proportion of patients not adherent and not at goal. Targeted interventions based on LDL-c goal attainment should be undertaken to ensure that adherence to statin therapy is maintained in this high-risk population of CAD patients.

Keywords: Statins, Adherence, Coronary artery disease

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PS2-28:

Primary Non-adherence and Health Care Utilization

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Background: New prescriptions unfilled by patients (primary non-adherence) contribute to the overwhelming problem associated with medication non-adherence. Little research has been conducted in this area relative to refill non-adherence. The overall impact of unclaimed prescriptions is potentially significant depending on the medication and its indication. Because primary non-adherence has been recognized as an issue within our organization, we are conducting a retrospective study to evaluate fills up to twelve months following a new prescription in order to assess patient and clinical variables associated with primary non-adherence. **Objective:** Our objectives are to compute prescription fill rates among subgroups defined by patient and drug attributes, and to determine how subsequent health care utilization differs for those who do and do not fill their prescriptions. **Methods:** This pilot study is a retrospective review of electronic medical record (EMR), prescription orders and fills 1/1/2009-6/30/2009 for patients aged 18+ with 12 months of continuous medical and prescription coverage 1/1/2008-6/30/2010 who have a clinic or emergency room visit and a new prescription order for a new diagnosis. We will evaluate this cohort for prescription fill data over the following 12 months (through 6/30/2010) to gather EMR, census, and patient visit data linked to the prescription order. We will quantify the number of patient visits (primary, specialty, and urgent care, ER and inpatient) for members who fill the original prescription, those who ultimately fill with the same or similar drug, and those who never fill the prescription (within one year of prescription order). **Results:** The data dictionary has been developed and project programming is underway. We anticipate we will complete data collection by January 2011 and analysis by March 2011. **Conclusion and Implications:** We expect primary non-adherence to occur within our integrated health system and to vary by diagnosis. Variables predicted to vary among those who fill and those who do not include plan design, benefit structure, gender, race, age and SES. This pilot study will be used to identify target populations for future interventional studies.

Keywords: Prescription refill, Non-adherence

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C-B3-04:

Use of Alternative Lifestyle Methods to Control Hypertension in Individuals Entering a Blood Pressure Clinical Trial

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Background/Aims: Lifestyle therapies are recommended as initial treatment or adjunctive therapy for all patients with hypertension. We describe the alternative therapies and lifestyle changes reported by patients with uncontrolled blood pressure (BP) enrolled in a hypertension clinical trial. **Methods:** Alternative therapies and lifestyle changes were self-reported in a survey administered at the participant's pre-randomization baseline visit. Patients were asked to report their use of alternative therapies and lifestyle changes specifically to control their high BP in the 12 months prior to starting the trial. Alternative therapies included yoga, meditation, acupuncture, biofeedback, paced breathing, herbal medications and vitamin supplements. Lifestyle changes included low salt diet, other dietary, weight loss, alcohol

reduction, and increased physical activity. Multiple alternative therapy or lifestyle changes could be indicated. **Results:** Among the 296 participants who completed the baseline questionnaire, mean age was 62 years, 44% were female, 17% were minority race/ethnicity, and 49% were college graduates. Of these, 96 (32%) had tried an alternative therapy and 177 (60%) had made a lifestyle change to control BP. The most common alternative therapy reported for control of BP was vitamin supplements (20%), but other techniques, including meditation (12%), yoga or paced breathing (both 5%), herbal medications (4%), and acupuncture (1%) were used. No participants had tried biofeedback. Of the lifestyle changes, increasing physical activity was most popular (34%), followed by other dietary changes (27%), weight loss (22%), low salt diet (16%), and alcohol reduction (11%). The 89 (30%) of participants who tried neither an alternative therapy nor a lifestyle change were slightly younger (mean age 60), less likely to be female (33%, $p = 0.01$), less likely to be minority race/ethnicity (11%, $p = 0.1$) but have similar education (52% college graduates, $p = 0.5$). **Conclusion:** Patients with uncontrolled BP who volunteered for a clinical trial report using a variety of non-pharmacologic methods to control hypertension; however, many of the methods used have scanty or inconsistent evidence for efficacy in lowering blood pressure. Health care providers should ask about alternative therapies and attempt to re-direct patients to more efficacious non-pharmacologic treatment modalities.

Keywords: Hypertension, Alternative therapies, Lifestyle changes

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C-B3-05:

Help for Parents of Children with Cancer: a Web-based Intervention

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Background: Children with cancer take complex life-saving chemotherapy regimens, many of which are administered at home by their parents. Our research indicates that errors in home medication use are common among children with cancer. In home visits, we found that the use of support tools significantly reduced the risk of errors. **Method:** We developed a web-based Home Medication Support intervention (HoMeS). The intervention development process steps were: convene work group, consult parent advisors, develop paper mock-ups, web-based development, and test-retest cycles. **Results:** Our work group consists of a pediatric oncologist, patient safety expert, cancer communication expert, and health information technology expert. We also consulted with four parents of children with cancer who were undergoing or recently completed home oral chemotherapy treatment. Parents identified needed improvements to a printed calendar which they received often, but not always, from their oncologist. Improvements included: check boxes to record when a dose was given, generic and brand names, metric conversion, and dosing support. Pediatric oncologists requested a computer program to create and save the medication calendar which they could save for each patient from month to month. We developed a paper mock up of a patient-specific monthly Home Medication Support (HoMeS) calendar, with both generic and brand names for each of the child's medications (e.g., meperidine = Demerol), abbreviations and generic names (e.g., 6-MP = 6-mercaptopurine), and dosing support. To prevent errors, we included color coded medication names, included check boxes for recording medication administration at home to support parent to parent communication, descriptions of how to prepare the medicine, and dosages for all as needed medicines, including pain medication. We are currently testing the HoMeS calendar, and developing supplemental educational tools to enhance parent understanding of cancer treatment. By spring 2011, we will implement and evaluate HoMeS using time-series methods. **Conclusions:** Parents and oncologists requested improvement in the home medication calendar to increase usability and prevent errors in home medication use among children with cancer. We developed a Home Medication Support (HoMeS) intervention