



KOMEN COMMUNITY HEALTH GRANTS

Because breast cancer is everywhere, SO ARE WE.

At Susan G. Komen, we are committed to **ENDING** breast cancer forever by **EMPOWERING PEOPLE, ENERGIZING SCIENCE** to find the cures and ensuring **QUALITY CARE** for all people, everywhere.

NATIONAL CAPITAL REGION COMMUNITY HEALTH GRANTS

2015 - 2016 REQUEST FOR APPLICATIONS

Susan G. Komen
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KEY DATES

Application System Open:	Monday, December 21, 2015
RFA Overview Webinar:	Thursday, December 17, 2015 at 2:00PM (register via email to nationalcapitalarea@komen.org)
Application Initiation Deadline:	Friday, January 8, 2016 at 1:00PM EDT
Application Completion Deadline:	Thursday, January 14, 2016 at 1:00PM EDT
Award Notification:	On or before March 31, 2016

ABOUT SUSAN G. KOMEN®

Susan G. Komen is the world's largest breast cancer organization, funding more breast cancer research than any other nonprofit while providing real-time help to those facing the disease. Since its founding in 1982, Komen has funded more than \$889 million in research, provided \$1.95 billion in funding to screening, education, treatment and psychosocial support programs, serving millions of people in more than 30 countries worldwide. Komen was founded by Nancy G. Brinker, who promised her sister, Susan G. Komen, that she would end the disease that claimed Suzy's life. Visit komen.org or call 1-877-GO-KOMEN. Connect with us on social at ww5.komen.org/social.

NATIONAL CAPITAL REGION PROFILE

The Komen National Capital Region (NCR), which includes Washington, DC and surrounding areas in Maryland and Virginia, faces pronounced disparate outcomes in breast cancer incidence and mortality. Recent analyses have shown that Washington, DC has the highest incidence and mortality rates for breast cancer in the United States, with incidence rates nearly 15 percent higher than the national average, and mortality rates more than 30 percent higher than the national average.ⁱ In addition, Washington, DC has one of the highest incidence rates of late-stage breast cancer.ⁱⁱ

In response to these findings, Susan G. Komen is conducting a Community Profile Assessment to investigate the health needs and assets in the NCR. Data obtained through this process allows Komen to pinpoint where our efforts will have the most impact.

The Community Profile development process includes:

- a comprehensive review of the demographic and breast cancer statistics of the NCR in order to identify those communities with the greatest needs,
- an analysis of the health systems to understand the gaps, needs, and barriers that women encounter as they access breast health services, and
- collection of data from women living in the NCR communities and health care professionals to gauge their understanding of breast cancer, knowledge of services, barriers to care, and the effectiveness of current outreach and education efforts

Please refer to "Appendix A: Susan G. Komen National Capital Region Community Profile Overview" on page 16 for breast cancer statistics, demographics, socioeconomic factors along with a summary of health system analysis and qualitative data findings. The full Profile will be released in early 2016.

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PRIORITY COMMUNITIES

Based on the Quantitative Data Report, the following are designated as priority communities for 2016 funding:

- Alexandria City, VA;
- Wards 2, 5, 7 and 8 within the District of Columbia (DC)

Alexandria, Virginiaⁱ

Alexandria was selected as a target community based on the age-adjusted death rate as well as late-stage incidence rates. The age-adjusted death rate for this area (23.0 per 100,000) is higher than that of the US overall. Alexandria, VA is the only area in the NCR to have an increasing death rate, which means that it is not likely to reach the Healthy People 2020 (HP2020) breast cancer death rate target. Late-stage incidence rates are also higher than the national rate as well as the rate for the NCR service area. It is predicted that Alexandria, VA will also not achieve the HP 2020 breast cancer target for late-stage incidence.

The percentage of the population in Alexandria City without health insurance is relatively high at 10.6 percent, and a quarter of the population is foreign born. These factors coupled with linguistic isolation percentages that exceed the national percentage may be contributing to the disparities in this community which is predominantly White (68.2 percent). Alexandria City has mammography screening percentages that are higher than the NCR service area (90.6 percent vs. 84.3 percent) which suggests that diagnosis may not be occurring in a timely manner.

District of Columbiaⁱ

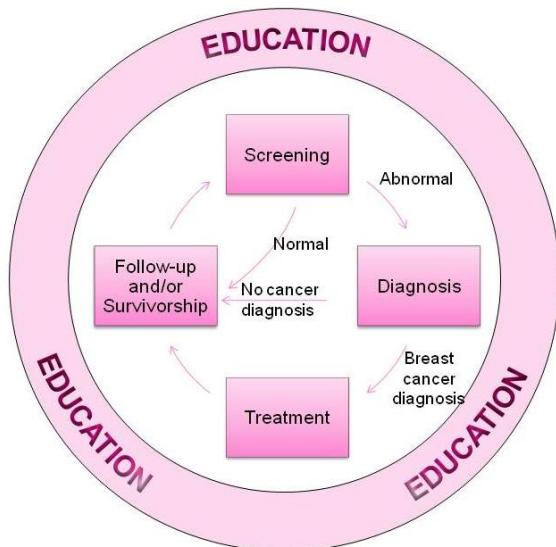
Data indicate that the District of Columbia as a whole will not quickly achieve the HP2020 targets for breast cancer death rate and late-stage incidence rate. However, the data also reveal distinct differences in the needs within the District across the Wards, leading to the selection of Wards 2, 5, 7 and 8 as target communities. All four of these Wards are among those with the highest breast cancer death rates and have age-adjusted death rates that exceed the national rate (22.6 per 100,000), the rate within the combined NCR Service Area (23.5 per 100,000), and the overall District of Columbia rate (29.3 per 100,000).

Applications must demonstrate benefit to one or more of the communities described above.

PRIORITY FOCUS AREAS

Applications must support high impact breast cancer programs focused on public and provider education OR addressing barriers to care, specifically in Alexandria, VA and District of Columbia Wards 2, 5, 7 or 8. No other project proposals will be accepted.

The Breast Cancer Continuum of Care represents how a woman typically moves through the health care system to get screened for breast cancer, and if necessary, undergo diagnostic tests and receive treatment for breast cancer. The Breast Cancer Continuum of Care has four stages: Screening, Diagnosis, Treatment, and Follow-up Care.



Priority I – Public and Provider Education

Education can play an important role throughout the entire CoC by encouraging women to get screened, noting the importance of follow-up, lessening fear, providing and understanding treatment options, and addressing barriers that prevent women from progressing through the entire care path.

Effective education efforts do more than simply raise awareness about breast cancer; they equip people to take action by providing in-depth education about breast cancer, breast cancer risk, screening options, knowing when and how to seek breast care (including for risk assessment, screening, diagnosis, treatment

and survivorship), community resources, and how to incorporate healthy choices into their lifestyles.

However, key to bringing about positive health outcomes in diverse populations is the delivery of healthcare services that are respectful of and responsive to health beliefs, practices and needs of diverse patients and that reflect individuals' cultural and language preference. In short, education of both patient and provider is needed.

The purpose of this priority is to:

- (1) initiate and support **public education** efforts focused on increasing knowledge and utilization of available breast cancer resources, the importance of early detection, and motivating women to action with an emphasis on reaching the low-income, underinsured, uninsured, working poor and racial and ethnic communities, or
- (2) to support programs that aim to improve health care quality and advance health equity through **health care provider training and assessment** utilizing the US Department of Health and Human Services Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards).

Education interventions for the public may be led by appropriately trained peer or community health workers (i.e., Promotoras), clinicians, or even faith-based organizations. However, regardless of who provides the education, **the program is required to incorporate the use of, and focus on, evidence-based education interventions that increase knowledge and encourage informed breast care decision making in culturally competent manners.**

Evidence-based practices refer to an intervention/activity that has been tested and shown to be effective through repeated, rigorous, quantitative/empirical data collection and analysis.

Applicants may use the following websites as resources for evidenced-based interventions:

- <http://www.thecommunityguide.org/cancer/screening/client-oriented/index.html>
- <http://rtips.cancer.gov/rtips/index.do>

In addition to the use of evidence-based interventions, proposed public education programs must also clearly delineate how the program will lead to action beyond education, including how women will be linked to, and followed throughout, the breast cancer continuum of care. **Therefore, proof of partnerships and/or collaborations with external providers is required.**

Please note, navigation or clinically-based navigation programs will not be considered under this priority. Applications that propose health fairs, the development of educational materials, outreach via mass media, or use patient incentives will also not be accepted.

Organizations/institutions applying for Priority I may request up to \$50,000 per year for one or two years. Komen will only support non-medical expenses for this funding opportunity.

Priority II – Addressing Barriers to Care

Identifying, understanding, and reducing barriers to quality cancer care are critical strategies for improving disparate breast health outcomes. Barriers to care may generally be characterized as structural, sociocultural, personal, and financial.

Structural barriers can include the geographic location of services, transportation needs, insufficient diagnostic or treatment services or an undertrained workforce. They also include inefficient or poorly coordinated services requiring multiple visits to initiate definitive diagnosis, poor referral networks, and inadequate patient navigation. **Sociocultural barriers** include myths and misconceptions about the causes and treatment of cancer, stigma, language, and discrimination. **Personal barriers** may include mistrust of the health system, fear of a cancer diagnosis, low health-literacy or competing family and work obligations. **Financial barriers** to accessing care include direct, out-of-pocket payment for services and indirect costs such as transportation, housing, childcare, and lost wages.

Remedies to barriers may include:

- Cancer patient navigation and/or community health worker programs to assist patients in accessing screening and transitioning throughout the breast cancer continuum of care;
- The development or expansion of programs to provide breast cancer services beyond normal business hours (8 a.m.- 5 p.m.), on weekends (i.e. Saturday and Sunday), and/or at alternative locations such as churches, community centers and places of employment; or
- The development or expansion of programs that reduces financial, communication and transportation barriers to breast cancer care.

Because barriers to care are often complex and involve multiple systems, **proposed programs are required to provide proof of partnership with external organizations/providers that demonstrate cooperation in addressing system fragmentation.**

Applicants may request up to \$100,000 per year for up to two years for project submitted under Priority II.

ELIGIBILITY

Applicant organizations/institutions **must be federally tax-exempt, non-profit entities providing services within the described priority communities.**

Any past and/or current Komen-funded grants or awards must be up-to-date and in compliance with Komen requirements.

Organizations with a current Komen Community Health Grant with an active term through March 2017 from Komen are not eligible to apply for funding.

FUNDING INFORMATION AND RESTRICTIONS

- Projects must be specific to breast health and/or breast cancer
- An organization may serve as the primary agency (agency that will manage the funds and report on the project) on only one application. Organizations may serve as collaborators on more than one application.
- Only organizations applying for Priority II may request funds for direct patient costs.
- Komen encourages leveraging funds from multiple funders to support program implementation to address demonstrated, immense community needs and gaps.
- If the Applicant organization is receiving in-kind support, please include a letter from a senior official of the institution providing the support, confirming the type of support and value in dollars. This letter should be uploaded under “Letters of Support” on the budget summary page in the system.
- Salaries, if requested, are for personnel related to this project only and not general work of applicant.
- **Funds may be used for the following types of program expenses:**
 - Salaries and fringe benefits for program staff
 - Consultant fees
 - Meeting costs
 - Supplies
 - Reasonable travel costs related to the execution of the program
 - Other direct program expenses including **(for Priority II organizations only):**
 - Screening or Diagnostic Services, including:
 - Clinical breast exams
 - Screening mammograms
 - Diagnostic mammograms
 - Breast ultrasounds

- Breast biopsies
 - MRI's
- Transportation assistance
- Childcare assistance
- Translation services
- Genetic testing to inform treatment decisions
- Equipment, not to exceed \$5,000
- Indirect costs, not to exceed 10% of total direct costs
 - This includes costs the organization would incur regardless of the project such as rent, telephone, internet, etc.
- **Funds may NOT be used for:**
 - Breast thermography
 - Treatment, including:
 - Surgery
 - Chemotherapy
 - Radiation therapy
 - Targeted therapy
 - Hormonal therapy
 - Wigs or scarves
 - Mastectomy bras
 - Research, which is defined as any project or program with the primary goal of gathering and analyzing data or information.
 - Specific examples include, but are not limited to, projects or programs designed to:
 - Understand the biology and/or causes of breast cancer
 - Improve existing or develop new screening or diagnostic methods
 - Identify approaches to breast cancer prevention or risk reduction
 - Improve existing or develop new treatments for breast cancer or to overcome treatment resistance, or to understand post-treatment effects
 - Organizational/Institutional liability coverage
 - Professional dues or memberships fees
 - Education regarding breast self-exams/use of breast models
 - Health Fairs
 - Development of educational materials
 - Outreach via mass media
 - Patient incentives
 - Construction or renovation of facilities
 - Political campaigns or lobbying
 - Endowments
 - General operating funds (except indirect cost)
 - Debt reduction
 - Annual fund-raising campaigns
 - Event sponsorships
 - Projects completed before the date of grant approval

- Building/renovation
- Capital campaigns
- Employee matching gifts
- Land acquisition
- Program-related investments/loans
- Scholarships or fellowships

RESPONSIBILITIES OF GRANTEES

All Grantees will be required to submit semi-annual progress and financial reports and a final report to include final expenditures. In addition, grantees will be required to submit a one page summary report to include notable lessons learned, challenges, successes and overall accomplishments of the program. This document will be shared with other breast health programs in the region in order to add to the body of literature on the topic and to benefit the breast cancer community at large. All reports will be submitted electronically via Komen's online Grants eManagement System (GeMS).

EDUCATIONAL MATERIALS AND MESSAGES

Susan G. Komen® is a source of information about breast cancer for people all over the world. **To reduce confusion and reinforce learning, we require that grantees provide educational messages and materials that are consistent with those promoted by Komen, including promoting the breast self-awareness messages - know your risk, get screened, know what is normal for you and make healthy lifestyle choices.**

Komen NCR Grantees must use/distribute only Komen-developed or Komen-approved educational resources, including messages, materials, toolkits or online content during their grant period. This is to ensure that all breast cancer messaging associated with the Komen name or brand are safe, accurate, based on evidence and consistent and to avoid expense associated with the duplication of effort to develop educational resources. If Grantees intend to develop educational materials that are otherwise not provided by Komen, they must be approved by Komen Headquarters prior to development.

The consistent and repeated use of the same messages will improve retention and the adoption of the action we think are important. Please visit the following webpage before completing your application and be sure that your organization can agree to promote these messages:

<http://ww5.komen.org/BreastCancer/BreastSelfAwareness.html>.

Komen does not recommend monthly breast self-exams and therefore will not fund programs that teach monthly breast self-exams or use breast models. To learn more, visit <http://ww5.komen.org/BreastCancer/BreastSelfExam.html>.

Susan G. Komen® grantees are eligible to receive preferred pricing for Komen educational materials. Komen materials should be used and displayed whenever possible. To view our educational materials, visit <http://www.shopkomen.com/>

Additional Komen educational resources can also be located on www.komen.org at the following links:

- Komen Educational Materials: <http://ww5.komen.org/BreastCancer/KomenEducationalMaterials.html>
- Komen Translated Materials: <http://ww5.komen.org/translations.html>
- Breast Cancer Education Toolkits: <http://komentoolkits.org>

SELECTION CRITERIA

Applications will be reviewed by a committee of experts in breast cancer care, grantmaking, nonprofit administration, program management, and public health. They will consider each of the selection criteria listed below. Final funding decisions will be made by Susan G. Komen leadership.

Statement of Need: Will the program benefit one or more of the priority communities described in the RFA? How closely does the program align with the funding priorities stated in the RFA?

Program Design/Collaboration: Is the program culturally competent? How well does this application utilize evidence-based theories/public health practices? How likely is it that the objectives and activities will be achieved within the scope of the funded program? Is the program well planned? Is the budget appropriate and realistic? Does the budget justification explain in detail the reasoning and need for the costs associated with the program? Does the application propose collaborations with appropriate organizations, **as required by the RFA?** Do the proposed collaborations clearly delineate how participants will progress through the breast health CoC? Are collaborations likely to be sustained beyond the grant term?

Impact: Will the program have a substantial positive impact on increasing the percentage of people who enter, stay in, or progress through the continuum of care? Will the program have a substantial impact on the need described in the funding priority selected? Is the impact likely to be long-term?

Organization Capacity: Does the applicant organization, Project Director and his/her team have the expertise to effectively implement all aspects of the program? Is there evidence of success in delivering services to the target population? Is the organization fiscally capable of managing the grant program, including having appropriate financial controls in place? Does the applicant organization have the equipment, resources, tools, space, etc., to implement all aspects of the program? Does the organization or staff have appropriate licenses, certifications, accreditations, etc. to deliver the proposed services? Does the organization have a plan to obtain the resources (financial, personnel, partnerships, etc.) needed to sustain the program beyond the grant term (if awarded)? Does the applicant organization have long-term support from organizational leadership?

Monitoring and Evaluation: Is there a documented plan to measure progress against the stated program goal and objectives, and the resulting outputs and outcomes? Is there sufficient monitoring and evaluation (M&E) expertise for the program? Are there sufficient resources in place for M&E efforts?

ONLINE APPLICATION INSTRUCTIONS

The Susan G. Komen® Community Grants Program uses an online grant application process. All applications and attachments must be submitted using the Komen Grants eManagement System (GeMS).

To access the system and register, please go to: <https://affiliategrants.komen.org>

To Register for GeMS:

- Access the following website: <https://affiliategrants.komen.org>
- Click “register now”
- Complete the registration form with the following information:
 - For position at your Affiliate, select “Applicant” – click the pink go button
 - For Affiliate State, select “District of Columbia” – click the pink go button
 - For Affiliate, select “Global Race for the Cure” – click the pink go button
 - Select your organization from the drop down menu. If your organization is not listed select “other” in the drop down menu, click the pink go button and complete the Organization section that will appear

Completed applications and all attachments must be submitted via the online system, on or before Thursday, January 14, 2016 at 1:00PM Eastern Time. NOTE: Susan G. Komen’s Grants eManagement System (GeMS) will stop accepting new applications on Friday, January 8, 2016 1:00PM EDT. Applications not submitted but started prior to this date will still have access to edit and submit by January 14, 2016 1:00PM EDT.

Applicants must follow the application submission instructions, including character counts, and submission of required application materials. All application materials must be in English and must be submitted online in GeMS. No paper applications or applications sent by email will be accepted.

Failure to adhere to these instructions will result in applications being administratively withdrawn from consideration, without appeal.

Applicants are strongly encouraged to complete, review and submit their applications with sufficient time to allow for technical difficulties, varying time zones, human error, loss of power/internet, sickness, travel, etc.

Extensions to the submission deadline will not be granted to allow for lateness, corrections or submissions of missing information, confusion about time zone, or for not starting an application by January 8, with the rare exception made for severe extenuating circumstances at the sole discretion of Komen.

Additional Support: If you have questions or need assistance with the use of GeMS, please email nationalcapitalarea@komen.org.

Below please see details regarding each section of the application that must be completed in the online application:

Project Profile

This section collects basic organization and project information, including the title of the project, contact information and partner organizations.

Required attachments for the Project Profile page:

- **Letters of support or memoranda of understanding from proposed collaborators**– To describe the nature of the collaboration and the services/expertise/personnel to be provided through the collaboration.
- If the Applicant organization is receiving in-kind support, please include a letter from a senior official of the institution providing the support, confirming the type of support and value in dollars.

Organization Summary

This section collects detailed information regarding your organization's history, mission, programs, staff/volunteers, budget, and social media.

Project Priorities and Abstract (limit 3,000 characters)

This section collects important information to classify the focus of the project, the priorities to be addressed and a summary of the project (abstract). This abstract should include the target communities to be served, the need to be addressed, a description of activities, the expected number of individuals served and the expected change your program will likely bring in your community. The abstract is typically used by Komen in public communications about funded projects.

Project Narrative

This is the core piece of the application. On the Project Narrative page of the application in GeMS, please address the requests below for each section.

Statement of Need (limit- 5,000 characters)

- Describe the population to be served.
- Describe evidence of the risk/need within that population, using the RFA funding priorities and Susan G. Komen National Capital Region Community Profile Overview (page 16) as a guide.
- Provide population characteristics (race, ethnicity, economic status, and breast cancer statistics) specific to the target population.
- Describe how this program aligns with Komen National Capital Region target communities and/or RFA funding priorities.

Program Design (limit- 5,000 characters)

- Explain the program's goal and objectives, as outlined in your Project Work Plan.
- Explain how the program will increase the percentage of people who enter, stay in, or progress through the continuum of care.
- Explain how the program is culturally competent.

- Explain how the program incorporates an evidence-based intervention (please cite references).
- Describe program collaboration and the roles and responsibilities of all organizations or entities participating in the program.
- Explain how the collaboration strengthens the program and why partnering organizations are best suited to assist in carrying out the program and accomplishing the goal and objectives set forth in this application.

Organization Capacity (limit- 5,000 characters)

- Explain why the applicant organization, Project Director and staff are best-suited to lead the program and accomplish the goals and objectives set forth in this application. Please include appropriate organization or staff licenses, certifications and/or accreditations.
- Describe evidence of success in delivering breast health/cancer services to the proposed population. If the breast health/cancer program is newly proposed, describe relevant success with other programs.
- Describe the equipment, resources, tools, space, etc., that the applicant organization possesses or will utilize to implement all aspects of the program.
- Describe fiscal capability to manage the delivery of the proposed goals and objectives and ensure adequate measures for internal control of grant dollars.
- Describe the organization's current financial state. How has your organizational budget changed over the last three years? Please explain increase or decrease.
- Describe the plan to secure and allocate resources (financial, personnel, partnerships, etc.) to sustain the program at the conclusion of the grant period.
- Describe the efforts you will take to communicate this program to your organizational leadership to ensure long-term support/buy-in.

Monitoring and Evaluation (limit- 5,000 characters)

Grantees will be required to report on the following outputs and outcomes in the progress and final reports: successes and accomplishments, challenges, lessons learned, best practice example, story from an individual that was served with the funding and number of individuals served for each objective (county, race and ethnicity, age and population group).

- Describe in detail how the organization(s) will measure progress against the stated program goal and objectives. Please include any templates, logic models, or surveys as attachments in the Project Work Plan – Objectives page.
- Describe how the organization(s) will assess how the program had an effect on the selected priority. Please include any templates, logic models, or surveys as attachments in the Project Work Plan – Objectives page.
- Describe how the organization(s) will assess program delivery. Please include any templates, logic models, or surveys as attachments in the Project Work Plan – Objectives page.
- Describe the monitoring and evaluation (M&E) expertise that will be available for this purpose.
- Describe the resources available for M&E during the course of the program. Specify if these resources are requested as part of this grant, or if they are existing organizational resources.

Project Target Demographics

This section collects information regarding the various groups you intend to target with your program. This does not include every demographic group your program will serve, but should be based on the groups on which you plan to focus your program's attention.

Project Work Plan

In the Project Work Plan component of the application on GeMS, you will be required to submit the goal and objectives:

- **Goals** are high level statements that provide overall context for what the program is trying to achieve.
- **Objectives** are specific statements that describe what the program is trying to achieve to meet the Goal. An objective should be evaluated at the end of the program to establish if it was met or not met.

The project goal should have at least one objective; there is no limit to the number of objectives that you include. Please ensure that all objectives are SMART objectives:

Specific
Measurable
Attainable
Realistic
Time-bound

You will also be required to submit timelines, the anticipated number of individuals to be served, and the evaluation method you will utilize for each objective.

Write your Project Work Plan with the understanding that each item must be accounted for during progress reporting. The Project Work Plan should include only one goal that will be accomplished with funds requested from Komen. Objectives that will be funded by other means should **not** be reported here, but instead, can be included in your overall program description.

Example Work Plan

GOAL: Provide patient navigation to women with screening abnormalities in order to reduce delays in and barriers to diagnostic care.

OBJECTIVE 1: During grant period, patient navigator will contact all women with an abnormal screening within three business days to schedule follow-up appointment.

OBJECTIVE 2: By end of grant period, provide 30 uninsured/underinsured women free/reduced cost diagnostic procedures.

Attachments for the Project Work Plan page:

- **Monitoring and Evaluation forms, surveys, logic model, etc.** – To monitor progress and determine the effectiveness of the proposed program.

Budget

Provide a detailed total program budget for the entire requested grant term. Budget sections include Key Personnel/Salaries, Consultants, Supplies, Travel, Patient Care, Sub-Contracts, Indirect, and Other. For each line item in the budget, provide a brief justification for how the funds will be used and why they are programmatically necessary.

Required Attachments

Letters of Support –

- **Letters of support or memorandums of understanding** – Partnerships and collaboration are required for each proposed program. A letter of memorandum must be attached for each partner. The letter or memorandum should specifically describe the partnership activities and must not be duplicative across organizations (*i.e. this should not be a template letter*).
- If the Applicant organization is receiving in-kind support, please include a letter from a senior official of the institution providing the support, confirming the type of support and value in dollars.

Attachments Needed for Key Personnel/Salaries Section:

- **Resume/Job Description** – For key personnel that are currently employed by the applicant organization, provide a resume or *curriculum vitae*. For new or vacant positions, provide a job description (*Two page limit per individual*).

Monitoring and Evaluation:

- **Forms, surveys, logic model, of other evaluation materials** that detail the information to be collected to gather outcomes on services provided to monitor progress and determine the effectiveness of the proposed program.

Attachments Needed for the Project Budget Summary Section:

- **Proof of Tax Exempt Status** – To document your federal tax-exempt status, attach your determination letter from the Internal Revenue Service. Evidence of state or local exemption will not be accepted. Please do not attach your Federal tax return. To request verification of your organization's tax-determination status, visit the following page on the IRS Web site:
<http://www.irs.gov/Charities-& Non-Profits/EO-Operational-Requirements:-Obtaining-Copies-of-Exemption-Determination-Letter-from-IRS>

Completed applications and all attachments must be submitted via the online system, on or before **Thursday, January 14, 2016** at 1:00PM Eastern Daylight Time.

Additional Support: If you have questions or need assistance please email
nationalcapitalarea@komen.org.

ⁱ Susan G. Komen. (2014). *Susan G. Komen National Capital Region quantitative data report: 2014*. Dallas, TX: Author. ⁱⁱ Henley SJ, King JB, German RR, Richardson LC, PLesica M; Centers for Disease Control and Prevention (CDC). Surveillance of screening-detected cancers (colon and

rectum, breast and cervix)- United States, 2004-2006. MMWR Surveillance Summaries 2010; 59(9):1-25.

ⁱⁱⁱ American Cancer Society, Breast Cancer Facts & Figures 2011-2012.

^{iv} American Cancer Society, Cancer Facts & Figures for African Americans 2013-2014

^v American Cancer Society, Cancer Facts & Figures for Hispanics/Latinos 2012-2014.

^{vi} The Guide to Community Preventive Services. Cancer prevention & control, client-oriented screening interventions: client reminders. Available online at:

<http://www.thecommunityguide.org/cancer/index/html>.

APPENDIX A: Susan G. Komen National Capital Region Community Profile Overview

Quantitative Data Report

Introduction

The purpose of the quantitative data report for Susan G. Komen® National Capital Region 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 the National Capital Region's 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 National Capital Region's Quantitative Data Report.

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 (Tables 2.1 and 2.2). 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 (Tables 2.1 and 2.2). 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, National Capital Region.

		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	-
District of Columbia	308,298	441	139.7	0.7%	98	29.8	NA	181	58.0	-4.3%
Maryland	2,942,268	4,206	128.0	1.7%	818	24.5	-2.0%	1,521	46.4	-0.5%
Virginia	3,993,827	5,420	124.8	1.3%	1,074	24.0	-1.9%	1,896	43.9	0.1%
Komen National Capital Region Service Area	2,324,241	2,939	126.0	1.3%	550	23.5	NA	1,064	45.2	-0.9%
White	1,323,847	1,822	130.6	1.6%	305	21.3	NA	592	42.4	0.3%
Black/African-American	718,248	853	122.6	1.2%	223	32.2	NA	377	53.6	-2.8%
AIAN	17,456	6	63.7	-1.7%	SN	SN	SN	SN	SN	SN
API	264,690	179	75.0	3.4%	22	9.2	NA	67	27.6	2.5%
Non-Hispanic/ Latina	2,009,819	2,791	130.2	1.4%	531	24.5	NA	1,006	46.7	-1.0%
Hispanic/ Latina	314,422	147	77.2	1.7%	18	9.8	NA	58	26.7	1.7%
District of Columbia - DC	308,298	441	139.7	0.7%	98	29.8	-2.3%	181	58.0	-4.3%
Montgomery County - MD	492,599	720	127.5	-0.5%	115	19.6	-3.0%	230	40.9	-4.4%
Prince George's County - MD	444,819	532	118.5	0.2%	121	27.8	-1.8%	214	47.0	-7.3%
Arlington County - VA	99,145	118	130.8	3.1%	20	21.9	-2.4%	39	43.7	-3.0%
Fairfax County - VA	530,502	693	126.7	1.7%	113	21.6	-2.5%	227	40.9	3.0%
Loudoun County - VA	147,541	144	122.5	-1.1%	23	21.2	-2.2%	49	41.9	-2.0%
Prince William County - VA	190,490	186	116.0	0.7%	34	22.7	-2.2%	67	40.8	2.5%
Alexandria City - VA	69,407	83	121.4	5.6%	16	23.0	15.7%	30	44.6	5.9%
Fairfax City - VA	11,197	17	124.8	-3.7%	4	32.0	-3.3%	5	37.9	-29.5%
Falls Church City - VA	5,868	9	143.5	25.7%	SN	SN	SN	4	51.3	48.7%
Manassas City - VA	17,895	18	118.3	5.4%	3	24.0	-2.7%	7	43.7	-7.9%
Manassas Park City - VA	6,482	4	93.7	6.0%	SN	SN	SN	SN	SN	SN

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 2005-2009 for incidence and late-stage data and 2006-2010 death data.

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 mortality data in SEER*Stat.

Source of death trend data: NCI/CDC State Cancer Profiles.

Table 2.2. Female breast cancer incidence and death rates, District of Columbia.

Population Group	Incidence		Deaths	
	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	# of Deaths (Annual Average)	Age-adjusted Rate/ 100,000
US	198,602	122.1	40,736	22.6
Komen National Capital Region Service Area	2,939	126.0	550	23.5
District of Columbia - DC	432	137.2	96	29.3
White	141	168.4	22	24.7
Black/African-American	266	127.0	71	33.1
Ward 1 – DC	38	110.8	7	21.8
Ward 2 – DC	38	124.9	11	35.7
Ward 3 – DC	74	154.1	13	23.4
Ward 4 – DC	69	125.9	15	27.4
Ward 5 – DC	61	124.9	17	33.9
Ward 6 – DC	50	135.1	10	26.2
Ward 7 – DC	49	109.5	14	30.1
Ward 8 – DC	43	146.0	8	30.9

Data are for years 2005-2009, except for the US and Komen National Capital Region Service Area which are for 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 data for US and Komen National Capital Region Service Area: NAACCR – CINA Deluxe Analytic File.

Source of death data for US and Komen National Capital Region Service Area: CDC – NCHS mortality data in SEER*Stat.

District of Columbia data contained in this table were provided by the District of Columbia Cancer Registry, District of Columbia Department of Health, program funded by NPCR – CDC.

Incidence rates and trends summary

Overall, the breast cancer incidence rate in the Komen National Capital Region (NCR) service area was slightly higher than that observed in the US as a whole and the incidence trend was higher than the US as a whole. The incidence rate of the NCR service area was significantly lower than that observed for the District of Columbia and the incidence trend was not significantly different than the District of Columbia. The incidence rate and trend of the NCR service area were not significantly different than that observed for the State of Maryland. The incidence rate and trend of the NCR service area were not significantly different than that observed for the State of Virginia.

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 NCR service area as a whole, the incidence rate was lower among Blacks 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.

The following area had an incidence rate **significantly higher** than the NCR service area as a whole:

- District of Columbia, DC

The incidence rate was significantly lower in the following county:

- Prince George's County, MD

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

In the District of Columbia, Wards 3, 6, and 8 have the highest breast cancer incidence rates. Like the NCR service area as a whole, the incidence rate was lower among Blacks/African-Americans than Whites in the District of Columbia.

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 National Capital Region service area was similar to 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 NCR service area was significantly lower than that observed for the District of Columbia. The death rate of the NCR service area was not significantly different than that observed for the State of Maryland. The death rate of the NCR service area was not significantly different than that observed for the State of Virginia.

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 NCR 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 NCR 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 areas had a death rate **significantly higher** than the NCR service area as a whole:

- District of Columbia, DC
- Prince George's County, MD

The death rate was significantly lower in the following county:

- Montgomery County, MD

Significantly more favorable trends in breast cancer death rates were observed in the following county:

- Montgomery County, MD

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

In the District of Columbia, Wards 2, 5, 7, and 8 have the highest breast cancer death rates. Like the NCR service area as a whole, the death rate was higher among Blacks/African-Americans than Whites in the District of Columbia.

Late-stage incidence rates and trends summary

Overall, the breast cancer late-stage incidence rate and trend in the Komen National Capital Region service area were slightly higher than that observed in the US as a whole. The late-stage incidence rate of the NCR service area was significantly lower than that observed for the District of Columbia and the late-stage incidence trend was not significantly different than the District of Columbia. The late-stage incidence rate and trend of the NCR service area were not significantly different than that observed for the State of Maryland. The late-stage incidence rate and trend of the NCR service area were not significantly different than that observed for the State of Virginia.

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 NCR 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 NCR 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.

The following area had a late-stage incidence rate **significantly higher** than the NCR service area as a whole:

- District of Columbia, DC

The late-stage incidence rate was significantly lower in the following counties:

- Montgomery County, MD
- Fairfax County, VA

Significantly less favorable trends in breast cancer late-stage incidence rates were observed in the following area:

- Falls Church City, VA

The rest of the counties had late-stage incidence rates and trends that were not significantly different than the NCR service area as a whole or did not have enough data available.

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 2.3 shows some screening recommendations among major organizations for women at average risk. Komen maintains the position that individuals of any age should have access to screening mammograms if need is determined by healthcare providers.

Table 2.3. 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		Informed decision-making with a health care provider ages 40-49
Mammography every year starting at age 45	Mammography every year starting at age 40	Mammography every 2 years ages 50-74
Mammography every other year beginning at age 55		

*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 whom 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 who 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 2.4 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 2.4. 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%
District of Columbia	1,407	1,177	83.7%	80.8%-86.2%
Maryland	5,028	4,096	82.6%	81.2%-83.9%
Virginia	2,644	2,156	79.8%	77.8%-81.7%
Komen National Capital Region Service Area	2,838	2,380	84.3%	82.5%-86.0%
White	1,542	1,265	83.9%	81.5%-86.0%
Black/African-American	1,126	975	88.1%	85.3%-90.4%
AIAN	14	12	94.5%	52.5%-99.6%
API	63	53	76.8%	60.8%-87.6%
Hispanic/ Latina	77	65	81.8%	67.0%-90.8%
Non-Hispanic/ Latina	2,747	2,305	84.5%	82.7%-86.2%
District of Columbia - DC	1,405	1,175	83.6%	80.8%-86.1%
Montgomery County - MD	504	413	81.8%	77.2%-85.7%
Prince George's County - MD	419	362	88.1%	83.6%-91.5%
Arlington County - VA	54	50	93.9%	79.7%-98.4%
Fairfax County - VA	214	178	84.0%	76.6%-89.4%
Loudoun County - VA	64	48	74.6%	59.7%-85.3%
Prince William County - VA	81	68	83.8%	70.4%-91.9%
Alexandria City - VA	48	44	90.6%	74.5%-96.9%
Fairfax City - VA	46	39	84.0%	66.0%-93.4%
Falls Church City - VA	SN	SN	SN	SN
Manassas City - VA	SN	SN	SN	SN
Manassas Park City - VA	SN	SN	SN	SN

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 National Capital Region service area was significantly higher than that observed in the US as a whole. The screening proportion of the NCR service area was not significantly different than the District of Columbia, was not significantly different than the State of Maryland and was significantly higher than the State of Virginia.

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 NCR service area as a whole, the screening proportion was not significantly different among Blacks/African-Americans than Whites, not significantly different among APIs than Whites, and not significantly different among AIANs than Whites. The screening proportion among Hispanics/Latinas was not significantly different than among Non-Hispanics/Latinas.

None of the counties in the NCR service area had substantially different screening proportions than the NCR 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 2.5, 2.6, 2.7 and 2.8). 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 2.5. Population characteristics – demographics, National Capital Region.

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 %
District of Columbia	41.1 %	53.7 %	0.6 %	4.6 %	91.3 %	8.7 %	41.5 %	29.8 %	12.9 %
Maryland	61.1 %	32.0 %	0.6 %	6.4 %	92.2 %	7.8 %	49.4 %	34.4 %	13.9 %
Virginia	71.9 %	21.1 %	0.6 %	6.5 %	92.3 %	7.7 %	48.5 %	33.9 %	13.9 %
Komen National Capital Region Service Area	56.7 %	30.5 %	0.8 %	12.0 %	85.4 %	14.6 %	45.5 %	30.4 %	11.3 %
District of Columbia - DC	41.1 %	53.7 %	0.6 %	4.6 %	91.3 %	8.7 %	41.5 %	29.8 %	12.9 %
Montgomery County - MD	64.1 %	19.7 %	0.7 %	15.5 %	83.3 %	16.7 %	50.1 %	34.7 %	14.0 %
Prince George's County - MD	24.8 %	69.4 %	1.1 %	4.7 %	86.7 %	13.3 %	46.0 %	30.9 %	11.0 %
Arlington County - VA	77.8 %	9.9 %	0.9 %	11.4 %	85.3 %	14.7 %	38.8 %	25.7 %	9.7 %
Fairfax County - VA	69.0 %	10.7 %	0.7 %	19.7 %	84.8 %	15.2 %	47.7 %	31.8 %	11.0 %
Loudoun County - VA	74.1 %	8.9 %	0.5 %	16.5 %	87.8 %	12.2 %	41.6 %	23.5 %	7.6 %
Prince William County - VA	66.4 %	23.2 %	1.2 %	9.3 %	80.4 %	19.6 %	41.3 %	25.0 %	7.9 %
Alexandria City - VA	68.2 %	23.5 %	0.8 %	7.6 %	84.7 %	15.3 %	42.5 %	28.3 %	10.4 %
Fairfax City - VA	75.4 %	6.5 %	1.1 %	17.0 %	84.3 %	15.7 %	50.3 %	35.7 %	15.6 %
Falls Church City - VA	82.9 %	5.2 %	0.4 %	11.5 %	90.8 %	9.2 %	50.4 %	33.9 %	11.6 %
Manassas City - VA	76.0 %	16.6 %	1.2 %	6.2 %	70.1 %	29.9 %	40.2 %	25.7 %	8.1 %
Manassas Park City - VA	72.0 %	15.9 %	1.5 %	10.6 %	68.0 %	32.0 %	34.5 %	19.8 %	6.2 %

Data are for 2011.

Data are in the percentage of women in the population.

Source: US Census Bureau – Population Estimates

Table 2.6. Population characteristics – demographics, District of Columbia.

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
District of Columbia	38.5 %	50.7 %	0.3 %	3.6 %	90.9 %	9.1 %	41.5 %	29.8 %	12.9 %
Ward 1	48.4%	32.5%	0.5%	4.2%	79.2%	20.8%	30.2%	20.0%	8.4%
Ward 2	71.7%	12.6%	0.3%	8.8%	90.5%	9.5%	27.8%	20.5%	9.1%
Ward 3	83.5%	5.0%	0.2%	6.7%	92.5%	7.5%	45.3%	33.5%	15.3%
Ward 4	24.5%	58.7%	0.4%	1.7%	81.3%	18.7%	52.7%	39.1%	18.2%
Ward 5	16.5%	76.0%	0.4%	1.4%	93.7%	6.3%	49.2%	36.6%	17.0%
Ward 6	49.7%	41.6%	0.4%	4.2%	95.2%	4.8%	29.1%	16.6%	11.1%
Ward 7	1.8%	94.9%	0.3%	0.2%	97.7%	2.3%	49.2%	35.3%	15.1%
Ward 8	3.7%	93.5%	0.2%	0.4%	98.2%	1.8%	38.0%	25.5%	8.8%

Race data include categories (not shown) "Some other Race" and "Two or More Races", so total percentages do not equal 100 percent.

Race data includes the percentage of people (men and women) in the population

Source of District of Columbia Race/Ethnicity Data: US Census Bureau, 2010

Source of Ward Data: District of Columbia Census 2010 Demographic Housing Profiles by Ward—DC Office of Planning

Table 2.7. Population characteristics – socioeconomics, National Capital Region.

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 Underserved 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 %
District of Columbia	12.9 %	18.2 %	34.2 %	10.0 %	13.3 %	2.6 %	0.0 %	27.7 %	7.9 %
Maryland	11.8 %	9.0 %	22.8 %	7.3 %	13.5 %	3.2 %	12.8 %	17.4 %	11.1 %
Virginia	13.4 %	10.7 %	26.9 %	6.5 %	11.0 %	2.7 %	24.5 %	27.2 %	13.3 %
Komen National Capital Region Service Area	10.2 %	7.8 %	18.4 %	6.4 %	24.2 %	5.7 %	2.4 %	7.7 %	11.2 %
District of Columbia - DC	12.9 %	18.2 %	34.2 %	10.0 %	13.3 %	2.6 %	0.0 %	27.7 %	7.9 %
Montgomery County - MD	8.9 %	6.3 %	16.1 %	5.7 %	31.4 %	7.6 %	2.4 %	6.2 %	11.7 %
Prince George's County - MD	14.2 %	8.2 %	22.9 %	8.8 %	19.8 %	4.0 %	2.0 %	11.6 %	13.9 %
Arlington County - VA	7.4 %	7.1 %	12.4 %	3.4 %	23.4 %	4.5 %	0.0 %	0.0 %	7.9 %
Fairfax County - VA	8.1 %	5.5 %	14.0 %	4.7 %	29.0 %	7.3 %	1.4 %	0.0 %	10.6 %
Loudoun County - VA	6.4 %	3.4 %	9.5 %	4.3 %	22.2 %	4.8 %	12.6 %	9.8 %	7.9 %
Prince William County - VA	11.4 %	5.6 %	16.8 %	5.4 %	21.3 %	6.1 %	4.2 %	0.0 %	13.9 %
Alexandria City - VA	9.0 %	7.8 %	16.4 %	4.5 %	24.5 %	5.8 %	0.0 %	0.0 %	10.6 %
Fairfax City - VA	6.7 %	5.9 %	13.7 %	4.4 %	24.2 %	4.6 %	0.0 %	0.0 %	10.4 %
Falls Church City - VA	4.0 %	3.9 %	6.3 %	6.3 %	20.2 %	2.5 %	0.0 %	0.0 %	5.3 %
Manassas City - VA	19.8 %	13.8 %	24.5 %	7.3 %	24.5 %	13.5 %	0.0 %	0.0 %	17.0 %
Manassas Park City - VA	17.9 %	4.3 %	28.0 %	4.9 %	31.0 %	12.4 %	0.0 %	0.0 %	19.4 %

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.

Table 2.8. Population characteristics – socioeconomics, District of Columbia.

Population Group	Less than HS Education	Income Below 100% Poverty	Income Below 250% Poverty (Age: 40-64)	Un-employed	Foreign Born	Linguistically Isolated	In Rural Areas	In Medically Underserved Areas	No Health Insurance (Age: 40-64)
District of Columbia	12.9 %	18.2 %	34.2 %	10.0 %	13.3 %	2.6 %	0.0 %	27.7 %	7.9 %
Ward 1	15.9%	15.0%	NA	8.7%	20.0%	NA	0.0%	NA	22.7%
Ward 2	7.3%	15.0%	NA	5.0%	19.5%	NA	0.0%	NA	9.7%
Ward 3	2.9%	7.9%	NA	2.6%	18.1%	NA	0.0%	NA	7.4%
Ward 4	15.9%	12.0%	NA	8.3%	20.3%	NA	0.0%	NA	18.7%
Ward 5	18.3%	20.0%	NA	13.7%	9.7%	NA	0.0%	NA	12.2%
Ward 6	10.0%	16.0%	NA	10.2%	9.4%	NA	0.0%	NA	5.4%
Ward 7	16.6%	26.0%	NA	16.8%	2.8%	NA	0.0%	NA	18.1%
Ward 8	19.4%	36.0%	NA	24.9%	2.7%	NA	0.0%	NA	5.7%

NA- Not available

Data are in the percentage of people (men and women) in the population.

Source of Ward level education level, poverty and foreign born data: Census Bureau- American Community Survey (ACS) for 2007-2011

Source of Ward level unemployment rate: Office of Labor Market Research and information estimates for 2012

Source of Ward level rural population data: US Census Bureau – Census 2010.

Source of Ward level health insurance data: Urban Institute tabulations on the 2009 DC Health Insurance Survey (DC-HIS)

Population characteristics summary

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

National Capital Region

The following areas have substantially larger Black/African-American female population percentages than that of the NCR service area as a whole:

- District of Columbia, DC
- Prince George's County, MD

The following areas have substantially larger API female population percentages than that of the NCR service area as a whole:

- Montgomery County, MD
- Fairfax County, VA
- Loudoun County, VA

- Fairfax City, VA

The following areas have substantially larger Hispanic/Latina female population percentages than that of the NCR service area as a whole:

- Manassas City, VA
- Manassas Park City, VA

The following areas have substantially lower education levels than that of the NCR service area as a whole:

- Manassas City, VA
- Manassas Park City, VA

The following areas have substantially lower income levels than that of the NCR service area as a whole:

- District of Columbia, DC
- Manassas City, VA

The following area has substantially lower employment levels than that of the NCR service area as a whole:

- District of Columbia, DC

The area with substantial foreign born and linguistically isolated populations is:

- Manassas Park City, VA

The following areas have substantially larger percentage of adults without health insurance than does the NCR service area as a whole:

- Manassas City, VA
- Manassas Park City, VA

District of Columbia

The following Wards have substantially larger Black/African-American female population percentages than that of the District of Columbia as a whole:

- Ward 4
- Ward 5
- Ward 7
- Ward 8

The following Wards have a substantially larger API female population than that of the District of Columbia as a whole:

- Ward 2
- Ward 3

The following Wards have substantially larger Hispanic/Latina female population percentages than that of the District of Columbia as a whole:

- Ward 1
- Ward 4

The following Ward has a substantially larger older female population than the District Columbia as a whole:

- Ward 4

The following Wards have substantially lower education levels than the District Columbia as a whole:

- Ward 5
- Ward 8

The following Wards have substantially lower income levels (below 100 percent poverty level) than the District of Columbia as a whole:

- Ward 7
- Ward 8

The following Wards have substantially lower employment levels than the District Columbia as a whole:

- Ward 7
- Ward 8

The following Wards have substantially larger percentage of adults without health insurance than the District Columbia as a whole:

- Ward 1
- Ward 4
- Ward 5
- Ward 7

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: 41.0 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 National Capital Region 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 2.9):

- 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 2.9. 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.

Affiliate Service Area Healthy People 2020 Forecasts and Priority Areas

The results presented in Table 2.10 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 2.10. Intervention priorities for Komen National Capital Region 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
Alexandria City - VA	Highest	13 years or longer	13 years or longer	
Falls Church City - VA	Highest	SN	13 years or longer	
District of Columbia - DC	High	13 years or longer	8 years	%Black/African-American, poverty, employment, medically underserved
Prince George's County - MD	Medium High	13 years or longer	2 years	%Black/African-American
Fairfax County - VA	Medium High	2 years	13 years or longer	%API
Prince William County - VA	Medium High	5 years	13 years or longer	
Fairfax City - VA	Medium	13 years or longer	Currently meets target	%API
Arlington County - VA	Medium Low	3 years	3 years	
Loudoun County - VA	Medium Low	2 years	1 year	%API, rural
Manassas City - VA	Medium Low	6 years	1 year	%Hispanic, education, poverty, language, insurance
Montgomery County - MD	Lowest	Currently meets target	Currently meets target	%API, foreign
Manassas Park City - VA	Undetermined	SN	SN	%Hispanic, education, foreign, language, insurance

Map of Intervention Priority Areas

Figure 2.1 shows a map of the intervention priorities for the counties in the Affiliate 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.

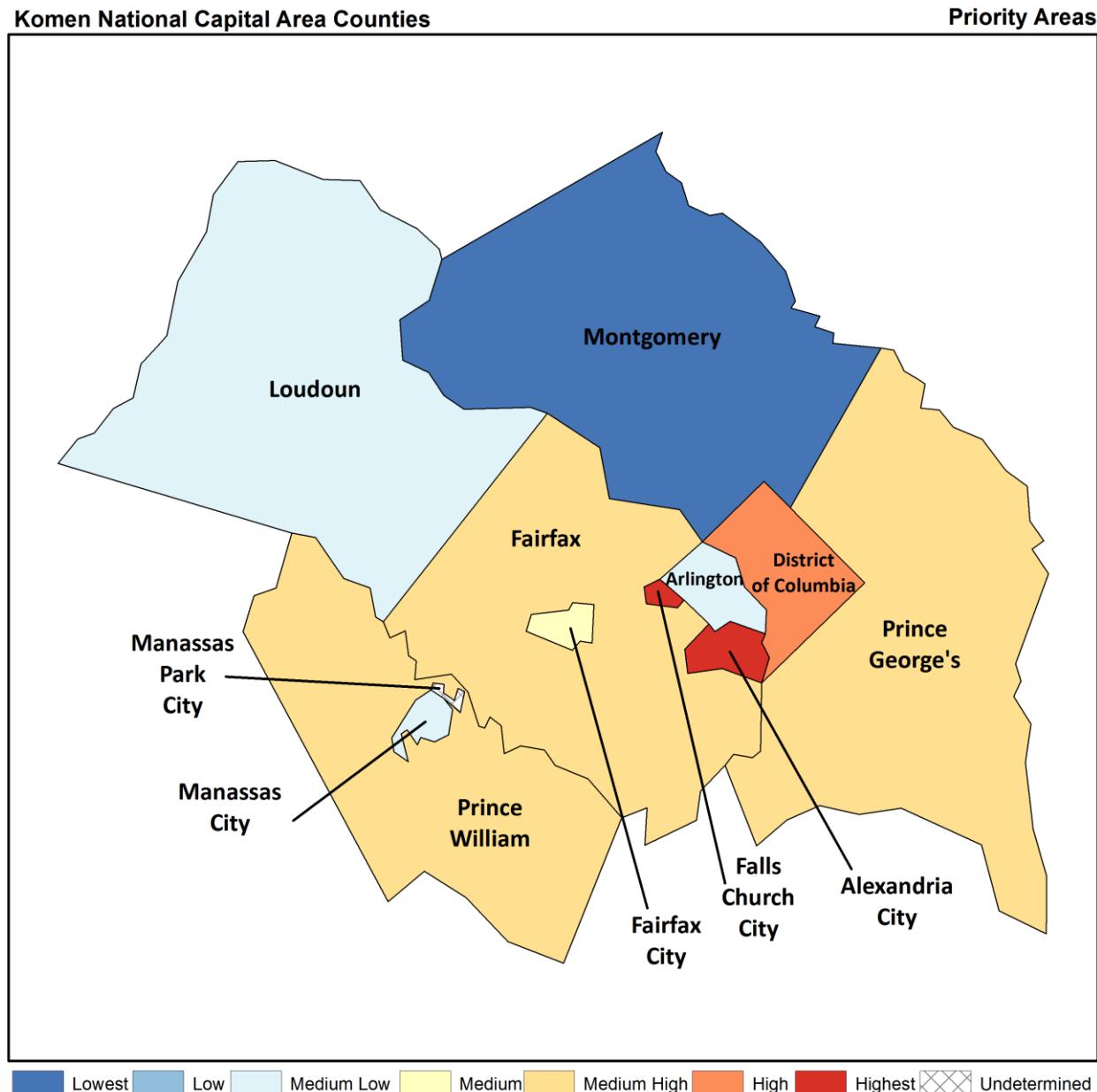


Figure 2.1. Intervention priorities.

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

Two areas in the Komen National Capital Region service area are in the highest priority category. Alexandria City, VA is not likely to meet either the death rate or late-stage incidence rate HP2020 targets. Falls Church City, VA is not likely to meet the late-stage incidence rate HP2020 target.

Late-stage incidence trends in Falls Church City, VA (48.7 percent per year) are significantly less favorable than the NCR service area as a whole (-0.9 percent per year).

High priority areas

One area in the Komen National Capital Region service area is in the high priority category. The District of Columbia is not likely to meet the death rate HP2020 target.

The incidence rates in the District of Columbia (139.7 per 100,000) are significantly higher than the NCR service area as a whole (126.0 per 100,000). The death rates in the District of Columbia (29.8 per 100,000) are significantly higher than the NCR service area as a whole (23.5 per 100,000). The late-stage incidence rates in the District of Columbia (58.0 per 100,000) are significantly higher than the NCR service area as a whole (45.2 per 100,000).

The District of Columbia has a relatively large Black/African-American population, high poverty rates and high unemployment.

Ward-level data show that death rates are highest in the District of Columbia in Ward 2 (35.7 per 100,000), Ward 5 (33.0 per 100,000), Ward 8 (30.9 per 100,000) and Ward 7 (30.1 per 100,000). In the District of Columbia the death rates for Blacks/African-Americans (33.1 per 100,000) are higher than that for Whites (24.7 per 100,000).

Selection of Target Communities

Four target communities have been selected from the National Capital Region (NCR) service area for evidence-based breast cancer interventions over the next several years. These communities were selected based on the data provided in the Quantitative Data Report (QDR). Specifically, the QDR was used to define those communities that are least likely to meet the Healthy People 2020 breast cancer objectives which include reducing women's breast cancer death rates and reducing late-stage breast cancer diagnoses. Selection of the target communities was based on how likely communities in the NCR are to meet the target HP2020 goals for these two objectives. Consideration was also given to other population demographics or socioeconomic factors when selecting target communities. The four target communities selected for further analysis in the Community Profile process include: Alexandria City, VA; and Ward 2, Ward 5, and Wards 7 and 8 (combined) within the District of Columbia (DC).

While Falls Church City, VA is classified as a highest priority community, after review of the quantitative data for Falls Church City, VA, the city was not selected as a target community. Falls Church City, VA's highest priority classification is based solely on the city's late-stage diagnosis rate as the death rate for the city were suppressed due to small numbers (15 cases or fewer for the 5-year data period). In addition, when compared to the service area as a whole, Falls Church City, VA has a substantially smaller Black/African-American and Hispanic/Latina female populations, higher education levels and lower levels of poverty and uninsured individuals (ages 40-64), while the selected target communities had both death and late-stage diagnosis data available to be compared to HP2020 targets as well as additional demographic and socioeconomic factors that may put residents at greater risk of not entering the continuum of care.

Alexandria City, VA was selected as a target community based on the age-adjusted death rate as well as late-stage incidence rates. The age-adjusted death rate for this area (23.0 per 100,000) is higher than that of the US overall and is very close to the Komen NCR service area (23.5 per 100,000) (Table 2.11). Alexandria, VA is the only area in the NCR to have an increasing death rate, which means that it is not likely to reach the HP2020 breast cancer death rate target. Late-stage incidence rates are also higher than the national rate as well as the rate for the NCR service area (Table 2.11). It is predicted that Alexandria, VA will not achieve the HP 2020 breast cancer target for late-stage incidence.

The percentage of the population in Alexandria City without health insurance is relatively high at 10.6 percent, and a quarter of the population is foreign born (Table 2.7). These factors coupled with linguistic isolation percentages that exceed the national percentage (Table 2.7) may be contributing to the disparities in this community which is predominantly White (68.2 percent; Table 2.5). Alexandria City has mammography screening percentages that are higher than the NCR service area (90.6 percent vs. 84.3 percent) (Table 2.11) which suggests that diagnosis may not be occurring in a timely manner.

Several wards within the **District of Columbia** were selected as target communities for the NCR. Data indicate that the District of Columbia as a whole will not quickly achieve the HP2020 targets for breast cancer death rate and late-stage incidence rate (Table 2.10). However, the data also reveal variation and distinct differences in the needs within the District across the wards, leading to the selection of Ward 2, Ward 5, and Wards 7 and 8 as target communities.

In the District of Columbia, Wards 2, 5, 7, and 8 are among those with the highest breast cancer death rates. All four of the wards have age-adjusted death rates that exceed the national rate (22.6 per 100,000), the NCR Service Area (23.5 per 100,000), and the overall District of Columbia rate (29.3 per 100,000) (Table 2.11). Individual screening rates are not available for the wards so further exploration will be needed to assess whether there are screening needs in the area.

- **DC Ward 2** has the highest age-adjusted death rate (35.7 per 100,000) of all the District of Columbia's Wards (Table 2.11). This rate far exceeds that of the NCR Service Area which is 23.5 per 100,000 and is well above the US rate of 22.6 per 100,000 (Table 2.11). This ward is predominantly White (71.7 percent) with a substantially larger API female population than the District of Columbia as a whole (Table 2.6). Although the Ward has one of the lowest unemployment rates, nearly 10 percent of the population ages 40-64 do not have health insurance (Table 2.8).
- **DC Ward 5** has an age-adjusted death rate of 33.9 per 100,000 (Table 2.11). The population of this Ward is 76.0 percent Black/African-American (Table 2.6). In addition, 18.3 percent of the population of this Ward lack a high school education, 20.0 percent have an income below the 100 percent poverty level, and 12.2 percent of those between the ages of 40 and 65 lack health insurance (Table 2.8). Each of these rates exceed that of the District of Columbia as a whole and may contribute to the disparities seen in this community.
- **DC Wards 7 and 8** both have high breast cancer death rates and are similar demographically, socioeconomically and geographically. Given this, Wards 7 and 8 have been combined into one target community. Ward 7 has an age-adjusted death rate of 30.1 per 100,000, while Ward 8 has a death rate of 30.9 per 100,000 (Table 2.11). Both Wards are predominantly Black/African-American (94.9 percent and 93.5 percent, respectively) (Table 2.6). Several population characteristics may be contributing to the disparities seen in this community. Over a quarter of the population (26.0 percent) in Ward 7 is below the 100 percent poverty level, while Ward 8 has the highest percentage of people below the 100 percent poverty level (36.0 percent) (Table 2.8). Additionally, the unemployment rates and low number of insured individuals may be contributing to the breast cancer disparities. Wards 7 and 8 have the two highest unemployment rates in DC (16.8 percent and 24.9 percent, respectively) (Table 2.8). Ward 7 has the third highest uninsured rate (18.1 percent) of the eight Wards, while Ward 8 has a small percentage of uninsured individuals age 40-64 (5.7 percent) (Table 2.8).

Table 2.11. Death and Late-Stage Incidence Rates and Mammography Screening Percentages in the National Capital Region Target Communities.

Community	Age-Adjusted Death Rate/100,000	Late-Stage Incidence Rate/100,000	Screening Percentages
Komen National Capital Region Service Area	23.5	45.2	84.3%
Alexandria City, VA	23.0	44.6	90.6%
District of Columbia - Ward 2	35.7	NA	NA
District of Columbia -Ward 5	33.9	NA	NA
District of Columbia -Ward 7	30.1	NA	NA
District of Columbia- Ward 8	30.9	NA	NA

NA-data not available.

The next section of the Community Profile Report investigates the health system and how the system impacts the breast health of women in these target communities. While these four target communities have been selected based on the quantitative data, it is important to understand the context of the health system as well as the public policy issues that may be contributing to the poor breast health outcomes in these communities.

Health Systems Analysis Findings

A review of the health system analysis identified needs and gaps within the breast cancer continuum of care for the target communities. District of Columbia (DC) Ward 2 has the greatest number of health care facilities and community organizations providing breast cancer services within each continuum of care component and includes the area's only National Cancer Institute Comprehensive Cancer Center. There are four health care facilities in DC Ward 2 that have at least one quality of care certification and/or accreditation. Within DC Ward 2, homeless individuals in the Downtown area have been designated as a medically underserved population indicating that they may face economic, cultural or linguistic barriers to health care (US Department of Health and Human Services, 2015). The South Capitol area of DC Ward 2 is designated as a medically underserved area indicating that residents have a shortage of personal health services (US Department of Health and Human Services, 2015).

Availability of breast cancer services in DC Ward 5 may be a concern since there are only eight health care facilities that provide at least one type of breast cancer service, the quality of care being received is proportionally greater than the other target communities as three of the facilities have some type of quality of care certification and/or accreditation. Furthermore, low income individuals within DC Ward 5 in Brentwood and Ft. Totten areas have been designated as a medically underserved population indicating that they may face economic, cultural or linguistic barriers to health care (US Department of Health and Human Services, 2015).

Residents of Alexandria, VA have available twelve health care facilities and community organizations that provide some type of breast cancer service within the continuum of care; however, only two of the health care facilities have at least one quality of care certification and/or accreditation. Within Alexandria, low income residents of the Arlandria neighborhood (north-eastern portion of Alexandria bordering Arlington County) are designated as a medically underserved population indicating that they may face economic, cultural or linguistic barriers to health care (US Department of Health and Human Services, 2015).

Within DC Wards 7 and 8 there are 14 health care facilities and community organizations that provide screening services and only three facilities that provide breast cancer diagnostic services. An individual diagnosed with breast cancer that resides in DC Wards 7 and 8 must travel outside of their neighborhood to receive breast cancer treatment as there are no facilities that provide cancer treatment located in these two Wards. Furthermore, survivorship support is extremely limited with few community organizations proving some type of support services. While availability of services are limited beyond screening and diagnosis, the quality of care that is available may be less than optimal as there are no quality of care certified and/or accredited health care facilities within Wards 7 and 8. Within Ward 8, the East Capitol Southeast area and Anacostia are designated as a medically underserved area which indicates, among other factors, a shortage of primary care providers. (US Department of Health and Human Services, 2015).

While breast cancer services may be available in each target community, accessibility and utilization of these services may be challenging due to social, economic, environmental and structural barriers encountered by the individuals when trying to receive care.

Qualitative Data Findings

Overall the concept of breast cancer risk is not easily understood by individuals within the target communities. In addition, while breast cancer is of concern for women within the target communities, other health concerns take precedence over breast cancer such as diabetes and heart disease/high blood pressure. Within each target community, focus groups participants and key informants indicated that women perceive screening mammograms as being painful and therefore are resistant to further breast cancer screening and/or diagnostic tests. Key informants indicated that in all target communities, low-income racial and ethnic subgroups, uninsured individuals, individuals with low health literacy, dual minorities and those that do not speak English fluently are less likely to get breast cancer screenings.

Alexandria, Virginia

Common barriers identified by key informants and/or focus group participants for women that reside in Alexandria in accessing and utilizing breast cancer screenings, diagnostics and treatment services include:

- *Lack of knowledge:* about reducing risk, early detection, where to find support, what to expect during a mammogram, what breast abnormalities to look for, how to be mentally prepared to receive a breast cancer diagnosis, not discussed unless there is a family history, confusion and inconsistent messaging, unaware of services available.
- *Lack of breast cancer services in Alexandria:* disconnected from majority of services in District of Columbia, little to no survivorship services, minimal providers.
- *Competing Priorities:* putting family and others first, work, other health conditions.
- *Communication Issues:* language, inability of health care provider to contact patient.
- *Transportation:* disproportional access to buses and metro, unreliable.
- *Financial:* insurance status, ability to pay copays, deductibles and out-of-pocket costs, ensuring services covered when continuing care from one facility to another.
- *Scheduling:* not patient-centered

- *Fragmented Health Care System*: “lost” when transitioning from one facility to another, unable to obtain mammography order from doctor.
- *Quality of Services*: long wait times for short visits with the provider, dependent on type of insurance, age and stage of treatment, different providers provide different levels of care.

Recommendations provided by key informants and/or focus group participants for addressing the barriers experienced by women in Alexandria, Virginia include:

- Community outreach about risk reduction, breast abnormalities, early detection, why additional diagnostic tests are needed and available local breast cancer services.
- Expanded capacity through the use of mobile mammography at locations where people congregate, community health workers to provide education, expanded hours (evenings, weekends and holidays) and ensure services are free to those that need them.
- Patient navigation programs that can support and assist residents in entering the continuum of care to receive screenings and move them seamlessly as needed through diagnostics and treatment into survivorship services. Navigators can also assist the individuals with “wrap around” services to reduce other barriers.
- Health care provider training about racial and ethnic health care practices and how to improve patient-provider and provider-provider communication.

District of Columbia Wards 2, 5, 7 and 8

Common barriers identified by key informants and/or focus group participants for women that reside in District of Columbia Wards 2, 5, 7 and 8 in accessing and utilizing breast cancer screenings, diagnostics and treatment services include:

- *Lack of Education*: information about when and how often to get a mammogram, what are the benefits to early detection, why are additional diagnostic tests needed, unaware of breast cancer services and survivorship services in the local community, breast health not discussed in their local community, survivorship care (i.e. treatment side-effects, follow-up) not discussed.
- *Fear*: pain or discomfort from the screenings, fear of diagnosis, fear of losing job.
- *Lack of Services Available in the Ward*: travel to other areas, attributed to poverty, little to no survivorship services.
- *Transportation*: have to make multiple bus or train transfers to get to facility, expensive, unreliable, accessibility.
- *Financial*: insurance status, ability to pay copays, deductibles and out-of-pocket costs, applying or recertifying public health insurance, ensuring services covered when continuing care from one facility to another, billing errors indicating payment required when services are covered by insurance, insurance does not cross state borders, finding a provider to accept insurance.
- *Competing Priorities*: putting family and others first, work, other health conditions.
- *Communication Issues*: language, inability of health care provider to contact patient.
- *Scheduling*: not patient-centered
- *Fragmented Health Care System*: “lost” when transitioning from one facility to another, patient may have to go to three different health care systems for treatment to be covered

by insurance, lack of coordinated care between the multiple doctors involved in treatment.

- *Quality of Services:* long wait times for short visits with the provider, dependent on type of insurance, age and stage of treatment, different providers provide different levels of care.

Recommendations provided by key informants and/or focus group participants for addressing the barriers experienced by women in District of Columbia Wards 2, 5, 7 and 8 include:

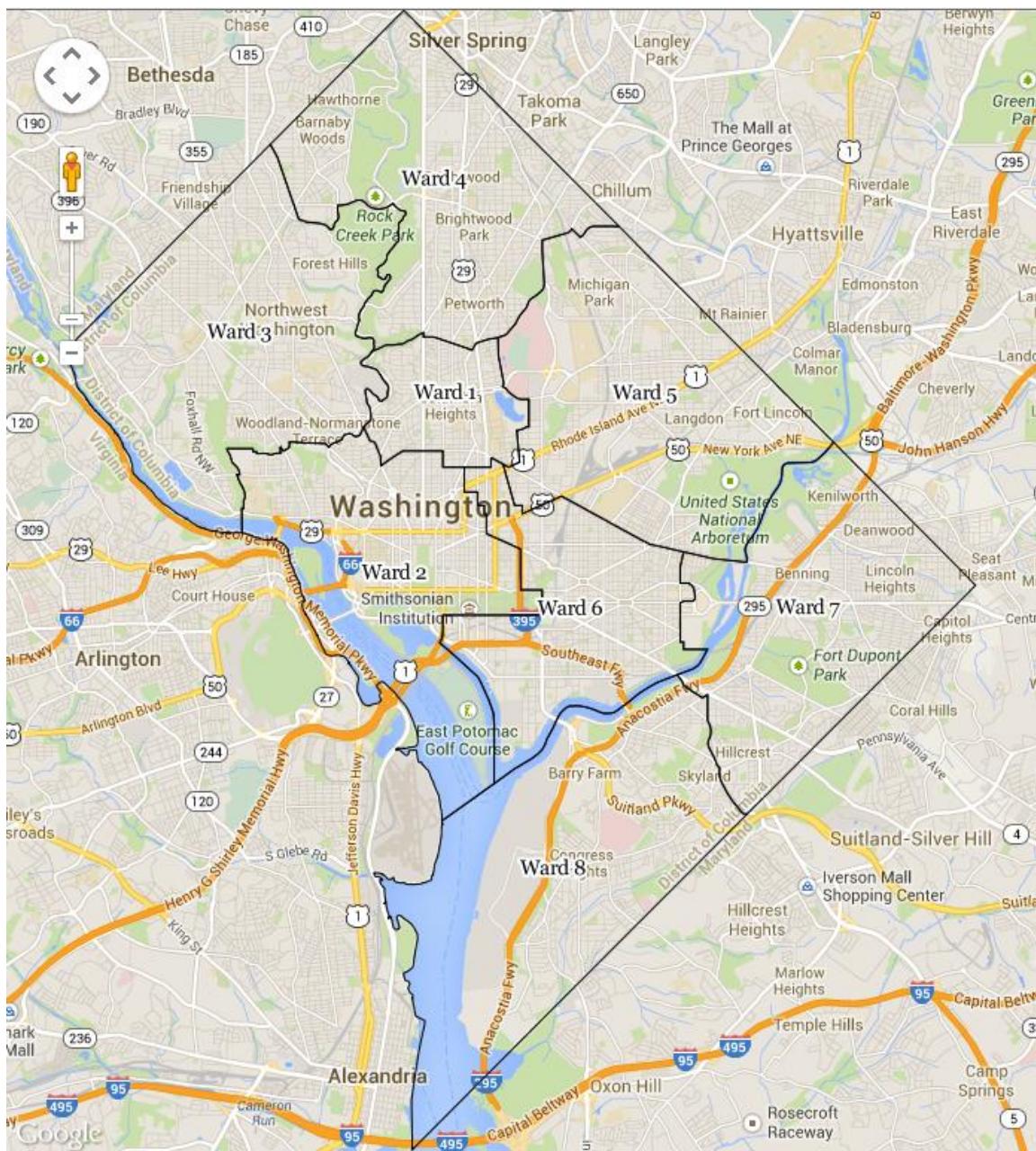
- Patient navigation programs that can support and assist residents in entering the continuum of care to receive screenings and move them seamlessly as needed through diagnostics and treatment into survivorship services. These navigation programs need to be available with each community (i.e., in each Ward) and specific populations (i.e., African-American, Hispanic/Latino, Immigrants, LGBT) so that the navigators can easily identify with the individuals that need assistance. Navigators can also assist the individuals with “wrap around” services to reduce other barriers.
- Development of a “health care oasis”, “PODS”, “one-stops” or “community assessment and referral sites” where all screening and survivorship services can be provided in one community location. These models could utilize mobile mammography units, offer support and provide transportation, childcare and additional health services.
- Expanded capacity of health care facilities to provide service outside of normal business hours, days and locations.
- Financial assistance that can reduce identified barriers (copays, deductibles, out-of-pocket costs, transportation).
- Community outreach that stresses survivorship issues, the importance of breast cancer early detection stressing breast self-awareness, self-advocacy, being proactive about one’s health and reducing stigmas and misperceptions about breast cancer through comprehensive, evidence-based education programs. Involve individuals that are trusted in the community such as health care providers and community and religious organizations.
- Health care provider training about racial and ethnic health care practices and how to improve patient-provider and provider-provider communication.

These recommendations presented by the focus groups and key informants mirror those presented by additional meetings in the District of Columbia about disparities and access to care: Susan G. Komen District of Columbia Disparities Roundtable (2015) and George Washington Cancer Institute’s Oncology Care Access Overview and Needs Assessment (2015). Participants at the Disparities Roundtable (2015) recommended engaging faith-based organizations through the development of a curriculum that can be implemented in faith-based institutions and use screening tools and a “buddy system” in the church to move from awareness to action. Disparities Roundtable (2015) participants also suggested trying to remove the silos to create continuity and continuum of care utilizing patient-centered approaches such as patient navigation. Some of the Oncology Care Access Needs Assessment (2015) potential solutions to barriers included development of an education campaign targeting health care providers on changes to DC Medicaid changes, new revenue or payment structures to incentive a broader network of health care providers accepting Medicaid as first-level payment, bundle provider payments to support a comprehensive set of services

for patients (i.e., patient navigation, care coordination, health promotion, symptom management, palliative care, psychosocial support and long-term survivorship care planning), utilize patient navigator/community health workers/other health care professionals to increase health literacy particularly in DC Wards 5, 7 and 8.

Appendices

Appendix A. District of Columbia Ward map



Source: Google Maps, 2013