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The Affiliate would like to thank interview and focus group participants for your invaluable input. You embody the hope we have that we will fulfill our shared mission of ending breast cancer.

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Susan G. Komen Philadelphia, which was established as an Affiliate in 2001, strives daily to fulfill the mission of eliminating breast cancer deaths in its 15-county service area which includes Kent County, DE, New Castle, County, DE, Sussex, County, DE, Adams County, PA, Berks County, PA, Bucks County, PA, Chester County, PA, Delaware County, PA, Lancaster County, PA, Lebanon County, PA, Lehigh County, PA, Montgomery County, PA, Philadelphia County, PA, York County, PA, and Camden County, NJ. Since the Affiliate’s inception, Komen Philadelphia has awarded $55.5 million in grants to local organizations, funded more than 155,000 mammograms for women in need, and contributed approximately $23 million towards breast cancer research.

Empowering women to strive to end breast cancer is a top-priority for Komen Philadelphia, which is why its key activities include breast health and breast cancer education events that target community members and underserved populations. These annual events include Sisters for the Cure, Latinas United for the Cure and Asian American Women’s Health Awareness Day, which bring together more than 3,000 women total. In 2013, Komen Philadelphia began an effort to engage young survivors (ages 20-40) through the Big Pink Footprint, a special series of education and community-building events. In 2014, Komen Philadelphia and Esperanza College of Eastern University partnered to build a college-based breast health advocate training programs that utilizes college students to engage with primarily Latino patients in health center settings in North Philadelphia. Other key activities include annual large-scale fundraising events such as the Pink Tie Ball and Race for the Cure. These events are the primary source of funding for the Community Grants Program, which allows the affiliate to award more than $1 million each year to breast health and education programs of local hospitals and organizations located throughout Komen Philadelphia’s priority and 15-county service areas.

The Community Profile Report is an assessment of the breast health needs in the Affiliate’s service area. The Affiliate conducts quantitative, qualitative and health systems analysis in order to identify priority areas for targeted service and to better understand the barriers women in such areas face in regards to access to care. Additionally, it is used to help develop strategies for addressing such barriers and eradicating breast health disparities. Komen Philadelphia will use the results of the analyses to establish education and funding priorities for the next five years.

**Quantitative Data: Measuring Breast Cancer Impact in Local Communities**

The quantitative analysis evaluates the data used to identify priorities within the Affiliate’s service area. Indicators used include breast cancer incidence rates, breast cancer death rates, late-stage breast cancer diagnosis rates, mammography screening rates, Healthy People 2020 (HP2020) forecast data, rates of uninsured individuals, and key demographic information. These indicators are assessed for each county within the Affiliate’s service area and then measured against state and national data. Based on these data, the following counties and municipalities (some with demographic specifications) have been identified as areas that will be the focus for healthy systems and policy and qualitative analyses:

- Camden County, NJ: Hispanic/Latina, Black/African-American women
- Philadelphia County, PA: Black/African-American women
- Delaware County, PA: No race/ethnic specification
- Reading area, Berks County, PA: Hispanic/Latina women
- Warminster area, Bucks County, PA: Hispanic/Latina women
Camden County, NJ is among the highest priority communities due to the large percentage of Spanish-speaking Latina women and the high incidence, death, and late-stage diagnosis rates among Black/African-Americans. Thus, the Affiliate has identified the Hispanic/Latina and Black/African-American female populations in Camden County as high priorities of interest. Philadelphia County, PA was selected as a priority community because women residing in this county experience significantly higher death and late-stage diagnosis incidence rates. Additionally, demographic information indicates that there are substantial racial and socioeconomic status (SES) disparities. Based on current trends, Philadelphia will take 13 years or more to meet breast cancer-specific HP2020 targets. Similarly, Delaware County, PA is a target community due to the fact that it will take 13 years or more for the county to meet breast cancer-specific HP2020 targets. All races of Delaware County exceed late-diagnosis rates in comparison to national data. Additional data was collected that indicated need in the Reading area of Berks County, PA and Warminster area of Bucks County, PA. The Reading area was selected in part due to the large percentage of Spanish-speaking Latina women in the municipality. The Warminster area of Bucks County, PA was selected due to demographic data also shows that there are dramatic disparities in comparison to state-data regarding individuals who are Hispanic/Latino, foreign-born, speak languages other than English, and/or live below the poverty level. The Affiliate conducted further health system and qualitative analysis to identify specific barriers that could be contributing to the needs of the identified priority communities.

**Health System and Public Policy Analysis**

The Affiliate conducted a Health System and Public Policy Analysis in order to identify strengths and weaknesses throughout the continuum of care in the identified target areas. Furthermore, the Affiliate analyzed key state policies that may impact breast health services low-income, uninsured, and underinsured women are able to receive. The findings demonstrate that while heavily populated areas such as Philadelphia County, PA, Camden County, NJ, and Delaware County, PA have an abundance of breast health resources, few of these resources offer breast health services across the continuum of care. Furthermore, as disparities persist, there is a desperate need for targeted outreach, patient navigation and coordination so that all women are able to access such services. Rural areas such as Reading, PA and Warminster, PA have minimal breast health resources. Those that are available are not likely to provide services throughout the continuum of care making adequate access difficult for women living in this area.

When it comes to the availability of state-funded financial assistance programs to help the low-income, uninsured and underinsured women access breast health services (HealthyWoman in PA, Screening for Life in DE and New Jersey Cancer Education and Early Detection in NJ), the amount of funds varies by state. More often than not, there are not enough funds available to cover the vast number of women who need these services in order to access and receive care. Additionally, eligibility for Medicaid varies by state. As of 2015, PA has opted into traditional Medicaid Expansion after initially declining and opting in via an alternative plan. NJ and DE have expanded Medicaid. Even with the expansion of Medicaid, disparities persist and populations with the highest need are still ineligible to receive Medicaid and/or unable to afford health insurance. These policy findings indicate that women residing in Komen Philadelphia’s priority and service areas are in desperate need of programs that assist with funding breast health services beyond the state-funded programs and other available options.

**Qualitative Data: Ensuring Community Input**

In order to gain a deeper understanding of the findings from the quantitative and health systems analysis, Komen Philadelphia collected and analyzed qualitative data across the five priority areas identified. The qualitative data included 47 key informant interviews with providers and six
focus group sessions with consumers. The key questions explored through this analysis focused on barriers to accessing breast health services, personal experiences with health insurance, knowledge of critical breast health information, and resources and perceptions of breast cancer at the community-level. Common themes that emerged in the Affiliate’s discussions with providers and consumers were barriers accessing and maintaining health insurance, financing care, breast health and resource awareness barriers, lack of transportation options and assistance, and cultural barriers including lack of cultural competence and language gaps. All targeted priority areas identified health insurance/financing care and breast health/resource awareness as major barriers that impeded many women from accessing available resources. Specifically in Camden County, NJ, Reading, PA and Warminster, PA, Hispanic/Latina consumers – and providers who serve a large percentage of Latinas – identified linguistic and cultural barriers as huge challenge to receiving proper care. Rural areas such as Reading, PA cited the lack of resources as an extreme barrier to receiving care. The findings from the qualitative analysis echoed the fact that there are severe obstacles that need to be addressed in the Affiliate’s targeted communities in order to help bridge the gaps and assist the underserved populations that fall through the cracks.

Mission Action Plan
Going forward, the Affiliate will identify the following communities as priority areas for targeted resources and support:

- Camden County, NJ (Black/African-American and Hispanic/Latina women)
- Philadelphia County, PA (Black/African-American women)
- Delaware County, PA
- Warminster, PA (Hispanic/Latina women)
- Reading, PA (Hispanic/Latina women)

The results of the 2015 Community Profile demonstrate that there is a substantial need for accessible, competent, and high quality breast health education, screening, treatment, and support/navigation services. Thus, the following needs and objectives will be a focus for the Affiliate within priority counties and populations:

Increase Access

Qualitative analysis suggest that there are extensive reasons as to why women have difficulty accessing breast health care in the targeted service areas of Camden County, NJ, Delaware County, PA, Philadelphia County, PA, Reading, PA, and Warminster, PA.

Priority #1: Make breast health services across the continuum of care, and support services to address barriers to care, more accessible to all women within the targeted service areas of Camden County, NJ, Delaware County, PA, Philadelphia County, PA, Reading, PA, and Warminster, PA.

Objectives:

1. Beginning in 2015, name Camden County, NJ, Delaware, Philadelphia, Reading and Warminster, PA as priority counties/populations in the Community Grants Program Request for Applications and encourage projects that target resources towards education, navigation and medical services.
2. Beginning in 2016-2017 grant cycle, include an Outreach, Education, and Navigation funding category in the Community Grants Program that is designed specifically to
identify culturally-competent programs that address barriers to care, lack of breast cancer awareness and resource availability.

3. By FY2017, use Komen's Breast Self-Awareness messages and grants program as a focal point of community-based marketing strategies throughout the Affiliate service area.

**Partnership Opportunities**

The health systems analysis data reveals that there is a lack of resources for women in the rural areas of Warminster, PA and Reading, PA. In the other priority counties of Camden County, NJ, Delaware County, PA, and Philadelphia County, PA, the analysis indicates a need for coordination of services among providers and increasing awareness of those resources among consumers.

**Priority #2:** Increase the Affiliate’s presence and leadership within the targeted service areas of Camden County, NJ, Delaware County, PA, Philadelphia County, PA, Reading, PA, and Warminster, PA by forming estimable partnerships with grass-roots organizations, nonprofits, hospitals, businesses and other organizations that advocate for the eradication of breast cancer by expanding knowledge of Komen's mission.

**Objectives:**

1. By December 2015, develop a Community Profile taskforce that includes at least one representative from one organization in each targeted community of Camden County, NJ, Delaware County, PA, Philadelphia County, PA, Reading, PA, and Warminster, PA; task force will work together to develop initiatives to address specific needs in their community by meeting twice per year beginning in Winter 2015 until Spring 2019 and developing an end-of-year report on the status of goals for each community.

2. By December 2015, leverage partnerships with organizations that represent the targeted service areas of Camden County, NJ, Delaware County, PA, Philadelphia County, PA, Reading, PA, and Warminster, PA built through county task forces to increase access for underserved (i.e., low-income and minority) women in these areas to Komen Philadelphia’s internal education programs: Latinas United for the Cure, Asian American Women’s Health Awareness Day, and Sisters for the Cure.

3. Komen Philadelphia will also continue to consider high-quality projects and programs for its annual Community Grants Program that clearly identify needs and solutions that pertain to increasing access and providing culturally competent services across the continuum of care.

**Disclaimer:** Comprehensive data for the Executive Summary can be found in the 2015 Komen Philadelphia Community Profile Report.
Affiliate History

Nancy G. Brinker promised her dying sister, Suzy, she would do everything in her power to end breast cancer. Today, Susan G. Komen® works to end breast cancer in the US and throughout the world by investing more than $847 million in breast cancer research and $1.8 billion in community outreach programs over the past 30 years; providing funding to help low-income and uninsured women get screened and get treatment; advocating for cancer research and outreach programs; and working globally in more than 30 countries.

Susan G. Komen Philadelphia was established in 2001, and since its inception, has served 15 counties under one premise— to eradicate breast cancer. Although the Affiliate was officially founded in 2001, Komen’s presence in the region began in 1991 when the Race for the Cure, spearheaded by CEO Elaine I. Grobman, was brought to Philadelphia. The first Race generated approximately $10,000 for the fight against breast cancer and brought together 1,983 participants. Through the years, the Race has grown exponentially and continues to be a key component in being able to carry out the Komen mission. In 2014, the Race generated more than $2 million and had upwards of 100,000 people on site. The Race is one of many testaments to the Affiliate’s growing presence in its service area and continued dedication to the Komen mission.

In 2004 and 2006, the Affiliate was named to the Education Outreach Honor Roll by Susan G. Komen Headquarters. Additionally, since 2004, the Affiliate has received eight awards from the American Cancer Society (ACS) in recognition for its educational programs and overall efforts in the fight against breast cancer. One of these awards was a Division Citation Award, a special award recognizing agencies that have provided outstanding cooperation in carrying out cancer control activities for the ACS. A number of local municipalities and entities have also recognized the Affiliate, including the most recent recognition from the Camden City Mayor’s Youth Council in Camden, NJ.

Komen Philadelphia works relentlessly in the communities of its service area to ensure access to breast screening and treatment services to the medically underserved, educate the population on critical breast health information, and provide support services for those who are coping with a breast cancer diagnosis. The Affiliate’s breast health education initiatives include three culturally-specific education events established to bring life-saving breast health information to the medically-underserved. Sisters for the Cure, established in 2003, is intended for Black/African-American women in the Affiliate’s service area; Latinas United for the Cure, also established in 2003, is intended for Hispanic/Latina women and includes breast health content delivered in both English and Spanish; Asian American Women’s Health Awareness Day, established in 2004, is intended for the Asian women in the service area and includes breast health content delivered in 12 different languages. Combined, these events serve more than 3,000 women annually. Furthermore, the Affiliate’s Big Pink Footprint series, which was established in 2013, functions to provide support services to young survivors, ages 25 to 40. In addition to the Affiliate’s larger-scaled events, Komen Philadelphia maintains a presence at local health fairs and as of 2014, has partnered with a local college to deliver breast health information to accessible locations in the community and train college students to be able to educate individuals in their communities about breast cancer.

The Affiliate manages a Community Grants Program, which has awarded more than $24 million since 2003 to hospitals and community-based organizations. Between 2013 and 2015, the Affiliate awarded an average of 19 grants per year to provide screening, diagnostic and treatment services to uninsured and underinsured individuals in the community, while encouraging interagency partnerships. Since the beginning of the Community Grants Program,
the Affiliate has been able to provide more than 150,000 mammograms and over 200,000 education/outreach contacts. See Figure 1.1 for more on Affiliate grant funding.

**Figure 1.1. Komen Philadelphia Grants Since 2003**

**Affiliate Organizational Structure**
The organizational components of the Affiliate are the Board of Directors, Affiliate staff, various standing committees, and dedicated volunteers. The Board of Directors is comprised of dedicated survivors and volunteers from a variety of disciplines, including health care, finance, business, public relations, and law. The 15-person Board of Directors works with a 10-person staff to fulfill the Komen promise. In 2014, the Affiliate's database records show that its work is supported by more than 2,700 volunteers throughout the region. See Figure 1.2 for the Affiliate organizational structure.

**Figure 1.2. Komen Philadelphia Organizational Structure**
**Affiliate Service Area**
The Affiliate's service area includes 15 counties in three states: Delaware, Pennsylvania, and New Jersey. The service area consists of all three counties in the state of Delaware (Kent, New Castle and Sussex), 11 counties in Pennsylvania (Adams, Berks, Bucks, Chester, Delaware, Lancaster, Lebanon, Lehigh, Montgomery, Philadelphia, and York), and Camden County in New Jersey. See Figure 1.3 for a map of the Affiliate service area.

![Komen Philadelphia Service Area](image_url)

*Figure 1.3. Susan G. Komen Philadelphia Service Area*
The Affiliate’s service area population was estimated to be 7,399,658 per 2010 Census Data. The service area includes a diverse population: approximately 71 percent White, 17 percent Black/African-American, eight percent Hispanic/Latino, and four percent Asian (Census Bureau, 2010). The Affiliate’s service area is diverse in many respects, covering urban, suburban and rural communities with widely varying racial, ethnic, and socioeconomic demographics.

Twenty-one percent of the service area population resides in Philadelphia County, a metropolitan area that is diverse on all fronts. The greater Philadelphia Metropolitan area, also called the Delaware Valley, includes seven counties: Camden County, NJ; Bucks, Chester, Delaware, Montgomery and Philadelphia Counties, PA; and New Castle County, DE. These counties are largely urban with robust health care systems and transportation services.

The Lehigh Valley is an area in the northern region of the Affiliate service area, of which the Affiliate serves Lehigh and Lebanon Counties. Because of the division of this region, the Affiliate works with the Komen Northeastern Pennsylvania (NEPA) Affiliate to ensure that there is no duplication of services and that there is a united message. The Affiliate’s service area also includes Berks, Lancaster and York Counties. These counties are largely rural and include the cities of Reading, York and Lancaster.

The Affiliate’s service area also includes the entire state of Delaware. New Castle County is the northernmost county in Delaware and is home to Wilmington, DE, the largest city in the state. Kent County is located in central Delaware. It includes Dover, DE, the state capital and second largest city in the state. Sussex County is the southernmost county in Delaware. The eastern part of this county includes many beach resort towns, while the western part is very rural.

**Purpose of the Community Profile Report**

In order to fulfill its mission, the Affiliate conducts a quantitative and qualitative needs assessment every four years. The findings from this needs assessment are reported in the Community Profile, which informs the Affiliate of assets and gaps in its service area, and guides funding priorities. Furthermore, the findings identify the regions, communities and populations where directing efforts will have the most impact. Thus, the Community Profile serves as a document to ensure that the Affiliate’s efforts are targeted and non-duplicative. This document is designed to help the Affiliate in the following ways:

- Establish focused granting and education priorities
- Identify new partnerships to increase awareness of Komen resources (e.g. grants program, free screenings, education events, etc.)

Through the development of the Community Profile, community strengths are assessed to develop partnerships and collaborations. Through interviews, focus groups and surveys, the Community Profile also includes the voices of individuals living and working in areas of highest need. The Affiliate will make this document accessible to all stakeholders including, but not limited to, health care systems, legislators, constituents, and funders.
Quantitative Data Report

Introduction
The purpose of the quantitative data report for Susan G. Komen® Philadelphia 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 (http://www.healthypeople.gov/2020/default.aspx).

The following is a summary of Komen® Philadelphia’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/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.

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Incidence Rates and Trends</th>
<th>Death Rates and Trends</th>
<th>Late-stage Rates and Trends</th>
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<tr>
<td></td>
<td>Female Population (Annual Average)</td>
<td># of New Cases (Annual Average)</td>
<td>Age-adjusted Rate/100,000</td>
</tr>
<tr>
<td>------------------</td>
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<td>---------------------------</td>
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<tr>
<td>US</td>
<td>154,540,194</td>
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<tr>
<td>Lebanon County - PA</td>
<td>67,205</td>
<td>100</td>
<td>114.7</td>
</tr>
<tr>
<td>Lehigh County - PA</td>
<td>177,396</td>
<td>269</td>
<td>125.8</td>
</tr>
<tr>
<td>Montgomery County - PA</td>
<td>407,295</td>
<td>669</td>
<td>134.1</td>
</tr>
<tr>
<td>Philadelphia County - PA</td>
<td>797,130</td>
<td>1,097</td>
<td>128.5</td>
</tr>
<tr>
<td>York County - PA</td>
<td>217,026</td>
<td>326</td>
<td>126.1</td>
</tr>
</tbody>
</table>

*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: NAACCR – CINA Deluxe Analytic File.
Source of death trend data: NCI/CDC State Cancer Profiles.

**Incidence rates and trends summary**
Overall, the breast cancer incidence rate and trend in the Komen Philadelphia service area were higher than that observed in the US as a whole. The incidence rate and trend of the Affiliate service area were not significantly different than that observed for the State of Delaware. The incidence rate and trend of the Affiliate service area were not significantly different than that observed for the State of New Jersey. The incidence rate of the Affiliate service area was significantly higher than that observed for the State of Pennsylvania and the incidence trend was not significantly different than the State of Pennsylvania.

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 APIs and 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 about the same among Blacks/African-Americans and Whites, lower among APIs than Whites, and lower among AIANs than Whites. The incidence rate among Hispanics/Latinas was lower than among Non-Hispanics/Latinas.
The following county had an incidence rate **significantly higher** than the Affiliate service area as a whole:

- Camden County, NJ

The incidence rate was significantly lower in the following counties:

- Lancaster County, PA
- Lebanon County, PA

The rest of the counties had incidence rates and trends that were not significantly different than the Affiliate service area as a whole.

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

**Death rates and trends summary**

Overall, the breast cancer death rate in the Komen Philadelphia service area was slightly higher than that observed in the US as a whole and the death rate trend was not available for comparison with the US as a whole. The death rate of the Affiliate service area was not significantly different than that observed for the State of Delaware. The death rate of the Affiliate service area was not significantly different than that observed for the State of New Jersey. The death rate of the Affiliate service area was not significantly different than that observed for the State of Pennsylvania.

For the United States, breast cancer death rates in Blacks/African-Americans are substantially higher than in Whites overall. The most recent estimated breast cancer death rates for APIs and AIANs were lower than for Non-Hispanic Whites and Blacks/African-Americans. The most recent estimated death rates for Hispanics/Latinas were lower than for Non-Hispanic Whites and Blacks/African-Americans. For the Affiliate service area as a whole, the death rate was higher among Blacks/African-Americans than Whites and lower among APIs than Whites. There were not enough data available within the Affiliate service area to report on AIANs so comparisons cannot be made for this racial group. The death rate among Hispanics/Latinas was lower than among Non-Hispanics/Latinas.

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

- Camden County, NJ
- Philadelphia County, PA

The death rate was significantly lower in the following counties:

- New Castle County, DE
- Montgomery County, PA
- York County, PA

The rest of the counties had death rates and trends that were not significantly different than the Affiliate service area as a whole.

**Late-stage incidence rates and trends summary**

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

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

The following counties had a late-stage incidence rate significantly higher than the Affiliate service area as a whole:
  • Camden County, NJ
  • Philadelphia County, PA

The late-stage incidence rate was significantly lower in the following counties:
  • New Castle County, DE
  • Lancaster County, PA
  • Lebanon County, PA

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>
<thead>
<tr>
<th>American Cancer Society</th>
<th>National Comprehensive Cancer Network</th>
<th>US Preventive Services Task Force</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informed decision-making with a health care provider at age 40</td>
<td>Mammography every year starting at age 40</td>
<td>Informed decision-making with a health care provider ages 40-49</td>
</tr>
<tr>
<td>Mammography every other year beginning at age 55</td>
<td>Mammography every other year starting at age 55</td>
<td>Mammography every 2 years ages 50-74</td>
</tr>
</tbody>
</table>

*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.

<table>
<thead>
<tr>
<th>Population Group</th>
<th># of Women Interviewed (Sample Size)</th>
<th># w/ Self-Reported Mammogram</th>
<th>Proportion Screened (Weighted Average)</th>
<th>Confidence Interval of Proportion Screened</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>174,796</td>
<td>133,399</td>
<td>77.5%</td>
<td>77.2%-77.7%</td>
</tr>
<tr>
<td>Delaware</td>
<td>2,000</td>
<td>1,651</td>
<td>82.8%</td>
<td>80.6%-84.7%</td>
</tr>
<tr>
<td>New Jersey</td>
<td>5,342</td>
<td>4,115</td>
<td>77.7%</td>
<td>76.3%-79.0%</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>7,404</td>
<td>5,654</td>
<td>77.8%</td>
<td>76.6%-78.9%</td>
</tr>
<tr>
<td>Komen Philadelphia Service Area</td>
<td>4,102</td>
<td>3,273</td>
<td>78.8%</td>
<td>77.2%-80.3%</td>
</tr>
<tr>
<td>White</td>
<td>3,305</td>
<td>2,600</td>
<td>77.8%</td>
<td>76.0%-79.4%</td>
</tr>
<tr>
<td>Population Group</td>
<td># of Women Interviewed (Sample Size)</td>
<td># w/ Self-Reported Mammogram</td>
<td>Proportion Screened (Weighted Average)</td>
<td>Confidence Interval of Proportion Screened</td>
</tr>
<tr>
<td>---------------------------</td>
<td>--------------------------------------</td>
<td>------------------------------</td>
<td>----------------------------------------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>Black/African-American</td>
<td>664</td>
<td>569</td>
<td>85.8%</td>
<td>82.0%-88.9%</td>
</tr>
<tr>
<td>AIAN</td>
<td>25</td>
<td>18</td>
<td>75.8%</td>
<td>46.1%-91.9%</td>
</tr>
<tr>
<td>API</td>
<td>25</td>
<td>22</td>
<td>70.4%</td>
<td>48.4%-85.8%</td>
</tr>
<tr>
<td>Hispanic/ Latina</td>
<td>81</td>
<td>66</td>
<td>73.1%</td>
<td>59.9%-83.2%</td>
</tr>
<tr>
<td>Non-Hispanic/ Latina</td>
<td>4,013</td>
<td>3,203</td>
<td>79.1%</td>
<td>77.5%-80.6%</td>
</tr>
<tr>
<td>Kent County - DE</td>
<td>556</td>
<td>448</td>
<td>79.2%</td>
<td>74.6%-83.1%</td>
</tr>
<tr>
<td>New Castle County - DE</td>
<td>797</td>
<td>657</td>
<td>83.1%</td>
<td>79.6%-86.0%</td>
</tr>
<tr>
<td>Sussex County - DE</td>
<td>633</td>
<td>535</td>
<td>84.6%</td>
<td>80.9%-87.7%</td>
</tr>
<tr>
<td>Camden County - NJ</td>
<td>264</td>
<td>193</td>
<td>69.2%</td>
<td>61.9%-75.7%</td>
</tr>
<tr>
<td>Adams County - PA</td>
<td>49</td>
<td>40</td>
<td>79.9%</td>
<td>63.3%-90.2%</td>
</tr>
<tr>
<td>Berks County - PA</td>
<td>87</td>
<td>66</td>
<td>80.4%</td>
<td>69.8%-87.9%</td>
</tr>
<tr>
<td>Bucks County - PA</td>
<td>140</td>
<td>104</td>
<td>76.3%</td>
<td>67.5%-83.3%</td>
</tr>
<tr>
<td>Chester County - PA</td>
<td>102</td>
<td>82</td>
<td>82.0%</td>
<td>72.4%-88.9%</td>
</tr>
<tr>
<td>Delaware County - PA</td>
<td>122</td>
<td>94</td>
<td>83.0%</td>
<td>74.5%-89.1%</td>
</tr>
<tr>
<td>Lancaster County - PA</td>
<td>114</td>
<td>83</td>
<td>73.5%</td>
<td>63.1%-81.8%</td>
</tr>
<tr>
<td>Lebanon County - PA</td>
<td>50</td>
<td>36</td>
<td>70.7%</td>
<td>54.7%-82.9%</td>
</tr>
<tr>
<td>Lehigh County - PA</td>
<td>142</td>
<td>100</td>
<td>70.8%</td>
<td>61.7%-78.5%</td>
</tr>
<tr>
<td>Montgomery County - PA</td>
<td>156</td>
<td>126</td>
<td>78.3%</td>
<td>70.6%-84.5%</td>
</tr>
<tr>
<td>Philadelphia County - PA</td>
<td>717</td>
<td>574</td>
<td>82.6%</td>
<td>78.7%-86.0%</td>
</tr>
<tr>
<td>York County - PA</td>
<td>173</td>
<td>135</td>
<td>78.8%</td>
<td>70.8%-85.1%</td>
</tr>
</tbody>
</table>

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 Philadelphia service area was not significantly different than that observed in the US as a whole. The screening proportion of the Affiliate service area was significantly lower than the State of Delaware, was not significantly different than the State of New Jersey and was not significantly different than the State of Pennsylvania.

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 significantly higher 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:
- Camden County, NJ

The following county had a screening proportion significantly higher than the Affiliate service area as a whole:
- Sussex County, DE
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.

<table>
<thead>
<tr>
<th>Population Group</th>
<th>White</th>
<th>Black /African-American</th>
<th>AIAN</th>
<th>API</th>
<th>Non-Hispanic /Latina</th>
<th>Hispanic /Latina</th>
<th>Female Age 40 Plus</th>
<th>Female Age 50 Plus</th>
<th>Female Age 65 Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>78.8%</td>
<td>14.1%</td>
<td>1.4%</td>
<td>5.8%</td>
<td>83.8%</td>
<td>16.2%</td>
<td>48.3%</td>
<td>34.5%</td>
<td>14.8%</td>
</tr>
<tr>
<td>Delaware</td>
<td>72.3%</td>
<td>23.4%</td>
<td>0.7%</td>
<td>3.7%</td>
<td>92.2%</td>
<td>7.8%</td>
<td>50.6%</td>
<td>36.6%</td>
<td>16.0%</td>
</tr>
<tr>
<td>New Jersey</td>
<td>74.6%</td>
<td>15.7%</td>
<td>0.6%</td>
<td>9.1%</td>
<td>82.5%</td>
<td>17.5%</td>
<td>50.9%</td>
<td>35.9%</td>
<td>15.5%</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>84.4%</td>
<td>12.1%</td>
<td>0.4%</td>
<td>3.1%</td>
<td>94.4%</td>
<td>5.6%</td>
<td>52.3%</td>
<td>38.6%</td>
<td>17.6%</td>
</tr>
<tr>
<td>Komen Philadelphia Service Area</td>
<td>75.4%</td>
<td>19.5%</td>
<td>0.6%</td>
<td>4.6%</td>
<td>91.1%</td>
<td>8.9%</td>
<td>50.0%</td>
<td>36.0%</td>
<td>15.8%</td>
</tr>
<tr>
<td>Kent County - DE</td>
<td>69.7%</td>
<td>26.6%</td>
<td>0.8%</td>
<td>2.9%</td>
<td>94.1%</td>
<td>5.9%</td>
<td>47.9%</td>
<td>34.1%</td>
<td>15.1%</td>
</tr>
<tr>
<td>New Castle County - DE</td>
<td>68.9%</td>
<td>25.9%</td>
<td>0.5%</td>
<td>4.7%</td>
<td>91.6%</td>
<td>8.4%</td>
<td>48.5%</td>
<td>33.9%</td>
<td>14.0%</td>
</tr>
<tr>
<td>Sussex County - DE</td>
<td>83.4%</td>
<td>13.9%</td>
<td>1.3%</td>
<td>1.4%</td>
<td>92.1%</td>
<td>7.9%</td>
<td>58.8%</td>
<td>46.2%</td>
<td>22.5%</td>
</tr>
<tr>
<td>Camden County - NJ</td>
<td>71.1%</td>
<td>22.5%</td>
<td>0.7%</td>
<td>5.7%</td>
<td>85.9%</td>
<td>14.1%</td>
<td>49.6%</td>
<td>35.1%</td>
<td>14.7%</td>
</tr>
<tr>
<td>Adams County - PA</td>
<td>96.7%</td>
<td>2.0%</td>
<td>0.3%</td>
<td>0.9%</td>
<td>94.5%</td>
<td>5.5%</td>
<td>53.9%</td>
<td>39.2%</td>
<td>17.4%</td>
</tr>
<tr>
<td>Berks County - PA</td>
<td>90.7%</td>
<td>6.8%</td>
<td>0.7%</td>
<td>1.8%</td>
<td>83.5%</td>
<td>16.5%</td>
<td>50.6%</td>
<td>36.2%</td>
<td>16.3%</td>
</tr>
<tr>
<td>Bucks County - PA</td>
<td>91.1%</td>
<td>4.2%</td>
<td>0.3%</td>
<td>4.4%</td>
<td>95.8%</td>
<td>4.2%</td>
<td>55.1%</td>
<td>39.4%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Chester County - PA</td>
<td>88.4%</td>
<td>6.9%</td>
<td>0.3%</td>
<td>4.4%</td>
<td>94.1%</td>
<td>5.9%</td>
<td>51.0%</td>
<td>35.5%</td>
<td>14.5%</td>
</tr>
<tr>
<td>Delaware County - PA</td>
<td>73.2%</td>
<td>21.5%</td>
<td>0.2%</td>
<td>5.1%</td>
<td>97.1%</td>
<td>2.9%</td>
<td>50.9%</td>
<td>37.0%</td>
<td>16.4%</td>
</tr>
<tr>
<td>Lancaster County - PA</td>
<td>92.6%</td>
<td>4.8%</td>
<td>0.4%</td>
<td>2.3%</td>
<td>91.3%</td>
<td>8.7%</td>
<td>49.7%</td>
<td>36.6%</td>
<td>16.9%</td>
</tr>
<tr>
<td>Lebanon County - PA</td>
<td>95.2%</td>
<td>3.0%</td>
<td>0.3%</td>
<td>1.5%</td>
<td>90.5%</td>
<td>9.5%</td>
<td>53.2%</td>
<td>39.8%</td>
<td>19.2%</td>
</tr>
<tr>
<td>Lehigh County - PA</td>
<td>87.4%</td>
<td>8.3%</td>
<td>0.8%</td>
<td>3.5%</td>
<td>80.9%</td>
<td>19.1%</td>
<td>51.1%</td>
<td>36.9%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Montgomery County - PA</td>
<td>83.3%</td>
<td>9.6%</td>
<td>0.3%</td>
<td>6.9%</td>
<td>96.0%</td>
<td>4.0%</td>
<td>53.3%</td>
<td>38.4%</td>
<td>17.2%</td>
</tr>
<tr>
<td>Philadelphia County - PA</td>
<td>45.2%</td>
<td>47.1%</td>
<td>1.0%</td>
<td>6.8%</td>
<td>88.0%</td>
<td>12.0%</td>
<td>44.1%</td>
<td>31.8%</td>
<td>14.0%</td>
</tr>
<tr>
<td>York County - PA</td>
<td>91.4%</td>
<td>6.7%</td>
<td>0.3%</td>
<td>1.6%</td>
<td>94.5%</td>
<td>5.5%</td>
<td>52.1%</td>
<td>37.2%</td>
<td>15.8%</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Less than HS Education</th>
<th>Income Below 100% Poverty</th>
<th>Income Below 250% Poverty (Age: 40-64)</th>
<th>Unemployed</th>
<th>Foreign Born</th>
<th>Linguistically Isolated</th>
<th>In Rural Areas</th>
<th>In Medically Under-served Areas</th>
<th>No Health Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>14.6 %</td>
<td>14.3 %</td>
<td>33.3 %</td>
<td>8.7 %</td>
<td>12.8 %</td>
<td>4.7 %</td>
<td>19.3 %</td>
<td>23.3 %</td>
<td>16.6 %</td>
</tr>
<tr>
<td>Delaware</td>
<td>12.6 %</td>
<td>11.2 %</td>
<td>28.5 %</td>
<td>7.7 %</td>
<td>8.3 %</td>
<td>2.3 %</td>
<td>16.7 %</td>
<td>25.4 %</td>
<td>10.4 %</td>
</tr>
<tr>
<td>New Jersey</td>
<td>12.4 %</td>
<td>9.4 %</td>
<td>23.6 %</td>
<td>8.7 %</td>
<td>20.6 %</td>
<td>7.3 %</td>
<td>5.3 %</td>
<td>12.6 %</td>
<td>14.5 %</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>12.1 %</td>
<td>12.6 %</td>
<td>30.3 %</td>
<td>7.9 %</td>
<td>5.7 %</td>
<td>2.2 %</td>
<td>21.3 %</td>
<td>15.2 %</td>
<td>11.0 %</td>
</tr>
<tr>
<td>Komen Philadelphia Service Area</td>
<td>13.1 %</td>
<td>12.5 %</td>
<td>28.3 %</td>
<td>8.6 %</td>
<td>8.5 %</td>
<td>3.6 %</td>
<td>10.0 %</td>
<td>14.0 %</td>
<td>11.2 %</td>
</tr>
<tr>
<td>Kent County - DE</td>
<td>15.1 %</td>
<td>12.4 %</td>
<td>33.9 %</td>
<td>8.2 %</td>
<td>4.9 %</td>
<td>1.6 %</td>
<td>27.0 %</td>
<td>0.0 %</td>
<td>10.6 %</td>
</tr>
<tr>
<td>New Castle County - DE</td>
<td>11.1 %</td>
<td>10.7 %</td>
<td>24.8 %</td>
<td>7.6 %</td>
<td>9.9 %</td>
<td>2.5 %</td>
<td>4.6 %</td>
<td>5.7 %</td>
<td>9.6 %</td>
</tr>
<tr>
<td>Sussex County - DE</td>
<td>14.7 %</td>
<td>11.5 %</td>
<td>33.9 %</td>
<td>7.8 %</td>
<td>6.8 %</td>
<td>2.2 %</td>
<td>41.3 %</td>
<td>100.0 %</td>
<td>12.5 %</td>
</tr>
<tr>
<td>Camden County - NJ</td>
<td>14.1 %</td>
<td>11.8 %</td>
<td>27.4 %</td>
<td>10.4 %</td>
<td>10.2 %</td>
<td>4.4 %</td>
<td>1.6 %</td>
<td>11.0 %</td>
<td>13.9 %</td>
</tr>
<tr>
<td>Adams County - PA</td>
<td>14.8 %</td>
<td>7.8 %</td>
<td>26.7 %</td>
<td>5.2 %</td>
<td>4.0 %</td>
<td>1.6 %</td>
<td>53.7 %</td>
<td>0.0 %</td>
<td>10.8 %</td>
</tr>
<tr>
<td>Berks County - PA</td>
<td>16.2 %</td>
<td>13.1 %</td>
<td>28.9 %</td>
<td>8.7 %</td>
<td>6.3 %</td>
<td>4.0 %</td>
<td>23.7 %</td>
<td>9.8 %</td>
<td>11.8 %</td>
</tr>
<tr>
<td>Bucks County - PA</td>
<td>7.6 %</td>
<td>5.2 %</td>
<td>17.4 %</td>
<td>6.7 %</td>
<td>8.1 %</td>
<td>2.4 %</td>
<td>8.8 %</td>
<td>0.0 %</td>
<td>8.1 %</td>
</tr>
<tr>
<td>Chester County - PA</td>
<td>7.4 %</td>
<td>6.1 %</td>
<td>15.2 %</td>
<td>5.6 %</td>
<td>8.5 %</td>
<td>2.2 %</td>
<td>13.3 %</td>
<td>3.0 %</td>
<td>7.8 %</td>
</tr>
<tr>
<td>Delaware County - PA</td>
<td>9.0 %</td>
<td>9.5 %</td>
<td>23.8 %</td>
<td>7.9 %</td>
<td>8.7 %</td>
<td>2.1 %</td>
<td>0.5 %</td>
<td>3.8 %</td>
<td>9.8 %</td>
</tr>
<tr>
<td>Lancaster County - PA</td>
<td>16.7 %</td>
<td>9.9 %</td>
<td>27.7 %</td>
<td>6.2 %</td>
<td>4.5 %</td>
<td>3.3 %</td>
<td>21.3 %</td>
<td>5.9 %</td>
<td>11.2 %</td>
</tr>
<tr>
<td>Lebanon County - PA</td>
<td>15.1 %</td>
<td>9.6 %</td>
<td>27.8 %</td>
<td>7.3 %</td>
<td>3.1 %</td>
<td>2.3 %</td>
<td>26.6 %</td>
<td>9.0 %</td>
<td>10.3 %</td>
</tr>
<tr>
<td>Lehigh County - PA</td>
<td>14.2 %</td>
<td>12.3 %</td>
<td>28.7 %</td>
<td>8.7 %</td>
<td>9.4 %</td>
<td>4.7 %</td>
<td>7.9 %</td>
<td>1.8 %</td>
<td>12.5 %</td>
</tr>
<tr>
<td>Montgomery County - PA</td>
<td>7.1 %</td>
<td>5.7 %</td>
<td>16.4 %</td>
<td>6.0 %</td>
<td>9.5 %</td>
<td>2.6 %</td>
<td>2.9 %</td>
<td>1.7 %</td>
<td>7.4 %</td>
</tr>
<tr>
<td>Philadelphia County - PA</td>
<td>20.0 %</td>
<td>25.6 %</td>
<td>49.7 %</td>
<td>13.4 %</td>
<td>11.6 %</td>
<td>6.6 %</td>
<td>0.0 %</td>
<td>40.0 %</td>
<td>16.3 %</td>
</tr>
<tr>
<td>York County - PA</td>
<td>12.5 %</td>
<td>9.4 %</td>
<td>25.6 %</td>
<td>7.4 %</td>
<td>3.6 %</td>
<td>1.3 %</td>
<td>24.7 %</td>
<td>0.0 %</td>
<td>10.9 %</td>
</tr>
</tbody>
</table>

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

- Kent County, DE
- New Castle County, DE
- Philadelphia County, PA

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

- Camden County, NJ
- Berks County, PA
- Lehigh County, PA

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

- Sussex County, DE

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

- Philadelphia County, PA

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

- Philadelphia County, PA

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

- Philadelphia County, PA

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

- Philadelphia County, PA

Priority Areas

Healthy People 2020 forecasts

Healthy People 2020 (HP2020) is a major federal government initiative that provides specific health objectives for communities and for the country as a whole. Many national health organizations use HP2020 targets to monitor progress in reducing the burden of disease and improve the health of the nation. Likewise, Komen believes it is important to refer to HP2020 to see how areas across the country are progressing towards reducing the burden of breast cancer.

HP2020 has several cancer-related objectives, including:

- Reducing women’s death rate from breast cancer (Target as of the writing of this report: 41.0 cases per 100,000 women).
- Reducing the number of breast cancers that are found at a late-stage (Target as of the writing of this report: 41.0 cases per 100,000 women).
To see how well counties in the Komen Philadelphia 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.

<table>
<thead>
<tr>
<th>Time to Achieve Death Rate Reduction Target</th>
<th>Time to Achieve Late-stage Incidence Reduction Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 years or longer</td>
<td>Highest 13 years or longer</td>
</tr>
<tr>
<td>7-12 yrs.</td>
<td>High 7-12 yrs.</td>
</tr>
<tr>
<td>0 – 6 yrs.</td>
<td>Medium 0 – 6 yrs.</td>
</tr>
<tr>
<td>Currently meets target</td>
<td>Low currently meets target</td>
</tr>
<tr>
<td>Unknown</td>
<td>Highest Unknown</td>
</tr>
</tbody>
</table>

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 rates and key breast cancer death determinants such as poverty and linguistic isolation.
## Table 2.7. Intervention priorities for Komen Philadelphia service area with predicted time to achieve the HP2020 breast cancer targets and key population characteristics.

<table>
<thead>
<tr>
<th>County</th>
<th>Priority</th>
<th>Predicted Time to Achieve Death Rate Target</th>
<th>Predicted Time to Achieve Late-stage Incidence Target</th>
<th>Key Population Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kent County - DE</td>
<td>Highest</td>
<td>13 years or longer</td>
<td>13 years or longer</td>
<td>%Black/African-American, rural</td>
</tr>
<tr>
<td>Camden County - NJ</td>
<td>Highest</td>
<td>13 years or longer</td>
<td>13 years or longer</td>
<td>%Hispanic</td>
</tr>
<tr>
<td>Delaware County - PA</td>
<td>Highest</td>
<td>13 years or longer</td>
<td>13 years or longer</td>
<td></td>
</tr>
<tr>
<td>Philadelphia County - PA</td>
<td>Highest</td>
<td>13 years or longer</td>
<td>13 years or longer</td>
<td>%Black/African-American, education, poverty, employment, language, insurance, medically underserved</td>
</tr>
<tr>
<td>Bucks County - PA</td>
<td>High</td>
<td>8 years</td>
<td>13 years or longer</td>
<td></td>
</tr>
<tr>
<td>New Castle County - DE</td>
<td>Medium High</td>
<td>1 year</td>
<td>13 years or longer</td>
<td>%Black/African-American</td>
</tr>
<tr>
<td>Sussex County - DE</td>
<td>Medium High</td>
<td>6 years</td>
<td>13 years or longer</td>
<td>Older, rural, medically underserved</td>
</tr>
<tr>
<td>Lancaster County - PA</td>
<td>Medium High</td>
<td>6 years</td>
<td>13 years or longer</td>
<td>Rural</td>
</tr>
<tr>
<td>Lebanon County - PA</td>
<td>Medium High</td>
<td>2 years</td>
<td>13 years or longer</td>
<td>Rural</td>
</tr>
<tr>
<td>York County - PA</td>
<td>Medium High</td>
<td>2 years</td>
<td>13 years or longer</td>
<td>Rural</td>
</tr>
<tr>
<td>Adams County - PA</td>
<td>Medium</td>
<td>Currently meets target</td>
<td>13 years or longer</td>
<td>Rural</td>
</tr>
<tr>
<td>Berks County - PA</td>
<td>Medium</td>
<td>5 years</td>
<td>10 years</td>
<td>%Hispanic, rural</td>
</tr>
<tr>
<td>Chester County - PA</td>
<td>Medium Low</td>
<td>3 years</td>
<td>5 years</td>
<td></td>
</tr>
<tr>
<td>Lehigh County - PA</td>
<td>Medium Low</td>
<td>2 years</td>
<td>2 years</td>
<td>%Hispanic</td>
</tr>
<tr>
<td>Montgomery County - PA</td>
<td>Medium Low</td>
<td>2 years</td>
<td>4 years</td>
<td></td>
</tr>
</tbody>
</table>

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.
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**

Four counties in the Komen Philadelphia service area are in the highest priority category. All of the four, Kent County, DE, Camden County, NJ, Delaware County, PA and Philadelphia County, PA, are not likely to meet either the death rate or late-stage incidence rate HP2020 targets.

The incidence rates in Camden County, NJ (142.7 per 100,000) are significantly higher than the Affiliate service area as a whole (129.2 per 100,000). The death rates in Camden County, NJ (28.3 per 100,000) and Philadelphia County, PA (29.0 per 100,000) are significantly higher than the Affiliate service area as a whole (24.6 per 100,000). The late-stage incidence rates in Camden County, NJ (53.3 per 100,000) and Philadelphia County, PA (51.6 per 100,000) are significantly higher than the Affiliate service area as a whole (46.8 per 100,000). Screening rates in Camden County, NJ (69.0 percent) are significantly lower than the Affiliate service area as a whole (79.0 percent).

Kent County, DE has a relatively large Black/African-American population. Camden County, NJ has a relatively large Hispanic/Latina population. Philadelphia County, PA has a relatively large Black/African-American population, low education levels, high poverty rates, high unemployment and a relatively large number of households with little English.

**High priority areas**

One county in the Komen Philadelphia service area is in the high priority category. Bucks County, PA is not likely to meet the late-stage incidence rate HP2020 target.

The late-stage incidence rates in Bucks County, PA (48.4 per 100,000) appear to be higher than the Affiliate service area as a whole (46.8 per 100,000) although not significantly. The late-stage incidence trends in Bucks County, PA (1.0 percent per year) indicate that late-stage incidence rates may be increasing.

**Additional Quantitative Data Exploration**

In addition to data provided by Susan G. Komen Philadelphia Quantitative Data Report (QDR), additional data from the following sources were also considered in selecting Community Profile target communities:

- Pennsylvania Cancer Registry (2009-2011)
- New Jersey Cancer Registry (2006-2010)
- Warminster Heights Census and Health Data (2008-2012)
- Reading City Census and Health Data (2008-2012)
- Preliminary field reports

Data reviewed from each of these sources are included in the following section of the report. The methodology applied in preparing this report includes:
1. Review of the QDR for the selection of priority counties.
2. Obtain and evaluate PA and NJ cancer registry data to evaluate potential changes in trends from the data provided in the QDR.
3. Obtain preliminary field reports on specific locations of need that are not represented by county level data.
4. Obtain community level cancer and census data to validate field reports of increased needs and complete an in-depth analysis.
5. Evaluate population trends in those areas considered high priority in the QDR.
6. Draft opinions for discussion with qualitative and policy Community Profile groups to define priority areas of service.
7. Re-evaluate opinions and/or obtain additional information and provide support to priority areas.
8. Select target communities.

Selection of Target Communities
Susan G. Komen Philadelphia QDR has provided the following guidance in selecting high and very high funding priority areas.

“To determine priority areas, each county’s estimated time to reach the HP2020 (US Department of Health and Human Services, 2010) target for late-stage diagnosis and death were compared and then each county was categorized into seven potential priority levels. Four counties in the Komen Philadelphia service area are in the highest priority category: Kent County, DE, Camden County, NJ, Delaware County, PA and Philadelphia County, PA. One county in the Komen Philadelphia service area is in the high priority category: Bucks County, PA.”

Traditionally, funding priorities have been established by county within Komen Philadelphia’s service area. The recommendations presented in this report follow this pattern for several of the highest priorities, but diverge in the provided recommendations in other parts of the service area. The rationale for not using counties alone as funding priority targets is based on several field reports from municipalities (e.g. grantees and other regional advisors). The municipalities indicate the presence of pockets of sufficient numbers of women in need to support targeted programming within a lower risk county. Data from small and medium size cities and their local suburbs were available and supported the identification of distinct high risk, poorly served clusters within counties, which have larger populations of women who are at low risk and well served comparatively. This represents a classic signal (finding those in need) to noise (overshadowed by large group of healthy women in the county) problem in targeting services. Several of the municipalities examined included populations of migrant Hispanics/Latinas who are often not able to seek services open to other minority groups.

Based on the data presented in this report, the selected county-level priorities include:
- Camden County, NJ – Hispanic/Latina, Black/African-American women
- Philadelphia County, PA – Black/African-American women
- Delaware County, PA – No race/ethnic specification

Selected municipality-level priorities include:
- Reading area, Berks County, PA – Hispanic/Latina women
- Warminster area, Bucks County, PA – Hispanic/Latina women

The US age-adjusted breast cancer incidence, death and late-stage diagnosis rates are 122.1 per 100,000, 22.6 per 100,000, and 43.8 per 100,000, respectively. Nearly all of the counties
and geographic regions in the Komen Philadelphia service area exceed the US rate for these measures. These locations vary from exceeding significantly to being significantly lower than other counties within their respective states for each of these three rates. The death rate trend is falling in all of the counties within the Komen Philadelphia service area. The specific rates for Philadelphia and Camden County were noted to be a specific concern and highlighted in the Affiliate QDR below:

“The incidence rates in Camden County, NJ (142.7 per 100,000) are significantly higher than the Affiliate service area as a whole (129.2 per 100,000). The death rates in Camden County, NJ (28.3 per 100,000) and Philadelphia County, PA (29.0 per 100,000) are significantly higher than the Affiliate service area as a whole (24.6 per 100,000). The late-stage incidence rates in Camden County, NJ (53.3 per 100,000) and Philadelphia County, PA (51.6 per 100,000) are significantly higher than the Affiliate service area as a whole (46.8 per 100,000). Screening rates in Camden County, NJ (69 percent) are significantly lower than the Affiliate service area as a whole (79 percent).”  (Susan G. Komen, 2014)

Camden County, NJ, Delaware County, PA, and Philadelphia County, PA are the highest priority counties. This recommendation is made based on a combination of the likelihood of attaining Healthy People 2020 goals, breast cancer incidence, death, screening and demographic trends. The data sources include material from the Affiliate QDR, 2015-2019, updated data from PA and NJ state wide registry data on deaths and incidence for these counties. Additionally, evaluation data by race/ethnicity has been completed where available for these counties to assist in targeting funding priorities within the counties.

Rationale for Priority County Selection

- Camden County, NJ

Camden County, NJ is among the highest priorities. According to the Affiliate QDR, there is a rising trend in breast cancer incidence, and **significantly higher** death and late-stage incidence rates compared to the Affiliate’s service area (Table 2.1). The proportion of women ages 50-74 with screening mammography in the last two years (self-report) was 69.2 percent compared to 77.5 percent in the US which is significantly lower than the service area (Table 2.3). There is a substantially larger Hispanic/Latina population percentage than that of the Affiliate service area as a whole and the county will take 13 years or longer to meet both the HP2020 death rate and late-stage incidence rates (Table 2.7). With a much higher percentage of Hispanic/Latinos than the Affiliate service area and high incidence, death and late stage diagnosis rates high among Black/African-Americans, targeting Camden County’s Hispanic/Latina and Black/African-American female populations are of specific interest.

New Jersey Cancer Registry data shown in Tables 2.8-2.10/Figures 2.2-2.3 provide support for Hispanics/Latinas and Black/African-Americans being targeted as a highest priority group. More specifically, Hispanic/Latinas had an age-adjusted incidence rate of 122.5 from 2009-2010. Likewise, the Camden County Hispanic/Latina death rate through 2010 is 15.8 versus the New Jersey rate of 13.2 and USA rate of 14.8 (National Cancer Institute, 2014). Camden County also has a higher percentage of foreign born and linguistically isolated population compared to the Komen Philadelphia service area (Table 2.5) likely due to the percentage of Hispanics/Latinos in the County. For Black/African-Americans, with an age-adjusted invasive incidence rate of 150.0 during 2006-2010 and increasing rates within that time period, there is evidence to demonstrate critical need.
Figure 2.2. Hispanic Latina Breast Cancer Incidence Rates
Camden County & NJ (2009-2010)

Note: All rates are per 100,000.
Source: State of NJ Department of Health, 2014

<table>
<thead>
<tr>
<th>Year</th>
<th>2009</th>
<th>2010</th>
<th>2009-2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population at Risk</td>
<td>35588</td>
<td>36649</td>
<td>72237</td>
</tr>
<tr>
<td>Total Cases</td>
<td>37</td>
<td>21</td>
<td>58</td>
</tr>
<tr>
<td>Crude Rate</td>
<td>104</td>
<td>57.3</td>
<td>80.3</td>
</tr>
<tr>
<td>Age-Adjusted Rate</td>
<td>161.7</td>
<td>85.1</td>
<td>122.5</td>
</tr>
<tr>
<td>95% Confidence Interval Lower</td>
<td>112</td>
<td>51.5</td>
<td>91.8</td>
</tr>
<tr>
<td>95% Confidence Interval Upper</td>
<td>225.2</td>
<td>132</td>
<td>159.8</td>
</tr>
<tr>
<td>Statewide Age-Adjusted Rate</td>
<td>121.7</td>
<td>118.2</td>
<td>119.9</td>
</tr>
<tr>
<td>Statewide 95% Confidence Interval Lower</td>
<td>112.6</td>
<td>109.5</td>
<td>113.5</td>
</tr>
<tr>
<td>Statewide 95% Confidence Interval Upper</td>
<td>131.3</td>
<td>127.3</td>
<td>126.4</td>
</tr>
</tbody>
</table>

Note: All rates are per 100,000. Rates are age-adjusted to the 2000 U.S. Standard Million Population; Incidence data for 2010 are considered preliminary due to possible reporting delays.

Source: State of NJ Department of Health, 2014
Philadelphia County, PA

Philadelphia is among the highest priorities. The basis of this recommendation is the history of significantly higher death and late-stage diagnosis incidence rates than the rest of the Affiliate service area. The population has lower education levels and substantially larger Black/African-American female population percentages, substantially lower income levels, substantially lower employment levels, and lower levels of insurance, which are all associated with poorer outcomes in breast cancer. Philadelphia will take 13 years or longer to meet HP2020 targets for death rate and late-stage diagnosis incidence rates. The evaluation of recent county data in Table 2.11 supports Black/African-Americans in Philadelphia County, PA being included in the highest priority group.
• Delaware County, PA
Delaware County is among the highest priorities. The county will take 13 years or longer to meet HP2020 targets for death rate and late-stage incidence rates (Table 2.7). The incidence rates are well above the US rate with 148.8 per 100,000 for Black/African-Americans and 151.9 for Whites. While all races exceed the percentage of late diagnosis, Black/African-American (34.4 percent) and Asian-Pacific Islander (30.8 percent) are of significant concern within the county (Table 2.11). The evaluation of recent data in Tables 2.10 and 2.11 supports Delaware County, PA being included in the highest priority group without race/ethnic specification.

Table 2.10 Female Invasive Breast Cancer Incidence Rates
By County and Race (2011, Delaware County: Philadelphia County)

<table>
<thead>
<tr>
<th>COUNTY</th>
<th>YEAR</th>
<th>AGE</th>
<th>SEX</th>
<th>RACE</th>
<th>INSITU #</th>
<th>INVAS #</th>
<th>EXP #</th>
<th>POP</th>
<th>RATE</th>
<th>Lower CI</th>
<th>Upper CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delaware</td>
<td>2011</td>
<td>All</td>
<td>Female</td>
<td>Black/African-American</td>
<td>11</td>
<td>77</td>
<td>69</td>
<td>60,780</td>
<td>148.8</td>
<td>116.6</td>
<td>187</td>
</tr>
<tr>
<td>Delaware</td>
<td>2011</td>
<td>All</td>
<td>Female</td>
<td>Hispanic</td>
<td>0</td>
<td>4</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Delaware</td>
<td>2011</td>
<td>All</td>
<td>Female</td>
<td>White</td>
<td>112</td>
<td>437</td>
<td>365</td>
<td>210,509</td>
<td>151.9</td>
<td>137.3</td>
<td>167.4</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>2011</td>
<td>All</td>
<td>Female</td>
<td>Black/African-American</td>
<td>138</td>
<td>496</td>
<td>498</td>
<td>372,157</td>
<td>151.9</td>
<td>137.3</td>
<td>167.4</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>2011</td>
<td>All</td>
<td>Female</td>
<td>Hispanic</td>
<td>14</td>
<td>45</td>
<td>42</td>
<td>97,428</td>
<td>67.5</td>
<td>48.3</td>
<td>93.9</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>2011</td>
<td>All</td>
<td>Female</td>
<td>White</td>
<td>140</td>
<td>547</td>
<td>531</td>
<td>361,028</td>
<td>131.5</td>
<td>120.2</td>
<td>143.3</td>
</tr>
</tbody>
</table>

Note: All rates are per 100,000.
Source: State of PA Department of Health, 2014

Table 2.11 Female Breast Cancer Incidence Rates
By County, Race, Stage (2009-2011, Delaware County: Philadelphia County)

<table>
<thead>
<tr>
<th>COUNTY/STATE</th>
<th>YEAR</th>
<th>AGE</th>
<th>SEX</th>
<th>RACE</th>
<th>STAGE</th>
<th>COUNT</th>
<th>PERCENT</th>
<th>Lower CI</th>
<th>Upper CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delaware</td>
<td>2009-11</td>
<td>All</td>
<td>Female</td>
<td>All</td>
<td>Early</td>
<td>1,372</td>
<td>72.6</td>
<td>68.7</td>
<td>76.4</td>
</tr>
<tr>
<td>Delaware</td>
<td>2009-11</td>
<td>All</td>
<td>Female</td>
<td>A/PI</td>
<td>Early</td>
<td>27</td>
<td>69.2</td>
<td>43.1</td>
<td>95.3</td>
</tr>
<tr>
<td>Delaware</td>
<td>2009-11</td>
<td>All</td>
<td>Female</td>
<td>Hispanic</td>
<td>Early</td>
<td>8</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
</tr>
<tr>
<td>Delaware</td>
<td>2009-11</td>
<td>All</td>
<td>Female</td>
<td>Hispanic</td>
<td>Late</td>
<td>1</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>2009-11</td>
<td>All</td>
<td>Female</td>
<td>All</td>
<td>Early</td>
<td>2,870</td>
<td>68.2</td>
<td>65.7</td>
<td>70.7</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>2009-11</td>
<td>All</td>
<td>Female</td>
<td>A/PI</td>
<td>Late</td>
<td>12</td>
<td>30.8</td>
<td>13.4</td>
<td>48.2</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>2009-11</td>
<td>All</td>
<td>Female</td>
<td>Hispanic</td>
<td>Early</td>
<td>1,250</td>
<td>29.7</td>
<td>28</td>
<td>31.3</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>2009-11</td>
<td>All</td>
<td>Female</td>
<td>White</td>
<td>Early</td>
<td>1,402</td>
<td>69.9</td>
<td>66.3</td>
<td>73.6</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>2009-11</td>
<td>All</td>
<td>Female</td>
<td>White</td>
<td>Late</td>
<td>554</td>
<td>27.6</td>
<td>25.3</td>
<td>29.9</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>2009-11</td>
<td>All</td>
<td>Female</td>
<td>Black/African-American</td>
<td>Early</td>
<td>1,333</td>
<td>66.9</td>
<td>63.3</td>
<td>70.4</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>2009-11</td>
<td>All</td>
<td>Female</td>
<td>Black/African-American</td>
<td>Late</td>
<td>631</td>
<td>31.6</td>
<td>29.2</td>
<td>34.1</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>2009-11</td>
<td>All</td>
<td>Female</td>
<td>A/PI</td>
<td>Early</td>
<td>70</td>
<td>62.5</td>
<td>47.9</td>
<td>77.1</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>2009-11</td>
<td>All</td>
<td>Female</td>
<td>A/PI</td>
<td>Late</td>
<td>40</td>
<td>35.7</td>
<td>24.6</td>
<td>46.8</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>2009-11</td>
<td>All</td>
<td>Female</td>
<td>Hispanic</td>
<td>Early</td>
<td>112</td>
<td>70</td>
<td>57</td>
<td>83</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>2009-11</td>
<td>All</td>
<td>Female</td>
<td>Hispanic</td>
<td>Late</td>
<td>47</td>
<td>29.4</td>
<td>21</td>
<td>37.8</td>
</tr>
</tbody>
</table>

Source: State of PA Department of Health, 2011
• Reading area of Berks County, PA

Field reports suggest a local region within Berks County, PA could be considered for promotion to a high priority area based on the county breast cancer incidence provided below. The Philadelphia QDR does not consider data from municipalities, as such, medium sized cities and their suburbs with clusters of women in need are overshadowed by other healthier populations of the rest of the county. The city of Reading and its regional area represents this case. The regional area presents with an accelerating non-age-adjusted incidence rate of 134.35 to 161.18 per 100,000 and an expanding population as demonstrated in Table 2.12/Figure 2.5. Additionally, Reading is one of several clusters of undocumented migrant populations with their origins in Mexico who are missed in census and health data. Hispanic/Latinas who suspect they are suffering from cancer often return to Mexico to obtain treatment and return to the US as survivors often experiencing the late effects here. Berks County has the third highest percentage (2.7 percent) of Mexican persons living in the county. Breast cancer incidence rates in Berks County and Reading area are presented in Tables 2.12-2.13.

**Figure 2.5: Breast Cancer Incidence Rate - Non-Age-Adjusted Reading Area, PA (2009-2011)**

Note: All rates are per 100,000.
Source: State of PA Department of Health, 2014
Table 2.12. Breast Cancer Incidence Rates- Non-Age-Adjusted
Reading, PA Area- Berks County (2009-2011)

<table>
<thead>
<tr>
<th>Municipality</th>
<th>Year</th>
<th>Incidence</th>
<th>Pop</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exeter Twp</td>
<td>2009</td>
<td>18</td>
<td>25335</td>
<td>142.1</td>
</tr>
<tr>
<td>Muhlenberg Twp</td>
<td>2009</td>
<td>18</td>
<td>18690</td>
<td>192.62</td>
</tr>
<tr>
<td>Reading city</td>
<td>2009</td>
<td>38</td>
<td>81000</td>
<td>93.83</td>
</tr>
<tr>
<td>Spring Twp</td>
<td>2009</td>
<td>22</td>
<td>26761</td>
<td>164.42</td>
</tr>
<tr>
<td>Wyomissing Boro</td>
<td>2009</td>
<td>13</td>
<td>10476</td>
<td>248.19</td>
</tr>
<tr>
<td><strong>Reading area</strong></td>
<td>2009</td>
<td>109</td>
<td><strong>162262</strong></td>
<td><strong>134.35</strong></td>
</tr>
<tr>
<td>Exeter Twp</td>
<td>2010</td>
<td>18</td>
<td>25550</td>
<td>140.9</td>
</tr>
<tr>
<td>Muhlenberg Twp</td>
<td>2010</td>
<td>16</td>
<td>19628</td>
<td>163.03</td>
</tr>
<tr>
<td>Reading city</td>
<td>2010</td>
<td>42</td>
<td>88082</td>
<td>95.37</td>
</tr>
<tr>
<td>Spring Twp</td>
<td>2010</td>
<td>22</td>
<td>27119</td>
<td>162.25</td>
</tr>
<tr>
<td>Wyomissing Boro</td>
<td>2010</td>
<td>17</td>
<td>10461</td>
<td>325.02</td>
</tr>
<tr>
<td><strong>Reading area</strong></td>
<td>2010</td>
<td>115</td>
<td><strong>170840</strong></td>
<td><strong>134.63</strong></td>
</tr>
<tr>
<td>Exeter Twp</td>
<td>2011</td>
<td>22</td>
<td>25634</td>
<td>171.65</td>
</tr>
<tr>
<td>Muhlenberg Twp</td>
<td>2011</td>
<td>28</td>
<td>19736</td>
<td>283.75</td>
</tr>
<tr>
<td>Reading city</td>
<td>2011</td>
<td>44</td>
<td>88129</td>
<td>99.85</td>
</tr>
<tr>
<td>Spring Twp</td>
<td>2011</td>
<td>30</td>
<td>27273</td>
<td>220.0</td>
</tr>
<tr>
<td>Wyomissing Boro</td>
<td>2011</td>
<td>14</td>
<td>10468</td>
<td>267.48</td>
</tr>
<tr>
<td><strong>Reading area</strong></td>
<td>2011</td>
<td>138</td>
<td><strong>171240</strong></td>
<td><strong>161.18</strong></td>
</tr>
</tbody>
</table>

Note: All rates are per 100,000.
Source: State of PA Department of Health, 2014

Figure 2.6 provides additional support for targeting the Reading Area. As Reading City is the most densely populated area with potential clusters developing outside of that immediate area, the data shows dramatic disparities compared to the State rates for Hispanic/Latinos, foreign born, language, income, and percentage below poverty level. In each metric, Reading City shows a high need for specialized services.

Figure 2.6 Rationale for Priority Municipality Selection Reading Area Berks County, PA
Warminster and its surrounding area have been selected as a highest priority area within Bucks County PA, which was classified as a high priority in the Susan G. Komen Philadelphia QDR, based on needing eight years to meet the HP2020 targeted death rate and 13 years or longer to meet the target for late-stage diagnosis (Table 2.7). As revealed in Figure 2.8, this portion of the county included a high level of Hispanic/Latina underserved women, which have not been captured in current reporting. As Warminster Heights is the most densely populated area with potential clusters developing outside of that immediate area, the data shows dramatic disparities compared to the State rates for Hispanic/Latinos, foreign born, language, income, percentage below poverty level. In each metric, Warminster Heights shows a high need for specialized services.
With regards to county non-age-adjusted incidence from 2009-2011, data are provided in Table 2.14/Figure 2.9. The non-age-adjusted incidence rate per 100,000 has increased from 189.26 in 2009 to 222.89 in 2011 among women. This data and the Affiliate QDR support the Warminster area inclusion in the highest priority category.

![Figure 2.9: Breast Cancer Incidence Rates- Non-Age Adjusted Warminster, PA Area- Bucks County (2009-2011)](image)

Note: All rates are per 100,000.
Source: State of PA Department of Health, 2014

<table>
<thead>
<tr>
<th>Table 2.14. Breast Cancer Incidence Rates- Non-Age-Adjusted Warminster PA Area- Bucks County (2009-2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Municipality</strong></td>
</tr>
<tr>
<td>Chalfont Boro</td>
</tr>
<tr>
<td>Doylestown Twp</td>
</tr>
<tr>
<td>Warminster Twp</td>
</tr>
<tr>
<td>Warrington Twp</td>
</tr>
<tr>
<td>Warwick Twp</td>
</tr>
<tr>
<td><strong>Warminster Area</strong></td>
</tr>
<tr>
<td>Chalfont Boro</td>
</tr>
<tr>
<td>Doylestown Twp</td>
</tr>
<tr>
<td>Warminster Twp</td>
</tr>
<tr>
<td>Warrington Twp</td>
</tr>
<tr>
<td>Warwick Twp</td>
</tr>
<tr>
<td><strong>Warminster Area</strong></td>
</tr>
<tr>
<td>Chalfont Boro</td>
</tr>
<tr>
<td>Doylestown Twp</td>
</tr>
<tr>
<td>Warminster Twp</td>
</tr>
<tr>
<td>Warrington Twp</td>
</tr>
<tr>
<td>Warwick Twp</td>
</tr>
<tr>
<td><strong>Warminster Area</strong></td>
</tr>
</tbody>
</table>

Note: All rates are per 100,000.
Source: State of PA Department of Health, 2014
**Municipality Level Recommendations**
The data suggests targeting funding for Hispanic/Latinas within Reading in Berks County, PA and Warminster in Bucks County, PA.

**Additional Rationale for Race/Ethnic Targeting**

*Hispanics/Latinas: Camden County, Reading Area, and Warminster Area*
Breast cancer is the most commonly diagnosed cancer and most common cause of cancer death among Hispanic/Latinas (Office on Women’s Health 2010). Furthermore, Hispanic/Latinas are more likely to be diagnosed with breast cancer at younger ages, have larger and high grade breast tumors, and have less treatable tumors in comparison to their non-Hispanic White counterparts (Office on Women’s Health, 2010). Access to adequate health care is a burden to Hispanic/Latinas as 29 percent are uninsured and only 38 percent routinely obtain mammography after the age of 40 (Office of Minority Health, 2014; Hoffman et al., 2011). These characteristics coupled with immigrant Hispanics/Latinos largely identifying Spanish as their primary language (Pew Research Center, 2012) indicates a need for specialized and language-specific services.

*Black/African-Americans: Philadelphia County and Camden County*
Breast cancer is the second most common cause of cancer death among Black/African-Americans (US Cancer Statistics Working Group, 2013). Black/African-Americans have the second highest incidence rates across all rates at 118.0 trailing only their white counterparts at 123.3 (Susan G. Komen, 2013). Across all races/ethnicities, Black/African-Americans have the highest death rates at 31.6 compared to 22.4 among whites (Susan G. Komen, 2013). With regards to insurance status, Black/African-Americans are 55 percent more likely to be uninsured than Whites (US Department of Health and Human Services, 2013). These characteristics indicate support for targeting Black/African-Americans for specialized services.

**Rationale for Excluding QDR Priority Area**

*Kent County, DE*
Recent data from Cancer Incidence and Death in Delaware, 2006–2010, show improvements in survival in the Black/African-American community. The extensive Screening for Life (SFL) programs are a challenge to retaining Kent County, DE as a member of the highest priority. The Affiliate recommends reviewing the needs for screening services based on their improvement in the statewide services (Delaware Division of Public Health, 2014). With improved detection and reduced death, this may be a location where supporting survivorship services to improve the quality of life may be a funding consideration. Part of the recommendation is based on the proportion of Black/African-Americans within the county, which appears to be stable at ~24 percent out to 2060 based on US census projections. Additionally, the 2011 census report indicated the number of Black/African-American women age 25 to 85 is 12,828; and when restricted to those 45 to 85 years of age 7,460. The Black/African-American breast cancer incidence is 133.4 per 100,000 women when ages 45 to 85 years are evaluated which will result in ~10 cases per year. The successful screening rates demonstrated in Black/African-American women are likely to reduce the later stage incidence rate noted above reducing the number of cases per year in the future (Delaware Division of Public Health, 2014). Potential modifiers to the recommendations above would be the impact of a reduction of support to programs, which have contributed to the success of increasing the screening rates of Black/African-American women.
**Issues for Health Systems and Policy Analysis**
The Health Systems and Policy Analysis will look more closely at the provision of health services in our selected target communities in order to identify potential gaps in or barriers to care especially as it pertains to our race/ethnic specifications.
Health Systems and Public Policy Analysis

Health Systems Analysis Data Sources

Data Collection and Review Process
Geographic regions were selected based on findings in the Quantitative Data Report. As such, an inventory of community resources was collected to determine the availability of resources like hospital systems, community health centers, and other community-based facilities. In addition to data derived from health systems, policy and resource inventories, research was done to understand the impact of NBCCEDP, the Affordable Care Act, Medicaid Expansion, and other policy-level factors on the Affiliate priority areas. Key findings from this analysis will be further explored in the Qualitative Analysis section.

Health Systems Overview

![Breast Cancer Continuum of Care (CoC)](image)

**Figure 3.1. Breast Cancer Continuum of Care (CoC)**

Strengths & Weaknesses of Target Communities

**Philadelphia County**
Philadelphia County was identified as a priority area based on the predicted time it would take for it to achieve Healthy People 2020 (HP2020) goals for death and late-stage incidence rates. In addition to the commitment to serve all underserved individuals, special emphasis will also be placed on serving Black/African-Americans due to Philadelphia having a higher percentage than the service area average. Philadelphia has a variety of resources available to support communities throughout the continuum of care. In 2014, there were 101 organizations that offered some type of breast health service in Philadelphia including Federally Qualified Health Centers (FQHC) and hospitals. Although there are a large number of facilities offering breast health services, only 20 facilities (19.8 percent) are certified by either the American College of Surgeons, College of Radiology Breast Imaging Centers of Excellence and/or National Cancer Institute cancer centers. Furthermore, as few as 19 facilities (18.8 percent) offer all services on the breast cancer continuum of care. There is an indication that an abundance of social service, health related resources is not enough to address persistent disparities. Therefore, issues seem to exist pertaining to access, awareness and provider coordination of available resources.

In 2014-2015, Komen Philadelphia funded four health systems to offer screening, diagnostic, treatment, education and survivorship services to medically underserved and uninsured patients. Community-based nonprofit organizations have also been funded in the past by
Komen to provide education, navigation and language support services to many communities in Philadelphia. At least two former Komen Philadelphia grantees have breast health programs that are still operational that target Black/African-American communities.

**Camden County, NJ**
Camden County was identified as a priority area based on the predicted time it would take for it to achieve HP2020 goals for death and late-stage incidence rates. In addition to Komen’s commitment to serve all underserved individuals, Komen will also be placing special emphasis on serving Hispanic/Latina and Black/African-American women in Camden County. Hispanic/Latina women were selected due to Camden County having a higher number of Hispanic/Latinas than the service area average, while Black/African-Americans were targeted due to high incidence rates of breast cancer in comparison to the New Jersey rate. Key to Camden County’s ability to engage underserved individuals is the presence of three major healthcare institutions. In 2014, there were 33 total organizations offering breast health services in Camden County, NJ, three of which are hospitals that are recognized by the American College of Surgeons and/or as an American College of Radiology Breast Imaging Center of Excellence. Of the 33 organizations offering breast health services, only three (9.1 percent) offer all services on the breast cancer continuum of care. Thus, patients may be more likely to have to go to multiple facilities in order to access the full continuum of care. The segmented nature of continuum of care offerings likely creates access and coordination of care barriers for providers and patients.

In 2014-2015, Komen Philadelphia funded MD Anderson Cancer Center at Cooper to offer screening, diagnostic, treatment, education and survivorship services to medically underserved and uninsured patients. Community-based nonprofit former Komen Philadelphia grantees are present in Camden County to provide education, navigation and language support services to Black/African-American and Hispanic/Latina communities.

**Reading, PA**
While Berks County data did not directly suggest including Reading as a priority area, Reading has the highest share of residents living under the poverty level. Because of this, additional quantitative data analysis was conducted. It was found that the Reading Area’s breast cancer status clearly indicates a need. In 2014, there were 10 organizations offering breast health services in Reading, two of which are hospitals. The American College of Radiology certifies one of those sites as a Breast Imaging Center of Excellence, and two are accredited by the American College of Surgeons. There is also a FQHC in the City of Reading and Reading Area Community College that works closely with the major hospitals to support Hispanic/Latinas and increasing their awareness of breast health issues. Two of the 10 (20 percent) organizations offering breast health services provide all services on the Breast Cancer Continuum of Care. These two organizations are also the two major health systems in the area. Reading is located in a more rural area with fewer breast health services. As such, there is an increased burden on a limited number of providers to conduct assertive outreach to individuals not already engaged in healthcare through the two hospitals and FQHC in the area.

In 2013-2014, Komen Philadelphia funded St. Joseph Medical Center to offer screening, diagnostic, treatment, education and survivorship services to medically underserved and uninsured patients in the Reading area.

**Delaware County, PA**
Delaware County was identified as a priority area based on the predicted time it would take for it to achieve HP2020 goals for death and late-stage incidence rates. Due to the significant...
diversity of Delaware County, there is no race/ethnic specification recommended. In 2014, there were 22 total organizations offering breast health services in Delaware County, PA, four of which are hospitals. Seven of these are certified by the American College of Radiology as Breast Imaging Centers of Excellence, and four by the American College of Surgeons. Five of the 22 (22.7 percent) organizations provide all services on the Breast Cancer Continuum of Care. Upon analysis of the location of facilities offering breast health services in Delaware County, it was determined that the distribution of such facilities were not equal throughout the county. Rural areas of Delaware County had lower numbers of facilities offering breast health services that likely limits access for care.

In 2014-2015, Komen Philadelphia funded Crozer-Chester Medical Center and Delaware County Memorial Hospital to offer screening, diagnostic, treatment, education and survivorship services to medically underserved and uninsured patients.

**Warminster, PA**

Bucks County, PA as a whole is an affluent area. However, the county does have pockets of low income communities. Additional Quantitative Data such as non-age adjusted incidence findings suggests the need for priority status. This area is a new priority area for Komen Philadelphia. As such, the Affiliate is currently in the process of identifying or fortifying relationships to better understand the nuances of the needs in Warminster.

In 2014, there were 21 total organizations offering breast health services in Warminster, PA, five of which are hospitals. Three of those hospitals are certified by the American College of Surgeons Commission on Cancer, four by the American College of Radiology as Breast Imaging Centers of Excellence, and three by the National Accreditation Program for Breast Centers. A long-time grantee, Abington Memorial Hospital, opened a satellite campus in Warminster to help serve community needs. Only four of the 21 (19.0 percent) organizations provide all services on the breast cancer continuum of care. In an area such as Warminster, PA with high rates of poverty and linguistic barriers, it may prove challenging to locate an organization that provides all services on the breast cancer continuum.

In 2014-2015, Komen Philadelphia funded Abington Memorial Health to offer screening, diagnostic, treatment, education and survivorship services to medically underserved and uninsured patients. While they primarily serve patients in Montgomery County, their satellite presence in Warminster provides access to Warminster residents.

**Summary of Current or Potential Mission Related Partnerships**

Komen Philadelphia has had a strong presence in the region for 25 years. In that time, the Affiliate has developed an extensive network of partnerships with community-based organizations, hospitals, policy makers, clinicians, business leaders, places of worship and other constituents. In the last two years, the Affiliate’s grants program has supported more than 40 hospitals and community-based organizations who are committed partners in the mission to educate, support, screen and treat women in need. Nevertheless, in new priority areas like Reading and Warminster, the Affiliate will need to build new partnerships. For example, the Affiliate will target places of worship and parish nurse organizations in Warminster. In Reading, the Affiliate will reach out to the Reading Area Community College and local FQHC that enjoy deep roots and strong reputations in the area.

Komen Philadelphia will also aim to fortify partnerships with NBCCEDP administrators specifically in New Jersey and Delaware State where interactions are not as frequent and significant.
Figure 3.2 Breast Cancer Services Available in Philadelphia County
Figure 3.3 Breast Cancer Services Available in Warminster County
Figure 3.4 Breast Cancer Services Available in Camden County
Figure 3.5 Breast Cancer Services Available in Delaware County
Public Policy Overview

National Breast and Cervical Cancer Early Detection Program (NBCCEDP)
The National Breast and Cervical Cancer Early Detection Program (NBCCEDP), which is partially funded by the Centers for Disease Control and Prevention (CDC), provides breast and cervical cancer screening services to women who are low-income and uninsured. States are able to determine the eligibility guidelines for their particular statewide program. Within the Affiliate service area, three NBCCEDP programs (PA – HealthyWoman Program; NJ – NJCEED; DE – Screening for Life) play critical roles in the funding of breast health services for underserved individuals.

Pennsylvania – HealthyWoman Program
Established in 1993, the Pennsylvania HWP provides breast and cervical cancer screening as well as treatment services to women who have pre-tax household income at or below 250 percent of federal poverty guidelines. The Alliance of Pennsylvania Councils, Inc. (APaC) is the lead agency awarded the CDC grant to administer HWP. Based on 2014 federal poverty guidelines, an individual must earn no more than $29,175 per year in order to qualify (Families USA, 2014). Additionally, women must be uninsured or have coverage that does not pay for screenings, or be financially unable to afford a required deductible or copayment. Women must also be between the ages of 40 to 64 for mammograms under this program. Women under 40 may also be eligible for services if symptomatic. If a woman without insurance is diagnosed with breast cancer, she can access Medicaid coverage through the Breast and Cervical Cancer Prevention and Treatment Program (BCCPT). No-cost services provided through HWP include:

- Yearly breast mammography
- Pelvic exam and Pap test
- Diagnostic follow up on abnormal test results
- Case management when cancer or a pre-cancerous condition is diagnosed

According to a report by the CDC, in the last five years (2008-2012), 15,872 women have received mammograms under the program and 217 breast cancers were detected (CDC, 2014c). According to Census and CDC estimates, 110,000 women are eligible for the HWP in Pennsylvania. However, funding currently covers the cost of screening for only 6,100 women a year. More recent data shows:

<table>
<thead>
<tr>
<th>Funding Levels (Most recent available)</th>
<th># of Women Screened (2009-2014)</th>
<th># of Breast Cancers Detected (2009-2014)</th>
<th>White (%)</th>
<th>Black/African-American (%)</th>
<th>Hispanic/Latina* (%)</th>
<th>Asian (%)</th>
<th>Other (%)</th>
</tr>
</thead>
</table>

*Ethnicity
APaC reports that a recent analysis of Pennsylvania’s cancer burden led to the CDC recommending a restructuring of priority areas. While areas like Philadelphia remain ‘Mandatory,’ there was the addition of other Pennsylvania counties. However, the program’s budget and the total number of HWP slots remains the same. Therefore, Philadelphia, while having the highest volume of need, will have fewer slots available. To ease the short-term impact of this reallocation, the HWP will phase those changes across the next few years.

**Delaware – Screening for Life**

In the State of Delaware, the Division of Public Health within the Delaware Department of Health and Social Services administers Screening for Life. Established in 1997, the program provides breast cancer screening and treatment services to women, ages 40 and above, who have a pre-tax household income between 100 and 250 percent of federal poverty guidelines (Delaware Division of Public Health, 2014a). Women must be uninsured and not eligible for Medicare or Medicaid, have coverage that does not pay for screenings, or be financially unable to afford a required deductible or copayment that is greater than five percent of their annual income. Screening for Life also provides screening for cervical, prostate, and colorectal cancers. Breast health services include office visits, clinical exams, mammograms, education, and assistance with “coordinating associated care.” The program does not cover mammograms for women under 40. Delaware provides free cancer treatment for residents through the Delaware Cancer Treatment Program for up to two years for those who cannot afford it (with incomes below 650 percent of the FPL) or who have insurance that will not pay for it (Delaware Division of Public Health, 2014b).

Over the last five completed fiscal years (2008-2012), Delaware’s Screening for Life Program has screened 4,834 women for breast cancer. Demographically, 40 percent of women using Screening for Life services are white, 30 percent are African-American, 24 percent are Hispanic, and four percent are Asian/Pacific Islander (approximately one percent are of unknown races or identify as “Other”). Women ages 50-64 make up 58 percent of those receiving Screening for Life services, and 37 percent are between 40 and 49 (CDC, 2014a).

**New Jersey - NJCEED**

The New Jersey Cancer Education and Early Detection Program (NJCEED) provides screening for prostate, colorectal, cervical, and breast cancer. The breast cancer screening program covers eligible women at or below 250 percent of the Federal Poverty Level who are uninsured or underinsured. Program services are provided through 22 screening providers. MD Anderson Cancer Center at Cooper is the provider in Camden County. From January 2008 through December 2012, 24,544 women received a mammogram through NJCEED. Over those same five years, 357 breast cancers were detected through the program. Demographically, 47 percent of women receiving NJCEED services were Hispanic, 29 percent were White, 17 percent were African-American, seven percent were Asian/Pacific Islander, and one percent were Other. 80.4 percent were between the ages of 50 and 64. 15.7 percent were between the ages of 40-49 (CDC, 2014b).

**Medicaid – Relationship with NBCCEDP and Accessing Care**

The working relationship between the state NBCCEDP programs and Medicaid is positive and ongoing. More specifically, within Pennsylvania, there is regular communication between the State Department of Health (DOH) and Medicaid. The DOH often serves as the liaison between HWP and Medicaid. Because of strong relationships across groups, Medicaid and HWP are very successful in ensuring that women receive the services they need, including those who are undocumented.
Under the Breast and Cervical Cancer Prevention and Treatment Act of 2000, the federal government matches $3 for every $1 that the state invests into its Medicaid program. If women lose their insurance or become ineligible for Medicaid, NBCCEDP is able to step in to provide coverage for services. Some women have experiences with both the NBCCEDP and Medicaid in that diagnostic services are covered with NBCCEDP for eligible patients and if they are diagnosed, Medicaid steps in to cover treatment. While health care providers indicate the paperwork may be cumbersome and sometimes prohibitive, providers are well versed in NBCCEDP and Medicaid enrollment processes thereby creating a web of support for women in need of services. In instances where support cannot be provided, providers are committed to using charity care to treat a diagnosed woman.

Eligibility for Medicaid by State

**Pennsylvania**
The state of Pennsylvania enacted Medicaid expansion on January 1, 2015. As of March 2014, 172,653 female residents have been newly enrolled under Medicaid. By July 27, 2015, 439,000 people had enrolled in Pennsylvania’s expanded Medicaid program – out of an estimated 600,000 to 700,000 eligible residents. Eligibility limits for women seeking Medicaid in Pennsylvania are as follows (Kaiser Family Foundation, 2015):

- Benefits packages are available for both individual women and women with dependent children with incomes up to 138 percent of the federal poverty level (FPL, $16,105 for an individual in 2014).
- More limited benefits packages may be available for women with incomes up to 213 percent of the poverty level and without dependent children.
- Benefits packages available for pregnant women with incomes at or below 220 percent of the FPL.
- Benefits packages available for disabled and aged women with incomes at or below 74 percent of the FPL.

**Delaware**
In the state of Delaware, where Medicaid Expansion was accepted, 6,338 women have been newly enrolled as of March 2014. Eligibility limits for women are as follows (Kaiser Family Foundation, 2014):

- Benefit packages available for women with incomes at 138 percent of the federal poverty level (FPL) and with dependent children.
- Benefits packages may be available for women with incomes up to 138 percent of the poverty level and without dependent children.
- Benefits packages available for pregnant women with incomes at or below 212 percent of the FPL.
- Benefits packages available for disabled and aged women with incomes at or below 74 percent of the FPL.

**New Jersey**
In New Jersey, where Medicaid Expansion was accepted, 85,805 women have been newly enrolled as of March 2014. Eligibility limits for women are as follows (Kaiser Family Foundation, 2014):

- Benefit packages available for women with dependent children with incomes at 138 percent of the FPL.
- Benefits packages may be available for women with incomes up to 138 percent of the poverty level and without dependent children.
- Benefit packages available for pregnant women with incomes at 200 percent of the FPL.
- Benefit packages available for disabled and aged women with incomes at 100 percent of the FPL.

Affiliate’s current relationship with the state NBCCEDP and plan for the next four years
For the past seven years, the Komen Philadelphia community grants program has taken a more structured approach for encouraging participation of grantees in the NBCCEDP programs. More specifically, in the Affiliate’s community grants Request for Application (RFA), it is required that all hospital grantee applicants be NBCCEDP providers. Komen Philadelphia believes that this is the most effective way of leveraging available breast cancer dollars to serve communities in need. As such, this process will be continued. Furthermore, over the course of 2013, Komen Philadelphia has kept open lines of communication with administrators of the HWP. As a means to continue this relationship, Komen Philadelphia will include NBCCEDP administrators in work groups and strategy discussions to increase awareness on the shared vision.

Due to the fact that much of Komen Philadelphia’s priority areas are in the state of Pennsylvania, the Affiliate’s focus has been primarily on building and maintaining relationships with the HWP. However, Komen Philadelphia recognizes the importance of having a relationship with the Delaware and New Jersey NBCCEDP administration. In terms of the NJCEED and Screening for Life programs, the Affiliate intends to be proactive with having more ongoing conversations in hopes of duplicating the relationship the Affiliate has built with HWP administrators.

State Comprehensive Cancer Control Coalition

States’ Comprehensive Cancer Control Plan breast cancer objectives
Pennsylvania
The Pennsylvania Cancer Control, Prevention and Research Advisory Board (CAB) is the legislatively mandated board established to advise the Pennsylvania Secretary of Health and report to the Governor and the General Assembly on matters pertaining to cancer control, risk reduction and research in the state. The current Board has spent the last two years developing a plan and is now moving into the implementation phase. A key member of the Affiliate’s advocacy efforts and lead administrator of APaC served as a member of the CAB Stakeholder Leadership Team. Additionally, members of the Affiliate staff have attended planning and implementation workshops.

Although this plan does not have objectives specific to breast cancer, several of the plan’s goals outlined can hold crucial implications for breast cancer initiatives. The Plan recommends:

- Enhancing the capacity and engagement of community leaders and stakeholders
- Coordinating approaches to promote access to affordable health care among public agencies and private organizations
- Moving to reduce cancer health disparities caused by social determinants of health
- Promoting evidence-based health provider practices across the cancer care delivery continuum

Working closely with the CAB and other PA Komen Affiliates, the Affiliate will advise and contribute where appropriate.
**New Jersey**

In 2006, New Jersey’s Breast Cancer work group congregated to identify five areas for action - early detection, therapeutics, research, health care policy and data. In consideration to the identified priority areas, New Jersey’s Comprehensive Cancer Control Plan prompted a call to action to increase the practice of breast cancer risk reduction strategies and improve public understanding of breast health, breast cancer and screening to promote the value of early detection and follow-up visits, especially for those at high risk of developing breast cancer. This would entail identifying areas and population at higher than expected risk of breast cancer incidence, including ethnic and racial groups. In conjunction, the plan calls to improve providers’ knowledge about currently available breast cancer resources and the importance of having an active provider role in formulating a risk reduction plan. Comprehensively, New Jersey hopes that these objectives will help to expand education and screening awareness efforts, and maximize optimal breast cancer outcomes in areas of most need.

In New Jersey, there are members of other state Komen Affiliates who serve as work group members on the state’s CCCP. Their efforts have been critically important in maintaining level funding for NJCEED. The Affiliate, in turn, works in close partnership with advocates and providers in Camden County to assure access to screening and care, especially in the Hispanic/Latina communities.

**Delaware**

The Delaware Cancer Consortium’s Four-Year Plan (2007-2011) resolves to expand Delaware’s outreach by identifying novel preventative strategies for the eradication of cancer. To ensure that Delaware residents have access to the highest quality cancer screening and care, the state of Delaware intends to eliminate racial, ethnic and economic disparities in cancer through studying the impact of barriers to cancer screening and the elimination of gaps in the quality of life services needed to meet the needs of patients, survivors and co-survivors. Additionally, the state also aims to improve the continuity of care through the improvement of cancer care coordination, including enhancements to the Cancer Screening Nurse Navigator program and the surveillance of clients served through the Delaware Cancer Treatment Program.

The main feature of Delaware’s Cancer Control Plan is their Screening for Life program that is discussed above. The Affiliate works closely with the major health providers in the state’s three counties (several of which are Komen grantees) to fill gaps of coverage for underserved women. Affiliate activities also include joining with the Cancer Support Network, the American Cancer Society and the Delaware Breast Cancer coalition in survivorship programs, as well as lobbying for the continued strong support of the Screening for Life Program. Through this work, Delaware has been successful in increasing mammography rates for women over 50 and decreasing breast cancer incidence (National Association of Chronic Disease Directors, 2014).

**Affiliate’s Current Relationship with the State Cancer Coalition and Plan for the Next Four Years**

For the next four years, the Affiliate intends to expand its preexisting relationships with the Pennsylvania, New Jersey, and Delaware state cancer coalitions. As of 2014, the Affiliate has been invited to serve on a stakeholder leadership team that informs the development, implementation, and review of the developing Pennsylvania Cancer Control plan. While the Pennsylvania cancer control plan does not have any concrete objectives targeting breast cancer, Komen Philadelphia intends to observe the process of the state’s evolving cancer control plan and advocate for breast cancer objectives where needed and appropriate. Furthermore, Komen Philadelphia is fortunate to have a number of partners in the cancer control leadership team.
In New Jersey and Delaware, Komen Philadelphia will use its current collaborations to establish and strengthen its roles with the states’ cancer coalitions. In New Jersey, Komen Philadelphia is able to collaborate with its fellow Affiliates that cover the rest of New Jersey. In Delaware, three major hospital partners of Komen Philadelphia are involved in cancer control activities. Komen Philadelphia is able to contribute on an as-needed basis.

**Affordable Care Act**
Prior to the implementation of the Affordable Care Act and the consequential insurance mandate, there were 1.4 million people in Pennsylvania, 1.3 million people in New Jersey, and 92,000 people in Delaware that were uninsured.

With regards to Health Insurance Marketplace status, New Jersey and Pennsylvania opted for a federally facilitated marketplace while Delaware selected the partnership option. By the end of open enrollment in 2014, more than 400,000 individuals selected a Marketplace plan in Pennsylvania, Delaware and New Jersey (Kaiser Family Foundation, 2014c).

**Table 3.2. Marketplace Enrollment for Delaware, New Jersey, and Pennsylvania**

<table>
<thead>
<tr>
<th>Location</th>
<th>Marketplace Type</th>
<th>Total Number of Individuals Determined Eligible to Enroll in a Marketplace Plan</th>
<th>Number of Individuals Eligible to Enroll in a Marketplace Plan with Financial Assistance</th>
<th>Determined or Assessed Eligible for Medicaid/CHIP by the Marketplace</th>
<th>Number of Individuals Who Have Selected a Marketplace Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delaware</td>
<td>Partnership</td>
<td>24,721</td>
<td>16,170</td>
<td>11,200</td>
<td>14,087</td>
</tr>
<tr>
<td>New Jersey</td>
<td>Federally-facilitated</td>
<td>301,965</td>
<td>193,286</td>
<td>179,872</td>
<td>161,775</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>Federally-facilitated</td>
<td>549,205</td>
<td>332,915</td>
<td>42,335</td>
<td>318,077</td>
</tr>
</tbody>
</table>

Pennsylvania and New Jersey fall slightly under the national average whereas Delaware equals the national average of 28 percent of potential enrollees (Polsky, et al., 2014)

**Figure 3.6. Marketplace Enrollment, Percent of Eligible Enrollees**
As of 2015, Pennsylvania, Delaware, and New Jersey have all opted to expand Medicaid.

**Medicaid Expansion - Pennsylvania**

Pennsylvania implemented the Affordable Care Act’s Medicaid expansion on January 1, 2015. Expansion of Medicaid impacts families earning less than 138 percent of the Federal poverty level. As a result, the impact of the law on reducing the numbers of uninsured Pennsylvanians has been minimal. An analysis by the Urban Institute compared the types of health coverage held by Philadelphians under the age of 65: there were 16.2 percent uninsured and 32.6 percent on Medicaid before the ACA took effect. Currently, 11.9 percent are uninsured and 34.1 percent are on Medicaid. Now that Pennsylvania has expanded Medicaid, it is projected that there will be seven percent uninsured and 41.1 percent on Medicaid (Buettgens & Dev, 2014). Despite Medicaid Expansion, 5 percent of Pennsylvanians still remain ineligible for Affordable Care Act coverage due to immigration status.

![Figure 3.17. Eligibility for Coverage as of 2014 Among Currently Uninsured Philadelphians](image)

**Medicaid Expansion - Delaware**

Delaware expanded Medicaid under the Affordable Care Act and created its own health insurance exchange called Choose Health. It is estimated that there were about 92,000 adults who were uninsured in the state prior to the law. Of these, approximately 86 percent of them were eligible for subsidies or Medicaid (Kaiser Family Foundation, 2014a). Only undocumented individuals (approximately 18 percent) are ineligible for coverage.
As of March 2014, approximately 14,000 became newly insured through Marketplace plans. The Centers for Medicare and Medicaid Services, originally projected 8,000 to enroll through the Marketplace. Specifically for Medicaid, approximately 7,000 individuals enrolled in Medicaid (Miller, 2014, August 5).

**Medicaid Expansion – New Jersey**

New Jersey agreed to participate in the expansion of Medicaid under the ACA (Kaiser Family Foundation, 2014b). Of the estimated 1.3 million uninsured in the state, about one-third are now eligible for Medicaid or subsidies. However, 18 percent are undocumented and cannot qualify.

**Figure 3.8. Eligibility for Coverage as of 2014 Among Currently Uninsured Delawareans**

**Figure 3.9. Eligibility for Coverage as of 2014 Among Currently Uninsured New Jerseyans**
The uninsured rate of New Jersey residents (ages 18-65) fell from 21.2 percent in September 2013 to 13.2 percent in March 2014. The uninsured rate is the lowest it has been since 1990 (Kitchenman, 2014 June 5). With regards to Medicaid Expansion specifically, since January 1, 2014, enrollment in Medicaid has increased by 201,095, which is in line with a 2011 projection made by Rutgers Center for State Health Policy (Kitchenman, 2014 May 23).

**Implications of the ACA on NBCCEDP, Providers and the Affiliate**

Two of the three states in the Affiliate coverage area are fully participating in the new law. Thousands who had no medical coverage are now eligible to receive it at low or no cost. The increase in the newly insured, and the prevalence of those still uninsured, has presented challenges for providers and the Affiliate. For providers and community-based organizations, there is a responsibility to conduct outreach and education for those newly eligible for insurance. Language barriers and illiteracy are factors that contribute to utilization problems. Additionally, ACA components do not address the needs of the undocumented individuals who will continue to need charitable care. For many newly insured there are many challenges in paying premiums or not being able to afford hefty copayments. Many have never had medical insurance before and are not fully aware about how insurance works. Concepts like “deductible” and “network providers” are misunderstood. People often selected a plan that was inexpensive (a Bronze or Silver type) without realizing that such plans had higher deductibles or limits on physician choice.

Providers are also dealing with the problem of being retroactively denied reimbursement for services that were given to patients who subsequently lost their coverage due to non-payment.

With regards to the impact of the ACA on NBCCEDP, the general consensus is that, as of 2014, Pennsylvania, Delaware and New Jersey recognize the need for their respective programs to meet the needs of people who remain uninsured. As a result, NBCCEDP providers and administrators strongly believe that these programs will be supported moving forward. That said, there is an understanding that the level of need will need to be reevaluated based on the results of marketplace and Medicaid expansion success.

For the Affiliate, there is an understanding of the shared responsibility to educate patients about health insurance options. As such, the mission programs set out to meet that need. In the affiliate’s culturally specific education events, Latinas United for the Cure and Sisters for the Cure, experts from UnitedHealth Care hosted breakout sessions for attendees. Through a partnership with the Pennsylvania Health Access Network in 2014, Community Grants Program awardees were provided a training session on the current status of the Affordable Care Act and Medicaid Expansion. The Affiliate Community Grants Program RFA requests information about how applicants have and will further adapt to the changing landscape of health insurance. The Affiliate will work closely with key stakeholders to determine the impact of the ACA on NBCCEDP, and with medical and community-based providers in order to identify the best additional efforts to support increasing access to care.

**Affiliate’s Public Policy Activities**

**Pennsylvania**

In order to play a more proactive role in policy discussions that impact women’s health and breast cancer screening and treatment, the Affiliate in 2010 joined with other Pennsylvania Komen Affiliates to form the Pennsylvania Komen Advocacy Alliance. In concert with the Pittsburgh, Northeastern Pennsylvania (NEPA), and Twin Tiers Affiliates, and with the guidance of the national Komen policy team, the Affiliate works to educate state and federal policy makers about breast cancer and advocate for the needs of underserved women. This PA Komen
Advocacy group also includes a representative from the lead agency managing the state HWP grant from the CDC. The Affiliate maintains a list of grassroots policy advocates in its service area and provides information to supporters on key policy issues. The team will continue to expand its coalition-building efforts with other statewide cancer organizations as well as with those grantees that are potential partners.

Some key policy and partnership activities include joining forces with other cancer advocacy groups like the Leukemia and Lymphoma Society and the American Cancer Society to lobby for an Oral/IV Chemo parity law. The Komen PA team also monitors the status of legislation implementation and the continued impact on providers, patients and survivors. Additionally, Komen Philadelphia has been successful advocating for Medicaid expansion. Despite a great deal of pressure to reduce state spending, HWP funding has remained stable since 2012.

**Delaware**
The Affiliate covers all three counties of Delaware. Nevertheless, the Affiliate’s Philadelphia name has often proved to be a handicap in reaching out to Delaware legislators and government officials since they often assume the Affiliate is only a Greater Philadelphia-oriented organization. Nevertheless, the affiliate has made inroads through the efforts of Delaware based volunteers. In 2011, Komen Philadelphia joined forces with the Leukemia and Lymphoma Society and the American Cancer Society and successfully passed an Oral/IV Parity Law. Funding for the Screening for Life program has remained steady. The Affiliate will continue to work with Delaware-based grantees and other community partners to do more outreach and education in Dover about the importance of breast health education and early detection. The Affiliate is exploring joining the Wilmington Health Planning Council whose mission is to improve the health of those who live and work in Wilmington through health promotion and disease risk reduction.

**New Jersey**
Komen Philadelphia covers one county in the state – Camden. From a political advocacy standpoint, the Affiliate coordinates its much focused efforts with its Camden-based grantees. The Affiliate also works cooperatively with other Komen Affiliates that have New Jersey as their primary focus (the Central/South Jersey and the North Jersey Affiliates). At the time of publication, it was expected that the NJCEED program would be level-funded for FY 2015.

**Health Systems and Public Policy Analysis Findings**

Through an analysis of the health systems available for breast cancer services in Komen Philadelphia’s priority areas (Philadelphia, PA, Reading, PA, Camden County, NJ, Warminster, PA, and Delaware County, PA) a number of needs have been identified. Across the five target areas, common needs to be addressed are support for increasing access to basic care, encouraging providers to offer linguistic support for growing Latino populations, and helping residents understand the implications of the Affordable Care Act (ACA). Komen Philadelphia continues to address these issues in collaboration with community partners such as NBCCEDP administrators, experts on ACA/Medicaid, hospital systems, community-based organizations, and policymakers.

Public policy has had a remarkable impact on breast health care in Komen Philadelphia’s service area. With the passage of the ACA, many people who were once uninsured are now able to receive the breast health services they need. However, as of 2014 undocumented immigrants still remain unaltered by the ACA. Because of this issues and many others, Komen Philadelphia remains active in policy work as it relates to breast cancer. The core of the
Affiliate’s policy efforts is the partnership of other Komen PA affiliates. Komen Philadelphia recognizes that continued policy work is necessary in order to advocate for breast health services for all women in need.
**Qualitative Data Sources and Methodology Overview**

Komen Philadelphia collected qualitative data within the five priority communities in order to better understand and place in context the results of both the quantitative and health systems analyses. The qualitative data included Key Informant Interviews with providers and Focus Groups with consumers. The qualitative data collection and analysis focuses on key variables identified in the quantitative and health systems analyses including access to breast health care across the continuum of care, racial and linguistic health disparities, and the effects of the Affordable Care Act (ACA). The Affiliate conducted Key Informant interviews of leading health care providers to gain an in-depth report of their experiences with providing breast health services within their communities. The Affiliate obtained information from these Key Informants in three ways—through an online survey, in-person and via telephone. Notes from the Key Informant interviews were securely stored in the Affiliate’s office. Different Key Informant data collection methods were used to accommodate provider preference and to yield a higher response rate from providers.

The web-based key informant surveys were created through Survey Monkey and emailed to various health care providers including program directors and breast health service providers in the Affiliate’s priority areas in an effort to broaden the Affiliate’s reach and generate a high response rate. The survey consisted of open-ended questions assessing the availability and variety of breast health services in the region as well as the barriers, challenges, and gaps to providing these services in their respective communities. The web-based survey also consisted of demographic questions (see Appendix A for Key Informant Interview questions). If the Key Informant indicated being a provider for multiple priority counties, their responses were applied to the analysis done for each county.

In addition to the Key Informant interviews, six focus groups were conducted in the priority geographic areas identified by the quantitative data report in order to gain perspective about the experiences women have when accessing breast health care services in their communities. Focus groups with Spanish-speaking consumers were conducted by a native-Spanish speaking facilitator and the notes from these groups were then translated by this facilitator into English. For both Spanish and English-speaking focus a group, a secure laptop was used to record the focus group sessions and a note-taker was also present. All focus group participants signed a consent form and completed a demographic information form. All focus group recordings were transcribed and all materials were stored – and saved – in the Affiliate’s office. (See Appendix B for the Focus Group Guide questions).

The data collection methods allowed Komen Philadelphia to gain insightful and in-depth information about key providers, leaders, and women who receive breast health services in the Affiliate’s priority areas. Key Informant interviews, open-ended surveys, and focus groups allow participants to express their opinions, beliefs and experiences. These questions were formulated based on the quantitative data and health systems analyses in order to allow for triangulation of the findings. The recurring themes in the qualitative analysis elaborate on the priorities identified in the quantitative data report and support the findings of the quantitative data and health systems analyses.

**Selection of Key Informants and Focus Group Participants**

Focus groups and Key Informant interviews were conducted in the five priority geographic areas of the Affiliate (Philadelphia County, Camden County, Delaware County, Reading, PA, and Warminster, PA). Focus group participants were selected based on the criteria that they lived in a priority county and were of the specified racial demographic for that priority area. Most participants had previous experience with breast cancer (e.g., survivor, co-survivor, in...
treatment, etc.). Key Informants (those who were interviewed in person, on the telephone and who completed an online survey) were selected if they worked for an organization that provided breast health services in a priority area and were known to have experience and knowledge of available services and consumers in their communities.

Partner hospital providers serving geographic priority areas were contacted to lead focus group participant recruitment. Each provider used a combination of recruitment including language-specific fliers being distributed at appointments and community events. If currently hosting breast cancer survivor support groups, providers announced the opportunity to participate in the focus group during their sessions. To encourage participation, the Affiliate provided refreshments during the focus group while some providers supplemented meals with gift cards.

The sample sizes by data collection method are shown in Table 4.1.

**Table 4.1. Qualitative Data Methods and Sample Sizes**

<table>
<thead>
<tr>
<th>Number and Type of Qualitative Data Collected</th>
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</thead>
<tbody>
<tr>
<td>Key Informant Interviews</td>
<td>Focus Groups</td>
</tr>
<tr>
<td>(target population of interest)</td>
<td>(target population of interest)</td>
</tr>
<tr>
<td>Camden County</td>
<td></td>
</tr>
<tr>
<td>6 Interviews</td>
<td>2 Focus Groups</td>
</tr>
<tr>
<td>(Black/African-American, Hispanic/Latina)</td>
<td>(1 Black/African-American, 1</td>
</tr>
<tr>
<td></td>
<td>Hispanic/Latina)</td>
</tr>
<tr>
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</tr>
<tr>
<td>22 Interviews</td>
<td>(1 Black/African-American)</td>
</tr>
<tr>
<td>(Black/African-American)</td>
<td></td>
</tr>
<tr>
<td>Delaware County</td>
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</tr>
<tr>
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</tr>
<tr>
<td>specifications</td>
<td>No specifications</td>
</tr>
<tr>
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</tr>
<tr>
<td>5 Interviews</td>
<td>(1 Hispanic/Latina)</td>
</tr>
<tr>
<td>(Hispanic/Latina)</td>
<td></td>
</tr>
<tr>
<td>Warminster Area</td>
<td>1 Focus Group</td>
</tr>
<tr>
<td>6 Interviews</td>
<td>(1 Hispanic/Latina)</td>
</tr>
<tr>
<td>(Hispanic/Latina)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>47 Key Informant Interviews</td>
</tr>
<tr>
<td></td>
<td>6 Focus Groups</td>
</tr>
</tbody>
</table>

*Some respondents indicated serving multiple priority counties.

**Ethics**

Those who participated in focus groups signed a consent form (see Appendix C for a sample consent form) while those who took the online survey provided their consent online prior to taking the survey. For the sake of confidentiality, last names were not collected from focus group participants or Key Informants nor did the Affiliate identify specific individuals by name as the focus group conversations were transcribed. Once collected, all data were securely stored in the Affiliate’s office space. Notes from all collection methods were stored on a password-protected computer.

**Qualitative Data Overview**

As noted above, original data gathered from Key Informant interviews, surveys and focus groups were in the form of interview notes, open-ended online survey responses, and verbatim transcripts, respectively. In order to ensure the most accurate data collection, focus groups were recorded for verbatim transcripts and facilitator notes were taken to provide any needed clarification of major themes. For online Key Informant interviews, Survey Monkey was used and selected for its open-ended question analysis capabilities. Using those features, key themes were identified across respondents. For Key Informant interviews, there was one person conducting the interview (via in-person or online) while another person was taking notes.
The major themes that were identified are shown in Table 4.2.

### Table 4.2. Major Themes Identified in the Target Communities

<table>
<thead>
<tr>
<th>Key Findings/Themes by Priority Geographic Area</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Philadelphia County</strong></td>
</tr>
<tr>
<td>Health Insurance and Financing Care</td>
</tr>
<tr>
<td>Fear and Support</td>
</tr>
<tr>
<td>Health Seeking Behaviors</td>
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</tbody>
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The section below first provides an overview of the major qualitative findings in common between Key Informants and focus groups by county. For each target community, if there were unique themes specifically introduced, then more detail is offered explaining how those findings differ from the common themes.

### Key Findings/Themes by Priority Geographic Area

#### Philadelphia County

**Demographics & Patient Population**

The Affiliate conducted a focus group in Philadelphia County with Black/African-American women due to the previously identified needs of this target population. Four women participated in the Philadelphia focus group. Half of the participants reported that their income was between $20,001 and $30,000 and one reported their income being between $10,001 and $20,000. Three of the four participants have received a breast cancer diagnosis with two of these women being survivors and one currently in treatment. All of the women that were diagnosed with breast cancer received treatment from a hospital with a previously Komen funded breast health program.

The key providers and administrators selected to serve as Key Informants in Philadelphia County provide services to a culturally diverse population with the majority of individuals being Black/African-American and/or Latino. The Key Informants report serving individuals who are mostly uninsured or receive government assistance including Medicaid and/or Medicare.

**Health Insurance and Financing Care**

Both consumers and Key Informants identified financial issues (e.g. having and keeping health insurance) as being a critical barrier to care for individuals in Philadelphia. Many of the women that participated in the focus group did not have insurance at the time of their diagnosis. They
reported that their lack of health insurance was due to it being too expensive. The women reported that not having insurance prevents many people from seeking care. In one case, a consumer said, “If I didn’t feel the lump under my arm I would have never went to the doctor because at the time I didn’t have insurance.” Aside from the immediate stressors related to not having insurance, the potential financial burdens of care weighs heavily. “A lot of people lose their home because of a health situation and you don’t want that happening to you.”

Similarly, Key Informants reported that many individuals in Philadelphia County lack health insurance, which presents their health system with a variety of challenges such as not having the financial capacity to assist all who are underserved. Although there are local government programs in place to assist with this barrier such as the HealthyWoman Program [PA’s National Breast and Cervical Cancer Early Detection Program (NBCCEDP)], a variety of Key Informants stated that there are not enough screening slots available to accommodate the increasing number of women needing mammograms. Key Informants stated that this is due to the influx of individuals into underserved communities in the area. To illustrate this point a provider stated that, “Some patients end up on waiting lists because the HealthyWoman cap was reached. HealthyWoman still meets loose criteria for the uninsured.” As such, community-based and hospital programs frequently manage limited charity care, Komen, and NBCCEDP (HealthyWoman in PA) funds to bridge the gap between need and resource availability.

While the ACA exists to address issues related to health insurance, consumers and providers find day-to-day challenges that require much time and attention. Women participating in the focus groups reported general challenges in understanding their health insurance benefits or the paperwork they are required to complete. Those women, however, found support from their providers to assist in educating them about their health insurance options and completing enrollment forms. Key Informants also commented on the lack of awareness that patients have regarding health insurance and the ACA. They reported that those who apply for insurance under the ACA cannot afford to pay the monthly premiums every month, which presents providers with many obstacles. Some Key Informants added that many individuals select the Bronze plan – one of the lower tiers – in order to afford the monthly premium. However, individuals do not understand that this lower tier of coverage has a high deductible. Therefore, patients must pay out-of-pocket for physician visits until this deductible is met. To illustrate the challenge this barrier presents, a Key Informant said, “Patients complain about the high copay for services and some do not follow-up with screening tests because of the high copay [they have to pay] for it.” Many Key Informants and consumers said that more education about financing their health care through different funding channels is needed in the community in order to ease concerns about coverage.

Breast Health and Resource Awareness
Philadelphia County is an area rich in breast health and support resources; however, the majority of consumers do not know these resources are available. Alongside lack of health insurance, many Key Informants recognized that there is a lack of awareness about free community and hospital programs designed to provide health services to the uninsured. Key Informants consistently said that patients do not make appointments for mammograms because they were uninsured and were not referred to the proper resource. To illustrate this point, a Key Informant said, “It all goes back to health promotion. We need to promote existing and available health and social resources in our community.” Another Key Informant added, “Advertisement and education about these services will increase access.”

In addition to educating the community about the health and support resources available, Key Informant in Philadelphia County unanimously agreed that community outreach and events
need to be more frequent in order to educate women, especially minority populations, about breast health and breast cancer. Many providers addressed that Black/African-American patients have the greatest tendency to delay treatment. According to the Key Informants, this issue can be associated with a lack of awareness among Black/African-American women of available resources and breast health information. Providers and administrators in Philadelphia County hand out educational materials and host educational events throughout the year. However, there was a consensus that these actions are not enough. In order to ensure that all underserved women have an equal opportunity for survival, Key Informants agree that breast health awareness events must occur more frequently. To illustrate this point, a Key Informant said:

’[We] need to educate [the community] on how to get linked to some of the services that are available, [promote] general breast self-awareness that extends from just finding a lump and refocus education to the people that are most at-risk and need to get proactive about being screened. We also need to tell young folks what they need to be aware of.’

When asked to address the barriers that Black/African-American women of Philadelphia County experience in accessing care, the focus group participants reported a consensus that a lack of awareness about breast cancer was the most important issue. More specifically, the women cited that most young women have no awareness of the symptoms of breast cancer, their family history of breast cancer, or screening options for breast cancer. Some of the women suggested using Facebook or other forms of social media to appeal to the younger women about breast cancer. In summation of the previous points a consumer stated, “I think being unaware. [There is a] lack of education, lack of insurance, a lack of awareness. We need to promote this thing.” Another consumer added:

“Before I got diagnosed, I participated in a research study for Black/African-American cardiovascular and cancer. All the things it taught us- about the way we eat, genetically- all these things were preparing me for the journey ahead and I didn’t know it.”

Many Key Informants stated that to address these cultural issues, they promote early detection as the best protection during their workshops and community events. However, it remains difficult to change cultural norms and perspectives.

Fear and Support – Reported by Focus Groups
Unique to the focus group discussion, the women reported fear as being a critical barrier to care. When asked to identify barriers specific to Black/African-American women in Philadelphia, there was a consensus that many people do not get screened for breast cancer because they are afraid of receiving a diagnosis. Furthermore, they reported that women who are diagnosed are afraid to receive treatment due to the side effects (e.g., losing their hair and losing their breasts). One consumer in active treatment regarding potential MRI testing said, “I’m never having an MRI. I’m not going in that machine,” despite being a staunch advocate of addressing fear in the Black/African-American community. In terms of pride, there was a consensus that many people in the Black/African-American community, particularly young people, do not think that a breast cancer diagnosis is something that can happen to them. A consumer stated, “I think it’s just fear and a lot of people think it would never happen to them. They think it’s someone else’s problem.” As a result, people in the Black/African-American community may delay screenings or not bother learning their family history.

As survivors, the consumers did not report a lack of support. Many of them felt supported through their families, coworkers and faith thereby indicating the importance of strong support
systems to combat fear. All of the women reported being spiritual and that prayer and support from their church was critical to their survival and remaining positive. One woman in regard to her upcoming treatment stated, “I’m only human but I’m still afraid. I don’t know what kind of surgery they will do yet but I see the doctor in a few days. I know God will work it out.” When asked to report on their rapport with providers, all of the focus group participants reported a positive experience. All of the consumers received treatment at the same hospital. Positive things that they reported were that the providers knew who they were by name; the providers were ‘persistent’ and ‘soothing.’ When asked about her experience with providers, one participant stated, “People know your name and it makes a difference.” Some participants reported not having a positive experience with other hospital staff such as receptionists. Participants also reported having negative experiences with other hospitals in Philadelphia.

Health Seeking/Learning Behaviors – Reported by Key Informants

In addition to the issues, providers reported that Black/African-American women in Philadelphia generally do not adopt a preventative approach to their health care. Rather, they only seek care when there is a problem. Many Key Informants interviewed proclaimed that addressing cultural beliefs surrounding health behaviors requires cultural competence. To illustrate this point, a Key Informant stated:

“For some reason, a lot of women don’t like going to the doctor on the regular… that’s the hardest part. Unfortunately, as part of the culture, [individuals] in this community don’t seek medical attention unless it’s absolutely necessary.”

A Key Informant indicated that a unique characteristic of the Black/African-American community is that they build informal community hubs, which become their support systems and sources of health information. Aside from more formal hubs like health centers and churches, some Black/African-American individuals rely more heavily on informal hubs from their peer or neighborhood networks. The usage of informal hubs contrasts with the needs of the non-English-speaking immigrant populations that find local support organizations to be key for support and health information. As such, Key Informants recommended more community-based approaches to reaching unscreened women.

Delaware County
Demographics and Patient Population

The Delaware County focus group consisted of four consumers, two of which were between the ages of 40 and 49, one was between the ages of 50 and 59, and one was 60 or older. Two of the consumers identified as Black/African-American, one identified as White, and one identified herself as Asian. Half of the consumers were unemployed and three of the four consumers reported a household income between $10,001 and $20,000. Three of the consumers had been diagnosed with breast cancer, one at the age of 36. Consumers reported that the overall biggest barriers women in Delaware County face when trying to receive breast health services are education, insurance, and fear.

Key Informants of Delaware County provide services to a culturally diverse population, but the majority of individuals include the White, Black/African-American and Asian community. Although some individuals are either insured through their employer or through the ACA, most are uninsured or receive government assistance including Medicaid and/or Medicare.
Health Insurance and Financing Care
Both the focus groups and Key Informants reported that health insurance (e.g., the lack of health insurance, understanding health insurance, the ACA, etc.) was a hindrance for many women accessing breast health services. The consensus among the women of the Delaware County focus group was that understanding health insurance and benefits is a barrier to receiving care. Two of the four women also reported not having insurance at the time of their diagnosis while one reported having Medicare. All of the women reported needing insurance navigation and assistance with understanding their benefits. Lack of insurance was also reported as a reason why women of Delaware County may delay screening because they may not know of other options to pay for screening or treatment. One consumer felt strongly that the lack of insurance should not come before a person’s well-being. She said:

“My doctor didn’t take that insurance but I wanted to keep him. It was stressful because you really want to make sure that you get the help that you need. I’m praying that God I need some type of insurance and the stress level with cancer- you aren’t supposed to be stressing and that was a huge stressor not having insurance.”

After being fired from her job and losing her insurance, another consumer shared that a main concern was getting on ‘the welfare insurance.’ She said:

“My doctor didn’t accept any of [the welfare plans] it meant I would have to uproot and go somewhere else and I had been going to my doctor since 2008… [My navigator] helped me with my insurance and to stay here and not to be uprooted.”

Key Informants in Delaware County reported during Key Informant Interviews that the number of uninsured patients continues to be challenging due to the lack of Medicaid expansion in Pennsylvania and the high cost of coverage through the ACA. To illustrate this point, a survey respondent said, “The future will be difficult as some patients choose policies with higher copays while they’re healthy and then get slammed when they get sick and can least afford it.” Providers during key informant interviews reported that many times patients were signed up for coverage through the ACA, “cleared and all set to go,” and then suddenly stopped paying premiums.

Breast Health and Resource Awareness
Focus group participants and Key Informants agree that the lack of awareness of available breast health resources is a hindrance in Delaware County. According to Key Informant Interviews, Delaware County is an area rich in resources, but many of these resources are not easily accessible in the community and consumers are unaware that there are services available. Providers refer consumers to churches where many support services such as child care are offered because there is a lack of other community-based organizations in the area. Although Delaware County also lacks their own health department, there are large health care institutions that have a presence in the community. Organizations believe that the community needs to be educated about the number of resources that are available, even though it may not seem that way. To illustrate this point, a Key Informant said:

“Lack of education of these services is an ongoing problem as the services and requirements frequently change without notice. It would be nice to have educational programs on what is available and how to access these resources throughout the county.”
Like Key Informants, the women of the focus groups also reported a lack of awareness about breast cancer as a barrier to accessing breast health services. One woman suggested that breast health awareness should be emphasized more broadly to include lesser known symptoms and family history. One consumer shared her story and said:

“I actually found out about the cancer I had by watching Dr. Oz in the morning… I missed one mammogram because I was in the process of moving. I did get the knowledge from the TV because I had never heard that [an inverted nipple means cancer] before and I think that is something that deserves more attention. Because of all the women that know me, I only know two women that knew that about the nipple.”

The consumers also suggested that fear is a key barrier in women receiving care and that many women may be afraid of a breast cancer diagnosis. Furthermore, women reported that mammograms are not as much of a priority for women, as they should be. That was the experience of a consumer that stated, “I think sometimes people are afraid to know they have cancer. It scares some people.” Another consumer echoed that thought by saying, “Some people are afraid to learn to have cancer.’

Experience with Providers – Reported by Focus Groups
Unique to focus group participants, all of the women that were diagnosed with breast cancer at the focus group received treatment at a hospital that had a Komen funded program. The women reported positive experiences with their providers through their treatment. The group was especially appreciative of the navigation and counseling they received in regards to health insurance. One participant stated, “I really don’t understand my insurance so I always come here to try to get some help.” Another woman also expressed that she is ‘very grateful for the doctors and nurses for helping with every step of the way. They are a great gift from God.’

Cultural Barriers – Reported by Key Informants
Key Informants provided a unique perspective on the cultural barriers that make accessing breast health care difficult for women in Delaware County. Key Informants stated that in Delaware as the population becomes more diverse and demographics continue to rapidly change, it is difficult to address the needs of their patients. A Key Informant reported that the changing population has dramatically increased the number of non-English speaking patients resulting in an increased need for ongoing outreach to get into the community. To illustrate this point, a Key Informant said, “Language, along with cultural beliefs, is a definite problem. Issues need to be identified…We need to continue building trust in these different cultural communities.” Key Informants also reported that fear of a breast cancer diagnosis is commonly seen among the immigrant population. A Key Informant reported that this fear and lack of knowledge has led to an increase in the number of mastectomies. To expand upon this point, a Key Informant stated, “There is a lack of prioritizing breast care and health care in general. [This population] is not good at navigating life crises.”

Camden County
Demographics and Patient Population
The Affiliate conducted a focus group of Black/African-American women in Camden County, in which there were 11 consumers. Ten of the consumers (91 percent) had been diagnosed with breast cancer with the youngest diagnosis being at age 33. Thirty-six percent of the consumers were unemployed with most consumers reporting their annual household income between $10,001 and $30,000. The consumers identified education, fear/ignorance/pride, outreach/awareness, transportation, and access as the biggest barriers for Black/African-
American women in Camden County seeking breast health services. All consumers are patients of a previously Komen-funded provider.

Thirteen women participated in the focus group targeting Hispanic/Latina women in Camden County. Most of the consumers had been diagnosed with breast cancer (62 percent). Although two women reported having a household income of $50,000 or more, all other consumers reported their household income to be $10,000 or less. Many consumers were insured through Medicaid/Medicare or public assistance. Four consumers stated that in the past year they have needed to seek medical attention but could not due to cost. All consumers are patients of a previously Komen-funded provider.

Providers and administrators selected as Key Informants in Camden County provide services to a culturally diverse population with the majority of served individuals being of Latino descent. Most individuals are uninsured or receive government assistance including Medicaid and/or Medicare.

Health Insurance and Financing Care
Health insurance was a major discussion point for both focus group participants and Key Informants. Many of the women of both focus groups (Black/African-American and Hispanic/Latina) had their treatment funded by the New Jersey Cancer Education and Early Detection (NJCEED) program and Komen programs. Therefore, they did not have health insurance at the time of their diagnosis. The women also reported that people without health insurance will be more likely to not actively seek care. To illustrate this point, one consumer stated:

“When I was diagnosed I was angry with myself because I lost my aunts and cousins to it and I knew better and I knew I should get a mammogram but I didn't have insurance and I put things off...I missed my mammograms two years in a row and the appointments were made through the NJCEED program but something happened and I cancelled each time. I had to move. I kept saying, 'oh I'll make another appointment,' but when I got to the third it was too late and I had already found it.”

Specifically, women of both focus groups mentioned that there is a fear that health care providers/systems discriminate against those who do not have insurance and will not take patients who are uninsured. One consumer specifically said, “When I told them I had no insurance, I thought they would let me die.” Furthermore, the Black/African-American focus group participants discussed feeling limited in their ability to receive opinions and care from other health providers due to fear of going to a provider that is not covered by their insurance. When asked about their understanding of the ACA, there was a consensus that there is a lot of confusion and misunderstanding surrounding what the ACA entails. They stated that many Black/African-American people in Camden County are not aware of the eligibility criteria and also reported that people did not want to provide personal information to the government when applying. In the Hispanic/Latina focus group, even consumers that did have insurance reported having issues. A consumer who had insurance was not able to get a mammogram – although she felt a lump in her breast – because she was not of the recommended age to have a mammogram that would be covered by insurance. When sharing her personal experiences she said:

“I was only 37 with no family history, so no one thought I needed one...almost a year after finding the ball, I was called and told that I was going to be given a mammogram for free since it was Breast Cancer Awareness Month...I was upset because I never asked
for a free mammogram. I had insurance and was able to pay for it… If they would have caught it earlier, I probably wouldn’t have had to go through all that treatment and my body wouldn’t be so damaged. Even with insurance, and with so many young women being diagnosed with breast cancer, hospitals are still reluctant giving mammograms to women under 40. So then, where is the prevention?”

Furthermore, in the Hispanic/Latina group the consumers without insurance shared similar frustrations including not knowing where to seek treatment or how to receive the health care they needed without insurance. A consumer spoke about the discrimination she faced when she did not have insurance. When sharing her personal story she said:

“When you don’t have insurance, they close the doors in your face and you have nowhere to go…In Camden there is a lot of discrimination when it comes to having or not having insurance. When I haven’t had insurance, no doors have opened for me. The minute I get insurance, the doors open again.”

Another problem uninsured and underinsured consumers identified was that many women do not qualify for the financial assistance available to them because they are employed. Thus, many of them have resorted to quitting their jobs to qualify.

According to the Key Informants, the majority of patients in Camden County are uninsured, which presents providers and organizations with many challenges. Although there are existing resources available to address the needs of the uninsured population, there is not enough funding to assist all those in need. This is especially true for the undocumented population that does not qualify for the coverage available. To illustrate this point, one Key Informant said:

“Komen [Philadelphia] is critically important for the newly insured and undocumented women. There are many programs dedicated to Medicaid and Medicare patients, but not to uninsured or undocumented patients.”

Many providers in Camden County assumed that the majority of uninsured patients would become insured under the provisions of the ACA. However, due to high premiums, patients are unable to afford coverage. To illustrate these points, a Key Informant said, “Some patients that have started to pay for Affordable Care Act [coverage] drop out because they are unable to afford it…those paying out of pocket also have issues.” Additionally, the patients that have been able to become insured under the provisions of the ACA and pay for their coverage are unaware of their benefits. A Key Informant stated, “Large numbers [of patients] are now insured, but are ignorant of their plan. They don’t know how it works, who can care for them, how to access the medical system, or what wording such as deductible or copay means.”

Pride, Fear and Awareness
Both focus group participants and Key Informants cited pride, fear and awareness as an area of priority to be addressed. In the focus group for Black/African-American women, most consumers reported knowing about breast cancer because they were aware of their family history of the disease. However, they acknowledged that many Black/African-American women in Camden County do not have an awareness of breast cancer or know their family history of breast cancer. The women also pointed out that there are many misconceptions among the Black/African-American community about breast cancer and a lack of awareness about early symptoms. “Everyone relates breast cancer to a lump but we have to tell people it’s not just that and to notice every difference in their breast,” a consumer shared. Exacerbating these issues is that
even when education is offered, pride comes to the forefront. A consumer specifically shared that:

“In our people there is a lot of pride. We know what we need to do and whether you are afraid or not. We often die because we don't get services. We have all this education. People are everywhere, in the churches, and we just fail to act on that.”

Another trend among both focus groups that consumers reported was a fear of receiving a diagnosis. Consumers stated that many people will not go to receive a mammogram because they do not want to know if they have breast cancer. To illustrate this point, a consumer said: “For my mother, it was fear because back then when you found out you had cancer, it was a death sentence…We didn’t know [she had cancer] until her nipple fell off and she had to get treatment. By that time, it was too late. [Key barriers] are education and fear.” One woman reported that the best way to relate to the Black/African-American community is through the testimony of women who are survivors and currently in treatment for breast cancer. “Us, as survivors, our stories matter because we are the awareness. We share our stories and tell our different experiences and it helps [people] to have the knowledge and education,” the participant said.

Hispanic/Latina women also reported being fearful of a breast cancer diagnosis. They fear not being able to provide for their family, take care of their children and keep their looks due to hair loss and the other side effects of breast cancer treatment. One consumer added, “When Hispanic women get diagnosed with breast cancer, they’re thinking about their hair falling out or looking ugly or what they’re friends are going to think. They think about how they’re going to look and not how they are going to survive.”

Transportation – Reported by Focus Groups
Unique to both focus groups, some reported that transportation was an issue in accessing breast health services. While there are many transportation resources in Camden County, the women reported that these services are not available in all neighborhoods. For the consumers who did not have their own modes of transportation, they said it was a burden to rely on a family member or friend to take them to their appointments. A consumer suggested that a transportation card should be given to breast cancer patients that need to utilize public transportation or taxis to get to their screening, follow-up and treatment appointments. One suggestion was to increase the number of mobile vans and to make them more accessible in neighborhoods. Regarding transportation, one consumer said, “It is an issue when you don’t have a car and can’t get there and you have to make arrangements with people. They need something like the truck they have for HIV/AIDS screening.”

Support – Reported by Focus Groups
Support was a topic discussed only among focus group participants. Consumers of both focus groups reported feeling well-supported by their health care providers, families, and other social networks. Many of them discussed how their spirituality and religion helped them to cope with their diagnosis and remain resilient throughout the treatment process. To illustrate this point one consumer said, “After four years of being diagnosed with breast cancer I always think to myself that if it wasn’t for my faith in God, support from my family and the support groups here at [the hospital] as well as [the staff], I wouldn’t know where I would be.” Some reported using the support services offered by the hospital. Participants of the Hispanic/Latina focus group unanimously agreed that support groups and emotional therapies were essential and necessary. One suggestion was that there should be more support for women diagnosed with breast cancer that have young children (e.g., free day care) since, in a consumer’s specific case
she said, “I had to take care of my daughter even when I wasn’t feeling well” after her treatment. Another suggestion was more support for women after they survive breast cancer and must cope with the aftermath of treatment.

**Language and Family – Reported by Hispanic/Latina Focus Group**

A unique cultural barrier for the Hispanic/Latina women was language and the prioritization of family obligations over treatment. To illustrate this point one consumer said, “Many times I knock on doors and there are Hispanic mothers who are attending their children and forgetting about themselves. These are the women that can be diagnosed too late because she isn’t worried about herself.” Cultural barriers such as language gaps, illiteracy and beliefs continue to be key issues for providers and administrators serving the community. Key Informants unanimously agreed that bilingual navigators and culturally competent staff were imperative to addressing population needs. Although some health systems and organizations in Camden County have the bilingual navigators and staff to assist the Latino population, many lack these resources due to limited funding. Furthermore, a Key Informant said, “[W]e need to improve access to social workers and patient navigation assistance services in the health care system and community.” Many Key Informants also suggested that culturally specific programs needed to be designed in order to properly serve the Latino community and address the existing cultural barriers. Key Informants suggested that an increase in the number of bilingual care providers would address this issue.

**Experience with Providers and Health System – Reported by Hispanic/Latina Focus Group**

Though all of the consumers emphasized the need for more support services and culturally competent staff in Camden County, they all agreed that the care they received from the doctors, nurse navigators and social workers at the hospital through the Komen funded breast health program was excellent. Additionally, they all agreed that if it was not for the Komen breast health program, they do not know where they would be or if they would have survived. One participant said, “The good part about this program too is the information and education we receive...you think you know everything about diseases, but you don’t know anything. We are always learning new things from [the staff] and this program.”

However, the focus group participants indicated that prior to being connected to the Komen program, they had negative experiences navigating provider systems (e.g. interpersonal interactions with front-line hospital staff). One consumer shared:

> “Many of these organizations that are supposed to help don’t and it really bothers because they act like the money is their own but it’s not. It’s frustrating because people are sick and need the help. Many people don’t understand the vulnerable state of mind that people diagnosed with cancer feel and some even try to take advantage of it...They made me feel like I was going to have to pay my bill, which was at $53,000...The first problem is that many of us are treated poorly when we need financial help... [The health system] has to have more consideration for those who are sick and vulnerable.”

While issues pertaining to insurance and language status are prevalent, a recurrent theme is that rapport with staff throughout their service experience is critical to feeling respected and less anxious in a time of fear.

**Need Exceeds Capacity – Reported by Key Informants**

Although the women of the focus groups felt well supported by providers and their own social networks, Key Informants revealed that there are not enough breast health screening, treatment, or support services. Because there is such a large underserved and uninsured
population in Camden County, there are not enough providers, organizations or resources available. Key Informants unanimously agreed that there was a dire need for an increase in the number of providers and assistance including transportation services and housing assistance for patients during breast cancer treatment. To illustrate this point, a Key Informant said: “Often patients must wait two to three months to get first-time appointments…Also, [patients] are unable to get same-day sick visits, leading to more frequent emergency room visits.” Key Informants agree that more resources need to be allocated to this community in order for the need to be properly addressed. A Key Informant suggested that there should “perhaps be a program to encourage providers to want to practice in our area.” With the growing number of survivors growing in Camden County, many Key Informants also reported a need for the development of survivorship programs and complementary medicine programs for them. Furthermore, many Hispanic/Latina women that participated in the focus group stated that although there are limited resources in Camden County, the resources that are available such as charity care through hospitals and Komen funded breast health programs, are not advertised as much as they should be.

Reading Area (Berks County)
Demographics and Patient Population
Six women and one man participated in the focus group targeting Hispanic/Latina women in the Reading Area. Five consumers had been diagnosed with breast cancer. Of those who responded to the question of household income, two consumers reported their household income was less than $10,000 and one reported it was between $40,001 and $50,000. Four consumers were insured through Medicaid/Medicare or public assistance, one consumer was uninsured, and one consumer had private insurance. Four consumers stated that in the past year they have needed to seek medical care but could not due to cost. All consumers (except for the male) were/are patients at a previously funded Komen program.

Key providers and organizations in the Reading Area (Berks County, PA) serving as Key Informants provide services to a culturally diverse population, but the majority of individuals include the Latino community. Although some individuals are either insured through their employer or through the ACA, most are uninsured or receive government assistance including Medicaid and/or Medicare.

Health Insurance and Financing Care
The acquisition of health insurance and misconceptions surrounding the ACA were topics discussed among focus group participants and Key Informants respectively. For Hispanic/Latina women residing in the Reading Area, not having health insurance was an issue that many participants stated was one of the greatest barriers to care. Many consumers spoke about their fear and worries that arose when they received a breast cancer diagnosis and had no health insurance to cover the cost of treatment. One consumer had to choose between keeping her job and continuing with treatment. Although she worked full-time, she still could not afford health insurance. Ultimately she made the decision to quit her job in order to qualify for public assistance to pay for her treatment. When telling her story she said:

“I don’t know about you guys, but when I was diagnosed with breast cancer, the first thing I thought about was death…I didn’t know where to begin. They moved very quickly here at [the hospital] to get me a plan and told me I had to quit my job because if not I wouldn’t qualify for the insurance plan. So right there I had to choose, do I want to have a job and get money or do I want to get treated and save my life?”
A Key Informant suggested that women are forgoing health insurance options for unexplained reasons. To illustrate this point the key informant said, “We have worked hard to serve the [uninsured and underinsured] community by shouldering the financial burden of charity health care...We are seeing a slight increase in those with insurance, but surprisingly, not as much as expected. Many are still opting to go without insurance.”

Key Informants reported that although many consumers in the Reading Area have been able to become insured through the ACA, there is still a large uninsured and underinsured population in the area that either cannot afford the ACA premiums or cannot access the help needed to enroll. Two focus group participants reported being recently insured through the ACA and said that it was quite expensive and still required high out-of-pocket costs for breast cancer treatments. Additionally, women stated that it is difficult to understand their insurance benefits. Thus, most focus group participants suggested that an educational session on the ACA would be extremely helpful.

Breast Health and Resource Awareness

Both focus group participants and Key Informants identified cultural barriers to women in Reading receiving breast health services. During the focus group, consumers identified that a lack of education about breast cancer and breast health services available in the community is one barrier for Hispanic/Latina women in Reading, PA. Many women in the area are unaware of the resources available, the signs and symptoms of breast cancer or the recommended age women should begin annual breast cancer screening. One focus group participant suggested that community outreach and family-friendly events should be organized to educate families and create awareness about proper breast health and breast health services available. Another focus group participant said that more screening events need to take place in order to be able to educate and serve the uninsured and underinsured women. To illustrate this point, a consumer said:

“It is very important, especially to the Latina population, to become educated. We have to have enough people educated and inform the community about breast cancer prevention. One of the things I think is the biggest problem within the Latina community is the fear of knowing if you have cancer. But the thing is, if you know, then you can survive and keep living.”

Language

Cultural barriers, such as language gaps and emotional support, were other issues that all focus group participants addressed. All consumers expressed that there is a need for more Spanish speaking and culturally competent physicians and staff that can understand Hispanic/Latina women and comfort them during their appointments and treatments. Additionally, consumers unanimously agreed that when physicians and staff at hospitals or health care organizations speak Spanish, they immediately feel more at ease. Similarly, Key Informants reported that the large Latino population and growing number of undocumented immigrants have led to an increase in cultural barriers including severe language gaps. Key Informants unanimously agreed that educational and promotional breast health materials needed to be translated to Spanish and that a bilingual Hispanic/Latina social worker has been critical to assisting patients in obtaining available services in the area. All Key Informants agreed that finding ways to continue reaching out to the Hispanic/Latina community was very important. To illustrate this point, a Key Informant said, “Because we have a very large Latino population, we run into many barriers. As a result, we are looking to fully integrate bilingual personnel, literature and necessary services in the community.” Another Key Informant suggested that health literacy classes needed to be developed for the Latino community.
Transportation
A lack of transportation assistance is another barrier for Hispanic/Latina women in Reading, PA identified solely by focus group participants. Public transportation in the Reading area is minimal. Focus group participants reported that the bus comes once an hour and is unreliable. Furthermore, they must walk quite a few blocks from their homes to get to the nearest bus stop. In addition to the inconvenience of the timing of their public transportation system, focus group participants unanimously agreed that waiting and relying on public transportation after breast cancer treatment is exhausting and dangerous. For example, a focus group participant said,

“Many people need to take the bus to get here or find a way to get here...for those getting chemotherapy, which is extremely strong, you’re not going to have the strength or cognitive level at the moment to wait at the corner for an hour...you walked to the stop to get here then you have to walk back to your house from that same spot because the bus doesn’t leave you in front of your house. Imagine how that must be for those who just get out of chemotherapy and feel weak and tired?”

At one of the main health systems in the Reading Area, there is a transportation assistance service called the Care Van that is available for patients, but the service may be terminated due to the expense. According to a focus group participant, about 75 percent of patients rely on this transportation service to get to their appointments. A consumer said, “There are some people that want to drive here and just can’t because they feel so weak. Without the Care Van, how are they going to get here? It’s a struggle.”

Resource Poor Area
Although Key Informants in the Reading Area said that they have “relatively good resources” for the English speaking community, resources for the Latino population are “just developing.” Grants are essential to help health care institutions provide adequate services to the Latino population in the area, but there is still a need for services such as transportation assistance, more screening events, translation services, and overall community outreach. To illustrate this point, a Key Informant said, “In many ways, we do not believe resources are sufficient in the area to provide adequate cancer care to many of the Latina population.” Although health care institutions work hand-in-hand with the welfare office and other social services, they many times end up shouldering the financial burden, which can make it difficult to assist all the patients in need. Similarly, all focus group participants stated that there are not enough support services or organizations available in the Reading Area.

Support – Reported by Focus Group
Support was a recurring theme during the focus group discussion. In addition to positive experiences with providers, a strong faith has been critical for all Hispanic/Latina women in the Reading Area who participated in the focus group and had been diagnosed with breast cancer. All consumers who were either breast cancer survivors or currently in treatment said that it was their faith that allowed them to have hope. For example, a focus group participant said:

“Me and all the other women I know have a lot of faith and try to keep a positive mindset...I have always been a woman with a lot of faith and I believed that God would help me. After I put my situation in the hands of God and didn’t let myself get stressed, I was able to get through it. First God, and second, not letting yourself get stressed.”

A focus group participant shared her personal experience with her breast health service providers and stated that when she had first called to schedule a mammogram, she never showed up to her appointment. However, the hospital called her until she finally came. She said:
“Even when I didn’t show up to my [first] appointment, [she] called and told me to come in late and not to worry. Even when I didn’t show up to redo my mammogram, they kept calling me to come in and I finally did. [The staff] was there for me from the beginning.”

Another focus group participant said she does not know what she would have done without the social worker that cared for her from the moment she was diagnosed. When sharing her story and talking about the social worker she said, “I am feeling great because I am now cured. [At the hospital], I found an angel that treated me extremely well…thanks to God.”

Warminster Area (Bucks County)
Demographics and Patient Population
The focus group in Warminster consisted of 10 Hispanic/Latinas residing in the Warminster Area. None of the consumers had ever been diagnosed with breast cancer. Of the focus group participants, 60 percent had previously had a mammogram and 40 percent had never had a mammogram. One focus group participant had never even heard of breast cancer before. For those who answered the question regarding their household income, two reported it was less than $10,000 and four said they did not know. Four consumers stated that in the past year they have needed to seek medical attention but couldn't due to cost.

Key providers and organizations in the Warminster Area (Bucks County) serving as Key Informants provide services to a culturally diverse population, but the majority of individuals include the Latino community. Although some individuals are either insured through their employer or through the ACA, most are uninsured or receive government assistance including Medicaid and/or Medicare.

Cultural Barriers
Both focus group participants and Key Informants brought up cultural barriers that women in Warminster face when attempting to access breast health services. Although none of the focus group participants have ever been diagnosed with breast cancer, they do worry about it and fear that one day they could receive a diagnosis. Furthermore, they expressed the likelihood that upon receiving a diagnosis they would not know where to receive treatment due to their lack of breast health education and language barriers. All consumers expressed their frustration with merely calling an organization, doctor’s office or hospital for help due to the lack of Spanish-speaking providers and staff. For example, one consumer said, “A lot of doctors speak Spanish, but many of the receptionists don’t…they are the ones that are supposed to help us fill out the forms and make appointments, but we can’t understand them.” Although Key Informants reported that there are interpreters, translation services and Spanish educational materials to adequately educate and serve the Latino population, it was stated that hospital personnel can be unwelcoming and hostile toward this community. Churches and faith-based support systems are what the Latino community heavily relies on to receive their health information in this area. Because of the hostility and discrimination many Hispanic/Latina women feel, an organization suggested that workshops should be developed in Spanish and there should be an increase in the number of bilingual hospital personnel, especially receptionists. To illustrate this point, a Key Informant said, “There should probably be workshops to address the cultural sensitivity and change of attitudes.”

Focus group participants mentioned that because they do not feel understood, they often feel embarrassed or fearful when going to a health care provider. These feelings, accompanied by a general lack of education when it comes to breast health, prevent many Hispanic/Latina women in the Warminster area from accessing services. In addition to these barriers, all focus group participants said that most Hispanic women prioritize caring for their families over seeking health services. To illustrate this point, one focus group participant said:
“We are more focused on raising our children and dedicating our lives to them that we forget about our health and ourselves. A lot of times we put it on the back burner and leave it for later, but we can’t do that. We need to be conscientious and remember that anything can happen at any moment.”

Another consumer added, “We need to take care of ourselves. If we don’t who will? A doctor isn’t going to knock on our door and remind us that it is time for our annual check-up.”

Transportation
During both the focus group discussion and Key Informant interviews it was revealed that a lack of transportation in the Warminster area hinders many of the Hispanic/Latina women trying to access breast health services in the area. Predominantly a rural area, women of the focus group reported there are not many organizations, hospitals or resources around. The hospital that can assist many of the uninsured Hispanic/Latina women in the area through the Komen funded breast health program is far from where many of them live. Many of the focus group participants said they rely on a friend from church or walk to get around. Public transportation is not reliable because it comes very infrequently and there are not many bus stops within close proximity. One focus group participant said, “If you don’t have transportation, you really don’t have many options.”

Key Informants similarly reported that financial assistance continues to be a barrier, along with transportation, particularly in the suburban communities. Although some providers have tried to address these barriers by providing vouchers, it is not enough. Additionally, some organizations that serve the Hispanic/Latina population in the Warminster area believe that not enough financial assistance is provided to support these women. To illustrate this point, a Key Informant said:

“It is so important that we put more effort into making resources available to ease the stress on women as they fight their battle. It is difficult for a woman to put herself first when she sees her family struggling…without the resources available, she may not have the strength to fight.”

Breast Health and Resource Awareness

Key Informants uniquely reported that Warminster is an area with many resources, but many resources are not utilized. Because of this, Key Informants agree that more education needs to be done in order for the Latino population to know what resources are available to them. A Key Informant said that although there are community events that take place, there is a low turn-out of Hispanic/Latinas at breast health outreach events. In order to change this, a provider during a key informant interview said, “We need to build trust in the area, increase prioritization of breast health and address the special needs [of this population].”

Similar to the point made by Key Informants, all focus group participants emphasized the need for more resources and health care providers in the Warminster area. There is only one major hospital in the area and not enough organizations or other providers to serve the community, which in turn contributes to the negative experiences Hispanic/Latina women in the Warminster area face with providers when trying to access services.

Health Insurance and Financing Care – Reported by Focus Group
Although not identified as a barrier during Key Informant interviews, Hispanic/Latina women living in the Warminster area reported the lack of health insurance as a barrier to receiving
breast health services. Not having insurance is a struggle for the Hispanic/Latina women residing in the Warminster area because they cannot afford to pay for preventive services such as a mammogram out-of-pocket. Many of the women said they have tried applying for public assistance, but the process and paperwork is extremely tedious and many of them do not have the documentation the applications require. When one focus group participant was sharing her experiences trying to access breast health services she said, “I worry a lot about going to the doctor because when the bills get to the house, I have no idea how I am going to pay for them.” Another participant added, “Not having insurance is a big problem for us, especially when we want to have exams like a mammography done. It costs a lot to pay on our own and we can't do it.”

Qualitative Data Findings

Linkage of Qualitative Data to the Quantitative and Health Systems Analyses

The Affiliate focused qualitative analysis of priority counties on topics related to health insurance access, breast health knowledge, health care access and impact of the Affordable Care Act based on findings of the quantitative and health systems report. While each county and population group revealed unique trends, the qualitative data supports key findings from quantitative and health systems data.

Strengths and Weaknesses of Data Sources and Methods

Strengths

Komen Philadelphia utilized convenient sampling for qualitative data collection. The strength of this method was that it allowed the Affiliate to gather specific information that would have been limited or not possible using probability sampling. Another strength of the qualitative data collection process was that the answers provided in the interviews, surveys, and focus groups were in a free response format, allowing participants to develop their own answers without being limited to selecting a choice. In terms of the surveys, a strength was that the answers were provided anonymously and thus participants were less likely to fabricate answers based on what they believed to be a desirable response.

Weaknesses

The primary limitation of the qualitative data collected pertains to sample size. The analysis presented assumes that the small sample of Key Informant and community participants represent entire target populations within priority counties. Therefore, there is a high likelihood of key issues not having been considered.

While some of the focus groups had fewer participants than expected, and the Key Informant interviews were conducted using multiple methods, there was both consistency in most of the major themes and the findings also highlight and expanded upon quantitative and health systems data.

Conclusion

Findings from the qualitative data collection process support that there is a substantial need for breast health treatment and support services in the priority areas of Philadelphia County, Camden County, Delaware County, Reading, PA, and Warminster, PA. The conclusions drawn from the analysis of qualitative data are consistent with the quantitative and health systems analyses. The aforementioned qualitative findings provide insight to the issues of low mammography screening rates, high late-stage breast cancer incidence rates and high breast cancer death rates in the priority areas identified. Furthermore, it explains why there is a substantial number of women uninsured or underinsured in such areas. In Warminster, PA,
Reading, PA, and Camden County, the qualitative findings support reasoning for a large need of Spanish interpretation services throughout the continuum of breast health care.

The Affiliate identified several key themes throughout the analysis of the qualitative data. In focus groups and key informant responses, all of the priority areas identified the lack of health insurance as a major barrier to accessing services. Furthermore, the respondents reported that navigation through the health insurance marketplace of the ACA was difficult for patients and the premiums were too expensive for much of the service population. This was especially true of the priority areas in Pennsylvania in which Medicaid has not been expanded as of 2014. Key cultural barriers were identified among Black/African-American and Hispanic/Latina women of the priority areas. For Black/African-American women, the common trend reported was postponing screening due to fear and lack of awareness. For Hispanic/Latina women, the need for bilingual support and awareness materials translated into Spanish was pressing. A common trend between both Black/African-American and Hispanic/Latina women was the reliance on family and spirituality as support during and after treatment. Furthermore, in resource-poor, rural areas such as Reading, PA, there is a need for a greater number of services that support Hispanic/Latina women throughout the continuum of breast health care. Additionally, in more rural areas, transportation was identified as a key barrier to accessing care. In heavily populated areas such as Philadelphia County and Camden County, there is a need for awareness and patient navigation through the high number of resources available. Given the common barriers and themes persistent throughout this report, Komen Philadelphia will seek to address such barriers through its mission activities and Community Grants Program.
Breast Health and Breast Cancer Findings of the Target Communities

The findings from the Quantitative Data Report demonstrate that there is a need for targeted breast health services in Philadelphia County, PA (Black/African-American women), Delaware County, PA (no demographic specification), Camden County, NJ (Black/African-American and Hispanic/Latina women), Warminster, PA (Hispanic/Latina women), and Reading, PA (Hispanic/Latina women). The target areas were selected due to the fact that they all have high rates of late-stage breast cancer diagnosis, high breast cancer death rates, high rates of poverty, large numbers of uninsured individuals and large numbers of racial and ethnic minorities. Furthermore, Warminster, PA, and Reading, PA have large numbers of women that primarily speak Spanish and that are immigrants. Additionally, the Healthy People 2020 forecasts state that Philadelphia County, Delaware County and Camden County will take 13 years or more to achieve breast cancer-related objectives.

The Health Systems and Public Policy analysis revealed that there are gaps in the amount of breast health services available to women in the target areas. Furthermore, there are few organizations that provide breast health services across the entire continuum of care. In rural areas such as Warminster, PA and Reading, PA, there are very few services available in areas where public transportation services are scarce. In heavily populated areas such as Philadelphia County, PA, Camden County, NJ, and Delaware County, PA there are large numbers of services, but insufficient coordination of services among providers and support for women navigating those resources. Although there are National Breast and Cervical Cancer Early Detection Programs (NBCCEDP) available in the states of the priority geographic areas, such programs are not able to accommodate the large number of women in need of services. Medicaid expansion and the Affordable Care Act has had mixed results in impacting the awareness, availability, and affordability of breast health services.

The Qualitative analysis provided explanations for the results found in the Quantitative Data Report and implications for the results found in the Health Systems analysis. According to the qualitative data, women are likely diagnosed at the later stages of breast cancer because they are delaying breast cancer screenings. The qualitative data reveals that reasons for this could be fear, lack of breast health awareness, difficulty in accessing breast health services, linguistic barriers and cultural barriers. Furthermore, the qualitative analysis demonstrates that barriers can vary by racial/ethnic background with Hispanic/Latina women citing that they have difficulty finding linguistically and culturally competent care while Black/African-American women cite prevalent myths and beliefs in their communities as reasons for delaying care (e.g. it is only necessary to seek health care when a health problem has occurred and not for preventative care).

The triangulation of data from the target communities demonstrate that there is a profound need for a change in the approach of addressing barriers in accessing breast health care. Specifically, more emphasis should be placed on addressing myths, fears, and lack of knowledge regarding breast cancer. Furthermore, many women in the metropolitan areas of Camden County, NJ, Philadelphia County, PA, and Delaware County, PA struggle to navigate the abundance of services available to them while women in the rural areas of Warminster, PA and Reading, PA struggle to find resources. Linguistic and cultural barriers also influence the likelihood that women will get screened and receive treatment. Furthermore, the women in the identified targeted service areas are more likely to be impoverished and lack health insurance.
Mission Action Plan
The Mission Action Plan seeks to address the barriers identified from quantitative, health systems and policy, and qualitative data collected. Komen Philadelphia will identify the following communities as priority areas for targeted resources and support:

- Camden County, NJ (Black/African-American and Hispanic/Latina women)
- Philadelphia County, PA (Black/African-American women)
- Delaware County, PA
- Warminster, PA (Hispanic/Latina women)
- Reading, PA (Hispanic/Latina women)

Through the data collected, Komen Philadelphia identified various problems and needs in the target communities selected. There are not enough targeted breast health services in Camden County, NJ, Delaware County, PA, Philadelphia County, PA, Reading, PA, and Warminster, PA. There is a need for broader access to breast health services in rural areas such as Reading, PA, and Warminster, PA. Women in urban areas do not have the support and navigation services they need to be able to access the widely available breast health resources and services in Camden County, NJ, Delaware County, PA, and Philadelphia County, PA. There is a lack of breast health awareness and a need for breast health education in Camden County, NJ, Delaware County, PA, Philadelphia County, PA, Reading, PA, and Warminster, PA. Lastly, there are cultural barriers including linguistic gaps that need to be addressed in Camden County, NJ, Reading, PA, and Warminster, PA, where there are large populations of Hispanic/Latina women that struggle finding culturally competent services.

To address the problems and needs identified in the selected target communities, the Affiliate will strive to make breast cancer screening and treatment more accessible, design culturally and linguistically competent education programs, enhance the presence of the Affiliate throughout the service area, especially in areas that have traditionally been difficult to reach, provide effective resource navigation, and advocate for public policy initiatives that direct funding and resources towards programs that ensure breast cancer screening and treatment for medically underserved women.

The following priorities were identified based on the findings of the quantitative, health systems, and qualitative analyses. Evidence from the quantitative analysis suggests that there is a need for women to have access to breast cancer screening services. The health systems analysis highlighted the gaps in the health care systems of the Affiliate’s areas regarding providing care across the breast health continuum. The qualitative analysis demonstrates the reasons that women have difficulty accessing the services available to them.

Increase Access
Qualitative analyses suggest that there are extensive reasons as to why women have difficulty accessing breast health care in the targeted service areas of Camden County, NJ, Delaware County, PA, Philadelphia County, PA, Reading, PA, and Warminster, PA. Some of the reasons cited include linguistic barriers, insurance and financial barriers, transportation barriers, lack of breast health awareness, and cultural barriers. The Affiliate determined that it is necessary to address such barriers by ensuring that breast health services are accessible to all women in target communities, which is why making breast health and support services more accessible to all women was selected as a priority. The following objectives were developed to meet the first selected priority.
**Priority #1:** Make breast health services across the continuum of care, and support services to address barriers to care, more accessible to all women within the targeted service areas of Camden County, NJ, Delaware County, PA, Philadelphia County, PA, Reading, PA, and Warminster, PA.

**Objectives:**

1. Beginning in 2015, name Camden County, NJ, Delaware, Philadelphia, Reading and Warminster, PA as priority counties/populations in the Community Grants Program Request for Applications and encourage projects that target resources towards education, navigation and medical services.
2. Beginning in 2016-2017 grant cycle, include an Outreach, Education, and Navigation funding category in the Community Grants Program that is designed specifically to identify culturally-competent programs that address barriers to care, lack of breast cancer awareness and resource availability.
3. By FY2017, use Komen’s Breast Self-Awareness messages and grants program as a focal point of community-based marketing strategies throughout the Affiliate service area.

**Partnership Opportunities**

The health systems analysis data reveals that there is a lack of resources for women in the rural areas of Warminster, PA and Reading, PA. In the other priority counties of Camden County, NJ, Delaware County, PA, and Philadelphia County, PA, the analysis indicates a need for coordination of services among providers and increasing awareness of those resources among consumers. The Affiliate seeks to address this by expanding its presence into these target areas by forming partnerships with local organizations, which is why the second priority was selected. The following objectives were developed to meet the second selected priority.

**Priority #2:** Increase the Affiliate’s presence and leadership within the targeted service areas of Camden County, NJ, Delaware County, PA, Philadelphia County, PA, Reading, PA, and Warminster, PA by forming estimable partnerships with grass-roots organizations, nonprofits, hospitals, businesses and other organizations that advocate for the eradication of breast cancer by expanding knowledge of Komen’s mission.

**Objectives:**

1. By December 2015, develop a Community Profile taskforce that includes at least one representative from one organization in each targeted community of Camden County, NJ, Delaware County, PA, Philadelphia County, PA, Reading, PA, and Warminster, PA; task force will work together to develop initiatives to address specific needs in their community by meeting twice per year beginning in Winter 2015 until Spring 2019 and developing an end-of-year report on the status of goals for each community.
2. By December 2015, leverage partnerships with organizations that represent the targeted service areas of Camden County, NJ, Delaware County, PA, Philadelphia County, PA, Reading, PA, and Warminster, PA built through county task forces to increase access for underserved (i.e., low-income and minority) women in these areas to Komen Philadelphia’s internal education programs: Latinas United for the Cure, Asian American Women’s Health Awareness Day, and Sisters for the Cure.
Komen Philadelphia will also continue to consider high-quality projects and programs for its annual Community Grants Program that clearly identify needs and solutions that pertain to increasing access and providing culturally competent services across the continuum of care.
References


Appendix A: Key Informant Interview & Survey Questions

1. How would you describe the availability and variety of the health/social resources that exist in your community? These health/social resources include primary care, financial assistance, housing, transportation assistance, and other similar services.
   1a. What needs to be done to increase access to these health and social health resources?
   1b. If the resources are sufficient, in what ways do they meet the needs of the population?

2. How are you addressing survivorship needs for patients and what challenges are you finding, if any?

3. What cultural barriers have you identified in your community and what services do you feel need to be implemented in order to accommodate the population you serve? These cultural barriers include linguistic, literacy, attitudes, beliefs and other similar cultural practices/values.

4. What are some of the specific ways that your organization educates the community about breast health and raises awareness about the importance of regular mammogram screening?
   4a. Are there some things you would like to be doing to raise this awareness that you are not doing now? If yes, what are they?

5. What are some ongoing challenges and/or trends you see in your community regarding breast health services?

6. What are some future trends and/or challenges you foresee in your community regarding breast health services?

7. What are your experiences to date with the Affordable Care Act?

8. How do you feel the Affordable Care Act has impacted the organization and provision of breast cancer services at your organization from a provider standpoint?

9. Lastly, please share any experiences or comments (both positive and negative) you feel are important and that we may not have addressed above in regards to providing breast health services.

10. In which of the following locations do you/your organization provide breast health services to women (check all that apply):
    - Camden County
    - Delaware County
    - Philadelphia County
    - Reading Area (Berks County)
    - Warminster Area (Bucks County)

11. Provide an estimate of the racial composition of the women to whom you provided breast health services in the last year (as a percentage)
    - White
    - Black/African-American
• Asian
• Other

11a Provide an estimate of the percentage of women to whom you provided breast health services in the last year who are of Hispanic descent (as a percentage).

12. In the past year, can you provide an estimate of the different types of health coverage had by the women you served (check all that apply):
• Uninsured
• Medicaid
• Medicare
• Insured through employer
• Insured through ACA
• Self-pay

13. What best describes your provider setting?
• City/County Health Center
• FQHC
• Hospital clinic
• Community-based nonprofit organization/Program
• Faith-based organization/Center
• Other (please specify):

14. Approximately how many individual patients have you provided a breast related health service to in the last calendar year?
• 250 or less
• 251-500
• 501-750
• 751-1,000
• More than 1,000

15. Of the following, which best describes your role within your organization? (Select all that apply)
• Executive Management (e.g., Director, Vice President, etc.)
• Program Manager (e.g., Breast Outreach Manager, Program Coordinator, etc.)
• Direct Provider (e.g., Nurse, Navigator, Community Worker, Health Educator, etc.),
• Other (please specify)
Appendix B: Focus Group Discussion Questions

1. Would you please tell us about your experience (e.g. yourself, family members, friends) with breast cancer?¹ (support, health care, insurance)
2. What do you think causes breast cancer? What can be done to prevent it?
3. When you think about things that concern you on a day-to-day basis, is breast cancer a daily concern? Is it a concern in your life at all?
4. Tell me about your experience with breast health providers.
5. What do you think are the barriers that prevent women from seeking or getting breast cancer screening in your community?
6. Are there cultural barriers (e.g. language, modesty) that keep you from seeking care?
7. What can be done differently in your community to make sure breast health messages and services get to the women that need them?
8. For women like yourself, what makes it difficult for you seek clinical examination/mammography screening services?
9. Do you trust the health care system? Why/Why not?
10. What has been your experience with the Affordable Care Act? Do you understand how it may or may not affect your ability to receive breast health services?
Appendix C: Focus Group Sample Consent Form

Focus Group Participant Consent Form, Camden County
Susan G. Komen Philadelphia

I understand that I was invited to participate in a focus group being conducted by Susan G. Komen Philadelphia. By conducting this focus group, the Affiliate will better understand the breast health and breast cancer priorities in their service area. In addition, the information provided by you will assist with the development of its comprehensive 2015 Community Profile, which is completed every four years.

I understand that I am being asked to take part because I fit the eligibility criteria, which includes being an Black/African-American or Hispanic/Latina woman who receives breast health services in Camden County.

I understand that my participation in this group discussion is voluntary and will in no way affect any current or future assistance I might receive from Susan G. Komen Philadelphia.

I understand that all information obtained from the focus group will be kept strictly confidential. All participants in this focus group will be asked not to disclose anything said within the focus group discussion. All identifying information will be removed from the collected materials. In addition, all materials will be kept securely in the affiliate’s office.

I understand that there are no physical risks to participating in this focus group, but I might not be completely comfortable discussing some of the questions being asked and I do not have to answer them. The discussion will last approximately an hour and a half.

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

_________________________________     _______________
Participant Signature or Initials      Date