P160 (continued)

extensive data collection instructions are included in the tool to ensure consistency across data collectors.

Evaluation: The Church Environment Audit Tool is being tested for reliability within 54 churches in a rural South Carolina county.

Conclusions and Implications: The Church Environment Audit Tool provides a resource to objectively measure the physical environment of churches as it relates to HE/PA behaviors. The tool could be used in faith-based interventions and as part of ongoing community assessments in health behavior programming.

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P161 Development of an Instrument Designed to Assess Intentions to Use Division of Responsibility in Child Feeding

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Objective: To minimize children's less-healthy eating behaviors, Satter proposes a division of responsibility in child feeding (sDOR): parents take responsibility for providing a healthy food environment and children have responsibility for choosing what and how much to eat. The Theory of Planned Behavior suggests a precursor to behavior is intention to perform that behavior. Hence, if parents plan (intend) to use sDOR, they will be more likely to do so. The objective of this study was to develop an instrument to measure sDOR intentions (sDOR-I).

Study Design, Setting, Participants, Intervention: Using a cross-sectional study design, we surveyed 421 undergraduate students from a major southeastern university who were enrolled in randomly-selected undergraduate courses. Two hundred ninety-seven students who plan to have children provided complete, valid data for all variables.

Outcome Measures and Analysis: We created a sDOR-I scale by modifying 13 sDOR items (Lohse, Satter & Arnold, 2014). The items, scored from 0-4 (strongly disagree-strongly agree), were pretested with college students and refined. Appropriate items were reverse-coded and scores summed (possible range 0-52). Using factor analysis and scale reliability testing, we identified four subscales (Leadership, Autonomy, Indulgence and Pressure-to-Eat). Subscales were created by averaging item scores (none reverse-coded; range 0-4).

Results: Students scored between 20 and 41 on the sDOR-I (mean=29.06). Means for Leadership, Autonomy, Indulgence, and Pressure-to-Eat subscales (Cronbach's alphas) were 3.23 (.624), 2.27 (.386), 1.92 (.664), and 2.91 (.521) respectively.

Conclusions and Implications: This study represents the first attempt to measure sDOR-I. Although further refinement of the scale may be indicated, understanding sDOR-I may lead to future development of interventions to improve child feeding behaviors.

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P162 Measuring How Systems Change in Clinics Facilitates Provider Education About Physical Activity and Increase Referrals to Community Resources

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Objective: To increase physical activity and refer more patients to University of Maryland EFNEP nutrition education classes and other community resources, CCI Health and Wellness Centers adopted Physical Activity as a Vital Sign (PAVS).

Theory, Prior Research, Rationale: Social Ecological Model. Previously used by Kaiser. PAVS screens patients for physical activity during routine vital signs assessments. It was initially pilot-tested in one CCI clinic.

Description: The target audience was pediatric clinic patients and their families in Latino communities. Clinic medical assistants asked physical activity screening questions. Activity "tip sheets" and local physical activity resource guides were distributed. EFNEP nutrition classes were added as a referral resource and patients were referred between February and September 2016. This effort required changes in the clinic electronic health record and workflow redesign. Patients showed improved physical activity and diet quality.

Evaluation: Interviews were conducted pre- and post-intervention with seven providers. All providers agreed that screening questions took little time and PAVS made it easier to address physical inactivity. Resource lists and referrals to EFNEP nutrition classes were especially important for providers to offer some options for patients. An estimated 40 new patients were referred to EFNEP. Providers reported more patients asking them about physical activity as well. All providers felt that PAVS was feasible and should be incorporated into clinic settings.

Conclusions: This program offers lessons learned regarding next steps for evaluating PSEs. First, by incorporating the screening questions and EFNEP referrals into the electronic health record, evaluation indicators were easily measured. Second, provider interviews revealed their priorities and level of support.

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P163 Not State Self-Control, but Time Predicts Unhealthy Food Purchases

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