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status, type of supplement plan, and residential location. **RESULTS:** Of the 2.2 million Medigap insureds eligible for the study, 25.4% (570,711) had CAD. Males were 60% ($p < 0.001$) more likely than females to have an office visit, but gender was not a significant predictor for the other services. Patients residing in high-minority neighborhoods were about 8% ($p < 0.001$) less likely to receive any services for CAD. Older individuals were significantly less likely ($p < 0.001$) to have invasive procedures (angiography and surgery). Patients residing in lower-income areas were about 9% ($p < 0.001$) more likely to receive any of the CAD services. Patients with mental health problems were about 45% ($p < 0.001$) less likely to receive any CAD services. Additionally, CAD-related care varied significantly by state of residence and urban versus rural location. Insureds with policies that covered more out-of-pocket costs were more likely to receive an office visit, however, policy type was not a significant predictor for invasive CAD procedures. **CONCLUSIONS:** Disparities in CAD-related care existed by age, income, and race, but the magnitude was relatively small (about 10%). Larger disparities were found by residential location and for those with mental health problems. AARP and UnitedHealth Group are designing interventions to address these disparities; such interventions will begin in mid-2009.

PCV92

HOW DOES THE OUT-OF-POCKET PAYMENT MATTER TO HYPERTENSIVE PATIENTS' CHOICES OF ACCESSING DIFFERENT MEDICAL FACILITIES IN TAIWAN? THE PRELIMINARY STUDY OF A DISCRETE CHOICE EXPERIMENT

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OBJECTIVES: With generous coverage and patients' full freedom to access different tiers of medical facilities, Taiwan's single payer national health insurance system is facing difficulties of escalating utilization and cost of out-patient care. Recently, out-patient co-payment has been largely increased in order to control unnecessary medical demands and encourage patients with minor illness of initial contact in primary care, but this policy has only shown limited impacts. To determine the relative importance of factors (attributes) associated with patients' choices on accessing different tiers of medical facilities, we conducted a qualitative study on hypertensive outpatients. **METHODS:** Focus groups were conducted on hypertensive outpatients from different tiers (clinics, local, regional hospitals and medical centers) of medical facilities in Southern Taiwan. **RESULTS:** Nine focus groups were conducted at local community (1), local hospital (2), regional hospital (2) and medical center (4), including 40 hypertensive participants. The saturated opinions indicated doctors' reputation and friendliness, tiers of hospitals, and transportation convenience as the three main considerations for participants to access different hospitals. Participants tend to visit a fixed doctors and hospitals because they believe hypertension needs a long-term, consecutive and quality treatment. Higher-tier medical facilities are symbolized as better medical care, drugs and equipments, yet the out-of-pocket payment is considered affordable, especially doctors prescribed continuous prescriptions to save patient's co-payment charge. Participants dislike being transferred from lower to higher tiers of medical facilities due to the inconvenient process and lack of price incentive. **CONCLUSIONS:** By identifying attributes to hypertensive outpatients' choices of accessing medical facilities, we found the current co-payment policy does not impact on hypertensive patients' affordability and accessibility in Southern Taiwan. Future study is going to determine the relative importance of attributes and whether and how much higher co-payment charge can influence on patients' decisions to access different tiers of medical facilities.

PCV93

CARDIOVASCULAR RISK (ACCORDING TO FRAGMINHAN) FOLLOW-UP OF A COHORT INSCRIBED IN THE DE TODO CORAZON (DTC) DISEASE MANAGEMENT PROGRAMME OF MUTUAL SER HMO IN COLOMBIA, 2004–2007

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OBJECTIVES: Top describe the tendency of cardiovascular risk and the determining factors of a cohort of patients enrolled in the De todo corazón disease management (DM) programme. **METHODS:** The DTC programme was begun in Colombia in 2004 and 19,697 patients have benefitted up to December 2007; it seeks to control cardiovascular risk (CVR) using a DM model. The present study represents a first approach to evaluate the programme's effectiveness by analysing the tendency of CVR marker variables, such as blood-pressure and lipid profile by CVR group. The population being studied consisted of patients who had formed part of the programme since 2004 and who had uninterrupted annual follow-up visits up to 2007. A descriptive analysis was made, annual CVR level was calculated using the methodology described by ATPIII and tendency was described by both variables and CVR groups. **RESULTS:** Average age for the final population to be analysed (5174) was 63.74 years (11.76 S.D) and mainly consisted of females (72%). A decreasing tendency in the high risk group was observed in analysis by CVR group, accompanied by a corresponding increase in patients classified in latent and intermediate levels. Similarly, analysing tendency by variable revealed how systolic blood-pressure tended to decrease consistently throughout the time spent on each visit in each risk group. LDL-cholesterol revealed a similar tendency in high and intermediate risk groups, less stable behaviour being seen in the latent risk group. HDL-cholesterol presented stable tendency in the three risk groups during successive visits. **CONCLUSIONS:** The results suggested that the De todo corazón DM programme had a positive impact during the period being studied, affecting modifiable risk factors such as TA and lipid profile and CVR control. Such tendencies should be compared with a control group for establishing whether they have really been produced by the DM programme.

PCV94

ASSESSMENT OF THE STATUS OF HYPERTENSION MANAGEMENT IN NEWLY DIAGNOSED AND ESTABLISHED HYPERTENSION PATIENTS IN PRIMARY CARE PRACTICE

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OBJECTIVES: This study compared hypertension management in newly treated and previously treated (established) adult patients (≥18 years) with hypertension. **METHODS:** A retrospective study was conducted using the GE Centricity electronic medical record database which contains ambulatory electronic health record data for over 7.4 million patients in the US. Patients were classified as newly treated hypertensives if they had no antihypertensive treatment within 24 months prior to the index date (date of the first anti-hypertensive prescription in 2006). Otherwise, patients were classified as established hypertensives if they received antihypertensive treatment during 24 months prior to index date. These two groups were compared to assess differences in comorbid conditions, proportion of patients treated per JNC-7 guidelines, distribution of index drugs, likelihood of achieving BP goal and changes in the antihypertensive therapy during 13 months follow-up period from the index date. **RESULTS:** A total of 28,276 newly treated patients (mean age 58.6 years; 55.7% women) and 78,450 (62.1 years; 57.1% women) established patients were identified. Newly diagnosed patients had fewer comorbidities (mean number 0.74 vs. 1.85; $p < 0.001$), less changes in anti-hypertensive medications (1.6 vs. 1.7; $p < 0.001$), less likely to be treated per JNC-7 guideline (52.7% vs. 60.2%; $p < 0.001$), and more likely to be treated on monotherapy at index (66.2% vs. 39.9%; $p < 0.001$) than established patients. Among the newly diagnosed patients, ACE inhibitors (ACEi) (30.6%) and diuretics (19.2%) were the most commonly prescribed first-line treatments, while ACEi (22.3%) and the combination of ACEi and diuretics (9.2%) were more commonly prescribed in the established patients. After controlling for age, gender, race, comorbid conditions, baseline BP, adherence to JNC-7, newly diagnosed patients were 38% more likely to achieve BP goal at follow-up ($p < 0.001$). **CONCLUSIONS:** Newly treated hypertensive patients tend to be younger, with less comorbidities, more likely to be treated on monotherapy and achieve BP goal compared with established patients.

PCV95

ELECTRONIC MEDICAL RECORD USE AND WARFARIN DRUG-DRUG INTERACTIONS DURING AMBULATORY VISITS IN THE UNITED STATES, 2003–2006

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OBJECTIVES: Elevated warfarin levels caused by drug-drug interactions (DDIs) increase the risk of gastrointestinal bleeding and vascular accidents. Electronic medical records (EMRs) have been associated with a greater potential for identifying DDIs. We evaluated the influence of EMR use on trends in prescribing potentially harmful drug combinations involving warfarin from a nationwide survey of ambulatory care office visits. **METHODS:** Data were derived from the 2003–2006 National Ambulatory Medical Care Survey (NAMCS), a public-use, nationwide probability sample survey of office visits by ambulatory patients to non-Federally employed physicians. Warfarin and interacting drugs prescribed within the same visit were identified. We evaluated the proportion of interaction-related encounters comparing visits with and without the availability of EMRs. Subgroup analyses were performed by combining 2-years of data (2003–2004 and 2005–2006) for more precise estimates. All analyses were weighted to reflect the sampling design of NAMCS to reflect representative ambulatory care use in the U.S. with appropriate variances. **RESULTS:** Total warfarin-related visits increased from 11.8 million in 2003 to 16.6 and 15.4 million in 2005 and 2006, respectively. In 2003–2004 (period 1) the proportion of warfarin visits in which an interacting drug was co-prescribed was 34.4% (95% CI: 21.4%–47.4%) with EMRs available and 32.0% (95% CI: 27.5%–36.5%) with no EMRs available. In 2005–2006 (period 2), the proportions were 36.7% (30.9%–42.4%) with EMRs and 33.5% (28.6%–38.3%) without EMRs. We observed no significant differences in the proportions of interaction-related encounters between EMR and non-EMR visits in both periods. **CONCLUSIONS:** Between 2003 and 2006, the rates of warfarin prescribing in ambulatory care increased by 27%. The proportions of interaction-related encounters were unaffected by EMR use, due possibly to the limited implementation of EMRs during that period. Further studies as newer data become available are needed.