trials mixed these types in different (and even unstated) proportions. Some \( n = 12 \) required sinus rhythm for various durations at randomization, increasing the chance of success; 4 ignored early recurrences or allowed for recardioversion, while 16 counted every recurrence. In addition, methods used to detect recurrence varied from ECG confirmation at regularly scheduled visits to much more sensitive trans-telephonic monitoring (\( n = 11 \)), which was employed in differing ways. Furthermore, efficacy endpoints were affected by biased termination of follow-up, as treatment withdrawal due to side effects leads to less detection of recurrence. Nevertheless, a published meta-analysis ignored these differences, citing similar recurrence rates in control groups and chi-squared tests that did not detect statistical heterogeneity. In our opinion, this does not adequately address heterogeneity in study designs, and the resulting estimates are unsuitable for economic modeling. CONCLUSION: Strict adherence to frequentist views can lead to inappropriate conclusions; and the resulting estimates are unsuitable for economic modeling.

CONCLUSION: to inappropriately pooling of trial data and erroneous inputs for economic models. A Bayesian perspective provides a more correct view of the intractable study design differences.

**PCV69**

**BLOOD PRESSURE SUCCESS ZONE LONGITUDINAL STUDY OF SUCCESS (BPSZ-BLISS). AN OBSERVATIONAL, MULTI-CENTER STUDY OF THE IMPACT OF THE BPSZ EDUCATIONAL PROGRAM ON BLOOD PRESSURE CONTROL, PERSISTENCE, COMPLIANCE, AND TREATMENT SATISFACTION. DESIGN AND METHODS**


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**OBJECTIVES:** Educating hypertensive patients in blood pressure management can improve clinical outcomes. The BPSZ Program is a nationwide educational program which provides participants with tailored educational materials in addition to a complimentary trial of one of three different antihypertensive medications. The BPSZ-BLISS study is a naturalistic study to evaluate the effectiveness of the BPSZ program by utilizing a sub-set of the Program participants and measuring the following: blood pressure (BP) control, compliance, persistence and treatment satisfaction. **METHODS:** 20,000 MDs enrolled in the BPSZ Success Zone program were invited to participate in the study. Using an Interactive Voice Response System (IVRS), MDs report BP and other data at the enrollment visit and at every usual care visit up to 12 +/-2 months; subjects self-report BPs, persistence, compliance and treatment satisfaction at 3, 6 and 12 months post BPSZ enrollment. MDs and subjects are supported by call center representatives as needed. In addition to BPSZ program enrollment medication, MDs prescribe anti-hypertensive medications and schedule visits as per usual care. The General Electric Health care database will be used as an external referent to facilitate interpretation of study outcomes. **RESULTS:** After 12 months, 2,000 IRB approved MDs have enrolled over 10,000 subjects (48% male; mean age 56 years; 26% newly diagnosed); 97% of MDs, and 75% of subjects successfully entered IVRS enrollment data. Automated IVRS validations have successfully maintained cohort integrity and data quality (less than 5% error on key study variables). MD and patient enrollment will continue until April 2007; study completion is scheduled for mid 2008. **CONCLUSION:** MD and patient enrollment, and the acquisition of outcomes data in a nationwide health education program require innovative design and automated data management and quality control methodologies. Strengths and weaknesses of the BPSZ-BLISS study design can help inform similar health education program evaluation initiatives.

**PCV70**

**MOBILE PHONE MESSAGE VERSUS POSTAL REMINDERS TO INCREASE TREATMENT ADHERENCE AFTER LIPID LOWERING THERAPY AMONG HYPERLIPIDEMIC PATIENTS IN PRIMARY CARE**

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**OBJECTIVES:** To compare mobile phone messaging and postal reminders as means of increasing the attendance rate during the first 24 weeks of lipid-lowering therapy among hyperlipidemic patients in primary care. **METHODS:** The study was a randomized controlled trial of 918 patients from 19 family practice clinics conducted between February 2003 and June 2005. Patients were randomly assigned to receive mobile phone message reminders, postal reminders, and control strategies. To ascertain attendance rates, patients were regularly followed up 12 to 24 weeks after their treatment. Reminders were sent on average at 16 weeks. The primary measure was the attendance rate at 24 weeks. A secondary outcome was identifying the direct cost and benefits of each reminder type. **RESULTS:** Overall attendance rate was 74.1%. This differed between groups, with 76.1% attendance for the mobile phone messaging group, 73.5% for postal reminders, and 72.4% for the control group. According to a multivariate analysis, the mobile phone messaging group had a significantly higher attendance rate (OR 1.48, 95% CI: 1.01–2.16) than the control group, but the postal reminder group (OR 1.15, 95% CI: 0.79–1.69) did not. Moreover, for one additional visit, the marginal cost of mobile phone messaging (USD 3.1) was much lower than that of postal reminders (USD 47.0). **CONCLUSION:** Mobile phone messaging is a more cost-effective method to increase the attendance rate at 24 weeks after lipid lowering therapy among hyperlipidemic patients.

**PCV71**

**THE IMPACT OF INTERACTIVE VOICE RECOGNITION TECHNOLOGY ON ADHERENCE TO STATIN THERAPY**

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**OBJECTIVES:** To evaluate the ability of interactive voice recognition (IVR) technology to improve statin adherence in a cohort of new statin patients. **METHODS:** Plan members were identified based on the existence of a filled prescription for statin therapy between May 1, 2005 and December 1, 2005 and randomized to intervention or control group. Statin prescription claims were evaluated through June 25, 2006 when study analysis was completed. Subjects had to be 18 years or older, continuously enrolled in the health plan for 2 years, and new users of statin therapy. Members enrolled in any other plan-sponsored IVR initiative were excluded from this analysis. The intervention group received three automated phone calls; call one provided disease state education, call two was a refill reminder, and call three addressed the importance of physician follow up. The program provided customized interaction based on patient response, primary vs. secondary prevention, and refill behavior. Persistence...