

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

surveyed members of Kaiser Permanente (KP) Member Voice, a representative online panel of KP members. Questions focused on communication with the cancer care team overall and during specific phases (e.g., diagnosis, chemotherapy). Respondents indicating less than excellent communication were asked to describe how communication fell short. We asked all respondents what aspects of communication were most important during cancer care. **Results:** A total of 375 members diagnosed with cancer completed the questionnaire. Respondents represented all KP regions; 57% (212/375) were female; 62% (233/375) had at least a college degree. Overall communication ratings varied by phase of care; the percentage of respondents rating “excellent” was lowest for Diagnosis (62%; 225/365); corresponding percentages for other phases included Decision-Making 71% (248/352); Surgery 73% (212/290); Radiation 65% (68/105); Drug Therapy 76% (82/108); Completing Treatment 70% (237/340). Only 55% (189/342) of respondents “strongly agreed” they were told their diagnosis in a sensitive, caring way. Asked where communication fell short, patients cited problems in providers’ manner, as well as the amount, timing and clarity of information. Initial analysis of what was most important revealed themes related to being treated like a person, conveying caring and optimism and providing clear, complete and timely information. **Conclusions:** Patients are willing to provide feedback on their cancer care experiences and to identify problematic aspects of communication and when they occurred. These items can be used to assess patients’ experiences and to prioritize quality improvement efforts. **Keywords:** Cancer; Communication

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C2-3:

Cancer Prognostic Resources: A Systematic Review and Central Repository of Web-based Cancer Prognostic Calculators

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Background/Aims: Cancer prognosis is one of the leading topics of interest for cancer patients, their caregivers and providers. Literature suggests that nomograms that use prognostic algorithms integrating several predictors improve prognostic accuracy. There has been increasing interest in the availability and use of web-based tools by both health care providers and patients for obtaining information about health promotion and disease management. Our study aimed to review the available online cancer prognostic tools, to provide input on the implications for their use in clinical settings, and to create a centralized repository for providers to access. **Methods:** Using a systematic approach, we searched the Internet, Medline, and consulted with experts to identify existing online prognostic tools. To be eligible, tools had to have an English version, focus on cancer, have an interactive component, and provide at least one of the following output measures: cancer or non-cancer specific mortality/overall survival; disease free survival (DFS)/recurrence; clinical response to treatment; progression free survival (PFS)/spread; cancer therapy induced side effects. Each tool was reviewed for content and format. **Results:** Twenty-two prognostic tools addressing 89 different cancers (min: 1, max: 84) were identified. We classified unique cancer sites under 13 main categories. Tools focused on prostate (n = 11), colorectal (n = 10), breast (n = 8), and melanoma (n = 6), though at least one tool was identified for most malignancies. The input variables for the tools included cancer characteristics (n = 22), with fewer having inputs for patient characteristics (n = 18) or comorbidities (n = 9). Effect of therapy on prognosis was included in 19 tools. The most common predicted outcome was cancer specific survival/mortality (n = 17) followed by disease free survival (DFS)/recurrence (n = 14). While all of the tools were available online, only four suggested usability by patients. **Conclusions:** The process of identifying available tools was time consuming as there was no one location where all existing cancer prognostic tools were easily accessible and compared. Using a systematic review, we identified and compiled a comprehensive repository of 22 currently existing online prognostic tools. A website was created for these tools: www.cancercalculators.org. Cancer prognostic tools hold great promise in facilitating patient-

centered communication and decision-making and helping patients prepare for life post treatment.

Keywords: Prognosis; Prediction

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C2-4:

Implementing an Evidence-based Breast Cancer Support Tool for Newly Diagnosed Breast Cancer Patients as Standard Care at Two Institutions

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Background/Aims: While many women turn to the Internet to obtain information, it is unlikely that unstructured internet use provides optimal benefit to women newly diagnosed with breast cancer, due to uneven quality, conflicting claims, redundancy, and search engine idiosyncrasies which may make finding desired information more difficult. To answer the need for information and support, an Interactive Cancer Communication System (“CHESS”) was developed, validated in several randomized trials, and is now being implemented to provide access to integrated information for decision-making, behavior change, and emotional support. We implemented a program to offer CHESS to all newly-diagnosed breast cancer patients as part of standard care (not as part of a research study) at two Denver healthcare systems: Kaiser Permanente Colorado (KPCO), and Exempla Health Care (EHC), which serves a larger proportion of minorities and those without insurance. **Methods:** All women who receive a breast cancer diagnosis at KPCO and EHC are to be offered access to CHESS during or very shortly after notification of their diagnosis and throughout the treatment process, thus making CHESS a part of standard care for hundreds of breast cancer patients. By qualitatively tracking the contextual factors related to CHESS implementation by date and occurrence, and through patient and provider interviews and surveys, this study is evaluating the real-world feasibility of CHESS integration into standard care. **Results:** We will report on the process of real-world implementation of CHESS at KPCO and EHC, the barriers to and facilitators of integrating the CHESS resource into standard care, and the expected and final process of how CHESS was finally integrated into standard care at each institution as a case-study example. We will also report on the initial impact of CHESS integration on the breast cancer care process and on providers at each institution. **Conclusions:** This case-study example demonstrates how CHESS implementation is informing dissemination to other KP regions and organizations and how the evaluation and tracking process provides guidance for implementation of other programs in large organizations.

Keywords: Breast cancer; Implementation

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PS1-48:

A Patient-centered Electronic Education Tool for Establishing Weight Loss Expectations after Bariatric Surgery

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Background/Aims: Bariatric surgery candidates often struggle when deciding between intensive lifestyle therapy, pharmacological therapy, and/or bariatric surgery for achieving their long-term weight loss (WL) goals. Moreover, they often have unrealistic WL expectations prior to surgery. Despite huge individual variation in surgically induced WL, patient education is currently based on average WL results derived from program experience or published literature. Improved patient education tools are needed to provide realistic individual expectations for surgical WL. The purpose of this study was to develop an electronic application for patient education that can aid in surgical decisions, establishing realistic WL goals, and monitoring WL success. **Methods:** Post-operative weight measurements from 2608 Roux-en-Y gastric bypass patients at Geisinger Clinic were collected over an eight