

Kansas Health Statistics Report

Kansas Department of Health and Environment – Center for Health and Environmental Statistics – No. 13 – May 2002

Falls Among Older Kansans: Fatalities and Hip Fractures

Among people aged 65 and older, falls are the leading cause of injury-related deaths and result in thousands of injuries each year. One out of every three persons aged 65 and older fall each year, and of those that fall, 20%-30% have a resulting injury serious enough to impair mobility and increase the risk of premature death (1).

Falls account for 90% of hip fractures, and the vast majority of these falls are from standing height (2). Although a fall from standing is unlikely to fracture a normal hip, it can result in severe injury to bones weakened by osteoporosis. Half of all persons in this age-group hospitalized for hip fracture are not able to return to home or independent living (3), and 20% of persons fracturing their hip die within one year. (2)

The Kansas fall-related death rate among persons aged 65 and older has been consistently higher than the US rate (Figure 1). In 1999, among US states, Kansas had the 12th highest fall-related death rate among persons aged 65 and older. (4)

Death Rate Due to Falls, by Age Group and Year
US and Kansas, 1984-1998

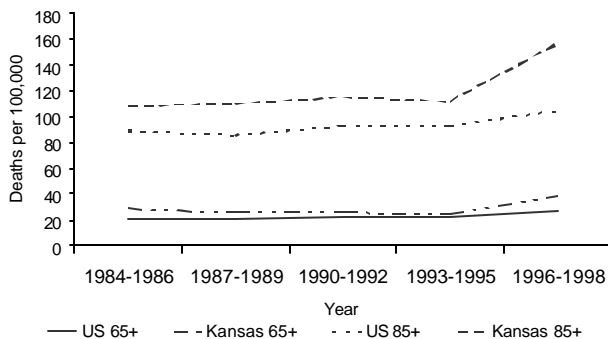


Figure 1

In 2000 in Kansas, 148 persons aged 65 and older died from fall-related injuries; 79% of all fatal falls occurred in this age-group. Among Kansans aged 65 and older who died from a fall, the most common sites of bodily injury were the head (49%) and the extremities (35%).

Age was a strong risk factor for fall-related deaths. Death rates increased from 11 deaths per 100,000 among persons aged 65-74, to 41 deaths per 100,000 among those 75-84, to 147 deaths per 100,000 among Kansans aged 85 and older (5). Males had higher age-specific fall-related mortality rates than females, particularly in the 75-85 year age-group (57 vs. 31).

Hospital Discharges Rates (per 100,000)
for Falls Among Kansans Aged 65+, by Risk
Factor, Oct 1999 – Sept 2000

All	962
Male	586
Age 65-74	174
Age 75-84	734
Age 85+	2,327
Female	1,221
Age 65-74	291
Age 75-84	1,286
Age 85+	3,488
Age 65-74	238
Age 75-84	1,068
Age 85+	3,160
White	885
Black	394
Frontier	972
Rural	1,029
Dense rural	1,085
Semi-urban	969
Urban	875

Table 1

During October, 1999 to September, 2000 (Federal Fiscal Year 2000), 3,426 hospitalizations with a primary or secondary diagnosis of hip fracture were identified in the Kansas hospital discharge data set (6).

Sex was a risk factor for hospitalizations with hip fracture. During the 2000 fiscal year, the incidence of hospitalization with hip fracture among females aged 65 and older (1221 discharges per 100,000 females aged 65 and older) was more than double the hospital discharge rate for males aged 65 and older (586 discharges per 100,000 males aged 65 and older) (Table 1).

In each age-group, women were more likely to have a hospitalization with a hip fracture than were men. Persons of white race were at markedly higher risk of hospitalization than persons of black race (885/100,000 whites aged 65 and older vs. 394/100,000 blacks aged 65 and older). This pattern is consistent with national data. Differences in hospitalization rates for hip fracture among

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geographic strata defined by population density were small (6).

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6. Kansas Hospital Association, Health Care Data Governing Board. Kansas Hospital Discharge Data.

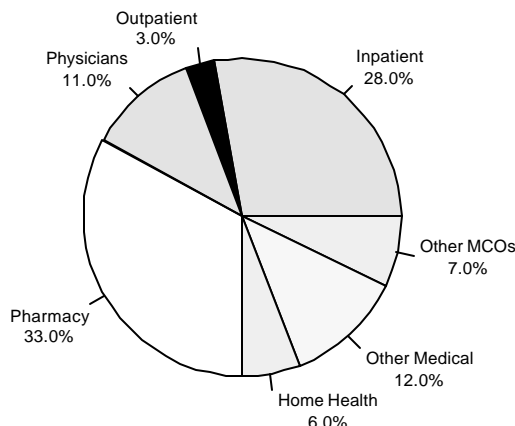
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Medicaid Evaluates Cost Drivers

Kansas Medicaid, the state's state/federal health insurance plan for low income families, people with disabilities, and the elderly has conducted an evaluation of the factors causing increased costs of delivering health services. Medicaid serves approximately 290,000 individuals yearly and is responsible for \$1.7 billion in expenditures for FY 2002. It is the third largest source of health benefits coverage after Blue Cross and Blue Shield and Medicare. The percentage of Medicaid expenditures by type of service is depicted in Figure 2.

Figure 2

Medicaid Program Expenditures by Category



Medicaid has experienced an average annual increase of 9.9% in the costs of services from FY1991 through FY2001. A study was conducted recently to determine the reasons why these increases were occurring. Cost drivers for the program included an increase:

- in the number of people served,
- in services per person, and
- due to improvements in medical technology.

Utilization rates also increased, with Pharmacy increasing an average of 15% for the past six years, Home health increasing over 15% in the last five years, and Transportation utilization increasing as well.

Strategies to curb costs are being considered and include:

- Disease management for selected disease states,
- Evaluating the use of market forces that modify consumer behavior,

- Working with providers and establishing practice guidelines that influence prescribing habits,
- Profiling patients with nine or more monthly prescriptions to determine if there are quality of care issues, and
- tightening home health, transportation and durable medical equipment (DME) guidelines.

Robert Day, Ph.D.
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Frank Webb

Kansas Department of Social and Rehabilitation Services

Abortion Report Issued

The Center for Health and Environmental Statistics released its preliminary analysis of 2001 abortion statistics in late March. A total of 12,404 abortions were reported to the Center, a slight increase (0.6 %) compared to 2000. In 2001, 6,003 abortions occurred in Kansas to out-of-state residents, 6,280 occurred in Kansas to in-state residents, and 121 occurred out-of-state to Kansas residents.

Fifty-four percent (53.8) of all reported abortions were to women aged 15-24, 81.7 percent were unmarried and 72.6 percent were white. The number of abortions to women of Hispanic origin decreased 9.2 percent from 2000 and accounted for 7.0 percent of all abortions in 2001.

Eighty-five percent (84.5) of all reported abortions were performed prior to the 13th week of gestation, while only 8.9 percent of abortions were performed after 16 weeks gestation (Table 2).

Abortions in Kansas, 2001

	N	Percent
<i>Residence</i>		
Total Reported	12,404	100.0
In-state residents	6,401	51.6
Out-of-state residents	6,003	48.4
<i>Age-group</i>		
Under 15 years	83	0.7
15-19 years	2,376	19.1
20-24 years	4,305	34.7
25-29 years	2,614	21.1
30-34 years	1,711	13.8
35-39 years	982	7.9
40-44 years	318	2.6
45 years and over	15	0.1
<i>Race</i>		
White	8,985	72.6
Black	2,706	21.9
Other	678	5.5
Not Stated	35	n.a.
<i>Hispanic Origin*</i>		
Hispanic	872	7.0
Non-Hispanic	11,532	93.0
<i>Marital Status</i>		
Married	2,255	18.3
Unmarried	10,099	81.7
Not Stated**	50	n.a.
<i>Weeks Gestation</i>		
Less than 9 weeks	7,301	59.0
9-12 weeks	3,152	25.5
13-16 weeks	819	6.6
17-21 weeks	477	3.8
22 weeks & over	635	5.1
Not Stated**	20	n.a.

* Hispanic origin may be of any race

** Gestation information not collected by other states

Table 2

The Center's preliminary report of 2001 abortions is available at <http://www.kdhe.state.ks.us/ches/> or by calling the Office of Health Care Information at 785-296-8627.

Office of Health Care Information

New Mortality Coding Evaluated

Implementation of International Classification of Diseases 10th revision (ICD-10) in 1999 changed the classification, processing, and presentation of mortality data. Some titles changed and some diseases moved to a new section. ICD-10 is more detailed, incorporating about 8,000 causes of death compared to about 5,000 causes in ICD-9.

While these changes were necessary to stay current with advances in medical science, they can introduce major disruptions in the mortality statistics time series. To address this disruption, the National Center of Health Statistics (NCHS) coded 1996 deaths under ICD-10 and compared the statistics to the original ICD-9 statistics. This resulted in a comparability ratio that could be used to adjust frequencies, crude mortality rates and age-adjusted mortality rates.

The Center for Health and Environmental Statistics used these NCHS-produced preliminary comparability ratios to study 1998 and 1999 mortality data. The comparison was based on the List of 113 Selected Causes of Death, developed for the general analysis of ICD-10 mortality statistics and for ranking leading causes of death in the United States.

A comparability ratio of 1.00 means the same number of deaths was assigned to the category under both ICD-9 and ICD-10, thus showing no net effect from the new revision on that particular cause. A comparability ratio of < 1.00 means fewer deaths being classified to a category under ICD-10 than under the prior revision. Comparability ratios > 1.00 mean more deaths will be reclassified to a category under ICD-10.

NCHS's preliminary comparability ratios decreased the counts and mortality rates for pre-1999 deaths assigned to 62 categories. Fifty-one categories had higher counts and rates as the result of applying the ratios. In one category there was no change. Comparability ratios could not be established for 21 categories because manual coding of deaths in the categories was incomplete or due to the relatively small number of events.

The makeup of the top ten leading causes of death in Kansas changed as a result of the ICD-10 revision. The top six leading causes remain unchanged in ranking (Table 3). Alzheimer's disease went from 11th to the 9th leading cause of death in 1998 after the comparability ratio was applied to ICD-9 mortality totals. In 1999 Alzheimer's was the 8th leading cause moving kidney disease to 9th. Atherosclerosis rounded out the ten leading causes, bumping suicide to 11th in 1999 (Table 3).

Leading Causes of Death, Kansas, 1998-1999

Cause	1998 Rank	1999		NCHS Ratio
		Rank	N	
Heart Disease	1	1	6,956	0.9858
Cancer	2	2	5,315	1.0068
Cerebrovascular Disease	3	3	1,837	1.0588
Chronic Lower Respiratory Disease	4	4	1,387	1.0478
Unintentional Injuries	5	5	1,093	1.0305
Pneumonia & Influenza	6	6	670	0.6982
Diabetes	7	7	645	1.0082
Alzheimer's Disease	11	8	509	1.5536
Kidney Disease	8	9	386	1.2320
Atherosclerosis	10	10	345	0.9637
Suicide	9	11	298	0.9982

Table 3

Among the 113 Selected Causes of Death and the 22 subgroups, mortality rates (crude and age-adjusted) were lower for 46 causes in 1999 compared to comparability-modified values for 1998. Mortality rates for 34 causes were higher in 1999 than in 1998. In seven instances, rates were unchanged. Small frequencies or the absence of a comparability ratio made rate comparisons impossible for 48 causes.

Of the 113 Selected Causes of Death only three showed a statistically significant change from 1998 to 1999 in spite of the application of the comparability ratio. The three causes were Alzheimer's Disease, Atherosclerosis and pneumonitis due to solids and liquids. In each group the number of deaths and rates increased significantly despite application of the comparability ratio.

The full report is available at the CHES web page <http://www.kdhe.state.ks.us/ches/>.

Greg Crawford
Vital Statistics Data Analysis

Childhood Asthma in Kansas

Asthma is a chronic respiratory problem that affects populations of all ages. Asthma is most common in childhood and occurs in 7-10% of the pediatric population, and about one third of the asthma population is made up of children under the age of eighteen (1,2). Children are very susceptible to asthma; pollens, allergens, pets, roaches, cigarette smoke, etc. are key factors that trigger asthma symptoms among children (3). Nationally, asthma is one of the most common and costly diseases. It accounts for a significant number of inpatient hospital days, which could be avoided with better access to primary care and proper disease management (4,5).

In an article published earlier, trends of asthma hospitalization in Kansas for all aged and its association with various socioeconomic and demographic factors were reported (6). In order to obtain a more complete picture about childhood asthma in Kansas, this article reports the prevalence of asthma hospitalization for children and young adults. Since Missouri and Kansas have similar demographics, a comparison is also made with asthma hospitalizations between the two states.

Data were selected from the Kansas Hospital Association's Information Systems (KHA) database from 1995 to 1999. The KHA database contains hospitalization information in relation to various demographic factors such as age, sex, race, county of residence, etc.

Data selected for the current analysis represent approximately 85% of community hospital hospitalizations in Kansas. With the exception of trend analysis, all results are reported as an average for the above years. To determine the impact of various demographic factors on the rates of asthma hospitalization, the data were adjusted by age or by population as required.

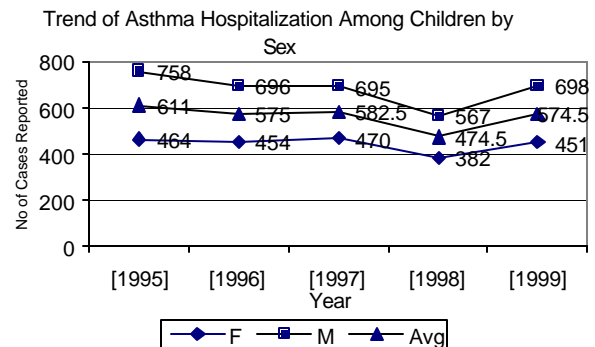


Figure 3

Rates of asthma hospitalization were found to be stable for both sexes during the five-year time period and no statistically significant relationship between asthma prevalence and time was observed (Figure 3).

Asthma hospitalization rates are approximately one and a half times higher among male children and adolescents than female (Figure 4). Age adjusted data show that children in the age-group 0-4 contribute to the largest number of asthma hospitalizations. A statistically significant inverse relationship between age ($p < .05$) and the number of asthma hospitalizations is observed. This is true for all races and for both genders.

The decrease in hospitalization rate with age is steeper for male than female children. This suggests that female children are less likely to be hospitalized during their early years, but they are more prone to being hospitalized in their teens. Similar trends were observed with asthma hospitalizations for children and adolescents in Missouri (7).

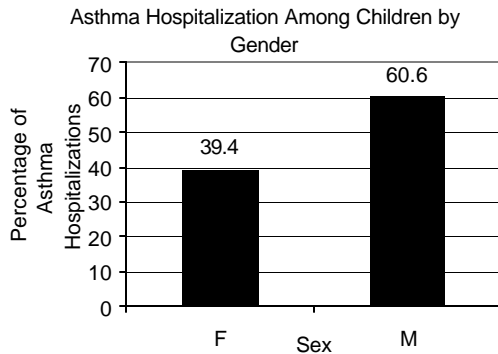


Figure 4

Racial influence is profound in childhood asthma hospitalizations. The overall rate of hospitalization is highest among Blacks. Black male children age 0-4 are hospitalized more frequently from asthma than black female children.

Race adjusted data show (Figure 5) that the rate of asthma hospitalization is about three times higher for Blacks (44 per 10,000) compared to Whites (12.1 per 10,000) and other racial groups (12.7 per 10,000). The effect of race on asthma is a matter of national concern, and this has been attributed to several causes, such as poverty, genetic features, living conditions, lack of education, etc. (1-5).

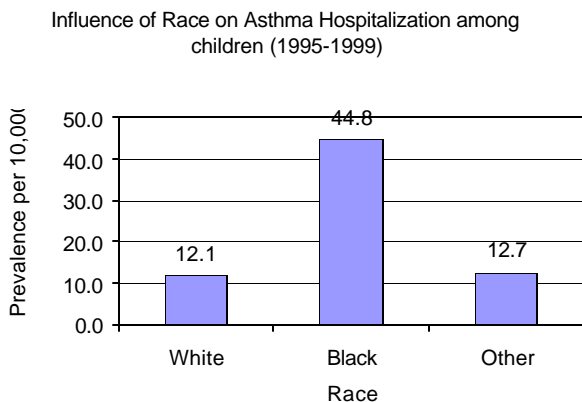


Figure 5

To assess the prevalence of asthma by population density group (8), hospitalization data was merged by zip code with Kansas population density data. As defined by population density peer groups, residents living in "Frontier" areas have the highest asthma rates, while residents living in "Densely Settled Rural"

areas have the lowest rates (Figure 6). No significant relationship between hospitalization and population density group ($p > .05$) was observed (Figure 6). However, both the "Frontier" and "Urban" areas register relatively high asthma hospitalization rates. A high asthma prevalence rate observed in "Frontier" areas may be attributed to respiratory irritants associated with farming activities as well as shortage of primary care physicians in those areas (9). Lack of preventive care may have resulted in more hospitalizations in "Frontier" areas. A relatively high rate in "Urban" areas may be related to higher level of industrial pollutions and auto emissions (10).

Asthma by Population Density Group

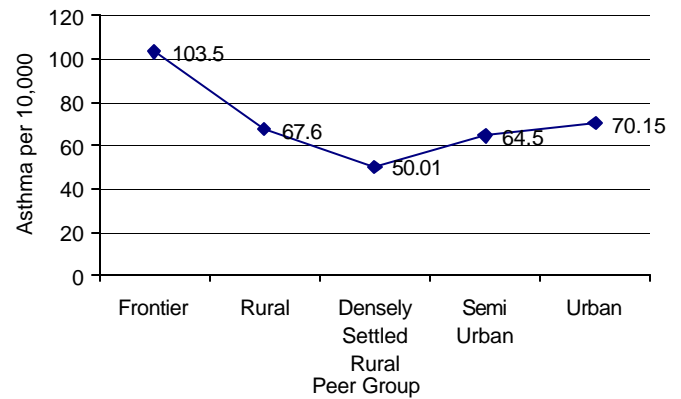


Figure 6

It is important to consider the limitations of the data that might have influenced the analysis. Incorrect diagnosis by physicians and miscoding by staff can affect the overall estimates. Assigning county of residence based on zip code may also lead to erroneous estimates due to county overlap within a particular zip code. All rates are based on number of hospitalizations and reflect multiple encounters.

The US Department of Health and Human Services set the goal of asthma for children aged 0-4 as 45.6 per 10,000 (11). In Kansas, the combined rate between 1995 and 1999 was 37.1 per 10,000, which is lower than the target and slightly lower than the neighboring state of Missouri (39.1). Though Kansans appear to be doing better with asthma overall, the hospitalization rates among the subgroups, such as black male children are much higher: (93 per 10,000 for males aged 0-4; 47 per 10,000 for females aged 0-4; 52 per 10,000 for females aged 5-9).

Although hospitalization data alone are not indicators of asthma prevalence, these data provide a useful source of information for surveillance of asthma. Based on this study, an effective intervention and prevention strategy could be developed to help the target populations that may be at greater risk of asthma morbidity. Strategies could be developed to reduce cost and mitigate the effect of this disease.

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5. New Asthma Estimates: Tracking Prevalence, Health Care and Mortality; National Center for Health Statistics, Centers for Disease Control, 2001.
6. Asthma Hospitalizations in Kansas, Kansas Health Statistics Report, Kansas Department of Health and Environment, No. 11, November, 2001.
7. Missouri Monthly Vital Statistics: Asthma Hospitalizations of Children and Young Adults, Vol. 35, No. 11, January 2002.
8. "Population density peer group" defined by KDHE Office of Local and Rural Health as: Less than 6.0 persons per sq mile - Frontier; 6.0-19.9 persons per sq mile - Rural; 20.0-39.9 persons per sq mile - Densely Settled Rural; 40.0-149.9 persons per sq mile - Semi Urban; 150.0 or more persons per sq mile - Urban.
9. Availability of Primary Care Providers and Pharmacists in the United States, Knapp et al, J. Am. Pharm. Assoc., 39, 127-135, 1999.
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11. <http://www.health.gov>, Healthy People 2000.

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Health Care Data Governing Board Obtains CARE Data

The Kansas Department on Aging has made Client Assessment Referral and Evaluation (CARE) data for Kansas available to the Health Care Data Governing Board. This rich dataset contains information on the care assessment process produced as elderly Kansans make decisions about receiving health care services in their own homes or in nursing facilities.

This is a great step forward in the Governing Board's ability to further analyze the decision making process used in nursing home placement versus in home care in Kansas. It will help decision makers to formulate health policies that can address critical health problems for the state's elder population.

The Governing Board would like to thank the Kansas Department on Aging for providing these data as a good faith effort to assure that decision makers and health officials have the information they need to protect and assure the health of elder Kansans. It will be important that the Governing Board continue to expand data collection from other health care settings.

Since its creation in 1993, the Health Care Data Governing Board has developed data submission, confidentiality and release policies that support the public health purpose of data provided to the state's health care database. These data will be made available to those conducting analyses for public health program management and research through the Governing Board's approved data request process. For more information, please contact Rachel Lindbloom, Office of Health Care Information, CHES, at 785-296-8627.

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Changes To OSHA Log And Other Forms

The Occupational Safety and Health Administration (OSHA) has implemented new forms for employers to record their work-related injuries and illness and has made major changes to the Record Keeping Rule. These are the first record keeping changes since the OSHA 200 log was implemented in 1970. The forms that employers were using prior to the year 2002 were the OSHA 200 Log and Summary and the OSHA 101 Supplemental Record.

The OSHA 200 Log and Summary were seen as sometimes being difficult to understand and were hard for some to tell where the injuries section stopped. The OSHA 101 Supplemental

Record did not ask enough questions on how the injury or illness occurred.

As of January 1, 2002, employers began using the new OSHA 300 Log, OSHA 300-A Summary, and the OSHA 301 Incident Report. The OSHA 300 Log has been simplified and printed on smaller legal-sized paper. The OSHA 300-A provides additional data to make it easier for employers to calculate their incident rates, and the OSHA 301 asks the employer for more information about how the injury or illness occurred.

Table 4 shows some of the major changes to the rules but is not inclusive of all the changes. More changes can be found by accessing OSHA's website, <http://www.osha.gov>.

Excerpts from OSHA Log Changes

Old Rule	New Rule
Day Counts: Count workdays No cap on count	Day Counts: Count Calendar days 180 day cap on count
Must enter the employee's name on all cases	Must enter 'Privacy Cases' rather than the employee's name, and keep a separate list of the case number and corresponding names for sensitive cases.
Carpal Tunnel Syndrome is considered an illness with repeated trauma.	Carpal Tunnel Syndrome is included in 'All other illnesses'
Injuries and Illnesses are recorded separately.	The criteria for Injuries and Illnesses have been eliminated. One criteria is used for both
Needlesticks and 'sharp injuries' – Record only if case results in medical treatment, days away, days restricted or sero-conversion.	Needlesticks and 'sharp injuries' – Record all needlesticks and injuries that result from sharps potentially contaminated with another person's blood or other potentially infectious material.

Table 4

Some of the record keeping standards have changed. OSHA's draft copy of the OSHA 300 Log originally included Musculoskeletal disorders and Hearing Loss, which both have been removed due to the enhancements of these two areas. Until new standards are approved, all Musculoskeletal disorders and Hearing loss will be included in the category 'All other illness'.

One major illness affected by this is Carpal Tunnel Syndrome. It will be impossible to determine the statistics on repetitive motion injuries, including Carpal Tunnel Syndrome, with these included in 'All other illnesses'. OSHA is hoping that standards will be approved for these two categories by the next year. If the new log is produced, all of the statistics for Musculoskeletal disorders will be unavailable for only one year, but if the standards are not established prior to next year, it will continue to affect the statistics for many categories other than Carpal Tunnel Syndrome.

If you would like to know more about other record keeping changes that have taken place you can access the information at <http://www.osha.gov>, or contact the OSHA area office in Wichita at (316) 269-6644 to find out more about the new guidelines.

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DHHS Proposes Changes To HIPAA Privacy Regulation

The US Department of Health & Human Services (DHHS) has proposed major changes to the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). DHHS is accepting comments on the proposed changes for 30 days after publication in the Federal Register,

which was scheduled for March 27.

A profound change is the elimination of the need for a written patient consent to allow providers to use protected health information for treatment, payment and operations. This consent is purely symbolic, because HIPAA effectively prevents anyone who refuses to give it from obtaining treatment. The requirement results in a great deal of regulatory complexity, and threatens to impede access to health care. In its place, the amendment would require direct treatment providers to use best efforts to obtain a written acknowledgement of receipt of their notice of privacy practices. The proposed rule would explicitly permit incidental disclosures resulting from such activities as discussions at nursing stations, the use of sign-in sheets, calling out names in waiting rooms, and the like.

Extension Forms Available Now:

Covered entities that will not be "HIPAA ready" by October 16, 2002, must complete extension forms and file them with the Centers for Medicare and Medicaid Studies (CMS). These forms are now available in .PDF format from CMS. The electronic version is coming soon! You can find further information at <http://www.cms.gov/hipaa>. Keep up with the latest changes through Kansas' state HIPAA implementation collaborative through <http://www.hark.info>.

News Notes

Expenditure Data Published

The Milbank Memorial Fund has released new state data in a publication entitled, "1998-1999 State Health Care Expenditure Report." This updated report indicates total state spending for health care remains at about 20 percent of national health care expenditures (States spent \$224 billion in fiscal year 1998 and \$238 billion in 1999). It arrays total spending for health care in each state across programs, using a common format. This edition also allows comparison of spending over two years and includes a category of "Public Health-Related Expenditures." The URL is <http://www.milbank.org/1998shcer/index.html#steering>.

The Association of State and Territorial Health Officials

NCHS Posts Aging Data

The National Center for Health Statistics has announced a new release of data in the Data Warehouse on Trends in Health and Aging. The new release contains the latest population estimates (1981-1999 with 6, 12, and 20 age-groups), new and updated data from the National Ambulatory Care Survey and Behavior Risk Factors Surveillance System, and updated data from the National Health Interview Survey on cigarette smoking, 1965-1998.

Most of the new and updated tables contain statistical confidence intervals for prevalence estimates, as well as graphically displaying population data. The Data Warehouse is located at <http://www.cdc.gov/nchs/agingact.htm>.

National Center for Health Statistics

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