

PS2-03:

### Chronic Hepatitis B Testing in US-born and Foreign-born Asia Pacific Islanders of Kaiser Permanente, Hawai'i

Vinutha Vijayadeva<sup>1</sup>; Mei Lu<sup>2</sup>; Cynthia Nakasato<sup>1</sup>; Stuart Gordon<sup>2</sup>; Loralee Rupp<sup>2</sup>; Emily Henkle<sup>3</sup>

<sup>1</sup>Kaiser Permanente Hawai'i; <sup>2</sup>Henry Ford Health System; <sup>3</sup>Kaiser Permanente Northwest

**Background/Aims:** Approximately two billion people worldwide have been infected with hepatitis B virus (HBV) and about 350 million live with chronic infection. Over half of all liver cancer cases in the world are attributable to chronic, or persistent, HBV infection. Of US residents chronically infected with HBV, 40% to 70% are foreign-born immigrants, mainly Asian/Pacific Islanders (APIs). Disparity by race exists for APIs which makeup approximately 4% of the U.S population and more than 2% of these races are affected with chronic HBV. The purpose of this study is to estimate the prevalence of HBV in foreign and US born APIs and test the differences in these groups for testing (HBV DNA or HBsAg), testing positive for HBV, alanine aminotransferase (ALT) level and other demographic variables. **Methods:** Utilization data from Kaiser Permanente, Hawai'i (KPHI) was used. All adults (18 yrs and older) with enrollment for any length of time from 2006 to 2008, with at least one health plan encounter and twelve months of continuous enrollment at any time were included. Persons with HBV diagnosis within six months of first encounter were excluded. We limited the analysis to Asians and Pacific Islanders. Date of birth, race, gender, and country of origin (COO), household income and education were obtained from the Virtual Data Warehouse (VDW) demographic and census tables. Results and **Discussion:** Among who met the inclusion criteria (N=191,335), 69,923 were APIs and of these 68% had information on country of origin. We plan to report (1) the prevalence of HBV in foreign and US born APIs (2) test the difference between the these two groups with respect to testing, testing positive for HBV infection, age, gender, annual income and ALT levels.

**Keywords:** HBV Testing; Asia Pacific Islanders; Healthcare Disparities  
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PS2-04:

### Knowledge of Heart Attack and Stroke Symptomology: A Cross-sectional Comparison of Rural and Non-rural US Adults

May Nawal Lutfiyya<sup>1</sup>; Michael Swanoski<sup>1</sup>; Michael Akers<sup>1</sup>; Maria Amaro<sup>1</sup>

<sup>1</sup>Essentia Health

**Background/Aims:** In the US heart disease is the number one cause of death and stroke is the leading cause of adult disability. Early treatment, received within three-hours after a heart attack or a stroke, is critical to lowering the risk of disability and/or death. Understanding the symptoms and signs of heart attacks and strokes are important not only in saving lives, but also in preserving quality of life. Findings from recent research have yielded that the prevalence of cardiovascular disease risk factors are higher in rural populations, suggesting that adults living in rural locales may be at higher risk for heart attack and/or stroke. Knowledge of heart attack and stroke symptomology as well as calling 911 as the appropriate first response to suspected heart attack or stroke are essential first steps in seeking care. This study sought to examine the knowledge of heart attack and stroke symptoms among rural adults in comparison to non-rural adults living in the US. **Methods:** Using multivariate techniques, a cross-sectional analysis of an amalgamated multi-year Behavioral Risk Factor Surveillance Survey (BRFSS) database was performed. The dependent variable for this analysis was low heart attack and stroke knowledge score. The covariates for the analysis were: age, sex, race/ethnicity, annual household income, attained education, health insurance status, health care provider (HCP), timing of last routine medical check-up, medical care deferment, self-defined health status and geographic locale. **Results:** Logistic regression analysis revealed that those US adults who had low composite heart attack and stroke knowledge scores were more likely to be rural (OR=1.218 95%CI 1.216-1.219) rather than non-rural residents. Furthermore, those with low scores were more likely to be: male (OR=1.353 95%CI 1.352-1.354), >65 years of age (OR=1.369 95%CI 1.368-1.371), African American (OR=1.892 95%CI

1.889-1.894), not educated beyond high school (OR=1.400 95%CI 1.399-1.402), uninsured (OR=1.308 95%CI 1.3-6-1.310), without a HCP (OR=1.216 95%CI 1.215-1.218), and living in a household with <\$50,000 annual income (OR= 1.429 95%CI 1.428-1.431). **Discussion:** Analysis identified clear disparities between the knowledge levels US adults have regarding heart attack and stroke symptoms. These disparities should inform education endeavors focused on improving knowledge of MI and stroke symptoms.

**Keywords:** MI and Stroke Symptoms; Health Knowledge Disparities; Healthcare Disparities

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CB3-01:

### Comparison of Ethnicity and Race Categorization in Electronic Medical Records and by Self-report

Anna Bergdall<sup>1</sup>; Stephen Asche<sup>1</sup>; Nicole Schneider<sup>1</sup>; Tessa Kerby<sup>1</sup>; Karen Margolis<sup>1</sup>; JoAnn Sperl-Hillen<sup>1</sup>; Jaime Sekenski<sup>1</sup>; Rachel Pritchard<sup>1</sup>; Michael Maciosek<sup>1</sup>; Patrick O'Connor<sup>1</sup>

<sup>1</sup>HealthPartners

**Background/Aims:** Members of minority groups are more likely than non-minorities to have worse health outcomes. Electronic medical records (EMR) data are often used for research on health disparities, and can help identify patient risk factors, but accuracy of ethnicity and race data in the EMR is often questioned. Aims: To compare HealthPartners Medical Group (HPMG) EMR data on ethnicity/race to self-reported classification. **Methods:** We compared percent agreement of self-reported and EMR data on ethnicity/race among 1719 patients who expressed interest in a hypertension clinical trial, completed an eligibility phone screen, and consented to EMR review. Patients classified their ethnicity/race in two questions: (1) Are you of Latino or Hispanic descent? (Yes, No, Don't know, Refused); (2) How would you describe your race (Check all that apply) (American Indian/Alaskan Native, Asian, Black or African American, Native Hawaiian or Pacific Islander, White or Caucasian, Other, Don't know, Refused). EMR race categories allowed multiple selections among: White, Black, Asian, Hispanic, American Indian, Other, and No Answer. **Results:** Race data was missing in 0.7% of phone screens and 1.2% of EMRs. Self-reported race was 79% white, 14% African American, 3% mixed, 2% other, 1% Asian, <1% Native American. In the EMR, race was recorded as 79% white, 14% African American, 3% mixed race, 1% Asian, <1% each for American Indian, and other. Overall agreement for race was 91.1%. EMR data agreed with self-report for 97% of those reporting white, 94% of those reporting African American, 83% Asian, 50% Native American, 9% mixed race and 6% other. Hispanic ethnicity was self-reported by 1.3% and coded for 2.4% in the EMR. EMR confirmed Hispanic ethnicity for 51% self-reporting Hispanic ethnicity. **Discussion:** EMR race/ethnicity data was quite complete, and agreement of data sources was high overall and among whites, African Americans and Asians. Lower agreement was observed among Hispanic, Native American, and mixed race patients, subgroups that may be disproportionately affected by disparities. Some caution is needed in interpreting EMR-based results for those subgroups, and their proper classification in the EMR is warranted. Similar comparisons should be conducted in other settings and patient populations.

**Keywords:** Healthcare Disparities; Race

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CB3-02:

### Demographic Differences Between US-born and Foreign-born Asia Pacific Islanders Among the Hepatitis B Patients of Kaiser Permanente, Hawai'i

Vinutha Vijayadeva<sup>1</sup>; Cynthia Nakasato<sup>1</sup>; Stuart Gordon<sup>2</sup>; Loralee Rupp<sup>2</sup>; Mei Lu<sup>2</sup>; Emily Henkle<sup>3</sup>; Joseph Boscarino<sup>4</sup>

<sup>1</sup>Kaiser Permanente Hawai'i; <sup>2</sup>Henry Ford Health System; <sup>3</sup>Kaiser Permanente Northwest; <sup>4</sup>Geisinger Health System

**Background/Aims:** Approximately two billion people worldwide have been infected with hepatitis B virus (HBV) and about 350 million live with chronic infection. Over half of all liver cancer cases in the world are attributable to chronic, or persistent, HBV infection. Of US residents chronically infected with HBV, 40% to 70% are foreign-born immigrants,