COMMUNITY PROFILE REPORT

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2011

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The information in this Community Profile Report is based on the work of Texarkana Affiliate of Susan G. Komen for the Cure® in conjunction with key community partners. The findings of the report are based on a needs assessment public health model but are not necessarily scientific and are provided "as is" for general information only and without warranties of any kind. Susan G. Komen for the Cure and its Affiliates do not recommend, endorse or make any warranties or representations of any kind with regard to the accuracy, completeness, timeliness, quality, efficacy or non-infringement of any of the programs, projects, materials, products or other information included or the companies or organizations referred to in the report.

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Executive Summary

Introduction

The Susan G. Komen for the Cure Texarkana Race for the Cure® is truly a grassroots movement adopted and championed by the twin cities of Texarkana, Arkansas and Texarkana, Texas and their many surrounding communities. It started with a handful of determined ladies with a vision in mind. Texarkana breast cancer survivors Kathi Couch and Becky Blake, along with Judy Morgan and a group of friends were part of a lobbying effort to have Texarkana approved by Komen as a Race host city. When approval was announced in October 1998, Texarkana was the smallest city approved as a Race site.

Arkansas' First Lady Janet Huckabee served as the first Honorary Chairman of the Komen Texarkana Race for the Cure. During the inaugural event, an impressive 3,300 people walked through the historic streets of Texarkana, Texas and raised $237,000 for breast cancer programs and research. Additionally, $172,000 in grants was awarded to area health care providers to help provide low-cost mammography screening.

In 2004, in an effort to meet the growing demands of the Affiliate, the board of directors began exploring the possibility of hiring staff. In July 2004, the first staff person was hired and the office began having regular office hours three days a week. In 2006, the staff person was promoted to Executive Director and the board began transitioning from a working board to a governing board with working committees.

In 2008, the Komen Texarkana Race for the Cure celebrated its ten year anniversary with over 8,200 participants and raising in excess of $422,000. To date, the Komen Texarkana Affiliate has awarded over $2.5 million in grants.

After eleven years at the Ben and Jane Collins Home in Texarkana, Texas, the Race Committee and Board of Directors agreed we had outgrown our current location and it was time to find a new Race home. In 2010, the Komen Texarkana Race for the Cure moved to the Four States Fairgrounds in Texarkana, Arkansas and had over 8,600 participants raising in excess of $450,000. As we enter our 13th year, we look forward to another successful year at the Four States Fairgrounds in Texarkana, Arkansas.

The Komen Texarkana Race for the Cure has received "The Best of Texarkana – Best Charity Event Reader's Choice Award for 2006-2007-2008-2009-2010-2011. Also in 2011, the Komen Texarkana Affiliate was awarded the Acts of Kindness Service Award by the Martin Luther King Jr. Gala Committee.

Every part of our Race is a step in fulfilling a sister's promise. The Affiliate is confident that our efforts will continue to inspire personal victories of breast cancer patients and save lives.

The purpose of this report is to align the mission and outreach efforts of the Affiliate to better suit the unmet needs of the service area. The Community Profile is conducted every two years to identify areas where we can have the most impact by not duplicating

services and focusing of key issues of breast health. It is also used to help our Board of Directors make good decisions in setting realistic, attainable goals with limited resources and maximum outcomes to create synergy between strategic plans and operational activities. More specifically, it will allow our Affiliate to fund, educate, and build awareness in the areas of the greatest need.

Statistics and Demographic Review

In order to provide a complete description of the Affiliate service area, several data resources were utilized to create a snapshot of breast health. The local information depicted in the charts throughout this profile came from University of Arkansas for Medical Sciences Area Health Education Center-Southwest (UAMS AHECSW) Cancer Registry (Registry). The most recent data used is from 2005-2009 to provide a better glimpse of breast cancer in the service area. A national comparison was made from 2000-2008.

In addition to the Thomson Reuter data facts provided by Komen headquarters, state profile rates per county were accessed from the Texas and Arkansas Cancer Registry, reflecting 2002-2007 mortality rates, and the American Cancer Society's *Breast Cancer Facts and Figures 2009-2010*. Data for 2009 was obtained from the U.S. Census Bureau's State and County QuickFacts to provide general demographic information for the Affiliate service area.

While reviewing the gathered data, it was determined that Bowie County, Texas had the highest mortality rate at 34.05percent, age adjusted compared to 2000 census data. The county also had the highest percentage of uninsured females at 29.0 percent, although it houses the most breast cancer resources in the Affiliate service area. While Miller County females have the same opportunity to take advantage of the resources located in Bowie County, Texas (the two counties share the town of Texarkana where the majority of resources are located), that county has the second highest incidence rate in women in Stage II (26.8 percent) and Stage III (3.3 percent) breast cancer. Lafayette County, Arkansas took the lead in Stage III (3.9 percent) and IV (5.3 percent) incidence rate and mortality rate (64.9 percent) in the "other" category. *(All rates age-adjusted to 2000 census population)*

Taking into account the astounding incidence and mortality rates of females in all races coupled with the percentages of low-income, uninsured, and uneducated females, the Community Profile Advisory Team picked the following three counties as target areas based on the reasons bulleted.

Bowie County, Texas

- Highest mortality rate in African Americans (42.83 percent) among service area
- Highest percentage of uninsured females (29 percent) among service area
- Highest local breast cancer cases (328) among service area
- Highest reported deaths(16) among service area

Miller County, Arkansas

- Second highest incidence rates among Caucasians (26.8 percent) among service area
- Second highest local breast cancer cases (137) among service area
- Second highest percentage of females ages 40 and above who have not had a mammogram (41.2 percent) among target counties
- Second highest percentage of population below federal poverty level (15.5 percent) among target area

Lafayette County, Arkansas

- Highest mortality rate (64.9 percent) in "other" category among service area
- Highest Stage III (3.9 percent) and IV (5.3 percent) incidence rate among service area
- Highest percentage of females ages 40 and above who have not had a mammogram (43 percent) among target area
- Highest percentage of population below federal poverty level (19.8 percent) among target area

Health Systems Analysis

The Affiliate inventory of breast cancer and services was completed by internet searches, key informant phone interviews, and contacting the Ark-La-Tex Health Network for provider information. Geographic information system (GIS) mapping is used to depict health service organizations ranging from provider offices, hospitals, surgery centers, to radiology consultants and imagining centers. Key Informants were selected from existing grantees and other community organizations providing resources to the underserved, uninsured and underinsured. The key informants selected in Bowie County, Texas and Miller County, Arkansas was CHRISTUS St. Michael Health System, Wadley Regional Medical Center, University of Arkansas for Medical Sciences Area Health Education Center-Southwest (UAMS AHEC-SW), Bowie County Health Department, Housing Authority, Domestic Violence Prevention, and Helping Hands of Texarkana. The key informant selected in Lafayette County, Arkansas was the Lafayette County Health Unit. The limitation was that not all key informants completed the questionnaire; especially those from organizations where potential non-medical partnerships may have been formed.

Qualitative Data Overview

The Affiliate used all three qualitative data measures; surveys, key informant interviews and focus groups. One hundred twenty eight online surveys were conducted and thirty-two were completed through Survey Monkey™ for survivors to help the Affiliate develop an understanding of the specifics of diagnosis, years of survival, concerns and amount of support during treatment. Seven key informant questionnaires and surveys were collected from existing grantees and potential partners in the target counties to determine financial assistance programs available, willingness to partner, provide, or

expand or address gaps in services. Forty-one provider surveys were distributed to local provider offices in person and to outlying offices by mail to determine the knowledge of the staff on breast cancer guidelines, educational materials available, and incentives used to encourage women to attend screenings. Fourteen (34.1 percent) of the surveys were completed. Focus groups were conducted in two target counties to gain a better idea of the knowledge of breast cancer, the women who need it the most in those counties, the barriers preventing those women from seeking services, the providers' role in the continuum of care and how the Affiliate could assist in addressing some of the issues raised.

From the uneven distribution of healthcare assets, as indicated in the maps in *Figures 5, 6,* and *7*, and from the key informants working hands-on in the community, it is apparent that partnerships be made with and funding opportunities made available to community organizations that are medical providers to offer opportunities to better screen and treat patients who are underserved. It is of the same importance to collaborate with non medical providers to better educate women on existing resources, support services, and help address major fears of breast cancer testing and diagnosis. Some of the areas that presented gaps are ethnic groups such as African Americans who appear to not have materials and programs written to speak to their cultural needs. Another critical gap outreach services for health professional shortage areas. Services should be expanded for Lafayette County, Arkansas to conquer barriers such as transportation and lack of access to screenings along with brochures, pamphlets and posters written for this target demographic, since 34.7 percent of the population has less than a high school diploma.

Conclusions

From the provider surveys, physician surveys, key informant interviews, and focus groups, we realized that no matter how abundant healthcare resources are in the area, without communication and coordination, the efforts to reduce breast care disparities are fragmented. All groups echoed the need to support services for the underserved populations in each of the target counties. In order to address the needs of the target area, the Affiliate developed the following action plan.

Priority #1: Education/Awareness

Goal #1: Increase breast cancer education and awareness to African American females in Bowie County, Texas by 2012.

Objective 1.1: To decrease late stage diagnosis and high mortality rates by increasing partnerships with community based organizations that predominantly serve African American females.

Objective 1.2: Support the development of culturally appropriate marketing materials to increase education and awareness about breast cancer

among African American women of a low socioeconomic status.

Goal #2: Increase breast cancer education and awareness among medical providers.

Objective 2.1: Hold Komen sponsored provider education workshops about breast health guidelines and resources available in the target communities by 2012.

Objective 2.2: Improve statistical gathering methods in our community by requesting that all grantees provide the Cancer Registry with annual data on all breast screenings.

Priority #2: Access

Goal #1: Increase funding for breast cancer prevention and screening services in Bowie County, Texas and Miller and Lafayette Counties in Arkansas by 2012.

Objective 1.1: Hold at least one grant writing workshop in the target areas by January 2012.

Objective 1.2: Explore partnerships with non-medical organizations in target areas to reach women by non-traditional means immediately.

Priority #3: Coordination of Resources

Goal #1: Hold at least one breast health resource symposium every year that facilitates knowledge-sharing of programs and resources among organizations.

Introduction

Affiliate History

The Race is truly a grassroots movement adopted and championed by the twin cities of Texarkana, Arkansas and Texarkana, Texas and their many surrounding communities.

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Every part of our Race is a step in fulfilling a sister's promise. The Affiliate is confident that our efforts will continue to inspire personal victories of breast cancer patients and save lives.

Organizational Structure

The Board of Directors is the governing entity of the Affiliate. The board president directs the Board of Directors and the committees including grants, personnel, fund development and governance. (*see Figure 1*). The daily operations of the Affiliate are run by one full-time staff. The Executive Director and the Board President are the faces and voices of the Affiliate in the community.

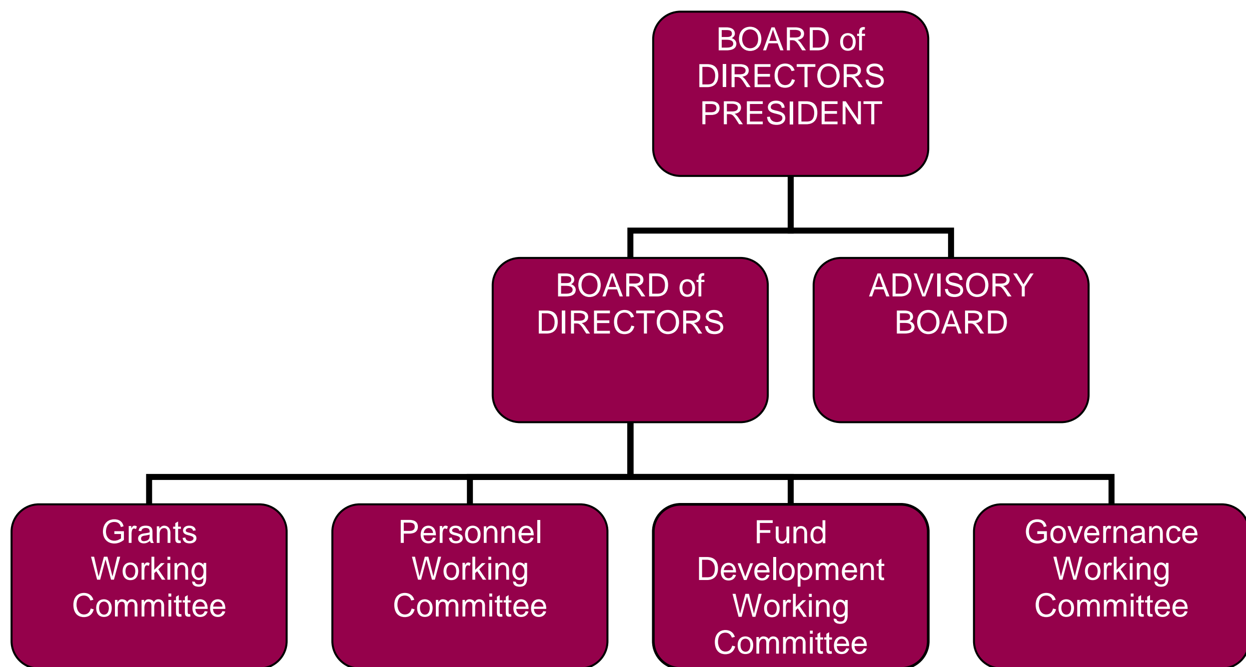

Figure 1. Affiliate organizational chart.

Description of Service Area

The city of Texarkana is shared by two states; Texas and Arkansas. It is located in the northeast corner of Texas and the southwest corner of Arkansas. There are two of almost everything: two city mayors, two city governments, two police departments, and two fire departments---and one unique Affiliate that covers counties in both states.

The Affiliate service area consists of Bowie and Cass Counties in the state of Texas and Miller, Littler River, Hempstead and Lafayette Counties in the state of Arkansas (see *Figure 2*). The total population of the Affiliate service area as of 2009 is 207,571. *(Thomson Reuters © 2009)* Bowie County makes up the largest population portion with approximately 93,000.

Figure 2. Affiliate service area map.

While Texarkana, Texas is home to the only fully accredited, comprehensive cancer center in the service area at CHRISTUS St. Michael Health System; Bowie County partially remains in a Health Professional Shortage Area. Cass County in Texas and Hempstead County in Arkansas are also counties that are partially designated Health Professional Shortage Areas. Furthermore, Lafayette County as a whole is designated as a Health Professional Shortage Area. The majority of the Affiliate service area counties and communities are rural.

Purpose of the Report

The purpose of this report is to align the mission and outreach efforts of the Affiliate to better suit the unmet needs of the service area. The Community Profile is conducted every two years to identify areas where we can have the most impact by not duplicating services and focusing on key issues of breast health. It is also used to help our Board of Directors make good decisions in setting realistic, attainable goals with limited resources and maximum outcomes to create synergy between strategic plans and operational activities. More specifically, it will allow our Affiliate to fund, educate, and build awareness in the areas of the greatest need.

Breast Cancer Impact in Affiliate Service Area

Methodology

In order to provide a complete description of the Affiliate service area, several data resources were utilized to create a snapshot of breast health. The local information depicted in the charts throughout this profile came from UAMS AHEC SW Cancer Registry (Registry). The Cancer Registry collects data in Texarkana and is the only resource of cancer statistics in the Affiliate service area. The Cancer Registry coordinates the Commission on Cancer Approved Program for CHRISTUS St. Michael Health System and Wadley Regional Medical Center and is ranked high in compliance in national benchmarking of local data against all Commission on Cancer (CoC) Approved Programs. The Registry staff compiles and analyzes data for quality improvement studies and submits resulting information to the Texas Cancer Registry, Arkansas Cancer Registry and the National Cancer Data Base (NCDB). The most recent data was used from 2005-2009 to provide a better glimpse of breast cancer in the service area. A national comparison was made from 2000-2008.

In addition to the information provided by Komen headquarters, state profile rates per county were accessed from the Texas and Arkansas Cancer Registries reflecting 2002-2007 mortality rates and the American Cancer Society's *Breast Cancer Facts and Figures 2009-2010*. State and County QuickFacts for 2009 obtained from the U.S. Census website to provide general demographic information.

Data limitations faced when conducting this Community Profile are the different years of data available. The latest data available was used. Other challenges faced were that locally diagnosed and treated outpatient cases are not reported and individuals seeking services outside of the target counties could possibly be reported in the county where seeking services.

The following pages depict graphs that will help paint a better picture of the presence of breast cancer in our local area compared to national and state numbers. It is also believed that the low education levels may contribute to low screening rates and late stage diagnosis.

Overview of the Affiliate Service Area

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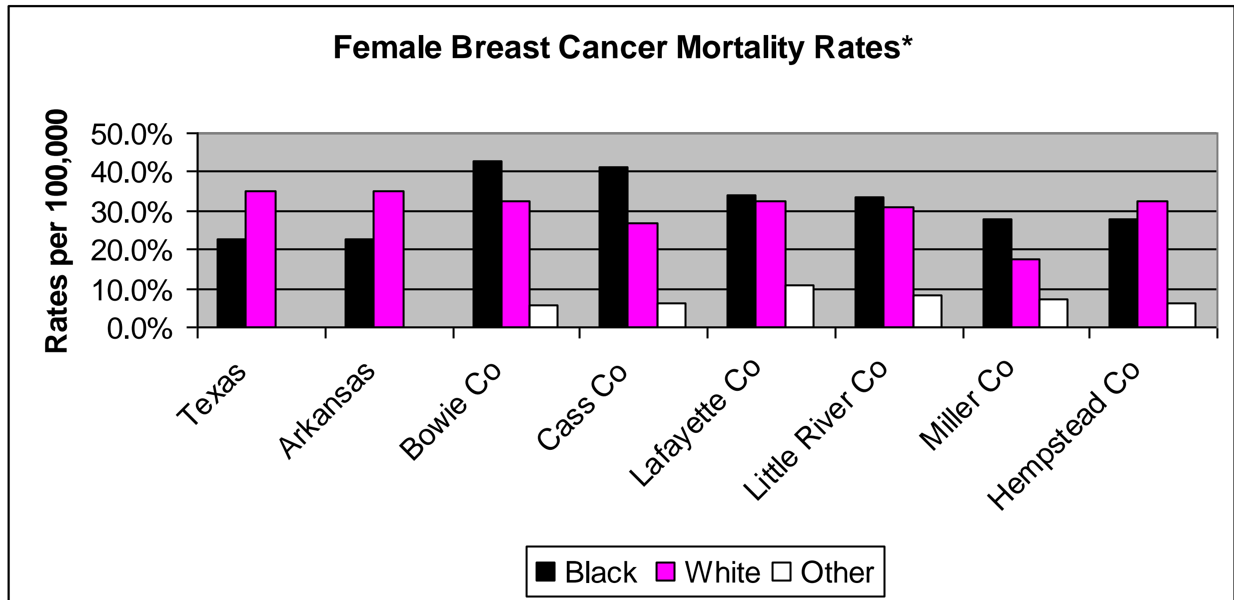

Figure 1. Female Breast Cancer Mortality Rates 2009-2010

Data Sources: American Cancer Society, *Breast Cancer Facts & Figures 2009-2010,* Thomson Reuters ©2009

*All rates are age adjusted to 2000 US standard population

When compared to the state mortality rates of Texas and Arkansas, the Affiliate service area rates are higher in African American females. Miller County, Arkansas was the only exception in Caucasian women at a lower mortality rate than the state levels. See *Figure 1* above.

African American women with breast cancer are less likely than white women to survive 5 years: 78 percent vs. 90 percent respectively. This difference can be attributed to bother later stage at detection and poorer stage-specific survival. (*Breast Cancer Facts and Figures 2009-2010*)

As we research a little deeper in the next graph, we can see that educational levels affect all races. It could possibly prevent a woman from entering the continuum of care if she doesn't fully understand the process or if she is not literate enough to comprehend the printed materials.

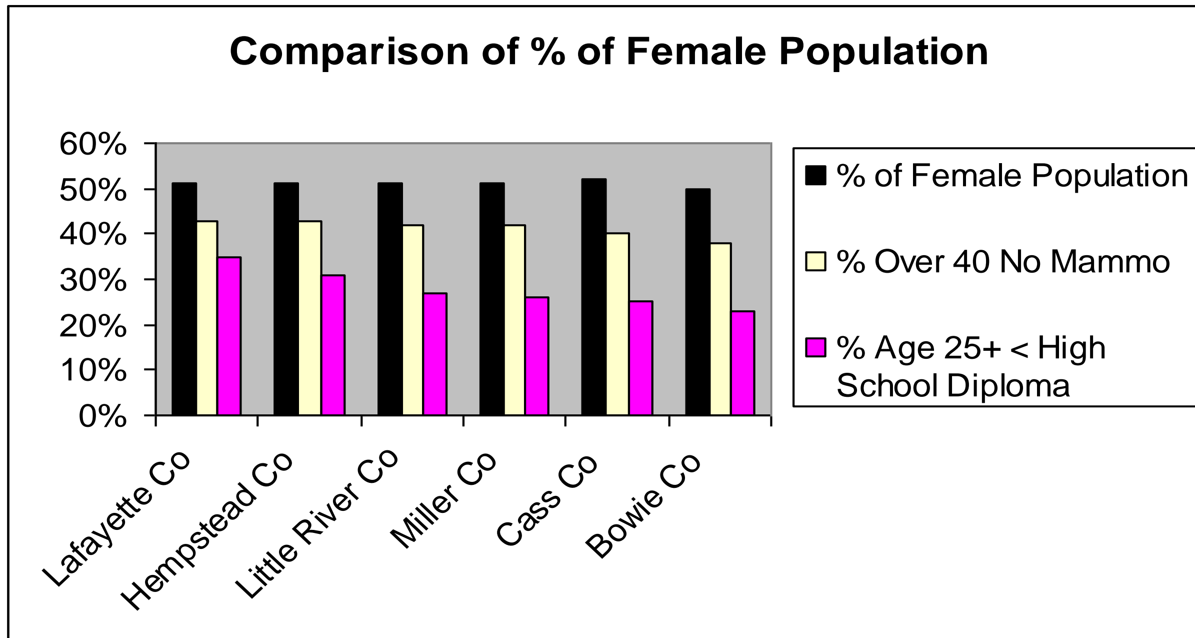

Figure 2. Comparison of Female Demographics, Census 2000
Data Source: Combined Data from Thomson Reuters © 2009

Strikingly, there is an exact trend in the ranking of the counties from highest to lowest in the percentages of female population over 40 that have not had a mammogram and of females 25 and older who do not have a high school diploma (*see Figure 2*).

Persons with lower socioeconomic status (SES) have disproportionately higher cancer death rates than those with higher SES, regardless of demographic factors such as race/ethnicity, residence, and sex. The causes of health disparities within each of those groups are complex and interrelated, but likely arise from inequities at work, wealth, income, education, housing, and overall standard of living, as well as social barriers to high-quality cancer prevention, early detection and treatment services. (*Cancer Facts and Figures 2010)*

The next graph reflects our local presence of breast cancer. It is expected to have more cases in Bowie County since it is the largest county in the service area and has the most readily available resources to detect the deadly disease.

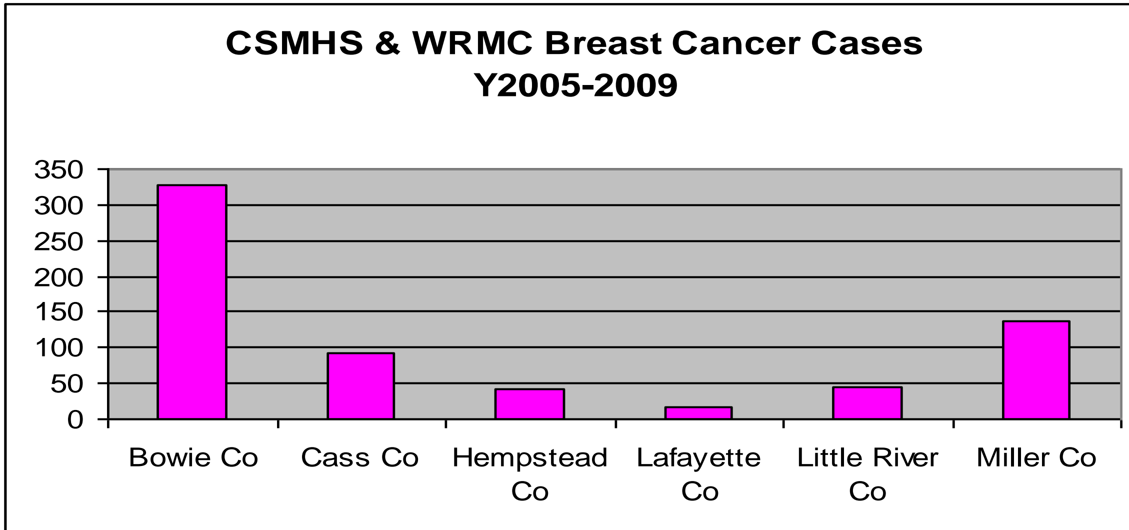

Figure 3. Local breast cancer cases reported by the only two hospitals in the service area.
Data Source: UAMS AHEC SW Cancer Registry

Figure 3 depicts the local number of breast cancer cases reported by the only two hospitals, CHRISUTS St. Michael Health System and Wadley Regional Medical Center in the Affiliate service area. Bowie County had 328 cases, Cass County had 93 cases, Hempstead County had 42 cases, Lafayette County had 16 cases, Little River had 44 cases and Miller County had 137 cases. Cases diagnosed and treated in Texarkana outpatient settings are not depicted in this graph.

Lastly, the next graph compares our local cancer cases by stages to the NCDB national comparison.

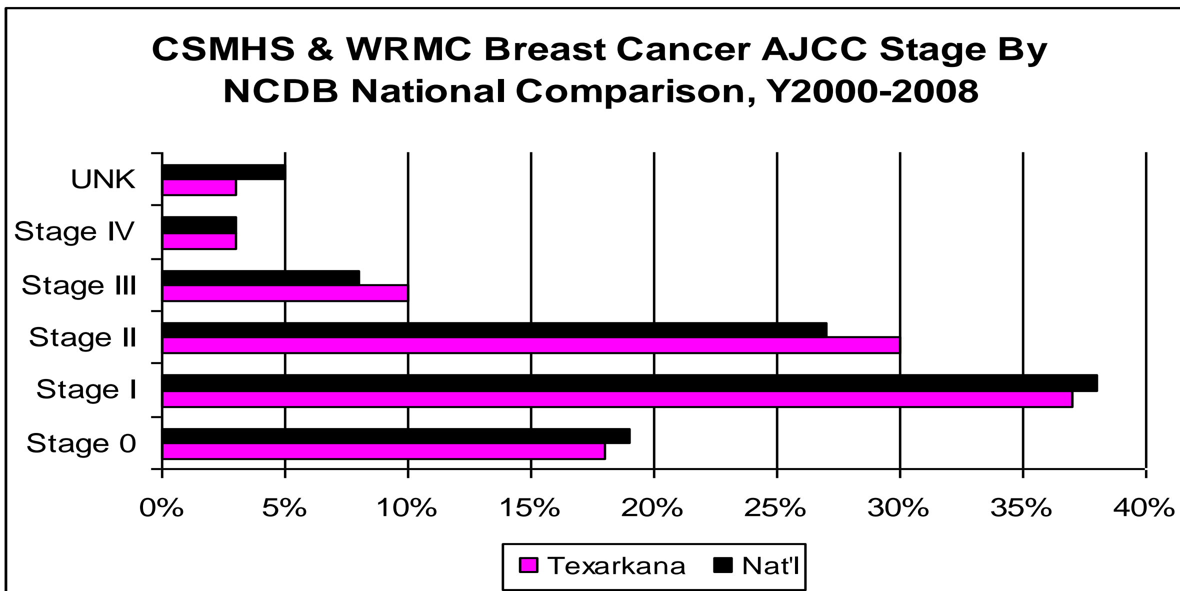

Figure 4. National comparison of breast cancer by stage with local cases

Data Source: UAMS AHEC Southwest Cancer Registry

The graph above depicts newly diagnosed breast cancer cases at CHRISTUS ST. Michael Health System and Wadley Regional Medical Center in Texarkana in the years of 2000-2008. The percentage of Stage O for the local data was 18 percent compared to 19 percent national data. Stage I local data was 37 percent of our total cases seen compared to 38 percent nationally. Stage II local data was 30 percent compared to 27 percent seen nationally. Stage III was 10 percent locally and 8 percent nationally and Stage IV local was comparable to national percentages with 3 percent of patients being diagnosed.

Eighty-six percent (86 percent) of the cases diagnosed locally and nationally were early stage disease (Stage 0, I and II). Our data revealed fourteen percent (14 percent) of cases were later stage (Stage III & Stage IV) compared to eleven percent (11 percent) being seen nationally for later stage. Our local cancer registry data revealed three (3 percent) of our cases were unstageable and nationally five percent (5 percent) of breast cancer cases were unstageable.

Communities of Interest

After review all data sources, the Affiliate felt is was most appropriate to focus on the following counties of interest:

Bowie County, Texas

According to the 2009 Census Quick Facts, Bowie County, Texas has approximately 93,237 in total population. Of that population, 46,127 are females. 45.4 percent of the female population is in the recommended age range of 40 and above to have regular mammography screening. Almost half the female population is at risk of developing breast cancer. Others factors that might hinder screening rates are females who are living in poverty, that have no insurance and no high school diploma. These particular factors affect approximately a quarter of the female population in Bowie County, Texas.

Fortunately, there are several resources available and the county has the highest screening rate of the six counties in the Affiliate service area. The screening rate and largest population of the service area may also contribute to the highest number of breast cancer cases and highest mortality rate when compared with the other five counties in the service area.

Miller County, Arkansas

According to the 2009 Census Quick Facts, Miller County, Arkansas has approximately 43,522 in total population. Of that population, 21,959 are females. 46.8 percent of the female population is in the recommended age range of 40 and above to have regular mammography screening. Miller County has a slightly significant higher female population at risk of developing breast cancer than Bowie County residents. Since Miller

County mirrors Bowie County, factors that might hinder screening rates are females who are living in poverty, that have no insurance and no high school diploma. These particular factors affect approximately a quarter of the female population in Miller County, Arkansas also.

Although, Miller County females have the same opportunity to take advantage of the resources located in Bowie County, Texas (the two counties share the town of Texarkana where the majority of resources are located), the county has the second highest incidence rate in women in Stage II and Stage III breast cancer. It is third in place with the percentage of women over 40 who have not had a mammogram when compared to the other five counties in the service area.

Lafayette County, Arkansas

According to the 2009 Census Quick Facts, Lafayette County, Arkansas has approximately 7,504 in total population. Of that population, 3,777 are females. 52.9 percent of the female population is in the recommend age range of 40 and above to have regular mammography screening. The county has the highest total population of all six counties below the federal poverty rate at 19.8 percent and 19.4 percent of females are uninsured. 34.7 percent of the total population has less than a high school diploma.

Consequently, there is not an abundance of resources to services for females in Lafayette County. 43 percent of females aged 40 or over have not had a mammogram. They are the highest ranked county in Stage III and Stage IV incidence rate compared to other five counties in the service area.

Conclusions

Many areas and populations are profoundly affected by breast cancer. The Affiliate service area is no exception. After reviewing all the demographic and breast cancer statistics researched and provided, the Community Profile Advisory Team selected Bowie County in Texas, Miller and Lafayette County in Arkansas as the target counties.

Health Systems Analysis of Target Communities

Overview of Continuum of Care

The continuum of care consists of four parts: Screening, Diagnosis, Treatment and Follow-Up Care. Completing the four step process has proven to be a challenge for both the patient and the provider across many Affiliate areas. Point of entry for a woman starts with education about breast cancer and screening. For a woman entering into the continuum of care in Bowie County, Texas or Miller County, Arkansas there are abundant resources and the process might go smoothly--if she is aware of the assistance available. This is certainly a challenge because data revealed that a quarter of the female population in the service area did not have a high school diploma. A woman may have to rely on family members or friends for information. Not only can second hand information be inaccurate but it could possibly be harmful.

Although there are several grant and facility resources in Texarkana to help a woman with screening, transitioning a woman in to the second phase for diagnostic testing can be deemed tough; especially in rural areas such as Lafayette County where a woman is required to travel more than an hour for further testing and treatment. This barrier may be attributed to the high rate of late stage diagnosis in that county.

The third stage, treatment, may equally be difficult to move into once a woman has been diagnosed. Even with abundant resources readily available regardless of her inability to pay, cultural barriers can halt the process. Focus groups discovered this fact in African Americans and we can see in the impact in the mortality rates for both Bowie and Miller counties.

Finally, if all barriers are resolved, follow-up care is accessible and important to providers. After reviewing the survivor and provider surveys, we concluded that survivors received the follow up care needed and providers were willing to take the time to address and answer any concerns post treatment.

To better assess the needs of our service area, an inventory of healthcare facilities, programs available and potential partners was taken to identify possible funding opportunities and outreach methods to reduce the astounding statistics of breast cancer in our area.

Methodology

The Affiliate inventory of breast cancer and services was completed by internet searches, seven key informant phone and email interviews and by contacting the Ark-La-Tex Health Network for provider information. Key Informants were selected from existing grantees and other community organizations providing resources to the underserved, uninsured and underinsured. The key informants selected in Bowie

County, Texas and Miller County, Arkansas was CHRISTUS St. Michael Health System, Wadley Regional Medical Center, UAMS AHEC-SW, Bowie County Health Department, Housing Authority, Domestic Violence Prevention, and Helping Hands of Texarkana. The key informant selected in Lafayette County, Arkansas was the Lafayette County Health Unit. The limitations were that not all key informants completed the questionnaire; especially those from organizations where non-medical partnerships could have potentially been formed.

The Ark-Tex Council of Governments, City of Texarkana and the Chief Information Officer at Collom and Carney Clinic in Texarkana, Texas helped create a usable map to depict health service organizations ranging from provider offices, hospitals and surgery centers to radiology consultants and imagining centers.

Figure 5. Healthcare Assets of Bowie County, Texas

Figure 6. Healthcare assets of Miller County, Arkansas

Figure 7. Healthcare assets of Lafayette County, Arkansas

After mapping the healthcare assets specific to breast health of all three counties, we can conclude the cluster of providers is located around Texarkana; mainly on the Texas side of Texarkana.

The limitations are reaching those individuals in the rural counties with a small number of providers and no screening facilities available. Rural residents in Lafayette County, Arkansas are not screened regularly and approximately 150 women were screened through a mobile mammography van in 2010.

Overview of Community Assets

Bowie County, Texas and Miller County, Arkansas

The W. Temple Webber Cancer Center at CHRISTUS St. Michael Hospital in Texarkana offers screening and diagnostic breast health services through Komen, Texas Breast and Cervical Care Program (BCCEDP) and in house financial assistance, as well as treatment and support services. The BCCEDP program offers assistance to women age 40 to 64 years of age, underinsured or uninsured at 250% the federal poverty level with breast screening. The women who are not eligible for the BCCEDP are helped though the Komen grant funds. Patient and family education resources are available as well. Services include wig selection and care for breast cancer patients. The St. Michael/ American Cancer Society Information Resource Center also offers a source for information about breast cancer prevention, screening, diagnosis, and treatment. No one is turned away regardless of their ability to pay.

Wadley Health System Breast Health Center offers screening and diagnostic mammography, surgical treatment, and adjuvant breast cancer treatment and support. Genetic and nutritional counseling services are also available at this site.

UAMS-Area Health Education Center-Southwest (AHEC-SW), a state funded educational outreach facility of the University of Arkansas for Medical Sciences (UAMS), was established in 1973.The center provides educational programs for community groups, and screening mammography. Bilingual materials and providers are available. The center collaborates with Wadley Breast Health Center and with CHRISTUS St. Michael Webber Cancer Center for assisting patients in diagnostic mammography referral and treatment of breast disease.

Bowie Miller County Health Departments are concerned with programs and policies dedicated to the protection of health and general welfare of the citizens of Bowie and Miller County. Currently, neither facility offers breast health resources but would be interested in partnering to provide needed services.

The Housing Authority of Texarkana, Texas (HATT) is a local public housing agency that provides safe, decent, and quality affordable housing and supportive services to eligible persons with limited incomes, through a variety of federal, state, local and

private resources. Currently, HATT does not offer any resources relating to breast care but would like to partner to educate African American women living on the premises.

Lafayette County

Lafayette County Health Unit is located in Lewisville, Arkansas and has a full time staff member dedicated to women's health. Currently, the facility offers assistance through Arkansas BreastCare and approximately six times a year, a mobile mammography van from Little Rock, Arkansas services women in the county.

Breast and Cervical Cancer Services and Arkansas BreastCare.

The Breast and Cervical Cancer Services program (BCCS) offers clinical breast examinations, mammograms, pelvic examinations, and Pap tests throughout Texas at no or low-cost to eligible women. BCCS is partly funded by the Centers for Disease Control and Prevention (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP). Congress established the NBCCEDP in 1991 and reauthorized in April 2007.

Arkansas Breast Care was established in 2000 as a subset of the Arkansas Department of Health and Human Services. This program offers low income women aged 40 and older access to screening mammography, clinical breast examination, and referral for treatment. The Arkansas Breast Care website also offers links to community and national support services and educational resources.

Public Policy

Komen focuses on a number of public policy priorities central to the delivery of quality breast health and breast cancer care. Several of these initiatives include increased funding for the NBCCEDP, increased funding for the National Institutes of Health (NIH)/National Cancer Institute (NCI), adequate protections for breast cancer patients and adequate reimbursement rates under Medicare.

Affiliates play a vital role in furthering the organization's public policy priorities by engaging activism at the federal, state and local levels. Affiliate involvement in the grassroots public policy program, Komen Champions for the Cure®, illustrates this effort. Komen Champions was inspired by thousands of Komen volunteers across the country who work in local communities and with their state health departments to educate Congress, the President and other policymakers about breast health and breast cancer care.

As part of Champions, Komen hosts an innovative public policy website, www.ActNowEndBreastCancer.org, which enables thousands of concerned individuals to join the fight against breast cancer. This virtual advocacy forum offers individuals the

opportunity to influence the federal government on crucial breast cancer issues by contacting their Members of Congress.

The Affiliate participates in partnership with the Little Rock Affiliate of Susan G. Komen for the Cure® on monthly calls.

Conclusion

From the uneven distribution of healthcare assets as indicated in the maps in *Figures 5, 6 and 7* and from the key informants working hands on in the community, it is apparent that partnerships and funding opportunities be made to community organizations that are medical providers to better screen and treat patients who are underserved. It is of the same importance to collaborate with non medical providers to better educate women on existing resources, support services and help address major fears of breast cancer testing and diagnosis. Some of the areas that presented gaps are ethnic groups such as African Americans that appear to not have materials and programs dedicated specially for their cultural needs. Another critical gap is that outreach services could be expanded to health professional shortage areas like Lafayette County, Arkansas to conquer barriers such as transportation and lack of access to screenings along with appropriate literate levels for brochures, pamphlets and posters since 34.7 percent have less than a high school diploma.

Breast Cancer Perspectives in the Target Communities

Methodology

The Affiliate decided to use focus groups, surveys and interviews to ensure community input in research and interventions. Online surveys were conducted through Survey Monkey for survivors to help the Affiliate develop an understanding of the specifics of diagnosis, years of survival, concerns and amount of support during treatment. Key informant questionnaires and surveys were collected from existing grantees and potential partners in the target counties to determine financial assistance programs available, willingness to partner, provide, or expand or address gaps in services. Provider surveys were distributed to local provider offices in person and to outlying offices by mail to determine the knowledge of the staff on breast cancer guidelines, educational materials available, and incentives used to encourage women to attend screenings. Focus groups were conducted in two target counties to gain a better idea of the knowledge of breast cancer, the women who need it the most in those counties, the barriers preventing those women from seeking services, the providers' role in the continuum of care and how the Affiliate could assist in addressing some of the issues raised.

Focus groups were conducted in two of the three target areas; one in Bowie County, Texas and one in Miller County, Arkansas. After review of the late stage diagnosis rates for African American women in Bowie County, a request was sent to the Texarkana Housing Authority (Housing Authority) to hold a focus group for underserved African American females at their new community center funded by Hope VI. Flyers and brochures for the event were made by the Housing Authority and distributed. A two hour session was held on a week night with light refreshments. Drawings for two $50 Visa Cards were provided by the Affiliate, two $25 Gift Cards and numerous door prizes were provided by the HATT for incentives. Eighteen African American females ranging in ages from 20 to 60, insured and uninsured, participated. Two African American males were also present.

A second focus group was conducted in Miller County, Arkansas for Caucasian females. A ninety minute session was held at a local community church on a week night with light refreshments. Drawings for two $50 Visa Cards were provided by the Affiliate as an incentive. Four Caucasian women 40 years of age and above, insured and uninsured participated.

One hundred twenty eight (128) survivor surveys were emailed using Survey Monkey with a three week time frame for completion. The survivors were chosen by an online database through the Affiliate for new survivors who registered for the Race for the first time in 2010. Thirty-two (32) survivors of the 128 emailed completed the survey.

Review of Qualitative Findings

Focus Groups

Despite the fact the two focus groups were completely diverse in ethnicity and skewed on number of participants; the same themes emerged among the women participating. The following themes were noted.

Educational Awareness: The groups urged that more educational sessions would attract more women for screenings. If materials were presented at a kindergarten level then females would know "that if breast cancer is caught earlier, women can possibly survive with treatment" and "what exactly the word biopsy means". They also wanted the hearsay about the pain from a mammography addressed.

Posted Information: All women agreed that there was enough information about breast cancer examinations available at their OB/GYNs offices. However, none felt there was enough information about screenings and resources posted elsewhere. They wanted to see more advertisements in the media, more brochures in other physician offices, and more posters in community organizations.

Financial Assistance: The uninsured women did not know where to go for financial assistance to help with screening costs and the cost of potential treatment. The insured women expressed a desire to help with co-pays for a mammography. The insured women also commented that their insurance did not pay for a mammogram until the age of 40—even if it was recommended by their provider or if they had a history of breast cancer in their family.

Transportation: The women mentioned transportation as a potential barrier to attending screenings and resources such as bus tickets, cab fares or gas cards available as potential resources to bring women to screening facilities.

The women shared some common concerns but there were also noted differences. The first is body image. African American females stressed taking pride in their bodies over one's personal health. One woman said, "A black woman would rather die with both breasts than to live feeling like less of a woman." Just the opposite was found in Caucasian women. They were more concerned with their health over appearance. However, they indicated they wanted to "look normal so no one would be able to tell that they weren't normal".

Caucasian women shared concerns about privacy at health fairs. While they agreed mobile mammography screening services were needed to reach individuals—especially in rural areas—they were a little more reluctant to get screened because they would know a lot of people and felt their privacy would be invaded. They also were uncomfortable with revealing private body parts in a large setting such as a health fair.

Provider Surveys

Provider surveys were mailed or delivered to forty-one providers in the three target counties. Fourteen completed surveys were returned. Although this is a low percentage of returns when comparing number sent to number received, we view the response rate as positive compared to the 2009 Community Profile.

A key conclusion drawn from survey responses is that limited financial assistance is available to women. Of the providers surveyed, 80 percent do not work for an organization that offers any type of financial assistance for the uninsured, underinsured or low income patients. 64 percent do not provide incentives for patients to seek mammography or diagnostic services. Only 21 percent of those surveyed partner with either Arkansas Breast Care and/or Affiliate. In contrast, 57 percent were interested or willing, if funding was available, to provide needed breast health services. Moreover, a potential opportunity and need for further education since approximately 40 percent of the respondents were interested in a brief training session on breast health for their staff.

Survivor Surveys

Thirty-two survivor surveys were completed through Survey Monkey. A majority of the questions required response. A few questions were optional to complete and some questions did not apply to applicants based on their circumstance and were indicated by N/A. Conditional logic was used to calculate responses from survivors who sought treatment locally.

The results concluded that 46 percent of survivor respondents completed their treatment in Texarkana. The primary reason given for seeking treatment outside Texarkana was that most obtained a second opinion and continued care with the second physician because of lack of trust in local physicians in Texarkana. The ones who did seek treatment in Texarkana felt the following processes took longer than they should have:

- Wait time for mammography or additional screenings
- Wait time between mammography and biopsy
- Wait time between biopsy and surgery
- Wait time between surgery and initiation of chemo and/or radiation therapy

Some areas of opportunity emerged when the question was asking about support services received. The graph below indicates the responses.

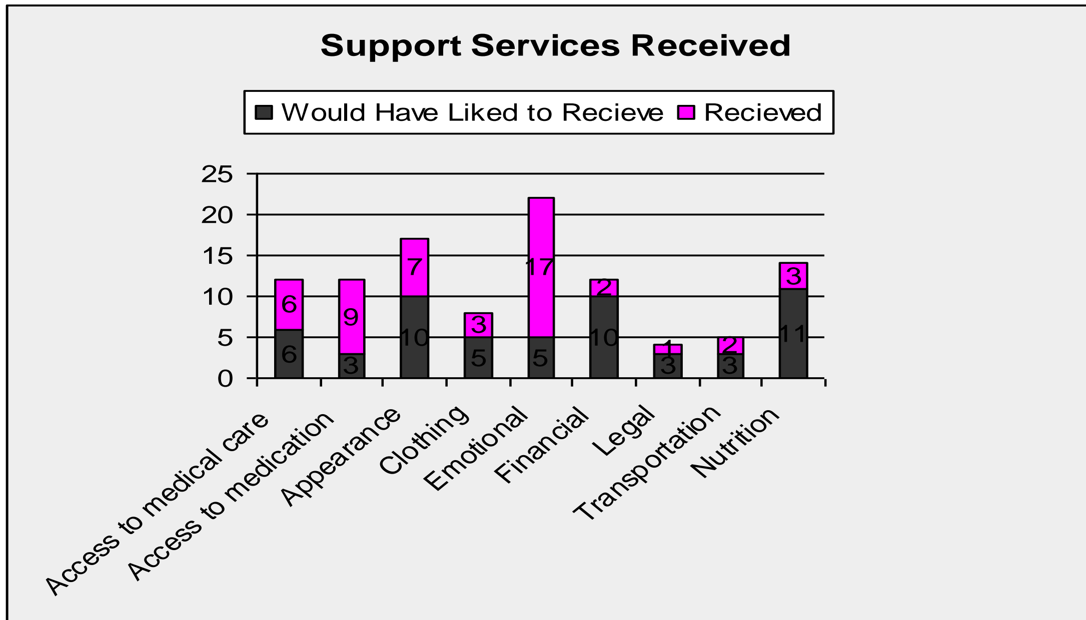

Figure 8. Services that survivors did receive and would have liked to received during treatment.
Data source: Survivor Surveys

Overall, a surprising 43.8 percent of survivors reported having no barriers to treatment. The greatest barrier reported was time constraint.

Key Informant Interviews

Key informant interviews were conducted in person and by email questionnaire to gain a better insight to breast health resources and barriers through a channel of community organizations: from existing grantees to potential partners in the target counties. The interviews revealed a strong willingness to partner to alleviate the identified barriers, shown below, and bridge the gaps in communication:

Education: All respondents listed a need for more education through brochures, seminars/conferences and health fairs to reach underserved individuals, uneducated individuals, and rural county individuals.

Financial Assistance: The interviewees who were not existing grantees suggested making financial assistance available to women with no insurance. For those with insurance, they suggested having financial assistance available for high deductibles or co-pays.

Transportation: All agreed it would help to offer assistance for transportation such as bus tickets, cab fares or gas cards available to bring women to screening facilities. Also, to have a mobile mammography van available consistently to reach underserved individuals, uneducated individuals, and rural county individuals.

Conclusions

The key informant interviews, provider and survivor surveys and focus groups all echoed the same needs for our community regardless of ethnicity; more education, financial assistance, and help with transportation. While Bowie County, Texas and Miller County, Arkansas have access to three major breast resources (Arkansas BreastCare, Texas Breast and Cervical Cancer services, and Komen) and a fully accredited, comprehensive cancer center at CHRISTUS St. Michael Health System, the screening rates, stage at diagnosis statistics and high mortality rates may indicate not enough women are being reached through existing educational methods. Several of the key informants and focus group participants were not aware of financial resources in any of the three counties.

Gaps in communication could be addressed by holding forums or symposiums for resource providers. Community leaders can learn about existing resources and partner to bridge gaps such as transportation, development of educational materials, or implementation of nurse navigators.

Conclusions: What We Learned, What We Will Do

Review of the Findings

Statistical data reviewed reported the counties of interest had high mortality rates in African Americans in Bowie County, Texas. Caucasian females had a higher incidence rates and local cancer cases in Miller County, Arkansas. Stage III and IV incidence rates in Caucasian females companied with high levels of poverty, low levels of education and higher percentages of uninsured females plagued Lafayette County, Arkansas.

Research of programs and services revealed all three target areas were either partially or fully designated as health professional shortage areas. Even with the concentration of medical providers and financial assistance in Texarkana, Texas, many women still cannot access necessary screenings and/or treatment because of barriers such as low educational levels, cultural beliefs and transportation.

After conducting focus groups and key informant interviews, we learned the women of the community and the community leaders were not aware of all breast health resources available. This is an opportunity for Komen to increase visibility and presence not only in the target area but in the service area as a whole. Gaps in communication could be addressed by holding forums or symposiums for resource providers. Community leaders can learn about existing resources and partner to bridge gaps such as transportation or develop an implementation of nurse navigators.

In addition, African American females were more culturally sensitive than Caucasian women when it came to body image after treatment. Both races were equally concerned with the perception of looking normal afterwards. However, the cultural pride of African American female is what will prevent the woman from seeking treatment. Komen can partner with non-medical providers such as the Texarkana Housing Authority and predominately African American churches to address these deadly concerns and help decrease mortality rates in African American females.

Provider surveys confirmed breast information was available at all OB/GYN offices but limited in other provider offices as stated in the focus groups. This one factor may contribute to the high incidence rate of Stage III and Stage IV diagnoses and high mortality rates in Bowie County, Texas and Miller County, Arkansas. We can also correlate those rural counties such as Lafayette County, Arkansas lack sufficient breast health services from the low mammography screening rates and late stage diagnosis. Komen can reach out to local educational institutions to develop literature that is appropriate reading level in our service area. Komen can also partner with local healthcare facilities in Lafayette County to assist with transportation expenses through means of gas cards.

Conclusions

From the provider surveys, physician surveys, key informant interviews, and focus groups, we realized that no matter how abundant healthcare resources are in the area, without communication and coordination, the efforts to reduce breast care disparities are fragmented. All groups echoed the need to support services for the underserved populations in each of the target counties. In order to address the needs of the target area, the Affiliate developed the following action plan.

Action Plan

Priority #1: Education/Awareness

Goal #1: Increase breast cancer education and awareness to African American females in Bowie County, Texas by 2012.

Objective 1.1: To decrease late stage diagnosis and high mortality rates by increasing partnerships with community based organizations that predominantly serve African American females.

Objective 1.2: Support the development of culturally appropriate marketing materials to increase education and awareness about breast cancer among African American women of a low socioeconomic status.

Goal #2: Increase breast cancer education and awareness among medical providers in Affiliate service area.

Objective 2.1: Hold Komen sponsored provider education workshops about breast health guidelines and resources available in the target communities by January 2012.

Objective 2.2: Improve statistical gathering methods in our community by requesting that all grantees provide the Cancer Registry with yearly data on all breast screenings by January 2012.

Priority #2: Access

Goal #1: Increase funding for breast cancer prevention and screening services Bowie County, Texas and Miller County and Lafayette County in Arkansas by 2012.

Objective 1.1: Hold at least one grant writing workshop in the target areas by January 2012.

Objective 1.2: Explore partnerships with non-medical organizations in target areas to reach women by non-traditional means immediately.

Priority #3: Coordination of Resources

Goal #1: Hold at least one breast health resource symposium every year that facilitate knowledge-sharing of programs and resources among organizations.

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