Reducing Breast Cancer Disparities at the State Level
Promising Practices from the ASTHO Breast Cancer Learning Community

Association of State and Territorial Health Officials
August 8, 2017
Webinar Agenda

• Learning Community Summary
• State Presentations
  • Arizona
  • Tennessee
  • West Virginia
• Breast Cancer Online Toolkit Overview
Learning Objectives

• Overview ASTHO’s learning community model
• Gain a better understanding of the breast cancer disparities in Arizona, Tennessee, and West Virginia
• Overview the data-driven action steps and key successes to date from each state team
• Learn more about the resources available online in ASTHO’s new Breast Cancer Disparities Online Toolkit
Webinar Logistics

• Two ways to listen to audio:
  • Through your computer speakers (preferred)
  • Via telephone
    (888-378-4398, passcode 060168)
  • Do not use both methods

• Submit questions through the chat box online (phone lines are muted for this webinar)

• This webinar is being recorded and the recording will be shared via email and the ASTHO website
ASTHO Systems Change Framework

Shared Vision

Open Communication

Policy Change

Evidence-Based Programs

Data-Driven Action

Complementary Sectors & Partners

Financing

Community-Level Resources

Engaged Individuals
ASTHO Breast Cancer Learning Community

ARIZONA

TENNESSEE

West Virginia
Breast Cancer Disparities

- Race
- Socioeconomic status
- Geographic location
Overview
In this collection of lessons, you’ll gain understanding about how mortality rates for breast cancer are higher for black women than for white women in the United States. First, you’ll explore maps to see what the mortality rates are for black and white women. Then, you’ll map the differences in mortality rates to see where the rates differ. You’ll map the ratio of mortality rates to see how much they differ. You’ll map significant clusters of higher and lower mortality rate ratios so you can focus on the most problematic areas. Finally, you’ll map selected breast cancer risk factors to look for explanations for the clusters.

To investigate this issue, you’ll take a spatial problem solving approach. You’ll start by exploring the issue and framing important questions. Then you’ll model the approach you’ll take and process the data analytically to draw out the answers. You’ll interpret the results to determine if they make sense. Finally, you’ll share your findings with others.

Build skills in these areas:
- Exploring maps and performing visual analysis
- Adding fields, selecting features, and calculating values
- Symbolizing the values
- Performing hot spot analysis
- Interpreting findings

What you need:
- ArcMap
- Estimated time: 2 hours

View the app
Using Data to Tell a Story

- Screening
- Follow-up time
- Quality of treatment
What do you have?

- Epidemiologist
- Cancer Registry
- Other State/Community Assessment Data
- Data Sharing Agreements
Cancer Registries: State

- monitor trends
- patterns
- set priorities
- advance research
- inform national database
State Registries are Critical

- addressing & understanding burden
- addressing & understanding risk
- targeting program focus
- identifying disparate groups/high risk
- investigating causes & excess cases
Other Data Sources

- Public Use Data Sets:
  - Community assessments/surveys
  - Behavioral Risk Factor Surveillance Survey (BRFSS)
  - NCI State Cancer Profiles
  - Community Commons
  - United States Cancer Statistics
  - NCI Small Area Estimates
  - Health Information National Trends (HINTS)
  - National Health Interview Survey (NHIS)
  - Ambulatory Surgical Treatment Centers
  - Vital Statistics Deaths
  - Regional Health Information Exchange
Other Data Sources

- Proprietary Use/Limited Use Data Sets:
  - Center of Medicaid Services (CMS) Data Navigator
  - State Employee Health Plan
  - National Cancer Database (NCDB)
  - Surveillance, Epidemiology and End Results (SEER)
  - Breast Cancer Surveillance Consortium (BCSM)
  - Healthcare Cost and Utilization Project (HCUP)
  - Hospital Discharge Data System
  - Outpatient Diagnostic Centers
  - Patient Tracking Billing Management Information System
Other Data Sources

• Quality Improvement Programs & Accountability Measures:
  • National Quality Forum
  • National Accreditation Program for Breast Centers (NAPBC)
  • FDA Mammography Quality Standards Act & Program (MQSA)
  • Commission on Cancer (CoC) of the American College of Surgeons (ACOS)
  • National Cancer Institute (NCI) Designation
Questions to Consider:

1. How does your data show the use and availability of screening services?
2. What unanswered questions were you able to answer after engaging your stakeholders in your data collection and analysis?
3. What unexpected disparities did your data analysis show you that you didn’t previously know?
Questions to Consider:

- How does your data analysis transfer to conversations and protocol modifications with partners outside of public health?
- What unexpected disparities did your data analysis show you that you didn’t previously know?
- To what extent do geographic disparities exist in breast cancer screening? Treatment?
Questions to Consider:

- What populations underutilize breast cancer services?
- What populations receive less than optimal breast cancer treatment?
- Does geographic access to mammography affect breast cancer screening or late-stage diagnosis rates?
- Does geographic access to breast cancer treatment affect adherence to breast cancer treatment or quality of care received?
• The report provides information about:
  • Statistics on breast cancer incidence, mortality, screening, and treatment quality
  • Treatment guidelines by stage
  • Lifestyle factors related to risk of breast cancer
  • Information on state-specific programs
    • Susan G. Komen Affiliates
    • Witness Program
  • Key issues regarding breast cancer survivorship (e.g., social and psychological needs)
  • A directory of breast cancer survivor support groups in SC
It Takes a Village…

• ASTHO Breast Cancer Learning Community Team
  • Christi Mackie, Chief, Community Health and Prevention
  • Elizabeth Walker Romero, MS, Senior Director, Health Improvement
  • Alicia Smith, MPH, Director, Chronic Disease Prevention
  • Josh Berry, MPH, Analyst, Health Promotion and Disease Prevention
  • Ramya Dronamraju, Intern, Breast Cancer Research

• ASTHO Breast Cancer Learning Community Consultants
  • Jan Eberth, Ph.D., MSPH, University of South Carolina
  • Swann Arp Adams, Ph.D., MS, University of South Carolina
  • Emily Kujawa, ASTHO Consultant
It Takes a Village...

• CDC Division of Cancer Prevention and Control Team
  • Mary White, ScD, MPH, Branch Chief, Epidemiology and Applied Research Branch
  • Arica White, PhD, MPH, Epidemiologist, Epidemiology and Applied Research Branch
  • S. Jane Henley, MSPH, Epidemiologist, Cancer Surveillance Branch
  • Jacqueline Miller, MD, FACS, Medical Director, National Breast and Cervical Cancer Early Detection Program
  • Brooke Steele, DO, Medical Officer, Comprehensive Cancer Control Branch
The ASTHO Breast Cancer Learning Collaborative: Arizona’s Findings from Years One and Two

Office of Cancer Prevention and Control
Arizona Department of Health Services
Overview

• Arizona Overview
• Year One ASTHO Project Data Review
• Lessons Learned from Year One
• Current Goals in Year Two
Arizona Overview

- Arizona has fifteen large counties
- 80 percent of the total population live in Maricopa and Pima counties
- Arizona has a racially and ethnically diverse population

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percent (US Census Data, 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White, not Hispanic or Latino</td>
<td>55.8%</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>30.7%</td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>5.3%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>4.8%</td>
</tr>
<tr>
<td>Asian</td>
<td>3.4%</td>
</tr>
<tr>
<td>Two or More Races</td>
<td>2.7%</td>
</tr>
</tbody>
</table>
Population by County
Arizona Tribal Lands and Reservations

Tribal Communities
- Ak-Chin Indian Community
- Cocopah Tribe
- Colorado River Indian Tribe
- Fort McDowell Yavapai Nation Reservation
- Fort Mojave Indian Tribe
- Fort Yuma Quechen Tribe
- Gila Bend
- Gila River Indian Community
- Havasupai Tribe
- Hopi Tribe
- Hualapai Tribe
- Kaibab-Paiute Tribe
- Navajo Nation
- Pascua Yaqui Tribe
- Salt River Pima-Maricopa Indian Community
- San Carlos Apache Tribe
- San Xavier
- Tohono O'odham Nation
- Tonto Apache Tribe
- White Mountain Apache Tribe
- Yavapai-Apache Nation
- Yavapai-Prescott Indian Tribe
- Zuni Pueblo
Problem Statement and Hypothesis

- Women of color have a lower incidence but higher breast cancer mortality rate than non-Hispanic white women in Arizona.
- Why?
- Our assumption: these women must not be getting screened.
Time Since Last Mammogram by Race/Ethnicity

- **White Non-Hispanic**
  - Within past year: 64%
  - Within past 2 years: 60%
  - Within past 3 years: 59%
  - Within past 5 years: 57%
  - 5+ years: 6%
  - Unsure: 0%

- **Black**
  - Within past year: 24%
  - Within past 2 years: 19%
  - Within past 3 years: 16%
  - Within past 5 years: 8%
  - 5+ years: 2%
  - Unsure: 0%

- **American Indian**
  - Within past year: 8%
  - Within past 2 years: 9%
  - Within past 3 years: 9%
  - Within past 5 years: 6%
  - 5+ years: 3%
  - Unsure: 1%

- **Hispanic**
  - Within past year: 7%
  - Within past 2 years: 7%
  - Within past 3 years: 8%
  - Within past 5 years: 4%
  - 5+ years: 7%
  - Unsure: 2%

Source: BRFSS, 2014
Women 40+ Who Have Had a Mammogram in the Past 2 Years

- White Non-Hispanic: 9% Unsure, 24% No, 67% Yes
- Black: 13% Unsure, 17% No, 70% Yes
- American Indian: 10% Unsure, 28% No, 63% Yes
- Hispanic: 10% Unsure, 25% No, 65% Yes

Source: BRFSS, 2014
We were wrong

• According to BRFSS, women of color were being screened in Arizona
• Their screening rate, according to BRFSS, was equal to or higher than non-Hispanic Whites.
• We had to look deeper into the data
Arizona Cancer Registry Data

• Ongoing collaboration with the Arizona Cancer Registry

• Findings
  – Women of color are diagnosed, at the median, 7 years younger
  – They are diagnosed with more aggressive cancers – triple negative
  – There were no significant differences in time to treatment
All Female Breast Cancer Cases by Race/Ethnicity and Age, 2010-2013

Legend for Race/Ethnicity
- White Non-Hispanic
- White Hispanic
- Black
- American Indian
- All other races & Unknown Race

Arizona
## Median Age of Diagnosis by Race/Ethnicity

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Median Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>White Non-Hispanic</td>
<td>64</td>
</tr>
<tr>
<td>White Hispanic</td>
<td>57</td>
</tr>
<tr>
<td>Black</td>
<td>58</td>
</tr>
<tr>
<td>American Indian</td>
<td>57</td>
</tr>
</tbody>
</table>
All Female Breast Cancer, 2010-2013: Race/Ethnicity by Days from Diagnosis to First Course of Treatment

Arizona

Days
0-29 days 30-59 days 60-89 days 90 and more days
Percent of Cases

White Non-Hispanic White Hispanic Black American Indian All other races & Unknown Race

ARIZONA DEPARTMENT OF HEALTH SERVICES
Health and Wellness for all Arizonans
Invasive Female Breast Cancer, 2010-2013: Race/Ethnicity by ER, PR, and HER2 Combination Results and County Groups

Arizona

Percent of Cases

ER, PR, & HER2 Assay Combination Value

White Non-Hispanic
White Hispanic
Black
American Indian
All other races & Unknown Race

ARIZONA DEPARTMENT OF HEALTH SERVICES
Health and Wellness for all Arizonans
Lessons Learned from Year One

1. Arizona’s women of color are diagnosed with breast cancer at a median age of seven years younger than non-Hispanic whites.

2. When diagnosed with breast cancer, their tumor types are more aggressive than those of non-Hispanic whites.

3. In Arizona, it is not feasible for this population to be screened using USPSTF guidelines (beginning at age 50).
Year One Activities

• Analyzed data from the U.S. Census, Behavior Risk Factor Surveillance Survey (BRFSS), Arizona Cancer Registry, and Vital Records
• Identified key stakeholders and partners
• Compiled the data into a report
• Convened partners and shared the findings
• Created an Action Plan with stakeholders’ support and buy-in
Project Partners

- AHCCCS (Medicaid)
- American Cancer Society
- Arizona Alliance for Community Health Centers
- Arizona Department of Health Services
- Arizona State University
- BAG IT!
- Breast Center of Southern Arizona
- Centers for Disease Control and Prevention
- Department of Education
- Ebony House
- Gila River Indian Community
- Health Net Health Plan
- Hispanic Nurses Association
- Hopi Tribe
- Hospice of the Valley
- Invitae
- Komen Arizona
- Maricopa County Department of Public Health
- Maricopa Integrated Health Services
- Mayo Clinic Cancer Center
- Mountain Park Community Health Center
- Navajo Nation
- Pilgrim Rest
- San Carlos Apache HealthCare Corporation
- Southwest Prostate Foundation
- Tohono O’odham Nation
- University of Arizona Cancer Center
Using Data to Reduce Disparities in Breast Cancer Mortality in Arizona

ASTHO Breast Cancer Learning Community
October 2016
Year Two Objectives

• Continue to increase breast cancer screening rates through focusing on patient navigation at the federally qualified health center (FQHC) level

• Explore the potential for a breast cancer focused Project ECHO
  – Increasing accessibility to high quality screening, diagnostic management, and cancer care across the entire state
  – Enhancing the capacity of rural providers to treat their patients where they live
FQHCs

• 22 FQHCs in Arizona
• Monthly Quality Improvement Committee with the Arizona Alliance for Community Health Centers (AACHC)
• ADHS staff now standing members of QIC
• FQHCs report screening rates monthly
FQHC Report Card

• Monthly reporting of screening rates
  – Breast, cervical and colorectal
• Learning to improve data capture in EHR
• Learning to implement Evidence Based Initiatives
• QIC participation based on collaboration and relationships over time
Project ECHO

• Currently working with partners to determine the opportunity to establish a breast cancer “hub” in Phoenix
  – Komen
  – UA Cancer Center at St. Joseph’s

• Reaching out to FQHCs and primary care providers in other parts of the state and rural areas

• Staff will attend training this year at the University of New Mexico
Team Arizona Primary Contacts

Virginia Warren, Office Chief, Cancer Prevention and Control, Arizona Department of Health Services
• Virginia.Warren@azdhs.gov
• (602) 542-1222

Emily Wozniak, Operations Manager, Cancer Prevention and Control, Arizona Department of Health Services
• Emily.Wozniak@azdhs.gov
• (602) 364-0214
Focus Areas of Breast Cancer Learning Community

Funding Year 1 (FY2016)
• Utilize data to identify disparities based on:
  – Race and Ethnicity
  – Geographic Location
  – Screening Rates
  – Follow-up/Time to Treatment
  – Quality of Treatment

Funding Year 2 (FY2017)
• Collaborate with key stakeholders to drive evidence-based interventions:
  – Screening and Follow-up
  – Patient Navigation
  – Timely Referrals for Positive Screens
Tennessee Breast Cancer Overview

- Breast cancer is the leading cause of new cancer cases and the second leading cause of cancer deaths among women in Tennessee.
- Although breast cancer incidence is similar among black and white women in Tennessee, black women are more likely to die from the disease.

Source: Tennessee Department of Health; Division of Policy, Planning and Assessment; Death Statistical System and Tennessee Cancer Registry
The following measures of breast cancer risk were mapped by county and/or region (Main data source in red):

- Incidence (Office of Cancer Surveillance)
- Mortality (Vital Statistics Death Data)
- Regional and distant stage cancers (Office of Cancer Surveillance)
- Days to treatment after diagnosis (Office of Cancer Surveillance)
- Women 40+ years of age not receiving a mammogram in the past 2 yrs (BRFSS)

Spatial analysis was used to confirmed the results of the incidence, mortality and stage data

Commission-on-Cancer-accredited hospitals were mapped and 30-, 45-, and 60-minute driving time buffers used to identify potentially underserved areas
Phase 1 Maps - Tennessee Results

- Highest breast cancer mortality was found in Northwest TN, Southwest TN and Shelby County with Shelby County having the highest rate.
- Highest rate of late stage disease was in Southwest TN and Shelby County.
- Highest mortality rates were noted in African American women in Northwest TN, Southwest TN and Shelby County.
- Drive time analysis showed large gaps in access to Commission of Cancer (CoC) approved hospitals.
Mapping - Mortality by Region

Breast Cancer Mortality Rate by Region, 2004-2013

State Rate: 23.3 / 100,000

Age-Adjusted Rate Per 100,000

- Dark brown: 23.8 - 30.4
- Brown: 22.3 - 23.7
- Orange: 21.6 - 22.2
- Yellow: 20.7 - 21.5
Mapping - Late Stage Diagnosis by Region

2004-2013 Female Breast Cancer Incidence
Regional and Distant Stage
By TN Health Department Regions

Age-Adjusted Rate Per 100,000

- 46.0 - 51.9
- 44.4 - 45.9
- 41.2 - 44.3
- 37.8 - 41.1
2004-2013 Female Breast Cancer Mortality
By Race

White

African-American

Age-Adjusted Rate Per 100,000
- 32.6 - 42.5
- 29.6 - 32.5
- 22.1 - 29.5
- 21.1 - 22.0
- 19.2 - 21.0
- Data Suppressed*

*Data suppressed when fewer than 11 cases.
Phase 2 Maps - Shelby County
Breast Cancer Risk vs. Mammogram Services

- Four measures of breast cancer risk were mapped by zip code:
  - Breast cancer incidence rate among women 40+ years (TN Cancer Registry)
  - Breast cancer mortality rate among women 40+ years (TN Vital Records)
  - Percent of women 45+ years in poverty (US Census)
  - Percent of women 45+ years without health insurance (US Census)

- Risk measures were combined into a single, weighted risk score for each zip code
Three aspects of mammography service delivery were examined:

- Location of mammography facilities (ASTHO)
- Location and volume of mobile mammography services (Baptist and Methodist Health Care Systems)
- Location and volume of Tennessee Breast and Cervical Screening Program services (TBCSP)

Service data were superimposed on risk score maps in order to identify underserved, high risk areas
Mammography Facilities vs. Risk Score

Mammography Facilities and Overall Risk

- Mammography Facility

Overall Risk:
- High
- Medium
- Low

Data source: Association of State and Territorial Health Officials
Map produced by Office of Healthcare Statistics, Division of Policy, Planning and Assessment, Tennessee Department of Health
Mobile Mammography Services vs. Risk Score

Mobile Mammography and Overall Risk

Number of Mammograms Provided, 2016
- 151 - 266
- 91 - 150
- 41 - 90
- 1 - 40

Overall Risk
- high
- medium
- low

Map produced by Office of Healthcare Statistics; Division of Policy, Planning and Assessment; Tennessee Department of Health
Accomplishments

• Located and Accessed Data
  – TN Cancer Registry (Began 1983; 2004 met national standards for data quality)
  – Hospital Discharge Data System (HDDS; 1998-2013)
  – Vital Statistics Deaths (1949-2014)
  – Ambulatory Surgical Treatment Centers (2008-14)
  – Outpatient Diagnostic Centers (2013-14)
  – Patient Tracking Billing Management Information System (PTBMIS)
  – Behavioral Risk Factor Surveillance System (BRFSS)
  – Regional HIEs; Reporting facilities

• Leveraged and Analyzed Data

• Engaged Stakeholders
  – Baptist Memorial Hospital-Memphis
    • Mapping has been utilized in strategic positioning of mobile mammography sites.
  – Memphis Breast Cancer Consortium (MBCC)
    • Mapping has been utilized to inform policymakers in Memphis
Where Are We Now?

• Screening
  – Gap Analysis
    • Review existing needs assessment documents (Methodist, Baptist, Regional One, Komen, CHEER)
    • Survey 100 community women and breast cancer survivors
    • Hold three focus groups (primary care/resource provider; providers on follow up care)
    • Develop GIS maps depicting gaps

• Patient Navigation
  – Survey
    • Systematically gather information on navigation services to better understand and highlight the state of patient navigation for breast cancer (screening through treatment and survivorship)
Monique Anthony, MPH, CHES
Director of Capacity Building
Office of Minority Health and Disparities Elimination
Monique.Anthony@tn.gov

Audrey Bauer, DVM, MPH
Epidemiologist
Division of Family Health and Wellness
Audrey.Bauer@tn.gov

Linda A. Clayton, MD, MPH
Medical Director
Reproductive and Women’s Health
Linda.Clayton@tn.gov

Fred Croom, MD
Epidemiologist/GIS Specialist
Division of Policy, Planning and Assessment
Fred.Croom@tn.gov

Kelly Luskin, MSN, WHNP-BC
Director
Reproductive and Women’s Health
Kelly.Luskin@tn.gov

Martin Whiteside, DC, PhD, MSPH
Director
Office of Cancer Surveillance
Martin.Whiteside@tn.gov

Mari Richardson, MPH
Program Director II
Tennessee Comprehensive Cancer Control Program
Mari.Richardson@tn.gov
West Virginia
Overview of Learning Community

Denise Smith, Director, Perinatal Programs
August 8, 2017
Charleston, WV 25301
WV: The Only True Appalachian State

The Appalachian Region

Source: Appalachian Regional Commission

March 12, 2002
West Virginia
West Virginia
Breast cancer is the most commonly diagnosed cancer and the second leading cause of cancer-related death in WV Women.

Each year, approximately 1,405 women are diagnosed and 288 women die of breast cancer.

Over half (54%) of women with breast cancer in WV are diagnosed with localized breast cancer.
Breast Cancer Burden in West Virginia

### Female Breast Cancer Mortality-Incidence Age-Adjusted Rate Ratio by Race and Diagnosis Date, WV and US

<table>
<thead>
<tr>
<th>Diagnosis Date</th>
<th>WV</th>
<th></th>
<th>US</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>White</td>
<td>Black</td>
<td>White</td>
<td>Black</td>
</tr>
<tr>
<td>2005 - 2009</td>
<td>0.207</td>
<td>0.298</td>
<td>0.181</td>
<td>0.264</td>
</tr>
<tr>
<td>2008 - 2012</td>
<td>0.203</td>
<td>0.230</td>
<td>0.172</td>
<td>0.248</td>
</tr>
<tr>
<td>Difference</td>
<td>0.004</td>
<td>0.068</td>
<td>0.009</td>
<td>0.016</td>
</tr>
</tbody>
</table>

Source: CDC Wonder

The difference in mortality/incidence ratio between whites and blacks in West Virginia has decreased significantly since 2009. For the 2008 – 2012 time period, the mortality/incidence ratio for blacks in West Virginia was lower than the mortality/incidence ratio for blacks in the United States overall.
## Characteristics of Female Breast Cancer Patients by Time from Diagnosis to Treatment, WV, 2009-2013

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>&lt;= 60 Days from Diagnosis to Treatment (n=6,136)</th>
<th>&gt; 60 Days from Diagnosis to Treatment (n=510)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>5963 (97.2)</td>
<td>494 (96.7)</td>
</tr>
<tr>
<td>Black</td>
<td>173 (2.8)</td>
<td>16 (3.1)</td>
</tr>
<tr>
<td>Stage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early</td>
<td>4050 (66.0)</td>
<td>313 (61.4)</td>
</tr>
<tr>
<td>Late</td>
<td>2054 (33.5)</td>
<td>197 (38.6)</td>
</tr>
<tr>
<td>Unknown</td>
<td>32 (0.5)</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Rurality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metro</td>
<td>3458 (56.4)</td>
<td>299 (58.6)</td>
</tr>
<tr>
<td>Nonmetro</td>
<td>2365 (38.5)</td>
<td>181 (35.5)</td>
</tr>
<tr>
<td>Rural</td>
<td>313 (5.1)</td>
<td>30 (5.9)</td>
</tr>
<tr>
<td>Age Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;50</td>
<td>1050 (17.1)</td>
<td>92 (18.0)</td>
</tr>
<tr>
<td>50+</td>
<td>5086 (82.9)</td>
<td>418 (82.0)</td>
</tr>
<tr>
<td>Primary Payer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private</td>
<td>2722 (44.4)</td>
<td>200 (39.2)</td>
</tr>
<tr>
<td>Medicaid</td>
<td>575 (9.4)</td>
<td>76 (14.9)</td>
</tr>
<tr>
<td>Medicare</td>
<td>2637 (43.0)</td>
<td>211 (41.4)</td>
</tr>
<tr>
<td>Not insured</td>
<td>98 (1.6)</td>
<td>10 (2.0)</td>
</tr>
<tr>
<td>Other</td>
<td>43 (0.7)</td>
<td>10 (2.0)</td>
</tr>
<tr>
<td>Unknown</td>
<td>61 (1.0)</td>
<td>3 (0.6)</td>
</tr>
</tbody>
</table>

Source: WV Cancer Registry

For those patients receiving delayed treatment, a higher percentage have a late stage diagnosis, live in a metro area, and have Medicaid insurance.
Populations and Geographic Area of Focus
Female Breast Cancer Age-Adjusted Mortality/Incidence Ratio* by County, West Virginia, 2009-2013

Higher mortality/incidence ratios are found in the east central counties, and scattered throughout the state.

* Due to low case counts in some areas, rate estimates may not be reliable for all counties.

Source: West Virginia Health Statistics Center
The percentage of patients receiving treatment more than 90 days after diagnosis was higher in the western and southwestern portions of the state, and in the eastern panhandle.

Source: WV Cancer Registry
A higher percentage of distant stage cancers are found in the east central border counties, and scattered throughout the state.

% of Distant Stage Female Breast Cancers by County, West Virginia, 2009-2013

Source: WV Cancer Registry
High rates of poverty exist in the southwestern and central portions of West Virginia. There is generally less poverty in the panhandles, and in the Charleston and Parkersburg areas.

Source: American Community Survey
Data Sources and Partners Involved

West Virginia Breast and Cervical Cancer Screening Program
West Virginia Office of Minority Health
West Virginia Cancer Registry
West Virginia Comprehensive Cancer Control Program
West Virginia Health Statistics Center
West Virginia WISEWOMAN Program
West Virginia Office of Maternal, Child and Family Health
Minnie Hamilton Healthcare System
Bonnie’s Bus Mobile Mammography Program
WV Komen Affiliate
Bureau for Medical Services (Medicaid)
Medicaid MCOs – Unicare, Aetna, WV Healthy Families, The Health Plan
Charleston Area Medical Center Cancer Center
Cabell-Huntington Hospital
Edwards Cancer Center
West Virginia University Cancer Institute, Cancer Prevention and Control
Marshall University School of Medicine
WV Department of Health and Human Resources Data Warehouse
Key Action Plan

Planned for the next year:

- Expand to additional sites using the same data parameters set in year 2
- Promote the Breast Cancer Enhancing Community Health Outcomes (ECHO) to rural healthcare providers
- Provide educational opportunities as needed to healthcare providers to improve survivorship care at the local provider level
- Address barriers identified in the patient surveys to improve screening, diagnosis and treatment
From the patient surveys in the Minnie Hamilton Healthcare System

- 118 surveys completed among screening-aged women
- 96% reported they had received a mammogram in the past year
- 86% reported that getting a mammogram was easy
Key successes

- Acquiring ArcGIS software and training
- Distribution of educational videos and flip charts to provider offices
- Increased screening at the pilot sites compared to previous year
- Nurse navigator to work closely with patients at the pilot sites to receive screening, follow-up and treatment if needed
- Increased locations for Bonnie’s Bus Mobile Mammography Unit to provide mammograms
- Collaboration between payer groups to provide data, increased follow-up of women due for a mammogram
- Charleston Area Medical Center starting the first breast cancer Project ECHO in the nation.
Work for this project was completed using funds from the following sources:

Centers for Disease Control and Prevention
#U55/CCU721904-04

Centers for Disease Control and Prevention
DP 12-120505CONT16

US Department of Health and Human Services
Centers for Disease Control and Prevention
5U38OT000161-03
Denise Smith, MS
Director, Perinatal Programs
350 Capitol Street, Room 427
304-356-4397
304-558-7164
denise.a.smith@wv.gov
Submit your questions through the Chat Box on your screen.
About the ASTHO Breast Cancer Learning Community

Learning Community Background

According to the CDC, black women in the U.S. are approximately 40% more likely to die of breast cancer than white women. ASTHO received funding from the CDC in fall of 2015 to form a learning community with state health department teams from Arizona, Tennessee, and West Virginia to improve epidemiologic capacity to identify breast cancer disparities, and position states to take data-driven action with the input of key stakeholders. The purpose of the ASTHO Breast Cancer Learning Community is to strengthen the ability of state public health departments to mobilize data resources more effectively to address disparities in breast cancer mortality.

In the first year of this learning community, ASTHO convened a series of in-person and virtual meetings with national experts and a variety of state stakeholders to obtain and analyze state-specific data using GIS mapping techniques. National experts involved in this project include CDC researchers from the Division of Cancer Prevention and Control, representatives from hospital systems, research institutions, and national foundations, and state-level breast cancer stakeholders including healthcare providers, community groups, and public and private healthcare payers. States focused their data analysis and mapping efforts in three CDC-recommended cancer continuum areas: screening, follow up after abnormal screening result, and treatment quality. At the conclusion of the first year of this project, states presented data reports before a national partner audience resulting in customized feedback on data analysis and expanded intervention considerations.

In the second year of this learning community, states are continuing collaboration with the above national experts and state-level stakeholders through in-person and virtual meetings to not only analyze additional data, but to draft and execute action plans that translate data findings and stakeholder recommendations into interventions that reduce sociodemographic disparities in breast cancer screening, follow up after abnormal screening result, and treatment quality. States are also working to create, refine, and enhance collaboration between health systems, public health payers, and community partners to create a “systems of care” network spanning clinical, community, and public health settings that identify individuals with breast cancer.
Breast Cancer Online Toolkit

• Purpose is to make resources, best practices, and reports from learning community available to a wider audience
• Developed by multi-disciplinary team of ASTHO staff, consultants, and partners
• Focus-group tested by learning community state teams, external state teams, CDC, and national partners
• Will be continually updated with new resources, information, and visuals
Six Online Toolkit Sections

- About
- Needs Assessment
- Resources
- Approaches
- Recommendations
- Tools

http://www.astho.org/BreastCancer.aspx
How Can You Use the Toolkit?

• Access breast cancer-specific resources relating to data, journal literature, community needs assessments, and more
• Reach out to the right stakeholders
• Review resources and instructions to help select and sustainably implement evidence-based interventions
• Work from report templates to compile reports and organize GIS maps for internal and external stakeholders
• All of the above
About Section

- Serves as a table of contents for all other toolkit sections
- Provides brief learning community overview
- Highlights key learning community partners
Needs Assessment

• Describes the importance of community needs and assets assessments
• Links to relevant ASTHO and external resources
• Exhaustive list of different stakeholders that worked with learning community state teams
  • Healthcare providers (e.g., hospitals, cancer clinics, primary care)
  • Healthcare payers (e.g., private insurers and state Medicaid)
  • Academic researchers
  • Community organizations
Resources

- Public Use Datasets
- Proprietary/Limited Use Datasets
- Quality Improvement Programs and Accountability Measures
- **Coming soon** – GIS Mapping Tools and Examples
Approaches

• Designed as a literature review that explores six key questions with journal literature references
• Research and evidence base are important to consider when identifying possible breast cancer disparities that might exist in one’s state or locality
• Full hyperlinked reference list included
Recommendations

• Listings on different evidence-based interventions to address breast cancer disparities
  • ASTHO Breast Cancer Change Package
  • Community Guide recommendations

• Suggestions on implementing selected interventions
Tools

• Provides examples and templates of different reports produced by learning community states ASTHO staff, and consultants
  • Data reports with GIS maps
  • One-pager summaries
  • White papers and journal articles
• Reports are key for communicating with new and existing stakeholders
• **Coming soon** – State Snapshot examples
Success Stories

• If you have used any element of this toolkit, ASTHO wants to know about it!
• Please send all success stories to jberry@astho.org
• Examples will be published as part of the online toolkit and will be circulated to ASTHO members and newsletter readers
http://www.astho.org/BreastCancer.aspx
Please complete your evaluations immediately following the webinar – we value your feedback!

WHAT
DO
YOU
THINK?
Thank You for Joining Us!

Alicia Smith
571-318-5464
asmith@astho.org

Josh Berry
571-318-5471
jberry@astho.org

http://www.astho.org/Programs/Prevention/Chronic-Disease/Breast-Cancer-Disparities/

http://www.astho.org/BreastCancer.aspx