The DDS results indicated small declines in medication adherence for cancer survivors native to beneficiaries without a cancer diagnosis in all three drug classes (3 to 5 percentage points), whereas longer term cancer survivors had much better adherence to all three drug classes (10 to 12 percentage points higher) relative to beneficiaries with cancer who had a poor prognosis. CONCLUSIONS: A diagnosis of colorectal cancer might be a trigger for improved medication adherence with evidence-based medications recommended in diabetes treatment guidelines.

PCN166
REGIONAL VARIATIONS IN HEALTH CARE EXPENDITURES AMONG MEDICARE BENEFICIARIES WITH COLORECTAL CANCER

Rane P.B., 1, Madhavan S., 1, Seung S.J., 1, Kalidindi S., 1, Hoch J., 1, Cheung M., 1, DeAngelis C., 1, Kalidindi S., 1, Madhavan S., 1, Newman AS., 2,1, \textit{Objectives:} To examine colorectal cancer treatment patterns in the initial phase-of-care among Medicare beneficiaries with colorectal cancer from a rural setting, and compare them with "national" estimates. METHODS: A population-based retrospective cohort-study was conducted on fee-for-service Medicare beneficiaries aged ≥66 years diagnosed with CRC between 2003-2006 identified from the West Virginia Cancer Registry (WVCCR)-Medicare linked database (n=2,119). A comparative cohort was identified from Surveillance, Epidemiology, and End Results (SEER)-Medicare (n=38,172). Medicare claim payment-amounts were used to calculate total average health care, inpatient, outpatient, physician-visits, and other health care-utilization expenditures. To control for geographic variation in cost-of-living across the different counties, health care-expenditures were expressed using county-specific cost-of-living indices (COLI). RESULTS: After COLI-adjustment, the average total health care expenditures in the first phase-of-care for colorectal cancer from the WVCCR-Medicare linked database were estimated at $46,644. The average total health care and inpatient expenditures in initial phase-of-care were found to be lower and significantly different (p<0.05) for those from WVCCR-Medicare as compared to those from SEER-Medicare. However, they had a higher co-morbidity burden, and significantly higher (45%) outpatient expenditures as compared to their "national" counterparts. Outpatient expenditures after specific diagnosis with chronic-conditions, which have a higher prevalence in the WVCCR-Medicare group as compared to those from SEER-Medicare. Further, the differences in total health care-expenditures between beneficiaries from WVCCR-Medicare and SEER-Medicare ranged from $2,892 to $898, and remained no longer significant in a multivariable setting after controlling for receipt of minimally-appropriate CRC treatment (MCT) and presence of chronic-conditions. CONCLUSIONS: This study highlights the importance of providing preventive health care services and better co-management of CRC and chronic-conditions, to control the higher outpatient expenditures among beneficiaries with CRC from a rural population. This study also showed that the differences in total health care-expenditures between rural and "national" populations were likely to be partially explained by the receipt of MACT and comorbidity-burden.

PCN167
TREATMENT AND SURVIVAL PATTERNS AMONG ELDERLY MEDICARE BENEFICIARIES WITH COLORECTAL CANCER: A COMPARATIVE ANALYSIS BETWEEN A RURAL STATE CANCER REGISTRY AND NATIONAL DATA

Rane P.B., 1, Kalidindi S., 1, Madhavan S., 1, Fan X. 1,2

\textit{Objectives:} To compare colorectal cancer (CRC) treatment patterns in the initial phase-of-care, the extent of receipt of minimally-appropriate CRC-treatment (MCT), the associated survival in a three-year period following a CRC-diagnosis in Medicare beneficiaries with CRC diagnosed with CRC from a rural setting, and to compare these findings with "national" estimates. METHODS: A population-based retrospective cohort-study was conducted with data from fee-for-service Medicare beneficiaries aged ≥66 years diagnosed with CRC between 2003-2006 identified from the West Virginia Cancer Registry (WVCCR)-Medicare linked database (n=2,119). A comparative "national" cohort was identified from Surveillance, Epidemiology, and End Results (SEER)-Medicare (n=38,168). CRC-treatment received was ascertained from beneficiaries' Medicare claims by following them for 12-months from their CRC-diagnosis date or until death. Receipt of MACT was defined based on National Cancer Institute CRC-treatment guidelines. All-cause and CRC-specific mortality in the 36-month period following CRC-diagnosis were examined after accounting for selection bias using inverse probability treatment weights. RESULTS: Although a higher proportion of beneficiaries from WVCCR-Medicare were diagnosed in the earlier stages of CRC (when it can still be treated effectively) as compared to their SEER-Medicare counterparts, they had poorer CRC-survivorship with adjusted hazards ratio (AHR)=1.26;95%CI=[1.20,1.32]. This poorer survivorship may be due to a lower likelihood (adjusted odds ratios [AOR]=0.85;95%CI=[0.76,0.96]) of beneficiaries from WVCCR-Medicare of receiving MCT as compared to their "national" counterparts. Differences in usage of CRC-surgery, chemotherapy and radiation were also observed in the two populations. Those from WVCCR-Medicare were less likely to receive any type of CRC-surgery with AOR=0.82;95%CI=[0.70,0.93]; CONCLUSION: This study highlights the need for an increased emphasis on adoption, and adherence to accepted surgical and adjuvant CRC-treatment guidelines, and improving access to CRC-care for those from rural settings. Further research needs to be conducted to determine if similar rural-urban differences in receipt of MACT exist in the elderly in other rural-areas of the nation.

PCN168
FIRST TWO YEARS OF HEALTH SYSTEM RESOURCES AND COSTS FOLLOWING A STAGED DEFINED BREAST CANCER DIAGNOSIS: A POPULATION-BASED APPROACH

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\textit{Objectives:} To determine the publicly funded health care costs associated with colorectal cancer in Medicare beneficiaries aged ≥66 years diagnosed with CRC from a rural setting, and compare with them with "national" estimates. METHODS: A population-based retrospective cohort-study was conducted with data from fee-for-service Medicare beneficiaries aged ≥66 years diagnosed with CRC between 2003-2006 identified from the West Virginia Cancer Registry (WVCCR)-Medicare linked database (n=2,114). Similarly, a comparative cohort was identified from Surveillance, Epidemiology, and End Results (SEER)-Medicare (n=38,172). Medicare claim payment-amounts were used to calculate total average health care, inpatient, outpatient, physician-visits, and other health care-utilization expenditures. To control for geographic variation in cost-of-living across the different counties, health care-expenditures were expressed using county-specific cost-of-living indices (COLI). RESULTS: After COLI-adjustment, the average total health care expenditures in the first phase-of-care for colorectal cancer from the WVCCR-Medicare linked database were estimated at $46,644. The average total health care and inpatient expenditures in initial phase-of-care were found to be lower and significantly different (p<0.05) for those from WVCCR-Medicare as compared to those from SEER-Medicare. However, they had a higher co-morbidity burden, and significantly higher (45%) outpatient expenditures as compared to their "national" counterparts. Outpatient expenditures after specific diagnosis with chronic-conditions, which have a higher prevalence in the WVCCR-Medicare group as compared to those from SEER-Medicare. Further, the differences in total health care-expenditures between beneficiaries from WVCCR-Medicare and SEER-Medicare ranged from $2,892 to $898, and remained no longer significant in a multivariable setting after controlling for receipt of minimally-appropriate CRC treatment (MCT) and presence of chronic-conditions. CONCLUSIONS: This study highlights the importance of providing preventive health care services and better co-management of CRC and chronic-conditions, to control the higher outpatient expenditures among beneficiaries with CRC from a rural population. This study also showed that the differences in total health care-expenditures between rural and "national" populations were likely to be partially explained by the receipt of MACT and comorbidity-burden.

PCN169
TREATMENT PATTERNS AMONG PATIENTS WITH BREAST CANCER: DOES INSURANCE STATUS MATTER?

Jiao X., Mu G., Cai Y.

\textit{Objectives:} To examine total medical expenditures in the initial phase-of-care for colorectal cancer among Medicare beneficiaries with diabetes significantly reduces adherence and comorbidity-burden.

This study highlighted the need for an increased emphasis on adoption, and adherence to accepted surgical and adjuvant CRC-treatment guidelines, and improving access to CRC-care for those from rural settings. Further research needs to be conducted to determine if similar rural-urban differences in receipt of MACT exist in the elderly in other rural-areas of the nation.