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Introduction to the Community Profile Report

Affiliate Overview

The Affiliate began as the Komen New Jersey Race for the Cure® in 1994. Recognizing the need for growth, key volunteers and Board members launched Susan G. Komen® Central and South Jersey in January 2005. Since its inception, the Affiliate has invested over $17 million in local nonprofit organizations and hospitals through the community grants program, and has helped to fund $3.9 million in research in New Jersey through the Susan G. Komen Research Programs.

Komen Central and South Jersey raises funds to make grants to nonprofit organizations offering breast health and breast cancer-related projects to medically underserved individuals through its community grants program. The goal is to ensure a patient’s needs are addressed throughout the entire continuum of care, including screening, diagnosis and follow-up care.

In addition to community grantmaking, the Affiliate’s other mission-related activities include local and national public policy efforts, community outreach in the form of breast health presentations, serving as a local resource for patients in need, and spearheading a multi-faceted initiative to reach breast cancer survivors.

The service area is both culturally and demographically diverse in terms of race and ethnicity, age, and wealth, and there are substantial issues apparent at the individual county level in terms of both demographic and socioeconomic statistics. Overall, the service area is one of stark contrasts. There are densely populated urban centers such as Camden and New Brunswick that are home to an array of health care services including top quality hospitals and academic research institutions. There are also very rural pockets in South Jersey (in counties such as Salem) where there are higher proportions of undocumented populations, transportation challenges, and generally fewer health care resources overall, leading to medically underserved populations.

Purpose of the Report

The Community Profile presents a compelling look at the state of breast cancer in the Affiliate’s 13-county service area, and is an invaluable tool for those working on the issue of breast cancer in New Jersey including hospitals, grassroots organizations, insurance companies, and politicians. It presents a comprehensive look at an array of breast cancer and demographic statistics, the distribution of health services by county, as well as the individual and systemic barriers patients face in navigating the continuum of care (CoC). Ultimately, the goal of this needs assessment is to drive the strategic operations of the Affiliate’s mission work by targeting the areas of greatest need and establishing measurable goals and objectives for the Affiliate’s work in these areas. Among its many functions, the Profile will be used to inform the Affiliate’s inclusion efforts (within the service area and more specifically the target communities and populations), proposed education/outreach activities, proposed grantmaking, community organizing/engagement, advocacy/public policy efforts, marketing/communications plans, sponsorship/fundraising (i.e. development activities), and strategic and operational planning.
Quantitative Data: Measuring Breast Cancer Impact in Local Communities

Based on an extensive statistical review, Susan G. Komen Central and South Jersey has chosen to target five communities (encompassing seven counties). Four counties will be grouped into two communities due to their similar population characteristics, creating a total of five target areas. The Affiliate will focus strategic efforts on the selected communities over the course of the next four years. The selected target communities are:

- Atlantic County
- Camden County
- Gloucester County
- Burlington and Monmouth Counties
- Salem and Cumberland Counties

The target communities were chosen because they have the most significant breast cancer-related issues as compared to other counties in the Affiliate service area. When selecting target communities, the Affiliate first considered counties classified in the quantitative data analysis as highest and high priority, as determined by Komen Headquarters. This classification of priority counties was primarily based on the projected time needed to achieve Healthy People 2020 (HP2020) health objectives for breast cancer late-stage diagnosis and death rates. The Affiliate also considered late-stage rates and trends, death rates and trends, incidence rates and trends, breast cancer screening proportions, socioeconomic conditions (e.g. income relative to the US poverty level, employment status, cultural barriers, lack of health insurance, and education), five-year relative survival rates, and population distribution and characteristics. A brief summary of the findings from the Quantitative Data Report and the Additional Quantitative Data Exploration for each target community is provided below.

**Atlantic County**

Atlantic County has the highest death rate among Black/African-American women compared to all of the other counties in the service area. Atlantic County’s five-year relative survival rate is considerably low in general and among Blacks/African-Americans. As compared to New Jersey and the Affiliate service area as a whole, a large percentage of the population is considered to be rural and medically underserved. Compared to other counties in the service area, Atlantic County has the second highest percentage of residents with no health insurance as well as incomes below 250 percent of the federal poverty level.

**Camden County**

Camden County has the highest late-stage diagnosis rate within the Affiliate service area. Black/African-American and Hispanic/Latina women are both faced with death rates that are substantially higher than the average rates of the Affiliate service area and New Jersey as a whole. Additionally, Hispanics/Latinas living in Camden County are experiencing the lowest five-year relative survival rate among all counties in the Affiliate service area while a large percentage of Blacks/African-Americans are being diagnosed with breast cancer at a late-stage. The data show that only 69.2 percent of women (ages 50-74) living in Camden County reported mammography screening in the past two years. This is the lowest screening percentage in the entire Affiliate service area. Compared to other counties in the Affiliate service area, the county has a substantially higher percentage of residents with income below 250 percent of the federal poverty level, no health insurance, and lack of employment.
Gloucester County
While Gloucester County has a fairly low incidence rate compared to the service area as a whole and to other counties within the service area, the death rate is high. The county currently has the third highest death and late-stage diagnosis rates in the service area, both of which are considerably higher than the average rates of the Affiliate service area and State of New Jersey. Black/African-American women of Gloucester County are suffering from a death rate that is notably higher than the average rates of the Affiliate service area and State of New Jersey. The data indicate that a considerably larger percentage of women ages 65 and older have experienced late-stage diagnoses in Gloucester County compared to the Affiliate service area and State of New Jersey. Despite better outcomes overall on socioeconomic indicators as compared to other counties in the Affiliate service area, Gloucester County has one of the lowest proportions of women ages 50-74 who reported obtaining screening mammography within the Affiliate service area.

Salem and Cumberland Counties
Salem and Cumberland Counties were chosen because of their high death rates, low screening prevalence, low five-year relative survival rates, and unique socioeconomic characteristics. In particular, Salem County has the highest death rate among all counties in the Affiliate service area, while Cumberland County is the poorest county in the service area. Both counties experienced low screening prevalence in the last two years among women ages 50-74, with Salem County having the second-lowest proportion of women screened in the Affiliate service area.

The majority of Salem and Cumberland Counties’ residents live in rural and medically underserviced areas. They are also among the top five counties with residents who have substantially higher unemployment, and substantially lower education and income levels. Major racial and age disparities also exist in both counties. Cumberland County has the largest Hispanic/Latina population and third largest Black/African-American population in the Affiliate service area. Although Salem County has a smaller concentration of Black/African-American and Hispanic/Latina women, the county has the third largest population of women ages 65 and older.

Burlington and Monmouth Counties
Both counties also have fairly high incidence rates with incidence trends increasing in Monmouth County. In Burlington County, the percentage of late-stage diagnoses is higher than the service area as a whole and the State of New Jersey, and presents as an increasing trend. While Burlington presents with a fairly high percentage of women, ages 50-74, who obtained a screening mammogram in comparison to the rest of the service area, the percentage of women screened in Monmouth County is lower than the service area average and the State of New Jersey.

Although the majority of the population in both counties is White, together the counties make up a considerably large population of women who are over the age of 40 and who identify as Black/African-American and/or Hispanic/Latina. In Burlington County, the percentage of Black/African-American women diagnosed with late-stage breast cancer is considerably higher than White women diagnosed with late-stage breast cancer. Moreover, this percentage of Black/African-American women diagnosed with late-stage breast cancer is also higher than the Affiliate service area’s percentage of Black/African-American women diagnosed with late-stage breast cancer.
breast cancer. Likewise, in Monmouth County, the death rate for Hispanics/Latinas is substantially higher and the five-year relative survival rate lower than the average death and five-year relative survival rates of the Affiliate service area and State of New Jersey.

**Health System and Public Policy Analysis**

For each target community, the strengths and weaknesses of the health system and potential barriers to accessing services across the CoC were assessed. Key partnerships in the target communities and potential new partners to address needs and key issues were identified, as were other potential issues to explore in the Qualitative Analysis. The major strengths and weaknesses related to the health system are outlined by target community below.

**Atlantic County**

The Health Systems Analysis (HSA) revealed a wealth of breast health services available in Atlantic County addressing all facets of the CoC, including those that specifically target vulnerable populations in areas of great need (e.g. Atlantic City). However, a key concern identified was the unequal geographic distribution of resources, leaving the key question of the impact of accessibility (particularly for rural residents), including any transportation challenges, vital to address through the Qualitative Analysis.

**Camden County**

Although Camden County has several strong health systems, the HSA revealed a major weakness to be the availability of comprehensive breast care services beyond the concentrated pocket of hospitals. This creates an accessibility issue for those who live a substantial distance away in areas where comprehensive breast care resources are not as readily available. There also appeared to be a general lack of resources available for those who cannot afford them. Questions were raised about the ability and willingness of poorer residents to travel for care to the few locations that do offer services, as well as other potential access issues, including transportation challenges, given the dearth of comprehensive resources available and accessible to a substantial portion of the county’s residents.

**Gloucester County**

The HSA revealed that Gloucester County appears to have a fair amount of resources overall, including several hospitals that provide access to care along the CoC. However, a key concern identified in the HSA was the unequal geographic distribution of resources in this community, leaving the key question of accessibility (particularly for rural residents), including any transportation challenges, vital to address in the Qualitative Analysis. Additionally, strategies for improving access to comprehensive programs, particularly for those with transportation challenges coming from other screening and diagnostic facilities in the region, was also identified as a key issue to further explore.

**Burlington and Monmouth Counties**

The HSA revealed that both counties appear to have an abundance of resources that address all facets of the CoC. However, given that the majority of the resources appeared to be located in specific pockets in each county, the question of accessibility issues (particularly for rural residents), including any transportation challenges, was vital to answer through the Qualitative Analysis in order to assess the potential impact. Additionally, the findings suggested a need for programs targeting Hispanic/Latina women in Monmouth County and additional programs...
targeting Black/African-American women Burlington County, given the issues of late-stage diagnoses and survival rates in these populations.

**Salem and Cumberland Counties**
The HSA revealed that this target community has a dearth of resources compared to the other target communities. Salem County has little to no resources available that span the entire CoC, and the few that do exist in Cumberland are concentrated in the northern portion of the county. In Salem County, there are no places to go for biopsies or treatment, and residents must travel to Vineland (in Cumberland County). In Cumberland County, Vineland is the only location providing treatment. Besides the NJCEED sites, there really are no programs for vulnerable populations to receive free or reduced cost care.

**Public Policy Implications**
The Affiliate’s policy work in the past has primarily revolved around meeting key advocacy priorities established by Komen Headquarters. The Affiliate will continue to focus on meeting these priorities as they are established each year, given that these are the key priorities for breast cancer care established through a national issue vetting process. The Affiliate will continue to monitor key aspects of the public policy realm that greatly impact breast cancer, including the New Jersey Cancer Education and Early Detection (NJCEED) Program funding and the Affordable Care Act (ACA), as it unfolds over the next few years. The Affiliate’s biggest policy goal is to establish relationships with a few key legislators. The findings from this assessment will be an important tool and conversation piece for developing these relationships, as well as a call to action to address the most vital issues outlined in the target communities. Additionally, the Affiliate will continue collaborating with NJCEED screening sites primarily through its community grants program, and will continue to hold influential roles on state coalitions and workgroups to help influence policy at a broad level.

**Health Systems Analysis Conclusions**
In general, the findings indicate that in the more resource-rich target communities, addressing needs should involve focusing on integrating existing resources and combining efforts when possible. In those target communities where there are less resources overall, the issues get a bit more complex, drawing the focus instead to how to maximize impact with a dearth of resources. The Affiliate will consider convening a coalition of key players in each of the target communities to address these issues collaboratively. It will also be important to ensure that all programs and resources connect women with the necessary care at every phase of the CoC, and that all collaborative efforts and partnerships attempt to focus, when possible, on providing targeted programs that reach the most vulnerable populations identified.

**Qualitative Data: Ensuring Community Input**
The purpose of the qualitative data are to further explore the breast health and breast cancer issues highlighted by the Quantitative Data Analysis and the Health Systems and Public Policy Analysis. The qualitative data provide insight into the community perspective as to what is working, what is not working, and what the various barriers are that lead to gaps in access, utilization and quality of services.

The Affiliate developed a specific set of assessment questions to address the key variables identified. Questions were specifically developed to further explore disparities in care, access, and utilization. For each target community, the Affiliate asked a generic set of questions about
barriers to care (both individual and systemic) along the continuum of care and the strengths and weaknesses of the health system. Additionally, for each community, supplemental questions were asked to explore specific issues identified that were unique to that county. The general assessment questions asked were:

- What are the greatest issues in the community related to breast health and breast cancer?
- What are the specific groups (racial/ethnic and geographic) that do not get the services they need in the community, and why?
- What barriers (individual or systemic) are faced at each stage of the continuum of care, and in transitioning through the stages? Why do they exist? What strategies are currently in place and/or need to be in place to address these barriers?
- What are the strengths and weaknesses of the health system and what new programs, resources, and policies are needed to deliver breast health more effectively?

The primary methods employed to collect data in each county were key informant interviews and document review. The key findings related to the qualitative data are outlined by target community below.

**Atlantic County**
The Qualitative Analysis identified the most frequently cited issues in the community related to breast health and breast cancer, which included financial barriers, a lack of education, competing priorities, and transportation barriers. Many of these issues were also given as potential explanations for the high death rate among Black/African-American women. The main reason why so much of population is considered to be medically underserved, despite having a wealth of resources in the area, was primarily attributed to access in general, and more specifically to transportation barriers (including insufficient distribution of bus routes and poor access to public transportation), and a lack of services and providers (particularly specialists) available.

**Camden County**
The Qualitative Analysis identified the most frequently cited issues in the community related to breast health and breast cancer as a lack of education, language barriers, fear, transportation barriers, financial barriers, and competing priorities. Many of these issues were highlighted as potential explanations for why this county experiences high late-stage diagnoses, low screening percentages, and issues related to survival and late-stage diagnoses among minority populations. The potential impact on breast health outcomes of the existence of population heavy areas where there are no resources available was noted as a key issue as well. The most substantial weakness of the health system identified was a lack of navigation, which was also acknowledged as the most common cause of delay in progression through the continuum of care.

**Gloucester County**
The Qualitative Analysis found that the most frequently cited issues in the community related to breast health and breast cancer were access (including transportation barriers, and particularly for rural populations), lack of education (among patients and conducted by providers), and fear. Many of these issues were given as potential explanations for why this county experiences high death rates among Blacks/African-Americans and high late-stage diagnoses among those 65 and older. The most commonly cited reasons as to why some of the key breast health statistics
are so poor despite a relatively low incidence of breast cancer and unremarkable socioeconomic indicators, were a lack of trust in the health system and issues of competing priorities among the working poor. Access to early screenings was described as one of the most pressing issues for the community, particularly given the low screening percentages.

In terms of issues related to access, just as the findings from the HSA suggest, it appears as though the major resources are concentrated mostly in the northern region of the county. Thus, accessing treatment can be particularly problematic for those who live a distance away, including those rural populations in the most southern portions of the county. Overall, the findings indicate a lack of transportation resources that can be attributed to a number of different issues including a lack of buses, a lack of awareness about availability, and inconvenient transportation schedules. A lack of vehicle access was cited, particularly for undocumented farm workers.

**Burlington and Monmouth Counties**

The Qualitative Analysis identified that the most frequently cited issue in the community related to breast health and breast cancer was access to care, with a specific emphasis on transportation barriers due to the sprawling and in some instances rural nature of this community. Accessibility issues cited included the geographic proximity of health care facilities (e.g. they are too spread out to access and not evenly distributed) and other transportation challenges (e.g. inconvenient times and stops, no walkable access to public transportation, and not enough routes).

Other issues cited often in both communities were a lack of education about breast health and fear. Financial/insurance barriers were also highlighted as key issues specifically in Monmouth County, while language barriers were highlighted in Burlington County. These were the issues most commonly cited as potential explanations for why these counties experience issues related to poor breast health outcomes, particularly among minority populations.

**Salem and Cumberland Counties**

The Qualitative Analysis results identified that the most frequently cited issues in the community related to breast health and breast cancer were a lack of education and transportation barriers. Other issues mentioned frequently included a lack of screening and financial barrier/insurance issues (particularly among undocumented populations), and to a lesser extent fear and competing priorities. Many of these issues were cited as potential explanations for why this community experiences poor breast health outcomes, particularly among minority populations.

The most substantial weakness of the system was identified to be access, with an emphasis on the geographic location of services. Access issues identified included the unequal distribution of services, a lack of providers, and transportation barriers. There was consensus in the Qualitative Analysis findings on a number of issues identified in the HSA, with the chief finding being that there are few resources available to address breast health across the entire continuum in this community. There was also agreement on a number of other potential access issues identified in the HSA including that:

- There are no resources that offer biopsies, treatment or follow-up services in these counties, and that this impacts breast health/breast cancer in the area.
- There are not enough resources for poor populations to receive free or reduced cost care, due to sparse, unequal distribution throughout the county.
Mission Action Plan

The key findings presented above for each of the target communities provide an overview of the triangulation of the findings conducted for each of the key components of the Profile analysis (Quantitative, Health Systems and Public Policy, and Qualitative). These findings provided the basis for the Mission Action Plan, which is intended to serve as a strategic and targeted roadmap for the Affiliate’s Mission work.

The Mission Action Plan was developed to focus on addressing three key problem areas identified in all of the target communities: education and outreach, access, and financial coverage, as well as crosscutting issues identified that impact all aspects of the Mission Action Plan. The priorities and measurable objectives are intended to address more specific issues identified related to each of the problem areas in the target communities, and are specific to certain target communities where the findings indicate a need to be. A short summary of each of the problem areas, including priorities and objectives, is provided below.

**EDUCATION & OUTREACH**

**Problem Statement:** The most substantial weakness identified in all target communities was a pervasive lack of education about breast health and breast cancer, as well as about the availability of existing resources and programs. A lack of education was also the most frequently cited reason for potential delays at various stages of the continuum of care that can contribute to poorer health outcomes. Low health literacy levels impact the acquisition of knowledge, while available services are underutilized by residents who need them because they do not know what is available. This is further complicated by issues such as competing priorities and cultural barriers, which can often lead to and be influenced by psychosocial issues such as fear.

**Priority:** Increase provider awareness about and develop collaborative solutions for addressing the lack of comprehensive, consistent, and coordinated information available for patients about breast health, breast cancer, and community resources in the target communities of Atlantic County, Camden County, Gloucester County, Burlington and Monmouth Counties and Salem and Cumberland Counties.

- **Objective 1:**
  By the end of 2015, meet with at least two different professional organizations that represent providers (e.g. The Medical Society of New Jersey) to develop a strategy for engaging providers throughout the target communities around the lack of education issue.

- **Objective 2:**
  By the end of 2016, hold at least three collaborative meetings for groups of providers from at least three of the target communities to share strategies and best practices for addressing the lack of education issue.

- **Objective 3:**
  By the end of 2017, collaborate with provider groups (e.g. professional organizations and groups from health systems in the target communities) to develop and disseminate a targeted educational campaign aimed at encouraging providers within the target communities to address issues relating to a lack of education among their patients.
Priority: Collaborate with patient navigators and social workers to improve patients’ from the target communities’ knowledgebase of breast health and breast cancer information and of existing community resources and to empower patients to more effectively navigate the continuum of care.

- **Objective 1:**
  Beginning with the 2016-17 grant cycle, revise the community grants program's RFA to include financial support in the target communities for patient navigators that focus specifically on providing breast cancer navigation as a funding priority.

- **Objective 2:**
  Beginning with the 2016-17 grant cycle, revise the community grants program’s RFA to require that all applicants provide a detailed plan that outlines the processes in place to connect women with the necessary resources and care at every phase of the Continuum of Care.

- **Objective 3:**
  By the end of 2016, hold at least three collaborative meetings for groups of navigators/social workers from at least three of the target communities to share strategies and best practices for addressing the lack of education issue.

- **Objective 4:**
  By the end of 2017, collaborate with navigator/social worker groups to develop and disseminate a targeted educational campaign aimed at encouraging navigators/social workers throughout the target communities to address key issues related to a lack of education among patients.

Priority: Support culturally and linguistically appropriate educational programs designed to meet the unique needs of minorities and other at-risk populations and decrease barriers to care by utilizing tailored messaging and strategies as well as partnerships with trusted community institutions.

- **Objective 1:**
  By November 2015, hold at least two specialized grant writing workshops aimed at existing grassroots organizations who specifically target minority populations that were identified on the resources map for each of the target communities.

- **Objective 2:**
  Beginning with the 2016-2017 grant cycle, revise the community grants program’s RFA to give priority to programs that implement innovative and evidence-based outreach efforts that specifically target Black/African-American populations in Atlantic, Burlington, Camden, Cumberland, and Gloucester Counties.

- **Objective 3:**
  Beginning with the 2016-2017 grant cycle, revise the community grants program’s RFA to give priority to programs that implement innovative and evidence-based outreach efforts that specifically target Hispanic/Latina populations in Camden, Cumberland, and Monmouth Counties.

- **Objective 4:**
  Beginning with the 2016-2017 grant cycle, revise the community grants program’s RFA to give priority to programs that implement innovative and evidence-based outreach efforts that specifically target undocumented populations in Camden, Cumberland, Gloucester, and Salem Counties.
Objective 5: Beginning with the 2016-2017 grant cycle, revise the community grants program’s RFA to give priority to programs that implement innovative and evidence-based outreach efforts that specifically target the 65+ population in Gloucester County.

Priority: Develop new and maintain existing Affiliate-based initiatives that address the lack of awareness about and existence of clear, consistent, accurate, and complete breast health and breast cancer information and comprehensive resources for patients from the target communities.

Objective 1: By July 2015, ensure that the Affiliate’s web-based Community Resource Guide is deemed comprehensive and is available for utilization by reaching out to and soliciting feedback from existing and potential partners identified on the resource maps.

Objective 2: Beginning with the 2016-2017 grant cycle, revise (on an annual basis) all Affiliate educational messaging and marketing materials to reflect clear and consistent screening guidelines and culturally and linguistically appropriate messages about breast cancer risk factors.

Objective 3: Beginning with the 2016-2017 grant cycle, train (on an annual basis) applicants through the applicant training session to deliver clear and consistent screening guidelines and culturally and linguistically appropriate messages about breast cancer risk factors.

Objective 4: By the end of 2016, collaborate with at least one grassroots organization and one health care institution in Atlantic County and in Salem/Cumberland Counties to provide a culturally appropriate breast health event where women ages 40+ can sign up for a mammography appointment and access targeted educational information.

Objective 5: By the end of 2017, collaborate with at least one grassroots organization and one health care institution in Camden County and in Burlington/Monmouth Counties to provide a culturally appropriate breast health event where women ages 40+ can sign up for a mammography appointment and access targeted educational information.

ACCESS

Problem Statement: All target communities identified numerous issues related to the uneven distribution of resources. In Camden, Burlington, and Monmouth Counties, residents must travel to specific pockets within the county to access care, as services are not equally distributed. Access issues are most pervasive in the rural and underserved target communities of Atlantic, Cumberland, and Salem, which have a dearth of resources overall. Transportation barriers inherent in all counties compound the challenges related to the distribution of resources and include complex systemic challenges such as unsafe access, limited hours, and insufficient distribution of bus routes. Challenges cited related to accessing providers include a lack of specialists available, a lack of physicians accepting Medicaid, a lack of primary care providers to initiate referrals, and a lack of providers who speak the appropriate language.
Priority: Maintain an ongoing dialogue with health systems in order to develop collaborative solutions for increasing access to providers at all phases of the Continuum of Care within the target communities.

- **Objective 1:**
  By the end of 2015, meet with key NJCEED program leaders, particularly those in Salem and Cumberland Counties, to discuss access issues cited in these communities including inconvenient screening site locations and limited screening site hours.

- **Objective 2:**
  By the end of 2016, meet with at least two different professional organizations representing providers (e.g. The Medical Society of New Jersey) to develop a strategy for engaging providers throughout the target communities around the lack of access to key providers issue.

- **Objective 3:**
  By the end of 2017, hold at least three collaborative meetings for groups of providers from at least three of the target communities to share strategies and best practices for addressing the lack of access to key providers issue.

Priority: Provide opportunities through the community grants program and through the establishment of key partnerships to enhance provider and patient communication within the target communities as it relates to linguistic challenges as well as the importance of connecting with a primary care home as a regular source of care.

- **Objective 1:**
  Beginning with the 2016-2017 grant cycle, revise the community grants program’s RFA to require that all programs that target linguistically isolated populations outline a plan which demonstrates their ability to provide all program services (e.g. presentations, materials, and care) in the appropriate language.

- **Objective 2:**
  Beginning with the 2016-2017 grant cycle, revise the community grants program’s RFA to require that all patients who are referred for care (either directly on-site or through referrals to sites) must be connected with a primary care home upon completion of their care and evidence of this connection must be documented in the program outcomes.

- **Objective 3:**
  By the end of 2016, meet with key leaders from the New Jersey Primary Care Association to discuss a potential partnership related to FQHC’s and their focus on connecting patients with a primary home model.

Priority: Address the awareness about and availability of transportation to screening, diagnostic, and treatment services in order to improve access to vital services integral to improving health outcomes in the target communities.

- **Objective 1:**
  By June 2016, convene at least one transportation meeting with key players (e.g. the Offices on Migrant Health and Aging) in each of the target communities in order to build new relationships and develop innovative and collaborative approaches to mobilizing existing resources (e.g. AccessLink, senior community vans, etc.) to comprehensively address transportation issues.
- **Objective 2:**
  Beginning with the 2017-2018 grant cycle, revise the community grants program’s RFA to provide priority funding in the target communities for innovative and collaborative approaches that mobilizing existing resources to comprehensively address transportation issues.

**FINANCIAL COVERAGE**

**Problem Statement:** Financial and insurance barriers were identified as major problems at all phases of the continuum, with the most frequently mentioned barrier being support for services beyond screening as well as for out-of-pocket costs. The most pervasive financial issues were identified in Atlantic, Cumberland, and Camden Counties, where there are a myriad of issues related to poverty, educational attainment, and unemployment. Socioeconomic factors have been extensively linked to breast cancer disparities in care and poor health outcomes. This is evident in the breast cancer outcomes in these communities.

*Priority:* Provide support for services beyond screening, including diagnostics and out-of-pocket costs (including co-pays, deductibles, prescriptions, and premiums) for underinsured, working poor populations in order to decrease disparities in care in the target communities.

- **Objective 1:**
  Beginning with the 2016-2017 grant cycle, revise the community grants program’s RFA to give priority to programs that use innovative and evidence-based approaches to reach underinsured, working poor populations in need of support for services beyond screening in the target communities.

- **Objective 2:**
  Beginning with the 2016-2017 grant cycle, revise the community grants program’s RFA to require that all programs that make referrals (and do not screen directly on-site) provide a letter of agreement outlining their partnership with a referring hospital system to provide screening and follow-up care on-site.

- **Objective 3:**
  By the end of 2016, hold collaborative meetings with at least three grassroots organizations that already provide financial support for services beyond screening (e.g. for prescription coverage) to residents of the target communities to discuss potential partnership opportunities.

- **Objective 4:**
  By the end of 2016, collaborate with Komen North Jersey to develop a strategy to address the Breast and Cervical Cancer Treatment Act at the state level in order to move legislation to Option 3 (which would allow for patients to receive services through the NJCEED program even if they did not receive their initial screening at a NJCEED screening site).

- **Objective 5:**
  By the end of 2017, hold strategic meetings with at least three different potential sponsors to explore the possibility of establishing a cancer fund that would be managed by an external grantee and would cover support for breast cancer services beyond screening.

- **Objective 6:**
  By the end of 2018, hold strategy meetings with at least three different health systems in the target communities to explore the complexity of and potential for treatment coverage.
Priority: Support financial navigation for those needing financial assistance in order to decrease barriers to care in un- and under-insured populations in the target communities.

- **Objective 1:**
  Beginning with the 2016-2017 grant cycle, revise the community grants program’s RFA to require that all programs that receive funding to make referrals or directly provide care must provide a financial counseling component for those in need of financial assistance.

Priority: Support free mammography screenings in the target communities with the lowest screening percentages in order to decrease barriers to care and improve health outcomes through early detection.

- **Objective 1:**
  Beginning with the 2016-2017 grant cycle, revise the community grants program’s RFA to require that all programs that receive funding for free mammography screenings must provide a financial counseling component for those in need of financial assistance.

  - **Objective 2:**
    Beginning with the 2016-2017 grant cycle, revise the community grants program’s RFA to give priority to programs that implement innovative and evidence-based outreach strategies and provide free screenings for uninsured populations in Gloucester, Camden, Cumberland, Salem, and Monmouth Counties.

  - **Objective 3:**
    Beginning with the 2016-2017 grant cycle, revise the community grants program’s RFA to require that all grants programs that target uninsured populations for free screenings must make an initial referral to the NJCEED program to see if the patient qualifies for services.

  - **Objective 4:**
    By the end of 2016, collaborate with at least one grassroots organization and one health care institution in Camden County to offer a screening event where women ages 40+ can receive a free mammography screening on-the-spot and access targeted educational information.

Priority: Provide support for special vulnerable populations within the target communities identified as experiencing extensive barriers to care, including financial difficulties.

- **Objective 1:**
  Beginning with the 2016-2017 grant cycle, revise the community grants program’s RFA to give priority to programs that implement innovative and evidence-based strategies that improve access, decrease financial barriers, and enhance outreach efforts for undocumented populations in Camden, Cumberland, Gloucester, and Salem Counties.

- **Objective 2:**
  Beginning with the 2016-2017 grant cycle, revise the community grants program’s RFA to give priority to grants programs that implement innovative and evidence-based strategies that improve access, decrease financial barriers, and enhance outreach efforts for casino workers impacted by recent casino closings in Atlantic City (Atlantic County).
Priority: Revise grantmaking priorities as necessary to respond to the Affordable Care Act

- **Objective 1:**
  By August 2015, hold regional meetings for current grantees to discuss the Affordable Care Act and what changes they are seeing to their programs as a result.

- **Objective 2:**
  Beginning with the 2016-2017 grant cycle, implement changes to the RFA for the community grants program and any corresponding grantwriting workshops as necessary to reflect the changing health care landscape (e.g. emphasize the need for quality grants that reduce financial barriers to necessary diagnostics and treatment).

- **Objective 3:**
  Beginning with the 2016-2017 grant cycle, ensure that all Affiliate-led and grantee initiatives and programs targeting uninsured populations provide appropriate linkages to information about obtaining coverage through the Affordable Care Act.

**CROSSCUTTING**

**Problem Statement:** There are numerous issues that impact the efficiency and efficacy of the Affiliate’s Mission work that cut across all of the problem areas (education & outreach, access, and financial) identified.

**Priority: Increase the quality of the applicant pool, applications, and programs for the community grants program to ensure identified gaps in the Continuum of Care are addressed in the target communities.**

- **Objective 1:**
  By September 2015 (and on an annual basis each September), hold two grant writing workshops for the target communities aimed at existing breast health providers identified on the resource maps.

- **Objective 2:**
  By August 2015 (and on an annual basis each August), work with at least three grantees to strengthen the evaluation of their grant projects in order to improve the overall quality of their programs.

**Priority: Develop and utilize partnerships and encourage collaborative efforts among grantees to more effectively and efficiently promote breast health education, breakdown financial and cultural barriers, and seamlessly connect patients with key resources throughout the Continuum of Care in the target communities.**

- **Objective 1:**
  From FY16 through FY19, annually convene a coalition of key players to collaboratively address major issues identified in each of the target communities by sharing strategies and best practices.

- **Objective 2:**
  From FY16 through FY19, work to strengthen the Affiliate’s relationship with NJCEED program by meeting biannually with NJCEED program leaders to maintain a dialogue that will address the needs of those at risk of or burdened by breast cancer and by attending quarterly NJCEED meetings, which bring together NJCEED providers in the state.

**Disclaimer:** Comprehensive data for the Executive Summary can be found in the 2015 Susan G. Komen® Central and South Jersey Community Profile Report.
**Affiliate History**

The Affiliate began as the Komen New Jersey Race for the Cure® in 1994. Recognizing the need for growth, key volunteers and Board members launched Susan G. Komen® Central and South Jersey in January 2005. Since its inception, the Affiliate has invested over $17 million in local nonprofit organizations and hospitals through the community grants program, and has helped to fund $3.9 million in research in New Jersey through the Susan G. Komen Research Programs.

Komen Central and South Jersey raises funds to make grants to nonprofit organizations offering breast health and breast cancer-related projects to medically underserved individuals through its community grants program. In addition to providing culturally and linguistically appropriate breast health education and outreach, programs provide mammography screening, primarily to individuals who do not have access to vital health care services. Programs either screen women directly on-site or make referrals to local screening sites. Programs may also provide transportation assistance and/or support for additional out-of-pocket expenses such as diagnostic services (e.g. biopsies). The goal is to ensure a patient’s needs are addressed throughout the entire continuum of care, including screening, diagnosis and follow-up care. The community grant programs exemplify the Komen promise in action. They help empower people by educating them about breast health and helping them to get the health care they need, and ensure quality care for everyone, regardless of their ability to pay, age, race, or where they live.

For the 2014-15 community grants cycle, the Affiliate awarded $1 million dollars to 16 nonprofit organizations throughout its service area who aimed to educate 23,000 about breast cancer and breast health awareness and refer to or directly provide (on-site) for 8,000 mammograms, as well as to provide 4,000 free mammograms, 250 diagnostic tests (including biopsies and ultrasounds), and 200 round trips to mammogram appointments. In addition to community grantmaking, the Affiliate’s other mission-related activities include local and national public policy efforts, community outreach in the form of breast health presentations, serving as a local resource for patients in need, and spearheading a multi-faceted initiative to reach breast cancer survivors.

In addition to the mission work, the Affiliate raises funds throughout the service area in the form of numerous signature and third-party events. The Race for the Cure® is the Affiliate’s largest signature event. In addition to the Race, the Affiliate promotes many important events during the year including a spring gala, the Golf for the Cure®, and the Ride for the Cure®, which is an equestrian event, among many others.

In March 2011, the Affiliate was recognized by Susan G. Komen's Headquarters with the prestigious Promise Award. The Promise Award is presented to a Komen Affiliate who has created innovative programs and rallied local community resources to make a measurable impact on breast cancer outcomes.

The Affiliate staff participates on a variety of councils, taskforces, and workgroups that serve as the leaders in the local breast health community. These include appointments by the Commissioner of Health to the New Jersey Chronic Disease Advisory Council, the Breast
Imaging Options Workgroup, the Chronic Disease Prevention and Health Promotion Planning Stakeholder Taskforce, and the Taskforce on Cancer Prevention, Early Detection, and Treatment in New Jersey. Involvement on these committees has included actively participating in drafting the state’s cancer plan. Additionally, the Affiliate attends regional chronic disease coalition meetings, as well as local cancer coalition meetings, when appropriate.

**Affiliate Organizational Structure**

As of March 2015, the Affiliate has six full-time employees who each manage a key aspect of the Affiliate’s development and mission activities (Figure 1.1).

![Figure 1.1. Susan G. Komen Central and South Jersey staff organizational chart](chart.png)

The Affiliate staff is assisted by interns from local universities as well as regular volunteers who help when needed to execute day-to-day office activities and also sit on specific committees that provide oversight of major Affiliate events and processes. Major committees that help to guide the Affiliate’s work include the Mission Committee, Survivorship Committee and Development Committee(s) in addition to numerous committees that work on special fundraising events including the Race for the Cure®, the Golf for the Cure®, the Ride for the Cure®, and the annual gala.

Governing the Affiliate’s work is the Board of Directors. The Board consists of a President, Secretary and Treasurer, as well as Mission Chair, Development Chair and Public Policy Chair positions. Additionally, Board members come from a variety of backgrounds, holding leadership positions in various sectors including finance, health care, and law.

**Affiliate Service Area**

The Affiliate serves 13 counties in central and southern New Jersey: Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Hunterdon, Mercer, Middlesex, Monmouth, Ocean, Salem, and Somerset (Figure 1.2).
For many of the key demographic and socioeconomic indicators (e.g. minority populations, educational attainment, health insurance status, and income below poverty), the Affiliate’s service area has lower percentages of these population characteristics as compared to New Jersey as a whole and the United States (Table 2.4). This means that the Affiliate’s service area as a whole fares better on these key indicators than all of New Jersey and the United States. However, the service area does have a higher percentage of the Asian/Pacific Islander
population than the United States does and is also older overall, having a higher percentage of 40, 50 and 65 plus female populations than both New Jersey and the United States (Table 2.4). The service area also has a higher percentage of foreign born than the United States, but is still lower than New Jersey overall (Table 2.5).

The service area is both culturally and demographically diverse in terms of race and ethnicity, age, and wealth, and there are substantial issues apparent at the individual county level. For example, Cape May, which shares a border with Cumberland County, is 5.3 percent Black/African-American and 5.8 percent Hispanic/Latina (Table 2.4). Conversely, Cumberland County is 20.7 percent Black/African-American and 26.7 percent Hispanic/Latina, which is the highest percentage of Hispanic/Latina in the service area (Table 2.4). The highest percentage of Blacks/African-Amercians in the service area is in Camden County (Table 2.4). Cape May (24.2 percent) and Ocean (23.7 percent) Counties have the largest percentages of 65 plus in the service area while Gloucester and Middlesex have the lowest percentages, both with 14.2 percent (Table 2.4).

In terms of socioeconomic statistics, there are also substantial differences among counties. For example, in the northern portion of the service area is Hunterdon County, which has 6.0 percent of the population with less than a high school education, 3.6 percent with incomes below 100 percent of poverty, 6.9 percent unemployed, and 0 percent living in medically underserved areas (Table 2.5). Conversely in the southern portion of the service area is Cumberland County, which has 23.3 percent of the population with less than a high school education, 15.7 percent with incomes below 100 percent of poverty, 12.7 percent unemployed, and 47.9 percent living in medically underserved areas (Table 2.5).

There are some counties like Cumberland where socioeconomic issues are poor across the board in comparison to other counties in the service area, as well as to New Jersey and the United States overall (Table 2.5). While in other counties such as Monmouth, some characteristics are comparatively better (e.g. the percentage of those with less than a high school education is much lower than the United States and New Jersey averages), while other characteristics (e.g. percentage of the population that is foreign born) point to notable issues when compared to the United States and/or New Jersey as a whole (Table 2.5). While it is clear that there are certain counties such as Atlantic, Cumberland and Camden that seem to have noticeably different, poorer socioeconomic and demographic indicators overall, it also appears that most of the counties in the service area have at least a few notable differences, although the extent of these issues may not be as pervasive as in other counties (Table 2.5).

Overall the service area is clearly one of stark contrasts. There are densely populated urban centers such as Camden and New Brunswick that are home to an array of health care services including top quality hospitals and academic research institutions. There are also very rural pockets in South Jersey (in counties such as Salem) where there are higher proportions of undocumented populations, transportation challenges, and generally fewer health care resources overall, leading to medically underserved populations (Table 2.5).
**Purpose of the Community Profile Report**

The purpose of the Komen Affiliates is to carry out the promise of Susan G. Komen at the local level. Thus, it is critical for each Affiliate to understand the unique issues regarding breast health and services within their service area in order to carry out Komen’s promise in a strategic, targeted, and effective manner and to have the greatest impact at the local level. Ultimately, the goal of this needs assessment is to drive the strategic operations of the Affiliate’s mission work by targeting the areas of greatest need and establishing measurable goals and objectives for the Affiliate’s work in these areas. The Affiliate makes its funding decisions to address the most urgent needs within its service area as identified through the Community Profile. It forms the foundation of the community grants program and guides the creation of the Request for Applications, allowing for the establishment of focused and inclusive granting priorities and strategies.

The Community Profile Report is the Affiliate’s main mission communication tool and will be used to educate and inform the Affiliate’s stakeholders (e.g. grantees, partners, donors, sponsors, legislators, other breast cancer-focused organizations and the community-at-large) regarding the state of breast cancer in the service area, the Affiliate’s current mission priorities, and the plan to address the identified breast health and breast cancer needs within the target communities. Among its many functions, the Profile will be used to inform the Affiliate’s inclusion efforts (within the service area and more specifically the target communities and populations), proposed education/outreach activities, proposed grantmaking, community organizing/engagement, advocacy/public policy efforts, marketing/communications plans, sponsorship/fundraising (i.e. development activities), and strategic and operational planning.

A number of different communications strategies will be employed to share the findings in the community. Strategies will include email blasts, press releases, website posting, and hardcopy distribution at forums. The methods selected will ultimately depend on the target audience. The Affiliate intends to share findings with current and potential partners identified in Health Systems and Public Policy Analysis including hospital systems, community-based organizations, local chronic disease and cancer coalitions, and local health departments at a series of regional forums. The Affiliate also intends to utilize local media contacts to secure featured newspaper articles and radio spots after the Profile is released to share the findings with the public.
Quantitative Data Report

Introduction
The purpose of the quantitative data report for Susan G. Komen® Central and South Jersey is to combine evidence from many credible sources and use the data to identify the highest priority areas for evidence-based breast cancer programs.

The data provided in the report are used to identify priorities within the Affiliate's service area based on estimates of how long it would take an area to achieve Healthy People 2020 objectives for breast cancer late-stage diagnosis and death rates (http://www.healthypeople.gov/2020/default.aspx).

The following is a summary of Komen® Central and South Jersey’s Quantitative Data Report. For a full report please contact the Affiliate.

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

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

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

To show trends (changes over time) in cancer incidence, data for the annual percent change in the incidence rate over a five-year period were included in the report. The annual percent change is the average year-to-year change of the incidence rate. It may be either a positive or negative number.
- A negative value means that the rates are getting lower.
- A positive value means that the rates are getting higher.
A positive value (rates getting higher) may seem undesirable—and it generally is. However, it's important to remember that an increase in breast cancer incidence could also mean that more breast cancers are being found because more women are getting mammograms. So higher rates don’t necessarily mean that there has been an increase in the occurrence of breast cancer.

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Incidence Rates and Trends</th>
<th>Death Rates and Trends</th>
<th>Late-stage Rates and Trends</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of New Cases (Annual Average)</td>
<td>Age-adjusted Rate/100,000</td>
<td>Trend (Annual Percent Change)</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>-----------------------------</td>
<td>------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>US</td>
<td>154,540,194</td>
<td>182,234</td>
<td>122.1</td>
</tr>
<tr>
<td>HP2020</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>New Jersey</td>
<td>4,476,452</td>
<td>6,754</td>
<td>129.3</td>
</tr>
<tr>
<td>Komen Central and South Jersey Service Area</td>
<td>2,380,641</td>
<td>3,767</td>
<td>132.4</td>
</tr>
<tr>
<td>White</td>
<td>1,871,852</td>
<td>3,230</td>
<td>135.6</td>
</tr>
<tr>
<td>Black/African-American</td>
<td>306,541</td>
<td>374</td>
<td>128.3</td>
</tr>
<tr>
<td>American Indian/Alaska Native (AIAN)</td>
<td>10,951</td>
<td>3</td>
<td>42.0</td>
</tr>
<tr>
<td>Asian Pacific Islander (API)</td>
<td>191,297</td>
<td>140</td>
<td>82.1</td>
</tr>
<tr>
<td>Non-Hispanic/ Latina</td>
<td>2,119,574</td>
<td>3,589</td>
<td>134.5</td>
</tr>
<tr>
<td>Hispanic/ Latina</td>
<td>261,066</td>
<td>178</td>
<td>105.4</td>
</tr>
<tr>
<td>Atlantic County - NJ</td>
<td>140,451</td>
<td>216</td>
<td>128.2</td>
</tr>
<tr>
<td>Burlington County - NJ</td>
<td>227,604</td>
<td>367</td>
<td>133.8</td>
</tr>
<tr>
<td>Camden County - NJ</td>
<td>265,702</td>
<td>426</td>
<td>142.7</td>
</tr>
<tr>
<td>Cape May County - NJ</td>
<td>50,235</td>
<td>97</td>
<td>125.6</td>
</tr>
<tr>
<td>Cumberland County - NJ</td>
<td>75,435</td>
<td>98</td>
<td>114.5</td>
</tr>
<tr>
<td>Gloucester County - NJ</td>
<td>146,776</td>
<td>207</td>
<td>126.4</td>
</tr>
<tr>
<td>Hunterdon County - NJ</td>
<td>64,438</td>
<td>120</td>
<td>153.7</td>
</tr>
<tr>
<td>Mercer County - NJ</td>
<td>186,534</td>
<td>278</td>
<td>132.3</td>
</tr>
<tr>
<td>Middlesex County - NJ</td>
<td>406,539</td>
<td>565</td>
<td>125.3</td>
</tr>
<tr>
<td>Monmouth County - NJ</td>
<td>322,678</td>
<td>547</td>
<td>140.1</td>
</tr>
<tr>
<td>Ocean County - NJ</td>
<td>296,765</td>
<td>543</td>
<td>128.8</td>
</tr>
<tr>
<td>Salem County - NJ</td>
<td>33,848</td>
<td>47</td>
<td>112.4</td>
</tr>
<tr>
<td>Somerset County - NJ</td>
<td>163,638</td>
<td>256</td>
<td>135.1</td>
</tr>
</tbody>
</table>

*Target as of the writing of this report.

NA – data not available.

SN – data suppressed due to small numbers (15 cases or fewer for the 5-year data period).

Data are for years 2006-2010.

Rates are in cases or deaths per 100,000.

Age-adjusted rates are adjusted to the 2000 US standard population.


Source of death rate data: Centers for Disease Control and Prevention (CDC) – National Center for Health Statistics (NCHS) mortality data in SEER*Stat.

Source of death trend data: National Cancer Institute (NCI)/CDC State Cancer Profiles.

### Incidence rates and trends summary

Overall, the breast cancer incidence rate in the Komen Central and South Jersey service area was higher than that observed in the US as a whole and the incidence trend was similar to the US as a whole. The incidence rate and trend of the Affiliate service area were not significantly different than that observed for the State of New Jersey.

For the United States, breast cancer incidence in Blacks/African-Americans is lower than in Whites overall. The most recent estimated breast cancer incidence rates for Asians and Pacific
Islanders (APIs) and American Indians and Alaska Natives (AIANs) were lower than for Non-Hispanic Whites and Blacks/African-Americans. The most recent estimated incidence rates for Hispanics/Latinas were lower than for Non-Hispanic Whites and Blacks/African-Americans. For the Affiliate service area as a whole, the incidence rate was lower among Blacks/African-Americans than Whites, lower among APIs than Whites, and lower among AIANs than Whites. The incidence rate among Hispanics/Latinas was lower than among Non-Hispanics/Latinas.

The following counties had an incidence rate significantly higher than the Affiliate service area as a whole:
- Camden County
- Hunterdon County
- Monmouth County

The incidence rate was significantly lower in the following counties:
- Cumberland County
- Middlesex County
- Salem County

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

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

**Death rates and trends summary**

Overall, the breast cancer death rate in the Komen Central and South Jersey service area was slightly higher than that observed in the US as a whole and the death rate trend was not available for comparison with the US as a whole. The death rate of the Affiliate service area was not significantly different than that observed for the State of New Jersey.

For the United States, breast cancer death rates in Blacks/African-Americans are substantially higher than in Whites overall. The most recent estimated breast cancer death rates for APIs and AIANs were lower than for Non-Hispanic Whites and Blacks/African-Americans. The most recent estimated death rates for Hispanics/Latinas were lower than for Non-Hispanic Whites and Blacks/African-Americans. For the Affiliate service area as a whole, the death rate was higher among Blacks/African-Americans than Whites and lower among APIs than Whites. There were not enough data available within the Affiliate service area to report on AIANs so comparisons cannot be made for this racial group. The death rate among Hispanics/Latinas was lower than among Non-Hispanics/Latinas.

None of the counties in the Affiliate service area had substantially different death rates than the Affiliate service area as a whole.

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

Overall, the breast cancer late-stage incidence rate in the Komen Central and South Jersey service area was slightly higher than that observed in the US as a whole and the late-stage incidence trend was slightly lower than the US as a whole. The late-stage incidence rate and
trend of the Affiliate service area were not significantly different than that observed for the State of New Jersey.

For the United States, late-stage incidence rates in Blacks/African-Americans are higher than among Whites. Hispanics/Latinas tend to be diagnosed with late-stage breast cancers more often than Whites. For the Affiliate service area as a whole, the late-stage incidence rate was higher among Blacks/African-Americans than Whites and lower among APIs than Whites. There were not enough data available within the Affiliate service area to report on AIANs so comparisons cannot be made for this racial group. The late-stage incidence rate among Hispanics/Latinas was lower than among Non-Hispanics/Latinas.

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

- Camden County

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

**Mammography Screening**

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

<table>
<thead>
<tr>
<th>Table 2.2.</th>
<th>Breast cancer screening recommendations for women at average risk*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>American Cancer Society</strong></td>
<td><strong>National Comprehensive Cancer Network</strong></td>
</tr>
<tr>
<td>Informed decision-making with a health care provider at age 40</td>
<td>Mammography every year starting at age 40</td>
</tr>
<tr>
<td>Mammography every year starting at age 45</td>
<td>Mammography every year starting at age 40</td>
</tr>
<tr>
<td>Mammography every other year beginning at age 55</td>
<td></td>
</tr>
</tbody>
</table>

*As of October 2015

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

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

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

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

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

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

For example, if screening proportion was reported as 50.0 percent, with a confidence interval of 35.0 to 65.0 percent, the real rate might not be exactly 50.0 percent, but it’s very unlikely that it’s less than 35.0 or more than 65.0 percent.

In general, screening proportions at the county level have fairly wide confidence intervals. The confidence interval should always be considered before concluding that the screening proportion in one county is higher or lower than that in another county.
Table 2.3. Proportion of women ages 50-74 with screening mammography in the last two years, self-report

<table>
<thead>
<tr>
<th>Population Group</th>
<th># of Women Interviewed (Sample Size)</th>
<th># w/ Self-Reported Mammogram</th>
<th>Proportion Screened (Weighted Average)</th>
<th>Confidence Interval of Proportion Screened</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>174,796</td>
<td>133,399</td>
<td>77.5%</td>
<td>77.2%-77.7%</td>
</tr>
<tr>
<td>New Jersey</td>
<td>5,342</td>
<td>4,115</td>
<td>77.7%</td>
<td>76.3%-79.0%</td>
</tr>
<tr>
<td>Komen Central and South Jersey Service Area</td>
<td>3,137</td>
<td>2,440</td>
<td>77.4%</td>
<td>75.6%-79.2%</td>
</tr>
<tr>
<td>White</td>
<td>2,714</td>
<td>2,107</td>
<td>76.7%</td>
<td>74.7%-78.5%</td>
</tr>
<tr>
<td>Black/African-American</td>
<td>275</td>
<td>218</td>
<td>82.3%</td>
<td>76.0%-87.2%</td>
</tr>
<tr>
<td>AIAN</td>
<td>14</td>
<td>11</td>
<td>73.5%</td>
<td>38.9%-92.4%</td>
</tr>
<tr>
<td>API</td>
<td>35</td>
<td>28</td>
<td>78.4%</td>
<td>63.5%-88.3%</td>
</tr>
<tr>
<td>Hispanic/ Latina</td>
<td>104</td>
<td>86</td>
<td>82.5%</td>
<td>71.3%-89.9%</td>
</tr>
<tr>
<td>Non-Hispanic/ Latina</td>
<td>3,024</td>
<td>2,348</td>
<td>77.1%</td>
<td>75.3%-78.9%</td>
</tr>
<tr>
<td>Atlantic County - NJ</td>
<td>376</td>
<td>294</td>
<td>76.8%</td>
<td>71.1%-81.6%</td>
</tr>
<tr>
<td>Burlington County - NJ</td>
<td>235</td>
<td>187</td>
<td>82.8%</td>
<td>76.2%-87.8%</td>
</tr>
<tr>
<td>Camden County - NJ</td>
<td>264</td>
<td>193</td>
<td>69.2%</td>
<td>61.9%-75.7%</td>
</tr>
<tr>
<td>Cape May County - NJ</td>
<td>251</td>
<td>214</td>
<td>86.0%</td>
<td>79.6%-90.6%</td>
</tr>
<tr>
<td>Cumberland County - NJ</td>
<td>217</td>
<td>168</td>
<td>78.0%</td>
<td>69.3%-84.7%</td>
</tr>
<tr>
<td>Gloucester County - NJ</td>
<td>198</td>
<td>143</td>
<td>74.7%</td>
<td>66.0%-81.7%</td>
</tr>
<tr>
<td>Hunterdon County - NJ</td>
<td>211</td>
<td>166</td>
<td>78.5%</td>
<td>71.2%-84.4%</td>
</tr>
<tr>
<td>Mercer County - NJ</td>
<td>200</td>
<td>164</td>
<td>80.3%</td>
<td>72.4%-86.4%</td>
</tr>
<tr>
<td>Middlesex County - NJ</td>
<td>253</td>
<td>199</td>
<td>79.5%</td>
<td>73.2%-84.6%</td>
</tr>
<tr>
<td>Monmouth County - NJ</td>
<td>238</td>
<td>183</td>
<td>76.4%</td>
<td>69.7%-82.0%</td>
</tr>
<tr>
<td>Ocean County - NJ</td>
<td>242</td>
<td>175</td>
<td>72.9%</td>
<td>66.2%-78.7%</td>
</tr>
<tr>
<td>Salem County - NJ</td>
<td>231</td>
<td>169</td>
<td>72.2%</td>
<td>64.4%-78.8%</td>
</tr>
<tr>
<td>Somerset County - NJ</td>
<td>221</td>
<td>185</td>
<td>87.5%</td>
<td>81.1%-92.0%</td>
</tr>
</tbody>
</table>

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

**Breast cancer screening proportions summary**

The breast cancer screening proportion in the Komen Central and South Jersey service area was not significantly different than that observed in the US as a whole. The screening proportion of the Affiliate service area was not significantly different than the State of New Jersey.

For the United States, breast cancer screening proportions among Blacks/African Americans are similar to those among Whites overall. APIs have somewhat lower screening proportions than Whites and Blacks/African Americans. Although data are limited, screening proportions among AIANs are similar to those among Whites. Screening proportions among Hispanics/Latinas are similar to those among Non-Hispanic Whites and Blacks/African Americans. For the Affiliate service area as a whole, the screening proportion was not significantly different among Blacks/African Americans than Whites, not significantly different among APIs than Whites, and not significantly different among AIANs than Whites. The
screening proportion among Hispanics/Latinas was not significantly different than among Non-Hispanics/Latinas.

The following counties had a screening proportion significantly higher than the Affiliate service area as a whole:
- Cape May County
- Somerset County

The remaining counties had screening proportions that were not significantly different than the Affiliate service area as a whole.

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

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

The demographic and socioeconomic data in this report are the most recent data available for US counties. All the data are shown as percentages. However, the percentages weren’t all calculated in the same way.
- The race, ethnicity, and age data are based on the total female population in the area (e.g. the percent of females over the age of 40).
- The socioeconomic data are based on all the people in the area, not just women.
- Income, education and unemployment data don’t include children. They’re based on people age 15 and older for income and unemployment and age 25 and older for education.
- The data on the use of English, called “linguistic isolation”, are based on the total number of households in the area. The Census Bureau defines a linguistically isolated household as one in which all the adults have difficulty with English.
### Table 2.4. Population characteristics – demographics

<table>
<thead>
<tr>
<th>Population Group</th>
<th>White</th>
<th>Black /African-Amercian</th>
<th>AIAN</th>
<th>API</th>
<th>Non-Hispanic /Latina</th>
<th>Hispanic /Latina</th>
<th>Female Age 40 Plus</th>
<th>Female Age 50 Plus</th>
<th>Female Age 65 Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>78.8%</td>
<td>14.1%</td>
<td>1.4%</td>
<td>5.8%</td>
<td>83.8%</td>
<td>16.2%</td>
<td>48.3%</td>
<td>34.5%</td>
<td>14.8%</td>
</tr>
<tr>
<td>New Jersey</td>
<td>74.6%</td>
<td>15.7%</td>
<td>0.6%</td>
<td>9.1%</td>
<td>82.5%</td>
<td>17.5%</td>
<td>50.9%</td>
<td>35.9%</td>
<td>15.5%</td>
</tr>
<tr>
<td>Komen Central and South Jersey Service Area</td>
<td>77.7%</td>
<td>13.1%</td>
<td>0.5%</td>
<td>8.7%</td>
<td>87.9%</td>
<td>12.1%</td>
<td>52.0%</td>
<td>37.1%</td>
<td>16.3%</td>
</tr>
<tr>
<td>Atlantic County - NJ</td>
<td>72.3%</td>
<td>18.7%</td>
<td>0.8%</td>
<td>8.2%</td>
<td>83.4%</td>
<td>16.6%</td>
<td>51.9%</td>
<td>37.2%</td>
<td>16.0%</td>
</tr>
<tr>
<td>Burlington County - NJ</td>
<td>76.5%</td>
<td>18.0%</td>
<td>0.4%</td>
<td>5.2%</td>
<td>93.8%</td>
<td>6.2%</td>
<td>53.2%</td>
<td>37.4%</td>
<td>16.0%</td>
</tr>
<tr>
<td>Camden County - NJ</td>
<td>71.1%</td>
<td>22.5%</td>
<td>0.7%</td>
<td>5.7%</td>
<td>85.9%</td>
<td>14.1%</td>
<td>49.6%</td>
<td>35.1%</td>
<td>14.7%</td>
</tr>
<tr>
<td>Cape May County - NJ</td>
<td>93.2%</td>
<td>5.3%</td>
<td>0.3%</td>
<td>1.2%</td>
<td>94.2%</td>
<td>5.8%</td>
<td>61.8%</td>
<td>49.0%</td>
<td>24.2%</td>
</tr>
<tr>
<td>Cumberland County - NJ</td>
<td>75.8%</td>
<td>20.7%</td>
<td>1.8%</td>
<td>1.7%</td>
<td>73.3%</td>
<td>26.7%</td>
<td>47.8%</td>
<td>34.2%</td>
<td>15.2%</td>
</tr>
<tr>
<td>Gloucester County - NJ</td>
<td>85.3%</td>
<td>11.4%</td>
<td>0.3%</td>
<td>3.1%</td>
<td>95.2%</td>
<td>4.8%</td>
<td>50.6%</td>
<td>34.9%</td>
<td>14.2%</td>
</tr>
<tr>
<td>Hunterdon County - NJ</td>
<td>93.2%</td>
<td>2.7%</td>
<td>0.2%</td>
<td>3.9%</td>
<td>95.0%</td>
<td>5.0%</td>
<td>58.4%</td>
<td>39.7%</td>
<td>14.5%</td>
</tr>
<tr>
<td>Mercer County – NJ</td>
<td>67.2%</td>
<td>22.4%</td>
<td>0.6%</td>
<td>9.8%</td>
<td>86.0%</td>
<td>14.0%</td>
<td>49.5%</td>
<td>34.8%</td>
<td>14.8%</td>
</tr>
<tr>
<td>Middlesex County - NJ</td>
<td>65.4%</td>
<td>11.5%</td>
<td>0.7%</td>
<td>22.4%</td>
<td>81.4%</td>
<td>18.6%</td>
<td>48.1%</td>
<td>33.5%</td>
<td>14.2%</td>
</tr>
<tr>
<td>Monmouth County - NJ</td>
<td>85.7%</td>
<td>8.4%</td>
<td>0.4%</td>
<td>5.5%</td>
<td>90.7%</td>
<td>9.3%</td>
<td>54.5%</td>
<td>38.2%</td>
<td>15.9%</td>
</tr>
<tr>
<td>Ocean County – NJ</td>
<td>93.8%</td>
<td>3.7%</td>
<td>0.3%</td>
<td>2.2%</td>
<td>92.0%</td>
<td>8.0%</td>
<td>56.0%</td>
<td>43.5%</td>
<td>23.7%</td>
</tr>
<tr>
<td>Salem County – NJ</td>
<td>82.3%</td>
<td>16.0%</td>
<td>0.5%</td>
<td>1.2%</td>
<td>93.5%</td>
<td>6.5%</td>
<td>53.4%</td>
<td>38.8%</td>
<td>16.9%</td>
</tr>
<tr>
<td>Somerset County - NJ</td>
<td>74.2%</td>
<td>10.2%</td>
<td>0.3%</td>
<td>15.2%</td>
<td>87.3%</td>
<td>12.7%</td>
<td>52.7%</td>
<td>35.5%</td>
<td>14.3%</td>
</tr>
</tbody>
</table>

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

### Table 2.5. Population characteristics – socioeconomics

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Less than HS Education</th>
<th>Income Below 100% Poverty</th>
<th>Income Below 250% Poverty (Age: 40-64)</th>
<th>Un-employed</th>
<th>Foreign Born</th>
<th>Linguistically Isolated</th>
<th>In Rural Areas</th>
<th>In Medically Underserved Areas</th>
<th>No Health Insurance (Age: 40-64)</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>14.6%</td>
<td>14.3%</td>
<td>33.3%</td>
<td>8.7%</td>
<td>12.8%</td>
<td>4.7%</td>
<td>19.3%</td>
<td>23.3%</td>
<td>16.6%</td>
</tr>
<tr>
<td>New Jersey</td>
<td>12.4%</td>
<td>9.4%</td>
<td>23.6%</td>
<td>8.7%</td>
<td>20.6%</td>
<td>7.3%</td>
<td>5.3%</td>
<td>12.6%</td>
<td>14.5%</td>
</tr>
<tr>
<td>Komen Central and South Jersey Service Area</td>
<td>11.2%</td>
<td>8.4%</td>
<td>21.5%</td>
<td>8.8%</td>
<td>15.0%</td>
<td>4.6%</td>
<td>6.9%</td>
<td>11.8%</td>
<td>12.7%</td>
</tr>
<tr>
<td>Atlantic County – NJ</td>
<td>15.8%</td>
<td>12.5%</td>
<td>32.5%</td>
<td>10.7%</td>
<td>15.5%</td>
<td>5.9%</td>
<td>12.7%</td>
<td>40.9%</td>
<td>16.2%</td>
</tr>
<tr>
<td>Burlington County – NJ</td>
<td>8.6%</td>
<td>5.3%</td>
<td>17.1%</td>
<td>8.0%</td>
<td>9.6%</td>
<td>2.0%</td>
<td>6.7%</td>
<td>0.0%</td>
<td>9.8%</td>
</tr>
<tr>
<td>Camden County - NJ</td>
<td>14.1%</td>
<td>11.8%</td>
<td>27.4%</td>
<td>10.4%</td>
<td>10.2%</td>
<td>4.4%</td>
<td>1.6%</td>
<td>11.0%</td>
<td>13.9%</td>
</tr>
<tr>
<td>Cape May County - NJ</td>
<td>11.1%</td>
<td>9.6%</td>
<td>27.8%</td>
<td>9.0%</td>
<td>4.3%</td>
<td>2.3%</td>
<td>17.5%</td>
<td>0.0%</td>
<td>14.6%</td>
</tr>
<tr>
<td>Cumberland County – NJ</td>
<td>23.3%</td>
<td>15.7%</td>
<td>36.2%</td>
<td>12.7%</td>
<td>10.4%</td>
<td>6.7%</td>
<td>23.0%</td>
<td>47.9%</td>
<td>18.0%</td>
</tr>
<tr>
<td>Gloucester County - NJ</td>
<td>10.0%</td>
<td>7.3%</td>
<td>20.2%</td>
<td>9.5%</td>
<td>5.0%</td>
<td>1.2%</td>
<td>8.3%</td>
<td>0.0%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Hunterdon County - NJ</td>
<td>6.0%</td>
<td>3.6%</td>
<td>11.0%</td>
<td>6.9%</td>
<td>8.4%</td>
<td>1.6%</td>
<td>49.6%</td>
<td>0.0%</td>
<td>7.0%</td>
</tr>
<tr>
<td>Mercer County – NJ</td>
<td>12.9%</td>
<td>10.7%</td>
<td>21.9%</td>
<td>9.0%</td>
<td>20.0%</td>
<td>5.6%</td>
<td>3.5%</td>
<td>12.8%</td>
<td>12.7%</td>
</tr>
<tr>
<td>Middlesex County - NJ</td>
<td>11.4%</td>
<td>7.5%</td>
<td>20.8%</td>
<td>7.9%</td>
<td>29.8%</td>
<td>9.2%</td>
<td>0.7%</td>
<td>5.0%</td>
<td>15.1%</td>
</tr>
<tr>
<td>Monmouth County - NJ</td>
<td>8.4%</td>
<td>6.5%</td>
<td>17.4%</td>
<td>7.7%</td>
<td>13.1%</td>
<td>3.9%</td>
<td>3.7%</td>
<td>3.4%</td>
<td>11.7%</td>
</tr>
<tr>
<td>Ocean County – NJ</td>
<td>10.8%</td>
<td>9.5%</td>
<td>24.0%</td>
<td>9.2%</td>
<td>7.8%</td>
<td>2.5%</td>
<td>2.9%</td>
<td>23.4%</td>
<td>13.1%</td>
</tr>
<tr>
<td>Salem County – NJ</td>
<td>14.3%</td>
<td>10.8%</td>
<td>27.7%</td>
<td>11.0%</td>
<td>3.8%</td>
<td>1.5%</td>
<td>45.3%</td>
<td>100.0%</td>
<td>12.5%</td>
</tr>
<tr>
<td>Somerset County - NJ</td>
<td>7.0%</td>
<td>3.7%</td>
<td>11.8%</td>
<td>6.4%</td>
<td>22.9%</td>
<td>5.5%</td>
<td>5.8%</td>
<td>0.0%</td>
<td>9.2%</td>
</tr>
</tbody>
</table>

Data are in the percentage of people (men and women) in the population.  
Source of health insurance data: US Census Bureau – Small Area Health Insurance Estimates (SAHIE) for 2011.  
Source of medically underserved data: Health Resources and Services Administration (HRSA) for 2013.  
Source of other data: US Census Bureau – American Community Survey (ACS) for 2007-2011.
Population characteristics summary
Proportionately, the Komen Central and South Jersey service area has a slightly smaller White female population than the US as a whole, a slightly smaller Black/African-American female population, a slightly larger Asian and Pacific Islander (API) female population, a slightly smaller American Indian and Alaska Native (AIAN) female population, and a slightly smaller Hispanic/Latina female population. The Affiliate’s female population is slightly older than that of the US as a whole. The Affiliate’s education level is slightly higher than and income level is substantially higher than those of the US as a whole. There are a slightly larger percentage of people who are unemployed in the Affiliate service area. The Affiliate service area has a slightly larger percentage of people who are foreign born and a slightly smaller percentage of people who are linguistically isolated. There are a substantially smaller percentage of people living in rural areas, a slightly smaller percentage of people without health insurance, and a substantially smaller percentage of people living in medically underserved areas.

The following counties have substantially larger Black/African-American female population percentages than that of the Affiliate service area as a whole:
- Atlantic County
- Camden County
- Cumberland County
- Mercer County

The following counties have substantially larger API female population percentages than that of the Affiliate service area as a whole:
- Middlesex County
- Somerset County

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

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

The following county has substantially lower education levels than that of the Affiliate service area as a whole:
- Cumberland County

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

The following county has substantially lower employment levels than that of the Affiliate service area as a whole:
- Cumberland County
The county with substantial foreign born and linguistically isolated populations is:
• Middlesex County

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

**Priority Areas**

**Healthy People 2020 forecasts**
Healthy People 2020 (HP2020) is a major federal government initiative that provides specific health objectives for communities and for the country as a whole. Many national health organizations use HP2020 targets to monitor progress in reducing the burden of disease and improve the health of the nation. Likewise, Komen believes it is important to refer to HP2020 to see how areas across the country are progressing towards reducing the burden of breast cancer.

HP2020 has several cancer-related objectives, including:

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

To see how well counties in the Komen Central and South Jersey service area are progressing toward these targets, the report uses the following information:

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

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

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

**Identification of priority areas**
The purpose of this report is to combine evidence from many credible sources and use the data to identify the highest priority areas for breast cancer programs (i.e. the areas of greatest need). Classification of priority areas are based on the time needed to achieve HP2020 targets in each area. These time projections depend on both the starting point and the trends in death rates and late-stage incidence.

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

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

Counties are classified as follows (Table 2.6):

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

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

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

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

**Affiliate Service Area Healthy People 2020 Forecasts and Priority Areas**

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

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

Trends can change for a number of reasons, including:

- Improved screening programs could lead to breast cancers being diagnosed earlier, resulting in a decrease in both late-stage incidence rates and death rates.
- Improved socioeconomic conditions, such as reductions in poverty and linguistic isolation could lead to more timely treatment of breast cancer, causing a decrease in death rates.
The data in this table should be considered together with other information on factors that affect breast cancer death rates such as screening percentages and key breast cancer death determinants such as poverty and linguistic isolation.

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

<table>
<thead>
<tr>
<th>County</th>
<th>Priority</th>
<th>Predicted Time to Achieve Death Rate Target</th>
<th>Predicted Time to Achieve Late-stage Incidence Target</th>
<th>Key Population Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlantic County - NJ</td>
<td>Highest</td>
<td>13 years or longer</td>
<td>13 years or longer</td>
<td>%Black/African-American, rural, medically underserved</td>
</tr>
<tr>
<td>Camden County - NJ</td>
<td>Highest</td>
<td>13 years or longer</td>
<td>13 years or longer</td>
<td>%Black/African-American</td>
</tr>
<tr>
<td>Gloucester County - NJ</td>
<td>Highest</td>
<td>13 years or longer</td>
<td>13 years or longer</td>
<td>%Black/African-American</td>
</tr>
<tr>
<td>Burlington County - NJ</td>
<td>High</td>
<td>8 years</td>
<td>13 years or longer</td>
<td></td>
</tr>
<tr>
<td>Monmouth County - NJ</td>
<td>High</td>
<td>7 years</td>
<td>13 years or longer</td>
<td></td>
</tr>
<tr>
<td>Cumberland County - NJ</td>
<td>Medium High</td>
<td>9 years</td>
<td>9 years</td>
<td>%Black/African-American, %Hispanic/Latina, education, poverty, employment, rural, insurance, medically underserved</td>
</tr>
<tr>
<td>Hunterdon County - NJ</td>
<td>Medium High</td>
<td>13 years or longer</td>
<td>4 years</td>
<td>Rural</td>
</tr>
<tr>
<td>Middlesex County - NJ</td>
<td>Medium High</td>
<td>7 years</td>
<td>12 years</td>
<td>%API, %Hispanic/Latina, foreign, language</td>
</tr>
<tr>
<td>Salem County - NJ</td>
<td>Medium High</td>
<td>13 years or longer</td>
<td>5 years</td>
<td>Rural, medically underserved</td>
</tr>
<tr>
<td>Cape May County - NJ</td>
<td>Medium</td>
<td>9 years</td>
<td>4 years</td>
<td>Older, rural</td>
</tr>
<tr>
<td>Mercer County - NJ</td>
<td>Medium</td>
<td>8 years</td>
<td>6 years</td>
<td>%Black/African-American</td>
</tr>
<tr>
<td>Ocean County - NJ</td>
<td>Medium</td>
<td>12 years</td>
<td>2 years</td>
<td>Medically underserved</td>
</tr>
<tr>
<td>Somerset County - NJ</td>
<td>Medium</td>
<td>4 years</td>
<td>8 years</td>
<td>%API, foreign</td>
</tr>
</tbody>
</table>

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

Figure 2.1 shows a map of the intervention priorities for the counties in the Affiliate service area. When both of the indicators used to establish a priority for a county are not available, the priority is shown as “undetermined” on the map.

Data Limitations

The following data limitations need to be considered when utilizing the data of the Quantitative Data Report:

- The most recent data available were used but, for cancer incidence and deaths, these data are still several years behind.
- For some areas, data might not be available or might be of varying quality.
- Areas with small populations might not have enough breast cancer cases or breast cancer deaths each year to support the generation of reliable statistics.
There are often several sources of cancer statistics for a given population and geographic area; therefore, other sources of cancer data may result in minor differences in the values even in the same time period.

Data on cancer rates for specific racial and ethnic subgroups such as Somali, Hmong, or Ethiopian are not generally available.

The various types of breast cancer data in this report are inter-dependent.

There are many factors that impact breast cancer risk and survival for which quantitative data are not available. Some examples include family history, genetic markers like HER2 and BRCA, other medical conditions that can complicate treatment, and the level of family and community support available to the patient.

The calculation of the years needed to meet the HP2020 objectives assume that the current trends will continue until 2020. However, the trends can change for a number of reasons.

Not all breast cancer cases have a stage indication.

Quantitative Data Report Conclusions

**Highest priority areas**

Three counties in the Komen Central and South Jersey service area are in the highest priority category. All of the three, Atlantic County, Camden County and Gloucester County, are not likely to meet either the death rate or late-stage incidence rate HP2020 targets.

The incidence rates in Camden County (142.7 per 100,000) are significantly higher than the Affiliate service area as a whole (132.4 per 100,000). The late-stage incidence rates in Camden County (53.3 per 100,000) are significantly higher than the Affiliate service area as a whole (47.0 per 100,000).

Atlantic County has a relatively large Black/African-American population. Camden County has a relatively large Black/African-American population.

**High priority areas**

Two counties in the Komen Central and South Jersey service area are in the high priority category. Both of the two, Burlington County and Monmouth County, are not likely to meet the late-stage incidence rate HP2020 target.

The incidence rates in Monmouth County (140.1 per 100,000) are significantly higher than the Affiliate service area as a whole (132.4 per 100,000).

**Additional Quantitative Data Exploration**

For each county, the Affiliate conducted a deeper analysis of several key breast cancer indicators including the percentage of late-stage diagnoses and death rates by race and ethnicity, and five-year relative survival rates overall and by race and ethnicity.

The Affiliate chose to collect additional data on these indicators primarily to gain a deeper understanding of where disparities may exist among certain target groups. Many populations within the US are disproportionately burdened by high incidence and death rates of breast cancer (Susan G. Komen [Komen], 2014a). For example, Black/African-American women have the highest death rates for breast cancer and lowest five-year relative survival rates for breast cancer.
cancer among all racial groups (Komen, 2013). These differences lead to disparities, which affect how different communities are impacted by breast cancer incidence, deaths and survival (Komen, 2014a). Understanding these differences is critical to reducing breast cancer disparities. Additionally, data on late-stage incidence and deaths can reflect a number of issues including mammography screening coverage, access to care and the quality of care in the health care delivery service area. Survival rates can also reflect these issues.

These data were used in conjunction with data from the Quantitative Data Report (QDR) to assist in identifying communities with the greatest needs in the service area. Data from both sections were reviewed and the communities with the greatest number of red flags were selected for further exploration. By identifying disparities among certain indicators or groups in the quantitative data analysis, the Affiliate was able to more effectively target the highest priority communities and further examine root causes for the disproportionate burden identified in subsequent sections of the analysis.

**Five- year relative survival rates (race and ethnicity specific)**
The breast cancer five-year relative survival rate provides statistics on the chance of survival within five years of diagnosis for all women or specific groups of women. It compares the survival of women with breast cancer to the survival of women in the general population who have not been diagnosed with breast cancer. For example, if the five-year relative survival rate for women with localized breast cancer was 99.0 percent, it would mean that women with localized breast cancer were, on average, 99.0 percent as likely as women in the general population to live five years beyond their diagnosis (Komen, 2014b). Five-year relative survival rates can provide an indication of prognosis in a certain population group and may also provide an indication of quality of care, but it is important to note that they are averages and vary depending on a person’s diagnosis and treatment (Komen, 2014b).

Five-year relative survival rates were collected from the New Jersey Cancer Registry (NJCR) and are presented in Table 2.8. Rates were calculated as the observed survival rate of women diagnosed with invasive breast cancer (between 2001-2005) who were alive five years after diagnosis divided by the expected survival rate for women who have not been diagnosed with cancer and are of similar age, race, and sex as those diagnosed with breast cancer. Rates are provided for all races combined and also separated by race (White, Black/African-American, and API). Rates for Hispanic/Latina ethnicity are also presented, but it is important to note that Hispanic/Latina ethnicity and race are not mutually exclusive. Hispanics/Latinas who identify themselves as White or Black/African-American are also included in that race category as well as the “all races” category. In New Jersey, the majority (89.0 percent) of Hispanics/Latinas identify themselves as White (New Jersey State Cancer Registry, 2013). Rates are presented as percentages; the higher the percentage the higher the survival rate, which is the most favorable outcome.
### Table 2.8. Female breast cancer five-year relative survival rates

<table>
<thead>
<tr>
<th>County</th>
<th>White</th>
<th>Black/African-American</th>
<th>API</th>
<th>Hispanic/Latina</th>
<th>All Races</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Rate</td>
</tr>
<tr>
<td>Atlantic</td>
<td>86.4%</td>
<td>73.3%</td>
<td>NA</td>
<td>90.8%</td>
<td>84.2%</td>
</tr>
<tr>
<td>Burlington</td>
<td>89.2%</td>
<td>84.7%</td>
<td>82.8%</td>
<td>94.6%</td>
<td>88.6%</td>
</tr>
<tr>
<td>Camden</td>
<td>86.3%</td>
<td>80.9%</td>
<td>93.1%</td>
<td>77.4%</td>
<td>85.7%</td>
</tr>
<tr>
<td>Cape May</td>
<td>89.1%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>89.1%</td>
</tr>
<tr>
<td>Cumberland</td>
<td>87.9%</td>
<td>71.5%</td>
<td>NA</td>
<td>82.1%</td>
<td>85.4%</td>
</tr>
<tr>
<td>Gloucester</td>
<td>87.5%</td>
<td>82.3%</td>
<td>NA</td>
<td>NA</td>
<td>87.1%</td>
</tr>
<tr>
<td>Hunterdon</td>
<td>91.3%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>90.6%</td>
</tr>
<tr>
<td>Mercer</td>
<td>90.3%</td>
<td>69.8%</td>
<td>91.6%</td>
<td>86.9%</td>
<td>86.9%</td>
</tr>
<tr>
<td>Middlesex</td>
<td>88.8%</td>
<td>81.2%</td>
<td>90.5%</td>
<td>88.1%</td>
<td>88.4%</td>
</tr>
<tr>
<td>Monmouth</td>
<td>89.4%</td>
<td>80.5%</td>
<td>85.5%</td>
<td>85.3%</td>
<td>88.8%</td>
</tr>
<tr>
<td>Ocean</td>
<td>88.9%</td>
<td>71.9%</td>
<td>NA</td>
<td>86.4%</td>
<td>88.5%</td>
</tr>
<tr>
<td>Salem</td>
<td>85.3%</td>
<td>78.4%</td>
<td>NA</td>
<td>NA</td>
<td>84.0%</td>
</tr>
<tr>
<td>Somerset</td>
<td>88.2%</td>
<td>69.6%</td>
<td>83.6%</td>
<td>89.5%</td>
<td>86.7%</td>
</tr>
<tr>
<td>Komen Central &amp; South Jersey Service Area</td>
<td>88.6%</td>
<td>78.1%</td>
<td>87.8%</td>
<td>86.9%</td>
<td>87.6%</td>
</tr>
<tr>
<td>New Jersey</td>
<td>89.3%</td>
<td>76.3%</td>
<td>88.4%</td>
<td>87.1%</td>
<td>87.9%</td>
</tr>
</tbody>
</table>

Note: Actuarial method was used.

NA - statistic not displayed (less than 25 cases).

Data are for years 2001-2005.

Data source: New Jersey State Cancer Registry, New Jersey Department of Health (NJDOH).

**Five-year relative survival rates (race and ethnicity specific) summary**

Overall five-year relative survival rates for the Affiliate service area and New Jersey were very similar. Rates for White and API races and Hispanic/Latina ethnicity were slightly lower for the Affiliate service area than New Jersey as a whole, while the rate for Blacks/African-Americans was higher in the Affiliate service area than New Jersey as a whole. It should be noted when reviewing comparisons below that data for certain counties are unavailable due to there being too small of a population sample available. This should be considered a limitation when reviewing the summary of key findings.

The lowest five-year relative survival rates for all races were found in the following counties:

- Salem County
- Atlantic County
- Cumberland County
- Cape May County
For Blacks, the lowest five-year relative survival rates were found in the following counties:

- Mercer County
- Somerset County
- Cumberland County
- Ocean County

For Whites, the lowest five-year relative survival rates were found in the following counties:

- Salem County
- Camden County
- Atlantic County

There were not enough data available within the Affiliate service area to make comparisons for APIs.

The lowest five-year relative survival rates among Hispanics/Latinas were found in the following counties:

- Camden County
- Cumberland County
- Monmouth County

**Death rates (race and ethnicity specific)**

As defined in the QDR, breast cancer death rates show the frequency of death from breast cancer among women living in a given area during a certain time period. Racial and ethnic differences in health can affect how women are impacted by cancer outcomes (e.g. incidence, deaths, and survival). Therefore, examining these differences is critical to reducing breast cancer disparities in cancer outcomes such as deaths (Komen, 2014a).

Race and ethnicity-specific death rates were provided by the New Jersey Department of Health using underlying death data from the National Center for Health Statistics (NCHS) SEER dataset and are presented in Table 2.9. The method used to calculate the death rate in the QDR (i.e. the number of women from a particular geographic area who died from breast cancer divided by the total number of women living in that area) is the same method used to calculate the death rates in this section, just applied to a specific racial or ethnic group. Rates for Hispanic/Latina ethnicity are also presented, but it is important to note that Hispanic/Latina ethnicity and race are not mutually exclusive. Hispanics/Latinas who identify themselves as White or Black/African-American are also included in that race category as well as the “all races” category. All rates are shown in terms of 100,000 women and adjusted for age. Rates that are the highest (e.g. 41.0 is higher than 33.8) are the least favorable.
### Table 2.9. Female breast cancer death rates by race/ethnicity

<table>
<thead>
<tr>
<th>County</th>
<th>White</th>
<th>Black/African-American</th>
<th>API</th>
<th>Hispanic/Latina</th>
<th>All Races</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Rate</td>
</tr>
<tr>
<td>Atlantic</td>
<td>25.6</td>
<td>41.0</td>
<td>NA</td>
<td>NA</td>
<td>26.7</td>
</tr>
<tr>
<td>Burlington</td>
<td>24.1</td>
<td>25.6</td>
<td>20.7</td>
<td>NA</td>
<td>24.5</td>
</tr>
<tr>
<td>Camden</td>
<td>28.2</td>
<td>32.7</td>
<td>NA</td>
<td>15.8</td>
<td>28.3</td>
</tr>
<tr>
<td>Cape May</td>
<td>24.2</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>23.7</td>
</tr>
<tr>
<td>Cumberland</td>
<td>23.8</td>
<td>20.7</td>
<td>NA</td>
<td>NA</td>
<td>23.5</td>
</tr>
<tr>
<td>Gloucester</td>
<td>27.7</td>
<td>33.8</td>
<td>NA</td>
<td>NA</td>
<td>27.8</td>
</tr>
<tr>
<td>Hunterdon</td>
<td>26.9</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>26.4</td>
</tr>
<tr>
<td>Mercer</td>
<td>23.7</td>
<td>35.4</td>
<td>NA</td>
<td>NA</td>
<td>25.0</td>
</tr>
<tr>
<td>Middlesex</td>
<td>26.2</td>
<td>30.6</td>
<td>9.4</td>
<td>12.9</td>
<td>24.4</td>
</tr>
<tr>
<td>Monmouth</td>
<td>24.6</td>
<td>26.2</td>
<td>18.5</td>
<td>14.8</td>
<td>24.5</td>
</tr>
<tr>
<td>Ocean</td>
<td>26.5</td>
<td>26.5</td>
<td>NA</td>
<td>NA</td>
<td>26.6</td>
</tr>
<tr>
<td>Salem</td>
<td>31.8</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>30.4</td>
</tr>
<tr>
<td>Somerset</td>
<td>23.6</td>
<td>23.4</td>
<td>13.1</td>
<td>NA</td>
<td>22.7</td>
</tr>
<tr>
<td>Komen Central &amp; South Jersey Service Area</td>
<td>25.6</td>
<td>30.2</td>
<td>11.1</td>
<td>12.7</td>
<td>25.4</td>
</tr>
<tr>
<td>New Jersey</td>
<td>25.1</td>
<td>30.9</td>
<td>11.7</td>
<td>13.2</td>
<td>25.2</td>
</tr>
</tbody>
</table>

NA - statistic not displayed (fewer than 10 cases).
Data are for years 2006-2010.
Rates are in deaths per 100,000. Age-adjusted rates are adjusted to the 2000 US standard population.
Source: CDC - NCHS mortality data in SEER*Stat.

### Death rates (race and ethnicity specific) summary

A summary of death rates overall for the Affiliate service area and by race and ethnicity is provided in the QDR section and will not be repeated here. It should be noted when reviewing comparisons below that data for certain counties are missing due to there being too small of a population sample available. This should be considered a limitation when reviewing the summary of key findings.

For Blacks, the highest death rates were found in the following counties:
- Atlantic County
- Mercer County
- Gloucester County
- Camden County

For Whites, the highest death rates were found in the following counties:
- Salem County
- Camden County
- Gloucester County
There were not enough data available within the Affiliate service area to make comparisons for APIs or Hispanics/Latinas.

**Late-stage diagnosis (race/ethnicity and age-specific)**

In the QDR, late-stage breast cancer is defined as regional or distant stage using the SEER Summary Stage definitions [SEER Summary Stage]. The outlook for late-stage diagnosis in a particular area is important to understand not only because the stage at diagnosis impacts breast cancer deaths and survival, but also because it reflects mammography screening coverage. Research also shows that women from minority and medically underserved populations are more likely to be diagnosed with late-stage breast cancer (Komen, 2014a).

Race and age-specific late-stage diagnosis data were collected from the NJCR and are presented in Tables 2.10 and 2.11. Late-stage diagnosis percentages are calculated as the number of women diagnosed with late-stage (regional or distant stage) breast cancer in a particular geographic area divided by the total number of women diagnosed with breast cancer in that area. These calculations are applied to particular racial, ethnic, and age groups. Late-stage diagnosis data for Hispanic/Latina ethnicity are also presented, but it is important to note that Hispanic/Latina ethnicity and race are not mutually exclusive. Hispanics/Latinas who identify themselves as White or Black/African-American are also included in that race category. It is also important to note that higher percentages are the least favorable since they equate to a greater amount of late-stage diagnoses in a particular area.

### Table 2.10. Female breast cancer late-stage diagnosis by race/ethnicity

<table>
<thead>
<tr>
<th>County</th>
<th>White</th>
<th>Black/African-American</th>
<th>API</th>
<th>Hispanic/Latina</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percent (Late-stage)</td>
<td>Total (All stages)</td>
<td>Percent (Late-stage)</td>
<td>Total (All stages)</td>
</tr>
<tr>
<td>Atlantic</td>
<td>27.0%</td>
<td>1,098</td>
<td>33.0%</td>
<td>182</td>
</tr>
<tr>
<td>Burlington</td>
<td>26.2%</td>
<td>1,935</td>
<td>34.9%</td>
<td>362</td>
</tr>
<tr>
<td>Camden</td>
<td>27.3%</td>
<td>2,161</td>
<td>36.4%</td>
<td>490</td>
</tr>
<tr>
<td>Cape May</td>
<td>29.8%</td>
<td>579</td>
<td>NA</td>
<td>26</td>
</tr>
<tr>
<td>Cumberland</td>
<td>33.7%</td>
<td>488</td>
<td>NA</td>
<td>87</td>
</tr>
<tr>
<td>Gloucester</td>
<td>30.1%</td>
<td>1,196</td>
<td>31.4%</td>
<td>140</td>
</tr>
<tr>
<td>Hunterdon</td>
<td>25.2%</td>
<td>760</td>
<td>NA</td>
<td>13</td>
</tr>
<tr>
<td>Mercer</td>
<td>25.9%</td>
<td>1,460</td>
<td>32.9%</td>
<td>295</td>
</tr>
<tr>
<td>Middlesex</td>
<td>24.4%</td>
<td>3,088</td>
<td>28.5%</td>
<td>333</td>
</tr>
<tr>
<td>Monmouth</td>
<td>23.3%</td>
<td>3,325</td>
<td>31.9%</td>
<td>220</td>
</tr>
<tr>
<td>Ocean</td>
<td>25.4%</td>
<td>3,423</td>
<td>NA</td>
<td>59</td>
</tr>
<tr>
<td>Salem</td>
<td>32.6%</td>
<td>252</td>
<td>43.2%</td>
<td>37</td>
</tr>
<tr>
<td>Somerset</td>
<td>26.4%</td>
<td>1,479</td>
<td>33.4%</td>
<td>120</td>
</tr>
<tr>
<td>Komen Central &amp; South Jersey Service Area</td>
<td>26.0%</td>
<td>21,244</td>
<td>33.6%</td>
<td>2,364</td>
</tr>
<tr>
<td>New Jersey</td>
<td>26.3%</td>
<td>37,017</td>
<td>35.4%</td>
<td>4,895</td>
</tr>
</tbody>
</table>

NA - statistic not displayed (fewer than five cases).
Data are for years 2006-2010.
Source: New Jersey State Cancer Registry – New Jersey Department of Health (NJDOH).
Table 2.11. Female breast cancer late-stage diagnosis by age

<table>
<thead>
<tr>
<th>County</th>
<th>Ages 65+</th>
<th></th>
<th></th>
<th>Ages &lt;65</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count (Late-stage)</td>
<td>Percent (Late-stage)</td>
<td>Total (All stages)</td>
<td>Count (Late-stage)</td>
<td>Percent (Late-stage)</td>
<td>Total (All stages)</td>
</tr>
<tr>
<td>Atlantic</td>
<td>143</td>
<td>23.9%</td>
<td>599</td>
<td>233</td>
<td>31.0%</td>
<td>752</td>
</tr>
<tr>
<td>Burlington</td>
<td>224</td>
<td>24.9%</td>
<td>898</td>
<td>427</td>
<td>29.1%</td>
<td>1,468</td>
</tr>
<tr>
<td>Camden</td>
<td>286</td>
<td>27.5%</td>
<td>1,041</td>
<td>508</td>
<td>29.8%</td>
<td>1,704</td>
</tr>
<tr>
<td>Cape May</td>
<td>98</td>
<td>32.0%</td>
<td>307</td>
<td>84</td>
<td>27.7%</td>
<td>303</td>
</tr>
<tr>
<td>Cumberland</td>
<td>79</td>
<td>32.4%</td>
<td>244</td>
<td>121</td>
<td>35.5%</td>
<td>341</td>
</tr>
<tr>
<td>Gloucester</td>
<td>151</td>
<td>30.6%</td>
<td>493</td>
<td>262</td>
<td>29.8%</td>
<td>878</td>
</tr>
<tr>
<td>Hunterdon</td>
<td>66</td>
<td>23.7%</td>
<td>278</td>
<td>135</td>
<td>26.2%</td>
<td>515</td>
</tr>
<tr>
<td>Mercer</td>
<td>164</td>
<td>22.8%</td>
<td>718</td>
<td>339</td>
<td>29.4%</td>
<td>1,155</td>
</tr>
<tr>
<td>Middlesex</td>
<td>326</td>
<td>22.4%</td>
<td>1,454</td>
<td>648</td>
<td>26.9%</td>
<td>2,413</td>
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<tr>
<td>Monmouth</td>
<td>308</td>
<td>22.3%</td>
<td>1,380</td>
<td>574</td>
<td>25.0%</td>
<td>2,299</td>
</tr>
<tr>
<td>Ocean</td>
<td>463</td>
<td>24.3%</td>
<td>1,908</td>
<td>440</td>
<td>27.3%</td>
<td>1,616</td>
</tr>
<tr>
<td>Salem</td>
<td>38</td>
<td>31.2%</td>
<td>122</td>
<td>60</td>
<td>35.9%</td>
<td>167</td>
</tr>
<tr>
<td>Somerset</td>
<td>147</td>
<td>24.0%</td>
<td>611</td>
<td>325</td>
<td>28.6%</td>
<td>1,136</td>
</tr>
<tr>
<td>Komen Central &amp; South Jersey Service Area</td>
<td>2493</td>
<td>24.8%</td>
<td>10,053</td>
<td>4156</td>
<td>28.2%</td>
<td>14,747</td>
</tr>
<tr>
<td>New Jersey</td>
<td>4488</td>
<td>25.8%</td>
<td>17,447</td>
<td>7653</td>
<td>28.4%</td>
<td>26,983</td>
</tr>
</tbody>
</table>

NA - statistic not displayed (fewer than five cases).
Data are for years 2006-2010.
Source: New Jersey State Cancer Registry – New Jersey Department of Health (NJDOH).

Late-stage diagnosis (race/ethnicity and age-specific) summary
A summary of late-stage incidence rates overall for the Affiliate service area and by race and ethnicity is provided in the QDR section and will not be repeated here. It should be noted when reviewing comparisons below that data for certain counties in Table 2.10 are missing due to there being too small of a population sample available, and thus should be considered a limitation when reviewing the summary of key findings.

For Blacks, the highest percentages of late-stage diagnoses were found in the following counties:
- Salem County
- Camden County
- Burlington County

For Whites, the highest percentages of late-stage diagnoses were found in the following counties:
- Salem County
- Gloucester County
- Cape May County
There were not enough data available within the Affiliate service area to make comparisons for APIs or Hispanics/Latinas.

For those 65 plus, the highest percentages of late-stage diagnoses were found in the following counties:
- Cumberland County
- Cape May County
- Salem County

For those under 65, the highest percentages of late-stage diagnoses were found in the following counties:
- Salem County
- Cumberland County
- Atlantic County

Data Limitations

The limitations of the additional data provided in this section are the same as those presented in the QDR.

Additional Data Exploration Conclusions

Five-year relative survival rates

The data indicate that the counties with some of the most pervasive issues include:
- Salem County: low five-year relative survival rate overall and among Blacks, as compared to other counties in service area
- Atlantic County: low five-year relative survival rate overall and among Blacks, as compared to other counties in service area
- Cumberland County: low five-year relative survival rate overall and among Hispanic/Latinas, as compared to other counties in service area
- Camden County: low five-year relative survival rate among Whites and Hispanic/Latinas, as compared to other counties in service area

Among all races combined, Cape May County also has a low five-year relative survival rate as compared to other counties while Mercer, Somerset and Ocean Counties have lower five-year relative survival rates among Blacks/African-Americans as compared to other counties. Additionally, Monmouth County has a low five-year relative survival rate among Hispanic/Latinas as compared to other counties in the service area.

In the QDR, Atlantic and Camden Counties were identified as the highest priority areas while Cumberland and Salem Counties were identified as medium-high priority areas.

Death rates

The data indicate that the counties with some of the most pervasive issues include:
- Camden County: high death rate among Blacks/African-Americans and Whites, as compared to other counties in service area
- Gloucester County: high death rate among Blacks/African-Americans and Whites, as compared to other counties in service area
Atlantic and Mercer Counties also have low rates among Blacks/African-Americans while Salem County has low rates among Whites, as compared to the rest of the counties in the service area.

Both Camden and Gloucester Counties were identified as the highest priority areas in the QDR.

**Late-stage diagnosis**
The data indicate that the counties with some of the most pervasive issues include:
- Salem County: high percentages of late-stage diagnoses among Blacks, Whites, 65 plus, and those less than 65, as compared to other counties in service area
- Cumberland County: high percentages of late-stage diagnoses among 65 plus and those less than 65, as compared to other counties in the service area
- Cape May County: high percentages of late-stage diagnoses among 65 plus and Whites as compared to other counties in service area

Additionally, Camden and Burlington Counties each have a high percentage of late-stage diagnoses among Blacks/African-Americans while Gloucester County has a high percentage of late-stage diagnoses among Whites, as compared to the other counties in the service area.

Atlantic County has a high percentage of late-stage diagnoses among those less than 65, as compared to the other counties in the service area.

Cumberland and Salem were identified as medium-high priority areas by the QDR.

**Selection of Target Communities**

Based on the results of the statistical review presented in the Quantitative Data Report and the Additional Quantitative Exploration section, Susan G. Komen Central and South Jersey has chosen to target five communities (encompassing seven counties) within the service area. Four counties will be grouped into two communities due to their similar population characteristics, creating a total of five target areas. The Affiliate will focus strategic efforts on the selected communities over the course of the next four years.

The selected target communities are:
- Atlantic County
- Camden County
- Gloucester County
- Burlington and Monmouth Counties
- Salem and Cumberland Counties

The target communities were chosen because they have the most significant breast cancer-related issues as compared to other counties in the Affiliate service area. When selecting target communities, the Affiliate first considered counties classified in the QDR as highest and high priority. This classification of priority counties was primarily based on the projected time needed to achieve Healthy People 2020 (HP2020) health objectives for breast cancer late-stage diagnosis and deaths. The Affiliate also considered late-stage rates and trends, death rates and trends, incidence rates and trends, breast cancer screening proportions, socioeconomic conditions (e.g. income relative to the US poverty level, employment status, cultural barriers, lack of health insurance, and education), five-year relative survival rates, and population...
distribution and characteristics. Data regarding these breast cancer-related issues are further described below for each target community.

**Atlantic County**

Atlantic County was chosen as a target community because it was identified in the QDR as one of the highest priority counties. It is estimated that the county will take more than 13 years to achieve HP2020’s breast cancer deaths and late-stage diagnosis targets (Table 2.7). The county’s current death rate is 26.7 deaths per 100,000 women (Table 2.1). Although this rate is expected to decrease over the next five years, it is substantially higher than the death rates of the Affiliate service area (25.4/100,000) and State of New Jersey (25.2/100,000) (Table 2.1). Atlantic County also has a fairly high late-stage diagnosis rate (45.2/100,000) that is expected to increase over the next five years (Table 2.1). This is a major concern because the stage of cancer at the time of diagnosis can affect the chances of survival and compared to the average rate of the service area (87.6/100,000), Atlantic County’s five-year relative survival rate is considerably low (Komen, 2014a; Table 2.8).

Socioeconomic conditions within the county are also a major concern. Socioeconomic factors, such as poverty, educational attainment and unemployment have been linked to breast cancer disparities in all areas of care, including screening (Komen, 2014a). Compared to other counties in the service area, Atlantic County has the second highest percentage of residents with low education levels (15.8 percent), no health insurance (16.2 percent), and income below 250 percent the federal poverty level (32.5 percent) (Table 2.5). A fairly high percentage of residents are also unemployed (10.7 percent) (Table 2.5). Additionally, as compared to New Jersey and the Affiliate service area as a whole, a large percentage of the population is considered to be rural (12.7 percent) and medically underserved (40.9 percent) (Table 2.5). Many rural regions have longer distances between medical facilities and less availability of health services, limiting access to breast cancer screening (Komen, 2014a). This may explain why fewer women ages 50-74 (76.8 percent) reported a screening mammogram within the last two years than women in the Affiliate service area (77.4 percent) and State of New Jersey (77.7 percent) (Table 2.3).

According to the QDR, the annual average female population in Atlantic County is 140,451 (Table 2.1). Although Whites constitute the majority of this population, Atlantic County has the fourth largest Black/African-American female population within the service area. Black/African-American women represent 18.7 percent of female residents in the county (Table 2.4). This is of concern because Atlantic County has the highest death rate among Black/African-American women compared to all of the other counties in the service area.

Atlantic County is home to AtlantiCare, which is a major health care system. However, many of the residents appear to live in more rural portions of the county and are unable to or prefer not to come to the metropolitan area to seek services. An additional area of concern is that the local NBCCEDP screening program site in this county is located in the suburbs, away from the majority of residents who would potentially qualify for this program. It is possible that uninsured, poor residents in this county are unable to access vital screening programs and thus are forgoing care altogether. The health systems analysis and subsequent sections of the report will explore potential issues that have arisen as a result of the proximity of vital screening sites. The analysis will also aim to find a reason for why Black/African-American women are experiencing such high death rates and low five-year relative survival rates in Atlantic County. Since a large number of the county’s residents live in rural and medically underserved areas, it
will also take a deeper look into the availability and accessibility of health services offered to women living in these particular areas.

**Camden County**
Camden County was chosen as a target community because it was identified in the QDR as one of the highest priority counties. It is predicted that Camden County will take more than 13 years to meet HP2020’s late-stage diagnosis and death rate targets (Table 2.7). Camden County has the highest late-stage diagnosis rate (53.3/100,000) and second highest death rate (28.3/100,000) within the Affiliate service area (Table 2.1). Although these rates are expected to decrease over the next five years, they are substantially higher than the average rates of the Affiliate service area and State of New Jersey (Table 2.1).

Camden County also has the second highest incidence rate (142.7/100,000) within the Affiliate service area, which is expected to increase over the next five years (Table 2.1). Breast cancer incidence is typically higher in communities with a higher socioeconomic status since residents are more likely to get screened (Komen, 2014a). However, socioeconomic conditions in Camden County are very poor. Compared to other counties in the Affiliate service area, the county has a substantially higher percentage of residents with income below 250 percent the federal poverty level (27.4 percent), no health insurance (13.9 percent), low education levels (14.1 percent), and lack of employment (10.4 percent) (Table 2.5). Camden County is home to Camden City, which is one of the poorest cities in the entire US (US Census Bureau, 2014). Interestingly, the biggest health system in the area, MD Anderson Cancer Center at Cooper, is located in this city. Many residents may be unable or prefer not to come to this area to seek services.

Furthermore, the data show that only 69.2 percent of women (ages 50-74) living in Camden County reported mammography screening in the past two years (Table 2.3). This is the lowest screening percentage in the entire Affiliate service area. Five-year relative survival rates for Camden County are also among the lowest in the entire Affiliate service area (Table 2.8).

Camden County is reported to have the largest concentration of Black/African-American (22.5 percent) female residents and the fourth largest concentration of Hispanic/Latina (14.1 percent) residents in the Affiliate service area (Table 2.4). This is noteworthy because among all races and ethnic groups in the area, Black/African-American and Hispanic/Latina women are most impacted by breast cancer deaths, late-stage diagnosis, and survival. Black/African-American and Hispanic/Latina women are both faced with death rates that are substantially higher than the average rates of the Affiliate service area and New Jersey as a whole (Table 2.9). Additionally, Hispanics/Latinas living in Camden County are experiencing the lowest five-year relative survival rate among all counties in the Affiliate service area while a large percentage of Blacks/African-Americans are being diagnosed with breast cancer at a late-stage (Tables 2.8 and 2.10).

Research shows that low-income women have the lowest percentage of breast cancer screening as compared to their wealthier counterparts, even when adjusted for race, ethnicity, and insurance status (Komen, 2014a). With such low screening numbers and poor socioeconomic conditions, it is possible that low-income women are experiencing barriers to receiving mammography screening in Camden County. The health systems analysis will examine the availability and accessibility of mammography screening services to try to...
determine why screening prevalence is so low in an area where incidence is so high. It will also look into the availability of screening services for Black/African-American and Hispanic/Latina women.

**Gloucester County**

Gloucester County was chosen as a target community because it was identified in the QDR as one of the highest priority counties. It is predicted that Gloucester County will take more than 13 years to meet HP2020’s late-stage diagnosis and death rate targets (Table 2.7). Gloucester County was selected as a target community based on its high late-stage diagnosis and death rates. The county currently has the third highest death (27.8/100,000) and late-stage diagnosis (50.5/100,000) rates in the service area, both of which are considerably higher than the average rates of the Affiliate service area and State of New Jersey (Table 2.1). While Gloucester County has a fairly low incidence rate compared to the service area as a whole and to other counties within the service area, the death rate is high. This is a troublesome combination which could indicate a number of issues. For example, women in Gloucester County might not be obtaining screening mammograms as consistently as in other counties, which could explain the lower incidence rate. As a result, when they finally do receive care these women are experiencing poorer health outcomes because they are being diagnosed at a later stage when the disease is more difficult to treat. This could explain the high death rate.

Despite better outcomes overall on socioeconomic indicators as compared to other counties in the Affiliate service area (Table 2.5), Gloucester County has one of the lowest proportions of women ages 50-74 who reported obtaining screening mammography within the Affiliate service area. Only 74.7 percent of women ages 50-74 reported obtaining a screening mammogram in the past two years (Table 2.3). This proportion is considerably lower than the proportion of women screened within the Affiliate service area as a whole and State of New Jersey. Gloucester County’s five-year relative survival rates are also lower than the average five-year relative survival rates of the Affiliate service area and State of New Jersey (Table 2.8).

Of the 146,776 females residing in Gloucester County, 85.3 percent of the population is White, 11.4 percent are Black/African-American, and 4.8 percent identify as Hispanic/Latina (Tables 2.1 and 2.4). This is important because Black/African-American women of Gloucester County are suffering from a death rate that is notably higher than the average rates of the Affiliate service area and State of New Jersey (Table 2.9). Furthermore, the data indicate that a considerably larger percentage of women ages 65 and older have experienced late-stage diagnoses in Gloucester County compared to the Affiliate service area and State of New Jersey (Table 2.11).

With screening proportions in Gloucester County below the average screening proportions of the Affiliate service area and State of New Jersey (Table 2.3), it is possible women are experiencing barriers to mammography screening. This may be associated with the higher percentages of late-stage diagnoses and death rates in this county. It may also explain the lower rates of incidence. The health systems analysis will inquire into the quality and accessibility of mammography screening services in the area, while paying special attention in subsequent sections of the analysis to barriers for specific populations such as Black/African-American women and those 65 and older.
**Burlington and Monmouth Counties**

Burlington and Monmouth Counties were both classified as high priority based on the predicted number of years needed to achieve HP2020’s late-stage diagnosis and death rate goals. Monmouth (24.5/100,000) and Burlington (24.5/100,000) Counties are estimated to take seven and eight years, respectively, to meet HP2020’s death rate target (Tables 2.1 and 2.7). However, it is predicted that both counties will take more than 13 years to reduce their late-stage diagnosis rates to meet HP2020’s target rate (Tables 2.1 and 2.7).

Both counties also have fairly high incidence rates with incidence trends increasing in Monmouth County (Table 2.1). In Burlington County, the percentage of late-stage diagnoses is higher than the service area as a whole and the State of New Jersey, and presents as an increasing trend (Table 2.1). While Burlington presents with a fairly high percentage of women, ages 50-74, who obtained a screening mammogram in comparison to the rest of the service area, the percentage of women screened in Monmouth County is lower than the service area average and the State of New Jersey (Table 2.3).

Although the majority of the population in both counties is White, together the counties make up a considerably large population of women who are over the age of 40 and who identify as Black/African-American and/or Hispanic/Latina. This is important to consider because Blacks/African-Americans and Hispanics/Latinas living in these counties face major disparities in health outcomes (e.g. breast cancer deaths, late-stage diagnosis and survival). In Burlington County, the percentage of Black/African-American women diagnosed with late-stage breast cancer (Table 2.10) is considerably higher than White women diagnosed with late-stage breast cancer. Moreover, this percentage of Black/African-American women diagnosed with late-stage breast cancer is also higher than the Affiliate service area’s percentage of Black/African-American women diagnosed with late-stage breast cancer. Likewise, in Monmouth County, the death rate for Hispanics/Latinas is substantially higher (Table 2.9) and the five-year relative survival rate lower (Table 2.8) than the average death and five-year relative survival rates of the Affiliate service area and State of New Jersey.

The Affiliate chose to combine Burlington and Monmouth Counties into a target community because they are:

- Geographically proximate (they share a border)
- More populous. Collectively, Monmouth and Burlington Counties afford the opportunity for the Affiliate to make a huge impact on a large population of women considering their total female population is 550,282 (Table 2.1).
- Socioeconomically similar. In general, many of the socioeconomic conditions for both counties are above average as compared to the rest of the Affiliate service area. However, both counties have pockets of wealth and poverty. For example, some of the poorest shore communities in Monmouth County (e.g. Asbury Park and Neptune) are bordered by some of the wealthiest in the entire state (e.g. Rumson and Little Silver). Burlington and Monmouth Counties are pretty similar in terms of education, income, and employment statistics. Monmouth County has a slightly higher percentage of foreign born while Burlington County is slightly more linguistically isolated. Burlington County is just slightly more rural while Monmouth County is just slightly more medically underserved.
Monmouth and Burlington Counties are demographically similar to one another in the sense that both have a similar distribution of females age 65 plus and of those of Hispanic/Latina ethnicity. However, Burlington County has a noticeably higher percentage of Blacks/African-Americans. Burlington County is also unique because it is home to Fort Dix, a massive military base which takes up a sizeable portion of the county. It would be interesting in subsequent sections of the report to try to ascertain the impact the existence of the base has on breast cancer rates and population demographics as well as the availability of services.

As mentioned in the QDR, an increase in breast cancer incidence could result from increased mammography screening. Breast cancer statistics reveal high incidence rates for both counties. Although data indicates a larger proportion of women ages 50-74 are being screened for breast cancer in Burlington County, it also shows that fewer women are being screened in Monmouth County. Both counties have notable strong health systems, and Monmouth County in particular appears to have a wealth of services available to residents. Given this, combined with a lack of major socioeconomic issues in the area overall, it is quite troublesome as to why some of the rates appear as they do. Thus, the health system analysis will explore potential issues that may be impacting mammography screening in particular in Monmouth County. Additionally, since Blacks/African-Americans and Hispanics/Latinas in both counties seem to be encountering disparities in deaths, survival, and late-stage diagnosis, the health systems analysis will also explore potential barriers to care and/or gaps in care that may be impacting these particular populations.

**Salem and Cumberland Counties**

Although both counties were classified in the QDR as medium-high priority, Salem and Cumberland Counties were chosen because of their high death rates, low screening prevalence, low five-year relative survival rates, and unique socioeconomic characteristics. In particular, Salem County has the highest death rate among all counties in the Affiliate service area, while Cumberland County has many issues related to breast cancer indicators in addition to being the poorest county in the service area. The majority of Salem and Cumberland Counties’ residents live in rural and medically underserved areas. They are also among the top five counties with residents who have substantially lower unemployment, education and income levels (Table 2.5). Poverty, poor education, and high unemployment have been linked to breast cancer disparities in all areas of care, from screening to diagnosis to treatment (Komen, 2014a). Many of Cumberland County’s residents are linguistically isolated and in need of health insurance - two major barriers to health care access. Language barriers, among other things, may prevent some women from getting screened, seeking out treatment in a timely manner or receiving the standard of care when seen by a doctor (Komen, 2014a).

Research indicates that women residing in rural areas of the US are screened for breast cancer less often than women in urban areas (Komen, 2014a). This could explain the reason both counties experienced low screening prevalence (Table 2.3) in the last two years among women ages 50-74, with Salem County having the second-lowest proportion of women screened in the Affiliate service area. Both counties also have fairly high percentages of late-stage diagnoses (Table 2.1) and low five-year relative survival rates (Table 2.8). However, there is a major difference in breast cancer death rates for the two counties. Salem County has the highest death rate in the Affiliate service area while Cumberland County has one of the lowest (Table 2.1).
Major racial and age disparities exist in both counties. Cumberland County has the largest Hispanic/Latina population and third largest Black/African-American population in the Affiliate service area. This is noteworthy due to Black/African-American and Hispanic/Latina women experiencing substantially low five-year relative survival rates when compared to other races (Table 2.8). Although Salem County has a smaller concentration of Black/African-American and Hispanic/Latina women, the county has the third largest population of women ages 65 and older. This is also notable because a large proportion of these women are being diagnosed with breast cancer at a late-stage (Table 2.11).

The Affiliate chose to combine Salem and Cumberland counties into a target community because they are:

- Geographically proximate (they share a border)
- Socioeconomically similar. In general, many of the socioeconomic conditions for both counties are considerably above average as compared to the rest of the Affiliate service area. Both are considered medically underserved and rural, with Cumberland County being slightly worse off overall.

Demographically, both counties have a large percentage of Blacks/African-Americans compared to the Affiliate service area and New Jersey as a whole. Both also have a similar distribution of females age 65 plus. However, Cumberland County is considerably more Hispanic/Latino.

The health systems analysis will explore the availability of breast cancer services in rural and medically underserved communities of Salem and Cumberland Counties, since most residents live in these particular areas. Considering the racial and age disparities identified in both counties, it is also important to establish whether the available services are affordable, culturally sensitive, and accessible.
Health Systems and Public Policy Analysis

**Health Systems Analysis Data Sources**

Through the Quantitative Data Analysis, the Affiliate identified health disparities for several population groups within each target community. These disparities pose a major concern because they indicate adverse differences in the incidence, prevalence, deaths and burden of breast cancer. The Health Systems and Public Policy Analysis was conducted to provide further insight into systemic factors contributing to these wide-ranging disparities and the reasons they exist in the Affiliate’s target communities. This section presents an in-depth review of the health system of each of the selected target communities as well as Komen’s current and future role in federal and state-level public policy issues.

Data were collected for the Health Systems Analysis (HSA) using an internal database of the Affiliate’s grantees and internet searches of breast care providers, programs and services in each county, including, but not limited to, hospitals, social service and support organizations, and financial assistance programs. Resources were compiled into a HSA template, which served as an inventory of resources, organizing detailed information about each resource such as location and service availability (e.g. screening, diagnostic and treatment services, as well as support programs). Providers were contacted by phone or email to verify service offerings that were unclear or not identified on their website. The Affiliate’s grantees, who are key partners based in each of the target communities, reviewed the template for accuracy and contributed additional resources when available.

Once the inventory was created, the resources were plotted and examined in Google maps to establish their location and availability within the target areas. The following sources were used by the Affiliate to obtain a comprehensive understanding of programs and services available in each target community:

**Mammography Centers**

http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfMQSA/mqsa.cfm

**Hospitals**

https://data.medicare.gov/Hospital-Compare/Hospital-General-Information/v287-28n3

http://nj-hospitals.net

**Local Health Departments**

http://www.naccho.org/about/lhd/

**Community Health Centers**

http://findahealthcenter.hrsa.gov/Search_HCC.aspx

Free Clinics
http://www.nafcclinics.org/clinics/search

Quality of Care: American College of Surgeons Commission on Cancer
http://datalinks.facs.org/cpm/CPMAcceptedHospitals_Search.htm

Quality of Care: American College of Radiology Centers of Excellence
http://www.acr.org/Quality-Safety/Accreditation/Accredited-Facility-Search

Quality of Care: American College of Surgeons National Accreditation Program for Breast Centers
http://napbc-breast.org/resources/find.html

State of New Jersey Department of Health: Office of Cancer Control and Prevention
http://web.doh.state.nj.us/apps2/cancerfacilities/cfsearch.aspx

Patient Advocate Foundation
http://www.patientadvocate.org/NURD/index2.php?application=uninsured#scrollto

Komen Central and South Jersey Resource Guide
http://www.komencsnj.org/site/PageServer?pagename=Resources#.U-KAPeNdVqJ

Health Systems Overview

Framework for analysis: The Breast Cancer Continuum of Care (CoC) (Figure 3.1)
Once a resource inventory was compiled, a complete analysis of gaps, needs, and barriers throughout the CoC, utilizing the HSA template as a guide, was conducted. The CoC is a valuable lens through which all aspects of the HSA, as well as qualitative data collection and analysis, will be viewed. The CoC was used to help identify what gaps and/or barriers exist that delay or prevent care and to help define and understand existing and needed partnerships, advocacy efforts, and legislator support.

The CoC is a model that shows how a woman typically moves through the health care system for breast care. A woman would ideally move through the CoC quickly and seamlessly, receiving timely, quality care in order to have the best outcomes. Education can play an important role throughout the entire CoC.

Figure 3.1. Breast Cancer Continuum of Care (CoC)
While a woman may enter the continuum at any point, ideally, a woman would enter the CoC by getting screened for breast cancer – with a clinical breast exam or a screening mammogram. If the screening test results are normal, she would loop back into follow-up care, where she would get another screening exam at the recommended interval. Education plays a role in both providing education to encourage women to get screened and reinforcing the need to continue to get screened routinely thereafter.

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

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

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

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

Health Systems: Strengths, Weaknesses, and Opportunities for Collaboration

Introduction

For each target community, the strengths and weaknesses of the health care system were assessed in the context of breast health services provided across the continuum of care, and potential barriers to accessing services for each type of care (i.e. screening, diagnosis, treatment, and follow-up care). Current partnerships at the time of writing were assessed and the potential for new partnerships and collaborations was explored. A more detailed analysis of
the implications of the resources available in each target community and the current and potential partnerships that exist is presented in the Health Systems and Public Policy Analysis Findings.

**Atlantic County**

*Strengths and Weaknesses of the Health System*

Atlantic County is home to two hospitals: AtlantiCare Regional Medical Center, which has campuses in Atlantic City and Pomona, and Shore Medical Center, which is located in Somers Point. AtlantiCare provides over 90 percent of charity care in this county (AtlantiCare, 2014) (Figure 3.2). AtlantiCare provides patients with screening, diagnostic, and surgery/reconstruction services at its main campuses in addition to chemotherapy, radiation, and the full spectrum of support services at the hospital’s Cancer Care Institute in Egg Harbor Township. The Institute facilitates access to treatment services by offering patients free transportation, patient navigation and educational support. It also partners with Gilda’s Club South Jersey to provide patients in treatment with support services that are free of charge, including support groups and wellness workshops.

The location of screening, diagnostic, and surgery/reconstruction services at AtlantiCare’s Atlantic City campus is a major asset in this community, given the composition of its population. Atlantic City’s population is 38.3 percent Black/African-American and approximately 29.9 percent of the population is living below poverty level (US Census Bureau, 2014). However, patients cannot receive chemotherapy or radiation at this location. The Cancer Care Institute, located in Egg Harbor Township, is the only location of all the AtlantiCare campuses that offers chemotherapy and radiation. This could be limiting for those receiving screening and diagnostic services at the hospital’s other locations, particularly for those who live a substantial distance from this area and/or those who have transportation challenges. Egg Harbor Township is at least 20 minutes by car or by bus from Atlantic City and Pleasantville, another major pocket of poverty and minority populations in this target community. In Pleasantville, 45.9 percent of the population is Black/African-American and 20.3 percent are living below the poverty level (US Census Bureau, 2014). The Nazha Cancer Center also provides chemotherapy and radiation at its locations in Northfield and Galloway.

Shore Medical Center provides residents with access to breast cancer screening, diagnostic, treatment and support services in one location. It also offers outreach, education, and screening services to uninsured and underinsured residents by serving as the county’s lead partner agency for the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), better known as the New Jersey Cancer Education and Early Detection (NJCEED) program. With the NJCEED site located in Somers Point, it may limit those from more disparate areas such as Atlantic City and Pleasantville from accessing care. Somers Point is over 20 minutes by car and by bus from Pleasantville, and over 20 minutes by car and 45 minutes by bus from Atlantic City.

Atlantic County is comprised of six community health centers and two free health clinics. Most of these facilities offer services to residents, regardless of their ability to pay. The county’s Division of Public Health operates two free women’s health clinics for residents over 18 years of age in Hammonton and Northfield. Services at each clinic include free clinical breast exams and referrals for diagnostic evaluations.
Affordable screening mammograms are made available to women through the NJCEED site and to those living in more underserved areas through the Dr. Jan Astin Mobile Digital Mammography Van, managed by the AMI Foundation ("AMI Assumes Operation", 2014). The Foundation is part of Atlantic Medical Imaging (AMI), a major provider of screening and diagnostic services to the insured at its five different locations throughout Atlantic County.

Since most of Atlantic County’s breast health facilities are limited to the eastern region of the county, this is problematic because for the large percentage of residents living in rural communities (Table 5), such as Mullica, Hamilton, Weymouth and Buena Vista Townships, because it limits their ability to access vital breast cancer care and support.

**Current and Potential Partnerships and Collaborations**

The Affiliate maintains strong relationships with social service organizations and direct providers through its four Komen-funded grant programs in Atlantic County. AtlantiCare’s grant program provides screening mammograms, breast health education, and patient navigation to minority and immigrant populations in Atlantic City, Pleasantville and other communities where there exists a high financial need for services. AtlantiCare has a history of collaborating with community partners and faith-based organizations to reach a wider audience of women, utilizing their extensive database to target areas where need is the greatest.

The AMI Foundation’s grant program provides greater access to screening programs through its Mobile Digital Mammography Van. In addition to setting a goal of screening almost 3,000 women during the 2014-2015 grant cycle, they intend to provide financial assistance to roughly one-third of their target population as well as first-time mammograms to at least 13 percent of the target group.

Jewish Family Service (JFS) of Atlantic and Cape May Counties, another Komen grant program, targets those dealing with mental health issues, disabilities, unemployment, low income and/or a lack of insurance and care providers through its Women’s Health Network (WHN). The program utilizes an intensive case management structure that helps clients navigate the health care system and provides coordinated care, reducing gaps in services. WHN maintains a network of care and screening providers who will accept underinsured and uninsured clients. It operates in more than 17 program areas that prioritize outreach to vulnerable populations.

Southern Jersey Family Medical Centers, Inc. (SJFMC) is an ideal home for a Komen community grant program. It is a federal qualified migrant and community health center that operates as the safety net for uninsured and underinsured residents. It targets the working poor and immigrant communities as well as migrant and seasonal farmworkers, a very socially isolated, but prominent population in this rural community. Bilingual outreach and health promoter staff have a unique ability to reach this population in a culturally competent way.

Beyond the Affiliate’s strong, existing relationships in Atlantic County lies the potential for new partnerships and collaborative efforts with the NJCEED site at Shore Memorial, the Nazha Cancer Center, as well as other community health centers in addition to SJFMC, such as the Family Medical Center of Atlantic City’s Women’s Health Pavilion.
Figure 3.2. Breast cancer services available in Atlantic County
Camden County
Strengths and Weaknesses of Health System
The HSA identified a concentration of breast cancer services across the northern and northeastern regions of Camden County, including four hospitals, one community health center (CAMcare Health Corporation), and 11 mammography facilities (Figure 3.3). Cooper University Hospital and Our Lady of Lourdes Medical Center have locations in Camden City, while Cooper and Virtua have sites in Voorhees and Camden City. Each hospital offers breast cancer care that addresses the unique needs of patients at every stage of the CoC. Patient navigation is provided at each hospital to help guide patients who are diagnosed with breast cancer through treatment and into survivorship care. Kennedy University Hospital is the remaining hospital in Camden County with facilities in Cherry Hill and Stratford. The two locations are not cancer care facilities and only screening and diagnostic services are provided at these sites.

Although Camden County has several strong hospital systems, three of which offer comprehensive breast care for every stage of the CoC, they are located mostly in the northern and northeastern regions of Camden County.

In terms of providers addressing disparate populations, Cooper University Hospital in Camden City and Virtua in Voorhees provide outreach, educational and screening services to uninsured and underinsured residents through the NJCEED program. Overall, having a concentration of resources in Camden City is a tremendous asset, as Camden City is one of the poorest cities in the entire US (US Census Bureau, 2014). However, besides the NJCEED programs in Camden City and Voorhees, there are very few resources offering breast cancer care to poor residents at little to no cost. Outside of Camden City, there are no free clinics or community health centers, no resources for rural residents, and no mobile mammography sites. South Jersey Radiology Associates is the largest radiology group in the area. It has numerous locations throughout the service area (including Sicklerville, Cherry Hill, Voorhees, and Haddonfield) providing screening and diagnostic services for those with insurance.

Current and Potential Partnerships and Collaborations
The Affiliate maintains strong partnerships with three organizations in Camden County through its community grants program: Clark Family Breast Cancer Services, Inc., MD Anderson Cancer Center at Cooper, and Virtua. All three of these programs have adapted evidence-based strategies from the National Cancer Institute’s Research-tested Intervention Programs (RTIPs).

Clark Family Breast Cancer Services, Inc. provides breast health outreach and referrals for free screenings to low-income, minority women (primarily Black/African-American) in Camden County while addressing barriers that impede mammography screenings such as cost, fear and mistrust of the health system, as well as language and cultural barriers. They also target insured and underinsured women to encourage them to utilize their insurance for breast cancer screenings. Partners include two other Komen-funded grant programs: Cooper and Virtua. This program has been very successful at reaching Black/African-American women in Camden.

As was discussed earlier in this section, MD Anderson Cancer Center at Cooper provides a comprehensive approach to breast care, addressing the complex needs of women throughout the entire CoC. Additionally, they are one of two NJCEED sites in the county that is focused on providing free screenings to underserved women. The Affiliate provides funding to Cooper to
execute their breast health outreach and free mammography screening efforts, as well as address transportation challenges, including funding for parking and taxi cab vouchers.

Virtua’s grant program focuses on identifying and addressing barriers to routine screening and assisting clients in overcoming them so regular screening can be achieved. The project targets uninsured and underinsured minority residents of Camden. It is also a NJCEED site.

Additional partnerships and collaborations in Camden County could include Our Lady Lourdes Medical Center, CAMCare, Kennedy University Hospital, and South Jersey Radiology Associates.
Figure 3.3. Breast cancer services available in Camden County
**Gloucester County**

**Strengths and Weaknesses of the Health System**

Findings from the QDR indicate that women in Gloucester County are experiencing high death and late-stage diagnosis rates (Table 2.1), implying that they may either be screened for breast cancer at a late stage or not at all. Although the county has one of the lowest proportions of women screened (Table 2.3) in the Affiliate’s service area, overall there appears to be an adequate number of screening, diagnostic, and treatment facilities available to residents (Figure 3.4). Gloucester County’s health system is comprised of seven mammography centers in addition to four hospitals and a surgical facility. Kennedy Cancer Center and Virtua Fox Chase Cancer Center are two hospitals, both located in Sewell, with accredited cancer programs that offer services across the CoC. Inspira Medical Center Woodbury is another hospital that provides patients with screening, diagnostic and treatment services, including free screening, outreach and educational services through the NJCEED program. Additional treatment services are made available to residents at the MD Anderson Cancer Center and the Inspira Medical Group Breast Surgery facility in Sewell. Residents are also able to access supplementary screening and diagnostic services through the Dr. Jan Astin Mobile Digital Mammography Van and imaging facilities throughout Woodbury, Woodbury Heights, Sewell, Turnersville, Swedesboro and Mullica Hills.

The majority of resources are located in the northern region of the county, which poses access issues for those residing in the rest of the county. For example, residents diagnosed with breast cancer must travel to Sewell for chemotherapy and radiation, as Inspira Woodbury does not provide these services. The county also lacks the necessary transportation and support services that make breast cancer care more accessible to women who are at-risk or experiencing breast cancer.

**Current and Potential Partnerships and Collaborations**

Currently, the Affiliate partners with three programs in Gloucester County through the community grants program: the AMI Foundation, Clark Family Breast Cancer Services, Inc., and Virtua. Further details about each of these programs were discussed under the Atlantic and Camden Counties sections. The AMI Foundation’s van travels throughout Gloucester County, targeting the uninsured population, as well as others who are insured but having difficulty accessing mammography. Clark Family Breast Cancer Services, Inc. has been very successful at reaching underserved Black/African-American women with breast health outreach and referrals for free screenings. Virtua’s grant program targets uninsured and underinsured minority residents, and makes referrals for screening to the NJCEED site at Inspira Medical Center Woodbury.

Potential partnerships and collaborative efforts could include Kennedy Cancer Center, Inspira Medical Center Woodbury, and South Jersey Radiology Associates.
Statistics

Total Locations in Region: 12

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<th>Service Type</th>
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<tr>
<td>Diagnostic</td>
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<table>
<thead>
<tr>
<th>Accreditation Type</th>
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</thead>
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<td>1</td>
</tr>
<tr>
<td>American College of Radiology Breast Imaging Ctr. of Excellence</td>
<td>5</td>
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<tr>
<td>American College of Surgeons NAPBC Accredited</td>
<td>1</td>
</tr>
<tr>
<td>NCI Designated Cancer Center</td>
<td>0</td>
</tr>
</tbody>
</table>

Figure 3.4. Breast cancer services available in Gloucester County
Burlington and Monmouth Counties

Strengths and Weaknesses of the Health System

Both Burlington and Monmouth Counties have notably strong health systems with a combined total of 38 breast health facilities (Figure 3.5). There are five hospitals spread over the central, eastern and northern regions of Monmouth County, including Riverview Medical Center in Red Bank, Jersey Shore University Medical Center in Neptune, Monmouth Medical Center in Long Branch, Centrastate Medical Center in Freehold, and Bayshore Community Hospital in Holmdel. Each of these hospitals has accredited cancer programs that offer services across the CoC. Screening and diagnostic services are also provided in several facilities throughout the eastern and central regions of the county, including 11 mammography facilities, eight community health centers, and two mammography clinics. Six of the eight community health centers offer clinical breast exams along with referrals for mammograms for women over 40 years of age. Free screening mammograms are made available to income eligible residents at the Visiting Nurses Association (VNA) of Central Jersey community health clinic in Red Bank, a lead agency of the NJCEED program. Free screening mammograms are also available at the two mammography clinics in Freehold and Neptune, which are operated by the Monmouth County Health Department.

Due to their location, eastern Monmouth County residents appear to have relatively easy access to screening, diagnostic and treatment resources, while residents located in other portions of the county need to travel longer distances to benefit from these services. Residents living in rural areas, such as Upper Freehold and Millstone Townships, are prime examples of those burdened by long-distance travel because there are no breast cancer facilities located in their communities. Under the direction of AMI, the Dr. Jan Astin Mobile Digital Mammography Van plans to extend its services to residents of Monmouth County (“AMI Assumes Operation”, 2014), which may help to alleviate some of the problem if services are offered in rural communities.

Burlington County residents also encounter barriers to care due to the geographic location of breast cancer services. Comprised of four hospitals, six mammography centers, and two community health centers, breast health services are dispersed primarily throughout the northwestern region of the county. Virtua Memorial Hospital’s Fox Chase Cancer Center in Mount Holly and Lourdes Medical Center of Burlington County in Willingboro both provide patients with services that span the CoC. MD Cancer Center at Cooper also has a facility in Willingboro that offers patients treatment and support services. The Southern Jersey Family Medical Centers, Inc. operates two community health centers in Burlington City and New Lisbon. Both of these facilities offer screening mammograms to minority populations, regardless of their ability to pay. Virtua Memorial Hospital in Mount Holly also serves as the lead agency for the NJCEED program, providing free screening to uninsured and underinsured residents.

Current and Potential Partnerships and Collaborations

Currently, the Affiliate partners with three programs in Monmouth County through the community grants program: the AMI Foundation, Monmouth Medical Center, and Jersey Shore University Medical Center (JSUMC). In Burlington County, the Affiliate partners with Clark Family Breast Cancer Services, Inc. and Virtua. Further details about the AMI Foundation, Clark Family, and Virtua are discussed in greater detail under Atlantic and Camden Counties.

The AMI Foundation’s van travels throughout Monmouth County, targeting uninsured populations, as well as others who are potentially insured but are having difficulty accessing
mammography. The purpose of Monmouth Medical Center's program is to reduce disparities that exist for low-income, minority women in Monmouth County. With its main location in Long Branch, and satellite screening locations which include Neptune, Lakewood, and Asbury Park, this program reaches some of Monmouth County’s most disadvantaged residents. Free mammograms and follow-up care are provided to those without health insurance. JSUMC’s program goal is to increase annual mammography screenings for low-income, uninsured, and underinsured women in Monmouth County, focusing on the Asbury Park community. Free screening mammograms and diagnostic imaging tests are provided to those without health insurance.

Clark Family Breast Cancer Services, Inc. has been very successful at reaching underserved Black/African-American women with breast health outreach and referrals for free screenings in Burlington County. Virtua’s grant program targets uninsured and underinsured minority residents in Burlington County and is also the lead NJCEED agency in this county.

Additional partners and collaborators could include Lourdes Medical Center and Larchmont Imaging Associates in Burlington County and the VNA of Central Jersey, CentraState Medical Center and Riverview Medical Center in Monmouth County.
Figure 3.5. Breast cancer services available in Burlington and Monmouth Counties
Salem and Cumberland Counties

Strengths and Weaknesses of the Health System

The United States Department of Agriculture classifies all of Salem County as rural and most regions in Cumberland County, except the cities of Vineland, Bridgeton and Millville (United States Department of Agriculture, 2012). Data from the QDR show that most residents of Salem and Cumberland Counties live within these rural communities (Table 2.5), which is a concern because health care resources are less likely to be found in such areas (National Association of Community Health Centers, 2013).

There are very few breast cancer resources available to residents of Salem County, and those that exist are confined to its eastern and western borders. Inspira Medical Center Elmer and Memorial Hospital of Salem County are two hospitals that offer screening and diagnostic services in locations proximate to the county’s eastern and western borders, respectively (Figure 3.6). Neither site offer biopsies, however. Residents must travel to surrounding counties, such as Cumberland County, to access biopsy, treatment, and support services, since there are no facilities that offer these types of care within Salem County. Screening mammograms can also be obtained at the Salem Health Center (which is part of SJFMC) and Salem County Department of Health, which are both located in Salem City. The health department serves as a lead agency of the NJCEED program, providing free screening mammograms to income eligible women. Since the Department of Health does not have the capability to screen on-site, it utilizes a network of local clinics and hospitals as partners to provide screening and diagnostic services. FamCare, a nonprofit agency in Pennsville, offers residents screening services, but only in the form of clinical breast exams. Diagnostic services are offered at Pennsville Radiology and Memorial Hospital of Salem County, which are also located in cities that border the eastern region of the county.

Similar to Cumberland County, residents must travel to specific pockets within the county to access care, as services are not equally distributed. Additionally, residents must travel outside of the county entirely to Cumberland County to access both biopsy and treatment services. It is unclear where residents of either county would obtain breast reconstruction, as it does not appear to be offered in either area.

In Cumberland County, breast cancer resources are confined to its three cities – Vineland, Bridgeton and Millville. These resources include three medical centers, two imaging facilities, and one hospital. Inspira Health Network’s Frank and Edith Scarpa Regional Cancer Pavilion is a fully accredited cancer program located in Vineland. The program provides patients with breast cancer services that cover most of spectrum of the CoC including screening, diagnosis and treatment (reconstruction is not available). Support services are also offered, but limited to exercise and nutrition programs. Residents of Cumberland County must travel to this site, since it is the only facility in the county that offers comprehensive cancer care. Screening and diagnostic services can also be obtained at Inspira’s Medical Centers in Vineland, Bridgeton and Millville, and the Center for Diagnostic Imaging’s sites in Vineland and Bridgeton. Free screening mammograms are offered to residents through AMI’s Dr. Jan Astin mobile mammography van, which travels throughout the county, and the NJCEED program at the Inspira Medical Center in Vineland.

While there are several resources available in Cumberland County, they are concentrated mostly in the northern portion of the county and around the county’s largest cities. It is an asset
to this community that the most populous areas are located closest to the major medical centers. However, much of the county, which is quite rural, has a substantial distance to travel for comprehensive care. For example, despite several screening and diagnostic locations, only Inspira’s Regional Cancer Pavilion in Vineland provides biopsies. Additionally, cancer patients have only one choice in the entire county for treatment.

**Current and Potential Partnerships and Collaborations**

Through its community grants program, the Affiliate partners with the AMI Foundation in Cumberland County, and two programs in Salem County: the AMI Foundation and SJFMC. Further details about each of these programs are discussed in the Atlantic County section. The AMI Foundation’s van travels throughout Salem and Cumberland Counties, targeting uninsured populations, as well as others who are potentially insured but having difficulty accessing mammography. As a federally-qualified health center, SJFMC focuses primarily on underserved populations, with a particular emphasis on minorities, immigrants and seasonal, migrant farm workers.

Potential new partnerships and collaborative efforts could include Inspira’s Regional Cancer Pavilion, stand-alone screening and diagnostic facilities in both counties, and FamCare, which is located in Pennsville in Salem County.
Figure 3.6. Breast cancer services available in Salem and Cumberland Counties

Statistics

Total Locations in Region: 11

Service Type
- Screening: 9
- Diagnostic: 9
- Treatment: 1
- Support Services: 1

Accreditation Type
- American College of Surgeons CoC Accredited: 1
- American College of Radiology Breast Imaging Ctr. of Excellence: 1
- American College of Surgeons NAPBC Accredited: 1
- NCI Designated Cancer Center: 0

Susan G. Komen® Central and South Jersey
Public Policy Overview

The Public Policy Overview presents a snapshot of critical information and key activities related to NBCCEDP, the State Comprehensive Cancer Control Coalition, the Affordable Care Act (ACA), and the Affiliate’s public policy activities. Each of these areas is outlined in greater detail in this section.

National Breast and Cervical Cancer Early Detection Program (NBCCEDP)

NJCEED is a state-organized NBCCEDP program that provides outreach, education and screening services for breast, cervical, colorectal and prostate cancers. Further diagnostic tests are also performed when indicated, such as needle biopsies, breast ultrasounds and colonoscopies. Jointly funded by the Centers for Disease Control and Prevention (CDC) and the State of New Jersey, NJCEED is offered to residents who are underinsured or uninsured and have incomes at or below 250 percent of the federal poverty level (New Jersey Department of Health, n.d.). In the fiscal year 2013 (FY13), the State of New Jersey allocated $9.5 million towards NJCEED, making a total budget of $12.0 million when combined with federal funding from the CDC (New Jersey Department of Health, 2013). At the time of writing, the NJCEED program has not received funding allocations for FY2014 (Melita Jordan, personal communication, July 2, 2014).

The NJCEED program is part of the New Jersey Department of Health and Senior Services (NJDHSS). NJDHSS is responsible for providing Health Services Grants to organizations to act as lead agencies for the program (New Jersey Department of Health, n.d.). The department also serves as the initial point of contact for eligible residents to enroll in the NJCEED program through its 800 number. There are NJCEED sites located at hospitals and health departments in each county throughout the Affiliate’s service area that receive referrals of eligible clients from the department. At that point, eligible clients work directly with the NJCEED site in their county of residence.

New Jersey exercises the option, under the Breast and Cervical Cancer Prevention and Treatment Act of 2000, to extend Medicaid benefits to women who are screened and diagnosed with cancer through the NJCEED program. These benefits provide low-income, uninsured women with immediate access to breast cancer treatment (Centers for Medicare & Medicaid Services, 2014). In order to be eligible for the Medicaid program, adults must be US citizens or permanent residents for more than five years and have incomes up to 138 percent of the federal poverty level. Pregnant women, however, must have incomes up to 200 percent of the federal poverty level to be eligible. In general, women can apply for Medicaid by enrolling online or enrolling in person at one of the designated application assistant sites.

NJCEED collaborates with Medicaid to ensure that women who have been diagnosed with breast cancer through its program are provided full Medicaid benefits for treatment and follow-up care. NJCEED sites are essentially responsible for initiating the eligibility determination and enrollment process for the Medicaid program (New Jersey Department of Human Services, 2012). If an individual is found to require treatment through NJCEED, and does not qualify for the Medicaid program or has other health coverage, they are referred to alternative Medicaid programs as long as their income does not exceed 250 percent of the federal poverty level (New Jersey Department of Human Services, 2012).
Currently, the Affiliate’s relationship with the NJCEED program exists primarily through its community grants program. The Affiliate funds screening, diagnostic, education and outreach services for several NJCEED sites (Community Medical Center, MD Anderson Cancer Center at Cooper, and Virtua). Estimates from the NJCEED program indicate that they are only able to screen about 10-15 percent of their eligible population each year (Melita Jordan, personal communication, July 2, 2014). Every site is different in terms of its need. Some areas have a greater burden overall and run out of funds each year, while others do not (Melita Jordan, personal communication, July 2, 2014). Additionally, the Director of the NJCEED program indicated that having sufficient funds to pay for additional diagnostic testing is problematic. Given the ongoing burden experienced by the NJCEED program and the reliance of the uninsured population on this program, the Affiliate will continue to offer the opportunity for NJCEED sites in the target communities to apply for support for screening, diagnostic, and transportation services, as part of the community grants program.

The Affiliate also plans to strengthen its relationship with the NJCEED program by meeting bi-annually with key NJCEED leaders to maintain a dialogue that will address the needs of those at risk of or burdened by breast cancer, and by attending quarterly NJCEED coalition meetings, which bring together all of the NJCEED providers in the state.

**State Comprehensive Cancer Control Coalition**

Through the Comprehensive Cancer Control Plan, the Governor’s Task Force on Cancer Prevention, Early Detection, and Treatment in New Jersey continues to fulfill its mission of reducing the incidence, illness and death due to cancer among New Jersey residents (New Jersey Department of Health and Senior Services, 2012). The Task Force is in the process of developing the third edition of the strategic plan, which is expected for release in fall 2014. The Affiliate will adjust its priorities, goals and objectives based on the breast cancer objectives presented in the forthcoming plan. The State’s second Comprehensive Cancer Control Plan for 2008-2012 focused on awareness and education for those at higher than expected risk of developing breast cancer (New Jersey Department of Health and Senior Services, 2012). It is also aimed to improve awareness and education relating to screening, rescreening, and follow-up visits in order to maximize optimal outcomes (New Jersey Department of Health and Senior Services, 2012). The breast cancer objectives for the 2008-2012 plan were as follows (New Jersey Department of Health and Senior Services, 2012):

**Objective 1.1:** To increase public and professional awareness of the factors that place women at high risk for developing breast cancer through wide dissemination of culturally and linguistically appropriate educational materials and curriculum development.

**Objective 1.2:** To increase public and professional awareness of breast cancer prevention strategies for those at high risk through wide dissemination of culturally and linguistically appropriate educational materials and curriculum development.

**Objective 1.3:** To educate women who come in for breast cancer screening about early detection and the need for appropriate follow-up, diagnostic testing, and annual rescreening.
Objective 2.1: To build consensus on what the public message should be regarding breast cancer education, impact of certain health and lifestyle factors, screening and treatment, and the benefits and risks of early detection.

Objective 2.2: To develop and implement a statewide breast cancer public awareness/media campaign to increase utilization of breast cancer screening services (in accordance with accepted public health practice and recommendations of the Centers for Disease Control and Prevention).

Objective 2.3: To develop and disseminate breast cancer educational materials and resources to increase knowledge, improve public understanding of the value of screening and early detection, and promote high-quality breast health, paying special attention to vulnerable, high-risk populations.

Objective 2.4: To increase education of high school students on breast cancer prevention and early detection by identifying and promoting a curriculum on the life-saving value of good breast health habits.

Objective 3.1: To increase appropriate treatment and follow-up for women who receive abnormal mammograms and/or abnormal clinical breast exams.

Objective 4.1: To increase professional education on assessment, e.g., symptoms, risk factors, screening, risk reduction, and follow-up care for breast cancer.

Objective 4.2: To encourage health care providers to increase referrals and improve patient awareness about breast cancer early detection and screening measures.

Objective 5.1: To identify areas in New Jersey where breast cancer death risk is greatest.

Objective 6.1: To support the National Cancer Institute’s Clinical Trial Implementation Committee Goals for Clinical Trials for breast cancer.

Objective 7.1: To continue to monitor and disseminate current advances in breast cancer prevention, screening, diagnosis and treatment.

Objective 7.2: To continue to monitor trends in breast cancer incidence, deaths and survival.

New Jersey cancer coalitions have transitioned from a sole focus on cancer control and prevention to addressing cancer within the context of chronic disease. Accompanying this change, the former 21 county cancer coalitions have been pared-down to 10 regional chronic disease coalitions (Sass, 2012). The Affiliate occasionally attends regional coalition meetings. Both the Executive Director and the Director of Mission also participated in the strategic planning process to create the state’s chronic disease plan. The Affiliate’s Executive Director currently sits on the Governor’s Task Force, and the Director of Mission sits on the Chronic Disease Advisory Council, which oversees the development of the strategic plans for chronic disease, with cancer as a subcomponent.
The Affiliate intends to continue each of the tasks outlined above as they relate to participation on various councils and taskforces that oversee the cancer and chronic disease plans. Additionally, the Affiliate intends to attend each of the 10 regional coalition meetings at least once over the course of the next two years.

**Affordable Care Act (ACA)**
New Jersey has elected to allow the federal government to operate a federal exchange in New Jersey (New Jersey Office of Legislative Services, 2014). A state-based exchange was designed and approved by the state legislature at one point, but was vetoed by the Governor (New Jersey Office of Legislative Services, 2014). As of January 1, 2014, New Jersey expanded Medicaid coverage through the ACA to parents and non-disabled adults less than 65 years of age with incomes up to 138 percent of the federal poverty level (Centers for Medicare & Medicaid Services, 2014). Based on findings from the Urban Institute’s Health Reform Monitoring Survey, the number of nonelderly adults who reported being uninsured prior to the Medicaid expansion has fallen from 1,080,900 (21.2 percent) in September 2013 to 670,158 (13.2 percent) in March 2014 (Hempstead & Cantor, 2014).

The ACA is projected to cause an increase in the number of insured, which should increase the number of women receiving screening through their insurance. In turn, there may be a decrease in the number of women getting screened through NJCEED (Levy, Bruen & Ku, 2012). However, because there will still be a sizeable uninsured population (i.e. those who don’t meet citizenship requirements and those who fall below 250 percent of the federal poverty level but do not qualify for Medicaid) the NJCEED program will still be necessary. The Cancer Action Network estimates that 50,859 women in New Jersey will not have access to breast cancer screenings, diagnostic or treatment services even after the implementation of the ACA (American Cancer Society, 2013).

Those who are not qualified for Medicaid, but eligible for NJCEED and diagnosed through the program, will be enrolled into Medicaid for treatment services as long as they meet the income requirements for NJCEED (and citizenship requirements for Medicaid). This might prompt a greater use in NJCEED services for people who are above the income threshold for Medicaid and cannot afford a plan in the marketplace. The Affiliate has polled many of its partners, both formally and informally, about the potential impact of the ACA. The NJCEED program indicated that they are unsure about the impact of the ACA on their program, as the data to evaluate it does not really exist yet (Melita Jordan, personal communication, July 2, 2014).

In thinking about the potential implications of the ACA on providers, one notable change is that many physicians are merging with other health care providers and hospitals so that they can provide the greatest range of services, since the ACA is all but eliminating the fee-for-service model (The Physicians Foundation, 2010). The Accountable Care Organization (ACO) model, encouraged by the Centers for Medicare and Medicaid services, consists of networks of physicians, hospitals and other health care providers and helps ensure a smoother continuum of care. Instead of being paid by the existing fee-for-service model, ACO’s receive a lump sum payment in advance that is either fixed or based on the number of its beneficiaries (Centers for Medicare & Medicaid Services, 2013). Patients can choose any provider, regardless of whether they are participating in an ACO or not. However, in order to provide the best care, it is becoming increasingly difficult for independent health care providers to remain competitive.
The ACA has also prompted an increase in the number of individuals enrolled in Medicaid. Low Medicaid reimbursement rates have deterred physicians from accepting new Medicaid patients (Rutgers Center for State Health Policy, 2014).

A survey was conducted by the Affiliate with FY2014 grantees to gauge their perspective on the overall impact of the ACA thus far. Many of these grantees are hospitals and thus are direct service providers. Results from the survey revealed that nearly half (46.7 percent) of the 15 grantee organizations indicated that their programs had been impacted by the ACA. Several grantees cited a decrease in their patient population, while a couple of others indicated they are seeing an increase in women who cannot pay their co-pays, no longer qualify for charity care, or have lost their benefits entirely. When asked about how they anticipate the ACA impacting their programs in their future, a few grantees indicated they would not be affected at all or could not tell yet, while other responses included:

- Seeing a reduction in the number of women who need their program as a result of having insurance.
- The focus may be turned away from screening, to educating the women of the community about breast health awareness instead.
- Anticipate seeing more women in the program due to increased unemployment in this geographical region, lack of insurance/benefits and no ability to pay for services.
- Seeing a number of patients who are now refusing or stopping their ACA coverage as they cannot afford it.

To date, there have not yet been any noticeable effects of the ACA on the Affiliate. Although there will be an increase in the number of people with access to affordable health care, there will remain a minority population that does not, or cannot, receive health insurance coverage (US Department of Health & Human Services, 2012). This may include individuals who are unable to afford a health insurance plan, undocumented immigrants, or individuals who have plans that do not cover preventive screenings (i.e. grandfathered plans that do not have to follow preventive coverage rules). It is within these populations that the Affiliate will continue to provide programs that offer screening services to women with limited access to health care. Once the ACA has been in existence for a few years and people begin to evaluate its impact and success, the Affiliate should be able to better gauge the impact of the ACA on the future of its Mission work.

**Affiliate’s Public Policy Activities**

Komen Headquarters establishes annual “advocacy priorities” that are meant to guide policy initiatives for the Affiliate. The 2014 advocacy priorities targeted protection of federal and state NBCCEDP funding, continued federal investment in cancer research, oral parity legislation and Medicaid expansion. Oral parity legislation and Medicaid expansion have already been achieved in the State of New Jersey. However, the Affiliate advocates for NBCCEDP funding and cancer research when requests come from Komen Headquarters or other federal and state partners.

Komen Headquarters has just begun its issue vetting process for its 2015 advocacy priorities. Thus, it is a bit premature to plan what the Affiliate’s public policy activities might be when the newest priorities have not been established yet. Moving forward, the Affiliate plans to collaborate, as needed, with Susan G. Komen North Jersey to develop state-based campaign
plans. Campaign plans will involve inviting state legislators to Komen events in an effort to establish new relationships. Fact sheets for government representatives will be developed and used to explain Komen’s mission and priority public policy issues. Attempts will be made to schedule district meetings and/or phone calls with key legislators (e.g. those on key committees or with specific interests), once a specific “ask” has been determined. The Affiliate also plans to incorporate local partners (e.g. grantees and local organizations) in its advocacy efforts as needed.

Other potential future activities will include:
- Monitoring NJCEED funding and advocating for preservation and expansion as needed
- Acting on Komen Headquarters priorities as needed (e.g. advocating for research funding and/or federal dollars)
- Encouraging staff, board, and constituents to sign-up to become an advocate and receive alerts about current legislative and advocacy actions
- Sharing actions via social media to increase voice/presence in DC
- Hosting a public policy tent, including petitions on a specific issue (typically preservation of NJCEED and/or research funding), at the Race each year
- Invite key state legislators to the Race for the Cure

Health Systems and Public Policy Analysis Findings

Key findings from Health Systems Analysis
The Health Systems Analysis provided a detailed look at the strengths and weaknesses of each target community. This helped to make apparent the needs in each target community related to the health system. Key partnerships in target communities and potential new partners to address needs and key issues were identified. Key findings for each county are outlined in this section.

In general, the findings indicate that in the more resource-rich target communities, addressing needs should involve focusing on integrating existing resources and combining efforts when possible. In those target communities where there are less resources overall, the issues get a bit more complex, drawing the focus instead to how to maximize impact with a dearth of resources. The Affiliate will consider convening a coalition of key players in each of the target communities to address these issues collaboratively. It will also be important to ensure that all programs and resources connect women with the necessary care at every phase of the CoC, and that all collaborative efforts and partnerships attempt to focus, when possible, on providing targeted programs that reach the most vulnerable populations identified in the QDR.

Atlantic County
Despite the wealth of breast health services available in Atlantic County addressing all facets of the CoC, including those that specifically target vulnerable populations, data from the QDR show that 40.9 percent of Atlantic County’s population lives in medically underserved areas (Table 2.5). A key concern identified in the HSA is the unequal geographic distribution of resources. Issues of accessibility (particularly for rural residents), including transportation challenges, appear vital to address for this community. Additionally, coordinating a more seamless transition through the CoC at the region’s largest hospital, particularly during the treatment phase, will be essential. Lastly, when possible, programs should specifically target
Black/African-American women, given that they have the highest death rate among Black/African-American women compared to all other counties in the service area (Table 2.9).

**Current partnerships/collaborations**
- AtlantiCare: Potentially expand this program to cover transportation to improve access to care on its multiple campuses, given that different facets of cancer care are provided on each campus.
- AMI Foundation: The Affiliate could consider expanding its relationship with AMI by utilizing its numerous satellite locations throughout county to reach women with education, screening, and diagnostic services.
- Jewish Family Service of Atlantic & Cape May Counties: One potential area of expansion for this program would be to build upon and enhance relationships with their existing, extensive network of partners, potentially targeting one or more of these programs to replicate JFS’s successful program model.

Each of the Komen grantees in Atlantic County already has collaborative relationships with one another. However, it would benefit the Affiliate to learn more about the specifics of their partnerships in order to avoid duplicative efforts, enhance complimentary ones, and maximize impact and funding.

**Potential partnerships/collaborations**
- Shore Memorial (NJCEED site): The Affiliate might consider partnering with this NJCEED site to provide a solution for transportation to their screening site and/or expansion of a satellite location for screening.
- The Nazha Cancer Center: Offers another potential option for connecting those diagnosed with chemotherapy and radiation.
- Community health centers: Partnering with other community health centers in addition to SJFMC, such as the Family Medical Center of Atlantic City’s Women’s Health Pavilion, offers a terrific opportunity to reach vulnerable populations. SJFMC offers a perfect model to adapt, as it has been extremely successful in reaching its target population.

**Camden County**
A major weakness identified in this county is the availability of comprehensive breast care services beyond the concentrated pocket of hospitals, as well as the accessibility to those resources for those in rest of the county who live a substantial distance away in areas where comprehensive breast care resources are not as readily available. There also appears to be a general lack of resources available for those who cannot afford them, which raises concerns about the ability and willingness of poorer residents to travel for care to the few locations that do offer services. It is plausible that the dearth of comprehensive resources available and accessible to a substantial portion of the county’s residents is having an impact on breast health outcomes (e.g. the QDR identified Camden as having the lowest screening percentage for the entire service area). Issues of accessibility (particularly for rural residents), including transportation challenges, appear vital to address for this community. Additionally, resources that focus on encouraging Camden City residents to initiate and complete their breast care will be essential, given that the health outcomes in Camden City are so poor (US Census Bureau, 2014) despite the availability of a multitude of comprehensive resources in the city itself.
Current partnerships/collaborations

- Clark Family Breast Cancer Services, Inc.: The potential exists to expand the reach of this program into additional pockets of the county as well as tap into their existing network of grassroots partners (e.g. faith-based organizations) to pilot a similar approach in another portion of the county.
- MD Anderson Cancer Center at Cooper (NJCEED site): Being the largest health system treating residents in Camden City, it is imperative for the Affiliate to continue to build upon this important partnership in order to improve health outcomes in Camden City and beyond.
- Virtua (NJCEED site): The Affiliate could consider enhancing this partnership by supporting efforts to increase accessibility to services (e.g. a transportation component) and/or support additional screening mammograms and/or diagnostic services.

Potential partnerships/collaborations

- Our Lady Lourdes Medical Center: Located in Camden City, presents an ideal opportunity to reach vulnerable populations in the city with the worst health outcomes in the service area (Table 2.1).
- CAMCare: As the area’s only community health center, its target population and location make it ideal for implementing and outreach and referral program similar to the Affiliate’s existing successful partnership with SJFMC (discussed in the Atlantic County section).
- Kennedy University Hospital: With campuses in Stratford and Cherry Hill, the Affiliate could focus on helping screening and diagnostic patients receive seamless care throughout all of the phases of the CoC, given that Kennedy does not provide treatment services.
- South Jersey Radiology Associates: Given its numerous locations throughout the county, they represent perhaps the best opportunity to reach a broad population with education, screening, and diagnostic services.

Gloucester County

While Gloucester County appears to have a fair amount of resources overall, including several hospitals that provide access to care along the CoC, a key concern identified in the HSA is the unequal geographic distribution of resources in this community. Issues of accessibility (particularly for rural residents), including transportation challenges, appear vital to address for this community. Additionally, improving access to comprehensive programs, particularly for those with transportation challenges coming from other screening and diagnostic facilities in the region, will be important. Efforts should also be made through current and potential partnerships and collaborations to target Black/African-American women (who have a substantially higher death rate) and women ages 65 and older (who experience high late-stage diagnoses) (Tables 2.9 and 2.11).

Current partnerships/collaborations

- AMI Foundation: The potential exists for the Affiliate to work with AMI to ensure they target pockets of the county that have the most difficult time accessing breast care, as and that those linked with screenings through AMI have an accessible option for follow-care and treatment, if necessary.
- Clark Family Breast Cancer Services, Inc.: Potentially expand the reach of the program into additional pockets of the county as well as tap into their existing network of
grassroots partners (e.g. faith-based organizations) to pilot a similar approach in another portion of the county.

- Virtua (NJCEED cite): The Affiliate could consider enhancing this partnership by supporting efforts to increase accessibility to services (e.g. a transportation component). and/or support additional screening mammograms and/or diagnostic services.

**Potential partnerships/collaborations**

- Work with major hospitals (Kennedy and Inspira Woodbury) to ensure there is seamless transition for patients from other screening and diagnostic facilities and improve access to their comprehensive programs, particularly for those with transportation challenges.
- South Jersey Radiology Associates: Since this radiology group has a location in Woodbury, a collaborative relationship with Inspira Woodbury might assist in providing more seamless care throughout the CoC. This group provides biopsies, which is a diagnostic service that Inspira Woodbury does not provide.

**Burlington and Monmouth Counties**

Both counties have an abundance of resources that address all facets of the CoC. However, given that the majority of the resources are located in specific pockets in each county, there are potential access issues, including transportation challenges, particularly for rural populations. Additionally, findings from the QDR indicate a need for programs targeting Hispanic/Latina women in Monmouth County given the substantially higher death rate and low survival rate for this population in this county (Tables 2.8 and 2.9). Burlington County could benefit from additional programs targeting Black/African-American women, given that the percentage of Black/African-American women diagnosed with late-stage breast cancer is considerably higher in this county than other counties (Table 2.10).

**Current partnerships/collaborations**

- AMI Foundation: The potential exists for the Affiliate to work with AMI to ensure they are targeting pockets of the county that have the most difficult time accessing breast care, and that those who are linked with screenings through AMI have an accessible option for follow-care and treatment, if necessary.
- Monmouth Medical Center: The Affiliate could enhance this partnership by supporting the continued expansion of this program into satellite facilities located in areas with a greater abundance of vulnerable populations.
- Jersey Shore University Medical Center: Potentially replicate the success of their program in Asbury Park in other catchment areas of JSUMC that are more predominately composed of low-income, uninsured populations (e.g. Neptune).
- Clark Family Breast Cancer Services, Inc.: Possibly expand the reach of the program into additional pockets of the county as well as tap into their existing network of grassroots partners (e.g. faith-based organizations) to pilot a similar approach in another portion of the county.
- Virtua (NJCEED site): The Affiliate could consider enhancing this partnership by supporting efforts to increase accessibility to services (e.g. a transportation component) and/or support additional screening mammograms and/or diagnostic services.
Potential partnerships/collaborations

- Lourdes Medical Center: Ensure there is seamless transition for patients from other screening and diagnostic facilities and improve access to its comprehensive programs, particularly for those with transportation challenges.
- Larchmont Imaging Associates: Given its numerous locations throughout Burlington County, they represent perhaps the best opportunity to reach a broad population with education, screening, and diagnostic services. Possible collaborative efforts exist with Lourdes Medical Center to transition patients to the full spectrum of CoC services, if needed.
- VNA of Central Jersey (NJCEED site): The Affiliate could support efforts to enhance accessibility to services (e.g. a transportation component) and/or support additional screening mammograms and/or diagnostic services.
- Riverview and CentraState: The Affiliate can replicate the success it has had with other comprehensive breast care programs in Monmouth (Monmouth Medical Center and JSUMC), but in locations (e.g. Red Bank and Freehold) that provide a better opportunity for those living outside the heavily concentrated service region to receive high-quality, seamless care. For example, a program in Freehold might help provide access for some of the more rural portions of this county that may be having difficulty accessing care near the shore-based hospitals.

Salem and Cumberland Counties

Overall, this target community has a dearth of resources compared to the other target communities the Affiliate has considered. The HSA revealed that Salem County has little to no resources available that span the entire CoC, and the few that do exist in Cumberland are concentrated in the northern portion of the county. In Salem County, there are no places to go for biopsies or treatment within the county. Instead, residents must travel to Vineland (in Cumberland County) for treatment. In Cumberland County, Vineland is the only location providing treatment. Besides the NJCEED sites, there really are no programs for vulnerable populations to receive free or reduced cost care.

The challenge in this target community will be to figure out how best to maximize existing resources and coordinate a more seamless transition through the CoC. This will be very tricky to accomplish given the piecemeal service availability throughout this target community. As with all of the other target communities identified, there is a need to deal with access issues (particularly for rural residents), including transportation challenges.

What also appear to be missing in this community are programs that target certain vulnerable populations, such as minorities. While SJFMC does a terrific job of targeting minorities in this area, this community would benefit from additional programs that also target minorities given that Cumberland has the largest Hispanic/Latina population and the third largest Black/African-American population in the Affiliate’s service area (Table 2.4).

Current partnerships/collaborations

- AMI Foundation: The potential exists for the Affiliate to work with AMI to ensure they are targeting pockets of the county that have the most difficult time accessing breast care, and that those that are linked with screenings through AMI have an accessible option for follow-care and treatment, if necessary.
• SJFMC: Might consider collaborating with SJFMC to expand its successful outreach and referral model to other health centers in the area, particularly in Cumberland County where the minority population is so abundant (Table 2.4).

**Potential partnerships/collaborations**

- Inspira’s Regional Cancer Pavilion: As the only source of comprehensive breast care throughout the target community’s two counties addressing all aspects of the CoC, it will be vital to work with this program to address gaps in the CoC.
- Initiate and/or build upon existing collaborative efforts with the other hospitals (e.g. Inspira Bridgeton and Memorial Hospital of Salem County) in the area to ensure there is a seamless transition from other screening and diagnostic facilities to the Regional Cancer Pavilion, and improve access to the cancer center’s comprehensive programs overall.
- Stand-alone screening and diagnostic facilities in both counties that could benefit from participating in a collaborative effort to coordinate and ensure comprehensive care in this community.
- FamCare, located in Pennsville in Salem County, which focuses on providing reproductive health care and educational services. This program appears poised with the right tools to develop an outreach and referral model similar to SJFMC.

**Key Findings from Public Policy Analysis**

Public policy has the potential to evoke considerable changes to the breast cancer health system. NBCCEDP fills a critical role in each of the target communities by providing screening and diagnostic care to their most vulnerable residents. Additionally, being fast-tracked into Medicaid helps ensure patients receive seamless care throughout the CoC. While the NJCEED program fills a tremendous need for vulnerable populations in the target communities, the data show that there is still a critical unmet need. The QDR indicates a plethora of issues in each county, while the NJCEED program indicates that they are unable to meet the demand for the program (Melita Jordan, personal communication, July 2, 2014).

The ACA has the potential to meet a sizeable portion of that need, particularly with New Jersey’s expansion of Medicaid. However, since the legislation is so new and the consensus among providers is that it has not yet made a big impact (although it has the potential to do so), the impact on breast care remains to be seen until the program can be evaluated.

The changing landscape of the state’s cancer coalitions, with a broader focus on chronic disease, presents a unique opportunity in that it might allow for learning and collaboration with other sectors of chronic disease. It also potentially shifts the sole focus away from cancer, which means that other health issues may now receive greater attention from the coalitions. However, the state’s cancer control plan is still in existence, and new goals and objectives will be released in late 2014.

The Affiliate’s policy work in the past has primarily revolved around meeting key advocacy priorities established by Komen Headquarters. The Affiliate will continue to focus on meeting these priorities as they are established each year, given that these are the key priorities for breast cancer care established through a national issue vetting process. The Affiliate will continue to monitor key aspects of the public policy realm that greatly impact breast cancer, including NJCEED funding and the ACA, as it unfolds over the next few years. The Affiliate’s
biggest policy goal is to establish relationships with a few key legislators. The findings from this assessment will be an important tool and conversation piece for developing these relationships, as well as a call to action to address the most vital issues outlined in the target communities. Additionally, the Affiliate will continue collaborating with NJCEED screening sites primarily through its community grants program, and will continue to hold influential roles on state coalitions and workgroups to help influence policy at a broad level.
Qualitative Data Sources and Methodology Overview

The purpose of the qualitative data are to further explore the breast health and breast cancer issues highlighted by the Quantitative Data Analysis (e.g. late-stage diagnoses rates) and the Health Systems and Public Policy Analysis. The qualitative data provide insight into a community’s attitudes, beliefs and behaviors about disparities, access to services, utilization of services, quality of care, and additional breast health and breast cancer issues (e.g. reasons behind low mammography screening percentages). Additionally, the qualitative process provides the community perspective as to what is working, what is not working, and what the various barriers are that lead to gaps in access, utilization and quality of services.

Methodology

Building on the findings from the previous sections, the Affiliate developed a specific set of assessment questions to address the key variables identified. Questions were specifically developed to further explore disparities in care, access, and utilization. For each target community, the Affiliate asked a generic set of questions about barriers to care (both individual and systemic) along the continuum of care and the strengths and weaknesses of the health system. Additionally, for each community, supplemental questions were asked to explore specific issues identified that were unique to that county (e.g. why certain rates were so high or if transportation was a challenge given the perceived lack of resources available). The general assessment questions asked were as follows:

- What are the greatest issues in the community related to breast health and breast cancer?
- What are the specific groups (racial/ethnic and geographic) that do not get the services they need in the community, and why?
- What barriers (individual or systemic) are faced at each stage of the continuum of care, and in transitioning through the stages? Why do they exist? What strategies are currently in place and/or need to be in place to address these barriers?
- What are the strengths and weaknesses of the health system and what new programs, resources, and policies are needed to deliver breast health more effectively?

The primary methods employed to collect data in each county were key informant interviews and document review. Key informant interviews were utilized because the Affiliate was primarily looking to gather expert knowledge on all phases of the continuum of care, and thus needed to speak with individuals who understand very well the systems and resources in the community, and how they are related. Key informant interviews are also advantageous because they allow for exploration of issues in depth, for clarification when possible, and for further relationship building in communities, particularly with new partners. Document review was utilized because it enabled the Affiliate to validate findings from its health provider assessments, provided another perspective from additional experts and community members, and provided access to readily available resources that have been recently collected. The documents reviewed explored issues similar to those the Affiliate is assessing (e.g. individual and systemic barriers to care) using similar methodology (e.g. key informant interviews and focus groups). Many of the answers the Affiliate was seeking have been explored by others already, and thus, the documents presented a great opportunity to capitalize on existing resources.
Both qualitative methods were selected because they allow questions to be answered about the needs, barriers, and existing gaps in addressing access to, utilization of, and quality of care in the Affiliate service area, allowing the Affiliate to draw appropriate conclusions and identify priorities that will be used to inform the Affiliate’s Mission Action Plan. The methods were selected to ensure that unanswered questions from the Quantitative Analysis and the Health Systems and Public Policy Analysis could be answered. The use of multiple sources and methods should help reveal similar patterns and conclusions in the data, allowing for the triangulation of findings among all of the sections of the Profile, and bringing the data together to make plausible connections regarding the issues identified to establish priorities.

Key informant interviews were conducted by an expert trained in qualitative analysis methodology. The same individual was used throughout the interview process to ensure consistency and to maintain the quality and integrity of the process. Thirty-minute telephone interviews were conducted with key informants. The interviewer used a prepared script that consisted of an introduction and open-ended questions that were designed to answer the key assessment questions. Answers were recorded via manual note taking by the interviewer as well as via digital recorder. Documents were collected by college interns who conducted Internet searches of hospital and public health department websites, of academic databases of journal articles, and from the Affiliate’s Grants eManagement System (GeMS). Relevant data from the documents were collected by a qualitative data analysis expert, who reviewed the data for specific codes and relevant themes developed to help answer the key assessment questions. Data were recorded manually using a data collection form.

Sampling
The Affiliate was seeking to answer key questions about all women in the target communities seeking care for breast health and breast cancer, in certain instances focusing on identifying potential issues in subsets of the population including Blacks/African-Americans, Hispanics/Latinas, those of low SES, the uninsured, and those residing in rural areas.

Key informant interviews were conducted with community experts. The primary sources of data collection for the document review portion of the analysis were:

1. Community Health Needs Assessments (CHNAs) from each of the target communities
2. Affiliate grantees’ (from each of the target communities) progress and final reports from the GeMS system
3. Peer-reviewed journal articles (not specific to the target communities).

Key informants were selected using a mix of sampling techniques. The sampling process was purposive, in that certain health systems in each community as well as certain roles (e.g. navigators, outreach staff, and social workers) were deliberately selected. A portion of the sample was acquired via convenience sampling, as key contacts (e.g. existing grantees) were selected for ease of access. The sample was completed using snowball sampling, given that those who had already been selected to participate provided contact information for other potential key informants.

For the document review, reports and applications from the Affiliate’s GeMS system were acquired via a convenience sample, given that they were pulled from an existing internal database and from the Affiliate’s pool of grantees. CHNAs and journal articles were collected using purposive sampling, as articles and reports were picked to answer specific assessment
questions, at times for specific counties. CHNAs were found using basic Internet searches while the journal articles were found using databases and libraries from various local universities.

Community health experts were selected for the key informant interviews on the basis of certain criteria. Each of the institutions identified through the inventory of resources developed for the HSA were contacted, with the goal of acquiring a representative sample of different types of organizations (e.g. hospital systems and community hospitals, grassroots outreach and social service organizations, NJCEED, FQHCs, and departments of health) as well as different perspectives from various roles (e.g. navigators, social workers, nurses, doctors, outreach workers, and public health professionals). These experts work in the target communities on breast health and breast cancer issues. They are the gatekeepers who have their finger on the pulse of the community, encountering populations of interest at all phases of the continuum of care. The total number of key informant interviews conducted was 42 (Atlantic: seven, Monmouth/Burlington: 11, Camden: 10, Salem/Cumberland: seven, Gloucester: six).

CHNAs were selected for the document review because they focus on the challenges of the health care system in each of the target communities of interest, implementing focus groups and key informant interviews with community members and community health experts to answer key questions. Completion of a CHNA is mandated by the ACA for all major health systems. Each of the CHNAs selected were recently (within the past few years) conducted by reputable sources (e.g. hospitals, departments of health, and/or county-wide coalitions) and provide a rich source of existing data about individual and systemic barriers to care. While the entire CHNA was reviewed, only relevant findings related to focus groups and key informant interviews were used. Six CHNAs were reviewed in total, as some of the target communities’ CHNAs were part of multi-county assessments. Within each CHNA, there were numerous key informant interviews and focus groups conducted.

The Affiliate grantees’ progress and final reports from the 2013-2014 (21 reports) and 2014-2015 (16 reports) grant cycles, as well as applications from the 2015-2016 (22 applications) grant cycles were reviewed as part of the document review. They were selected because they provided qualitative information about best practices, lessons learned, existing partnerships and perceptions about and from the target community about individual and systemic barriers to accessing care from the perspective of community health experts who work in the target communities on a daily basis. Much of the information provided comes from their experiences working one-on-one with community members.

The final component of the document review was a literature review of peer-reviewed journal articles related to key assessment questions and variables of interest. These articles were used to enhance and to add credibility to the other qualitative findings, as some of the key questions and variables being assessed have already been studied by others. Although not specifically focused on the target communities, the articles provide findings from similar communities with similar target populations. A sample of 17 peer reviewed journal articles was returned.

**Ethics**

A consent form was used for all key informant interviews. Each interviewee received the consent form and was required to complete the form and return it prior to the interview. The consent form contained details on the purpose of the study, privacy and confidentiality procedures, potential risks, right to refuse, anticipated benefits, investigator contact information,
and the right for withdrawal. External documents used in the document review analysis documented their own confidentiality and consent procedures in their respective reports, with most directly citing the use of consent forms as a best practice to ensure ethical data collection. CHNAs and literature review documents are public information and thus did not require consent to obtain. The Affiliate’s grantees all provided permission to use the contents of the internal documents (i.e. the grantee reports and applications) for the assessment.

To protect the anonymity of the key informants, documents which contain their names are part of a password-protected file system, stored on a password-protected computer that only key Affiliate staff have access to. Interview transcripts, audio recording files, and consent forms do not contain any identifiable information (only an assigned number), and no names were used in the summary of the findings. All of the grantee-related documents used in the document review are stored on a password-protected web-based grants management system, which only the lead investigator has access to. All paper files (notes, consent forms, etc.) were scanned electronically, discarded and shredded after they were saved, and were stored via the same method as the other electronic files discussed above.

**Qualitative Data Overview**

**Data management/analysis**

The format of the original key informant interview data were interview notes, verbatim transcripts created from listening to audio files of the interviews, and the audio files from the digital recorder used during all interviews. The format of the original document review data were as follows:

1. CHNAs: an electronic Portable Document Format (PDF) that provided summary findings from the various data collection methods used
2. Peer reviewed literature: electronic PDF that provided summary findings from the various data collection methods used
3. Grantee reports and applications: part of the Affiliate’s electronic database known as the GeMS System

The ground rules and key steps established for the data collection process were that:

1. Data were processed and recorded immediately.
2. Data were coded and analyzed as collected
3. Data were reviewed by multiple experts to ensure the key questions were answered and to reduce selection bias
4. Data were summarized by identifying themes and descriptions
5. Data were formatted according to guidelines and to answer assessment questions most succinctly

To generate themes/categories, hand analysis was conducted by a qualitative expert. The procedure for coding the data were as follows:

1. Initially read through text data
2. Divide the text into segments of information
3. Label the segments of information with codes
4. Reduce overlap and redundancy of codes
5. Collapse codes into themes
Direct quotes/written statements were used when possible to illustrate and clarify findings. Themes/categories were used to answer assessment questions in a number of different formats including direct quotes/written statements and comparison tables.

Common Findings
Common findings shared between the key informant interviews and the document review processes are outlined by each target community below. More detailed findings outlined by the major assessment questions can be found in the Qualitative Data Findings section.

Atlantic County
The most frequently cited issues in the community related to breast health and breast cancer by both the key informant interviews and the document review were:

- Financial barriers, including a lack of insurance. A major concern was the large group of newly uninsured employees due to casino closings in Atlantic City.
- Lack of education about breast health, the importance of screening, and available resources
- Competing priorities (specifically the notion that women are more worried about basic needs and survival than health)
- Transportation barriers (specifically for the elderly and disabled)

The most substantial weakness of the health system identified by both key informants and through document review was poor communication, and more specifically, follow-up with providers. Other weaknesses of the health system that were identified include a lack of providers (specifically specialists) and a lack of navigation services available.

Strategies (e.g. new services, programs, and policies) cited by key informants and through document review to address these barriers include providing culturally and linguistically appropriate education and navigation (to address myths, risk factors etc.), establishing trust via partnership with faith-based organizations, providing free screenings and other coverage, connecting patients with a primary care home, and addressing health literacy issues.

Camden County
The most frequently cited issues in the community related to breast health and breast cancer by both the key informant interviews and the document review were:

- Lack of education about breast health, screening guidelines, and available resources
- Language barriers (between patients and providers)
- Fear
- Transportation barriers
- Financial barriers (particularly co-pays and deductibles)
- Competing priorities (time and convenience)

The most substantial weakness of the health system identified by both key informants and through document review was a lack of navigation, which was also acknowledged as the most common cause of delay in progression through the continuum of care. A lack of navigation was defined as not having a navigator to assist with appointments, with understanding finances, and in understanding cancer plans. Other systemic weaknesses identified were poor transportation, lack of financial support, and language and cultural insensitivity.
Both the key informants and the document review noted changes in the health system since the implementation of the ACA, which included seeing more patients for diagnostic services and a reduction in those seeking free screenings (because more patients are now insured).

Strategies (e.g. new services, programs, and policies) cited by key informants and through document review to address these barriers include providing greater community outreach and navigation, psychosocial support and survivorship programs, and transportation assistance.

**Gloucester County**
The most frequently cited issues in the community related to breast health and breast cancer by both the key informant interviews and document review were:

- Access, which includes access for and to (e.g. education) rural populations, including transportation barriers
- Lack of education about breast health importance, guidelines, available resources, and program availability
- Fear

Other issues mentioned frequently include financial/insurance barriers (particularly coverage for screenings and also co-pays and deductibles), and language barriers.

The most substantial weakness of the health system identified by both key informants and through document review was a lack of education/outreach conducted by providers. Another systemic weakness identified was the need for more specialists in the area.

A key strategy (e.g. new services, programs, and policies) cited by key informants and through document review to address these barriers was to improve access to mammography screenings. In particular, the need for changes to NJCEED’s policies, which dictate that patients can only benefit from the services offered by the program (e.g. have diagnostics covered and be fast-tracked into the Medicaid program for treatment support) if they are initially screened at a NJCEED site, was discussed. This was cited as a major limitation for patients to access care throughout the continuum.

**Burlington and Monmouth Counties**
The most frequently cited issue in the community related to breast health and breast cancer by both the key informant interviews and document review was access to care (e.g. providers accepting Medicaid), with a strong emphasis on transportation barriers.

Other issues cited often in both communities were a lack of education about breast health (guidelines, importance of screening, and risk factors) as well as available resources, and also fear. In Burlington, language barriers were also highlighted while in Monmouth issues related to financial/insurance barriers (e.g. co-pays, premiums, and coverage delays) were more prominent. While in Monmouth it was universally agreed upon that there are many services available, in Burlington accessing treatment at certain facilities and accessing diagnostic services in rural areas were both areas of concern.

The most substantial weakness of the system identified by both key informants and through document review was access, with a strong emphasis on transportation barriers. The geographic proximity of health care facilities was identified as the main factor, with facilities...
described as being “too spread out” throughout the region to allow for equal access for all, with a specific concern about rural communities in Burlington.

A key strategy (e.g. new services, programs, and policies) cited by key informants and through document review to address these barriers was to provide more outreach (e.g. more staffing). In Monmouth, the need for navigation and for coverage beyond screening was also noted, while in Burlington having more services available overall was important.

**Salem and Cumberland Counties**

The most frequently cited issues in the community related to breast health and breast cancer by both the key informant interviews and document review were a lack of education (about screening importance and guidelines) and transportation (resources not available at all, limited hours, and/or too cost prohibitive).

Other issues mentioned frequently include a lack of screening and financial barrier/insurance issues (particularly among undocumented populations), and to a lesser extent fear and competing priorities.

The most substantial weakness of the system identified by both key informants and through document review was access, with an emphasis on the geographic location of services, and including unequal distribution of services, a lack of providers, and transportation barriers.

Key strategies (e.g. new services, programs, and policies) cited by key informants and through document review to address these barriers were to expand the services available through the NJCEED program, enhance transportation services, and provide more education/outreach programs.

**Qualitative Data Findings**

**Limitations of the Qualitative Data**

While every attempt was made to obtain a representative sample of the target communities, there were challenges to doing so. The majority of the target communities were sampled to saturation, meaning that key informants began saying the same thing over and over after a certain point and no new information was generated. For the target communities of Atlantic, Burlington and Monmouth, Camden, and Gloucester, consensus among key informants was achieved on most of the answers, therefore themes could be more easily extracted and basic conclusions drawn. However, in Salem and Cumberland, a smaller sample size was obtained than in the other communities, despite the Affiliate’s best efforts at recruiting. This sample size achieved is attributed primarily to the small number of resources available in this community overall. Thus, it was not feasible to obtain the best practice amount in some of the smaller communities, because of the dearth of resources available to meet the number.

The final sample in each community covered all major medical centers, all existing Komen grantees, and all major FQHCs. Difficulties were encountered in speaking with a representative from each of the smaller community hospitals and standalone screening facilities. It was challenging to identify a gatekeeper at these facilities, particularly when the Affiliate did not have a referral to initiate contact with. Additionally, many of these places felt they did not have the right person available to participate. Even when utilizing direct referrals, great difficulty was
encountered in securing interviews with small clinics, most of whom did not return repeated calls or emails. In all counties, the sample size targeted was greater than the best practice suggested and many attempts at contact, through multiple methods, were made to each potential resource. There were also quite a few cancelled interviews, for which even after multiple attempts, the targeted interviewer could not be found to reschedule. The large number of target communities also presented a substantially challenge in that additional resources were needed to tackle the large quantity of interviews needed.

Interviewer bias is noted as another limitation. However, an attempt to control for this was made by assigning two individuals to listen to the recordings, review transcripts, and extract themes/categories. Analysts were also careful not to make assumptions about information that was said anecdotally by one individual, looking instead for themes/categories to be confirmed by multiple sources.

The Affiliate acknowledges that the findings of the key informant interviews have limited generalizability to the larger population as a whole due to the small sample size and to the use of non-random sampling techniques. The findings also reflect the thoughts and opinions of some community leaders, but not all. Before beginning any major initiative or strategy change based on these findings, the Affiliate will perform its due diligence and conduct additional assessments if deemed necessary.

Limitations related to the document review include the potential for the selective survival of information and reviewer bias. Additionally, the CHNAs and journal articles used in the document review each acknowledged the limited generalizability of their findings and challenges encountered in obtaining a representative sample with their own focus groups and key informant interviews.

A final limitation acknowledged is that the Affiliate did not directly speak directly with the non-provider, non-expert population (due to time and resource constraints), although data related to this population (in the form of focus group findings) were available through document review sources and were utilized as a key resource throughout the analysis. Data from the community experts and the findings from document review sources were very informative and provided a solid set of data from which conclusions were drawn. The potential exists to build upon these findings in the future and conduct more assessments directly with community members to address key issues, if necessary.

Ultimately, the Affiliate has presented what was feasible, realistic, and reasonable given time and resource constraints, while making every attempt to meet best practice guidelines.

**Atlantic County**

**Greatest issues facing women in this community related to breast health and breast cancer:**
The most frequently cited issue was financial barriers, including a lack of resources for coverage after screening. The casino closings in Atlantic City were the most commonly cited concern.

"I would hate to see someone fall out of the health care system that needs the services just because they are afraid of the bill or they can’t afford the bill. It’s hard to think women aren’t getting preventive services because of the inability to pay.”
“We don’t have the services in place after a screening mammography turns positive. We are challenged with what we are going to do with this person now. We just fly by the seat of our pants to try and get them through as much as we can without them facing that big financial burden.”

“Our community has recently experienced a drastic rise in the number of unemployed and uninsured citizens. Due to the latest casino closings, thousands of people no longer have stable employment or they have experienced a great reduction in benefits with a raise in insurance premiums.”

Other issues discussed frequently include a lack of education about breast health (including the importance of screening and risk factors) and about available resources, as well as competing priorities (specifically the notion that women are more worried about basic needs and survival than health).

“People don’t want to know cancer is there until it is at their doorstep.”

“There is the commonly held belief that no one in my family has breast cancer, so I don’t have to have a mammogram.”

“Although there are a lot of resources out there, unless some of the patients have a social worker or case manager to help them identify the different resources that are available to them, if nobody lets them know, or you don’t know the programs are out there, then I guess you are not going to access them.”

Additional key issues cited include transportation barriers (including insufficient distribution of bus routes and poor access to public transportation), navigation, and a lack of services and providers (particularly specialists) available.

“Women can see general health care providers, but not specialized services like a breast surgeon or navigator; especially women who have no insurance or can’t drive off-shore.”

“There is only one clinic surgeon in the system, so you have to outsource. Then you no longer have good communication with the patients. Also, it is very overwhelming for the clinic surgeon to see everyone who has an abnormal diagnosis, and that will then lead to delays.”

“Buses don’t reach into the far little areas of the community. To go anywhere with public transportation requires women to walk a far distance.”

The most frequently cited populations to target to address these issues include Black/African-American and/or Hispanic/Latina populations, and the uninsured. The newly unemployed, low-income, Vietnamese and Atlantic City residents were all mentioned as well.

**The Continuum of Care:**
Key informants were asked to discuss barriers (individual and/or systemic) that exist at each stage of the continuum that may delay/prevent care. Barriers highlighted in yellow were
mentioned by more than one key informant, while those with asterisks were mentioned by the majority of informants (Table 4.1).

**Table 4.1: Barriers to care along the continuum, Atlantic County**

<table>
<thead>
<tr>
<th>Screening</th>
<th>Diagnosis</th>
<th>Treatment</th>
<th>Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial/insurance*</td>
<td>Lack of follow-up care due to*:</td>
<td>Financial/insurance*</td>
<td>Competing priorities/ lack of motivation*</td>
</tr>
<tr>
<td></td>
<td>-lack of education</td>
<td>-poor coverage for specialists</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-competing priorities</td>
<td>-co-pays</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-no physician reminder</td>
<td>-medication</td>
<td></td>
</tr>
<tr>
<td>Lack of education about:*</td>
<td>Cultural beliefs</td>
<td>Transportation*</td>
<td>Lack of education about:</td>
</tr>
<tr>
<td></td>
<td>-guidelines</td>
<td></td>
<td>-guidelines/standards</td>
</tr>
<tr>
<td></td>
<td>-resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural beliefs</td>
<td>Transportation</td>
<td>Lack of education</td>
<td>Cultural beliefs</td>
</tr>
<tr>
<td>Transportation</td>
<td>Fear</td>
<td>Fear</td>
<td>Transportation</td>
</tr>
<tr>
<td>Fear</td>
<td>Lack of providers</td>
<td>Lack of providers</td>
<td>Transient populations (e.g. homeless)</td>
</tr>
<tr>
<td>Lack of providers</td>
<td>Language</td>
<td>Access (support programs)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Competing priorities</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Navigation</td>
<td></td>
</tr>
</tbody>
</table>

**Follow-up on outstanding questions/issues identified in the Quantitative Data Analysis and the Health Systems and Public Policy Analysis:**

In discussing why Atlantic County has such a higher death rate among Blacks/African-Americans as compared to the rest of the Affiliate’s service area, the most commonly cited reason was late-stage diagnosis as a result of various factors including access to care (the most frequently cited), competing priorities, a lack of education about myths and available of resources, cultural beliefs, and risky lifestyle behaviors.

HRSA data indicated that a substantial portion of the population in this community lives in medically underserved areas, while the HSA Analysis findings identified what appeared to be numerous resources available in the county to address breast health across the continuum. The reason for this discrepancy was most often attributed to access. A need for more primary care physicians (to initiate referrals) and for more satellite offices representing the larger health systems in the area spread throughout the community were specifically addressed.

“**Hospitals are centered in certain areas, then directly around the hospital there are services. Doctors want to be close to the hospitals since it works with their practice, but we have areas that don’t have a lot of services or access to medical care now.**”

“**Health care tends to be closer to the shore where the bulk of the population is. Transportation is not good where the other people are.**”

In exploring whether there is an issue for those residing in more suburban or urban locations to access the NJCEED screening site (which was identified by the HSA as being located in a more rural area), a clear answer was not obtained. Some suggested there was an issue due to poor transportation. Others felt there was not a major issue because the main site is centrally located and there are additional satellite offices located throughout the region.
However, when asked if rural populations experienced issues accessing major medical systems, most thought they did to some extent, due primarily to transportation challenges (e.g. a long drive and poor/complicated access to direct public transportation). However several entities offering transportation (including a van through AtlantiCare, South Jersey Cancer Fund, LogistiCare, and Access Link) were discussed as potential solutions, as was the notion that there are more satellite locations being built in rural areas (although many still felt more locations are needed).

Lastly, there were no major transition issues (from diagnosis to treatment) noted for the AtlantiCare Health System, even though treatment is offered in a different location than other services, mainly because the treatment facility is in close proximity to the other services (about 15 miles).

Camden County

Greatest issues facing women in this community related to breast health and breast cancer:

The most frequently cited issue was a lack of education about breast health and breast cancer (including screening guidelines, the importance of screening, and risk factors) and about available resources. Much of the reason for the low level of awareness about the resources available was attributed to a lack of coordination of information and services in the community. Fear and mistrust, which are related to a lack of education, were also acknowledged as key issues, particularly among undocumented populations. A lack of knowledge about the resources available was specifically mentioned as a problem among low-income populations.

“There are conflicting reports about how frequently people should be getting mammograms. It confuses people, especially people who are afraid. They may not go. They think that since they have no family history they don’t need to be screened…they turn a blind eye to it. We need to dispel fear about mammograms being painful, to teach how important it is for women no matter if they have family history or not, and to go to a regular gynecologist appointment. We need to get the word out to people that it is a very quick test. It is not painful, just slightly uncomfortable."

“Some clients are afraid of discomfort with a mammogram, fear of diagnosis of cancer…or they just have total mistrust of the health care system.”

“There are no regular visits to gynecologists to get proper education about the importance of screening.”

Other issues discussed frequently include language/cultural barriers (including a lack of providers who speak the language and a lack of translators), which cause misperceptions and mistrust, transportation barriers (for rural populations, for Medicare populations, and for those accessing treatment), competing priorities (particularly for those living in poverty), and navigation.

“Language is a gatekeeper in accessing resources for life’s basic necessities including basic health and medical care. When they are able to access health care, linguistic and cultural differences between health providers and the newcomers cause communication unease for both parties so that follow-up instructions are misunderstood and medical care is compromised.”
“With unemployment and crime in Camden City, breast cancer takes a back seat to many things.”

“People living in poverty live on stretched incomes and have difficulty meeting day-to-day costs of living, leaving little room in their limited budget for anything beyond the essentials of food and shelter. As a result, their health becomes less and less of a priority for them until they are faced with a life or death situation, such as a late-stage diagnosis of breast cancer.”

“We are fortunate that we are saturated with health care in the area, but it comes down to the transportation. Being in the city of Camden there are two great hospitals. They can get there for the diagnostics but when it comes down to the actual treatment plans they need to go outside the actual city and that can become very cumbersome, in particular with Medicare population, who aren’t entitled to transportation. They need to have both Medicaid and Medicare, which is a hardship because a lot of seniors are just getting by. They don’t have family members readily available for them to help drive them.”

“Finding a reasonably cost-effective transportation service and trusting the company to pick up the patients for appointments is another challenge. Therefore, access to appointments for patients in rural towns can be an issue.”

Another key issue identified was financial/insurance barriers, and more specifically premiums and out-of-pocket expenses such as co-pays, deductibles, and prescription costs. Additionally, changes to the health system since the start of the ACA related to insurance status were noted.

“I’m seeing a lot of people for the first time, because they never had access. This is due to affordable care kicking in and to New Jersey expanding Medicaid. So I’m seeing more people coming in for diagnostics than ever before.”

“Our program has lost one-third of our patients to insurance since the ACA. The new health care law has challenged us to expand outreach to additional sites as the number of clients returning to our program has been reduced.”

The most frequently cited populations to target to address these issues were Black/African-American and Hispanic/Latina populations. Uninsured and underinsured populations were highlighted frequently as well, particularly those who fall outside the guidelines for assistance.

“I’m concerned with the women who work at Wal-Mart, Target or Home Depot, or the category of women who work for health care systems like nursing homes who do not have health insurance. They don’t qualify for insurance, even for the new marketplace, because the premium may be too high and they also make too much money to qualify for the NJCEED program.”

The Continuum of Care:
Key informants were asked to discuss barriers (individual and/or systemic) that exist at each stage of the continuum that may delay/prevent care. Barriers highlighted in yellow were mentioned by more than one informant, while those with asterisks were mentioned by the majority of informants (Figure 4.2).
### Table 4.2: Barriers to care along the continuum, Camden County

<table>
<thead>
<tr>
<th>Screening</th>
<th>Diagnosis</th>
<th>Treatment</th>
<th>Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of education about:*&lt;br&gt;-importance&lt;br&gt;-guidelines&lt;br&gt;-purpose&lt;br&gt;-resources</td>
<td>Lack of education about:*&lt;br&gt;-importance&lt;br&gt;-purpose&lt;br&gt;-resources</td>
<td>Lack of education about:*&lt;br&gt;-details of tmt. plan&lt;br&gt;-resources</td>
<td>Lack of education about:*&lt;br&gt;-importance</td>
</tr>
<tr>
<td>Financial/insurance*&lt;br&gt;(deductibles)</td>
<td>Financial/insurance*(co-pays,&lt;br&gt;-deductibles,&lt;br&gt;-challenges for the undocumented)</td>
<td>Financial/insurance*(co-pays)</td>
<td></td>
</tr>
<tr>
<td>Fear</td>
<td>Fear</td>
<td>Fear</td>
<td>Fear</td>
</tr>
<tr>
<td>Undocumented</td>
<td>Fear</td>
<td>Fear</td>
<td>Fear</td>
</tr>
<tr>
<td>Transportation</td>
<td>Denial</td>
<td>Competing priorities (child care)</td>
<td>Lack of support programs&lt;br&gt;-support groups&lt;br&gt;-survivors</td>
</tr>
<tr>
<td>Competing priorities (child care)</td>
<td>Language</td>
<td></td>
<td>Lack of staff (navigators)</td>
</tr>
</tbody>
</table>

**Follow-up on outstanding questions/issues identified in the Quantitative Data Analysis and the Health Systems and Public Policy Analysis:**

In discussing why Camden County has the highest rate of late-stage diagnosis in the entire Komen CSNJ service area, the most commonly cited reason was a lack of education, followed closely by a lack of early detection (through regular visits for preventive care) and fear. Other issues discussed include a lack of access for underserved populations, financial/insurance barriers, and the existence of a large minority community. Increasing outreach and awareness efforts (including tailored messaging), providing mobile mammography, and more navigation for the uninsured were all mentioned as strategies for addressing this issue.

In discussing why Camden County has the lowest screening percentage in the entire Komen CSNJ service area, the most commonly cited reason was a lack of education.

“All of the health care organizations in Camden need to do a better job of education instead of assuming people already know.”

Other issues mentioned that could be impacting this statistic include a lack of insurance coverage, poverty, and cultural barriers (including denial).

The most frequently cited reason why Camden County has the lowest survival rate and the second highest death rate in the entire Komen CSNJ service area was language barriers, followed closely by cultural beliefs (and fear related to those beliefs). Others potential reasons include barriers faced specifically by undocumented populations (e.g. fear of being deported), a lack of education/awareness about existing programs, late-stage diagnosis due to late screenings, and competing priorities related to low SES.

“Usually those of lower SES maybe work at Wawa, they make just enough to live, but not enough for public assistance, so going for screenings and paying for tests are not a priority.”
They are also dealing with kids and keeping a roof over their head. They have extended families that they’re responsible for. They work long hours and can’t take a day off.”

The most frequently cited strategy to address this issue was education/outreach about the importance of early detection to overcome fears, which includes providing more culturally appropriate messaging. Other strategies suggested include building greater trust among health care providers and patients, and providing more bilingual staff and translators.

The HSA identified what appeared to be a wealth of resources in the county that address breast health across the entire continuum. Most agreed with this finding, indicating that there are many programs and services available, but that accessing them is still a challenge. Additionally, there was consensus that there are an adequate number of resources available for poor populations to receive free or reduced cost care distributed throughout the entire county, including major hospitals (through charity care) and two NJCEED programs with both urban and suburban locations.

When asked to confirm whether the geographic location of the screening services (identified in the HSA to be concentrated mostly in the north/northeastern regions) impacts breast care in the area, most acknowledged the potential impact, indicating that there are population heavy areas where there are no resources available and that access could be a challenge. More satellite locations of the major health systems in the area were suggested. However, there were a few key informants who felt as though there were adequate resources available because while Lourdes and Cooper provide services in the city of Camden, Virtua and Kennedy hospitals still provide services outside of the city.

“For the people in rural areas, even if there is a bus, to get to that bus stop, it’s not like walking to a bus stop where there’s pavement. They are asking people to walk on roads that may or may not have sidewalks or guardrails. They’ll be able to get to a bus stop, but it’s a much more challenging route.”

Findings from the QDR and the Health Systems and Public Policy Analysis showed that despite the perceived wealth of resources in and around Camden City, the health outcomes in this area are still pretty poor. The most commonly cited reason for this was competing priorities.

“Health care takes a backseat to try and survive every day in a poor environment. They have to put food on the table and take care of their children…the last thing they worry about is their breast health that is not impacting them at the time. We need to provide them with a better system to take care of their socioeconomic concerns so we can make health care a number one priority. We need to develop quality programs that stress in a culturally appropriate, bilingual manner, the importance of breast care.”

**Gloucester County**

**Greatest issues facing women in this community related to breast health and breast cancer:**

The most frequently cited issue was access to care, particularly for the uninsured and for rural populations. Since much of the county was described as “farmland,” many felt that rural populations would be difficult to reach as a result.
“Many women, even those with the ability to pay, will not actively have a screening mammogram done if the situation is not convenient.”

Access to early screenings was described as one of the most pressing issues for the community. Access to those accepting Medicaid, specialists, bilingual providers, and to transportation were all mentioned as key issues as well. Improving transportation options was identified as a solution for patients to receive comprehensive care in this community.

After access, a lack of education about breast health guidelines and available resources was the most frequent cited issue. A lack of education was also the most frequently cited reason for potential delays at the screening stage of the continuum of care.

“When you hear breast cancer, you think, oh no I’m going to die, the treatments aren’t worth it, when really we’ve advanced so much.”

“The public has difficulty accessing services and finding ways to get information about available programs. We estimate that 35.0 percent of the populations that are eligible for our program don’t know they are eligible.”

Fear (of treatment and of applying for insurance) was also cited frequently.

“They are more afraid of the treatment than the disease and once they come into our organization, it is already stage four breast cancer.”

“People are more fearful of applying for a screening because they are supposed to have insurance now by law, so it is almost like they are admitting they haven’t gotten insurance.”

The most frequently cited population to target to address these issues was those who are low-income and likely uninsured. A specific emphasis was placed on the working poor, including small business owners.

“It’s not really about any particular race per se. It has more to do with the economics of the patients of our service area. There are more patients that are working poor here.”

“They are looked over (the working poor). It is automatically perceived that women who need services are down and out, like women in shelter, but what I have found in my outreach efforts is that is not our target population. The poor have Medicaid, and might need awareness, but they have the services to obtain screening. Their issue might be travel instead. The issue is for those whose income still isn’t great, and they can’t afford health insurance so they don’t go to the doctor unless there is a great need to go to the doctor. They are just getting by and even with the ACA they can’t afford healthcare. They fall just between the cracks.”

The Continuum of Care:
Key informants were asked to discuss barriers (individual and/or systemic) that exist at each stage of the continuum that may delay/prevent care. Barriers highlighted in yellow were mentioned by more than one informant, while those with asterisks were mentioned by the majority of informants (Figure 4.3).
Table 4.3. Barriers to care along the continuum, Gloucester County

<table>
<thead>
<tr>
<th>Screening</th>
<th>Diagnosis</th>
<th>Treatment</th>
<th>Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of education about:</td>
<td>Lack of education about:</td>
<td>Financial/Insurance</td>
<td>Lack of education about:*</td>
</tr>
<tr>
<td>-resources</td>
<td>-resources</td>
<td>-deductibles</td>
<td>-importance</td>
</tr>
<tr>
<td>-program eligibility</td>
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<td>-copays</td>
<td>-standards</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>-guidelines</td>
</tr>
<tr>
<td>Financial/insurance*</td>
<td>Fear</td>
<td>Transportation</td>
<td>Lack of staff</td>
</tr>
<tr>
<td>Competing priorities</td>
<td>Denial</td>
<td>Lack of education/navigation (insurance plans)</td>
<td>Lack of support programs</td>
</tr>
<tr>
<td>Transportation</td>
<td>Navigation</td>
<td>Quality care</td>
<td>Language</td>
</tr>
<tr>
<td>Access</td>
<td>Quality care</td>
<td></td>
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<tr>
<td>Language</td>
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</table>

Follow-up on outstanding questions/issues identified in the Quantitative Data Analysis and the Health Systems and Public Policy Analysis:

In discussing why Gloucester County has a high death rate among Blacks/African-Americans as compared to the entire Komen CSNJ service area, the most commonly cited reasons were late-stage diagnosis and fear and mistrust of the medical community.

“They don’t feel comfortable. The doctors don’t look like the minority communities being outreached to. They are most comfortable with someone who represents himself or herself.”

Other reasons cited included a lack of education (e.g. about resources available) and lack of access to care (e.g. transportation). Free screening programs and targeted outreach were highlighted as potential strategies to address this issue.

Other reasons cited included a lack of education (e.g. about resources available) and lack of access to care (e.g. transportation). Free screening programs and targeted outreach were highlighted as potential strategies to address this issue.

In discussing why Gloucester County has a high rate of late-stage diagnoses among those 65 and older as compared to the entire Komen CSNJ service area, the most commonly cited reason was a lack of education about care and about risk factors.

“They feel that after they hit a certain age, they don’t have to go for mammograms because there is nothing they can do anyway.”

Strategies mentioned to address this issue include visiting senior centers, building up trust (to overcome the “stubbornness”), and communicating with this population that “people with breast cancer diagnosis are now living and we are having success.”

The most commonly cited reason as to why some of the key breast health statistics (e.g. screening rates, death rates, and late-stage diagnoses) are so poor despite a relatively low incidence of breast cancer and socioeconomic indicators that are comparatively better than the rest of the Komen CSNJ service area, was a lack of trust in the health system and in particular, in the providers.
“I think it’s because of in the past our county health system hasn’t had the greatest reputation. It has come a long way in the past five to 10 years. We have a lot of partnerships with a couple different hospitals in Philadelphia. We have a great hospital now here in Washington Township. But what can happen is that with the years of a bad reputation, the people don’t have a trust in the healthcare system.”

Another issue cited was competing priorities, particularly among the working poor.

“In Gloucester, as it is in South Jersey, blue-collar workers and small businesses can’t take time off. There are a lot of mom and pop storeowners and entrepreneurs here. You have those who are not prioritizing health. I just don’t think their health is a major issue.”

Overall, there was consensus that there is an adequate amount of resources available to address breast health across the entire continuum, and that changing the statistics involves “getting the word out to the community.”

In terms of issues related to access, just as the findings from the HSA suggest, it appears as though the major resources are concentrated mostly in the northern region of the county. It was discussed that accessing the hospital in Washington Township can be problematic for people who live a distance away, particularly those who are in treatment. Some in this county might have to travel into Cumberland County or over the bridge into Philadelphia instead. The need for more satellite locations and for better transportation options was highlighted.

Access issues for rural populations were addressed as well, particularly in the most southern portions of the county, which are the furthest away from the largest concentration of resources. Transportation challenges, such as poor public transportation and lack of vehicle access were cited, in particular for farm workers (who may not have a driver’s license). Overall, the findings indicate a lack of transportation resources that can be attributed to a number of different issues including a lack of buses, a lack of awareness about availability, and inconvenient transportation schedules. While there are some already working on this issue, the need for more funding for programs that allow for an increase in the number of drivers and in the number of pick-up times was suggested.

“We have a van that can pick patients up for radiation, but that’s it. So if someone needs a mammogram and they don’t have Medicaid it can be difficult for them to get transportation.”

“Gloucester County does have transportation for the elderly and disabled but a lot of the people in our community aren’t aware of that and they need a week notice beforehand to get the transportation schedule, so it can be difficult.”

Burlington and Monmouth Counties

Greatest issues facing women in this community related to breast health and breast cancer:
The most frequently cited issue was access to care, with a specific emphasis on transportation barriers due to the sprawling (and in some instances rural) nature of this community. The most substantial weakness cited in this community was access to care due to the geographic proximity of health care facilities (e.g. they are too spread out to access and not evenly distributed) and other transportation challenges (e.g. inconvenient times and stops, no walkable
access to public transportation, and not enough routes). Additional access issues highlighted include a lack of providers (both primary care and specialty), a lack of translators, and in Burlington County in particular, problems accessing diagnostic care (in rural areas) and treatment services (at certain facilities).

“There aren’t adequate public transportation systems in place within the community. Buses don’t run often enough or take people close enough to their desired location. There is some transportation for seniors but it isn’t always reliable. Because the community is so spread out, walking isn’t always an option. People in this community need a car in order to get where they need to go in a timely manner.”

“You have people who are obviously ill. Even if they could drive, they can’t drive now and they need to get to treatment. And so there are some services out there. There are some senior services, American Cancer Society has some services. We’re going to probably say that they can’t take buses at that point. They certainly can’t walk, although I’ve heard nightmare stories where people were waiting for buses for like six hours, for five different buses that they had to take to get to chemotherapy. So there are services out there, but they’re just not sufficient.”

A lack of education/knowledge about breast health (guidelines, importance of screening, and risk factors) and available resources was also addressed as a key issue.

“The message that women don’t always get is that every year counts. A year is the difference between being diagnosed and not getting chemotherapy or having a larger cancer that has moved to other organs and now you are looking at a poorer prognosis.”

“The services provided are there and they’re excellent, but the community doesn’t know about them. They’re not educated about the available services.”

“I think we’ve always kind of gotten to the point where it’s not about developing new programs, it’s about creating awareness and making it more of a connected community in some way and increasing knowledge, awareness, about what services are out there. We struggle with trying to get people to come out to different programs all the time. I know that’s shared amongst many of the agencies.”

Financial/insurance barriers were also highlighted as key issues specifically in Monmouth County, with an emphasis on prescriptions, co-pays, and coverage for services beyond screening. In terms of insurance coverage, the issue extends beyond the barriers faced by being uninsured and includes issues such as delayed approval for procedures (particularly with Medicaid) and physicians not accepting Medicaid at all.

“We can provide access to mammograms with funding, but after they are diagnosed we don’t have the funds to move forward and they fall through the cracks.”

“They don’t have the health insurance so they don’t think they can have the services provided to them nor do they want to know about the services. It’s wishful thinking it will go away.”

“Even though this immediate area is kind of well off, as you go into the surrounding areas, there are a lot of people who are more middle class and lower class so they don’t have as much of
the economic ability to just go to the doctors whenever or avail themselves of the services that we do have."

“The majority of the women served are low-income and uninsured or underinsured. They cannot afford the cost of medical deductibles and co-payments and often make a choice between taking care of their own medical needs or their children’s medical needs. They routinely state that they would rather use their limited income to take their child to the pediatrician than pay for a mammogram.”

Language barriers and fear were specifically discussed in Burlington County.

“The greatest challenge experienced by the program staff is encouraging people who have had an abnormality found in their screening to come back for further work-up. Not all abnormalities result in a cancer diagnosis, but the fear of getting bad news is strong enough that many women and men do not want to undergo further testing that may result in a cancer diagnosis.”

The most frequently cited populations to target to address these issues were Black/African-American and Hispanic/Latina populations. Geographic areas mentioned include Keansburg, Asbury Park, and Union Beach (which was hit very hard by Superstorm Sandy).

“We are seeing more African-Americans diagnosed at later stages…not obtaining Obamacare, Medicaid, and insurances they should be obtaining. It’s not until there is an acute illness that they are seeking care…so, they are putting off wellness care.”

The Continuum of Care:
Key informants were asked to discuss barriers (individual and/or systemic) that exist at each stage of the continuum that may delay/prevent care. Barriers highlighted in yellow were mentioned by more than one informant, while those with asterisks were mentioned by the majority of informants Table 4.4 and Table 4.5). Separate tables are presented for each county in the target community because while the barriers cited in both counties were essentially the same, the emphasis placed on the importance of these barriers at various phases differed slightly by county.

Table 4.4. Barriers to care along the continuum, Burlington County

<table>
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<tr>
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<th>Treatment</th>
<th>Follow-Up</th>
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<td>Financial/insurance</td>
<td>Navigation</td>
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<tr>
<td>Fear</td>
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Table 4.5. Barriers to care along the continuum, Monmouth County

<table>
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<th>Treatment</th>
<th>Follow-Up</th>
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</thead>
<tbody>
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<td>Lack of education about next steps*</td>
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<td>-next steps</td>
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<td>-coverage options</td>
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<td>Language</td>
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<tr>
<td>Cultural</td>
<td>Fear</td>
<td>Fear</td>
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<tr>
<td>Transportation</td>
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<tr>
<td>Competing priorities</td>
<td>Access</td>
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Follow-up on outstanding questions/issues identified in Quantitative Data Analysis and Health Systems and Public Policy Analysis:

Burlington County:
When prompted to explain why Burlington County has a high percentage of late-stage diagnoses among Blacks/African-Americans compared to the entire CSNJ service area, with an increasing trend, key reasons cited include a lack of education (e.g. myths and not knowing the guidelines), trust, fear, and fatalism. Others issues cited included access, and in particular, transportation barriers.

“If they can’t get there, then it is going to be late-stage.”

The need for greater targeted education and outreach to address this issue was suggested, as was building trust using relevant community institutions (e.g. churches and exercise groups) and targeted messages.

“We need to do more than just pass out flyers. We need to tie education/awareness into action and show them that more people are surviving among their population.”

There was a general consensus that there is a wealth of resources in the county to address breast health across the entire continuum, although some still cited a need for more satellite locations in rural areas.

When asked to explain why despite the perceived wealth of resources in the county and the overall lack of major issues related to socioeconomic status, outcomes related to late-stage diagnoses are still increasing, top reasons cited include a lack of education about the importance of screening, screening guidelines, and available resources. Fear and trust were also mentioned. More education/awareness was cited as a strategy to address this issue.

“People are overwhelmed with the pink in October, so we need to let them know it is not just in October, and that just because October is over doesn’t mean breast cancer takes a holiday. People know programs are still out there throughout the year.”

There was consensus that there are accessibility issues for rural populations because the geographic locations of the major health systems not near the rural areas, and because of transportation barriers. Solutions mentioned include education about available resources, establishing more satellite locations, and providing mobile mammography screening.
Monmouth County:
In discussing why Monmouth County has high death rates and low survival rates among Hispanic/Latina populations as compared to the rest of the Affiliate’s service area, the most commonly cited reasons were late-stage diagnosis, lack of education (about importance of screening) and language barriers.

“They are just not seeking wellness care until there is an advanced situation or acute disease.”

The most commonly cited strategy mentioned to address this issue was more education. Specific suggestions included hosting events where the Hispanic/Latina population gathers most, improve their knowledge about coverage options, and collaborating with Hispanic/Latina community groups who best understand the language and the culture.

There was consensus that there is a wealth of resources in the county that address breast health across the entire continuum. When asked to explain why, despite the perceived wealth of resources in the county and the overall lack of major issues related to socioeconomic status there are still issues with health outcomes (e.g. low screening percentages and survival rates among Hispanic/Latina populations), the most commonly cited reasons were a lack of education (about screening importance) and competing priorities (e.g. they are too busy and/or are worried about other things). Other issues discussed were financial/insurance barriers, fear, and cultural barriers.

“For Hispanic/Latina populations, whatever the family says goes, because of that culture, and it being a large family unit of several generations. If family believes you are too young to have it, then it is ignored.”

Providing more culturally appropriate education and outreach programs about breast health importance was cited as a strategy to address this issue.

When asked to identify geographic pockets where there might be a concentration of issues, Freehold, Ocean Grove, Asbury Park, Neptune and Lakewood were all mentioned. Adding additional satellite facilities in these areas was suggested as an option to address these pockets of issues.

Salem and Cumberland Counties:

Greatest issues facing women in this community related to breast health and breast cancer:
The most frequently cited issues were a lack of education (including confusion over screening guidelines, the importance of screening, myths, and available resources), which can lead to fear, as well as issues obtaining screening due to insurance barriers. A lack of education about the reasons behind certain treatment choices was highlighted as a potential reason for delays at the treatment phase of the continuum. Available services are thought to be underutilized by residents who need them because they do not know what is available. Health literacy is believed to impact the acquisition of knowledge as well.

“Because women do not know that programs are out there, they do not have access to being helped. They will choose not to do anything.”
“The doctors need to explain why they need a second form of treatment and having this road bump causes delays in treatment.”

“Older women continue to present challenges by exhibiting barriers to mammography screening. They have lived this long without a mammogram and nothing has happened or they have heard about the impact of a friend’s painful experience with mammography technicians.”

“Getting women to return for follow-up visits presents a challenge to our Promotoras. We’ve found that many of these women are fearful of what a second screening may reveal and they tend not to reschedule their appointment.”

Lack of screening was also cited as a major issue, due in part to a lack of education, but also to financial/insurance barriers as well as numerous access issues including an unequal distribution of services and a lack of providers. Transportation was also cited as a key issue in both communities.

“The turnover rate for providers is very high. Funding runs out for grant-based services so the doctors will pick up and leave. The patients aren’t aware of this and expect the services to still be there and then they don’t know where to go.”

The most frequently cited populations to target to address these issues were Blacks/African-Americans and Hispanics/Latinas. Rural populations (i.e. those considered to live furthest from medical facilities) and the uninsured/underinsured were also mentioned, specifically those who cannot afford their coverage under the ACA and have “dropped out” as a result.

“We have not done a good job at all. Incidence is fairly low compared to the state, but mortality is high compared to the state. We have not done a good job reaching those people in pockets to screen and treat them.”

**The Continuum of Care:**
Key informants were asked to discuss barriers (individual and/or systemic) that exist at each stage of the continuum that may delay/prevent care. Barriers highlighted in yellow were mentioned by more than one informant, while those with asterisks were mentioned by the majority of informants (Table 4.6).

| Table 4.6. Barriers to care along the continuum, Salem and Cumberland Counties |
|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| **Screening**               | **Diagnosis**               | **Treatment**               | **Follow-Up**               |
| Lack of education*          | Lack of education           | Transportation*             | Financial/insurance*         |
| -guidelines                 | -significance               |                             |                             |
| -risk factors               | -seriousness                |                             |                             |
| -resources                  |                             |                             |                             |
| -importance                 |                             |                             |                             |
| Transportation              | Transportation              | Financial/insurance         | Lack of education/motivation |
| Financial/insurance         | Lack of communication/navigation | Lack of communication | Transportation |
| Fear                        | Fear                        |                             |                             |
| Language                    |                             |                             |                             |

Susan G. Komen® Central and South Jersey
Follow-up on outstanding questions/issues identified in the Quantitative Data Analysis and the Health Systems and Public Policy Analysis:

Salem County
In discussing why Salem County has the highest death rate in the entire Komen CSNJ service area, the most commonly cited issue was financial/insurance barriers, along with access issues due to limited resource availability and transportation barriers. These issues lead to late-stage diagnosis, ultimately contributing to more frequent deaths. Solutions include providing immediate access to coverage to avoid delays in treatment, providing more funding to the NJCEED program to serve a larger population, and greater resource availability.

There was consensus that there are few resources available to address breast health across the entire continuum in this community. A poor economy and a lack of transportation infrastructure were cited as key issues. A lack of coordination among agencies addressing similar issues was highlighted as a major issue. Of those resources that do exist, they appear to be concentrated mostly on the eastern and western boarders of the county, impacting access issues for the rest of the county. There was also agreement on a number of other potential access issues identified in the HSA including:

- There are no resources that offer biopsies, treatment or follow-up services in these counties, and that this impacts breast health/breast cancer in the area.
- There is an accessibility issue for eligible populations (e.g. the uninsured) to reach the NJCEED screening site. Inconvenient locations, transportation barriers, and limited hours (e.g. screenings can only be done on Tuesdays) were all cited as barriers.
- There are not enough resources for poor populations to receive free or reduced cost care, due to sparse, unequal distribution throughout the county.

“Places that don’t have the resources are less likely to be aware and take advantage of services.”

“They have a place to go, but the disadvantage is that it is in another county, and based on availability people will face long waits. Long wait times contribute to the fear. It is a mental missile. If they had their own facility for these areas that do necessary procedures they could reduce wait times, ease patients’ mentality, and provide necessary follow-up care.”

Greater outreach in the areas without resources (which would include increasing the number of staff) was cited as a potential solution, as was the provision of more services (e.g. specialists) in more centralized locations and through satellite locations, an increase in the availability of appointments to be more accommodating of schedules, and transportation improvements (including better routes and increasing availability).

Cumberland County
In discussing why Cumberland County has a low survival rate among Blacks/African-Americans as compared to the entire Komen CSNJ service area, the most commonly cited issue was delayed screening, while education/outreach about the importance of early detection was the most commonly cited strategy for addressing this issue.

In discussing why Cumberland County has a low survival rate among Hispanics/Latinas as compared to the entire Komen CSNJ service area, the most commonly cited reason was financial barriers/insurance, particularly among the undocumented.
“The treatment is probably different because they can’t afford the medication to go with the treatment.”

Strategies suggested to address this issue include focusing more on undocumented populations through bilingual outreach as well as the expansion of the NJCEED program, so that more support can be provided to reach this population.

There was consensus that the concentration of resources in the northern part of the service area impacts breast health because there are people who do not have access to vital education and resources as a result. The Cancer and Chronic Disease Coalition is working to target the areas outside of the northern part of the county to help improve access to resources. There also appears to be an accessibility issue for rural populations, and expanding bus routes was suggested as a part of the solution.

There was also consensus that there are not enough resources for poor populations, particularly given that some doctors do not accept charity care and that co-pays are likely a barrier as well. Expansion of the NJCEED program and providing greater support for undocumented populations were mentioned as potential solutions.

**Overall Conclusions**

Many of the barriers/issues identified translate across multiple counties in terms of their importance and impact on health behaviors and health outcomes. In all of the target communities there was emphasis on:

- Lack of education: related to understanding risk and the importance of screening, as well as the availability of resources.
- Access: includes issues such as a lack of specialists and a lack of physicians accepting Medicaid, as well as numerous transportation barriers (e.g. unsafe access to routes and limited hours) related to the uneven distribution of resources.
- Financial/insurance barriers: includes the need for support at all phases of the continuum, but the most frequently mentioned were co-pays, deductibles, prescriptions, and premiums.

While there seems to be consensus about the major barriers present in all the target communities, it is clear from the analysis that the level of influence and priority rankings are different in each community, as are the resources available to help address these issues. Therefore, while the general list of barriers might be the same, there are small nuances and different targets within each community. For example, in Atlantic County, there is the issue of the large newly unemployed and uninsured population due to casino closings in Atlantic City, which is unique to that community. In Camden County, racial/ethnic and language barriers were a large portion of the discussion related to poor health outcomes in a fairly resource-rich community. In Gloucester County, the issue appears to be more about the working poor population, such as small business owners, that fall through the cracks in terms of coverage. In Cumberland and Salem Counties, the issues seems to be related to poverty and a complete dearth of resources overall. In Burlington and Monmouth Counties, a picture was painted of a community that mostly has the resources available, but instead experiences access issues due to unequally distributed resources located in a sprawling community with pockets of disparities.
In comparison to some of the findings from previous Community Profiles conducted by the Affiliate, some major differences have appeared that may impact the focus of the Affiliate’s mission work going forward. One of the key differences is the importance of and the emphasis on individual verses systemic barriers. While there were many barriers identified for the continuum of care that are individual (e.g. fear and competing priorities), many of those that were identified are systemic barriers (e.g. transportation challenges, a lack of specialists, and the need for satellite locations) that will require complex strategies and new partnerships and collaborations to address effectively. The Affiliate’s programs have traditionally focused mostly on funding programs that address individual, rather than systemic barriers to care.

On a related note, the findings also suggest that a lack of education in the target communities is just as much about the providers as it is about the individuals. More specifically, a lack of education was perceived as both an individual and a systemic barrier. On the one hand, individuals might not comprehend the message due to literacy levels or fear, and might also be influenced by cultural beliefs or competing priorities. However, it is also perceived that individuals are not receiving the appropriate message initially about the risk factors and screening guidelines, and that they also do not have a clear understanding of the resources that are available. This is possibly because the availability of these resources is not being communicated at all, or at the very least is not being communicated effectively. This last set of issues can be attributed directly to the programs in these communities. Thus, while the emphasis has traditionally been on understanding why individuals do not act on the message, it seems maybe now it should also be on what the message says, how often it says it, and so forth. Additionally, it seems that the messaging might need to change depending on the phase of the continuum (and possibly within the county itself). For example, in moving from diagnosis to the treatment stage, the message might be about clarifying the various treatment options, while at the follow-up stage it might be more focused on the reasons to come back each year.

While the emphasis on education/outreach has never waned in the Affiliate’s work, much of the focus of late has been on supporting financial/insurance barriers (e.g. paying for screening and diagnostic services). While the importance of these services has not diminished, the findings suggest a need to possibly evaluate and potentially extend the types of services covered to include items such as co-pays and deductibles.

Traditionally, the Affiliate’s focus has been on providing funding for the screening phase of the continuum, and to a lesser extent, on diagnostic services. While the importance of these services has not diminished, the findings suggest a need to possibly evaluate and potentially extend the types of services covered to include items such as co-pays and deductibles.

It also appears that the chief issues in many of the target communities may not be a dearth of programs overall or major financial concerns. Instead, in some cases, it may be more about the need for improved access to those resources, which may then involve more complex factors such as the unequal distribution of resources overall.
In terms of transportation challenges, it seems that the issue may be far more complex than simply lacking the money to pay for transportation, and includes complex systemic challenges such as unsafe access to bus stops, inconvenient route times, and in a few cases in the more rural counties, about that lack of a system to begin with. In the past, the need for transportation funding has been acknowledged and supported, but strategies may need to expand to include establishing partnerships and collaborations among some of the key players in the target communities to help modify components of the infrastructure itself.

Overall, the findings suggest that the needs appear to have evolved far beyond free screenings, and include complex individual and systemic barriers that will be vital to address in order to impact health outcomes in the target communities. The Affiliate must now consider all that has been learned throughout the analysis, focusing on the greatest needs identified and the resources that exist (and those that may need still to be developed/enhanced) to address these needs, and develop realistic strategic priorities geared towards achieving the greatest impact in each the target communities identified while addressing what makes each of those communities unique.

Lastly, it is worth noting again that these conclusions are based on those who participated in this analysis, and are limited in their generalizability to the entire population in the target communities.
Mission Action Plan

Breast Health and Breast Cancer Findings of the Target Communities

Each section of the Profile provided a piece of the puzzle essential to develop the Mission Action Plan. The QDR (Section 1) served as the basis for the selection of the target communities, based primarily on Healthy People 2020 indicators. The additional data exploration provided in Section 2 allowed for a deeper dive into the quantitative data to help further identify and confirm the target communities and also to help identify other potential issues in these communities, including those related to minority populations. The Health Systems Analysis (Section 3) helped to identify systemic strengths and weaknesses as well as potential areas of collaboration. The HSA also helped to answer some of the key questions posed about the breast cancer and demographic statistics identified. The Qualitative Analysis (Section 4) provided the perspective of those who live and work in the target communities, using the CoC as a framework to identify barriers to care and other key issues impacting the statistical outcomes identified in the Quantitative Analysis as well as the potential systemic challenges and opportunities identified through the Health Systems and Public Policy Analysis.

The key findings presented for each of the target communities below provide an overview of the triangulation of the findings conducted for each target communities based on the key components of the entire Profile analysis (Quantitative, Health Systems and Public Policy, and Qualitative). These findings provided the basis for the Mission Action Plan, which is intended to serve as a strategic and targeted roadmap for the Affiliate’s Mission work.

Atlantic County

The Quantitative Analysis revealed that Atlantic County has the highest death rate among Black/African-American women in the Affiliate’s service area. Atlantic County’s five-year relative survival rate is considerably low in general, and among Blacks/African-Americans. A large percentage of the population is considered to be rural and medically underserved. The Quantitative Analysis results identified key issues to explore further in the Health Systems Analysis and the Qualitative Analysis including the availability and accessibility of health services (particularly given the rurality of this community), as well as identifying a potential explanation for the poor health outcomes affecting the Black/African-American population in this community.

The Health Systems Analysis revealed a wealth of breast health services available in Atlantic County addressing all facets of the CoC, including those that specifically target vulnerable populations. However, a key concern identified in the HSA was the unequal geographic distribution of resources, leaving the key question of the impact of accessibility (particularly for rural residents), including any transportation challenges, vital to address through the Qualitative Analysis.

The Qualitative Analysis identified the most frequently cited issues in the community related to breast health and breast cancer, which included financial barriers, a lack of education, competing priorities, and transportation barriers. Many of these issues were also given as potential explanations for the high death rate among Black/African-American women. The main reason why so much of the population is considered to be medically underserved, despite having a wealth of resources in the area, was primarily attributed to access in general, and more
specifically to transportation barriers (including insufficient distribution of bus routes and poor access to public transportation), and a lack of services and providers (particularly specialists) available.

**Camden County**

The Quantitative Analysis revealed that Camden County has the highest late-stage diagnosis rate and the lowest screening percentage in the entire Affiliate service area. Hispanics/Latinas living in Camden County are experiencing the lowest five-year relative survival rate among all counties in the Affiliate service area while a large percentage of Blacks/African-Americans are being diagnosed with breast cancer at a late-stage. The demographics in this area are quite poor overall given the high percentage of residents who have incomes below 250 percent the federal poverty level and no health insurance.

The Quantitative Analysis results identified key issues to explore further in the Health Systems Analysis and Qualitative Analysis, including the availability and accessibility of mammography screening services, in order to try to determine why screening prevalence is so low in an area where incidence is so high, particularly among Black/African-American and Hispanic/Latina women.

The Health Systems Analysis revealed that a major weakness in this county is the availability of comprehensive breast care services beyond the concentrated pocket of hospitals, creating an accessibility issue for those who live a substantial distance away in areas where comprehensive breast care resources are not as readily available. There also appeared to be a general lack of resources available for those who cannot afford them. Questions were raised about the ability and willingness of poorer residents to travel for care to the few locations that do offer services, as well as other potential access issues, including transportation challenges, given the dearth of comprehensive resources available and accessible to a substantial portion of the county’s residents.

The Qualitative Analysis identified the most frequently cited issues in the community related to breast health and breast cancer as a lack of education, language barriers, fear, transportation barriers, financial barriers, and competing priorities. Many of these issues were highlighted as potential explanations for why this county experiences high late-stage diagnoses, low screening percentages, and issues related to survival and late-stage diagnoses among minority populations. The Qualitative Analysis findings confirmed that there are many programs and services available, but accessing them is still a challenge. The potential impact on breast health outcomes of the existence of population heavy areas where there are no resources available was noted as a key issue as well. The most substantial weakness of the health system identified was a lack of navigation, which was also acknowledged as the most common cause of delay in progression through the continuum of care.

**Gloucester County**

The Quantitative Analysis revealed that while Gloucester County has a fairly low incidence rate, the death rate is high, which is a troublesome combination. The county has both high death and late-stage diagnosis rates. Despite better outcomes overall on socioeconomic indicators, Gloucester has one of the lowest proportions of women who reported obtaining screening mammography. Black/African-American women in this county are suffering from a death rate
that is notably higher than average while a large percentage of women ages 65 and older have experienced late-stage diagnoses.

The Quantitative Analysis results identified key issues to explore further in the Health Systems Analysis and the Qualitative Analysis including the quality and accessibility of mammography screening services in the area, with a focus on barriers impacting specific populations such as Black/African-American women and those 65 and older.

The Health Systems Analysis revealed that Gloucester County appears to have a fair amount of resources overall, including several hospitals that provide access to care along the CoC. However, a key concern identified in the HSA was the unequal geographic distribution of resources in this community, leaving the key question of accessibility (particularly for rural residents), including any transportation challenges, vital to address in the Qualitative Analysis. Additionally, strategies for improving access to comprehensive programs, particularly for those with transportation challenges coming from other screening and diagnostic facilities in the region, was also identified as a key issue to address with the key informants.

The Qualitative Analysis found that the most frequently cited issues in the community related to breast health and breast cancer were access (including transportation barriers, and particularly for rural populations), lack of education (among patients and conducted by providers), and fear. Many of these issues were given as potential explanations for why this county experiences high death rates among Blacks/African-Americans and high late-stage diagnoses among those 65 and older. The most commonly cited reasons as to why some of the key breast health statistics are so poor despite a relatively low incidence of breast cancer and unremarkable socioeconomic indicators, were a lack of trust in the health system and issues of competing priorities among the working poor. Access to early screenings was described as one of the most pressing issues for the community, particularly given the low screening percentages.

In terms of issues related to access, just as the findings from the HSA suggest, it appears as though the major resources are concentrated mostly in the northern region of the county, and that accessing treatment can be particularly problematic for those who live a distance away. Access issues for rural populations were highlighted as well, particularly in the most southern portions of the county, which are the furthest away from the largest concentration of resources. Overall, the findings indicate a lack of transportation resources that can be attributed to a number of different issues including a lack of buses, a lack of awareness about availability, and inconvenient transportation schedules. A lack of vehicle access was cited, particularly for undocumented farm workers.

**Burlington and Monmouth Counties**

The Quantitative Analysis revealed that both counties have fairly high incidence rates. In Burlington County, the percentage of late-stage diagnoses is high, while in Monmouth County the percentage of women who obtained a screening mammogram is low comparatively. Together the counties make up a considerably large population of women who are over the age of 40 and who identify as Black/African-American and/or Hispanic/Latina. In Burlington County, the percentage of Black/African-American women diagnosed with late-stage breast cancer is high comparatively, and this county has a high percentage of Blacks/African-Americans overall. In Monmouth County, the death rate for Hispanics/Latinas is high and the five-year relative survival rate is low comparatively.
The Quantitative Analysis results identified key issues to explore further in the Health Systems Analysis and Qualitative Analysis including why despite a lack of major socioeconomic issues in the area overall, some of the breast cancer rates appear as poor as they do. Also included were any potential issues impacting mammography screening in Monmouth County, and any potential barriers to care and/or gaps in care that may be impacting the particular minority populations experiencing poor breast cancer outcomes that were identified in both counties.

The Health Systems Analysis revealed that both counties appear to have an abundance of resources that address all facets of the CoC. However, given that the majority of the resources appeared to be located in specific pockets in each county, the question of accessibility issues (particularly for rural residents), including any transportation challenges, was vital to answer through the Qualitative Analysis in order to assess the potential impact. Additionally, the findings suggested a need for programs targeting Hispanic/Latina women in Monmouth County and additional programs targeting Black/African-American women Burlington County, given the issues of late-stage diagnoses and survival rates in these populations.

The Qualitative Analysis identified that the most frequently cited issue in the community related to breast health and breast cancer was access to care, with a specific emphasis on transportation barriers due to the sprawling and in some instances rural nature of this community. Accessibility issues cited included the geographic proximity of health care facilities (e.g. they are too spread out to access and not evenly distributed) and other transportation challenges (e.g. inconvenient times and stops, no walkable access to public transportation, and not enough routes).

There was a general consensus in the Qualitative Analysis findings that there is a wealth of resources in this area to address breast health across the entire continuum, although some still cited a need for more satellite locations in rural areas. There was also consensus that there are accessibility issues for rural populations both because the geographic locations of the major health systems are not near the rural areas and because of transportation barriers.

Other issues cited often in both communities were a lack of education about breast health and fear. Financial/insurance barriers were also highlighted as key issues specifically in Monmouth County, while language barriers were highlighted in Burlington County. These were the issues most commonly cited as potential explanations for why these counties experience issues related to poor breast health outcomes, particularly among minority populations.

Salem and Cumberland Counties
Salem and Cumberland Counties were chosen because of their high death rates, low screening prevalence, low five-year relative survival rates, and unique socioeconomic characteristics. In particular, Salem County has the highest death rate among all counties in the Affiliate service area, while Cumberland County has many issues related to breast cancer indicators in addition to being the poorest county in the service area. The majority of Salem and Cumberland Counties' residents live in rural and medically underserved areas. Both counties are also among the top five counties with residents who have substantially higher unemployment, and substantially lower education and income levels. Both counties experienced low screening prevalence in the last two years, and have fairly high percentages of late-stage diagnoses and low five-year relative survival rates. Major racial and age disparities exist in both counties.
The Quantitative Analysis results identified key issues to explore further in the Health Systems Analysis and the Qualitative Analysis including the availability of breast cancer services in these rural and medically underserved communities, as well as whether the available services are affordable, culturally sensitive, and accessible given the racial and age disparities identified in both counties.

The Health Systems Analysis revealed that this target community has a dearth of resources compared to the other target communities. Salem County has little to no resources available that span the entire CoC, and the few that do exist in Cumberland are concentrated in the northern portion of the county. In Salem County, there are no places to go for biopsies or treatment, and residents must travel to Vineland (in Cumberland County). In Cumberland County, Vineland is the only location providing treatment. Besides the NJCEED sites, there really are no programs for vulnerable populations to receive free or reduced cost care.

Key questions to answer in this community through the Qualitative Analysis included how best to maximize existing resources and coordinate a more seamless transition through the CoC, the pervasiveness and level of impact of access issues, including transportation challenges, and whether there are sufficient programs that target certain vulnerable populations, such as minorities.

The Qualitative Analysis results identified that the most frequently cited issues in the community related to breast health and breast cancer were a lack of education and transportation barriers. Other issues mentioned frequently included a lack of screening and financial barrier/insurance issues (particularly among undocumented populations), and to a lesser extent fear and competing priorities. Many of these issues were cited as potential explanations for why this community experiences poor breast health outcomes, particularly among minority populations.

The most substantial weakness of the system was identified to be access, with an emphasis on the geographic location of services. Access issues identified included the unequal distribution of services, a lack of providers, and transportation barriers. There was consensus in the Qualitative Analysis findings on a number of issues identified in the HSA, with the chief finding being that there are few resources available to address breast health across the entire continuum in this community. This is believed to impact breast health because there are many residents who do not have access to vital education and resources as a result. Of those resources that do exist, they appear to be concentrated in certain pockets, impacting access issues for the rest of the community. There was also agreement on a number of other potential access issues identified in the HSA including that:

- There are no resources that offer biopsies, treatment or follow-up services in these counties, and that this impacts breast health/breast cancer in the area.
- There are not enough resources for poor populations to receive free or reduced cost care, due to sparse, unequal distribution throughout the county.
Mission Action Plan

The Mission Action Plan was developed to focus on addressing three key problem areas identified in all of the target communities: education and outreach, access, and financial coverage, as well as crosscutting issues identified that impact all aspects of the Mission Action Plan. The priorities and objectives are intended to address more specific issues identified related to each of the problem areas and are specific to certain target communities when relevant to the specific findings in these communities.

EDUCATION & OUTREACH

Problem Statement
The most substantial weakness identified in all target communities was a pervasive lack of education about breast health and breast cancer, as well as about the availability of existing resources and programs. A lack of education was also the most frequently cited reason for potential delays at various stages of the continuum of care that can contribute to poorer health outcomes. Low health literacy levels impact the acquisition of knowledge, while available services are underutilized by residents who need them because they do not know what is available. This is further complicated by issues such as competing priorities and cultural barriers, which can often lead to and be influenced by psychosocial issues such as fear.

Priority: Increase provider awareness about and develop collaborative solutions for addressing the lack of comprehensive, consistent, and coordinated information available for patients about breast health, breast cancer, and community resources in the target communities of Atlantic County, Camden County, Gloucester County, Burlington and Monmouth Counties and Salem and Cumberland Counties.

- Objective 1:
  By the end of 2015, meet with at least two different professional organizations that represent providers (e.g. The Medical Society of New Jersey) to develop a strategy for engaging providers throughout the target communities around the lack of education issue.

- Objective 2:
  By the end of 2016, hold at least three collaborative meetings for groups of providers from at least three of the target communities to share strategies and best practices for addressing the lack of education issue.

- Objective 3:
  By the end of 2017, collaborate with provider groups (e.g. professional organizations and groups from health systems in the target communities) to develop and disseminate a targeted educational campaign aimed at encouraging providers within the target communities to address issues relating to a lack of education among their patients.
**Priority: Collaborate with patient navigators and social workers to improve patients’ from the target communities’ knowledgebase of breast health and breast cancer information and of existing community resources and to empower patients to more effectively navigate the continuum of care.**

- **Objective 1:**
  Beginning with the 2016-17 grant cycle, revise the community grants program’s RFA to include financial support in the target communities for patient navigators that focus specifically on providing breast cancer navigation as a funding priority.

- **Objective 2:**
  Beginning with the 2016-17 grant cycle, revise the community grants program’s RFA to require that all applicants provide a detailed plan that outlines the processes in place to connect women with the necessary resources and care at every phase of the Continuum of Care.

- **Objective 3:**
  By the end of 2016, hold at least three collaborative meetings for groups of navigators/social workers from at least three of the target communities to share strategies and best practices for addressing the lack of education issue.

- **Objective 4:**
  By the end of 2017, collaborate with navigator/social worker groups to develop and disseminate a targeted educational campaign aimed at encouraging navigators/social workers throughout the target communities to address key issues related to a lack of education among patients.

**Priority: Support culturally and linguistically appropriate educational programs designed to meet the unique needs of minorities and other at-risk populations and decrease barriers to care by utilizing tailored messaging and strategies as well as partnerships with trusted community institutions.**

- **Objective 1:**
  By November 2015, hold at least two specialized grant writing workshops aimed at existing grassroots organizations who specifically target minority populations that were identified on the resources map for each of the target communities.

- **Objective 2:**
  Beginning with the 2016-2017 grant cycle, revise the community grants program’s RFA to give priority to programs that implement innovative and evidence-based outreach efforts that specifically target Black/African-American populations in Atlantic, Burlington, Camden, Cumberland, and Gloucester Counties.

- **Objective 3:**
  Beginning with the 2016-2017 grant cycle, revise the community grants program’s RFA to give priority to programs that implement innovative and evidence-based outreach efforts that specifically target Hispanic/Latina populations in Camden, Cumberland, and Monmouth Counties.

- **Objective 4:**
  Beginning with the 2016-2017 grant cycle, revise the community grants program’s RFA to give priority to programs that implement innovative and evidence-based outreach efforts that specifically target undocumented populations in Camden, Cumberland, Gloucester, and Salem Counties.

- **Objective 5:**
Beginning with the 2016-2017 grant cycle, revise the community grants program’s RFA to give priority to programs that implement innovative and evidence-based outreach efforts that specifically target the 65+ population in Gloucester County.

**Priority: Develop new and maintain existing Affiliate-based initiatives that address the lack of awareness about and existence of clear, consistent, accurate, and complete breast health and breast cancer information and comprehensive resources for patients from the target communities.**

- **Objective 1:**
  By July 2015, ensure that the Affiliate’s web-based Community Resource Guide is deemed comprehensive and is available for utilization by reaching out to and soliciting feedback from existing and potential partners identified on the resource maps.

- **Objective 2:**
  Beginning with the 2016-2017 grant cycle, revise (on an annual basis) all Affiliate educational messaging and marketing materials to reflect clear and consistent screening guidelines and culturally and linguistically appropriate messages about breast cancer risk factors.

- **Objective 3:**
  Beginning with the 2016-2017 grant cycle, train (on an annual basis) applicants through the applicant training session to deliver clear and consistent screening guidelines and culturally and linguistically appropriate messages about breast cancer risk factors.

- **Objective 4:**
  By the end of 2016, collaborate with at least one grassroots organization and one health care institution in Atlantic County and in Salem/Cumberland Counties to provide a culturally appropriate breast health event where women ages 40+ can sign up for a mammography appointment and access targeted educational information.

- **Objective 5:**
  By the end of 2017, collaborate with at least one grassroots organization and one health care institution in Camden County and in Burlington/Monmouth Counties to provide a culturally appropriate breast health event where women ages 40+ can sign up for a mammography appointment and access targeted educational information.

**ACCESS**

**Problem Statement**

All target communities identified numerous issues related to the uneven distribution of resources. In Camden, Burlington, and Monmouth Counties, residents must travel to specific pockets within the county to access care, as services are not equally distributed. Access issues are most pervasive in the rural and underserved target communities of Atlantic, Cumberland, and Salem, which have a dearth of resources overall. Transportation barriers inherent in all counties compound the challenges related to the distribution of resources and include complex systemic challenges such as unsafe access, limited hours, and insufficient distribution of bus routes. Challenges cited related to accessing providers include a lack of specialists available, a lack of physicians accepting Medicaid, a lack of primary care providers to initiate referrals, and a lack of providers who speak the appropriate language.
Priority: Maintain an ongoing dialogue with health systems in order to develop collaborative solutions for increasing access to providers at all phases of the Continuum of Care within the target communities.

- **Objective 1:**
  By the end of 2015, meet with key NJCEED program leaders, particularly those in Salem and Cumberland Counties, to discuss access issues cited in these communities including inconvenient screening site locations and limited screening site hours.

- **Objective 2:**
  By the end of 2016, meet with at least two different professional organizations representing providers (e.g. The Medical Society of New Jersey) to develop a strategy for engaging providers throughout the target communities around the lack of access to key providers issue.

- **Objective 3:**
  By the end of 2017, hold at least three collaborative meetings for groups of providers from at least three of the target communities to share strategies and best practices for addressing the lack of access to key providers issue.

Priority: Provide opportunities through the community grants program and through the establishment of key partnerships to enhance provider and patient communication within the target communities as it relates to linguistic challenges as well as the importance of connecting with a primary care home as a regular source of care.

- **Objective 1:**
  Beginning with the 2016-2017 grant cycle, revise the community grants program’s RFA to require that all programs that target linguistically isolated populations outline a plan which demonstrates their ability to provide all program services (e.g. presentations, materials, and care) in the appropriate language.

- **Objective 2:**
  Beginning with the 2016-2017 grant cycle, revise the community grants program’s RFA to require that all patients who are referred for care (either directly on-site or through referrals to sites) must be connected with a primary care home upon completion of their care and evidence of this connection must be documented in the program outcomes.

- **Objective 3:**
  By the end of 2016, meet with key leaders from the New Jersey Primary Care Association to discuss a potential partnership related to FQHC’s and their focus on connecting patients with a primary home model.

Priority: Address the awareness about and availability of transportation to screening, diagnostic, and treatment services in order to improve access to vital services integral to improving health outcomes in the target communities.

- **Objective 1:**
  By June 2016, convene at least one transportation meeting with key players (e.g. the Offices on Migrant Health and Aging) in each of the target communities in order to build new relationships and develop innovative and collaborative approaches to mobilizing existing resources (e.g. AccessLink, senior community vans, etc.) to comprehensively address transportation issues.
Objective 2: 
Beginning with the 2017-2018 grant cycle, revise the community grants program’s RFA to provide priority funding in the target communities for innovative and collaborative approaches that mobilizing existing resources to comprehensively address transportation issues.

FINANCIAL COVERAGE

Problem Statement
Financial and insurance barriers were identified as major problems at all phases of the continuum, with the most frequently mentioned barrier being support for services beyond screening as well as for out-of-pocket costs. The most pervasive financial issues were identified in Atlantic, Cumberland, and Camden Counties, where there are a myriad of issues related to poverty, educational attainment, and unemployment. Socioeconomic factors have been extensively linked to breast cancer disparities in care and poor health outcomes. This is evident in the breast cancer outcomes in these communities.

Priority: Provide support for services beyond screening, including diagnostics and out-of-pocket costs (including co-pays, deductibles, prescriptions, and premiums) for underinsured, working poor populations in order to decrease disparities in care in the target communities.

Objective 1: 
Beginning with the 2016-2017 grant cycle, revise the community grants program’s RFA to give priority to programs that use innovative and evidence-based approaches to reach underinsured, working poor populations in need of support for services beyond screening in the target communities.

Objective 2: 
Beginning with the 2016-2017 grant cycle, revise the community grants program’s RFA to require that all programs that make referrals (and do not screen directly on-site) provide a letter of agreement outlining their partnership with a referring hospital system to provide screening and follow-up care on-site.

Objective 3: 
By the end of 2016, hold collaborative meetings with at least three grassroots organizations that already provide financial support for services beyond screening (e.g. for prescription coverage) to residents of the target communities to discuss potential partnership opportunities.

Objective 4: 
By the end of 2016, collaborate with Komen North Jersey to develop a strategy to address the Breast and Cervical Cancer Treatment Act at the state level in order to move legislation to Option 3 (which would allow for patients to receive services through the NJCEED program even if they did not receive their initial screening at a NJCEED screening site).

Objective 5: 
By the end of 2017, hold strategic meetings with at least three different potential sponsors to explore the possibility of establishing a cancer fund that would be managed by an external grantee and would cover support for breast cancer services beyond screening.

Objective 6: 
By the end of 2018, hold strategy meetings with at least three different health systems in the target communities to explore the complexity of and potential for treatment coverage.
Priority: Support financial navigation for those needing financial assistance in order to decrease barriers to care in un- and under-insured populations in the target communities.

- **Objective 1:**
  Beginning with the 2016-2017 grant cycle, revise the community grants program’s RFA to require that all programs that receive funding to make referrals or directly provide care must provide a financial counseling component for those in need of financial assistance.

Priority: Support free mammography screenings in the target communities with the lowest screening percentages in order to decrease barriers to care and improve health outcomes through early detection.

- **Objective 1:**
  Beginning with the 2016-2017 grant cycle, revise the community grants program’s RFA to give priority to programs that implement innovative and evidence-based outreach strategies and provide free screenings for uninsured populations in Gloucester, Camden, Cumberland, Salem, and Monmouth Counties.

- **Objective 2:**
  Beginning with the 2016-2017 grant cycle, revise the community grants program’s RFA to require that all grants programs that target uninsured populations for free screenings must make an initial referral to the NJCEED program to see if the patient qualifies for services.

- **Objective 3:**
  By the end of 2016, collaborate with at least one grassroots organization and one health care institution in Camden County to offer a screening event where women ages 40+ can receive a free mammography screening on-the-spot and access targeted educational information.

- **Objective 4:**
  By the end of 2017, collaborate with at least one grassroots organization and one health care institution in Gloucester County to offer a screening event where women ages 40+ can receive a free mammography screening on-the-spot and access targeted educational information.

Priority: Provide support for special vulnerable populations within the target communities identified as experiencing extensive barriers to care, including financial difficulties.

- **Objective 1:**
  Beginning with the 2016-2017 grant cycle, revise the community grants program’s RFA to give priority to programs that implement innovative and evidence-based strategies that improve access, decrease financial barriers, and enhance outreach efforts for undocumented populations in Camden, Cumberland, Gloucester, and Salem Counties.

- **Objective 2:**
  Beginning with the 2016-2017 grant cycle, revise the community grants program’s RFA to give priority to grants programs that implement innovative and evidence-based strategies that improve access, decrease financial barriers, and enhance outreach efforts for casino workers impacted by recent casino closings in Atlantic City (Atlantic County).
Priority: Revise grantmaking priorities as necessary to respond to the Affordable Care Act

- **Objective 1:**
  By August 2015, hold regional meetings for current grantees to discuss the Affordable Care Act and what changes they are seeing to their programs as a result.

- **Objective 2:**
  Beginning with the 2016-2017 grant cycle, implement changes to the RFA for the community grants program and any corresponding grantwriting workshops as necessary to reflect the changing health care landscape (e.g. emphasize the need for quality grants that reduce financial barriers to necessary diagnostics and treatment).

- **Objective 3:**
  Beginning with the 2016-2017 grant cycle, ensure that all Affiliate-led and grantee initiatives and programs targeting uninsured populations provide appropriate linkages to information about obtaining coverage through the Affordable Care Act.

**CROSSCUTTING**

**Problem Statement**
There are numerous issues that impact the efficiency and efficacy of the Affiliate’s Mission work that cut across all of the problem areas (education & outreach, access, and financial) identified.

Priority: Increase the quality of the applicant pool, applications, and programs for the community grants program to ensure identified gaps in the Continuum of Care are addressed in the target communities.

- **Objective 1:**
  By September 2015 (and on an annual basis each September), hold two grant writing workshops for the target communities aimed at existing breast health providers identified on the resource maps.

- **Objective 2:**
  By August 2015 (and on an annual basis each August), work with at least three grantees to strengthen the evaluation of their grant projects in order to improve the overall quality of their programs.

Priority: Develop and utilize partnerships and encourage collaborative efforts among grantees to more effectively and efficiently promote breast health education, breakdown financial and cultural barriers, and seamlessly connect patients with key resources throughout the Continuum of Care in the target communities.

- **Objective 1:**
  From FY16 through FY19, annually convene a coalition of key players to collaboratively address major issues identified in each of the target communities by sharing strategies and best practices.

- **Objective 2:**
  From FY16 through FY19, work to strengthen the Affiliate’s relationship with NJCEED program by meeting biannually with NJCEED program leaders to maintain a dialogue that will address the needs of those at risk of or burdened by breast cancer and by attending quarterly NJCEED meetings, which bring together NJCEED providers in the state.
References


