.1
Sheridan	2,531	2,539	8	0.3
Sherman	6,107	6,110	3	0.0
Smith	3,720	3,769	49	1.3
Stafford	4,350	4,297	-53	-1.2
Stanton	2,167	2,111	-56	-2.6
Stevens	5,790	5,801	11	0.2
Sumner	23,614	23,528	-86	-0.4
Thomas	8,001	7,891	-110	-1.4
Trego	2,959	2,902	-57	-1.9
Wabaunsee	7,041	7,022	-19	-0.3
Wallace	1,562	1,506	-56	-3.6
Washington	5,628	5,598	-30	-0.5
Wichita	2,186	2,176	-10	-0.5
Wilson	9,105	9,028	-77	-0.8
Woodson	3,206	3,157	-49	-1.5
Wyandotte	160,601	161,636	1,035	0.6

1] Some values are zero due to rounding.

Note: The estimates are based on the 2010 Census and reflect changes to the April 1, 2010 population due to the Count Question Resolution program and geographic program revisions. All geographic boundaries for the 2014 population estimates series except statistical area delineations are as of January 1, 2014

Source: U.S. Census Bureau, Population Division. Estimates of Resident Population Change & Rankings: July 1, 2013 to July 1, 2014 Released: March 2015

The Public Health Informatics Unit (PHI) of the Kansas Department of Health and Environment's Bureau of Epidemiology and Public Health Informatics 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: PHI, 1000 SW Jackson, Suite 130 Topeka, KS, 66612-1354, Kansas.Health.Statistics@kdheks.gov, or 785-296-8627. Robert Moser, MD, Secretary KDHE; D. Charles Hunt, MPH, State Epidemiologist and Director, BEPHI; Elizabeth W. Saadi, PhD, State Registrar, Deputy Director, BEPHI; Greg Crawford, Editor.

PRST STD
US Postage
Paid
Topeka, KS
Permit No. 157

264-39
Bureau of Epidemiology and Public Health Informatics
Kansas Dept. of Health & Environment
1000 SW Jackson, Suite 130
Topeka, KS 66612-1354