Adenomas were more often detected among those >60 years (aOR 1.69, 95%CI 1.21-2.36) and males (aOR 1.61, 95%CI 1.15-2.26). The mean PPAC overall was 0.34 (SD 0.68) and was associated with age >60 years (P<0.001) and male gender (P<0.001). When analysis was restricted to only those with =1 adenomas, a negative linear trend of PPAC was observed with PPAC highest among excellent quality preparations (1.48 [SD 1.05]), and lowest for poor preparation quality (1.00 [SD 0.00], P = 0.55). The overall ADR was 25.0% and by bowel preparation quality was 21.7% for excellent preparation, 26.6% for good, 25.5% for fair, and 13.1% for poor. **Conclusions:** Our findings suggest that PPAC is sensitive to changes in bowel preparation quality but is particularly sensitive when restricted to only those in whom adenomas were seen. Further exploration of PPAC as a bowel preparation quality indicator is warranted.

Keywords: Colonoscopy quality; Adenoma detection

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C1-3:

Longitudinal Predictors of Initial and Repeat Colorectal Cancer Screening

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Background/Aims: Few studies have used longitudinal data to examine predictors of colorectal cancer screening (CRCS). Further, there has been little research on repeat, on-schedule CRCS. **Methods:** We conducted a secondary analysis of data from the Systems of Support to Increase Colorectal Cancer Screening Trial (SOS), a randomized trial to increase CRCS in adults not current with screening recommendations. The sample consisted of 1,247 participants that completed a supplemental survey at baseline. Potential predictors included sociodemographics, medical/health history, intervention group assignment, and previously validated scales of CRCS pros, cons, self-efficacy, social influence, and cancer worry. Univariable and multivariable analyses were used to identify predictors of: 1) CRCS completion during the first year of the study, and 2) repeat, on-schedule CRCS during the second year of the study among those that completed an FOBT in Year 1. We also tested for moderation effects of the intervention on baseline predictors of screening completion. **Results:** In multivariable analysis, prior CRCS at baseline (OR 2.67, 95% CI 2.01–3.55) and intervention group assignment (Automated: OR 2.06 95% CI 1.44–2.96; Assisted: OR 3.97, 95% CI 2.65–5.92; Navigated: OR 5.65, 95% CI 3.76–8.49) were statistically significant predictors of CRCS completion at Year 1. Family history of colorectal cancer, higher self-efficacy, and higher health rating trended towards significance. For repeat CRCS at Year 2, prior CRCS at baseline (OR 1.97, 95% CI 1.26–3.07), intervention group (Automated: OR 9.97, 95% CI 4.97–19.98; Assisted: OR 12.34, 95% CI 6.07–25.09; Navigated: OR 14.44, 95% CI 1.06–29.52) and self-efficacy (OR 1.35, 95% CI 1.03–1.77) were statistically significant predictors. The intervention moderated the effect of prior CRCS and smoking status on CRCS completion at Year 1: 79.5% with prior CRCS were screened vs. 55.2% with no prior CRCS and 70.2% of non-smokers were screened vs. 53.9% of current smokers. **Conclusions:** Prior screening experience was a significant determinant of CRCS in both years 1 and 2, and the intervention amplified the effect of prior screening in Year 1. The intervention also was an important determinant of screening in both years suggesting that removing major access barriers increased screening completion.

Keywords: Colorectal cancer screening; Intervention trial

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PS1-44:

Time to Surgery for Melanoma

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Background/Aims: Cutaneous melanoma is among the most rapidly increasing malignancies in the United States, afflicting approximately 77,000 persons and causing over 9,000 deaths annually. Over half of incident melanoma and melanoma-related deaths occurs in patients older than age 65. Barriers to accessing dermatologic care may impede timely surgical therapy for patients with melanoma, potentially resulting in psychological or physical harm. Accordingly, given the disproportionate burden of melanoma borne by the elderly and limited availability of dermatologic care, we sought to determine timeliness of surgical resection of melanoma and identify factors associated with time to surgery in the Medicare population. **Methods:** We conducted a population-based, retrospective cohort study of melanoma cases from years 2000 to 2009 using linked data from the Surveillance, Epidemiology, and End Results (SEER)-Medicare database. We identified cases of melanoma using ICD-O-3 and ICD-9 codes. Our primary outcome of interest was time to surgery (dichotomized at 21 days), ascertained by dates of ICD-9 and CPT skin biopsy and surgical procedure codes from Medicare administrative claims. Multivariate logistic regression with clustering of cases by patient and fixed effects for hospital referral region was used to evaluate the impact of type of surgery (Mohs versus non- Mohs technique), patient-level factors (age, gender, race, comorbidities, marital status, income, and prior history of melanoma), and tumor-level factors (stage and anatomic location). **Results:** We identified 32,666 cases of melanoma (1.04 cases per patient) during our study period. The median time to surgery was 27 days (IQR 16-42). Significant predictors of surgical delay (P<0.05) included: Mohs surgery (OR 1.10), Elixhauser comorbidity index of 3 or greater (OR 1.16), unmarried status (OR 1.17), regional disease (OR 1.44), and anatomic localization to trunk (OR 0.67) and extremities (OR 0.74). Age, gender, race, income, and history of prior melanoma were not associated with time to surgery. **Conclusions:** Time to surgery exhibits substantial variation among the Medicare population, with longer delays associated with select patient-, provider-, and tumor-level risk factors. Future research is needed to better understand the role these factors may play as possible barriers to dermatologic surgical care and their potential impact on patient morbidity and mortality.

Keywords: Melanoma; Surgical delay

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PS2-28:

Members' Suggestions for Improving FIT Kits

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Background/Aims: Our aim was to get member feedback about KPNC's FIT kit and changes they think would improve the kit. **Methods:** Self-administered survey of 3 groups of White, Black, and Latino KPNC members aged 52-75 who were mailed FIT kits in 2010, 2011, and 2012: "Compliers" (CMs) – did FIT all 3 years; "Converts" (CVs) - did FIT in 2012 but not 2010-2011; "Non-Compliers" (NCs) - no FITs 2010-12. **Results:** Preliminary based on responses from 596 CMs, 300 CVs, and 114 NCs. All comparisons reported are statistically significant. Nearly 90% suggested at least one change to the kit. About 53% suggested including a disposable glove (40% currently use their own to get their sample) and about 40% an antibacterial wipe. About half suggested an extra sheet of paper (1/3 have some trouble catching sample on the sheet), 45% a tube with a wider opening, and 22% a longer scooping stick. Blacks and Latinos were more likely than Whites to request the glove (60% vs. 41%), the wipe (46% vs. 26%), a wider tube (49% vs. 37%), and a longer stick (25% vs. 15%), and CVs were more likely than CMs to request a glove and longer stick. NCs recommended these additions also, but mostly wanted a frank discussion with their PCP. Only about 9% were interested in a video showing how to use the FIT kit (10% of Blacks and Latinos vs. 5% of Whites). For reminders, over 80% wanted to get mailed letters, with robo-calls and secure messages preferred by 19% and text messages by about 10%. Seniors were less interested than non-seniors in getting secure messages and texts. **Conclusions:** Adding items to the FIT kit to address concerns about mess/ bacterial exposure and need for precision might encourage adults to start or continue using this CRC screening tool.

Keywords: Colorectal cancer screening; Race-ethnic differences

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