



# COMMUNITY PROFILE REPORT

## **Puget Sound Affiliate Susan G. Komen for the Cure®**

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## Executive Summary

### Introduction

The Susan G. Komen Foundation began as a promise between two sisters to end breast cancer forever. Susan Goodman Komen was diagnosed with breast cancer at the age of 33 and died three years later. Ms. Komen's younger sister, Nancy Goodman Brinker, founded the foundation in 1982. The Komen Puget Sound Affiliate was founded in 1993 to forward the mission of our national organization – to save lives and end breast cancer forever by empowering people, ensuring quality of care for all and energizing science to find the cures. Since its inception, the Komen Puget Sound Affiliate has invested nearly \$23 million in local nonprofit, tribal and government agencies that provide breast health and breast cancer services to medically underserved residents of our 16-county service area (Service Area).

The purpose of the community profile is to take a timely assessment of the state of breast cancer in the Affiliate's Service Area. This report examines statistics, services and community perspectives to identify disparities, gaps in service and barriers to care that prevent women who live in our community from accessing, early detecting and surviving breast cancer. This report will be used to set the Affiliate's priorities, goals and objectives in its strategic planning, grant making and educational efforts to ensure that we are meeting our promise to save lives.

### Statistics and Demographic Review

The majority of data used in the demographic section of the community profile was obtained through Thomson Reuters © 2009, a National Komen commissioned custom module of estimated demographic data for the Affiliate's Service Area. Statistical data on breast cancer incidence and mortality was obtained from the Washington State Cancer Registry and the Cancer Surveillance System, the Surveillance Epidemiology and End Results (SEER) Program cancer registry serving 13 of the 16 counties in our service area that is funded by the National Cancer Institute.

The Service Area as a whole, with 69 percent (or 4,607,327) of the total state population, is the densest and most racially/ethnically diverse area in the state. Within the Service Area, the Greater Metropolitan areas of King, Snohomish, Pierce and Kitsap counties had the greatest number of residents (78.6 percent or 3,623,557) and the greatest diversity (25 percent minorities). While King, Snohomish and Pierce counties have the greatest numbers of uninsured residents and families living below the poverty level, the counties in the southwest region of the state have the highest percentages of families below the poverty line and individuals who are uninsured.

Breast cancer is the most frequently diagnosed cancer among Washington State women and the second leading cause of cancer death. Washington ranks 12<sup>th</sup> highest in incidence and 35<sup>th</sup> highest in mortality in the country.

Higher proportions of cases diagnosed at advanced stage and/or lower proportions diagnosed at the in situ stage are likely indicators of insufficient rates of mammogram screening. African American, Hispanic, American Indian/Alaskan Native (AI/AN), and Vietnamese, Pacific

Islander and Asian Indian/Pakistani women had the highest proportions of breast cancers that were advanced stage at diagnosis. African American, AI/AN, Asian Indian/Pakistani and Pacific Islander women have the lowest five year rates of survival among all the ethnic and racial groups in the Service Area, with the majority of these women living in King, Pierce and Snohomish counties.

Lewis and Pacific counties had the highest proportion (both at 32 percent) of breast cancer cases diagnosed with advanced stage in the Service Area. Compared to the statewide average (20 percent), several counties had considerably lower proportions of cases with an in situ diagnosis – Pacific (12.4 percent), Clallam (13.7 percent), Grays Harbor (15.6 percent) and Thurston (17.2 percent).

Seven counties (of the 13 with breast cancer survival data) had lower than average five year survival rates: Mason, Grays Harbor, Jefferson, Clallam, Skagit, Whatcom and Pierce.

It is important to note that the three most densely populated counties (King, Pierce and Snohomish), although not the worst performers in terms of proportions of cases with advanced stage at diagnosis and survival, carry some of the heaviest burdens in our service area because of the sheer large numbers of women diagnosed with advanced stage or dying from breast cancer.

With respect to utilization of breast cancer screening, 76 percent of Washington women over age 40 who were surveyed reported having a mammogram in the past two years, which mirrors the national average. Of the 16 counties in the Service Area, the five counties with the lowest screening rates were Wahkiakum (48.4 percent screened), Lewis (64.7 percent), Grays Harbor (70.1 percent), San Juan (71.9 percent) and Clallam (72.3 percent). American Indian/Alaskan Native women had the lowest screening rate at 54 percent reporting having a mammogram within the past two years.

### **Health Systems Analysis**

Identification and updating of breast cancer resources were focused more on the “new” counties and populations not previously identified as areas of interest in the 2009 Community Profile. These are Clallam, Whatcom, Skagit and Thurston counties and Pacific Islander and Asian Indian/Pakistani women. For these “new” counties identified for further exploration, snapshots from the 2007 report were sent to key informants in those counties to confirm accuracy and for any additions or changes. These snapshots include information on breast health resources and gaps in services in their community.

For the previously identified counties of interest in the 2009 report – Greater Metropolitan counties of King, Pierce and Snohomish and Southwestern counties (Grays Harbor, Lewis, Pacific and Mason) – key informants from those communities were asked to verify/update statements from the last report.

Western Washington is home to many state-of-the-art medical facilities, mammography centers, and cancer treatment centers; however, the majority of services are clustered in the Greater Metropolitan (Seattle/Tacoma) area. The challenge in this region is not so much the lack of facilities and resources, but rather disparities in utilization or access. The focus must be on

ensuring that women are knowledgeable about and can access existing resources, and that providers and programs have the capacity to meet the demands for breast cancer screening and treatment of low-income residents who require no-cost care.

Many women living in the Southwest Washington region struggle with lack of information about breast health resources, transportation and poverty. Women's health care is very fragmented and typically involves sending a woman to several providers when she is diagnosed with breast cancer. Communication can be difficult and women may get lost in the system.

## **Qualitative Data Review**

The Affiliate gathered input from key stakeholders whose connection to residents of targeted geographic areas and to racial and ethnic communities and their issues would be helpful to the community profile process. Key informant interviews and/or focus groups were conducted to get perspectives from those living and working in the target areas and populations. Participants included community leaders, employees of county health departments, representatives from local hospitals, WBCCHP Prime Contractors and subcontractors, breast cancer survivors and health care providers.

Financial barriers and lack of health care insurance are the most commonly reported reasons why women of color don't get screened. This is followed by the lack of awareness or prioritization of breast health or preventive health care practices in general. Myths about breast cancer and mammograms, as well as cultural taboos, fears and modesty issues were all commonly cited as barriers to screening among women of color.

There are many concerns among racial and ethnic minorities about trust, and the intentions of the healthcare system. Based on their past history, this is especially true for African American and Native American women who may fear experimentation or doubt the intention of healthcare providers to care for people of color. Undocumented Hispanic women often fear the consequences of entering a government-supported program, doubt the actual anonymity of care and may find questions from providers to be intrusive and alarming.

## **Conclusions**

Based on detailed analyses of the breast cancer statistics, demographic information, health system resources and qualitative data, we identified areas of need:

- African American, Hispanic, American Indian/Alaska Native, Vietnamese, Pacific Islander and Asian Indian women need early detection services and support during treatment.
- Lewis, Pacific, Grays Harbor and Mason counties in Southwest Washington continue to need increased access to quality and convenient breast cancer treatment as well as early detection services.
- King, Pierce and Snohomish counties have the greatest burden of women in need of service, particularly women of color; women living in these counties need more information about available resources, as well as increased capacity for screening, patient navigation and treatment support.

- A common theme heard among all counties and populations was the need to increase awareness about breast health and about available resources and the need to address gaps in transportation, particularly in rural areas, and interpretation services to address language barriers of racial and ethnic minority women.

However, the current economic climate has resulted in tremendous increase in demand for free or low cost breast health services. The Affiliate does not have adequate resources to meet this demand, but is committed to working with our partners to preserve and protect current services and will continue our commitment to increase funding to invest in proven effective life-saving strategies.

### **Action Plan**

**Goal:** Increase breast cancer screening, patient navigation and treatment support services offered in Grays Harbor, Lewis, Pacific and Mason counties, particularly for low-income, Hispanic and American Indian/Alaska Native women.

Objective 1 – By March 2014, increase investments in effective screening, patient navigation and treatment support services and cultivate new applicants to the Affiliate’s grant programs that meet our target communities and priority service areas.

Objective 2 – Each grant period, increase by 5% the number of women enrolled and screened through WBCCHP and other partners providing low/no-cost screening, especially among Hispanic and American Indian/Alaska Native women.

Objective 3 – By March 2014, work with local partners to develop new and expand current awareness campaigns (using traditional and social media, Worship in Pink, Hispanic Initiative, etc.) that target low-income, Hispanic and American Indian/Alaska Native women in these counties.

**Goal:** Increase breast cancer awareness, screening and patient navigation in King, Snohomish and Pierce counties for low-income, African American, Hispanic, American Indian/Alaska Native, Vietnamese, Pacific Islander and Asian Indian women.

Objective 1 – By March 2014, increase investments in effective education, screening and patient navigation services and cultivate new applicants to the Affiliate’s grant programs that meet our target (current and new) communities and priority services.

Objective 2 – By March 2014, expand Worship in Pink campaign to include faith-based organizations beyond the African American community.

Objective 3 – By March 2014, increase the number of African American, Hispanic, American Indian/Alaska Native, Vietnamese, Pacific Islander and Asian Indian women who are enrolled in WBCCHP by 5% each grant period.

Objective 4 – By March 2014, work with local partners to develop new and expand current awareness campaigns (using traditional and social media, Worship in Pink, Hispanic Initiative, etc.) that target low-income, African American, Hispanic, American Indian/Alaska Native, Vietnamese, Pacific Islander and Asian Indian women in these counties.

**Goal:** Improve access to breast health and treatment services throughout our Service area through strategic alliances and change in public policy.

Objective 1 – By March 2014, work with National Komen, regional and local partners to advocate for increased federal and state funding for WBCCHP.

Objective 2 – By March 2014, work with Affiliate lobbyist to advocate for and prevent cuts to existing transportation programs and collaborate with American Cancer Society to expand its volunteer transportation program.

Objective 3 – By March 2014, work with Affiliate lobbyist and other partners to preserve and/or increase funding for medical interpretation services.

Objective 4 – By March 2014, develop strong alliances with existing and new partners that can help to move the Komen mission forward through Health Reform implementation.

# Introduction

## Purpose of Community Profile Report

The purpose of this updated report is to assess the extent and prevalence of breast cancer in the Service Area. The writers of this report examined statistics, services and community perspectives to identify disparities, gaps in service and barriers to care that prevent women from detecting breast cancer early. This report will be used to set Affiliate priorities, goals and objectives in its strategic planning, grant making and educational efforts to ensure that we are meeting our promise to save and improve lives.

## Affiliate History

Nancy G. Brinker promised her dying sister, Susan G. Komen, she would do everything in her power to end breast cancer forever. In 1982, that promise became Susan G. Komen for the Cure, which is the world's largest breast cancer organization and the largest source of nonprofit funds dedicated to the fight against breast cancer with more than \$1.3 billion invested to date.

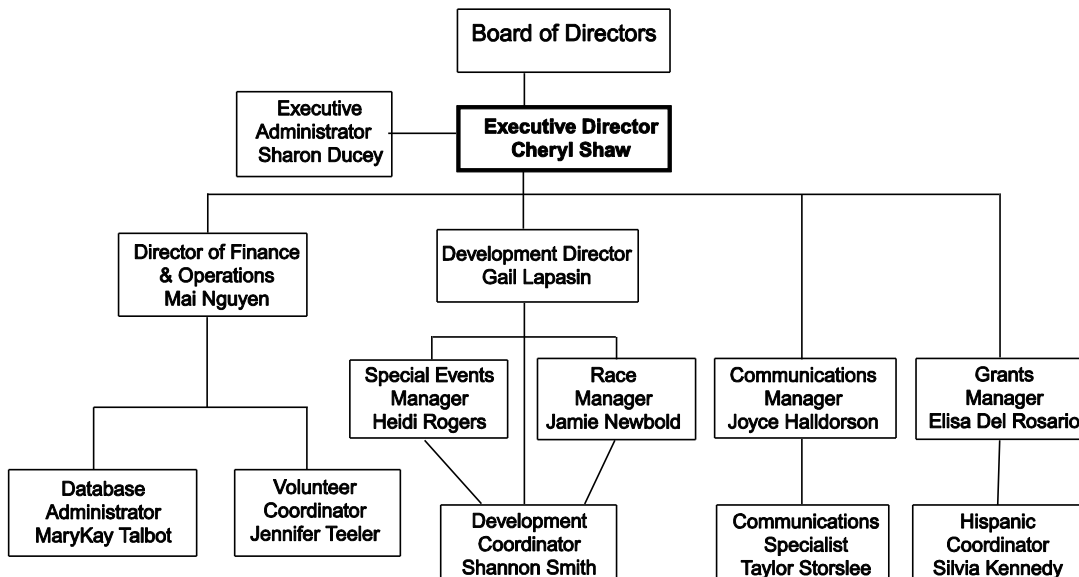
The Komen Puget Sound Affiliate in Washington (the Affiliate) was founded in 1993 to forward the mission of the National organization – to save lives and end breast cancer forever by empowering people, ensuring quality of care for all and energizing science to find the cures. Since inception, the Affiliate has invested nearly \$23 million in local nonprofit, tribal and government agencies that provide breast health/breast cancer services to medically underserved residents of our sixteen county service area.

## Affiliate Organizational Structure

The Affiliate is led by a 15-member board of directors and 13 employees. The Affiliate also relies on hundreds of volunteers to fulfill its scope of work.

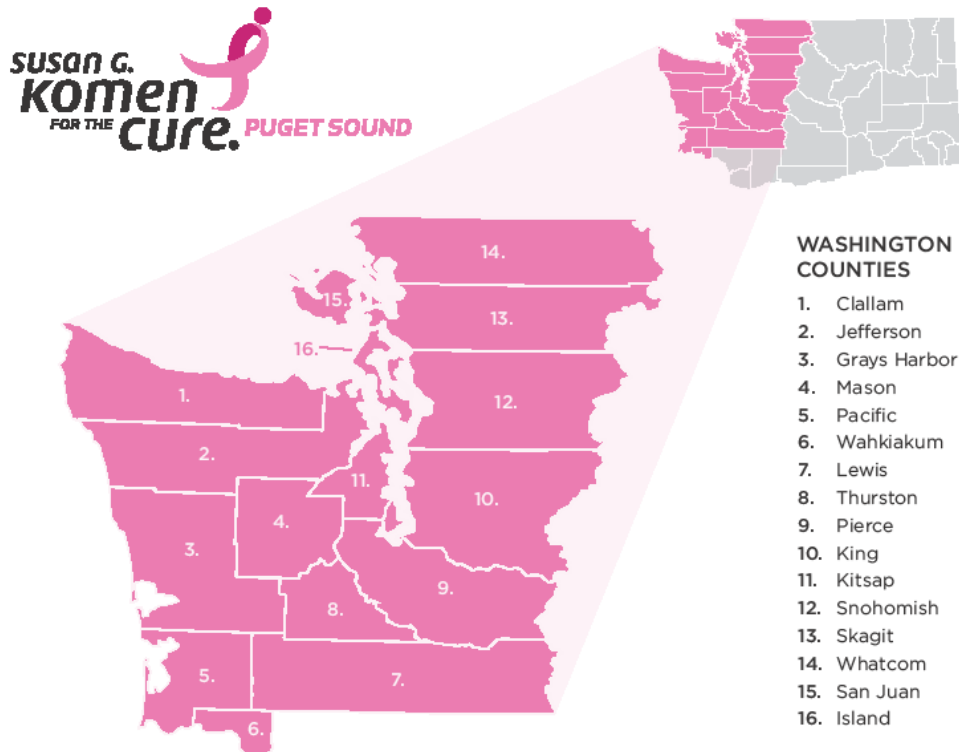
**Puget Sound Affiliate Organizational Chart**

May 2011



## Description of Service Area

The Affiliate serves 16 counties in Western Washington that includes Whatcom, Skagit, San Juan, Island, Snohomish, King, Kitsap, Clallam, Jefferson, Mason, Pierce, Thurston, Lewis, Grays Harbor, Pacific and Wahkiakum Counties (the Service Area). The Service Area contains major metropolitan cities, rural towns, remote coastal communities and islands that can only be accessed by boat or plane. See map below.



For the purposes of this report, the Service Area is divided into four regions:

### Greater Metropolitan Area

**King County** is the most populated county in Washington. Its largest city is Seattle, with a population of more than 600,000. Other primary population centers located on the I-5 or I-405 corridor include Bellevue, Redmond, Kirkland, Renton, Kent and Federal Way. The eastern most part of the county is more rural and less densely populated.

**Kitsap County** is located on the Kitsap Peninsula in the center of the Puget Sound Basin. The population is concentrated within seven major communities – Bremerton, Port Orchard, Poulsbo, Hansville, Silverdale, Kingston and Bainbridge Island. Bremerton is the largest city with a population of 37,700 but due to the presence of the military, the population tends to be transient. In fact, nearly 70 percent of the county is unincorporated. The northern part of the county includes two tribal areas – Suquamish and S’Klallam.

**Pierce County** is located in the southern Puget Sound area and contains a large metropolitan area (Tacoma), rural farmland, national park and forest area (Mt. Rainier) and two military bases. The majority of people are concentrated in Tacoma and along the I-5 corridor. The largest employer in Pierce County is the Joint Base Lewis McChord. There are a number of tribal areas in Pierce County, including the Puyallup and Nisqually reservations.

**Snohomish County** is located in the north Puget Sound area. The largest city is Everett, which has 24 percent of the entire county's population. Other major cities in the western region include Lynnwood, Bothell, Marysville and Edmonds. The eastern part of the county is primarily rural and has limited public transportation.

### **Olympic Peninsula**

**Clallam County** is west of Seattle and bordered by the Pacific Ocean, the Strait of Juan de Fuca and Jefferson County. Major population centers with health services, east to west along State Route 101, are Sequim, Port Angeles and Forks. Most of the southern part of Clallam County is part of national or state forestland and therefore is not inhabited.

**Jefferson County** is located on the Olympic Peninsula, west of Seattle. The largest town is Port Townsend, which is located in the extreme northeast corner. Other towns include Brinnon and Quilcene in the southeast part of the county. The entire middle of the county is composed of Olympic National Park. A small, remote strip of Jefferson County lies along the Pacific Ocean and includes Kalalock, Queets and Clearwater.

### **Northwestern Counties**

**Island County** is comprised of Whidbey Island and Camano Island. While Whidbey Island is a true island, Camano is physically connected to Snohomish County. This physical connection has resulted in a stronger linkage between Camano and Snohomish and Skagit counties for purposes of seeking services. The majority of Whidbey Island is rural. There are three population centers - Oak Harbor in the north, Coupeville on central Whidbey Island and Clinton in the south. Oak Harbor is home to the Whidbey Island Naval Air Station.

**San Juan County** is located in the northwest corner of the state and comprised of multiple small islands. Population and services are principally located on one of three larger islands, San Juan, Lopez and Orcas.

**Skagit County** is located in northwestern Washington and bordered by Whatcom County to the north, Snohomish County to the south, the Puget Sound to the west and Chelan and Okanogan Counties to the east. Mount Vernon and Anacortes are the largest cities.

**Whatcom County** is located on the northern boundary of Washington State with British Columbia, Canada to the north. The county is surrounded by Puget Sound to the west, Skagit County to the south and Okanogan County to the east. Most of the population in Whatcom County is concentrated along the I-5 corridor. The major population center is Bellingham, which accounts for 59 percent of the county population. Bellingham is also the location of

Western Washington University. The eastern and northern portions of Whatcom County are rural.

### **Southwestern Counties**

**Grays Harbor County** is situated on the coast, bordering Mason and Thurston counties. The county is largely rural. The largest incorporated cities are Aberdeen and Hoquiam. Other smaller towns lie along the main road to Olympia and along the coast.

**Lewis County** is situated at the southern end of the Puget Sound region, just below Thurston County. It has the sixth largest land area of all counties in the state, and is predominantly rural. Centralia is the largest city in the county.

**Mason County** lies on the southern end of the Olympic Peninsula, south of the Hood Canal. A large portion of Mason County is part of Olympic National Forest and uninhabited. Shelton is the largest town in the county and accounts for almost 65 percent of the county's population. The county is home to the Skokomish and Squaxin Island Indian Reservations.

**Pacific County** is on the west coast of Washington. It is primarily rural and composed of small towns, most of which hug the coastline. Most of the population lives in unincorporated areas. The largest town is Raymond.

**Thurston County** is the fifth most populous county in the Affiliate's Service Area and lies at the southern tip of Puget Sound. The population of residents is concentrated in Olympia and Lacey, which account for nearly 82 percent of the county's population.

**Wahkiakum County** is located in the southwest corner of Washington, along the Columbia River. It is the least populated county in the Affiliate's Service Area with less than 4,000 people. Due to its rural nature, services are limited and the nearest access requires extensive travel.

## **Breast Cancer Impact in Affiliate Service Area**

### **Methodology**

The majority of data used in the demographic section of the Community Profile was obtained through the Thomson Reuters © 2009 package: a Komen National commissioned custom module of estimated demographic data for the Service Area.

The Affiliate relied on local and national sources for our region's breast cancer statistics. Data directly available from the Washington State Cancer Registry and the Western Washington Surveillance Epidemiology and End Results (SEER) cancer registry, which serves 13 of the 16 counties in the Service Area, were used for this report.

The initial step in updating the Community Profile was to gather and analyze the demographic data, such as population count, race/ethnicity, income and health insurance status for each of the Service Area's 16 counties. We then analyzed the breast cancer data by county/region and by race/ethnicity using incidence rates, distribution of stage at diagnosis and five year conditional survival rates.

In interpreting the available breast cancer data, populations of potential concern were identified if they were below the Service Area average on at least two of our three breast cancer indicators (i.e. high proportion of advanced stage cancer, lower proportion of in situ stage, and/or lower rate of conditional survival).

County/counties of interest were identified if they were:

- On the worse end of at least two of our three breast cancer indicators, and/or
- On the worse end of socioeconomic status indicators (either proportionately or in terms of sheer large numbers in this category).
- Additionally, counties can also be identified on the basis of having a large number of women in an underserved ethnic racial group for any ethnic/racial group shown to have worse staging/mortality.

### **Overview of the Affiliate Service Area**

#### **Demographic Information**

In 2009, Washington State (comprised of 39 counties) had an estimated population of 6,664,195 individuals (See Table 1). This total represents a 12 percent increase in population since the year 2000.

The 16 county Puget Sound Service Area had an estimated population of 4,607,327 individuals in 2009. It is the densest region of the state population-wise and includes 69 percent of the entire state's population. Twenty-five percent of the Service Area population is women age 40 or older. The number of minorities grew by 50 percent over the past decade in the Service Area.

The majority of the estimated population within the Service Area overall is Caucasian/non-Hispanic (74 percent). Asian/Pacific Islanders make up the second largest racial/ethnic group (9 percent), followed by Hispanics (7.3 percent), African Americans (4.2 percent), Other (4 percent) and American Indian/Alaskan Native (1.3 percent).

The Greater Metropolitan region (GM), comprising of four counties, had the greatest number of residents at 78.6 percent (or 3,623,557) of the Service Area population. The GM region is also the most diverse in terms of race/ethnicity (almost 25 percent non-White).

Of the 16 counties in the Service Area, King County has by far the largest estimated population, is the single most diverse county (31.9 percent non-White), and, in keeping with the two prior points, has the highest absolute numbers of racial/ethnic minority individuals:

- Asian/Pacific Islander: 13.8 percent or 261,486
- Hispanic: 7.6 percent or 144,007
- African American: 5.6 percent or 106,110
- American Indian/Alaskan Native (AI/AN): 0.8 percent or 15,159

Note: More recent Census 2010 results, show that within King County, the suburbs south of Seattle experienced the most dramatic changes, where four cities now have more minorities than non-Hispanic Whites: Tukwila (62.4 percent), SeaTac (60.5 percent), Renton (50.6 percent) and Kent (50.3 percent). (Source: *The Seattle Times*, Census 2010, Counting Washington, Feb. 24, 2011)

Counties with the estimated largest proportions of specific ethnic/racial minority subgroups are listed as follows: Pierce County has the highest proportion of African Americans at 6.5 percent (51,568 individuals); Skagit County has the highest proportion of Hispanics at 14.3 percent (17,191 individuals); and Clallam County has the highest percentage of AI/AN at nearly 5 percent (3,429 individuals), with Grays Harbor County next at 4 percent (3,625 individuals) of its population being AI/AN.

In terms of counties with the largest estimated counts (outside of the GM region) of specific ethnic/racial minority subgroups, Thurston County had the highest count of African Americans (6,802) and Asian Pacific Islanders (9,231) and second highest for Hispanics (14,332), Whatcom County for American Indian/Alaskan Native (4,831), and Skagit County for Hispanics (17,191).

(Source: Thomson Reuters © 2009)

**Table 1. Estimated Race/Ethnicity Population**

Location	Total Pop		White *		African American *		AI/AN*		API*		All Other*		Hispanic	
	Count		Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
<b>WA</b>	6,664,195		5,031,467.2	75.5%	246,575.2	3.7%	113,291.3	1.7%	479,822.0	7.2%	206,590.0	3.1%	653,091.1	9.8%
<b>PSA</b>	4,607,327		3,423,244	74.3%	193,508	4.2%	59,895	1.3%	414,659	9.0%	184,293	4.0%	336,335	7.3%
<b>GM</b>														
King	1,894,829		1,290,379	68.1%	106,110	5.6%	15,159	0.8%	261,486	13.8%	77,688	4.1%	144,007	7.6%
Kitsap	241,611		197,396	81.7%	5,799	2.4%	3,624	1.5%	12,322	5.1%	11,114	4.6%	11,597	4.8%
Pierce	793,361		579,154	73.0%	51,568	6.5%	10,314	1.3%	51,568	6.5%	40,461	5.1%	60,295	7.6%
Snoh	693,756		536,273	77.3%	15,263	2.2%	9,019	1.3%	58,276	8.4%	24,281	3.5%	49,950	7.2%
<b>GM Tot/Avg</b>	<b>3,623,557</b>		<b>2,603,202</b>	<b>75.0%</b>	<b>178,740</b>	<b>4.2%</b>	<b>38,115</b>	<b>1.2%</b>	<b>383,653</b>	<b>8.5%</b>	<b>153,545</b>	<b>4.3%</b>	<b>265,850</b>	<b>6.8%</b>
<b>OP</b>														
Clallam	71,434		61,076	85.5%	643	0.9%	3,429	4.8%	1,214	1.7%	1,714	2.4%	3,286	4.6%
Jeff	28,448		25,831	90.8%	171	0.6%	341	1.2%	512	1.8%	882	3.1%	711	2.5%
<b>OP Tot/Avg</b>	<b>99,882</b>		<b>86,907</b>	<b>88.2%</b>	<b>814</b>	<b>0.8%</b>	<b>3,770</b>	<b>3.0%</b>	<b>1,726</b>	<b>1.8%</b>	<b>2,596</b>	<b>2.8%</b>	<b>3,997</b>	<b>3.6%</b>
<b>NW</b>														
Island	81,237		69,458	85.5%	1,625	2.0%	731	0.9%	3,493	4.3%	2,437	3.0%	3,493	4.3%
San Juan	15,627		14,330	91.7%	47	0.3%	125	0.8%	203	1.3%	359	2.3%	547	3.5%
Skagit	120,217		95,212	79.2%	842	0.7%	1,923	1.6%	2,525	2.1%	2,525	2.1%	17,191	14.3%
Whatcom	193,237		161,546	83.6%	1,739	0.9%	4,831	2.5%	7,150	3.7%	5,217	2.7%	12,754	6.6%
<b>NW Tot/Avg</b>	<b>410,318</b>		<b>340,546</b>	<b>85.0%</b>	<b>4,252</b>	<b>1.0%</b>	<b>7,611</b>	<b>1.5%</b>	<b>13,371</b>	<b>2.9%</b>	<b>10,538</b>	<b>2.5%</b>	<b>33,985</b>	<b>7.2%</b>
<b>SW</b>														
G.Harbor	74,205		62,258	83.9%	445	0.6%	3,265	4.4%	1,039	1.4%	2,004	2.7%	5,120	6.9%
Lewis	76,247		66,869	87.7%	457	0.6%	915	1.2%	686	0.9%	1,372	1.8%	5,947	7.8%
Mason	55,317		46,688	84.4%	664	1.2%	1,825	3.3%	885	1.6%	1,604	2.9%	3,651	6.6%
Pacific	21,111		18,029	85.4%	106	0.5%	464	2.2%	443	2.1%	570	2.7%	1,520	7.2%
Thurston	242,923		196,282	80.8%	6,802	2.8%	3,401	1.4%	12,875	5.3%	9,231	3.8%	14,332	5.9%
Wahkiakum	3,767		3,518	93.4%	8	0.2%	57	1.5%	11	0.3%	90	2.4%	79	2.1%
<b>SW Tot/Avg</b>	<b>473,570</b>		<b>393,643</b>	<b>85.9%</b>	<b>8,481</b>	<b>1.0%</b>	<b>9,927</b>	<b>2.3%</b>	<b>15,940</b>	<b>1.9%</b>	<b>14,872</b>	<b>2.7%</b>	<b>30,650</b>	<b>6.1%</b>

\*Non- Hispanic AI/AN = American Indian/Alaskan Native API = Asian/Pacific Islander Source: Thomson Reuters © 2009

**Income and Insurance** (See Tables 2 and 3)

The current economic recession has seriously affected the lives of many Washington residents. From December of 2008 to December 2010, unemployment increased, from 7 to 9.2 percent throughout Washington.

([https://fortress.wa.gov/esd/lmea/countydashboard/URateDetails.aspx?area=53\\_01\\_000000](https://fortress.wa.gov/esd/lmea/countydashboard/URateDetails.aspx?area=53_01_000000))

Household income and the health insurance status of people living in Washington has been particularly influenced by the state’s economic downturn.

Low household income and lack of health insurance are often key barriers to obtaining mammograms and other preventive health care. In the 16 county Service Area, 77,256 (or 6.6 percent) of families were estimated in 2009 to have incomes below the federal poverty level (100 percent Federal Poverty Level for a family of four is \$22,050). Approximately 11 percent of individuals in the Service Area were estimated to have been uninsured in 2009. It is important to note that, for both income and health insurance, there was also regional and county variation in the percentages uninsured which is highlighted below:

- **Southwestern Counties (SW):** Among the four regions, the SW region has the highest percentage of families with incomes below the federal poverty level (8.9 percent) and the highest proportion of individuals who are uninsured (14.3 percent).

- Grays Harbor (11.4 percent), Lewis (11.1 percent) and Pacific (10.5 percent) Counties in the SW region have the highest proportion of families living below poverty level among all 16 counties. Similarly, Grays Harbor (18.1 percent), Lewis (15.3 percent) and Pacific (15.8 percent) Counties have greater proportions of individuals who are uninsured.
- Although Thurston County has one of the lowest proportions of families with incomes below poverty level (5.9 percent), it is the largest county population-wise within the SW region and thus has the highest number of families (n= 3,872) at this lower income level and uninsured individuals (n=26,787).
- Olympic Peninsula (OP): The two-county region is by far the least populated region in the Service Area. It is second only to the SW Washington region in terms of both the percentage of the population with an income level below the poverty line and that are uninsured. This appears to be primarily driven by the adverse numbers in Clallam County, where 9.2 percent of families fall below the federal poverty level and 15.2 percent are uninsured.
- Greater Metropolitan (GM): Seventy-four percent of all uninsured individuals within the Service Area reside in the GM region. Although this region has lower proportions of families living below the poverty level and uninsured individuals within the Service Area, the sheer magnitude of population density concentrated in this region results in the greatest numbers of disadvantaged families and individuals residing here. Specifically, King (27,042), Pierce (15,102) and Snohomish (9,930) Counties have the highest counts of families living below the poverty level. The GM region has approximately 377,535 uninsured individuals with the greatest count (200,362) residing in King County.
- Northwestern Counties (NW): Whatcom County, the largest county in the NW region and the sixth largest county in the Service Area, has a high percentage (8.4 percent or 4,061) of families living below the poverty level and a high percentage (17.6 percent or 34,027) of individuals who are uninsured.

**Table 2. Estimated 2009 Family Income by County/Region**

Location	2009 Families	Income Below Poverty Level		Median Household Income
		Families	%	
WA*				\$52,413
PSA	1,177,087	77,256	6.6%	\$63,697
<u>GMA</u>				
King	459,601	27,042	5.9%	\$71,075
Kitsap	64,626	4,027	6.2%	\$61,952
Pierce	205,252	15,102	7.4%	\$59,429
Snohomish	182,878	9,930	5.4%	\$68,022
GM Tot/Avg	912,357	56,101	6.2%	\$65,120
<u>OP</u>				
Clallam	20,592	1,893	9.2%	\$42,933
Jefferson	8,440	565	6.7%	\$50,015
OP Tot/Avg	29,032	2,458	8.0%	\$46,474
<u>NW</u>				
Island	23,362	1,384	5.9%	\$58,385
San Juan	4,559	333	7.3%	\$53,711
Skagit	31,803	2,535	8.0%	\$53,148
Whatcom	48,093	4,061	8.4%	\$49,195
NW Tot/Avg	107,817	8,313	7.4%	\$53,610
<u>SW</u>				
Grays Harbor	19,142	2,183	11.4%	\$43,064
Lewis	20,854	2,308	11.1%	\$44,546
Mason	15,365	1,322	8.6%	\$51,026
Pacific	6,048	635	10.5%	\$40,064
Thurston	65,357	3,872	5.9%	\$59,120
Wahkiakum	1,115	64	5.7%	\$48,954
SW Tot/Avg	127,881	10,384	8.9%	\$47,796

**Table 3. Estimated 2009 Insurance by County/Region**

Location	Total Pop Count	Uninsured	
		Count	%
PSA	4,607,327	512,410	11.1%
<u>GMA</u>			
King	1,894,829	200,362	10.6%
Kitsap	241,611	24,790	10.3%
Pierce	793,361	94,377	11.9%
Snohomish	693,756	58,006	8.4%
GM Tot/Avg	3,623,557	377,535	10.3%
<u>OP</u>			
Clallam	71,434	10,828	15.2%
Jefferson	28,448	3,667	12.9%
OP Tot/Avg	99,882	14,495	14.0%
<u>NW</u>			
Island	81,237	7,346	9.0%
San Juan	15,627	2,248	14.4%
Skagit	120,217	13,495	11.2%
Whatcom	193,237	34,027	17.6%
NW Tot/Avg	410,318	57,116	13.1%
<u>SW</u>			
Grays Harbor	74,205	13,428	18.1%
Lewis	76,247	11,641	15.3%
Mason	55,317	7,614	13.8%
Pacific	21,111	3,340	15.8%
Thurston	242,923	26,787	11.0%
Wahkiakum	3,767	452	12.0%
SW Tot/Avg	473,570		14.3%

Source: Thomson Reuters © 2009

### Breast Cancer Statistics

Breast cancer is the most frequently diagnosed cancer among Washington women and the second leading cause of cancer death. While there is uncertainty regarding strategies to prevent the disease, it is well proven that early stage diagnoses can greatly improve a woman's chance for survival. The most effective way to identify breast cancer at its earliest stages is through regular mammography screening.

Given that in situ breast cancer rates are in great part a reflection of mammography utilization (i.e., higher incidence of in situ disease is correlated with higher mammography use), it is useful to identify populations with lower proportions of cases diagnosed with in situ disease.

**Invasive Breast Cancer Incidence by Race/Ethnicity** (See Table 4)

In the Service Area the age-adjusted incidence rate of invasive breast cancer is highest among American Indian/Alaska Native women (141.1/100,000) followed by Non-Hispanic White women (137.2/100,000) and Black women (122.7/100,000).

Hispanic White women and Asian/Pacific Islander women have noticeably lower incidence rates.

**Table 4. Incidence of newly diagnosed invasive breast cancer in women by race/ethnicity for 2003-2007 -- in the Service Area**

Race/Ethnicity	Average Annual Number of Observed (new cases)	Average Annual Population	Age Adjusted Rate*	95% CI <sup>+</sup>
Non-Hispanic White	2,807	1,754,858	137.2	134.9-139.5
Hispanic White	41	107,604	88.3	75.2-103.6
African American <sup>£</sup>	86	102,032	122.7	110.9-135.6
American Indian/Alaska Native <sup>£</sup>	35	34,570	141.1	118.6-167.8
Asian/Pacific Islander <sup>£</sup>	177	206,656	95.6	89.1-102.5

\*Age adjusted rate per 100,000 (year 2000 standard US population)

<sup>+</sup> 95% confidence interval

<sup>£</sup> includes Hispanic and non-Hispanic women

**Breast Cancer Stage at Diagnosis by Race/Ethnicity** (See Table 5)

African American (37.4 percent), Hispanic White (35.7 percent) and American Indian/Alaskan Native (32.5 percent) women had the highest proportions of breast cancers that were advanced stage at diagnosis.

Non-Hispanic White (27.3 percent) and Asian/Pacific Islanders (27.7 percent) as a whole had lower (albeit still unacceptably high) proportions of breast cancers diagnosed at an advanced stage. However, disaggregated data for the Asian/Pacific Islander group paint a different picture for particular sub-groups (see Table 6).

Hispanic (15.2 percent) and American Indian/Alaska Native (16.3 percent) women had noticeably lower proportions of cases diagnosed with in situ disease as compared to other racial groups.

**Table 5. Distribution of stage at breast cancer diagnosis by race/ethnicity among cases diagnosed in 2003-2007 -- in the Service Area**

Race/Ethnicity	<u>In situ</u>		<u>Localized</u>		<u>Advanced (regional or distant)</u>		Total number of cases
	No.	(%)	No.	(%)	No.	(%)	
<b>Non-Hispanic White</b>	3,627	(20.5)	8,928	(50.6)	4,823	(27.3)	17,660
<b>Hispanic White</b> <sup>1,2</sup>	37	(15.2)	115	(47.1)	87	(35.7)	244
<b>African American</b> <sup>£1,2</sup>	101	(19.1)	219	(41.3)	198	(37.4)	530
<b>American Indian/Alaska Native</b> <sup>£1,2</sup>	34	(16.3)	101	(48.3)	68	(32.5)	209
<b>Asian/Pacific Islander</b> <sup>£</sup>	290	(24.7)	539	(45.9)	325	(27.7)	1,175
<b>Unknown</b>	77	(21.8)	173	(49.0)	83	(23.5)	353

<sup>£</sup> includes Hispanic and non-Hispanic women

<sup>1</sup> Lower proportion of breast cancer cases diagnosed at in situ breast cancer or stage zero compared to state average (20.0) (yellow)

<sup>2</sup> Higher proportion of breast cancer cases diagnosed at advanced stage compared to state average (27.9) (yellow)

### **Breast Cancer Stage at Diagnosis by Asian/Pacific Islander Ethnicity (See Table 6)**

#### Observations:

There was some discernible heterogeneity amongst the subgroups comprising the Asian/Pacific Islander group.

Pacific Islander (45.6 percent) and Asian Indian/Pakistani (40 percent) women had the highest percentages of newly diagnosed breast cancers presenting with advanced stage.

Vietnamese (30 percent) and Chinese (27.7 percent) women had more intermediate proportions with advanced stage disease, and Japanese (22.1 percent) and Filipino (25.0 percent) women had the lowest proportions of advanced stage diagnoses.

The proportions of breast cancer diagnosed at the in situ stage also varied considerably. Vietnamese (14.3 percent), Pacific Islander (15.8 percent) and Asian Indian/Pakistani (16.7 percent) had lower proportions of newly diagnosed cases detected at the in situ stage whereas Filipino (29.1 percent), Japanese (24.4 percent) and Chinese (23.9 percent) women all had higher proportions of in situ cancers.

**Table 6. Distribution of stage at diagnosis by Asian/Pacific Islander ethnicity among cases diagnosed in 2003-2007 -- in the 13 counties of the Service Area covered by the SEER cancer registry.**

Race/Ethnicity	<u>In situ</u>		<u>Localized</u>		<u>Advanced (regional or distant)</u>		Total number of cases
	No.	(%)	No.	(%)	No.	(%)	
<b>Chinese</b>	38	(23.9)	77	(48.4)	44	(27.7)	159
<b>Japanese</b>	41	(24.4)	90	(53.6)	37	(22.0)	168
<b>Filipino</b>	78	(29.1)	123	(45.9)	67	(25.0)	268
<b>Asian Indian/Pakistani</b> <sup>1,2</sup>	10	(16.7)	26	(43.3)	24	(40.0)	60
<b>Vietnamese</b> <sup>1,2</sup>	10	(14.3)	39	(55.7)	21	(30.0)	70
<b>Pacific Islander</b> <sup>1,2</sup>	9	(15.8)	22	(38.6)	26	(45.6)	57

<sup>1</sup> Lower proportion of breast cancer cases diagnosed at in situ breast cancer (stage zero) compared to state average (20.0) (yellow)

<sup>2</sup> Higher proportion of breast cancer cases diagnosed at advanced stage compared to state average (27.9) (yellow)

### **Five Year Survival Rate by Race/Ethnicity (See Table 7)**

Among the five primary racial categories examined, African American and American Indian/Alaska Native women had the worst survival pattern, with 81.7 percent and 77.6 percent survival after five years, respectively. Non-Hispanic Whites and Asian/Pacific Islanders as aggregate groups had noticeably better five year survival (90.9 percent and 92.3 percent). The five year survival rate in Hispanic White women was intermediate to the two previous groups (89.2 percent).

Despite the overall better survival pattern among Asian/Pacific Islanders, there was discernible heterogeneity across subgroups. Asian Indian/Pakistani (70 percent) and Pacific Islanders (76.5 percent) had the worst five year survival of any single racial/ethnic group whereas five year survival rates were relatively high in Chinese (93.4 percent), Korean (94.9 percent) and Vietnamese (98.1 percent) women.

Changes over time: For Hispanic White, American Indian/Alaska Native, Asian Indian/Pakistani and Japanese women, there is some suggestion that survival is worsening over time. However, some results are based on small numbers and therefore conclusions must be made cautiously. In such instances, the distribution of stage at diagnosis may be helpful in interpreting the big picture. As an example, for Japanese women, while there is some suggestion of possibly worsening survival over time, the distribution of stage at diagnosis, with both the lowest proportion of advanced stage diagnosis of any racial/ethnic group and one of the highest proportions of in situ diagnoses, suggests that this group is generally very well-screened. In contrast, for Vietnamese and Chinese women, the data on survival are suggestive of improvement in recent years. However, the stage data suggest that Vietnamese women may still lag in screening given their somewhat higher rates of advanced stage disease and lower rates of in situ disease.

Cautionary note: Follow-up time is incomplete for the women diagnosed 2002-2006 and some of the numbers of deaths for individual racial/ethnic groups are quite small. Thus, while these results are the most recent available, they must be interpreted cautiously. We show the results for cases from 1997-2001 for comparison purposes, but focus comments above on the most recent five-year period.

**Table 7. Five-year cause-specific survival from invasive breast cancer by race/ethnicity among cases diagnosed in 1997-2001 and 2002-2006 -- in the 13 counties of the Service Area covered by the SEER registry**

	<u>1997-2001</u>			<u>2002-2006</u>		
	Number with breast cancer	Number of deaths	5-year cause specific survival rate	Number with breast cancer	Number of death	5-year cause specific survival rate
Non-Hispanic White	13,920	1,340	89.9 (89.4-90.4)	13,976	861	90.9 (90.3-91.6)
Hispanic White <sup>1</sup>	231	17	92.4 (88.1-95.2)	267	20	89.2 (82.8-93.3)
African American <sup>1</sup>	345	64	80.6 (75.9-84.5)	437	56	81.7 (75.7-86.3)
American Indian/Alaska Native <sup>1</sup>	149	16	89.0 (82.7-93.1)	187	22	77.6 (65.9-85.8)
Asian/Pacific Islander	629	57	90.6 (88.0-92.7)	877	45	92.3 (89.5-94.3)
- Chinese	69	7	89.6 (79.4-94.9)	119	6	93.4 (85.7-91.7)
- Japanese <sup>1</sup>	119	9	92.1 (85.3-95.8)	137	10	89.1 (79.8-94.2)
- Filipino	137	17	87.1 (80.0-91.8)	187	9	92.8 (85.8-96.5)
- Korean	62	8	86.1 (74.1-92.8)	98	4	94.9 (86.9-98.1)
- Asian Indian/Pakistani <sup>1</sup>	19	1	94.7 (68.1-99.2)	40	5	70.0 (30.7-89.8)
- Vietnamese	41	8	80.3 (64.5-89.6)	54	1	98.1 (87.4-99.7)
- Pacific Islanders <sup>1</sup>	12	3	74.1 (39.1-90.9)	33	6	76.5 (53.9-89.0)

<sup>1</sup> Worse survival among breast cancer cases; defined as 5-year survival rate below the lower confidence limit for the average rate across all 13 counties (90.6) (yellow).

Date Source: Cancer Surveillance System (CSS), a SEER population-based cancer registry covering 13 counties in Western Washington State

Note: These analyses exclude 1) breast cancer cases diagnosed only at autopsy and 2) women with breast cancer who were alive at diagnosis but have no additional follow-up time.

### **Breast Cancer Screening by Race/Ethnicity (See Table 8)**

American Indian/Alaska Native women had the lowest screening rate with only 54 percent reporting having a mammogram within the past two years. Asian/Pacific Islander women and Hispanic women have the next worse rate, both at 68 percent. While it appears that African American women have a higher screening rate (72 percent), it should be noted that the sample size is fairly small (58 women) and caution should be used in interpreting the data. As seen in the table below, the sample sizes for racial/ethnic women are relatively small in comparison to the sample size for White women.

**Table 8. Screening rates for women age 40-75 by Race/Ethnicity in Service Area**

	5+ yrs+/Never		0-2 yrs		2-5 yrs		Total	
White, non-Hisp	593	13%	3726	79%	408	9%	4727	100%
African American	14	24%	42	72%	2	*	58	100%
Asian/Pac.Is.	17	15%	79	68%	21	18%	117	100%
Amer.Ind./AN	20	28%	39	54%	13	18%	72	100%
Hispanic (white)	15	19%	54	68%	10	13%	79	100%
Total	659	13%	3940	78%	454	9%	5053	100%

\*Insufficient sample size.

(Source: Behavioral Risk Factor Surveillance System – BRFSS, 2008)

**Breast Cancer Incidence by County/Region (See Table 9)**

Compared to the entire State of Washington, rates of invasive breast cancer were statistically higher in the Service Area as a whole, in both the Greater Metropolitan and Olympic Peninsula regions as well as in Clallam, King and Snohomish counties in particular. In addition, although differences did not achieve statistical significance, invasive breast cancer rates in Island, Jefferson, Mason, Thurston and Whatcom counties were observably higher than those for the State as a whole.

Compared to the State, rates of in situ breast cancer were statistically higher in the Service Area overall, specifically in the Greater Metropolitan region and in King and Whatcom counties. In situ incidence rates were also higher in Island, Jefferson, Kitsap and Snohomish counties but these differences were not statistically significant.

**Table 9. Incidence rates of newly diagnosed breast cancer (in situ and invasive) in women by county and region for 2003-2007 --in the Service Area**

Region	Average Annual Female Population	<u>In Situ</u> Breast Cancer			<u>Invasive</u> Breast Cancer		
		Avg. Annual Number of New Cases	Age Adj. Rate*	95% CI*	Avg. Annual Number of New Cases	Age Adj. Rate*	95% CI*
Clallam <sup>2,3</sup>	33,779	13	23.8	18.1-31.7	79	153.0	137.6-170.4
Grays Harbor <sup>2,4</sup>	35,070	9	21.1	15.4-28.6	51	113.6	99.8-129.1
Island	37,961	18	40.1	32.2-49.5	67	145.1	129.7-162.1
Jefferson	13,896	7	34.9	24.0-52.7	32	144.7	122.2-173.1
King <sup>1,3</sup>	911,122	375	38.8	37.1-40.6	1,310	135.8	132.5-139.2
Kitsap	118,776	46	36.0	31.4-41.1	168	130.7	121.9-140.0
Lewis	36,239	12	26.4	20.0-34.7	53	119.6	105.3-135.8
Mason	25,173	11	32.8	24.6-43.7	48	141.1	123.4-161.3
Pacific <sup>4</sup>	10,710	2	NC	NC	17	97.5	76.3-125.9
Pierce	381,494	126	32.2	29.7-34.8	505	130.6	125.5-135.8
San Juan	7,868	3	NC	NC	13	105.2	80.9-141.3

Skagit	55,957	19	28.5	22.9-35.1	85	126.0	114.2-138.9
Snohomish <sup>3</sup>	329,179	116	35.3	32.5-38.4	454	139.6	133.8-145.6
Thurston	114,824	37	28.7	24.7-33.2	180	140.3	131.2-150.0
Wahkiakum	1,937	NC	NC	NC	3	NC	NC
Whatcom <sup>1</sup>	91,735	38	40.0	34.4-46.2	135	141.4	130.8-152.7
Service Area <sup>1,3</sup>	2,205,719	833	35.1	34.1-36.2	3,201	135.1	133.0-137.2
Greater Metropolitan Area <sup>1,3</sup>	1,740,571	663	36.5	35.3-37.8	2,437	134.9	132.5-137.4
Olympic Peninsula <sup>3</sup>	47,675	20	27.5	22.2-34.4	111	150.9	138.1-165.2
Northwestern Counties	193,521	78	35.7	32.3-39.6	301	135.6	128.7-142.7
Southwestern Counties <sup>2</sup>	223,953	73	26.8	24.0-29.7	352	129.3	123.2-135.6
WA State	3,149,611	1,108	33.0	32.1-33.8	4,429	131.5	129.7-133.2

\*Age adjusted rate per 100,000 (year 2000 standard US population) <sup>+</sup>95% confidence interval

NC =Not calculated (if the total number of cases is less than 20 for the 2003-2007)

GM: King, Kitsap, Pierce, Snohomish

OP: Clallam, Jefferson

NW: Island, San Juan, Skagit, Whatcom

SW: Grays Harbor, Mason, Thurston (missing Lewis, Pacific, Wahkiakum counties)

<sup>1</sup> Higher incidence rate of in situ breast cancer compared to Washington State rate (statistically significant difference)

<sup>2</sup> Lower incidence rate of in situ breast cancer compared to Washington State rate (statistically significant difference)

<sup>3</sup> Higher incidence rate of invasive breast cancer compared to Washington State rate (statistically significant difference)

<sup>4</sup> Lower incidence rate of invasive breast cancer compared to Washington State rate (statistically significant difference)

#### Data Source:

Incidence Data: Washington State Cancer Incidence Data: Washington State Department of Health, Washington State Cancer Registry, released in January 2010.

Population Data: Population Estimates: Washington State Department of Health, Washington State Office of Financial Management, Krupski Consulting; Washington State Population Estimates for Public Health. January 2010.

### Breast Cancer Stage at Diagnosis by County/Region (See Table 10)

Lewis and Pacific counties had the highest proportion (32 percent) of resident cases diagnosed with advanced stage (defined as regional or distant stage) disease in the Service Area. Other counties that exceeded the statewide proportions of breast cancers diagnosed at advanced stage include Kitsap (29.7 percent), Clallam (28.9 percent), Thurston (28.9 percent), Skagit (28.8 percent), Jefferson (28.7 percent), San Juan (28.1 percent) and Pierce (28.0 percent).

Compared to the statewide proportion with in situ disease (20 percent), both the Olympic Peninsula (15.1 percent) and Southwestern (17.1 percent) regions had lower proportions of cases diagnosed with in situ breast cancer. Compared to the statewide average, several counties had considerably lower proportions of in situ diagnoses – specifically Pacific (12.4 percent), Clallam (13.7 percent), Grays Harbor (15.6 percent), and Thurston (17.2 percent). Other counties on the lower side include: Skagit (18.0 percent), Lewis (18.2 percent), San Juan (18.3 percent) and Jefferson (18.5 percent).

Counties with high proportions of cases diagnosed with advanced stage disease and/or low proportions of in situ disease are locales likely to have insufficient rates of mammographic screening.

It is worth noting that, while some of our most densely populated counties do not get highlighted for having the most adverse profiles in terms of proportion of stage distribution, some of these areas carry a heavy burden nonetheless due to the sheer large number of residents diagnosed with advanced stage disease (e.g. King County with over 2200 such cases).

**Table 10. Proportional distribution of stage of breast cancer at diagnosis in 2003-2007 by county and region -- in the Service Area**

Region	<u>In Situ</u>	<u>Local Stage</u>	<u>Advanced (Regional or Distant) Stage</u>	<u>Unstaged</u>	<u>Total</u>
	No. (%)	No. (%)	No. (%)	No. (%)	No.
Clallam <sup>1,2</sup>	63 (13.7)	253 (55.0)	133 (28.9)	11 (2.4)	460
Grays Harbor <sup>1</sup>	47 (15.6)	165 (54.8)	74 (24.6)	15 (5.0)	301
Island	92 (21.7)	219 (51.5)	110 (25.9)	NC	425
Jefferson <sup>1,2</sup>	36 (18.5)	98 (50.3)	56 (28.7)	NC	195
King	1,874 (22.2)	4,117 (48.9)	2,296 (27.3)	136 (1.6)	8,423
Kitsap <sup>2</sup>	229 (21.4)	504 (47.2)	317 (29.7)	19 (1.8)	1,069
Lewis <sup>1,2</sup>	59 (18.2)	156 (48.0)	104 (32.0)	6 (1.9)	325
Mason <sup>1</sup>	56 (19.0)	153 (51.9)	74 (25.1)	12 (4.1)	295
Pacific <sup>1,2</sup>	12 (12.4)	51 (52.6)	31 (32.0)	NC	97
Pierce <sup>1,2</sup>	629 (19.9)	1,596 (50.6)	885 (28.0)	46 (1.5)	3,156
San Juan	15 (18.3)	42 (51.2)	23 (28.1)	NC	82
Skagit <sup>1,2</sup>	94 (18.0)	269 (51.6)	150 (28.8)	8 (1.5)	521
Snohomish	581 (20.4)	1,448 (50.8)	782 (27.4)	41 (1.4)	2,852
Thurston <sup>1,2</sup>	187 (17.2)	561 (51.7)	314 (28.9)	24 (2.2)	1,086
Whatcom	190 (21.9)	432 (49.8)	232 (26.8)	13 (1.5)	867
Wahkiakum	NC	11 (64.7)	NC	NC	17
<b>Service Area</b>	4,166 (20.7)	10,075 (50.0)	5,584 (27.7)	346 (1.7)	20,171
<b>Greater Metropolitan Area</b>	3,313 (21.4)	7,665 (49.5)	4,280 (27.6)	242 (1.6)	15,500
<b>Olympic Peninsula <sup>1,2</sup></b>	99 (15.1)	351 (53.6)	189 (28.9)	16 (2.4)	655
<b>Northwestern Counties</b>	391 (20.6)	962 (50.8)	515 (27.2)	27 (1.4)	1,895
<b>Southwestern Counties <sup>1,2</sup></b>	363 (17.1)	1,097 (51.7)	600 (28.3)	61 (2.9)	2,121
<b>WA State</b>	5,538 (20.0)	13,904 (50.2)	7,725 (27.9)	516 (1.9)	27,683

NC=Not Calculated if the number of cases is less than 5

<sup>1</sup> Lower proportion of breast cancer cases diagnosed as in situ breast cancer or stage zero compared to state average (yellow)

<sup>2</sup> Higher proportion of breast cancer cases diagnosed at advanced stage compared to state average (yellow)

**Data Source:**

Incidence Data. Washington State Cancer Incidence Data: Washington State Department of Health, Washington State Cancer Registry, released in January 2010.

National (17 SEER sites) data are from SEER\*Stat, public use file, released in April 2010.

### **Five Year Survival Rate by County/Region (See Table 11)**

These data characterize the five year conditional survival rate after invasive breast cancer for women diagnosed in the period 2002-2006 within the 13 county CSS region\*.

Overall, in the 13 county area covered by the CSS, 90.6 percent of women diagnosed with invasive breast cancer in the period 2002-2006 remained alive five years after diagnosis. In terms of our four regions, the Olympic Peninsula and Southwestern regions had the lowest five year survival (88.6 percent and 88.9 percent).

In terms of county-specific results, six counties had five year survival rates below the lower confidence interval for the 13 county CSS area-wide estimate. In order, starting with the worst mortality profile, the counties demonstrating worse survival than the 13 county area as a whole included: Mason (85.2 percent), Grays Harbor (87.3 percent), Jefferson (88.3 percent), Clallam (88.6 percent), Skagit (88.8 percent), Whatcom (88.9 percent) and Pierce (90.3 percent). Again, as was true for the burden of advanced stage disease, some of the more populated counties (e.g. King and Snohomish) do not fall into the worst survival tier in terms of proportions of deaths but because of population density carry the largest mortality burden in terms of absolute numbers of deaths.

\*Note that the CSS registry does not cover Lewis, Pacific or Wahkiakum counties and thus they are excluded from this analysis. For these three counties, insights regarding mortality will need to rely on other less direct information, primarily stage of diagnosis, which is available from the State for all 16 counties. As noted earlier, both Lewis and Pacific counties have high proportions of cases being diagnosed with advanced stage disease (and both also have lower proportions of in situ diagnoses), suggesting that these counties likely have lower rates of survival after breast cancer.

Washington State data on annual breast cancer mortality show that 546 women per year died from breast cancer in the Service Area during the years 2003-2007 (data not shown in any table). The largest number of these deaths occurred in King County (n=215 per year), followed by Pierce County (n=95 deaths per year) and Snohomish County (n=64 deaths per year).

### **Breast Cancer Screening by County/Region (No Table)**

The 2008 Behavioral Risk Factor Surveillance System (BRFSS) shows that 76 percent of Washington women ages 40 and older report having a mammogram within the past two years. This is relatively within the range of rates from other parts of the country. For the total Service Area, the rate is higher than the state at 78 percent. With the exception of Lewis (64.7 percent) and Wahkiakum (48.4 percent), the 14 other counties in our Service Area had rates within one to two percent of the state rate (allowing for confidence intervals).

**Table 11. Five-year cause-specific survival from invasive breast cancer for cases diagnosed 2002-2006 by county -- in the 13-county area covered by CSS**

County	Number with breast cancer	Number of deaths	5-year cause-specific survival rate	95% CI
<b>All 13 counties</b>	15,763	1,004	90.6%	89.9-91.2
<b>Clallam</b> <sup>1</sup>	419	32	88.6%	83.6-92.2
<b>Grays Harbor</b> <sup>1</sup>	280	22	87.3%	80.6-91.8
<b>Island</b>	338	17	91.8%	86.5-95.1
<b>Jefferson</b> <sup>1</sup>	150	11	88.3%	78.6-93.8
<b>King</b>	6,634	405	91.1%	90.2-92.0
<b>Kitsap</b>	879	54	90.4%	97.1-92.8
<b>Mason</b> <sup>1</sup>	255	26	85.2%	78.0-90.2
<b>Pierce</b>	2,536	175	90.3%	88.7-91.7
<b>San Juan</b>	65	2	94.4%	79.5-98.6
<b>Skagit</b> <sup>1</sup>	432	34	88.8%	84.3-92.0
<b>Snohomish</b>	2,253	120	91.4%	89.5-92.9
<b>Thurston</b>	875	62	90.6%	87.8-92.8
<b>Whatcom</b> <sup>1</sup>	647	44	88.9%	94.6-92.0
<b>Greater Metropolitan Area (GM)</b>	12,302	754	91.0%	90.2-91.6
<b>Olympic Peninsula (OP)</b> <sup>1</sup>	569	43	88.6%	94.4-91.7
<b>Northwestern Counties (NW)</b> <sup>1</sup>	1,482	97	89.8%	87.4-91.8
<b>Southwestern Counties (SW)</b> <sup>1</sup>	1,410	110	88.9%	86.5-90.9

<sup>1</sup> Worse survival among breast cancer cases; defined as 5-year survival rate below the lower confidence limit for the average rate across all 13 counties (yellow).

Date Source: Cancer Surveillance System (CSS), a SEER population-based cancer registry covering 13 counties in Western Washington State

Note: These analyses exclude 1) breast cancer cases diagnosed only at autopsy and 2) women with breast cancer who were alive at diagnosis but have no additional follow-up time.

## Communities of Interest

Analysis of the updated breast cancer statistics show that there are populations in the Service Area that continue to suffer disproportionately from breast cancer that may contribute to breast cancer disparities. These groups were also previously identified in the 2009 Community Profile:

- **African American, Hispanic and American Indian/Alaska Native** women are more likely to be diagnosed with late-stage breast cancer than women of other races and ethnicities.
- Among Asian and Pacific Islander women, while survival data for **Vietnamese women** suggests improvement in recent years, the stage data indicates that Vietnamese women

delay screening, which is attributable to their somewhat higher rates of advanced stage disease and lower rates of in situ disease.

This report identified new groups of women under the Asian Pacific Islander category:

- **Pacific Islander and Asian Indian/Pakistani** women had the highest rates of newly diagnosed breast cancers presenting with advance stage and worst five year survival rates.

## Conclusions

In addition to the identified at-risk populations above, there are specific geographic areas that continue to warrant further attention based on demographic and breast cancer statistics:

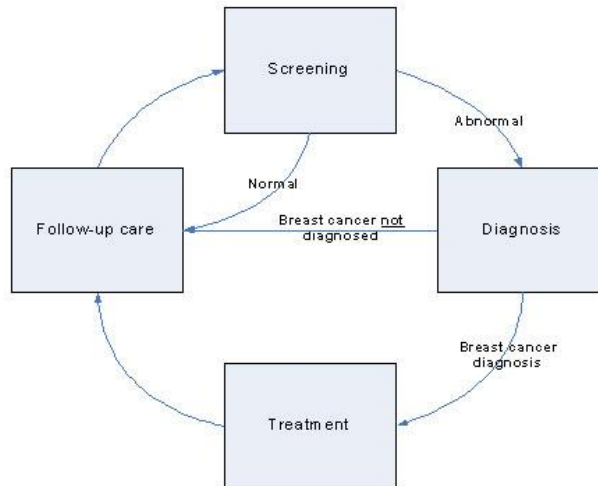
- **Grays Harbor, Lewis, Pacific, and Mason** counties in southwest Washington have some of the worse socioeconomic status (SES) indicators, advance stage breast cancer rates and breast cancer mortality rates.
- **King, Snohomish and Pierce** counties are home to the majority of the population in the region, as well as the majority of the at-risk populations identified above, and therefore have the most women in need of breast cancer services.

This report also identified four counties not previously identified in the 2009 Community Profile Report that need further study: **Clallam, Skagit, Whatcom and Thurston** counties have some of the worse SES indicators and some of the worse late stage breast cancer rates and/or mortality rates. In the next section, *Health Systems Analysis*, these counties were added as “new” areas for further exploration.

## Health Systems Analysis of Target Communities

### Overview of Continuum of Care

The continuum of care includes all phases of breast health services: screening, diagnosis, treatment and follow-up care. This section of the report presents an analysis of available breast health/breast cancer resources to determine any gaps in the continuum for the identified geographic areas and populations of interest.



### Methodology

For the previously identified counties and populations in the 2009 report – Greater Metropolitan counties of King, Pierce and Snohomish and Southwestern counties (Grays Harbor, Lewis, Pacific and Mason), African American, Hispanic, American Indian/Alaska Native and Vietnamese women – key informants from those communities were asked to verify/update statements from the last report.

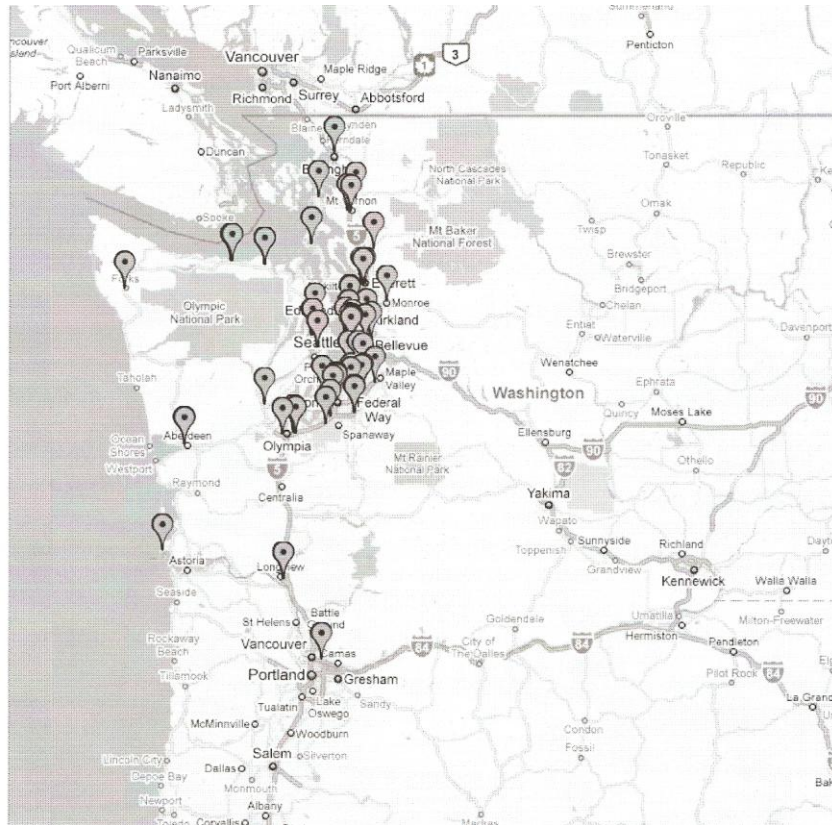
Based on the demographic and breast cancer statistics presented in the previous section of this report, there are “new” areas/populations of interest, which include Clallam, Whatcom, Skagit and Thurston counties and Pacific Islander and Asian Indian/Pakistani women.

For the “new” counties identified for further exploration, snapshots from the 2007 report (which were also used to develop the 2009 report) were sent to key informants in those counties to verify accuracy and for any additions or changes. These snapshots include information on breast health resources (which were derived from updates to the third edition of the Affiliate’s *Finding Your Way to Wellness* Resource Directory) and gaps in services in their community.

Specific breast health resources and service gaps for Pacific Islander and Asian Indian/Pakistani women will be discussed in the next section.

## Overview of Community Assets

The Service Area is home to internationally known cancer research centers, numerous comprehensive breast centers and state-of-the-art treatment facilities. The area also has four mobile mammography providers that can travel off-site to provide high quality mammography screening. However, the majority of these services are located in the Greater Metropolitan areas of King, Snohomish and Pierce Counties and along the I-5 corridor.



Map of Breast Cancer Screening and Treatment Providers in Western Washington  
Source: Google Maps

### King, Pierce and Snohomish Counties

As reflected in the map above, the majority of breast cancer screening services and treatment support are located in the Greater Metropolitan (GM) area. This area also has multiple culturally specific education and outreach programs targeting African American, Hispanic, American Indian/Alaska Native, Asian and Pacific Islander and sexual minority women. With the exception of support groups for women of color, the area has numerous support groups in various locations for breast cancer patients and survivors. The challenge in this area is not so much the lack of facilities and resources, but ensuring that women, particularly women of color, are knowledgeable about existing resources and the capacity (and sometimes willingness) of providers and programs to be able to meet the need of the

thousands of low-income women living in the area. This is especially true with the economic recession, resulting in marked increases in numbers of women who have lost jobs and/or health care coverage and possible cuts in already limited publicly funded breast health services.

Outside of the Greater Metropolitan area it is much easier to access medical care if one lives along the I-5 corridor. Accessing medical care becomes more difficult the further one lives from the freeway. Women in rural counties are unmistakably among the most underserved in the Service Area. Although mobile mammography has increased access to screening, it can still be difficult for women living in rural counties to access mammography locally. Women who are diagnosed with breast cancer are generally unable to access high quality treatment options without extensive travel. In addition to a lack of medical amenities, services for survivors such as assistance with daily living, support groups and commodities such as wigs, hats and prosthetics are virtually nonexistent.

**Southwest Washington** has few breast cancer screening and treatment providers. Providence Western Washington Oncology is the largest provider of services and serves Lewis, Thurston, Pacific, Mason and Grays Harbor counties. RadiantCare provides radiation therapy services and Western Washington Oncology Group provides oncology services to the region. While most women can access mammography and diagnostic procedures in their county, many must travel to the larger cities for specialized care.

Because of the primarily rural nature of this region, many women living in this area struggle with transportation to access health care. Women's health care in this area is very fragmented and typically involves sending a woman to several providers when she is diagnosed with breast cancer. Communication can be difficult and many women may not be accounted for. There are even greater challenges in reaching Latina women in this region, many of whom are undocumented workers and limited-English speakers. Similarly, greater efforts are needed to reach native women from several tribal reservations in the area.

**Grays Harbor** has six medical clinics in the county contracted with the Washington Breast Cervical Colon Health Program (WBCCHP) ( in Aberdeen, Neilton and Pe Ell) where low-income women can access no-cost screenings. The majority of screening and treatment services in Grays Harbor are provided in Aberdeen at the Grays Harbor Community Hospital, which offers screening and diagnostic services and chemotherapy. Grays Harbor Imaging provides breast biopsies and ultrasounds for low-income women. Western Washington Oncology has an office in Aberdeen and provides medical oncology and radiation therapy. There are currently no cancer support groups in Grays Harbor.

Women living in **Pacific County** can access no-cost women's health exams in South Bend, Long Beach, Naselle, Ocean Park and Ilwaco. The largest provider of care is Ocean Beach Hospital in Ilwaco, which provides screening and diagnostic services as well as breast surgery, medical oncology and chemotherapy. Women must travel elsewhere to get radiation therapy. Southwest Medical Center has ten primary care offices throughout the county. Many women living in this area travel to larger facilities in Lewis and Thurston counties to

the north or Longview or Vancouver, Washington to the south to access care. There are currently no breast cancer support groups in Pacific County.

**Mason County** has five clinics in Shelton and one clinic in Hoodspport that are contracted with WBCCHP. Mason General Hospital in Shelton offers mammograms and breast diagnostic services for women in the area and has a relationship with Western Washington Oncology group for oncology services. The hospital also has a fund to pay for mammograms for women in need, a breast cancer patient navigator and partners with the local American Cancer Society “Reach to Recovery, which offers a support group for women going through treatment.

**Lewis County** has ten contracted WBCCHP providers in Centralia, Chehalis, Morton and Onalaska. Women can access screening, diagnostic and some treatment services at the Providence Centralia Hospital and Morton General Hospital. Cancer patients receive outpatient chemotherapy and radiation therapy at Providence Western Washington Oncology clinic near the hospital in Centralia. The Providence System opened a new cancer center at the Centralia Hospital in June 2009 and offers radiation/oncology expanded chemotherapy and infusion services.

**Thurston County** has three mammography providers – Capital Medical Center, South Sound Radiology and TRA Imaging – and three cancer treatment centers: Capital Oncology, Vista Oncology and Western WA Oncology. There are 12 WBCCHP contracted primary care providers. Close coordination with Medicaid through the (Department of Social Health Services) takes place to identify eligible women for referral into BCCHP. Project Access provides access to free care with multiple providers in the area and St. Peter Hospital provides charity care services. SeaMar Health Clinic has recently added a second clinic location in the Lacey area, providing low-cost or sliding fee scale medical care. The Providence Regional Cancer System in Olympia is in its early stages of developing a cancer survivorship program.

There are a few groups in the Southwest Washington area that provide culturally specific services to American Indian/Alaska Native and Hispanic women. The South Puget Intertribal Planning Agency (SPIPA) provides breast health outreach, screening and support activities to women in rural tribal communities in the area and serves the reservation communities of Chehalis, Nisqually, Shoalwater Bay, Skokomish, Squaxin Island and Quinault Indian Nations. SeaMar Community Health Centers is staffed with Spanish speaking providers and has clinics in Grays Harbor and Thurston counties. Mason General Hospital also has some Spanish-speaking capacity in its breast health outreach and support services. Southwest Medical Center in Vancouver provides no cost language appropriate materials and onsite clinical and phone interpretation.

**Whatcom County** has a wide variety of available community resources, including full service providers, community clinics, and education and outreach services. St. Joseph’s Hospital, Mount Baker Planned Parenthood, SeaMar clinics, Lummi Nation Tribal Clinic, Interfaith Community Health Center and Whatcom Alliance for Health Care Access (WAHCA) collaborate to serve the county’s population. There is very limited support for

survivors in the county. Wigs, prosthesis and lymphedema treatment are very difficult to find locally. There are not enough formal WBCCHP contracts with specialists or treatment providers in the area. Mammograms and diagnostic services are provided by Mt. Baker Imaging in Bellingham and Lynden, while a technician goes out to Inter Island Clinic in Friday Harbor. Oncology is available at Peace Health Medical Group in Bellingham and several surgeons are available at various medical groups in the county.

**Skagit County** houses three state-of-the-art hospitals, including two major cancer care centers. Mammograms and diagnostic services are available at Breast Care Center Skagit Valley Ultrasound in Mt. Vernon, Island Hospital in Anacortes and United Hospital in Sedro Woolley. Oncology services are available in Mt. Vernon through North Puget Sound Cancer Center, Skagit Valley Hospital and Seattle Cancer Care Alliance - Skagit. The hospitals host various health promotion activities including fairs, support groups and educational programs for survivors. Citrine Health offers outreach, support services and breast health education to rural areas of the county.

**Clallam County** has four mammogram sites – two in Port Angeles, one in Sequim and one in Forks. Olympic Medical Cancer Care Center (OMC) is a state-of-the-art treatment center in Sequim. OMC also provides cancer treatment in Port Angeles. There is one support group run by Operation Uplift in Port Angeles.

## **Partnerships and Grant Opportunities**

The Affiliate is an active partner with the Washington Breast, Cervical and Colon Health Program (WBCCHP), its prime contractors and subcontractors. The Affiliate participates in the Washington Comprehensive Cancer Control Partnership and is a member of the Breast and Cervical Cancer Task Force subcommittee of the partnership. In addition, the Affiliate regularly partners with Cancer Information Services to plan and implement community education programs and with the American Cancer Society for public policy efforts.

### Grantees

The Affiliate allocated more than \$2.2 million in FY2010-11 for its large and small grant programs to nonprofit, tribal and government institutions. One million dollars was granted to the WBCCHP to increase screening capacity in our Service Area. Other grants include funding for patient assistance for low-income women living throughout the Service Area; outreach and breast health education for medically underserved women living in the Greater Metropolitan area, the Olympic Peninsula and some of the southwestern counties; patient navigation for medically underserved women living in King, Pierce and Mason counties, and a few treatment support services for women living in Pierce, King, Thurston, Clallam and San Juan counties. The Affiliate grants primarily target African American, Hispanic, Asian and Pacific Islander, and lesbian and bisexual women living in the Greater Metropolitan areas. In addition, Affiliate grants reach Hispanic and low-income White women living in rural areas, and American Indian/Alaska Native women living in Southwest Washington and on the Olympic Peninsula.

## Washington Breast, Cervical and Colon Health Program (WBCCHP)

The Washington State Department of Health, through a grant from the Centers for Disease Control and Prevention (CDC), administers a breast, cervical and colon cancer early detection program for low-income women in Washington State. Women who are at or below 250 percent of the federal poverty level, ages 40 to 64 years, and are uninsured or underinsured, are eligible for Washington's Breast Cervical and Colon Health Program (WBCCHP). Women diagnosed through the program are eligible for no-cost treatment through the Medicaid Breast, Cervical and Colon Cancer Treatment Program, which provides a seamless continuum of care.

Program services are available statewide and include screening, public education, professional education, quality assurance, tracking and surveillance and evaluation of service delivery components. The Department of Health provides technical assistance and support to local WBCCHP Prime Contractors who administer the program regionally. Clinics, private physicians, hospitals, local health departments, laboratories and radiology facilities provide services. Reimbursement is at the Medicaid rate and includes routine office visits, clinical breast exams, screening mammograms, Pap tests and other authorized diagnostic procedures. Community based organizations, including local health departments, provide outreach activities with public education and community involvement.

Federal funding during the current five-year (FY07-12) grant period is approximately \$21.5 million for Washington State. Every \$3 of federal funding is matched with \$1 of state and/or local in-kind resources. For the 2009-11 biennium, \$5.6 million in state funds is available for screening, coordination and outreach services. Sixty percent of total funding is spent on screening and follow-up activities and 40 percent on state and local capacity building. The program is also supported by private funding of more than \$1 million from Susan G. Komen for the Cure Washington and Oregon affiliates, the American Cancer Society and the Breast Cancer Prevention Fund (Source: Washington State Department of Health).

### **Promising Practices and Evidence-Based Programs**

There are several evidence-based and promising practices being successfully implemented in the Service Area.

Our partners have had much success with targeted, culturally competent outreach and education to medically underserved women. Effective outreach is typically done by a trusted member of the target community (bilingual/bicultural when appropriate) in a one-on-one or small group setting in an environment where women feel safe and comfortable. Most recently, digital storytelling has proven to be an effective tool for sharing information on the importance of early detection.

Mobile mammography has proven to be an effective way to support hard-to-reach women in our Service Area. The Affiliate offers funding through small grants for organizations to bring mobile mammography units to their community. Currently, the mobile units are going out to

Clallam, Kitsap, King, Snohomish and Pierce counties, and several of the tribal reservations in the Service Area.

Patient navigation is helping medically underserved patients make their way through the complex medical system and adhere to their treatment. We have seen success with programs that utilize community/lay navigators as well as nurses and social workers.

The Komen Patient Assistance Fund is helping low-income breast cancer patients continue with their treatment by assisting them to pay for specific living expenses. This, in addition to a patchwork of other funds, has proven to be a much needed resource. However, existing funds do not adequately cover the demand, further exacerbated by the economic recession.

### **Legislative Issues in Target Communities**

The legislative issues in our target communities are generally the same as for the entire Service Area. The current economic recession has forced the Legislature and Governor to cut \$5 billion out of the state budget. An estimated 92,000 women are eligible for WBCCHP services in 2011, a 25 percent increase over last year, but a nearly 100 percent increase over the past two years. Approximately 20,000 women were enrolled and screened last year, leaving more than 70,000 women not served. Fortunately, the Komen affiliates in Washington and Oregon, together with the Komen National lobbyist, American Cancer Society and other partners lobbied hard to prevent a \$1.5 million cut to WBCCHP in the 2011 supplemental budget and any cuts to the program's budget in the next biennium (FY11-13) budget. In addition, all partners are working closely to plan for how programs and services will be affected by the Affordable Care Act, with its emphasis on preventative health care.

### **Interpretation Services**

Limited English proficient women in our area often struggle getting appropriate medical interpretation. Too often, women report being asked to bring a family member or friend to their appointments to provide this service. This creates issues around patient confidentiality and can be dangerous if the person who is providing interpretation does not understand what the provider is saying. Many providers in the area report using the AT&T language line, which involves both the provider and patient talking to a third person on a phone line to communicate with one another. Some providers report using speaker phones for this service, which may compromise patient confidentiality in some medical settings.

Federal law requires that health care providers who serve patients in federally funded programs must provide language access services to all patients with limited English proficiency. Nevertheless, most health care providers lack systems and financial resources to provide these services. In addition, Medicaid reimbursements for interpretive services do not cover full costs. Many private insurers and the Washington Basic Health plan (which is currently under threat for elimination) do not reimburse providers for interpretive services.

Last legislative session, Senate Bill 5140 looked to address the issue of medical interpretation reimbursement. It passed with an inclusion of collective bargaining for state-used interpreters

and the use of a costly brokerage system. The Governor's office has proposed to cut the program in the next biennium budget. There is also a new bill, SB 5807, introduced by the Washington Federation of State Employees that would combine traditional interpreter services with more telephonic and video services. It's a bill that is definitely a work in progress. Key informants report that it will be very difficult, but not impossible, to preserve funding for interpreters. Not providing funding will cause many providers to refuse to serve non-English speaking patients since the cost of providing interpreters is much more than the Medicaid reimbursement. (Source: Northwest Advocates).

## **Transportation**

There are no known programs in the area that pay for transportation for women to access breast cancer screening. The American Cancer Society offers volunteer drivers that can take cancer patients to and from treatment, but the success of this program depends on volunteer availability and varies from community to community. Currently, transportation to cancer treatment is covered by Medicaid. However, it will only reimburse patients' travel to the closest medical center. This does not allow patients to choose where they seek treatment or to access specialized care. However, due to the state budget crisis, this funding is vulnerable to cuts or complete elimination. (Source: Northwest Advocates).

## **Key Informant Findings**

Despite the richness of resources in the King, Pierce and Snohomish counties, there is continued need for greater access throughout these counties to ensure women have access to the breast health continuum of care. Women are either not aware of such resources and/or there is limited capacity in the system to meet the demand for services due to the sheer numbers of uninsured residents in these counties who are eligible for services and who suffer from breast cancer disparities. There are very limited options for support during treatment for women of color, especially those who have language barriers.

Women in rural areas are often unable to access the care they need due to where they live. This is especially true for women living in Grays Harbor, Lewis, Pacific and Mason counties,. These areas still have fewer options in their breast health and cancer care than other counties that were identified as new areas of interest: Clallam, Skagit, Whatcom and Thurston counties.

## **Conclusions**

Based on health systems analysis findings, as well as breast cancer and demographic statistics, the Affiliate will continue to focus on prioritizing the following counties in our Service Area:

- King, Pierce and Snohomish Counties
- Grays Harbor, Lewis, Pacific and Mason Counties

While the new counties of interest – Clallam, Skagit, Whatcom and Thurston – appear to suffer disproportionately from some of the breast cancer and/or socio-economic indicators, residents

have more options for breast health resources to tap into than the four southwest Washington counties.

Yet, no matter where they live, many women of color face unique cultural and language barriers to screening and treatment that prevent them from accessing care. In order to better understand the barriers to care, we will examine the following in the next section:

- Specific barriers to care for African American, Hispanic, American Indian/Alaska Native, Vietnamese, Pacific Islander and Asian Indian/Pakistani women.
- Recommendations from the communities above on resources needed to overcome barriers.

## Breast Cancer Perspectives in the Target Communities



### Methodology

The Affiliate gathered additional ideas and input from key stakeholders whose connection to the target populations and issues would be helpful to the Community Profile process.

Snapshots from the 2007 Community Profile for African American, American Indian/Alaska Native and Hispanic women were sent to key informants for review and feedback on their currency and accuracy.

Focus groups were conducted among:

- Vietnamese women (one focus group consisting of five women);
- Pacific Islander women (one focus group of 12 mixed Pacific Islander community members in Pierce County and one focus group of ten Tongan women in King County);
- Asian Indian women (two focus groups of 12 women each from two Sikh temples in King County)

Key informants and focus group participants included target community members and leaders, employees of county health departments, representatives from local hospitals, WBCCHP Prime Contractors and subcontractors, breast cancer survivors and health care providers.

A nurse practitioner, who is also a WBCCHP provider earning her doctorate, assisted in conducting and facilitating many of the focus groups. A list of commonly reported barriers was distributed and participants were asked to select the top five reasons why they personally (or women they know in their community) choose not to get screened. This list allowed us to gather data on barriers and also served to initiate discussion about community resources, gaps in services and effective strategies to reach women and disseminate information as well as an opportunity to suggest improvements in the Affiliate's services.

## **Review of Qualitative Findings**

### **Common Themes Among Women of Color**

Financial barriers and lack of health care insurance are the most commonly reported reasons for why women of color don't get screened. This is followed by the lack of awareness or prioritization of breast health or preventive health care practices in general. There is also the mistaken belief that one can't get breast cancer if there is no family history. Traditional taboos, modesty issues and privacy reasons are also commonly reported.

There are many concerns among racial and ethnic minorities about trust, and the intentions of the healthcare system. This is especially true for African American and Native American women who may fear "being targets of an experiment" or doubt healthcare providers' intention to care for people of color. Undocumented Hispanic women often fear the possibility of deportation, doubt assurances of confidentiality and may find questions from providers to be intrusive.

### **Key Informant Findings**

#### **African American Women**

##### Assets/Strengths:

- Strong advocacy and skilled outreach workers
- Communal sense of trust and support within the community
- Strong relationships, connections and new collaborations

##### Barriers:

- Feeling discrimination when they access healthcare
- Stigma attached to no-cost care as being inferior
- Transportation for older women who no longer drive or not informed about free/low-cost transportation resources.

##### Effective Strategies:

- Materials using images of African American women.
- Educational activities conducted one-on-one by a trusted member of the community.
- Messages giving women permission to prioritize self-care over family/community needs.
- Dissemination of breast health information through churches, nail salons and beauty shops and family members, particularly men and school-aged children.
- Mammogram screening provided in conjunction with other general health screenings
- Offering incentives such as grocery gift cards (especially during this economy) to women who keep their scheduled appointments for mammograms.
- Testimonials by African American survivors to counter the stigma attached to breast cancer, showing that one can still live a full and active life after treatment.

#### **American Indian/Alaska Native Women**

##### Assets/Strengths:

- Tribal communities allow for powerful dissemination, networking and collaboration
- Tribal clinics provide medical care, health promotions and referrals in a culturally competent setting; some coverage of medical costs by Indian Health Services
- Wisdom of Native elders and those who are breast cancer survivors who can serve as advocates and support leaders

#### Barriers:

- Transportation
- Lack of mammography facilities in tribal clinics; women referred to non-native clinics for care where women may feel uncomfortable and unwelcome.
- Mobile mammography has varying levels of success; when available, mobile mammography provides limited windows for screening reliant on factors such as road conditions and local staff schedules that do not always align with the work and life schedules of native women.
- Patient navigation is reportedly more complicated for women who are covered by Indian Health Services;
- Clinic structure, limited case management and difficulty in tracking referrals out of the clinic require extensive communication and coordination; often results in some women falling through the cracks.
- Limited emotional support for native women in treatment; cost of gas and travel often means that family members cannot be with a patient as she goes through treatment.

#### Effective Strategies:

- Need to explore innovative approaches that emphasize building relationships and partnerships from multiple sources of support within and beyond the native community to ensure successful outcomes.
- Printed materials that are culturally relevant and address literacy and numeracy needs are well received if disseminated by trusted members of the community.
- Tribal and intertribal newspapers and radio as well as personal narrative in the form of storytelling are also effective means of promoting health messages.
- Breast health programs need to recognize multiple social and health needs of native women (substance abuse, sexual abuse, depression) that affect their likelihood to receive preventive care.
- Need for recruiting, retaining and training more outreach workers and providers who are sensitive to the needs of native women and promote early detection; stable funding is needed to provide competitive salaries for these positions to prevent high staff turn-over in tribal clinics.

### **Hispanic Women**

#### Assets/Strengths:

- Several excellent organizations involved in breast health promotion, education, treatment
- Generally receptive to outreach and welcoming of services such as mobile mammography and translated materials, especially when distributed by trusted, native Spanish speaker.

- Generally access healthcare system for treatment of chronic diseases (diabetes, heart disease) or for family planning.

Barriers:

- Uninsured women, especially undocumented women, typically believe there are no breast health services available to them.
- Cultural beliefs, poverty, transportation and multiple health/social issues (such as domestic violence, illiteracy, substance abuse) are huge barriers to care.
- Migrant farm workers may have difficulty accessing follow-up care due to the transient nature of their jobs.
- Undocumented women distrust offers of no-cost screenings, fearing it a trap by immigration officials who have been increasing raids, detention and deportation efforts.

Effective Strategies:

- Need for social marketing to create breast health awareness.
- Outreach by trusted community members at churches, laundry mats, grocery stores (“tiendas”) or at service sites providing prenatal, maternal, children health services or food banks are needed to make women aware of resources
- Need to recognize the diversity within the Hispanic community; for example, indigenous Mexican and Guatemalan women do not necessarily speak or read Spanish and recent immigrants rarely speak or read English.
- Educational materials are most effective when highly visual and written using appropriate translation and word choices that recognize different countries of origin and literacy levels.
- Affiliate is strongly encouraged to collaborate with existing organizations that are effective in reaching Hispanic women.

**Focus Group Findings**

Vietnamese Women

Available data for this community show there are approximately 60,000 Vietnamese people in the state, with an estimated 55 percent residing in King County. Of those in King County, 11.4 percent are at poverty level and 53.2 percent speak English less than “very well.” (Source: 2007-2009 American Community Survey 3-Year Estimates, US Census).

As mentioned earlier, the most commonly reported barrier to getting mammograms is lack of awareness about the importance of screening. Key stakeholders report that Vietnamese physicians who operate small private clinics, where many community members often prefer to go, do not emphasize preventive health care. These small clinics have no screening capacity and some tell patients wrong information about how often to get mammograms. For modesty reasons, Vietnamese women prefer female providers of which there are very few in King County. Other barriers reported include lack of time and limited English-speaking skills. Some feel that medical interpreters intrude on doctor-patient privacy. Low-income women often work multiple jobs and prioritize family responsibilities over their own health needs. Some women also report embarrassment because they do not have healthcare insurance.

There is great stigma associated with cancer. Many women feel shame with a breast cancer diagnosis and survivors and/or their families keep their diagnosis and treatment quiet, often resulting in depression and isolation among survivors.

Effective strategies suggested include providing education/awareness activities at natural gathering sites (e.g. churches or temples, cultural festivals, exercise/movement classes and English as a Second Language classes), conducted by a trusted community member and disseminating information through local Vietnamese community newspapers, TV stations and radio.

### Pacific Islander Women

In the 2000 US census, Washington reportedly had the third-largest Pacific Islander population in the country. There are at least 20 Pacific Islander cultures, representing four percent of the Asian/Pacific Islander aggregate racial category. There are approximately 33,000 Pacific Islander residents in the Service Area, and most of them live in King County (14,100) and Pierce County (10,200). There is no income or language data available at this time for this community. (Source: US Census, 2010 Redistricting data).

Apart from the common barriers mentioned above women from this region of the world also report that mammograms are too painful. Beliefs such as a diagnosis of breast cancer “will be taken care of by God” or the “traditional medicines and healers from back home” are also common. Many Pacific Islander women tend to “not complain, and put on a happy face,” choosing to ignore aches and pains and putting family and community needs before their own. “Talking about breast cancer gives it more power and will make it happen.” Such beliefs are more prevalent among the older generation of Pacific Islander women. There is also a great need for information on how to and where to get free mammograms.

There is a clear need for culturally appropriate education and awareness activities that recognize the importance of family and community. Effective strategies of outreach involve accessing the women through the churches or faith-based organizations, as these institutions are regarded as more than a place for worship, but also as “their village away from the village.” Gaining entry into the churches requires approval and involvement of male church leaders. Male pastors must be convinced to allow a trusted messenger to share the information with the women and preferably in a setting separated from the male members of the parish. Dissemination of information about available breast health resources is greatly needed and can take place at cultural celebrations or through youth programs. Younger women are more open to talking about women’s health and can share the information with the older generation. Highly visual and translated (in multiple languages and dialects) educational materials are also very effective.

### Asian Indian Women

There are more than 56,000 Asian Indian residents in Washington, with 68 percent (38,500) living in King County. Eighty-one percent speak a language other than English, with nearly 22 percent speaking English less than “very well.” The median household income is

\$97,000, with only two percent of Asian Indian families at the poverty level. (Source: 2007-2009 American Community Survey 3-Year Estimates, US Census).

While available demographic data suggests or confirms a common perception that Asian Indians are well-to-do, employed in the high-tech or bio-tech fields and highly educated, key informants from the Sikh community report that segment of the population represent only the most recent wave of immigrants from India. Members of two Sikh Gurudwaras (temples) report coming from primarily the Punjabi (northwestern) region of India which is an agricultural economy. Many of these individuals are employed as temporary or part time workers in the service industry (hotel, restaurant, transport, retail). Some are self-employed or small business owners. When they do have health insurance, it is often too expensive to cover the entire family or extended family members (parents and grandparents) who may live in the same household.

In addition to lack of awareness about breast health and women's preventive health, in general, there is also a misperception that mammograms are not safe, exposing women to dangerous levels of radiation. Language and transportation barriers affect Asian Indian women's access to care. It was reported that some women diagnosed with breast cancer prefer the traditional healing practices of their homeland, rather than western medicine for treatment.

Key stakeholders suggest the need for culturally competent breast health education and awareness for women in this community. Information about available resources for low-cost or free mammograms is needed. Although many can read Hindi, materials in Punjabi are preferred. The most effective outreach is through the Gurudwara, the Sikh place of worship, as well as the community's social center. Female medical providers who are familiar with both traditional and western health practices and who speak Punjabi would be most effective in reaching and educating these women.

## **Conclusions**

The exploratory data reinforces information gathered in the other two sections of this report. Gaps in education, awareness, transportation, interpretation and patient navigation create barriers to care for women of color who are most adversely affected by breast cancer in the Service Area. Many struggle with issues of culture, language, fear and trust, in addition to financial and access barriers.

Culturally specific education and outreach are needed to effectively reach women of color with breast cancer education. Culturally sensitive care, including medical interpretation, is needed to ensure that women have the means to access the care they need.

In addition, patient navigation services are needed to overcome cultural barriers for American Indian/Alaska Native, Hispanic, African American, Vietnamese, Pacific Islander and Asian Indian women to improve screening and treatment compliance. Patient navigators are also needed in rural areas to help women from these communities piece together fragmented care.

Finally, transportation issues need to be resolved for women who live in rural communities and for older women who no longer drive. Long distances to mammography and cancer treatment centers are significant barriers to accessing care.

## Conclusions: What We Learned, What We Will Do

### Review of the Findings

Based on poverty and insurance indicators, breast cancer stage of diagnosis and survival data, and an analysis of available breast screening and treatment resources, the following are the Affiliate's priorities:

- Lewis, Pacific, Grays Harbor and Mason Counties with particular attention to low income, Hispanic and American Indian/Alaskan Native women
- King, Pierce and Snohomish Counties, with special emphasis on women of color.
- African American, Hispanic, American Indian/Alaska Native, Vietnamese, Pacific Islander and Asian Indian women throughout our Service Area.

Key stakeholder interviews and analysis of current resources provided further insight to the potential causes of breast cancer disparities in these areas and populations, as well as provided suggestions for ways to overcome barriers to care. A common theme heard among all counties and populations was the need to increase awareness about breast health and about available resources and the need to address gaps in transportation, particularly in rural areas, and interpretation services to address language barriers of racial and ethnic minority women.

While it appears that we have avoided any cuts to the publically funded Breast Cervical Colon Health Program in the next biennium, given the current economic climate, the demand for services continues to increase. The Affiliate does not have adequate resources to meet the increased demand, but is committed to working with our partners to preserve and protect current services and will continue our commitment to increase funding to invest in proven effective life-saving strategies. The Affiliate will also form strategic alliances in preparing for Health Reform.

### Action Plan

**Goal:** Increase breast cancer screening, patient navigation and treatment support services offered in Grays Harbor, Lewis, Pacific and Mason counties, particularly for low-income, Hispanic and American Indian/Alaska Native women.

Objective 1 – By March 2014, increase investments in effective screening, patient navigation and treatment support services and cultivate new applicants to the Affiliate's grant programs that meet our target communities and priority service areas.

Objective 2 – Each grant period, increase by 5% the number of women enrolled and screened through WBCCHP and other partners providing low/no-cost screening, especially among Hispanic and American Indian/Alaska Native women.

Objective 3 – By March 2014, work with local partners to develop new and expand current awareness campaigns (using traditional and social media, Worship in Pink, Hispanic Initiative, etc.) that target low-income, Hispanic and American Indian/Alaska Native women in these counties.

**Goal:** Increase breast cancer awareness, screening and patient navigation in King, Snohomish and Pierce counties for low-income, African American, Hispanic, American Indian/Alaska Native, Vietnamese, Pacific Islander and Asian Indian women.

Objective 1 – By March 2014, increase investments in effective education, screening and patient navigation services and cultivate new applicants to the Affiliate’s grant programs that meet our target (current and new) communities and priority services.

Objective 2 – By March 2014, expand Worship in Pink campaign to include faith-based organizations beyond the African American community.

Objective 3 – By March 2014, increase the number of African American, Hispanic, American Indian/Alaska Native, Vietnamese, Pacific Islander and Asian Indian women who are enrolled in WBCCHP by 5% each grant period.

Objective 4 – By March 2014, work with local partners to develop new and expand current awareness campaigns (using traditional and social media, Worship in Pink, Hispanic Initiative, etc.) that target low-income, African American, Hispanic, American Indian/Alaska Native, Vietnamese, Pacific Islander and Asian Indian women in these counties.

**Goal:** Improve access to breast health and treatment services throughout our Service area through strategic alliances and change in public policy.

Objective 1 – By March 2014, work with National Komen, regional and local partners to advocate for increased federal and state funding for WBCCHP.

Objective 2 – By March 2014, work with Affiliate lobbyist to advocate for and prevent cuts to existing transportation programs and collaborate with American Cancer Society to expand its volunteer transportation program.

Objective 3 – By March 2014, work with Affiliate lobbyist and other partners to preserve and/or increase funding for medical interpretation services.

Objective 4 – By March 2014, develop strong alliances with existing and new partners that can help to move the Komen mission forward through Health Reform implementation.

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