

susan g. komen.  **COMMUNITY**
PROFILE REPORT 2015



SUSAN G. KOMEN®
INLAND EMPIRE

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Sarah R. Bryant, B.S., M.B.A.

Mission Programs Manager
Susan G. Komen® Inland Empire

Motomi Elliott

Administrative & Financial Associate
Susan G. Komen® Inland Empire

Janie Campbell

Administrative Assistant in Training
SER Jobs for Progress

Shelly De Anda B.A., PSY.M.

Mission Programs Coordinator
Susan G. Komen® Inland Empire

Yvonne R. Graham, B.A., M.P.A

Community Resource Advocate
Susan G. Komen® Inland Empire

Lilly Kalisher

Administrative Assistant in Training
SER Jobs for Progress

Barb Killian

Board Member, Grant Chair, Community Profile Board Liaison
Susan G. Komen® Inland Empire

Katie Parker, RT (R) (M)

Executive Director
Susan G. Komen® Inland Empire

Teresa Segovia, M.A.

Research & Evaluation Associate
HARC, Inc.- Health Assessment Resource Center

Jessica Wilson, M.P.H.

Student Intern
Loma Linda University

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Report Prepared by:

Susan G Komen® Inland Empire
43397 Business Park Drive, Ste. D-9
Temecula, CA 92590
(951) 676-7465
www.komenie.org

Executive Summary

Introduction to the Community Profile Report

Susan G. Komen® Inland Empire was founded in 1996 in Temecula, California. In 1998, the Affiliate was incorporated and pledged that it would do all it could to provide needed resources and improve breast health/breast cancer in the communities within the area of Riverside and San Bernardino Counties, also known as the Inland Empire. In 1999, the Affiliate held its first Susan G. Komen Inland Empire Race for the Cure®. In 2009, the Affiliate opened the Susan G. Komen Inland Empire Breast Cancer Resource Center located in Rancho Mirage, California. The Komen Promise is to save lives and end breast cancer forever by empowering people, ensuring quality care for all and energizing science to find the cures is supported by many dedicated individuals and community partnerships wanting to make a difference.

Seventy-five percent of the net funds raised by the Affiliate remain in the Inland Empire to provide breast health education programs and community grants to nonprofit organizations that offer education, screening, diagnostic services and treatment support programs, while the remaining 25 percent supports breast cancer research. Since the 1999 inaugural Komen Inland Empire Race for the Cure, the Affiliate has funded more than \$6.4 million in local community grants to meet the Inland Empire breast health needs for the uninsured or underinsured residents, and over \$2.3 million to the Susan G. Komen Research Programs.

Komen Inland Empire serves more than 4.3 million people residing in Riverside and San Bernardino Counties, hosting 27,000 square miles of diverse geographic terrain from mountains and valleys to below sea level in the desert. The majority of the population is concentrated in the southwestern area of both counties. Many miles of the service area are national parks, military bases and desert.

Komen Inland Empire was the recipient of the 2008 and 2011 Service/Charitable Organization of the Year by the Temecula Valley Chamber. This award recognized the Affiliate's generosity and philanthropic efforts that benefit many women and families throughout the community. Furthermore, the Affiliate has received various recognitions from local cities and elected officials throughout the years.

Advocacy plays a crucial role in the Inland Empire, State of California, and the US, where the Affiliate serves as a committed partner with other community partners, Komen Affiliates, and policymakers to ensure access to services and continued research funding for breast cancer.

The Affiliate participates in the local state cancer coalition, Inland Empire Access to Cancer Care Coalition (IEATCCC), working with various hospitals, businesses and organizations to address the cancer care needs of the region and the state as a whole. Furthermore, the Affiliate hosts the region's only Breast Health Collaborative (BHC), comprised of hospitals, businesses and organizations providing breast health services in the Inland Empire. Together, both the IEATCCC and BHC are imperative to leveraging partnerships and resources to meet the breast health needs of the region. As the leading breast cancer organization, Komen Inland Empire strives to integrate best practices, funding opportunities, and field knowledge among community health professionals, health systems, breast health and cancer organizations, as well as community members.

In order to fulfill Komen's Promise, a Community Profile assists the Affiliate by identifying communities facing breast health/breast cancer disparities. Through analyzing the gaps in breast health/breast cancer services and programs, as well as barriers to accessing breast health care, the Affiliate is able to understand community needs, develop objectives to address community needs, and leverage partnerships, funding, as well as resources to fulfill the needs of the communities. The Community Profile serves as a "roadmap" for the Affiliate's education, outreach, community grant funding priorities, and advocacy strategies. Furthermore, the Community Profile is relevant to the overall strategic planning activities of the Affiliate. Finally, the Community Profile provides an analysis of community data, as well as the voices of those residing in the communities the Affiliate serves.

The Community Profile is used in various capacities by the Affiliate to address the breast health needs and concerns of the community. It is further used to inform health care professionals and systems, community organizations, governments, and community partners about the breast health needs of the region, and assist in developing viable, community-based solutions to fulfill those needs as a region.

Quantitative Data: Measuring Breast Cancer Impact in Local Communities

In order to provide focused target communities, this report uses the Medical Service Study Areas (MSSAs) as the unit of analysis. Based on these criteria, and on the Quantitative Data Report findings, the three following target communities are identified (presented in numeric order):

- MSSA 128 (Riverside County) includes the communities of Arabia, Coachella, Desert Beach, Flowing Wells, Indio South, La Quinta East, Mecca, Oasis, and Thermal
- MSSA 145.2 (San Bernardino County) includes the communities of Adelanto, Phelan, Pinon Hills, and Victorville
- MSSA 151g and MSSA 151k (San Bernardino County) includes the communities of Highland, Muscoy and San Bernardino

The Quantitative Data Report identified that the communities within MSSA 128 are extremely impoverished, and nearly half of residents lack a high school education. Furthermore, nearly a fourth of the population residing in these communities are unemployed, lack health insurance and are medically underserved. The majority of the population in MSSA 128 is Hispanic/Latina and it has been noted that more than a quarter are considered to be linguistically isolated and foreign-born.

The MSSA communities of MSSA 145.2 and MSSA 151g and 151k indicate that Black/African-American women in these communities have higher breast cancer incidence rates, late-stage incidence rates, and death rates than their White counterparts. In addition, these communities are considered to be impoverished, with low education rates, high unemployment percentages and a large percentage indicated as being uninsured or underinsured, as well as considered medically underserved. Furthermore, language barriers to receiving health care have been identified as well in these communities.

Health System and Public Policy Analysis

The breast cancer “continuum of care” (the continuum) defines the best practice for how an individual should move through the health system to be screened for breast cancer, receive any necessary diagnostic care, get treatment if breast cancer is diagnosed, and receive follow-up care after treatment. The best case: individuals move through the continuum quickly and seamlessly, receiving timely, quality care to ensure the best outcomes.

The continuum is also used to: 1) assess and understand why some individuals never enter or delay entry into the continuum; 2) uncover gaps in service availability; 3) identify barriers faced; and finally 4) figure out what can be done to address those gaps and barriers.

However, findings from the Health System and Public Policy Analysis indicate several strengths and weaknesses of the continuum of care in specific communities:

MSSA 128, in Riverside County, includes the communities of Arabia, Coachella, Desert Beach, Flowing Wells, Indio South, La Quinta East, Mecca, Oasis, and Thermal. There are approximately eleven community health centers offering breast health screening services. All of these facilities provide clinical breast exams, a fewer number also provide screening mammograms and/or offer referrals for mammograms. However, only two facilities provide any diagnostic services, treatment services and/or support services. There is only one hospital in this area; however it does not offer patient navigation services. Another weakness identified, is that none of the facilities maintain quality of care indicators. It should be noted that this is considered a rural community of a large size. Furthermore, access to transportation services is severely limited. To strengthen collaboration and community partnerships in this target area, the Affiliate will reach out to community and business leaders, community health centers and imaging centers to introduce Komen’s mission, provide a primer on the services available and begin to identify potential programs to bridge the barriers to care that have been uncovered.

MSSA 145.2, in San Bernardino County, includes the communities of Adelanto, Phelan, Pinon Hills, and Victorville Northwest. The area’s greatest strength is that it contains six centers for breast health and one hospital. However, not all of the breast health centers offer clinical breast exams and/or mammography; all other resources refer out for mammogram screenings. Three of these facilities offer diagnostic, treatment and/or support services for breast cancer; and none maintain quality of care indicators. It should be noted that this is considered a rural community of a large size. Furthermore, access to transportation services is severely limited. To strengthen collaboration and community partnerships in this target area, the Affiliate will reach out to community and business leaders, community health centers and imaging centers to introduce Komen’s mission, provide a primer on the services available and begin to identify potential programs to bridge the barriers to care that have been uncovered.

MSSA 151g and 151k, in San Bernardino County, includes the communities of Muscoy, Highland, San Bernardino East and San Bernardino Central. This region contains thirteen community health centers, three hospitals and three imaging centers. The area has at least one resource for each step of the continuum of care. Only one facility maintains one quality of care indicator. While having a resource for every step of the continuum of care is a great benefit, there is still only one resource for treatment services and one resource for support services in this target area (a former Komen Inland Empire grant recipient). It would be ideal to have more

than one option for the size of the population the facility serves. The variety of resources may be greater than other target communities, but the need is greater in this area as well. The Affiliate intends to strengthen collaboration and community partnerships in this target area, the Affiliate will reach out to community and business leaders, community health centers and imaging centers to introduce Komen's mission, provide a primer on the services available and begin to identify potential programs to bridge the barriers to care that have been uncovered.

In addition to the priority communities discussed, further findings from the Health Systems and Public Policy Analysis indicate that the Affiliate service region throughout Riverside and San Bernardino Counties face several other barriers to care. The majority of the Affiliate service region is considered largely rural, breast health services are primarily located in the western portion of the Affiliate service area and thus transportation to access breast health care services is a primary barrier to care for the majority of rural communities. Furthermore, financial assistance remains a barrier to care throughout the 27,000 sq. mile service area, as only one financial assistance program for breast cancer patients is available that serves the entire service area. Furthermore, state and federal programs for breast cancer screening, detection and treatment also impact constituents residing in Riverside and San Bernardino Counties. In addition, last resort safety net programs may be available for California residents that meet specific criteria. The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) supports the provision of the following breast cancer services: clinical breast exams, mammograms, and diagnostic testing for women whose screening outcome is abnormal, as well as referrals to treatment. The program is supported by the Centers for Disease Control and Prevention (CDC), which provides a federal grant to each State. The California state program is named Every Woman Counts (EWC).

In California, EWC has a payer of last resort requirement, which exhausts all other possible payers before EWC (such as California's Low Income Health Program (LIHP – through a Medicaid Demonstration Waiver). However, EWC does not cover medically-necessary diagnostic MRIs certain biopsy services, as well as BRCA testing.

Treatment is provided to eligible individuals through the Breast and Cervical Cancer Treatment Program (BCCTP). The federal BCCTP provides full-scope Medi-Cal to eligible women who meet all the federal criteria. However, there are specific limitations to the state and federal treatment programs, including immigration status, permanent residency, gender, re-diagnosis, and limited access to breast health providers.

While much excitement has surrounded the Affordable Care Act, Medicaid expansion, and the roll out of the health care marketplace, a lot remains undetermined in terms of quality, access and utilization for residents in the Inland Empire and the MSSA communities discussed above.

Qualitative Data: Ensuring Community Input

The Qualitative Data Report further supplements the identified priorities within the target communities within Riverside and San Bernardino Counties. Through key informant interviews, focus groups and document review, it has been noted that financial assistance, insurance/access to care, culture, transportation and survivorship are barriers within the targeted communities. The financial impact of breast cancer on middle and low-income individuals is a substantial barrier to care and affects quality of life long-term. Furthermore,

access to care has been identified as extremely limited for those that are uninsured and underinsured, even under the state's Medicaid program, Medi-Cal, and indicates that late-stage diagnosis is more prevalent, as well as a decreased chance of survival.

Transportation remains a common theme throughout the sections of the Community Profile, as the Affiliate service region is more than 27,000 square miles. The Qualitative Data Report indicates that transportation is a serious barrier to care throughout the continuum of care, from accessing screening to treatment services. Survivorship also is a key concern in the Qualitative Data Report, with limited access to patient navigation, education surrounding healthy lifestyles, and future implications of treatment affecting health. However, the Qualitative Data Report outlines that family and friend support was imperative throughout treatment.

Culture was also addressed as a barrier to care, as breast cancer is often not a topic of conversation in some cultures, specifically in some Hispanic/Latina and Black/African-American communities. Cultural beliefs and behaviors are also identified as being a barrier and delay in accessing screening and treatment due to religious beliefs, care delivery prejudices, and pessimistic expectations of survival.

Overall, the communities within MSSA 128 indicate that Hispanic/Latina communities are most at-risk and face issues related to access to care for screening, diagnostic, treatment and support services, as well as transportation and financial assistance. Programs should further address cultural and survivorship needs, in addition to overall breast health education.

Overall, the communities within MSSA 151g and 151k indicate that Black/African-American communities are most at-risk and face numerous issues related to access to care for screening, diagnostic, treatment and support services, as well as transportation and financial assistance. Programs should further address cultural and survivorship needs.

Mission Action Plan

These priorities were developed to address the needs of MSSA 128 and MSSA's 145.2/151g/151k, and as identified throughout the Community Profile process. By addressing these specific priorities, a measurable impact to reduce disparities within the targeted community is expected in years to come. The Mission Action Plan below is developed using the following structure to outline problems/needs, priorities, and objectives for each MSSA community.

MSSA 128

Problem: Hispanic/Latina communities in MSSA 128 lack health insurance and are medically underserved.

Priority: Improve access to breast health services along the continuum among women age 40 and older in MSSA 128.

Objective: By 2017, collaborate with at least three providers that serve Hispanic/Latina women to provide culturally competent breast health services and community-based patient navigation services for residents of MSSA 128.

Problem: Communities within MSSA 128 have very limited access to culturally competent breast health education.

Priority: Increase access to culturally competent breast health education among Hispanic/Latina women in MSSA 128.

Objective: By 2016, launch an Affiliate-based culturally-competent breast health education program, addressing the needs of Hispanic/Latina women in MSSA 128, as measured by reaching 1,500 Hispanic/Latina women through education and outreach.

Objective: By 2017, expand Affiliate-based Prayer in Pink, faith-based breast health education and resource program in MSSA 128 to improve breast health education and knowledge of local resources to 1,500 residents annually.

Problem: Communities within MSSA 128 have extremely limited access to culturally competent breast health care services including screening, diagnostic and treatment, especially related to the lack of insurance, transportation, and financial assistance.

Priority: Reduce barriers to care by addressing transportation and financial assistance needs in MSSA 128.

Objective: By 2017, develop new, collaborative relationship with at least one community-based organization to provide transportation services for residents of MSSA 128.

Problem: Communities within MSSA 128 lack culturally competent survivorship programs and patient navigation.

Priority: Increase access to culturally competent breast cancer survivorship and patient navigation services for women in MSSA 128.

Objective: By 2017, develop new, collaborative relationships with at least three community-based organizations whose target population is Hispanic/Latina women in MSSA 128 to engage in culturally competent survivorship services.

MSSA's 145.2/151g/151k

Problem: Black/African-American communities in MSSA 145.2/151g/151k have higher than average breast cancer incidence rates, late-stage incidence rates, and death rates.

Priority: Increase knowledge regarding breast health, access to screening and breast health resources to potentially reduce the chance of late-stage diagnoses within Black/African-American women residing in MSSA's 145.2/151g/151k.

Objective: By 2017, expand Affiliate-based Circle of Promise program to address cultural and community resource education needs for 1,000 Black/African-American women in MSSA's 145.2/151g/151k.

Objective: By 2017, expand Affiliate-based Prayer in Pink, faith-based breast health education and resource program in MSSA's 145.2/151g/151k to improve breast health education and knowledge of local resources to 5,000 residents annually.

Problem: Black/African-American communities in MSSA 145.2/151g/151k have limited access to culturally competent breast health care services including screening, diagnostic and treatment, especially related to the lack of insurance, transportation, and financial assistance.

Priority: Improve access to culturally competent breast health services along the continuum of care among Black/African-American women age 40 and older in MSSA's 145.2/151g/151k.

Objective: By 2017, collaborate with at least three providers that serve African-American women to provide culturally competent breast health services for residents of MSSA's 145.2/151g/151k.

Priority: Reduce barriers to care by addressing transportation and financial assistance needs in MSSA's 145.2/151g/151k.

Objective: By 2017, develop new, collaborative relationship with at least one community-based organization to provide transportation services for residents of MSSA's 145.2/151g/151k.

Problem: Communities within MSSA 145.2/151g/151k lack culturally competent survivorship programs.

Priority: Increase access to culturally competent breast cancer survivorship services for women in MSSA's 145.2/151g/151k.

Objective: By 2016, develop new, collaborative relationships with at least three community-based organizations whose target population is Black/African-American women in MSSA's 145.2/151g/151k to engage in culturally competent survivorship services.

Overall Affiliate Service Region

Problem: Affiliate service region of San Bernardino and Riverside Counties have limited access to care related to lack of transportation and financial assistance.

Priority: Reduce barriers to care by addressing transportation and financial assistance needs throughout Affiliate service region.

Objective: Beginning with the FY2017 Community Grant Request for Application, programs that assist with the financial needs of accessing breast health services and treatment support for residents of San Bernardino and Riverside Counties will be a funding priority.

Objective: Beginning with the FY2017 Community Grant Request for Application, programs that provide transportation services to and from breast health service appointments for residents of San Bernardino and Riverside Counties will be a funding priority.

Problem: Residents of the Affiliate service region that are enrolled in EWC lack access to medically- necessary diagnostic MRIs, BRCA testing, some diagnostic biopsy services, and breast surgeons/general surgeons.

Priority: Improve access to medically-necessary MRI, biopsy services, and breast surgeons/general surgeons for EWC and Medi-Cal enrollees residing in Affiliate service region.

Objective: By 2019, collaborate with California Komen Affiliates, EWC program and Medi-Cal to address disparities in breast cancer diagnostic services for EWC enrollees to improve timely access to care by qualitative measurement of meeting minutes and policy changes to EWC.

Problem: Residents of the Affiliate service region that are enrolled in Medi-Cal may lack access to a local breast surgeon/general surgeon.

Priority: Improve access to medically-necessary MRI, biopsy services, and breast surgeons/general surgeons for EWC and Medi-Cal enrollees residing in Affiliate service region.

Objective: By 2019, collaborate with California Komen Affiliates, EWC program and Medi-Cal to address disparities in breast cancer diagnostic services for EWC enrollees to improve timely access to care by qualitative measurement of meeting minutes and policy changes to EWC.

Problem: Residents of the Affiliate service region that are enrolled in the NBCCTP may lack access to additional breast cancer treatment when re-diagnosed with breast cancer after initial treatment period has ended.

Priority: Improve access to treatment services for re-diagnosed patients ineligible for NBCCTP enrollees residing in Affiliate service region.

Objective: By 2019, collaborate with California Komen Affiliates and the BCCTP program to address disparities in breast cancer treatment for re-diagnosed breast cancer patients to improve timely access to care by qualitative measurement of meeting minutes and proposed policy changes to BCCTP.

Problem: Male residents within the Affiliate service region are not eligible for diagnostic services through neither EWC, nor treatment for breast cancer through the BCCTP.

Priority: Improve access to diagnostic services and treatment programs for men residing in Affiliate service region.

Objective: By 2019, collaborate with California Komen Affiliates, grant recipients, EWC, and BCCTP programs to address disparities in breast cancer diagnosis and treatment for men by qualitative measurement of meeting minutes and proposed policy changes to EWC and BCCTP.

Disclaimer: Comprehensive data for the Executive Summary can be found in the 2015 Susan G. Komen® Inland Empire Community Profile Report.

Introduction

Affiliate History

Susan G. Komen[®] Inland Empire (SGKIE) was founded in 1996 in Temecula, California. In 1998, Komen Inland Empire was incorporated and pledged that it would do all it could to provide needed resources and improve breast health/breast cancer in the communities within the area of Riverside and San Bernardino Counties, also known as the Inland Empire. In 1999, the Affiliate held its first Susan G. Komen Inland Empire Race for the Cure[®]. In 2009, the Affiliate opened the Rancho Mirage Breast Cancer Resource Center located in Rancho Mirage, California. The Komen Promise is to save lives and end breast cancer forever by empowering people, ensuring quality care for all and energizing science to find the cures is supported by many dedicated individuals and community partnerships wanting to make a difference.

Up to seventy-five percent of the net funds raised by the Affiliate remain in the Inland Empire to provide breast health education programs and community grants to nonprofit organizations that offer education, screening, diagnostic services and treatment support programs, while the remaining 25 percent supports breast cancer research. Since the 1999 inaugural Komen Inland Empire Race for the Cure, the Affiliate has funded more than \$6.2 million in local community grants to meet the Inland Empire breast health needs for the uninsured or underinsured residents, and over \$2.3 million to the Susan G. Komen Research Programs.

Komen Inland Empire was the recipient of the 2008 and 2011 Service/Charitable Organization of the Year by the Temecula Valley Chamber of Commerce. This award recognized the Affiliate's generosity and philanthropic efforts that benefit many women and families throughout the community. Furthermore, the Affiliate has received various recognitions from local cities and elected officials throughout the years.

The Affiliate participates in the local state cancer coalition, Inland Empire Access to Cancer Care Coalition (IEATCCC), working with various hospitals, businesses and organizations to address the cancer care needs of the region and the state as a whole. Furthermore, the Affiliate hosts the region's only Breast Health Collaborative (BHC), comprised of hospitals, businesses and organizations providing breast health services in the Inland Empire. Together, both the IEATCCC and BHC are imperative to leveraging partnerships and resources to meet the breast health needs of the region. As the leading breast cancer organization, Komen Inland Empire strives to integrate best practices, funding opportunities, and field knowledge among community health professionals, health systems, breast health and cancer organizations, as well as community members.

Affiliate Organizational Structure

As of January 2015, Komen Inland Empire retains seven staff members, which include an Executive Director, Mission Programs Manager, Development Manager, Administrative and Financial Associate, two Mission Programs Coordinators, and a Community Resource Advocate (Figure 1.1).



Figure 1.1. Susan G. Komen Inland Empire staff positions

The staff reports to the Executive Director, and the Executive Director reports to the Board of Directors, a working board, of the Affiliate. As of January 2015, nine members serve on the Board of Directors for the Affiliate (Table 1.1).

Table 1.1. Susan G. Komen Inland Empire Board of Directors

<i>Name</i>	<i>Position Title</i>
Debbie Gilligan	President
Cindy Golden	Co-Race Chair/Secretary
Craig Webber	Member-At-Large
Cindy Fitch	Co-Race Chair
Sharon Tisdale	President-Elect
Esther Phahla	Treasurer
Carl Pinkard	Member-At-Large
Jolene Church	Member-At-Large
Vanessa Ruelas	Member-At-Large

Volunteers play a vital role in the work of the Affiliate. Volunteers are overseen by Affiliate staff and members of the Board of Directors. Volunteers are engaged in community outreach and education programs, special events, administrative activities, community grants, and advocacy efforts.

Furthermore, the Affiliate aims to engage the growing aging population, offering opportunities to serve and gain additional knowledge and skills to better serve the community at large. Komen Inland Empire is a partner of the SER Jobs for Progress, a federal program to prepare the local community to attain socioeconomic inclusion in a growing global economy.

Affiliate Service Area

Komen Inland Empire's service area includes San Bernardino and Riverside Counties, totaling approximately 27,000 square miles (Figure 1.2). Unlike most metropolitan areas that have grown up around a central city, the Inland Empire is composed of many small and medium-sized cities as well as unincorporated communities, that together form the 14th-largest metropolitan area in the nation. San Bernardino is the largest county in the contiguous United States (Figure 1.3).

Komen Inland Empire serves more than 4.3 million people residing in Riverside and San Bernardino Counties, hosting 27,000 square miles of diverse geographic terrain from mountains and valleys to below sea level in the desert. The majority of the population is concentrated in the southwestern area of both counties. Many miles of the service area are national parks, military bases and desert.

Los Angeles County and Orange County border the Inland Empire to the West; Inyo and Kern to the North, San Diego and Imperial County to the South and the States of Arizona and Nevada to the East. The Inland Empire stretches from the Los Angeles County - San Bernardino County border through the San Bernardino Valley, encompassing the San Bernardino Mountains and the high and low deserts to the Nevada and Arizona state lines. Suburban sprawl, centering around the cities of Riverside, San Bernardino, and Ontario, spreads out to form a unified whole with the Greater Los Angeles area, with further development encroaching past the mountains into the outlying desert areas. The San Bernardino valley floor houses roughly over 80 percent of the total human population in the Inland Empire. Due to the vast size of the service area and the location of the majority of the region's human population, transportation is often a barrier to accessing programs and services for those living in rural communities.

Elevations throughout the region range from 11,499 feet (3,505 m) at the top of the San Gorgonio Mountain to 220 ft (-67.1 m) below sea level at the Salton Sea. The San Bernardino mountains are home to the San Bernardino National Forest and the resort communities of Big Bear Lake, Lake Arrowhead, and Running Springs. The Santa Ana River extends from Mt. San Gorgonio for nearly 100 miles (160 km) through San Bernardino, Riverside, and Orange Counties before it eventually spills into the Pacific Ocean. While temperatures are generally cool to cold in the mountains it can get hot in the valleys. In the desert resort of Palm Springs, near Joshua Tree National Park, summer temperatures can reach well over 110 degrees.

The developed area of the Inland Empire consists of the following valleys: Chino Valley, Coachella Valley, Cucamonga Valley, Menifee Valley, Murrieta Valley, Perris Valley, San Bernardino Valley (largest valley in the Inland Empire), Temecula Valley (known as Southern California Wine Country), and Victor Valley. The Inland Empire is popular for recreational activities such as skiing the San Bernardino Mountains, biking, hiking, and camping in both the mountains and deserts. Additionally, resident and visitors enjoy off road vehicle entertainment, Nascar racing, boating, tennis, and golf. The famous resorts of the Coachella Valley such as Indian Wells, La Quinta, Rancho Mirage, Palm Springs and Palm Desert are located in eastern Riverside County.

Region Demographics & Socioeconomic Data

According to the 2010 US Census, the population of the Inland Empire region is estimated at 4.381 million residents, which is comprised of 2.293 million residents in Riverside County and 2.088 million residents in San Bernardino County. Proportionally, the SGKIE service area has substantially fewer Black/African-American women than the US as a whole, and a substantially larger Latina population. Women in the SGKIE service area are younger than those in the US, indicating they are less likely to have breast cancer than areas with higher proportions of older women.

Typically, people who are socioeconomically disadvantaged (that is, with those with low income levels, low education levels, high levels of unemployment, high levels of poverty, etc.) have poorer health than those with higher socioeconomic levels.

Overall, the population in the SGKIE service area have low socioeconomic levels. The educational attainment in the SGKIE service area is lower than that in the US as a whole, as is the income level. A larger proportion of people in the SGKIE service area are unemployed when compared to the US population.

Additionally, people in certain situations may also be especially disadvantaged in relation to health. For example, those who do not speak English fluently may be unable to get health care in their native tongue, thus lowering their comprehension. People living in highly rural areas may struggle to get to the health care facilities they need to receive treatment, as there are a limited number of medical providers in rural communities. In addition, those without health insurance may be unable to afford treatment or obtain local access to treatment providers within their local community.

As illustrated in Table 2.5 from the Susan G. Komen® Inland Empire Quantitative Data Report furnished by Komen Headquarters, there are substantially more people in the SGKIE service area that are foreign born and/or linguistically isolated than in the US as a whole, indicating that language barriers may prevent people from obtaining adequate health care.

There are substantially more people in the SGKIE service area who lack health care coverage, indicating that they may not have the insurance needed to seek treatment, should they need it. In contrast, fewer people in the SGKIE service area are living in rural areas than in the US as a whole, and fewer are living in medically underserved areas than in the US. This indicates that while some people still have geographic barriers to receiving treatment, the problem is not as widespread in the SGKIE service area than in other service areas nationally.

Military Presence

March Air Reserve Base (ARB) located in Riverside County, California between the cities of Riverside and Moreno Valley is the home to the Air Force Reserve Command's largest air mobility wing of the 4th Air Force. March ARB is also home to units from the Army Reserve, Navy Reserve, Marine Corps Reserve and the California Air National Guard.

The Naval Surface Warfare Center (NSWC) located in Corona, is a division of the US Navy organization under the oversight of NAVSEA. NSWC consists of 10 major divisions.

The Marine Corps Air Ground Combat Center (MCAGCC), also known as 29 Palms, Twentynine Stumps, or simply the Stumps, is the United States Marine Corps' largest base. Officially known as Twentynine Palms Base, California is located adjacent to the city of Twentynine Palms in southern San Bernardino County, California.

Fort Irwin is located approximately 37 miles northeast of Barstow in the High Mojave Desert, midway between Las Vegas, Nevada and Los Angeles, California. Fort Irwin serves as a National Training Center and Army base.

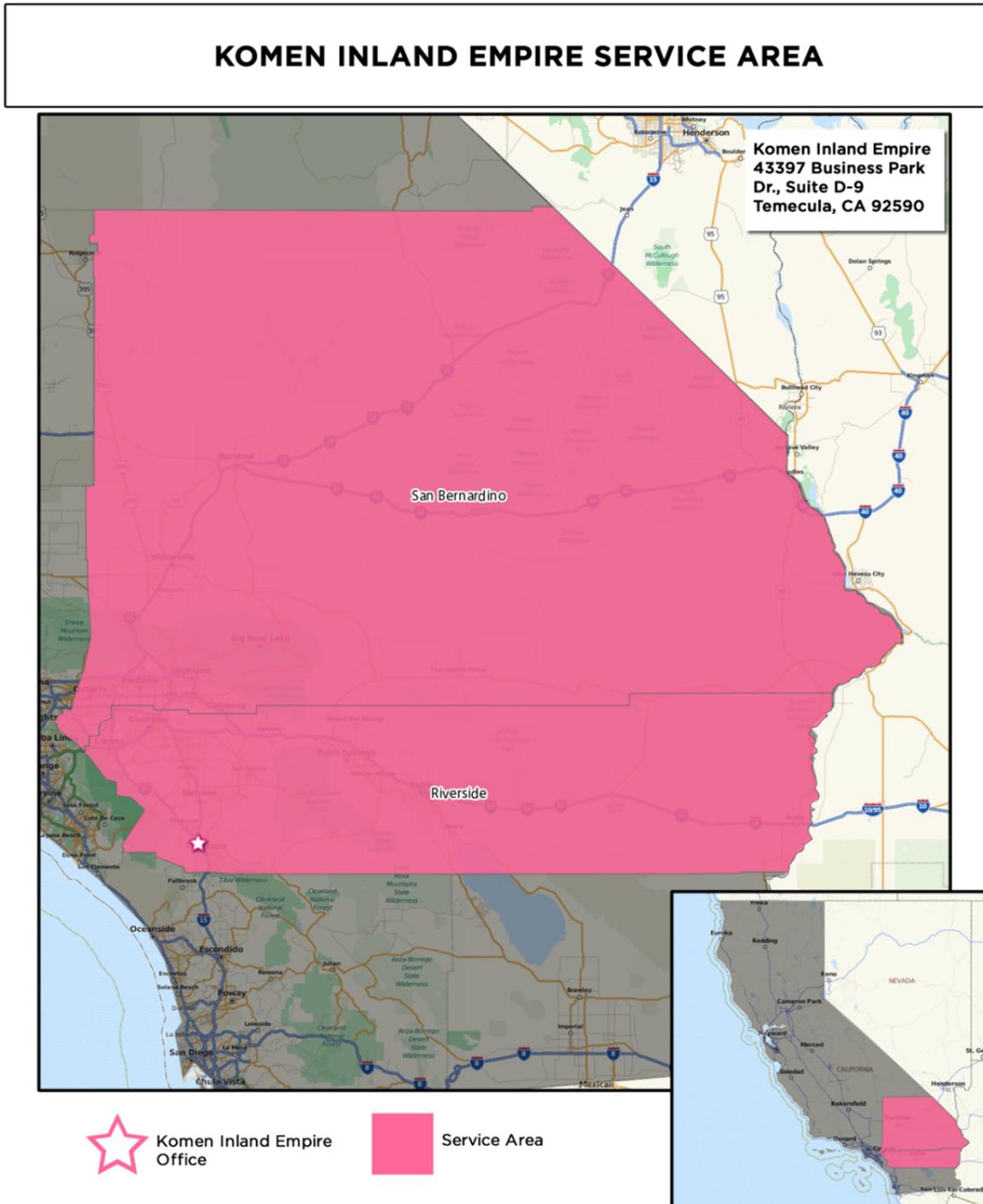


Figure 1.2. Susan G. Komen Inland Empire service area

San Bernardino and Riverside County

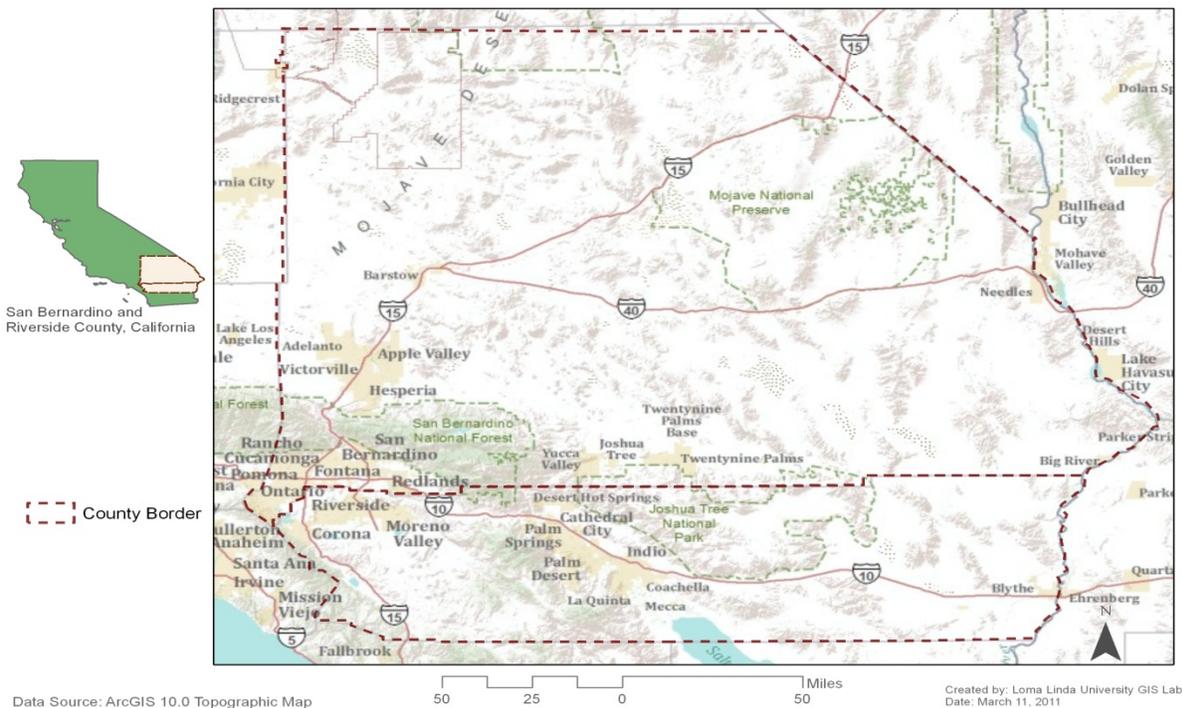


Figure 1.3. Map of San Bernardino County and Riverside County

Purpose of the Community Profile Report

In order to fulfill the Susan G. Komen® Promise, a comprehensive community needs assessment is conducted by the Affiliate every four years. The outcome is a document referred to as the Community Profile Report. The Community Profile assists the Affiliate by identifying gaps in services and programs throughout underserved communities throughout the service region. The Community Profile serves as a “road map” for the Affiliate’s mission activities, including education, outreach and granting strategies. Furthermore, the Community Profile is relevant to the overall strategic planning activities of the Affiliate. The Community Profile includes analysis of community data as well as voices of those living in the area.

The Community Profile will update demographics and breast cancer statistics in order to identify new and/or previous gaps in services and barriers to access within the service area. New gaps and barriers will be analyzed to pin point “target areas” where the Affiliate’s efforts will have the most impact. These gaps in services are incorporated into the annual Community Grant RFA (Request for Application) as possible pilot or continued projects of importance, therefore establishing focused education and granting priorities. An important component of the profile is to document existing resources so that efforts supported by Komen are non-duplicative.

It is essential to be aware of available community assets that can be evaluated for future partnerships and collaborations. Working together for solutions that improve health disparities, access to services and reducing deaths from breast cancer is vital.

The Community Profile is used in various capacities by the Affiliate to address the breast health needs and concerns of the community. It is further used to inform health care professionals and systems, community organizations, governments, and community partners about the breast health needs of the region, and assist in developing viable, community-based solutions to fulfill those needs as a region.

Quantitative Data: Measuring Breast Cancer Impact in Local Communities

Quantitative Data Report

Introduction

The purpose of the quantitative data report for Susan G. Komen® Inland Empire is to combine evidence from many credible sources and use the data to identify the highest priority areas for evidence-based breast cancer programs.

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 death rates (<http://www.healthypeople.gov/2020/default.aspx>).

The following is a summary of Komen® Inland Empire's Quantitative Data Report. For a full report please contact the Affiliate.

Breast Cancer Statistics

Incidence rates

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 (Table 2.1). 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).

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.

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. 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.

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

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 (Table 2.1). Like incidence rates, death rates may be calculated for all women or for specific groups of women (e.g. Black/African-American women).

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. Death rates are shown in terms of 100,000 women and adjusted for age.

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 incidence rates

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 (<http://seer.cancer.gov/tools/ssm/>). 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 (Table 2.1). Late-stage incidence rates are shown in terms of 100,000 women and adjusted for age.

Table 2.1. 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	198,602	122.1	-0.2%	40,736	22.6	-1.9%	70,218	43.7	-1.2%
HP2020	.	-	-	-	-	20.6*	-	-	41.0*	-
California	18,413,837	23,266	122.0	-0.6%	4,251	21.9	-2.1%	8,287	43.5	-1.7%
Komen Inland Empire Service Area	2,064,619	2,243	114.8	-1.7%	467	23.9	NA	825	41.9	-1.1%
White	1,681,767	1,919	117.4	-2.5%	395	23.9	NA	702	42.9	-1.6%
Black/African-American	185,121	175	120.1	-0.8%	49	34.5	NA	80	53.3	2.7%
American Indian/Alaska Native (AIAN)	43,702	10	30.8	1.5%	SN	SN	SN	4	11.4	-19.9%
Asian Pacific Islander (API)	154,028	112	74.6	5.9%	20	14.1	NA	36	23.8	-0.7%
Non-Hispanic/ Latina	1,124,117	1,728	124.2	-2.3%	387	26.9	NA	608	44.6	-2.1%
Hispanic/ Latina	940,501	515	89.1	0.7%	80	15.2	NA	216	35.9	2.3%
Riverside County - CA	1,058,154	1,245	117.7	-2.1%	246	22.9	-1.6%	432	41.0	-3.4%
San Bernardino County - CA	1,006,465	998	110.6	-1.4%	221	25.1	-1.2%	393	42.6	1.7%

*Target as of the writing of this report.

NA – data not available

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

Data are for years 2006-2010.

Rates are in cases or deaths per 100,000.

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

Source of incidence and late-stage data: North American Association of Central Cancer Registries (NAACCR) – Cancer in North America (CINA) Deluxe Analytic File.

Source of death rate data: Centers for Disease Control and Prevention (CDC) – National Center for Health Statistics (NCHS) mortality data in SEER*Stat.

Source of death trend data: National Cancer Institute (NCI)/CDC State Cancer Profiles.

Incidence rates and trends summary

Overall, the breast cancer incidence rate and trend in the Komen Inland Empire service area were lower than that observed in the US as a whole. The incidence rate of the Affiliate service area was significantly lower than that observed for the State of California and the incidence trend was not significantly different than the State of California.

For the United States, breast cancer incidence in Blacks/African-Americans is lower than in Whites overall. The most recent estimated breast cancer incidence rates for Asians and Pacific Islanders (APIs) and American Indians and Alaska Natives (AIANs) were lower than for Non-Hispanic Whites and Blacks/African-Americans. The most recent estimated incidence rates for Hispanics/Latinas were lower than for Non-Hispanic Whites and Blacks/African-Americans. For the Affiliate service area as a whole, the incidence rate was slightly higher among Blacks/African-Americans than Whites, lower among APIs than Whites, and lower among AIANs than Whites. The incidence rate among Hispanics/Latinas was lower than among Non-Hispanics/Latinas.

None of the counties in the Affiliate service area had substantially different incidence rates 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.

Death rates and trends

Overall, the breast cancer death rate in the Komen Inland Empire 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 **significantly higher** than that observed for the State of California.

For the United States, breast cancer death rates in Blacks/African-Americans are substantially higher than in Whites overall. The most recent estimated breast cancer death rates for APIs and AIANs were lower than for Non-Hispanic Whites and Blacks/African-Americans. The most recent estimated death rates for Hispanics/Latinas were lower than for Non-Hispanic Whites and Blacks/African-Americans. For the Affiliate service area as a whole, the death rate was higher among Blacks/African-Americans 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.

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

- San Bernardino 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 Inland Empire service area was slightly lower than that observed in the US as a whole and the late-stage incidence trend was similar to 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 California.

For the United States, late-stage incidence rates in Blacks/African-Americans are higher than among Whites. Hispanics/Latinas tend to be diagnosed with late-stage breast cancers more often than Whites. For the Affiliate service area as a whole, the late-stage incidence rate was higher among Blacks/African-Americans than Whites, lower among APIs than Whites, and lower among AIANs than Whites. The late-stage incidence rate among Hispanics/Latinas was lower than among Non-Hispanics/Latinas.

None of the counties in the Affiliate service area had substantially different late-stage incidence rates than the Affiliate service area as a whole.

Mammography Screening

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. Table 2.2 shows some screening recommendations among major organizations for women at average risk.

Table 2.2. Breast cancer screening recommendations for women at average risk

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

Because having regular 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. 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). The proportions in Table 2.3 are based on the number of women age 50 to 74 who reported in 2012 having had a mammogram in the last two years.

The data have been weighted to account for differences between the women who were interviewed and all the women in the area. For example, if 20.0 percent of the women interviewed are Hispanic/Latina, but only 10.0 percent of the total women in the area are Hispanic/Latina, weighting is used to account for this difference.

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 50.0 percent.

Because the screening proportions come from samples of women in an area and are not exact, Table 2.3 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 50.0 percent, with a confidence interval of 35.0 to 65.0 percent, the real rate might not be exactly 50.0 percent, but it's very unlikely that it's less than 35.0 or more than 65.0 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.

Table 2.3. 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%
California	4,347	3,512	81.8%	80.3%-83.2%
Komen Inland Empire Service Area	457	354	78.4%	73.2%-82.7%
White	409	319	78.1%	72.7%-82.6%
Black/African-American	26	21	82.8%	56.0%-94.8%
AIAN	10	4	43.1%	13.4%-78.8%
API	11	9	87.3%	57.8%-97.2%
Hispanic/ Latina	74	55	76.6%	62.1%-86.7%
Non-Hispanic/ Latina	381	298	78.8%	73.5%-83.3%
Riverside County - CA	253	201	78.8%	71.8%-84.4%
San Bernardino County - CA	204	153	77.9%	69.8%-84.2%

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

Data are for 2012.

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

Breast cancer screening proportions summary

The breast cancer screening proportion in the Komen Inland Empire service area was not significantly different 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 California.

For the United States, breast cancer screening proportions among Blacks/African-Americans are similar to those among Whites overall. APIs have somewhat lower screening proportions than Whites and Blacks/African-Americans. Although data are limited, screening proportions among AIANs are similar to those among Whites. Screening proportions among Hispanics/Latinas are similar to those among Non-Hispanic Whites and Blacks/African-Americans. For the Affiliate service area as a whole, the screening proportion was not

significantly different among Blacks/African-Americans than Whites, not significantly different among APIs than Whites, and not significantly different among AIANs than Whites. 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.

Population Characteristics

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 (Tables 2.4 and 2.5). 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.

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.

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.

Table 2.4. Population characteristics – demographics

Population Group	White	Black /African-American	AIAN	API	Non-Hispanic /Latina	Hispanic /Latina	Female Age 40 Plus	Female Age 50 Plus	Female Age 65 Plus
US	78.8 %	14.1 %	1.4 %	5.8 %	83.8 %	16.2 %	48.3 %	34.5 %	14.8 %
California	75.1 %	7.3 %	2.0 %	15.6 %	62.5 %	37.5 %	45.5 %	31.5 %	13.1 %
Komen Inland Empire Service Area	80.7 %	9.1 %	2.3 %	8.0 %	52.5 %	47.5 %	42.1 %	28.6 %	11.7 %
Riverside County - CA	82.3 %	7.6 %	2.2 %	7.8 %	54.4 %	45.6 %	43.4 %	29.9 %	13.1 %
San Bernardino County - CA	78.8 %	10.6 %	2.4 %	8.1 %	50.4 %	49.6 %	40.8 %	27.2 %	10.2 %
126 - Blythe	54.8%	10.0%	2.3%	2.5%	45.7%	54.3%	41.3%	28.1%	11.3%
127 - Chiriaco Summit/ Desert Center/ Eagle Mountain	68.9%	20.9%	1.2%	1.0%	49.1%	50.9%	50.7%	38.8%	16.5%
128 - Arabia/ Coachella/ Desert Beach/ Flowing Wells/ Indio South/ La Quinta East/ Mecca/ Oasis/ Thermal	50.3%	1.5%	1.3%	1.8%	15.1%	84.9%	33.5%	21.6%	8.2%

Population Group	White	Black /African-American	AIAN	API	Non-Hispanic /Latina	Hispanic /Latina	Female Age 40 Plus	Female Age 50 Plus	Female Age 65 Plus
129.1 - Bermuda Dunes South/ Indian Wells/ La Quinta West/ Palm Desert/ Rancho Mirage Central and South	80.3%	2.4%	1.1%	4.2%	72.9%	27.1%	63.7%	51.5%	29.3%
129.2 - Bermuda Dunes North/ Indio North	66.0%	2.4%	1.3%	3.3%	42.4%	57.6%	48.0%	37.7%	21.8%
129.3 - Agua Caliente/ Palm Springs Central	80.0%	2.7%	1.5%	4.9%	75.0%	25.0%	69.1%	59.1%	35.7%
129.4 - Cathedral City Southeast/ Palm Desert North/ Palm Springs South/ Rancho Mirage North	66.6%	5.1%	1.9%	5.0%	53.1%	46.9%	50.3%	37.6%	19.4%
130 - Idyllwild/ Pine Cove	81.5%	1.7%	4.5%	3.1%	79.4%	20.6%	59.7%	45.3%	18.6%
131a - Lake Elsinore/ Murrieta West/ Sedco Hills/ Wildomar	65.9%	5.7%	2.0%	8.2%	61.9%	38.1%	40.9%	25.8%	10.0%
131b - French Valley/ Murrieta East/ Temecula/ Winchester	69.4%	6.3%	2.0%	13.4%	75.2%	24.8%	41.6%	25.0%	9.3%
132 - East Hemet/ Hemet/ Valle Vista	66.6%	6.9%	3.3%	4.3%	60.8%	39.2%	47.6%	35.7%	19.6%
133.1 - Canyon Lake/ Perris/ Quail Valley/ Romoland/ Sun City/ Winchester	59.3%	8.7%	1.8%	6.1%	50.7%	49.3%	41.5%	28.8%	14.0%
133.2 - Homeland/ Lakeview/ San Jacinto	62.2%	6.5%	2.5%	5.0%	55.7%	44.3%	45.0%	33.0%	15.1%
133.3 - Glen Valley/ Mead Valley	51.5%	7.4%	1.9%	2.4%	35.3%	64.7%	39.6%	26.0%	9.5%
134 - Banning/ Beaumont/ Cabizon/ Calimesa/ Cherry Valley	56.9%	12.9%	2.9%	8.2%	59.2%	40.8%	45.0%	32.9%	15.4%
135a - Eastside/ Fairmont Park/ Riverside Downtown/ Rubidoux/ University	46.1%	9.6%	1.9%	9.9%	40.2%	59.8%	31.1%	19.6%	7.1%
135b - Edgemont/ Orange Crest/ Woodcrest	56.7%	11.4%	1.7%	8.8%	55.3%	44.7%	41.2%	26.8%	9.7%
135c - Casablanca/ Riverside Central	58.6%	6.9%	2.7%	4.8%	46.3%	53.7%	40.4%	27.5%	11.8%
135d - Arlington/ Corona East/ Home Gardens/ La Sierra/ Riverside Southwest	51.8%	5.7%	2.0%	8.3%	36.8%	63.2%	36.3%	22.9%	8.7%
135e - Corona North/ Glen Avon/ Jurupa/ Norco	54.8%	8.0%	1.6%	13.9%	54.6%	45.4%	39.4%	24.3%	8.2%
135f - Corona South/ El Cerrito/ Temescal	63.8%	6.0%	1.4%	12.5%	62.9%	37.1%	43.1%	26.5%	9.6%
135g - Moreno Valley	44.7%	18.7%	2.0%	8.9%	49.3%	50.7%	38.1%	24.4%	7.8%
142 - Argus/ Borosalvay/ Trona	80.8%	5.2%	5.8%	2.0%	84.4%	15.6%	53.2%	39.8%	17.6%
143 - Big River/ Needles	75.6%	2.8%	13.0%	1.5%	80.5%	19.5%	57.6%	45.1%	22.5%
144.1 - USMC Air-Ground Combat Training Center	75.4%	8.6%	2.6%	6.5%	78.0%	22.0%	3.6%	1.4%	0.3%
144.2 - Joshua Tree/ Landers/ Morongo Valley/ Rimrock/ Yucca Valley	84.1%	3.5%	3.0%	3.1%	83.2%	16.8%	54.3%	41.9%	19.4%
144.3 - Cadiz/ Twentynine Palms	70.3%	10.4%	3.2%	8.5%	80.7%	19.3%	39.2%	28.2%	11.5%

Population Group	White	Black /African-American	AIAN	API	Non-Hispanic /Latina	Hispanic /Latina	Female Age 40 Plus	Female Age 50 Plus	Female Age 65 Plus
145.1a - Hesperia West/ Mountain View Acres/ Victorville Central and South	54.9%	12.3%	2.4%	5.3%	52.5%	47.5%	38.1%	24.7%	9.4%
145.1b - Apple Valley/ Hesperia East	69.2%	8.7%	2.4%	4.3%	67.4%	32.6%	47.2%	34.0%	15.4%
145.2 - Adelanto/ Phelan/ Pinon Hills/ Victorville Northwest	48.6%	20.2%	2.8%	4.9%	50.2%	49.8%	33.2%	20.0%	6.4%
145.3 - Lucerne Valley	80.6%	3.5%	2.8%	2.7%	78.9%	21.1%	52.6%	37.5%	13.4%
146 - Big Bear Lake/ Fawnskin/ Moorridge/ Running Springs/ Sugarloaf	84.7%	1.5%	3.3%	2.5%	82.3%	17.7%	56.4%	41.9%	15.4%
147 - Blue Jay/ Crestline/ Lake Arrowhead/ Skyforest/ Twin Peaks	84.9%	2.0%	3.3%	2.7%	80.2%	19.8%	54.9%	39.9%	13.4%
148 - Lytle Creek/ Wrightwood	86.1%	1.7%	2.1%	5.0%	86.3%	13.7%	57.5%	41.4%	14.1%
149 - Barstow/ Daggett/ Lenwood/ Nebo Center/ Oro Grande/ Yermo	64.2%	10.7%	3.7%	4.9%	65.4%	34.6%	47.6%	34.0%	14.4%
150 - Baker/ Harvard/ Newberry Springs	63.9%	11.7%	2.8%	7.1%	72.2%	27.8%	21.6%	13.0%	4.7%
151a - Chino Hills/ Chino West Central/ Los Serranos/ Sleepy Hollow	52.8%	5.8%	1.4%	23.5%	58.4%	41.6%	43.7%	26.7%	8.2%
151b - Ontario Northeast/ Rancho Cucamonga South	56.3%	9.5%	2.0%	8.2%	47.4%	52.6%	39.8%	26.3%	9.8%
151c - Montclair/ Ontario Northwest/ Upland South	51.9%	6.1%	1.8%	6.9%	27.9%	72.1%	36.2%	22.9%	9.0%
151d - Rancho Cucamonga Northwest/ San Antonio Heights/ Upland North	70.5%	7.0%	1.5%	10.4%	70.3%	29.7%	51.8%	36.5%	13.8%
151e - Fontana North/ Rancho Cucamonga Northwest/ Rialto Northeast	51.4%	14.8%	1.7%	14.1%	57.2%	42.8%	38.8%	22.6%	6.2%
151f - Bloomington/ Colton Central and West/ Fontana South/ Rialto South	48.1%	6.4%	2.0%	3.5%	20.6%	79.4%	34.6%	21.5%	8.0%
151g - Muscoy/ San Bernardino Central	42.9%	16.2%	2.4%	4.0%	33.2%	66.8%	33.5%	21.2%	8.0%
151h - Fontana Central/ Rialto Central	44.9%	12.2%	1.8%	2.9%	23.8%	76.2%	32.8%	20.2%	7.1%
151i - Colton Southeast/ Grand Terrace/ Loma Linda/ Redlands North	54.5%	10.7%	1.7%	17.2%	65.0%	35.0%	41.5%	28.2%	10.9%
151j - Mentone/ Redlands South/ Yucaipa	78.1%	3.5%	2.0%	6.1%	75.2%	24.8%	50.8%	36.8%	16.1%
151k - Highland/ San Bernardino East	46.0%	16.6%	2.3%	6.9%	46.2%	53.8%	37.9%	25.5%	10.4%
151l - Chino Northeast/ Fontana Southwest/ Ontario South	52.4%	9.5%	1.7%	10.2%	40.4%	59.6%	38.1%	22.9%	6.9%

US, state, and county data are for 2011; MSSA data are for 2010.
Data are in the percentage of women in the population.
Source: US Census Bureau – Population Estimates and Census 2010.

Table 2.5. Population characteristics – socioeconomics

Population Group	Less than HS Education	Income Below 100% Poverty	Income Below 250% Poverty (Age: 40-64)	Un-employed	Foreign Born	Linguistic-ally Isolated	In Rural Areas	In Medically Under-served Areas	No Health Insurance (Age: 40-64)*
US	14.6 %	14.3 %	33.3 %	8.7 %	12.8 %	4.7 %	19.3 %	23.3 %	16.6 %
California	19.2 %	14.4 %	35.6 %	10.1 %	27.2 %	10.3 %	5.0 %	16.7 %	20.2 %
Komen Inland Empire Service Area	21.4 %	15.1 %	40.4 %	12.9 %	21.8 %	8.0 %	4.7 %	14.9 %	23.2 %
Riverside County - CA	20.7 %	14.2 %	39.8 %	12.9 %	22.2 %	7.8 %	4.6 %	18.2 %	23.2 %
San Bernardino County - CA	22.2 %	16.0 %	41.0 %	12.9 %	21.4 %	8.2 %	4.7 %	11.4 %	23.2 %
126 - Blythe	25.7%	17.9%	NA	15.8%	15.8%	10.2%	20.0%	0.0%	18.5%
127 - Chiriaco Summit/ Desert Center/ Eagle Mountain	38.6%	25.0%	NA	20.6%	19.3%	8.2%	100.0%	98.3%	25.3%
128 - Arabia/ Coachella/ Desert Beach/ Flowing Wells/ Indio South/ La Quinta East/ Mecca/ Oasis/ Thermal	46.3%	29.9%	NA	20.3%	39.4%	25.6%	10.2%	23.7%	31.9%
129.1 - Bermuda Dunes South/ Indian Wells/ La Quinta West/ Palm Desert/ Rancho Mirage Central and South	9.6%	10.3%	NA	10.7%	16.3%	4.1%	1.5%	0.0%	14.2%
129.2 - Bermuda Dunes North/ Indio North	21.7%	16.8%	NA	16.3%	22.0%	9.0%	2.3%	0.0%	20.7%
129.3 - Agua Caliente/ Palm Springs Central	13.2%	16.7%	NA	11.8%	20.5%	4.9%	4.3%	14.2%	18.4%
129.4 - Cathedral City Southeast/ Palm Desert North/ Palm Springs South/ Rancho Mirage North	21.9%	19.1%	NA	13.2%	26.7%	8.3%	5.7%	7.5%	24.0%
130 - Idyllwild/ Pine Cove	13.9%	13.1%	NA	16.0%	7.8%	3.1%	100.0%	0.0%	24.8%
131a - Lake Elsinore/ Murrieta West/ Sedco Hills/ Wildomar	17.2%	11.9%	NA	14.6%	17.9%	5.4%	2.9%	0.0%	18.8%
131b - French Valley/ Murrieta East/ Temecula/ Winchester	8.4%	7.2%	NA	10.6%	14.9%	3.3%	7.6%	0.0%	13.0%
132 - East Hemet/ Hemet/ Valle Vista	21.7%	20.9%	NA	18.3%	14.8%	4.9%	2.1%	30.7%	18.3%
133.1 - Canyon Lake/ Perris/ Quail Valley/ Romoland/ Sun City/ Winchester	23.4%	17.8%	NA	17.7%	19.5%	6.6%	2.3%	52.7%	21.0%
133.2 - Homeland/ Lakeview/ San Jacinto	19.2%	14.4%	NA	17.0%	20.1%	7.8%	13.0%	70.2%	19.5%
133.3 - Glen Valley/ Mead Valley	39.2%	28.4%	NA	22.8%	25.2%	9.2%	27.7%	23.6%	33.6%
134 - Banning/ Beaumont/ Cabizon/ Calimesa/ Cherry Valley	16.3%	14.2%	NA	13.3%	17.9%	6.3%	6.9%	47.0%	17.6%

Population Group	Less than HS Education	Income Below 100% Poverty	Income Below 250% Poverty (Age: 40-64)	Un-employed	Foreign Born	Linguistically Isolated	In Rural Areas	In Medically Under-served Areas	No Health Insurance (Age: 40-64)*
135a - Eastside/ Fairmont Park/ Riverside Downtown/ Rubidoux/ University	33.0%	27.1%	NA	18.8%	27.9%	13.0%	0.0%	62.3%	27.4%
135b - Edgemont/ Orange Crest/ Woodcrest	20.0%	16.5%	NA	13.2%	21.8%	6.5%	1.2%	0.0%	20.1%
135c - Casablanca/ Riverside Central	26.6%	17.7%	NA	15.1%	23.1%	8.8%	0.0%	0.0%	23.1%
135d - Arlington/ Corona East/ Home Gardens/ La Sierra/ Riverside Southwest	31.1%	17.6%	NA	15.2%	31.4%	12.5%	0.1%	42.8%	25.5%
135e - Corona North/ Glen Avon/ Jurupa/ Norco	20.1%	7.9%	NA	12.1%	24.7%	6.8%	0.0%	4.2%	17.2%
135f - Corona South/ El Cerrito/ Temescal	13.9%	6.5%	NA	11.1%	22.7%	5.0%	0.7%	0.0%	14.0%
135g - Moreno Valley	21.1%	18.5%	NA	13.1%	24.0%	6.6%	0.4%	0.0%	21.3%
142 - Argus/ Borosalvay/ Trona	20.4%	22.3%	NA	11.7%	2.1%	1.2%	92.4%	0.0%	23.8%
143 - Big River/ Needles	18.1%	24.7%	NA	10.4%	5.3%	2.2%	33.5%	78.3%	21.2%
144.1 - USMC Air-Ground Combat Training Center	1.0%	12.0%	NA	14.0%	5.7%	0.0%	0.7%	0.0%	0.0%
144.2 - Joshua Tree/ Landers/ Morongo Valley/ Rimrock/ Yucca Valley	14.0%	18.8%	NA	16.4%	6.3%	1.3%	42.8%	65.2%	18.3%
144.3 - Cadiz/ Twentynine Palms	13.8%	18.7%	NA	18.0%	7.3%	2.3%	35.0%	0.0%	13.4%
145.1a - Hesperia West/ Mountain View Acres/ Victorville Central and South	22.5%	23.0%	NA	18.0%	15.2%	5.8%	6.0%	0.0%	20.1%
145.1b - Apple Valley/ Hesperia East	16.6%	20.3%	NA	17.1%	8.6%	3.0%	2.4%	0.0%	16.7%
145.2 - Adelanto/ Phelan/ Pinon Hills/ Victorville Northwest	28.1%	27.1%	NA	20.6%	19.2%	5.1%	15.0%	0.0%	21.2%
145.3 - Lucerne Valley	10.6%	17.2%	NA	7.9%	9.4%	1.6%	61.7%	0.0%	15.7%
146 - Big Bear Lake/ Fawnskin/ Moorridge/ Running Springs/ Sugarloaf	12.7%	16.0%	NA	13.5%	10.7%	2.4%	18.8%	7.4%	25.3%
147 - Blue Jay/ Crestline/ Lake Arrowhead/ Skyforest/ Twin Peaks	9.2%	14.7%	NA	11.6%	8.3%	1.9%	7.6%	0.0%	15.2%
148 - Lytle Creek/ Wrightwood	3.2%	3.7%	NA	11.7%	9.0%	1.7%	36.9%	0.0%	9.8%
149 - Barstow/ Daggett/ Lenwood/ Nebo Center/ Oro Grande/ Yermo	16.3%	20.0%	NA	12.8%	10.5%	3.7%	29.0%	0.0%	16.6%
150 - Baker/ Harvard/ Newberry Springs	11.1%	15.8%	NA	18.9%	11.9%	4.0%	30.3%	0.0%	7.8%

Population Group	Less than HS Education	Income Below 100% Poverty	Income Below 250% Poverty (Age: 40-64)	Un-employed	Foreign Born	Linguistically Isolated	In Rural Areas	In Medically Under-served Areas	No Health Insurance (Age: 40-64)*
151a - Chino Hills/ Chino West Central/ Los Serranos/ Sleepy Hollow	15.3%	8.3%	NA	10.5%	26.2%	7.1%	2.8%	0.0%	16.0%
151b - Ontario Northeast/ Rancho Cucamonga South	20.4%	12.3%	NA	13.2%	26.2%	8.2%	0.0%	0.0%	20.1%
151c - Montclair/ Ontario Northwest/ Upland South	33.3%	20.1%	NA	14.6%	34.2%	14.7%	0.0%	2.4%	27.9%
151d - Rancho Cucamonga Northwest/ San Antonio Heights/ Upland North	8.3%	8.9%	NA	9.1%	16.2%	4.0%	0.0%	0.0%	12.2%
151e - Fontana North/ Rancho Cucamonga Northwest/ Rialto Northeast	11.9%	5.6%	NA	11.7%	20.5%	5.4%	1.2%	5.3%	14.0%
151f - Bloomington/ Colton Central and West/ Fontana South/ Rialto South	38.2%	20.7%	NA	15.4%	32.3%	16.7%	0.0%	48.5%	30.1%
151g - Muscoy/ San Bernardino Central	38.1%	33.9%	NA	18.6%	25.5%	13.7%	0.0%	22.6%	25.9%
151h - Fontana Central/ Rialto Central	40.2%	25.2%	NA	18.1%	31.8%	18.9%	0.0%	32.3%	30.6%
151i - Colton Southeast/ Grand Terrace/ Loma Linda/ Redlands North	12.6%	13.3%	NA	9.3%	21.8%	5.2%	0.7%	3.1%	14.9%
151j - Mentone/ Redlands South/ Yucaipa	9.7%	9.5%	NA	10.8%	10.8%	2.6%	3.6%	22.2%	14.0%
151k - Highland/ San Bernardino East	31.8%	29.5%	NA	17.1%	21.5%	10.1%	0.0%	17.0%	24.1%
151l - Chino Northeast/ Fontana Southwest/ Ontario South	22.5%	9.3%	NA	12.9%	24.9%	8.9%	1.4%	0.0%	20.1%

* Health Insurance coverage data for MSSAs are for all ages.

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 and American Community Survey (ACS) for 2008-2012.

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 and 2008-2012.

Population characteristics summary

Proportionately, the Komen Inland Empire service area has a slightly larger White female population than the US as a whole, a substantially smaller Black/African-American female population, a slightly larger Asian and Pacific Islander (API) female population, a slightly larger American Indian and Alaska Native (AIAN) female population, and a substantially larger Hispanic/Latina female population. The Affiliate's female population is younger than that of the US as a whole. The Affiliate's education level is substantially lower than and income level is slightly lower than those of the US as a whole. There are a substantially larger percentage of people who are unemployed in the Affiliate service area. The Affiliate service area has a substantially larger percentage of people who are foreign born and a substantially larger

percentage of people who are linguistically isolated. There are a substantially smaller percentage of people living in rural areas, a substantially larger percentage of people without health insurance, and a substantially smaller percentage of people living in medically underserved areas.

The following MSSAs have substantially larger Black/African-American female population percentages than that of the Affiliate service area as a whole:

- 127 - Chiriaco Summit/ Desert Center/ Eagle Mountain
- 135g - Moreno Valley
- 145.2 - Adelanto/ Phelan/ Pinon Hills/ Victorville Northwest
- 151e - Fontana North/ Rancho Cucamonga Northwest/ Rialto Northeast
- 151g - Muscoy/ San Bernardino Central
- 151k - Highland/ San Bernardino East

The following MSSAs have substantially larger API female population percentages than that of the Affiliate service area as a whole:

- 131b - French Valley/ Murrieta East/ Temecula/ Winchester
- 135e - Corona North/ Glen Avon/ Jurupa/ Norco
- 135f - Corona South/ El Cerrito/ Temescal
- 151a - Chino Hills/ Chino West Central/ Los Serranos/ Sleepy Hollow
- 151e - Fontana North/ Rancho Cucamonga Northwest/ Rialto Northeast
- 151i - Colton Southeast/ Grand Terrace/ Loma Linda/ Redlands North

The following MSSAs have substantially larger AIAN female population percentages than that of the Affiliate service area as a whole:

- 142 - Argus/ Borosalvay/ Trona
- 143 - Big River/ Needles

The following MSSAs have substantially larger Hispanic/Latina female population percentages than that of the Affiliate service area as a whole:

- 126 - Blythe
- 128 - Arabia/ Coachella/ Desert Beach/ Flowing Wells/ Indio South/ La Quinta East/ Mecca/ Oasis/ Thermal
- 129.2 - Bermuda Dunes North/ Indio North
- 133.3 - Glen Valley/ Mead Valley
- 135a - Eastside/ Fairmont Park/ Riverside Downtown/ Rubidoux/ University
- 135c - Casablanca/ Riverside Central
- 135d - Arlington/ Corona East/ Home Gardens/ La Sierra/ Riverside Southwest
- 151b - Ontario Northeast/ Rancho Cucamonga South
- 151c - Montclair/ Ontario Northwest/ Upland South
- 151f - Bloomington/ Colton Central and West/ Fontana South/ Rialto South
- 151g - Muscoy/ San Bernardino Central
- 151h - Fontana Central/ Rialto Central
- 151k - Highland/ San Bernardino East
- 151l - Chino Northeast/ Fontana Southwest/ Ontario South

The following MSSAs have substantially older female population percentages than that of the Affiliate service area as a whole:

- 129.1 - Bermuda Dunes South/ Indian Wells/ La Quinta West/ Palm Desert/ Rancho Mirage Central and South
- 129.2 - Bermuda Dunes North/ Indio North
- 129.3 - Agua Caliente/ Palm Springs Central
- 129.4 - Cathedral City Southeast/ Palm Desert North/ Palm Springs South/ Rancho Mirage North
- 130 - Idyllwild/ Pine Cove
- 132 - East Hemet/ Hemet/ Valle Vista
- 142 - Argus/ Borosalvay/ Trona
- 143 - Big River/ Needles
- 144.2 - Joshua Tree/ Landers/ Morongo Valley/ Rimrock/ Yucca Valley

The following MSSAs have substantially lower education levels than that of the Affiliate service area as a whole:

- 127 - Chiriaco Summit/ Desert Center/ Eagle Mountain
- 128 - Arabia/ Coachella/ Desert Beach/ Flowing Wells/ Indio South/ La Quinta East/ Mecca/ Oasis/ Thermal
- 133.3 - Glen Valley/ Mead Valley
- 135a - Eastside/ Fairmont Park/ Riverside Downtown/ Rubidoux/ University
- 135c - Casablanca/ Riverside Central
- 135d - Arlington/ Corona East/ Home Gardens/ La Sierra/ Riverside Southwest
- 145.2 - Adelanto/ Phelan/ Pinon Hills/ Victorville Northwest
- 151c - Montclair/ Ontario Northwest/ Upland South
- 151f - Bloomington/ Colton Central and West/ Fontana South/ Rialto South
- 151g - Muscoy/ San Bernardino Central
- 151h - Fontana Central/ Rialto Central
- 151k - Highland/ San Bernardino East

The following MSSAs have substantially lower income levels than that of the Affiliate service area as a whole:

- 127 - Chiriaco Summit/ Desert Center/ Eagle Mountain
- 128 - Arabia/ Coachella/ Desert Beach/ Flowing Wells/ Indio South/ La Quinta East/ Mecca/ Oasis/ Thermal
- 132 - East Hemet/ Hemet/ Valle Vista
- 133.3 - Glen Valley/ Mead Valley
- 135a - Eastside/ Fairmont Park/ Riverside Downtown/ Rubidoux/ University
- 142 - Argus/ Borosalvay/ Trona
- 143 - Big River/ Needles
- 145.1a - Hesperia West/ Mountain View Acres/ Victorville Central and South
- 145.1b - Apple Valley/ Hesperia East
- 145.2 - Adelanto/ Phelan/ Pinon Hills/ Victorville Northwest
- 151c - Montclair/ Ontario Northwest/ Upland South
- 151f - Bloomington/ Colton Central and West/ Fontana South/ Rialto South
- 151g - Muscoy/ San Bernardino Central
- 151h - Fontana Central/ Rialto Central
- 151k - Highland/ San Bernardino East

The following MSSAs have substantially lower employment levels than that of the Affiliate service area as a whole:

- 127 - Chiriaco Summit/ Desert Center/ Eagle Mountain
- 128 - Arabia/ Coachella/ Desert Beach/ Flowing Wells/ Indio South/ La Quinta East/ Mecca/ Oasis/ Thermal
- 129.2 - Bermuda Dunes North/ Indio North
- 130 - Idyllwild/ Pine Cove
- 132 - East Hemet/ Hemet/ Valle Vista
- 133.1 - Canyon Lake/ Perris/ Quail Valley/ Romoland/ Sun City/ Winchester
- 133.2 - Homeland/ Lakeview/ San Jacinto
- 133.3 - Glen Valley/ Mead Valley
- 135a - Eastside/ Fairmont Park/ Riverside Downtown/ Rubidoux/ University
- 144.2 - Joshua Tree/ Landers/ Morongo Valley/ Rimrock/ Yucca Valley
- 144.3 - Cadiz/ Twentynine Palms
- 145.1a - Hesperia West/ Mountain View Acres/ Victorville Central and South
- 145.1b - Apple Valley/ Hesperia East
- 145.2 - Adelanto/ Phelan/ Pinon Hills/ Victorville Northwest
- 150 - Baker/ Harvard/ Newberry Springs
- 151g - Muscoy/ San Bernardino Central
- 151h - Fontana Central/ Rialto Central
- 151k - Highland/ San Bernardino East

The MSSAs with substantial foreign born and linguistically isolated populations are:

- 128 - Arabia/ Coachella/ Desert Beach/ Flowing Wells/ Indio South/ La Quinta East/ Mecca/ Oasis/ Thermal
- 135a - Eastside/ Fairmont Park/ Riverside Downtown/ Rubidoux/ University
- 135d - Arlington/ Corona East/ Home Gardens/ La Sierra/ Riverside Southwest
- 151c - Montclair/ Ontario Northwest/ Upland South
- 151f - Bloomington/ Colton Central and West/ Fontana South/ Rialto South
- 151h - Fontana Central/ Rialto Central

The following MSSAs have substantially larger percentage of adults without health insurance than does the Affiliate service area as a whole:

- 128 - Arabia/ Coachella/ Desert Beach/ Flowing Wells/ Indio South/ La Quinta East/ Mecca/ Oasis/ Thermal
- 133.3 - Glen Valley/ Mead Valley
- 151f - Bloomington/ Colton Central and West/ Fontana South/ Rialto South
- 151h - Fontana Central/ Rialto Central

Priority Areas

Healthy People 2020 forecasts

Healthy People 2020 (HP2020) is a major federal government initiative that provides specific health objectives for communities and for the country as a whole. 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 (Target as of the writing of this report: 41.0 cases per 100,000 women).
- Reducing the number of breast cancers that are found at a late-stage (Target as of the writing of this report: 41.0 cases per 100,000 women).

To see how well counties in the Komen Inland Empire service area are progressing toward these targets, the report uses the following information:

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

These data are used to estimate how many years it will take for each county to meet the HP2020 objectives. 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 and late-stage diagnosis 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.

Identification of priority areas

The purpose of this report is to combine evidence from many credible sources and use the data 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.

Counties are classified as follows (Table 2.6):

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

Table 2.6. 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.

Affiliate Service Area Healthy People 2020 Forecasts and Priority Areas

The results presented in Table 2.7 help identify which counties have the greatest needs when it comes to meeting the HP2020 breast cancer targets.

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

Trends can change for a number of reasons, including:

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

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

Table 2.7. Intervention priorities for Komen Inland Empire service area with predicted time to achieve the HP2020 breast cancer targets and key population characteristics

Population Group	Priority	Predicted Time to Achieve Death Rate Target	Predicted Time to Achieve Late-stage Incidence Target	Key Population Characteristics
San Bernardino County - CA	Highest	13 years or longer	13 years or longer	
Riverside County - CA	Medium Low	7 years	Currently meets target	
126 - Blythe	NA	NA	NA	%Hispanic/Latina, rural
127 - Chiriaco Summit/ Desert Center/ Eagle Mountain	NA	NA	NA	%Black/African-American, education, poverty, employment, rural, medically underserved
128 - Arabia/ Coachella/ Desert Beach/ Flowing Wells/ Indio South/ La Quinta East/ Mecca/ Oasis/ Thermal	NA	NA	NA	%Hispanic/Latina, education, poverty, employment, foreign, language, rural, insurance, medically underserved
129.1 - Bermuda Dunes South/ Indian Wells/ La Quinta West/ Palm Desert/ Rancho Mirage Central and South	NA	NA	NA	Older
129.2 - Bermuda Dunes North/ Indio North	NA	NA	NA	%Hispanic/Latina, older, employment
129.3 - Agua Caliente/ Palm Springs Central	NA	NA	NA	Older
129.4 - Cathedral City Southeast/ Palm Desert North/ Palm Springs South/ Rancho Mirage North	NA	NA	NA	Older
130 - Idyllwild/ Pine Cove	NA	NA	NA	Older, employment, rural
131b - French Valley/ Murrieta East/ Temecula/ Winchester	NA	NA	NA	%API
131c - Temecula South	NA	NA	NA	%API
132 - East Hemet/ Hemet/ Valle Vista	NA	NA	NA	Older, poverty, employment, medically underserved
133.1 - Canyon Lake/ Perris/ Quail Valley/ Romoland/ Sun City/ Winchester	NA	NA	NA	Employment, medically underserved
133.2 - Homeland/ Lakeview/ San Jacinto	NA	NA	NA	Employment, rural, medically underserved

Population Group	Priority	Predicted Time to Achieve Death Rate Target	Predicted Time to Achieve Late-stage Incidence Target	Key Population Characteristics
133.3 - Glen Valley/ Mead Valley	NA	NA	NA	%Hispanic/Latina, education, poverty, employment, rural, insurance, medically underserved
134 - Banning/ Beaumont/ Cabizon/ Calimesa/ Cherry Valley	NA	NA	NA	Medically underserved
135a - Eastside/ Fairmont Park/ Riverside Downtown/ Rubidoux/ University	NA	NA	NA	%Hispanic/Latina, education, poverty, employment, foreign, language, medically underserved
135c - Casablanca/ Riverside Central	NA	NA	NA	%Hispanic/Latina, education
135d - Arlington/ Corona East/ Home Gardens/ La Sierra/ Riverside Southwest	NA	NA	NA	%Hispanic/Latina, education, foreign, language, medically underserved
135e - Corona North/ Glen Avon/ Jurupa/ Norco	NA	NA	NA	%API
135f - Corona South/ El Cerrito/ Temescal	NA	NA	NA	%API
135g - Moreno Valley	NA	NA	NA	%Black/African-American
142 - Argus/ Borosalvay/ Trona	NA	NA	NA	%AIAN, older, poverty, rural
143 - Big River/ Needles	NA	NA	NA	%AIAN, older, poverty, rural, medically underserved
144.2 - Joshua Tree/ Landers/ Morongo Valley/ Rimrock/ Yucca Valley	NA	NA	NA	Older, employment, rural, medically underserved
144.3 - Cadiz/ Twentynine Palms	NA	NA	NA	Employment, rural
145.1a - Hesperia West/ Mountain View Acres/ Victorville Central and South	NA	NA	NA	Poverty, employment
145.1b - Apple Valley/ Hesperia East	NA	NA	NA	Employment
145.2 - Adelanto/ Phelan/ Pinon Hills/ Victorville Northwest	NA	NA	NA	%Black/African-American, education, poverty, employment, rural
145.3 - Lucerne Valley	NA	NA	NA	Rural
146 - Big Bear Lake/ Fawnskin/ Moorridge/ Running Springs/ Sugarloaf	NA	NA	NA	Rural

Population Group	Priority	Predicted Time to Achieve Death Rate Target	Predicted Time to Achieve Late-stage Incidence Target	Key Population Characteristics
148 - Lytle Creek/ Wrightwood	NA	NA	NA	Rural
149 - Barstow/ Daggett/ Lenwood/ Nebo Center/ Oro Grande/ Yermo	NA	NA	NA	Poverty, rural
150 - Baker/ Harvard/ Newberry Springs	NA	NA	NA	Employment, rural
151a - Chino Hills/ Chino West Central/ Los Serranos/ Sleepy Hollow	NA	NA	NA	%API
151b - Ontario Northeast/ Rancho Cucamonga South	NA	NA	NA	%Hispanic/Latina
151c - Montclair/ Ontario Northwest/ Upland South	NA	NA	NA	%Hispanic/Latina, education, poverty, foreign, language
151e - Fontana North/ Rancho Cucamonga Northwest/ Rialto Northeast	NA	NA	NA	%Black/African-American, %API
151f - Bloomington/ Colton Central and West/ Fontana South/ Rialto South	NA	NA	NA	%Hispanic/Latina, education, poverty, foreign, language, insurance, medically underserved
151g - Muscoy/ San Bernardino Central	NA	NA	NA	%Black/African-American, %Hispanic/Latina, education, poverty, employment, language, medically underserved
151h - Fontana Central/ Rialto Central	NA	NA	NA	%Hispanic/Latina, education, poverty, employment, foreign, language, insurance, medically underserved
151i - Colton Southeast/ Grand Terrace/ Loma Linda/ Redlands North	NA	NA	NA	%API
151j - Mentone/ Redlands South/ Yucaipa	NA	NA	NA	Medically underserved
151k - Highland/ San Bernardino East	NA	NA	NA	%Black/African-American, %Hispanic/Latina, education, poverty, employment
151l - Chino Northeast/ Fontana Southwest/ Ontario South	NA	NA	NA	%Hispanic/Latina

NA – data not available.

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

Data Limitations

The following data limitations need to be considered when utilizing the data of the Quantitative Data Report:

- The most recent data available were used but, for cancer incidence and deaths, these data are still several years behind.
- For some areas, data might not be available or might be of varying quality.
- Areas with small populations might not have enough breast cancer cases or breast cancer deaths each year to support the generation of reliable statistics.
- There are often several sources of cancer statistics for a given population and geographic area; therefore, other sources of cancer data may result in minor differences in the values even in the same time period.
- Data on cancer rates for specific racial and ethnic subgroups such as Somali, Hmong, or Ethiopian are not generally available.
- The various types of breast cancer data in this report are inter-dependent.
- 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.
- 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.
- Not all breast cancer cases have a stage indication.

Quantitative Data Report Conclusions

Highest priority areas

One county in the Komen Inland Empire service area is in the highest priority category. San Bernardino County is not likely to meet either the death rate or late-stage incidence rate HP2020 targets.

The death rate trend in San Bernardino County (-1.2 percent) is significantly less favorable than that of California (-2.1 percent). The late-stage incidence rate trend in San Bernardino County (1.7 percent), while not significantly lower than that of the Affiliate service area as a whole (-1.1 percent), appears to be rising.

Medium low priority areas

The other county in the Komen Inland Empire service area is in the medium low priority category. Riverside County is expected to take seven years to reach the death rate HP2020 target.

Selection of Target Communities

Purpose of Report

This narrative report provides a brief summary of the data contained in “Susan G. Komen® Inland Empire Quantitative Data Report 2014”. This report synthesizes this data to identify high priority areas and target communities within the geographic bounds of SGKIE.

Healthy People 2020 Framework

Healthy People 2020 (HP2020) is a major federal government initiative that has set specific health objectives for improving the health of communities and for the country as a whole by the year 2020. Specifically, these objectives include:

- Reducing the rate of late-stage breast cancer diagnoses to 19.6 cases per 100,000 women
- Reducing the rate of breast cancer death to 20.6 breast cancer-related deaths per 100,000 women

The HP2020 framework is utilized here to identify areas that are at risk—that is, communities where trends indicate there may be issues in reaching the HP2020 objectives in time.

Thus, the purpose of this document is to identify between two to five target communities within the SGKIE service area that have the highest risk of not achieving the HP2020 targets.

Summary of Quantitative Data

HP2020 Priority Areas

SGKIE's service area is comprised of two counties: Riverside County and San Bernardino County. Based on the HP2020 benchmarks, San Bernardino County is rated in the “highest priority” category. Specifically, San Bernardino County is not likely to meet either the death rate or the late-stage incidence rates set by the HP2020 objectives within the next 13 years.

In contrast, Riverside County is rated “medium low priority” category. Riverside County has already met the HP2020 late-stage incidence target, and is anticipated to take approximately seven years to meet the death rate target. Thus, overall, SGKIE will focus primarily on services for the San Bernardino County, with a lesser focus on the Riverside County service areas.

Breast Cancer Incidence Rates and Trends

Breast cancer incidence rates show the frequency of new cases of breast cancer. Breast cancer incidence rates in the SGKIE service area were lower than in the US as a whole and the State of California. There was no significant change in SGKIE incidence trend compared to that of the State of California, indicating that SGKIE incidence trends mirror those in the state as a whole. In the SGKIE service area, the incidence rate was highest for Black/African-American women (120.1 new cases per 100,000 women), followed by White women (117.4), and finally by Asian and Pacific Islander (API) women at 74.6 (Table 2.1). American Indian/Alaskan Native women had the lowest incidence rate of all at 30.8 new cases per 100,000, but these numbers should be interpreted cautiously, as the sample size was very small. Thus, it is clear that Black/African-American women have a higher incidence of breast cancer than other races in the SGKIE service area, and are a population with a high level of need.

Breast Cancer Deaths

Death rates are the frequency of death from breast cancer. A fundamental goal of SGKIE is to reduce the number of women dying from breast cancer (i.e., lower the death rate) and to have negative death rate trends. As illustrated in Table 2.1, the target rate set by HP2020 is 20.6 deaths per 100,000 women.

Overall, the breast cancer death rate in the SGKIE service area was higher than that for the State of California and the US as a whole. As illustrated in Table 2.1, both Riverside County and

San Bernardino County currently have death rates higher than the targeted rate of 20.6 per 100,000 women (22.9 and 25.1, respectively).

Death rates in the US and the SGKIE service area are especially high for Black/African-American women. As illustrated in Table 2.1, in the SGKIE service area, the death rate for Black/African-American women was 34.5 per 100,000 women versus only 23.9 for White women and 14.1 for API women (no data were available for AIAN women, due to small sample sizes). Thus, it is clear that Black/African-American women have a high need for SGKIE services. Death rates were lower among Hispanic/Latinas than among non-Hispanics/Latinas, indicating a lower level of need.

As illustrated in Table 2.1, San Bernardino County has a worse death rate trend than SGKIE as a whole, indicating that the death rate is not falling as fast as it should be in that particular county. Additionally, it is predicted that San Bernardino County will need 13 years or more to reach the HP2020, and thus, is identified as an area with a high need (Table 2.7).

Late-stage Incidence Rate and Trends

People with breast cancer have a better chance of survival if the disease is discovered early and treated immediately. Typically, the later the stage of cancer at diagnosis, the poorer the chances for survival are. HP2020 set a target goal of 41.0 late-stage cases per 100,000 women. As illustrated in Table 2.1, Riverside County currently meets this goal, but unfortunately, San Bernardino County does not (42.6 per 100,000 women). Additionally, it is anticipated that San Bernardino County will take 13 years or longer to achieve the HP2020 goal, making it an area of great need (Table 2.7).

The late-stage incidence rates in the SGKIE service area as a whole were relatively similar to that in the state of California and the US as a whole. Mirroring national trends, Black/African-American women in the SGKIE service area had higher late-stage incidence rates than Whites, again emphasizing the need to focus on this population (53.3 per 100,000 women versus 42.9; Table 2.1). As illustrated in Table 2.1, API women and AIAN women had the lowest levels of late-stage incidence (23.8 per 100,000 women and 11.4, respectively, although due to relatively small sample size, the AIAN statistics should be interpreted with caution).

As illustrated in Table 2.1, late-stage incidence rates were lower in Hispanic/Latina women than non-Hispanic women (35.9 versus 44.6, respectively).

Breast Cancer Mammography Screening

Regular mammograms can help to diagnose breast cancer early and may lower the risk of dying from breast cancer. As illustrated in Table 2.3, 78.4 percent of women in the SGKIE service area between the ages of 50 to 74 report having a mammogram within the last two years.

This proportion was not significantly different than that observed in the US as a whole or in the State of California (78.4 percent compared to 77.5 percent and 81.8 percent, respectively, as illustrated in Table 2.3). This indicates that the proportion of women in the SGKIE service area getting mammograms is comparable to elsewhere in the country. As illustrated in Table 2.3, there were no significant racial/ethnic differences in proportion of women getting mammograms in the SGKIE service area, indicating that comparable proportions of all races are receiving mammograms (78.1 percent for Whites, 82.8 percent for Blacks/African-Americans, 87.3

percent for API, and 43.1 percent for AIAN, although this last number should be interpreted cautiously due to low sample size). Both counties had similar mammography screening levels as well.

Population Characteristics

Certain demographic characteristics can influence a person's health and wellness. As illustrated previously Black/African-American women have higher breast cancer death rates and late-stage diagnoses rates, putting them at especially high risk.

Proportionally, the SGKIE service area has substantially fewer Black/African-American women than the US as a whole, and a substantially larger Hispanic/Latina population (Table 2.4). As illustrated in Table 2.4, women in the SGKIE service area are younger than those in the US, indicating they are less likely to have breast cancer than areas with higher proportions of older women.

Typically, people who are socioeconomically disadvantaged (that is, with those with low income levels, low education levels, high levels of unemployment, high levels of poverty, etc.) have poorer health than those with higher socioeconomic levels.

Overall, the population in the SGKIE service area have low socioeconomic levels. As illustrated in Table 2.5, the educational attainment in the SGKIE service area is lower than that in the US as a whole, as is the income level. A larger proportion of people in the SGKIE service area are unemployed when compared to the US population.

Additionally, people in certain situations may also be especially disadvantaged in relation to health. For example, those who do not speak English fluently may be unable to get health care in their native tongue, thus lowering their comprehension. People living in highly rural areas may struggle to get to the health care facilities they need to receive treatment, and those without health insurance may be unable to afford treatment.

As illustrated in Table 2.5, there are substantially more people in the SGKIE service area that are foreign born and/or linguistically isolated than in the US as a whole, indicating that language barriers may prevent people from obtaining adequate health care. There are substantially more people in the SGKIE service area who lack health care coverage, indicating that they may not have the insurance needed to seek treatment, should they need it.

In contrast, fewer people in the SGKIE service area are living in rural areas than in the US as a whole, and fewer are living in medically underserved areas than in the US, as illustrated in Table 2.5. This indicates that while some people still have geographic barriers to receiving treatment, the problem is not as widespread in the SGKIE service area than in other service areas nationally.

Identification of Target Communities and Justification

As per the HP2020 benchmarks, San Bernardino County is rated as the "highest priority" level in relation to the ability to meet both death rate and late-stage incidence rate targets. Thus, SGKIE will focus efforts on San Bernardino County.

Black/African-American women have higher breast cancer incidence rates, late-stage incidence rates, and death rates than their White counterparts, making them an especially high priority group. Thus, SGKIE will focus efforts in areas that have a high proportion of Black/African-American women.

Typically, people with low income, low education levels, low rates of health insurance, and high rates of unemployment are at great risk for health disparities. Thus, SGKIE will also focus heavily on communities that are impoverished and/or lacking in health insurance.

In order to provide focused target communities, this report uses the Medical Service Study Areas (MSSAs) as the unit of analysis. Based on these criteria, and on the Quantitative Data Report findings, the three following target communities are identified (presented in numeric order):

- MSSA 128 (Riverside County)
- MSSA 145.2 (San Bernardino County)
- MSSA 151g and MSSA 151k (San Bernardino County)

MSSA 128

MSSA 128, in Riverside County, includes the communities of Arabia, Coachella, Desert Beach, Flowing Wells, Indio South, La Quinta East, Mecca, Oasis, and Thermal (Figure 2.1). Approximately 97,097 people live in this MSSA.

This MSSA is extremely impoverished; as illustrated in Table 2.5, 46.3 percent have less than a high school education. As illustrated in Table 2.5, 29.9 percent of the population are living in poverty—a rate more than double the rate in the US and the state of California. As illustrated in Table 2.5, 20.3 percent are unemployed, and 25.3 percent lack health insurance. Nearly a quarter of this MSSA (23.7 percent) are considered medically underserved, as illustrated in Table 2.5.

This MSSA has by far the largest population of linguistically isolated people in the SGKIE service area; as illustrated in Table 2.5, 25.6 percent are considered linguistically isolated, compared to only 8.0 percent for the SGKIE service area as a whole, and 10.3 percent for the state of California. Not surprisingly, 39.4 percent of this MSSA are foreign-born, as illustrated in Table 2.5. Language barriers are likely to be extremely common in this population.

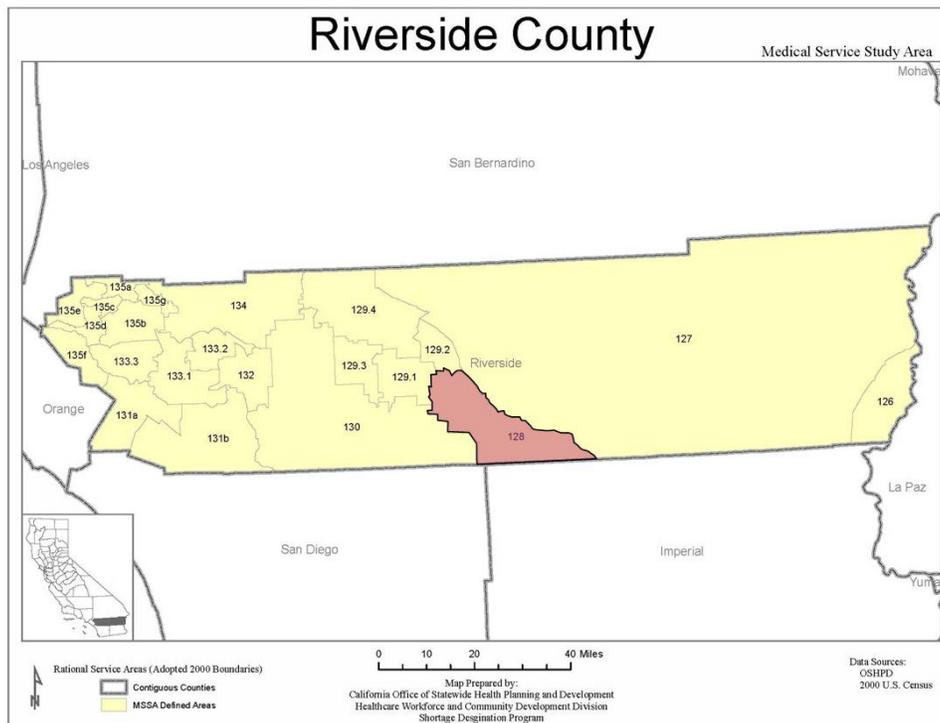


Figure 2.1. Map of MSSA 128

MSSA 145.2

MSSA 145.2, in San Bernardino County, includes the communities of Adelanto, Phelan, Pinon Hills, and Victorville Northwest (Figure 2.2). Approximately 54,324 people live in this MSSA.

In addition to being located in the high-priority county of San Bernardino, this MSSA has a large number of Black/African-American people, as illustrated in Table 2.4, 20.2 percent of the population. As mentioned previously, Black/African-American women in the SGKIE service area have higher breast cancer incidence rates, higher late-stage incidence rates, and higher death rates than White women, making them a population with high risk.

The area is also impoverished; as illustrated in Table 2.5, 28.1 percent lacking a high school education and 27.1 percent of the population living in poverty. As illustrated in Table 2.5, 20.6 percent are unemployed, and 21.2 percent of people age 40 to 64 lack health insurance. Language may also be a barrier to receiving health care in this area; as illustrated in Table 2.5, 19.2 percent of the population is foreign born and 5.1 percent are linguistically isolated.

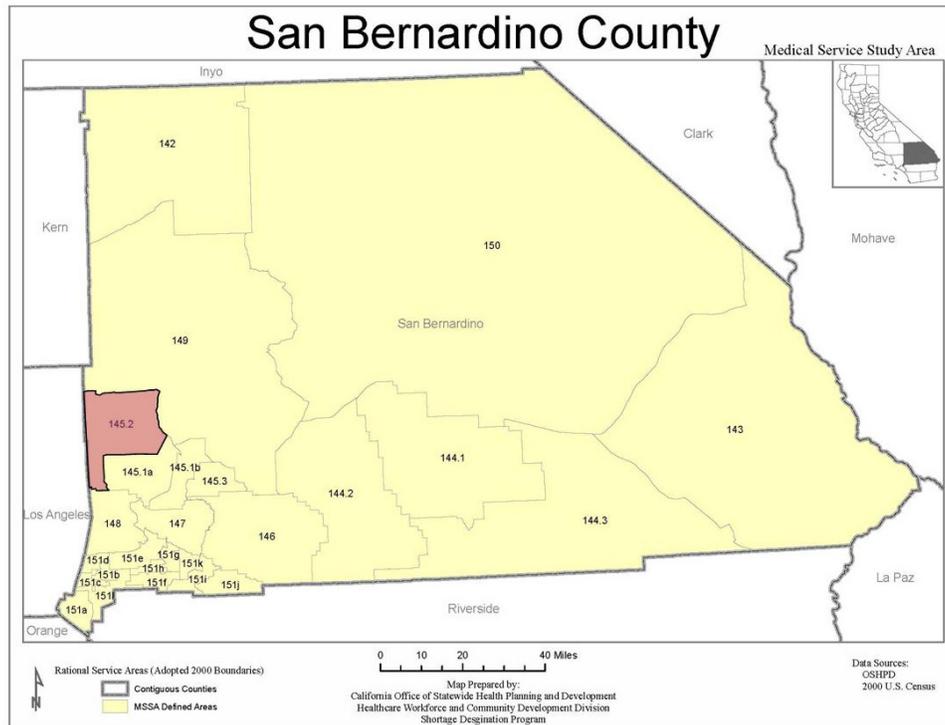


Figure 2.2. Map of MSSA 145.2

MSSA 151g and MSSA 151k

MSSA 151g, in San Bernardino County, includes the communities of Muscoy and San Bernardino Central (Figure 2.3). Approximately 126,048 people live in this MSSA. MSSA 151k, in San Bernardino County, includes the communities of Highland and San Bernardino East. Approximately 120,383 people live in this MSSA. For the purposes of this Community Profile, these two small MSSAs have been combined into a single target area. The two areas have been combined as they are adjacent to one another (as illustrated in Figure 2.5), and both have high needs.

Both MSSA 151g and MSSA 151k have a large number of Black/African-American women (16.2 percent and 16.6 percent, respectively, as illustrated in Table 2.4). This is nearly twice the proportion in the SGKIE service area as a whole. As mentioned previously, Black/African-American women in the SGKIE service area have higher breast cancer incidence rates, higher late-stage incidence rates, and higher death rates than White women, making them a population with high risk.

The area is also seriously impoverished: 33.9 percent of MSSA 151g and 29.5 percent of MSSA 151k live below the poverty line, as illustrated in Table 2.5. As illustrated in Table 2.5, 38.1 percent of people in MSSA 151g lack a high school education, as do 31.8 percent in MSSA 151k. As illustrated in Table 2.5, 18.6 percent of adults in MSSA 151g are unemployed, as are 17.1 percent in MSSA 151k. As illustrated in Table 2.5, 22.6 percent of MSSA 151g is considered a medically underserved area, as is 17.0 percent of MSSA 151k. As illustrated in Table 2.5, 25.9 percent of adults age 40 to 64 in MSSA 151g lack health insurance; this proportion is 24.1 percent in MSSA 151k.

Language may also be a major barrier to receiving health care in this area; as illustrated in Table 2.5, 25.5 percent of MSSA 151g are foreign-born, as are 21.5 percent of MSSA 151k. As

illustrated in Table 2.5, 13.7 percent of MSSA 151g is linguistically isolated, as are 10.1 percent in MSSA 151k.

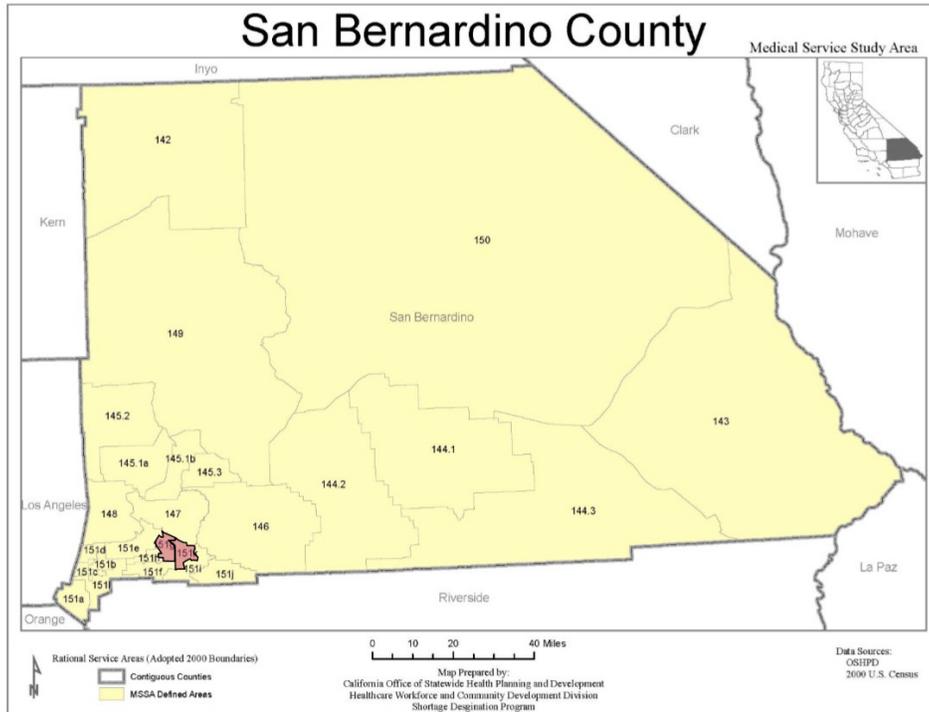


Figure 2.3. Map of MSSA 151g and MSSA 151k

Health Systems and Public Policy Analysis

Health Systems Analysis Data Sources

Susan G. Komen® Inland Empire strives to keep an up-to-date breast health service resource list available to the community. This comprehensive resource – targeting this Community Profile’s target communities -- was sourced from:

- Susan G. Komen Inland Empire Grantees
- Susan G. Komen Inland Empire Community Partners and Collaborating Medical Organizations
- The FDA certified Mammography Facilities database
- The Medicare registered hospital’s database
- The National Association of County and City Health Officials Directory of Local Health Departments
- The Health Resources and Services Administration Directory of Community Health Centers
- The National Association of Free and Charitable Clinics Directors

Accurate information was collected by staff and volunteers through a number of different means: web searches, telephone interviews with the appropriate departments within the facilities, interviews with the California Department of Health, the San Bernardino County and Riverside County Public Health Department, Komen Inland Empire grantees and several community partners. The final product was reviewed, cross referenced and approved by the Affiliate’s Executive Director and Mission staff.

The health systems list was then analyzed by staff to see where resources are available in the continuum of care and where there are gaps in each target area.

Health Systems Overview

The breast cancer “continuum of care” (the continuum) defines the best practice for how an individual should move through the health system to be screened for breast cancer, receive any necessary diagnostic care, get treatment if breast cancer is diagnosed, and receive follow-up care after treatment. The best case: individuals move through the continuum quickly and seamlessly, receiving timely, quality care to ensure the best outcomes (Figure 3.1).

The continuum is also used to: 1) assess and understand why some individuals never enter or delay entry into the continuum; 2) uncover gaps in service availability; 3) identify barriers faced; and finally 4) figure out what can be done to address those gaps and barriers.

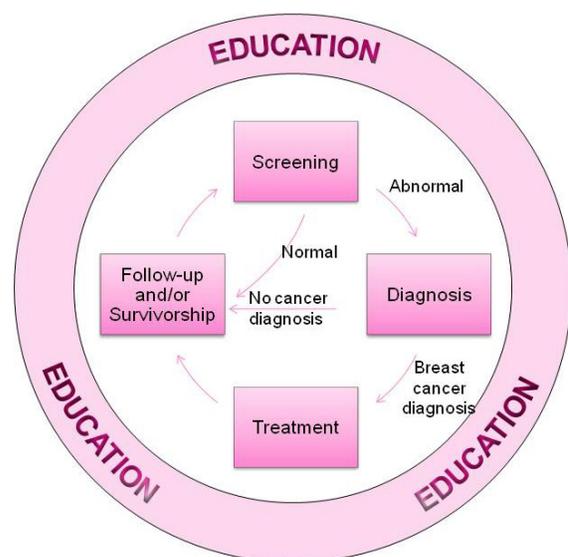


Figure 3.1. Breast Cancer Continuum of Care

Defining the Continuum of Care

Education is the first step into the continuum. Once an individual is educated about the need for medical help, they enter at one of these phases: screening, diagnosis, treatment; and follow up care (which may include survivorship issues, and/or end-of-life care).

Screening: Ideally, a woman would enter the continuum by getting screened for breast cancer – with a clinical breast exam and/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. Because screening tests can detect cancer early, when it's most treatable, getting screened regularly for breast cancer is the best way for women to lower their risk of dying from the disease.

Diagnosis: If a mammogram or clinical breast exam reveals an abnormality, a women's health care provider may recommend follow-up diagnostic tests. These tests might include a diagnostic mammogram, breast ultrasound, MRI or biopsy. It is important that women receive timely follow-up tests after an abnormal screening result. If further testing reveals that the abnormality is not cancer, the women should continue follow screening guidelines. 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.

Treatment: If breast cancer is diagnosed, a woman will enter the treatment phase of the continuum. Each woman will work with her health care providers to determine her best treatment plan. 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.

Follow-up Care/Survivorship: Following screening, diagnostic testing, or treatment, a woman will enter the follow-up phase of the continuum. During this phase, her health care providers will recommend regular screening tests and follow-up visits to keep track of her breast health concerns and, if in treatment of breast cancer, for recovery and quality of life, manage side effects, and, if cancer reoccurs, detect it early. Furthermore, a woman may need support to continue breast health screenings, make recommended lifestyle changes, cope with stress and fear, and may require assistance with long- term care.

While the continuum 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.

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 continuum. These barriers can include things like 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 continuum more quickly.

An Analysis of the Health Systems Available in Target Areas

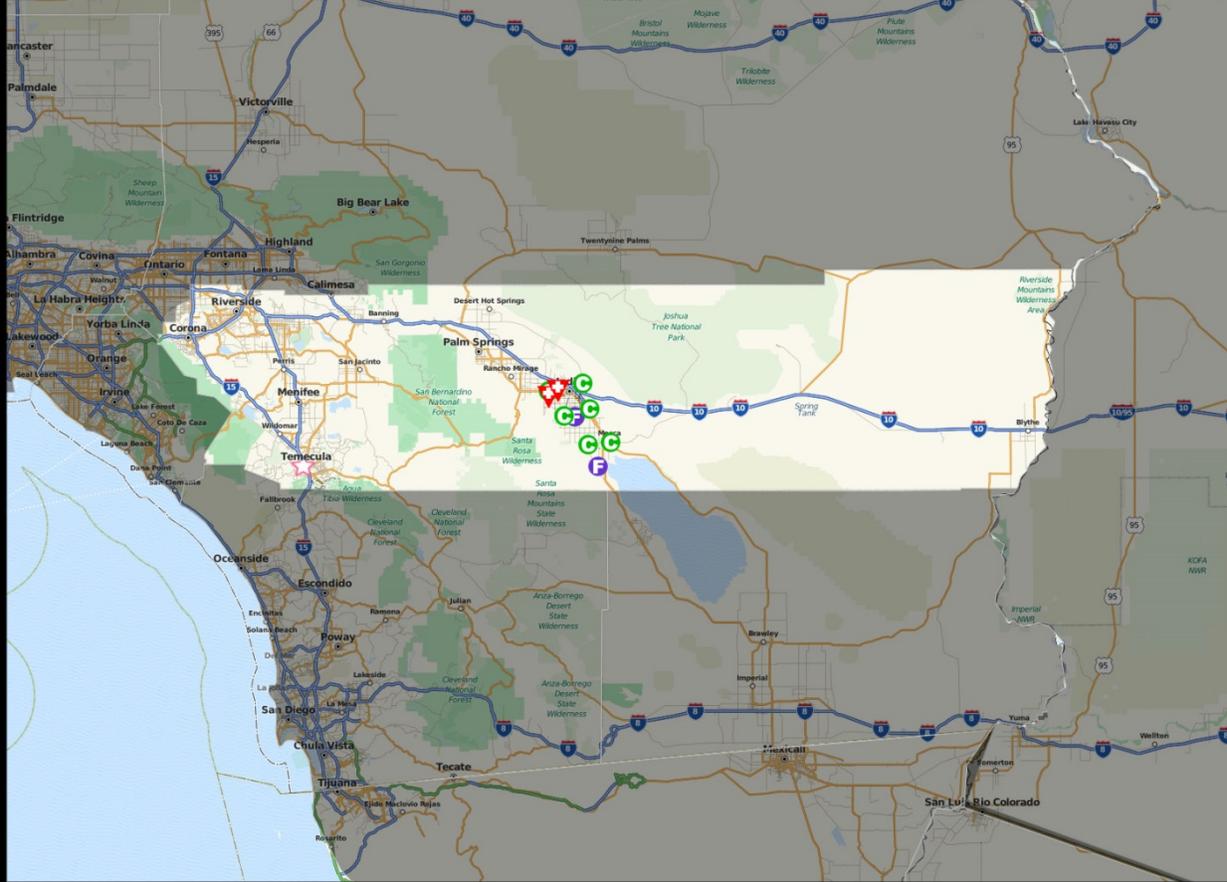
MSSA 128, in Riverside County, includes the communities of Arabia, Coachella, Desert Beach, Flowing Wells, Indio South, La Quinta East, Mecca, Oasis, and Thermal. There are approximately eleven community health centers offering breast health screening services (Figure 3.2). All of these facilities provide clinical breast exams, a fewer number also provide screening mammograms and/or offer referrals for mammograms. However, only two facilities provide any diagnostic services, treatment services and/or support services. There is only one hospital in this area; however it does not offer patient navigation services. Another weakness identified, is that none of the facilities maintain quality of care indicators. It should be noted that this is considered a rural community of a large size. Furthermore, access to transportation services is severely limited. To strengthen collaboration and community partnerships in this target area, the Affiliate will reach out to community and business leaders, community health centers and imaging centers to introduce Komen's mission, provide a primer on the services available and begin to identify potential programs to bridge the barriers to care that have been uncovered.

MSSA 145.2, in San Bernardino County, includes the communities of Adelanto, Phelan, Pinon Hills, and Victorville Northwest. The area's greatest strength is that it contains six centers for breast health and one hospital (Figure 3.3). However, not all of the breast health centers offer clinical breast exams and/or mammography; all other resources refer out for mammogram screenings. Three of these facilities offer diagnostic, treatment and/or support services for breast cancer; and none maintain quality of care indicators. It should be noted that this is considered a rural community of a large size. Furthermore, access to transportation services is severely limited. To strengthen collaboration and community partnerships in this target area, the Affiliate will reach out to community and business leaders, community health centers and imaging centers to introduce Komen's mission, provide a primer on the services available and begin to identify potential programs to bridge the barriers to care uncovered.

MSSA 151g and 151k, in San Bernardino County, includes the communities of Muscoy, Highland, San Bernardino East and San Bernardino Central. This region contains thirteen community health centers, three hospitals and three imaging centers (Figure 3.4). The area has at least one resource for each step of the continuum of care. Only one facility maintains one quality of care indicator. While having a resource for every step of the continuum of care is a great benefit, there is still only one resource for treatment services and one resource for support services in this target area (a former Komen Inland Empire grant recipient). It would be ideal to have more than one option for the size of the population the facility serves. The variety of resources may be greater than other target communities, but the need is greater in this area as well. The Affiliate intends to strengthen collaboration and community partnerships in this target area, the Affiliate will reach out to community and business leaders, community health centers and imaging centers to introduce Komen's mission, provide a primer on the services available and begin to identify potential programs to bridge the barriers to care uncovered.

MSSA 128

+ Hospital
 C Community Health Center
 O Other
F Free Clinic
 + Department of Health
 ☆ Affiliate Office



Statistics

Total Locations in Region: 11

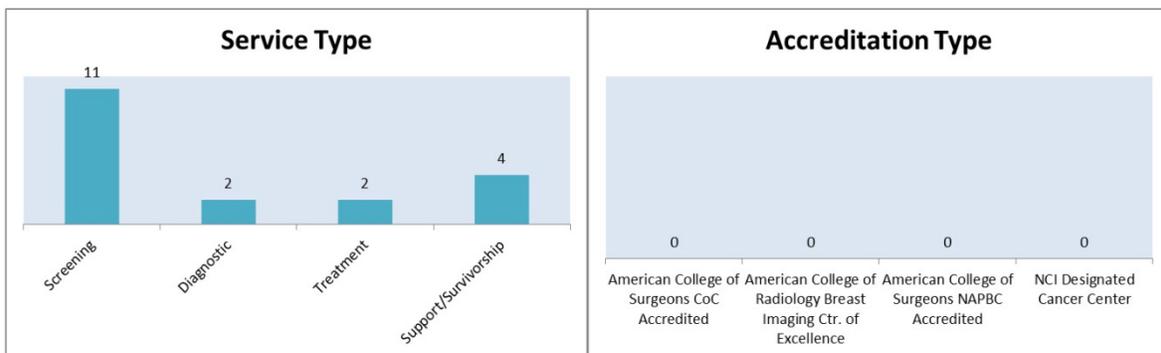
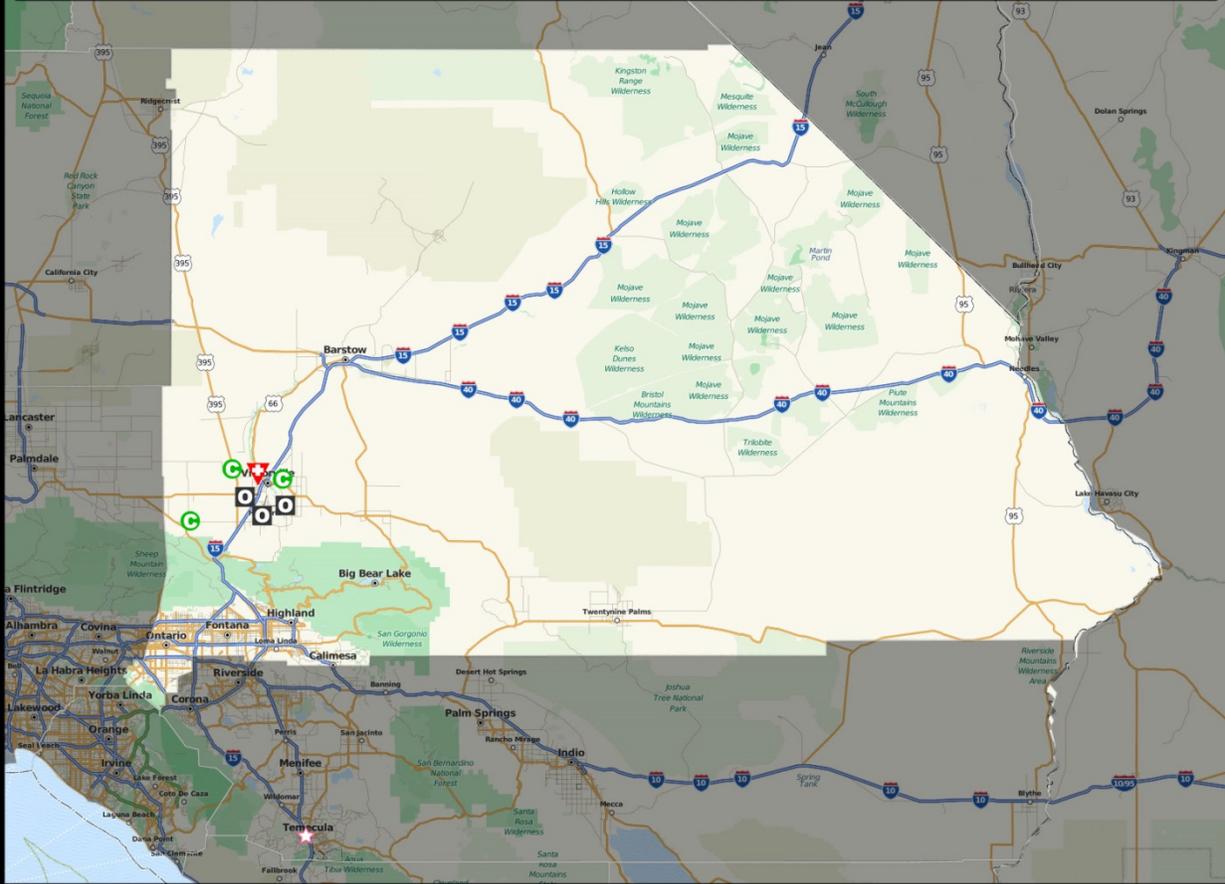


Figure 3.2. Breast cancer services available in MSSA 128

MSSA 145.2

 Hospital	 Community Health Center	 Other
 Free Clinic	 Department of Health	 Affiliate Office



Statistics

Total Locations in Region: 7

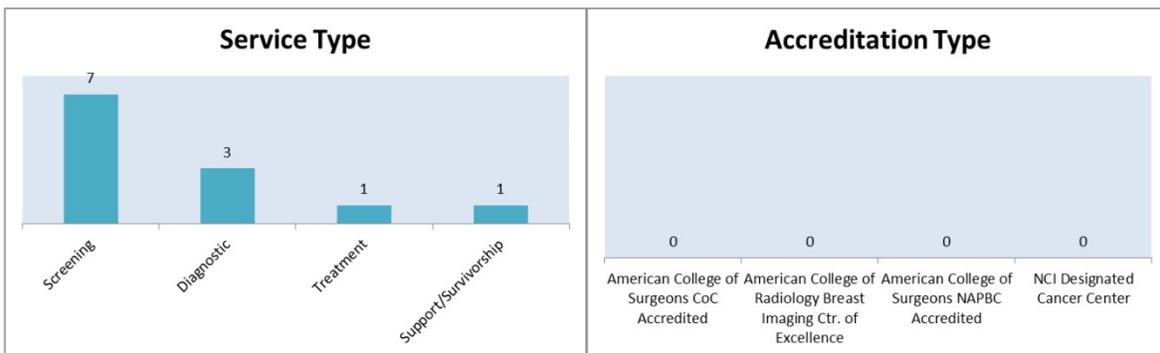
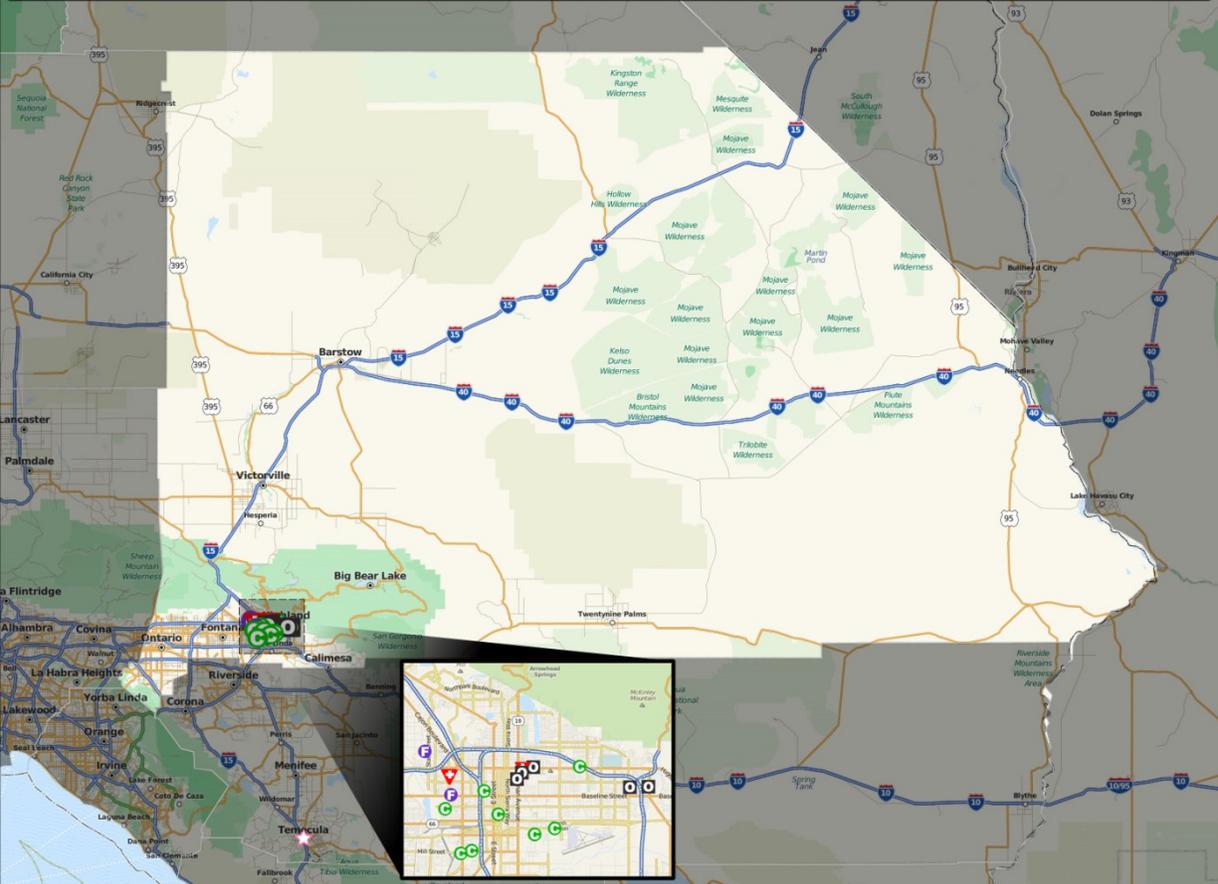


Figure 3.3. Breast cancer services available in MSSA 145.2

MSSA 151g - 151k

 Hospital	 Community Health Center	 Other
 Free Clinic	 Department of Health	 Affiliate Office



Statistics

Total Locations in Region: 19

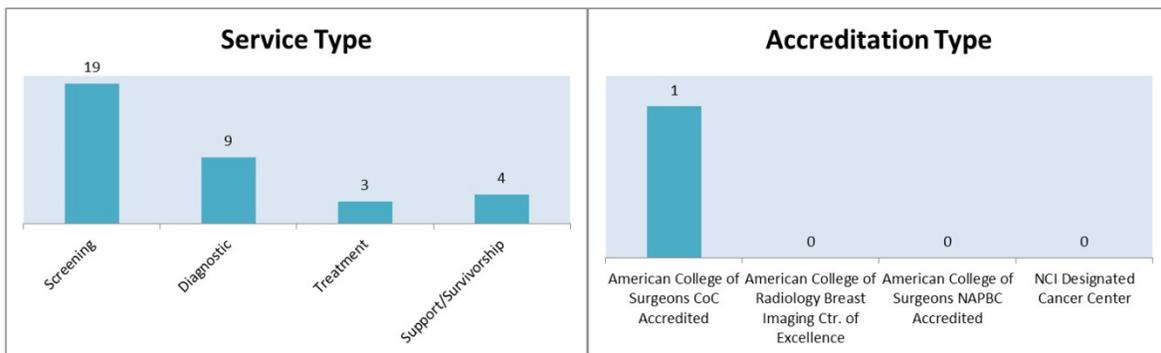


Figure 3.4. Breast cancer services available in MSSA 151g and 151k

Public Policy Overview

National Breast and Cervical Cancer Early Detection Program (NBCCEDP)

The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) supports the provision of the following breast cancer services: clinical breast exams, mammograms, and diagnostic testing for women whose screening outcome is abnormal, as well as referrals to treatment. The program is supported by the Centers for Disease Control and Prevention (CDC), which provides a federal grant to each State. The California state program is named Every Woman Counts (EWC). EWC is a program built on a model originally created by the CDC comprised of six interdependent components: screening, tracking, follow-up and case-management; quality assurance and improvement; professional education; public education and outreach; surveillance and evaluation; and coalitions and Partnerships. Both Federal and State funding sustain EWC. The sources of funding for EWC are: Centers for Disease Control and Prevention under the Breast and Cervical Cancer Mortality Prevention Acts of 1990 (Public Law 101-354), Proposition 99 – Tobacco Tax and Health Promotion Act account, and The California Breast Cancer Act of 1993 (mandates 50 percent of the revenues collected from a 2-cent tax on tobacco products towards breast cancer control). EWC is part of the Department of Health Care Service's Cancer Detection and Treatment Branch (CDTB) (California Department of Health Services, 2014) and is separate from Medi-Cal (California's Medicaid program). However, the program uses Medi-Cal billing codes. The mission of EWC is to save lives by preventing and reducing the devastating effects of cancer for Californians through education, early detection, diagnosis and treatment, and integrated preventive services, with special emphasis on the underserved (California Department of Health Services, Every Woman Counts, 2014). In California, EWC has a payer of last resort requirement, which exhausts all other possible payers before EWC (such as California's Low Income Health Program (LIHP – through a Medicaid Demonstration Waiver). However, EWC does not cover medically-necessary diagnostic MRIs certain biopsy services, as well as BRCA testing.

The federal eligibility baseline to direct services for this program are to uninsured and underinsured women at or below 200 percent of federal poverty level; ages 21–64 for cervical screening; ages 40–64 for breast screening. In California, a woman can receive Medicaid services regardless of where she was originally screened, as long as she would otherwise meet the other eligibility requirements for the program. Additional program eligibility requirements in California include not getting these services through Medi-Cal or another government-sponsored program and living in California (California Department of Health Services, Every Woman Counts Program, 2014). In California, services are provided through regional contractors throughout the state. A 1-800 number is available, Monday to Friday from 8:30am to 5:00pm, in English, Spanish, Mandarin, Cantonese, Korean and Vietnamese, for program eligibility and referrals to services (California Department of Health Services, Every Woman Counts Program, 2014). Regional contractors can also help to refer individuals to other screening programs, if they are not eligible to EWC. It should be noted that EWC does not provide diagnostic breast health services for men.

Treatment is provided to eligible individuals through the Breast and Cervical Cancer Treatment Program (BCCTP). The federal BCCTP provides full-scope Medi-Cal to eligible women who meet all the federal criteria. The state-funded BCCTP only provides cancer treatment and related services to any individual, including men, who does not meet the federal criteria. The State BCCTP program provides no cost breast cancer treatment services for up to 18

continuous months and cervical cancer treatment services for up to 24 continuous months (California Department of Health Services, Breast and Cervical Cancer Treatment Program, 2014). The application work sheet and required documents for the BCCTP program are available in 11 languages, including English, Spanish, Vietnamese, Cambodian, Hmong, Armenian, Cantonese, Korean, Russian, Farsi and Laotian (California Department of Health Services, Breast and Cervical Cancer Treatment Program, 2014). It should be noted that men are not eligible for this program. In addition, undocumented persons are eligible for the state's program but may only receive treatment for the length of 18 months and may not qualify again for the program if re-diagnosed. In addition, the federal BCCTP program is available for qualifying documented residents for a period of 24 months, but may not qualify again for the program if re-diagnosed. Furthermore, those enrolled in the state's Medicaid program, Medi-Cal have limited access to breast surgeons/general surgeons that accept this form of insurance.

Komen Inland Empire consistently partners with representatives from Every Woman Counts in Riverside and San Bernardino Counties on cancer coalitions and activities. There are quarterly coalition and partnership meetings among the Affiliate, community partners and the Every Woman Counts regional representatives. These meetings enable community partners, Komen Inland Empire, and Every Woman Counts to provide updates on a state, county, and local level regarding the state of the breast health environment and leverage available resources. The Affiliate also works through the Komen California Public Policy Collaborative, in partnership with the other six California Komen Affiliates throughout the state, to be aware of changes with the state NBCCEDP.

The Affiliate aims to provide education about the changes in policy that effect access to NBCCEDP regularly. Furthermore, the Affiliate works with local community members and the CA Public Policy Collaborative to advocate for support of maintaining the NBCCEDP in the state of California to ensure access to breast cancer screenings, diagnostic and treatment services for eligible women for State and Federal Treatment Programs. The Affiliate will continue to support the NBCCEDP and strengthen relationships at the local and state level to stay abreast of program adjustments and changes that may impact access for breast health services.

State Comprehensive Cancer Control Coalition

California's Comprehensive Cancer Control plan is a strategic plan to reduce the burden of cancer in the state. This is the state's second comprehensive plan and focuses on cancer control efforts through 2015. The current strategic plan addresses the cancer continuum and includes primary prevention, early detection and screening, treatment, quality of life and end-of-life care, as well as such cross-cutting issues as advocacy, eliminating disparities, research, and surveillance.

The State Cancer Control plan has two breast cancer objectives:

1. By 2015, increase the prevalence of women 40 years and older who report having both a mammogram and a clinical breast exam (CBE) within the prior two years by 7.5 percent, from a baseline prevalence of 79.1 percent to 85.0 percent and
2. By 2015, increase the proportion of early-stage diagnoses of breast cancer among all women by 29 percent, from the baseline proportion of 69.0 percent to 89.0 percent (California Dialogue on Cancer, 2014).

Komen Inland Empire works with the local Cancer Coalition for the region, known as the Inland Empire Access to Cancer Care Coalition, and attends its bi-monthly meetings. The Access to Cancer Care Coalition works with the state cancer coalition and participates in its annual convening to learn best practices and lessons learned and to network with other colleagues in cancer education, prevention, screening, and advocacy. The Mission Programs Manager for Susan G. Komen Inland Empire acts as the current chair for the Inland Empire Access to Care Coalition (2013-present). For the next four years and beyond, the Affiliate intends to continue participation with the Inland Empire Access to Cancer Care Coalition and the State Coalition as a whole, to provide leadership in breast health issues.

Affordable Care Act

In 2010, the state of California was the first state in the nation, to enact legislation to implement the provisions of the federal Affordable Care Act (ACA), creating *Covered California* (Covered California, 2014). This health care marketplace was established to help Californians choose affordable and quality health care. California also decided to expand its Medi-Cal Program and eligibility can also be determined through *Covered California* (Covered California, 2014). California has the greatest number of uninsured of all the states, seven million uninsured (California Health Care Foundation, 2014). By 2014, about 2.6 million Californians will be able to access financial assistance through *Covered California* to pay for their health insurance, and 1.4 million will be newly eligible for Medi-Cal (Covered California, 2014). However, a large number of individuals (nearly three million) will remain uninsured in California (California Health Care Foundation, 2014). Approximately 703,000 will be eligible to Medi-Cal and not enroll; 959,000 will be undocumented and ineligible for insurance coverage; and 1.4 million will be eligible for coverage through *Covered California* and not enroll (California Health Care Foundation, 2014). Of this 1.4 million, 577,000 will be eligible for subsidy but will not take it and 832,000 are not eligible for the subsidy (California Health Care Foundation, 2014).

The ACA, through its marketplace health plans, cover the following preventive health services for women, specific to breast health, without charging the patient a co-payment or co-insurance:

1. Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer,
2. Breast Cancer Mammography screenings every one to two years for women over 40, and
3. Breast Cancer Chemoprevention counseling for women at higher risk (Affordable Care Act website, 2014).

However, individuals who remain uninsured, due to ineligibility or opting not to purchase coverage, will not have access to these early detection health services for women. As a result, the NBCCEDP/EWC program will still be needed to help provide clinical breast exams, screening mammograms, diagnostic testing for women whose screening outcome is abnormal, and referrals to treatment for women (Levy, Bruen & Ku, 2012). While the overall number of women eligible to receive services through NBCCEDP will reduce due to ACA and Medicaid expansion, a large number of women will remain uninsured and will still need access to these program services. It is estimated that funding for the NBCCEDP will only be able to help serve about one-fifth to one-third of those eligible due to limited federal and state appropriations (Levy, Bruen & Ku, 2012). Therefore access to NBCCEDP will be imperative to serving those that do not have access to other programs and services, in addition to those offered by community resources.

While much excitement has surrounded the ACA and the roll out of the health care marketplace, a lot remains undetermined in terms of access and utilization. Some have expressed concerns about the availability of health care providers to respond to an increase of 30 million insured Americans across the country (Anderson, 2014). Some studies report not only a shortfall in health care providers, but also in the health care workforce as a whole, in responding to the ACA changes (Anderson, 2014). While these concerns may be warranted, other efforts are taking place at all levels to ensure collaboration and partnership across providers (safety net providers, private providers, Medi-Cal providers, hospitals, and health systems) to ensure strategies to meet the changing needs of health care delivery (Health Resources and Services Administration, 2014).

For Komen Inland Empire, there will remain a number of uninsured individuals who are in need of breast health services and may need access to NBCCEDP/EWC or Affiliate resources to ensure timely and quality access to breast health services. The Affiliate will continue to work closely with its partners in health and health policy to stay abreast of the breast health needs in the Affiliate service area and respond accordingly in providing support for access to care.

Affiliate's Public Policy Activities

Komen Inland Empire continues to be closely involved in the Komen California Collaborative Public Policy Committee (KCCPPC). Each year, the KCCPPC organizes a State Lobby Day in Sacramento in the spring in which the seven California Komen Affiliates meet with state legislative offices, including state senators and assembly members, as well as leadership at the Department of Health Services and Every Woman Counts, the Women's Caucus, and other relevant committees and leadership. These meetings serve as an opportunity for each Affiliate to address district and state breast health concerns, connect with freshman representatives, cultivate existing relationships with representatives, reaffirm and rebuild prior relationships with representatives and also to inform and discuss with California representatives Komen California Collaborative's state-wide African-American initiative. These meetings are key to the Affiliate's success on a district and state-wide level of leveraging resources, gaining support for breast health issues, engaging legislative offices in the fight against breast cancer in their districts and aiding Komen's mission.

In addition, Komen Inland Empire has had success in lobby and advocacy efforts on a district level. Since 2013, Komen Inland Empire has held a Local Advocacy Week during the summer recesses to meet with state and federal representatives to discuss local, state, and federal priority issues, maintain a relationship with legislators and their district offices, garner support for Affiliate activities throughout the year, and provide updates about the impact and resources of the Komen Affiliate.

The Affiliate also intends to advocate for Federal issues as requested by Susan G. Komen Advocacy Team.

Health Systems and Public Policy Analysis Findings

A common thread throughout the Komen Inland Empire target communities is a lack of breast cancer diagnostic services, treatment and support services, as well as a need for additional screening mammography facilities. While there are resources for these services in the Inland

Empire service area in various pocket communities, there is only one financial assistance program serving San Bernardino County. Furthermore, knowing that transportation can often be a barrier to care, in addition to the Affiliate's learned best practices of providing services to those in need where they live, work, play and pray, it seems that these areas are at higher risk than the qualitative data alone represents. All of the available resources in these target communities may not be aware of additional resources for referrals or additional needed services. In addition many of the resources located outside of the target areas cross county lines, and are limited only to county residents. Entering the continuum in one area of the county, and having to travel to another county to progress to the next step in the continuum, if the patient is even eligible for services outside of their residing county, is disjointed, to say the least, and enough of a barrier for some to prevent progress through the continuum.

In order to address these barriers to care, Komen Inland Empire will continue to utilize key partnerships in these target communities to bridge these uncovered barriers, as well as incorporate partnerships outside the target areas that could be brought into the target areas-for instance, a Komen Inland Empire-funded mobile mammography program. In addition to targeting mobile mammography events to these areas, the Affiliate will need to conduct education and resource in-services with community health centers and partners located in the target areas to inform them of the breast cancer disparities in their community, as well as how to increase access to resources for residents. Furthermore, the Affiliate will work with community health centers and partners to develop diagnostic, treatment and support services in the target areas and call upon local public elected officials as well as community leaders and business owners to become involved in efforts to raise awareness of the lack of services in these areas in order to bridge these barriers to care. It will be imperative for Komen Inland Empire to develop new partnerships and sustain current partnerships with trusted community leaders and health providers in each target area of the county to assist in accomplishing these goals.

The Komen California Collaborative Public Policy Committee and Komen Inland Empire have been very successful in their public policy efforts. In recent years, the lobbying and advocacy efforts of Komen Inland Empire have helped established the California Oral Anticancer Treatment Access Law into place, reinstate funding for the California state program Every Woman Counts, increase support of the Federal Oral Cancer Drug Parity Act, bring attention to the issues within Covered California (California's ACA option) and keep legislators updated and involved with the Affiliate's efforts in the community. Inland Empire residents and Californians have a more comprehensive safety net for breast health care due to the efforts and partnerships of Komen California Affiliate's public policy work.

The various shifting pieces in the breast health environment require the Affiliate to remain vigilant, connected and vocal about the breast health needs of the community. In order to remain current in public policy issues that affect the state and local communities, the Affiliate will continue to be involved in key collaborative partnerships, including the Breast Health Collaborative, Komen California Public Policy Collaborative and the Inland Empire Access to Cancer Care Coalition. Furthermore, the Affiliate will continue to leverage partnerships, dollars, and efforts with Komen Inland Empire grant recipients, community partners, key stakeholders, community leaders, and others in order address the breast cancer disparities in target communities across the Inland Empire service area.

Qualitative Data: Ensuring Community Input

Qualitative Data Sources and Methodology Overview

Methodology

The Affiliate was interested in finding where there may be barriers to or gaps in the Breast Cancer Continuum of Care, including health care access issues for women and survivors, health care providers' awareness of breast health disparities, women's knowledge of breast health services and survivorship issues. To assist with the qualitative data collection and analysis process, the Affiliate contracted with HARC, Inc., a nonprofit organization specializing in community-based health and wellness research.

Initially, the Affiliate chose to use two key methods of data collection: focus groups and key informant interviews. Key informant interviews provide detailed personal information about individual experiences, while focus groups provide insight into shared experiences, especially highlighting commonalities and differences in local experiences.

However, subsequent efforts to schedule focus groups became challenging; coordinating the schedules of multiple individuals to find a mutually acceptable date and time for the focus group proved difficult. Affiliate staff utilized various means of advertisement to recruit focus group participants, including contacting grant partners, clinics and local community leaders as well as recruitment via social media and email lists. Unfortunately, due to the lack of focus group registration, the majority of the scheduled focus groups were cancelled except for two groups in the San Bernardino area (MSSA 151g and 151k). As a result, the Affiliate replaced the focus group data collection method with document review, as described below. The two focus groups that did occur, in the San Bernardino area, were retained, as they provided valuable information. These focus groups were audio recorded and transcribed verbatim for analysis.

Key Informant Interviews

The purpose of the key informant interviews was to gather detailed information about individual experiences. This method provided a personalized approach and a high response rate. HARC worked with the Affiliate to design interview guides that were methodologically sound and would provide clear, informative information on the topics of interest. Affiliate staff and volunteers were then responsible for recruiting participants and HARC was responsible for conducting the interviews. All key informant interviews were conducted by HARC as well as one of the two focus groups—the other focus group was conducted by Affiliate staff.

Potential participants were contacted by telephone or email to schedule the interview and were then interviewed by phone as this was the most convenient for participants. All participants agreed to a 30-minute interview. Verbal consent was obtained and the interviews followed a semi-structured, open-ended format. All interviews were audio-recorded, per HARC's best practices recommendations. The informants included physicians, nurses, community health educators, health care administrators, women over 30 and breast cancer survivors. The audio files were then transcribed and analyzed by HARC.

Document Review

Document review was selected to supplement the information provided by the key informant interviews and the focus groups. This method is inexpensive, reliable and valid. Trained

researchers from HARC gathered the documents through scholarly search engines. The following key words were used in different combinations to identify relevant articles: breast cancer, survivors, Latinas, African-American women, barriers to health care, breast cancer outreach, programs, and health care providers. The documents used here included qualitative studies of survivors, health care providers, and women over 30. After assembling the articles, HARC then organized, annotated and analyzed them. See References for a list of the articles used for data analysis.

The use of multiple data collection methods allows for a more comprehensive and deeper understanding of the existing barriers and gaps in Continuum of Care. Additionally, using multiple methods increases the validity of the findings and reduces bias.

Sampling

In the quantitative data collection phase, the Affiliate identified three geographic areas of interest:

- MSSA 128: Arabia, Coachella, Desert Beach, Flowing Wells, Indio South, La Quinta East, Mecca, Oasis, and Thermal.
- MSSA 145.2: Adelanto, Phelan, Pinon Hills, and Victorville Northwest.
- MSSA 151g and MSSA 151k: Muscoy and San Bernardino Central, Highland and San Bernardino East.

Within each of these three communities, the Affiliate's target populations of interest included:

- Hispanic/Latina and Black/African-American women age 30 and over,
- Breast cancer survivors, and
- Health care providers

These populations of interest were determined by the Affiliate after conducting the quantitative portion of the Community Profile. The women and men chosen for the interviews were selected based on their geographical location and how well they fit the criteria of health care provider, woman over 30, and/or survivor.

Susan G. Komen Headquarters recommended collecting 12 key informant interviews in each of the communities of interest (for a total of 36 key informant interviews). Unfortunately, due to low participation rates, only 22 key informant interviews were conducted.

Susan G. Komen Headquarters recommended collecting five articles per MSSA (for a total of 15 articles). HARC found 15 relevant articles, per recommendations.

Ethics

The interview script began with a section on informed consent. See Appendices A, B, C, D and E for the full text of the interview and focus group guides, including the informed consent section. This section covered all of the elements of informed consent, including a description of the purpose of the research and the types of questions to expect; a description of anticipated risks and benefits of participation; their rights to skip questions or cease participation at any time; and a statement of how their confidentiality would be protected. After hearing the informed consent script, all participants gave their verbal consent for continued participation. For those

who were audio-recorded, they were informed of the purpose of audio recording and gave verbal consent to be audio recorded prior to the beginning of audio recording.

Data collected from the interviews was stored on a password protected computer server, and names were omitted in order to ensure confidentiality. At no time in this report are individual responses identified.

All documents reviewed were available publicly, and thus, there were no ethical concerns in the utilization of said documents. See References for the list of articles included in this study.

Qualitative Data Overview

All audio recordings were transcribed and analyzed. This included 22 recorded interviews and two recorded focus groups. HARC used the transcriptions of the focus groups and the key informant interviews to extract key themes for analyses. These findings were supplemented by the 15 articles that HARC found during the document review process. The results are described here.

MSSA 128

MSSA 128 includes the communities of Arabia, Coachella, Desert Beach, Flowing Wells, Indio South, La Quinta East, Mecca, Oasis, and Thermal.

Barriers: Finances and Insurance

Several key informants indicated that finances were the biggest barriers for them. One survivor stated the following in regards to the financial impact breast cancer had on her life: “It was devastating financially. Even though we were in a good place and we had insurance, insurance only pays for so much. And then there was out-of-pocket expenses.” She went on to say that it was especially difficult because she was not able to work and contribute financially: “I didn’t work. I just started a new job, and I didn’t have any sick time. So, I didn’t have any income for a month either.” Another survivor made a similar comment about finances as a stressor: “I had to go and have mammograms every six months and blood tests and just the financial burden of having to pay for that...it’s overwhelming if you don’t have no money.”

Additionally, one key informant in the health field addressed this financial issue as a barrier to receiving care: “I think one level is a financial level, where if you don’t have insurance or you don’t have the best insurance and you know you’re going to pay out of pocket it’s almost like you don’t want to go to a doctor, you don’t want to get tests done because they’re going to run up all kinds of bills.” He also suggested talking to women facing breast cancer about their finances: “It is very important to get somebody financial counseling so to see if there’s resources that they can qualify for that they didn’t even know that they could get.”

Furthermore, another key informant stated that cost could be a barrier for women seeking treatment. When asked what barriers she thought prevented women from getting screenings, she stated, “It could possibly be the cost. That would be the main reason. Not everyone has health care and it can get expensive.” Another key informant also mentioned fear of cost in her interview: “They don’t know what that’s gonna cost. I think that comes up to be one of the biggest factors in them, is the cost. How much is this all gonna cost me and who’s going to pay for it? How am I going to pay for it?”

A study done on cost as a barrier to screening mammography indicates that cost is indeed a barrier to care for many women, “Perceived cost has been shown to be a substantial barrier to medical care, and presents a greater burden to people who are Black or Hispanic, younger, unemployed, or have lower income or education levels...As cost is an important barrier to women who have received mammograms, it is likely to also be a reason for lack of compliance with mammography screening guidelines.” (McAlearney, Reeves, Tatum & Paskett, 2007). The study went on to say that providing information about the actual cost of having a mammogram done might lessen cost as a barrier.

Barriers: Culture

Several Hispanic/Latino key informants addressed culture as a barrier to accessing care. One Hispanic/Latina woman felt that cancer was a death sentence: “Well, my sister had cancer so the first thought was that she was going to die.” She later mentioned that this had to do with the fact that cancer was not discussed in her family. She also mentioned other misconceptions that exist in the Hispanic/Latino culture in regards to cancer. For example, “Well, that it’s painful and then a lot of people think that they’re too young to get it or it should only be after a certain age that you would have to get tested for it.” She felt that this belief kept women from being proactive about their care. Another Hispanic/Latina key informant indicated that many other Hispanic/Latina women don’t trust the health system, “The culture, the intimidation, them not knowing where they’re going to be sent to, is someone there going to look like me, speak my language?” She said she felt this was a reason why many women do not follow up on their referrals.

Additionally, health care providers also agreed that culture is a barrier for many women. One key informant felt that there is some sexism in the Hispanic/Latino culture that prevents women from getting treatment: “There is still some sexism and maybe oppression of women in the Latino population, maybe more so than others, maybe where you might have a couple where the man doesn’t really want her to go to get this kind of examination, especially if it’s a male provider...the thought of ‘I don’t want a man touching your breasts’.”

One study on breast and cervical cancer screening addressed culture as a barrier for many Hispanic/Latina women and supports the comments made by key informants: “In Hispanic women, great fear of cancer is associated with extreme fatalism about the disease. Most believe that cancer cannot be cured, and a diagnosis is considered a death sentence. This fear leads to avoidance of the subject and discussion of cancer.” (Austin, Ahmad, McNally & Stewart, 2002).

Barriers: Lack of Knowledge

Key informants indicated that there are many barriers in this community, but they all agreed that these could be improved by increasing education on breast health. One key informant in the health field indicated that there are enough services in this community, but women do not know about them: “The problem is the not knowing. There’s a lot of people who don’t know that they could get a free mammogram...we need to pass the information along. Be better communicators.” One study stressed the importance of health care providers being informed on available resources so that they may communicate this to their patients: “These community members felt that it is the responsibility of the health care system to become more culturally responsive by increasing staff diversity, knowledge about community resources and psychosocial service partnership and programs.” (Ashing-giwa et al., 2004). Additionally,

another study on health care access and Hispanic/Latina's supports health care providers educating their patients, "Regular breast cancer screening increases early stage cancer detection and reduces the morbidity of late-stage diagnosis...the encouragement to have an annual physical examination appears to be the most important health promotion message to convey." (Castaneda et al., 2014).

Another health care provider agreed that there is a lack of awareness in the community. When asked what about the biggest barriers she sees, she said, "I think it's the lack of awareness of the services that are available." Additionally, one woman in the community mentioned in her interview that she did not know about resources on breast health in her area: "That is one part of my lack of awareness, the fact that I'm not out there where the information is. And secondly, I don't have a direct family member who it has affected." This seemed to be the case for many women over 30 who were interviewed. Many did not know about resources because they did not have a direct relationship with the disease. Outreach and education efforts may benefit from emphasizing that this information is relevant to all women, as all are susceptible to the disease.

Survivorship

All survivors that were interviewed indicated that the biggest change they have made after cancer has been a change in their eating habits and increase in physical activity. One key informant stated, "I try to exercise. It's been a little bit difficult, because of my working schedule, but that is going to change. And I will increase that. I try to eat more fresh fruits and vegetables." Another survivor said she's made some big changes: "Everything...eating properly, walking, and exercising". On the other hand, a few Hispanic/Latina survivors indicated not making any changes to their lifestyle. This is important to note considering that one study found that many Black/African-American and Hispanic/Latino survivors are more likely to have difficulty maintaining a healthy weight than White women, "Alcohol consumption among Caucasian women and physical activity among African-American women remain a concern regardless of women's survivorship status, while sustaining healthy weight appears to be a problem in African-American and Hispanic breast cancer survivors. These patterns indicate potential areas for preventative services that could be tailored to address specific needs within each of the racial/ethnic groups." (Yaghjian, Wolin, Chang & Colditz, 2014).

Survivors agreed that support from family members and friends are very important. One survivor said, "I have a loving family. I didn't need to go anywhere outside of my family." In contrast, another survivor stated that she wished she had more support from friends and family: "I think the barrier was moving here and not having friends to give support. Because not only to me, but to my husband to give him some rest, because he was the one taking care of me." A study on social support for breast cancer patients further addressed the importance of having family and friend support: "As the health care system shifts to a greater emphasis on outpatient care, family caregivers are increasingly assuming tasks previously carried out by health care professionals. Individuals who have someone available to actively provide this kind of care may be protected from more adverse outcomes." (Kroenke et al., 2006). The study went on to say: "Women with no close relatives had an elevated risk of all-cause mortality, and breast cancer mortality compared with those with 10 or more close relatives." (Kroenke et al., 2006).

MSSA 145.2

MSSA 145.2 includes the communities of Adelanto, Phelan, Pinon Hills, and Victorville Northwest.

Barriers: Finances

The financial impact of breast cancer and lack of financial resources is a major barrier for this community. One survivor mentioned that she was unable to work during her treatment and as a consequence was forced to file bankruptcy: "I didn't work for 10 months and they didn't pay my medical premiums any longer because I technically was on a leave of absence...so because I was paying my \$1,200 a month [insurance] payment, I could not pay my \$1,200 a month mortgage so we fell into delinquency with our mortgage, we ended up having to go bankrupt." A study done on women and breast cancer addresses the financial stress associated with breast cancer treatment. A few of the participants from the study mentioned out-of-pocket expenses, "I had to postpone my breast cancer surgery because I'm hoping I would get my Medi-Cal. However, my doctor said, 'Don't wait anymore' because he's worried that my cancer would spread. After two months, my application was denied. I had to pay the doctor \$4,000 and each doctor visit was \$70." (Ashing-giwa et al., 2004).

Additionally, one survivor mentioned not being able to receive any financial help because she did not qualify as "low income". When asked about resources that would have helped her during her treatment she stated, "Financial assistance...we're middle class so they're like, 'oh no there's nothing that you can qualify for' you have to pretty much be lower income or a single woman. I don't know, we didn't qualify for anything." Similarly, when asked about barriers experienced during treatment, one survivor said, "It was finances, my husband had just been laid off from a huge firm making a lot of money, to making zero." She went on to say the following, "I'm fortunate that my husband is now able to work some. Although, he's going to be seventy years old, he's still finding it necessary to continue working so we can make sure that I have proper treatment."

Furthermore, one key informant in the health field also addressed the financial impact of breast cancer: "For our clients whose medical expenses shoot up or now they have zero or reduced income because they can't work as much or at all during treatment. Just paying for general daily living expenses, that's a huge barrier."

Barriers: Insurance

Key informants in the health field as well as a survivor key informant stated that insurance is often a barrier for people trying to access care. When asked about Centers for Disease Control and Prevention (CDC) guidelines and regulations on breast health, one key informant in the health field said that it is easier for patients with insurance to move through each continuum of care than women that are uninsured. When asked about whether or not women in this community move through the continuum of care as recommended by CDC guidelines, the key informant stated, "I would say for women who have private insurance or who are already in the pathways for different state or federal programs, I would say yes. I would say for women who are uninsured who don't have that kind of ready access to providers because they don't have insurance. And so there's a time needing to be spent getting them enrolled in programs and what not, I would say possibly not."

When asked about barriers to care, another key informant in the health field stated, “The biggest one that I generally see is finding breast surgeons who accept Medi-Cal.” She went on to say, “Sometimes in some of the areas in Riverside and San Bernardino Counties, we have clinics who are doing the initial screening. So they’ll do the mammogram, they’ll do the breast exam, but when they’re ready to refer them out to a surgeon, they have a lot of trouble finding surgeons who will take Medi-Cal.” This indicates that the problem exists not only for those who are uninsured, but also for those who are insured through low-income programs.

Even women with adequate insurance can experience barriers to treatment caused by their insurance. One survivor said, “For six months, I went through all these HMO hoops. Because I had to get a referral to the radiologist, I had to get a referral for a mammogram, I had to get a referrals for the biopsy, I had to get a referrals to the surgeon, there was a three week window between each referral.”

One study done on the relation between insurance and clinical outcomes demonstrates that insurance plays a large role in the outcome of women with breast cancer: “Women without health insurance and those covered by Medicaid had more advanced breast cancer than women with private insurance when the disease was initially diagnosed.” (Ayanian et al., 1993). This indicates that many women may delay their treatment due to not having health insurance, which decreased their chances of survival.

Barriers: Culture

As indicated in the Health Systems and Public Policy Analysis, this area has a large percentage of foreign-born people, which play a major role in accessing health care. One key informant stated the following in regards to health care and culture: “I would argue that there are always—in any community—cultural barriers to accessing care. Just preconceived thoughts and ideas about medicine and physicians, and health care providers in general. I think that people can become uncertain about what to expect, what is going to be involved in treatment.”

Additionally, one study supports this notion and indicated that even if women have access to free services, cultural beliefs may get in the way of getting care, “Consistent with our participants’ responses, fear of cost has been shown to persist even when women are provided with free or low-cost mammograms...particularly if women are African-American, low income, older, and/or from an inner-city area.” (Fayanju et al., 2014). The study went on to say, “African-American and Hispanic women have been found to be more likely than white women to report fear of procedural pain as a concern that might keep them from getting mammograms.” (Fayanju et al., 2014). This is perhaps because breast cancer is not talked about in their culture, and as indicated by key informants, women then do not know how much it will cost or what to expect.

Barriers: Transportation

Key informants indicated that transportation is a big barrier for this community. One key informant in the health field said, “Transportation is a huge barrier for Inland Empire. And I’m sure you’re going to get that answer from everybody you talk to.” When asked about barriers, another key informant stated, “Transportation is a big issue a lot of the times. Women have trouble getting off of work, if they have worked, and getting transportation to and from the clinic.” It is important to note that this area is geographically spread out and so access to care becomes difficult if the individual does not have reliable transportation, as one key informant stated: “...so

many people live in remote areas. And so travel time to get to physicians or appointments that becomes a huge barrier. You're looking at a time issue. You're looking at the ability to put gas in the car. If somebody can't drive, do they have somebody who can drive then to treatment when public transportation is not available?"

A study on breast cancer and women in rural communities supports the comments brought up by key informants in this region. When speaking of transportation the study stated, "This issue has particular relevance for women living in rural areas, who may find it harder than their urban counterparts to get access to information they need because of social isolation, the risk of stigma in small communities, scarcity of providers, poverty, inadequate transportation, and geographic distances between patients and providers." (Collie et al., 2005).

Survivorship

Key informants in this community discussed changing their eating habits and increasing physical activity as ways of maintaining their health. One survivor stated, "I've changed my eating habits and try to do a little more physical things now." Another survivor said the following keep her healthy, "eating properly, getting enough sleep, exercise, and communication with friends and family. An article on the power of exercise supports this notion: "Physical activity can help lessen certain side effects of treatment, such as fatigue and depression, and has been shown to reduce risk of recurrence and improve survival." (Mendes, 2014).

Furthermore, when asked about what kinds of support they had during treatment, key informants shared the importance of family support. One survivor said, "My family was very supportive the whole time. If I needed anything they would always come and help me. I had a lot of emotional support from a lot of different people."

Some of the concerns survivors had in regards to their health now included future consequences of chemotherapy, congestive heart failure and fear of the disease coming back. As one survivor indicated, "My main concern at this point, is what long-term ramifications am I going to have from chemo."

MSSA 151g and MSSA 151k

MSSA 151g includes the communities of Muscoy and San Bernardino Central. MSSA 151k includes the communities of Highland and San Bernardino East. As suggested by the Quantitative Data Report, geographically and statistically, these two areas are very similar in regards to poverty, education and unemployment and therefore were combined to avoid duplicative work.

Barriers: Finances

As indicated by key informants, breast cancer can cause extreme financial stress on women. One survivor addressed this in her interview: "I didn't have the money that I needed to pay my bills. And I always had to call on my family, 'could you possibly pay my light bill for me, or my gas bill?'" A key informant in the health field stated that she sees the financial impact breast cancer has on her patients: "I do know that we've seen examples of women who have lost everything. Their homes, their jobs, everything." One focus group participant mentioned losing all she had, "I suffered because I had to stop working. I could not work, and the disability, you know so I suffered. I suffered a lot. I actually lost everything."

Additionally, one article from a nearby news channel addressed the consequences of breast cancer. It focused on joblessness as a side effect of cancer and chemotherapy, saying that those who received chemotherapy were 1.4 times more likely to be unemployed than those who didn't have that treatment (Doheny, 2014). This suggests that there is a need for financial resources for breast cancer survivors during and after treatment or the consequences could be financially devastating.

Barriers: Insurance

Insurance was brought up as a barrier in this community by a number of different key informants. When asked about barriers to care, one key informant in the health field stated, "I think it primarily is whether they have insurance or not, that's where the barrier is." She went on to say that many of the women she sees present at later stages due to lack of access to health care: "I just saw a woman, very advanced breast cancer. The only reason she didn't, couldn't come in earlier, was because she was not able to get a mammogram or have access into health care." That same key informant felt that many women are eligible for Medicare (referring to older women), but they don't know how to access it, so outreach and education to increase awareness would be beneficial. Another key informant mentioned health insurance as a barrier for women in getting the necessary breast exams and mammograms: "If they don't have any kind of insurance, that would stop them."

Furthermore, one survivor who addressed the importance of having health insurance stated the following: "I was fortunate I had insurance at the time I was going through chemo...I'm sure if I didn't, it would've been terrible because I looked at the prices of things. I don't know how people do it without insurance."

One focus group participant felt that it was better for her not to have insurance, "I found that it was better for me not to have insurance, I said 'Good, I can go get this done through the county because now I'm not going to have to wait for this referral for this, for that'." A study done with health care providers addresses these barriers within the health system, "key informants viewed the health care system as contributing to treatment delays, such as delaying referral to specialist." (Ashing-giwa et al., 2004).

Barriers: Culture

When asked about barriers, a few key informants in the health field mentioned culture. One key informant stated, "Culture plays a role in actively getting services. They like to see physicians that look like them and speak their language." Furthermore, one Black/African-American woman stated that cancer is just something you don't talk about in her culture, "Sometimes you're raised in a home, where these things are not talked about and that hurts women in the long run." She also mentioned that religion is a big part of the culture and that many women rely on prayer instead of accessing health care: "They just pray that they don't get it, and it's like out of mind, out of sight." Another survivor addressed spirituality as well in her interview: "I just put it in God's hands and whatever his will was would be done."

A study done on survivorship supports the comments brought up by the survivor key informants stating, "Almost all of the participants discussed their spirituality as central and critical to their survivorship" (Davis et al., 2014).

Additionally, another study further elaborates on culture as a barrier, stating that cultural beliefs often result in the delay of screening and treatment. The study addressed a few cultural factors that influence a woman's decision to delay treatment, including religious beliefs about cure, experienced prejudice in care delivery, and pessimistic expectations about survival: "Fatalism is often related to a lack of participation in health-seeking behavior...In the event of breast cancer, the likely result will be a more advanced stage of cancer at diagnosis and lower survival potential" (Facione et al., 2002).

Barriers: Transportation

One survivor discussed transportation being the biggest barrier she faced during her treatment: "...just transportation. How am I going to get to my chemo? My next-door neighbor took me down because my husband was teaching." Another survivor mentioned transportation services for daily activities and resources: "There needs to be a place like meals-on-wheels...there needs to be resources locally here in the Inland Empire rather than going all the way into Temecula, especially with transportation being an issue."

It appears that transportation is not only a barrier for women receiving chemo but also a barrier in getting other treatments such as radiation therapy (XRT) and breast-conserving surgery (BCS), especially in areas like this where there are large rural communities. One study found that transportation is indeed an issue for many women, "Women who live in rural areas were less likely to receive BCS and XRT... and likely reflect multiple factors, including barriers to travel in rural areas that make access to XRT more difficult." (Haggstrom, Quale & Smith-Bindman, 2005). This indicates that some women might have limited options in regards to treatment and therefore decreased chances of survival.

Survivorship:

Key informants indicated that they've made several changes to stay healthy. One survivor said, "I'm exercising more and I've had to change my diet. I cut out all the junk food, all the sweets." Another survivor made a similar comment, but stated that she need to be aware of her weight: "I have started exercising a little bit more, but I need to lose weight. My doctor keeps telling me, 'you need to lose weight'." Similarly, another survivor mentioned, "I have changed my eating habits. I exercise every day and I try not to stress out too much." Additionally, when asked what it means to her to be healthy, one focus group participant said, "For me it just means being able to take care of myself and my family. That's what being healthy is, healthy enough to work, to walk, to live, to love, to share. That's health for me." One study on the health of survivors indicates that eating healthy and staying active is very important, "Developing and sustaining healthy diet and exercise behaviors are a very important aspect of preventative health considering that nine out of 10 women originally diagnosed with early stage breast carcinoma will be considered cured of the disease. Breast cancer recurrence can be influenced by lifestyle changes, especially diet and exercise." (DeNysschen et al., 2014).

All key informants addressed the importance of family support in their interviews. One survivor said, "It [support] is very important, because when you're home and when your mind starts wandering and if you get a card in the mail or phone call, then those words of inspiration and just knowing that your family and friends are there supporting you, that gives you power, the willpower to keep on going, knowing someone cares." Another survivor said, "My family was wonderful. I mean, my family and friends. They'd cook dinner for my family, knowing that I'd be

tired.” One survivor included support systems along with family and friends, “I had a strong support group through church, work, social friends.”

Furthermore, one survivor mentioned the importance of having resources to support her and her family during her treatment, “The American Cancer Society, I learned about them, where as they provide transportation. So I was able to tap into that resource and someone was able to take me to and from my appointments, so that relieves my family...there needs to be more resources, though.” Focus group participants also agreed that their families and friends were a great support. One survivor said, “I had a strong support group at work, church, my husband, school, so I was well cared for. My neighbor took me to my chemo.”

Qualitative Data Findings

Limitations of the Qualitative Data

The data gathered identified specific barriers that exist in each targeted community and also demonstrated the need to improve breast cancer awareness and screening percentages. However, there are important limitations to this data, for example, the small sample size. Only 22 of the recommended 36 key informants participated, and only two of the recommended nine focus groups were conducted. While the key informant interviews were helpful, in terms of learning how health care providers, women and survivors perceive breast health issues; they were limited to a select few informants who were willing to participate. Furthermore, those key informants that participated may be different from those that did not participate and therefore may have different views on breast health issues that were not captured.

Focus groups were particularly hard to recruit for, many women either did not have the time to participate or simply did not feel comfortable participating. Potential focus group participants were called, emailed and followed up with but as mentioned, very few expressed interest in participating. Different dates and times were provided to accommodate women’s busy schedules and although this allowed a few more women to participate, those times often did not work for a large enough group of people to conduct a successful focus group.

Additionally, there are some limitations to consider with the document review method. Although, the recommended five articles per target community were gathered, the articles collected may not match the need in terms of locations or population. Some articles address breast health issues in different parts of California and the United States and therefore are not specific to the Inland Empire and the Affiliate’s communities of interest.

Overall, as a result of these limitations, this data may not fully capture the gaps that exist in breast health related issues in the Affiliates communities of interest.

MSSA 128

MSSA 128 was chosen for being extremely impoverished with a high percentage of people with a high school education and high rates of unemployment. As indicated by the Quantitative Data Report, this MSSA has double the rate of people living in poverty than the US and the state of California. It is no surprise then that key informants indicated that cost is one of the reasons why women do not get the recommended screenings. Thus increasing both programs that fund free screenings or low cost screening would be recommended for this community. Additionally,

although there are 11 community health centers offering breast health screening services, and one hospital, but many women indicated having difficulty with insurance and therefore do not access care. Furthermore, key informants indicated that many women do not know about resources that currently exist thus limiting their access to care. It was recommended that more outreach and education occur in this community to raise awareness on breast health related issues.

MSSA 145.2

Women in MSSA 145.2 seem to face similar barriers to those women in other communities of interest. According to the Quantitative Data Reports and Health Systems and Public Policy Analysis, this MSSA is also impoverished and has high rates of unemployment. Additionally, this MSSA has a large number of Black/African-American residents. In this community, Black/African-American women have higher breast cancer incidence rates, higher late-stage incidence rates, and higher death rates than White women, making them a population with high risk. This MSSA is also a rural community so access to transportation is severely limited and a large barrier for women looking for breast health services. It is no surprise then that many key informants indicated that transportation was one of the biggest barriers for them. Furthermore, although this area's greatest strength is that it contains six community health centers and one hospital, not all health centers offer clinical breast exams or mammography. Additionally, the Affiliate had an especially difficult time recruiting participants in this area, indicating that more outreach needs to occur to develop a relationship with the community and trust.

MSSA 151g and MSSA 151k

MSSA 151g and MSSA 151k were combined into a single target area because they are adjacent to one another and both have high needs. These MSSA's have a large number of Black/African-American women and therefore are considered a population with high risk. Additionally, approximately a quarter of residents 40 to 64 years old lack health insurance in both MSSA's making them particularly vulnerable. Furthermore, as indicated by the Health Systems and Public Policy Analysis, although this area has thirteen community health centers, three hospitals and three imaging centers, it is not enough to fulfill this community's need. Several key informants indicated that the greatest barrier they face is insurance related. This demonstrates that there needs to be outreach focused around how to navigate the insurance system. Another barrier in this community was transportation; many key informants agreed that transportation plays a large role in women accessing breast related care. Therefore, increasing funding for programs that provide transportation would be of benefit to this community.

Conclusions

The data gathered demonstrates that there are a great number of barriers that exist in the target communities. Several common barriers that emerged in multiple communities included insurance-related issues, financial impact of breast cancer, cultural barriers to seeking treatment, lack of transportation, and lack of knowledge/awareness. Thus, it is clear that the Affiliate's efforts to educate and raise awareness need to increase to continue improve breast cancer survival rates.

On the other hand, there are some excellent existing resources in the Affiliate's communities of interest including clinics, free screening and financial assistance programs such as Every Woman Counts. Additionally, many key informants indicated that the Affiliate's efforts are extremely helpful. One key informant said, "I think that [Susan G. Komen] is doing such a

wonderful job and I just truly appreciate every individual that is volunteering or working for Susan G. Komen to get the word out to women and men pertaining to cancer.” Another survivor said, “I’m very pleased that Susan G. Komen is doing this assessment to find out if the community needs this because that way programs and services are targeted to what the needs are.” One key informant in the health field was especially appreciative of the Affiliate’s efforts: “I think they do a really good job of informing agencies that they partner with and work with, not just their grantee agencies...they really do try to keep people in the loop about what’s going on in Inland Empire, what are the needs, making sure they can bring up all together in some kind of collaborative forum as often as possible to share information and really figure out good ways to address the needs of the community.”

Overall, the barriers in the Continuum of Care are numerous but nonetheless, understanding the barriers and gaps within these communities is a necessary initial step. Through education and outreach, Susan G. Komen and its partners can facilitate needed change and save more lives.

Mission Action Plan

Breast Health and Breast Cancer Findings of the Target Communities

The breast health and breast cancer findings as identified by the Quantitative Data Report, Health Systems and Public Policy Analysis, as well as the Qualitative Data Report have led to the selection of three target communities:

- MSSA 128 (Riverside County) which comprises the communities of Arabia, Coachella, Desert Beach, Flowing Wells, Indio South, La Quinta East, Mecca, Oasis and Thermal.
- MSSA 145.2 (San Bernardino County) which comprises the communities of Adelanto, Phelan, Pinon Hills, and Victorville Northwest.
- MSSA 151g and 151k (San Bernardino County) which comprises the communities of Highland, Muscoy, San Bernardino Central and San Bernardino East.

MSSA 128: Riverside County

The Quantitative Data Report also identified that the communities within MSSA 128 are extremely impoverished, and nearly half lack a high school education. Furthermore, nearly a fourth of the population residing in these communities are unemployed, lack health insurance and are medically underserved. The majority of the population in MSSA 128 is Hispanic/Latina and it has been noted that more than a quarter are considered to be linguistically isolated and foreign-born.

The Healthy Systems and Public Policy Analysis indicate that in the communities of MSSA 128 screening mammography, diagnostic services and treatment services are very limited. In addition, patient navigation is not available in these communities and there exists a lack of quality of care indicators. MSSA 128 is considered a rural community of large size and transportation is noted as a serious limitation to accessing to care. In addition, there are two financial assistance programs for cancer patients serving MSSA 128 specifically.

In the communities within MSSA 128, the Qualitative Data Report indicates that financial assistance, insurance, culture, lack of knowledge, and survivorship were key concerns surrounding breast health and breast cancer. Through key informant interviews and document review, the Qualitative Data Report outlines that finances were a barrier to accessing services throughout the continuum of care. In addition, the lack of health insurance and costs associated with care were of concern, coupled with lack of knowledge of breast health and resources, indicate that access to care is extremely limited.

Culture was also identified as a barrier in MSSA 128, as cultural beliefs and behaviors in the primarily Hispanic/Latino community indicate a strong belief that breast cancer is a death sentence and other misconceptions about breast cancer. This was further supported by health care providers in the region, indicating that their patients faced cultural barriers in understanding breast health, breast cancer, and accessing breast health services. Furthermore, knowledge surrounding breast health and resources to access breast health services is limited within the community.

A common theme in MSSA 128 as identified in the Qualitative Data Report is that of survivorship, indicating that support from family and friends was important, and those without familial support are at an increased risk for death.

Overall, the communities within MSSA 128 indicate that Hispanic/Latina communities are most at-risk and face issues related to access to care for screening, diagnostic, treatment and support services, as well as transportation and financial assistance. Programs should further address cultural and survivorship needs, in addition to overall breast health education.

MSSA 145.2/151g/151k: San Bernardino County

According to the Quantitative Data Report, it has been identified that San Bernardino County is rated as the “highest priority” in relation to the ability to meet both death rate and late-stage incidence rate targets as proposed by the Healthy People 2020 benchmarks. The MSSA communities of MSSA 145.2 and MSSA 151g and 151k indicate that Black/African-American women in these communities have higher breast cancer incidence rates, late-stage incidence rates, and death rates than their White counterparts. In addition, these communities are considered to be impoverished, with low education rates, high unemployment percentages and a large percentage indicated as being uninsured or underinsured, as well as considered medically underserved. Furthermore, language barriers to receiving health care have been identified as well in these communities.

The Health Systems and Public Policy Analysis has further indicated a lack of breast cancer diagnostic services, treatment and support services, as well as a need for additional screening mammography facilities. In the MSSA communities identified as a priority in San Bernardino County, it has been noted that these communities are considered rural and of large size with limited breast health centers offering clinical breast exams and/or mammography, in addition to minimal access to diagnostic and treatment services. Most breast health centers refer out of the area for these services, as the size of the population and need for services exceed the capacity of the available services in these communities. In addition, there is only one financial assistance program serving San Bernardino County. Transportation is often a barrier to care in these communities as well. Furthermore, many of the resources available in the Affiliate service region are located outside of the target communities, and often are across county lines.

The Qualitative Data Report further supplements the identified priorities within the target communities of San Bernardino County. Through key informant interviews, focus groups and document review, it has been noted that financial assistance, insurance/access to care, culture, transportation and survivorship are barriers within the targeted communities. The financial impact of breast cancer on middle and low-income individuals is a substantial barrier to care and quality of life long-term. Furthermore, access to care has been identified as extremely limited for those that are uninsured and underinsured, even under the state’s Medicaid program, Medi-Cal, and indicates that late-stage diagnosis is more prevalent, as well as a decreased chance of survival.

Transportation remains a common theme throughout the sections of the Community Profile, as the Affiliate service region is more than 27,000 square miles. The Qualitative Data Report indicates that transportation is a serious barrier to care throughout the continuum of care, from accessing screening to treatment services. Survivorship also is a key concern in the Qualitative Data Report, with limited access to patient navigation, education surrounding healthy lifestyles, and future implications of treatment affecting health. However, the Qualitative Data Report outlines that family and friend support was imperative throughout treatment.

Culture was also addressed as a barrier to care, as breast cancer is often not a topic of conversation in some cultures, specifically in some Black/African-American communities. Cultural beliefs and behaviors are also identified as being a barrier and delay in accessing screening and treatment due to religious beliefs, care delivery prejudices, and pessimistic expectations of survival.

Overall, the communities within MSSA 151g and 151k indicate that Black/African-American communities are most at-risk and face numerous issues related to access to care for screening, diagnostic, treatment and support services, as well as transportation and financial assistance. Programs should further address cultural and survivorship needs.

Additional Summary Findings Across Affiliate Service Region

In addition to the priority communities discussed, further findings from the Health Systems and Public Policy Analysis indicate that the Affiliate service region throughout Riverside and San Bernardino Counties face several other barriers to care. Due to the large geographic size of the Affiliate service region, transportation remains a substantial barrier to care. There exists only one county hospital per county. Due to the large size of the Affiliate service region, the distribution of available breast health centers offering screening, diagnostic and treatment services is far and few between in rural communities. As the majority of the Affiliate service region is considered largely rural, breast health services are primarily located in the western portion of the Affiliate service area and thus transportation to access breast health care services is a primary barrier to care for the majority of rural communities. Furthermore, financial assistance remains a barrier to care throughout the 27,000 sq. mile service area, as only one financial assistance program for breast cancer patients is available that serves the entire service area. However, an additional financial assistance program is available only in the Coachella Valley region of the Affiliate service area.

It should also be noted that the state's National Breast and Cervical Cancer Early Detection Program (NBCCEDP), Every Woman Counts (EWC), is available in various communities throughout the service region, however there exists serious gaps in the continuum to care for specific populations. It should be noted that EWC does not provide diagnostic breast health services for men. Also, many residents of the Affiliate service region are considered to be undocumented and do not qualify for EWC or state insurance programs such as Medi-Cal or Covered California programs. In addition, EWC does not cover medically-necessary diagnostic MRIs and certain biopsy services, as well as BRCA testing. Therefore, Susan G. Komen® Inland Empire has remained the only community-based organization that has historically funded the cost of medically-necessary diagnostic MRIs and remaining biopsy services for those enrolled in EWC and those ineligible for EWC or other health care support programs. These services are expensive and place burden on Affiliate funding to nonprofit organizations providing these services, even at a reduced cost.

In regards to state and federally funded treatment services through the Breast and Cervical Treatment Program (BCCTP), there exists several gaps in care. Firstly, men are not eligible for this program. Furthermore, undocumented persons are eligible for the program but may only receive treatment for the length of 18 months and may not qualify again for the program if re-diagnosed. In addition, the BCCTP program is available for qualifying documented residents for a period of 24 months, but may not qualify again for the program if re-diagnosed. Furthermore, those enrolled in the state's Medicaid program, Medi-Cal have limited access to breast

surgeons/general surgeons that accept this form of insurance. These gaps in breast cancer treatment are not addressed by any other form of services within the Affiliate service region.

Mission Action Plan

These priorities were developed to address the needs of MSSA 128 and MSSA's 145.2/151g/151k, and as identified throughout the Community Profile process. By addressing these specific priorities, a measurable impact to reduce disparities within the targeted community is expected in years to come. The Mission Action Plan below is developed using the following structure to outline problems/needs, priorities, and objectives for each MSSA community.

MSSA 128

Problem: Hispanic/Latina communities in MSSA 128 lack health insurance and are medically underserved.

Priority: Improve access to breast health services along the continuum among women age 40 and older in MSSA 128.

Objective: By 2017, collaborate with at least three providers that serve Hispanic/Latina women to provide culturally competent breast health services and community-based patient navigation services for residents of MSSA 128.

Problem: Communities within MSSA 128 have very limited access to culturally competent breast health education.

Priority: Increase access to culturally competent breast health education among Hispanic/Latina women in MSSA 128.

Objective: By 2016, launch an Affiliate-based culturally-competent breast health education program, addressing the needs of Hispanic/Latina women in MSSA 128, as measured by reaching 1,500 Hispanic/Latina women through education and outreach.

Objective: By 2017, expand Affiliate-based Prayer in Pink, faith-based breast health education and resource program in MSSA 128 to improve breast health education and knowledge of local resources to 1,500 residents annually.

Problem: Communities within MSSA 128 have extremely limited access to culturally competent breast health care services including screening, diagnostic and treatment, especially related to the lack of insurance, transportation, and financial assistance.

Priority: Reduce barriers to care by addressing transportation and financial assistance needs in MSSA 128.

Objective: By 2017, develop new, collaborative relationship with at least one community-based organization to provide transportation services for residents of MSSA 128.

Problem: Communities within MSSA 128 lack culturally competent survivorship programs and patient navigation.

Priority: Increase access to culturally competent breast cancer survivorship and patient navigation services for women in MSSA 128.

Objective: By 2017, develop new, collaborative relationships with at least three community-based organizations whose target population is Hispanic/Latina women in MSSA 128 to engage in culturally competent survivorship services.

MSSA's 145.2/151g/151k

Problem: Black/African-American communities in MSSA 145.2/151g/151k have higher than average breast cancer incidence rates, late-stage incidence rates, and death rates.

Priority: Increase knowledge regarding breast health, access to screening and breast health resources to potentially reduce the chance of late-stage diagnoses within Black/African-American women residing in MSSA's 145.2/151g/151k.

Objective: By 2017, expand Affiliate-based Circle of Promise program to address cultural and community resource education needs for 1,000 Black/African-American women in MSSA's 145.2/151g/151k.

Objective: By 2017, expand Affiliate-based Prayer in Pink, faith-based breast health education and resource program in MSSA's 145.2/151g/151k to improve breast health education and knowledge of local resources to 5,000 residents annually.

Problem: Black/African-American communities in MSSA 145.2/151g/151k have limited access to culturally competent breast health care services including screening, diagnostic and treatment, especially related to the lack of insurance, transportation, and financial assistance.

Priority: Improve access to culturally competent breast health services along the continuum of care among Black/African-American women age 40 and older in MSSA's 145.2/151g/151k.

Objective: By 2017, collaborate with at least three providers that serve African-American women to provide culturally competent breast health services for residents of MSSA's 145.2/151g/151k.

Priority: Reduce barriers to care by addressing transportation and financial assistance needs in MSSA's 145.2/151g/151k.

Objective: By 2017, develop new, collaborative relationship with at least one community-based organization to provide transportation services for residents of MSSA's 145.2/151g/151k.

Problem: Communities within MSSA 145.2/151g/151k lack culturally competent survivorship programs.

Priority: Increase access to culturally competent breast cancer survivorship services for women in MSSA's 145.2/151g/151k.

Objective: By 2016, develop new, collaborative relationships with at least three community-based organizations whose target population is Black/African-American women in MSSA's 145.2/151g/151k to engage in culturally competent survivorship services.

Overall Affiliate Service Region

Problem: Affiliate service region of San Bernardino and Riverside Counties have limited access to care related to lack of transportation and financial assistance.

Priority: Reduce barriers to care by addressing transportation and financial assistance needs throughout Affiliate service region.

Objective: Beginning with the FY2017 Community Grant Request for Application, programs that assist with the financial needs of accessing breast health services and treatment support for residents of San Bernardino and Riverside Counties will be a funding priority.

Objective: Beginning with the FY2017 Community Grant Request for Application, programs that provide transportation services to and from breast health service appointments for residents of San Bernardino and Riverside Counties will be a funding priority.

Problem: Residents of the Affiliate service region that are enrolled in EWC lack access to medically- necessary diagnostic MRIs, BRCA testing, some diagnostic biopsy services, and breast surgeons/general surgeons.

Priority: Improve access to medically-necessary MRI, biopsy services, and breast surgeons/general surgeons for EWC and Medi-Cal enrollees residing in Affiliate service region.

Objective: By 2019, collaborate with California Komen Affiliates, EWC program and Medi-Cal to address disparities in breast cancer diagnostic services for EWC enrollees to improve timely access to care by qualitative measurement of meeting minutes and policy changes to EWC.

Problem: Residents of the Affiliate service region that are enrolled in Medi-Cal may lack access to a local breast surgeon/general surgeon.

Priority: Improve access to medically-necessary MRI, biopsy services, and breast surgeons/general surgeons for EWC and Medi-Cal enrollees residing in Affiliate service region.

Objective: By 2019, collaborate with California Komen Affiliates, EWC program and Medi-Cal to address disparities in breast cancer diagnostic services for EWC enrollees to improve timely access to care by qualitative measurement of meeting minutes and policy changes to EWC.

Problem: Residents of the Affiliate service region that are enrolled in the NBCCTP may lack access to additional breast cancer treatment when re-diagnosed with breast cancer after initial treatment period has ended.

Priority: Improve access to treatment services for re-diagnosed patients ineligible for NBCCTP enrollees residing in Affiliate service region.

Objective: By 2019, collaborate with California Komen Affiliates and the BCCTP program to address disparities in breast cancer treatment for re-diagnosed breast cancer patients to improve timely access to care by qualitative measurement of meeting minutes and proposed policy changes to BCCTP.

Problem: Male residents within the Affiliate service region are not eligible for diagnostic services through neither EWC, nor treatment for breast cancer through the BCCTP.

Priority: Improve access to diagnostic services and treatment programs for men residing in Affiliate service region.

Objective: By 2019, collaborate with California Komen Affiliates, grant recipients, EWC, and BCCTP programs to address disparities in breast cancer diagnosis and treatment for men by qualitative measurement of meeting minutes and proposed policy changes to EWC and BCCTP.

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Appendices

Appendix A. Key Informant Interview Script: Health Care Providers

Introduction:

Hello, my name is _____. I am assisting the Inland Empire Affiliate of Susan G. Komen in assessing where there may be barriers to or gaps in breast health services in the Affiliate's three target areas. The themes that emerge from the interviews will be used to set priorities and inform the efforts of the Inland Empire Affiliate of Susan G. Komen. The priorities that we establish will help us determine where to target our grantmaking, as well as help us build community relationships, learn about programs taking place in your community, and address outreach and policy needs.

Your knowledge is valuable and the Affiliate appreciates you making yourself available for an interview. The interview will take about 20-30 minutes. Your participation in the interview is voluntary. You may choose not to participate in the interview at any time. Whether you chose to participate or not participate in the interview will in no way impact your relationship with the Affiliate and the services they provide. If you decide to stop prior to the interview being completed, I will ask you how you would like us to handle the data collected up to that point. If you do not want to answer some of the questions, you do not have to.

(Ask for verbal consent)

With your permission, I'd like to audio-tape the interview. This is because everything you have to say is very important, and we don't want to miss a word. The audio-recordings will be password protected at all times, and only accessed by researchers who are trained in conducting confidential research. Are you comfortable participating in the interview?

If yes: Is it OK for me to record the interview? [continue]

If no: OK, not a problem. Thank you for your time, have a wonderful day. [end]

If yes: Then I'll turn on the recorder and we can get started.

If no: That's fine, I'll just take notes. Forgive me if I'm a little slow between questions, I just want to make sure I get everything you say.

If you have any questions during the interview, please feel free to ask them at any time.

Questions:

Q1. Would you tell me a little about yourself? What is your role in the health field?

Q2. Are you familiar with the CDC guidelines/ regulations on breast health? (CDC guidelines: Time between referral and initial mammogram less than 90 days. Time between initial mammogram and date of diagnosis less than 60 days. Time between diagnosis and start of treatment less than 60 days). If yes, how did you learn about them? (Self? Required? Other?)

Q3. For women who have been diagnosed, what barriers within the health system do you see for them in accessing screening, diagnosis, and treatment of their breast cancer?

Q4. Breast cancer treatment can often be costly, especially for those that are uninsured. With that being said, how do you address the potential financial impact of breast cancer with your patients? Do you provide them with resources that can help them cover some of the costs?

Q5. Do you know about free (screening) services in the community? Do you offer any free services to women in this community?

Q6. How do you keep up with new legislation regarding changes in breast health protocols and advancements?

Q7. Does your office/clinic/organization presently partner with any other local organizations in providing breast health services to women in your community? If yes, which ones?

Q8. Would you be interested in partnering with Susan G. Komen on issues related to access?

Closing:

Thank you very much for your time. Your knowledge and insights will be very helpful in assisting the Inland Empire Affiliate of Susan G. Komen identify gaps and unmet needs in the breast health services community.

Thank you again for your assistance.

Appendix B. Key Informant Interview Script: Survivors

Introduction:

Hello, my name is _____. I am assisting the Inland Empire Affiliate of Susan G. Komen in assessing where there may be barriers to or gaps in breast health services in the Affiliate's three target areas. The themes that emerge from the interviews will be used to set priorities and inform the efforts of the Inland Empire Affiliate of Susan G. Komen. The priorities that we establish will help us determine where to target our grantmaking, as well as help us build community relationships, learn about programs taking place in your community, and address outreach and policy needs.

Your knowledge is valuable and the Affiliate appreciates you making yourself available for an interview. The interview will take about 20-30 minutes. Your participation in the interview is voluntary. You may choose not to participate in the interview at any time. Whether you chose to participate or not participate in the interview will in no way impact your relationship with the Affiliate and the services they provide. If you decide to stop prior to the interview being completed, I will ask you how you would like us to handle the data collected up to that point. If you do not want to answer some of the questions, you do not have to.

(Ask for verbal consent)

With your permission, I'd like to audio-tape the interview. This is because everything you have to say is very important, and we don't want to miss a word. The audio-recordings will be password protected at all times, and only accessed by researchers who are trained in conducting confidential research. Are you comfortable participating in the interview?

If yes: Is it OK for me to record the interview? [continue]

If no: OK, not a problem. Thank you for your time, have a wonderful day. [end]

If yes: Then I'll turn on the recorder and we can get started.

If no: That's fine, I'll just take notes. Forgive me if I'm a little slow between questions, I just want to make sure I get everything you say.

If you have any questions during the interview, please feel free to ask them at any time.

Introduction: I'd like to start by asking you to state your name and how long you have been living cancer free

Questions:

Q1. When you think about "good health" what comes to mind? As a breast cancer survivor, what changes have you made to stay healthy?

Q2. Thinking back to when you first received a diagnosis, did anything get in the way of receiving that diagnosis (ex. Money, transportation, work, fear of the process, family commitments, could not get an appointment, no insurance, doctor did not follow through on symptoms)?

- Q3. Where did you receive screening, diagnosis and/or treatment from? Please provide us with the name of the hospital or clinic.
- Q4. What were some of the barriers/problems, if any, that you experienced when going through treatment?
- Q5. What financial impact, if any, did breast cancer have on your life? Did you have any resources available to you to help with the costs during treatment? If so, which ones?
- Q6. What support or assistance do you wish had been available to you when going through treatment?
- Q7. What are the major health problems that concern you the most as a breast cancer survivor? Have you had the resources, information and support you need to help with these?
- Q8. How has this affected your life- physically, financially and emotionally?

Lastly, do you have any questions or would you like to add any comments or insights about any of the topics we've discussed?

Closing:

Thank you very much for your time. Your knowledge and insights will be very helpful in assisting the Inland Empire Affiliate of Susan G. Komen identify gaps and unmet needs in the breast health services community.

Thank you again for your assistance.

Appendix C. Key Informant Interview Script: Women over 30

Introduction:

Hello, my name is _____. I am assisting the Inland Empire Affiliate of Susan G. Komen in assessing where there may be barriers to or gaps in breast health services in the Affiliate's three target areas. The themes that emerge from the interviews will be used to set priorities and inform the efforts of the Inland Empire Affiliate of Susan G. Komen. The priorities that we establish will help us determine where to target our grantmaking, as well as help us build community relationships, learn about programs taking place in your community, and address outreach and policy needs.

Your knowledge is valuable and the Affiliate appreciates you making yourself available for an interview. The interview will take about 20-30 minutes. Your participation in the interview is voluntary. You may choose not to participate in the interview at any time. Whether you chose to participate or not participate in the interview will in no way impact your relationship with the Affiliate and the services they provide. If you decide to stop prior to the interview being completed, I will ask you how you would like us to handle the data collected up to that point. If you do not want to answer some of the questions, you do not have to.

(Ask for verbal consent)

With your permission, I'd like to audio-tape the interview. This is because everything you have to say is very important, and we don't want to miss a word. The audio-recordings will be password protected at all times, and only accessed by researchers who are trained in conducting confidential research. Are you comfortable participating in the interview?

If yes: Is it OK for me to record the interview? [continue]

If no: OK, not a problem. Thank you for your time, have a wonderful day. [end]

If yes: Then I'll turn on the recorder and we can get started.

If no: That's fine, I'll just take notes. Forgive me if I'm a little slow between questions, I just want to make sure I get everything you say.

If you have any questions during the interview, please feel free to ask them at any time.

Introduction: I'd like to start by asking you to state your name.

Questions:

Q1. What comes to mind when you think about breast cancer? What do you think it means to your friends and relatives?

Q2. Do you know about available services for breast health and/or breast cancer?

Q3. If a woman told you she was at risk for breast cancer, what would that mean to you?

- Q4. If you were diagnosed, where would you go for information? Where would you go for support?
- Q5. What do you think are the barriers that prevent women from seeking or getting breast cancer screening in your community?
- Q6. What do you think the financial impact of breast cancer would be? Are you aware of any resources that might help cover some of the costs for breast cancer patients?
- Q7. Where do you get health information? Where do other women get health information?
- Q8. What knowledge do you have about early detection programs and sources of breast health information?
- Q9. What do you know about Susan G. Komen Inland empire Affiliate and what do you know about Susan G. Komen as national organization?

Lastly, do you have any questions or would you like to add any comments or insights about any of the topics we've discussed?

Closing:

Thank you very much for your time. Your knowledge and insights will be very helpful in assisting the Inland Empire Affiliate of Susan G. Komen identify gaps and unmet needs in the breast health services community.

Thank you again for your assistance.

Appendix D. Focus Group Discussion Guide: Survivors

Opening Comments

Susan G. Komen's promise is to save lives and end breast cancer forever by empowering people, ensuring quality care for all and energizing science to find the cures.

Community profile refers to the assessment process that Affiliates like Susan G. Komen Inland Empire, complete every four years in order to understand the state of the breast cancer burden and needs in their service areas. Through the Community Profile, we will be able to build awareness in the areas of greatest need and bridge gaps on breast health education, access to services and treatment.

What we are trying to achieve today with this discussion group is to learn about the strengths, challenges and opportunities to improve breast health and breast cancer outcomes in the community.

Introduction to the Focus Group Moderator

My name is _____. My role is to ask some basic questions and to moderate the discussion so that everyone here has an opportunity to share their opinions and ideas.

Confidentiality

Whatever you say here today is going to remain completely confidential. Your name will not be associated with any comments that are made in this setting.

As you can see by the equipment on the table, however, our session today will be audio-taped. This is because everything you have to say is very important, and we don't want to miss a word. Having the audio tape will enable us to carefully review what is said. Is it all right with each of you to tape this discussion? (Go around the table to obtain a "yes" answer from everyone).

Good.

For the record, your participation in this group is entirely voluntary, and you are free to leave at any point if you find it necessary. I will be available after the session this evening to answer any questions you may have. Let me also add that this group is being conducted for research purposes only. No one is going to follow up or try to sell you any kind of product or service.

Discussion Group Rules

First, since each and every person's comments are important, I ask that only one person speak at a time. This practice will help us to hear each other. Side conversations are distracting. There is no such thing as a right or wrong answer in this group. We have no expectations about what is going to be said. Tell us what you honestly think, and feel free to share whatever is on your mind. Everyone here will be considered equally. If you disagree with something that you hear, let us know. If you agree, don't just say, "I agree," but try to add your own perspective. We want to hear as many different opinions and ideas as possible.

Although I'll be asking the questions, please do not feel you need to respond directly to me. In fact, I strongly encourage you to discuss these matters with each other.

Warm-up

May I start by asking you to state your name? If you feel comfortable, you can also share a bit of personal information, so that we can get to know you a little better. I'll go first.

Introduction

Q1. I'd like to start with a general question. When you think about "good health" what comes to mind? What does it mean to you as a breast cancer survivor?

Needs Assessment

Q2. Thinking back to when you first received a diagnosis, did anything get in the way of receiving that diagnosis (ex. Money, transportation, work, fear of the process, family commitments, could not get an appointment, no insurance, doctor did not follow through on symptoms)?

Probe: Are any of these a problem now?

Q3. Where did you receive screening, diagnosis and/or treatment from? Please provide us with the name of the hospital or clinic.

Q4. What were some of the barriers/problems, if any, that you experienced when going through treatment?

Q5. What financial impact, if any, did breast cancer have in your life? Did you have any resources available to you to help with the costs during treatment? If so, which ones?

Q6. What support or assistance do you wish had been available to you when going through treatment?

Q7. What are the major health problems that concern you the most as a breast cancer survivor?

Q8. What information, support, or resources have you had or lacked during your survivorship years?

Q9. How has this affected your life- physically, financially and emotionally?

Q10. Since your diagnosis, what changes have you made to stay healthy?

Q11. Do you have any questions or would you like to add any comments or insights about any of the topics we've discussed?

Closing Remarks

Thank you very much for your participation in this discussion. Your feedback is very valuable and is much appreciated.

Appendix E. Focus Group: Participant Consent Form

**Focus Group Participant Consent Form
Susan G. Komen® Inland Empire**

This focus group is being conducted by HARC on behalf of Susan G. Komen® Inland Empire. By conducting this focus group, the Komen Inland Empire Affiliate aims to understand the barriers that exist in receiving breast health information and services.

A focus group is a discussion between several people. The facilitator will ask a few questions to gain understanding about a topic and then ask my thoughts and opinions on the topic. The discussion will last approximately 1 hour and will be audio recorded.

I understand that I do not have to participate in this focus group and can choose to leave at any time. My participation is voluntary, and I may change my mind at any time. There will be no penalty if I decide not to participate, nor if I start to participate and decide to stop early. I understand that my participation in the focus group will in no way affect any current or future assistance from the Affiliate.

I understand that all information obtained from the focus group will be kept strictly confidential. All participants will be asked not to disclose anything said within the focus group discussion. All identifying information will be removed from the collected materials. In addition, all materials will be handled by solely by Affiliate staff and the researchers analyzing the data.

I understand that there are no physical risks to participating in this focus group, but I might not be completely comfortable answering some of the questions being asked. I understand that I am free not to answer any of the questions asked.

I also understand that my words may be quoted directly in reports but quotes will NEVER be connected to me, my name or to information that can identify me.

By signing this consent form, I indicate that I fully understand the above information and I agree to participate in the focus group.

Participant Printed Name

Participant Signature

Date