answering the "how much" and "why" questions of utilization at both the institutional and patient levels. **Results:** Preliminary results indicate consistent offering of CHESS by multiple providers, and utilization of the CHESS tool by 50% of all newly diagnosed breast cancer patients. Of those accessing CHESS, most are currently using the tool at least once and visiting multiple pages. Based on interview and survey data conducted two months post-diagnosis, we will also present preliminary data on why some women use CHESS and some do not. Through provider surveys, we will show how staff perceptions and actions affect patient perceptions and use, and how organizational strategies affect CHESS adoption and use. **Conclusions:** Conclusions from this study provide information on logistics, challenges and successes of the dissemination of a new standard of care for breast cancer patient support, and why patients choose to utilize this tool or not. This will provide evidence of how much reach an intervention like CHESS can achieve in two real-world settings, and be relevant to decisions about whether and how to disseminate CHESS more broadly.

**Keywords:** Implementation; Breast Cancer; e-Health

doi:10.3121/cmr.2013.1176.ps2-30

PS2-31:

**Implementation of Universal Lynch Syndrome Screening in an Integrated Health Care Delivery System**

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**Background/Aims:** Lynch syndrome (LS) is a hereditary form of colon cancer that is present in about 3% of colon cancer patients. Seventy-one percent (71%) of the NCI Comprehensive Cancer Centers conduct universal LS screening, while only 15% of the community hospital cancer programs regularly screen for LS. A previous 7 site HMORN study found that none of those sites were performing universal LS screening, and fewer than 4% of colon cancer patients were tested for LS. Currently, fewer than 5% of patients diagnosed with colorectal cancer (CRC) at Kaiser Permanente Northwest (KPNW) receive Lynch syndrome screening. KPNW relies on provider or self-referrals to Medical Genetics for appropriate LS screening. How do we improve access to LS screening? **Methods:** Through a randomized controlled trial, we are evaluating the effectiveness of universal LS screening compared to usual care. We began recruitment in February 2012. We will determine the types and impacts of system barriers on effective LS screening implementation. **Results:** Stakeholder engagement was challenging to obtain due to variation in knowledge of LS but has proven crucial to success. Cultivating relationships generated willingness and interest among stakeholders in solving issues. The pathology procedure required extensive coordination for appropriate specimen handling and timely testing. The algorithm to identify eligible patients among those scheduled for bowel surgery daily from the EMRs required revisions to locate patients correctly. We will share the lessons we have learned in implementing a universal screening program in the health plan. **Conclusions:** So far, universal LS screening implementation has yielded both successes and hurdles. Developing strong relationships with stakeholders has led to their active participation in problem-solving. The pathology procedure required extensive coordination for specimen handling and testing. Developing methods to quickly identify issues with sample processing and testing improved turnaround time. Patients had to be identified quickly in the EMR given the often short time from surgery scheduling to surgery completion. Evaluation of the implementation steps will help determine best strategies for successful universal LS screening. Since LS screening rates are low at many HMORN sites, we hope that the lessons we learned will inform future implementation efforts.

**Keywords:** Implementation Research; Lynch Syndrome

doi:10.3121/cmr.2013.1176.ps2-31

PS2-33:

**Seniors' Uptake of Online Survey Completion - Experience of the 2011 KPNC Member Health Survey**

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**Background/Aims:** The aim was to describe the percentages and characteristics of seniors eligible to receive an emailed link to an online health survey and that chose to respond online vs. by hardcopy. **Methods:** We analyzed the response (69%) to a health survey mailed to 9796 seniors with contact letter containing url for online version; 5064 of these also were sent emails with a link to their personalized online survey. Response data was linked with age (65-69, 70-74, 75-79, ≥80), gender, race/ethnicity, and education from other sources. **Results:** We found: (1) Eligibility to receive the emailed link declined with age (65-69, 62.5%; 70-74, 53.5%; 75-79, 47.7%; ≥80, 40.1%); increased with education (<12 yrs, 33.4%; high school graduate, 44.0%; some college, 55.9%; college grad, 64.8%), and was lower among African-Americans, Latinos, and Filipinos compared to nonHispanic Whites, Chinese, and Japanese ethnicities (33.9%, 37.8%, and 43.8% vs. 56.6%, 57.0%, and 53.4%, respectively); (2) Only 8.2% of respondents completed the survey online. Respondent online participation declined with age (13.6%, 10.2%, 5.8%, and 3.5%, respectively), was higher among those with some college or college degree (1.5%, 4.6% vs. 9.2%, 11.3%, respectively), and was higher among those sent emails (approximately 18% of 65-74 and 9% of ≥75 vs. <1% of those not sent an email; by education: 4.1%, 9.8%, 15.6%, and 16.5% vs. 0.2%, 0.4%, 0.9%, and 1.4%); (3) Of those who received the email and completed the survey online, approximately 61% reached the survey using the hyperlink. Seniors aged >75 were more likely to use the hyperlink than those aged 65-74 (68.1% vs. 56.7%); and (4) Due to relatively small differences in response by age, the age distribution of the initial and final samples are essentially the same. However, had the survey only been conducted online, the resultant sample, in addition to being significantly smaller, would have been significantly younger, better educated, and less representative of the race-ethnic distribution of the population. **Conclusions:** Results suggest that most seniors still prefer print over online questionnaires, even when emailed a link to the online survey. Without an emailed link, online participation will be hard to achieve.

**Keywords:** Survey Research; Seniors; Online Data Collection

doi:10.3121/cmr.2013.1176.ps2-33

PS2-34:

**Communication Barriers and Preferences of Limited English Proficient Chinese Speaking Members in Kaiser Permanente**

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**Background/Aims:** Our aim was to learn about the literacy and communication difficulties and preferences of Limited English Proficient Chinese speakers. **Methods:** This was a self-administered waiting room survey of KP Bilingual Chinese module patients. The study sample includes 1672 patients aged 35+ (775 aged 35-59, 897 aged 60+) classified from self-report as Very Limited English Proficient (VLEPs, n = 1242, speaks English not at all or not well) or Limited English Proficient (LEPs, n = 430, speaks English well, but not very well). **Results:** We found: 1) Educational attainment was low overall (approximately 36% had not completed the equivalent of high school, 37% were high school graduates, 15% had some college, and 12% were college graduates), and significantly lower among older patients and within age groups, VLEP versus LEP; (2) 97% of VLEPs and 13% of LEPs do not read English well, 13% of both VLEPs and LEPs do not read Chinese well, and 13% of VLEPs do not read either language well, with older VLEPs having the lowest literacy; (3) 88% of VLEPs and 55% of LEPs usually have trouble understanding letters in English and 43% of VLEPs and 35% of LEPs usually have trouble understanding letters in Chinese; (4) Among VLEPs, 43% preferred print instructions in Chinese, 2% in English, and 55% in both languages; among LEPs: 8% preferred Chinese, 28% English, and 64% both languages; (5) 76% of VLEPs and 42% of LEPs usually have trouble interacting with the KP Call Center on their own; Chinese Call Center agents were desired by 96% of VLEPs and 74% of

LEPs; (6) VLEPs are more likely than LEPs to have difficulty understanding instructions (VLEPs: 42% sometimes, 15% usually; LEPs: 25% and 2%) and test results (VLEPs: 41% sometimes, 39% usually; LEPs: 49% and 8%), and more frequently require help from others to understand (VLEPs: 30% sometimes, 60% usually; LEPs 43% and 12%); and (7) VLEPs are less likely than LEPs to use email and Internet, and more likely to need help when doing so. **Conclusions:** Limited English Proficient Chinese patients face many difficulties related to language, literacy, and education in ability to receive and understand health-related communications.

**Keywords:** Limited English Proficiency (Chinese); Communication Barriers; Health Services Delivery

doi:10.3121/cmr.2013.1176.ps2-34

PS2-35:

**Adaptation of a Disease-Specific Research Instrument for Quality of Life Assessments in Emergency Department Patients with Atrial Fibrillation/Flutter**

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**Background/Aims:** The Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) is a novel disease-specific quality-of-life (QoL) instrument for patients with atrial fibrillation/flutter (AF/F). The AFEQT, which evaluates a patient's perception of their AF/F symptoms, physical function, and emotional health, can serve as a marker of quality of care. To date, there are no reports of its practical performance. We describe the feasibility of simplifying the AFEQT for short-term QoL assessments via phone within a diverse population of AF/F patients receiving Emergency Department (ED) care across seven community hospitals. **Methods:** As part of a multicenter observational study of ED management and short-term outcomes of AF/F patients, we adapted the AFEQT for use in one month phone follow-up in patients with newly diagnosed or recent-onset (less than or equal to 48 hours) AF/F. We kept the original 20-item AFEQT format, but condensed the 7-point Likert response scale to 5 for ease of interviewing. We added questions about health in weeks prior to the ED visit, effectiveness of ED treatment, and medication compliance. The instrument was piloted to assess length and clarity of wording. Patients were consented for participation by phone and excluded if: unable to discriminate between AF/F and other comorbidities; unable to recall diagnosis; too ill to talk; deceased; non-English speaking. **Results:** Among 1013 patients with newly diagnosed or recent-onset AF/F, 722 (76%) were eligible for an interview. Of these, 620 (86%) were interviewed. Twenty-two (3%) refused to participate; 80 (11%) were lost to follow-up or unreachable. Reasons for refusal included discomfort with discussing health and informed choice not to participate in research. The average time per call in a sample of 106 patients was 11.2 minutes (interquartile range [IQR] 6). **Conclusions:** These interim results suggest that our modified AFEQT is a practical and feasible research tool for QoL assessments within a diverse subpopulation of AF/F patients. Additional analyses will evaluate QoL scores with relation to patient and treatment factors. Future investigations utilizing this and other disease-specific tools may consider modifications, such as adaptation to phone interview, to match the instrument to the study population and survey modality.

**Keywords:** Atrial Fibrillation; Atrial Flutter; Quality of Life

doi:10.3121/cmr.2013.1176.ps2-35

PS2-36:

**HMO Research Network Rural Health SIG: First Report**

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**Background/Aims:** The HMORN Rural Health SIG aims to facilitate rural health research by providing a forum to discuss ideas, determine needs, and identify investigators and resources that lead to research proposals, sponsored projects, and published manuscripts in peer-reviewed scientific literature. Rural areas have about 25% of the USA population (75 million people). Their health status and needs are distinctly different from non-rural populations and have been disproportionately understudied, but yet have great health disparities. At least 7 HMORN member organizations have substantial rural populations that provide compelling research opportunities. **Methods:** The Rural Health SIG has been convened using similar methods as the 11 other SIGs, including monthly teleconference meetings, annual face-to-face meetings, and several subgroups working on various projects. Our goals: 1) implement and sustain this SIG, 2) leverage other HMORN SIGs and funded research networks, 3) determine rural research studies done or in progress by HMORN investigators, 4) produce research grant applications, 5) publish results of our research, and 6) assemble rural health-focused investigators and resources to achieve these goals. **Results:** We currently have 29 active members from 7 HMORN member organizations that have contributed to collaborative and innovative rural health research. To date, the Rural Health SIG has one manuscript under review, 3 manuscripts in process, and several initiatives that may lead to collaborative research grant applications over the next year or two. **Conclusions:** Much has been accomplished since the HMORN Rural Health SIG was formed in early 2012. We will present our work completed through April 2013, our short- and long-term goals, and encourage other HMORN organizations and investigators to join in this effort.

**Keywords:** Rural Health; Scientific Interest Group

doi:10.3121/cmr.2013.1176.ps2-36

PS2-46:

**Examining Post-Discharge Medication Adherence and Gender in a Medical Aid Population**

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**Background/Aims:** After hospital discharge, low-income populations are at risk for adverse events, partly due to poor medication adherence. HIV and CHF studies suggest that men are more likely than women to take medications properly; however, little knowledge exists regarding medication adherence in low-income populations. If gender differences also exist in adherence after discharge, those differences could potentially be addressed by tailoring interventions to meet each group's needs. The purpose of this study was to compare medication adherence by gender following hospital discharge in patients receiving medical aid. **Methods:** Adults (n = 90) completed in-person surveys within 15 days of hospital discharge from one hospital. All were members of the hospital's medical aid program or were Medicaid beneficiaries, and they were hospitalized for reasons other than labor/delivery. Surveys assessed demographics, health literacy (REALM-SF), depressive symptoms (CES-D), motivation for following discharge instructions, and several self-care measures including Morisky's self-reported adherence. We employed the Chi-square test to test the hypothesis that medication adherence levels (poor, moderate, and high) differed between men and women on the Morisky scale. **Results:** The majority of the sample was female (62%), with a mean age of 50.4 (SD = 13.5). Most (56%) of the population was White; one-fifth (20%) reported Hispanic ethnicity and 26% were African-American. Most reported medium (37.8%) or high adherence (48.9%) following discharge. The level of medication adherence did not differ between genders following hospital discharge for medical aid program members (Chi-square = .180, df = 2, $P$ = .914). **Conclusions:** We observed no gender differences in medication adherence following hospital discharge among medical aid program members. However, several other behavioral or psychosocial factors conducive to appropriate adherence may differ between men and women, such as patient-activation or levels of depression. Future analyses will focus on testing for other equity issues that may warrant special attention in low-income populations.

**Keywords:** Medication Adherence; Low-Income Population; Gender

doi:10.3121/cmr.2013.1176.ps2-46