of Americans have completed ADs. The limited effectiveness of traditional interventions to increase AD completion may be because they do not address the behavioral aspects of advance care planning. Behavioral Design is an innovative approach that combines design thinking and behavioral economics to identify predictable behavioral bottlenecks and create real-time solutions. This study used Behavioral Design to address low AD completion rates of long-term care residents. Consistent with the Behavioral Design process, an interdisciplinary team compiled evidence from 10 diverse data sources to identify behavioral bottlenecks to AD completion. These barriers were analyzed using the cognitive bias codex to determine behavioral levers for intervention. Informed by these findings, the study team designed multicomponent interventions to address behavioral aspects of AD completion. Four behavioral bottlenecks incorporating ten behaviorally mediated causes for lack of AD completion were identified. For example, AD completion is affected by complexity mediated by hassle factor, choice overload, and ambiguity effect. Three interventions were designed to address these behaviorally mediated causes. For example, the intervention HeAD Start would provide a simple, easy to read AD (addressing choice overload) to residents upon admission (addressing hassle factor) with scheduled follow-up by trained staff (addressing ambiguity effect). Behavioral Design incorporates design thinking and leverages behavioral economic principles to create behaviorally mediated AD interventions. Next steps include testing behaviorally informed designs in practice.

ASPIRIN BENEFIT IS NOT AFFECTED BY BODY WEIGHT IN HEALTHY OLDER PERSONS

Robyn L.. Woods,[1] Galina Polekhina,[1] Mark Nelson,[2] Rory Wolfe,[3] Michael E. Ernst,[4] Anne M. Murray,[5] and John McNeil[6], *1. Monash University, Melbourne, Victoria, Australia, 2. University of Tasmania, Hobart, Tasmania, Australia, 3. Monash University, Melbourne, Australia, 4. University of Iowa College of Pharmacy, Iowa City, Iowa, United States, 5. Berman Center for Outcomes and Clinical Research, Minneapolis, Minnesota, United States, 6. Department of Epidemiology & Preventive Medicine, Monash University, Melbourne VIC, Australia, Melbourne VIC, Australia, Australia*

Recent meta-analysis (Rothwell et al, Lancet 2018;392:387-99) of aspirin trials in predominantly middle-aged people suggested that aspirin's effects on clinical outcomes vary according to dose and body weight, concluding that under dosing in heavier people may be responsible for reduced efficacy of aspirin. Data from ASPREE (ASPirin in Reducing Events in the Elderly; randomized primary prevention trial of low dose aspirin versus placebo in 19,114 healthy older participants, mainly aged 70+ years) were analyzed for interaction of body habitus on the main outcomes after 4.7 years of study treatment. Increases in body weight, BMI or waist circumference (WC) did not influence cardiovascular endpoints or incident cancers in the aspirin group compared with placebo. In ASPREE men, an increase of 10 kg body weight elevated the risk of major hemorrhage with aspirin (HR 1.20; 95% confidence interval 1.01-1.43; P=0.04) and 10 cm increase in WC elevated all-cause mortality by 23% with aspirin (HR 1.23; 95% confidence interval 105-1.44; P=0.01), driven by cancer-related deaths (HR 1.39; 95% confidence interval 1.11-1.73; P=0.004). These effects of increased abdominal girth were not seen in women. Evidence from ASPREE does not support increasing the dose of aspirin in larger older people to improve the drug's efficacy. Our results point to a link between central adiposity, hemorrhage risk and cancer-related death in older men taking aspirin.

A HOSPICE COLLABORATIVE NETWORK TO IMPROVE SERIOUS ILLNESS CARE IN A LARGE HEALTHCARE SYSTEM

Richard E. Leiter,[1] Charles T. Pu,[2] Emanuele Mazzola,[1] and Rachelle E. Bernacki[1], *1. Dana-Farber Cancer Institute, Boston, Massachusetts, United States, 2. Massachusetts General Hospital, Boston, Massachusetts, United States*

The quality of hospice care in the United States varies significantly, yet healthcare systems lack methods to comprehensively evaluate and stimulate quality improvement in organizations that serve their patients. Partners HealthCare, an integrated healthcare system located in Eastern Massachusetts, sought to create a high-quality hospice collaborative network based on objective and quantitative criteria obtained from public reporting as well as the hospice itself. Through a modified Delphi procedure, clinicians, administrators, and data scientists developed a set of criteria and a scoring system focused on three areas: organizational information, clinical care quality indicators, and training and satisfaction. All Medicare-certified hospices in good-standing in Massachusetts were eligible to participate in a request for information (RFI) process. We blinded all hospice data prior to scoring and invited hospices scoring above the 15th percentile to join the collaborative for a 2-year initial term. Of 72 eligible hospices, the majority (53%) responded to the RFI, of which 60% submitted completed surveys. Hospices could receive up to 23.75 points with scores ranging from 2.25 to 19.5. The median score was 13.62 (IQR: 10.5-16.75). For the 19 hospices scoring above the 15th percentile, scores ranged from 10.0-19.5 (median: 14, IQR: 11.1-16.9). There was no association between quality score and continuous (Spearman's correlation 0.24, p=0.27) or dichotomous (Wilcoxon rank sum test p=0.13) measures of hospice size. The hospice collaborative network is one healthcare system's initial attempt to effectively leverage its influence and relationships to improve hospice quality for the benefit of its seriously ill patients and their families.

TRENDS AND FACTORS ASSOCIATED WITH PLACE OF DEATH AMONG INDIVIDUALS WITH CARDIOVASCULAR DISEASE IN THE UNITED STATES

Sarah H. Cross,[1] Brystana G. Kaufman,[2] and Haider Warraich[3], *1. Duke University, Durham, North Carolina, United States, 2. Duke-Margolis Center for Health Policy, Durham, North Carolina, United States, 3. Duke University, North Carolina, United States*

While most patients prefer to die at home, trends and factors associated with place of death for patients dying of cardiovascular disease (CVD) remain unknown. Using data from the National Center for Health Statistics from 2003-2017, we described trends and conducted multivariable logistic regression to evaluate associations between demographic characteristics and place of death among CVD patients in the United States. From