

susan G. Komen.  **COMMUNITY**
PROFILE REPORT 2015



INDIANA

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Introduction

About Susan G. Komen®

Susan G. Komen is the world's largest breast cancer organization, funding more breast cancer research than any other nonprofit while providing real-time help to those facing the disease. Since 1982, Komen has funded more than \$889 million in research and provided \$1.95 billion in funding to screening, education, treatment and psychosocial support programs serving millions of people in more than 30 countries worldwide. Komen was founded by Nancy G. Brinker, who promised her sister, Susan G. Komen, that she would end the disease that claimed Suzy's life.

Since 1982, Komen has contributed to many of the advances made in the fight against breast cancer and transformed how the world treats and talks about this disease and have helped turn millions of breast cancer patients into breast cancer survivors:

- **More early detection and effective treatment.** Currently, about 70 percent of women 40 and older receive regular mammograms, the single most effective screening tool to find breast cancer early. Since 1990, early detection and effective treatment have resulted in a 34 percent decline in breast cancer mortality in the US.
- **More hope.** In 1980, the five-year relative survival rate for women diagnosed with early stage breast cancer was about 74 percent. Today, it's 99 percent.
- **More research.** The federal government now devotes more than \$850 million each year to breast cancer research, treatment and prevention, compared to \$30 million in 1982.
- **More survivors.** Today, there are more than three million breast cancers survivors in the US.

Visit komen.org or call 1-877 GO KOMEN. Connect with us on social at ww5.komen.org/social.

Susan G. Komen Affiliate Network

Thanks to survivors, volunteers and activists dedicated to the fight against breast cancer, the Komen Affiliate Network is working to better the lives of those facing breast cancer in the local community. Through events like the Komen Race for the Cure® series, the local Komen Affiliates invest funds raised locally into community health programs to provide evidence-based breast health education and breast cancer screening, diagnostic and treatment programs, and contribute to the more than \$889 million invested globally in research.

For more information or to connect with a local Affiliate, contact the following Komen Affiliates that are located in or provides services to the State of Indiana as of February 2017:

Susan G Komen® Central Indiana
3500 DePauw Boulevard, Suite 2070
Indianapolis, IN 46268
317- 638-2873
www.komencentralindiana.org/

Susan G Komen® Evansville Tri-State

4424 Vogel Road, Suite 205
Evansville, IN 47715
812-962-2202
www.komenevansville.org

Susan G Komen® Kentucky

www.komenkentucky.org

Louisville Office

1201 Story Avenue/ Suite 205
Louisville, KY 40206
502-495-7824

Lexington Office

207 N. Upper Street Suite D
Lexington, KY 40507
859-368-7133

Susan G Komen® Southwest Ohio

6120 South Gilmore Road, Suite 206
Fairfield, OH 45014
513-671-9100
www.komencincinnati.org

Purpose of the State Community Profile Report

The purpose of the Indiana Community Profile is to assess breast cancer burden within the state by identifying areas at highest risk of negative breast cancer outcomes. Through the Community Profile, populations most at-risk of dying from breast cancer and their demographic and socioeconomic characteristics can be identified; as well as, the needs and disparities that exist in availability, access and utilization of quality care.

The Community Profile consists of the following three sections:

- **Quantitative Data:** This section provides secondary data on breast cancer rates and trends that include incidence, deaths and late-stage diagnosis along with mammography screening proportions. This section also explores demographic, social and geographic characteristics that influence breast cancer outcomes such as race/ethnicity, socioeconomic status, educational attainment and insurance status.
- **Health System Analysis:** This section tells the story of the breast cancer continuum of care and the delivery of quality health care in the community. Key to this section is the observation of potential strengths and weaknesses in the health care system that could compromise a women's health as she works her way through the continuum of care (e.g., screening, diagnosis, treatment and follow-up/survivorship services).
- **Public Policy Overview:** This section provides an overview of key breast cancer policies that affect the ability of at-risk women in accessing and utilizing quality care. This section covers the state's National Breast and Cervical Cancer Early Detection Program, the state's National Comprehensive Cancer Control Program and the Affordable Care Act.

Quantitative Data: Measuring Breast Cancer Impact in Local Communities

The purpose of the quantitative data report for the State of Indiana is to provide quantitative data from many credible sources and use the data to identify the highest priority areas in the state for evidence-based breast cancer programs.

The quantitative data report provides the following data at the state and county-level as well as for the United States:

- Female breast cancer incidence (new cases)
- Female breast cancer death rates
- Late-stage diagnosis
- Screening mammography proportions
- Population demographics (e.g. age, race/ethnicity)
- Socioeconomic indicators (e.g. income and education level)

The data provided in the report can be used to identify priorities within the state based on estimates of how long it would take an area to achieve Healthy People 2020 objectives for breast cancer late-stage diagnosis and death rates (Healthy People 2020, 2010).

Quantitative Data

This section of the report provides specific information on the major types of data that are included in the report.

Incidence Rates

“Incidence” means the number of new cases of breast cancer that develop in a specific time period.

If the breast cancer incidence rate increases, it may mean that more women are getting breast cancer. However, it could also mean that more breast cancers are being found because of an increase in screening.

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

How incidence rates are calculated

The female breast cancer incidence rate is calculated as the number of females in an area who were diagnosed with breast cancer divided by the total number of females living in that area. Incidence rates are usually expressed in terms of 100,000 people. For example, suppose there are 50,000 females living in an area and 60 of them are diagnosed with breast cancer during a

certain time period. Sixty out of 50,000 is the same as 120 out of 100,000. So the female breast cancer incidence rate would be reported as 120 per 100,000 for that time period.

Adjusting for age

Breast cancer becomes more common as women grow older. When comparing breast cancer rates for an area where many older people live to rates for an area where younger people live, it's hard to know whether the differences are due to age or whether other factors might also be involved.

To account for age, breast cancer rates are usually adjusted to a common standard age distribution. This is done by calculating the breast cancer rates for each age group (such as 45- to 49-year-olds) separately, and then figuring out what the total breast cancer rate would have been if the proportion of people in each age group in the population that's being studied was the same as that of the standard population.

Using age-adjusted rates makes it possible to spot differences in breast cancer rates caused by factors other than differences in age between groups of women.

Trends over time

To show trends (changes over time) in cancer incidence, data for the annual percent change in the incidence rate over a five-year period were included in the report. The annual percent change is the average year-to-year change of the incidence rate. It may be either a positive or negative number.

- A negative value means that the rates are getting lower.
- A positive value means that the rates are getting higher.
- A positive value (rates getting higher) may seem undesirable—and it generally is. However, it's important to remember that an increase in breast cancer incidence could also mean that more breast cancers are being found because more women are getting mammograms. So higher rates don't necessarily mean that there has been an increase in the occurrence of breast cancer.

Confidence intervals

Because numbers for breast cancer rates and trends are not exact, this report includes confidence intervals. A confidence interval is a range of values that gives an idea of how uncertain a value may be. It's shown as two numbers—a lower value and a higher one. It is very unlikely that the true rate is less than the lower value or more than the higher value. For example, if a breast cancer incidence rate was reported as 120 per 100,000 women, with a confidence interval of 105 to 135, the real rate might not be exactly 120 per 100,000, but it's very unlikely that it's less than 105 or more than 135.

Breast cancer incidence rates and trends

Breast cancer incidence rates and trends are shown in Table 2.1 for:

- United States
- State of Indiana
- Each county of Indiana

For the State of Indiana, rates are also shown by race for Whites, Blacks/African-Americans, Asians and Pacific Islanders (API), and American Indians and Alaska Natives (AIAN). In addition, rates are shown by ethnicity for Hispanics/Latinas and women who are not Hispanic/Latina (regardless of their race).

The rates in Table 2.1 are shown per 100,000 females from 2006 to 2010.

Table 2.1. Female breast cancer incidence rates and trends

Population Group	Female Population (Annual Average)	# of New Cases (Annual Average)	Age-adjusted Incidence Rate /100,000	Confidence Interval of Age-adjusted Incidence Rate	Incidence Trend (Annual Percent Change)	Confidence Interval of Incidence Trend
US (states with available data)	145,332,861	198,602	122.1	121.9 : 122.4	-0.2%	-2.0% : 1.7%
Indiana	3,260,368	4,287	117.4	115.8 : 119.0	-0.3%	-2.6% : 2.1%
White	2,867,623	3,901	117.1	115.5 : 118.8	-0.2%	-3.3% : 2.9%
Black/African-American	323,657	320	117.6	111.9 : 123.6	1.7%	-3.5% : 7.2%
AIAN	13,284	SN	SN	SN	SN	SN
API	55,804	27	71.2	58.5 : 85.8	10.3%	1.5% : 20.0%
Non-Hispanic/ Latina	3,090,982	4,225	118.4	116.8 : 120.1	-0.3%	-2.5% : 2.0%
Hispanic/ Latina	169,386	62	70.9	62.6 : 79.9	-1.6%	-13.0% : 11.2%
Adams County	17,274	21	111.0	90.2 : 135.2	0.1%	-22.0% : 28.6%
Allen County	179,827	236	122.8	115.8 : 130.2	-3.2%	-9.9% : 3.9%
Bartholomew County	38,387	50	110.3	96.8 : 125.2	2.1%	-16.7% : 25.3%
Benton County	4,456	5	78.1	48.9 : 119.6	8.0%	-25.1% : 55.8%
Blackford County	6,563	9	94.8	68.5 : 129.0	7.6%	-14.8% : 35.8%
Boone County	27,834	41	133.8	115.8 : 153.7	5.9%	-10.2% : 24.9%
Brown County	7,679	9	81.9	59.5 : 111.4	-17.3%	-49.9% : 36.5%
Carroll County	10,059	12	100.0	75.7 : 130.0	21.7%	-12.3% : 68.9%
Cass County	19,493	25	107.0	88.6 : 128.2	-0.7%	-21.1% : 25.1%
Clark County	54,876	85	132.3	119.9 : 145.7	-3.2%	-9.4% : 3.4%
Clay County	13,735	22	131.5	107.4 : 159.6	-6.2%	-25.2% : 17.5%
Clinton County	16,842	18	94.1	75.4 : 116.2	-6.7%	-28.3% : 21.3%
Crawford County	5,342	8	132.9	95.0 : 181.4	13.4%	-20.3% : 61.4%
Daviess County	15,604	18	102.1	81.7 : 126.0	-5.5%	-18.1% : 9.0%
Dearborn County	24,959	39	132.7	114.4 : 153.3	-9.6%	-24.5% : 8.2%
Decatur County	12,940	13	84.8	65.3 : 108.5	0.6%	-14.8% : 18.8%
DeKalb County	21,118	32	138.0	117.2 : 161.4	-4.4%	-10.3% : 1.9%
Delaware County	60,910	87	129.9	117.6 : 143.1	-0.3%	-17.2% : 20.0%

Population Group	Female Population (Annual Average)	# of New Cases (Annual Average)	Age-adjusted Incidence Rate /100,000	Confidence Interval of Age-adjusted Incidence Rate	Incidence Trend (Annual Percent Change)	Confidence Interval of Incidence Trend
Dubois County	21,212	31	124.4	105.4 : 146.1	-0.2%	-16.2% : 19.0%
Elkhart County	99,555	124	119.1	109.8 : 129.0	-1.2%	-8.9% : 7.3%
Fayette County	12,450	14	86.9	66.8 : 111.4	-2.5%	-23.7% : 24.4%
Floyd County	37,982	45	104.4	91.0 : 119.3	6.3%	-15.0% : 33.0%
Fountain County	8,740	19	166.5	133.7 : 205.4	-2.6%	-12.3% : 8.2%
Franklin County	11,624	6	46.1	31.0 : 66.3	-1.0%	-19.7% : 22.0%
Fulton County	10,413	17	128.8	102.0 : 160.7	-3.9%	-24.6% : 22.5%
Gibson County	16,870	27	132.4	110.7 : 157.2	-3.8%	-32.2% : 36.4%
Grant County	36,459	57	123.5	109.2 : 139.2	2.7%	-13.8% : 22.4%
Greene County	16,608	22	99.8	81.6 : 121.1	-3.0%	-31.7% : 37.7%
Hamilton County	133,552	158	124.1	115.4 : 133.3	-0.7%	-14.5% : 15.3%
Hancock County	34,608	51	131.1	115.3 : 148.5	-2.7%	-13.3% : 9.3%
Harrison County	19,331	22	98.1	80.4 : 118.6	9.7%	-9.1% : 32.3%
Hendricks County	70,202	81	110.9	100.3 : 122.4	0.7%	-11.4% : 14.5%
Henry County	24,390	36	110.9	94.9 : 128.9	0.0%	-25.0% : 33.2%
Howard County	43,251	63	117.0	104.1 : 131.0	-8.6%	-21.2% : 6.0%
Huntington County	19,044	28	118.6	99.2 : 140.9	-4.3%	-24.0% : 20.4%
Jackson County	21,100	32	129.0	109.6 : 150.9	6.8%	-13.2% : 31.3%
Jasper County	16,579	22	113.6	92.8 : 137.7	15.1%	-14.3% : 54.6%
Jay County	10,899	21	149.9	121.8 : 182.9	-4.5%	-22.5% : 17.6%
Jefferson County	16,692	24	121.3	100.1 : 145.8	-4.8%	-20.1% : 13.5%
Jennings County	14,226	15	97.1	76.3 : 121.9	13.3%	-9.1% : 41.3%
Johnson County	69,202	86	115.0	104.3 : 126.5	4.0%	-9.8% : 19.8%
Knox County	19,103	30	121.2	102.2 : 143.1	4.7%	-13.8% : 27.3%
Kosciusko County	38,683	51	119.9	105.5 : 135.8	7.1%	-13.6% : 32.8%
LaGrange County	18,280	18	103.5	82.9 : 127.7	-8.7%	-20.0% : 4.2%
Lake County	255,819	339	115.8	110.3 : 121.5	2.1%	-6.1% : 10.9%
LaPorte County	53,630	75	111.5	100.2 : 123.7	4.1%	-7.2% : 16.7%
Lawrence County	23,429	34	111.6	95.1 : 130.5	-0.8%	-5.2% : 3.8%
Madison County	65,827	94	112.6	102.4 : 123.6	3.5%	-2.0% : 9.3%
Marion County	461,040	572	122.1	117.6 : 126.7	0.4%	NA
Marshall County	23,675	31	110.1	93.1 : 129.5	-5.4%	-19.2% : 10.8%
Martin County	5,083	8	126.3	89.2 : 174.5	4.1%	-27.1% : 48.9%
Miami County	17,427	24	116.3	96.0 : 139.7	-5.8%	NA
Monroe County	67,600	74	123.1	110.7 : 136.5	-2.9%	-11.3% : 6.3%
Montgomery County	18,949	24	99.0	81.7 : 119.1	-13.4%	-32.6% : 11.3%
Morgan County	34,558	51	127.7	112.4 : 144.7	-4.4%	-12.3% : 4.1%
Newton County	7,063	8	83.3	58.4 : 115.9	-20.7%	-58.9% : 53.3%
Noble County	23,720	30	116.6	98.5 : 137.2	9.8%	-14.0% : 40.2%
Ohio County	3,060	4	110.2	66.0 : 174.0	-13.2%	-46.7% : 41.3%

Population Group	Female Population (Annual Average)	# of New Cases (Annual Average)	Age-adjusted Incidence Rate /100,000	Confidence Interval of Age-adjusted Incidence Rate	Incidence Trend (Annual Percent Change)	Confidence Interval of Incidence Trend
Orange County	9,980	13	105.0	80.9 : 134.4	8.1%	-4.5% : 22.4%
Owen County	10,837	14	106.6	82.4 : 136.0	-0.9%	-30.9% : 42.0%
Parke County	9,235	13	117.0	90.4 : 149.4	-18.1%	-35.8% : 4.7%
Perry County	9,083	11	87.6	65.5 : 115.5	11.8%	NA
Pike County	6,487	9	103.9	75.6 : 140.3	6.3%	-27.1% : 55.0%
Porter County	82,331	111	120.0	110.1 : 130.6	-2.9%	NA
Posey County	13,073	15	91.5	71.3 : 115.8	7.8%	NA
Pulaski County	6,746	9	106.2	76.2 : 144.5	-7.3%	-19.9% : 7.2%
Putnam County	18,015	23	109.2	90.0 : 131.4	-6.2%	-22.5% : 13.6%
Randolph County	13,338	21	118.5	96.1 : 144.8	1.4%	-27.5% : 41.7%
Ripley County	14,458	21	121.6	99.0 : 148.1	8.9%	-6.8% : 27.4%
Rush County	8,882	10	94.4	70.1 : 124.8	1.3%	-21.5% : 30.7%
St. Joseph County	137,274	196	129.0	120.9 : 137.5	-1.1%	-12.9% : 12.2%
Scott County	12,164	14	100.5	78.0 : 127.6	4.6%	-20.7% : 38.0%
Shelby County	22,245	30	115.6	97.6 : 136.0	10.8%	-9.3% : 35.5%
Spencer County	10,417	13	98.6	75.8 : 126.6	10.6%	-23.2% : 59.2%
Starke County	11,803	16	113.4	89.8 : 141.6	-16.2%	-38.7% : 14.8%
Steuben County	16,896	24	114.4	94.6 : 137.5	-13.1%	-32.3% : 11.6%
Sullivan County	9,872	12	94.1	71.4 : 122.4	-4.4%	-26.8% : 24.9%
Switzerland County	5,104	4	61.4	36.6 : 97.6	50.1%	-9.0% : 147.6%
Tippecanoe County	82,470	86	119.8	108.6 : 131.9	5.4%	NA
Tipton County	8,198	10	93.1	69.1 : 123.6	20.1%	2.7% : 40.5%
Union County	3,762	SN	SN	SN	SN	SN
Vanderburgh County	92,447	127	117.2	108.1 : 127.0	-2.1%	-13.8% : 11.2%
Vermillion County	8,322	13	111.1	85.0 : 143.5	13.0%	-19.3% : 58.3%
Vigo County	53,140	79	127.4	114.9 : 141.0	0.8%	-2.1% : 3.8%
Wabash County	17,075	23	102.6	84.1 : 124.3	-1.5%	-26.5% : 31.8%
Warren County	4,285	4	73.2	43.8 : 116.2	-11.5%	-44.0% : 39.7%
Warrick County	29,649	42	116.0	100.4 : 133.3	1.5%	-20.2% : 29.1%
Washington County	14,083	19	120.1	97.1 : 147.0	10.6%	-22.5% : 57.7%
Wayne County	35,642	44	94.8	82.4 : 108.7	-3.6%	-29.7% : 32.3%
Wells County	14,061	18	106.6	84.9 : 132.3	-15.3%	-44.3% : 28.8%
White County	12,564	18	108.8	86.7 : 135.0	-17.5%	-43.4% : 20.2%
Whitley County	16,599	23	114.9	94.3 : 138.9	-5.6%	-21.8% : 13.9%

NA – data not available.

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

Data are for years 2006-2010.

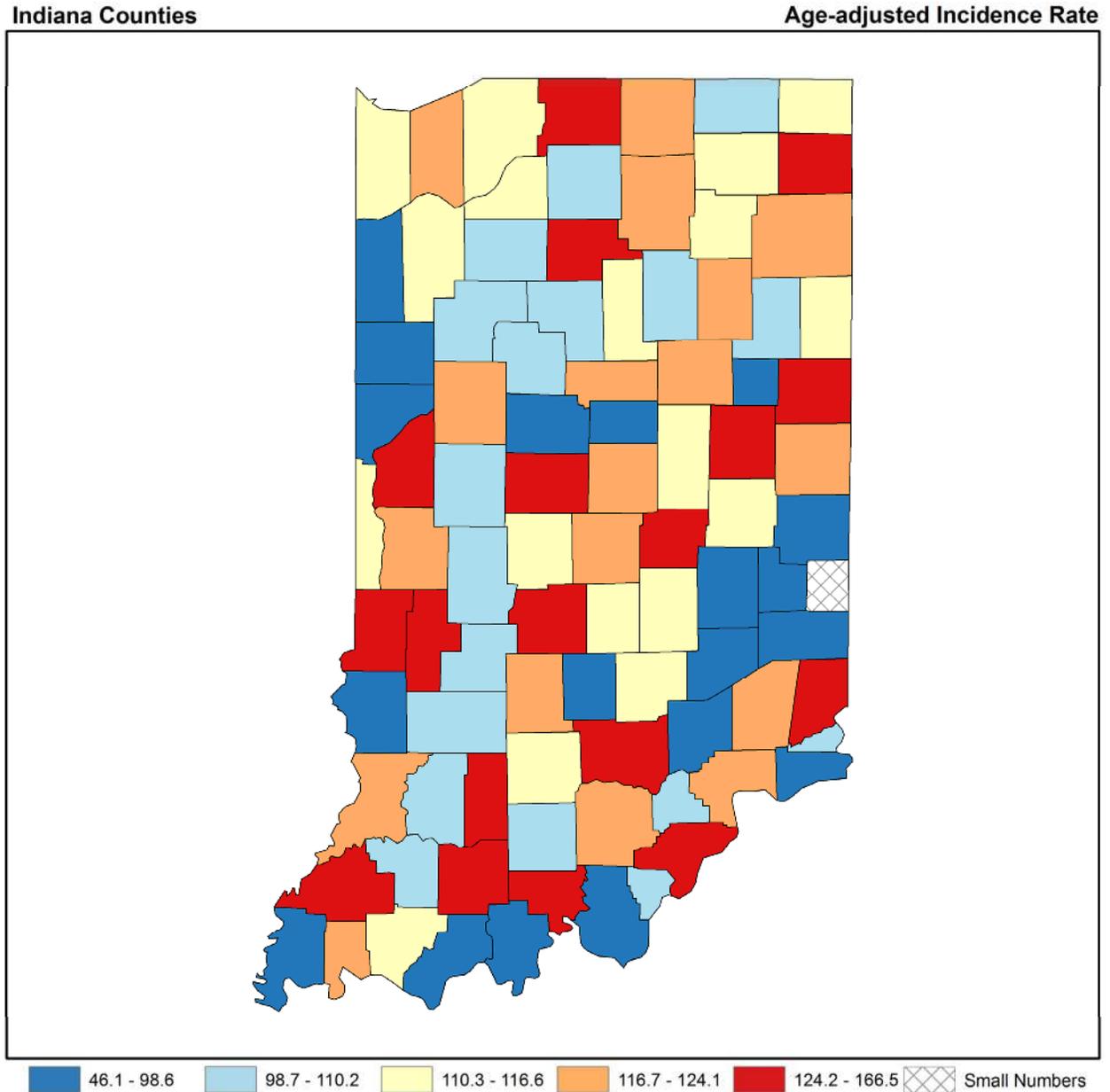
Rates are in cases per 100,000.

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

Source: NAACCR – CINA Deluxe Analytic File.

Map of incidence rates

Figure 2.1 shows a map of breast cancer incidence rates for the counties in Indiana. When the numbers of cases used to compute the rates are small (15 cases or fewer for the 5-year data period), those rates are unreliable and are shown as “small numbers” on the map.



*Map with counties labeled is available in Appendix.
Data are for years 2006-2010.
Rates are in cases per 100,000.
Age-adjusted rates are adjusted to the 2000 US standard population.
Source: NAACCR – CINA Deluxe Analytic File.

Figure 2.1. Female breast cancer age-adjusted incidence rates

Conclusions: Breast cancer incidence rates and trends

Overall, the breast cancer incidence rate in the State of Indiana was slightly lower than that observed in the US as a whole and the incidence trend was similar to the US as a whole.

For the United States, breast cancer incidence in Blacks/African-Americans is similar to Whites overall. The most recent estimated breast cancer incidence rates for APIs and AIANs were lower than for Non-Hispanic Whites and Blacks/African-Americans. The most recent estimated incidence rates for Hispanics/Latinas were lower than for Non-Hispanic Whites and Blacks/African-Americans. For the State of Indiana, the incidence rate was about the same among Blacks/African-Americans and Whites and lower among APIs than Whites. There were not enough data available within the state to report on AIANs so comparisons cannot be made for this racial group. The incidence rate among Hispanics/Latinas was significantly lower than among Non-Hispanics/Latinas.

The following counties had an incidence rate **significantly higher** than the state as a whole:

- Clark County (Komen Louisville)
- Fountain County (Komen Central Indiana)
- Jay County (Komen Central Indiana)
- St. Joseph County

The incidence rate was significantly lower in the following counties:

- Brown County (Komen Central Indiana)
- Decatur County (Komen Central Indiana)
- Fayette County (Komen Central Indiana)
- Franklin County (Komen Central Indiana)
- Perry County (Komen Evansville Tri-State)
- Switzerland County (Komen Southwest Ohio)
- Wayne County (Komen Central Indiana)

Significantly less favorable trends in breast cancer incidence rates were observed in the following county:

- Tipton County (Komen Central Indiana)

The rest of the counties had incidence rates and trends that were not significantly different than the state as a whole or did not have enough data available. It's important to remember that an increase in breast cancer incidence could also mean that more breast cancers are being found because more women are getting mammograms.

Death Rates

A fundamental goal is to reduce the number of women dying from breast cancer.

Death rate trends should always be negative: death rates should be getting lower over time.

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

How death rates are calculated

The death rate is calculated as the number of women from a particular geographic area who died from breast cancer divided by the total number of women living in that area.

Like incidence rates, death rates are often shown in terms of 100,000 women and adjusted for age.

Death rate trends

As with incidence rates, data are included for the annual percent change in the death rate over a five-year period.

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

Confidence intervals

As with incidence rates, this report includes the confidence interval of the age-adjusted breast cancer death rates and trends because the numbers are not exact. The confidence interval is shown as two numbers—a lower value and a higher one. It is very unlikely that the true rate is less than the lower value or more than the higher value.

Breast cancer death rates and trends

Breast cancer death rates and trends are shown in Table 2.2 for:

- United States
- State of Indiana
- Each county of Indiana

For the state, rates are also shown by race for Whites, Blacks/African-Americans, Asians and Pacific Islanders (API), and American Indians and Alaska Natives (AIAN). In addition, rates are shown by ethnicity for Hispanics/Latinas and women who are not Hispanic/Latina (regardless of their race).

The rates in Table 2.2 are shown per 100,000 females from 2006 to 2010. The HP2020 death rate target is included for reference.

Table 2.2. Female breast cancer death rates and trends

Population Group	Female Population (Annual Average)	# of Deaths (Annual Average)	Age-adjusted Death Rate /100,000	Confidence Interval of Age-adjusted Death Rate	Death Trend (Annual Percent Change)	Confidence Interval of Death Rate Trend
US	154,540,194	40,736	22.6	22.5 : 22.7	-1.9%	-2.0% : -1.8%
HP2020	-	-	20.6*	-	-	-
Indiana	3,260,368	909	23.9	23.2 : 24.6	-1.9%	-2.2% : -1.6%
White	2,867,623	822	23.4	22.7 : 24.2	-1.9%	-2.2% : -1.6%
Black/African-American	323,657	83	31.6	28.5 : 34.8	-1.3%	-2.2% : -0.3%
AIAN	13,284	SN	SN	SN	SD	SD
API	55,804	3	11.4	6.0 : 19.2	SD	SD
Non-Hispanic/ Latina	3,090,982	898	24.1	23.4 : 24.8	-1.8%	-2.1% : -1.6%
Hispanic/ Latina	169,386	7	8.8	5.8 : 12.6	-2.7%	-5.9% : 0.5%
Adams County	17,274	4	17.6	10.4 : 28.2	-1.7%	-4.9% : 1.6%
Allen County	179,827	55	27.3	24.1 : 30.8	-1.6%	-2.9% : -0.3%
Bartholomew County	38,387	10	21.0	15.5 : 27.9	-2.9%	-4.7% : -1.1%
Benton County	4,456	SN	SN	SN	SN	SN
Blackford County	6,563	SN	SN	SN	SN	SN
Boone County	27,834	10	31.8	23.5 : 42.1	-0.1%	-2.8% : 2.8%
Brown County	7,679	SN	SN	SN	SN	SN
Carroll County	10,059	3	25.4	14.3 : 42.3	-0.8%	-4.2% : 2.7%
Cass County	19,493	5	19.3	12.3 : 29.2	-5.7%	-8.9% : -2.5%
Clark County	54,876	11	17.0	12.8 : 22.3	-3.1%	-5.2% : -1.1%
Clay County	13,735	4	25.3	15.7 : 38.9	0.5%	-3.1% : 4.3%
Clinton County	16,842	4	16.8	10.1 : 26.7	-4.0%	-6.1% : -1.9%
Crawford County	5,342	SN	SN	SN	SN	SN
Daviess County	15,604	5	24.5	15.5 : 37.1	-2.6%	-5.6% : 0.6%
DeKalb County	21,118	6	24.5	16.4 : 35.4	-0.5%	-3.4% : 2.6%
Dearborn County	24,959	6	22.7	15.4 : 32.3	-0.6%	-3.1% : 2.0%
Decatur County	12,940	5	27.4	17.3 : 41.7	-0.3%	-3.3% : 2.7%
Delaware County	60,910	16	23.0	18.2 : 28.8	-1.4%	-3.1% : 0.3%
Dubois County	21,212	6	23.6	15.8 : 34.2	0.6%	-2.2% : 3.4%
Elkhart County	99,555	22	20.3	16.6 : 24.5	-3.1%	-4.5% : -1.7%
Fayette County	12,450	4	20.6	12.0 : 33.6	-3.1%	-5.5% : -0.6%
Floyd County	37,982	11	25.1	18.9 : 32.7	-1.2%	-3.5% : 1.2%
Fountain County	8,740	5	36.0	22.4 : 55.7	0.1%	-3.9% : 4.3%
Franklin County	11,624	3	24.5	14.2 : 39.7	NA	NA

Population Group	Female Population (Annual Average)	# of Deaths (Annual Average)	Age-adjusted Death Rate /100,000	Confidence Interval of Age-adjusted Death Rate	Death Trend (Annual Percent Change)	Confidence Interval of Death Rate Trend
Fulton County	10,413	6	40.8	27.2 : 59.5	2.5%	-0.9% : 6.0%
Gibson County	16,870	5	25.6	16.7 : 37.9	-1.8%	-5.7% : 2.3%
Grant County	36,459	11	21.9	16.4 : 28.9	-3.9%	-7.0% : -0.7%
Greene County	16,608	6	26.4	17.7 : 38.3	-0.3%	-3.3% : 2.7%
Hamilton County	133,552	27	23.4	19.5 : 27.7	-2.3%	-4.0% : -0.6%
Hancock County	34,608	9	22.7	16.5 : 30.5	-2.9%	-5.3% : -0.5%
Harrison County	19,331	5	22.2	14.3 : 33.2	-3.6%	-6.2% : -1.0%
Hendricks County	70,202	15	21.2	16.6 : 26.6	-1.7%	-3.9% : 0.6%
Henry County	24,390	8	24.0	16.9 : 33.3	-0.1%	-2.7% : 2.5%
Howard County	43,251	13	22.7	17.4 : 29.2	-1.7%	-2.9% : -0.4%
Huntington County	19,044	5	21.4	13.9 : 31.9	-1.8%	-4.8% : 1.4%
Jackson County	21,100	5	20.1	13.0 : 29.7	-4.3%	-7.2% : -1.3%
Jasper County	16,579	7	34.5	23.9 : 48.4	-1.1%	-4.0% : 1.9%
Jay County	10,899	5	31.8	20.1 : 48.3	NA	NA
Jefferson County	16,692	4	18.6	11.3 : 29.2	-4.8%	-7.8% : -1.6%
Jennings County	14,226	SN	SN	SN	SN	SN
Johnson County	69,202	18	22.5	18.0 : 27.8	-2.3%	-4.4% : -0.2%
Knox County	19,103	8	30.2	21.6 : 41.5	-0.7%	-3.8% : 2.6%
Kosciusko County	38,683	10	22.5	16.7 : 29.6	-3.1%	-5.2% : -0.9%
LaGrange County	18,280	SN	SN	SN	SN	SN
LaPorte County	53,630	18	24.8	19.8 : 30.8	-2.5%	-4.0% : -1.0%
Lake County	255,819	86	28.2	25.5 : 31.0	-1.9%	-2.9% : -0.9%
Lawrence County	23,429	7	21.7	15.0 : 30.7	-1.2%	-3.7% : 1.3%
Madison County	65,827	19	21.2	17.0 : 26.1	-2.3%	-3.7% : -0.9%
Marion County	461,040	123	26.1	24.1 : 28.3	-1.6%	-2.4% : -0.9%
Marshall County	23,675	6	19.6	13.1 : 28.6	-2.0%	-4.6% : 0.8%
Martin County	5,083	SN	SN	SN	SN	SN
Miami County	17,427	4	19.4	12.0 : 29.9	-2.9%	-5.5% : -0.1%
Monroe County	67,600	14	22.7	17.6 : 28.7	-1.1%	-3.2% : 1.0%
Montgomery County	18,949	4	17.9	11.1 : 27.6	-3.0%	-5.5% : -0.4%
Morgan County	34,558	9	22.8	16.5 : 30.8	0.7%	-1.8% : 3.2%
Newton County	7,063	SN	SN	SN	SN	SN
Noble County	23,720	6	23.1	15.5 : 33.3	-3.0%	-5.7% : -0.3%
Ohio County	3,060	SN	SN	SN	SN	SN
Orange County	9,980	SN	SN	SN	SN	SN
Owen County	10,837	4	30.8	18.9 : 48.0	0.0%	-3.2% : 3.4%
Parke County	9,235	SN	SN	SN	SN	SN

Population Group	Female Population (Annual Average)	# of Deaths (Annual Average)	Age-adjusted Death Rate /100,000	Confidence Interval of Age-adjusted Death Rate	Death Trend (Annual Percent Change)	Confidence Interval of Death Rate Trend
Perry County	9,083	3	22.5	12.6 : 38.1	NA	NA
Pike County	6,487	SN	SN	SN	SN	SN
Porter County	82,331	24	25.5	21.1 : 30.6	-1.5%	-3.1% : 0.2%
Posey County	13,073	SN	SN	SN	SN	SN
Pulaski County	6,746	SN	SN	SN	SN	SN
Putnam County	18,015	5	22.3	14.4 : 33.4	-2.5%	-6.2% : 1.3%
Randolph County	13,338	4	21.8	12.8 : 35.0	-3.3%	-6.5% : 0.0%
Ripley County	14,458	3	17.5	10.0 : 28.9	-13.9%	-25.5% : -0.4%
Rush County	8,882	3	27.7	15.6 : 46.2	NA	NA
Scott County	12,164	SN	SN	SN	SN	SN
Shelby County	22,245	6	23.6	16.0 : 33.6	-1.8%	-4.5% : 1.0%
Spencer County	10,417	SN	SN	SN	SN	SN
St. Joseph County	137,274	36	21.3	18.2 : 24.8	-2.5%	-3.6% : -1.5%
Starke County	11,803	6	43.4	29.6 : 61.9	NA	NA
Steuben County	16,896	6	27.7	18.8 : 39.9	NA	NA
Sullivan County	9,872	5	36.8	23.7 : 55.3	NA	NA
Switzerland County	5,104	SN	SN	SN	SN	SN
Tippecanoe County	82,470	17	23.0	18.3 : 28.5	-3.1%	-5.1% : -1.0%
Tipton County	8,198	SN	SN	SN	SN	SN
Union County	3,762	SN	SN	SN	SN	SN
Vanderburgh County	92,447	27	23.1	19.3 : 27.6	-1.5%	-3.0% : 0.1%
Vermillion County	8,322	SN	SN	SN	SN	SN
Vigo County	53,140	17	25.1	20.0 : 31.2	-1.5%	-3.1% : 0.2%
Wabash County	17,075	5	16.7	10.5 : 25.9	-4.2%	-7.0% : -1.4%
Warren County	4,285	SN	SN	SN	SN	SN
Warrick County	29,649	9	24.8	18.0 : 33.5	-1.1%	-3.4% : 1.2%
Washington County	14,083	3	20.5	11.9 : 33.2	NA	NA
Wayne County	35,642	12	23.4	17.6 : 30.6	-1.6%	-3.5% : 0.3%
Wells County	14,061	4	21.0	12.7 : 33.3	-3.4%	-6.8% : 0.2%
White County	12,564	4	22.6	13.6 : 35.9	3.4%	-3.0% : 10.2%
Whitley County	16,599	5	23.3	15.0 : 35.0	-3.2%	-6.1% : -0.2%

*Target as of the writing of this report.

NA – data not available.

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

Data are for years 2006-2010.

Rates are in deaths per 100,000.

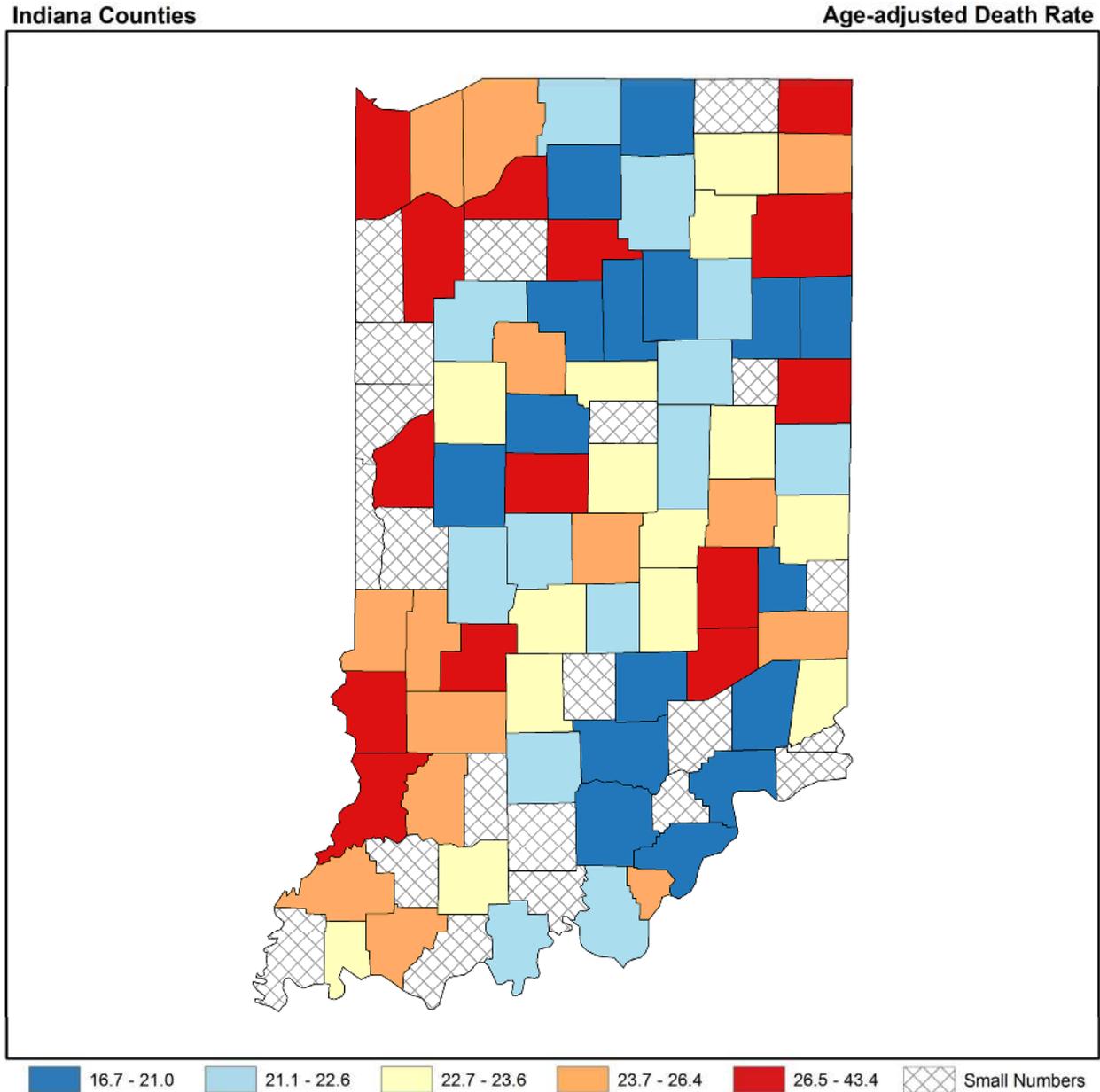
Age-adjusted rates are adjusted to the 2000 US standard population.

Source of death rate data: CDC – NCHS mortality data in SEER*Stat.

Source of death trend data: NCI/CDC State Cancer Profiles.

Map of death rates

Figure 2.2 shows a map of breast cancer death rates for the counties in Indiana. When the numbers of deaths used to compute the rates are small (15 cases or fewer for the five-year data period), those rates are unreliable and are shown as “small numbers” on the map.



*Map with counties labeled is available in Appendix.
Data are for years 2006-2010.
Rates are in deaths per 100,000.
Age-adjusted rates are adjusted to the 2000 US standard population.
Source: CDC – NCHS mortality data in SEER*Stat.

Figure 2.2. Female breast cancer age-adjusted death rates

Conclusions: Breast cancer death rates and trends

Overall, the breast cancer death rate in the State of Indiana was slightly higher than that observed in the US as a whole and the death rate trend was similar to the US as a whole.

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

The following counties had a death rate **significantly higher** than the state as a whole:

- Fulton County
- Lake County
- Starke County

The death rate was significantly lower in the following county:

- Clark County (Komen Louisville)

Significantly less favorable trends in breast cancer death rates were observed in the following county:

- Fulton County

Significantly more favorable trends in breast cancer death rates were observed in the following county:

- Cass County

The rest of the counties had death rates and trends that were not significantly different than the state as a whole or did not have enough data available.

Late-Stage Diagnosis

People with breast cancer have a better chance of survival if their disease is found early and treated.

The stage of cancer indicates the extent of the disease within the body. Most often, the higher the stage of the cancer, the poorer the chances for survival will be.

If a breast cancer is determined to be regional or distant stage, it's considered a late-stage diagnosis.

Medical experts agree that it's best for breast cancer to be detected early. Women whose breast cancers are found at an early stage usually need less aggressive treatment and do better overall than those whose cancers are found at a late-stage (US Preventive Services Task Force, 2009).

How late-stage breast cancer incidence rates are calculated

For this report, late-stage breast cancer is defined as regional or distant stage using the Surveillance, Epidemiology and End Results (SEER) Summary Stage definitions (SEER Summary Stage, 2001). State and national reporting usually uses the SEER Summary Stage. It provides a consistent set of definitions of stages for historical comparisons.

The late-stage breast cancer incidence rate is calculated as the number of women with regional or distant breast cancer in a particular geographic area divided by the number of women living in that area.

Like incidence and death rates, late-stage incidence rates are often shown in terms of 100,000 women and adjusted for age.

Proportion of late-stage diagnoses

Another way to assess the impact of late-stage breast cancer diagnosis on a community is to look at the proportion (percentage) of breast cancers that are diagnosed at late-stage. By lowering the proportion of female breast cancer cases that are diagnosed at late-stage in a given community, it is reasonable to expect that the community will observe a lower breast cancer death rate.

A change in the proportion of late-stage breast cancer cases can be a good indicator of the direction the breast cancer death rate will move over time. In addition, the proportion of late-stage breast cancer is an indicator of the success of early detection efforts (Taplin et al., 2004). So, in addition to the late-stage breast cancer incidence rate, this report includes the late-stage breast cancer proportion (the ratio of late-stage cases to total cases). Note that the late-stage incidence rate may go down over time yet the late-stage proportion may not if the overall incidence rate is declining as well.

How late-stage breast cancer proportions are calculated

The late-stage breast cancer proportion is the ratio between the number of cases diagnosed at regional or distant stages and the total number of breast cancer cases that have been diagnosed and staged in a particular geographic area. It is important to note that cases with unknown stage are excluded from this calculation. However, assuming the size and distribution of cases with unknown stage does not change significantly, the late-stage proportion can be a very good indicator of the need for or effectiveness of early detection interventions.

Confidence intervals

As with incidence and death rates, this report includes the confidence interval of the late-stage incidence rates and trends, and the late-stage proportions and trends because the numbers are not exact. The confidence interval is shown as two numbers—a lower value and a higher one. It is very unlikely that the true rate is less than the lower value or more than the higher value.

Late-stage breast cancer incidence, proportions and trends

Late-stage breast cancer incidence rates, proportions and trends are shown in Tables 2.3 and 2.4 for:

- United States
- State of Indiana
- Each county of Indiana

For the State of Indiana, rates are also shown by race for Whites, Blacks/African-Americans, Asians and Pacific Islanders (API), and American Indians and Alaska Natives (AIAN). In addition, rates are shown by ethnicity for Hispanics/Latinas and women who are not Hispanic/Latina (regardless of their race).

The rates in Table 2.3 are shown per 100,000 females from 2006 to 2010. The HP2020 late-state incidence rate target is included for reference.

Table 2.3. Female breast cancer late-stage incidence rates and trends

Population Group	Female Population (Annual Average)	# of New Late-stage Cases (Annual Average)	Age-adjusted Late-stage Incidence rate /100,000	Confidence Interval of Age-adjusted Incidence Rate	Late stage Trend (Annual Percent Change)	Confidence Interval of Late-stage Trend
US (states with available data)	145,332,861	70,218	43.7	43.5 : 43.8	-1.2%	-3.1% : 0.8%
HP2020	-	-	41.0*	-	-	-
Indiana	3,260,368	1,488	41.1	40.2 : 42.1	-0.6%	-2.5% : 1.3%
White	2,867,623	1,330	40.4	39.4 : 41.4	-0.9%	-3.4% : 1.6%
Black/African-American	323,657	137	50.2	46.4 : 54.1	2.8%	0.5% : 5.0%
AIAN	13,284	SN	SN	SN	SN	SN
API	55,804	10	26.7	19.0 : 36.4	12.8%	-26.3% : 72.7%
Non-Hispanic/ Latina	3,090,982	1,462	41.5	40.5 : 42.4	-0.6%	-2.4% : 1.2%
Hispanic/ Latina	169,386	25	27.8	22.8 : 33.6	3.2%	-6.5% : 13.9%
Adams County	17,274	8	42.8	30.2 : 58.9	5.0%	-33.1% : 64.6%
Allen County	179,827	85	44.4	40.2 : 48.9	-3.3%	-16.8% : 12.3%
Bartholomew County	38,387	17	36.8	29.2 : 45.8	2.6%	-28.4% : 47.3%
Benton County	4,456	SN	SN	SN	SN	SN
Blackford County	6,563	3	34.2	19.4 : 57.4	NA	NA
Boone County	27,834	13	40.3	30.9 : 51.9	10.5%	-13.7% : 41.4%
Brown County	7,679	4	35.1	20.5 : 57.3	-27.2%	-71.8% : 88.1%
Carroll County	10,059	5	37.9	23.8 : 57.8	32.9%	-20.3% : 121.8%
Cass County	19,493	9	38.6	27.7 : 52.4	3.9%	NA
Clark County	54,876	25	38.2	31.7 : 45.8	3.9%	-15.8% : 28.3%
Clay County	13,735	7	41.1	28.2 : 58.1	-12.5%	-44.8% : 38.7%
Clinton County	16,842	6	35.7	24.2 : 50.9	-21.6%	NA
Crawford County	5,342	SN	SN	SN	SN	SN
Daviess County	15,604	6	34.0	22.8 : 49.0	-5.7%	NA
Dearborn County	24,959	12	40.5	30.7 : 52.6	-16.6%	-41.5% : 18.8%
Decatur County	12,940	4	26.0	15.7 : 40.6	-8.2%	-36.7% : 33.1%
DeKalb County	21,118	10	43.7	32.5 : 57.6	6.4%	-16.1% : 34.8%
Delaware County	60,910	28	43.0	36.0 : 51.0	-2.0%	-20.8% : 21.2%
Dubois County	21,212	9	37.1	26.8 : 50.1	-8.1%	-50.2% : 69.4%
Elkhart County	99,555	44	43.1	37.5 : 49.2	-3.6%	-15.8% : 10.4%
Fayette County	12,450	6	36.7	23.9 : 54.0	-3.0%	-38.9% : 54.1%
Floyd County	37,982	18	41.9	33.5 : 51.8	6.3%	-35.8% : 76.1%
Fountain County	8,740	6	59.0	39.5 : 85.1	-17.0%	-30.1% : -1.5%
Franklin County	11,624	SN	SN	SN	SN	SN
Fulton County	10,413	7	49.4	33.5 : 70.5	-0.4%	NA
Gibson County	16,870	9	44.4	32.1 : 60.2	-14.4%	-51.1% : 49.8%
Grant County	36,459	16	37.8	29.8 : 47.4	-7.7%	-24.7% : 13.1%

Population Group	Female Population (Annual Average)	# of New Late-stage Cases (Annual Average)	Age-adjusted Late-stage Incidence rate /100,000	Confidence Interval of Age-adjusted Incidence Rate	Late stage Trend (Annual Percent Change)	Confidence Interval of Late-stage Trend
Greene County	16,608	6	28.8	19.4 : 41.4	-2.3%	-39.6% : 58.0%
Hamilton County	133,552	50	39.1	34.2 : 44.4	-0.3%	-22.3% : 27.9%
Hancock County	34,608	18	45.6	36.4 : 56.4	1.1%	-23.1% : 32.9%
Harrison County	19,331	7	32.6	22.8 : 45.3	0.4%	-25.5% : 35.2%
Hendricks County	70,202	25	34.2	28.4 : 40.8	2.5%	-15.3% : 24.0%
Henry County	24,390	9	29.1	21.1 : 39.4	-2.4%	-26.0% : 28.9%
Howard County	43,251	20	38.5	31.2 : 47.0	-3.2%	-22.1% : 20.4%
Huntington County	19,044	10	45.5	33.6 : 60.4	-8.9%	-38.0% : 33.6%
Jackson County	21,100	10	39.3	28.9 : 52.2	-1.3%	-19.8% : 21.4%
Jasper County	16,579	8	43.9	31.2 : 60.3	18.5%	-14.2% : 63.6%
Jay County	10,899	7	47.9	32.7 : 68.2	-8.1%	-51.0% : 72.4%
Jefferson County	16,692	9	45.8	33.5 : 61.3	13.8%	-8.9% : 42.0%
Jennings County	14,226	6	40.3	27.4 : 57.4	27.9%	-21.0% : 107.0%
Johnson County	69,202	29	39.3	33.1 : 46.2	9.8%	-21.2% : 53.1%
Knox County	19,103	15	59.9	46.9 : 75.8	-7.0%	-31.4% : 25.9%
Kosciusko County	38,683	16	37.3	29.4 : 46.7	9.7%	-26.6% : 64.0%
LaGrange County	18,280	4	23.1	14.0 : 35.8	26.5%	-0.5% : 60.8%
Lake County	255,819	136	46.8	43.3 : 50.5	2.0%	-5.1% : 9.7%
LaPorte County	53,630	29	44.4	37.3 : 52.5	5.2%	-16.3% : 32.2%
Lawrence County	23,429	13	42.9	32.8 : 55.4	-2.5%	-27.0% : 30.3%
Madison County	65,827	27	32.7	27.2 : 39.0	8.1%	-5.1% : 23.3%
Marion County	461,040	201	43.2	40.5 : 46.0	-2.8%	-5.7% : 0.3%
Marshall County	23,675	14	48.4	37.4 : 61.8	-1.3%	-9.0% : 7.1%
Martin County	5,083	SN	SN	SN	SN	SN
Miami County	17,427	6	31.3	21.2 : 44.8	4.1%	NA
Monroe County	67,600	25	41.3	34.3 : 49.3	-0.9%	-6.4% : 4.9%
Montgomery County	18,949	8	36.1	25.8 : 49.4	-9.3%	-39.5% : 35.9%
Morgan County	34,558	19	47.9	38.6 : 58.9	-5.3%	-30.6% : 29.3%
Newton County	7,063	SN	SN	SN	SN	SN
Noble County	23,720	12	48.8	37.2 : 62.9	6.7%	-26.2% : 54.1%
Ohio County	3,060	SN	SN	SN	SN	SN
Orange County	9,980	5	38.7	24.5 : 58.6	11.3%	-27.2% : 70.2%
Owen County	10,837	5	41.3	26.4 : 61.9	-3.2%	-44.3% : 68.3%
Parke County	9,235	5	41.7	26.6 : 62.8	-15.2%	-44.5% : 29.5%
Perry County	9,083	5	36.9	22.9 : 57.0	-4.2%	-45.1% : 67.2%
Pike County	6,487	SN	SN	SN	SN	SN
Porter County	82,331	40	41.9	36.2 : 48.2	-2.2%	-15.5% : 13.2%

Population Group	Female Population (Annual Average)	# of New Late-stage Cases (Annual Average)	Age-adjusted Late-stage Incidence rate /100,000	Confidence Interval of Age-adjusted Incidence Rate	Late stage Trend (Annual Percent Change)	Confidence Interval of Late-stage Trend
Posey County	13,073	5	30.0	18.8 : 45.8	-27.4%	NA
Pulaski County	6,746	4	44.5	25.8 : 71.9	-8.4%	-53.2% : 79.2%
Putnam County	18,015	10	46.5	34.0 : 62.3	-3.0%	-28.3% : 31.1%
Randolph County	13,338	6	35.7	24.1 : 51.4	7.5%	-34.3% : 76.0%
Ripley County	14,458	8	49.9	35.6 : 68.1	7.9%	-24.0% : 53.2%
Rush County	8,882	4	42.5	26.4 : 65.2	1.3%	-27.5% : 41.4%
St. Joseph County	137,274	76	50.8	45.7 : 56.4	-0.6%	-20.3% : 23.8%
Scott County	12,164	5	32.9	20.7 : 49.9	-3.8%	-35.7% : 44.0%
Shelby County	22,245	11	45.6	34.2 : 59.6	10.7%	-20.8% : 54.8%
Spencer County	10,417	4	30.2	18.6 : 47.2	24.7%	-50.0% : 210.8%
Starke County	11,803	7	47.2	32.2 : 67.1	-9.6%	-43.9% : 45.7%
Steuben County	16,896	11	52.3	39.2 : 68.7	-3.3%	-45.3% : 71.0%
Sullivan County	9,872	4	36.0	22.2 : 55.6	-26.0%	-53.8% : 18.6%
Switzerland County	5,104	SN	SN	SN	SN	SN
Tippecanoe County	82,470	29	40.9	34.5 : 48.2	-3.1%	-15.7% : 11.4%
Tipton County	8,198	SN	SN	SN	SN	SN
Union County	3,762	SN	SN	SN	SN	SN
Vanderburgh County	92,447	39	35.6	30.7 : 41.2	-3.7%	-14.2% : 8.1%
Vermillion County	8,322	4	38.0	23.1 : 59.8	18.3%	-39.7% : 132.3%
Vigo County	53,140	25	40.3	33.4 : 48.3	12.9%	-21.7% : 62.7%
Wabash County	17,075	8	40.3	28.5 : 55.5	-26.0%	NA
Warren County	4,285	SN	SN	SN	SN	SN
Warrick County	29,649	12	32.4	24.5 : 42.3	16.9%	-25.4% : 83.3%
Washington County	14,083	6	39.2	26.7 : 55.9	9.3%	-44.2% : 114.5%
Wayne County	35,642	14	30.1	23.3 : 38.4	3.7%	-31.3% : 56.4%
Wells County	14,061	6	38.3	25.3 : 55.6	-18.3%	-59.0% : 62.6%
White County	12,564	6	33.9	22.2 : 50.1	-4.0%	-57.2% : 115.2%
Whitley County	16,599	8	37.8	26.5 : 52.4	-15.9%	-39.3% : 16.4%

* Target as of the writing of this report.

NA – data not available.

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

Data are for years 2006-2010.

Rates are in cases per 100,000.

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

Source: NAACCR – CINA Deluxe Analytic File.

Table 2.4. Female breast cancer late-stage proportion and trends and distant-stage proportion for women age 50-74

Population Group	# of New Staged Cases (Annual Average)	# of Cases Diagnosed at Late-stage (Annual Average)	Proportion Diagnosed at Late-stage	Confidence Interval of Late-stage Proportion	Late-stage Proportion Trend (Annual Percent Change)	Confidence Interval of Late-stage Proportion Trend	Proportion Diagnosed at Distant-stage
US	111,487	39,543	35.5%	35.3% : 35.6%	-1.4%	-1.7% : -1.1%	5.6%
Indiana	2,458	839	34.1%	33.3% : 35.0%	0.0%	-1.8% : 1.8%	6.1%
White	2,231	749	33.6%	32.7% : 34.4%	-0.2%	-2.2% : 1.8%	5.9%
Black/African-American	190	80	41.9%	38.7% : 45.0%	0.6%	-7.0% : 9.0%	8.6%
AIAN	SN	SN	SN	SN	SN	SN	SN
API	16	6	35.4%	24.9% : 46.0%	1.0%	-24.5% : 35.1%	SN
Non-Hispanic/Latina	2,428	828	34.1%	33.3% : 34.9%	0.0%	-1.8% : 1.9%	6.1%
Hispanic/Latina	30	11	37.7%	30.0% : 45.5%	-4.2%	-24.7% : 21.9%	6.6%
Adams County	11	5	44.6%	31.6% : 57.7%	-1.1%	-27.2% : 34.4%	SN
Allen County	132	51	38.5%	34.8% : 42.2%	1.7%	-7.0% : 11.1%	7.3%
Bartholomew County	30	11	37.6%	29.8% : 45.4%	2.6%	-13.2% : 21.2%	6.0%
Benton County	SN	SN	SN	SN	SN	SN	SN
Blackford County	6	2	39.3%	21.2% : 57.4%	NA	NA	14.3%
Boone County	22	7	31.5%	22.7% : 40.2%	5.2%	-29.4% : 56.7%	4.6%
Brown County	7	2	36.4%	20.0% : 52.8%	NA	NA	SN
Carroll County	7	3	39.4%	22.7% : 56.1%	NA	NA	SN
Cass County	16	5	34.6%	24.1% : 45.2%	3.4%	-31.1% : 55.4%	SN
Clark County	55	15	27.4%	22.1% : 32.7%	13.4%	-14.9% : 51.1%	4.0%
Clay County	10	4	36.5%	23.5% : 49.6%	-0.2%	-15.9% : 18.6%	7.7%
Clinton County	9	3	37.2%	22.8% : 51.7%	-15.9%	-46.1% : 31.2%	16.3%
Crawford County	4	1	28.6%	9.2% : 47.9%	NA	NA	SN
Daviess County	10	4	36.7%	23.2% : 50.2%	6.4%	-30.5% : 62.8%	12.2%
Dearborn County	22	7	30.6%	21.9% : 39.2%	-10.4%	-27.3% : 10.4%	3.7%
Decatur County	8	3	35.9%	20.8% : 51.0%	3.5%	-7.4% : 15.8%	15.4%
DeKalb County	17	5	31.0%	21.3% : 40.8%	-7.9%	-28.7% : 19.0%	SN
Delaware County	50	16	31.2%	25.5% : 36.9%	-1.6%	-12.7% : 10.8%	2.0%
Dubois County	18	5	27.8%	18.5% : 37.0%	-22.5%	-60.9% : 53.8%	SN
Elkhart County	72	26	36.5%	31.5% : 41.5%	3.7%	-17.2% : 29.9%	5.8%
Fayette County	6	2	38.7%	21.6% : 55.9%	-2.6%	-40.5% : 59.3%	SN
Floyd County	24	9	37.7%	29.1% : 46.3%	6.5%	-33.7% : 71.0%	7.4%
Fountain County	10	3	34.0%	20.9% : 47.1%	-4.9%	-43.4% : 59.8%	8.0%
Franklin County	SN	SN	SN	SN	SN	SN	SN
Fulton County	10	4	43.8%	29.7% : 57.8%	21.5%	-0.7% : 48.7%	10.4%
Gibson County	16	5	33.3%	23.1% : 43.6%	-17.9%	-43.7% : 19.6%	SN
Grant County	33	8	25.1%	18.6% : 31.7%	-17.4%	-41.4% : 16.6%	5.4%
Greene County	13	4	31.7%	20.3% : 43.2%	-6.0%	-34.3% : 34.4%	9.5%

Population Group	# of New Staged Cases (Annual Average)	# of Cases Diagnosed at Late-stage (Annual Average)	Proportion Diagnosed at Late-stage	Confidence Interval of Late-stage Proportion	Late-stage Proportion Trend (Annual Percent Change)	Confidence Interval of Late-stage Proportion Trend	Proportion Diagnosed at Distant-stage
Hamilton County	82	25	30.6%	26.2% : 35.1%	-2.6%	-14.6% : 11.1%	4.9%
Hancock County	32	10	32.1%	24.8% : 39.3%	-8.5%	-21.8% : 7.1%	5.7%
Harrison County	12	5	37.1%	25.1% : 49.1%	-11.5%	-33.8% : 18.3%	8.1%
Hendricks County	46	13	29.3%	23.4% : 35.2%	1.3%	-18.5% : 26.0%	5.2%
Henry County	23	5	23.9%	16.0% : 31.8%	-1.7%	-11.2% : 8.9%	7.1%
Howard County	36	11	30.7%	24.0% : 37.5%	10.6%	9.0% : 12.3%	5.6%
Huntington County	15	5	34.2%	23.4% : 45.1%	4.4%	-19.8% : 35.8%	SN
Jackson County	18	6	33.0%	23.3% : 42.6%	-2.3%	-27.9% : 32.2%	7.7%
Jasper County	12	4	36.7%	24.5% : 48.9%	-16.7%	-43.9% : 23.5%	10.0%
Jay County	11	4	34.5%	22.0% : 47.1%	-0.6%	-38.2% : 59.8%	SN
Jefferson County	13	6	46.3%	34.3% : 58.2%	14.1%	-11.8% : 47.5%	7.5%
Jennings County	9	4	40.9%	26.4% : 55.4%	NA	NA	SN
Johnson County	48	15	32.0%	26.1% : 37.8%	1.7%	-22.9% : 34.1%	4.1%
Knox County	17	9	51.2%	40.5% : 61.9%	-12.7%	-24.1% : 0.4%	6.0%
Kosciusko County	31	9	28.7%	21.6% : 35.7%	0.8%	-22.8% : 31.5%	7.0%
LaGrange County	9	3	30.2%	16.5% : 44.0%	6.3%	NA	9.3%
Lake County	193	75	39.1%	36.1% : 42.2%	-0.6%	-7.0% : 6.3%	8.2%
LaPorte County	45	17	38.5%	32.2% : 44.8%	3.1%	-12.3% : 21.2%	8.4%
Lawrence County	20	8	39.4%	29.8% : 49.0%	2.0%	-16.3% : 24.3%	11.1%
Madison County	55	14	24.9%	19.8% : 30.0%	-3.7%	-19.1% : 14.7%	3.7%
Marion County	326	110	33.7%	31.4% : 36.0%	-1.6%	-5.5% : 2.5%	6.1%
Marshall County	18	8	45.6%	35.3% : 55.8%	4.0%	-19.2% : 33.8%	7.8%
Martin County	5	1	24.0%	7.3% : 40.7%	SN	SN	SN
Miami County	15	3	23.0%	13.4% : 32.6%	15.4%	-24.6% : 76.7%	SN
Monroe County	41	15	35.4%	28.9% : 42.0%	7.7%	-9.6% : 28.1%	5.3%
Montgomery County	14	5	32.9%	21.9% : 43.9%	NA	NA	SN
Morgan County	33	10	28.9%	22.0% : 35.8%	-7.7%	-32.1% : 25.5%	4.8%
Newton County	4	1	30.0%	9.9% : 50.1%	NA	NA	SN
Noble County	18	7	39.1%	29.2% : 49.1%	-10.3%	-37.0% : 27.7%	9.8%
Ohio County	SN	SN	SN	SN	SN	SN	SN
Orange County	9	3	31.1%	17.6% : 44.6%	-2.4%	-35.9% : 48.7%	17.8%
Owen County	8	2	28.9%	14.5% : 43.4%	3.8%	-30.2% : 54.4%	13.2%
Parke County	10	3	28.6%	15.9% : 41.2%	-4.6%	-29.8% : 29.7%	8.2%
Perry County	5	2	42.3%	23.3% : 61.3%	NA	NA	SN
Pike County	5	1	25.9%	9.4% : 42.5%	NA	NA	SN
Porter County	65	26	39.8%	34.5% : 45.1%	-1.0%	-19.1% : 21.0%	6.5%
Posey County	10	3	25.0%	13.2% : 36.8%	NA	NA	SN
Pulaski County	4	2	40.9%	20.4% : 61.5%	NA	NA	SN
Putnam County	15	5	35.5%	24.8% : 46.3%	5.4%	-19.5% : 38.0%	7.9%

Population Group	# of New Staged Cases (Annual Average)	# of Cases Diagnosed at Late-stage (Annual Average)	Proportion Diagnosed at Late-stage	Confidence Interval of Late-stage Proportion	Late-stage Proportion Trend (Annual Percent Change)	Confidence Interval of Late-stage Proportion Trend	Proportion Diagnosed at Distant-stage
Randolph County	13	4	33.3%	21.7% : 45.0%	5.9%	-19.0% : 38.4%	6.3%
Ripley County	11	5	45.6%	32.7% : 58.5%	6.9%	-20.7% : 44.1%	7.0%
Rush County	7	3	38.2%	21.9% : 54.6%	11.2%	-16.3% : 47.9%	14.7%
St. Joseph County	106	38	36.4%	32.3% : 40.5%	-6.0%	-16.5% : 5.9%	4.9%
Scott County	8	3	32.5%	18.0% : 47.0%	NA	NA	SN
Shelby County	16	5	32.5%	22.2% : 42.8%	7.5%	-30.1% : 65.3%	5.0%
Spencer County	8	3	36.8%	21.5% : 52.2%	-10.6%	-56.8% : 84.9%	SN
Starke County	9	4	38.3%	24.4% : 52.2%	4.2%	-24.8% : 44.3%	SN
Steuben County	17	9	49.4%	38.9% : 59.9%	14.1%	-19.5% : 62.0%	10.3%
Sullivan County	8	2	31.6%	16.8% : 46.4%	NA	NA	13.2%
Switzerland County	SN	SN	SN	SN	SN	SN	SN
Tippecanoe County	49	17	35.4%	29.4% : 41.4%	-5.3%	NA	4.9%
Tipton County	6	2	25.8%	10.4% : 41.2%	NA	NA	SN
Union County	SN	SN	SN	SN	SN	SN	SN
Vanderburgh County	75	22	29.1%	24.5% : 33.7%	0.2%	-7.8% : 8.8%	4.0%
Vermillion County	7	3	35.1%	19.8% : 50.5%	6.5%	-22.2% : 46.0%	SN
Vigo County	47	15	30.8%	24.9% : 36.7%	12.4%	-15.6% : 49.6%	5.9%
Wabash County	14	5	33.8%	22.8% : 44.8%	-12.4%	-50.3% : 54.3%	5.6%
Warren County	SN	SN	SN	SN	SN	SN	SN
Warrick County	25	6	24.4%	16.9% : 31.9%	7.7%	-39.6% : 92.3%	SN
Washington County	12	4	32.8%	20.7% : 44.8%	-8.3%	-37.1% : 33.6%	SN
Wayne County	27	9	32.8%	24.9% : 40.8%	2.5%	-23.5% : 37.5%	5.2%
Wells County	9	2	27.9%	14.5% : 41.3%	11.7%	-13.4% : 44.0%	SN
White County	11	3	32.1%	19.5% : 44.6%	41.6%	-30.5% : 188.2%	SN
Whitley County	13	5	38.1%	26.1% : 50.1%	-5.6%	-28.0% : 23.8%	SN

NA – data not available.

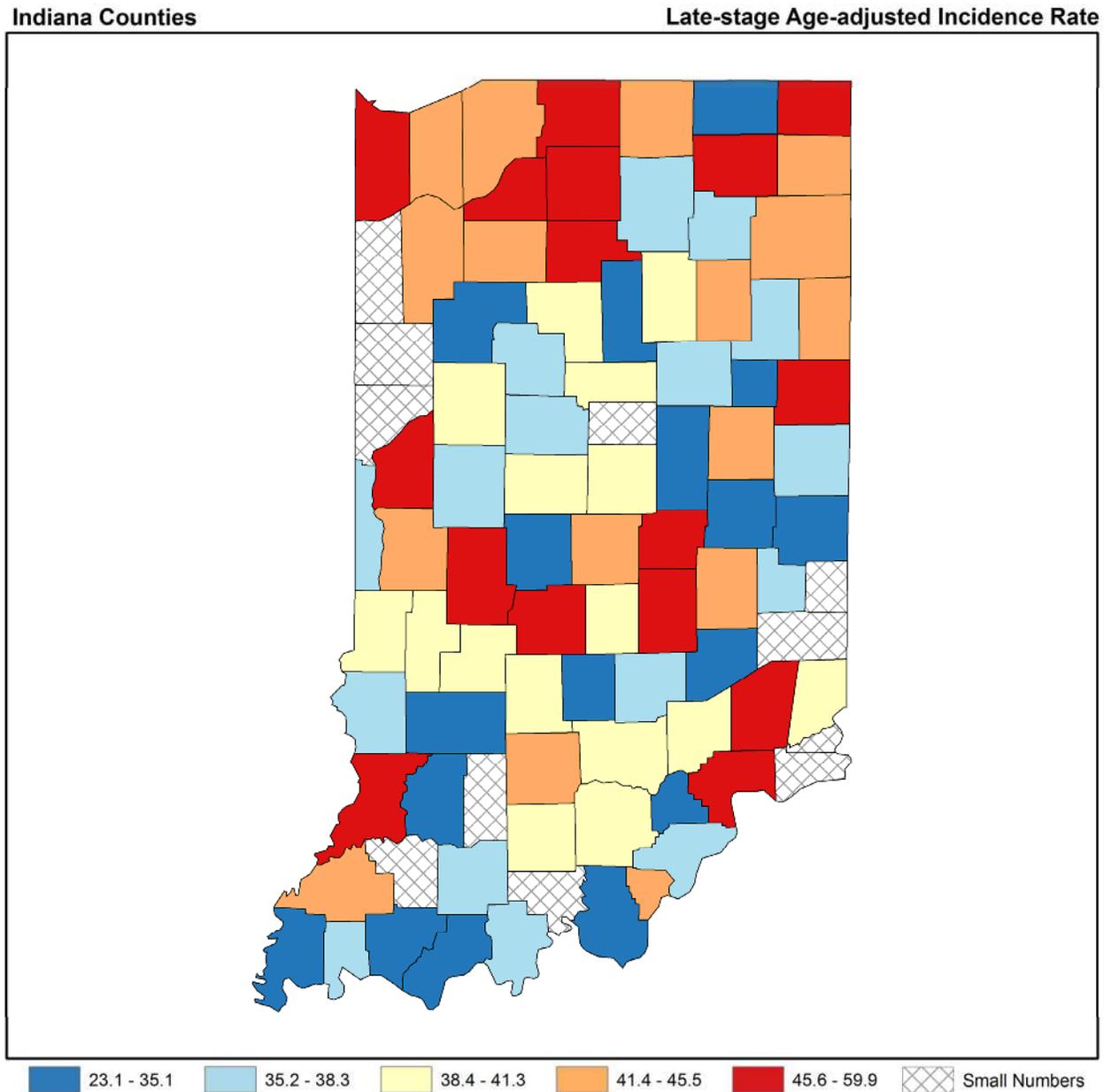
SN – data suppressed due to small numbers (15 cases or fewer for the 5-year data period).

Data are for years 2006-2010.

Source: NAACCR – CINA Deluxe Analytic File.

Map of late-stage incidence rates

Figure 2.3 shows a map of late-stage incidence rates for the counties in Indiana. When the numbers of cases used to compute the rates are small (15 cases or fewer for the five-year data period), those rates are unreliable and are shown as “small numbers” on the map.



*Map with counties labeled is available in Appendix.
Data are for years 2006-2010.
Rates are in cases per 100,000.
Age-adjusted rates are adjusted to the 2000 US standard population.
Source: NAACCR – CINA Deluxe Analytic File.

Figure 2.3. Female breast cancer age-adjusted late-stage incidence rates

Conclusions: Breast cancer late-stage rates, proportions and trends

Late-stage incidence rates and trends

Overall, the breast cancer late-stage incidence rate in the State of Indiana was significantly lower than that observed in the US as a whole and the late-stage incidence trend was higher than the US as a whole.

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

The following counties had a late-stage incidence rate **significantly higher** than the state as a whole:

- Knox County (Komen Evansville Tri-State)
- Lake County
- St. Joseph County

The late-stage incidence rate was significantly lower in the following counties:

- Henry County (Komen Central Indiana)
- LaGrange County
- Madison County (Komen Central Indiana)
- Wayne County (Komen Central Indiana)

The rest of the counties had late-stage incidence rates and trends that were not significantly different than the state as a whole or did not have enough data available.

Late-stage proportions and trends

Overall, the breast cancer late-stage proportion in the State of Indiana was significantly lower than that observed in the US as a whole and the late-stage proportion trend was higher than the US as a whole.

For the State of Indiana, the late-stage proportion was significantly higher among Blacks/African-Americans than Whites and slightly higher among APIs than Whites. There were not enough data available within the state to report on AIANs so comparisons cannot be made for this racial group. The late-stage proportion among Hispanics/Latinas was slightly higher than among Non-Hispanics/Latinas.

The following counties had a late-stage proportion **significantly higher** than the state as a whole:

- Knox County (Komen Evansville Tri-State)
- Lake County

- Marshall County
- Steuben County

The late-stage proportion was significantly lower in the following counties:

- Clark County (Komen Louisville)
- Grant County (Komen Central Indiana)
- Henry County (Komen Central Indiana)
- Madison County (Komen Central Indiana)
- Miami County
- Warrick County (Komen Evansville Tri-State)

Significantly less favorable trends in breast cancer late-stage proportions were observed in the following county:

- Howard County (Komen Central Indiana)

The rest of the counties had late-stage proportions and trends that were not significantly different than the state as a whole or did not have enough data available.

Mammography Screening

Getting regular screening mammograms (along with treatment if diagnosed) lowers the risk of dying from breast cancer.

Knowing whether or not women are getting regular screening mammograms as recommended by their health care providers can be used to identify groups of women who need help in meeting screening recommendations.

Why mammograms matter

Getting regular screening mammograms (and treatment if diagnosed) lowers the risk of dying from breast cancer. Screening mammography can find breast cancer early, when the chances of survival are highest. The US Preventive Services Task Force found that having screening mammograms reduces the breast cancer death rate for women age 40 to 74. The benefit of mammograms is greater for women age 50 to 74. It's especially high for women age 60 to 69 (Nelson et al., 2009). Because having mammograms lowers the chances of dying from breast cancer, it's important to know whether women are having mammograms when they should. This information can be used to identify groups of women who should be screened who need help in meeting the current recommendations for screening mammography.

Mammography recommendations

Table 2.5 shows some screening recommendations among major organizations for women at average risk.

Table 2.5. Breast cancer screening recommendations for women at average risk.*

American Cancer Society	National Comprehensive Cancer Network	US Preventive Services Task Force
<p>Informed decision-making with a health care provider at age 40</p> <p>Mammography every year starting at age 45</p> <p>Mammography every other year beginning at age 55</p>	<p>Mammography every year starting at age 40</p>	<p>Informed decision-making with a health care provider ages 40-49</p> <p>Mammography every 2 years ages 50-74</p>

*As of October 2015

Where the data come from

The Centers for Disease Control and Prevention’s (CDC) Behavioral Risk Factors Surveillance System (BRFSS) collected the data on mammograms that are used in this report. The data come from interviews with women age 50 to 74 from across the United States. During the interviews, each woman was asked how long it has been since she has had a mammogram. BRFSS is the best and most widely used source available for information on mammography usage among women in the United States, although it does not collect data matching Komen screening recommendations (i.e., from women age 40 and older).

For some counties, data about mammograms are not shown because not enough women were included in the survey (less than 10 survey responses).

The data have been weighted to account for differences between the women who were interviewed and all the women in the area. For example, if 20 percent of the women interviewed are Latina, but only 10 percent of the total women in the area are Latina, weighting is used to account for this difference.

Calculating the mammography screening proportion

This report uses the mammography screening proportion to show whether the women in an area are getting screening mammograms when they should.

Mammography screening proportion is calculated from two pieces of information:

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

The number of women who had a mammogram is divided by the number who should have had one. For example, if there are 500 women in an area who should have had mammograms and

250 of those women actually had a mammogram in the past two years, the mammography screening proportion is 50.0 percent.

Confidence intervals

As with incidence and death rates, this report includes the confidence interval of the screening proportions because numbers are not exact. The confidence interval is shown as two numbers—a lower value and a higher one. It is very unlikely that the true rate is less than the lower value or more than the higher value.

In general, screening proportions at the county level have fairly wide confidence intervals. The confidence interval should always be considered before concluding that the screening proportion in one county is higher or lower than that in another county.

Breast cancer screening proportions

Breast cancer screening proportions are shown in Table 2.6 for:

- United States
- State of Indiana
- Each county in Indiana

For the State of Indiana, proportions are also shown for Whites, Blacks/African-Americans, Asians and Pacific Islanders (API), and American Indians and Alaska Natives (AIAN). In addition, proportions are shown for Hispanics/Latinas and women who are not Hispanic/Latina (regardless of their race).

The proportions in Table 2.6 are based on the number of women age 50 to 74 who reported in 2012 having had a mammogram in the last two years. The data source is the BRFSS, which only surveys women in this age range for mammography usage. The data on the proportion of women who had a mammogram in the last two years have been weighted to account for differences between the women who were interviewed and all the women in the area. For example, if 20.0 percent of the women interviewed are Hispanic/Latina, but only 10.0 percent of the total women in the area are Hispanic/Latina, weighting is used to account for this difference.

Table 2.6. Proportion of women ages 50-74 with screening mammography in the last two years, self-report

Population Group	# of Women Interviewed (Sample Size)	# w/ Self-Reported Mammogram	Proportion Screened (Weighted Average)	Confidence Interval of Proportion Screened
US	174,796	133,399	77.5%	77.2% : 77.7%
Indiana	3,249	2,306	69.5%	67.5% : 71.5%
White	2,786	1,958	69.8%	67.6% : 71.9%
Black/African-American	375	290	70.5%	63.3% : 76.8%
AIAN	28	15	38.9%	18.5% : 64.1%
API	11	8	66.7%	28.8% : 90.9%
Hispanic/ Latina	50	33	43.7%	26.3% : 62.8%
Non-Hispanic/ Latina	3,182	2,261	70.0%	68.0% : 72.0%
Adams County	23	15	55.3%	32.8% : 75.8%
Allen County	152	98	59.1%	49.5% : 68.1%
Bartholomew County	30	22	73.7%	50.3% : 88.6%
Benton County	SN	SN	SN	SN
Blackford County	SN	SN	SN	SN
Boone County	23	17	67.1%	40.3% : 86.1%
Brown County	SN	SN	SN	SN
Carroll County	17	11	72.7%	43.9% : 90.1%
Cass County	20	12	63.7%	35.8% : 84.7%
Clark County	35	30	80.9%	62.9% : 91.4%
Clay County	18	12	64.0%	36.1% : 84.9%
Clinton County	16	10	54.7%	28.2% : 78.8%
Crawford County	SN	SN	SN	SN
Daviess County	22	15	65.4%	41.1% : 83.7%
DeKalb County	19	10	53.5%	27.8% : 77.5%
Dearborn County	22	17	72.4%	47.6% : 88.3%
Decatur County	11	9	76.8%	41.5% : 93.9%
Delaware County	48	35	72.2%	54.4% : 85.0%
Dubois County	21	14	74.3%	49.3% : 89.6%
Elkhart County	92	65	66.8%	53.9% : 77.7%
Fayette County	16	11	68.2%	38.5% : 88.0%
Floyd County	22	15	71.4%	48.0% : 87.1%
Fountain County	25	20	84.4%	60.0% : 95.2%
Franklin County	12	9	78.9%	40.6% : 95.4%
Fulton County	25	15	58.5%	33.3% : 80.0%

Population Group	# of Women Interviewed (Sample Size)	# w/ Self-Reported Mammogram	Proportion Screened (Weighted Average)	Confidence Interval of Proportion Screened
Gibson County	21	19	90.2%	67.2% : 97.6%
Grant County	38	30	82.1%	62.6% : 92.6%
Greene County	17	10	62.8%	33.6% : 84.9%
Hamilton County	58	44	77.0%	61.0% : 87.8%
Hancock County	14	11	72.9%	40.0% : 91.6%
Harrison County	15	11	70.9%	40.5% : 89.7%
Hendricks County	34	26	73.8%	51.5% : 88.2%
Henry County	27	24	91.0%	70.1% : 97.7%
Howard County	44	32	78.1%	59.0% : 89.9%
Huntington County	29	19	67.3%	44.6% : 84.1%
Jackson County	16	11	73.0%	40.7% : 91.4%
Jasper County	15	8	62.3%	31.7% : 85.5%
Jay County	22	13	58.7%	32.9% : 80.4%
Jefferson County	19	12	62.6%	35.9% : 83.3%
Jennings County	11	8	67.7%	35.3% : 88.9%
Johnson County	47	34	73.7%	55.9% : 86.0%
Knox County	14	13	88.2%	53.9% : 98.0%
Kosciusko County	41	23	52.3%	34.8% : 69.2%
LaGrange County	26	20	76.4%	50.8% : 91.1%
LaPorte County	44	29	68.1%	49.3% : 82.5%
Lake County	373	268	69.0%	62.7% : 74.7%
Lawrence County	26	19	75.8%	51.6% : 90.2%
Madison County	60	38	60.0%	43.9% : 74.1%
Marion County	450	342	75.4%	69.8% : 80.3%
Marshall County	19	14	65.8%	40.0% : 84.7%
Martin County	SN	SN	SN	SN
Miami County	16	10	54.4%	25.9% : 80.3%
Monroe County	38	31	81.0%	62.2% : 91.7%
Montgomery County	16	12	78.4%	48.7% : 93.3%
Morgan County	27	21	71.8%	50.2% : 86.6%
Newton County	SN	SN	SN	SN
Noble County	26	18	74.1%	50.8% : 88.8%
Ohio County	SN	SN	SN	SN
Orange County	20	14	71.1%	42.7% : 89.0%
Owen County	SN	SN	SN	SN

Population Group	# of Women Interviewed (Sample Size)	# w/ Self-Reported Mammogram	Proportion Screened (Weighted Average)	Confidence Interval of Proportion Screened
Parke County	18	11	49.3%	24.3% : 74.7%
Perry County	16	9	56.5%	22.9% : 85.0%
Pike County	SN	SN	SN	SN
Porter County	40	27	71.5%	53.3% : 84.6%
Posey County	SN	SN	SN	SN
Pulaski County	15	11	75.7%	44.1% : 92.5%
Putnam County	SN	SN	SN	SN
Randolph County	42	29	71.4%	52.5% : 85.0%
Ripley County	18	12	67.3%	36.6% : 88.0%
Rush County	28	21	76.8%	53.9% : 90.4%
Scott County	12	7	60.3%	31.4% : 83.4%
Shelby County	19	12	67.9%	42.3% : 85.9%
Spencer County	24	20	81.7%	59.4% : 93.2%
St. Joseph County	92	61	67.2%	54.2% : 78.0%
Starke County	31	21	65.5%	43.6% : 82.3%
Steuben County	19	11	58.5%	32.5% : 80.4%
Sullivan County	12	8	66.0%	33.8% : 88.0%
Switzerland County	SN	SN	SN	SN
Tippecanoe County	52	41	73.6%	55.4% : 86.3%
Tipton County	SN	SN	SN	SN
Union County	SN	SN	SN	SN
Vanderburgh County	92	78	84.0%	72.9% : 91.1%
Vermillion County	SN	SN	SN	SN
Vigo County	41	26	63.6%	43.8% : 79.7%
Wabash County	24	17	71.3%	44.5% : 88.4%
Warren County	SN	SN	SN	SN
Warrick County	23	17	77.0%	54.1% : 90.5%
Washington County	10	7	69.3%	34.9% : 90.5%
Wayne County	36	24	61.7%	40.8% : 79.0%
Wells County	11	8	66.2%	30.2% : 89.9%
White County	45	35	81.5%	65.3% : 91.2%
Whitley County	15	9	55.7%	30.1% : 78.6%

SN – data suppressed due to small numbers (fewer than 10 samples).

Data are for 2012.

Source: CDC – Behavioral Risk Factor Surveillance System (BRFSS).

Conclusions: Breast cancer screening proportions

The breast cancer screening proportion in the State of Indiana was **significantly lower** than that observed in the US as a whole.

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

The following county had a screening proportion significantly higher than the state as a whole:

- Vanderburgh County (Komen Evansville Tri-State)

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

Demographic and Socioeconomic Measures

Demographic and socioeconomic data can be used to identify which groups of women are most in need of help and to figure out the best ways to help them.

The report includes basic information about the women in each area (demographic measures) and about factors like education, income, and unemployment (socioeconomic measures) in the areas where they live.

Demographic measures in the report include:

- Age
- Race
- Ethnicity (whether or not a woman is Hispanic/Latina – can be of any race)

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

Socioeconomic measures for the areas covered in this report include:

- Education level
- Income
- Unemployment
- Immigration (how many of the people living in an area were born in another country)

- Use of the English language
- Proportion of people who have health insurance
- Proportion of people who live in rural areas
- Proportion of people who in areas that don't have enough doctors or health care facilities (medically underserved areas)

Why these data matter

Demographic and socioeconomic data can be used to identify which groups of women need the most help and to figure out the best ways to help them.

Important details about these data

The demographic and socioeconomic data in this report are the most recent data available for US counties. All the data are shown as percentages. However, the percentages weren't all calculated in the same way.

- The race, ethnicity, and age data are based on the total female population in the area (e.g. the percent of females over the age of 40).
- The socioeconomic data are based on all of the people in the area, not just women.
- Income, education and unemployment data don't include children. They're based on people age 15 and older for income and unemployment and age 25 and older for education.
- The data on the use of English, called "linguistic isolation", are based on the total number of households in the area. The Census Bureau defines a linguistically isolated household as one in which all the adults have difficulty with English.

Where the data come from

The demographic and socioeconomic sources of data are:

- Race/ethnicity, age, and sex data come from the US Census Bureau estimates for July 1, 2011.
- Most of the other data come from the US Census Bureau's American Community Survey program. The most recent data for counties are for 2007 to 2011.
- Health insurance data come from the US Census Bureau's Small Area Health Insurance Estimates program. The most recent data are for 2011.
- Rural population data come from the US Census Bureau's 2010 population survey.
- Medically underserved area information comes from the US Department of Health and Human Services, Health Resources and Services Administration. The most recent data are for 2013.

Population characteristics

Race, ethnicity, and age data for the US, the state, and each of the counties in the state is presented in Table 2.7:

- Race percentages for four race groups: White, Black/African-American, American Indian and Alaska Native (AIAN), and Asian and Pacific Islander (API).
- Percentages of women of Hispanic/Latina ethnicity (who may be of any race).

- Percentages of women in three age-groups: 40 and older, 50 and older, and 65 and older.

Table 2.8 shows socioeconomic data for the US, the state, and each of the counties in the state:

- Educational attainment as the percentage of the population 25 years and over that did not complete high school
- Income relative to the US poverty level. Two levels are shown – the percentage of people with income less than the poverty level (below 100 percent) and less than 2.5 times the poverty level (below 250 percent).
- Percentage of the population who are unemployed
- Percentage of the population born outside the US
- Percentage of households that are linguistically isolated (all adults in the household have difficulty with English)
- Percentage living in rural areas
- Percentage living in medically underserved areas as determined by the Health Resources and Services Administration (HRSA)
- Percentage between ages 40 and 64 who have no health insurance

Table 2.7. Population characteristics – demographics

Population Group	White	Black/ African- American	AIAN	API	Non- Hispanic/ Latina	Hispanic/ Latina	Female Age 40 Plus	Female Age 50 Plus	Female Age 65 Plus
US	78.8 %	14.1 %	1.4 %	5.8 %	83.8 %	16.2 %	48.3 %	34.5 %	14.8 %
Indiana	87.4 %	10.2 %	0.4 %	1.9 %	94.2 %	5.8 %	48.0 %	34.6 %	14.8 %
Adams County	98.9 %	0.5 %	0.2 %	0.4 %	96.0 %	4.0 %	45.5 %	33.8 %	16.0 %
Allen County	82.9 %	13.5 %	0.5 %	3.0 %	93.7 %	6.3 %	45.7 %	32.6 %	13.5 %
Bartholomew County	93.4 %	2.5 %	0.5 %	3.7 %	94.6 %	5.4 %	49.3 %	35.8 %	15.9 %
Benton County	98.7 %	0.9 %	0.1 %	0.4 %	95.5 %	4.5 %	53.0 %	38.8 %	18.3 %
Blackford County	98.5 %	0.9 %	0.3 %	0.3 %	98.9 %	1.1 %	55.7 %	42.2 %	20.4 %
Boone County	96.4 %	1.4 %	0.2 %	2.1 %	97.7 %	2.3 %	49.4 %	33.1 %	12.8 %
Brown County	98.2 %	0.9 %	0.4 %	0.6 %	98.8 %	1.2 %	60.9 %	47.2 %	18.4 %
Carroll County	98.6 %	0.8 %	0.4 %	0.2 %	96.6 %	3.4 %	52.9 %	39.7 %	17.6 %
Cass County	95.6 %	1.9 %	1.1 %	1.4 %	87.8 %	12.2 %	50.6 %	37.5 %	17.6 %
Clark County	90.5 %	7.9 %	0.4 %	1.1 %	95.7 %	4.3 %	49.2 %	35.5 %	14.6 %
Clay County	98.7 %	0.7 %	0.2 %	0.4 %	98.9 %	1.1 %	51.5 %	38.1 %	17.1 %
Clinton County	98.6 %	0.7 %	0.4 %	0.3 %	87.4 %	12.6 %	48.8 %	36.1 %	16.6 %
Crawford County	98.4 %	0.8 %	0.4 %	0.4 %	98.6 %	1.4 %	52.5 %	39.1 %	16.3 %
Daviess County	98.1 %	1.0 %	0.4 %	0.6 %	96.1 %	3.9 %	46.7 %	34.5 %	16.2 %
Dearborn County	98.2 %	0.9 %	0.2 %	0.7 %	99.0 %	1.0 %	51.9 %	36.8 %	14.7 %
Decatur County	98.1 %	0.6 %	0.3 %	1.0 %	98.6 %	1.4 %	50.4 %	36.9 %	16.7 %
DeKalb County	98.4 %	0.7 %	0.3 %	0.7 %	97.8 %	2.2 %	48.8 %	35.2 %	15.1 %
Delaware County	90.4 %	7.8 %	0.3 %	1.4 %	98.2 %	1.8 %	45.7 %	34.4 %	16.4 %
Dubois County	98.5 %	0.6 %	0.3 %	0.7 %	94.3 %	5.7 %	51.5 %	37.7 %	17.1 %
Elkhart County	91.2 %	6.8 %	0.6 %	1.3 %	86.5 %	13.5 %	45.2 %	32.1 %	14.0 %
Fayette County	97.7 %	1.8 %	0.2 %	0.4 %	99.0 %	1.0 %	53.0 %	40.4 %	18.5 %
Floyd County	92.4 %	6.1 %	0.3 %	1.2 %	97.6 %	2.4 %	50.9 %	36.3 %	14.7 %
Fountain County	98.6 %	0.6 %	0.4 %	0.4 %	97.9 %	2.1 %	54.8 %	41.0 %	20.3 %
Franklin County	99.0 %	0.6 %	0.2 %	0.3 %	99.0 %	1.0 %	52.0 %	37.4 %	16.3 %
Fulton County	97.5 %	1.1 %	0.8 %	0.7 %	95.9 %	4.1 %	52.9 %	40.3 %	18.9 %
Gibson County	96.6 %	2.6 %	0.2 %	0.6 %	98.8 %	1.2 %	52.1 %	38.7 %	17.8 %
Grant County	91.1 %	7.7 %	0.5 %	0.8 %	96.7 %	3.3 %	50.6 %	38.4 %	18.1 %
Greene County	98.7 %	0.5 %	0.3 %	0.4 %	99.0 %	1.0 %	53.7 %	39.4 %	18.0 %
Hamilton County	90.1 %	4.2 %	0.3 %	5.4 %	96.5 %	3.5 %	44.5 %	27.6 %	9.8 %
Hancock County	96.0 %	2.5 %	0.3 %	1.2 %	98.1 %	1.9 %	50.6 %	35.0 %	14.0 %
Harrison County	98.4 %	0.7 %	0.3 %	0.6 %	98.5 %	1.5 %	52.3 %	37.6 %	15.7 %
Hendricks County	92.0 %	5.0 %	0.4 %	2.6 %	97.0 %	3.0 %	46.9 %	31.4 %	12.4 %

Population Group	White	Black/ African- American	AIAN	API	Non- Hispanic/ Latina	Hispanic/ Latina	Female Age 40 Plus	Female Age 50 Plus	Female Age 65 Plus
Henry County	98.0 %	1.3 %	0.2 %	0.5 %	98.7 %	1.3 %	54.4 %	40.6 %	19.2 %
Howard County	90.5 %	7.8 %	0.4 %	1.2 %	97.5 %	2.5 %	53.0 %	40.0 %	18.5 %
Huntington County	98.1 %	0.9 %	0.4 %	0.6 %	98.2 %	1.8 %	50.7 %	37.5 %	16.9 %
Jackson County	97.6 %	1.1 %	0.3 %	1.0 %	94.9 %	5.1 %	50.2 %	36.5 %	16.3 %
Jasper County	98.2 %	0.9 %	0.3 %	0.6 %	94.7 %	5.3 %	49.4 %	36.1 %	15.7 %
Jay County	98.8 %	0.6 %	0.1 %	0.5 %	97.4 %	2.6 %	50.5 %	37.1 %	17.2 %
Jefferson County	96.4 %	2.5 %	0.2 %	0.9 %	97.8 %	2.2 %	50.8 %	36.9 %	16.0 %
Jennings County	98.4 %	1.1 %	0.1 %	0.4 %	97.8 %	2.2 %	49.5 %	34.7 %	14.3 %
Johnson County	95.7 %	1.6 %	0.3 %	2.4 %	97.1 %	2.9 %	47.5 %	33.2 %	14.0 %
Knox County	96.2 %	2.9 %	0.2 %	0.7 %	98.4 %	1.6 %	51.8 %	39.6 %	18.9 %
Kosciusko County	97.4 %	1.1 %	0.4 %	1.1 %	93.1 %	6.9 %	48.9 %	35.3 %	15.2 %
LaGrange County	98.6 %	0.7 %	0.2 %	0.5 %	96.5 %	3.5 %	41.0 %	29.8 %	13.1 %
Lake County	69.7 %	28.0 %	0.6 %	1.6 %	83.6 %	16.4 %	48.8 %	35.5 %	15.0 %
LaPorte County	88.6 %	10.0 %	0.5 %	0.8 %	94.8 %	5.2 %	52.3 %	38.9 %	16.9 %
Lawrence County	98.2 %	0.7 %	0.4 %	0.7 %	98.8 %	1.2 %	54.4 %	40.6 %	18.8 %
Madison County	91.0 %	7.9 %	0.4 %	0.7 %	96.9 %	3.1 %	51.7 %	38.5 %	17.8 %
Marion County	67.7 %	29.3 %	0.6 %	2.4 %	91.4 %	8.6 %	43.7 %	30.7 %	12.3 %
Marshall County	97.9 %	1.0 %	0.4 %	0.7 %	91.9 %	8.1 %	50.2 %	36.8 %	16.9 %
Martin County	98.6 %	0.7 %	0.3 %	0.5 %	98.9 %	1.1 %	53.8 %	40.5 %	17.8 %
Miami County	96.2 %	2.1 %	1.2 %	0.6 %	97.9 %	2.1 %	51.8 %	38.2 %	17.0 %
Monroe County	89.8 %	4.0 %	0.4 %	5.8 %	96.9 %	3.1 %	37.3 %	27.3 %	11.8 %
Montgomery County	97.8 %	1.1 %	0.4 %	0.6 %	95.8 %	4.2 %	51.9 %	38.2 %	17.9 %
Morgan County	98.4 %	0.6 %	0.3 %	0.7 %	98.8 %	1.2 %	51.8 %	36.5 %	14.7 %
Newton County	98.3 %	0.7 %	0.4 %	0.6 %	94.9 %	5.1 %	54.9 %	41.3 %	19.0 %
Noble County	98.2 %	0.8 %	0.4 %	0.6 %	90.8 %	9.2 %	48.1 %	34.8 %	14.6 %
Ohio County	98.5 %	0.7 %	0.3 %	0.5 %	98.8 %	1.2 %	56.1 %	42.1 %	19.0 %
Orange County	97.9 %	1.3 %	0.4 %	0.4 %	99.0 %	1.0 %	52.5 %	38.9 %	17.5 %
Owen County	98.3 %	0.8 %	0.5 %	0.5 %	98.8 %	1.2 %	54.4 %	39.7 %	16.2 %
Parke County	94.8 %	4.3 %	0.5 %	0.4 %	98.7 %	1.3 %	52.1 %	36.7 %	15.6 %
Perry County	98.5 %	0.6 %	0.3 %	0.6 %	98.9 %	1.1 %	53.9 %	41.1 %	18.6 %
Pike County	98.7 %	0.6 %	0.3 %	0.3 %	99.0 %	1.0 %	55.2 %	41.5 %	19.1 %
Porter County	94.2 %	3.8 %	0.5 %	1.6 %	91.4 %	8.6 %	49.6 %	35.6 %	14.0 %
Posey County	97.9 %	1.4 %	0.2 %	0.5 %	99.0 %	1.0 %	54.1 %	39.4 %	16.4 %
Pulaski County	98.1 %	1.1 %	0.3 %	0.5 %	97.8 %	2.2 %	54.2 %	40.0 %	18.9 %
Putnam County	96.9 %	1.7 %	0.3 %	1.0 %	98.6 %	1.4 %	50.0 %	36.4 %	16.3 %

Population Group	White	Black/ African- American	AIAN	API	Non- Hispanic/ Latina	Hispanic/ Latina	Female Age 40 Plus	Female Age 50 Plus	Female Age 65 Plus
Randolph County	98.2 %	1.0 %	0.4 %	0.4 %	97.4 %	2.6 %	53.1 %	39.9 %	19.4 %
Ripley County	98.4 %	0.6 %	0.3 %	0.7 %	98.5 %	1.5 %	50.8 %	36.7 %	16.7 %
Rush County	98.1 %	1.2 %	0.3 %	0.4 %	98.9 %	1.1 %	53.1 %	38.9 %	17.8 %
St. Joseph County	82.6 %	14.4 %	0.6 %	2.4 %	92.9 %	7.1 %	47.2 %	34.5 %	15.2 %
Scott County	98.5 %	0.7 %	0.2 %	0.7 %	98.7 %	1.3 %	51.1 %	36.2 %	15.4 %
Shelby County	97.5 %	1.4 %	0.3 %	0.8 %	96.5 %	3.5 %	52.0 %	37.1 %	16.0 %
Spencer County	98.1 %	1.0 %	0.3 %	0.5 %	97.7 %	2.3 %	53.4 %	39.3 %	16.7 %
Starke County	98.4 %	0.7 %	0.6 %	0.4 %	96.7 %	3.3 %	51.9 %	38.2 %	16.5 %
Steuben County	98.1 %	0.8 %	0.4 %	0.6 %	97.2 %	2.8 %	52.8 %	39.1 %	16.9 %
Sullivan County	98.7 %	0.7 %	0.3 %	0.3 %	99.0 %	1.0 %	53.9 %	40.6 %	18.9 %
Switzerland County	98.6 %	0.8 %	0.3 %	0.3 %	99.0 %	1.0 %	51.0 %	36.0 %	16.2 %
Tippecanoe County	88.8 %	5.1 %	0.4 %	5.7 %	92.5 %	7.5 %	37.5 %	27.0 %	11.2 %
Tipton County	98.7 %	0.6 %	0.3 %	0.5 %	98.0 %	2.0 %	56.3 %	41.8 %	19.7 %
Union County	98.1 %	1.0 %	0.4 %	0.6 %	98.8 %	1.2 %	53.2 %	38.3 %	16.5 %
Vanderburgh County	88.2 %	10.1 %	0.3 %	1.4 %	97.9 %	2.1 %	49.0 %	36.7 %	16.5 %
Vermillion County	98.6 %	0.7 %	0.4 %	0.3 %	98.9 %	1.1 %	55.6 %	41.9 %	19.5 %
Vigo County	91.2 %	6.4 %	0.4 %	2.0 %	98.3 %	1.7 %	47.5 %	35.5 %	16.3 %
Wabash County	97.7 %	1.1 %	0.7 %	0.5 %	98.0 %	2.0 %	54.0 %	41.5 %	20.8 %
Warren County	98.5 %	0.7 %	0.2 %	0.5 %	98.8 %	1.2 %	54.9 %	40.6 %	19.0 %
Warrick County	96.1 %	1.8 %	0.2 %	1.8 %	98.4 %	1.6 %	51.8 %	37.3 %	15.3 %
Washington County	98.7 %	0.6 %	0.3 %	0.4 %	98.9 %	1.1 %	50.4 %	36.1 %	14.8 %
Wayne County	92.7 %	5.9 %	0.4 %	1.1 %	97.6 %	2.4 %	52.6 %	39.4 %	18.6 %
Wells County	98.5 %	0.7 %	0.2 %	0.5 %	98.0 %	2.0 %	52.7 %	39.4 %	18.1 %
White County	98.0 %	0.9 %	0.5 %	0.5 %	93.4 %	6.6 %	55.0 %	41.9 %	19.7 %
Whitley County	98.5 %	0.6 %	0.3 %	0.5 %	98.5 %	1.5 %	52.7 %	38.9 %	16.5 %

Data are for 2011.

Data are in the percentage of women in the population.

Source: US Census Bureau – Population Estimates.

Table 2.8. Population characteristics – socioeconomics

Population Group	Less than HS Education	Income Below 100% Poverty	Income Below 250% Poverty (Age: 40-64)	Un-employed	Foreign Born	Linguistically Isolated	In Rural Areas	In Medically Under-served Areas	No Health Insurance (Age: 40-64)
US	14.6 %	14.3 %	33.3 %	8.7 %	12.8 %	4.7 %	19.3 %	23.3 %	16.6 %
Indiana	13.4 %	14.1 %	32.9 %	9.0 %	4.5 %	1.8 %	27.6 %	14.7 %	15.6 %
Adams County	16.0 %	15.5 %	38.4 %	8.6 %	1.0 %	1.3 %	53.7 %	0.0 %	18.5 %
Allen County	11.1 %	13.4 %	32.3 %	8.9 %	5.6 %	2.0 %	11.9 %	0.0 %	16.1 %
Bartholomew County	11.0 %	11.4 %	30.7 %	6.9 %	6.8 %	3.2 %	33.7 %	0.0 %	14.3 %
Benton County	10.8 %	12.0 %	36.8 %	7.9 %	1.6 %	0.6 %	100.0 %	0.0 %	17.4 %
Blackford County	13.6 %	15.8 %	39.8 %	12.9 %	0.6 %	0.0 %	50.6 %	0.0 %	16.4 %
Boone County	6.7 %	7.9 %	18.1 %	4.6 %	3.1 %	0.3 %	34.4 %	0.0 %	9.3 %
Brown County	11.5 %	11.2 %	33.0 %	8.8 %	1.6 %	0.6 %	100.0 %	100.0 %	17.0 %
Carroll County	11.0 %	10.4 %	30.2 %	8.1 %	2.1 %	1.6 %	81.4 %	0.0 %	15.0 %
Cass County	16.5 %	15.1 %	38.9 %	9.3 %	7.8 %	3.6 %	44.7 %	100.0 %	19.4 %
Clark County	14.2 %	11.9 %	33.2 %	8.2 %	3.6 %	1.4 %	20.5 %	0.0 %	15.0 %
Clay County	12.4 %	12.7 %	38.7 %	8.4 %	0.9 %	0.1 %	60.9 %	100.0 %	16.5 %
Clinton County	17.7 %	13.9 %	36.2 %	9.2 %	6.7 %	3.2 %	49.8 %	12.4 %	18.1 %
Crawford County	18.9 %	18.5 %	44.9 %	9.4 %	0.3 %	0.0 %	100.0 %	100.0 %	17.3 %
Daviess County	24.6 %	13.1 %	38.8 %	5.0 %	2.6 %	2.2 %	60.3 %	100.0 %	19.1 %
Dearborn County	11.3 %	7.4 %	27.0 %	7.9 %	1.3 %	0.0 %	53.1 %	0.0 %	12.3 %
Decatur County	15.2 %	12.5 %	35.4 %	9.0 %	2.3 %	0.8 %	53.8 %	6.9 %	14.7 %
DeKalb County	12.0 %	10.6 %	33.4 %	10.3 %	1.4 %	0.5 %	42.3 %	0.0 %	16.1 %
Delaware County	14.9 %	20.6 %	38.9 %	12.9 %	2.0 %	0.7 %	22.8 %	0.0 %	15.4 %
Dubois County	14.4 %	8.5 %	26.5 %	4.4 %	3.7 %	2.4 %	49.2 %	0.0 %	13.4 %
Elkhart County	20.1 %	15.7 %	36.1 %	10.9 %	8.4 %	5.3 %	20.6 %	0.0 %	19.8 %
Fayette County	23.1 %	22.1 %	44.3 %	14.2 %	0.8 %	0.2 %	36.8 %	4.4 %	16.7 %
Floyd County	12.3 %	11.4 %	28.0 %	7.7 %	2.3 %	0.5 %	20.3 %	0.0 %	12.5 %
Fountain County	16.3 %	12.4 %	34.6 %	9.3 %	1.5 %	0.6 %	66.0 %	100.0 %	15.3 %
Franklin County	15.2 %	12.4 %	31.2 %	6.4 %	0.8 %	0.6 %	88.9 %	100.0 %	14.8 %
Fulton County	14.2 %	12.7 %	39.0 %	8.2 %	2.6 %	0.4 %	64.9 %	0.0 %	17.2 %
Gibson County	10.6 %	12.6 %	29.5 %	6.9 %	0.8 %	0.8 %	53.6 %	25.4 %	12.5 %
Grant County	16.0 %	17.8 %	41.2 %	11.2 %	1.6 %	0.4 %	28.9 %	0.0 %	16.2 %
Greene County	15.2 %	12.8 %	37.4 %	9.5 %	0.7 %	0.2 %	74.8 %	15.0 %	16.9 %
Hamilton County	4.0 %	4.7 %	13.7 %	4.6 %	6.7 %	1.2 %	5.6 %	0.0 %	9.2 %
Hancock County	8.3 %	7.3 %	24.3 %	6.3 %	1.5 %	0.6 %	30.4 %	0.0 %	12.2 %
Harrison County	12.5 %	11.9 %	32.3 %	8.7 %	1.2 %	0.2 %	85.8 %	0.0 %	15.5 %

Population Group	Less than HS Education	Income Below 100% Poverty	Income Below 250% Poverty (Age: 40-64)	Un-employed	Foreign Born	Linguistically Isolated	In Rural Areas	In Medically Under-served Areas	No Health Insurance (Age: 40-64)
Hendricks County	6.6 %	5.1 %	19.4 %	5.1 %	3.8 %	1.0 %	17.8 %	0.0 %	10.8 %
Henry County	15.5 %	14.6 %	39.0 %	11.4 %	0.8 %	0.2 %	42.9 %	0.0 %	16.7 %
Howard County	12.9 %	15.3 %	33.8 %	11.2 %	1.7 %	0.4 %	21.5 %	33.0 %	13.2 %
Huntington County	11.8 %	11.2 %	33.5 %	11.1 %	1.1 %	0.1 %	51.0 %	3.4 %	15.6 %
Jackson County	15.0 %	12.7 %	36.1 %	10.2 %	4.6 %	3.2 %	43.7 %	0.0 %	17.3 %
Jasper County	12.5 %	7.7 %	27.7 %	7.9 %	2.1 %	0.6 %	68.0 %	0.0 %	14.2 %
Jay County	15.4 %	15.0 %	40.9 %	9.8 %	1.1 %	0.1 %	55.7 %	0.0 %	17.0 %
Jefferson County	15.8 %	12.7 %	37.3 %	8.1 %	2.1 %	0.9 %	45.1 %	13.4 %	15.9 %
Jennings County	15.9 %	12.2 %	42.3 %	14.3 %	1.1 %	0.1 %	60.2 %	5.4 %	17.1 %
Johnson County	9.3 %	8.5 %	23.1 %	6.0 %	3.4 %	0.6 %	13.9 %	14.6 %	11.7 %
Knox County	14.9 %	16.0 %	38.9 %	6.9 %	1.8 %	0.2 %	36.2 %	0.0 %	16.0 %
Kosciusko County	15.5 %	10.7 %	31.0 %	9.3 %	3.9 %	2.4 %	46.6 %	0.0 %	17.0 %
LaGrange County	39.5 %	15.5 %	42.1 %	8.9 %	1.8 %	6.7 %	91.6 %	0.0 %	22.6 %
Lake County	13.5 %	16.6 %	34.6 %	10.3 %	6.7 %	2.7 %	4.0 %	27.3 %	17.6 %
LaPorte County	14.5 %	15.2 %	33.2 %	10.3 %	3.2 %	1.4 %	35.6 %	0.0 %	15.5 %
Lawrence County	17.8 %	15.8 %	37.3 %	9.2 %	1.0 %	0.3 %	58.4 %	0.0 %	16.5 %
Madison County	13.2 %	16.1 %	36.2 %	10.9 %	1.9 %	0.5 %	23.1 %	0.0 %	15.7 %
Marion County	15.8 %	18.3 %	39.3 %	10.7 %	8.2 %	3.6 %	0.6 %	21.0 %	17.9 %
Marshall County	15.7 %	12.0 %	34.9 %	8.8 %	4.2 %	2.9 %	63.3 %	14.2 %	17.3 %
Martin County	17.8 %	14.4 %	34.6 %	7.3 %	1.3 %	0.4 %	72.3 %	34.5 %	14.1 %
Miami County	17.1 %	17.6 %	39.3 %	11.7 %	1.1 %	0.1 %	46.5 %	0.0 %	17.3 %
Monroe County	8.5 %	25.3 %	31.5 %	7.1 %	7.5 %	2.4 %	21.2 %	0.0 %	14.9 %
Montgomery County	12.6 %	13.1 %	33.6 %	8.0 %	3.1 %	1.5 %	52.8 %	0.0 %	16.2 %
Morgan County	14.5 %	9.6 %	29.6 %	9.1 %	1.2 %	0.1 %	49.1 %	0.0 %	14.2 %
Newton County	13.2 %	11.3 %	33.8 %	9.1 %	2.9 %	0.5 %	100.0 %	0.0 %	17.3 %
Noble County	17.8 %	11.6 %	35.4 %	11.6 %	5.3 %	3.2 %	68.0 %	0.0 %	18.4 %
Ohio County	17.4 %	8.4 %	34.5 %	8.7 %	0.2 %	0.0 %	100.0 %	100.0 %	14.0 %
Orange County	20.3 %	18.1 %	46.0 %	11.7 %	0.8 %	0.2 %	83.5 %	0.0 %	17.3 %
Owen County	18.3 %	13.9 %	40.2 %	8.6 %	1.2 %	0.1 %	100.0 %	100.0 %	18.1 %
Parke County	19.2 %	14.8 %	39.8 %	8.7 %	1.2 %	1.2 %	75.0 %	3.4 %	18.5 %
Perry County	17.9 %	10.1 %	33.8 %	7.1 %	0.4 %	0.1 %	55.0 %	16.6 %	15.1 %
Pike County	16.0 %	13.5 %	34.9 %	7.6 %	0.7 %	0.0 %	100.0 %	100.0 %	14.0 %
Porter County	8.4 %	9.6 %	23.3 %	7.8 %	3.6 %	0.9 %	20.8 %	0.0 %	12.2 %
Posey County	10.6 %	10.1 %	22.8 %	7.1 %	1.2 %	0.0 %	66.8 %	33.6 %	10.2 %

Population Group	Less than HS Education	Income Below 100% Poverty	Income Below 250% Poverty (Age: 40-64)	Un-employed	Foreign Born	Linguistically Isolated	In Rural Areas	In Medically Underserved Areas	No Health Insurance (Age: 40-64)
Pulaski County	14.7 %	16.6 %	36.4 %	8.5 %	0.4 %	0.1 %	80.9 %	0.0 %	15.9 %
Putnam County	14.1 %	11.4 %	32.4 %	8.1 %	1.6 %	0.5 %	64.8 %	0.0 %	14.4 %
Randolph County	14.7 %	14.8 %	40.6 %	8.8 %	1.2 %	0.6 %	61.9 %	0.0 %	17.1 %
Ripley County	14.2 %	10.5 %	30.8 %	8.3 %	1.2 %	0.4 %	83.2 %	21.9 %	13.7 %
Rush County	14.7 %	14.2 %	36.3 %	9.4 %	0.3 %	0.5 %	61.2 %	0.0 %	15.8 %
St. Joseph County	12.5 %	16.0 %	34.1 %	10.1 %	5.3 %	1.9 %	9.0 %	10.1 %	17.6 %
Scott County	24.0 %	17.8 %	43.3 %	13.4 %	1.1 %	0.6 %	52.7 %	100.0 %	15.3 %
Shelby County	14.2 %	11.1 %	31.2 %	8.0 %	2.7 %	0.8 %	52.0 %	0.0 %	15.5 %
Spencer County	14.3 %	12.3 %	30.9 %	6.6 %	1.8 %	1.2 %	100.0 %	100.0 %	13.0 %
Starke County	20.7 %	16.5 %	43.6 %	13.6 %	1.5 %	0.6 %	82.4 %	100.0 %	17.5 %
Steuben County	9.8 %	10.4 %	32.1 %	9.9 %	1.9 %	0.3 %	67.2 %	0.0 %	16.4 %
Sullivan County	14.1 %	13.2 %	36.9 %	8.3 %	1.2 %	0.4 %	79.0 %	0.0 %	15.6 %
Switzerland County	22.5 %	14.3 %	45.9 %	10.0 %	1.2 %	0.9 %	100.0 %	100.0 %	17.4 %
Tippecanoe County	9.5 %	20.8 %	29.5 %	7.8 %	10.3 %	3.7 %	14.5 %	100.0 %	15.4 %
Tipton County	10.9 %	7.0 %	28.8 %	7.1 %	1.4 %	0.5 %	61.6 %	0.0 %	14.1 %
Union County	13.9 %	12.3 %	40.0 %	7.5 %	0.8 %	0.1 %	100.0 %	14.6 %	17.0 %
Vanderburgh County	12.1 %	15.5 %	34.4 %	6.8 %	2.4 %	0.9 %	9.2 %	15.7 %	14.6 %
Vermillion County	12.2 %	13.6 %	36.6 %	8.0 %	0.4 %	0.0 %	60.4 %	0.0 %	14.6 %
Vigo County	14.3 %	18.5 %	40.0 %	8.3 %	3.1 %	0.6 %	23.8 %	0.0 %	15.9 %
Wabash County	13.9 %	13.6 %	34.8 %	10.2 %	1.6 %	0.4 %	50.0 %	0.0 %	15.2 %
Warren County	18.2 %	9.9 %	30.9 %	7.6 %	1.6 %	0.0 %	77.1 %	0.0 %	14.0 %
Warrick County	8.4 %	7.3 %	20.9 %	6.1 %	2.8 %	0.4 %	29.3 %	0.0 %	11.1 %
Washington County	21.3 %	14.8 %	43.5 %	9.8 %	0.6 %	0.2 %	76.8 %	28.1 %	17.1 %
Wayne County	17.8 %	18.4 %	40.0 %	11.6 %	2.1 %	0.8 %	33.0 %	0.0 %	16.6 %
Wells County	10.8 %	9.0 %	30.5 %	9.3 %	1.0 %	0.1 %	50.6 %	0.0 %	14.0 %
White County	12.2 %	10.1 %	35.4 %	8.4 %	4.2 %	1.8 %	68.0 %	17.1 %	17.6 %
Whitley County	9.4 %	7.5 %	28.3 %	10.1 %	0.9 %	0.0 %	71.2 %	0.0 %	13.8 %

Data are in the percentage of people (men and women) in the population.

Source of health insurance data: US Census Bureau – Small Area Health Insurance Estimates (SAHIE) for 2011.

Source of rural population data: US Census Bureau – Census 2010.

Source of medically underserved data: Health Resources and Services Administration (HRSA) for 2013.

Source of other data: US Census Bureau – American Community Survey (ACS) for 2007-2011.

Conclusions: Population characteristics

Proportionately, the State of Indiana has a substantially larger White female population than the US as a whole, a slightly smaller Black/African-American female population, a substantially smaller Asian and Pacific Islander (API) female population, a slightly smaller American Indian and Alaska Native (AIAN) female population, and a substantially smaller Hispanic/Latina female population. The state's female population is about the same age as that of the US as a whole. The state's education level is slightly higher than and income level is slightly higher than those of the US as a whole. The state's unemployment level is slightly larger than that of the US as a whole. The state has a substantially smaller percentage of people who are foreign born and a slightly smaller percentage of people who are linguistically isolated. There are a substantially larger percentage of people living in rural areas, a slightly smaller percentage of people without health insurance, and a substantially smaller percentage of people living in medically underserved areas.

The following counties have substantially larger Black/African-American female population percentages than that of the state as a whole:

- Lake County
- Marion County (Komen Central Indiana)

The following counties have substantially larger API female population percentages than that of the state as a whole:

- Hamilton County (Komen Central Indiana)
- Monroe County (Komen Central Indiana)
- Tippecanoe County (Komen Central Indiana)

The following counties have substantially larger Hispanic/Latina female population percentages than that of the state as a whole:

- Cass County
- Clinton County (Komen Central Indiana)
- Elkhart County
- Lake County

The following counties have substantially older female populations than that of the state as a whole:

- Blackford County (Komen Central Indiana)
- Fountain County (Komen Central Indiana)
- Wabash County

The following counties have substantially lower education levels than that of the state as a whole:

- Crawford County
- Daviess County (Komen Evansville Tri-State)
- Elkhart County

- Fayette County (Komen Central Indiana)
- LaGrange County
- Orange County
- Parke County (Komen Central Indiana)
- Scott County (Komen Louisville)
- Starke County
- Switzerland County (Komen Southwest Ohio)
- Washington County

The following counties have substantially lower income levels than that of the state as a whole:

- Delaware County (Komen Central Indiana)
- Fayette County (Komen Central Indiana)

The following counties have substantially lower employment levels than that of the state as a whole:

- Blackford County (Komen Central Indiana)
- Delaware County (Komen Central Indiana)
- Fayette County (Komen Central Indiana)
- Jennings County
- Scott County (Komen Louisville)
- Starke County

The following county has a substantially larger percentage of adults without health insurance than does the state as a whole:

- LaGrange County

Healthy People 2020 Forecasts

Healthy People 2020 is a major federal government program that has set specific targets (called “objectives”) for improving Americans’ health by the year 2020.

This report shows whether areas are likely to meet the two Healthy People 2020 objectives related to breast cancer: reducing breast cancer death rate and reducing the number of late-stage breast cancers.

Healthy People 2020 (HP2020) is a major federal government initiative that provides specific health objectives for communities and for the country as a whole (HP 2020, 2010). Many national health organizations use HP2020 targets to monitor progress in reducing the burden of disease and improve the health of the nation. Likewise, Komen believes it is important to refer to HP2020 to see how areas across the country are progressing towards reducing the burden of breast cancer.

HP2020 has several cancer-related objectives, including:

- Reducing women’s death rate from breast cancer.
- Reducing the number of breast cancers that are found at a late-stage.

The HP2020 objective for breast cancer death rates

As of the writing of this report, the HP2020 target for the breast cancer death rate is 20.6 breast-cancer related deaths per 100,000 females – a 10 percent improvement in comparison to the 2007 rate.

To see how well counties in Indiana are progressing toward this target, this report uses the following information:

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

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

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

The calculation was conducted using the following procedure:

- The annual percent change for 2006-2010 was calculated.
- Using 2008 (the middle of the period 2006-2010) as a starting point, the annual percent change was subtracted from (or added to) the expected death rate (based on the 2006-2010 death rate) for each year between 2010 and 2020.
- These calculated death rates were then compared with the target.
 - If the breast cancer death rate for 2006-2010 was already below the target, it is reported that the area “Currently meets target.”
 - If it would take more than 12 years (2008 to 2020) to meet the target, it is reported that the area would need “13 years or longer” to meet the target.
 - If the rate is currently below the target but the trend is increasing such that the target will no longer be met in 2020, it is reported that the area would need “13 years or longer” to meet the target.
 - In all other cases, the number of years it would take for the area to meet the target is reported. For example, if the area would meet the target in 2016, it would be reported as “eight years,” because it’s eight years from 2008 to 2016.

The HP2020 objective for late-stage breast cancer diagnoses

Another Healthy People 2020 objective is a decrease in the number of breast cancers diagnosed at a late stage. As of the writing of this report, the HP2020 target for late-stage diagnosis rate is 41.0 late-stage cases per 100,000 females. For each county in the state, the

late-stage incidence rate and trend are used to calculate the amount of time, in years, needed to meet the HP2020 target, assuming that the trend observed from 2006 to 2010 continues for years 2011 and beyond.

The calculation was conducted using the following procedure:

- The annual percent change for 2006-2010 was calculated.
- Using 2008 (the middle of the period 2006-2010) as a starting point, the annual percent change was subtracted from (or added to) the expected late-stage incidence rate (based on the 2006-2010 rate) for each year between 2010 and 2020.
- The calculated late-stage incidence rates were then compared with the target.
 - If the late-stage incidence rate for 2006-2010 was already below the target, it is reported that the area “Currently meets target.”
 - If it would take more than 12 years (2008 to 2020) to meet the target, it is reported that the area would need “13 years or longer” to meet the target.
 - If the rate is currently below the target but the trend is increasing such that the target will no longer be met in 2020, it is reported that the area would need “13 years or longer” to meet the target.
 - In all other cases, the number of years it would take for the area to meet the target is reported.

Identification of HP2020 breast cancer at-risk areas

Identifying geographic areas and groups of women with high needs will help develop effective, targeted breast cancer programs.

Priority areas are identified based on the time needed to meet Healthy People 2020 targets for breast cancer.

The purpose of this report is to combine evidence from many credible sources and use it to identify the highest HP2020 breast cancer priority areas (at-risk areas) for breast cancer programs (i.e., the areas of greatest need).

Classification of at-risk areas is based on the time needed to achieve HP2020 targets in each area. These time projections depend on both the starting point and the trends in death rates and late-stage incidence.

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

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

How counties are classified by need

Counties are classified as follows.

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

Table 2.9 shows how counties are assigned to at-risk categories.

Table 2.9. Needs/At-risk classification based on the projected time to achieve HP2020 breast cancer targets

		Time to Achieve Late-stage Incidence Reduction Target				
		13 years or longer	7-12 yrs.	0 – 6 yrs.	Currently meets target	Unknown
Time to Achieve Death Rate Reduction Target	13 years or longer	Highest	High	Medium High	Medium	Highest
	7-12 yrs.	High	Medium High	Medium	Medium Low	Medium High
	0 – 6 yrs.	Medium High	Medium	Medium Low	Low	Medium Low
	Currently meets target	Medium	Medium Low	Low	Lowest	Lowest
	Unknown	Highest	Medium High	Medium Low	Lowest	Unknown

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

Healthy People 2020 forecasts and at-risk areas

The results presented in Table 2.10 help identify which counties have the greatest needs when it comes to meeting the HP2020 breast cancer targets.

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

Trends can change for a number of reasons, including:

- Improved screening programs could lead to breast cancers being diagnosed earlier, resulting in a decrease in both late-stage incidence rates and death rates.
- Improved socioeconomic conditions, such as reductions in poverty and linguistic isolation could lead to more timely treatment of breast cancer, causing a decrease in death rates.

The data in this table should be considered together with other information on factors that affect breast cancer death rates such as screening percentages and key breast cancer death determinants such as poverty and linguistic isolation.

Table 2.10. Breast cancer at-risk area for Indiana with predicted time to achieve the HP2020 breast cancer targets and key population characteristics

County	Komen Affiliate	Priority	Predicted Time to Achieve Death Rate Target	Predicted Time to Achieve Late-stage Incidence Target	Key Population Characteristics
Boone County	Komen Central Indiana	Highest	13 years or longer	13 years or longer	Rural
Carroll County		Highest	13 years or longer	13 years or longer	Rural
DeKalb County		Highest	13 years or longer	13 years or longer	Rural
Floyd County	Komen Louisville	Highest	13 years or longer	13 years or longer	
Fulton County		Highest	13 years or longer	13 years or longer	Rural
Jasper County		Highest	13 years or longer	13 years or longer	Rural
Jennings County		Highest	SN	13 years or longer	Employment, rural
LaGrange County		Highest	SN	13 years or longer	Education, language, rural, insurance
Lake County		Highest	13 years or longer	13 years or longer	%Black/African-American, %Hispanic/Latina, medically underserved
Orange County		Highest	SN	13 years or longer	Education, rural
Rush County	Komen Central Indiana	Highest	SN	13 years or longer	Rural
Spencer County	Komen Evansville Tri-State	Highest	SN	13 years or longer	Rural, medically underserved
Vermillion County	Komen Central Indiana	Highest	SN	13 years or longer	Rural
Vigo County	Komen Central Indiana	Highest	13 years or longer	13 years or longer	
Warrick County	Komen Evansville Tri-State	Highest	13 years or longer	13 years or longer	
Washington County		Highest	NA	13 years or longer	Education, rural, medically underserved
LaPorte County		High	8 years	13 years or longer	Rural
Shelby County	Komen Central Indiana	High	8 years	13 years or longer	Rural
Wayne County	Komen Central Indiana	High	8 years	13 years or longer	Rural
Allen County		Medium High	13 years or longer	3 years	
Bartholomew County	Komen Central Indiana	Medium High	1 year	13 years or longer	Rural
Fountain County	Komen Central Indiana	Medium High	13 years or longer	2 years	Older, rural, medically underserved

County	Komen Affiliate	Priority	Predicted Time to Achieve Death Rate Target	Predicted Time to Achieve Late-stage Incidence Target	Key Population Characteristics
Hancock County	Komen Central Indiana	Medium High	4 years	13 years or longer	
Hendricks County	Komen Central Indiana	Medium High	2 years	13 years or longer	
Johnson County	Komen Central Indiana	Medium High	4 years	13 years or longer	
Knox County	Komen Evansville Tri-State	Medium High	13 years or longer	6 years	Rural
Kosciusko County		Medium High	3 years	13 years or longer	Rural
Madison County	Komen Central Indiana	Medium High	2 years	13 years or longer	
Marion County	Komen Central Indiana	Medium High	13 years or longer	2 years	%Black/African-American, medically underserved
Morgan County	Komen Central Indiana	Medium High	13 years or longer	3 years	Rural
Noble County		Medium High	4 years	13 years or longer	Rural
Owen County	Komen Central Indiana	Medium High	13 years or longer	1 year	Rural, medically underserved
Porter County		Medium High	13 years or longer	1 year	
Randolph County	Komen Central Indiana	Medium High	2 years	13 years or longer	Rural
St. Joseph County		Medium High	2 years	13 years or longer	
Steuben County		Medium High	NA	8 years	Rural
Adams County		Medium	Currently meets target	13 years or longer	Rural
Cass County		Medium	Currently meets target	13 years or longer	%Hispanic/Latina, rural, medically underserved
Clark County	Komen Louisville	Medium	Currently meets target	13 years or longer	
Clay County	Komen Central Indiana	Medium	13 years or longer	Currently meets target	Rural, medically underserved
Dearborn County	Komen Southwest Ohio	Medium	13 years or longer	Currently meets target	Rural
Decatur County	Komen Central Indiana	Medium	13 years or longer	Currently meets target	Rural
Delaware County	Komen Central Indiana	Medium	8 years	3 years	Poverty, employment
Dubois County	Komen Evansville Tri-State	Medium	13 years or longer	Currently meets target	Rural
Gibson County	Komen Evansville Tri-State	Medium	12 years	1 year	Rural, medically underserved
Greene County	Komen Central Indiana	Medium	13 years or longer	Currently meets target	Rural
Henry County	Komen Central Indiana	Medium	13 years or longer	Currently meets target	Rural

County	Komen Affiliate	Priority	Predicted Time to Achieve Death Rate Target	Predicted Time to Achieve Late-stage Incidence Target	Key Population Characteristics
Jefferson County		Medium	Currently meets target	13 years or longer	Rural
Marshall County		Medium	Currently meets target	13 years or longer	Rural
Miami County		Medium	Currently meets target	13 years or longer	Rural
Monroe County	Komen Central Indiana	Medium	9 years	1 year	%API
Ripley County		Medium	Currently meets target	13 years or longer	Rural, medically underserved
White County		Medium	13 years or longer	Currently meets target	Rural
Daviess County	Komen Evansville Tri-State	Medium Low	7 years	Currently meets target	Education, rural, medically underserved
Huntington County		Medium Low	3 years	2 years	Rural
Jay County	Komen Central Indiana	Medium Low	SN	2 years	Rural
Lawrence County		Medium Low	5 years	2 years	Rural
Parke County	Komen Central Indiana	Medium Low	SN	1 year	Education, rural
Pulaski County		Medium Low	SN	1 year	Rural
Putnam County	Komen Central Indiana	Medium Low	4 years	5 years	Rural
Starke County		Medium Low	NA	2 years	Education, employment, rural, medically underserved
Vanderburgh County	Komen Evansville Tri-State	Medium Low	8 years	Currently meets target	
Elkhart County		Low	Currently meets target	2 years	%Hispanic/Latina, education, language
Grant County	Komen Central Indiana	Low	2 years	Currently meets target	
Hamilton County	Komen Central Indiana	Low	6 years	Currently meets target	%API
Harrison County	Komen Louisville	Low	3 years	Currently meets target	Rural
Howard County	Komen Central Indiana	Low	6 years	Currently meets target	Medically underserved
Tippecanoe County	Komen Central Indiana	Low	4 years	Currently meets target	%API, foreign, medically underserved
Wells County		Low	1 year	Currently meets target	Rural
Whitley County		Low	4 years	Currently meets target	Rural

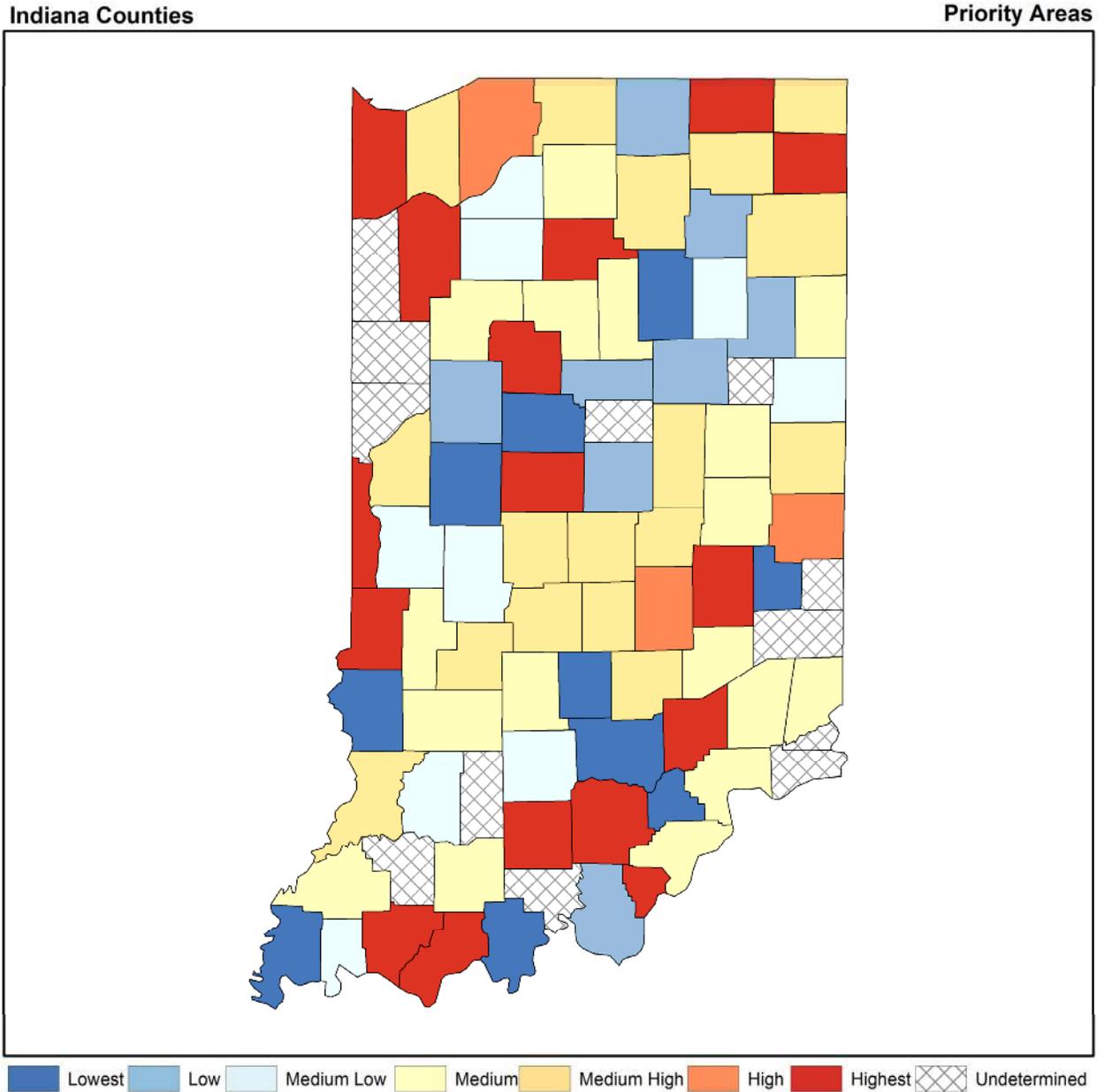
County	Komen Affiliate	Priority	Predicted Time to Achieve Death Rate Target	Predicted Time to Achieve Late-stage Incidence Target	Key Population Characteristics
Brown County	Komen Central Indiana	Lowest	SN	Currently meets target	Rural, medically underserved
Clinton County	Komen Central Indiana	Lowest	Currently meets target	Currently meets target	%Hispanic/Latina, rural
Fayette County	Komen Central Indiana	Lowest	Currently meets target	Currently meets target	Education, poverty, employment, rural
Jackson County		Lowest	Currently meets target	Currently meets target	Rural
Montgomery County	Komen Central Indiana	Lowest	Currently meets target	Currently meets target	Rural
Perry County	Komen Evansville Tri-State	Lowest	SN	Currently meets target	Rural
Posey County	Komen Evansville Tri-State	Lowest	SN	Currently meets target	Rural, medically underserved
Scott County	Komen Louisville	Lowest	SN	Currently meets target	Education, employment, rural, medically underserved
Sullivan County	Komen Central Indiana	Lowest	NA	Currently meets target	Rural
Wabash County		Lowest	Currently meets target	Currently meets target	Older, rural
Benton County		Undetermined	SN	SN	Rural
Blackford County	Komen Central Indiana	Undetermined	SN	SN	Older, employment, rural
Crawford County		Undetermined	SN	SN	Education, rural, medically underserved
Franklin County	Komen Central Indiana	Undetermined	SN	SN	Rural, medically underserved
Martin County		Undetermined	SN	SN	Rural, medically underserved
Newton County		Undetermined	SN	SN	Rural
Ohio County	Komen Southwest Ohio	Undetermined	SN	SN	Rural, medically underserved
Pike County	Komen Evansville Tri-State	Undetermined	SN	SN	Rural, medically underserved
Switzerland County	Komen Southwest Ohio	Undetermined	SN	SN	Education, rural, medically underserved
Tipton County	Komen Central Indiana	Undetermined	SN	SN	Rural
Union County	Komen Central Indiana	Undetermined	SN	SN	Rural
Warren County	Komen Central Indiana	Undetermined	SN	SN	Rural

NA – data not available.

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

Map of intervention at-risk areas

Figure 2.4 shows a map of the intervention categories for the counties in Indiana. When both of the indicators used to establish a category for a county are not available, the priority is shown as “undetermined” on the map.



*Map with counties labeled is available in Appendix.

Figure 2.4. Intervention categories

Data Limitations

The quantitative data in this report have been gathered from credible sources and uses the most current data available at the time.

Recent data

The most recent data available were used but, for cancer incidence and mortality, these data are still several years behind. The most recent breast cancer incidence and mortality data available in 2013 were data from 2010. For the US as a whole and for most states, breast cancer incidence and mortality rates do not often change rapidly. Rates in individual counties might change more rapidly. In particular if a cancer control program has been implemented in 2011-2013, any impact of the program on incidence and mortality rates would not be reflected in this report.

Over the planning period for this report (2015 to 2019), the data will become more out-of-date. The trend data included in the report can help estimate more current values. Also, the State Cancer Profiles Web site (<http://statecancerprofiles.cancer.gov/>) is updated annually with the latest cancer data for states and can be a valuable source of information about the latest breast cancer rates for your community.

Data availability

For some areas, data might not be available or might be of varying quality. Cancer surveillance programs vary from state to state in their level of funding and this can impact the quality and completeness of the data in the cancer registries and the state programs for collecting death information. There are also differences in the legislative and administrative rules for the release of cancer statistics for studies such as these. These factors can result in missing data for some of the data categories in this report.

Small populations

Areas with small populations might not have enough breast cancer cases or breast cancer deaths each year to support the generation of reliable statistics. Because breast cancer has relatively good survival rates, breast cancer deaths occur less often in an area than breast cancer cases. So it may happen that breast cancer incidence rates are reported for a county with a small number of people but not breast cancer death rates.

The screening mammography data have a similar limitation because they are based on a survey of a small sample of the total population. So screening proportions may not be available for some of the smaller counties. Finally, it may be possible to report a late-stage incidence rate but not have enough data to report a late-stage trend and to calculate the number of years needed to reach the HP2020 late-stage target.

Data on population characteristics were obtained for all counties, regardless of their size. These data should be used to help guide planning for smaller counties where there are not enough specific breast cancer data to calculate a priority based on HP2020 targets.

Other cancer data sources

If a person has access to other sources of cancer data for their state, they might notice minor differences in the values of the data, even for the same time period. There are often several sources of cancer statistics for a given population and geographic area. State registries and vital statistics offices provide their data to several national organizations that compile the data. This report used incidence data compiled by the North American Association of Central Cancer Registries (NAACCR) and the National Cancer Institute (NCI) and mortality (death) data compiled by the National Center for Health Statistics (NCHS).

Individual state registries and health departments often publish their own cancer data. These data might be different from the data in this report for several reasons. The most common reason is differences in the timing of when cases are reported.

Sometimes, a small number of cancer cases are reported to cancer registries with as much as a five year delay. Because of this delay, counts of cancer cases for a particular year may differ. In addition, data need to be checked to see whether the same case might have been counted twice in different areas. If a case is counted twice, one of the two reports is deleted. These small adjustments may explain small inconsistencies in the number of cases diagnosed and the rates for a specific year. However, such adjustments shouldn't have a substantial effect on cancer rates at the state level.

Specific groups of people

Data on cancer rates for specific racial and ethnic subgroups such as Somali, Hmong, or Ethiopian are not generally available. Records in cancer registries often record where a person was born if they were born in a foreign country. However, matching data about the population in an area are needed to calculate a rate (the number of cases per 100,000 people) and these matching population data are often not available.

Inter-dependent statistics

The various types of breast cancer data in this report are inter-dependent. For example, an increase in screening can result in fewer late-stage diagnoses and fewer deaths. However, an increase in screening mammography can also result in an increase in breast cancer incidence – simply because previously undetected cases are now being diagnosed. Therefore, caution is needed in drawing conclusions about the causes of changes in breast cancer statistics.

It is important to consider possible time delay between a favorable change in one statistic such as screening and the impact being reflected in other statistics such as the death rate. There can take 10 to 20 years for favorable changes in breast cancer control activities to be reflected in death rates.

Missing factors

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

community support available to the patient. Good quantitative data are not available on how factors such as these vary from place to place. The quantitative data in this report should be supplemented by qualitative information about these other factors from your communities whenever possible.

Trend limitations

The calculation of the years needed to meet the HP2020 objectives assume that the current trends will continue until 2020. However, the trends can change for a number of reasons. For example, breast cancer programs, if they are successful, should change the trends. In fact, this is the primary goal of breast cancer programs.

However, trends could also change from differences in the population characteristics of the area such as shifts in the race or ethnicity of the people in the area or changes in their general socioeconomics. Areas with high migration rates, either new people moving into an area or existing residents moving elsewhere, are particularly likely to see this second type of change in breast cancer trends.

Late-stage data and un-staged cases

Not all breast cancer cases have a stage indication. Breast cancer might be suspected in very elderly women and a biopsy may not be performed. Also, some breast cancer cases may be known only through an indication of cause-of-death on a death certificate. When comparing late-stage statistics, it is assumed that the rates of unknown staging don't change and are similar between counties. This may not be a good assumption when comparing data between urban and rural areas or between areas with younger and older populations. It is also assumed that the size and types of unknown cases do not change over time when the trends in late-stage statistics are calculated.

In this report, both late-stage incidence rates and late-stage proportions are provided. These two statistics differ in how un-staged cases are represented. With late-stage incidence rates, un-staged cases are excluded from the numerator (the number of late-stage cases) but are included in the denominator (total number of people in the population). With late-stage proportions, un-staged cases are excluded from both the numerator (the number of late-stage cases) and the denominator (number of staged cases). These differences can explain why comparisons using the two late-stage statistics may get different results

Conclusions: Healthy People 2020 Forecasts

Breast Cancer Death Rates

The State of Indiana as a whole is **likely to achieve** the HP2020 death rate target. The state had a base rate of 23.9 breast cancer deaths per 100,000 females per year from 2006 to 2010 (age-adjusted). This rate coupled with a desirable direction (decrease) in the recent death rate trend, indicates that the State of Indiana will likely achieve the HP2020 target of 20.6 female breast cancer deaths per 100,000.

The following counties **currently meet** the HP2020 breast cancer death rate target of 20.6:

- Adams County
- Cass County
- Clark County (Komen Louisville)
- Clinton County (Komen Central Indiana)
- Elkhart County
- Fayette County (Komen Central Indiana)
- Jackson County
- Jefferson County
- Marshall County
- Miami County
- Montgomery County (Komen Central Indiana)
- Ripley County
- Wabash County

The following counties are **likely to miss** the HP2020 breast cancer death rate target unless the death rate falls at a faster rate than currently estimated:

- Allen County
- Boone County (Komen Central Indiana)
- Carroll County
- Clay County (Komen Central Indiana)
- Dearborn County (Komen Southwest Ohio)
- Decatur County (Komen Central Indiana)
- DeKalb County
- Dubois County (Komen Evansville Tri-State)
- Floyd County (Komen Louisville)
- Fountain County (Komen Central Indiana)
- Fulton County
- Greene County (Komen Central Indiana)
- Henry County (Komen Central Indiana)
- Jasper County
- Knox County (Komen Evansville Tri-State)
- Lake County
- Marion County (Komen Central Indiana)
- Morgan County (Komen Central Indiana)
- Owen County (Komen Central Indiana)
- Porter County
- Vigo County (Komen Central Indiana)
- Warrick County (Komen Evansville Tri-State)
- White County

Because data for small numbers of people are not reliable, it can't be predicted whether Benton County, Blackford County, Brown County, Crawford County, Franklin County, Jay County, Jennings County, LaGrange County, Martin County, Newton County, Ohio County, Orange County, Parke County, Perry County, Pike County, Posey County, Pulaski County, Rush County, Scott County, Spencer County, Starke County, Steuben County, Sullivan County, Switzerland County, Tipton County, Union County, Vermillion County, Warren County and Washington County will reach the death rate target. The remaining counties are likely to achieve the target by 2020 or earlier.

Breast Cancer Late-Stage Incidence Rates

The State of Indiana as a whole **currently meets** the HP2020 late-stage incidence rate target. The state had a base rate of 41.1 new late-stage cases per 100,000 females per year from 2006 to 2010 (age-adjusted). This rate coupled with a desirable direction (decrease) in the recent late-stage incidence rate trend, indicates that the State of Indiana will meet the HP2020 target of 41.0 new late-stage cases per 100,000.

The following counties **currently meet** the HP2020 late-stage incidence rate target of 41.0:

- Brown County (Komen Central Indiana)
- Clay County (Komen Central Indiana)
- Clinton County (Komen Central Indiana)
- Daviess County (Komen Evansville Tri-State)
- Dearborn County (Komen Southwest Ohio)
- Decatur County (Komen Central Indiana)
- Dubois County (Komen Evansville Tri-State)
- Fayette County (Komen Central Indiana)
- Grant County (Komen Central Indiana)
- Greene County (Komen Central Indiana)
- Hamilton County (Komen Central Indiana)
- Harrison County (Komen Louisville)
- Henry County (Komen Central Indiana)
- Howard County (Komen Central Indiana)
- Jackson County
- Montgomery County (Komen Central Indiana)
- Perry County (Komen Evansville Tri-State)
- Posey County (Komen Evansville Tri-State)
- Scott County (Komen Louisville)
- Sullivan County (Komen Central Indiana)
- Tippecanoe County (Komen Central Indiana)
- Vanderburgh County (Komen Evansville Tri-State)
- Wabash County
- Wells County
- White County
- Whitley County

The following counties are **likely to miss** the HP2020 late-stage incidence rate target unless the late-stage incidence rate falls at a faster rate than currently estimated:

- Adams County
- Bartholomew County (Komen Central Indiana)
- Boone County (Komen Central Indiana)
- Carroll County
- Cass County
- Clark County (Komen Louisville)
- DeKalb County
- Floyd County (Komen Louisville)
- Fulton County
- Hancock County (Komen Central Indiana)
- Hendricks County (Komen Central Indiana)
- Jasper County
- Jefferson County
- Jennings County
- Johnson County (Komen Central Indiana)
- Kosciusko County
- LaGrange County
- Lake County
- LaPorte County
- Madison County (Komen Central Indiana)
- Marshall County
- Miami County
- Noble County
- Orange County
- Randolph County (Komen Central Indiana)
- Ripley County
- Rush County (Komen Central Indiana)
- St. Joseph County
- Shelby County (Komen Central Indiana)
- Spencer County (Komen Evansville Tri-State)
- Vermillion County (Komen Central Indiana)
- Vigo County (Komen Central Indiana)
- Warrick County (Komen Evansville Tri-State)
- Washington County
- Wayne County (Komen Central Indiana)

Because data for small numbers of people are not reliable, it can't be predicted whether Benton County, Blackford County, Crawford County, Franklin County, Martin County, Newton County, Ohio County, Pike County, Switzerland County, Tipton County, Union County and Warren

County will reach the late-stage incidence rate target. The remaining counties are likely to achieve the target by 2020 or earlier.

HP2020 Conclusions

Highest at-risk areas

Sixteen counties in the State of Indiana are in the highest priority category. Nine of the sixteen, Boone County, Carroll County, DeKalb County, Floyd County, Fulton County, Jasper County, Lake County, Vigo County and Warrick County, are not likely to meet either the death rate or late-stage incidence rate HP2020 targets. Seven of the sixteen, Jennings County, LaGrange County, Orange County, Rush County, Spencer County, Vermillion County and Washington County, are not likely to meet the late-stage incidence rate HP2020 target.

The age-adjusted death rates in Fulton County (40.8 per 100,000) and Lake County (28.2 per 100,000) are significantly higher than the state as a whole (23.9 per 100,000). Death trends in Fulton County (2.5 percent per year) are significantly less favorable than the state as a whole (-1.9 percent per year). The age-adjusted late-stage incidence rates in Lake County (46.8 per 100,000) are significantly higher than the state as a whole (41.1 per 100,000).

Jennings County has high unemployment. LaGrange County has low education levels and a relatively large number of households with little English. Lake County has a relatively large Black/African-American population and a relatively large Hispanic/Latina population. Orange County has low education levels. Washington County has low education levels.

High at-risk areas

Three counties in the State of Indiana are in the high priority category. All of the three, LaPorte County, Shelby County and Wayne County, are not likely to meet the late-stage incidence rate HP2020 target.

Health Systems Analysis

This section of the state report tells the story of the breast cancer continuum of care and the delivery of quality health care in the community. Key to this section is the observation of potential strengths and weaknesses in the health care system that could compromise a women's health as she works her way through the continuum of care (e.g., screening, diagnosis, treatment and follow-up/survivorship services).

Health Systems Analysis Data Sources

Breast Cancer Programs and Services

An inventory of breast cancer programs and services in the state were collected through a comprehensive internet search to identify the following types of health care facilities or community organizations that may provide breast cancer related services:

- Hospitals- Public or private, for-profit or nonprofit.
- Community Health Centers (CHC) - Community based organizations that provide primary care regardless of ability to pay; include Federally Qualified Health Centers (FQHCs) and FQHC look-alikes.
- Free Clinic- Free and charitable clinics are safety-net health care organizations that utilize a volunteer/staff model and restrict eligibility for their services to individuals who are uninsured, underinsured and/or have limited or no access to primary health care.
- Health Department- Local health department run by government entity (e.g. county, city) focused on the general health of its citizens.
- Title X Provider- Family planning centers that also offer breast and cervical cancer screening. Services are provided through state, county, and local health departments; community health centers; Planned Parenthood centers; and hospital-based, school-based, faith-based, other private nonprofits.
- Other- Any institution that is not a hospital, CHC, free clinic, health department or Title X provider (e.g., FDA certified mammography center that is not a hospital/CHC, community organization that is not a medical provider but does connect people to services or provide support services such as financial/legal assistance).

Information collected through these means was inputted into a Health Systems Analysis spreadsheet by service type: screening, diagnostics, treatment, and support. The screening service category encompasses clinical breast exams (CBEs), screening mammograms, mobile mammography units, ultrasounds, and patient navigation. The category of diagnostics includes diagnostic mammograms, ultrasounds, biopsy, MRI, and patient navigation. Treatment modalities counted were chemotherapy, radiation, surgery consultations, surgery, reconstruction, and patient navigations. Support encompasses a broad range of services including support groups, wigs, mastectomy wear, individual counseling/psychotherapy, exercise/nutrition programs, complementary therapies, transportation assistance, financial assistance for cost of living expenses, as well as end of life care, legal services, and education.

In order to understand the effect available health systems have on the state, the identified resources were plotted on an asset map by Susan G. Komen Information Technology (IT) staff to visually illustrate the services (or lack thereof) available in the state. While every effort was

made to ensure these findings were comprehensive, it may be possible that a facility or organization was missed or has since closed; as a result, these findings should not be considered exhaustive and/or final.

Quality of Care Indicators

For all health care facilities and hospitals, an additional layer of analysis was applied using quality of care indicators. Quality of care indicators are quantifiable measures related to the process of care, outcomes of care, and patient satisfaction levels from a particular program and/or organization. Multiple national organizations have developed key quality of care indicators for breast health services, and if an organization meets all of the key indicators they are designated an “accredited” health care institution. These accreditations outline key quality of care indicators health care institutions must meet in order to obtain and/or retain accreditation status. The following five accreditations were considered high quality of care indicators in the state’s health system analysis.

- ***FDA Approved Mammography Facilities***

The Food and Drug Administration (FDA) passed the Mammography Quality Standards Act (MQSA) in 1992 to ensure facilities meet standards for performing high quality mammography. Accreditation bodies administer the MQSA to evaluate and accredit mammography facilities based upon quality standards. These quality standards are extensive and outline how a facility can operate. For instance, physicians interpreting mammograms must be licensed to practice medicine, be certified to interpret radiological procedures including mammography, and must complete continuing experience or education to maintain their qualifications (US Food and Drug Administration [US FDA], 2014). Radiologic technologists must also be trained and licensed to perform general radiographic procedures and complete continuing experience or education to maintain their qualifications. Facilities are required to maintain personnel records to document the qualifications of all personnel who work at the facility such as physicians, radiologic technologists or medical physicists.

All radiographic equipment used in FDA approved mammography centers must be specifically designed for mammography and must not be equipment designed for general purpose or equipment that has been modified with special attachments for mammography. Equipment regulations also apply to compression paddles, image receptor size, light fields and magnification, focal spot selection, x-ray film, film processing solutions, lighting and film masking devices. Facilities must also prepare a written report of the results of each mammography examination performed under its certificate. The report must include the name of the patient and an additional patient identifier, date of examination, the name of the interpreting physician, and the overall final assessment of findings. Findings from mammograms are classified into four different categories, including negative, benign, probably benign, and highly suggestive of malignancy. An assessment can also be assigned as incomplete indicating additional imaging evaluation is needed.

FDA approved mammography facilities are obligated to communicate the results of mammograms to the patient and the patient's primary care provider in a written report within 30 days. Each facility must also maintain mammography films and reports in a permanent medical record for a period of no less than five years or longer if mandated by State or local law. Patients can request to permanently or temporarily transfer the original mammograms and patient report to a medical institution, physician, health care provider, or to the patient directly. Any fees for providing transfer services shall not exceed the documented costs associated with this service.

A quality assurance program must be established at each facility to ensure safety, reliability, clarity, and accuracy of mammography services. At least once a year, each facility undergoes a survey by a medical physicist that includes the performance of tests to ensure the facility meets quality assurance requirements. The FDA evaluates the performance of each certificated agency annually through the use of performance indicators that address the adequacy of program performance in certification, inspection, and enforcement activities. Only facilities that are accredited by FDA accrediting bodies or are undergoing accreditation by accrediting bodies may obtain a certificate from the FDA to legally perform mammography (US FDA, 2014). Only FDA approved mammography centers were included in the health system analysis for each target community.

- ***American College of Surgeons Commission on Cancer Certification (CoCC)***
Applying and sustaining an American College of Surgeons Commission on Cancer Certification (CoCC) is a voluntary effort a cancer program can undertake to ensure a range of services necessary to diagnose and treat cancer, as well as rehabilitate and support patients and their families, are available (American College of Surgeons [ACoS], 2013). There are various categories of cancer programs, and each facility is assigned a category based on the type of facility or organization, services provided, and cases accessioned or recorded. Program categories include: Integrated Network Cancer Program (INCP); NCI-Designated Comprehensive Cancer Center Program (NCIP); Academic Comprehensive Cancer Program (ACAD); Veterans Affairs Cancer Program (VACP); Comprehensive Community Cancer Program (CCCP); Hospital Associate Cancer Program (HACP); Pediatric Cancer Program (PCP); and Freestanding Cancer Center Program (FCCP) (ACoS, 2013).

CoCC cancer programs are surveyed every three years. In preparation for survey, the cancer committee for that facility must assess program compliance with the requirements for all standards outlined in *Cancer Program Standards 2012: Ensuring Patient-Centered Care*. An individual must then review and complete an online Survey Application Record (SAR). In addition, the individual responsible for completing the SAR will perform a self-assessment and rate compliance with each standard using the Cancer Program Ratings Scale.

The surveyor's role is to assist in accurately defining the standards and verifying the facility's cancer program is in compliance. To accomplish this task, the surveyor will meet with the cancer committee, cancer registry staff and cancer liaison physicians, review pathology reports, and attend a cancer conference to observe the multidisciplinary patient management discussions and confirm treatment is planned using nationally recognized, evidence-based treatment guidelines. CoCC-accredited programs must also submit documentation of cancer program activities with the SAR using multiple sources such as policies, procedures, manuals, and grids.

Each cancer program standard is rated on a compliance scale that consists of the score of (1+) commendation, (1) compliance, (5) noncompliance, and (8) not applicable. A deficiency is defined as any standard with a rating of five. A deficiency in one or more standards will affect the accreditation award. Commendation ratings (+1) are valid for eight standards, can only be earned at the time of survey, and are used to determine the accreditation award and award level (bronze, silver, or gold). Accreditation awards are based on consensus ratings by the cancer program surveyor, CoCC staff and when necessary, the Program Review Subcommittee. A program can earn one of the following Accreditation Awards; three-year with commendation accreditation, three-year accreditation, three-year accreditation with contingency, provisional accreditation, or no accreditation. Programs are surveyed at three-year intervals from the date of survey.

Award notification takes place within 45 days following the completed survey and will include The Accredited Cancer Program Performance Report. This report includes a comprehensive summary of the survey outcome and accreditation award, the facility's compliance rating for each standard, an overall rating compared with other accredited facilities nation- and state-wide, and the category of accreditation. In addition, a narrative description of deficiencies that require correction, suggestions to improve or enhance the program, and commendations awarded are also included.

- ***American College of Surgeons National Accreditation Program for Breast Centers (NAPBC)***

The American College of Surgeons' National Accreditation Program for Breast Centers (NAPBC) is a consortium of national professional organizations focused on breast health and dedicated to improving quality of care and outcomes for patients with diseases of the breast (ACoS, 2014). The NAPBC utilizes evidence-based standards as well as patient and provider education, and encourages leaders from major disciplines to work together to diagnose and treat breast disease. The NAPBC has defined 28 program standards and 17 program components of care that provide the most efficient and contemporary care for patients diagnosed with diseases of the breast. Quality standards cover a range of topics and levels of operation including leadership, clinical management, research, community outreach, professional education, and quality improvement (ACoS, 2014).

To be considered for initial survey, breast center leadership must ensure clinical services, interdisciplinary/multidisciplinary conference(s), and quality management programs are in place and ensure a facility can meet the requirements outlined for all standards. Critical standards include having breast program leadership that is responsible and accountable for services and also establishes, monitors, and evaluates the interdisciplinary breast cancer conference frequency, multidisciplinary and individual attendance, prospective case presentation, and total case presentation annually. In addition, the interdisciplinary patient management standard requires patient management to be conducted by an interdisciplinary team after a patient is diagnosed with breast cancer.

Breast center leadership then completes a pre-application to participate and pay for the survey fee within 30 days of the receipt from the NAPBC. To prepare for a survey, the breast center must complete a Survey Application Record (SAR) prior to the on-site visit. The SAR is intended to capture information about the breast center activity and includes portions of individuals to perform a self-assessment and rate compliance with each standard using a provided rating system. The NAPBC will then complete a survey of the facility within six months. A survey of a facility typically includes a tour of the center, a meeting between the surveyor and breast center leadership and staff, chart and medical record review, and the attendance of a breast conference.

Accreditation awards are based on consensus ratings by the surveyor, the NAPBC staff, and, if required, the Standards and Accreditation Committee. Accreditation award is based on compliance with 28 standards. A three year, full accreditation is granted to centers that comply with 90 percent or more of the standards with resolution of all deficient standards documented within 12 months of survey. Centers that do not resolve all deficiencies within the 12 month period risk losing NAPBC accreditation status and are required to reapply. Once a performance report and certificate of accreditation are issued, these centers are surveyed every three years.

A three-year contingency accreditation is granted to centers that meet less than 90 percent, but more than 75 percent of the standards at the time of survey. The contingency status is resolved by the submission of documentation of compliance within 12 months from the date of survey. A performance report and certificate of accreditation are issued, and these facilities are surveyed every three years. An accreditation can be deferred if a center meets less than 75 percent of the standards at the time of the survey. The deferred status is resolved by the submission of documentation of compliance within 12 months from the date of survey. Based on the resolution of deficiencies and survey results, a performance report and certificate of accreditation are issued, and these facilities are surveyed every three years. For the complete list of NAPBC quality standards, visit: <http://www.napbc-breast.org/standards/standards.html>.

- American College of Radiology Breast Imaging Centers of Excellence (BICOE)**
 The American College of Radiology (ACR) Breast Imaging Centers of Excellence (BICOE) designation is awarded to breast imaging centers that seek and earn accreditation in the ACR's entire voluntary breast imaging accreditation programs and modules, in addition to the Mandatory Mammography Accreditation Program (MMAP) (American College of Radiology [ACR], n.d.). The ACR MMAP is designed to provide facilities with peer review and constructive feedback on staff qualifications, equipment, quality control, quality assurance, image quality, and radiation dose. This ensures facilities comply with the 1992 Mammography Quality Standards Act (MQSA), which requires all mammography facilities be accredited. In order to receive the ACR's BICOE designation, a facility must be accredited by the ACR in mammography, stereotactic breast biopsy, breast ultrasound, and effective January 1, 2016, breast MRI.

The ACR will send a BICOE certificate to each facility that fulfills the necessary requirements. The designation remains in effect as long as all breast imaging facilities (an organizations home location or a different location) remain accredited in all required breast imaging services provided. If the center or facility neglects to renew any of its accreditations or fails during renewal, the facility will be notified that it no longer has the BICOE designation and the BICOE certificate must be removed from public display. Some centers will need to specifically request a BICOE designation, while in most cases the ACR will consult its database and automatically provide an eligible center a BICOE certificate if the center is at a single physical location and meets all breast imaging requirements (ACR, n.d.).

- National Cancer Institute Designated Cancer Centers**
 A National Cancer Institute (NCI) designated Cancer Center is an institution dedicated to researching the development of more effective approaches to the prevention, diagnosis, and treatment of cancer (National Cancer Institute [NCI], 2012). A NCI-designated Cancer Center conducts cancer research that is multidisciplinary and incorporates collaboration between institutions and university medical centers. This collaboration also provides training for scientists, physicians, and other professionals interested in specialized training or board certification in cancer-related disciplines. NCI-designated Cancer Centers also provide clinical programs that offer the most current forms of treatment for various types of cancers and typically incorporate access to clinical trials of experimental treatments. In addition, public education and community outreach regarding cancer prevention and screening are important activities of a NCI-designated Cancer Center (NCI, 2012).

HRSA Shortage Designations

The US Department of Health and Human Services-Health Resources and Services Administration (HRSA) designations for Health Professional Shortage Areas (HSPAs) and Medically Underserved Areas/Populations (MUA/Ps) were used to identify areas within the state where individuals may have inadequate access to primary care providers and facilities (US Department of Health and Human Services, n.d.).

- **Health Professional Shortage Areas (HPSAs)** are designated by HRSA as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), population (e.g. low income or Medicaid eligible) or facilities (e.g. federally qualified health center or other state or federal prisons).
- **Medically Underserved Areas/Populations (MUA/Ps)** are areas or populations designated by HRSA as having too few primary care providers, high infant mortality, high poverty or a high elderly population.

Breast Cancer Continuum of Care

The Breast Cancer Continuum of Care (CoC), shown in Figure 3.1, is a model that shows how a woman typically moves through the health care system for breast care. A woman would ideally move through the CoC quickly and seamlessly, receiving timely, quality care in order to have the best outcomes. Education can play an important role throughout the entire CoC.

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

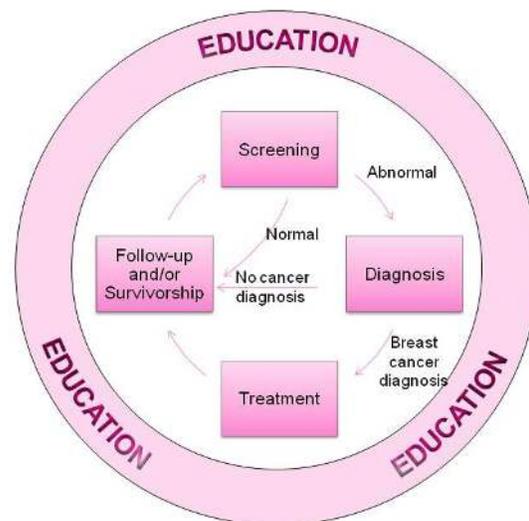


Figure 3.1. Breast Cancer Continuum of Care (CoC)

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

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

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

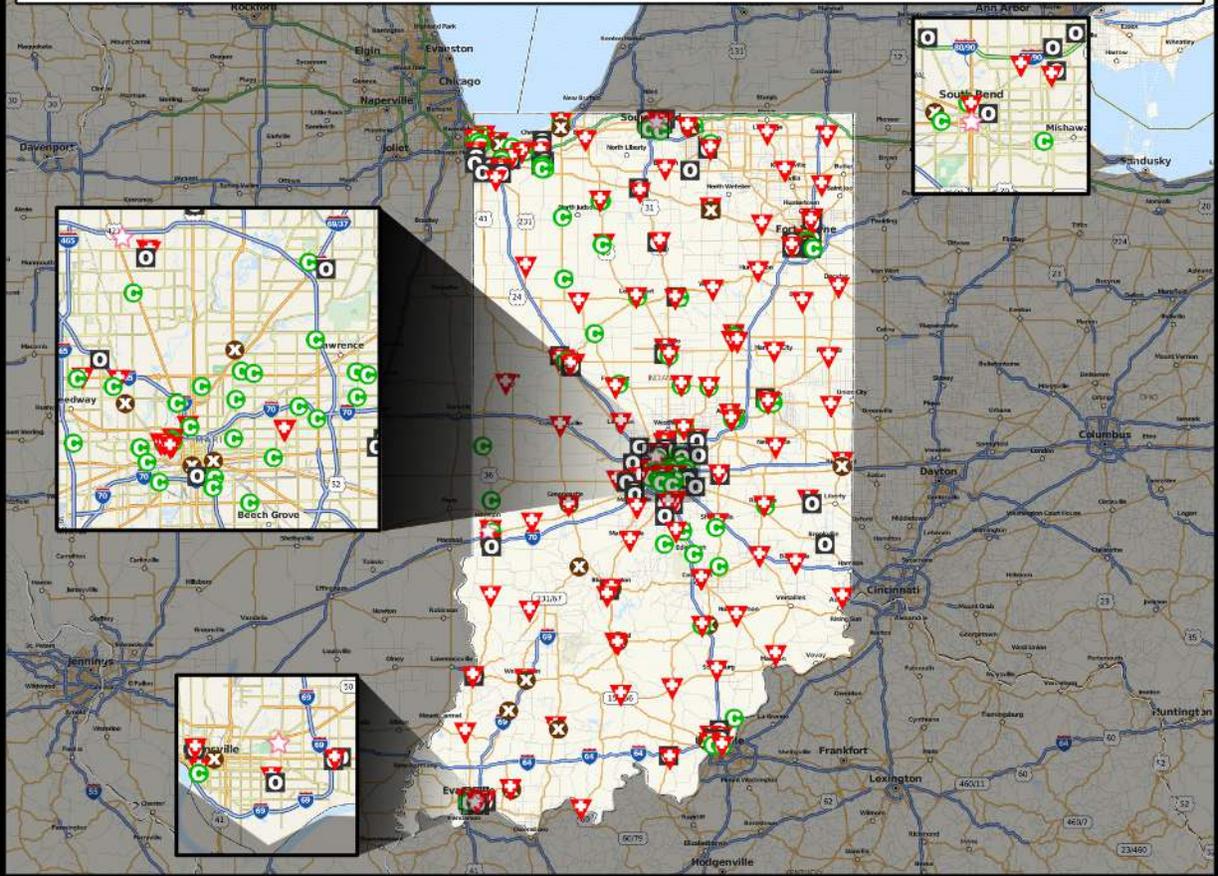
There are often delays in moving from one point of the continuum to another – at the point of follow-up of abnormal screening exam results, starting treatment, and completing treatment – that can all contribute to poorer outcomes. There are also many reasons why a woman does not enter or continue in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

Health Systems Analysis Findings

In the State of Indiana there were 329 locations found to provide breast cancer services varying between screening, diagnostic, treatment, and survivorship (Figure 3.2). There were 327 locations that provided screening services, 198 locations in the state that provide diagnostic services and 86 locations providing treatment services. In the state there were 80 locations that provided survivorship services or care. Identified facilities that provide mammography services were all accredited by the Federal Drug Administration. There were 47 locations accredited by the American College of Surgeons Commission on Cancer, 39 locations accredited by the American College of Radiology as a Breast Imaging Center of Excellence and 19 locations accredited as an American College of Surgeons NAPBC program. There were two locations designated as a NCI Cancer Center.

The following counties are designated as a Medically Underserved Area/Population and/or a Health Professional Shortage Area for primary care: Adams, Allen, Bartholomew, Benton, Blackford, Brown, Carroll, Cass, Clark, Clay, Clinton, Crawford, Daviess, De Kalb, Decatur, Delaware, Elkhart, Fayette, Floyd, Fountain, Franklin, Fulton, Gibson, Grant, Greene, Henry, Howard, Huntington, Jackson, Jasper, Jay, Jefferson, Jennings, Johnson, Knox, Kosciusko, Lagrange, La Porte, Lake, Lawrence, Madison, Marion, Marshall, Martin, Miami, Monroe, Montgomery, Newton, Noble (HPSAS only), Ohio, Orange, Owen, Parke, Perry, Pike, Porter, Posey, Pulaski, Putnam, Randolph, Ripley, Rush, Scott, Spencer, St. Joseph, Starke, Steuben, Sullivan, Switzerland, Tippecanoe, Union, Vanderburgh, Vermillion, Vigo, Wabash, Warren, Washington, Wayne, Wells, White and Whitley.

Indiana



Statistics

Total Locations in Region: 329

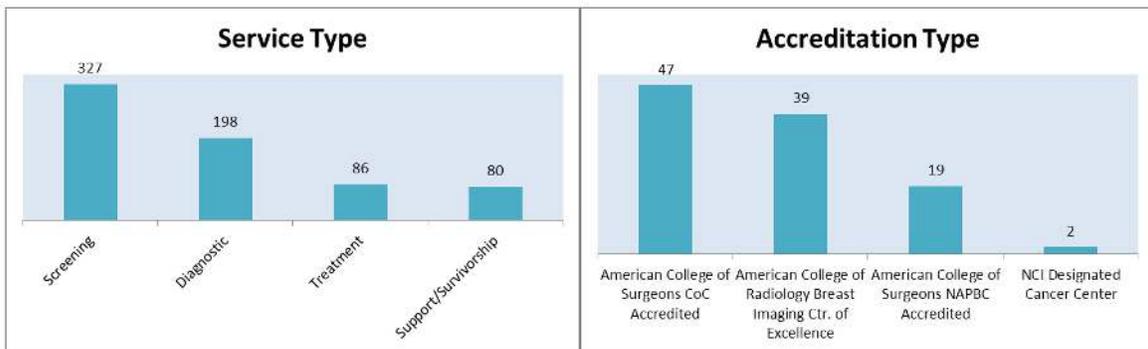


Figure 3.2. Breast cancer services available in Indiana

Public Policy Overview

In recent years, public policies pertaining to breast cancer have undergone substantial changes that will affect at-risk women across the United States. States have responded differently to the public policy developments concerning access to services within the breast cancer continuum of care (screening, diagnostic, treatment and survivorship care); therefore, women are dependent on their state's agenda and action on health care reform. This section of the state report will focus on the following public policies that affect breast cancer care in the state: National Breast and Cervical Cancer Early Detection Program, State Comprehensive Cancer Control Plan, the Affordable Care Act and Medicaid Expansion.

Susan G. Komen Advocacy

Susan G. Komen is the voice for the more than three million breast cancer survivors and those who love them, working to ensure that the fight against breast cancer is a priority among policymakers in Washington, D.C., and every Capitol across the country.

Each year, Komen works to identify, through a transparent and broad-based, intensive vetting and selection process, the policy issues that have the greatest potential impact on Komen's mission. This process includes the collection of feedback from Komen Headquarters leadership, policy staff, and subject matter experts; Komen Affiliates from across the country; advisory groups including the Komen Advocacy Advisory Taskforce (KAAT), Advocates in Science (AIS), and Komen Scholars; and other stakeholders with a vested interest in breast cancer-related issues.

The selected issues are the basis for Komen's state and federal advocacy work in the coming year. While the priority issues may change on an annual basis, the general focus for Komen's advocacy work is to ensure high-quality, affordable care for all, though access to services and an increased investment in research to ensure the continued development of the latest technologies and treatments. For more information on Komen's current Advocacy Priorities, please visit: <http://ww5.komen.org/WhatWeDo/Advocacy/Advocacy.html>.

National Breast and Cervical Cancer Early Detection Program

The United States Congress passed the Breast and Cervical Cancer Mortality Prevention Act of 1990, which directed the Centers for Disease Control and Prevention (CDC) to create the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) to improve access to screening (CDC, 2015a). NBCCEDP is a federal-state partnership which requires states to satisfy a 1:3 matching obligation (\$1 in state funds or in-kind funds for every \$3 in federal funds provided to that state) (CDC, n.d.). Currently, the NBCCEDP funds all 50 states, the District of Columbia, five US territories, and 11 American Indian/Alaska Native tribes or tribal organizations, to provide the following services to women (CDC, 2015a; CDC, n.d.):

- Breast and cervical cancer screening for women with priority to low-income women.
- Providing appropriate follow-up and support services (i.e., case management and referrals for medical treatment).
- Developing and disseminating public information and education programs.

- Improving the education, training and skills of health professionals.
- Monitoring screening procedure quality and interpretation.

To be eligible to receive NBCCEDP services, uninsured and underinsured women must be at or below 250 percent of the federal poverty level and between the ages of 40 to 64 for breast cancer screening (CDC, 2015a; CDC, n.d.). Uninsured women between the ages of 50 and 64 who are low-income (up to 250 percent federal poverty level) and who have not been screened in the past year are a priority population for NBCCEDP (CDC, n.d.).

While federal guidelines are provided by the CDC, there are some variations among states, tribal organizations and territories (CDC, 2015b):

- Program funding, clinical costs and additional eligibility guidelines vary by state, tribal organization and territory which influence the number of services that can be provided.
- Flexibility of the program allows each state, tribal organization and territory to adopt an operational model that is appropriate for their respective public health infrastructure and legislative policies.

Since the launch of the program in 1991, NBCCEDP has served more than 4.8 million women providing over 12 million breast and cervical cancer screening services that has resulted in more than 67,900 women being diagnosed with breast cancer (CDC, 2015a).

Congress passed the Breast and Cervical Cancer Prevention and Treatment Act in 2000 to provide states the option to offer Medicaid coverage for breast cancer treatment for women who were diagnosed when receiving services through from the NBCCEDP (CDC, 2015a). To date, all 50 states and the District of Columbia have approved provision of Medicaid coverage for cancer treatment; therefore, providing low-income, uninsured and underinsured women coverage from screening through completion of treatment (CDC, 2015a). Congress expanded this option 2001, with the passage of the Native American Breast and Cervical Cancer Treatment Technical Amendment Act, to include eligible American Indians and Alaska Natives that receive services by the Indian Health Service or by a tribal organization (CDC, 2015a).

In the State of Indiana, the NBCCEDP is known as Indiana's Breast and Cervical Cancer Early Detection Program and is administered by the Indiana State Department of Health. From July 2009 to June 2014, Indiana's Breast and Cervical Cancer Early Detection Program provided 20,782 breast cancer and cervical cancer screening and diagnostic services to women. The program provided 13,764 mammograms that resulted in 2,111 women receiving an abnormal result and 198 women being diagnosed with breast cancer (NBCCEDP Minimum Data Elements, 2015). To find out more information about getting screened and eligibility, contact the Breast and Cervical Cancer Early Detection Program (1-800-433-0746).

State Comprehensive Cancer Control Plan

Comprehensive cancer control is a process through which communities and partner organizations pool resources to reduce cancer risk, find cancers earlier, improve treatments, increase the number of people who survive cancer and improve quality of life for cancer survivors to ultimately reduce the burden of cancer in the state (CDC, 2015d).

The National Comprehensive Cancer Control Program (NCCCP) (<http://www.cdc.gov/cancer/ncccp/>) is an initiative by the CDC to help states, tribes, US affiliated Pacific Islands, and territories form or support existing coalitions to fight cancer by using local data to determine the greatest cancer-related needs in their area (2015d). Once areas have been identified, the state coalition works collaborative to develop and implement a State Comprehensive Cancer Control Plan to meet the identified needs (CDC, 2015d). These plans include initiatives involving healthy lifestyles, promotion of cancer screening tests, access to good cancer care, and improvement in the quality of life for people who survive cancer (CDC, 2015d). State Comprehensive Cancer Control Plans (2015c) can be located at the following link: http://www.cdc.gov/cancer/ncccp/ccc_plans.htm.

Indiana's comprehensive cancer control plan for 2010-2014 (<http://indianacancer.org/wp-content/uploads/2010/04/ICCP-FINAL-1-6-10-3.pdf>) includes the following goals and objectives specific for breast cancer:

Early Detection Goal: Increase early detection and appropriate screening for cancer

Breast Cancer Objectives:

- By 2014, increase the percentage of women aged 40 and older who receive annual breast cancer screening from 62 percent to 67 percent as measured by the Indiana Behavioral Risk Factor Surveillance System.
- Promote evidence based interventions that target women not receiving annual mammography and clinical breast exams
- Expand the use of provider reminder systems for annual mammograms and clinical breast exams
- Use interventions targeted to population characteristics and tailored on breast cancer risks and cognitive, attitudinal, and socio-cultural factors
- Support efforts to increase funding for programs providing free screening to low income, uninsured, and underinsured women
- Disseminate information related to breast cancer screening through lay health advisors, peer educators, and community outreach workers
- Promote media campaigns to inform the public of the need for regular breast cancer screening

For more information regarding Indiana's comprehensive cancer plan please visit: <http://www.state.in.us/isdh/24935.htm>

Affordable Care Act

In 2010, Congress passed the Patient Protection and Affordable Care Act (commonly known as Affordable Care Act or ACA) to expand access to care through insurance coverage, enhance the quality of health care, improve health care coverage for those with health insurance and to make health care more affordable (US Department of Health and Human Services, 2015a).

The ACA includes the following mandates to improve health insurance coverage and enhance health care quality (US Department of Health and Human Services, 2015a):

- Prohibit insurers from denying coverage based on pre-existing conditions
- Prohibit insurers from rescinding coverage
- Prohibit annual and lifetime caps on coverage
- Provide coverage of preventive services with no cost-sharing (including screening mammography, well women visits)
- Establish minimum benefits standards, known as the Essential Health Benefits (EHB)

The ACA provides tax subsidies for middle-income individuals to purchase insurance through the health insurance exchanges (commonly called the Marketplace). To be eligible to receive health coverage through the Marketplace, an individual must live in the United States, be a US citizen or national (or lawfully present), cannot be incarcerated, fall into certain income guidelines and cannot be eligible for other insurance coverage (i.e., Medicaid, Medicare and employer sponsored health care coverage) (US Centers for Medicare and Medicaid Services, n.d.).

Based on 2015 data, of the estimated 686,000 total number of uninsured in Indiana, 45.0 percent are Medicaid eligible, 19.0 percent are eligible for tax subsidies and 36.0 percent are ineligible for financial assistance due to income, employer sponsored insurance offer or citizenship status (Garfield et al., 2015).

Some of the ways that the ACA has affected Indiana over the past five years include (US Department of Health and Human Service, 2015b):

- Making health care more affordable and accessible through Health Insurance Marketplaces.
 - In Indiana, 219,185 consumers selected or were automatically re-enrolled in health insurance coverage.
- Reducing the number of uninsured.
 - The number of uninsured in Indiana decreased to 13.6 percent (2014) from 15.3 percent (2013).
- Removing lifetime limits on health benefits and discrimination for pre-existing conditions resulting in cancer patients not having to worry about going without treatment.
 - In Indiana, over 822,000 women no longer have to worry about lifetime limits on coverage.

- Making prescription drug coverage more affordable for those on Medicare.
 - In Indiana, Medicare covered individuals have saved nearly \$377,084,734 on prescription drugs.
- Covering preventive services, such as screening mammograms, with no deductible or co-pay.
 - In Indiana, over 609,000 women received preventive services without cost-sharing.
- Providing increased funding to *support* health care delivery improvement projects that offer a broader array of primary care services, extend hours of operations, employ more providers and improve health care facilities.

Indiana received \$103,961,786 under the health care law.

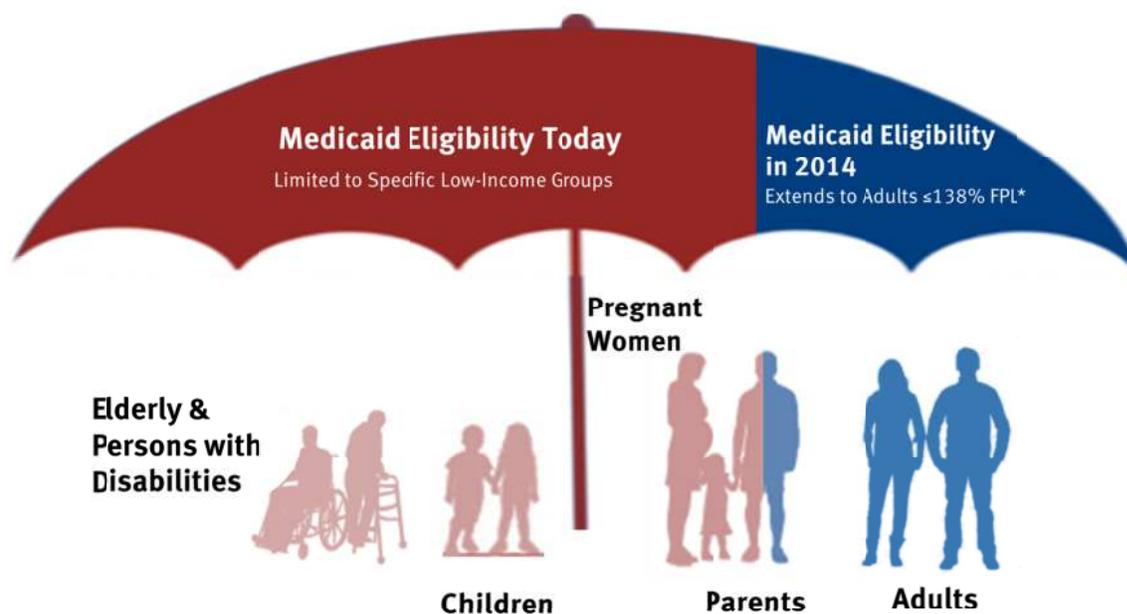
For more information about the Affordable Care Act or to obtain coverage, please visit the following websites:

- US Department of Health and Human Services: <http://www.hhs.gov/healthcare>
- Information about health insurance coverage: 1-800-318-2596 or www.healthcare.gov
- ACA assistance in the local community: <https://localhelp.healthcare.gov/#intro>

Medicaid Expansion

Traditional Medicaid had gaps in coverage for adults because eligibility was restricted to specific categories of low-income individuals (i.e., children, their parents, pregnant women, the elderly, or individuals with disabilities) (Figure 4.1) (The Henry J. Kaiser Family Foundation, 2014). In most states, non-elderly adults without dependent children were ineligible for Medicaid, regardless of their income.

Under the ACA, states were provided the option to expand Medicaid coverage to a greater number of non-elderly adults with incomes at or below 138 percent of poverty (about \$16,242 per year for an individual in 2015); thus reducing the number of uninsured, low-income adults (The Henry J. Kaiser Family Foundation, n.d.). As of January 2016, 32 states including the District of Columbia have adopted and implemented Medicaid Expansion, three states are still considering adopting Medicaid Expansion and 16 are not adopting Medicaid Expansion at this time (The Henry J. Kaiser Family Foundation, n.d.).



NOTE: The June 2012 Supreme Court decision in *National Federation of Independent Business v. Sebelius* maintained the Medicaid expansion, but limited the Secretary's authority to enforce it, effectively making the expansion optional for states. 138% FPL = \$15,856 for an individual and \$26,951 for a family of three in 2013.



Figure 4.1. The ACA Medicaid Expansion fills current gaps in coverage

Additional information regarding Medicaid Expansion can be found at the following websites:

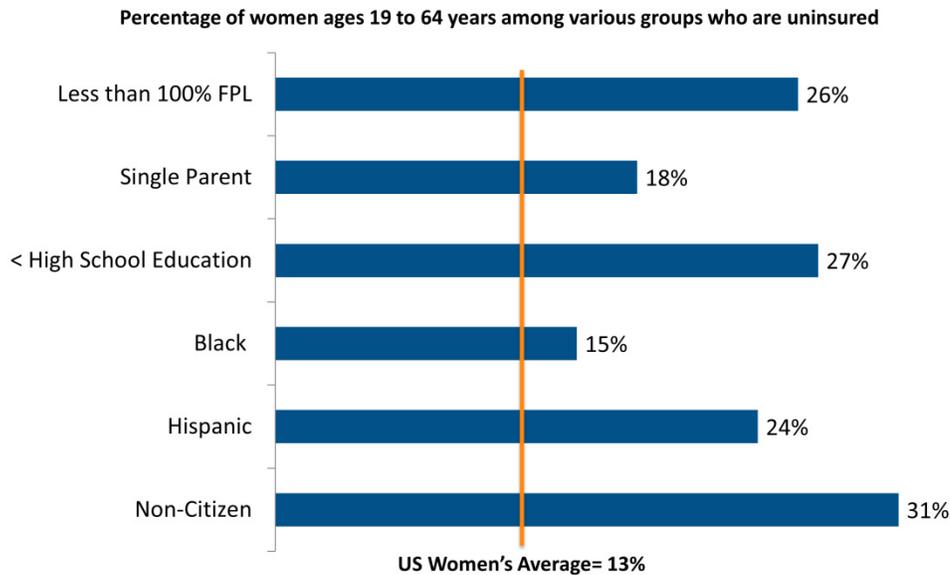
- The Henry J. Kaiser Family Foundation State Health Facts: <http://kff.org/>
- US Centers for Medicare and Medicaid Services: <https://www.healthcare.gov/medicaid-chip/medicaid-expansion-and-you/>

Indiana adopted Medicaid expansion, effective February 1, 2015. There are currently 686,000 total individuals who are uninsured and 310,000 are Medicaid eligible (The Henry J. Kaiser Family Foundation, 2016). The Indiana Medicaid program is administered by the Indiana Family and Social Services Administration. Under the “Healthy Indiana Plan” program, adults between the ages of 19 and 64 with incomes 133 percent of the federal poverty level (FPL) or less are eligible for health care coverage (Indiana Family and Social Services Administration, 2014). There are multiple health plans within the Healthy Indiana Plan with different eligibility requirements and benefits. More information about Health Indiana Plan programs can be found at the following website: <http://member.indianamedicaid.com/>.

Affordable Care Act, Medicaid Expansion and Uninsured Women

Even after implementation of the ACA and Medicaid Expansion (in some states), there are approximately 12.8 million women (ages 19 to 64) in the US that remain uninsured (The Henry J. Kaiser Family Foundation, 2016). Uninsured women have been found to have inadequate access to care and receive a lower standard of care within health systems that lead to poorer health outcomes (Kaiser Commission on Medicaid and the Uninsured, 2013). Women that are

single parents, have incomes below 100 percent federal poverty level, have less than a high school education, are women of color or immigrants are at greatest risk of being uninsured (Figure 4.2) (The Henry J. Kaiser Family Foundation, 2016).



Note: The Federal Poverty Level (FPL) in 2014 was \$19,790 for a family of three.
 SOURCE: Kaiser Family Foundation analysis of 2015 Current Population Survey, U.S. Census Bureau.



Figure 4.2. Women at greatest risk of being uninsured, 2014

A 2014 survey by The Henry J. Kaiser Family Foundation (2016) found that 47.0 percent of uninsured women indicated that insurance was too expensive, 13.0 percent were unemployed/work does not offer/not eligible through work, 8.0 percent tried to obtain coverage but were told they were ineligible, 7.0 percent were not eligible due to immigration status and 4.0 percent indicated that they did not need coverage. Of the 1,946,000 women in Indiana, 272,440 (14.0 percent) were without health insurance coverage in 2014 (The Henry J. Kaiser Family Foundation, 2016).

Community Profile Summary

Introduction to the Community Profile Report

Susan G. Komen is the world's largest breast cancer organization, funding more breast cancer research than any other nonprofit while providing real-time help to those facing the disease. Since its founding in 1982, Komen has funded more than \$889 million in research and provided \$1.95 billion in funding to screening, education, treatment and psychosocial support programs serving millions of people in more than 30 countries worldwide. Komen was founded by Nancy G. Brinker, who promised her sister, Susan G. Komen, that she would end the disease that claimed Suzy's life.

The purpose of the Indiana Community Profile is to assess breast cancer burden within the state by identifying areas at highest risk of negative breast cancer outcomes. Through the Community Profile, populations most at-risk of dying from breast cancer and their demographic and socioeconomic characteristics can be identified; as well as, the needs and disparities that exist in availability, access and utilization of quality care.

Quantitative Data: Measuring Breast Cancer Impact in Local Communities

After review of breast cancer late-stage diagnosis and death rates and trends for each county in the state, areas of greatest need were identified based on if the county would meet Healthy People 2020 late-stage diagnosis rate (41.0 per 100,000 women) and death rate (20.6 per 100,000 women) targets.

Breast Cancer Death Rates

The State of Indiana as a whole is **likely to achieve** the HP2020 death rate target. The state had a base rate of 23.9 breast cancer deaths per 100,000 females per year from 2006 to 2010 (age-adjusted). This rate coupled with a desirable direction (decrease) in the recent death rate trend, indicates that the State of Indiana will likely achieve the HP2020 target of 20.6 female breast cancer deaths per 100,000.

The following counties **currently meet** the HP2020 breast cancer death rate target of 20.6:

- Adams County
- Cass County
- Clark County (Komen Louisville)
- Clinton County (Komen Central Indiana)
- Elkhart County
- Fayette County (Komen Central Indiana)
- Jackson County
- Jefferson County
- Marshall County
- Miami County
- Montgomery County (Komen Central Indiana)
- Ripley County
- Wabash County

The following counties are **likely to miss** the HP2020 breast cancer death rate target unless the death rate falls at a faster rate than currently estimated:

- Allen County
- Boone County (Komen Central Indiana)
- Carroll County
- Clay County (Komen Central Indiana)
- Dearborn County (Komen Southwest Ohio)
- Decatur County (Komen Central Indiana)
- DeKalb County
- Dubois County (Komen Evansville Tri-State)
- Floyd County (Komen Louisville)
- Fountain County (Komen Central Indiana)
- Fulton County
- Greene County (Komen Central Indiana)
- Henry County (Komen Central Indiana)
- Jasper County
- Knox County (Komen Evansville Tri-State)
- Lake County
- Marion County (Komen Central Indiana)
- Morgan County (Komen Central Indiana)
- Owen County (Komen Central Indiana)
- Porter County
- Vigo County (Komen Central Indiana)
- Warrick County (Komen Evansville Tri-State)
- White County

Because data for small numbers of people are not reliable, it can't be predicted whether Benton County, Blackford County, Brown County, Crawford County, Franklin County, Jay County, Jennings County, LaGrange County, Martin County, Newton County, Ohio County, Orange County, Parke County, Perry County, Pike County, Posey County, Pulaski County, Rush County, Scott County, Spencer County, Starke County, Steuben County, Sullivan County, Switzerland County, Tipton County, Union County, Vermillion County, Warren County and Washington County will reach the death rate target. The remaining counties are likely to achieve the target by 2020 or earlier.

Breast Cancer Late-Stage Incidence Rates

The State of Indiana as a whole **currently meets** the HP2020 late-stage incidence rate target. The state had a base rate of 41.1 new late-stage cases per 100,000 females per year from 2006 to 2010 (age-adjusted). This rate coupled with a desirable direction (decrease) in the recent late-stage incidence rate trend, indicates that the State of Indiana will meet the HP2020 target of 41.0 new late-stage cases per 100,000.

The following counties **currently meet** the HP2020 late-stage incidence rate target of 41.0:

- Brown County (Komen Central Indiana)
- Clay County (Komen Central Indiana)
- Clinton County (Komen Central Indiana)
- Daviess County (Komen Evansville Tri-State)
- Dearborn County (Komen Southwest Ohio)
- Decatur County (Komen Central Indiana)
- Dubois County (Komen Evansville Tri-State)
- Fayette County (Komen Central Indiana)
- Grant County (Komen Central Indiana)
- Greene County (Komen Central Indiana)
- Hamilton County (Komen Central Indiana)
- Harrison County (Komen Louisville)
- Henry County (Komen Central Indiana)
- Howard County (Komen Central Indiana)
- Jackson County
- Montgomery County (Komen Central Indiana)
- Perry County (Komen Evansville Tri-State)
- Posey County (Komen Evansville Tri-State)
- Scott County (Komen Louisville)
- Sullivan County (Komen Central Indiana)
- Tippecanoe County (Komen Central Indiana)
- Vanderburgh County (Komen Evansville Tri-State)
- Wabash County
- Wells County
- White County
- Whitley County

The following counties are **likely to miss** the HP2020 late-stage incidence rate target unless the late-stage incidence rate falls at a faster rate than currently estimated:

- Adams County
- Bartholomew County (Komen Central Indiana)
- Boone County (Komen Central Indiana)
- Carroll County
- Cass County
- Clark County (Komen Louisville)
- DeKalb County
- Floyd County (Komen Louisville)
- Fulton County
- Hancock County (Komen Central Indiana)
- Hendricks County (Komen Central Indiana)
- Jasper County

- Jefferson County
- Jennings County
- Johnson County (Komen Central Indiana)
- Kosciusko County
- LaGrange County
- Lake County
- LaPorte County
- Madison County (Komen Central Indiana)
- Marshall County
- Miami County
- Noble County
- Orange County
- Randolph County (Komen Central Indiana)
- Ripley County
- Rush County (Komen Central Indiana)
- St. Joseph County
- Shelby County (Komen Central Indiana)
- Spencer County (Komen Evansville Tri-State)
- Vermillion County (Komen Central Indiana)
- Vigo County (Komen Central Indiana)
- Warrick County (Komen Evansville Tri-State)
- Washington County
- Wayne County (Komen Central Indiana)

Because data for small numbers of people are not reliable, it can't be predicted whether Benton County, Blackford County, Crawford County, Franklin County, Martin County, Newton County, Ohio County, Pike County, Switzerland County, Tipton County, Union County and Warren County will reach the late-stage incidence rate target. The remaining counties are likely to achieve the target by 2020 or earlier.

HP2020 Conclusions

Highest at-risk areas

Sixteen counties in the State of Indiana are in the highest priority category. Nine of the sixteen, Boone County, Carroll County, DeKalb County, Floyd County, Fulton County, Jasper County, Lake County, Vigo County and Warrick County, are not likely to meet either the death rate or late-stage incidence rate HP2020 targets. Seven of the sixteen, Jennings County, LaGrange County, Orange County, Rush County, Spencer County, Vermillion County and Washington County, are not likely to meet the late-stage incidence rate HP2020 target.

The age-adjusted death rates in Fulton County (40.8 per 100,000) and Lake County (28.2 per 100,000) are significantly higher than the state as a whole (23.9 per 100,000). Death trends in Fulton County (2.5 percent per year) are significantly less favorable than the state as a whole

(-1.9 percent per year). The age-adjusted late-stage incidence rates in Lake County (46.8 per 100,000) are significantly higher than the state as a whole (41.1 per 100,000).

Jennings County has high unemployment. LaGrange County has low education levels and a relatively large number of households with little English. Lake County has a relatively large Black/African-American population and a relatively large Hispanic/Latina population. Orange County has low education levels. Washington County has low education levels.

High at-risk areas

Three counties in the State of Indiana are in the high priority category. All of the three, LaPorte County, Shelby County and Wayne County, are not likely to meet the late-stage incidence rate HP2020 target.

Health Systems Analysis

The Breast Cancer Continuum of Care (CoC), shown in Figure 5.1, is a model that shows how a woman typically moves through the health care system for breast care. A woman would ideally move through the CoC quickly and seamlessly, receiving timely, quality care in order to have the best outcomes. Education can play an important role throughout the entire CoC.

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

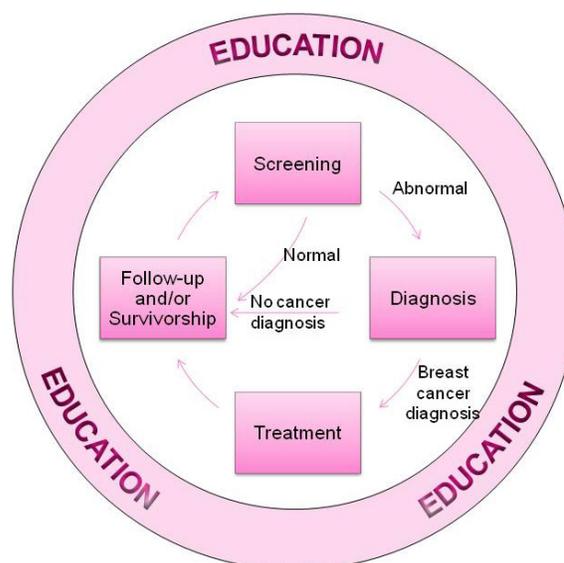


Figure 5.1. Breast Cancer Continuum of Care (CoC)

In the State of Indiana there were 329 locations found to provide breast cancer services varying between screening, diagnostic, treatment, and survivorship (Figure 3.2). There were 327 locations that provided screening services, 198 locations in the state that provide diagnostic services and 86 locations providing treatment services. In the state there were 80 locations that provided survivorship services or care. Identified facilities that provide mammography services

were all accredited by the Federal Drug Administration. There were 47 locations accredited by the American College of Surgeons Commission on Cancer, 39 locations accredited by the American College of Radiology as a Breast Imaging Center of Excellence and 19 locations accredited as an American College of Surgeons NAPBC program. There were two locations designated as a NCI Cancer Center.

The following counties are designated as a Medically Underserved Area/Population and/or a Health Professional Shortage Area for primary care: Adams, Allen, Bartholomew, Benton, Blackford, Brown, Carroll, Cass, Clark, Clay, Clinton, Crawford, Daviess, De Kalb, Decatur, Delaware, Elkhart, Fayette, Floyd, Fountain, Franklin, Fulton, Gibson, Grant, Greene, Henry, Howard, Huntington, Jackson, Jasper Jay, Jefferson, Jennings, Johnson, Knox, Kosciusko, Lagrange, La Porte, Lake, Lawrence, Madison, Marion, Marshall, Martin, Miami, Monroe, Montgomery, Newton, Noble (HPSAS only), Ohio, Orange, Owen, Parke, Perry, Pike, Porter, Posey, Pulaski, Putnam, Randolph, Ripley, Rush, Scott, Spencer, St. Joseph, Starke, Steuben, Sullivan, Switzerland, Tippecanoe, Union, Vanderburgh, Vermillion, Vigo, Wabash, Warren, Washington, Wayne, Wells, White and Whitley.

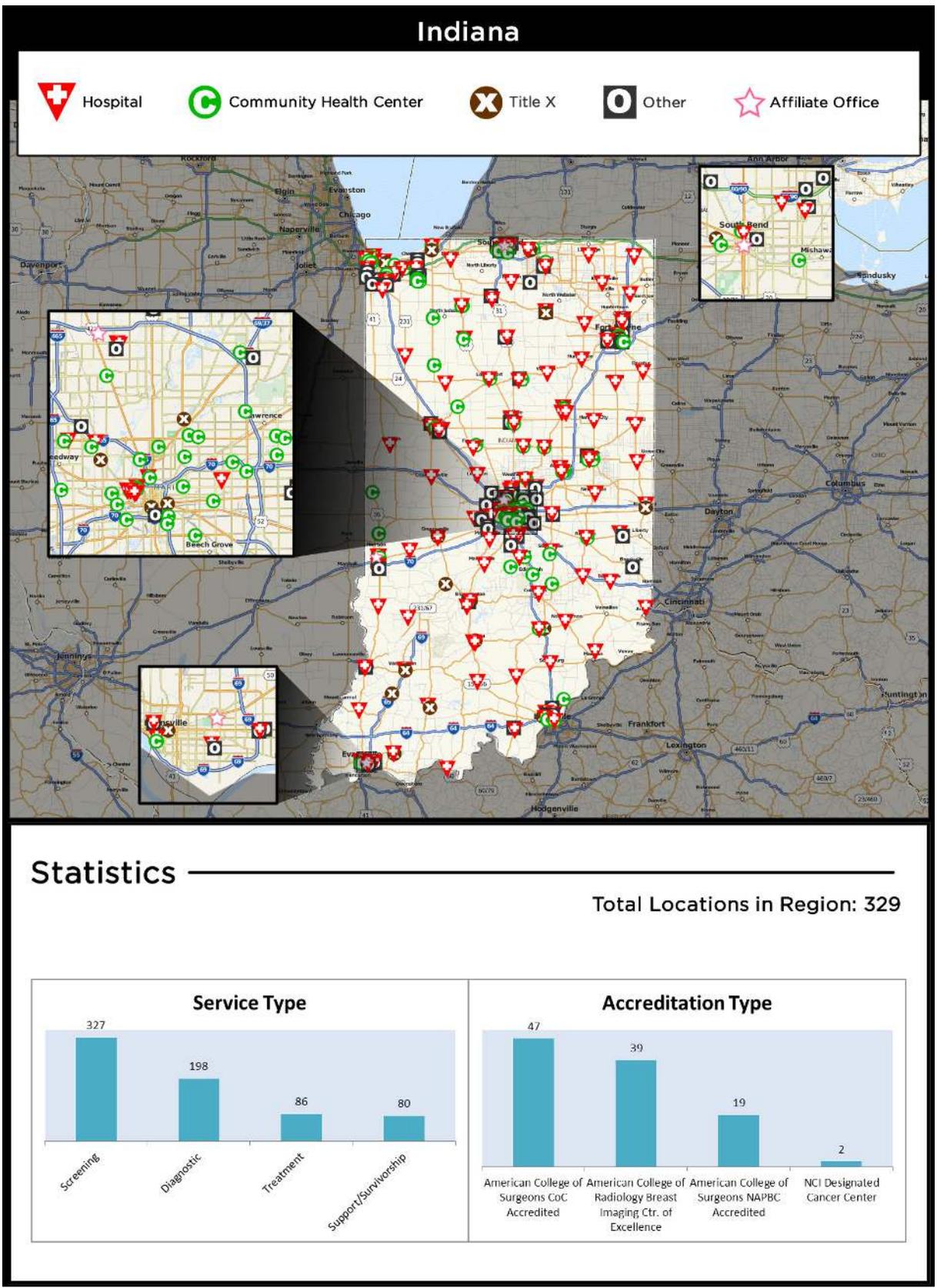


Figure 5.2. Breast cancer services available in Indiana

Public Policy Overview

In recent years, public policies pertaining to breast cancer have undergone substantial changes that will affect at-risk women across the United States. States have responded differently to the public policy developments concerning access to services within the breast cancer continuum of care (screening, diagnostic, treatment and survivorship care); therefore, women are dependent on their state's agenda and action on health care reform.

National Breast and Cervical Cancer Early Detection Program (NBCCEDP)

The NBCCEDP is a nationwide program that provides low-income women with breast and cervical cancer screening, follow-up and support services (i.e., case management and referrals for medical treatment), developing and disseminating public information and education programs and improving the education, training and skills of health professionals.

In the State of Indiana, the NBCCEDP is known as Indiana's Breast and Cervical Cancer Early Detection Program and is administered by the Indiana State Department of Health. From July 2009 to June 2014, Indiana's Breast and Cervical Cancer Early Detection Program provided 20,782 breast cancer and cervical cancer screening and diagnostic services to women. The program provided 13,764 mammograms that resulted in 2,111 women receiving an abnormal result and 198 women being diagnosed with breast cancer (NBCCEDP Minimum Data Elements, 2015). To find out more information about getting screened and eligibility, contact the Breast and Cervical Cancer Early Detection Program (1-800-433-0746).

State Comprehensive Cancer Control Plan

Comprehensive cancer control is a process through which communities and partner organizations pool resources to reduce cancer risk, find cancers earlier, improve treatments, increase the number of people who survive cancer and improve quality of life for cancer survivors to ultimately reduce the burden of cancer in the state. Under the National Comprehensive Cancer Control Program (NCCCP), state cancer coalitions develop and implement a State Comprehensive Cancer Control Plan to meet identified cancer needs.

Indiana's comprehensive cancer control plan for 2010-2014 (<http://indianacancer.org/wp-content/uploads/2010/04/ICCP-FINAL-1-6-10-3.pdf>) includes the following goals and objectives specific for breast cancer:

Early Detection Goal: Increase early detection and appropriate screening for cancer

Breast Cancer Objectives:

- By 2014, increase the percentage of women aged 40 and older who receive annual breast cancer screening from 62 percent to 67 percent as measured by the Indiana Behavioral Risk Factor Surveillance System.
- Promote evidence based interventions that target women not receiving annual mammography and clinical breast exams

- Expand the use of provider reminder systems for annual mammograms and clinical breast exams
- Use interventions targeted to population characteristics and tailored on breast cancer risks and cognitive, attitudinal, and socio-cultural factors
- Support efforts to increase funding for programs providing free screening to low income, uninsured, and underinsured women
- Disseminate information related to breast cancer screening through lay health advisors, peer educators, and community outreach workers
- Promote media campaigns to inform the public of the need for regular breast cancer screening

For more information regarding Indiana's comprehensive cancer plan please visit:

<http://www.state.in.us/isdh/24935.htm>.

Affordable Care Act

In 2010, Congress passed the Patient Protection and Affordable Care Act (commonly known as Affordable Care Act or ACA) to expand access to care through insurance coverage, enhance the quality of health care, improve health care coverage for those with health insurance and to make health care more affordable.

The ACA includes the following mandates to improve health insurance coverage and enhance health care quality (US Department of Health and Human Services, 2015a):

- Prohibit insurers from denying coverage based on pre-existing conditions
- Prohibit insurers from rescinding coverage
- Prohibit annual and lifetime caps on coverage
- Provide coverage of preventive services with no cost-sharing (including screening mammography, well women visits)
- Establish minimum benefits standards, known as the Essential Health Benefits (EHB)

The ACA provides tax subsidies for middle-income individuals to purchase insurance through the health insurance exchanges (commonly called the Marketplace). To be eligible to receive health coverage through the Marketplace, an individual must live in the United States, be a US citizen or national (or lawfully present), cannot be incarcerated, fall into certain income guidelines and cannot be eligible for other insurance coverage (i.e., Medicaid, Medicare and employer sponsored health care coverage) (US Centers for Medicare and Medicaid Services, n.d.).

Based on 2015 data, of the estimated 686,000 total number of uninsured in Indiana, 45.0 percent are Medicaid eligible, 19.0 percent are eligible for tax subsidies and 36.0 percent are ineligible for financial assistance due to income, employer sponsored insurance offer or citizenship status (Garfield et al., 2015).

Medicaid Expansion

Traditional Medicaid had gaps in coverage for adults because eligibility was restricted to specific categories of low-income individuals (i.e., children, their parents, pregnant women, the elderly, or individuals with disabilities). In most states, non-elderly adults without dependent children were ineligible for Medicaid, regardless of their income.

Under the ACA, states were provided the option to expand Medicaid coverage to a greater number of non-elderly adults with incomes at or below 138 percent of poverty (about \$16,242 per year for an individual in 2015); thus reducing the number of uninsured, low-income adults.

Indiana adopted Medicaid expansion, effective February 1, 2015. There are currently 686,000 total individuals who are uninsured and 310,000 are Medicaid eligible (The Henry J. Kaiser Family Foundation, 2016). The Indiana Medicaid program is administered by the Indiana Family and Social Services Administration. Under the “Healthy Indiana Plan” program, adults between the ages of 19 and 64 with incomes 133 percent of the federal poverty level (FPL) or less are eligible for health care coverage (Indiana Family and Social Services Administration, 2014). There are multiple health plans within the Healthy Indiana Plan with different eligibility requirements and benefits. More information about Health Indiana Plan programs can be found at the following website: <http://member.indianamedicaid.com/>.

Affordable Care Act, Medicaid Expansion and Uninsured Women

Even after implementation of the ACA and Medicaid Expansion (in some states), there are approximately 12.8 million women (ages 19 to 64) in the US that remain uninsured. Of the 1,946,000 women in Indiana, 272,440 (14.0 percent) were without health insurance coverage in 2014.

Uninsured women have been found to have inadequate access to care and receive a lower standard of care within health systems that lead to poorer health outcomes. Women that are single parents, have incomes below 100 percent federal poverty level, have less than a high school education, are women of color or immigrants are at greatest risk of being uninsured.

Conclusions

Overall, Indiana is likely to miss the HP2020 late-stage incidence target and is likely to achieve the HP2020 death rate target. A total of 329 locations were identified as providing at least one type of breast cancer service along the continuum of care. While all of the facilities providing mammography services were accredited by the FDA, only 33.0 percent of the locations have been recognized as receiving additional quality of care accreditations. Indiana also has many designated areas that are rural and/or medically underserved - where individuals may have inadequate access to health care. Although Indiana has implemented programs (i.e., NBCCEDP, Medicaid Expansion) to assist low-income and uninsured individuals, there are still far too many individuals that have inadequate access to health care and may be receiving a lower standard of care. Both may contribute to poorer breast cancer outcomes.

The information provided in this report can be used by public health organizations, local service providers and policymakers to identify areas of greatest need and the potential demographic and socioeconomic factors that may be causing suboptimal breast cancer outcomes. Susan G. Komen will continue to utilize evidence-based practices to reduce breast cancer late-stage diagnosis and death rates by empowering others, ensuring quality care for all and energizing science to find the cures.

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Appendix

Appendix A. State Map with County Names



Source: US Census Bureau, 2014