enrollee-only unique patients for the year 2007, and all charts were reviewed (n=1116). NMSC cases were confirmed via chart review in 96.7% of ICD-9 identified patients, 98.5% of CPT-identified patients, and 98.9% of patients identified using both codes. **Conclusions:** HMO computerized claims data can be used to identify NMSC. Preliminary analysis suggests that the use of an algorithm which requires that both a CPT and ICD-9 code be recorded may be slightly better compared to either ICD-9 or CPT codes for case identification. This algorithm should be validated in a population captured by reputable tumor registry to determine sensitivity and specificity.

PS2-35:

Variation in Capture of Chemotherapy Data: Preliminary Findings From the CRN Economic Rx Burden Pilot Study

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Background: A number of high-cost chemotherapy agents, including targeted biologic and genetic therapies, have been introduced to the U.S. in recent years. Much of the literature on use and costs of these new agents has been derived from clinical trials and Medicare/SEER-based studies. To date, few studies have been published describing diffusion and costs of new cancer therapies within or across health plan populations. **Aims:** To describe capture of chemotherapy use (antineoplastics, hormone therapies, immune therapies, infusion time and site, ancillary therapeutics) within and across four Cancer Research Network (CRN) health plans for older (age 50+) cancer patients. **Methods:** Using data from health plan pharmacy systems and the Virtual Data Warehouse (VDW) Tumor Registry (TR), Pharmacy (Rx), and Procedure (PROC) files, we created dichotomous variables from each file separately denoting capture of chemotherapy use for each cancer patient aged 50 and older for the years 2000–2007. Variables were created using chemotherapy-specific national drug codes (NDCs) stratified by type of product (antineoplastic, hormone, immune) and route of administration (oral, infused/injectable) (Rx), procedure codes (CPT4, HCPCS, CPT4 Q codes, and revenue center codes) (PROC), and chemotherapy treatment flags (TR). Data were then stratified by health plan, year, cancer site, and stage. Chi-square analyses were employed to measure variations over time, within and across the four health plans' Group Health, KPCO, KPNW, and HFHS. **Results:** Preliminary findings show significant variation in chemotherapy capture by data source over time within and across the four health plans, and by cancer site and stage. While the VDW TR has complete capture of abstracted data that denote whether or not chemotherapy was recommended in the initial treatment plan, other VDW-based sources may not be as complete with respect to detailed capture of the products by NDC code, dosing, and infusion time and site. **Conclusion:** Additional analyses are required to investigate how missing data affect the use of VDW chemotherapy data for research and to develop the steps to improve data capture. Algorithms may be needed to impute the average cost of some therapies for subsets of cancer cases across the four health plans. This project complements and builds on several components of the CRN infrastructure projects, and will leverage the expansion the VDW with respect to the inclusion of chemotherapy services.

PS2-36:

Influence of Travel Time on the Receipt of Surveillance Mammograms for Women With History of Breast Cancer

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This presentation will assess the impact of travel time to the nearest breast cancer mammographic facility on receipt of surveillance mammography following completion of breast cancer treatment. The study population includes women (n=1,312) diagnosed with stage I or stage II breast cancer (TNM classification) from 1990 to 1997 at Group Health Cooperative enrolled in either the Breast Cancer Treatment Effectiveness in Older Women (BOW) or Optimizing Breast Cancer Outcomes: BMI, tumor marker, and quality of care (ACS) retrospective cohort studies. We will obtain information on receipt of screening mammograms up to 5 years after enrollment, women's demographics at cancer diagnosis, and link them to a geospatial database created to assess distance to nearest mammography facility and area-level socioeconomic characteristics. We will employ generalized linear regression models to assess the relationship between receipt of surveillance mammography following completion of breast cancer treatment and travel time adjusting for women level socio-demographic factors, tumor stage, type of cancer treatment, and comorbidities if they are found significantly related to receipt of mammography. Receipt of surveillance mammography will be defined in two ways: (1) ever receiving a surveillance mammogram and (2) average surveillance mammogram interval over the 5 years of follow-up. We will account for different censoring mechanisms, such as recurrence, all cause mortality, breast cancer-specific mortality, and disenrollment from Group Health, and their impact on our measure of receipt of surveillance mammography.

PS2-37:

Oral Cancer Information on the Web: Assessing the Quality and Content of English and Spanish Oral Cancer Websites

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Background/Aims: In the United States, about 8,000 people a year die from oral cancer and more than 30,000 new cases are diagnosed annually. A recent study showed that 80% of American adult Internet users have searched the Web for health information and 15% of those specifically searched for dental health information. Having high quality oral cancer information available via the Web is important given the significance of this health problem. The goal of this study was to evaluate the quality and content of multiple English and Spanish oral cancer websites. **Methods:** We developed a search strategy using the keywords: oral cancer, mouth cancer, and tongue cancer to find oral cancer sites via Medline Plus, Google, and Yahoo. We then used the translations cancer oral, cancer de la boca, and cancer de la lengua to search Medline Plus en Español, Google Español, and Yahoo Telemundo. We added sites to the datasets based on inclusion/exclusion criteria. Two native speaking raters evaluated each site within their set for quality using the modified Information Quality Tool (IQT). We then developed a survey tool to asses the content of the sites. Two native speaking oral cancer experts evaluated each site within their set using this new tool. **Results:** Our search strategy produced 24 English language sites and 24 Spanish language sites for evaluation. English language websites had an average IQT score of 74.7 (out of 100) and average content score of 51.5 (out of 100). Spanish-language sites had an average IQT score of 48.8 and an average content score of 25.9. **Conclusions:** Despite higher scores for the English language websites, our analysis showed that there was a great variation in overall quality and content with room for improvement for both language types. English sites could make the biggest improvements by providing more information about their sponsors and who controls site content as well as updated and fixing links and author credentials. The Spanish sites should focus on improving information about their agenda and overall site design. For content, both types of sites need to provide more images and information on etiology and risk factors. Both English and Spanish sites scored highest in coverage of clinical presentation, treatment and follow-up care after treatment. Overall, this study identifies several information gaps and areas for improvements for oral cancer websites. We hope our results will be used to improve online oral cancer information.