gender, race, ethnicity, BMI, diet, and hours of PA per week. **Results:** Age and PA were strongly related to ST. Obese participants (BMI >30 (24% of the sample) had significantly higher mean ST (6.75 hours/day, P <.001) compared to overweight (6.06) and normal weight (5.67) older adults. Those with diabetes (14% of the sample), had significantly higher ST (6.42 hours/day) than those without (6 hours/day; P = .01). Total healthcare costs increase on average $139 for each additional hour of sitting (P = .03). **Conclusions:** After adjusting for demographic, health behaviors, and health conditions, older adults with a higher BMI, diabetes, and higher total healthcare costs had greater self-reported ST. These patterns indicate that ST may be an important health behavior to target for intervention as people age.

Keywords: Physical activity; Electronic health records

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PS2-8:

Development and Implementation of Clinical Decision Support Tools in Epic to Standardize Dementia Diagnosis and Care at Essentia Health

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Background/Aims: The current estimated prevalence of Alzheimer's disease and related dementias in the US is over 5 million and projected to increase to over 15 million by 2050. The already overwhelming personal and economic burden this represents for patients, families, and health care providers is only expected to increase as well. Essentia Health recognizes the urgent need to standardize dementia diagnosis and management system-wide to enhance earlier detection of cognitive issues that will lead to better management of dementia and comorbid conditions to reduce the burden of this devastating disease and improve quality of life for patients and their caregivers. **Methods:** The Division of Primary Care at Essentia Health is developing a standardized approach to dementia diagnosis and care to be implemented system-wide. An advisory workgroup consisting of physicians and NPs from primary care (family practice, internal medicine), specialty care (elder care, neurology, neuropsychology), and community partners (Alzheimer's Association, Arrowhead Area Agency on Aging, Family Memory Care Consultants) continues to meet monthly to plan integration and implementation. We have initiated a pilot study in two of our primary care clinics to implement and evaluate this approach and to inform further development. **Results:** Two separate smartsets have been created–the EH Memory Screen/MiniCog Smartset (MCOG Set) and the Memory Screen/MOCA SmartSet (MOCA Set). The first is intended to guide cognitive screening at the annual wellness visit (AWV) and the other to serve as a guide for a follow-up examination if indicated from the MOCA Set. **Conclusions:** We plan to present both quantitative and qualitative information based on our experience through the first few months of implementation. This will include a thorough evaluation of the work plan as well as lessons learned to inform further implementation at EH and other systems.

Keywords: Clinical decision support; Dementia

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PS2-9:

The KPSC Experience of Recruiting 18-year old Emerging Adults

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Background/Aims: The challenges of obesity interventions have led researchers and policy makers to focus on obesity prevention. Studying normal weight individuals as they transition from adolescence into adulthood is an interesting group because they have avoided obesity thus far in their life. However, it is a period of weight gain. HMOs have unparalleled access to young adults, but they are typically hard to reach; effective methods to recruit them into studies are relatively unknown. The purpose of this study was to identify effective recruitment methods of 18 year old Kaiser Permanente Southern California (KPSC) members. **Methods:** The study population was age 18 years in 2012, had at least one outpatient visit with a body mass index (BMI) in 2012, was generally healthy, and normal weight (BMI <25kg/m2). From over 13,000 individuals that met criteria, 500 were randomly selected (55% female) to be contacted through mail, telephone, email, or text. We asked them to complete a 9-item survey. Recruitment was conducted over 6 weeks by 2 research associates. Attempts were made to contact 320 individuals, of which 185 members had an email in our electronic records. The protocol allowed for 5 email attempts, after which telephone attempts were made. **Results:** Overall 82 persons (25.6%) completed the survey and 30 (9%) actively refused. For those with an email, 27 surveys were completed (15%), with 4 refusals. Another 23 completed the survey by telephone, with 8 refusals. Of the telephone-only persons, 32 surveys were completed and 18 refused. Incorrect contact information was found for 23 persons. At the end of 6 weeks, we did not reach the remaining members, although anecdotally we spoke to many parents. **Conclusions:** Future efforts may require more staff time. Even though the members were adults, many parents were still gatekeepers for their children. It may be more effective to target a younger age group to recruit parents as well as children to obtain informed consent.

Keywords: Emerging adults; Recruitment

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Communication/Dissemination

C2-1:

Choosing Hospice or Choosing Dying: The Cultural and Medical Meanings of "Hospice" and the Role of Provider Referrals in Transition to Hospice Care

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Background/Aims: Hospice care is widely used at the end of life yet it remains stigmatized and feared. Current research on the transition to hospice overlooks the dimension of patient choice and the symbolic importance of hospice to patients and families. Understanding the transition from the point of view of patients and family members is critical in increasing use of hospice care and decreasing "late referrals." **Methods:** This research draws on in-depth retrospective interviews with 18 patients in home hospice care in the United States and 11 family members/caregivers. **Results:** Examining narratives about transitioning to hospice reveals two insights. First, the referral is one highly variable element of a more complex process better conceptualized as a transition. Transitions may be (1) provider-driven or (2) patient/family-driven. Some patients and families play a very active role in this transition, including self-referring to hospice. Second, the style of provider referrals is commonly remembered as being very negative. Negative referrals tend to draw on a cultural meaning of hospice as "giving up" or "choosing dying", while positive referrals conceptualize hospice as a medical and psychosocial strategy that is advantageous for patients and families. **Conclusions:** Understanding referral as a discrete, but critical component of a longer strategy for transitioning to hospice care, should lead providers to carefully plan when and how they present hospice care to patients. Understanding the spectrum of patient and family perspectives can also improve providers' ability to customize their referrals and the likelihood that patients will transition to hospice care if and when it would benefit them.

Keywords: Hospice; Referral

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C2-2:

Assessing Patient Perceptions of Communication throughout Cancer Care: Results of an Initial Administration of a New Item Set

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Background/Aims: Patient-centered communication is vital to quality care. Strategies are needed for assessing patients' views on communication over the entire course of cancer care. We sought to describe cancer patients' perceptions of their communication experiences using a new set of items. Of particular interest were patients' reports of when communication "fell short" and the aspects of communication considered most important. **Methods:** We