

Tennessee Multi-Regional Community Engagement and Outreach Plan

SelfMade Health Network (SMHN)

Regional Resource Lead Organization - Meharry Medical College



BREAST CANCER PREVENTION AND SURVIVORSHIP

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Supported by DP13-1314 National Networks to Reduce Cancer and Tobacco Related Disparities.



Dear Fellow Tennessee Communities and other Stakeholders:

Funded since 2016, the Community Engagement Roundtable organizations (Roundtable) comprised of breast cancer coalitions and partners from across the state of Tennessee including the Tennessee Department of Health Office of Minority Health, social services agencies, breast cancer advocacy organizations, breast cancer organizations, breast cancer centers, breast cancer survivorship groups, breast cancer screening and hospital services, churches, and businesses, have worked together to develop this Community Engagement and Outreach Plan.

We are proud to present the 2017-2018 Tennessee Multi-Regional Community Engagement and Outreach Plan. This Plan presents goals, objectives, strategies and approaches for disseminating breast cancer education and resources from the SelfMade Health Network, Center for Disease Control Prevention, American Cancer Society, American Lung Association, the Intercultural Cancer Council, and other national and local resources. These resources are aimed at improving the health of low resourced (including low-income) women including Black (African-American) women along the continuum from cancer prevention to survivorship. It provides guidance for designing, implementing, evaluating, and monitoring cancer-related actions and addressing an array of concerns, issues, and solutions.

The Plan provides directions in understanding the cancer health disparities landscape in Tennessee and ways forward to reduce cancer health disparities through education, employers/ businesses, academic institutions, non-profit community- based organizations and other major decision makers. Members of the community, policymakers, healthcare providers, patients, cancer survivors, and other health care experts will benefit from the guidance the plan provides.

We offer our appreciation to the members of the Roundtable and the coalition members for their commitment to developing and implementing the 2017-2018 Tennessee Multi- Regional Community Engagement and Outreach Plan Roundtable Plan. Join us in the fight against breast cancer.

Cordially,

A handwritten signature in blue ink, reading "Pat Matthews-Juarez". The signature is fluid and cursive, with a large, stylized initial "P" and "J".

Pat Matthews-Juarez, PhD, Professor
Regional Resource Lead Organization
Department of Family and Community Medicine



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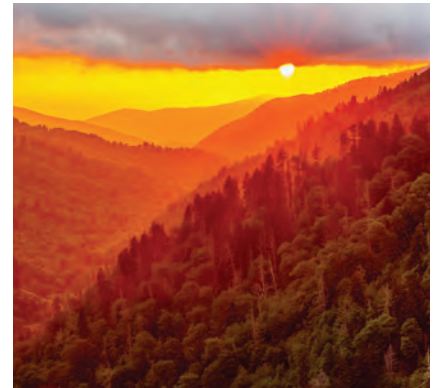
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Introduction

Breast Cancer and
Women's Health

Introduction

Breast Cancer and Women's Health:

The Importance of Addressing and Reducing Breast Cancer (Late/Advanced Stage) among Low-Income Women

There are approximately 15.5 million cancer survivors in the United States. Among cancer survivors, the most common cancer sites include female breast (23%, 3.6 million), prostate (21%, 3.3 million), colorectal (9%, 1.5 million), gynecologic (8%, 1.3 million) and melanoma (8%, 1.2 million).¹ In the United States, approximately 1 in 8 women will develop breast cancer during their lifetime. In Tennessee, cancer was the second leading cause of death among all Tennesseans. In addition, Tennessee women who died of breast cancer died nearly 10.4 years earlier than expected.² Although cancer impacts people of all ages, races/ethnicities, genders as well as varying levels of education and income; some populations bear a disproportionate burden of cancer compared to others. Differences in an array of factors such as: genetics, hormones, populations with environmental exposures, and other factors can contribute to differences in risk, morbidity (illness) and mortality among different populations.³ As noted by the National Cancer Institute (NCI), cancer disparities are defined as differences in cancer measures including: incidence (new cases), mortality (deaths), morbidity (cancer-related health complications) survivorship (including quality of life following cancer treatment), screening rates, stage at diagnosis as well as burden of cancer or related health conditions.

More specifically, the relationship between socioeconomic status (SES) and stage of breast cancer is complex. There is a critical need to understand more fully social determinants of disease burden along with behavioral, environmental (e.g. community) and other contextual characteristics that influence women's access to and use of breast cancer services across the breast cancer continuum from risk and prevention to treatment and mortality in order to address cancer health inequalities or disparities. Disparities in cancer screening and treatment exist across other domains of disparities including age, health insurance status, and socioeconomic status.⁴ Late or advanced cancer can potentially translate into unnecessary coverage or healthcare costs, potential days missed from work, financial strain, reduced or significant loss of household income, psychological distress, etc.

In the United States, significant differences in breast cancer mortality rates exist. Breast cancer mortality rates are higher among African-American (Black) women than White (Caucasian) women. The mortality gap is widening as the breast cancer incidence rate increases in African-American (Black) women, which historically in the past had been lower than that in White (Caucasian) women. However, in recent years, the breast cancer incidence rate has caught up or increased to that in White (Caucasian) women.⁵ Compared to White (Caucasian) women, African-American (Black) women are more likely to be diagnosed with "triple- negative" breast cancer, a kind of breast cancer that often is aggressive and returns after treatment. Moreover, African-American (Black) women are less likely to survive for 5 years following cancer diagnosis and breast cancer mortality rates are approximately 40% higher among African-American (Black) women compared to White (Caucasian) women.⁶ Numerous factors account for these differences such as: having more aggressive cancers, socioeconomic factors and other factors.⁷



Socioeconomic disparities reflect inequitable access to opportunities and resources such as: employment or work, annual household income, education, housing, and overall standard of living, as well as healthcare-related barriers related to high-quality cancer prevention, early detection, and treatment information and services along the cancer continuum. Higher mortality rates among African-American (Black) women potentially reflects a combination of factors including differences in stage at diagnosis, and comorbidities, and tumor characteristics, as well as access, adherence, and response to high-quality cancer treatment. Late stage diagnosis among African-American (Black) women has been largely attributed to lower frequency of breast cancer and longer intervals between recommended mammograms, and lack of timely follow-up of abnormal results. Lower stage-specific survival has been explained in part by unequal access to and receipt of prompt, high-quality cancer treatment among African-American (Black) women compared to White (Caucasian) women.⁸

In addition, only 69% of African-American (Black) women begin breast cancer treatment as within 30 days of diagnosis compared to 83% of White (Caucasian) women. African-American (Black) women are also more likely to be diagnosed with breast cancer at later stages of the disease, and experience delays in treatment of two or more months after initial diagnosis. Long intervals between screening, lack of timely follow-up of suspicious results, and delays in treatment post-diagnosis likely contribute to the lower stage-specific survival among African-American (Black) women.⁹

Evidence demonstrates a greater risk for advanced stage breast cancer at diagnosis, and also worse survival rates in neighborhoods of lower socioeconomic status, and among low-income women. Yet, there are limited or minimal studies that examine whether greater risk of advanced stage disease at diagnosis is due to characteristics of women within neighborhoods, characteristics of the neighborhood itself, or a combination of these factors.¹⁰



Cancer-3: Reduce the female breast cancer death rate

Cancer-11: Reduce late-stage female breast cancer

Cancer-13: Increase the proportion of cancer survivors who are living 5 years or longer after diagnosis

Female breast cancer is one of the medical conditions reflected in the Healthy People 2020 national objectives. Although breast cancer remains the second leading cause of cancer deaths among women, breast cancer mortality rates remain higher among African-American (Black) women, followed by White (Caucasian), Hispanic, Asian/Pacific Islander, and American Indian/Alaska Native women. Compared with Caucasian (White) women, breast cancer incidence rates are higher among black women who are younger than 60 years old, but lower among black women who are 60 years old or older.¹¹ However, between 65-84 years of age, White (Caucasian) women (non-Hispanic) possess higher rates of breast cancer compared to African-American (Black) women.¹²

Among the country's 50 largest cities, the breast cancer mortality disparity is highest in Memphis, Tennessee.¹³ Several critical factors associated with higher breast cancer mortality rate including: lower median household income, as well as financial and geographical barriers to care² may contribute to breast cancer disparities.

As a result, a primary role of the Regional Resource Lead Organizations (RRLOs) is advance Healthy People 2020 Objectives from a geographic and culturally relevant perspective to eliminate health disparities and through the establishment of partnerships with other organizations subsequent expand to impact lives in additional states. Since 2016, Meharry Medical College located in Nashville, Tennessee is one of SMHN's designated Regional Resource Lead Organization (RRLO).

To achieve these objectives, Meharry Medical College RRLO role in Tennessee involves creating and promoting health equity affecting low-income African-American (Black) women who are potentially at risk for breast cancer in counties and reduce the number of all low-income Tennessee women who die at rates greater than the national, state and county averages. As part of a broader multi-phase approach, an initial strategic focus involving six Tennessee counties: Haywood, Williamson, Knox, Fayette, Davidson, Lauderdale, and Shelby occurred.^{14,15}

These efforts involve investing in community-based cultural interventions such as breast cancer education along with community engagement involving a range of organizations and aligned with breast cancer survivors representative of low income, and underserved communities is an integral part of RRLO's approach.

Factors Associated with Breast Cancer Disparities

An overview of the current literature identifies a number of factors that impact breast cancer mortality rates among African-American (Black) women including biology, social determinants, lifestyle, health literacy, cultural competency of providers, and access to health care services.

Breast cancer prognosis varies considerably by subtypes. Differences in tumor morphology not only dictate treatment but also correlated with prognosis. For example, triple-negative breast cancer (a breast cancer subtype that does not have estrogen receptor, progesterone receptor, or HER2 protein) is a more aggressive tumor associated with a lower survival and is diagnosed more often among African-American (Black) females.¹⁶

There is a significant amount of evidence supporting the biological basis of racial disparity which originates at genetic/epigenetic, hormonal, tumor biology level and includes diet and lifestyle as well contributing to breast cancer disparities in African-American (Black) and Caucasian (White) women.¹⁷

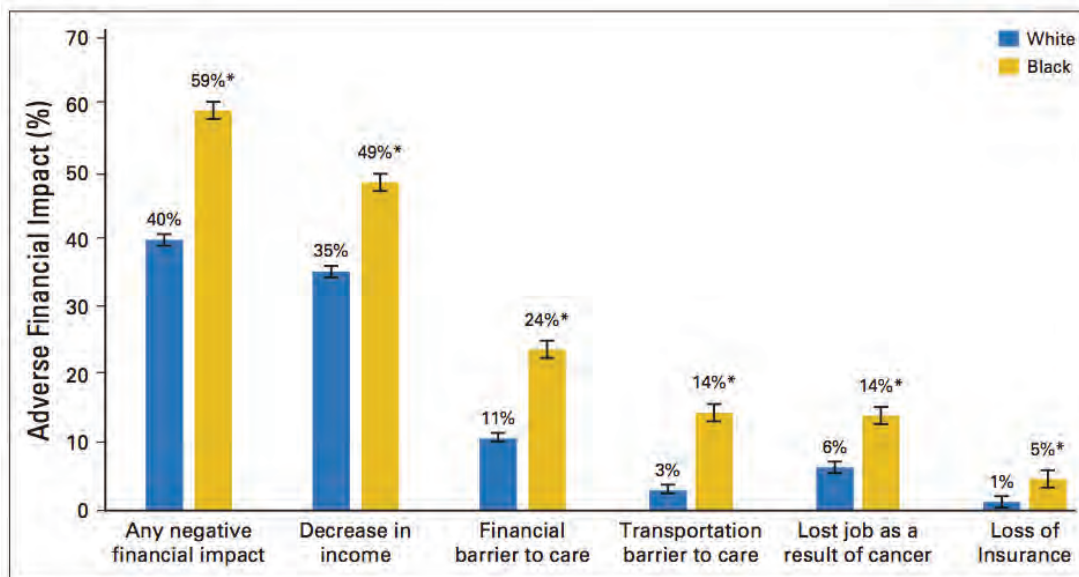
Compared with White (Caucasian) women, African-American (Black) women more frequently are found to have tumor subtypes with a poorer prognosis, especially the triple negative subtype. African-American (Black) women are more likely than White (Caucasian) women to be diagnosed with triple-negative breast cancer, a kind of breast cancer that often is aggressive, more difficult to treat than other subtypes of breast cancer and sometimes return after treatment.¹⁸ Women with first degree relatives who have been diagnosed with breast cancer also have a higher risk of developing the disease.

In addition to age at first live birth, women with first degree relatives diagnosed with breast cancer as well as the number of first-degree relatives with breast cancer are also considered at higher risk for developing breast cancer.¹⁹

While the overall incidence rate of breast cancer for African-American (Black) women is 10% lower than for White (Caucasian) women, breast cancer mortality rates are approximately 40% higher among black women compared to white women. and are diagnosed more frequently at a regional or distant cancer stage



Figure 1. Unadjusted Probability of Adverse Financial Impact Among Women by Race



Financial Barriers

Some studies reveal that African-American (Black) women diagnosed with breast cancer experience a significantly worse or adverse financial impact attributed to numerous factors (shown in Figure 1). And as a result, a disproportionate financial strain may contribute to higher levels of stress, lower treatment adherence or compliance, and worse cancer outcomes by race. Moreover, high cancer-related financial burden has been shown to affect treatment choice, treatment compliance, and cancer-related outcomes.²⁰ Current studies also reveal that differences in health insurance coverage explains about 35% of the excess risk of death in African-American (Black) women compared to White (Caucasian) women. In addition, differences in tumor characteristics explained about 20% of a African- American (Black) woman's excess risk of death from breast cancer.²¹ Policies that help to limit or alleviate this cascade effect are needed.

Lifestyle

In addition to family history and other biological factors associated with breast cancer, lifestyle factors including weight, nutritional deficits, and physical inactivity all have been associated with a higher risk of breast cancer. Obesity or a higher body mass index (BMI) has been associated with advanced breast cancer at diagnosis, high tumor proliferation rates, and more triple-negative

phenotypes, indicating that it may adversely contribute to prognosis. A modest increase in risk of breast cancer among post menopausal women. Among post menopausal women, those who are classified as obese possess a 20% to 40% increase in risk of developing breast cancer compared with women with a normal weight (based on body mass index).²² Breast-feeding, in contrast, has been found to be associated with lower breast cancer risk, especially if a woman breastfeeds for longer than one year.²³



Health Care Services

Declines in breast cancer mortality among women has been attributed to numerous factors such as advances in early detection and treatment. However, not all populations have benefited equally. Disparities in access to care, screening, follow-up, treatment initiation and completion after diagnosis, quality of care received, and differences in adherence to recommended mammography intervals all have been associated with breast cancer.

Race/ethnicity and sociodemographic factors may influence a woman's adherence to current recommendations for clinical breast examination, breast self-examination, or screening mammogram and the likelihood of seeking timely and appropriate care in the event that a breast mass is detected.²⁴

Barriers to healthcare access that result in underutilization of breast cancer screening, delays in diagnosis and treatment, and a later or advanced stage at diagnosis also contribute to these differences between racial and ethnic populations. In addition to behavioral and cultural differences, a lower rate of adequate surgical treatment and a lower proportion of patients receiving adjuvant therapy among African-American (Black) patients is noted as a contributing factor.²⁵

Low socio-economic status (SES) continues to remain a consistent marker for mammography underuse or underutilization; women with lower SES are more likely to be uninsured and lack a routine source of healthcare services. Several reasons account for the breast cancer screening disparity associated with low SES women are multifactorial and include inadequate cancer prevention knowledge and behaviors, lower levels of health literacy, lower educational attainment, and suboptimal access to routine healthcare services.²⁶ Fewer African-American (Black) women receive the recommended surgery, radiation, and hormone treatments. Some studies have revealed that racial/ethnic disparities associated with the receipt of a cancer-directed therapy, radiation therapy after breast-conserving surgery, clinical staging, and adjuvant therapy continue to exist.²⁷



Mammogram

Cultural Competency and Health Literacy

Cultural differences, exacerbated by socioeconomic factors, are a major determinant of unequal access to cancer prevention, screening, optimal standard care and cancer survivorship care. Cultural competence is increasingly considered a major factor, contributing to the elimination of disparities in healthcare and reduce the burden of unequal cancer treatment.²⁸ Cultural competency and health literacy both influence how illness is defined, how health messages are transmitted and perceived, how symptoms are described, when and where care is obtained, and how treatment options are considered.²⁹

Cultural and linguistic competence is a combined set of behaviors, attitudes, and policies that come together in a system, agency or among professionals that enables more effective work in cross-cultural situations.³⁰ Cultural competency is defined as the acquisition and integration of knowledge, with awareness, attitudes, and skills about culture and cultural differences that enables healthcare professional to provide optimal and expert care to patients from different racial, ethnic, socio-economic, and cultural backgrounds the integration of patterns of human behavior that includes language, thoughts, communications, behaviors, customs, beliefs, values and institutions of different racial, ethnic, religious, and /or social groups.³¹



Low health literacy has been associated with decreased use of preventive services, increased use of emergency services, poorer medication adherence, and increased likelihood of having a chronic disease, and poorer health outcomes.³² According to The Institute of Medicine (IOM), health literacy should be understood and viewed in the context of language and culture.³³ IOM defines health literacy as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions”.³⁴ The IOM now known as the The National Academies of Sciences, Engineering, and Medicine (NASEM). Health literacy is not always constant, but is a dynamic state that may change with the situation or certain diagnosis. For example, a patient’s health literacy can plummet when presented with a cancer diagnosis.³⁵

Upon closer examination of race, it has been revealed that upon addressing the role of culture and psychosocial issues that affect African-American women, key psychosocial and cultural issues or multiple barriers may exist including: fear, distrust, fatalism, anxiety, faith, lack of empowerment, real or perceived racial discrimination, putting one’s family needs above one’s own needs, the role of the extended family, among other factors.³⁶ In addition, low-income African-American women primarily are concerned with immediate economic and societal needs.³⁷ Guidry and Matthews-Juarez (2002) also noted that some barriers African-American (Black) women experienced were tied to geographical location and lack of healthcare services offered.³⁸





Purpose and Overview

Purpose and Overview

The Meharry Medical College RRLO seeks to advance health equity efforts in Tennessee by partnering with national, state and local organizations committed to economically disadvantaged and overburden communities.

Designated as a “Regional Hub” of engagement, training, dissemination and community-clinical linkages, the Regional Resource Lead Organization (RRLO) at Meharry Medical College has “taken on” an important role to reduce Breast Cancer disparities among African-American (Black) women and other low-resourced female populations.

As part of this approach, Meharry Medical College RRLO defined the term “low-resourced” women as female populations that possess any or a combination of characteristics including: living near or at the federal poverty level, residing within a geographic area possessing limited access to primary care or specialty health services, as well as a deficiency of other services such as: transportation, low-income housing, childcare or located in a food desert (lack of grocery stores, farmers’ markets, and healthy food providers).

One overarching goal of this Tennessee Multi-Regional Community Engagement and Outreach Plan is to increase awareness and a commitment among organizations in their efforts to reach, influence, inform, engage and support women with low socioeconomic status (SES) characteristics. Therefore, establishing non-traditional partnerships became essential due to the complex and multi-faceted challenges faced by all low-income women; including women considered at high risk for breast cancer well as those diagnosed with breast cancer.

As Meharry Medical College RRLO strives to provide greater insight and guidance about breast cancer disparities among partner organizations, and other major stakeholders; additional goals of this Community Engagement and Outreach Plan include:

- Encourage organizations to incorporate breast cancer disparities into their strategic planning processes or plans as well as state chronic disease plans or other health-related reports or documents
- Influence organizations to consider the inclusion of breast cancer disparities as a community priority or within their organizational model or employee health programming.
- Encourage organizations to plan and implement or enhance existing coordinated, breast cancer interventions (state, community-level) that take into consideration disparities impacting breast cancer survivors as part of their strategic approach
- Strengthen or establish multi-level linkages among organizations seeking to increase community collaboration and capacity breast cancer disparities among African-American (Black) women or other low-income (female) populations residing in urban, rural and other medically underserved areas.
- Mobilize organizations seeking to increase the number African-American (Black) and other low-income (including low-resourced) women with becoming knowledgeable about breast cancer survivorship and prevention through culturally-tailored interventions
- Cultivate, educate and strengthen organizations seeking to change attitudes and beliefs about breast cancer health or breast cancer disparities through culturally-tailored interventions including workshops, focus groups, and educational or events.
- Influence organizations to consider the inclusion of breast cancer disparities as part of their community health needs assessment (CHNA).
- Encourage organizations to consider developing partnerships (involving breast cancer disparities) while addressing solutions related to county health rankings.
- Increase awareness among new partners (including non-traditional organizations), thereby leading to an increase in low-income women utilizing services provided by the Tennessee Breast and Cervical Screening Program and other organizations.

Meharry Medical College (SMHN Regional Resource Lead Organization) established new partnerships as well as leveraged existing partnerships. A community-based participatory approach to create this Community Engagement and Outreach Plan. This model consisted of engagement with breast cancer survivors, community resource organizations as well as state, local along with national agencies, businesses, churches, and other organizations to learn, examine and address factors experienced by primarily African-American (Black) women along with other women representing populations with low socioeconomic status (SES) characteristics. This plan was conceived by utilizing Self-Made Health Network's partnership suggestions. As a result, this approach adopted by Meharry Medical College RRLO involved engagement with both traditional organizations such as; cancer education programs as well as non-traditional organizations. For example, partnerships with Goodwill Industries, Women's Rescue Mission, Men's Health Network, Nashville Career College and other organizations were established.

Over the last two years, strategies included the convening of roundtables, focus groups, (including educational workshops) as well as teleconferences and community-related events.

Action Steps:

1. Contacted existing organizations via e-mails and telephone calls.
2. Reached out to new organizations and utilized a key informant process
3. Established routine scheduled meetings both face to face and teleconferences with a defined agenda, garnered continuous feedback, and evaluated programming using a plan, study, do, and act process(PSDA).
4. Used personal networks from focus groups to expand the number of low-resourced women reached.
5. Invited low-resourced women to attend work-group meetings in their communities.
6. Utilized social media such as Facebook and customized website to disseminate information and cancer education materials.



Roundtable Meetings and Focus Group Sessions

In recent years, the roundtable meetings were structured and facilitated by the Meharry Medical College RRLO and comprised of organizations representing a broad array of sectors.

Summary of Findings: Organizational Level

- Urgent Care Centers also utilized as a routine source of medical care.
- Additional information is needed about how to access to affordable mammography services among low-income women that do not meet the income eligibility requirements for services provided by the Tennessee Breast and Cervical Screening Program.
- Additional information is needed on how low-income women can easily access affordable primary care physicians and specialists as part of the referral process to confirm a breast cancer diagnosis and receive follow-up care.
- Increased access to healthcare providers along the entire cancer care continuum and information about health insurance coverage (including estimated out-of-pocket expenses) are needed to account for expenses associated with cancer treatment and post-treatment survivorship (e.g. cancer recurrence, testing, follow-up care and recovery).
- Although information about breast cancer treatment exists, in some cities, towns or counties; gaps continue to exist among low-resourced women in services or ancillary/supportive networks. Examples include: affordability or availability of healthcare or

other services (including specialists) within or in adjacent communities as well as challenges navigating the cancer care system, transportation issues, etc.

- Of specific concern by the Regional Resource Lead Organization (RRLO) Roundtable members was how to ensure that low-income women (including African-American women) residing in rural areas or communities are connected with breast cancer resources and appropriate services in a timely manner prevent the onset of late-stage breast cancer.

The focus groups are led by a breast cancer survivor or a professional who has empathy and compassionate about breast cancer and may have been a professional social worker in oncology or related field. These leaders of workgroups are instrumental in expanding awareness and reach throughout community networks. Members are recruited from churches, colleges, civic and service organizations. The focus groups attendance range is between 7 and 25 adults depending on the subject matter.

Over the course of two years, nearly 90% of the focus group participants reported as breast cancer survivors. In addition, approximately 20% of participants were 18-44 years of age and approximately 75% of participants were 45-70 years of age. Most participants are low-resourced women who are at risk for breast cancer or are survivors and are concerned about second occurrences of breast cancer. In addition, 70 male adults participated in focus group as a form of support and also provided feedback. Over 300 low-income women participated in focus groups during this period.

Conference Affiliation Statement: Preliminary results were featured as a poster presentation at the 2017 Tenth American Association for Cancer Research (AACR) Conference on The Science of Cancer Health Disparities in Racial/Ethnic Minorities and the Medically Underserved. Poster: Investing in Public-Private Partnerships to Address Breast Cancer Disparities among African-American Women (Low-Income) within a Non-Medicaid ACA Expansion State and Appalachian Region

Summary of Findings: Individual Level

- Breast cancer affects the entire family.
- Males would be supportive of their significant other diagnosed with breast cancer, if they had acquired a better understanding about breast cancer and the “whole picture” concerning breast cancer treatment.
- Fear of marriage and relationship disruption as a result of breast cancer diagnosis or corresponding treatment are involved.
- Lack of access to primary care physicians in areas where women are employed (where applicable) and live (reside).
- Solutions to address inadequate or lack of health insurance covering the “full scope” breast cancer care are recommended.

Common reasons that lead African-American (Black) women and other low-income women and who may hold fatalistic views to participate in breast cancer screening or routine medical care include:

- 1.) Influence or encouragement by family members.
- 2.) Persistent symptoms that cannot be ignored any more.
- 3.) Interest in improving or living a good quality of life.
- 4.) Wellness program offered at job.
- 5.) Affordable health insurance coverage (with minimal or no co-payment).
- 6.) Access to primary care services and other facilities if diagnosed.

Common reasons cited by low-income African-American (Black) women and other low-resource women about a lack of participation in breast cancer screening or routine medical care include:

- 1) Influence from husband or significant other.
- 2) Fear and fatalism (fear that death is inevitable).
- 3) Lack of health insurance (uninsured).
- 4) Unemployed or temporary employment status.
- 5) Lack of access to primary care services and facilities and.
- 6) Lack of awareness about breast cancer education and services.

Additional findings are reflected in the section: Tackling the Disparity Gap in Breast Cancer Awareness and Prevention





Partnerships

Partnerships:

American Cancer Society

* Bethel Village

Carin' and Sharin Breast Cancer Education Group

Cervical Cancer Coalition

Chattanooga First

Claiborne Family of Faith

*Common Table Health Alliance

Connect Us Ministries

East Tennessee State University – College of Public Health

*Fisk University

*Fortis Career Institute

*Goodwill Industries

Greater Christ Temple

Greater Revelations Baptist Church

*Hospital Corporation of America

Intercultural Cancer Council

The Links, Parthenon Chapter

The Links, Nashville Chapter

The Links, Music City Chapter

Meharry – Vanderbilt Alliance

*Men's Health Network

*Metro General Hospital

*Metro Public Health Department (Nashville/Davidson County)

*100 Black Women

Metropolitan Interdenominational Church

*Nashville Career College

Nashville General Hospital Mammography Unit

PWC – People Who Care

*Saint Louis University – School of Public Health

Sisters Network- Nashville Chapter

St. Thomas Health Mobile Mammography

Susan G. Komen for the Cure

*Tennessee Area Health Education Center (AHEC)

*Tennessee Cancer Coalition

*Tennessee Cancer Consortium

*Tennessee Department of Health-Breast and Cervical Cancer Program

*Tennessee Department of Health – Office of Minority Health and Disparities Elimination

Tennessee: Men's Health Network

*Tennessee State University – Women's Health TG, Incorporated

*Vanderbilt – Ingram Cancer Center (Vanderbilt University Medical Center)

*Women's Rescue Mission

YMCA (Tennessee)- Breast Cancer

*Please note: Asterisk * denotes organizations that participated in Roundtable Meetings*

Additional Support:

Meharry Medical College – Health Disparities Research Center of Excellence

Meharry Medical College –

- Department of Family and Community Medicine
- Center for Women's Health
- Department of Pediatrics

Lessons Learned

Working closely with each organization to continually address how participation occurs while retaining the organization's identity.



Results from the Pilot Phase

Highlights, Unanticipated Findings and Recommendations

The pilot phase involved a review of the Tennessee Community Engagement and Outreach Plan. This plan was reviewed by a committee comprised of 10 members organizations representing nearly 100 organizations.

The Meharry RRLO adopted an approach similar to a community of practice whereby a group of people who share a concern or a passion for something they do, engage and learn how to improve as they interact regularly.

Committee Feedback:

- Identify potential opportunities for future use of the Tennessee Multi-Regional Community Engagement and Outreach Plan by a variety organizations and sectors.
- Discuss and propose ways in which the Tennessee Mutli-Regional Community Engagement and Outreach Plan can be used by organizations to address social determinants of health both traditional and non-traditional and historical challenges or barriers related healthcare access, patient navigation and limited health literacy as well as cultural factors contributing to racial/ethnic differences in cancer screening, diagnosis, and and geographically cancer survivorship.
- Suggest ways in which the Tennessee Multi-Regional Community Engagement and Outreach Plan can be used by organizations and policymakers to address breast cancer disparities from a geographic lens encompassing breast cancer survivors residing in metropolitan communities as well as those residing in rural counties or other medically underserved areas.
- Reinforce the importance of ensuring breast cancer services along the continuum are provided, affordable and that strategies developed be culturally relevant, have the potential to be replicated in local communities, and to allow low-income African-American (Black) women and other low-income populations to

be comfortable in accessing resources without fear of judgment. Explore innovative way to present breast cancer prevention and survivorship services in a manner that is considered “welcoming” An emphasis was expressed regarding the importance of The National Standards for Culturally and Linguistically Appropriate Services (CLAS) standards as important for increasing the delivery of patient-centered care.

- Dr. Matthews-Juarez who founded the collaborative breast cancer coalition as a holistic group in Memphis, emphasized the importance of continuing to advance health equity efforts in the state by collaborating with local community-based organizations committed to serving economically disadvantaged communities located in both rural and urban/metropolitan areas.

Invite a cross-section of women from the community to include women of various backgrounds, level of education, life experiences and all “walks of life” including:

- 1) African-American (Black) women who are very vocal and not always tactful in the delivery of their perspective which is often of great value.
- 2) African-American (Black) women who are younger than the traditional groups. Approximately 11% of all new breast cancer cases exists in women younger than 45 years of age.³⁹ Breast cancer is diagnosed at an earlier age in African-American (Black) women compared to Whites (Caucasians).
- 3) The Tennessee Department of Health and Tennessee Office of Minority Health and Disparities Elimination emphasized the need for additional “safe spaces” within communities where people would feel comfortable to meet and engage in ongoing dialogue. This included traditional spaces such as: libraries, churches, and other meeting rooms in local community-based organizations.



An abbreviated version of a SWOT analysis was conducted by the Meharry RRLO to determine which strategies might be employed in addition to Focus Groups, the Christmas Goes Pink event, and other community engagement strategies to expand reach among African-American (Black) women and other low-income populations across the state of Tennessee. Strengths, weaknesses, opportunities, and threats were discussed and they include::

Strengths: Building and maintaining breast cancer coalitions, community based organizations, agencies, groups, and members across the state. Maintaining responsiveness to their respective issues within their cultural context.

Weaknesses: Identifying gaps and ensuring continuous access to a variety of resources, while including financial assistance for breast cancer treatment, transportation, as well as patient navigation to achieve patient-centered in cancer care and care coordination including chemotherapy.

Opportunities: Promote more inclusive membership to breast cancer coalitions, community based organizations, agencies, historically non-traditional groups, and members across the state for greater involvement in breast cancer awareness, education, and breast cancer survivorship.

Threats: The inability of organizations and some groups to obtain and retain adequate funding for breast cancer education, screening, or ancillary services support. Another threat is the transitioning of members of the various community-based organizations and groups, who may have been diagnosed with breast cancer late or advanced.



Community Engagement and Outreach

Community Engagement and Outreach

Highlights

The Meharry Medical College RRLO began to leverage resources, and establish new community-clinical linkages by bringing in new partners such as the St. Thomas Mobile Van and the Links, INC and to enhance our relationships with our existing partners and collaborators. The Annual “Christmas Goes Pink” event was an example of leveraging resources in which 16 organizations from the Roundtable and 520 women came together with speakers to participate in a cancer awareness and education day at Meharry Medical College. One of its unique features, is the involvement of experts providing education and resources about lifestyle changes (exercise, nutrition, smoking cessation), health services (free mammograms, dental screenings, blood pressure checks), and addressing health literacy among persons who are diagnosed with breast cancer, have been diagnosed, have a family history, and those who are not aware of breast cancer resources.

Live Just As You Are (Facebook) <https://www.facebook.com/LiveJustAsYouAre/>

Twitter:@livejustasweare <https://twitter.com/livejustasweare>

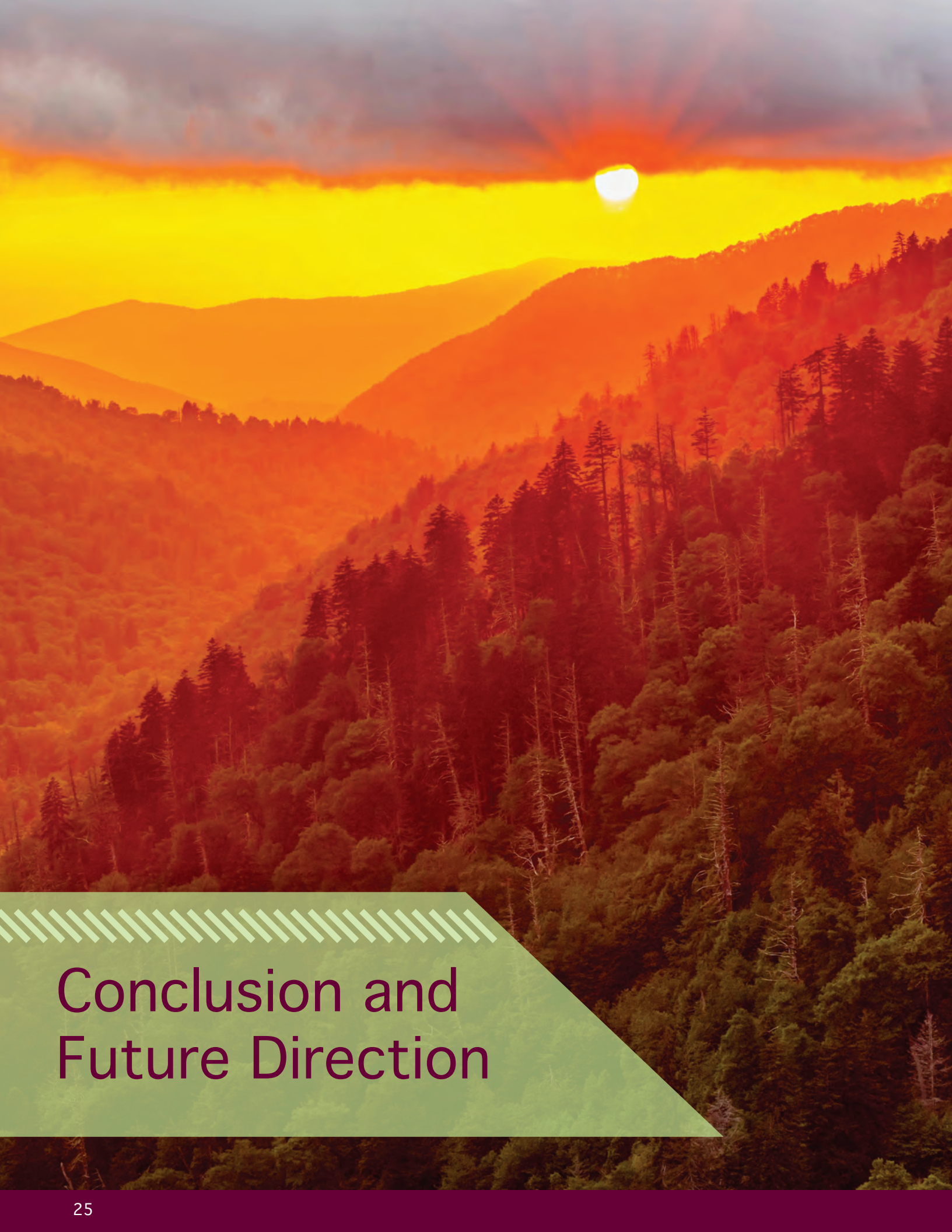
Website: LIVE! JUST AS YOU ARE <http://livejustasyouare.com/>

- The inclusion of the mobile van, Nashville General Mammography Unit, and Center for Women Health at Meharry Medical College led to 45 low resourced women being screened for breast cancer and smoking. Five women were screened for the first time gaining a baseline examination.
- Faith-based organizations such as the Greater Revelation Missionary Baptist Church Focus Group led to family members and others in the church talking about diagnosis of breast cancer as well as the hope and aspiration of survivorship.
- Educational Workshops were held included approximately 262 attendees (including women from targeted counties). Some community advocates wear pink each fourth Sunday to raise awareness and hope.

While community health fairs are helpful, utilization of workgroups, church events, large community health gatherings, and social media to reach low-resourced women proved to be beneficial.

Expanded breast cancer coalition efforts have included the following activities:

- Planned and conducted a breast cancer summit that brought together 520 participants from 9 counties in Tennessee. More than 90% of the participants who attended indicated that they knew someone who was a breast cancer survivor or had recently been diagnosed.
- Residents and faculty preceptors from the School of Dentistry performed dental examinations on women to determine the impact of smoking and other chronic problem associated with and breast cancer. Ten women were referred to the department of Family and Community Medicine Clinic at Meharry Medical College.
- A partnership with The Links and three mobile mammography van screening units was established.
- Nashville General Hospital Mammography Unit continues to offer women who attended a summit previously hosted a free mammogram to enhance reach within targeted counties.



Conclusion and Future Direction

Conclusion and Future Direction



Potential contributing factors to disparities in breast cancer mortality are complex and multi-dimensional including both biological and social determinants, as well as healthcare access and quality, health literacy, and health behaviors or lifestyle as well as cultural competency of providers.⁴⁰ “Although a diagnosis of breast cancer is distressing at any age, the occurrence of breast cancer in young women is fraught with several unique challenges.”⁴¹

Sociodemographic variables including income, education level, and inadequate access to healthcare are recognized as major contributors to disparities in breast cancer survival. Low socioeconomic status (SES) remain an important risk factor for unfavorable breast cancer outcomes, regardless of race/ ethnicity. Public health programs that alleviate environmental conditions that may make low-income women more susceptible to cancer may help to reduce socioeconomically driven disparities in cancer outcomes. Likewise, public health programs aimed at increasing preventive behaviors among low-income persons may also lessen the gap in cancer outcomes.⁴²

Low socioeconomic status is linked to decreased rates of breast cancer screening, a greater probability for advanced or late-stage diagnosis, receipt of inadequate and disparate treatment, and higher mortality from breast cancer. Poverty is associated with poorer breast cancer outcomes for all Americans, regardless of race.⁴³ Geographic disparities, which have increased over time, sometime reflect the national distribution of poverty.

Low-income women continue to account for disproportionate breast cancer morbidity and mortality rates. However, the existence of a routine source of medical care or a physician recommendation for screening are two of the most consistent predictors of cancer screening among women of all income and demographic groups.⁴⁴ Moreover, extending health care coverage to uninsured individuals is also likely to improve health outcomes. These economic barriers or challenges to timely and routine healthcare access contribute to delays in breast cancer diagnosis and treatment, ultimately resulting in higher mortality rates. Socioeconomic status (SES) remains a major determinant of poor or unfavorable outcomes by leading to advanced stage at cancer diagnosis.⁴⁵ Certain public policies related to public health insurance coverage, eligibility for certain preventive health screening programs continue to vary by age and geography.⁴⁶

Access to screening mammography is a fundamental determinant of the stage of breast cancer at diagnosis and can vary between persons within neighborhoods or across neighborhoods based on individual-level or area-level socioeconomic factors.⁴⁷ In addition, unfavorable or poorer survival rates among African-American (Black) women may also be attributed to racial differences in patterns of care unequal patterns of care along the cancer continuum.⁴⁸

Timeliness of follow-up care after an abnormal screening test is a critical step to optimal outcomes. Extensive delay after an abnormal screening mammogram leads to larger cancers, more positive lymph nodes, and subsequently poorer cancer outcomes.⁴⁹ Patient navigation is a proven intervention in high-risk populations that could decrease cancer inequities in access to timely follow-up and high-quality state-of-the-art treatment for breast cancer.⁵⁰

Studies have revealed that racial disparities in breast cancer mortality have emerged due to four factors: (a) differential access to cancer screening; (b) differential quality in the screening process; (c) differential access to breast cancer treatment; and (d) differential quality of cancer treatment.⁵¹ A continuous examination and analysis on the influence of specific social or economically barriers to cancer treatment, such as transportation to medical appointments, type of health insurance coverage, copayment amounts, availability of a support system or care (i.e., the ability to take time off work, availability of childcare), knowledge of most appropriate preventive and treatment, as well as beliefs and attitudes toward cancer treatment may prove more informative for the development of multi-level interventions (including community engagement) designed to significantly reduce health disparities among low-income populations.

Continuous feedback and other results obtained from the adoption of a multi-prong approach designed to uncover challenges and examine gaps associated with breast cancer disparities continues to evolve. Although several Tennessee counties with different demographic features were involved in this initial work, proposed recommendations will be considered to guide future strategic planning and multi-sector engagement.



General Recommendations

(Cumulative recommendations garnered from roundtable meetings, focus groups and community engagement events)

Recommendations for State Cancer Prevention and Control Programs	<p>Identify, engage and establish partnerships focused on reducing client out-of-pocket costs to increase community access to cancer screening services among populations with low socioeconomic status (SES) characteristics.</p> <p>Identify, engage and establish partnerships or collaborations with organizations to enhance the implementation of patient navigation to facilitate timely access to screening and support related to abnormal results.</p> <p>Collaborate with the Consortium of National Networks and other organizations to pilot or develop culturally-relevant media to increase population or community demand for cancer screening and treatment services.</p> <p>Educate decision-makers about economic and health insurance barriers related to healthcare for cancer survivors (including low-income survivors).</p>
Human Services	<p>Explore partnership opportunities with other agencies to examine the waiting period for women who qualify for Medicaid (at the county level) to promote timely utilization of services along the cancer continuum of care.</p>
Recommendations for Non-Profit Organizations (NPOs) and Community-Based Organizations (CBOs)	<p>NPOs and CBOs may want to consider developing or sponsoring develop workshops that provide financial information for low-resourced women on breast cancer that address housing, transportation costs, daycare costs or other barriers mentioned from roundtables and focus groups.</p> <p>Establish partnerships with organizations with an existing patient navigation model or adopt a community health worker (CHW) model to increase reach among populations representing diverse cultures and other traditionally “hard to reach” populations.</p>
Recommendations for Employers or Worksites with Low-income/Seasonal/Temporary/Part-time Employees	<p>Organize and implement free mammograms at least on an annual basis for employees.</p> <p>Coordinate financial support workshops for low-resourced women on breast cancer through regular program planning with the Tennessee Breast and Cervical Program.</p>
Recommendations for Other Types of Organizations-Interested in Addressing Breast Cancer Disparities Among Low-Income Women	<p>Organize and implement free mammograms with local breast screening programs in the community such as programs may be funded by Susan B. Komen, local hospital with a mammogram van, or rural health clinic. These programs will provide referral and follow-up if abnormal findings from mammograms are detected.</p> <p>Develop and design a cultural competent communication process that depicts the targeted audience in which you are trying to reach. This may include developing by age, gender, race/ethnicity, socioeconomic status, etc., that include using a variety of social media and traditional media methods such as: Facebook, Instagram, or YouTube.</p>

Recommendations for Policymakers (Local-City/County, State and National Level)-Interested in Addressing Breast Cancer Disparities Among African-American (Black) Women and Low-Income Women and Low-Resource African-American (Black) Women	<p>Inquire about the provision of referral and follow-up services offered by local county health departments, rural health clinics and other health service providers.</p> <p>Invite organizations to regular health briefings on the state of breast cancer for those groups at highest risk as defined by hospitalization rates, incidence, morbidity and mortality (death) rates.</p> <p>Develop or collaborate in the development of a policy agenda to increase access to and affordability of expenses associated with cancer screening, and follow-up medical services recommended (based on abnormal test results or findings) among women who may not meet the financial criteria set forth by the state's Breast and Cervical Cancer Screening.</p>
Recommendations for breast cancer survival networks and advocacy groups interested in addressing Breast Cancer Disparities Among African-American (Black) Women and Low-Income Women	Networks and advocacy groups must work in a collaborative process to address breast cancer disparities through education and awareness coalitions.
Recommendations for Cancer Coalitions or Health-Related Coalitions Interested in Addressing Breast Cancer Disparities Among Low-Income Women	Inclusion at every level in coalition and capacity building that address cancer care for low-resourced women. Through the voices of this constituency barriers will be eliminated.
Recommendations for Health Systems, Physicians and Other Members of the Multi-Disciplinary Team - Interested in Addressing Breast Cancer Disparities Among African-American Women, Low-Income Women and Low-Resourced	<p>Strive and invest in efforts to deliver patient-centered care in which the patient is the center of care. The care is team-based, coordinated, cost efficient, and the quality and performance are deemed to be excellent as defined by the patient through patient satisfaction surveys.</p> <p>Consider the inclusion of mental health services that are embedded in primary care practices, thereby promoting a "one-stop shopping" experience for accessibility and reduced stigma. Or enhanced coordination among systems to facilitate increased access to affordable mental health support services.</p> <p>Maintain engagement with local community leaders for sustainability that include cancer care collaboratives and partnership with the American Cancer Society, Tennessee Cancer Coalition, Susan B. Komen, and other national organizations who conduct state, regional and/or local programming for women with breast cancer.</p>
	Establish partnerships with organizations with an existing CHW model or adopt a community health worker (CHW) model to increase reach among populations representing diverse cultures and other traditionally "hard to reach" populations.
Recommendations for Faith-Based Organizations (FBOs)	Offer meeting spaces for breast cancer coalitions at no charge. Provide breast cancer messages in the brochure weekly and host a breast cancer awareness day quarterly.
Recommendations for Affordable or Low-Income Housing Communities-Interested in Addressing Breast Cancer Disparities Among Low-Income Women (With Demographics Similar to Counties in Tennessee)	Coalitions may decide to consider including a representative from the department of housing or Public Housing Authority (PHA) as members of the coalitions.

References

- 1 American Cancer Society. Cancer Treatment & Survivorship Facts & Figures 2016-2017. Atlanta: American Cancer Society; 2016.
- Miller, K. D., Siegel, R. L., Lin, C. C., Mariotto, A. B., Kramer, J. L., Rowland, J. H., Stein, K. D., Alteri, R. and Jemal, A. (2016), Cancer treatment and survivorship statistics, 2016. CA: A Cancer Journal for Clinicians.
- 2 Richards J.E., Whiteside M.A. Cancer in Tennessee. 2010-2014. Tennessee Department of Health: Division of Policy, Planning & Assessment – Office of Cancer Surveillance. Nashville, Tennessee, December 2017
- 3 U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on November 2017 submission data (1999-2015): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; June 2018.
- 4 Bigby, J. & Holmes, M.D. Cancer Causes Control (2005) 16: 35. <https://doi.org/10.1007/s10552-004-1263-1>
- 5 National Cancer Institute (NCI)-Cancer Disparities <https://www.cancer.gov/about-cancer/understanding/disparities>
- 6 Centers for Disease Control and Prevention-Vital Signs: Breast Cancer <https://www.cdc.gov/vitalsigns/breastcancer/index.html>
- 7 Richardson LC, Henley J, Miller J, Massetti G, Thomas CC. Patterns and trends in black-white differences in breast cancer incidence and mortality—United States, 1999–2013. MMWR 2016;65(40):1093–1098.
- 8 American Cancer Society. Cancer Facts & Figures for African-Americans 2016-2018. Atlanta: American Cancer Society, 2016.
- 9 Sassi F, Luft HS, Guadagnoli E. Reducing Racial/Ethnic Disparities in Female Breast Cancer: Screening Rates and Stage at Diagnosis. American Journal of Public Health. 2006;96(12):2165–2172. doi:10.2105/AJPH.2005.071761
- 10 Lobb R, Ayanian JZ, Allen JD, et al. Stage of breast cancer at diagnosis among low-income women with access to mammography. Cancer. 2010;116:5487–5496.
- 11 Richardson LC, Henley J, Miller J, Massetti G, Thomas CC. Patterns and trends in black-white differences in breast cancer incidence and mortality—United States, 1999–2013. MMWR 2016;65(40):1093–1098.
- 12 Race, Ethnicity, and Breast Cancer. Susan G. Komen. Available at <https://www5.komen.org/BreastCancer/RaceandEthnicity.html>
- 13 Hunt BR, Whitman S, Hurlbert MS. Increasing black:white disparities in breast cancer mortality in the 50 largest cities in the United States. Cancer Epidemiol. 2014;38:118–123.
- 14 American Cancer Society. Breast Cancer Facts & Figures 2017-2018. Atlanta: American Cancer Society, Inc. 2017.
- 15 Surbone; Cultural competence in oncology: where do we stand?, Annals of Oncology, Volume 21, Issue 1, 1 January 2010, Pages 3–5, <https://doi.org/10.1093/annonc/mdp546>
- 16 Miller JW, Lee Smith J, Ryerson AB, Tucker TC, Allemani C. Disparities in breast cancer survival in the United States (2001-2009): findings from the CONCORD-2 study. Cancer. 2017;123:5100–5118.
- 17 Gupta V, Haque I, Chakraborty J, et al. Racial disparity in breast cancer: can it be mattered for prognosis and therapy. J Cell Commun Signal. 2017;54:566–573.
- 18 Richardson LC, Henley J, Miller J, Massetti G, Thomas CC. Patterns and trends in black-white differences in breast cancer incidence and mortality—United States, 1999–2013. MMWR 2016;65(40):1093–1098. https://www.cdc.gov/cancer/dpcp/research/articles/breast_cancer_rates_women.htm
- 19 Lee CH, Dershaw DD, Kopans D, Evans P, Monsees B, Monticciolo D, Brenner RJ, Bassett L, Berg W, Feig S, Hendrick E, Mendelson E, D'Orsi C, Sickles E, Burhenne LW. Breast cancer screening with imaging: Recommendations from the Society of Breast Imaging and the ACR on the use of mammography, breast MRI, breast ultrasound, and other technologies for the detection of clinically occult breast cancer. Journal of the American College of Radiology 2010;7(1):18–27
- 20 Wheeler SB, Spencer JC, Pinheiro LC, Carey LA, Olshan AF, Reeder-Hayes KE. Financial Impact of Breast Cancer in Black Versus White Women. Journal of Clinical Oncology. 2018;36(17):1695–1701. doi:10.1200/JCO.2017.77.6310. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5993169/>
- 21 Jemal A, Robbins AS, Lin CC et al (2018) Factors that contributed to black-white disparities in survival among nonelderly women with breast cancer between 2004 and 2013. J Clin Oncol 36(1):14–24.
- 22 Munsell MF, Sprague BL, Berry DA, Chisholm G, Trentham-Dietz A. Body mass index and breast cancer risk according to post menopausal estrogen-progestin use and hormone receptor status. Epidemiologic Reviews 2014; 36:114–136.
- 23 Nelson HD, Zakher B, Cantor A, et al. Risk factors for breast cancer for women aged 40 to 49 years: a systematic review and meta-analysis. Ann Intern Med. 156(9):635–48, 2012.
- 24 Iqbal J, Ginsburg O, Rochon PA, Sun P, Narod SA. Differences in breast cancer stage at diagnosis and cancer-specific survival by race and ethnicity in the United States. JAMA. 2015;313:165–173.
- 25 Race and Ethnicity and Breast Cancer Outcomes in an Underinsured Population. Ian K. Komenaka, Maria Elena Martinez, Robert E. Pennington, Chiu-Hsieh Hsu, Susan E. Clare, Patricia A. Thompson, Colleen Murphy, Noelia M. Zork, Robert J. Goulet; Race and Ethnicity and Breast Cancer Outcomes in an Underinsured Population, JNCI: Journal of the National Cancer Institute, Volume 102, Issue 15, 4 August 2010, Pages 1178–1187,

- 26 Peek ME, Han JH. Disparities in Screening Mammography: Current Status, Interventions, and Implications. *Journal of General Internal Medicine*. 2004;19(2):184-194. doi:10.1111/j.1525-1497.2004.30254.x. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1492136/>
- 27 Shavers VL, Brown ML. Racial and ethnic disparities in the receipt of cancer treatment. *J Natl Cancer Inst* 2002;94:334-357.
- 28 A. Surbone; Cultural competence in oncology: where do we stand?, *Annals of Oncology*, Volume 21, Issue 1, 1 January 2010, Pages 3-5, <https://doi.org/10.1093/annonc/mdp546>
- 29 Saha S, Beach MC, Cooper LA. Patient Centeredness, Cultural Competence and Healthcare Quality. *Journal of the National Medical Association*. 2008;100(11):1275-1285.
- 30 Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989). *Towards A Culturally Competent System of Care*, Volume I. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.
- 31 US Department of Health and Human Services, The Office of Minority Health - What Is Cultural Competency? https://www.cdc.gov/nchhstp/socialdeterminants/docs/what_is_cultural_competency.pdf
- 32 Berkman ND, Sheridan SL, Donahue KE, Halpern DJ, Crotty K. Low Health Literacy and Health Outcomes: An Updated Systematic Review. *Ann Intern Med*. ;155:97-107. doi: 10.7326/0003-4819-155-2-201107190-00005. https://www.cdc.gov/nchhstp/socialdeterminants/docs/what_is_cultural_competency.pdf
- 33 Andrulis DP, Brach C. Integrating Literacy, Culture, and Language to Improve Health Care Quality for Diverse Populations. *American journal of health behavior*. 2007;31(Suppl 1):S122-S133. doi:10.5555/ajhb.2007.31.supp.S122.
- 34 Institute of Medicine (US) Committee on Health Literacy; Nielsen-Bohman L, Panzer AM, Kindig DA, editors. *Health Literacy: A Prescription to End Confusion*. Washington (DC): National Academies Press (US); 2004. 4, Culture and Society. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK216037/>
- 35 Andrulis DP, Brach C. Integrating Literacy, Culture, and Language to Improve Health Care Quality for Diverse Populations. *American journal of health behavior*. 2007;31(Suppl 1):S122-S133. doi:10.5555/ajhb.2007.31.supp.S122.
- 36 Guidry, J & Matthews-Juarez, P. (2003) Barriers to Breast Cancer Control for African-American (Black) Women, The Interdependence of Culture and Psychosocial Issues, *Cancer*. Jan 1:97 (1Suppl):318-323.
- 37 Guidry JJ, Matthews-Juarez P, Copelan VA. Barriers to breast cancer control for African American women. *Cancer*. 2003;91:318S-23S.
- 38 Matthews-Juarez, PA & Weinberg, AD., *Cultural Competence in Cancer Care: A Health Care Professional's Passport*. 2nd Edition, Baylor School of Medicine, Houston, Texas Chapter - Peer Reviewed: 2006.
- 39 Centers for Disease Control and Prevention-Breast Cancer in Young Women https://www.cdc.gov/cancer/breast/young_women/index.htm
- 40 Rust G, Zhang S, Malhotra K, et al. Paths to Health Equity – Local Area Variation in Progress toward Eliminating Breast Cancer Mortality Disparities, 1990-2009. *Cancer*. 2015;121(16):2765-2774. doi:10.1002/cncr.29405.
- 41 Anders CK, Johnson R, Litton J, Phillips M, Bleyer A. Breast Cancer Before Age 40 Years. *Seminars in oncology*. 2009;36(3):237-249. doi:10.1053/j.seminoncol.2009.03.001.
- 42 Cathy J. Bradley, Charles W. Given, Caralee Roberts; Race, Socioeconomic Status, and Breast Cancer Treatment and Survival, *JNCI: Journal of the National Cancer Institute*, Volume 94, Issue 7, 3 April 2002, Pages 490-496,
- 43 Gerend MA, Pai M. Social determinants of Black-White disparities in breast cancer mortality: a review. *Cancer Epidemiol Biomarkers Prev* 2008;17:2913-23.
- 44 O'Malley AS, Forrest CB, Mandelblatt J. Adherence of Low-income Women to Cancer Screening Recommendations: The Roles of Primary Care, Health Insurance, and HMOs. *Journal of General Internal Medicine*. 2002;17(2):144-154. doi:10.1046/j.1525-1497.2002.10431.x.
- 45 Newman LA. Breast cancer in African-American women. *Oncologist*. 2005; 10: 1-14.
- 46 Sighoko D, Hunt BR, Irizarry B, Watson K, Ansell D, Murphy AM. *Cancer Epidemiol*. 2018 Apr;53:178-183. doi: 10.1016. Disparity in breast cancer mortality by age and geography in 10 racially diverse US cities.
- 47 Stage of Breast Cancer at Diagnosis among Low-Income Women with Access to Mammography
- 48 Baquet CR, Mishra SI, Commiskey P, Ellison GL, DeShields M. Breast cancer epidemiology in blacks and whites: disparities in incidence, mortality, survival rates and histology. *Journal of the National Medical Association*. 2008;100(5):480-488.
- 49 Rosenberg RD, Haneuse SJPA, Geller BM, et al. Timeliness of Follow-up after Abnormal Screening Mammogram: Variability of Facilities. *Radiology*. 2011;261(2):404-413. doi:10.1148/radiol.11102472. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3198220/>
- 50 Centers for Disease Control and Prevention: Vital signs: Racial disparities in breast cancer severity—United States, 2005-2009. *MMWR* 61:922-926, 2012.
- 51 Hunt BR, Whitman S, Hurlbert MS. Increasing black:white disparities in breast cancer mortality in the 50 largest cities in the United States. *Cancer Epidemiol*. 2014;38:118-123.

TACKLING THE DISPARITY GAP IN BREAST CANCER AWARENESS AND PREVENTION

According to the CDC, breast cancer mortality rates disproportionately affect low-income African American women.¹ So how do we change that? SelfMade Health Network's Regional Resource Lead Organization, Meharry Medical College, sat down with two focus groups to discuss potential solutions to eliminate disparities in affected communities. We posed the question...

"What do you think healthcare providers should do to help low-income women who need breast cancer screening and treatment?"

"Improving education, transportation and financial opportunities, as well as providing more informational displays in plain language will help low-income women who need breast cancer screening and treatment."

"A mammogram bus that goes to African American neighborhoods and areas will help."

"Offering financial assistance to single mothers to get the treatment and screening they need so children are taken care of. A sole income supporting a family can be very draining for these moms."

"Providing more information in the physician's office where patients can access treatment for free."

"Remove the age limit for breast cancer screenings. Spread the word to the low-income community the rules have been changed."

"Remove the fear. I was scared to go see the doctor when I thought something was wrong."

"Provide more educational opportunities and share with inner-city churches. Let them know about screenings and social workers who may be able to guide them through the process."

"Increase charity care initiatives and new funding opportunities to help in the hospitals."

"Setting up mammogram appointments during physicals might help."

"Getting out there and telling our story. My sister died of breast cancer because she was afraid to get tested and it spread. We have to tell people how and where to go for screening and treatment."

"Building more hospitals in lower-income areas so everyone can access the same resources."

"Have more free testing, transportation and health fairs. Advertise with flyers, on television, radio and newspapers so everyone knows."

"Create and advertise more breast cancer support groups in the communities so no one is alone."



The two focus groups were held in January and February 2016 in Nashville, Tennessee. Many participants were female African American breast cancer survivors from Alabama and Tennessee. To learn more about our Communities of Promise initiatives, visit selfmadehealth.org/mobilize/communities-of-promise
1) CDC, Breast Cancer Rates by Ethnicity, www.cdc.gov/cancer/breast/statistics/race.htm

"Cultural barriers." "Lack of education." "Limited transportation access."

These were just a few of the explanations for breast cancer disparities provided by patients and survivors in two focus groups hosted at Meharry Medical College in Nashville, Tennessee.

The groups explored barriers to care as well as solutions to help eliminate health disparities in affected communities.



IDENTIFYING BARRIERS TO CARE.

- **Social and Cultural:** Many long-held social and cultural beliefs prevalent in disparate populations, such as fear or disinterest within affected communities, contributed to lack of or delayed care.
- **Lack of Educational Resources:** Participants suggested that plain-language communication about available resources was rare or nonexistent in their community.
- **Limited Transportation:** Affording and obtaining means to travel to and from care was a common area of concern for contributors.

"Improving education, transportation and financial opportunities, as well as providing more informational displays in plain language will help low-income women who need breast cancer screening and treatment."



PROVIDING POTENTIAL SOLUTIONS.

- **Social and Cultural:** Some participants suggested that places of worship hold health fairs so information comes from a trusted community-based source. A few voiced that residents within those communities should become health advocates to increase credibility and disseminate information.
- **Lack of Education:** Suggestions for using humor and having accessible materials in plain-language to increase comprehension and ward off fear were voiced. This may also help dispel myths and reduce outdated home remedies to treat cancer. Participants stressed the use of non-threatening language when sharing resources. Information about identifying risk in family history, preventive screening, and financial resources were all suggested tools to share.
- **Limited Transportation:** Many shared that there are no specialists or oncologists and very limited healthcare facilities in many low-income areas. It was suggested that one way to alleviate the transportation burden is to come to the affected areas directly via a mammogram bus or mobile cancer-screening van.

"A mammogram bus that goes to African American neighborhoods and areas will help."



The two focus groups were held in January and February 2016 in Nashville, Tennessee. Many participants were female African American breast cancer survivors from Alabama and Tennessee. To learn more about our Communities of Promise initiatives, visit selfmadehealth.org/mobilize/communities-of-promise

Resource Directory

Name of Organization	Address	City	State	Zip	Phone Number	Web Address	Services Provided
Davidson County							
American Cancer Society	2000 Charlotte Avenue	Nashville	TN	37203	615.327.0992	www.cancer.org/about-us/local/tennessee	Cancer Treatment and Support
Bethlehem Center	1417 Charlotte Avenue	Nashville	TN	37209	615.329.3386	www.needhelppayingbills.com/html/nashville_food_banks_and_pantr.html	
Catholic Charities North Nashville	1700 Heiman Street	Nashville	TN	37208	615.891.1074	cctenn.org	
Centennial Imaging Center	356 24th Avenue North	Nashville	TN	37203	615.342.8700	www.tristarcentennial.com/service/imaging-diagnostics	Digital Mammograms
Edgehill Center	935 Edgehill Avenue	Nashville	TN	37203	615.256.5108	www.needhelppayingbills.com/html/nashville_food_banks_and_pantr.html	
Gilda's Club of Nashville	1707 Division Street	Nashville	TN	37203	615.329.1124	https://www.gildasclubmiddletn.org/	Cancer Support
Kayne Ave. Baptist Church	1025 12th Avenue South	Nashville	TN	37203	615.255.5528	http://www.kayneavenuebaptist.org/	
Komen of Greater Nashville	4009 Hillsboro Pike	Nashville	TN	37215	615.383.0017	komencentraltennessee.org	Cancer Support
Margaret Maddox Family YMCA (Before and After Breast Cancer)	2624 Gallatin Pike	Nashville	TN	37206	615.228.525	www.ymcamidtn.org	Cancer Support, Education, Outreach, and Education
Martha O'Bryan Center	711 South 7th Street	Nashville	TN	37206	615.254.1791	www.needhelppayingbills.com/html/nashville_food_banks_and_pantr.html	
Nashville Cares Food Pantry	633 Thompson Lane	Nashville	TN	37204	615.259.4866	www.nashvillecares.org	
Nashville Metro General Hospital	1818 Albion Street	Nashville	TN	37208	615.341.4000	nashvillegeneral.org	Cancer Support, Treatment, Research, Education, Outreach, and Digital Mammograms
Nashville Mobile Market	5610 California Avenue	Nashville	TN	37203	615.324.8364		
Nashville Rescue Mission Men's	639 Lafayette Street	Nashville	TN	37203	615.255.2475	nashvillerescuemission.org	
Nashville Rescue Mission Women's	1716 Rosa L Parks Boulevard	Nashville	TN	37208	615.312.1574	nashvillerescuemission.org	
Nashville Skin & Cancer	2525 21st Ave S #100	Nashville	TN	37212	615.327.9797	www.nashvilleskinandcancer.com	
New Song Christian Fellowship	2949 Nolensville Pike	Nashville	TN	37211	615.837.9353	www.needhelppayingbills.com/html/nashville_food_banks_and_pantr.html	
Project Return	806 4th Avenue South	Nashville	TN	37210	615.327.9654	www.projectreturninc.org	
Radiology Alliance	210 25th Avenue North, Ste. 602	Nashville	TN		615.312.0600	http://www.radalliance.com/	Digital Mammograms
Salvation Army Magness Potter	611 Stockell Street	Nashville	TN	37206	615.255.0554	www.salvationarmyusa.org/usn/	
Samaritan Soup Kitchen		Nashville	TN			www.foodpantries.org	
Sarah Cannon Cancer Institute @ Tri-Star Centennial	2300 Patterson Street	Nashville	TN	37203	615.342.1000	www.sarahcannon.com	Cancer Support, Treatment, Research, Education, Outreach, and Digital Mammograms
Second Harvest Food Bank Middle Tennessee	331 Great Circle Road	Nashville	TN	37228	615.329.3491	secondharvestmidtn.org	

Name of Organization	Address	City	State	Zip	Phone Number	Web Address	Services Provided
Sisters Network	2916 Claymille Blvd.	Nashville	TN	37207	615.299.5574	siternetworknashville.org	Cancer Support and Education
TennCare	310 Great Circle Road	Nashville	TN	37243	800.342.3145	https://www.tn.gov/tenncare.html	Cancer Support, Treatment, Research, Education, Outreach, and Digital Mammograms
Tennessee Breast and Cervical Cancer Program (statewide reach)	2500 Charlotte Avenue North	Nashville	TN	37209	615.741.7353	www.tn.gov https://www.tn.gov/health/health-program-areas/fhw/mch-cancer.html	Cancer Support, Education, Outreach, and Education
Tennessee Oncology PLLC: St. Thomas Midtown	300 20th Ave N #301	Nashville	TN	37203	615.312.3333	www.tnoncology.com	Cancer Support, Treatment, Research, Education, Outreach, and Digital Mammograms
The Help Center	3918 Dickerson Pike	Nashville	TN	37207	615.349.8349	thehelpcenter.org	
The Nashville Food Project	3605 Hillsboro Pike	Nashville	TN	37215	615.460.0172	thenashvillefoodproject.org	
Tennessee Breast Cancer Coalition	3939 Old Hickory Blvd.	Old Hickory	TN	37128	615.377.8777	https://www.tbcc.org/	Cancer Support
TriStar Centennial Medical Center	2221 Murphy Avenue	Nashville	TN	37203	615.695.7230	tristarcentennial.com/service/imaging-diagnostics	Cancer Support, Treatment, Research, Education, Outreach, and Digital Mammograms
Vanderbilt Breast Center	719 Thompson Lane	Nashville	TN	37204	615.322.2064	https://www.vanderbilthealth.com/breastcenter/	Digital Mammograms
Vanderbilt University Medical Center	1211 Medical Center Drive	Nashville	TN	37232	615.322.5000	www.vanderbilthealth.com	Cancer Support, Treatment, Research, Education, Outreach, and Digital Mammograms
Vanderbilt-Ingram Center	2220 Pierce Avenue	Nashville	TN	37232	615.936.8422	www.vanderbilthealth.com	Cancer Support, Treatment, Research, Education, and Outreach
Shelby, Fayette, Haywood, Lauderdale, Tipton Counties							
American Cancer Society	718 Union Avenue	Memphis	TN	38104	901.576.0664	www.cancer.org	Cancer Support, Treatment, Research, and Education
Brinkley Heights Baptist Church	3277 Rosamond Avenue	Memphis	TN	38122	901.458.0617	www.needhelppayingbills.com	
Calvary Episcopal Church	102 N. Second Street	Memphis	TN	38103	901.525.6602		
Catholic Charities, Inc.	1325 Jefferson	Memphis	TN	38104	901.722.4700	www.needhelppayingbills.com	
Collierville Food Pantry	136 Shelton Rd. E	Collierville	TN	38017	901.854.0288		
Mid- South Food Bank	239 Suth Dudley	Memphis	TN	38104	901.527.0841	www.midsouthfoodbank.org	

Name of Organization	Address	City	State	Zip	Phone Number	Web Address	Services Provided
The University of Tennessee West Cancer Center	1211 Union Avenue Ste. 300	Memphis	TN	38104	901.609.3525	www.westcancercenter.org	Cancer Support, Treatment, Research, Education, Outreach, and Digital Mammograms
Knox County							
American Cancer Society	871 N. Weisgarber Road	Knoxville	TN	37909	865.584.1669	www.cancer.org	Cancer Support, Treatment, Research, and Education
Food in the Fort	1642 Highland Avenue	Knoxville	TN	37916	865.524.4552	www.fishpanry.com	
Hospitality Pantries	600 S Chestnut Street	Knoxville	TN	37919	865.588.9200	www.fishpanry.com	
Love Kitchen	2418 Martin Luther King Blvd.	Knoxville	TN	37914	865.546.3248	www.fishpanry.com	
Tennessee Cancer Specialist	1415 Old Weisgarber Road	Knoxville	TN	37909	865.934.5800	www.tncancer.com/cancers-treatments/	Cancer Support, Treatment, Research, Education, Outreach, and Digital Mammograms
Williamson County							
GraceWorks Ministries	104 Southeast Parkway	Franklin	TN	37064	615.794.9055	www.graceworksministries.net	
GraceWorks West	2382 Fairview Boulevard, Suite 102	Fairview	TN	37062	615.799.0006	www.graceworksministries.net	
Williamson Medical Center	4321 Carothers Pkwy	Franklin	TN	37076	615.435.5000	www.williammedicalcenter.org	Cancer Support, Treatment, Research, Education, Outreach, and Digital Mammograms
Williamson Medical Center	2629 Fairview Blvd	Fairview	TN	37062	615.799.2389	www.tn.gov	Cancer Support and Education

Additional Resources

Breast Cancer in Young Women

https://www.cdc.gov/cancer/breast/young_women/bringyourbrave/breast_cancer_young_women/

Bring Your Brave Campaign

Bring Your Brave Campaign Home

Breast Cancer in Young Women -

Risk Factors for Breast Cancer at a Young Age

Symptoms of Breast Cancer

Health Care Provider Education +

Hereditary Breast Cancer and BRCA Genes +

Take Action +

Women's Stories +

About the Campaign

Share Your Story +

Campaign Resources +

CDC > Cancer Home > Bring Your Brave Campaign Home

Breast Cancer In Young Women

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[Breast cancer](#) is the most common cancer in women in the United States. About 1 in 8 women will get breast cancer during her life.

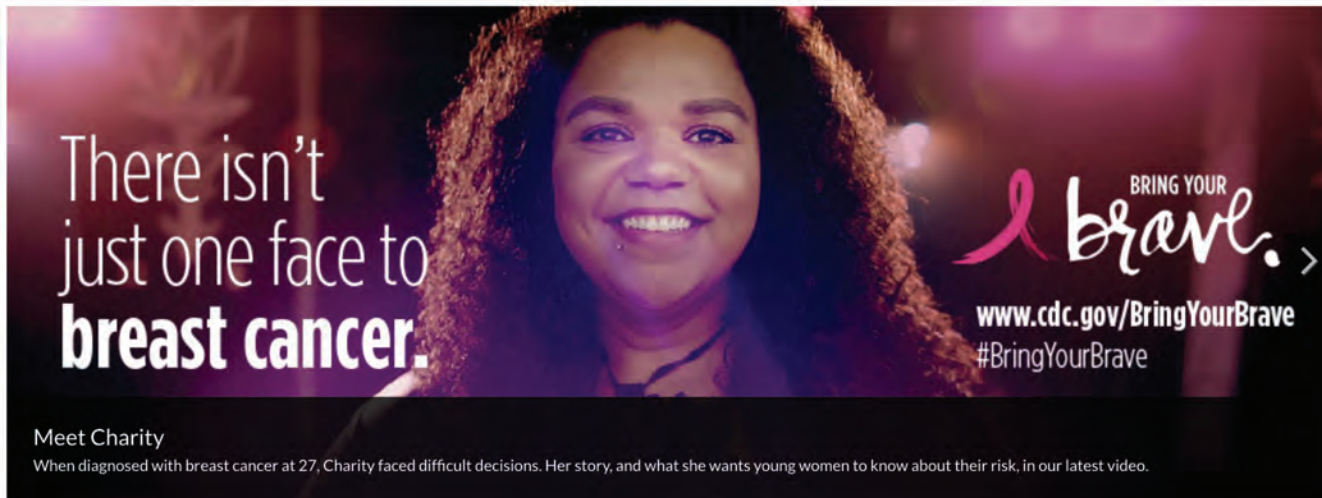
“Bring Your Brave” Campaign (Centers for Disease Control and Prevention)

https://www.cdc.gov/cancer/breast/young_women/bringyourbrave/index.htm

Bring Your Brave Campaign

CDC > Cancer Home

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There isn't just one face to breast cancer.

BRING YOUR brave.

www.cdc.gov/BringYourBrave

#BringYourBrave

Meet Charity

When diagnosed with breast cancer at 27, Charity faced difficult decisions. Her story, and what she wants young women to know about their risk, in our latest video.




National Breast and Cervical Cancer Early Detection Program (NBCCEDP)

<https://www.cdc.gov/cancer/nbccedp/index.htm>

National Breast and Cervical Cancer Early Detection Program (NBCCEDP)

[CDC > Cancer Home](#)

National Breast and Cervical Cancer Early Detection Program (NBCCEDP)


  

SCREENOUTCANCER
POWERED BY CDC
National Breast & Cervical Cancer
Early Detection Program

For more than 25 years, CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) has provided low-income, uninsured, and underserved women access to timely breast and cervical cancer screening and diagnostic services.

Find a Screening Provider Near You

Find out if you qualify for free or low-cost breast and cervical cancer screenings through the NBCCEDP, and [contact the program](#) in your state, tribe, or territory.



CDC's Latest Research

- Cervical cancer screening in the NBCCEDP in four US-Affiliated Pacific Islands between 2007 and 2015 [↗](#)
- Using evidence-based interventions to improve cancer screening in the NBCCEDP [↗](#)
- *Cancer Causes and Control* journal supplement

[More research](#)


- Find a Screening Provider Near You
- About the Program
- Screening Program Data
- Journal Supplement: The Reach and Health Impacts of the NBCCEDP
- Journal Supplement: Two Decades of Service to Underserved Women
- Guide for Measuring Cancer Screening Rates in Health System Clinics
- Partnership Toolkit and Resources
- Partners
- Contact a Local Program
- Web Badges

National Cancer Institute (NCI)- National Organizations That Offer Cancer-Related Support Services


<https://www.cancer.gov/about-cancer/managing-care/services/support>

SelfMade Health Network (SMHN)-Determinants of Health Fact Sheets

<https://selfmadehealth.org/>



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Help Others
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FOSTER PREVENTION AMONG DISPARATE POPULATIONS

RETHINK HEALTH

Via education, we boost awareness of cancer & tobacco-related disparities providing greater understanding among organizations and policymakers.

MAKE BETTER HEALTH THE NORM

We promote greater capacity within regions by identifying, developing and connecting resources to stakeholders key to changing community norms.

PUT PREVENTION INTO PRACTICE

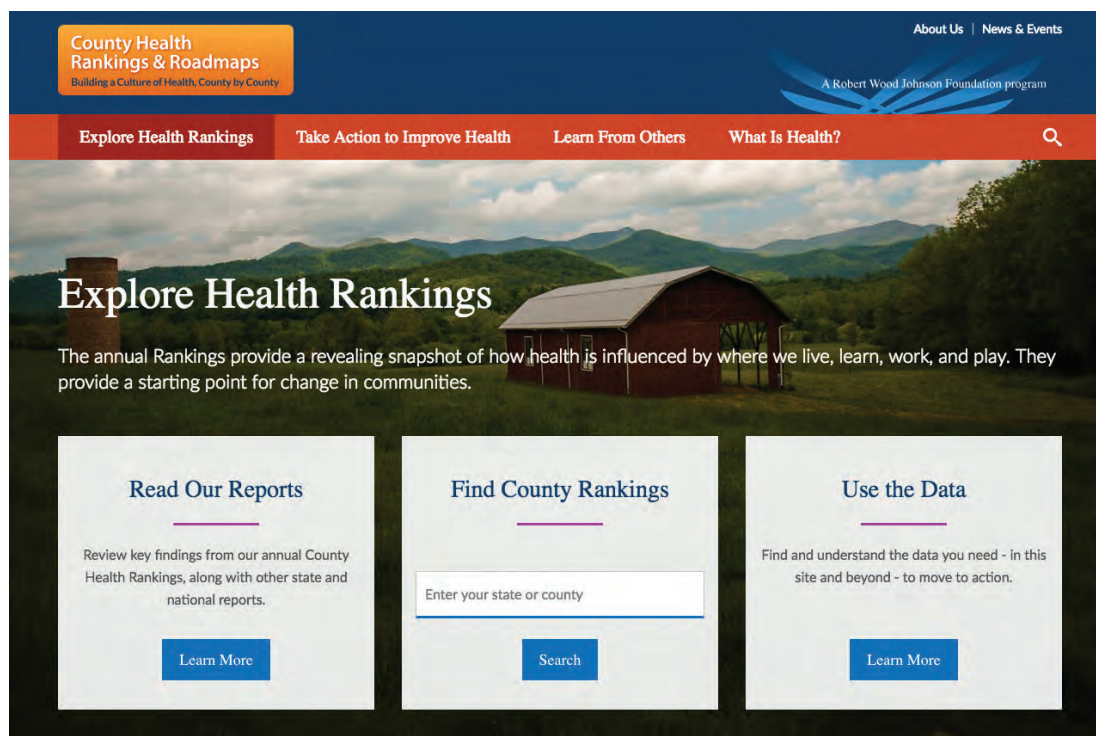
Through partnerships and collaborations, we support the expansion of *promising practices* and models about prevention, treatment and survivorship.

Community Guide [Community Preventive Services Task Force (CPSTF)]

<https://www.thecommunityguide.org/>

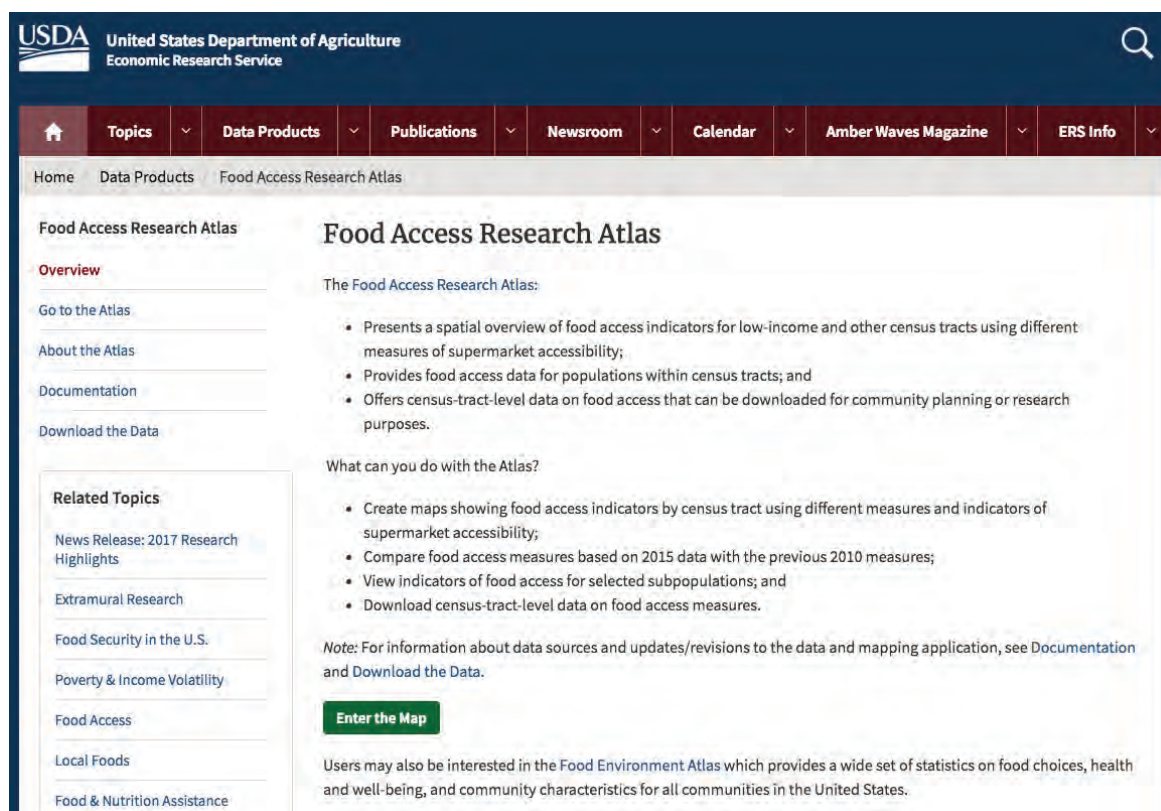
County Health Rankings & Roadmaps (Robert Wood Johnson Foundation)

<http://www.countyhealthrankings.org/explore-health-rankings>




Food Access Research Atlas (United States Department of Agriculture)

<https://www.ers.usda.gov/data/fooddesert/>






500 Cities: Local Data for Better Health (Centers for Disease Control and Prevention)
<https://www.cdc.gov/500cities/>


**Centers for Disease Control and Prevention**
CDC 24/7: Saving Lives. Protecting People™

SEARCH

CDC A-Z INDEX


500 Cities: Local Data for Better Health





The 500 Cities project is a collaboration between CDC, the Robert Wood Johnson Foundation, and the CDC Foundation. The purpose of the 500 Cities Project is to provide city- and census tract-level small area estimates for chronic disease risk factors, health outcomes, and clinical preventive service use for the largest 500 cities in the United States. These small area estimates will allow cities and local health departments to better understand the burden and geographic distribution of health-related variables in their jurisdictions, and assist them in planning public health interventions. See bottom of page for the note for data users. [Learn more about the 500 Cities Project.](#)


How are you using 500 Cities data?





Please tell us how you are using 500 Cities data and the 500 Cities website. Your feedback is valued and greatly appreciated.

More >

American Cancer Society
<https://www.cancer.org/>

 Cancer Helpline
800.227.2345


 Live Chat



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CANCER A-Z | STAY HEALTHY | TREATMENT & SUPPORT | OUR RESEARCH | GET INVOLVED | OUR PARTNERS | ABOUT US



Unite, Ignite, Fight.
Help us beat breast cancer.

DONATE NOW

Healthy People 2020-National Objectives

<https://www.healthypeople.gov/>

Increasing Population-based Breast and Cervical Cancer Screenings: An Action Guide to Facilitate Evidence-based Strategies

<https://www.cdc.gov/cancer/nbccedp/pdf/breastcanceractionguide.pdf>

