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ACKNOWLEDGEMENTS

The National Capital Region Community Profile Report could not have been accomplished without the exceptional work, effort, time, and commitment from many people and organizations involved in the process.

Susan G. Komen® would like to extend its deepest gratitude to the residents of the District of Columbia Wards 2, 5, 7 and 8 and Alexandria, Virginia that participated in the focus groups and to the individuals from health care systems and community organizations that participated in the key informant interviews.

Komen also extends appreciation to CommonHealth ACTION for completing the breast health focus groups in spring 2015 to inform the update of the Community Profile Report. The focus group qualitative summary was prepared through the collaboration of CommonHealth ACTION staff and partners. Focus group recruitment and implementation were completed by Chanel Barnes-Osula, MA, MHS, Program Associate; Julia W. DeAngelo, MPH, Program Manager; Nabihah Maqbool, MPH, Health Equity Intern; and Katy Weeks, MPH, Program Associate with direction and input from Natalie S. Burke, President & CEO. Focus group data analyses were completed by Melody Johnson Morales, PhD, Independent Research and Evaluation Consultant, and focus group discussions were transcribed by the team at Exceptional Transcription & Business Solutions, Inc.

Komen also thanks the following Komen Affiliates which contributed to the Health System and Public Policy Analysis sections: Komen Central Virginia, Komen Maryland, and Komen Northwest Ohio.

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EXECUTIVE SUMMARY

At Susan G. Komen, our mission is to save lives by meeting the most critical needs of our communities and investing in breakthrough research to prevent and cure breast cancer.

The Komen National Capital Region (NCR) is a community served by Komen, which includes the District of Columbia, Montgomery County and Prince George's County in Maryland and Prince William County, Loudoun County, Arlington County, Fairfax County and the cities of Alexandria, Fairfax, Falls Church, Manassas, and Manassas Park in Virginia.

The NCR has one of the highest rates for breast cancer incidence and mortality in the nation. The District of Columbia, specifically, 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.

Working in consultation with local community leaders, Susan G. Komen conducted a quantitative and qualitative assessment and a health systems analysis – called the Community Profile -- to better understand the barriers women face in regards to access to and utilization of care. The resulting Community Profile Report is used to help develop strategies for addressing such barriers and eradicating breast health disparities. Komen will use the results of the analyses to establish target populations and mission action priorities for the next five years.

Primarily, Komen centers its mission action priorities in the NCR through the National Capital Region Community Grants Program. Other notable activities aimed at addressing the goals of the NCR include Komen’s leadership and participation in local breast cancer coalitions/summits, patient advocacy efforts and survivor networks; the African-American Health Equity Initiative; and scientific research activities designed to find the cures for breast cancer.

QUANTITATIVE DATA: MEASURING BREAST CANCER IMPACT IN LOCAL COMMUNITIES

The Quantitative Data Report (QDR) for the NCR combines evidence from many credible sources to identify the highest priority areas for evidence-based breast cancer programs. The QDR utilized breast cancer statistics (e.g., death and late-stage incidence rates and trends) to predict if communities would meet Healthy People 2020 (HP2020) breast cancer targets by year 2020.

HP2020 is a major federal government initiative that provides specific health objectives for communities and for the country. 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 assess how areas across the country are progressing towards reducing the burden of breast cancer.

The HP2020 breast cancer targets used in the analysis are:

- Reducing women’s death rate from breast cancer [Target as of the writing of this report: 20.6 cases (age-adjusted) 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 (age-adjusted) per 100,000 women].

To assess how communities in the NCR are progressing toward these targets, the report used age-adjusted breast cancer death and late-stage incidence rates and trends for years 2006 to 2010 to estimate how many years it will take for each community to meet the HP2020 objectives (Table 1). Communities were classified on a spectrum from “Highest” to “Lowest,” depending on the number of years needed to achieve the HP2020 targets (Table 1).
Communities that are not likely to achieve either of the HP2020 targets are considered to have the highest needs.

Communities that have already achieved both targets are considered to have the lowest needs.

The time estimated for each community to achieve HP2020 targets was combined with demographic and socioeconomic data to select four target communities in the National Capital Region service area. These target communities will be prioritized for evidence-based breast cancer interventions over the next several years:

- Alexandria, VA
- Ward 2 in District of Columbia
- Ward 5 in District of Columbia
- Wards 7 and 8 in District of Columbia

Alexandria, 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 NCR (23.5 per 100,000). 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. It is predicted that Alexandria, VA will not achieve the HP 2020 breast cancer target for late-stage incidence.

While data indicate that the entire District of Columbia will not quickly achieve the HP2020 targets, 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. These Wards have age-adjusted death rates that exceed the national rate (22.6 per 100,000), the NCR death rate (23.5 per 100,000), and the overall District of Columbia death rate (29.3 per 100,000) (Table 1).

- **DC Ward 2** has the highest age-adjusted death rate (35.7 per 100,000) of all the District of Columbia’s Wards (Table 1). This rate far exceeds that of the NCR which is 23.5 per 100,000 and is well above the US rate of 22.6 per 100,000 (Table 1). This ward is predominantly White (71.7 percent) with a substantially larger Asian/Pacific Islander (API) female population than the entire District of Columbia. Although the Ward has one of the lowest unemployment rates, nearly 10 percent of the population ages 40-64 do not have health insurance.

- **DC Ward 5** has an age-adjusted death rate of 33.9 per 100,000 (Table 1). The population of this Ward is 76.0 percent Black/African-American. In addition, 18.3 percent of the population of this Ward lacks 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. Each of these characteristics exceeds that of the entire District of Columbia and may contribute to the disparities seen in this community.

- **DC Ward 7 and Ward 8** both have high breast cancer death rates and are similar demographically, socioeconomically and geographically. Given this, Ward 7 and Ward 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 1). Both Wards are predominantly Black/African-American (94.9 percent and 93.5 percent, respectively). 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). Additionally, Wards 7 and 8 have the two highest unemployment rates in DC (16.8 percent and 24.9 percent, respectively). 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). The unemployment rates and low number of insured individuals may be contributing to the breast cancer disparities.
Table 1. Female breast cancer incidence, death and late-stage incidence rates and trends and Healthy People 2020 priority classification, National Capital Region

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Female Population (Annual Average)</th>
<th># of New Cases (Annual Average)</th>
<th>Age-adjusted Rate/100,000</th>
<th>Trend (Annual Percent Change)</th>
<th># of Deaths (Annual Average)</th>
<th>Age-adjusted Rate/100,000</th>
<th>Trend (Annual Percent Change)</th>
<th># of New Cases (Annual Average)</th>
<th>Age-adjusted Rate/100,000</th>
<th>Trend (Annual Percent Change)</th>
<th>Healthy People 2020 Priority Classification</th>
<th>Key Population Characteristics</th>
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<tbody>
<tr>
<td>US</td>
<td>154,540,194</td>
<td>198,602</td>
<td>122.1</td>
<td>-0.2%</td>
<td>40,736</td>
<td>22.6</td>
<td>-1.9%</td>
<td>70,218</td>
<td>43.7</td>
<td>-1.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HP2020</td>
<td>.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>20.6</td>
<td>-</td>
<td>-</td>
<td>41.0</td>
<td>-</td>
<td></td>
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<tr>
<td>District of Columbia</td>
<td>308,298</td>
<td>441</td>
<td>139.7</td>
<td>0.7%</td>
<td>98</td>
<td>29.8</td>
<td>NA</td>
<td>181</td>
<td>58.0</td>
<td>-4.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maryland</td>
<td>2,942,268</td>
<td>4,206</td>
<td>128.0</td>
<td>1.7%</td>
<td>818</td>
<td>24.5</td>
<td>-2.0%</td>
<td>1,521</td>
<td>46.4</td>
<td>-0.5%</td>
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<tr>
<td>Virginia</td>
<td>3,993,827</td>
<td>5,420</td>
<td>124.8</td>
<td>1.3%</td>
<td>1,074</td>
<td>24.0</td>
<td>-1.9%</td>
<td>1,896</td>
<td>43.9</td>
<td>0.1%</td>
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<td>Komen National Capital Region Service Area</td>
<td>2,324,241</td>
<td>2,939</td>
<td>126.0</td>
<td>1.3%</td>
<td>550</td>
<td>23.5</td>
<td>NA</td>
<td>1,064</td>
<td>45.2</td>
<td>-0.9%</td>
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<tr>
<td>White</td>
<td>1,323,847</td>
<td>1,822</td>
<td>130.6</td>
<td>1.6%</td>
<td>305</td>
<td>21.3</td>
<td>NA</td>
<td>592</td>
<td>42.4</td>
<td>0.3%</td>
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<tr>
<td>Black/African-American</td>
<td>718,248</td>
<td>853</td>
<td>122.6</td>
<td>1.2%</td>
<td>223</td>
<td>32.2</td>
<td>NA</td>
<td>377</td>
<td>53.6</td>
<td>-2.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AlAN</td>
<td>17,456</td>
<td>6</td>
<td>63.7</td>
<td>-1.7%</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
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<tr>
<td>API</td>
<td>264,690</td>
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<td>75.0</td>
<td>3.4%</td>
<td>22</td>
<td>9.2</td>
<td>NA</td>
<td>67</td>
<td>27.6</td>
<td>2.5%</td>
<td></td>
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<tr>
<td>Non-Hispanic/ Latina</td>
<td>2,009,819</td>
<td>2,791</td>
<td>130.2</td>
<td>1.4%</td>
<td>531</td>
<td>24.5</td>
<td>NA</td>
<td>1,006</td>
<td>46.7</td>
<td>-1.0%</td>
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<tr>
<td>Hispanic/ Latina</td>
<td>314,422</td>
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<td>77.2</td>
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<td>18</td>
<td>9.8</td>
<td>NA</td>
<td>58</td>
<td>26.7</td>
<td>1.7%</td>
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<tr>
<td>District of Columbia - DC</td>
<td>308,298</td>
<td>441</td>
<td>139.7</td>
<td>0.7%</td>
<td>98</td>
<td>29.8</td>
<td>-2.3%</td>
<td>181</td>
<td>58.0</td>
<td>-4.3%</td>
<td>High</td>
<td>%Black/African-American, poverty, employment, medically underserved</td>
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<tr>
<td>Ward 1</td>
<td>NA</td>
<td>38</td>
<td>110.8</td>
<td>NA</td>
<td>7</td>
<td>21.8</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
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<tr>
<td>Ward 2</td>
<td>NA</td>
<td>38</td>
<td>124.9</td>
<td>NA</td>
<td>11</td>
<td>35.7</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
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<td>Ward 3</td>
<td>NA</td>
<td>74</td>
<td>154.1</td>
<td>NA</td>
<td>13</td>
<td>23.4</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
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<tr>
<td>Ward 4</td>
<td>NA</td>
<td>69</td>
<td>125.9</td>
<td>NA</td>
<td>15</td>
<td>27.4</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward 5</td>
<td>NA</td>
<td>61</td>
<td>124.9</td>
<td>NA</td>
<td>17</td>
<td>33.9</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
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<td></td>
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<tr>
<td>Ward 6</td>
<td>NA</td>
<td>50</td>
<td>135.1</td>
<td>NA</td>
<td>10</td>
<td>26.2</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
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<td>NA</td>
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<td>109.5</td>
<td>NA</td>
<td>14</td>
<td>30.1</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
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<td></td>
</tr>
<tr>
<td>Ward 8</td>
<td>NA</td>
<td>43</td>
<td>146.0</td>
<td>NA</td>
<td>8</td>
<td>30.9</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
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<td>Montgomery County - MD</td>
<td>492,599</td>
<td>720</td>
<td>127.5</td>
<td>-0.5%</td>
<td>115</td>
<td>19.6</td>
<td>-3.0%</td>
<td>230</td>
<td>40.9</td>
<td>-4.4%</td>
<td>Lowest</td>
<td>%API, foreign born</td>
</tr>
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<td>Prince George's County - MD</td>
<td>444,819</td>
<td>532</td>
<td>118.5</td>
<td>0.2%</td>
<td>121</td>
<td>27.8</td>
<td>-1.8%</td>
<td>214</td>
<td>47.0</td>
<td>-7.3%</td>
<td>Medium High</td>
<td>%Black/African-American</td>
</tr>
<tr>
<td>Arlington County - VA</td>
<td>99,145</td>
<td>118</td>
<td>130.8</td>
<td>3.1%</td>
<td>20</td>
<td>21.9</td>
<td>-2.4%</td>
<td>39</td>
<td>43.7</td>
<td>-3.0%</td>
<td>Medium Low</td>
<td></td>
</tr>
<tr>
<td>Population Group</td>
<td>Female Population (Annual Average)</td>
<td># of New Cases (Annual Average)</td>
<td>Age-adjusted Rate/100,000</td>
<td>Trend (Annual Percent Change)</td>
<td># of Deaths (Annual Average)</td>
<td>Age-adjusted Rate/100,000</td>
<td>Trend (Annual Percent Change)</td>
<td># of New Cases (Annual Average)</td>
<td>Age-adjusted Rate/100,000</td>
<td>Trend (Annual Percent Change)</td>
<td>Healthy People 2020 Priority Classification</td>
<td>Key Population Characteristics</td>
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</tr>
<tr>
<td>Fairfax County - VA</td>
<td>530,502</td>
<td>693</td>
<td>126.7</td>
<td>1.7%</td>
<td>113</td>
<td>21.6</td>
<td>-2.5%</td>
<td>227</td>
<td>40.9</td>
<td>3.0%</td>
<td>Medium</td>
<td>%API</td>
</tr>
<tr>
<td>Loudoun County - VA</td>
<td>147,541</td>
<td>144</td>
<td>122.5</td>
<td>-1.1%</td>
<td>23</td>
<td>21.2</td>
<td>-2.2%</td>
<td>49</td>
<td>41.9</td>
<td>-2.0%</td>
<td>Medium Low</td>
<td>%API, rural</td>
</tr>
<tr>
<td>Prince William County - VA</td>
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<td>186</td>
<td>116.0</td>
<td>0.7%</td>
<td>34</td>
<td>22.7</td>
<td>-2.2%</td>
<td>67</td>
<td>40.8</td>
<td>2.5%</td>
<td>Medium High</td>
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<tr>
<td>Alexandria City- VA</td>
<td>69,407</td>
<td>83</td>
<td>121.4</td>
<td>5.6%</td>
<td>16</td>
<td>23.0</td>
<td>15.7%</td>
<td>30</td>
<td>44.6</td>
<td>5.9%</td>
<td>Highest</td>
<td></td>
</tr>
<tr>
<td>Fairfax City - VA</td>
<td>11,197</td>
<td>17</td>
<td>124.8</td>
<td>-3.7%</td>
<td>4</td>
<td>32.0</td>
<td>-3.3%</td>
<td>5</td>
<td>37.9</td>
<td>-29.5%</td>
<td>Medium High</td>
<td>%API</td>
</tr>
<tr>
<td>Falls Church City - VA</td>
<td>5,868</td>
<td>9</td>
<td>143.5</td>
<td>25.7%</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>4</td>
<td>51.3</td>
<td>48.7%</td>
<td>Highest</td>
<td></td>
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<tr>
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<td>18</td>
<td>118.3</td>
<td>5.4%</td>
<td>3</td>
<td>24.0</td>
<td>-2.7%</td>
<td>7</td>
<td>43.7</td>
<td>-7.9%</td>
<td>Medium Low</td>
<td>%Hispanic/Latina, education, poverty, language, insurance</td>
</tr>
<tr>
<td>Manassas Park City - VA</td>
<td>6,482</td>
<td>4</td>
<td>93.7</td>
<td>6.0%</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>Undetermined</td>
<td>%Hispanic/Latina, education, foreign, language, insurance</td>
</tr>
</tbody>
</table>

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

Data are for years 2006-2010 except for the incidence and late-stage data for the State of Virginia, Virginia counties and NCR and Ward level incidence and death rates which are from 2005-2009.
Rates are in cases or deaths per 100,000 women.
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 trend data: NCI/CDC State Cancer Profiles.
Source of District of Columbia Ward incidence and death data: District of Columbia Cancer Registry, District of Columbia Department of Health, program funded by NPCR-CD.
Health Systems Overview

The Breast Cancer Continuum of Care (CoC) is a framework that highlights how a person typically will move through the health care system for breast care, including screening, diagnosis, treatment, follow-up and/or survivorship.

Figure 1 provides a visual representation of the cycle of care that a person will complete while seeking breast health information or care. Throughout the entire CoC, breast health education is essential to each step in the process.

To better understand the available resources for the entire CoC in the NCR, health systems data were collected through a comprehensive internet search.

The following types of health care facilities or community organizations that may provide breast cancer related services were identified:

- **Hospitals** - Public or private, for-profit or nonprofit.
- **Community Health Centers (CHC)** - Community based organizations that provide primary care regardless of ability to pay; include Federally Qualified Health Centers (FQHCs) and FQHC look-alikes.
- **Free Clinics** - Safety-net health care organizations that utilize a volunteer/staff model and restrict eligibility for their services to individuals who are uninsured, underinsured, and/or have limited or no access to primary health care.
- **Health Departments** - Run by government entity (e.g. county, city) and focused on the general health of its citizens.
- **Title X Providers** - Family planning centers that also offer breast and cervical cancer screening. Services are provided through state, county, and local health departments; community health centers; Planned Parenthood centers; and hospital-based, school-based, faith-based, other private nonprofits.
- **Others** - Any institution that is not a hospital, CHC, free clinic, health department or Title X provider (e.g., FDA certified mammography center that is not a hospital/CHC, community organization that is not a medical provider but does connect people to services or provide support services such as financial/legal assistance).

Information collected through these means was inputted into a Health Systems Analysis spreadsheet by service type: screening, diagnostics, treatment, and support.

- **The screening** service category encompasses clinical breast exams (CBEs), screening mammograms, mobile mammography units, ultrasounds, and patient navigation.
- **The category of diagnostics** includes diagnostic mammograms, ultrasounds, biopsy, MRI, and patient navigation.
- **Treatment modalities counted** were chemotherapy, radiation, surgery consultations, surgery, reconstruction, and patient navigation.
- **Support encompasses** a broad range of services including support groups, wigs, mastectomy wear, individual counseling/psychotherapy, exercise/nutrition programs, complementary
therapies, transportation assistance, financial assistance for cost of living expenses, as well as end of life care, legal services, and education.

Also included in the Health Systems Analysis spreadsheet were accreditation standards that these local resources may have including: National Cancer Institute Designated Cancer Centers, American College of Radiology Breast Imaging Centers for Excellence, American College of Surgeons Accreditation Program for Breast Centers, American College of Surgeons on Cancer Certification, and Food and Drug Administration (FDA) approved Mammography Facilities.

Alexandria, Virginia has a total of 10 facilities that provide screening services, six that provide diagnostic services, three that provide treatment, and three that provide survivorship support.

A total of 24 facilities provide screening services in DC Ward 2, eight provide diagnostic services, four provide treatment, and five provide survivorship services. DC Ward 5 had five facilities that provide screening only and three facilities that provide the entire continuum of care for breast health. In DC Wards 7 and 8 there are 14 identified health care facilities and community organizations that provide screening services, three provide diagnostic services, and one provides survivorship support services.

A review of the health system analysis identified needs and gaps within the breast cancer continuum of care for the target communities. Although there are services available in the target communities, the services that are available may not be sufficient to service the community. Per the US Department of Health and Human Services (2015), each of the target communities have areas designated as medically underserved or have medically underserved populations.

Public Policy Overview

The Breast and Cervical Cancer Mortality Prevention Act was signed into Public Law (101-354) in 1990 to improve access to cancer screening for underserved women, establishing the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). NBCCEDP funds all 50 states, the District of Columbia, five US territories, and 11 American Indian/Alaskan native tribal organizations, providing breast and cervical cancer screening. The Centers for Disease Control and Prevention (CDC) developed a National Comprehensive Cancer Control Program (NCCCP) in 1998. The NCCCP has been active in promoting health equity as it relates to cancer control throughout the 50 US states, District of Columbia, tribal groups, and Associated Pacific Islands/territories.

The NCR is serviced by three NBCCEDP and NCCCP programs: District of Columbia, State of Maryland, and the Commonwealth of Virginia. Komen works with the NBCCEDP implementing organizations to ensure uninsured and underinsured women receive necessary breast cancer screenings, diagnostics, and treatment services through collaboration in the local communities. In addition, Komen has participated in the development of the Comprehensive Cancer Control (CCC) plans in Virginia, Maryland, and the District of Columbia.

The Patient Protection and Affordable Care Act (ACA) was signed into Public Law by President Barack Obama on March 23, 2010. ACA has several provisions including guaranteed issue of health care coverage to individuals with pre-existing health conditions, prohibition of annual limits on the amount spent for coverage by insurers and more. Under ACA state Medicaid programs have the option to expand eligibility to ensure health care coverage for individuals who were previously ineligible, reducing the number of uninsured Americans. As of August 2015, the Commonwealth of Virginia has not adopted Medicaid expansion, while the District of Columbia and the State of Maryland have.

Each year, Komen works to identify, through a transparent, broad-based, and intensive vetting and selection process, the policy issues that have the greatest potential impact on Komen’s mission. This process includes the collection of feedback from Komen Headquarters leadership, policy staff, and subject matter experts; Komen Affiliates from across the country; advisory groups including the Komen Advocacy Advisory Taskforce (KAAT), Advocates in Science (AIS), and Komen Scholars; and other stakeholders with a vested interest in breast cancer-related issues. The selected issues are the basis for Komen’s annual state and federal advocacy work.
Komen advocacy priorities include, but are not limited to:

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

Partnerships and Collaborations

Partnerships and collaborations are essential to Komen’s work in the NCR. Komen relies on these relationships to assist in addressing the goals of reducing late-stage diagnosis and mortality, and eliminating breast cancer disparities within the NCR. Partnerships primarily consist of collaborations with grantees through our Community Grants Program. These partnerships have proven invaluable, as grantees have a close pulse on the myriad of challenges faced by underserved women in need of breast health and breast cancer services within the NCR target communities.

In the past, Komen has partnered with the DC Department of Health, and has maintained ties with the US Congress to close the gaps in research and public policy that lead to breast cancer disparities. Recently, however, there has been a deficit in partnerships involving other federal/governmental, and health department agencies in the NCR. Without federal action and/or cooperation to bridge the gaps in early detection and treatment on a national level, many racial and ethnic minorities, the poor, and those with little or no health insurance will continue to receive low quality cancer care, and will therefore be more likely to die because of a breast cancer diagnosis. Thus, expanding Komen’s existing relationships to include these overarching partnerships is critical to addressing the goals of reducing late-stage diagnosis and mortality in the NCR.

Komen currently partners with community-based organizations, through the Community Grants Program, in support of programs that address the unmet needs of breast cancer patients, survivors, and their families. These partners and programs provide a broad range of direct services, including: breast cancer screening, diagnosis, and treatment assistance; patient navigation/support services; community education about breast cancer risk factors, the importance of early detection, and breast health resources available within the community; and education for health practitioners regarding cultural competency in breast care, with the goal of reducing/eliminating bias, confusion, and/or fear as patients make their way through the cancer care continuum.

For a full list of the current NCR Grantees, and a description of their catchment areas, please see Appendix A. For a full list of our NCR partners over the past five years, please see Appendix B.

QUALITATIVE DATA: ENSURING COMMUNITY INPUT

The NCR Community Profile Team conducted key informant interviews as well as focus groups in each of the target communities. Key informant interviews are structured conversations between an interviewer and a representative from a target population or community that allows for in-depth and probing questions on specific issues. Focus groups are structured discussions used to obtain in-depth information from a group of five to ten people about a specific topic.

In each target community, the main questions that focus group participants answered included:

- Types of breast health services and support available and used.
- Interactions with health care providers and if their needs were met.
- Quality of breast cancer services (e.g., screening, diagnostics, and treatment) provided.
• Barriers experienced by community members in accessing and/or utilizing available breast health services.
• Solutions that could be implemented to reduce the identified barriers.

Key informant interview participants answered the following questions:

• Whether breast cancer is perceived as a concern.
• Who may be less likely to access breast cancer screenings.
• Barriers experienced in accessing and/or utilizing available breast health services.
• Solutions that could be implemented to reduce the identified barriers.

Of the 97 eligible invitees, 75 women participated in a total of 10, 90-minute focus groups. These participants represented District of Columbia Wards 2, 5, 7 and 8 and Alexandria, Virginia. The average age of the focus group participant was 47. Focus group participants identified with the following race/ethnicity groups: Black/African-American (61); White/Non-Hispanic (6); Hispanic/Latino (4); Asian (e.g., South Asian, Chinese, Filipino, Japanese, Korean, and Vietnamese) (2); Native Hawaiian or Other Pacific Islander (e.g., Native Hawaiian, Guamanian/Chamorro, and Samoan) (1); and one participant chose not to disclose race/ethnicity.

A total of 34 potential key informants were contacted for an interview, and of those participants a total of 20 key informant interviews and/or surveys were conducted. The key informants were staff members of local organizations that provide services to residents of the target communities.

Through these qualitative data collection activities, we learned that 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, 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 breast cancer screening and/or further diagnostic tests. Key informants indicated that in all target communities, low-income racial and ethnic subgroups, uninsured individuals, individuals with low health literacy (education), dual minorities and those that do not speak English fluently are less likely to get breast cancer screenings.

Within each of the target communities, focus group participants identified key themes regarding potential barriers to care:

• Focus group participants from Alexandria, Virginia listed a lack of knowledge about breast cancer and how to detect it early, as well as the need for services as overall themes.
• In District of Columbia (DC) Ward 2, the focus group participants listed fear of the tests being painful and lack of education as barriers to breast health and self-advocacy as a necessary practice for being proactive about their health.
• In DC Ward 5, three key themes emerged from discussions with participants, including a lack of information, fear as a barrier to receiving services, and the need for more outreach in the community. Many participants in DC Ward 5 were unaware of breast health services in their community and travelled to other areas to receive care.
• In DC Wards 7 and 8 the overall themes included lack of services in low-income communities and the need for education and outreach.

Key informants identified four barriers that prevented residents within the target communities from accessing and remaining in the continuum of care: personal, environmental, financial and health care system operations. Table 2 represents overall themes as well as barriers revealed by key informant
participants of organizations that provide services to residents of Alexandria, Virginia and DC Wards 2, 5, 7 and 8.

Table 2. Barriers to continuum of care services identified by key informants

<table>
<thead>
<tr>
<th>Screen Barriers</th>
<th>Diagnostic Barriers</th>
<th>Treatment Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Competing priorities (e.g., family and work)</td>
<td>• Language</td>
<td>• Competing priorities (e.g., family, work, other health issues)</td>
</tr>
<tr>
<td>• Language</td>
<td>• Do not understand why additional tests are needed</td>
<td>• Language</td>
</tr>
<tr>
<td>• Cultural (i.e. not supportive of screening, God will heal)</td>
<td>• Fatalism</td>
<td>• Time</td>
</tr>
<tr>
<td>• Fear</td>
<td>• Fear</td>
<td>• Time</td>
</tr>
<tr>
<td>• Lack of understanding where to go</td>
<td>• Provider unable to reach patient with abnormal results and next steps</td>
<td>• Lack of resources (i.e. support)</td>
</tr>
<tr>
<td>• Age</td>
<td>• Time</td>
<td></td>
</tr>
<tr>
<td>• Health literacy</td>
<td>• Cultural (e.g., do not question doctors, family does not want them to go back)</td>
<td></td>
</tr>
<tr>
<td>• Mistrust of health care providers/system</td>
<td>• Transport</td>
<td></td>
</tr>
<tr>
<td>• Lack of support system</td>
<td>• Lack of comprehensive services within local community</td>
<td></td>
</tr>
<tr>
<td>Environmental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Transportation</td>
<td>• Facilities providing diagnostic services are located outside of local community</td>
<td>• Transportation</td>
</tr>
<tr>
<td>• Lack of comprehensive services within local community</td>
<td>• Access to providers/facilities in local community</td>
<td>• Access to providers/facilities in local community</td>
</tr>
<tr>
<td>Financial</td>
<td>• Level of care accessible less than other facilities</td>
<td></td>
</tr>
<tr>
<td>• Insurance status</td>
<td>• Delays in applying or re-certifying public insurance</td>
<td>• Level of care accessible less than other facilities</td>
</tr>
<tr>
<td>• Copays/deductibles/out-of-pocket costs</td>
<td>• Billing mistakes (e.g., receive a bill and cannot pay, so do not return for services)</td>
<td>• Level of care accessible less than other facilities</td>
</tr>
<tr>
<td>• Coverage verification issues-takes multiple appointments</td>
<td>• Copays/deductibles/out-of-pocket costs</td>
<td>• Lack of coordinated care between the multidisciplinary team</td>
</tr>
<tr>
<td>• Financial assistance not determined until after service has been completed</td>
<td>• Patient gets lost in transitioning from one facility to another for services</td>
<td>• Fragmentation of care-to complete treatment may have to go to three different facilities</td>
</tr>
<tr>
<td>Health Care System Operations</td>
<td>• All services not offered in one facility</td>
<td>• Level of care accessible less than other facilities</td>
</tr>
<tr>
<td>• Scheduling not patient-centered</td>
<td>• Scheduling provider-centered not patient-centered</td>
<td>• Lack of coordinated care between the multidisciplinary team</td>
</tr>
<tr>
<td>• Unwelcoming atmosphere of facilities – not treated like others</td>
<td>• Fragmentation of care-to complete treatment may have to go to three different facilities</td>
<td></td>
</tr>
<tr>
<td>• Go to doctor for mammogram order, but other conditions treated first and order not received</td>
<td>• Level of care accessible less than other facilities</td>
<td></td>
</tr>
</tbody>
</table>

Recommendations provided by focus group participants and key informants 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 using 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, receiving screenings, and moving 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.

Recommendations provided by focus group participants and key informants 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, receiving screenings, and moving them seamlessly as needed through diagnostics and treatment into survivorship services. These navigation programs need be available in each Ward and for specific populations (e.g., Black/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.

**MISSION ACTION PLAN**

Utilizing the key findings from the quantitative, health system, public policy and partnership analysis, and qualitative data, the Komen Community Profile Team along with the Community Health Grantmaking and Advocacy Teams developed a comprehensive Mission Action Plan to address the identified issues in each of the target communities.

**Problem Statement:** It is predicted that Alexandria, Virginia and the District of Columbia will not achieve the Healthy People 2020 breast cancer late-stage diagnosis and death rate targets. Health system analyses found that within the target communities there is disproportionate access to breast cancer services among specific populations, even if services are available within the local communities. Common target community barriers identified by focus group participants and key informants included lack of breast cancer education and training, communication issues, competing priorities, transportation, financial, scheduling flexibility, and fragmented quality health care services.

**Priority:** Enhance the ability of health care systems and community organizations that provide breast cancer services to residents in Alexandria, Virginia and District of Columbia Wards 2, 5, 7 and 8 to provide seamless continuity of care between referral, screening, diagnosis, treatment, and survivorship services.

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1 “Wrap-around” services include the non-medical services that increase the availability or effectiveness of healthcare by linking, retaining, and supporting those who may need help taking their medications regularly, getting to their appointments on time, or coping with the psychological and emotional stresses surrounding their diagnosis. These services can include housing support, transportation, child care, emergency financial assistance, and psychosocial counseling.
Objective: Support the development and/or growth of breast cancer patient navigation and/or community health worker programs within Alexandria, Virginia and District of Columbia Wards 2, 5, 7 and 8 to assist residents in accessing screening and transitioning throughout the breast cancer continuum of care.

Objective: Support 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 in Alexandria, Virginia and District of Columbia Wards 2, 5, 7 and 8 such as churches, community centers, and places of employment.

Objective: Support the development or expansion of programs that reduce financial, communication and transportation barriers to breast cancer care for underserved residents of Alexandria, Virginia and District of Columbia Wards 2, 5, 7 and 8.

Objective: 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).

Priority: Initiate and support 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 minorities in Alexandria, Virginia and District of Columbia Wards 2, 5, 7 and 8.

Objective: Support culturally-appropriate, evidence-based one-on-one and group breast cancer education programs to underserved populations in Alexandria, Virginia and District of Columbia Wards 2, 5, 7 and 8.

Priority: Advocate to ensure that the fight against breast cancer is a priority among policymakers that serve the NCR.

Objective: On an annual basis, provide Maryland and Virginia US Representatives and Senators and District of Columbia policymakers at least one policy briefing regarding one of Komen’s Advocacy Priorities.

Note: Comprehensive data for the Executive Summary can be found in the 2015 Susan G. Komen® NCR Community Profile Report.
INTRODUCTION

ABOUT SUSAN G. KOMEN®

Susan G. Komen is the world’s largest breast cancer organization, funding more breast cancer research than any other nonprofit outside of the federal government while providing real-time help to those facing the disease. Since its founding in 1982, Komen has funded more than $920 million in research and provided more than $2 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.

PURPOSE OF THE COMMUNITY PROFILE REPORT

To fulfill our mission, Susan G. Komen conducts a Community Profile in each of the local communities it serves to investigate the health needs and assets related to breast health and breast cancer. An effective Community Profile will help Komen:

- Include a variety of people and organizations as stakeholders to strategically address breast health and breast cancer service gaps in the community;
- Communicate the breast cancer needs of the community to interested parties, including community organizations, hospitals, governmental agencies, and others;
- Make data-driven decisions about how to leverage community resources in the best way to have the greatest impact on breast cancer disparities;
- Support breast cancer programs in areas of greatest need, such as those defined as underserved by their demographic and socioeconomic status;
- Prevent duplication of existing services and programs;
- Provide information to public policy makers to help drive public policy that helps minimize breast cancer disparities;
- Direct culturally-competent, evidence-based breast cancer outreach programs toward areas of greatest need.

This Report will be used for strategically planning grantmaking and partnerships over the next five years to aid in the reduction of breast cancer late-stage incidence and mortality, with an emphasis on eliminating breast cancer disparities in the Komen National Capital Region.

NATIONAL CAPITAL REGION HISTORY

The Komen National Capital Region (NCR) includes the District of Columbia, Montgomery County and Prince George’s County in Maryland and Prince William County, Loudoun County, Arlington County, Fairfax County and the cities of Alexandria, Fairfax, Falls Church, Manassas, and Manassas Park in Virginia (Figures 1.2 and 1.3). Residents of the NCR face one of the highest rates for breast cancer incidence and mortality in the nation. The District of Columbia, specifically, 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 (Table 2.1).
In response to these findings, Susan G. Komen works in consultation with local staff and leadership to investigate the unique health needs of the NCR, and develops solutions to address those through community driven initiatives, aimed at reducing and eliminating breast cancer disparities.

Primarily, Komen centers its efforts in the NCR through the National Capital Region Community Grants Program. Other notable activities aimed at addressing the goals of the NCR include Komen's African-American Health Equity Initiative, leadership and participation in local breast cancer coalitions/summits, patient advocacy efforts and survivor networks, and scientific research activities designed to find the cures for breast cancer.

Since its inception in 1990, the District of Columbia (DC) Race for the Cure® (formerly known as the Global Race for the Cure), and other events such as the Honoring the Promise Gala, have raised funds for Komen's mission within the NCR. Approximately 75 percent of the funds raised stay within the NCR, and are granted out locally. These generous dollars have allowed Komen to invest more than $36 million in over 300 community grants within the Region. The remaining dollars support the Komen Research Program, which seeks to drive development of transformational technologies and novel treatments for incurable breast cancers.

National Capital Region grants have been awarded to a myriad of not-for-profit organizations and institutions that work to support Komen’s mission through the provision of breast cancer education, screening/diagnostics, treatment assistance, and patient navigation/support services. Current and past grantees have included community-based organizations, academic institutions, local hospital systems, and charitable foundations that target underserved communities such as low-income, minority and/or under- and uninsured individuals.

At the time of this report, there are 16 active grantees within the NCR. Each funded program has been developed in direct response to the needs identified within the National Capital Region, and demonstrates a diverse set of services warranted across multiple communities. For example:

- Culturally-competent navigation programs for Hispanic/Latina women that aid patients as they make their way through doctors’ offices, clinics, hospitals, outpatient centers, insurance/payment systems, patient-support organizations, and other components of the breast cancer continuum of care.

- Lay community advisor programs that address the needs of Black/African-American women through empowerment, and provide breast cancer education where women live, work, play, and pray.

- Programs that break down transportation, translation, or childcare barriers that may prevent patients from entering, or remaining in breast cancer treatment.

During the most recently completed grant cycle, Komen’s National Capital Region funding provided:

Source: FY14 Komen Grants eManagement System (GeMS) for NCR grantees
Through this funding, local programs and services are contributing to reductions in breast cancer mortality and the number of late-stage diagnoses in the National Capital Region. Additional information about our NCR grantees and their local impact can be found on the Komen website at www.komen.org.

**African-American Health Equity Initiative**

Komen believes that where you live should not determine whether you live, and that all women should have equal access to quality breast health care. According to both the Centers for Disease Control and Prevention (CDC) and the National Cancer Institute (NCI) at the National Institute of Health (NIH), although White women have the highest breast cancer incidence rate, Black/African-American women have the highest morbidity across all races and are 40 percent more likely to die due to breast cancer than are White women. Contributing factors to these statistics include a lack of access to high-quality treatment, decreased prevalence of follow-up care and treatment, and more persistent and faster-growing cancers. These disparities are worse in the NCR, as Black/African American women in the NCR are 51 percent more likely to die due to breast cancer than are White women in the NCR (Table 2.1).

Through our commitment to bridge the gaps in healthcare access and outcomes, Komen has recently launched a health equity initiative specifically focused on addressing and eliminating breast cancer disparities for Black/African-American communities in Washington, DC, as well as in nine other communities nationwide. The goals of this initiative include: the achievement of health equity and the establishment of trust in Black/African-American communities; the reduction of barriers to quality care through patient navigation; and the empowerment of community through patient advocacy.
Figure 1.2. Komen National Capital Region service area
Figure 1.3. District of Columbia Wards serviced by Komen National Capital Region
ORGANIZATIONAL STRUCTURE

The Komen National Capital Region is overseen by staff at Susan G. Komen Headquarters, and is supported through key teams based in Dallas, TX [Research/Community Health Program Operations, Evaluation and Outcomes (E&O), Marketing, Development and Operations Support], and locally in Washington, DC (Public Policy/Advocacy, Health Equities Initiative, and Race for the Cure) (Figure 1.1).

Figure 1.1. Komen National Capital Region organizational chart

Research and Community Health Programs Operations
The National Capital Region Community Grants Program is overseen by dedicated and qualified staff located at Komen Headquarters. Program oversight and strategic goals are directed by the Vice President of Research and Community Health Program Operations, while program implementation is overseen by the Manager, National Community Programs. The daily management of programmatic activities and inquiries is conducted by the Community Grants Manager, with the support of a Community Grants Administrator. Through closely coordinated efforts, the National Capital Region Community Grants team works in tandem with local Komen leadership in Washington, DC to monitor program impact, and develop innovative strategies that address policy and health disparity issues.

In addition to staff oversight, the NCR Community Grants Program is facilitated by a Committee of local experts who review applications, and assist in identifying programs that are likely to have the greatest impact in the NCR. Komen Headquarters relies on this diverse committee, with backgrounds in breast cancer care, grantmaking, nonprofit administration, program management, and public health, to ensure that funded programs are robust, evidence-based, and aligned with Komen’s priorities as identified within the NCR Community Profile.

Evaluation and Outcomes (E&O)
The Komen E&O Team led by the Senior Director, conducts the Community Profile process every five years to provide an in-depth analysis of the state of breast cancer in the NCR, and conduct periodic assessments of the community health activities related to grantmaking and health equity initiative as needed.
Public Policy and Advocacy
The Public Policy and Advocacy staff, led by the Director of Public Policy, work to ensure that the fight against breast cancer is a priority among policymakers in Washington, DC, and every Capitol across the country. Komen staff in Washington, DC work to identify, through a transparent and broad-based, intensive vetting and selection process, policy issues that have the greatest potential impact on Komen’s mission in the NCR, and nationwide. This process includes the collection of feedback from Komen Headquarters leadership, policy staff, and subject matter experts including; Komen Affiliates; advisory groups including the Komen Advocacy Advisory Taskforce (KAAT), Advocates in Science (AIS), and Komen Scholars; and other stakeholders with a vested interest in breast cancer-related issues. The selected issues are the basis for Komen’s state and federal advocacy work within the National Capital Region, and elsewhere, in the coming year.

African-American Health Equity Initiative
The Sr. Manager, Special Initiatives serves in a key role to execute select programs in the 10 communities where disparities in breast cancer outcomes for Black/African-American women are greatest, including Washington, DC.

NATIONAL CAPITAL REGION DEMOGRAPHICS

Race and Ethnicity
The NCR is diverse with an average of 33.4 percent of residents self-identifying as Black/African-American, 14.7 percent as Hispanic/Latino and 8.5 percent as Asian and Pacific Islander (Table 1.1). Within the National Capital Region, Prince George’s County, MD had the largest percentage of residents self-identifying as Black/African-American (62.8 percent); Prince William, VA the largest percentage of Hispanic/Latino residents (21.5 percent) and Fairfax City (15.6 percent) and Loudon County (16.6 percent), VA the largest percentage of Asian and Pacific Islander residents.

<table>
<thead>
<tr>
<th></th>
<th>District of Columbia</th>
<th>Maryland Counties (average)</th>
<th>Virginia Counties (average)</th>
<th>NCR (average)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White (Non-Hispanic)</td>
<td>35.8%</td>
<td>30.8%</td>
<td>56.6%</td>
<td>53.0%</td>
</tr>
<tr>
<td>Black/African-American (Non-Hispanic)</td>
<td>47.9%</td>
<td>40.1%</td>
<td>12.3%</td>
<td>33.4%</td>
</tr>
<tr>
<td>Asians and Pacific Islanders (APIs)</td>
<td>4.0%</td>
<td>9.9%</td>
<td>11.5%</td>
<td>8.5%</td>
</tr>
<tr>
<td>American Indians and Alaska Native (AIANs)</td>
<td>0.6%</td>
<td>0.9%</td>
<td>0.8%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>10.1%</td>
<td>17.3%</td>
<td>16.8%</td>
<td>14.7%</td>
</tr>
</tbody>
</table>

Source: US Census Bureau, population Estimates Program (PEP), 2013

Income and Employment
The unemployment level within the NCR averages to 6.1 percent with the highest level experienced by District of Columbia residents (8.3 percent) (Table 1.2). In terms of income equality, residents in the District of Columbia experience a greater division between the higher and lower ends of the income spectrum. In addition, the District of Columbia’s median household income is 22.0 percent lower than the Maryland counties in the service area and 32.0 percent lower than Virginia counties in the service area.
Table 1.2. Income and employment characteristics of the National Capital Region

<table>
<thead>
<tr>
<th></th>
<th>District of Columbia</th>
<th>Maryland Counties (average)</th>
<th>Virginia Counties (average)</th>
<th>NCR (average)</th>
<th>Top US Performers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployment (Age 16 and older)</td>
<td>8.3%</td>
<td>6.0%</td>
<td>4.1%</td>
<td>6.1%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Income Inequality:</td>
<td>6.9</td>
<td>4.0</td>
<td>3.7</td>
<td>4.9</td>
<td>3.7</td>
</tr>
<tr>
<td>Higher inequality ratio</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>indicates greater division</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>between top and bottom ends of</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>the income spectrum</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median Household Income</td>
<td>$66,326</td>
<td>$84,778</td>
<td>$97,591</td>
<td>$82,898</td>
<td>NA</td>
</tr>
</tbody>
</table>

NA= Not available.

Education

In terms of educational attainment, approximately 8 out of 10 ninth graders within the Maryland and Virginia counties will graduate in four years compared to only 6 out 10 in the District of Columbia (Table 1.3). Within the National Capital Region service area, almost 76 percent of 25-44 years olds have some post-secondary education. Arlington County is the most educated county in the Nation. In 2013, 71.7 percent of adults age 25 and older had a bachelor’s degree or higher and 37.4 percent had a graduate or professional degree (Arlington County Government, 2015).

Table 1.3. Education characteristics of the National Capital Region service area

<table>
<thead>
<tr>
<th></th>
<th>District of Columbia</th>
<th>Maryland Counties (average)</th>
<th>Virginia Counties (average)</th>
<th>NCR (average)</th>
<th>Top US Performers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of ninth graders</td>
<td>59.0%</td>
<td>80.0%</td>
<td>83.0%</td>
<td>74.0%</td>
<td>NA</td>
</tr>
<tr>
<td>that graduate in 4 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of adults ages 25-44</td>
<td>78.5%</td>
<td>68.1%</td>
<td>80.5%</td>
<td>75.7%</td>
<td>71.0%</td>
</tr>
<tr>
<td>with some post-secondary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NA= Not available.
Source of ninth graders that graduate: Data.gov, Adjusted Cohort Graduation Rates at the Local Education Agency, 2011-2012.

Health Status and Insurance Coverage

On average, only 11.3 percent of residents of the National Capital Region self-report their health as poor or fair and 10.7 percent have self-reported that they were unable to visit a doctor within the past 12 months because of the cost that would be incurred (Table 1.4). Within the National Capital Region, Maryland counties had the highest percentage of uninsured adults (18.0 percent) with 1 in 5 adults in Prince George’s County reported as being uninsured.
### Table 1.4. Health status and insurance coverage characteristics of the National Capital Region service area

<table>
<thead>
<tr>
<th></th>
<th>District of Columbia</th>
<th>Maryland Counties (average)</th>
<th>Virginia Counties (average)</th>
<th>NCR (average)</th>
<th>Top US Performers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of Adults Reporting Poor or Fair Health</td>
<td>12.0%</td>
<td>11.0%</td>
<td>10.8%</td>
<td>11.3%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Percentage of Adults Who Could Not See A Doctor in the Past 12 Months Because of Cost</td>
<td>9.0%</td>
<td>12.5%</td>
<td>10.5%</td>
<td>10.7%</td>
<td>NA</td>
</tr>
<tr>
<td>Uninsured Adults</td>
<td>8.0%</td>
<td>18.0%</td>
<td>14.2%</td>
<td>13.4%</td>
<td>11%</td>
</tr>
</tbody>
</table>

NA= Not available.


### Medically Underserved Areas and Populations within the National Capital Region

The US Department of Health and Human Services Health Resources and Services Administration (HRSA) designates areas in the United States as Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs):

- To be designated as an MUA, four variables are involved- ratio of medical care providers, infant mortality rate, poverty level and percentage of population over the age of 65.
- To be designated as a MUP, specific population groups have to experience economic or cultural/linguistic barriers in accessing medical care.

Within the National Capital Region, there are eight US Department of Health and Human Services Medically Underserved Areas (MUAs) and nine Medically Underserved Populations (Table 1.5).

### Table 1.5. MUAs and MUPs within the National Capital Region service area

<table>
<thead>
<tr>
<th></th>
<th>District of Columbia</th>
<th>Maryland Counties</th>
<th>Virginia Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medically Underserved Areas</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Anacostia</td>
<td></td>
<td>Accokeek Neighborhood (Prince George’s County)</td>
<td>Loudoun Service Area (Loudoun County)</td>
</tr>
<tr>
<td>• East Capitol Southeast</td>
<td></td>
<td>Aspen Hill (Montgomery County)</td>
<td></td>
</tr>
<tr>
<td>• South Capital</td>
<td></td>
<td>Collington Neighborhood (Prince George’s County)</td>
<td></td>
</tr>
<tr>
<td>• District Heights/Capitol Heights (Prince George’s County)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medically Underserved Population</strong></td>
<td></td>
<td>Low-income- Brandywine (Prince George’s County)</td>
<td>Low-income- Arlandria (Alexandria City /Arlington County)</td>
</tr>
<tr>
<td>• Homeless- Downtown Washington</td>
<td></td>
<td>Low-income- Takoma/Langley (Montgomery Co/Prince George’s County)</td>
<td>Low-income- Manassas Park City (Prince William County)</td>
</tr>
<tr>
<td>• Low-income- Brentwood</td>
<td></td>
<td>Medicaid eligible- College Park (Prince George’s County)</td>
<td>Low-income- Woodbridge (Prince William County)</td>
</tr>
<tr>
<td>• Low-income- Columbia Heights/Ft. Totten/ Takoma</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: US Department of Health and Human Services, Health Resources and Services Administration, Data Warehouse, 2016.
QUANTITATIVE DATA: MEASURING BREAST CANCER IMPACT IN LOCAL COMMUNITIES

INTRODUCTION

The purpose of the quantitative data report for the 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).

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. Thus, 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 can be difficult to determine 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 is 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 screened. So higher rates do not 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. 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

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Female Population (Annual Average)</th>
<th># of New Cases (Annual Average)</th>
<th>Age-adjusted Rate/100,000</th>
<th>Trend (Annual Percent Change)</th>
<th># of Deaths (Annual Average)</th>
<th>Age-adjusted Rate/100,000</th>
<th>Trend (Annual Percent Change)</th>
<th># of New Cases (Annual Average)</th>
<th>Age-adjusted Rate/100,000</th>
<th>Trend (Annual Percent Change)</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>154,540,194</td>
<td>198,602</td>
<td>122.1</td>
<td>-0.2%</td>
<td>40,736</td>
<td>22.6</td>
<td>-1.9%</td>
<td>70,218</td>
<td>43.7</td>
<td>-1.2%</td>
</tr>
<tr>
<td>HP2020</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>20.6</td>
<td>-</td>
<td>-</td>
<td>41.0</td>
<td>-</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>308,298</td>
<td>441</td>
<td>139.7</td>
<td>0.7%</td>
<td>98</td>
<td>29.8</td>
<td>NA</td>
<td>181</td>
<td>58.0</td>
<td>-4.3%</td>
</tr>
<tr>
<td>Maryland</td>
<td>2,942,268</td>
<td>4,206</td>
<td>128.0</td>
<td>1.7%</td>
<td>818</td>
<td>24.5</td>
<td>-2.0%</td>
<td>1,521</td>
<td>46.4</td>
<td>-0.5%</td>
</tr>
<tr>
<td>Virginia</td>
<td>3,993,827</td>
<td>5,420</td>
<td>124.8</td>
<td>1.3%</td>
<td>1,074</td>
<td>24.0</td>
<td>-1.9%</td>
<td>1,896</td>
<td>43.9</td>
<td>0.1%</td>
</tr>
<tr>
<td>Komen National Capital Region Service Area</td>
<td>2,324,241</td>
<td>2,939</td>
<td>126.0</td>
<td>1.3%</td>
<td>550</td>
<td>23.5</td>
<td>NA</td>
<td>1,064</td>
<td>45.2</td>
<td>-0.9%</td>
</tr>
<tr>
<td>White</td>
<td>1,323,847</td>
<td>1,822</td>
<td>130.6</td>
<td>1.6%</td>
<td>305</td>
<td>21.3</td>
<td>NA</td>
<td>592</td>
<td>42.4</td>
<td>0.3%</td>
</tr>
<tr>
<td>Black/African-American</td>
<td>718,248</td>
<td>853</td>
<td>122.6</td>
<td>1.2%</td>
<td>223</td>
<td>32.2</td>
<td>NA</td>
<td>377</td>
<td>53.6</td>
<td>-2.8%</td>
</tr>
<tr>
<td>AIAN</td>
<td>17,456</td>
<td>6</td>
<td>63.7</td>
<td>-1.7%</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>API</td>
<td>264,690</td>
<td>179</td>
<td>75.0</td>
<td>3.4%</td>
<td>22</td>
<td>9.2</td>
<td>NA</td>
<td>67</td>
<td>27.6</td>
<td>2.5%</td>
</tr>
<tr>
<td>Non-Hispanic/ Latina</td>
<td>2,009,819</td>
<td>2,791</td>
<td>130.2</td>
<td>1.4%</td>
<td>531</td>
<td>24.5</td>
<td>NA</td>
<td>1,006</td>
<td>46.7</td>
<td>-1.0%</td>
</tr>
<tr>
<td>Hispanic/ Latina</td>
<td>314,422</td>
<td>147</td>
<td>77.2</td>
<td>1.7%</td>
<td>18</td>
<td>9.8</td>
<td>NA</td>
<td>58</td>
<td>26.7</td>
<td>1.7%</td>
</tr>
<tr>
<td>District of Columbia - DC</td>
<td>308,296</td>
<td>441</td>
<td>139.7</td>
<td>0.7%</td>
<td>98</td>
<td>29.8</td>
<td>-2.3%</td>
<td>181</td>
<td>58.0</td>
<td>-4.3%</td>
</tr>
<tr>
<td>Montgomery County - MD</td>
<td>492,599</td>
<td>720</td>
<td>127.5</td>
<td>-0.5%</td>
<td>115</td>
<td>19.6</td>
<td>-3.0%</td>
<td>230</td>
<td>40.9</td>
<td>-4.4%</td>
</tr>
<tr>
<td>Prince George's County - MD</td>
<td>444,819</td>
<td>532</td>
<td>118.5</td>
<td>0.2%</td>
<td>121</td>
<td>27.8</td>
<td>-1.8%</td>
<td>214</td>
<td>47.0</td>
<td>-7.3%</td>
</tr>
<tr>
<td>Arlington County - VA</td>
<td>99,145</td>
<td>118</td>
<td>130.8</td>
<td>3.1%</td>
<td>20</td>
<td>21.9</td>
<td>-2.4%</td>
<td>39</td>
<td>43.7</td>
<td>-3.0%</td>
</tr>
<tr>
<td>Fairfax County - VA</td>
<td>530,502</td>
<td>693</td>
<td>126.7</td>
<td>1.7%</td>
<td>113</td>
<td>21.6</td>
<td>-2.5%</td>
<td>227</td>
<td>40.9</td>
<td>3.0%</td>
</tr>
<tr>
<td>Loudoun County - VA</td>
<td>147,541</td>
<td>144</td>
<td>122.5</td>
<td>-1.1%</td>
<td>23</td>
<td>21.2</td>
<td>-2.2%</td>
<td>49</td>
<td>41.9</td>
<td>-2.0%</td>
</tr>
<tr>
<td>Prince William County - VA</td>
<td>190,490</td>
<td>186</td>
<td>116.0</td>
<td>0.7%</td>
<td>34</td>
<td>22.7</td>
<td>-2.2%</td>
<td>67</td>
<td>40.8</td>
<td>2.5%</td>
</tr>
<tr>
<td>Alexandria City - VA</td>
<td>69,407</td>
<td>83</td>
<td>121.4</td>
<td>5.6%</td>
<td>16</td>
<td>23.0</td>
<td>15.7%</td>
<td>30</td>
<td>44.6</td>
<td>5.9%</td>
</tr>
<tr>
<td>Fairfax City - VA</td>
<td>11,197</td>
<td>17</td>
<td>124.8</td>
<td>-3.7%</td>
<td>4</td>
<td>32.0</td>
<td>-3.3%</td>
<td>5</td>
<td>37.9</td>
<td>-29.5%</td>
</tr>
<tr>
<td>Falls Church City - VA</td>
<td>5,868</td>
<td>9</td>
<td>143.5</td>
<td>25.7%</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>4</td>
<td>51.3</td>
<td>48.7%</td>
</tr>
<tr>
<td>Manassas City - VA</td>
<td>17,895</td>
<td>18</td>
<td>118.3</td>
<td>5.4%</td>
<td>3</td>
<td>24.0</td>
<td>-2.7%</td>
<td>7</td>
<td>43.7</td>
<td>-7.9%</td>
</tr>
<tr>
<td>Manassas Park City - VA</td>
<td>6,482</td>
<td>4</td>
<td>93.7</td>
<td>6.0%</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
</tbody>
</table>

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 trend data: NCI/CDC State Cancer Profiles.
Table 2.2. Female breast cancer incidence and death rates, District of Columbia

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

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 and the incidence trend was higher than the US. The incidence rate of the NCR 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 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 Asian 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, 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:
• 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 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, the incidence rate was lower among Blacks/African-Americans than Whites in the District of Columbia.
It is 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 screened.

**Death rates and trends summary**

Overall, the breast cancer death rate in the NCR 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.

**Table 2.3. Breast cancer screening recommendations for women at average risk**

<table>
<thead>
<tr>
<th>American Cancer Society</th>
<th>National Comprehensive Cancer Network</th>
<th>US Preventive Services Task Force</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informed decision-making with a health care provider ages 40-44</td>
<td>Every year starting at age 45-54</td>
<td>Informed decision-making with a health care provider ages 40-49</td>
</tr>
<tr>
<td>Every 2 years (or every other year if a woman chooses to do so) starting at age 55, for as long as a woman is in good health</td>
<td>Every year starting at age 40, for as long as a woman is in good health</td>
<td>Every 2 years ages 50-74</td>
</tr>
</tbody>
</table>

*As of August 2016

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

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

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

- The number of women living in an area that the BRFSS determines should have mammograms (i.e. women age 50 to 74).
- The number of these women who 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 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

<table>
<thead>
<tr>
<th>Population Group</th>
<th># of Women Interviewed (Sample Size)</th>
<th># w/ Self-Reported Mammogram</th>
<th>Proportion Screened (Weighted Average)</th>
<th>Confidence Interval of Proportion Screened</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>174,796</td>
<td>133,399</td>
<td>77.5%</td>
<td>77.2%-77.7%</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>1,407</td>
<td>1,177</td>
<td>83.7%</td>
<td>80.8%-86.2%</td>
</tr>
<tr>
<td>Maryland</td>
<td>5,028</td>
<td>4,096</td>
<td>82.6%</td>
<td>81.2%-83.9%</td>
</tr>
<tr>
<td>Virginia</td>
<td>2,644</td>
<td>2,156</td>
<td>79.8%</td>
<td>77.8%-81.7%</td>
</tr>
<tr>
<td>Komen National Capital Region Service Area</td>
<td>2,838</td>
<td>2,380</td>
<td>84.3%</td>
<td>82.5%-86.0%</td>
</tr>
<tr>
<td>White</td>
<td>1,542</td>
<td>1,265</td>
<td>83.9%</td>
<td>81.5%-86.0%</td>
</tr>
<tr>
<td>Black/African-American</td>
<td>1,126</td>
<td>975</td>
<td>86.1%</td>
<td>85.3%-90.4%</td>
</tr>
<tr>
<td>API</td>
<td>63</td>
<td>53</td>
<td>76.8%</td>
<td>60.8%-87.6%</td>
</tr>
<tr>
<td>Hispanic/ Latina</td>
<td>77</td>
<td>65</td>
<td>81.8%</td>
<td>67.0%-90.8%</td>
</tr>
<tr>
<td>Non-Hispanic/ Latina</td>
<td>2,747</td>
<td>2,305</td>
<td>84.5%</td>
<td>82.7%-86.2%</td>
</tr>
<tr>
<td>District of Columbia – DC</td>
<td>1,405</td>
<td>1,175</td>
<td>83.6%</td>
<td>80.8%-86.1%</td>
</tr>
<tr>
<td>Montgomery County – MD</td>
<td>504</td>
<td>413</td>
<td>81.8%</td>
<td>77.2%-85.7%</td>
</tr>
<tr>
<td>Prince George's County – MD</td>
<td>419</td>
<td>362</td>
<td>88.1%</td>
<td>83.6%-91.5%</td>
</tr>
<tr>
<td>Arlington County – VA</td>
<td>54</td>
<td>50</td>
<td>93.9%</td>
<td>79.7%-98.4%</td>
</tr>
<tr>
<td>Fairfax County – VA</td>
<td>214</td>
<td>178</td>
<td>84.0%</td>
<td>76.6%-89.4%</td>
</tr>
<tr>
<td>Loudoun County – VA</td>
<td>64</td>
<td>48</td>
<td>74.6%</td>
<td>59.7%-85.3%</td>
</tr>
<tr>
<td>Prince William County – VA</td>
<td>81</td>
<td>68</td>
<td>83.8%</td>
<td>70.4%-91.9%</td>
</tr>
<tr>
<td>Alexandria City – VA</td>
<td>48</td>
<td>44</td>
<td>90.6%</td>
<td>74.5%-96.9%</td>
</tr>
<tr>
<td>Fairfax City – VA</td>
<td>46</td>
<td>39</td>
<td>84.0%</td>
<td>66.0%-93.4%</td>
</tr>
<tr>
<td>Falls Church City – VA</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>Manassas City – VA</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>Manassas Park City – VA</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
</tbody>
</table>

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. 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, 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 overall.

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

<table>
<thead>
<tr>
<th>Population Group</th>
<th>White</th>
<th>Black/African-American</th>
<th>AIAN</th>
<th>API</th>
<th>Non-Hispanic/Latina</th>
<th>Hispanic/Latina</th>
<th>Female Age 40 Plus</th>
<th>Female Age 50 Plus</th>
<th>Female Age 65 Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>78.8%</td>
<td>14.1%</td>
<td>1.4%</td>
<td>5.8%</td>
<td>83.8%</td>
<td>16.2%</td>
<td>48.3%</td>
<td>34.5%</td>
<td>14.8%</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>41.1%</td>
<td>53.7%</td>
<td>0.6%</td>
<td>4.6%</td>
<td>91.3%</td>
<td>8.7%</td>
<td>41.5%</td>
<td>29.8%</td>
<td>12.9%</td>
</tr>
<tr>
<td>Maryland</td>
<td>61.1%</td>
<td>32.0%</td>
<td>0.6%</td>
<td>6.4%</td>
<td>92.2%</td>
<td>7.8%</td>
<td>49.4%</td>
<td>34.4%</td>
<td>13.9%</td>
</tr>
<tr>
<td>Virginia</td>
<td>71.9%</td>
<td>21.1%</td>
<td>0.6%</td>
<td>6.5%</td>
<td>92.3%</td>
<td>7.7%</td>
<td>48.5%</td>
<td>33.9%</td>
<td>13.9%</td>
</tr>
<tr>
<td>Komen National Capital Region Service Area</td>
<td>56.7%</td>
<td>30.5%</td>
<td>0.8%</td>
<td>12.0%</td>
<td>85.4%</td>
<td>14.6%</td>
<td>45.5%</td>
<td>30.4%</td>
<td>11.3%</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>38.5%</td>
<td>50.7%</td>
<td>0.3%</td>
<td>3.6%</td>
<td>90.9%</td>
<td>9.1%</td>
<td>41.5%</td>
<td>29.8%</td>
<td>12.9%</td>
</tr>
<tr>
<td>Montgomery County - MD</td>
<td>64.1%</td>
<td>19.7%</td>
<td>0.7%</td>
<td>15.5%</td>
<td>83.3%</td>
<td>16.7%</td>
<td>50.1%</td>
<td>34.7%</td>
<td>14.0%</td>
</tr>
<tr>
<td>Prince George’s County – MD</td>
<td>24.8%</td>
<td>69.4%</td>
<td>1.1%</td>
<td>4.7%</td>
<td>86.7%</td>
<td>13.3%</td>
<td>46.0%</td>
<td>30.9%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Arlington County - VA</td>
<td>77.8%</td>
<td>9.9%</td>
<td>0.9%</td>
<td>11.4%</td>
<td>85.3%</td>
<td>14.7%</td>
<td>38.8%</td>
<td>25.7%</td>
<td>9.7%</td>
</tr>
<tr>
<td>Fairfax County – VA</td>
<td>69.0%</td>
<td>10.7%</td>
<td>0.7%</td>
<td>19.7%</td>
<td>84.8%</td>
<td>15.2%</td>
<td>47.7%</td>
<td>31.8%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Loudoun County - VA</td>
<td>74.1%</td>
<td>8.9%</td>
<td>0.5%</td>
<td>16.5%</td>
<td>87.8%</td>
<td>12.2%</td>
<td>41.6%</td>
<td>23.5%</td>
<td>7.6%</td>
</tr>
<tr>
<td>Prince William County - VA</td>
<td>66.4%</td>
<td>23.2%</td>
<td>1.2%</td>
<td>9.3%</td>
<td>80.4%</td>
<td>19.6%</td>
<td>41.3%</td>
<td>25.0%</td>
<td>7.9%</td>
</tr>
<tr>
<td>Alexandria City – VA</td>
<td>68.2%</td>
<td>23.5%</td>
<td>0.8%</td>
<td>7.6%</td>
<td>84.7%</td>
<td>15.3%</td>
<td>42.5%</td>
<td>28.3%</td>
<td>10.4%</td>
</tr>
<tr>
<td>Fairfax City – VA</td>
<td>75.4%</td>
<td>6.5%</td>
<td>1.1%</td>
<td>17.0%</td>
<td>84.3%</td>
<td>15.7%</td>
<td>50.3%</td>
<td>35.7%</td>
<td>15.6%</td>
</tr>
<tr>
<td>Falls Church City - VA</td>
<td>82.9%</td>
<td>5.2%</td>
<td>0.4%</td>
<td>11.5%</td>
<td>90.8%</td>
<td>9.2%</td>
<td>50.4%</td>
<td>33.9%</td>
<td>11.6%</td>
</tr>
<tr>
<td>Manassas City – VA</td>
<td>76.0%</td>
<td>16.6%</td>
<td>1.2%</td>
<td>6.2%</td>
<td>70.1%</td>
<td>29.9%</td>
<td>40.2%</td>
<td>25.7%</td>
<td>8.1%</td>
</tr>
<tr>
<td>Manassas Park City - VA</td>
<td>72.0%</td>
<td>15.9%</td>
<td>1.5%</td>
<td>10.6%</td>
<td>68.0%</td>
<td>32.0%</td>
<td>34.5%</td>
<td>19.8%</td>
<td>6.2%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Population Group</th>
<th>White</th>
<th>Black/African-American</th>
<th>AIAN</th>
<th>API</th>
<th>Non-Hispanic/Latina</th>
<th>Hispanic/Latina</th>
<th>Female Age 40 Plus</th>
<th>Female Age 50 Plus</th>
<th>Female Age 65 Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>District of Columbia</td>
<td>38.5%</td>
<td>50.7%</td>
<td>0.3%</td>
<td>3.6%</td>
<td>90.9%</td>
<td>9.1%</td>
<td>41.5%</td>
<td>29.8%</td>
<td>12.9%</td>
</tr>
<tr>
<td>Ward 1</td>
<td>48.4%</td>
<td>32.5%</td>
<td>0.5%</td>
<td>4.2%</td>
<td>79.2%</td>
<td>20.8%</td>
<td>30.2%</td>
<td>20.0%</td>
<td>8.4%</td>
</tr>
<tr>
<td>Ward 2</td>
<td>71.7%</td>
<td>12.6%</td>
<td>0.3%</td>
<td>8.8%</td>
<td>90.5%</td>
<td>9.5%</td>
<td>27.8%</td>
<td>20.5%</td>
<td>9.1%</td>
</tr>
<tr>
<td>Ward 3</td>
<td>83.5%</td>
<td>5.0%</td>
<td>0.2%</td>
<td>6.7%</td>
<td>92.5%</td>
<td>7.5%</td>
<td>45.3%</td>
<td>33.5%</td>
<td>15.3%</td>
</tr>
<tr>
<td>Ward 4</td>
<td>24.5%</td>
<td>58.7%</td>
<td>0.4%</td>
<td>1.7%</td>
<td>81.3%</td>
<td>18.7%</td>
<td>52.7%</td>
<td>39.1%</td>
<td>18.2%</td>
</tr>
<tr>
<td>Ward 5</td>
<td>16.5%</td>
<td>76.0%</td>
<td>0.4%</td>
<td>1.4%</td>
<td>93.7%</td>
<td>6.3%</td>
<td>49.2%</td>
<td>36.6%</td>
<td>17.0%</td>
</tr>
<tr>
<td>Ward 6</td>
<td>49.7%</td>
<td>41.6%</td>
<td>0.4%</td>
<td>4.2%</td>
<td>95.2%</td>
<td>4.8%</td>
<td>29.1%</td>
<td>16.6%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Ward 7</td>
<td>1.8%</td>
<td>94.9%</td>
<td>0.3%</td>
<td>0.2%</td>
<td>97.7%</td>
<td>2.3%</td>
<td>49.2%</td>
<td>35.3%</td>
<td>15.1%</td>
</tr>
<tr>
<td>Ward 8</td>
<td>3.7%</td>
<td>93.5%</td>
<td>0.2%</td>
<td>0.4%</td>
<td>98.2%</td>
<td>1.8%</td>
<td>38.0%</td>
<td>25.5%</td>
<td>8.8%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Less than HS Education</th>
<th>Income Below 100% Poverty</th>
<th>Income Below 250% Poverty (Age: 40-64)</th>
<th>Unemployed</th>
<th>Foreign Born</th>
<th>Linguistically Isolated</th>
<th>In Rural Areas</th>
<th>In Medically Underserved Areas</th>
<th>No Health Insurance (Age: 40-64)</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>14.6%</td>
<td>14.3%</td>
<td>33.3%</td>
<td>8.7%</td>
<td>12.8%</td>
<td>4.7%</td>
<td>19.3%</td>
<td>23.3%</td>
<td>16.6%</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>12.9%</td>
<td>18.2%</td>
<td>34.2%</td>
<td>10.0%</td>
<td>13.3%</td>
<td>2.6%</td>
<td>0.0%</td>
<td>27.7%</td>
<td>7.9%</td>
</tr>
<tr>
<td>Maryland</td>
<td>11.8%</td>
<td>9.0%</td>
<td>22.8%</td>
<td>7.3%</td>
<td>13.5%</td>
<td>3.2%</td>
<td>12.8%</td>
<td>17.4%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Virginia</td>
<td>13.4%</td>
<td>10.7%</td>
<td>26.9%</td>
<td>6.5%</td>
<td>11.0%</td>
<td>2.7%</td>
<td>24.5%</td>
<td>27.2%</td>
<td>13.3%</td>
</tr>
<tr>
<td>Komen National Capital Region Service Area</td>
<td>10.2%</td>
<td>7.8%</td>
<td>18.4%</td>
<td>6.4%</td>
<td>24.2%</td>
<td>5.7%</td>
<td>2.4%</td>
<td>7.7%</td>
<td>11.2%</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>12.9%</td>
<td>18.2%</td>
<td>34.2%</td>
<td>10.0%</td>
<td>13.3%</td>
<td>2.6%</td>
<td>0.0%</td>
<td>27.7%</td>
<td>7.9%</td>
</tr>
<tr>
<td>Montgomery County - MD</td>
<td>8.9%</td>
<td>6.3%</td>
<td>16.1%</td>
<td>5.7%</td>
<td>31.4%</td>
<td>7.6%</td>
<td>2.4%</td>
<td>6.2%</td>
<td>11.7%</td>
</tr>
<tr>
<td>Prince George's County – MD</td>
<td>14.2%</td>
<td>8.2%</td>
<td>22.9%</td>
<td>8.8%</td>
<td>19.8%</td>
<td>4.0%</td>
<td>2.0%</td>
<td>11.6%</td>
<td>13.9%</td>
</tr>
<tr>
<td>Arlington County - VA</td>
<td>7.4%</td>
<td>7.1%</td>
<td>12.4%</td>
<td>3.4%</td>
<td>23.4%</td>
<td>4.5%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>7.9%</td>
</tr>
<tr>
<td>Fairfax County – VA</td>
<td>8.1%</td>
<td>5.5%</td>
<td>14.0%</td>
<td>4.7%</td>
<td>29.0%</td>
<td>7.3%</td>
<td>1.4%</td>
<td>0.0%</td>
<td>10.6%</td>
</tr>
<tr>
<td>Loudoun County - VA</td>
<td>6.4%</td>
<td>3.4%</td>
<td>9.5%</td>
<td>4.3%</td>
<td>22.2%</td>
<td>4.8%</td>
<td>12.6%</td>
<td>9.8%</td>
<td>7.9%</td>
</tr>
<tr>
<td>Prince William County – VA</td>
<td>11.4%</td>
<td>5.6%</td>
<td>16.8%</td>
<td>5.4%</td>
<td>21.3%</td>
<td>6.1%</td>
<td>4.2%</td>
<td>0.0%</td>
<td>13.9%</td>
</tr>
<tr>
<td>Alexandria City – VA</td>
<td>9.0%</td>
<td>7.8%</td>
<td>16.4%</td>
<td>4.5%</td>
<td>24.5%</td>
<td>5.8%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>10.6%</td>
</tr>
<tr>
<td>Fairfax City – VA</td>
<td>6.7%</td>
<td>5.9%</td>
<td>13.7%</td>
<td>4.4%</td>
<td>24.2%</td>
<td>4.6%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>10.4%</td>
</tr>
<tr>
<td>Falls Church City - VA</td>
<td>4.0%</td>
<td>3.9%</td>
<td>6.3%</td>
<td>6.3%</td>
<td>20.2%</td>
<td>2.5%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Manassas City – VA</td>
<td>19.8%</td>
<td>13.8%</td>
<td>24.5%</td>
<td>7.3%</td>
<td>24.5%</td>
<td>13.5%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>17.0%</td>
</tr>
<tr>
<td>Manassas Park City - VA</td>
<td>17.9%</td>
<td>4.3%</td>
<td>28.0%</td>
<td>4.9%</td>
<td>31.0%</td>
<td>12.4%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>19.4%</td>
</tr>
</tbody>
</table>

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 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

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

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 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
- 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
- Manassas City, VA

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

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

To see how well counties in the Komen 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

<table>
<thead>
<tr>
<th>Time to Achieve Death Rate Reduction Target</th>
<th>Time to Achieve Late-stage Incidence Reduction Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 years or longer</td>
<td>Highest</td>
</tr>
<tr>
<td>7-12 yrs.</td>
<td>High</td>
</tr>
<tr>
<td>0 – 6 yrs.</td>
<td>Medium High</td>
</tr>
<tr>
<td>Currently meets target</td>
<td>Medium Low</td>
</tr>
<tr>
<td>Unknown</td>
<td>Highest</td>
</tr>
</tbody>
</table>

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 does not mean that the county may not have high needs; it only means that sufficient data are not available to classify the county.

NCR 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 several 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

<table>
<thead>
<tr>
<th>County</th>
<th>Priority</th>
<th>Predicted Time to Achieve Death Rate Target</th>
<th>Predicted Time to Achieve Late-stage Incidence Target</th>
<th>Key Population Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alexandria City - VA</td>
<td>Highest</td>
<td>13 years or longer</td>
<td>13 years or longer</td>
<td>%Black/African-American, poverty, employment, medically underserved</td>
</tr>
<tr>
<td>Falls Church City - VA</td>
<td>Highest</td>
<td>SN</td>
<td>13 years or longer</td>
<td>%Black/African-American</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>High</td>
<td>13 years or longer</td>
<td>8 years</td>
<td>%Black/African-American, poverty, employment, medically underserved</td>
</tr>
<tr>
<td>Prince George's County – MD</td>
<td>Medium High</td>
<td>13 years or longer</td>
<td>2 years</td>
<td>%Black/African-American</td>
</tr>
<tr>
<td>Fairfax County - VA</td>
<td>Medium High</td>
<td>2 years</td>
<td>13 years or longer</td>
<td>%API</td>
</tr>
<tr>
<td>Prince William County - VA</td>
<td>Medium High</td>
<td>5 years</td>
<td>13 years or longer</td>
<td>%Black/African-American</td>
</tr>
<tr>
<td>Fairfax City - VA</td>
<td>Medium</td>
<td>13 years or longer</td>
<td>Currently meets target</td>
<td>%API</td>
</tr>
<tr>
<td>Arlington County - VA</td>
<td>Medium Low</td>
<td>3 years</td>
<td>3 years</td>
<td>%API, rural</td>
</tr>
<tr>
<td>Loudoun County - VA</td>
<td>Medium Low</td>
<td>2 years</td>
<td>1 year</td>
<td>%Hispanic/Latina, education, poverty, language, insurance</td>
</tr>
<tr>
<td>Manassas City - VA</td>
<td>Medium Low</td>
<td>6 years</td>
<td>1 year</td>
<td>%Hispanic/Latina, education, poverty, language, insurance</td>
</tr>
<tr>
<td>Montgomery County - MD</td>
<td>Lowest</td>
<td>Currently meets target</td>
<td>Currently meets target</td>
<td>%API, foreign born</td>
</tr>
<tr>
<td>Manassas Park City - VA</td>
<td>Undetermined</td>
<td>SN</td>
<td>SN</td>
<td>%Hispanic/Latina, education, foreign, language, insurance</td>
</tr>
</tbody>
</table>
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 HP2020 targets 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). 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 or progressing through 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 rate. 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.

**Wards 2, 5, 7 and 8 in 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. These 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 ages 40-64 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

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

NA-data not available.
HEALTH SYSTEMS, PARTNERSHIPS AND POLICY

HEALTH SYSTEMS ANALYSIS DATA SOURCES

An inventory of breast health and breast cancer programs and services in the four target communities were collected through a comprehensive internet search to identify the following types of health care facilities or community organizations that may provide breast cancer related services:

- Hospitals - Public or private, for-profit or nonprofit.
- Community Health Centers (CHC) - Community based organizations that provide primary care regardless of ability to pay; include Federally Qualified Health Centers (FQHCs) and FQHC look-alikes.
- Free Clinics - Safety-net health care organizations that utilize a volunteer/staff model and restrict eligibility for their services to individuals who are uninsured, underinsured and/or have limited or no access to primary health care.
- Health Departments - Run by government entity (e.g. county, city) and focused on the general health of its citizens.
- Title X Providers - Family planning centers that also offer breast and cervical cancer screening. Services are provided through state, county, and local health departments; community health centers; Planned Parenthood centers; and hospital-based, school-based, faith-based, other private nonprofits.
- Others - Any institution that is not a hospital, CHC, free clinic, health department or Title X provider (e.g., FDA certified mammography center that is not a hospital/CHC, community organization that is not a medical provider but does connect people to services or provide support services such as financial/legal assistance).

Information collected through these means was inputted into a Health Systems Analysis spreadsheet by service type: screening, diagnostics, treatment, and support. The screening service category encompasses clinical breast exams (CBEs), screening mammograms, mobile mammography units, ultrasounds, and patient navigation. The category of diagnostics includes diagnostic mammograms, ultrasounds, biopsy, MRI, and patient navigation. Treatment modalities counted were chemotherapy, radiation, surgery consultations, surgery, reconstruction, and patient navigation. Support encompasses a broad range of services including support groups, wigs, mastectomy wear, individual counseling/psychotherapy, exercise/nutrition programs, complementary therapies, transportation assistance, financial assistance for cost of living expenses, as well as end of life care, legal services, and education.

In order to understand the effect available health systems have on the National Capital Region target communities, the identified resources were plotted on asset maps to visually illustrate the services (or lack thereof) available in each county. While every effort was made to ensure these findings were comprehensive, it may be possible that a facility or organization was missed or has since closed; thus, these findings should not be considered exhaustive and/or final.

QUALITY OF CARE INDICATORS

For all health care facilities and hospitals, an additional layer of analysis was applied using quality of care indicators. Quality of care indicators are quantifiable measures related to the process of care, outcomes of care, and patient satisfaction levels from a particular program and/or organization. Multiple national organizations have developed key quality of care indicators for breast health services, and if an organization meets all the key indicators they are designated an "accredited" health care institution. These accreditations outline key quality of care indicators health care institutions must meet to obtain and/or retain accreditation status. The following five accreditations were considered high quality of care indicators in Komen National Capital Region’s health system analysis.

FDA Approved Mammography Facilities
The Food and Drug Administration (FDA) passed the Mammography Quality Standards Act (MQSA) in 1992 to ensure facilities meet standards for performing high quality mammography. Accreditation bodies administer the MQSA to evaluate and accredit mammography facilities based upon quality standards.
These quality standards are extensive and outline how a facility can operate. For instance, physicians interpreting mammograms must be licensed to practice medicine, be certified to interpret radiological procedures including mammography, and must complete continuing experience or education to maintain their qualifications (US Food and Drug Administration [US FDA], 2014). Radiologic technologists must also be trained and licensed to perform general radiographic procedures and complete continuing experience or education to maintain their qualifications. Facilities are required to maintain personnel records to document the qualifications of all personnel who work at the facility such as physicians, radiologic technologists or medical physicists.

All radiographic equipment used in FDA approved mammography centers must be specifically designed for mammography and must not be equipment designed for general purpose or equipment that has been modified with special attachments for mammography. Equipment regulations also apply to compression paddles, image receptor size, light fields and magnification, focal spot selection, x-ray film, film processing solutions, lighting and film masking devices. Facilities must also prepare a written report of the results of each mammography examination performed under its certificate. The report must include the name of the patient and an additional patient identifier, date of examination, the name of the interpreting physician, and the overall final assessment of findings. Findings from mammograms are classified into four different categories, including negative, benign, probably benign, and highly suggestive of malignancy. An assessment can also be assigned as incomplete indicating additional imaging evaluation is needed.

FDA approved mammography facilities are obligated to communicate the results of mammograms to the patient and the patient’s primary care provider in a written report within 30 days. Each facility must also maintain mammography films and reports in a permanent medical record for a period of no less than five years or longer if mandated by State or local law. Patients can request to permanently or temporarily transfer the original mammograms and patient report to a medical institution, physician, health care provider, or to the patient directly. Any fees for providing transfer services shall not exceed the documented costs associated with this service.

A quality assurance program must be established at each facility to ensure safety, reliability, clarity, and accuracy of mammography services. At least once a year, each facility undergoes a survey by a medical physicist that includes the performance of tests to ensure the facility meets quality assurance requirements. The FDA evaluates the performance of each certificated agency annually using performance indicators that address the adequacy of program performance in certification, inspection, and enforcement activities. Only facilities that are accredited by FDA accrediting bodies or are undergoing accreditation by accrediting bodies may obtain a certificate from the FDA to legally perform mammography (US FDA, 2014). Only FDA approved mammography centers were included in the health system analysis for each target community.

American College of Surgeons Commission on Cancer Certification (CoCC)

Applying and sustaining an American College of Surgeons Commission on Cancer Certification (CoCC) is a voluntary effort a cancer program can undertake to ensure a range of services necessary to diagnose and treat cancer, as well as rehabilitate and support patients and their families, are available (American College of Surgeons [ACoS], 2013). There are various categories of cancer programs, and each facility is assigned a category based on the type of facility or organization, services provided, and cases accessioned or recorded. Program categories include: Integrated Network Cancer Program (INCP); NCI-Designated Comprehensive Cancer Center Program (NCIP); Academic Comprehensive Cancer Program (ACAD); Veterans Affairs Cancer Program (VACP); Comprehensive Community Cancer Program (CCCP); Hospital Associate Cancer Program (HACP); Pediatric Cancer Program (PCP); and Freestanding Cancer Center Program (FCCP) (ACoS, 2013).

CoCC cancer programs are surveyed every three years. In preparation for survey, the cancer committee for that facility must assess program compliance with the requirements for all standards outlined in Cancer Program Standards 2012: Ensuring Patient-Centered Care. An individual must then review and complete an online Survey Application Record (SAR). In addition, the individual responsible for completing the SAR will perform a self-assessment and rate compliance with each standard using the Cancer Program Ratings Scale.

The surveyor’s role is to assist in accurately defining the standards and verifying the facility’s cancer program is in compliance. To accomplish this task, the surveyor will meet with the cancer committee, cancer registry staff and cancer liaison physicians, review pathology reports, and attend a cancer conference to observe the multidisciplinary patient management discussions and confirm treatment is
planned using nationally recognized, evidence-based treatment guidelines. CoCC-accredited programs must also submit documentation of cancer program activities with the SAR using multiple sources such as policies, procedures, manuals, and grids.

Each cancer program standard is rated on a compliance scale that consists of the score of (1+) commendation, (1) compliance, (5) noncompliance, and (8) not applicable. A deficiency is defined as any standard with a rating of five. A deficiency in one or more standards will affect the accreditation award. Commendation ratings (+1) are valid for eight standards, can only be earned at the time of survey, and are used to determine the accreditation award and award level (bronze, silver, or gold). Accreditation awards are based on consensus ratings by the cancer program surveyor, CoCC staff and when necessary, the Program Review Subcommittee. A program can earn one of the following Accreditation Awards; three-year with commendation accreditation, three-year accreditation, three-year accreditation with contingency, provisional accreditation, or no accreditation. Programs are surveyed at three-year intervals from the date of survey.

Award notification takes place within 45 days following the completed survey and will include The Accredited Cancer Program Performance Report. This report includes a comprehensive summary of the survey outcome and accreditation award, the facility’s compliance rating for each standard, an overall rating compared with other accredited facilities nation- and state-wide, and the category of accreditation. In addition, a narrative description of deficiencies that require correction, suggestions to improve or enhance the program, and commendations awarded are also included.

**American College of Surgeons National Accreditation Program for Breast Centers (NAPBC)**

The American College of Surgeons’ National Accreditation Program for Breast Centers (NAPBC) is a consortium of national professional organizations focused on breast health and dedicated to improving quality of care and outcomes for patients with diseases of the breast (ACoS, 2014). The NAPBC utilizes evidence-based standards as well as patient and provider education, and encourages leaders from major disciplines to work together to diagnose and treat breast disease. The NAPBC has defined 28 program standards and 17 program components of care that provide the most efficient and contemporary care for patients diagnosed with diseases of the breast. Quality standards cover a range of topics and levels of operation including leadership, clinical management, research, community outreach, professional education, and quality improvement (ACoS, 2014).

To be considered for initial survey, breast center leadership must ensure clinical services, interdisciplinary/multidisciplinary conference(s), and quality management programs are in place and ensure a facility can meet the requirements outlined for all standards. Critical standards include having breast program leadership that is responsible and accountable for services and establishes, monitors, and evaluates the interdisciplinary breast cancer conference frequency, multidisciplinary and individual attendance, prospective case presentation, and total case presentation annually. In addition, the interdisciplinary patient management standard requires patient management to be conducted by an interdisciplinary team after a patient is diagnosed with breast cancer.

Breast center leadership then completes a pre-application to participate and pay for the survey fee within 30 days of the receipt from the NAPBC. To prepare for a survey, the breast center must complete a Survey Application Record (SAR) prior to the on-site visit. The SAR is intended to capture information about the breast center activity and includes portions of individuals to perform a self-assessment and rate compliance with each standard using a provided rating system. The NAPBC will then complete a survey of the facility within six months. A survey of a facility typically includes a tour of the center, a meeting between the surveyor and breast center leadership and staff, chart and medical record review, and the attendance of a breast conference.

Accreditation awards are based on consensus ratings by the surveyor, the NAPBC staff, and, if required, the Standards and Accreditation Committee. Accreditation award is based on compliance with 28 standards. A three year, full accreditation is granted to centers that comply with 90 percent or more of the standards with resolution of all deficient standards documented within 12 months of survey. Centers that do not resolve all deficiencies within the 12-month period risk losing NAPBC accreditation status and are required to reapply. Once a performance report and certificate of accreditation are issued, these centers are surveyed every three years.

A three-year contingency accreditation is granted to centers that meet less than 90 percent, but more than 75 percent of the standards at the time of survey. The contingency status is resolved by the
submission of documentation of compliance within 12 months from the date of survey. A performance report and certificate of accreditation are issued, and these facilities are surveyed every three years. An accreditation can be deferred if a center meets less than 75 percent of the standards at the time of the survey. The deferred status is resolved by the submission of documentation of compliance within 12 months from the date of survey. Based on the resolution of deficiencies and survey results, a performance report and certificate of accreditation are issued, and these facilities are surveyed every three years. For the complete list of NAPBC quality standards, visit: http://www.napbc-breast.org/standards/standards.html.

**American College of Radiology Breast Imaging Centers of Excellence (BICOE)**
The American College of Radiology (ACR) Breast Imaging Centers of Excellence (BICOE) designation is awarded to breast imaging centers that seek and earn accreditation in the ACR’s entire voluntary breast imaging accreditation programs and modules, in addition to the Mandatory Mammography Accreditation Program (MMAP) (American College of Radiology [ACR], n.d.). The ACR MMAP is designed to provide facilities with peer review and constructive feedback on staff qualifications, equipment, quality control, quality assurance, image quality, and radiation dose. This ensures facilities comply with the 1992 Mammography Quality Standards Act (MQSA), which requires all mammography facilities be accredited. To receive the ACR’s BICOE designation, a facility must be accredited by the ACR in mammography, stereotactic breast biopsy, breast ultrasound, and effective January 1, 2016, breast MRI.

The ACR will send a BICOE certificate to each facility that fulfills the necessary requirements. The designation remains in effect as long as all breast imaging facilities (an organization’s home location or a different location) remain accredited in all required breast imaging services provided. If the center or facility neglects to renew any of its accreditations or fails during renewal, the facility will be notified that it no longer has the BICOE designation and the BICOE certificate must be removed from public display. Some centers will need to specifically request a BICOE designation, while in most cases the ACR will consult its database and automatically provide an eligible center a BICOE certificate if the center is at a single physical location and meets all breast imaging requirements (ACR, n.d.).

**National Cancer Institute Designated Cancer Centers**
A National Cancer Institute (NCI) designated Cancer Center is an institution dedicated to researching the development of more effective approaches to the prevention, diagnosis, and treatment of cancer (National Cancer Institute [NCI], 2012). A NCI-designated Cancer Center conducts cancer research that is multidisciplinary and incorporates collaboration between institutions and university medical centers. This collaboration also provides training for scientists, physicians, and other professionals interested in specialized training or board certification in cancer-related disciplines. NCI-designated Cancer Centers also provide clinical programs that offer the most current forms of treatment for various types of cancers and typically incorporate access to clinical trials of experimental treatments. In addition, public education and community outreach regarding cancer prevention and screening are important activities of a NCI-designated Cancer Center (NCI, 2012).

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**HEALTH SYSTEMS AND PARTNERSHIPS OVERVIEW**

The Breast Cancer Continuum of Care (CoC) is a model that shows how a woman typically moves through the health care system for breast care (Figure 3.1). A woman would ideally move through the CoC quickly and seamlessly, receiving timely, quality care to have the best outcomes. Education can play an important role throughout the entire CoC.

While a woman may enter the continuum at any point, ideally, a woman would enter the CoC by getting screened for breast cancer – with a clinical breast exam or a screening mammogram. If the screening test results are normal, she would loop back into follow-up care, where she would get another screening exam at the recommended interval. Education plays a role in both providing education to encourage women to get screened and reinforcing the need to continue to get screened routinely thereafter.

If a screening exam resulted in abnormal results, diagnostic tests would be needed, possibly several, to determine if the abnormal finding is in fact breast cancer. These tests might include a diagnostic mammogram, breast ultrasound or biopsy. If the tests were negative (or benign) and breast cancer was not found, she would go into the follow-up loop, and return for screening at the recommended interval. The recommended intervals may range from three to six months for some women to 12 months for most.
women. Education plays a role in communicating the importance of proactively getting test results, keeping follow-up appointments and understanding what it all means. Education can empower a woman and help manage anxiety and fear.

If breast cancer is diagnosed, she would proceed to treatment. Education can cover such topics as treatment options, how a pathology report determines the best options for treatment, understanding side effects and how to manage them, and helping to formulate questions a woman may have for her providers.

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

There are often delays in moving from one point of the continuum to another – at the point of follow-up of abnormal screening exam results, starting treatment, and completing treatment – that can all contribute to poorer outcomes. There are also many reasons why a woman does not enter or continue in the breast cancer CoC. These barriers can include things such as lack of transportation, system issues including long waits for appointments and inconvenient clinic hours, language barriers, fear, and lack of information - or the wrong information (myths and misconceptions). Education can address some of these barriers and help a woman progress through the CoC more quickly.

Breast Cancer Continuum of Care Services in the Target Communities

**Alexandria, Virginia**

Health system analysis identified twelve health care providers and community organizations that provide at least one component of the breast cancer CoC in Alexandria, VA (Figure 3.2). There are 10 facilities that provide screening services, six that provide diagnostic services, three provide treatment and three provide survivorship support. Only two of the facilities provide all four CoC components and are recognized as American College of Surgeons Commission on Cancer certified and as a National Accreditation Program for Breast Centers.

**Partnerships in Alexandria, VA**

Komen has a granting partnership with the Prevent Cancer Foundation and Nueva Vida which are physically located in and serve residents of Alexandria, VA. Additional granting partnerships that serve women from Alexandria, VA, but are not physically located within its boundaries include Mary’s Center for Maternal and Child Health, Inc., Capital Breast Care Center (Georgetown University), Smith Center for Healing and the Arts, Korean Community Service Center of Greater Washington, Breast Care for Washington, Vietnamese Resettlement Association, Inc., Boat People SOS, CASA de Maryland, African Women’s Cancer Awareness Association, and the Primary Care Coalition of Montgomery County.

Through these granting partnerships residents of Alexandria, VA are educated about breast cancer, including risk and available services, and can access patient navigation services to improve their access to and progression through the breast cancer continuum of care. These programs provide culturally tailored messaging while minimizing structural, personal, and financial barriers for those seeking breast health services. Additionally, provider education and training to ensure culturally competent care is also being addressed through these partners.
Over the next several years, Komen will work on identifying and reaching out to potential partners in Alexandria, VA to continue to improve access to timely, quality breast cancer care throughout the continuum.

**District of Columbia Ward 2**

In District of Columbia Ward 2, 25 health care providers and community organizations were identified as providing at least one component of the breast cancer CoC (Figure 3.3). A total of 24 facilities provide screening services, eight provide diagnostic services, four provide treatment and five provide survivorship support. When considering quality of care, two facilities are American College of Surgeons Commission on Cancer certified, three are designated as an American College of Radiology Breast Imaging Center of Excellence and two are National Accreditation Program for Breast Centers. Within Ward 2 is the National Capital Region’s only National Cancer Institute Comprehensive Cancer Center (Georgetown Lombardi Comprehensive Cancer Center).

**Partnerships in District of Columbia Ward 2**

Komen has a granting partnership with the Smith Center for Healing and the Arts, which is the only grantee physically located in Ward 2 of the District of Columbia. Other grantees that serve women from this community include Mary’s Center for Maternal and Child Care, Inc., Korean Community Service Center of Greater

Through these granting partnerships residents of Ward 2 are educated about breast cancer, including risk and available services, and can access patient navigation services to improve their access to and progression through the breast cancer continuum of care.

Over the next several years, Komen will work on identifying and reaching out to potential partners in Ward 2 to continue to improve access to timely, quality breast cancer care throughout the continuum.

**District of Columbia Ward 5**

A total of eight health care facilities were identified in Ward 5 as providing at least one component of the breast cancer CoC (Figure 3.4). Of the eight health care facilities, five provide screening services only. The remaining three health care facilities each provide all four breast cancer CoC components: screening, diagnostic, treatment and survivorship support services. Two of the three facilities that provide the full CoC are American College of Surgeons Commission on Cancer certified. The remaining health care facility is certified by the American College of Surgeons Commission on Cancer, is an
American College of Radiology Breast Imaging Center of Excellence and a National Accreditation Program for Breast Center.

**Partnerships in District of Columbia Ward 5**
Komen has a granting partnership with the Providence Health Foundation, which is the only grantee physically located within Ward 5. Grantees that serve women from Ward 5 also include Mary’s Center, Capital Breast Care Center, Smith Center for Healing and the Arts, Nueva Vida, Breast Care for Washington, Primary Care Coalition, and African Women’s Cancer Awareness Association.

Through these granting partnerships residents of Ward 5 are educated about breast cancer, including risk and available services, and can access patient navigation services to improve their access to and progression through the breast cancer continuum of care. These partners implement culturally tailored programs to address the unique needs of the communities they serve.

Over the next several years, Komen will work on identifying and reaching out to potential partners in Ward 5 to continue to improve access to timely, quality breast cancer care throughout the continuum.

**Figure 3.4.** Breast cancer services available in District of Columbia Ward 5
District of Columbia Wards 7 and 8

In Wards 7 and 8, 14 health care facilities and community organizations were identified as providing at least one component of the breast cancer CoC (Figure 3.5). All 14 of the identified health care facilities and community organizations provide screening services, three provide diagnostic services and one provides survivorship support services. There are no cancer treatment services located within Wards 7 and 8. In addition, none of the health care facilities providing services are breast cancer certified or accredited as an American College of Surgeons Commission on Cancer facility, an American College of Surgeons National Accreditation Program for Breast Centers, or as an American College of Radiology Breast Imaging Center of Excellence.

Partnerships in District of Columbia Wards 7 and 8 Komen has a granting partnership with Breast Care for Washington, which is the only grantee physically present in these target communities (Ward 8). Through this granting partnership, medically underserved residents of Wards 7 and 8 can access timely breast cancer screening and diagnostic imaging. Grantees that serve women from Wards 7 and 8 also include Mary’s Center, Capital Breast Care Center, Smith Center for Healing and the Arts, Nueva Vida, Breast Care for Washington, Primary Care Coalition, Prevent Cancer Foundation (Ward 7), Providence Health Foundation (Ward 8), and African Women’s Cancer Awareness Association.

Over the next several years, Komen will work on identifying and reaching out to potential partners in Wards 7 and 8 to continue to improve access to timely, quality breast cancer care throughout the continuum.

Figure 3.4. Breast cancer services available in District of Columbia Wards 7 and 8
In recent years, public policies pertaining to breast cancer have undergone substantial changes that will affect at-risk women in the National Capital Region service area. Within the National Capital Region, the District of Columbia and the states of Maryland and Virginia have responded differently to the public policy developments concerning access to services within the breast cancer continuum of care (screening, diagnostic, treatment, and survivorship care). The following is an overview of key breast cancer policies that may affect the ability of at-risk women in accessing and utilizing quality care.

**National Breast and Cervical Cancer Early Detection Program (NBCCEDP)**

The Breast and Cervical Cancer Mortality Prevention Act was signed into Public Law (101-354) in 1990 to improve access to cancer screening for underserved women, establishing the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). Currently, the NBCCEDP funds all 50 states, the District of Columbia, 5 US territories, and 11 American Indian/Alaska Native tribal organizations to provide breast and cervical cancer screening.

NBCCEDP tries to reach as many women in medically underserved communities as possible, including older women, women who are recent immigrants and women who are members of racial and ethnic minorities. Screening services are offered mainly through nonprofit organizations, hospitals, and local health clinics. Through these NBCCEDP partners, uninsured or underinsured women can receive breast and cervical cancer testing for free or at very low cost. By providing these women access to cancer screening methods, it is more likely that breast and cervical cancer will be identified at earlier stages, when treatment costs are lower and prognosis is more favorable. From January 2009 to December 2013 NBCCEDP provided 1,689,832 screening mammograms that resulted in 251,538 abnormal mammogram results and 18,171 women being diagnosed with breast cancer (Centers for Disease Control and Prevention, 2015).

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA), Public Law 106-354, was signed into law on October 24, 2000 by President William Clinton, establishing a new state coverage option under Medicaid. This important legislation permitted states to extend Medicaid to uninsured women under 65 who were screened and/or diagnosed with breast or cervical cancer under the Centers for Disease Control and Prevention (CDC) funded National Breast and Cervical Cancer Early Detection Program (NBCCEDP). The BCCPTA Medicaid coverage option was a groundbreaking effort to use population-wide public health screening programs like the NBCCEDP.

The Komen National Capital Region is serviced by three NBCCEDP programs: District of Columbia, State of Maryland, and the State of Virginia. Within each state and the District of Columbia, Susan G. Komen works with the NBCCEDP implementing organization to ensure uninsured and underinsured women receive necessary breast cancer screenings, diagnostics, and treatment services.

**District of Columbia**

In the District of Columbia, Project WISH (Women Into Staying Healthy) has served as the proxy for the National Breast and Cervical Cancer Early Detection Program since 1997, providing clinical breast exams (CBEs), screening and diagnostic mammograms, and referrals to treatment. Project WISH also provides patient navigation, transportation assistance, and cancer education to all women enrolled in the project (District of Columbia Department of Health, n.d.). From January 2009 to December 2013 Project WISH provided 3,540 screening mammograms that resulted in 468 abnormal mammogram results and 23 women being diagnosed with breast cancer (Centers for Disease Control and Prevention, 2015).

Women that are diagnosed with breast cancer by a Project WISH NBCCEDP provider can receive treatment coverage through District of Columbia Medicaid for Breast and Cervical Cancer Patients program (DCMBCCP). Coverage under this program continues as long as a treating physician certified that the individual requires active treatment for breast cancer. To be eligible for DCMBCCP a woman must be under the age of 65, a District of Columbia resident, uninsured, a US citizen or eligible to have immigration status and have been screened and diagnosed by a NBCCEDP provider (District of Columbia Department of Health, n.d.).

Priority populations for Project WISH include medically underserved populations, women who have never received screening, and ethnic minorities that reside in the District of Columbia and are uninsured and
underinsured and between the ages of 21 and 64. Project WISH can be contacted at 202-442-5900 or http://doh.dc.gov/service/breast-and-cervical-cancer-program-project-wish for additional information.

In addition, the Comprehensive Cancer Control Program (CCCP) can be contacted at 202-442-9170 for information about free prevention, screening and health services.

**State of Maryland**
The Maryland Breast and Cervical Cancer Early Detection Program (MBCCEDP) was started in 1992 and is funded by grants from the State of Maryland and the Centers for Disease Control and Prevention (CDC). MBCCEDP provides breast and cervical cancer screening for women 40-64 years of age who are Maryland residents, uninsured or underinsured (having insurance that does not cover these services or with a high deductible), and have incomes of less than 250 percent of the Federal Poverty Level. MBCCEDP has a network of more than 950 private providers and community centers throughout the state (Maryland Department of Health and Mental Hygiene, 2015). MBCCEDP programs also now have the option of paying for client services in the case of cost-sharing situations as well, such as deductibles, co-pays, and co-insurance for otherwise eligible women. In addition to an annual screening mammogram and CBEs, the program also pays for diagnostic mammograms, breast ultrasounds, surgical consultations and biopsies. The MBCCEDP program also provides patient navigation services that assists a woman in navigating the health care system, outreach and education using lay health outreach workers to educate women in priority populations, and professional development to advance health care providers' knowledge, attitudes and behaviors about breast cancer screening and early detection and MBCCEDP guidelines (Maryland Department of Health and Mental Hygiene, 2015). From January 2009 to December 2013 MBCCEDP provided 38,153 screening mammograms that resulted in 6,029 abnormal mammogram results and 271 women being diagnosed with breast cancer (Centers for Disease Control and Prevention, 2015).

In addition to MBCCEDP, funding is available through the Maryland Breast and Cervical Cancer Diagnosis and Treatment Program (MBCCDTP) for additional diagnostic tests and treatment for breast cancer when necessary. MBCCDTP is a state-funded program unique to Maryland. The program pays for a diagnostic work-up and treatment for Maryland residents who have received an abnormal screening result for breast (and cervical) cancer. Applicants (male or female) of any age must be Maryland residents, prove medical need, meet income guidelines (250 percent of the Federal Poverty Level) and be uninsured or underinsured.

Additional information regarding the Maryland Breast and Cervical Cancer Early Detection Program can be found at http://phpa.dhmh.maryland.gov/cancer/pages/bccp_home.aspx or by calling 1-800-477-9774.

**State of Virginia**
The Virginia Breast and Cervical Cancer Early Detection Program, known as Every Woman’s Life (EWL), has been screening women since 1997. The mission of the program is to provide high-quality breast and cervical screening, diagnostic and health services to low-income, uninsured women in the most cost efficient manner.

To be eligible to receive screening services, women must live in Virginia, be between the ages of 18-64, have no health insurance or be underinsured, and have an annual income at or below 200 percent of the Federal Poverty Level (FPL). In July 2006, upon the receipt of state funds, the program expanded services to younger women between the ages of 18-39 that are symptomatic for breast and/or cervical cancer.

The State of Virginia General Assembly passed legislation to allow women in Virginia that are screened and/or diagnosed through EWL to be eligible for treatment coverage under the BCCPTA. However, not all women diagnosed with breast and/or cervical cancer will be eligible for the BCCPTA, such as illegal immigrants, women with creditable health insurance or deemed eligible for another Medicaid covered group. EWL providers ensure that women not eligible for medical assistance under the BCCPTA receive appropriate treatment services; connecting women to community resources, such as charity care, faith-based organizations, and health institutions that serve indigent populations to ensure treatment services are provided.

It is estimated that 72,552 women age 18-64 in Virginia are eligible for the EWL program, but funding will allow for only 7,896 – or 10.9 percent - to be served in state fiscal year 2015 (Virginia Department of Health, 2014). Since 1997, EWL has provided services to 45,351 low-income, uninsured women, has
performed 86,688 mammograms and diagnosed 1,681 women with breast cancer (Virginia Department of Health, 2014). Women requiring breast cancer treatment are referred to Medicaid under the BCCPTA. Women that do not meet BCCPTA eligibility criteria (e.g. non-US citizen) receive pro-bono or sliding scale treatment through charity care or other means.

EWL is operated through 33 local providers with statewide oversight provided by EWL staff at the Virginia Department of Health. Local EWL providers include health departments, free clinics, federally qualified health centers and large health systems. The 33 providers in turn have an extensive network of sub-providers that provide screening and diagnostic services in almost every locality across the state. Women in need of EWL services can locate a provider through the EWL toll free line, 1-866-395-4968 (1-866-EWL-4YOU) or online at http://www.vdh.state.va.us/ofhs/prevention/ewl/client.htm.

Comprehensive Cancer Control Program (CCCP)
Since 1998, CDC’s National Comprehensive Cancer Control Program (NCCCP) has been active in promoting health equity as it relates to cancer control throughout the 50 US states, District of Columbia, tribal groups and Associated Pacific Islands/territories. Based on the social ecological model, long-term outcomes of the program include increased early detection practices and improved survivorship practices that will lead to an increase in quality of life, reduced disparities, reduction in costs associated with cancer and decreases in cancer incidence, morbidity, recurrence, and death (Given et al., 2005).

The Komen National Capital Region is covered by three Comprehensive Cancer Control Plans: District of Columbia, State of Maryland and the State of Virginia. Komen has participated in the development of the Comprehensive Cancer Control (CCC) plans in each state and the District of Columbia.

District of Columbia
The District of Columbia Cancer Consortium and its member organizations - through collaboration and community engagement - are committed to serving the medically underserved of DC. The 2013-2018 DC Cancer Control Plan, of which Komen was a Steering Committee member, identifies five priority cancers including breast cancer. The overarching goal of the plan is to “reduce overall cancer incidence and death, reduce racial and other disparities in cancer incidence and outcomes and improve the quality of care for and the lives of cancer survivors” (DC Cancer Consortium, 2013).

The DC Cancer Control Plan 2013-2018 includes the following breast cancer goal and objectives:

- Reduce the District’s deaths due to breast cancer.
  - Objective 1: Increase from 81.6 percent to 90.0 percent the number of women aged 40 years and older who have received a mammogram within the past two years.
  - Objective 2: Increase early detection and prevention by improving the role of health care providers in ensuring access to appropriate women’s health care, including risk reduction and clinical breast examination.
  - Objective 3: Decrease to no more than 30 days the time from abnormal breast cancer screening to definitive cancer diagnosis for all racial and income groups.
  - Objective 4: Decrease to no more than 30 days the time from diagnosis of breast cancer to treatment for all racial and income groups.

Additional related goals include:

- Cancer Clinical Trials- Increase by 15.0 percent the participation of the District’s minority populations in clinical trials.
- Health Equity- Reduce/eliminate cancer burden disparities attributable to race/ethnicity, gender, culture, socio-economic status, language and other social determinants.
- Palliative Care- Improve the quality of education about palliative care and related services in the District.
- Access to Care and Patient Navigation- Sustain District-wide longitudinal navigation services for District residents with cancer. Increase the quality of care received by District residents. Advocate for patient navigation as a reimbursable cost.
- Survivorship- Increase access to follow-up care, reduce recurrence and improve the overall quality of life for the District’s cancer survivors.
State of Maryland

The Maryland Comprehensive Cancer Control Plan (MCCP) is a resource for all those engaged in cancer control in Maryland. Susan G. Komen® Maryland participated in the process of providing updates to the breast cancer plan and currently participates as an active member of the Maryland Cancer Collaborative (MCC) which serves to bring together existing groups and new partners from across the state to collaborate to implement the Maryland Comprehensive Cancer Control Plan. In particular, involvement in the MCC’s Survivorship workgroup has increased with Komen Maryland taking on an increased role within the steering committee for the group. According to the MCCP (2011) the goal for Maryland is to reduce incidence, death, and morbidity from breast cancer through prevention, early detection, treatment, and effective survivorship care.

The Maryland Cancer Control Plan includes the following breast cancer goals and objectives (Maryland Department of Health and Mental Hygiene, 2009):

- **Goal 1: Reduce the incidence of breast cancer in Maryland**
  - **Objective 1:** By 2015, improve healthy behaviors of Marylanders including decreasing the number of women who are overweight or obese and increasing physical activity.
  - **Objective 2:** By 2015, increase the proportion of Maryland women breastfeeding up to 12 months.
  - **Objective 3:** By 2015, incorporate breast cancer risk assessment as a part of routine health care for all women and conduct appropriate risk-based counseling for breast cancer prevention and screening.

- **Goal 2: Reduce the morbidity and death from breast cancer in Maryland**
  - **Objective 1:** By 2015, increase the percentage of females in Maryland ages 40 and above who have received a mammogram in the past two years to greater than 77.0 percent.
  - **Objective 2:** By 2015, ensure that all individuals are promptly diagnosed within 60 days of abnormal screening and receive appropriate surgical options and adjuvant therapy treatment according to national guidelines.
  - **Objective 3:** By 2015, ensure that all patients have a survivorship care plan as part of routine care and have adequate access to supportive care for pain and other symptom management for those living with, through, and beyond cancer.

Additional related goals include:

- Cancer Surveillance- Collect, analyze, develop, and disseminate Maryland cancer information.
- Cancer Disparities- Reduce cancer disparities in Maryland.
- Patient Issues and Cancer Survivorship- Enhance the quality of life of cancer survivors in Maryland through information and supportive services.
- Pain Management- Empower cancer patients to take an active role in partnering with health care providers in managing pain and minimizing impact on quality of life. Educate and involve clinicians to optimize cancer pain control and take an active role in partnering with other health care providers and patients in managing pain and minimizing impact on quality of life.
- Palliative and Hospice Care- Implement a blueprint for success for palliative and hospice care for patients and families experiencing cancer in the State of Maryland.

State of Virginia

The Cancer Action Coalition of Virginia (CACV) consists of diverse organizations who are involved in cancer control and who commit to work together to:

- Leverage their collective strengths and resources
- Document areas of greatest need and gaps in cancer related efforts
- Identify efforts that no one organization would do alone, and
- Avoid duplication of activities

CACV was organized by the Virginia Department of Health in 1998 for writing a statewide cancer plan. CACV not only develops the state cancer plan, but meets quarterly to inform organizations and individuals about current cancer issues and facilitates statewide collaborations focused on the objectives in the state plan. The plan includes four goals which are managed by four multi-organization action
teams: Prevention, Early Detection, Treatment, and Survivorship and Palliative Care. The Susan G. Komen Virginia Affiliates are members of the CACV and are represented on the Early Detection Action Team.

The Virginia Cancer Plan 2013-1017 goals and objectives (Virginia Department of Health, 2013):

- Prevention- Reduce risks of cancer for all Virginians through awareness, education, and behavior change.
  - Objective 1: Reduce exposure to cancer causing substances.
  - Objective 2: Reduce the risk of cancer for all Virginians by encouraging an active lifestyle and health eating.
  - Objective 3: Improve public awareness and knowledge of age-appropriate preventive action as well as screenings and self-examinations (all types of cancer).

- Early Detection- Virginians are diagnosed with cancer at its earliest (local), most curable stage.
  - Objective 1: Increase dissemination of public information of age-appropriate, evidence-based, comprehensive cancer screening guidelines and resources and encourage an increase in educational activities in the Virginia health districts with the highest death rates.
  - Objective 2: Increase cancer screening rates among Virginians by 10.0 percent.
  - Objective 3: Support Virginia health care providers in promoting age-appropriate, evidence-based screening early detection guidelines.

- Treatment- Virginians with cancer will have access to appropriate and effective cancer treatment and care.
  - Objective 1: Increase Virginia health care providers’ awareness of national cancer care standards and guidelines.
  - Objective 2: Increase Virginians’ knowledge and awareness of patient navigation programs and services.
  - Objective 3: Connect Virginians with information and access to innovative and evidence-based cancer treatments.

- Survivorship and Palliative Care- Optimize the quality of life for every person affected by cancer across the continuum of care.
  - Objective 1: Increase the number of cancer patients who are provided with a comprehensive care summary and follow-up plan.
  - Objective 2: Increase utilization of survivorship services by survivors, cancer patients, families, and caregivers in Virginia.
  - Objective 3: Increase education among patients, families, and health care providers about palliative care.

Affordable Care Act and Medicaid Expansion
The Patient Protection and Affordable Care Act (111-148), often referred to as the Affordable Care Act (ACA), was signed into Public Law by President Barack Obama on March 23, 2010. Representing one of the largest overhauls of the US health care system, the goal of ACA is to “significantly reduce the number of uninsured by providing a continuum of affordable coverage options through Medicaid and the Health Insurance Marketplaces” (Henry J Kaiser Family Foundation, 2015a). Mandates, subsidies, and insurance exchanges were implemented as mechanisms to increase coverage and affordability, with various provisions taking effect between 2010 and 2020.

Some of the key provisions enacted by the ACA include:

- Guaranteed issue of health care coverage to individuals with pre-existing health conditions (Effective Jan 1, 2014).
- Prohibition of annual limits on the amount spent for coverage by insurers (Effective Jan 1, 2014).
- The law requires insurers to cover all applicants within new minimum standards for health insurance policies (Effective Jan 1, 2014).
- An individual mandate, upheld by the Supreme Court, requires all individuals to maintain health care coverage through employee sponsored health plans, Medicaid, Medicare, private insurance,
or other public insurance programs. Otherwise, individuals will be penalized with the exception of financial hardship or religious objection (Effective Jan 1, 2014).

- Health insurance exchanges operate as avenues by which individuals and small businesses can compare and purchase health policies (Effective Jan 1, 2014).
- Low-income (100 to 400 percent of FPL) individuals and families receive sliding scale federal subsidies for insurance policies purchased through exchanges (Effective Jan 1, 2014).
- Businesses that employ 50 or more people are required to provide health insurance to full-time employees or otherwise pay a tax penalty; this is commonly known as the employer mandate (Effective Jan 1, 2016, delayed full implementation).
- Medicaid eligibility will expand to include individuals and families with income up to 133 percent of federal poverty line (FPL), including adults without disabilities and without dependent children (Effective April 1, 2010 without adoption deadline).

Under the Affordable Care Act (ACA), state Medicaid programs have the option to expand eligibility to ensure health care coverage for individuals who were previously ineligible, reducing the number of uninsured Americans. As enacted, the ACA permitted expansion of Medicaid to nearly all individuals with incomes at or below 138 percent FPL ($16,104 for an individual or $27,310 for a family of three in 2014) beginning January 1, 2014 (Henry J Kaiser Family Foundation, 2015a). However, this expansion was made a state option by the Supreme Court ruling on the ACA (Supreme Court of the United States, 2011).

The District of Columbia and the State of Maryland adopted Medicaid expansion (Henry J Kaiser Family Foundation, 2015a) (Table 3.1). As of August 2015, the State of Virginia has not adopted Medicaid expansion resulting in approximately 171,000 residents falling into the coverage gap where “they earned too much to qualify for Medicaid but not enough to qualify for Marketplace premium tax credits” (Henry J Kaiser Family Foundation, 2015b) (Table 3.1).

The District of Columbia and State of Maryland implemented a State-based Marketplace (Henry J Kaiser Family Foundation, 2015a) (Table 3.1). Implementation of a State-based Marketplace means that the “District or state are responsible for performing all Marketplace functions and consumers in the District or state apply for and enroll in coverage through websites established and maintained by the District or state” (Henry J Kaiser Family Foundation, 2015a). As of March 2015, a total of 14,960 individuals (46.0 percent of potential enrollees) in the District of Columbia have enrolled in the Marketplace with 10.0 percent receiving tax credits and 3.0 percent receiving cost-sharing reductions (Henry J Kaiser Family Foundation, 2015c; Henry J Kaiser Family Foundation, 2015d) (Table 3.1). In the State of Maryland, 114,559 residents (25.0 percent of potential enrollees) enrolled in the Marketplace with 68.0 percent receiving tax credits and 47.0 percent receiving cost-sharing reductions (Henry J Kaiser Family Foundation, 2015c; Henry J Kaiser Family Foundation, 2015d) (Table 3.1). Consumers with “household incomes between 100 percent and 400 percent of the Federal Poverty Level may qualify for Advanced Premium Tax Credit that helps make their coverage more affordable by lowering their share of monthly premium costs” (Henry J Kaiser Family Foundation, 2015c). Cost-Sharing Reductions (CSRs) are “only available to people with incomes between 100 and 250 percent of Federal Poverty Level and enroll in a silver plan through the Marketplace” (Henry J Kaiser Family Foundation, 2015c). CSRs increase the value of a plan depending on income so that their out-of-pocket costs are lower.

The State of Virginia adopted a Federally-facilitated Marketplace (Henry J Kaiser Family Foundation, 2015a) (Table 3.1). In a Federally-facilitated Marketplace, the US Department of Health and Human Services “performs all Marketplace functions and consumers apply for and enroll in coverage through www.healthcare.gov” (Henry J Kaiser Family Foundation, 2015a). As of March 2015, a total of 335,033 (40.0 percent of potential enrollees) Virginia residents have enrolled in the Marketplace with 85.0 percent receiving tax credits and 56.0 percent receiving cost-sharing reductions (Henry J Kaiser Family Foundation, 2015c; Henry J Kaiser Family Foundation, 2015d) (Table 3.1).
### Table 3.1. Medicaid expansion, Marketplace type and enrollment

<table>
<thead>
<tr>
<th>Medicaid Expansion</th>
<th>Marketplace Expansion</th>
<th>Total Enrollment***</th>
<th>Percent of Potential Marketplace Population Enrolled****</th>
<th>Percent Receiving Advance Premium Tax Credits***</th>
<th>Percent Receiving Cost-Sharing Reductions***</th>
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<tr>
<td><strong>Decision</strong>*</td>
<td><strong>Medicaid Coverage Gap</strong></td>
<td><strong>Marketplace Type</strong>*</td>
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<tr>
<td>District of Columbia</td>
<td>NA</td>
<td>State-based</td>
<td>14,960</td>
<td>46.0%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Maryland</td>
<td>NA</td>
<td>State-based</td>
<td>114,559</td>
<td>25.0%</td>
<td>68.0%</td>
</tr>
<tr>
<td>Virginia</td>
<td>117,000</td>
<td>Federally-facilitated</td>
<td>335,033</td>
<td>40.0%</td>
<td>85.0%</td>
</tr>
</tbody>
</table>

****Henry J Kaiser Family Foundation, 2015d.

Additional information about the Affordable Care Act and Medicaid Expansion can be found on the following websites:

- Health Insurance Marketplace: [https://www.healthcare.gov/](https://www.healthcare.gov/)

### HEALTH SYSTEMS, PARTNERSHIPS AND POLICY 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 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 Arlandia 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 only one community organization providing some type of support services. While availability of services is 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 indicating that residents have a shortage of personal health services (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 personal, environmental and structural barriers encountered by the individuals when trying to receive care. These barriers will be explored further through qualitative data inquiry with key stakeholders and residents within each target community.

The effect of ACA and Medicaid expansion on health care availability, access and utilization are still being determined. Therefore, Komen will continue to work with state and federal legislators and health policy coalitions to ensure every individual has access to health insurance coverage and a source of ongoing breast cancer care.
QUALITATIVE DATA SOURCES AND METHODOLOGY OVERVIEW

To complement the quantitative and health system analysis data, qualitative data were conducted within each target community. Qualitative data methods involve the collection of information and stories from individuals living and working in specific areas. These stories speak to the real matters reflected by the numbers and provide insights and a more comprehensive understanding of issues facing those communities.

Methodology
The NCR Community Profile Team utilized a combination of focus groups and key informant interviews in each of the target communities.

- **Focus groups** are structured discussions used to obtain information from a group of five to ten people about a specific topic. The purpose of a focus group is to collect information about people’s opinions, beliefs, attitudes, behaviors, motivations, and perceptions – not to come to a consensus or conclusion. These discussions are an efficient way to assess the range and depth of an issue and uncover factors that influence opinions, behaviors, or motivations.

- **Key informant interviews** are structured conversations between an interviewer and a representative from a target population or community that allow for in-depth and probing questions on specific issues. These types of interviews help gain a better understanding of the attitudes and beliefs of target population members. They also allow the respondent to openly discuss a topic at length to clarify issues and responses as needed so definitive connections can be made between breast cancer statistics and community issues.

Based on the quantitative and the health system data, the purpose of the community member focus groups was to answer the following questions within each target community:

- Types of breast health services and support available and being used.
- Interactions with health care providers and if an individual’s needs were being met.
- Quality of breast cancer services (i.e., screening, diagnostic, and treatment) being provided.
- Barriers experienced by community members in accessing and/or utilizing available breast cancer screening, diagnostic, treatment, and survivorship services.
- Solutions that could be implemented to reduce the identified barriers.

Similarly, using the quantitative and health system data as a foundation, the purpose of the key informant interviews with providers and community organizations was to answer the following questions in each target community:

- Was breast cancer perceived as a concern?
- Who may be less likely to access breast cancer screenings?
- What barriers are experienced in accessing and/or utilizing available breast cancer screening, diagnostic, treatment, and survivorship services?
- What solutions could be implemented to reduce the identified barriers?

**Sampling**

**Focus Groups**
Focus group participants were required to be residents of one of the target communities (District of Columbia Wards 2, 5, 7 and 8 and Alexandria, Virginia), be between the ages of 20 and 64, identify as female, and have an ability to speak and understand English fluently. Participants entered the zip code of their residence to determine if they lived in one of the four target communities, their education level, and household income range to assess if they were members of an under-resourced demographic. When possible, under-resourced females were recruited to participate in the focus groups. Potential participants completed an online eligibility survey or responded to questions regarding demographics, health history, income, scheduling availability, and employment status via a phone discussion. Females who had breast cancer were eligible for a separate focus group that included females from any of the four target communities. Participants were recruited through dissemination of focus group information to local health
care providers and community organizations, a media press release, and social networking sites. Focus groups were held at locations within each target community where the participants lived and were selected based on accessibility to public transportation.

A total of 97 eligible people were invited to participate in the focus groups. Once selected, participants were emailed and/or called to confirm the date, time, and location of the focus groups. A total of 10 (90-minute) focus groups were conducted that included 75 females (Table 4.1). Each participant received a $50.00 gift card upon completion of the focus group. The largest group had 10 participants and the smallest had five participants. The size of the groups allowed for a robust discussion that reflected perspectives from each target community. Focus group participants identified with the following race/ethnicity groups: Black/African-American (61); White/Non-Hispanic (6); Hispanic/Latino (4); Asian (e.g., South Asian, Chinese, Filipino, Japanese, Korean, and Vietnamese) (2); Native Hawaiian or Other Pacific Islander (e.g., Native Hawaiian, Guamanian/Chamorro, and Samoan) (1); and one participant chose not to disclose race/ethnicity. The average age was 47. Forty-six participants reported incomes less than $25,000 per household and 16 reported incomes over $50,000. Sixty-seven participants (89.0 percent) reported having health insurance. Sixty-one participants did not disclose the type of health insurance coverage they had and 17 reported being on Medicaid.

**Key Informants**

Key informants were selected using convenience sampling followed by snowball sampling. From a list of previous Komen grantees and partners, all potential informants were contacted for an interview. During the interview, informants were asked if there were additional breast cancer stakeholders that Komen should contact that provide services to residents in the target communities. To be eligible to participate in the key informant interview, the individual had to be an employee of either a health care facility or community organization that provides breast cancer related services to residents of the target communities. Potential informants were contacted via email from Komen to participate in an interview. If a potential informant was not able to participate in an interview, they were asked to complete an online survey that asked the same questions as the interview guide.

At total of 34 potential key informants were contacted for an interview. Of those, a total of 20 key informant interviews and/or surveys were conducted (Table 4.1). A majority of the informants represented more than one of the target communities and were counted as an informant for each target community represented. Of the 18 informants that completed an interview or survey, eight were from community organizations and 10 were health care providers.

<table>
<thead>
<tr>
<th></th>
<th>Alexandria, Virginia</th>
<th>District of Columbia Ward 2</th>
<th>District of Columbia Ward 5</th>
<th>District of Columbia Wards 7 and 8</th>
<th>Breast Cancer Survivors</th>
<th>Females Under 40 Years of Age</th>
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**Ethics**

Focus group participants and key informants were provided information about the purpose of the focus group and interview/survey and voluntarily provided written or verbal consent to participate in the focus group or interview/survey. In addition, written or verbal consent was provided for the focus groups and interviews to be audio recorded. Participants were also informed that all data would be reported in aggregate (de-identified) to protect anonymity. All data collected from the focus groups and key informant interviews/surveys were stored on a password protect server and/or in a locked office with limited access. All audio recorded data will be destroyed upon completion of analysis to protect ongoing anonymity and confidentiality of the participants. All non-audio recorded, de-identified data will be securely stored for a period of five years.
The focus groups were audio recorded and transcribed verbatim. Prior to analysis, the interviewers compared the transcripts with the focus group recordings for accuracy. The transcripts were reviewed line-by-line and passages were highlighted while potential themes were written in the margin. The key informant interviews were audio recorded. The recordings were referenced during analysis of the hand-written notes taken during the interviews. The interview hand-written notes and surveys were reviewed and statements were entered into Excel for thematic coding.

**Alexandria, Virginia**

**Focus Groups**

Conversations with females in Alexandria revealed themes related to the lack of knowledge about breast health and the need for services.

**Lack of Knowledge**

Participants expressed the need for more information on ways to prevent breast cancer, how to detect it early, and where to get support. They wanted to know what to expect during the mammogram, what to look for during breast self-examinations, and how to be prepared mentally if they received a cancer diagnosis. They mentioned that many lack knowledge of breast health and do not talk about cancer if there is no family history or until they know someone is diagnosed. They also mentioned confusion and inconsistent messages about when to get their first breast examination. **Note:** Although participants expressed that they wanted to know what to look for during a breast self-exam, Susan G. Komen uses breast self-awareness messaging because breast self-exams are not an evidence-based practice. To learn more about breast self-awareness, go to [http://ww5.komen.org/BreastCancer/BreastSelfAwareness.html](http://ww5.komen.org/BreastCancer/BreastSelfAwareness.html).

One participant who recently moved to the United States mentioned that in her country, no one talks about their breasts so they do not know about self-examinations and mammograms. She suggested that education about breast cancer and breast health be introduced to those who are new to the United States.

**Need for Services**

Participants were asked where they received breast health services. Although some participants received services at their primary care provider’s office, many reported that they were unaware of services in the area. They recommended that mobile vans circulate in areas where a lot of people congregate, such as places of employment, libraries, hospitals, and grocery stores. These vans would employ community outreach workers to provide education about breast cancer and breast health, have expanded hours (evenings, weekends, and holidays), and provide free services to anyone who needed them.

Over half of the participants in the Alexandria focus group were under 40, therefore, many of them were not aware of services in the community. However, several participants said that both education about breast health and breast screening should start earlier than age 40—a commonly recommended age for the first mammogram. They also thought that information should be made available to everyone, because “cancer doesn’t know color and it doesn’t know age.”

**Key Informants**

Key informants indicated that for residents in Alexandria breast cancer is a general concern and is a high priority; however, there is a gap between intention and action. Health concerns that take precedence over breast cancer for residents include diabetes and heart disease/high blood pressure. Key informants also indicated that residents in Alexandria are not aware of who would be considered high-risk versus low-risk. Barriers that key informants identified for Alexandria residents to access and remain within the continuum of care fall within four overall themes: personal, environmental, financial, and health care system operations (Table 4.2).

**Personal Barriers**

The most cited personal barriers to screening by the key informants for Alexandria residents include communication issues (i.e., language), competing priorities (i.e., work, family) and not understanding where to go for services. Personal barriers most commonly experienced when trying to access diagnostic services were fear about being diagnosed with breast cancer, communication issues (i.e., individual not
understanding why additional tests are needed, language, inability of the facility to get in contact with the patient) and being able to make time to go for additional tests. Barriers cited by key informants for individuals beginning or continuing treatment are communication issues (i.e., language) and family support.

**Environmental Barriers**
Accessible and reliable transportation was the most identified environmental barrier for screening, diagnostic, and treatment services. Transportation can become more of a barrier when going through breast cancer treatment and handling the treatment’s side effects. Another barrier for accessing screening and treatment services identified by key informants was the lack of available breast cancer services in the local community. Key informants indicated that there are little to no survivorship services located in Alexandria.

**Financial Barriers**
Key informants stated that the most common financial barrier related to screening was insurance status. When seeking diagnostic services, key informants indicated that the most common barrier is ensuring that the patient’s insurance benefits are accepted when continuing care from one facility to another. The most commonly cited treatment financial issues are the application and paying for copays, deductibles, and out-of-pocket costs.

**Health Care System Operations Barriers**
Key informants indicated that scheduling not being patient-centered is the biggest health care system barrier for residents of Alexandria to receive screening services. Another screening barrier included going to the doctor for a mammography order and not receiving one because other health issues took priority. For diagnostic and treatment services, the most commonly cited barrier for Alexandria residents is the patient becoming “lost” when transitioning from one health care facility to another for continuing care. Some of this fragmentation is a result of insurance benefits not universally covering services at one facility and limitations in geography as some insurances do not cross state lines. Therefore, Alexandria residents may not be able to access services in the District of Columbia.

**Recommended Solutions to Identified Barriers**
After the key informants considered the barriers experienced by Alexandria residents throughout the continuum of care, key informants indicated that navigation programs that assist residents in entering the continuum of care to receive screening and to assist them in moving seamlessly as needed through diagnostics, treatment and into survivorship services would be beneficial to residents. In addition, these navigators can assist the individual with “wrap-around” services to decrease communication and transportation barriers. Additional screening barrier solutions include expanded capacity of health care facilities to provide service outside of normal business hours/days and additional financial assistance for services. Besides patient navigation, key informants indicated that information about “what is a diagnostic test,” “why these tests may be needed,” and “what to do if you received a letter indicating you need a diagnostic test” be incorporated into the screening appointment. Key informants stated improved communication between an individual’s primary care physician and oncologist may assist in the transitioning between providers during breast cancer treatment.

**District of Columbia (DC) Ward 2 Focus Groups**
The dominant themes that emerged from the focus group discussions in DC Ward 2 were barriers to receiving breast care such as fear of pain or discomfort during a screening mammogram, fear of diagnosis, and lack of education. Self-advocacy and self-care were also important themes.

**Pain as a Barrier**
When asked what would prevent them from seeking or getting breast cancer screening, diagnosis, and treatment, participants reported experiencing pain during their first mammogram. The fear of enduring the pain again prevented them from returning for follow-up exams. Note: Other barriers mentioned by participants included transportation, financial burdens, and putting others first.

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2 “Wrap-around” services include the non-medical services that increase the availability or effectiveness of healthcare by linking, retaining, and supporting those who may need help taking their medications regularly, getting to their appointments on time, or coping with the psychological and emotional stresses surrounding their diagnosis. These services can include housing support, transportation, child care, emergency financial assistance, and psychosocial counseling.
“The mammogram, I didn't like it because it was uncomfortable. It hurt. So I haven't been back. This was last year and I haven't been back since...they said it looked like something was on my left breast but I haven't gone back yet because I feel uncomfortable with the mammogram. It hurt and I didn't like it...when I feel something uncomfortable like that I don't follow-up on it.”

“My breast health provider stays on me about going back to keep getting checked out and I just keep telling him it's uncomfortable. If it's uncomfortable, I am not going to do it, I'm sorry. If something is there, it's just there, until they find something better.”

One participant speculated that getting a mammogram was difficult for young females because they feared someone touching them. Some females assumed that only older females develop breast cancer and they did not have to be concerned because of their age. Other participants mentioned avoiding breast screening for fear of finding out that something is wrong.

In contrast, for others, the fear of developing cancer prompted them to get mammograms regularly. As stated by a participant who underwent a biopsy, “the biopsy pretty much scared me to death. It scared me so much 'til it kept me going back [to get a mammogram].”

Self-Advocacy
DC Ward 2 participants were also asked what would affect the quality of early detection and treatment from medical staff. Rather than focusing on the responsibility of the provider, participants stressed the importance of self-advocacy and being proactive about their health.

“I think every client should be their own advocate for their own health and when you show up you should have a list of questions that you want to ask the provider...because if you don’t it will definitely affect the quality of your experience.”

“You have to be a participant in your own life. You have to participate in your own health, because you are the only one who can really see if something is really not right.”

“I think caring about yourself, paying attention to yourself can help you detect earlier.”

“I believe that you know your body better than anybody else. You know if you feel funny, something feels different...you just know your body better than anybody, so if you go to the doctor and say for instance if your breast feels funny and they say to you, “well you just had a mammogram like 8 months ago.” You can say “I know that I did, but something is going on and I want to have another one because it doesn’t feel right.” You need to just ask them where can you get it examined and push for it because you know your body better than anybody else even your doctor.”

Lack of Education
Some participants lacked information about the importance of breast health and had never received a mammogram. One learned how to perform a breast self-exam while working at the health department and relied on that method instead of getting screened. Another had not received a mammogram because she was told by her doctor that she was too young. For that reason, she was also unaware of the breast services that were available in her community. Note: Although a participant expressed that they learned how to conduct a breast self-exam, Susan G. Komen uses breast self-awareness messaging because breast self-exams are not an evidence-based practice. To learn more about breast self-awareness, go to http://ww5.komen.org/BreastCancer/BreastSelfAwareness.html.

Due to the dearth of information in their community, participants mentioned education most frequently as a health service or support that the community should provide to females. They suggested that more outreach efforts such as annual reminders on billboards, at bus and subway stops, and on college campuses would encourage females of all ages to get mammograms.

“Get your breast examined. Early detection can save your life.”

“A lot more outreach work needs to be done to bring in the different age groups of women because a lot of them out there just -- nobody is outreaching to them, and they are dying due to the lack of knowledge.”
Equally important was access to clearer information about when and how often to have a mammogram and whether the exam was beneficial.

“What I personally struggle with is misinformation about whether it’s actually beneficial to have the mammogram…that information is really confusing.”

**Key Informants**

Key informants indicated that for residents of DC Ward 2 breast cancer is a concern and that awareness of breast cancer is higher than other health issues especially during specific times of the year (i.e., October); however, their ability to act on seeking care depends on other health concerns and impeding factors. Key informants indicated that chronic conditions, such as heart disease/high blood pressure and diabetes, take precedence over breast cancer screenings. Residents in DC Ward 2 have reported to key informants that when they have gone to their doctor to receive an order for a screening mammogram it resulted in other immediate or chronic conditions being addressed and not the patient’s intended purpose of the appointment which was to get a screening order. Key informants indicated that women in DC Ward 2 think that mammograms are painful as they have heard this from others or have had past experiences that have been painful. Barriers that key informants identified for DC Ward 2 residents to access and remain within the continuum of care fall within four overall themes: personal, environmental, financial, and health care system operations (Table 4.2).

**Personal Barriers**

The most cited personal barriers by key informants for DC Ward 2 women to access screening include competing priorities (i.e., work, family) and language issues. Personal barriers most commonly experienced by DC Ward 2 residents when trying to access diagnostic services were communication issues (i.e., individual not understanding why additional tests are needed, language, inability of the facility to get in contact with the patient due to relocation or being out of pre-paid phone minutes) followed by fear and fatalism. Barriers cited by key informants for individuals beginning or continuing treatment are competing priorities such as family obligations, work and fear of losing their job, being overwhelmed with other health conditions (i.e., treatment fatigue) and concern about interaction of breast cancer treatment with other medications.

**Environmental Barriers**

The most commonly mentioned barrier by key informants that hinder women in DC Ward 2 in accessing and utilizing screening, diagnostic, and treatment services was transportation. Key informants indicated that residents must exchange buses or trains multiple times in order get to the health care facility and repeat the process to return home. This process becomes more of a barrier when going through breast cancer treatment and coping with the treatment’s side effects. In addition, the cost of transportation is expensive, especially taxi service. In regards to survivorship services, many key informants indicated that while there are some services available in DC Ward 2, the current services are fragmented and there is a lack of knowledge of what services are available in the local community for breast cancer survivors. Key informants indicated that after survivors complete treatment they feel at a loss because they no longer have the same level of support that they had during treatment.

**Financial Barriers**

The most commonly mentioned financial barriers for DC Ward 2 residents related to screening services were insurance status and the ability to afford copays, deductibles, and out-of-pocket costs. When women are seeking diagnostic services, key informants indicated that the most common barrier is ensuring that the patient’s insurance benefits are accepted when continuing care from one facility to another. The most commonly cited treatment financial issues by the key informants are the time-lag between application and approval for public insurance and the re-certifying of the insurance before and during treatment due to the system being overwhelmed.

**Health Care System Operation Barriers**

Key informants indicated that scheduling being provider-centered and not patient-centered is one of the biggest health care system barriers for residents of DC Ward 2 to receive screening services. While scheduling was also mentioned as a barrier by the key informants for receiving diagnostic services, the most commonly cited barrier is the patient becoming “lost” when transitioning from one health care facility to another facility for continuing care. Transitioning from one facility to another was also identified by key informants as the most common barrier to beginning and completing treatment. Treatment fragmentation may result in a patient having to go to multiple facilities to complete physician recommended treatment (i.e., one facility for surgery, another for chemotherapy and potentially another facility for radiation).
Some of this fragmentation is a result of insurance benefits not universally covering treatment services at one facility and limitations in geography as some insurances do not cross state lines. Therefore, DC Ward 2 residents may not be able to access services in neighboring states (i.e., Maryland and Virginia).

**Recommended Solutions to Identified Barriers**

After consideration of the barriers experienced by DC Ward 2 residents throughout the continuum of care, key informants mentioned most often that navigation programs that can assist residents in entering the continuum of care to receive screening and to assist them in moving seamlessly as needed through diagnostics and treatment and into survivorship services would be beneficial in assisting local residents. These navigation programs need be available for each community (i.e., in each Ward) and specific populations (i.e., Black/African-American, Hispanic/Latino, Immigrants, LGBT) so that the navigators can easily identify with the individuals that need assistance. In addition, these navigators can assist the individual with additional barriers such as communication and transportation. Additional screening barrier solutions included expanded capacity of health care facilities to provide service outside of normal business hours and days and additional financial assistance for services; development of a “health care oasis,” “community assessment and referral sites,” or “one-stops” where all screening services can be provided in one community location; health care provider training about racial and ethnic health care practices; and comprehensive breast cancer education in partnership with trusted community stakeholders (i.e., health care providers, community and religious organizations, schools, meetings/clubs) that have a cultural connection to the target audience. Besides patient navigation, key informants indicated that information about “what is a diagnostic test,” “why these tests may be needed,” and “what to do if you received a letter indicating you need a diagnostic test” be incorporated into the screening appointment. Key informants identified improved communication between an individual’s primary care physician and oncologist may assist in the transitioning between providers during breast cancer treatment.

**District of Columbia (DC) Ward 5**

**Focus Groups**

Three key themes emerged from discussions with participants in DC Ward 5: Lack of information, fear as a barrier to receiving services, and the need for more outreach in the community.

**Lack of Information**

Many participants in DC Ward 5 were unaware of breast health services in their community and travelled to other areas to receive care. Some participants were unaware of services because breast health or breast cancer was not discussed in their community.

“In my community, they don’t mention nothing about breast cancer.”

“Especially in the Black community. We don’t really talk about stuff like that.”

“Unless you go to your primary care physician to get a mammogram, you know, and be referred somewhere else to a specialist. But as far as this community right here, there is nothing.”

“I never thought of having breast cancer, because I never had any breast until recently.”

**Fear of Pain**

Although services, particularly mammograms, might be available in the community, participants avoided them for fear of the pain that they either experienced previously or heard about.

“I had my first mammogram. To me it was horrible. Something like that I think you need to be prepared for, because to me it was a horrible experience.”

One participant avoided getting a mammogram for years because she heard it was painful. After her first exam, she avoided following up and cancelled a biopsy because she did not want to experience the pain again.
Need for Outreach
Given the lack of information about breast health and breast services, participants in DC Ward 5 stressed the need for more community outreach to inform females of the importance of breast care. As stated by one participant:

“I would not have had my first exam if it wasn’t for community outreach.”

Participants also suggested that a nurse, navigator, or community health worker could offer support to females who are fearful of getting mammograms. These support providers could encourage more females to get screened and support them before, during, and after the mammogram by informing them how to prepare for the exam, explaining the steps of the exam, and providing encouragement while they await diagnosis.

Key Informants
Key informants indicated that for residents in DC Ward 5 breast cancer is a “big” concern; however, breast cancer is less of a health concern compared to diabetes and heart disease/high blood pressure. Key informants also indicated that residents in DC Ward 5 are not aware of who would be considered high-risk versus low-risk in terms of breast cancer risk and current screening recommendations. In addition, key informants mentioned that DC Ward 5 residents have low health literacy levels. Key informants stated that DC Ward 5 women they have interacted with indicated that they perceive mammograms as painful as others have told them that it was painful or they had a previous painful experience when receiving a mammogram. Barriers that key informants identified for DC Ward 5 residents to access and remain within the continuum of care fall within four overall themes: personal, environmental, financial and health care system operations (Table 4.2).

Personal Barriers
The most cited personal barriers by the key informants for women in DC Ward 5 accessing screening services include competing priorities (i.e., work, family) and language issues. Personal barriers most commonly experienced when trying to access diagnostic services were fear about being diagnosed with breast cancer and communication issues (i.e., individual not understanding why additional tests are needed, language, inability of the facility to get in contact with the patient). Barriers cited by key informants for individuals beginning or continuing treatment are those considered to be competing priorities such as family obligations, work and fear of losing job, being overwhelmed with other health conditions (i.e., treatment fatigue), and concern about interaction of breast cancer treatment with other medications.

Environmental Barriers
Transportation was the most identified environmental barrier for screening, diagnostic and treatment services as key informants indicated that DC Ward 5 residents may have difficulty accessing public transportation and may have to exchange buses or trains multiple times in order get to the health care facility. Transportation can also be expensive and unreliable. This process becomes more of a barrier when going through breast cancer treatment and handling the treatment’s side effects. In regards to survivorship services, many key informants indicated there are little to no survivorship services located within DC Ward 5. Key informants indicated that after survivors complete treatment they feel at a loss because they no longer have the same level of support that they had during treatment.

Financial Barriers
The most commonly cited screening financial barriers were insurance status and the ability to afford copays, deductibles, and out-of-pocket costs. When seeking diagnostic services, key informants indicated that the most common barrier is ensuring that the patient’s insurance benefits are accepted when continuing care from one facility to another. The most commonly cited treatment financial issues are the time-lags between application and approval for public insurance and the re-certifying of the insurance before and during treatment due to the system being overwhelmed and billing errors. Key informants indicated that billing errors result in patients thinking they owe money for services, while they do not. This error results in the patient feeling like they cannot continue treatment as they cannot pay the bill.

Health Care System Operation Barriers
Key informants indicated that scheduling being provider-centered and not patient-centered is the biggest health care system barrier for residents of DC Ward 5 to receive screening services. For diagnostic and treatment services, the most commonly cited barrier for DC Ward 5 residents is the patient becoming
“lost” when transitioning from one health care facility to another facility for continuing care. Treatment services fragmentation may result in a patient having to go to multiple facilities to complete physician recommended treatment (i.e., one facility for surgery, another for chemotherapy and potentially another facility for radiation). Some of this fragmentation is a result of insurance benefits not universally covering treatment services at one facility and limitations in geography as some insurances do not cross state lines. Therefore, DC Ward 5 residents may not be able to access services in neighboring states (Maryland and Virginia). Key informants indicated that survivorship services that are provided in Ward 5 tend to be in silos and not connected to each other and providers do not know what survivorship services are available for breast cancer survivors.

Recommended Solutions to Identified Barriers
After the key informants considered the barriers experienced by DC Ward 5 residents throughout the continuum of care, key informants indicated that navigation programs that can assist residents in entering the continuum of care to receive screening and to assist them in moving seamlessly as needed through diagnostics, treatment and into survivorship services would reduce the risk of a patient being lost in the system. These navigation programs need be available for each community (i.e., in each Ward) and specific populations (i.e., Black/African-American, Hispanic/Latino, Immigrants, LGBT) so that the navigators can easily identify with the individuals that need assistance. In addition, these navigators can assist the individual with “wrap-around” services to decrease communication and transportation barriers. Additional screening barrier solutions include expanded capacity of health care facilities to provide service outside of normal business hours and days; additional financial assistance for services; development of a “health care oasis,” “community assessment and referral sites,” or “one-stops” where all screening services can be provided in one community location; health care provider training about racial and ethnic health care practices; and comprehensive breast cancer education in partnership with trusted community stakeholders (i.e., health care providers, community and religious organizations, schools, meetings/clubs) that have a cultural connection to the target audience. Besides patient navigation, key informants indicated that information about “what is a diagnostic test”, “why these tests may be needed” and “what to do if you received a letter indicating you need a diagnostic test” be incorporated into the screening appointment. Key informants stated improved communication between an individual’s primary care physician and oncologist may assist in the transitioning between providers during breast cancer treatment.

District of Columbia (DC) Wards 7 and 8

Focus Groups
Several themes came out of the discussion with participants in DC Wards 7 and 8, namely a lack of services in low-income communities, the need for comprehensive services, and the need for education and outreach.

Lack of Services
When asked what types of breast health resources and services were provided in their community, many participants reported receiving services such as mammograms from their primary care provider, which in many instances was outside of the community. The participants noted that there were limited services in DC Wards 7 and 8 and the few that existed lacked sufficient information about breast health. They attributed such lack of services to poverty.

“When you live in low income Wards, I don’t think we are being educated enough about breast cancer.”

“When you live in areas like this, nobody is telling you please, go get your breasts examined.”

“There is nothing in this area that warns women about the dangers of breast cancer.”

“For years we have known that poverty is linked to a lot of unhealthy behaviors in healthy people…so, it doesn’t surprise me that in the poorest neighborhoods, they have the highest rates of breast cancer.”

Need for Comprehensive Services
Participants wanted comprehensive breast health services that are affordable and accessible to everyone, even those without insurance.

When asked about the components of comprehensive services, participants suggested that they be in the form of mobile units located in areas where people need them most—in the poorest neighborhoods where cancer is more prevalent. These units would provide transportation, childcare, an extensive support
network, and they would provide screening for all types of cancer, not just breast cancer. Lastly, they wanted more sensitive health care providers “who are able to explain information to you in a nicer way…to help you understand.” According to one participant, “having someone there that is warm, respectful, and professional will make a big difference.”

More Education and Outreach Needed
Participants noted the need for more education and outreach in their community. As one participant noted, “it’s not just about people knowing that they need a breast exam or knowing that they need to have check-ups.” It was also about providing information about why breast screening is important and reducing stigma and misperceptions about breast screening. In addition, participants wanted information on how to conduct breast self-examinations and what to look for when performing the exam. Note: Although participants expressed that they wanted to know how to conduct a breast self-exam and what to look for during a breast self-exam, Susan G. Komen uses breast self-awareness messaging because breast self-exams are not an evidence-based practice. To learn more about breast self-awareness, go to http://ww5.komen.org/BreastCancer/BreastSelfAwareness.html.

Key Informants
Key informants indicated that for residents in DC Wards 7 and 8 breast cancer is a substantial concern as many have not been screened or have not kept up with annual screening. While key informants indicated that residents of DC Wards 7 and 8 are aware of the importance of breast cancer screenings, the residents are more aware of their risk of developing diabetes and heart disease/high blood pressure than understanding their risk of breast cancer. In terms of breast cancer screenings, key informants stated that DC Wards 7 and 8 women perceive the test as painful. This perception comes from either their own personal experience or hearing from others that it is painful. Barriers that key informants identified for Wards 7 and 8 residents to access and remain within the continuum of care fall within four overall themes: personal, environmental, financial, and health care system operations (Table 4.2).

Personal Barriers
The most cited personal barriers to screening by the key informants for women in DC Wards 7 and 8 include competing priorities (i.e., work, family) and language issues. Additional screening barriers identified by key informants include cultural (i.e. not supportive of screenings) and a lack of awareness of where to go for services. Personal barriers most commonly experienced when trying to access diagnostic services were fear about being diagnosed with breast cancer and communication issues (i.e., individual not understanding why additional tests are needed, language, inability of the facility to get in contact with the patient). Personal barriers most commonly cited by key informants for individuals beginning or continuing treatment are those considered to be competing priorities such as family obligations, work and fear of losing job, being overwhelmed with other health conditions (i.e., treatment fatigue), and concern about interaction of breast cancer treatment with other medications.

Environmental Barriers
Transportation was the most identified environmental barrier for screening, diagnostic, and treatment services as DC Wards 7 and 8 residents may have difficulty accessing services due to the cost. Transportation can also not be easily accessible or reliable. In addition, key informants indicated that residents have difficulty accessing services due to the lack of breast cancer services available in DC Wards 7 and 8. In regards to survivorship services, many key informants indicated there are little to no survivorship services located within DC Wards 7 and 8. Key informants indicated that after survivors complete treatment they feel at a loss because they no longer have the same level of support that they had during treatment.

Financial Barriers
The most commonly cited screening financial barriers by key informants for DC Wards 7 and 8 residents were insurance status and the ability to afford copays, deductibles, and out-of-pocket costs. When seeking diagnostic services, key informants indicated that the most common barriers are seamless insurance coverage between facilities and the ability to pay copays, deductibles, and out-of-pocket costs. The most commonly cited treatment financial issues are the time-lags between application and approval for public insurance and the re-certifying of the insurance before and during treatment due to the system being overwhelmed and billing errors. Key informants indicated that billing errors result in patients thinking they owe money for services, while they do not. This error results in the patient feeling like they cannot continue treatment as they cannot pay the bill.
Health Care System Operations Barriers

Key informants indicated that scheduling being provider-centered and not patient-centered is the biggest health care system barrier for residents of DC Wards 7 and 8 to receive screening services. For diagnostic and treatment services, the most commonly cited barrier for DC Wards 7 and 8 residents is the patient becoming "lost" when transitioning from one health care facility to another facility for continuing care. Treatment services fragmentation may result in a patient having to go to multiple facilities to complete physician recommended treatment (i.e. one facility for surgery, another for chemotherapy and potentially another facility for radiation). Some of this fragmentation is a result of insurance benefits not universally covering treatment services at one facility and limitations in geography as some insurances do not cross state lines. Therefore, DC Wards 7 and 8 residents may not be able to access services in neighboring states (i.e., Maryland and Virginia). The second most commonly mentioned barrier by key informants for residents in DC Wards 7 and 8 in beginning or continuing breast cancer treatment is a lack of coordinated care between the multiple doctors involved in treatment. In addition, key informants indicated that survivorship services that are provided tend to be fragmented and not connected to each other. Also, there is a lack of awareness among key informants of what services are available within DC Wards 7 and 8.

Recommended Solutions to Identified Barriers

After the key informants considered the barriers experienced by DC Wards 7 and 8 residents throughout the continuum of care, key informants indicated that navigation programs that can assist residents in entering the continuum of care to receive screening and to assist them in moving seamlessly as needed through diagnostics, treatment and into survivorship services would be beneficial for residents. These navigation programs need be available for each community (i.e., in each Ward) and specific populations (i.e., Black/African-American, Hispanic/Latino, Immigrants, LGBT) so that the navigators can easily identify with the individuals that need assistance. In addition, these navigators can assist the individual with receiving additional services to decrease communication and transportation barriers. Two additional common suggestions for continuum of care services were the establishment of health care “one-stops,” “PODS,” “community assessment and referral sites,” or “health care oasis” throughout the community where women can be provided comprehensive breast cancer education, patient-centered services and patient navigation by individuals that look like them and that the community trusts (i.e., health care providers, community and religious organizations, schools, meetings/clubs) and increased collaboration between doctors. Besides patient navigation, key informants indicated that information about “what is a diagnostic test,” “why these tests may be needed,” and “what to do if you received a letter indicating you need a diagnostic test” be incorporated into the screening appointment to assist with diagnostic barriers.

Breast Cancer Survivors

Focus Groups

The dominant theme among breast cancer survivors was related to the quality of services they received, particularly during diagnosis and treatment.

Quality of Services

When asked about their use of breast health services, many participants were dissatisfied with the quality of the services they received. Some thought the quality of service depended on the type of insurance they had, or whether they had insurance at all. One participant who did not have health insurance mentioned the challenge of getting a mammogram referral. Another shared her experience with trying to get a mammogram.

“I was in between jobs and didn’t have health insurance, so I had to call the Avon Breast Center, and about six weeks later is when they contacted me…I had to wait those four to six weeks for them to call me back; and by the time they called me back I was at stage 2. It’s in my lymph nodes, too.”

However, another participant saw age as a factor in the quality of services she received. She suggested that services for females age 35 and older were abundant, yet the same services did not exist for younger survivors.

“For a 22-year-old, they refused a mammogram because they said that it was impossible for me to have breast cancer. They misdiagnosed me twice over a period of nine months before I was diagnosed with breast cancer, and that’s because even though when I finally got a mammogram nine months in it showed nothing. They had to do a biopsy to find it, and it was everywhere at that point. So, for me it’s not about region, because I have a great insurance provider. It’s about the age. So, in my community for a young breast cancer patient, there are no resources available at all.”
Other participants thought the quality of care depended on the stage of treatment. Many reported being treated very well during diagnosis and treatment, but were ignored once treatment was over.

“At certain times, I felt really taken care of well...if you're in there they take good care of you. After I finished treatment, I felt a little pushed out.”

“When you're first diagnosed, they do a lot of hand holding. It's a scary time. You don't know what's going on. There are a lot of questions. But I do think somewhere in that process, after that process, after treatment is done...I was like, I'm just another number. I battle with feeling like just another number.”

“Once I found mine out, my oncologist, the whole treatment scene, everybody was great, everybody was great. Once I finished my 44th session, it was like they had my stuff packed up and ready to throw me out of the door. They didn't want to answer any more questions or anything.”

Although not classified as themes, there were additional points made during the discussion that are worth noting. For example, one participant experienced long wait times but short visits with her provider. As she stated, “I had an 11:30 appointment and my doctor did not see me until 12:45. And then he came in, and I timed it, it was seven minutes.”

Another participant reported being sexually harassed by a male nurse. Although she filed a formal complaint, she reported that there has been no follow-up because she refused to disclose her name to her health insurance provider.

Based on their experiences, the survivors expressed the need for navigators or peer support in their communities, where there is a lack of resources as well as a gap in education and awareness. As one participant offered, “it would be nice if newly diagnosed women could be peer matched up with someone who is going through the process or maybe a little further along on in the process, maybe like maybe two categories ahead.

“A lot of women in the community, they just won’t know about stuff.”

Another participant suggested that there is a need for better education, particularly related to breast cancer detection, atypical symptoms, and various types of breast cancer.

**Females Under 40 Years of Age**

*Focus Groups*

The common themes among this group were related to inconsistent quality of care and barriers to accessing care.

**Quality of Care**

Most participants felt that providers were helpful, informative, and they follow up regularly. In addition, they provide thorough education on what to look for and what to expect during the mammogram.

However, one participant expressed frustration with radiologists who performed her mammograms because they never seemed to be familiar with her chart. She was particularly irritated with a radiologist who seemed impersonal.

“It was like you are doing something that could mean that I could have cancer and you're kinda brushing it off like it's no big deal; like I'm just another patient rotating through the day.”

Other participants mentioned that different types of providers offered different levels of care. For one participant, her primary care provider never mentioned a clinical breast exam to her, but the gynecologist provided details and taught her how to do her own self-exam. According to the participant, “it was kind of nice to actually have someone sit down and talk to you and give you the time of day to kind of explain exactly what it is they're doing and not just another routine annual examination.” Note: Although interviewees expressed the need for BSE, Susan G. Komen uses BSA messaging because BSE is not an evidence-based practice. To learn more about BSA, go to [http://ww5.komen.org/BreastCancer/BreastSelfAwareness.html](http://ww5.komen.org/BreastCancer/BreastSelfAwareness.html).

Similarly, other participants thought that providers didn’t think it was necessary to talk about breast health because they were so young.
“I noticed that…we just haven’t really gotten the type of detailed attention that’s probably necessary.”

“The first time I went to the doctor, they didn’t really give me much information because they just said, ‘oh, you’re really young.’

“I think it’s just not being brought up as early on as it should be and it’s not given as much attention at an earlier phase where people think that you have to get diagnosed much later and then it’s not much of a concern in your 20’s.”

When one participant asked her provider questions about breast health, the provider told her that the information did not apply to her because of her age. The provider stated, “well, it’s not as much of a concern for you to be thinking about these things right now, but it’s good that you’re like trying to get informed,” which the participant thought was “a little condescending.” This discouraged her from asking questions.

**Barriers to Care**

When asked what would prevent them from getting breast cancer screenings, diagnosis, or treatment, participants listed a number of barriers including lack of education, insurance, applicability, and transportation. Although some participants received a thorough education as it relates to breast self-awareness and mammograms, others were not aware of what they should look for. They also reported wanting more information such as statistics and demographics that were more age-specific.

Participants noted that those without insurance may not seek out or receive breast cancer screening; those with insurance may not be fully covered if the provider deems the procedure as not medically necessary due to their age.

Participants suggested that many young females believe that breast cancer affects older females and not them. In addition, if they have a family history of breast cancer they may avoid getting screened for fear that they also have breast cancer. Because the images of those affected by breast cancer are usually of older females, participants recommended that marketing and outreach materials include younger females to which they could better relate.

**Table 4.2. Barriers to continuum of care services**

<table>
<thead>
<tr>
<th>Screening Barriers</th>
<th>Diagnostic Barriers</th>
<th>Treatment Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Competing priorities (i.e., family and work)</td>
<td>• Language</td>
<td>• Competing priorities (i.e., family, work, other health issues)</td>
</tr>
<tr>
<td>• Language</td>
<td>• Do not understand why additional tests are needed</td>
<td>• Language</td>
</tr>
<tr>
<td>• Cultural (i.e. not supportive of screening, God will heal)</td>
<td>• Fatalism</td>
<td>• Time</td>
</tr>
<tr>
<td>• Fear</td>
<td>• Fear</td>
<td>• Lack of resources (i.e. support)</td>
</tr>
<tr>
<td>• Lack of understanding where to go</td>
<td>• Provider unable to reach patient with abnormal results and next steps</td>
<td>• Time</td>
</tr>
<tr>
<td>• Age</td>
<td>• Cultural (i.e., do not question doctors, family does not want them to go back)</td>
<td>• Time</td>
</tr>
<tr>
<td>• Unsure where insurance is accepted</td>
<td>• Time</td>
<td>• Lack of support system</td>
</tr>
<tr>
<td>• Time</td>
<td>• Health literacy</td>
<td>• Treatment barriers</td>
</tr>
<tr>
<td>• Mistrust of health care providers/system</td>
<td>• Facilities providing diagnostic services are located outside of local community</td>
<td>• Transportation</td>
</tr>
<tr>
<td>• Lack of support system</td>
<td>•</td>
<td>• Access to providers/facilities in local community</td>
</tr>
<tr>
<td>Environmental</td>
<td>Transportation</td>
<td>Transportation</td>
</tr>
<tr>
<td>• Transportation</td>
<td>• Facilities providing diagnostic services are located outside of local community</td>
<td>• Transportation</td>
</tr>
<tr>
<td>• Lack of comprehensive services within local community</td>
<td>•</td>
<td>• Access to providers/facilities in local community</td>
</tr>
<tr>
<td>• Ability to easily access facilities if have disability</td>
<td>•</td>
<td></td>
</tr>
<tr>
<td>Financial</td>
<td>Screening Barriers</td>
<td>Diagnostic Barriers</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>----------------------------------------------------------</td>
<td>-----------------------------------------------------------</td>
</tr>
<tr>
<td>• Insurance status\textsuperscript{1,2,3,4}</td>
<td>• Insurance coverage issues between facilities\textsuperscript{2,3,4}</td>
<td>• Delays in applying or re-certifying public insurance\textsuperscript{2,3,4}</td>
</tr>
<tr>
<td>• Copays/deductibles/out-of-pocket costs\textsuperscript{1,2,3,4}</td>
<td>• Copays/deductibles/out-of-pocket costs\textsuperscript{3,4}</td>
<td>• Billing mistakes (i.e., receive a bill and cannot pay, so do not return for services)\textsuperscript{1,2,3,4}</td>
</tr>
<tr>
<td>• Coverage verification issues-takes multiple appointments\textsuperscript{1,4}</td>
<td>• Patient gets lost in transitioning from one facility to another for services\textsuperscript{1,2,3,4}</td>
<td>• Cost will burden family\textsuperscript{1}</td>
</tr>
<tr>
<td>• Financial assistance not determined until after service has been completed\textsuperscript{1}</td>
<td>• All services not offered in one facility\textsuperscript{1}</td>
<td>• Difficulty finding provider that accepts insurance\textsuperscript{3}</td>
</tr>
<tr>
<td></td>
<td>• Scheduling not patient-centered\textsuperscript{1,2,3,4}</td>
<td>• Scheduling provider-centered not patient-centered\textsuperscript{1,2}</td>
</tr>
<tr>
<td></td>
<td>• Unwelcoming atmosphere of facilities – not treated like others\textsuperscript{1,2}</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Go to doctor for mammogram order, but other conditions treated first and order not received\textsuperscript{1,4}</td>
<td>• Communication Issues: language, inability of health care provider to contact patient.</td>
</tr>
</tbody>
</table>

\textsuperscript{1} = District of Columbia Ward 2  
\textsuperscript{2} = District of Columbia Ward 5  
\textsuperscript{3} = District of Columbia Ward 7 and 8  
\textsuperscript{4} = Alexandria, Virginia

### 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, 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 (education), dual minorities, and those that do not speak English fluently are less likely to get breast cancer screenings.

**Alexandria, Virginia**

Common barriers 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 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 need, 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 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:** must make multiple bus or train transfers to get to facility, expensive, unreliable, accessibility issues.
- **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 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 for each community (i.e., in each Ward) and specific populations (i.e., Black/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 DC Medicaid changes, new revenue or payment structures to incentivize 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.

Limitations of Qualitative Data
While steps were taken to ensure the accuracy of the information collected from focus groups and key informant interviews, there are limitations that need to be considered when using the data. For example, the interviewers did not validate the findings with the focus group participants and key informants following the focus groups or interviews. However, the interviewers conducted several member checks during the focus groups and interviews to ensure that the information was understood. The focus group discussions and interviews were limited to 45 to 60 minutes. Thus, in some instances, the moderator or interviewer was unable to probe for further details to cover all questions during the discussion. While only two focus groups were conducted per target community, the information presented in the second focus group in each target community confirmed the perceptions of those that participated in the first focus group. Overall, the conversations provided a rich description of participant’s experiences related to breast cancer in each target community. However, due to the limitations of the data, the perspectives provided represent only those that participated in the focus groups and interviews and do not represent the general population of the community, health care providers, or community organizations as a whole.
Alexandria, Virginia
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 and is very close to the Komen NCR service area (23.5 per 100,000) (Table 2.11). Alexandria 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 (Table 2.11). It is predicted that Alexandria will not achieve the HP 2020 breast cancer target for late-stage incidence.

The percentage of the population in Alexandria 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 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.

Residents of Alexandria have twelve health care facilities and community organizations available 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).

Focus group participants and key informants identified the following common barriers for women that reside in Alexandria in accessing and utilizing breast cancer screenings, diagnostics, and treatment services:

- **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.

Focus group participants’ and key informants’ recommendations 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 using 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 received screenings and move them seamlessly as needed through diagnostics and
treatment into survivorship services. Navigators can also assist the individuals with 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**

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.

**District of Columbia (DC) Ward 2**

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 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).

**District of Columbia (DC) Ward 5**

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.

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 the 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).

**District of Columbia (DC) Wards 7 and 8**

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).

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 only one community organization proving some type of support services. While availability of services is 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 medically underserved areas indicating that residents have a shortage of personal health services (US Department of Health and Human Services, 2015).

Common barriers 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**: must make multiple bus or train transfers to get to facility, expensive, unreliable, accessibility issues.
- **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 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 be available for each community (i.e., in each Ward) and specific populations (i.e., Black/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.

MISSION ACTION PLAN

Utilizing the key findings from the quantitative, health system and public policy analysis, and qualitative data, the Komen Community Profile Team along with the Community Health Grantmaking and Advocacy Teams developed a comprehensive Mission Action Plan to address the identified issues in each of the target communities.

Problem Statement: It is predicted that Alexandria, Virginia and the District of Columbia will not achieve the Healthy People 2020 breast cancer late-stage diagnosis and death rate targets. Health system analyses found that within the target communities there is disproportionate access to breast cancer services among specific populations, even if services are available within the local communities. Common target community barriers identified by focus group participants and key informants included lack of breast cancer education and training, communication issues, competing priorities, transportation, financial, scheduling flexibility, and fragmented quality health care services.

Priority: Enhance the ability of health care systems and community organizations that provide breast cancer services to residents in Alexandria, Virginia and District of Columbia Wards 2, 5, 7 and 8 to provide seamless continuity of care between referral, screening, diagnosis, treatment, and survivorship services.
  • Objective: Support the development and/or growth of breast cancer patient navigation and/or community health worker programs within Alexandria, Virginia and District of Columbia Wards 2, 5, 7 and 8 to assist residents in accessing screening and transitioning throughout the breast cancer continuum of care.
  • Objective: Support 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 in Alexandria, Virginia and District of Columbia Wards 2, 5, 7 and 8 such as churches, community centers, and places of employment.
  • Objective: Support the development or expansion of programs that reduce financial, communication and transportation barriers to breast cancer care for underserved residents of Alexandria, Virginia and District of Columbia Wards 2, 5, 7 and 8.
  • Objective: 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).

Priority: Initiate and support 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 minorities in Alexandria, Virginia and District of Columbia Wards 2, 5, 7 and 8.
  • Objective: Support culturally-appropriate, evidence-based one-on-one and group breast cancer education programs to underserved populations in Alexandria, Virginia and District of Columbia Wards 2, 5, 7 and 8.

Priority: Advocate to ensure that the fight against breast cancer is a priority among policymakers that serve the National Capital Region.
  • Objective: On an annual basis, provide Maryland and Virginia US Representatives and Senators and the District of Columbia policymakers at least one policy briefing regarding one of Komen’s Advocacy Priorities.
REFERENCES


Susan G. Komen. 2015. DC Roundtable Meeting Notes (unpublished). Susan G. Komen, Dallas, TX.


### APPENDIXES

**Appendix A.** Current National Capital Region Grantees and Service Areas

<table>
<thead>
<tr>
<th>Organization</th>
<th>Physical Location</th>
<th>Target Areas Served</th>
<th>Other NCR Areas Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>African Women’s Cancer Awareness Association</td>
<td>Prince George’s County, MD</td>
<td>Ward 2, Ward 5, Ward 7, Ward 8 and Alexandria City, VA</td>
<td>Ward 3, Ward 6, Montgomery County, MD and Prince George’s County, MD</td>
</tr>
<tr>
<td>Boat People SOS</td>
<td>Fairfax County, VA</td>
<td>Alexandria City, VA</td>
<td>Montgomery County, MD, Prince George’s County, MD, Fairfax County, VA, Prince William County, VA, Loudoun County, VA and Arlington County, VA</td>
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<tr>
<td>Breast Care for Washington</td>
<td>Ward 8</td>
<td>Ward 2, Ward 5, Ward 7, Ward 8 and Alexandria City, VA</td>
<td>Ward 1, Ward 3, Ward 4, Ward 6, Montgomery County, MD, Prince George’s County, MD, Fairfax County, VA, Prince William County, VA, Loudoun County, VA and Arlington County, VA</td>
</tr>
<tr>
<td>Capital Breast Care Center</td>
<td>Ward 6</td>
<td>Ward 2, Ward 5, Ward 7, Ward 8 and Alexandria City, VA</td>
<td>Ward 1, Ward 3, Ward 4, Ward 6, Montgomery County, MD, Prince George’s County, MD, Fairfax County, VA, Prince William County, VA, Loudoun County, VA and Arlington County, VA</td>
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<tr>
<td>CASA de Maryland</td>
<td>Montgomery County, MD and Prince George’s County, MD</td>
<td>Alexandria City, VA</td>
<td>Montgomery County, MD, Prince George’s County, MD, Fairfax County, VA, Prince William County, VA, Loudoun County, VA and Arlington County, VA</td>
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<tr>
<td>Korean Community Service Center of Greater Washington</td>
<td>Fairfax County, VA</td>
<td>Ward 2 and Alexandria City, VA</td>
<td>Ward 6, Montgomery County, MD, Prince George’s County, MD, Fairfax County, VA, Prince William County, VA, Loudoun County, VA and Arlington County, VA</td>
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<tr>
<td>Mary’s Center for Maternal and Child Care, Inc.</td>
<td>Ward 1, Ward 4, Montgomery County, MD and Prince George’s County, MD</td>
<td>Ward 2, Ward 5, Ward 7, Ward 8 and Alexandria City, VA</td>
<td>Ward 1, Ward 3, Ward 4, Ward 6, Montgomery County, MD, Prince George’s County, MD, Fairfax County, VA, Prince William County, VA, Loudoun County, VA and Arlington County, VA</td>
</tr>
<tr>
<td>Nueva Vida, Inc.</td>
<td>Alexandria City, VA</td>
<td>Ward 2, Ward 5, Ward 7, Ward 8 and Alexandria City, VA</td>
<td>Ward 1, Ward 3, Ward 4, Ward 6, Montgomery County, MD, Prince George’s County, MD, Fairfax County, VA, Prince William County, VA, Loudoun County, VA and Arlington County, VA</td>
</tr>
<tr>
<td>Prevent Cancer Foundation</td>
<td>Alexandria City, VA</td>
<td>Ward 5, Ward 7 and Alexandria City, VA</td>
<td>Ward 1, Ward 3, Ward 4, Montgomery County, MD, Prince George’s County, MD, Fairfax County, VA, Prince William County, VA, Loudoun County, VA and Arlington County, VA</td>
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<tr>
<td>Primary Care Coalition of Montgomery County</td>
<td>Montgomery County, MD</td>
<td>Ward 2, Ward 5, Ward 7, Ward 8 and Alexandria City, VA</td>
<td>Ward 1, Ward 3, Montgomery County, MD, Prince George’s County, MD, Fairfax County, VA and Arlington County, VA</td>
</tr>
<tr>
<td>Organization</td>
<td>Physical Location</td>
<td>Target Areas Served</td>
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<tr>
<td>Providence Health Foundation</td>
<td>Ward 5</td>
<td>Ward 5 and Ward 8</td>
<td>Ward 6 and Prince George’s County, MD</td>
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<tr>
<td>Smith Center for Healing and the Arts</td>
<td>Ward 2</td>
<td>Ward 2, Ward 5, Ward 7, Ward 8 and Alexandria City, VA</td>
<td>Ward 1, Ward 3, Ward 4, Ward 6, Montgomery County, MD, Prince George’s County, MD, Fairfax County, VA and Arlington County, VA</td>
</tr>
<tr>
<td>Vietnamese Resettlement Association, Inc.</td>
<td>Fairfax County, VA</td>
<td>Alexandria City, VA</td>
<td>Fairfax County, VA, Prince William County, VA, Loudoun County, VA and Arlington County, VA</td>
</tr>
</tbody>
</table>
Appendix B. National Capital Region Grantees (2011-present)

2011  Adventist Healthcare, Inc.
      American Association on Health and Disability
      Arlington Free Clinic
      Capital Breast Cancer Care, Georgetown University's Lombardi Cancer Center
      CASA de Maryland, Inc
      Georgetown University - Lombardi Cancer Center
      Korean Community Service Center of Greater Washington
      Mary's Center for Maternal & Child Care, Inc.
      Mautner Project
      Nueva Vida, Inc.
      Prevent Cancer Foundation
      Prince George's County Health Department
      Providence Health Foundation
      Vietnamese Resettlement Association, Inc.
      Washington Hospital Center Foundation

2012  Howard University
      Boat People SOS
      Capital City Area Health Education Center
      Doctors Community Hospital
      Primary Care Coalition of Montgomery County
      George Washington University
      Howard University
      Greater Baden Medical Services, Inc.

2013  Alexandria Neighborhood Health Services, Inc.
      Arlington Free Clinic
      Ethiopian Community Development Council, Inc.
      Muslim Community Center Medical Center
      Nueva Vida, Inc.
      CASA de Maryland, Inc
      Prevent Cancer Foundation

2014  Mobile Medical Care
      Mary's Center for Maternal & Child Care, Inc.
      Vietnamese Resettlement Association
      The Red Devils, Inc.
      Smith Center for Healing and the Arts
      Prince William Hospital
      Capital City Area Health Education Center
2015 Arlington Free Clinic
Breast Care for Washington
African Women's Cancer Awareness Association
Capital Breast Care Center
Korean Community Service Center of Greater Washington
Prevent Cancer Foundation
Boat People SOS
CASA de Maryland