and number of BP readings were 39 and 12.4 at G and 33 and 9.9 at P. The mean number of comorbidities was 3.4 at G and 3.7 at P and, by race, 3.5 for C, 3.9 for AA. Medicare coverage was slightly more common at P (32 vs 29%) and commercial insurance slightly more common at G (63 vs 58%). BP was controlled in a similar proportion of readings overall, 66% and 65% (G and P). Binary logit models were constructed using percent of visits with BP controlled (%vBPc) as the dependent variable as a function of the above factors. Overall, increasing comorbidity was associated with a slightly greater %vBPc (P<0.0001), with an effect size averaging 1–2% for each comorbidity. Increasing number of unrelated comorbidities was associated with better BP control, while the opposite was true for related comorbidities. Stratified analyses conducted because of significant interactions showed the effect of related comorbidities to be more dominant in African Americans than Caucasians, particularly in patients over age 60. Nevertheless, similar effects were seen independent of race, age, gender and insurance. After accounting for race, there were no differences between the urban and rural systems. These findings suggest that race may explain urban-rural contrasts in BP control, and management of comorbidities may complicate control in African Americans more so than in Caucasians.

C-D2-04:

Persistence With Statins and All-Cause Mortality: A Population-based Cohort Study

Varda Shalev, MD, *Maccabi Healthcare Services*; Gabriel Chodick, PhD, *Maccabi Healthcare Services*; Haim Silber, MD, *Maccabi Healthcare Services*; Ehud Kokia, MD, *Maccabi Healthcare Services*; Joseph Jan, MHA, *Maccabi Healthcare Services*; Anthony D Heymann MD, *Maccabi Heatlhcare Services*

Background: The beneficial effects of statins in secondary-prevention on cardiovascular mortality have been established in several long-term placebo-controlled trials; however, the value of statin therapy in reducing overall mortality in patients without coronary heart disease (CHD) is questionable. The study objective was to evaluate the effect of statin therapy in an unselected cohort of subjects with no indication of a cardiovascular-disease (primary-prevention) and patients with known CHD (secondary-prevention). **Methods:** Retrospective cohort study including 229,918 adult HMO enrollees in Israel, who initiated statin treatment in 1998–2006 (mean age 57.6; 50.8% female), and were followed-up for a maximum of 9.5 years. Proportion of days covered (PDC) with statins was measured by the number of dispensed statin prescriptions during the interval between the date of the first statin and end of follow-up. Adjustments were made for baseline values of age, sex and other personal characteristics, chronic medical conditions and healthcare utilization. **Results:** During 4.02 and 4.98 years of mean follow-up, there were 4,259 and 8,906 deaths among primary prevention and secondary prevention cohorts, respectively. In both cohorts, high persistence with statins (PDC>90%) confers at least 45% reduction in risk of death compared to patients with a PDC of <10%. Stronger risk reduction was calculated among patients with baseline LDL of >190 mg/dl and patients initially treated with high-efficacy statins. **Conclusion:** Better persistence with statin treatment provided an ongoing reduction in mortality among patients with and without known history of CHD. The observed benefits from statins were greater than expected from randomized clinical trials.

PS2-02:

Using a Patient's Absolute and Relative Risk for Cardiovascular Disease to Manage Therapy

Nirav R Shah, MD, MPH, *Geisinger Center for Health Research*; JB Jones, PhD, MBA, *Geisinger Center for Health Research*; Walter F Stewart, PhD, MPH, *Geisinger Center for Health Research*

Background: As the patient role evolves from that of a traditional, passive participant in the care process to an engaged, active consumer of health care goods and services, new venues and/or tools for provider-patient communication will be required. The Electronic Health Record (EHR) can be used to facilitate such communication. We consider one model for how measures of individual risk derived from EHR data can be used in different ways to improve and maintain health. **Objective:** To explore how use of absolute risk (AR) or relative risk (RR) of cardiovascular disease can be used to select patients for intervention, communicate risks for informed choice and shared decision making, and then guide clinical decision support for targeted intervention and continuous care. **Methods:** We embedded the Framingham risk score in our EHR to calculate a patient's individual risk for cardiovascular disease. Absolute risk for 10-year mortality from cardiovascular disease (CVD) was calculated based on actual patient data, with decision support automatically ordering any missing values such as labs. A patient's relative risk (compared to a hypothetical, optimally managed age- and sex-matched control) was used to select patients for intervention. Patients then selected therapeutic preferences from among multiple evidence-based and rank-ordered options for their modifiable risk factors, via an interactive touch-screen kiosk in the waiting room. These selections were summarized and used to guide clinical decision support. The specific treatment options presented to each patient were selected as a function of the maximal relative risk reduction that could be achieved by compliance with those treatments. **Application:** Risk scores were used for four purposes in this study: patient stratification, selecting only those patients for intervention who are at high risk, and have available options to reduce that risk; informed choice, allowing patients to model risk scenarios by selecting different combinations of interventions; optimizing decision making, presenting a final list of patient-selected interventions that summarize relative risk reduction across all modifiable risk factors for a patient; and outcomes tracking, following risk over time to guide care. **Conclusions:** Behavior change is most likely to occur when patients understand the severity of their modifiable risks in the context of available treatment options.

PS2-05:

The Readiness of U.S. Health Plans to Manage Cardiometabolic Risk

Thomas E Kottke, MD, MSPH, *HealthPartners Research Foundation*; Courtney O Jordan, MD, *University of Minnesota School of Public Health and Medicine*; Patrick J O'Connor, MD, MPH, *HealthPartners Research Foundation*; Nicolaas P Pronk, PhD, *HealthPartners Research Foundation*; Rita Carreón, BS, *America's Health Insurance Plans (AHIP)*

Background: A large proportion of health status is determined by personal behavior. One manifestation of unhealthy personal behavior is the development of elevated cardiometabolic risk. Because health plans already manage care for a large proportion of the United States population, they are in a position to make a significant contribution to the control of cardiometabolic risk if they are prepared to offer health assessment, feedback, and behavior change support. Our goal in conducting this research was to assess health plan awareness of cardiometabolic risk and their current activities aimed at preventing and managing cardiometabolic risk. **Methods:** In January 2008, Americas Health Insurance Plans, in collaboration with the HealthPartners Research Foundation, surveyed 74 member health insurance plans that offer commercial Health Maintenance Organization, Point of Service and Preferred Provider Organization insurance. The response rate was 47%, representing 47 million lives. **Results:** The 35 responding health plans reported that they identify members with cardiometabolic risk through referral from case or care management (89%), health risk assessment data (86%), claims data (82%), and pharmaceutical utilization data (79%). Nearly all (97%) plans currently offer interventions for tobacco use, obesity/overweight, and nutrition. Ninety-four percent of the plans reported that they offer interventions to increase physical activity. All plans reported that they offer health risk appraisal or assessment with feedback and education, 91% reported that they use web-based tools, and 85% reported that they use health coaching to help plan members lower their risk. Perceived barriers to broader implementation of cardiometabolic risk control programs included lack of resources (79%), limited availability of enrollee level data (74%), and lack the reporting systems that would be necessary to manage individual plan members (79%). While one quarter of the responding health plans viewed lack of purchaser interest in cardiometabolic risk management programs as an important barrier to program implementation, only 6% named lack of purchaser interest as one of the three most important barriers to implementation. **Conclusion:** While the responses probably represent the best case scenario because of potential response bias, U.S. health plans appear to be well positioned to provide cardiometabolic risk control services.