

**Greater Atlanta Affiliate
of Susan G. Komen®
Quantitative Data Report**



2015-2019

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1. Purpose, Intended Use, and Summary of Findings

The purpose of the quantitative data report for the Greater Atlanta Affiliate of Susan G. Komen® is to combine evidence from many credible sources (see Section 5) and use the data to identify the highest priority areas for evidence-based breast cancer programs.

The report's intended use is to provide quantitative data to guide the 2015 Susan G. Komen Community Profile process by providing data tables, maps, preliminary data interpretation, and identification of priority areas.

The quantitative data report provides the following data at the Affiliate and county-level, as well as for the United States and State(s):

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

The data provided in the report are used to identify priorities within the Affiliate's service area based on estimates of how long it would take an area to achieve Healthy People 2020 objectives for breast cancer late-stage diagnosis and mortality [HP 2020].

Nancy G. Brinker promised her dying sister, Susan G. Komen, she would do everything in her power to end breast cancer forever. In 1982, that promise became Susan G. Komen® and launched the global breast cancer movement. Today, Susan G. Komen is the boldest community fueling the best science and making the biggest impact in the fight against breast cancer by empowering people, ensuring quality care for all and energizing science to find the cures. This promise is put into action at a local level through a network of 117 Affiliates.

Limitations in the use of the data

The quantitative data presented in this report have been gathered from credible sources using the most current data available at the time the report was generated. However, there are some limitations of these data and with the application of the data in planning for breast cancer programs. See Section 6 for additional details about data limitations.

- Data can change over time. The most recent data available were utilized in this report. However, data may change during the five year planning period for this report (2015 to 2019).

- Limited available data. The breast cancer data available in this report may be limited for a number of reasons including source data restrictions or counties with small populations. Data on population characteristics, which are available for all counties, can be used to help guide planning for where specific breast cancer data are not available.
- Affiliates with a small number of counties. When there are just a few counties in the Affiliate's service area, the Affiliate can refer to the state report to compare its counties to neighboring counties in the state.
- Difference with other cancer data sources. There may be minor differences between the breast cancer data in this report and data reported by state registries and health departments due to registry database updates between the times when the data were extracted for the two reports.
- Data on specific racial and ethnic subgroups. Data on cancer rates for specific racial and ethnic subgroups such as Somali, Hmong, or Ethiopian are not generally available.
- Reasons for changes in cancer rates may not be obvious. The various types of breast cancer data in this report are inter-dependent. For example, 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.
- Missing factors. Quantitative data are not available for some factors that impact breast cancer risk and survival such as family history, genetic markers like HER2 and BRCA, and the presence of other medical conditions that can complicate treatment.

Summary of key findings

To determine priority areas, each county's estimated time to reach the HP2020 target for late-stage diagnosis and mortality were compared and then each county was categorized into seven potential priority levels. Four counties in the Komen Greater Atlanta Affiliate service area are in the highest priority category: Clayton County, DeKalb County, Fulton County and Henry County.

One county in the Komen Greater Atlanta Affiliate service area is in the high priority category: Cherokee County.

2. Quantitative Data

2.1 Data Types

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.

Death rates

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

It is desirable that death rate trends 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 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.

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].

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]. 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.

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.

Mammography recommendations

There is some controversy over breast cancer screening recommendations for women of average risk. For example, Susan G. Komen®, the American Cancer Society, and the National Comprehensive Cancer Network all recommend that women with average risk of breast cancer have a screening mammogram every year starting at age 40. Meanwhile, the US Preventive Services Task Force recommends that women age 50 to 74 have a screening mammogram every two years and encourages women ages 40 to 49 to discuss the pros and cons of mammography screening with their health care providers.

Table 2.1. Breast cancer screening recommendations for women at average risk.

Susan G. Komen	American Cancer Society	National Cancer Institute	National Comprehensive Cancer Network	US Preventive Services Task Force
Mammography every year starting at age 40	Mammography every year starting at age 40	Mammography every 1-2 years starting at age 40	Mammography every year starting at age 40	Informed decision-making with a health care provider ages 40-49 Mammography every 2 years ages 50-74

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.]. 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.

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

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

Mammography screening proportion is calculated from two pieces of information:

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

The number of women who had a mammogram is divided by the number who should have had one. For example, if there are 500 women in an area who should have had mammograms and 250 of those women actually had a mammogram in the past two years, the mammography screening proportion is 50 percent.

Confidence intervals

Because the screening proportions come from samples of women in an area and 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 screening proportion was reported as 50 percent, with a confidence interval of 35 to 65, you would know that the real rate might not be exactly 50 percent, but it's very unlikely that it's less than 35 or more than 65 percent.

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

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 the 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 live 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 are most in need of 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 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.

2.2 Breast Cancer Incidence, Death, and Late-stage Diagnosis Rates and Trends

Breast cancer incidence, death, and late-stage diagnosis rates are shown in Table 2.2a for:

- United States
- State of Georgia
- Komen Greater Atlanta Affiliate service area
- Each of Komen Greater Atlanta Affiliate's service area counties

For the Komen Greater Atlanta Affiliate service area, rates are also shown by race for Whites, Blacks, 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 2.2a are age-adjusted and are shown per 100,000 females from 2006 to 2010. The HP2020 death rate and late-stage incidence rate targets are included for reference.

In addition, Table 2.2a shows:

- Average number of breast cancer cases or deaths per year from 2006 to 2010
- Incidence, death, and late-stage diagnosis trends (as annual percent change) from 2006 to 2010
- Average size of the female population for 2006 through 2010

Table 2.2b compares the Affiliate service area incidence, death, and late-stage rates to state rates, and compares county rates to the Affiliate service area rate.

Table 2.2c indicates whether the trends for the Affiliate service area incidence, death, and late-stage rates and each of its service area counties are generally rising, falling, or not changing.

Table 2.2d compares the Affiliate service area incidence, death, and late-stage trends to state trends and compares county trends to Affiliate service area trends.

Table 2.2a. Female breast cancer incidence rates and trends, death rates and trends, and late-stage rates and trends.

Population Group	Incidence Rates and Trends				Death Rates and Trends			Late-stage Rates and Trends		
	Female Population (Annual Average)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of Deaths (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)
US	154,540,194	182,234	122.1	-0.2%	40,736	22.6	-1.9%	64,590	43.8	-1.2%
HP2020	.	-	-	-	-	20.6	-	-	41.0	-
Georgia	4,838,820	5,997	121.5	-0.3%	1,146	23.4	-1.4%	2,253	45.5	-0.4%
Komen Greater Atlanta Affiliate Service Area	2,249,867	2,743	128.7	0.0%	490	24.4	NA	1,010	46.5	-0.5%
White	1,270,141	1,781	131.9	0.3%	290	21.9	NA	583	43.1	-0.1%
Black	841,707	874	127.7	-0.5%	193	31.7	NA	395	56.2	-0.8%
AIAN	11,834	SN	SN	SN	SN	SN	SN	SN	SN	SN
API	126,185	73	71.8	-0.2%	7	8.6	NA	28	27.8	-8.2%
Non-Hispanic/ Latina	2,036,045	2,650	130.4	0.4%	484	25.1	NA	968	47.0	-0.3%
Hispanic/ Latina	213,822	93	94.2	-6.0%	5	7.1	NA	42	38.6	-5.8%
Cherokee County - GA	104,297	125	121.5	7.6%	21	21.7	-0.8%	42	39.9	7.9%
Clayton County - GA	135,658	135	117.0	-2.6%	28	26.9	0.9%	57	46.1	3.0%
Cobb County - GA	347,082	428	127.5	0.7%	70	22.3	-1.3%	149	43.7	-4.7%
Coweta County - GA	61,922	77	124.8	-4.2%	12	21.6	-3.3%	29	46.4	-8.1%
DeKalb County - GA	357,137	465	135.0	0.4%	87	26.1	-1.2%	183	51.8	0.2%
Douglas County - GA	66,109	76	124.0	-5.4%	15	25.1	-0.6%	30	46.9	-5.9%
Fayette County - GA	54,387	85	131.8	-3.8%	14	21.0	-2.4%	26	42.6	3.2%
Forsyth County - GA	82,179	99	125.0	5.3%	10	13.9	-2.3%	32	39.3	-1.0%
Fulton County - GA	453,948	590	135.1	-0.7%	124	29.2	-1.1%	218	49.6	-0.5%
Gwinnett County - GA	392,752	437	127.8	1.2%	67	21.9	-2.0%	163	46.1	2.5%
Henry County - GA	100,440	109	118.2	1.0%	22	25.1	-0.9%	43	45.6	5.1%
Newton County - GA	50,580	60	124.8	-7.3%	13	27.6	-0.5%	20	40.6	-4.7%
Rockdale County - GA	43,375	56	120.7	-0.4%	9	21.1	-2.3%	18	38.7	-9.8%

NA – data not available

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

Data are for years 2006-2010.

Rates are in cases or deaths per 100,000.

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

Source of incidence and late-stage data: NAACCR – CINA Deluxe Analytic File.

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

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

Table 2.2b. Comparison of female breast cancer incidence rates, death rates, and late-stage rates.

Geographic Area	Incidence Rate Comparison	Death Rate Comparison	Late-stage Rate Comparison
Komen Greater Atlanta Affiliate compared to State Rate Statistics			
Georgia	Significantly Higher	Not Significantly Different	Not Significantly Different
Counties compared to Komen Greater Atlanta Affiliate Statistics			
Cherokee County - GA	Not Significantly Different	Not Significantly Different	Not Significantly Different
Clayton County - GA	Not Significantly Different	Not Significantly Different	Not Significantly Different
Cobb County - GA	Not Significantly Different	Not Significantly Different	Not Significantly Different
Coweta County - GA	Not Significantly Different	Not Significantly Different	Not Significantly Different
DeKalb County - GA	Not Significantly Different	Not Significantly Different	Significantly Higher
Douglas County - GA	Not Significantly Different	Not Significantly Different	Not Significantly Different
Fayette County - GA	Not Significantly Different	Not Significantly Different	Not Significantly Different
Forsyth County - GA	Not Significantly Different	Significantly Lower	Not Significantly Different
Fulton County - GA	Not Significantly Different	Significantly Higher	Not Significantly Different
Gwinnett County - GA	Not Significantly Different	Not Significantly Different	Not Significantly Different
Henry County - GA	Not Significantly Different	Not Significantly Different	Not Significantly Different
Newton County - GA	Not Significantly Different	Not Significantly Different	Not Significantly Different
Rockdale County - GA	Not Significantly Different	Not Significantly Different	Not Significantly Different

NA – data not available.

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

Rate Comparison
<p>Significantly Higher: based on statistical methods, there is a significant likelihood that female breast cancer occurred more frequently among women in the county than among those in the Affiliate as a whole, which is generally unfavorable for the county.</p> <p>Not Significantly Different: statistical methods were unable to determine whether female breast cancer occurred with a different frequency among women in the county than it occurred among those in the Affiliate as a whole.</p> <p>Significantly Lower: based on statistical methods, there is a significant likelihood that female breast cancer occurred less frequently among women in the county than among those in the Affiliate as a whole, which is generally favorable for the county.</p> <p>The statistical methods used to determine whether an area is classified as either Significantly Higher, Not Significantly Different, or Significantly Lower than another area depends on comparing the confidence intervals (not shown in Table 2.2a) for each area. For more information on confidence intervals, see Sections 2.1 (under “Mammography Screening”) and 2.3.</p>

Table 2.2c. Interpretation of female breast cancer incidence, death, and late-stage trend direction.

Geographic Area	Incidence Rate Trend Direction	Death Rate Trend Direction	Late-stage Rate Trend Direction
Affiliate-level Trend Statistics			
Komen Greater Atlanta Affiliate Service Area	No Significant Change	NA	No Significant Change
County-level Trend Statistics			
Cherokee County - GA	Rising	No Significant Change	No Significant Change
Clayton County - GA	No Significant Change	No Significant Change	No Significant Change
Cobb County - GA	No Significant Change	Falling	Falling
Coweta County - GA	Falling	Falling	No Significant Change
DeKalb County - GA	No Significant Change	Falling	No Significant Change
Douglas County - GA	No Significant Change	No Significant Change	No Significant Change
Fayette County - GA	No Significant Change	No Significant Change	Rising
Forsyth County - GA	No Significant Change	No Significant Change	No Significant Change
Fulton County - GA	No Significant Change	Falling	No Significant Change
Gwinnett County - GA	No Significant Change	Falling	No Significant Change
Henry County - GA	No Significant Change	No Significant Change	No Significant Change
Newton County - GA	No Significant Change	No Significant Change	No Significant Change
Rockdale County - GA	No Significant Change	Falling	No Significant Change

NA – data not available.

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

Trend Direction
<p>Rising: based on statistical methods, there is a significant likelihood of an increase in the occurrence of female breast cancer among women in the area over the observation period, which is unfavorable for women in the area.</p> <p>No Significant Change: statistical methods were unable to conclude whether there was a general tendency with respect to female breast cancer occurrence among women in the area over the observation period.</p> <p>Falling: based on statistical methods, there is a significant likelihood of a decrease in the occurrence of female breast cancer among women in the area over the observation period, which is favorable for women in the area.</p> <p>The statistical methods used to determine whether an area is classified as either Rising, No Significant Change, or Falling depends on examining the confidence intervals (not shown in Table 2.2a) for each area. For more information on confidence intervals, see Sections 2.1 (under “Mammography Screening”) and 2.3.</p>

Table 2.2d. Comparison of female breast cancer incidence, death, and late-stage trend sizes.

Geographic Area	Incidence Trend Comparison	Death Trend Comparison	Late-stage Trend Comparison
Komen Greater Atlanta Affiliate compared to State Statistics			
Georgia	Not Significantly Different	NA	Not Significantly Different
Counties compared to Komen Greater Atlanta Affiliate Statistics			
	Counties compared to Affiliate Incidence Rate Trend	Counties Compared to State* Death Rate Trend	Counties compared to Affiliate Late-Stage Rate Trend
Cherokee County - GA	Unfavorable	Not Significantly Different	Not Significantly Different
Clayton County - GA	Not Significantly Different	Unfavorable	Not Significantly Different
Cobb County - GA	Not Significantly Different	Not Significantly Different	Favorable
Coweta County - GA	Not Significantly Different	Not Significantly Different	Not Significantly Different
DeKalb County - GA	Not Significantly Different	Not Significantly Different	Not Significantly Different
Douglas County - GA	Not Significantly Different	Not Significantly Different	Not Significantly Different
Fayette County - GA	Not Significantly Different	Not Significantly Different	Unfavorable
Forsyth County - GA	Not Significantly Different	Not Significantly Different	Not Significantly Different
Fulton County - GA	Not Significantly Different	Not Significantly Different	Not Significantly Different
Gwinnett County - GA	Not Significantly Different	Not Significantly Different	Not Significantly Different
Henry County - GA	Not Significantly Different	Not Significantly Different	Not Significantly Different
Newton County - GA	Not Significantly Different	Not Significantly Different	Not Significantly Different
Rockdale County - GA	Not Significantly Different	Not Significantly Different	Not Significantly Different

* The death rate trend is not available for the Affiliate as a whole so this comparison is to the state trend.

NA – data not available.

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

Trend Size Comparison

Unfavorable: based on statistical methods, there is a significant likelihood that the trend of female breast cancer occurrence among women in the county was **less favorable** than among those in the Affiliate as a whole. This means the rate of female breast cancer occurrence decreased less (or increased more) than the Affiliate rate.

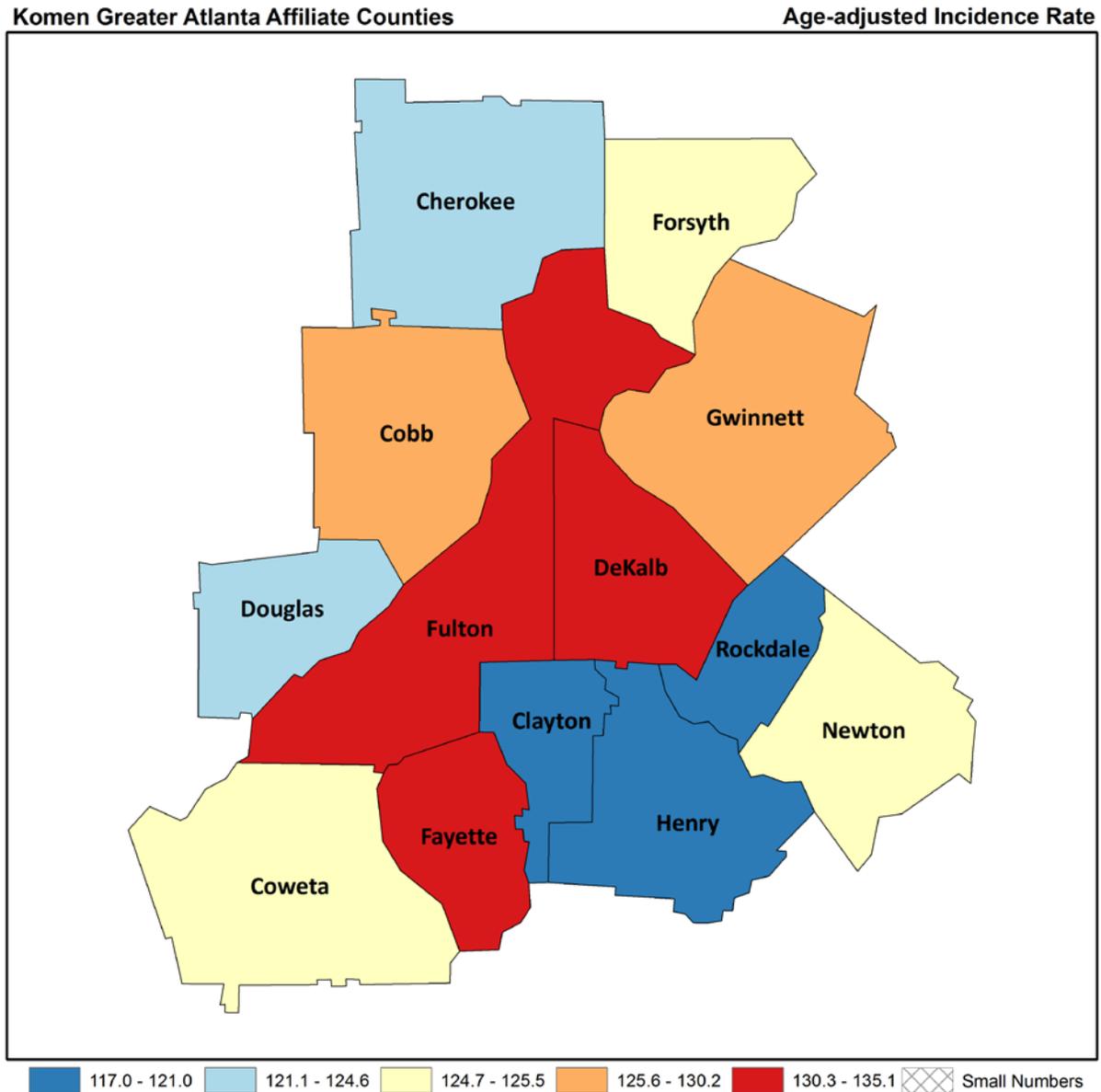
Not Significantly Different: statistical methods were **unable to conclude** whether the trend of female breast cancer occurrence among women in the county was different than the trend among those in the Affiliate as a whole.

Favorable: based on statistical methods, there is a significant likelihood that the trend of female breast cancer occurrence among women in the county was **more favorable** than the trend among those in the Affiliate as a whole. This means the rate of female breast cancer occurrence decreased more (or increased less) than the Affiliate rate.

The statistical methods used to determine whether an area is classified as either Significantly Higher, Not Significantly Different, or Significantly Lower than another area depends on comparing the confidence intervals (not shown in Table 2.2a) for each area. For more information on confidence intervals, see Sections 2.1 (under "Mammography Screening") and 2.3.

Maps of Breast Cancer Incidence, Death, and Late-stage Incidence

Figures 2.2a, 2.2b, and 2.2c show maps of breast cancer incidence (new cases), death, and late-stage incidence rates for the counties in the Affiliate service area. When the numbers of cases or deaths 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 maps.



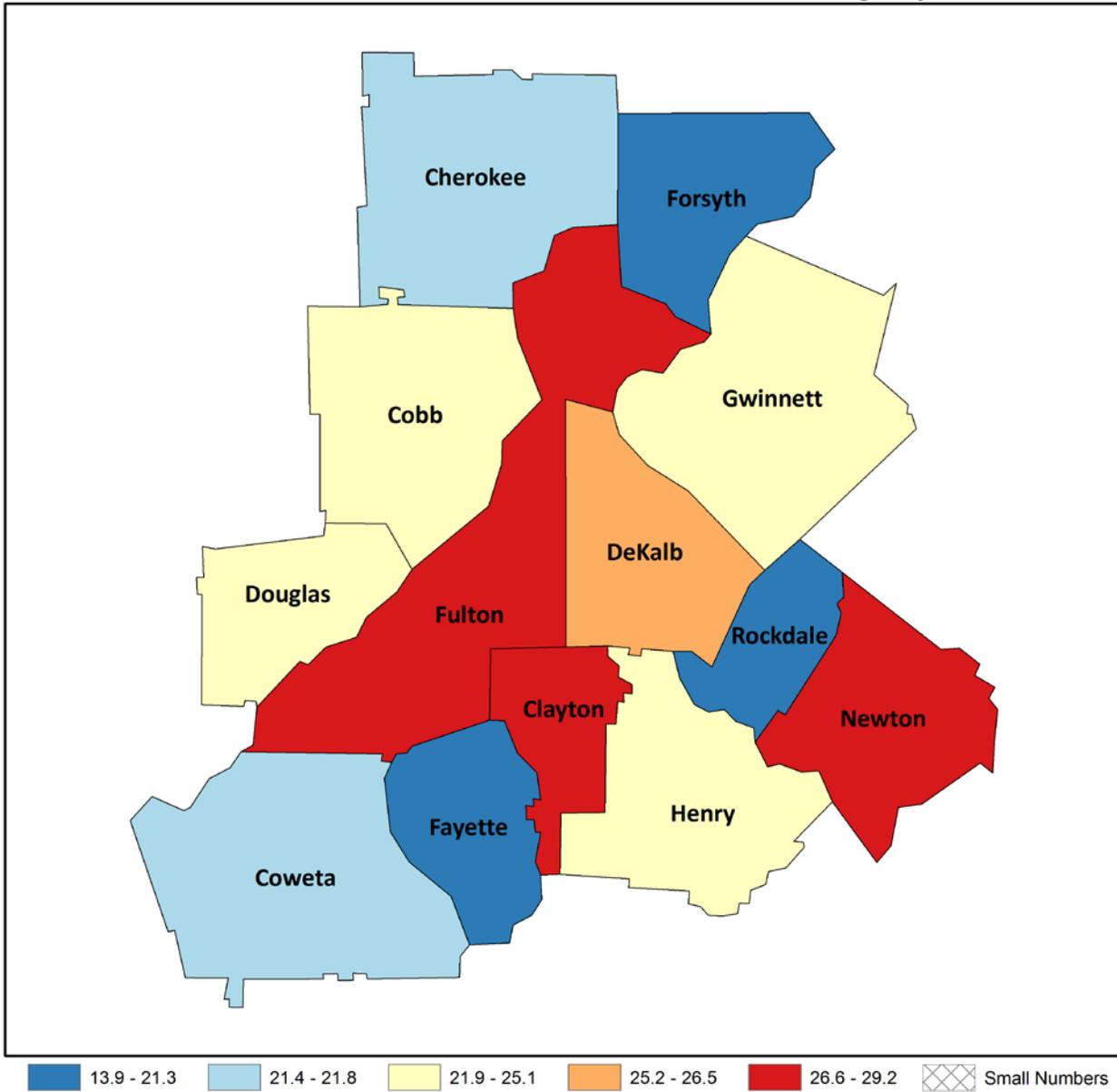
Data are for years 2006-2010.

Rates are in cases per 100,000.

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

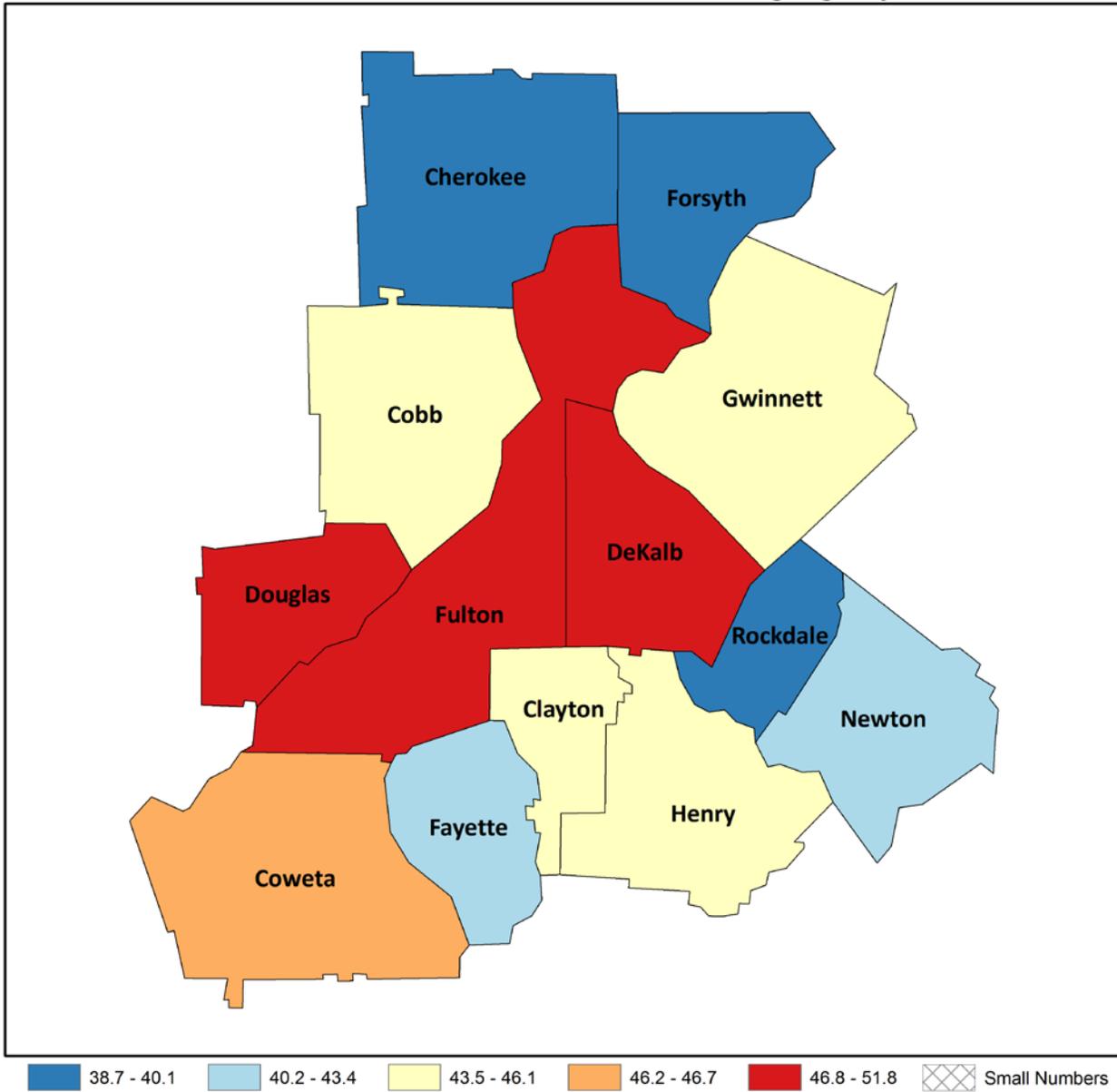
Source: NAACCR – CINA Deluxe Analytic File.

Figure 2.2a. Female breast cancer age-adjusted incidence rates.



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 2.2b. Female breast cancer age-adjusted death rates.



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 2.2c. Female breast cancer age-adjusted late-stage incidence rates.

Conclusions: Breast Cancer Incidence, Death, and Late-stage Diagnosis

Incidence rates and trends

Overall, the breast cancer incidence rate in the Komen Greater Atlanta Affiliate service area was higher than that observed in the US as a whole and the incidence trend was slightly higher than the US as a whole. The incidence rate of the Affiliate service area was **significantly higher** than that observed for the State of Georgia and the incidence trend was not significantly different than the State of Georgia.

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

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

- Cherokee County

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

It's important to remember that an increase in breast cancer incidence could also mean that more breast cancers are being found because more women are getting mammograms. Section 2.3 contains information about screening rates.

Death rates and trends

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

For the United States, breast cancer death rates in Blacks 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. The most recent estimated death rates for Hispanics/Latinas were lower than for Non-Hispanic Whites

and Blacks. For the Affiliate service area as a whole, the death rate was higher among Blacks than Whites and lower among APIs than Whites. There were not enough data available within the Affiliate service area to report on AIANs so comparisons cannot be made for this racial group. The death rate among Hispanics/Latinas was lower than among Non-Hispanics/Latinas.

The following county had a death rate **significantly higher** than the Affiliate service area as a whole:

- Fulton County

The death rate was significantly lower in the following county:

- Forsyth County

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

- Clayton County

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

Late-stage incidence rates and trends

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

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

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

- DeKalb County

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

- Fayette County

Significantly more favorable trends in breast cancer late-stage incidence rates were observed in the following county:

- Cobb County

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

2.3 Breast Cancer Screening Proportions

Breast cancer screening proportions are shown in Table 2.3a for:

- United States
- State of Georgia
- Komen Greater Atlanta Affiliate service area
- Each of Komen Greater Atlanta Affiliate's service area counties

For the Komen Greater Atlanta Affiliate service area, proportions are also shown for Whites, Blacks, 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 2.3a are based on the number of women age 50 to 74 who reported in 2012 having had a mammogram in the last two years. As mentioned in Section 2.1, 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 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.

Table 2.3a shows:

- Number of women interviewed
- Number who had a mammogram in the last two years
- Proportion of women who had a mammogram in the last two years (weighted)
- Confidence interval for the proportion

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.

Table 2.3b provides a comparison of the county screening rates to the Affiliate service area rate. These comparisons, determining significance, take the confidence interval into account.

Table 2.3a. 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%
Georgia	2,341	1,874	81.0%	78.8%-83.1%
Komen Greater Atlanta Affiliate Service Area	733	595	83.7%	79.9%-86.9%
White	485	383	80.9%	76.2%-84.9%
Black	223	193	88.8%	81.9%-93.3%
AIAN	SN	SN	SN	SN
API	SN	SN	SN	SN
Hispanic/ Latina	15	14	93.8%	65.5%-99.2%
Non-Hispanic/ Latina	715	578	83.1%	79.2%-86.4%
Cherokee County - GA	41	29	77.5%	57.2%-89.9%
Clayton County - GA	93	79	88.4%	75.6%-94.9%
Cobb County - GA	85	67	80.0%	67.3%-88.6%
Coweta County - GA	27	22	79.5%	54.1%-92.8%
DeKalb County - GA	137	113	85.4%	75.9%-91.6%
Douglas County - GA	27	20	83.5%	60.7%-94.4%
Fayette County - GA	19	14	89.0%	66.8%-97.0%
Forsyth County - GA	23	18	79.6%	56.7%-92.0%
Fulton County - GA	137	117	86.4%	76.4%-92.6%
Gwinnett County - GA	76	61	83.7%	70.8%-91.6%
Henry County - GA	32	29	87.7%	66.1%-96.3%
Newton County - GA	19	15	79.2%	51.7%-93.1%
Rockdale County - GA	17	11	80.8%	56.3%-93.2%

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

Data are for 2012.

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

Table 2.3b. Comparison of the proportion of women with screening mammography in the last two years.

Geographic Area	Counties compared to Komen Greater Atlanta Affiliate
Cherokee County - GA	Not Significantly Different
Clayton County - GA	Not Significantly Different
Cobb County - GA	Not Significantly Different
Coweta County - GA	Not Significantly Different
DeKalb County - GA	Not Significantly Different
Douglas County - GA	Not Significantly Different
Fayette County - GA	Not Significantly Different
Forsyth County - GA	Not Significantly Different
Fulton County - GA	Not Significantly Different
Gwinnett County - GA	Not Significantly Different
Henry County - GA	Not Significantly Different
Newton County - GA	Not Significantly Different
Rockdale County - GA	Not Significantly Different

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

Rate Comparison

Significantly Lower: based on statistical hypothesis testing, it can be concluded that female breast cancer screening occurred less frequent among the county residents than among Affiliate women in general, which is **unfavorable** for the county residents.

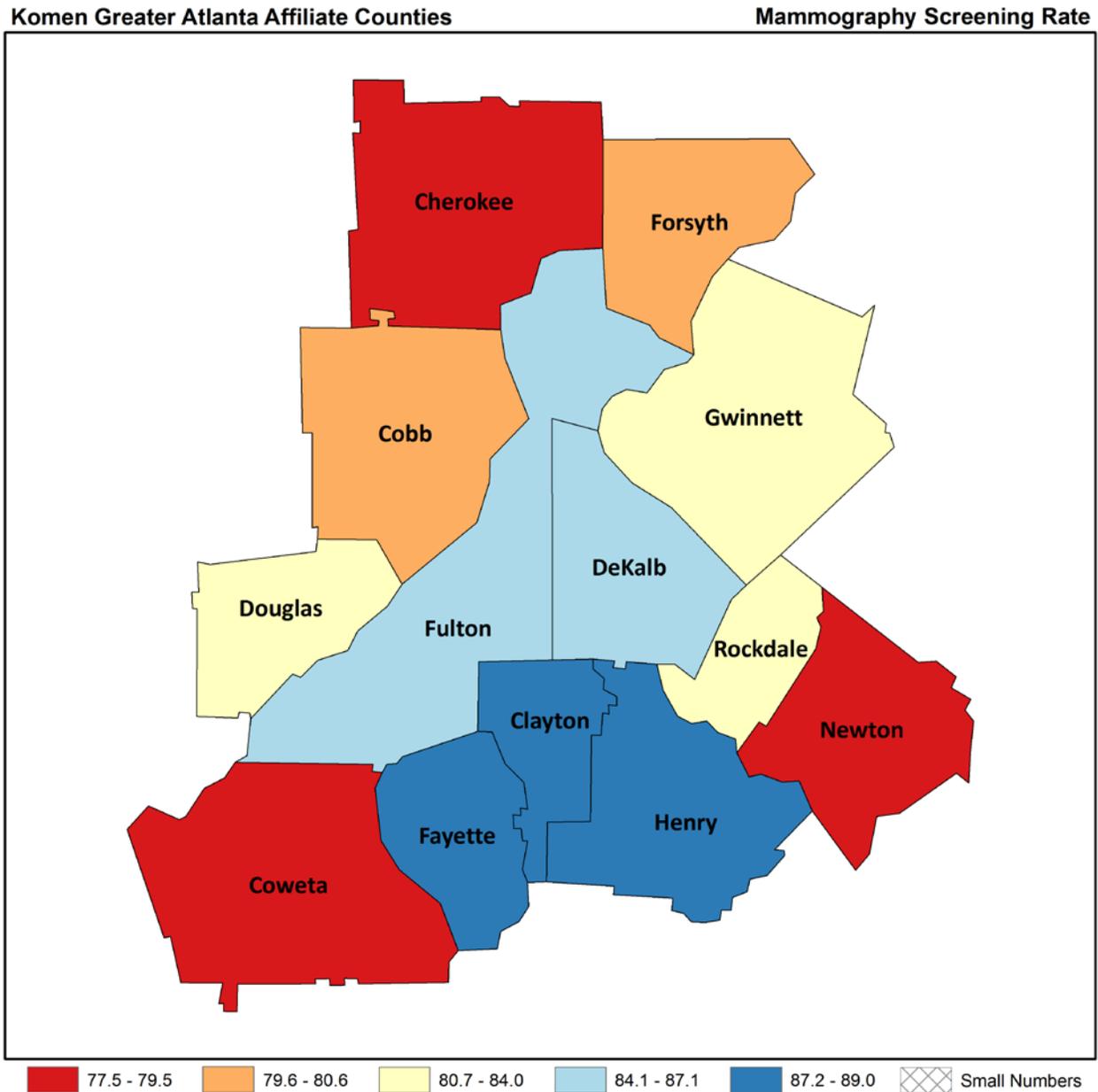
Not Significantly Different: statistical hypothesis testing was **unable to conclude** whether female breast cancer occurred among the county residents with a different frequency than it occurred among Affiliate women in general.

Significantly Higher: based on statistical hypothesis testing, it can be concluded that female breast cancer screening occurred more frequent among the county residents than among the Affiliate women in general, which is **favorable** for the county residents.

The statistical methods used to determine whether an area is classified as either Significantly Higher, Not Significantly Different, or Significantly Lower than another area depends on comparing the confidence intervals for each area.

Map of Screening Rates

Figure 2.3 shows a map of breast cancer mammography screening rates for the counties in the Affiliate service area. When the numbers of samples used to compute the rates are small (fewer than 10 samples), those rates are unreliable and are shown as “small numbers” on the map.



Data are for 2012.

Data are in the percentage of women who had a mammogram.

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

Figure 2.3. Mammography screening rates for women ages 50-74 in the last two years, self-report.

Conclusions: Breast Cancer Screening Proportions

The breast cancer screening proportion in the Komen Greater Atlanta Affiliate service area was significantly higher than that observed in the US as a whole. The screening proportion of the Affiliate service area was not significantly different than the State of Georgia.

For the United States, breast cancer screening proportions among Blacks are similar to those among Whites overall. APIs have somewhat lower screening proportions than Whites and Blacks. 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. For the Affiliate service area as a whole, the screening proportion was not significantly different among Blacks than Whites. There were not enough data available within the Affiliate service area to report on APIs and AIANs so comparisons cannot be made for these racial groups. The screening proportion among Hispanics/Latinas was not significantly different than among Non-Hispanics/Latinas.

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

2.4 Population Characteristics

Race, ethnicity, and age data for the US, the state, the Komen Greater Atlanta Affiliate service area, and each of the counties in the Affiliate's service area are presented in Table 2.4a.

Table 2.4a shows:

- Race percentages for four groups: White, Black, American Indian and Alaska Native (AIAN), and Asian and Pacific Islander (API)
- Percentages of women that are 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 2.4b shows socioeconomic data for the US, the state, the Komen Greater Atlanta Affiliate service area, and each of the counties in the Affiliate's service area.

Table 2.4b shows:

- 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%) and less than 2.5 times the poverty level (below 250%).
- 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 US Health Resources and Services Administration (HRSA)
- Percentage between ages 40 and 64 who have no health insurance

Table 2.4a. Population characteristics – demographics.

Population Group	White	Black	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 %
Georgia	62.8 %	32.9 %	0.5 %	3.7 %	91.8 %	8.2 %	45.5 %	31.0 %	12.3 %
Komen Greater Atlanta Affiliate Service Area	55.3 %	38.1 %	0.6 %	6.0 %	89.6 %	10.4 %	43.9 %	28.2 %	10.0 %
Cherokee County - GA	90.3 %	6.9 %	0.6 %	2.3 %	90.9 %	9.1 %	46.0 %	29.7 %	10.7 %
Clayton County - GA	24.7 %	69.3 %	0.7 %	5.3 %	88.2 %	11.8 %	39.8 %	24.8 %	7.7 %
Cobb County - GA	66.5 %	27.9 %	0.5 %	5.1 %	88.4 %	11.6 %	45.0 %	29.0 %	10.0 %
Coweta County - GA	78.2 %	19.3 %	0.4 %	2.1 %	93.8 %	6.2 %	46.7 %	30.8 %	11.8 %
DeKalb County - GA	36.6 %	57.5 %	0.6 %	5.4 %	91.8 %	8.2 %	44.0 %	29.4 %	10.7 %
Douglas County - GA	55.1 %	42.4 %	0.5 %	2.0 %	92.0 %	8.0 %	44.2 %	27.7 %	9.9 %
Fayette County - GA	73.2 %	21.7 %	0.4 %	4.7 %	93.7 %	6.3 %	56.4 %	39.0 %	14.8 %
Forsyth County - GA	88.8 %	3.5 %	0.5 %	7.1 %	91.0 %	9.0 %	46.0 %	27.3 %	10.1 %
Fulton County - GA	46.2 %	47.5 %	0.4 %	5.8 %	92.7 %	7.3 %	42.7 %	28.3 %	10.6 %
Gwinnett County - GA	60.8 %	26.8 %	0.9 %	11.4 %	81.0 %	19.0 %	42.1 %	25.5 %	8.1 %
Henry County - GA	56.2 %	39.8 %	0.4 %	3.6 %	94.2 %	5.8 %	44.4 %	27.1 %	9.5 %
Newton County - GA	55.0 %	43.4 %	0.3 %	1.2 %	95.5 %	4.5 %	44.6 %	29.0 %	11.3 %
Rockdale County - GA	48.3 %	49.1 %	0.4 %	2.2 %	91.5 %	8.5 %	48.1 %	32.3 %	12.2 %

Data are for 2011.

Data are in the percentage of women in the population.

Source: US Census Bureau – Population Estimates

Table 2.4b. 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 Underserved 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 %
Georgia	16.0 %	16.5 %	37.6 %	9.9 %	9.7 %	3.3 %	24.9 %	37.3 %	20.7 %
Komen Greater Atlanta Affiliate Service Area	11.5 %	13.3 %	31.7 %	10.0 %	15.1 %	4.8 %	5.1 %	17.8 %	20.6 %
Cherokee County - GA	11.0 %	7.7 %	24.4 %	7.3 %	8.5 %	2.7 %	17.1 %	12.3 %	18.1 %
Clayton County - GA	17.9 %	18.4 %	48.1 %	14.4 %	14.7 %	5.9 %	0.9 %	0.0 %	25.3 %
Cobb County - GA	9.5 %	11.3 %	26.2 %	8.5 %	15.2 %	4.0 %	0.2 %	0.0 %	18.2 %
Coweta County - GA	12.8 %	11.1 %	28.7 %	7.0 %	5.7 %	2.1 %	32.9 %	91.6 %	16.6 %
DeKalb County - GA	11.7 %	17.1 %	36.4 %	12.5 %	16.3 %	5.6 %	0.3 %	9.0 %	23.1 %
Douglas County - GA	13.7 %	12.7 %	34.1 %	12.3 %	8.6 %	2.3 %	15.8 %	0.0 %	20.0 %
Fayette County - GA	6.5 %	5.9 %	16.1 %	7.0 %	9.1 %	1.6 %	18.2 %	0.1 %	11.4 %
Forsyth County - GA	9.4 %	6.6 %	16.8 %	7.4 %	13.2 %	3.6 %	9.9 %	100.0 %	14.6 %
Fulton County - GA	9.9 %	15.9 %	34.8 %	9.8 %	12.8 %	3.8 %	1.1 %	13.0 %	22.1 %
Gwinnett County - GA	12.9 %	12.4 %	31.6 %	9.2 %	25.5 %	9.8 %	0.5 %	0.0 %	22.3 %
Henry County - GA	10.3 %	9.5 %	29.8 %	9.6 %	7.4 %	1.5 %	13.9 %	100.0 %	17.8 %
Newton County - GA	16.4 %	14.0 %	40.2 %	12.6 %	6.5 %	1.3 %	31.2 %	100.0 %	22.1 %
Rockdale County - GA	14.9 %	12.9 %	35.5 %	12.6 %	11.4 %	3.0 %	14.9 %	0.0 %	22.1 %

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.

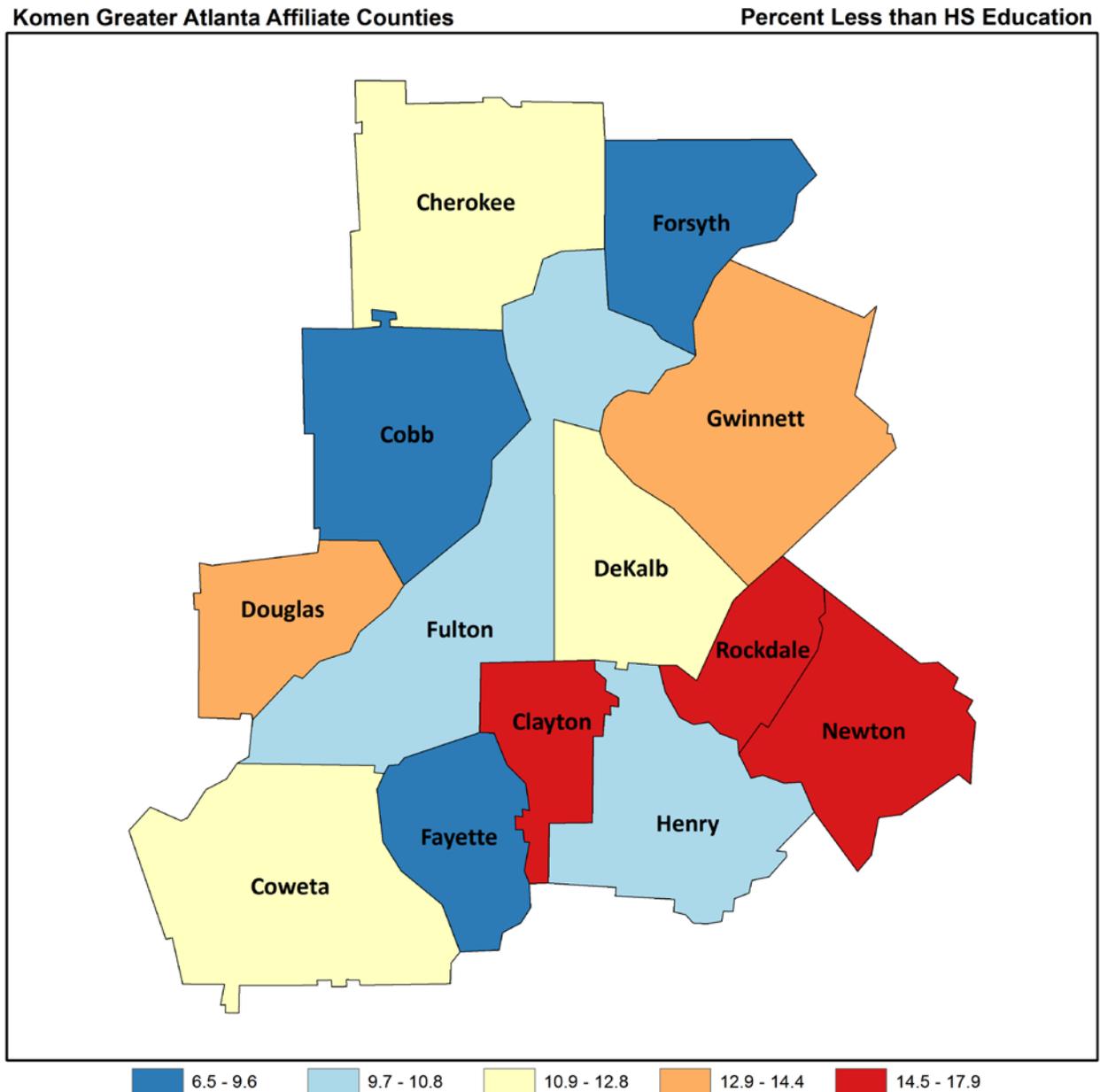
Source of medically underserved data: Health Resources and Services Administration (HRSA) for 2013.

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

Map of Education Level and Linguistic Isolation

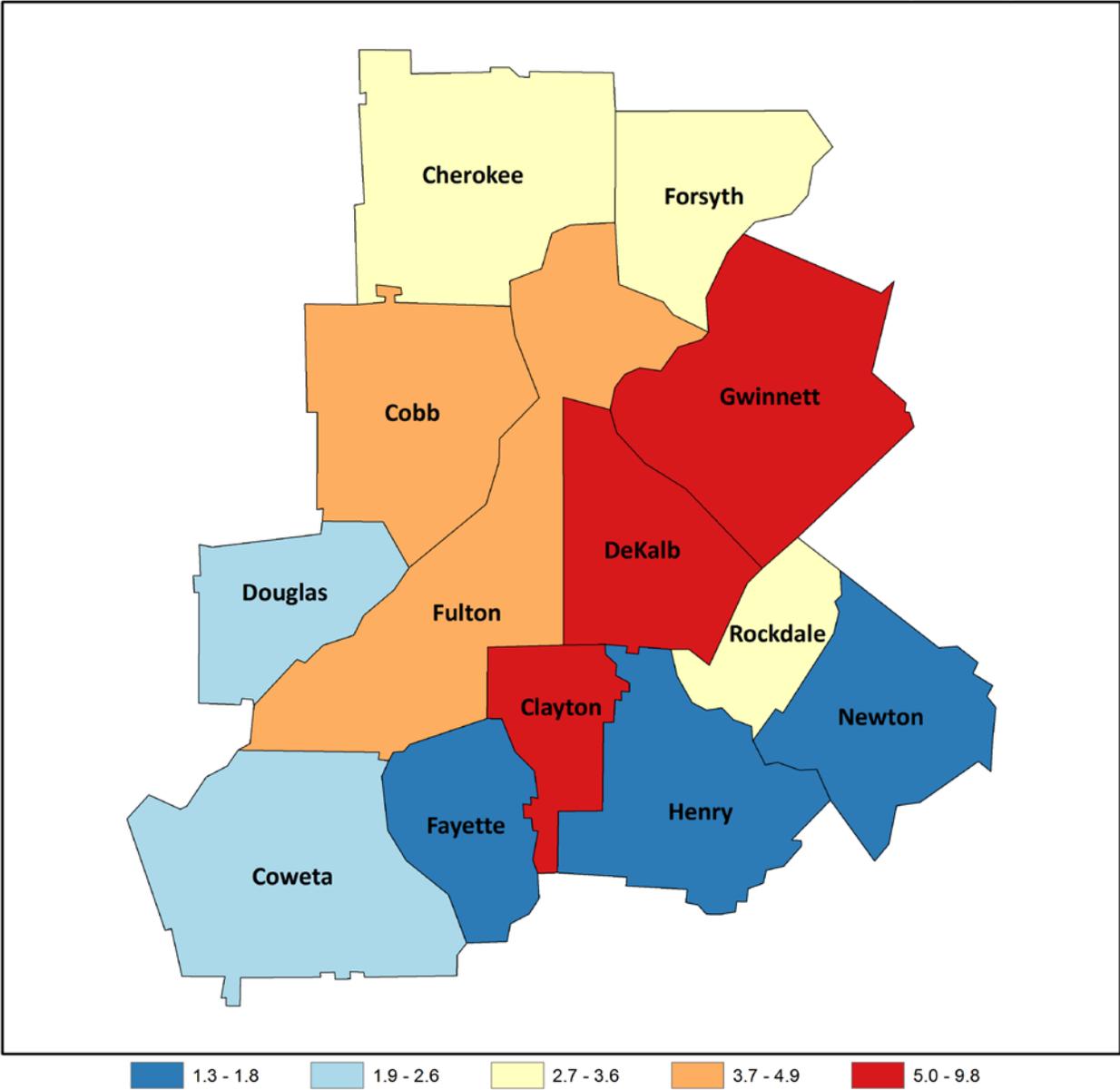
Figure 2.4a shows a map of the percent of people with less than a high school education for the counties in the Affiliate service area.

Figure 2.4b shows a map of the percent of people who are linguistically isolated (living in a household in which all the adults have difficulty with English) for the counties in the Affiliate service area.



Data are in the percentage of people (men and women) in the population.
Source: US Census Bureau – American Community Survey (ACS) for 2007-2011.

Figure 2.4a. Percent less than high school education.



Data are in the percentage of people (men and women) in the population.
Source: US Census Bureau – American Community Survey (ACS) for 2007-2011.

Figure 2.4b. Percent linguistically isolated.

Conclusions: Population Characteristics

Proportionately, the Komen Greater Atlanta Affiliate service area has a substantially smaller White female population than the US as a whole, a substantially larger Black female population, a slightly larger Asian and Pacific Islander (API) female population, a slightly smaller American Indian and Alaska Native (AIAN) female population, and a substantially smaller Hispanic/Latina female population. The Affiliate's female population is slightly younger than that of the US as a whole. The Affiliate's education level is slightly higher than and income level is slightly higher than those of the US as a whole. There are a slightly larger percentage of people who are unemployed in the Affiliate service area. The Affiliate service area has a slightly larger percentage of people who are foreign born and a slightly larger percentage of people who are linguistically isolated. There are a substantially smaller percentage of people living in rural areas, a slightly larger 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 female population percentages than that of the Affiliate service area as a whole:

- Clayton County
- DeKalb County
- Fulton County
- Newton County
- Rockdale County

The following county has a substantially larger API female population percentage than that of the Affiliate service area as a whole:

- Gwinnett County

The following county has a substantially larger Hispanic/Latina female population percentage than that of the Affiliate service area as a whole:

- Gwinnett County

The following county has a substantially lower education level than that of the Affiliate service area as a whole:

- Clayton County

The following county has a substantially lower income level than that of the Affiliate service area as a whole:

- Clayton County

The following county has a substantially lower employment level than that of the Affiliate service area as a whole:

- Clayton County

The county with a substantial foreign born and linguistically isolated population is:

- Gwinnett County

3. Priority Areas

3.1 Methods for Setting Priorities

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.

The 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]. 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

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 the Komen Greater Atlanta Affiliate service area are progressing toward this target, the 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. The section on **Incidence Rates** (Section 2.1) explains age adjustment.

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 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 “8 years,” because it’s 8 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.

For each county in the Affiliate service area, 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 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 priority 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 priority areas for breast cancer programs (i.e. the areas of greatest need).

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

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

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

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 3.1 shows how counties are assigned to priority categories.

Table 3.1. Needs/priority 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.

3.2 Healthy People 2020 Forecasts

Table 3.2a shows for individual counties and the Komen Greater Atlanta Affiliate service area as a whole:

- Predicted number of years needed to achieve the HP2020 breast cancer death rate target. The starting year is 2008 – the middle of the range of years for the initial death rate.
- Initial (2006-2010) death rate
- Annual percent change (2006-2010)

Table 3.2b shows:

- Predicted number of years needed to achieve the HP2020 breast cancer late-stage incidence target. The starting year is 2008 – the middle of the range of years for the initial late-stage incidence rate.
- Initial (2006-2010) late-stage incidence rate
- Annual percent change (2006-2010)

HP2020 forecasts are reported for the Affiliate service area as a whole as well as the individual counties. The forecasts can be different – counties with the largest populations will have the greatest influence on the Affiliate service area forecast.

The results presented in Tables 3.2a and 3.2b 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 these tables should be considered together with other information on factors that affect breast cancer death rates such as screening rates and key breast cancer death determinants such as poverty and linguistic isolation.

Table 3.2a. Predicted number of years needed to achieve HP2020 target for female breast cancer death rates.

Target is **20.6** deaths per 100,000.
Starting year is 2008 – the middle of the 2006-2010 range.

Geographic Area	Female Breast Cancer Death Rate		
	Base Rate for years 2006-2010	Trend (In Annual Percent Change for years 2006-2010)	Predicted # of Years Needed to Achieve Target
Komen Greater Atlanta Affiliate Service Area	24.4	NA	NA
Cherokee County - GA	21.7	-0.8%	7 years
Clayton County - GA	26.9	0.9%	13 years or longer
Cobb County - GA	22.3	-1.3%	7 years
Coweta County - GA	21.6	-3.3%	2 years
DeKalb County - GA	26.1	-1.2%	13 years or longer
Douglas County - GA	25.1	-0.6%	13 years or longer
Fayette County - GA	21.0	-2.4%	1 year
Forsyth County - GA	13.9	-2.3%	Currently meets target
Fulton County - GA	29.2	-1.1%	13 years or longer
Gwinnett County - GA	21.9	-2.0%	4 years
Henry County - GA	25.1	-0.9%	13 years or longer
Newton County - GA	27.6	-0.5%	13 years or longer
Rockdale County - GA	21.1	-2.3%	2 years

NA – data not available.

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

Data are for years 2006-2010.

Rates are in cases or deaths per 100,000.

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

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

Table 3.2b. Predicted number of years needed to achieve HP2020 target for female breast cancer late-stage incidence rates.

Target is **41.0** cases per 100,000.
Starting year is 2008 – the middle of the 2006-2010 range.

Geographic Area	Late-stage Female Breast Cancer Rate		
	Base Rate for years 2006-2010	Trend (In Annual Percent Change for years 2006-2010)	Predicted # of Years Needed to Achieve Target
Komen Greater Atlanta Affiliate Service Area	46.5	-0.5%	13 years or longer
Cherokee County - GA	39.9	7.9%	13 years or longer*
Clayton County - GA	46.1	3.0%	13 years or longer
Cobb County - GA	43.7	-4.7%	2 years
Coweta County - GA	46.4	-8.1%	2 years
DeKalb County - GA	51.8	0.2%	13 years or longer
Douglas County - GA	46.9	-5.9%	3 years
Fayette County - GA	42.6	3.2%	13 years or longer
Forsyth County - GA	39.3	-1.0%	Currently meets target
Fulton County - GA	49.6	-0.5%	13 years or longer
Gwinnett County - GA	46.1	2.5%	13 years or longer
Henry County - GA	45.6	5.1%	13 years or longer
Newton County - GA	40.6	-4.7%	Currently meets target
Rockdale County - GA	38.7	-9.8%	Currently meets target

* While this county currently meets the HP2020 target, because the trend is increasing it should be treated the same as a county that will not meet the HP2020 target.

NA – data not available.

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

Data are for years 2006-2010.

Rates are in cases or deaths per 100,000.

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

Source: NAACCR – CINA Deluxe Analytic File.

Conclusions: Healthy People 2020 Forecasts

Because death rate trend data are not available for the Komen Greater Atlanta Affiliate service area, it can't be predicted whether the Affiliate service area will meet the HP2020 target of 20.6 female breast cancer deaths per 100,000.

The following county **currently meets** the HP2020 breast cancer death rate target of 20.6:

- Forsyth 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:

- Clayton County
- DeKalb County
- Douglas County
- Fulton County
- Henry County
- Newton County

The remaining counties are likely to achieve the target by 2020 or earlier.

As shown in Table 3.2b, the Komen Greater Atlanta Affiliate service area as a whole is **likely to miss** the HP2020 late-stage incidence rate target. The Affiliate service area had a base rate of 46.5 new late-stage cases per 100,000 females per year from 2006 to 2010 (age-adjusted). This rate coupled with the recent late-stage incidence rate trend, indicates that the Komen Greater Atlanta Affiliate service area is likely to miss 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:

- Forsyth County
- Newton County
- Rockdale 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:

- Cherokee County
- Clayton County
- DeKalb County
- Fayette County
- Fulton County
- Gwinnett County
- Henry County

The remaining counties are likely to achieve the target by 2020 or earlier.

3.3 Needs Assessment and Priority Areas

Table 3.3 shows the priority levels for each county in the Komen Greater Atlanta Affiliate service area, determined as described in Section 3.1.

Table 3.3 also shows:

- Predicted number of years needed to achieve the HP2020 death rate and late-stage incidence targets
- Population characteristics from Tables 2.4a and 2.4b that are substantially different than the Affiliate service area as a whole (e.g. county has substantially lower education rate and is substantially more rural than Affiliate service area as a whole)

Table 3.3. Intervention priorities for Komen Greater Atlanta Affiliate service area with predicted time to achieve the HP2020 breast cancer targets and key population characteristics.

County	Priority	Predicted Time to Achieve Death Rate Target	Predicted Time to Achieve Late-stage Incidence Target	Key Population Characteristics
Clayton County - GA	Highest	13 years or longer	13 years or longer	%Black, education, poverty, employment
DeKalb County - GA	Highest	13 years or longer	13 years or longer	%Black
Fulton County - GA	Highest	13 years or longer	13 years or longer	%Black
Henry County - GA	Highest	13 years or longer	13 years or longer	Rural, medically underserved
Cherokee County - GA	High	7 years	13 years or longer	Rural
Douglas County - GA	Medium High	13 years or longer	3 years	Rural
Fayette County - GA	Medium High	1 year	13 years or longer	Rural
Gwinnett County - GA	Medium High	4 years	13 years or longer	%API, %Hispanic, foreign, language
Cobb County - GA	Medium	7 years	2 years	
Newton County - GA	Medium	13 years or longer	Currently meets target	%Black, rural, medically underserved
Coweta County - GA	Medium Low	2 years	2 years	Rural, medically underserved
Rockdale County - GA	Low	2 years	Currently meets target	%Black, rural
Forsyth County - GA	Lowest	Currently meets target	Currently meets target	Medically underserved

NA – data not available.

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

Map of Intervention Priority Areas

Figure 3.3 shows a map of the intervention priorities for the counties in the Affiliate service area. When both of the indicators used to establish a priority for a county are not available, the priority is shown as “undetermined” on the map.

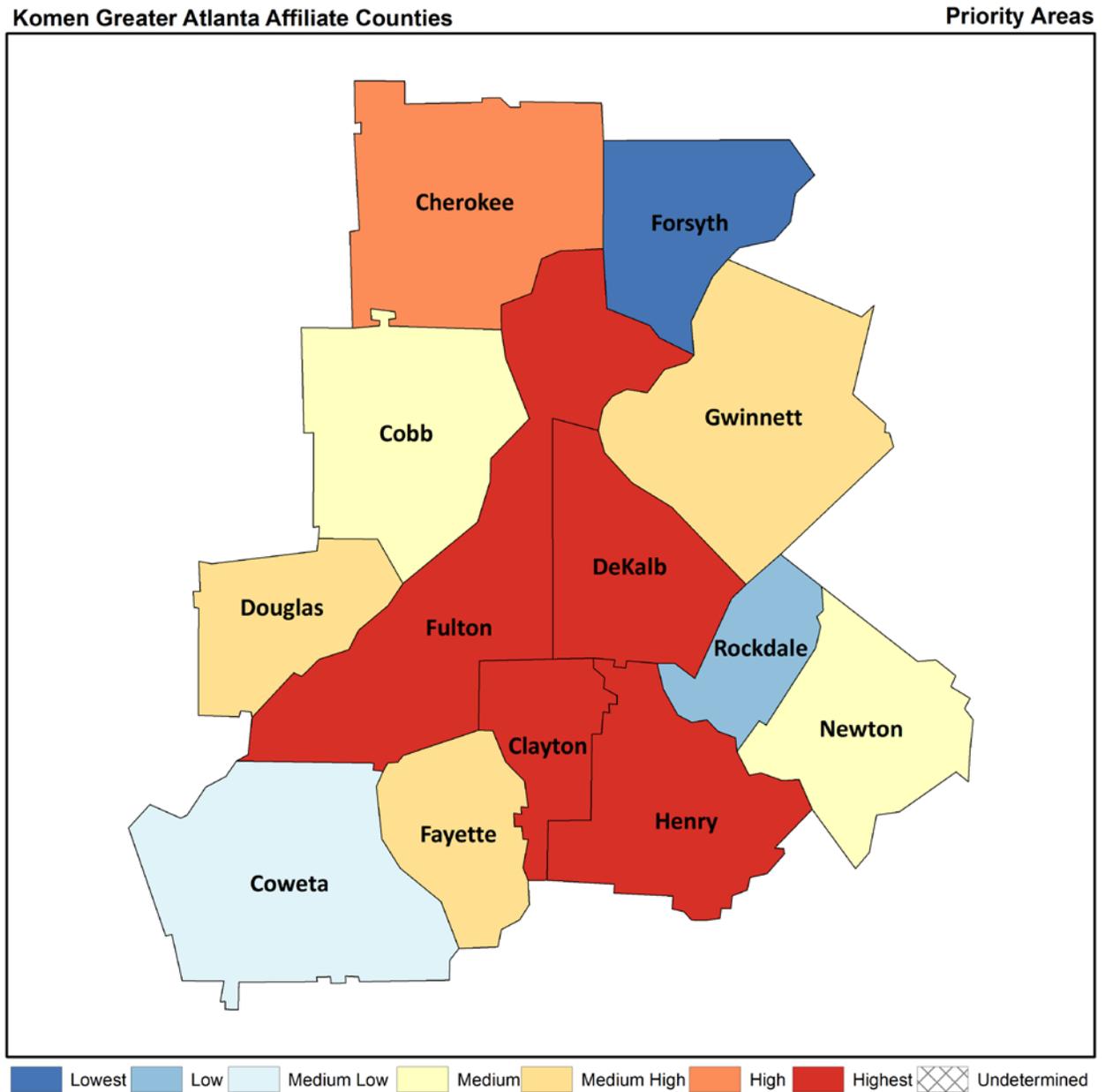


Figure 3.3. Intervention priorities.

Conclusions: Needs Assessment and Priority Areas

Table 3.3 shows that the counties classified as **highest** priority are:

- Clayton County
- DeKalb County
- Fulton County
- Henry County

The county classified as **high** priority is:

- Cherokee County

The counties classified as **medium high** priority are:

- Douglas County
- Fayette County
- Gwinnett County

The counties classified as **medium** priority are:

- Cobb County
- Newton County

4. Conclusions

Highest priority areas

Four counties in the Komen Greater Atlanta Affiliate service area are in the highest priority category. All of the four, Clayton County, DeKalb County, Fulton County and Henry County, are not likely to meet either the death rate or late-stage incidence rate HP2020 targets.

The death rates in Fulton County (29.2 per 100,000) are significantly higher than the Affiliate service area as a whole (24.4 per 100,000). The late-stage incidence rates in DeKalb County (51.8 per 100,000) are significantly higher than the Affiliate service area as a whole (46.5 per 100,000).

Clayton County has a relatively large Black population, low education levels, high poverty rates and high unemployment. DeKalb County has a relatively large Black population. Fulton County has a relatively large Black population.

High priority areas

One county in the Komen Greater Atlanta Affiliate service area is in the high priority category. Cherokee County is not likely to meet the late-stage incidence rate HP2020 target.

Incidence trends in Cherokee County (7.6% per year) are significantly less favorable than the Affiliate service area as a whole (0.0% per year).

Notes for program planning

Plans for breast cancer programs should be based mainly on observed breast cancer trends, in particular the trend of the HP2020 breast cancer death and late-stage targets. Plans could also consider additional breast cancer data such as late-stage proportion and screening rates as well as population characteristics such as poverty and linguistic isolation.

5. Summary of Data Sources

Table 5.1. Data sources and years.

Data Item	Source	Years
Incidence rates	North American Association of Central Cancer Registries (NAACCR) – Cancer in North America (CINA) Deluxe Analytic File	2006-2010
Incidence trends	NAACCR – CINA Deluxe Analytic File	2006-2010
Mortality rates	CDC – National Center for Health Statistics (NCHS) mortality data in SEER*Stat	2006-2010
Mortality trends	NCI/CDC – State Cancer Profiles	2006-2010
Late-stage diagnoses	NAACCR – CINA Deluxe Analytic File	2006-2010
Late-stage trends	NAACCR – CINA Deluxe Analytic File	2006-2010
Population denominators for calculating breast cancer incidence and death rates	Census Bureau – Population Estimates*	2011 release of counts for July 1 2006-2010
Mammography screening	CDC – Behavioral Risk Factor Surveillance System (BRFSS)	2012
Population counts by race/ethnicity and age	Census Bureau – Population Estimates*	2011 release of counts for July 1 2011
Socioeconomic indicators	Census Bureau – American Community Survey (ACS)	2007-2011
Rural population	Census Bureau – Census 2010	2010
Health insurance	Census Bureau – Small Area Health Insurance Estimates (SAHIE)	2011
Medically underserved areas	Health Resources and Services Administration (HRSA) – Medically Underserved Areas (MUAs)	2013

* Population estimates for bridged single-race estimates derived from the original multiple race categories provided by the Census Bureau to the National Cancer Institute. See <http://seer.cancer.gov/popdata/>.

6. Data Limitations

The quantitative data in the 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 rates 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.

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