ethnic disparities are present among patients whose physicians are not using EHRs or CDS. However, there is no disparity between white and black patients whose physicians use EHRs with CDS. Furthermore, we found that Hispanic patients had the greatest change in BP control rates when their physicians use EHRs with CDS.

Our findings are subject to type II error because we are interpreting the lack of a statistical difference between groups as evidence that there is no disparity in BP control at a population level. However, our analysis is based on thousands of sampled visits in each EHR use category. Second, our analysis was limited by an approximately 30% rate of imputed race/ethnicity data, but NCHS uses validated methods to address missing data. Third, though we controlled for practice ownership on the basis of association with both the exposure and outcome, unmeasured confounding by physician or practice characteristics is possible. Last, owing to the cross-sectional study design, we cannot ascertain whether EHRs with CDS decrease disparities or through which mechanism they have an effect (eg, intervening on physician barriers to guideline adherence).

Prospective trials must be conducted to answer these important questions. Nonetheless, our findings suggest that primary care implementation of EHRs with CDS may mitigate BP control disparities between whites and blacks, which may in turn reduce racial/ethnic disparities in morbidity and mortality from cardiovascular disease.

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Primary Health Care Providers’ Attitudes and Counseling Behaviors Related to Dietary Sodium Reduction

High sodium intake is associated with increased blood pressure. Average sodium intake among US adults far exceeds recommendations. Primary care physicians and nurse practitioners are the first line of medical care and can influence opinions and behaviors of their patients. Although some information exists about perceived advice from health professionals related to sodium reduction, little is known about health care providers’ own perceptions about sodium intake and patient counseling behaviors about reducing sodium intake. We used data from DocStyles, a Web-based survey of health care providers. Participants included health care providers who practiced in the United States; worked in an individual, group, or hospital setting; and had practiced medicine for a minimum of 3 years. In 2010, family/general practitioners (FGPs), internists, and nurse practitioners were asked questions on sodium. Response rates were 45.2% for FGPs and internists combined and 52.6% for nurse practitioners.

The sodium intake component of this survey consisted of 6 questions assessing health care providers’ opinions and perceived counseling behaviors related to reducing dietary sodium intake. The survey also included questions about health care provider characteristics, including sociodemographic (age, sex, and race/ethnicity), medical practice (type of practitioner, practice setting, years of practice, whether they practice at a teaching hospital, and the financial situation of the majority of their patients), and health-related behavior (self-
reported height and weight; the number of days per week they eat at least 5 cups of fruit or vegetables; smoke cigarettes, cigars, or pipes; and exercise or keep their heart rate up for at least 30 min/d).

Differences in response frequency were determined with /H9273/2 tests for categorical variables and Mann-Whitney test for Likert scales. All analyses were conducted using SPSS statistical software (SPSS Inc).

Results. The 2010 Survey included 539 FGPs, 461 internists, and 254 nurse practitioners. Compared with internists and FGPs, a higher percentage of nurse practitioners were female, non-Hispanic white, and obese (eTable; http://www.archinternmed.com).

The majority of primary health care providers agreed or strongly agreed with the statement “Most of my patients should reduce their sodium intake” (Table). More than 94% indicated “cut down salt” as advice they provided to adult patients about preventing and treating high blood pressure. When asked what specific advice they provided to patients on how to consume less salt, 87% indicated “read nutrition labels for sodium” and “eat less processed foods”; 78% reported they provided examples of specific foods to avoid; 73% advised to cook with less sodium; and 69% advised to remove the salt shaker from the table. When asked which patients they advised to consume less salt, a majority indicated patients with prehypertension, hypertension, or chronic kidney disease but not African American patients or patients with diabetes or older than 40 years. The proportion who reported giving advice varied little by sociodemographic, health, behavior, and practice characteristics with 1 exception: compared with health care providers in all other race/ethnic groups (Table).
60.5% of African American providers advised their African American patients to consume less salt (P < .001). Thirty-one percent of primary health care providers reported the biggest barrier to counseling their prehypertensive and hypertensive patients about sodium intake was that “patients are unlikely to comply”; 22% cited “lack of time”; and 11% reported “patients have other immediate health issues.”

**Comment.** The majority of primary health care providers agree that their patients should reduce sodium intake; report providing specific advice in line with recommended strategies; and counsel patients with prehypertension, hypertension, or chronic kidney disease to consume less salt. In contrast to 2010 dietary guidelines, a minority of health care providers report counseling patients with diabetes or older patients to consume less salt. Also, a minority of providers of race/ethnicity groups other than African American report counseling African American patients to consume less salt.

The most frequent types of advice provided to patients were in line with current recommended strategies to reduce sodium intake.7 Interestingly, the majority of health care providers also indicated they advise patients to remove the salt shaker or add less salt during cooking, despite current knowledge that for most people these behaviors are unlikely to result in major salt reduction.7 The results should be interpreted in the context of some potential selection and reporting biases. The survey was not a nationally representative sample of physicians or nurse practitioners, and health care providers who are more concerned about patient care may be more likely to respond and respondents may overstate their counseling behaviors. However, physicians were selected to be representative of the age, sex, and race/ethnicity of the American Medical Association master file.

Our results suggest that more effort is required to inform health care providers about the need for all patients to reduce sodium intake and their ability to make a difference in their patient’s behavior.8 Specifically, the primary care physicians and nurse practitioners’ knowledge, attitudes, and practices regarding dietary salt intake will play an important role in the effort to reduce sodium intake for Americans, especially for those who seek care for hypertension and other cardiovascular diseases.

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**Online-Only Material:** The eTable is available at http://www.archinternmed.com.


**The FDA and New Safety Warnings**

In response to postmarket drug safety surveillance and research data, the US Food and Drug Administration (FDA) and drug manufacturer may take 1 of 2 types of action. In extreme cases the FDA may remove a drug from the market. More often the product label or package insert is revised to reflect newly discovered risks. The most clinically significant new information is added to 1 of 3 legally defined sections of the prescribing information1: (1) a boxed warning (information that is essential to be considered when prescribing the drug); (2) a contraindication (clinical situations when a drug’s risks clearly outweigh its benefits); and (3) a warning (adverse reactions with reasonable evidence of a causal association, reactions that may require discontinuation, or reactions that interfere with a laboratory test).

We analyzed 1 calendar year of these major label changes to provide insights into this safety program. We report the number of actions, severity of events, and nature and scope of the safety information. We also describe the types of drugs affected, whether they were recently approved drugs or established treatments, and what type and level of scientific evidence was used to support these label changes.