COMMUNITY PROFILE REPORT 2015

SUSAN G. KOMEN®
OREGON AND SW WASHINGTON

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Acknowledgments

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Gloria Coronado, Ph.D., Chair, Community Profile Task Force
Senior Investigator, Health Disparities
Kaiser Permanente Center for Health Research

Jackie R. Babb
Director of Operations, Breast Care Centers of Excellence
Saint Alphonsus Health System

Karen Caul, BS
SCREEN Program Coordinator
Samaritan Health Services

Kristin Kane, MSW
Manager, Oregon Breast and Cervical Cancer Program
Oregon Health Authority

Machell Dawson
Public Member

Eva Hawes
Research Associate
Oregon Health Sciences University

Chonitia Smith
Community Health Advocate
Native American Youth & Family Center

Tuyen Tran, MPA-HA
Community Outreach Coordinator, Providence Cancer Center
Providence Health & Services

Melinda Williams
Survivor
Public Member

Darren Yesser, BA, JD
Program Analyst, Oregon Breast and Cervical Cancer Program
Oregon Health Authority

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- Samaritan Health Services
- Samaritan Valley Imaging
- Washington Breast, Cervical and Colon Cancer Program

Report Prepared by:

Susan G. Komen® Oregon and SW Washington
1500 SW First Avenue, Suite 270
Portland, OR 97201
503–552-9160
www.komenoregon.org

Executive Summary

Introduction to the Community Profile Report

Susan G. Komen Oregon and SW Washington is working to fulfill the Komen promise to save lives and end breast cancer forever by empowering people, ensuring quality of care for all and energizing science to find the cures. The 2015 Community Profile provides a thorough assessment of breast health services and the state of breast cancer in the Komen Oregon and SW Washington service area, which includes all of Oregon and three counties in SW Washington. The Community Profile identifies service gaps, establishes priorities for improving breast health services, and evaluates the impact of breast health programs and public policies across the service area. An effective Community Profile allows the Affiliate to better align programs, funding and educational activities toward the same goal.

Komen Oregon and SW Washington serves a total of 39 counties, the 36 counties of Oregon, and three counties of SW Washington. The counties vary in population and service levels from very rural small counties to more urban metropolitan areas. To address this diversity and direct efforts and resources to increase efficiency, the Affiliate grouped these 39 counties into eight geographic regions serviced through a central office located in Portland, Oregon. Among the eight geographic regions, the Affiliate identified the following four target communities as being the highest priority areas due to having higher than state average late-stage diagnosis rates. These four target communities represent the following six (6) counties within the Affiliate service area:

- Linn County within the Mid-Willamette region;
- Curry County within the Southern Oregon region;
- Cowlitz County within the SW Washington region; and
- Women of color within the three counties of Clackamas, Multnomah and Washington in the NW Metro region.

After considering the quantitative data, the Community Profile Task force was able to narrow its focus to these four target communities. This analysis provided the Task Force with the opportunity to not only look at specific statistics of each geographic region, but to also conduct interviews with key informants and, where possible, facilitate focus groups with cohort representatives and those who serve them.

Komen Oregon and SW Washington was established in 1991 and held its first Portland Race for the Cure in 1992 with just 6,200 participants. The Affiliate has experienced growth since its beginning and has diversified its offerings beyond a single race event. The Affiliate now offers race events in Portland and Eugene, the Lunch for the Cure, and the Breast Cancer Issues (BCI) Conference, the only event of its kind within the Susan G. Komen Affiliate s. In addition, the Affiliate is actively involved in multiple third-party events, which combined with all other events and in-kind donations generates approximately $5.1 million per year in revenue. Annually, the Affiliate awards nearly three-quarters of a million dollars in community and disparity grant funding. Since its inception, the Affiliate has donated over $30 million dollars in community and disparity grants and in research grants. Currently, the Affiliate is in the midst of a five year disparity initiative to improve Hispanic/Latina screening rates, supported by $822,000 in cash donations, exclusive of in-kind donations, and a $1.2 million allocation from Kaiser

Permanente to support screening and needed treatment for this patient population. The Affiliate's signature education program is the annual Breast Cancer Issues Conference with events and presentations focused on the latest information on breast cancer treatment, support and research for survivors, health care professionals and the general public.

Komen Oregon & SW Washington funds community programs throughout Oregon and SW Washington and partners with 211 Info to offer treatment access assistance to an average of 300 women per year. This assistance helps to cover the costs of mileage, lodging and meals for those needing assistance in accessing screening and treatment. The community programs offered through the Affiliate or in conjunction with the Affiliate reach nearly 30,000 men and women each year.

Quantitative Data: Measuring Breast Cancer Impact in Local Communities

Multiple data sources were used to characterize the impact of breast cancer in the Affiliate service area. Census and demographic information were obtained from the U.S. Census Bureau and intercensal information was obtained from the Washington Office of Financial Management and the annual Oregon Population Report published by the Portland State University Population Research Center. Incidence, death, and late-stage diagnosis data were provided by the Oregon State Cancer Registry (OSCaR) and the Washington State Cancer Registry.

Mammography screening information was provided by the Oregon and Washington Behavioral Risk Factor Surveillance System (BRFSS), which included information gathered from women who had received a mammogram in the past two years and were 40-plus years of age. Insurance coverage information was obtained from the U.S. Census Bureau, the Oregon Health Authority, and the Kaiser Foundation.

It is important to understand the influence of geographic distance that women must travel on access to screening and treatment services. In much of the Affiliate service area, women must drive 30-60 minutes or more to access the nearest screening location, with the exception of the more urban areas along the Interstate-5 (I-5) corridor, from mid-valley, north.

Socioeconomic condition is another major factor in determining the health status of women. Low-income women are less likely to obtain regular screening and have limited access to quality health care. In the Affiliate service area, one third of women aged 40 to 64 years are below 250 percent of the Federal Poverty Level with women in the Southern Oregon and Mid-Willamette regions being above the service area average.

All counties within the service area have been impacted by the economic downturn. Oregon is considered to have the largest non-taxable federal land area in the United States. Within Oregon, 33 of the 36 counties receive Payments in Lieu of Taxes (PILT) from the federal government. In 2013, PILT payments amounted to $15.5 million. Due to the sequestration order of the current federal administration in 2013, the PILT payments were cancelled for all states starting in fiscal year 2015, which will have a detrimental impact on accessing services in Oregon.

Curry and Linn counties within the Southern Oregon and Mid-Willamette regions were particularly affected by the economic downturn and experienced higher levels of unemployment and reduced taxable income, as did most counties within the state. Counties across the state have been required to reduce public spending to address the effect of this tax reduction. With the expected elimination of PILT payments, it is anticipated that available funds for public services will be further reduced. These reductions will lead to additional challenges in the availability of personal and public resources, which directly contributes to a person's ability to access health care. Women in Curry County have a particularly difficult challenge in accessing breast cancer screening and treatment services, with available services being a two to three hour drive from one's home.

Women of color tend to be affected by the dual impact of socioeconomic and psychosocial barriers to accessing services. Hispanic/Latina and Black/African-American women are less likely to develop breast cancer in comparison to women. However, due to disparities in the delivery of, and access to, health care services, they are more likely to present with a late-stage diagnosis, and may have higher death rates as a result. Language barriers are another important contributing factor as to why women of color may delay accessing screening services. These language barriers, coupled with cultural differences and a potential distrust or lack of understanding of the health care system are often seen as additional contributors limiting access to services for screening and treatment.

A more complete understanding of the potential barriers to accessing care and available community resources was determined through a comprehensive health systems analysis. This analysis included looking at breast health resources and gaps in care. Analysis focused on the targeted communities of Clackamas, Curry, Linn, Multnomah, and Washington counties in Oregon, and Cowlitz County in SW Washington.

Health System and Public Policy Analysis

As identified in the Quantitative Analysis section, the target communities for the health systems analysis were the three counties of Curry and Linn, in Oregon; and, Cowlitz County in SW Washington; and the target community of women of color, specifically within the geographic areas of Clackamas, Multnomah and Washington Counties. The Community Profile Committee focused its efforts on researching and understanding the location of services and the potential barriers to accessing services within these specific communities. These communities were selected as target areas due to screening rates, high death rates and high late-stage diagnosis rates.

Recent changes to national and state health care policy (in Oregon and Washington) have resulted in a higher number of individuals who have comprehensive health care coverage. Nevertheless, there remain important gaps in coverage for some women. The primary conclusion is that those seeking services in the rural communities require greater information and education on how to access services, as well as the financial support to access services across the continuum of cancer care. Providers in rural areas need to know more about the Oregon and Washington Breast and Cervical Cancer Program (OR-BCCP and WA-BCCHP)

systems and how to ensure effective access for patients within these rural target communities. Additional education, access and advocacy provided by the Affiliate will help improve the quality of breast health services.

Screening and treatment access assistance that encourages women to obtain mammograms and to complete treatment if they are diagnosed with breast cancer is also a vast gap, particularly in the rural areas where extended travel is required. To address this issue, the Affiliate partnered with 211 Info in 2014 to provide transportation assistance to low-income women for both screening and treatment services. Prior to 2014, Komen Oregon & SW Washington partnered with the American Cancer Society to provide transportation assistance to this same population of women. Since 2014, the Affiliate has partnered with 211 Info in providing this assistance. The Treatment Access Program provides cards for gas, food and lodging for women who must travel to obtain services.

Over the past two years, the Affiliate has worked to develop strong strategic partnerships with health system leaders throughout the state and specifically within the target communities. In addition, the Affiliate has a very strong working relationship with the OR-BCCP and the WA-BCCHP. These relationships allow the Affiliate to leverage funding for screening services and to benefit from partnerships with enrolling providers within the target communities.

Building on these existing partnerships, the Affiliate has identified additional relationships that, if strengthened, can further raise the profile of breast health in the Affiliate service area. One is with the Conference of Local Health Officials and a second is with the Association of Oregon Counties. These relationships will focus on aligning the Affiliate with local county health departments and providers and establishing greater awareness of breast health opportunities based on the county's specific breast cancer burden. Additionally, the Affiliate is building a strategic relationship with the Oregon Health Leadership Council, which brings together Chief Executive Officers from the 31 health system and health plans throughout the state of Oregon. The goal of this partnership is to facilitate a broad-based approach to sustained transformational growth in the area of breast cancer awareness and intervention with health system and health plan strategic partners.

Komen Oregon & SW Washington enjoys a strong partnership with elected officials and has celebrated numerous victories over the past few legislative sessions, including legislation associated with clinical breast examinations being covered by insurance and women being notified of the presence and risks of dense breast tissue. In the 2013 legislative session, the Affiliate played an integral role in securing $700,000 for the OR-BCCP – the first time State general funds had been allocated to the program. During the 2014 legislative session, Komen worked to secure an additional $270,000, bringing Oregon's investment in OR-BCCP to $970,000.

Partnership with OR-BCCP and WA-BCCHP screening and treatment access services, coupled with the development of strategic alliances with health care providers, health care systems, and Coordinated Care Organizations (health entities that provide coordinated care to Medicaid enrollees) will be leveraged to address disparities in targeted counties across the Affiliate

service area. The Affiliate remains committed to strengthening its public policy positions within the communities served, developing statewide coalitions and working with elected and appointed officials to advance the agenda of the importance of breast health across the Affiliate service area.

Qualitative Data: Ensuring Community Input

The primary conclusions of the Qualitative Data report are consistent with the findings identified in previous Community Profile Reports. If someone is uninsured it is unlikely that she will receive high quality health care in a respectful, effective and timely manner. If a woman does not speak English or has different cultural beliefs, the quality of care will depend on the provider's cultural competence. Key informant interview and focus group respondents identified some important systems and structural barriers; that is, there is still a tremendous need for more screening availability and better access to treatment for women of all racial and ethnic groups. In some cases there were few facilities that offer screening or treatment services and in other cases high clinic volumes can limit access to available services. Moreover, access to transportation was cited as a concern in most geographic regions. Accessing services in remote geographic regions presents a considerable concern, highlighting the need for expanded access to screening and treatment services. Personal barriers included low awareness of the need for screening and how to access screening services, cited for Latinas in particular, and fear of the pain associated with a mammogram, among women in general.

The Task Force found that there is a continuing need to increase education and awareness, among both providers and patients, about breast health and the importance of regular screenings as well as how to navigate the health care system. Interviews demonstrated some unfamiliarity, on the part of both the provider and patient with the OR-BCCP and how patients access and receive services. Providers and key informants also expressed frustration with OR-BCCP screening allocations not always being available to fulfill the community need.

Curry County, Oregon

The main findings from the key informant interviews focused on barriers to accessing breast health care services and/or resources. The primary barrier identified was the lack of available providers, services and resources, which caused women to travel long distances to access available care. This created a financial burden that deterred some women from getting screened. Additionally, informants perceived some women as being unwilling and/or reluctant to travel outside their geographic area to receive care, given the long distances to reach a medical facility. Some informants cited distrust between local providers and those coming in from the outside the county to provide assistance or offer support in addressing local issues. This distrust was thought to limit collaborative efforts to raise awareness of the importance of breast health and the need for annual screenings. The distrust of outside stakeholders may emphasize the need to establish trusting relationships before attempting to influence change within this target community.

Linn County, Oregon

A main finding from the key informant interviews was the concern that providers were giving inconsistent recommendations to women about when to begin screening and how often to screen. This inconsistency was thought to cause uncertainty and concern among women. Informants identified several systems barriers, including a lack of breast screening facilities on the east side of the county and inadequate or non-existent public transportation services among all women. Latinas, in particular, were thought to experience low awareness of the need for screening and of how to access available breast health care resources/services. There were thought to be few local resources or efforts to address this awareness gap. The survey results, while limited in number, provided interesting insight. An important finding is that fear of the pain associated with a mammogram was a key deterrent to obtaining a mammogram.

Cowlitz County, SW Washington

While the responses varied, the leading concern was the lack of available primary care providers and screening services. This was heightened by the increased enrollment in AppleCare (Washington State's Medicaid Health Plan), the resulting higher clinic volumes, and the loss of primary care physician availability. Additionally, many of the new AppleCare enrollees were thought to face obstacles related to understanding how to access and utilize available services and resources. A specific area of concern was the apparent lack of knowledge as to the importance of breast health screening and/or the perception that screening was not important in one's overall health.

Clackamas/Multnomah/Washington Counties, Oregon

A main finding of the key informant interviews was the lack of understanding of how to access available breast care services. Specifically, women were thought to lack understanding of how to access transportation and financial resources to obtain a mammogram. A second identified concern involved cultural barriers, including distrust of the medical community specifically from the Black/African-American and American Indian/Alaskan Native populations; and language barriers, particularly for members of the Hispanic/Latina community. Additionally it was perceived that many providers lacked a good understanding of cultural values and beliefs of these women, which diminished trust and hindered patient-provider communication. Women identified the need for greater self-advocacy in clinical settings and open and trusting communication with providers. These factors were thought to be important to achieve heightened understanding of breast cancer prevention behaviors and increased participation in decisions about their care.

The three focus groups identified the following major themes: 1) lack of trust of the health care systems as perceived by women within these specific ethnic groups; 2) language barriers; 3) placing a higher priority on the needs of family members than on one's own needs; 4) lack of insurance to access services; 5) lack of accessible transportation, particularly among Hispanic/Latinas; and, 6) lack of a general understanding of the health system and how to navigate it. Women with no insurance noted difficulties in receiving health information, getting diagnosed, obtaining full or proper treatment, and generally reported experiencing a poorer

quality of care. Some women with insurance faced difficulty paying for services not covered by their plan; in some cases this led to decisions to decline needed services.

Mission Action Plan

The primary issues to be addressed in each of the identified target communities are the lower than state average screening rates, higher than state average for late-stage diagnosis rates and the need for greater education and outreach to improve breast health knowledge and awareness of available resources.

As noted previously, there are four target communities from across the Affiliate service area that have been identified as those with the most significant problems to be addressed. These are: Linn County within the Mid-Willamette region; Curry County within the Southern Oregon region; Cowlitz County within the SW Washington region; and, Women of Color within the three counties of Clackamas, Multnomah and Washington in the NW Metro region.

Based on the data collected through the quantitative and qualitative analysis process, coupled with the findings of the health system analysis, the priorities for the next four years will focus on three key priorities:

1. Improve Outcomes in Screening and Late-Stage Diagnosis Rates in Minorities
2. Improve Access to Treatment Services
3. Ensure Effective Education and Outreach

Within each of the three priorities, specific goals and objectives were identified that are specific, measurable, attainable, relevant and time-based. These differ depending on the specific priority, but each share the common thread of improving screening and late-stage diagnosis rates, increasing awareness, and ensuring the lives of those affected by breast cancer are improved.

Priority 1: Improve Outcomes in Screening and Late-Stage Diagnosis Rates in Minorities

For this first priority, two main goals were identified: (1) Implementation of the disparity grants with a primary focus to improve targeted disparity outcomes. This work is aimed at improving screening rates and decreasing late stage diagnosis rates within the targeted communities of women of color. This will primarily involve continuing and expanding the work of the Latina Initiative and building on the Worship in Pink program, focused on the Black/African-American community. (2) Improve access to treatment by developing of strategic partnerships and programs with the 31 health care systems and health plans within the targeted service areas. The objective of this goal is to implement a three-year best-practice plan aimed at improving awareness with health system patients and health plan members to ensure improved screening among their specific populations.

Priority 2: Improve Access to Treatment Services

For the second priority, two main goals were identified: (1) Raise awareness about how to obtain treatment access services. This goal is aimed at improving communication with providers, including case managers and nurse navigators, as well as with the general public regarding the availability of Treatment Access funds, and how these can be obtained and used.

This will involve outreach and education of health care providers and breast cancer survivors. (2) Maintain and, if feasible, increase funding of the Treatment Access Program. This will include maintaining support from grant allocations and seeking external foundation funding to support this critically important survivor service.

Priority 3: Ensure Effective Education and Outreach

For the third priority, four main goals were identified: (1) Continue to educate providers about the importance of Komen's screening guidelines and how to access the OR-BCCP and WA-BCCHP screening programs. The primary objective of this goal is to work in collaboration with the OR-BCCP and the WA-BCCHP, the American Cancer Society, and the Affiliate Medical Advisory Committee to develop and integrate a provider education program. (2) Ensure all Affiliate grant recipients appropriately integrate provider education into their funded programs. (3) Update the Affiliate website to provide easy access to resource information and references for survivors, co-survivors and health care professionals. (4) Continue to raise awareness among the general public about the importance of regular breast cancer screening, and the opportunities for financial assistance through programs like the OR-BCCP and WA-BCCHP.

Within this priority, and in conjunction with elements of the first priority, the Affiliate plans to develop stronger and more strategic relationships with minority communities and implement culturally appropriate ways to increase awareness of breast health and the importance of breast screening. This involves the continued work of the Latina Initiative to provide culturally appropriate education to Latinas and, development and implementation of an expanded approach to reaching the Black/African-American community, building on the foundation established through the Komen Worship in Pink Program.

Finally, advocacy remains an important element of the work of Komen. Within this priority is the goal to continue to educate Oregon and Washington legislators on behalf of the public on breast health issues and, where appropriate, to offer effective testimony on legislative issues related to breast health and breast cancer. This plan involves an approach to strengthening strategic alliances with the American Cancer Society to advance the needs of those who may be affected by breast cancer.

Disclaimer: Comprehensive data for the Executive Summary can be found in the 2015 Susan G. Komen Oregon and South West Washington Community Profile Report.

Introduction

Affiliate History

Susan G. Komen® Oregon and SW Washington is consistently striving to fulfill the Komen promise to save lives and end breast cancer forever by empowering people, ensuring quality care for all, and energizing science to find the cures. The 2015 Community Profile provides a thorough assessment of breast health services and the state of breast cancer in the Komen® Oregon and SW Washington Affiliate service area, which includes all of Oregon and three counties of SW Washington. The Community Profile identifies service gaps, establishes priorities for improving breast health services, and evaluates the impact of breast health programs and public policies across the service area. An effective Community Profile allows the Affiliate to better align programs, funding and educational activities toward the same goal.

Komen Oregon and SW Washington was created in 1991 and held its first Portland Race for the Cure® in 1992. It has grown from its initial modest beginnings to be seen as a community leader in breast health services, offering the Komen Race for the Cure in both Portland and Eugene, the Annual Lunch for the Cure, the Breast Cancer Issues Conference, and many other events, which together generate about $5.5 million per year in revenue. The Affiliate has given over $30 million in community and research grants since 1992. The Affiliate's signature education program is the annual Breast Cancer Issues Conference with events and presentations for both health care providers and the general public. The program includes speakers presenting on the latest innovations in breast cancer screening, treatment, support and research and includes a Hispanic/Latina track for Spanish-speaking survivors.

The Affiliate funds community programs throughout the state focused on reducing breast cancer disparities and partners with 211Info to offer low-income women in need of financial assistance access to necessary treatment services. Community programs reach greater than 35,000 people annually.

The Affiliate has a strong partnership with the Breast and Cervical Cancer Programs (BCCPs) in both Oregon and Washington. Partnership with BCCP screening and treatment referral services, coupled with the development of strategic alliances with health care providers, health care systems, and Coordinated Care Organizations will be leveraged to address disparities in targeted counties across the Affiliate service area. The Affiliate is an active participant in the Breast Cancer Coalitions in both the states of Oregon and Washington, and is regularly called upon to address breast health issues across the community.

Affiliate Organizational Structure

The Affiliate has a staff of fourteen full and part-time employees, an independent contractor to address public relations needs, and a part-time independent contractor to address information technology needs and issues. Oversight of the Affiliate is the responsibility of the Board of Directors. The primary duties of the Board include appointment and oversight of the Executive Director, the establishment and annual revision of the Affiliate's strategic plan, fiscal oversight, adoption of the annual budget, and the establishment of policies and procedures. Board

members are drawn from the Affiliate service area and include a diverse group of individuals with backgrounds in health care, business and other nonprofits. All Board members actively participate on one of these committees: Executive, Board Development, Finance, Grants, Program, Medical Advisory, Advocacy, and Development. There are 13 members of the Affiliate Board of Directors.

Affiliate Service Area

The Affiliate serves 39 counties, including all 36 counties in the state of Oregon as well as Clark, Skamania and Cowlitz Counties in SW Washington State (see Figure 1.1). The Affiliate service area includes sparsely populated rural counties, primarily in central and eastern Oregon and on the coast, as well as densely populated urban counties located primarily along the Interstate (I-5) corridor. This urbanization stretches about 130 miles, starting north of Vancouver, Washington in Clark County, moving south to Eugene, Oregon in Lane County, and beyond to the Grants Pass, Medford and Ashland area in southern Oregon. More importantly, portions of the densely populated counties also have rural areas with low population densities and agricultural economies.

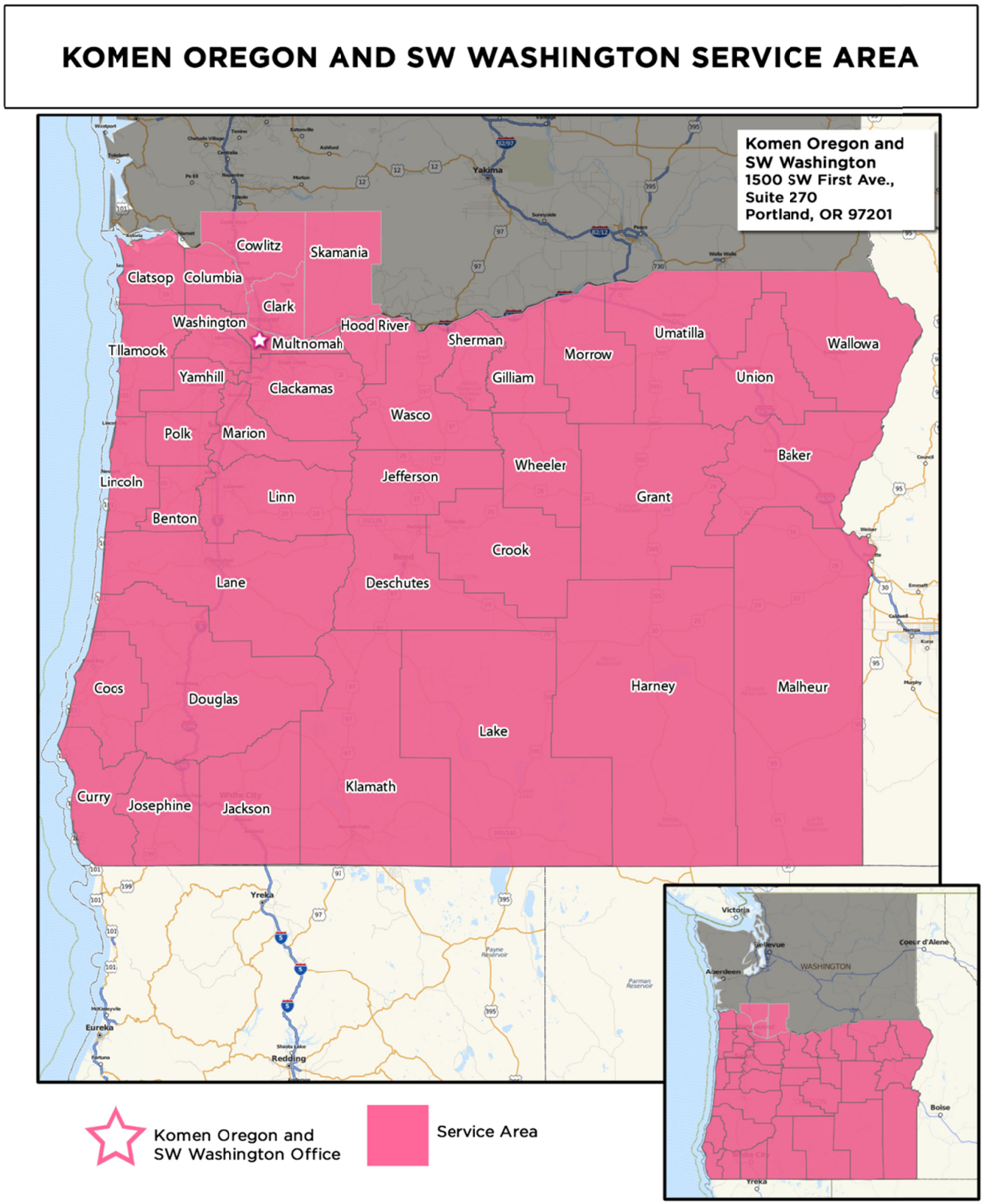

Figure 1.1. Susan G. Komen Oregon & SW Washington Service Area

Purpose of the Community Profile Report

Every four years, the Affiliate gathers information to build a Community Profile that will enable the Affiliate to better understand the state of breast cancer in the service area.
An effective Community Profile allows the Affiliate to better align programs, funding and support activities towards the same goal. It also serves as a valuable resource that allows the Affiliate to:

- Become more diverse by including a broad range of people in the Affiliate 's work;
- Fund, educate, and build awareness in the areas of greatest need;
- Make good decisions about how to use resources to make the greatest impact;
- Spread the life-saving message of early detection in a more targeted way;
- Strengthen relationships with the community and community partners;
- Provide information to the public and to public policymakers to focus their work;
- Provide strategic direction to Affiliate services – mission, marketing and outreach programs;
- Create synergy between the Affiliate's strategic plans and operational activities.

The Community Profile will be shared through a variety of different methodologies. It will be posted and available on the Affiliate website, through social media, and through direct community presentations. In addition, the Community Profile will be shared through news media with concurrent survivor-oriented features that will help to put a "face" to breast cancer and the data contained within the Community Profile.

Quantitative Data: Measuring Breast Cancer Impact in Local communities

Quantitative Data Report

Introduction

The purpose of the quantitative data report for Susan G. Komen® Oregon and SW Washington 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® Oregon and SW Washington's Quantitative Data Report. For a full report please contact the Affiliate.

Breast Cancer Statistics

Incidence rates

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

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

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

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

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

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

Death rates

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

The death rate is calculated as the number of women from a particular geographic area who died from breast cancer divided by the total number of women living in that area. Death rates are shown in terms of 100,000 women and adjusted for age. Data are included for the annual percent change in the death rate over a five-year period.

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

Late-stage incidence rates

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

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

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

		Incidence Rates and Trends			Death Rates and Trends			Late-stage Rates and Trends		
Population Group	Female Population (Annual Average)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of Deaths (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)
US	154,540,194	198,602	122.1	-0.2%	40,736	22.6	-1.9%	70,218	43.7	-1.2%
HP2020	.	-	-	-	-	20.6*	-	-	41.0*	-
Oregon	1,899,501	2,892	129.5	-1.1%	508	21.6	-2.0%	953	43.3	-1.7%

		Incidence Rates and Trends			Death Rates and Trends			Late-stage Rates and Trends		
Population Group	Female Population (Annual Average)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of Deaths (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)
Washington	3,293,650	4,757	131.0	1.3%	802	21.5	-2.1%	1,599	44.2	-0.4%
Komen Oregon and SW Washington Service Area	2,166,084	3,258	129.3	-0.8%	576	21.8	NA	1,079	43.4	-1.7%
White	1,974,557	3,047	128.4	-0.1%	555	22.1	NA	1,001	43.0	-0.8%
Black/African-American	47,283	31	102.1	4.0%	7	22.3	NA	16	48.1	9.2%
American Indian/Alaska Native (AIAN)	41,616	35	121.5	-9.4%	5	17.0	NA	13	42.6	-16.8%
Asian Pacific Islander (API)	102,628	70	77.9	9.1%	10	12.0	NA	27	30.0	6.9%
Non-Hispanic/ Latina	1,949,978	3,164	130.7	-0.6%	565	22.0	NA	1,040	43.8	-1.4%
Hispanic/ Latina	216,105	94	98.4	-1.8%	11	12.4	NA	39	37.7	-4.4%
Baker County - OR	8,020	13	102.7	-9.0%	4	25.9	NA	6	47.3	-4.1%
Benton County - OR	42,027	59	135.4	-3.6%	10	21.3	-0.4%	21	49.3	-17.0%
Clackamas County - OR	188,193	307	135.7	-1.0%	56	23.9	-1.6%	97	42.5	-1.7%
Clatsop County - OR	18,550	33	132.6	-6.7%	6	22.1	-3.5%	14	59.4	-7.6%
Columbia County - OR	24,409	37	126.1	-3.0%	5	17.5	-4.1%	14	46.9	-1.4%
Coos County - OR	32,065	58	120.1	-3.5%	11	19.8	-2.7%	18	40.7	12.1%
Crook County - OR	10,852	15	110.1	0.9%	4	24.7	-1.3%	6	50.4	17.4%
Curry County - OR	11,390	24	115.2	-6.6%	5	21.9	NA	9	45.9	0.0%
Deschutes County - OR	78,088	121	129.5	1.4%	19	19.0	-3.7%	37	40.3	8.0%
Douglas County - OR	54,303	91	111.1	-4.2%	15	17.3	-1.7%	29	36.4	0.2%
Gilliam County - OR	908	SN	SN	SN	SN	SN	SN	SN	SN	SN
Grant County - OR	3,686	5	85.4	-3.4%	SN	SN	SN	SN	SN	SN
Harney County - OR	3,621	4	86.8	14.6%	SN	SN	SN	SN	SN	SN
Hood River County - OR	10,869	15	126.5	-16.8%	SN	SN	SN	5	40.3	-22.7%
Jackson County - OR	102,787	173	125.5	1.2%	35	24.0	-2.5%	53	39.2	-5.4%
Jefferson County - OR	10,458	13	109.0	-17.2%	SN	SN	SN	4	31.6	-33.5%
Josephine County - OR	42,232	81	124.5	-2.6%	16	23.2	-2.0%	29	44.7	-1.7%
Klamath County - OR	33,370	47	109.9	-2.3%	13	28.1	0.2%	16	38.2	3.1%
Lake County - OR	3,774	7	126.5	5.4%	SN	SN	SN	SN	SN	SN
Lane County - OR	176,284	277	129.5	-0.9%	47	21.2	-2.5%	98	47.3	1.0%
Lincoln County - OR	23,530	45	114.2	0.4%	12	28.5	-0.1%	15	40.3	-11.7%
Linn County - OR	57,924	93	130.4	6.6%	16	21.8	-0.7%	27	39.7	8.6%
Malheur County - OR	14,389	20	116.3	-3.5%	SN	SN	SN	7	45.1	-9.9%
Marion County - OR	155,028	213	123.1	-1.6%	37	20.3	-1.9%	68	40.0	0.6%

		Incidence Rates and Trends			Death Rates and Trends			Late-stage Rates and Trends		
Population Group	Female Population (Annual Average)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of Deaths (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)
Morrow County - OR	5,404	7	117.4	2.7%	SN	SN	SN	SN	SN	SN
Multnomah County - OR	360,285	523	138.1	-1.0%	88	22.5	-2.0%	171	44.8	-5.1%
Polk County - OR	37,916	58	131.2	0.5%	10	20.5	-1.9%	18	41.4	5.0%
Sherman County - OR	847	SN	SN	SN	SN	SN	SN	SN	SN	SN
Tillamook County - OR	12,482	26	129.7	-4.3%	SN	SN	SN	7	38.4	5.0%
Umatilla County - OR	35,892	47	117.0	-4.1%	8	20.2	-2.1%	16	41.8	-2.5%
Union County - OR	12,911	20	131.6	11.6%	SN	SN	SN	6	41.3	7.4%
Wallowa County - OR	3,511	5	86.9	-14.6%	SN	SN	SN	SN	SN	SN
Wasco County - OR	12,479	21	123.0	-6.0%	4	22.2	-3.8%	6	36.8	-10.4%
Washington County - OR	262,133	353	135.3	-1.3%	58	22.1	-1.4%	118	44.7	-2.3%
Wheeler County - OR	713	SN	SN	SN	SN	SN	SN	SN	SN	SN
Yamhill County - OR	48,172	77	142.2	2.2%	12	20.9	-2.3%	25	46.8	2.7%
Clark County - WA	209,958	272	124.5	2.0%	50	22.3	-1.5%	94	43.1	-1.4%
Cowlitz County - WA	51,206	89	144.2	2.6%	16	24.6	-0.9%	31	51.8	2.8%
Skamania County - WA	5,419	5	73.4	NA	SN	SN	SN	SN	SN	SN

*Target as of the writing of this report.
NA – data not available.
SN – data suppressed due to small numbers (15 cases or fewer for the 5-year data period).
Data are for years 2006-2010.
Rates are in cases or deaths per 100,000.
Age-adjusted rates are adjusted to the 2000 US standard population.
Source of incidence and late-stage data: North American Association of Central Cancer Registries (NAACCR) – Cancer in North America (CINA) Deluxe Analytic File.
Source of death rate data: Centers for Disease Control and Prevention (CDC) – National Center for Health Statistics (NCHS) death data in SEER*Stat.
Source of death trend data: National Cancer Institute (NCI)/CDC State Cancer Profiles.

Incidence rates and trends summary

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

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

lower among Blacks/African-Americans than Whites, lower among APIs than Whites, and lower among AIANs than Whites. The incidence rate among Hispanics/Latinas was lower than among Non-Hispanics/Latinas.

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

- Multnomah County, OR

The incidence rate was significantly lower in the following counties:

- Douglas County, OR
- Klamath County, OR
- Skamania County, WA

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

- Hood River County, OR

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

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

Death rates and trends summary

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

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 about the same among Blacks/African-Americans and Whites, lower among APIs than Whites, and lower among AIANs than Whites. The death rate among Hispanics/Latinas was lower than among Non-Hispanics/Latinas.

None of the counties in the Affiliate service area had substantially different death rates than the Affiliate service area as a whole.

Late-stage incidence rates and trends summary

Overall, the breast cancer late-stage incidence rate in the Komen Oregon and SW Washington service area was similar to that observed in the US as a whole and the late-stage incidence

trend was lower than the US as a whole. The late-stage incidence rate and trend of the Affiliate service area were not significantly different than that observed for the State of Oregon. The late-stage incidence rate and trend of the Affiliate service area were not significantly different than that observed for the State of Washington.

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

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

- Clatsop County, OR

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

Mammography Screening

Getting regular screening mammograms (and treatment if diagnosed) lowers the risk of dying from breast cancer. Screening mammography can find breast cancer early, when the chances of survival are highest. Table 2.2 shows some screening recommendations among major organizations for women at average risk.

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

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

*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.

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

The report uses the mammography screening proportion to show whether the women in an area are getting screening mammograms when they should. Mammography screening proportion is calculated from two pieces of information:

- The number of women living in an area whom the BRFSS determines should have mammograms (i.e. women age 50 to 74).
- The number of these women who actually had a mammogram during the past two years.

The number of women who had a mammogram is divided by the number who should have had one. For example, if there are 500 women in an area who should have had mammograms and 250 of those women actually had a mammogram in the past two years, the mammography screening proportion is 50.0 percent.

Because the screening proportions come from samples of women in an area and are not exact, Table 2.3 includes confidence intervals. A confidence interval is a range of values that gives an idea of how uncertain a value may be. It's shown as two numbers—a lower value and a higher one. It is very unlikely that the true rate is less than the lower value or more than the higher value.

For example, if screening proportion was reported as 50.0 percent, with a confidence interval of 35.0 to 65.0 percent, the real rate might not be exactly 50.0 percent, but it's very unlikely that it's less than 35.0 or more than 65.0 percent.

In general, screening proportions at the county level have fairly wide confidence intervals. The confidence interval should always be considered before concluding that the screening proportion in one county is higher or lower than that in another county.

Table 2.3. Proportion of women ages 50-74 with screening mammography in the last two years, self-report.

Population Group	# of Women Interviewed (Sample Size)	# w/ Self-Reported Mammogram	Proportion Screened (Weighted Average)	Confidence Interval of Proportion Screened
US	174,796	133,399	77.5%	77.2%-77.7%
Oregon	2,054	1,552	74.5%	72.0%-76.9%
Washington	5,748	4,377	75.8%	74.4%-77.2%
Komen Oregon and SW Washington Service Area	2,426	1,865	75.5%	73.2%-77.6%
White	2,298	1,775	76.3%	74.1%-78.4%
Black/African-American	18	13	56.7%	30.3%-79.8%
AIAN	22	17	65.2%	40.9%-83.6%
API	27	21	69.6%	48.4%-84.9%
Hispanic/ Latina	37	28	81.1%	55.3%-93.7%
Non-Hispanic/ Latina	2,378	1,830	75.4%	73.2%-77.5%
Baker County - OR	14	10	68.2%	34.3%-89.8%
Benton County - OR	66	49	73.1%	57.1%-84.8%
Clackamas County - OR	213	174	83.2%	76.3%-88.4%
Clatsop County - OR	19	13	70.4%	41.6%-88.8%
Columbia County - OR	32	25	77.9%	55.4%-90.9%
Coos County - OR	51	39	66.2%	50.7%-78.8%
Crook County - OR	18	15	84.3%	59.0%-95.3%
Curry County - OR	12	8	68.0%	32.1%-90.5%
Deschutes County - OR	94	75	81.3%	69.7%-89.2%
Douglas County - OR	79	58	79.1%	66.8%-87.6%
Gilliam County - OR	SN	SN	SN	SN
Grant County - OR	SN	SN	SN	SN
Harney County - OR	SN	SN	SN	SN
Hood River County - OR	12	8	58.8%	29.6%-82.9%
Jackson County - OR	119	82	68.2%	57.0%-77.6%
Jefferson County - OR	11	9	90.6%	50.5%-98.9%
Josephine County - OR	67	39	61.1%	45.9%-74.5%
Klamath County - OR	42	31	71.3%	53.1%-84.5%
Lake County - OR	SN	SN	SN	SN
Lane County - OR	222	167	72.2%	64.2%-79.0%
Lincoln County - OR	33	21	62.7%	42.4%-79.4%
Linn County - OR	65	49	72.4%	57.2%-83.7%
Malheur County - OR	13	11	81.5%	49.1%-95.3%
Marion County - OR	150	115	77.9%	68.1%-85.3%
Morrow County - OR	SN	SN	SN	SN

Population Group	# of Women Interviewed (Sample Size)	# w/ Self-Reported Mammogram	Proportion Screened (Weighted Average)	Confidence Interval of Proportion Screened
Multnomah County - OR	293	235	76.2%	69.2%-81.9%
Polk County - OR	37	25	66.3%	46.1%-82.0%
Sherman County - OR	SN	SN	SN	SN
Tillamook County - OR	10	8	78.3%	35.5%-95.9%
Umatilla County - OR	44	30	67.8%	49.2%-82.1%
Union County - OR	26	20	71.4%	47.9%-87.2%
Wallowa County - OR	SN	SN	SN	SN
Wasco County - OR	10	8	58.3%	28.5%-83.1%
Washington County - OR	211	162	76.2%	67.9%-83.0%
Wheeler County - OR	SN	SN	SN	SN
Yamhill County - OR	42	34	80.7%	58.4%-92.5%
Clark County - WA	305	257	81.2%	75.2%-86.0%
Cowlitz County - WA	116	88	76.5%	66.1%-84.4%
Skamania County - WA	SN	SN	SN	SN

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 Oregon and SW Washington service area was not significantly different than that observed in the US as a whole. The screening proportion of the Affiliate service area was not significantly different than the State of Oregon and was not significantly different than the State of Washington.

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

None of the counties in the Affiliate service area had substantially different screening proportions than the Affiliate service area as a whole.

Population Characteristics

The report includes basic information about the women in each area (demographic measures) and about factors like education, income, and unemployment (socioeconomic measures) in the areas where they live (Tables 2.4 and 2.5). Demographic and socioeconomic data can be used

to identify which groups of women are most in need of help and to figure out the best ways to help them.

It is important to note that the report uses the race and ethnicity categories used by the US Census Bureau, and that race and ethnicity are separate and independent categories. This means that everyone is classified as both a member of one of the four race groups as well as either Hispanic/Latina or Non-Hispanic/Latina.

The demographic and socioeconomic data in this report are the most recent data available for US counties. All the data are shown as percentages. However, the percentages weren't all calculated in the same way.

- The race, ethnicity, and age data are based on the total female population in the area (e.g. the percent of females over the age of 40).
- The socioeconomic data are based on all the people in the area, not just women.
- Income, education and unemployment data don't include children. They're based on people age 15 and older for income and unemployment and age 25 and older for education.
- The data on the use of English, called "linguistic isolation", are based on the total number of households in the area. The Census Bureau defines a linguistically isolated household as one in which all the adults have difficulty with English.

Table 2.4. Population characteristics – demographics.

Population Group	White	Black /African-American	AIAN	API	Non-Hispanic /Latina	Hispanic /Latina	Female Age 40 Plus	Female Age 50 Plus	Female Age 65 Plus
US	78.8 %	14.1 %	1.4 %	5.8 %	83.8 %	16.2 %	48.3 %	34.5 %	14.8 %
Oregon	90.5 %	2.3 %	2.1 %	5.0 %	88.7 %	11.3 %	49.6 %	36.7 %	15.6 %
Washington	84.0 %	4.4 %	2.2 %	9.4 %	89.0 %	11.0 %	48.0 %	34.3 %	13.9 %
Komen Oregon and SW Washington Service Area	90.6 %	2.3 %	2.0 %	5.1 %	89.1 %	10.9 %	49.5 %	36.4 %	15.4 %
Baker County - OR	97.1 %	0.7 %	1.5 %	0.7 %	96.4 %	3.6 %	61.0 %	48.9 %	23.1 %
Benton County - OR	91.2 %	1.4 %	1.2 %	6.1 %	93.6 %	6.4 %	44.0 %	33.4 %	13.6 %
Clackamas County - OR	92.7 %	1.2 %	1.3 %	4.9 %	92.5 %	7.5 %	53.2 %	38.7 %	15.6 %
Clatsop County - OR	95.3 %	1.1 %	1.5 %	2.1 %	92.4 %	7.6 %	55.6 %	43.6 %	18.3 %
Columbia County - OR	95.5 %	0.8 %	1.8 %	1.9 %	96.1 %	3.9 %	53.7 %	39.3 %	15.4 %
Coos County - OR	93.9 %	0.7 %	3.6 %	1.7 %	94.6 %	5.4 %	59.7 %	48.4 %	22.7 %
Crook County - OR	96.7 %	0.6 %	2.0 %	0.8 %	93.4 %	6.6 %	58.5 %	46.6 %	21.4 %
Curry County - OR	95.3 %	0.6 %	2.8 %	1.2 %	94.3 %	5.7 %	68.2 %	56.9 %	29.1 %
Deschutes County - OR	96.3 %	0.6 %	1.5 %	1.6 %	92.4 %	7.6 %	52.6 %	38.9 %	16.3 %
Douglas County - OR	95.5 %	0.5 %	2.5 %	1.5 %	95.3 %	4.7 %	58.8 %	46.7 %	22.4 %

Population Group	White	Black /African-American	AIAN	API	Non-Hispanic /Latina	Hispanic /Latina	Female Age 40 Plus	Female Age 50 Plus	Female Age 65 Plus
Gilliam County - OR	97.5 %	0.5 %	0.8 %	1.2 %	94.8 %	5.2 %	65.3 %	52.3 %	24.9 %
Grant County - OR	97.2 %	0.7 %	1.5 %	0.6 %	96.7 %	3.3 %	62.3 %	50.8 %	24.4 %
Harney County - OR	94.4 %	0.9 %	4.0 %	0.6 %	95.4 %	4.6 %	56.6 %	44.7 %	19.9 %
Hood River County - OR	95.7 %	1.1 %	1.3 %	1.8 %	72.1 %	27.9 %	49.3 %	34.8 %	14.6 %
Jackson County - OR	95.1 %	0.9 %	1.8 %	2.1 %	89.6 %	10.4 %	54.4 %	42.2 %	19.4 %
Jefferson County - OR	78.2 %	1.2 %	19.8 %	0.8 %	80.3 %	19.7 %	50.8 %	38.0 %	16.8 %
Josephine County - OR	95.8 %	0.7 %	2.0 %	1.5 %	93.6 %	6.4 %	60.5 %	48.7 %	24.2 %
Klamath County - OR	91.9 %	1.2 %	5.4 %	1.5 %	89.5 %	10.5 %	53.6 %	41.2 %	18.4 %
Lake County - OR	94.8 %	1.0 %	3.0 %	1.3 %	92.5 %	7.5 %	60.3 %	47.5 %	21.4 %
Lane County - OR	93.1 %	1.5 %	1.7 %	3.7 %	92.7 %	7.3 %	50.6 %	38.8 %	16.8 %
Lincoln County - OR	92.7 %	0.8 %	4.8 %	1.7 %	92.6 %	7.4 %	63.7 %	52.3 %	23.3 %
Linn County - OR	95.6 %	0.8 %	2.0 %	1.6 %	92.5 %	7.5 %	50.5 %	38.1 %	16.9 %
Malheur County - OR	94.4 %	1.2 %	2.1 %	2.3 %	68.3 %	31.7 %	47.1 %	36.3 %	18.0 %
Marion County - OR	92.3 %	1.5 %	2.8 %	3.5 %	76.7 %	23.3 %	46.0 %	33.9 %	14.8 %
Morrow County - OR	95.4 %	1.1 %	2.0 %	1.4 %	69.4 %	30.6 %	46.0 %	34.4 %	13.4 %
Multnomah County - OR	83.1 %	6.7 %	1.8 %	8.4 %	89.7 %	10.3 %	44.6 %	31.2 %	12.2 %
Polk County - OR	93.3 %	1.0 %	2.8 %	2.9 %	88.5 %	11.5 %	48.1 %	36.2 %	16.2 %
Sherman County - OR	96.7 %	0.7 %	2.1 %	0.5 %	94.0 %	6.0 %	60.4 %	47.7 %	22.8 %
Tillamook County - OR	96.3 %	0.7 %	1.6 %	1.4 %	91.2 %	8.8 %	60.7 %	49.1 %	22.6 %
Umatilla County - OR	92.6 %	1.0 %	4.9 %	1.5 %	76.6 %	23.4 %	45.8 %	33.4 %	14.2 %
Union County - OR	95.4 %	0.8 %	1.5 %	2.4 %	95.8 %	4.2 %	50.7 %	39.8 %	18.3 %
Wallowa County - OR	97.5 %	0.9 %	0.8 %	0.7 %	97.8 %	2.2 %	63.0 %	50.9 %	23.6 %
Wasco County - OR	92.3 %	0.9 %	5.1 %	1.8 %	85.6 %	14.4 %	53.2 %	41.6 %	19.1 %
Washington County - OR	85.6 %	2.3 %	1.3 %	10.8 %	84.8 %	15.2 %	44.8 %	30.5 %	11.8 %
Wheeler County - OR	96.0 %	1.2 %	1.7 %	1.1 %	97.0 %	3.0 %	69.1 %	57.9 %	30.3 %
Yamhill County - OR	94.5 %	1.0 %	2.2 %	2.4 %	86.4 %	13.6 %	48.0 %	35.3 %	15.2 %
Clark County - WA	90.1 %	2.6 %	1.3 %	6.0 %	92.4 %	7.6 %	47.3 %	33.1 %	13.0 %
Cowlitz County - WA	94.3 %	1.1 %	2.4 %	2.2 %	92.5 %	7.5 %	51.9 %	38.9 %	17.1 %
Skamania County - WA	95.0 %	1.1 %	2.4 %	1.5 %	94.8 %	5.2 %	56.7 %	41.8 %	15.6 %

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

Table 2.5. Population characteristics – socioeconomics.

Population Group	Less than HS Education	Income Below 100% Poverty	Income Below 250% Poverty (Age: 40-64)	Un-employed	Foreign Born	Linguistic-ally Isolated	In Rural Areas	In Medically Under-served Areas	No Health Insurance (Age: 40-64)
US	14.6 %	14.3 %	33.3 %	8.7 %	12.8 %	4.7 %	19.3 %	23.3 %	16.6 %
Oregon	11.1 %	14.8 %	34.4 %	9.8 %	9.8 %	3.1 %	19.0 %	13.0 %	16.7 %
Washington	10.2 %	12.5 %	28.3 %	8.4 %	12.8 %	4.2 %	16.0 %	26.2 %	14.6 %
Komen Oregon and SW Washington Service Area	11.0 %	14.5 %	33.9 %	10.0 %	9.7 %	3.1 %	18.9 %	12.6 %	16.4 %
Baker County - OR	11.6 %	20.0 %	42.0 %	11.3 %	1.5 %	1.0 %	41.0 %	66.6 %	18.1 %
Benton County - OR	5.8 %	21.0 %	26.5 %	7.3 %	9.0 %	2.6 %	18.8 %	20.3 %	12.4 %
Clackamas County - OR	8.2 %	9.5 %	24.8 %	8.7 %	8.5 %	1.9 %	18.1 %	3.8 %	13.1 %
Clatsop County - OR	8.5 %	14.2 %	37.4 %	8.3 %	5.3 %	1.7 %	39.0 %	39.6 %	17.7 %
Columbia County - OR	11.6 %	11.8 %	30.1 %	12.5 %	3.5 %	0.8 %	43.6 %	0.0 %	14.1 %
Coos County - OR	12.6 %	16.0 %	44.9 %	11.2 %	3.2 %	0.9 %	38.4 %	27.2 %	17.2 %
Crook County - OR	14.3 %	15.8 %	38.3 %	14.5 %	3.2 %	0.9 %	48.0 %	45.0 %	19.0 %
Curry County - OR	8.3 %	14.2 %	41.4 %	9.1 %	3.5 %	0.7 %	38.7 %	100.0 %	18.6 %
Deschutes County - OR	6.7 %	11.4 %	31.1 %	10.7 %	4.4 %	1.1 %	27.6 %	4.4 %	17.1 %
Douglas County - OR	13.2 %	16.0 %	43.2 %	12.9 %	2.5 %	0.6 %	41.2 %	0.0 %	18.3 %
Gilliam County - OR	13.3 %	9.9 %	33.2 %	7.9 %	4.4 %	1.8 %	100.0 %	100.0 %	16.6 %
Grant County - OR	11.0 %	15.8 %	44.3 %	9.3 %	1.3 %	0.6 %	100.0 %	100.0 %	18.8 %
Harney County - OR	11.2 %	20.5 %	46.4 %	8.8 %	2.0 %	0.4 %	44.3 %	0.0 %	22.1 %
Hood River County - OR	17.5 %	10.0 %	35.1 %	5.5 %	18.8 %	6.5 %	52.2 %	0.0 %	21.6 %
Jackson County - OR	11.2 %	15.8 %	39.8 %	11.4 %	5.9 %	2.1 %	20.1 %	0.0 %	19.6 %
Jefferson County - OR	16.4 %	20.2 %	44.1 %	15.2 %	8.3 %	3.6 %	63.1 %	0.0 %	25.0 %
Josephine County - OR	12.6 %	18.8 %	45.5 %	12.6 %	3.1 %	0.7 %	45.0 %	93.7 %	18.1 %
Klamath County - OR	13.1 %	18.1 %	44.0 %	10.8 %	4.9 %	1.5 %	37.6 %	0.0 %	21.3 %
Lake County - OR	12.8 %	18.7 %	43.8 %	13.7 %	3.0 %	0.8 %	63.3 %	14.2 %	19.8 %
Lane County - OR	9.7 %	17.4 %	38.2 %	10.4 %	5.7 %	1.6 %	17.5 %	3.9 %	17.6 %
Lincoln County - OR	10.1 %	16.2 %	41.9 %	9.7 %	5.5 %	1.1 %	37.6 %	4.4 %	19.6 %
Linn County - OR	11.4 %	15.9 %	38.2 %	8.5 %	4.3 %	1.2 %	31.6 %	0.0 %	16.8 %
Malheur County - OR	20.4 %	22.6 %	50.1 %	12.3 %	10.3 %	6.0 %	48.4 %	9.8 %	21.1 %
Marion County - OR	17.5 %	17.3 %	38.9 %	11.5 %	13.9 %	5.5 %	13.1 %	16.7 %	19.8 %

Population Group	Less than HS Education	Income Below 100% Poverty	Income Below 250% Poverty (Age: 40-64)	Un-employed	Foreign Born	Linguistic-ally Isolated	In Rural Areas	In Medically Under-served Areas	No Health Insurance (Age: 40-64)
Morrow County - OR	22.9 %	16.4 %	39.3 %	10.7 %	15.8 %	7.5 %	45.9 %	71.6 %	19.5 %
Multnomah County - OR	10.7 %	16.5 %	35.2 %	9.7 %	14.0 %	5.0 %	1.3 %	15.5 %	16.5 %
Polk County - OR	10.2 %	12.7 %	29.6 %	8.7 %	7.4 %	2.6 %	19.9 %	4.6 %	14.8 %
Sherman County - OR	9.7 %	18.6 %	33.8 %	8.3 %	3.9 %	1.3 %	100.0 %	100.0 %	16.3 %
Tillamook County - OR	11.9 %	17.6 %	39.4 %	7.5 %	6.5 %	2.3 %	69.6 %	100.0 %	20.8 %
Umatilla County - OR	18.2 %	14.8 %	38.8 %	9.5 %	9.9 %	4.0 %	29.1 %	52.1 %	20.1 %
Union County - OR	11.0 %	16.6 %	36.8 %	7.8 %	3.5 %	1.2 %	42.1 %	33.9 %	15.2 %
Wallowa County - OR	7.3 %	15.9 %	41.2 %	11.2 %	1.3 %	0.1 %	100.0 %	0.0 %	19.6 %
Wasco County - OR	16.6 %	19.4 %	39.2 %	6.9 %	11.5 %	1.3 %	33.1 %	0.0 %	20.9 %
Washington County - OR	9.5 %	10.4 %	25.0 %	8.5 %	16.8 %	5.1 %	5.6 %	2.6 %	13.0 %
Wheeler County - OR	12.6 %	12.6 %	51.1 %	7.2 %	1.8 %	0.0 %	100.0 %	100.0 %	21.8 %
Yamhill County - OR	13.4 %	12.8 %	32.7 %	9.2 %	8.4 %	3.1 %	22.6 %	11.4 %	18.5 %
Clark County - WA	9.2 %	11.7 %	28.3 %	10.3 %	10.0 %	3.3 %	13.8 %	9.0 %	14.0 %
Cowlitz County - WA	13.5 %	17.5 %	36.8 %	11.6 %	4.9 %	1.7 %	28.7 %	10.4 %	16.2 %
Skamania County - WA	9.7 %	11.1 %	33.5 %	7.7 %	2.6 %	0.3 %	100.0 %	0.0 %	15.7 %

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

Population characteristics summary

Proportionately, the Komen Oregon and SW Washington service area has a substantially larger White female population than the US as a whole, a substantially smaller Black/African-American female population, a slightly smaller Asian and Pacific Islander (API) female population, a slightly larger 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 lower than those of the US as a whole. There is a slightly larger 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 slightly smaller percentage of people living in rural areas, a slightly 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 API female population percentages than that of the Affiliate service area as a whole:

- Multnomah County, OR
- Washington County, OR

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

- Jefferson County, OR
- Klamath County, OR
- Wasco County, OR

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

- Hood River County, OR
- Jefferson County, OR
- Malheur County, OR
- Marion County, OR
- Morrow County, OR
- Umatilla County, OR

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

- Baker County, OR
- Coos County, OR
- Crook County, OR
- Curry County, OR
- Douglas County, OR
- Gilliam County, OR
- Grant County, OR
- Josephine County, OR
- Lake County, OR
- Lincoln County, OR
- Sherman County, OR
- Tillamook County, OR
- Wallowa County, OR
- Wheeler County, OR

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

- Hood River County, OR
- Jefferson County, OR
- Malheur County, OR
- Marion County, OR
- Morrow County, OR
- Umatilla County, OR
- Wasco County, OR

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

- Baker County, OR
- Harney County, OR
- Jefferson County, OR
- Malheur County, OR

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

- Crook County, OR
- Jefferson County, OR
- Lake County, OR

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

- Hood River County, OR
- Morrow County, OR

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

- Harney County, OR
- Hood River County, OR
- Jefferson County, OR
- Wheeler County, OR

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 Oregon and SW Washington service area are progressing toward these targets, the report uses the following information:

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

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

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

Identification of priority areas

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

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

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

Counties are classified as follows (Table 2.6):

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

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

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

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

Affiliate Service Area Healthy People 2020 Forecasts and Priority Areas

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

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

Trends can change for a number of reasons, including:

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

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

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

County	Priority	Predicted Time to Achieve Death Rate Target	Predicted Time to Achieve Late-stage Incidence Target	Key Population Characteristics
Crook County - OR	Highest	13 years or longer	13 years or longer	Older, employment, rural, medically underserved
Curry County - OR	Highest	NA	13 years or longer	Older, rural, medically underserved
Klamath County - OR	Highest	13 years or longer	13 years or longer	%AIAN, rural
Tillamook County - OR	Highest	SN	13 years or longer	Older, rural, medically underserved
Union County - OR	Highest	SN	13 years or longer	Rural, medically underserved
Cowlitz County - WA	Highest	13 years or longer	13 years or longer	Rural
Linn County - OR	High	9 years	13 years or longer	Rural
Lane County - OR	Medium High	2 years	13 years or longer	
Yamhill County - OR	Medium High	1 year	13 years or longer	
Benton County - OR	Medium	9 years	1 year	Medically underserved
Clackamas County - OR	Medium	10 years	2 years	
Coos County - OR	Medium	Currently meets target	13 years or longer	Older, rural, medically underserved
Deschutes County - OR	Medium	Currently meets target	13 years or longer	Rural
Lincoln County - OR	Medium	13 years or longer	Currently meets target	Older, rural
Marion County - OR	Medium	Currently meets target	13 years or longer	%Hispanic, education
Polk County - OR	Medium	Currently meets target	13 years or longer	
Baker County - OR	Medium Low	NA	4 years	Older, poverty, rural, medically underserved
Clatsop County - OR	Medium Low	2 years	5 years	Rural, medically underserved
Columbia County - OR	Medium Low	Currently meets target	10 years	Rural
Jackson County - OR	Medium Low	7 years	Currently meets target	

County	Priority	Predicted Time to Achieve Death Rate Target	Predicted Time to Achieve Late-stage Incidence Target	Key Population Characteristics
Josephine County - OR	Medium Low	6 years	5 years	Older, rural, medically underserved
Malheur County - OR	Medium Low	SN	1 year	%Hispanic, education, poverty, rural
Multnomah County - OR	Medium Low	5 years	2 years	%API
Washington County - OR	Medium Low	5 years	4 years	%API, foreign
Clark County - WA	Medium Low	6 years	4 years	
Umatilla County - OR	Low	Currently meets target	1 year	%Hispanic, education, rural, medically underserved
Wasco County - OR	Low	2 years	Currently meets target	%AIAN, education, rural
Douglas County - OR	Lowest	Currently meets target	Currently meets target	Older, rural
Hood River County - OR	Lowest	SN	Currently meets target	%Hispanic, education, foreign, language, rural, insurance
Jefferson County - OR	Lowest	SN	Currently meets target	%AIAN, %Hispanic, education, poverty, employment, rural, insurance
Gilliam County - OR	Undetermined	SN	SN	Older, rural, medically underserved
Grant County - OR	Undetermined	SN	SN	Older, rural, medically underserved
Harney County - OR	Undetermined	SN	SN	Poverty, rural, insurance
Lake County - OR	Undetermined	SN	SN	Older, employment, rural
Morrow County - OR	Undetermined	SN	SN	%Hispanic, education, foreign, language, rural, medically underserved
Sherman County - OR	Undetermined	SN	SN	Older, rural, medically underserved
Wallowa County - OR	Undetermined	SN	SN	Older, rural
Wheeler County - OR	Undetermined	SN	SN	Older, rural, insurance, medically underserved
Skamania County - WA	Undetermined	SN	SN	Rural

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

Map of Intervention Priority Areas

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

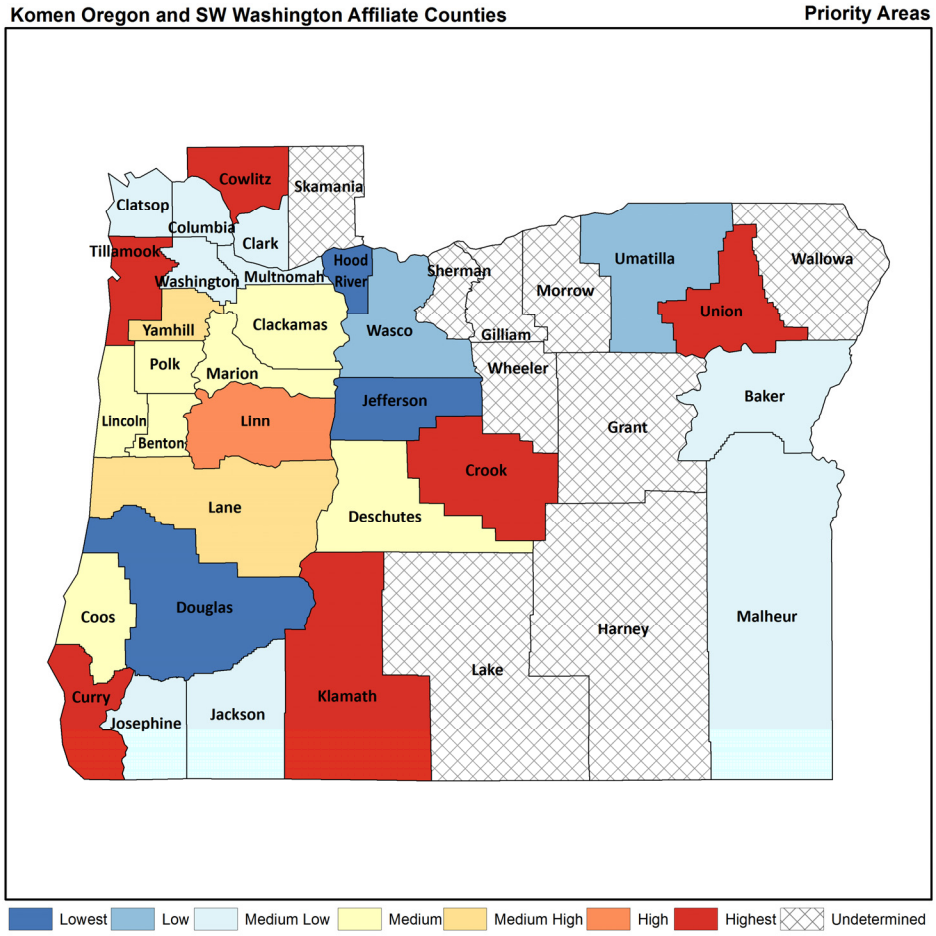


Figure 2.1. Intervention priorities.

Data Limitations

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

- The most recent data available were used but, for cancer incidence and deaths, these data are still several years behind.
- For some areas, data might not be available or might be of varying quality.
- Areas with small populations might not have enough breast cancer cases or breast cancer deaths each year to support the generation of reliable statistics.
- There are often several sources of cancer statistics for a given population and geographic area; therefore, other sources of cancer data may result in minor differences in the values even in the same time period.

- Data on cancer rates for specific racial and ethnic subgroups such as Somali, Hmong, or Ethiopian are not generally available.
- The various types of breast cancer data in this report are inter-dependent.
- There are many factors that impact breast cancer risk and survival for which quantitative data are not available. Some examples include family history, genetic markers like HER2 and BRCA, other medical conditions that can complicate treatment, and the level of family and community support available to the patient.
- The calculation of the years needed to meet the HP2020 objectives assume that the current trends will continue until 2020. However, the trends can change for a number of reasons.
- Not all breast cancer cases have a stage indication.

Quantitative Data Report Conclusions

Highest priority areas

Six counties in the Komen Oregon and SW Washington service area are in the highest priority category. Three of the six, Crook County, OR, Klamath County, OR and Cowlitz County, WA, are not likely to meet either the death rate or late-stage incidence rate HP2020 targets. Three of the six, Curry County, OR, Tillamook County, OR and Union County, OR, are not likely to meet the late-stage incidence rate HP2020 target.

Crook County, OR has an older population and high unemployment. Curry County, OR has an older population. Klamath County, OR has a relatively large AIAN population. Tillamook County, OR has an older population.

High priority areas

One county in the Komen Oregon and SW Washington service area is in the high priority category. Linn County, OR is not likely to meet the late-stage incidence rate HP2020 target.

Additional Quantitative Data Exploration

The data report provided by Komen Headquarters identified seven counties as “highest priority” areas, and one county as a “high priority” area (See Table 2.8). The seven counties identified are rural counties with small populations and small case numbers for incidence, death (death), and late-stage diagnoses, despite having high age-adjusted rates. Given the small populations and low precision of the estimates, Affiliate staff obtained additional data from Oregon and Washington Cancer Registries, and the National Cancer Institute Surveillance, Epidemiology and End Results Program. In reviewing all available data and considering Affiliate resource availability, the Affiliate determined to focus efforts on a limited number of target communities with the highest overall need.

Table 2.8 shows each of these data elements as a rate per 100,000 for seven geographic regions that were defined as part of the Affiliates grants and planning process in 2010. These regions are: NW Metro (10 counties), Mid-Willamette (four counties), Southern Oregon (five

counties), Eastern Oregon (four counties), the Gorge (five counties), Central Oregon (eight counties), and SW Washington (three counties). Table 2.8 specifically shows the incidence, death and late-stage diagnosis, with rates calculated by summing cases across the region and dividing by the number of women in that region. All rates are per 100,000 women. Percent screened was obtained from the Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System and reported as the number of women who obtained a mammogram within the past two years as a proportion of women who are age-eligible (i.e. aged 40-75).

This data is useful for comparing one region to another, but cannot be used to compare individual counties or differences across racial or ethnic groups. This data was not age-adjusted due to the limited availability of age-specific data. There are limitations in drawing comparisons from non-age adjusted data. However, in comparing regions, this data demonstrates that both the Southern Oregon and Mid-Willamette regions have consistently high rates in all three categories (incidence, death and late-stage diagnosis), which are noted to be above the service area overall averages for these same three categories. While screening rates were weighted in the data provided by Komen Headquarters, when reconfigured these same weightings were not applied. Through calculations made by the Affiliate, it would appear that the percentage of women being screened is lower than the service area average in both of the Southern and Mid-Willamette regions, with the screening rates in the Southern Oregon region noted to be the lowest among all regions.

Table 2.8. 2006-2010 Breast Cancer Incidence, Death and Late-stage Diagnosis Data

Region	Female Population (Annual Average)	Incidence		Death		Late-stage		Screening %	Priority Counties
		# of New Cases (Annual Average)	Rate/ 100,000	# of Deaths (Annual Average)	Rate/ 100,000	# of New Cases (Annual Average)	Rate/ 100,000		
Affiliate Service Area	2,166,085	3258	150	576	27	1079	50	75.5	
Eastern Oregon	38,831	58	149	4	10	19	49	77.4	Union(Ht)
Southern Oregon	242,777	427	176	82	34	138	57	68.9	Curry(Ht)
NW Metro	1,118,037	1642	147	272	24	537	48	78.4	Tillamook (Ht)
Central Oregon	143,849	212	147	36	25	63	44	78.8	Crook(Ht),Klamath (Ht)
Gorge	56,243	75	133	12	21	22	39	70.4	
Mid-Willamette	299,765	474	158	85	28	161	54	74.1	Linn(H)
SW Washington	266,583	366	137	66	25	125	47	81.9	Cowlitz (Ht)

Ht = Highest priority H = High Priority

The data report provided by Komen Headquarters identified data for the incidence, death and late-stage diagnosis based on ethnicity and race. These data were presented as age-adjusted rates per 100,000. However, the Affiliate was interested in obtaining data on late-stage proportion, as well. Therefore, additional data were obtained from both the Oregon and Washington Cancer Registries (2006-2010); these data provide the proportion of cases diagnosed in late-stages for ethnic and racial groups within the service area. Data in Tables 2.9 and 2.10 demonstrate that compared to Whites, women of color have higher percentages of late-stage diagnoses, with Black/African-American and Hispanic/Latina women, hereinafter referred to as Latinas, having the highest overall proportions.

Table 2.9. Stage at Diagnosis by Race for Breast Cancer, Oregon 2006-2010

Stage of diagnosis	All races		White		Black/African-American		AI/AN CHSDA		API		Hispanic	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
All Ages												
Regional	4112	22.9	3827	22.8	59	34.1	44	25.7	98	24.7	169	32.2
Distant	651	3.6	605	3.6	14	8.1	11	6.4	15	3.8	17	3.2
Late-stage total	4763	26.5	4432	26.4	73	42.2	55	32.2	113	28.5	186	35.4
All Cases	17976		16783		173		171		397		525	

Table 2.10. Stage at Diagnosis by Race for Breast Cancer, Washington 2006-2010

Stage of diagnosis	All races		White		Black/African-American		AI/AN CHSDA		API		Hispanic	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
All Ages												
Regional	6920	22.9	6164	22.7	181	26.1	124	32.4	345	21.6	229	29.6
Distant	1073	3.6	954	3.5	42	6.1	14	3.7	58	3.6	36	4.7
Late-stage total	7993	26.5	7118	26.3	223	32.2	138	36.0	403	25.3	265	34.2
All Cases	30218		27096		693		383		1595		774	

Table 2.11 provides detail for Latinas within the three, targeted counties for women of color. The 131 cases are derived from those identified as regional and distant at the time of diagnosis. Late-stage diagnosis occurs in 36 percent of cases across the service area. Of these late-stage cases, 58.7 percent occur within the three counties of Clackamas, Multnomah, and Washington.

Table 2.11. Breast cancer Incidence among Hispanic/Latina Women by Stage and County, Oregon 2006 - 2010 combined - OR and SW Washington Service Area

	Hispanic/Latina cases	Insitu	Local	Regional	Distant	Un-staged	Total	
	% of cases by County	Count	Count	Count	Count	Count	Count	% of Regional & Distant
Clackamas	13.7%	8	23	11	4	0	46	32.6%
Multnomah	23.8%	11	40	23	4	2	80	33.8%
Washington	25.7%	14	36	33	2	1	86	40.7%
OR Cases - All		59	152	111	10	3	335	121 /335 = 36.1%
WA Cases - All		0	26	10	0	0	36	10/36 = 27.8%
Total cases - OR/WA		**59**	**178**	**121**	**10**	**3**	**371**	
Totals SW WA and OR - Late Stage only				121	10			**131**
Late Stage diagnoses in all counties of Service Area compared to Service Area total incidence								**131/371 = 35.3%**
Late Stage diagnoses in Clackamas, Washington, and Multnomah Counties compared to Service Area late-stage diagnoses				67	10		77	**77/131 = 58.7%**

*Using NHIA derived ethnicity

In considering the rural nature of the Affiliate service area it is important to understand the influence of geographic distance that women must travel on access to screening and treatment services. The Drive Times to Mammography Sites map (Figure 2.2) was developed through a 2009 study from Oregon Health & Sciences University of Mammography sites and represents services provided within each county. While originally developed in 2009, there have been no major changes to the delivery of services in the more rural areas of the Affiliate service area. The map demonstrates that for most counties within the service area, women need to drive 30-60 minutes or more to access the nearest screening location, with the exception of the more urban areas along the Interstate-5 (I-5) corridor, from mid-valley, north.

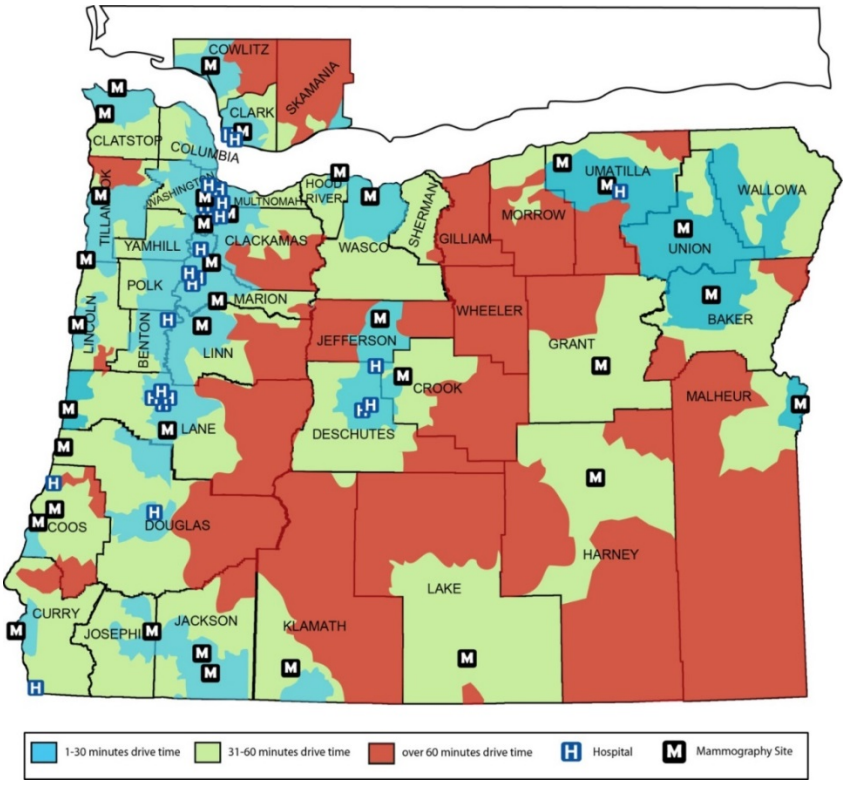


Figure 2.2. Drive Times to Mammography Sites

Socioeconomic advantage is a major factor in determining the health status of women. Low-income women are less likely to have regular screening or access to quality healthcare. In the Affiliate service area, one third of women aged 40 to 64 years are below 250 percent of the federal poverty level (FPL). The Southern Oregon and Mid-Willamette regions are both above the service area average. (See Table 2.12.) (Source: US Census Bureau – American Community Survey (ACS) for 2007-2011.)

Table 2.12. Poverty Level among Women Aged 40 to 64 years

Region	Income Below 100% Poverty	Income Below 250% Poverty
Komen Oregon and SW Washington Affiliate	14.5	33.9
Eastern Oregon	18.8	42.5
Southern Oregon	16.2	43.0
NW Metro	13.3	32.8
Central Oregon	17.2	41.7
Gorge	15.3	39.2
Mid-Willamette	17.6	36.2
SW Washington	13.4	32.9

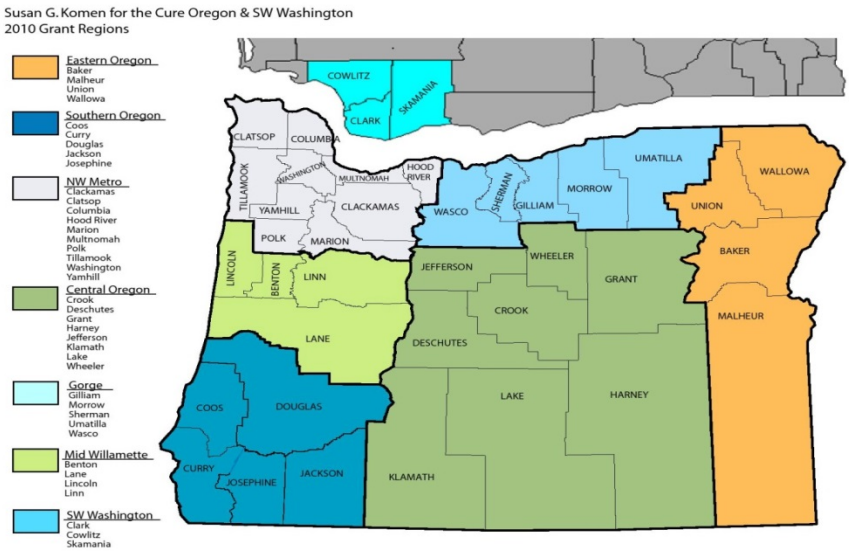
Selection of Target Communities

The Affiliate has selected the following target communities, which represent six (6) counties within the Affiliate service area. These are:

- Linn county within the Mid-Willamette region, due to higher than state average death and late-stage diagnoses rates;
- Curry county within the Southern Oregon region, due to higher than state average death rate and late-stage diagnoses rates;
- Cowlitz county within the SW Washington region, due to higher than state average death rate and late-stage diagnoses rates;
- The three counties of Clackamas, Multnomah and Washington in the NW Metro region, due to the high percentage of late-stage diagnoses among women of color, and relatively high concentration of women of color in these counties.

Komen Oregon and SW Washington serves 39 counties, the 36 counties of Oregon, and three counties of SW Washington. The counties vary in population and service levels from very rural small counties to the more urban Metropolitan areas. In order to address this diversity and concentrate efforts and resources to increase efficiency, the Affiliate grouped these 39 counties into seven geographic regions that are serviced through a central office located in Portland, Oregon. These regions are: NW Metro (ten counties), Mid-Willamette (four counties), Southern Oregon (five counties), Eastern Oregon (four counties), the Gorge (five counties), Central Oregon (eight counties), and SW Washington (three counties).

Table 2.13. Susan G. Komen Oregon and SW Washington Service Area



The data report provided by Komen Headquarters identified Curry county as the highest priority within the Southern Oregon region; and, Linn county as high priority within the Mid-Willamette

region. These two counties are located within regions that are largely rural and have been identified as being unable to achieve the expected Healthy People 2020 targets for either reduction in death or late-stage diagnosis rates within 13 years. Komen Headquarters also identified Crook, Klamath, Tillamook and Union counties as highest or high priority counties. However, when further data, including from the state cancer registry, were considered, the Affiliate determined that these four counties would be a lower priority than the six target communities that were chosen.

The Affiliate has a strong partnership with the Breast and Cervical Cancer Programs (BCCPs) in both Oregon and Washington. Partnership with and access to BCCP screening and treatment services, coupled with the development of strategic alliances with health care providers, health care systems, and Coordinated Care Organizations will be leveraged to address disparities in targeted counties across the Affiliate service area.

All counties within the service area have been impacted by the economic downturn. Oregon is considered to have the largest non-taxable federal land area in the United States. Within Oregon, 33 of the 36 counties receive Payments in Lieu of Taxes (PILT) from the federal government. In 2013, this amounted to $15.5 million. Due to the sequestration order of the current federal administration in 2013, the PILT payments were cancelled for all states starting in fiscal year 2015, which will have a detrimental impact on accessing services in Oregon.

Curry and Linn counties within the Southern Oregon and Mid-Willamette regions were particularly affected by the economic downturn and experienced higher levels of unemployment and reduced taxable income, as did most counties within the state. Counties across the state have been required to reduce public spending to overcome the effect of this tax reduction. With the expected elimination of PILT payments, it is anticipated that available funds for public services will be additionally reduced. These reductions will lead to additional challenges in the availability of personal and public resources, which directly contributes to a person's ability to access health care. Women in Curry County have a particularly difficult challenge in accessing breast cancer screening and treatment services, with available services a two to three hour drive from one's home. Socioeconomic conditions are a major factor in determining the health status of women, and those of low income are less likely to have regular screening or access to quality healthcare.

Women of color tend to be affected by the dual impact of socioeconomic conditions and psychosocial barriers of accessing services. Hispanic/Latina and Black/African-American women are less likely to develop breast cancer in comparison to Caucasian women. However, due to potential disparities in the delivery of and access to health care services they are more likely to present with a late-stage diagnosis, and may have higher death rates as a result. Language barriers are another important contributing factor as to why women of color may delay accessing screening services. These language barriers may be coupled with cultural differences and a potential distrust or lack of understanding of the general health care system, which often are seen as additional contributors limiting access to available services for screening and treatment.

A more complete understanding of the potential issues of accessing care and the available community resources will be determined through a thorough health systems analysis. This component will include looking at breast health resources and gaps in care. These activities will focus on the targeted communities of Clackamas, Curry, Linn, Multnomah, and Washington counties in Oregon, and Cowlitz County in SW Washington.

Health Systems Analysis Data Sources

The target area for the health systems analysis focused on six counties within the Affiliate service area. These counties are: Linn county within the Mid-Willamette region, due to higher than state average death and late-stage diagnoses rates; Curry county within the Southern Oregon region, due to higher than state average death and late-stage diagnoses rates; Cowlitz county within the SW Washington region, due to higher than state average death and late-stage diagnoses rates; and, the three counties of Clackamas, Multnomah and Washington in the NW Metro region, due to the high percentage of late-stage diagnoses among women of color, and in that these counties demonstrate the highest concentration of women of color in the service area.
The Community Profile Task Force researched the locations of breast health services and potential barriers to accessing those services. The research included listing all of the hospitals, mammography sites, contracted breast and cervical screening enrolling providers, support groups, Federally Qualified Health Centers (FQHCS), hospice and palliative care services, and Affiliate grantees on a spreadsheet. Task Force members also conducted key informant interviews with clinics and service providers serving women at risk for late-stage diagnosis.

The access to services for education, screening, treatment and support are excellent along the Interstate 5 (I-5) corridor and in the Portland Metropolitan area, which encompasses the three counties of Clackamas, Multnomah and Washington counties. Along the I-5 corridor there are major cities with excellent health systems, up-to-date medical technology and easy driving distances. However, once outside of the I-5 corridor, into the more rural counties of Curry and Linn Counties in Oregon, and Cowlitz County in Washington, women must drive longer distances to access fewer providers. On the east side of the I-5 corridor, there are no mammography machines once one travels beyond the community of Lebanon, Oregon. On the west side, there are facilities on the central coast, but no services on the southern coast. To access services, women living on the coast are required to travel low mountain passes on winding roads to access services. While the urban areas have nearly all elements of the continuum of care within reasonable distance, rural areas are missing between one to all four of the required elements of the continuum, such as radiation treatment or support groups for survivors.

Data were collected from a variety of sources, which included the U.S. Food and Drug Administration Mammography Facility Database for mammography centers within the target communities; the national Medicare website and the Oregon/Washington Hospice Association websites provided information on all hospital and hospice facilities; while the Oregon and Washington Public Health websites and the National Association of County and City Health Officials website provided contact information for county health departments and available resources. The U.S. Department of Health and Human Services Health Resources and Service Administration website listed Federally Qualified Health Centers (FQHCs) and FQHC look-a-likes. The National Association of Free and Charitable Clinics website provided listings of free health care organizations for economically disadvantaged populations within the target areas. Lastly, the websites for the American College of Surgeons Commission on Cancer, the

American College of Radiology Centers of Excellence, the American College of Surgeons National Accreditation Program for Breast Cancers, and the National Cancer Institute Designation Cancer Centers, indicated designations, certifications and accreditations of providers within the target communities.

The data were analyzed by considering each of the target communities, the population within each county, and then the availability and scope of providers and services within the immediate geographic area. In addition, the data were analyzed to consider the distances that individuals would need to travel to access necessary services that were not immediately available within the target community.

Health Systems Overview

Continuum of Care

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

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

If a screening exam resulted in abnormal results, diagnostic tests would be needed, possibly several, to determine if the abnormal finding is in fact breast cancer. These tests might include a diagnostic mammogram, breast ultrasound or biopsy. If the tests were negative (or benign) and breast cancer was not found, she would go into the follow-up loop, and return for screening at the recommended interval. The recommended intervals may range from three to six months for some women to twelve months for most women. Education plays a role in communicating the importance of proactively getting test results, keeping follow-up appointments and understanding what it all means. Education can empower a woman and help manage anxiety and fear. If breast cancer is diagnosed, she would proceed to treatment. Education can cover such topics as treatment options, how a pathology reports determines the best options for treatment, understanding side effects and how to manage them, and helping to formulate questions a woman may have for her providers.

For some breast cancer patients, treatment may last a few months and for others, it may last years. While the CoC model shows that follow up and survivorship come after treatment ends, they actually may occur at the same time. Follow up and survivorship may include things like navigating insurance issues, locating financial assistance, symptom management, such as pain, fatigue, sexual issues, bone health, etc. Education may address topics such as making healthy

lifestyle choices, long-term effects of treatment, managing side effects, the importance of follow-up appointments and communication with their providers. Most women will return to screening at a recommended interval after treatment ends, or for some, during treatment (such as those taking long term hormone therapy).

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

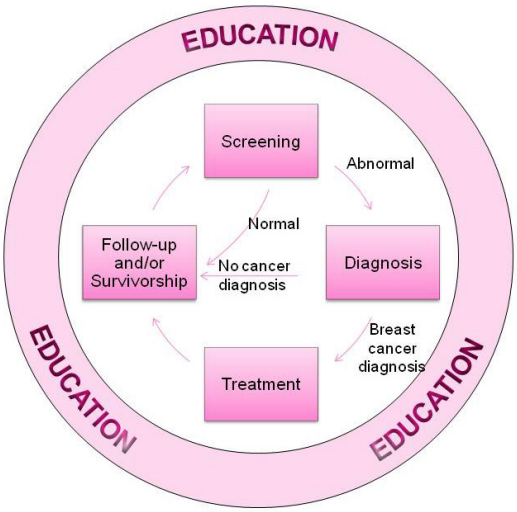


Figure 3.1. Breast Cancer Continuum of Care (CoC)

The Continuum of Care (CoC) is the foundation for the structure of Affiliate programs. The elements of the CoC are focused on the key outcomes of increasing screening rates, and decreasing late-stage diagnosis and death rates. When women are not educated about the value of early detection through mammography screening, then they will not seek the necessary services. If the screening rate is low, then there is the likelihood for a higher rate of increased late-stage diagnosis and death.

<u>Strengths and Weaknesses for each Target Community</u>:

Target Community: Curry County, Oregon
Curry County is the most southern and western county within the state of Oregon. There is a single hospital serving Curry County, which is located in the County seat of Gold Beach, Oregon. Curry Health District's service area covers 10 zip codes and an estimated population of 22,000, of which 30 percent fall between the ages of 45 to 64 (US Census, 2010). Curry County

has a Community Health/Public Health and Human Services Department that is a nonprofit community-based organization. It is involved in facilitating women and reproductive health needs and works in coordination with the Breast & Cervical Cancer Program (BCCP).

Basic screening services and inpatient care services are available through Curry General Hospital. However, more advanced treatment services are only accessible outside of the county more than a 60-minute drive away. The Affiliate Treatment Access Program administered through 211Info, a phone helpline, connects individuals to resources for social and health services. 211Info facilitates access to funds for travel, food and lodging for individuals needing financial support to complete their treatment plan. Curry County has no Federally-Qualified Health Centers or Free-Clinics within its geographic area. Primary care services are provided through independent practitioners within the county and through a nonprofit health entity established with the elimination of the public health department. However, there are a limited number of primary care providers with a greater majority of the primary care services being provided through nurse practitioner independent practices.

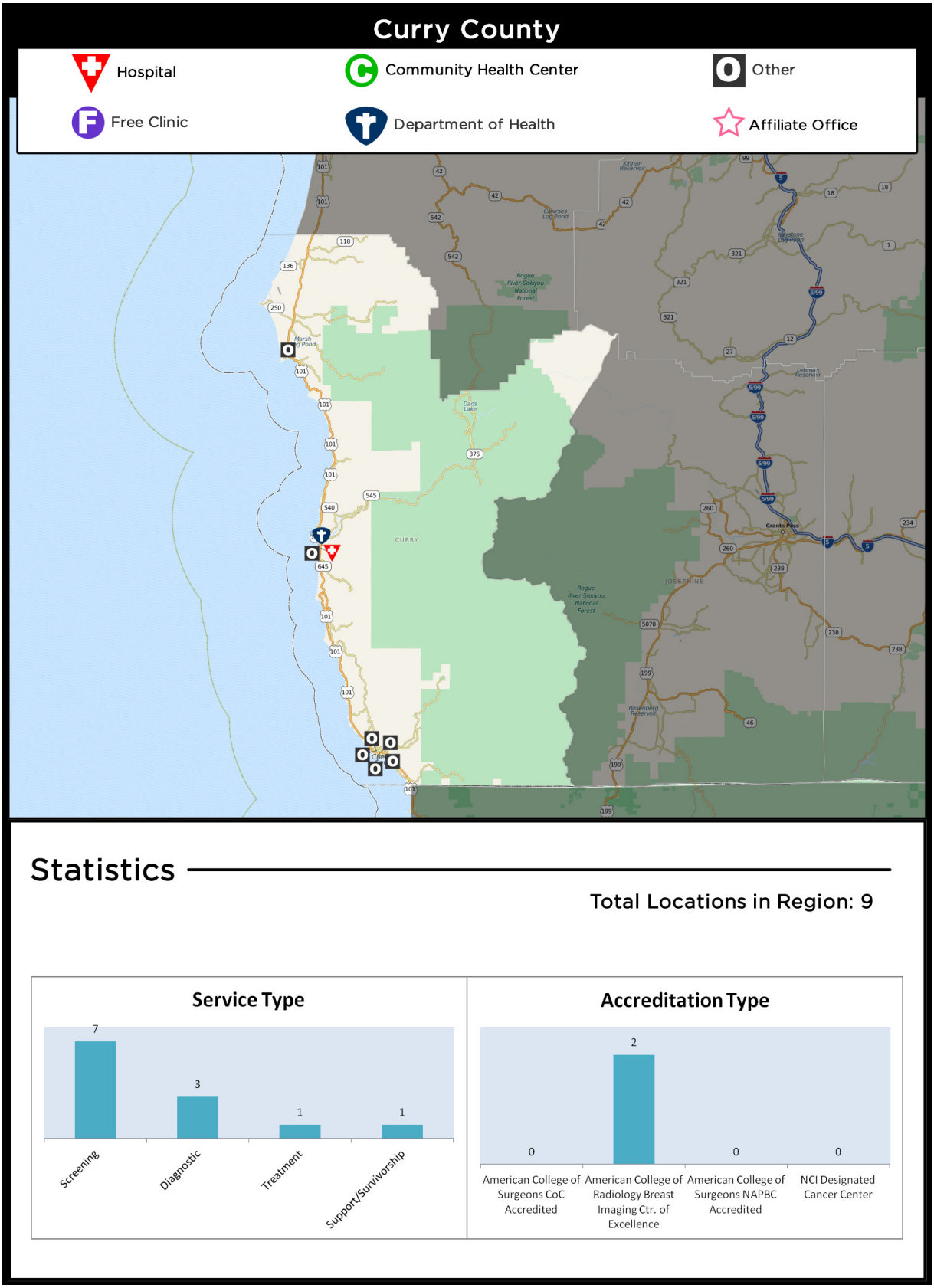


Figure 3.2. Breast Cancer Services Available in Curry County

Target Community: Linn County, Oregon

Linn County sits in the middle of the Willamette Valley within the state of Oregon. According to the US Census, the population was 117,000, of which 24 percent were between the ages of 45 to 64 years of age (2010). While the Interstate-5 (I-5) corridor cuts through Linn County it runs along its Western border, leaving much of the county more rural and remote with no easy access to health care services without traveling at least 30-60 miles. The Affiliate Treatment Access Program administered through 211Info facilitates access to funds for travel, food and lodging for individuals needing financial support to complete their treatment plan. There is one major health system that is represented in Linn County, with two smaller sized hospitals serving the communities of Albany and Lebanon. Both of these facilities provide basic services. Its parent organization, Samaritan Health System is located in the city of Corvallis in Benton County, a county adjacent to Linn County. Samaritan Health System provides diagnostic and treatment services to Linn county residents. The Linn County Department of Health Services provides direct medical services, which includes basic clinical breast examinations as a component of female physical examinations.

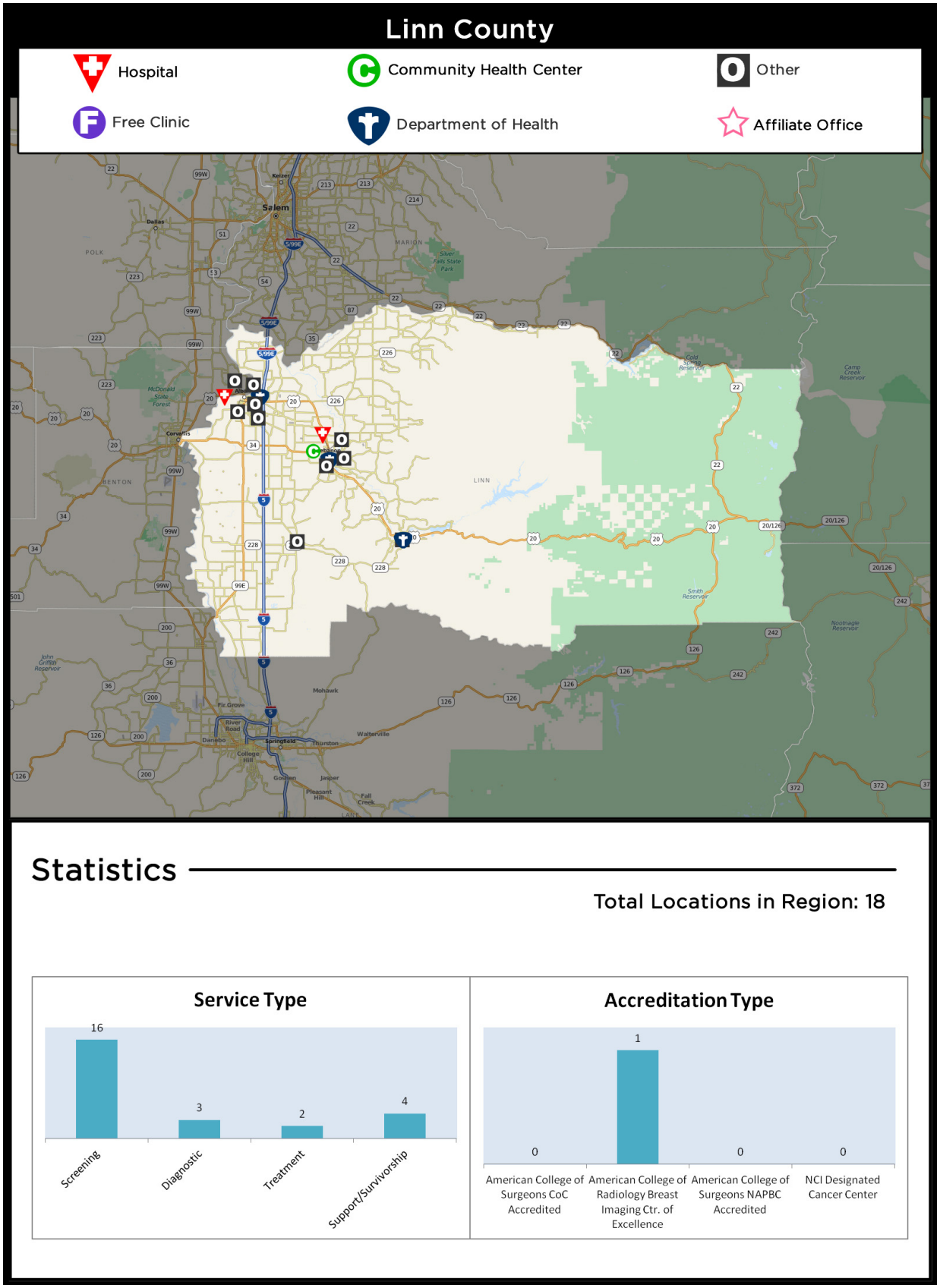


Figure 3.3. Breast Cancer Services Available in Linn County

Target Community: Cowlitz County, Washington

Cowlitz County is located in the State of Washington with a population of just over 102,000 with 24 percent falling within the 45 to 64 age group (US Census, 2010). A portion of the county sits alongside of the Columbia River and has a strong timber and fishing industry that is primarily seasonal. The remainder of the county is rural and nestled against the Cascade Mountains with no easy access to health care services without traveling at least 30-60 miles. The Affiliate Treatment Access Program administered through 211Info facilitates access to funds for travel, food and lodging for individuals needing financial support to complete their treatment plan. PeaceHealth is the primary health care system within the county and has a hospital facility located in Longview. Kaiser Permanente has a large clinic system in the community, with the closest Kaiser-hospital based services located within the local Portland Metropolitan communities. The Cowlitz County Health and Human Services Departments are co-located in Longview, and provide a wide variety of public health referral and direct services to residents of the community.

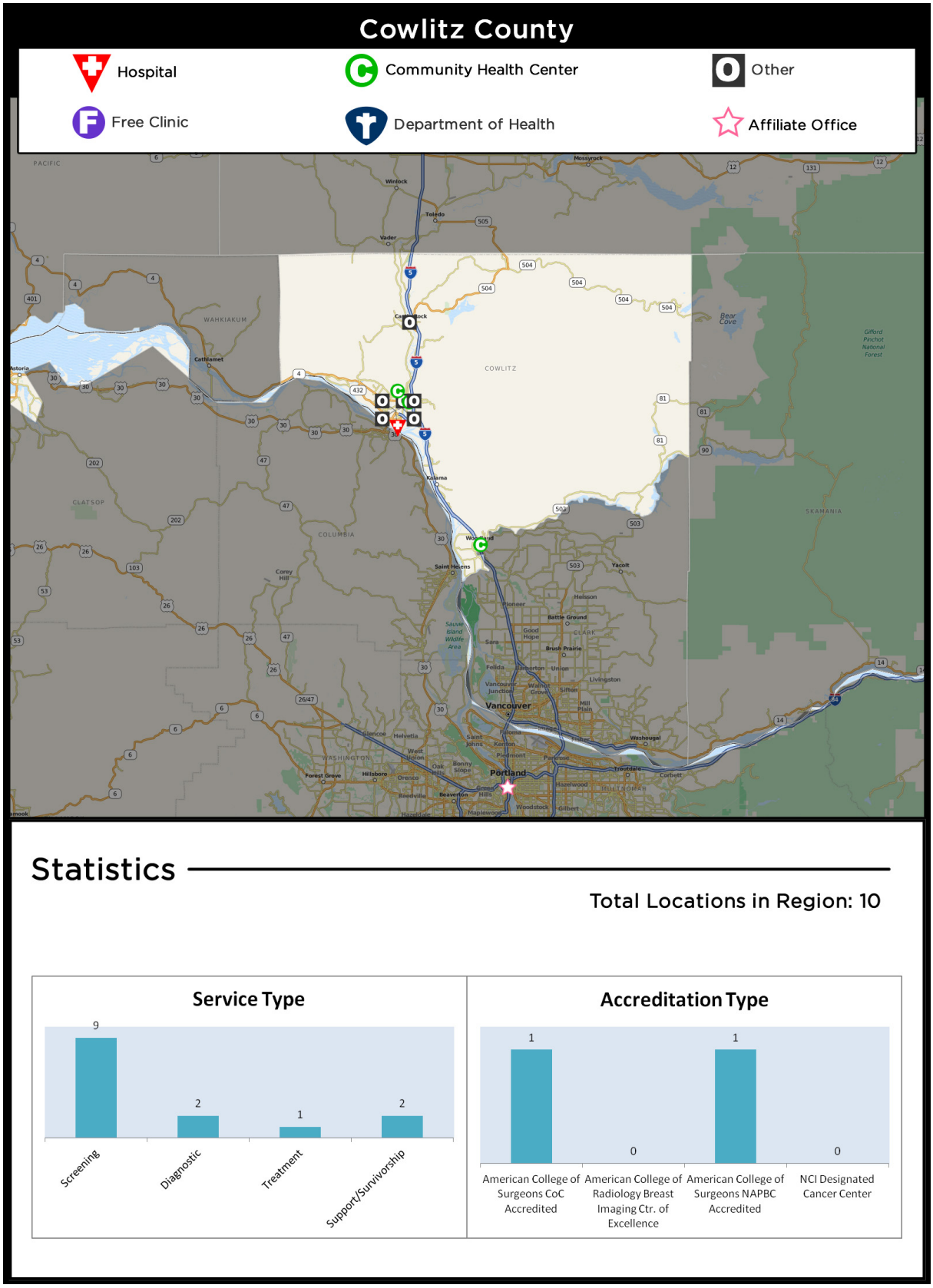


Figure 3.4. Breast Cancer Services Available in Cowlitz County

Target Community: Women of Color, Tri-County area of Clackamas, Multnomah and Washington Counties, Oregon

In the Affiliate Service area, the three counties of Clackamas, Multnomah and Washington have a population that totals nearly 1.7 million people and have the highest population density in the state. Within these counties, Latinos account for the largest percentage of non-Caucasian persons totaling 22 percent of the total population, with Black/African-American persons accounting for 7.5 percent of the population primarily centered in Multnomah County. This geographic area is both urban and rural, and has the largest availability of health care services in the state with four large and prominent health systems providing the complete range of breast health and breast cancer treatment services. While largely urban, the three counties comprise remote rural areas that extend into the Columbia River Gorge and Willamette Valley regions where women are required to travel between 30-60 miles to access appropriate treatment. The Affiliate Treatment Access Program administered through 211Info facilitates access to funds for travel, food and lodging for individuals needing financial support to complete their treatment plan. County health departments within this target community provide direct care access and there are numerous Federally Qualified Health Centers and Free-Clinics that can be accessed for basic health screening services.

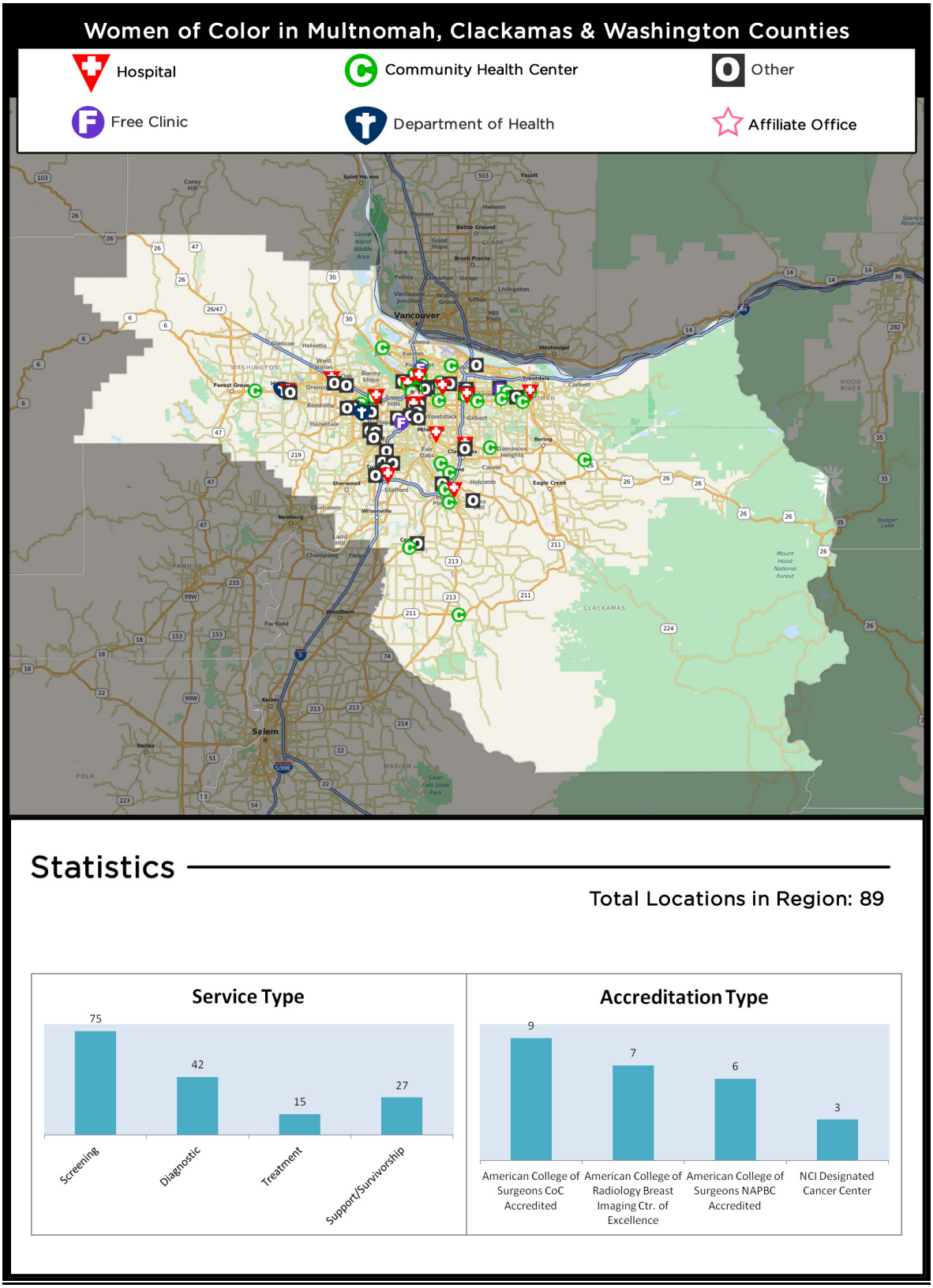


Figure 3.5. Breast Cancer Services Available in Clackamas, Multnomah and Washington Counties

Key Mission Related Partnerships – Now and in The Future:
The Affiliate, over the past two years, has worked to develop strong strategic partnerships with health system leaders throughout the state and specifically within the target communities. In addition, the Affiliate has a very strong working relationship with the Oregon Breast and Cervical Cancer Program (OR-BCCP) and the Washington Breast, Cervical and Colon Health Program (WA-BCCHP). These relationships allow the Affiliate to leverage funding for screening services and to benefit from partnerships with enrolling providers within the target communities.

Building on these existing partnerships, the Affiliate has identified additional relationships that, if strengthened, can further raise the profile of breast health in the state. One is with the Conference of Local Health Officials and a second is with the Association of Oregon Counties. These relationships will focus on aligning the Affiliate with local county health departments and providers and establishing greater awareness of breast health opportunities based on the county's specific breast cancer burden. Additionally, the Affiliate is building a strategic relationship with the Oregon Health Leadership Council, which brings together Chief Executive Officers from the 31 health systems and health plans throughout the state of Oregon. The goal of this partnership is to facilitate a broad-based approach to sustained transformational growth in the area of breast cancer awareness and intervention with health system and health plan strategic partners.

Public Policy Overview

National Breast and Cervical Cancer Early Detection Program (NBCCEDP)

The federal Breast and Cervical Cancer Prevention and Treatment Act of 2000 allows states to provide presumptive Medicaid eligibility to women diagnosed with breast or cervical cancer and, as a result, access to federally-funded life-saving medical treatment.

Oregon Breast and Cervical Cancer Program
The Oregon Breast and Cervical Cancer Program (OR-BCCP) of the Oregon Health Authority, provides free breast and cervical cancer testing to eligible adults in Oregon. OR-BCCP receives state funding as well as grants from the Centers for Disease Control and Prevention (CDC) and the Affiliate.

As required through funding awards that support OR-BCCP, at least 75 percent of initial mammograms must be provided to women ages 50 and above. As a result of limited funding, OR-BCCP prioritizes populations for services including:

- Women living in rural areas
- Women of color
- Women with disabilities
- Lesbian women

Table 3.1. Oregon BCCP Eligibility Requirements

Be an Oregon resident or intends to move to Oregon
Have a household income at or below 250 percent of Federal Poverty Level
Have no health insurance or health insurance does not cover eligible procedures

Based on data from the CDC (2012), Oregon's eligible population under the Breast and Cervical Cancer Program (BCCP) will decrease from 77,000 before the Affordable Care Act (ACA) to approximately 26,000 as a result of expanded Medicaid and the commercial insurance marketplace (Cover Oregon).

The OR-BCCP was one of five grantees awarded a six-month National Association of Chronic Disease Directors (NACDD) planning grant, that began in March 2013. This grant supported the planning of a multi-stakeholder effort to increase cancer screening among enrollees in Oregon's Medicaid program. The finalized plans will serve as guiding documents as national health reform expansions are implemented in Oregon. Since the end of the NACDD grant (September 2013), the OR-BCCP has strengthened key relationships with the state's Division of Medical Assistance Programs (DMAP) Medicaid office. The OR-BCCP is now in discussions with DMAP about several potential areas for collaboration, including population-based patient outreach, alignment in data and billing policies and cross referencing program lists of OR-BCCP and state Medicaid providers.

Most OR-BCCP providers will likely see a reduction in BCCP clients as more women become eligible for full coverage through expanded Medicaid and Cover Oregon programs. Current OR-BCCP providers, who are also providers with Oregon Health Plan (OHP) and part of a Coordinated Care Organization (CCO), may be able to continue serving former OR-BCCP clients who are now covered on Medicaid. However, non-Medicaid OR-BCCP providers will no longer be allowed to serve OR-BCCP clients once they transition to Medicaid. OR-BCCP is an integral partner with the Affiliate and plays a key role in supporting implementation of the Affiliate's Latina Initiative (Poder y Vida). The OR-BCCP/WISEWOMAN Program Coordinator serves on the Latina Advisory Council. In this partnership, OR-BCCP will use data obtained from the Initiative to identify, support and train specific OR-BCCP network providers who are most likely to serve the targeted Hispanic/Latina population.

In Oregon, Senate Bill 433 (2011) expanded treatment access for women diagnosed with breast and cervical cancer. Prior to January 1, 2012 women were only eligible for treatment through the Breast and Cervical Treatment Program (OR-BCCTP) if they were diagnosed while enrolled in the BCCP. Since January 2012, eligible women can now be enrolled in the treatment program, regardless of their enrollment status at the time of diagnosis. OR-BCCP is no longer the only "door" into the treatment program.

OR-BCCTP provides eligible women with medical assistance through the Oregon Health Plan (OHP) coverage for treatment for qualifying cancer diagnoses. Through this program a provider determines whether a woman is presumptively eligible for the program following a specified

eligibility checklist. Once presumptive eligibility has been established, treatment can begin immediately. Once full determination has been completed, the woman will initially be enrolled in the OHP for one year. Near the end of the first year the woman will receive a redetermination letter that asks for the provider to certify if she is still in need of treatment. This process repeats until the woman is no longer in need of treatment or is otherwise found not to be eligible for the program. Women requiring treatment may incur medical costs associated with their diagnoses prior to the date of their diagnoses. OHP coverage may start retroactively up to 90 days prior to the application, if the woman would have been eligible during this period.

Table 3.2. OR-BCCTP – Presumptive Eligibility Requirements

Be an Oregon resident or intend to live in Oregon
Have a household income at or below 250 percent of Federal Poverty Level
Be less than 65 years old
Be without creditable health insurance covering treatment, and
Have been diagnosed as needing treatment for breast or cervical cancer or specific precancerous conditions.
The woman may be asked to fill out forms for other medical programs. This is to see if she can obtain benefits from a different program. A woman who states she is a US citizen may be asked to provide verification of her citizenship.

Washington Breast, Cervical and Colon Health Program

The Washington Breast, Cervical and Colon Health Program (WA-BCCHP) through the Washington State Department of Health provides free breast, cervical, and colon cancer screenings to eligible people with low incomes in Washington State. The program funds six regional organizations known as Prime Contractors, who coordinate local health care providers to screen patients. Persons diagnosed with breast or cervical cancer, are enrolled onto the Medicaid Breast and Cervical Cancer Treatment Program (WA-MBCCTP).

WA-BCCHP receives state funding as well as grants from the Centers for Disease Control and Prevention (CDC) and the Affiliate. Federal and Affiliate funding is currently stable. However, Washington State funding is expected to be phased out and eliminated by July 2015.

Table 3.3. Key Points of the WA - BCCHP

WA-BCCHP continues to provide services to eligible clients in 2014 and beyond
Persons must demonstrate ineligibility for Washington state's Medicaid program, Apple Health to enroll
WA-BCCHP screen persons who are at or below 250 percent of the Federal Poverty Level (FPL)
WA-BCCHP screens women for breast cancer who are at or below 300 percent FPL
The Medicaid treatment program for persons diagnosed with breast and cervical cancer was reinstated as of April 1, 2014.

State Comprehensive Cancer Control Coalition (CCCC)

The States of Oregon and Washington both have Comprehensive Cancer Control Programs with associated Task Forces that oversee the objectives of the Comprehensive Cancer Control Plan. The Affiliate is represented on each of the two state task forces. The Affiliate served on the founding OR-CCCC Task Force in 2005 and co-chaired the Task Force for several years. The Affiliate was instrumental in facilitating quarterly network meetings held throughout Oregon and is in the process of working within the CCCC to develop and implement regularly scheduled webinars to advance breast health knowledge and information sharing. The Affiliate plans to continue to be actively involved with the CCCC program, as has been the case since the inception.

One of the Oregon CCCC Task Force objectives is to increase the percentage of women in Oregon who are screened at the appropriate age for breast cancer. By doing so, the hope is to reduce death from 22.2 to 20.6 (per 100,000/population) by 2020. In order to meet this objective, the OR-CCCC plans to collaborate among community organizations to reach a diverse population of women, explore ways to increase access to mammography screening for rural counties and increase access to breast cancer early detection, diagnosis, treatment and support throughout the continuum of care.

The most recent Washington State Cancer Control Plan was designed as a five-year plan from 2009 through 2013, with an updated plan currently in development. The goal of the Plan was to reduce breast cancer deaths and late-stage diagnosis by increasing the percentage of age-eligible women who receive a screening mammogram within a two year period. To do this, the WA-CCCC planned to engage in targeted outreach to Hispanic/Latina and other minority populations, to provide translated materials. The WA-CCCC also strategized to educate women under 40 on breast cancer risk factors, while continuing to support policy, environmental and system changes to increase access to screening, diagnostic and treatment services.

The Affiliate plans to continue its involvement with the Comprehensive Cancer Control Coalitions in both the states of Oregon and Washington as a means to represent the voice of breast cancer survivors and to assist in setting the focus for cancer prevention efforts. Through continued active development the Affiliate will help to ensure the issues of survivors are effectively addressed across the Affiliate Service area and specifically within the targeted communities.

Affordable Care Act

The Patient Protection and Affordable Care Act (ACA) is the most comprehensive national health reform legislation enacted in decades. Along with improving health care access and quality, the ACA's goal is to shift the focus of health care from treating disease to ending disease. The ACA requires health insurance plans to provide essential health benefits (such as breast, cervical, and colon cancer screenings) at no cost to participants. This means that many more people will have access to these screenings.

Table 3.4. Provisions of the Affordable Care Act

Provisions of the Affordable Care Act
1. Ensure that individuals are no longer denied coverage because of a pre-existing condition, such as breast cancer. (Effective beginning 2014 for most plans) 2. Prohibit the sudden discontinuation of coverage because a patient is diagnosed with breast cancer or another health condition. (Effective beginning 2014) 3. Prohibit the use of annual dollar limits on coverage and lifetime limits that leave patients without coverage. (Effective beginning 2014) 4. Require that all commercial health insurance plans cover mammograms for women starting at age 40 and cover BRCA1 and BRCA2 genetic testing and counseling for women who have a family history of breast and ovarian cancer. (Rollout for new plans began 2010; most group and individual plans by 2014) 5. Ensure that mammograms and other proven preventive services are administered at no cost to patients. (Effective as of 2011 in Medicare; effective in 2010 for new plans and 2014 for those newly eligible for Medicaid) 6. Create a national prevention and public health fund to expand and sustain national investment in prevention and public health programs, including health screenings. (Effective as of 2010) 7. Establish public education campaigns on young women's breast health. (Effective as of 2010)

In Oregon, nearly seven in ten of the non-elderly uninsured are eligible for financial aid either through the commercial marketplace or Medicaid (Oregon is a Medicaid expansion state). Nearly half (46 percent) of uninsured Oregonians are eligible for either Medicaid or the Children's Health Insurance Program (CHIP) as of 2014. Nearly a quarter (23 percent) of all uninsured people in Oregon is eligible for premium tax credits to assist in the purchase of insurance through the Marketplace. Another 21 percent of uninsured Oregonians have incomes too high to receive premium tax subsidies or have an affordable offer of coverage through their employers. The remaining 10 percent is comprised of undocumented immigrants who do not qualify for Medicaid and have no marketplace purchase option. This group will remain uninsured, though they will still have a need for health care services.

Medicaid Expansion and Estimated Number of Covered Persons

The State of Oregon has one of the most extensive state managed exchange programs named Cover Oregon. The Oregon exchange offers 102 individual and 72 small group medical plans; it also provides financial assistance for premiums and out of pocket payments. Under the ACA all plans are required to offer preventive and wellness services, and chronic disease management. Under the ACA, Oregon opted to increase the coverage under Medicaid from 100 percent of the Federal Poverty Level (FPL) to 138 percent FPL. Under this expansion, an additional 240,000 persons in the state of Oregon now qualify for Medicaid.

As with Oregon and the Oregon Health Authority, the state of Washington and the Washington State Department of Health plays an important role in disease prevention, and in helping build

healthier communities. Both state agencies work to assure the quality of the state health system, and provide data and information necessary for research and resource planning.

According to the US Department of Health and Human Services, within the state of Oregon there are 519,986 persons who are considered to be uninsured and eligible for coverage under the ACA (2013). Of these 483,637 may qualify for lower costs on coverage in the Marketplace exchange, including Medicaid. When considering the three-counties of SW Washington included within the Affiliate Service area (Clark, Cowlitz and Skamania) there are another 79,200 who are uninsured with 62,500 being eligible for coverage under the ACA.

Implications of the ACA on OR-BCCP and WA-BCCHP

The ACA aims to improve access to evidence-based preventive services without any co-payments or deductibles. The state of Oregon mandates the coverage of breast cancer screening for women aged 40 or older or by referral, with the state of Washington mandating coverage of breast cancer screening only if recommended by a clinical provider. Self-insured or self-funded plans do not have to follow state requirements for breast cancer screening, but are governed by the ACA, which requires coverage for breast cancer screening. However, any self-insured plan that was in effect prior to the enactment of the ACA does not need to meet this requirement. Insured women who are diagnosed as high-risk (at least three percent chance of developing breast cancer over the next five years) are eligible to receive preventive medications with no out-of-pocket payment under the ACA.

The OR-BCCP and WA-BCCHP anticipate changes in their client population and provider networks as a result of the ACA. It is expected that BCCP providers will see a reduction in BCCP eligible women as they enroll in health care coverage through expanded Medicaid and market-place covered options. Based on the most recent analysis, the following changes in the composition of its program populations are expected:

- Increase in undocumented, non-US Citizen population
- Increase in Hispanic/Latina and Asian/Pacific Islander population
- Increase in clients with limited English proficiency and less education
- Increase in women who are harder to reach and out of contact with the health care system
- Clients who are less likely to be motivated by preventive health concerns

OR-BCCP eligibility criteria overlap significantly with new eligibility criteria of Medicaid and ACA plans. However, applicants who are undocumented non-citizens will not be eligible for Medicaid or premium/tax credit assistance through Cover Oregon and will remain OR-BCCP eligible.

The OR-BCCP is a grant program, and its funding is limited by federal and state appropriations and variable funding levels; the program has never had sufficient funds to serve all eligible women. Although an increase in the insured population is good news, current and anticipated need still far exceeds the capacity to serve all OR-BCCP-eligible women with available funding. In recent years, approximately 7,000 out of the 77,000 eligible women age 40 to 60 years (per 2010 American Community Survey estimate) in Oregon received screening services. For fiscal

year 2014, funding reductions and increased costs per OR-BCCP client reduced the number of women the program can serve to an estimated 5,400, including CDC, State General Funds and grant funding provided through the Affiliate. Faced with additional potential funding cuts next year, BCCP will only be able to serve a small fraction of the 26,000 women anticipated to have a need to access BCCP screening services.

Full implementation of the ACA in Washington also offers new insurance options for many WA-BCCHP clients. Clients with income levels at or below 138 percent of the Federal Poverty Level (FPL) could be eligible for Washington Apple Health. This income range accounted for 75 percent of the Washington State client base prior to ACA implementations. For those clients with income levels above 139 percent FPL may be eligible to buy a Qualified Health Plan with cost sharing and tax credit options. Approximately 25 percent of the pre-ACA implementation clients fall into this category. The WA-BCCHP continues to serve eligible clients with low income who don't qualify for Washington Apple Health or remain uninsured or underinsured. Clients are required to demonstrate ineligibility for Washington Apple Health to receive WA-BCCHP services.

Implications of ACA for Health Care Providers

Under the ACA, a greater number of low-income women will have access to insurance, and through this should have increased access to the screening services. In 2011-2012 in Oregon, an estimated 163,000 low-income women, ages 18-64 years old, were uninsured. Under the Medicaid expansion and Cover Oregon many of these women are anticipated to qualify for insurance. While there is increased coverage, this does not address a lack of available service providers or the potential for current service provider capacity to be insufficient to meet the increased demand. Under the ACA primary doctor reimbursement rates are to increase for an initial two-year window, as an incentive for providers to accept Marketplace patients. In 2013 Oregon passed SB440 to support primary care for Medicaid beneficiaries. The program provides loan repayment by the state for the primary care doctors serving the Medicaid population in underserved areas of the state. The program provides $35,000 per year for minimum of three years and up to five years for services provided in qualifying areas.

With the implementation of the ACA, it is estimated that approximately 18,225 people In Washington will need WA-BCCHP services for the 2015-2016 program year. This estimate includes undocumented and documented persons ineligible for Washington Apple Health. With anticipated funds from combined sources, it is estimated that the state of Washington will only be able to serve about 9,150 clients, which means potentially missing the diagnosis of 174 cancers (WA Department of Health and Human Services, 2014). Missed diagnosed clients will likely result in increased emergency room visits for cancer care and a higher percentage presenting at late stage of diagnosis.

Implications of ACA for the Affiliate

The ACA presents new opportunities for the Affiliate to develop transformational partnerships with Coordinated Care Organizations across the service area. Implementation of the ACA has the potential to provide improved access to comprehensive screening and treatment services for

many previously uninsured persons. Newly enrolled persons will have access to preventive services, such as mammography with no cost-sharing requirement. However, there remains uncertainty as to the full impact of implementation of the ACA and the potential numbers to be served, which will require continued tracking. Implementation of the ACA is creating a new phenomenon, whereby persons may be accessing health care services for the first time. This unfamiliarity with the health care system will require additional education and proper guidance on how to navigate the system to access available services. The Affiliate plans to collaborate with the Coordinated Care Organizations (CCOs) within the service area and to partner in developing approaches to improve education and understanding directed towards improved access to screening and treatment services.

Affiliate's Public Policy Activities

The Affiliate enjoys a strong partnership with elected officials and has celebrated numerous victories over the past few legislative sessions, including legislation associated with clinical breast examinations being covered by insurance and women being notified of the presence and risks of dense breast tissue. During the 2014 legislative session, the Affiliate played an integral role in ensuring for the first time in Oregon history that the State would allocate $1 million dollars to OR-BCCP screening and treatment services. These state funds were particularly important in the face of reductions in BCCP funding at the national level.
Examples of Affiliate Public Policy Efforts:

- The Affiliate actively participated in legislative activities during 2011 and 2013 sessions, which resulted in favorable results. SB362 (2013) requires the Oregon Health Authority to provide medical assistance to women for breast and cervical cancer screenings under Oregon Breast and Cervical Cancer Program. SB420 (2013) known as the dense breast tissue bill requires any facility that performs a mammogram to notify patients of dense tissue results and possible increased risk of breast cancer and to advise the patient to contact their health care provider regarding appropriateness of supplemental testing. SB433 (2011) expanded eligibility for medical assistance for low-income and uninsured women diagnosed with breast or cervical cancer.
- During the 2013 Legislative session, the Affiliate was a key proponent of efforts that resulted in the allocation of state of Oregon general funds to the BCCP program totaling nearly $1 million dollars. This was the first time in state history that this allocation was made, which moved it from one of only five states who had not provided state funding.
- The Affiliate has developed an ongoing communication approach with elected officials that involve eBlast communications, letters and personal meetings. These communications share with the elected officials the data for their respective areas and how they can assist in facilitating improved breast health outcomes in their communities.
- The Affiliate serves on the State Comprehensive Cancer Control Coalitions for both Oregon and Washington, as well as on the Task Forces for writing of the administrative rules governing the operations of the ORBCCP and Dense Tissue Bill.

Future Policy Activities for the Affiliate**:**
The Affiliate is developing an advocacy coalition for the next legislative session that will lobby for additional state funding for the Oregon Breast and Cervical Cancer Program. The target for this work is to obtain a sustained $2 million in OR-BCCP appropriation.

Other future public policy efforts include:

- Work in partnership with the Oregon Health Authority and other agencies to review, monitor and if necessary, assist with implementation of legislation and regulations with respect to breast health and cancer care services.
- Engagement of key state agencies in bi-directional strategic planning in advancing the Affiliate 's mission to increase breast cancer screening, decrease late-stage diagnosis, and decrease death related to breast cancer
- Schedule regular public reports and presentation to County Commissioners and City Councils to educate on the cancer burden and challenge within their respective communities and to share information as to the Affiliate 's on-going work and potential opportunities within their respective areas
- Enhance Affiliate advocacy and presence during the legislative session

Health Systems and Public Policy Analysis Findings

As identified in the Quantitative Analysis section, the target communities for the health systems analysis were the three counties of Curry and Linn, in Oregon; and, Cowlitz County in SW Washington; and the target community of women of color, specifically within the geographic areas of Clackamas, Multnomah and Washington Counties. The Community Profile Committee focused its efforts on researching and understanding the location of services and the potential barriers to accessing services within these specific communities. These communities were selected as the target areas due to high death rates and high late-stage diagnosis rates.

Recent changes to national and state health care policy (in Oregon and Washington) have resulted in a higher number of individuals who have comprehensive health care coverage. Nevertheless, there remain important gaps in coverage for some women. The primary conclusion is that those seeking services in the rural communities require greater information and education on how to access services, as well as the financial support to access services across the continuum of cancer care. Providers in rural areas need to know more about the Oregon and Washington Breast and Cervical Cancer Program (OR-BCCP and WA-BCCHP) systems and how to ensure effective access for patients within these rural target communities. Additional education, access and advocacy provided by the Affiliate will help improve the quality of breast health services.

Treatment access assistance that encourages women to obtain mammograms and to complete treatment if they are diagnosed with breast cancer is also a vast gap, particularly in the more rural areas where extended travel is required to access services. Due to the extended travel distances, the Affiliate partnered with 211Info in 2014 to provide treatment assistance to low-income women for both screening and treatment services. Prior to 2014, the Affiliate partnered

with the American Cancer Society (ACS) to provide transportation assistance to this same population of women. The Treatment Assistance Program provides cards for gas, food and lodging for women traveling to services.

The Affiliate, over the past two years, has worked to develop strong strategic partnerships with health system leaders throughout the state and specifically within the target communities. In addition, the Affiliate has a very strong working relationship with the OR-BCCP and the WA-BCCCHP. These relationships allow the Affiliate to leverage funding for screening services and to benefit from partnerships with enrolling providers within the target communities.

Building on these existing partnerships, the Affiliate has identified additional relationships that, if strengthened, can further raise the profile of breast health in the state. One is with the Conference of Local Health Officials and a second is with the Association of Oregon Counties. These relationships will focus on aligning the Affiliate with local county health departments and providers and establishing greater awareness of breast health opportunities based on the county's specific breast cancer burden. Additionally, the Affiliate is building a strategic relationship with the Oregon Health Leadership Council, which brings together Chief Executive Officers from the 31 health system and health plans throughout the state of Oregon. The goal of this partnership is to facilitate a broad-based approach to sustained transformational growth in the area of breast cancer awareness and intervention with health system and health plan strategic partners.

The Affiliate enjoys a strong partnership with elected officials and has celebrated numerous victories over the past few legislative sessions, including legislation associated with clinical breast examinations being covered by insurance and women being notified of the presence and risks of dense breast tissue. During the 2014 legislative session, the Affiliate played an integral role in ensuring for the first time in Oregon history that the State would allocate $1 million dollars to OBCCP screening and treatment services. The Affiliate remains committed to the continuing strengthening of their public policy position within the communities they serve, working closely to develop statewide coalitions and working with elected and appointed officials to advance the agenda of the importance of breast health across the Affiliate Service Area.

Qualitative Data Sources and Methodology Overview

Methodology and Sampling

The purpose of this qualitative research is to gain insights from providers and survivors to explain some of the findings of the quantitative data and health systems analysis. The Community Profile Task Force sought information from three types of key informants: (1) Clinical providers, clinic administrators and program directors; (2) Community-based support service providers; and (3) Survivors and women from three groups: Black/African-American, American Indian/Alaskan Native, and Hispanic/Latina women. Qualitative data collection relied on three approaches: key informant interviews (conducted either by phone or in-person), focus groups, and surveys. In total, the Task Force conducted 30 in-depth key informant interviews, three focus groups, and surveys with eight responses received. Together this totaled input from 78 participants. The method used to gather information was influenced by the likelihood of obtaining valuable data. Key informant interviews were believed to be the most beneficial in gathering information and were used among providers within each target community. Recognizing limitations on willingness of individuals to participate and on staff time to coordinate, focus groups were conducted among patients and patient advocates in urban areas only. Use of a survey tool was attempted among providers, survivors, and community members with limited success. The tool was distributed two different times, using two different formats. However, there was limited response.

Selection of participants for key informant interviews was guided by the quantitative research findings. As quantitative data showed low screening rates and high rates of late-stage diagnosis among Black/African-American and Hispanic/Latina women, women in these groups were recruited for separate focus groups. The key informants were selected to achieve balance in distributions across geographic areas of interest, health care systems, and racial/ethnic groups. Key informants and focus group participants were selected by social networks currently available to the Affiliate and through Komen grantees working with special target populations. Women participated voluntarily. Participants in the focus groups were gifted with a small token. No financial incentives were paid to key informants or focus group participants.

Assessment questions were used in all modalities. These focused on access to care, potential barriers to receiving care or screening, knowledge of the health care system, resource and insurance availability, factors that could contribute to late-stage diagnosis, and the steps that the Affiliate could take to reduce the incidence of late-stage diagnosis. For survivor interviews, additional questions focused on personal challenges during treatment and in accessing services, availability of resources and support, barriers perceived or experienced based on culture, ethnicity or race; and, geographic influences related to screening and treatment access.

Participating clinical providers included nurse practitioners, nurse navigators, clinic administrators and program coordinators; health department officials; social workers; imaging technicians; and cancer registrars. Additionally, community-based support service providers were interviewed, which represented multiple culturally-specific organizations. Three focus groups were conducted with Black/African-American (two) and Hispanic/Latina (one) groups

with bi-lingual and bi-cultural representation. The Affiliate distributed electronic surveys to all women with recorded email addresses in their volunteer and donor database, within the target communities.

Volunteers (interns) and Affiliate staff conducted the interviews, surveys and the focus groups. The Community Profile Task Force helped to develop the survey, interview and focus group questions. Questions differed slightly depending on the type of key informant. Findings from each interview and focus group were summarized through a qualitative data analysis process. Thematic content analysis was used to review the data from each key informant group. A summary of highlights and key themes follows in the next section. While these interviews were extremely informative, there are limitations to the conclusions that can be drawn due to the selection process and sample size.

Ethics

Different methodologies were used to gather data for the Qualitative Data Assessment. Data were collected and utilized in a de-identified form to ensure the confidentiality of the respondents. For in-person and phone interviews, as well as focus groups, data were captured through contemporaneous notes that summarized the comments made, as it was not possible to capture these comments verbatim. Participation was entirely voluntary. Respondents had the ability to opt-out of any and all questions asked during the process.

Data collected for the Community Profile is maintained in a secure and encrypted data base only accessible by local Affiliate personnel. Hand-written notes are kept in a file cabinet until transcribed and are then discarded through confidential recycling. A qualitative data analysis and management tool was selected, which provided a standardized approach to both data collection and analysis.

Qualitative Data Overview

Data were analyzed according to recommendations from Komen Headquarters through the Community Profile Toolkit. Themes were identified from the Toolkit (Code Book) that focused on barriers to screening, diagnosis and treatment, which included: fear, knowledge deficit, physician and health system issues, mammography not being a priority, access to services, medical complications, and cultural barriers. From these themes, a qualitative data analysis program was used to compile the data.

Common themes were identified and summarized for each data collection method. Key challenges identified were a lack of available providers, services and resources, which caused women to travel long distances to access available care. This created a financial burden that deterred some women from getting screened. Some informants perceived women as being unwilling and/or reluctant to travel outside their geographic area to receive care, given the long distances to reach a treatment facility. Additionally, informants cited distrust between local providers and those coming in from the outside to provide assistance or offer support in

addressing local issues. This distrust was thought to limit collaborative efforts to raise awareness of the importance of breast cancer prevention.

The details of the assessment findings are listed in the next section. It is important to note that a key gap occurred in the representation of the individuals and providers who participated; that is, the data indicate that women are entering the system with late-stage diagnosis, but the Task Force was unable to find these women or the physicians treating them. Without further information or research, the Task Force is unable to determine why the late-stage diagnosis rates were high in some geographic regions. Because of low population counts, the Cancer Registry cannot reveal data on population segments smaller than a whole county. Further elucidation of factors that influence late-stage diagnosis is needed.

Qualitative Data Findings

Qualitative data is provided for each of the targeted geographic regions and communities. This includes Curry and Linn Counties in Oregon; Cowlitz County in SW Washington; and, the counties representing the highest percentage of women of color, these being Clackamas, Multnomah and Washington Counties.

Curry County, Oregon

Within Curry County there are a limited number of clinical providers. Key informant interviews were conducted with three providers, who represent the majority of those providing local health care services. Attempts made to interview other providers within the county went unanswered. In addition, two attempts were made to survey providers, survivors and female community members. No response from either attempt was received. No focus group was conducted in this target community due to its remote location, and the inability to locate willing focus group participants.

The main findings from the key informant interviews focused on barriers to accessing breast health care services and/or resources. The primary barrier identified was the lack of available providers, services and resources, which caused women to travel long distances to access available care. This created a financial burden that deterred some women from getting screened. Additionally, informants perceived some women as being unwilling and/or reluctant to travel outside their geographic area to receive care, given the long distances to reach a treatment facility. Some informants cited distrust between local providers and those coming in from the outside to provide assistance or offer support in addressing local issues. This distrust was thought to limit collaborative efforts to raise awareness of the importance of breast health and the need for annual screenings. The distrust of outside stakeholders may emphasize the need to establish trusting relationships before attempting to influence change within this target community.

Linn County, Oregon

Key informant interviews were conducted with ten community members and health system representatives, who represent a cross-section of those providing breast health services from

both a direct or supportive role. This included representatives from the OR-BCCP-contracted provider, Cancer Registry, health system, and general community members. In addition to key informant interviews, surveys were conducted of general community members (women) with a small return realized.

A main finding from the key informant interviews was the concern that providers were giving inconsistent recommendations to women about when to begin screening and how often to screen. This inconsistency was thought to cause uncertainty and concern among women. Informants identified several systems barriers, including a lack of breast screening facilities on the east side of the county and inadequate or non-extant public transportation services among all women. Latinas, in particular, were thought to experience low awareness of the need for screening and of how to access available breast health care resources/services. There were thought to be few local resources or efforts to address this awareness gap. The survey results, while limited in number, provided interesting insight. An important finding is that fear of the pain associated with a mammogram was a key deterrent to obtaining a mammogram.

Cowlitz County, SW Washington

There are a number of clinics for general health services in Cowlitz County. However, few offer screening services for breast cancer. Three facilities offer breast cancer screening and one also offers breast cancer treatment. While there are a number of providers within this geographic area, attempts to reach them to request their participation in key informant interviews were unsuccessful. Of the fourteen (14) individuals at clinic locations that were contacted on multiple occasions, eleven (11) either refused to participate or never responded to the request. The three individuals willing to participate included a representative of the Washington BCCCHP, a provider's nurse navigator and the clinic manager. Attempts to interview primary care providers went unanswered. In addition, two attempts were made to survey providers, survivors and female community members. Unfortunately, no responses from either attempt were received. No focus group was conducted in this target community due to the remote location of the community, and the inability to locate willing focus group participants.

While the responses varied, the leading concern was the lack of available primary care providers and screening services. This was heightened with the increased enrollment of AppleCare (Washington State's Medicaid Health Plan), the resulting higher clinic volumes, and the loss of primary care physician availability. Additionally, many of these new AppleCare enrollees were thought to face obstacles related to understanding how to access and utilize available services and resources. A specific area of concern was the apparent lack of knowledge as to the importance of breast health screening and/or the perception that screening was not important in one's overall health.

Clackamas/Multnomah/Washington counties, Oregon

Key informant interviews and community-based focus groups were the primary approaches for gathering information from this target community. Key informant interviews were conducted with 14 providers and survivors and three community focus groups were conducted. Key informant interviews involved nurse navigators and social workers from the larger health systems and

cancer treatment programs, from the county health clinics within the Portland Metropolitan area; as well as interviews with culturally-specific organizations, and survivors.

A main finding of the key informant interviews was the lack of understanding of how to access available breast care services. Specifically, women were thought to lack understanding of how to access transportation and financial resources to obtain a mammogram. A second identified concern was cultural barriers, including distrust of the medical community specifically from the Black/African-American and American Indian/Alaskan Native populations; and language barriers, particularly for members of the Hispanic/Latina community. Additionally it was perceived that many providers lacked a good understanding of cultural values and beliefs of these women, which diminished trust and hindered patient-provider communication. Women identified the need for greater self-advocacy in clinical settings and open and trusting communication with providers. These factors were thought to be important to achieve heightened understanding of breast cancer prevention behaviors and increased participation in decisions about their care.

The three focus groups identified the following major themes: 1) lack of trust of the health care systems as perceived by women within these specific ethnic groups; 2) language barriers; 3) placing a higher priority on the needs of family members than on one's own needs; 4) lack of insurance to access services; 5) lack of accessible transportation, particularly among Latinas; and, 6) lack of a general understanding of the health system and how to navigate it. Women with no insurance noted difficulties in receiving health information, getting diagnosed, obtaining full or proper treatment, and generally reported experiencing a poorer quality of care. Some women with insurance faced difficulty paying for services not covered by their plan; in some cases this led to decisions to decline needed services.

Limitations

As noted previously, a major challenge was the limitation of available data being obtained through the use of surveys and focus groups, particularly in the two rural areas of Curry and Cowlitz Counties. Two attempts were made to survey providers, survivors and female community members. However, neither attempt resulted in responses being received. In addition, it was not possible to conduct focus groups within either of these same target communities due to its remote location and the inability to locate willing focus group participants. Due to these challenges it is important to note that the limitation of data collected through only key informant interviews, and the low response rate to surveys collected in Linn County, may limit the generalizability of the findings.

Conclusions

The primary conclusions of this report are consistent with the findings identified in previous Community Profile Reports. If someone is uninsured it is unlikely that she will receive high quality health care in a respectful, effective and timely manner. If a woman does not speak English or has different cultural beliefs from the White community, the quality of care will depend on the provider and will vary with the provider's cultural competence. Key informant interview and focus group respondents identified some important system and structural barriers; that is,

there is still a tremendous need for more screening availability and better access to treatment for women of all racial and ethnic groups. In some cases there were few facilities that offered screening or treatment services and in other cases high clinic volumes meant that access to available services was diminished. Moreover, access to transportation was cited as a concern in most geographic regions. Because of geographic challenges within the Affiliate service area, accessing services in more remote locations presents a considerable concern and improved treatment access assistance is a significant need. Personal barriers included low awareness of the need for screening services and how to access such services, cited for Latinas in particular, and fear of the pain associated with a mammogram, among women in general.

Breast Health and Breast Cancer Findings of the Target Communities

Quantitative Data Report Findings
Highest priority areas

Komen Oregon and SW Washington serves a total of 39 counties, the 36 counties of Oregon, and three counties of SW Washington. The counties vary in population and service levels from very rural small counties to more urban metropolitan areas. To address this diversity and direct efforts and resources to increase efficiency, the Affiliate grouped these 39 counties into seven geographic regions serviced through a central office located in Portland, Oregon. From this the Affiliate identified the following four target communities as being the highest priority areas due to having higher than state average late-stage diagnosis rates. These four target communities represent the following six (6) counties within the Affiliate service area:

- Linn county within the Mid-Willamette region;
- Curry county within the Southern Oregon region;
- Cowlitz county within the SW Washington region; and
- Women of color within the three counties of Clackamas, Multnomah and Washington in the NW Metro region.

After considering the quantitative data, the Community Profile Task force was able to narrow its focus to these four target communities. This analysis provided the Task Force with the opportunity to not only look at specific statistics of each geographic region, but to also conduct interviews with key informants and, where possible, focus groups with cohort representatives and those who serve them.

It is important to understand the influence of geographic distance that women must travel on access to screening and treatment services. In much of the Affiliate service area, women must drive 30-60 minutes or more to access the nearest screening location, with the exception of the more urban areas along the Interstate-5 (I-5) corridor, from mid-valley, north.

Socioeconomic condition is another major factor in determining the health status of women. Low-income women are less likely to have regular screening or access to quality health care. In the Affiliate service area, one third of women aged 40 to 64 years are below 250 percent of the Federal Poverty Level (FPL) with women in the Southern Oregon and Mid-Willamette regions being above the service area average.

All counties within the service area have been impacted by the economic downturn. Oregon is considered to have the largest non-taxable federal land area in the United States. Within Oregon, 33 of the 36 counties receive Payments in Lieu of Taxes (PILT) from the federal government. In 2013, PILT payments amounted to $15.5 million. Due to the sequestration order of the current federal administration in 2013, the PILT payments were cancelled for all states starting in fiscal year 2015, which will have a detrimental impact on accessing services in Oregon.

Curry and Linn counties within the Southern Oregon and Mid-Willamette regions were particularly affected by the economic downturn and experienced higher levels of unemployment and reduced taxable income, as did most counties within the state. Counties across the state have been required to reduce public spending to address the effect of this tax reduction. With the expected elimination of PILT payments, it is anticipated that available funds for public services will be further reduced. These reductions will lead to additional challenges in the availability of personal and public resources, which directly contributes to a person's ability to access health care. Women in Curry County have a particularly difficult challenge in accessing breast cancer screening and treatment services, with available services a two to three hour drive from one's home.

Women of color tend to be affected by the dual impact of socioeconomic and psychosocial barriers to accessing services. Hispanic/Latina and Black/African-American women are less likely to develop breast cancer in comparison to Caucasian women. However, due to disparities in the delivery of, and access to, health care services, they are more likely to present with a late-stage diagnosis, and may have higher death rates as a result. Language barriers are another important contributing factor as to why women of color may delay accessing screening services. These language barriers, coupled with cultural differences and a potential distrust or lack of understanding of the health care system are often seen as additional contributors limiting access to services for screening and treatment.

A more complete understanding of the potential issues of accessing care and available community resources was determined through a comprehensive health systems analysis. This analysis looked at breast health resources and gaps in care. Activities focused on the targeted communities of Clackamas, Curry, Linn, Multnomah, and Washington counties in Oregon, and Cowlitz County in SW Washington.

Health Systems and Public Policy Analysis Findings

As identified in the Quantitative Analysis section, the target communities for the health systems analysis were the three counties of Curry and Linn, in Oregon; and, Cowlitz County in SW Washington; and the target community of women of color, specifically within the geographic areas of Clackamas, Multnomah and Washington Counties. The Community Profile Task Force focused its efforts on researching and understanding the location of services and the potential barriers to accessing services within these specific communities. These communities were selected as the target areas due to high death rates and high late-stage diagnosis rates.

Recent changes to national and state health care policy (in Oregon and Washington) have resulted in a higher number of individuals who have comprehensive health care coverage. Nevertheless, important gaps remain in coverage for some women. The primary conclusion is that those seeking services in the rural communities require greater information and education on how to access services, as well as the financial support to access services across the continuum of cancer care. Providers in rural areas need to know more about the Oregon and Washington Breast and Cervical Cancer Program (OR-BCCP and WA-BCCHP) systems and how to ensure effective access for patients within these rural target communities. Additional

education, access and advocacy provided by the Affiliate will help improve the quality of breast health services.

Screening and treatment access assistance that encourages women to obtain mammograms and to complete treatment if they are diagnosed with breast cancer is also a vast gap, particularly in the more rural areas where extended travel is required to access services. Due to the extended travel distances, the Affiliate partnered with 211Info in 2014 to provide transportation assistance to low-income women for both screening and treatment services. Prior to 2014, the Affiliate partnered with the American Cancer Society (ACS) to provide transportation assistance to this same population of women. The Screening and Treatment Assistance Program provides cards for gas, food and lodging for women traveling to services.

Over the past two years, the Affiliate has worked to develop strong strategic partnerships with health system leaders throughout the state and specifically within the target communities. In addition, the Affiliate has a very strong working relationship with the OR-BCCP and the WA-BCCHP. These relationships allow the Affiliate to leverage funding for screening services and to benefit from partnerships with enrolling providers within the target communities.

Building on these existing partnerships, the Affiliate has identified additional relationships that, if strengthened, can further raise the profile of breast health in the Affiliate service area. One is with the Conference of Local Health Officials and a second is with the Association of Oregon Counties. These relationships will focus on aligning the Affiliate with local county health departments and providers and establishing greater awareness of breast health opportunities based on the county's specific breast cancer burden. Additionally, the Affiliate is building a strategic relationship with the Oregon Health Leadership Council, which brings together Chief Executive Officers from the 31 health system and health plans throughout the state of Oregon. The goal of this partnership is to facilitate a broad-based approach to sustained transformational growth in the area of breast cancer awareness and intervention with health system and health plan strategic partners.

The Affiliate enjoys a strong partnership with elected officials and has celebrated numerous victories over the past few legislative sessions, including legislation associated with clinical breast examinations being covered by insurance and women being notified of the presence and risks of dense breast tissue. In the 2013 legislative session, the Affiliate played an integral role in securing $700,000 for the OR-BCCP – the first time state general revenue funds had been allocated to the program. During the 2014 legislative session, Komen worked to secure an additional $270,000, bringing Oregon's investment in OR-BCCP to $970,000. During the 2015 legislative session, Komen worked to successfully secure continued funding for the OR-BCCP, and participated as a strategic partner in a coalition to advance palliative care understanding and availability.

Partnership with OR-BCCP and WA-BCCHP screening and treatment access services, coupled with the development of strategic alliances with health care providers, health care systems, and Coordinated Care Organizations will be leveraged to address disparities in targeted counties across the Affiliate service area. The Affiliate remains committed to strengthening its public

policy position within the communities served, developing statewide coalitions and working with elected and appointed officials to advance the agenda of the importance of breast health across the Affiliate service area.

Qualitative Data Report Findings

The primary conclusions of the Qualitative Data report are consistent with the findings identified in previous Community Profile Reports. If someone is uninsured it is unlikely that she will receive high quality health care in a respectful, effective and timely manner. If a woman does not speak English or, has different cultural beliefs from the Caucasian community, the quality of care will depend on the provider's cultural competence. Key informant interview and focus group respondents identified some important system and structural barriers; that is, there is still a tremendous need for more screening availability and better access to treatment for women of all racial and ethnic groups. In some cases there were few facilities that offered screening or treatment services and in other cases high clinic volumes meant that access to available services was diminished. Moreover, access to transportation was cited as a concern in most geographic regions. Because of geographic challenges within the Affiliate service area, accessing services in more remote locations presents a considerable concern and improved screening and treatment access assistance is a significant need. Personal barriers included low awareness of the need for screening services and how to access such services, cited for Latinas in particular, and fear of the pain associated with a mammogram, among women in general.

The Community Profile Task Force found that there is a continuing need to increase education and awareness, among both providers and patients, about breast health and the importance of regular screenings as well as how to navigate the health care system. Interviews demonstrated some unfamiliarity, on the part of both the provider and patient, with the Oregon Breast and Cervical Cancer Program (OR-BCCP) and how to access and receive services. Providers and key informants also expressed frustration with OR-BCCP mammogram allocations not always being available to fulfill the community need.

Curry County, Oregon

The main findings from the key informant interviews focused on barriers to accessing breast health care services and/or resources. The primary barrier identified was the lack of available providers, services and resources, which caused women to travel long distances to access available care. This created a financial burden that deterred some women from getting screened. Additionally, informants perceived some women as being unwilling and/or reluctant to travel outside their geographic area to receive care, given the long distances to reach a medical facility. Some informants cited distrust between local providers and those coming in from the outside to provide assistance or offer support in addressing local issues. This distrust was thought to limit collaborative efforts to raise awareness of the importance of breast health and the need for annual screenings. The distrust of outside stakeholders may emphasize the need to establish trusting relationships before attempting to influence change within this target community.

Linn County, Oregon

A main finding from the key informant interviews was the concern that providers were giving inconsistent recommendations to women about when to begin screening and how often to screen. This inconsistency was thought to cause uncertainty and concern among women. Informants identified several systems barriers, including a lack of breast screening facilities on the east side of the county and inadequate or non-extant public transportation services among all women. Latinas, in particular, were thought to experience low awareness of the need for screening and of how to access available breast health care resources/services. There were thought to be few local resources or efforts to address this awareness gap. The survey results, while limited in number, provided interesting insight. An important finding is that fear of the pain associated with a mammogram was a key deterrent to obtaining a mammogram.

Cowlitz County, SW Washington

While the responses varied, the leading concern was the lack of available primary care providers and screening services. This was heightened by the increased enrollment of AppleCare (Washington State's Medicaid Health Plan), the resulting higher clinic volumes, and the loss of primary care physician availability. Additionally, many of these new AppleCare enrollees were thought to face obstacles related to understanding how to access and utilize available services and resources. A specific area of concern was the apparent lack of knowledge as to the importance of breast health screening and/or the perception that screening was not important in one's overall health.

Clackamas/Multnomah/Washington counties, Oregon

A main finding of the key informant interviews was the lack of understanding of how to access available breast care services. Specifically, women were thought to lack understanding of how to access transportation and financial resources to obtain a mammogram. A second identified concern involved cultural barriers, including distrust of the medical community specifically from the Black/African-American and American Indian/Alaskan Native populations; and language barriers, particularly for members of the Hispanic/Latina community. Additionally it was perceived that many providers lacked a good understanding of cultural values and beliefs of these women, which diminished trust and hindered patient-provider communication. Women identified the need for greater self-advocacy in clinical settings and open and trusting communication with providers. These factors were thought to be important to achieve heightened understanding of breast cancer prevention behaviors and increased participation in decisions about their care.

The three focus groups identified the following major themes: 1) lack of trust of the health care systems as perceived by women within these specific ethnic groups; 2) language barriers; 3) placing a higher priority on the needs of family members than on one's own needs; 4) lack of insurance to access services; 5) lack of accessible transportation, particularly among Latinas; and, 6) lack of a general understanding of the health system and how to navigate it. Women with no insurance noted difficulties in receiving health information, getting diagnosed, obtaining full or proper treatment, and generally reported experiencing a poorer quality of care. Some

women with insurance faced difficulty paying for services not covered by their plan; in some cases this led to decisions to decline needed services.

Mission Action Plan

Problem/Need Statement – Applies to All Target Communities

The primary issues to be addressed in each of the identified target communities are the lower than state average screening rates, higher than state average for late-stage diagnosis rates and the need for greater education and outreach to improve breast health knowledge and awareness of available resources through the treatment access program, as indicated by the quantitative and qualitative data that was collected.

Identified Target Communities

There are four target communities from across the Affiliate service area identified as those with the most significant problems to be addressed. These are:

- Linn county within the Mid-Willamette region
- Curry county within the Southern Oregon region
- Cowlitz county within the SW Washington region
- Women of color within the three counties of Clackamas, Multnomah and Washington in the NW Metro region

Priority 1: Improve access, availability, and utilization of screening and diagnostic services within minority communities that will improve outcomes in Screening and Late-Stage Diagnosis Rates

Goal 1: Implement disparity grant funding with the primary focus to improve targeted disparity outcomes.

- Objective 1: By FY19, improve screening rates and late-stage diagnosis rates to meet 2020 expected outcomes for the target communities.
    - Tactic 1: Work in collaboration with the Oregon Breast and Cervical Cancer Program, and the American Cancer Society in development and implementation of strategic outreach efforts aimed at increasing outreach in the targeted minority communities, as identified through quantitative and qualitative data.
    - Tactic 2: Ensure successful implementation of the Hispanic/Latina and Black/African-American Initiatives within the targeted communities (as noted in Objectives 2 and 3 below).

- Objective 2: In FY16 and beyond, continue the work of the Latina Initiative in improving screening and late-stage diagnosis rates in the Hispanic/Latina community.
    - Tactic 1: Expand Latina Initiative activities to the four identified target communities in FY16.
        - Beaverton/Hillsboro, Gresham/Rockwood, Inner Southeast Portland, Salem/Keizer
    - Tactic 2: Facilitate increased outreach to the 13 identified communities within the framework of the Latina Initiative, FY16 - FY18.

    - Tactic 3: Develop a plan for sustaining Hispanic/Latina outreach after conclusion of the five-year Latina Initiative, to be implemented in FY18.

- Objective 3: In FY16 develop, and in FY17 implement, the Black/African-American Initiative within the tri-county area of Multnomah, Washington and Clackamas counties to improve screening and late-stage diagnosis rates.
    - Tactic 1: Establish the Black/African-American Initiative Advisory Council to guide the development and implementation of the Black/African-American Initiative, in FY16.
    - Tactic 2: Implement expansion of the Worship in Pink Program, in FY16.
    - Tactic 3: Implement a pilot program to test the Ambassador Navigator approach to increasing breast health screening rates in FY16; and, based on evaluation of the pilot, implement an integrated Ambassador Navigation Program in FY17.

- Objective 4: During FY16-FY17, develop strategic relationships with minority communities to implement culturally appropriate ways of increasing awareness of breast health and the importance of breast screening and early detection.
    - Tactic 1: Beginning in FY16, annually provide at least ten (10) culturally appropriate education events to the Hispanic/Latina community through the Latina Initiative.
    - Tactic 2: Beginning in FY17, collaborate with at least five (5) organizations within the Black/African-American community to provide a minimum of five (5) annual educational events through the Black/African-American Initiative.

Priority 2: Improve Access to Treatment Services

Goal 1: Continue to improve communication to cancer treatment programs (case managers and nurse navigators), and breast cancer forever fighters and survivors about the Komen Treatment Access Program grant managed by 211Info.

- Objective 1: By FY17, implement strategies to educate providers, and breast cancer forever fighters and survivors as to the availability of funds through the Komen Treatment Access Program, with the goal of distributing educational materials to 100 percent of cancer treatment programs in the Affiliate service area.
    - Tactic 1: Disseminate Komen Treatment Access Program materials on a bi-annual basis to case managers and nurse navigators at all treatment centers within the State of Oregon.
    - Tactic 2: Utilize social media and eBlast communications to inform breast cancer forever fighters and survivors of the availability and the steps to take in accessing Komen Treatment Access Program funds.

Goal 2: Continue to fund the Komen Treatment Access Program as a strategic priority for the Affiliate.

- Objective 1: From FY16-FY19, increase funding allocated in future Affiliate budgets to allow for the continuation of treatment access grant funding. The percentage and

allocation of funding dependent on the availability of development funds during the fiscal year, with the allocation to be determined during the annual budget process.

- Tactic 1: Evaluate the annual utilization and projected needs for funding of the Treatment Access Program based on quantitative data available, and an assessment of the allocation of funds through the prior revolving two year period.
- Tactic 2: Work with Affiliate leadership during the budgeting process in the allocation of grant funds to support the Treatment Access Program.

- Objective 2: In FY16 develop, and in FY17 implement, a strategy to secure development funds (grants and direct donations) dedicated to support the Komen Treatment Access Program.
  - Tactic 1: Work with the Development Department in creating a grant request template for use in requesting external foundation dollars in support of the Komen Treatment Access program.
  - Tactic 2: Create and implement a direct donation campaign in support of the Treatment Access Program.

Priority 3: Ensure Effective Education and Outreach

Goal 1: Educate providers and the general public about the importance of Komen's breast self-awareness messaging, screening guidelines and the Oregon and Washington screening programs.

- Objective 1: In FY16-FY17, work in collaboration with the Oregon Breast and Cervical Cancer Program and the Washington Breast, Cervical and Colon Health Program; the American Cancer Society; the Affiliate Medical Advisory Committee; and the Mission Advisory Committee, in the development of an integrated provider and general public education program.
  - Tactic 1: Establish a Mission Advisory Committee of breast cancer forever fighters, survivors, and co-survivors that among its activities will be input into the development of appropriate breast awareness messaging for each of the target communities.
  - Tactic 2: Review quantitative and qualitative data for each of the identified target communities to develop strategies for implementation of breast health and screening messaging.
  - Tactic 3: Develop an implementation plan to facilitate activation of the identified mutual strategies.

- Objective 2: In the FY17-FY19 Community Grant RFA, grant recipients will be required to utilize Komen educational materials in Komen supported provider education programs.
  - Tactic 1: Include language in the Community Grant RFA that will require grant recipients to utilize Komen educational materials; and, as a component of the RFA identify how these materials will be shared on a no-less than bi-annual basis.

- Objective 3: In FY16, update the Affiliate website based on input from the Medical Advisory Committee, to include information for providers regarding breast awareness, breast health, screening guidelines, available screening programs, and available Treatment Access Program funding that is easy to access and utilize.
    - Tactic 1: Work with the Medical Advisory Committee in developing provider appropriate messaging, and the Communications team to incorporate this information into the Affiliate website.

Goal 2: Develop a strategic partnership with the Oregon Health Leadership Council (OHLC) and local Coordinated Care Organizations to promote increased awareness of the need for breast cancer screening and the importance of early detection.

- Objective 1: From FY16-FY18, collaborate with OHLC and community partners to develop and implement a three-year best-practice plan with Oregon Hospitals and Health Systems that will promote awareness of the need for breast cancer screening and the importance of early detection.
    - Tactic 1: Develop and implement a bi-annual communication plan focused on breast health awareness and breast cancer screening to be utilized within OHLC facilities and Coordinated Care Organizations for two target audiences.
        - Women, ages 40-74, who are patients, members and employees of OHLC facilities and Coordinated Care Organizations.
        - Women, ages 40-74, who have not had a screening mammogram in two years.
    - Tactic 2: Develop and establish a social media campaign for use by OHLC facilities and Coordinated Care Organizations to be utilized in October of each year coinciding with national Breast Cancer Awareness Month, which includes web-site presence, focused on breast health and the importance of screening to achieve early detection.

Goal 3: Develop a strategy to educate Oregon and Washington legislators within the Affiliate service area on behalf of the public on breast health issues.

- Objective 1: In FY16, enhance the strategic partnership with the American Cancer Society - Cancer Action Network to facilitate breast health issues being effectively addressed within the community and among legislative representatives, from FY16-FY19.
    - Tactic 1: Provide educational information through written correspondence, in-person visits and in-person testimony for all applicable initiatives related to breast health, breast cancer screening, and related issues that would influence the quality of life and delivery of care and/or treatment of those with breast cancer.
    - Tactic 2: Provide educational information through written letters of support, in-person visits and/or in-person testimony for all applicable initiatives of the Oregon Women's Health and Wellness Alliance related to breast health, breast cancer screening, and related issues that would influence the quality of life and delivery of care and/or treatment of those with breast cancer.

- Tactic 3: Facilitate bi-annual mailings to Oregon and Washington legislative representatives within the Affiliate service area to increase Affiliate visibility as a trusted local resource on breast health and breast cancer.

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