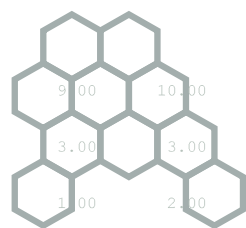


The HMO Cancer Research Network (CRN)



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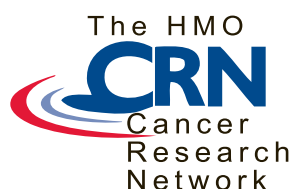


CAPACITY,
COLLABORATION,
AND INVESTIGATION

APRIL 2010 UPDATE

The HMO Cancer Research Network (CRN)

CAPACITY,
COLLABORATION,
AND INVESTIGATION



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LIST OF ABBREVIATIONS

ACOSOG = American College of Surgeons Oncology Group	HPV = Human Papillomavirus
AHRQ = Agency for Healthcare Research and Quality	IRB = Institutional Review Board
ARRA = American Recovery and Reinvestment Act	KPCO = Kaiser Permanente Colorado (Institute for Health Research)
BCSC = Breast Cancer Surveillance Consortium	KPG = Kaiser Permanente Georgia (Center for Health Research–Southeast)
caBIG® = Cancer Bioinformatics Grid	KPH = Kaiser Permanente Hawaii (Center for Health Research–Hawaii)
CanCORS = Cancer Care Outcomes Research and Surveillance Consortium	KPNC = Kaiser Permanente Northern California (Division of Research)
CCRC = Cancer Communication Research Center	KPNW = Kaiser Permanente Northwest (Center for Health Research–Northwest)
CDC = Centers for Disease Control and Prevention	KPSC = Kaiser Permanente Southern California (Department of Research and Evaluation)
CECCR = Center of Excellence in Cancer Communication Research	LCF = Lovelace Health System (Lovelace Clinic Foundation Research)
CER = Comparative Effectiveness Research	MCRF = Marshfield Clinic/Security Health Plan (Marshfield Clinic Research Foundation)
CERT = Center for Education and Research in Therapeutics	MPCI = Fallon Community Health Plan (Meyers Primary Care Institute)
CISNET = Cancer Intervention and Surveillance Modeling Network	NCI = National Cancer Institute
CRN = Cancer Research Network	NHGRI = National Human Genome Research Institute
cTAKES = Clinical Text Analysis and Knowledge Extraction System	NHLBI = National Heart, Lung and Blood Institute
CTSU = Cancer Trials Support Unit	NIH = National Institutes of Health
CVRN = Cardiovascular Research Network	NLP = Natural Language Processing
DCIS = Ductal Carcinoma <i>in situ</i>	NLST = National Lung Screening Trial
ECOG = Eastern Cooperative Oncology Group	NSABP = National Surgical Adjuvant Breast and Bowel Project
EMR = Electronic Medical Record	PA = Program Announcement
FDA = Food and Drug Administration	PLCO = Prostate, Lung, Colorectal and Ovarian Cancer Screening Trial
GHC = Group Health Cooperative (Group Health Research Institute)	RFA = Request for Applications
GHS = Geisinger Health System (Geisinger Center for Health Research)	RTOG = Radiation Therapy Oncology Group
GO Grant = Grand Opportunity Grant	SEER = Surveillance Epidemiology and End Results
HFHS = Henry Ford Hospital and Health System/ Health Alliance Plan (Department of Biostatistics and Research Epidemiology and Center for Health Services Research)	SELECT = Selenium and Vitamin E Cancer Prevention Trial
HIPAA = Health Insurance Portability and Accountability Act	SIG = Scientific Interest Group
HMORN = Health Maintenance Organization Research Network	SWOG = Southwest Oncology Group
HPHC = Harvard Pilgrim Health Care Institute and Harvard Medical School (Department of Population Medicine)	VDW = Virtual Data Warehouse
HPRF = HealthPartners (HealthPartners Research Foundation)	WHI = Women's Health Initiative

The utilization of health care systems as a platform for basic, clinical, and population sciences research is a central component of the National Cancer Institute's (NCI) strategic vision. In the 11 years since the HMO Cancer Research Network (CRN) was initiated as a cooperative agreement, the network has provided a framework for leading and working with others to address some of the most perplexing cancer research challenges.

The CRN has evolved to encompass research organizations affiliated with 14 large health care delivery systems covering nearly 11 million individuals, conducted dozens of joint research projects, and published over 175 peer-reviewed papers. It has become a national cancer research resource through increased support for data standardization and dissemination that facilitates collaboration with researchers outside the network.

Originally conceived as a "population laboratory" centered in community-based health care systems, the CRN is able to harness these organizations' data and health information systems, as well as their clinical staff and enrolled populations to conduct cancer etiology, epidemiology, and health services research. It allows for large, multicenter, multidisciplinary intervention research that addresses the spectrum of cancer control, including studies of prevention, early detection, treatment, survivorship, surveillance, and end-of-life care. The CRN is also uniquely positioned to study the quality of cancer care in community-based settings.

The generation of new research ideas is a core value of the CRN, and partnership is at the heart of every project. Through innovative research initiatives, strong leadership, and teamwork with top cancer experts across the country, the network has come to stand as a model for data sharing and collaborative research.

This publication was conceived as an important tool for laying out the CRN's goals and challenges by describing the CRN's research agenda, accomplishments, capacity, and future research potential as well as serving as a "user's guide" for potential collaborators. It is our hope that readers will gain a greater understanding of how to become partners in this scientific community, how to work successfully with CRN members, and how to utilize the CRN's unique research resources and scientific expertise. Readers will then have a greater capacity to undertake research projects that will both benefit the research community and advance knowledge crucial to the progress of cancer control in the United States.

I thank the many colleagues and investigators involved in the CRN, and our partner, the Agency for Healthcare Research and Quality, for their expertise, dedication, and enthusiasm in ensuring that the CRN continues to respond to NCI's priorities for the diffusion of cancer care innovations into practice and health services.

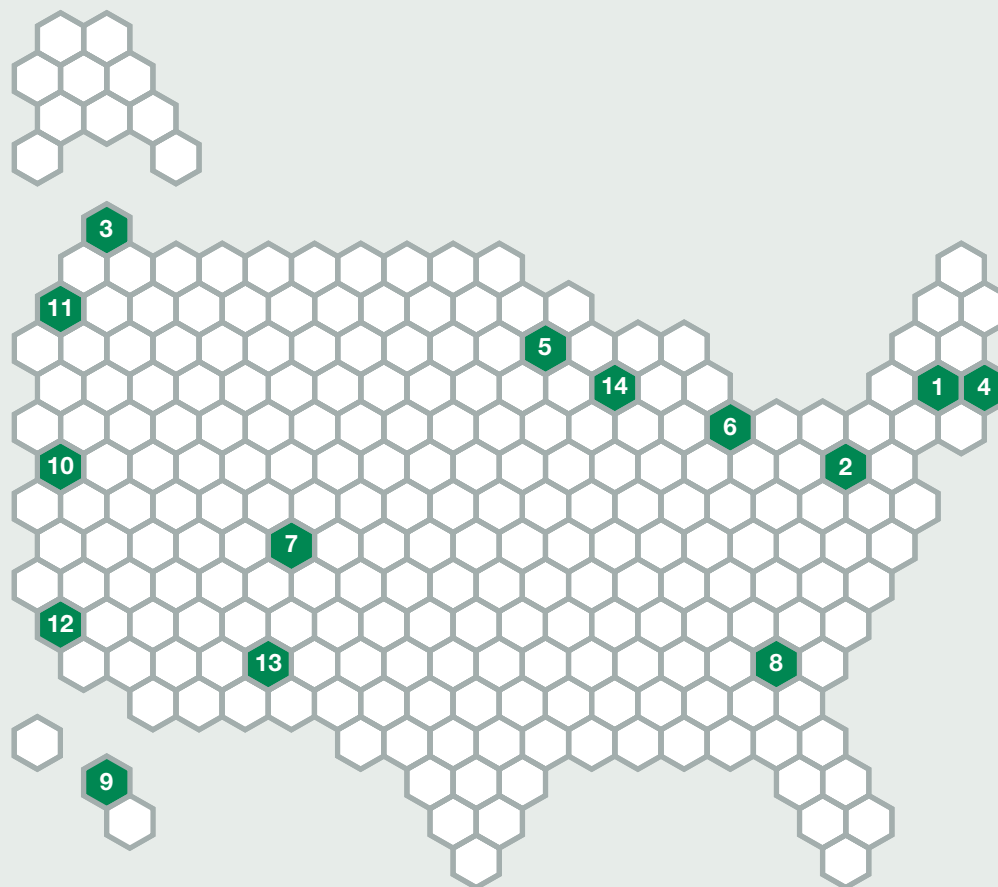


Robert T. Croyle, Ph.D.

*Director, Division of Cancer Control and
Population Sciences
National Cancer Institute*

OVERVIEW

Cancer Research Network Sites & Participating Delivery Systems



- | | | |
|--|--|--|
| <p>1 Fallon Community Health Plan,
Meyers Primary Care Institute (MPCI)</p> <p>2 Geisinger Health System,
Geisinger Center for Health Research (GHS)</p> <p>3 Group Health Cooperative,
Group Health Research Institute (GHC)</p> <p>4 Harvard Pilgrim Health Care Institute and Harvard Medical School,
Department of Population Medicine (HPHC)</p> <p>5 HealthPartners,
HealthPartners Research Foundation (HPRF)</p> | <p>6 Henry Ford Hospital and Health System/Health Alliance Plan,
Department of Biostatistics and Research Epidemiology and Center for Health Services Research (HFHS)</p> <p>7 Kaiser Permanente Colorado,
Institute for Health Research (KPCO)</p> <p>8 Kaiser Permanente Georgia,
The Center for Health Research-Southeast (KPG)</p> <p>9 Kaiser Permanente Hawaii,
The Center for Health Research-Hawaii (KPH)</p> <p>10 Kaiser Permanente Northern California,
Division of Research (KPNC)</p> | <p>11 Kaiser Permanente Northwest,
The Center for Health Research-Northwest (KPNW)</p> <p>12 Kaiser Permanente Southern California,
Department of Research and Evaluation (KPSC)</p> <p>13 Lovelace Health System,
Lovelace Clinic Foundation Research (LCF)</p> <p>14 Marshfield Clinic/ Security Health Plan,
Marshfield Clinic Research Foundation (MCRF)</p> |
|--|--|--|

The Cancer Research Network (CRN) is a consortium of 14 non-profit research centers based in large, integrated health care delivery organizations. Collectively, these organizations provide care to nearly 11 million individuals.

To achieve its scientific goals, the CRN fosters collaborations among CRN investigators and with investigators and research institutions outside of the CRN member organizations.

The CRN is funded through a National Cancer Institute (NCI) cooperative agreement grant that ensures substantial NCI involvement in attaining research goals and catalyzing new collaborations. The Agency for Healthcare Research and Quality (AHRQ) also supports the CRN, especially in the area of protecting research data for the purposes under which they were originally collected.

CRN research focuses on examining the characteristics of patients, families, clinicians, communities, and healthcare systems that lead to the best possible outcomes in cancer prevention, treatment, survivorship, and end-of-life care. The CRN also develops and uses standardized

approaches to data collection, data management, and analyses across health systems. By starting from the foundation of integrated health care delivery systems with defined populations and comprehensive health informatics systems, the CRN is able to measure complete episodes of all types of care, including prevention, screening, diagnosis, treatments (neoadjuvant, primary, adjuvant), surveillance for metastases and recurrence, secondary preventive care, and end-of-life care.

Beginnings

In 1997, the National Cancer Institute (NCI) issued a Request for Applications (RFA) entitled “Cancer Research Network Across Health Care Systems.” In doing so, it acknowledged the need for data from representative populations with lengthy follow-up periods and a comprehensive range of patient information to examine important questions about prevention, diagnosis, treatment, long-term outcomes, costs, and other issues important to cancer care delivery, cancer patients, and overall health. By virtue of their organized care structures, defined populations, and extensive data systems, health maintenance organizations (HMOs) were seen as promising venues and as a strategic resource to address unmet research needs. Previously, comprehensive health care utilization and cost information related to cancer prevention and care was largely limited to the NCI-supported Surveillance

Epidemiology and End Results (SEER)–Medicare linked data for non-HMO cancer patients aged 65 and older. However, NCI envisioned a research network that would include population-based data for people younger than 65 and those at risk for cancer, including children. The CRN’s response to the RFA grew out of discussions among leaders of the established HMO Research Network (HMORN) and now includes 14 of the 16 HMORN members, all of which have an established program in cancer research and are based in integrated healthcare delivery systems.

CRN1: 1999–2003

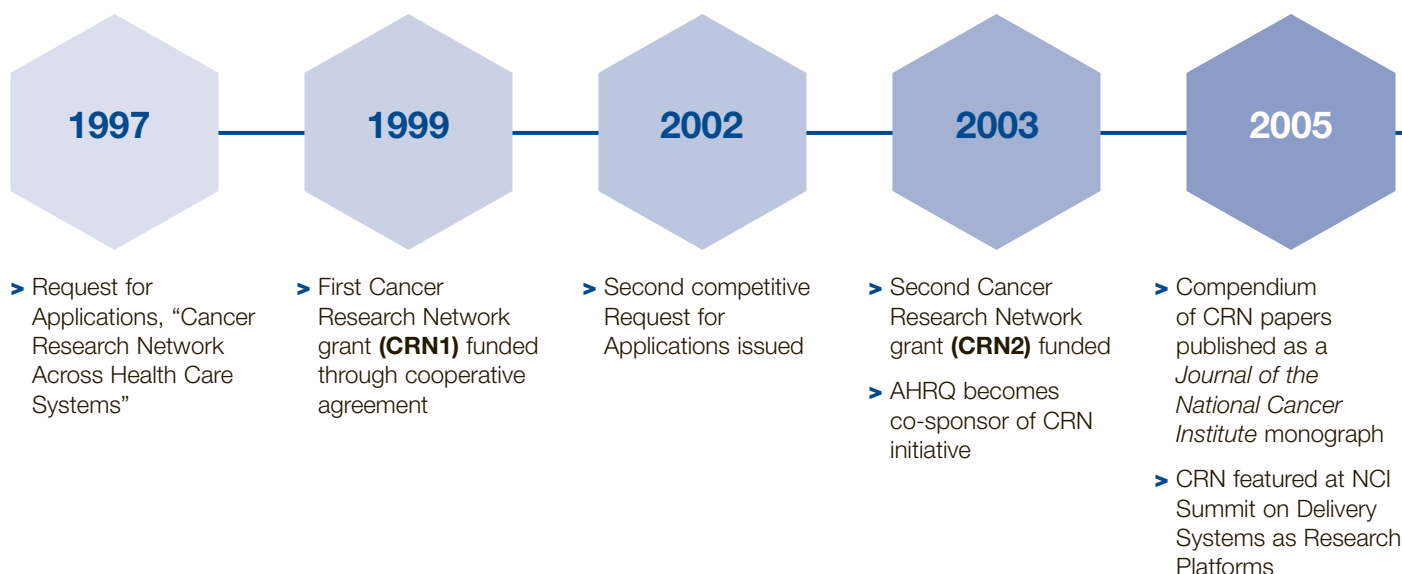
The first CRN grant cycle (CRN1) included 10 funded sites and one affiliate site. CRN1 aimed to improve the effectiveness of cancer prevention and care through research that identified system, provider, and patient factors affecting outcomes. The CRN’s initial core research projects focused on three areas paramount to cancer control: effectiveness of breast and cervical cancer screening in community practice; extent of adherence to tobacco control guidelines at the system, provider, and patient levels; and efficacy of prophylactic mastectomy and early screening among women at increased risk for breast cancer. Several administrative supplements, R01 grants, and other funded projects added to the CRN’s initial research portfolio.

CRN2: 2003–2007

The second CRN grant cycle (CRN2) included 11 funded sites and two affiliate sites. Core research projects included in CRN2 broadened the scope of the original investigations to include randomized trials examining the use of electronic medical records (EMRs) to improve adherence to tobacco control guidelines, and the effectiveness of an individually tailored, Web-based program to promote daily fruit and vegetable consumption. A third project studied the clinical and pathologic predictors of recurrence among women with ductal carcinoma in situ (DCIS). As with the previous

grant, several supplements, R01 grants, and pilot funds augmented the core research, including a multi-center study of pancreatic cancer etiology and several information technology studies aimed at improving the research capacity of the CRN's data and informatics resources. The Virtual Data Warehouse (VDW), a pivotal tool to facilitate multi-site cancer research through development of standardized, interoperable data files across multiple CRN sites, was a key product of CRN2. In addition, the DCIS and pancreatic cancer

projects expanded CRN's scientific agenda to include linking of biomarker examinations with population-based studies. CRN2 was also marked by formal collaborations with cancer centers and increased efforts to support the professional development of junior investigators through mentorship and availability of pilot funds for small studies.

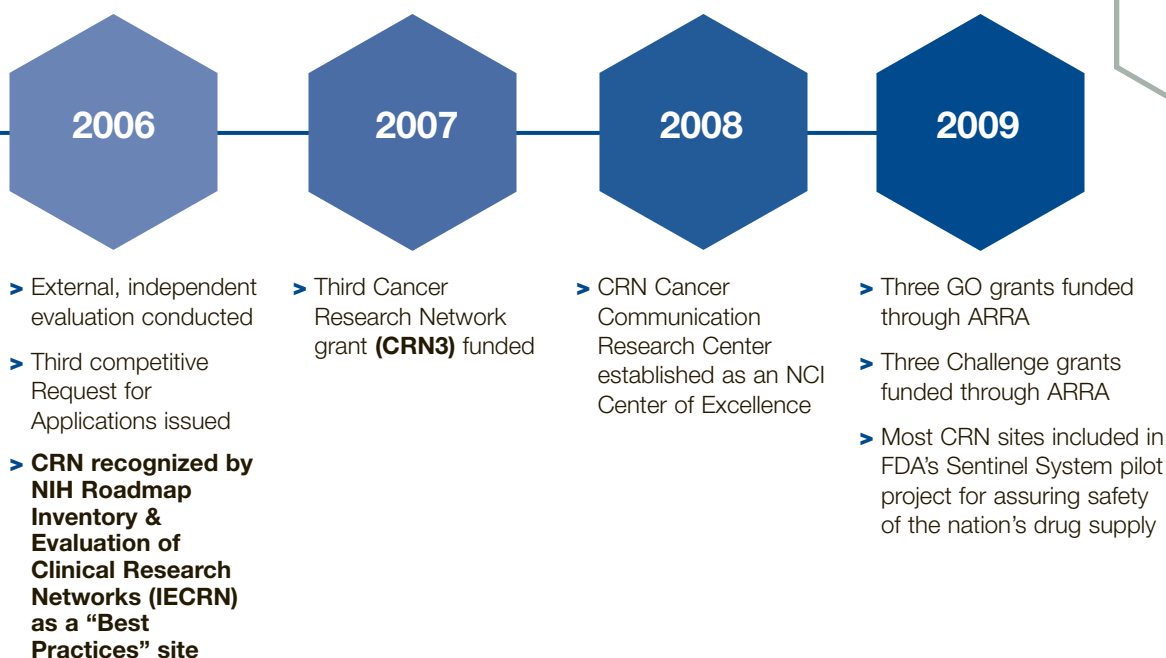


CRN3: 2007–2012

The third CRN grant cycle (CRN3) includes 14 funded sites. Activities in CRN3 involve increasing collaboration with external researchers, research institutions, and networks outside the CRN member organizations; further development of standardized data resources, particularly informatics; increasing support and focus on career development for junior investigators through a formalized CRN Scholars Program; and the initiation of a pilot grant program with more funding opportunities than during CRN2. In addition, core research projects are investigating the economic burden of cancer, developing and testing measures of oral health literacy, and examining the potential for applying metrics to

assess the quality of preventive care for cancer. With its emphasis on data infrastructure and collaborative capacity, CRN3 also provides an ideal research platform for addressing the newly emerging area of Comparative Effectiveness Research (CER). In 2009, CRN investigators and collaborators successfully competed for multiple CER grants, including three NCI Grand Opportunity (GO) grants to support initial development of Centers for CER in the areas of screening, treatment, and genomic medicine and three NCI Challenge grants in the areas of data

development using natural language processing, effectiveness of hormonal therapy for localized prostate cancer, and improving surgical quality for breast cancer. The success of the CRN has inspired other NIH Institutes to adopt and replicate this model for their own research needs.





RESEARCH THEMES

In 2008, scientists from the National Institutes of Health (NIH) and the CRN, advisors, non-CRN cancer researchers, and patient advocates participated in a concept mapping process to identify scientific priorities for the CRN. The following eight CRN priority research themes that emerged from this exercise, although not exclusive, include most of the CRN's current work, as well as areas of particular interest for future research.

Health Care Delivery, Quality, Costs, and Outcomes

Examining the influence of alternate health care delivery processes on quality, cost, and outcomes is a key foundation of CRN research centers. Studies in this area address the nature and quality of services for cancer prevention, screening, treatment, supportive care, and survivorship care, and their impacts on health outcomes and costs. The relatively large number of clinical sites and the size and diversity of CRN patient populations facilitate studies of practice variation and disparities in care and outcomes, as well as intervention studies.

Health Insurance Benefit Design and Patterns of Care Utilization

Innovations in benefit structure that improve care can be advanced with research that examines the relationships among patients' benefit design, in the form of cost sharing or out-of-pocket costs for medical services (e.g., copayments, coinsurance, deductible rates); patient use of cancer prevention, screening, and treatment services; and outcomes.

Cancer Epidemiology, Prevention, and Health Promotion

The CRN consists of large and diverse populations for conducting cross-sectional, case-control, cohort, and randomized controlled intervention studies to examine numerous cancer-related conditions, including rare outcomes. Studies of health promotion strategies, lifestyle changes, and risk factor assessment and identification all benefit from being conducted in the HMO setting. This setting enhances the ability to define populations to facilitate recruitment and follow-up, work with the health care system to improve retention of study participants, and provide detailed information on medical care and comorbid conditions that may impact patient outcomes of interest.

Enhancing Cancer Communication and Decision-Making

With its extensive data on patients, providers, health care delivery, and patient outcomes, a key CRN strength is the capacity to examine and optimize the quality of patient communication and decision-making about cancer screening, diagnosis, treatment, and survivorship in diverse populations. CRN studies in this area examine a wide range of issues—from shared clinical decision-making to Web-based consumer information.

Dissemination and Implementation Research in Cancer Prevention, Screening, and Treatment

The CRN's population size, diversity, and data resources provide rich opportunities to study cancer prevention and care in different care settings, patient populations, and regions of the country over time. Of particular interest are studies of the introduction of new diagnostic and treatment modalities and their diffusion into practice, as well as the conduct of pharmacoepidemiologic and pharmacogenomic studies of the effectiveness of cancer drugs and related prognostic markers as delivered in community practice.

Psychosocial Factors and Burden of Cancer

Factors such as education, financial assets, literacy, psychosocial distress, and costs of treatment have an impact on cancer care, patient outcomes (such as quality of life), and patient care experiences. Studies that characterize these effects are the basis for identifying and developing interventions to ameliorate them. Examining disparities in cancer access, outcomes, and treatment, as well as in the effectiveness of psychosocial interventions for cancer patients, are priority research areas.

Data Resources and Infrastructure

CRN member organizations have electronic medical records (EMRs), patient Web sites with secured communication access to providers, and rich arrays of current and historical electronic data on enrollee populations. A major priority is the continued improvement of the CRN standardized data infrastructure and the development and testing of research, surveillance, and medical practice innovations built upon EMRs, patient Web portals, computer-based physician order entry systems, and automated records of complete health service utilization.

Building Capacity to Support Emerging Areas of Cancer Control Research

CRN investigators and health care organizations have tremendous potential to advance research activities to develop, enhance, and test health informatics, database, and biospecimen tools and resources to support research in areas such as cancer risk assessment and modeling; studies of behavioral, environmental, and genetic factors; and personalized health care approaches to preventive care, screening, diagnosis/prognosis, and treatment. In addition, the CRN aims to develop activities to increase the timeliness, efficiency, and effectiveness of recruitment to phase 2 and phase 3 prevention and treatment trials.



COMPARATIVE EFFECTIVENESS RESEARCH (CER)

Recently, comparative effectiveness research (CER) has emerged as a national priority. Much of the previous and emerging CRN research has been focused in this area, and it remains a high priority within the Network.

What is CER?

CER is the conduct and synthesis of research comparing the benefits and harms of interventions and strategies to prevent, diagnose, treat, and monitor health conditions in “real world” settings. The purpose of this research is to improve health outcomes by developing and disseminating evidence-based information to patients, clinicians, and other decision-makers, responding to their expressed needs about which interventions (e.g., medications, procedures, medical and assistive devices and technologies, diagnostic testing, behavioral change, delivery system strategies) are most effective for which patients under specific circumstances.

CER is generally conducted using:

- Randomized controlled clinical trials
- Observational studies of retrospective and prospective cohorts, including secondary data analysis of registries and linked databases
- Simulation modeling

As part of the 2009 American Recovery and Reinvestment Act (ARRA), the Department of Health and Human Services received \$400 million to invest in CER. CRN sites and their collaborators successfully competed for ARRA funds, resulting in almost \$10 million in additional awards. Most of these additional dollars will be used to conduct CER studies. The CRN continues to respond to federal funding announcements to work on CER-related studies.

CER in the CRN

Much of the work that the CRN has conducted in CER to date has been through observational studies, particularly secondary data analyses or primary data collection enhanced with secondary data. In moving forward, however, the CRN is committed to developing infrastructure to conduct prospective, pragmatic clinical trials in CER, which will likely emerge as critical tools for evidence-based decision-making. The CRN is ideally poised to develop such an infrastructure in the integrated health care delivery setting that will allow investigators to rapidly and efficiently mount trials that address real-world questions in population laboratory models.

The HMO Research Network, a consortium of large health maintenance organizations... may serve as a model for its capacity to implement studies and capture data within the context of usual care.

Sean R. Tunis; Daniel B. Stryer; Carolyn M. Clancy. Practical Clinical Trials: Increasing the Value of Clinical Research for Decision Making in Clinical and Health Policy. *JAMA*. 2003;290(12):1624–1632.

ARRA Funding for CER Projects

The following two-year projects pertaining to CER were proposed by CRN investigators and funded by NIH using 2009 ARRA funds:

Research on the Effectiveness of Advanced Cancer Treatments (REACT)

Principal Investigators: Jane C. Weeks (Dana-Farber Cancer Institute) and Debra Ritzwoller (KPCO); CRN Sites: KPCO, KPG, KPNC, KPNW, GHC; Non-CRN Site: Dana-Farber Cancer Institute

This project will use the CRN VDW and other large databases to evaluate alternative therapeutic approaches for patients with advanced cancer, and to build capacity within the CRN to conduct large, efficient prospective CER trials.

Comparative Effectiveness in Genomic and Personalized Medicine for Colon Cancer

Principal Investigators: Katrina Goddard (KPNW), Evelyn Whitlock (KPNC), and Lawrence Kushi (KPNC); CRN Sites: KPNW, HFHS, HPRF, KPCO, KPH, KPNC, MCRF, KPH, KPG; Non-CRN Sites: Georgetown University, Oregon Health & Sciences University

This project will use primary and secondary data to investigate the comparative effectiveness of two tests related to colorectal cancer, the KRAS test and the Lynch syndrome prediction test, and will evaluate the utilization of these tests.

SEARCH: Cancer Screening Effectiveness and Research in Community-based Healthcare

Principal Investigators: Diana Buist (GHC) and Chyke Doubeni (MPCI); CRN Sites: GHC, GHS, HPRF, KPH, KPNC, KPNW, GHS, MCRF, MPCI; Non-CRN Sites: University of Massachusetts, University of Washington

This project will study effective cancer screening delivery approaches to enhance colorectal and cervical cancer detection, diminish morbidity and other adverse effects, and reduce mortality; develop a stronger CRN collaboration with the NCI-sponsored Cancer Intervention and Surveillance Modeling Network (CISNET); and, develop methodological capacity for future large-scale, population-based CER studies in the area of cancer screening to address important evidence gaps.

Natural Language Processing for Cancer Research Network Surveillance

Principal Investigator: David Carrell (GHC); CRN Sites: GHC, HFHS; Non-CRN Sites: University of Pittsburgh Medical Center, Vanderbilt University, Mayo Clinic

This project will develop new measurement technologies for extracting disease and treatment information from text data available in EMRs to advance epidemiologic and clinical breast cancer research and will develop an algorithm to identify recurrent breast cancer diagnoses.

Improving Breast Cancer Surgery Quality through a Collaborative Surgery Database

Principal Investigator: Laurence McCahill (Van Andel Research Institute); CRN Sites: GHC, KPCO, MCRF; Non-CRN Sites: Van Andel Research Institute, University of Vermont

This project will develop a breast cancer surgery outcomes database enabling CER studies to be conducted, particularly as related to current controversies in the management of breast cancer, such as an appropriate pathologic margin of clearance in partial mastectomies, which can be used to improve outcomes and reduce health care costs.

Cost-Effectiveness of Hormonal Therapy for Clinically Localized Prostate Cancer

Principal Investigators: Stephen K. Van Den Eeden (KPNC), Marianne Ulcickas Yood (HFHS), and Arnold Potosky (Georgetown University); CRN Sites: KPNC, HFHS; Non-CRN Site: Georgetown University

This project will provide information on the risks and potential benefits of immediate androgen deprivation therapy in men diagnosed with localized prostate cancer, and will help to estimate costs, calculate the cost-effectiveness, and determine the cost-utility of this treatment.



COLLABORATING WITH THE CRN

Visit the CRN Web site (<http://crn.cancer.gov>) to learn about CRN data resources and research priorities, and to see how well they fit your research interests and data needs.

If you are interested in collaborating with the CRN, you will need to complete the Web inquiry form found on the CRN Web site. This form is used to describe:

- Any current or previous involvement with the CRN
- A statement of your main research questions and hypotheses
- The nature of the data needed from the CRN to address your research questions
- A description of your project team or potential collaborators
- An estimated timeline for proposal development and submission
- The type of proposal you are planning to submit (e.g., an NIH R01), and whether it is in response to a particular Request for Applications (RFA) or Program Announcement (PA)

The Principal Investigator's office will connect you with appropriate partners at one or more CRN sites or affiliates to determine whether your interests and/or data needs align with the CRN.

Promising collaborations generally lead either directly to the development of a research proposal, or to participation by external collaborators in a CRN Scientific Interest Group (SIG). The CRN has developed guiding principles for initiating and participating in CRN SIGs, which are forums that enable investigators interested in a particular topic to discuss research interests and ideas.

For collaborations leading to proposals, the following resources assure effective communication and increase the likelihood of a successful proposal.

- The CRN New Proposals Committee has outlined policies and procedures for reviewing and submitting new collaborative proposals. The Committee assesses feasibility, potential for overlap with existing projects, and appropriateness of the CRN as the setting to answer your research questions.

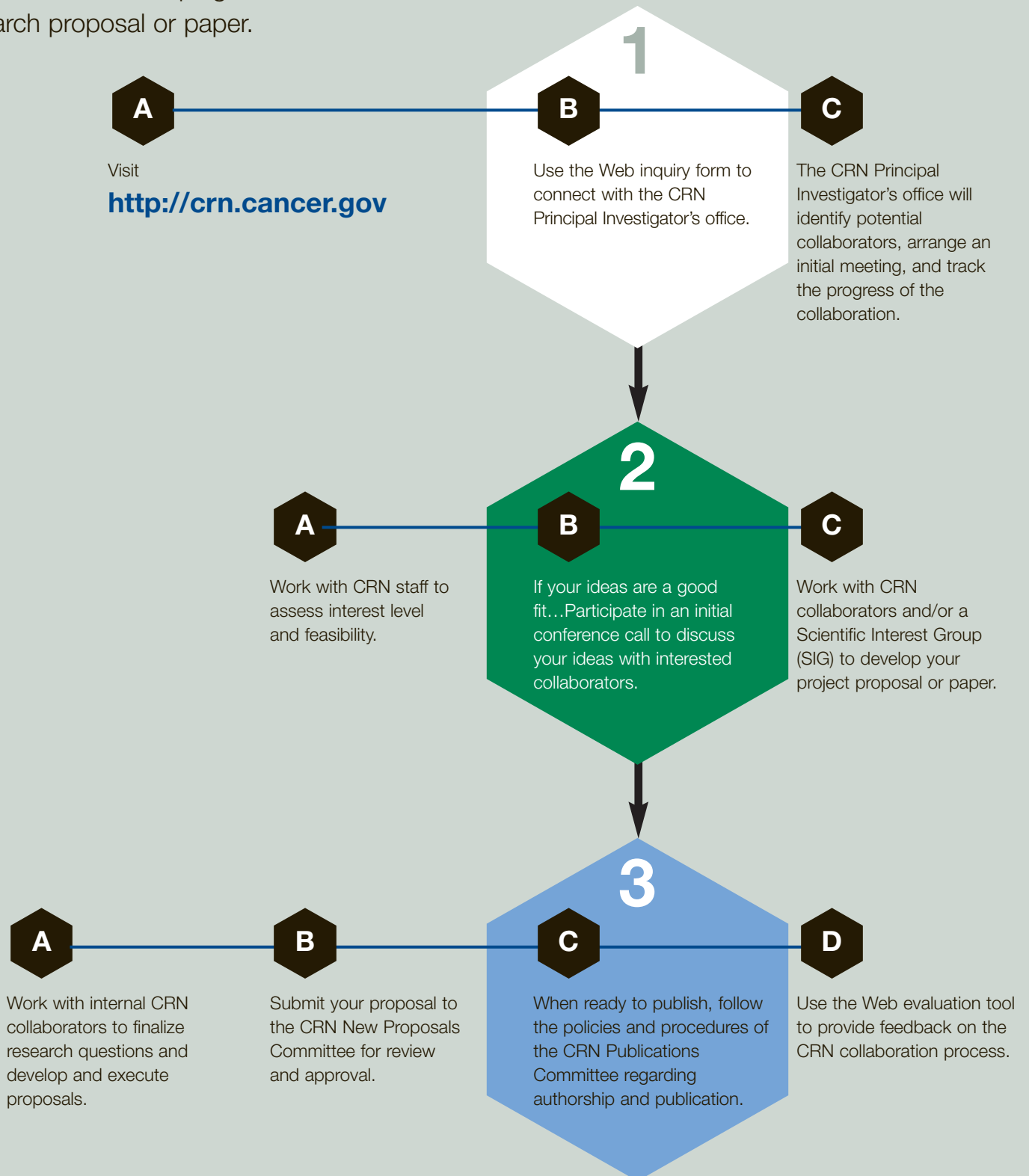
- Experienced CRN investigators are available for direct involvement in all aspects of the research, including research design, conduct, analysis, and dissemination.
- CRN sites contributing data to your project will review and comment on your research proposal.
- The CRN Publications Committee has outlined policies and procedures for authorship and publication of CRN-related research.

This has been an outstanding opportunity to broaden our collaborations with researchers beyond the University and to connect our faculty to populations for the study of cancer. From the Cancer Center's perspective, our clinicians (in particular) will have new opportunities to study various aspects of cancer prevention, early detection, treatment, and survivorship questions.

DeAnn Lazovich, Ph.D., Associate Professor, Division of Epidemiology and Community Health, University of Minnesota

Collaboration at a Glance

A successful collaboration involves sharing ideas, aligning with CRN priority areas of research, and developing an innovative research proposal or paper.





EXAMPLES OF CRN COLLABORATIONS

The CRN recognizes the critical importance of growth through collaboration with both internal and external research partners and has made this a high priority since its inception.

Collaboration with external partners, such as affiliated cancer centers, other academic institutions, research consortia and networks, and NCI researchers has enabled the CRN to initiate studies that might not have otherwise been possible. Fruitful collaborations among large, established entities require thoughtful negotiation and recognition of the interpersonal, technical, and financial considerations of all parties. The CRN has developed a large knowledge base on how to successfully collaborate with other groups, as evidenced by the myriad partnerships in which they are engaged.

Collaboration with Cancer Centers

The NCI-designated Cancer Centers are a major source of discovery regarding the nature of cancer and the development of more effective approaches to cancer prevention, diagnosis, and therapy. They also deliver medical advances to patients and their families, educate health care professionals and the public, and reach out to underserved populations. The CRN's growing

collaborations with NCI-designated Comprehensive Cancer Centers provide vehicles for facilitating and triaging research inquiries and also provide access to critical scientific expertise. In particular, external biomedical and clinical collaborators (e.g., oncology researchers, pathologists) have played critical scientific roles in CRN research projects. Eight CRN sites currently have active collaborations with Cancer Centers.

Harvard Pilgrim Health Care Institute in Boston was the first group to initiate an affiliation agreement on behalf of the CRN with the Dana-Farber Cancer Institute/Harvard Cancer Center (DF/HCC). The agreement was signed in 2005 and has since served as a model for other CRN-Cancer Center partnerships with the following universities: Oregon Health Sciences, Hawaii, Emory, California–San Francisco, Wisconsin, Minnesota, and New Mexico.

Example: Through a partnership between the CRN and DF/HCC, investigators funded through a CER grant are developing a resource to support high quality cancer CER that addresses two key knowledge gaps: (1) treatment of advanced disease and (2) patterns and outcomes of cancer care for patients not represented in the SEER-Medicare database (e.g., patients younger than 65, patients receiving their care through an HMO). This project will generate new and improved methods to help advance

the field of cancer CER, and it will provide insights into the nature and causes of variation in important patterns of cancer care.

Collaboration with Academic Institutions

The reach and visibility of the CRN has extended into the academic research community, which has increased access to superb investigators and biologic laboratories. Collaborations are facilitated by the Academic Liaison Committee, which was designed to advise the CRN on overall objectives, provide guidance on directions for new research, and identify potential collaborators outside of CRN sites. Many new collaborations and ties have developed as a result of this Committee's involvement.

Example: Researchers from the CRN have teamed up with investigators at Van Andel Research Institute and the University of Vermont to expand the University of Vermont's electronic breast cancer surgical outcomes database to three CRN sites. Researchers will use this database to develop and assess measures of surgical quality by examining variation in outcomes of initial breast cancer surgery at the patient, surgeon, hospital, and geographic levels. They will explore how this system can be implemented in other CRN sites, with a long-term goal of facilitating comparative effectiveness research throughout the network, especially in the area of breast cancer management.

The National Cancer Institute (NCI) has created the potential for rapid breakthroughs in clinical science through computerized databases, data sharing, and networked research communities. The NCI supports the Cancer Research Network (CRN), with the HMO Research Network, an alliance of... large research health maintenance organizations (HMOs) that have ten [now eleven] million enrollees, with compatible electronic health record (EHR) systems and research programs.... The NCI-funded CRN is already a model for collaborative cancer networks...

Lynn M. Etheredge. Medicare's Future: Cancer Care. *Health Affairs* 2009;28:148–159.

Example: Researchers from seven CRN sites are collaborating with investigators from the University of California–San Francisco to investigate patterns and variability of medical imaging over time and patterns of radiation exposure associated with medical imaging. These data will provide critical information that will allow researchers to estimate the increased risk of radiation-sensitive cancers associated with medical radiation exposure as a result of imaging.

Collaboration with Federally Funded Research Consortia and Networks

The CRN provides a platform for rapidly conducting population-based studies, which has been leveraged by federally funded research consortia and scientists within the government.

The Clinical and Translational Science Awards (CTSA) program, which is funded by the NIH National Center for Research Resources, uses a consortium model to create academic homes for clinical and translational science across the country by developing teams of researchers to bring laboratory science into the clinic. The CRN is well positioned to collaborate with this national consortium because it provides a population-based health care environment in which to conduct further research. Eight CRN sites currently are members or have partnerships with members of the CTSA consortium.

Example: The Oregon Clinical and Translational Research Institute (OCTRI) is one example of a CRN-CTSA collaboration. Oregon Health Sciences University and Kaiser Permanente Northwest have teamed up to accelerate the translation of research from bench to bedside to populations and develop feedback loops from clinical trials and population science back to basic scientists. By bringing together a strong biomedical research university and an innovative practice-based research center associated with a large patient population, OCTRI is attempting to remove barriers to the pace and growth of research and improve patient care.

Example: Nine CRN research programs participate in an AHRQ-funded Center for Education and Research in Therapeutics (CERT). For the past few years, CRN and CERT leadership have met regularly to discuss the development of the VDW to ensure that it can meet the needs of both networks. The proposed program to study the diffusion, cost, and outcomes of new cancer therapy innovations takes advantage of the pharmacoepidemiologic experience and skills of our CERT colleagues.

Example: The CRN is also involved with other NCI research consortia and cooperative groups. CRN work includes actively enrolling patients to cancer treatment clinical trials through cooperative groups such as the: National Surgical Adjuvant Breast and Bowel Project (NSABP),

Southwest Oncology Group (SWOG), Radiation Therapy Oncology Group (RTOG), American College of Surgeons Oncology Group (ACOSOG), Eastern Cooperative Oncology Group (ECOG), and Cancer Trials Support Unit (CTSU).

Investigators affiliated with the CRN also have helped to recruit patients into prevention and screening trials such as the Prostate, Lung, Colorectal and Ovarian (PLCO) Cancer Screening Trial, the National Lung Screening Trial (NLST), and the Selenium and Vitamin E Cancer Prevention Trial (SELECT). The CRN is a participating research site of the NCI Cancer Care Outcomes Research and Surveillance Consortium (CanCORS).

Example: CRN investigators have also formed collaborations with intramural researchers at NCI. Researchers from both organizations are teaming up to investigate the association between chronic immune stimulation and risk of lymphomas and related precursor conditions. Conducting this study within the CRN framework will improve on previous studies because the results will be more generalizable to the U.S. population and researchers will be better able to capture exposures through use of both inpatient and outpatient data. Incorporation of laboratory, medication, and survival data will also provide a more comprehensive picture of the issues surrounding lymphomagenesis.

CAPACITY

With 14 research centers based in large, integrated health care delivery organizations nationwide, the CRN is heavily influenced by its proximity to and familiarity with the day-to-day provision of cancer prevention, diagnosis, and care.

All CRN sites are longstanding organizations with a stable presence

in their communities. They also offer research centers and highly skilled investigators who understand their enrollee populations, the organization and delivery of care, and the associated data systems.

Population Coverage

CRN member organizations have a combined population of nearly 11 million enrollees. The age and sex distributions of enrollees collectively reflect those of the general U.S. population, although individual plans vary widely. The CRN includes population centers with a high percentage of African Americans (Henry Ford Hospital and Health System/Health Alliance

Plan, Harvard Pilgrim Health Care Institute, and Kaiser Permanente Georgia); Asian Americans (Kaiser Permanente Hawaii, Kaiser Permanente Northern California, and Kaiser Permanente Southern California); Hispanics (Lovelace Health System, Kaiser Permanente Southern California, Kaiser Permanente Northern California, and Kaiser Permanente Colorado); and rural and under-served rural populations (Geisinger Health System and Marshfield Clinic). Racial, ethnic, and socioeconomic diversity is an important strength of the CRN, which permits studies emphasizing effectiveness research focused on these subpopulations.

QUICK FACTS

- > Between 1999 and 2009, CRN researchers have published more than 175 peer-reviewed journal articles on CRN-related projects.
- > Across the CRN sites, there are over 200 scientific and program staff conducting and supporting cancer research.
- > Most of the CRN sites actively enroll patients to cancer treatment clinical trials through cooperative groups, such as the NSABP, SWOG, RTOG, ACOSOG, ECOG, and CTSU. Investigators affiliated with the CRN also have helped to recruit patients into prevention and screening trials such as the PLCO Cancer Screening Trial, the NLST, and the SELECT.
- > CRN partnerships and affiliations include the HMO Research Network, many NCI-designated Cancer Centers, and several federal agencies, including NCI, NHLBI, NHGRI, CDC, and AHRQ.
- > The CRN has significantly leveraged its core funding since the original grant to develop and receive many infrastructure or core research grants; administrative or minority supplements; pilot studies; challenge grants; and GO grants.
- > Investigators from the CRN have participated in other funded work, including R21, R01, U01, P50, and training grants as well as career awards.

Characteristics of the CRN Research Centers

	GHC	GHS	HFHS	HPHC	HPRF	KPCO	KPG	KPH	KPNC	KPNW	KPSC	LCF	MCRF	MPCI
Year Established	1983	2003	1948	1969	1989	1991	1998	1991	1961	1964	1975	1990	1959	1996
2009 Funding, Millions	36	8.9	60.9	30	10.5 (2008)	14.4	2.3	4	73	35 (2008)	25.9	4.9	27 (2008)	2.9
% Extramural	92	90	81	84	69.6	54	75	90	80	90	72	100	40	80
# Full-time M.D./Ph.D. -level staff	36	18	80	38	19	30	3	4	46	54	20	6	26	10
# Programmers	42	2	23	8	15	23	3.5	4	88	24	31	3	15	4
Total Staff	297	120	484	140	88	111	12	34	509	250	186	31	190	24
Research Facilities														
Survey Research	•	•	•	•	•	•		•	•	•		•	•	•
Clinical Center	•	•	•	•	•		•	•	•	•			•	•
Chart Abstraction	•	•	•	•	•	•	•	•	•	•	•	•	•	•

Key (table column heads, pages 17–18):

GHC = Group Health Cooperative (Group Health Research Institute)

GHS = Geisinger Health System (Geisinger Center for Health Research)

HFHS = Henry Ford Hospital and Health System/Health Alliance Plan (Department of Biostatistics and Research Epidemiology and Center for Health Services Research)

HPHC = Harvard Pilgrim Health Care Institute and Harvard Medical School (Department of Population Medicine)

HPRF = HealthPartners (HealthPartners Research Foundation)

KPCO = Kaiser Permanente Colorado (Institute for Health Research)

KPG = Kaiser Permanente Georgia (Center for Health Research-Southeast)

KPH = Kaiser Permanente Hawaii (Center for Health Research-Hawaii)

KPNC = Kaiser Permanente Northern California (Division of Research)

KPNW = Kaiser Permanente Northwest (Center for Health Research-Northwest)

KPSC = Kaiser Permanente Southern California (Department of Research and Evaluation)

LCF = Lovelace Health System (Lovelace Clinic Foundation Research)

MCRF = Marshfield Clinic/Security Health Plan (Marshfield Clinic Research Foundation)

MPCI = Fallon Community Health Plan (Meyers Primary Care Institute)

Characteristics of the Health Plans

	GHC	GHS	HFHS	HPHC	HPRF	KPCO	KPG	KPH	KPNC	KPNW	KPSC	LCF	MCRF	MPCI
Year Established	1947	1915	1976	1969	1957	1969	1985	1958	1945	1942	1947	1973	1916	1977
Structure, %														
Staff/Group	80	90	100	20	15	100	90	100	100	100	100	52	70	53
Independent Phys. Assn.	20	10	0	80	0	0	10	0	0	0	0	48	30	46
Preferred Provider	0	0	0	0	85	0	0	0	0	0	0	0	0	1
Clinic Sites	33	60	27	14 ^a	45	18	10	17	159	28 ^b	150	20 ^c	48	20
Total enrollment, x 1,000^d	617	229	208	762	717	451	271	216	3,130	471	3,324	194	160	220
1-year retention	84	82	99.5	78	73	83	87	85	87	82	87	78	92	95 ^e
3-year retention	66	54	86.4	47	46	66	67	72	75	66	70	66	78	92
5-year retention	55	41	62.6	35	38	56	54	63	66	57	59	57	68	92
Age, Years, %														
0-17	20	19	18	24	25	22	24	22	22	23	25	39	24	19
18-44	33	29	29	39	38	34	39	35	35	34	36	25	33	33
45-64	33	28	35	33	30	30	31	30	29	31	28	20	26	29
65+	13	24	18	4	8	14	7	13	13	13	11	15	17	19
Female, %	53	52	55	52	51	53	53	50	52	52	52	55	52	52
Race, %														
White	82	96	54	75	81	74	63	25	51	84	38	55	97	87
African American	3	<1	33	16	9	5	33	<1	8	3	8	1	<1	2
Asian American	6	0	3	5	5	3	<1	63	17	5	10	1	<1	3
American Indian	1	<1	<1	<1	1	1	<1	<1	<1	1	<1	2	<1	<1
Hispanic	4	1.4	1	4	2	15	<1	3	19	6	41	38	<1	8
Other	3 ^f	<1	8	0	2	2	4	17	5	1	<1	0	<1	0

^a HVMA (Harvard Vanguard Medical Associates)

^b Does not include KPNW's 16 dental offices

^c ABQ Health Partners

^d Total enrollment, all sites combined: 10,872,000 members

^e Retention among cancer survivors only

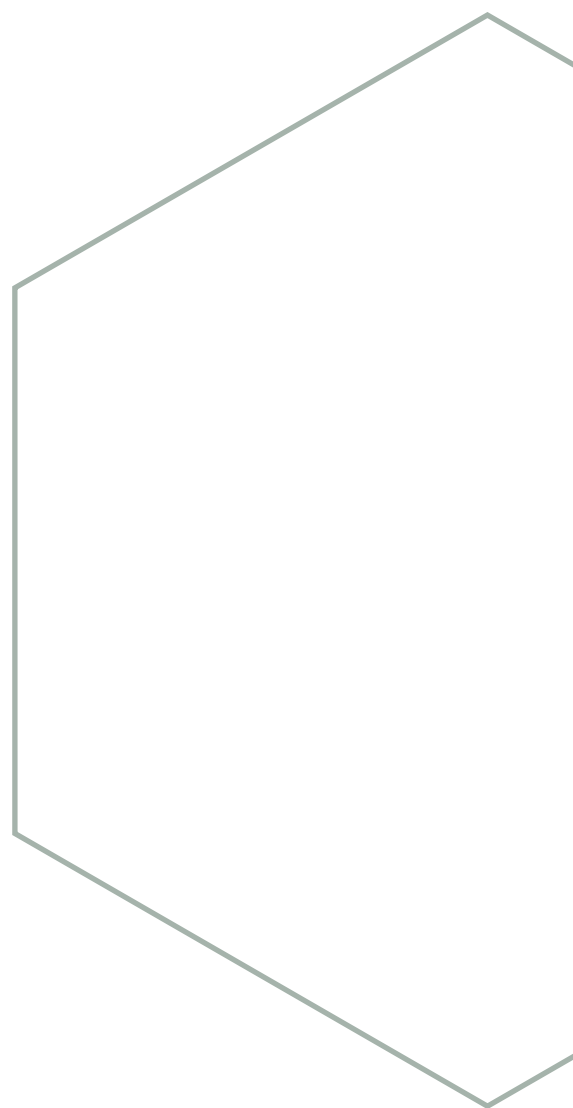
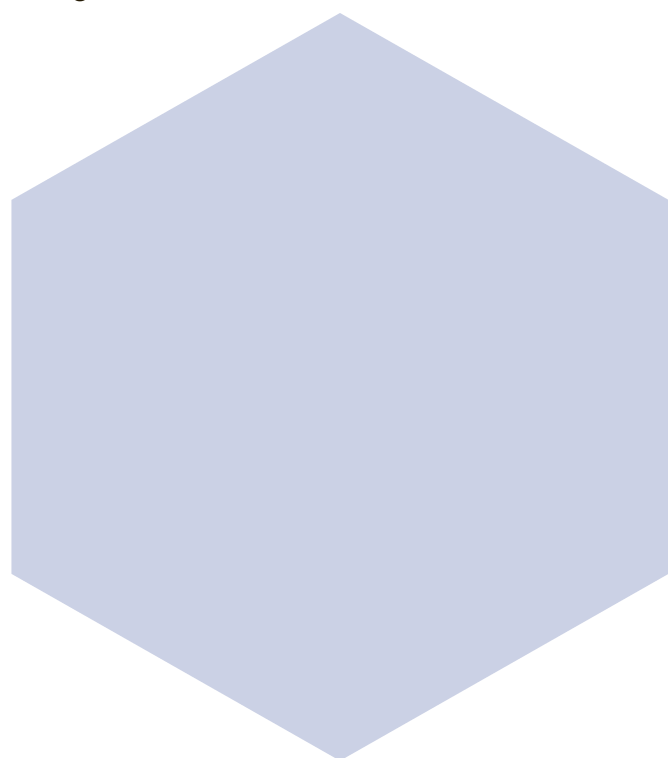
^f Includes persons reporting more than one race

Administrative Data Resources

CRN sites have a rich array of legacy data systems that date back many years. These data systems include information about:

- HMO enrollment
- Outside claims and referrals
- Patient scheduling and registration
- Births and deaths
- Cost of services
- Outpatient visits
- Hospitalizations
- Emergency room visits
- Prescriptions
- Laboratory tests
- Long-term care

The year of initiation for collecting these data varies by CRN site. These data systems have been used for research for decades for both single-site and multisite studies. The number of collaborating sites and the complexity of CRN research questions required the CRN to create a more efficient and standardized approach to data aggregation. The CRN chose to create a VDW, consisting of databases with a common set of standardized variables in each CRN site. The variability of the legacy data systems has made developing the VDW the CRN's most formidable challenge.





INFORMATICS AND RESEARCH TOOLS

The HMOs affiliated with the CRN have an ethical and legal obligation to safeguard the confidentiality of medical information of their individual members.

Thus, it is natural that CRN scientists and their home organizations have long been concerned about the sensitivity of health system data, especially medical information about

individuals as well as data related to quality or delivery of care and prices paid for medical care. HMO leaders have legitimate concerns that without careful stewardship, such data could be compromised or misrepresented. Because of these concerns, the CRN Steering Committee rejected the notion of establishing a centralized repository of generic data on the enrollees of each HMO for use in current and future studies. However, the CRN proposed developing standardized data resources to increase the quality and efficiency of research using automated data: the VDW,

cancer counters, EMRs, and natural language processing (NLP). Research information containing patient or provider identification is protected from third-party discovery by federal statute.

The Virtual Data Warehouse (VDW)

The VDW is a distributed data warehouse, a federated database that is made up of standardized datasets stored behind separate security firewalls at each participating CRN site. The datasets include variables with identical names, formats, and specifications (including definitions,

Emerging Partnerships in Informatics

The CRN is coordinating its informatics development efforts with NCI's Cancer Biomedical Informatics Grid (caBIG®) to facilitate collaboration. The aim of the caBIG® collaboration is to use caBIG® tools to improve the VDW's compatibility and interoperability with national standards. The CRN also is an active contributor to the caBIG® Population Sciences Special Interest Group and the cross-cutting Data Sharing and Intellectual Capital Workspace, both of which are working on strategies to facilitate multisite collaboration, data collection, and stewardship.

The CRN has also partnered with the SEER Program to pilot a project in Hawaii in which VDW data is electronically transmitted to the geographically co-existing central cancer registry. This unique partnership will enable investigators to conduct analyses relating to comorbidities, such as examination of the association between the number and severity of comorbidities present during the year prior to diagnosis and treatment modalities, survival, and other patient outcomes. It will also allow investigators to determine whether CRN records are able to enhance SEER registry data, and vice versa. If the pilot proves useful to CRN and SEER investigators, periodic transmission of data from the CRN to SEER registries at multiple sites may be considered.

Finally, the CRN has partnered with Harvard University to test a system developed by Harvard that locates and retrieves tissue specimens and pertinent clinical and outcome data on an as-needed (just-in-time) basis. Testing of this system is being conducted within the CRN to determine how well it functions in a large HMO setting and whether it can reliably remove all personal health data identifiers while maintaining usable data extracted from medical records. This system has the potential to substantially enhance the capability of the CRN to conduct multisite cancer control research projects involving pathological specimens and associated clinical/outcome data.

labels, and coding). This structure is a vital element of the VDW because it allows the same SAS program, written at one site, to be run against all participating sites' databases. Person-level data at each CRN site remains under local control at that site. The VDW is supported by a set of informatics tools—hardware and software—that facilitate storage, retrieval, processing, and managing of VDW datasets; a set of access policies and procedures governing use of VDW resources; and documentation of all elements of the VDW. The VDW is a cornerstone of today's "rapid-cycle" research environment, because it allows for responsiveness and efficiency while maintaining data privacy and security, as well as local autonomy over the data at each site.

The VDW files cover the following areas of information:

- Demographics and vital signs
- Enrollment into the health care plan
- Utilization, including inpatient and outpatient visits, emergency department visits, long-term care admissions and home health visits, and communications with health professionals via phone
- Diagnoses, procedures, and lab tests/results
- Incident cancer
- Pharmacy data
- Provider information
- Census data
- Birth and death data

The VDW files are linked together using a unique person identifier. Researchers working with the CRN can receive more detailed and specific information about the content of the VDW once an official collaboration has been established.

Cancer Counters

To facilitate efficient study planning, CRN staff developed virtual data marts or "counters." The Cancer Counter includes summarized, de-identified data that can produce counts of patients with cancer aggregated by tumor site, morphology, stage, health plan, vital status, race, gender, and Hispanic ethnicity, and that allows users to select one- and two-way frequencies of these variables. The Cancer Counter has proven to be invaluable for estimating study population sizes for new cancer research proposals.

Electronic Medical Records (EMRs)

EMRs allow researchers to manipulate and standardize free-text clinical data such as clinical assessment findings, image interpretations, surgical operative reports, pathology evaluations, hospital discharge summaries, and consultant evaluations. In addition to the standard physician user-interface, many of the EMRs also have a patient interface, where patients can view items in their medical record (such as visit summaries and laboratory test results), send secure messages to

their physicians, and enter information into a health risk assessment survey or other survey instrument. This provides the CRN with opportunities for innovative interventions. Several EMR systems are employed across CRN member organizations, although EpicCare is the most commonly used. Beacon Oncology Information System, also an Epic software product, will be used by at least eight of the CRN sites to document patient consult and chemotherapy infusion visits, and manage patient treatment plans.

Natural Language Processing (NLP)

NLP helps investigators convert a variety of sentences, clauses, words, symbols, and abbreviations that represent synonyms into measurable concepts of research interest. CRN informaticists developed an NLP tool called MediClass[®] to collect standardized information about tobacco control counseling in "Using Electronic Medical Records to Measure and Improve Adherence to Tobacco Treatment Guidelines in Primary Care." In 2009, the CRN was awarded ARRA stimulus funds to integrate the Clinical Text Analysis and Knowledge Extraction System (cTAKES), a powerful and expandable NLP system, into the infrastructure of the CRN coordinating site and test a complex NLP algorithm for identifying recurrent breast cancer diagnoses in clinical text.



ORGANIZATIONAL STRUCTURE

The CRN is overseen by Academic Liaison, Executive, and Steering Committees. As a cooperative agreement grant, the CRN Principal Investigator's Office and NCI program staff collaborate actively. The CRN's administrative structure is made up of four cores, a Clinical Applications and Translation Program, and research projects including a pilot studies program.

The four cores include Administrative Committees, an Evaluation Core, a Scientific and Data Resources Core, and the CRN Scholars Program. The Clinical Applications and Translation Program emphasizes work in two major areas: improving enrollment in cancer clinical trials and studying diffusion of innovations in cancer prevention and care. Scientific Interest Groups (SIGs) are initiated and led by investigators with shared interests in emerging areas of high-priority research.

CRN SCIENTIFIC INTEREST GROUPS (SIGs)

- > Obesity
- > Family History
- > Cancer Survivorship
- > Pharmacogenomics
- > Patient-Centered Communication in Cancer Care
- > Racial Disparities
- > Others

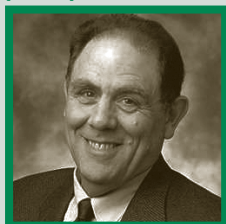
The Pharmacogenomics SIG is organized through the larger HMORN and led by CRN scientists. Many other CRN researchers are active participants. This SIG brings interested researchers together to learn about existing pharmacogenomics projects within the HMORN as well as upcoming research opportunities. The SIG also facilitates collaboration between the HMORN and external investigators on pharmacogenomics topics.

The Pharmacogenomics SIG laid the foundation for a GO grant funded by NCI in 2009 entitled **Comparative Effectiveness Research in Genomic and Personalized Medicine of Colorectal Cancer** and led by principal investigators Dr. Katrina Goddard (KPNW), Dr. Evelyn Whitlock (KPNW), and Dr. Lawrence Kushi (KPNC). The grant will use the CRN health systems as platforms to explore the comparative effectiveness of genomic and molecular tests, including those for KRAS and Lynch Syndrome, related to colorectal cancers. Researchers will also measure psychosocial issues related to testing to help inform understanding of genetic test results in decision making. This research will build the experience, data systems, and methods that can be applied to other cancer-related genetic or molecular tests in the future.



SITE PRINCIPAL INVESTIGATORS

Group Health Cooperative, Group Health Research Institute (GHC)



Edward H. Wagner, M.D., M.P.H.

CRN Principal Investigator

Senior Investigator,
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Director, MacColl Institute

Research Interests: studies of interventions to reduce disability in seniors and to enhance the care of persons with cancer and other chronic illnesses; cluster randomized trials

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Kaiser Permanente Northern California, Division of Research (KPNC)



Lawrence H. Kushi, Sc.D.

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Research Interests: role of diet and nutrition in the etiology of breast and other cancers; epidemiologic studies of cancer prognosis

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Kaiser Permanente Northwest, Center for Health Research- Northwest (KPNW)



Mark C. Hornbrook, Ph.D.

CRN Co-Principal Investigator

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Research Interests: health care cost and utilization analysis; economic evaluation methods; patient classification methods; health status measurement; predictive modeling; health-based payment systems

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Fallon Community Health Plan, Meyers Primary Care Institute (MPCI)



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Research Interests: providing safe and
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Geisinger Health System, Geisinger Center for Health Research (GHS)



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Adjunct Associate Professor, Department of
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Research Interests: cancer control and early
detection; prevention of obesity; breast
cancer prevention; screening mammography
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detection and recurrence; prevention of
chronic health problems secondary to
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Harvard Pilgrim Health Care Institute and Harvard Medical School, Department of Population Medicine (HPHC)



Suzanne W. Fletcher, M.D., M.Sc.

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Research Interests: prevention, especially
related to breast cancer screening; DCIS;
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**HealthPartners,
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Research Interests: health services; health disparities; economics and risk adjustment; biostatistics

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Douglas W. Roblin, Ph.D.

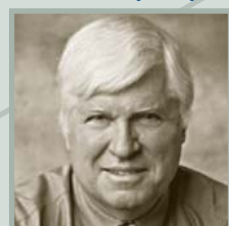
Senior Investigator, Kaiser Permanente Southeast Center for Health Research

Adjunct Assistant Professor of Health Policy and Management, Rollins School of Public Health at Emory University

Research Interests: organizational and financial characteristics of health care systems affecting patient outcomes, such as medical services use and cost; visit satisfaction; quality of chronic disease care

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**Lovelace Health System,
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Research Interests: comparative effectiveness for cancer therapies; ethnic disparities in cancer treatment, alcohol abuse, and diabetes

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**Henry Ford Hospital and Health
System/Health Alliance Plan,
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Center for Health Services Research
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Christine Cole Johnson, Ph.D., M.P.H.

Senior Staff Scientist, Henry Ford Health System Chair, Department of Biostatistics and Research Epidemiology; Director, Henry Ford Hospital and Health System, Epidemiology, Prevention, and Control Program, Josephine Ford Cancer Center, Henry Ford Health System; Director, Center for Allergy, Asthma, and Immunology Research, Henry Ford Health System

Research Interests: cancer epidemiology and prevention; pharmacoepidemiology; etiologies of allergy and asthma

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**Kaiser Permanente Hawaii, Center
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Research Interests: medical judgment and decision making; health services

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**Marshfield Clinic/Security Health Plan,
Marshfield Clinic Research
Foundation (MCRF)**



Robert T. Greenlee, Ph.D., M.P.H.

Marshfield Epidemiologic Study Area Lead Scientist, Marshfield Clinic Research Foundation

Research Interests: cancer surveillance and control; sociodemographic disparities in prevention, early detection, and treatment; clinical epidemiology of cardiovascular disease, particularly arrhythmias and conduction disorders

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SITE PRINCIPAL INVESTIGATORS

**Kaiser Permanente Colorado,
Institute for Health Research (KPCO)**



Debra P. Ritzwoller, Ph.D.

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Research Interests: costs and cost-effectiveness of behavioral interventions; the uninsured; disease management interventions; vaccine effectiveness; public health surveillance systems; physician compensation; comorbidities; cost estimation; cost-effectiveness

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**Kaiser Permanente Southern
California,
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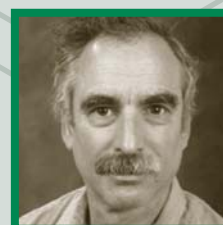
Virginia P. Quinn, Ph.D.

Research Scientist, Department of Research and Evaluation, Kaiser Permanente Southern California

Research Interests: lifestyle and health behavior change; prevention, screening, and adherence; adolescents and depression; quality of cancer-related care

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National Cancer Institute



Martin L. Brown, Ph.D.

CRN Program Director

Chief, Health Services and Economics Branch, Applied Research Program, Division of Cancer Control and Population Sciences, National Cancer Institute

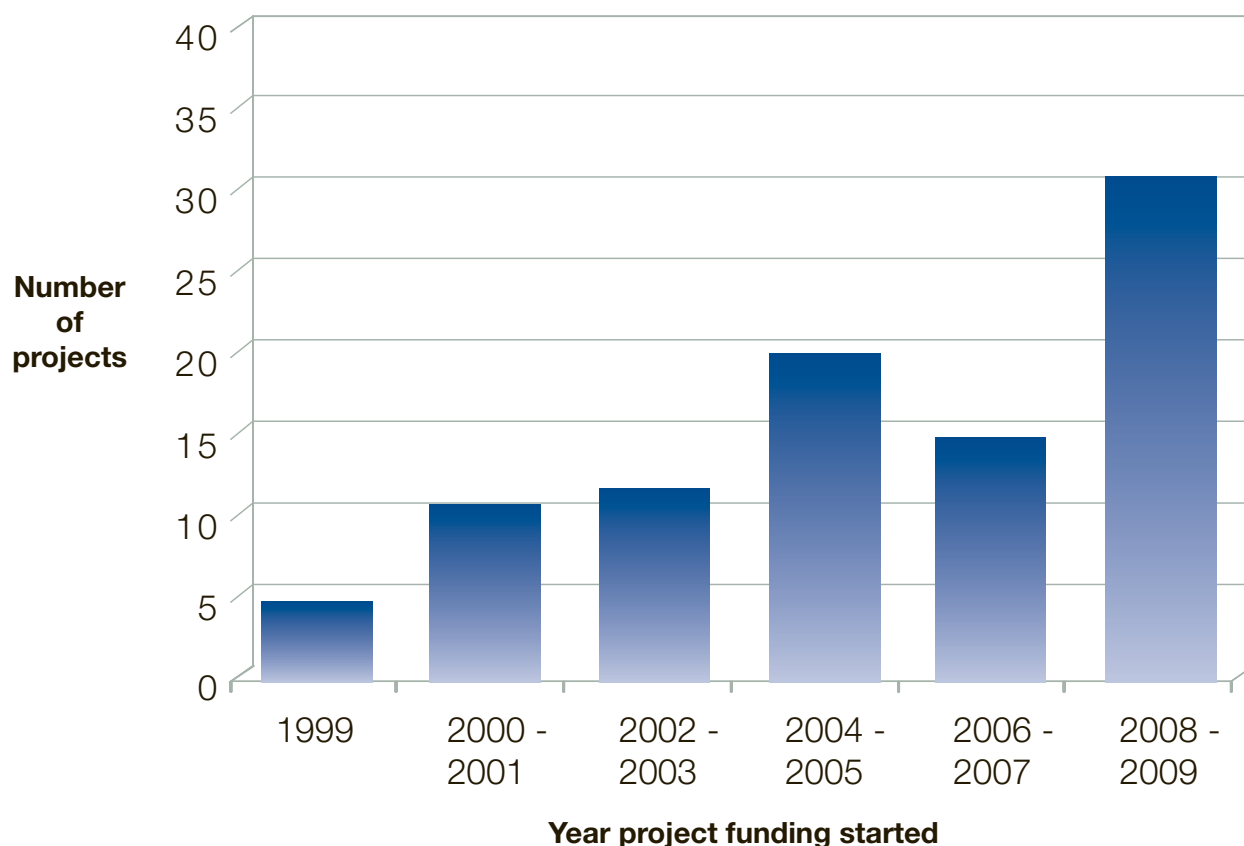
Research interests: health services; economics of cancer; cost effectiveness of cancer control

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RESEARCH PROJECTS BY CRN RESEARCH THEME AND YEAR

Since its inception, the number of funded CRN research projects has increased dramatically, from three core research projects funded as part of the original grant in 1999 to more than 25 active projects in 2008–2009. This increase in research projects reflects the many successful collaborations and ongoing efforts to address important cancer control questions in the CRN population laboratory. Research projects are listed according to themes described on pages 8 and 9, and selected studies are highlighted in each section.

GROWTH IN FUNDED CRN RESEARCH PROJECTS, 1999-2009



Health Care Delivery, Quality, Costs, and Outcomes

CRN studies in this area address the nature and quality of cancer prevention services, screening, treatment, supportive care, and survivorship care, and their impacts on health outcomes, resource use, and costs. The relatively large number of clinical sites and the size and diversity of CRN patient populations facilitate studies of practice variation, disparities in care and outcomes, and intervention studies.

PROJECT TITLE	FUNDING SOURCE	YEAR FUNDED
Outcomes of Prostate Cancer Androgen Deprivation Therapy	NCI R01 Grant	2010
Cost-Effectiveness of Hormonal Therapy for Clinically Localized Prostate Cancer	NCI Challenge Grant	2009
Improving Breast Cancer Surgery Effectiveness through Establishment of an Electronic Cancer Surgery Database	NCI Challenge Grant	2009
Preventing Errors in the Home Care of Children with Cancer	NCI CRN Pilot Project	2009
Long-Term Survivorship in Older Women with Early Stage Breast Cancer (BOW II)	NCI R01 Grant	2008
Opportunistic Colorectal Cancer Screening: Providing FIT with Annual Flu Shots	NCI CRN Pilot Project	2008
Systems Failures Contributing to Chemotherapy Error: A Project of the HMORN Center of Education in Research & Therapeutics	AHRQ Contract	2006
4CQuality: Quality of Patient-Centered Cancer Care, Communication, and Coordination	NCI Contract	2005
Do Acute and Chronic Illness Trump Preventive Care? A Case Study of Breast and Colon Cancer Screening	NCI CRN Pilot Project	2004
Research Supplement for Underrepresented Minorities Program: Patterns of Preventive Services Utilization of Cancer Survivors	NCI CRN Administrative Supplement	2003
Evaluation of Hospice Referral and Palliative Care for Ovarian Cancer in the Managed Care Environment	CDC Task Order	2002
Breast Cancer Treatment Effectiveness in Older Women (BOW I)	NCI R01 Grant	2002
Lung/Colon Cancer Outcomes: Cancer Care Outcomes Research and Surveillance Consortium (CanCORS)	NCI Cooperative Agreement	2001
A Pilot Study of Disenrollment among HMO Patients with Cancer	NCI CRN Administrative Supplement	2001
Design, Implementation & Analysis of a Clinician Survey (DETECT supplement)	NCI CRN Administrative Supplement	2000
HMOs Investigating Tobacco (HIT)	NCI CRN Core Research Project	1999
Toward Reducing Cervical and Late-Stage Breast Cancer: Detecting Early Tumors Enables Cancer Therapy (DETECT)	NCI CRN Core Research Project	1999

Selected research projects are highlighted below.

Breast Cancer Treatment Effectiveness in Older Women (BOW I) and Long-Term Survivorship in Older Women with Early Stage Breast Cancer (BOW II)

Dr. Rebecca Silliman (Boston University), a member of the CRN Academic Liaison Committee, led this large-scale cohort study of the care and outcomes of 1,859 older women with breast cancer at six CRN sites. By reviewing medical records and using administrative data,

information was collected on initial surgery, adjuvant treatments, long-term surveillance, and recurrence and mortality outcomes. The team compared the effectiveness of different treatment and surveillance patterns, and identified the characteristics of providers, tumors, and patients associated with various treatment choices. The study found that less-than-standard treatment is associated with increased rates of recurrence and breast cancer-specific mortality, while mammography

surveillance during the first five years after diagnosis is associated with a reduced rate of breast cancer mortality.

Following successful completion of BOW I, study investigators received a renewal to collect additional information about this cohort of breast cancer survivors through 15 years after diagnosis. This new study will evaluate the effectiveness of mammography surveillance for recurrence and second primaries beyond five years; the cost

Health Care Delivery, Quality, Costs, and Outcomes (cont.)

implications associated with short-term and long-term survivorship care; and the risk of late treatment effects.

A Pilot Study of Disenrollment among HMO Patients with Cancer

This study assessed turnover among enrollees with cancer diagnoses in five HMOs and how turnover may affect longitudinal cancer outcomes research. The Principal Investigator, Dr. Terry Field (MPCI), and colleagues studied the retention rates among cancer survivors over a six-year period. Enrollees were followed from diagnosis through death, disenrollment, or end of follow-up. The

retention rates among survivors for all cancers combined at one and five years after diagnosis were 96.0 percent and 83.9 percent, respectively. The proportion of enrollees who remained enrolled and available for evaluation suggests that the CRN is well suited for studies of cancer quality of care, survivorship, and long-term outcomes. This led to a follow-up study that assessed racial disparities in cancer care and survival in more than 130,000 cancer patients.

Toward Reducing Cervical and Late-Stage Breast Cancer: Detecting Early Tumors Eases Cancer Therapy (DETECT)

This eight-HMO project, led by Dr. Stephen Taplin (NCI; formerly

of GHC), identified women with invasive cervical cancer or late-stage breast cancer. The project estimated the proportion of each group attributable to potential problems in care delivery—absence of screening and detection and/or deficiencies in follow-up. The project team created a model for considering quality issues in cancer care. They also profiled the screening practices and policies in the HMOs and surveyed clinician attitudes about screening policies and practices. The absence of screening accounted for most of the late-stage breast and cervical cancers.

Health Insurance Benefit Design and Patterns of Care Utilization

CRN studies examine the relationship between patients' benefit design and use of cancer screening and treatment services.

PROJECT TITLE	FUNDING SOURCE	YEAR FUNDED
Medical Care Burden of Cancer: System and Data Issues Supplement	NCI R01 Grant Administrative Supplement	2009
High Deductible Health Plans and Receipt of Cancer Prevention Services	ACS Research Scholar Grant	2008
Chemotherapy and Coinsurance: The Effect of Cost Sharing on Cancer Care	NCI CRN Pilot Project	2008
Economic Burden Pilot Study	NCI CRN Core Research Project	2007
Medical Care Burden of Cancer: System and Data Issues	NCI R01 Grant	2007

Selected research projects are highlighted below.

Chemotherapy and Coinsurance: The Effect of Cost Sharing on Cancer Care

Dr. Debra Ritzwoller (KPCO) is leading this multiyear, multisite CRN pilot study to assess the impact of coinsurance on receipt of cancer chemotherapy services among breast, colorectal, and lung cancer patients. This observational study will compare the rates of chemotherapy regimen use for a cohort of HMO cancer patients, before and after the implementation

of 20% coinsurance on all infused chemotherapy services, at one of the sites. This study will leverage the ongoing efforts of the CRN VDW chemotherapy working group, and it is an unparalleled opportunity for the CRN to help inform policymakers of the potential impact of cost-sharing changes on cancer care. Given the potentially large economic and clinical consequences of new cancer therapies and greater patient cost-sharing requirements, this study will inform our

understanding of how these changes may impact cancer treatment, compliance, outcomes, and costs.

Medical Care Burden of Cancer: System and Data Issues

Most cancer cost estimates are from NCI's SEER cancer registries linked to Medicare claims (SEER-Medicare). These data only represent the experience of the more than 80% of aged Medicare beneficiaries enrolled in the fee-for-service (FFS) indemnity option; no information is available about the remaining

seniors enrolled in Medicare HMOs. In addition to differences in patient benefits, HMO providers face different incentives, and because beneficiaries select their coverage, the populations may differ in their health status and preferences in ways that are difficult to measure. These factors may cause selection and omission biases in cancer cost estimates based on either group alone.

This project, led by Dr. Mark Hornbrook (KPNW), will extend

and complement the SEER-Medicare link by (1) estimating the incremental medical care cost of all cancers by cancer site, stage at diagnosis, patient demographics, and source of health insurance (FFS vs. HMO); (2) estimating costs of non-Medicare covered services; and (3) modeling the determinants of cancer costs across HMO and FFS systems, correcting for selection and omissions biases. The study team received an NCI supplement to estimate the costs of

cancer care in the non-elderly population. Additionally, Dr. Hornbrook is leading the study team with a pilot study to estimate the cancer-related pharmacy costs among aged Medicare HMO beneficiaries that are not covered in FFS Medicare. A byproduct of this body of research will be the development of a reusable infrastructure that will enhance the CRN VDW for other uses, including efforts focused on the dissemination of pharmacotherapy among cancer patients over time.

Cancer Epidemiology, Prevention, and Health Promotion

CRN populations are the basis for conducting cross-sectional, case-control, cohort, and intervention studies to examine numerous cancer-related conditions, including rare outcomes. Studies of health promotion strategies, lifestyle change, and risk factor assessment and identification benefit from the HMO setting, and particularly from the detailed information on medical care and comorbid conditions that may impact patient outcomes.

PROJECT TITLE	FUNDING SOURCE	YEAR FUNDED
Establish a Prospective Cohort to Investigate Obesity, Diabetes and the Metabolic Syndrome as Risk Factors in Young Adult Cancer	NCI CRN Pilot Project	2010
Lymph Node Examination in Colorectal Cancer: Predictors of Adequate Staging and Its Influence on Cancer Survival in Community Practice	NCI CRN Pilot Project	2010
Non-Melanoma Skin Cancer Ascertainment in the HMO Setting	NCI CRN Pilot Project	2010
Statins and Lymphoid Malignancy Risk in a Large Multi-Site Population-Based Cohort	NCI R01 Grant	2010
Medical Radiation Induced Cancers	NCI CRN Pilot Project	2009
Development of a Model for Predicting Prostate Cancer	NCI CRN Pilot Project	2009
Is Stroke a Late Effect of Chemotherapy?	NCI R01 Grant	2006
Residential Segregation, Housing Status, and Prostate Cancer in African American and White Men	Department of Defense Training Grant	2006
New Markers: Clinical & Pathologic Predictors of Ductal Carcinoma <i>in Situ</i>	NCI CRN Administrative Supplement	2005
Medications and Colorectal Cancer Risk	NCI R03	2004
Statins and Risk of Site-Specific Cancers	NCI R03	2004
Investigation of Age-Specific Differences and Cancer of the Cecal Colon	NCI CRN Pilot Project	2004
African American Disparities in Lung Cancer Outcomes	NCI CRN Pilot Project	2004
Multicenter Study of Pancreatic Cancer Etiology	NCI R01 Grant	2004
Making Effective Nutritional Choices (MENU)	NCI CRN Core Research Project	2003
Clinical and Pathologic Predictors of Ductal Carcinoma <i>in Situ</i>	NCI CRN Core Research Project	2003
Optimizing Breast Cancer Outcomes: BMI, Tumor Markers, and Quality of Care	ACS Career Development Grant	2003
Medication Use and Risk of Esophageal Adenocarcinoma and Barrett's Esophagus	NCI Contract	2002
Colon Cancer Survivors—Medications and Risk of Recurrence	NCI R01 Grant	2001
The Impact of Endocrine Therapy on Survival in Men with Local or Regional Prostate Cancer—Feasibility Study	NCI CRN Administrative Supplement	2001
Program Testing Early Cancer Treatment and Screening (PROTECTS)	NCI CRN Core Research Project	1999

Selected research projects are highlighted on the following page.

Cancer Epidemiology, Prevention, and Health Promotion (cont.)

Is Stroke a Late Effect of Chemotherapy?

This grant, led by Dr. Ann Geiger (Wake Forest University; formerly of KPSC), explores the hypothesis that chemotherapy may increase stroke risk for years afterward. The study team will estimate the relative risks of stroke as a result of chemotherapy among ethnically diverse patients with bladder, female breast, colorectal, Hodgkin's lymphoma, adult leukemia, multiple myeloma, non-Hodgkin's lymphoma, and ovarian cancers, adjusting for numerous demographic and clinical characteristics.

Making Effective Nutritional Choices for Cancer Prevention (MENU)

Dr. Christine Cole Johnson (HFHS) led the development and evaluation of an individually tailored, Web-based program to promote daily fruit and vegetable (F&V) consumption. Its efficacy was tested in a randomized trial of five HMOs. The online intervention was shown to be effective in the diverse sample of healthy adults who enrolled. All three intervention arms (untailored and tailored Web program and tailored Web program plus email support) showed early and sustained increases of more than two F&V servings per day. The untailored

Web program arm was least effective. Those participating online at a higher rate had more gain in F&V servings, the retention rate was high, and reported satisfaction with the online program overall was high. Analyses exploring the effects of additional variables on dietary behaviors are ongoing.

Clinical and Pathologic Predictors for Recurrence after Ductal Carcinoma *in Situ* (DCIS)

In this project, led by Dr. Laurel Habel (KPNC), investigators at three CRN sites are studying clinical and pathologic factors that could be used to identify DCIS patients at high and low recurrence risk. From medical records, investigators have identified DCIS patients treated with breast-conserving surgery (BCS) and followed for recurrence. Recurrence rates after BCS for DCIS have declined as treatment with adjuvant radiotherapy and tamoxifen have increased; adjuvant treatment use does not appear to differ markedly across racial/ethnic groups; and surveillance mammography after BCS for DCIS declines over time and becomes inadequate. This large,

comprehensive study on prognostic factors will improve understanding of the natural history of DCIS and help in developing individually tailored DCIS treatment strategies. It also serves as a model of a CRN project that benefits from the unique electronic and biologic specimens available in the CRN health plans.

Effectiveness of Early Screening and Prophylactic Mastectomy in Women at Increased Risk for Breast Cancer: Program Testing Early Cancer Treatment and Screening (PROTECTS)

This project, led by Dr. Suzanne Fletcher (HPHC), evaluated the efficacy of bilateral prophylactic mastectomy (BPM) and contralateral prophylactic mastectomy (CPM) among women with unilateral breast cancer in



reducing subsequent breast cancer incidence and mortality, compared to women who had not undergone these surgeries. The women who underwent BPM had a significant reduction in breast cancer risk, but approximately two-thirds experienced significant adverse effects. Compared with breast cancer patients without CPM, the risk of contralateral breast cancer in these women was also reduced significantly. The project also

evaluated the efficacy of mammography and clinical breast exam in real-world settings and contributed methodologic innovations and analyses.

Multicenter Study of Pancreatic Cancer Etiology

The Pancreatic Cancer Investigation: Finding Causes (PACIFIC) study is a large, comprehensive case-control study with recruitment from two HMOs

that have infrastructure to support ultra-rapid case identification during diagnostic evaluation. Led by Dr. Margaret Mandelson (GHC), Dr. John Potter (Fred Hutchinson Cancer Research Center), and Dr. Stephen Van Den Eeden (KPNC), this study's methods allow enrollment of patients who represent the full spectrum of disease, including those typically omitted from prior epidemiologic research because of death shortly following diagnosis.

Enhancing Cancer Communication and Decision-Making

Increasingly, CRN projects are leveraging the extensive data on patients, providers, health care delivery, and outcomes to examine and optimize the quality of communication with and among patients; patient decision-making about cancer screening, diagnosis, treatment, and survivorship in diverse populations; and the communication and coordination that characterize the best health care teams in support of their patients. CRN studies in this area examine a wide range of issues, from shared clinical decision-making to outreach strategies, high-risk members, and Web-based consumer information.

PROJECT TITLE

Studying Communication over the Cancer Continuum: A Feasibility Study

Development of an Online Dissemination Planning Tool

CRN Cancer Communication Research Center

Effective Communication for Preventing and Responding to Oncology Adverse Events

Improving Physician-Parent Communication to Reduce Home Medication Errors and Improve Adherence in Children with Cancer

Oral Health Communication and Latinos in a Managed Care Organization: Does Understanding Vary by Knowledge Level of Colorectal Cancer and Acculturation?

Health Literacy and Cancer Prevention: Do People Understand What They Hear?

Use of an Interactive Voice Response System, with Physician Feedback, to Reduce Cancer Symptoms: A Pilot Study

Michigan Center for Health Communications Research

Selected research projects are highlighted on the following page.

FUNDING SOURCE

NCI CRN Pilot Project

CCRC Administrative Supplement

NCI P20

CCRC RO1 Project

CCRC Developmental Project

CCRC Developmental Project

NCI CRN Core Research Project

NCI CRN Pilot Project

NCI P50 Grant

YEAR FUNDED

2010

2009

2008

2008

2008

2008

2007

2005

2003

Enhancing Cancer Communication and Decision-Making (cont.)

CRN Cancer Communication Research Center

The CRN Cancer Communication Research Center (CCRC) was funded by NCI in 2008 as a program project (P20) to advance research about cancer communication in clinical settings. Led by Dr. James Dearing (KPCO), this is the first communication research center founded within the CRN. The Center identifies, tests, and applies optimal communication and coordination processes that facilitate patient-centered cancer care. Two initial core R01 projects are *Testing an Optimal Model of Patient-Centered Cancer Care* and *Effective Communication for Preventing and Responding to Oncology Adverse Events*. Eighteen investigators at eight CRN sites participate in the Center. The CCRC also ties the CRN into the Center of

Excellence in Cancer Communication Research (CECCR) network of cancer communication research centers at Washington University, the University of Pennsylvania, the University of Michigan, and the University of Wisconsin. Through its shared resource cores that study and explore new practice-based approaches to cancer communication across the CRN as well as how to most effectively disseminate effective cancer communication interventions across clinical settings, the Center is heavily involved in translational research from the processes of innovation to the processes of replication and diffusion. Communication and care coordination processes are assessed across the cancer care continuum from prevention to early detection, diagnosis, treatment, survivorship, and end of life as well as across types, including breast, cervical, colorectal, lung, and prostate cancers.

Health Literacy and Cancer Prevention: Do People Understand What They Hear?

This study, led by Dr. Kathy Mazor of the Meyers Primary Care Institute at the University of Massachusetts, is developing a test of comprehension of oral (i.e., spoken) messages about cancer prevention and screening. Current measures of health literacy involve comprehension of written material, which is not how most key health information is transmitted. The team will examine the relationship between health literacy and cancer prevention using both quantitative and qualitative methods. Findings will lay the foundation for future research into the prevalence of inadequate oral health literacy, identification of groups and individuals with inadequate comprehension skills, and identification of risk factors and causes of limited comprehension. The project will develop recommendations for modifying oral messages so that they are easily comprehensible, and will test the impact of specific enhancements in a randomized experiment.

Managed care research networks have several potential advantages for studying questions about cancer care in older women. First, access to care is removed from the equation in survival outcomes. Second, they include large proportions of the population from almost all regions of the United States, providing an alternative universe for population-based studies. Third, the availability of computerized administrative databases linked to laboratory and pathology data and often electronic medical records allows careful delineation of disease and interventions and comprehensive, cost-efficient long-term follow-up. Thus, this network provides high-quality data for observational research and can fill critical gaps in our knowledge, especially in situations where large-scale clinical trials are not likely to be mounted.

Mandelblatt J. To Screen or Not to Screen Older Women for Breast Cancer: A New Twist on an Old Question or Will We Ever Invest in Getting the Answers? *J Clin Oncol* 2007;25(21):2991–2992.

Dissemination and Implementation Research in Cancer Prevention, Screening, and Treatment

CRN studies of the introduction and diffusion of new diagnostic and treatment modalities into practice, and the conduct of pharmacoepidemiologic and pharmacogenomic studies of the effectiveness of cancer drugs as delivered in community practice are priority research areas.

PROJECT TITLE	FUNDING SOURCE	YEAR FUNDED
Media Coverage and Direct-to-Consumer Advertising of Genetic Tests	NCI CRN Pilot Project	2008
Ovarian Cancer Treatment Diffusion Study	NCI CRN Administrative Supplement	2006
Anti-Estrogen Therapies for Breast Cancer	NCI CRN Infrastructure Project	2005
Diffusion of Breast MRI Technology in Community Clinical Settings	NCI CRN Administrative Supplement	2005
HRT Initiation and Cessation after WHI Results	NCI CRN Administrative Supplement	2002

Selected research projects are highlighted below.

Anti-Estrogen Therapies for Breast Cancer

As early as 2001, several randomized trials demonstrated that adjuvant aromatase inhibitor treatment is superior to tamoxifen for decreasing breast cancer recurrence among women with estrogen receptor positive breast cancer. CRN investigators used automated pharmacy data from seven CRN sites to assess the use of aromatase inhibitors and tamoxifen between 1996 and 2003. This study, co-led by Dr. Edward Wagner (GHC) and Ms. Erin Aiello Bowles (GHC), also included an oncologist survey to assess whether and how CRN organizations and oncology groups made policy decisions about cancer interventions. Aromatase inhibitor use rose dramatically after 2001, while tamoxifen use decreased. Regardless of whether their site had formal treatment guidelines, almost all oncologists reported prescribing aromatase inhibitors under various

circumstances: metastatic breast cancer, after completion of tamoxifen, or in lieu of tamoxifen.

HRT Initiation and Cessation after WHI Results

On May 31, 2002, the Women's Health Initiative (WHI) randomized trial of hormone therapy (HT) was stopped early because the risks of HT were found to outweigh the benefits. Women randomized to estrogen plus progestin therapy (EPT) experienced an excess risk of invasive breast cancer, coronary heart disease, stroke, venous thromboembolism, and pulmonary embolism compared to women randomized to placebo. To ascertain the effect of this pivotal announcement in community-based delivery settings, the CRN received an NCI administrative supplement to conduct an observational cohort study using automated pharmacy dispensing data. This study, led by Dr. Diana Buist (GHC), provided important information on the rapid

translation of the WHI results into clinical practice, use of HT in relation to current clinical recommendations, and patterns of re-initiation after cessation. The prevalence of EPT and estrogen alone declined 46% and 28%, respectively, after the WHI announcement. These findings demonstrate the CRN's ability to rapidly examine changes in therapies over time. A follow-up study being conducted by NCI investigators in collaboration with two CRN sites is examining these data at the individual patient level to determine the association between patterns of HT usage and subsequent breast cancer occurrence. The results of this study will be utilized to improve the specification of breast cancer natural history used in the prevention component of breast cancer simulation models (Cancer Intervention and Surveillance Modeling Network [CISNET]).

Psychosocial Factors and Burden of Cancer

CRN studies that characterize patient education, financial assets, literacy, psychosocial distress, and outcomes such as care experiences and quality of life are the basis for identifying and developing interventions to improve care. Examining disparities in access, treatment, and outcomes are priority research areas.

PROJECT TITLE	FUNDING SOURCE	YEAR FUNDED
Race, Treatment and Cardiovascular Health: A Study of Men with Prostate Cancer	Department of Defense	2009
Childhood, Adolescent and Young Adult Cancer Survivors—CRN Feasibility Pilot	NCI CRN Pilot Project	2009
Socioeconomic Diversity in Integrated Healthcare Delivery Systems	NCI CRN Pilot Project	2008
Testing an Optimal Model of Patient-Centered Care	CCRC R01 Project	2008
Intestinal Ostomies and Informal Caregiving for Colorectal Cancer Survivors	NCI R21 Grant	2008
Understanding Racial and Ethnic Differences in Survival from Colorectal Cancer	NCI K01 Grant	2007
Informing an R01 Application: Interviewing Long-Term Colorectal Cancer Survivors	NCI CRN Pilot Project	2005
Patient-Oriented Outcomes of Prophylactic Mastectomy	NCI R01 Grant	2001
Evaluation of End-of-Life Care for Prostate Cancer in the Managed Care Environment	CDC Task Order	2000

Selected research projects are highlighted below.

Testing an Optimal Model of Patient-Centered Cancer Care

The goal of this study is to develop an Oncology Nurse Care Management program for newly diagnosed breast, colorectal, and lung cancer patients that will address patient questions, symptoms, and psychosocial needs, and facilitates timely, coordinated care. Led by Dr. Edward Wagner (GHC), the study team will develop an early notification system of cancer diagnosis using automated data; develop and implement the case management system; and test its effectiveness in improving patient quality of care, psychosocial distress, and depression. This innovative care management program to enhance patient-centered care will help to fill an important gap in efforts to improve quality of cancer care surrounding diagnosis and treatment decision making.

Intestinal Ostomies and Informal Caregiving for Colorectal Cancer Survivors

Many colorectal cancer survivors are living with intestinal ostomies, which can lead to bowel incontinence, unless managed daily with special equipment, diet, and behavior. Losing the ability to manage one's ostomy independently can transform an ostomy from a manageable impairment to a source of profound disempowerment, stigma, and disability. This study, led by Dr. Carmit McMullen (KPNW), uses a social model of disability framework to better understand the interrelationships among disability and caregiving in this population, and identifies strategies that ostomates and their caregivers employ to cope with caregiving challenges. This study builds on a longstanding research program on the quality of life of long-term colorectal cancer survivors.

Patient-Oriented Outcomes of Prophylactic Mastectomy

This study, led by Dr. Ann Geiger (Wake Forest University; formerly of KPSC), used the prophylactic mastectomy efficacy study cohort of nearly 800 women who had undergone contralateral prophylactic mastectomy, bilateral prophylactic mastectomy, or neither of these surgeries (comparison group) at six CRN sites. A survey ascertained willingness to recommend prophylactic mastectomy, decision satisfaction, breast cancer risk-related stress, body image, and sexual activity. Most women undergoing prophylactic mastectomy were satisfied with their decision and reported quality of life comparable to similarly at-risk women in the comparison group. Investigators also examined decision-making research questions and contributed methods papers pertaining to medical records data validity and the impact of IRB reviews on study operations and response rates.

Data Resources and Infrastructure

In addition to maintaining existing electronic medical record systems and patient Web sites, projects in the CRN are continuing to standardize data infrastructure and develop and test research, surveillance, and medical practice innovations built upon these systems; patient Web portals; and computer-based physician order entry systems.

PROJECT TITLE	FUNDING SOURCE	YEAR FUNDED
Natural Language Processing for Cancer Research Network: Surveillance Studies	NCI Challenge Grant	2009
Socioeconomic Diversity in Integrated Healthcare Delivery Systems	NCI CRN Pilot Project	2008
Cancer Biomedical Informatics Grid (caBIG®) Data Sharing and Intellectual Capital Workspace	NCI caBIG® Participant Contract	2008
Development of a Versatile Geospatial Database within the CRN	NCI CRN Pilot Project	2008
HMO Cancer Research Network: Infrastructure	NCI CRN Infrastructure Grant	2007
caBIG® Population Sciences Special Interest Group	NCI caBIG® Participant Contract	2006
Development of a Shareable Analytic Dataset for Studies of Racial Disparities	NCI CRN Administrative Supplement	2005
Comparing Pancreatic Cancer Identification Using Health Plan Automated Data and SEER Cancer Registry	NCI CRN Administrative Supplement	2005
Virtual Data Warehouse (VDW) Enhancement	NCI CRN Administrative Supplement	2005
Increasing Technology to Maximize Use of the Virtual Data Warehouse (VDW)	NCI CRN Administrative Supplement	2005
Accuracy of Automated Data on Colorectal Cancer Screening	NCI CRN Pilot Project	2004
Using Electronic Medical Records to Measure and Improve Adherence to Tobacco Treatment Guidelines in Primary Care (HIT2)	NCI CRN Core Project and Administrative Supplement	2003
HMO Cancer Research Network: Infrastructure	NCI CRN Infrastructure Grant	2003
Investigating Medical Patient Records and Administrative Data in Case Identification and Treatment (IMPACT)	NCI R01 Grant	2001
HMO Cancer Research Network: Infrastructure	NCI CRN Infrastructure Grant	1999

Selected research projects are highlighted below.

Development of a Versatile Geospatial Database within the CRN

Geographic information associated with health records and facilities has a broad range of applications, including calculation of geographic access to health services, examination of service areas for health care systems, and measurement of geographically-based exposures. This project, led by Dr. Andrea Cook (GHC) and Dr. Tracy Onega (Dartmouth Medical School), will expand existing geocoding infrastructure to create a versatile geospatial database that will

include individual, demographic, and facility-level geographic variables. The geocoded facility and member data will be used to examine the influences of travel time to facility, facility availability, and socioeconomic indicators on receipt of surveillance mammography.

Using Electronic Medical Records to Measure and Improve Adherence to Tobacco Treatment Guidelines in Primary Care (HIT2)

EMRs offer an attractive method for evaluating guideline implementation and improving quality of care. This study, led by Dr. Victor Stevens

(KPNW), developed a method for coding tobacco-cessation activities (the “Five A’s”) in four HMOs using EMRs. Data were obtained from coded fields, and information entered in free-text fields (e.g., progress notes) was coded using MediClass, a natural language processing program. The team evaluated the accuracy of MediClass in assessing whether clinicians adhered to the national tobacco treatment guidelines (the “Five A’s”) with patients. MediClass performed as well as the human abstractors and was found to be practical for assessing primary care adherence to the tobacco treatment guidelines.

Building Capacity to Support Emerging Areas of Cancer Control Research

CRN investigators and health care organizations have tremendous potential to advance research activities to develop, enhance, and test health informatics, database, and biospecimen tools. Moreover, they have the resources to support research in areas such as cancer risk assessment and modeling; studies of behavioral, environmental, and genetic factors; and personalized health care approaches to preventive care, screening, diagnosis/prognosis, and treatment in relation to patient outcomes. Currently, the CRN is developing activities to increase the timeliness, efficiency, and effectiveness of recruitment to phase 2 and phase 3 prevention and treatment trials.

PROJECT TITLE	FUNDING SOURCE	YEAR FUNDED
SEARCH: Screening Effectiveness and Research in Community-Based Healthcare	NCI GO Grant	2009
Comparative Effectiveness Research in Genomic and Personalized Medicine of Colorectal Cancer	NCI GO Grant	2009
Building CER Capacity: Aligning CRN, CMS and State Resources to Map Cancer Care	NCI GO Grant	2009
Building a Population Laboratory for Pharmacoepidemiologic and Pharmacogenomic Studies in Cancer: Cardiotoxicity following Systemic Therapy for Breast Cancer	NCI CRN Administrative Supplement	2008
Cancer Prevention Index: Using Electronic Records to Improve Cancer Prevention	NCI CRN Core Research Project	2008
DEcIDE Distributed-Data Network: Comparative Effectiveness and Safety of Second-Line Anti-Hypertensive Agents	AHRQ Contract	2007
Effect of HIPAA Privacy Rule on Health Research	IOM Contract	2007
Increasing Patient Participation in Clinical Trials	NCI R01 Grant	2007
Multiplex Genetic Susceptibility Testing: An Interdisciplinary Collaboration	NHGRI Administrative Supplement to CRN	2006
Outcomes of Genetic Counseling for Heritable Breast/Ovarian Cancer: Feasibility of Identifying Cohort Through EMR	NCI CRN Administrative Supplement	2005
Development of a Method to Assess Obesity and Treatment via EMR	NCI CRN Administrative Supplement	2005
Enrolling Vietnamese and Chinese Women in Breast Cancer Treatment and Prevention Trials	NCI CRN Administrative Supplement	2001
Pilot Study to Identify Organizational Barriers to HMO Participation in Clinical Trials	NCI CRN Administrative Supplement	2000

Selected research projects are highlighted on the following page.

Building a Population Laboratory for Pharmacoepidemiologic and Pharmacogenomic Studies in Cancer: Cardiotoxicity following Systemic Therapy for Breast Cancer

This CRN proposal represents the collaborative efforts of four multicenter efforts involving members of the HMO Research Network (HMORN)—the AHRQ-funded HMORN Center for Education and Research in Therapeutics (CERTs), the NHLBI-funded Cardiovascular Research Network (CVRN), the Pharmacogenomics Scientific Interest Group of the HMORN, and the CRN. These networks contribute to and use a common data infrastructure. This project, led by Dr. Edward Wagner (GHC), is creating a population research laboratory to conduct pharmacoepidemiologic and pharmacogenomic studies, and will use this laboratory to examine important questions about the cardiotoxicity of systemic agents used to treat invasive breast cancer. Capacity development will assess the validity of electronic data on chemotherapy infusion; adapt and test alternative strategies for identifying cardiotoxicity using VDW data or other electronic data; explore the feasibility of strategies for assembling biological specimens and collecting DNA samples on study subjects; and add analytic variables for chemotherapy dose, route, and type and cardiotoxicity outcomes data to improve the VDW among the eight participating HMORN sites.

Cancer Prevention Index: Using Electronic Records to Improve Cancer Prevention

This two-year pilot study, led by Dr. Thomas Vogt (KPH), will use the Prevention Index methodology and the CRN VDW to develop and apply a set of Cancer Prevention Index (CPI) metrics to assess the quality of primary and secondary preventive care for cancer. The study will identify the variation in CPI scores across clinics and practices, determine the association of these variations with selected event rates several years later, and evaluate the association of clinician adherence to guidelines with subsequent events among their patients. The study will assess the CPI for secondary prevention (i.e., screening for breast, cervical, colorectal, and prostate cancers) and relate this index to stage at diagnosis, survival, and medical care utilization with 5- and 10-year follow-up for all persons by practice-level performance. A complementary CPI study that incorporates preventive practices relevant to cardiovascular disease was recently funded as part of the CVRN, sponsored by NHLBI.

Increasing Patient Participation in Clinical Trials and Pilot Study to Identify Organizational Barriers to HMO Participation in Clinical Trials

Clinical trials are the primary mechanism by which new approaches to cancer treatment can be evaluated, yet only a very small proportion of eligible cancer patients are offered the

opportunity to participate in clinical trials, and fewer actually enroll.

Dr. Carol Somkin (KPNC) investigated attitudinal and organizational barriers to clinical trial participation at multiple CRN sites in a pilot study. The study revealed enthusiasm for clinical trials, but also a critical need for infrastructure to support trials, better intra-organizational communication, and consideration of a trial design's impact on health plan resources. The study team next received a larger grant to increase patient participation in clinical trials, known as CHOICES: Understanding Clinical Trials as a Treatment Option. This study will use a cluster randomized trial to evaluate the effectiveness of a telephone counseling intervention to increase enrollment, knowledge, and satisfaction with treatment decision. The intervention will be tailored to patient language (English and Spanish), ethnic and cultural background, knowledge, attitudes, and beliefs about clinical trials.

Multiplex Genetic Susceptibility Testing: An Interdisciplinary Collaboration

The Multiplex Initiative, led by Dr. Colleen McBride (NHGRI), is a collaborative effort between NHGRI, NCI, HFHS, and GHC that was funded through a CRN supplement from NHGRI. The objectives are to explore individual response to being offered the Multiplex Genetic Test for complex common diseases and receiving test results, and to develop an infrastructure through which future research participants can be offered the Multiplex Genetic Test protocol.

ENHANCING CRN RESEARCH CAPACITY AND COLLABORATIONS

CRN priorities in the near term emphasize further development of the CRN research infrastructure and capacity.

This will be accomplished through:

- > Enhancement of the CRN VDW, including continual incorporation of data elements from the EMR systems of the CRN member integrated health care systems.
- > Development, evaluation and implementation of informatics tools to enhance the research utility of CRN data and research materials, including: NLP tools for extracting and standardizing EMR data elements, the use of administrative and EMR data to rapidly and efficiently identify subjects for observational studies and accrual into prospective trials, and the evaluation of informatics tools for inventory control and retrieval of biospecimen material.
- > Increasing CRN human scientific resources by supporting career development of junior investigators through the CRN Scholars Program and increased support for pilot projects, with a special emphasis on collaborations between CRN junior investigators and outside investigators.

In addition, CRN-related grants and other research projects are utilizing the multisite collaborative approach pioneered by the CRN to extend research into new areas. Examples include: CRN-affiliated Challenge and GO grants in CER, the CRN CCRC, and the CVRN. Increasingly, HMO-based cohorts are being developed to study cancer-related outcomes, such as those related to human papillomavirus (HPV) vaccination and the influence of lifestyle factors and molecular markers on breast cancer recurrence and survival.

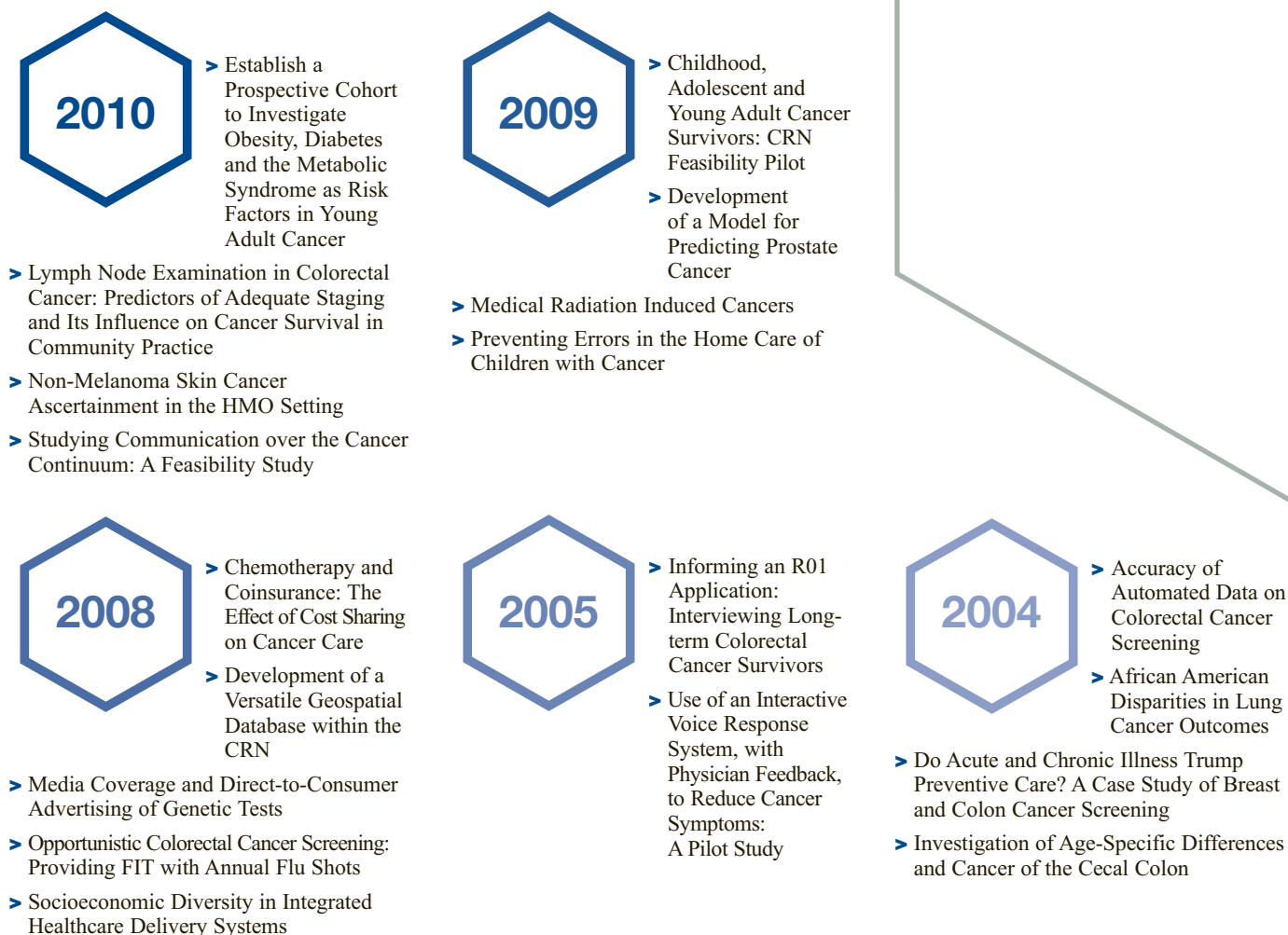
It has been an absolute pleasure collaborating with CRN investigators. They have been generous with their expertise as well as their data. The research that we are conducting could not be done in any other setting. Our pilot project has focused on understanding the utilization of diagnostic imaging, and in particular CT, and its associated radiation exposure. As part of this work we have been able to improve the standardization of the data regarding imaging contained within the virtual data warehouse (VDW), and we and other investigators are already submitting broader grant projects that will utilize these newly improved data.

Rebecca Smith-Bindman, M.D.

Professor in Residence, Radiology and Biomedical Imaging and Epidemiology & Biostatistics, Obstetrics, Gynecology, and Reproductive Medicine, UCSF Helen Diller Family Comprehensive Cancer Center

CRN Developmental Pilot Funds

NCI awarded the CRN a developmental fund for pilot activities that are consistent with the CRN's scientific priorities and leverage unique features of the CRN. The expectation is that the funded pilots will lead to larger fundable grants. Pilot activities involve at least one CRN site and have the potential to lead to research projects that involve multiple CRN sites. All investigators from within the 14 CRN sites are eligible to submit proposals. The CRN also welcomes new collaborators, including investigators external to the CRN. Projects that have already been funded using CRN developmental pilot funds are listed below by year.



CRN Scholars Program

The CRN Scholars Program was designed to nurture and develop new talent. Designed as a 20-month training activity, the program helps junior investigators develop research independence by serving as a principal investigator on a successful investigator-initiated grant and authoring peer-reviewed, published articles that report original research. The program has two components, including a one-on-one mentoring of 28 CRN Scholars (two groups of 14) over the five years of the grant cycle, and group sessions, including biweekly conference calls and in-person meetings at annual meetings of the CRN. The faculty leaders of the CRN Scholars Program are Drs. Suzanne and Robert Fletcher (HPHC). Both are active in the CRN, Dr. Suzanne Fletcher as Site Principal Investigator of HPHC and Project Leader of the PROTECTS project, and Dr. Robert Fletcher as Co-Principal Investigator of the CRN component of the CanCORS project. Drs. Suzanne and Robert Fletcher have extensive experience in investigator development. Other senior CRN investigators participate in the program to expose participants to leaders in cancer research beyond those at their home institutions, and to increase the breadth and depth of expertise available to them.

Highlighting CRN Scholar

Chyke Doubeni, M.D., F.R.C.S., M.P.H.



Dr. Chyke Doubeni is a physician researcher and epidemiologist who has built strong collaborative ties with the CRN throughout his career. He was a member of the 2009 class of CRN scholars and is currently an Assistant Professor in Family Medicine and Community Health and Associate Vice Provost for Diversity at the University of Massachusetts Medical School. In 2004, Dr. Doubeni received a CRN research supplement for underrepresented minorities to conduct a multicenter study evaluating patterns of cancer early detection services in women following diagnosis of breast or cervical cancer, and examining cancer disparities in

these patients. Following completion of the CRN research supplement, Dr. Doubeni received a career development award (*Understanding Racial and Ethnic Disparities in Survival from Colorectal Cancer*) from NCI in 2007. The research component of the career development program utilizes the integrated health care delivery systems of the CRN to assess colorectal cancer care in vulnerable populations. Dr. Doubeni led a recently awarded CRN pilot grant, *Socioeconomic Diversity in Integrated Healthcare Delivery Systems*, to assess the area-level socioeconomic status and race structure of enrollees in integrated health delivery systems of the CRN. Building on this body of research and his CRN collaborations, Dr. Doubeni is currently the Co-Principal Investigator for a CER GO grant: *SEARCH: Cancer Screening Effectiveness and Research in Community Based Healthcare*.

Highlighting CRN Scholar

Reina Haque, Ph.D., M.P.H.



Dr. Reina Haque is an epidemiologist and member of the 2009 class of CRN scholars. She is a Research Scientist in the Department of Research and Evaluation, KPSC, and a Scientific Advisor to the KPSC Cancer Registry. In 2005, Dr. Haque led a CRN pilot study, *Comparing Pancreatic Cancer Case Identification Using Health Plan Automated Data and SEER Cancer Registry*, to develop methods for rapid case ascertainment. She has served as a co-investigator and Site PI for several CRN studies, including *Clinical and Pathologic Predictors for Recurrence after Ductal Carcinoma in Situ*, *Molecular Epidemiology of Fatal Prostate Cancer*,

and *Outcomes of Prostate Cancer Androgen Deprivation Therapy*. She has also received pilot funding from the University of California Breast Cancer Research Program to examine adverse effects of combined tamoxifen and antidepressants on breast cancer recurrence. Dr. Haque will build on this body of research and her CRN collaborations to lead a recently awarded multisite R01 grant, *ABC: Antidepressants and Breast Cancer Pharmacoepidemiology*, which will assess interactions between tamoxifen and antidepressant use in a large cohort of nearly 25,000 women.

CRN Scholars

2007–2009 COHORT

Fallon Community Health Plan

(Meyers Primary Care Institute)

Chyke A. Doubeni, M.D., F.R.C.S., M.P.H.

Geisinger Health System

(Geisinger Center for Health Research)

James B. Jones, M.B.A., Ph.D.

Nirav Shah, M.D., M.P.H.

Harvard Pilgrim Health Care and Harvard Medical School

(Department of Population Medicine)

Michael Klompas, M.D.

Natasha K. Stout, Ph.D.

HealthPartners

(HealthPartners Research Foundation)

Robin R. Whitebird, Ph.D., M.S.W.

Henry Ford Hospital and Health System/ Health Alliance Plan

(Department of Biostatistics and Research
Epidemiology and Center for Health Services Research)

Andrea E. Cassidy-Bushrow, Ph.D., M.P.H.

Lovelace Health System

(Lovelace Clinic Foundation Research)

Scott B. Robinson, M.A., M.P.H.

Kaiser Permanente Hawaii

(The Center for Health Research–Hawaii)

Andrew E. Williams, Ph.D.

Kaiser Permanente Northern California

(Division of Research)

Maryam M. Asgari, M.D., M.P.H.

Kaiser Permanente Northwest

(The Center for Health Research–Northwest)

Carmit K. McMullen, Ph.D.

Kaiser Permanente Southern California

(Department of Research and Evaluation)

Reina Haque, Ph.D., M.P.H.

Marshfield Clinic/Security Health Plan

(Marshfield Clinic Research Foundation)

Laura A. Coleman, Ph.D., R.D.

Robert T. Greenlee, Ph.D., M.P.H.

2009–2011 COHORT

Fallon Community Health Plan

(Meyers Primary Care Institute)

Kathleen E. Walsh, M.D., M.S.C.

Geisinger Health System

(Geisinger Center for Health Research)

Diane Smelser, Ph.D.

Group Health Cooperative

(Group Health Research Institute)

Jessica Chubak, Ph.D.

Harvard Pilgrim Health Care and Harvard Medical School

(Department of Population Medicine)

Lingling Li, Ph.D.

HealthPartners

(HealthPartners Research Foundation)

Kenneth F. Adams, Ph.D.

Henry Ford Hospital and Health System/ Health Alliance Plan

(Department of Biostatistics and Research
Epidemiology and Center for Health Services Research)

Melody Eide, M.D., M.P.H.

Christine M. Neslund-Dudas, Ph.D.

Kaiser Permanente Colorado

(Institute for Health Research)

Heather S. Feigelson, Ph.D., M.P.H.

Borsika Rabin, Ph.D., Pharm.D., M.P.H.

Kaiser Permanente Georgia

(The Center for Health Research–Southeast)

Pamela J. Mink, Ph.D. (Emory University)

Kaiser Permanente Hawaii

(The Center for Health Research–Hawaii)

Katie M. Heinrich, Ph.D. (University of Hawaii at Manoa)

Kaiser Permanente Northwest

(The Center for Health Research–Northwest)

Nangel Lindberg, Ph.D.

Kaiser Permanente Southern California

(Department of Research and Evaluation)

Corinna Koebnick, Ph.D.

Marshfield Clinic/Security Health Plan

(Marshfield Clinic Research Foundation)

Adedayo A. Onitilo, M.D.

To me, the CRN has provided unparalleled opportunities to test systems interventions on important cancer outcomes and cancer health disparities. I have had the opportunity to work and partner with investigators at various levels of experience, develop mentoring relationships with renowned investigators, and build collaborative relationships. The combination of data resources, systems to support the development of new investigators, and the academic partnerships has made it possible for me to train and grow as an investigator.

Chyke Doubeni, M.D., F.R.C.S., M.P.H., University of Massachusetts Medical School, Fallon Community Health Plan, Meyers Primary Care Institute

THE HMO-BASED CARDIOVASCULAR RESEARCH NETWORK (CVRN)

In December of 2006, the NHLBI issued an RFA for a CVRN, with the goal of increasing scientific knowledge of cardiovascular diseases, including their epidemiology, risk and risk factors, prevention, detection and diagnosis, treatment, and prognosis, in the context of community-based health care delivery, which is the environment in which most clinical and preventive care is delivered. The RFA further stated that the research should be designed to take advantage of existing integrated data systems and use complementary resources for collaborative activities relevant to the goal.

A cooperative agreement grant totaling \$7.5 million was awarded to an HMO-based CVRN led by Dr. Alan S. Go of KPNC. Research collaborators within the CVRN span all 14 of the CRN sites, as well as other external organizations.

Initial CVRN research projects include studies of:

- Hypertension recognition, treatment, and control.
- Quality of care and outcomes of the blood thinner, warfarin, for atrial fibrillation and blood clots.
- Use, outcomes, and costs of implantable cardiac defibrillators for primary prevention of sudden death in heart failure.

Most collaborating research organizations in the HMO Research Network are participating in both the CRN and the CVRN. Through these common links, the CRN and the CVRN will have many opportunities to coordinate research activities of mutual interest, share complementary research infrastructure and expertise, and create many synergies between the two networks.

The CVRN, like the CRN, was successful in competing for CER GO grants. The NHLBI awarded two CER GO grants to the CVRN, one to develop a cardiovascular surveillance system and one to study treatment and outcomes for atrial fibrillation.

Development of HMO-Based Cohorts at CRN Sites

With its extensive data on patients, providers, health care delivery, and patient outcomes, the HMOs are ideally suited for the development of large prospective cohorts to study cancer-related outcomes. For example, the Vaccine Safety Datalink (VSD), funded by the CDC, is the primary mechanism for population-based evaluations of vaccine safety in the United States.

Eight of the CRN sites participate in the VSD to assess patterns of uptake of the human papillomavirus (HPV) vaccine, a significant new tool for the control of cervical cancer. The VSD is currently assessing capabilities for incorporating the procedure, pharmacy, cytology, and histology data necessary to measure vaccine impact in routine clinical care into their infrastructure. The project will also measure baseline cervical cancer precursor disease, genital warts, and type-specific HPV infection in the period prior to vaccine introduction (i.e., 2000–2005). After the cohort is established, the CDC will be able to monitor outcomes such as autoimmune reactions, type-specific HPV infection, age-specific immunization rates, and possible long-term adverse effects and the durability of the immune response.

Another HMO-based cohort is the Pathways Study. Led by Dr. Lawrence Kushi (KPNC), this study has identified over 2,900 newly



diagnosed breast cancer patients at KPNC who will be followed for multiple years. The multidisciplinary team of investigators from KPNC, the Roswell Park Cancer Institute, and the University of California–San Francisco will study the influence of lifestyle factors, such as diet and physical activity, the built environment, and molecular markers, including genetic factors and epigenetic modification of tumor DNAs on breast cancer recurrence and survival. Because disparities in prognosis by race may be influenced in part by these factors, the study is emphasizing enrollment of minority participants. Investigators will conduct studies in two areas that may provide insight into racial differences in prognosis, namely the role of inflammatory and immune factors, and vitamin D levels. With data from interviews and questionnaires, blood samples, saliva as a source of DNA, availability of tumor blocks, clinical data from KPNC resources and databases, and contextual-level data, the Pathways Study will be a major resource for the epidemiologic investigation of breast cancer prognosis.

CRN scientists and oncologists are very interested in assuring optimal safety of cancer patients, most of whom are exposed to therapies with complex risk profiles. Starting in 2009, most of the CRN sites were included in the Food and Drug

Administration's (FDA's) Sentinel System pilot project, which was established to monitor drug safety using electronic health data. Ultimately, the FDA plans to expand use of this active surveillance system to monitor all FDA-regulated products continuously and in real time through a larger linked system.

Biospecimen Resources

Recognizing the growing importance of population-based normal tissue specimens as well as tumor specimens linked to rich demographic, risk factor, and medical history data, the CRN Genomics Working Group, which is part of the eight-site CRN Pharmacovigilance Administrative Supplement, has conducted an appraisal of current and potential CRN capacity in this area. Two sites (MCRF and KPNC) currently have large-scale repositories of banked blood or saliva specimens collected under protocols that allow broad access for future research. Multiple CRN sites have access to banked formalin-fixed paraffin-embedded tumor blocks, several of which date back multiple decades. Currently, one site (HFHS) stores fresh frozen tissue as a standard procedure. Infrastructure regarding access, use, and cost of these materials varies across sites and funding under which materials may have been collected. Three sites (GHC, HFHS,

MCRF) currently have the capacity to electronically identify specimens. The CRN Genomics Working Group identified 33 past or current studies at CRN sites that included specimen collection as part of protocols.

CRN Cancer Communication Research Center (CCRC)

The CRN CCRC was established in 2008 at the Institute for Health Research of Kaiser Permanente Colorado and is a partnership among eight of the 14 CRN sites. Funded by NCI, this CECCR aims to identify and describe optimal communication structures and processes in organizations that facilitate patient-centered communication in cancer care. It also extends the CRN in new ways, including research on health care team-based approaches to communication about cancer, the reduction of patient uncertainty and anxiety, strategies for improving physician-patient communication about cancer, how organizational aspects of our health care systems affect communication quality, and the application of dissemination science to evidence-based practices. The strength of the CRN infrastructure, both interpersonally and technologically, was critical for obtaining this award.

CRN Grand Opportunity (GO) Grants for Building CER Capacity

The NCI CER GO grant funding opportunity was issued with the specific intent of building capacity and accelerating scientific progress in cancer comparative effectiveness research. Its goal was to sponsor initial two-year efforts to build coherent teams of interdisciplinary researchers to leverage and integrate existing data and health system research resources through such activities as CER study prioritization; data and informatics development; development of CER trials resources and operating procedures; development of CER statistical, psychometric, econometric, and modeling methods; and conduct of proof of principle CER retrospective or prospective pilot studies.

Through the competitive funding process, the CRN received three of the 13 CER GO grants awarded by the NCI. These CER capacity development projects will complement the general capacity development efforts of CRN over the next two years in the areas of breast, cervical, and colorectal cancer screening; clinical and genomic tests for colorectal cancer risk and chemotherapy response; and treatment approaches for recurrent and progressive cancer.

The GO grants awarded to the CRN include:

Research on the Effectiveness of Advanced Cancer Treatments (REACT)

Through a partnership between investigators in the CRN and Dana-Farber/Harvard Cancer Center, this study will support high-quality cancer CER by addressing two key knowledge gaps: (1) the treatment of advanced cancer; and (2) research on patterns and outcomes of cancer care for patients not represented in SEER-Medicare, the dominant data source in the field. Namely, these patients are less than 65 years of age, receive their health care through an HMO, and are ranked as ‘poor’ based on select criteria. This study will use cancer patient-level data and region-specific data to support studies of patterns of care and outcomes among patients with advanced cancer, and will also look at the capacity and limitations of these datasets. A comparative effectiveness study for patients with advanced cancer will be specified, and an evaluation trial will be designed. The output of this activity will be used to engage stakeholders in building CER capacity in cancer.

Comparative Effectiveness in Genomic and Personalized Medicine for Colon Cancer

This study will investigate the comparative effectiveness of two tests related to colorectal cancer, the KRAS test and the Lynch Syndrome (LS) prediction test, and will have two main components: (1) data collection conducted through evidence synthesis and cost-effectiveness analysis and (2) primary data collection conducted through a proof-of principle study, which will evaluate the utilization of KRAS and LS genetic tests within several integrated health care delivery systems and measure the effectiveness of KRAS testing compared with a patient population that does not receive testing. Patient and physician interviews will be conducted to assess psychosocial and decision-making issues related to KRAS testing. This study will create a unique research network spanning several member sites of the CRN as well as academic partners.



SEARCH: Cancer Screening Effectiveness and Research in Community-based Healthcare

This study will create a multidisciplinary, multisite center for CER focused on the delivery of cancer screening in a community-based setting. The SEARCH study will be used to conduct two proof-of-principle studies, one comparing liquid-based vs. conventional cytology for cervical cancer screening and one comparing screening colonoscopy vs. fecal-based tests and flexible sigmoidoscopy for colorectal cancer screening. This project will also develop methodological capacity for future large-scale, population-based CER studies, make comparisons of the performance and impact of available and emerging options for population-based cancer screening, and demonstrate the ability to conduct research that addresses important evidence gaps.

Other GO Grants with CRN Participation

Comparative Effectiveness of Breast Imaging Strategies in Community Practice

CRN investigators are collaborating with investigators from other institutions, including the University of Vermont, the University of California–San Francisco, Georgetown University, and the University of North Carolina to conduct CER on breast cancer imaging modalities and gather evidence on how to optimize breast cancer screening in community practice. Using the NCI-funded Breast Cancer Surveillance Consortium (BCSC), rigorous comparative effectiveness studies on conventional and new breast imaging technologies will inform how screening strategies can be personalized based on patient demographic and risk factor information, and aid in optimizing the balance of screening benefits and harms. In addition, BCSC data will be used to compare the clinical effectiveness of mammography screening intervals, decipher health care utilization and costs of digital vs. film-screen mammography, discern the cost-effectiveness of various breast cancer screening strategies, capture clinically and scientifically relevant data on breast MRI, and develop epidemiologic and statistical methods focused on conducting CER in community settings.

ADVancing Innovative Comparative Effectiveness Research—Cancer Diagnostics (ADVICE)

CRN investigators are collaborating with researchers from the University of Washington and the Fred Hutchinson Cancer Research Center to establish a unique research platform designed to perform CER on cancer diagnostics to fill the evidence gap for technologies used in the diagnosis and post-treatment monitoring of cancer. ADVICE will establish a multidisciplinary and cross-institutional network of health delivery systems and researchers in western Washington State for evaluating the comparative effectiveness of cancer diagnostics in real-world settings. Proof-of-principle studies will be conducted to assess diagnostic tools used for establishing extent of disease among newly diagnosed Stage I–III breast cancer and examine priority topics around in vitro diagnostic and imaging modalities and their clinical applications. Over the long run, the study will use the Puget Sound ADVICE network to conduct retrospective and prospective community-based CER with a focus on rapid turnaround and observational and randomized studies.

PUBLICATIONS BY CRN RESEARCH THEME, 1999–2009

Health Care Delivery, Quality, Costs, and Outcomes

2009

Fenton JJ, Reid RJ, Baldwin LM, Elmore JG, Buist DS, Franks P. Influence of primary care use on population delivery of colorectal cancer screening. *Canc Epidemiol Biomarkers Prev*. 2009;18(2):640–645.

Fishman PA, Hornbrook MC. Assigning resources to health care use for health services research: options and consequences. *Med Care*. 2009;47(7 suppl 1):S70–75.

Gold HT, Thwin SS, Buist DS, Field TS, Wei F, Yood MU, Lash TL, Quinn VP, Geiger AM, Silliman RA. Delayed radiotherapy for breast cancer patients in integrated delivery systems. *Am J Manag Care*. 2009;15(11):785–789.

Nekhlyudov L. “Doc, should I see you or my oncologist?” A primary care perspective on the opportunities and challenges in providing comprehensive care for cancer survivors. *J Clin Oncol*. 2009;27:2424–2426.

Nekhlyudov L, Greenfield S. Cancer survivorship for the general internist: Have we paved the way for a smoother transition? *J Gen Intern Med*. 2009;24(suppl 2):381–382.

Nekhlyudov L, Habel LA, Achacoso NS, Jung I, Haque R, Collins LC, Schnitt SJ, Quesenberry CP Jr, Fletcher SW. Adherence to long-term surveillance mammography among women With ductal carcinoma *in situ* treated with breast-conserving surgery. *J Clin Oncol*. 2009;27(19):3211–3216.

Sukhanova A, Ritzwoller DP, Alexander GL, Calvi JH, Carlier C, McClure JB, Rolnick S, Johnson CC. Cost analyses of a web-based behavioral intervention to enhance fruit and vegetable consumption. *Int J Behav Nutr Phys Activ*. 2009;6:92.

Walsh KE, Dodd KS, Seetharaman K, Roblin DW, Herrinton LJ, Von Worley A, Usmani GN, Baer D, Gurwitz JH. Medication errors among adults and children with cancer in the outpatient setting. *J Clin Oncol*. 2009;27(6):891–896.

2008

Fenton JJ, Franks P, Reid RJ, Elmore JG, Baldwin LM. Continuity of care and cancer screening among health plan enrollees. *Med Care*. 2008;46(1):58–62.

Field TS, Doubeni C, Fox MP, Buist DS, Wei F, Geiger AM, Quinn VP, Lash TL, Prout MN, Yood MU, Frost FJ, Silliman RA. Under utilization of surveillance mammography among older breast cancer survivors. *J Gen Intern Med*. 2008;23(2):158–163.

Owusu C, Buist DS, Field TS, Lash TL, Thwin SS, Geiger AM, Quinn VP, Frost F, Prout M, Ulcickas Yood M, Wei F, Silliman RA. Predictors of tamoxifen discontinuation among older women with estrogen receptor positive breast cancer. *J Clin Oncol*. 2008;26(4):549–555.

2007

Buist DSM, Ichikawa L, Prout MN, Ulcickas Yood M, Field TS, Owusu C, Geiger AM, Quinn VP, Wei F, Silliman RA. Receipt of breast cancer therapy and adjuvant therapy are not associated with obesity in older women with access to health care. *J Clin Oncol*. 2007;25(23):3428–3436.

Fenton JJ, Cai Y, Weiss NS, Elmore JG, Pardee RE, Reid RJ, Baldwin LM. Delivery of cancer screening: how important is the preventive health examination? *Arch Intern Med*. 2007;167(6):580–585.

Herrinton L, Hornbrook MC, Coughlin S, et al. Complications at the end of life in ovarian cancer. *J Pain Symptom Manag*. 2007;34(3):237–243.

Rolnick SJ, Jackson J, Nelson WW, Butani A, Herrinton LJ, Hornbrook M, Neslund-Dudas C, Bachman DJ, Coughlin SS. Pain management in the last six months of life among women who died of ovarian cancer. *J Pain Symptom Manag*. 2007;33(1):24–31.

2006

Boudreau DM, Buist DS, Rutter CM, Fishman PA, Beverly KR, Taplin S. Impact of hormone therapy on false-positive recall and costs among women undergoing screening mammography. *Med Care*. 2006;44(1):62–69.

Doubeni C, Field T, Ulcickas Yood M, Rolnick SJ, Quesenberry C, Fouayzi H, Gurwitz J, Wei F. Patterns and predictors of mammography utilization among breast cancer survivors. *Cancer*. 2006;106(11):2482–2488.

Enger S, Thwin S, Buist D, Field T, Frost F, Geiger A, Lash TL, Prout M, Yood M, Wei F, Silliman R. Breast cancer treatment of older women in integrated health care settings. *J Clin Oncol*. 2006;24(27):4377–4383.

Malin JL, Ko C, Ayanian JZ, Harrington D, Nerenz DR, Kahn KL, Ganther-Urmie J, Catalano PJ, Zaslavsky AM, Wallace RB, Guadagnoli E, Arora NK, Roudier MD, Ganz PA. Understanding cancer patients' experience and outcomes: development and pilot study of the Cancer Care Outcomes Research and Surveillance patient survey. *Support Care Canc*. 2006;14(8):837–848.

2005

Fletcher SW, Elmore JG. False-positive mammograms—can the USA learn from Europe? *Lancet*. 2005;365(9453):7–8.

Hornbrook MC. On the definition and measurement of the economic burden of cancer. In: Lipscomb J, Gotay CC, Snyder C, eds. *Outcomes Assessment in Cancer: Findings and Recommendations of the Cancer Outcomes Measurement Working Group*. Oxford: Cambridge University Press; 2005:480–502.

Keating NL, Herrinton LJ, Zaslavsky AM, Liu L, Ayanian JZ. Variations in hospice use among cancer patients. *J Natl Canc Inst*. 2006;98(15):1053–1059.

Leyden WA, Manos MM, Geiger AM, Weinmann S, Mouchawar J, Bischoff K, Yood MU, Gilbert J, Taplin Sh. Cervical cancer in women with comprehensive health care access: attributable factors in the screening process. *J Natl Canc Inst*. 2005;97(9):675–683.

Mouchawar J, Taplin S, Ichikawa L, Barlow WE, Geiger AM, Weinmann S, Gilbert J, Manos MM, Ulcickas Yood M. Late-stage breast cancer among women with recent negative screening mammography: do clinical encounters offer opportunity for earlier detection? *J Natl Canc Inst Monogr*. 2005;35:39–46.

Puleo E, Zapka JG, Goins KV, Yood MU, Mouchawar J, Manos M, Somkin C, Taplin S. Recommendations for care related to follow-up of abnormal cancer screening tests: accuracy of patient report. *Eval Health Prof*. 2005;28(3):310–327.

Ritzwoller DP, Goodman MJ, Maciosek MV, Elston Lafata J, Meenan R, Hornbrook MC, Fishman PA. Creating standard cost measures across integrated health care delivery systems. *J Natl Canc Inst Monogr*. 2005;35:80–87.

Stevens VJ, Solberg LI, Quinn VP, Rigotti NA, Hollis JA, Smith KS, Zapka JG, France E, Vogt T, Gordon N, Fishman P, Boyle RG. Relationship between tobacco control policies and the delivery of smoking cessation services in nonprofit HMOs. *J Natl Canc Inst Monogr*. 2005;35:75–80.

Weinmann S, Taplin SH, Gilbert J, Beverly RK, Geiger AM, Yood MU, Mouchawar J, Manos MM, Zapka JG, Westbrook E, Barlow WE. Characteristics of women refusing follow-up for tests or symptoms suggestive of breast cancer. *J Natl Canc Inst Monogr*. 2005;35:33–38.

Zapka JG, Puleo E, Taplin S, Solberg LI, Mouchawar J, Somkin C, Geiger AM, Ulcickas Yood M. Breast and cervical cancer screening: clinicians' views on health plan guidelines and implementation efforts. *J Natl Canc Inst Monogr*. 2005;35:46–54.

2004

Ayanian JZ, Chrischilles EA, Fletcher RH, Fouad MN, Harrington DP, Kahn KL, Kiefe CI, Lipscomb J, Malin JL, Potosky AL, Provenzale DT, Sandler RS, van Ryn M, Wallace RB, Weeks JC, West DW. Understanding cancer treatment and outcomes: the Cancer Care Outcomes Research and Surveillance Consortium. *J Clin Oncol*. 2004;22(15):2992–2996.

Field TS, Cernieux J, Buist D, Geiger A, Lamerato L, Hart G, Bachman D, Krajenta R, Greene S, Hornbrook MC, Ansell G, Herrinton L, Reed G. Retention of enrollees following a cancer diagnosis within health maintenance organizations in the Cancer Research Network. *J Natl Canc Inst*. 2004;96(2):148–152.

Health Care Delivery, Quality, Costs, and Outcomes (cont.)

Solberg LI, Quinn VP, Stevens VJ, Vogt TM, Rigotti NA, Zapka JG, Ritzwoller DP, Smith KS. Tobacco control efforts in managed care: what do the doctors think? *Am J Manag Care*. 2004;10(3):193–198.

Taplin SH, Ichikawa L, Yood MU, Manos MM, Geiger AM, Weinmann S, Gilbert J, Mouchawar J, Leyden WA, Altaras R, Beverly RK, Casso D, Westbrook EO, Bischoff K, Zapka JG, Barlow WE. Reason for late-stage breast cancer: absence of screening or detection, or breakdown in follow-up? *J Natl Canc Inst*. 2004;96(20):1518–1527.

Zapka JG, Puleo E, Taplin SH, Goins KV, Ulcickas Yood M, Mouchawar J, Somkin C, Manos MM. Processes of care in cervical and breast cancer screening and follow-up—the importance of communication. *Prev Med*. 2004;39(1):81–90.

2003

Goins KV, Zapka JG, Geiger AM, Solberg LI, Taplin S, Yood MU, Gilbert J, Mouchawar J, Somkin CP, Weinmann S. Implementation of systems strategies for breast and cervical cancer screening services in health maintenance organizations. *Am J Manag Care*. 2003;9(11):745–755.

Solberg LI, Hollis JA, Stevens VJ, Rigotti NA, Quinn VP, Aickin M. Does methodology affect the ability to monitor tobacco control activities? Implications for HEDIS and other performance measures. *Prev Med*. 2003;37(1):33–40.

Zapka JG, Taplin SH, Solberg LI, Manos MM. A framework for improving the quality of cancer care: the case of breast and cervical cancer screening. *Canc Epidemiol Biomarkers Prev*. 2003;12(1):4–13.

2000

Fletcher SW. Following up abnormal breast cancer screening results: lessons for primary care clinicians. *J Am Board Fam Pract*. 2000;13(2):152–154.

1999

Fletcher SW. False-positive screening mammograms: good news, but more to do. *Ann Intern Med*. 1999;131(1):60–62.

Cancer Epidemiology, Prevention, and Health Promotion

2009

Ahern TP, Bosco JLF, Silliman RA, Ulcickas Yood M, Field TS, Wei F. Potential misinterpretations caused by collapsing upper categories of comorbidity indices: an illustration from a cohort of older breast cancer survivors. *Clin Epidemiol*. 2009;1:93–100.

Asgari MM, Tang J, Epstein EH Jr, Chren MM, Warton EM, Quesenberry CP Jr, Go AS, Friedman GD. Statin use and risk of basal cell carcinoma. *J Am Acad Dermatol*. 2009;61(1):66–72.

Bosco JL, Lash TL, Prout MN, Buist DS, Geiger AM, Haque R, Wei F, Silliman RA, BOW Investigators. Breast cancer recurrence in older women five to ten years after diagnosis. *Canc Epidemiol Biomarkers Prev*. 2009;18(11):2979–2983.

Bosco JL, Silliman RA, Thwin SS, Geiger AM, Buist DS, Prout MN, Yood MU, Haque R, Wei F, Lash TL. A most stubborn bias: no adjustment method fully resolves confounding by indication in observational studies. *J Clin Epidemiol*. 2010;63(1):64–74. Epub 2009 May 19.

Collins LC, Achacoso N, Nekhlyudov L, Fletcher SW, Haque R, Quesenberry CP Jr, Puligandla B, Alshak NS, Goldstein LC, Gown AM, Schnitt SJ, Habel LA. Relationship between clinical and pathologic features of ductal carcinoma in situ and patient age: an analysis of 657 patients. *Am J Surg Pathol*. 2009;33(12):1802–1808.

Eide MJ, Krajenta R, Johnson D, Long JJ, Jacobsen G, Asgari MM, Lim HW, Johnson CC. Identification of patients with nonmelanoma skin cancer using health maintenance organization claims data. *Am J Epidemiol*. 2010;171(1):123–128. Epub 2009 Dec 6.

Habel LA, Achacoso NS, Haque R, Nekhlyudov L, Fletcher SW, Schnitt SJ, Collins LC, Geiger AM, Puligandla B, Acton L, Quesenberry CP Jr. Declining recurrence among ductal carcinoma in situ patients treated with breast-conserving surgery in the community setting. *Breast Canc Res*. 2009;11(6):R85–R85.

Hexsel CL, Eide MJ, Johnson CC, Krajenta R, Jacobsen G, Hamzavi I, Lim HW. Incidence of nonmelanoma skin cancer in a cohort of vitiligo patients. *J Amer Acad Derm*. 2009;60:929–933.

Tewari A, Gold HT, Demers RY, Johnson CC, Yadav R, Wagner EH, Field TS, Divine G, Menon M. Effect of socioeconomic factors on long-term mortality in men with clinically localized prostate cancer. *Urology*. 2009;73:624–630.

Yu O, Boudreau DM, Buist DS, Miglioretti DL. Statin use and female reproductive organ cancer risk in a large population-based setting. *Cancer Causes Control* 2009;20(5):609-16.

2008

Boudreau DM, Koehler E, Rulyak SJ, Haneuse S, Harrison R, Mandelson MT. Cardiovascular medication use and risk for colorectal cancer. *Canc Epidemiol Biomarkers Prev*. 2008;17(11):3076–3080.

Boudreau DM, Yu O, Buist DS, Miglioretti DL. Statin use and prostate cancer risk in a large population-based setting. *Canc Causes Contr*. 2008;19(7):767–774.

Resnicow K, Davis RE, Zhang G, Konkel J, Strecher VJ, Shaikh AR, Tolsma D, Calvi J, Alexander G, Anderson JP, Wiese C. Tailoring a fruit and vegetable intervention on novel motivational constructs: results of a randomized study. *Ann Behav Med*. 2008;35(2):159–169.

Ulcickas Yood M, Owusu C, Buist DSM, Geiger AM, Field TS, Thwin SS, Lash TL, Prout MN, Frost FJ, Wei F, Quinn VP, Silliman RA. The mortality impact of less than standard therapy in older breast cancer patients. *J Am Coll Surg*. 2008;206:66–75.

2007

Boudreau DM, Yu O, Miglioretti DL, Buist DS, Heckbert SR, Daling JR. Statin use and breast cancer risk in a large population-based setting. *Canc Epidemiol Biomarkers Prev*. 2007;16(3):416–421.

Collins LC, Achacoso NA, Nekhlyudov L, Fletcher SW, Haque R, Quesenberry CP Jr, Alshak NS, Puligandla B, Brodsky GL, Schnitt SJ, Habel LA. Clinical and pathologic features of ductal carcinoma in situ associated with the presence of flat epithelial atypia: an analysis of 543 patients. *Mod Pathol*. 2007;20(11):1149–1155. Epub 2007 Aug 31.

Fenton JJ, Rolnick SJ, Harris EL, Barton MB, Barlow WE, Reisch LM, Herrinton LJ, Geiger AM, Fletcher SW, Elmore JG. Specificity of clinical breast examination in community practice. *J Gen Intern Med*. 2007;22(3):332–337.

Fortuny J, Johnson CC, Bohlke K, Chow WH, Hart G, Kucera G, Mujumdar U, Ownby D, Wells K, Yood MU, Engel LS. Use of anti-inflammatory drugs and lower esophageal sphincter-relaxing drugs and risk of esophageal and gastric cancers. *Clin Gastroenterol Hepatol*. 2007;5(10):1154–1159.

Geiger A, Thwin S, Lash T, Buist D, Prout M, Wei F, Field TS, Ulcickas Yood M, Frost F, Enger S, Silliman R. Recurrences and second primary breast cancers in older women with initial early-stage disease. *Cancer*. 2007;109(5):966–974.

Geiger AM, Prout MN, Silliman RA. Adjuvant radiation and hormonal therapy prevent recurrences and second primary breast cancers in older women. *Am J Hematol Oncol*. 2007;6:400–405.

Herrinton LJ, Liu L, Lafata JE, Allison JE, Andrade SE, Korner EJ, Chan KA, Platt R, Hiatt D, O'Connor S. Estimation of the period prevalence of inflammatory bowel disease among nine health plans using computerized diagnoses and outpatient pharmacy dispensings. *Inflamm Bowel Dis*. 2007;13(4):451–461.

Lash TL, Fox MP, Buist DS, Wei F, Field TS, Frost FJ, Geiger AM, Quinn VP, Yood MU, Silliman RA. Mammography surveillance and mortality in older breast cancer survivors. *J Clin Oncol*. 2007;25(21):3001–3006.

Lash TL, Fox MP, Thwin SS, Geiger AM, Buist DS, Wei F, Field TS, Yood MU, Frost FJ, Quinn VP, Prout MN, Silliman RA. Using probabilistic corrections to account for abstractor agreement in medical record reviews. *Am J Epidemiol*. 2007;165(12):1454–1461.

Thwin SS, Clough-Gorr KM, McCarty MC, Lash TL, Alford SH, Buist DS, Enger SM, Field TS, Frost F, Wei F, Silliman RA. Automated inter-rater reliability assessment and electronic data collection in a multi-center breast cancer study. *BMC Med Res Methodol*. 2007;7(1):23.

2006

Feldstein AC, Vogt TM, Aickin M, Hu WR. Mammography screening rates decline: a person-time approach to evaluation. *Prev Med*. 2006;43(3):178–182.

Cancer Epidemiology, Prevention, and Health Promotion (cont.)

Habel LA, Shak S, Jacobs MK, Capra A, Alexander C, Pho M, Baker J, Walker M, Watson D, Hackett J, Blick NT, Greenberg D, Fehrenbacher L, Langholz B, Quesenberry CP. A population-based study of tumor gene expression and risk of breast cancer death among lymph node-negative patients. *Breast Canc Res*. 2006;8(3):R25.

2005

Barton MB, West CN, Liu IL, Harris EL, Rolnick SJ, Elmore JG, Herrinton LJ, Greene SM, Nekhlyudov L, Fletcher SW, Geiger AM. Complications following bilateral prophylactic mastectomy. *J Natl Canc Inst Monogr*. 2005;35:61–66.

Elmore JG, Armstrong K, Lehman CD, Fletcher SW. Screening for breast cancer. *JAMA*. 2005;293(10):1245–1256.

Elmore JG, Reisch LM, Barton MB, Barlow WE, Rolnick S, Harris EL, Herrinton LJ, Geiger AM, Beverly RK, Hart G, Yu O, Greene SM, Weiss NS, Fletcher SW. Efficacy of breast cancer screening in the community according to risk level. *J Natl Canc Inst*. 2005;97(14):1035–1043.

Fenton JJ, Barton MB, Geiger AM, Herrinton LJ, Rolnick SJ, Harris EL, Barlow WE, Reisch LM, Fletcher SW, Elmore JG. Screening clinical breast examination: how often does it miss lethal breast cancer? *J Natl Canc Inst Monogr*. 2005;35:67–71.

Fletcher SW. *Risk Stratification for Breast Cancer Detection: Better Quality Mammography for Women through Better Focusing of Services. Saving Women's Lives: Strategies for Improving Breast Cancer Detection and Diagnosis. A Breast Cancer Research Foundation and Institute of Medicine Symposium*. Washington, D.C.: National Academies Press; 2005:43–50.

Geiger AM, Yu O, Herrinton LJ, Barlow WE, Harris EL, Rolnick S, Barton MB, Elmore JG, Fletcher SW. A population-based study of bilateral prophylactic mastectomy efficacy in women at elevated risk for breast cancer in community practices. *Arch Intern Med*. 2005;165(5):516–520.

Herrinton LJ, Barlow WE, Yu O, Geiger AM, Elmore JG, Barton MB, Harris EL, Rolnick S, Pardee R, Husson G, Macedo A, Fletcher SW. Efficacy of prophylactic mastectomy in women with unilateral breast cancer: a cancer research network project. *J Clin Oncol*. 2005;23(19):4275–4286.

2004

Tammemagi CM, Neslund-Dudas C, Simoff M, Kvale P. In lung cancer patients, age, race-ethnicity, gender and smoking predict adverse comorbidity, which in turn predicts treatment and survival. *J Clin Epidemiol*. 2004;57(6):597–609.

Tammemagi CM, Neslund-Dudas C, Simoff M, Kvale P. Smoking and lung cancer survival: the role of comorbidity and treatment. *Chest*. 2004;125(1):27–37.

2003

Fletcher SW, Elmore JG. Clinical practice. Mammographic screening for breast cancer. *N Engl J Med*. 2003;348(17):1672–1680.

Tammemagi CM, Neslund-Dudas C, Simoff M, Kvale P. Impact of comorbidity on lung cancer survival. *Int J Canc*. 2003;103(6):792–802.

2002

Elmore JG, Miglioretti DL, Reisch LM, Barton MB, Kreuter W, Christiansen CL, Fletcher SW. Screening mammograms by community radiologists: variability in false-positive rates. *J Natl Canc Inst*. 2002;94(18):1373–1380.

2000

Christiansen CL, Wang F, Barton MB, Kreuter W, Elmore JG, Gelfand AE, Fletcher SW. Predicting the cumulative risk of false-positive mammograms. *J Natl Canc Inst*. 2000;92(20):1657–1666.

Enhancing Cancer Communication and Decision-Making

2010

Fagerlin A, Zikmund-Fisher BJ, Smith DM, Nair V, Derry HA, McClure JB, Greene S, Stark A, Alford SH, Lantz P, Hayes DF, Wiese C, Zweig SC, Pitsch R, Jankovic A, Ubel PA. Women's decisions regarding tamoxifen for breast cancer prevention: responses to a tailored decision aid. *Breast Canc Res Treat*. 2010;119(3):613–20.

Ubel PA, Smith DM, Zikmund-Fisher BJ, Derry HA, McClure J, Stark A, Wiese C, Greene S, Jankovic A, Fagerlin A. Testing whether decision aids introduce cognitive biases: results of a randomized trial. *Patient Educ Counsel*. 2010. [Epub ahead of print]

2009

Jackson JM, Rolnick SJ, Asche SE, Heinrich RL. Knowledge, attitudes, and preferences regarding advance directives among patients of a managed care organization. *Am J Manag Care*. 2009;15(3):177–186.

Nekhlyudov L, Braddock CH. An approach to enhance communication about screening mammography in primary care. *J Women Health*. 2009;18:1403–1412.

2008

Aiello Bowles EJ, Tuzzio L, Wiese CJ, Kirlin B, Greene SM, Clauser SB, Wagner EH. Understanding high-quality cancer care: a summary of expert perspectives. *Cancer*. 2008;112(4):934–942.

Nekhlyudov L, Li R, Fletcher SW. Informed decision-making before initiating screening mammography: does it occur and does it make a difference? *Health Expectations*. 2008; 11:366–375.

Strecher VJ, McClure JB, Alexander GL, Chakraborty B, Nair VN, Konkel JM, Greene SM, Collins LM, Carlier CC, Wiese CJ, Little RJ, Pomerleau CS, Pomerleau OF. Web-based smoking-cessation programs results of a randomized trial. *Am J Prev Med*. 2008;34(5):373–381.

Zikmund-Fisher PJ, Ubel PA, Smith DM, Derry HA, McClure JB, Stark A, Pitsch RK, and Fagerlin A. Communicating side effect risks in a Tamoxifen prophylaxis decision aid: the de-biasing influence of pictographs. *Patient Educ Counsel*. 2008;73:209–214.

2006

Rothert K, Strecher VJ, Doyle LA, Caplan WM, Joyce JS, Jimison HB, Karm LM, Mims AD, Roth MA. Web-based weight management programs in an integrated health care setting: a randomized, controlled trial. *Obesity*. 2006;14(2):266–272.

2005

Nekhlyudov L, Bower M, Herrinton LJ, Altschuler A, Greene SM, Rolnick S, Elmore JG, Harris EL, Liu A, Emmons KM, Fletcher SW, Geiger AM. Women's decision-making roles regarding contralateral prophylactic mastectomy. *J Natl Canc Inst Monogr*. 2005;35:55–60.

Nekhlyudov L, Li R, Fletcher SW. Information and involvement preferences of women in their 40s before their first screening mammogram. *Arch Intern Med*. 2005;165:1370–1374.

2003

Nekhlyudov L, Ross-Degnan D, Fletcher SW. Beliefs and expectations of women under 50 years old regarding screening mammography: a qualitative study. *J Gen Intern Med*. 2003;18:182–189.

Dissemination and Implementation Research in Cancer Prevention, Screening, and Treatment

2009

Beck A, Bergman DA, Rahm AK, Dearing JW, Glasgow RE. Using implementation and dissemination concepts to spread 21st-century well child care at a health maintenance organization. *The Permanente Journal*. 2009;13(3):10–17.

Dearing JW. Applying diffusion of innovation theory to intervention development. *Res Soc Work Pract*. 2009;19:503–518.

Quinn VP, Hollis JF, Smith KS, Rigotti NA, Solberg LI, Hu W, Stevens VJ. Effectiveness of the 5-As tobacco cessation treatments in nine HMOs. *J Gen Intern Med*. 2009;24(2):149–154.

2008

Aiello EJ, Buist DS, Wagner EH, Tuzzio L, Greene SM, Lamerato LE, Field TS, Herrinton LJ, Haque R, Hart G, Bischoff KJ, Geiger AM. Diffusion of aromatase inhibitors for breast cancer therapy between 1996 and 2003 in the Cancer Research Network. *Breast Canc Res Treat*. 2008;107(3):397–403.

Dearing JW. Evolution of dissemination and diffusion theory. *J Publ Health Manag Pract*. 2008;14(2):99–108.

Dissemination and Implementation Research in Cancer Prevention, Screening, and Treatment (cont.)

Dearing JW. The will to change at Kaiser Permanente. *The Permanente Journal*. 2008;12(3):58–60.

Dearing JW, Kim DK. Diffusion of information and innovation. In: Donsbach W ed. *The International Encyclopedia of Communication. Volume III*. London: Blackwell; 2008:1299–1304.

Newton KM, Buist DS, Yu O, Hartsfield CL, Andrade SE, Wei F, Connelly MT, Chan KA. Hormone therapy initiation after the Women's Health Initiative. *Menopause*. 2008;15(3):487–493.

2005

Dearing JW. On the Gyant's shoulders: purposive diffusion as an outcome of the diffusion paradigm. In: Griffen A, Otnes C, eds. *16th Paul D. Converse Symposium*. Chicago: American Marketing Association; 2000:152–162.

Hartsfield CL, Connelly MT, Newton KM, Andrade SE, Wei F, Buist DS. Health system responses to the Women's Health Initiative findings on estrogen and progestin: organizational response. *J Natl Canc Inst Monogr*. 2005;35:113–115.

Mouchawar J, Laurion S, Ritzwoller DP, Ellis J, Kulchak-Rahm A, Hensley-Alford S. Assessing controversial direct-to-consumer advertising for hereditary breast cancer testing: reactions from women and their physicians in a managed care organization. *Am J Manag Care*. 2005;11(10):601–608.

Mouchawar J, Hensley-Alford S, Laurion S, Ellis J, Kulchak-Rahm A, Finucane ML, Meenan R, Axell L, Pollack R, Ritzwoller D. Impact of direct-to-consumer advertising for hereditary breast cancer testing on genetic services at a managed care organization: a naturally-occurring experiment. *Genet Med*. 2005;7(3):191–197.

Newton KM, Buist DS, Miglioretti DL, Beverly K, Hartsfield CL, Chan KA, Andrade SE, Wei F, Connelly MT, Kessler L. The impact of comorbidities on hormone use. After the 2000 release of the Women's Health Initiative. *J Gen Intern Med*. 2005;20(4):350–356.

Wei F, Miglioretti DL, Connelly MT, Andrade SE, Newton KM, Hartsfield CL, Chan KA, Buist DS. Changes in women's use of hormones after the Women's Health Initiative estrogen and progestin trial by race, education, and income. *J Natl Canc Inst Monogr*. 2005;35:106–112.

2004

Buist DS, Newton KM, Miglioretti DL, Beverly K, Connelly MT, Andrade S, Hartsfield CL, Wei F, Chan KA, Kessler L. Hormone therapy prescribing patterns in the United States. *Obstet Gynecol*. 2004;104(5):1042–1050.

Dearing JW. Improving the state of health programming by using diffusion theory. *J Health Comm*. 2004;9:1–16.

2003

Mouchawar J, Valentine Goins K, Somkin C, Puleo E, Hensley Alford S, Geiger AM, Taplin S, Gilbert J, Weinmann S, Zapka J. Guidelines for breast and ovarian cancer genetic counseling referral: adoption and implementation in HMOs. *Genet Med*. 2003;5(6):444–450.

Winickoff JP, Glauber JH, Perrin JM, Boch B, Rigotti NA. Improving tobacco dependence medication use in a Medicaid managed care organization: a practical systems-level approach. *J Clin Outcome Manag*. 2003;10:535–539.

2002

Rigotti NA, Quinn VP, Stevens VJ, Solberg LI, Hollis JF, Rosenthal AC, Zapka JG, France E, Gordon N, Smith S, Monroe M. Tobacco-control policies in 11 leading managed care organizations: progress and challenges. *Eff Clin Pract*. 2002;5(3):130–136.

Psychosocial Factors and Burden of Cancer

2009

Altschuler A, Ramirez M, Grant M, Hornbrook M, Herrinton L, Krouse R. The influence of husbands' or male partners' support on women's psychosocial adjustment to having an ostomy resulting from colorectal cancer. *J Wound Ostomy Continence Nurs*. 2009;36(3):299–305.

Baldwin, CM, Grant M, Wendel C, Hornbrook M, Herrinton L, McMullen C, Krouse RS. Gender differences in sleep disruption and fatigue on quality of life among persons with ostomies. *J Clin Sleep Med*. 2009;5(4):335–343.

Doubeni CA, Li W, Fouayzi H, DiFranza JR. Perceived accessibility of cigarettes among youth: a prospective cohort study. *Am J Prev Med*. 2009;36(3):239–242.

Doubeni CA, Laiyemo AO, Reed G, Field TS, Fletcher RH. Socioeconomic and racial patterns of colorectal cancer screening among Medicare enrollees in 2000 to 2005. *Canc Epidemiol Biomarkers Prev*. 2009;18:2170–2175.

Krouse RS, Herrinton LJ, Grant M, Wendel CS, Green SB, Mohler MJ, Baldwin CM, McMullen C, Rawl SM, Matayoshi E, Coons SJ, Hornbrook MC. Health-related quality of life among long-term rectal cancer survivors with an ostomy: manifestations by sex. *J Clin Oncol*. 2009;27(28):4664–4670.

Lundy JJ, Coons SJ, Wendel CS, Hornbrook MC, Herrinton LJ, Grant M, Krouse RS. Exploring household income as a predictor of psychological well-being among long-term colorectal cancer survivors. *Qual Life Res*. 2009;18(2):157–161.

McClure JB, Divine G, Alexander G, Tolsma D, Rolnick SJ, Stopponi M, Richards J, Johnson CC. A comparison of smokers' and nonsmokers' fruit and vegetable intake and relevant psychosocial factors. *Behav Med*. 2009;35(1):14–22.

Tolsma D, Calvi J, Davis RE, Greene SM, Resnicow K, Anderson J, Wiese C, Alexander G. Challenges in researching racially sensitive topics in HMOs. *Health Psychol*. 2009;28(4):389–390.

2008

Altschuler A, Nekhlyudov L, Rolnick SJ, Greene SM, Elmore JG, West C, Herrinton LJ, Harris EL, Fletcher SW, Emmons KM, Geiger AM. Positive, negative and disparate: women's differing long-term psychosocial experiences of bilateral or contralateral prophylactic mastectomy. *Breast J*. 2008;14(1):25–32.

McMullen CK, Hornbrook MC, Grant M, Baldwin CM, Ramirez ML, Wendel CS, Mohler MJ, Altschuler A, Krouse RS. The greatest challenges reported by long-term colorectal cancer survivors with stomas. *J Support Oncol*. 2008;6(4):175–182.

Mohler MJ, Coons SJ, Hornbrook MC, Herrinton LJ, Wendel CS, Grant M, Krouse RS. The Health-Related Quality of Life in Long-Term Colorectal Cancer Survivors Study: objectives, methods and patient sample. *Curr Med Res Opin*. 2008;24(7):2059–2070.

Doubeni CA, Field TS, Buist DS, Korner EJ, Bigelow C, Lamerato L, Herrinton L, Quinn VP, Hart G, Hornbrook MC, Gurwitz JH, Wagner EH. Racial differences in tumor stage and survival for colorectal cancer in an insured population. *Cancer*. 2007;109(3):612–620.

Geiger AM, Nekhlyudov L, Herrinton LJ, Rolnick SJ, Greene SM, West CN, Harris EL, Elmore JG, Altschuler A, Liu IL, Fletcher SW, Emmons KM. Quality of life after bilateral prophylactic mastectomy. *Ann Surg Oncol*. 2007;14(2):686–694.

Rolnick SJ, Altschuler A, Nekhlyudov L, Elmore JG, Greene SM, Harris EL, Herrinton LJ, Barton MB, Geiger AM, Fletcher SE. What women wish they knew before prophylactic mastectomy. *Canc Nurs*. 2007;30(4):285–291.

2006

Geiger AM, West CN, Nekhlyudov L, Herrinton LJ, Liu IL, Altschuler A, Rolnick SJ, Harris EL, Greene SM, Elmore JG, Emmons KM, Fletcher SW. Contentment with quality of life among breast cancer survivors with and without contralateral prophylactic mastectomy. *J Clin Oncol*. 2006;24(9):1350–1356.

Jackson JM, Rolnick SJ, Coughlin SS, Neslund-Dudas C, Hornbrook MC, Darbinian J, Bachman DJ, Herrinton LJ. Social support among women who died of ovarian cancer. *Support Care Canc*. 2006;15(5):547–556.

Lambing A, Markey CA, Neslund-Dudas CM, Bricker LJ. Completing a life: comfort level and ease of use of a CD-ROM among seriously ill patients. *Oncol Nurs Forum*. 2006;33(5):999–1006.

2005

Field TS, Buist DS, Doubeni C, Enger S, Fouayzi H, Hart G, Korner EJ, Lamerato L, Bachman DJ, Ellis J, Herrinton L, Hornbrook MC, Krajenta R, Liu L, Yao J. Disparities and survival among breast cancer patients. *J Natl Canc Inst Monogr*. 2005;35:88–95.

Nguyen TT, Somkin CP, Ma Y. Participation of Asian-American women in cancer chemoprevention research: physician perspectives. *Cancer*. 2005;104(12 suppl):3006–3014.

Psychosocial Factors and Burden of Cancer (cont.)

Nguyen TT, Somkin CP, Ma Y, Fung LC, Nguyen T. Participation of Asian-American women in cancer treatment research: a pilot study. *J Natl Canc Inst Monogr.* 2005;35:102–105.

Quinn VP, Stevens VJ, Hollis JF, Rigotti NA, Solberg LI, Gordon N, Ritzwoller D, Smith KS, Hu W, Zapka J. Tobacco-cessation services and patient satisfaction in nine nonprofit HMOs. *Am J Prev Med.* 2005;29(2):77–84.

Rolnick S, Hensley Alford S, Kucera GP, Fortman K, Ulcickas Yood M, Jankowski M, Johnson CC. Racial and age differences in colon examination surveillance following a diagnosis of colorectal cancer. *J Natl Canc Inst Monogr.* 2005;35:96–101.

Rolnick SJ, Kopher RA, DeFor TA, Kelley ME. Hormone use and patient concerns after the findings of the Women's Health Initiative. *Menopause.* 2005;12(4):399–404.

Tammemagi CM, Nerenz D, Neslund-Dudas C, Feldkamp C, Nathanson D. Comorbidity and survival disparities among black and white patients with breast cancer. *JAMA.* 2005;294(14):1765–1772.

2002

Ford ME, Hill DD, Nerenz D, Hornbrook M, Zapka J, Meenan R, Greene S, Johnson CC. Categorizing race and ethnicity in the HMO Cancer Research Network. *Ethn Dis.* 2002;12(1):135–140.

Tammemagi CM, Neslund-Dudas C, Simoff M, Kvale P. Lung carcinoma symptoms—an independent predictor of survival and an important mediator of African-American disparity in survival. *Cancer.* 2004;101(7):1655–1663.

2000

Reisch LM, Barton MB, Fletcher SW, Kreuter W, Elmore JG. Breast cancer screening use by African Americans and Whites in an HMO. *J Gen Intern Med.* 2000;15(4):229–234.

Data Resources and Infrastructure

2009

Aiello Bowles EJ, Tuzzio L, Ritzwoller DP, Williams AE, Ross T, Wagner EH, Neslund-Dudas C, Altschuler A, Quinn V, Hornbrook M, Nekhlyudov L. Accuracy and complexities of using automated clinical data for capturing chemotherapy administrations: implications for future research. *Med Care.* 2009;47(10):1091–1097.

Rahm AK, Gaglio B, Bodily M, Palen TE, Ritzwoller DP, Sukhanova A, Glasgow RE. A tale of two projects: challenges faced by research projects during a change in electronic medical record systems. *Electron Healthc.* 2009;7(3):1–8.

Rolnick SJ, Calvi J, Heimendinger J, McClure JB, Kelley M, Johnson C, Alexander GL. Focus groups inform a web-based program to increase fruit and vegetable intake. *Patient Educ Counsel.* 2009;77(2):314–318.

Stopponi MA, Alexander GL, McClure JB, Carroll NM, Divine GW, Calvi JH, Rolnick SJ, Strecher VJ, Johnson CC, Ritzwoller DP et al. Recruitment to a randomized web-based nutritional intervention trial: characteristics of participants compared to non-participants. *J Med Internet Res.* 2009;11(3):e38.

2008

Strecher VJ, McClure J, Alexander G, Chakraborty B, Nair V, Konkel J, Greene S, Couper M, Carlier C, Wiese C, Little R, Pomerleau C, Pomerleau O. The role of engagement in a tailored web-based smoking cessation program: randomized controlled trial. *J Med Internet Res.* 2008;10(5):e36.

2006

Greene SM, Geiger AM. A review finds that multicenter studies face substantial challenges but strategies exist to achieve Institutional Review Board approval. *J Clin Epidemiol.* 2006;59(8):784–790.

2005

Greene SM, Hart G, Wagner EH. Measuring and improving performance in multicenter research consortia. *J Natl Canc Inst Monogr.* 2005;35:26–32.

Haque R, Chiu V, Mehta KR, Geiger AM. An automated data algorithm to distinguish screening and diagnostic colorectal cancer endoscopy exams. *J Natl Canc Inst Monogr*. 2005;35:116–118.

Hazlehurst B, Frost HR, Sittig DF, Stevens VJ. MediClass: a system for detecting and classifying encounter-based clinical events in any electronic medical record. *J Am Med Inform Assoc*. 2005;12(5):517–529.

Hornbrook MC, Hart G, Ellis JL, Bachman DJ, Ansell G, Greene SM, Wagner EH, Pardee R, Schmidt MM, Geiger A, Butani AL, Field T, Fouayzi H, Miroshnik I, Liu L, Diseker R, Wells K, Krajenta R, Lamerato L, Neslund Dudas C. Building a virtual cancer research organization. *J Natl Canc Inst Monogr*. 2005;35:12–25.

Wagner EH, Greene SM, Hart G, Field TS, Fletcher S, Geiger AM, Herrinton LJ, Hornbrook MC, Johnson CC, Mouchawar J, Rolnick SJ, Stevens VJ, Taplin SH, Tolsma D, Vogt TM. Building a research consortium of large health systems: the Cancer Research Network. *J Natl Canc Inst Monogr*. 2005;35:3–11.

West CN, Geiger AM, Greene SM, Harris EL, Liu IL, Barton MB, Elmore JG, Rolnick S, Nekhlyudov L, Altschuler A, Herrinton LJ, Fletcher SW, Emmons KM. Race and ethnicity: comparing medical records to self-reports. *J Natl Canc Inst Monogr*. 2005;(35):72–74.

2004

Rolnick SJ, Hart G, Barton MB, Herrinton L, Flores SK, Paulsen KJ, Husson G, Harris EL, Geiger AM, Elmore JG, Fletcher SW. Comparing breast cancer case identification using HMO computerized diagnostic data and SEER data. *Am J Manag Care*. 2004;10(4):257–262.

Vogt TM, Elston-Lafata J, Tolsma D, Greene SM. The role of research in integrated healthcare systems: the HMO Research Network. *Am J Manag Care*. 2004;10(9):643–648.

2003

Geiger AM, Greene SM, Pardee RE III, Hart G, Herrinton LJ, Macedo AM, Rolnick S, Harris EL, Barton MB, Elmore JG, Fletcher SW. A computerized system to facilitate medical record abstraction in cancer research (United States). *Canc Causes Control*. 2003;14(5):469–476.

Reisch LM, Fosse JS, Beverly K, Yu O, Barlow WE, Harris EL, Rolnick S, Barton MB, Geiger AM, Herrinton LJ, Greene SM, Fletcher SW, Elmore JG. Training, quality assurance, and assessment of medical record abstraction in a multisite study. *Am J Epidemiol*. 2003;157(6):546–551.

Building Capacity to Support Emerging Areas of Cancer Control Research

2009

Alexander GL, McClure JB, Calvi JH, Divine GW, Stopponi MA, Rolnick SJ, Heimendinger JB, Tolsma DD, Resnicow K, Campbell MK, Strecher VJ, Johnson CC. A randomized clinical trial evaluating online interventions to improve fruit and vegetable consumption. *Am J Public Health*. epub 2009 Dec 17.

2008

Alexander GL, Divine GW, Couper MP, McClure JB, Stopponi MA, Fortman KK, Tolsma DD, Strecher VJ, Johnson CC. Effect of incentives and mailing features on online health program enrollment. *Am J Prev Med*. 2008;34(5):382–388.

Geiger AM, Buist DS, Greene SM, Altschuler A, Field TS; Cancer Research Network. Survivorship research based in integrated healthcare delivery systems: the Cancer Research Network. *Cancer*. 2008;112(11 suppl):2617–2626.

McBride CM, Alford SH, Reid RJ, Larson EB, Baxevas AD, Brody LC. Putting science over supposition in the arena of personalized genomics. *Nat Genet*. 2008;40(8):939–942.

Vogt TM. Improving CRC screening requires innovative approaches: can electronic medical records help? *Am J Prev Med*. 2008;35(3):317–318.

2007

Vogt TM, Feldstein AC, Aickin M, Hu WR, Uchida A. Electronic medical records and prevention quality: the prevention index. *Am J Prev Med*. 2007;33(4):291–296.

Wallace P. Reshaping cancer learning through the use of health information technology. *Health Aff*. 2007;26(2):w169–w177.

Building Capacity to Support Emerging Areas of Cancer Control Research (cont.)

2006

Elmore JG, Fletcher SW. The risk of cancer risk prediction: “what is my risk of getting breast cancer?” *J Natl Canc Inst.* 2006;98(23):1673–1675.

Greene SM, Geiger AM, Harris EL, Altschuler A, Nekhlyudov L, Barton MB, Rolnick SJ, Elmore JG, Fletcher S. Impact of IRB requirements on a multicenter survey of prophylactic mastectomy outcomes. *Ann Epidemiol.* 2006;16(4):275–278.

McClure JB, Greene SM, Wiese C, Johnson KE, Alexander G, Strecher V. Interest in an online smoking cessation program and effective recruitment strategies: results from Project Quit. *J Med Internet Res.* 2006;8(3):e14.

2005

Hazlehurst B, Sittig DF, Stevens VJ, Smith KS, Hollis JF, Vogt TM, Winickoff JP, Glasgow R, Palen TE, Rigotti NA. Natural language processing in the electronic medical record: assessing clinician adherence to tobacco treatment guidelines. *Am J Prev Med.* 2005;29(5):434–439.

Somkin CP, Altschuler A, Ackerson L, Geiger AM, Greene SM, Mouchawar J, Holup J, Fehrenbacher L, Nelson A, Glass A, Polikoff J, Tishler S, Schmidt C, Field T, Wagner E. Organizational barriers to physician participation in cancer clinical trials. *Am J Manag Care.* 2005;11(7):413–421.

2002

Field TS, Cadoret CA, Brown ML, Ford M, Greene SM, Hill D, Hornbrook MC, Meenan RT, White MJ, Zapka JM. Surveying physicians: do components of the “Total Design Approach” to optimizing survey response rates apply to physicians? *Med Care.* 2002;40(7):596–605.

Puleo E, Zapka J, White MJ, Mouchawar J, Somkin C, Taplin S. Caffeine, cajoling, and other strategies to maximize clinician survey response rates. *Eval Health Prof.* 2002;25(2):169–184.

Editorials and Commentary

2009

Bastian LA. If it is as simple as AAAAA B C, why don’t we do it? *J Gen Intern Med.* 2009;24:248–255.

2008

Kahn KL. Moving research from bench to bedside to community: there is still more to do. *J Clin Oncol.* 2008;26(4):523–526.

Norman GJ. Answering the “what works?” question in health behavior change. *Am J Prev Med.* 2008;34(5):449–450.

2007

Mandelblatt J. To screen or not to screen older women for breast cancer: a new twist on an old question, or will we ever invest in getting the answers? *J Clin Oncol.* 2007;25(21):2991–2992.

Tuma R. Surveillance mammography extends overall survival in older breast cancer survivors. *Oncol Times.* 2007;29(20):24–25.

Key Resources

Breast Cancer Surveillance Consortium (BCSC):

<http://breastscreening.cancer.gov>

Cancer Care Outcomes Research and Surveillance (CanCORS) Consortium:

<http://outcomes.cancer.gov/cancors>

Cardiovascular Research Network (CVRN):

<http://www.cvrn.org>

Centers for Education & Research in Therapeutics (CERTs):

<http://www.certs.hhs.gov>

CRN Cancer Communication Research Center:

<http://www.crn-ccrc.org>

HMO Research Network (HMORN):

<http://hmoresearchnetwork.org>

NCI Division of Cancer Control and Population Sciences (DCCPS):

<http://cancercontrol.cancer.gov>

NCI Centers of Excellence in Cancer Communication Research:

<http://cancercontrol.cancer.gov/hcirb/ceccr>

CRN Research Themes

- Health Care Delivery, Quality, Costs, and Outcomes
- Health Insurance Benefit Design and Patterns of Care Utilization
- Cancer Epidemiology, Prevention, and Health Promotion
- Enhancing Cancer Communication and Decision-Making
- Dissemination and Implementation Research in Cancer Prevention, Screening, and Treatment
- Psychosocial Factors and Burden of Cancer
- Data Resources and Infrastructure
- Building Capacity to Support Emerging Areas of Cancer Control Research

CRN Sites

GHC = Group Health Cooperative
(Group Health Research Institute)

GHS = Geisinger Health System
(Geisinger Center for Health Research)

HFHS = Henry Ford Hospital and Health System/
Health Alliance Plan (Department of
Biostatistics and Research Epidemiology and
Center for Health Services Research)

HPHC = Harvard Pilgrim Health Care Institute and
Harvard Medical School (Department of
Population Medicine)

HPRF = HealthPartners
(HealthPartners Research Foundation)

KPCO = Kaiser Permanente Colorado
(Institute for Health Research)

KPG = Kaiser Permanente Georgia
(Center for Health Research – Southeast)

KPH = Kaiser Permanente Hawaii
(Center for Health Research – Hawaii)

KPNC = Kaiser Permanente Northern California
(Division of Research)

KPNW = Kaiser Permanente Northwest (Center for
Health Research – Northwest)

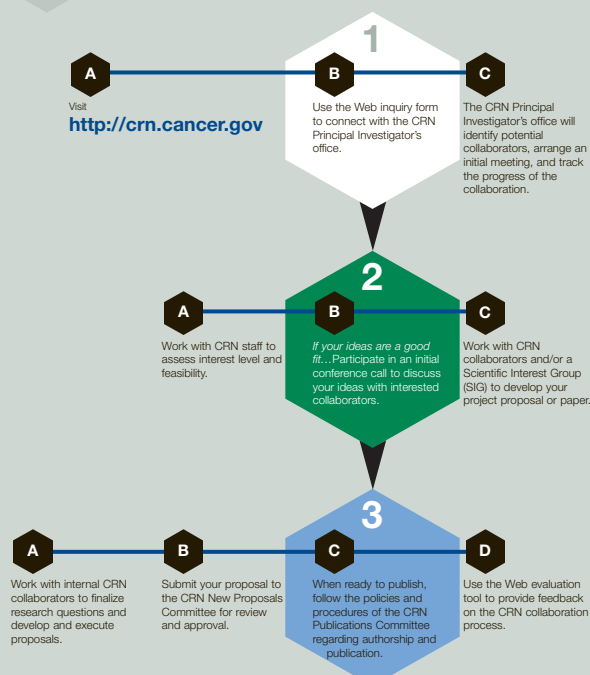
KPSC = Kaiser Permanente Southern California
(Department of Research and Evaluation)

LCF = Lovelace Health System
(Lovelace Clinic Foundation Research)

MCRF = Marshfield Clinic/Security Health Plan
(Marshfield Clinic Research Foundation)

MPCI = Fallon Community Health Plan
(Meyers Primary Care Institute)

Collaborating with the CRN





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