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University of Louisville College of Business Professor

**MBA Consultants Program**  
University of Louisville College of Business

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University of Louisville | MBA Consultants (Team 2)

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Affiliate History

Since 1982, Susan G. Komen® (Komen) has dedicated billions of dollars globally toward the elimination of breast cancer and mitigation of its effects. The founder, Nancy G. Brinker, named the foundation for her sister who lost her fight to breast cancer after diagnosis at just 33 years of age. Komen now addresses breast cancer on a continuum to include advocacy, research, education, outreach, screening, treatment and survivor support. Komen’s reach has expanded to over 50 nations worldwide and continues to grow; each Komen-covered region has its own division. The primary division for the Ohio Valley region is Komen Louisville (KL).

KL began in Louisville, KY in 1996; its emergence happened at the same time the Junior League hosted the inaugural Komen Race for the Cure®. In 1999, the local Affiliate was founded and various programs, events and services rolled out to the community. The annual Pink Tie Ball, an event to raise funds for the foundation, became the second annual fundraiser on KL’s official schedule in 2005. To date, KL has contributed over $6 million dollars to community services and $2.1 million dollars to cancer research. KL’s services include breast cancer education, breast cancer screening support, treatment support, survivor support, special events, fundraisers, research contributions and grant offerings.

Affiliate Organizational Structure

The Board of Directors functions to advise assist and aid in efforts to support breast cancer education and outreach programs serving the service area of Komen Louisville. Komen Louisville has 11 members that represent the Affiliate service area as Board of Directors. The Affiliate has an Executive Director and part time Finance Coordinator.

Affiliate Service Area

The service area of KL includes 15 counties in Kentucky (Breckinridge, Bullitt, Grayson, Hardin, Jefferson, LaRue, Meade, Oldham, Nelson, Shelby and Spencer) and Indiana (Clark, Floyd, Harrison and Scott) (Figure 1.1). KL is projected to benefit upwards of 57,000 local lives in 2014, with over 4,000 locals receiving breast cancer education, over 3,800 receiving breast cancer screenings, over 600 receiving treatment support, over 100 survivors receiving support and an additional 48,000 being educated via special events. The KL impact is expanded further through its grant offerings. Some current grantees are as follows:

- KentuckyOne Health - Jewish Hospital and St. Mary’s Foundation
  - Reducing health disparities through outreach screening and diagnosis
- KentuckyOne Health - Jewish Hospital and St. Mary’s Foundation
  - Serving the needs of uninsured, underinsured and single, low-income breast patients
- University of Louisville Research Foundation, Kentucky Cancer Program
  - Mammography screening and survivor support for low-income women, primarily African-American
Despite the great strides KL has made since its inception, the organization continually strives to meet the needs of yet-identified populations and remain effective within the ever changing policy climate. KL approached the University of Louisville MBA program to for assistance on how to better meet the needs of five target constituencies and assess how recent policy alterations will affect its services.

Figure 1.1. Susan G. Komen Louisville service area
Purpose of the Community Profile Report

The Community Profile will allow Komen Louisville to:

- Include a broad range of people and stakeholders in the Affiliate’s work and become more diverse
- Fund, educate and build awareness in the areas of greatest need
- Make data-driven decisions about how to use its resources in the best way – to make the greatest impact
- Strengthen relationships with sponsors by clearly communicating the breast health and breast cancer needs of the community
- Provide information to public policymakers to assist focusing their work
- Strategize direction to marketing and outreach programs toward areas of greatest need
- Create synergy between Mission-related strategic plans and operational activities
Quantitative Data Report

Introduction
The purpose of the quantitative data report for Susan G. Komen® Louisville 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 Louisville’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

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Incidence Rates and Trends</th>
<th>Death Rates and Trends</th>
<th>Late-stage Rates and Trends</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female Population</td>
<td># of New Cases / 100,000</td>
<td>Age-Adjusted Rate 100,000</td>
</tr>
<tr>
<td>US</td>
<td>154,540,194</td>
<td>182,234</td>
<td>122.1</td>
</tr>
<tr>
<td>HP2020</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indiana</td>
<td>3,260,368</td>
<td>4,287</td>
<td>117.4</td>
</tr>
<tr>
<td>Kentucky</td>
<td>2,179,870</td>
<td>3,056</td>
<td>121.3</td>
</tr>
<tr>
<td>Komen Louisville Service Area</td>
<td>712,597</td>
<td>1,058</td>
<td>129.5</td>
</tr>
<tr>
<td>White</td>
<td>595,769</td>
<td>929</td>
<td>130.0</td>
</tr>
<tr>
<td>Black/African-American</td>
<td>101,682</td>
<td>120</td>
<td>132.1</td>
</tr>
<tr>
<td>American Indian/Alaska Native (AIAN)</td>
<td>2,385</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>Asian Pacific Islander (API)</td>
<td>12,761</td>
<td>7</td>
<td>60.2</td>
</tr>
<tr>
<td>Non-Hispanic/ Latina</td>
<td>690,475</td>
<td>1,050</td>
<td>130.4</td>
</tr>
<tr>
<td>Hispanic/ Latina</td>
<td>22,122</td>
<td>7</td>
<td>77.1</td>
</tr>
<tr>
<td>Clark County - IN</td>
<td>54,876</td>
<td>85</td>
<td>132.3</td>
</tr>
<tr>
<td>Floyd County - IN</td>
<td>37,982</td>
<td>45</td>
<td>104.4</td>
</tr>
<tr>
<td>Harrison County - IN</td>
<td>19,331</td>
<td>22</td>
<td>98.1</td>
</tr>
<tr>
<td>Scott County - IN</td>
<td>12,164</td>
<td>14</td>
<td>100.5</td>
</tr>
<tr>
<td>Breckinridge County - KY</td>
<td>9,965</td>
<td>12</td>
<td>93.4</td>
</tr>
<tr>
<td>Bullitt County - KY</td>
<td>36,591</td>
<td>54</td>
<td>136.3</td>
</tr>
<tr>
<td>Grayson County - KY</td>
<td>12,647</td>
<td>16</td>
<td>100.4</td>
</tr>
<tr>
<td>Hardin County - KY</td>
<td>50,664</td>
<td>68</td>
<td>126.0</td>
</tr>
<tr>
<td>Jefferson County - KY</td>
<td>378,103</td>
<td>610</td>
<td>136.8</td>
</tr>
<tr>
<td>Larue County - KY</td>
<td>7,113</td>
<td>8</td>
<td>88.8</td>
</tr>
<tr>
<td>Meade County - KY</td>
<td>14,425</td>
<td>15</td>
<td>111.5</td>
</tr>
<tr>
<td>Nelson County - KY</td>
<td>21,564</td>
<td>31</td>
<td>134.0</td>
</tr>
<tr>
<td>Oldham County - KY</td>
<td>27,812</td>
<td>38</td>
<td>133.2</td>
</tr>
<tr>
<td>Shelby County - KY</td>
<td>21,205</td>
<td>29</td>
<td>124.6</td>
</tr>
<tr>
<td>Spencer County - KY</td>
<td>8,156</td>
<td>9</td>
<td>118.5</td>
</tr>
</tbody>
</table>

*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 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 Louisville service area were higher than that observed in the US as a whole. The incidence rate of the Affiliate service area was significantly higher than that observed for the State of Indiana and the incidence trend was not significantly different than the State of Indiana. The incidence rate of the Affiliate service area was significantly higher than that observed for the State of Kentucky and the incidence trend was not significantly different than the State of Kentucky.

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 slightly higher among Blacks/African-Americans than Whites and lower among APIs than Whites. There were not enough data available within the Affiliate service area to report on AIANs so comparisons cannot be made for this racial group. The incidence rate among Hispanics/Latinas was lower than among Non-Hispanics/Latinas.

The incidence rate was significantly lower in the following counties:
- Floyd County, IN
- Harrison County, IN
- Breckinridge County, KY
- Larue County, KY

The rest of the counties had incidence rates and trends that were not significantly different than the Affiliate service area as a whole.

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

Death rates and trends summary
Overall, the breast cancer death rate in the Komen Louisville 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 Indiana. The death rate of the Affiliate service area was not significantly different than that observed for the State of Kentucky.

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.

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

**Late-stage incidence rates and trends summary**

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

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*

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

*As of October 2015

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

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

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

- The number of women living in an area whom the BRFSS determines should have mammograms (i.e. women age 50 to 74).
- The number of these women who actually had a mammogram during the past two years.
The number of women who had a mammogram is divided by the number who should have had one. For example, if there are 500 women in an area who should have had mammograms and 250 of those women actually had a mammogram in the past two years, the mammography screening proportion is 50.0 percent.

Because the screening proportions come from samples of women in an area and are not exact, Table 2.3 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

<table>
<thead>
<tr>
<th>Population Group</th>
<th># of Women Interviewed (Sample Size)</th>
<th># w/ Self-Reported Mammogram</th>
<th>Proportion Screened (Weighted Average)</th>
<th>Confidence Interval of Proportion Screened</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>174,796</td>
<td>133,399</td>
<td>77.5%</td>
<td>77.2%-77.7%</td>
</tr>
<tr>
<td>Indiana</td>
<td>3,249</td>
<td>2,306</td>
<td>69.5%</td>
<td>67.5%-71.5%</td>
</tr>
<tr>
<td>Kentucky</td>
<td>4,570</td>
<td>3,422</td>
<td>74.6%</td>
<td>72.9%-76.3%</td>
</tr>
<tr>
<td>Komen Louisville Service Area</td>
<td>1,089</td>
<td>853</td>
<td>75.9%</td>
<td>72.5%-79.0%</td>
</tr>
<tr>
<td>White</td>
<td>641</td>
<td>475</td>
<td>75.3%</td>
<td>71.1%-79.0%</td>
</tr>
<tr>
<td>Black/African-American</td>
<td>420</td>
<td>359</td>
<td>84.8%</td>
<td>78.8%-89.3%</td>
</tr>
<tr>
<td>AIAN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>API</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>Hispanic/ Latina</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>Non-Hispanic/ Latina</td>
<td>1,072</td>
<td>842</td>
<td>76.1%</td>
<td>72.7%-79.2%</td>
</tr>
<tr>
<td>Clark County - IN</td>
<td>35</td>
<td>30</td>
<td>80.9%</td>
<td>62.9%-91.4%</td>
</tr>
<tr>
<td>Floyd County - IN</td>
<td>22</td>
<td>15</td>
<td>71.4%</td>
<td>48.0%-87.1%</td>
</tr>
<tr>
<td>Harrison County - IN</td>
<td>15</td>
<td>11</td>
<td>70.9%</td>
<td>40.5%-89.7%</td>
</tr>
<tr>
<td>Scott County - IN</td>
<td>12</td>
<td>7</td>
<td>60.3%</td>
<td>31.4%-83.4%</td>
</tr>
<tr>
<td>Breckinridge County - KY</td>
<td>17</td>
<td>13</td>
<td>78.9%</td>
<td>49.7%-93.4%</td>
</tr>
<tr>
<td>Bullitt County - KY</td>
<td>19</td>
<td>15</td>
<td>80.0%</td>
<td>53.3%-93.4%</td>
</tr>
<tr>
<td>Grayson County - KY</td>
<td>30</td>
<td>23</td>
<td>72.7%</td>
<td>51.4%-87.0%</td>
</tr>
<tr>
<td>Hardin County - KY</td>
<td>106</td>
<td>76</td>
<td>67.9%</td>
<td>55.0%-78.6%</td>
</tr>
<tr>
<td>Jefferson County - KY</td>
<td>731</td>
<td>583</td>
<td>76.3%</td>
<td>72.0%-80.0%</td>
</tr>
<tr>
<td>Larue County - KY</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>Meade County - KY</td>
<td>26</td>
<td>24</td>
<td>93.0%</td>
<td>69.7%-98.7%</td>
</tr>
<tr>
<td>Nelson County - KY</td>
<td>38</td>
<td>26</td>
<td>69.7%</td>
<td>48.2%-85.0%</td>
</tr>
<tr>
<td>Oldham County - KY</td>
<td>10</td>
<td>7</td>
<td>75.8%</td>
<td>40.9%-93.4%</td>
</tr>
<tr>
<td>Shelby County - KY</td>
<td>14</td>
<td>12</td>
<td>87.0%</td>
<td>61.0%-96.6%</td>
</tr>
<tr>
<td>Spencer County - KY</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
</tbody>
</table>

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

**Breast cancer screening proportions summary**

The breast cancer screening proportion in the Komen Louisville service area was not significantly different than that observed in the US as a whole. The screening proportion of the Affiliate service area was significantly higher than the State of Indiana and was not significantly different than the State of Kentucky.
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>
<thead>
<tr>
<th>Population Group</th>
<th>White</th>
<th>Black /African-American</th>
<th>AIAN</th>
<th>API</th>
<th>Non-Hispanic /Latina</th>
<th>Hispanic /Latina</th>
<th>Female Age 40 Plus</th>
<th>Female Age 50 Plus</th>
<th>Female Age 65 Plus</th>
</tr>
</thead>
<tbody>
<tr>
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<td>1.4%</td>
<td>5.8%</td>
<td>83.8%</td>
<td>16.2%</td>
<td>48.3%</td>
<td>34.5%</td>
<td>14.8%</td>
</tr>
<tr>
<td>Indiana</td>
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<td>0.4%</td>
<td>1.9%</td>
<td>94.2%</td>
<td>5.8%</td>
<td>48.0%</td>
<td>34.6%</td>
<td>14.8%</td>
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<tr>
<td>Kentucky</td>
<td>89.8%</td>
<td>8.5%</td>
<td>0.3%</td>
<td>1.4%</td>
<td>97.2%</td>
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<td>35.6%</td>
<td>15.2%</td>
</tr>
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<td>0.3%</td>
<td>1.9%</td>
<td>96.4%</td>
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<td>35.3%</td>
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<td>95.7%</td>
<td>4.3%</td>
<td>49.2%</td>
<td>35.5%</td>
<td>14.6%</td>
</tr>
<tr>
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<td>1.2%</td>
<td>97.6%</td>
<td>2.4%</td>
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<td>14.7%</td>
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<td>0.6%</td>
<td>98.5%</td>
<td>1.5%</td>
<td>52.3%</td>
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<td>98.5%</td>
<td>0.7%</td>
<td>0.2%</td>
<td>0.7%</td>
<td>98.7%</td>
<td>1.3%</td>
<td>51.1%</td>
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<td>0.7%</td>
<td>98.6%</td>
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<td>Grayson County - KY</td>
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<td>0.2%</td>
<td>0.3%</td>
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<td>51.5%</td>
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</tr>
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<td>3.1%</td>
<td>95.0%</td>
<td>5.0%</td>
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<td>12.7%</td>
</tr>
<tr>
<td>Jefferson County - KY</td>
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<td>22.5%</td>
<td>0.3%</td>
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<td>96.0%</td>
<td>4.0%</td>
<td>49.5%</td>
<td>36.2%</td>
<td>15.5%</td>
</tr>
<tr>
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<td>0.3%</td>
<td>97.7%</td>
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<td>18.4%</td>
</tr>
<tr>
<td>Meade County - KY</td>
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<td>4.5%</td>
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<td>1.1%</td>
<td>96.4%</td>
<td>3.6%</td>
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<tr>
<td>Nelson County - KY</td>
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<td>0.6%</td>
<td>98.2%</td>
<td>1.8%</td>
<td>48.7%</td>
<td>33.8%</td>
<td>13.1%</td>
</tr>
<tr>
<td>Oldham County - KY</td>
<td>94.8%</td>
<td>3.2%</td>
<td>0.2%</td>
<td>1.8%</td>
<td>96.9%</td>
<td>3.1%</td>
<td>50.2%</td>
<td>31.9%</td>
<td>10.5%</td>
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<tr>
<td>Shelby County - KY</td>
<td>89.9%</td>
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<td>Spencer County - KY</td>
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<td>98.5%</td>
<td>1.5%</td>
<td>49.5%</td>
<td>32.0%</td>
<td>11.2%</td>
</tr>
</tbody>
</table>

Data are for 2011.
Data are in the percentage of women in the population.
Source: US Census Bureau – Population Estimates
Table 2.5. Population characteristics – socioeconomics

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Less than HS Education</th>
<th>Income Below 100% Poverty</th>
<th>Income Below 250% Poverty (Age: 40-64)</th>
<th>Unemployed</th>
<th>Foreign Born</th>
<th>Linguistically Isolated</th>
<th>In Rural Areas</th>
<th>In Medically Under-served Areas</th>
<th>No Health Insurance (Age: 40-64)</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>14.6%</td>
<td>14.3%</td>
<td>33.3%</td>
<td>8.7%</td>
<td>12.8%</td>
<td>4.7%</td>
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<td>23.3%</td>
<td>16.6%</td>
</tr>
<tr>
<td>Indiana</td>
<td>13.4%</td>
<td>14.1%</td>
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<td>9.0%</td>
<td>4.5%</td>
<td>1.8%</td>
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<td>15.6%</td>
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<td>Kentucky</td>
<td>18.3%</td>
<td>18.1%</td>
<td>39.3%</td>
<td>8.9%</td>
<td>3.1%</td>
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<td>9.1%</td>
<td>4.4%</td>
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</tr>
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<td>Clark County - IN</td>
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<td>8.2%</td>
<td>3.6%</td>
<td>1.4%</td>
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<td>28.0%</td>
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<td>2.3%</td>
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<td>20.3%</td>
<td>0.0%</td>
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</tr>
<tr>
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<td>8.7%</td>
<td>1.2%</td>
<td>0.2%</td>
<td>85.8%</td>
<td>0.0%</td>
<td>15.5%</td>
</tr>
<tr>
<td>Scott County - IN</td>
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<td>43.3%</td>
<td>13.4%</td>
<td>1.1%</td>
<td>0.6%</td>
<td>52.7%</td>
<td>100.0%</td>
<td>15.3%</td>
</tr>
<tr>
<td>Breckinridge County - KY</td>
<td>23.3%</td>
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<td>48.4%</td>
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<td>0.4%</td>
<td>0.3%</td>
<td>100.0%</td>
<td>0.0%</td>
<td>19.7%</td>
</tr>
<tr>
<td>Bullitt County - KY</td>
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<td>10.0%</td>
<td>32.1%</td>
<td>8.5%</td>
<td>1.1%</td>
<td>0.3%</td>
<td>30.4%</td>
<td>100.0%</td>
<td>14.5%</td>
</tr>
<tr>
<td>Grayson County - KY</td>
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<td>12.6%</td>
<td>0.5%</td>
<td>0.2%</td>
<td>73.6%</td>
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</tr>
<tr>
<td>Hardin County - KY</td>
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<td>35.5%</td>
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<td>4.2%</td>
<td>1.1%</td>
<td>34.2%</td>
<td>6.2%</td>
<td>14.4%</td>
</tr>
<tr>
<td>Jefferson County - KY</td>
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<td>33.8%</td>
<td>9.5%</td>
<td>6.0%</td>
<td>2.0%</td>
<td>1.4%</td>
<td>18.1%</td>
<td>15.1%</td>
</tr>
<tr>
<td>Larue County - KY</td>
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<td>41.8%</td>
<td>8.1%</td>
<td>1.5%</td>
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<td>76.0%</td>
<td>100.0%</td>
<td>17.9%</td>
</tr>
<tr>
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<td>40.2%</td>
<td>10.5%</td>
<td>1.6%</td>
<td>0.9%</td>
<td>85.9%</td>
<td>100.0%</td>
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</tr>
<tr>
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<td>1.5%</td>
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<tr>
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<td>15.3%</td>
<td>6.1%</td>
<td>4.0%</td>
<td>0.8%</td>
<td>20.3%</td>
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<tr>
<td>Shelby County - KY</td>
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<td>5.8%</td>
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<td>47.0%</td>
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<tr>
<td>Spencer County - KY</td>
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<td>25.9%</td>
<td>9.5%</td>
<td>1.1%</td>
<td>0.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>13.1%</td>
</tr>
</tbody>
</table>

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

**Population characteristics summary**
Proportionately, the Komen Louisville service area has a slightly larger White female population than the US as a whole, a slightly larger 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 about the same age as that of the US as a whole. The Affiliate’s education level is slightly higher 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 substantially smaller percentage of people who are linguistically isolated. There are a slightly larger percentage of people living in rural areas, a slightly smaller percentage of people without health insurance, and a slightly larger percentage of people living in medically underserved areas.

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

The following counties have substantially lower education levels than that of the Affiliate service area as a whole:
- Scott County, IN
- Breckinridge County, KY
- Grayson County, KY
- Larue County, KY

The following counties have substantially lower income levels than that of the Affiliate service area as a whole:
- Breckinridge County, KY
- Grayson County, KY

The following counties have substantia[l lower employment levels than that of the Affiliate service area as a whole:
- Scott County, IN
- Breckinridge County, KY
- Grayson County, KY

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 Louisville 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

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

If the time to achieve a target cannot be calculated for one of the HP2020 indicators, then the county is classified based on the other indicator. If both indicators are missing, then the county is not classified. This 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 Louisville service area with predicted time to achieve the HP2020 breast cancer targets and key population characteristics

<table>
<thead>
<tr>
<th>County</th>
<th>Priority</th>
<th>Predicted Time to Achieve Death Rate Target</th>
<th>Predicted Time to Achieve Late-stage Incidence Target</th>
<th>Key Population Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Highest</td>
<td>13 years or longer</td>
<td>13 years or longer</td>
<td></td>
</tr>
<tr>
<td>Oldham County - KY</td>
<td>Highest</td>
<td>13 years or longer</td>
<td>13 years or longer</td>
<td></td>
</tr>
<tr>
<td>Spencer County - KY</td>
<td>Highest</td>
<td>SN</td>
<td>13 years or longer</td>
<td>Rural, medically underserved</td>
</tr>
<tr>
<td>Shelby County - KY</td>
<td>High</td>
<td>7 years</td>
<td>13 years or longer</td>
<td>Rural</td>
</tr>
<tr>
<td>Bullitt County - KY</td>
<td>Medium High</td>
<td>13 years or longer</td>
<td>6 years</td>
<td>Rural, medically underserved</td>
</tr>
<tr>
<td>Hardin County - KY</td>
<td>Medium High</td>
<td>5 years</td>
<td>13 years or longer</td>
<td>Rural</td>
</tr>
<tr>
<td>Jefferson County - KY</td>
<td>Medium High</td>
<td>8 years</td>
<td>10 years</td>
<td>%Black/African-American</td>
</tr>
<tr>
<td>Clark County - IN</td>
<td>Medium</td>
<td>Currently meets target</td>
<td>13 years or longer</td>
<td></td>
</tr>
<tr>
<td>Nelson County - KY</td>
<td>Medium</td>
<td>1 year</td>
<td>8 years</td>
<td>Rural, medically underserved</td>
</tr>
<tr>
<td>Meade County - KY</td>
<td>Medium Low</td>
<td>SN</td>
<td>1 year</td>
<td>Rural, medically underserved</td>
</tr>
<tr>
<td>Harrison County - IN</td>
<td>Low</td>
<td>3 years</td>
<td>Currently meets target</td>
<td>Rural</td>
</tr>
<tr>
<td>Scott County - IN</td>
<td>Lowest</td>
<td>SN</td>
<td>Currently meets target</td>
<td>Education, employment, rural, medically underserved</td>
</tr>
<tr>
<td>Breckinridge County - KY</td>
<td>Lowest</td>
<td>SN</td>
<td>Currently meets target</td>
<td>Education, poverty, employment, rural</td>
</tr>
<tr>
<td>Grayson County - KY</td>
<td>Lowest</td>
<td>NA</td>
<td>Currently meets target</td>
<td>Education, poverty, employment, rural</td>
</tr>
<tr>
<td>Larue County - KY</td>
<td>Undetermined</td>
<td>SN</td>
<td>SN</td>
<td>Education, rural, medically underserved</td>
</tr>
</tbody>
</table>

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

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
Three counties in the Komen Louisville service area are in the highest priority category. Two of the three, Floyd County, IN and Oldham County, KY, are not likely to meet either the death rate or late-stage incidence rate HP2020 targets. One of the three, Spencer County, KY is not likely to meet the late-stage incidence rate HP2020 target.

The death rates in Oldham County, KY (26.6 per 100,000) appear to be higher than the Affiliate service area as a whole (23.2 per 100,000) although not significantly. The death rate trends in Oldham County, KY (0.3 percent per year) indicate that late-stage incidence rates may be increasing. The late-stage incidence rates in Spencer County, KY (51.8 per 100,000) appear to be higher than the Affiliate service area as a whole (44.3 per 100,000) although not significantly. The late-stage incidence trends in Floyd County, IN (6.3 percent per year), Oldham County, KY (3.3 percent per year) and Spencer County, KY (0.7 percent per year) indicate that late-stage incidence rates may be increasing.

In Spencer County, KY a relatively large proportion of the population is living in rural and medically underserved areas.

High priority areas
One county in the Komen Louisville service area is in the high priority category. Shelby County, KY is not likely to meet the late-stage incidence rate HP2020 target. The late-stage incidence trends in Shelby County, KY (4.9 percent per year) indicate that late-stage incidence rates may be increasing. In Shelby County, KY a relatively large proportion of the population is living in rural areas.
Selection of Target Communities

In order to be the most efficient steward of resources, Susan G. Komen Louisville has chosen five target communities within the service area. The Affiliate will focus strategic efforts on these target communities over the course of the next five years. Target communities are those communities which have cumulative key indicators showing an increased chance of vulnerable populations likely at risk for experiencing gaps in breast health services and/or barriers in access to care.

When selecting target communities, the Affiliate reviewed Healthy People 2020, a major federal government initiative that provides specific health objectives for communities and the country as a whole. Specific to Komen Louisville’s work, goals around reducing women’s death rate from breast cancer and reducing the number of breast cancers found at a late-stage were analyzed. Through this review, areas of priority were identified based on the time needed to meet Healthy People 2020 targets for breast cancer.

Additional key indicators the Affiliate reviewed when selecting target communities included, but were not limited to:

- Incidence rates and trends
- Death rates and trends
- Late-stage rates and trends
- Below average screening percentages
- Residents living below poverty level
- Residents living in rural and medically underserved areas
- Educational attainment levels
- Unemployment percentages

The selected target communities are:

- Floyd County, Indiana
- Oldham County, Kentucky
- Spencer County, Kentucky
- Shelby County, Kentucky
- Jefferson County, Kentucky

Floyd County, Indiana:
Floyd County, Indiana is located within the immediate Louisville Metropolitan area, adjacent to both the Indiana and Kentucky state borders. It has been identified as a highest priority county due to the amount of intervention time needed to achieve the Healthy People 2020 breast cancer target goals for both death rate and late-stage incidence rate.

The increasing trends in incidence and late-stage diagnosis indicate a potential rise in these rates, suggesting a strong likelihood that more women will be diagnosed with breast cancer at a later stage throughout Floyd County. Additionally, screening percentages in Floyd County are
below average with the proportion screened (weighted average) at 71.4 percent compared to a national average of 77.5 percent and service area average of 75.9 percent.

Below average screening percentages may contribute to the increasing trends in incidence and late-stage diagnosis, and is likely a result of a lack of available breast health resources and services within the county. The actual availability of these will be reviewed in the health systems analysis component of this report.

**Oldham County, Kentucky:**
Oldham County, Kentucky is located within the immediate Louisville Metropolitan area, adjacent to both the Kentucky and Indiana state borders. It has been identified as a highest priority county due to the amount of intervention time needed to achieve the HP2020 breast cancer targets for both death rate and late-stage incidence rate.

Oldham County exhibits positive trends in multiple areas of female breast cancer rates; a 2.8 percent trend in the incidence rate; a 0.3 percent trend in the death rate; and a 3.3 percent trend in the late-stage incidence rate. The county’s death rates are above average when compared to the Affiliate’s service area as a whole, and the death rate trend indicates that late-stage incidence rates may be on the rise. Furthermore, screening percentages are below the national and service area averages. This may be a contributing factor to the increasing trends throughout Oldham County.

**Spencer County, Kentucky:**
Spencer County, Kentucky is located within the immediate Louisville Metropolitan area, and has been identified as a highest priority county due to the amount of intervention time needed to achieve the HP2020 breast cancer target for late-stage incidence rate. The county’s late-stage incidence trend reveals a potential increase in this rate as well.

The county’s 8,156 women represent one of the smallest populations within the Affiliate’s service area. Caucasian females make up the majority of this population at 97.1 percent; 2.0 percent are Black; and 1.5 percent identify as Hispanic/Latina. When comparing demographics, both of the latter percentages are below the national, state and service area averages. Additionally, although Spencer County is located in the metropolitan area, a relatively significant proportion of the county’s population is living in rural and medically underserved areas.

Spencer County has been chosen as a target community due to the key population and socioeconomic characteristics. Below average education and employment levels suggest the potential for concern regarding a woman’s access to affordable breast health services in a largely rural area noted to be medically underserved. A health systems analysis will provide a

<table>
<thead>
<tr>
<th></th>
<th>Oldham County Rate</th>
<th>Affiliate Service Area Rate</th>
<th>United States Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death Rates*</td>
<td>26.6</td>
<td>23.2</td>
<td>22.6</td>
</tr>
</tbody>
</table>

*Rates are age-adjusted and are figured per 100,000 women*
better understanding of the resources and services available to the residents of Spencer County.

**Shelby County, Kentucky:**
Shelby County, Kentucky is located within the immediate Louisville Metropolitan area, though a relatively large proportion of the county’s population is living in rural areas. It has been identified as a high priority county based on the intervention times needed to meet the goals outlined in HP2020.

Shelby boasts the highest percentage of Hispanic/Latina population at 7.7 percent, which is more than double that of the Affiliate’s service area average as a whole. Additionally, 5.8 percent are foreign born and 3.1 percent are linguistically isolated, a rate substantially higher than the average of the Affiliate service area.

Shelby County has been chosen as a target community due to its unique population demographics and socioeconomic characteristics in regards to lower education levels than that of the Affiliate service area and United States as a whole.

<table>
<thead>
<tr>
<th>Table 2.9. Shelby County population characteristics – socioeconomics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shelby County</strong></td>
</tr>
<tr>
<td>Less than HS Education</td>
</tr>
</tbody>
</table>

A positive late-stage trend of 4.9 percent indicates the late-stage incidence rates may be increasing throughout Shelby County. This may be in part to the county socioeconomic characteristics and population demographics. The health systems analysis portion will allow for a better understanding of the contributing factors.

**Jefferson County, Kentucky:**
Jefferson County is located in the heart of the Louisville Metropolitan area. Adjacent to both the Kentucky and Indiana state borders, it is comprised largely of the city of Louisville, Kentucky. Aside from being the most populous county in the metropolitan area; Jefferson County is considered the most populous county in the state of Kentucky. The county’s 378,103 women represent the largest population in the Affiliate’s service area. Of these women, 22.5 percent are black, a rate substantially larger than that of the Affiliate service area as a whole. This is significant due to the high death rates Black/African-American women experience from breast cancer when compared to other races.

Jefferson County has been chosen as a target community due to its unique population demographics, as well as the below average income and employment levels observed when compared to United States and service area averages. Furthermore, it has been identified as a medium-high priority due to the amount of intervention time needed to achieve the Healthy People 2020 target goals.
Screening percentages in Jefferson are below the national average; and socioeconomic factors, such as low income and employment levels, present further potential challenges for county residents when seeking assistance.

Although Jefferson County is considered the central focus of the Louisville Metropolitan area and services are more likely to be readily available, the health systems analysis component of this report will provide a deeper insight and better understanding of those available breast health services.
Health Systems Analysis Data Sources

Several resources were used to identify health care facilities that provide breast health services including clinical breast exams, screening mammograms, diagnostic screenings, treatment, financial assistance and patient navigation. The following resources enabled the team to have a comprehensive understanding of the programs and services that exist in priority areas:

- American College of Radiology (ACR).
  [http://www.acr.org/Quality-Safety/Accreditation/Accredited-Facility-Search](http://www.acr.org/Quality-Safety/Accreditation/Accredited-Facility-Search)

- American College of Surgeons Commission on Cancer.
  [http://datalinks.facs.org/cpm/CPMAccreditedFacilitySearch.htm](http://datalinks.facs.org/cpm/CPMAccreditedFacilitySearch.htm)

- American College of Surgeons. National Accreditation Program for Breast Centers.
  [http://napbc-breast.org/resources/find.html](http://napbc-breast.org/resources/find.html)

- National Association of County and City Health Officials (NACCHO).
  [http://www.naccho.org/about/lhd/](http://www.naccho.org/about/lhd/)

- National Association of Free and Charitable Clinics (NAFC).
  [http://www.nafcclinics.org/clinics/search](http://www.nafcclinics.org/clinics/search)


  [http://findahealthcenter.hrsa.gov/Search_HCC.aspx](http://findahealthcenter.hrsa.gov/Search_HCC.aspx)

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.

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

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

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

For some breast cancer patients, treatment may last a few months and for others, it may last years. While the CoC model shows that follow up and survivorship come after treatment ends, they 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 continuum of care is a valuable lens through which all aspects of the Health Systems Analysis (HSA), as well as qualitative data collection and analysis will be viewed. (Refer to the diagram below.) This model will help organize the data collected in the Health Systems Analysis template, identifying any gaps and barriers that delay or prevent access to care. The continuum of care can also be used to help define and understand existing and needed partnerships, advocacy efforts and legislator support. In the Health Services Analysis Template, the
Community Profile Team reviewed the target communities of Floyd County (IN), Jefferson County (KY), Oldham County (KY), Shelby County (KY) and Spencer County (KY). In addition to publicly available information online, designation databases, accreditation databases, community health networks and direct contacts were included to complete the analysis.

- **Floyd County, Indiana (Figure 3.2)**
  Floyd County has limited services: two facilities provide screening mammography; two provide clinical breast exams; and one provides screenings, patient navigation, diagnostic services, chemotherapy, radiation, patient support, complementary therapies and end of life care. Overall, this target community lacks most services across all types of cancer care. Individuals seeking services outside of this county will typically go to Clark County (IN) or Jefferson County (KY).

- **Jefferson County, Kentucky (Figure 3.3)**
  Jefferson County has the most offerings of the counties the Affiliate reviewed with numerous centers dedicated to early screening and detection. There are also hospitals that have multiple locations thus spreading their reach of care across the county. Norton in particular has diagnosis facilities spread out to provide care with ease. It is apparent that Jefferson County services patients not only within the county but accepts patients being navigated in from surrounding counties; thus resources are strained within this county.

- **Oldham County, Kentucky (Figure 3.4)**
  While Oldham County benefits from having a strong number of facilities offering some form of cancer-related services, the variety of services available could be improved. The majority of centers listed are satellite offices of their larger, accredited hospitals in neighboring counties. The more immobile residents of Oldham County therefore receive surface-level local cancer services, like basic screening and diagnostics. The more complicated patient navigation systems, biopsy services, surgery and reconstructive services are lacking. Oldham County also offers very few support options, with support groups, side effect management, complimentary therapies, financial assistance, end of life care and legal services difficult to find locally.

- **Shelby County, Kentucky (Figure 3.5)**
  Shelby County has very few medical practices for women’s health services. Jewish Hospital Shelbyville is the only facility in Shelby County to be accredited by one of the quality of care indicators. Jewish Hospital Shelbyville is part of Kentucky One Health system so if a patient needs a treatment that isn’t available in Shelbyville, they are sent to one of the Louisville area KentuckyOne hospitals. There are also two clinics in Shelbyville, one of which provides some women’s support; the other provides almost no women’s services.
Spencer County, Kentucky (Figure 3.6)
The medical locations in Spencer County are all smaller locations. The county is in close proximity to Louisville city proper, so nearly all local centers refer most procedures (anything beyond a clinical breast examination) into the city. This leads to no local cancer treatment options or support services being offered in this area.
Figure 3.2. Breast cancer services available in Floyd County
Figure 3.3. Breast cancer services available in Jefferson County
Figure 3.4. Breast cancer services available in Oldham County
Figure 3.5. Breast cancer services available in Shelby County
Figure 3.6. Breast cancer services available in Spencer County
Public Policy Overview

This public policy review examines the local issues affecting women’s transition through the continuum of care in Kentucky and Indiana. Within this report, the following perspectives of public policy are addressed: the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), the State Comprehensive Cancer Control Coalition, The Affordable Care Act and the Affiliate’s Public Policy Activities.

National Breast and Cervical Cancer Early Detection Program (NBCCEDP)

Kentucky

The Department of Public Health’s Kentucky Women’s Cancer Screening Program (KWCSP) provides breast screenings and follow-up services, education, outreach, quality assurance and surveillance. The program allows for women who are low-income or uninsured to receive mammograms at little or no cost through health departments in every county in Kentucky. The program is funded by both state and federal funds and is part of the CDC’s National Breast and Cervical Cancer Early Detection Program (NBCCEDP). To utilize the program, women must enter the system through their local health department. If they do not initially go through the health department before diagnosis, they are ineligible for the program. More information on the KWCSP can be found online at http://cfhs.ky.gov/dph/info/dwh/cancerscreening.htm.

A letter addressed to the Affiliate from Republican Leader and United States Senator for Kentucky, Mitch McConnell regarding support for increased funding for breast cancer research and early detection programs states:

“As a senior member of the Senate Appropriations Committee, one of my top priorities is to strengthen biomedical research, including cancer research, at Kentucky’s universities. Over the past decade, I have secured tens of millions of dollars for this cause, designating funds for cancer prevention at the University of Kentucky (UK) and training cancer nurses at the University of Louisville (U of L). I also strongly supported UK’s Markey Cancer Center application to win designation as a cancer center from the National Cancer Institute (NCI). This designation, along with the partnership with the Norton Cancer Institute, means UK will be one of the pre-eminent cancer research and treatment centers in the United States. The university will be able to recruit the brightest researchers and clinical scientists to develop novel cancer treatments, and most importantly, Kentuckians will not have to travel out of the state to find the most advanced care and clinical trials.”

As Kentucky is a Medicaid Option 1a state, the Affiliate has a standardized methodology with SIPP data: the option 1a states there are no adjustments for time-limited disregards. This means that more women have access to health care than in years previous. This access will specifically help with the diagnosis and treatment of cancers and specifically breast cancers, which will hopefully make cancer related deaths a thing of the past.

Women can get access to this new level of care by applying through the Medicaid/CHIP application process, created to simplify and lessen the anxiety associated with past application
processes. After the application has been submitted, a woman’s eligibility is verified using a standardized process in the Marketplace; however this is strictly Medicaid’s classification. Kentucky is an option 2 state for the NBCCEDP classifications. This means that a woman is eligible if (1) her provider receives NBCCEDP funds and (2) the service was within the scope of a grant, sub-grant or contract under that state program — even if the woman’s screening may not have been paid directly from NBCCEDP funds. This means that Kentucky is more open than option 1 states but not as well off as option 3 states.

While all women who fall into the approved category can get service through the NBCCEDP through Medicaid, there is only one in the state. This location is in Frankfort which is located approximately one hour from Louisville. However since these services are for the low income population, the distance becomes much greater. There are no public transports from Louisville to Frankfort. This indicates that the Kentucky Medicaid and the NBCCEDP are working together as little as possible.

**Indiana**

The Indiana Breast and Cervical Cancer Program (IN-BCCP) is funded through the Centers for Disease Control (CDC) and state funding. The IN-BCCP provides access to breast and cervical cancer screening and diagnostic services to women between the ages of 40 and 64 with no creditable insurance, who fall at 200 percent of the federal poverty level or below (http://www.in.gov/isdh/24967.htm). Women are recruited through regional coordinators or enrolled at the offices of providers who participate in the program. Women are tracked via a data management system, and providers are reimbursed at Medicare rates. Women are matched with a case manager if an abnormal diagnosis is found to ensure timely and appropriate follow up and diagnosis. If women are diagnosed with breast or cervical cancer, they are enrolled into Medicaid and receive full coverage for the duration of their treatment. Individuals who are diagnosed with triple negative breast cancer are restricted from the Medicaid treatment program as soon as they have completed radiation. This is an issue, as many with triple negative breast cancer face reoccurrence and need to be followed closely by an oncologist.

IN-BCCP patient navigators transition women enrolled in IN-BCCP into the Medicaid Treatment Program if diagnosed with breast or cervical cancer. The Indiana State Department of Health (ISDH) supports a full-time position to coordinate the Option 3 Treatment Program application process with the Medicaid Office for women diagnosed with breast or cervical cancer outside of the IN-BCCP.

IN-BCCP has a Memorandum of Understanding with the Family and Social Services Administration (FSSA), including the Office of Medicaid Policy and Planning and the Division of Family Resources, to implement the provisions of the Breast and Cervical Cancer Prevention and Treatment Act of 2000, Public Law 106-354, to ensure eligible women diagnosed with breast or cervical cancer through IN-BCCP or by another provider receive Medicaid to cover treatment. ISDH ensures that women meet the eligibility requirements, and FSSA provides final eligibility determination and coverage.
Recently, the ISDH Cancer Early Detection Section was awarded funds through the National Association of Chronic Disease Directors (NACDD) to partner with the Office of Medicaid Policy and Planning (OMPP) to plan collaborative approaches to cancer screening through aggressive outreach to targeted, high-burden populations. Roadmaps will be developed to:

- Increase cancer screening among never or rarely screened populations;
- Sustain appropriate cancer screening and follow-up for current Indiana Breast and Cervical Cancer Program (IN-BCCP) enrollees transitioning into Medicaid; and
- Enhance or combine existing data systems to support population-based education, outreach, screening registries, diagnosis and follow up.

Continued and future involvement in advocacy and public policy activities in both Kentucky and Indiana is an opportunity for the Affiliate to become more involved and expand services to the community.

**State Comprehensive Cancer Control Coalition**

**Kentucky**

Comprehensive Cancer Control in Kentucky is handled by the Kentucky Cancer Consortium (KCC), which is part of the Kentucky Department for Public Health and Kentucky’s grant recipient of the CDC’s National Comprehensive Cancer Control Program. In addition to leveraging over 55 partnered organizations to reduce the burden of cancer in Kentucky, the KCC also develops the Kentucky Cancer Action Plan in collaboration with its regional Kentucky Cancer Program (KCP). This Kentucky Cancer Action Plan directly addresses the strategy and goals of the program; the latest version lists most objectives through 2013.

The KCC lists three primary items on its policy agenda for 2010-2015 to include: (1) the enactment of a comprehensive state-wide smoke-free law according to the Fundamentals of Smoke-Free workplaces (2) increased access to colon cancer screening by reducing PSE barriers for patients in Kentucky and (3) increased utilization of shared use agreements with Kentucky schools to provide communities with more opportunities to increase physical activity.

The KCC describes itself as a common forum for organizations from a broad spectrum to address the shared vision of cancer control within the state. In addition to researching the needs of the state, the KCC sets priorities and develops resources to work collaboratively across the state. Members are kept informed via a multi-faceted communications strategy with meetings, a newsletter called “Wednesday’s Word”, an e-mail list, a website and more; they are also invited to participate in various committees, including the Policy, Systems and Environmental Change (PSE) Team, the Resource Plan Team, the Survivorship and Patient Navigation Team, the Affordable Care Act and Cancer Team and the Colon Cancer Prevention Team. A full list of the KCC’s member organizations is available on its website.

The KCC’s programs are indicative of the strong, interdisciplinary support it has from its members. For example, the KCC supports the Smoke-Free KY van which tours the state to promote the passage of comprehensive, smoke-free workplace legislation. The KCC also has
the SOAR program (Shaping Our Appalachian Region). SOAR is currently touring a discussion entitled “Finding Solutions & Celebrating Champions for Cancer, Diabetes, Heart Disease & Obesity Awareness”. In addition to special events, the KCC also develops fact sheets and builds support networks.

While some states are still pursuing a regional network, the KCC has already established 13 regional offices staffed with cancer control specialists via the Kentucky Cancer Program (KCP). The KCP is jointly led by the University of Kentucky Lucille Parker Markey Cancer Center and the University of Louisville James Graham Brown Cancer Center. The program implements cancer control strategies on a local level in addition to collecting data for report back to the KCC and National Cancer Control Program. Through its university affiliations, the KCP works to add the scientific, research-based perspective to the development and implementation of the Kentucky Cancer Action Plan.

The Kentucky Cancer Action Plan clearly lists objectives for comprehensive cancer control in the state, ranging from environment and prevention to post-treatment quality of life. The plan also prescribes strategies and measures to achieve these goals. Goal 5 in the Kentucky Cancer Action Plan directly refers to breast cancer:

- Goal 5: Reduce the proportion of late-stage diagnosis and death from breast cancer through screening and early detection.

The breast and cervical cancer sections of the Kentucky Cancer Action Plan are scheduled to be updated by June 2015.

**Indiana**

The Indiana Comprehensive Cancer Control Plan is managed collaboratively by the Indiana Cancer Control Program and the Indiana Cancer Consortium (ICC). The ICC is Indiana’s only comprehensive cancer control coalition comprised of both public and private partners, with the shared goal of reducing the harmful effects of cancer in the state. The ICC is funded by the Center for Disease Control’s (CDC) National Comprehensive Cancer Control Program. The latest version is the Indiana Cancer Control Plan 2010 - 2014 which remains in effect through the end of 2015.

The ICC policy agenda for 2014/2015 aims to (as listed on indianacancer.org): (1) pass a statewide comprehensive smoke-free air law (2) increase the cigarette tax (3) pass complete street policies at the state or local level and (4) influence local schools to add policies requiring elementary school students to have at least 30 minutes of physical activity per day.

The ICC is proactively creating “priority projects” in order to strengthen its relationship the Comprehensive Cancer Control Program.

For example:

- The ICC has developed an Employer Gold Standard Initiative designed to reduce the effects of cancer in their Indiana businesses and the communities. The goal of the program is to identify Indiana employers who promote verified cancer screenings.
• In order to create a more grassroots approach to plan implementation, the Indiana Cancer Control Program and ICC are currently offering funding to establish two new ICC District regional coalitions. These sub-organizations are intended to directly contribute to the mission of the Indiana Cancer Control Program.

• In addition to collecting statistics to publish the “2015 Indiana Cancer Facts and Figures” periodical, the ICC also aims to have a 2014 Clinical and Community Linkages Conference.

Housed within the Indiana Public Health Association in Indianapolis, IN, membership into the ICC is free and includes admittance into annual meetings. Any organization or community member is welcomed to join. The ICC is responsible for the assessment of cancer concerns, engaging the needs of the affected community, planning comprehensive cancer control and implementing control methods. The Indiana Cancer Control Plan is developed by a wide range of participating members in the ICC, to include government, community organizations, businesses, insurers, providers and survivors.

The objectives of the Indiana Cancer Control plan are built around the following six focus areas (with descriptions as listed on the indianacancer.org):

- Primary Prevention: Decrease cancer risk through lifestyle behavioral interventions.
- Early Detection: Increase early detection and appropriate screening for cancer.
- Treatment: Promote informed decision making and utilization of appropriate cancer treatment.
- Quality of Life: Improve quality of life for cancer patients, survivors, and their families.
- Data: Increase the quantity, quality and availability of complete and timely cancer data.
- Advocacy: Advocate cancer-related policy initiatives.

A focus area listed is assigned a primary goal and SMART objectives; the acronym stands for Specific, Measurable, Attainable, Realistic and Time-phased. From these objectives, experts craft research-and-experience-based strategies for the ICC to implement.

The Indiana Cancer Control Plan offers the following goal in direct reference to breast cancer:

• Early Detection. Objective 1: By 2014, increase the percentage of women aged 40 and older who receive annual breast cancer screening from 62.0 percent to 67.0 percent as measured by the Indiana Behavioral Risk Factor Surveillance System.

To further promote this goal, the ICC’s website lists a Breast Cancer Toolkit which includes a link to the Indiana Cancer Control Plan.

**Affordable Care Act**

**Kentucky**

Upon the passage of the Affordable Care Act, the State of Kentucky opted to operate its own state-based exchange entitled Kynect (Figure 3.7). Those who obtained coverage via the exchange are cited as having paid an average premium of $122 after tax credits. Kentucky has also decided to take advantage of the Medicaid expansion offered by the federal government,
increasing state revenue by a projected $800 million by 2021 based upon independent studies conducted by the University of Louisville and Price Waterhouse Cooper (Figure 3.8). According to Kentucky’s Department of Medicaid Services, the new health care system will increase Kentucky’s “adult preventive services by 36.7 percent: breast cancer breast screening services will increase by 20.6 percent. Kentucky’s uninsured percentage has also decreased dramatically thanks to the public exchange, with the rate of those uninsured decreasing from 17.3 percent to 8.95 percent during the open enrollment period.

**Table 3.7. Marketplace/Exchange information**

<table>
<thead>
<tr>
<th>Location</th>
<th>Marketplace Type</th>
<th>Total Number of Individuals Determined Eligible to Enroll in a Marketplace Plan</th>
<th>Number of Individuals Eligible to Enroll in a Marketplace Plan with Financial Assistance</th>
<th>Determined or Assessed Eligible for Medicaid/CHIP by the Marketplace</th>
<th>Number of Individuals Who Have Selected a Marketplace Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indiana</td>
<td>Federally-facilitated</td>
<td>220,815</td>
<td>155,961</td>
<td>94,495</td>
<td>132,423</td>
</tr>
<tr>
<td>Kentucky</td>
<td>State-based</td>
<td>201,593</td>
<td>91,092</td>
<td>357,990</td>
<td>82,747</td>
</tr>
</tbody>
</table>

**Table 3.8. Medicaid income eligibility limits for adults at application**

<table>
<thead>
<tr>
<th>Location</th>
<th>Parents of Dependent Children</th>
<th>Other Non-Disabled Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indiana</td>
<td>25%</td>
<td>0%</td>
</tr>
<tr>
<td>Kentucky</td>
<td>138%</td>
<td>138%</td>
</tr>
</tbody>
</table>


**Indiana**

Upon the passage of the Affordable Care Act (ACA), the State of Indiana opted to participate in the federal exchange as opposed to creating its own state based exchange. This new means of obtaining insurance works in conjunction with the current Healthy Indiana Plan that is subsidized by a Medicaid waiver obtained and renewed by the state. Goals of the Healthy Indiana Plan include:

- Reduce the number of uninsured residents in the state
- Improve statewide access to health care services for low-income residents
- Promote value-based decision making and personal responsibility
- Promote primary care and prevention
- Prevent chronic disease progression with secondary prevention (treatment, prescriptions)
- Provide appropriate, and quality or evidence-based, health care services
- Ensure state fiscal responsibility and efficient management of the program

Healthy Indiana’s reliance on the Medicaid waiver expanding coverage to include adults would need to be terminated in order to allow the Medicaid expansion that is offered by the Affordable
Care Act. Analysis has been conducted by the state to evaluate the impact of both; pursuing either option would result in some individuals losing insurance while others without insurance being able to obtain it. Ongoing evaluation of the two options will be conducted by the state, and the next expiration date for the waiver is set for September of 2014. The open enrollment period has allowed for 132,423 Indiana residents to receive health insurance, resulting in a decrease in the uninsured percentage from 14.8 percent to 12.78 percent.

The demographics of those who selected a plan are:

- 56 percent female and 44 percent male
- 33 percent are under the age of 35
- 26 percent are between the ages of 18 and 34
- 67 percent selected a Silver plan, 28 percent selected Bronze
- 89 percent were able to obtain financial assistance for their plan

**Implications of ACA on state NBCCEDP eligibility and utilization**

According to the Center for Disease Control (CDC):

“Health care reform through the Affordable Care Act (ACA) will increase access to breast and cervical cancer screening services for many low-income, underserved women through expanded insurance coverage and eliminating cost-sharing. Other provisions of the ACA and the American Reinvestment and Recovery Act (ARRA, the stimulus bill) will also improve delivery of these essential services by improving health care quality and driving wider adoption of electronic health records. However, all ACA provisions will not be implemented until 2015 and some effects will take longer. Currently, even with adequate health insurance, many women will still face substantial barriers to obtaining breast and cervical cancer screening such as geographic isolation, limited health literacy or self-efficacy, lack of provider recommendation, inconvenient times to access services, and language barriers.”

Essentially, the Affordable Care Act aims to provide greater access to cancer screenings. The CDC and other agencies have an unprecedented opportunity to build onto all that the NBCCEDP has done for health screenings. The CDC says a large focus will be on ensuring the delivery of clinical preventative services. These programs now have the opportunity to have a larger outreach to underserved communities through a variety of approaches. Refer to “Moving Forward in an Era of Reform” for further opportunity descriptions (www.cdc.gov/cancer/).

According to Kentucky breast cancer fact sheets from the American Cancer Society Cancer Action Network (ACS CAN), “it is estimated that over 53,920 Kentucky women will continue to lack access to cervical cancer screenings, and 22,422 women will lack access to breast cancer screenings in 2014.” This demonstrates that there are still gaps in providing the preventative cancer screenings and treatment. Women may still be uninsured or underinsured due to affordability, literacy, or language related barriers. More information is available on http://www.acscan.org/pdf/breastcancer/factsheets/state-facts/Kentucky.pdf
Sarah Rosenbaum, JD of The George Washington University, School of Public Health and Health Services, Department of Health Policy in Washington, DC wrote an article in “Law and the Public’s Health” that focuses on/highlights the ACA and breast and cervical cancer procedures. The article is called “The ACA: Implications for the Accessibility and Quality of Breast and Cervical Cancer Prevention and Treatment Services” and can be found at the end of this report. Rosenbaum discusses the pitfalls of the NBCCEDP that were marginally met by the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). With the ACA taking effect, women who receive abnormal screening results can no longer be denied coverage in the private insurance market.

The ACA will allow the NBCCEDP to increase their focus on providing preventative screenings to more women with hope of treatment because more women now have a means of health care to treat them after detection.

Implications of ACA for health care providers
The Affordable Care Act has a large impact on everyone in the country, especially doctors. The Affiliate found a quick guide to the Affordable Care Act written by the National Physicians Alliance (http://npalliance.org/wp-content/uploads/NPA-ACA.Quick_Guide_for_Physicians.041311.pdf). Overall, the National Physician's Alliance believes that the Affordable Care Act (ACA) is a good thing because it shifts some of the power away from insurers to the doctors and patients. Insurers cannot deny coverage to children based on pre-existing conditions and they cannot discriminate against adults with pre-existing conditions. Lifetime and annual limits on insurance coverage have been made illegal. Insurance companies are not allowed to rescind coverage. Finally, the Medicare part D prescription drug coverage gap will be closed by 2020. Those rules will give the doctors more control and will also lower the number of payments that insurers refuse to cover.

In addition to forcing insurers to pay for procedures that would have been denied in the past, the ACA also provides other monetary benefits to doctors. The ACA provides a 10 percent Medicare bonus payment for primary care services and a 10 percent bonus to general surgeons practicing in rural areas. Medicaid reimbursement rates will increase to match Medicare rates. Doctors with small practices will be able join together to have more bargaining power when selecting health insurance for their employees; the ACA has $50 million available for grant funding to help support this effort.

Another very positive result of the ACA is that patients will have better access to preventative care. The ACA requires all new insurance plans to cover certain preventative services such as mammograms and colonoscopies without charging a deductible. It also provides no-cost preventative care for seniors on Medicare. The ACA incentivizes state Medicaid programs to provide free or low-cost preventative care by giving them more money if they provide those services. Finally, the main thing that people know about the ACA is that it requires all Americans to purchase health insurance.
The Affordable Care Act as well as the Health Information Technology for Economic and Clinical Health (HITECH) Act has rules that will lead to most practices having electronic health information. Practices risk having decreased reimbursements if they fail to meet standards of secure and accessible electronic health information exchanges. This will help lessen the insurance paperwork and bureaucracy, which will in turn lower costs. Another positive of electronic health information is that it will encourage coordination between doctors, which will lower costs, stress preventative care and reduce unnecessary hospital admissions. The last big effect the ACA will have on physicians is that it will help reduce shortages by increased scholarships, higher payments and lower taxes for doctors and nurses working in underserved communities.

In conclusion the National Physicians Alliance seems to think that the Affordable Care Act will have a positive effect on how they will do their business. They said “By 2014, the Affordable Care Act will give millions of Americans access to reliable, high quality medical care, while advancing programs to hold costs in check. Benefits of the law include: insurance subsidies for consumers; transparent Exchanges to shop for insurance; new rules protecting consumers from insurance abuses; increased Medicare payments for physicians; and more.”

Implications of ACA for Affiliate service area and possible impact on the Affiliate’s mission work
The direct implications of the ACA for Komen Louisville’s service area are a greater outreach to those who did not previously have access to health care and preventative care, further opportunities for treatment after diagnosis, and greater opportunities for education of women’s health. These are all very important opportunities in providing care to women who may have went undiagnosed with breast and cervical cancers. The ACA has allowed not only services to a larger number of women, but also improves the care that they are able to receive. As mentioned before, many women did not have the funds to obtain treatment once they went through screenings provided by the NBCCEDP. The ACA allows these underserved women to get even further care.

Because Susan G. Komen Louisville serves a service area spanning between two states (Kentucky and Indiana) there are additional implications of the ACA to consider. Kentucky has opted to expand Medicaid while Indiana is in open debate for alternative expansion plans. The two marketplaces differ as well with Kentucky being state-based and Indiana being federally facilitated. This may allow for a different level of care to be provided throughout the Affiliate service area. A possible impact could be to provide a greater focus where the most underserved women are within the service area and overlook some because they aren’t the most underserved. All women deserve to have access to these screenings and it would be most unfortunate if this became the case.

Health Systems and Public Policy Analysis Findings
The Health Systems and Public Policy findings highlighted a lack of screening and diagnostic services in target communities.
Breast Health and Breast Cancer Findings of the Target Communities

Using data on female breast cancer death rates, late-stage diagnosis, and the time needed to reach Healthy People 2020 targets, as well as information on barriers to accessing quality breast cancer education, diagnosis and treatment that are prevalent in the service area, three counties – Floyd County, Indiana and Oldham County, Spencer County, Shelby County, and Jefferson County in Kentucky- have been selected to be priority communities.

Floyd County, Indiana
Floyd County, Indiana is located within the immediate Louisville Metropolitan area, adjacent to both the Indiana and Kentucky state borders. It has been identified as a highest priority county due to the amount of intervention time needed to achieve the Healthy People 2020 breast cancer target goals for both death rate and late-stage incidence rate.

The increasing trends in incidence and late-stage diagnosis indicate a potential rise in these rates, suggesting a strong likelihood that more women will be diagnosed with breast cancer at a later stage throughout Floyd County. Additionally, screening percentages in Floyd County are below average with the proportion screened (weighted average) at 71.4 percent compared to a national average of 77.5 percent and service area average of 75.9 percent.

Below average screening percentages may contribute to the increasing trends in incidence and late-stage diagnosis, and is likely a result of a lack of available breast health resources and services within the county. There are five locations in the county that provide breast care services. There are three that provide screening, two that provide diagnostic services and only one location that provides treatment or survivorship services.

Oldham County, Kentucky
Oldham County, Kentucky is located within the immediate Louisville Metropolitan area, adjacent to both the Kentucky and Indiana state borders. It has been identified as a highest priority county due to the amount of intervention time needed to achieve the HP2020 breast cancer targets for both death rate and late-stage incidence rate.

Oldham County exhibits positive trends in multiple areas of female breast cancer rates; a 2.8 percent trend in the incidence rate; a 0.3 percent trend in the death rate; and a 3.3 percent trend in the late-stage incidence rate. The county’s death rates are above average when compared to the Affiliate’s service area as a whole, and the death rate trend indicates that late-stage incidence rates may be on the rise. Furthermore, screening percentages are below the national and service area averages. This may be a contributing factor to the increasing trends throughout Oldham County. There are six locations that provide breast cancer services within this county. Three locations provide screening services, two locations provide diagnostic services and there are no locations that provide treatment or survivorship services.
Spencer County, Kentucky
Spencer County, Kentucky is located within the immediate Louisville Metropolitan area, and has been identified as a highest priority county due to the amount of intervention time needed to achieve the HP2020 breast cancer target for late-stage incidence rate. The county’s late-stage incidence trend reveals a potential increase in this rate as well.

The county’s 8,156 women represent one of the smallest populations within the Affiliate’s service area. White females make up the majority of this population at 97.1 percent; 2.0 percent are Black/African-American; and 1.5 percent identify as Hispanic/Latina. When comparing demographics, both of the latter percentages are below the national, state and service area averages. Additionally, although Spencer County is located in the metropolitan area, a relatively significant proportion of the county’s population is living in rural and medically underserved areas.

Spencer County has been chosen as a target community due to the key population and socioeconomic characteristics. Below average education and employment levels suggest the potential for concern regarding a woman’s access to affordable breast health services in a largely rural area noted to be medically underserved. There are four locations that provide breast cancer services in the county. There are four locations that provide screening services but there are no locations that provide diagnostic, treatment or survivorship services.

Shelby County, Kentucky
Shelby County, Kentucky is located within the immediate Louisville Metropolitan area, though a relatively large proportion of the county’s population is living in rural areas. It has been identified as a high priority county based on the intervention times needed to meet the goals outlined in HP2020.

Shelby boasts the highest percentage of Hispanic/Latina population at 7.7 percent, which is more than double that of the Affiliate’s service area average as a whole. Additionally, 5.8 percent are foreign born and 3.1 percent are linguistically isolated, a rate substantially higher than the average of the Affiliate service area.

Shelby County has been chosen as a target community due to its unique population demographics and socioeconomic characteristics in regards to lower education levels than that of the Affiliate service area and United States as a whole.

A positive late-stage trend of 4.9 percent indicates the late-stage incidence rates may be increasing throughout Shelby County. This may be in part to the county socioeconomic characteristics and population demographics. There are three locations that provide breast cancer services in this county. There are three locations that provide screening services, there is one location that provides diagnostic services, there is one location that provides treatment services and two locations that provide survivorship services in the county.
Jefferson County, Kentucky
Jefferson County is located in the heart of the Louisville Metropolitan area. Adjacent to both the Kentucky and Indiana state borders, it is comprised largely of the city of Louisville, Kentucky. Aside from being the most populous county in the metropolitan area; Jefferson County is considered the most populous county in the state of Kentucky. The county’s 378,103 women represent the largest population in the Affiliate’s service area. Of these women, 22.5 percent are Black/African-American, a rate substantially larger than that of the Affiliate service area as a whole. This is significant due to the high death rates Black/African-American women experience from breast cancer when compared to other races.

Jefferson County has been chosen as a target community due to its unique population demographics, as well as the below average income and employment levels observed when compared to United States and service area averages. Furthermore, it has been identified as a medium-high priority due to the amount of intervention time needed to achieve the Healthy People 2020 target goals.

Screening percentages in Jefferson are below the national average; and socioeconomic factors, such as low income and employment levels, present further potential challenges for county residents when seeking assistance. There are 45 locations in the county that provide breast cancer services. There are 28 locations that provide screening services, there are 22 locations that provide diagnostic services, there are 11 locations that provide treatment services and there are 15 locations that provide survivorship services.

Mission Action Plan
The Mission Action Plan was developed directly from quantitative and health system analysis data. Major themes were drawn from these data and priorities and objectives were set to address the concerns that were identified.

Spencer County and Shelby County, Kentucky
Problem Statement: Spencer County is categorized as highest priority with predicted time to achieve the HP2020 breast cancer targets and key populations characteristics. Shelby County is categorized as high priority with predicted time to achieve the HP20 breast cancer targets and key populations. Spencer County and Shelby County are predicted to take 13 years or longer to achieve late-stage incidence target for HP2020. Shelby County is predicted to take seven years to achieve death rate target for HP2020. Both of these counties have a large rural population that may have unique access barriers to breast cancer services.

Priority: Increase access to breast cancer services for women residing in rural Spencer and Shelby Counties.

● Objective: From FY2017 through FY2019, Komen Louisville Community Grant Request for Application (RFA) will specify that evidence-based programs providing assistance for rural women in Shelby and Spencer County to access available breast cancer services are a funding priority.
Floyd County, Indiana & Oldham County, Kentucky

**Problem Statement:** Floyd County Indiana and Oldham County Kentucky are categorized as highest priority with predicted time to achieve the HP2020 breast cancer targets and key populations characteristics. Both counties are predicted to take 13 years or longer to achieve death rate and late-stage incidence targets for Healthy People2020.

*Priority:* Increase access to breast cancer services for women in Floyd County, Indiana and Oldham County, Kentucky.

- **Objective:** From FY2017 through FY2019, the Komen Louisville Community Grant Request for Application (RFA) will specify that evidence-based programs providing assistance for women in Floyd County, Indiana and Oldham County, Kentucky to access available breast cancer services are a funding priority.

Jefferson County, Kentucky

**Problem Statement:** Jefferson County is categorized as medium high priority with predicted time to achieve the HP2020 breast cancer targets and key populations characteristics. The County is predicted to take eight years to achieve death rate and 10 years to achieve late-stage incidence targets for Healthy People2020. This county also has the largest Black/African-American population within the Affiliate service area that may have unique access barriers to breast cancer services.

*Priority:* Increase access to breast cancer services for Black/African-American women residing in Jefferson County.

- **Objective:** From FY2017 through FY2019, the Komen Louisville Community Grant Request for Application (RFA) will specify that evidence-based programs providing assistance for Black/African-American women in Jefferson County to access available breast cancer services are a funding priority.
References


