susan g. komen®

COMMUNITY PROFILE REPORT 2015

SUSAN G. KOMEN®
ARKANSAS

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Acknowledgments

The Community Profile Report could not have been accomplished without the exceptional work, effort, time and commitment from many people involved in the process.

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Executive Summary

Introduction to the Community Profile Report

Susan G. Komen® promise is to save lives and end breast cancer forever by empowering people, ensuring quality care for all, and energizing science to discover the cures. To meet this promise, Komen Arkansas relies on the information obtained through the Community Profile process to guide the work needed to accomplish the promise in its communities. A quality Community Profile guarantees that local efforts by Komen Arkansas are targeted to the greatest needs and non-duplicative.

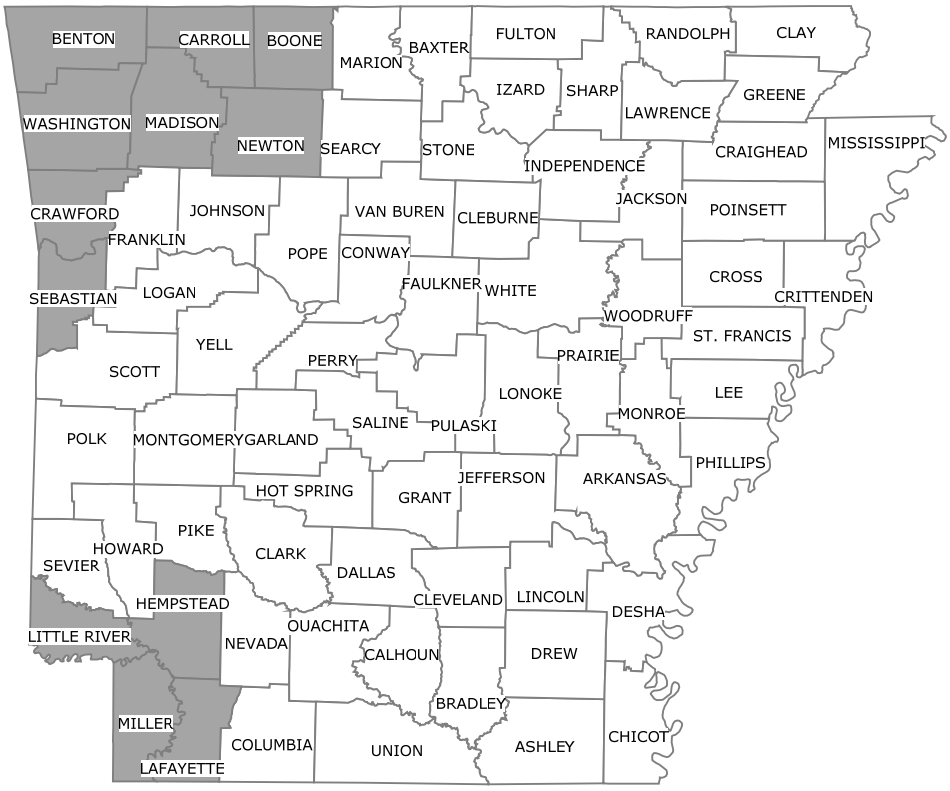
In 1992, Susan G. Komen Arkansas was incorporated by Terri DeSio, Pat McClelland and Pat Torvestad and originally covered all of the 75 counties in Arkansas. After 1998, Komen Arkansas was only responsible for 63 of the 75 counties, with eight counties formed part of the Ozark Affiliate service area and four counties in the Texarkana Affiliate service area (Figure 1). Up to 75 percent of the Affiliate's net income goes toward funding grants to local hospitals and community organizations that provide breast health education and breast cancer screening and treatment programs for medically underserved women. The remaining net income (a minimum of 25 percent) supports the Susan G. Komen Research Programs to find cures for breast cancer. Over the past 21 years Komen Arkansas has given $5.3 million to research and $15.3 million to community grant programs in the service area.

The Komen Arkansas Race for the Cure® is one of the best responded to Affiliate events held each year. The Komen Arkansas Race has been held for over 20 years and has raised $24 million, funding grants and educational programs which have provided support and information focused on early detection to thousands of Arkansas women and their families. The first race held in 1994, had 2,200 participants. The most recent, 21st race had close to 30,000 participants.

Since 2001, Komen Arkansas has received recognition for a number of local and state awards in addition to Susan G. Komen Headquarters awards. Komen Arkansas —along with those who generously support the Affiliate with their talent, time and resources—is working to better the lives of those facing breast cancer in the State. The Affiliate joins hundreds of thousands of breast cancer survivors and activists around the globe as part of the world's largest and most progressive grassroots network fighting breast cancer. In 2014, $1,006,737 was awarded to 18 local programs via the grant recipients by Komen Arkansas. The grant recipients provide breast health and breast cancer education, screening and treatment services assisting the medically underserved in the region.

To understand where Komen Arkansas' granting efforts will have the most impact, the Affiliate relies on information obtained through the Community Profile. The Community Profile is a qualitative and quantitative assessment that identifies gaps and barriers throughout the health system for breast cancer. The Community Profile includes an overview of demographic and breast cancer statistics that highlight target areas, groups or issues. The information for the profile is gathered through policy, resource allocation, interviews, surveys and the most current, available statistics. The Affiliate takes the information gathered and uses it to strategically plan for the next four years to identify access to services.

Arkansas



Note: The counties with no shading represent the 63 counties in the service area of Komen Arkansas.

Figure 1. Susan G. Komen Arkansas service area

The Community Profile includes an overview of demographic and breast cancer statistics that after preliminary analysis highlight target areas, groups or issues. The statistics pinpoint where efforts are most needed. In order to ensure effective and targeted efforts, it is important to understand what program and service gaps, needs and barriers exist, as well as what existing assets can be utilized for partnership and collaborative interventions. The Community Profile also includes analysis of the community within, including the voices of those living in target areas and representing target populations.

Quantitative Data: Measuring Breast Cancer Impact in Local Communities

In order to be efficient stewards of resources, Komen Arkansas has identified four highest priority target communities within the 63 county service area. The Affiliate will focus strategic efforts on these target communities over the course of the next four years. The selected target communities are Arkansas County, Arkansas; St. Francis County, Arkansas, Northeast Arkansas Region (Izard County, Lawrence County, Randolph County, and Sharp County); and Southeast Arkansas Region (Bradley County, Chicot County and Drew County). By clustering counties of similar key population characteristics in regions, the Affiliate can reach more of the population in an efficient manner.

Target communities are communities which have cumulative key indicators showing vulnerable populations likely at risk for experiencing gaps in breast health services and/or barriers in access to care. When selecting target communities, the Affiliate reviewed Healthy People 2020, a major federal government initiative that provides specific health objectives for communities and the country as a whole. Through this review, areas of priority were identified based on the time needed to meet Healthy People 2020 targets for breast cancer. The 2020 goals are death rate (20.6 per 100,000 women) and late-stage rate (41.0 per 100,000 women).

Data were gathered from the following resources: North American Association of Central Cancer Registries (NAACCR), State Cancer Profiles, State Cancer Registries, the Behavioral Risk Factor Surveillance Systems (BRFSS) and the US Census Bureau.

Arkansas County, Arkansas
Arkansas County has been identified as a high priority county due to the amount of intervention time needed to achieve the HP2020 targets. The late-stage incidence rate in Arkansas County (67.4 per 100,000) is substantially higher than the Affiliate service area as a whole (46.0 per 100,000) and Arkansas County is the only county in the state with that high rate. Although trends were not available to determine if the county will meet the HP2020 death rate target, Arkansas County's death rate (24.1 per 100,000 women) is higher than the State of Arkansas (23.4 per 100,000) and the US (22.6 per 100,000). With a late-stage trend of 5.7 percent, it is predicted that it will take Arkansas county 13 years or more to meet the late-stage HP2020 target.

St. Francis County, Arkansas
St. Francis County has been identified as a high priority county due to the amount of intervention time needed to achieve the HP2020 targets. The late-stage incidence rates in St. Francis County (47.6 per 100,000) are only slightly higher than the Affiliate service area as a whole (46.0 per 100,000). The death rate for St. Francis County is 30.8 per 100,000 while the rate for the Affiliate service area is 23.6 per 100,000. Both the late-stage diagnosis and death rates are predicted to take 13 years or longer to reach the targeted HP2020 rates.

Northeast (NE) Arkansas Region, Arkansas (Izard County, Lawrence County, Randolph County and Sharp County, Arkansas)
Due to small population sizes, similar demographics and contingent borders, these counties have been combined into one region for the purpose of this report and for the Affiliate's targeted efforts. The Northeast Arkansas Region aligns with the Arkansas state border with Missouri. All counties in the region are considered rural. With a combined population of 33,561, these counties have been chosen due to their status as being highest intervention priority and because they are all medically underserved, have older populations and are impoverished. Unlike most of Arkansas, these four counties are predominantly White. Lawrence County is the most diverse of the four counties with 98.1 percent White and 1.3 percent Black/African-American.

Izard County, Arkansas
The incidence of breast cancer in Izard County is slightly less than the incidence rate in the US (122.1 per 100,000) at 110.3 per 100,000, but higher than the Arkansas rate (109.5 per 100,000). Furthermore the death rate for Izard County (32.7 per 100,000) is higher than the death rate for the US (22.6 per 100,000) and for the Affiliate service area (23.6 per 100,000).

Izard County is one of the three counties with a higher late-stage rate than the US (43.7 per 100,000), but slightly lower than the Affiliate service area (46.0 per 100,000) with 45.1 per 100,000.

Lawrence County, Arkansas
The incidence of breast cancer in Lawrence County is lower than the incidence rate in the US (122.1 per 100,000) at 118.8 per 100,000, but higher than the Arkansas rate (109.5 per 100,000). In addition the death rate for Lawrence County (35.6 per 100,000) is higher than the death rate for the US (22.6 per 100,000) and for the Affiliate Service Area (23.6 per 100,000).Lawrence County is one of the three counties with a higher late-stage rate than the US (43.7 per 100,000) or the Affiliate service area (46.0 per 100,000) with 47.0 per 100,000.

Randolph County, Arkansas
Of all the counties in the NE region, the incidence rate of breast cancer in Randolph County (103.6 per 100,000) is the lowest when compared to the incidence rate in the US (122.1 per 100,000) and the State of Arkansas (109.5 per 100,000). However, the death rate for Randolph County (30.8 per 100,000) is higher than the death rate for the US (22.6 per 100,000) and for the Affiliate Service Area (23.6 percent). Randolph County is one of the three counties with a higher late-stage rate than the US (43.7 per 100,000) or the Affiliate service area (46.0 per 100,000) with 47.6 per 100,000.

Sharp County, Arkansas
The incidence rate of breast cancer in Sharp County is lower than the incidence rate in the US (122.1 per 100,000) at 118.7 per 100,000, but higher than the Arkansas rate (109.5 per 100,000). There were no significant numbers to determine the death rate for Sharp County in comparison to the other counties in the NE region. In addition Sharp County, from this group, was the only county in the State of Arkansas that had a substantially less favorable trend in breast cancer late-stage incidence rates.

All of the counties identified in the NE region are designated as medically underserved areas. The Northeast Arkansas Region will provide a different challenge than the Southeast Arkansas Region because of its demographic makeup and accessibility.

Southeast (SE) Arkansas Region, Arkansas (Bradley County, Chicot County and Drew County, Arkansas)
Due to small population sizes, similar demographics and contingent borders, these counties have been combined into one region for the purpose of this report and for the Affiliate's targeted efforts. The Southeast Arkansas region is located in South Eastern Arkansas and aligns with the Arkansas state border with Mississippi. Bradley County is only one of two counties in Arkansas with a substantial Hispanic/Latino population (12.4 percent).

These counties have been chosen due to their status in the highest intervention priority and because they are all medically underserved and are poorly educated. They have a combined population of 21,658, including a large Black/African-American population: Bradley County (28.8 percent), Chicot County (55.5 percent) and Drew County (29.0 percent). This is of importance due to the high death rates Black/African-American women experience from breast cancer when compared to other races. Additionally, the late-stage rate in Arkansas for Black/African-American women is 55.8 per 100,000 while for Arkansas as a whole is 44.2 per 100,000. As a

result Black/African-American women experience a high death rate from breast cancer when compared to other races in these combined counties.

Bradley County, Arkansas

The incidence rate of breast cancer in Bradley County is lower than the incidence rate in the US (122.1 per 100,000) and the Arkansas rate (109.5 per 100,000) at 108.3 per 100,000. There were no significant numbers to determine the death rate for Bradley County in comparison to the other counties in the SE region. In addition the late-stage incidence rate for Bradley County (59.9 per 100,000) is higher than the late-stage rate of the US (43.7 per 100,000) and the Affiliate Service Area (46.0 per 100,000).

Chicot County, Arkansas

The incidence rate of breast cancer in Chicot County is higher than the incidence rate in the US (122.1 per 100,000) and the Arkansas rate (109.5 per 100,000) at 123.7 per 100,000. Additionally the death rate for Chicot County (35.6 per 100,000) is higher than the death rate for the US (22.6 per 100,000) and for the Affiliate Service Area (23.6 percent). Chicot County was one of two counties in the SE region with a higher late-stage rate of 47.0 percent compared to the US (43.7 per 100,000) and the Affiliate service area (46.0 per 100,000).

Drew County, Arkansas

Among the counties in the SE region, the incidence rate of breast cancer in Drew County is considerably lower than the incidence rate in the US (122.1 per 100,000) and the Arkansas rate (109.5 per 100,000) at 85.3 per 100,000. At this time there may be some unforeseen challenges that may be affecting this rate in Drew County and will need to be watched closely to determine possible inconsistency. Similar to Bradley County, Drew County does not have significant numbers to determine screening percentages therefore these numbers may need to be watched closely. The death rate for Drew County (34.0 per 100,000) is higher than the death rate for the US (22.6 per 100,000) and for the Affiliate Service Area (23.6 percent). Drew County has the lowest late-stage rate of 32.2 percent compared to the US (43.7 per 100,000) and the Affiliate service area (46.0 per 100,000). The SE region is part of the Delta, which has long been considered one of the poorest and most needy areas of the country, and designated as medically underserved areas. The Southeast Arkansas Region will be a challenge to address because of the great need.

Health System and Public Policy Analysis

The Affiliate inventory of breast cancer services was completed by Google internet searches, the Arkansas Department of Health website and resource document(s) provided by Komen Headquarters. Sources used to obtain a comprehensive understanding of programs and services data consisted of webs searches to locate medical facilities within target area(s); in addition to telephonic outreach to primary leaders (i.e., Chamber of Commerce) within target communities to validate findings.

Based on initial analysis, the target communities are made up of a number of state funded local health units (LHUs) and satellite clinics that can provide basic breast services but are limited with providing next step services if a patient is diagnosed with an abnormal screening for diagnostic and/or treatment services. Specifically for treatment services, patients in Arkansas and St. Francis Counties are referred to a medical facility in the general Little Rock area -

Baptist Health, University of Arkansas for Medical Sciences, St Vincent Health Systems, which includes a lengthy commute of two or more hours. Patients in the Northeast region are referred to St. Bernards Hospital in Jonesboro, AR, and patients in the Southeast Region are referred to Jefferson Regional Medical Center in Pine Bluff, AR. The next few paragraphs will provide analysis on breast cancer services offered in the targeted communities identified by Komen Arkansas.

Arkansas County is made up of two local health units (LHU), located in the cities of De Witt and Stuttgart, operated by Arkansas state funds where only clinical breast exams (CBE) are performed due to facility limitations. If a patient receives an abnormal result, they are referred to the closest facility (i.e., hospital) capable of providing follow-up care, which is located in the city of Stuttgart. This satellite site can provide both screening and diagnostic breast services onsite; however, patients who need further treatment services (i.e., chemotherapy, radiation, etc) are referred to the main Baptist Health Hospital System located 55 miles away in the capital city of Little Rock, AR. The other hospital in this county is located in the city of De Witt and can only provide clinical breast exams.

St. Francis County has a for-profit hospital, Forrest City Medical Center, that can provide screening services (CBE, screening mammogram) and diagnostic services (diagnostic mammogram, ultrasound and MRI). The Lee County Cooperative clinic has two satellite sites in this county located in Hughes and Madison. These clinics are open on various days and provide CBEs and ultrasounds. For other breast services, patients are referred to Forrest City Medical Center where diagnostic services are provided. For treatment services, patients are referred to one of the larger hospitals in Little Rock previously mentioned. Last, there is a mobile unit with St. Bernards Hospital, located in Jonesboro, that provides screening mammograms in the city of Forrest City three to four times a year.

The Northeast Region

Izard County contains a local health unit and ARcare, a community health center, both located in the city of Melbourne. These facilities along with the Melbourne clinics can only provide clinical breast exams, but will refer for additional screening and treatment services. The mobile unit from Baxter Regional Hospital is able to provide CBEs as well as screening mammograms but only frequents this area once every three months.

Lawrence County contains a local health unit (Lawrence, AR) and three community health centers (1st Choice Healthcare- Walnut Ridge, Strawberry Medical, Corning Area Healthcare) that are able to provide clinical breast exams. The mobile unit from St. Bernards hospital can provide screening mammograms, but comes to this area once every six months. Lawrence Memorial Hospital, located in Lawrence, AR, is the only medical facility in this region that has medical tools for screening and diagnostic mammography, as well as ultrasound.

Randolph County also has a local health unit and community health center (Pocahontas Family Medical) both located in the city of Pocahontas, and are able to provide clinical breast exams. Unlike Sharp and Lawrence counties, St. Bernards mobile mammography frequents Randolph County weekly. This is due to the lack of available resources in this remote area since the only medical facility in the area, Five Rivers Medical, no longer provides any breast health services as of April 2013.

Sharp County contains two community health centers (Cave City, Hardy Medical). The White River Imaging Center and local health unit located in the city of Ash Flat are all able to provide clinical breast exams. The mobile units from both St. Bernards and Baxter County are able to provide screening mammograms; for additional diagnostic and/or treatment services patients travel to Baxter Regional Medical Center (Mountain Home), St. Bernards (Jonesboro) or facilities in the central Arkansas area.

Southeast Region

Similar to the NE Region, the counties in the Southeast Region contain at least one local health unit and/or clinic that can only provide clinical breast exams. The SE region is unique in that patients have access to three medical facilities - Bradley County Medical Center (Warren), Chicot Memorial Medical Center (Lake Village) and Drew Memorial Hospital (Monticello) - that provide additional breast cancer screening services that are not available at the LHUs or clinics.

Bradley County has a local health unit and the Marsh-George clinic, both in the city of Warren that are able to provide clinical breast exams. The Bradley County Medical Center can provide screening mammography, diagnostic mammography and ultrasound in addition to CBE.

Chicot County contains Chicot Memorial, a large medical facility located in the city of Lake Village, which is able to provide CBEs, screening/ diagnostic mammography, ultrasound, biopsy and the following treatment services: surgery and reconstruction. There are a few support services (exercise/nutrition) offered at this location as well. In addition to Chicot Memorial, this county also has a LHU and the following community health centers, Lake Village Clinic, Dermott and Eudora Medical both part of Mainline Health Systems.

Drew County also contains a LHU and the Monticello community health clinic, both located in the city of Monticello. Drew Memorial hospital, also located in Monticello, provides CBEs, screening/ diagnostic mammography, ultrasound and biopsy similar to Chicot Memorial. Drew Memorial is the only medical facility within the target areas that is able to provide chemotherapy as a treatment option.

The Southeast Region is unique because they have The Greater Delta Alliance for Health, Inc. (GDAH), a current grant recipient governed by CEOs of surrounding medical facilities within the region. GDAH provides screening and diagnostic mammography, and ultrasound services via the mobile health screening unit. GDAH has partnered with several local and statewide agencies and foundations to provide general health programs and services throughout Southeast Arkansas. The Alliance has proven itself as a resource to local community health organizations and will continue to expand and nurture these relationships to other outreach programs throughout the Alliance service area. The Alliance is made up of the following: De Witt Hospital and Nursing Home, Chicot Memorial Medical Center, Delta Memorial Hospital, Ashley County Medical Center, Baptist Health-Stuttgart, Bradley County Medical Center, McGehee Hospital, Jefferson Regional Medical Center and Drew Memorial Hospital.

Komen Arkansas joined a coalition that addressed public policy concerns called Breast Health Initiative (BHI). The BHI was made up of three Komen Affiliates (Arkansas, Ozark and Texarkana) mission staff and representatives from other stakeholders: Arkansas Central Cancer Registry, the Winthrop P. Rockefeller Cancer Institute, the American Cancer Society, Community Health Centers of Arkansas, Arkansas Center for Health Advancement, the local

Hometown Health Coalitions and survivors who utilized the BreastCare program. The mission of this group was to restore funding of the Arkansas' BCCCP program, BreastCare,that had a dramatic drop in funds for breast services due to a state and federal excise tax on tobacco. The BHI coalition advocated and educated the Governor and state legislators to ensure the awareness and importance for continued monetary support for breast services was met. Although this coalition no longer exists, the Affiliates in Arkansas, along with other community supporters continue to advocate for sustaining this program at its prior level.

Arkansas has been fortunate to expand Medicaid, but elections in November of 2014 could threaten the state of health care coverage in Arkansas. A crucial topic to be addressed during the 2016 legislative session is updating the policy on BreastCare eligibility to include women with health insurance but with minimum or limited coverage. Komen Arkansas, along with Komen Ozark and Komen Texarkana, will advocate for continuing the Private Option and educate lawmakers on the need for continued funding of BreastCare at the level committed.

The Affiliate encourages grantees to contact local, state and federal governmental officials on breast cancer/breast care issues. Grantees and the Affiliate work together to invite local dignitaries and lawmakers to site visits to see the impact Komen funding has in their community. In summary, all of the target areas have at least one facility that is easily accessible to receive a clinical breast exam. Patients who require additional screening and/or treatment will need to seek out the nearest hospital facility or travel to central Little Rock area for those additional services. In addition to lack of screening and treatment options, the majority of the target areas are in need of some type of support/survivorship service(s). Looking at the information obtained, the Affiliate has determined that there is a substantial need for breast health services in these target areas.

Qualitative Data: Ensuring Community Input

A qualitative analysis was undertaken to examine important beliefs and attitudes associated with understanding breast health and breast health services available to women within the four target communities. The data collection efforts lasted from November 2014 through January 2015.

To gain perspective from participants living in the four target communities, online surveys and focus groups were conducted by the Affiliate to answer the following topics: 1) knowledge of breast health, including their own family history and/or the value of knowing family history related to breast health; 2) awareness of breast health services in their community; and 3) access and barriers to breast cancer screening, treatment and survivorship/aftercare. Data collection efforts were not limited to just breast cancer survivors or women in general; men were also invited to participate. The Affiliate wanted insight from as many individuals as possible who may have been a past Komen Arkansas Race for the Cure participant, a member of a faith-based organization, part of community based organizations and/or a provider of health care services.

The purpose of this assessment was to further comprehend the access and barriers to breast cancer screening and treatment, as well as existing outreach strategies used to educate women on breast health awareness in the target areas. Based on findings from the Affiliate's qualitative assessment, there are a number of factors and/or gaps that contribute to why respondents feel

women in their community do not enter or continue in the breast cancer continuum of care (CoC). There was a consensus that better outreach efforts are needed to reach more women to educate them on breast health services and resources available in their target communities.

Although there was difficulty in recruiting participants for focus groups, the Affiliate was ultimately able to gain incredible knowledge from opinions given through the focus groups. Sessions were well attended and participants were open to sharing their personal experiences with breast cancer and their opinions about the best way to reach out to women in their community. As a result of time constraints the Affiliate was unable to schedule several sessions to capture more diversity within target communities. Due to the limitations of the data, the perspectives provided represent only those that participated in the focus groups and surveys and do not represent the general population of the community or providers as a whole.

The online survey approach had a low response rate and this may be due to the software application used. The online survey response rate may have been higher if the 'sender' field contained verbiage similar to "Komen Arkansas" or "Susan G. Komen", rather than SurveyMonkey. Other possible reasons for the low survey response may have been a result of emails being filtered to SPAM folder(s) or survey responses being 'open-ended' or 'free text' versus multiple choice. Although the response rate was low, the Affiliate was able to use responses given to understand respondents' views on what is needed in their community.

For all target communities, commonalities found that respondents are aware of breast health screening services within their area. Also traveling up to 200 miles away for diagnostic and/or treatment services was not a deterrent for care. Participants mentioned that spreading the word or education messaging throughout the year would help bring constant attention to breast health awareness instead of just focusing on the month of October. In addition, effective social marketing strategies to publicize breast health programs and recruit participants/patients include tapping the established social structures and modes of communication. This involves identifying and working through the key social organizations (e.g., churches and barber shops) and indigenous leaders/roles (e.g., Church Pastors/Priests, family elders) within each community. Dissemination of information is most effective when delivered through established channels (e.g., Hispanic/Latino broadcast radio, ethnic newspapers). Using these strategies will help resolve potential barriers for why women within the target communities do not enter or continue in the breast cancer CoC.

In conclusion, personally reaching out to individuals in the four target communities allowed the Komen Arkansas to better understand where there may be barriers or gaps in breast health services. Themes that emerged from the data collected will be used to set priorities for grantmaking, as well as help build community relationships and partnerships with health facilities in the target communities. Furthermore this knowledge will allow the Affiliate to support existing breast health programs taking place in the communities and address future outreach and policy needs.

Mission Action Plan

Taking the information gained throughout the processes of the Community Profile the next steps for the Affiliate were to create priorities with SMART (Specific, Measurable, Attainable, Realistic and Time-bound) objectives. To identify appropriate action plans and priorities incorporating this new information, Komen Arkansas President of the Board of Directors, Executive Director, Mission Director, Grants Committee Chair and members of the Board came together to discuss how the Affiliate will approach these counties while continuing to assist the existing 63 county service area. The team wanted to focus on 1) outreach and educational messaging to women within the communities, particularly through community or faith-based organizations; 2) promote provider trainings for health professionals in the target communities to increase screening percentages; 3) increase the quality of the grant funding process; and 4) collaborate with other organizations on continued advocacy and policymaking. The Mission Action Plan developed by Komen Arkansas for the target communities is outlined below.

Problem Statement:
Women in the identified counties have higher annual death rates, higher late-stage diagnosis incidence and lower screening percentages than the Affiliate service area as a whole. Qualitative data found that women in the target communities felt that there is a lack of breast health education and awareness.

Priority: Increase breast health outreach and education within target communities - Arkansas County, St. Francis County, Northeast Region (Izard, Lawrence, Randolph, Sharp) and Southeast Region (Bradley, Chicot, Drew) - that address breast health and increase awareness of available services.

- Objective 1: By March 2016, identify and initiate contact with at least one community organization within each target community that is willing to collaborate with Komen Arkansas to discuss breast health outreach.

- Objective 2: From April 1, 2016 - March 31, 2020, partner with at least one community organization per target community to provide a culturally appropriate breast health event(s) for women of all ages.

- Objective 3: From April 1, 2016 - March 31, 2020, partner annually with at least one identified community organization to distribute at least 100 pieces of educational information on breast health to cultural and health literacy challenged populations.

Priority: Increase understanding of breast cancer screening recommendations by health professionals supported by Susan G. Komen® and knowledge of various referral processes to better navigate their patients through the continuum of care in the target communities.

- Objective 1: From April 1, 2015 - March 31, 2020, annually the Affiliate will promote attendance to upcoming regional conference(s) to educate interprofessionals about the most current breast health recommendations, resources available in the community, and other evidence-based programs that would increase their patients' screening percentages.

Priority: Develop and utilize partnerships to enhance Komen Arkansas' public policy efforts in order to improve breast health outcomes of women in the Affiliate service area.

- Objective 1: From January 1, 2016 - March 31, 2020, advocate to assure continued funding for BreastCare- Arkansas' Breast and Cervical Cancer Program by contacting at least two state legislators.

- Objective 2: From April 1, 2015 - March 31, 2020, collaborate with Arkansas Cancer Coalition and other organizations on advocacy and public policy efforts for the State of Arkansas by attending at least two meetings a year.

Priority: Increase the quality of Affiliate funded grants to ensure identified gaps in the continuum of care are addressed within the identified target communities.

- Objective 1: By August 2015, revise the Community Grant RFA to include at least one funding priority specific to innovative or evidence-based approaches that result in improved breast cancer screening, diagnostic, treatment and/or supportive services among the priority population groups and target communities identified in the Community Profile.

- Objective 2: By August 2016, conduct at least one grant workshop with potential grantees that provides an overview of the Community Grant Requests for Application (RFA) to increase potential awareness within one of the target communities.

- Objective 3: By March 2017, work with at least three (3) grantees within the target communities to strengthen and standardize the evaluation of their grant projects, in order to improve the overall quality of their programs, as well as articulate the grantee impact to community stakeholders.

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

Affiliate History

Susan G. Komen® Arkansas (AR) was incorporated in 1992 by Terri DeSio, Pat McClelland, and Pat Torvestad, initially covering the entire State of Arkansas. In October 1998, the Texarkana Affiliate joined other Affiliates across the country and began serving four counties in Southwest Arkansas (including two counties in Texas). The next year, 1999, the Ozark Affiliate formed to cover counties in Northwest Arkansas and the Southwest corner of Missouri. Komen Arkansas is now responsible for 63 of the 75 Arkansas counties (Figure 1.3). The creation of these two Affiliates alleviated the role of Komen Arkansas in those areas; and the three Affiliates have continued working together fighting to help the women of Arkansas overcome breast cancer.

Since its founding, Komen Arkansas has held over 20 Race for the Cure® events, welcoming women, men and children from throughout the state. The Race began in 1994 with 2,200 participants and has grown to over 30,000 participants in recent years, peaking at 46,000 participants in 2011. The Race has raised awareness of breast cancer health in the State of Arkansas.

Komen Arkansas became a powerful voice for change through their help in the passage of the Breast Cancer Act of 1997. Statistics prove that the number of women diagnosed with early stage breast cancers has notably increased while the numbers of later stage cancers has decreased. Komen Arkansas will continue to partner with other organizations such as Arkansas BreastCare, Arkansas Cancer Coalition and the American Cancer Society to promote breast cancer awareness, provide continued support, education and advocate for more effective treatment and care for breast cancer patients from increased funding for breast cancer research.

Since 2001, Komen Arkansas has received recognition for a number of local and state awards in addition to Susan G. Komen awards listed below:

Komen Headquarters Awards	
Komen Affiliate of the Year Award	1998
Outstanding Media Award	2000
Jill Ireland Award	2001, 2006
Lifetime Volunteer Award	2002
Outstanding Volunteer Group	2002, 2004
Outstanding Individual Volunteer	2003
Co-Survivor	2010

State/Local Awards	
Best Charity of Arkansas - Arkansas Times	1998- 2008
Society of the Double Helix - UAMS	2001
Circles of Excellence - Baptist Health	2002
Josetta Wilkins Award	2002
Best of Business Non Profit Fund Raising Event - Arkansas Business	2006

Susan G. Komen Arkansas —along with those who generously support the Affiliate with their talent, time and resources—is working to better the lives of those facing breast cancer in the state. The Affiliate joins hundreds of thousands of breast cancer survivors and activists around the globe as part of the world's largest and most progressive grassroots network fighting breast cancer. Through events like the Komen Arkansas Race for the Cure®, the Affiliate has invested $14,363,544 in local breast health and breast cancer awareness programs. Up to 75 percent of net proceeds generated by the Komen Arkansas stay in the 63 county service area. The remaining income-$4,923,292 dollars to be exact- has gone to the Susan G. Komen Research Programs, which supports grants and scientific partnerships to find the cures. In 2014, $1,006,737 was awarded to 18 local programs via the grant recipients. The grant recipients address breast health and breast cancer education, screening and treatment services assisting the medically underserved in the region.

Affiliate Organizational Structure

Organizational Structure

Komen Arkansas continues to be a voice for the uninsured and underinsured women concerning breast health. The Affiliate is incorporated in the State of Arkansas as a 501(c)3 nonprofit, nonstock corporation that is organized and operated exclusively for charitable, scientific and educational purposes. The business and affairs of the corporation are managed under the direction of its Board of Directors (BOD) - a working board that is heavily involved in making decisions for the Affiliate. The Board also plays a vital role in the strategic planning process by putting the business and marketing plans in writing and implementing the strategic plan. Members of the board are appointed to one of the following committees based on their interests and expertise: Executive, Governance, Development/Marketing, Finance and Strategic/Mission (Figure 1.1). These established committees play a key role in decision-making work, allowing the board to be more efficient, and it is a way to actively involve all board members in tasks needed by the Affiliate.

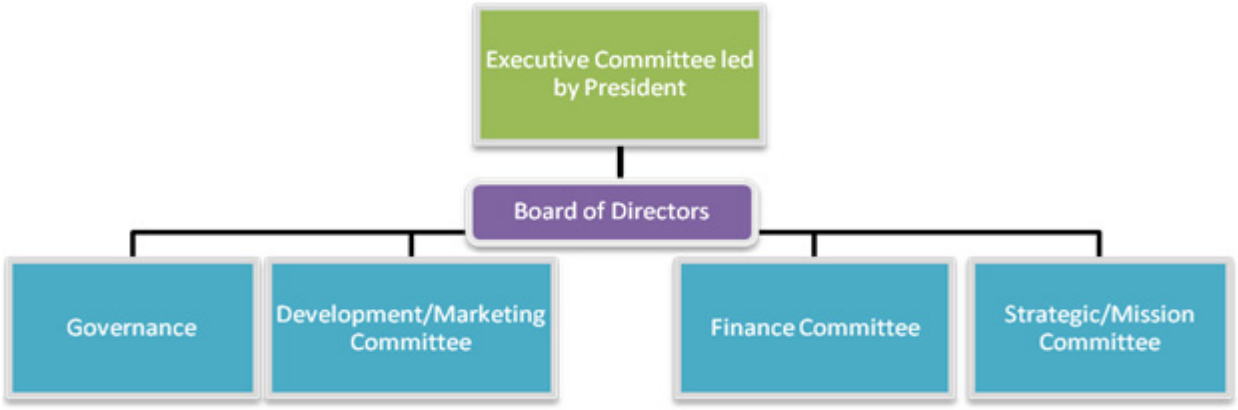


Figure 1.1. Susan G. Komen Arkansas Board of Directors and Committees

Komen Arkansas staff is comprised of six individuals, which includes the Executive Director who reports directly to the President of the Board, and five staff members, who are directed by the Executive Director (Figure 1.2).

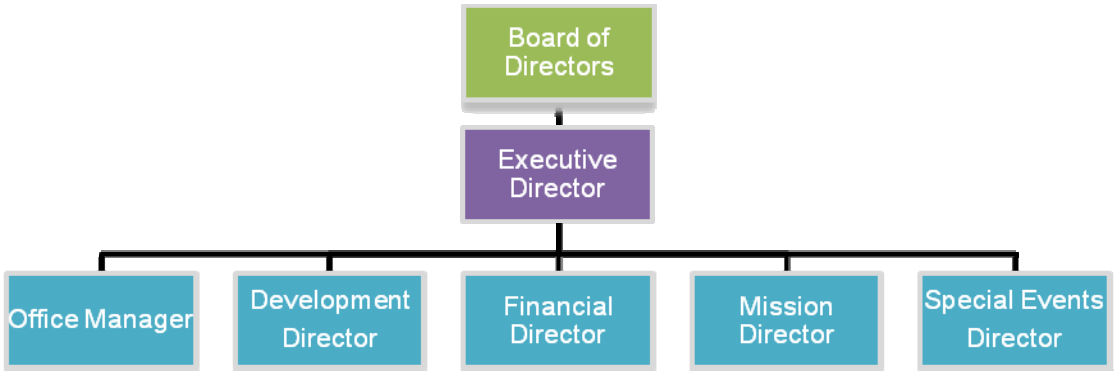


Figure 1.2. Susan G. Komen Arkansas organizational chart

Volunteers have always played a vital role in the success, support and delivery of the Affiliates programs. Volunteers of any age are welcome and the Affiliate assigns them to age-appropriate tasks. The success of the Susan G. Komen Arkansas Race for the Cure depends heavily on the support received from hundreds of volunteers in the months leading up to the Race and on Race Day. Volunteers are invaluable and are one of the Affiliates greatest assets. Their passion and commitment is what makes the Affiliate's breast health mission a success!

Affiliate Service Area

Description of Service Area

Komen Arkansas' service area is comprised of 63 of the 75 counties in the State of Arkansas (Figure 1.3). Of the twelve remaining counties, eight are part of the Ozark Affiliate service area and four are in the Texarkana Affiliate service area.

KOMEN ARKANSAS SERVICE AREA

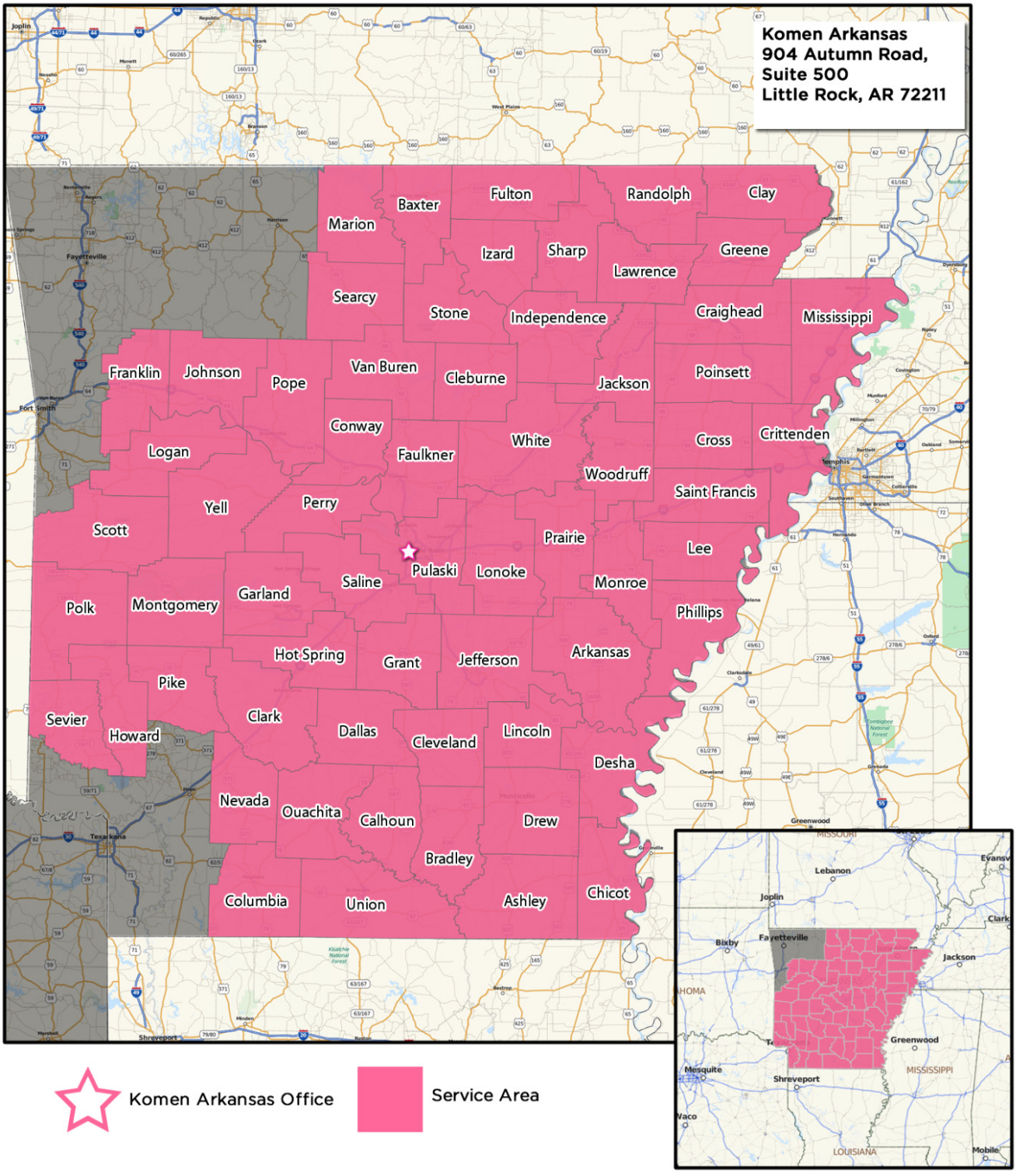


Figure 1.3. Susan G. Komen Arkansas service area

The 63 counties are bordered by Missouri on the north, formed by the Mississippi River on the east to Tennessee and Mississippi; border Louisiana on the south and Oklahoma to the west. Within these counties, one can dig for diamonds in the only diamond mine in the United States, explore limestone caves in the Ozark Mountains in the north, float the country's first National River; the Buffalo River, soak in the thermal waters of the country's first National Park; Hot Springs, hike trails through the 2.67 million acres of national forest, fish the 600,000 acres of lakes and 9,700 miles of streams and rivers, and hunt ducks along the fly-way of the Mississippi Delta. While traveling through the Affiliate service area, one can visit Nashville, Moscow, London, Paris, England, Palestine, and also stop by Pickles Gap or Toad Suck Lock and Dam. Stopping in Little Rock, a visit can be made to the William J. Clinton Presidential Center and Park with its museum, archival collection and educational and research facilities. From the North Western Mountains, through the timberlands, prairies and central river valley to the Oxbow Lakes and bayous of the South and Eastern Delta, the 63 counties within Komen Arkansas definitely demonstrate why Arkansas' slogan is "The Natural State."

Using the 2011 US Census Bureau data, the female population for the entire State of Arkansas is 1,463,198. Within the 63 county service area the female population is 1,075,198; of this total, 78.0 percent are White, 20.0 percent Black/African-American, and 4.0 percent Hispanic/Latino. The socioeconomic status of women who reside within the service area is a major determinant of health status. For instance, 42.9 percent of these women aged 40-64 have income below 250 percent poverty level, 17.3 percent have less than a high school education, and 19.0 percent of the women have no health insurance. According to Healthinsurance.org in January 2015, "the implementation of the Affordable Care Act had a significant impact on Arkansas' estimated uninsured rate. The rate dropped 7.1 percent – falling from 20.87 percent pre-open enrollment to 13.77 percent post-open enrollment. Enrollment in qualified health plans (QHPs), qualifications for Medicaid or the Children's Health Insurance Program (CHIP) under existing eligibility requirements, and Medicaid/CHIP qualifications under expanded eligibility rules all contributed to the drop". A huge proportion of these women live in rural, medically underserved areas (66.3 percent) where access to medical facilities is difficult.

Purpose of the Community Profile Report

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 discover the cures. To fulfill this promise, Komen Arkansas relies on the information obtained through the Community Profile process to guide the work needed to fulfill the promise in its communities. A quality Community Profile guarantees that local efforts backed by Susan G. Komen are targeted to the greatest needs and are non-duplicative.

The Community Profile allows the Affiliate to have clear priorities based on sound information and allows the organization to:

- •Align the strategic and operational plans
- •Drive inclusion efforts in the community
- •Drive public policy efforts
- •Establish focused granting priorities
- •Establish focused education needs

•Establish directions for marketing and outreach
•Strengthen sponsorship efforts

The Community Profile includes an overview of demographic and breast cancer statistics that after preliminary analysis highlight target areas, groups, or issues. The Affiliate takes the information gathered and uses it to strategically plan for the next four years to identify access to service and to aid in the understanding of where granting efforts will have the most impact.

In order to ensure effective and targeted efforts, it is important to understand what program and service gaps, needs and barriers exist, as well as what existing assets that can be utilized for partnership and collaborative interventions. The Community Profile also includes analysis of the target communities within the service area, and includes the voices of those living in target areas and representing target populations. The information for the Profile is gathered through policy, resource allocation, interviews, surveys and the most current, available statistics.

The Community Profile in its entirety will be shared with the Komen Arkansas Board of Directors, local organization partners, current and future grantees. The document will also be accessible via website (www.komenarkansas.org) for anyone in the community to access. Excerpts from the Community Profile will be used in the development of materials for continued marketing and fundraising efforts.

Quantitative Data: Measuring Breast Cancer Impact in Local Communities

Quantitative Data Report

Introduction

The purpose of the quantitative data report for the Susan G. Komen® Arkansas 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 the Komen® Arkansas' 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

		Incidence Rates and Trends			Death Rates and Trends			Late-stage Rates and Trends		
Population Group	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*	-
Arkansas	1,463,198	1,804	109.5	-0.3%	416	23.4	-1.2%	717	44.2	-2.3%
Komen Arkansas Service Area	1,075,822	1,382	110.7	-0.9%	317	23.6	NA	565	46.0	-2.7%
White	840,019	1,167	110.9	-0.5%	252	21.8	NA	454	44.0	-2.7%
Black/African-American	218,291	196	104.1	-3.8%	64	33.3	NA	105	55.8	-3.7%
American Indian/Alaska Native (AIAN)	6,653	SN	SN	SN	SN	SN	SN	SN	SN	SN
Asian Pacific Islander (API)	10,859	7	113.5	-3.5%	SN	SN	SN	SN	SN	SN
Non-Hispanic/ Latina	1,038,430	1,375	111.6	-0.9%	316	23.8	NA	562	46.4	-2.6%
Hispanic/ Latina	37,392	7	39.6	-4.5%	SN	SN	SN	3	15.4	10.7%
Arkansas County - AR	9,971	16	128.6	3.7%	3	24.1	NA	8	67.4	5.7%
Ashley County - AR	11,448	13	94.2	0.8%	3	22.0	NA	6	47.7	-4.8%
Baxter County - AR	21,464	43	121.1	10.2%	8	18.7	-3.7%	16	44.6	13.9%
Bradley County - AR	5,962	8	108.3	2.6%	SN	SN	SN	4	59.9	18.6%
Calhoun County - AR	2,747	SN	SN	SN	SN	SN	SN	SN	SN	SN
Chicot County - AR	6,172	10	123.7	13.5%	SN	SN	SN	4	52.3	25.7%
Clark County - AR	12,010	17	136.5	-8.8%	SN	SN	SN	8	63.2	-5.6%
Clay County - AR	8,333	10	87.7	-7.8%	SN	SN	SN	4	35.0	-2.8%
Cleburne County - AR	13,044	21	116.4	-1.2%	5	23.6	2.0%	7	36.5	9.0%
Cleveland County - AR	4,440	4	72.0	24.4%	SN	SN	SN	SN	SN	SN
Columbia County - AR	12,925	16	105.8	9.0%	5	31.0	2.0%	8	55.7	5.3%
Conway County - AR	10,691	17	131.4	-13.5%	3	23.4	-2.9%	6	46.7	-18.3%
Craighead County - AR	47,871	48	100.9	-3.3%	13	25.1	0.5%	20	41.5	2.9%
Crittenden County - AR	26,518	23	87.5	-2.5%	8	31.5	0.6%	11	42.8	-18.5%
Cross County - AR	9,394	10	94.0	-14.8%	3	24.9	0.6%	6	53.6	-25.5%
Dallas County - AR	4,243	5	101.2	28.1%	SN	SN	SN	SN	SN	SN
Desha County - AR	7,071	10	116.1	-1.3%	SN	SN	SN	6	78.0	-7.3%
Drew County - AR	9,524	9	85.3	1.4%	4	34.0	NA	3	32.2	9.1%
Faulkner County - AR	55,251	54	113.9	-1.0%	9	17.7	-1.2%	18	37.8	-1.4%
Franklin County - AR	9,191	12	101.0	-14.2%	SN	SN	SN	5	44.2	-26.2%
Fulton County - AR	6,274	7	76.8	5.5%	SN	SN	SN	3	37.1	-2.5%
Garland County - AR	49,036	84	120.0	7.7%	19	25.1	-1.6%	29	42.8	8.6%
Grant County - AR	8,867	10	101.1	15.2%	3	30.2	NA	4	40.1	NA
Greene County - AR	21,052	19	85.1	-13.5%	6	24.5	-0.4%	8	37.3	-17.1%
Hot Spring County - AR	16,079	23	114.3	-1.8%	4	18.1	NA	11	55.7	-14.6%
Howard County - AR	7,125	10	107.8	-5.4%	SN	SN	SN	SN	SN	SN
Independence County - AR	18,379	22	99.6	-2.3%	3	14.1	-0.9%	9	43.9	9.5%
Izard County - AR	6,609	11	110.3	9.9%	3	32.7	NA	4	45.1	22.7%
Jackson County - AR	9,158	11	87.4	-8.3%	SN	SN	SN	3	25.8	-16.5%

		Incidence Rates and Trends			Death Rates and Trends			Late-stage Rates and Trends		
Population Group	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)
Jefferson County - AR	39,927	54	117.9	3.5%	13	27.8	-0.7%	29	65.1	-11.3%
Johnson County - AR	12,693	15	105.2	8.0%	SN	SN	SN	5	35.4	19.9%
Lawrence County - AR	8,893	13	118.8	-0.8%	4	35.6	NA	5	47.0	1.9%
Lee County - AR	4,789	6	99.2	-29.0%	SN	SN	SN	SN	SN	SN
Lincoln County - AR	5,666	6	87.0	10.5%	SN	SN	SN	SN	SN	SN
Logan County - AR	11,288	17	116.0	-9.8%	4	27.0	0.2%	8	53.5	-14.9%
Lonoke County - AR	33,442	35	106.7	-2.6%	7	21.9	-1.0%	13	40.9	1.1%
Marion County - AR	8,424	12	97.9	0.2%	SN	SN	SN	5	49.7	10.0%
Mississippi County - AR	24,179	30	112.9	7.2%	6	24.6	-1.8%	14	52.5	0.6%
Monroe County - AR	4,470	6	93.3	12.3%	SN	SN	SN	SN	SN	SN
Montgomery County - AR	4,770	8	115.5	-12.7%	SN	SN	SN	SN	SN	SN
Nevada County - AR	4,693	6	105.1	-7.8%	SN	SN	SN	3	55.2	6.9%
Ouachita County - AR	13,829	20	116.3	-14.5%	5	26.6	NA	7	41.9	-13.8%
Perry County - AR	5,258	6	87.0	-1.5%	SN	SN	SN	SN	SN	SN
Phillips County - AR	11,971	16	112.7	-7.5%	4	28.5	-1.9%	8	56.9	-20.3%
Pike County - AR	5,690	7	86.3	-4.1%	SN	SN	SN	SN	SN	SN
Poinsett County - AR	12,671	19	125.9	-17.9%	3	21.1	NA	8	48.7	-2.9%
Polk County - AR	10,420	12	87.9	15.4%	SN	SN	SN	5	36.5	3.3%
Pope County - AR	30,592	33	101.7	7.3%	7	21.0	-2.0%	17	53.9	0.9%
Prairie County - AR	4,466	7	117.7	-18.8%	SN	SN	SN	3	55.9	-19.2%
Pulaski County - AR	196,115	271	129.4	-5.3%	56	25.4	-1.3%	102	49.0	-5.9%
Randolph County - AR	9,196	10	88.9	13.9%	4	30.3	NA	5	48.7	6.2%
Saline County - AR	51,848	56	97.2	17.0%	13	21.2	-1.5%	22	39.1	5.4%
Scott County - AR	5,562	7	104.2	-12.5%	SN	SN	SN	SN	SN	SN
Searcy County - AR	4,124	5	88.9	18.4%	SN	SN	SN	SN	SN	SN
Sevier County - AR	8,396	7	85.2	14.1%	SN	SN	SN	SN	SN	SN
Sharp County - AR	8,863	17	118.7	-1.0%	SN	SN	SN	8	58.8	22.2%
St. Francis County - AR	13,026	15	103.6	3.1%	5	30.8	-2.2%	7	47.6	9.4%
Stone County - AR	6,237	8	84.6	-12.3%	SN	SN	SN	SN	SN	SN
Union County - AR	21,680	31	108.3	-1.7%	9	27.6	-2.4%	11	40.4	-2.4%
Van Buren County - AR	8,682	12	101.9	-10.5%	SN	SN	SN	5	42.1	-8.3%
White County - AR	38,230	52	125.2	-4.4%	10	23.2	-1.4%	22	55.2	1.3%
Woodruff County - AR	3,942	5	85.3	4.8%	SN	SN	SN	SN	SN	SN
Yell County - AR	10,943	12	99.3	-10.4%	SN	SN	SN	5	44.1	-8.3%

*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 2004-2008 for incidence and late-stage data and 2006-2010 death data.

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 Arkansas service area were lower than that observed in the US as a whole. The incidence rate and trend of the Affiliate service area were not significantly different than that observed for the State of Arkansas.

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

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

- Pulaski County

The incidence rate was significantly lower in the following counties:

- Crittenden County
- Greene County

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

- Searcy County

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

It's important to remember that an increase in breast cancer incidence could also mean that more breast cancers are being found because more women are getting mammograms.

Death rates and trends summary
Overall, the breast cancer death rate in the Komen Arkansas service area was similar to that observed in the US as a whole and the death rate trend was not available for comparison with the US as a whole. The death rate of the Affiliate service area was not significantly different than that observed for the State of Arkansas.

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. There were not enough data available within the Affiliate service area to report on APIs and AIANs so comparisons cannot be made for

these racial groups. Also, there were not enough data available within the Affiliate service area to report on Hispanics/Latinas so comparisons cannot be made for this group.

None of the counties in the Affiliate service area had substantially different death rates than the Affiliate service area as a whole or did not have enough data available.

Late-stage incidence rates and trends summary

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

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. There were not enough data available within the Affiliate service area to report on APIs and AIANs so comparisons cannot be made for these racial groups. The late-stage incidence rate among Hispanics/Latinas was lower than among Non-Hispanics/Latinas.

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

- Arkansas County
- Desha County
- Jefferson County

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

- Jackson County

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

- Sharp County

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

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	Informed decision-making with a health care provider ages 40-49 Mammography every 2 years ages 50-74

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%
Arkansas	2,179	1,513	69.2%	66.5%-71.7%
Komen Arkansas Service Area	1,467	1,025	70.4%	67.2%-73.4%
White	1,156	804	69.8%	66.3%-73.2%
Black/African-American	264	191	76.0%	67.8%-82.7%
AIAN	14	8	56.3%	23.9%-84.1%
API	SN	SN	SN	SN
Hispanic/ Latina	23	14	68.6%	35.8%-89.5%
Non-Hispanic/ Latina	1,427	1,001	70.7%	67.5%-73.7%
Arkansas County - AR	17	12	71.1%	35.6%-91.7%
Ashley County - AR	20	15	78.5%	50.4%-93.0%
Baxter County - AR	51	37	74.7%	58.0%-86.3%
Bradley County - AR	SN	SN	SN	SN
Calhoun County - AR	SN	SN	SN	SN
Chicot County - AR	SN	SN	SN	SN
Clark County - AR	SN	SN	SN	SN
Clay County - AR	21	8	35.9%	15.5%-63.0%
Cleburne County - AR	19	14	75.1%	46.6%-91.3%
Cleveland County - AR	SN	SN	SN	SN
Columbia County - AR	21	16	83.0%	58.2%-94.5%
Conway County - AR	16	12	86.2%	57.9%-96.6%
Craighead County - AR	34	19	51.9%	31.8%-71.4%
Crittenden County - AR	48	30	49.6%	32.5%-66.8%
Cross County - AR	16	11	81.2%	50.3%-94.9%
Dallas County - AR	SN	SN	SN	SN
Desha County - AR	SN	SN	SN	SN
Drew County - AR	10	10	100%	60.2%-100%
Faulkner County - AR	52	36	76.6%	57.3%-88.9%
Franklin County - AR	14	10	70.1%	36.7%-90.5%
Fulton County - AR	SN	SN	SN	SN
Garland County - AR	68	46	62.4%	46.5%-76.0%
Grant County - AR	17	12	74.3%	46.4%-90.6%
Greene County - AR	24	16	72.3%	45.2%-89.2%
Hot Spring County - AR	18	7	26.0%	7.2%-61.5%
Howard County - AR	SN	SN	SN	SN
Independence County - AR	25	19	70.4%	47.0%-86.4%

Population Group	# of Women Interviewed (Sample Size)	# w/ Self-Reported Mammogram	Proportion Screened (Weighted Average)	Confidence Interval of Proportion Screened
Izard County - AR	17	8	43.5%	20.3%-69.9%
Jackson County - AR	10	7	79.1%	43.2%-95.0%
Jefferson County - AR	97	77	76.8%	63.4%-86.4%
Johnson County - AR	13	9	61.2%	28.8%-86.0%
Lawrence County - AR	SN	SN	SN	SN
Lee County - AR	SN	SN	SN	SN
Lincoln County - AR	SN	SN	SN	SN
Logan County - AR	SN	SN	SN	SN
Lonoke County - AR	34	26	79.2%	60.0%-90.6%
Marion County - AR	18	12	56.9%	33.4%-77.7%
Mississippi County - AR	34	25	76.1%	54.5%-89.4%
Monroe County - AR	SN	SN	SN	SN
Montgomery County - AR	SN	SN	SN	SN
Nevada County - AR	SN	SN	SN	SN
Ouachita County - AR	37	26	70.7%	49.9%-85.4%
Perry County - AR	SN	SN	SN	SN
Phillips County - AR	39	23	55.3%	34.2%-74.6%
Pike County - AR	SN	SN	SN	SN
Poinsett County - AR	16	14	88.5%	60.1%-97.5%
Polk County - AR	18	10	36.7%	15.3%-65.1%
Pope County - AR	49	31	70.3%	52.3%-83.7%
Prairie County - AR	SN	SN	SN	SN
Pulaski County - AR	326	237	74.2%	67.3%-80.1%
Randolph County - AR	SN	SN	SN	SN
Saline County - AR	58	50	84.8%	69.8%-93.0%
Scott County - AR	SN	SN	SN	SN
Searcy County - AR	SN	SN	SN	SN
Sevier County - AR	21	11	39.4%	17.1%-67.1%
Sharp County - AR	11	7	65.3%	29.8%-89.3%
St. Francis County - AR	21	14	69.3%	40.8%-88.0%
Stone County - AR	15	7	42.8%	17.3%-72.8%
Union County - AR	28	23	85.0%	61.5%-95.2%
Van Buren County - AR	13	10	75.9%	35.1%-94.8%
White County - AR	38	25	67.7%	46.6%-83.5%
Woodruff County - AR	SN	SN	SN	SN
Yell County - AR	17	11	61.9%	32.3%-84.7%

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 Arkansas service area was **significantly lower** 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 Arkansas.

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 and not significantly different among AIANs than Whites. There were not enough data available within the Affiliate service area to report on APIs so comparisons cannot be made for this racial group. The screening proportion among Hispanics/Latinas was not significantly different than among Non-Hispanics/Latinas.

The following counties had a screening proportion **significantly lower** than the Affiliate service area as a whole:

- Clay County
- Crittenden County
- Hot Spring County
- Polk County
- Sevier County

The remaining counties had screening proportions that were not significantly different 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 %
Arkansas	80.8 %	16.5 %	1.0 %	1.7 %	93.9 %	6.1 %	48.6 %	35.7 %	16.1 %
Komen Arkansas Service Area	77.7 %	20.4 %	0.7 %	1.2 %	96.0 %	4.0 %	49.7 %	36.8 %	16.8 %
Arkansas County - AR	73.3 %	25.7 %	0.3 %	0.7 %	97.9 %	2.1 %	52.6 %	40.3 %	18.4 %
Ashley County - AR	71.1 %	27.9 %	0.6 %	0.4 %	95.7 %	4.3 %	51.5 %	38.2 %	17.6 %
Baxter County - AR	98.2 %	0.5 %	0.6 %	0.7 %	98.2 %	1.8 %	64.6 %	53.1 %	29.3 %
Bradley County - AR	69.2 %	28.8 %	1.7 %	0.4 %	87.6 %	12.4 %	52.6 %	39.2 %	19.7 %
Calhoun County - AR	75.6 %	24.0 %	0.2 %	0.2 %	97.2 %	2.8 %	57.1 %	42.1 %	18.8 %
Chicot County - AR	43.5 %	55.5 %	0.4 %	0.6 %	95.5 %	4.5 %	54.9 %	43.7 %	21.5 %
Clark County - AR	73.1 %	25.4 %	0.7 %	0.8 %	96.0 %	4.0 %	44.6 %	34.1 %	16.8 %
Clay County - AR	98.7 %	0.7 %	0.4 %	0.2 %	98.8 %	1.2 %	57.0 %	43.6 %	22.4 %
Cleburne County - AR	98.3 %	0.6 %	0.8 %	0.4 %	98.0 %	2.0 %	60.0 %	47.4 %	25.3 %
Cleveland County - AR	86.3 %	12.9 %	0.5 %	0.3 %	98.2 %	1.8 %	51.4 %	38.3 %	17.6 %
Columbia County - AR	60.9 %	38.0 %	0.3 %	0.9 %	98.1 %	1.9 %	48.6 %	36.0 %	18.3 %
Conway County - AR	86.7 %	11.9 %	0.9 %	0.5 %	96.3 %	3.7 %	52.4 %	38.9 %	18.6 %
Craighead County - AR	83.8 %	14.3 %	0.6 %	1.2 %	96.0 %	4.0 %	43.7 %	31.2 %	13.8 %
Crittenden County - AR	45.9 %	52.9 %	0.4 %	0.9 %	98.1 %	1.9 %	44.5 %	31.0 %	12.6 %
Cross County - AR	75.5 %	23.6 %	0.4 %	0.6 %	98.6 %	1.4 %	51.5 %	37.8 %	17.4 %
Dallas County - AR	56.1 %	42.9 %	0.7 %	0.3 %	97.6 %	2.4 %	56.2 %	43.3 %	21.0 %
Desha County - AR	49.3 %	49.7 %	0.5 %	0.5 %	95.9 %	4.1 %	50.2 %	38.1 %	17.1 %
Drew County - AR	70.0 %	29.0 %	0.5 %	0.6 %	97.4 %	2.6 %	48.5 %	35.2 %	16.3 %
Faulkner County - AR	86.3 %	11.4 %	0.8 %	1.5 %	96.5 %	3.5 %	40.3 %	27.8 %	11.2 %
Franklin County - AR	96.4 %	1.0 %	1.4 %	1.2 %	97.8 %	2.2 %	52.2 %	39.2 %	18.8 %
Fulton County - AR	98.0 %	0.8 %	0.8 %	0.4 %	99.2 %	0.8 %	60.6 %	47.2 %	23.1 %
Garland County - AR	89.6 %	8.6 %	0.8 %	1.0 %	95.6 %	4.4 %	57.1 %	44.7 %	22.6 %
Grant County - AR	96.1 %	2.8 %	0.6 %	0.5 %	98.1 %	1.9 %	51.0 %	36.6 %	16.0 %
Greene County - AR	98.0 %	1.0 %	0.6 %	0.4 %	97.8 %	2.2 %	48.5 %	35.0 %	16.0 %
Hot Spring County - AR	87.8 %	11.0 %	0.6 %	0.5 %	97.2 %	2.8 %	52.4 %	39.6 %	17.6 %
Howard County - AR	75.9 %	22.1 %	1.0 %	0.9 %	90.1 %	9.9 %	49.7 %	35.7 %	17.1 %
Independence County - AR	95.7 %	2.4 %	0.7 %	1.2 %	94.7 %	5.3 %	50.6 %	37.5 %	17.7 %
Izard County - AR	97.7 %	0.9 %	1.0 %	0.4 %	98.7 %	1.3 %	61.7 %	49.2 %	25.1 %
Jackson County - AR	81.6 %	17.3 %	0.6 %	0.5 %	97.8 %	2.2 %	52.8 %	38.6 %	17.9 %
Jefferson County - AR	41.7 %	56.9 %	0.4 %	1.0 %	98.5 %	1.5 %	49.3 %	36.5 %	15.5 %
Johnson County - AR	95.6 %	2.0 %	1.2 %	1.1 %	88.1 %	11.9 %	47.5 %	34.6 %	16.1 %
Lawrence County - AR	98.1 %	1.3 %	0.4 %	0.2 %	99.1 %	0.9 %	53.2 %	40.4 %	20.4 %
Lee County - AR	41.1 %	57.8 %	0.6 %	0.5 %	98.5 %	1.5 %	53.9 %	42.1 %	19.8 %

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
Lincoln County - AR	75.3 %	24.1 %	0.4 %	0.2 %	97.2 %	2.8 %	51.5 %	37.2 %	17.4 %
Logan County - AR	95.2 %	1.9 %	1.3 %	1.6 %	97.7 %	2.3 %	53.6 %	40.0 %	19.2 %
Lonoke County - AR	91.0 %	7.0 %	0.7 %	1.3 %	97.0 %	3.0 %	44.9 %	30.9 %	12.7 %
Marion County - AR	97.8 %	0.8 %	1.0 %	0.5 %	97.8 %	2.2 %	64.5 %	51.9 %	24.8 %
Mississippi County - AR	63.1 %	35.8 %	0.3 %	0.7 %	96.7 %	3.3 %	45.5 %	32.7 %	13.9 %
Monroe County - AR	57.0 %	41.7 %	0.6 %	0.7 %	98.4 %	1.6 %	56.9 %	44.5 %	21.4 %
Montgomery County - AR	97.2 %	1.0 %	1.1 %	0.7 %	96.0 %	4.0 %	60.8 %	47.7 %	24.7 %
Nevada County - AR	67.1 %	31.9 %	0.6 %	0.4 %	97.3 %	2.7 %	53.5 %	40.5 %	19.7 %
Ouachita County - AR	56.7 %	42.5 %	0.4 %	0.4 %	98.5 %	1.5 %	54.5 %	41.6 %	19.3 %
Perry County - AR	96.6 %	2.3 %	0.7 %	0.3 %	97.9 %	2.1 %	54.5 %	40.3 %	18.6 %
Phillips County - AR	34.6 %	64.6 %	0.4 %	0.4 %	98.7 %	1.3 %	48.8 %	37.0 %	16.7 %
Pike County - AR	94.9 %	3.4 %	0.8 %	0.8 %	93.6 %	6.4 %	52.9 %	39.6 %	19.2 %
Poinsett County - AR	91.1 %	8.2 %	0.3 %	0.4 %	98.1 %	1.9 %	51.5 %	38.6 %	18.1 %
Polk County - AR	96.7 %	0.8 %	2.0 %	0.6 %	94.2 %	5.8 %	55.5 %	42.9 %	21.1 %
Pope County - AR	94.3 %	3.2 %	1.2 %	1.3 %	93.4 %	6.6 %	46.3 %	33.4 %	14.9 %
Prairie County - AR	86.3 %	13.1 %	0.4 %	0.1 %	99.0 %	1.0 %	58.3 %	43.6 %	21.9 %
Pulaski County - AR	59.8 %	37.1 %	0.6 %	2.4 %	94.9 %	5.1 %	46.9 %	33.9 %	13.8 %
Randolph County - AR	97.9 %	1.1 %	0.5 %	0.4 %	98.7 %	1.3 %	54.2 %	41.1 %	20.9 %
Saline County - AR	92.5 %	5.6 %	0.7 %	1.2 %	96.4 %	3.6 %	49.7 %	35.9 %	15.9 %
Scott County - AR	92.3 %	1.5 %	2.4 %	3.8 %	93.7 %	6.3 %	51.6 %	37.7 %	18.7 %
Searcy County - AR	97.6 %	0.7 %	1.4 %	0.3 %	98.5 %	1.5 %	59.6 %	46.8 %	23.8 %
Sevier County - AR	90.6 %	5.2 %	3.5 %	0.7 %	70.4 %	29.6 %	43.5 %	30.9 %	14.4 %
Sharp County - AR	97.6 %	1.0 %	1.0 %	0.4 %	98.0 %	2.0 %	60.1 %	48.1 %	25.3 %
St. Francis County - AR	43.5 %	55.5 %	0.5 %	0.6 %	98.5 %	1.5 %	48.5 %	36.3 %	15.5 %
Stone County - AR	98.2 %	0.6 %	0.7 %	0.5 %	98.6 %	1.4 %	60.0 %	48.0 %	24.4 %
Union County - AR	64.1 %	34.6 %	0.5 %	0.8 %	96.7 %	3.3 %	52.1 %	38.8 %	17.7 %
Van Buren County - AR	97.6 %	1.0 %	0.8 %	0.5 %	97.4 %	2.6 %	59.4 %	47.4 %	24.3 %
White County - AR	93.9 %	4.6 %	0.7 %	0.8 %	96.6 %	3.4 %	46.9 %	34.1 %	16.0 %
Woodruff County - AR	71.0 %	28.4 %	0.3 %	0.3 %	98.9 %	1.1 %	56.0 %	43.7 %	20.9 %
Yell County - AR	95.4 %	2.0 %	0.9 %	1.7 %	81.6 %	18.4 %	49.9 %	36.6 %	17.6 %

Data are for 2011.
Data are in the percentage of women in the population.
Source: US Census Bureau – Population Estimates

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 %
Arkansas	17.3 %	18.4 %	42.1 %	8.4 %	4.4 %	1.7 %	43.8 %	58.7 %	19.5 %
Komen Arkansas Service Area	17.3 %	18.9 %	42.9 %	9.1 %	3.0 %	1.2 %	46.9 %	66.3 %	19.0 %
Arkansas County - AR	19.2 %	18.2 %	42.1 %	7.6 %	2.5 %	2.7 %	34.7 %	100.0 %	18.7 %
Ashley County - AR	18.4 %	17.9 %	45.6 %	9.7 %	1.9 %	0.9 %	51.7 %	100.0 %	19.3 %
Baxter County - AR	14.7 %	16.0 %	44.8 %	8.9 %	1.9 %	0.6 %	65.8 %	100.0 %	21.1 %
Bradley County - AR	26.2 %	25.4 %	50.8 %	6.8 %	6.3 %	2.5 %	49.6 %	100.0 %	24.3 %
Calhoun County - AR	20.4 %	9.8 %	44.3 %	6.2 %	0.0 %	0.1 %	100.0 %	100.0 %	21.7 %
Chicot County - AR	29.3 %	32.5 %	58.3 %	10.7 %	2.3 %	2.4 %	54.3 %	100.0 %	21.4 %
Clark County - AR	15.9 %	23.0 %	44.2 %	9.8 %	2.1 %	1.1 %	54.4 %	100.0 %	18.9 %
Clay County - AR	25.5 %	17.8 %	49.5 %	13.0 %	0.3 %	0.0 %	58.9 %	100.0 %	20.9 %
Cleburne County - AR	18.5 %	16.6 %	41.8 %	8.2 %	1.7 %	0.3 %	75.5 %	100.0 %	21.5 %
Cleveland County - AR	14.5 %	17.8 %	40.9 %	9.3 %	0.7 %	0.0 %	100.0 %	100.0 %	19.7 %
Columbia County - AR	15.6 %	24.8 %	43.3 %	10.1 %	2.6 %	0.6 %	57.5 %	100.0 %	16.3 %
Conway County - AR	17.7 %	21.9 %	45.1 %	9.3 %	2.0 %	2.5 %	70.5 %	100.0 %	18.8 %
Craighead County - AR	15.9 %	20.3 %	40.4 %	8.7 %	3.2 %	1.0 %	32.2 %	4.8 %	18.0 %
Crittenden County - AR	22.8 %	27.9 %	48.1 %	12.7 %	1.4 %	0.4 %	20.9 %	100.0 %	18.4 %
Cross County - AR	22.2 %	16.7 %	46.1 %	8.8 %	0.5 %	0.2 %	56.8 %	100.0 %	20.7 %
Dallas County - AR	20.0 %	18.1 %	50.3 %	12.0 %	0.2 %	1.5 %	52.6 %	100.0 %	20.7 %
Desha County - AR	24.5 %	23.8 %	49.8 %	12.6 %	2.2 %	1.3 %	31.4 %	100.0 %	19.2 %
Drew County - AR	18.1 %	25.0 %	43.9 %	11.8 %	1.9 %	1.7 %	48.6 %	100.0 %	18.1 %
Faulkner County - AR	12.4 %	15.4 %	34.0 %	7.5 %	3.6 %	1.2 %	38.8 %	100.0 %	15.9 %
Franklin County - AR	16.3 %	20.1 %	46.1 %	9.9 %	0.7 %	0.5 %	82.6 %	100.0 %	20.4 %
Fulton County - AR	19.0 %	19.6 %	54.4 %	11.8 %	1.2 %	0.0 %	92.9 %	100.0 %	23.4 %
Garland County - AR	14.9 %	18.5 %	46.1 %	8.8 %	4.2 %	1.7 %	36.9 %	61.3 %	22.7 %
Grant County - AR	16.0 %	8.7 %	34.0 %	7.4 %	1.8 %	0.3 %	75.0 %	0.0 %	16.5 %
Greene County - AR	17.8 %	15.8 %	46.3 %	8.0 %	0.9 %	0.6 %	41.5 %	100.0 %	18.0 %
Hot Spring County - AR	18.8 %	13.4 %	45.6 %	11.2 %	1.2 %	0.5 %	66.0 %	100.0 %	19.8 %
Howard County - AR	22.9 %	22.6 %	49.0 %	7.1 %	5.5 %	2.8 %	67.5 %	100.0 %	23.9 %
Independence County - AR	18.5 %	21.4 %	44.6 %	7.1 %	4.3 %	2.0 %	68.6 %	100.0 %	20.5 %
Izard County - AR	19.9 %	17.8 %	51.0 %	10.7 %	1.4 %	0.7 %	100.0 %	100.0 %	22.4 %
Jackson County - AR	24.7 %	25.1 %	52.4 %	12.2 %	1.1 %	0.4 %	65.1 %	100.0 %	20.6 %
Jefferson County - AR	17.4 %	22.9 %	44.8 %	14.1 %	1.3 %	0.4 %	30.9 %	76.8 %	16.2 %
Johnson County - AR	23.6 %	19.9 %	51.6 %	6.9 %	7.5 %	2.5 %	71.4 %	100.0 %	22.9 %
Lawrence County - AR	24.2 %	23.3 %	53.9 %	9.2 %	0.7 %	0.0 %	63.6 %	100.0 %	19.9 %
Lee County - AR	31.3 %	28.7 %	60.2 %	17.7 %	1.5 %	0.1 %	63.5 %	100.0 %	20.9 %

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)
Lincoln County - AR	29.1 %	23.9 %	46.8 %	10.8 %	0.8 %	0.0 %	100.0 %	100.0 %	19.7 %
Logan County - AR	21.8 %	15.6 %	47.9 %	8.8 %	1.1 %	0.0 %	71.0 %	100.0 %	20.1 %
Lonoke County - AR	14.4 %	13.4 %	32.9 %	7.2 %	1.7 %	0.3 %	44.8 %	100.0 %	17.1 %
Marion County - AR	15.2 %	17.0 %	52.6 %	8.0 %	1.9 %	0.1 %	100.0 %	100.0 %	21.9 %
Mississippi County - AR	24.3 %	26.1 %	50.1 %	12.6 %	2.0 %	0.7 %	36.3 %	100.0 %	18.8 %
Monroe County - AR	28.5 %	25.4 %	55.7 %	10.2 %	1.0 %	0.4 %	69.0 %	100.0 %	20.6 %
Montgomery County - AR	18.7 %	20.2 %	51.9 %	7.0 %	1.7 %	0.5 %	100.0 %	100.0 %	25.9 %
Nevada County - AR	23.6 %	23.1 %	49.3 %	14.2 %	0.5 %	0.0 %	69.2 %	100.0 %	19.6 %
Ouachita County - AR	16.8 %	20.8 %	48.3 %	13.4 %	0.8 %	0.1 %	56.4 %	100.0 %	18.3 %
Perry County - AR	18.5 %	14.4 %	43.5 %	5.1 %	0.9 %	0.0 %	100.0 %	100.0 %	19.2 %
Phillips County - AR	27.1 %	31.6 %	58.1 %	17.7 %	0.3 %	0.1 %	48.0 %	100.0 %	19.9 %
Pike County - AR	21.2 %	19.4 %	51.2 %	10.2 %	4.6 %	1.9 %	100.0 %	100.0 %	25.1 %
Poinsett County - AR	27.2 %	26.0 %	52.5 %	12.9 %	0.6 %	0.0 %	71.1 %	100.0 %	18.9 %
Polk County - AR	18.4 %	20.2 %	51.3 %	5.7 %	2.9 %	1.5 %	73.4 %	100.0 %	26.6 %
Pope County - AR	17.8 %	18.9 %	43.0 %	7.6 %	3.4 %	2.0 %	54.5 %	31.2 %	20.4 %
Prairie County - AR	23.3 %	17.2 %	47.2 %	5.2 %	0.2 %	0.0 %	100.0 %	100.0 %	22.0 %
Pulaski County - AR	11.2 %	16.7 %	34.2 %	8.1 %	5.4 %	2.0 %	12.3 %	22.5 %	15.7 %
Randolph County - AR	20.0 %	19.9 %	51.7 %	8.1 %	1.3 %	0.4 %	67.4 %	100.0 %	21.3 %
Saline County - AR	11.4 %	9.1 %	30.7 %	6.2 %	2.2 %	0.6 %	36.2 %	6.1 %	16.3 %
Scott County - AR	24.0 %	22.8 %	53.7 %	8.7 %	5.0 %	0.6 %	70.4 %	100.0 %	25.4 %
Searcy County - AR	27.1 %	22.1 %	61.8 %	5.8 %	1.3 %	0.0 %	100.0 %	100.0 %	25.2 %
Sevier County - AR	30.0 %	21.3 %	52.1 %	10.0 %	16.5 %	10.9 %	63.6 %	10.1 %	30.1 %
Sharp County - AR	17.0 %	24.0 %	56.4 %	10.2 %	0.7 %	0.1 %	80.1 %	100.0 %	23.5 %
St. Francis County - AR	25.9 %	29.7 %	57.2 %	13.2 %	1.5 %	0.8 %	51.6 %	100.0 %	19.2 %
Stone County - AR	20.8 %	22.4 %	55.0 %	7.3 %	0.6 %	0.2 %	100.0 %	100.0 %	24.3 %
Union County - AR	18.4 %	22.0 %	42.9 %	8.7 %	2.1 %	0.9 %	54.5 %	22.6 %	18.2 %
Van Buren County - AR	18.7 %	24.9 %	48.3 %	9.6 %	1.4 %	0.2 %	100.0 %	100.0 %	21.3 %
White County - AR	17.5 %	16.4 %	41.3 %	7.4 %	2.2 %	0.7 %	54.3 %	42.8 %	19.7 %
Woodruff County - AR	27.1 %	23.1 %	55.4 %	9.6 %	0.7 %	0.0 %	100.0 %	100.0 %	21.1 %
Yell County - AR	29.2 %	18.5 %	51.9 %	7.3 %	13.2 %	4.6 %	79.1 %	6.6 %	26.9 %

Data are in the percentage of people (men and women) in the population.
Source of health insurance data: US Census Bureau – Small Area Health Insurance Estimates (SAHIE) for 2011.
Source of rural population data: US Census Bureau – Census 2010.
Source of medically underserved data: Health Resources and Services Administration (HRSA) for 2013.
Source of other data: US Census Bureau – American Community Survey (ACS) for 2007-2011.

Population characteristics summary

Proportionately, the Komen Arkansas service area has a slightly smaller White female population than the US as a whole, a substantially larger Black/African-American female population, a substantially smaller Asian and Pacific Islander (API) female population, a slightly smaller American Indian and Alaska Native (AIAN) female population, and a substantially smaller Hispanic/Latina female population. The Affiliate's female population is slightly older than that of the US as a whole. The Affiliate's education level is slightly lower than and income level is slightly lower than those of the US as a whole. There are a slightly larger percentage of people who are unemployed in the Affiliate service area. The Affiliate service area has a substantially smaller percentage of people who are foreign born and a substantially smaller percentage of people who are linguistically isolated. There are a substantially larger percentage of people living in rural areas, a slightly larger percentage of people without health insurance, and a substantially larger percentage of people living in medically underserved areas.

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

- Arkansas County
- Ashley County
- Bradley County
- Chicot County
- Clark County
- Columbia County
- Crittenden County
- Dallas County
- Desha County
- Drew County
- Jefferson County
- Lee County
- Mississippi County
- Monroe County
- Nevada County
- Ouachita County
- Phillips County
- Pulaski County
- St. Francis County
- Union County
- Woodruff County

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

- Bradley County
- Howard County
- Johnson County
- Sevier County
- Yell County

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

- Baxter County
- Clay County
- Cleburne County
- Fulton County
- Garland County
- Izard County
- Marion County
- Montgomery County
- Prairie County
- Searcy County
- Sharp County
- Stone County
- Van Buren County

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

- Bradley County
- Chicot County
- Clay County
- Crittenden County
- Desha County
- Howard County
- Jackson County
- Johnson County
- Lawrence County
- Lee County
- Lincoln County
- Mississippi County
- Monroe County
- Nevada County
- Phillips County
- Poinsett County
- Prairie County
- Scott County
- Searcy County
- Sevier County
- St. Francis County
- Woodruff County
- Yell County

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

- Bradley County
- Chicot County
- Crittenden County
- Jackson County

- Lee County
- Mississippi County
- Monroe County
- Phillips County
- Poinsett County
- Sharp County
- St. Francis County
- Van Buren County

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

- Clay County
- Crittenden County
- Desha County
- Jackson County
- Jefferson County
- Lee County
- Mississippi County
- Nevada County
- Ouachita County
- Phillips County
- Poinsett County
- St. Francis County

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

- Sevier County
- Yell County

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

- Bradley County
- Montgomery County
- Pike County
- Polk County
- Scott County
- Searcy County
- Sevier County
- Stone County
- Yell County

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 Arkansas 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				
Time to Achieve Death Rate Reduction Target		13 years or longer	7-12 yrs.	0 – 6 yrs.	Currently meets target	Unknown
	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 Arkansas service area with predicted time to achieve the HP2020 breast cancer targets and key population characteristics

County	Priority	Predicted Time to Achieve Death Rate Target	Predicted Time to Achieve Late-stage Incidence Target	Key Population Characteristics
Arkansas County - AR	Highest	NA	13 years or longer	%Black/African-American, medically underserved
Bradley County - AR	Highest	SN	13 years or longer	%Black/African-American, %Hispanic/Latino, education, poverty, insurance, medically underserved
Chicot County - AR	Highest	SN	13 years or longer	%Black/African-American, education, poverty, rural, medically underserved
Cleburne County - AR	Highest	13 years or longer	13 years or longer	Older, rural, medically underserved
Columbia County - AR	Highest	13 years or longer	13 years or longer	%Black/African-American, rural, medically underserved
Craighead County - AR	Highest	13 years or longer	13 years or longer	
Drew County - AR	Highest	NA	13 years or longer	%Black/African-American, medically underserved
Garland County - AR	Highest	13 years or longer	13 years or longer	Older
Izard County - AR	Highest	NA	13 years or longer	Older, rural, medically underserved
Johnson County - AR	Highest	SN	13 years or longer	%Hispanic/Latino, education, rural, medically underserved
Lawrence County - AR	Highest	NA	13 years or longer	Education, rural, medically underserved
Marion County - AR	Highest	SN	13 years or longer	Older, rural, medically underserved
Nevada County - AR	Highest	SN	13 years or longer	%Black/African-American, education, employment, rural, medically underserved
Polk County - AR	Highest	SN	13 years or longer	Rural, insurance, medically underserved
Randolph County - AR	Highest	NA	13 years or longer	Rural, medically underserved
Sharp County - AR	Highest	SN	13 years or longer	Older, poverty, rural, medically underserved
St. Francis County - AR	Highest	13 years or longer	13 years or longer	%Black/African-American, education, poverty, employment, medically underserved

County	Priority	Predicted Time to Achieve Death Rate Target	Predicted Time to Achieve Late-stage Incidence Target	Key Population Characteristics
Lonoke County - AR	High	7 years	13 years or longer	Medically underserved
Mississippi County - AR	High	10 years	13 years or longer	%Black/African-American, education, poverty, employment, medically underserved
White County - AR	High	9 years	13 years or longer	Rural
Clark County - AR	Medium High	SN	8 years	%Black/African-American, rural, medically underserved
Crittenden County - AR	Medium High	13 years or longer	1 year	%Black/African-American, education, poverty, employment, medically underserved
Cross County - AR	Medium High	13 years or longer	1 year	Rural, medically underserved
Desha County - AR	Medium High	SN	9 years	%Black/African-American, education, employment, medically underserved
Jefferson County - AR	Medium High	13 years or longer	4 years	%Black/African-American, employment, medically underserved
Logan County - AR	Medium High	13 years or longer	2 years	Rural, medically underserved
Phillips County - AR	Medium High	13 years or longer	2 years	%Black/African-American, education, poverty, employment, medically underserved
Pope County - AR	Medium High	1 year	13 years or longer	Rural
Pulaski County - AR	Medium High	13 years or longer	3 years	%Black/African-American
Saline County - AR	Medium High	2 years	13 years or longer	
Baxter County - AR	Medium	Currently meets target	13 years or longer	Older, rural, medically underserved
Greene County - AR	Medium	13 years or longer	Currently meets target	Medically underserved
Independence County - AR	Medium	Currently meets target	13 years or longer	Rural, medically underserved
Union County - AR	Medium	13 years or longer	Currently meets target	%Black/African-American, rural
Ashley County - AR	Medium Low	NA	4 years	%Black/African-American, medically underserved
Conway County - AR	Medium Low	5 years	1 year	Rural, medically underserved
Franklin County - AR	Medium Low	SN	1 year	Rural, medically underserved

County	Priority	Predicted Time to Achieve Death Rate Target	Predicted Time to Achieve Late-stage Incidence Target	Key Population Characteristics
Hot Spring County - AR	Medium Low	NA	2 years	Rural, medically underserved
Ouachita County - AR	Medium Low	NA	1 year	%Black/African-American, employment, rural, medically underserved
Poinsett County - AR	Medium Low	NA	6 years	Education, poverty, employment, rural, medically underserved
Prairie County - AR	Medium Low	SN	2 years	Older, education, rural, medically underserved
Van Buren County - AR	Medium Low	SN	1 year	Older, poverty, rural, medically underserved
Yell County - AR	Medium Low	SN	1 year	%Hispanic, education, foreign, language, rural, insurance
Clay County - AR	Lowest	SN	Currently meets target	Older, education, employment, rural, medically underserved
Faulkner County - AR	Lowest	Currently meets target	Currently meets target	Medically underserved
Fulton County - AR	Lowest	SN	Currently meets target	Older, rural, medically underserved
Jackson County - AR	Lowest	SN	Currently meets target	Education, poverty, employment, rural, medically underserved
Calhoun County - AR	Undetermined	SN	SN	Rural, medically underserved
Cleveland County - AR	Undetermined	SN	SN	Rural, medically underserved
Dallas County - AR	Undetermined	SN	SN	%Black/African-American, rural, medically underserved
Grant County - AR	Undetermined	NA	NA	Rural
Howard County - AR	Undetermined	SN	SN	%Hispanic, education, rural, medically underserved
Lee County - AR	Undetermined	SN	SN	%Black/African-American, education, poverty, employment, rural, medically underserved
Lincoln County - AR	Undetermined	SN	SN	Education, rural, medically underserved
Monroe County - AR	Undetermined	SN	SN	%Black/African-American, education, poverty, rural, medically underserved

County	Priority	Predicted Time to Achieve Death Rate Target	Predicted Time to Achieve Late-stage Incidence Target	Key Population Characteristics
Montgomery County - AR	Undetermined	SN	SN	Older, rural, insurance, medically underserved
Perry County - AR	Undetermined	SN	SN	Rural, medically underserved
Pike County - AR	Undetermined	SN	SN	Rural, insurance, medically underserved
Scott County - AR	Undetermined	SN	SN	Education, rural, insurance, medically underserved
Searcy County - AR	Undetermined	SN	SN	Older, education, rural, insurance, medically underserved
Sevier County - AR	Undetermined	SN	SN	%Hispanic, education, foreign, language, rural, insurance
Stone County - AR	Undetermined	SN	SN	Older, rural, insurance, medically underserved
Woodruff County - AR	Undetermined	SN	SN	%Black/African-American, education, rural, medically underserved

NA – data not available.
SN – data suppressed due to small numbers (15 cases or fewer for the 5-year data period).

Map of Intervention Priority Areas

Figure 2.1 shows a map of the intervention priorities for the counties in the Affiliate service area. When both of the indicators used to establish a priority for a county are not available, the priority is shown as "undetermined" on the map.

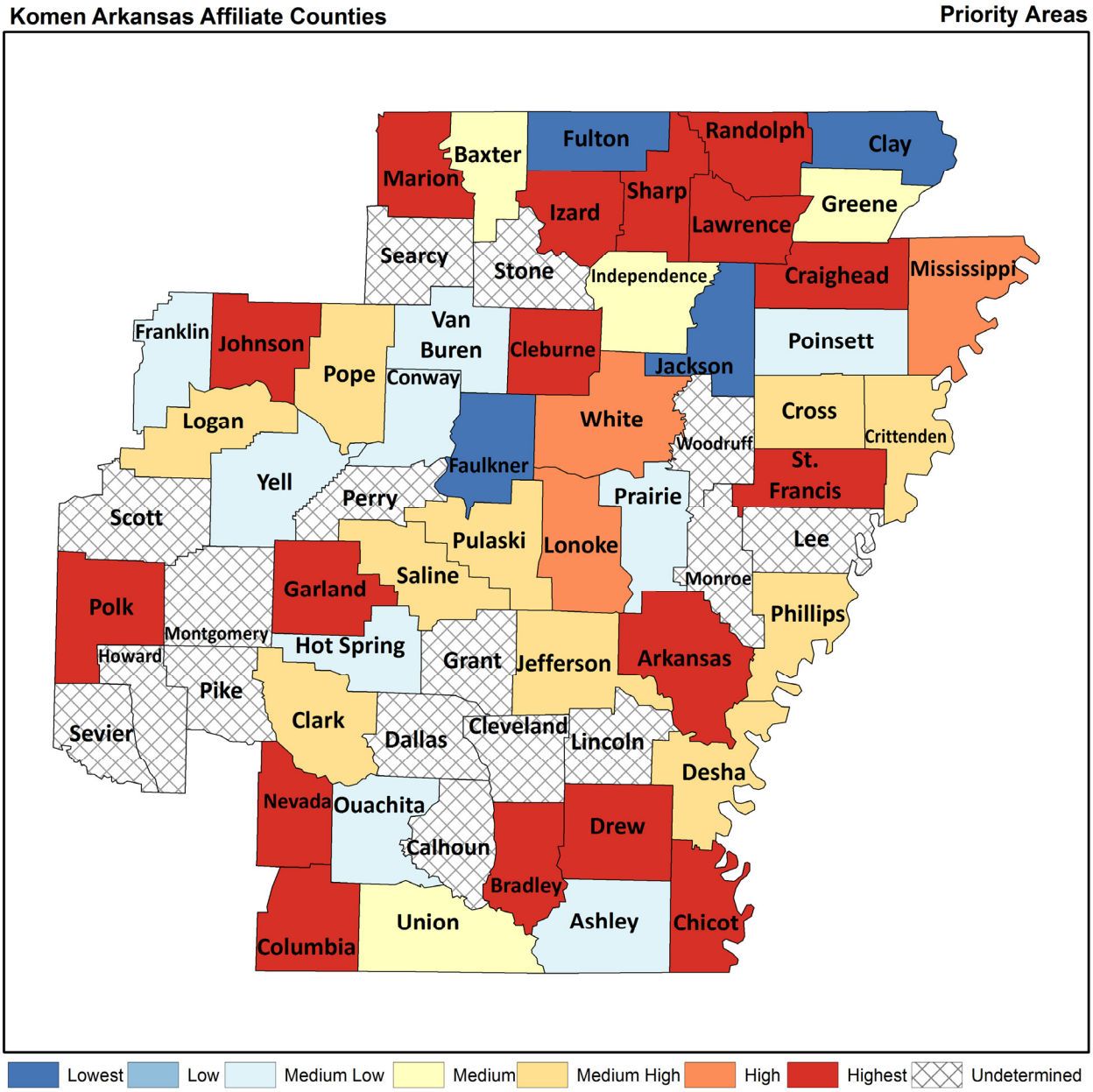


Figure 2.1. Intervention priorities.

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

Seventeen counties in the Komen Arkansas service area are in the highest priority category. Five of the seventeen, Cleburne County, Columbia County, Craighead County, Garland County and St. Francis County, are not likely to meet either the death rate or late-stage incidence rate HP2020 targets. Twelve of the seventeen, Arkansas County, Bradley County, Chicot County, Drew County, Izard County, Johnson County, Lawrence County, Marion County, Nevada County, Polk County, Randolph County and Sharp County, are not likely to meet the late-stage incidence rate HP2020 target.

The late-stage incidence rates in Arkansas County (67.4 per 100,000) are significantly higher than the Affiliate service area as a whole (46.0 per 100,000). Late-stage incidence trends in Sharp County (22.2 percent per year) are significantly less favorable than the Affiliate service area as a whole (-2.7 percent per year). Screening percentages in Polk County (37.0 percent) are significantly lower than the Affiliate service area as a whole (70.0 percent).

Arkansas County has a relatively large Black/African-American population. Bradley County has a relatively large Black/African-American population, a relatively large Hispanic/Latina population, low education levels and high poverty. Chicot County has a relatively large Black/African-American population, low education levels and high poverty. Cleburne County has an older population. Columbia County has a relatively large Black/African-American population. Drew County has a relatively large Black/African-American population. Garland County has an older population. Izard County has an older population. Johnson County has a relatively large Hispanic/Latina population and low education levels. Lawrence County has low education levels. Marion County has an older population. Nevada County has a relatively large Black/African-American population, low education levels and high unemployment. Sharp County has an older population and high poverty. St. Francis County has a relatively large Black/African-American population, low education levels, high poverty and high unemployment.

High priority areas

Three counties in the Komen Arkansas service area are in the high priority category. All of the three, Lonoke County, Mississippi County and White County, are not likely to meet the late-stage incidence rate HP2020 target.

Mississippi County has a relatively large Black/African-American population, low education levels, high poverty and high unemployment.

Selection of Target Communities

Komen Arkansas has 17 counties that are of the highest priority for intervention to achieve the HP2020 breast cancer targets because of key population characteristics. To target all 17 counties would not have been possible with current Affiliate resources.

In order to be efficient stewards of resources, Susan G. Komen Arkansas has chosen four highest priority target communities within the 63 county service areas. The Affiliate will focus strategic efforts on these target communities over the course of the next four years.

Target communities are communities which have cumulative key indicators showing an increased chance of vulnerable populations likely at risk for experiencing gaps in breast health services and/or barriers in access to care. When selecting target communities, the Affiliate reviewed Healthy People 2020, a major federal government initiative that provides specific health objectives for communities and the country as a whole. Specific to Komen Arkansas' work, goals around reducing women's death rate from breast cancer and reducing the number of breast cancers found at a late-stage were analyzed. Through this review, areas of priority were identified based on the time needed to meet Healthy People 2020 targets for breast cancer. The 2020 goals are death rate (20.6 per 100,000 women) and late-stage rate (41.0 per 100,000 women).

Additional key indicators the Affiliate reviewed when selecting target counties included, but were not limited to:

- Incidence rates and trends
- Death rates and trends
- Late-stage rates and trends
- Below average screening percentages
- Residents living below poverty level
- Residents living without health insurance
- Unemployment percentages
- Residents who are linguistically isolated and/or foreign born

By clustering counties of similar key population characteristics in regions, the Affiliate felt they could reach more population numbers in an efficient manner.

The selected target communities are:

- Arkansas County, Arkansas
- St. Francis County, Arkansas
- Northeast Arkansas Region (Izard County, Lawrence County, Randolph County, and Sharp County)
- Southeast Arkansas Region (Bradley County, Chicot County and Drew County)

Arkansas County, Arkansas:
Arkansas County, Arkansas has dual county seats in De Witt and Stuttgart. It is an urban county with 64.0 percent of its population in its county seats. Of the county's 9971 women, 25.7 percent are Black/African-American, a rate almost double the national average and 9.2 percent higher than the State of Arkansas rate. This is of importance due to the high death rates Black/African-American women experience from breast cancer when compared to other races.

The incidence rate in Arkansas County is 128.6 per 100,000 while the State of Arkansas rate is 109.5 per 100,000 (Table 2.8). In addition, Arkansas County has 42.1 percent of its population earning an annual income below 250 percent of the poverty level, and 24.3 percent of the same population has no health insurance. Arkansas County is a designated medically underserved area.

Arkansas County has been identified as a high priority county due to the amount of intervention time needed to achieve the HP2020 targets. The late-stage incidence rate in Arkansas County (67.4 per 100,000) is substantially higher than the Affiliate service area as a whole (46.0 per 100,000) and Arkansas County is the only county in the state with that high rate (Table 2.1). Although trends were not available to determine if the county will meet the HP2020 death rate target, Arkansas County's death rate (24.1 per 100,000 women) is higher than the State of Arkansas (23.4 per 100,000) and the US (22.6 per 100,000).

Table 2.8. Arkansas County breast cancer statistics

	Arkansas County	Affiliate Service Area	Arkansas	US
Incidence Rate	128.6	110.7	109.5	122.1
Death Rate	24.1	23.6	23.4	22.6
Late-Stage Rate	67.4	46.0	44.2	43.7

The relative ease of reaching a large percentage of the population in two towns makes this county appealing to make an impact in an easier manner than the more rural counties. With a late-stage trend of 5.7 percent, it is predicted that it will take Arkansas county 13 years or more to meet the late-stage HP2020 target (Table 2.7).

St. Francis County, Arkansas:
St. Francis County, Arkansas has one large town, Forrest City, which is also the county seat. Of the county's 13,026 women, 55.5 percent are Black/African-American, a percentage almost four times the national rate and over three times the Arkansas percentage. This is of importance due to the high death rates Black/African-American women experience from breast cancer when compared to other races.

The incidence rate of breast cancer in St. Francis County is 103.6 per 100,000 (Table 2.9). While this is lower than the Arkansas rate, 109.5 per 100,000, many other socioeconomic factors determine that St. Francis should be included as a targeted community. For example, St. Francis County has 57.2 percent of its population at income below 250 percent of poverty; 19.2 percent of the population has no health insurance; and almost 52.0 percent of the population of this county is rural with 25.9 percent who have less than a high school education. In addition to this being a designated medically underserved area; it also has one of the highest unemployment percentages in the state at 13.9 percent. Study of this easily accessible community on Interstate 40, should provide the Affiliate with interesting ways to access this rural, predominantly Black/African-American community.

St. Francis County has been identified as a high priority county due to the amount of intervention time needed to achieve the HP2020 targets. The late-stage incidence rates in St. Francis County (47.6 per 100,000) are only slightly higher than the Affiliate service area as a whole (46.0 per 100,000). The death rate for St. Francis County is 30.8 per 100,000 while the rate for the Affiliate service area is 23.6 per 100,000. Both of these rates are predicted to take 13 years or longer to obtain the targeted HP2020 rates.

Table 2.9. St. Francis County breast cancer statistics

	St. Francis County	Affiliate Service Area	Arkansas	US
Incidence Rate	103.6	110.7	109.5	122.1
Death Rate	30.8	23.6	23.4	22.6
Late-Stage Rate	47.6	46.0	44.2	43.7

Northeast (NE) Arkansas Region, Arkansas (Izard County, Lawrence County, Randolph County, and Sharp County, Arkansas)

Due to small population sizes, similar demographics, and contingent borders, these counties have been combined into one region for the purpose of this report and for the Affiliate's targeted efforts. The Northeast Arkansas Region aligns with the Arkansas state border with Missouri. All counties in the region are considered rural. With a combined population of 33,561, these counties have been chosen due to their status in the highest intervention priority and because they are all medically underserved, have older populations, and are impoverished. Unlike most of Arkansas, these four counties are predominantly White. Lawrence County is the most diverse of the four counties with 98.1 percent White and 1.3 percent Black/African-American.

Below is a brief description of demographics and breast cancer statistics for the Northeast Arkansas Region counties:

Izard County, Arkansas is known for its rugged and mountainous terrain and Melbourne is the county seat. Of the 6,609 women in Izard County, 19.9 percent of the population has less than a high school education and 51.0 percent of the county's population has an income below 250 percent. Izard County ranks the highest among the other counties grouped in this region with the percentage of the population designated as rural at 100 percent.

The incidence of breast cancer in Izard County is slightly less than the incidence rate in the US (122.1 per 100,000) at 110.3 per 100,000 (Table 2.10), but higher than the Arkansas rate (109.5

per 100,000). Furthermore the death rate for Izard County (32.7 per 100,000) is higher than the death rate for the US (22.6 per 100,000) and for the Affiliate Service Area are 23.6 per 100,000. Izard County is one of the three counties with a higher late-stage rate than the US (43.7 per 100,000), but slightly lower than the Affiliate service area (46.0 per 100,000) with 45.1 per 100,000.

Table 2.10. Izard County breast cancer statistics

	Izard County	Affiliate Service Area	Arkansas	US
Incidence Rate	110.3	110.7	109.5	122.1
Death Rate	32.7	23.6	23.4	22.6
Late-Stage Rate	45.1	46.0	44.2	43.7

Lawrence County, Arkansas known for its agricultural economy, has the highest percentage of population with less than a high school education at 24.2 percent amongst other counties in NE region. The percentage of the population designated as rural is 63.3 percent and 19.9 percent of the population without insurance.

The incidence of breast cancer in Lawrence County is lower than the incidence rate in the US (122.1 per 100,000) at 118.8 per 100,000 (Table 2.11), but higher than the Arkansas rate (109.5 per 100,000). In addition the death rate for Lawrence County (35.6 per 100,000) is higher than the death rate for the US (22.6 per 100,000) and for the Affiliate Service Area 23.6 per 100,000. Lawrence County is one of the three counties with a higher late-stage rate than the US (43.7 per 100,000) or the Affiliate service area (46.0 per 100,000) with 47.0 per 100,000.

Table 2.11. Lawrence County breast cancer statistics

	Lawrence County	Affiliate Service Area	Arkansas	US
Incidence Rate	118.8	110.7	109.5	122.1
Death Rate	35.6	23.6	23.4	22.6
Late-Stage Rate	47.0	46.0	44.2	43.7

Randolph County, Arkansas is made up of the beautiful Ozark Mountains and the only county in the state with five rivers. Of the 9,196 women in Randolph County, 20.0 percent of the population has less than a high school education and 51.7 percent has an income below 250 percent. The percent of the population without insurance is 21.3 and 67.4 percent of Randolph County is designated as rural.

Of all the counties in the NE region, the incidence rate of breast cancer in Randolph County (103.6 per 100,000) is the lowest when compared to the incidence rate in the US (122.1 per 100,000) and the State of Arkansas (109.5 per 100,000) (Table 2.12). However, the death rate for Randolph County (30.8 per 100,000) is higher than the death rate for the US (22.6 per 100,000) and for the Affiliate Service Area (23.6 percent). Randolph County is one of the three counties with a higher late-stage rate than the US (43.7 per 100,000) or the Affiliate service area (46.0 per 100,000) with 47.6 per 100,000.

Table 2.12. Randolph County breast cancer statistics

	Randolph County	Affiliate Service Area	Arkansas	US
Incidence Rate	103.6	110.7	109.5	122.1
Death Rate	30.8	23.6	23.4	22.6
Late-Stage Rate	47.6	46.0	44.2	43.7

Sharp County, Arkansas another county in the NE region known for its agricultural economy has the highest percentage of population without insurance at 23.5 percent. The percentage of the population designated as rural is 67.4 percent and 56.4 percent with an income below 250 percent poverty level rate.

The incidence rate of breast cancer in Sharp County is lower than the incidence rate in the US (122.1 per 100,000) at 118.7 per 100,000, but higher than the Arkansas rate (109.5 per 100,000). There were no significant numbers to determine the death rate for Sharp County in comparison to the other counties in the NE region. In addition Sharp County, from this group, was the only county in the State of Arkansas that had a substantially less favorable trend in breast cancer late-stage incidence rates (Table 2.13).

Table 2.13. Sharp County breast cancer statistics

	Sharp County	Affiliate Service Area	Arkansas	US
Incidence Rate	118.7	110.7	109.5	122.1
Death Rate	SN	23.6	23.4	22.6
Late-Stage Rate	58.8	46.0	44.2	43.7

As stated above, these counties are all designated as medically underserved areas. The Northeast Arkansas Region will provide a different challenge than the Southeast Arkansas Region because of its demographic makeup and accessibility. The Affiliate is interested in discovering the information needed to address the unique issues to this area.

Southeast (SE) Arkansas Region, Arkansas (Bradley County, Chicot County, and Drew County, Arkansas)

Due to small population sizes, similar demographics, and contingent borders, these counties have been combined into one region for the purpose of this report and for the Affiliate's targeted efforts. The Southeast Arkansas region is located in South Eastern Arkansas and aligns with the Arkansas state border with Mississippi. Bradley County is only one of two counties in Arkansas with a substantial Hispanic/Latino population (12.4 percent).

These counties have been chosen due to their status in the highest intervention priority and because they are all medically underserved and are poorly educated. They have a combined population of 21,658, including a large Black/African-American population: Bradley County (28.8 percent), Chicot County (55.5 percent), and Drew County (29.0 percent). This is of importance due to the high death rates Black/African-American women experience from breast cancer when compared to other races. Additionally, the late-stage rate in Arkansas for Black/African-American women is 55.8 per 100,000 while for Arkansas as a whole is 44.2 per 100,000. As a

result Black/African-American women experience a high death rate from breast cancer when compared to other races in these combined counties.

Below is a brief description of demographics and breast cancer statistics for the Southeast Arkansas Region counties:

Bradley County, Arkansas known for its Pink Tomato festival has the highest percentage of population without insurance at 23.5 percent among the other counties in SE region. The percentage of the population designated as rural is 49.6 percent and 50.8 percent with an income below 250 percent poverty level.

The incidence rate of breast cancer in Bradley County is lower than the incidence rate in the US (122.1 per 100,000) and the Arkansas rate (109.5 per 100,000) at 108.3 per 100,000. There were no significant numbers to determine the death rate for Bradley County in comparison to the other counties in the SE region (Table 2.14). In addition the late-stage incidence rate for Bradley County (59.9 per 100,000) is higher than the late-stage rate of the US (43.7 per 100,000) and the Affiliate Service Area (46.0 per 100,000).

Table 2.14. Bradley County breast cancer statistics

	Bradley County	Affiliate Service Area	Arkansas	US
Incidence Rate	108.3	110.7	109.5	122.1
Death Rate	SN	23.6	23.4	22.6
Late-Stage Rate	59.9	46.0	44.2	43.7

Chicot County, Arkansas known for its rich farmland has the highest percentage of the population designated as rural (54.3 percent), income below 250 percent the poverty level at 58.3 percent and 29.3 percent population with less than a high school education among other counties in SE region. The percentage of the population without insurance is 21.4 percent.

The incidence rate of breast cancer in Chicot County is higher than the incidence rate in the US (122.1 per 100,000) and higher than the Arkansas rate (109.5 per 100,000) at 123.7 per 100,000 (Table 2.15). Additionally the death rate for Chicot County (35.6 per 100,000) is higher than the death rate for the US (22.6 per 100,000) and for the Affiliate service area (23.6 percent). Chicot County was one of two counties in the SE region with a higher late-stage rate of 47.0 per 100,000 compared to the US (43.7 per 100,000) and the Affiliate service area (46.0 per 100,000).

Table 2.15. Chicot County breast cancer statistics

	Chicot County	Affiliate Service Area	Arkansas	US
Incidence Rate	123.7	110.7	109.5	122.1
Death Rate	35.6	23.6	23.4	22.6
Late-Stage Rate	47.0	46.0	44.2	43.7

Drew County, Arkansas known for its farmland and rolling hills has the lowest percentage of population with less than a high school education among other counties in SE region 18.1 percent and percent of population without insurance 18.1 percent. The percentage of the population designated rural is 48.6 percent.

Amongst the counties in the SE region, the incidence rate of breast cancer in Drew County is considerably lower than the incidence rate in the US (122.1 per 100,000) and the Arkansas rate (109.5 per 100,000) at 85.3 per 100,000 (Table 2.16). At this time there may be some unforeseen challenges that may be affecting this rate in Drew County and will need to be watched closely to determine possible inconsistency. Similar to Bradley County, Drew County does not have enough numbers to determine screening percentages therefore these numbers may need to be watched closely. The death rate for Drew County (34.0 per 100,000) is higher than the death rate for the US (22.6 per 100,000) and for the Affiliate service area (23.6 percent). Drew County has the lowest late-stage rate of the three counties at 32.2 percent compared to the US (43.7 per 100,000) and the Affiliate service area (46.0 per 100,000).

Table 2.16: Drew County breast cancer statistics

	Drew County	Affiliate Service Area	Arkansas	US
Incidence Rate	85.3	110.7	109.5	122.1
Death Rate	34.0	23.6	23.4	22.6
Late-Stage Rate	32.2	46.0	44.2	43.7

The SE region is part of the Delta, which has long been considered one of the poorest and most needy areas of the country, are all designated as medically underserved areas. The Southeast Arkansas Region will be a challenge to address because of the great need. The Affiliate is interested in discovering the information needed to address the unique issues to this area.

In summary, looking at all of the factors combined to obtain information used to identify the target communities of interest, the Affiliate has recognized that there is a substantial need for breast health services in these target areas. The continuum of care provides a framework for health communication and understanding a woman's experience when moving through the health care system for breast cancer. To identify the gaps and barriers that exist throughout the continuum, it is important to talk with key stakeholders, breast cancer survivors, and community members. Advocacy efforts and partnerships can be formed with the information obtained from these individuals.

Health Systems Analysis Data Sources

The Affiliate inventory of breast cancer services was completed by Google internet searches, the Arkansas Department of Health website, and resource document(s) provided by Komen Headquarters. Sources used to obtain a comprehensive understanding of programs and services data consisted of web searches to locate medical facilities within target area(s); in addition to telephonic outreach to primary leaders (i.e., Chamber of Commerce etc.) within target communities to validate findings.

Based on initial analysis, the target communities are made up of a number of state funded local health units (LHUs) and satellite clinics that can provide basic breast services but are limited with providing next step services if a patient is diagnosed with an abnormal screening for diagnostic and/or treatment services. Specifically for treatment services, patients in Arkansas and St. Francis County are referred to a medical facility in the general Little Rock area -Baptist Health, University of Arkansas for Medical Sciences, St. Vincent Health Systems- which includes a lengthy commute of two or more hours. Patients in the Northeast region are referred to St. Benards Hospital in Jonesboro, AR, and patients in the Southeast region are referred to Jefferson Regional Medical Center in Pine Bluff, AR.

Health Systems Overview

Overview of Continuum of Care

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

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

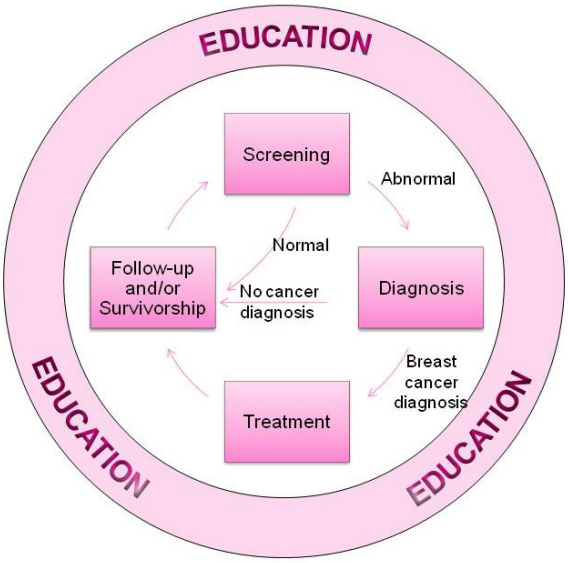


Figure 3.1. Breast Cancer Continuum of Care (CoC)

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

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

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

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

misconceptions). Education can address some of these barriers and help a woman progress through the CoC more quickly.

Summary of health systems strengths and weaknesses for each target community
After review of all data sources, the Affiliate felt it was most appropriate to focus on the following counties of interest: Arkansas, St. Francis, Izard, Lawrence, Randolph, Sharp, Bradley, Chicot, and Drew. The next few paragraphs will provide analysis on the breast cancer service offerings in the targeted communities the Affiliate has decided to focus on in the next four years.

Arkansas County is made up of two local health units (LHU) , located in the cities of De Witt and Stuttgart, operated by Arkansas state funds where only clinical breast exams (CBE) are performed due to facility limitations (Figure 3.2). If patient receives an abnormal result, they are referred to the closest facility (i.e. hospital) capable of providing follow-up care, which is located in the city of Stuttgart. This satellite site can provide both screening and diagnostic breast services onsite; however, patients who need further treatment services (i.e. chemotherapy, radiation etc.) are referred to the main Baptist Health Hospital System located 55 miles away in the capital city of Little Rock, AR. The other hospital in this county is located in the city of De Witt and can only provide clinical breast services.

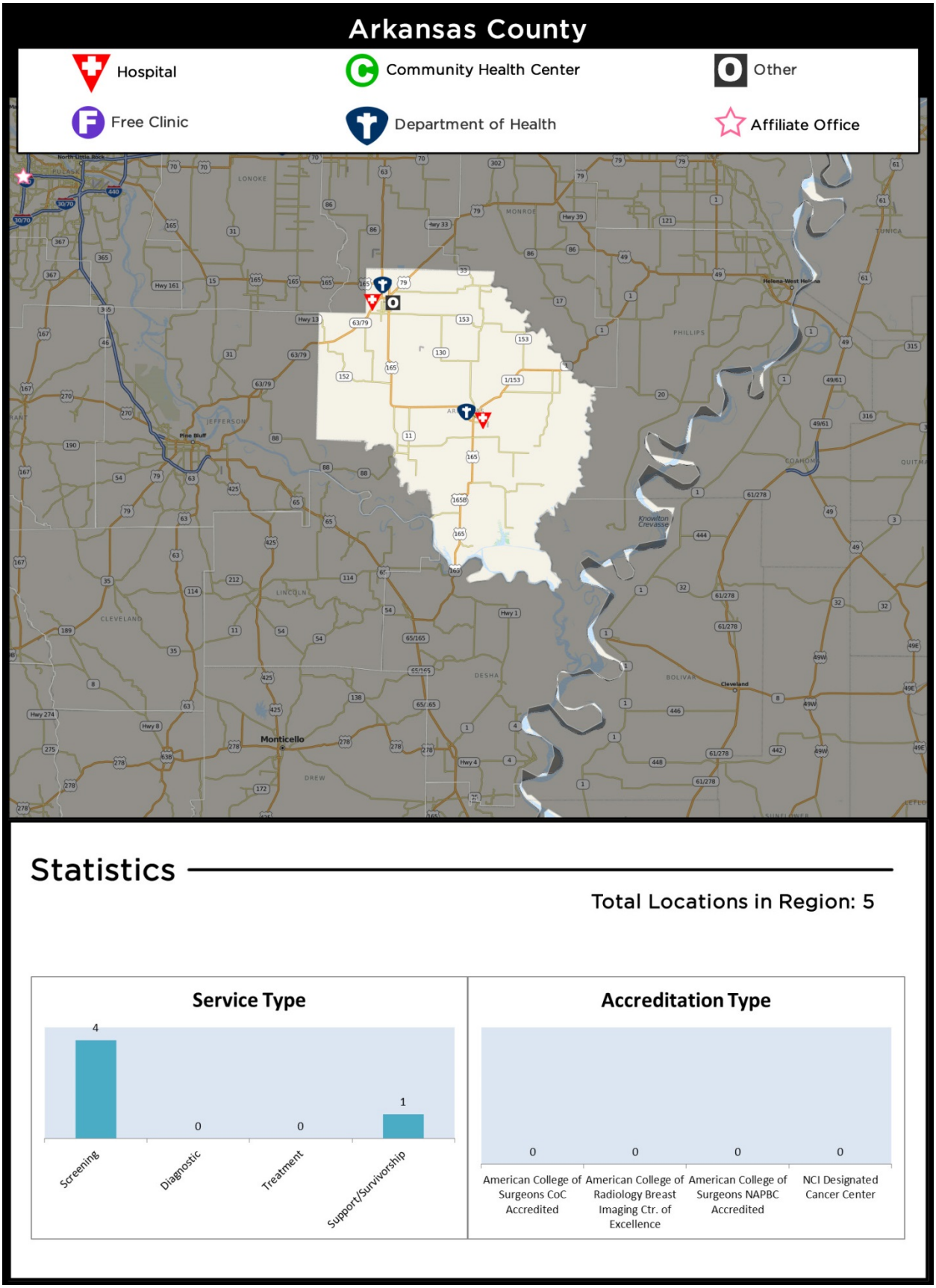


Figure 3.2. Breast cancer services available in Arkansas County

St. Francis County has a for-profit hospital, Forrest City Medical Center, that can provide screening services (CBE, screening mammogram) and diagnostic services (diagnostic mammogram, ultrasound and MRI) (Figure 3.3). The Lee County Cooperative clinic has two satellite sites in this county located in Hughes and Madison. These clinics are open on various days and provide CBEs and ultrasounds. For other breast services, patients are referred to Forrest City Medical Center where diagnostic services are provided. For treatment services, patients are referred to one of the larger hospitals in Little Rock previously mentioned. Last, there is a mobile unit with St. Bernards Hospital, located in Jonesboro, that provides screening mammograms in the city of Forrest City 3-4 times a year.

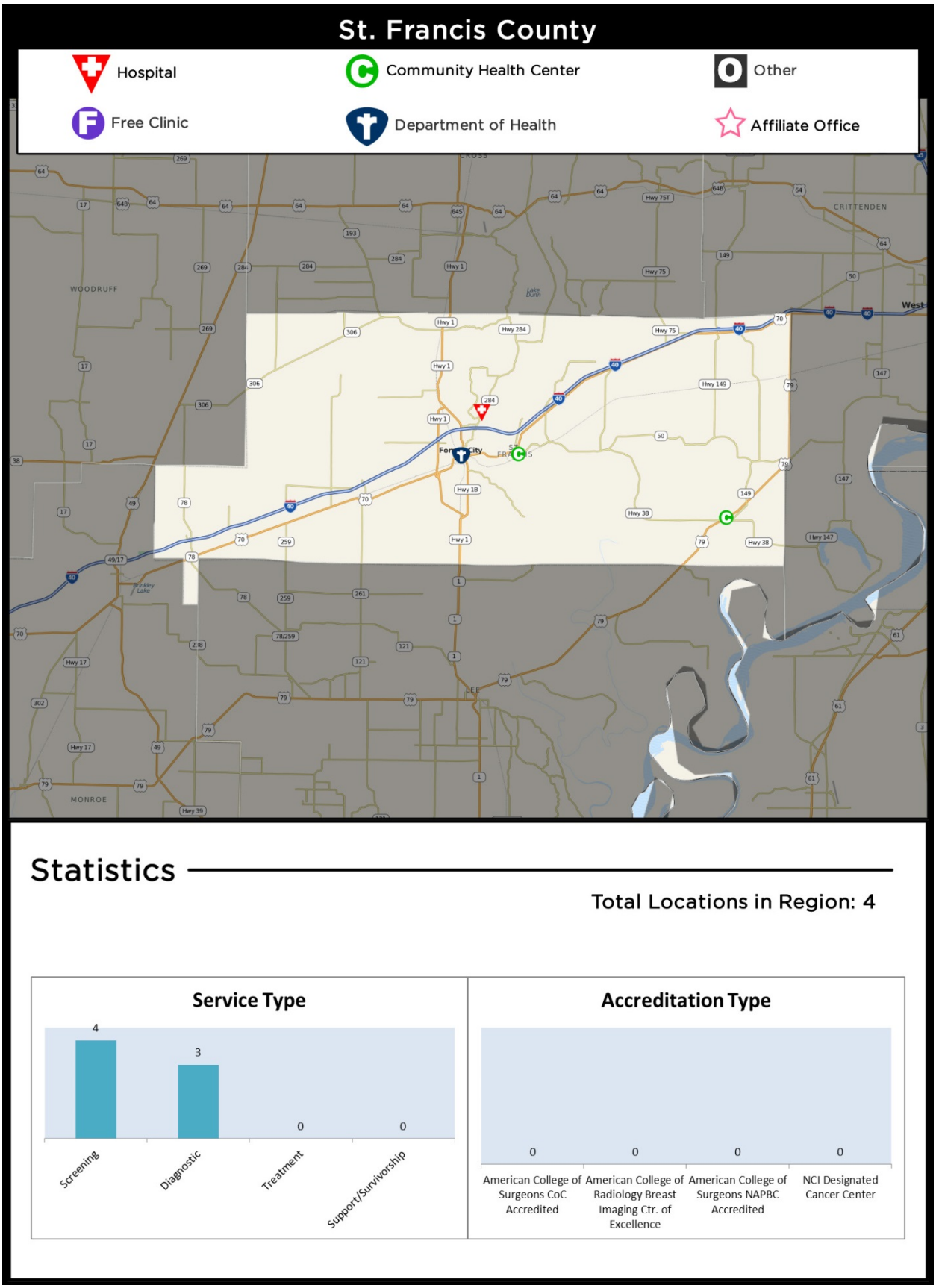


Figure 3.3. Breast cancer services available in St. Francis County

The Northeast Region

Izard County contains a local health unit and ARcare, a community health center, both located in the City of Melbourne (Figure 3.4). These facilities along with the Melbourne clinics can only provide clinical breast exams, but will refer out for additional screening and treatment services. The mobile unit from Baxter Regional hospital is able to provide a CBE, as well as, screening mammograms but only frequents this area once every three months.

Lawrence County contains a local health unit (Lawrence, AR) and three community health centers (1st Choice Healthcare- Walnut Ridge, Strawberry Medical, Corning Area Healthcare) that is able to provide clinical breast exams. The mobile unit from St. Benards hospital can provide screening mammograms, but comes to this area once every six months. Lawrence Memorial Hospital is the only medical facility in this region that has medical tools for screening and diagnostic mammography, as well as, ultrasound.

Randolph County also has a local health unit and community health center (Pocahontas Family Medical) both located in the city of Pocahontas, and are able to provide clinical breast exams. Unlike Sharp and Lawrence counties, St. Benards mobile mammography frequents Randolph county weekly. This is due to the lack of available resources in this remote area since the only medical facility in the area, Five Rivers Medical, no longer provides any breast health services as of April 2013.

Sharp County contains two community health centers (Cave City, Hardy Medical), the White River Imaging Center and local health unit located in the city of Ash Flat, are all able to provide clinical breast exams. The mobile units from both St. Benards and Baxter County are able to provide screening mammograms; for additional diagnostic and/or treatment services patients would travel to Baxter Regional Medical Center (Mountain Home), St. Bernards (Jonesboro) or facilities in the central Little Rock area.

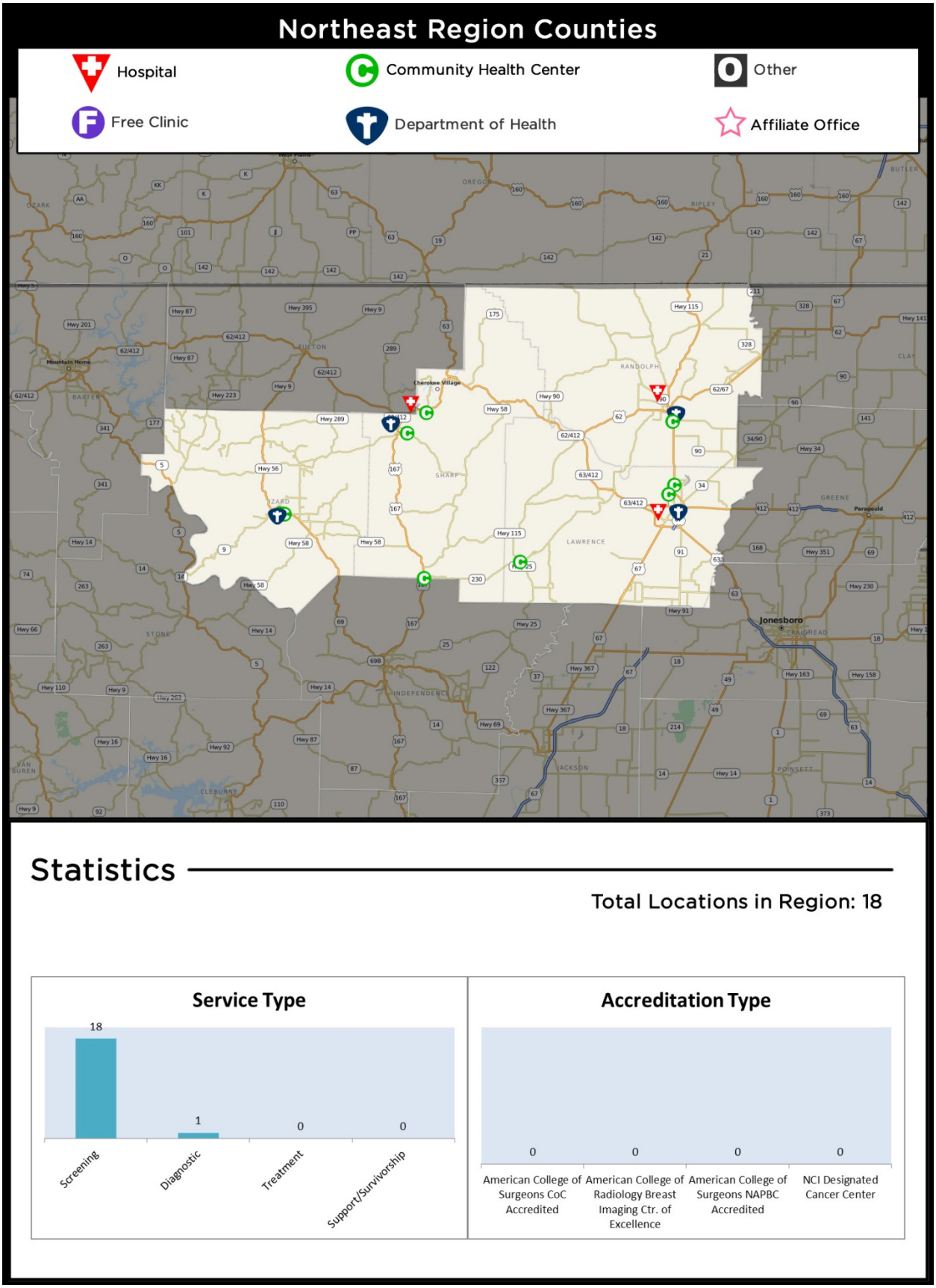


Figure 3.4. Breast cancer services available in the Northeast Region

The Southeast Region

Similar to the NE Region, the counties in the Southeast Region contain at least one local health unit and/or clinic that can only provide clinical breast exams (Figure 3.5). The SE region is unique in that patients have access to three medical facilities - Bradley County Medical Center (Warren), Chicot Memorial Medical Center (Lake Village), and Drew Memorial Hospital (Monticello) - that provide additional breast cancer screening services that are not available at the LHUs or clinics.

Bradley County has a local health unit, in the city of Warren, and the Marsh-George clinic that are both able to provide clinical breast exams. The Bradley County Medical center can provide screening mammography, diagnostic mammography, and ultrasound in addition to CBE.

Chicot County contains Chicot Memorial, a large medical facility located in the city of Lake Village, is able to provide CBE, screening/diagnostic mammography, ultrasound, biopsy and the following treatment services: surgery and reconstruction. There are a few support services (exercise/nutrition) offered at this location as well. In addition to Chicot Memorial, this county also has a LHU and the following community health centers, Lake Village clinic, Dermott and Eudora Medical both part of Mainline Health Systems.

Drew County also contains a LHU and the Monticello community health clinic both located in the city of Monticello. Drew Memorial hospital, also located in Monticello, provides the CBE, screening/diagnostic mammography, ultrasound, biopsy similar to Chicot Memorial. Drew Memorial is the only medical facility within target areas that is able to provide chemotherapy as a treatment option.

The Southeast Region is unique because they have The Greater Delta Alliance for Health, Inc. (GDAH), a current grant recipient governed by CEOs of surrounding medical facilities within the region. GDAH provides screening and diagnostic mammography, and ultrasound services via the mobile health screening unit. GDAH has partnered with several local and statewide agencies and foundations to provide general health programs and services throughout Southeast Arkansas. The Alliance has proven itself as a resource to local community health organizations and will continue to expand and nurture these relationships to other outreach programs throughout the Alliance service area. The Alliance is made up of the following hospitals: De Witt Hospital and Nursing Home, Chicot Memorial Medical Center, Delta Memorial Hospital, Ashley County Medical Center, Baptist Health-Stuttgart, Bradley County Medical Center, McGehee Hospital, Jefferson Regional Medical Center, and Drew Memorial Hospital.

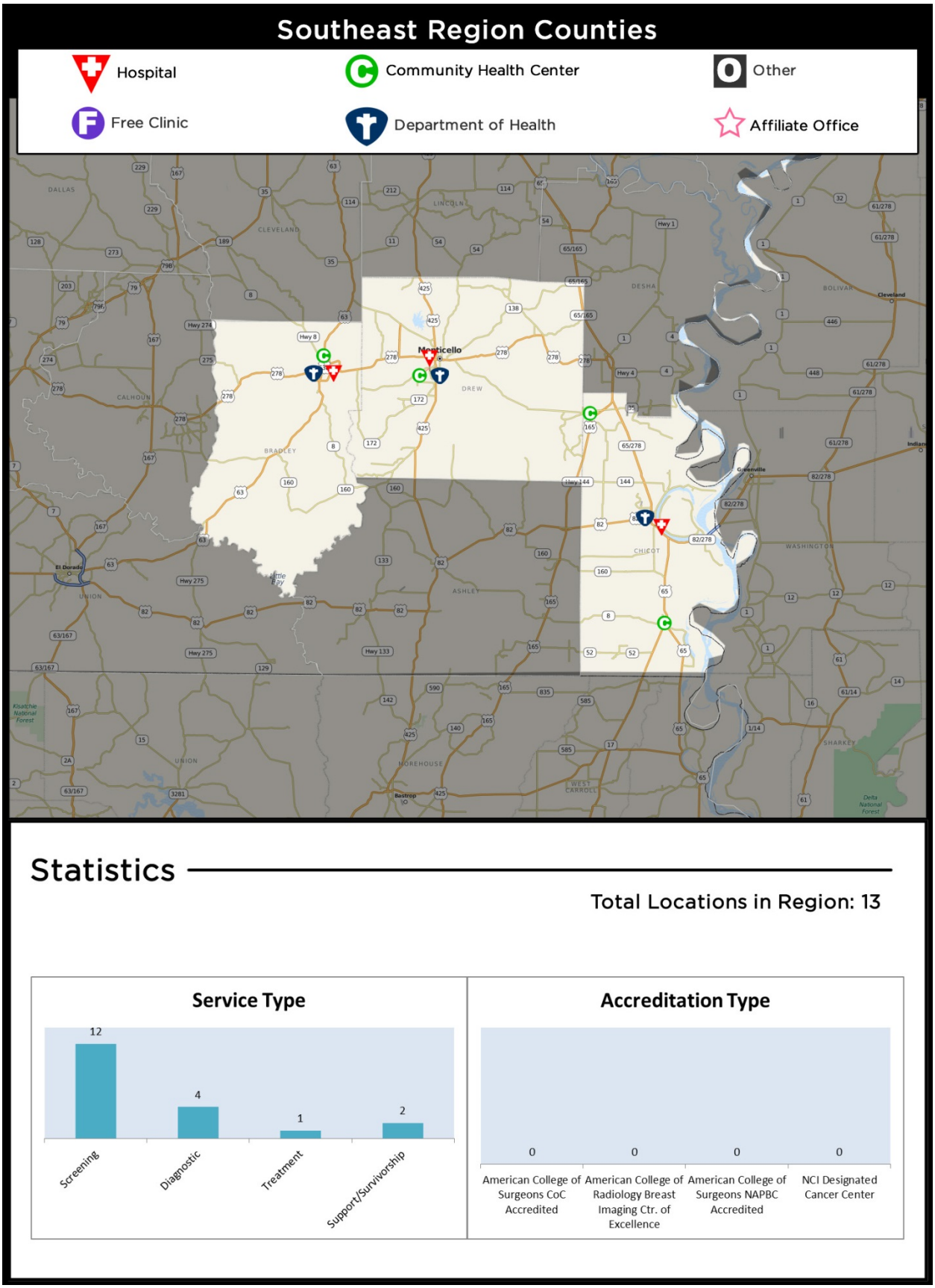


Figure 3.5. Breast cancer services available in the Northeast Region

Public Policy Overview

National Breast and Cervical Cancer Early Detection Program (NBCCEDP)

One well known and established partnership that currently exists for Komen Arkansas is BreastCare, which is Arkansas' Breast and Cervical Cancer program. The BreastCare Program administered by the Arkansas Department of Health, is guided by an eight member Breast Cancer Control Advisory Board (BCCAB) who has been appointed by the Governor of Arkansas. The program was created by the passage in the Arkansas General Assembly of the Breast Cancer Act of 1997. Komen Arkansas was instrumental in the passage of this act and has a permanent position on the Breast Cancer Control Advisory Board. This person is recommended to the Governor by Komen Arkansas. The Affiliate and BreastCare will continue their partnership to serve the women of Arkansas.

The Arkansas BreastCare program targets Arkansas women 40 years of age and older, with incomes at or below 250 percent of the federal poverty level, who do not have health insurance coverage. Under the Breast and Cervical Cancer Prevention and Treatment Act of 2000, states have the option to provide full Medicaid benefits to uninsured women under age 65 who are diagnosed with cervical or breast cancer through the National Breast and Cervical Cancer Early Detection Program. Coverage extends throughout the duration of treatment. There are three options that a state can chose from, and Arkansas has chosen Option 3, which means that any woman screened by a provider the state identifies as part of the CDC screening network is eligible for treatment. Presumptive eligibility allows women who appear to be eligible for Medicaid to enroll in the program on a temporary basis and receive services while their Medicaid applications are processed (Kaiser State Health Facts, 2014).

BreastCare Program facts/statistics for FY 2013:

- 13,355 women were served while 58,493 were eligible
- 7,379 mammograms provided
- $3,773,136 was spent on direct services to women enrolled in the program. These services consisted of recruitment, screening, diagnostic, and case management services.

Komen Arkansas also has existing partnership with the American Cancer Society and the Arkansas Cancer Coalition. Additional partnerships include teaming up with the Patient Navigator from the Winthrop P. Rockefeller Cancer Institute to receive the mammovan schedule and updates as they are available for the UAMS mobile mammography unit so the Affiliate is able to provide this schedule to patients who are in need of these services.

Arkansas State's Comprehensive Cancer Control Plan 2008-2012 (2015-2020 in process)

In 1992, Arkansas' breast cancer control program began, and one year later, the Arkansas Cancer Control Coalition (ACC) formed to support and monitor the state's breast cancer control plan. This coalition joined forces with the Arkansas Department of Health's (ADH) Breast and Cervical Cancer Control Program to initiate a five-year agreement with the Centers for Disease Control (CDC) and Prevention to provide services for early detection of breast and cervical cancer.

The coalition led the way for the passage of The Breast Cancer Act of 1997. This act appropriated $4 million in state general revenue with a back fill funding from a tobacco tax. This funding provided breast cancer screening, diagnosis, treatment and research and complemented CDC funds to ensure a timely diagnosis and treatment for eligible Arkansas women.

In 1998, Arkansas was selected to participate in a case study of cancer prevention and control conducted by Battelle Centers for Health Research and Evaluation, a contractor of CDC. Arkansas was selected based on previous attempts at comprehensive cancer planning, the degree of centralization of public health functions, presence of a cancer registry and resources available to support cancer planning activities. Later that year, Arkansas submitted a Comprehensive Cancer Control grant application and was designated a CDC planning state but did not receive funding. Following the release of the Battelle report in September 1998, ADH formed an internal taskforce for comprehensive cancer planning.

According to information in the Arkansas Cancer Coalition's Cancer Plan:
Priorities for Change

- Reduce deaths from female breast cancer
- Increase proportion of women aged 40 and older who have received a mammogram within the preceding two years
- Follow-up care
- Quality Assurance of breast cancer screening and follow-up

Breast Cancer Screening and Detection
Goal A: Promote and Increase the Appropriate Utilization of High-Quality Breast Cancer Screening and Follow-up Services

- Objective 1: Public Education for Breast Cancer Screening- Increase knowledge and improve attitudes of all women with regards to the importance of breast cancer screening.
- Objective 2: Provider Referral/Promotion for Breast Cancer Screening- Increase the proportion of primary care providers who recommend regular mammograms to their patients.
- Objective 3: Access to Services for Breast Cancer Screening- Increase the availability of breast cancer screening to populations facing geographic, economic or cultural barriers
- Objective 4: Access to Follow-up Care- Educate women about their risk of breast cancer and the need to return routinely for appropriate re-screening and/or diagnostic testing.

Currently, Komen Arkansas serves as a representative on the Arkansas Cancer Coalition. The coalition offers insight, expertise, opportunities and resources in order to collaborate on ideas to work together with other agencies towards the mission of the ACC. The Director of Mission Services also takes part in a workgroup dedicated to breast cancer and attends quarterly meetings when time permits.

Over the next four years, the Affiliate will continue to work with the ACC and their Call to Action to:

- Provide cancer awareness information to constituents
- Promote cancer screening among clients
- Encourage participation in clinical trials
- Collaborate to provide community prevention programs

Affordable Care Act

In April 2013, Arkansas chose to implement the Affordable Care Act through a waiver request to Centers for Medicare/Medicaid Services (CMS) in a model called the "Arkansas Healthcare Independence Program". The program, called the Private Option, is an innovative way under the Affordable Care Act to fund Medicaid expansion. The Private Option allows people up to 138 percent of the Federal Poverty Level (FPL) to receive health care benefits not from Medicaid but though private insurance coverage.

The Private Option is funded with federal Medicaid dollars and patients at 138 percent or below the FPL receive insurance coverage from commercial insurance companies and may choose their provider. The Private Option provides subsidies to private health insurers to assist low-income Arkansans with the costs of premiums. Under this legislation, participants choose a qualified plan on the Insure Arkansas Portal. As of September 2014, according to the US Department of Health and Human Services (DHHS) Office of the Assistance Secretary for Planning and Evaluation, to be eligible, one must be between the ages of 19 and 65 and have an income of no more than 138 percent of the FPL. For an individual, 138 percent of FPL is $16,105; for a four-person family, it is $32,913. The Medicaid expansion targets adults below 138 percent of FPL. Adults over age 65 qualify for Medicare. Children 18 and under in Arkansas are generally covered by the ARKids programs. Arkansas' traditional Medicaid program was one of the most stringent programs in the US and covered adults at 0-100 percent FPL or who were pregnant or disabled. For individuals above 138 percent of FPL there is a graduated subsidy scale to assist with the purchase of insurance up to 400 percent of FPL or around $46,680 annually for an individual.

As many as 250,000 Arkansans were estimated to be eligible for Private Option coverage. Enrollment in the program began on October 1, 2013. According to the Arkansas Department of Human Services, 170,033 people statewide through the end of April have been deemed eligible and gained coverage under the Private Option. Because the Arkansas Constitution requires all fiscal measures of this magnitude to be voted on annually, in the 2014 fiscal session the Private Option was at risk of being defunded by the State Legislature due to the fear that in three years there would not be enough state funds to meet the ten-percent state share for the Private Option. This argument was used to advocate for defunding the Private Option. After several votes, the State Legislature voted to keep the Private Option in place. They did, however, eliminate the funding for all Assisters (573) who were in place to help enroll many Arkansans for the Private Option.

According to a recent survey completed by Gallup Inc., Arkansas had a larger drop this year in the percentage of its adult residents who lack insurance than any other state. The survey found that 12.4 percent of Arkansas adults lacked insurance as of midyear (2014), a drop of 10.1 percentage points compared with 22.5 percent who lacked insurance in 2013. As a result, the state went from having the second-highest rate of uninsured adults in the country, to being tied

with New Hampshire at No. 22 in the percentage of adults who reported having insurance. Arkansas was one of 10 states with a large reduction that chose to expand their Medicaid option, mentioned earlier, to set up the health exchange under partnership with the federal government. It is anticipated that in year 2015, Arkansas will no longer continue their partnership with the federal government and will establish a state-run exchange. Arkansas officials credits the state's expansion of Medicaid under the so-called Private Option, in which the Medicaid program buys coverage for eligible recipients on the health insurance exchange, for leading to the drop in the state's uninsured rate (*Arkansas Democrat Gazette, August 6, 2014*).

In 2001, Arkansas Department of Health partnered with the Department of Human Services to provide treatment services for women diagnosed with breast cancer through a special category of Medicaid. The Affordable Care Act changed the partnership and the special category no longer exists. BreastCare still has a contact at the Department of Human Services that helps patients with the initial enrollment online.

Most of the implications of the Affordable Care Act and the Private Option are largely unknown at this time. Rural hospitals, large hospital systems, private providers and community health centers have prepared for increased demand for services. With only four months since full enrollment, data are inconclusive at this time.

The continuing changes in health care have kept the Affiliate constantly seeking training for Affiliate staff and grantees on how this will impact programs and clients. There will always be a need for screening and diagnostic services in the Affiliate service area; however as the number of people gaining access to health care due to the Affordable Care Act increases, the Affiliate will not only continue to analyze the statistics and situation, but also adjust funding priorities accordingly. In the future, the Affiliate anticipates a funding shift to breast health navigation, programs to address direct barriers to care like transportation and survivorship programs.

Affiliate's Public Policy Activities

Komen Arkansas joined a coalition that addressed public policy concerns called Breast Health Initiative (BHI). The BHI was made up of three Komen Affiliates (Arkansas, Ozark, & Texarkana) mission staff and representatives from other stakeholders: Arkansas Central Cancer Registry, the Winthrop P. Rockefeller Cancer Institute, the American Cancer Society, the Community Health Centers of Arkansas, Arkansas Center for Health Advancement, the local Hometown Health Coalitions, and survivors who utilized the BreastCare program. The mission of this group was to restore the Arkansas' BCCCP program, BreastCare, to its prior position as a result of a dramatic drop in funds for breast services which resulted from a state and federal excise tax on tobacco. The BHI coalition advocated and educated the Governor and state legislators to ensure the awareness and importance for continued monetary support for breast services was met. Although this coalition no longer exists, the Affiliates in Arkansas, along with other community supporters continue to advocate for sustaining this program at its prior level to continue to save many lives.

Komen Arkansas will continue to reach out to local Representatives and Senators to educate them on the needs in the community and what the Affiliate and grantees are doing to address those needs. The Affiliate will also send copies of findings from the Community Profile to local legislators.

Arkansas has been fortunate to expand Medicaid, but elections in November of 2014 could threaten the state of health care coverage in Arkansas. A crucial topic to be addressed during the next legislative session is updating the policy on BreastCare eligibility to include women with health insurance but with minimum or limited coverage. Komen Arkansas, along with Komen Ozark and Komen Texarkana, will advocate for continuing the Private Option and educate lawmakers on the need for continued funding of BreastCare at the level committed.

The Affiliate encourages grantees to contact local, state and federal governmental officials on breast cancer/breast care issues. Grantees and the Affiliate work together to invite local dignitaries and lawmakers to site visits to see the impact Komen funding has in their community.

Health Systems and Public Policy Analysis Findings

In summary, all of the target areas have at least one facility that is easily accessible to receive a clinical breast exam. Patients who require additional screening and/or treatment will need to seek out the nearest hospital facility or travel to central Little Rock area for those additional services. In addition to lack of screening and treatment options, a majority of the target areas are in need of some type of support/survivorship service(s). Looking information obtained, the Affiliate has determined that there is a substantial need for breast health services in these target areas.

Completing this health system analysis allows Komen Arkansas to have an understanding of how a woman moves through the continuum of care for breast health and where the gaps and barriers are along the way. To begin working towards solution(s) to address these gaps and barriers, the Affiliate hopes to form partnerships with entities providing breast services and utilizing these partnerships to prioritize a plan of action for these targeted areas.

Qualitative Data Sources and Methodology Overview

Methodology

A complementary qualitative analysis was undertaken to examine important beliefs and attitudes associated with understanding breast health and breast health services available to women within the four target communities. The methodology used for the development of this assessment was agreed upon by the Executive Director and the Mission Director of the Affiliate. The data collection efforts included the following activities within the four target communities:

- Surveys sent via email blast (November 2014 - December 2014) with several reminders
- Focus groups scheduled and complete (November 2014 - December 2014, January 2015)
- Final reminder sent in form of email blast (December 2014)
- Data collection ended (January 2015)

To gain perspective from participants living in the four target communities online surveys and focus groups were conducted by Komen Arkansas to answer the following questions: 1) knowledge of breast health, including their own family history and/or the value of knowing family history related to breast health; 2) awareness of breast health services in their community; and 3) access and barriers to breast cancer screening, treatment, and survivorship/aftercare. Data collection efforts were not limited to just breast cancer survivors or women in general; men were also invited to participate. The Affiliate wanted insight from as many individuals as possible who may have been a past Affiliate Race for the Cure participant, a member of a faith based organization, part of community based organizations and/or a provider of health care services.

Open-ended questions grouped by topics (themes) were asked on the online survey and during focus group(s). The questions asked were derived using the existing question bank provided by Komen Headquarters. The first data collection method, cross-sectional population-based online survey using Survey Monkey, was completed by a sample of participants with multiple email reminders sent to non-responders until the end of the survey period. The second data collection method, focus groups using semi-structured, open-ended interviews were conducted by a member of the Affiliate staff. Focus groups were conducted at the location arranged by the point of contact for that target community and lasted between 45 to 60 minutes.

Sampling

Komen Arkansas sought information from anyone who lived and/or provided breast health services to anyone living in one of the target communities. The Affiliate sought representation from everyone with no exclusion due to race, gender, occupation, or religious affiliation. However, specific to focus groups, the Affiliate was able to seek information from persons with similar characteristics by survivorship, organization affiliation, or health care personnel.

Key assessment questions and variables identified included service offerings, access, and utilization. For both data collection methods there were a total of 12 open-ended questions provided to survivors and non-survivors (general population). The most common responses to

each of these questions were clustered by theme and given descriptive category headings (Table 4.3).

For the online survey, a stratified sample approach was used to pull participants from the 2013 and 2014 Komen Arkansas Race for the Cure registration database who indicated residence in one of the target areas. Online surveys were sent to 366 unduplicated email addresses who fit the criteria previously mentioned. After multiple email reminders were sent, there were a total of 296 non respondents, 24 opted out or email bounced, and only 46 completed surveys yielding a 12 percent response rate. See Table 4.1 for a breakdown of survey and focus group participants by target community.

Table 4.1. Breakdown of survey and focus group participants

Target Community	Focus Group Participants	Online Survey Participants
Arkansas County	17	9
St. Francis County	6	10
Northeast Region (Izard County, Lawrence County, Randolph County, Sharp County)	8	14
Southeast Region (Bradley County, Chicot County, Drew County)	10	13

A cluster group sampling was the approach used to recruit persons willing to participant in the focus groups, totaling 41 individuals. These groups were arranged using key Affiliate contacts, as well as, reaching out to Chambers of Commerce within target communities for lists of social or civic organizations to recruit focus group participants. Incentives, free meals or gift cards, were provided to show the Affiliate's gratitude for their participation. See Table 4.2 for personal characteristics of all participants.

Table 4.2. Personal characteristics of participants

Personal Characteristics	**Focus Group Participants**	**Online Survey Participants**
Age		
20-29y	2	2
30-39y	6	11
40-49y	10	12
50-59y	10	8
60-69y	7	10
70+	6	3
Gender		
Female	25	40
Male	16	6
Race/Ethnicity		
Black/African-American, non-Hispanic	1	12
Hispanic	0	0
White, non-Hispanic	40	34

Ethics

Participation in the online survey and focus group(s) were strictly voluntary. To ensure confidentiality, Komen Arkansas received written consent from each focus group participant to tape-record the sessions and to use anonymous quotations in any published material by the Affiliate. Online survey participants voluntarily consented to taking part by completing the survey. Data and notes collected were stored in a locked cabinet in the office of the Affiliate and/or will be stored in a secure secondary location and discarded no sooner than four years after data collection.

Qualitative Data Overview

This assessment sought to discover the different ways participants chose to answer open-ended questions and develop a thematic framework. Data collected from focus groups and online surveys were analyzed through the constant comparison method (Patton, M.Q, 1990). That is, the data were coded inductively, and each segment of the data were compared to other categories and other segments of data within the same category. This helped to ensure relevance and consistency and allowed for new categories and relationships to develop as appropriate. A second level of analysis was then undertaken to identify patterns and relationships among the participant's comments and/or experiences. These comments were then coded into themes and category descriptors to assist with reporting collected data (Table 4.3).

Table 4.3. Collected data themes/categories and descriptors

Theme	Category
General Questions	Family history
	Health problems/concerns
Breast Health Screening/Diagnostic/Treatment	Service offerings
	Access to care (transportation)
	Barriers to care
	Health disparities
	Referrals to treatment
Education/Outreach	Health fair
	Marketing methods
	School involvement
	Clinic/hospital
	Religious affiliation (Church etc)
	Resources
Survivorship/Aftercare	Follow up care
	Support groups
	Financial assistance
	Recognition
	Resources

Below is a general idea of common findings among persons who participated in the focus groups or online survey. Just a reminder that participants either reside within the target communities, may or may not be a breast cancer survivor, and/or provide health services for persons within that community.

Arkansas County, Arkansas

Arkansas County's focus group did not have any participants diagnosed with breast cancer, but they have had some experience with a spouse, relative or friend who had breast cancer. This group consisted of a majority of men, with women the minority. Three were married to survivors. Participants acknowledged the major health concerns in their community were diabetes, obesity, and all cancers - breast cancer especially for women. This group also stated that they would be willing to travel up to 200 miles for primary or secondary care. Surprisingly, word of mouth was the primary source for receiving health information, rather than local medical clinics or hospitals. Other than mammograms, they were not fully aware of other available breast health services within their area.

Focus group participants stated that messaging specific to breast health education is only done in the month of October, with community members preparing for the Race for the Cure, and survivors recognized during halftime of high school football games. Participants agreed that starting early education with high school females and connecting with churches would help spread the word year round not just during Breast Cancer Awareness month. When participants were asked about their knowledge of inheriting breast cancer, the majority of them agreed that breast cancer could be inherited; however they felt that other factors - lifestyle and/or environmental factors - may be attributed to the cause of breast cancer.

Survey results analyzed for this target community were very similar to the data collected from focus groups, particularly regarding dissemination of health information using faith based organizations. Something to note, from focus group participants, survivor support groups were not viewed as being particularly favorable since their perception was that primary support comes from family, then friends and/or church members. In regard to marketing, the month of October, around race time, is the only instance where the community's focus is on raising awareness about breast cancer. For both collection methods, all participants agreed that lack of knowledge was the main reason why women in their community did not receive breast cancer screenings, followed by lack of insurance, transportation and the fear of the unknown or bad results.

St. Francis County, Arkansas

All of St. Francis' focus group participants indicated that they had received a mammogram, and the majority of this group were breast cancer survivors. The majority of participants receive health information by word of mouth (local survivor group), as well as, from the internet or local clinic(s). Participants also looked to the newspaper and radio to find out about community events. Since Little Rock is only a 60 mile commute from this area, participants were more willing to schedule screening and treatment appointments there than use local health clinics or hospitals. This is possibly a result of survivors having established relationships with providers from their health care plan. Participants in this group felt very strongly about the emotional, educational and spiritual support received from their monthly breast cancer support group. The women in this group really enjoy the ongoing support and compassion received by other survivors in their support group.

Focus group participants mentioned that utilizing churches and/or faith based organizations could reach more women by spreading the word on breast health education, awareness and outreach. Interesting to note that focus group participants were split on knowing if breast cancer could be inherited or not. This led to a brief discussion on genetic testing where one survivor

had genetic testing done and another survivor questioned if this would have helped her and her twin sister on their dual diagnosis. The other survivors in this group did not have genetic testing done but were aware that breast cancer could be inherited.

In contrast to focus group comments, survey respondents in the area stated that they would seek primary care from local clinics or the health department for screenings rather than travel to Little Rock. They were willing to travel up to two hours away (Little Rock, AR or Memphis, TN) for specialized care. Having to schedule time off ("personal" or "sick leave") for screenings or appointments was seen as a barrier for the large population of working women with families that reside in the area. Both focus group and survey participants stated that cancer (all types) was the greatest health concern as a result of chemicals used for farming in their agricultural community. In regard to educational outreach, the majority of respondents from both data sources mentioned there were many activities done in the month of October to raise awareness about breast cancer but not the rest of the year. They agreed that having educational messaging via newspaper, radio, or local health fairs throughout the year would bring continued awareness and education for the entire state.

Northeast (NE) Arkansas Region (Izard County, Lawrence County, Randolph County, and Sharp County)

The participants in this focus group were all women who reside within the target area(s) and are all over the age of 40 and have all had at least one mammogram. No one from this group had been diagnosed with breast cancer but know a family member or friend that has been diagnosed. Participants were all aware that breast cancer could be inherited but had not participated in any genetic testing. Obesity, high blood pressure, heart disease and cancer are health problems of greatest concern for members in their community.

Focus group participants were aware of the numerous clinics and hospitals in their area(s) that provide screenings for breast cancer, including the mobile units from Baxter Regional Medical Center and St. Bernards Medical Center. This group also agreed that someone who needs further breast screenings or treatment would have to travel almost three hours to Little Rock, AR or Memphis, TN. The majority of the focus group participants stated that women in their area receive educational information through the internet or by word of mouth. However, using radio, local newspapers and church bulletins more often were additional ways to disseminate breast cancer information.

There were very few survey respondents from this area. Based on the data collected, participants indicated that the internet and word of mouth were the top two sources for health information. Participants indicated trying to find a way to recruit more physician specialists to assist with breast health screenings but understand that it would be hard to recruit to small towns. Survey respondents also indicated that they looked to the newspaper and radio to find out about local events within the community.

Similar to other focus groups, raising awareness throughout the year versus just in the month of October would encourage women to get screenings year round. This can be done by inviting mobile units and involving all faith based organizations in a city-wide health fair. Most responses from online surveys were in line with responses from participants from the focus group. Last, the majority of the focus group participants indicated that they had some form of insurance whether it was social insurance or private health insurance.

Southeast (SE) Arkansas Region (Bradley County, Chicot County, and Drew County)
All of the participants in the focus group held in this target community were health professionals who reside and/or provide some type of health care service in this target area. The majority of the participants agreed that education and outreach efforts should be partnered with faith-based organizations in order to further reach the population who are not getting screened. The group was very aware of all screening and diagnostic service offerings, but felt that most women are not seeking breast health services due to distrust of medical staff, fear of the unknown and transportation issues. In addition to trust issues, there are cultural differences or disparities (language barriers and/or perceived discrimination) that exist in this region for Black/African-American and Hispanic/Latino populations. Both racial groups mentioned are not aware of available resources due to lack of education and language barriers.

Focus group participants were familiar with hospitals/clinics that offer breast health services in this region, including clinical breast exams, mammograms and ultrasounds. Breast biopsy services are limited in this area(s). There was one outlying suggestion to have the mobile mammography unit from UAMS make house-calls versus posting in locations within the community. Furthermore for treatment services, focus group and online participants indicated they would be willing to travel up to two hours away to Arkansas cities (El Dorado, Pine Bluff or Little Rock) Greenville, MS or Monroe, LA.

Similar to responses from focus group participants, survey respondents felt that survivorship recognition efforts are very important; however existing support groups in their area are not specific to just breast cancer survivors, but for all cancers. A number of both online and focus group participants mentioned the beauty technique program provided by the American Cancer Society, "Look Good, Feel Better" that is available to all women with cancer who are undergoing chemotherapy, radiation or other forms of treatment.

Focus group participants also mentioned that during the month of October, there are a number of health fairs free to the public that offer education, free mammograms onsite to women who are eligible, and immediate referrals if an abnormal reading is found. Last, there was group consensus that combining efforts of more advertisement and free transportation offerings should be done to help spread the word on breast health for this target area. Last, participants in this focus group agreed that connecting women with a health professional and navigation of the health care system are key elements needed to keep women within the continuum of care (CoC).

Qualitative Data Findings

The purpose of this assessment was to further comprehend the access and barriers to breast cancer screening and treatment, as well as existing outreach strategies used to educate women on breast health awareness in the target areas. Based on findings from the Affiliate's qualitative assessment, there are a number of factors and/or gaps that contribute to why participants feel women in their community do not enter or continue in the breast cancer CoC. There was a consensus that better outreach efforts are needed to reach more women to educate them on breast health services and resources available in their target community.

To understand the perspectives of persons living in the target communities the Affiliate sent online surveys and conducted focus groups. The online survey approach had a low response rate and this may be due to the software application used. The online survey response rate may have been higher if the 'sender' field contained verbiage similar to "Komen Arkansas" or "Susan G. Komen", rather than Survey Monkey. Other possible reasons for the low survey response may have been a result of emails being filtered to SPAM folder(s) or survey responses being 'open-ended' or 'free text' versus multiple choice. Although the response rate was low, the Affiliate was able to use responses given to understand participants' views on what is needed in their community.

Although there was difficulty in recruiting focus groups, the Affiliate was able to gain incredible knowledge from opinions given through the focus groups. Sessions were well attended and participants were open to sharing their personal experiences with breast cancer and their opinions on the best way to reach out to women in their community. As a result of time constraints the Affiliate was unable to schedule several sessions to capture more diversity within target communities. Due to the limitations of the data, the perspectives provided represent only those that participated in the focus groups and surveys and do not represent the general population of the community or providers as a whole.

For all target communities, commonalities found that participants are aware of breast health screening services within their area. Also traveling up to 200 miles away for diagnostic and/or treatment services was not a deterrent for care. Participants mentioned that spreading the word or education messaging throughout the year would help bring constant attention to breast health awareness instead of just focusing on the month of October. In addition, effective social marketing strategies to publicize breast health programs and recruit participants/patients include tapping the established social structures and modes of communication. This involves identifying and working through the key social organizations (e.g., churches and barber shops) and indigenous leaders/roles (e.g., Church Pastors/Priests, family elders) within each community. Dissemination of information is most effective when delivered through established channels (e.g., Hispanic/Latino broadcast radio, ethnic newspapers). Using these strategies will help resolve potential barriers previously discussed for why women within the target communities do not enter or continue in the breast cancer CoC.

In conclusion, personally reaching out to individuals in the four target communities allowed the Komen Arkansas to better understand where there may be barriers or gaps in breast health services. Themes that emerged from the data collected will be used to set priorities for grantmaking, as well as help build community relationships and partnerships with health facilities in the target communities. Furthermore this knowledge will allow the Affiliate to support existing breast health programs taking place in the communities and address future outreach and policy needs.

Breast Health and Breast Cancer Findings of the Target Communities

Komen Arkansas identified four target communities of interest within the service area: Arkansas County, St. Francis County, Northeast Region (Izard, Lawrence, Randolph, Sharp), and Southeast Region (Bradley, Chicot, Drew). The target counties were identified using the available breast cancer data (incidence rate, late-stage diagnosis, death rate, demographics and socioeconomic) information provided by Komen Headquarters. Compared to the Affiliate's 63 county service area, as a group the nine counties selected have below median income, below median education, above state median uninsured rate, and are below the state average on usage of any breast health service. Without assistance or intervention from the Komen Arkansas, women living within the target communities mentioned above are unlikely to meet HP2020 targets for both breast cancer death rates and late-stage incidence and have limited access to culturally competent health care services, especially primary care and screening from most breast health providers.

After identifying the target areas, the Affiliate completed an analysis to determine the type of breast health services available within the designated target communities. This includes which breast health services are offered in the local health units or clinics, in addition to the area medical centers and availability of mobile mammography unit(s) that travel statewide. According to this analysis, it was found that there is at least one facility that is easily accessible for women to receive a clinical breast exam. For additional screening, diagnostic and/or treatment services, patients would travel 1-3 hours to a larger medical facility in the central Little Rock, AR area; Jonesboro located in Northwest AR; or travel to a medical facility in Tennessee or Louisiana, right outside the Arkansas state line.

Completing this analysis helped the Affiliate understand how a woman moves through the continuum of care. Furthermore, the analysis identified entities the Affiliate could form partnerships with to begin working toward solutions and prioritize a plan of action to increase access to breast health services within the four target communities.

In order to understand the perspectives of survivors and individuals living in the target communities, Komen Arkansas took on the approach of an online survey and conducting focus groups. Feedback gathered from focus groups and the online survey allowed the Affiliate to explain the gaps, needs or issues why women within these areas do not enter or stay within the continuum of care for breast health. The most common responses confirmed that women within the target communities are not getting screened because they do not have access to services and if access is available, they are unable to afford the services. Additionally, there is a lack of outreach and education among the diverse populations within the target communities. Furthermore, breast health educational messaging should last throughout the year beyond the month of October using effective social marketing strategies. These strategies would involve collaborating with key social organizations (faith-based, rotary club, etc.) and their leaders to effectively deliver educational messaging about the importance of breast health.

Mission Action Plan

Taking the information gained throughout the processes of the Community Profile the next steps for the Affiliate were to create problem statements and priorities with *SMART (Specific, Measurable, Attainable, Realistic and Time-bound)* objectives. To identify appropriate problem statements and priorities incorporating this new information, Komen Arkansas President of the Board of Directors, Executive Director, Mission Director, Grants Committee Chair, and members of the Board came together to discuss how the Affiliate will approach these counties while continuing to assist the existing 63 county service area. Using the data collected the Team determined the best use of Affiliate resources were to focus on 1) outreach and educational messaging to women within the target communities, particularly through community or faith-based organizations; 2) promote provider trainings for health professionals in the target communities to increase screening percentages; 3) enhance the quality of the grant funding process; and 4) collaborate with other organizations on continued advocacy and policymaking. The Mission developed by Komen Arkansas for the target communities is outlined below.

Problem Statement:
Women in the identified counties have higher annual death rates, higher late-stage diagnosis incidence and lower screening percentages than the Affiliate service area as a whole. Qualitative data found that women in the target communities felt that there is a lack of breast health education and awareness.

Priority: Increase breast health outreach and education within target communities - Arkansas County, St. Francis County, Northeast Region (Izard, Lawrence, Randolph, Sharp), and Southeast Region (Bradley, Chicot, Drew) - that address breast health and increase awareness of available services.

- Objective 1: By March 2016, identify and initiate contact with at least one community organization within each target community that is willing to collaborate with the Affiliate to discuss breast health outreach.

- Objective 2: From April 1, 2016 - March 31, 2020, partner with at least one community organization per target community to provide a culturally appropriate breast health event(s) for women of all ages.

- Objective 3: From April 1, 2016 - March 31, 2020, partner annually with at least one identified community organization to distribute at least 100 pieces of educational information on breast health to cultural and health literacy challenged populations.

Priority: Increase understanding of breast cancer screening recommendations by health professionals supported by Susan G. Komen® and knowledge of various referral processes to better navigate their patients through the continuum of care in the target communities.

- Objective 1: From April 1, 2015 - March 31, 2020, annually the Affiliate will promote attendance to upcoming regional conference(s) to educate interprofessionals about the most current breast health recommendations, resources available in the community, and other evidence-based programs that would increase their patients' screening percentages.

Priority: Develop and utilize partnerships to enhance Komen Arkansas' public policy efforts in order to improve breast health outcomes of women in the Affiliate service area.

- Objective 1: From January 1, 2016-March 31, 2020, advocate to assure continued funding for BreastCare - Arkansas' Breast and Cervical Cancer Program by contacting at least two state legislators.

- Objective 2: From April 1, 2015-March 31, 2020, collaborate with Arkansas Cancer Coalition and other organizations on advocacy and public policy efforts for the State of Arkansas by attending at least two meetings a year.

Priority: Increase the quality of Affiliate funded grants to ensure identified gaps in the continuum of care are addressed within the identified target communities.

- Objective 1: By August 2015, revise the Community Grant RFA to include at least one funding priority specific to innovative or evidence-based approaches that result in improved breast cancer screening, diagnostic, treatment and/or supportive services among the priority population groups and target communities identified in the Community Profile.

- Objective 2: By August 2016, conduct at least one grant workshop with potential grantees that provides an overview of the Community Grant Requests for Application (RFA) to increase potential awareness within one of the target communities.

- Objective 3: By March 2017, work with at least three (3) grantees within the target communities to strengthen and standardize the evaluation of their grant projects, in order to improve the overall quality of their programs, as well as articulate the grantee impact to community stakeholders.

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