

BEYOND OCTOBER HOW FAR HAVE WE COME?



BREAST CANCER DISPARITIES

IMPROVING ACCESS TO AND QUALITY
OF BREAST HEALTH SERVICES

IN CHICAGO

A Report by the
Metropolitan Chicago Breast Cancer Task Force

October 30, 2014



DEDICATION

HUMAN PROGRESS IS NEITHER AUTOMATIC NOR INEVITABLE... EVERY STEP TOWARD THE GOAL OF JUSTICE REQUIRES SACRIFICE, SUFFERING, AND STRUGGLE; THE TIRELESS EXERTIONS AND PASSIONATE CONCERN OF DEDICATED INDIVIDUALS.

- MARTIN LUTHER KING, JR.

THIS REPORT IS DEDICATED TO ALL WOMEN IN CHICAGO,
WE HAVE ACCEPTED THE CHARGE TO DEMAND BETTER SO THAT WE ALL WILL SURVIVE TOGETHER.



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NIKHIL PRACHAND

DANA HARPER

MARGARITA REINA

ARLENE HANKINSON

JANIS SAYER

PARTNERS

SINAI URBAN HEALTH INSTITUTE

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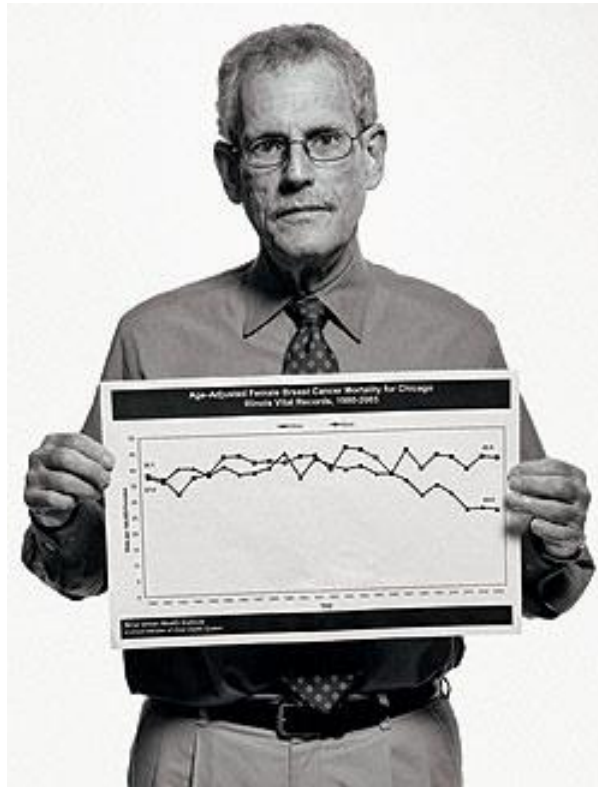
MELISSA SIMON

JACKIE KENDALL

RONNA S. STAMM

BABS H. WALDMAN

IN HONOR AND MEMORY



Dr. Steven Whitman
"The Deadly Difference" Chicago Magazine, 2007

In July 2014, the Task Force lost one of its founders. The leadership and vision of Dr. Steve Whitman guided the Sinai Urban Health Institute in ground breaking research that revealed the devastating racial disparity in breast cancer mortality here in Chicago and across the nation. Dr. Whitman's work was renowned across the country and refocused our lens to work toward meaningful change for minority women in Chicago. Dr. Whitman's legacy is profound and his charge is heavy. He lived with audacity and challenged all of us to do the same. It is with heavy hearts but clarity of focus that we write this report in honor of Dr. Whitman. He was a great mentor, teacher, statistician, activist, colleague and friend and he is greatly missed.

BEYOND OCTOBER
HOW FAR HAVE WE COME?

BREAST CANCER
DISPARITIES

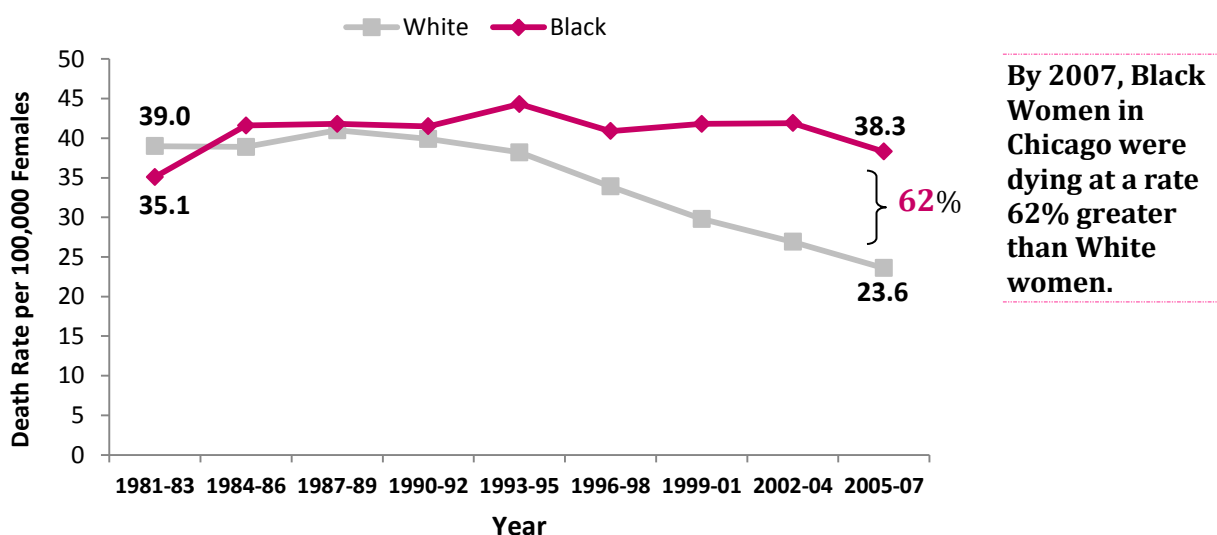
IMPROVING ACCESS AND QUALITY OF BREAST
HEALTH SERVICES IN CHICAGO

A REPORT BY THE:
METROPOLITAN CHICAGO BREAST CANCER TASK FORCE

INTRODUCTION

The Metropolitan Chicago Breast Cancer Task Force (Task Force) was founded in 2007 following the release of disturbing data showing unacceptable breast cancer outcomes for black women compared to white women in Chicago.¹ Building upon this original research and illustrated below, the data shows that between 1981 and 2007, there was a large and growing disparity in breast cancer survival for black women compared to their white counterparts.

Figure 1. Black: White 3 Year Age-Adjusted Aggregate Breast Cancer Mortality Rates in Chicago, 1981-2007



Data Source: Illinois Department of Public Health Vital Statistics

Data Prepared By: Sinai Urban Health Institute

In 2008, the Task Force was established as a nonprofit dedicated to promoting health equity and increasing access to quality health care for all women. From the beginning, the Task Force has led the charge in eliminating racial-ethnic and class based disparities in breast cancer outcomes for minority and underserved women. The Task Force has continued to work diligently to address the issues underlying the unnecessary deaths of our mothers, sisters and friends. In the past few years, the Task Force has initiated projects that have established best practice guidelines in breast cancer mortality prevention efforts. The Task Force takes a comprehensive approach to understanding and solving this complex problem by gathering data, conducting quality improvement projects, providing support and advocating on behalf of minority and underserved women. This report is a reflection on the accomplishments of the Task Force since inception and an examination of the state of breast cancer disparities in Chicago today.

CALL TO ACTION

DOCUMENTING DISPARITIES IN BREAST CANCER MORTALITY IN CHICAGO

Community concern surrounding the published disparities data led to a Call to Action that mobilized the metropolitan area to demand change. As a result, physicians, community leaders, and public health advocates across the Chicagoland area convened to form the Metropolitan Chicago Breast Cancer Task Force in 2007. The Task Force published an initial report in October 2007 entitled “Improving Quality and Reducing Disparities in Breast Cancer Mortality in Metropolitan Chicago.”² The report summarized, for the first time, the state of breast cancer disparities in Chicago and highlighted three possible issues causing the increased death rate for Black women:

- ❖ *Less Access to mammography,*
 - ❖ *Lower Quality of mammography services,*
 - ❖ *Less Access to and lower quality of treatment.*
-

These findings began a city, state and national conversation about the impact of gross inequity in health care for minority and underserved populations.

Following the published report, further investigation into the problem by Task Force associated researchers confirmed that differences in access to breast cancer screening and treatment, poor quality mammograms, and overall insufficient use of breast health services are major contributors to this problem.^{3,4,5,6,7}

In Chicago, access to and quality of breast care are related to capacity and geography. A local study of mammography capacity in Chicago demonstrated a considerable unmet need in screening mammography services.⁴ The city does not have adequate screening mammography capacity defined by the number of machines to adequately screen every woman over 40 years old annually. In addition, just following the initial report, there was a shortage in fellowship-trained radiologists and specialized radiology technologists. Over the past several years, there is no longer a shortage in specialized or fellowship-trained radiologists³; however, our data shows there is still a considerable inequitable geographic distribution of these providers. These specialized providers

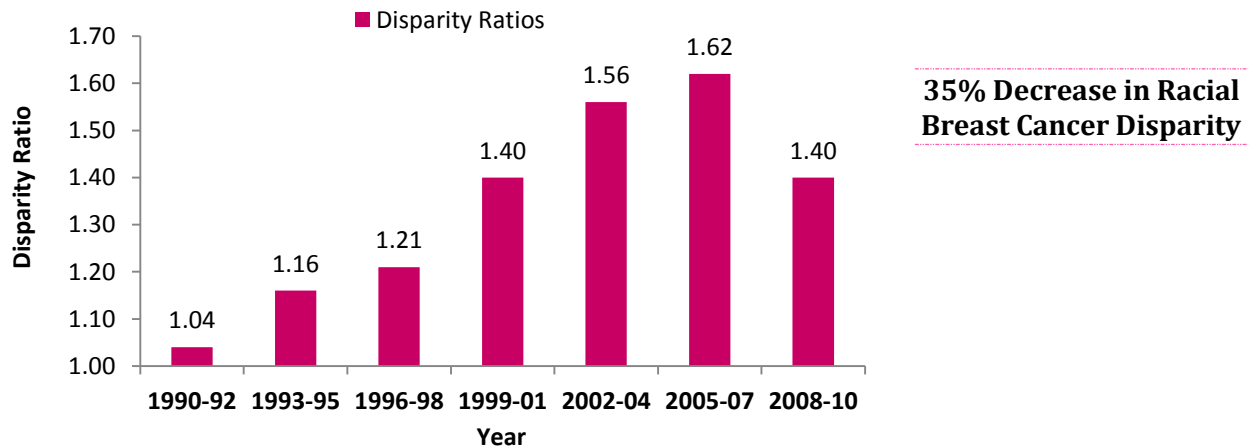
equate to quality care, which is concentrated in high volume and/or academic facilities in the Chicago metro area. The study also found that high volume facilities were less likely to serve patient populations who were majority Black or Hispanic.⁵ To further exacerbate the problem of access, Chicago's largest public hospital reduced their provision of screening mammograms; eliminating 10,000 screening exams that were previously provided annually to predominantly underserved women.⁸ The City of Chicago's Department of Public Health clinics have also decreased the volume of mammograms they provide and have recently lost state funding for mammography services due to state alleged poor quality.⁹ Furthermore, the statewide screening program for uninsured women (the Illinois Breast and Cervical Cancer Program) is underfunded. In the last two years, the statewide program ran out of funds for screening mammograms within the first 3 or 4 months of the state fiscal year. Insufficient capacity and uneven geographic distribution of the capacity that does exist are among the major contributing factors to these disparities. In addition, Black women are less likely to have their mammograms read by breast imaging specialists;³ more likely to present with later stage breast cancer;^{1, 10} and more likely to experience delays in diagnosis and treatment compared to White women.³ In the recently completed Breast Cancer Care in Chicago study, Black and Hispanic breast cancer patients in Chicago were less likely to report a screen-detected breast cancer when compared to non-Hispanic white patients (53% and 58% vs. 41%, respectively, $p=0.0001$). Some of this disparity may be due to lower rates of screening in ethnic minorities. However, even among patients reporting a recent screening mammogram (within the last 2 years), symptomatic detection was higher for Black and Hispanic than for non-Hispanic white patients (36% and 43% vs. 26%, respectively, $p=0.0003$). These results suggest that ethnic minorities may also experience a greater extent of ineffective screening mammography.¹¹ All these circumstances may lead to worse breast cancer outcomes and higher death rates.

A report by the Dartmouth Institute for Health Policy and Clinical Practice in September 2010 showed that among Medicare recipients aged 67 to 69; Chicago has the lowest mammogram screening rates in the nation.¹² Even lower screening rates are found in Illinois Medicaid.¹³ A local study exploring the impact of interpersonal barriers show that compared to Caucasian woman, Black women held more cultural beliefs and fear about breast cancer that caused them to delay seeking care for suspicious breast symptoms.¹⁴ These studies suggest that the disparity in mortality may be exacerbated by lack of effective breast cancer education, in addition to systemic barriers to access timely, quality mammography screening and treatment.

HOW FAR HAVE WE COME IN REDUCING DISPARITIES IN BREAST CANCER MORTALITY?

This report documents the first sign of a decrease in the mortality disparity here in Chicago, as seen in Figure 2. Since the 2005-2007 time period, the racial breast cancer disparity has decreased 35 percent. Given all the attention and work directed toward the goal of reducing this disparity, this result is heartening.

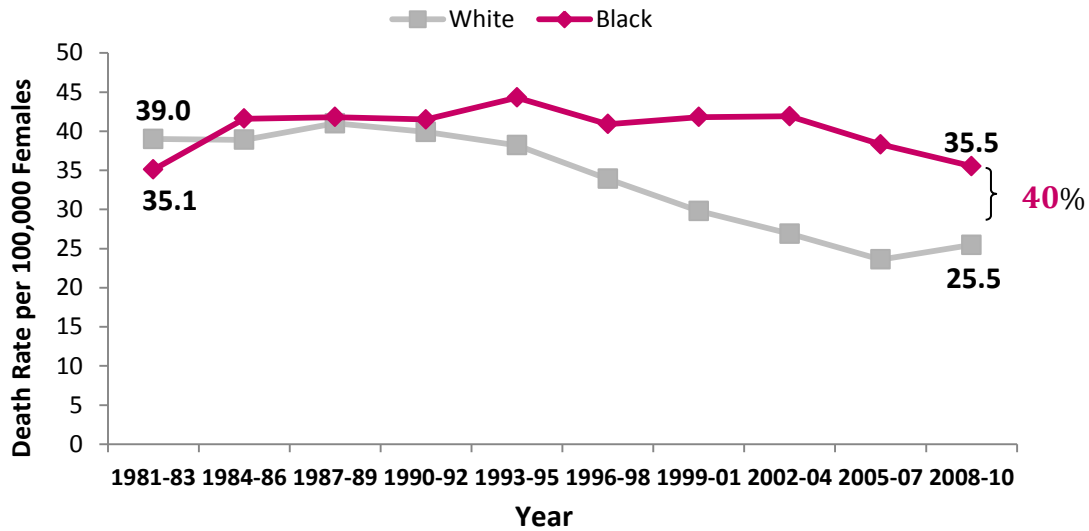
Figure 2. Breast Cancer Mortality Disparity Trend, 1990 - 2010



Data Source: Illinois Department of Public Health Vital Statistics
1990-2007 Data Prepared By: Sinai Urban Health Institute
2008 - 2010 Data Prepared By: Chicago Department of Public Health

When researchers from the Sinai Urban Health Institute first reported on Chicago's breast cancer disparity, it had been persistently increasing for close to 20 years. Finally, 2008-2010 averaged death rates shown in Figure 3 illustrate a considerable decrease in the disparity. While we cannot say with any certainty what specifically has caused the reduction in the disparity, we are encouraged to see the decline amidst a wide array of activities by ourselves and others whose goal is to reduce this unjust disparity. While there is a slight increase in the death rate for White women, the decrease in the gap is primarily due to a much more pronounced reduction in mortality for Black women.

Figure 3. Black: White 3 Year Age-Adjusted Aggregate Breast Cancer Mortality Rates in Chicago, 1981-2010



Data Source: Illinois Department of Public Health Vital Statistics
 1981 – 2007 Data Prepared By: Sinai Urban Health Institute
 2008 – 2010 Data Prepared By: Chicago Department of Public Health

Between 2005 and 2007, there were on average 80 excess deaths annually in Black women due to this disparity. Between 2008 and 2010, the annual excess deaths in Black women were down to on average 55 Black women. As shown in Figure 4, the 35% reduction in the disparity saved the lives of on average 25 Black women annually between 2008 and 2010. However, we still have a considerable amount of work to do to eliminate all excess deaths due to unequal access and quality of breast health services for minority women. The 55 gray silhouettes representing the unnecessary loss of Black women’s lives in Figure 4 poignantly illustrate the importance of your support to continue addressing this problem.

Figure 4. Between 2005 and 2007, each year 80 Black women died unnecessarily due to the disparity. However, the recent (2008 - 2010) decrease in the disparity resulted in 25 lives saved.

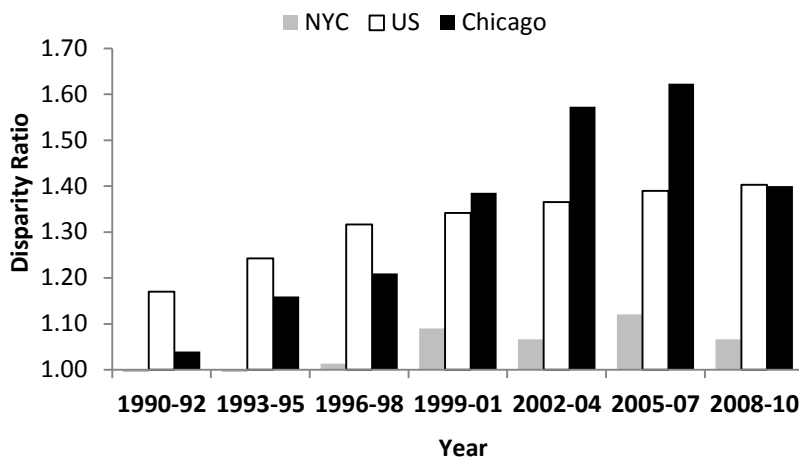
Figure 4. Lives of Black Women Impacted by Breast Cancer Disparities in Chicago



HOW FAR HAVE WE COME COMPARED TO THE US AND OTHER CITIES?

While progress has been made in the last few years, Chicago's inequality has represented one of the highest racial disparities in breast cancer mortality in the United States. A recent study of similar metropolitan cities in the US demonstrates that Chicago has the seventh highest racial disparity in breast cancer mortality – 40% – compared to New York at 19%. Other cities such as San Francisco have no disparity.¹⁵ This extreme geographic variability in breast cancer mortality between numerous racially/ethnically diverse cities across the United States suggests that differential biology is not the driving force behind this problem. Even if scientific literature identifies a subset of women who have more aggressive tumors in particular among women of African descent,¹⁶ the fact that the mortality disparity is so much lower in New York, Baltimore and San Francisco compared to Chicago suggests that the health system in these cities better supports survival compared to Chicago's health system.

Figure 5. Black: White Disparities in Breast Cancer 3 Year Age-Adjusted Average Annual Mortality Rates in Chicago, New York City and the United States, 1990-2010

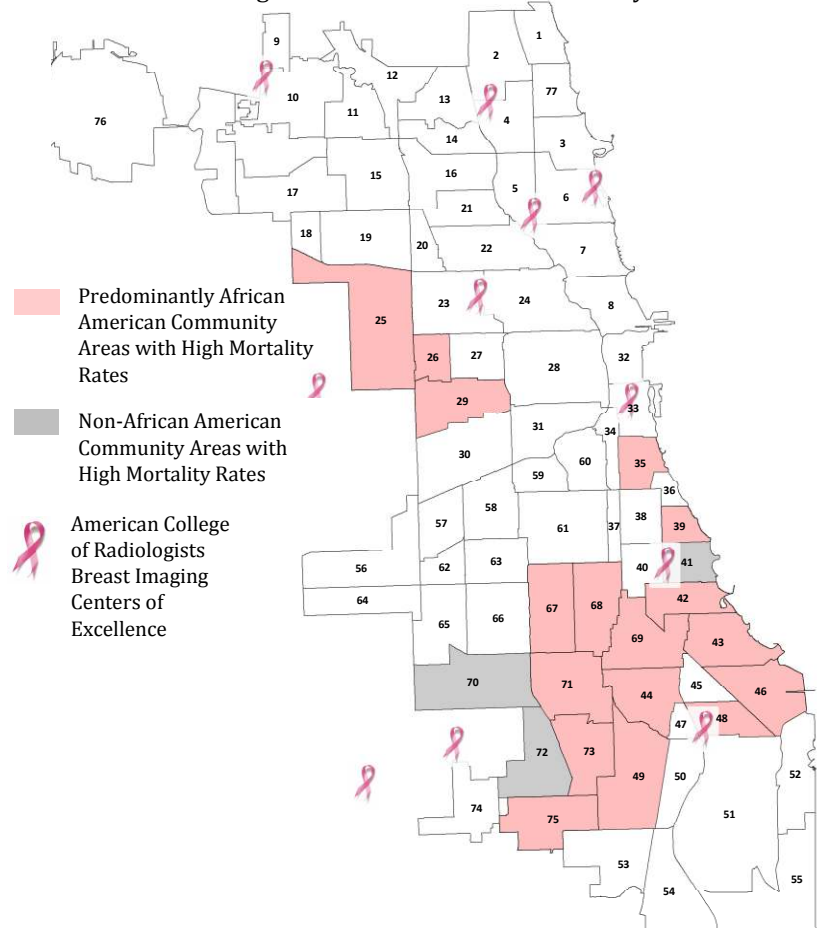


Data Source: New York State Cancer Registry,
Illinois Department of Public Health Vital Statistics, National Center for Health Statistics

WHAT IS HAPPENING IN CHICAGO NEIGHBORHOODS?

Despite its rich diversity, the city of Chicago is the most racially and economically segregated city in the country.¹⁷ The impact of a long history of systematic racism is quite visible by looking at important economic and resource differences between the 77 community areas across the city. Figure 6 reveals that the communities impacted the most by the disparity in breast cancer deaths remain on the South and Westside of the city. The map illustrates the 20 community areas with highest death rates. Seventeen out of the 20 communities are predominantly African American communities, indicated by the areas shaded in pink; the remaining three areas shaded in grey are high mortality areas that are not predominantly African American communities. In addition, the map depicts the location of the American College of Radiology Breast Imaging Centers of Excellence. Only one of these centers is located in a high breast cancer mortality community; thus documenting the inequitable distribution of resources for communities in need.

Figure 6. Twenty Chicago Community Areas with the Highest 2006-2010 Average Annual Breast Cancer Mortality Rates



Data Source: Illinois Department of Public Health Vital Statistics.

THE CHANGING GEOGRAPHY OF BREAST CANCER DISPARITIES

Further studies of Chicago's community areas, with respect to where the highest burden of death is since 2007, reveal a variety of changes in the locations most affected by high breast cancer mortality. In 2007, available data revealed a concentration of high death rates on the south and west sides of the city.² Recently, we compared the trends in breast cancer death rates for several community areas illustrated in the map in Figure 7. The most recent data indicates a decline in death rates for black women across the city generally, but community level analysis reveals thought provoking trends in death rates for several areas. The map illustrates the change in breast cancer death rates from 1999-2003 and 2006-2010 for the 20 Chicago community areas with the highest breast cancer death rates during these two periods. Trends in mortality rates were only compared when the community area had a greater than 20 breast cancer deaths in at least one of the two time periods.

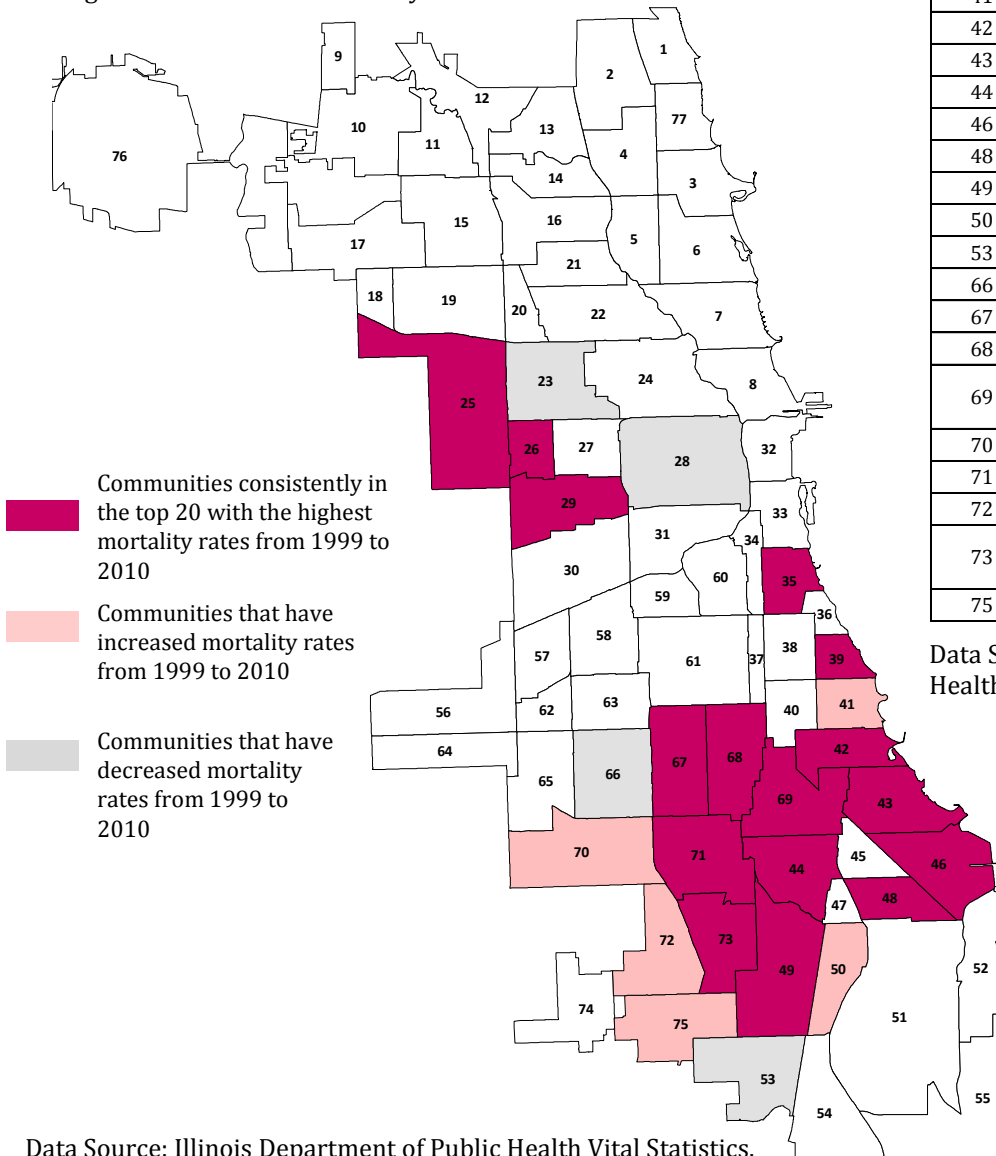
- The areas with the darkest shading represent communities that have suffered with excess mortality since 1999 and saw no improvements in breast cancer mortality. Some examples are Englewood, West Englewood, Woodlawn, South Shore, Roseland, Calumet Heights, West Garfield Park. These communities are represented on Table 1 as "consistently high".
- Areas shaded in light pink have experienced an increase in their death rates. Some examples are Hyde Park, Beverly, Ashburn and Morgan Park. The Pullman community did not have over 20 breast cancer deaths in either time period; however, there was a considerable increase in the number of breast cancer deaths increasing the overall breast cancer mortality rate.
- There are a number of community areas such as Humboldt Park, Near West Side, Chicago Lawn and West Pullman that have improved from 1999-2003 to 2006-2010 indicated by the grey shaded areas.

Further study of the community level trends are needed in context with the trends in access to clinical resources and population demographics with respect to race-ethnicity, employment and median income. Understanding the population and environmental changes overtime may shed light on the observed trends in breast cancer mortality while indicating key facilitators and barriers necessary to improve outcomes for the most impacted communities.

Table 1. Trends of Chicago Community Areas with the Highest Breast Cancer Mortality Rates

| Community Area | | 1999-2010 Mortality Trends |
|----------------|------------------------|----------------------------|
| 23 | Humboldt Park | Decreased |
| 25 | Austin | Consistently High |
| 26 | West Garfield Park | Consistently High |
| 28 | Near West Side | Decreased |
| 29 | North Lawndale | Consistently High |
| 35 | Douglas | Consistently High |
| 39 | Kenwood | Consistently High |
| 41 | Hyde Park | Increased |
| 42 | Woodlawn | Consistently High |
| 43 | South Shore | Consistently High |
| 44 | Chatham | Consistently High |
| 46 | South Chicago | Consistently High |
| 48 | Calumet Heights | Consistently High |
| 49 | Roseland | Consistently High |
| 50 | Pullman* | Increased |
| 53 | West Pullman | Decreased |
| 66 | Chicago Lawn | Decreased |
| 67 | West Englewood | Consistently High |
| 68 | Englewood | Consistently High |
| 69 | Greater Grand Crossing | Consistently High |
| 70 | Ashburn | Increased |
| 71 | Auburn Gresham | Consistently High |
| 72 | Beverly | Increased |
| 73 | Washington Heights | Consistently High |
| 75 | Morgan Park | Increased |

Figure 7. Geographic Distribution of the Chicago Community Areas with the Highest Breast Cancer Mortality Rates from 1999-2010



Data Source: Illinois Department of Public Health Vital Statistics.

HOW FAR HAVE WE COME IN IMPROVING ACCESS TO AND QUALITY OF BREAST HEALTH CARE IN METROPOLITAN CHICAGO?

THE CHICAGO BREAST CANCER QUALITY CONSORTIUM

A central Task Force hypothesis is that a significant driver in Chicago's healthcare inequities is unequal access to high quality care. The first step in quality improvement is quality measurement. To achieve this goal, the Task Force immediately after its establishment, created the Chicago Breast Cancer Quality Consortium (the Consortium). The Consortium is a healthcare collaborative bringing together healthcare facilities to measure breast care quality. The Consortium originally set up both a mammography and treatment quality data collection system working with facilities all across Metropolitan Chicago. The Consortium received federal designation as a Patient Safety and Quality Improvement organization in 2009, which provided federal confidentiality protection to the data collection. The results of the first two years of data collection were widely reported by the media in 2010 and the mammography results were published in the scientific literature earlier this year.¹⁸ The mammography paper demonstrated widespread variation in the ability of Metropolitan Chicago facilities to meet screening mammography quality benchmarks. Preliminary analysis of the treatment quality data has not yielded as wide a variation in facilities ability to meet the benchmarks chosen for measurement. This may be due to a lower level of participation by mid-sized facilities that serve a predominantly minority population, or perhaps is due to the benchmarks chosen or truly represents an absence in variation. Subsequent analysis of the processes of care across 26 facilities and later 90% of mammography and treatment facilities in Metropolitan Chicago yielded results suggesting considerable variation in resources available to navigate patients and a much more fragmented care system for many women relying on more limited service hospitals for care.^{19,20,21,22,23,24}



October 21, 2010, Monifa Thomas

The mammography quality measurement program has recently been incorporated into the state's Medicaid program. Mammography providers all across Illinois who sign up for the program and agree to submit quality metric data to the Consortium are eligible for a significant increase in their Medicaid reimbursement for mammography. In this first year of the initiative, 160 different facilities have submitted 124 sets of quality data representing 584,245 mammograms statewide.

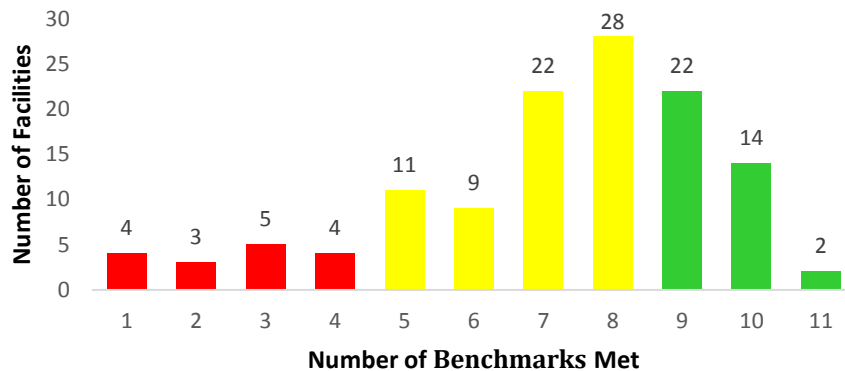
This is a tremendous level of participation and represents 80% by Medicaid volume of mammography across Illinois.

This project has 11 quality benchmarks and measures quality in 2 basic ways:

1. **Radiologist quality** – These metrics ask whether cancers are being found (cancer detection rate), whether they are found when small (% of cancers that are minimal), whether too few or too many women are called in for follow up after a screening mammogram (recall rate), whether too few or too many abnormal mammograms yield cancers (PPV1), or whether too few or too many biopsies yield cancers (PPV3).
2. **Facility care processes quality** – These metrics ask whether necessary follow up is happening on time, whether patients are lost to follow up at the time of diagnostic mammogram or at the time of biopsy.

Both of these types of measures are important for optimal identification of early stage breast cancer. Reading mammograms is a highly skilled procedure and a body of literature indicates that reading a certain volume of mammograms,²⁵ fellowship trained breast imaging specialists²⁶ or those radiologists who specialize or focus on reading mammograms do so more proficiently.²⁷ Additionally, there is considerable variation in the processes in place at facilities to ensure that necessary follow up takes place. Figure 8 below shows the overall results of the first year of mammography quality measurement statewide and demonstrates the considerable variation in the ability of facilities to meet these benchmarks. Only 2 facilities met all 11 benchmarks and 38 facilities met 9 or more of the 11 quality benchmarks. A full description of the metrics and the benchmarks is contained in the Statewide Mammography Quality Community Report.

Figure 8. The distribution of facilities submitting data meeting benchmarks



In addition to looking at overall attainment of quality benchmarks, we looked at how well facilities met specific benchmarks within the two classifications discussed above (radiologist quality and facility care processes).

Radiologist quality: Were cancers found? (Figure 9), were cancers found when small? (Figure 10)

Figure 9. Finding cancers. One in three facilities was unable to find enough cancers.

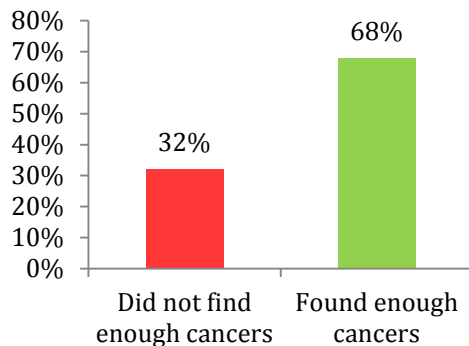
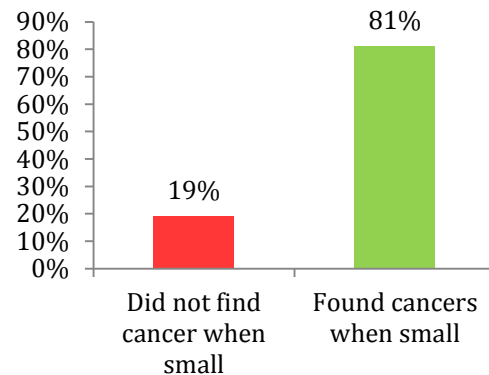


Figure 10. Finding small cancers. One in five facilities were unable to find cancers when they were small



Facilities care processes: Was necessary follow up happening on time? (Figures 11 and 12), Were patients lost to follow up at the time of diagnostic mammogram (Figure 13) or at the time of biopsy (Figure 14).

Nearly half of participating facilities (47%) were unable to meet the benchmark for timeliness of a diagnostic mammogram or timely receipt of a biopsy, as shown in Figures 11 and 12 below.

Figure 11: Timely diagnostic mammogram

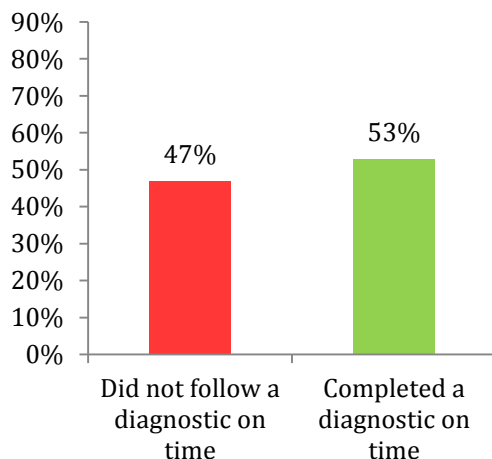
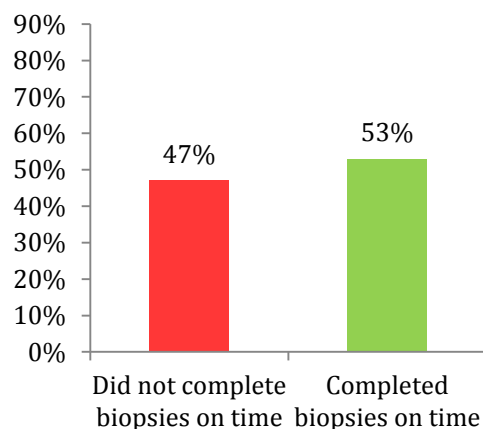


Figure 12: Timely biopsy



Loss to Follow-up: One out of every 4 facilities (25%) lost track of patients during the process of diagnostic mammogram follow up. One of every 5 facilities (19%) lost track of patients during the biopsy process.

Figure 13: Loss to follow up at Diagnostic Mammogram

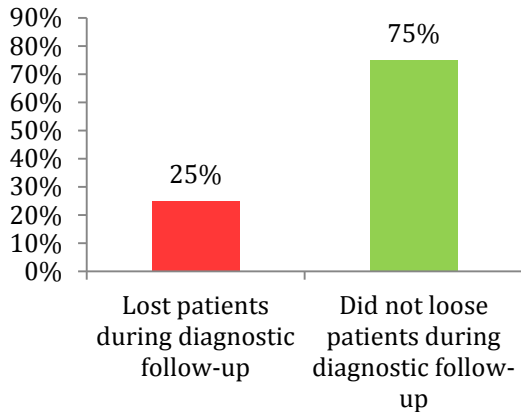
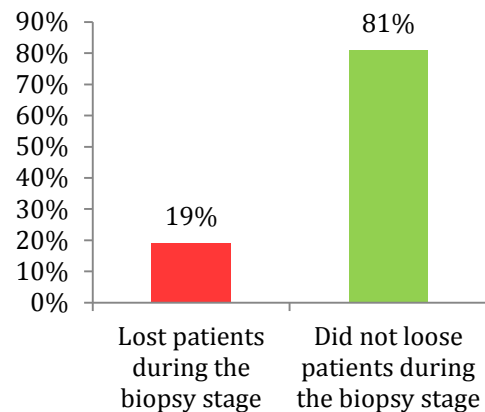


Figure 14: Loss to follow up at Biopsy



Additional details regarding how facilities statewide did with respect to each measure are available in our Statewide Mammography Quality Community report, published on the Task Force website at www.chicagobreastcancer.org.

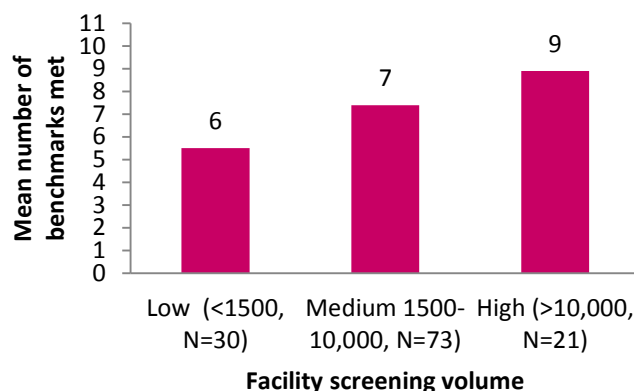
HOW DID DIFFERENT TYPES OF FACILITIES MEASURE UP?

We looked at a variety of different types of facilities to see how each type was or was not able to meet the various benchmarks. We looked at both overall achievement of benchmarks and also at achievement of specific benchmarks or benchmark types. Again, more information on the full array of analysis is provided in the Statewide Mammography Quality Community Report. A subset of the results is highlighted below.

VOLUME MATTERS – HIGH VOLUME MAMMOGRAPHY FACILITIES MEET MORE BENCHMARKS:

Similar to many other areas in healthcare and more generally, facilities that do a large volume of mammography tend to meet more benchmarks compared to those that do lower volumes of mammography. High volume facilities were those that performed 10,000 or more mammograms per year. Low volume facilities were those that performed 1,500 or less mammograms per year. On average, high volume facilities were able to meet 9 out of 11 benchmarks, compared to low volume facilities who met on average 6 out of 11 benchmarks (Figure 15 below).

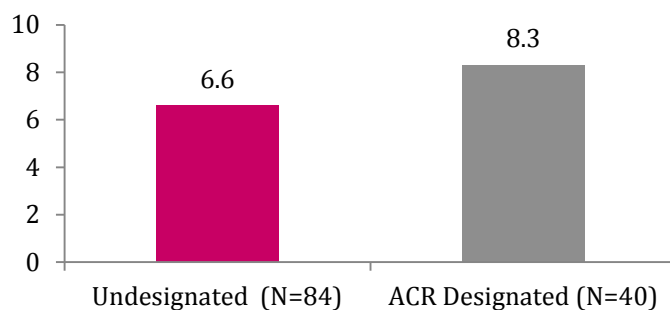
Figure 15. Mean Number of Screening Quality Benchmarks Met by Facility Screening Volume



CENTERS OF IMAGING EXCELLENCE MEET MORE QUALITY STANDARDS

Mammography facilities that go through a rigorous accreditation process by meeting certain standards set by the American College of Radiology are designated as breast imaging centers of excellence. We looked at whether facilities in the state that have this designation were more likely to meet the mammography quality benchmarks. Figure 16 below shows that American College of Radiology designated Breast Imaging Centers of Excellence are indeed able to meet a greater number of quality benchmarks compared to undesignated facilities (8.3 out of 11 benchmarks met by designated sites, compared to 6.6 benchmarks met by undesignated sites)

Figure 16. Number of Benchmarks Met by Centers of Imaging Excellence

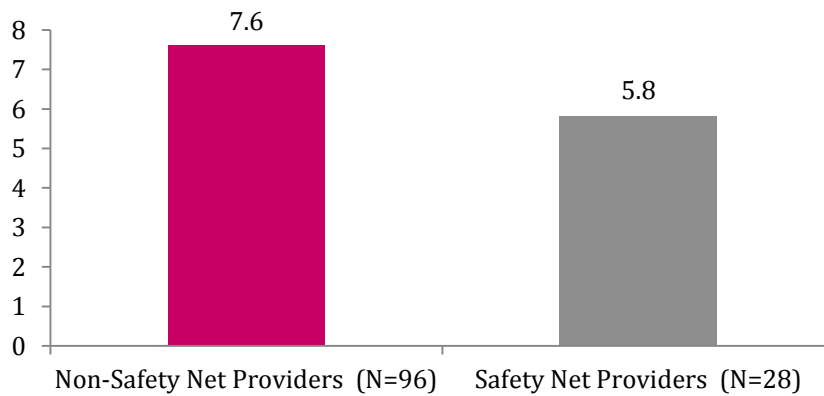


SAFETY NET FACILITIES - HAVE MORE CHALLENGES

We looked at facilities that are designated either as public providers or who qualify for specific safety net provider payments in Illinois Medicaid. These are facilities that disproportionately serve the poor and have fewer resources because of their payor mix. They have far more uninsured patients and patients served by Medicaid some of whom have significant challenges in life that makes loss to follow up potentially more likely. The Medicaid program in

Illinois reimburses providers in general well below all other payors including Medicare. This puts additional burden on these facilities to support their patients with fewer resources than other facilities. The Figure below shows that indeed, safety nets were less likely to meet the quality benchmarks (5.8 out of 11 for safety net providers compared to 7.6 out of 11 for non-safety net providers). In particular, meeting timeliness and loss to follow up benchmarks were more challenging for the safety net.

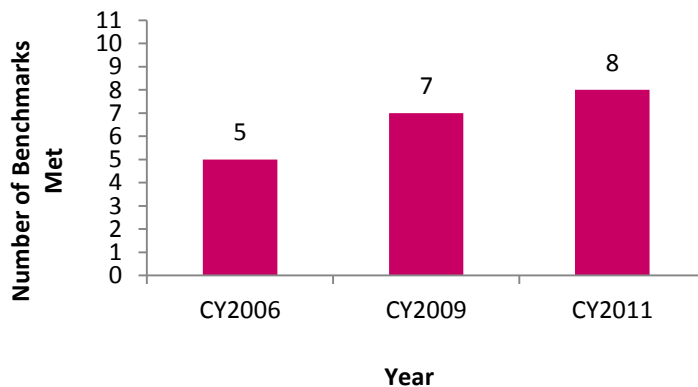
Figure 17. Benchmark Attainment for Safety Net vs Non-Safety Net Facilities



IMPROVEMENT OVER TIME:

The mammography quality measurement project has been in operation on a voluntary basis in Metro Chicago since 2009. Figure 18 below shows that facilities who have participated continually over that period show improvements over time, as demonstrated by the steady increase in the total number of mammography quality benchmarks met over time.

Figure 18: Average Number of Benchmarks Met by Calendar Year



ADVOCACY AND PUBLIC POLICY

The Task Force's community organizing and public policy programs are working to address breast cancer death disparity in Chicago. Working with our community partners, we launched the Screening Saves Lives advocacy campaign in 2010 with the goal of increasing funding for the Illinois Breast and Cervical Cancer Program (IBCCP), which provides free mammogram screenings and breast cancer treatment

for uninsured women. Women of color rely on this program more than other groups because they are more likely to be uninsured. Each year, this critical funding, which serves less than 10% of eligible women, is threatened. The Task Force responds with advocacy and legislative initiatives. These efforts have successfully preserved \$8.2 million in funding for the program. Importantly, the Task Force engages grass roots organizations that serve African American and Latina women, helping to increase success and engaging the community.



Advocacy Day 2012, Springfield

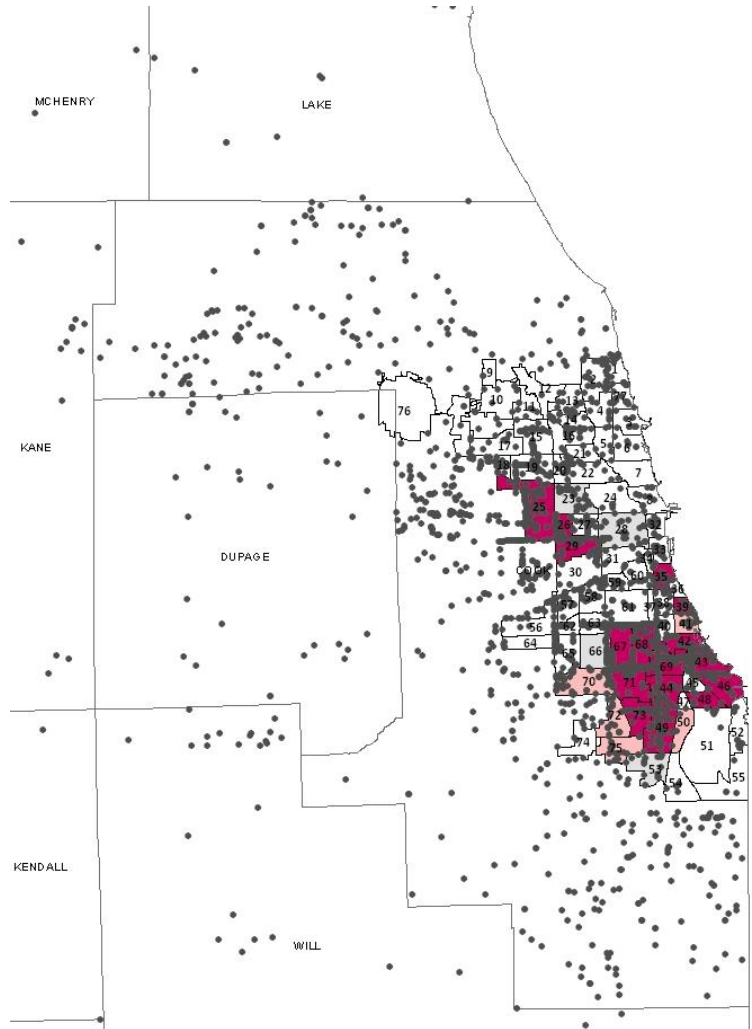
In addition to supporting funding for IBCCP, the Task Force is working on new legislation to improve our healthcare delivery system so that, in particular, medically underserved, minority, and poor women have improved access to high quality care. Representative Mike Smiddy has introduced the Breast Excellence in Screening and Treatment Act (HB6285) and the Task Force, in collaboration with Susan G. Komen Illinois affiliates and the American Cancer Society, is working to pass this legislation.

THE METROPOLITAN CHICAGO NAVIGATION INITIATIVES

Patient navigation has emerged over the past decade as an effective intervention to address individual level barriers, facilitating screening utilization and navigating a fragmented health care system. Over the past several years, numerous organization and health care facilities have implemented client navigation programs to address contributing factors to disparate breast cancer outcomes. One challenge to the success of existing programs is the variation in points of intervention as well as the narrow scope of many of the programs. In 2012, the Task Force implemented two community navigation programs, Screen to Live and Beyond October. The programs were designed to use community based outreach and media campaigns respectively, to reach women and connect them to quality breast health care from screening through diagnostic follow up.

Through collaborations with area facilities, over 2300 mammograms have been donated to the Task Force. To date, over 2000 women have been navigated and 1602 have completed their mammograms. We navigated 226 women through diagnostic follow up. 13 women have been diagnosed with cancer; all of these women have been navigated to academic Commission on Cancer accredited comprehensive cancer programs. Figure 19 depicts the geographic reach of our program.

Figure 19. Distribution of Women Navigated by the Task Force.



Data Source: Illinois Department of Public Health Vital Statistics.

One of the most profound lessons learned over the past eighteen months came at the cost of a young woman's life. Six months ago, a young woman in her mid-thirties was referred to the Task Force by a clinical partner. When we met her, the woman had gone to the doctor concerned about a rash on her breast that persisted for over six months. She was provided with several rounds of antibiotics to no avail. After some time and several tests, she was advised to get a biopsy. A health care worker was concerned about her patient because she did not have insurance in addition to several other barriers. The health care worker referred the young woman to the Task Force to see if we could assist the client in accessing quality care at no out of pocket cost. A week following the referral we were able to get the young woman a biopsy. She was diagnosed with STAGE 4 Inflammatory Breast Cancer. She was immediately linked into treatment; however, she died three weeks later. There are numerous factors that must go right to give women optimal outcomes. While we did everything we could in the brief time of navigating the young woman, her experience is a constant reminder of the importance of our interventions and the truly devastating impact of this disparity. From each woman we navigate, we learn more about our health care system and establish improved mechanisms to facilitate screening utilization through education and access to quality care.

As a result recently, the Task Force began two pilot navigation programs, *Extra Help Extra Care* and *Beyond Enrollment*. *Extra Help Extra Care* is a pilot project created to demonstrate the benefit that a shared nurse navigator can have for community hospitals and most importantly their patients. Through this initiative, a dedicated nurse navigator will work across multiple healthcare facilities in order to ensure their patients receive timely, appropriate, and quality care across the continuum of their breast care. *Beyond Enrollment* responds directly to the impact of the Affordable Care Act on the Task Force's target population. Many thousands of low-income minority women in Metropolitan Chicago over the age of 40 have enrolled or will enroll in Medicaid or subsidized health insurance through 2015. The vast majority has been uninsured for years and, as newly insured, will need assistance identifying available high-quality PCPs and learning how to appropriately access primary and preventive care. *Beyond Enrollment* works directly with safety-net PCPs to improve breast health referrals, and monitors women's overall satisfaction with primary care.

WHERE DO WE GO FROM HERE?

It is the mission of the Metropolitan Chicago Breast Cancer Task Force to save women's lives by eliminating health disparities in Illinois, through the lens of breast cancer. We aim to overcome this unfair disadvantage in breast cancer mortality and to go beyond by decreasing breast cancer mortality for all women by:

1. Increasing access to quality breast health care for all women: This year, we are on target to navigate over two thousand women in partnership with 18 institutions, a 25% increase from last year. In addition, via our innovative *"Extra Help, Extra Care"* program, women in need of diagnostics and breast cancer treatment will receive more cohesive and comprehensive navigation.
2. Improving the quality of mammography for all women across Illinois: Through our Mammography Quality initiative, we expect mammography facility and radiologist provider participation to increase between 5-10%. This will allow us to provide feedback on the quality of an estimated 650,000 mammograms across the state, a first in the nation effort to build such informative mammography surveillance system. Armed with this data, we will continue to engage relevant stakeholders in custom process improvement initiatives to collectively increase the quality of mammography at the provider, technician and facility level. This information-intervention approach represents one more step towards eliminating the disparity. It is also a replicable and scalable model to address breast cancer disparities across the country.
3. Improving access to high quality treatment: We will continue to build upon our treatment quality data project and to potentially retool it to more accurately and comprehensively measure attainment of the full complement of breast cancer treatment. We will also move forward with our new *Extra Help-Extra Care* program to ensure that more women of color access comprehensive care at Academic Commission on Cancer accredited cancer programs.
4. Advocating to enact policy changes to strengthen our healthcare system: Our fierce ladies in pink will once again travel to Springfield to passionately advocate against cut to the Illinois Breast and Cervical Cancer program and to advocate for new legislation HB6285 recently introduced by Representative Mike Smiddy.

5. Partnering with you: While the funding environment over the past several years has been challenging, our organization prides itself on its resilience and resourcefulness. This is a reflection of our staff and our partners. Therefore, we will continue to knock at your door and invite you into our home through events such as the upcoming Gala - Celebrating Life on March 21st, 2015 at Ida Noyes in Chicago and other community events that we do during the year. We hope you will continue to support our efforts.

It is our hope that this report inspires you to take action, whether it is via direct volunteering, fundraising or advocacy, our work begins and ends with you. Together we can work to ensure that every woman in Chicago has an equal chance at survival from breast cancer.

EQUAL CARE ❖ EQUAL CHANCE ❖ EQUAL HOPE

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For more information about the **Metropolitan Chicago Breast Cancer Task Force**, please contact:

Anne Marie Murphy, PhD
Executive Director
AnneMarie_Murphy@rush.edu

Teena L. Francois-Blue, MPH
Associate Director
Community Health Initiatives and Research
Teena_L_Francois@rush.edu

Katherine Tossas-Milligan, MS, PhD(c)
Associate Director
Chicago Breast Cancer Quality Consortium
Katherine_Tossas-Milligan@rush.edu

Metropolitan Chicago Breast Cancer Task Force
1645 West Jackson Blvd., Suite 450
Chicago, IL 60612
www.chicagobreastcancer.org