

CDC Town Hall Teleconference

Breast Cancer

November 20, 2012  
2:00pm – 3:00pm EST

Coordinator: Welcome and thank you for standing by. At this time all participants will be in a listen-only mode. After the presentation, we will conduct a question-and-answer session. To ask a question at that time, please press star 1.

Today's conference is being recorded. If you have objections, you may disconnect at this time. I would now like to turn the meeting over to Dr. Dan Baden. You may begin.

Dan Baden: Thank you very much. Good afternoon, everyone. As the operator said, I'm Dr. Dan Baden. I'm a Senior Liaison from our Office for State, Tribal, Local and Territorial Support to our National Center for Chronic Disease Prevention and Health Promotion here at CDC.

I'm glad you could join us today but before we get started, I wanted to go over some housekeeping details. Remember to go online and download today's PowerPoint presentation so you can follow along with the presenters.

The Web address for that is [www.cdc.gov/stltpublichealth](http://www.cdc.gov/stltpublichealth). That's S-T-L-T public health. There's a link directly to the town hall Website under the highlights products and resource on the bottom right.

On this page you can also view bios of each of the presenters. This is where we will add the audio recording and transcript from today's meeting. They should be available next week.

Today we're here to discuss the latest *Vital Signs* report which focuses on breast cancer disparities. The good news is that deaths from breast cancer have declined within the past two decades primarily due to early detection and advances in treatment.

However, all racial groups have not benefited equally. In fact the latest *Vital Signs* report released earlier this month alerts us that black women are more likely to die of breast cancer than any other racial or ethnic group.

There are numerous factors to consider when reviewing racial disparities regarding breast cancer. These include not only screening process, follow-up and treatment but what action is being taken by the federal government as well as by state and local health agencies.

These important factors and efforts include the Affordable Care Act and the National Breast and Cervical Center Early Detection Program which we'll learn more about during our teleconference today.

On today's call we'll hear from three esteemed colleagues, all of whom are experts in the field of public health. They will share the latest statistics and insights regarding this crucial topic and what can be done to counter it.

We'll hear first from Captain Jacqueline W. Miller, MD who is a Medical Director of CDC's National Breast and Cervical Cancer Early Detection Program. Dr. Miller will provide a summary of this month's *Vital Signs* report.

She will then hand over the call to Nancy Wright, the Director of Cancer Prevention and Control Division for the Alabama Department of Public

Health. She will primarily discuss the vital role of patient navigation and its impact on serving the Hispanic population.

Ms. Wright will then turn over the call to Allison McGuire, the Program Manager of the Division of Prevention Medicine at the University of Alabama at Birmingham. Ms. McGuire will share accomplishments of an interesting program called Sowing the Seeds of Health.

Please note that there will be time for questions after the presentations but you can get in the queue early to ask a question at any time during the teleconference. Please just press star 1 and record your name when prompted. With that, I'll now turn over the call to Dr. Miller.

Jacqueline Miller: Good afternoon. This afternoon I will review the highlights from our report on racial disparities in breast cancer severity in the United States from 2005 to 2009. It's noted that nearly 4,000 women die of breast cancer and that black women are about 40% more likely to die of breast cancer than white women. In fact black women have the highest death rates of all women.

If rates were equal for death among black and white women, there would be at least 18,000 fewer deaths among these women. Black women had the lowest incidence rates of breast cancer compared to white women at rates of 117 per 100,000 cases compared to 122 per 100,000 cases.

Black women also had higher numbers of both regional and distant breast cancer cases when compared with white women at rates of 46% to 35%. On our Slide 4, here we see a map that looks at the additional breast cancer deaths among black women by each state.

This map actually shows what we call a mortality-to-incidence ratio. This is calculated by looking at the age-adjusted mortality rate compared to the age-adjusted incidence rate. This is a population-based measure that can give us an assessment of vitality and prognosis after the diagnosis of breast cancer and can be used to compare groups.

The difference in MIRs can be estimated as saying the excess of deaths or additional deaths in a population. An MIR of 0.14 is an indication of 14 breast cancer deaths that occur for what every 100 cases diagnosed.

When we look at this map, we see that overall the MIR for black women was 0.27 compared to the MIR of 0.18. That means there are at least nine more deaths per 100 cases diagnosed for black women compared to the 100 cases diagnosed for white women.

In our next slide, we look at differences in screening, follow-up and treatment. I've already stated that black women have a higher spread rate of distant disease compared to white women but in the screening rates, black women and white women have reported equal breast cancer screening.

Black women have more of a delay in follow up after having a mammogram result. Blacks tend to have a longer time period before starting treatment and are less likely to get surgery, radiation and hormonal treatment as indicated by their diagnosis.

On the next slide, this is a diagram of the steps to follow-up and improve access to high-quality treatment. Women and their healthcare providers should know what to do, and what should be expected, throughout the screening process.

This diagram addresses steps to know before testing. The first test is just if there is cancer on the mammogram and what to expect if the doctor says it is cancer.

On the next slide, this talks about what is being done to address breast cancer disparities. This is through steps by the federal government with the implementation of the Affordable Care Act.

Throughout this Act, we will have coverage of clinical preventive services, such as mammograms without copay, and health plans. The law will expand access to health insurance coverage for an additional 30 million previously-uninsured Americans.

Another example is investment in the electronic health records and case management services among our federally-funded health clinics, supporting state efforts such as the National Breast and Cervical Cancer Early Detection Program which helps uninsured women to get screening and access to treatment and by supporting research on health disparities in breast cancer.

What can be done at state and local health department agencies? The use of private and public partnerships to support healthcare systems and health insurance companies to help educate women and their doctors about the importance of timely and high-quality breast cancer care.

The use of outreach strategies to make sure that women understand why they need a mammogram and what to expect when a mammogram finds that something is not normal.

What can be done to address disparities on the healthcare systems level? Healthcare systems can work to engage well-trained case managers, well-

trained health educators and well-trained community health workers to help with patient navigation so that women can understand how to get through the system and can help guide these women through the healthcare system.

Healthcare systems to make sure doctors are informed about their screening and treatment rates of patients they're seeing in their clinic and explore strategies to help improve or enhance the patient-doctor communications. What can doctors, nurses and others who care for patients do?

Make sure that women get the recommended test and treatment, use tools such as electronic systems and other reminders that can notify patients when it's time to get a mammogram and they can continue to talk to women to educate them about their risk for breast cancer, help explain all of their test results and refer patients to specialists as needed for care.

Now, but what can women do themselves to help address disparities? On this site we have a link to 10 questions; send communications among the doctors doing appointments. This can help women make sure they understand and get the education that they need.

Women should make sure that they get the recommended mammogram. Women who cannot afford to get a mammogram can contact their local health department or community health centers to help them with assistance with getting that mammogram.

If the mammogram is abnormal and needs a follow-up, women should be sure to return for the recommended test. If they indeed are told they have breast cancer, they must ask about the kinds of treatment that are available and be sure that they get the treatment needed. Thank you and now I'll turn over to Ms. Wright.

Nancy Wright: Thank you, Dr. Miller. I am Nancy Wright and I run the Breast and Cervical Cancer Early Detection Program here in Alabama. It's part of the Alabama Department of Public Health. What I'd like to begin with is a brief overview of our care coordination program.

The ABCCEDP or the Alabama Breast and Cervical Cancer Early Detection Program submitted a grant with the CDC. Our goal is to provide proactive patient navigation that target a countywide healthcare delivery system and specifically to target the Hispanic population.

In the past our program was more reactive than proactive, more retrospective even than prospective. Our program was used to support providers and follow-up their patients who had an abnormal screening test.

We were comfortable with discussing questions or concerns about the diagnostic care with the patients if they were to call. We didn't hesitate to contact the providers if, while we were monitoring their data, we discovered that the patients hadn't received their diagnostic services in a timely manner.

We didn't even mind working with the providers to help remind the patients to come back in, but we wanted to move more, as I said earlier, to a proactive effort. We wanted to reach out to target populations that had disparate care.

We wanted to coordinate that care from the beginning -- from recruiting them to getting them into the screening -- helping them with other healthcare concerns, linking them with the healthcare system, and then of course, following-up if there was an abnormal result or a need for treatment.

Let me tell you a little bit about the countywide healthcare delivery system that we were working in. We chose Marshall County. Marshall County was a rural county - still is - and they have a population of under 20,000.

In that county, they only one hospital although it's in two locations. They have one federally-qualified healthcare center and one county health department. They have practically nonexistent public transportation across the entire county and in the last couple of years, that county has seen a rapid increase in Hispanic and Latino residents.

The site that we chose in Marshall County was the Marshall County Health Department. With this grant, what we did was hire a social worker that had been working in that health department and designated her as a patient navigator for the program.

We also contracted with one of our partners in the state, Sowing the Seeds of Health. Sowing the Seeds of Health is with UAB, which is the University of Alabama in Birmingham. They have an evidence-based program that essentially helps to reach out and recruit the Hispanic Latino population and link them, or give them access to, the healthcare system.

This partnership was the core of this grant activity and the reason for our success. If you'll look on Slide 18, I put together a visual to depict the partnership that we have with the Sowing the Seeds of Health.

Towards the top you see three squares. On the left side is the Hispanic community, in the middle is the cancer screening and then follow-up care if needed. What I'm trying to depict there is the care continuum.

You've got a community that is not receiving care and doesn't have access to care and we wanted to reach out to them and bring them in to receive breast and cervical cancer screening. Then, if there's an abnormal result, to help them access follow-up care and treatment if needed.

Within the Hispanic community, with this model, through the Sowing the Seeds of Health, we were able to work with the (promotores) in that community. They are Hispanic lay health educators and they helped us to recruit women and to educate them about the need for breast and cervical cancer screening.

The (promotores) through the Sowing the Seeds of Health, actually would setup an event, sometimes on a large scale, sometimes on a small scale and we would be there to assist. At those events, not only would education happen but also we would be able to work with women directly to go ahead and setup appointments.

Once those appointments were set up, then the promotores helped with the transportation to get women to that cancer screening at the Marshall County Health Department. At that point, ADPH would assist with the screening. We had interpreters available there and we were able to give the psychosocial assessment to those women.

The promotores were always welcome to be there. They were there to help us make or help the woman feel comfortable.

For those that had an abnormal result, again we tried to navigate them to receive follow-up care. Again the promotores were there often times to help us get back in touch with those women and help to communicate with those women that they needed to call the health department back.

Then often they would assist with the transportation. And then we were there with interpreters to accompany them and to help them understand what diagnostic testing was going on and answer any questions that they may have had.

The real point to this slide really is to show that there was interaction between the Sowing the Seeds of Health and their promotores and the Alabama Department of Public Health. Or Marshall County Health Department is a part of them.

That's what ADPH stands for. For the social worker in that unit - the patient navigator - to be able to work closely with women throughout the continuum of care; there was constant interaction and there was accountability.

In the beginning it may be more that the promotores led and were more supportive. And then it flips near the end -- where Marshall County Health Department -- the patient navigator may have had a more direct role. But throughout, they stayed in touch and both were there for those women.

All right, I would like to now give Allison a chance maybe to go more into depth about the Sowing the Seeds of Health and how their program works. Allison?

Allison McGuire: Yes, thank you, Nancy. Again I'm Allison McGuire with the University of Alabama at Birmingham Division of Preventive Medicine and I run the Sowing the Seeds of Health program that Nancy's been speaking of. So just to give you a brief overview of our component of the project, Sowing the Seeds of Health is a community-based educational program conducted by UAB.

The program educates lay individuals from the Latino community with knowledge and skills necessary to promote health and connect individuals to affordable healthcare.

The overall goal of the program is to educate Latina immigrants on breast and cervical cancer, early detecting screening via community health advisors or promotores de salud. The program is implemented by identifying and recruiting natural helpers or volunteers from the Latino community.

These natural helpers are then trained on health topics such as breast cancer, cervical cancer, family planning, sexually-transmitted infections, healthcare access. And we also do a skills component of the training that focuses on skills such as communication, problem-solving, stages of change, public speaking and those sorts of thing.

The empowerment model is used to encourage the promoters to take responsibility for their own health as well as facilitating responsibility among other Latinos in their community. These trained promotores, as we call them, then educate and disseminate health information to other Latinos in the community via events or activities as they see fit.

So once these promoters are identified and trained, they develop their own plan of action to determine what they want to do, where they want to do it, and how they want to reach the Latino community, based on the needs of the community.

This project is focused on breast and cervical cancer. So the group of promoters decided they wanted to host an educational luncheon or event on the topic of breast and cervical cancer.

So in order for us to offer screening services along with the education, we partnered with the Breast and Cervical Cancer Early Detection Program, the local health department, as well as hospital administration, to provide pap smears and mammogram appointments as part of the events.

So the clinics would block the appointment times prior to the event so the women attending the luncheon could leave the event with their scheduled appointment in hand.

If you are following on the slides - I'm moving on to Slide Number 20, I believe. So, as mentioned, the lay health providers plan, organize and implement the educational events and play a central role in promoting the event in the community by health-related newsletters that they distribute in local churches, by encouraging priests and pastors to promote the event, posting flyers in the community, radio advertisements on the Latino radio stations as well as word-of-mouth in their social networks.

As Nancy kind of mentioned, the events themselves consist of an educational talk on breast and cervical cancer early detection and screening. The talk is given by a Spanish-speaking physician so that they have the opportunity to ask any questions they may have.

And we also have a testimony by a Latina breast cancer survivor which has proven to be a very important aspect of these events. It allows the women to see someone such as themselves who has survived with cancer. Then, following the educational sessions, the participants are able to schedule a pap smear or mammogram at a local clinic, as we discussed earlier.

And although the program historically has held larger events at local churches, the State of Alabama recently passed a local anti-immigration law that has called for new innovative ways of reaching this population.

So the promoters decided, given immigrants' fear of driving because of their legal status, that rather than hold larger events at the local churches, they decided to have neighborhood gatherings in local trailer parks or apartment complexes where the women could walk to the sessions from their homes.

During these sessions, the women were provided with similar education, as well as given the opportunity to sign-up for appointments. And as Nancy mentioned, the promoters then coordinated transportation to the clinics or helped link them to someone that could take them -- that had, you know, had a driver's license -- and so they could obtain their free or low-cost pap smear or mammograms through the early detection program.

So essentially the promoters served as a link to the breast and cervical cancer screening visit. And then, once they arrived at the health department is where the patient navigation piece came in -- to make sure that they got all of the follow-up care that they needed. So, Nancy, do you want to go on and share what the health department did once we got them to the clinic?

Nancy Wright: Sure. Once the patients came to the health department for those appointments, they met with the patient navigator or the social worker that was assigned to Marshall County. In that appointment, the patient navigator did a psychosocial assessment. And an alternate interpreter was there in case there was a language barrier.

When I say psychosocial assessment, what that includes is sort of an interview that goes over what the woman's finances might be, what her living environment might be, her work history.

There's a screening for depression, for domestic violence, for human trafficking and various other parts to that screening, the idea being that the patient navigator could then refer them to resources that may be beyond the breast and cervical cancer screening.

Together the patient navigator and the woman would come up with a case plan or a plan of action and the plan of action would be to eliminate barriers not necessarily to this screening but to also review future screenings and future healthcare needs and whatever other issues had come up with the psychosocial assessment.

The purpose of all of this was so that the patient navigator could provide resources to that woman so that she could be self-sufficient. Once the psychosocial assessment was complete and the initial office visit was held, the patient navigator worked with her to setup a mammogram appointment. Often she accompanied the patient with the interpreter.

Again if follow-up was needed then the patient navigator assisted with that follow-up appointment by accompanying them or being there when they arrived. Sometimes some (promotores) were there as well and answering any questions and helping her as the continuum of care moved forward. Again if treatment was needed, the patient navigator was there as well.

In order to fulfill this role, the patient navigator had to do a lot of initial work as well as continuous work throughout the grant. She had to identify and negotiate for low-cost mammograms from other providers in that community.

Often there would be women that maybe were not eligible specifically for the breast and cervical cancer program. They may not be the right age range, may not have the right income so she would find other providers that would enable the opportunity to offer not only low-cost mammograms and pap smears but even low-cost diagnostic care.

She developed a resource book that had all these resources in it. She developed it in Spanish so that not only the patients would benefit but also the other providers in the community.

She often assisted in resolving patient billing issues for a lot of these women and we had the opportunity to provide medical dictionaries in Spanish to the medical providers in Marshall county which they were very appreciative of so what were the results of our program?

We saw a significant increase in the number of Hispanic women that we served in Marshall County Health Department. It was a 77% increase. Normally we may see 66 - a little over 60 - Hispanic or Latino women. That moved to 117 women. Forty-eight of those women that really accounted for most of that change were refers from the Sowing the Seeds of Health program.

The results of improved infrastructure. By working with all those providers and negotiating with them to offer low-cost services, it helps the whole care system collaborate better and work together better to serve these patients that needed access.

A fund was established at the hospital. It was expanded so that more women could be reached. Again the resource book was available to the community

and more important than anything else, the value of patient navigation was demonstrated to the providers in that community.

The hospital began to see how patient navigation could work and how making these links between the health department and the hospital and the gynecologists and all the other providers could help improve care for the patients. I do believe that disparities can be reduced by using patient navigators and taking advantage of and setting-up partnerships like this.

We will continue to work with the Sowing the Seeds of Health. Even though the grant has ended, the experience has been invaluable. Currently we're trying to setup something similar in Dallas County which is a county that has a disparate African-American population.

And the idea there is they're saying can we work with that health department to block-off appointments and make sure we have a resource book and make sure the social workers there are taking on that patient navigator role and linking those in need in the community with not only their services but the services and the other providers and the hospitals in that community to make sure that everyone whether they're eligible for breast and cervical program or not can tap into the resources available.

All right, I think that concludes our presentation. Allison, did you have anything to add?

Allison McGuire: No, I think you pretty much covered it, thank you.