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## Kansas Violent Death Reporting System: Statistics for Suicides and Homicides in Kansas, 2015-2018

### Introduction

The Kansas Violent Death Reporting System (KSVDRS) is a surveillance system that collects data on violent deaths that occur in the state.<sup>1</sup> Violent deaths are defined as “a death that results from the intentional use of physical force or power, threatened or actual against oneself, another person, or a group or community” and include incidents such as homicide, suicide, legal intervention or war, unintentional firearm death, and deaths with an undetermined intent.<sup>2</sup> Kansas has been collecting data for this system since 2015 and this data is collected through partnerships at the state, county and city level. KSVDRS abstractors collect information from death certificates, law enforcement reports, coroner and medical examiner reports, and toxicology reports.<sup>1</sup> Data from KSVDRS is analyzed regularly to provide an understanding of the status of violent deaths in the state. KSVDRS collects detailed demographic information and circumstances that contribute to a violent death such as mental health, relationship problems, life events and stressors, criminal activity and other specific circumstances for suicides, homicides, and unintentional deaths.

### Methods

Data from KSVDRS was analyzed for the years 2015 to 2018. Counts and rates were calculated using aggregated data over this period unless stated as a trend over time. For suicide counts and rates, only those decedents ages 10 years and over were included in the analysis. Statistical analyses were completed using SAS 9.4 and data visualizations were completed in Microsoft Excel. Age-adjusted rates were calculated by direct standardization using the U.S. 2000 standard population along with 95% confidence intervals (CI). Non-overlapping CIs indicate significant difference between rates. Rates for counts less than 20 are suppressed due to instability, and thus rates for two or more races were not calculated.

### Results

Between 2015 and 2018, there were a total of 2,851 violent deaths in Kansas (see Table 1). Suicides made up about 74% (n=2,097) of all violent deaths and had the highest age-adjusted rate (20.5 per 100,000 residents, 95% CI:19.6-21.4). Homicides contributed to about 21% (n=591) of violent deaths with an age-adjusted rate of 5.3 per 100,000 residents (95% CI: 4.9-5.8).

Table 1: Frequency, Percent and Age-Adjusted Rates by Incident, 2015-2018

Incident	N	%	Age-Adjusted Rate per 100,000 Residents (95% CI)
Suicide	2097	73.6	20.5 (19.6, 21.4)
Homicide	591	20.7	5.3 (4.9, 5.8)
Legal Intervention/War	35	1.2	0.3 (0.2, 0.4)
Unintentional Firearm	24	0.8	0.2 (0.1, 0.3)
Undetermined	104	3.7	0.9 (0.7, 1.1)
Total	2851	3.7	24.9 (23.9, 25.8)

## Trends

The suicide mortality rate increased from 17.1 per 100,000 persons (95% CI: 16.0, 19.4) in 2015 to 22.4 per 100,000 persons (95%CI: 20.5, 24.3) in 2018. The homicide mortality rate increased from 4.4 per 100,000 persons (95%CI: 3.6, 5.2) in 2015 to 5.7 per 100,000 persons (95% CI: 4.7, 6.6) in 2018.

## Demographics

For suicide and homicide, males had significantly higher mortality rates than females (Table 2). White, non-Hispanic persons had the highest mortality rate of suicide (22.5 per 100,000 persons) while Black or African American, non-Hispanic persons had the highest mortality rate for homicide (23.8 per 100,000 persons). The age group 25-34 years had the highest suicide mortality rate (26.4 per 100,000 residents). The age group 20-24 had the highest homicide mortality rate (12.3 per 100,000 residents).

Table 2. Selected Demographic Characteristics, Homicides and Suicides – Kansas Violent Death Reporting System, 2015-2018

Demographic Variable	N	%	Rate* per 100,000 Residents (95% CI)
<b>Suicide (n=2097)</b>			
<b>Race/Ethnicity (n=2090) †</b>			
White‡	1754	83.9	22.5 (21.4, 23.6)
Black or African American‡	80	3.8	12.1 (9.3, 14.8)
American Indian/Alaska Native‡	24	1.2	22.3 (12.9, 31.6)
Asian/Pacific Islander‡	42	2.0	12.9 (8.8, 17.1)
Hispanic	138	6.6	11.7 (9.6, 13.7)
Two or more races‡	47	2.3	-
<b>Age Group (n=2096) †</b>			
10-14 years	28	1.3	3.5 (2.2, 4.8)
15-19 years	125	6.0	15.6 (12.9, 18.3)
20-24 years	194	9.3	22.4 (19.2, 25.5)
25-34 years	406	19.4	26.4 (23.8, 29.0)
35-44 years	362	17.3	25.8 (23.2, 28.5)
45-54 years	340	16.2	24.3 (21.8, 26.9)
55-64 years	319	15.2	21.5 (19.1, 23.8)
65-74 years	176	8.4	17.6 (15.0, 20.2)
75 years and older	149	6.9	18.8 (15.7, 21.8)
<b>Homicide (n=591)</b>			
<b>Sex (n=591)</b>			
Male	439	74.3	7.8 (7.0, 8.5)
Female	152	25.7	2.8 (2.3, 3.2)
<b>Race/Ethnicity (n=590) †</b>			
White‡	248	42.0	3.0 (2.6, 3.3)
Black or African American‡	188	31.9	23.8 (20.3, 27.3)
American Indian/Alaska Native‡	11	1.9	-
Asian/Pacific Islander‡	16	2.7	3.9 (1.9, 5.8)
Hispanic	99	16.8	7.3 (5.8, 8.8)
Two or more races‡	24	4.1	-
<b>Age Group (n=591)</b>			
19 years or younger	85	14.4	2.7 (2.1, 3.2)
20-24 years	107	18.1	12.3 (10.0, 14.7)
25-34 years	140	23.7	9.1 (7.6, 10.7)
35-44 years	116	19.6	8.3 (6.8, 9.8)
45 years or older	143	24.2	3.1 (2.6, 3.6)

\*Rates for sex and race/ethnicity are age-adjusted; rates for age groups are crude rates residents

†Count differences due to missing values for the variable

‡Non-Hispanic

Abbreviation: CI = confidence interval.

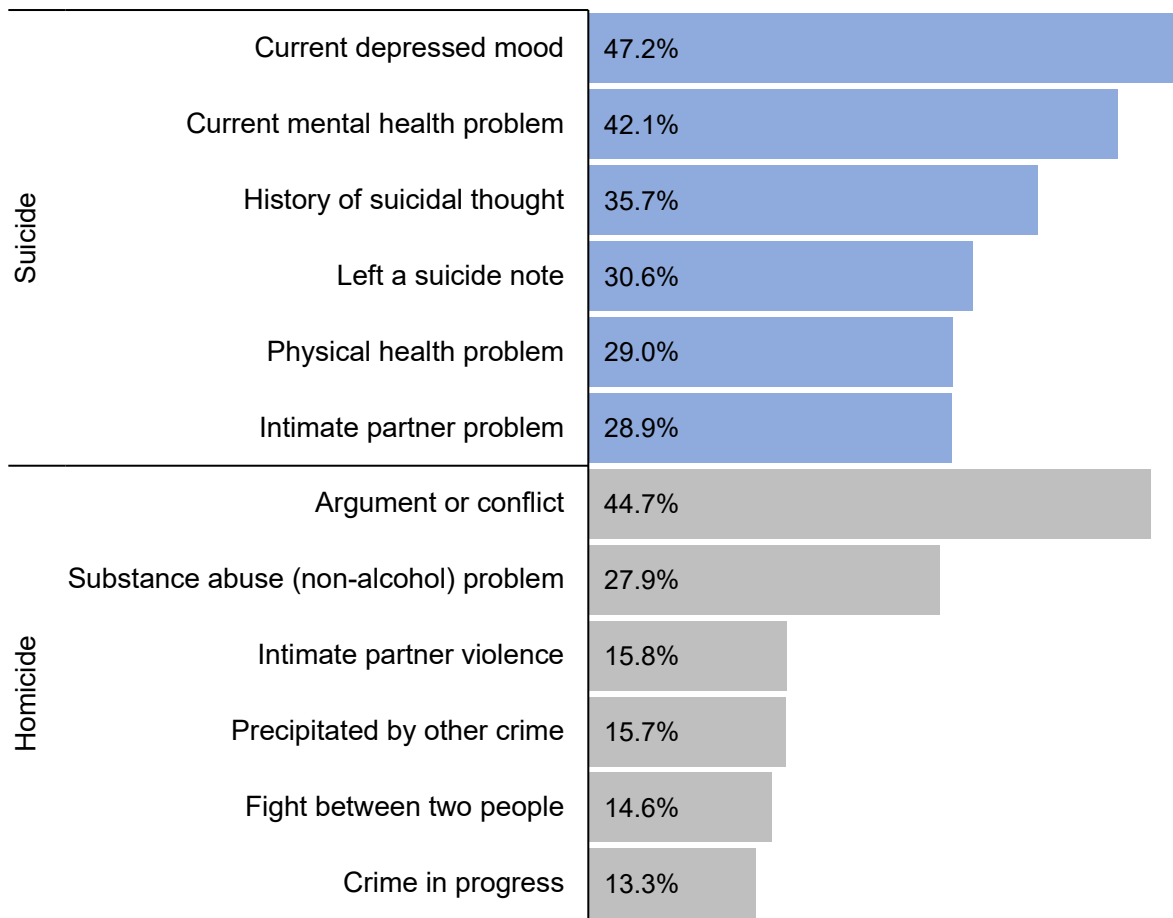
**Mechanism**

Drug overdose (drug poisoning) was the most common mechanism of suicide in females (34%) and the use of a firearm was the most common mechanism in males (58%). For both males (80%) and females (55%), the use of a firearm was the most common mechanism of homicide.

**Circumstances**

Figure 1 (below) depicts the top six (6) reported circumstances that were reported for suicides and homicides. Of circumstances that are known, a current depressed mood was the most reported circumstance for suicides (47.2%) and an argument or conflict prior to the death was the most commonly reported circumstance for homicides (44.7%).

Figure 1. Percentage of Reported Circumstances for Suicides and Homicides, 2015-2018



**Conclusion**

The Kansas Violent Death Reporting System is a robust data collection system. KSVDRS is unique in that it collects a wide array of information, especially information regarding circumstances surrounding violent deaths. Data analyzed from KSVDRS can be used to inform prevention efforts and increase awareness of the toll that violent deaths have on Kansas communities.

Lauren Gracy, MPH  
Bureau of Epidemiology and Public Health Informatics

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## Health Status Indicators, Health Risk Behaviors and Conditions By Rural-Urban Classification in Kansas, 2020 Kansas Behavioral Risk Factor Surveillance System

### Background

Research shows that health disparities exist between residents living in rural versus urban counties.<sup>1,2</sup> KDHE previously used an urban-rural classification based on population density.<sup>3</sup> The year 2018 was the first instance where Kansas BRFSS data were analyzed using the 2013 National Center for Health Statistics (NCHS) Urban-Rural Classification Scheme for Counties.<sup>4</sup> Data are analyzed in this report using the 2020 Kansas BRFSS.

### Methods

Data from the 2020 Kansas BRFSS were analyzed to assess the prevalence of selected health status indicators, behaviors, and conditions by urban-rural categories. Descriptive analyses were conducted, prevalence estimates and 95% confidence intervals (CI) were calculated. All analyses were performed using SAS version 9.4 survey procedures to account for complex sample design and unequal selection probabilities. The 2013 NCHS Urban-Rural Classification Scheme for Counties uses 2010 census data and the February 2013 Office of Management and Budget designations of metropolitan statistical area (MSA), micropolitan statistical area, or noncore area to assign each U.S. county to one of six (four metropolitan, one micropolitan, and one noncore) following categories:

- 1) Large central metro counties in MSA of 1 million population that contain the entire population of the largest principal city of the MSA, or are completely contained within the largest principal city of the MSA, or contain at least 250,000 residents of any principal city in the MSA;
- 2) Large fringe metro counties in MSA of 1 million or more population that do not qualify as large central metro counties;
- 3) Medium metro counties in MSA of 250,000-999,999 population;
- 4) Small metro counties are counties in MSAs of less than 250,000 population;
- 5) Micropolitan counties in micropolitan urban cluster population of 10,000-49,000 population;
- 6) Noncore counties not in micropolitan areas and might be thought of as rural or mostly rural. Researchers sometimes use noncore and rural or most rural interchangeably. We have used noncore as rural in this analysis.

### Results

Significantly higher percentage of urban county adults reported frequent mental distress, depressive disorder, and being unable to see a doctor because of cost as compared with rural adults. Compared to urban county adults, rural county adults had a significantly higher prevalence of arthritis, currently using any smokeless tobacco products, not participating in any physical activity other than the regular job in the past month, not always wearing a seatbelt when they drive or ride in a car, never had a pneumonia vaccination (65 years and older) and had all of their permanent teeth removed (65 years and older). In addition, rural counties had a higher prevalence of women aged 50-74 years who had not had a mammogram within the past two years, women aged 21-65 years who did not have a pap smear within

the past three years, and adults aged 50-75 years who did not meet the recommendation for colorectal cancer screening (Table 1).

Table 1: Prevalence of selected health status, health risk behaviors, and conditions among adults aged 18 years and older, by urban-rural status\* — Behavioral Risk Factor Surveillance System, Kansas, 2020

Selected health status, health risk behaviors, and conditions	Urban	Rural
	% (95% CI)	% (95% CI)
Frequent Mental Distress	14.4 (13.4-15.4)	11.3 (9.5-13.1)
Depressive Disorder	20.0 (18.9-21.2)	14.3 (12.5-16.1)
Unable to see a Doctor because of Cost in the past 12 months	10.8 (9.8-11.7)	7.9 (6.3-9.5)
Arthritis	23.9 (22.8-25.0)	28.3 (26.0-30.6)
Current Smokeless Tobacco Products Use	4.8 (4.2-5.5)	7.4 (6.0-8.8)
Not Participating in Any Physical Activity Other Than the Regular Job in The Past Month	21.0 (19.9-22.1)	28.4 (25.9-30.8)
Does Not Always Use a Seatbelt	14.7 (13.7-15.7)	29.8 (27.4-32.2)
Women Aged 50-74 Years Who Had Not had Mammogram Within the Past Two Years	25.5 (23.1-27.8)	33.2 (28.4-38.0)
Women Aged 21-65 Years Who Did Not Have a Pap Smear Within the Past Three Years	21.5 (19.2-23.8)	30.7 (25.3-36.1)
Adults Aged 50-75 Years Who Did Not Meet the Colorectal Cancer Screening Recommendation	28.6 (26.7-30.5)	39.5 (35.7-43.2)
Adults Aged 65 Years and Older Who Never Had a Pneumonia Vaccination	24.8 (22.7-26.8)	31.7 (27.8-35.6)
Adults Aged 65 Years and Older Who Had All of their Permanent Teeth Removed	11.2 (9.7-12.8)	17.2 (14.0-20.5)

Excludes unknowns and refusals.

Source: 2020 Kansas Behavioral Risk Factor Surveillance System, KDHE.

Abbreviation: CI = confidence interval.

\* As defined in the National Center for Health Statistics 2013 Urban-Rural Classification Scheme for Counties. Noncore counties not in micropolitan areas are classified as rural or most rural, and all other counties are classified as urban for this analysis. Rural or most rural counties in this analysis include: Allen, Anderson, Barber, Bourbon, Brown, Chase, Chautauqua, Cherokee, Cheyenne, Clark, Clay, Cloud, Coffey, Comanche, Decatur, Dickinson, Edwards, Elk, Ellsworth, Gove, Graham, Grant, Gray, Greeley, Greenwood, Hamilton, Harper, Haskell, Hodgeman, Jewell, Kiowa, Lane, Lincoln, Logan, Marion, Marshall, Meade, Mitchell, Morris, Morton, Nemaha, Neosho, Ness, Norton, Osborne, Pawnee, Phillips, Pratt, Rawlins, Republic, Rice, Rooks, Rush, Russell, Scott, Sheridan, Sherman, Smith, Stafford, Stanton, Stevens, Thomas, Trego, Wallace, Washington, Wichita, Wilson, Woodson.

† Frequent mental distress, defined as 14 or more self-reported mentally unhealthy (stress, depression, and problems with emotions) days in the past 30 days. The depressive disorder includes depression, major depression, dysthymia, or minor depression. Arthritis includes rheumatoid arthritis, gout, lupus, or fibromyalgia, some form of arthritis, excluding osteoporosis. Current smokeless tobacco product use is defined as currently using chewing tobacco, snuff, or snus every day or some days at the time of the survey. Any physical activities or exercises are exercises such as running, calisthenics, golfing, gardening, or walking for exercise. Does Not Always Use a Seatbelt were respondents who answered, “Nearly Always”, “Sometimes”, “Seldom”, or “Never” to “How often do you use seat belts when you drive or ride in the car? Would you say – “. Colorectal Cancer Screening recommendation is defined as the percentage of adults aged 50–75 years who reported having had a blood stool test (FOBT or FIT) within the past year, a sigmoidoscopy within the past five years, and/or a colonoscopy within the past ten years.

## Conclusion

These data findings provide the prevalence of health status, health risk behaviors, and conditions related to disparities in rural and urban counties in Kansas. This population-based information indicates the need for evidence-based strategies to improve health-related behaviors and an ongoing need for awareness, education, and support, particularly in rural counties.

Pratik Pandya, MPH  
Steven Corbett, PhD  
Bureau of Epidemiology and Public Health Informatics

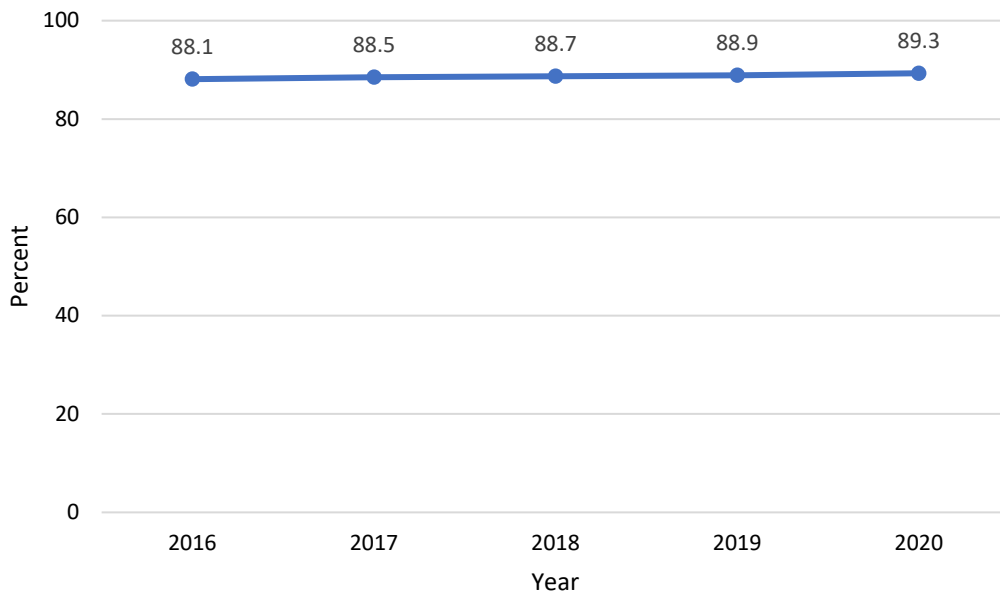
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## Overall Breastfeeding Rates Improve

In 2020, Kansas birth certificate data showed that mothers initiated breastfeeding in 89.3% of resident live births. This was a small increase from the 88.9% reported in 2019 and surpassed the Healthy People 2020 target of an 81.9% breastfeeding initiation rate.<sup>1</sup> The overall breastfeeding initiation rate has been significantly increasing by 0.3% per year (95% Confidence Interval: 0.2%, 0.4%) for the past five-year period (2016-2020).

Figure 1. Trends in breastfeeding initiation among infants born in Kansas, 2016-2020



Source: Birth certificate data (Resident)

Breastfeeding initiation rates varied across racial and ethnic groups (Table 1). In 2018-2020, non-Hispanic Asian mothers had the highest breastfeeding initiation rate (93.9%), followed by non-Hispanic White (90.1%), Hispanic (87.4%), non-Hispanic Other (86.2%), non-Hispanic Black (81.4%), non-Hispanic American Indian or Alaska Native (80.7%), and non-Hispanic Native Hawaiian or Other Pacific Islander (80.6%) mothers. Most notably, for non-Hispanic Black mothers, breastfeeding initiation rate increased significantly from 77.7% in 2015-2017 to 81.4% in 2018-2020. Furthermore, the racial/ethnic gaps in breastfeeding initiation decreased. However, non-Hispanic Black mothers breastfeeding initiation continued to remain the lowest among the three largest race and Hispanic-origin groups.

Table 1. Breastfeeding initiation by maternal race and ethnicity, Kansas, 2018-2020 vs. 2015-2017

Maternal race/ethnicity	Initiated breastfeeding	Resident live births	2018-2020 % (95% CI)	Trend	2015-2017 % (95% CI)
Asian, non-Hispanic	3213	3420	93.9 (93.1-94.7)	▲	93.4 (92.5-94.2)
White, non-Hispanic	65570	72780	90.1 (89.9-90.3)	▲*	89.2 (89.0-89.4)
Hispanic	15662	17926	87.4 (86.9-87.9)	▲	86.7 (86.2-87.2)
Other, non-Hispanic	2904	3370	86.2 (85.0-87.3)	▲	85.5 (84.3-86.7)
Black, non-Hispanic	5884	7229	81.4 (80.5-82.3)	▲*	77.7 (76.7-78.6)
American Indian or Alaska Native, non-Hispanic	369	457	80.7 (77.1-84.4)	▲	79.9 (76.4-83.3)
Native Hawaiian or Other Pacific Islander, non-Hispanic	170	211	80.6 (75.2-85.9)	▲	78.9 (72.8-85.1)
Total	93869	105512	89.0 (88.8-89.2)	▲*	88.0 (87.8-88.2)

\*Statistically significant (p<0.05)

CI=confidence interval

Note: Missing/unknown breastfeeding status and infants that died shortly after birth were excluded.

Source: Birth certificate data (Resident)

Breastfeeding initiation rates also varied widely based on where in the state a mother resided at the time of the birth (Figures 2 and 3). From 2015-2017 to 2018-2020, the overall percentage of breastfeeding initiation increased significantly in Kansas (88.0% and 89.0%, respectively) (Figure 2 and Figure 3).

Counties with significantly higher breastfeeding initiation rate in 2018-2020 than in 2015-2017:

- Anderson
- Atchison
- Ellis
- Finney
- Ford
- Franklin
- Harper
- Johnson
- Kingman
- Leavenworth
- Rice
- Sedgwick
- Shawnee
- Wyandotte

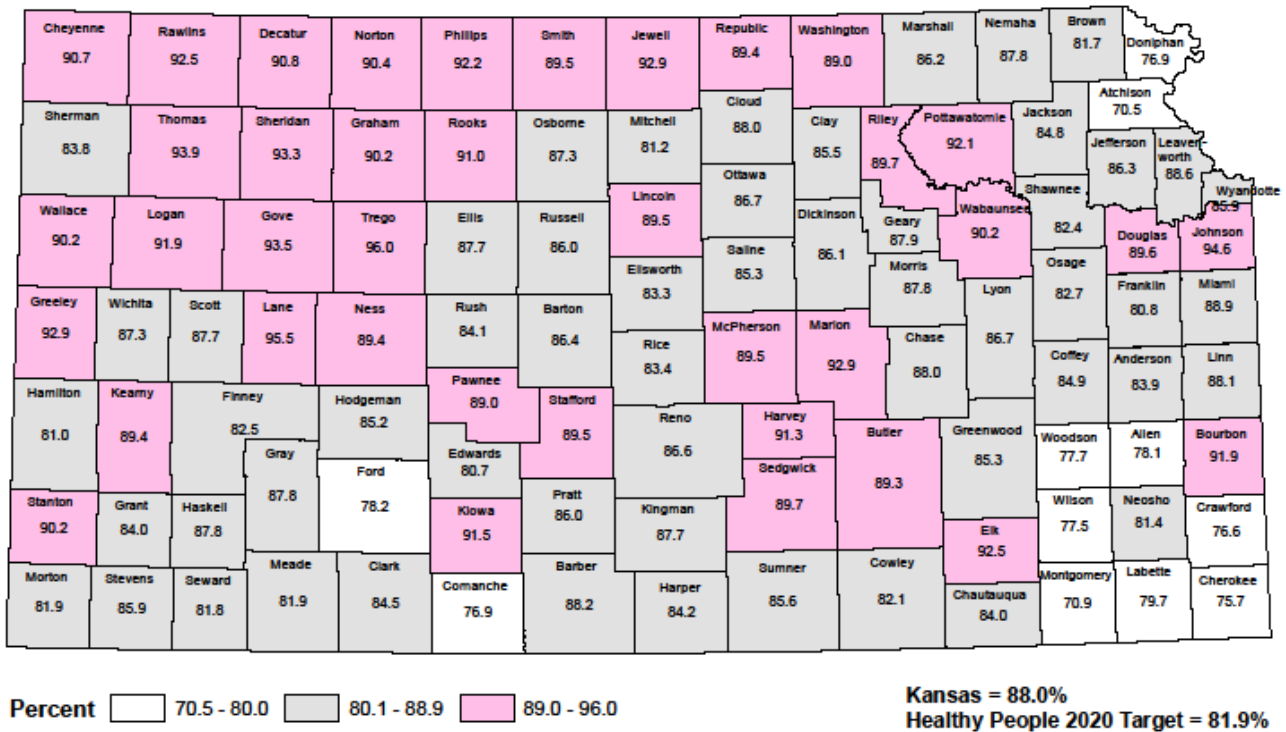


Counties with significantly lower breastfeeding initiation rate in 2018-2020 than in 2015-2017:

- Bourbon
- Labette
- Logan
- Lyon
- Seward
- Thomas

Infants born in the Northeast, Northcentral and Southcentral regions, were most likely to be breastfed. These regions have eight of ten Kansas hospitals that are currently recognized as ‘Baby-Friendly Designated Facilities’ through the Baby-Friendly Hospital Initiative.<sup>2</sup>

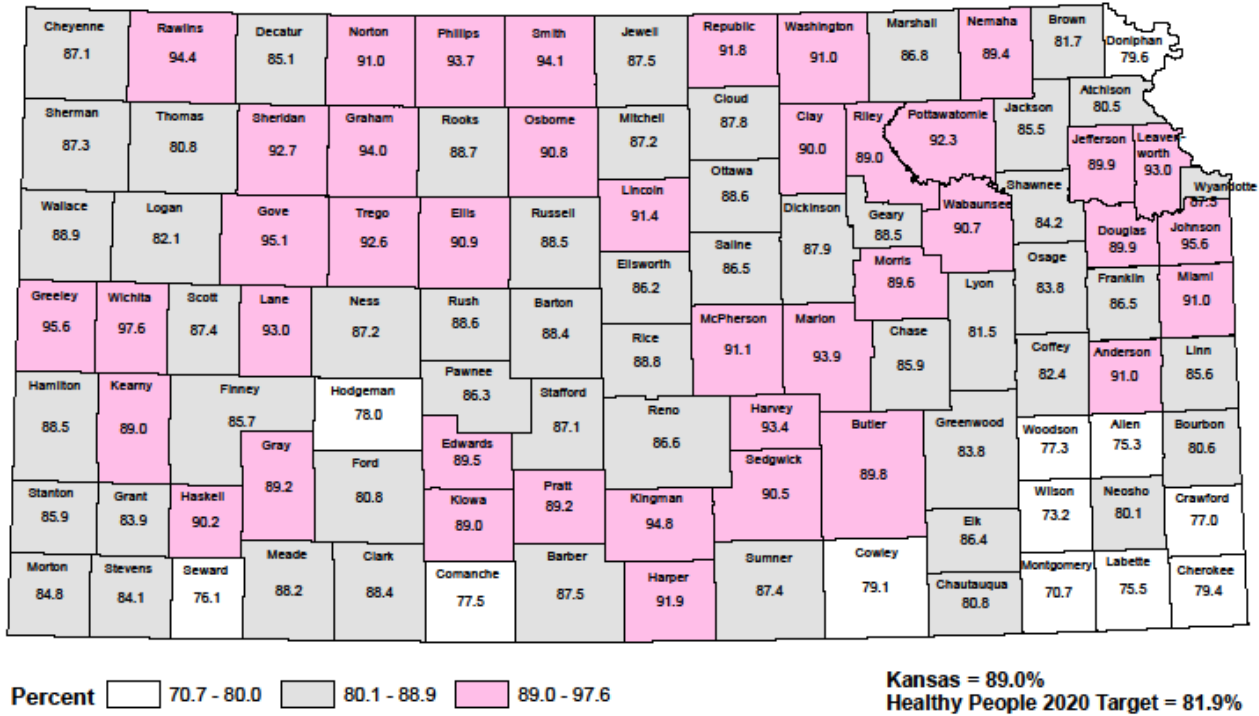
Figure 2. Breastfeeding initiation by county of residence, Kansas, 2015-2017



Note: Missing/unknown breastfeeding status and infants that died shortly after birth were excluded.  
Source: Birth certificate data (Resident)



Figure 3. Breastfeeding initiation by county of residence, Kansas, 2018-2020



Note: Missing/unknown breastfeeding status and infants that died shortly after birth were excluded.  
Source: Birth certificate data (Resident)

According to the most recent National Immunization Survey (NIS), for infants born in Kansas, in 2018, 87.9% of mothers reported ever breastfeeding, 60.2% reported breastfeeding at six months, and 32.0% reported exclusive breastfeeding at six months.<sup>3</sup> While there has been an improvement in exclusive breastfeeding at six months, more work is needed to meet the Healthy People 2030 goal (42.4%).<sup>4</sup> Breastfeeding is linked to a reduced risk for many illnesses in children and mothers. The U.S. Dietary Guidelines for Americans and the American Academy of Pediatrics recommend exclusive breastfeeding for about 6 months, and then continuing breastfeeding while introducing complementary foods until your child is 12 months old or older. Preventative health through exclusive breastfeeding can save health care dollars through reduction in acute illnesses and chronic disease.<sup>1,3</sup> One of the factors contributing to stopping breastfeeding earlier than 6 months may include lack of accessible breastfeeding support especially for those returning to work or school soon after birth. Breastfeeding support programs including Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Breastfeeding Peer Counselors, lactation consultants, workplace policies, and supportive communities can help address these barriers.

The Centers for Disease Control and Prevention (CDC) biennially invites all hospitals across the country to complete the Maternity Practices in Infant Nutrition and Care Survey (mPINC\*<sup>5</sup>). The Survey measures maternal care practices and policies that impact newborn feeding, feeding education, staff skills and discharge support.<sup>5</sup> A Total mPINC score indicates its overall level of maternity care practices and policies that support breastfeeding as the optimal infant feeding method. Sub-scores further categorize maternity care practice subdomains: Immediate Postpartum Care, Rooming-In, Feeding Practices, Feeding Education and Support, Discharge Support, Institutional Management.<sup>5</sup> Responses are scored using an algorithm that denotes the evidence and best practices to promote optimal infant feeding within the maternity care setting.<sup>5</sup> Possible scores range from 0 to 100, with higher scores

indicating better maternity care practices and policies.<sup>5</sup> The mPINC survey results provide feedback to encourage hospitals to make improvements that better support breastfeeding.<sup>5</sup> In the most recent 2020 mPINC survey<sup>6</sup>, 44 of 57 eligible Kansas hospitals (77%) that deliver babies participated. Kansas scored 83/100, which was higher than the national average (81/100). Kansas scored higher than three out of four neighboring states - Nebraska 73%, Missouri and Oklahoma 79%, and Colorado 85%. Kansas hospitals are doing well in the domains related to Feeding Practices, Feeding Education and Support and Discharge Support, which positively impact early initiation. However, improvement could be made in the domain of Institutional Management.

\*The mPINC survey was redesigned in 2018. Results from the mPINC surveys 2018 or later cannot be compared with results from 2007-2015 mPINC surveys.

Jamie Kim, MPH  
Bureau of Epidemiology and Public Health Informatics  
Emily Brinkman, RDN, LD, CLC  
Bureau of Family Health, Nutrition & WIC Services

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