

Welcome

Office for State, Tribal, Local and Territorial Support
presents . . .

CDC Vital Signs

Preventable Deaths from Heart Disease and Stroke: Improving Care Can Save More Lives

September 10, 2013

2:00–3:00 pm (EDT)



Centers for Disease Control and Prevention
Office for State, Tribal, Local and Territorial Support

Agenda

2:00 pm	Welcome & Introductions	Dan Baden, MD Associate Director for Field Services Outreach and Engagement, Office of State, Tribal, Local and Territorial Support, CDC
2:04 pm	Presentations	Barbara Bowman, PhD Director, Division for Heart Disease and Stroke Prevention, National Center for Chronic Disease Prevention and Health Promotion, CDC Linda Schieb, MSPH Epidemiologist, Division for Heart Disease and Stroke Prevention, National Center for Chronic Disease Prevention and Health Promotion, CDC Laura Nasuti, MPH Deputy Director, Office of Statistics & Evaluation, Bureau of Community Health and Prevention, Massachusetts Department of Public Health Brandon Skidmore Deputy Director, Bureau of Health Promotion, Kansas Department of Health & Environment
2:30 pm	Q&A and Discussion	Dan Baden, MD
2:55 pm	Wrap-up	
3:00 pm	End of Call	



CDC
Vitalsigns™ Teleconference
to support STLT efforts and build
momentum around the monthly
release of **CDC Vital Signs**



Preventable Deaths from Heart Disease and Stroke

Linda Schieb, MSPH

Epidemiologist

Centers for Disease Control and Prevention
Division for Heart Disease and Stroke Prevention

Vital Signs Town Hall Teleconference

September 10, 2013

National Center for Chronic Disease Prevention and Health Promotion
Division for Heart Disease and Stroke Prevention



The Burden of Cardiovascular Disease

- ❑ Each year, nearly **800,000 people** in the United States die from cardiovascular disease (CVD)¹
 - That's **1 in every 3 deaths**

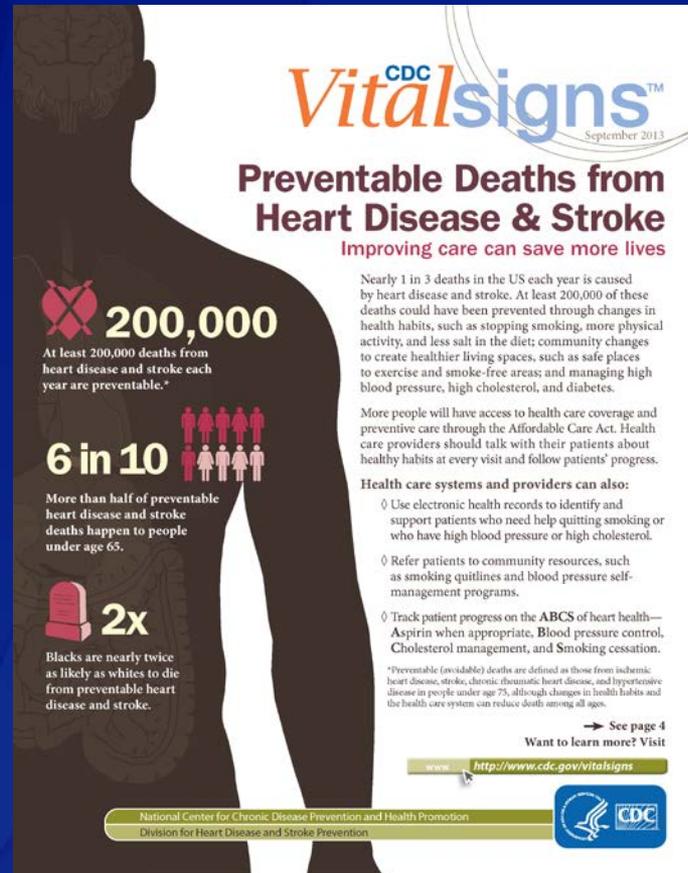
- ❑ About **1 in every 6 healthcare dollars** is spent on CVD²
 - Total costs each year—**\$312.6 billion**³
 - \$192.1 billion in direct medical expenses
 - \$120.5 billion in lost productivity costs

¹ Kochanek KD, Xu JQ, Murphy SL, Miniño AM, Kung HC. Deaths: final data for 2009. Natl Vital Stat Rep. 2011;60(3).

² Heidenreich PA, Trogdon JG, Khavjou OA, Butler J, Dracup K, Ezekowitz MD, et al. Forecasting the future of cardiovascular disease in the United States: a policy statement from the American Heart Association. Circulation. 2011;123(8):933–44.

³ Go AS, Mozaffarian D, Roger VL, Benjamin EJ, Berry JD, Borden WB, et al. Heart disease and stroke statistics—2013 update: a report from the American Heart Association. Circulation. 2012:e2–241.

Overview of Vital Signs



Vital^{CDC}signs™
September 2013

Preventable Deaths from Heart Disease & Stroke

Improving care can save more lives

200,000
At least 200,000 deaths from heart disease and stroke each year are preventable.*

6 in 10
More than half of preventable heart disease and stroke deaths happen to people under age 65.

2x
Blacks are nearly twice as likely as whites to die from preventable heart disease and stroke.

Nearly 1 in 3 deaths in the US each year is caused by heart disease and stroke. At least 200,000 of these deaths could have been prevented through changes in health habits, such as stopping smoking, more physical activity, and less salt in the diet; community changes to create healthier living spaces, such as safe places to exercise and smoke-free areas; and managing high blood pressure, high cholesterol, and diabetes.

More people will have access to health care coverage and preventive care through the Affordable Care Act. Health care providers should talk with their patients about healthy habits at every visit and follow patients' progress.

Health care systems and providers can also:

- ◊ Use electronic health records to identify and support patients who need help quitting smoking or who have high blood pressure or high cholesterol.
- ◊ Refer patients to community resources, such as smoking quitlines and blood pressure self-management programs.
- ◊ Track patient progress on the ABCS of heart health—Aspirin when appropriate, Blood pressure control, Cholesterol management, and Smoking cessation.

*Preventable (avoidable) deaths are defined as those from ischemic heart disease, stroke, chronic rheumatic heart disease, and hypertensive disease in people under age 75, although changes in health habits and the health care system can reduce deaths among all ages.

→ See page 4
Want to learn more? Visit
<http://www.cdc.gov/vitalsigns>

National Center for Chronic Disease Prevention and Health Promotion
Division for Heart Disease and Stroke Prevention



Centers for Disease Control and Prevention

MMWR

Morbidity and Mortality Weekly Report

Early Release / Vol. 62

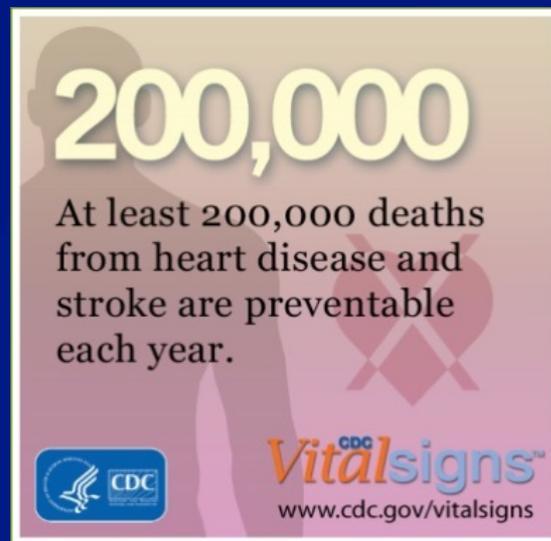
September 3, 2013

Vital Signs: Avoidable Deaths from Heart Disease, Stroke, and Hypertensive Disease — United States, 2001–2010

- ❑ What are preventable deaths?
- ❑ What factors affect one's risk?
- ❑ What can be done?

What Are Preventable Heart Disease and Stroke Deaths?

- ❑ Deaths attributed to lack of preventive health care or timely and effective medical care
- ❑ Definition
 - Under 75 years
 - Underlying cause
 - Ischemic heart disease
 - Cerebrovascular disease
 - Hypertensive disease
 - Chronic rheumatic heart disease



200,000

At least 200,000 deaths from heart disease and stroke are preventable each year.

 
www.cdc.gov/vitalsigns

Factors Affecting Risk of Preventable Death

- ❑ Total preventable deaths in 2010 = 200,070
- ❑ Factors
 - Age
 - Race/Ethnicity
 - Gender
 - Where you live

Vitalsigns™
Your chances of dying early from **heart disease & stroke** depend on **many factors**.

Find out what they are.

Vitalsigns™
Black men have the highest risk of dying from preventable **heart disease & stroke**.

Find out more.

PREVENTABLE DEATHS FROM HEART DISEASE & STROKE

MANY DEATHS FROM HEART DISEASE AND STROKE CAN BE PREVENTED

1 IN 3
Nearly 1 in 3 deaths in the US each year is caused by heart disease and stroke.

200,000
At least 200,000 deaths from heart disease and stroke each year are preventable.

YOUR CHANCES OF DYING FROM HEART DISEASE AND STROKE ARE RELATED TO MANY THINGS

AGE
6 to 30: More than half of preventable heart disease and stroke deaths happen to people under age 65.
While the number of preventable deaths has declined in people ages 65-74, it has remained nearly unchanged in people under 65.

SEX
Men have a higher risk of death across all races and ethnic groups. Black men are most at risk.

RACE/ETHNICITY **2X**
Black men nearly twice as likely as whites to die early from heart disease and stroke.

LOCATION
Risk of preventable deaths from heart disease and stroke varies by county, even within the same state.
Counties in southern states have the greatest risk overall.

IMPROVING HEALTH HABITS CAN SAVE MORE LIVES

THE ABCS OF HEART HEALTH

- 1. **A**gents when appropriate: Prescription smoking quitlines
- 2. **B**lood pressure control
- 3. **C**holesterol management
- 4. **S**moking cessation

COMMUNITIES CAN CREATE HEALTHIER LIVING SPACES

- Promote smoking quitlines
- Create tobacco-free areas
- Make safe walking areas

INDIVIDUALS CAN TAKE STEPS TO REDUCE THEIR RISK

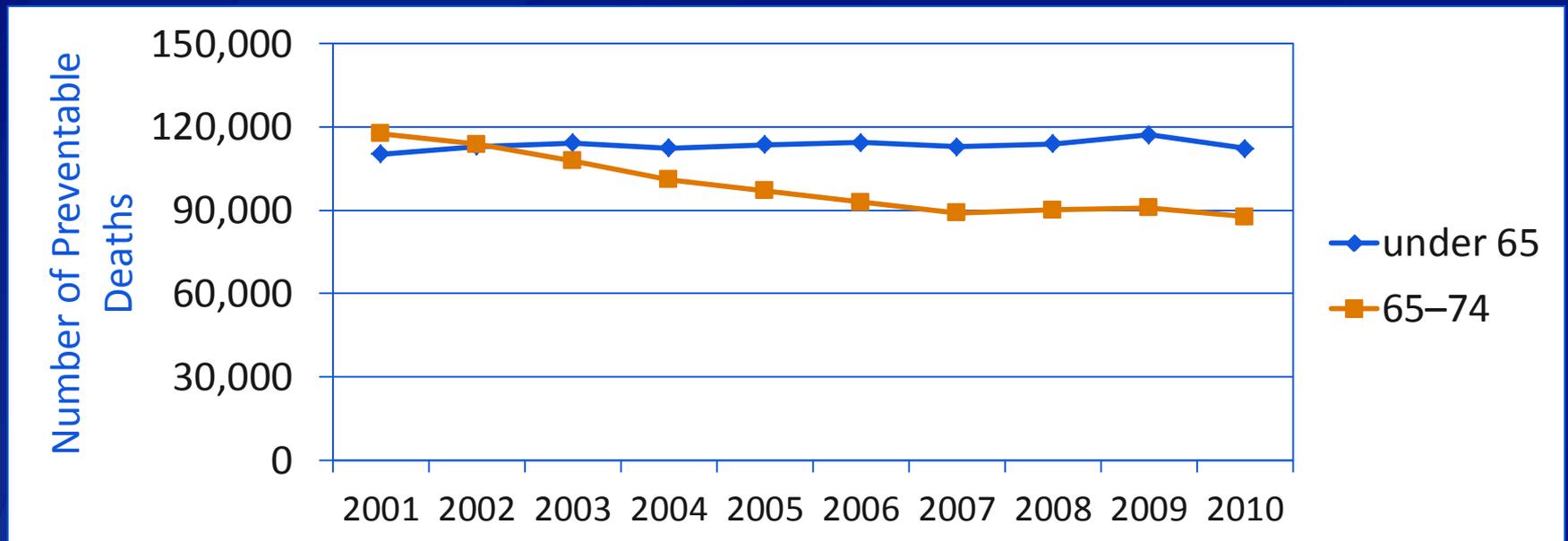
- Eat a heart-healthy diet with more fruits and vegetables and less sodium and trans fat.
- Talk with your health care provider about the ABCS of heart health.
- Know the signs and symptoms of heart attack and stroke, and get help as needed.
- 9-1-1
- Get help to stop smoking. If you don't smoke, don't start.
- To going for a brisk 30-minute walk, 3 times a day, 5 days a week.

Vitalsigns™
www.cdc.gov/vitalsigns

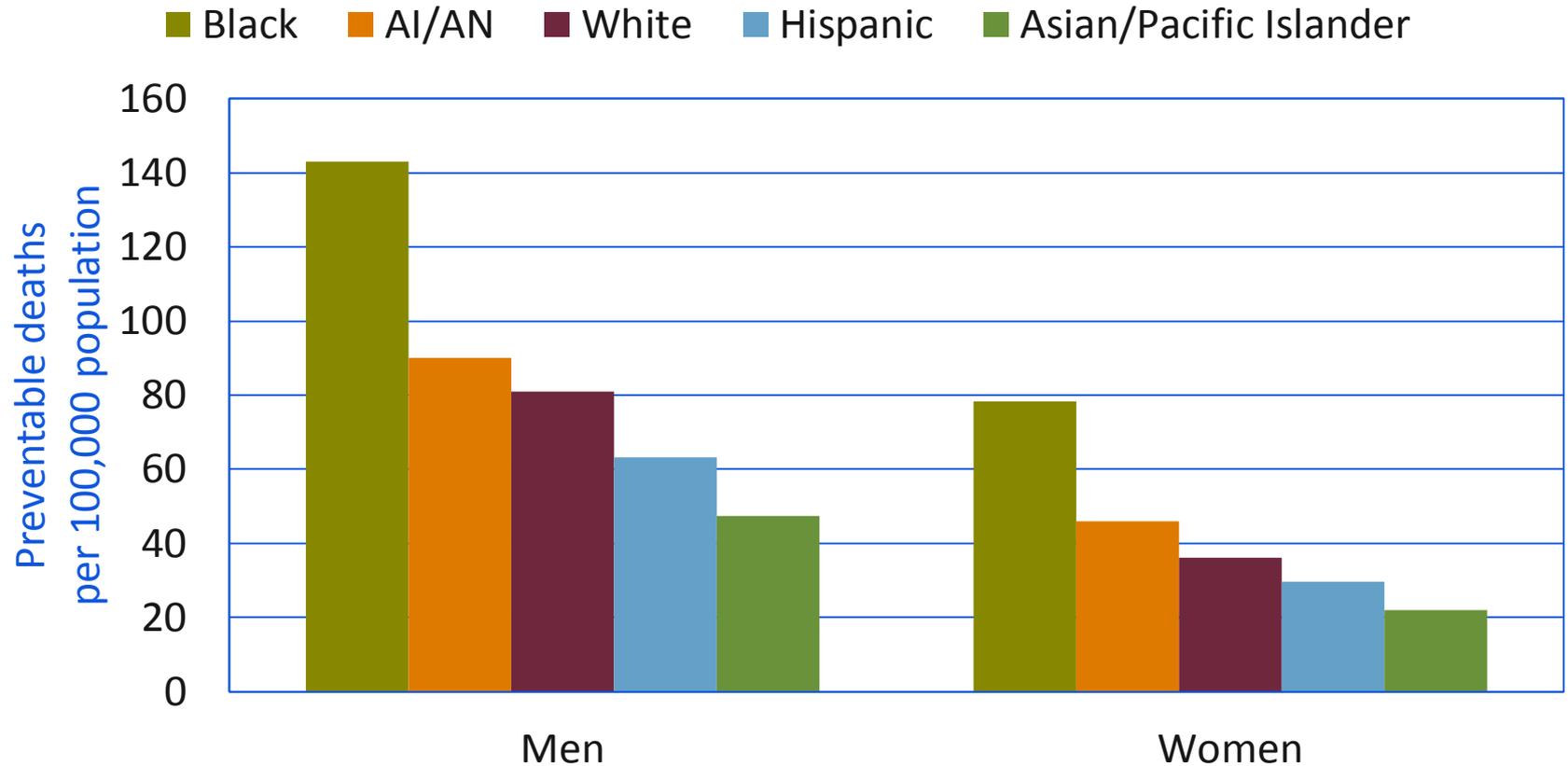
Prevention Center for Chronic Disease, Prevention and Health Promotion
Division of Heart Disease and Stroke Prevention

Age

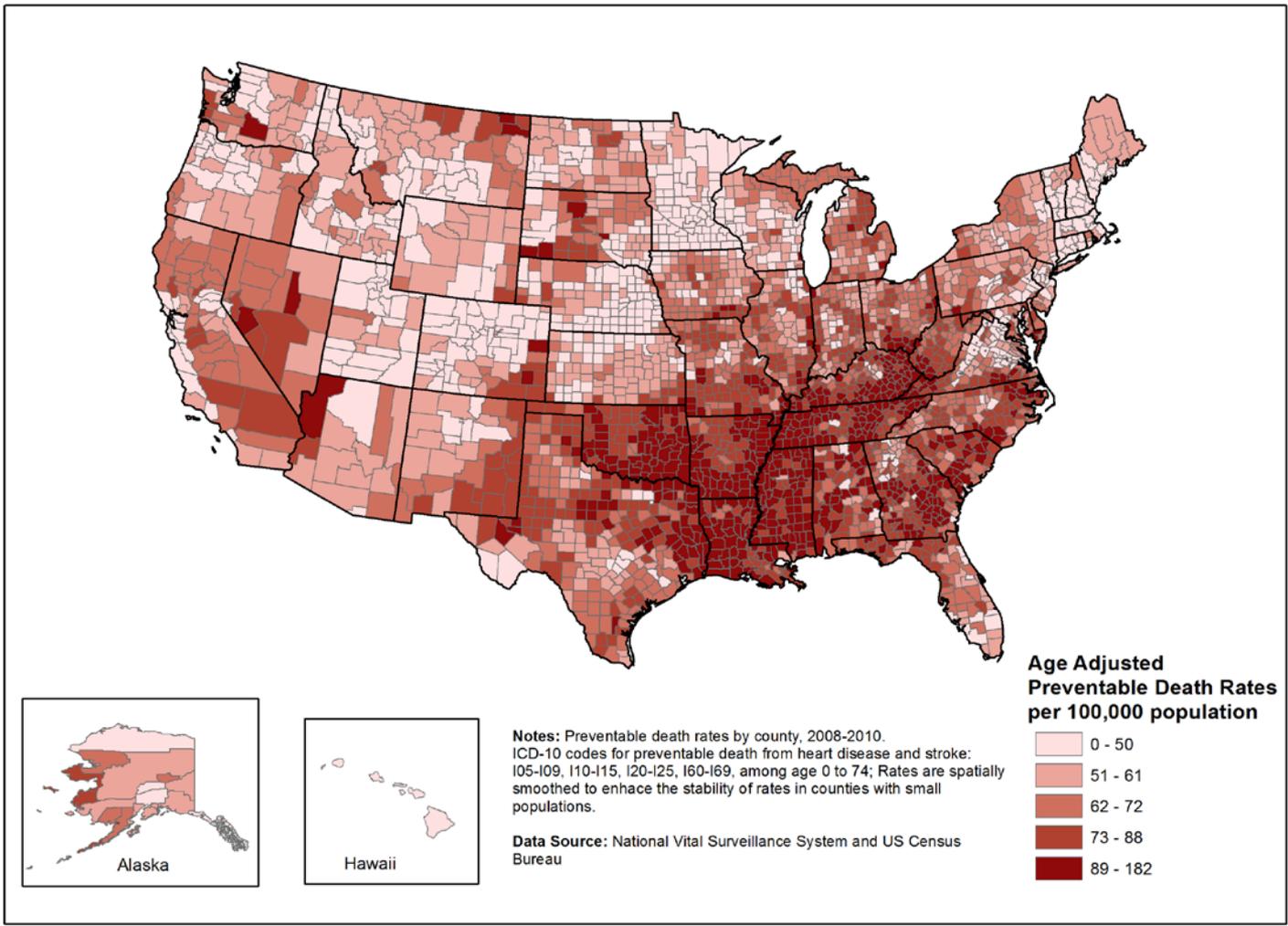
- ❑ Preventable death rates highest in those 65–74
- ❑ Rates and numbers have declined less in those under 65



Race/Ethnicity and Gender



Where You Live



What Can Be Done?

- ❑ Communities and health departments can help by
 - Partnering with healthcare systems on
 - Improving adherence to quality indicators
 - Monitoring patients on the ABCs of heart health
 - Increasing awareness of community needs
 - Promoting healthier living through
 - Tobacco-free areas
 - Safe walking areas
 - Access to healthy food options, including those with lower sodium

Preventable Deaths
from Heart Disease & Stroke

Many deaths from heart disease and stroke **can be prevented**

1 IN 3
Nearly 1 in 3 deaths in the US each year is caused by heart disease and stroke.

200,000
At least 200,000 deaths from heart disease and stroke each year are preventable.

Your chances of dying from heart disease and stroke are related to many things

Age
6 in 10: More than half of preventable heart disease and stroke deaths happen to people under age 65.
While the number of preventable deaths has declined in people ages 65–74, it has remained virtually unchanged in people under 65.

Race/ethnicity
2x: Blacks are nearly twice as likely as whites to die early from heart disease and stroke.

Sex
Men have a higher risk of death across all races and ethnic groups. Black men are most at risk.

Location
Risk of preventable death from heart disease and stroke varies by county, even within the same state. Counties in southern states have the greatest risk overall.

Improving health habits can save more lives

The ABCs of heart health

- Aspirin when appropriate
- Blood pressure control
- Cholesterol management
- Smoking cessation

Communities can create healthier living spaces

- Promote smoking quitlines.
- Create tobacco-free areas.
- Make safe walking areas.
- Improve access to healthy food.

Individuals can take steps to reduce their risk

- Talk with your health care provider about the ABCs of heart health.
- Get help to stop smoking. If you don't smoke, don't start.
- Try going for a brisk 10-minute walk, 3 times a day, 5 days a week.
- Eat a heart-healthy diet with more fruits and vegetables and less sodium and trans fat.
- Know the signs and symptoms of heart attack and stroke, and get help as needed.

Vital^{cdc}**signs**[™]
www.cdc.gov/vitalsigns

National Center for Chronic Disease Prevention and Health Promotion
Division for Heart Disease and Stroke Prevention

Communication Activities

- ❑ MMWR
- ❑ Factsheet
- ❑ Press Release
- ❑ Podcast
- ❑ Message from the Director Video
- ❑ Social Media
 - Twitter
 - Facebook
 - E-cards
 - Buttons/badges
 - Pinterest Infographic
 - Instagram



Do you know the **ABCS** of heart health?

- A**spirin when appropriate
- B**lood pressure control
- C**holesterol management
- S**moking cessation

Find out more.



Healthy lifestyle changes can help reduce preventable deaths from heart disease and stroke!



Learn more about the **healthy habits** you can put into practice every day in the [latest report](#) from CDC Vital Signs.

National Center for Chronic Disease Prevention and Health Promotion
Division for Heart Disease and Stroke Prevention



Other Resources

- ❑ *Vital Signs* Town Hall Teleconference: <http://www.cdc.gov/stltpublichealth/townhall/2013/09/vitalsigns.html>
- ❑ *Vital Signs*: www.cdc.gov/VitalSigns/HeartDisease-Stroke (English and Spanish language materials)
- ❑ *Vital Signs* Digital Press Kit: www.cdc.gov/media/dpk/2013/dpk-vs-heart-disease.html#graphics (English and Spanish language materials)
- ❑ Interactive Atlas of Heart Disease and Stroke: <http://nccd.cdc.gov/DHDSPAtlas/>
- ❑ Million Hearts: millionhearts.hhs.gov
- ❑ CDC Heart Disease: www.cdc.gov/heartdisease
- ❑ CDC Stroke: www.cdc.gov/stroke

Thank you!

For more information please contact Centers for Disease Control and Prevention

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E-mail: cdcinfo@cdc.gov Web: www.cdc.gov

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.





Commonwealth of Massachusetts

Executive Office of Health and Human Services



Enhancing Community-Clinical Linkages through an Open-Source, Bi-Directional Electronic Referral System: Massachusetts e-Referral Project

Laura Nasuti, MPH

Deputy Director

Office of Statistics & Evaluation, Bureau of Community
Health and Prevention, Massachusetts Department of
Public Health

September 10, 2013

Overview

- Centers for Medicare & Medicaid Services (CMS) State Innovation Model (SIM) Award
- History of e-Referral Project
- e-Referral Project
- Prevention & Wellness Trust Fund

MA State Innovation Model Award

What is our goal?

**The Triple Aim—
Better population
health, better
experience of
care, lower costs**

How do we do it?

Payment reform

**Delivery system
transformation**

**Cost and quality
accountability**

How does the State Innovation Model (SIM) help us get there?

- Medicaid's Primary Care Payment Reform Initiative
- The Group Insurance Commission's (GIC) value based purchasing strategy
- Provider portal on the All Player Claims Database (APCD)
- Adoption of the Health Information Exchange
- Data infrastructure for Long Term Support Services (LTSS) Providers
- Electronic referrals to community resources
- Access to pediatric behavioral health consultation
- Linkages between primary care and LTSS
- Technical assistance to primary care providers
- Health Information Exchange (HIE) functionality for quality reporting
- Statewide quality measurement and reporting
- Payer and provider focused learning collaboratives
- Rigorous evaluation

History of e-Referral Program

The concept of creating a bi-directional electronic referral is not new with this grant:

- In 2008, Frieden and Mostashari listed 12 key features that would be necessary for a system of electronic health records to function as effectively as possible.* Of the 12 features, only “Linking electronic medical records (EMRs) to community resources” has had no forward movement.
- In 2010, the Massachusetts Department of Public Health and the New Hampshire Department of Health sponsored a project to create electronic referrals to the Tobacco Quitline using a proprietary software: www.health-e-link.net
- For this project, the wide array of community resources underscores the importance of a flexible translator model for communication.

Create

- e-Referral requires a bi-directional electronic as well as organizational conversation to initiate community-clinical linkages

Evaluate

- e-Referral system can provide baseline reports on the number of referrals, number of services received, and number of pounds lost
- When integrated with the electronic health record (EHR), health systems can evaluate the impact of these community programs on population health

Sustain

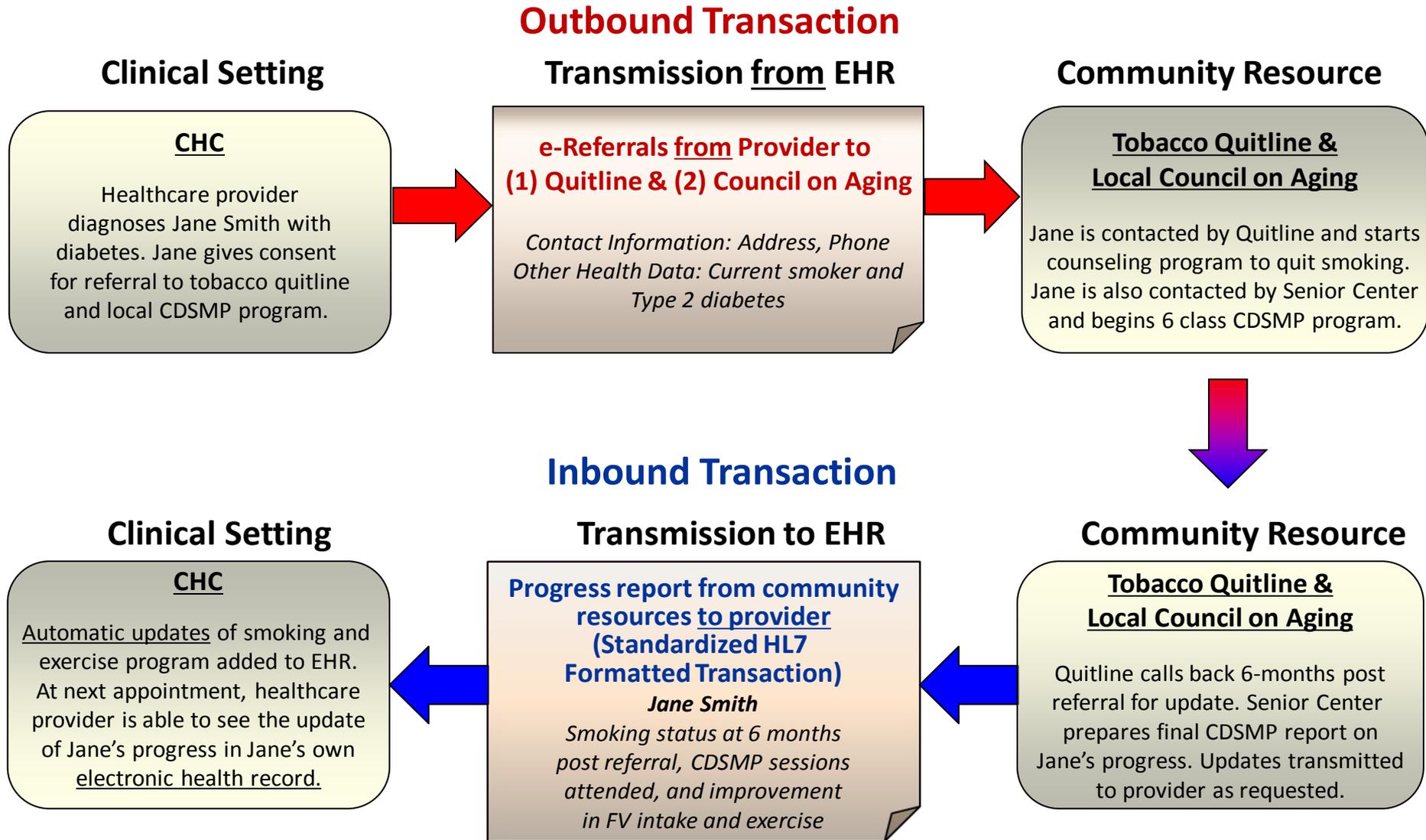
- Once installed, the e-Referral system can be modified to add additional types of community resources
- Using the e-Referral software and EHRs, community-based organizations can make the case for clinically meaningful and cost-effective programming

MA SIM e-Referral Program

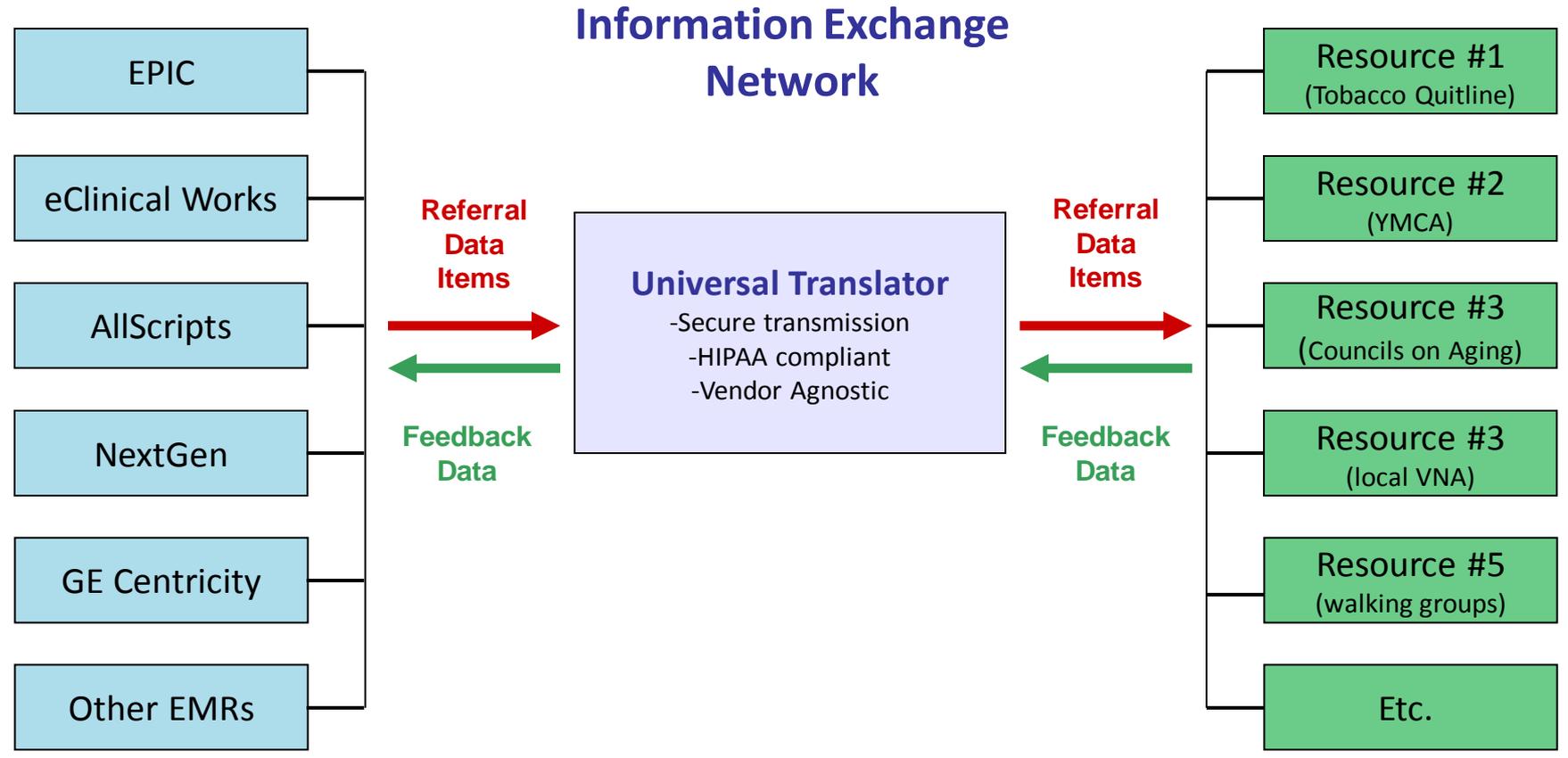
In early 2013, Massachusetts was awarded the SIM Testing Award. Part of this award was to create an open-source, bi-directional referral system to formalize community-clinical linkages.

- \$3.8 million over the course of 4 years
- A minimum of referrals to 4 community-based organizations
- The Massachusetts League of Community Health Centers (CHCs) are our primary clinical partners
 - Their Community Health Information Association Data Reporting and Visualization System (CHIA DRVS) data system will allow us to evaluate the impact of the e-Referral program both on referrals to community resources as well as health outcomes
- Our initial pilot sites would be 3 CHCs affiliated with the Mass League who are on CHIA DRVS and four community resources: Tobacco Quitline, Councils on Aging, Visiting Nursing Associations, YMCAs
- Part of grant includes a roll-out plan to make software available state-wide, as well as technical instructions on how other states or organizations can adopt this tool

Example of Bi-directional Referral



A Model for Bi-directional e-Referrals



Smokers Quitline

- Tobacco cessation

YMCA

- Y Diabetes Prevention Program
- Fitness programs for childhood obesity
- General fitness, nutrition

Visiting Nurses Association

- Transitions of Care services
- Diabetes Self-Management Education

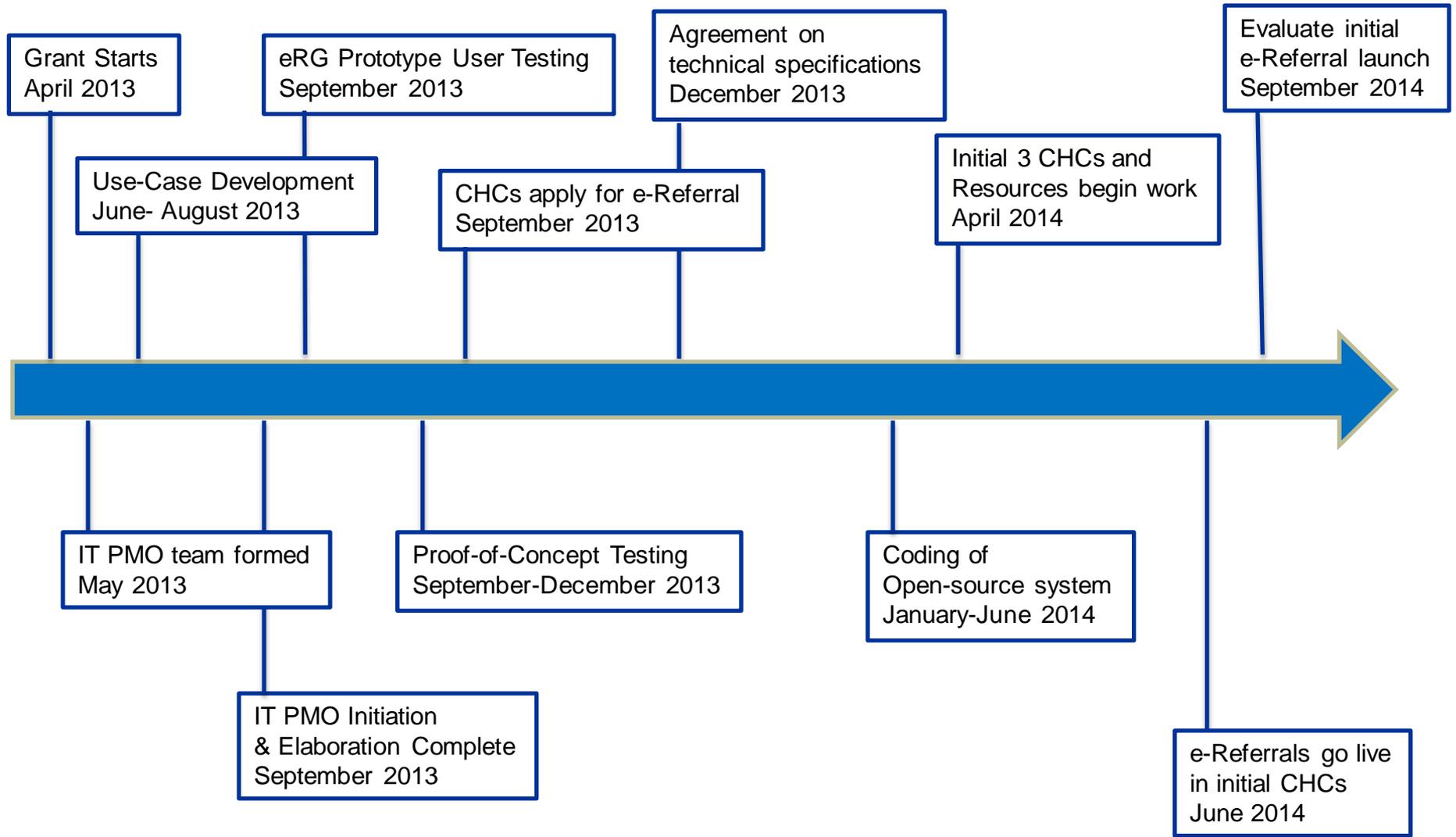
Council on Aging

- Chronic Disease Self-Management Education (CDSME) programs
- Falls prevention

Four ‘buckets’ of information that need to be transmitted with each referral

- Patient Information
 - Patient Name, Telephone, Email, Address, Preferred Language, Transportation, Unique ID
- Referring Provider Information
 - Provider Name, Provider Organization, Provider Address, Phone, Unique Provider ID, Unique Organization ID
- Referred to Provider Information
 - Community-based Organization, Address, Phone Number, Referral Manager, Unique Community-based Organization (CBO) ID
- Referral-Specific Information
 - Type of Referral, Weight, Height, Special Needs, Parent/Guardian (if applicable), Special Instructions

e-Referral Project Timeline Implementation & Year1



Prevention & Wellness Trust Fund

- \$57 million over the next 3 years to lead to better health outcomes and a decrease in healthcare cost in Massachusetts
- Formalizing a community-clinical linkage for each priority condition is required
- The e-Referral system will be available to grantees to test novel referrals

Thank you!

Laura Nasuti

Contact: Laura.Nasuti@state.ma.us

Quality Improvement for a Changing Environment

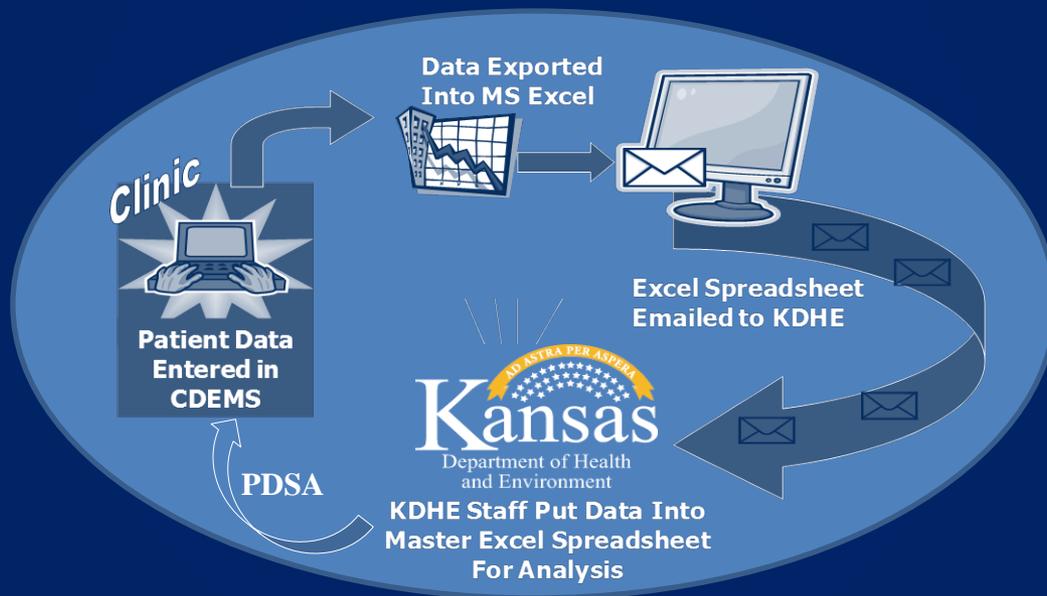


Brandon Skidmore
Deputy Director
Bureau of Health Promotion
Kansas Department of Health and Environment

Our Mission: To protect and improve the health and environment of all Kansans.

Kansas Quality of Care Background

- 2004—Program launched by Kansas Department of Health and Environment's (KDHE) Diabetes Prevention and Control Program (DPCP)

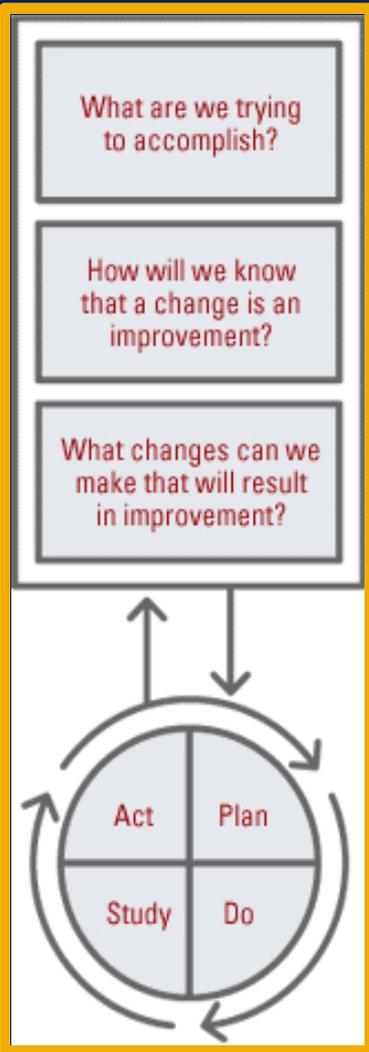


- 2007—DPCP collaborated with Heart Disease and Stroke Prevention Program (HDSP)

Our Mission: To protect and improve the health and environment of all Kansans.

Implementing the PDSA cycles

- The KQOC project provides tools for improving chronic illness care by providing training and guidance to participants on Quality Improvement efforts through the Plan-Do-Study-Act (PDSA) cycle



KANSAS QOC PROJECT - PDSA Worksheet for Testing Change

Clinic Name: **Date:** October 2012-April 2013

Aim: (overall goal you wish to achieve)

Every goal will require multiple smaller tests of change

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
Improve the number of patients with foot checks.	Doctors/ Nurses	Now	Clinic

Plan

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
Ran list of each provider's patients with their last office visit and their last foot check. Gave these plus a letter explaining what we were doing to the providers.	Sara	October	Clinic
At the end of the 6 months run another list of the provider's patients with the same information to see if we had any improvement in the number of patients with foot checks	Sara	April	Clinic

Collection of Patient and Clinic Level Data

Quality of Care Data

Electronic Health Record (EHR)

- Patient health information collected at the clinic level
- Dual entry eliminated
- Quality improvement data readily available to clinic



Quality of Care Data

Chronic Disease Electronic Management System (CDEMS)

- Database to track patient care and outcomes
- Collected at clinic level

Mapping to EHR's

- Links EHR systems from all KQOC participating clinics
- Guides QI team decision making for quality of care improvements
- Supports robust evaluation designs to assess impact both narrowly and across domains
- All information accessible in a single interface



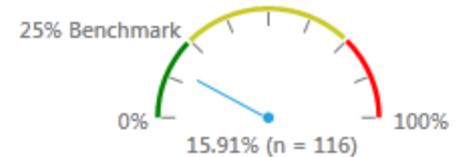
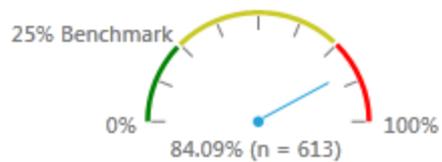
Hypertension



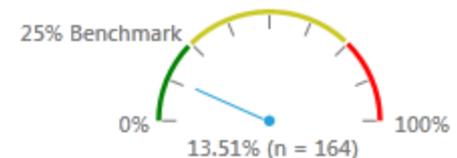
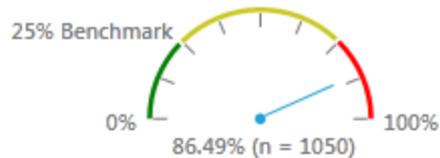
Pre-Hypertension (SBP 120-139 or DBP 80-89)

Hypertension (SBP \geq 140 or DBP \geq 90)

Site



Region



- Gender
- BMI
- Type 2 Diabete
- Tobacco Use
- Hypertension
- Age
- Race

Site		Gender	
		Male	Female
Hypertension	Hypertension	3.98%	11.93%
	Pre-Hypertension	43.21%	40.88%

Region

Region		Gender	
		Male	Female
Hypertension	Hypertension	2.55%	10.96%
	Pre-Hypertension	43.74%	42.75%

Quality of Care Report (ABCs)

Reports: [Criteria](#) [Print](#)

Quality of Care Summary

From 5/1/2013 to 8/23/2013

Total Patients: 3,631

[Apply Filters](#)

<input checked="" type="checkbox"/>	Medications	Count	Percent
<input checked="" type="checkbox"/>	ACE	0	0%
<input checked="" type="checkbox"/>	AGI	13	0.36%
<input checked="" type="checkbox"/>	AldoANT	0	0%
<input checked="" type="checkbox"/>	Alphaagonist	0	0%
<input checked="" type="checkbox"/>	AlphaANT	0	0%
<input checked="" type="checkbox"/>	ARB	184	5.07%
<input checked="" type="checkbox"/>	ASA	729	20.08%
<input checked="" type="checkbox"/>	Beta Blocker	207	5.7%
<input checked="" type="checkbox"/>	BP Med	379	10.44%
<input checked="" type="checkbox"/>	CCB	47	1.29%
<input checked="" type="checkbox"/>	Diuretic	27	0.74%
<input checked="" type="checkbox"/>	Fibrates	8	0.22%
<input checked="" type="checkbox"/>	Glitazones	148	4.08%
<input checked="" type="checkbox"/>	Glucophage	846	23.3%
<input checked="" type="checkbox"/>	Insulin	219	6.03%
<input checked="" type="checkbox"/>	Niacin	4	0.11%
<input checked="" type="checkbox"/>	Omega 3	60	1.65%
<input checked="" type="checkbox"/>	Other Chol Med	1	0.03%
<input checked="" type="checkbox"/>	Resins	0	0%
<input checked="" type="checkbox"/>	Statin	864	23.8%
<input checked="" type="checkbox"/>	Vasodilator	0	0%

[Apply Filters](#)

<input checked="" type="checkbox"/>	Blood Pressure	Count	Percent
<input checked="" type="checkbox"/>	Normal: SBP < 120 and DBP < 80	26	0.72%
<input checked="" type="checkbox"/>	Pre-HTN: SBP 120-139 or DBP 80-89	80	2.2%
<input checked="" type="checkbox"/>	HTN Stage 1: SBP 140-159 or DBP 90-99	44	1.21%
<input checked="" type="checkbox"/>	HTN Stage 2: SBP >= 160 or DBP >= 100	10	0.28%
<input checked="" type="checkbox"/>	Diabetes Treatment Goal: SBP < 130 and DBP < 80	64	1.76%
<input checked="" type="checkbox"/>	Missing SBP or DBP	3,471	95.59%
<input checked="" type="checkbox"/>	Not Missing SBP or DBP	160	4.41%
Average Systolic: 132 Average Diastolic: 73			

[Apply Filters](#)

<input checked="" type="checkbox"/>	Lipid Profile	Count	Percent
<input checked="" type="checkbox"/>	Patients With Cholesterol Test	58	1.6%
<input checked="" type="checkbox"/>	Cholesterol Numeric Results	58	1.6%
<input checked="" type="checkbox"/>	Cholesterol >= 200	13	22.41%
Cholesterol Average: 170			
<input checked="" type="checkbox"/>	Patients With Triglycerides Test	63	1.74%
<input checked="" type="checkbox"/>	Triglycerides Numeric Results	63	1.74%
<input checked="" type="checkbox"/>	Triglycerides >= 200	19	30.16%
Triglycerides Average: 165			
<input checked="" type="checkbox"/>	Patients With HDL Test	63	1.74%
<input checked="" type="checkbox"/>	HDL Numeric Results	63	1.74%
<input checked="" type="checkbox"/>	HDL < 35	12	19.05%
HDL Average: 46			
<input checked="" type="checkbox"/>	Patients With LDL Test	61	1.68%
<input checked="" type="checkbox"/>	LDL Numeric Results	61	1.68%
<input checked="" type="checkbox"/>	LDL < 100	37	60.66%
<input checked="" type="checkbox"/>	LDL 100 - 129	14	22.95%
<input checked="" type="checkbox"/>	LDL >= 130	10	16.39%
<input checked="" type="checkbox"/>	LDL < 130	51	83.61%
LDL Average: 91			

[Apply Filters](#)

<input checked="" type="checkbox"/>	Health Profile	Count	Percent
<input checked="" type="checkbox"/>	Cerebrovascular	19	0.52%
<input checked="" type="checkbox"/>	CHQOC	0	0%
<input checked="" type="checkbox"/>	CAD	40	1.1%
<input checked="" type="checkbox"/>	CKD	2	0.06%
<input checked="" type="checkbox"/>	DM-1	402	11.07%
<input checked="" type="checkbox"/>	DM-2	2,303	63.43%
<input checked="" type="checkbox"/>	DQOC	22	0.61%
<input checked="" type="checkbox"/>	Heart Disease/CAD	113	3.11%
<input checked="" type="checkbox"/>	HQOC	0	0%
<input checked="" type="checkbox"/>	Hypertension	797	21.95%
<input checked="" type="checkbox"/>	Hx-GDM	0	0%
<input checked="" type="checkbox"/>	Hyperlipidemia	542	14.93%
<input checked="" type="checkbox"/>	Nephropathy	26	0.72%
<input checked="" type="checkbox"/>	Neuropathy	44	1.21%
<input checked="" type="checkbox"/>	Periph Vascular	40	1.1%
<input checked="" type="checkbox"/>	Pre-Diabetes	1	0.03%
<input checked="" type="checkbox"/>	Prior MI	9	0.25%
<input checked="" type="checkbox"/>	Retinopathy	2	0.06%
<input checked="" type="checkbox"/>	Self Monitors BG	154	4.24%
<input checked="" type="checkbox"/>	Current Tobacco User	177	4.87%

Our Mission: To protect and improve the health and environment of all Kansans.



Contacts

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CDC *Vital Signs* Electronic Media Resources

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Vital Signs interactive buttons and banners

www.cdc.gov/vitalsigns/SocialMedia.html

Public Health Practice Stories from the Field

- Stories about the implementation of Public Health Practice Stories from the Field



www.cdc.gov/stltpublichealth/phpracticestories

Provide feedback on this teleconference:

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Please mark your calendars for the next
Vital Signs Town Hall Teleconference

October 8, 2013

2:00–3:00 pm (EDT)

For more information, please contact Centers for Disease Control and Prevention.

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The findings and conclusions in this presentation are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.



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