never been examined for oral cancer by a doctor or a dentist. Those who correctly recognized the most common sign of oral cancer were about three times more likely (OR=3.75; 95% CI: 1.04 – 13.50) to have had an exam for oral cancer (p=0.04). The survey participants who lived alone were more likely (OR = 4.39; 95% CI = 0.95 – 20.26) to have been examined for oral cancer (p = 0.05). During the interview, older adult participants rarely mentioned oral cancer with regards to an unhealthy mouth. The interview participants revealed that living alone gave them more time to pay attention to their health. For the older adults, prevention of oral diseases was grounded in the autonomy in their own behaviors, while the key informants saw more macro community and systems- level factors as the solution.

INVESTIGATING THE INVERSE RELATIONSHIP BETWEEN SMOKING AND PARKINSON'S: EVIDENCE FROM A MULTIETHNIC COHORT

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Parkinson's disease (PD) is the second most common neurodegenerative disease in the United States with more than 50,000 new cases annually. Studies have reported an inverse relationship between smoking status and the risk for PD. Current smoking status, the number of pack-years smoked, and the lifetime duration of smoking have all been shown to have a lower risk for PD compared to non-smokers. However, studies exploring smoking behaviors in a multiethnic cohort with an ample sample size of PD cases to analyze smoking differences between men and women are rare. Using the Multiethnic Cohort (MEC), our study included 680 self-reported cases of PD from total sample of 98,191 Blacks, Latinos, Japanese, Native Hawaiians, and Whites from Hawaii and Los Angeles surveyed in 2003-2007. Stratified by sex, we conducted a cross-sectional logistic regression analysis to examine the odds of developing PD by various smoking indicators. Overall, current smokers had the lowest risk for PD (OR=0.46, 95%CI 0.27-0.76) compared to non-smokers. The odds of developing PD gradually decreased as the number of years of smoking increased with participants that smoked for 50 years or more having the lowest odds of developing PD (OR= 0.41, 95%CI 0.22-0.78) compared to non-smokers. Using a multiethnic cohort, our analyses further supported the inverse association between PD and smoking status, as well as the number of years of smoking. Future studies are necessary to investigate the possible genetic modulation on the relationship between tobacco and PD.

DISCUSSING SPIRITUAL HEALTH IN PRIMARY CARE IN ENGLAND

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The organisation that regulates doctors and family physicians' professional body in the UK both require doctors to consider patients' spiritual health, especially towards the end of life. Discussion of spiritual health can encapsulate positive aspects of patients' lives, and may be valuable for older people as physical and mental health decline. Tools are available for doctors to structure discussion of spiritual health in consultations but anecdotal reports suggest that this seldom happens. This study aimed to understand the barriers to GPs discussing spiritual health and their knowledge and views of current tools, particularly the HOPE tool by Anandarajah and Hight. Narrative literature review using systematic methods and mixed methods investigation into current practice, An online survey was conducted with 177 family physicians in England, investigating how doctors define spiritual health, their comfort with the topic, and their knowledge and acceptability of the HOPE tool, using patient vignettes. Definitions of spiritual health were heterogeneous, within three themes: self-actualisation and meaning; transcendence and relationships beyond self; and expressions of spirituality. Doctors felt more comfortable discussing spiritual health after a patient-led cue. Introduction of the HOPE tool increased doctors' comfort with the topic. Discordance between doctor and patient beliefs and cultural backgrounds influenced views and practice. Concerns about regulator disapproval was a major barrier to discussions. Spiritual health does not appear to be a routine part of family practice in the UK. Tailored education, containing a structured tool such as HOPE, with regulatory approval, may help overcome barriers to discussion of spiritual health.

BARRIERS AND SOLUTIONS TO IMPROVE AGE-RELATED SERVICE ACCESS IN UTAH: A QUALITATIVE STUDY

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Utah is projected to be in the top 10 states for growth in the aging population, but it is among the most rural. Local and regional contexts guide policy and practice, and these perspectives will inform solutions as more older adults require services in rural and other under-served areas in the coming decades. Guided by Bronfenbrenner's Process-Person-Context-Time model, this study used a qualitative participatory research orientation involving stakeholders in Utah's aging service system in order to identify local barriers and solutions to accessing rural aging services. The stakeholders included service providers, caregivers, older adults, state-administrators, and other community members. There were 3 male and 7 female participants ranging in age from 40 to 80. Thematic analysis revealed that communities faced barriers common to rural areas (local service insufficiencies, distance and time concerns, systemic issues such as healthcare and ageism, finances - both personal and programmatic were deemed a recurrent barrier, in addition to transportation issues. However, participants reported assets in rural areas, such as a strong sense of belonging in the community and creative problem solving. Solutions for improving access to age-related services included strategies for making information more available, publicized, and centralized and increasing access to telehealth or internet-delivered services and health information. These barriers and solutions were nested across the levels of context in Bronfenbrenner's model, with both person, time, and in interactions (processes) having influence,