

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



SUSAN G. KOMEN®  
CENTRAL AND WESTERN OKLAHOMA

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# Introduction

## **Affiliate History**

Dr. Glenna Young and several female health care professionals whose work involved the treatment of cancer were active in getting an Affiliate of Susan G. Komen® started in Oklahoma City. This group approached Project Woman in 1993, showed the board a video of the Dallas Race for the Cure®, and explained that they wanted to start one in Central Oklahoma.

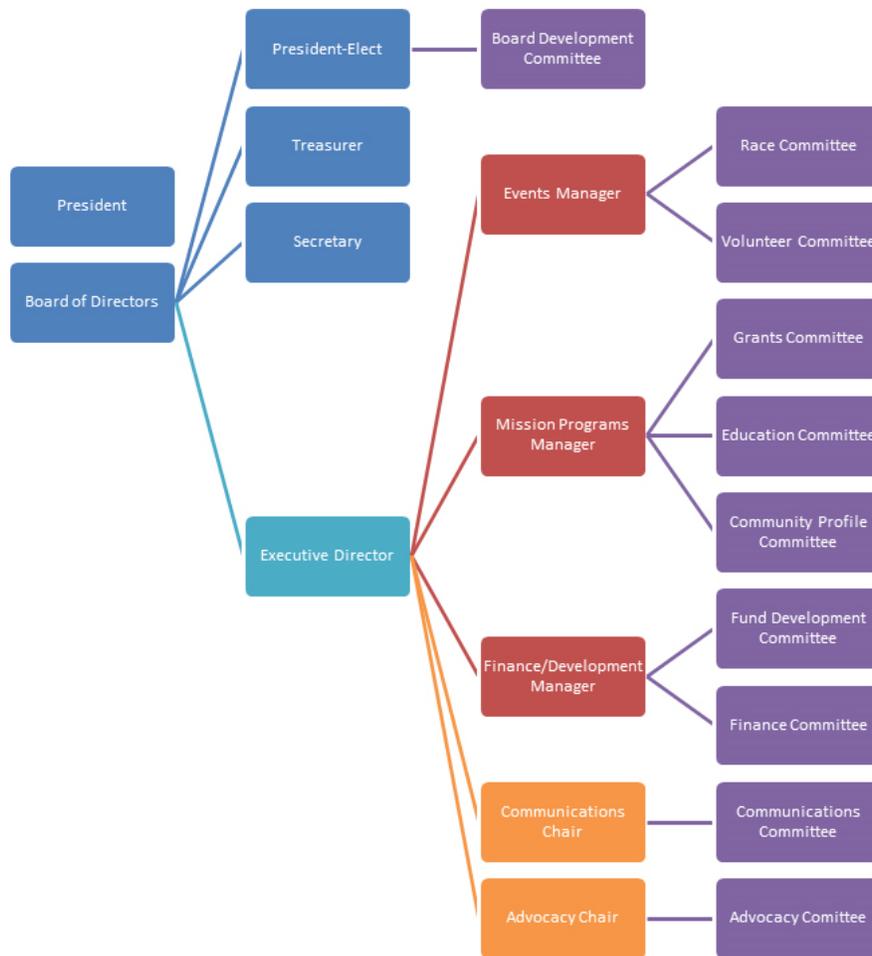
Funds raised from the Susan G. Komen Oklahoma City Race for the Cure® are granted to local programs that support Susan G. Komen's promise to save lives and end breast cancer forever by empowering people, ensuring quality care for all and energizing science to find cures. Since inception, Komen® Central and Western Oklahoma has granted over 10 million dollars to local organizations providing life-saving breast health services for breast cancer prevention and early detection, education, patient navigation, and support. Currently, the Affiliate is funding four local organizations that cover a multitude of services including patient navigation, low or no cost mammography and diagnostics, and innovative community education programs.

Until 2010, Komen Central and Western Oklahoma's service area included ten central Oklahoma counties. As a result of findings from the 2009 Community Profile, it was determined that there was a need to expand much needed services to women in the western half of Oklahoma. In 2010, Komen Central and Western Oklahoma applied for and received approval for expansion thus adding thirty-seven counties to the service area and officially changing their name from Susan G. Komen® Central Oklahoma to Susan G. Komen® Central and Western Oklahoma.

Komen Central and Western Oklahoma has served on the Oklahoma Comprehensive Cancer Coalition since its inception, has had a member on the now-defunct breast and cervical cancer advisory board for the State of Oklahoma, and along with Susan G. Komen® Tulsa created the Breast Cancer Awareness Day at the State Capitol.

## **Affiliate Organizational Structure**

The Affiliate has a staff of three full-time employees, with one open full-time position. The organizational chart shown below provides titles and functions filled by board members, staff and volunteers (see Figure 1.1). Oversight of the Affiliate is the responsibility of the Board of Directors. The primary duties of the Board include appointment and oversight of the Executive Director, the establishment and annual revision of the organization's strategic plan, fiscal oversight, adoption of an annual budget, and the establishment of policies and procedures, as may be needed. Board members are drawn from the Affiliate service area and include a diverse group of individuals with backgrounds in health care, other non-profits or business. Most Board members actively participate in one of these committees: Executive, Screening, Grants, Education, Medical Advisory, Advocacy, Development and Communications, Board Development or Finance. There are currently eleven Board members.



**Figure 1.1.** Komen Central and Western Oklahoma organizational chart

**Affiliate Service Area**

The Affiliate serves 47 of the 77 counties in the State of Oklahoma (Figure 1.2). The service area includes both densely populated urban counties as well as sparsely populated rural counties. The rural areas are primarily west of the central core of the service area which includes urban counties, located primarily along the Interstate 35 and Interstate 40 corridors. This urbanization begins north of Oklahoma City (Oklahoma County) south to Norman (Cleveland County) east to Midwest City (Oklahoma County) and west to Yukon (Canadian County). Even the densely populated counties also have rural areas with low population densities and some agricultural economies. Since the Affiliate expansion now encompasses such a large area, work is in progress to divide the service area into regions: Central, North Central, South Central, Western, Northwestern and Southwestern Oklahoma. The regions are not equal in size or population, but rather are drawn to closely parallel where people may access breast cancer services.

Oklahoma is the home of 39 federally recognized tribes. In the Affiliate service area, 21 of the 39 tribes have tribal land. Moreover, the service area includes Oklahoma City, which includes the third largest urban American Indian/Alaskan Native population in the US.

# KOMEN CENTRAL AND WESTERN OKLAHOMA SERVICE AREA

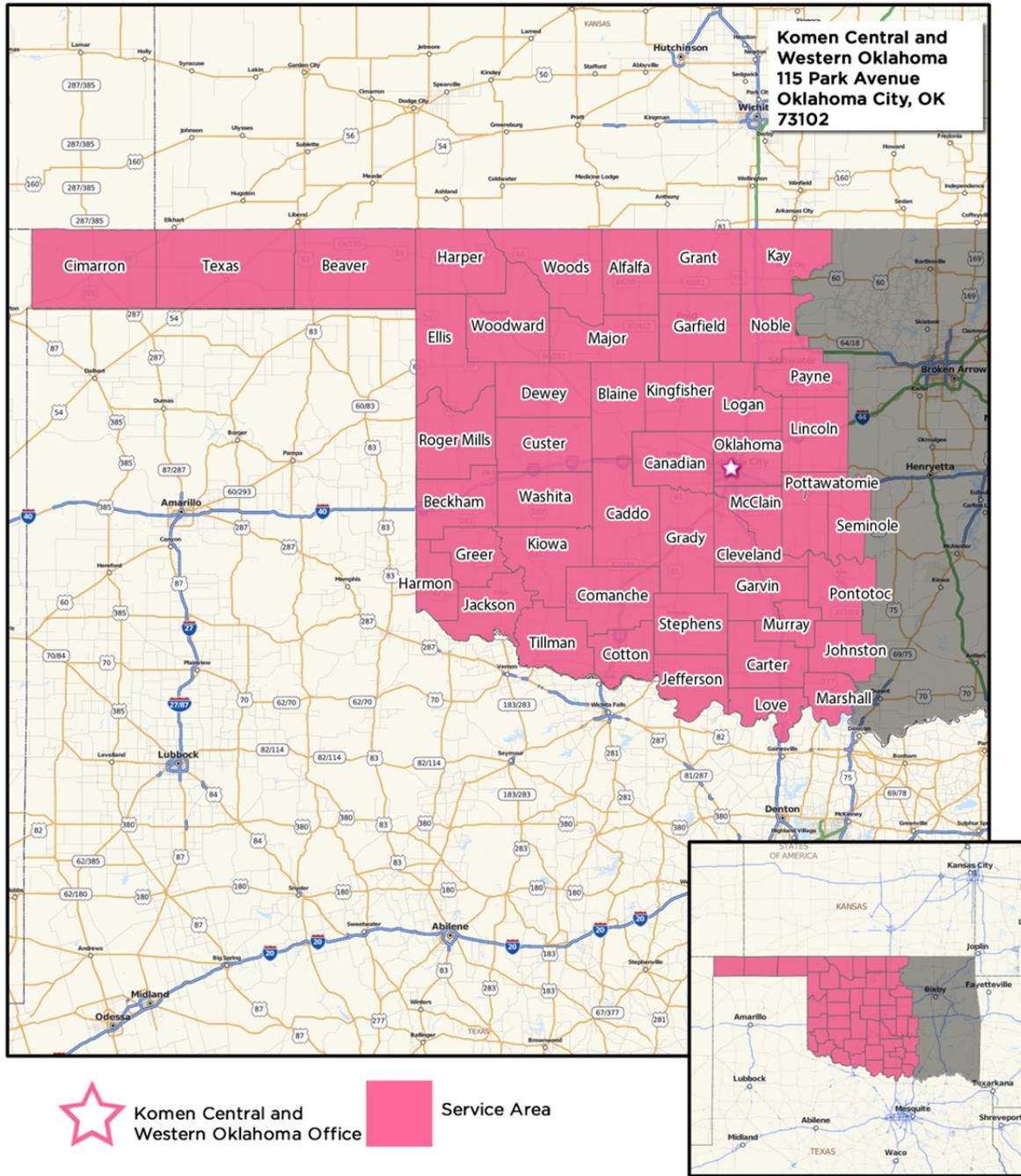


Figure 1.2. Susan G. Komen Central and Western Oklahoma service area

## **Purpose of the Community Profile Report**

The purpose of the Community Profile is to provide a thorough assessment of breast health in the Komen Central and Western Oklahoma service area. The Affiliate identified service, access, and education/awareness gaps, established priorities for improving breast health services and evaluated the impact of public health programs and policies on the community. This report serves as the basis for goals included in the Affiliate's Strategic Plan and the strategies to reach those goals. This document will also drive grantmaking programs to ensure grant dollars are properly utilized by those most in need.

The Community Profile has long served Affiliate partners as a reference for their own strategies in the area of breast health. It is also available on the Affiliate's website to the public as a resource for available services and as a reliable and respected reference tool.

Work on the Community Profile started in March 2014 and will be completed in 2015. All of the research and writing was completed with the help of the Komen staff and those partners listed in the Acknowledgment Section.

# Quantitative Data: Measuring Breast Cancer Impact in Local Communities

## **Quantitative Data Report**

### **Introduction**

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

The data provided in the report are used to identify priorities within the Affiliate's service area based on estimates of how long it would take an area to achieve Healthy People 2020 objectives for breast cancer late-stage diagnosis and death rates (<http://www.healthypeople.gov/2020/default.aspx>).

The following is a summary of Komen® Central and Western Oklahoma's Quantitative Data Report. For a full report please contact the Affiliate.

### **Breast Cancer Statistics**

#### ***Incidence rates***

The breast cancer incidence rate shows the frequency of new cases of breast cancer among women living in an area during a certain time period (Table 2.1). Incidence rates may be calculated for all women or for specific groups of women (e.g. for Asian/Pacific Islander women living in the area).

The female breast cancer incidence rate is calculated as the number of females in an area who were diagnosed with breast cancer divided by the total number of females living in that area. Incidence rates are usually expressed in terms of 100,000 people. For example, suppose there are 50,000 females living in an area and 60 of them are diagnosed with breast cancer during a certain time period. Sixty out of 50,000 is the same as 120 out of 100,000. So the female breast cancer incidence rate would be reported as 120 per 100,000 for that time period.

When comparing breast cancer rates for an area where many older people live to rates for an area where younger people live, it's hard to know whether the differences are due to age or whether other factors might also be involved. To account for age, breast cancer rates are usually adjusted to a common standard age distribution. Using age-adjusted rates makes it possible to spot differences in breast cancer rates caused by factors other than differences in age between groups of women.

To show trends (changes over time) in cancer incidence, data for the annual percent change in the incidence rate over a five-year period were included in the report. The annual percent change is the average year-to-year change of the incidence rate. It may be either a positive or negative number.

- A negative value means that the rates are getting lower.

- A positive value means that the rates are getting higher.
- A positive value (rates getting higher) may seem undesirable—and it generally is. However, it's important to remember that an increase in breast cancer incidence could also mean that more breast cancers are being found because more women are getting mammograms. So higher rates don't necessarily mean that there has been an increase in the occurrence of breast cancer.

### ***Death rates***

The breast cancer death rate shows the frequency of death from breast cancer among women living in a given area during a certain time period (Table 2.1). Like incidence rates, death rates may be calculated for all women or for specific groups of women (e.g. Black/African-American women).

The death rate is calculated as the number of women from a particular geographic area who died from breast cancer divided by the total number of women living in that area. Death rates are shown in terms of 100,000 women and adjusted for age.

Data are included for the annual percent change in the death rate over a five-year period.

The meanings of these data are the same as for incidence rates, with one exception. Changes in screening don't affect death rates in the way that they affect incidence rates. So a negative value, which means that death rates are getting lower, is always desirable. A positive value, which means that death rates are getting higher, is always undesirable.

### ***Late-stage incidence rates***

For this report, late-stage breast cancer is defined as regional or distant stage using the Surveillance, Epidemiology and End Results (SEER) Summary Stage definitions (<http://seer.cancer.gov/tools/ssm/>). State and national reporting usually uses the SEER Summary Stage. It provides a consistent set of definitions of stages for historical comparisons.

The late-stage breast cancer incidence rate is calculated as the number of women with regional or distant breast cancer in a particular geographic area divided by the number of women living in that area (Table 2.1). Late-stage incidence rates are shown in terms of 100,000 women and adjusted for age.

**Table 2.1.** Female breast cancer incidence rates and trends, death rates and trends, and late-stage rates and trends

Population Group	Incidence Rates and Trends				Death Rates and Trends			Late-stage Rates and Trends		
	Female Population (Annual Average)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of Deaths (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)
US	154,540,194	182,234	122.1	-0.2%	40,736	22.6	-1.9%	64,590	43.8	-1.2%
HP2020	-	-	-	-	-	20.6*	-	-	41.0*	-
Oklahoma	1,857,419	2,568	121.7	-0.8%	520	23.9	-1.3%	931	44.8	-1.6%
Komen Central and Western Oklahoma Service Area	1,059,333	1,415	121.3	-1.1%	276	23.0	NA	516	44.8	-1.8%
White	863,507	1,227	120.4	-2.1%	241	22.6	NA	435	43.5	-3.2%
Black/African-American	97,537	94	124.8	8.0%	24	33.6	NA	46	59.1	10.6%
American Indian/Alaska Native (AIAN)	71,372	64	120.8	-4.8%	9	18.0	NA	25	46.4	-11.6%
Asian Pacific Islander (API)	26,916	18	83.0	10.3%	SN	SN	SN	7	32.9	0.5%
Non-Hispanic/ Latina	963,756	1,370	122.1	-0.8%	272	23.4	NA	497	45.0	-1.6%
Hispanic/ Latina	95,576	46	105.1	-5.9%	4	9.9	NA	19	42.4	-7.9%
Alfalfa County - OK	2,316	4	114.2	-25.8%	SN	SN	SN	SN	SN	SN
Beaver County - OK	2,748	SN	SN	SN	SN	SN	SN	SN	SN	SN
Beckham County - OK	10,176	13	105.2	3.8%	SN	SN	SN	5	37.1	17.9%
Blaine County - OK	5,019	9	115.2	-0.9%	SN	SN	SN	SN	SN	SN
Caddo County - OK	14,271	18	108.1	-9.9%	4	21.9	-0.8%	6	33.8	-27.2%
Canadian County - OK	55,312	68	116.3	-4.5%	12	20.5	-2.0%	24	40.7	-6.1%
Carter County - OK	24,065	35	119.3	-4.4%	8	26.5	-2.4%	15	50.3	1.7%
Cimarron County - OK	1,254	SN	SN	SN	SN	SN	SN	SN	SN	SN
Cleveland County - OK	123,344	128	107.0	-5.8%	22	19.3	-1.8%	42	35.2	-3.7%
Comanche County - OK	57,983	63	110.6	-2.7%	12	21.2	-1.9%	23	41.7	-6.8%
Cotton County - OK	3,164	5	116.5	12.2%	SN	SN	SN	SN	SN	SN
Custer County - OK	13,562	16	111.1	-4.4%	3	20.1	-0.5%	6	38.5	-13.6%
Dewey County - OK	2,377	4	117.0	-6.4%	SN	SN	SN	SN	SN	SN
Ellis County - OK	2,071	SN	SN	SN	SN	SN	SN	SN	SN	SN
Garfield County - OK	30,087	41	107.7	-1.6%	10	25.6	-0.7%	12	31.3	2.3%
Garvin County - OK	14,053	22	124.4	4.3%	3	19.1	-4.3%	8	52.4	-15.3%
Grady County - OK	25,965	28	96.3	-5.8%	6	18.0	-2.5%	11	36.3	-10.2%
Grant County - OK	2,319	4	120.0	12.9%	SN	SN	SN	SN	SN	SN
Greer County - OK	2,670	4	109.9	NA	SN	SN	SN	SN	SN	SN
Harmon County - OK	1,491	SN	SN	SN	SN	SN	SN	SN	SN	SN
Harper County - OK	1,811	SN	SN	SN	SN	SN	SN	SN	SN	SN
Jackson County - OK	13,258	18	130.3	-5.0%	SN	SN	SN	8	56.1	1.1%

Population Group	Incidence Rates and Trends				Death Rates and Trends			Late-stage Rates and Trends		
	Female Population (Annual Average)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of Deaths (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)
Jefferson County - OK	3,246	4	89.3	-10.9%	SN	SN	SN	SN	SN	SN
Johnston County - OK	5,470	8	122.4	-5.8%	SN	SN	SN	4	60.0	-12.4%
Kay County - OK	23,570	37	122.5	22.2%	8	26.8	NA	13	45.1	9.7%
Kingfisher County - OK	7,450	14	161.4	-2.6%	SN	SN	SN	6	64.5	7.3%
Kiowa County - OK	4,808	9	130.9	12.5%	SN	SN	SN	4	59.3	SN
Lincoln County - OK	17,031	21	107.9	-0.1%	6	30.9	-1.2%	7	38.1	-12.7%
Logan County - OK	20,117	23	102.7	-1.0%	5	20.5	-1.3%	8	34.8	-1.8%
Love County - OK	4,733	7	119.2	13.1%	SN	SN	SN	SN	SN	SN
McClain County - OK	16,690	23	123.6	-7.3%	4	20.7	-4.2%	8	40.5	-6.3%
Major County - OK	3,797	7	135.4	-2.3%	SN	SN	SN	SN	SN	SN
Marshall County - OK	7,759	12	124.0	8.4%	SN	SN	SN	4	41.9	13.0%
Murray County - OK	6,623	9	99.5	-6.9%	SN	SN	SN	4	45.5	-22.6%
Noble County - OK	5,803	9	115.5	-5.5%	SN	SN	SN	4	55.9	-11.2%
Oklahoma County - OK	360,394	525	136.5	-0.8%	98	24.6	-0.8%	188	49.4	-0.3%
Payne County - OK	37,202	45	131.0	-10.3%	9	25.8	-19.4%	19	56.3	1.2%
Pontotoc County - OK	18,880	22	95.9	3.8%	5	20.2	-2.1%	8	37.3	22.1%
Pottawatomie County - OK	35,741	51	125.9	6.5%	11	28.1	-2.0%	20	50.9	-5.2%
Roger Mills County - OK	1,782	3	115.5	4.9%	SN	SN	SN	SN	SN	SN
Seminole County - OK	12,946	16	101.2	11.3%	4	24.8	NA	5	32.1	NA
Stephens County - OK	22,810	36	119.0	-6.1%	7	21.5	-3.4%	14	48.3	-3.6%
Texas County - OK	9,554	11	115.9	23.3%	SN	SN	SN	4	37.6	32.3%
Tillman County - OK	4,077	7	123.3	8.6%	SN	SN	SN	SN	SN	SN
Washita County - OK	5,922	10	130.1	-0.7%	SN	SN	SN	3	41.4	-13.2%
Woods County - OK	4,087	7	126.7	-2.4%	SN	SN	SN	SN	SN	SN
Woodward County - OK	9,526	12	101.1	5.2%	SN	SN	SN	5	41.4	NA

\*Target as of the writing of this report.

NA – data not available.

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

Data are for years 2006-2010.

Rates are in cases or deaths per 100,000.

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

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

Source of death rate data: Centers for Disease Control and Prevention (CDC) – National Center for Health Statistics (NCHS) death 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 in the Komen Central and Western Oklahoma service area was similar to that observed in the US as a whole and the incidence trend was lower than 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 Oklahoma.

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

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

- Kingfisher County
- Oklahoma County

The incidence rate was significantly lower in the following counties:

- Cleveland County
- Grady County
- Pontotoc County

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

- Kay County

Significantly more favorable trends in breast cancer incidence rates were observed in the following counties:

- Alfalfa 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 Central and Western Oklahoma 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 Oklahoma.

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

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 Central and Western Oklahoma service area was similar to 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 Oklahoma.

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

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

- Cleveland County
- Garfield County

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

- Texas 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 Comprehensive Cancer Network	US Preventive Services Task Force
<p>Informed decision-making with a health care provider at age 40</p> <p>Mammography every year starting at age 45</p> <p>Mammography every other year beginning at age 55</p>	<p>Mammography every year starting at age 40</p>	<p>Informed decision-making with a health care provider ages 40-49</p> <p>Mammography every 2 years ages 50-74</p>

\*As of October 2015

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. 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%
Oklahoma	3,034	2,076	69.1%	67.0%-71.2%
Komen Central and Western Oklahoma Service Area	1,584	1,108	70.7%	67.8%-73.5%
White	1,383	970	71.0%	68.0%-73.9%
Black/African-American	85	61	71.6%	57.8%-82.2%
AIAN	79	59	74.7%	61.6%-84.5%
API	12	8	78.7%	39.7%-95.4%
Hispanic/ Latina	46	25	51.7%	32.8%-70.1%
Non-Hispanic/ Latina	1,537	1,082	71.4%	68.5%-74.2%
Alfalfa County - OK	SN	SN	SN	SN
Beaver County - OK	SN	SN	SN	SN
Beckham County - OK	18	8	37.6%	14.5%-68.0%
Blaine County - OK	SN	SN	SN	SN
Caddo County - OK	42	32	71.5%	53.9%-84.3%
Canadian County - OK	146	100	71.4%	61.6%-79.5%
Carter County - OK	59	30	48.8%	33.6%-64.2%
Cimarron County - OK	SN	SN	SN	SN
Cleveland County - OK	118	80	65.8%	55.2%-75.0%
Comanche County - OK	95	73	73.1%	60.2%-83.0%
Cotton County - OK	SN	SN	SN	SN
Custer County - OK	28	21	84.8%	59.1%-95.6%
Dewey County - OK	SN	SN	SN	SN

Population Group	# of Women Interviewed (Sample Size)	# w/ Self-Reported Mammogram	Proportion Screened (Weighted Average)	Confidence Interval of Proportion Screened
Ellis County - OK	SN	SN	SN	SN
Garfield County - OK	76	49	61.7%	48.2%-73.7%
Garvin County - OK	36	21	57.4%	37.9%-74.9%
Grady County - OK	53	40	72.3%	55.0%-84.8%
Grant County - OK	SN	SN	SN	SN
Greer County - OK	SN	SN	SN	SN
Harmon County - OK	SN	SN	SN	SN
Harper County - OK	SN	SN	SN	SN
Jackson County - OK	27	18	62.8%	37.3%-82.7%
Jefferson County - OK	SN	SN	SN	SN
Johnston County - OK	SN	SN	SN	SN
Kay County - OK	36	26	76.6%	56.1%-89.4%
Kingfisher County - OK	26	19	76.8%	53.4%-90.5%
Kiowa County - OK	SN	SN	SN	SN
Lincoln County - OK	31	21	62.4%	41.8%-79.3%
Logan County - OK	48	33	65.6%	47.2%-80.2%
Love County - OK	SN	SN	SN	SN
Major County - OK	SN	SN	SN	SN
Marshall County - OK	30	18	58.9%	38.8%-76.4%
McClain County - OK	38	27	63.2%	42.7%-79.9%
Murray County - OK	11	8	66.7%	33.3%-88.9%
Noble County - OK	SN	SN	SN	SN
Oklahoma County - OK	361	272	76.4%	70.7%-81.4%
Payne County - OK	52	34	71.2%	53.8%-84.0%
Pontotoc County - OK	35	25	78.5%	56.9%-91.0%
Pottawatomie County - OK	95	66	72.8%	61.4%-81.8%
Roger Mills County - OK	SN	SN	SN	SN
Seminole County - OK	25	16	67.9%	40.8%-86.7%
Stephens County - OK	53	36	71.2%	53.1%-84.4%
Texas County - OK	19	12	61.8%	35.0%-82.9%
Tillman County - OK	SN	SN	SN	SN
Washita County - OK	SN	SN	SN	SN
Woods County - OK	SN	SN	SN	SN
Woodward County - OK	26	23	90.5%	65.6%-98.0%

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 Central and Western Oklahoma 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 Oklahoma.

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

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

- Carter 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 %
Oklahoma	78.9 %	8.6 %	10.3 %	2.2 %	91.5 %	8.5 %	47.2 %	34.6 %	15.2 %
Komen Central and Western Oklahoma Service Area	80.8 %	9.5 %	7.0 %	2.7 %	89.9 %	10.1 %	45.8 %	33.5 %	14.6 %
Alfalfa County - OK	96.1 %	1.2 %	2.5 %	0.2 %	96.3 %	3.7 %	58.8 %	46.8 %	25.2 %
Beaver County - OK	96.4 %	1.2 %	2.0 %	0.4 %	80.4 %	19.6 %	51.7 %	38.1 %	16.2 %
Beckham County - OK	92.3 %	2.5 %	4.5 %	0.7 %	91.3 %	8.7 %	46.8 %	34.8 %	15.8 %
Blaine County - OK	84.0 %	4.3 %	11.1 %	0.6 %	91.9 %	8.1 %	52.7 %	41.4 %	20.5 %
Caddo County - OK	67.0 %	2.7 %	29.8 %	0.5 %	91.3 %	8.7 %	49.6 %	36.7 %	17.2 %
Canadian County - OK	88.1 %	2.7 %	5.8 %	3.4 %	93.2 %	6.8 %	45.1 %	31.3 %	12.3 %
Carter County - OK	79.3 %	8.0 %	11.4 %	1.3 %	94.5 %	5.5 %	49.3 %	36.8 %	16.7 %
Cimarron County - OK	97.6 %	1.0 %	1.0 %	0.4 %	82.0 %	18.0 %	55.5 %	44.7 %	24.5 %
Cleveland County - OK	84.6 %	5.1 %	5.8 %	4.6 %	93.0 %	7.0 %	42.3 %	30.0 %	11.8 %
Comanche County - OK	69.3 %	19.4 %	7.0 %	4.3 %	88.9 %	11.1 %	41.2 %	28.9 %	11.9 %
Cotton County - OK	83.4 %	3.2 %	12.7 %	0.6 %	93.9 %	6.1 %	52.7 %	40.3 %	18.7 %
Custer County - OK	86.9 %	3.7 %	7.9 %	1.6 %	85.7 %	14.3 %	41.7 %	31.5 %	14.8 %
Dewey County - OK	91.9 %	1.0 %	6.4 %	0.7 %	95.5 %	4.5 %	56.1 %	44.1 %	23.4 %
Ellis County - OK	96.9 %	0.7 %	2.1 %	0.3 %	93.5 %	6.5 %	54.8 %	43.6 %	20.7 %
Garfield County - OK	90.1 %	3.6 %	3.2 %	3.1 %	91.0 %	9.0 %	49.0 %	37.1 %	17.4 %
Garvin County - OK	86.6 %	3.4 %	9.4 %	0.6 %	94.1 %	5.9 %	51.4 %	39.0 %	18.8 %
Grady County - OK	89.2 %	3.1 %	7.0 %	0.7 %	95.3 %	4.7 %	49.6 %	36.2 %	15.7 %
Grant County - OK	94.7 %	2.2 %	2.7 %	0.4 %	96.8 %	3.2 %	56.7 %	44.2 %	23.2 %
Greer County - OK	93.2 %	3.4 %	3.1 %	0.3 %	89.0 %	11.0 %	54.8 %	42.7 %	22.9 %
Harmon County - OK	88.2 %	8.9 %	2.4 %	0.5 %	73.2 %	26.8 %	50.3 %	37.9 %	18.5 %
Harper County - OK	98.1 %	0.7 %	0.9 %	0.4 %	83.7 %	16.3 %	51.6 %	40.8 %	21.2 %
Jackson County - OK	86.0 %	8.6 %	3.2 %	2.2 %	79.0 %	21.0 %	44.9 %	32.8 %	14.6 %
Jefferson County - OK	89.9 %	1.7 %	7.9 %	0.5 %	91.8 %	8.2 %	54.0 %	42.2 %	20.5 %
Johnston County - OK	77.8 %	3.0 %	18.8 %	0.3 %	96.1 %	3.9 %	49.9 %	37.5 %	17.6 %
Kay County - OK	85.2 %	2.7 %	11.4 %	0.8 %	93.8 %	6.2 %	51.1 %	39.6 %	19.2 %
Kingfisher County - OK	93.6 %	1.7 %	4.3 %	0.4 %	87.5 %	12.5 %	49.1 %	36.1 %	16.8 %
Kiowa County - OK	85.3 %	5.4 %	8.9 %	0.4 %	90.7 %	9.3 %	54.6 %	42.6 %	20.0 %
Lincoln County - OK	89.1 %	2.5 %	8.1 %	0.3 %	97.5 %	2.5 %	51.9 %	38.2 %	16.7 %
Logan County - OK	84.6 %	10.5 %	4.0 %	0.9 %	94.7 %	5.3 %	48.1 %	34.6 %	13.4 %
Love County - OK	87.4 %	3.3 %	8.8 %	0.4 %	88.4 %	11.6 %	50.9 %	38.1 %	18.2 %
McClain County - OK	90.5 %	1.3 %	7.6 %	0.6 %	93.5 %	6.5 %	48.8 %	34.6 %	14.2 %

Population Group	White	Black /African-American	AIAN	API	Non-Hispanic /Latina	Hispanic /Latina	Female Age 40 Plus	Female Age 50 Plus	Female Age 65 Plus
Major County - OK	94.8 %	1.5 %	3.2 %	0.6 %	92.7 %	7.3 %	53.3 %	40.9 %	20.4 %
Marshall County - OK	85.2 %	2.5 %	12.1 %	0.3 %	86.2 %	13.8 %	54.6 %	42.9 %	21.3 %
Murray County - OK	82.4 %	2.2 %	14.9 %	0.5 %	95.1 %	4.9 %	52.6 %	39.8 %	18.3 %
Noble County - OK	86.9 %	2.3 %	10.2 %	0.5 %	97.3 %	2.7 %	52.7 %	39.0 %	18.7 %
Oklahoma County - OK	74.0 %	17.6 %	4.8 %	3.6 %	85.7 %	14.3 %	44.7 %	32.3 %	13.7 %
Payne County - OK	86.0 %	4.3 %	6.0 %	3.7 %	96.1 %	3.9 %	36.7 %	27.2 %	12.0 %
Pontotoc County - OK	75.5 %	3.2 %	20.5 %	0.9 %	96.0 %	4.0 %	46.9 %	35.1 %	16.6 %
Pottawatomie County - OK	80.3 %	4.2 %	14.5 %	1.0 %	95.9 %	4.1 %	47.5 %	34.5 %	15.6 %
Roger Mills County - OK	90.5 %	1.4 %	7.6 %	0.5 %	94.4 %	5.6 %	49.7 %	37.8 %	17.6 %
Seminole County - OK	72.2 %	5.8 %	21.4 %	0.5 %	96.4 %	3.6 %	50.3 %	37.7 %	17.2 %
Stephens County - OK	90.1 %	2.6 %	6.7 %	0.7 %	93.8 %	6.2 %	52.6 %	40.1 %	19.2 %
Texas County - OK	93.5 %	1.9 %	2.2 %	2.4 %	57.7 %	42.3 %	39.6 %	27.5 %	11.1 %
Tillman County - OK	86.7 %	8.5 %	4.3 %	0.6 %	78.2 %	21.8 %	53.5 %	40.3 %	20.8 %
Washita County - OK	93.1 %	1.7 %	4.5 %	0.6 %	91.9 %	8.1 %	50.0 %	38.0 %	18.9 %
Woods County - OK	94.4 %	1.6 %	2.7 %	1.3 %	95.6 %	4.4 %	49.1 %	38.8 %	20.2 %
Woodward County - OK	94.8 %	0.8 %	3.6 %	0.8 %	90.0 %	10.0 %	47.9 %	35.9 %	16.5 %

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 %
Oklahoma	14.1 %	16.3 %	37.4 %	6.5 %	5.4 %	2.2 %	33.8 %	30.3 %	20.7 %
Komen Central and Western Oklahoma Service Area	13.8 %	15.8 %	36.0 %	6.0 %	6.3 %	2.5 %	30.2 %	24.2 %	20.1 %
Alfalfa County - OK	16.0 %	11.2 %	35.3 %	4.2 %	2.8 %	0.4 %	100.0 %	100.0 %	21.4 %
Beaver County - OK	17.9 %	13.2 %	33.0 %	4.7 %	10.2 %	3.8 %	100.0 %	0.0 %	21.3 %
Beckham County - OK	19.1 %	15.8 %	36.6 %	4.1 %	3.2 %	0.9 %	32.7 %	0.0 %	18.7 %
Blaine County - OK	18.8 %	15.6 %	38.5 %	3.9 %	6.0 %	2.1 %	57.4 %	72.7 %	20.8 %
Caddo County - OK	18.1 %	20.9 %	47.6 %	9.0 %	3.1 %	1.1 %	80.0 %	100.0 %	27.0 %
Canadian County - OK	8.8 %	7.8 %	23.5 %	5.7 %	4.5 %	1.1 %	22.5 %	3.1 %	14.5 %
Carter County - OK	16.2 %	16.2 %	41.4 %	5.0 %	2.8 %	1.3 %	56.1 %	0.0 %	23.1 %
Cimarron County - OK	21.5 %	23.7 %	45.9 %	1.6 %	10.4 %	6.8 %	100.0 %	100.0 %	28.1 %
Cleveland County - OK	9.1 %	12.1 %	27.2 %	5.1 %	5.9 %	2.0 %	16.9 %	2.0 %	15.7 %
Comanche County - OK	11.0 %	16.9 %	38.5 %	8.4 %	5.6 %	1.4 %	21.8 %	32.4 %	19.4 %
Cotton County - OK	15.7 %	13.8 %	38.9 %	4.7 %	2.4 %	0.9 %	59.5 %	100.0 %	20.4 %
Custer County - OK	16.9 %	17.7 %	35.9 %	3.7 %	5.5 %	1.9 %	30.3 %	0.0 %	20.8 %
Dewey County - OK	14.1 %	12.9 %	35.0 %	2.0 %	1.3 %	0.7 %	100.0 %	100.0 %	22.3 %
Ellis County - OK	13.0 %	15.3 %	31.4 %	2.0 %	1.9 %	0.5 %	100.0 %	0.0 %	17.9 %
Garfield County - OK	13.5 %	16.3 %	38.0 %	5.7 %	6.0 %	2.0 %	21.4 %	5.6 %	20.3 %
Garvin County - OK	17.2 %	15.0 %	43.7 %	4.9 %	3.1 %	0.6 %	68.7 %	100.0 %	21.9 %
Grady County - OK	14.7 %	14.3 %	35.5 %	4.8 %	2.1 %	0.9 %	63.9 %	0.0 %	18.5 %
Grant County - OK	9.9 %	11.6 %	34.1 %	6.5 %	0.8 %	0.0 %	100.0 %	100.0 %	19.7 %
Greer County - OK	21.6 %	11.0 %	44.1 %	2.5 %	0.6 %	0.7 %	52.7 %	100.0 %	20.0 %
Harmon County - OK	23.9 %	30.6 %	49.5 %	3.8 %	1.9 %	0.9 %	100.0 %	100.0 %	26.5 %
Harper County - OK	16.1 %	11.6 %	34.9 %	4.1 %	9.8 %	5.3 %	100.0 %	0.0 %	21.8 %
Jackson County - OK	17.6 %	18.9 %	37.8 %	7.9 %	6.4 %	2.8 %	24.8 %	0.0 %	18.2 %
Jefferson County - OK	22.9 %	18.4 %	50.0 %	3.6 %	2.4 %	0.3 %	100.0 %	100.0 %	24.8 %
Johnston County - OK	18.6 %	22.6 %	50.8 %	10.4 %	2.7 %	0.2 %	100.0 %	100.0 %	22.3 %
Kay County - OK	14.2 %	18.3 %	41.5 %	7.7 %	3.5 %	1.4 %	24.5 %	20.4 %	21.7 %
Kingfisher County - OK	15.1 %	10.4 %	33.0 %	4.2 %	6.7 %	2.4 %	72.4 %	0.0 %	21.1 %
Kiowa County - OK	15.2 %	21.2 %	48.0 %	3.7 %	1.2 %	0.5 %	61.7 %	100.0 %	22.2 %
Lincoln County - OK	14.7 %	14.8 %	42.1 %	7.4 %	0.9 %	0.2 %	92.1 %	100.0 %	22.6 %
Logan County - OK	12.8 %	14.9 %	33.4 %	6.0 %	2.4 %	0.9 %	55.4 %	100.0 %	19.1 %

Population Group	Less than HS Education	Income Below 100% Poverty	Income Below 250% Poverty (Age: 40-64)	Un-employed	Foreign Born	Linguistically Isolated	In Rural Areas	In Medically Underserved Areas	No Health Insurance (Age: 40-64)
Love County - OK	18.3 %	16.0 %	41.1 %	2.2 %	5.4 %	1.6 %	100.0 %	100.0 %	22.4 %
McClain County - OK	11.8 %	11.6 %	31.6 %	4.4 %	3.0 %	1.0 %	77.2 %	100.0 %	19.3 %
Major County - OK	14.4 %	10.4 %	34.5 %	2.4 %	4.2 %	1.7 %	100.0 %	0.0 %	19.9 %
Marshall County - OK	20.3 %	14.3 %	48.1 %	6.8 %	7.2 %	3.4 %	72.1 %	100.0 %	28.0 %
Murray County - OK	17.3 %	15.7 %	40.6 %	5.6 %	2.4 %	0.9 %	45.7 %	0.0 %	21.0 %
Noble County - OK	12.0 %	13.7 %	35.9 %	5.5 %	0.4 %	0.3 %	56.3 %	0.0 %	17.8 %
Oklahoma County - OK	14.2 %	17.3 %	36.7 %	6.5 %	10.1 %	4.4 %	6.3 %	16.4 %	21.4 %
Payne County - OK	11.0 %	23.2 %	35.2 %	4.8 %	5.9 %	2.0 %	33.7 %	0.0 %	19.2 %
Pontotoc County - OK	14.7 %	17.5 %	41.4 %	5.0 %	1.6 %	0.4 %	53.6 %	23.5 %	20.6 %
Pottawatomie County - OK	15.2 %	17.6 %	42.2 %	6.4 %	1.5 %	0.4 %	50.7 %	7.0 %	21.5 %
Roger Mills County - OK	12.0 %	14.1 %	31.9 %	3.3 %	2.3 %	0.7 %	100.0 %	100.0 %	21.2 %
Seminole County - OK	19.1 %	22.4 %	51.8 %	9.4 %	1.5 %	0.6 %	64.7 %	100.0 %	24.2 %
Stephens County - OK	15.2 %	13.0 %	36.7 %	6.4 %	2.0 %	0.8 %	43.3 %	18.8 %	19.7 %
Texas County - OK	28.0 %	14.6 %	39.1 %	6.2 %	21.2 %	9.5 %	45.1 %	0.0 %	25.8 %
Tillman County - OK	23.8 %	21.7 %	49.2 %	11.3 %	4.8 %	2.6 %	51.2 %	100.0 %	25.6 %
Washita County - OK	15.9 %	15.4 %	35.8 %	4.0 %	1.7 %	1.0 %	75.3 %	100.0 %	20.5 %
Woods County - OK	10.7 %	15.8 %	32.3 %	3.2 %	0.8 %	0.1 %	36.7 %	100.0 %	17.2 %
Woodward County - OK	15.7 %	12.4 %	31.9 %	4.1 %	5.2 %	1.6 %	43.5 %	0.0 %	19.4 %

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 Central and Western Oklahoma service area has a slightly larger White female population than the US as a whole, a slightly smaller Black/African-American female population, a substantially smaller Asian and Pacific Islander (API) female population, a substantially larger American Indian and Alaska Native (AIAN) female population, and a substantially smaller Hispanic/Latina female population. The Affiliate's female population is slightly younger than that of the US as a whole. The Affiliate's education level is slightly higher than and income level is slightly lower than those of the US as a whole. There are a slightly smaller 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 slightly 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 slightly 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:

- Comanche County
- Oklahoma County

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

- Blaine County
- Caddo County
- Carter County
- Cotton County
- Johnston County
- Kay County
- Marshall County
- Murray County
- Noble County
- Pontotoc County
- Pottawatomie County
- Seminole County

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

- Beaver County
- Cimarron County
- Harmon County
- Harper County
- Jackson County
- Texas County
- Tillman County

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

- Alfalfa County
- Blaine County
- Cimarron County
- Dewey County
- Ellis County
- Grant County
- Greer County
- Harper County
- Jefferson County
- Kiowa County
- Major County

- Marshall County
- Tillman County

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

- Beckham County
- Blaine County
- Cimarron County
- Greer County
- Harmon County
- Jefferson County
- Marshall County
- Seminole County
- Texas County
- Tillman County

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

- Caddo County
- Cimarron County
- Harmon County
- Johnston County
- Kiowa County
- Seminole County
- Tillman County

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

- Johnston County
- Seminole County
- Tillman County

The county with a substantial foreign born and linguistically isolated population is:

- Texas County

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

- Caddo County
- Cimarron County
- Harmon County
- Marshall County
- Texas County
- Tillman 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: 20.6 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 Central and Western Oklahoma service area are progressing toward these targets, the report uses the following information:

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

These data are used to estimate how many years it will take for each county to meet the HP2020 objectives. Because the target date for meeting the objective is 2020, and 2008 (the middle of the 2006-2010 period) was used as a starting point, a county has 12 years to meet the target.

Death rate and late-stage diagnosis data and trends are used to calculate whether an area will meet the HP2020 target, assuming that the trend seen in years 2006 to 2010 continues for 2011 and beyond.

### ***Identification of priority areas***

The purpose of this report is to combine evidence from many credible sources and use the data to identify the highest priority areas for breast cancer programs (i.e. the areas of greatest need). Classification of priority areas are based on the time needed to achieve HP2020 targets in each area. These time projections depend on both the starting point and the trends in death rates and late-stage incidence.

Late-stage incidence reflects both the overall breast cancer incidence rate in the population and the mammography screening coverage. The breast cancer death rate reflects the access to care and the quality of care in the health care delivery area, as well as cancer stage at diagnosis.

There has not been any indication that either one of the two HP2020 targets is more important than the other. Therefore, the report considers them equally important.

Counties are classified as follows (Table 2.6):

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

**Table 2.6.** Needs/priority classification based on the projected time to achieve HP2020 breast cancer targets.

		Time to Achieve Late-stage Incidence Reduction Target				
		13 years or longer	7-12 yrs.	0 – 6 yrs.	Currently meets target	Unknown
Time to Achieve Death Rate Reduction Target	13 years or longer	Highest	High	Medium High	Medium	Highest
	7-12 yrs.	High	Medium High	Medium	Medium Low	Medium High
	0 – 6 yrs.	Medium High	Medium	Medium Low	Low	Medium Low
	Currently meets target	Medium	Medium Low	Low	Lowest	Lowest
	Unknown	Highest	Medium High	Medium Low	Lowest	Unknown

If the time to achieve a target cannot be calculated for one of the HP2020 indicators, then the county is classified based on the other indicator. If both indicators are missing, then the county is not classified. This doesn't mean that the county may not have high needs; it only means that sufficient data are not available to classify the county.

**Affiliate Service Area Healthy People 2020 Forecasts and Priority Areas**

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

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

Trends can change for a number of reasons, including:

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

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

**Table 2.7.** Intervention priorities for Komen Central and Western Oklahoma 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
Beckham County - OK	Highest	SN	13 years or longer	Education
Garfield County - OK	Highest	13 years or longer	13 years or longer	
Jackson County - OK	Highest	SN	13 years or longer	%Hispanic/Latina
Kay County - OK	Highest	NA	13 years or longer	%AIAN
Kingfisher County - OK	Highest	SN	13 years or longer	Rural
Marshall County - OK	Highest	SN	13 years or longer	%AIAN, older, education, rural, insurance, medically underserved
Oklahoma County - OK	Highest	13 years or longer	13 years or longer	%Black/African-American
Texas County - OK	Highest	SN	13 years or longer	%Hispanic/Latina, education, foreign, language, rural, insurance
Carter County - OK	High	11 years	13 years or longer	%AIAN, rural
Payne County - OK	Medium High	2 years	13 years or longer	
Pottawatomie County - OK	Medium High	13 years or longer	5 years	%AIAN, rural
Lincoln County - OK	Medium	13 years or longer	Currently meets target	Rural, medically underserved
Pontotoc County - OK	Medium	Currently meets target	13 years or longer	%AIAN, rural
Caddo County - OK	Medium Low	8 years	Currently meets target	%AIAN, poverty, rural, insurance, medically underserved
Comanche County - OK	Medium Low	2 years	1 year	%Black/African-American, medically underserved
Johnston County - OK	Medium Low	SN	3 years	%AIAN, poverty, employment, rural, medically underserved
Murray County - OK	Medium Low	SN	1 year	%AIAN, rural

<b>County</b>	<b>Priority</b>	<b>Predicted Time to Achieve Death Rate Target</b>	<b>Predicted Time to Achieve Late-stage Incidence Target</b>	<b>Key Population Characteristics</b>
Noble County - OK	Medium Low	SN	3 years	%AIAN, rural
Stephens County - OK	Medium Low	2 years	5 years	Rural
Washita County - OK	Medium Low	SN	1 year	Rural, medically underserved
Garvin County - OK	Low	Currently meets target	2 years	Rural, medically underserved
McClain County - OK	Low	1 year	Currently meets target	Rural, medically underserved
Canadian County - OK	Lowest	Currently meets target	Currently meets target	
Cleveland County - OK	Lowest	Currently meets target	Currently meets target	
Custer County - OK	Lowest	Currently meets target	Currently meets target	
Grady County - OK	Lowest	Currently meets target	Currently meets target	Rural
Logan County - OK	Lowest	Currently meets target	Currently meets target	Rural, medically underserved
Alfalfa County - OK	Undetermined	SN	SN	Older, rural, medically underserved
Beaver County - OK	Undetermined	SN	SN	%Hispanic/Latina, rural
Blaine County - OK	Undetermined	SN	SN	%AIAN, older, education, rural, medically underserved
Cimarron County - OK	Undetermined	SN	SN	%Hispanic/Latina, older, education, poverty, language, rural, insurance, medically underserved
Cotton County - OK	Undetermined	SN	SN	%AIAN, rural, medically underserved
Dewey County - OK	Undetermined	SN	SN	Older, rural, medically underserved
Ellis County - OK	Undetermined	SN	SN	Older, rural
Grant County - OK	Undetermined	SN	SN	Older, rural, medically underserved
Greer County - OK	Undetermined	SN	SN	Older, education, rural, medically underserved

<b>County</b>	<b>Priority</b>	<b>Predicted Time to Achieve Death Rate Target</b>	<b>Predicted Time to Achieve Late-stage Incidence Target</b>	<b>Key Population Characteristics</b>
Harmon County - OK	Undetermined	SN	SN	%Hispanic/Latina, education, poverty, rural, insurance, medically underserved
Harper County - OK	Undetermined	SN	SN	%Hispanic/Latina, older, rural
Jefferson County - OK	Undetermined	SN	SN	Older, education, rural, medically underserved
Kiowa County - OK	Undetermined	SN	SN	Older, poverty, rural, medically underserved
Love County - OK	Undetermined	SN	SN	Rural, medically underserved
Major County - OK	Undetermined	SN	SN	Older, rural
Roger Mills County - OK	Undetermined	SN	SN	Rural, medically underserved
Seminole County - OK	Undetermined	NA	NA	%AIAN, education, poverty, employment, rural, medically underserved
Tillman County - OK	Undetermined	SN	SN	%Hispanic/Latina, older, education, poverty, employment, rural, insurance, medically underserved
Woods County - OK	Undetermined	SN	SN	Rural, medically underserved
Woodward County - OK	Undetermined	SN	NA	Rural

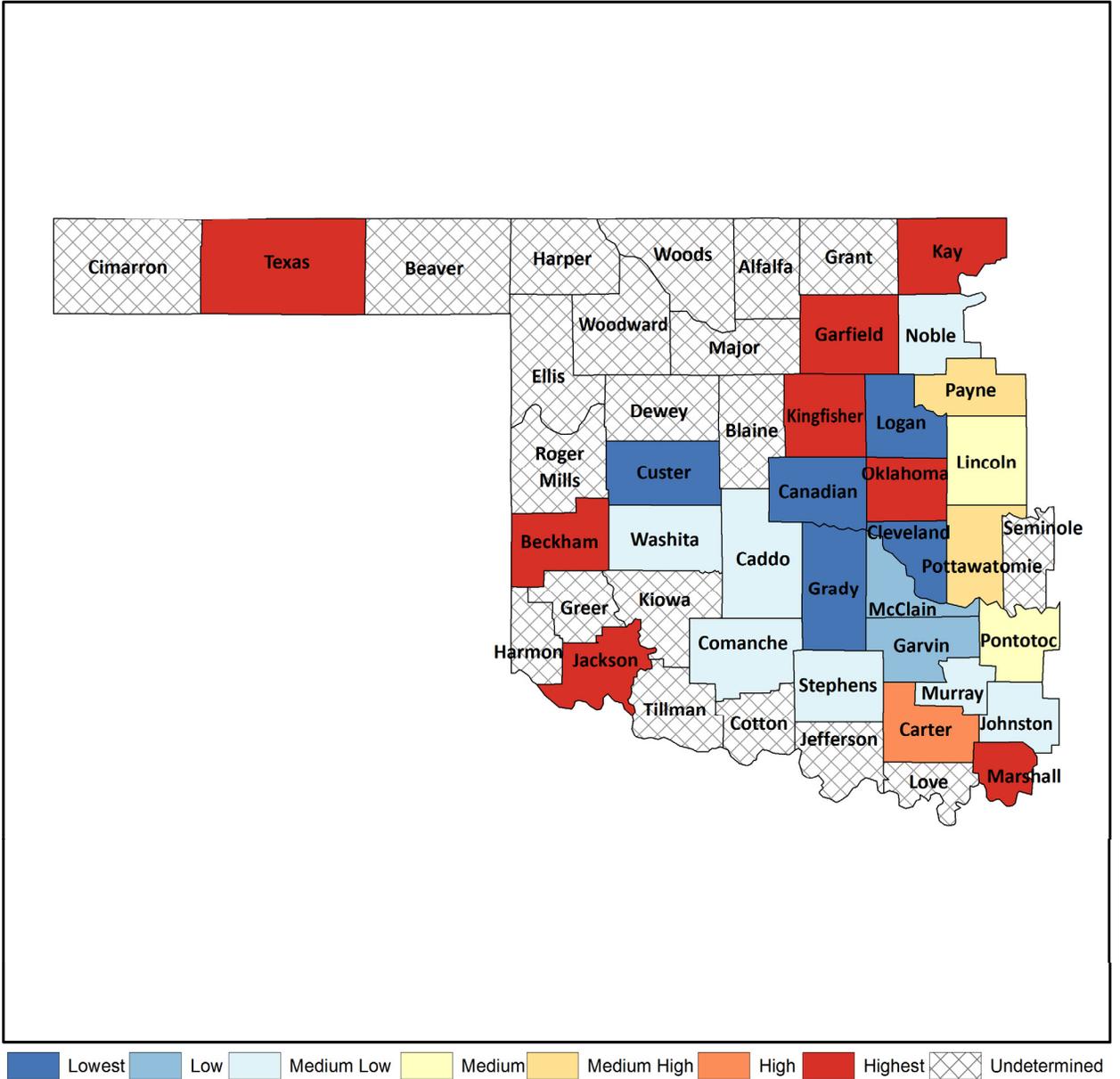
NA – data not available.

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.

**Komen Central and Western Oklahoma Affiliate Counties** **Priority Areas**



**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***

Eight counties in the Komen Central and Western Oklahoma service area are in the highest priority category. Two of the eight, Garfield County and Oklahoma County, are not likely to meet either the death rate or late-stage incidence rate HP2020 targets. Six of the eight, Beckham County, Jackson County, Kay County, Kingfisher County, Marshall County and Texas County, are not likely to meet the late-stage incidence rate HP2020 target.

The incidence rates in Kingfisher County (161.4 per 100,000) and Oklahoma County (136.5 per 100,000) are significantly higher than the Affiliate service area as a whole (121.3 per 100,000). Incidence trends in Kay County (22.2 percent per year) are significantly less favorable than the Affiliate service area as a whole (-1.1 percent per year). Late-stage incidence trends in Texas County (32.3 percent per year) are significantly less favorable than the Affiliate service area as a whole (-1.8 percent per year).

Beckham County has low education levels. Jackson County has a relatively large Hispanic/Latina population. Kay County has a relatively large AIAN population. Marshall County has a relatively large AIAN population, an older population and low education levels. Oklahoma County has a relatively large Black/African-American population. Texas County has a relatively large Hispanic/Latina population, low education levels, a relatively large foreign-born population and a relatively large number of households with little English.

### ***High priority areas***

One county in the Komen Central and Western Oklahoma service area is in the high priority category. Carter County is not likely to meet the late-stage incidence rate HP2020 target.

Screening percentages in Carter County (49.0 percent) are significantly lower than the Affiliate service area as a whole (71.0 percent).

Carter County has a relatively large AIAN population.

### **Selection of Target Communities**

Susan G. Komen® Central and Western Oklahoma is dedicated to delivering necessary resources for breast cancer prevention and early detection to medically underserved individuals across the 47-county service area. This vast, diverse area is faced with many barriers, which were considered when choosing target communities. In an effort to strategically approach these communities, the service area is divided into regions – Northeast, Southeast, Southwest, Northwest, and Central.

The selected high priority counties will be the primary focus of the regions, and are described as those that have the greatest risk and vulnerability to breast cancer incidence and death rates due to gaps in the Continuum of Care and/or limited access to quality health care services. Over the next three years, the Affiliate will focus on reaching the high priority counties according to their respective region in hopes the message(s) will expand beyond the borders, into the surrounding counties. As a result, twelve counties have been selected and are discussed by region below.

In addition to Healthy People 2020, key indicators considered for 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
- Population size
- Geographical location
- Residents living below poverty level
- Residents living without health insurance
- Unemployment percentage
- Residents who are linguistically isolated and/or foreign born

The selected high priority counties within the target communities, or regions, are:

- Northeast Region: Garfield County
- Southeast Region: Carter County
- Southwest Region: Comanche County
- Northwest Region: Texas County
- Central Region: Oklahoma County

**Northeast Region (Garfield County, Oklahoma):**

Garfield County, situated in north central Oklahoma, is highly populated for this region with over 30,000 women, and nearly a majority of them are 40 and older. Although indicators suggest this county is not medically underserved, screening percentages are alarmingly low, while incidence and death rates are not improving. Additionally, it is projected by Healthy People 2020 data that this county will miss all breast cancer related objectives. This is likely due to lack of education and navigation-based programs along the Continuum of Care for this particular county, which will be investigated further in the Health Systems Analysis.

**Southeast Region (Carter County, Oklahoma):**

Carter County is a somewhat balanced mixture of rural and urban communities. Predominantly white and centered on the City of Ardmore, OK, there are nearly 25,000 women residing here. Data indicate alarming late-stage incidence and death rates even though it appears it is not a medically underserved area. This is likely due to the staggering poverty percentage, with 41.4 percent, ages 40-64 living below 250 percent of the poverty level, as well as nearly a quarter living without health insurance and the consideration of distance for those living in the vast rural areas of the county. This also may explain the alarmingly low screening percentages among women 40 and older. Healthy People 2020 projections indicate this county is off target by at least 11 years unless drastic measures are taken to improve late-stage incidence and death rates. Overall, it seems that access to timely and quality care may be the issue, which will be better understood in the Health Systems Analysis.

**Southwest Region (Comanche County, Oklahoma):**

Among this region is a vast rural area, centered around Comanche County, which is where Oklahoma's fifth largest city is located, Lawton, OK. Home to over 57,000 women, Comanche County is improving compared to screening, incidence, death data reported in the Affiliate's 2011 Community Profile. The current data suggests all of which are relatively stable. In fact, the county is only 1-2 years behind the Healthy People 2020 targets. Still, over a third of this county is considered to be medically underserved and faced with poverty issues, which will be investigated in relation to the Continuum of Care in the Health Systems Analysis.

**Northwest Region (Texas County, Oklahoma):**

This is the most geographically isolated and rural region among the service area. Texas County is the most densely populated of the region, situated around the moderately populated Guymon, OK area. This county is identified as the highest priority due to low screening percentages. Incidence and late-stage rates are stable, while rates related to death are undetermined due to small numbers. As a result, postulating possible breast cancer survival rates will be a focus for

this county. The Health Systems and Qualitative Data Analyses will gauge the level of efficacy regarding the existing Continuum of Care, related specifically to Survivor programs – treatment and follow-up care. Also, Texas County struggles with low education levels and a high percentage of linguistically isolated individuals, which is most likely reflective of the high Hispanic/Latina population. Overall, this area will be the top priority for the Health Systems Analysis to determine the level of access to quality health care, as well as the extent to which individuals are utilizing health care in Kansas and/or Texas rather than Oklahoma.

**Central Region (Oklahoma County, Oklahoma):**

The most populous county in Oklahoma, Oklahoma County is home to 360,394 women. Home to the State’s most advanced health care systems, the rate of medically underserved areas is very low at 16.4 percent and screening percentages are moderately stable. Yet this calls into question the level of access and efficacy of the systems due to staggering late-stage and death rates. Oklahoma County is expected to miss all Healthy People 2020 targets by thirteen years or more. Socioeconomic measures of this county indicate income and language are two primary barriers for individuals in need of services. This county also has a high proportion of Hispanic/Latina and Black/African-American women, which are high risk groups for late-stage diagnosis and death. This county will be the focus of this region and highest priority for the Affiliate’s strategic plan. The Health Systems Analysis will help further understand gaps related to the Continuum of Care.

# Health Systems and Public Policy Analysis

A survey of health care systems across the five target communities was conducted to gain further knowledge related specifically to timely access to quality breast screening services. Completing the Continuum of Care (CoC), diagnostic, treatment, and support services were also considered. Quoted by Levit, Balogh, Nass, and Ganz (2013), access to care is “the timely use of personal health services to achieve the best possible health outcomes.” Too often, issues related to access contribute to staggering statistics, especially in the case of cancer care. The Health Systems and Public Policy Analysis will inform the Affiliate on the state of current health care facilities as it pertains to the occurrence of breast cancer among underserved populations within the target communities – Carter, Comanche, Garfield, Oklahoma, and Texas Counties.

## **Health Systems Analysis Data Sources**

A comprehensive review of health care systems was conducted utilizing the following sources, listed and discussed briefly below.

### **American College of Radiology**

<http://www.acr.org/Quality-Safety/Accreditation/Accredited-Facility-Search>

Lists organizations accredited according to Medicare Improvements for Patients and Providers Act (MIPPA) and the Mammography Quality Standards Act (MQSA).

### **American College of Surgeons National Accreditation Program for Breast Centers (NAPBC)**

<https://www.facs.org/quality-programs/napbc>

Provides a listing of accredited breast centers dedicated to providing the most efficient and contemporary breast care suited for the patient.

### **Google Search Engine**

[www.google.com](http://www.google.com)

Google Search provides a way to look for publicly available documents offered by web servers.

### **Health Resources and Services Administrations (HRSA)**

[http://findahealthcenter.hrsa.gov/Search\\_HCC.aspx?byCounty=1&unbrand=](http://findahealthcenter.hrsa.gov/Search_HCC.aspx?byCounty=1&unbrand=)

Aligned with the US Department of Health and Human Services, HRSA maintains this listing of community health centers (CHCs) that provide comprehensive medical services to the underserved.

### **Mammography Center Database**

<http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfMQSA/mqsa.cfm>

Updated on a regular basis, this site lists facilities certified by the FDA in accordance with the Mammography Quality Standards Act of 1992 (MQSA) and subsequent Mammography Quality Standards Reauthorization Act (MQSRA) amendments.

**Medicare Hospital Database**

<https://data.medicare.gov/Hospital-Compare/Hospital-General-Information/v287-28n3>

Current listing of hospitals contracted with Medicare.

**National Association of County and City Health Officials Health Department Database**

[www.naccho.org/about/lhd/](http://www.naccho.org/about/lhd/)

Provides a directory of area health departments.

**National Association of Free and Charitable Clinics**

<http://www.nafclinics.org/clinics/search>

Considered a safety-net, free clinics serve those with limited access to health care. This complete listing of free and charitable clinics provides information on locations, dates, and times in the area.

**National Cancer Institute Designated Cancer Centers**

[www.cancer.gov/researchandfunding/extramural/cancercenters/find-a-cancer-center](http://www.cancer.gov/researchandfunding/extramural/cancercenters/find-a-cancer-center)

Listing of comprehensive cancer centers.

**Oklahoma Health Care Authority**

<http://www.okhca.org/>

Complete provider directory available, in addition to statistics.

**Oklahoma Hospital and Health care Guide 2014**

Medical Publishing, LLC

Complete, up-to-date listing of providers by county.

**Oklahoma State Department of Health**

[www.ok.gov/health/](http://www.ok.gov/health/)

Updated regularly, this site discusses the condition of health care in Oklahoma using data from state programs.

**Susan G. Komen Grants eManagement System (GeMS) Database**

<https://affiliategrants.komen.org>

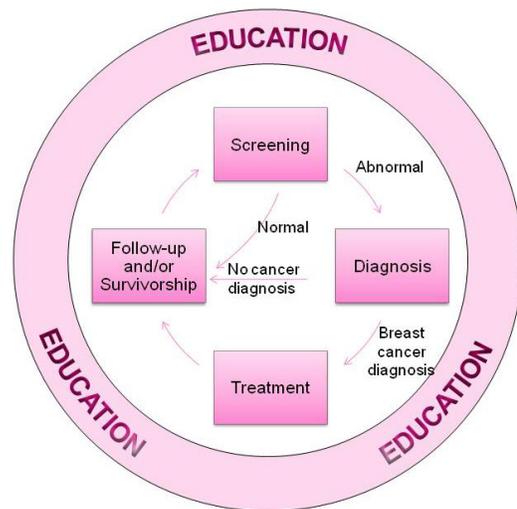
GeMS provides a central location for grantee and grantee applicants' information of Komen Affiliates.

Beginning with data from these sources, supplementary data were collected by conducting cold calls and scheduled calls, interviews, and networking with existing partners to authenticate or add to the information. Next, the data were charted in an extensive database to help identify gaps, or barriers along the Continuum of Care (CoC) for each target community.

## Health Systems Overview

The Breast Cancer 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 encouraging 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 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 topics such as treatment options, how a pathology report 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, and 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).

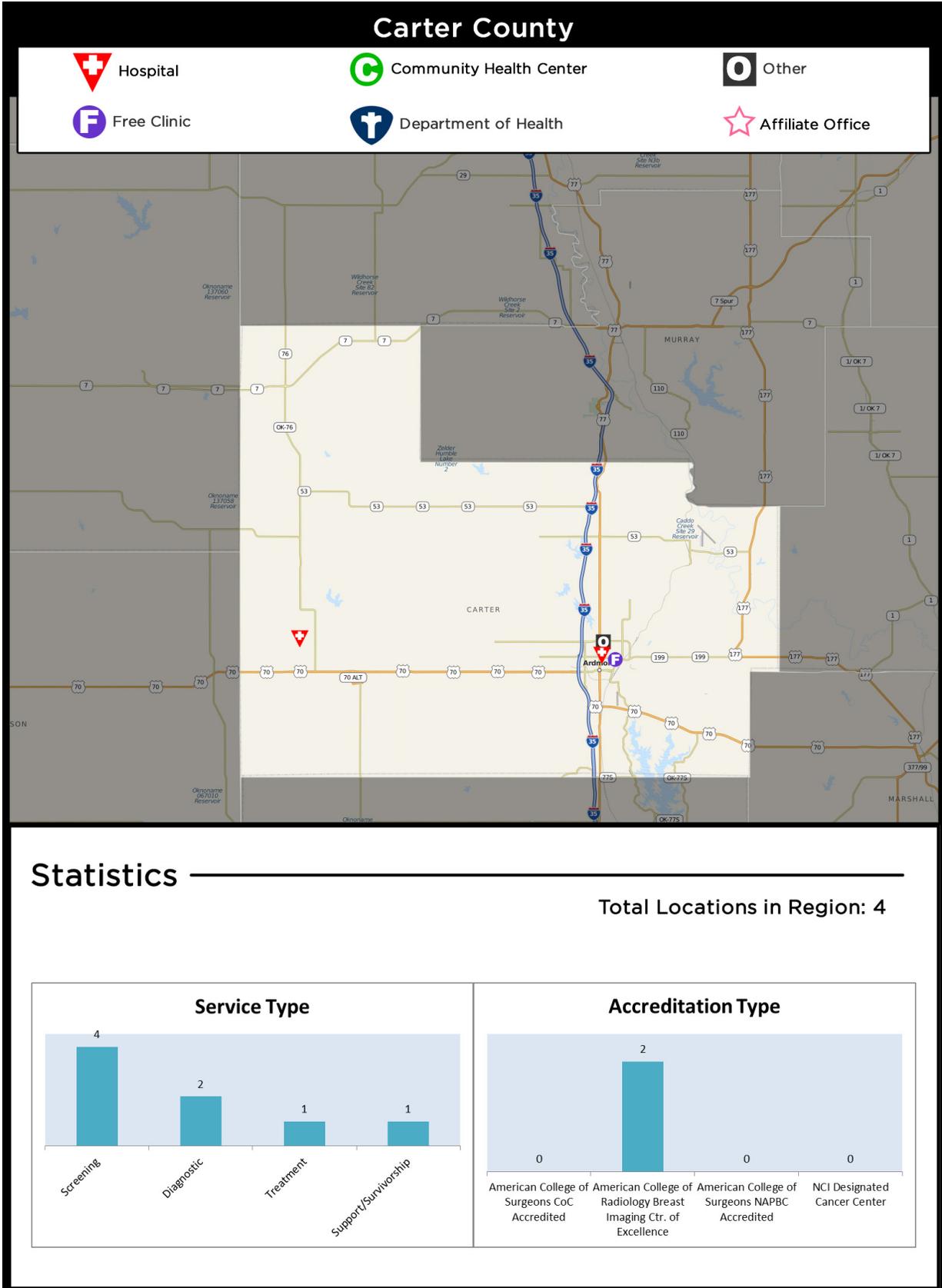
There are often delays in moving from one point of the continuum to another – at the point of follow-up of abnormal screening exam results, starting treatment, and/or completing treatment – that can all contribute to poorer outcomes. There are also many reasons why a woman does not enter or continue 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.

### **Health Systems Analysis by County**

The Affiliate currently serves 47 counties spanning Central and Western Oklahoma. This vast and diverse service area was narrowed down to five target communities, or counties, based on the findings from the previously discussed Quantitative Data Analysis. Using the Health Systems and Public Policy Analysis as a lens to view the target communities' data deeper, strengths and weaknesses were identified, as well as current and potential Mission-related partnerships for each.

#### ***Carter County***

Moderately populated and centered around Ardmore, OK, Carter County is considered not medically underserved based on the findings of the Quantitative Data Analysis. In fact, there are two health care facilities run by the Mercy Hospital network, one in Ardmore, the more densely populated area, and Healdton, considered the hub of the rural population (Figure 3.2). Targeting the needs of specific populations, Ardmore is also home to the Chickasaw Nation Health Clinic and the Good Shepherd free clinics. All of these provide breast health services, and the Mercy Memorial Hospital in Ardmore is the county's only facility offering services along the entire Continuum of Care. Still, this county has among the lowest screening percentages of the Affiliate Service Area, and is likely to miss the Healthy People 2020 late-stage incidence rate target. The Affiliate does not currently have any partnerships in place, but plans on building on its relationship with Mercy Hospital in Oklahoma City, a long standing and current grantee.



**Figure 3.2.** Breast cancer services available in Carter County

### ***Comanche County***

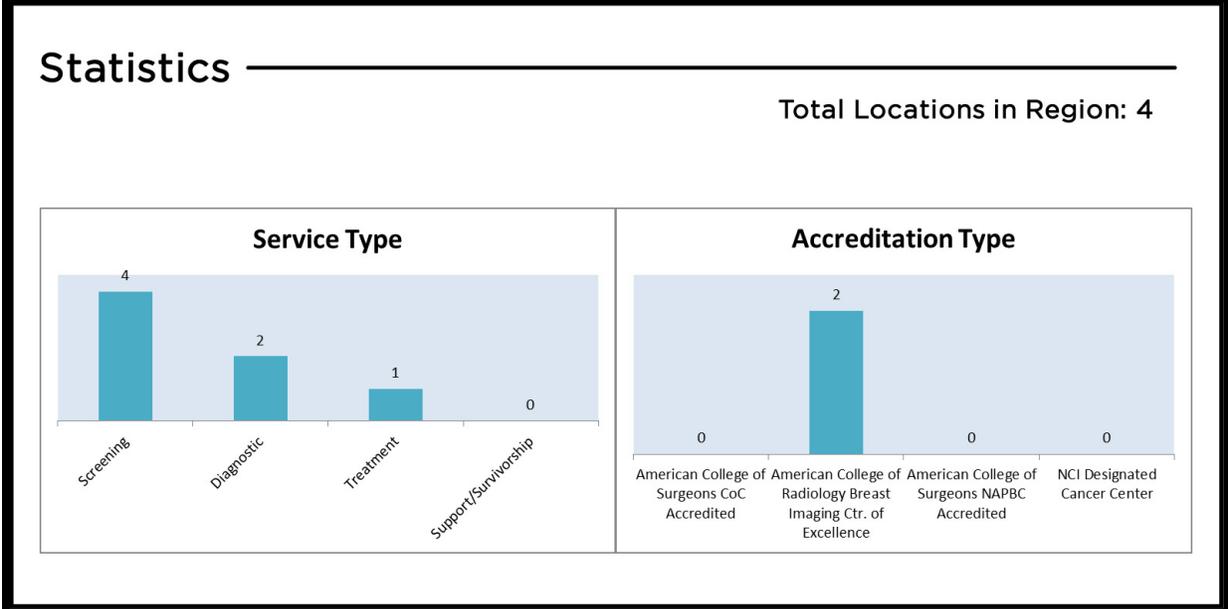
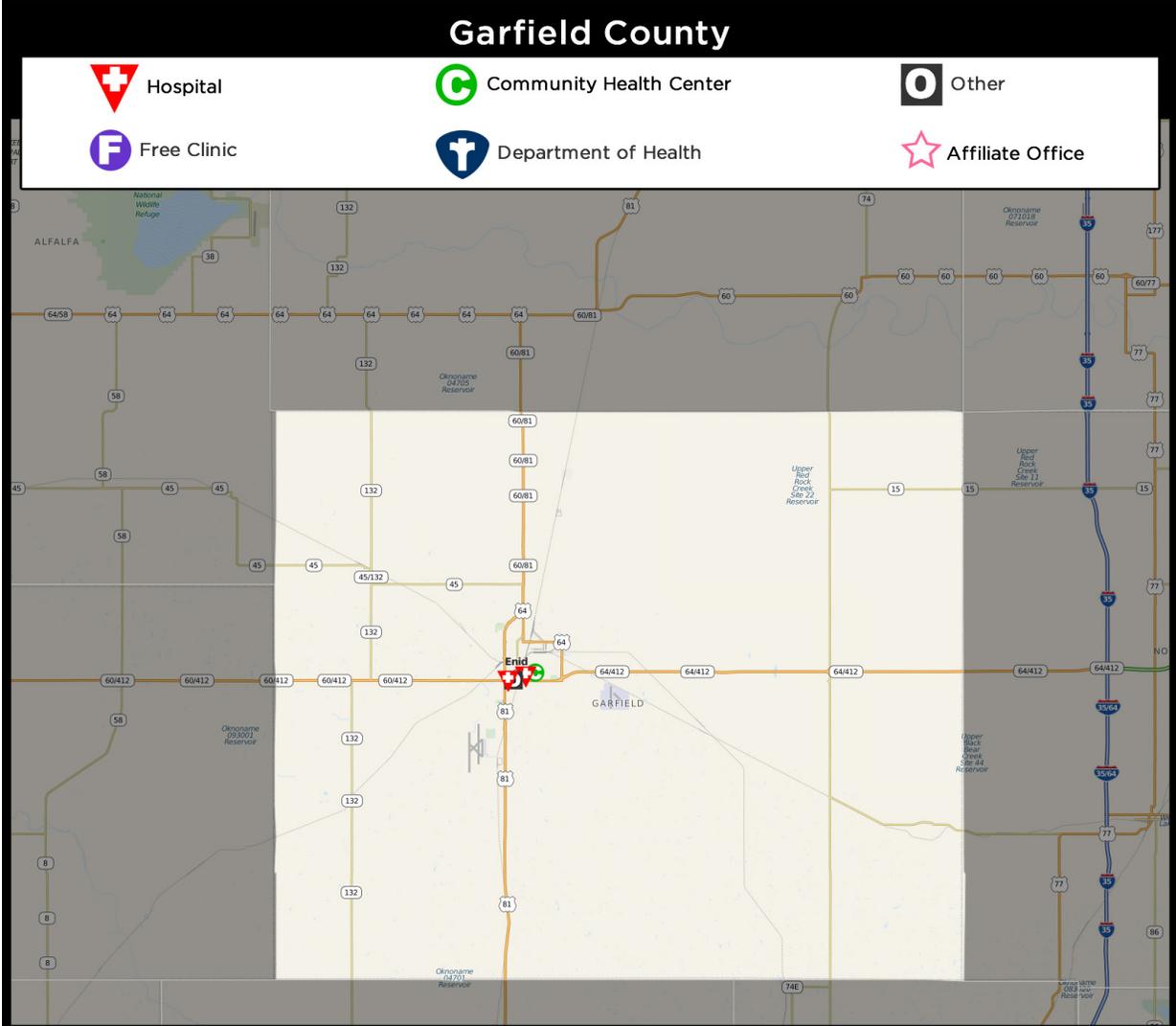
Situated in the Southwest corner of the state, Comanche County is the hub for health care in this area. There are four hospitals, as well as a fully comprehensive cancer center (Figure 3.3). Two of the four hospitals target and serve populations unique to the area – American Indians/Alaskan Natives and US Army Service members, delivering breast screening services. In addition, one of the Affiliate’s current grantees, Oklahoma Project Woman, serves individuals in need by contracting with health care facilities to eliminate cost as a barrier. There is also a community health center that provides Clinical Breast Exams and a medical home for clients. Although the systems are in place and this county is considered medium-low priority, it has been included as a target community because of the influence they have on the bordering counties, as well as the partnerships the Affiliate has maintained. In fact, the Affiliate has a strong partnership with Southwestern Medical Center, who’s CEO, Steve Hyde, was recognized as a Pink Tie Guy in 2014. Their mission is closely aligned with the Affiliate’s and they are dedicated to delivering quality health care fit for the community of Lawton and beyond.



**Garfield County**

Also a moderately populated county, Garfield County is outfitted with two hospitals, a community health center, and a current Affiliate grantee, Oklahoma Project Woman, to provide the breast health services to those in need (Figure 3.4). In fact, one of the hospitals is affiliated with a large network out of Oklahoma City, INTEGRIS. Therefore, this county is not considered to be medically underserved, yet rates are among the lowest of the Affiliate service area and the county is expected to miss the Healthy People 2020 targets. The Quantitative Data Report revealed this county has a moderately high poverty level. The Qualitative Data Analysis will explore this factor specifically, as well as other possible barriers for why screening percentages are so low in this county.

There are no current partnerships established in this county, but plans are in place to utilize connections with the local INTEGRIS network.

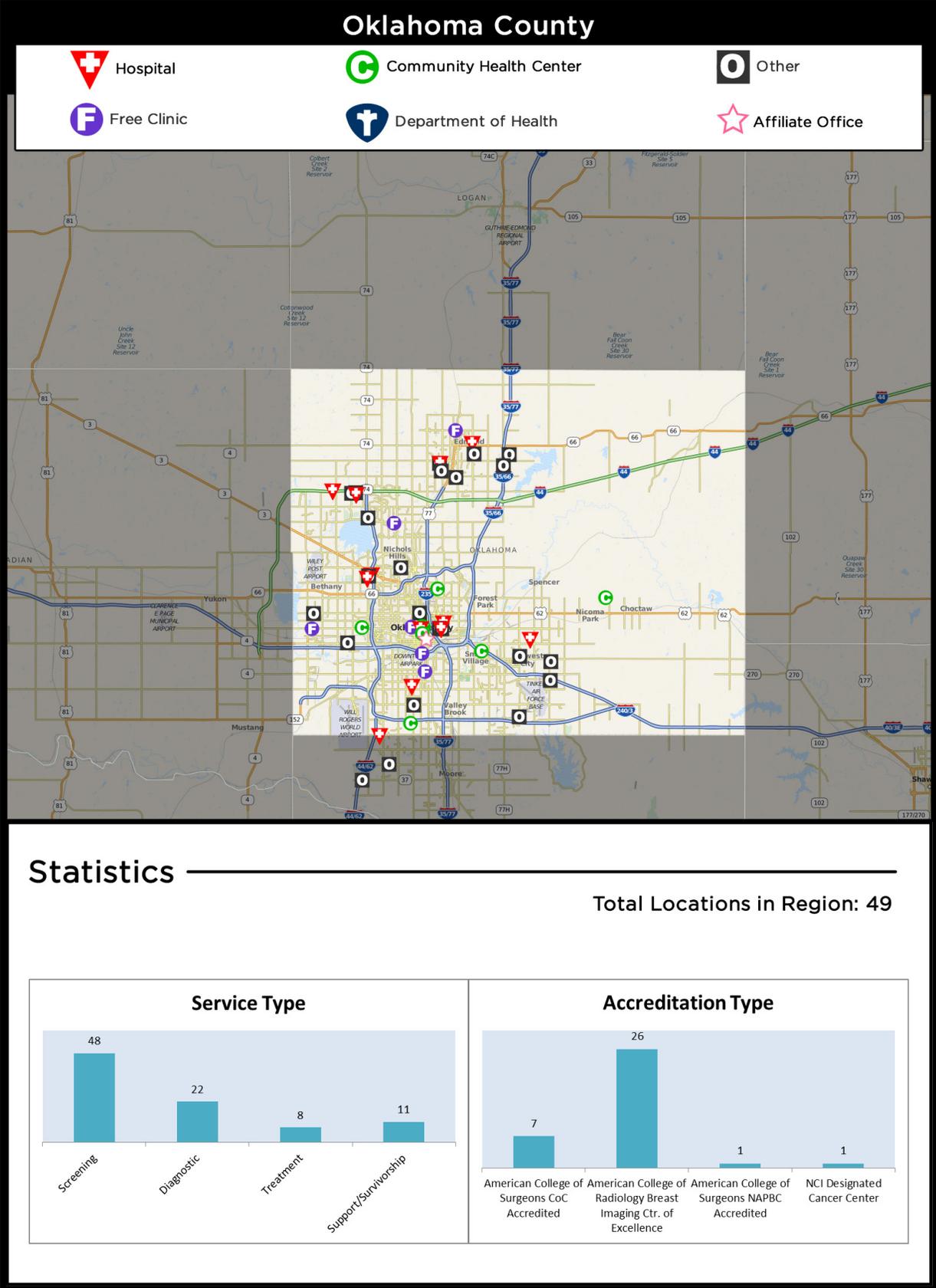


**Figure 3.4.** Breast cancer services available in Garfield County

### ***Oklahoma County***

The service area and state's most densely populated county, this area continually experiences barriers related to access. There are four major health care networks with main campuses here – OU Medical Center, Integris, Mercy, and Saint Anthony's (Figure 3.5). In fact, the Stephenson Cancer Center on the OU Medical Center campus is considered an NCI qualified comprehensive cancer center. Still, poverty remains a pervasive issue for this county, which can be a barrier to timely access in particular as it pertains to paying for services and distance. With a population nearing one million in a highly widespread metro area, transportation continues to be an overwhelming factor for seeking care. Luckily, there are many programs and organizations that aid with transportation issues. There are also a number of specialized programs targeting specific ethnic populations and the homeless.

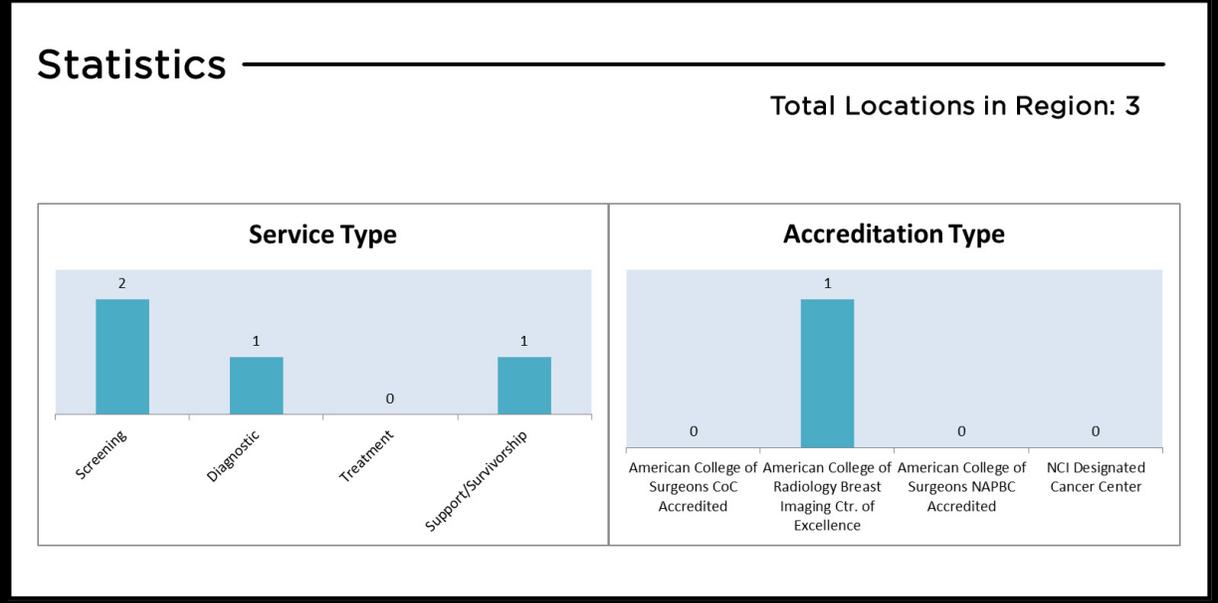
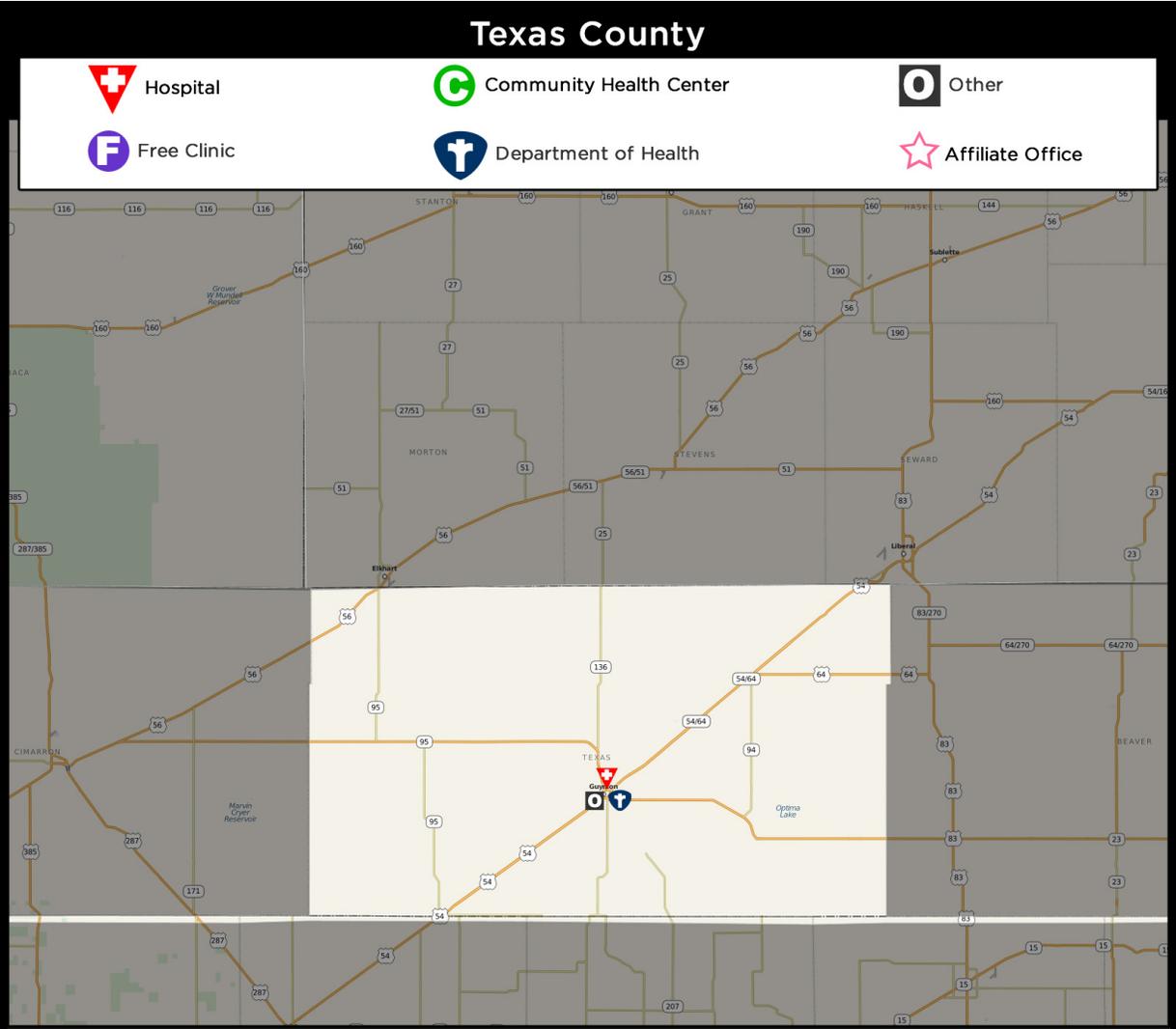
The Affiliate is based in this county and has developed many very strong partnerships, specifically with long-standing grantees of past and present, including The University of Oklahoma Breast Institute, Mercy Hospital, Community Health Centers, Inc., and the Oklahoma City Indian Clinic. In fact, the Affiliate has convened many partnerships among its grantees, and will remain dedicated to this in effort to be good stewards of fundraising dollars, leveraging resources whenever possible.



**Figure 3.5.** Breast cancer services available in Oklahoma County

### ***Texas County***

The most geographically isolated, Texas County also ranks as the highest priority county due to the lack of health care services equipped to adequately serve the population, composed largely of migrant workers and individuals faced with insurmountable poverty issues. Most notably, this county supports a hospital which provides the greatest access to care for all (Figure 3.6). Yet, limitations apply. Screening and minimal diagnostics are performed at this site, while only Clinical Breast Exams are offered by the local county health department. Anything more, and travel is required, which presents the most ominous barrier for many. Since expanding the Affiliate service area to cover this county in late 2010, little work has been done. But, recently, the Affiliate established communication with a representative from Oklahoma Panhandle Partners, which seeks to alleviate barriers related to all cancers in the area, offering travel grants and screening resources. In fact, they are encouraged by the Affiliate's recently released Request for Applications and plan on applying in 2015. This will be where the Affiliate will begin developing future partnerships in the area.



**Figure 3.6.** Breast cancer services available in Texas County

## **Public Policy Overview**

### **National Breast and Cervical Cancer Early Detection Program (NBCCEDP)**

The Centers for Disease Control's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) provides access to breast and cervical cancer screening services to underserved women through grants that support the implementation of state programs.

The Oklahoma NBCCEDP program, called Take Charge! provides breast and cervical cancer screening for eligible Oklahoma women. It is funded through a CDC grant and a three-to-one match from the state. In addition, the Oklahoma Breast and Cervical Cancer Act established the Breast and Cervical Cancer Act Revolving Fund. The monies in the revolving fund consist of gifts or donations, and contributions from individual income tax returns, as well as monies from the sale of breast cancer license plates. These funds pay for breast and cervical cancer screening and diagnostic services for women enrolled in the Take Charge! program.

Take Charge! services are provided through contracts with health care providers, federally-qualified health centers, health care organizations, laboratories, surgical consultants, mammography facilities, and colposcopy providers. Beginning September 15<sup>th</sup>, 2014, to enroll in the program, women call a toll-free number and speak with a patient navigator who will help them determine if they meet the eligibility requirements based upon income, insurance status and age, for the services they are seeking. If women are determined ineligible, the patient navigator refers them to community resources, such as the Affiliate's Community Grants program.

Women with abnormal findings on breast and/or cervical cancer screening examinations through Take Charge! receive referral and access to diagnostic services. Some women will be eligible for these services through Oklahoma Cares, a Medicaid program administered through the Oklahoma Health Care Authority. The Oklahoma Cares Program is a product of the National Breast and Cervical Cancer Prevention and Treatment Act of 2000. The program is a partnership between the Oklahoma State Department of Health (OSDH), the Oklahoma Health Care Authority (OHCA), the Cherokee Nation, the Kaw Nation of Oklahoma, and the Oklahoma Department of Human Services (OKDHS) to provide treatment for breast and cervical cancer and pre-cancerous conditions to eligible women. Eligibility requirements include uninsured women who meet income qualifications and are between the ages of 19-65 with an abnormal breast or cervical finding or diagnosis of breast or cervical cancer (Oklahoma State Department of Health, 2014). Women enrolled in the Oklahoma Cares program receive full-scope Medicaid coverage inclusive of diagnostic and treatment services (Oklahoma Breast and Cervical Cancer Prevention & Treatment Advisory Committee Annual Report, FY2012). For those women who are screened but not eligible for Oklahoma Cares, diagnostic services will be provided through Take Charge!.

The Oklahoma Breast and Cervical Cancer Prevention and Treatment (BCCPT) Advisory Committee was formed to provide oversight for the Oklahoma Breast and Cervical Cancer Act. The Affiliate's Executive Director was appointed by the Governor of Oklahoma to serve as a

member of the BCCPT Committee for two years and was subsequently appointed by the Oklahoma Commissioner of Health to serve an additional year as the chairperson.

Through its work on the BCCPT and other projects the Affiliate has developed and maintained a good and productive working relationship with the Take Charge! program staff. Sharing information on the Take Charge! program and providers at the annual Komen Oklahoma City Race for the Cure<sup>®</sup>, utilizing Komen education materials and serving on the Community Profile project team are just some examples of how the two organizations work together to educate and address the breast health needs of the underserved women of Oklahoma.

The state of Oklahoma has chosen not to expand Medicaid since the implementation of the Affordable Care Act. Because of this, the Take Charge! program will continue to provide breast cancer screening for eligible women for the foreseeable future. While Komen messaging aligns with the American Cancer Society guidelines for breast cancer screening, Take Charge! follows the US Preventive Services Task Force guidelines providing screening for women between the ages of 50 and 65. This creates a gap for women between the ages of 40 and 49, so there is an opportunity for the Affiliate and Take Charge! to continue to work together to fill the need for these women.

### **State Comprehensive Cancer Control Coalition**

Comprehensive cancer control (CCC) is a process through which communities and partner organizations pool resources to reduce the burden of cancer. These combined efforts help to reduce cancer risk, find cancers earlier, increase treatment effectiveness and increase the number of people who survive cancer.

In 2003, the Oklahoma State Department of Health (OSDH) took the administrative initiative to form the Oklahoma Comprehensive Cancer Network (OCCN) to address the cancer burden in Oklahoma. The coalition is comprised of representatives of organizations who have cancer prevention and control as a major focus of their mission. Working together, the coalition members created the Oklahoma Cancer State Plan (2006-2010) in order to decrease cancer-related morbidity and death by focusing on the priority areas of:

- Prevention
- Early Detection
- Diagnosis & Treatment
- Quality of Life
- Survivorship

The Cancer Plan identifies goals to advance cancer control in Oklahoma. Following are the objectives related to breast cancer:

- Increase public knowledge and understanding regarding breast cancer risk factors, signs and symptoms and importance of routine screening to survival.
- Ensure primary care providers are recommending and/or conducting appropriate breast cancer screening tests according to established guidelines.

- Identify and incorporate strategies to overcome barriers to breast cancer screening for all women age 40 and older.
- Identify and target counties with disparities in breast cancer screening percentages either by location or by race/ethnicity in Oklahoma.
- Ensure that women with abnormal breast cancer screening results receive timely and appropriate follow-up.

Each breast cancer objective will use cancer surveillance data to re-evaluate incidence rates, screening percentages and changes in prevalence every four years (Oklahoma State Department of Health, 2009).

From 2006-2008 the Affiliate was a member of the OCCN serving on the Diagnosis & Treatment work group. Due to resource limitations, the Affiliate was no longer able to actively participate in coalition meetings but has maintained communication with the coordinator and provided support as resources and time allow.

After a period of inactivity, the coalition has recently formed a core steering committee that is currently reviewing the CDC grant and supporting documents, which funds the Oklahoma Comprehensive Cancer Control Program (OKCCC) and coalition implementation. This review will increase the steering committee's knowledge and understanding of what must be achieved by both the coalition and the program in order to meet the grant requirements and provides a solid base upon which to build.

Priorities for the steering committee and program staff include:

- Revise the program's FY15 action plan to include the enhancement of current implementations that impact cancer.
- Revise the mission statement and invitation to potential stakeholders.
- Revise the Oklahoma Cancer State Plan with a focus on gaps not addressed in the Oklahoma Health Improvement Plan and Coordinated Chronic Disease Plan.
- Prepare a media plan and evaluation plan (Oklahoma State Department of Health, personal communication, August 4, 2014).

As the steering committee and program staff determine next steps for the coalition, the addition of resources will allow the Affiliate to once again take an active role as needed.

### **Affordable Care Act**

In total, an estimated 623,000 Oklahoma residents remain uninsured even after the Affordable Care Act (ACA) established a new minimum of Medicaid eligibility for non-disabled adults who live 138 percent below the federal poverty line. Oklahoma, along with 38 percent of the nation, chose not to expand Medicaid throughout the state (Kaiser Family Foundation, 2014). Currently, Oklahoma offers a state plan to provide affordable health care called Insure Oklahoma. This program is guaranteed funding through 2015 (Insure Oklahoma, 2013). Uninsured and privately self-insured patients have also been directed to the federal website to sign up for insurance through the federally-organized health insurance exchange. About 69,000 of Oklahoma's

previously uninsured residents selected and joined an ACA Marketplace Plan, leaving more than 58,000 people who qualify for coverage through the ACA, but did not sign up (Kaiser Family Foundation, 2014). Over 144,480 of Oklahoma's population fall into the coverage gap. They do not qualify for financial assistance via the health exchanges, and are ineligible for Medicaid due to non-expansion of Medicaid (Kaiser Family Foundation, 2014).

Since before the implementation of the ACA, Oklahoma has two federally funded programs that play a large role in influencing breast health in Oklahoma: Oklahoma's BCCEDP (Take Charge!) and the Oklahoma Cares Program. Continued funding of these programs will be vital in order to screen, diagnose, and treat breast cancer for those who remain uninsured. At this time, under the ACA, a total of 22 different preventative services are provided to insured women without requiring them to pay an out-of-pocket expense through their insurance provider. Mammography screenings every one to two years for women over 40 are one of the preventative services included. Providers are now promised that they will receive reimbursement for this service without collecting money from the patient. Providers now have the responsibility to inform their patients that preventative health services are now covered under the ACA so that patients are aware that cost is no longer a barrier to accessing care. However, while the ACA has provided increased insurance coverage, it has not guaranteed access for all.

While screening is now covered with no out-of-pocket expense to those who are insured, gaps may remain in diagnosis and treatment. Many women who purchase high deductible insurance plans through the federal exchange may be unable to pay for the needed diagnostic services if an abnormality is found on their screening mammogram. If diagnosed with breast cancer, treatment expenses for those with high deductible plans might be unaffordable.

The 69,000 newly-insured patients in Oklahoma will highlight the need for additional primary care providers in the state, especially in rural parts of the Affiliate's target populations. Oklahoma faces a primary care provider shortage. As of April 2014, the amount of primary health care professionals in Oklahoma only met 63.8 percent of the need for the state. (Kaiser Family Foundation, 2014).

In many respects, it is too soon to tell what sort of implications the ACA will have on the Affiliate. Utilization of Oklahoma's BCCEDP has remained consistent since before the open enrollment period of the ACA (Oklahoma State Department of Health, personal communication, July 1, 2014), but possible implications on the Affiliate could include a shift in a need for funds to cover diagnostic services given the possible increase of insured women who have access to screening but not diagnosis. The Affiliate will continue to monitor the situation and keep up-to-date with community partners to determine if Affiliate Mission activities need to be adjusted in the future to keep up with the changing needs.

### **Affiliate's Public Policy Activities**

In the 2013 Legislative Session, Oklahoma House Bill 1467 was enacted to consolidate several state health department advisory committees into a fewer number of newly-established councils.

The BCCPT Advisory Committee was consolidated into the Advancement of Wellness Advisory Council and legislation directed the Governor to appoint two members to the Council, one of which must be a member who is knowledgeable about breast and cervical cancer issues. The Executive Director from Komen Tulsa, Komen Oklahoma's fellow state Affiliate, was recently appointed by the Governor of Oklahoma to serve on the Council for a three year term.

Also, every spring the Affiliate participates in the Breast Cancer Awareness Day at the Oklahoma State Capitol, which was originally developed to be a high exposure advocacy event. However, in recent years, the focus on advocacy has become less and less under the current leadership of the event. Still, the Affiliate provides the opportunity for participants to sign petitions to state legislators to keep funding Oklahoma's BCCEDP program.

### **Health Systems and Public Policy Analysis Findings**

The Affiliate's work is energized in part to ensure quality care for all. Therefore, identifying gaps and barriers related to timely, quality access to care is a priority and the driving force behind establishing funding priorities for grant programs. This analysis revealed the need to continue developing strong, effective partnerships, connecting those in need with necessary, life-saving services along the Continuum of Care (CoC). Further, the Affiliate will serve as the convening group for mutual partners to approach access issues in a cost-effective, timely manner. Barriers related specifically to access will be investigated further and discussed for each of the target communities in the Qualitative Data Analysis (QDA). Overall, the strengths of the target communities are availability of services, while the weaknesses are often proximity and poverty. The QDA will help identify others as well.

# Qualitative Data: Ensuring Community Input

## Qualitative Data Sources and Methodology Overview

### Methodology

In addition to collecting key informant interviews for each target county, surveys were conducted for four of the five target counties – Carter, Comanche, Garfield, and Oklahoma, while a focus group was conducted for Texas County. Key informant interviews, surveys, and focus groups were selected as the best options for reaching the target counties directly, one-on-one, and intimately. Asking open-ended questions through this process, the Affiliate hoped to gain trust and contacts for potential partnerships in three of the five target counties where no previous work has been done since expanding in 2010. Texas County was the first to be investigated, and it was determined surveys would be a better option than focus groups for the remaining four counties due to time constraints and venues for the remaining counties. Still, respondents were asked the same questions, which are listed below for both the survey/focus groups and the key informant interviews. The questions were written to primarily assess barriers related to accessing care and to identify groups in need of services.

<b>Survey/Focus Group Questions</b>	<b>Key Informant Interview Questions</b>	<b>Key Informant Survey Questions</b>
<ol style="list-style-type: none"> <li>1. Please describe your experience with breast cancer in your county/community</li> <li>2. Is breast cancer a major health problem in this county/community? How does it compare with other health, mental health, and/or social concerns here?</li> <li>3. Are health care providers respected, trusted, and valued in the community?</li> <li>4. What can be done differently in your community to make sure breast health messages and services get to the women that need them the most?</li> <li>5. Where do most women in this community get health information?</li> <li>6. What knowledge do you have about early detection programs for breast cancer and sources of (breast health) information?</li> <li>7. For individuals like yourself, what makes it difficult for you to seek, or find, clinical breast examination/mammography screening services?</li> <li>8. Is there anything you would like to add?</li> </ol>	<ol style="list-style-type: none"> <li>1. Are there certain types of patients that have problems accessing services at your office/clinic/agency/organization?</li> <li>2. Are there any specific racial, ethnic, cultural, or linguistic groups in your county that you believe do not get the services they need?</li> <li>3. How do you respond to young women in need of breast screening?</li> <li>4. Please walk me through the Continuum of Care you provide.</li> <li>5. Do you notice a need for more breast health service in any particular areas of this county?</li> <li>6. What services, programs, and/or policies are needed in your area to deliver timely and quality breast health services?</li> <li>7. Why would a woman in your area not get screened?</li> <li>8. Based on your experience, what factors might contribute to a late-stage diagnosis?</li> <li>9. What group(s) or women does your office/clinic/agency/organization target for breast health services you provide?</li> <li>10. Is there anything you would like to add, or hoped I would have asked?</li> </ol>	<ol style="list-style-type: none"> <li>1. Do you notice a need for more breast health services in particular areas of this county?</li> <li>2. Where do you refer patients that are in need of a mammogram?</li> <li>3. Are there certain types of patients that have problems accessing services at your office/clinic/organization?</li> <li>4. In your experience, what is the most effective way to educate women in your area about breast health issues?</li> <li>5. What types of assistance programs do you think help improve the delivery of breast health services within the current system?</li> <li>6. Is the current health care system meeting the needs for breast health care and breast cancer treatment successful?</li> <li>7. What are the barriers that prevent women from seeking or obtaining breast health services in your county?</li> <li>8. Where do uninsured women in your county go for breast health services?</li> <li>9. Do you know about resources in your county that provide free or low-cost mammography and/or diagnostic services?</li> <li>10. What factors contribute to late-stage diagnosis of breast cancer in this county?</li> </ol>

Affiliate Mission staff on the Community Profile Team visited each target county collecting data. Same as the key informant interviews for each county, the focus group in Texas County was dictated in person and electronically. Survey forms for the other four target counties were printed and completed by shoppers at local grocery stores before, during, or after their visit. An electronic survey was also created and distributed via e-mail and Facebook. Only those responses originating from one of the five target counties was included in the data. Each respondent was incentivized with a Komen “goodie bag” for their participation in person, while a drawing for five \$25 gift cards was done for the electronic survey.

### **Sampling**

Surveys and focus groups invited willing individuals to provide feedback about the incidence of breast cancer in their community, or target county. Participation was welcomed for all age, gender, and ethnic groups. Whereas, the key informant interviews were more selective and specific in order to gain bigger picture insight based on their status as health care providers, public health professionals, and/or key community stakeholders for each target county. Simple random sampling was in effect for the surveys collected. Referrals from key community contacts, established prior to data collection for each target county, were used to promote participation in key informant interviews and the Texas County focus group. These methods were selected to validate the Affiliate presence in the community and increase the reliability of the data collected.

### **Ethics**

Participants were asked to acknowledge and sign consent forms, or statements, for each method of data collection. They were informed about why the data are being collected and how it will be analyzed, reported, and utilized for the purpose of Affiliate grant-making and community organizing efforts. Participants were ensured in each statement that they shall remain anonymous and documents, electronic and hard copy, will be stored securely either on external hard drives or at an off-site storage facility.

### **Qualitative Data Overview**

Too often, breast cancer is the topic of discussion in any given community. Individuals raise their concerns and observations with friends, Survivors, and advocates alike, but still question how to solve, or alleviate, the issue(s). The Community Profile Team was welcomed to each target county with enthusiasm and encouragement that their feedback and support can start to make a difference. While limitations apply, the outcomes are valuable as a step in the right direction for approaching and serving the diverse needs of the Central and Western Oklahoma Service Area.

Survey responses were combined among the four target counties to yield a larger sample size for analysis, 181 to be exact. Themes emerging from the focus group in Texas County will be discussed independently, in addition to overall emerging themes resulting from the key informant interviews. Lastly, common findings resulting from all data points will be discussed.

## Survey – Carter, Comanche, Oklahoma, and Garfield Counties

It was just another trip to the grocery store, yet an unexpected and rare opportunity to provide feedback about breast cancer. Simple random sampling, perhaps at its finest. Everyone needs food! Survey booths were assembled for 2-3 hours at stores in each target county. The same survey was also sent out electronically via e-mail and Facebook, bolstering the overall response rate, yet not as random. Table 4.1, 4.2, 4.3, 4.4 provide respondent demographics and emerging themes.

**Table 4.1.** Descriptive summary of survey participation among Oklahoma, Carter, Comanche and Garfield Counties in 2014

COUNTY	Frequency	Percent
Carter	14	7.65
Comanche	16	8.74
Garfield	10	5.46
Oklahoma	143	78.14

**Table 4.2.** Descriptive summary of gender among participants in Oklahoma, Carter, Comanche and Garfield Counties in 2014

GENDER	Frequency	Percent
Female	171	94.48
Male	10	5.52

**Table 4.3.** Descriptive summary of race among participants in Oklahoma, Carter, Comanche and Garfield Counties in 2014

RACE	Frequency	Percent
AI/AN	13	7.18
Asian	4	2.21
Black/AA	37	20.44
NH/PI	1	0.55
Other	9	4.97
White	117	64.64

**Table 4.4.** Descriptive summary of breast cancer diagnosis reported among Oklahoma, Carter, Comanche and Garfield Counties

SURVIVOR	Frequency	Percent
No	147	82.58
Yes	31	17.42

The Community Profile Team created code dictionary based on responses from participants completing either hardcopy or electronic surveys. For the question regarding access to health care: ‘What makes it difficult for you to seek, or find, clinical breast examination/mammography screening services’? Individuals who responded having difficult to access health care (cost, timing, transportation, fear, unpleasant procedure), was coded as ‘barrier’ and ‘no barrier’ otherwise. Those who did not response were coded as ‘missing’.

For the question regarding suggestion for better services: ‘What can be done differently in your community to make sure breast health messages and services get to women who need them the most’? Participants who suggest options including health education, free mammography screening, social marketing, and community outreach were coded as ‘Suggestion’ and those who answered that there is no need for a change were coded as ‘No suggestion’, and participants who responded ‘I don’t know’ were coded as ‘no knowledge’. Those who did not response were coded as ‘missing’.

SAS version 9.3 was applied to analyze the data. The age variable was categorized into three groups, which are: ‘14-39 years old’, ‘40-64 years old’, and ‘65 and older’ (Table 4.5). The team then assessed the distributions of barrier to health care and suggestions for better services by the whole population and the age group of interest which is 40-64 years old (Tables 4.6 and 4.7, Figures 4.1 and 4.2).

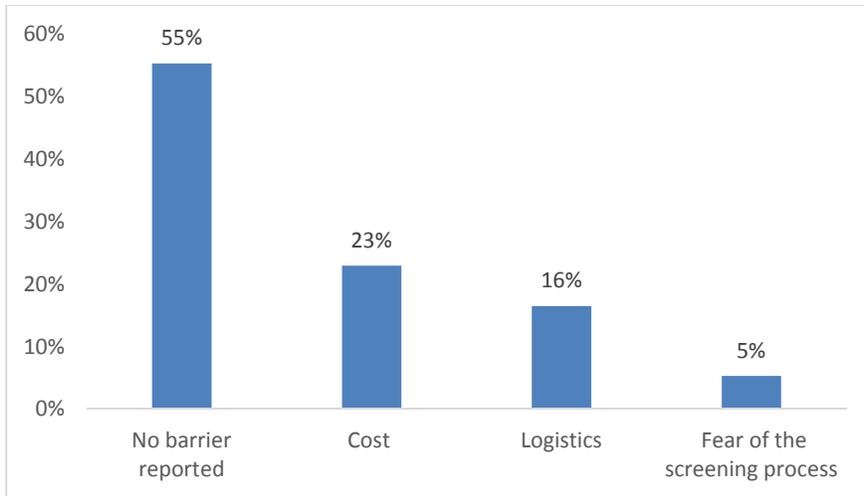
**Table 4.5.** Descriptive summary of age distribution among participants in Oklahoma, Carter, Comanche and Garfield Counties in 2014

Age group	Frequency	Percent
14-39 years old	52	28.42
40-64 years old	118	64.48
65 and older	13	7.10

**Table 4.6.** Descriptive summary of suggestion for better services among age group 40-64 years old participants in Oklahoma, Carter, Comanche and Garfield Counties in 2014

Health care access	Frequency	Percent
No Barrier	64	58.18
Barrier	46	41.82

Note: Seven percent of the data were missing

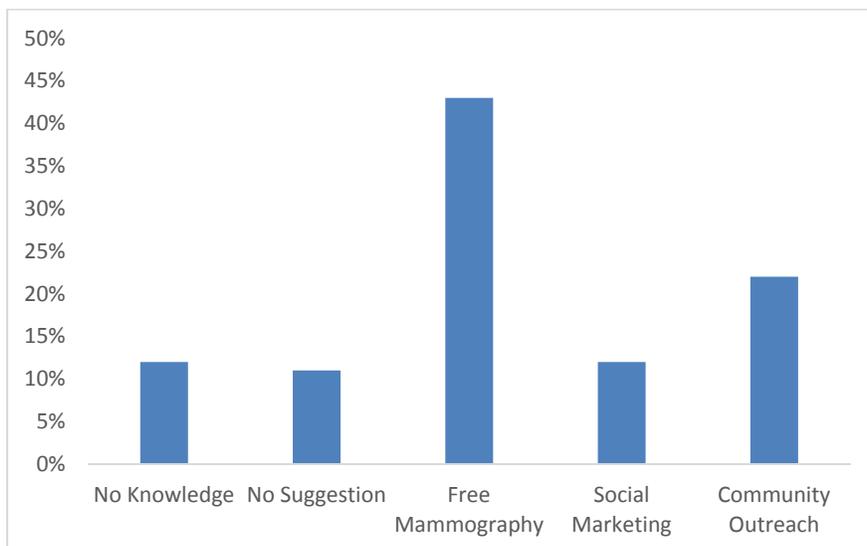


**Figure 4.1** Barriers to health care among participants in Oklahoma, Carter, Comanche and Garfield Counties in 2014

**Table 4.7.** Descriptive summary of suggestion for better services among age group 40-64 years old participants in Oklahoma, Carter, Comanche and Garfield Counties in 2014

Suggestions for better services	Frequency	Percent
No knowledge	21	11.73
No suggestion	19	10.61
Suggestion	139	77.65

Note: Two percent of the data were missing



**Figure 4.2.** Suggestions for health care among participants in Oklahoma, Carter, Comanche and Garfield Counties in 2014

### Focus Group – Texas County

Findings synthesized from the survey analysis was consistent with the focus group, where seven women ages 35-65 were in attendance, with backgrounds ranging across the field of health care, business development, education, and community organizing. The meeting was held at the Memorial Hospital of Texas County and convened by key community stakeholder there, who was also responsible for the article published on the front page of their local paper the week before. Similar themes involving barriers and improvements to health care, consistent with those found by the survey (Table 4.8).

**Table 4.8.** List of barriers and suggestions resulting from Texas County focus group

Barrier	Suggestion
1. Language/Cultural Barriers – Over 20 different languages and dialects are spoken in public schools here	1. More health care options, access points, OBGYN doctors
2. No insurance/cost of health care	2. Translated brochures, pamphlets, handouts and in-person translators/navigators
3. Fear of diagnosis; Cancer should be spelled B.U.R.D.E.N.	3. Reach families with breast health education through public schools
4. Access to care – Limited options, high turnover of OBGYNs	4. Offer free services, mobile if possible
5. Time – Busy at work, or busy with family	5. More or stronger partnerships leveraging resources

### Key Informant Interview – Garfield, Oklahoma, and Texas Counties

Next, to gain insight on the other side of health care specifically related to the Continuum of Care, the Community Profile Team asked professionals in the field and/or community advocates to provide their responses to open-ended questions either in person or over the phone (Table 4.9).

**Table 4.9.** Distribution of key informant interviews collected among target counties

County	Responses
Garfield	2
Oklahoma	5
Texas	5
<b>TOTAL</b>	<b>12</b>

Interviews confirmed the same barriers discussed by participant surveys and focus group. Additional themes include the overwhelming need for education and re-education, support for refugee populations/linguistically isolated groups of migrant workers, improving wait times by streamlining referrals process, and strengthening and/or implementing patient navigation programs. Often times, key informants are on the front lines serving the needs of so many. They are considered valuable partners, and/or gatekeepers, and will be utilized as a first step of implementing the Mission Action Plan.

## Key Informant Survey – Carter and Comanche Counties

In effort to gain an exhaustive understanding of previous findings, which were suggested by the focus groups that there is an exigent need for developing an efficient measures to alleviate barriers as well as to improve health care delivery services to the underserved populations, The Community Profile Team has therefore developed a comprehensive opened-ended and short-responses survey to assess key informants' opinions and suggestions on the same subject matter for Carter and Comanche Counties. The survey analysis was divided into two categories which mainly focused on evaluating key informants' suggestions for an innovative way of improving breast health service (a) as well as their cognizance of major barriers that prevent susceptible individuals from seeking or receiving breast health service in their area (b).

1. For Carter County, there were three participants (n=3) from different clinics including one operation manager and two nurse managers.
  - a. "In your experience, what is the **most effective way to educate women** in your area about breast health issues? What **types of assistance programs** do you think help improve the delivery of breast health services within the current system?"

In response to these questions, all informants similarly stated that health education about breast self-exam techniques<sup>1</sup>, community health fairs or outreach, patient navigators in clinics, social media (such as television, internet, newspapers, magazines, radio, apps, e-mail, standard mail, etc.), free mammogram service, and availability of transportation are altogether the most effective ways to educate women in order to have a large-scale impact on targeting the whole population in their area. These suggestions, **specifically free mammogram service and community outreach**, were interestingly similar to the recommendations from the focus group participants in the previous study. This evidence yet highlights the importance of a common need of free mammogram service and community outreach. This might also suggest, if these services or programs are already existed, that they are not maximally effective in reaching out to the vulnerable populations in this particular area.

- b. Are there certain types of patients that have **problems accessing services** at your office/clinic/organization? What are the **barriers** that prevent women from seeking or obtaining breast health services in your community/county? What **factors contribute to late-stage diagnosis** of breast cancer in this county? What are some **challenges faced** when someone is in breast cancer treatment?

Fear, lack of transportation, lack of free mammogram service, distance, referral, mistrust, uninsured, uneducated, timing, and program eligibility are major problems that prevent patients from accessing to health care services. In addition, these factors are also leading to late-stage diagnosis of breast cancer in

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<sup>1</sup> Note: Although participants expressed that health education about breast self-exam were the most effective way to educate women, Susan G. Komen uses breast self-awareness messaging because breast self-exams are not an evidence-based practice. To learn more about breast self-awareness, go to <http://www5.komen.org/BreastCancer/BreastSelfAwareness.html>

this county. Besides that, informants specifically indicated that financial, referral, **and transportation** are challenges faced when someone is in breast cancer treatment. Even though barriers were not reported by the focus group, financial and logistic problems were the most common one being reported compared to other barriers. This finding again reflect why the foregoing suggestion of **free mammogram** are amongst the most needed programs that could have been used to effectively diminish the financial barrier issue among the deprived population in this area. Likewise, fears of screening were also recognized by both the focus group and key informants but not as significance as other barriers (only five percent).

2. For Comanche County, there are also three participants (n=3) from different health care facilities in this survey including radiographers and fund development specialist. Similar questions format were applied to evaluate key informants' opinions regarding barriers as well as breast health services in their region.

a. "In your experience, what is the **most effective way to educate women** in your area about breast health issues? What **types of assistance programs** do you think help improve the delivery of breast health services within the current system?"

Most of the informants detailed that health education, community health fairs, patient navigators in clinics, social media (television, internet, newspapers, magazines, radio, apps, e-mail, standard mail), free mammogram service, and availability of transportation are the most effective way to educate women about breast cancer and types of programs that can be applied to improve the delivery of breast health services within the current system in their area. Similar to Carter County, **free mammogram service and community outreach** are both highly recommended by these informants as an effective tool to eliminate major barriers as they have indicated in the following section.

b. Are there certain types of patients that have **problems accessing services** at your office/clinic/organization? What are the **barriers** that prevent women from seeking or obtaining breast health services in your community/county? What **factors contribute to late-stage diagnosis** of breast cancer in this county? What are some **challenges faced** when someone is in breast cancer treatment?

Informants said that although there is no problem for patients accessing services at their office/clinic/organization, there are some barriers that avert women from seeking or obtaining health care on a timely fashion including fear, lack of transportation, distance, uninsured, uneducated, lack of support, spousal neglect, don't know where to start, childcare, and poor health standards. Among those, uninsured, uneducated, and lack of free mammogram service, care management, screening, and limited resources are factors that contribute to late-stage diagnosis. Financial and transportation again are the challenges faced when patient is in breast cancer treatment. As a result, this implies that all of these barriers are not only impede susceptible women from seeking a proper health care service but also exacerbate the health

condition of those who are already diagnosed with breast cancer due to the lack of follow-up treatment. Thus, creating measures that can effectively address these issues is a must, especially financial (costs of screening and treatment) and transportation (availability) barriers as indicated as most needed in this county.

### **Qualitative Data Findings**

Overall, findings from the qualitative data collection confirmed questions discussed in the previous sections. According to surveys and focus group, breast cancer is described as a problem in each respective community, which was also confirmed by key informants for three of the five at least, not surprisingly. Specifically, the Community Profile Team confirmed the limitations of the health care system(s) currently in place for each target county. Yet, key informants expressed individuals simply are not aware of the services they offer. And, in between that, lies the challenge for the Affiliate and the proposed Mission Action Plan, which will be discussed in the next section.

Although limitations of the data are outweighed by strengths, the Affiliate recognizes the outcomes as a critical starting point for reaching populations specifically within the recent expansion area, which is four of the five target counties selected. Strengths include the sampling methods, while weaknesses include time constraints, sample size, and missing data points for key informants.

In conclusion, the Affiliate is energized and looking forward to reaching individuals with education inclusive primarily of tips and resources for taking preventative action, working with key informants to develop new and/or current community organizing programs, providing translated materials and training to linguistically isolated groups, and helping strengthen patient navigation programs where ancillary services are needed.

# Mission Action Plan

## Mission Action Plan

Susan G. Komen Central and Western Oklahoma developed the following plan to address the priority areas using the data gathered throughout the Community Profile. The following problem statements, priorities and objectives are specific to the target communities and needs that exist.

 <b>MISSION ACTION PLAN</b> <i>Our Mission is to save lives and end breast cancer forever.</i>			
Target Counties	Current Health Issues	Priorities	Objectives
Oklahoma County	<ul style="list-style-type: none"> <li>Income and language are two primary barriers that avert highly susceptible individuals, specifically Hispanic/Latina and Black/African-American women, from seeking and obtaining quality and timely breast health services.</li> <li>Unlikely to meet HP2020 targets for both breast cancer death and late-stage incidence rates.</li> </ul>	Projects focusing on providing a certified, onsite bilingual/bicultural interpreter or staff, patient navigation, free mammogram, and diagnostics to low-income, uninsured/underinsured, Hispanic/Latina, and/or Black/African-American women ages 40-49.	<ul style="list-style-type: none"> <li>FY2017 develop relationships with at least three Hispanic/Latino media outlets to promote targeted breast self-awareness messaging.</li> <li>FY17-18 Community Grant RFA funding priority focusing on quality and timely access to breast screening programs.</li> </ul>
Comanche County	<ul style="list-style-type: none"> <li>Over a third of the county is considered to be in poverty and medically underserved.</li> </ul>	Projects supporting the expansion of accessible facilities for breast cancer screening and diagnostics for the low-income, uninsured/underinsured, and medically underserved.	<ul style="list-style-type: none"> <li>FY2017 develop relationships with community based organizations serving low income populations.</li> <li>FY17-18 Community Grant RFA funding priority focusing on quality and timely access to breast screening programs.</li> </ul>
Carter County	<ul style="list-style-type: none"> <li>Screening percentages (48.8%) are significantly lower among women, specifically American Indian/Alaska Native (AIAN) populations, aged 40 and older compared to that of the Affiliate service area as a whole (71%).</li> <li>Unlikely to meet the HP 2020 target for late-stage incidence rate.</li> </ul>	Projects focusing on a community-wide breast cancer awareness and free mammogram programs that specifically target the AIAN populations ages 40 and older for a better understanding of breast cancer risk factors as well as a higher screening percentage for breast cancer, respectively.	<ul style="list-style-type: none"> <li>FY2017 develop relationships with Tribal affiliations in and surrounding Carter County.</li> <li>FY17-18 Community Grant RFA funding priority focusing on grassroots education and patient navigation programs.</li> </ul>

Texas County	<ul style="list-style-type: none"> <li>• With a high percentage of Hispanic/Latina and foreign-born female population, language barriers are a major issue in Texas County.</li> <li>• High proportion of uneducated and uninsured adult populations.</li> <li>• Unlikely to meet the HP2020 target for late-stage incidence rate.</li> </ul>	<p>Projects promoting a multicultural/multilingual community health education and awareness programs that focus primarily on informing the uninsured/underinsured, undereducated, and low-income Hispanic/Latina populations of all ages about breast cancer risk factors, free mammogram opportunities, as well as financial assistance programs for diagnostic services.</p>	<ul style="list-style-type: none"> <li>• FY2017 develop relationships with community groups serving linguistically isolated populations.</li> <li>• FY17-18 Community Grant RFA funding priority focusing on grassroots education and navigation programs.</li> </ul>
Garfield County	<ul style="list-style-type: none"> <li>• Low screening percentages among women of all races aged 40 and older.</li> <li>• Unlikely to meet the HP 2020 targets for both breast cancer death and late-stage incidence rates.</li> </ul>	<p>Projects focusing on both a primary and tertiary prevention approach that provides free mammograms to women of any ethnic group ages 40-49 and breast cancer Survivors, respectively.</p>	<ul style="list-style-type: none"> <li>• FY2017 develop relationships with local screening sites serving low income populations.</li> <li>• FY17-18 Community Grant RFA funding priority focusing on quality and timely access to breast screening programs.</li> </ul>

# References

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