



Kansas Health Statistics Report

Kansas Department of Health and Environment – Division of Health
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Increasing the Kansas Primary Health Care Workforce

Recently, the KANSASWORKS State Board, within the Kansas Department of Commerce, took a leadership role in soliciting a grant from Health Resources Services Administration (HRSA) that resulted in the creation of the Health Care Workforce Partnership (HCWP)—a diverse committee representing workforce, government, education and health care. The HCWP’s purpose is to investigate the current primary health care workforce in order to develop a plan leading to an increase in Kansas’ primary health care workforce by 2022. Primary care is defined by HRSA as clinicians who provide integrated, accessible health care services, e.g., able to diagnose and write a prescription. The HCWP began meeting in December 2010 to research, identify, describe, and analyze data in order to develop a Kansas plan to increase the primary health care workforce.

HCWP stakeholders agreed to an aggressive work plan [1]. Workgroups met to:

- Discover what data existed, analyze the available data and solicit additional data.
- Investigate the resources available to Kansas communities to recruit and retain a health care workforce.
- Learn how the academic training of the primary health care industry skill sets was achieved and where the training programs exist.

Workgroup meetings included presentations, questions and answers, discussions and decisions, on next steps.

The HCWP held a symposium in April 2011 with a goal of planning activities leading to a 10 to 25 percent increase in primary health care workforce by 2022. A reference notebook, posted at <http://www.kansasworksstateboard.org/HCWP/HCWPM/symposium/Pages/default.aspx>, was prepared for participants, containing information about perspectives on the Kansas primary health care sector including demand, supply and barriers that must be addressed in order to increase health care access in underserved locations. Suggestions about how to recruit and retain each category of provider were included in the information along with barriers that might hamper the development of a plan to increase numbers. Representatives from each primary care health professional training program category presented information about their academic training pipeline for graduating new primary care health care professionals.

Symposium participants agreed on four ideas for further work, including:

- Continuing and maintaining the existing multi-stakeholder collaborative approach through creation of an on-line health care workforce clearinghouse.
- Increasing inter-professional educational opportunities in Kansas by training the health care workforce utilizing a multi-professional, multi-disciplinary approach that provides interaction in both the classroom and clinical sites.
- Developing methods for improving and enhancing community capability for recruiting and retaining pri-

mary health care professionals.

- Establishing a funding pool to offer financial support to advanced practice registered nurses (APRNs) and physician assistants (PAs) in training, similar to the successful Kansas Medical Student Loan Program. This program attempts to solve medical access and shortage problems by encouraging medical practice in underserved communities in exchange for individual health care professional debt reduction.

The HCWP concluded that a critical starting point for increasing and creating a stable primary health care workforce in Kansas is to improve data collection so that a greater understanding can be gleaned of the factors that influence practice location choices made by primary health care professionals. To decrease the knowledge gap, the HCWP will:

- Conduct a study to create a more comprehensive description of the Kansas APRN workforce and the educational pathways to APRN certification in Kansas.
- Solicit additional data about physicians and PAs in order to identify workforce practice location trends.

Acquisition of improved health care professional data collection will put the HCWP in a much stronger position to articulate what Kansas can do to educate, recruit, and retain a primary health care workforce that can offer greater access to health care throughout the state. For additional information about the Health Care Workforce Partnership Committee, see the coalition’s website at: <http://www.kansasworksstateboard.org/HCWP/Pages/default.aspx>.

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1. Table 1 Health Care Workforce Partnership Work Plan. Kansas [2010] available from: <http://www.kansasworksstateboard.org/>. Health Care Workforce Partnership Committee, Workgroups, Work Plan

Disparities in Diabetes Prevalence in Kansas

About 179,000 Kansas adults 18 years and older (8.4%; 95% confidence interval: 7.8% to 9.1%) reported they had ever been diagnosed with diabetes. The prevalence of diabetes increased dramatically from 1992 to 2010 in Kansas, more than doubling from 4.0 percent in 1992 to 8.4 percent in 2010. Diabetes is a leading cause of cardiovascular disease, end-stage renal disease, blindness and lower extremity amputations and constitutes a significant economic burden to individuals and to the health care system.

Inside	
Increasing the Kansas Primary Health Care Workforce	1
Disparities in Diabetes Prevalence in Kansas	1
Announcements	3
FastStats	5

The burden of diabetes is disproportionately high in certain population subgroups in Kansas. Health disparities such as these usually occur among population subgroups that differ on the basis of socioeconomic status, age, gender, race, ethnicity, education, annual household income, disability or other characteristics. Together, these factors are called social determinants of health. Individuals in certain of these groups may have less access to healthy food, good housing, quality education and safe neighborhoods and may be affected by racism or another form of discrimination [1]. The purpose of this report is to describe the prevalence of diabetes among Kansas adults with respect to selected social determinants of health using data from the Kansas Behavioral Risk Factor Surveillance System (BRFSS).

Methods

The Kansas BRFSS is an ongoing population-based telephone survey of non-institutionalized adults ages 18 years and older in Kansas. Diabetes status was determined from responses to the following question: "Have you ever been told by a doctor that you have diabetes?" Women told only during pregnancy that they had diabetes and those reporting pre-diabetes or borderline diabetes were excluded. Data from the 2010 Kansas BRFSS were analyzed for diabetes prevalence by age, gender, annual household income, education and disability status. Data from the 2006-2010 Kansas BRFSS were combined to produce age-adjusted prevalence estimates for racial and ethnic subgroups. All prevalence estimates and 95 percent confidence intervals (C.I.) are presented as weighted estimates, calculated using SAS version 9.2 to account for the BRFSS survey design.

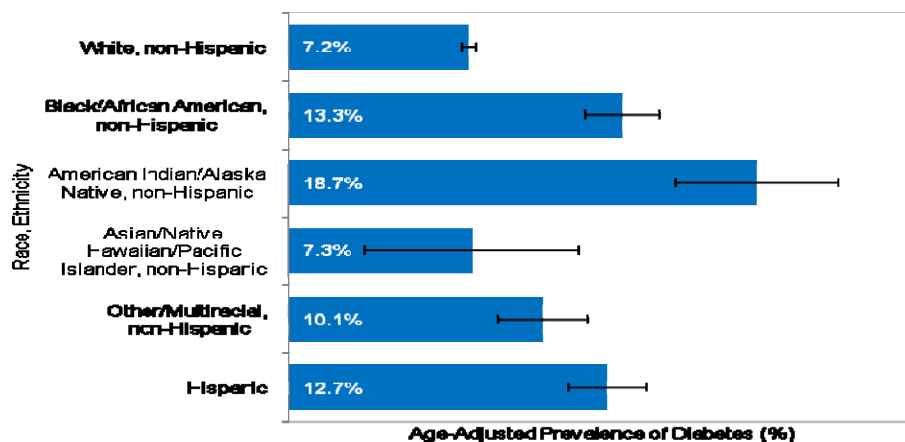
Results

The percentage of adults 18 years and older with diabetes increased substantially with age (Table 1). Nearly one in five (18.5%; 95% confidence interval: 16.9% to 20.0%) Kansans 65 years and older had been diagnosed with diabetes. Overall, the prevalence of diabetes was 8.2 percent (95% confidence interval 7.4% to 9.0%) among women 18 years and older and 8.6 percent (95% confidence interval: 7.7% to 9.6%) among men 18 years and older. Diabetes prevalence was higher among men ages 65 years and older (21.1%; 95% confidence interval: 18.5% to 23.7%) compared to women 65 years and older (16.5%; 95% confidence interval: 14.7% to 18.3%). For all other age groups, the prevalence of diabetes was not significantly different for women than for men.

Table 1. Percentage of adults 18 years and older diagnosed with diabetes by age and gender, 2010 Kansas BRFSS

Age Group	Diabetes Prevalence In Men (95% Confidence Intervals)	Diabetes Prevalence In Women (95% Confidence Intervals)	Overall Diabetes Prevalence Both Gender Groups (95% Confidence Intervals)
18 to 34 Years	1.6% (0.3% to 2.9%)	1.7% (0.3% to 3.0%)	1.6% (0.7% to 2.6%)
35 to 44 Years	4.5% (2.45 to 6.6%)	4.2% (2.7% to 5.8%)	4.4% (3.1% to 5.7%)
45 to 64 years	11.6% (9.9% to 13.4%)	11% (9.5% to 12.4%)	11.3% (10.2% to 12.4%)
65 Years and Older	21.1% (18.5% to 23.7%)	16.5% (14.7% to 18.3%)	18.5% (16.9% to 20.0%)
All Age Groups	8.6% (7.7% to 9.6%)	8.2% (7.4% to 9.0%)	8.4% (7.8% to 9.1%)

Figure 1. Age-adjusted percentage of adults 18 years and older diagnosed with diabetes by race and ethnicity, Kansas 2006-2010.



Prevalence estimates were age-adjusted to the U.S. 2000 standard population. Error bars indicate 95% confidence intervals.

Figure 1 provides the age-adjusted percentage of adults 18 years and older with diagnosed diabetes by race and ethnicity using data from 2006 through 2010. The age-adjusted prevalence of diabetes among non-Hispanic African American adults (13.3%; 95% confidence interval: 11.8% to 14.9%), non-Hispanic American Indian or Alaska Native adults (18.7%; 95% confidence interval: 14.5% to 23.0%), non-Hispanic adults of other race or multiple race (10.1%; 95% confidence interval: 8.3% to 11.8%) and Hispanic adults (12.7%; 95% confidence interval: 11.2% to 14.3%) were all significantly higher than for non-Hispanic white adults (7.2%; 95% confidence interval: 6.9% to 7.5%).

Table 2. Percentage of adults 18 years and older diagnosed with diabetes by annual household income, Education and Disability Status, 2010 Kansas BRFSS.

Factor	Prevalence of Diabetes (%)	95% Confidence Interval
<i>Annual Household Income Groups</i>		
Below \$15,000	14.4%	11.1% to 17.7%
\$15,000 to \$24,999	13.3%	10.8% to 15.8%
\$25,000 to \$34,999	9.9%	7.9% to 11.8%
\$35,000 to \$49,999	9.7%	8.0% to 11.3%
\$50,000 or Higher	5.3%	4.6% to 6.1%
<i>Education Groups</i>		
Did not Graduate High School	12.5%	9.4% to 15.6%
High School Graduate	9.3%	8.0% to 10.5%
Some Technical or College	9.3%	8.0% to 10.5%
College or Technical Graduate	6.5%	5.7% to 7.4%
<i>Disability Status</i>		
Living with a Disability	17.1%	15.4% to 18.9%
Not Living with a Disability	5.9%	5.3% to 6.5%

In 2010, the percentage of adults 18 years and older with diagnosed diabetes was higher among persons with lower annual household income (Table 2). The prevalence of diabetes was significantly lower among those with an annual household income of \$50,000 or more (5.3%; 95% confidence interval: 4.6% to 6.1%) compared to all other income groups. The percentage of adults 18 years and older with diagnosed diabetes was higher among persons with lower levels of education (Table 2). The prevalence of diabetes was significantly lower among college or technical school graduates (6.5%; 95% confidence interval: 5.7% to 7.4%) compared to all other levels of educa-

tion. Differences in diabetes prevalence by annual household income and education were present in all age groups (data not shown).

Kansans living with a disability were disproportionately affected by diabetes (Table 2). The Behavioral Risk Factor Surveillance System defines disability as reporting an activity limitation due to physical, mental or emotional problems or having a health problem that requires the use of special equipment such as a cane, wheelchair, special bed or special telephone. In 2010, 17.1 percent (95% confidence interval: 15.4% to 18.9%) of adults 18 years and older who reported living with a disability, had been diagnosed with diabetes, compared to 5.9 percent (95% confidence interval: 5.3% to 6.5%) of those not living with a disability. This disparity in diabetes prevalence by disability status was present regardless of gender, age, race, ethnicity, annual household income or education (data not shown).

Discussion

The prevalence of diabetes in Kansas is significantly higher among African-Americans, Hispanics and American Indians/Alaska Natives in Kansas, among those with lower levels of income and education and among Kansans living with a disability. Health disparities such as the disparities in diabetes burden presented in this report have been well documented for decades. Nevertheless, inequalities in health persist at the national level as well as in states and communities for a variety of health issues.

One of the overarching goals for Healthy People 2020 is to “achieve health equity, eliminate disparities, and improve the health of all groups” [2]. The recently published National

Stakeholder Strategy for Achieving Health Equity provides a set of goals and objectives for public and private sector initiatives [3]. Goals outlined in this strategy for eliminating health disparities include (1) increasing awareness of the significance of health disparities, (2) strengthening and broadening leadership for addressing health disparities at all levels, (3) improving health and healthcare outcomes for racial, ethnic and underserved populations, (4) improving cultural and linguistic competency and diversity of the health-related workforce and (5) improving data availability, coordination, utilization and diffusion of research and evaluation outcomes. The results presented here underscore the need to integrate social determinants of health into public health programs and other health improvement efforts in Kansas and to support ongoing efforts to address health inequity in Kansas.

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Announcements

Kansas Resident Infant Mortality Declined in 2010

Infant mortality is an important indicator of the health of a community or a state. The Kansas Department of Health and Environment Bureau of Epidemiology and Public Health Informatics (BEPHI) tracks infant mortality based on information from the Kansas civil registration system maintained by the Bureau's Office of Vital Statistics (OVS).

Kansas resident infant deaths dropped from 290 in 2009 to 254 in 2010. The number of Kansas resident births in 2010 was 40,439. This resulted in an infant mortality rate of 6.28 per 1,000 live births compared to 7.01 in 2009. Although the one year decline was not statistically significant at the 95 percent confidence interval, the number of infant deaths was the lowest in Kansas since recordkeeping began in 1912. The infant mortality rate was the lowest recorded. Over the last 22 years, Kansas has experienced a statistically significant declining trend in the annual infant mortality rate (with a lot of ups and downs in between).

Most of the reduction (31 of 36 fewer deaths) in infant mortality occurred among infants classified as post-neonatal (28-364 days of age). The decrease was smaller among neonatal infants (five).

The reduction in infant mortality observed in Kansas in 2010 is encouraging, but it is important to note that the relatively

small number of events that occur are subject to volatility, and trends should not be based on analyses of single year fluctuations. Joinpoint regression analysis showed a statistically significant decrease in infant mortality rates from 1990 to 1998, and a virtually unchanged rate from 1999-2009 (*Selected Special Statistics, Stillbirths and Infant Deaths, Kansas, 2010*). Joinpoint regression analysis of IMR from 2007-2010 indicates a statistically significant decrease during the four year period.

These findings are provisional. This means that only some analyses have been performed on the data. Results released as part of the *2010 Annual Summary of Vital Statistics, and Selected Special Statistics, Stillbirths and Infant Deaths, Kansas, 2010* will be more complete and comprehensive.

These findings are subject to at least two limitations. Some very small under-reporting of vital events may occur. Additionally some infant deaths occur in other states. Late reporting of those events may affect totals. BEPHI quality improvement processes identified no under-reporting by other state vital events jurisdictions.

The full research brief, *Infant Mortality, 2010, Kansas, Provisional Findings*, is available at the KDHE website, http://www.kdheks.gov/phi/download/Infant_Mortality_Kansas_2010_Provisional_Findings.pdf

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Peer Groups Revised in Kansas

Errata Note: Statistics in this article were updated after printing the original issue, KSH #50. Changes to the PDF version of this article reflect the use of accepted methodology for calculating population density, the total population divided by land area in square miles. The original article incorrectly used total county area which included square miles of water in the area. As a result of the corrected population densities, Doniphan County remains in the densely-settled rural peer group. Corrections to peer group listings in the Annual Summary of Kansas Vital Statistics have also been made.

Kansas is a diverse state, with 82 counties (78.1%) having less than 25,000 population [1]. The state's most populous county, Johnson, is 436 times larger than the least populous, Greeley. Public health issues addressed by the two counties represent different challenges.

In order to assist counties in comparison of public health statistics, the Bureau of Epidemiology and Public Health Informatics began using population density peer groups (Table 1). Population density is based on the population of an area divided by the number of square miles in a county. The *Kansas Annual Summary of Vital Statistics, 2010*, used peer group summaries for comparison of birth and death statistics with county statistics.

Table 1, Kansas Peer Group Categories

Category	Population Density
Frontier	less than 6 people per square mile
Rural	6-19.9 people per square mile
Densely-settled rural	20-39.9 people per square mile
Semi-urban	40-149.9 people per square mile
Urban	150+ people per square mile

Under agreement with other Division of Public Health units, peer groups are based on a decennial census and are not changed until the next census. This ensures more consistency in year-to-year comparison and less confusion among the consumers of the information.

The 2010 Census resulted in eight changes to the makeup of the peer groups (Table 2). Five counties slipped from rural to frontier status. Leavenworth County is now a part of the Urban group.

Wyandotte County is no longer the most densely populated county. Johnson County's rate is 1149.6 people per square mile compared to Wyandotte County's 1039.0. During the decade, the population density in Johnson County increased 22.4 percent while Wyandotte County's density increased by just 2.5 percent.

Johnson County's percentage increase was not the largest in the state, even if it was the largest numerically. Geary County's population density increased 29.2 percent, from 69.1 people per square mile in 2000 to 89.3 in 2010. Population density was unchanged or increased in just 35 counties.

In the 70 counties in which population density decreased, the largest decrease (2.9 people per square mile) occurred in Finney County. The largest percentage decrease was 22.1 percent in Kiowa County.

While population change in Kansas is not new, it is worthwhile to note that in 61 of the 70 counties that had decreases, the amount of decrease was less than one person per square mile.

Vital statistics information reported in the Kansas Annual Summary of Vital Statistics, 2010, incorporated the revised peer groups. Peer Group statistics for prior years will continue to be grouped according to the categories in place for that decade.

Population density based peer groups is just one taxonomy for Kansas counties.

As part of public health preparedness activities, Kansas counties self-defined health preparedness regions.

Presently there are 15 such regions and two counties that are not part of a region. This taxonomy represents an important component of the community health needs assessment process starting in public health agencies. In support of that process, BEPHI will be developing statistics based on the health preparedness regions.

For a map of Kansas Counties by peer group visit: <http://www.socwel.ku.edu/occ/projects/articles/2010%20Census%20Map.pdf>. [2] To view the worksheet used for this article, open the Excel attachment to this issue's PDF file, <http://www.kdheks.gov/phi/khsnews/khs50.pdf>.

Table 2. Peer Group Changes by County, 2000-2010, Kansas

County	2000 Density	2010 Density	Change	Percent Change	Impact on Peer Group
Chautauqua	6.8	5.7	-1.1	-16.2%	Rural to Frontier
Greenwood	6.7	5.9	-0.8	-11.9%	Rural to Frontier
Jackson	19.2	20.5	1.3	6.8%	Rural to Densely-Settled Rural
Leavenworth	146.7	164.7	18.0	12.3%	Semi-Urban to Urban
Lyon	42.0	39.8	-2.2	-5.2%	Semi-Urban to Densely-Settled Rural
Rooks	6.3	5.8	-0.5	-7.9%	Rural to Frontier
Sherman	6.4	5.7	-0.7	-10.9%	Rural to Frontier
Stafford	6.0	5.6	-0.4	-6.7%	Rural to Frontier

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References

[1] Census Bureau [Internet] Gazetteer Files, Kansas county files, 2010.[February 2011, accessed 5-4-2011] Available from: <http://www.census.gov/geo/www/gazetteer/gazetteer2010.html>. U.S.

[2] University of Kansas School of Social Welfare. Improving Health Access in Frontier and Rural Counties Report [accessed 7-18-2011] Available from; <http://www.socwel.ku.edu/occ/viewProject.asp?ID=76>,

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KIC 25 Annual Tables Released

The Bureau of Epidemiology and Public Health Informatics at the Kansas Department of Health and Environment has issued the first set of annual statistical tables for 2010 vital events. The tables are available online at the KDHE Website.

The 25 annual tables available at <http://kic.kdhe.state.ks.us/kic/OHA/anntable10.html> represent the most frequently requested tables of statistics on births, deaths, marriages, divorces.

Birth and death statistics are based on residence data. Marriage and Divorce statistics are based on occurrence data.

These tables are part of the Bureau's Kansas Information for Communities Fast Stats pages, at <http://kic.kdhe.state.ks.us/kic/fs.html>.

BEPHI has also created a new web page with maps of selected regional groupings of counties, at <http://kic.kdhe.state.ks.us/kic/OHA/ksmap.html>. Bureau statistics are frequently based on these county groupings. In light of the new census data, the population density peer groups have been revised to reflect changes in county population statistics.

Links to all of the Bureau of Epidemiology and Public Health Informatics materials can be found at <http://www.kdheks.gov/phi/index.htm>.

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FastStats

2010 Kansas Vital Statistics – County Summary

County of Residence*	Live Births	Deaths	Marriages	Marriage Dissolutions
Kansas	40,439	24,429	18,150	10,579
Allen	137	182	68	32
Anderson	106	95	33	41
Atchison	225	190	100	42
Barber	74	51	39	20
Barton	355	295	216	84
Bourbon	220	177	88	66
Brown	127	104	81	16
Butler	805	619	397	155
Chase	23	40	24	5
Chautauqua	25	53	28	17
Cherokee	237	278	114	83
Cheyenne	25	37	9	12
Clark	27	30	16	3
Clay	107	108	67	18
Cloud	130	130	55	23
Coffey	106	111	51	124
Comanche	20	39	13	3
Cowley	487	416	219	150
Crawford	478	439	199	154
Decatur	26	46	17	12
Dickinson	284	234	147	96
Doniphan	99	77	44	31
Douglas	1,263	627	773	291
Edwards	40	34	21	11
Elk	35	48	12	6
Ellis	375	225	204	89
Ellsworth	56	99	34	47
Finney	765	190	232	108
Ford	677	266	252	131
Franklin	337	245	158	143
Geary	1,051	204	687	384
Gove	29	26	10	7
Graham	31	39	20	12
Grant	128	57	59	17
Gray	94	54	33	19
Greeley	12	14	3	2
Greenwood	58	95	38	24
Hamilton	57	28	14	4
Harper	72	101	36	17
Harvey	463	399	240	93
Haskell	61	28	30	10
Hodgeman	22	17	14	12
Jackson	165	118	81	33
Jefferson	199	183	120	65
Jewell	25	35	17	8
Johnson	7,390	3,300	2,456	1,620
Kearny	65	34	26	13
Kingman	79	81	43	29
Kiowa	28	22	9	7
Labette	277	249	97	95
Lane	16	16	13	8
Leavenworth	946	555	399	321
Lincoln	35	40	15	11
Linn	92	109	46	36
Logan	36	29	26	8

County of Residence*	Live Births	Deaths	Marriages	Marriage Dissolutions
Lyon	426	263	237	76
McPherson	300	348	171	90
Marion	126	141	66	29
Marshall	111	131	77	28
Meade	52	50	26	11
Miami	384	290	235	143
Mitchell	66	99	49	25
Montgomery	426	456	219	132
Morris	54	71	30	15
Morton	34	36	25	14
Nemaha	131	135	77	37
Neosho	226	196	111	67
Ness	39	37	11	6
Norton	47	65	33	27
Osage	185	164	85	92
Osborne	47	46	20	14
Ottawa	80	72	38	14
Pawnee	77	73	45	41
Phillips	57	70	35	21
Pottawatomie	382	146	101	58
Pratt	113	121	77	31
Rawlins	23	35	13	1
Reno	762	685	434	331
Republic	35	80	24	13
Rice	129	121	35	33
Riley	1,118	312	664	245
Rooks	66	56	28	13
Rush	30	46	13	12
Russell	93	105	35	28
Saline	805	518	398	254
Scott	43	56	42	18
Sedgwick	8,058	3,920	3,393	2,508
Seward	468	134	182	84
Shawnee	2,496	1,641	1,178	605
Sheridan	20	35	12	12
Sherman	83	62	44	42
Smith	31	63	31	12
Stafford	41	68	25	7
Stanton	30	17	16	12
Stevens	83	52	43	28
Sumner	312	276	192	89
Thomas	115	87	49	43
Trego	27	47	13	9
Wabaunsee	77	76	47	20
Wallace	12	21	11	6
Washington	57	73	40	10
Wichita	35	22	8	5
Wilson	128	129	59	32
Woodson	43	49	23	8
Wyandotte	2,754	1,308	1,087	260
N.S.	0	7	0	0

* Residence data are presented for births and deaths
 Occurrence data are presented for marriages and marriage dissolutions
 Source: Kansas Department of Health and Environment

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