Health Systems Analysis Data Sources:

Susan G. Komen Columbus conducted extensive investigation to identify breast health services located in the three target communities. A list was compiled of all potential health resources in each target community using the resources in Table 12.

Table 12. Resources for Health Systems Analysis

Continuum of Care Health System Resource Sources		**Quality of Care Certification/Accreditation Sources**
Resource Type	*Source*	*Source*
Mammography Centers	Food and Drug Administration Certified Mammography Facilities	American College of Surgeons Commission on Cancer
Hospitals	Medicare registered hospitals	American College of Radiology Centers of Excellence
Local Health Departments	National Association of County and City Health Officials	American College of Surgeons National Accreditation Program for Breast Centers (NAPBC)
Community Health Centers	Health Resources and Services Administration	National Cancer Institute Designated Cancer Centers
Free Clinics	National Association of Free and Charitable Clinics	

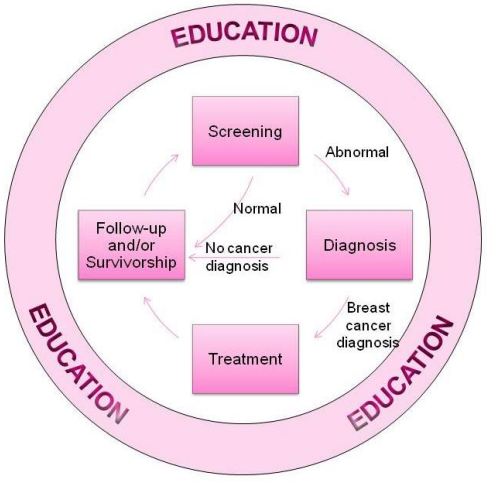
Source web links listed in Works Cited.

Online search engines were used to identify any additional community health centers, free clinics, hospitals, accredited breast care centers and local health departments and to verify updated contact information for each resource. Behavioral and mental health programs that were comprehensive in nature and may serve those affected by breast cancer were included as resources, as were Hospice and home care programs. The findings from this exhaustive search were compiled in an excel spreadsheet that was organized by target community. Using the diagram of the Continuum of Care (CoC), the findings for each target community were reviewed for potential gaps in services, and other barriers to access, in particular, geography.

Health Systems Overview

The Breast Cancer Continuum of Care (CoC) (Figure 3) 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.

Figure 3. Breast Cancer Continuum of Care (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.
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 3 to 6 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 it all means. Education can empower a woman and help manage anxiety and fear.

If breast cancer is diagnosed, she would proceed to treatment. 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. This piece of CoC is especially important as treatment continues to become more personalized.

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 progress through the CoC more quickly.

An analysis of the health system assets available in each Komen Columbus target community was conducted. This work gives insight into the strengths and weaknesses of the CoC within each target community. A few themes carry throughout all target communities. Mobile mammography units are only housed in Franklin County, though they are utilized throughout the service area. With the exception of Franklin County, despite the number of resources available, resources are almost always concentrated in one or two cities per county. The availability of patient navigation varies greatly between target communities. Beyond the question of where patient navigation is located, there is also a question of the quality and comprehensiveness of those services.

National projections for nursing and primary care shortages include Ohio and the service area. Nine Appalachian counties and Franklin County are Health Professional Shortage Areas. (Health Policy Institute of Ohio, 2012) The American Society of Clinical Oncology's report, "State of Cancer Care in America 2014", notes that the vast majority of oncology care providers

are concentrated in certain regions, particularly in urban areas. Nationally, only 3 percent of providers are based in rural areas, where 20 percent of Americans live. The Komen Columbus service area includes 22 rural counties.

Rural-Appalachian Target Community
The Rural-Appalachian target community includes six counties without a hospital that offers treatment services (Perry, Hocking, Morgan, Monroe, Vinton and Noble). Six counties are medically underserved and Guernsey, Meigs, Monroe, Morgan, Muskingum, Noble, Perry and Vinton are economically distressed. There are a few screening options, and have some diagnostic services available, but these services are usually concentrated in one town of the county. Free clinics and health departments are the main points of access in these communities, where quality may not be high due to the absence of accredited facilities. Treatment or reconstructions options are not available.

Counties without hospitals rely on hubs within the larger group of counties where accredited facilities are available with higher quality screening and diagnosis, and specialty services. For northern counties, the hubs are Zanesville in Muskingum County and Cambridge in Guernsey County, where larger, accredited hospitals are located. For the southern counties, these hubs are in Marietta in Washington County and Gallia County, which is outside the target community. This means education about available services and quality, transportation and navigation are critical in these areas. Health departments represent important partners in this effort, as they can operate as outreach arms that navigate women appropriately to the hubs. Mobile mammography is sometimes offered in these areas, but by units that are from hospitals in Franklin County. The availability of mobile mammography in the hubs of this community could make a large impact.

Marion County is located away from the rest of this target community but shares the same kinds of access issues. The rural county has a few quality screening and diagnostic sites, but patients may need to travel to Columbus for treatment, reconstruction or palliative care options.
The Affiliate has worked with Perry, Meigs, Vinton and Hocking County Health Departments. Partnerships could be improved with Cambridge-Guernsey, Zanesville-Muskingum, Noble, Morgan, Monroe, Washington, Marion County and City of Marietta Health Departments. The Affiliate could also strengthen its relationship with the Appalachian Community Cancer Network. There may also be an opportunity to work with local faith or civic organizations.
Within all of these counties, patient navigation is extremely rare, as are reconstruction and survivorship support options. Information about the services provided by these resources is difficult to find, and could be addressed with patient navigation. Patient navigation can also assist women who may experience transportation and other barriers while they must utilize many different providers for the various services they need.

Suburban Target Community
The Suburban area also lacks a locally-run mobile mammography unit. Clark, Delaware and Licking counties each have several screening and treatment options and at least one treatment and reconstruction option at accredited facilities that offer nearly comprehensive services. Free clinics also offer some screening and diagnostic services. Madison County has only one resource for all of these services- the local hospital. There are a few quality surgical options throughout this area, but almost no patient navigation services are available. Travel would be necessary for most survivorship services, including palliative care.

The Affiliate has worked with the Licking County Health Department in the past, but could build partnerships with Clark County Combined Health District, Delaware General Health District and

Madison County- London City Health Department. Partnerships are needed with the hospitals in each of these four counties to support patient navigation. There may also be an opportunity to work with local faith or civic organizations.

Metropolitan Target Community

Franklin County is saturated with hospital systems offering comprehensive services across the CoC. Four facilities offer mobile mammography throughout Franklin County and beyond into the majority of the Komen Columbus service area, including Suburban and Rural-Appalachian areas. Quality care is available at many different accredited providers, including an NCI-designated Comprehensive Cancer Center. Clinical trial access is much higher than elsewhere in the area. There is access to a large number of survivorship services, including at least three breast cancer-specific boutiques and at least ten palliative care facilities.

Patient navigation is available at all public, non-profit hospitals, where the majority of treatment may occur. However, patient navigation is not available at any private provider offices, where many diagnoses may occur.

Komen Columbus has not worked specifically with Columbus Public Health, which could help with access to minority communities, especially. Partnerships with the local faith communities are being built.

Local Hospitals' Community Health Needs Assessments

All available Community Health Needs Assessments for hospitals in the Komen Columbus service areas were evaluated in March 2014. Twenty-seven of the 38 hospital assessments listed breast cancer as a health priority. Seventy percent of hospitals in Central and Southeast Ohio recognize a need for increased breast cancer treatment and prevention. Komen Columbus is specifically mentioned in 15 of these assessments, either as a potential or existing partner/funder. Hospitals that name cancer as a health priority can be seen in Table 13, listed by county.

Table 13. Priorities of Community Hospital Needs Assessments in Service Area by County

County	Hospital	CHNA lists cancer as priority	Current partner or grantee	Target community
Athens Co	OhioHealth O'Bleness Hospital	✓	✓	
	Doctors Hospital of Nelsonville	✓	✓	
Champaign Co	Mercy Memorial Hospital-Urbana			
Clark Co	Springfield Regional Medical Center		✓	✓
Delaware Co	Grady Memorial-Ohio Hlth		✓	
Fairfield Co	Fairfield Medical Center-Lancaster	✓	✓	
	Diley Ridge Medical Center-Pickerington	✓		
Fayette Co	Fayette Co Memorial Hospital-Washington C.H.		✓	
Franklin Co	Dublin Methodist Hospital (OhioHealth)	✓	✓	✓
	Doctors Hospital West (OhioHealth)	✓	✓	✓
	Grant Hospital (OhioHealth)	✓	✓	✓
	Riverside Methodist Hospital (OhioHealth)	✓	✓	✓

	Mount Carmel East	✓	✓	✓
	Mount Carmel West	✓	✓	✓
	Mt. Carmel St. Ann's	✓	✓	✓
	Mt. Carmel Grove City	✓	✓	✓
	Mt. Carmel New Albany	✓	✓	✓
	The Ohio State University Wexner Medical Center	✓	✓	✓
	The Ohio State University Hospitals East	✓	✓	✓
Gallia Co	Holzer Medical Center-Gallipolis		✓	
Guernsey Co	Southeastern Ohio Regional Medical Center-Cambridge	✓	✓	✓
Hocking Co	Hocking Valley Community Hospital			✓
Jackson Co	Holzer Medical Center - Jackson	✓	✓	
Knox Co	Knox Community Hospital	✓	✓	
Licking Co	Licking Memorial Hospital-Newark	✓		✓
Madison Co	Madison County Hospital	✓	✓	✓
Marion Co	Marion General-Ohio Hlth			✓
Morrow Co	Morrow Co Hospital- Mt Gilead	✓		
Muskingum Co	Genesis Bethesda Hospital	✓	✓	✓
	Genesis Good Samaritan Hospital	✓	✓	✓
Pickaway Co	Berger Health System	✓		
Pike Co	Pike Community Hospital-Waverly			
Ross Co	Adena Regional Medical Center-Chillicothe		✓	
Scioto Co	Southern Ohio Medical Center	✓	✓	
Union Co	Memorial Hospital-Marysville	✓	✓	
Washington Co	Marietta Memorial Hospital		✓	✓

CHNA sources listed in Works Cited. Target Community key: Rural or Appalachian, green. Suburban, orange, Metropolitan, blue.

Table 13 identifies current partners and hospitals in target communities. Komen Columbus currently has a partnership with every hospital in the target communities, except Licking Memorial Hospital in Newark, Ohio. Historically, Komen Columbus has partnered with the Licking County Health Department (also the seat of the Region 6 BCCP program), which refers patients to Licking Memorial Hospital.

Outside of the target communities, there are several hospitals that are not current partners, including Berger Health System (a past grantee), Morrow County Hospital, Pike Community Hospital, and Diley Ridge Medical Center. Ensuring that these providers are aware of nearby resources could be an area for improvement.

Partnerships with health departments are essential, especially those the Affiliate has not worked with previously. Health departments should be considered in the mission plan and be made aware of the resources offered so that the Affiliate may effectively support their outreach, education and referral efforts. Health departments are also excellent connecting partners for mobile mammography. The need is also great for more mobile mammography opportunities, especially in the Rural-Appalachian communities.

Transportation needs for the Metropolitan target community differ from the transportation needs of Suburban and Rural or Appalachian communities. Non-traditional partners may be necessary

to address these needs, including cab companies, the Red Cross, local public transportation and other groups. Addressing patient assistance needs for medication assistance or medical supplies, groceries, child care and housing needs will also require partners outside of the health system. An ideal partner would be a nonprofit that could work with these various non-traditional partners to deliver both transportation and patient assistance services throughout the target communities.

Public Policy Overview

Ohio Breast and Cervical Cancer Project

Ohio's Breast and Cervical Cancer Project (BCCP) provides breast and cervical cancer screening and diagnostic services to women in Ohio who do not qualify for Medicaid, between 100 percent and 200 percent of the Federal Poverty Level (FPL). This is a critical and lifesaving safety net for the working poor in our state. In Ohio, these are the same women who earn too much income in order to qualify for Medicaid, but not enough qualify for tax credits in the state insurance marketplace. Without BCCP, they would not have affordable access to these services.

Women can self-refer to BCCP by contacting the appropriate regional enrollment agency. Many providers have been educated about this resource and will also refer women to the program. The Komen Columbus service area includes counties covered by BCCP regions 2, 5, 6, 7 and 8 (Ohio Department of Health, 2012). Enrollment contacts are listed in Table 12. In addition to being at or below 200 percent FPL, women must be uninsured and be 40 years or older for Pap tests and clinical breast exams or be 50 years or older to receive mammograms. Women who are 40-49 may receive a mammogram if indicated by clinical breast exam or if they are considered high-risk. In 2014, Ohio BCCP adopted revisions from Centers for Disease Control to include coverage for MRI for high-risk individuals.

Table 14. BCCP regions and points of contact

BCCP Region	Counties	Point of contact to enroll
2	Clark, Champaign	Breast and Cervical Cancer Project, University of Cincinnati;1-888-727-6266
5	Marion, Morrow, Knox	Breast & Cervical Health Screening Project, Mansfield Ontario Richland County Health Department;1-800-655-4707
6	Union, Delaware, Madison, Fayette, Pickaway, Franklin, Licking, Fairfield	Breast and Cervical Cancer Project, Licking County Health Department; 1-866-418-4963
7	Ross, Pike, Scioto, Jackson, Vinton, Gallia, Lawrence	Southern Ohio Women's Cancer Project, Ross County Health District; 1-800-944-2232
8	Perry, Hocking, Athens, Meigs, Morgan, Muskingum, Guernsey, Noble, Monroe, Washington	Southeastern Ohio Breast & Cervical Cancer Project, Noble County Health Department; 1-800-236-6253

(Ohio Department of Health, 2012)

Komen Columbus grant programs are educated to screen patients for Medicaid or Ohio Hospital Care Assistance Program (HCAP) eligibility as the first safety net, screen for BCCP eligibility as the second safety net, and utilize Komen funds for those who fall through the cracks as a third safety net. Women diagnosed through BCCP have historically been enrolled in BCCP Medicaid for their treatment and this keeps women in the continuum of care. Since Medicaid was expanded in Ohio to 138 percent FPL, women who are eligible for BCCP at 138-200 percent FPL are not Medicaid eligible and may be eligible to purchase insurance with tax credits from

the state insurance marketplace. Currently, these women are still being enrolled in BCCP Medicaid, but Komen is working with BCCP to be aware of any potential changes to this policy in the future. Changes could result in uninsured women being screened and diagnosed through BCCP, but then having no affordable treatment options.

State funding to BCCP was reduced from $5 million in general revenue funds in FY 08/09 to only $1.6 million in FY 12/13 – a cut of almost 70 percent. The budget for FY 13/14 maintained steady funding levels, though healthcare costs increased, resulting in fewer women served. According to estimates BCCP provided to Komen Columbus, in 2012, 164,665 women were eligible for BCCP services in Ohio (McMahon, J, personal communication, July 23, 2014). In that same year, BCCP provided 12,756 screenings, serving approximately 8 percent of the eligible population. In 2013, Ohio BCCP served 10,808 women (eligibility estimates were not available for 2013). Throughout 2013, due to limited funds, BCCP was no longer able to accept new screening patients. In 2013, new patients were only able to access the program if an abnormality or symptoms were present.

Komen Columbus works to educate providers about BCCP as a resource for referral, and to promote the program to local women who need linked to screening services. The Affiliate also communicates with BCCP throughout the year about funding levels, the status of resources available (i.e. accepting new patients), and progress on providing services and detecting cancers. This information is communicated to legislators and advocates for adequate funding for the program, for example, at Lobby Day. A new tax check-off option will bring additional funds to the program in FY 15. Komen Columbus will maintain its current relationship with BCCP to address any emerging issues.

Alignment with Coalitions and Statewide Plans

State Comprehensive Cancer Control Coalition

The Ohio Partners for Cancer Control is a statewide consortium dedicated to reducing the cancer burden in Ohio. The group consists of member organizations representing comprehensive cancer needs across the state. Two of 14 objectives in the Ohio Comprehensive Cancer Control Plan directly address breast cancer issues. Objective 8.1 to “increase the proportion of women aged 40 years and older who have had a mammogram within the past two years” seeks to increase the screening proportions from a baseline of 60 percent to a goal of 66 percent. Strategies to accomplish this include advocating for increased funding for programs that support free and low-cost mammography for women with no or limited health insurance and improving age-appropriate screening among members of large health plans and employers to impact breast cancer screening. Susan G. Komen Columbus is named under Responsible Parties/Partners and has been an active partner in these strategies under Objective 8.1.

Objective 9.1 is to “provide 175 educational talks to Ohio healthcare professionals annually (about the established referral guidelines (NCCN, ACOG, NSGC) for cancer risk assessment)". This objective involves encouraging healthcare degree-granting programs in Ohio to integrate education about cancer genetics into their curriculum. These actions have not been initiated to date, though Komen Columbus has made attempts at provider education throughout the years.

Several other objectives in the plan apply to a general wellness and prevention approach for all forms of cancer. These include objectives to increase the accuracy of cancer data reporting, emphasize physical activity and fruits and vegetables consumption, and support of worksite policies for breast feeding mothers. Although these objectives were targeted to reduce obesity, the outcomes will also reduce one’s risk for breast cancer.

Goals 10, 11, 12, and 13 target the treatment/survivorship/palliative care of cancer survivors. These goals and their respective objectives and strategies can be applied to individuals with all forms of cancer, including breast cancer survivors served by Komen Columbus. Goal 14 focuses on advocacy/communication. By increasing interest in cancer surveillance, prevention, and control activities, Ohio legislators and organizational policy makers will be motivated to influence policy and system changes. This goal, again, targets all cancers.

To date, these objectives have not been adequately measured for progress. That will be an emphasis moving forward. The current plan will end in 2014 and discussion of the new plan began in summer 2014. Komen is an active participant in OPCC quarterly meetings, and is a member of the Early Detection and Prevention Subcommittee. The Affiliate has been active in encouraging more measurement and with an effort to collect information from partner organizations throughout the state on the actions they have taken to meet the objectives of the plan.

Komen Columbus will continue to engage with OPCC via quarterly meetings and monthly subcommittees meetings of the prevention and early detection and policy subcommittees when appropriate. The Affiliate plans to be very involved in the writing of the next OPCC plan, to advocate specifically for evidence-based strategies and measurable objectives, to assist in implementing a plan for ongoing evaluation of progress, and to represent the needs of breast cancer patients.

State Health Improvement Plan

The Ohio Department of Health convened stakeholders to complete a State Health Assessment and then to create Ohio's State Health Improvement Plan (SHIP). The Plan includes an objective to increase the percent of breast cancer diagnosed at early-stage (ages 50-74) by 5 percent, increase screening utilization. Strategies employed include creating partnerships with health systems and educating primary care physicians. Another objective is to increase the use of Community Health Workers (CHWs) by educating providers on how to utilize the community health worker model and providing culturally appropriate tools and resources for CHWs that address screening, tobacco cessation, nutrition and physical activity. Other aspects of the plan focus on access to care with the objective to move towards patient-centered care, disseminate information and education for minority groups, and strengthen the safety net system.

Komen Columbus engaged in the review process of the SHIP as a community partner and will continue to participate in the writing of the next plan, specifically as a member of the Chronic Disease Workgroup.

Ohio's Plan to Prevent and Reduce Chronic Disease

After the Department of Health and stakeholders completed work on the SHIP, the Chronic Disease Workgroup from the State Health Improvement Plan process developed a more specific plan to address chronic disease. This plan includes built-environment approaches to increase physical activity and nutrition and to decrease obesity prevalence. Specifically for breast health, Objective 2.2 aims to increase age-appropriate screening for breast cancers, from a baseline of 78.2 percent to a 5-year outcome of 82.1 percent (as measured and reported by the Behavioral Risk Factor Surveillance System). Strategies include: partnerships with health systems and providers, provider education, and targeted awareness campaigns in high-need communities. Objective 3.3 aims to use the CHW model to address disease prevention and management through the following strategies: assessing the current state of the CHW model and available resources, linking CHWs into existing provider models, training CHWs in disease prevention and control, expanding models for reimbursement, and developing and piloting

models to integrate CHWs with public health models to develop community teams to improve disease management and risk factors.

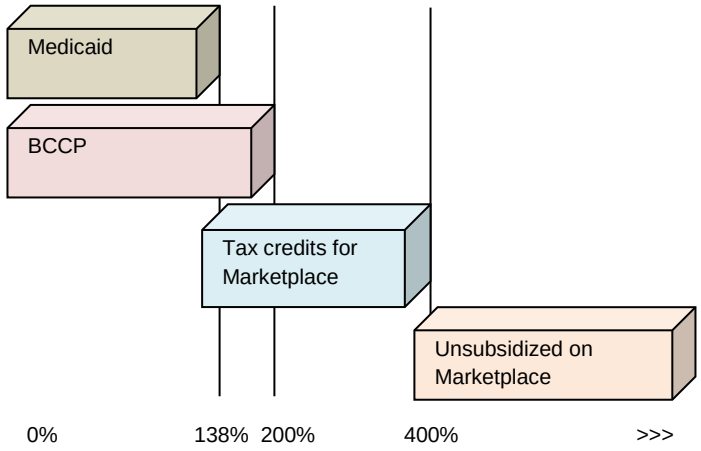
Komen Columbus is an official objective partner on Objective 2.2 and can participate in the plan through its programming and through role as a funder.

Affordable Care Act

The 2010 Affordable Care Act (ACA) aimed to expand access to care through insurance coverage, enhance the quality of care and make health care more affordable. To expand access to insurance coverage, the law included an insurance mandate requiring all individuals to have insurance, and expanded access to insurance by expanding Medicaid and establishing state insurance marketplaces, where individuals could purchase insurance with financial assistance.

The Ohio legislature expanded access to Medicaid from 100 percent FPL to 138 percent FPL. Ohio opted to implement a federally run insurance marketplace as opposed to operating its own state-run exchange Under the ACA, people with incomes between 138 percent and 400 percent FPL may be eligible for sliding scale tax credits when purchasing insurance on the Ohio Health Insurance Marketplace, established by ACA. As a result of Ohio's federally run exchange, many people who tried to obtain insurance in the winter and spring of 2014 (open enrollment) through the state insurance marketplace website (Healthcare.gov) encountered technical glitches experienced nationwide. An extension was offered so that these individuals could still enroll and satisfy the ACA's insurance mandate. Ohio's utilization of the federally run exchange also involves some enrollees in the pending court issues regarding the legality of tax credits.

Figure 4. Income eligibility levels for Medicaid, BCCP services, and Ohio Health Insurance Marketplace Tax Credits in Ohio



Because of the expanded eligibility shown in Figure 4, it is estimated that the number of uninsured will continue to decline (Health Policy Institute of Ohio, 2012). The number of Ohioans who gained access to insurance through either Medicaid expansion or Ohio's Health Insurance Marketplace are listed in Table 15. Those who remain uninsured may include the following groups:

- Individuals eligible for Medicaid but not enrolled
- Undocumented immigrants
- Those exempt from the individual mandate
- Individuals eligible for subsidized coverage but not enrolled
- Other uninsured adults who have an affordable private option, but do not qualify for a subsidy and voluntarily remain uninsured despite the mandate.

Projections estimate that 157,218 men and women, ages 19-64, were newly eligible for Medicaid in the service area alone, (734,000 in all Ohio) once Medicaid was expanded to 138 percent FPL. Actual numbers of newly eligible individuals that enrolled in Medicaid are not available. Healthcare.gov reports that 84,262 Ohio women enrolled in a marketplace plan and that 84 percent of those women were ages 35-64. Table 15 lists projections and actual

enrollment numbers under expanded Medicaid and the Marketplace, to give an idea of the number of previously uninsured people in Ohio and the Komen Columbus service area who now have insurance.

Table 15. Estimates of ACA's impact on Ohio's uninsured

Target Community	Uninsured in 2012 (prior to insurance mandate)	Projected new 19-64 year olds covered due to Medicaid Expansion	Eligible for tax credits for Ohio Health Insurance Marketplace	Actual Insured through Ohio Health Insurance Marketplace
Service Area	175,081	157,218	Data unavailable	Data unavailable
Ohio	1,460,000	734,000	385,000	154,668

Note: The actual numbers of additional enrollees through Medicaid Expansion is not known publicly at this time. It is assumed that the actual number of additional insured will be significantly lower than the potential numbers, as many people do not know about the availability of resources or have chosen not to enroll in insurance. These projections include men and women, ages 19-64.
(The Kaiser Family Foundation, 2014) (Health Policy Institute of Ohio, 2013) (U.S. Census Bureau, 2008-2012)

Expanded coverage under Medicaid and access to the state insurance marketplace may have implications for BCCP in the future. We are aware that other states have moved away from funding BCCP programs, under the assumption that the insurance mandate and attempts towards affordability will erase the need for the BCCP safety net. In the future, if the changes made under ACA are successful, there is potential that the need for BCCP will diminish over time, and eventually, altogether. In fact, the Ohio Medicaid Expansion Study estimated Medicaid expansion alone could lead to $2 million in savings on BCCP alone by 2014 (Health Policy Institute of Ohio, 2013). However, changes have not been universally successful or adopted, and BCCP remains a critical piece of the safety net in Ohio.

In addition to expanded insurance and access, the ACA also requires insurance to cover preventive services, including mammograms and annual well-woman visits where CBE can be offered at no cost to the patient, coverage of standard of care treatment for those participating in clinical trials, risk-reduction medication for individuals at high-risk of breast cancer. The law prohibits lifetime caps on coverage, prohibits insurers from denying coverage based on pre-existing conditions, and establishes minimum benefit standards.

The implications of healthcare reform and ACA mean access to preventive care and higher demands on the health system. Adaptations are needed not only to mission priorities, but also to whom and how the Affiliate makes grants. Two specific examples include a shift towards diagnostics and patient navigation, and adapting relationships with Local Health Departments. Many current grantees are reporting less need for the free and low-cost mammography being offered by their grant programs. Though many individuals have gained access to screening and primary care with no cost sharing, when abnormalities require further testing, diagnostic testing is often subject to high deductibles and no cost sharing. Even before the ACA, 23 percent of polled Ohioans reported the largest amount of their unpaid medical debt was a result of tests and diagnostic procedures (Health Policy Institute of Ohio, 2012). That number can only be expected to increase, as preventive visits become more universally covered. This is an issue that will be explored further through qualitative methods.

The ACA has implications for the funding of Local Health Departments (LHDs), which are often important partners and grantees of Komen Columbus. Most LHDs do not offer clinical breast exams or mammography. Historically, their efforts have been focused on education, and sometimes, LHDs have requested funding to provide mammograms through third parties or

other Komen grantees. This practice has declined as the Affiliate restructured its funding rules to emphasize LHDs as a resource for education and referral to existing programs, to best utilize resources, however, more work is needed. It is important to understand the structure and funding sources of LHDs, in order to build granting guidelines that are shaped to empower LHDs to be effective and impactful in breast health. Many LHDs are moving towards cost and resource sharing models with each other, especially for salary and benefits. Staff time is usually very valuable and devoted to many projects, often across various grant projects. Funding is mostly from local non-profit grants, local general revenue and public health levies. The ACA also mandated LHDs to participate in accreditation, which includes developing community needs assessments and health improvement plans. This will be an extra burden for LHDs financially and logistically. Finally, LHDs may represent an important resource for the community to learn about and be referred to Medicaid or state insurance exchanges.

Finally, though expanded access has been achieved by offering more affordable insurance coverage to new audiences, not all who have experienced increased access opportunity have utilized it by enrolling in insurance or utilizing care. In particular, the “working poor”, or those above 138 percent FPL who are not Medicaid eligible, may find it difficult to afford insurance through the state exchange, and many remain uninsured. Undocumented individuals also represent an important gap that is widely left out of any safety net coverage. Balancing those remaining needs and targeting these more specific gaps with early detection programming must be balanced with the need to shift toward later points of the continuum of care, like diagnostics and patient navigation.

Affiliate’s Public Policy Activities

Komen Columbus collaborates with the other three Ohio Affiliates on all possible advocacy work, communicating via monthly calls as appropriate. In 2013, the Ohio Affiliates moved Ohio Lobby Day from the spring, to October, Breast Cancer Awareness Month, in an attempt to best leverage the political attention paid to breast issues during that time. Each Affiliate schedules and meets with representatives from their area, delivering resources and discussing pending state issues, and advocating for BCCP.

From 2013-2014, the Ohio Affiliates achieved passage of oral anti-cancer drug parity legislation, expansion of Medicaid coverage in Ohio, protected state funding for BCCP and achieved passage of a tax check-off option to add additional funding to BCCP. After years of work, Governor John Kasich signed into law the Oral Chemotherapy bill (SB99) on June 17th, 2014. This means that patients who are prescribed an orally administered cancer medication will receive as much coverage by their insurance as they would for IV administered cancer medications. This bill is important because more than a quarter of the anti-cancer drugs in the research pipeline today are intended as oral drugs. Unfortunately, insurance practices have not kept up with advancements in science. Now, SB99 allows patients and their doctors to review the best possible treatment options based on what is best for the patient- not a price tag of treatment. The bill will go into effect January 1, 2015.

Coalition work, efforts to bring media attention through letters to the editor and media pitches, and activating the grassroots network with e-alerts to the Komen Advocacy Alliance have been effective tools in local advocacy work .For example, more than 385 Komen Advocacy Alliance supporters helped in the passage of SB99 (oral parity) in 2014 by writing letters to their House or Senate representatives through our e-alerts.

Komen Columbus participated in advocacy for Medicaid expansion, which was successfully achieved in the fall of 2013, through work with several coalitions and leveraging the Komen Advocacy Alliance (KAA) e-alerts in the area to write legislators.

The Ohio Affiliates were proud to support House Bill (HB) 112, which will allow Ohio taxpayers to contribute a portion of their tax refund to the Ohio Breast and Cervical Cancer Project (BCCP). The bill was signed into law July 11, 2013 and contributions can be made for the tax year beginning January 1, 2014. The BCCP Tax Check-Off will enable the program to serve up to 1,700 additional women (approximately an 11 percent increase) with lifesaving and cost saving access to early detection and diagnostics.

Komen Columbus has a public policy committee, which follow the priorities set out by Komen HQ's public policy model. The committee and Director of Mission will utilize the state toolkit for guidance and resources in working towards the state priorities set out by HQ.
Of the priorities in the 2014 priorities, the only state issue that remains is to continue advocating for BCCP funding in the FY16/17 biennial budget, and to promote the tax-check-off option in the 2015 tax season to maximize funding to the program. Other upcoming or pending legislation in Ohio that affects breast health includes S.B. 54 requiring physicians interpreting a mammogram who determines that the patient has dense breast tissue to specify this in the mammography report sent to the patient. As this bill is not currently endorsed as a Komen policy priority at the state level, its' progress will be monitored. Implications of ACA and any new legislation will also be monitored. We will look to summarize current law and educate women on the laws that affect their insurance coverage and treatment rights. A summary of Ohio Breast Health Laws is included in Appendix A.

Health Systems and Public Policy Analysis Findings

There are many changes occurring in healthcare, many of which are important to the context of community breast health and the work of Susan G. Komen Columbus. Rising demand, an aging population, rising costs, growing acceptance of prevention, ever-changing information technology, projected shortages of healthcare professionals, and a shift towards inter-professional team based, patient-centered care all play a role and have been drivers of reform of the U.S. healthcare system.

New models of healthcare delivery are emerging and will continue to do so as a result of these factors driving healthcare reform. Healthcare is shifting in general toward an approach that emphasizes wellness overall (not just breast health). This shift includes growing emphasis on interdependent, integrative care models-- an area in which patient navigation is especially important. These factors should be considered not only in the content and priorities of grants and programs, but also in the review and awards process.

In the context of such shortages, increase in demand, a shift toward overall wellness and prevention, and improving access to care, the American Hospital Association's Primary Care Delivery Model report emphasizes the emerging priorities for primary health care delivery, including: communication, patient and family centered decision making and care planning, accessible care that meets the patient where the patient is ((i.e. after-hours visits, online communication tools such as patient portal sites, email addresses of health care providers, etc.), and an evidence-based, outcomes-oriented safety and quality improvement culture that is supported by meaningful measurement. These points are important for an understanding of where and how to educate women about entry into screening and the continuum of care. These factors should be considered in the priorities, process and partnerships of Affiliate grants and

programs. There may be a new opportunity to assist patients with education throughout the continuum of care, beyond screening, with patient navigation.

Specifically, gaps are present within the target communities of the service area. Rural-Appalachian counties have fewer specialists and access screening and diagnostics mostly through clinics and health departments. Often, these services are of lower quality. Treatment, reconstruction, survivorship and palliative services are available at hubs where hospitals are located, which means transportation and patient navigation to quality resources is necessary. Suburban counties have slightly better access to quality CoC services, though for survivorship, palliative and reconstruction needs, may also need to travel. The Metropolitan area serves as a large hub to all other areas of the service area, where many comprehensive and high quality services are available. However, education about these resources may be lacking and this area may face different, urban transportation barriers.

Whether or not patient navigation is available in each target community, its quality is unknown, and should be investigated further. As most resources throughout the service areas' counties tend to be concentrated, transportation also remains a critical piece of the CoC.
Several potential partners may be important to addressing these gaps. Hospitals' Community Health Needs Assessments demonstrate that the target communities share concern about breast cancer in their communities. These hospitals will be important partners as the central providers in those areas. Redefining the role of LHDs in the grant programs is important, and new relationships must be created with several LHDs in the target communities.

The actual quality of cancer care presents an aspect of Komen's mission that has been largely unaddressed through reform, and may vary greatly even in areas with plenty of resources. More information is needed through qualitative data regarding the dissemination of research and quality of the care which so many have gained access to recently. For example, survivorship care plans, patient navigation and the personalization of treatments are all excellent tools that increase quality of care, but may not be of equal quality or available to much of the service area, even when a hospital or other resource is present. The American Hospital Association, American Society of Clinical Oncology and Institute of Medicine have published recommendations that may guide the role Komen Columbus can play to improve access to and quality of care, which will be discussed in the Mission Action Plan.

The impact of public policy on breast health care can be substantial, which is demonstrated by the recent improvements in access to primary care and screening. The Affiliate has discovered that the grassroots approach to state policy issues through storytelling and use of KAA e-alerts is the most effective and efficient approach to local public policy work. Komen Columbus has been successful working within the Public Policy priorities established, and will continue to focus on advocacy priorities within the Public Policy Model, with a focus on state issues. In the future, grassroots resources will be leveraged over direct lobbying.

More can be learned about the impact of healthcare reform and resulting needs of hospitals, LHDs and providers through qualitative data collection. Information is needed on the quality and consistency of patient navigation throughout the service area. Komen Columbus grantees may also provide valuable information about the impact of ACA on the demand for screenings and diagnostics and other types of services. Need may increase for diagnostics, personalized treatment, education, transportation, patient assistance and survivorship needs.

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To be included in an Appendix A:

Appendix A

Summary of Ohio Breast Health Laws

Ohio Revised Code Section	Summary
Awareness days	
5.2213	Designates October as "Ohio Breast Cancer Awareness Month," with the third Thursday in October specifically designated as "Ohio Mammography Day".
5.2291	Designates the 13th day of October as "Metastatic Breast Cancer Awareness Day".
Screening coverage	
1751.62	Requires every individual or group health insuring corporation policy that provides basic health care services in Ohio to provide benefits to cover the expense of a screening mammography to detect the presence of breast cancer in adult women. (This does not include diagnostic mammography)
3923.52	Requires every policy of individual or group sickness and accident insurance in Ohio to provide benefits to cover the expense of a screening mammography to detect the presence of breast cancer in adult women.
3923.53	Requires every public employee benefit plan in Ohio to provide benefits to cover the expense of a screening mammography to detect the presence of breast cancer in adult women.
5164.08	Requires Medicaid to provide benefits to cover the expense of a screening mammography to detect the presence of breast cancer in adult women.
Treatment coverage	
3923.80	Prohibits a health benefit plan or public employee benefit plan from denying coverage for the costs of care provided to an insured participating in an eligible cancer clinical trial if the care would be covered under the plan if the insured was not participating in the clinical trial
5163.06	Requires Medicaid to cover certain low-income women in need of treatment for breast cancer as specified in the federal Social Security Act
1739.05 and 5162.20	Prohibits health insurance provided by certain insurers from providing less favorable coverage for orally administered cancer medication than for intravenously administered or injected cancer medications.
4729.43	Prohibits pharmacists from dispensing certain

	non-self-injectable cancer drugs by delivering them or causing them to be delivered directly to the patient, the patient's representative, or the patient's private residence.
Grants and funds	
3701.046	Authorizes the Director of Health to make grants for women's health services from funds appropriated for that purpose by the General Assembly, including for breast examinations and patient education on breast cancer.
3701.601 and 5747.113	Creates the Breast and Cervical Cancer Project Income Tax Contribution Fund in the state treasury. Funds are to be distributed to the Breast and Cervical Cancer Project to be used specifically to provide breast and cervical cancer screening, diagnostic, and outreach services to uninsured and underinsured women. The funds must first be used to pay for services provided directly by personnel of local departments of health, federally qualified health centers, or other community health centers. Permits a taxpayer to designate on the taxpayer's income tax return an amount the taxpayer wishes to contribute to the Breast and Cervical Cancer Project Income Tax Contribution Fund and requires the Tax Commissioner to deposit funds so designated.
4501.21 and 4503.491	Permits persons to apply to the Registrar of Motor Vehicles for "Breast Cancer Awareness" license plates. The license plates must be inscribed with words or markings that promote breast cancer awareness. Directs the Registrar to pay contributions received from "Breast Cancer Awareness" license plates to the Breast Cancer Fund of Ohio, which uses the money to pay for programs that provide assistance and education to Ohio breast cancer patients and that improve access for such patients to quality health care and clinical trials.
Professional regulation and research	
3701.261, 3701.262, and 3701.264	Requires the Director of Health to establish the Ohio Cancer Incidence Surveillance System, a population-based cancer registry, to monitor the incidence of various malignant diseases, make studies to research causal relations, and alleviate or eliminate the disease.

	Requires certain health care providers providing diagnosis or treatment services to cancer patients to report each case of cancer to the Department of Health and to provide the Department access to all records that identify cases of cancer or establish characteristics and treatment of cancer or medical status of any identified cancer patient. The reports are to be analyzed by the Arthur G. James Cancer Hospital and the Richard L. Solove Research Institute of the Ohio State University. Creates the Ohio Cancer Incidence Surveillance System Advisory Boar dot provide oversight to the Director of Health and the Arthur G. James Cancer Hospital and the Richard L. Solove Research Institute of the Ohio State University in implementing the System.
4731.73	Requires a surgeon who will perform a mastectomy in a hospital, or the surgeon's designee, to guide a patient through provided and referred services in a manner consistent with standards by the National Accreditation Program for Breast Centers of the American College of Surgeons (NAPBC). If the mastectomy surgeon considers breast reconstruction appropriate for a patient, the surgeon, or the surgeon's designee, must offer the patient a preoperative referral to a reconstructive or plastic surgeon in accordance with NAPBC standards.

Summary of Federal Breast Health Laws

The Women's Health and Cancer Rights Act (WHCRA) (October 1998):

- Applies to group health plans for plan years starting on or after October 1, 1998
- Applies to group health plans, health insurance companies, and HMOs, as long as the plan covers medical and surgical costs for mastectomy

Under the WHCRA, mastectomy benefits must cover:

- Reconstruction of the breast that was removed by mastectomy
- Surgery and reconstruction of the other breast to make the breasts look symmetrical or balanced after mastectomy
- Any external breast prostheses breast forms that fit into your bra) that are needed before or during the reconstruction
- Any physical complications at all stages of mastectomy, including lymphedema

Mastectomy benefits may have a yearly deductible and may require that you pay co-insurance. Co-insurance is when less than the full amount of the bill is paid by the insurance company and the patient must pay the difference.

The Patient Protection and Affordable Care Act (ACA) (March 2014):

- Eliminates of co-pays for preventive services (including mammography, yearly well-woman visits, annual preventive primary care visits, and certain prescriptions for risk-reduction among high-risk women)
- Eliminates lifetime caps or limits in coverage
- Makes coverage available for patients who take part in clinical trials
- Ends higher charges or discrimination against people with pre-existing coverage
- Ends recissions (when insurance is revoked)- insurance plans cannot stop coverage because a patient gets sick.
- Increases access to insurance through insurance exchanges and assists certain income levels with affordability of insurance