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## ADDRESSING PRENATAL SMOKING CESSATION IN AMERICAN INDIAN COMMUNITIES

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*Purpose:* The Smoke-Free Families National Dissemination Office is funded by The Robert Wood Johnson Foundation to translate the results of effective smoking cessation interventions into practice. We collaborate with American Indian organizations to increase outreach, training and intervention capacity for providers in their communities. Data are being gathered via needs assessments and focus groups to learn about the current status of tobacco treatment services during pregnancy, and how to create culturally relevant cessation programs and materials for Native populations.

*Methods:* IRB-approved, self-administered surveys were distributed to Tribal Support Centers, clinics and hospitals. As of August 2004, over 260 needs assessments have been collected and analyzed from physicians, nurses, health educators, and other health care practitioners across the country. Focus groups have been conducted with both providers and pregnant American Indian women to supplement the survey data.

*Results:* Preliminary findings from the needs assessment indicate that many providers discuss tobacco use with their clients, but there is a dearth of culturally appropriate client materials and a need for additional technical assistance such as access to clinical practice guidelines. Preliminary findings from focus groups reveal specific educational and cultural issues that should be incorporated into smoking cessation counseling protocols and patient materials. These include the ceremonial or sacred use of tobacco, and the belief that smoking does not cause low birthweight among American Indian babies.

*Discussion:* The implications of the study results will inform efforts to develop a national action plan for providing pregnancy-specific tobacco dependence treatment within the American Indian community.

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## EVALUATING THE NATIONAL PARTNERSHIP TO HELP PREGNANT SMOKERS QUIT

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*Purpose:* The objective of this study is to evaluate the collaborative efforts and methods used by the National Partnership to Help Pregnant Smokers Quit. Launched in May 2002, the National Partnership is a diverse coalition of over 60 leading philanthropic, health, business and government organizations dedicated to getting pregnant women the help they want and the support they need to quit smoking and stay smoke-free. The National Partnership adopted, and is implementing, an Action Plan to provide proven clinical and community-based interventions to every pregnant smoker in the United States.

*Methods:* Representatives from partner organizations formed five working groups to implement evidence-based strategies to help pregnant women quit smoking. These representatives convened, identified a core set of objectives and established benchmarks to gauge their progress. On monthly conference calls, these representatives work to develop, implement, and support activities to move toward the benchmarks. Using MS Access, this study monitored and recorded all communications, strategies, actions, and products of the five working groups since their inception in 2002.

*Results:* Data on select benchmarks will be used to illustrate National Partnership progress on a wide range of activities including the development of provider training materials, promotion of a nationwide quit line, and development of materials to increase the accessibility of prenatal smoking cessation services.

*Discussion:* These data document the process and substantiate the progress of the National Partnership toward its 2010 goal. These results will illustrate how partnerships between health services and community organizations can work to accomplish shared goals.

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### EFFECTIVENESS OF A COMMUNITY-BASED CANCER AWARENESS INTERVENTION

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From the Morehouse School of Medicine (BT, DS, JS, SS), National Black Leadership Initiative on Cancer II: Network Project (DS, JS, SS), Thomas Jefferson University (ED), University of Illinois at Chicago (RJ)

*Purpose:* The purpose of the study was to understand differential impacts associated with a dietary intervention given variations in intervention setting. To this end, we focused on changes in cancer/diet-related knowledge, attitudes and beliefs as the intermediate outcome, which will enhance fruit and vegetable consumption, the primary outcome, in health care versus faith-based settings.

*Methods:* A cohort of 291 participants was randomized into two groups: 1) control cohort/CC (45-minute informational video) and 2) intervention cohort/IC (60-minute skills-building/interactive lecture and cooking demonstration). Study participants completed pre- and post- knowledge, attitudes, practices and beliefs surveys.

*Results:* A total of 10 healthcare and eight faith-based sessions were conducted. The intervention appears to have been most effective in strengthening positive and appropriate perceptions associated with cancer healthy diets, particularly in participants' understanding of food properties supportive of health and reduced cancer risk. Participants in the intervention group tended to have stronger beliefs about food properties, responding at the scale extremes, eg, "strongly agree" than participants in the control groups. In post-intervention surveys, participants in the faith-based groups tended to respond more "strongly" than members in the health care group across a variety of survey items.

*Conclusions:* Preliminary findings suggest participants' beliefs about the links between diet and cancer are enhanced by the Get With It 5-A-Day Program.

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004

### INITIAL ADHERENCE IS A POSITIVE PREDICTOR OF IMMUNIZATION COMPLETION

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From the Department of Pediatrics (DK) and the Clinical Research Center (RM, RA), Morehouse School of Medicine, Atlanta, Ga

*Objectives:* Immunization surveys during the early 1990s demonstrated coverage levels for childhood vaccines were below US Public Health Service goals in inner-city populations.<sup>1</sup> Recent studies suggest immunizations may not be initiated on time.<sup>2</sup> We sought to evaluate the timeliness of initial immunization in an inner-city population, and to assess timeliness as a predictor for immunization completion.

*Methods:* We evaluated initial timeliness and completion by analyzing coverage data collected from patients seen at a single, inner-city site using immunization registry and clinic records. We calculated the odds of immunization completion given initial timeliness for each patient at two years of age.

*Results:* Only 42.2% of patients received initial immunizations on-time. Only 13.3% of children sampled completed vaccination. Children were 8.9 times more likely to complete vaccinations by 24 months of age if they received initial immunizations by 3 months (95% CI: 3.2–24.2).

*Conclusions:* In patients who did not receive their initial vaccination on-time, the coverage level at 24 months of age was low. Interventions that improve timely initiation may improve coverage levels and should be developed and tested, and implemented.

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005

**CULTURAL DYNAMICS AND HIV AMONG AFRICAN AND AFRICAN-AMERICAN YOUTH**

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From the Morehouse School of Medicine

*Objectives:* Given that Swaziland has the highest HIV rate in the world (38.8%) and African-American youth are disproportionately affected, we must understand the interplay of cultural dynamics related to HIV.<sup>1,2</sup> To initiate this process, focus groups and surveys were conducted in Swaziland, Africa among youth.

*Methods:* The study featured qualitative and quantitative components. Focus groups were held among HIV peer counselors and survey data was collected from clients of health clinics in Swaziland during July–August 2004. Twenty-five counselors participated in focus groups held at five clinics in rural Swaziland. The study was designed to assess the attitudes, knowledge, beliefs, and cultural dynamics related to HIV prevention. For the second part of the study, focus groups and surveys will be conducted in Fulton County, Georgia using similar groups and clinic settings. This research has been approved by the Morehouse School of Medicine IRB (#674FWA4535).

*Results:* Focus group participants in Swaziland identified social and cultural issues that possibly promote the spread of HIV among the population. The dominant themes were the: (a) imbalance of power in relationships; (b) fear of HIV testing; and (c) lack of economic opportunities. The survey data is currently being analyzed.

*Conclusion:* According to the Swaziland youth, abstinence is the only definite way to protect oneself from HIV. However, culture and tradition may impede HIV prevention efforts.

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006

**HEALTH LITERACY: A NEW TOOL IN DIABETES MANAGEMENT**

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From the Department of Medicine, Morehouse School of Medicine

*Study Objective:* The purpose of the study is to examine the relationship between health literacy and diabetes self-management, specifically self-monitoring of blood glucose (SMBG). This project will evaluate the rate of SMBG among diabetic patients with adequate and inadequate health literacy. The study hypothesizes that the rate of SMBG will be lower in low literate diabetic patients than patients with adequate literacy.

*Background and Rationale:* Health communication, specifically health literacy and language barriers, are gaining increasing attention as a means of improving health outcomes. Health literacy is a measure of a patient's ability to read, understand and act on medical instructions. One out of three Americans has inadequate functional health literacy (FHL). The prevalence of low FHL especially among vulnerable populations mandates exploration of the relationship between FHL and disease care. In the case of type 2 diabetes, for example, inadequate functional health literacy is independently associated with worse glycemic control. Understanding the relationship between inadequate FHL and self-management, ie, SMBG, in diabetics may provide an opportunity to achieve targets in the management of diabetes mellitus.

*Study Methodology:* This study will compare the rate of SMBG among low literate diabetic patients and adequate literate diabetic patients. The study site is an inner city urban diabetic clinic with approximately 20,000 registered diabetics with 3000 visits monthly.

*Study Design:* A cross-sectional descriptive study will be conducted to determine the rate of SMBG among diabetic patients by health literacy. Patients with diabetes will complete an interview-administered questionnaire developed from previously published instruments. The questionnaire will consist of questions to determine demographics, chronic conditions, health care utilization, self-rated health, barriers to SMBG and health literacy skills.

*Main Outcome Measure:* The main outcome variable of interest is daily SMBG. We will measure SMBG as a discrete variable using zero, once daily or 2 or more times daily. Additional explanatory variables will be examined to determine their direct and indirect effect on daily SMBG.

*Analytical Plan:* The main independent variable, health literacy, will be assessed by a shortened version of the test of Functional Health Literacy in Adults (S-TOFHLA). Scores are classified as inadequate, marginal and adequate. We will examine S-TOFHLA as a categorical variable in the preliminary descriptive analysis (comparing inadequate and marginal to adequate skills). Data analyses will be directed towards establishing a relationship between health literacy and SMBG using the chi-squared test. Multivariate logistic regression will

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be used to determine whether health literacy is a predictor of SMBG, accounting for covariates such as social economic status, age, sex, race, education, insurance.

*Study Implications:* This research study is an attempt to sustain self-management programs in diabetic patients. Traditional educational efforts have shown moderate but short term improvements. Overcoming the barriers to self empowerment in patients who do not understand their medical conditions will likely achieve lasting results.

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007

### THE CHALLENGES OF IMPLEMENTING ELECTRONIC MEDICAL RECORDS IN A PRIMARY CARE SETTING

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The use of the electronic medical records (EMR) is beneficial in improving patient care and healthcare outcomes; however implementing these systems has been fraught with many challenges. We discuss these challenges, relating our experience in two large urban internal medicine residents' clinics and offer possible solutions.

The Institute of Medicine in various reports has acknowledged the limitations of paper-based records [1, 2]. These include illegibility, incomplete records, and unavailability of records among others. These shortcomings highlight the importance of EMR. Thus we sought to implement an EMR system in two internal medicine residents' clinics supervised by attending physicians with a primary goal of providing comprehensive, evidenced-based care of diabetic patients.

Some of the challenges we faced were the computer literacy and attitude of the end users to the program implementation. More time was spent in patient consultation, resulting in a heavier administrative burden, at least initially for the residents. Others include incorporation of a computer network within the existing infrastructure, concerns about patient confidentiality in compliance with the Health Insurance Portability and Accountability Act (HIPAA), legality of the EMR, and the required administrative approval for use in the clinics. Other concerns were the functionality of the EMR system, flexibility of paper records, and technical issues about the reliability of software. Considerable time allocation for training must be made up front when transitioning from the paper to the electronic medical record.

The EMR has many advantages for the primary care practitioner: enhancing prompt patient care, facilitating continuity and coordination of care between primary care providers and consultants. It provides easy access to data for primary care based clinical research and improves clinical decision-making.

Successful implementation of the EMR system therefore requires continuous experimentation, evaluation, and improvement of the technical process as well as ongoing training for the end user to promote familiarity with software. To facilitate this, health care providers and hospital management should be involved in the planning process of design and development of these systems, as this will aid final acceptance. Incorporation of EMR training in the residency curriculum will enhance the clinical training of future primary care providers. It has the potential to improve resident teaching. In addition, it would likely ensure complete and accurate documentation, which, in turn, should significantly improve patient care and reduce unreimbursed health care costs.

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008

**COMORBID DIAGNOSES IN BIOPSY PROVEN SARCOIDOSIS**

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*Introduction:* Sarcoidosis is a chronic, granulomatous, inflammatory disease manifesting similarities in pathology, yet with racial/ethnic differences in disease expression. Racial/ethnic disparities are seen in other chronic diseases, with evidence now of some modifiable risk factors. Understanding the complexity of comorbid illnesses in sarcoidosis may have important implications for management of this disease.

*Objectives:* This study will describe the comorbid illnesses in patients with biopsy proven sarcoidosis (BPS).

*Methods:* The study population was obtained from a search of the Grady Health System database from 11/1999–12/2003, for patients with ICD-9 codes 135 or 519.8. Requested variables included demographic data, clinical encounters, and all secondary and tertiary diagnostic codes. Pathology reports were reviewed for documentation of non-caseating granulomas.

*Results:* A total of 838 patients were captured. 172 (21%) patients had BPS, were  $43 \pm 10$  yrs at biopsy, 63% female, 96% Black. Hospitalization occurred in 74 (length of stay  $15 \pm 22.9$  days) and clinic encounters in 163 patients ( $4 \pm 3.7$  per patient). There were  $12 \pm 14$  codes per patient. Hypertension, Dyspnea, Anemia, Cough, Depression, GERD, Diabetes, Pneumonia, Chest pain were most common.

*Discussion:* Comorbid diagnoses involved multiple systems and may have important implications for management.

*Conclusions:* Further study is needed to determine which co-morbid illnesses and modifiable risk factors impact sarcoidosis.

009

**AFRICAN-AMERICAN WOMEN, AIDS STIGMA AND ACCESS TO CARE**

HT Muhammad, MPH

From the Research Center on Health Disparities at Morehouse College

*Purpose:* The United States has struggled to properly respond to AIDS-related stigma, which hinders infected individuals from being tested and seeking or utilizing treatment.<sup>1</sup> In Georgia, African-American women report limited access to care and a need for HIV/AIDS services.<sup>2</sup> Furthermore, studies show that African-American women avoid care due to their experiences with the stigma related to AIDS.<sup>3</sup> The aim of this study is to explore the influence of AIDS stigmatization on access to healthcare for HIV positive African-American women living in Metropolitan Atlanta, Georgia.

*Methods:* Three anonymous focus groups were used to explore availability of services, interactions with healthcare workers, quality of services and healthcare seeking behaviors among a convenience sample of HIV positive, African-American women above age 18. The study was exempt by the Institutional Review Board on Human Research at the Morehouse School of Medicine.

*Results:* Unlike previous studies stigma did not present a barrier to accessing HIV-related care and services in this study. Stigma experiences were infrequent and more obvious when first diagnosed as HIV positive. Personal acceptance of their condition, spirituality, social support and increased knowledge about HIV/AIDS helped the women deal with stigma and access healthcare. Confronting stigma also helped them. Racial, sexual and gender bias reportedly created greater barriers to care than AIDS-related stigma.

*Discussion:* The majority of women in this study were older in age, had a strong spiritual foundation and a sense of empowerment to confront stigma, which may have attributed to their experiences. Future studies should include discussions with younger women or women recently diagnosed with HIV.

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