Local Issues Affecting Women’s Transition through the Continuum of Care

Introduction

The analysis of health systems in the target counties of Edgecombe, Halifax and Wilson provides insights to what is available and how residents are utilizing those resources. The Affiliate can see the gaps that are present in the continuum of care and try to close those gaps. The Affiliate examines partnerships to determine how to strengthen existing ones and if new partnerships could be established for more efficient care of women in the service area. Any obstacles women face while seeking breast health care can be identified and addressed.

Health Systems Analysis Data Sources

After reviewing and analyzing the breast cancer impact in the Affiliate service area, several data sources were used to assess the continuum of care and complete the health system analysis for the target communities.

- Demographic data in this section were collected from the US Census Bureau and the North Carolina Central Cancer Registry.
- Secondary data were collected from multiple websites and documents contained within those websites. Sites researched include: county websites, US Department of Health and Human Services; the Upper Coastal Plain Breast Cancer Resource Directory October 2013; the Breast Cancer Resource Directory of North Carolina, Fourth Edition; Medicaid; North Carolina BCCCP; State Cancer Control Program: A Call to Action, North Carolina Comprehensive Cancer Control Plan 2014-2020; National Cancer Institute for clinical trial information; Area Health Education Centers; National Association of Schools of Public Health; Federal Drug Administration; Health Resources and Services Administration; National Association of Free and Charitable Clinics; American College of Surgeons Commission on Cancer; American College of Radiology Centers of Excellence; American College of Surgeons National Accreditation Program for Breast Centers (NAPBC); and National Cancer Institute Designated Cancer Centers.
- A health systems survey tool was developed and sent to service providers throughout the three county target area including hospitals, health departments, community health centers, and free clinics.
- Charts on page 9 were developed using data from the Health Systems Analysis Spreadsheet

Data were reviewed from the websites and then summarized. The data from the survey tools that were returned were added to the Health Systems Analysis spreadsheets to determine what is available in each of the target counties. For the service providers that did not respond to the survey, data were completed utilizing web information and historic data.

Health Systems Overview

The comprehensive cycle of services known as the continuum of care is an integrated system of breast health programs and services including varying levels of education, screening, diagnosis,
treatment, post-diagnosis, and follow-up. After reviewing the breast health statistics, programs, and services in the NC Triangle to the Coast Affiliate service area, the Affiliate selected three counties in the North Central, Eastern region of our service area to be the focus of our health system analysis: Edgecombe, Halifax and Wilson. A Health Systems Analysis was conducted to better understand the gaps, needs and barriers throughout the continuum of care. Edgecombe County has been part of the service area since the Affiliate incorporated in 2000. Halifax County was added to the service area in 2010 and Wilson County was added in the most recent expansion in 2012.

- Each county has a major hospital which is now linked to or owned by a larger hospital system.
- There is a county health department located in each of the three communities.
- Each county has one or more NC BCCCP (Breast and Cervical Cancer Control Program) providers located within the county.
- Each county is located in a region of the state referred to as Area L or the Upper Coastal Plain and is characterized as having breast cancer mortality rates that are considerably higher than the average rates in both North Carolina and the United States.
- The three county area consists of 229 physicians (1 per 838 persons) and 88 Primary Care Physicians (1 per 2183 persons).
- Although hospitals and health care providers are represented throughout the three county region, data reveal that often breast cancer patients travel to Greenville in Pitt County despite the further distance to receive consolidated services and unified medical records.
- Area L AHEC is located in Rocky Mount and serves all three target communities. Komen NC Triangle to the Coast Affiliate is a partnering organization but sees the potential to strengthen and expand collaborative efforts.

**Overview of Continuum of Care**

The continuum of care (CoC) graphic (Figure 1) illustrates how a woman systematically progresses, ideally, from screening all the way through to follow-up and/or survivorship. Examining each step of the process, with education being a part of every step, helps determine where there are strengths in the CoC and where improvements can be made.
Public Policy Overview

North Carolina Breast and Cervical Cancer Control Program

The North Carolina Breast and Cervical Cancer Control Program (NC BCCCP) provides free or low-cost breast and cervical cancer screenings and follow-up to eligible women in North Carolina. Each year, NC BCCCP strives to provide services to over 12,000 women.

NC BCCCP services are offered at most local health departments as well as some community health centers, hospitals and private physicians’ offices across the state. Approximately 102 local health agencies work in cooperation with physicians, hospitals, and other health care facilities to provide services to eligible North Carolina women. Services offered include: clinical breast exams; screening mammograms; Pap tests; diagnostic procedures, as indicated (diagnostic mammograms, ultrasounds, colposcopies, breast and cervical biopsies); and medical consultations.

To be eligible for the NC BCCCP women must be: uninsured or underinsured; without Medicare Part B or Medicaid; between ages 40 - 64 for breast screening services and 21 - 64 for cervical screening services; and have a household income at or below 250 percent of the federal poverty level. Breast and Cervical Cancer Medicaid (BCCM) provides funding for treatment to NC BCCCP enrolled clients who are diagnosed with breast or cervical cancer and who meet additional requirements. BCCM eligible women must be enrolled in NC BCCCP prior to a cancer diagnosis. Women are enrolled by their physician. If a physician is unaware of the program, a qualified woman could potentially face the high costs of treatment that could have otherwise been covered by the program. For the eligibility flow chart for breast screening, which illustrates where women could potentially lose a good flow in the continuum of care, see Appendix A. Women who are ages 40-49 are only eligible if they are symptomatic or if NC BCCCP funding is available. Similarly women who are ages 65-75 are eligible if NC BCCCP funding is available.

Because of higher mortality rates, NC BCCCP has focused increased recruitment and education strategies to prompt more African American, Hispanic, and American Indian women to get breast and cervical cancer screenings.

The current relationship with NC BCCCP is a partnership. The NC BCCCP has assisted the Komen North Carolina Triangle to the Coast Affiliate with Mission activities and the Affiliate participates in their Advisory committee. The Affiliate is invited to attend all meetings and participate with subcommittees on prevention and early detection of cancer. Since much of the staff at Komen NCTC are new, over the next several years, developing strong relationships with local BCCCP providers in the 29 county service area will be a key priority.
Table 1. NC BCCCP Current Income Guidelines

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Gross Yearly Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$29,175</td>
</tr>
<tr>
<td>2</td>
<td>$39,325</td>
</tr>
<tr>
<td>3</td>
<td>$49,475</td>
</tr>
<tr>
<td>4</td>
<td>$59,625</td>
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<tr>
<td>5</td>
<td>$69,775</td>
</tr>
<tr>
<td>6</td>
<td>$79,925</td>
</tr>
<tr>
<td>7</td>
<td>$90,075</td>
</tr>
<tr>
<td>8</td>
<td>$100,225</td>
</tr>
</tbody>
</table>

For each additional family member (beyond 8) Add $10,150


To locate a NC BCCCP provider in the Susan G. Komen North Carolina Triangle to the Coast Affiliate Service Area, go to the following website: http://bcccp.ncdhhs.gov/Eligibility.asp.

State Comprehensive Cancer Control Program

In 2014, the State of North Carolina released The North Carolina Comprehensive Cancer Control Plan 2014-2020: A Call to Action. This plan was developed by a large and diverse group dedicated to saving lives and improving the quality of life for North Carolinians affected by cancer. The Cancer Plan serves as a working guide to help public health and healthcare groups, community organizations, institutions, agencies and individuals across NC work together to address cancer prevention and control. It is designed to address the barriers to cancer prevention and care while outlining a plan of action for cancer programs, community organizations, policy makers and individuals in North Carolina. The overarching goals of the plan are:

- Prevent new cancers
- Detect cancer at its earliest stages
- Treat all cancer patients with the most appropriate and effective therapy
- Enhance the quality of life for every person affected by cancer
- Reduce cancer-related disparities in North Carolina

In order to meet these goals the Cancer Plan has specific objectives and strategies to address the cancer continuum, the six specific cancers, including breast cancer, cancer surveillance and plan evaluation. The cancer continuum, which includes prevention, early detection, care and treatment and survivorship, is a useful framework to view plans, priorities and progress, as well as identifying research and resource needs. The Action Plan will be implemented by a diverse partnership of NC cancer programs, organizations and individuals to assure North Carolinians timely and equitable access to healthcare throughout the cancer care continuum.
The efforts to reduce the cancer burden in NC will require a coordinated and collective effort of communities, public and private organizations and individuals. Representatives of many agencies and organizations such as the North Carolina Advisory Committee for Cancer Coordination and Control, North Carolina Cancer Partnership, North Carolina Department of Health and Human Services, American Cancer Society and many others, including Susan G. Komen North Carolina Triangle to the Coast Affiliate, are working together to develop the strategies and action plan for the successful implementation of the comprehensive cancer plan. Affiliate staff serves on the implementation workgroup of both the Early Detection and the Care and Treatment Subcommittees of the NC Advisory Committee for Cancer Coordination and Control.

Breast cancer has been designated as one of six priority cancers in the Cancer Plan, therefore a section of the plan includes information summarizing breast cancer risk factors, prevention and treatment. It includes objectives and specific strategies for addressing these objectives. The three identified breast cancer objectives for the plan are:

1. Reduce the mortality rate in women due to breast cancer.
2. Reduce the rate of stage III and IV breast cancer in women.
3. Increase the percentage of North Carolina women over the age of 50 who have had a mammogram according to the recommended guidelines within the past two years.

The breast cancer strategies included in the plan are:

- Conduct targeted outreach using evidence-based strategies to decrease disparities in breast cancer mortality among women who experience high death rates from breast cancer.
- Partner with NC BCCCP and WISEWOMAN providers and other agencies to improve data sharing and patient tracking to assure that eligible patients get appropriate screening and treatment services for breast cancer.
- Promote the use of the guidelines and recommendations of the North Carolina Advisory Committee on Cancer Control and Coordination.

Table 2. North Carolina Comprehensive Cancer Control Plan Breast Cancer Objectives

<table>
<thead>
<tr>
<th>Measures</th>
<th>Baseline</th>
<th>2020 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Mortality Rate</td>
<td>21.4/100,000</td>
<td>16.8/100,000</td>
</tr>
<tr>
<td>Stage III and IV Breast Cancer Rate</td>
<td>46.3/100,000</td>
<td>40.9/100,000</td>
</tr>
<tr>
<td>% Women Over Age 50 Who Had Mammograms within the Past Two Years</td>
<td>79.4%</td>
<td>TBD*</td>
</tr>
</tbody>
</table>

*NOTE: Recommendations have changed recently and awaiting BRFSS data changes
Over the next four years, Komen NCTC will continue to work with the Advisory committee for the successful implementation of the Cancer Plan to ensure the goals, specifically as they relate to breast cancer, are achieved.

**Affordable Care Act**

The Affordable Care Act provides Americans with better health security by putting in place comprehensive health insurance reforms that expand access to care through insurance coverage, lower health care costs making it more affordable, guarantee more choices, improve coverage for those with health insurance, enhance the quality of health care for all Americans and hold insurance companies accountable.

The Affordable Care Act (ACA) actually refers to two separate pieces of legislation - the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) - that together expand Medicaid coverage to millions of low-income Americans and make numerous improvements to both Medicaid and the Children's Health Insurance Program (CHIP).

Medicaid is a long-standing government-funded health insurance program for low-income individuals and families who cannot afford health care costs. Eligibility requirements were determined by each state individually. Under the ACA, states were to expand their Medicaid programs, making more people eligible by specifically raising the household income requirement to at or below 138 percent of the federal poverty level. In 2013, in North Carolina, this equaled approximately $32,000 for a family of four, according to a 2014 Fact Sheet published in January of that year by the Henry J. Kaiser Family Foundation (KFF) entitled “How Will the Uninsured in North Carolina Fare Under the Affordable Care Act?”.

The U.S. Federal Government offered to pay 100 percent of the costs of newly enrolled Medicaid patients from 2013 to 2016. After that time, the federal share of the reimbursement rate would decrease, reaching 90 percent in 2020.

In 2012, the US Supreme Court ruled that individual states could decide whether to expand their Medicaid programs and North Carolina chose not to expand thus creating gaps in coverage within the state. These coverage gaps mean income is above the current Medicaid eligibility rate but below the lower limit to receive ACA tax credits. According to the 2014 Fact Sheet published by the KFF, 319,000 uninsured individuals in NC who would have been insured if NC had expanded, fall into the coverage gap. This represents 20 percent of the uninsured in the state. These adults are all below the poverty line and have very limited incomes. Since they will not receive an affordable coverage option under the ACA, they will most likely continue to be uninsured. The KFF Fact Sheet also states that uninsured undocumented immigrants, who make up 16 percent of the uninsured non-elderly in the state, were ineligible to enroll in Medicaid before the ACA and under the ACA that has remained the same making the gaps in coverage even greater.
The ACA will increase access to breast and cervical cancer screening services for many low-income, underserved women through expanded insurance coverage and eliminating cost-sharing. Other provisions of the ACA and the American Reinvestment and Recovery Act will also improve delivery of these essential services by improving health care quality. However, all ACA provisions will not be implemented until 2015 and some effects will take even longer. Currently, many women will still face barriers to obtaining breast and cervical cancer screening such as geographic isolation, limited health literacy, inconvenient times to access services, and language barriers.

It is important to note that under the health care reform, all of Susan G. Komen’s priorities were included. These include: mammography as a required benefit, breast cancer education for young women, access to clinical trials and patient navigation, elimination of pre-existing condition exclusions, and lifetime and annual caps on out of pocket spending limits. A recent study found a significant increase in the number of women with Medicaid coverage who received mammograms when compared to those who applied for coverage but were unable to enroll. This reinforces the fact that access to Medicaid makes a big difference in who receives mammograms and adheres to current screening guidelines. North Carolina’s decision not to expand Medicaid coverage will result in fewer women in the state having access to mammography services making the Affiliate’s role in providing funds for free services to uninsured women even more critical than ever.

The Affordable Care Act in NC has not had a large impact on the intended target population. NC decided not to expand Medicaid coverage and the health insurance exchange is federally managed.

According to the Fact Sheet, “A Closer Look at the Impact of State Decisions Not to Expand Medicaid Coverage for Uninsured Adults,” published by the Kaiser Family Foundation in April 2014; 549,000 persons are eligible for Medicaid coverage under the Affordable Care Act’s expanded coverage. Since NC decided not to expand coverage, this leaves only 38,000 (6.9%) eligible for Medicaid in the state. In NC, 193,000 (35.2%) persons may be eligible for Marketplace Tax credits, while 319,000 (58.1%) fall into the coverage gap.

**Table 3. Eligible for Medicaid Under the ACA Medicaid Expansion (<138% FPL)**

<table>
<thead>
<tr>
<th>State</th>
<th>Total</th>
<th>Currently Eligible for Medicaid</th>
<th>Currently in the Coverage Gap (&lt;100% FPL)</th>
<th>Currently May be Eligible for Marketplace Tax Credits (100%-138% FPL)</th>
<th>Excluded from Medicaid due to State Decisions not to Expand Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>NC</td>
<td>549,000</td>
<td>38,000</td>
<td>319,000</td>
<td>193,000</td>
<td>511,000</td>
</tr>
</tbody>
</table>

Source: Kaiser Family Foundation, (excerpt): Current Eligibility Among Uninsured Adults in Non-Expansion States Who Would be Eligible for Medicaid if their State Expanded.
The NC BCCCP program director noted that with all of the changes happening with the Affordable Care Act and the state’s position on expanding coverage there has been little change to a slight decrease in utilization of programs.

**Affiliate’s Public Policy Activities**

Komen North Carolina Triangle to the Coast (NCTC) Affiliate’s public policy activities include providing information to local, state and federal legislators on the Affiliate’s community health grants program, the Area L special grants program in North Central, Eastern NC, major findings of the Community Profile including the state of breast cancer in the Affiliate’s 29 county service area and breast cancer research grants awarded in North Carolina through the Komen National Research Program. Duke Cancer Institute and UNC Lineberger Cancer Center, both located in our service area, received $3.6 million in 2013-14.

Komen NCTC Affiliate has been actively supporting public policies that benefit breast cancer patients in North Carolina. The most recent activity has focused on the introducing and passing House Bill 609, the Cancer Treatment Fairness Act. This Act would modernize insurance laws to ensure that all chemotherapy treatment drugs, whether intravenous (IV) or oral, would be accessible and affordable to all cancer patients.

When relevant committees held hearings on the issue in the spring of 2013, Komen NCTC public policy advocates visited numerous state legislators and staff members to spread awareness of the need to eliminate the disparity in co-pays between IV chemotherapy and oral chemotherapy. Thirty-five states and the District of Columbia have enacted oral chemo parity legislation with either zero co-pays or co-pays no higher than $100.

Medical plans cover intravenous chemotherapy, while prescription drug plans cover oral chemotherapy. Most prescription drug plans require high out-of-pocket costs that can prevent patients from receiving the treatment that is recommended most appropriate by their oncologist. As introduced in 2013, the Cancer Treatment Fairness Act specified zero co-pays for oral chemotherapy. As passed in the House, however, the legislation included a $100 cap.

In addition to all five of the North Carolina Affiliates, and under the leadership of Komen Charlotte, the NCTC Affiliate generated emails and phone calls from its boards of directors, staff, grantees and public policy advocates to urge North Carolina legislators to support the Act. Together, the NC Affiliates have been working with a strong coalition including the North Carolina Oncology Association, the Leukemia & Lymphoma Society, the American Cancer Society Cancer Action Network and others committed to the legislation.

During the legislative process, a $300 cap replaced the $100 cap. Therefore, Komen and coalition efforts targeted Senators to pass a bill that would contain a co-pay cap no higher than $100. The $100 co-pay was reinstated, but the proposed legislation then became part of a large regulatory reform bill.

Komen NCTC and the other NC affiliates also monitor the state’s budget to ensure legislators do not cut funding for the North Carolina Breast & Cervical Cancer Control Program. NCBCCCP
provides mammograms and treatment for women not eligible for Medicaid. Current funding has been $1.2 million annually. That amount covers less than 8 percent of those eligible. Additional funding cuts would be devastating for women in North Carolina, so advocating for those dollars remains a critical part of our public policy efforts.

Health Systems and Public Policy Analysis Findings

After conducting research on what health systems are available in the target communities and how the CoC is executed by the facilities, the current and future partnerships in these communities, what state policy work is being done and finally the impact of the ACA; the Affiliate can see that there are some positives for the area and much work that needs to be completed to reach Affiliate goals.

Positives in this area are the availability of a hospital and the NC BCCP in each county. The three counties have resources for screenings from each of the identified health systems. The state’s Cancer Control Plan addresses breast cancer as a priority with strategies and objectives designed to reduce disparity. The Affiliate continues to work with legislators to provide affordable co-pays and treatment options for breast cancer patients.

All three counties are lacking services that facilitate easy progression through the CoC. Improvements to existing providers could bridge some of the gaps in the CoC, such as availability of care in one facility. This could also make it easier for a woman to seek screening, diagnosis, treatment, follow-up and education.

Health systems survey tools were mailed or emailed to 22 entities with only a 30 percent return rate. Since the majority of the staff at the Affiliate is relatively new, relationships with the health system providers as well as NC BCCCP need to be better established to work on sharing of data and resources. This will be a priority over the next few years.

There are twenty-eight providers serving the three target counties chosen. One provider services all three areas and therefore is counted only once in the total, but included in each total for the target counties. With this research, we understand that some providers could be overlooked. As relationships are built, outreach, and education improved; a more inclusive list of resources can be achieved.

![Percentage of Providers with Patient Navigation](image)

**Figure 2.** Patient Navigation Among Providers
None of the target communities have mobile mammography available which could be an obstacle for those lacking good transportation. Figure 2 shows the percentage of patient navigation provided in each county. Neither Edgecombe nor Wilson County offer patient navigation from screening to diagnosis. Wilson County has the highest percentage of navigation from diagnosis to treatment at 20.0 percent. Edgecombe County offers the highest percentage (23.3%) of navigation from treatment to support services. Increasing the percentage of patient navigation could help women receive education and information throughout each stage of the CoC.

![Services Available from Providers](image)

**Figure 3. Services Offered Among Providers**

While there are multiple providers in each target community, the percentage of each specific service is not higher than forty percent. This illustrates that while there are multiple providers, there are few providers with consolidated service, thereby causing patients to visit multiple providers to follow the CoC from screening to diagnosis to treatment and finally follow-up care. As aforementioned, a facility in Edgecombe County provides service to women from all three of the target counties. Wilson County has only one provider for biopsies, treatment and support/survivorship that is located within the county.

*Note: Once maps are inserted, we will include narrative that discusses any obstacles related to proximity or the target population with the health service provider.*

Key partnerships in this area include past and current grantees funded by the Komen NCTC Affiliate. Potential new partners could be the community health centers in the target counties and the BCCCP coordinators at the county health departments. Another partner could be the UNC School of Public Health for interns who could potentially complete ongoing survey projects to measure the impact of current partnerships and research the opportunities of untapped grass-root partnerships with churches or other community groups which may exist. Using the National Cancer Institute (NCI), the Affiliate noted there are 37 existing clinical trials. Partnerships with the researchers could provide additional service avenues to the target counties. An Area Health Education Center exists in Rocky Mount that could be another potential partner for an educational partnership.

North Carolina’s decision not to expand Medicaid coverage and to have a federally managed health insurance exchange has caused little impact by the ACA on those uninsured and underinsured people in the state. A measure to help this group is ensuring eligible women are enrolled in the NC BCCCP before a cancer diagnosis is imperative so they will not be left...
struggling to afford treatment and care. The Affiliate needs to educate providers in the area to have their eligible patients enrolled in this program at the time of screening to meet the requirements of the NC BCCCP.

The Affiliate’s policy work is targeted to assist the women in its service area. The Affiliate may have more work to do once the outcome of HB 609 is known. The Affiliate will continue to strive for better, more affordable breast health care for the women in its service area by monitoring the state budget and working with legislators.
APPENDIX A

BCCP SCREENING AND FOLLOW UP PROTOCOL

PATIENT INTAKE

AGE ELIGIBLE - 40-64 y.o. for mammogram* and Pap tests. 21-39 y.o. only if symptomatic.
INCOME ELIGIBLE - refer to eligibility guidelines.

PROVIDE CLINICAL SERVICES
- History - breast and cervical
- Pelvic exam, Pap test*
- Clinical breast exam*
- Education - BSE, need for rescreening
- Referral for mammography*

*May or may not be needed. If this has already been done by an outside provider, obtain documentation of the results and include in patient's chart.

TRACKING - receive Pap test and/or mammogram reports. Use tickler or log system.

NORMAL RESULTS
- NOTIFY PATIENT
- RESCREENING DATE
- REMINDER OF APPOINTMENT
- RESCREEN

ABNORMAL RESULTS
- NOTIFY PATIENT
- REFER TO APPROPRIATE PROVIDER
- TRACKING - RECEIVE REPORTS

NORMAL - FOLLOW
- NO CANCER
- CANCER OR PRECANCEROUS

ENROLL IN BCCAI

RESCREEN

TREATMENT

RESCREEN

* Screening mammograms for women age 40-49 are provided only if state funding is available.
NC BCCCP Eligibility Flow Chart
Breast Screening

CLINICAL BREAST EXAMS

<250% FPL, not enrolled in Medicaid, Medicare Part B or Title X

No

Not Eligible

Yes

Determine Age

Age 40-64

Priority Population Provide CBE every year

Age 21-39

Eligible if symptomatic or if STATE BCCCP funding is available

MAMMOGRAMS

<250% FPL, not enrolled in Medicaid, Medicare Part B or Title X

No

Not Eligible

Yes

Determine Age

Age 50-64

Priority Population Provide mammogram every year

Age 40-49

Eligible if symptomatic or if STATE BCCCP funding is available

Age 21-39

Eligible only if symptomatic

Age 65-75

Eligible if STATE BCCCP funding is available

NOTE: The priority population for FEDERAL BCCCP mammography services is women between the ages of 50 and 64 who are low-income (up to 250% of federal poverty level), who have not been screened in the past year, and who have no other source of health-care reimbursement, such as insurance. Recruitment efforts should be concentrated on this population. A minimum of 75% of all FEDERAL BCCCP reimbursed mammograms should be provided to program-eligible women who are 50 years of age and older. Mammograms provided to program-eligible women less than 50 years of age should not exceed 25% of all mammograms provided by FEDERAL BCCCP and should be reserved for those women who present with clinical symptoms suspicious for breast cancer.
Revised 03/11/13

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