susan g. komen®

COMMUNITY PROFILE REPORT 2015

SUSAN G. KOMEN® CHATTANOOGA

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Acknowledgments

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

Susan G. Komen® Chattanooga would like to extend its deepest gratitude to the Board of Directors and the following individuals who participated on the 2015 Community Profile Team:

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A special thank you to the following entities for their assistance with data collection and analyses, as well as providing information included in this report:

- Debbie Chestnutt, Manager, Murray County Health Department
- Diane Conway, Murray County Medical Center
- Lisa Morris, Nurse Navigator, Erlanger Health System
- Women's Ministry Team, Olivet Baptist Church
- Women's Ministry Team, Avondale Baptist Church

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Executive Summary

Introduction to the Community Profile Report

Susan G. Komen® Chattanooga was established in January 2000 under the leadership of David Watson and Sarah Bowen. Today, Komen Chattanooga's fundraising efforts continue to support local breast health organizations in Northwest Georgia and Southeast Tennessee. Komen Chattanooga's community outreach in the fight against breast cancer includes partnerships with several local health care providers, hospitals, educational institutions and governmental agencies. The 16 county Affiliate service area includes ten counties in SE Tennessee; Hamilton, Bradley, Polk, McMinn, Meigs, Rhea, Bledsoe, Sequatchie, Grundy and Marion, and six counties in NW Georgia; Catoosa, Dade, Fannin, Murray, Walker and Whitfield.

Since its inception in 2000, Komen Chattanooga has awarded grants totaling over $2.7 million to local breast health organizations to provide screening, diagnostics, treatment support and educational services to the Affiliate service area. Over $900,000 dollars, which is 25.0 percent of local net revenue, has been contributed to Komen's National Research Programs for ground-breaking breast cancer research.

Chattanooga, in Hamilton County, Tennessee, is home to the Affiliate Race for the Cure® and the Affiliate business office. This county has three major medical systems including two accredited breast care centers. Hamilton County has both the largest female population (over 469,200) and the largest Black/African-American population of the Affiliate service areas. The populations in Rhea, Fannin and Murray Counties are predominately White. Murray County reports the 2nd largest Hispanic/Latina population in the Affiliate service area at 12.9 percent. Murray and Rhea Counties are 100 percent medically underserved.

In the Affiliate service area combined, 41.8 percent of the population falls below the 250 percent poverty line. Hamilton County has 35.8 percent of the population living below the 250 percent poverty level, slightly below the Affiliate service area percentage. However, Rhea, Fannin and Murray Counties, all rural areas, are reporting higher with ratios of 46.2 percent, 49.0 percent and 50.4 percent respectively. Fannin and Murray Counties in Georgia also have higher percentages of uninsured population than the Affiliate service area average ratio of 19.1 percent and the state ratio of 20.7 percent. These three counties also have unemployment numbers that exceed both the state and national averages. These factors make traveling to and paying for medical services challenging.

The Community Profile is intended to evaluate the burden of breast cancer within the Komen Chattanooga service area, identify the needs of the community, and determine any gaps or barriers that exist concerning breast health and breast cancer. The process serves as a tool to help the Affiliate continually learn and understand breast health issues within the service area, allowing it to engage further in community collaboration. The findings of the Community Profile will provide direction for outreach, allocation of grant funds and resources and provide a foundation for the Affiliate's strategic planning efforts. This report will be shared with community partners, area breast health providers, policymakers and other stakeholders in the community.

Quantitative Data: Measuring Breast Cancer Impact in Local Communities

Current economic conditions in the Affiliate service area served as the basis to conduct additional research into unemployment figures. The unemployment rate and lack of job growth impact residents' ability to access health care services. While unemployment data was provided in the QDR, the stagnated local economic conditions warranted further investigation.

Although there are discrepancies among researchers on how socioeconomic factors affect breast cancer screening and survival, the unemployment rates in the priority target areas are consistently reporting higher than the national average. All four counties are consistently higher than the respective state average for unemployment as well.

Recent data regarding unemployment have been researched from the Georgia Department of Labor and the Tennessee Department of Labor statistical databases to gather both county level and state level unemployment rates. A concern for the priority counties in the Affiliate service area is the long-term unemployment numbers and how they will affect the overall health of the population (University of Georgia, 2014), (Tennessee Department of Labor, 2014). Statistical data from March 2014 confirm reason for concern. Hamilton County, TN reported an unemployment rate of 6.8 percent, Rhea County, TN at 9.2 percent, and the priority counties in Georgia are Fannin at 7.2 percent and Murray County at 9.8 percent. During that same month, Tennessee reported an unemployment rate of 6.7 percent and Georgia reported 7.0 percent. The national unemployment rate for the same time period was reported at 6.7 percent.

Another primary concern for Murray County is the sharing of resources with Whitfield County, which is reporting an unemployment rate of 8.1 percent. Whitfield and Murray Counties historically share health care resources. These resources are being exhausted as more residents require free and reduced rate services. The qualitative data will explore how much stress is being placed on providers of breast health screening, education, and treatment services. This increased population of unemployed and underemployed residents, as well as many who are considered long-term unemployed, will have a direct impact on those needing breast health care and, for financial reasons, are not receiving it. Long-term unemployed is defined by the US Department of Labor as unemployed for more than six consecutive months.

Upon review of the Quantitative Data Report, Komen Chattanooga has selected four target communities in the 16 county service area to be the focus of strategic intervention for the next four-year cycle. The Affiliate considered all of the quantitative data provided along with the latest state and county unemployment rates in the process of choosing the target communities.

The Community Profile Team also considered how the selected communities ranked in achieving the goals of the Healthy People 2020 Objectives. Healthy People 2020 (HP2020) has established national, evidence-based goals to improve the overall health of Americans. Released in 2010, these objectives are aggressive, but attainable within the 10 year period with appropriate interventions.

Two objectives identified and specifically related to improvements in breast cancer health outcomes are to reduce female breast cancer death rate, and to reduce cases of late-stage female breast cancer diagnosis. These objectives will be the focus of Affiliate interventions. The objective to reduce female breast cancer deaths is to improve from 22.6 deaths per 100,000 to 20.6 per 100,000. The objective to reduce cases of late-stage breast cancer diagnosis is to decrease from 44.8 per 100,000 to 41.0 per 100,000. These objectives are consistent with Susan G. Komen's mission "to save lives and end breast cancer forever," and served as one criteria for selection of the priority counties.

Additional indicators the Affiliate reviewed included incidence rates and trends, late-stage/death rates and trends, population age and race characteristics, socioeconomics, and access to insurance and services.

Target Communities
The selected target communities are Fannin County, GA, Murray County, GA, Hamilton County, TN and Rhea County, TN.

Fannin County
Fannin County was identified as the highest priority in terms of Affiliate intervention and was predicted to take 13 years or longer to achieve the HP2020 late-stage incidence target. Fannin County was one of the counties predicted to show an increasing trend in both incidence and late-stage breast cancer diagnosis. Fannin County was also selected on the basis of its socioeconomic characteristics: 21.7 percent of the population has less than a high school education, 18.9 percent have income below 100 percent of the poverty level, and 49.0 percent below 250 percent of the poverty level. All of these statistics are above the Georgia and Chattanooga service area average.

Murray County
Murray County was ranked as a highest priority for Affiliate intervention. It is predicted that it will take the county 13 years or more to reach the Healthy People 2020 breast cancer targets for the breast cancer late-stage diagnosis rate. The late-stage diagnosis rate is trending upward at 17.5 percent annually. Murray County's incidence rate has a 9.5 percent trend increase annually.

Murray County has the second largest Hispanic/Latina population in the Affiliate service area. The population has additional barriers in both language and cultural challenges. These barriers could contribute to the population's risk. Murray County has the second highest rate of those with less than a high school education in the Affiliate service area at 31.6 percent. 50.4 percent have income below 250 percent of the poverty level.

Murray County's socioeconomic factors reported 70.1 percent of its population living in rural areas, 100 percent of the population living in areas that are medically underserved, and 23.3 percent are reported as having no health insurance. All of these factors are higher than the Affiliate service area.

Rhea County

Rhea County was identified as a highest priority county for Affiliate interventions. It is predicted that it will take 13 years or longer to achieve the HP 2020 target for late-stage incidence rate. Rhea County has the highest incidence rate of any county in the service area at 176.3 per 100,000, which is actually reflecting a downward trend of -14.3 percent. Data available on late-stage diagnosis show an age-adjusted rate of 45.3 per 100,000 and an increasing trend of 11.2 percent, which is the second largest increase in the Affiliate service area. Data needed to predict the length of time to achieve the death rate target were not available. Qualitative research will investigate the difference in incidence rate and late-stage diagnosis.

Rhea County is similar to Fannin County in regards to socioeconomic indicators, including 24.1 percent of the population having less than a high school education, 20.3 percent of the population living below 100 percent of the poverty level and 46.2 percent living below 250 percent. Sixty-eight percent of the population lives in rural areas and 100 percent are medically underserved.

Hamilton County

Hamilton County was ranked as a Medium-High Priority for Affiliate intervention. The 2013-2014 Cancer Facts and Figures from the American Cancer Society states the most common risk factors for breast cancer are being female and growing older. The report also identifies Black/African-American women in the US as having a 41.0 percent higher death rate from breast cancer than White women as of 2010. Black/African-American women are also diagnosed more frequently under the age of 40 and more Black/African-American women die from breast cancer in all age groups. Black/African-American women are more often diagnosed with larger tumors (greater than 5.0 cm).

The Affiliate has included Hamilton County as a target due to the large population of Black/African-American women and the fact that 51.3 percent of the female population is age 40 or over. The incidence age-adjusted rate is 124.0 per 100,000 and late-stage age-adjusted rate is 49.0 per 100,000. Hamilton County is predicted to reach the HP2020 death rate target in two years but will take 13 years or longer to achieve the late-stage breast cancer diagnosis target. The current death rate is 21.5 per 100,000 with a downward trend of 2.5 percent annually. This corresponds with a predicted time of two years to meet the Healthy People 2020 target for female breast cancer death rate of 20.6 per 100,000.

Although Hamilton County as a whole is not a priority by reviewing socioeconomic indicators, there are pockets of extremely financially challenged, hard to serve and underserved communities where access to services and ability to pay are deterrents to breast health care. The Affiliate recognizes this as a factor in the 13 years or longer predicted time to achieve the late-stage incidence target. The Affiliate will focus on these specific areas when gathering the health systems analysis and qualitative data.

Health Systems and Public Policy Analysis

Hamilton County Health System Analysis

Strengths

Hamilton County is a large metropolitan county with 22 incorporated and unincorporated cities within its boundaries. This county has a large medical community with four distinct hospital systems. These hospital systems have numerous satellite offices spread throughout the county. The widespread and diverse medical options provide numerous access points into the health care system.

Weaknesses

Hamilton County has challenges just as any other community when providing health care to a diverse population. The satellites spread throughout the community are access points to entry of services but many do not offer the wide array of services needed for long term and follow up care. This will require patients to travel into the metropolitan area to receive specialized care when needed. In gathering the local information, many of the smaller agencies, organizations and even clinics were identified as merely referral sources for the larger hospital system services and programs. Patient navigation is very limited outside of the major hospital systems.

The area's only two mobile mammography units have lost funding for maintenance and upkeep. This began to impact service in the 3rd quarter of last year and now both units are often in need of repair and are not being consistently utilized in the community. These Mobile Units are, when operable, serving every county in the Affiliate service area and are heavily engaged with the area's largest employers. This will have a substantial impact, especially on the blue-collar population. The Health System Analysis revealed that there is a distinct lack of support for breast cancer patients, survivorship, and enhanced quality of life programs.

Rhea County Health System Analysis

Strengths

As of November 2013, Rhea Medical Center opened a state of the art 75,000 square foot facility offering the latest digital mammography in Tennessee. This facility is accredited by the American College of Radiology Breast Imaging Center of Excellence. Although data is too new to evaluate statistical impact, the new facility and new equipment should result in improved statistics around breast cancer diagnosis and death rates. Rhea County conducted a community needs assessment that was approved by the Rhea County Medical Center Board of Directors along with an implementation plan designed against the assessment in May 2013. Fundraising efforts by the Rhea Medical Foundation have resulted in the purchase of a Hologic Selenia Dimensions Digital Mammography Unit. According to the Hologic website, this equipment can provide quality digital mammography imaging with the lowest radiation dosage and maximum flexibility.

Weaknesses

Prior to the Rhea County Medical Center opening in 2013, the area service providers were a local health department and a primary health care center. The local services available in Rhea

County leave a gap for those in need of treatment such as chemotherapy, radiation, counseling and reconstruction. Patients have to travel to the Chattanooga Metropolitan area for the aforementioned treatments, creating transportation, cost, and time challenges for a population that is largely economically disadvantaged.

Murray County Health System Analysis

Strengths

Murray County has several medical clinics and private physicians that provide access to clinical breast exams. Mammography and screening is available through Murray County Medical Center.

Weaknesses

This county is small, predominately rural, and only has a small primary care hospital with limited specialized care facilities in the system. Murray is largely served by local walk-in type clinics and health centers that are satellite offices of larger medical facilities from other parts of the state. These facilities are referral sources for patients with specialized needs who are traveling to other Affiliate service areas for medical treatments. Murray County is experiencing a large growth in their Hispanic/Latino population. Cultural and communication barriers make it difficult to get and keep these Hispanic/Latina women into the Continuum of Care.

Fannin County Health System Analysis

Strengths

Fannin County has a specialized cancer facility, Georgia Cancer Specialist, with two oncologists on location. One specializes in malignancies and the other physician specializes in breast cancer.

Weaknesses

Fannin County is the most remote, rural county in the Affiliate service area. The county is the most removed from the larger medical systems with specialized services. The population faces an even greater challenge traveling to other areas to receive chemotherapy, radiation, counseling and reconstruction.

Public Policies

Relevant public policies for the states of Tennessee and Georgia include:

- National Breast and Cervical Cancer Early Detection Program
- Tennessee Breast and Cervical Cancer Program
- Tennessee Cancer Control Plan
- Georgia Breast and Cervical Cancer Program
- Georgia Comprehensive Cancer Control Program
- GCCCP Breast Cancer Objectives
- Affordable Care Act in Tennessee
- Tennessee Medicaid expansion, Affordable Care Act in Georgia

Affiliate Public Policy Activities

Komen Chattanooga follows Komen Headquarters Public Policy Model guidelines in promoting the following advocacy priorities:

- Protecting federal and state funding for the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), to ensure all women have access to potentially lifesaving breast cancer screening.
- Ensuring continued federal investment in cancer research through the National Institutes of Health (NIH), National Cancer Institute (NCI) and Department of Defense (DOD), to discover and deliver the cures.
- Requiring insurance companies provide coverage for oral anti-cancer drugs on a basis that is no less favorable than what's already provided for intravenously-administered chemotherapy, to protect patients from high out-of-pocket costs; and
- Expanding Medicaid Coverage to ensure the availability of the full-range of breast health services to low-income women, including cancer screening, diagnostics and treatment.

Members of the Komen Chattanooga community (including board members, grantees, and race participants) are encouraged to join the efforts regarding these particular priorities. Komen Chattanooga plans to utilize the State Campaign Issues Toolkit in the coming years to better communicate advocacy priorities to legislators. Komen hopes to collaborate with other Tennessee Affiliates to schedule meetings with members of Congress whose districts correspond with the Affiliate's service area during their recess to discuss these issues.

Komen Chattanooga includes several advocacy activities in their annual mission plan. All elected officials will receive a copy of the completed community profile to inform them of the work Komen is doing in their service area. Also, local city and county mayors are invited to participate in the Race for the Cure® and are given an opportunity to say a few words to the participants before the start. Komen Chattanooga continues to have great support from political leaders, with Breast Cancer Awareness Month being endorsed state-wide by Governor Bill Haslam. The Tennessee Affiliates meet twice per year to discuss legislation and visit the state capitol to visit state representatives and discuss Komen Advocacy priorities. The State of Tennessee has additional organizations furthering breast cancer advocacy, including the Tennessee Breast Cancer Coalition, the Tennessee Cancer Coalition, and American Cancer Society's Cancer Action Network.

In Georgia, the Affiliates have met as a group one time. The Affiliates work in a more loose relationship but pull together when working on an advocacy issue. Other organizations in the state with interest in furthering breast health advocacy are Georgia Breast Cancer Coalition, American Cancer Society, and Georgia Cancer Coalition.

The findings of the Health Systems and Public Policy emphasize the fact that many women and men are still in need of our services. The overall conclusion of the Health Systems Analysis revealed that many of resources exist for screening and several access points exist in the largest county, Hamilton County. In the more rural counties, there are very limited access

points and often these access points are satellite locations of the larger health systems in Hamilton County.

In order to keep women and men in the continuum of care, other issues such as transportation, time, and distance will impact the overall effectiveness of diagnosis, treatment, and ultimately, survivorship. The resources currently available to support a breast cancer patient along the Continuum of Care will not support the number of diagnoses expected. There is a need for more facilities with mammography units and centers that are certified in breast cancer surgery, care, and treatment. Quality of life and survivorship programs are also not up to the capacity needed with the expected diagnoses.

The largest factor affecting the Affiliate service area is the decision of both Tennessee and Georgia not to expand Medicaid. The large number of adults who will not qualify for Medicaid or who do not have enough income to qualify for the subsidy from the federal government will be a huge deterrent to reaching the overall Healthy People 2020 goals. The large number of adults who will remain uninsured must be served if breast cancer rates are moved toward the Healthy People 2020 goals. This very large gap will be the focus of Komen Chattanooga for the next four years.

Politically, the Affiliate must make extra efforts to inform our elected officials of the dire circumstances. Komen Chattanooga is finding many who are in need of help. It will be crucial for the Affiliate to use every opportunity to educate the public, elected officials, and health care practitioners to affect the overall health of the four priority counties. The Affiliate must work in collaboration with other key stakeholders in the counties to make sure the message is heard. The Affiliate must be actively engaged with any legislation that goes up for a vote and has an impact on the quality of health care for breast cancer patients in Tennessee or Georgia.

Qualitative Data: Ensuring Community Input

Fannin County

Key informant interviews and document review were used to gather data in Fannin County. Access to medical providers with an expertise in breast cancer was extremely limited in this target area. The key informant interview conducted with a Health Clinic worker resulted in information being more applicable to general health issues. The Quantitative Data Report from the Susan G. Komen Community Profile proved to be the most current and comprehensive data to be located. Other requests for document review produced no results. The largest factors identified are the lack of Education/Awareness, Access, and Lack of Insurance/Ability to Pay.

Murray County

Key Informant Interviews and Document Review were used to gather data in this rural county. Health care professionals from local Health Care clinics were interviewed to determine the population of need, barriers to screening, and challenges to access services. The key factors determined by this data were; Outreach/Education, Lack of Insurance/Ability to Pay and Access.

Rhea County
Rhea County is a remote-rural area, only recently the home of a full-service medical center. Most residents in this community are accustomed to traveling for medical services beyond general care. Lack of access to services has been a major barrier. Educating the population about utilizing services and resources is the current focus of this new medical community. Data collection showed that the key factors to address in this county are; Outreach/Education/ Awareness and Lack of Insurance/Ability to Pay.

Hamilton County
A total of four survey events were held in Hamilton County. Surveys were presented to a total of 98 participants. The survey included questions about attitudes, beliefs and understanding of breast health/breast cancer, screening, outreach resources and access to care. The analysis of the collected data revealed three overarching themes: lack of insurance/inability to pay for screening, lack of knowledge/misinformation, cultural/desire for privacy/modesty. This information was consistent with the responses from the Key Informant Interview conducted with a Breast Specialist/Nurse Navigator from a local major health care system.

Qualitative Data Findings
Using the Healthy People 2020 goals of reducing both death and late-stage diagnosis of breast cancer throughout the Affiliate service area, four counties were selected as target areas for emphasis and funding. The key questions and resources used for gathering data in the Qualitative Data Report were selected based on the initial conclusions drawn from the information in the Quantitative Data Reports and the Health System and Public Policy Analysis. Key informant interviews, document review and population sampling surveys were determined to be the best tools for gauging the grass roots community perceptions of the current knowledge of breast health, barriers that prevent screening, and the needs of the target communities.

Strengths
Key informant interviews allowed for interactive conversation and detailed comments. Document review was helpful in the instances where direct access to interview subjects or surveying was not an option. The survey groups were extremely valuable in giving insight to the perception of the target population in a way that afforded them the opportunity to be truthful with anonymity.

Survey groups were also a method to educate the sample group about the purpose of the Community Profile and the role it plays in determining the impact of Komen grant funding in the Affiliate service Area.

Weaknesses
The counties that ranked the highest for priority needs were also the counties that proved the hardest to evaluate and gather current data from. The lack of medical service facilities, lack of breast health education/knowledge and limited access to breast health specific professionals presented a challenge in gathering current data from knowledgeable resources in some of the target areas.

The responses from the survey participants in Hamilton County, where 41.0 percent of those surveyed thought that breast cancer was an inherited disease and 28.0 percent listed fear as a barrier to being screened, show a need for increased breast health education. Information gathered from Key Informant Interviews and Document Reviews in Fannin, Murray and Rhea County were all consistent in the need for local access to affordable services.

Based on this Qualitative Data, it is evident that the key factors to address in these target areas are; Education/Outreach/Awareness, Lack of Insurance/Ability to Pay, and Access to Services. In the target areas, including those where breast health services are accessible, there is still a lack of understanding concerning the importance of screening as well as where and how to access services and utilize available resources.

Mission Action Plan

PROBLEM STATEMENT 1. According to the quantitative data report for the Komen Chattanooga, women in Murray, Hamilton, and Rhea Counties have higher than average rates for late-stage breast cancer diagnosis, compared to the US average. Fannin County has a higher than average rate of breast cancer death, compared to the US average. These statistics suggest a need for breast health education and services in these four counties.

Priority 1. Address the need for outreach education about breast health and breast health services to women and men in all four target communities.

Objective 1: Provide a Breast Health Education Toolkit to at least three local health care providers in each target community that includes information about breast health, breast cancer, self-awareness and co-survivor support in FY16.

Objective 2: Provide at least three local health care providers in each target community with a listing of online accessible Komen Educational Materials that can be downloaded and reproduced for distribution in FY16.

Objective 3: Attend at least one community event in each of the four target communities to represent/speak about the Komen Mission and share information about breast health awareness and breast health information FY17.

Priority 2. Increase the understanding of where and how to access Komen funded services for screening, mammography and diagnostics.

Objective 1: Provide health departments/clinics in the four target communities with a listing of Komen Chattanooga funded service providers that can be accessed for low-cost or no-cost screening and diagnostic needs in FY16 and updated in FY17 and FY18.

Objective 2: Contact health care providers in each target community with a specific invitation for the Komen Chattanooga Grant Writing Workshop and encourage them to write for Komen Chattanooga Community Grant funding in fall FY16

Objective 3: Feature a "Grantee in the Spotlight" section in the Affiliate newsletter to highlight each of our grantees over the course of the FY16 fiscal year. This will be updated and continued as the grant cycle changes in FY17 and FY18.

PROBLEM STATEMENT 2. Key informant interviews and survey reports indicated that there are cultural beliefs, fearful thinking and misinformation surrounding breast health that inhibit regular breast screening and mammography for women in the target communities.

Priority 1. Leverage technology to address misinformation in the target communities.

Objective 1: Include a re-occurring section in the bi-weekly e-newsletter to share correct information and messaging that is focused on specific high risk populations, including the large Black/African-American demographic in Hamilton County and the growing number of Hispanic/Latina women in Murray County that were identified in the quantitative data report.

Objective 2: Schedule weekly messaging through social media outlets; Facebook, Twitter, Instagram, etc.; to share the latest information about breast health and dispel the myths that are preventing women and men from seeking preventative and diagnostic breast health services in FY16.

Priority 2. Redesign affiliate specific marketing materials to promote breast health education and awareness in the target communities.

Objective 1: Create an Affiliate specific marketing-education infographic by FY17 that includes a "Myth Busters" or "Did You Know" message with images of people that depict a diverse population mirroring the affiliate demographics to be distributed at community health fairs, expos, and to the clients of our affiliate grantees.

Objective 2: Prepare a presentation that addresses the fear based thinking that prevents early detection and results in late-stage diagnosis and higher death rates as they apply to the specific population of Black/African-American and Hispanic/Latina women and men to be presented to at least six of the October 2016 speaker requested events. This will be repeated in FY17 and FY18.

Objective 3: Re-design the two display boards used at health fairs and community events in FY16 to visually reinforce correct information and dispel some of the fear that is created by misinformation.

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

Affiliate History

Nancy G. Brinker promised her dying sister, Susan G. Komen, she would do everything in her power to end breast cancer forever. In 1982, her promise became Susan G. Komen® and launched a global breast cancer movement. Today, the organization is the world's largest grassroots network of breast cancer survivors and activists fighting to save lives, empower people, ensure quality care for all and energize science to find cures. Thanks to events like Susan G. Komen Race for the Cure®, the organization has invested more than $2.6 billion in ground breaking research, community health, outreach, advocacy and programs in more than 30 countries.

Susan G. Komen® Chattanooga was established in January 2000 under the leadership of David Watson and Sarah Bowen. The first Chattanooga Race for the Cure® was held that fall and drew 4,300 people to the newly opened Coolidge Park. Through the leadership of many talented volunteers, supporters and sponsors, the Affiliate has grown to include a small dedicated staff and a diverse Board of Directors whom all share the same vision…a world without breast cancer. Today, Komen® Chattanooga's fundraising efforts continue to support local breast health organizations in Northwest Georgia and Southeast Tennessee. Komen Chattanooga's community outreach in the fight against breast cancer includes partnerships with several local health care providers, hospitals, educational institutions and governmental agencies.

The 16 county Affiliate service area includes ten counties in SE Tennessee; Hamilton, Bradley, Polk, McMinn, Meigs, Rhea, Bledsoe, Sequatchie, Grundy and Marion, and six counties in NW Georgia; Catoosa, Dade, Fannin, Murray, Walker and Whitfield.

Since its inception in 2000, Komen Chattanooga has awarded grants totaling over $2.7 million to local breast health organizations to provide screening, diagnostics, treatment support and educational services to the Affiliate service area. Over $900,000 dollars, 25.0 percent of local net revenue has been contributed to Komen's National Research and Grant Program for ground-breaking breast cancer research. Komen Chattanooga is a participant in both the Tennessee and Georgia State Cancer Coalitions.

Affiliate Organizational Structure

Komen Chattanooga is governed by a six member Board of Directors comprised of health care professionals, business leaders, accounting and financial professionals, breast cancer survivors and community volunteers. The board's primary duties include appointment and oversight of staff, fiscal oversight, and adoption of the annual budget, the establishment of policies and procedures and overview of the strategic plan. There is one full time staff position, Operations Director and three part-time staff positions, Office Manager/Financial Coordinator, Event/Marketing Manager and an Information Technology Manager. The Operations Director reports to the Board President and oversees the chairs of the Volunteer Ambassador Committees that support the Affiliate (Figure 1.1).

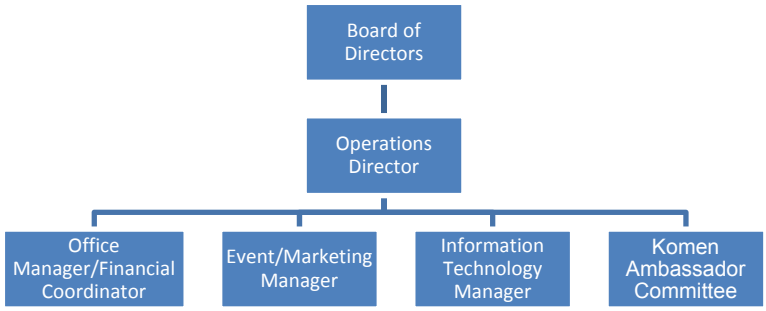

Figure 1.1. Susan G. Komen Chattanooga organizational chart

Affiliate Service Area

Komen Chattanooga's service area, depicted in Figure 1.2, consists of 16 counties in two states; Hamilton, Bradley, Polk, McMinn, Meigs, Rhea, Bledsoe, Sequatchie, Grundy and Marion Counties in Tennessee and Catoosa, Dade, Fannin, Murray, Walker and Whitfield Counties in Georgia. The female population for the Affiliate service area is over 469,200.

Chattanooga, in Hamilton County, Tennessee, is home to the Affiliate Race for the Cure and the Affiliate business office. This county has three major medical systems including two accredited breast care centers.

As shown in Table 2.4, Hamilton County has both the largest female population and the largest Black/African-American population of the Affiliate service areas. The populations in Rhea, Fannin and Murray Counties are predominately White. Murray County has the 2nd largest Hispanic/Latina proportion in the Affiliate service area, 12.9 percent, as reported in Table 2.4. Fannin, Murray and Rhea Counties are 100 percent medically unserved.

In the Affiliate service area combined, 41.8 percent of the population falls below the 250 percent poverty line. Hamilton County has 35.8 percent of the population living below the 250 percent poverty level, slightly below the Affiliate service area percentage. However, Rhea, Fannin and Murray Counties, all rural areas, are reporting higher with ratios of 46.2 percent, 49.0 percent and 50.4 percent respectively. Fannin and Murray Counties in Georgia also have higher percentages of uninsured population than the Affiliate service area average ratio of 19.1 percent and the state ratio of 20.7 percent. These three counties also have unemployment numbers that exceed both the state and national averages. These factors make traveling to and paying for medical services challenging.

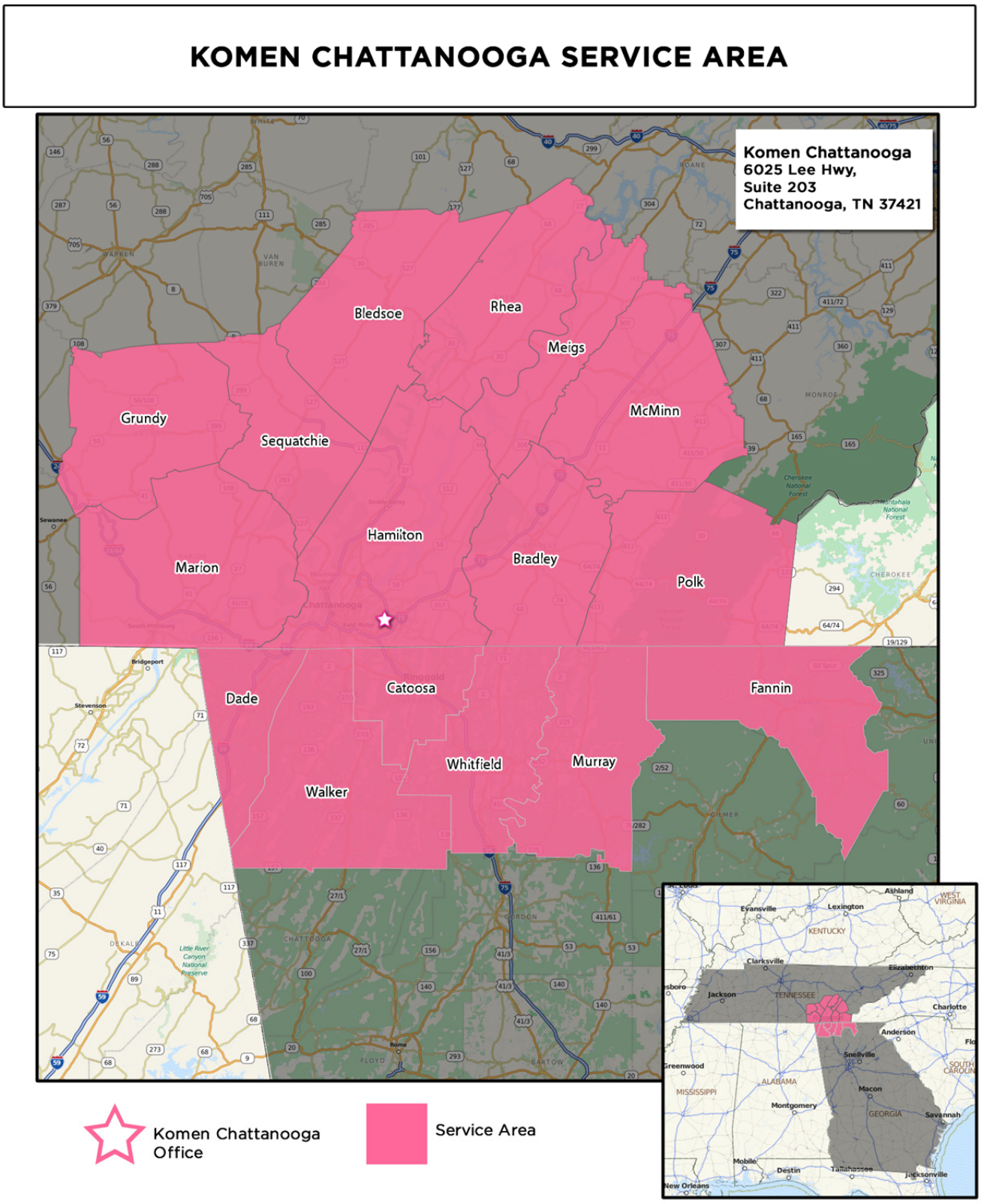

Figure 1.2. Susan G. Komen Chattanooga service area

Purpose of the Community Profile Report

The mission of Susan G. Komen is “to save lives and end breast cancer forever by empowering people, ensuring quality care for all and energizing science to find the cures.” To help achieve that mission, the Community Profile is intended to evaluate the burden of breast cancer within the Komen Chattanooga service area, identify the needs of the community, and determine any gaps or barriers that exist concerning breast health and breast cancer. The process serves as a tool to help the Affiliate continually learn and understand breast health issues within the service area, allowing it to engage further in community collaboration. The findings of the Community Profile will provide direction for outreach, allocation of grant funds and resources and provide a foundation for the Affiliate’s strategic planning efforts. This report will be shared with community partners, area breast health providers, policymakers and other stakeholders in the community.

Quantitative Data: Measuring Breast Cancer Impact in Local Communities

Quantitative Data Report

Introduction

The purpose of the quantitative data report for Susan G. Komen® Chattanooga 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 Affiliate's service area based on estimates of how long it would take an area to achieve Healthy People 2020 objectives for breast cancer late-stage diagnosis and death rates (http://www.healthypeople.gov/2020/default.aspx).

The following is a summary of Komen Chattanooga's Quantitative Data Report. For a full report please contact the Affiliate.

Breast Cancer Statistics

Incidence rates

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

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

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

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

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

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

Death rates

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

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

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

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

Late-stage incidence rates

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

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

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

		Incidence Rates and Trends			Death Rates and Trends			Late-stage Rates and Trends		
Population Group	Female Population (Annual Average)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of Deaths (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)
US	154,540,194	182,234	122.1	-0.2%	40,736	22.6	-1.9%	64,590	43.8	-1.2%
HP2020	.	-	-	-	-	20.6*	-	-	41.0*	-
Georgia	4,838,820	5,997	121.5	-0.3%	1,146	23.4	-1.4%	2,253	45.5	-0.4%
Tennessee	3,195,539	4,363	118.8	0.0%	880	23.3	-1.6%	1,605	44.1	-3.0%
Komen Chattanooga Service Area	469,231	654	116.6	-1.3%	130	22.6	NA	246	44.8	-0.2%
White	414,627	586	114.9	-1.2%	115	21.7	NA	216	43.2	0.0%
Black/African-American	46,136	65	142.5	-2.4%	15	33.2	NA	29	63.4	-0.4%
American Indian/Alaska Native (AIAN)	2,564	SN	SN	SN	SN	SN	SN	SN	SN	SN
Asian Pacific Islander (API)	5,905	SN	SN	SN	SN	SN	SN	SN	SN	SN
Non-Hispanic/ Latina	441,448	648	118.1	-1.4%	129	22.9	NA	243	45.4	-0.4%
Hispanic/ Latina	27,783	6	56.8	-4.9%	SN	SN	SN	SN	SN	SN
Catoosa County - GA	32,416	43	114.6	7.5%	8	20.4	-1.4%	17	47.0	8.2%
Dade County - GA	8,394	9	95.7	-25.4%	3	32.3	NA	4	39.8	-25.3%
Fannin County - GA	11,955	15	89.9	8.7%	4	25.1	NA	5	31.3	3.2%
Murray County - GA	20,082	26	129.1	9.5%	7	37.8	NA	9	45.3	17.5%
Walker County - GA	34,570	41	97.8	3.0%	12	28.0	-1.2%	19	45.7	8.2%
Whitfield County - GA	49,877	53	105.0	-7.8%	10	19.0	-2.6%	23	45.3	-8.9%
Bledsoe County - TN	5,954	7	82.3	-26.1%	SN	SN	SN	SN	SN	SN
Bradley County - TN	49,817	65	111.8	-2.5%	16	26.8	-1.5%	22	37.1	-6.0%
Grundy County - TN	7,027	11	111.5	-1.3%	3	34.6	NA	5	49.1	3.8%
Hamilton County - TN	170,841	259	124.0	-0.5%	47	21.5	-2.5%	99	49.0	0.8%
McMinn County - TN	26,804	39	113.7	4.2%	6	15.1	-1.3%	13	40.3	-5.3%
Marion County - TN	14,313	25	135.3	1.8%	4	23.9	NA	9	45.8	6.1%
Meigs County - TN	5,816	9	124.7	-6.1%	SN	SN	SN	3	45.0	-10.2%
Polk County - TN	8,397	11	98.8	-1.7%	SN	SN	SN	4	38.3	-20.3%
Rhea County - TN	15,984	34	176.3	-14.3%	4	20.1	NA	8	45.3	11.2%
Sequatchie County - TN	6,984	8	89.6	-7.5%	SN	SN	SN	SN	SN	SN

*Target as of the writing of this report.
NA – data not available.
SN – data suppressed due to small numbers (15 cases or fewer for the 5-year data period).
Data are for years 2006-2010.
Rates are in cases or deaths per 100,000.
Age-adjusted rates are adjusted to the 2000 US standard population.
Source of incidence and late-stage data: North American Association of Central Cancer Registries (NAACCR) – Cancer in North America (CINA) Deluxe Analytic File.
Source of death rate data: Centers for Disease Control and Prevention (CDC) – National Center for Health Statistics (NCHS) death data in SEER*Stat.
Source of death trend data: National Cancer Institute (NCI)/CDC State Cancer Profiles.

Incidence rates and trends summary

Overall, the breast cancer incidence rate and trend in the Komen Chattanooga service area were lower than that observed in the US as a whole. The incidence rate and trend of the Affiliate service area were not significantly different than that observed for the State of Georgia. The incidence rate and trend of the Affiliate service area were not significantly different than that observed for the State of Tennessee.

For the United States, breast cancer incidence in Blacks/African-Americans is lower than in Whites overall. The most recent estimated breast cancer incidence rates for Asians and Pacific Islanders (APIs) and American Indians and Alaska Natives (AIANs) were lower than for Non-Hispanic Whites and Blacks/African-Americans. The most recent estimated incidence rates for Hispanics/Latinas were lower than for Non-Hispanic Whites and Blacks/African-Americans. For the Affiliate service area as a whole, the incidence rate was higher among Blacks/African-Americans than Whites. There were not enough data available within the Affiliate service area to report on APIs and AIANs so comparisons cannot be made for these racial groups. The incidence rate among Hispanics/Latinas was lower than among Non-Hispanics/Latinas.

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

- Rhea County, TN

Significantly more favorable trends in breast cancer incidence rates were observed in the following counties:

- Dade County, GA

The rest of the counties had incidence rates and trends that were not significantly different than the Affiliate service area as a whole or did not have enough data available. It's important to remember that an increase in breast cancer incidence could also mean that more breast cancers are being found because more women are getting mammograms.

Death rates and trends summary

Overall, the breast cancer death rate in the Komen Chattanooga service area was similar to that observed in the US as a whole and the death rate trend was not available for comparison with the US as a whole. The death rate of the Affiliate service area was not significantly different than that observed for the State of Georgia. The death rate of the Affiliate service area was not significantly different than that observed for the State of Tennessee.

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 Affiliate service area as a whole, the death rate was higher among Blacks/African-Americans than Whites. There were not enough data available within the Affiliate service area to report on APIs and AIANs so comparisons cannot be made for

these racial groups. Also, there were not enough data available within the Affiliate service area to report on Hispanics/Latinas so comparisons cannot be made for this group.

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

- Murray County, GA

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

Late-stage incidence rates and trends summary

Overall, the breast cancer late-stage incidence rate in the Komen Chattanooga service area was similar to that observed in the US as a whole and the late-stage incidence trend was higher than the US as a whole. The late-stage incidence rate and trend of the Affiliate service area were not significantly different than that observed for the State of Georgia. The late-stage incidence rate and trend of the Affiliate service area were not significantly different than that observed for the State of Tennessee.

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 Affiliate service area as a whole, the late-stage incidence rate was higher among Blacks/African-Americans than Whites. There were not enough data available within the Affiliate service area to report on APIs and AIANs so comparisons cannot be made for these racial groups. Also, there were not enough data available within the Affiliate service area to report on Hispanics/Latinas so comparisons cannot be made for this group.
None of the counties in the Affiliate service area had substantially different late-stage incidence rates than the Affiliate service area as a whole.

Mammography Screening

Getting regular screening mammograms (and treatment if diagnosed) lowers the risk of dying from breast cancer. Screening mammography can find breast cancer early, when the chances of survival are highest. Table 2.2 shows some screening recommendations among major organizations for women at average risk.

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

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

*As of October 2015

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

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

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

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

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

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

For example, if screening proportion was reported as 50.0 percent, with a confidence interval of 35.0 to 65.0 percent, the real rate might not be exactly 50.0 percent, but it's very unlikely that it's less than 35.0 or more than 65.0 percent. In general, screening proportions at the county level have fairly wide confidence intervals. The confidence interval should always be considered before concluding that the screening proportion in one county is higher or lower than that in another county.

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

Population Group	# of Women Interviewed (Sample Size)	# w/ Self-Reported Mammogram	Proportion Screened (Weighted Average)	Confidence Interval of Proportion Screened
US	174,796	133,399	77.5%	77.2%-77.7%
Georgia	2,341	1,874	81.0%	78.8%-83.1%
Tennessee	2,882	2,209	76.6%	74.5%-78.5%
Komen Chattanooga Service Area	491	380	76.6%	71.3%-81.2%
White	430	334	76.9%	71.4%-81.6%
Black/African-American	51	41	83.4%	64.5%-93.2%
AIAN	SN	SN	SN	SN
API	SN	SN	SN	SN
Hispanic/ Latina	SN	SN	SN	SN
Non-Hispanic/ Latina	489	378	76.6%	71.4%-81.0%
Catoosa County - GA	25	20	79.6%	54.9%-92.6%
Dade County - GA	SN	SN	SN	SN
Fannin County - GA	SN	SN	SN	SN
Murray County - GA	15	8	57.6%	30.6%-80.7%
Walker County - GA	19	15	86.1%	56.8%-96.7%
Whitfield County - GA	21	16	72.5%	40.5%-91.1%
Bledsoe County - TN	12	7	58.0%	28.1%-83.0%
Bradley County - TN	54	42	79.3%	61.7%-90.1%
Grundy County - TN	17	10	61.8%	32.6%-84.4%
Hamilton County - TN	197	160	80.5%	71.7%-87.0%
McMinn County - TN	32	24	78.6%	54.4%-91.9%
Marion County - TN	23	14	51.6%	28.7%-73.8%
Meigs County - TN	SN	SN	SN	SN
Polk County - TN	23	18	78.5%	55.4%-91.5%
Rhea County - TN	25	21	93.5%	70.8%-98.8%
Sequatchie County - TN	11	10	97.2%	59.3%-99.9%

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 Chattanooga service area was not significantly different than that observed in the US as a whole. The screening proportion of the Affiliate service area was not significantly different than the State of Georgia and was not significantly different than the State of Tennessee.

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 Affiliate service area as a whole, the screening proportion was not significantly different among Blacks/African-Americans than Whites. There were not enough data available within the Affiliate service area to report on APIs and AIANs so comparisons cannot be made for these racial groups. Also, there were not enough data available within the Affiliate service area to report on Hispanics/Latinas so comparisons cannot be made for this group.

None of the counties in the Affiliate service area had substantially different screening proportions than the Affiliate service area as a whole or did not have enough data available.

Population Characteristics

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

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

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

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

Table 2.4. Population characteristics – demographics

Population Group	White	Black /African-American	AIAN	API	Non-Hispanic /Latina	Hispanic /Latina	Female Age 40 Plus	Female Age 50 Plus	Female Age 65 Plus
US	78.8 %	14.1 %	1.4 %	5.8 %	83.8 %	16.2 %	48.3 %	34.5 %	14.8 %
Georgia	62.8 %	32.9 %	0.5 %	3.7 %	91.8 %	8.2 %	45.5 %	31.0 %	12.3 %
Tennessee	79.9 %	17.9 %	0.4 %	1.8 %	95.8 %	4.2 %	49.3 %	35.5 %	15.2 %
Komen Chattanooga Service Area	87.9 %	10.1 %	0.6 %	1.4 %	93.5 %	6.5 %	50.9 %	37.2 %	16.5 %
Catoosa County - GA	95.0 %	3.1 %	0.3 %	1.6 %	97.7 %	2.3 %	50.2 %	35.4 %	15.2 %
Dade County - GA	96.6 %	1.8 %	0.6 %	1.1 %	98.3 %	1.7 %	50.8 %	37.7 %	16.1 %
Fannin County - GA	98.3 %	0.8 %	0.4 %	0.5 %	98.3 %	1.7 %	62.8 %	50.1 %	23.7 %
Murray County - GA	96.7 %	1.5 %	0.8 %	0.9 %	87.1 %	12.9 %	45.9 %	30.9 %	12.5 %
Walker County - GA	94.6 %	4.5 %	0.3 %	0.6 %	98.4 %	1.6 %	52.1 %	38.5 %	17.7 %
Whitfield County - GA	92.3 %	4.6 %	1.3 %	1.7 %	69.4 %	30.6 %	43.9 %	30.0 %	12.9 %
Bledsoe County - TN	97.8 %	1.5 %	0.5 %	0.2 %	98.2 %	1.8 %	55.0 %	40.5 %	18.2 %
Bradley County - TN	93.4 %	4.9 %	0.6 %	1.2 %	95.6 %	4.4 %	49.6 %	35.7 %	15.9 %
Grundy County - TN	98.5 %	0.7 %	0.5 %	0.3 %	99.1 %	0.9 %	54.1 %	41.9 %	20.0 %
Hamilton County - TN	75.9 %	21.5 %	0.6 %	2.1 %	96.0 %	4.0 %	51.3 %	38.0 %	16.8 %
McMinn County - TN	94.1 %	4.7 %	0.5 %	0.8 %	97.4 %	2.6 %	54.2 %	40.3 %	18.8 %
Marion County - TN	94.8 %	4.2 %	0.4 %	0.5 %	98.7 %	1.3 %	55.7 %	41.8 %	18.2 %
Meigs County - TN	97.3 %	1.8 %	0.7 %	0.2 %	98.5 %	1.5 %	55.9 %	40.9 %	18.0 %
Polk County - TN	98.3 %	1.0 %	0.4 %	0.3 %	98.6 %	1.4 %	54.7 %	40.6 %	18.5 %
Rhea County - TN	96.4 %	2.5 %	0.5 %	0.6 %	96.7 %	3.3 %	51.8 %	38.3 %	17.4 %
Sequatchie County - TN	98.1 %	0.9 %	0.5 %	0.5 %	97.5 %	2.5 %	53.2 %	39.5 %	17.9 %

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

Table 2.5. Population characteristics – socioeconomics

Population Group	Less than HS Education	Income Below 100% Poverty	Income Below 250% Poverty (Age: 40-64)	Un-employed	Foreign Born	Linguistic-ally Isolated	In Rural Areas	In Medically Under-served Areas	No Health Insurance (Age: 40-64)
US	14.6 %	14.3 %	33.3 %	8.7 %	12.8 %	4.7 %	19.3 %	23.3 %	16.6 %
Georgia	16.0 %	16.5 %	37.6 %	9.9 %	9.7 %	3.3 %	24.9 %	37.3 %	20.7 %
Tennessee	16.8 %	16.9 %	38.9 %	9.2 %	4.5 %	1.5 %	33.6 %	47.7 %	17.6 %
Komen Chattanooga Service Area	20.6 %	17.1 %	41.8 %	10.3 %	5.1 %	2.2 %	37.4 %	39.9 %	19.1 %
Catoosa County - GA	17.3 %	12.2 %	39.0 %	7.8 %	2.0 %	0.3 %	28.1 %	10.8 %	17.9 %
Dade County - GA	19.7 %	16.3 %	42.0 %	10.8 %	1.7 %	0.5 %	72.1 %	100.0 %	17.8 %
Fannin County - GA	21.7 %	18.9 %	49.0 %	12.4 %	1.2 %	0.5 %	100.0 %	100.0 %	24.0 %
Murray County - GA	31.6 %	19.4 %	50.4 %	12.9 %	8.1 %	4.0 %	70.1 %	100.0 %	23.3 %
Walker County - GA	22.8 %	16.0 %	46.0 %	12.3 %	1.5 %	0.5 %	43.9 %	15.3 %	19.9 %
Whitfield County - GA	31.5 %	19.2 %	45.8 %	10.1 %	18.1 %	10.3 %	29.1 %	0.0 %	26.5 %
Bledsoe County - TN	27.4 %	21.0 %	55.6 %	14.3 %	1.9 %	0.6 %	100.0 %	100.0 %	23.8 %
Bradley County - TN	19.8 %	16.9 %	40.8 %	9.8 %	3.9 %	2.0 %	33.0 %	51.1 %	18.0 %
Grundy County - TN	35.0 %	30.6 %	59.9 %	8.6 %	0.7 %	0.2 %	100.0 %	100.0 %	20.6 %
Hamilton County - TN	14.2 %	15.9 %	35.8 %	9.6 %	4.9 %	1.7 %	10.0 %	16.3 %	16.8 %
McMinn County - TN	21.6 %	18.3 %	45.9 %	9.5 %	2.1 %	0.7 %	60.3 %	100.0 %	18.1 %
Marion County - TN	25.5 %	17.8 %	43.4 %	8.9 %	1.1 %	0.4 %	77.0 %	100.0 %	16.9 %
Meigs County - TN	25.0 %	23.6 %	46.6 %	16.3 %	1.0 %	0.0 %	100.0 %	100.0 %	17.4 %
Polk County - TN	25.2 %	17.6 %	49.7 %	13.1 %	1.2 %	0.4 %	100.0 %	25.8 %	19.8 %
Rhea County - TN	24.1 %	20.3 %	46.2 %	14.3 %	2.3 %	0.7 %	68.0 %	100.0 %	18.5 %
Sequatchie County - TN	25.1 %	18.0 %	48.1 %	10.1 %	1.5 %	0.0 %	73.8 %	100.0 %	19.2 %

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

Population characteristics summary

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

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

- Hamilton County, TN

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

- Murray County, GA
- Whitfield County, GA

The following county has substantially older female population percentages than that of the Affiliate service area as a whole:

- Fannin County, GA

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

- Murray County, GA
- Whitfield County, GA
- Bledsoe County, TN
- Grundy County, TN

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

- Grundy County, TN

The following counties have substantially lower employment levels than that of the Affiliate service area as a whole:

- Bledsoe County, TN
- Meigs County, TN
- Rhea County, TN

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

- Whitfield County, GA

The following county has substantially larger percentage of adults without health insurance than does the Affiliate service area as a whole:

- Whitfield County, GA

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 Chattanooga service area are progressing toward these targets, the report uses the following information:

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

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

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

Identification of priority areas

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

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

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

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

Counties are classified as follows (Table 2.6):

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

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

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

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

Affiliate Service Area Healthy People 2020 Forecasts and Priority Areas

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

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

Trends can change for a number of reasons, including:

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

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

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

County	Priority	Predicted Time to Achieve Death Rate Target	Predicted Time to Achieve Late-stage Incidence Target	Key Population Characteristics
Fannin County - GA	Highest	NA	13 years or longer	Older, rural, medically underserved
Murray County - GA	Highest	NA	13 years or longer	%Hispanic/Latina, education, rural, medically underserved
Walker County - GA	Highest	13 years or longer	13 years or longer	Rural
Grundy County - TN	Highest	NA	13 years or longer	Education, poverty, rural, medically underserved
Marion County - TN	Highest	NA	13 years or longer	Rural, medically underserved
Rhea County - TN	Highest	NA	13 years or longer	Employment, rural, medically underserved
Hamilton County - TN	Medium High	2 years	13 years or longer	%Black/African-American
Catoosa County - GA	Medium	Currently meets target	13 years or longer	
Bradley County - TN	Medium	13 years or longer	Currently meets target	Medically underserved
Meigs County - TN	Medium Low	SN	1 year	Employment, rural, medically underserved
Whitfield County - GA	Low	Currently meets target	2 years	%Hispanic/Latina, education, foreign, language, insurance
Dade County - GA	Lowest	NA	Currently meets target	Rural, medically underserved
McMinn County - TN	Lowest	Currently meets target	Currently meets target	Rural, medically underserved
Polk County - TN	Lowest	SN	Currently meets target	Rural
Bledsoe County - TN	Undetermined	SN	SN	Education, employment, rural, medically underserved
Sequatchie County - TN	Undetermined	SN	SN	Rural, medically underserved

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

Map of Intervention Priority Areas

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

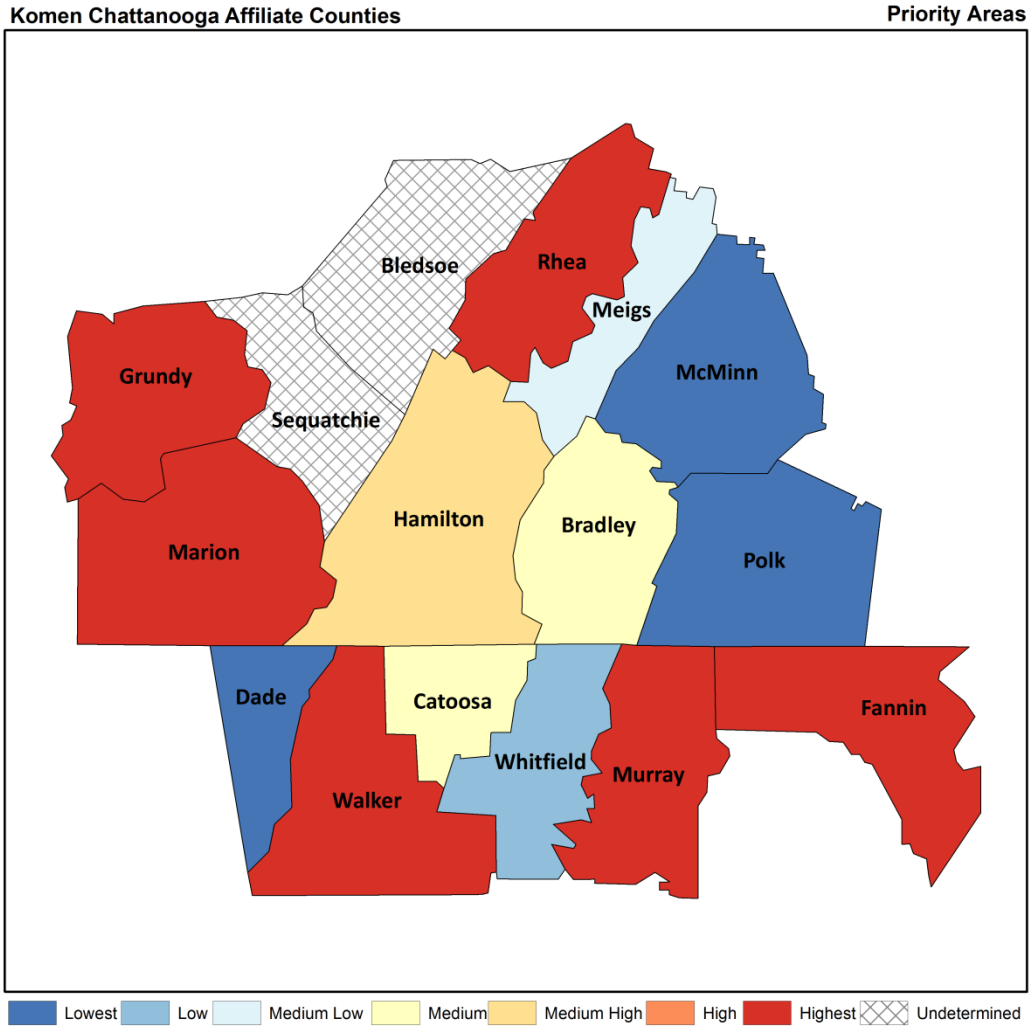

Figure 2.1. Intervention priorities

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

Six counties in the Komen Chattanooga service area are in the highest priority category. One of the six, Walker County, GA, is not likely to meet either the death rate or late-stage incidence rate HP2020 targets. Five of the six, Fannin County, GA, Murray County, GA, Grundy County, TN, Marion County, TN, and Rhea County, TN, are not likely to meet the late-stage incidence rate HP2020 target.

The incidence rates in Rhea County, TN (176.3 per 100,000) are significantly higher than the Affiliate service area as a whole (116.6 per 100,000). The death rates in Murray County, GA (37.8 per 100,000) are significantly higher than the Affiliate service area as a whole (22.6 per 100,000).

Fannin County, GA, has a relatively older population. Murray County, GA, has a relatively large Hispanic/Latina population and low education levels. Grundy County, TN, has relatively low education levels and high poverty level. Rhea County, TN, has relatively high unemployment.

Medium high priority areas

One county in the Komen Chattanooga service area is in the medium high priority category. Hamilton County, TN, is not likely to meet the late-stage incidence rate HP2020 target. Hamilton County, TN, has a relatively large Black/African-American population.

Additional Quantitative Data Exploration

Current economic conditions in the Komen Chattanooga service area served as the basis to conduct additional research into unemployment figures. The unemployment rate and lack of job growth impact residents' ability to access health care services. While unemployment data was provided in the QDR, the stagnated local economic conditions warranted further investigation.

Although there are discrepancies among researchers on how socioeconomic factors affect breast cancer screening and survival, the unemployment rates in the priority target areas are consistently reporting higher than the national average. All four counties are consistently higher than the respective state average for unemployment as well.

Recent data regarding unemployment have been researched from the Georgia Department of Labor and the Tennessee Department of Labor statistical databases to gather both county level and state level unemployment rates. A concern for the priority counties in the Affiliate service area is the long-term unemployment numbers and how they will affect the overall health of the population (University of Georgia, 2014), (Tennessee Department of Labor, 2014).

Statistical data from March 2014 confirm reason for concern. Hamilton County, TN reported an unemployment rate of 6.8 percent, Rhea County, TN at 9.2 percent, and the priority counties in Georgia are Fannin at 7.2 percent and Murray County at 9.8 percent. During that same month, Tennessee reported an unemployment rate of 6.7 percent and Georgia reported 7.0 percent. The national unemployment rate for the same time period was reported at 6.7 percent.

Another primary concern for Murray County is the sharing of resources with Whitfield County which is reporting an unemployment rate of 8.1 percent. Whitfield and Murray Counties historically share health care resources. These resources are being exhausted as more residents require free and reduced rate services. The qualitative data will explore how much stress is being placed on providers of breast health screening, education, and treatment services.

These increased populations of unemployed and underemployed residents as well as many who are considered long-term unemployed will have a direct impact on those needing breast health care and, for financial reasons, are not receiving it. Long-term unemployed is defined by the US Department of Labor as unemployed for more than six consecutive months.

Upon review of the Quantitative Data Report, Susan G. Komen Chattanooga has selected four target communities in the 16 county service areas to be the focus of strategic intervention for the next four year cycle. The Affiliate considered all of the quantitative data provided along with the latest state and county unemployment rates in the process of choosing the target communities.

The Community Profile Team also considered how the selected communities ranked in achieving the goals of the Healthy People 2020 Objectives. Healthy People 2020 (HP2020) has established national, evidence-based goals to improve the overall health of Americans. Released in 2010, these objectives are aggressive, but attainable within the 10 year period with appropriate interventions.

Two objectives identified and specifically related to improvements in breast cancer health outcomes: reduce female breast cancer death rate, and reduce cases of late-stage female breast cancer diagnosis will be the focus of Affiliate interventions. The objective to reduce

female breast cancer death is to improve from 22.6 deaths per 100,000 to 20.6 per 100,000. The objective to reduce cases of late-stage breast cancer diagnosis is to decrease from 44.8 per 100,000 to 41.0 per 100,000. These objectives are consistent with Susan G. Komen's mission "to save lives and end breast cancer forever," and served as one criteria for selection of the priority counties.

Additional indicators the Affiliate reviewed included:

- Incidence rates and trends
- Late-stage/death rates and trends
- Population, age and race characteristics
- Socioeconomics, access to insurance and services

Selection of Target Communities

The selected target communities are (Table 2.8)**:**

- Fannin County, GA,
- Murray County GA,
- Hamilton County, TN and
- Rhea County, TN.

Table 2.8. Breast cancer rates for target communities

Target Communities Incidence, Death, and Late-stage Diagnosis Rates			
Population Group	**Age-Adjusted Incidence Rate/100,000**	**Age-Adjusted Death Rate/ 100,000**	**Age-Adjusted Late-stage Rate/100,000**
US	122.1	22.6	43.8
Komen Chattanooga Service Area	116.6	22.6	44.8
Fannin	89.9	25.1	31.3
Murray	129.1	37.8	45.3
Rhea	176.3	20.1	45.3
Hamilton	124.0	21.5	49.0
Healthy People 2020 Target	*NA*	*20.6*	*41.0*

Fannin County was identified as the highest priority in terms of Affiliate intervention based on Table 2.7 - which predicted that it will take 13 years or longer for Fannin County to achieve the HP2020 late-stage incidence target. The death rate target numbers were not available for this county. Other data from the QDR that indicate Fannin County women may face barriers to health care include: 100 percent rural, 100 percent medically underserved and 24.0 percent uninsured.

Fannin County incidence rates are around 89.9 per 100,000 females, which is lower than the US and state average, however the death rate is higher at 25.1. Table 2.1 shows Fannin was one of the counties predicted to show an increasing trend in both incidence and late-stage

breast cancer diagnosis. Table 2.3 shows Fannin County has a population too small to calculate statistics on the number of women proportionally screened. Qualitative data will investigate this further.

Fannin County was also selected on the basis of its socioeconomic characteristics: 21.7 percent of the population has less than a high school education, 18.9 percent have income below 100 percent of the poverty level, and 49.0 percent below 250 percent of the poverty level. All of these statistics are above the Georgia and Komen Chattanooga service area average.

Murray County was ranked as a highest priority for Affiliate intervention in Table 2.7 of the QDR. It is predicted it will take the county 13 years or more to reach the HP2020 breast cancer targets for breast cancer late-stage diagnosis rate. Female breast cancer death rate data were reported at 37.8 per 100,000. The sample size was too small to calculate a trend. The late-stage diagnosis rate is trending upward at 17.5 percent annually. While the number of late-stage diagnosis is small, reviewing the incidence rate reveals reason for concern. Murray County's incidence rate was 129.1 per 100,000 women with a 9.5 percent trend increase annually.

Murray County has the second largest Hispanic/Latina population in the Affiliate service area. The population has additional barriers in both language and cultural challenges. These barriers could contribute to the population's risk. Murray County has the second highest rate of those with less than a high school education in the Affiliate service area at 31.6 percent and 50.4 percent have income below 250 percent of the poverty level (Table 2.9).

Table 2.9. Select socioeconomic characteristics for Murray County

Population Group	Less than HS Education	Income Below 100% Poverty	Income Below 250% Poverty
Komen Chattanooga Service Area	20.6%	17.1%	41.8%
Murray County	31.6%	19.4%	50.4%

Murray County socioeconomic factors reported 70.1 percent of its population living in rural areas, 100 percent of the population living in areas that are medically underserved, and 23.3 percent are reported as having no health insurance. All of these factors are higher than the Affiliate service area (Table 2.5).

Rhea County was identified as a highest priority county for Affiliate interventions. It is predicted that it will take 13 years or longer to achieve the HP 2020 target for late-stage incidence rate. Rhea County has the highest incidence rate of any county in the service area at 176.3 per 100,000, which is actually reflecting a downward trend of -14.3 percent. Data available on late-stage diagnosis show an age-adjusted rate of 45.3 per 100,000 and an increasing trend of 11.2 percent; the second largest increase in the Affiliate service area, as shown in Table 2.1. Data

needed to predict the length of time to achieve the death rate target were not available. Qualitative research will investigate the difference in incidence rate and late-stage diagnosis.

Table 2.10. Select socioeconomic characteristics for Rhea County

Population Group	Less than HS Education	Income Below 250% Poverty (Age 40-64)	In Rural Areas	In Medically Underserved Areas
US	14.6%	33.3%	19.3%	23.3%
Tennessee	16.8%	38.9%	33.6%	47.7%
Komen Chattanooga Service Area	20.6%	41.8%	37.4%	39.9%
Rhea County	24.1%	46.2%	68.0%	100.0%

Rhea County is similar to Fannin County in regards to socioeconomic indicators, including 24.1 percent of the population having less than a high school education, 20.3 percent of the population living below 100 percent of the poverty level and 46.2 percent living below 250 percent (Table 2.10). Sixty-eight percent of the population lives in rural areas and 100 percent are medically underserved.

Hamilton County was ranked as a Medium-High Priority for Affiliate intervention in Table 2.7. The 2013-2014 Cancer Facts and Figures from the American Cancer Society states the most common risk factors for breast cancer are being female and growing older. The report also identifies Black/African-American women in the US as having a 41.0 percent higher death rate from breast cancer than White women as of 2010. Black/African-American women are also diagnosed more frequently under the age of 40 and more Black/African-American women die from breast cancer in all age groups. Black/African-American women are more often diagnosed with larger tumors (greater than 5.0 cm) (Susan G. Komen, 2014).

The Affiliate has included Hamilton County as a target due to the large population of Black/African-American women and the fact that 51.3 percent of the female population is age 40 or over. (Table 2.4). The incidence age-adjusted rate is 124.0 per 100,000 and late-stage age-adjusted rate is 49.0 per 100,000 (Table 2.1). Data provided in Table 2.7 show that Hamilton County is predicted to reach the HP2020 death rate target in two years but will take 13 years or longer to achieve the late-stage breast cancer diagnosis target. The current death rate is 21.5 per 100,000 with a downward trend of 2.5 percent annually. This corresponds with a predicted time of two years to meet the HP2020 target for female breast cancer death rate of 20.6 per 100,000.

Table 2.11. Select demographic characteristics for Hamilton County

Population Group	Black/African-American	Female Age 40 Plus
US	14.1%	48.3%
Tennessee	17.9%	49.3%
Komen Chattanooga Service Area	10.1%	50.9%
Hamilton County	21.5%	51.3%

Although Hamilton County as a whole is not a priority by reviewing socioeconomic indicators, there are pockets of extreme financially challenged, hard to serve and underserved communities where access to services and ability to pay are deterrents to breast health care (Table 2.11).

The Affiliate recognizes this as a factor in the 13 years or longer predicted time to achieve the late-stage incidence target. The Affiliate will focus on these specific areas when gathering the health systems analysis and qualitative data.

Health Systems Analysis Data Sources

Komen Chattanooga began the Health Systems and Public Policy Analysis by reviewing programs and data that could be collected from the internet, provided to the Affiliate via Susan G. Komen Headquarters, and local sources.

The Community Profile Team met to review sources and discuss questions around programs provided at the local and state level. The Community Profile Team members are representatives from both the Tennessee and Georgia medical community, breast cancer survivors, Komen Chattanooga Board members, and local program directors. The materials were reviewed and an analysis resulted in the team dividing the missing data into manageable pieces. Each member participated in conducting a surveillance of the Health Systems of the four priority counties.

The finding of the analysis determined the Affiliate service area has four large hospital systems; each county has a state health department, several free clinics, and various satellite offices of larger organizations.

The findings revealed several FDA certified mammography services in the priority counties –

- Murray County – Murray Medical Center
- Fannin County – Fannin Regional Hospital
- Hamilton County – Parkridge Medical Hospital, Chattanooga Imaging (2 locations), Erlanger (all locations), MaryEllen Locher Breast Center, Women's Health Services, Associates in Oncology and Hematology, Digital Imaging of North Georgia
- Rhea County **–** Rhea Medical Center

The analysis also revealed some locations with additional accreditations:

Hamilton County

- MaryEllen Locher Breast Center – American College of Surgeons national accreditation program for breast cancers
- Digital Imaging of North Georgia - American College of Radiology Breast Imaging Centers of Excellence
- Chattanooga Imaging East - American College of Radiology Breast Imaging Centers of Excellence

Rhea County – No specialized certification for breast cancer

Murray County – No specialized certification for breast cancer

Fannin County - No specialized certification for breast cancer

Health Systems 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 in order to have the best outcomes. Education can play an important role throughout the entire CoC.

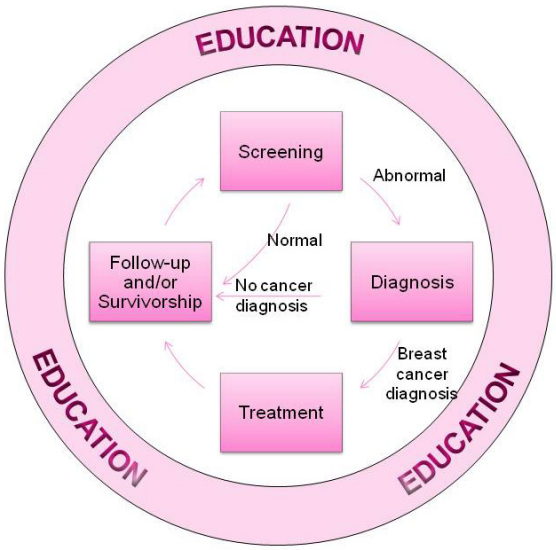

Figure 3.1. Breast Cancer Continuum of Care (CoC)

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 reports 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 actually 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.

The four selected counties in the Affiliate service area (Hamilton County, and Rhea County, TN, and Murray and Fannin County, GA) were evaluated for strengths and weaknesses across the CoC, current relationships, and the possibility of future partnerships.

Hamilton County

Health System Strengths

Hamilton County is a large metropolitan county with 22 incorporated and unincorporated cities within its boundaries. This community has a large medical community with four distinct hospital systems (Figure 3.2). These hospital systems have numerous satellite offices spread throughout the county. The widespread and diverse medical options provide numerous access points into the health care system.

Health System Weaknesses

Hamilton County has challenges just as any other community when providing health care to a diverse population. The satellites spread throughout the community are access points to entry of services but many do not offer the wide array of services needed for long term and follow up care. This will require patients to travel into the metropolitan area to receive specialized care when needed.

In gathering the local information, many of the smaller agencies, organizations and even clinics were identified as merely referral sources for the larger hospital system services and programs. Patient navigation is very limited outside of the major hospital systems.

The area's only two mobile mammography units have lost funding for maintenance and upkeep. This began to impact service in the 3rd quarter of last year and often one or both units are in need of repair and are not being utilized in the community. These Mobile Units serve every county in the Affiliate service area and are heavily engaged with the area's largest employers. These issues that limit mobile mammography access will have a substantial impact, especially on the blue-collar population.

The Health System Analysis revealed that there is a distinct lack of support for breast cancer patients, survivorship, and enhanced quality of life programs.

Key Relationships

The Affiliate is a funding source to two of the largest hospital systems in the service area, Memorial Health Care Systems and Erlanger Health System. Memorial is the parent organization to the MaryEllen Locher Breast Care Center, the owner/operator of the two Mobile Mammography Units. Erlanger Health System has a state of the art Breast Care Center and oversees the Southside and Dodson Community Health Care Centers which are located inside the outreach community identified as a priority target in Hamilton County.

Hamilton Health Department and Tennessee BCCP are long time recipients of the Affiliate's grant funding. These funds are used throughout the service area for patients who do not have insurance or the ability to pay and do not qualify for state funding. The Affiliate has an ongoing partnership with the Tennessee Cancer Coalition.

Potential Partnerships

Survivorship and quality of life partnerships need to be strengthened. The Affiliate will actively seek partnerships in the community to fill those needs. The Affiliate will reconnect with Breast Cancer Support Services, a grant recipient in previous years. The Affiliate also feels that increasing partnership with Hamilton County YMCAs and the programming offered for health and wellness can benefit survivors and increase community impact.

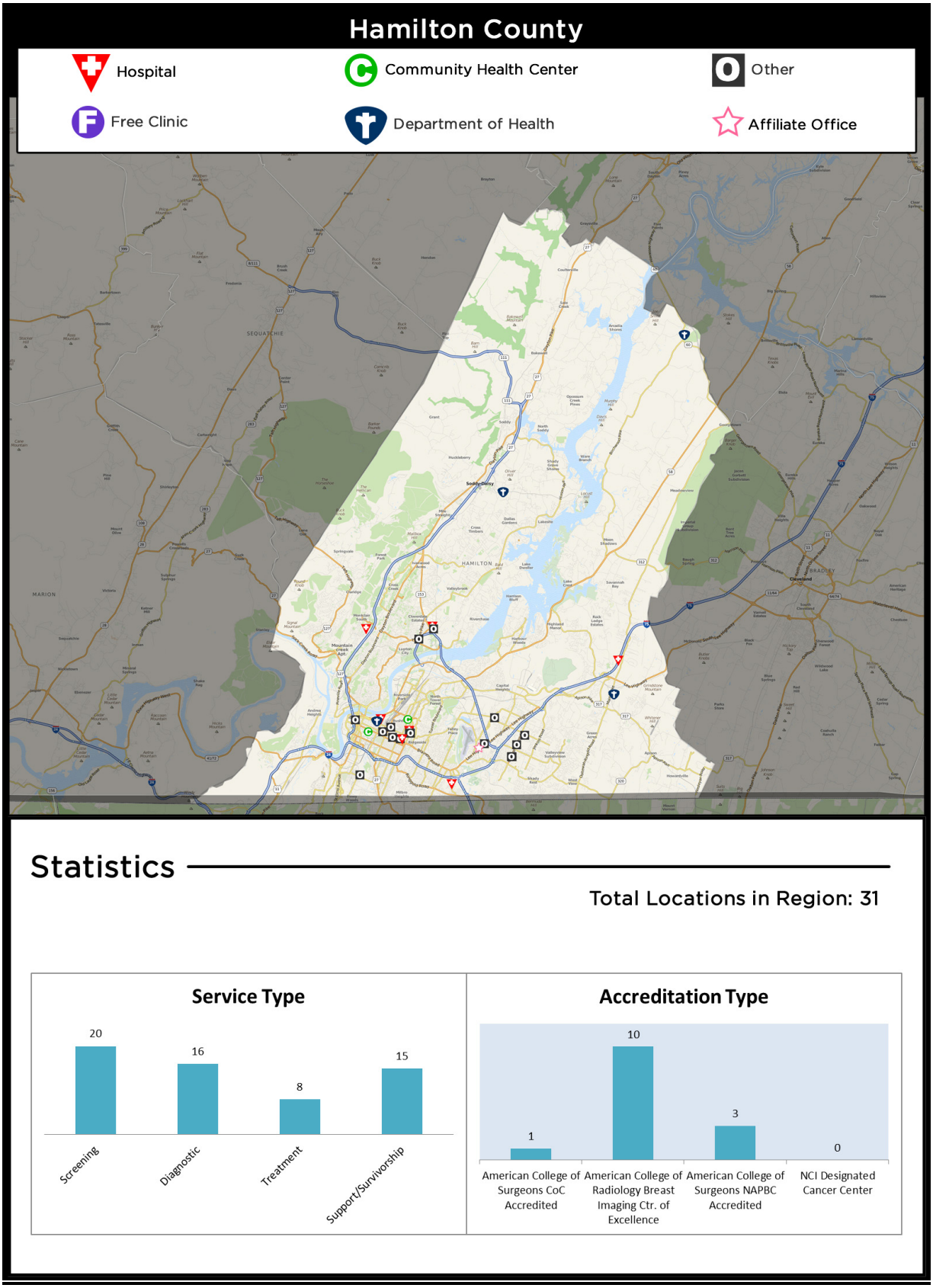

Figure 3.2. Breast cancer services available in Hamilton County

Rhea County

Health System Strengths

As of November 2013, Rhea Medical Center opened a state of the art 75,000 square foot facility offering the latest digital mammography in Tennessee (Figure 3.3). This facility is accredited by the American College of Radiology Breast Imaging Center of Excellence. Although data is too new to evaluate statistical impact, the new facility and new equipment should result in improved statistics around breast cancer diagnosis and death rates.

Rhea County conducted a community needs assessment that was approved by the Rhea County Medical Center Board of Directors along with an implementation plan designed against the assessment in May 2013. Fundraising efforts by the Rhea Medical Foundation have resulted in the purchase of a Hologic Selenia Dimensions Digital Mammography Unit. According to the Hologic website, this equipment can provide quality digital mammography image with the lowest radiation dosage and maximum flexibility. The results are ready in just seconds (Hologic, 2014).

Health System Weaknesses

Prior to the Rhea County Medical Center opening in 2013, the area service providers were a local health department and a primary health care center. The local services available in Rhea County leave a gap for those in need of treatment such as chemotherapy, radiation, counseling and reconstruction. Patients have to travel to the Chattanooga Metropolitan area for the aforementioned treatments, creating a transportation/cost/time challenge for a population that is largely economically disadvantaged.

Key Relationships

Tennessee Breast and Cervical Screening Program is the most effective way the Affiliate currently has of reaching this population.

Potential Partnership

The Affiliate will focus on developing partnerships with Rhea Medical Center and the Rhea County YMCA.

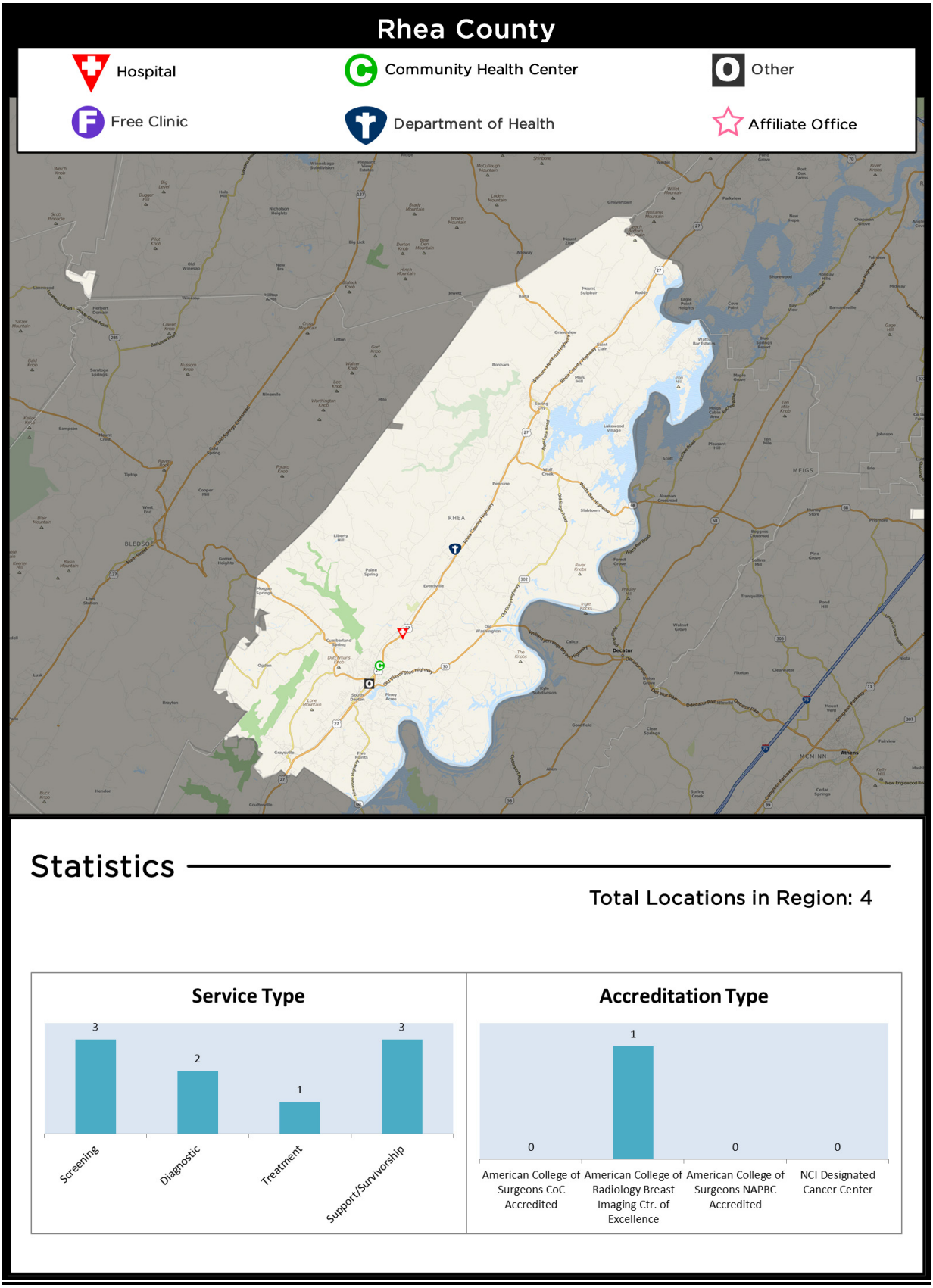

Figure 3.3. Breast cancer services available in Rhea County

Murray County

Health System Strengths

Murray County has several medical clinics and private physicians that provide access to clinical breast exams (Figure 3.4). Mammography and screening is available through Murray County Medical Center.

Health System Weaknesses

This county is small, predominately rural and only has a small primary care hospital with limited specialized care facilities in the system. Murray is largely served by local walk-in type clinics and health centers that are satellite offices of larger medical facilities from other parts of the state. These facilities are referral sources for patients with specialized needs who are traveling to other Affiliate service areas for medical treatments.

Murray County is experiencing a large growth in their Hispanic/Latino population. Cultural and communication barriers make it difficult to get and keep these Hispanic/Latina women into the Continuum of Care.

Key Relationships

A North Georgia grantee, Promotoras De Salud, has a program that will help educate and navigate the Hispanic/Latina women (and men) through their evidence based programming. Although geared toward Hispanic/Latino families, the program will also serve any underserved resident in need of breast health services.

Potential Partnership

Partnerships will be established or strengthened with Murray County Health Department, Murray Mountain Medical, and Georgia Mountain Health Services

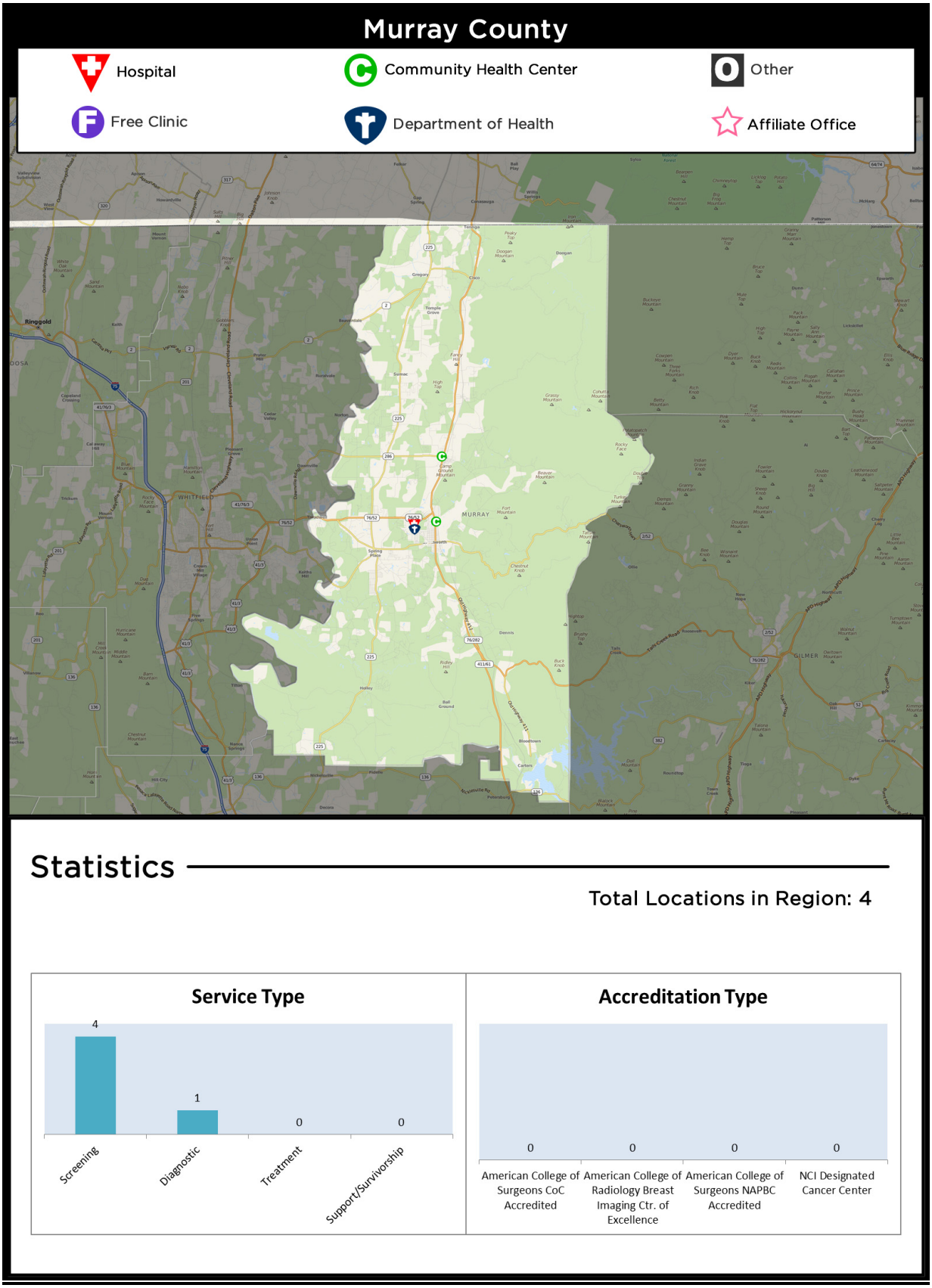

Figure 3.4. Breast cancer services available in Murray County

Fannin County

Health System Strengths

Fannin County has a specialized cancer facility, Georgia Cancer Specialist, with two oncologists on location (Figure 3.5). One specializes in malignancies and the other physician specializes in breast cancer.

Health System Weaknesses

Fannin County is the most remote, rural county in the Affiliate service area. The county is the most removed from the larger medical systems with specialized services. The population faces an even greater challenge traveling to other areas to receive chemotherapy, radiation, counseling and reconstruction.

Key Relationships

No current relationships were identified for this county at the present time.

Potential Partnerships

The Affiliate would like to explore the possibility of creating a relationship with the Georgia Cancer Specialists.

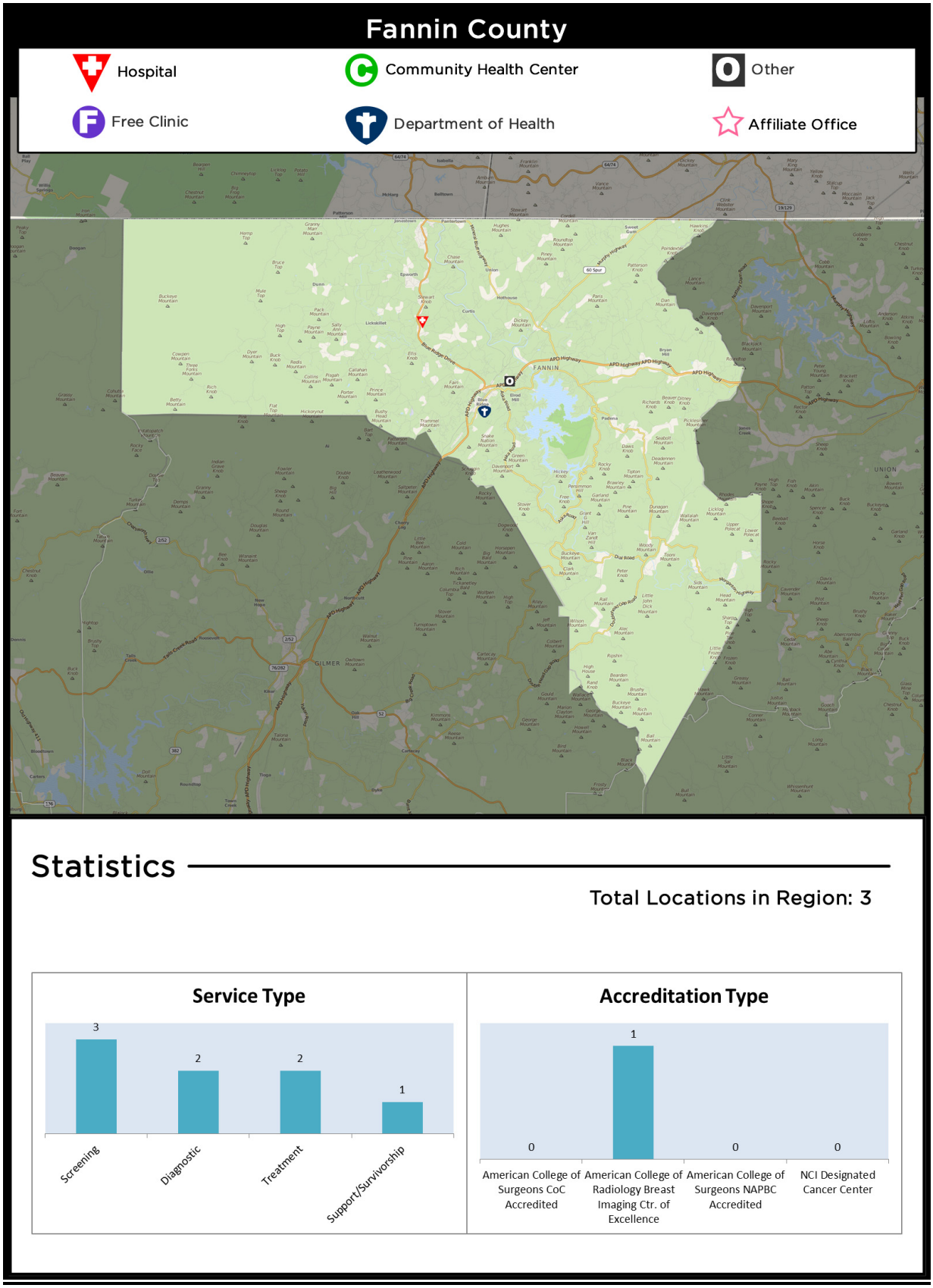

Figure 3.5. Breast cancer services available in Fannin County

Public Policy Overview

National Breast and Cervical Cancer Early Detection Program

Since 1998, Center for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) has made great strides to reduce the burden of cancer in the United States (NBCCEDP, 2014). NBCCEDP supports all 50 states, the District of Columbia, seven tribal groups, and seven US Associated Pacific Islands/territories to establish coalitions, assess the burden of cancer, determine priorities, develop and implement cancer plans. Comprehensive cancer control (CCC) is a collaborative process through which a community and its partners pool resources to reduce the burden of cancer. CCC programs across the nation are working in communities to promote healthy lifestyles and recommended cancer screenings, educate people about cancer symptoms, increase access to quality cancer care, and enhance cancer survivors' quality of life (NBCCEDP, 2014). The Breast and Cervical Cancer Prevention and Treatment Act of 2000 gives states the option to provide medical assistance through Medicaid to eligible women who were screened for and found to have breast or cervical cancer, including precancerous conditions, through the NBCCEDP. (Center for Disease Control, 2014).

Tennessee Breast and Cervical Cancer Program

The Tennessee Breast and Cervical Cancer Program is administered through the Tennessee Department of Health. The program is funded by both state and federal funding as well as funding from all six Komen Affiliates in Tennessee. The Breast and Cervical Screening Program provides breast and cervical cancer screening to eligible women and diagnostic follow up tests for those with suspicious results. Women diagnosed with breast or cervical cancer or pre-cancerous conditions for these cancers are enrolled for treatment coverage through the state's TennCare Program (Tennessee Department of Health, 2014).

Women must meet eligibility requirements for services. The eligibility requirements are women aged 40 to 64, have an income below 250 percent of the federal poverty level, and be uninsured or underinsured. Women ages 50 - 64 can receive mammography services and women ages 40 – 49 can receive mammography services with a family history of breast cancer. Women under 40 who have confirmed suspicious results from screening can be enrolled for diagnosis and/or treatment. It is estimated 65,000 women are eligible for services in Tennessee. Access to these services are provided at Memorial Hospital locations for the Tennessee Department of Health and local health departments (Tennessee Department of Health, 2014).

Georgia Breast and Cervical Cancer Program

In Georgia, the state's public health department runs the Georgia Breast and Cervical Cancer program (BCCP), funded by both federal and state revenues through the NBCCEDP, the Master Settlement Agreement, and state resources. Despite its funding sources, the state only receives enough funding to provide breast cancer services to 16,000 women (Georgia Department of Public Health, 2014), covering less than 15 – 20 percent of the program's eligible population (Center for Disease Control, 2014). Within Georgia, approximately 35,000 women

were provided with mammography services through the NBCCEDP between 2008 and 2012 (Georgia Department of Public Health, 2014).

To be eligible for the BCCP, women must be a resident of the state, between the ages of 40 and 64, low-income (less than 200 percent of the federal poverty level), uninsured, or underinsured. Through the BCCP, eligible women will receive clinical breast examinations, mammograms, and diagnostic evaluation in case of abnormal results. Should results be conclusive of breast cancer, women will be referred to treatment options through Georgia's Women's Health Medicaid Program. Services will be available throughout treatment. In order to enroll in the program or find a BCCP provider, women can contact their local county public health department (Georgia Department of Public Health, 2014).

State Comprehensive Cancer Control Plans

Tennessee Cancer Control Plan

Tennessee's Comprehensive Cancer Control Program, referred to as the Tennessee Cancer Coalition (TC2), was formed in 2003 to measurably reduce cancer burden in Tennessee by implementing a collaborative statewide plan driven by data, science, capacity and outcomes (State Cancer Plan, 2013). TC2 has now grown to include over 500 members including health care providers, researchers, cancer survivors, advocates, public health professionals, insurers and employers from seven regions across the state (State Cancer Plan, 2013).
TC2 has released three state cancer plans since its inception. The latest Tennessee Comprehensive Cancer Control Plan was released in 2013 and provides a roadmap for the coalition activities for years 2013-2017. The plan includes cancer specific chapters that identify goals, objectives and strategies to improve cancer outcomes across the state. Chapter 19 is dedicated to women's cancer with objectives related to breast cancer and strategies that increase collaboration with Tennessee Susan G. Komen Affiliates.

The State of Tennessee Cancer Plan 2013-2017 includes the following goal and objectives that include breast cancer:

Goal 1

Reduce female breast, cervical, ovarian and uterine cancer death through increased awareness, early detection, diagnosis and treatment. Death rates for 2005-2009 and reduction goal by June 2017: breast rate of 24.0, reduce to 22.0; cervical rate of 2.8, reduce to 1.8; ovarian rate of 8.1, reduce to 7.1; and uterine rate of 3.8, reduce to 2.8.

Objective 1.1

Increase awareness of these cancers, current incidence rates, current death rates and screening guidelines and to promote access to services and increase screenings by conducting annual updates on the rates to each of the TC2 regions.

Strategies:

- Develop and promote public information campaigns with state partners (American Cancer Society (ACS), the six Susan G. Komen Affiliates, family practice physicians, OB/GYN physicians, mammography facilities, etc.).
- Identify counties with the highest rates of breast and cervical cancer for special community-based campaigns through the work of the regional Tennessee Cancer Coalition (TC2) coalitions.
- Continue to emphasize targeted outreach to underserved groups through the University of TN Extension statewide, county-based educational delivery systems, The Witness Project of Davidson County, Komen grantees and other local initiatives for breast and cervical cancer awareness and screening.
- Promote awareness in January (Cervical Cancer prevention Month), September (Gynecological Cancer Awareness Month), and October (Breast Cancer Awareness Month) through TC2 regional coalitions.
- Work with medical and health care practitioner societies to encourage members to promote regular, periodic screening for breast and cervical cancer.
- Review trends in ovarian and uterine cancer, at least bi-annually, and advocate for screening if evidence-based screening methods become available before 2017.

Objective 1.2
By June 2017, increase funding for breast and cervical cancer screening.

Strategies:

- Advocate for expansion of state funding to improve TN's incidence and death rates for these two highly treatable cancers when the cancers are caught early.
- Support local Susan G. Komen Affiliates fund raising activates which in turn support local education and screening services.
- Advocate for an increased appropriation from the federal government so that all states have additional resources for their state breast and cervical screening programs.

Georgia Comprehensive Cancer Control Program

In 1998, the CDC established the National Comprehensive Cancer Control Program in an effort to reduce cancer-related morbidity and death through the creation of coalitions, assessment of burden and priorities, and development of tailored plans within each state. Consequently, the Georgia Comprehensive Cancer Control Program (GCCCP) was created as part of the CDC's national initiative. The GCCCP is run by the Georgia Department of Public Health and aligns its goals and efforts with those of the Healthy People 2020 National Objectives. The GCCCP brings together various stakeholders from the Georgia Cancer Control Consortium to develop the Georgia Cancer plan, in which priority cancer conditions are highlighted and plans of action are determined to help reduce rates of morbidity and death.

The most recent Cancer Control Plan for Georgia has established goals and objectives that align with the National Healthy People 2020 objectives. In the 2014-2019 Georgia Cancer Plan, the GCCCP has outlined several priority areas to focus its attention, including breast cancer.

The GCCCP acknowledges that breast cancer remains a leading cause of death within the state, and that if certain efforts, including increased screening percentages, are undertaken, prevalence and death rates can be greatly reduced.

The Georgia Cancer Control Plan states Georgia has some of the strongest networks of programs and resources in the United States. The Georgia Cancer Coalition pools resources to promote cancer prevention, improve cancer detection, increase access to health and social services, and reduce the burden of cancer.

One particular project entitled, “Georgia Breast Cancer Genomics ESP: Enhancing Breast Cancer Genomics through Education, Surveillance, and Policy,” is to promote the use of evidence-based guidelines to improve the identification of young women at genetic risk for breast and ovarian cancer burden in this population as well as disparate sub-populations. The main areas of focus include education, surveillance, and policy. The four targeted groups are clinicians, public health practitioners, policymakers, and young women at risk (Georgia Cancer Plan, 2014).

The breast cancer specific objectives outlined in the plan seek to reduce the number of breast cancer diagnoses and to ensure that all women have access to high quality screening, genetic screening, counseling, and preventative services. In order to meet their objectives, the GCCCP strives to sustain current community-based screening programs that focus on racial and ethnic minority groups, with the goal of reducing disparities in screening percentage by 10.0 percent by 2019.

Georgia is one of three states to receive funding for hereditary breast and ovarian cancer screening. The GCCCP aims to promote genetic screening in an effort to increase the proportion of high-risk individuals receiving genetic risk assessment and appropriate screening by 25.0 percent. All women seen in primary care settings should be screened. The goal is to increase education and awareness of the BRCA1 gene mutation for both health care providers and the community. Surveillance in six Georgia health districts has been initiated and resulted with more than 3,600 women screened, using the B-RST (Breast Referral Screening Tool) and has resulted in 146 positive screenings. Following the genetic testing, 14 women were positive for the BRCA1 mutation (Georgia Cancer Control Plan, 2014).

The 2019 objectives specific for breast cancer is to increase the number of women who receive screening from 77.0 to 81.0 percent, to reduce income and insurance overage disparities in breast and cervical screening by 10.0 percent, and to increase the percentage of women screened for genetic risk of breast cancer.

GCCCP also seeks Medicaid and state insurance reimbursement for genetic testing and counseling, as well as preventative procedures such as mastectomies in high-risk individuals. Additional preventative measures, such as educational campaigns focused on screening, the promotion of breastfeeding (which is linked to reducing the risk of breast cancer), as well as

reduction in obesity, are also initiatives supported by the GCCCP (Georgia Department of Health, 2014).

Komen Chattanooga and State Cancer Coalitions

The Affiliate has been involved with the cancer coalitions of both Georgia and Tennessee for the past four years. The Affiliate has hosted meetings of the Tennessee Cancer Coalition as well as provided resources for outside events. The Affiliate has participated in the Tennessee Cancer Coalition statewide meeting. The Georgia Cancer Coalition meets less frequently; however, the Executive Director attends the board meetings for the Northwest Georgia Cancer Coalition regional group. In addition, educational materials are provided to each coalition for distribution into the counties.

In the next four years, the Affiliate will continue to build relationships with both the Tennessee and Georgia Cancer Coalition. Komen Chattanooga will leverage technology to provide more cost effective ways to share Komen educational materials specific to targeted needs.

Affordable Care Act

Tennessee

According to the Kaiser Family Foundation, the 2010 Affordable Care Act (ACA) has the potential to extend coverage to many of the 47 million nonelderly uninsured people nationwide, including the 850,000 uninsured Tennesseans. The ACA establishes coverage provisions across the income spectrum, with the expansion of Medicaid eligibility for adults serving as the vehicle for covering low income individuals and premium tax credits to help people purchase insurance directly through new Health Insurance Marketplaces serving as the vehicle for covering people with moderate incomes. With the June 2012 Supreme Court ruling, the Medicaid expansion became optional for states

Tennessee Medicaid expansion

As of December 2013, Tennessee was not planning to implement the expansion. As a result, many uninsured adults in Tennessee who would have been newly eligible for Medicaid will remain without a coverage option (The Henry J. Kaiser Family Foundation, January 2014).

In 2012, Governor Bill Haslam, announced Tennessee would not develop and administer a State Health Insurance Exchange. Therefore, in Tennessee, the health insurance exchange is federally facilitated. In March of 2013, the Governor announced the State would not expand Medicaid. As stated above, prior to the enactment of the ACA, it was estimated there were 850,000 uninsured Tennesseans. Of the 850,000 uninsured, 305,628 were determined eligible to enroll in a marketplace plan, and, of that number, 169,470 individuals were determined eligible to enroll in a marketplace plan with financial assistance.

In Tennessee at the end of the open enrollment period, 151,352 individuals have selected a marketplace plan (Henry J. Kaiser Family Foundation, May 1. 2014). According to a report recently issued by the Council of Economic Advisors, an additional 254,000 Tennesseans would

have insurance coverage by the year 2016, if the state were to expand Medicaid (The Council of Economic Advisers, July 2014).

The decision not to expand Medicaid may have grave consequences, not only for the uninsured in Tennessee, but for medical providers, such as rural hospitals and disproportionate share hospitals, which serve a high number of uninsured individuals. Uninsured adults who do not fall within Tennessee's narrow TennCare (Medicaid in Tennessee) eligibility categories are left facing huge barriers. Because the ACA was written to mandate the expansion of Medicaid in every state, there was not provision for financial assistance, such as premium tax credits, to purchase insurance through the health insurance marketplace for individuals or families whose income would make them eligible for Medicaid under the expansion.

With the Supreme Court ruling that Medicaid expansion is optional for states, hundreds of thousands of Tennesseans whose income is below 138 percent of the federal poverty level (FPL) ($16,100 for an individual, $27,300 for a family), find themselves eligible to purchase a plan through the marketplace, but at full cost, a virtual impossibility for this vulnerable group. Hundreds of thousands of Tennesseans will, therefore, remain uninsured. According to The Tennessee Justice Center, a small non-profit law firm that provides free legal services to vulnerable Tennesseans, statewide, 47.0 percent of all uninsured Tennesseans, ages 18 to 64 have incomes below 138 percent of the federal poverty level, which would make them eligible for Medicaid under the new law. Expanding Medicaid, TennCare in Tennessee, could extend health coverage to over 300,000 Tennesseans (Tennessee Justice Center, February 26, 2014).

The January 20, 2014 fact sheet; *How will the Uninsured in Tennessee Face Under the Affordable Care Act?* (Henry J. Kaiser Family Foundation) states, even though the state is not expanding Medicaid eligibility, some currently uninsured people are eligible for Medicaid in 2014. Half (50 percent) of uninsured Tennesseans eligible for Medicaid are children who are already eligible but not yet enrolled in coverage. A small number of uninsured adult parents (nine percent of the uninsured in the state) are eligible for Medicaid in Tennessee under eligibility pathways in place before the ACA. Not all eligible individuals are enrolled in the program due to lack of knowledge about eligibility and historic enrollment barriers. As the ACA expansions are implemented it is likely that broad outreach efforts and new streamlined enrollment processes will lead to increased enrollment of eligible individuals into Medicaid.

Regarding Medicaid, the state of Tennessee recently received notification, in the form of a letter, dated June 27, 2014, from CMS (Centers for Medicare & Medicaid Services), the federal agency overseeing TennCare, requiring the state to submit a plan, no later than July 14, 2014 to remedy its problems. An article appearing in the Chattanooga Times Free Press states "Though six states received similar letters from CMS about their findings, Tennessee's letter indicates that its level of compliance is worst among the group: it failed to meet all but one of "seven critical success factors" for implementing new Medicaid rules. Many of those rules are based on a new system for determining Medicaid eligibility under the Affordable Care Act" (Chattanooga Times Free Press, July 10, 2014).

The point of the somewhat exhaustive detail above is that while 151,352 Tennesseans have enrolled in a health care plan under the ACA, due state decisions, hundreds of thousands of state citizens are not able to benefit from possible coverage available under the Affordable Care Act. The state's decision not to expand Medicaid will make services provided by the Tennessee BCCP critical to those women who will remain uninsured and unable to take advantage of affordable insurance through the Health Insurance Marketplace.

For medical providers such as rural hospitals or hospitals that serve a high number of uninsured individuals the effect of not expanding Medicaid could have serious consequences. Hospitals that serve a disproportionate share of uninsured individuals receive additional funding (DSH) payments. But hospitals agreed to accept cuts in DSH along with other Medicare and Medicaid payments. To quote the Tennessee Justice Center, "In a world where almost everybody had insurance, as envisioned by the law, hospitals could afford to take those cuts. Without the expansion, hospitals will still be stuck providing care to lots of uninsured patients, but they will have to do it on tighter budgets. Many hospitals will not be able to survive if Tennessee does not expand Medicaid" (Tennessee Justice Center Fact Sheet, 2014).

Under the provisions of the ACA all health plans in the Health Insurance Marketplace must offer "essential benefits" which include breast cancer mammography screenings every one to two years for women over 40, breast cancer genetic test counseling (BRCA) for women at higher risk for breast cancer, and breast cancer chemoprevention counseling. These services must be provided without charging a co-pay or co-insurance. However, although many more women in Tennessee may have insurance coverage through the ACA Health Insurance Marketplace, and have these benefits available to them, many barriers still exist that could prevent full utilization of these benefits. These barriers include lack of education, geographic isolation, access to services/providers, access to reliable transportation, misunderstanding/fear of the need for cancer screenings, and language /cultural barriers.

The role of Komen and the role of each Affiliate in Tennessee is as critical as it has always been. The Affiliate mission has not changed and the challenges faced by those the Affiliate has promised to help has not changed.

Georgia

Georgia also decided not to expand Medicaid under the Affordable Care Act of 2010. The Georgia Medicaid Program (PeachCare for adults, CHIP for children under 18) was undergoing a redesign to streamline services and reduce costs and administrative burden in 2010. Georgia did ultimately decide to participate in the Federally Facilitated Exchange (FFE). At the end of the open enrollment period, 316,543 individuals enrolled in the Marketplace. Enrollment in Medicaid and CHIP is open year round allowing Georgians to enroll as needed into the system. More than 1.6 million Georgians were eligible for the new health care plans under the ACA.

As of January 2014, in Georgia, Medicaid eligibility for non-disabled adults is limited to parents with incomes below 38.0 percent of the federal poverty level, or about $9,000 a year for a family of four, and adults without dependent children remain ineligible regardless of their income. All

states previously expanded eligibility for children to higher levels than adults through Medicaid and the Children's Health Insurance Program (CHIP), and in Georgia, children with family incomes up to 250 percent of poverty (about $59,300 for a family of four) are eligible for Medicaid or CHIP. As was the case before the ACA, undocumented immigrants will remain ineligible to enroll in Medicaid, and recent lawfully residing immigrants are subject to certain Medicaid eligibility restrictions (The Henry Kaiser Family Foundation, 2014).

The ACA will help many currently uninsured Georgians gain health coverage, but many who could have obtained financial assistance through the Medicaid expansion will remain outside its reach. Further, the impact of the ACA will depend on take-up of coverage among the eligible uninsured, and outreach and enrollment efforts will be an important factor in determining how the law affects the uninsured in the state. The ACA includes a requirement that most individuals obtain health coverage, but some people (such as the lowest income or those without an affordable option) are exempt and others may still remain uninsured. Notably, there is no deadline for state decisions about implementing the Medicaid expansion, and open enrollment in the Marketplaces continued through March 2014. Continued attention to who gains coverage as the ACA is fully implemented and who is excluded from its reach—as well as whether and how their health needs are being met—can help inform decisions about the future of health coverage in Georgia (The Henry Kaiser Family Foundation, 2014).

In a recent article from Georgia Health News dated July 14, 2014, Georgia was also among seven states to be investigated for a large backlog of approving eligible applicants for Medicaid (PeachCare). The letter from the Center for Medicaid Services dated July 9 indicated "a substantial backlog of pending applications." Georgia cited costs as a reason not to expand Medicaid. Yet an enrollment surge is still anticipated. That's because Georgia has tens of thousands of people who are already eligible for Medicaid or PeachCare but have not been getting it. Their names have emerged through the enrollment process in the ACA's insurance exchange, and under the health law's design, they would be referred to the two government health programs (Georgia Health News, July 14, 2014). Rural Georgians stand to gain the most from a Medicaid expansion according to the Georgia Budget and Policy Institute. In a policy brief published February 2014, Medicaid expansion could cover as many as 50.0 percent of uninsured adults ages 18 – 64. In the Affiliate priority counties of Fannin and Murray, this expansion would provide access to services for 47.2 percent more adults in Fannin and 49.3 percent more adults in Murray.

The decision by Georgia to not expand Medicaid impacts the health of many rural residents. Georgians with income above the federal poverty level will be eligible for subsidies to aid in the purchase of private health insurance. That income is $11,500 for individuals and $19,500 for a family of three. But those below the poverty level will not be eligible. The average poverty percentage among Georgia's rural counties was nearly 25.0 percent in 2011. So Georgia's decision not to expand Medicaid coverage creates a coverage gap that will, on average, leave close to 25.0 percent of rural Georgian's ages 18-64 without new coverage options (Georgia Budget and Public Policy Institute, 2013).

The limitations of rural Georgians to access health care will be important as the Affordable Care Act is implemented. The role of the Affiliate will be critical to provide access for women and men who would otherwise have no access to care.

Affiliate Public Policy Activities

Komen Chattanooga follows Komen Headquarters Public Policy Model guidelines in promoting the following advocacy priorities:

- Protecting federal and state funding for the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), to ensure all women have access to potentially lifesaving breast cancer screening;
- Ensuring continued federal investment in cancer research through the National Institutes of Health (NIH), National Cancer Institute (NCI) and Department of Defense (DOD), to discover and deliver the cures.
- Requiring insurance companies provide coverage for oral anti-cancer drugs on a basis that is no less favorable than what's already provided for intravenously-administered chemotherapy, to protect patients from high out-of-pocket costs; and
- Expanding Medicaid Coverage to ensure the availability of the full-range of breast health services to low-income women, including cancer screening, diagnostics and treatment.

Members of the Komen Chattanooga community (including board members, grantees, and race participants) are encouraged to join the efforts regarding these particular priorities. Komen Chattanooga plans to utilize the State Campaign Issues Toolkit in the coming years to better communicate advocacy priorities to legislators; and hopes to collaborate with other Tennessee Affiliates to schedule meetings with members of Congress whose districts correspond with the Affiliate's service area during their recess to discuss these issues.

Komen Chattanooga includes several advocacy activities in their annual mission plan. All elected officials will receive a copy of the completed community profile to inform them of the work Komen is doing in their service area. Also, local city and county mayors are invited to participate in the Race for the Cure® and are given an opportunity to say a few words to the participants before the start. Komen Chattanooga continues to have great support from political leaders, with Breast Cancer Awareness Month being endorsed state wide by Governor Bill Haslam. The Tennessee Affiliates meet twice per year to discuss legislation and visit the state capitol to visit state representatives and discuss Komen Advocacy priorities. The Affiliates have not been as active for the past couple of years but plan to re-engage in this activity in the spring of 2015.

The State of Tennessee has additional organizations furthering breast cancer advocacy, including the Tennessee Breast Cancer Coalition, the Tennessee Cancer Coalition, and American Cancer Society's Cancer Action Network.

In Georgia, the Affiliates have met as a group one time. The Affiliates work in a more loose relationship but pull together when working on an advocacy issue. Other organizations in the

state with interest in furthering breast health advocacy are Georgia Breast Cancer Coalition, American Cancer Society, and Georgia Cancer Coalition.

Health Systems and Public Policy Analysis Findings

The findings of the Health Systems and Public Policy emphasize the fact that many women and men are still in need of our services. The overall conclusion of the Health Systems Analysis revealed lots of resources exist for screening and lots of access points exist in the largest county – Hamilton County. In the more rural counties, there are very limited access points and often these access points are only entry into the larger systems of Hamilton County.

In order to keep women and men in the continuum of care, other issues such as transportation, time, and distance will impact the overall effectiveness of diagnosis, treatment, and ultimately, survivorship. The resources currently available to support a breast cancer patient along the continuum of care will not support the number of diagnoses expected. An example of these resources is the number of mammography units, those centers who are certified in breast cancer surgery, care and treatment. Quality of life and survivorship programs are also not up to the capacity needed with the expected diagnoses.

The largest factor affecting the Affiliate service area is the decision of both Tennessee and Georgia not to expand Medicaid. The large number of adults who will not qualify for either Medicaid or have enough income to qualify for the subsidy from the federal government will be a huge deterrent to reaching the overall HP2020 goals. The large number of adults who will remain uninsured must be served if breast cancer rates are moved toward the HP2020 goals. This very large gap will be the focus of Komen Chattanooga for the next four years.

Politically, Komen Chattanooga must make extra efforts to inform elected officials of the many dire circumstances that the Affiliate is finding of those in need of help. It will be crucial for the Affiliate to use every opportunity to educate the public, elected officials, and health care practitioners to affect the overall health of the four priority counties. The Affiliate must work in collaboration with other key stakeholders in the counties to make sure the message is heard. The Affiliate must be actively engaged with any legislation that goes up for a vote and has an impact on the quality of health care for breast cancer patients in Tennessee or Georgia.

Qualitative Data Sources and Methodology Overview

Methodology

Two collection methods were used to gather qualitative data in each of the priority communities. The resources for these methods were identified by the health system analysis conducted for each of the counties. The key assessment questions were chosen by the Community Profile Team to help understand each community's knowledge/understanding of breast health, breast cancer, medical access and utilization of services.

Key informant interviews were the best method of data collection for these target counties due to the remote/rural population areas and limited access to breast health services within the communities. Health care professionals, medical providers and breast cancer navigators were interviewed to determine the barriers, challenges, needs and gaps in service delivery as well as the programs and outreach initiatives that might help women access breast health services.

Document review was used as a method in the most remote target communities where access to specific services for breast health was less available. Service in these areas is largely provided by small satellite facilities that are part of larger health care systems in other counties.

Surveys were used in Hamilton County, TN to collect information from the target population in that county, Black/African-American women in low income zip codes. The questions were chosen to gather information about the ideas, beliefs, barriers, challenges and misconceptions that might prevent them from seeking or accessing medical services for breast health.

Sampling

Based on results from the health system analysis, the Community Profile Team identified key informants for interview. A list of stakeholders from the medical community in each target community was compiled and contact made based on the availability of the stakeholder. All key informants were individuals from the target areas who are regarded as experts on breast cancer related issues in their communities.

Larger, parent health systems to local, satellite general care facilities in the target areas were identified and explored for document review. Community health providers referred Komen Chattanooga to online documentation and their most recent community health system analysis for review and download.

Surveys were conducted in low-income, outreach areas of Hamilton County involving a total of 98 Black/African-American women from four different survey groups. Based on the quantitative data analysis, sections of Hamilton County were chosen as a target area due to the highest rates of late-stage diagnosis and high death rates for Black/African-American women in the Komen Chattanooga service area. Surveys were provided to Black/African-American women; ages 20-84 (with the majority of them in the 50-65 year old range) at local community women's group meetings. Requirements for participating in the survey were to be female, at least 18 years of age, and that the survey be completed and returned during the survey event.

Key Informant interviews and Document Reviews were the methods utilized for gathering data in Fannin, Murray and Rhea Counties. Key informant interviews were identified by researching the breast care medical services in each community. During the Key Informant interviews, resources for Document Review were requested and shared by the interview participant.

Ethics

Prior to key informant interviews, participants were read aloud a description of what the interview would consist of and how Komen Chattanooga would utilize gathered data. Participants were also read a consent statement explaining that participation was entirely voluntary, while stating that partaking in the study would in no way impact a relationship with, or services received, from the Affiliate. Key informants were made aware that the notes would be taken during the interview and that while some of the findings of the interview would be utilized; the discussion itself would remain confidential and anonymous. After the interview's conclusion, interviewers were read the notes and conclusions that had been made and the key informants were given the opportunity to edit or revise their statements. The key informants were then allowed to add any additional comments or conclusions. Key informants were then asked to verify that their statement had been captured and conveyed correctly.

All members of a survey group were given an overview of the purpose of the survey, the Community Profile project and the anonymity of their participation. Each survey participant was assured that while some information would be utilized in the Community Profile Report, and that they could be quoted directly, their names would not be published. They were also advised that consent would be implied with the return of the completed survey.

Data from key informant interviews and surveys have been securely stored in the Komen Chattanooga computer system. Backup of this data is kept on an external hard drive. All hard copy data, original notes and signed consent forms on paper have been filed in a secure cabinet in the Komen Chattanooga office.

Qualitative Data Overview

Qualitative data was collected through key informant interviews, surveys and document review. Questions were chosen for each county based on the analysis of the quantitative data and the health system analysis to determine the grass roots responses from participants. Questions were presented to key informants and notes were taken, confirmed and recorded with their consent and confirmation. These interviews were typed or scanned and saved into the Komen Chattanooga Mission computer for future reference, as needed.

Survey questions were presented to Hamilton County participants along with optional fields for race and age. The questions were consistent from survey group to survey group and included questions from several subject fields in the provided question bank. The groups chosen to participate were Black/African-American women who live or work in the targeted population of Hamilton County identified by zip codes. These survey groups were asked to complete and return the surveys during the survey event. The data from each group was then analyzed, compiled on a spread sheet, coded by response pattern and calculated by percentage of similar

answers. This process was then completed for the entire survey pool as a whole. The analysis of the collected data revealed four overarching themes: Lack of insurance, Inability to pay for screening, Lack of Knowledge/Misinformation, Cultural desire for privacy/modesty.

Fannin County

Key informant interview and document review were used to gather data in Fannin County. Access to medical providers with an expertise in breast cancer was extremely limited in this target area. The key informant interview conducted with a Health Clinic worker resulted in information being more applicable to general health issues. The Quantitative Data Report from the Susan G. Komen Community Profile proved to be the most current and comprehensive data to be located. Other requests for document review produced no results. The largest factors identified are the lack of Education/Awareness, Access, and Lack of Insurance/Ability to Pay.

Education/Awareness

Key informant comments verified that they are unaware of any specific educational programs or support groups for breast health. The response to the question of what might prevent women in this community from receiving mammography was:

- "They think it will hurt"

Access

Local Health Clinics in this county are satellites of a larger Atlanta based health system. Services for those diagnosed with breast cancer are referred to various outside areas:

- "There is not a facility that can do breast MRI, those have to be referred to Canton, GA or Cleveland, TN. Chemo can be given at Georgia Cancer Specialist – Northside and radiation patients are referred to Blairsville, GA. There is a Cancer Center in Blue Ridge GA, also"

Lack of Insurance/Ability to Pay

In the remote-rural county of Fannin, 49 percent of the population is below 250 percent of poverty. Key informant interviews report that this is a barrier to screening and treatment as:

- "…there are a lot of uninsured patients and self-pay is required for services"

Murray County

Key Informant Interviews and Document Review were used to gather data in this rural county. Health care professionals from local Health Care clinics were interviewed to determine the population of need, barriers to screening and challenges to access services. The key factors determined by this data were; Outreach/Education, Lack of Insurance/Ability to Pay and Access.

Outreach/Education/Awareness

An increasing Hispanic/Latino population presents the need for cultural outreach that would provide bi-lingual education about breast health/awareness. Key Informant Interview responses highlight concerns about breast health education and the cultural barriers to care.

Lack of Insurance/Ability to Pay

This community, which is predominantly made up of Hispanic/Latino and White residents has limited access to low-cost or free services. Key needs for this community surround the issues of unemployment, poverty and access.

Murray County has limited access to specialized care beyond general health services. Document review of the Georgia Trends 2013 Hospital Ranking show Murray County's hospital ranked number 32 of 41 in the small hospital category.

- Georgia Trend's 2013 hospital rankings divide 138 of the state's hospitals into five separate categories: Teaching Hospitals, Large Hospitals (more than 400 beds), Medium-sized Hospitals (151-399 beds), Small Hospitals (fewer than 150 beds) and Critical Access Hospitals (rural community hospitals).

Key informant interviews confirmed the lack of access to service for Murray County residents.

- "We have to send folks to walk-in clinics because the local hospital has been bought by a for-profit group. Payment is required up-front. Distance to the hospital in the adjacent county is an issue – gas, no money, childcare limitations…after screening, women have to be sent elsewhere for follow-up. There are no breast cancer specialists in this county."

There is also a challenge in accessing more specialized medical services after breast cancer is diagnosed.

- "Once diagnosed, there is nowhere to go in this county. All breast cancer treatment are performed outside the county."

Rhea County

Rhea County is a remote-rural area, only recently the home of a full-service medical center. Most residents in this community are accustomed to traveling for medical services beyond general care. Lack of access to services has been a major barrier. Educating the population about utilizing services and resources is the current focus of this new medical community. Data collection showed that the key factors to address in this county are; outreach/education/awareness, lack of insurance/ability to pay.

The information gathered from the two Key informant interviews and document review revealed that there is need to serve the Hispanic/Latino population in this county as well as the remote-rural population. This county is a rural farming community and attracts seasonal migrant workers. Summer migrant clinics offer services on a sliding pay scale to the uninsured and underinsured during the summer months. Local residents who live in the community year round have concerns about access to services when the migrant clinic is closed.

Statements from the document review of the "2013 Community Health Needs Assessment and Implementation Plan, Rhea County" support the determined barriers to breast health. (Rhea Medical Center, Dayton, TN, 2013)

- "…area residents participated in a survey asking opinions about their perception of local health care needs. In descending order of opinion, five topics were identified as being of "Major Concern" or "Most Important Issue to Resolve":

  1. Lack of insurance – 76 percent listed as a major concern
  2. Access to affordable care – 53 percent listed as a major concern
  3. Lifestyle health education and practice – 47 percent listed as a major concern

  (Conclusions from Public Input to Community Health Needs Assessment, 2013)

- "Mammography screening (in Rhea County) is below Tennessee and the national benchmark, an adverse finding."
  (Conclusions from Public Input to Community Health Needs Assessment, 2013)

Hamilton County

A total of four survey events were held in Hamilton County. Surveys were presented to a total of 98 participants, Black/African-American women between the ages of 20-84. The survey included questions about attitudes, beliefs and understanding of breast health/breast cancer, screening, outreach resources and access to care. The analysis of the collected data revealed three overarching themes: lack of insurance/inability to pay for screening, lack of knowledge/misinformation, cultural/desire for privacy/modesty. This information was consistent with the responses from the Key Informant Interview conducted with a Breast Specialist/Nurse Navigator from a local major health care system.

Lack of Insurance/Inability to Pay

While the targeted population in this county is surrounded by three major hospital systems, and 76.0 percent of the sampling responded that they were aware of where to seek services, the lack of insurance was reported by 30.0 percent of those surveyed as to a major barrier for screening (Table 4.1). Inability to pay was the third largest response to this question, at 26.0 percent.

Table 4.1. Survey responses

Factors That Affect Seeking Breast Health Services?

Answers	Code: 105	Results	Percentage
Lack of Insurance	105.01	29	30%
Money	105.02	25	26%
Lack of Knowledge	105.03	13	13%
Fear (of knowing, doctors)	105.04	27	28%
Transportation	105.05	7	7%
Mammogram (uncomfortable)	105.06	2	2%
Not Sure	105.07	6	6%
Won't Happen to Me	105.08	1	1%
Not Important/ Too Busy	105.09	8	8%
No Support	105.10	4	4%

Lack of Knowledge/Information

The compiled survey results revealed that 41.0 percent of those surveyed believed that breast cancer was an inherited disease. Twenty-eight percent of this same survey sampling believed that breast cancer was caused by external influences; chemicals, smoking, drugs, birth-control and other environmental exposures. (See Table 4.2)

Table 4.2. Survey responses

What Causes Cancer?

Answers	Code: 101	Results	Percentage
Unknown	101.01	14	14%
Family History/Genetics	101.02	40	41%
Diet/Nutrition	101.03	18	18%
Stress	101.04	6	6%
Exercise	101.05	8	8%
Chemicals (Smoking, Drugs, Birth-Control, Environmental)	101.06	27	28%
Lack of Attention to Health	101.07	3	3%
Lack of Knowledge/Info	101.08	3	3%
Variety of Things	101.09	6	6%
Abnormal Cell Growth/Hormones	101.10	17	17%

Cultural/Desire for Privacy/Modesty

Of those surveyed, 60.0 percent shared that they would not share/discuss their breast health concerns or conditions outside the family. Only 47.0 percent responded that they felt a family member would tell them if they had concerns about their breast health.

A Key Informant interview with a local breast cancer nurse navigator supported this data. When asked about the types of patients that have problems accessing services, the response was:

- *"*The low-income patients from local health clinics are not comfortable associating the clinics with the larger medical systems. When, after screening, they are referred for further testing or diagnostics, they become fearful of the cost and do not follow through. Often they do not even share with friends or family that there is a concern and it goes untreated."

<u>Qualitative Data Findings</u>

Using the Healthy People 2020 goals of reducing both death and late-stage diagnosis of breast cancer throughout the Affiliate service area, four counties were selected as target areas for emphasis and funding. The key questions and resources used for gathering data in the Qualitative Data Report were selected based on the initial conclusions drawn from the information in the Quantitative Data Reports and the Health System and Public Policy Analysis. Key informant interviews, document review and population sampling surveys were determined

to be the best tools for gauging the grass roots community perceptions of the current knowledge of breast health, barriers that prevent screening, and the needs of the target communities.

Strengths
Key informant interviews allowed for interactive conversation and detailed comments. Document review was helpful in the instances where direct access to interview subjects or surveying was not an option. The survey groups were extremely valuable in giving insight to the perception of the target population in a way that afforded them the opportunity to be truthful with anonymity.

Survey groups were also a method to educate the sample group about the purpose of the Community Profile and the role it plays in determining the impact of Komen grant funding in the Affiliate service area.

Weaknesses
The counties that ranked the highest for priority needs were also the counties that proved the hardest to evaluate and gather current data from. The lack of medical service facilities, lack of breast health education/knowledge and limited access to breast health specific professionals presented a challenge in gathering current data from knowledgeable resources in some of the target areas.

Conclusions
The responses from the survey participants in Hamilton County, where 41.0 percent of those surveyed thought that breast cancer was an inherited disease and 28.0 percent listed fear as a barrier to being screened, show a need for increased breast health education. Information gathered from Key Informant Interviews and Document Reviews in Fannin, Murray and Rhea Counties were all consistent in the need for local access to affordable services. Based on this Qualitative Data, it is evident that the key factors to address in these target areas are; Education/Outreach/Awareness, Lack of Insurance/Ability to Pay, and Access to Services.

In the target areas, including those where breast health services are accessible, there is still a lack of understanding the importance of screening as well as where and how to access services and utilize available resources.

Breast Health and Breast Cancer Findings of the Target Communities

Susan G. Komen Chattanooga has identified four counties as target communities for priority focus within our 16 county service area for the 2015 Community Profile.

The Healthy People 2020 (HP2020) federal government initiative, along with the review of the Quantitative and Qualitative Data Reports provided by Susan G. Komen, and other local community resources determined the target communities of Fannin and Murray Counties in NW Georgia and Hamilton and Rhea Counties in SE Tennessee. Determining factors for these target communities are high percentages of breast cancer diagnosis, late-stage breast cancers and high breast cancer death rates. These counties also ranked high in the Komen Chattanooga service area for unemployment, lack of insurance and lack of access to services. Murray County has a substantial Hispanic/Latino population and Hamilton County has the highest Black/African-American population in the Komen Chattanooga service area.

Fannin, Hamilton, Murray, and Rhea Counties are not likely to meet the HP2020 late-stage target. Hamilton County had the highest late-stage incidence rate in the service area. Hamilton County and Rhea county late-stage incidence rates are both higher than the State of Tennessee and the US average with Rhea County having an increasing annual trend of 11.2 percent.

Fannin County late-stage incidence rates are below both the State of Georgia and the US average. Murray County late-stage incidence rates are below the US average and only slightly below the US average, but report an annual trend increase of 17.5 percent, which result in the prediction that Murray County will not meet the HP2020 target for late-stage incidence.

Hamilton County has a death rate of 21.5 percent, a downward annual trend of -2.5 percent and is predicted to reach the HP2020 target for death rate in two years. The death rate and trend data were not available for Fannin, Murray and Rhea Counties due to the low number of deaths that occur in these counties. Therefore, the number of years it would take to reach the HP2020 target is not predictable.

Hamilton County is a large county made up of 22 incorporated and unincorporated cities. Hamilton County has a large medical community with four distinct hospital systems, two of which have specific centers dedicated to breast health. Each of these hospitals has satellite offices spread throughout the county, offering multiple access points of service for residents. Although there are services available and several locations to access service, within this county there is still a lack of education, transportation and ability to pay that inhibit breast care.

Fannin and Murray Counties both have regional hospitals with no local options for chemotherapy, radiation, reconstruction and counseling. Local health clinics serve as the main entry point for health services to those who are uninsured and underinsured. Once diagnosed, patients have to travel to neighboring counties for specialized treatment service, creating a financial hardship on families that are already economically challenged due to high unemployment and under-employment.

In November 2013, Rhea County opened a new state of the art medical facility, Rhea Medical Center. This facility is accredited by the American College of Radiology Breast Imaging Center of Excellence and offers the latest digital mammography. Although too new to impact current statistical data, the new facility in this area that was formerly without access to local services should result in improved late-stage diagnosis and death rates for this target area. Prior to 2013, the primary health service providers were a local health department and a primary health care center.

Information gathered from surveys, key informant interviews and document reviews in these target counties identified a lack of education, lack of access to care, being uninsured/underinsured and without the ability to pay as barriers for breast health services for women and men in these communities.

The feedback from surveys identified that there is a large amount of misunderstanding, cultural beliefs and fear surrounding breast health, breast cancer and treatment. There is also a lack of understanding about how and where to access low-cost or no-cost care. Key informant interviews confirmed that transportation, ability to pay, unemployment and lack of insurance are key reasons why patients are not seeking regular screening or medical treatment. Document review confirmed that local medical systems are general health centric, and not equipped to meet the needs after a diagnosis is made.

Mission Action Plan

PROBLEM STATEMENT 1. According to the quantitative data report for the Komen Chattanooga, women in Murray, Hamilton, and Rhea Counties have higher than average rates for late-stage breast cancer diagnosis, compared to the US average. Fannin County has a higher than average rate of breast cancer death, compared to the US average. These statistics suggest a need for breast health education and services in these four counties.

Priority 1. Address the need for outreach education about breast health and breast health services to women and men in all four target communities.

Objective 1: Provide a Breast Health Education Toolkit to at least three local health care providers in each target community that includes information about breast health, breast cancer, self-awareness and co-survivor support in FY16.

Objective 2: Provide at least three local health care providers in each target community with a listing of online accessible Komen Educational Materials that can be downloaded and reproduced for distribution in FY16.

Objective 3: Attend at least one community event in each of the four target communities to represent/speak about the Komen Mission and share information about breast health awareness and breast health information FY17.

Priority 2. Increase the understanding of where and how to access Komen funded services for screening, mammography and diagnostics.

Objective 1: Provide health departments/clinics in the four target communities with a listing of Komen Chattanooga funded service providers that can be accessed for low-cost or no-cost screening and diagnostic needs in FY16 and updated in FY17 and FY18.

Objective 2: Contact health care providers in each target community with a specific invitation for the Komen Chattanooga Grant Writing Workshop and encourage them to write for Komen Chattanooga Community Grant funding in fall FY16

Objective 3: Feature a "Grantee in the Spotlight" section in the Affiliate newsletter to highlight each of our grantees over the course of the FY16 fiscal year. This will be updated and continued as the grant cycle changes in FY17 and FY18.

PROBLEM STATEMENT 2. Key informant interviews and survey reports indicated that there are cultural beliefs, fearful thinking and misinformation surrounding breast health that inhibit regular breast screening and mammography for women in the target communities.

Priority 1. Leverage technology to address misinformation in the target communities.

Objective 1: Include a re-occurring section in the bi-weekly e-newsletter to share correct information and messaging that is focused on specific high risk populations, including the large Black/African-American demographic in Hamilton County and the growing number of Hispanic/Latina women in Murray County that were identified in the quantitative data report.

Objective 2: Schedule weekly messaging through social media outlets; Facebook, Twitter, Instagram, etc.; to share the latest information about breast health and dispel the myths that are preventing women and men from seeking preventative and diagnostic breast health services in FY16.

Priority 2. Redesign affiliate specific marketing materials to promote breast health education and awareness in the target communities.

Objective 1: Create an Affiliate specific marketing-education infographic by FY17 that includes a "Myth Busters" or "Did You Know" message with images of people that depict a diverse population mirroring the affiliate demographics to be distributed at community health fairs, expos, and to the clients of our affiliate grantees.

Objective 2: Prepare a presentation that addresses the fear based thinking that prevents early detection and results in late-stage diagnosis and higher death rates as they apply to the specific population of Black/African-American and Hispanic/Latina women and men to be presented to at least six of the October 2016 speaker requested events. This will be repeated in FY17 and FY18.

Objective 3: Re-design the two display boards used at health fairs and community events in FY16 to visually reinforce correct information and dispel some of the fear that is created by misinformation.

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