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COMMUNITY PROFILE REPORT 2015

SUSAN G. KOMEN DETROIT RACE FOR THE CURE®

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Executive Summary

Introduction to the Community Profile Report

The Komen Detroit Race for the Cure® (RFTC) was established in 1992 in partnership with the Michigan Cancer Foundation, now the Barbara Ann Karmanos Cancer Institute (KCI). KCI is a National Cancer Institute (NCI) designated Comprehensive Cancer Center and has served as the local presenting sponsor for the Komen Detroit RFTC since inception. More than $28 million has been raised and invested in the fight against breast cancer since 1992 with 25.0 percent of net proceeds dedicated to Susan G. Komen's Research and Training Grant Program. The remaining 75.0 percent helps fund local community grants supporting funding priorities related to improving breast cancer outcomes in Wayne, Oakland and Macomb Counties. More than $16 million has been invested into local grant programs since 1992.

The Komen Detroit RFTC is a top-tier event in the Susan G. Komen Race for the Cure® Series of more than 150 events, the world's largest and most successful breast cancer education and fundraising event ever created. With the help of approximately 100 community volunteers the Komen Detroit RFTC staff work year-round providing resources and information to address the breast cancer burden in metropolitan Detroit. Such resources include breast cancer education, grantmaking, public policy and advocacy, engagement with community organizations and resources for patient navigation and support. The Komen Detroit RFTC actively participates in coalitions dedicated to fighting cancer in Michigan, along with maintaining productive relationships with state and federal elected officials. Because of its continued public policy and advocacy work, the Komen Detroit RFTC staff was recognized as the Susan G. Komen Public Policy Advocate of the year by Susan G. Komen Headquarters in 2009. Komen Detroit RFTC staff is active with organizations in the metropolitan Detroit community and committed to furthering Komen's mission of ending breast cancer forever.

The Komen Detroit RFTC service area includes Wayne, Oakland and Macomb Counties each located in Michigan's southeast region. These counties are the three most populous counties in Michigan and contain nearly 40.0 percent of the State's population. Detroit is located in Wayne County and is the state's most populous city. Wayne, Oakland and Macomb Counties are home to a diverse population of ethnic groups. Uniquely, the Detroit metropolitan area is home to the largest proportion of Arab Americans residing outside of the Middle East. Arab Americans are one of the fasted growing immigrant groups in the country. The total population is likely underreported as Arab Americans are not recognized as an ethnic minority group and are counted as White when race or ethnicity data are collected. Detroit's metropolitan area is home to the 21st largest Jewish community in the nation; concentrated mostly in central and southern Oakland County. Additionally, Oakland County is home to the 36th largest Asian/Pacific Islander population in the United States.

All three American automotive manufacturers are headquartered in metropolitan Detroit making this region a historic economic powerhouse. Automotive manufacturing and health care are Michigan's largest industries. However, over the past several years due to the economic downturn, the Komen Detroit RFTC service area has struggled with high unemployment percentages, directly affecting health and health care access for its residents.

The *Community Profile* is a periodic assessment that describes the state of breast cancer in the Komen Detroit RFTC service area. An effective profile helps the local Komen Organization align its community outreach, grantmaking, public policy activities and all day-to-day operations toward the same mission goal.

The *Community Profile* is a resource that allows Komen Detroit RFTC staff and volunteers to:

- Include a broad and diverse range of people and stakeholders in its work
- Fund, educate and build awareness in the areas of greatest need
- Make data-driven decisions about resource allocations to make the greatest impact
- Strengthen relationships with supporters by clearly communicating the breast health and breast cancer needs of the community
- Advocate to policymakers
- Direct marketing and outreach to areas of greatest need
- Assure synergy between mission-related and operational strategic plans

The themes that emerge during this process will determine funding priorities and help develop an action plan for the next four years to address community needs. Themes will also help determine necessary community partnerships to address breast health and breast cancer service gaps in Wayne, Oakland and Macomb Counties. The *Komen Detroit Race for the Cure®* *Executive Summary* will be posted on the Komen Detroit RFTC website with the full report available upon request. The report will also be shared with prospective grantees and public officials to make them aware of breast cancer's effects in the districts they represent, and to encourage them to address resource and health system gaps. The Komen Detroit RFTC will continue to serve Wayne, Oakland and Macomb Counties as a year-round resource, and work to implement practical solutions to issues discovered during the profile process.

Quantitative Data: Measuring Breast Cancer Impact in Local Communities

Initial county-level quantitative data were gathered for the Komen Detroit RFTC service area including breast cancer incidence, death and late-stage incidence rates. Overall, the Komen Detroit RFTC service area rates for breast cancer incidence, death and late-stage incidence are significantly higher when compared to the State of Michigan. Out of all three counties, Wayne County solely had breast cancer death rates that were significantly higher when compared to the Komen Detroit RFTC service area collectively. Comparatively, Oakland County has the highest incidence rate of all three counties followed by Wayne and Macomb Counties respectively. Conversely, Oakland County has the lowest death rates out of all three counties, along with the lowest rates for late-stage incidence. Screening percentages for breast cancer were highest in Oakland County followed by Wayne County, then Macomb County. These screening data could account for the counties' comparative incidence rates. According to the CDC-Behavioral Risk Factor Surveillance System (BRFSS), more than 80.0 percent (80.2) of women in the Komen Detroit RFTC service area had a screening mammogram in the last two years compared to 79.5 percent for the State of Michigan and 77.5 percent for the United States.

Demographically, when compared to the United States female population, the Komen Detroit RFTC service area has a substantially larger Black/African-American female population. There are also lower income levels and higher unemployment levels than the United States in this

area. Income and unemployment levels are substantially lower for Wayne County than Oakland and Macomb Counties.

Based on these statistics it is unlikely that the Komen Detroit RFTC service area will reach the Healthy People 2020 (HP2020) targets for late-stage incidence. Healthy People 2020 is a major federal government program that has set specific targets for improving Americans' health by the year 2020. The target for late-stage incidence is 41.0 cases per 100,000 individuals. The base rate for the Komen Detroit RFTC service area collectively, and the rates for Wayne, Oakland and Macomb individually are 45.1, 46.2, 44.1 and 44.3 respectively. Based on trend data, Wayne and Oakland Counties are not expected to meet the HP2020 target for late-stage incidence. Additionally, Wayne County is unlikely to meet the HP2020 target for breast cancer death rates based on trend data. The base rate for Wayne County was 29.2 deaths per 100,000; the HP2020 target is 20.6 deaths per 100,000.

The initial county-level incidence, death and late-stage incidence rate data gathered suggest that Wayne County is the highest priority for intervention. However, it was vital to examine sub-county level data to ensure that communities and/or populations outside of Wayne County that may be experiencing negative breast cancer-related outcomes are not overlooked. The Komen Detroit RFTC Community Profile Team examined breast cancer screening, incidence, death, late-stage incidence and demographic data at the sub-county level. Additional data were obtained from the Michigan Behavioral Risk Factor Surveillance System (MIBRFSS), the Michigan Division of Vital Records and Health Statistics, the United States Census Bureau American Fact Finder website, and the Detroit Surveillance, Epidemiology, and End Results (SEER).

Additional data from the MIBRFSS showed that screening percentages were just slightly greater than 50.0 percent (50.8 percent) for the Komen Detroit RFTC service area and 48.6, 56.1 and 48.2 percent for Wayne, Oakland and Macomb Counties respectively. Furthermore, 52.5 percent of women with health insurance surveyed received their annual breast cancer screening in the past year, and just 31.9 percent of uninsured surveyed women received their annual screenings during that time period. Though the CDC BRFSS data show comparatively a larger percentage of the women in the Komen Detroit RFTC service area are having regular breast cancer screenings, the MIBRFSS numbers show that low annual screening numbers may likely be contributing to the grim outlook for breast cancer death and late-stage incidence rates.

When exploring sub-county demographic data related to income, there is a possible link between poverty and access to the Breast Cancer Continuum of Care. Data gathered in the 2011 Komen Detroit RFTC Community Profile showed a strong likelihood of being uninsured for populations living in poverty and thus a stronger likelihood for breast cancer to be detected at later stages when it is less treatable. Further, the likelihood for the disease to go undetected altogether was higher in these populations. While Oakland and Macomb Counties have fewer people living in poverty than Wayne County, the State of Michigan and the United States, there are communities in both of these counties that are experiencing high poverty and lower instances of breast cancer early detection. When examining sub-county level data for Oakland and Macomb Counties, the percentages of breast cancer cases diagnosed at later stages (i.e. regional and distant) generally increased as the percent of the population living in poverty increased.

When comparing breast cancer diagnoses in areas where 20.0 percent or more live below the Federal Poverty Level (FPL), to areas where less than 20.0 percent of the population live in poverty, there seems to be an association with late-stage incidence. Across the Komen Detroit RFTC service area, poorer individuals may be more likely to be diagnosed at later stages, even though Oakland and Macomb Counties are more affluent overall than Wayne County. There are still communities within these two counties with 20.0 percent or more of the population living in poverty, similar to many areas in Wayne County. Additionally, racial and ethnic minorities are disproportionately represented in poorer communities across the Komen Detroit RFTC service area with the majority of Blacks/African-Americans and Hispanics/Latinos being impoverished in Wayne, Oakland and Macomb Counties. These data are important because Black/African-American women currently have the highest death rates from breast cancer despite less frequent diagnosis of breast cancer than Whites. Blacks/African-Americans are often diagnosed at later stages when the disease is more challenging to treat. This may possibly be credited to less screening mammography, longer intervals between screenings and lack of timely follow-up for abnormal results for both Blacks/African-Americans and Hispanics/Latinos alike. Hispanics/Latinos are the least likely group in the United States to have regular and timely breast cancer screenings, and breast cancer is often discovered at a much advanced stage.

Other likely contributors to poor outcomes in these populations are low education attainment and unemployment. Individuals living in poverty across the Komen Detroit RFTC service area are less likely to have completed a high school education and more likely to experience unemployment. Both of these factors may decrease the likelihood of people having regular access to breast cancer screening and other necessary follow-up services due to the increased likelihood of not having adequate income or health insurance.

Many of the communities with large populations of people living in poverty are also located within HRSA-designated Medically Underserved Areas (MUAs). MUAs by definition face barriers to health care access and have a demonstrable shortage of health care resources relative to community needs. The Komen Detroit RFTC service area has 20 MUAs with 17 located in Wayne County, one located in Oakland County and two in Macomb County.

For all three counties in the Komen Detroit RFTC service area, people who are diagnosed with breast cancer are at least 0.8 times more likely to die within four years of their initial diagnosis. Based on these reasons individuals living in HRSA-designated Medically Underserved Areas and communities with high levels of poverty were chosen as the Komen Detroit RFTC target populations.

Health System and Public Policy Analysis

Given the poor breast cancer outcomes for women in the target populations, Komen Detroit RFTC felt it was necessary to explore strengths and weaknesses in the health systems serving these populations. Health system strengths for the Komen Detroit RFTC service area include having several local facilities that provide breast health services offering many opportunities for women to enter the Breast Cancer Continuum of Care (CoC), which is a model that shows how women may move through the health care system for breast care. This model includes breast cancer screening, diagnosis, treatment, follow-up and/or survivorship care, with education incorporated into each. Many of these facilities are located in MUAs and other communities where the target populations reside, and include hospitals offering the services spanning the full

extent of the CoC. However, severe gaps in access exist in the target populations which may be contributors to the high breast cancer death and late-stage incidence rates in Wayne, Oakland and Macomb Counties.

In Wayne County, there are numerous hospitals located in or near HRSA-designated MUAs offering the full array of breast health services. Wayne County MUAs include all or portions of Detroit, Dearborn, Ecorse, Hamtramck, Harper Woods, Highland Park, Inkster, Lincoln Park, River Rouge, Romulus and Taylor. Additionally, there are eight Federally Qualified Health Centers (FQHCs) and Look-Alike clinics across Wayne County, which serve individuals from the target populations.

Michigan's health care safety net is strong and includes the Breast and Cervical Cancer Control Program (BCCCP) of which Wayne County has the largest of these programs in Michigan. Eligible uninsured and underinsured women in Wayne County can enroll in the program to receive an annual clinical breast exam and mammogram, and treatment if needed. Despite Wayne County's local health system strengths the number of women receiving regular breast cancer screening is low. This is possibly due to the lack of FQHCs in Wayne County offering services beyond clinical breast exams and referrals to mammography. Barriers may be present for vulnerable populations with few resources including access to reliable transportation, having to attend multiple appointments in multiple locations and such facilities may not have convenient hours of service for the target populations. For those who remain uninsured or underinsured there may be cost barriers preventing access to the CoC.

Oakland County has one HRSA-designated MUA located in Pontiac, Michigan, where three hospitals offer breast cancer screening services. Two of the three hospitals offer the complete range of services along the CoC. Two FQHCs and one Look-Alike clinic offering clinical breast exams and mammogram referrals are also located in Pontiac.

Other communities located in Oakland County, but outside of its only MUA, have high levels of poverty. These communities have breast health services available in neighboring cities. Hazel Park and Oak Park citizens in Oakland County must travel to nearby Southfield or Royal Oak to seek services at hospitals.

Uninsured and underinsured women in Oakland County also have access to the BCCCP to receive timely breast cancer screening and have breast health resources available within close proximity. However, there remain many barriers to accessing the available resources. Similar to Wayne County, Oakland County FQHCs do not offer breast health services beyond the clinical breast exam or referrals to mammograms, which requires women to schedule appointments at multiple locations. This could prove difficult for those with transportation limitations even when facilities are close. Whether a woman is uninsured or underinsured, financial barriers can prevent her from accessing these services.

There are no hospitals in Macomb County located in the county's HRSA-designated MUAs, which include the cities of Center Line, Lenox, Ray, Richmond and Washington. There are several hospitals in nearby communities that serve the target populations which include one in Warren that neighbors Center Line, and in Clinton Township. Although Warren and Clinton Township have high levels of poverty, they are not HRSA-designated MUAs. Only a few FQHCs and Look-Alike Clinics are located in Macomb County offering clinical breast exams and

referrals to mammography. One of the FQHCs in Macomb County administers the Macomb County BCCCP for uninsured and underinsured women providing access to breast cancer screening. Macomb County also offers breast health-related services. However, the Macomb County BCCCP is limited to screening services solely and must refer enrollees to the Wayne County BCCCP for treatment if diagnosed with breast cancer. This referral process may cause a delay in treatment because of the time taken to exchange patients across programs.

The Breast and Cervical Cancer Control Program (BCCCP) is Michigan's version of the National Breast and Cervical Cancer Early Detection Program (NBCCEDP); a partnership between the US Centers for Disease Control and Prevention (CDC) and state health departments. The program provides low-income, uninsured and underinsured women ages 40-64 with life-saving breast cancer screening, diagnostics, education, outreach and patient navigation. It exists in all 50 states, Washington DC, 11 tribal organizations and five US Territories. The CDC provides program funding for women ages 50 to 64 with the State of Michigan funding coverage for women ages 40-49. Appropriations for this program vary from year to year depending on state budget priorities. Wayne County's program has received funds from a Komen Detroit RFTC community grant and local donations from community to help more women get access to services. Most recently, the State of Michigan produced a specialty pink ribbon breast cancer awareness license plate with proceeds allocated to the BCCCP. Eligible women are in most cases the same women who live in communities experiencing high levels of poverty and lack health insurance. The data show that limited program capacity can make a serious difference in whether or not people in the Komen Detroit RFTC target populations access the CoC. Women diagnosed with breast cancer through the BCCCP are automatically enrolled into Medicaid if they meet residency and citizenship criteria. Women who are not US citizens are eligible to enroll in the BCCCP. However, non-citizens cannot enroll in Medicaid. This policy also extends to women who have had US citizenship for less than five years and for those who have Medicare Part A and have not purchased Part B.

The Patient Protection and Affordable Care Act (ACA) of 2010 eliminated annual lifetime limits on health care, declared discrimination against people with pre-existing conditions illegal and outlawed price gauging women for the same coverage as men. ACA requires all Americans to have some form of health insurance coverage or face a tax penalty. The ACA extends tax credits and subsidies for people who may have difficulty paying for coverage, and places new restrictions on collecting profit by insurance companies.

States were given the option to expand Medicaid eligibility to include more low-income families and individuals previously ineligible for Medicaid. Michigan chose to expand its Medicaid program in accordance with the ACA. The Healthy Michigan Plan provides comprehensive health coverage for individuals between ages 19 and 64 who were not previously eligible for Medicaid or Medicare, along with prescription benefits and incentives for managing chronic health conditions including elimination of copays. This program is intended to make it easier for more low-income residents to access the Breast Cancer Continuum of Care.

Qualitative Data: Ensuring Community Input

The Barbara Ann Karmanos Cancer Institute is the local presenting sponsor for the Komen Detroit RFTC and is affiliated with Wayne State University (WSU) School of Medicine. Because of these contractual relationships with both Karmanos and WSU, the Community Profile process

has been deemed human subjects research requiring approval by the WSU Institutional Review Board (IRB). All study methods and tools were approved by the IRB prior to collecting any data. Based on data gathered in the Quantitative Data Section and the Health Systems Analysis and Public Policy Section, the Komen Detroit RFTC service area has high levels of insurance coverage, but low rates of screening for breast cancer. The target populations are more likely to be uninsured and experience challenges when attempting to access the Breast Cancer Continuum of Care (CoC). Additionally, women with health insurance may not utilize breast health services due to other challenges related to access. Demographics show higher death rates from breast cancer in MUAs and amongst those living in poverty. All qualitative data collection efforts sought to identify the access and utilization factors that may contribute to these data.

Key informant interviews were done with staff and board members at health care facilities that serve the target populations. Health plan administrators for health insurance plans serving the target populations were also interviewed. This data collection method was chosen based on the high likelihood of receiving valuable information that could provide potential insight into the possible reasons for such poor outcomes in the Komen Detroit RFTC target populations. In addition, focus groups were held in communities across Wayne, Oakland and Macomb Counties that included members from the target populations in order to hear directly from community members on what they feel are the biggest complicating factors stopping them from accessing the CoC.

A few conclusions were drawn from each key informant interview and focus group for the target populations in the Komen Detroit RFTC service area. Data gathered through these collection methods will help the Komen Detroit RFTC develop an action plan that may help reduce the number of breast cancer cases diagnosed at late-stages and ultimately reduce the number of deaths. Conclusions for each county are as follows:

Conclusions from data for Wayne County

1. Health care affordability remains a major contributing factor to why women in the Wayne County target populations don't get screened for breast cancer. There is a need for programs to assist with financial barriers preventing women from entering and remaining in the CoC.
2. Attitudes toward personal health in the Wayne County target populations are overwhelmingly reactive, rather than proactive, leading people to only seek health care when their health is in crisis. Resource awareness and education about the importance of regular breast cancer screening may help change health behaviors.
3. Myths and fears related to breast cancer seem common in the Wayne County target populations possibly leading to low rates of breast cancer screening. Education and community outreach programs may help change beliefs and attitudes toward breast cancer in the target populations.

Conclusions from data for Oakland County

1. Many in the Oakland County target populations have difficulty adjusting to the changes implemented by the Affordable Care Act. Patient navigation services may help eliminate confusion on how health insurance works and ultimately increase the number of people entering and remaining in the CoC in the target populations.

2. Affordability of out-of-pocket costs and transportation to appointments are barriers that seem to prevent people in the target populations from entering and remaining in the CoC. Increasing awareness of available resources for low income and underinsured women may help more individuals in the target populations get access to regular breast cancer screenings.
3. Myths and fears related to breast cancer seem to be common in the Oakland County target populations possibly leading to low rates of breast cancer screening. Education and community outreach programs may help change beliefs and attitudes toward breast cancer in the target populations.

Conclusions from data for Macomb County

1. Many people in Macomb County's target populations now have access to health care and are newly insured. Patient navigation services may help eliminate confusion about health insurance and potentially increase the number of people entering and remaining in the CoC in the target populations.
2. Many people in Macomb County's target populations do not recognize the need for regular breast health screenings. This might explain why Macomb County has the lowest screening percentages for breast cancer out of the three counties in the Komen Detroit RFTC service area; possibly a big reason why late-stage incidence and death rates are high in the target communities. Education and community outreach programs may help increase rates for screening and the likelihood for early detection of breast cancer.
3. There still remain people in the target populations who are uninsured or underinsured. Lack of US citizenship and the affordability of out-of-pocket costs are barriers that seem to prevent people in the target populations from entering and remaining in the CoC. Increasing awareness of available resources for low income, uninsured and underinsured women may help more individuals in the target populations get access to regular breast cancer screenings.

Conclusions from health plan administrator key informant interviews

1. There are differences in the audiences targeted for breast cancer screening in the target populations based on the breast cancer screening guidelines being followed (i.e. recommending annual mammography at age 40 or 50). Such differences may account for the low level screening for breast cancer across the Komen Detroit RFTC service area. Stronger outreach and education may help to eliminate confusion for women in the target populations and increase the number of women screened regularly.
2. Barriers to breast cancer screening still exist for women who have health insurance in the target populations which include lack of transportation, child care and misunderstanding of insurance coverage for services. Navigation services may be a necessary component for ensuring that women enter and remain in the CoC.

Mission Action Plan

Based on data gathered from the Quantitative Data, Health Systems Analysis and Public Policy, and Qualitative Data Sections, the Komen Detroit RFTC has drafted an action plan including feasible priorities and objectives to address critical needs in the target populations identified in the Komen Detroit RFTC service area. The action plan will be implemented from FY16 through

FY19 and has been organized into three categories: Community Education and Outreach, Partnership Opportunities and Grantmaking.

Community Education and Outreach

Problem Statement 1: Annual breast cancer screening percentages for women in Wayne, Oakland and Macomb Counties are low, which is a likely contributor to high rates of late-stage incidence and death in the Komen Detroit RFTC service area.

Priority 1*:* Increase education about breast cancer in target populations in Wayne, Oakland and Macomb Counties.

- *Objective 1:* Recruit three college student interns, one each for Wayne, Oakland and Macomb Counties, to each conduct 12 group education sessions per year in Komen Detroit RFTC target populations starting September 2016 to consistently educate target populations on the importance of breast cancer screening. Based on data gathered in focus groups and key informant interviews, taking a more proactive approach in finding audiences that may benefit from this type of education may help to increase the number of those being screened for breast cancer in Komen Detroit RFTC target populations.
- *Objective 2:* In preparation to strengthen outreach efforts and increase education in Komen Detroit RFTC target populations, reinforce breast cancer knowledge for Komen Detroit RFTC community volunteers through developing an annual, comprehensive training program to sustain knowledge about breast cancer and breast cancer screening by June 2016. Developing such a program may help to ensure that volunteers are prepared and equipped to provide accurate information that may encourage target populations to seek timely breast cancer screening.

Priority 2*:* Increase community involvement in developing Komen Detroit RFTC programs to reduce and dispel myths and fears about breast cancer and breast cancer screening. Special focus is needed on this topic especially based on feedback from focus group participants to help increase regular and timely screening for breast cancer in the target populations.

- *Objective 1:* Create a community advisory council for the Komen Detroit RFTC service area composed of focus group participants, breast cancer survivors and Komen Detroit RFTC grantees by December 2016. Such members will , help develop at least one breast cancer community outreach initiative focused on reducing fears and dispelling myths about breast cancer and breast cancer screening for specific target populations in each county. Developing such a community council may help determine the best strategy to implement in each target population in each county.
- *Objective 2:* Develop a breast cancer survivor ambassador program and identify at least three breast cancer survivors from each county in the Komen Detroit RFTC service area to partner with interns and community volunteers to help implement initiatives developed by the community advisory council in the target populations by December 2016. Based on feedback from focus group participants, hearing directly from breast cancer survivors about their personal experiences may help to ease their fears about screening and the disease itself.

***Priority 3**:* Improve public awareness of breast cancer and patient navigation resources to guide women through the Breast Cancer CoC.

- *Objective 1:* Implement an evidence-based, comprehensive, social media campaign to increase public awareness of breast health and breast cancer screening recommendations to begin in January 2016, monitored through the use of web analytics. Based on the feedback from focus group participants, many women in Wayne, Oakland and Macomb Counties are unaware of general breast cancer information and the recommended screening regimen; increasing public awareness via online platforms may lead to higher screening percentages in all three counties.
- *Objective 2:* Develop a comprehensive resource page on the Komen Detroit RFTC website including information for patient navigation, support and breast cancer education by December 2016. Such information will include website links to the *CDC Bring Your Brave Campaign* for young survivors, the Metastatic Breast Cancer Alliance and others.

Partnership Opportunities

Problem Statement 1: Only half of women with health insurance and less than one-third of women with no health insurance are receiving annual breast cancer screening in Wayne, Oakland and Macomb Counties.

***Priority 1**:* Increase the number of organizations partnered with Komen Detroit RFTC that offer resources to the community to assist both insured and uninsured women in Wayne Oakland and Macomb Counties with entering and remaining in the Breast Cancer Continuum of Care (CoC).

- *Objective 1:* Develop partnerships with at least five community organizations trained as Affordable Care Act navigator sites to help get people connected to breast cancer screening during the open enrollment period in Wayne, Oakland and Macomb Counties by December 2016.
- *Objective 2:* Connect with at least five health plans serving Wayne, Oakland and Macomb Counties to explore potential opportunities to educate enrollees about breast cancer screening and help connect them to services by December 2016.

***Priority 2**:* Engage community partners to provide educational resources in target populations including Komen Detroit RFTC sponsors, businesses and organizations located in Wayne, Oakland and Macomb County target communities and/or serving Wayne, Oakland and Macomb County target populations.

- *Objective 1:* Working with current Komen Detroit RFTC grantees, identify at least three businesses serving the target populations to explore sponsorship and community partnership potential to provide breast cancer education to consumers by December 2016. Such businesses include Walgreens and local dollar stores.
- *Objective 2:* Identify at least three current Komen Detroit RFTC sponsors located in key communities in Wayne, Oakland and Macomb Counties that can help with community education and outreach to target populations by December 2016.

- *Objective 3:* Collaborating with the Michigan Cancer Consortium, identify at least three current Komen Detroit RFTC sponsors to implement evidence-based Community Guide strategies to increase breast cancer screening percentages for employees by January 2017.

Grantmaking

Problem Statement 1: Women in HRSA-designated Medically Underserved Areas (MUAs) and communities with high rates of poverty in Wayne, Oakland and Macomb counties are disproportionately diagnosed with breast cancer at late-stages.

Priority 1: Ensure Komen Detroit RFTC grant program funding priorities for 2015 through 2019 address possible factors contributing to late-stage incidence rates in Wayne, Oakland and Macomb County MUAs and communities with high poverty.

- *Objective 1:* Beginning with the FY17 Community Grant Request for Applications (RFA), funding priority will be provided to proposals that seek to increase the proportion of breast cancer diagnoses at earlier stages in the Komen Detroit RFTC target populations by increasing awareness of breast cancer risk factors and the importance of breast cancer screening.
- *Objective 2:* Beginning with the FY17 Community Grant RFA funding priority will be provided to proposals that seek to support strong community education and outreach programs in the Komen Detroit RFTC target populations focused on dispelling myths, reducing fears and providing support services related to breast cancer.
- *Objective 3:* Beginning with the FY17 Community Grant RFA funding priority will be provided to proposals that seek to increase timely and complete breast cancer screening, follow-up care and treatment in the Komen Detroit RFTC target populations through patient navigation and by reducing financial, individual, provider and other barriers to care (e.g. co-pays, deductibles, transportation, etc.).
- *Objective 4:* Beginning with FY17 Community Grant RFA funding priority will be provided to proposals that seek to increase support for health care safety net programs that help increase timely and complete access to the Breast Cancer Continuum of Care for underinsured and uninsured in the Komen Detroit RFTC target populations.

Priority 2: Market community grant program and funding opportunity to nonprofit organizations serving the Komen Detroit RFTC target populations to diversify grant slate.

- *Objective 1:* Beginning with the FY17 Community Grant Writing Workshop, recruit five new nonprofit organizations to participate in annual grant writing workshops each year.
- *Objective 2:* Annually, beginning with the FY17 Community Grant cycle, through the use of surveys identify barriers that are preventing organizations from applying for a grant and work to reduce these barriers for the next grantmaking period.

Disclaimer: Comprehensive data for the Executive Summary can be found in the 2015 Susan G Komen Detroit Race for the Cure® Community Profile Report.

Introduction

Detroit Race for the Cure® History

The Komen Detroit Race for the Cure® (RFTC) was established in 1992 in partnership with the Michigan Cancer Foundation, now the Barbara Ann Karmanos Cancer Institute. The Karmanos Cancer Institute is a National Cancer Institute-designated Comprehensive Cancer Center, and has always served as the Komen Detroit RFTC Local Presenting Sponsor. Since the first Detroit Race in 1992, more than $28 million has been raised and invested in the fight against breast cancer consistent with Susan G. Komen's formula of 25.0 percent of net proceeds dedicated to Komen's research grant program, and the remaining 75.0 percent invested into local community grants supporting screening, treatment support and education for underserved communities. Since 1992, approximately $16,105,900 has been invested into local community grants.

Komen Detroit RFTC staff and volunteers work year-round providing a community resource to address the breast cancer burden in metro Detroit. This includes grantmaking, community education, public policy and advocacy, engagement with community organizations and patient and family navigation to resources. Komen Detroit RFTC staff actively engages with the Michigan Cancer Consortium (MCC), the Southeast Michigan Partners against Cancer (SEMPAC) and numerous other coalitions. Komen Detroit RFTC maintains strong relationships with local, state and federal elected officials who serve as honorary co-chairs for the Race. In 2009 Komen Detroit RFTC was recognized by Komen Headquarters as Susan G. Komen Public Policy Advocate of the Year.

Komen Detroit RFTC staff and volunteers support research by serving as survivor advocates on several protocols with area researchers. A staff member serves on Wayne State University's Institutional Review Board and co-chairs the advocacy section of the Translational Research Cancer Centers Consortium (TRCCC), a coalition formed to expedite progress in immunotherapy and other biologic therapies.

Komen Detroit RFTC Director/Race chair facilitates two community support groups for women of color and young survivors as a trained social worker and is a board member for two prominent local nonprofits.

Two staff members and numerous Komen Detroit RFTC-related organizations and individuals have received Karmanos Cancer Institute Heroes of Breast Cancer Awards, recognizing outstanding contributions in the fight against breast cancer. More information is available at the Komen Detroit RFTC website (www.karmanos.org/komendetroit).

Detroit Race for the Cure® Organizational Structure

The Komen Detroit RFTC is a top-tier event in the Susan G. Komen Race for the Cure® Series of more than 150 events, the world's largest and most successful breast cancer education and fundraising event ever created.

About 100 community volunteers serve on the Komen Detroit Planning Committee (KDPC), supported by Komen Detroit RFTC staff (Figure 1.1). The KDPC includes survivors, co-survivors, business and community leaders who are knowledgeable and passionate about Komen's mission and local operations. The KDPC is organized into 25 subcommittees and, consistent with the Community Profile, helps plan and execute day-to-day Komen Detroit RFTC operations.

Several hundred additional volunteers assist with community outreach and education, grantmaking, advocacy and Race day tasks.

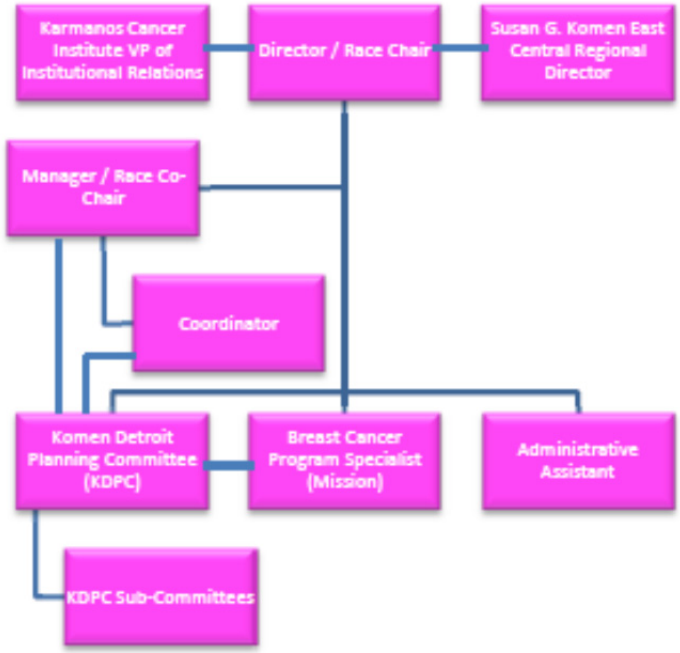

Figure 1.1. Susan G. Detroit Race for the Cure organizational structure

Detroit Race for the Cure® Service Area

According to the US Census Bureau, Michigan is the ninth most populous state in the US Though the state has developed a more diverse economy, it is still highly dependent on the automotive industry. Home to Ford Motor Company, General Motors Corporation and Fiat Chrysler Automobiles , Michigan has historically been an economic powerhouse. However, through the recent economic downturn Michigan has struggled with unemployment, directly affecting health and health care access for its citizens.

The Komen Detroit RFTC service area includes three counties located in the southeast region of the state: Wayne, Oakland and Macomb (Figure 1.2). These are the three most populous counties in Michigan with nearly 40.0 percent of Michigan residents. Detroit, located in Wayne County, is Michigan's most populous city.

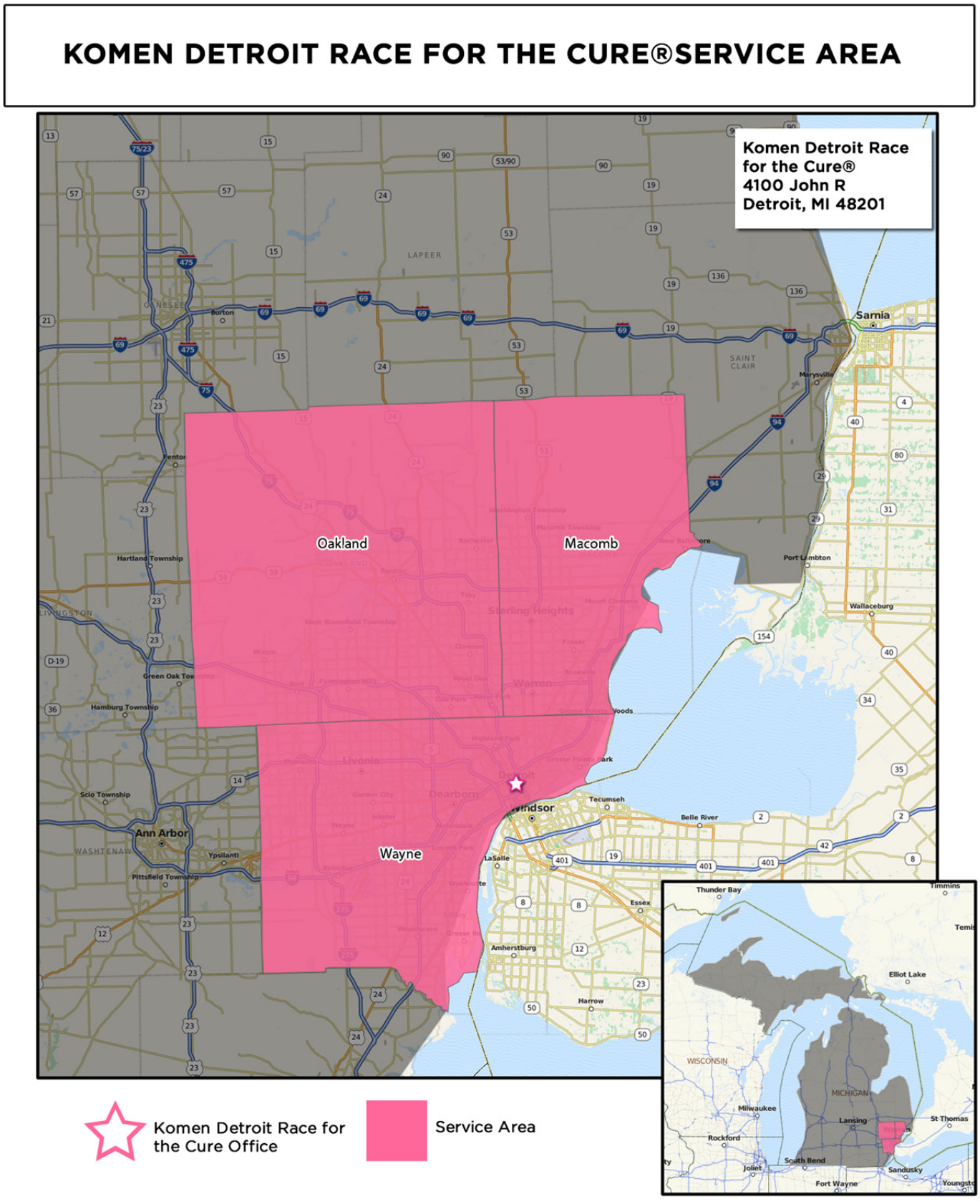

Figure 1.2. Susan G. Komen Detroit Race for the Cure® service area

Wayne County

According to the US Census Bureau's American Community Survey, Wayne County is comprised of 34 cities, nine townships and one village. It borders Oakland County to the southeast and Macomb County to the southwest. It is home to approximately 1.8 million people, making it Michigan's population core and the 17th most populous county in the nation. A mix of urban and suburban communities, Wayne County is racially and ethnically diverse: comprised of 52.3 percent Whites, 40.5 percent Blacks/African-Americans, 5.2 percent Hispanics/Latinos (may be of any race), 2.5 percent Asians/Pacific Islanders and 4.2 percent from other races or more than one race. The City of Detroit, Wayne's county seat, is more than 80.0 percent Black/African-American, making Detroit the city with the largest proportion of Blacks/African-Americans in the nation. Approximately 18.6 percent of Wayne County's immigrant population is Hispanic/Latino, comprised primarily of people of Mexican and Puerto Rican backgrounds. Of the immigrants in Wayne County, Hispanics/Latinos make up 9.3 percent of the foreign-born, naturalized citizens and nearly 30.0 percent of foreign-born non-citizens (29.2 percent). Uniquely, the Detroit metropolitan area is also home to the largest proportion of Arab Americans residing outside of the Middle East. Arab Americans are one of the fastest growing immigrant groups in the country and, as yet unrecognized by the US Census as an ethnic minority. This population is largely underreported and often counted as White when race or ethnicity population data are collected. Of those counted in the 2010 Census, Arabs are approximately 4.5 percent (81,232) of Wayne County's population and include immigrants from Egypt, Iraq, Jordan, Lebanon, Morocco, Palestine and Syria (US Census, ACS 2009-2013).

The median household income in Wayne County is $41,184 with Wayne County's top five employers including Ford Motor Company, Oakwood Healthcare, Inc., Henry Ford Health System, Johnson Controls-Automotive Experience, and US Steel-Great Lakes Works, each reflecting Michigan's largest industries: automotive manufacturing and health care (Crain's Business Detroit, 2013 Crain's List Detroit). Detroit is known as "the Motor City;" with almost everyone relying on personal transportation. Approximately 86.2 percent of Wayne County households have one or more vehicles available. Of the employed adults in Wayne County, 90.9 percent either drive themselves or carpool to work; a mere 3.2 percent rely on public transportation— particularly a challenge in the City of Detroit, due to financial difficulties plaguing the city for several years (US Census, ACS 2009-2013). For years, Detroit's operating budget has fallen short affecting city services including the bus system. Industrial restructuring, suburbanization and job losses have plagued the manufacturing industries causing massive unemployment across the Detroit metropolitan area. This had an especially devastating effect in the city of Detroit. Once a thriving manufacturing town with a population of 1.8 million people during the 1950s, Detroit's population has dwindled to a mere 713,000 residents with many people leaving the county and leaving the state to seek better employment opportunities. In spite of the drastic drop in population, Detroit still remains Michigan's most populous city ranking number 18 in the United States.

As of January 2015, Detroit is emerging from bankruptcy and transitioning from the authority of the emergency manager appointed in 2014 by Governor Rick Snyder who declared a financial emergency for Detroit. During 2014, officials developed a financial plan and the city, led by Mayor Mike Duggan and a newly elected city council, are working hard to recover economically.

Oakland County

Oakland County located northwest of Wayne County and west of Macomb County, is home to 61 cities, villages and townships with approximately 1.2 million residents. Oakland County is mainly suburban with some urban and rural communities. Population proportions are 77.3 percent White, 13.6 Black/African-American, 5.6 percent Asian/Pacific Islander, 3.5 percent Hispanic/Latino (may be of any race) and 3.2 percent from other races or more than one race. Oakland County also has a diverse ethnic population including a large Jewish community. The Jewish community of metropolitan Detroit is approximately 72,000 and the 21st largest Jewish community in the nation, concentrated mostly in central and southern Oakland County. Oakland County has the 36th largest Asian/Pacific Islander population of any county in the United States. Oakland County's Asian/Pacific Islander population is primarily composed of people from eight ethnic groups including, Indian, Chinese, Filipino, Korean, Japanese, Hmong, Pakistani and Vietnamese. Of the immigrants in Oakland County, Asians/Pacific Islanders make up 37.1 percent of the total immigrant population in Oakland County. 33.8 percent are naturalized citizens and just over 40.0 percent are non-citizens (40.6 percent) (US Census, ACS 2009-2013).

With the median household income of $61,907, Oakland County is the most affluent of the three counties in the Komen Detroit RFTC service area. Like Wayne County, automobile manufacturing and health care are the main industries. The top five largest employers are Beaumont Health System, Fiat Chrysler Automobiles, General Motors Corporation, CHE Trinity Health and St. John Providence Health System (Crain's Business Detroit, 2013 Crain's List Detroit). Oakland County fared better than Wayne County during the economic downturn due to a more diverse economy that relies less on manufacturing jobs; but the county has still experienced economic challenges. Formerly among the top ten wealthiest counties in the nation, its ranking has fallen but remains among the highest-income counties in the United States with more than one million residents.

Echoing the dominance of the automobile manufacturing industry in the region, approximately 94.4 percent of Oakland County households have one or more vehicles available. A mere 0.6 percent of Oakland County residents rely on public transportation. (US Census, ACS 2009-2013). Pontiac, Oakland's county seat has suffered financially from the elimination of manufacturing jobs. For the past five years, Pontiac has had a governor-appointed emergency financial manager to help balance the city's budget. Located in central Oakland County, Pontiac has strikingly dissimilar demographics to the rest of Oakland County. The majority of residents (approximately two-thirds) are Black/African-American or Hispanic/Latino, and 22.1 percent of residents live below the federal poverty level (US Census, ACS 2009-2013).

Macomb County

Macomb County is located east of Oakland County and northeast of Wayne County. It is the third most populous county in Michigan. Composed of suburban communities with some rural areas, more than 840,000 Michigan residents call Macomb County home. Three of the state's most populous communities are part of the county's 27 cities, villages and townships: including Warren (third), Sterling Heights (fourth) and Clinton Township (tenth). Macomb County's population is the least diverse of the Detroit RFTC service area's three counties: 85.4 percent White, 8.6 percent Black/African-American, 3.0 percent Asian/Pacific Islander, 2.3 percent Hispanic/Latino (may be of any race), and 2.7 percent from other races of more than one race.

Like Wayne County, Macomb County is experiencing an increase in Arab immigrants, most of whom reside in Sterling Heights. (US Census, ACS 2009-2013).

Macomb County's median household income is $52,102, with the top five employers primarily reflecting Michigan's strong manufacturing and health care industries: General Motors Corporation, Fiat Chrysler Automobiles, the US Government, Ford Motor Company and St. John Providence Health System (Crain's Business Detroit, 2013 Crain's List Detroit). A vast majority of Macomb County households (approximately 93.4 percent) have access to at least one or more vehicles. Approximately 0.8 percent of people in Macomb County depend on public transportation, again demonstrating the effects of the automobile industry. (US Census, ACS 2009-2013). Macomb County employs federal government workers at the Selfridge Air National Guard Base in Harrison Township. The base hosts a variety of military personnel and civilians including Air and Army National Guards, Air Force, Navy, Marine Corps and Army Reserves, and Coast Guard. The base contributes greatly to the state's manufacturing economy by supplying tank construction jobs (Crain's Business Detroit, 2013 Crain's List Detroit).

Purpose of the Community Profile Report

The *Community Profile* is the periodic assessment that describes the state of breast cancer in the Komen Detroit RFTC service area (Wayne, Oakland and Macomb Counties). An effective profile helps the local Komen organization align its community outreach, grantmaking and public policy activities and all day-to-day operations toward the same mission goal.

The *Community Profile* is a resource that allows Komen Detroit RFTC staff and volunteers to:

- Include a broad and diverse range of people and stakeholders in its work
- Fund, educate and build awareness in the areas of greatest need
- Make data-driven decisions about resource allocations to make the greatest impact
- Strengthen relationships with supporters by clearly communicating the breast health and breast cancer needs of the community
- Advocate to policymakers
- Direct marketing and outreach to areas of greatest need
- Assure synergy between mission-related and operational strategic plans

The themes that emerge during this process will determine funding priorities and help develop an action plan for the next four years to address community needs. Themes will also help determine necessary community partnerships to address breast health and breast cancer service gaps in Wayne, Oakland and Macomb Counties. The *Komen Detroit Race for the Cure®* *Executive Summary* will be posted on the Komen Detroit RFTC website with the full report available upon request. The report will also be shared with prospective grantees and public officials to make them aware of breast cancer's effects in the districts they represent, and to encourage them to address resource and health system gaps. The Komen Detroit RFTC will continue to serve Wayne, Oakland and Macomb Counties as a year-round resource, and work to and implement practical solutions to issues discovered during the profile process.

Quantitative Data: Measuring Breast Cancer Impact in Local Communities

Quantitative Data Report

Introduction

The purpose of the quantitative data report for the Susan G. Komen Detroit Race for the Cure® (Komen Detroit RFTC) is to combine evidence from many credible sources and use the data to identify the highest priority areas for evidence-based breast cancer programs.

The data provided in the report are used to identify priorities within Komen Detroit RFTC service area based on estimates of how long it would take an area to achieve Healthy People 2020 objectives for breast cancer late-stage diagnosis and death rates (http://www.healthypeople.gov/2020/default.aspx).

The following is a summary of the Komen Detroit Race for the Cure® Quantitative Data Report. For a full report please contact the Komen Detroit RFTC.

Breast Cancer Statistics

Incidence rates

The breast cancer incidence rate shows the frequency of new cases of breast cancer among women living in an area during a certain time period (Table 2.1). Incidence rates may be calculated for all women or for specific groups of women (e.g. for Asian/Pacific Islander women living in the area).

The female breast cancer incidence rate is calculated as the number of females in an area who were diagnosed with breast cancer divided by the total number of females living in that area.

Incidence rates are usually expressed in terms of 100,000 people. For example, suppose there are 50,000 females living in an area and 60 of them are diagnosed with breast cancer during a certain time period. Sixty out of 50,000 is the same as 120 out of 100,000. So the female breast cancer incidence rate would be reported as 120 per 100,000 for that time period.

When comparing breast cancer rates for an area where many older people live to rates for an area where younger people live, it's hard to know whether the differences are due to age or whether other factors might also be involved. To account for age, breast cancer rates are usually adjusted to a common standard age distribution. Using age-adjusted rates makes it possible to spot differences in breast cancer rates caused by factors other than differences in age between groups of women.

To show trends (changes over time) in cancer incidence, data for the annual percent change in the incidence rate over a five-year period were included in the report. The annual percent change is the average year-to-year change of the incidence rate. It may be either a positive or negative number.

- A negative value means that the rates are getting lower.
- A positive value means that the rates are getting higher.

- A positive value (rates getting higher) may seem undesirable—and it generally is. However, it's important to remember that an increase in breast cancer incidence could also mean that more breast cancers are being found because more women are getting mammograms. So higher rates don't necessarily mean that there has been an increase in the occurrence of breast cancer.

Death rates

The breast cancer death rate shows the frequency of death from breast cancer among women living in a given area during a certain time period (Table 2.1). Like incidence rates, death rates may be calculated for all women or for specific groups of women (e.g. Black/African-American women).

The death rate is calculated as the number of women from a particular geographic area who died from breast cancer divided by the total number of women living in that area. Death rates are shown in terms of 100,000 women and adjusted for age.

Data are included for the annual percent change in the death rate over a five-year period.

The meanings of these data are the same as for incidence rates, with one exception. Changes in screening don't affect death rates in the way that they affect incidence rates. So a negative value, which means that death rates are getting lower, is always desirable. A positive value, which means that death rates are getting higher, is always undesirable.

Late-stage incidence rates

For this report, late-stage breast cancer is defined as regional or distant stage using the Surveillance, Epidemiology and End Results (SEER) Summary Stage definitions (http://seer.cancer.gov/tools/ssm/). State and national reporting usually uses the SEER Summary Stage. It provides a consistent set of definitions of stages for historical comparisons.

The late-stage breast cancer incidence rate is calculated as the number of women with regional or distant breast cancer in a particular geographic area divided by the number of women living in that area (Table 2.1). Late-stage incidence rates are shown in terms of 100,000 women and adjusted for age.

Table 2.1. Female breast cancer incidence rates and trends, death rates and trends, and late-stage rates and trends

		Incidence Rates and Trends			Death Rates and Trends			Late-stage Rates and Trends		
Population Group	Female Population (Annual Average)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of Deaths (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)
US	154,540,194	198,602	122.1	-0.2%	40,736	22.6	-1.9%	70,218	43.7	-1.2%
HP2020	.	-	-	-	-	20.6	-	-	41.0	-
Michigan	5,067,869	7,029	120.0	-1.1%	1,468	24.0	-2.0%	2,371	41.0	-0.6%
Detroit RFTC® Service Area	2,018,524	2,895	124.6	-0.2%	643	26.6	NA	1,044	45.1	-0.3%
White	1,384,289	2,083	121.8	-0.8%	451	24.5	NA	711	42.1	-0.9%
Black/African-American	547,579	652	120.2	-0.5%	187	34.5	NA	279	50.8	-0.9%
AIAN	10,575	3	31.3	16.5%	SN	SN	SN	SN	SN	SN
API	76,082	41	63.2	10.1%	4	6.1	NA	13	20.4	6.7%
Non-Hispanic/ Latina	1,944,542	2,860	125.7	0.0%	635	26.7	NA	1,030	45.5	-0.1%
Hispanic/ Latina	73,983	35	79.5	-16.8%	8	19.3	NA	14	29.2	-18.4%
Macomb County - MI	429,294	627	121.8	-1.2%	136	24.7	-1.9%	227	44.3	-1.1%
Oakland County - MI	616,775	944	129.5	-0.5%	181	24.0	-2.0%	320	44.1	0.0%
Wayne County - MI	972,455	1,324	122.6	0.5%	326	29.2	-1.6%	497	46.2	-0.1%

NA – data not available.
SN – data suppressed due to small numbers (15 cases or fewer for the 5-year data period).
Data are for years 2006-2010.
Rates are in cases or deaths per 100,000.
Age-adjusted rates are adjusted to the 2000 US standard population.
Source of incidence and late-stage data: NAACCR – CINA Deluxe Analytic File.
Source of death rate data: CDC – NCHS death data in SEER*Stat.
Source of death trend data: NCI/CDC State Cancer Profiles.

Incidence rates and trends summary

Overall, the breast cancer incidence rate in the Komen Detroit RFTC service area was slightly higher than that observed in the US as a whole and the incidence trend was similar to the US as a whole. The incidence rate of the Komen Detroit RFTC service area was **significantly higher** than that observed for the State of Michigan and the incidence trend was not significantly different than the State of Michigan.

For the United States, breast cancer incidence in Blacks/African-Americans is lower than in Whites overall. The most recent estimated breast cancer incidence rates for Asians and Pacific Islanders (APIs) and American Indians and Alaska Natives (AIANs) were lower than for Non-Hispanic Whites and Blacks/African-Americans. The most recent estimated incidence rates for Hispanics/Latinas were lower than for Non-Hispanic Whites and Blacks/African-Americans. For the Komen Detroit RFTC service area as a whole, the incidence rate was slightly lower among Blacks/African-Americans than Whites, lower among APIs than Whites, and lower among AIANs than Whites. The incidence rate among Hispanics/Latinas was lower than among Non-Hispanics/Latinas.

None of the counties in the Komen Detroit RFTC service area had substantially different incidence rates than the Detroit RFTC service area as a whole.

It's important to remember that an increase in breast cancer incidence could also mean that more breast cancers are being found because more women are getting mammograms.

Death rates and trends summary

Overall, the breast cancer death rate in the Komen Detroit RFTC service area was higher than that observed in the US as a whole and the death rate trend was not available for comparison with the US as a whole. The death rate of the Komen Detroit RFTC service area was **significantly higher** than that observed for the State of Michigan.

For the United States, breast cancer death rates in Blacks/African-Americans are substantially higher than in Whites overall. The most recent estimated breast cancer death rates for APIs and AIANs were lower than for Non-Hispanic Whites and Blacks/African-Americans. The most recent estimated death rates for Hispanics/Latinas were lower than for Non-Hispanic Whites and Blacks/African-Americans. For the Komen Detroit RFTC service area as a whole, the death rate was higher among Blacks/African-Americans than Whites and lower among APIs than Whites. There were not enough data available within the Komen Detroit RFTC service area to report on AIANs so comparisons cannot be made for this racial group. The death rate among Hispanics/Latinas was lower than among Non-Hispanics/Latinas.

The following county had a death rate **significantly higher** than the Komen Detroit RFTC service area as a whole:

- Wayne County

The rest of the counties had death rates and trends that were not significantly different than the Komen Detroit RFTC service area as a whole or did not have enough data available.

Late-stage incidence rates and trends summary

Overall, the breast cancer late-stage incidence rate in the Komen Detroit RFTC service area was slightly higher than that observed in the US as a whole and the late-stage incidence trend was higher than the US as a whole. The late-stage incidence rate of the Komen Detroit RFTC service area was **significantly higher** than that observed for the State of Michigan and the late-stage incidence trend was not significantly different than the State of Michigan.

For the United States, late-stage incidence rates in Blacks/African-Americans are higher than among Whites. Hispanics/Latinas tend to be diagnosed with late-stage breast cancers more often than Whites. For the Komen Detroit RFTC service area as a whole, the late-stage incidence rate was higher among Blacks/African-Americans than Whites and lower among APIs than Whites. There were not enough data available within the Komen Detroit RFTC service area to report on AIANs so comparisons cannot be made for this racial group. The late-stage incidence rate among Hispanics/Latinas was lower than among Non-Hispanics/Latinas.

None of the counties in the Komen Detroit RFTC service area had substantially different late-stage incidence rates than the Komen Detroit RFTC service area as a whole.

Mammography Screening

Getting regular screening mammograms (and treatment if diagnosed) lowers the risk of dying from breast cancer. Screening mammography can find breast cancer early, when the chances

of survival are highest. Table 2.2 shows some screening recommendations among major organizations for women at average risk.

Table 2.2. Breast cancer screening recommendations for women at average risk*

American Cancer Society	National Comprehensive Cancer Network	US Preventive Services Task Force
Informed decision-making with a health care provider at age 40 Mammography every year starting at age 45 Mammography every other year beginning at age 55	Mammography every year starting at age 40	Informed decision-making with a health care provider ages 40-49 Mammography every 2 years ages 50-74

*As of October 2015

Because having regular mammograms lowers the chances of dying from breast cancer, it's important to know whether women are having mammograms when they should. This information can be used to identify groups of women who should be screened who need help in meeting the current recommendations for screening mammography. The Centers for Disease Control and Prevention's (CDC) Behavioral Risk Factors Surveillance System (BRFSS) collected the data on mammograms that are used in this report. The data come from interviews with women age 50 to 74 from across the United States. During the interviews, each woman was asked how long it has been since she has had a mammogram. The proportions in Table 2.3 are based on the number of women age 50 to 74 who reported in 2012 having had a mammogram in the last two years.

The data have been weighted to account for differences between the women who were interviewed and all the women in the area. For example, if 20.0 percent of the women interviewed are Hispanic/Latina, but only 10.0 percent of the total women in the area are Hispanic/Latina, weighting is used to account for this difference.

The report uses the mammography screening proportion to show whether the women in an area are getting screening mammograms when they should. Mammography screening proportion is calculated from two pieces of information:

- The number of women living in an area that the BRFSS determines should have mammograms (i.e. Women age 50 to 74).
- The number of these women who actually had a mammogram during the past two years.

The number of women who had a mammogram is divided by the number who should have had one. For example, if there are 500 women in an area that should have had mammograms and 250 of those women actually had a mammogram in the past two years, the mammography screening proportion is 50.0 percent.

Because the screening proportions come from samples of women in an area and are not exact, Table 2.3 includes confidence intervals. A confidence interval is a range of values that gives an idea of how uncertain a value may be. It's shown as two numbers—a lower value and a higher one. It is very unlikely that the true rate is less than the lower value or more than the higher value.

For example, if screening proportion was reported as 50.0 percent, with a confidence interval of 35.0 to 65.0 percent, the real rate might not be exactly 50.0 percent, but it's very unlikely that it's less than 35.0 or more than 65.0 percent.

In general, screening proportions at the county level have fairly wide confidence intervals. The confidence interval should always be considered before concluding that the screening proportion in one county is higher or lower than that in another county.

Table 2.3. Proportion of women ages 50-74 with screening mammography in the last two years, self-report

Population Group	# of Women Interviewed (Sample Size)	# w/ Self-Reported Mammogram	Proportion Screened (Weighted Average)	Confidence Interval of Proportion Screened
US	174,796	133,399	77.5%	77.2%-77.7%
Michigan	4,151	3,285	79.5%	77.9%-81.0%
Detroit RFTC® Service Area	1,596	1,284	80.2%	77.5%-82.7%
White	941	738	80.2%	76.7%-83.2%
Black/African-American	610	511	79.7%	74.8%-83.9%
AIAN	12	11	98.9%	59.1%-100%
API	SN	SN	SN	SN
Hispanic/ Latina	15	10	69.9%	36.0%-90.6%
Non-Hispanic/ Latina	1,573	1,270	80.5%	77.8%-83.0%
Macomb County - MI	226	174	78.4%	70.8%-84.5%
Oakland County - MI	442	364	81.3%	76.3%-85.4%
Wayne County - MI	928	746	80.3%	76.5%-83.5%

SN – data suppressed due to small numbers (fewer than 10 samples).
Data are for 2012.
Source: CDC – Behavioral Risk Factor Surveillance System (BRFSS).

Breast cancer screening proportions summary

The breast cancer screening proportion in the Komen Detroit RFTC service area was not significantly different than that observed in the US as a whole. The screening proportion of the Komen Detroit RFTC service area was not significantly different than the State of Michigan.

For the United States, breast cancer screening proportions among Blacks/African-Americans are similar to those among Whites overall. APIs have somewhat lower screening proportions than Whites and Blacks/African-Americans. Although data are limited, screening proportions among AIANs are similar to those among Whites. Screening proportions among Hispanics/Latinas are similar to those among Non-Hispanic Whites and Blacks/African-Americans. For the Komen Detroit RFTC service area as a whole, the screening proportion was not significantly different among Blacks/African-Americans than Whites and not significantly different among AIANs than Whites. There were not enough data available within the Komen

Detroit RFTC service area to report on APIs so comparisons cannot be made for this racial group. The screening proportion among Hispanics/Latinas was not significantly different than among Non-Hispanics/Latinas.

None of the counties in the Komen Detroit RFTC service area had substantially different screening proportions than the Komen Detroit RFTC service area as a whole.

Population Characteristics

The report includes basic information about the women in each area (demographic measures) and about factors like education, income, and unemployment (socioeconomic measures) in the areas where they live (Tables 2.4 and 2.5). Demographic and socioeconomic data can be used to identify which groups of women are most in need of help and to figure out the best ways to help them.

It is important to note that the report uses the race and ethnicity categories used by the US Census Bureau, and that race and ethnicity are separate and independent categories. This means that everyone is classified as both a member of one of the four race groups as well as either Hispanic/Latina or Non-Hispanic/Latina.

The demographic and socioeconomic data in this report are the most recent data available for US counties. All the data are shown as percentages. However, the percentages weren't all calculated in the same way.

- The race, ethnicity, and age data are based on the total female population in the area (e.g. The percent of females over the age of 40).
- The socioeconomic data are based on all the people in the area, not just women.
- Income, education and unemployment data don't include children. They're based on people age 15 and older for income and unemployment and age 25 and older for education.
- The data on the use of English, called "linguistic isolation", are based on the total number of households in the area. The Census Bureau defines a linguistically isolated household as one in which all the adults have difficulty with English.

Table 2.4. Population characteristics – demographics

Population Group	White	Black/ African-American	AIAN	API	Non-Hispanic /Latina	Hispanic /Latina	Female Age 40 Plus	Female Age 50 Plus	Female Age 65 Plus
US	78.8 %	14.1 %	1.4 %	5.8 %	83.8 %	16.2 %	48.3 %	34.5 %	14.8 %
Michigan	80.8 %	15.5 %	0.9 %	2.8 %	95.6 %	4.4 %	50.5 %	36.7 %	15.6 %
Detroit RFTC® Service Area	68.3 %	27.2 %	0.5 %	4.0 %	96.0 %	4.0 %	50.7 %	36.2 %	15.2 %
Macomb County - MI	85.9 %	10.2 %	0.5 %	3.5 %	97.7 %	2.3 %	52.3 %	37.5 %	16.5 %
Oakland County - MI	77.8 %	15.7 %	0.4 %	6.1 %	96.5 %	3.5 %	52.7 %	37.3 %	15.1 %
Wayne County - MI	53.8 %	42.6 %	0.7 %	2.9 %	94.9 %	5.1 %	48.6 %	34.9 %	14.6 %

Data are for 2011.
Data are in the percentage of women in the population.
Source: US Census Bureau – Population Estimates

Table 2.5. Population characteristics – socioeconomics

Population Group	Less than HS Education	Income Below 100% Poverty	Income Below 250% Poverty (Age: 40-64)	Un-employed	Foreign Born	Linguistic-ally Isolated	In Rural Areas	In Medically Under-served Areas	No Health Insurance (Age: 40-64)
US	14.6 %	14.3 %	33.3 %	8.7 %	12.8 %	4.7 %	19.3 %	23.3 %	16.6 %
Michigan	11.6 %	15.7 %	34.1 %	12.3 %	6.0 %	1.7 %	25.4 %	17.6 %	13.4 %
Detroit RFTC® Service Area	12.7 %	16.1 %	33.9 %	14.0 %	9.2 %	2.6 %	2.4 %	17.8 %	14.1 %
Macomb County - MI	12.1 %	11.0 %	30.1 %	12.4 %	9.9 %	3.0 %	2.8 %	1.0 %	13.5 %
Oakland County - MI	7.5 %	9.5 %	22.9 %	9.9 %	11.1 %	2.6 %	4.8 %	4.7 %	10.6 %
Wayne County - MI	16.5 %	22.7 %	43.7 %	17.4 %	7.7 %	2.4 %	0.7 %	34.2 %	17.0 %

Data are in the percentage of people (men and women) in the population.
Source of health insurance data: US Census Bureau – Small Area Health Insurance Estimates (SAHIE) for 2011.
Source of rural population data: US Census Bureau – Census 2010.
Source of medically underserved data: Health Resources and Services Administration (HRSA) for 2013.
Source of other data: US Census Bureau – American Community Survey (ACS) for 2007-2011.

Population characteristics summary

Proportionately, the Komen Detroit RFTC service area has a substantially smaller White female population than the US as a whole, a substantially larger Black/African-American female population, a slightly smaller Asian and Pacific Islander (API) female population, a slightly smaller American Indian and Alaska Native (AIAN) female population, and a substantially smaller Hispanic/Latina female population. The Komen Detroit RFTC service area's female population is slightly older than that of the US as a whole. The education level within the Komen Detroit RFTC service area is slightly higher than and income level is slightly lower than those of the US as a whole. There are a substantially larger percentage of people who are unemployed in the Komen Detroit RFTC service area. The Komen Detroit RFTC service area has a slightly smaller percentage of people who are foreign born and a slightly smaller percentage of people who are linguistically isolated. There are a substantially smaller percentage of people living in rural areas, a slightly smaller percentage of people without health insurance, and a substantially smaller percentage of people living in medically underserved areas.

The following county has substantially larger Black/African-American female population percentages than that of the Komen Detroit RFTC service area as a whole:

- Wayne County

The following county has substantially lower income levels than that of the Komen Detroit RFTC service area as a whole:

- Wayne County

The following county has substantially lower employment levels than that of the Komen Detroit RFTC service area as a whole:

- Wayne County

Priority Areas

Healthy People 2020 forecasts

Healthy People 2020 (HP2020) is a major federal government initiative that provides specific health objectives for communities and for the country as a whole. Many national health organizations use HP2020 targets to monitor progress in reducing the burden of disease and improve the health of the nation. Likewise, Komen believes it is important to refer to HP2020 to see how areas across the country are progressing towards reducing the burden of breast cancer.

HP2020 has several cancer-related objectives, including:

- Reducing women's death rate from breast cancer (Target as of the writing of this report: 20.6 cases per 100,000 women).
- Reducing the number of breast cancers that are found at a late-stage (Target as of the writing of this report: 41.0 cases per 100,000 women).

To see how well counties in the Komen Detroit Race for the Cure service area are progressing toward these targets, the report uses the following information:

- County breast cancer death rate and late-stage diagnosis data for years 2006 to 2010.
- Estimates for the trend (annual percent change) in county breast cancer death rates and late-stage diagnoses for years 2006 to 2010.
- Both the data and the HP2020 target are age-adjusted.

These data are used to estimate how many years it will take for each county to meet the HP2020 objectives. Because the target date for meeting the objective is 2020, and 2008 (the middle of the 2006-2010 period) was used as a starting point, a county has 12 years to meet the target.

Death rate and late-stage diagnosis data and trends are used to calculate whether an area will meet the HP2020 target, assuming that the trend seen in years 2006 to 2010 continues for 2011 and beyond.

Identification of priority areas

The purpose of this report is to combine evidence from many credible sources and use the data to identify the highest priority areas for breast cancer programs (i.e. The areas of greatest need).

Classification of priority areas are based on the time needed to achieve HP2020 targets in each area. These time projections depend on both the starting point and the trends in death rates and late-stage incidence.

Late-stage incidence reflects both the overall breast cancer incidence rate in the population and the mammography screening coverage. The breast cancer death rate reflects the access to care and the quality of care in the health care delivery area, as well as cancer stage at diagnosis.

There has not been any indication that either one of the two HP2020 targets is more important than the other. Therefore, the report considers them equally important.

Counties are classified as follows (Table 2.6):

- Counties that are not likely to achieve either of the HP2020 targets are considered to have the highest needs.
- Counties that have already achieved both targets are considered to have the lowest needs.
- Other counties are classified based on the number of years needed to achieve the two targets.

Table 2.6. Needs/priority classification based on the projected time to achieve HP2020 breast cancer targets

		Time to Achieve Late-stage Incidence Reduction Target				
Time to Achieve Death Rate Reduction Target		13 years or longer	7-12 yrs.	0 – 6 yrs.	Currently meets target	Unknown
	13 years or longer	**Highest**	**High**	**Medium High**	**Medium**	**Highest**
	7-12 yrs.	**High**	**Medium High**	**Medium**	**Medium Low**	**Medium High**
	0 – 6 yrs.	**Medium High**	**Medium**	**Medium Low**	**Low**	**Medium Low**
	Currently meets target	**Medium**	**Medium Low**	**Low**	**Lowest**	**Lowest**
	Unknown	**Highest**	**Medium High**	**Medium Low**	**Lowest**	**Unknown**

If the time to achieve a target cannot be calculated for one of the HP2020 indicators, then the county is classified based on the other indicator. If both indicators are missing, then the county is not classified. This doesn't mean that the county may not have high needs; it only means that sufficient data are not available to classify the county.

Detroit Race for the Cure® Service area Healthy People 2020 Forecasts and Priority Areas

The results presented in Table 2.7 help identify which counties have the greatest needs when it comes to meeting the HP2020 breast cancer targets.

- For counties in the "13 years or longer" category, current trends would need to change to achieve the target.
- Some counties may currently meet the target but their rates are increasing and they could fail to meet the target if the trend is not reversed.

Trends can change for a number of reasons, including:

- Improved screening programs could lead to breast cancers being diagnosed earlier, resulting in a decrease in both late-stage incidence rates and death rates.
- Improved socioeconomic conditions, such as reductions in poverty and linguistic isolation could lead to more timely treatment of breast cancer, causing a decrease in death rates.

The data in this table should be considered together with other information on factors that affect breast cancer death rates such as screening percentages and key breast cancer death determinants such as poverty and linguistic isolation.

Table 2.7. Intervention priorities for Komen Detroit Race for the Cure® service area with predicted time to achieve the HP2020 breast cancer targets and key population characteristics

County	Priority	Predicted Time to Achieve Death Rate Target	Predicted Time to Achieve Late-stage Incidence Target	Key Population Characteristics
Wayne County - MI	Highest	13 years or longer	13 years or longer	%Black/African-American, poverty, employment, medically underserved
Oakland County - MI	High	8 years	13 years or longer	
Macomb County - MI	Medium High	10 years	7 years	

NA – data not available.
SN – data suppressed due to small numbers (15 cases or fewer for the 5-year data period).

Map of Intervention Priority Areas

Figure 2.1 shows a map of the intervention priorities for the counties in the Komen Detroit RFTC service area. When both of the indicators used to establish a priority for a county are not available, the priority is shown as "undetermined" on the map.

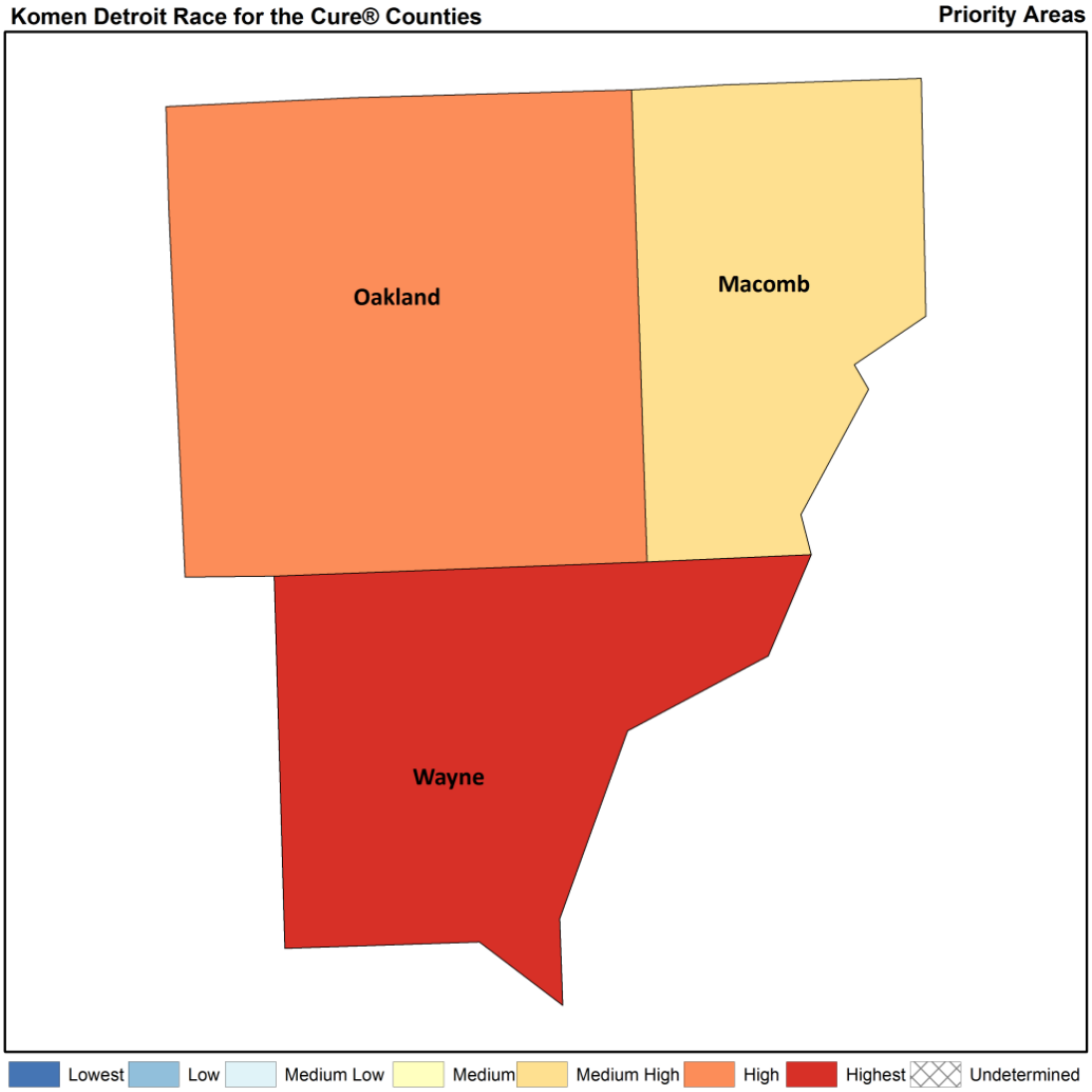

Figure 2.1. Intervention priorities

Data Limitations

The following data limitations need to be considered when utilizing the data of the Quantitative Data Report:

- The most recent data available were used but, for cancer incidence and deaths, these data are still several years behind.
- For some areas, data might not be available or might be of varying quality.
- Areas with small populations might not have enough breast cancer cases or breast cancer deaths each year to support the generation of reliable statistics.
- There are often several sources of cancer statistics for a given population and geographic area; therefore, other sources of cancer data may result in minor differences in the values even in the same time period.
- Data on cancer rates for specific racial and ethnic subgroups such as Somali, Hmong, or Ethiopian are not generally available.
- The various types of breast cancer data in this report are inter-dependent.
- There are many factors that impact breast cancer risk and survival for which quantitative data are not available. Some examples include family history, genetic markers like HER2 and BRCA, other medical conditions that can complicate treatment, and the level of family and community support available to the patient.
- The calculation of the years needed to meet the HP2020 objectives assume that the current trends will continue until 2020. However, the trends can change for a number of reasons.
- Not all breast cancer cases have a stage indication.

Quantitative Data Report Conclusions

Highest priority areas

One county in the Komen Detroit RFTC service area is in the highest priority category. Wayne County is not likely to meet either the death rate or late-stage incidence rate HP2020 targets.

The death rates in Wayne County (29.2 per 100,000) are significantly higher than the Komen Detroit RFTC service area as a whole (26.6 per 100,000).

Wayne County has a relatively large Black/African-American population, high poverty levels and high unemployment.

High priority areas

One county in the Komen Detroit RFTC service area is in the high priority category. Oakland County is not likely to meet the late-stage incidence rate HP2020 target.

Additional Quantitative Data Exploration

The Quantitative Data Report (QDR) suggests that Wayne County is the highest priority for intervention due to high death and late-stage incidence rates along with high levels of poverty and several Health Resources and Services Administration (HRSA)-designated Medically Underserved Areas (MUAs). However, it is important to look more closely at the data to be sure communities and/or populations outside of Wayne County that may be experiencing negative outcomes when it comes to breast cancer diagnosis, survival and accessing the breast cancer continuum of care are not overlooked.

Similar to the information in the QDR section, Komen Detroit RFTC examined breast cancer screening, incidence, deaths, late-stage incidence and demographic data. Data gathered from the 2011 Komen Detroit RFTC Community Profile show that two of the three counties in the Komen Detroit RFTC service area are ranked among the most affluent in Michigan (Oakland County ranked second, Macomb County ranked tenth out of 83 counties). Yet some communities in Oakland and Macomb are quite disparate in terms of income, education attainment and other social determinants of health. Likewise, they experience disparate outcomes when it comes to breast cancer deaths and late-stage incidence. It was important to obtain updated information on these communities in order to see if there has been any change since the previous report.

Also in the QDR section, target populations were selected based mainly on the likelihood of reaching the Healthy People 2020 (HP2020) objectives for breast cancer death and late-stage incidence rates. HP2020 is a major federal government initiative that sets forth specific health objectives to achieve by 2020. Breast cancer screening percentages and other relevant population characteristics have strong influence on outcomes for breast cancer deaths and late-stage incidence. The likelihood for counties in the Komen Detroit RFTC service area to achieve these objectives was determined by using data for the populations by county. In order to take a closer look at communities at the sub-county level, additional breast cancer screening data were gathered from the Michigan Behavioral Risk Factor Surveillance System (MIBRFSS); along with breast cancer incidence, deaths and late-stage incidence data by zip code from the Michigan Division of Vital Records and Health Statistics. Further information relevant to social determinants of health including population living below the Federal Poverty Level (FPL) and health insurance status were gathered using the United States Census Bureau American Fact Finder website. Additional data on health status for populations in Medically Underserved Areas were obtained from the Detroit Surveillance, Epidemiology and End Results (SEER). Each of these sources helped to examine the communities within the three Komen Detroit RFTC counties to determine if there were groups within Oakland and Macomb Counties who may be experiencing the same or similar outcomes as those in Wayne County and who are not likely to achieve the HP2020 objectives to determine target communities and populations. The new data will enhance the county level data and help in understanding which populations are most affected by breast cancer deaths and late-stage incidence. This will, in turn, help determine the best approach to rectify these problems across the Komen Detroit RFTC service area.

Data Findings

When compared to the United States (77.5 percent) and the State of Michigan (79.5 percent), data from the CDC-Behavioral Risk Factor Surveillance System (BRFSS) show higher levels of mammography screening in the last two years for the Komen Detroit RFTC service area overall, and for each of the three counties individually (Komen Detroit RFTC service area -80.2 percent, Wayne County - 80.3 percent, Oakland County - 81.3 percent and Macomb County - 78.4 percent).

Susan G. Komen screening recommendations include a clinical breast exam (CBE) and mammogram beginning at age 40 for women who are at average risk to ensure early detection. According to the Michigan Behavioral Risk Factor Surveillance System (MIBRFSS) survey data for 2012, screening percentages were just barely over 50 percent for the Komen Detroit RFTC service area (50.8 percent) and were 48.6, 56.1 and 48.2 percent for Wayne, Oakland and

Macomb Counties respectively. Only 52.5 percent of women with health insurance who were surveyed had received their annual CBE and mammogram in the past year, and 31.9 percent of uninsured surveyed women received their annual screenings during that time period. These numbers are likely contributors to the grim outlook for breast cancer death and late-stage incidence rates.

When examining sub-county demographic data related to income, there may be a link between poverty and access to the Breast Cancer Continuum of Care. As shown in the 2011 Komen Detroit RFTC Community Profile, for populations living in poverty there is a strong likelihood of being uninsured. Further, there may be a stronger likelihood for breast cancer to be detected at later stages, when it is less treatable, or for the disease to go undetected altogether. While Oakland and Macomb Counties have less poverty than Wayne County, the State of Michigan and the United States, there are communities in Oakland and Macomb Counties that are experiencing lower instances of breast cancer early detection. When examining sub-county level data for Oakland and Macomb Counties, the percentages of breast cancer cases diagnosed at late- stages (i.e., regional and distant) generally increased as the percent of those living below the poverty level increased, as shown in Tables 2.8, 2.9 and 2.10. The communities with the lowest proportion of people living in poverty were compared with the communities with the highest proportion of those living in poverty for each Komen Detroit RFTC county to show this relationship.

Table 2.8: Wayne County stage of diagnosis (2006-2010) by zip code, percent living below poverty and uninsured

City	Zip Code	Stage of Diagnosis					Percent Living Below Poverty	Percent Uninsured
		In Situ	Localized	Regional	Distant	Unknown		
Northville	48168	26.0%	53.0%	16.0%	5.0%	1.0%	2.6%	4.3%
Grosse Pointe	48230	18.0%	49.0%	27.0%	4.0%	3.0%	3.9%	5.7%
Northville	48167	20.0%	55.0%	18.0%	4.0%	3.0%	4.1%	8.4%
Grosse Ile	48138	28.0%	48.0%	18.0%	4.0%	1.0%	4.5%	3.6%
Plymouth	48170	27.0%	52.0%	17.0%	4.0%	1.0%	4.5%	6.8%
Detroit	48215*	20.0%	51.0%	16.0%	8.0%	4.0%	44.5%	16.0%
Hamtramck	48211*	22.0%	28.0%	33.0%	17.0%	0.0%	45.1%	17.2%
Detroit	48210*	26.0%	35.0%	26.0%	11.0%	3.0%	46.0%	27.4%
Hamtramck	48212*	15.0%	42.0%	27.0%	13.0%	2.0%	48.5%	22.5%
Detroit	48208*	26.0%	37.0%	16.0%	19.0%	2.0%	51.5%	20.0%

* Zip code located in a HRSA-designated Medically Underserved Area (MUA)
Stage of Diagnosis Data are in the percentage of people (women) in the population
Poverty and Uninsured Data are in the percentage of people (men and women) in the population
Source of staging data by zip code: MDCH - Michigan Resident Cancer Incidence File
Source of medically underserved data: Health Resources and Services Administration (HRSA) for 2013
Source of other data: US Census Bureau – American Community Survey (ACS) for 2008-2012

Table 2.9. Oakland County stage of diagnosis (2006-2010) by zip code, percent living below poverty and uninsured

City	Zip Code	Stage of Diagnosis					Percent Living Below Poverty	Percent Uninsured
		In Situ	Localized	Regional	Distant	Unknown		
Huntington Woods	48070	26.0%	38.0%	26.0%	3.0%	6.0%	2.2%	2.9%
Franklin	48025	19.0%	49.0%	24.0%	5.0%	3.0%	2.4%	3.9%
Rochester	48306	29.0%	41.0%	25.0%	4.0%	2.0%	2.4%	4.5%
Milford	48380	22.0%	49.0%	27.0%	2.0%	0.0%	2.7%	3.9%
Troy	48098	23.0%	55.0%	20.0%	2.0%	0.0%	2.9%	5.2%
Oak Park	48237	19.0%	48.0%	24.0%	4.0%	5.0%	18.8%	17.3%
Hazel Park	48030	25.0%	49.0%	15.0%	11.0%	0.0%	26.0%	19.7%
Pontiac	48341*	26.0%	41.0%	27.0%	4.0%	1.0%	24.7%	16.7%
Pontiac	48340*	28.0%	49.0%	16.0%	6.0%	1.0%	33.5%	19.8%
Pontiac	48342*	21.0%	38.0%	29.0%	10.0%	2.0%	42.5%	20.9%

* Zip Code located in a HRSA-designated Medically Underserved Area (MUA)
Stage of Diagnosis Data are in the percentage of people (women) in the population
Poverty and Uninsured Data are in the percentage of people (men and women) in the population
Source of staging data by zip code: MDCH - Michigan Resident Cancer Incidence File
Source of medically underserved data: Health Resources and Services Administration (HRSA) for 2013
Source of other data: US Census Bureau – American Community Survey (ACS) for 2008-2012

Table 2.10. Macomb County stage of diagnosis (2006-2010) by zip code, percent living below poverty and uninsured

City	Zip Code	Stage of Diagnosis					Percent Living Below Poverty	Percent Uninsured
		In Situ	Localized	Regional	Distant	Unknown		
Rochester	48306	29.0%	41.0%	25.0%	4.0%	2.0%	2.4%	4.5%
Macomb	48042	29.0%	55.0%	13.0%	2.0%	1.0%	4.5%	5.6%
Armada	48005	11.0%	57.0%	18.0%	11.0%	4.0%	5.5%	9.4%
Macomb	48044	23.0%	49.0%	25.0%	3.0%	1.0%	5.2%	7.5%
New Baltimore	48047	18.0%	60.0%	16.0%	3.0%	1.0%	5.2%	7.5%
Center Line	48015*	14.0%	49.0%	35.0%	0.0%	3.0%	17.4%	10.0%
Sterling Hts.	48310	22.0%	46.0%	24.0%	4.0%	4.0%	17.8%	17.5%
Mount Clemens	48043	15.0%	47.0%	29.0%	6.0%	3.0%	21.3%	14.5%
Eastpointe	48021	13.0%	54.0%	24.0%	6.0%	3.0%	21.9%	13.0%
Warren	48091	20.0%	51.0%	21.0%	5.0%	3.0%	22.4%	18.2%
Warren	48089	13.0%	46.0%	34.0%	5.0%	3.0%	23.2%	17.1%

* Zip Code located in a HRSA-designated Medically Underserved Area (MUA)
Stage of Diagnosis Data are in the percentage of people (women) in the population
Poverty and Uninsured Data are in the percentage of people (men and women) in the population
Source of staging data by zip code: MDCH - Michigan Resident Cancer Incidence File
Source of medically underserved data: Health Resources and Services Administration (HRSA) for 2013
Source of other data: US Census Bureau – American Community Survey (ACS) for 2008-2012

When comparing breast cancer diagnoses in areas where 20.0 percent or more live below the FPL, to areas where less than 20.0 percent of the population live in poverty, there appears to be an association with late-stage incidence. Across the Komen Detroit RFTC tri-county area, people who are poorer may be more likely to be diagnosed at later stages, as shown in Table

2.11. Figure 2.2 shows the distribution of poverty throughout the Komen Detroit RFTC service area. Even though Oakland and Macomb Counties are more affluent overall than Wayne County, it appears that there are still communities with 20.0 percent or more of the population living in poverty, similar to many areas in Wayne County.

Table 2.11. SEER malignant breast cancers 2006-2010 by stage and poverty status

Macomb County, MI	**Poverty Index**			
Stage Distribution	**Under 20.0% Poverty**		**20.0% of Higher Poverty**	
	N	%	**N**	%
Local	1810	61.5	131	55.0
Regional	911	30.9	76	31.9
Distant	177	6.0	21	8.8
Unstaged	47	1.6	10	4.2
Oakland County, MI	**Poverty Index**			
Stage Distribution	**Under 20.0% Poverty**		**20.0% of Higher Poverty**	
	N	%	**N**	%
Local	2823	62.6	191	58.8
Regional	1359	30.1	102	31.4
Distant	244	5.4	32	9.9
Unstaged	83	1.8	-	-
Wayne County, MI	**Poverty Index**			
Stage Distribution	**Under 20.0% Poverty**		**20.0% or Higher Poverty**	
	N	**%**	**N**	**%**
Local	2642	62.8	1393	52.5
Regional	1226	29.1	912	34.4
Distant	264	6.3	309	11.6
Unstaged	75	1.8	41	1.5

Source: Detroit Surveillance, Epidemiology and End Results (SEER)

Racial and ethnic minorities in the Komen Detroit RFTC service area are overwhelmingly represented in the populations living in poverty across each county. Data in Table 2.12 show that Blacks/African-Americans and Hispanics/Latinos are the two groups living in poverty the most across Wayne, Oakland and Macomb Counties. This is crucial because Blacks/African-Americans currently have the highest death rates for breast cancer in the US. Even though Blacks/African-Americans are diagnosed with breast cancer less frequently than Whites, Blacks/African-Americans tend to be diagnosed at later-stages when the disease is far more difficult to treat. Likewise, Hispanics/Latinos are the least likely group in the United States to have regular and timely breast cancer screenings, and breast cancer is often detected at a much more advanced stage in Hispanics/Latinos compared to Whites. This may be attributed to less screening mammography, longer intervals between screenings and lack of timely follow-up for abnormal results. Such a combination of these racial/ethnic cancer disparities and poverty could be a major contributing factor to the high amounts of breast cancer deaths and late-stage incidence in the Komen Detroit RFTC service area.

Table 2.12. Comparison of proportion of population living below 100% of the Federal Poverty Level by county and race, 2008-2012 American Community Survey 5-year estimates

	Whites	Blacks/African-Americans	Hispanic/Latinos
Wayne County	14.0%	36.1%	28.7%
Oakland County	8.5%	18.1%	24.0%
Macomb County	9.8%	27.6%	24.0%

Source: US Census Bureau – American Community Survey (ACS) for 2008-2012

Additionally, data in Table 2.13 show that people who live in poverty in the Komen Detroit RFTC service area are less likely to have finished high school and more likely to experience unemployment when compared to others in the area. Both low educational attainment and unemployment can decrease the likelihood of individuals achieving regular and timely access to the Breast Cancer Continuum of Care due to the increased likelihood of not having adequate income and lack of health insurance. These factors may also contribute to high rates of late-stage breast cancer incidence and death in the Komen Detroit RFTC service area.

Table 2.13. Education attainment and unemployment comparison by county and poverty status

	Less than HS Education for Overall Population	Less than HS Education for Population Below 100% FPL	Unemployed Overall Population	Unemployed Population Below 100% FPL
Wayne County	16.2%	35.8%	17.9%	40.5%
Oakland County	7.4%	24.0%	10.2%	25.4%
Macomb County	12.0%	22.1%	12.6%	25.6%

Unemployed Data are in percentage of people (men and women) age 16 and over in the population
Source US Census Bureau - American Community Survey (2008-2012)

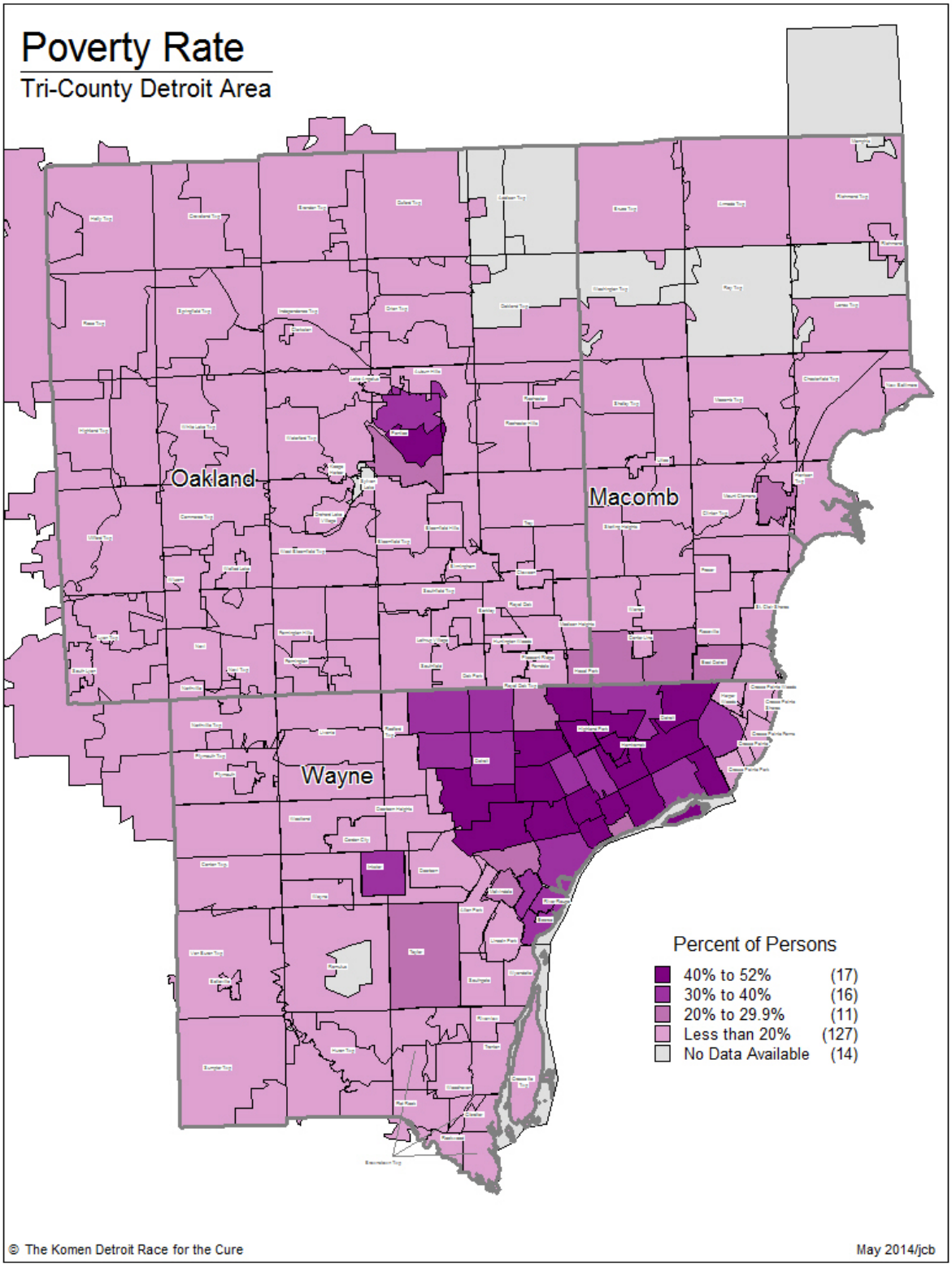

Figure 2.2. Percent of persons living below 100 percent of the Federal Poverty Level in Komen Detroit RFTC service area

Further, many of these poorer communities are also within HRSA-designated MUAs, which, by definition face barriers to health care access and have a demonstrable shortage of health care resources relative to community needs. The Komen Detroit RFTC service area has 20 MUAs.

Most of the MUAs are in Wayne County. However, Oakland County has one MUA and Macomb County has two MUAs, one designated by HRSA, which includes Center Line, Michigan, and another designated by Michigan's Governor, which includes Lenox, Ray, Richmond and Washington. Figure 2.3 shows where each MUA is located throughout the three counties.

Although Oakland and Macomb Counties have fewer designated MUAs than Wayne County, there are still communities in these counties outside of these areas where poverty and access to health care present challenges to breast cancer early detection. As shown in Tables 2.9 and 2.10, Hazel Park, in Oakland County, and Warren, in Macomb County, have high levels of poverty and uninsured populations along with large percentages of people diagnosed with breast cancer at later stages.

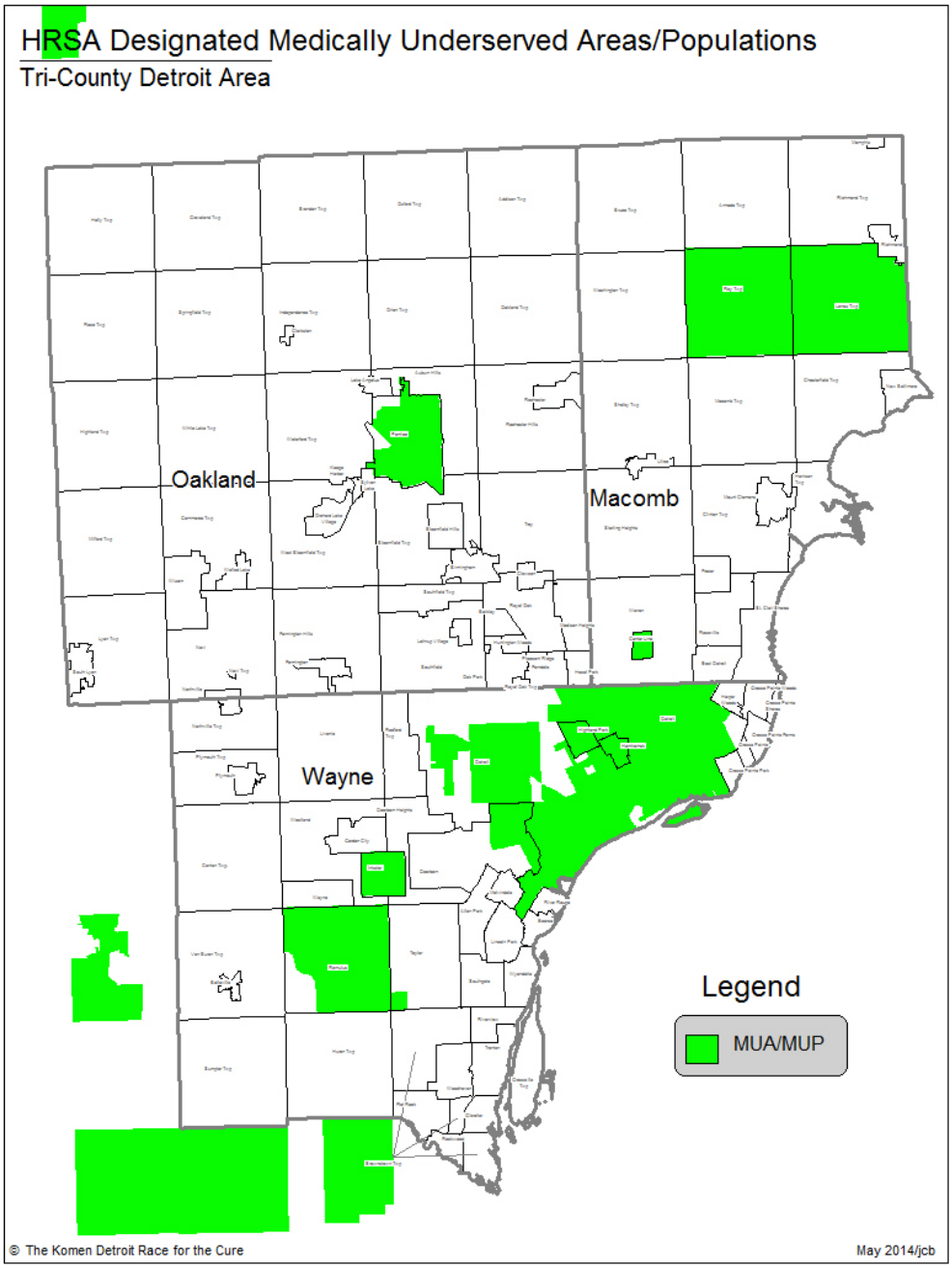

Figure 2.3. HRSA-designated Medically Underserved Areas in Wayne, Oakland and Macomb Counties

When comparing those diagnosed with breast cancer in Medically Underserved Areas and those who do not live in these designations, there also may be an association with late-stage incidence. Data in Table 2.14 show that people who live in MUAs may be more likely to be diagnosed at later stages across all three Komen Detroit RFTC counties than those who do not live in a MUA, with more cases being diagnosed at regional and distant stages for MUA populations.

Table 2.14. SEER malignant breast cancers 2006-2010 for MUA populations by stage

Macomb County, MI	**Medically Underserved Area**			
Stage Distribution	**No**		**Yes**	
	N	%	**N**	%
Local	1927	61.0	21	61.8
Regional	977	30.9	13	38.2
Distant	198	6.3	-	-
Unstaged	57	1.8	-	-
Oakland County, MI	**Medically Underserved Area**			
Stage Distribution	**No**		**Yes**	
	N	%	**N**	%
Local	2940	62.5	80	57.6
Regional	1418	30.1	45	32.4
Distant	262	5.6	14	10.1
Unstaged	87	1.9	-	-
Wayne County, MI	**Medically Underserved Area**			
Stage Distribution	No		Yes	
	N	%	N	%
Local	3065	61.2	972	52.2
Regional	1498	29.9	646	34.7
Distant	363	7.3	210	11.3
Unstaged	80	1.6	36	1.9

Source: Detroit Surveillance, Epidemiology and End Results

Breast cancer survival rates are also affected, as shown in Table 2.15. In communities where poverty is more than 20.0 percent, the 4-year survival rates are lower than for those in communities where poverty is less widespread.

Table 2.15. SEER malignant breast cancers (2006-2010) 4-year survival rates by poverty index and county

	Under 20.0% Poverty	**20.0% or Higher Poverty**
Macomb County, MI	79.0%	68.0%
Oakland County, MI	81.0%	69.0%
Wayne County, MI	77.0%	65.0%

Source: Detroit Surveillance, Epidemiology and End Results

For all three Komen Detroit RFTC counties, people diagnosed with breast cancer from very poor areas were at least 0.8 times more likely to die within 4 years of their initial diagnosis.

When examining sub-county level data, there are several communities in Oakland and Macomb Counties with striking similarities to Wayne County in breast cancer late-stage incidence, survival rates and other important indicators. Consequently, these target populations and communities most in need were chosen in order to help them reach the HP2020 objectives.

Selection of Target Populations

Komen Detroit RFTC is committed to decreasing breast cancer late-stage incidence and death rates in its service area. When reviewing the data to select the Komen Detroit RFTC target populations, HP2020 objectives were considered a high priority. Additional key indicators and contributing factors for high late-stage incidence and death rates were also examined. The indicators included below average screening percentages, high numbers of people living in poverty, high numbers of people without health insurance and the number of people in identified Medically Underserved Areas.

Based on the additional data collected, the Komen Detroit RFTC has selected as its target populations Wayne, Oakland and Macomb county communities living in poverty and in Medically Underserved Areas (MUAs).

These target populations are highest priority in terms of breast cancer deaths and late-stage incidence and may be less likely to enter the Breast Cancer Continuum of Care, thus increasing the likelihood of late-stage incidence. By focusing funding, operational and outreach efforts on these target populations; Komen Detroit RFTC can help the tri-county area achieve the HP2020 goals for breast cancer death and late-stage incidence rates.

Wayne County

Wayne County is located in southeast Michigan and is home to Detroit, the largest city in Michigan. Wayne County is home to approximately 972,455 women, whose population is comprised of 53.8 percent Whites, 42.6 percent Blacks/African-Americans, and 5.1 percent Hispanic/Latinas.

Proportionately, the Detroit RFTC service area has a larger Black/African-Americans population when compared to the US and Michigan as a whole. Wayne County has a substantially higher percentage of Black/African-American women (42.6 percent) when compared to the State of Michigan (15.5 percent) and the US (14.1 percent). The City of Detroit's overall Black/African-American population (both male and female) percentage is 82.7 percent, making it the city with the largest proportion of Blacks/African-Americans in the country. As mentioned in the Data Findings Section, Blacks/African-Americans currently have the highest death rates for breast cancer in the US, and are diagnosed with breast cancer less frequently and at later stages than Whites.

Conversely, the Komen Detroit RFTC service area has a substantially lower number of Hispanic/Latinos (4.0 percent) compared to the US as a whole (16.2 percent).

In the QDR section, Wayne County was identified as the highest priority county in the Komen Detroit RFTC service area. The data show that it will take an estimated 13 years or longer for Wayne County to reach the HP2020 objectives for both late-stage incidence and death rates.

Currently, the late-stage incidence rate for Wayne County is 46.2 per 100,000 women, which is higher when compared to the US (43.7), the State of Michigan (41.0) and the Komen Detroit RFTC service area overall (45.1). Likewise, Wayne County has a higher death rate (29.2) than the US (22.6), the State of Michigan (24.0) and the overall service area (26.6).

These outcomes may be attributed to high levels of poverty throughout Wayne County. Wayne County also has the highest proportion of residents living below 100 percent of the FPL (22.7 percent) when compared to Oakland and Macomb Counties. As shown in Table 2.12, poor populations in the Komen Detroit RFTC service area are mostly comprised of Blacks/African-Americans and ethnic minorities. In the Komen Detroit RFTC tri-county area, Blacks/African-Americans are more likely to be poor than Whites. Wayne County is no exception with 36.1 percent of Blacks/African-Americans in Wayne County living in poverty compared to 14.0 percent of Whites, making it 2.6 times more likely for Blacks/African-Americans to be poor compared to Whites in Wayne County.

In spite of the Komen Detroit RFTC service area having a substantially lower number of Hispanic/Latinos compared to the US as a whole, this ethnic group is highly represented in the area's poor population. Hispanics/Latinos are 2.1 times more likely to be poor compared to non-Hispanic Whites in Wayne County with 28.7 percent living below the FPL, also outlined in Table 2.12.

Blacks/African-Americans and Hispanics/Latinos both experience disparities in breast cancer outcomes and are highly represented in Komen Detroit RFTC chosen target populations. As demonstrated in the Data Findings Section, poverty may increase the chance that people are not accessing the Breast Cancer Continuum of Care for regular screening and, if needed, for treatment.

Further, the Komen Detroit RFTC service area's poor population is less likely to have finished high school and more likely to be unemployed, two commonly recognized social determinants of poor health. For Wayne County, 35.8 percent of residents who live in poverty have less than a high school education and an average of 40.5 percent of Wayne County's poor population have been unemployed during the measured time frame, as outlined in Table 2.13. Both of these factors may increase the likelihood of having no health insurance and minimal access to the Breast Cancer Continuum of Care.

In Wayne County, there are 17 designated MUAs. The MUAs in Wayne County are comprised mostly of the city of Detroit, but also include all or portions of Dearborn, Ecorse, Hamtramck, Harper Woods, Highland Park, Inkster, Lincoln Park, River Rouge, Romulus and Taylor. Many of these cities, including Detroit, Highland Park, Inkster and River Rouge, have majority Black/African-American populations. However, some of these areas are home to growing ethnic and immigrant populations. For example, Dearborn is home to the highest proportion of Arab Americans in the United States. Also, southwest Detroit is predominantly populated by Hispanics/Latinos. These immigrant populations can face substantial barriers to health care due in part to limited English language proficiency and citizenship status. The percent of Wayne County people living below the FPL ranges from 13.9 percent (Harper Woods) to 46.7 percent (Highland Park). Median household incomes range from $20,298 to $46,972, with unemployment ranging from 12.9 percent to 27.5 percent. (ACS 2008-2012). Table 2.14 outlines the disparity between those who live in MUAs compared with those who do not when it

comes to stage of breast cancer diagnosis in Wayne County. For those living in Wayne County's MUAs, 52.2 percent were diagnosed with breast cancer at a local stage, compared to 61.2 percent for those who do not live in a MUA. Moreover, 34.7 percent were diagnosed at regional stages and 11.3 percent were diagnosed at distant stage compared to 29.9 percent and 7.3 percent respectively for those not living in MUAs.

For Wayne County, each of these factors could be contributing to the data showing that just 65.0 percent of those living in an area where at least 20.0 percent of the population lives in poverty survive four years after their initial diagnosis compared to 77.0 percent of those who live in areas were poverty is less than 20.0 percent as outlined in Table 2.15.

Because Wayne County is highly populated when compared to other Michigan counties, there are a high number of health care facilities including hospitals and Federally Qualified Health Centers (FQHCs) due to the high number of MUAs. FQHCs are responsible for addressing the primary health care needs of medically underserved communities. The Health Systems Analysis component of this report will explore what services are currently available to help people living in poverty access the Breast Cancer Continuum of Care, and whether or not those services are adequate to meet the needs of the populations.

Oakland County

Oakland County is also located in southeast Michigan, just northwest of Wayne County and east of Macomb County. Oakland County is one of the most affluent counties in Michigan with communities like Birmingham, Bloomfield Hills, Novi and Rochester Hills, where the median household incomes range from $77,764 to $136,875 per year. Oakland County is home to 616,775 women, 77.8 percent of whom are White, 15.7 percent Black/African-American and 3.5 percent Hispanic/Latinas.

Oakland County was identified in the QDR section of this report as high priority due to the estimated length of time it will take to reach HP2020 objectives for late-stage incidence and death rates. The current breast cancer death rate for Oakland County is 24.0, which is higher when compared to the US rate (22.6), but equal to the State of Michigan and lower than the Detroit RFTC service area (26.6), yielding an estimated eight-year projection for achieving HP2020 objectives. However, Oakland County's rate for late-stage incidence (44.1) is higher than the US (43.7) and the State of Michigan (41.0); and it is estimated that it will take 13 years or longer to reach HP2020 objectives.

Despite Oakland County's affluence, there are many communities in the county that have high levels of poverty whose residents likely experience many, if not all, of the same challenges as those living in similar circumstances in Wayne County. Table 2.9 shows that communities like Hazel Park and Pontiac, which have more than 20.0 percent of their populations living in poverty, also have a higher proportion of late-stage incidence for breast cancer like poor populations in Wayne County. These populations are likely to face the same challenges in accessing the Breast Cancer Continuum of Care and are more likely to be diagnosed with breast cancer at a later stage compared with people who do not live in poverty. Similar to Wayne County, Blacks/African-Americans and ethnic minorities make up the majority of those who live in poverty. As shown in Table 2.12, Blacks/African-Americans are 2.1 times more likely than Whites to be poor with 18.1 percent living in poverty compared to just 8.5 percent for

Whites. Hispanics/Latinos are 3.0 times more likely to be poor compared to non-Hispanic Whites in Oakland County, with 24.0 percent living in poverty.

Again, education and unemployment are major determinants of access to the Breast Cancer Continuum of Care. For Oakland County's poor populations, 24.0 percent have less than a high school education while an average of 25.4 percent were unemployed, as shown in Table 2.13.

In Oakland County, the single MUA designation is comprised mostly of Pontiac and portions of neighboring Auburn Hills. Pontiac is Oakland's county seat and home to county government administrative offices. Blacks/African-Americans and Hispanics/Latinos make up over two-thirds of Pontiac's population at 52.1 and 16.8 percent respectively, followed by Whites (34.4 percent) and Asians/Pacific Islanders (2.3 percent). The median household income is $28,825, with 21.4 percent unemployment and 34.2 percent living in poverty. (ACS 2008-2012). The three zip codes for Pontiac were also listed in Table 2.9 as those with the highest proportion of people living in poverty in Oakland County with as much as 10.0 percent of women diagnosed at a distant stage for breast cancer. Data from Table 2.14 show for those residing in this MUA, 32.4 percent were diagnosed with breast cancer at a regional stage and 10.1 percent were diagnosed at a distant stage. This is quite different from those in Oakland County who do not live in its sole MUA; just 30.1 percent were diagnosed at a regional stage while 5.6 percent were diagnosed at a distant stage.

A very large gap in the four-year survival rate may show that poverty and lack of access to adequate health care may be the cause of high late-stage incidence and death rates in Oakland County. Table 2.15 shows that for people living in areas with at least 20.0 percent of the population lives in poverty, just 69.0 percent survive four years after receiving a breast cancer diagnosis. For those who live in other areas, the four year survival rate is 81.0 percent.

With Oakland County's more affluent demographics, there are also several health care facilities available for its residents. However, for those who live in poverty and those who live in the sole Medically Underserved Area in the county, such resources may be out of reach even when geographically proximate.

In the Health Systems Analysis section, Komen Detroit RFTC will seek a better understanding of which resources are available to these populations.

Macomb County

Macomb County is located in southeast Michigan and is the least populated county in the Komen Detroit RFTC service area. Home to 429,294 women, Macomb County residents are predominantly White (85.9 percent) with 10.2 percent of women who are Black/African-American and 2.3 percent Hispanic/Latina.

Identified as a medium high priority area in the QDR section, Macomb County is projected to meet the HP2020 objectives for breast cancer death rates in 10 years, and late-stage incidence target rates in seven years. Currently, the death rate is 24.7, which is slightly higher than the State of Michigan (24.0) but lower than the US rate (22.6) and the rate for the Komen Detroit RFTC service area (26.6). Further, the late-stage incidence rate for Macomb County is 44.3, which is higher than both the US (43.7) and State of Michigan (41.0) rates yet lower than the Komen Detroit RFTC service area (45.1).

Though Macomb County seems to be doing better when it comes to the HP2020 objectives when compared to Wayne and Oakland Counties, it is important to note that Macomb County has the lowest proportion of women who are receiving timely breast cancer screenings in the Komen Detroit RFTC service area at 48.2 percent. Poverty is likely a barrier to screening in Macomb County where Blacks/African-Americans and Hispanics/Latinos make up the majority of people living in poverty, similar to both Wayne and Oakland Counties. Table 12 data show 27.6 percent of Blacks/African-Americans are poor, making them 2.8 times more likely than Whites (9.8 percent) to be poor in Macomb County, while 24.0 percent of Hispanics/Latinos are poor, making them 2.5 times more likely to be poor compared to non-Hispanic Whites in Macomb County.

In Macomb County, the HRSA-designated MUA encompasses the city of Center Line. The other Macomb County MUA, designated by Governor James Blanchard in 1988, is comprised of Lenox, Ray, Richmond and Washington. Center Line is located in the southwestern corner of Macomb County and is home to 8,257 people. The small population is mostly White (82.5 percent), followed by Blacks/African-Americans (12.0 percent), Asians/Pacific Islanders (2.5 percent) and Hispanics/Latinos (1.7 percent). The population living below the FPL is 17.4 percent with the median household income of $31,411 and 11.9 percent unemployed. (US Census Bureau American Community Survey [ACS] 2008-2012). For those who reside in Macomb County MUAs, 38.2 percent were diagnosed at a late-stage (i.e. regional stage) compared to 30.9 for those who live outside of an MUA as shown in Table 2.14.

Table 2.15 shows that areas where at least 20.0 percent of the population live in poverty, 68.0 percent of people who received a breast cancer diagnosis survived four years after their initial diagnosis compared to 79.0 percent of those who do not live in such highly impoverished areas, demonstrating that poverty may be an important determinant for breast cancer deaths and stage of diagnosis in Macomb County.

The Health Systems Analysis section will explore the availability of services for those who are negatively affected by lack of access to regular health care. This section will also address how Michigan's health policies, newly developed in compliance with the Patient Protection and Affordable Care Act (ACA), will alleviate challenges for those living in Medically Underserved Areas.

Health Systems Analysis Data Sources

For Komen Detroit RFTC service area target populations based on breast cancer death and late-stage incidence rates, it is important to explore access and availability to breast health services. Availability and accessibility can determine whether or not individuals can enter and remain in the Breast Cancer Continuum of Care (CoC). For the selected target populations (i.e., Wayne, Oakland and Macomb county populations living in poverty and in Medically Underserved Areas) it can be difficult to enter the CoC due to lack of health insurance and other barriers. This section will explore accessibility, availability and barriers to care.

To determine which organizations offer services to individuals living in poverty and to those residing in Medically Underserved Areas the *Michigan Primary Care Association 2013-14 Guide to Michigan Health Centers and MPCA Members*, which contains a list of Federally Qualified Health Centers (FQHCs) and Look-Alike Clinics for the State of Michigan, was used. Additionally, the Health Resources and Services Administration (HRSA) Data Warehouse provided a comprehensive list of community health centers for Wayne, Oakland and Macomb counties. Further information regarding hospitals / major area health systems accreditation of services and quality of care indicators was obtained from the following databases: the American College of Surgeons Commission on Cancer, the American College of Radiology, the National Accreditation Program for Breast Centers, and the National Cancer Institute. Information also came from the Food and Drug Administration (FDA) Database for Mammography Facilities. The Greater Detroit Area Health Council Find MI Care website provided information about local clinics and health care resources in the selected target populations.

Information on health care services for area hospitals, FQHCs and Look-Alike Clinics, mammography facilities and other cancer support organizations were compiled. This list included specific services currently offered by each facility offering services to the selected target populations in the Komen Detroit RFTC service area. Facilities located in Medically Underserved Areas and zip codes with at least 10.0 percent of the population living at or below the Federal Poverty Level (FPL) were included.

Services were compared across health care organizations in the Komen Detroit RFTC target populations to determine resources and CoC gaps.

Health Systems Overview

The Breast Cancer Continuum of Care (CoC) is a model that shows how a woman may move through the health care system for breast care. Ideally, this would be quickly and seamlessly, receiving timely, quality care in order to have the best outcomes. Education can play an important role throughout the entire CoC.

While a woman may enter the continuum at any point, ideally, she would enter the CoC by getting screened for breast cancer – with a clinical breast exam or a screening mammogram. If the screening test results are normal, she would loop back into follow-up care, where she would get another screening exam at the recommended interval. Education plays a role throughout--

providing information to encourage screening and reinforcing the need for continued, routine screening.

When a screening exam reports abnormal results, potentially multiple diagnostic tests are recommended. These tests may include a diagnostic mammogram, breast ultrasound and/or biopsy. If diagnostic test results are negative (or benign) for breast cancer, the patient goes into the follow-up loop returning for screening at the recommended interval. Intervals may range from three to six months for some women and 12 months for most women. Education plays a role in communicating the importance of being proactive in getting test results, keeping follow-up appointments and understanding what it all means. Education can empower a woman, help manage anxiety and fear and keep her in the CoC.

If breast cancer is diagnosed, she would proceed to treatment. Then, education can cover treatment options, understanding pathology reports and other test results, anticipating side effects and how to manage them and formulating questions the patient can ask her providers.

For some patients, treatment may last a few months; for others, it may last years. While the CoC model shows follow-up and survivorship after treatment ends, they actually should be concurrent to treatment. Follow-up and survivorship may include navigating insurance issues (locating financial assistance) and symptom management (such as pain, fatigue, sexual issues, bone health, etc.). Education can address healthy lifestyle choices, long-term effects of treatment, managing side effects, the importance of follow-up appointments and communication with providers. Most women will return to screening at a recommended interval after treatment ends, or for some, during treatment, such as those taking long term hormone therapy.

There are often delays in moving from one point of the continuum to another—for example; at the point of follow-up of abnormal screening exam results, starting treatment, and completing treatment. These delays can all contribute to poorer outcomes. There are also many reasons why a woman does not enter or continue in the breast cancer CoC. These barriers can include lack of transportation, system issues like long waits for appointments and inconvenient clinic hours, language barriers, fear and lack of information – or wrong information (myths and misconceptions). Education can help address these barriers and help a patient progress through the CoC. A visual depiction of the CoC is shown in Figure 3.1.

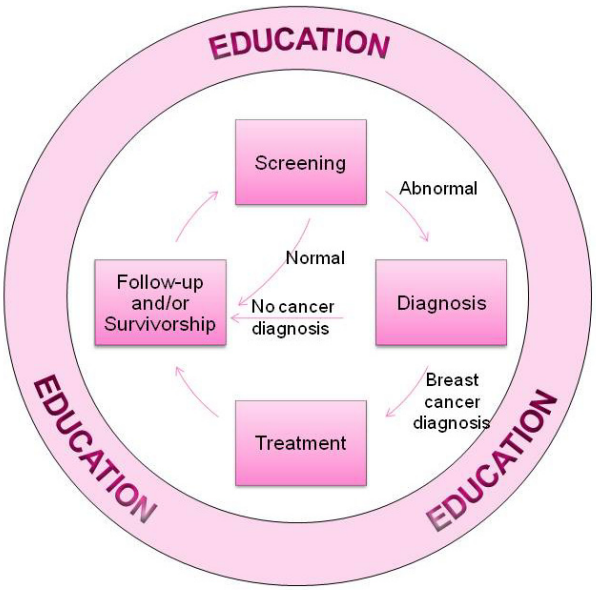

Figure 3.1. Breast Cancer Continuum of Care (CoC)

The Detroit RFTC service area health systems strengths include having several facilities located within the region offering breast health services that allow many opportunities for women to enter the CoC. Many facilities are located within HRSA-designated MUAs and near large populations living in poverty, including hospitals affiliated with larger health systems. Every

hospital in metro Detroit's target communities offers services that span the full Breast Cancer Continuum of Care: breast cancer screening, diagnostics, treatment and support services. However, there remain severe gaps that contribute to the high breast cancer death and late-stage incidence rates.

Wayne County

In Wayne County, there is an abundant supply of hospitals located within or near HRSA-designated MUAs (Figure 3.2). The MUAs in Wayne County include all or portions of Detroit, Dearborn, Ecorse, Hamtramck, Harper Woods, Highland Park, Inkster, Lincoln Park, River Rouge, Romulus and Taylor. Wayne County is home to the Barbara Ann Karmanos Cancer Institute, one of the 45 National Cancer Institute (NCI)-designated Comprehensive Cancer Centers in the US and is located in mid-town Detroit. Additionally, Wayne County is home to other outstanding hospitals that offer the full array of breast health services along the CoC including Henry Ford Hospital, also located in Detroit, which is an American College of Radiology Breast Imaging Center of Excellence, accredited by the American College of Surgeons Commission on Cancer and part of the National Accreditation Program for Breast Centers. Further, Oakwood Hospital is located in Dearborn, Michigan, another MUA in Wayne County, and is also part of the American College of Surgeons Commission on Cancer and is an American College of Radiology Breast Imaging Center of Excellence.

Eight organizations have Federally Qualified Health Centers (FQHCs) and Look-Alike clinics serving the Wayne County target populations. These centers serve people in Wayne County's Medically Underserved Areas (MUAs) and those who live in poverty. Along with other general health care services, most of the centers offer clinical breast exams and referrals for mammograms. The centers ensure that community members have local primary care access, reducing some of the distance and transportation barriers.

Michigan has a strong health care safety-net that includes the Breast and Cervical Cancer Control Program (BCCCP). The Wayne County BCCCP is the largest of these programs in Michigan, and has a history of successful outreach and patient recruitment in Wayne County target populations. Uninsured and underinsured women in Wayne County have used this important program since inception for no-cost breast cancer screening. Additionally, many of the Wayne County FQHCs serve as clinical sites for women to receive an annual clinical breast exam and referral for an annual mammogram as part of this program in Wayne County.

In spite of Wayne County's local health system strengths, there are still factors that may contribute to the high levels of late-stage incidence and death rates.

As mentioned in the Quantitative Data Section, the percentage of women in the Komen Detroit RFTC service area receiving the recommended breast cancer screenings is low (48.6 percent). While the major hospitals and large health systems offer the full range of services for breast health, none of the FQHCs in Wayne County offers services beyond clinical breast exams and mammography referrals. Because FQHCs do not have on-site mammography, this can be a barrier to patients in their pursuit of thorough and timely breast cancer screening. When patients require multiple services offered at different locations, transportation and facility hours can present challenges to accessing care. Further, while all of the large health systems offer the full range of services, some may only offer limited assistance for those who are uninsured or underinsured, creating a cost barrier to remain in the CoC.

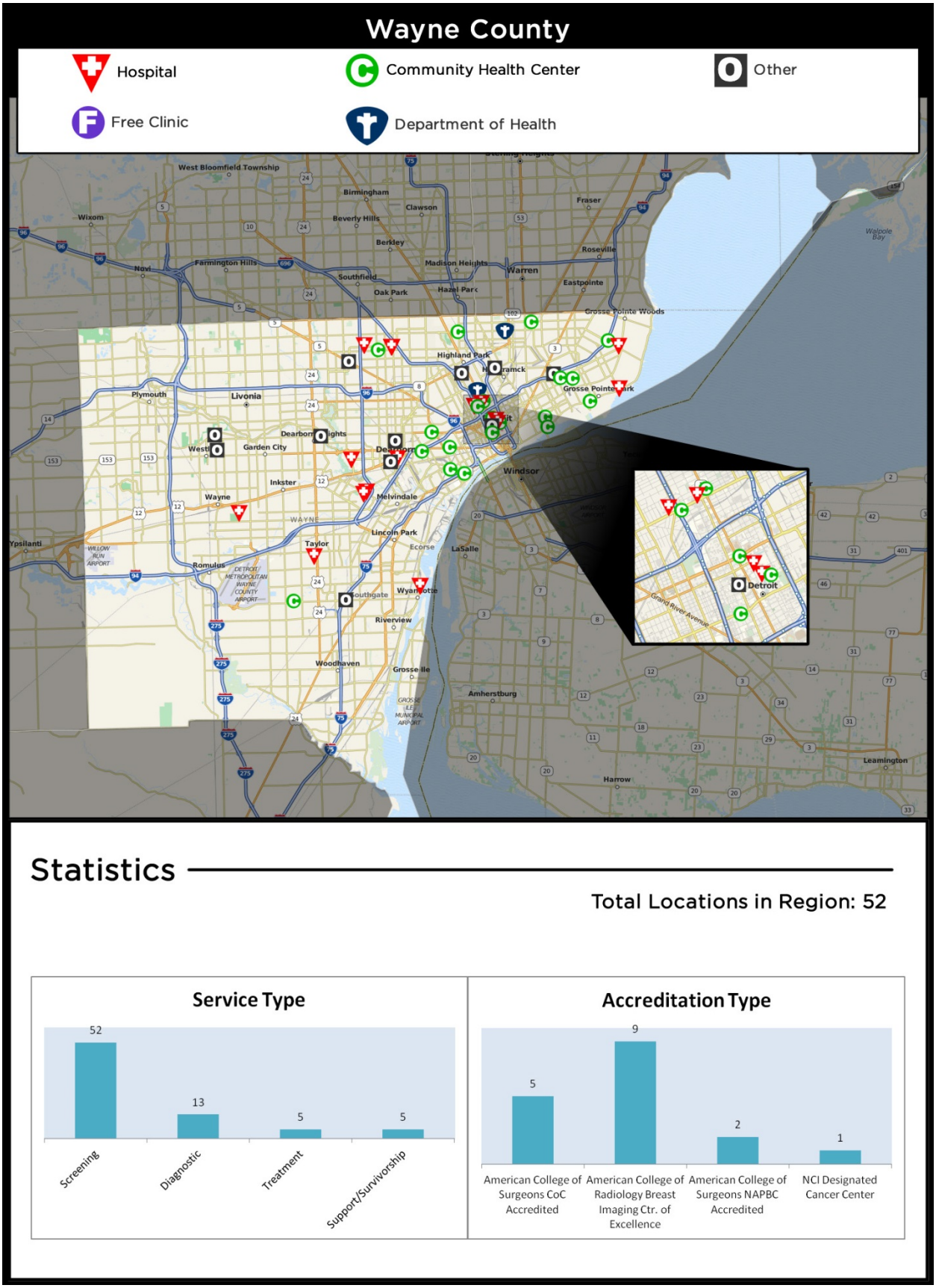

Figure 3.2. Breast cancer services available in Wayne County

Oakland County

Oakland County's sole MUA, Pontiac, Michigan, is home to three hospitals that offer breast cancer screening services including mammography (Figure 3.3). Two of the three hospitals offer the full range of breast health services along the CoC. Of these two, St. Joseph Mercy Oakland Hospital is an American College of Radiology Breast imaging Center of Excellence, accredited by the American College of Surgeons Commission on Cancer and is also part of the National Accreditation Program for Breast Centers. Additionally, Pontiac is home to two FQHCs and one Look-Alike clinic that offer clinical breast exams and referrals to mammograms.

For populations in Oakland County located outside of its only MUA in Pontiac, Michigan, with high levels of poverty, breast health services are available either within the local community or in a nearby community. For example, there are high poverty levels in Hazel Park and Oak Park, both located in Oakland County, but there isn't a hospital in either city. Neighboring Oakland County cities Royal Oak and Southfield have large hospitals that offer the full range of services along the CoC. Both Beaumont Hospital in Royal Oak and Providence Hospital in Southfield are accredited by the American College of Surgeons Commission on Cancer and are part of the National Accreditation Program for Breast Centers.

Like, Wayne County, uninsured and underinsured women in Oakland County, many of whom reside in the selected target communities, also have access to the BCCCP, which helps women receive timely breast cancer screening services as a health care safety net program. As an unofficial practice of accommodation, some Oakland County women are served through the Wayne County Program due to limited program capacity in Oakland County.

Those who reside in Oakland County's selected target populations have breast health resources either within or near their local communities. However, based on the data for late-stage incidence and the fact that a mere 56.1 percent of women in Oakland County have received a clinical breast exam and mammogram in the past year, there may be a problem accessing these resources. Similar to Wayne County, none of the FQHCs in Oakland County offer services beyond clinical breast exams. Having to schedule appointments in multiple locations can create obstacles to timely screenings and—when a cancer is detected—to treatment. Even though nearby hospitals offer outstanding services, they are of no value to women who cannot get to these locations due to lack of transportation or other factors. Further, for those who do have reliable transportation to the nearby hospitals, there still may be a cost barrier if these facilities do not offer adequate financial assistance for those who may be uninsured or underinsured.

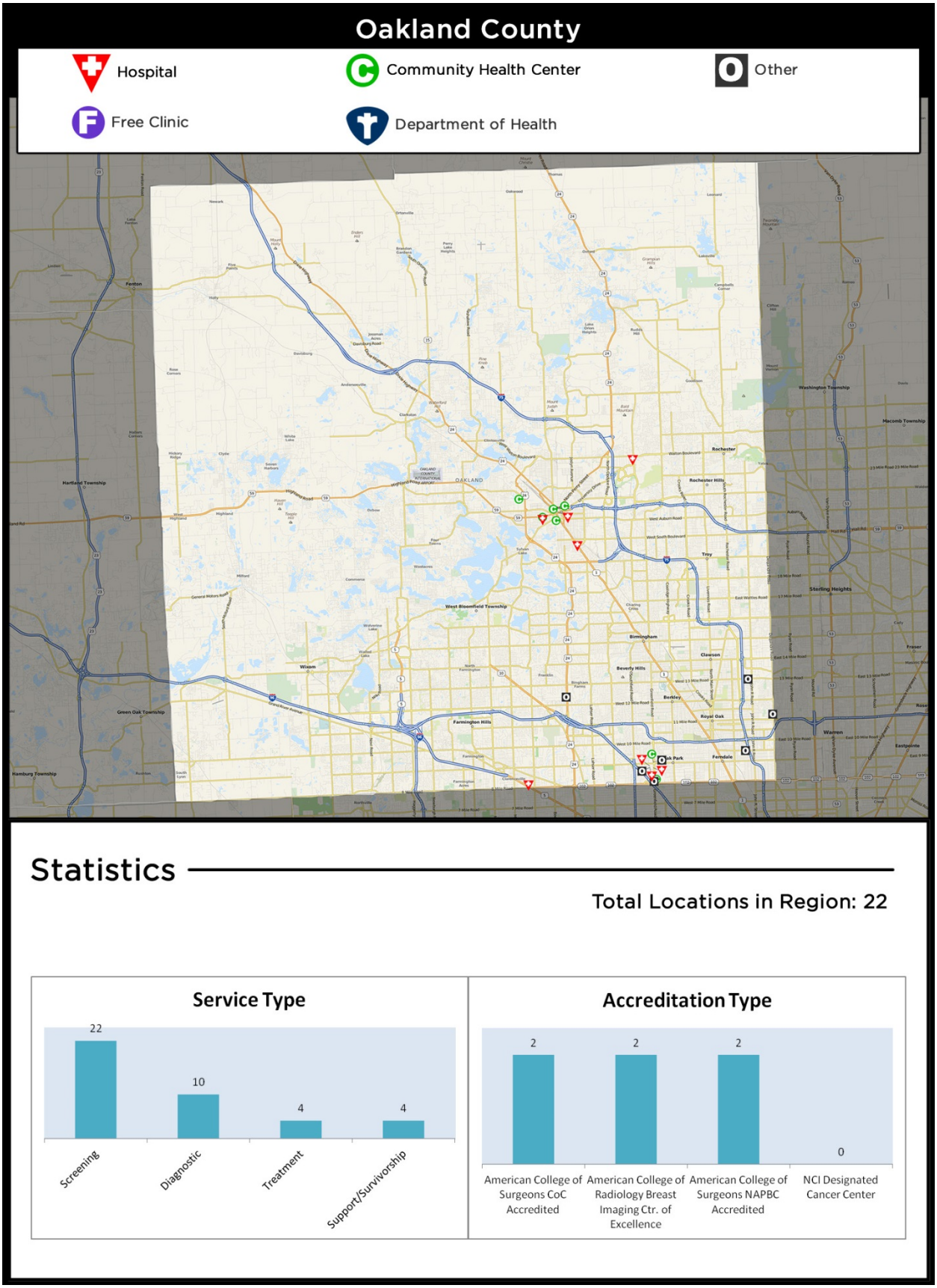

Figure 3.3. Breast cancer services available in Oakland County

Macomb County

There are no hospitals in Macomb County Medically Underserved Areas (MUAs), which include the cities of Center Line, Lenox, Ray, Richmond and Washington (Figure 3.4). Like Oakland, Macomb County has several hospitals located in or close to the remaining target populations offering the full range of breast health services. For example, St. John Macomb Hospital in Warren is accredited by the American College of Surgeons Commission on Cancer and is part of the National Accreditation Program for Breast Centers. Due to the high levels of poverty, Warren is a target community and neighbors Center Line, one of Macomb County's MUAs. Further, Henry Ford Macomb Hospital in Clinton Township offers the full range of breast health services and is also accredited by the American College of Surgeons Commission on Cancer and an American College of Radiology Breast Imaging Center of Excellence. Clinton Township in Macomb County has high levels of poverty, but is not a MUA.

Throughout the Macomb County target populations there are only a few FQHCs and Look-Alike Clinics offering clinical breast exams and referrals to mammography. Uniquely, one of the FQHCs in Macomb County administers the Macomb County BCCCP for uninsured and underinsured women, many of whom are part of the selected target populations. Additionally, Macomb County's Health Department offers clinical breast exams at two locations serving the target populations across the county. Macomb County's Health Department is the only health department out of the Komen Detroit RFTC three counties to offer breast health services.

As with Wayne and Oakland Counties, Macomb County has similar CoC barriers. The Macomb County BCCCP is limited to screening services and must refer breast cancer patients in need of treatment to Wayne County's BCCCP. This can cause treatment delays due to the time it can take to exchange patients across programs.

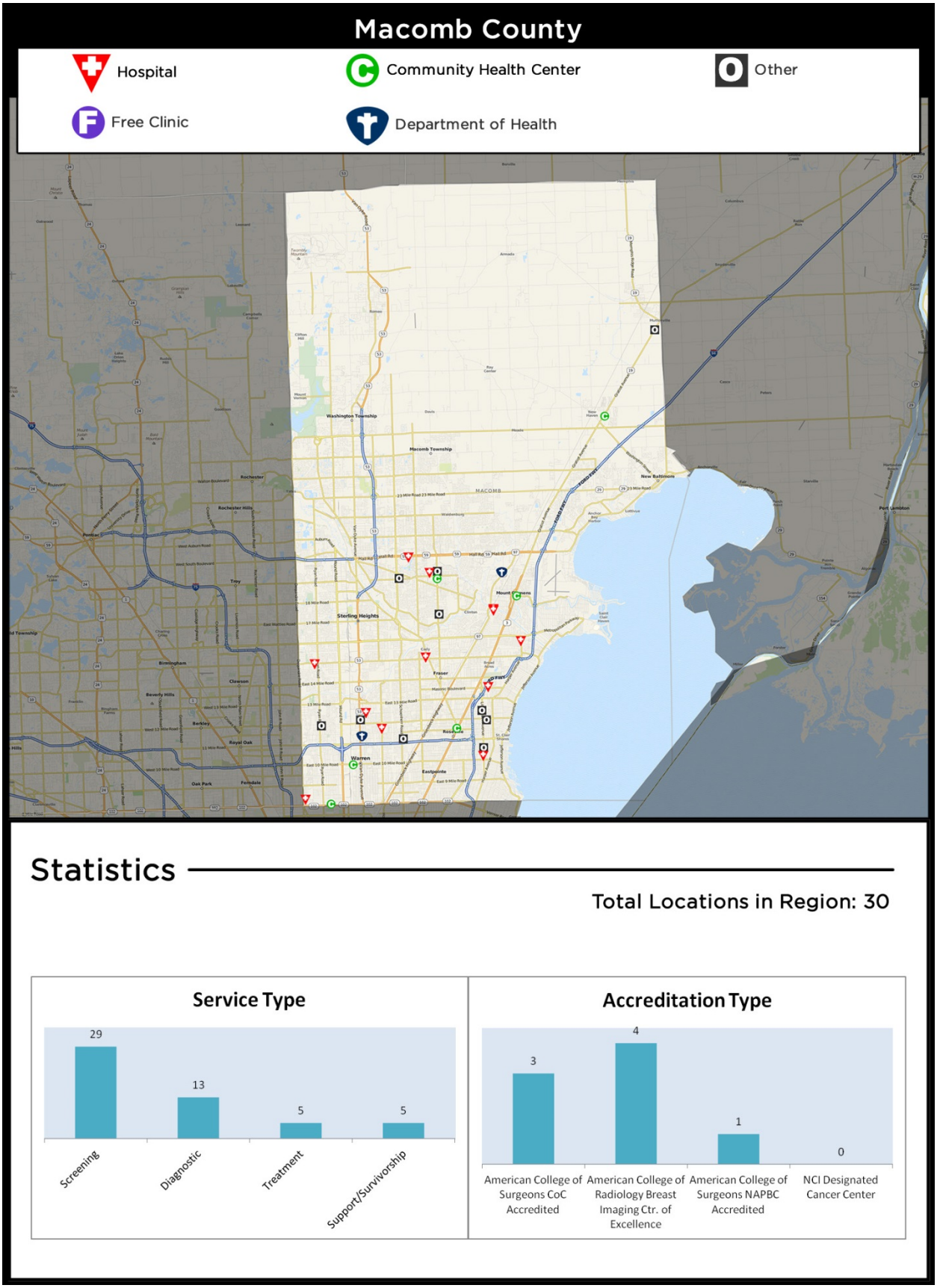

Figure 3.4. Breast cancer services available in Macomb County

Many hospitals and clinics throughout the Komen Detroit RFTC service area refer uninsured women to the BCCCP. For low-income and uninsured women, the BCCCP is a crucial resource connecting them to free breast cancer screenings. Women eligible for this important program are often the same women who live where there are high levels of poverty and many uninsured people. Still, the number of women using BCCCP services is far less than the number of women who are eligible as shown in the Table 3.1.

Over the past several years, as few as 3.4 percent and no more than 22.3 percent of eligible women in Wayne, Oakland and Macomb Counties were enrolled in the BCCCP. Again, eligible women likely are part of the Komen Detroit RFTC target populations. The BCCCP has clearly defined limitations to funding-- enrollment is capped, diagnostic services are not fully covered and treatment for breast cancer is not available to women who are Medicaid-ineligible. These data demonstrate that limited program capacity-- as in Macomb County, where the reported number of breast cancer screenings is lowest (48.2 percent)—can make a critical difference in the continuum of care. Women who are part of the target populations in the Komen Detroit RFTC service area without other access to appropriate and timely health care often go without screening, especially if there are no other health care facilities or programs offering free or low-cost breast health services in the area.

Based on the health systems data, the Komen Detroit RFTC service area is strong in breast health services that span the Breast Cancer Continuum of Care, but there are still major gaps when it comes to access.

Table 3.1. Michigan Breast and Cervical Cancer Control Program (BCCCP) caseload 2008-2012

County	Year	Michigan BCCCP Caseload	Uninsured**		Insured		Demographic Group	Est. % of uninsured women****
			Number	%	Number	%	Number ***	
Macomb	2012	584	12,721	25.9	36,429	74.1	49,150	4.6%
	2011	459	13,718	28.5	34,348	71.5	48,066	3.4%
	2010	476	12,771	26.8	34,870	73.2	47,641	3.7%
	2009	510	11,536	37.5	30,350	72.5	41,855	4.4%
	2008	450	8,763	24.2	27,379	75.8	36,142	5.1%
Oakland	2012	1,575	16,600	29.0	40,625	71.0	57,226	9.5%
	2011	1,295	16,751	29.8	39,548	70.2	56,299	7.7%
	2010	1,387	14,958	27.3	39,866	72.7	54,824	9.3%
	2009	1,496	12,425	26.7	34,118	73.3	46,544	12.0%
	2008	1,208	11,526	25.5	33,743	74.5	45,269	10.5%
Wayne	2012	8,392	37,722	26.4	105,274	73.6	142,996	22.3%
	2011	7,505	37,260	26.0	105,913	74.0	143,173	20.1%
	2010	7,699	36,075	25.9	103,361	74.1	139,436	21.3%
	2009	7,956	37,206	24.4	115,342	75.6	152,549	21.4%
	2008	6,771	30,782	21.5	112,964	78.5	143,837	22.0%

** Estimated number of people who are known eligible for the BCCCP
***Estimated number of women for the year, age group, poverty level, and county listed
****Estimated percent of uninsured women <=250% poverty screened by county
Source: Michigan Department of Community Health

The Komen Detroit RFTC has outstanding community partnerships focused on meeting breast health needs in target populations. Partnership activities seek to help increase the proportion of breast cancer diagnoses at earlier stages, promote timely and complete breast cancer screening, follow up and treatment, and reduce barriers to entering and remaining in the CoC. The Komen Detroit RFTC partners with the following organizations:

Arab Community Center for Economic & Social Services (ACCESS)
The Komen Detroit RFTC has partnered with ACCESS for over 10 years to address the needs of the Arab-American community in southeast Michigan. ACCESS is located in Dearborn, Michigan, which is part of a HRSA-designated MUA, one of the Komen Detroit RFTC target populations. Although the Arab-American community of southeastern Michigan has the largest proportion of Arabs outside of the Middle East, the community lacks federal recognition as a ethnic minority population. Therefore, despite the fact that the local community is beset with many of the same barriers as other low income minority communities, no federal funding is available to address the gaps in Arab-American health status and health care access. Private charitable funding and limited state grants have served a vital role in filling the unmet needs of this population. This community also faces barriers due to the high number of immigrants without US citizenship, thus ineligible for some health programs. It is particularly difficult to measure the cancer burden in this community because people of Arab ancestry are most often listed as Caucasian in both census data and medical research. ACCESS has made important strides in raising breast cancer awareness and increasing access to screening and education in Arab-American women.

ACCESS primarily serves members of the Arab American community as well as others in need of their services. ACCESS houses a Community Health & Research Center, a fully integrated community health center that provides public health, research and medical services. "The Breast Cancer Outreach Project," a Komen Detroit RFTC-funded program, provides breast cancer education, outreach and screening services for low-income Arab American women. This program helps eliminate social stigmas associated with breast cancer in this community through its outstanding education and outreach methods. Through this program, women receive one-on-one breast health education through in-home visits and are navigated to screening through the BCCCP. ACCESS works with its media partners serving the Arab-American community to include bi-lingual Susan G. Komen breast health messages on television, radio, print, and social media outlets. The Komen Detroit RFTC has also assisted ACCESS in planning the International Conference on Health Issues in Arab Communities and the ACCESS Breast Cancer Breakfast to spread awareness and reduce cancer-related stigma in the Arab-American community.

Barbara Ann Karmanos Cancer Institute
Since 1992, the Barbara Ann Karmanos Cancer Institute has been the Local Presenting Sponsor of the Komen Detroit RFTC. Located in mid-town Detroit, Michigan, the Barbara Ann Karmanos Cancer Institute, a subsidiary of McLaren Health Care, is one of 45 National Cancer Institute-designated comprehensive cancer centers in the United States. Karmanos is among the nation's best cancer centers. Through the commitment of 1,000 staff, including nearly 300 physicians and researchers on faculty at the Wayne State University School of Medicine, and supported by thousands of volunteers and

financial donors, Karmanos strives to prevent, detect and eradicate all forms of cancer. Its long-term partnership with the WSU School of Medicine enhances the collaboration of critical research and academics related to cancer care.

Located in a HRSA-designated MUA, which is part of the Komen Detroit RFTC selected target populations, approximately 60.0 percent of Karmanos patients are un- or underinsured. Consequently, the Institute makes a substantial annual commitment to uncompensated care of those persons who are ineligible for funding through current service systems.

For the past 20 years the Komen Detroit RFTC has partnered with Karmanos to work toward the common mission of eradicating cancer. Karmanos Cancer Institute's Alexander J. Walt Breast Center administers the "Helping Hands" program, funded for several years by the Komen Detroit RFTC, to reduce barriers of socio-economics and access by providing breast care to at-risk populations in metropolitan Detroit. The program covers diagnostic and limited breast cancer treatment for women and men who are uninsured or underinsured and are not served by other programs due to eligibility requirements (for example, a women under 40 who would otherwise qualify for BCCCP or a male underinsured patient). Additionally, Komen Detroit RFTC funds assist with meeting service gaps for patients currently enrolled in the BCCCP. Karmanos staff evaluates all requests for financial assistance, provides Komen educational materials, assists with system navigation, helps with transportation and outpatient prescription needs and encourages follow-up service. Additionally, Karmanos strives to work within established community health care networks to provide continuity of care for all patients who need breast care services.

Because Karmanos is home to several talented doctors and research scientists, the Komen Detroit RFTC regularly engages researchers and cancer clinicians to provide the community with up-to-date information about progress made toward finding the cures for breast cancer. The Komen Detroit RFTC engages researchers several times a year for donor recognition events including the September Celebration where a panel of doctors and researchers respond to questions posed by the audience and the Promise Club where top donors can have dinner with breast cancer researchers. Further, the community education and government relations department works collaboratively with the Komen Detroit RFTC mission staff on initiatives throughout the year.

McLaren Oakland Foundation

McLaren Oakland Hospital is a community hospital located in the heart of Pontiac, Michigan, Oakland County's sole HRSA-designated MUA, and one of the Komen Detroit RFTC target populations. The Komen Detroit RFTC has partnered with the McLaren Oakland Foundation whose mission is to ensure access to quality health care, regardless of race, sex, age or financial status. The foundation provides millions of dollars to cover the costs of care each year to individuals without the ability to pay.

Since 2009, the Komen Detroit RFTC has helped fund McLaren Oakland Foundation's Sister& Sister Free Mammogram Program for uninsured, at-risk or low-income women in Oakland County. The program targets the Black/African-American and Hispanic/Latina communities through community-based health and education programs with the purpose

of increasing mammography screening and breast cancer survival rates in these two populations. Modeled after the Witness Project, survivors teach other women about the importance of early detection, and train Health Outreach Leaders to carry these messages to more women.

Michigan Cancer Consortium (MCC)
Komen Detroit RFTC staff members, along with other Michigan Komen Affiliates, are active members of this state-wide consortium of 113 organizations dedicated to reducing the cancer burden in Michigan. The MCC provides a forum for collaboration among its members to improve cancer outcomes for Michigan residents by committing to the MCC Comprehensive Cancer Control Plan for Michigan. As MCC members and partners implement strategies from this plan, it produces a synergy that has an impact far greater than that which might have been accomplished by these agencies, organizations and individuals working independently of one another. Member organizations include hospitals, primary care clinics, physician offices, professional and trade organizations, community-based organizations, state and local agencies, and many other organizations and agencies that commit to take actions to reduce the state cancer burden.

Southeast Michigan Partners against Cancer (SEMPAC)
In 2010, Komen Detroit RFTC joined the Southeast Michigan Partners against Cancer (SEMPAC). SEMPAC was created by three partnering organizations (Barbara Ann Karmanos Cancer Institute, Josephine Ford Cancer Center at Henry Ford Hospital, and Wayne State University School of Medicine). SEMPAC is dedicated to fighting cancer and reducing cancer disparities in urban communities. The partnership was made possible by a four million dollar-plus, five-year grant from the National Cancer Institute, and focuses cancer health disparities among older, underserved Blacks/African-Americans in urban areas.

Wayne County Breast & Cervical Cancer Control Program (BCCCP)
The Wayne County BCCCP is administered through the Karmanos Cancer Institute and is part of Michigan's National Breast and Cervical Cancer Early Detection Program (NBCCEDP). The program's mission is to assure that uninsured women have full access to breast and cervical cancer screening, follow-up and treatment. Eligible women receive an annual free clinical breast exam and mammogram along with treatment assistance when needed. The Michigan BCCCP caps funding for enrollees and does not fully cover diagnostic care. The Komen Detroit RFTC has awarded grant funds to extend the reach of this program, allowing more eligible women to enroll. Grant funds are also used to enhance the program by paying for treatment services for women ineligible to enroll in Medicaid. Additional services, including genetic counseling, genetic testing and patient navigation are also provided through Komen Detroit RFTC grant funds. The Wayne County BCCCP actively recruits women throughout Wayne County Komen Detroit RFTC target populations to enroll in this important program and is an outstanding partner.

Currently, the Komen Detroit RFTC has strong partnerships with several outstanding organizations. However, there are opportunities to grow and develop new partnerships and collaborations, especially in the selected target populations. There are several FQHCs across the Komen Detroit RFTC service area that may be open to developing a relationship to address

the needs in their respective communities. Because FQHCs are crucial community-based, health care safety net providers, they are required to have a board of directors that include patients and people from the communities they serve. Developing relationships with board members as well as staff at these facilities to create breast cancer related initiatives may be a good strategy to help improve outcomes in target populations.

Public Policy Overview

National Breast and Cervical Cancer Early Detection Program (NBCCEDP)

The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) is a partnership between the US Centers for Disease Control and Prevention (CDC) and state departments of health, which helps provide life-saving breast cancer screening, diagnostics, education, outreach and patient navigation for low income, uninsured and underinsured women who do not qualify for Medicaid. This program funds all 50 states, Washington, D.C., 11 tribal organizations and five US territories.

The Breast and Cervical Cancer Control Program (BCCCP) is Michigan's version of the NBCCEDP. The state program contracts with Local Coordinating Agencies (LCAs) throughout Michigan whose staff helps to enroll patients into the program and coordinate their care with contracted providers. Many health care organizations act as LCAs. For example, . in Macomb County the MyCareClinic, an FQHC serves as the LCA, and in Wayne County, the Barbara Ann Karmanos Cancer Institute serves as the LCA.

Funding for women aged 50 to 64 comes from the CDC, while the remaining funds for the program (covering women ages 40 to 49) come from the State of Michigan. Annually, the Michigan state legislature appropriates funds to the Michigan Department of Community Health (MDCH) to cover eligible women ages 40 to 49. The appropriation varies year to year, depending on the state's budget priorities. The MDCH determines the amount of money that is designated to the BCCCP, and correspondingly assigns a specific caseload (number of women to be served) allocation for each LCA. As mentioned in the Health Systems Analysis Section, program capacity for the BCCCP is limited by state and federal funding and is routinely unable to serve all eligible women. Wayne County's program has been able to request permission for additional caseload from the MDCH and cover the cost of additional cases with funding from Komen Detroit RFTC community grants and donations from other community organizations in order to extend services to more eligible women in need of breast cancer screening. Additionally, State Senator Glenn Anderson and Representative Amanda Price, working with the Michigan Komen organizations, authored legislation for a specialty pink ribbon breast cancer awareness license plate with proceeds designated to the BCCCP. The legislation was signed into law by Governor Rick Snyder in January, 2014, and the license plate is now available to Michigan residents.

Women who are diagnosed with cancer through the BCCCP are automatically enrolled into Medicaid to access cancer treatment. While the BCCCP has a strong working relationship with Michigan's Medicaid program, not all women who have been diagnosed with cancer through the program are enrolled into Medicaid. For example, women who are not US citizens are able to enroll into the BCCCP if they can prove Michigan residency, but, due to lack of citizenship, they are not Medicaid-eligible. The same rule applies to women who have had US citizenship for

less than five years. Also, women who have Medicare Part A, but have not purchased Medicare Part B, are eligible to receive services from the BCCCP, but ineligible to enroll in Medicaid.

Currently, the Komen Detroit RFTC has a great relationship with the Wayne County BCCCP as a grantee. Representatives from the BCCCP regularly serve on the Komen Detroit RFTC Planning Committee and have accompanied staff members on visits with elected officials to explain the importance of the program. Additionally, the Komen Detroit RFTC has a good relationship with the BCCCP Program Director for the State of Michigan and fully expects to continue both the local and state level relationships with this program. Over the next four years, the Komen Detroit RFTC will continue its partnership with the BCCCP in working with state and federal elected officials to preserve funding for this important program.

State Comprehensive Cancer Control Coalition

The Michigan Cancer Consortium (MCC) is a statewide, broad-based partnership that strives to include all interested public and private organizations in a forum for collaboration, communication, coordination, and the sharing of resources. MCC's mission is to reduce the burden of cancer among the citizens of Michigan by achieving the consortium's evidence-based and results-oriented cancer prevention and control priorities. The MCC is comprised of a dedicated group of 113 public, private and voluntary organizations committed to reducing the human and economic impact of cancer in Michigan.

Through membership and involvement with the MCC, Komen Detroit RFTC staff contributed to the formation and implementation of the MCC Initiative 2009 Strategic Plan, coordinated and communicated the State's Breast Cancer goals and action plan to Komen Detroit RFTC grantees and provided an annual report on progress and accomplishments with regards to MCC Initiatives. Komen Detroit RFTC staff members serve on the MCC Membership Committee and the Cancer Disparities Workgroup.

Michigan's Comprehensive Cancer Control Plan covers years 2009 through 2015, and was revised in September 2013. The plan represents the collective wisdom of a wide range of individuals and organizations in Michigan: nationally recognized cancer experts, state health care leaders, health care providers, insurers and representatives of community-based organizations, all working together to achieve common goals. All goals include objectives and strategies with supporting data and information on health disparities. Michigan's Comprehensive Cancer Control Plan for breast cancer consists of two objectives to be achieved during the 2009-2015 time-frame:

***Objective 1*: By 2011, 90.0 percent of women will report being offered age-appropriate breast cancer risk information, education, and suitable services.**

Strategies to meet this objective include developing and implementing breast cancer risk assessment programs through strategic partnerships, and collaboration with the MCC Genomics Workgroup members to educate providers about guidelines for breast cancer risk assessment and genetic counseling referrals. Progress data show in Table 3.2 that Michigan is close in achieving these objectives.

Table 3.2: Objective 1: Michigan Cancer Consortium Breast Cancer Control Plan Progress

Progress Markers					
Available Data Markers	**Data Source**	**Baseline (2006)**	**Interim Update (2008)**	**Interim Update (2009)**	**Target (2011)**
Percent of all adult women who ever discussed family history of **breast or ovarian** cancer with a health care provider	Michigan Behavioral Risk Factor Surveillance Survey (MIBRFSS)	Not available	Not available	82.7% --83.8% White, non-Hispanic --78.6% Black/ African-Americans, non-Hispanic --90.2% Other, non-Hispanic	90.0%
Percent of all women aged 40 years or older who ever discussed family history of **breast** cancer with a health care provider.	Special Cancer Behavioral Risk Factor Survey (SCBRFS)	87.9%	89.3% --80.6% Hispanics/Latinos --72.8% Asian Americans --70.1% Arab Americans	Not available	90.0%
Percent of all women aged 40 years or older reporting family history or hereditary would increase a woman's risk for breast cancer.	SCBRFS	Not available	46.3%	Not available	50.0%

Source: Comprehensive Cancer Control Plan for Michigan, 2009-2015 (September 2013 revision)

Objective 2: ***By 2015, 80.0 percent of women aged 40 years and older will report having received both a clinical breast exam (CBE) and a mammogram within the past year.***

Three strategies to help achieve this objective include:

1. Working in partnership with health providers, health systems, insurance providers, community organizations and businesses to provide information on the importance of breast health and age-appropriate cancer screening.
2. Providing breast cancer screening information using evidence-based interventions (one-on-one education, Websites, fact sheets, pamphlets, small media, etc.) focusing the message for never/rarely screened women in counties with high breast cancer incidence/death rates and
3. Promoting and supporting organizational partnerships to reach minority women and populations experiencing disparities in health care with breast health education, mammography screening and navigation to services and care. Unfortunately, the last

reported data show in Table 3.3 just 53.0 percent of Michigan women receiving a CBE and annual mammogram in the past year.

Table 3.3. Objective 2: Michigan Cancer Consortium Breast Cancer Control Plan progress

Progress Markers				
Activity	**Data Source**	**Baseline (2006)**	**Interim Update (2010)**	**Target (2011)**
Women aged 40 years and older who had both a clinical breast exam and mammogram in the past year	Michigan BRFSS	57.2%	53.0%	80.0%
Women who had an appropriately timed clinical breast exam	Michigan BRFSS	75.4%	69.9%	80.0%
Women aged 40 years and older who had a mammogram in the past year	Michigan BRFSS	64.3%	61.4%	80.0%

Source: Comprehensive Cancer Control Plan for Michigan, 2009-2015 (September 2013 revision)

The Komen Detroit RFTC plans to continue its relationship with the MCC over the next four years in an effort to help achieve the goals and objectives in the state's Comprehensive Cancer Control plan through its continued participation on the MCC.

Affordable Care Act

The Patient Protection and Affordable Care Act (ACA), signed into law in March 2010, is intended to help remove barriers to health care for Americans. The ACA eliminated annual and lifetime limits on care, made it illegal to discriminate against people with pre-existing conditions and made it illegal for insurers to charge women more than men for the same coverage. The law requires all Americans to have some form of health insurance coverage or face a tax penalty.

Because all Americans are required to have health insurance and many people may not be able to afford coverage, tax credits, subsidies and new restrictions on collecting profit by insurance companies were incorporated into the law. States were given the option to expand their current Medicaid programs to accommodate more low-income individuals and families. Michigan decided to expand its Medicaid program, but chose to delay program implementation until April 1, 2014 rather than begin implementation on January 1, 2014 as the ACA originally required. The Healthy Michigan Plan is an expansion and modification of Medicaid that provides comprehensive health care coverage for individuals between ages 19 and 64 who were not previously eligible for Medicaid or Medicare. Enrollees must be US citizens or lawfully admitted into the US, and have incomes less than 133 percent of the FPL. Most enrollees are required to select and enroll in a managed care plan of their choice. Healthy Michigan Plan enrollees must pay copays for prescriptions and office visits, but not for emergency or preventive services. Copays may be waived for services that allow enrollees to better manage chronic diseases or

prevent disease complications. Healthy Michigan Plan enrollees with incomes between 100 and 133 percent of the FPL will be required to make an income-based contribution to a "MI Health Account" up to 2.0 percent of their annual family income. Such contributions to this account along with copays can be reduced if "healthy behaviors" are attained. This program is meant to expand benefits to 322,000 low-income Michigan residents without health insurance.

Prior to implementation of the Healthy Michigan Plan, an estimated 1.1 million people were uninsured. According to a report by the MDCH entitled *The Uninsured in Michigan-A Profile*, Michigan has a lower percentage of uninsured residents than the majority of other states in the country. (The Uninsured in Michigan-A Profile, Michigan Department of Community Health, December 2013). Michigan is ranked 16th among states in having a low percentage of uninsured non-elderly residents at 14.6 percent. Additionally, a higher percentage of Michigan residents have employer-based health insurance when compared to other states, ranking 18th in the country at 62.8 percent. However, across Michigan, Blacks/African-Americans (17.2 percent) and Hispanics/Latinos (19.9 percent) are more likely than Whites (13.7 percent) to be uninsured. Rates of uninsured individuals decrease as the education level increases. In Michigan, the percentage of uninsured individuals is higher in the families without a high school diploma (28.9 percent) as compared to those who have family members with a college degree or higher level of education (7.0 percent).

The Healthy Michigan Plan is intended to make it easier for more low-income residents to access the Breast Cancer Continuum of Care.

For Michigan's low-income and uninsured women, the BCCCP is a resource for accessing timely breast cancer screening. However, many of the women previously enrolled in the BCCCP are now eligible for the Healthy Michigan Plan and others are eligible for subsidies to purchase insurance in the health insurance marketplace with fewer people qualifying for BCCCP services. Women who have insurance plans that don't cover necessary procedures beyond annual breast cancer screening (e.g., diagnostic and treatment procedures) or that have high out-of-pocket costs (e.g. deductibles, co-insurance, co-pays, etc.) can be enrolled with proof that their health plan does not cover these services. Additionally, uninsured women with incomes between 138 and 250 percent of the FPL are eligible to enroll, but encouraged to seek insurance coverage via the health care marketplace to be in compliance with the ACA. The BCCCP has transitioned to focus more on the needs for underinsured women and to fill the gaps in the Breast Cancer Continuum of Care.

Now that ACA implementation is underway, providers must consider accommodating the influx of new patients. For the newly insured, finding a provider is crucial to entering the Breast Cancer Continuum of Care. It is vital for the health care system to be able to effectively handle the increase in patient volume. According to the Annual America's Health Rankings Report for 2013, Michigan ranked 21st for the number of primary care physicians per 100,000 population at approximately 120.0 per 100,000. Primary care physicians include Obstetrics & Gynecology doctors who provide clinical breast exams as part of routine care for patients. Also, according to the *2012 MDCH Survey of Michigan Physicians*, the majority of physicians in Michigan reported that their practice is nearly full and able to accept only a few new patients (46.0 percent) or far from full and able to accept many new patients (42.0 percent). Just 12.0 percent of Michigan licensed and active physicians reported that their practice is full and unable to accept new patients. Another important factor is whether there are enough providers accepting Medicaid for

newly enrolled individuals. Overall, data from the same survey show approximately 86.0 percent of fully licensed and active physicians in Michigan reported that they currently provide care to Medicaid patients. Those physicians who provide care to new Medicaid patients account for 76.0 percent of those surveyed, which is higher than any other year since 2007. Among Michigan counties, Wayne, Oakland and Macomb Counties are expected to have the highest number of new Medicaid recipients with 47,186, 17,843 and 15,034 newly enrolled patients respectively. According to a study done by the Center for Healthcare Research & Transformation (*Primary Care Capacity and Health Reform: Is Michigan Ready? CHRT Policy Brief, January 2013*), 86.0 percent of primary care physicians in Wayne County expect to have capacity for new Medicaid recipients. In Oakland and Macomb Counties those numbers are 80.0 and 82.0 percent respectively. Compared to the United States (120.9), Michigan (119.4) has a slightly lower volume of primary care physicians. Primary care physicians per 100,000 people in Wayne, Oakland and Macomb Counties are 65.0, 146.5 and 57.2 respectively. Oakland County is well above the national and state rate for primary care doctors. However, Macomb and Wayne Counties fall short of both Michigan and the US rates in this category, which may account for some of the lower rates for breast cancer screening in these areas as shown in Table 3.4.

Table 3.4. Primary care providers in Michigan and Komen Detroit RFTC counties

Geographic Area	Total Number of Primary Care Physicians	Primary Care Physicians per 100,000 population	Population to Primary Care Physician Ratio
Michigan	7,789	119.4	1,268:1
Wayne County	1,171	65.0	1,539:1
Oakland County	1,773	146.5	683:1
Macomb County	482	57.2	1,747:1

Source of data for Michigan: American Health Rankings 2005-2013
Source of data for Detroit RFTC counties: County Health Rankings and Roadmaps 2011

In addition to some of the selected Komen Detroit RFTC target populations residing in designated as Medically Underserved Areas, many are also designated as Health Professional Shortage Areas (HPSAs). HPSAs are defined as areas designated by HRSA as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), demographic (low income population), or institutional (comprehensive health center, federally qualified health center or public health facility). According to HRSA, each of the Federally Qualified Health Centers and Look Alike-Clinics for Wayne, Oakland and Macomb Counties are considered HPSAs. Additionally, most of the HPSA geographic areas include those who live in poverty.

The ability to accommodate newly insured patients is particularly critical in the selected Komen Detroit RFTC target populations. Lack of primary care access can mean that patients do not have a “medical home” where they seek regular health care. For those with medical homes, patient care is coordinated across the health care system, working to address all preventive, acute, and chronic health care needs. In the 2011 Komen Detroit RFTC Community Profile, focus group participants emphasized the need for more coordination of breast health services. Without primary care access, navigating the CoC is difficult for patients. This can result in late-stage diagnosis and, when a diagnosis is made, a delay in treatment and, ultimately, increased deaths. Additionally, patients dealing with co-morbidities, poverty and other negative outcomes

due to social determinants of health often prioritize other needs ahead of breast cancer screening. Many people living in the Komen Detroit RFTC target populations may seek their care at a community health center (CHC). Such facilities must not only help people access the CoC, but remain in the continuum at all times. ACA lawmakers considered the importance of CHCs in providing care to low-income and medically underserved populations and invested $11 billion over five years to expand the health center program. However, this plan has been met with funding challenges. First, the regular federal appropriations for health centers were cut in 2011 by $600 million, causing health centers to divert an equal amount from the Health Center Trust Fund to avoid reducing patient capacity. Second, the budget sequester caused a 51.9 percent cut in their base appropriations in the second half of FY 2013. This translates to 900,000 fewer patients served at CHCs. Also, many providers do not accept Medicaid, particularly specialists. The federal government will pay 100 percent of the cost of boosting low Medicaid reimbursements for primary care providers to the same level as Medicare physician fees for 2013 and 2014, but such provisions do not include specialists. (*Community Health Centers in an Era of Health Reform: An Overview and Key Challenges to Health Center Growth, Issue Paper, Kaiser Family Foundation, March 2013*) This could prove challenging for providers working in these settings and for those who are seeking their care for breast health services.

The Komen Detroit RFTC has served Wayne, Oakland and Macomb Counties since 1992, navigating patients and families by providing information about local and national breast cancer resources. Moving forward, the Komen Detroit RFTC will continue to address the changing needs of this service area. Many people will gain health insurance coverage because of the ACA, and the Komen Detroit RFTC staff and key volunteers will continuously examine priorities to ensure Komen funds make greatest possible impact in the fight against breast cancer.

Komen Detroit Public Policy Activities

The Komen Detroit RFTC regularly works together with the Komen Affiliates serving Michigan to address Komen's Advocacy Priorities:

- Support for expanded federal funding for breast cancer research at the National Institutes of Health (NIH) and the Department of Defense (DOD);
- Support state and federal funding for the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP);
- Advocate for policies to improve insurance coverage of breast cancer treatments, including those that would require oral parity, preclude specialty tiesrs and prevent step therapy protocols; and
- Evaluate state and federal policites to reduce or eliminate out-of-pocket costs for medically necessary diagnostic mammography

The Komen Detroit RFTC has a Public Policy/Advocacy (PPA) sub-committee as part of its larger Komen Detroit RFTC Planning Committee. The PPA is guided by staff and engages volunteers to focus on Komen's priorities by planning and executing activities related to advocacy efforts. In past years, PPA members have attended federal Lobby Days, driven support for action alerts and advanced Komen's advocacy priorities in a variety of ways. They have attended local coffee hours and town halls presented by state legislators on the Michigan Legislature Appropriations Committees to advocate for BCCCP funding preservation. PPA members have traveled to Lansing, Michigan's state capitol, to attend Appropriations Committee hearings and obtain information about the upcoming fiscal year budget and its effect on the BCCCP.

The PPA has met with federal officials to discuss preserving federal funding for the NBCCEDP, breast cancer research funding and the importance of oral cancer drug parity legislation. Further, during the 2014 and 2015 Komen Detroit Race for the Cure events the sub-committee carried on its tradition of gathering petition signatures. More than 2,000 petition signatures were collected to support NBCCEDP funding, and the signatures were shared with each of the Komen Detroit RFTC service area federal elected officials. Through collaboration with the Michigan Secretary of State's office, a voter registration drive was held at the Race. Michigan Sen. Glenn Anderson, who authored legislation for the "pink license plate" benefitting the BCCCP visited with Race participants to promote plate sales.

As has been the Komen Detroit RFTC tradition for several years, key federal, state and city officials served as Honorary Co-Chairs for the Race, most of who were present to address the crowd and speak with media to communicate their support of Komen's work. 2015 Honorary Co-Chairs included , Sen. Debbie Stabenow, , Sen. Gary Peters and his wife Colleen Peters , Rep. John Conyers ,Rep. Debbie Dingell and her husband John Dingell, Rep. Brenda Lawrence and her husband Mcarthur Lawrence, Gov. Rick Snyder and his wife Sue Snyder and Detroit Mayor Mike Duggan and his wife Lori Maher.

The Komen Detroit RFTC participates with other patient advocacy groups on the Michigan Oral Oncology Parity Coalition, whose purpose is to help pass legislation in Michigan requiring insurance companies to cover orally-administered cancer drugs at the same level as intravenously-administered cancer drugs. Currently, the Coalition is seeking a new bill champion and sponsor to re-introduce the legislation as the original legislation has stalled in the Michigan House Health Policy Committee during the previous legislative term, and the original bill sponsor was term-limited.

The Komen Detroit RFTC plans to continue working together with the Michigan Komen Affiliates to engage elected officials on Komen priorities.

Health Systems and Public Policy Analysis Findings

Women entering and remaining in the CoC can mean the difference between an early-stage breast cancer diagnosis where the likelihood of survival is 99.0 percent, and a late-stage diagnosis where the likelihood of survival severely drops. The Komen Detroit RFTC service area is home to many outstanding health care facilities, many located in close proximity to selected target populations, but challenged by poor public transportation and pockets of profound poverty. The Michigan BCCCP is a strong safety net program that helps women enter and remain in the CoC. However, women in the Komen Detroit RFTC selected target populations still experience high levels of breast cancer late-stage incidence and deaths more likely due to poor access rather than availability of breast health services. In previous Komen Detroit RFTC Community Profile qualitative data, the need for assistance in navigating through various components of the CoC was demonstrated. In the Qualitative Data Section of this profile, the Komen Detroit RFTC will explore whether or not this is still the case.

The Komen Detroit RFTC works to fill service gaps in the CoC by funding grants to organizations that provide life-saving access to breast cancer education, screening and

treatment. Important partnerships with the Michigan Cancer Consortium and Southeast Michigan Partners Against Cancer (SEMPAC) help to develop effective strategies to meet community breast cancer needs. However, there are opportunities to develop relationships with community health centers and other organizations to assess and address needs for the target populations.

Current and potential partnerships are critical given the drastically changing health care landscape. Because the ACA requires all citizens to have health insurance coverage, the Komen Detroit RFTC plans to examine the remaining gaps in the CoC to focus operational efforts. The Komen Detroit RFTC will explore whether or not the facilities serving the target populations are ready to accommodate the potential influx of new patients in the Qualitative Data Section.

The Komen Detroit RFTC will continue its work to address Susan G. Komen Advocacy Priorities.

Qualitative Data: Ensuring Community Input

Qualitative Data Sources and Methodology Overview

The Komen Detroit RFTC is fortunate to have the Barbara Ann Karmanos Cancer Institute as a partner. Karmanos is also affiliated with the Wayne State University (WSU) School of Medicine. Because the Komen Detroit RFTC has contractual relationships with both Karmanos and WSU, the Community Profile process has been deemed human subjects research requiring approval by the WSU Institutional Review Board (IRB). All study methods and tools were approved by the IRB prior to commencing data collection.

Based upon data collected in both the Quantitative Data Analysis and Health Systems Analysis and Public Policy Sections, the Komen Detroit RFTC service area has high levels of insurance coverage, yet low levels of breast cancer screening. Breast cancer screening for women in the Komen Detroit RFTC service area is slightly more than 50 percent (50.8 percent) and 48.6, 56.1 and 48.2 percent respectively for Wayne, Oakland and Macomb Counties. Approximately half of women with health insurance (52.5 percent) received recommended breast health screening while just under one-third (31.9 percent) of women without health insurance reported having annual screenings within the Komen Detroit RFTC service area. Women in the Komen Detroit RFTC target populations (i.e. Those living in poverty and Medically Underserved Areas) are more likely to be uninsured and experience difficulty accessing breast health services despite the vast amount of facilities offering comprehensive services within the geographical area. Insured women in these target populations may not be utilizing these services for other critical reasons, which may account for the high levels of late-stage breast cancer incidence and death. Based upon data collected in previous sections of this report there may be higher rates of late-stage incidence and death from breast cancer for those living in Medically Underserved Areas (MUAs) and those living in poverty. All qualitative data collection efforts sought to identify the health care access and utilization factors that contribute to these data.

Key Informant Interviews were done with staff at Community Health Centers (CHC), hospitals and other health care-related facilities serving the target populations to determine whether or not the women residing in these communities are accessing and remaining in the Breast Cancer Continuum of Care (CoC) along with the possible reasons why or why not. With approximately half of women with health insurance in Michigan reportedly receiving their annual screenings for breast cancer, interviews were done with health plan administrators serving women in the Komen Detroit RFTC target populations to determine whether or not those with health insurance were accessing and remaining in the CoC. All prospective key informants were contacted over the telephone by Komen Detroit RFTC staff to request an interview with the appropriate personnel. Once prospective key informants confirmed their participation, per WSU IRB regulations, they were provided a research information sheet outlining the purpose of the study, risks, benefits and their rights as a study participant. Prior to beginning the interview each participant was required to give oral consent. Interviews were conducted either in-person or over the telephone depending on the participant's preference. Responses to questions were recorded on question sheets approved by the WSU IRB and then coded to identify themes and overall ideas that may provide insight into the poorer breast cancer survival and diagnostic outcomes in the target populations.

In order to help determine possible health care access and utilization factors affecting breast cancer outcomes, it was also important to hear from target population members directly. For this reason, focus groups were chosen as the second qualitative data collection method. Those participating in focus groups each met the following criteria:

- Participants were at least 18 years old
- And were at least 20 years old and have never had a clinical breast exam
- Or were at least 40 years old and have not had a mammogram or clinical breast exam within the past year
- Or were at least 40 years old and have never had a mammogram
- Or recently obtained health insurance for the first time
- Or have health insurance that does not cover breast health services beyond breast cancer screening
- Or were without health insurance

Flyers advertising focus groups were distributed at Community Health Centers, hospitals, businesses and organizations serving each of the target populations. Flyers were also shared with Komen Detroit RFTC community partners, including grantees to post on their websites and in their electronic newsletters. Incentives for participation were provided and prospective participants contacted the Komen Detroit RFTC office to sign up for a session. Each prospective participant was screened to ensure eligibility criteria were met over the telephone. Prior to focus group participation, all participants signed a consent form. Each question was posed in a nominal process by a moderator, while a recorder wrote responses on a large poster. This nominal group process allowed each participant to share ideas. Once all ideas were shared and recorded, all participants chose the three ideas from the list they thought were most important. Responses were then coded by Komen Detroit RFTC staff to identify recurring themes across all groups. Focus group questions sought to determine experiences of the target populations when navigating through the breast cancer CoC. Questions especially sought to determine barriers to accessing and remaining in the CoC and possible reasons why women in the target populations do not receive timely breast cancer screening and follow-up.

Key informant interviews and focus groups were chosen as the data collection methods due to the high likelihood that valuable information would be obtained in an effort to help explain previously collected quantitative and health systems analysis data for the Komen Detroit RFTC service area, and to help determine possible remedies for negative outcomes. By utilizing these two data collection methods, important data were gathered directly from the people residing in the Komen Detroit RFTC target populations and the organizations that serve them, thus making it much easier to determine how best to address the breast health needs in the Komen Detroit RFTC service area.

In order to collect data on health care access in the target populations, key informant interviews were done with staff at community health centers, hospitals and other health care facilities serving the target populations who had first-hand knowledge of the breast health services offered by their organizations and the clientele served by their organizations. This population is best equipped to respond to interview questions due to their regular access to women in the target populations. These individuals have direct knowledge and expertise on what breast health services and resources are available in these communities, how women are learning of and accessing these resources and services, the existing resource gaps, the barriers and

challenges that currently exist for women when accessing the available services, and possible solutions to such existing problems. Using a non-probability, purposive approach, the selection for key informants was non-random and based on the high likelihood that the individuals would have the information needed to answer key assessment questions, including possible reasons why high rates of late-stage incidence and death exist in the Komen Detroit RFTC target populations.

Similarly, in order to collect data concerning insured women's utilization of breast cancer screening services, key informant interviews were done with quality managers at health plans serving Wayne, Oakland and Macomb Counties, particularly the Komen Detroit RFTC target populations. Such administrators have knowledge of how many enrollees are getting recommended breast cancer screenings in a timely regimen, what the possible barriers that prevent them from entering and remaining in the CoC, what programs or resources they have in place to help eliminate such barriers, and what other possible solutions can be employed. Selection of key informants was purposive and based on the high likelihood that the individuals would have vital information that would shed light on possible reasons for the low utilization of breast cancer screening services in the Komen Detroit RFTC service area.

In order to find possible answers to why high breast cancer death rates exist and why there are such low rates of screening utilization it was also important to engage members of the target populations in focus groups. Specifically, women who had not received the recommended breast cancer screenings in the past year, women who have never had the recommended breast cancer screenings, women who are uninsured or underinsured or women who have health insurance for the first time were invited to participate. Hearing directly from people in the target populations was crucial in getting the possible answers sought. These participants could provide perceptions and personal experiences relevant to the current late-stage incidence and breast cancer death rates in the target populations. Focus group participants were recruited throughout the Komen Detroit RFTC service area based upon eligibility criteria. The process was non-random and based on the high likelihood that participants had information needed to answer key assessment questions.

Because the Komen Detroit RFTC is required to obtain approval from the WSU IRB for its Community Profile, all study personnel are required to complete training through the Collaborative Institutional Training Initiative (CITI) prior to beginning data collection. Such training consists of courses on the ethical treatment of human subjects in research studies. Additionally, the WSU IRB offered training sessions on proper informed consent procedures for study participants. All proper training procedures were implemented when recruiting study participants. All key informants were provided with research information sheets outlining study risks, benefits, qualifications, procedures, and verbal consent was provided prior to the interview. No identifiable information was attached to their responses. All responses were reported in aggregate. Any identifiable information was stored in a protected computer file in the Komen Detroit RFTC office with hard copies stored in a locked file cabinet accessible by study personnel only.

Focus group participants were screened over the telephone to ensure they met eligibility criteria prior to the focus group session. During the screening process, verbal consent was obtained due to the personal information requested. Once eligibility was determined, a research information sheet was shared via email or postal mail outlining study qualifications, risks,

benefits and procedures. Upon arriving at the focus group session, each participant provided written consent, and was allowed to begin participation in the group.

Qualitative Data Overview

Because the previously collected data show the Komen Detroit RFTC service area has high levels of insurance coverage despite low rates of breast cancer screening, it was necessary to speak with people providing breast health services to the target populations and those who reside in these communities to determine the factors surrounding these data. Key informant interviews and focus groups were chosen as the data collection methods due to the direct interaction with community members. By having the direct interaction with key informants and focus group participants there was an increased chance of getting quality data.

Key informant interviews were divided into two separate categories: interviews with community health center, hospital and health care facilities staff and interviews with health plan administrators. Interview questions were approved by the WSU IRB before the study commenced. Key informant interview questions were listed on a question sheet allowing for the interviewer to record notes. Because this is an exempt study and audio and video recording of interviews was not allowed; notes paraphrasing the key informants' responses were used to develop conclusions. No identifiable information was included in the notes or in the data findings. Once responses were recorded, they were coded based on theme categories. Based on the codes most frequently used to categorize the responses to interview questions, common findings were determined.

Focus group eligibility screening criteria and focus group questions were approved by the WSU IRB before the study commenced. Responses for focus groups were gathered in a nominal group process, in which questions were posed to the group and each participant was allowed to provide ideas in response to the question. Each idea was recorded on a large flip chart and participants were asked to choose the responses they felt were the most important by placing a sticker next to the response on the flip chart. The three answers with the highest number of stickers were regarded as the consensus for the group. Like the key informant interviews audio and video recording of focus groups was not allowed, and notes paraphrasing the responses from focus group participants were used to develop conclusions. No identifiable information was included in the notes or in the data findings. Once responses were recorded, they were coded based on theme categories. Based on the codes most frequently used to categorize the responses to interview questions, common findings were determined.

In both the Quantitative Data and Health Systems and Public Policy Analysis sections of the report, data showed that individuals living in poverty and in Medically Underserved Areas (MUAs) had difficulties accessing and remaining in the Breast Cancer Continuum of Care (CoC), which may be the reason for high rates of late-stage incidence and deaths from the disease in the target populations. Through key informant interviews with community health center staff and other health care facility personnel serving the Komen Detroit RFTC target populations, clues were discovered pertaining to the possible reasons why higher rates of late-stage incidence and deaths for breast cancer exist in these populations.

Based on the breast cancer screening data, and the insurance coverage data from the Quantitative Data section, it was important to explore the possible factors relating to the

reported low levels of timely screening. Through conducting key informant interviews with insurance plan administrators with knowledge of enrollees' utilization of breast health related services, especially breast cancer screening, possible factors relating to both late-stage incidence and deaths were discovered.

Lastly, it was necessary to hear directly from the target community residents regarding some of the reasons why they thought such rates for late-stage incidence and death exist. Focus groups were convened including members of the target populations to discuss barriers to timely and continued access to the CoC, their knowledge of available resources for breast cancer screening and treatment, and how these things can be improved.

While the data gathered through both key informant interviews and focus groups are valuable in providing possible reasons for the high rates of breast cancer late-stage incidence and death, such data collection methods are limited. Key informant interviews helped to yield data rich in details and allowed for relationship building with community organizations. Additionally, data were gathered from people who had first-hand knowledge of these topics. However, challenges were met in scheduling interviews with appropriate individuals, particularly if there was not an existing relationship established. A total of 27 key informant interviews were done with community health center and hospital personnel (i.e.11 in Wayne County, eight in Oakland County and eight in Macomb County) and eight total key informant interviews were done with health plans serving all three counties in the Komen Detroit RFTC service area. Thusly, it is difficult to generalize such data to the larger population because the number of interviews falls slightly short of the best practice recommendations for studies of this nature. However, the information gathered from the key informant interviews greatly sheds light on the information sought through this research process.

Similarly, focus groups allowed for engagement with individuals who possessed first-hand knowledge of each topic area and helps to capture rich and in-depth data. However, challenges with timing and recruiting participants arose and it may be difficult to generalize data to the large population. A total of six focus groups were held throughout the Komen Detroit RFTC service area (two in Wayne County, one in Oakland County and three in Macomb County) including a total of 36 individuals.

Wayne County

Health care facility key informant interviews

Upon interviewing key informants at health care facilities, including hospitals and community clinics, a few themes emerged that provided some insight into reasons for such high rates of breast cancer late-stage incidence and death in addition to possible explanations for low rates for breast cancer screening in Wayne County. Questions posed included:

- *Do women complete and remain in the Breast Cancer Continuum of Care in the community your organization serves? Why or why not?*

  Key informants in Wayne County shared that they work very hard to ensure their patients remains in the CoC once they receive services from their organization by providing education and regularly following up to remind patients to get screened. If barriers are identified many organizations offer services to help clients navigate through the CoC including transportation to and from appointments along with connection to additional support services if needed. Many of the key informants

feel that once clients connect to their organizations they remain in the CoC. However, most feel they are only helping a fraction of the women in need of services in Wayne County, and the community as a whole is not receiving the care they need. Many existing barriers prevent access to the CoC including lack of health insurance, low income, and being unaware of available resources and services. Fear is also a barrier, along with low personal awareness or education about breast cancer.

- *As a result of the Affordable Care Act (ACA), what changes have you seen in the way women access breast health services?*

  In spite of the Affordable Care Act, many women in Wayne County still remain uninsured according to key informants. Some reasons include a lack of understanding of how the law works. Key informants shared that many have had negative experiences in the past when applying for insurance, and were denied insurance due to a pre-existing condition or because of their income levels. Because of these past experiences many believe they will be denied if they were to apply now. Further, many do not understand that subsidies are available for those purchasing health insurance plans through the marketplace or that Michigan chose to expand its Medicaid program and that they may be eligible to enroll in the Healthy Michigan Plan. Additionally, immigrant populations in Wayne County may find it exceptionally difficult to get health insurance because they may lack US citizenship. The ACA prohibits non-US citizens from obtaining insurance through the marketplace and through state Medicaid expansion programs if they have been in the US for less than five years, which is a major barrier. Key informants also shared that many women in the Komen Detroit RFTC target populations work hourly-wage jobs where employers often cut hours and may not offer affordable insurance. Many feel that the available insurance plans are not affordable due to the out-of-pocket costs (i.e. premiums, high co-pays and deductibles).

- *Since implementation of the Affordable Care Act have you noticed any lingering health care gaps when it comes to patients seeking health care?*

  According to key informants in Wayne County the most consequential gaps in health care involve women still being underinsured. Some health insurance plans available through the insurance marketplace only include coverage for Essential Health Benefits (EHBs) under the ACA, which are a set of health care service categories that must be covered by all health insurance plans under the law. While breast cancer screening is an EHB, some plans only partially cover or don't cover services beyond screening such as diagnostic tests. Further, plans with high co-pays and deductibles leave many women having to decide whether or not to take care of basic needs (e.g. food, bills, shelter, etc.) or abide by the law and purchase insurance. Of course, these issues can be huge road blocks for women entering and remaining in the CoC.

- *Why do you think there are high rates of breast cancer late-stage diagnoses and deaths in your local community?*

  Key informants suggested a variety of possible reasons why women in their communities were experiencing high rates of late-stage incidence and death for

breast cancer. First, they overwhelmingly agreed that socioeconomics are a factor. Many low income individuals are forced to choose health care services based on affordability and which services they feel are most important. In many instances they are waiting to seek health care services until their health is at the point of crisis because of the need to pay for other more urgent expenses. Further, many in the target populations also have other more pressing co-morbidities including chronic diseases, mental illness, substance abuse and other psychosocial issues that prevent regular breast health services. Additionally, key informants described the target populations to be more reactive rather than proactive when it comes to their health. There were a number of possible reasons given for this attitude toward one's personal health. First, many do not have basic knowledge about breast cancer and the importance of breast cancer screening and early detection. There are also many myths in the community about breast cancer and screening for breast cancer. Some women believe that breast cancer is caused by breast cancer screening (i.e. mammography), which leads to fear of getting screened. Many women may also feel that breast cancer is an automatic death sentence and that getting screened is not beneficial. All of these factors including fear can prevent women in the Komen Detroit RFTC target populations from entering and remaining in the CoC, and possibly lead a community to high rates for breast cancer late-stage incidence and death.

Focus groups

Several themes emerged from focus groups held in Wayne County that provided some possible reasons for such high rates of breast cancer late-stage incidence and death in addition to possible explanations for low rates for breast cancer screening in Wayne County. Questions posed included:

- *Based on the initial data gathered in the Quantitative Data Section for Wayne County, breast cancer late-stage incidence and death rates were especially higher in areas where many women are low-income, uninsured and/or underinsured. Why do you think this is the case?*

  Focus group participants in Wayne County suggested that many low-income women are focused on day-to-day survival. Paying their bills and attending to basic needs (i.e. food, clothing, shelter, etc.) are extremely high priorities: overlooking regular breast cancer screening. Many women must work as many hours as possible in order to earn enough money to take care of themselves and their families and are too busy to attend screening appointments.

  Other low-income women have competing chronic health conditions that must be addressed on a regular basis. Such conditions take priority over breast cancer screening. Further, some women with chronic conditions can get tired of going to the doctor and simply choose not to get breast cancer screening.

  Lastly, there are not many people who know about the importance of regular breast cancer screening, nor do they recognize changes in their breasts that may warrant breast cancer screening. Many women often ignore the changes in their breasts hoping they will just go away, and wait until it is too late to get screened.

- *Breast cancer screening guidelines include an annual clinical breast exam (CBE) and mammogram beginning at age 40. For Wayne County only 48.6 percent of women have had a mammogram in the past year. What are some possible reasons why women in your community have not received a CBE or mammogram in the past year?*

  Participants expressed that so many women in the Wayne County target populations simply don't recognize the need to get screened for breast cancer. A lot of women feel healthy and don't think it is necessary to go to the doctor when there is nothing wrong. Some just simply are unaware of the screening guidelines for breast cancer. Others who may be experiencing some of the signs and symptoms associated with breast cancer may ignore them hoping they will go away over time, and only seek screening when symptoms are severe.

  For those who are interested in regular screening but don't have insurance access to a CBE and mammogram can be challenging. Many women are unaware of the available resources that can help uninsured women get access to free or low-cost screening. Finally, many women are afraid of finding out they have breast cancer and would much rather not know. Others are afraid of getting screened because of the expected pain and discomfort of mammography and choose to forego screening.

- *The Affordable Care Act (ACA) requires everyone to be covered by health insurance either by purchasing health insurance or enrolling in Medicaid if eligible. Data indicates there are people who have yet to get coverage. Why do you think there continue to be people without health insurance?*

  Participants expressed that the process for applying for health insurance through both the health care marketplace and Medicaid were extremely difficult and complicated. When seeking assistance with the application process participants shared those who were trained to guide people through the application process only had slightly more knowledge than they had. Many people simply get frustrated and give up, ultimately not receiving timely breast cancer screening.

  Further, many people in the target populations feel that the insurance available through the marketplace is unaffordable. When people are low-income, their basic needs become the priority rather than purchasing health insurance.

  Others shared that many people in the target populations have low literacy and have a difficult time when asked to complete paperwork related to applying for health insurance. Many with low literacy may feel embarrassment or shame when seeking assistance in applying for health insurance, and may ultimately decide to forego the process all together.

- *What barriers still prevent women from gaining access to breast health resources?*

  Participants overwhelmingly agreed that the three likely barriers preventing women from accessing breast health resources are lack of education and awareness about breast cancer, unaffordable insurance and fear.

Many women in the target populations don't know the importance of breast cancer screening and the resources available to assist them with accessing services.

Lack of health insurance is also a major factor holding women back from getting access to and remaining in the CoC. Having to decide between basic needs and obtaining health insurance is indeed a hindrance to timely screening for breast cancer, and can be a huge contributing factor to high rates of breast cancer late-stage incidence and death.

Likewise, fear of receiving a breast cancer diagnosis or the discomfort related to breast cancer screening tests can contribute to negative outcomes in the target populations.

- *What can Susan G. Komen do to help your community?*

  Participants overwhelmingly recommended heightened community education and outreach efforts to inform people in target populations about the importance of breast cancer screening and the resources available to help connect them with services. They also suggested having a larger media presence to get the word out to even more people. Participants really emphasized the need for more focus groups so they could provide insight into their personal experiences as residents of Wayne County.

Oakland County

Health care facility key informant interviews

Key informants at health care facilities in Oakland County were interviewed to determine possible reasons for such high rates of breast cancer late-stage incidence and death in Oakland County target populations. The same questions were posed in Oakland County as in Wayne County and included the following responses:

- *Do women complete and remain in the Breast Cancer Continuum of Care in the community your organization serves? Why or why not?*

  Key informants serving Oakland County target populations shared that challenges still exist for underserved and low-income women when it comes to accessing breast health services. Many still remain uninsured and seek health care only when there is an emergency. In many instances many low-income women are uninsured and seek health care at community health centers and free clinics. Such facilities offer clinical breast exams to patients and refer to an outside facility for mammograms and diagnostic services. Some clinics have partnerships with specific health care imaging facilities that may provide free or discounted mammography or diagnostic services. But, transportation problems and not being able to take time away from work (i.e. Inconvenient hours of operation at imaging facilities) can stop women from progressing through the CoC. When patients are required to make multiple appointments and travel away from their local communities for care such challenges may lead to an increased likelihood for late-stage incidence.

- *As a result of the Affordable Care Act (ACA), what changes have you seen in the way women access breast health services?*

  Key informants shared that those who are newly insured are seeking health care services for the things they feel are the most important. Unfortunately, breast cancer screening has not ranked at the top of the priority list for most. Because many have been uninsured for a long period of time, they may have had to wait to address other co-morbidities. Now that they have health insurance they are using it to address more pressing health care matters.

  For those who have been using community health centers and free clinics for their health care while uninsured, obtaining insurance for the first time has created some confusion. Many may not have a thorough understanding of the benefits that are covered by their insurance plans or how to even use their insurance appropriately to navigate through the CoC. A lot of people think they will receive a bill for services that are covered by their insurance plans, which leads them to delay necessary and recommended follow-up care. Further, those who were regularly seeking care at free clinics may have come to regard these facilities as their established medical homes. Now that they have health insurance, they can be forced to seek health care elsewhere. Similarly, those with a new insurance plan may be required to change doctors and establish a new medical home. Some may be reluctant to make these changes, thus leading them to not enter and remain in the CoC.

- *Since implementation of the Affordable Care Act have you noticed any lingering health care gaps when it comes to patients seeking health care?*

  For Oakland County, many women in the target populations are underinsured having health insurance plans that don't cover breast health services beyond breast cancer screening. These women face unaffordable out-of-pocket costs for services within the CoC. Additionally, many key informants explained that safety net programs are evolving and changing policies on eligibility and service availability due to ACA implementation. Safety net programs are no longer offering the full range of services once offered due to the ACA requirements for most people to have health insurance. These programs provided access to breast health services for those who may have experienced job loss or for those who are not eligible for Medicaid. With such changes many are left uninsured and without access to the CoC.

- *Why do you think there are high rates of breast cancer late-stage diagnoses and deaths in your local community?*

  Key informants shared a few reasons why they think high rates for breast cancer death and late-stage incidence exist in Oakland County. First, there is a low awareness and education about breast cancer screening guidelines. This is evident by the myths many believe about breast cancer in the target populations. Myths include that breast cancer screening (i.e. mammography) causes breast cancer and that breast cancer is a death sentence. Other myths include the belief that because one has no family history they are not at risk for breast cancer or breast cancer cannot happen to them.

Other possible reasons were that women in the target populations simply are not aware of these available resources. Some organizations provide financial assistance for co-pays and deductibles and even transportation assistance for appointments and many people are not aware of these available services. Lastly, many are simply afraid of breast cancer screening and diagnosis. There is a mentality of denial and that if one doesn't get screened then it cannot happen to them. Others in the target populations don't trust medical establishments due to personal experiences or from what they have heard from others.

Focus groups

Focus group participants in Oakland County also provided valuable information related to possible reasons for such high rates of breast cancer late-stage incidence and death in Oakland County target populations. The same questions were posed in Oakland County as in Wayne and included the following responses:

- *Based on the initial data gathered in the Quantitative Data Section for Oakland County, breast cancer late-stage incidence and death rates were especially higher in areas where many women are low-income, uninsured and/or underinsured. Why do you think this is the case?*

  Participants in Oakland County felt strongly that health insurance was unaffordable and that the out-of-pocket costs associated with health insurance kept people in the target populations from accessing timely breast cancer screening and treatment when needed. Additionally, the group felt that there simply isn't enough awareness of the importance of regular breast cancer screening or even regular health care access in the target populations in Oakland County, which could contribute to the high rates of breast cancer late-stage incidence and death. Lastly, the group expressed that there are several people who think that breast cancer will never happen to them and that they shouldn't bother going to get screened for the disease.

- *Breast cancer screening guidelines include an annual clinical breast exam (CBE) and mammogram beginning at age 40. For Oakland County only 56.1 percent of women have had a mammogram in the past year. What are some possible reasons why women in your community have not received a CBE or mammogram in the past year?*

  The group shared a few possible reasons for the low screening percentages in Oakland County. Many women in the target populations have heard negative accounts related to breast cancer screening (e.g. mammograms are painful) and they decide not to go. Additionally, some think that they may be too young or too old to get screened and are not aware of the recommended screening regimen for breast cancer.

  Fear is also a factor with many women in the target populations who feel that cancer of any kind is a death sentence and that they would much rather not know if they have it.

- *The Affordable Care Act (ACA) requires everyone to be covered by health insurance either by purchasing health insurance or enrolling in Medicaid if eligible. Data indicates there are people who have yet to get coverage. Why do you think there continue to be people without health insurance?*

  Participants shared that even though people are required to get health insurance, insurance costs are still unaffordable for the people in the target populations. For some, they feel that the process for getting health insurance is too complicated and they choose not to follow through in completing the appropriate applications. Finally, many feel that they will not get sick so they do not need health insurance.

- *What barriers still prevent women from gaining access to breast health resources?*

  The group overwhelmingly agreed that fear was the greatest barrier for women accessing breast health resources. Many women are afraid of hearing that they have breast cancer or some other breast health problem. Also, many women are afraid of the actual screening test due to things they have heard from people they trust (e.g. mammograms are painful). However, the group felt that there really shouldn't be such barriers since quality information was easily accessible online.

- *What can Susan G. Komen do to help your community?*

  The group really was enthusiastic about getting more education to the people in the target populations about breast cancer. They also suggested that Komen Detroit RFTC supports personal advocates and breast health navigators for patients as they go through the Breast Cancer Continuum of Care. Additionally, they felt that having survivors do some of the community outreach and education would go a long way in demonstrating that breast cancer is not a death sentence.

Macomb County

Health care facility key informant interview

Key informants at health care facilities in Macomb County were interviewed to determine possible reasons for such high rates of breast cancer late-stage incidence and death in Macomb County target populations. The same questions were posed in Macomb County as in Wayne and Oakland Counties and included the following responses:

- *Do women complete and remain in the Breast Cancer Continuum of Care in the community your organization serves? Why or why not?*

  Macomb County key informants feel that their programs do a good job in caring for their patients. Most have systems in place that track patients from their initial screening to follow-up care and send regular communications reminding them about their follow-up appointments. However, for facilities that do not offer both screening and follow-up care, it can be challenging to track the patients through the entire CoC. Because these facilities provide referrals to outside organizations for imaging and diagnostic services, the follow-up is often left in the hands of the organization the patient is referred to.

  Those key informants providing education and community outreach programs about breast cancer feel that they have made impressive progress in getting women to screening and in the early detection of breast cancer.

- *As a result of the Affordable Care Act (ACA), what changes have you seen in the way women access breast health services?*

  According to key informants, more people in Macomb County target populations are now accessing health care services due to having health insurance either through the marketplace or through Michigan Medicaid Expansion program called the Healthy Michigan Plan. Many people are accessing health care for the first time in many years and need assistance in understanding exactly how to go about using their insurance. Some key informants shared that they offered some education and navigation to and through the appropriate services. For those who are newly insured it can be overwhelming to navigate the CoC and it has proven helpful to have assistance.

- *Since implementation of the Affordable Care Act have you noticed any lingering health care gaps when it comes to patients seeking health care?*

  While many people in the Macomb County target populations now have access to insurance, there are still challenges when trying to enter and remain in the CoC. Many women are unable to afford the co-pays and deductibles that come with their insurance plans, which may prevent many from entering and remaining in the CoC. Additionally, for immigrants residing in Macomb County, accessing health care is especially challenging due to their lack of citizenship. Many immigrants in Macomb County are refugees from Arab countries and have been in the US for less than five years, which bars them from purchasing health insurance through the marketplace or enrolling in Medicaid. Being underinsured or uninsured continue to be problems that prevent women in the Macomb County target populations from entering and remaining in the CoC.

- *Why do you think there are high rates of breast cancer late-stage diagnoses and deaths in your local community?*

  Key informants felt that many in the Macomb County target populations are low-income and must prioritize basic needs over seeking regular health care. Many families must work as many hours as possible in order to earn enough to support themselves and their families, and cannot afford to take time off of work or the child care needed in order to go to the doctor. Others have challenges with transportation, especially when it is needed to attend multiple appointments in multiple locations.

  Some simply do not recognize the need to go to the doctor for regular screening or are in denial about the signs and symptoms of a breast problem they may be experiencing. Further, many women who remain uninsured may not know where to go to access health care services. Lastly, many women are afraid of receiving a breast cancer diagnosis and simply would rather not know.

Focus groups

Participants in Macomb County were also provided thorough insight into some possible reasons for such high rates of breast cancer late-stage incidence and death in Macomb County target populations. The same questions were posed in Macomb County as in Wayne and Oakland Counties and included the following responses:

- *Based on the initial data gathered in the Quantitative Data Section for Macomb County, breast cancer late-stage incidence and death rates were especially higher in areas where many women are low-income, uninsured and/or underinsured. Why do you think this is the case?*

  Most of the focus group participants felt that being uninsured and not being able to afford the out-of-pocket costs associated with health care, including co-pays and deductibles, contribute greatly to the data for late-stage incidence and death amongst the target populations in Macomb County. Because some have low income or no income at all they are simply unable to afford the necessary services to maintain their breast health. Additionally, many are without reliable transportation in the target populations, preventing them from attending screening and follow-up appointments regularly.

  Participants also expressed that there is a lack of knowledge of the available resources for the uninsured and low-income. Many do not know of the programs available to help women access clinical breast exams and mammograms for free or at a reduced cost if they cannot afford them. Others simply have no knowledge about breast cancer in general or the importance of regular breast cancer screening. For those who do have the knowledge about screening, many are afraid to get screened because of the possibility of receiving a breast cancer diagnosis or because of the discomfort of the mammography test.

  Also, many shared that they simply feel that they must put themselves last due to other obligations. Many women are taking care of other family members and making sure their needs are met and often feel they do not have the time to go to the doctor unless it is an emergency.

- *Breast cancer screening guidelines include an annual clinical breast exam (CBE) and mammogram beginning at age 40. For Macomb County only 48.2 percent of women have had a mammogram in the past year. What are some possible reasons why women in your community have not received a CBE or mammogram in the past year?*

  Again, most participants expressed that lack of health insurance accounted greatly for the low screening percentages of women in Macomb County. Further, the participants said they were rarely encouraged to go to the doctor by others. For example, for those who are around others who also do not go to the doctor the subject of breast cancer screening rarely or almost never comes up in conversation. Additionally, for those who have a doctor they see regularly, when the doctor's office does not send a communication reminding them to get their annual screening it can prevent them from going to get screened.

  Alternatively, many expressed that most people they know feel that there is nothing wrong with them that would prompt them to go to get screened. They simply do not recognize the need to get screened or seek health care unless there is a problem.

  Lastly, fear of being diagnosed with breast cancer was overwhelmingly mentioned as a possible reason for not going to get screened.

- *The Affordable Care Act (ACA) requires everyone to be covered by health insurance either by purchasing health insurance or enrolling in Medicaid if eligible. Data indicates there are people who have yet to get coverage. Why do you think there continue to be people without health insurance?*

  Most participants shared that the insurance available through the health insurance marketplace in Michigan was unaffordable due to having high out-of-pocket costs, including high co-pays and deductibles. Also, there are still many who simply do not understand the process for enrolling in a health care plan either through the marketplace or in Medicaid. They feel the process is too complicated and they experience frustration when attempting to get health insurance. Some hear about the difficulty others experience with the enrollment process and just don't bother trying to get coverage based on the experiences of others.

- *What barriers still prevent women from gaining access to breast health resources?*

  Most simply do not know about the importance of breast cancer and the importance of screening regularly for the disease. Others simply are not aware of the available resources for low-income, uninsured and underinsured people that can help them access breast cancer screening, diagnostics and treatment if diagnosed.

  For those who are in the target populations, it may be difficult for them to admit that they may need help. Many do not want to be viewed as a charity case and will choose to go without the needed breast health services. Others cannot afford the out-of-pocket costs for health care services.

- *What can Susan G. Komen do to help your community?*

  Participants overwhelmingly expressed the need for more community outreach and educational events in Macomb County. They would like for Susan G. Komen to have more of these kinds of events on a consistent basis in their local community. Additionally, they expressed the need for more programs to help cover the out-of-pocket costs for breast health services for those who cannot afford to pay.

Health plan administrators key informant interviews – Wayne, Oakland and Macomb Counties

The Komen Detroit RFTC Community Profile Team contacted health insurance plan administrators with knowledge of enrollee utilization of breast health-related services to gain perspective on possible reasons for such low rates of breast cancer screening in Wayne, Oakland and Macomb Counties. Questions posed included:

- *Are women enrollees receiving recommended screenings at the appropriate screening intervals (i.e. CBE and mammogram annually at age 40)? Do women enrollees complete and remain in the Breast Cancer Continuum of Care? Why or why not?*

  The responses to this question were mixed with some health plans having only half of their enrollees receiving annual mammograms and clinical breast exams and others being in the 75th percentile nationally. However, key informants could only provide data based on enrollees age 50 and older due to data collection

practices. It was learned that each health plan collects data for submission to the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data Information Set (HEDIS), a tool used to measure performance on important dimensions of health care service. HEDIS measures match the recommendations from the United States Preventive Services Task Force (USPSTF), an independent, volunteer panel of national experts in prevention and evidence-based medicine. At the time of the interviews, the USPSTF only recommends mammography for women beginning at age 50, and for this reason health plans only collect such utilization data for women enrollees meeting this age threshold. Susan G. Komen recommends individuals talk to their health care provider about mammography and clinical breast exams beginning at age 40 to ensure early detection of breast cancer. While health plans will pay for a mammogram for women between ages 40 to 49, they do not actively recommend such screening until age 50 for enrollees.

The variance in compliance with annual screening was greatly related to the types of plans offered by each health plan. Health plans reported the strongest compliance amongst women enrolled in their commercial health plans where patients purchased them on their own. Lower compliance was reported for those who had Medicaid health plans or plans that were offered as part of the Healthy Michigan Plan, which is Michigan's Medicaid Expansion program as part of the Affordable Care Act.

- *What barriers exist that inhibit women from entering and remaining in the Breast Cancer Continuum of Care?*

  Key informants shared a mix of responses relating to personal life and personal awareness barriers for enrollees, along with health system barriers that inhibit people from entering and remaining in the CoC. Key informants suggested that for patients who are not entering and remaining in the CoC many do not have a full understanding of the screening guidelines and the importance of breast cancer screening and don't recognize the need for screening. Further, many may face challenges when it comes to transportation and child care and often forego timely breast cancer screening for these reasons. Additionally, many enrollees may prioritize the care of other family members or they must focus on other more urgent health issues. This may also cause them to skip timely breast cancer screening. Fear was also something that was suggested as a strong factor in whether or not enrollees enter and remain in the CoC. Many are afraid of getting a mammogram because they have heard from others that it is harmful or painful or they are afraid cancer will be found.

  Key informants shared some potential health system barriers including patient's lack of an established medical home or a primary care doctor. Health Resources and Services Administration (HRSA) defines a medical home as a cultivated partnership between the patient, family, and primary provider in cooperation with specialist and support from the community. The key informants expressed challenges for newly insured patients to schedule timely appointments with primary care doctors due to the influx of new patients, especially as part of the Healthy Michigan Plan. Additionally, newly insured patients may need help

understanding how their insurance plans work and what benefits are covered, which can prove complicated for someone who has never had insurance before. Because of these challenges, many patients continue to patronize emergency rooms to seek medical care and only when their health is in crisis.

- *How do you communicate the importance of breast cancer screening to enrollees?*

  Each key informant shared that their companies have a system for tracking patient compliance to breast cancer screening amongst enrollees. The organizations will often communicate via postal mail to send a reminder letter to enrollees regarding annual screenings. Such mailings include educational materials emphasizing the importance of such annual exams. Additionally, insurers will offer incentives to enrollees for healthy behaviors such as a $10.00 gift card for getting an annual breast cancer screening. Insurers have even offered incentives to providers who encouraged their patients to get their annual screening, such as offering a dollar amount per patient who received their annual screening. Companies have also organized special community breast cancer screening events, either working with a radiology clinic or mobile mammography unit to accommodate enrollees who have not received their annual breast cancer screenings. Educational presentations and materials are offered at these events and attendees have the opportunity to get screened on-site.

  Service coordinators and case managers are often used to make contact with enrollees who are overdue for their annual breast cancer screening tests. Once the non-compliant enrollees are contacted, service coordinators and case managers can often quickly assess some of the factors that prevent enrollees from getting the needed services. At this point of contact, the coordinators share information about upcoming events and provide connection to transportation or other services if necessary.

- *Since implementation of the Affordable Care Act, have you noticed any lingering health care gaps when it comes to patients seeking health care?*

  Responses to this question were mixed depending on the insurance plans offered by the companies and the population served. For companies whose plans were overwhelmingly Medicaid plans or plans that were part of the Healthy Michigan Plan, the gaps were related to accessing the services. Medicaid plans are rather comprehensive in terms of service coverage for enrollees. Screening, diagnostic and treatment services are all covered with Medicaid and plans that are part of the state expansion for the program under the Affordable Care Act. However, due to the increase in enrollment in the Healthy Michigan Plan and the sudden increase of insurance coverage across the Komen Detroit RFTC service area, accessing a primary care doctor has proven challenging. Additionally, the key informants said that other personal life barriers prevented Medicaid and Healthy Michigan Plan enrollees from getting the necessary breast cancer screening and treatment services. Such barriers included not having reliable transportation, not having child care, not being able to take time off of work, not understanding the services covered by their insurance or understanding how to use their insurance.

For women who are not eligible for Medicaid or the Healthy Michigan Plan, who must purchase a commercial plan through the marketplace, issues included having high co-pays and high deductibles as part of their insurance plans. These are huge barriers that stop women from entering and remaining in the CoC. Many in this situation find themselves having to decide which medical issues are the most urgent or decide whether or not to address their health at all versus making sure another basic need is met.

Qualitative Data Findings

Some important conclusions were determined from each key informant interview and focus group for the target populations in the Komen Detroit RFTC service area. Data gathered through these collection methods will help the Komen Detroit RFTC develop an action plan that may help reduce the number of breast cancer cases diagnosed at late-stages and ultimately reduce the number of deaths. Conclusions for each county are as follows:

Conclusions from data for Wayne County:

1. Health care affordability still seems to be a major contributing factor to why women in the Wayne County target populations are not getting screened for breast cancer. There is a need for programs that can help reduce the financial barriers preventing women from entering and remaining in the CoC.
2. Attitudes toward personal health in the Wayne County target populations are overwhelmingly reactive, rather than proactive, leading people to only seek health care when their health is in crisis. Increased awareness of available resources and education about the importance of regular breast cancer screening may be helpful in changing health behaviors.
3. Myths and fears related to breast cancer seem to be common in the Wayne County target populations possibly leading to low rates of breast cancer screening. Education and community outreach programs may help change beliefs and attitudes toward breast cancer in the target populations.

Conclusions from data for Oakland County:

1. Many in the Oakland County target populations are having difficulty adjusting to the changes implemented by the Affordable Care Act. Patient navigation services may help eliminate confusion on how health insurance works and ultimately increase the number of people entering and remaining in the CoC in the target populations.
2. Affordability of out-of-pocket costs and transportation to appointments are barriers that seem to prevent people in the target populations from entering and remaining in the CoC. Increasing awareness of available resources for low-income and underinsured women may help more individuals in the target populations get access to regular breast cancer screenings.
3. Myths and fears related to breast cancer seem to be common in the Oakland County target populations possibly leading to low rates of breast cancer screening. Education and community outreach programs may help change beliefs and attitudes toward breast cancer in the target populations.

Conclusions from data for Macomb County:

1. Many in Macomb County target populations now have access to health care and are newly insured. Patient navigation services may help eliminate confusion on how health insurance works and ultimately increase the number of people entering and remaining in the CoC in the target populations.
2. Many people in Macomb County target populations do not recognize the need for regular breast health screenings, which may account for the fact that Macomb County has the lowest screening percentages for breast cancer out of the three counties in the Komen Detroit RFTC service area. This may also be a big reason why late-stage incidence and death rates are high in the target populations. Education and community outreach programs may help increase rates for screening and the likelihood for early detection of breast cancer.
3. There are still people in the target populations who remain uninsured or underinsured. Lack of US citizenship and the affordability of out-of-pocket costs are barriers that seem to prevent people in the target populations from entering and remaining in the CoC. Increasing awareness of available resources for low income, uninsured and underinsured women may help more individuals in the target populations get access to regular breast cancer screenings.

Conclusions from health plan administrator key informant interviews:

1. There is a difference in the audiences targeted for breast cancer screening in the target populations based on the breast cancer screening guidelines being followed (i.e. recommending annual mammography at age 40 or 50). Such differences may account for the low level screening for breast cancer across the Komen Detroit RFTC service area. Stronger outreach and education may help to eliminate confusion for women in the target populations and increase the number of women screened regularly.
2. Barriers to breast cancer screening still exist for women who have health insurance in the target populations including, lack of transportation, child care and lack of understanding of insurance coverage for services. Navigation services may be a necessary component for ensuring that women enter and remain in the CoC.

Breast Health and Breast Cancer Findings of the Target Communities

Quantitative data for the Komen Detroit Race for the Cure (RFTC) service area (i.e. Wayne, Oakland and Macomb Counties) show a number of alarming statistics. Breast cancer incidence, death and late-stage incidence rates for the Komen Detroit RFTC service area are significantly higher than the rates for Michigan. The data also predict that these counties collectively are unlikely to meet the Healthy People 2020 (HP2020) targets for breast cancer late-stage incidence rates.

Based upon the initial quantitative data collection, further exploration was done to determine possible factors for the poor outcomes in the Komen Detroit RFTC service area counties. While data from the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance Survey (BRFSS) show the mammography screening proportions for the Komen Detroit RFTC service area are higher when compared to the United States (77.5 percent) and the State of Michigan (79.5 percent) in the last two years, the screening percentages within the past year tell a different story. According to the Michigan BRFSS data, screening percentages in the Komen Detroit RFTC service area were just 50.8 percent with only 52.5 percent of insured women and 31.9 percent of uninsured women receiving an annual screening. The low screening percentages have likely contributed to the poor rates of breast cancer late-stage incidence and deaths in the Komen Detroit RFTC service area.

Additionally, for geographic areas with high poverty levels the number of breast cancer cases diagnosed at later stages, when it is more difficult to treat, is higher in each of the three counties in the Komen Detroit RFTC service area. These communities overlap many of the Health Resources and Services Administration (HRSA)-designated Medically Underserved Areas in Wayne, Oakland and Macomb Counties and have higher populations of racial and ethnic minorities. Further, education and unemployment levels are respectively lower and higher when compared to each county's overall population.

Finally, data showed that those living in areas with high poverty levels had poorer survival after four years than those who did not. Based upon the data findings, Wayne County, Oakland County and Macomb County populations living in poverty and in Medically Underserved Areas (MUAs) were chosen as the target populations. The Komen Detroit RFTC Community Profile Team sought to explore the possible health system and public policy factors that may be contributing to the poor outcomes in the target populations.

Through analysis of health systems in the Komen Detroit RFTC service area, it was determined that several facilities offering breast health services are available to people in the target populations. Each hospital located in a HRSA-designated Medically Underserved Area offers a full range of breast cancer screening, treatment and education services. In spite of this, several severe gaps that may contribute to the devastating late-stage incidence and death rates in the target populations remain. For example, the Breast and Cervical Cancer Control Program (BCCCP), which is Michigan's version of the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), provides free breast cancer screening for eligible low-income women and treatment coverage for those with a cancer diagnosis. However, only a small percentage of eligible women are enrolled in this vital safety net program.

Another possible gap is the fact that many facilities serving the target populations, like community health centers, don't offer all of the services along the Breast Cancer Continuum of Care (CoC), requiring women to get referrals to other facilities and to schedule additional appointments. This can present major barriers to women without transportation or for those who work hourly-wage jobs and cannot afford to take the time away from work.

The Komen Detroit RFTC has strong community partnerships focused on meeting the breast health and breast cancer-related needs in Wayne, Oakland and Macomb Counties. The partnership activities with grantees and other community organizations seek to help increase the proportion of breast cancers diagnosed at early stages, promote timely and complete breast cancer screening, follow up and treatment, and reduce the barriers to entering the CoC. However, there is still further opportunity to develop relationships with more organizations that serve the needs of the target populations.

The State of Michigan decided to expand its Medicaid program to allow more underserved people to enroll as part of the provisions in the Patient Protection and Affordable Care Act (ACA). The Healthy Michigan Plan is for eligible individuals with incomes between 100 and 133 percent of the Federal Poverty Level (FPL) and will incorporate incentives for "healthy behaviors" like having annual health screenings. This program may have a tremendous effect on the target populations in Wayne, Oakland and Macomb Counties when it comes to eliminating the barrier of not having health insurance and attempting to access the CoC. However, future analysis will provide more insight into whether or not health outcomes, specifically breast cancer screening, late-stage incidence and death rates have improved in the Komen Detroit RFTC service area over the next several years.

Breast cancer and breast health resource access and utilization factors were further explored in the Qualitative Data Section of the report to try to determine the possible reasons for high rates of late-stage incidence and death in the target populations.

To help determine the breast health services access and utilization factors affecting the rates of late-stage incidence and death, it was vital to gather qualitative data from health care facilities that serve the target populations. Additionally, focus groups were convened to gain important information directly from the target populations regarding their personal experiences in accessing the CoC.

Key informants and focus group participants in Wayne County emphasized three main factors that are likely contributing to high rates of late-stage incidence and deaths in Wayne County:

1. Health care affordability is a major barrier to entering and remaining in the CoC.
2. Attitudes toward personal health in the target populations are more reactive rather than proactive. More awareness and education about available breast health resources and the importance of early detection may help change negative outcomes.
3. Many people in the Wayne County target populations believe myths about breast cancer and experience a lot of fear related to the disease. Education and community outreach programs may help to dispel such myths and decrease fears in an effort to improve breast health outcomes in Wayne County.

Key informants and focus group participants in Oakland County also emphasized three main ideas that could be contributing to poor breast health in the county's target populations:

1. Confusion about health care coverage is possibly preventing access to the CoC for Oakland County target populations. Patient navigation programs may help to eliminate this confusion.
2. Out-of-pocket costs are unaffordable and barriers, like transportation, stop people from entering and remaining in the CoC. Increased awareness of available community resources for the target populations may help eliminate or reduce these barriers.
3. Myths and fears are common in the Oakland County target populations. More targeted community outreach and education events may be beneficial.

Like in both Wayne and Oakland Counties, key informants and focus group participants in Macomb County identified three main challenges that could be contributing to the poor late-stage incidence and death rates for the target populations.

1. Patient navigation may help to educate newly insured individuals from the target populations about how health insurance works. This may help to increase the number of individuals who enter and remain in the CoC.
2. Education programs and community outreach may help more people in the target populations to recognize the need for regular screening. Screening percentages for Macomb County are the lowest of the three Komen Detroit RFTC counties and many in the target populations wait to seek health care when their health is in crisis.
3. There are some who remain uninsured and underinsured in the Macomb County target populations due to lack of US citizenship and affordability of out-of-pocket costs. Increasing the awareness of available resources may help to alleviate these barriers.

As far as health plans serving the Komen Detroit RFTC service area, two main challenges were identified as being possible factors contributing to the poor breast cancer outcomes in the Wayne County, Oakland County and Macomb County target populations:

1. Health plans track enrollee utilization of breast cancer screening services for patients beginning at age 50 in accordance to the United States Preventive Services Task Force recommendations, and do not encourage enrollees to seek screening until age 50. Screening for breast cancer is recommended by Susan G. Komen beginning at age 40. Stronger education about breast screening could help to eliminate confusion.
2. Barriers including lack of child care, transportation and thorough understanding of health coverage prevent people in the target populations from entering and remaining in the CoC.

Mission Action Plan

Based on data gathered from the Quantitative Data, Health Systems Analysis and Public Policy, and Qualitative Data Sections, the Komen Detroit RFTC has drafted an action plan including feasible priorities and objectives to address critical needs in the target populations identified in the Komen Detroit RFTC service area. The action plan will be implemented from FY16 through FY19 and has been organized into three categories: Community Education and Outreach, Partnership Opportunities and Grantmaking.

Community Education and Outreach

Problem Statement 1: Annual breast cancer screening percentages for women in Wayne, Oakland and Macomb Counties are low, which is a likely contributor to high rates of late-stage incidence and death in the Komen Detroit RFTC service area.

Priority 1*:* Increase education about breast cancer in target populations in Wayne, Oakland and Macomb Counties.

- *Objective 1:* Recruit three college student interns, one each for Wayne, Oakland and Macomb Counties, to each conduct 12 group education sessions per year in Komen Detroit RFTC target populations starting September 2016 to consistently educate target populations on the importance of breast cancer screening. Based on data gathered in focus groups and key informant interviews, taking a more proactive approach in finding audiences that may benefit from this type of education may help to increase the number of those being screened for breast cancer in Komen Detroit RFTC target populations.
- *Objective 2:* In preparation to strengthen outreach efforts and increase education in Komen Detroit RFTC target populations, reinforce breast cancer knowledge for Komen Detroit RFTC community volunteers through developing an annual, comprehensive training program to sustain knowledge about breast cancer and breast cancer screening by June 2016. Developing such a program may help to ensure that volunteers are prepared and equipped to provide accurate information that may encourage target populations to seek timely breast cancer screening.

Priority 2*:* Increase community involvement in developing Komen Detroit RFTC programs to reduce and dispel myths and fears about breast cancer and breast cancer screening. Special focus is needed on this topic especially based on feedback from focus group participants to help increase regular and timely screening for breast cancer in the target populations.

- *Objective 1:* Create a community advisory council for the Komen Detroit RFTC service area composed of focus group participants, breast cancer survivors and Komen Detroit RFTC grantees by December 2016. Such members will , help develop at least one breast cancer community outreach initiative focused on reducing fears and dispelling myths about breast cancer and breast cancer screening for specific target populations in each county. Developing such a community council may help determine the best strategy to implement in each target population in each county.
- *Objective 2:* Develop a breast cancer survivor ambassador program and identify at least three breast cancer survivors from each county in the Komen Detroit RFTC service area to partner with interns and community volunteers to help implement initiatives developed by the community advisory council in the target populations by December 2016. Based on feedback from focus group participants, hearing directly from breast cancer survivors about their personal experiences may help to ease their fears about screening and the disease itself.

***Priority 3**:* Improve public awareness of breast cancer and patient navigation resources to guide women through the Breast Cancer CoC.

- *Objective 1:* Implement an evidence-based, comprehensive, social media campaign to increase public awareness of breast health and breast cancer screening recommendations to begin in January 2016, monitored through the use of web analytics. Based on the feedback from focus group participants, many women in Wayne, Oakland and Macomb Counties are unaware of general breast cancer information and the recommended screening regimen; increasing public awareness via online platforms may lead to higher screening percentages in all three counties.
- *Objective 2:* Develop a comprehensive resource page on the Komen Detroit RFTC website including information for patient navigation, support and breast cancer education by December 2016. Such information will include website links to the *CDC Bring Your Brave Campaign* for young survivors, the Metastatic Breast Cancer Alliance and others.

Partnership Opportunities

Problem Statement 1: Only half of women with health insurance and less than one-third of women with no health insurance are receiving annual breast cancer screening in Wayne, Oakland and Macomb Counties.

***Priority 1**:* Increase the number of organizations partnered with Komen Detroit RFTC that offer resources to the community to assist both insured and uninsured women in Wayne Oakland and Macomb Counties with entering and remaining in the Breast Cancer Continuum of Care (CoC).

- *Objective 1:* Develop partnerships with at least five community organizations trained as Affordable Care Act navigator sites to help get people connected to breast cancer screening during the open enrollment period in Wayne, Oakland and Macomb Counties by December 2016.
- *Objective 2:* Connect with at least five health plans serving Wayne, Oakland and Macomb Counties to explore potential opportunities to educate enrollees about breast cancer screening and help connect them to services by December 2016.

***Priority 2**:* Engage community partners to provide educational resources in target populations including Komen Detroit RFTC sponsors, businesses and organizations located in Wayne, Oakland and Macomb County target communities and/or serving Wayne, Oakland and Macomb County target populations.

- *Objective 1:* Working with current Komen Detroit RFTC grantees, identify at least three businesses serving the target populations to explore sponsorship and community partnership potential to provide breast cancer education to consumers by December 2016. Such businesses include Walgreens and local dollar stores.
- *Objective 2:* Identify at least three current Komen Detroit RFTC sponsors located in key communities in Wayne, Oakland and Macomb Counties that can help with community education and outreach to target populations by December 2016.

- *Objective 3:* Collaborating with the Michigan Cancer Consortium, identify at least three current Komen Detroit RFTC sponsors to implement evidence-based Community Guide strategies to increase breast cancer screening percentages for employees by January 2017.

Grantmaking

Problem Statement 1: Women in HRSA-designated Medically Underserved Areas (MUAs) and communities with high rates of poverty in Wayne, Oakland and Macomb Counties are disproportionately diagnosed with breast cancer at late-stages.

Priority 1: Ensure Komen Detroit RFTC grant program funding priorities for 2015 through 2019 address possible factors contributing to late-stage incidence rates in Wayne, Oakland and Macomb County MUAs and communities with high poverty.

- *Objective 1:* Beginning with the FY17 Community Grant Request for Applications (RFA), funding priority will be provided to proposals that seek to increase the proportion of breast cancer diagnoses at earlier stages in the Komen Detroit RFTC target populations by increasing awareness of breast cancer risk factors and the importance of breast cancer screening.
- *Objective 2:* Beginning with the FY17 Community Grant RFA funding priority will be provided to proposals that seek to support strong community education and outreach programs in the Komen Detroit RFTC target populations focused on dispelling myths, reducing fears and providing support services related to breast cancer.
- *Objective 3:* Beginning with the FY17 Community Grant RFA funding priority will be provided to proposals that seek to increase timely and complete breast cancer screening, follow-up care and treatment in the Komen Detroit RFTC target populations through patient navigation and by reducing financial, individual, provider and other barriers to care (e.g. co-pays, deductibles, transportation, etc.).
- *Objective 4:* Beginning with FY17 Community Grant RFA funding priority will be provided to proposals that seek to increase support for health care safety net programs that help increase timely and complete access to the Breast Cancer Continuum of Care for underinsured and uninsured in the Komen Detroit RFTC target populations.

Priority 2: Market community grant program and funding opportunity to nonprofit organizations serving the Komen Detroit RFTC target populations to diversify grant slate.

- *Objective 1:* Beginning with the FY17 Community Grant Writing Workshop, recruit five new nonprofit organizations to participate in annual grant writing workshops each year.
- *Objective 2:* Annually, beginning with the FY17 Community Grant cycle, through the use of surveys identify barriers that are preventing organizations from applying for a grant and work to reduce these barriers for the next grantmaking period.

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