# Table of Contents

- **Table of Contents** ........................................................................................................................ 2
- **Acknowledgments** ......................................................................................................................... 3
- **Executive Summary** ....................................................................................................................... 5
  - Introduction to the Community Profile Report ........................................................................... 5
  - Quantitative Data: Measuring Breast Cancer Impact in Local Communities ......................... 6
  - Health System and Public Policy Analysis ................................................................................. 8
  - Qualitative Data: Ensuring Community Input .......................................................................... 11
  - Mission Action Plan .................................................................................................................... 12
- **Introduction** ............................................................................................................................... 16
  - Affiliate History ......................................................................................................................... 16
  - Affiliate Organizational Structure ............................................................................................ 16
  - Affiliate Service Area ................................................................................................................. 17
  - Purpose of the Community Profile Report ............................................................................ 20
- **Quantitative Data: Measuring Breast Cancer Impact in Local Communities** .................... 21
  - Quantitative Data Report ......................................................................................................... 21
  - Selection of Target Communities ............................................................................................ 37
- **Health Systems and Public Policy Analysis** ............................................................................. 43
  - Health Systems Analysis Data Sources .................................................................................. 43
  - Health Systems Overview ....................................................................................................... 44
  - Public Policy Overview .......................................................................................................... 53
  - Health Systems and Public Policy Analysis Findings .............................................................. 59
- **Qualitative Data: Ensuring Community Input** ......................................................................... 61
  - Qualitative Data Sources and Methodology Overview ............................................................ 61
  - Qualitative Data Overview ...................................................................................................... 63
  - Qualitative Data Findings ........................................................................................................ 69
- **Mission Action Plan** .................................................................................................................. 72
  - Breast Health and Breast Cancer Findings of the Target Communities .................................. 72
  - Mission Action Plan .................................................................................................................... 75
- **References** ................................................................................................................................. 79
The Community Profile report could not have been accomplished without the exceptional work, effort, time and commitment from many people involved in the process.

Susan G. Komen® Greater Kansas City would like to extend its deepest gratitude to the Board of Directors and the following individuals who participated on the 2015 Community Profile Team:

- Morgan Cimpl
  Student Intern
  William Jewell College

- Carli H. Good
  Executive Director
  Susan G. Komen Greater Kansas City

- Cheryl Jernigan
  Board Member
  Susan G. Komen Greater Kansas City

- Laurie Roberts
  Board President
  Susan G. Komen Greater Kansas City

- Theresa Osenbaugh
  Community Health Manager
  Susan G. Komen Greater Kansas City

- Margaret Swenson
  Program and Events Coordinator
  Susan G. Komen Greater Kansas City

A special thank you to the following entities for their assistance with data collection and analyses, as well as providing information included in this report:

- All Anonymous Key Informant Responders
- Cancer Action, Inc.
- Clay County Public Health Department
- Coalition of Hispanic Women Against Cancer
- Diagnostic Imaging Centers
- HCA Health care
- Healthy Living Kansas, University of Kansas
- Hiawatha Community Hospital
- Kansas Department of Health and Environment
- Mary Ann Meudt, Atchison Hospital Association
- Ms. Delia Gillis, University of Central Missouri
- North Kansas City Hospital
- Northland Health Care Access
- Phoenix Family
- Saint Luke’s Health System
- Saint Vincent Clinics
- Samuel U. Rodgers Health Center
• Shawnee Mission Health
• The Chambers Family
• Truman Medical Centers
• Unified Government Public Health Department
• Wathena Health care and Rehabilitation Center

Report Prepared by:
Susan G Komen® Greater Kansas City
1111 Main Street, Suite 450
Kansas City, MO 64105
816-842-0410
www.komenkansascity.org
Contact: Theresa Osenbaugh
Introduction to the Community Profile Report

Susan G. Komen® Greater Kansas City began with a Race for the Cure® event in 1994, organized by three inexperienced, headstrong women who relocated to Kansas City from Washington, DC, with a “can do” attitude. In those days, a small core of committed women kept files in their homes and cars, had all Race phone calls on an answering machine in a spare bedroom and treated Komen as their second job. It was truly a grassroots effort.

The need for management grew increasingly evident over the years. Thus, the first Board of Directors was formed and an office was generously donated in 1999. Today, Komen Greater Kansas City serves ten counties in Kansas and seven counties in Missouri, and has a staff of six while continuing to have nearly 200+ active volunteers serving on various committees. The annual Race for the Cure has grown to be the largest nonprofit run/walk in the Greater Kansas City community with over 15,000 in attendance annually.

With the help of passionate volunteers, a dedicated board and staff members, Komen Greater Kansas City has funded over $19 million in support of the mission. $11 million dollars has been invested in grants to local community organizations; nearly $4 million has been given in support of scientific research, and over $4 million has been used in support of educational events, outreach programs, referrals to services, public policy and more. Komen Greater Kansas City prides itself on being invested in the community. Staff actively participates in several local and state wide groups including serving as the Chair for the State of Missouri Show Me Healthy Women Advisory Board and also the Missouri Cancer Summit Planning Committee. Throughout the year, the Affiliate takes on a voice for the community through advocacy efforts with state and federal breast health legislation. Also, community members come to Komen for their breast health needs including speakers for events, information on breast screening services, and support during their fight against breast cancer. Many survivors come to Komen to volunteer or access resources and quickly become part of the Affiliate’s family as Komen journeys beside them during difficult times.

In recent years, Susan G. Komen Greater Kansas City has been recognized for excellent work in both the breast health and nonprofit fields. Staff proudly accepted an award for first place in the NonProfit Connect Philly Awards for social media. The Philly Awards are an annual competition honoring excellence in nonprofit communications. Additionally, in 2014 Susan G. Komen Greater Kansas City was honored to receive the National “Promise Award” from Susan G. Komen headquarters. This award, named in honor of the promise Komen’s founder made to her dying sister, Susan G. Komen, recognizes the Affiliate’s commitment to forward thinking in reducing overall breast cancer death, as well as disparities in breast cancer death.

Komen’s promise is to save lives and end breast cancer forever by empowering people, ensuring quality care for all and energizing science to discover the cures. To meet this promise, Komen Greater Kansas City relies on the information obtained through the Community Profile process to guide the work needed to accomplish the promise in its communities.
The purpose of the 2015 Community Profile report (CP) is to conduct an updated needs assessment of Komen Greater Kansas City’s 17 county service area. This comprehensive study utilizes quantitative (statistical) and qualitative (focus group and provider interview) data collection and analysis. The assessment is used to establish priorities for the Affiliate’s decisions regarding grant funding, education, marketing and outreach and public policy activities. It is a road map for future funding and will guide the Affiliate’s Strategic Plan for the next several years.

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

In order to be efficient stewards of resources, Susan G. Komen Greater Kansas City has chosen five target communities within the service area. The Affiliate will focus their strategic efforts on these target communities over the course of the next five years. Target communities are those communities which have cumulative key indicators showing an increased chance of vulnerable populations likely at risk for experiencing gaps in breast health services and/or barriers in access to care.

The selected target communities are:
- Clay County, Missouri
- Jackson County, Missouri
- Johnson County, Missouri
- Northeast Kansas Region (Atchison, Brown, Doniphan, Jackson Counties)
- Wyandotte County, Kansas

**Clay County, Missouri**

Clay County has been chosen as a target community due to breast cancer death rates and trends, as well as the breast cancer incidence and late-stage diagnosis of breast cancer rates. It is also a high priority county based on the intervention times needed to meet Healthy People 2020 goals.

The county’s breast cancer incidence, death, and late-stage diagnosis rates are all higher than the United States, as well as the service area’s averages. Additionally, trends in data show these incidence rates and late-stage diagnosis rates are getting higher. Simultaneously, the breast cancer death rates are lowering.

On the plus side, Clay County women (ages 50-74) self-reported obtaining a screening mammogram within the last two years at a rate higher than the service area and the United States averages. The increase in incident rate may be correlated to the above average mammography screening percentage in Clay County.

**Jackson County, Missouri**

Jackson County, Missouri, is a high priority county in regards to meeting the Healthy People 2020 goals. Jackson County has been chosen as a target community due to rates and trends regarding breast cancer deaths, as well as the rates of breast cancer incidence and late-stage diagnosis. Additionally, Jackson County residents reflect a diverse population with many
women who may be more vulnerable to breast cancer due to known poorer prognosis rates (i.e., late-stage diagnosis or more aggressive cancers). Finally, compared to the service area average, more residents in this county are living below 250 percent poverty, have higher unemployment, and are less likely to have health insurance making affordable access to breast health care potentially difficult.

Data for Jackson County show the breast cancer death and late-stage diagnoses rates are currently higher than both the United States’ and the service area’s average rates. However, there are promising trends in the rates of incidence, deaths from breast cancer and late-stage diagnoses. All categories are expected to show lowering rates in upcoming years.

Women in Jackson County, ages 50-74, have reported obtaining a screening mammogram at a rate comparable to the service area average. This is positive since mammography can facilitate early detection.

**Johnson County, Missouri**

Johnson County, Missouri, has been chosen as a target community due to higher than average breast cancer death rates, late-stage diagnosis rates and an increasing trend in incidence rates. In the Affiliate’s 17-county service area, Johnson has one of the highest death rates and the highest rates of late-stage breast cancer diagnosis. Consequently, Johnson County has also been identified as a high priority county due to the amount of time needed to meet the Healthy People 2020 goals.

Johnson County currently has breast cancer incidence rates lower than both the United States and service area averages. However, trends show incidence rates increasing. Also problematic, both breast cancer death and late-stage diagnosis rates are above the United States and service area averages, with an increasing trend for late-stage diagnosis. No data were available for trends related to the death rates from breast cancer.

With the screening percentage in Johnson County below the United States and service area averages, it is possible women are experience barriers to receiving mammography screening. This may be associated with higher rates of late-stage diagnoses and more women dying from breast cancer. It may also explain the lower rate of incidence.

**Northeast Kansas Region, Kansas**  
(Atchison, Brown, Doniphan, Jackson Counties, Kansas)

Due to small population sizes, data have been suppressed for many of Northeast Kansas counties. These counties have been combined into one region for the purpose of this report and for the Affiliate’s targeted efforts. The Northeast Kansas Region is located in eastern Kansas and aligns with the Missouri state border. All counties in the region are considered rural.

These counties have been chosen due to low screening percentages, unique population demographics, and identification as medically underserved and having lower income levels.
Although, the demographic makeup of this region’s female residents is primarily White, several American Indian reservations are located in the region. In the past, breast cancer in American Indians was rare. Unfortunately, the last two decades have seen large increases in both incidence and death rates for this group of women.

Additionally, socioeconomic characteristics of the region indicate a potential concern about women’s access to affordable breast health care. All counties in the region, with the exception of Jackson County, Kansas have substantially higher percentages of residents living below 250 percent poverty income than the service area average. Additionally, Doniphan County is considered to be in a medically underserved area compounding potential barriers to breast health care. Only two providers in the entire region participate in the National Breast and Cervical Cancer Early Detection Program; and one of those providers is limited to only providing services to American Indian women.

**Wyandotte County, Kansas**

Wyandotte County, Kansas represents the most diverse population in the service area. 27.8 percent of women are Black/African-American, a rate higher than the national average and double that of the service area average. This is significant due to the high death rates Black/African-American women experience from breast cancer when compared to other races. Additionally, 24.9 percent of the county is Hispanic/Latina, 7.2 percent are linguistically isolated, and 14.2 percent are foreign born. All of these percentages are substantially higher than the service area’s averages.

Wyandotte has been identified as a high priority county due to the amount of intervention time needed to achieve the federal government’s healthy people 2020 goals. For instance, the county’s death rate of breast cancer was 28.5 per 100,000 women. This is higher than the United States rate (22.6), as well as the service area’s rate (24.9). The death rate is expected to decrease over the next few years. But currently, the county continues to have one of the highest rates of breast cancer death in the service area. Data showing late-stage diagnosis rates and trends were not available for this county.

The screening percentage in Wyandotte County is lower than the United States; and service area averages and socioeconomic data for the county show several concerning areas. Wyandotte residents are substantially more likely to have less than a high school education, an income below 250 percent poverty, and be unemployed than others in the United States and the service area. Wyandotte County residents are also the least likely in the service area to have health insurance.

**Health System and Public Policy Analysis**

In addition to quantitative data review, Komen Greater Kansas City utilized multiple sources to collect data for an analysis on the breast health systems of the service area. The information and data collected from these resources was obtained and analyzed in order to create an accurate depiction of the systems and services impacting breast health in the target communities of the Greater Kansas City area. Identifying services available in target
communities allows Komen Greater Kansas City to understand the strengths and opportunities for growth in each county. This includes all aspects of breast health and care, revealing where the counties are excelling and any gaps that may be present.

**Analysis by Target Community**

**Clay County, Missouri**
Clay County has a substantial amount of breast health services available to residents. Multiple hospitals provide a full “continuum of care” for breast cancer. However, Clay County also has a relatively high number of breast cancer deaths and late-stage diagnosis rate. Considering that the screening percentage in this county is not significantly different than the service area’s average, a strong emphasis must be placed on navigation, diagnosis, and treatment of breast cancer. In addition, the analysis reveals that the majority of breast health services, particularly treatment, are in the Southwest region of the county, centered in North Kansas City and Liberty. Those in other regions of the county have very few readily accessible breast health services.

**Jackson County, Missouri**
As seen through mapping of services, Jackson County has breast health resources all along the “continuum of care.” Kansas City, Missouri, and the immediate area have numerous health centers providing screening, diagnostics, treatment, and support. However, urban Jackson County remains a target area due to late-stage diagnosis rates, education levels, poverty levels, and hard to reach populations. Therefore, Komen Greater Kansas City works with multiple partners to provide better access to breast health to the least reached populations of Jackson County.

**Johnson County, Missouri**
Johnson County, Missouri, lacks the breast health services of the metropolitan regions of Komen Greater Kansas City’s service area. With the only health department and hospital located in Warrensburg, Missouri, any residents not living in this city lack convenient access to services. Western Medical Center in Warrensburg partners with Saint Luke’s Hospital to provide diagnostic and screening services, as well as a biweekly oncology clinic providing physicians, infusion therapy, and labs. However, patients needing radiation therapy are sent to Saint Luke’s East in Lee’s Summit, Missouri. Residents in Johnson County, Missouri have limited access to treatment and survivorship services, forcing them to travel to the nearby cities in order to receive care. Johnson County Cancer Foundation provides financial assistance to cancer patients. However, barriers faced are not solely financial in nature.

**Northeast Kansas**
Atchison, Brown, Doniphan, and Jackson Counties make up the target community of the Northeast Region of Kansas. This rural area of Kansas, while having a hospital and health department in each county, lacks readily accessible services along the complete “continuum of care.” Residents of this area without independent transportation would most likely be unable to receive any breast care. In addition, Atchison, Kansas has the lowest screening level in Komen Greater Kansas City’s entire service area.
Wyandotte County, Kansas
As seen through mapping of services, Wyandotte County has breast health resources all along the Continuum of Care. Despite the resources available, breast health screening percentage and late-stage diagnosis rate in Wyandotte County remain a concern. Low income, racial and ethnic disparities, and lack of insurance continue to create barriers in this area.

Komen Greater Kansas City’s target communities each face different but equally challenging barriers to breast health. While Clay, Jackson, and Wyandotte counties have various services available in all areas of the Continuum of Care (CoC), women are not accessing these services fully. Neither Johnson County, Missouri, nor the Eastern Kansas region has readily available services in all areas of the CoC. Residents of these counties face the barrier of traveling to other counties for many of their necessary screening, diagnostic, treatment, and survivorship services.

Public Policy Implications
The Affordable Care Act (ACA) works to expand access to care through insurance, enhance the quality of health care, improve coverage for those with insurance, and make health care more affordable. ACA mandates health insurance for Americans (with a few exemptions). ACA prohibits denying coverage based on pre-existing conditions, annual or lifetime caps, and rescinding coverage. It also establishes minimum benefit standards and coverage for preventative services. In both Kansas and Missouri, a federally administered plan was chosen as the method for the insurance exchange program.

For breast cancer, ACA impacts all parts of the continuum of care. ACA includes breast cancer education for young women, mammography as a required benefit, and increased access to clinical trials and patient navigation. Eliminating pre-condition exclusions and lifetime and annual caps are also vital for breast cancer treatment and follow-up care.

Despite these positive changes, gaps will still exist. Undocumented immigrants, un-enrolled Medicaid eligible individuals, those exempt from the mandate, and those that choose not to enroll will remain without insurance. It is estimated that this will make up 30 million Americans that will remain uninsured in 2016.

Because Missouri and Kansas chose not to expand Medicaid, a coverage gap is left of people making too little to qualify for federal help. The authors of ACA intended these individuals to be covered by Medicaid expansion, but both states in the service area opted to not expand. Therefore, most of Kansas and Missouri’s poorest, working-age residents — those under age 65 and below the poverty line of $11,490 for an individual and $15,510 for a couple — aren’t eligible for government help. In Kansas, there are currently 369,000 uninsured individuals-78,000 in Kansas (21 percent of uninsured) who would have been eligible for Medicaid if the state expanded will fall into the coverage gap. In Missouri, 93,000 of the 834,000 uninsured adults (23 percent of the uninsured) will fall into this gap.
Through advocacy efforts and partnerships, Komen Greater Kansas City continues to be a voice for breast health in both Missouri and Kansas. Komen Greater Kansas City advocates for funding of breast health screening, research, and treatment programs.

**Qualitative Data: Ensuring Community Input**

In order to gain a deeper understanding of the communities above, qualitative data were collected through focus groups and contacts with community providers. The use of two different data collection methods as well as the efforts to have multiple groups from each target area assisted with triangulation of the data. This allowed for the community to be directly involved in assessing the needs and issues, as well as potential solutions, to the initial findings from the quantitative data. By directly working with those living in the communities targeted, the Affiliate explored beliefs and behaviors around disparities, knowledge of breast health, access to services, utilization of services and more regarding breast health and breast cancer care. This process allowed for comments by the community on what is working and what can be improved.

**Conclusions**

Similar themes often correlated between focus group findings and provider interview findings. Barriers were often confirmed by both parties, such as cost of health care and access to transportation. In some instances one data source (focus groups or providers) were unaware or did not commonly express that certain barriers existed for the other party. For example, the women in the community repeatedly expressed frustration with the communication from providers but the providers did not note that time with the patient or communication of health information with the patient was an issue. Providers listed a lack of desire to access health care as a barrier. Some women in the focus groups shared they didn’t want to go to the doctors, but not because a lack of desire to receive health care. Rather, they expressed a lack of confidence in the providers stemming from a negative experience as the rationale behind not seeking care. The combination of information from each party led to a deeper understanding of key issues.

Some questions asked of focus group participants touched on key issues around access to health care, such as where individuals go when they need to see a doctor and what are perceived barriers to accessing health care. Sixteen percent listed they had no one they considered their primary care giver. Additionally, 55.0 percent of women disclosed they had not seen a doctor in the past year due to cost. Cost was always listed as the number one factor in preventing women from accessing health care.

Fortunately, the Affiliate has strong National Breast and Cervical Cancer Early Detection Programs on either side of the service area state line. However, it is clear that women and providers are unaware of the resources that this program provides. Furthermore, for women who do have insurance, there is little known about the recent provisions in the Affordable Care Act which often times remove the copay for preventative services such as mammograms. With cost being the biggest barrier for many women, it is imperative that time and education is spent around what is already available to those who cannot or think they cannot afford a mammogram.
It is also clear, by the numerous discussions around breast health education, that women, in general, realize they are at risk for breast cancer but are still unaware of their personal risk factors and the things they can do to lower their risk for breast cancer. On a positive note, women do tend to share health information with their friends and family. However, it is important that educators are getting accurate material to women so they do not share inaccurate information. Continued year-long education around breast self-awareness and other evidence based information is needed to be delivered to the community in an innovative way that people will retain. Additionally, bringing the education to the appointment itself, whether by the nurse or physician, seems to have strong potential for making a larger impact on patients instead of relying on them to digest materials available in the lobby.

Access to health care is embedded from systematic issues that are difficult to change swiftly. However, small changes can be made in order to accommodate those facing challenges. Examples could include extended hours for screenings and streamlining of services such as clinical breast exams and mammograms at the same appointment. Additionally, there was a strong desire for mobile mammography to be brought back to the area, particularly in geographic locations without nearby access to mammography services. However, in order to be of most use to the community, a mobile program would need to work in partnership with the National Breast and Cervical Cancer Early Detection Programs. When available, additional subcontracts for the state programs may also provide benefit to the service area.

One of the biggest barriers women face is their personal mindset. It is vital for women to understand that their personal health is a key component to their entire family and that it is ok to take care of themselves as they take care of others. Addressing the resounding fear of a mammogram and fear of a breast cancer diagnosis is also imperative but difficult. These fears are ingrained in the community and although the five-year survival rate for early stage breast cancer is now 99.0 percent, many women still feel that breast cancer, regardless of when found, is deadly.

Lastly, providers reacted positively to the notion of additional training around breast health. It may be useful to find a way to communicate directly with providers to supply the most up to date breast health information whether it is in the form of education to patients, knowledge around new techniques and treatments, or other forms of learning. While providers do have a strong desire for this information, the strong demand and time constraints placed on providers make it difficult to find the most effective way to reach them.

In the words of one focus group participant when discussing why someone would access breast care, “It’s either going to be inspiration or desperation.” The Affiliate needs to continue to find relevant ways to inspire women so they don’t wait until desperation occurs.

**Mission Action Plan**

Once all data were combined and each county was reviewed for a total picture of the state of breast health, the Affiliate began strategic planning to address the needs found in each county.
The Mission Action Plan provides the opportunity to make plausible connections regarding the issues in each county and the establishment of Affiliate priorities in the counties. For each county, a problem statement is presented based on the review of the available data for each community. Then, priorities of intervention have been selected. Finally, each priority has measurable objectives that will be implemented over the next several years.

**Problem Statement: Clay County, Missouri**

Women in Clay County have incidence rates, death rates and late-stage diagnosis rates that are higher than the US and service area averages. Incidence and late-stage diagnosis rates are expected to increase. The health system analysis found that there are multiple hospitals providing the full breast cancer continuum of care but the majority of those services are available in the Southwest region of the county (North Kansas City and Liberty).

In order to address the issues identified in Clay County, the Affiliate plans to focus efforts around patient navigation support, provision of Affiliate-based education to individuals, and raising awareness amongst the health system of the needs in the county. Komen Greater Kansas City has set the following objectives for work in the community:

- Beginning with FY17, a key funding priority will be developing or improving patient navigation programs targeting Clay County women
- By the end of FY19, a minimum of 15 outings will be conducted in Clay County using the Affiliate’s Connecting for a Cure curriculum
- In FY16, hold at least two collaborative meetings with health care providers in Clay County to develop a plan on how to improve breast health needs

**Problem Statement: Johnson County, Missouri**

Women in Johnson County, Missouri, have high breast cancer death rates & late-stage diagnosis rates. Mammography screening percentage is below average. Johnson County can be considered "rural" and outside of Warrensburg, the county has no additional hospitals or health departments. Residents have to travel to the metropolitan area in order to receive the full continuum of care.

To address the high needs in Johnson County, Missouri, the Affiliate will work diligently to increase the number of women getting preventative breast health screening. The Affiliate will also work to pull together the health systems to discuss transitions for treatment of women diagnosed with breast cancer. Additionally, the Affiliate will work to increase presence in the county as well as increase capacity to provide individual education to women in the area.

- By the end of FY16 identify the best plan for women to receive services from Show Me Healthy Women
- By the end of FY17, develop and implement a campaign encouraging women to make their health care a priority
- By the end of FY17, develop and implement a campaign to educate the population and those who work directly with them on Show Me Healthy Women as well as the breast health provisions outlined with the Affordable Care Act
• In FY16, hold at least two collaborative meetings with health care providers and community organizations to develop a plan on how to improve the breast cancer treatment process
• Beginning with FY17, a key funding priority will be developing or improving patient navigation programs targeting Johnson County women
• By the end of FY19, a minimum of eight outings will be conducted in Johnson County using the Affiliate’s Connecting for a Cure curriculum
• By the end of FY19, a minimum of six members will be recruited and remain active in the Komen Greater Kansas City "Pink Army"
• Recruit and retain a minimum of one Board Member who resides in Johnson County, Missouri during FY18

Problem Statement: Jackson County, Missouri
Women in Jackson County have breast cancer death and late-stage diagnosis rates which are higher than the US and service area averages and a higher level of residents who are vulnerable to a poorer prognosis of breast cancer survival. Additionally, more residents are living below poverty, have higher unemployment and are less likely to have health insurance.

The Affiliate’s work in Jackson County will continue to expand with a strong focus on providing meaningful education to individuals in the community. The Affiliate will also work with the health systems to discuss the found breast needs and collaboratively create a plan to further address those needs. The Affiliate will also work tirelessly to increase the number of women obtaining preventative breast health screenings in the county.
• In FY16, hold at least two collaborative meetings with health care providers in Jackson County to develop a plan on how to improve breast health needs
• By the end of FY18, a minimum of 20 outings will be conducted in Jackson County using the Affiliate’s Connecting for a Cure curriculum
• By the end of FY19 hold at least one local "Mammacare" training event for providers
• By the end of FY19, in partnership with other entities, hold at least five breast health screening events for the public
• By the end of FY 17, develop and implement a campaign encouraging women to make their health care a priority
• By the end of FY17, develop and implement a campaign to educate the population and those who work directly with them on Show Me Healthy Women as well as the breast health provisions outlined with the Affordable Care Act

Problem Statement: Northeast Kansas Region
Women living in Northeast Kansas have the lowest screening percentage in the entire service area. The area is considered to be "rural" and full breast health services are not available along the continuum of care in the region. Additionally, there are only two Early Detection Works providers in the entire region.

The Affiliate will continue to work in the area with efforts to increase the number of women receiving preventative breast health screenings as well as increase the region’s capacity to
provide breast health care in Northeast Kansas. Lastly, the Affiliate will work to increase educational outreach to women in the community.

- By the end of FY 2019, a minimum of eight outings will be conducted in Northeast Kansas using the Affiliate’s Connecting for a Cure curriculum
- Work with local resources and key influencers in NE Kansas to hold a minimum of four screening events by March, 2019
- By the end of FY17, develop and implement a campaign to educate the population and those who work directly with them on Early Detection Works as well as the breast health provisions outlined with the Affordable Care Act
- Identify and assist with recruiting of one additional Early Detection Works Provider in NE Kansas by October, 2017
- By the end of FY17, a key funding priority will be developing or improving patient navigation programs targeting Northeast Kansas Women

Problem Statement: Wyandotte County, Kansas

Women in Wyandotte County have a higher death rate than the US and service area averages. Women are receiving mammography screenings at a rate that is lower than the comparable averages. The socioeconomic data of the county is concerning with residents being less likely to have a high school education, income below 250.0 percent of the poverty level, and the least likely to have health insurance in the area. Residents also are more likely to be unemployed.

In Wyandotte County, the Affiliate will implement strategies to increase the number of women obtaining a preventative breast health screening. The Affiliate will also enhance the work to provided education to women residing in the county. Lastly, the Affiliate will meet with key players in the health system to discuss the needs of the county and potential ways to address those needs.

- In FY16, hold at least two collaborative meetings with health care providers in Wyandotte to develop a plan on how to improve breast health needs
- By the end of FY19, a minimum of 15 outings will be conducted in Wyandotte using the Affiliate’s Connecting for a Cure curriculum
- By the end of FY18 partner with at least two non-health organizations to coordinate comprehensive education and screening events
- By the end of FY17, develop and implement a campaign to educate the population and those who work directly with them on Early Detection Works as well as the breast health provisions outlined with the Affordable Care Act

Disclaimer: Comprehensive data for the Executive Summary can be found in the 2015 Susan G. Komen® Greater Kansas City Community Profile Report.
Affiliate History

Susan G. Komen® Greater Kansas City began with a Race for the Cure® event in 1994 organized by three inexperienced, headstrong women who relocated to Kansas City from Washington, DC, with a “can do” attitude. In those days, a small core of committed women kept files in their homes and cars, had all Race phone calls on an answering machine in a spare bedroom and treated Komen as their second job. It was truly a grassroots effort.

The need for management grew increasingly evident over the years. Thus, the first Board of Directors was formed and an office was generously donated in 1999. Today, Komen Greater Kansas City serves ten counties in Kansas and seven counties in Missouri, and has a staff of six while continuing to have nearly 200+ active volunteers serving on various committees. The annual Race for the Cure has grown to be the largest nonprofit run/walk in the Greater Kansas City community with over 15,000 in attendance annually.

With the help of passionate volunteers, a dedicated board and staff members, Komen Greater Kansas City has funded over $19 million in support of the mission. $11 million dollars has been invested in grants to local community organizations; nearly $4 million has been given in support of scientific research, and over $4 million has been used in support of educational events, outreach programs, referrals to services, public policy and more. Komen Greater Kansas City prides itself on being invested in the community. Staff actively participates in several local and state wide groups including serving as the Chair for the State of Missouri Show Me Healthy Women Advisory Board, Co-Chair and founding member of Wyandotte County Breast Cancer Taskforce and also the Missouri Cancer Summit Planning Committee. Throughout the year, the Affiliate takes on a voice for the community through advocacy efforts with state and federal breast health legislation. Community members come to Komen for their breast health needs including speakers for events, information on breast screening services, and support during their fight against breast cancer. Many survivors come to Komen to volunteer or access resources and quickly become part of the Affiliate family as the Affiliate journeys beside them during difficult times.

In recent years, Susan G. Komen Greater Kansas City has been recognized for excellent work in both the breast health and nonprofit fields. Staff proudly accepted an award for first place in the Nonprofit Connect Philly Awards for the Affiliate’s social media efforts. The Philly Awards are an annual competition honoring excellence in nonprofit communications. Additionally, in 2014 Susan G. Komen Greater Kansas City was honored to receive the National “Promise Award” from Susan G. Komen Headquarters. This award, named in honor of the promise Komen’s founder made to her dying sister, Susan Komen, recognizes the Affiliate’s commitment to forward thinking in reducing overall breast cancer death, as well as disparities in breast cancer death.

Affiliate Organizational Structure

Susan G. Komen Greater Kansas City has a full-time staff of six (Figure 1.1) and an 11-person Board of Directors. The Affiliate is grateful to have approximately 200 active volunteers giving
their time to Komen Greater Kansas City’s Pink Army, serving on planning committees such as Race for the Cure and the Pink Promise Brunch, serving on organizational structure committees such as the Strategic Mission and Marketing and Development committees, acting as educational ambassadors and volunteering for events such as the annual Kansas City Race for the Cure.

Figure 1.1. Susan G. Komen Greater Kansas City Staff Organizational Chart

According to By-Laws, the Board of Directors of Komen Greater Kansas City may have a capacity of 15 voting members. Board members take office in April of each year and serve a three year term with an optional second term. Each board member makes a personal financial commitment to the Affiliate as part of his/her Board service. The staff at Susan G. Komen Greater Kansas City is currently made up of six members who also, each, make an annual financial contribution.

Affiliate Service Area

Komen Greater Kansas City serves 17 counties in a bi-state area, ten counties in Eastern Kansas and seven in Western Missouri (Figure 1.2). In Kansas, the service area stretches from the northeast corner of Kansas (Brown, Doniphan, and Atchison Counties) to Miami County in the south. In Missouri, the service area reaches from Buchanan County in the north to Bates County in the south.

The service area is unique due to the fact that it borders a state line (Kansas/Missouri) and also covers a large metropolitan area as well as territory classified as rural. Several of the Affiliate’s counties make up the metropolitan area and have better access to public transportation than the outlying rural areas. The Affiliate office is located centrally in the service area and is able to reach each of the county seats within a few hours’ drive time.

Recent census data (2014) show that the Affiliate’s service area is made up of over 2.2 million residents serving approximately 21.0 percent of Missouri’s population and 34.0 percent of Kansas’ population. Proportionately, the Affiliate’s service area has a larger White female population than the US as a whole, a slightly smaller Black/African-American female population,
a slightly smaller Asian and Pacific Islander female population, and a substantially smaller Hispanic/Latina female population. The Affiliate’s female population is slightly younger, education level is higher and the income level is slightly higher than those of the US as a whole. There are a substantially 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 than the US.

However, certain counties have higher rates of specific demographics than the service area as a whole. For example, Wyandotte County and Jackson County, Missouri, have a substantially larger Black/African-American female population than the area average. Brown and Jackson Counties in Kansas have substantially larger American Indian/Alaskan Native populations as a whole. Wyandotte County also has a substantially larger Hispanic/Latina population, lower education levels, lower income levels, lower employment levels, more linguistically isolated residents and a substantially larger percentage of adults without health insurance than the service area as a whole (Susan G. Komen, 2014).
Figure 1.2. Susan G. Komen Greater Kansas City Service Area
Purpose of the Community Profile Report

Komen’s promise is to save lives and end breast cancer forever by empowering people, ensuring quality care for all and energizing science to discover the cures. To meet this promise, Komen Greater Kansas City relies on the information obtained through the Community Profile process to guide the work in its communities.

The purpose of the 2015 Community Profile Report (CP) is to conduct an updated needs assessment of Komen Greater Kansas City’s 17 county service areas. The assessment is used to establish priorities for the Affiliate’s decisions regarding grant funding, education, advocacy, marketing, and outreach and public policy activities. It is the road map for future funding and will guide the Affiliate’s Strategic Plan for the next several years. The profile will be shared with the entire service area and specifically in target communities through town hall meetings, local television, print and social media, along with other communication methods over the next several years.

The CP is a snapshot of the state of female breast cancer in the Affiliate’s service area, allowing the Affiliate to pinpoint where efforts will have the most impact. This comprehensive study utilizes quantitative (statistical) and qualitative (focus group and provider interview) data collection and analysis. An updated assessment of the programs and services gaps, as well as needs and barriers for breast health in the service area, allows the Affiliate to focus on closing the gap between the needs and the available resources and services in the target communities. The updated assessment also determines how to remove barriers inhibiting access to care encountered by medically underserved women in the community. The Affiliate can ensure effective and targeted efforts by identifying the geographic areas, demographic groups and disadvantaged populations who are most in need of access to breast health programs and services, allowing funding and community outreach efforts to have the greatest impact possible. In addition, the CP offers updated information about the assets in the target communities that can be looked to for partnership and collaborative interventions.
Quantitative Data: Measuring Breast Cancer Impact in Local Communities

**Quantitative Data Report**

**Introduction**
The purpose of the quantitative data report for Susan G. Komen® Greater Kansas City 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® Greater Kansas City’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

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Female Population (Annual Average)</th>
<th>Incidence Rates and Trends</th>
<th>Death Rates and Trends</th>
<th>Late-stage Rates and Trends</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td># of New Cases (Annual Average)</td>
<td>Age-adjusted Rate/100,000</td>
<td>Trend (Annual Percent Change)</td>
</tr>
<tr>
<td>US</td>
<td>154,540,194</td>
<td>198,602</td>
<td>122.1</td>
<td>-0.2%</td>
</tr>
<tr>
<td>HP2020</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Kansas</td>
<td>1,416,658</td>
<td>1,951</td>
<td>123.2</td>
<td>-2.4%</td>
</tr>
<tr>
<td>Missouri</td>
<td>3,024,156</td>
<td>4,264</td>
<td>121.5</td>
<td>0.0%</td>
</tr>
<tr>
<td>Komen Greater Kansas City Service Area</td>
<td>1,117,822</td>
<td>1,498*</td>
<td>126.7*</td>
<td>-1.2%*</td>
</tr>
<tr>
<td>White</td>
<td>930,956</td>
<td>1,321</td>
<td>126.8</td>
<td>-1.2%</td>
</tr>
<tr>
<td>Black/African-American</td>
<td>145,643</td>
<td>163</td>
<td>129.5</td>
<td>-1.8%</td>
</tr>
<tr>
<td>American Indian/Alaska Native (AIAN)</td>
<td>10,910</td>
<td>NA</td>
<td>NA</td>
<td>SN</td>
</tr>
<tr>
<td>Asian Pacific Islander (API)</td>
<td>30,312</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Non-Hispanic/ Latina</td>
<td>1,039,999</td>
<td>1,460</td>
<td>128.0</td>
<td>-1.1%</td>
</tr>
<tr>
<td>Hispanic/ Latina</td>
<td>77,822</td>
<td>38</td>
<td>95.4</td>
<td>-1.1%</td>
</tr>
<tr>
<td>Komen Greater Kansas City Counties in KS</td>
<td>490,232</td>
<td>652*</td>
<td>132.1*</td>
<td>-3.1%*</td>
</tr>
<tr>
<td>Atchison County - KS</td>
<td>8,636</td>
<td>NA</td>
<td>NA</td>
<td>SN</td>
</tr>
<tr>
<td>Brown County - KS</td>
<td>5,152</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Doniphan County - KS</td>
<td>3,961</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Douglas County - KS</td>
<td>54,439</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Jackson County - KS</td>
<td>6,682</td>
<td>NA</td>
<td>NA</td>
<td>SN</td>
</tr>
<tr>
<td>Jefferson County - KS</td>
<td>9,388</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Johnson County - KS</td>
<td>271,895</td>
<td>NA</td>
<td>NA</td>
<td>63</td>
</tr>
<tr>
<td>Leavenworth County - KS</td>
<td>35,024</td>
<td>NA</td>
<td>NA</td>
<td>10</td>
</tr>
<tr>
<td>Miami County - KS</td>
<td>16,215</td>
<td>NA</td>
<td>NA</td>
<td>4</td>
</tr>
<tr>
<td>Wyandotte County - KS</td>
<td>78,840</td>
<td>NA</td>
<td>NA</td>
<td>23</td>
</tr>
<tr>
<td>Bates County - MO</td>
<td>8,677</td>
<td>10</td>
<td>86.1</td>
<td>-5.3%</td>
</tr>
<tr>
<td>Buchanan County - MO</td>
<td>44,243</td>
<td>61</td>
<td>116.5</td>
<td>-5.3%</td>
</tr>
<tr>
<td>Cass County - MO</td>
<td>49,866</td>
<td>67</td>
<td>117.7</td>
<td>2.9%</td>
</tr>
<tr>
<td>Clay County - MO</td>
<td>110,058</td>
<td>157</td>
<td>134.8</td>
<td>5.2%</td>
</tr>
<tr>
<td>Jackson County - MO</td>
<td>344,786</td>
<td>468</td>
<td>123.4</td>
<td>-1.5%</td>
</tr>
<tr>
<td>Johnson County - MO</td>
<td>25,795</td>
<td>28</td>
<td>117.7</td>
<td>3.5%</td>
</tr>
<tr>
<td>Platte County - MO</td>
<td>44,168</td>
<td>55</td>
<td>114.6</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

*Target as of the writing of this report.
NA – data not available.
SN – data suppressed due to small numbers (15 cases or fewer for the 5-year data period).
Data are for years 2006-2010.
Rates are in cases or deaths per 100,000.
Age-adjusted rates are adjusted to the 2000 US standard population.
Source of 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

Susan G. Komen® Greater Kansas City
Incidence rates and trends summary
Overall, the breast cancer incidence rate in the Komen Greater Kansas City service area was slightly 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 Kansas. The incidence rate of the Affiliate service area was significantly higher than that observed for the State of Missouri, and the incidence trend was not significantly different than the State of Missouri.

For the United States, breast cancer incidence in Blacks/African-Americans is lower than in Whites overall. The most recent estimated breast cancer incidence rates for Asians and Pacific Islanders (APIs) and American Indians and Alaska Natives (AIANs) were lower than for Non-Hispanic Whites and Blacks/African-Americans. The most recent estimated incidence rates for Hispanics/Latinas were lower than for Non-Hispanic Whites and Blacks/African-Americans. For the Affiliate service area as a whole, the incidence rate was slightly higher among Blacks/African-Americans than Whites. Incidence data were not available for APIs and AIANs for Kansas, so comparisons cannot be made for these racial groups. The incidence rate among Hispanics/Latinas was lower than among Non-Hispanics/Latinas.

The incidence rate was significantly lower in the following county:
- Bates County, MO

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 Greater Kansas City service area was slightly higher than that observed in the US as a whole and the death rate trend was not available for comparison with the US as a whole. The death rate of the Affiliate service area was significantly higher than that observed for the State of Kansas. The death rate of the Affiliate service area was not significantly different than that observed for the State of Missouri.

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

- Douglas County, KS

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

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

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

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. Late-stage incidence data were not available for APIs and AIANs for Kansas, so comparisons cannot be made for these racial groups. The late-stage incidence rate among Hispanics/Latinas was lower than among Non-Hispanics/Latinas.

None of the counties in the Affiliate service area had substantially different late-stage incidence rates than the Affiliate service area as a whole.

**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*

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

*As of October 2015

Because having regular mammograms lowers the chances of dying from breast cancer, it’s important to know whether women are having mammograms when they should. This information can be used to identify groups of women who should be screened who need help in meeting the current recommendations for screening mammography. The Centers for Disease Control and Prevention’s (CDC) Behavioral Risk Factors Surveillance System (BRFSS) collected the data on mammograms that are used in this report. The data come from interviews with women age 50 to 74 from across the United States. During the interviews, each woman was asked how long it has been since she has had a mammogram. The proportions in Table 2.3 are based on the number of women age 50 to 74 who reported in 2012 having had a mammogram in the last two years.

The data have been weighted to account for differences between the women who were interviewed and all the women in the area. For example, if 20.0 percent of the women interviewed are Latina, but only 10.0 percent of the total women in the area are 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 that should have had mammograms and 250 of those women actually had a mammogram in the past two years, the mammography screening proportion is 50.0 percent.
Because the screening proportions come from samples of women in an area and are not exact, Table 2.3 includes confidence intervals. A confidence interval is a range of values that gives an idea of how uncertain a value may be. It’s shown as two numbers—a lower value and a higher one. It is very unlikely that the true rate is less than the lower value or more than the higher value.

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

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

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

<table>
<thead>
<tr>
<th>Population Group</th>
<th># of Women Interviewed (Sample Size)</th>
<th># w/ Self-Reported Mammogram</th>
<th>Proportion Screened (Weighted Average)</th>
<th>Confidence Interval of Proportion Screened</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>174,796</td>
<td>133,399</td>
<td>77.5%</td>
<td>77.2%-77.7%</td>
</tr>
<tr>
<td>Kansas</td>
<td>4,733</td>
<td>3,672</td>
<td>77.4%</td>
<td>75.8%-78.9%</td>
</tr>
<tr>
<td>Missouri</td>
<td>2,778</td>
<td>2,055</td>
<td>77.0%</td>
<td>74.9%-79.0%</td>
</tr>
<tr>
<td>Komen Greater Kansas City Service Area</td>
<td>2,231</td>
<td>1,758</td>
<td>79.6%</td>
<td>77.3%-81.7%</td>
</tr>
<tr>
<td>White</td>
<td>1,875</td>
<td>1,463</td>
<td>79.5%</td>
<td>77.1%-81.8%</td>
</tr>
<tr>
<td>Black/African-American</td>
<td>286</td>
<td>239</td>
<td>82.7%</td>
<td>75.5%-88.1%</td>
</tr>
<tr>
<td>AIAN</td>
<td>16</td>
<td>11</td>
<td>28.3%</td>
<td>9.7%-59.2%</td>
</tr>
<tr>
<td>API</td>
<td>11</td>
<td>8</td>
<td>64.1%</td>
<td>18.2%-93.5%</td>
</tr>
<tr>
<td>Hispanic/ Latina</td>
<td>43</td>
<td>36</td>
<td>75.2%</td>
<td>51.3%-89.7%</td>
</tr>
<tr>
<td>Non-Hispanic/ Latina</td>
<td>2,182</td>
<td>1,718</td>
<td>79.7%</td>
<td>77.4%-81.8%</td>
</tr>
<tr>
<td>Atchison County - KS</td>
<td>34</td>
<td>18</td>
<td>49.8%</td>
<td>30.4%-69.2%</td>
</tr>
<tr>
<td>Brown County - KS</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>Doniphan County - KS</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>Douglas County - KS</td>
<td>138</td>
<td>111</td>
<td>80.4%</td>
<td>69.6%-88.0%</td>
</tr>
<tr>
<td>Jackson County - KS</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>Jefferson County - KS</td>
<td>25</td>
<td>20</td>
<td>86.7%</td>
<td>60.7%-96.5%</td>
</tr>
<tr>
<td>Johnson County - KS</td>
<td>844</td>
<td>690</td>
<td>82.6%</td>
<td>79.1%-85.6%</td>
</tr>
<tr>
<td>Leavenworth County - KS</td>
<td>115</td>
<td>84</td>
<td>70.7%</td>
<td>57.8%-80.9%</td>
</tr>
<tr>
<td>Miami County - KS</td>
<td>63</td>
<td>50</td>
<td>77.8%</td>
<td>61.5%-88.5%</td>
</tr>
<tr>
<td>Wyandotte County - KS</td>
<td>384</td>
<td>289</td>
<td>74.6%</td>
<td>67.4%-80.6%</td>
</tr>
<tr>
<td>Bates County - MO</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>Buchanan County - MO</td>
<td>104</td>
<td>80</td>
<td>79.2%</td>
<td>64.7%-88.7%</td>
</tr>
<tr>
<td>Cass County - MO</td>
<td>22</td>
<td>18</td>
<td>90.1%</td>
<td>63.2%-98.0%</td>
</tr>
<tr>
<td>Clay County - MO</td>
<td>49</td>
<td>41</td>
<td>86.5%</td>
<td>70.6%-94.5%</td>
</tr>
<tr>
<td>Jackson County - MO</td>
<td>384</td>
<td>305</td>
<td>79.1%</td>
<td>73.5%-83.7%</td>
</tr>
<tr>
<td>Johnson County - MO</td>
<td>45</td>
<td>36</td>
<td>72.5%</td>
<td>51.5%-86.8%</td>
</tr>
<tr>
<td>Platte County - MO</td>
<td>18</td>
<td>13</td>
<td>63.7%</td>
<td>35.2%-85.0%</td>
</tr>
</tbody>
</table>

SN – data suppressed due to small numbers (fewer than 10 samples).
Data are for 2012.
Source: CDC – Behavioral Risk Factor Surveillance System (BRFSS).
**Breast cancer screening proportions summary**

The breast cancer screening proportion in the Komen Greater Kansas City 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 Kansas and was not significantly different than the State of Missouri.

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 **significantly lower** among AIANs than Whites. The screening proportion among Hispanics/Latinas was not significantly different than among Non-Hispanic/Latinas.

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

- Atchison County, KS

The remaining counties had screening proportions that were not significantly different than the Affiliate service area as a whole.

**Population Characteristics**

The report includes basic information about the women in each area (demographic measures) and about factors like education, income, and unemployment (socioeconomic measures) in the areas where they live (Tables 2.4 and 2.5). Demographic and socioeconomic data can be used to identify which groups of women are most in need of help and to figure out the best ways to help them.

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

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

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

**Table 2.4. Population characteristics – demographics**

<table>
<thead>
<tr>
<th>Population Group</th>
<th>White</th>
<th>Black /African-American</th>
<th>AIAN</th>
<th>API</th>
<th>Non-Hispanic /Latina</th>
<th>Hispanic /Latina</th>
<th>Female Age 40 Plus</th>
<th>Female Age 50 Plus</th>
<th>Female Age 65 Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>78.8 %</td>
<td>14.1 %</td>
<td>1.4 %</td>
<td>5.8%</td>
<td>83.8 %</td>
<td>16.2 %</td>
<td>48.3 %</td>
<td>34.5 %</td>
<td>14.8 %</td>
</tr>
<tr>
<td>Kansas</td>
<td>88.9 %</td>
<td>6.8 %</td>
<td>1.4 %</td>
<td>2.9%</td>
<td>89.7 %</td>
<td>10.3 %</td>
<td>47.1 %</td>
<td>34.3 %</td>
<td>15.0 %</td>
</tr>
<tr>
<td>Missouri</td>
<td>84.6 %</td>
<td>12.7 %</td>
<td>0.6 %</td>
<td>2.1%</td>
<td>96.5 %</td>
<td>3.5 %</td>
<td>49.3 %</td>
<td>36.0 %</td>
<td>15.8 %</td>
</tr>
<tr>
<td>Komen Greater Kansas City Service Area</td>
<td>82.9 %</td>
<td>13.2 %</td>
<td>1.0 %</td>
<td>2.9%</td>
<td>92.4 %</td>
<td>7.6 %</td>
<td>46.6 %</td>
<td>33.0 %</td>
<td>13.5 %</td>
</tr>
<tr>
<td>Atchison County - KS</td>
<td>92.7 %</td>
<td>5.9 %</td>
<td>0.7 %</td>
<td>0.7%</td>
<td>97.8 %</td>
<td>2.2 %</td>
<td>48.3 %</td>
<td>36.1 %</td>
<td>17.3 %</td>
</tr>
<tr>
<td>Brown County - KS</td>
<td>87.2 %</td>
<td>2.4 %</td>
<td>9.9 %</td>
<td>0.5%</td>
<td>96.8 %</td>
<td>3.2 %</td>
<td>54.7 %</td>
<td>42.6 %</td>
<td>20.5 %</td>
</tr>
<tr>
<td>Doniphan County - KS</td>
<td>95.2 %</td>
<td>3.0 %</td>
<td>1.2 %</td>
<td>0.6%</td>
<td>97.8 %</td>
<td>2.2 %</td>
<td>52.0 %</td>
<td>38.6 %</td>
<td>18.5 %</td>
</tr>
<tr>
<td>Douglas County - KS</td>
<td>87.3 %</td>
<td>5.0 %</td>
<td>3.1 %</td>
<td>4.6%</td>
<td>94.7 %</td>
<td>5.3 %</td>
<td>36.8 %</td>
<td>26.2 %</td>
<td>10.3 %</td>
</tr>
<tr>
<td>Jackson County - KS</td>
<td>89.4 %</td>
<td>1.0 %</td>
<td>9.1 %</td>
<td>0.4%</td>
<td>96.5 %</td>
<td>3.5 %</td>
<td>52.9 %</td>
<td>38.8 %</td>
<td>16.9 %</td>
</tr>
<tr>
<td>Jefferson County - KS</td>
<td>97.9 %</td>
<td>0.8 %</td>
<td>1.0 %</td>
<td>0.3%</td>
<td>98.2 %</td>
<td>1.8 %</td>
<td>55.1 %</td>
<td>39.6 %</td>
<td>16.7 %</td>
</tr>
<tr>
<td>Johnson County - KS</td>
<td>89.5 %</td>
<td>5.1 %</td>
<td>0.6 %</td>
<td>4.8%</td>
<td>93.0 %</td>
<td>7.0 %</td>
<td>47.1 %</td>
<td>32.4 %</td>
<td>12.5 %</td>
</tr>
<tr>
<td>Leavenworth County - KS</td>
<td>88.6 %</td>
<td>8.2 %</td>
<td>1.0 %</td>
<td>2.3%</td>
<td>94.8 %</td>
<td>5.2 %</td>
<td>47.8 %</td>
<td>34.0 %</td>
<td>13.5 %</td>
</tr>
<tr>
<td>Miami County - KS</td>
<td>96.9 %</td>
<td>1.7 %</td>
<td>0.8 %</td>
<td>0.6%</td>
<td>97.5 %</td>
<td>2.5 %</td>
<td>51.2 %</td>
<td>35.9 %</td>
<td>14.7 %</td>
</tr>
<tr>
<td>Wyandotte County - KS</td>
<td>67.6 %</td>
<td>27.8 %</td>
<td>1.7 %</td>
<td>3.0%</td>
<td>75.1 %</td>
<td>24.9 %</td>
<td>42.5 %</td>
<td>30.1 %</td>
<td>12.2 %</td>
</tr>
<tr>
<td>Bates County - MO</td>
<td>97.8 %</td>
<td>1.1 %</td>
<td>0.8 %</td>
<td>0.3%</td>
<td>98.6 %</td>
<td>1.4 %</td>
<td>53.5 %</td>
<td>40.6 %</td>
<td>19.7 %</td>
</tr>
<tr>
<td>Buchanan County - MO</td>
<td>92.8 %</td>
<td>5.3 %</td>
<td>0.6 %</td>
<td>1.3%</td>
<td>95.0 %</td>
<td>5.0 %</td>
<td>48.4 %</td>
<td>35.7 %</td>
<td>16.5 %</td>
</tr>
<tr>
<td>Cass County - MO</td>
<td>94.1 %</td>
<td>4.1 %</td>
<td>0.7 %</td>
<td>1.0%</td>
<td>96.2 %</td>
<td>3.8 %</td>
<td>49.4 %</td>
<td>35.3 %</td>
<td>15.3 %</td>
</tr>
<tr>
<td>Clay County - MO</td>
<td>90.5 %</td>
<td>6.0 %</td>
<td>0.7 %</td>
<td>2.8%</td>
<td>94.3 %</td>
<td>5.7 %</td>
<td>46.5 %</td>
<td>32.1 %</td>
<td>12.8 %</td>
</tr>
<tr>
<td>Jackson County - MO</td>
<td>70.8 %</td>
<td>26.2 %</td>
<td>0.8 %</td>
<td>2.2%</td>
<td>92.1 %</td>
<td>7.9 %</td>
<td>47.1 %</td>
<td>33.9 %</td>
<td>14.3 %</td>
</tr>
<tr>
<td>Johnson County - MO</td>
<td>91.9 %</td>
<td>5.1 %</td>
<td>0.7 %</td>
<td>2.3%</td>
<td>96.6 %</td>
<td>3.4 %</td>
<td>39.8 %</td>
<td>28.1 %</td>
<td>11.6 %</td>
</tr>
<tr>
<td>Platte County - MO</td>
<td>89.5 %</td>
<td>6.7 %</td>
<td>0.7 %</td>
<td>3.1%</td>
<td>95.1 %</td>
<td>4.9 %</td>
<td>49.4 %</td>
<td>33.9 %</td>
<td>12.6 %</td>
</tr>
</tbody>
</table>

Data are for 2011.
Data are in the percentage of women in the population.
Source: US Census Bureau – Population Estimates
Table 2.5. Population characteristics – socioeconomics

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Less than HS Education</th>
<th>Income Below 100% Poverty</th>
<th>Income Below 250% Poverty (Age: 40-64)</th>
<th>Unemployed</th>
<th>Foreign Born</th>
<th>Linguistically Isolated</th>
<th>In Rural Areas</th>
<th>In Medically Underserved Areas</th>
<th>No Health Insurance (Age: 40-64)</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>14.6 %</td>
<td>14.3 %</td>
<td>33.3 %</td>
<td>8.7 %</td>
<td>12.8 %</td>
<td>4.7 %</td>
<td>19.3 %</td>
<td>23.3 %</td>
<td>16.6 %</td>
</tr>
<tr>
<td>Kansas</td>
<td>10.5 %</td>
<td>12.6 %</td>
<td>29.6 %</td>
<td>6.4 %</td>
<td>6.5 %</td>
<td>2.5 %</td>
<td>25.8 %</td>
<td>12.5 %</td>
<td>13.2 %</td>
</tr>
<tr>
<td>Missouri</td>
<td>13.2 %</td>
<td>14.3 %</td>
<td>34.4 %</td>
<td>8.1 %</td>
<td>3.8 %</td>
<td>1.3 %</td>
<td>29.6 %</td>
<td>22.9 %</td>
<td>15.4 %</td>
</tr>
<tr>
<td>Komen Greater Kansas City Service Area</td>
<td>9.6 %</td>
<td>12.2 %</td>
<td>27.1 %</td>
<td>7.4 %</td>
<td>6.2 %</td>
<td>2.3 %</td>
<td>12.3 %</td>
<td>5.1 %</td>
<td>13.4 %</td>
</tr>
<tr>
<td>Atchison County - KS</td>
<td>11.2 %</td>
<td>13.0 %</td>
<td>36.7 %</td>
<td>7.7 %</td>
<td>0.4 %</td>
<td>0.0 %</td>
<td>34.2 %</td>
<td>3.6 %</td>
<td>13.3 %</td>
</tr>
<tr>
<td>Brown County - KS</td>
<td>10.9 %</td>
<td>20.2 %</td>
<td>37.3 %</td>
<td>5.3 %</td>
<td>1.8 %</td>
<td>0.5 %</td>
<td>68.4 %</td>
<td>0.0 %</td>
<td>15.9 %</td>
</tr>
<tr>
<td>Doniphan County - KS</td>
<td>12.0 %</td>
<td>12.5 %</td>
<td>33.4 %</td>
<td>5.4 %</td>
<td>1.4 %</td>
<td>0.0 %</td>
<td>70.2 %</td>
<td>100.0 %</td>
<td>14.3 %</td>
</tr>
<tr>
<td>Douglas County - KS</td>
<td>4.7 %</td>
<td>19.0 %</td>
<td>27.0 %</td>
<td>7.0 %</td>
<td>6.6 %</td>
<td>2.2 %</td>
<td>11.0 %</td>
<td>0.0 %</td>
<td>12.4 %</td>
</tr>
<tr>
<td>Jackson County - KS</td>
<td>6.6 %</td>
<td>9.5 %</td>
<td>31.4 %</td>
<td>3.8 %</td>
<td>1.1 %</td>
<td>0.6 %</td>
<td>75.9 %</td>
<td>11.6 %</td>
<td>15.3 %</td>
</tr>
<tr>
<td>Jefferson County - KS</td>
<td>7.2 %</td>
<td>6.3 %</td>
<td>26.0 %</td>
<td>4.9 %</td>
<td>0.4 %</td>
<td>0.0 %</td>
<td>98.8 %</td>
<td>31.5 %</td>
<td>12.3 %</td>
</tr>
<tr>
<td>Johnson County - KS</td>
<td>4.4 %</td>
<td>5.9 %</td>
<td>14.9 %</td>
<td>4.9 %</td>
<td>8.1 %</td>
<td>2.5 %</td>
<td>3.8 %</td>
<td>0.0 %</td>
<td>8.0 %</td>
</tr>
<tr>
<td>Leavenworth County - KS</td>
<td>8.6 %</td>
<td>8.8 %</td>
<td>23.5 %</td>
<td>7.3 %</td>
<td>3.4 %</td>
<td>0.9 %</td>
<td>29.1 %</td>
<td>0.0 %</td>
<td>10.0 %</td>
</tr>
<tr>
<td>Miami County - KS</td>
<td>7.3 %</td>
<td>8.4 %</td>
<td>24.4 %</td>
<td>7.1 %</td>
<td>0.9 %</td>
<td>0.3 %</td>
<td>51.0 %</td>
<td>20.6 %</td>
<td>11.0 %</td>
</tr>
<tr>
<td>Wyandotte County - KS</td>
<td>21.4 %</td>
<td>21.9 %</td>
<td>44.7 %</td>
<td>12.7 %</td>
<td>14.2 %</td>
<td>7.2 %</td>
<td>6.1 %</td>
<td>8.7 %</td>
<td>20.7 %</td>
</tr>
<tr>
<td>Bates County - MO</td>
<td>17.2 %</td>
<td>16.7 %</td>
<td>42.4 %</td>
<td>8.4 %</td>
<td>1.0 %</td>
<td>0.2 %</td>
<td>77.3 %</td>
<td>6.3 %</td>
<td>18.3 %</td>
</tr>
<tr>
<td>Buchanan County - MO</td>
<td>13.8 %</td>
<td>15.8 %</td>
<td>37.6 %</td>
<td>7.3 %</td>
<td>2.9 %</td>
<td>1.4 %</td>
<td>13.4 %</td>
<td>29.0 %</td>
<td>14.7 %</td>
</tr>
<tr>
<td>Cass County - MO</td>
<td>8.1 %</td>
<td>7.9 %</td>
<td>25.5 %</td>
<td>6.1 %</td>
<td>2.1 %</td>
<td>0.6 %</td>
<td>32.4 %</td>
<td>0.0 %</td>
<td>12.6 %</td>
</tr>
<tr>
<td>Clay County - MO</td>
<td>8.1 %</td>
<td>7.8 %</td>
<td>23.4 %</td>
<td>5.9 %</td>
<td>4.7 %</td>
<td>1.4 %</td>
<td>9.8 %</td>
<td>0.0 %</td>
<td>11.9 %</td>
</tr>
<tr>
<td>Jackson County - MO</td>
<td>12.7 %</td>
<td>16.5 %</td>
<td>34.2 %</td>
<td>9.2 %</td>
<td>5.8 %</td>
<td>2.3 %</td>
<td>3.8 %</td>
<td>7.0 %</td>
<td>17.8 %</td>
</tr>
<tr>
<td>Johnson County - MO</td>
<td>8.9 %</td>
<td>16.4 %</td>
<td>33.2 %</td>
<td>8.0 %</td>
<td>2.7 %</td>
<td>0.7 %</td>
<td>50.4 %</td>
<td>7.3 %</td>
<td>14.4 %</td>
</tr>
<tr>
<td>Platte County - MO</td>
<td>5.9 %</td>
<td>7.1 %</td>
<td>18.4 %</td>
<td>6.0 %</td>
<td>5.5 %</td>
<td>1.8 %</td>
<td>15.8 %</td>
<td>0.0 %</td>
<td>9.0 %</td>
</tr>
</tbody>
</table>

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

Population characteristics summary
Proportionately, the Komen Greater Kansas City service area has a larger White female population than the US as a whole, a slightly smaller Black/African-American female population, a slightly smaller Asian and Pacific Islander (API) female population, a slightly smaller American Indian and Alaska Native (AIAN) female population, and a substantially smaller Hispanic/Latina female population. The Affiliate’s female population is slightly younger than that of the US as a whole. The Affiliate’s education level is higher than and income level is slightly higher than those of the US as a whole. There are a slightly smaller percentage of people who are unemployed in the Affiliate service area. The Affiliate service area has a substantially smaller percentage of people who are foreign born and a slightly smaller percentage of people who are linguistically isolated. There are a substantially smaller percentage of people living in rural areas.
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 Black/African-American female population percentages than that of the Affiliate service area as a whole:
- Wyandotte County, KS
- Jackson County, MO

The following counties have substantially larger AIAN female population percentages than that of the Affiliate service area as a whole:
- Brown County, KS
- Jackson County, KS

The following county has substantially larger Hispanic/Latina female population percentages than that of the Affiliate service area as a whole:
- Wyandotte County, KS

The following counties have substantially older female population percentages than that of the Affiliate service area as a whole:
- Brown County, KS
- Doniphan County, KS
- Bates County, MO

The following counties have substantially lower education levels than that of the Affiliate service area as a whole:
- Wyandotte County, KS
- Bates County, MO

The following counties have substantially lower income levels than that of the Affiliate service area as a whole:
- Brown County, KS
- Wyandotte County, KS

The following county has substantially lower employment levels than that of the Affiliate service area as a whole:
- Wyandotte County, KS

The county with substantial foreign born and linguistically isolated populations is:
- Wyandotte County, KS

The following county has substantially larger percentage of adults without health insurance than does the Affiliate service area as a whole:
- Wyandotte County, KS
Priority Areas

Healthy People 2020 forecasts

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

HP2020 has several cancer-related objectives, including:

- Reducing women’s death rate from breast cancer (Target as of the writing of this report: 20.6 cases per 100,000 women).
- Reducing the number of breast cancers that are found at a late-stage (Target as of the writing of this report: 41.0 cases per 100,000 women).

To see how well counties in the Komen Greater Kansas City service area are progressing toward these targets, the report uses the following information:

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

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

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

Identification of priority areas

The purpose of this report is to combine evidence from many credible sources and use the data to identify the highest priority areas for breast cancer programs (i.e. The areas of greatest need).

Classification of priority areas are based on the time needed to achieve HP2020 targets in each area. These time projections depend on both the starting point and the trends in death rates and late-stage incidence.

Late-stage incidence reflects both the overall breast cancer incidence rate in the population and the mammography screening coverage. The breast cancer death rate reflects the access to care and the quality of care in the health care delivery area, as well as cancer stage at diagnosis.
There has not been any indication that either one of the two HP2020 targets is more important than the other. Therefore, the report considers them equally important.

Counties are classified as follows (Table 2.6):

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

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

<table>
<thead>
<tr>
<th>Time to Achieve Death Rate Reduction Target</th>
<th>Time to Achieve Late-stage Incidence Reduction Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 years or longer</td>
<td>13 years or longer</td>
</tr>
<tr>
<td>Highest</td>
<td>Highest</td>
</tr>
<tr>
<td>High</td>
<td>Medium High</td>
</tr>
<tr>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Lowest</td>
<td>Lowest</td>
</tr>
<tr>
<td>Unknown</td>
<td>Highest</td>
</tr>
</tbody>
</table>

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

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

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

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

Trends can change for a number of reasons, including:

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

The data in this table should be considered together with other information on factors that affect breast cancer death rates such as screening percentages and key breast cancer death determinants such as poverty and linguistic isolation.
### Table 2.7. Intervention priorities for Komen Greater Kansas City service area with predicted time to achieve the HP2020 breast cancer targets and key population characteristics

<table>
<thead>
<tr>
<th>County</th>
<th>Priority</th>
<th>Predicted Time to Achieve Death Rate Target</th>
<th>Predicted Time to Achieve Late-stage Incidence Target</th>
<th>Key Population Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Douglas County - KS</td>
<td>Highest</td>
<td>13 years or longer</td>
<td>NA</td>
<td>%Black/African-American, %Hispanic/Latina education, poverty, employment, foreign, language, insurance</td>
</tr>
<tr>
<td>Wyandotte County - KS</td>
<td>Highest</td>
<td>13 years or longer</td>
<td>NA</td>
<td>%Black/African-American</td>
</tr>
<tr>
<td>Bates County - MO</td>
<td>Highest</td>
<td>13 years or longer</td>
<td>SN</td>
<td>Older, education, rural</td>
</tr>
<tr>
<td>Clay County - MO</td>
<td>Highest</td>
<td>13 years or longer</td>
<td>13 years or longer</td>
<td></td>
</tr>
<tr>
<td>Jackson County - MO</td>
<td>Highest</td>
<td>13 years or longer</td>
<td>13 years or longer</td>
<td>%Black/African-American</td>
</tr>
<tr>
<td>Johnson County - MO</td>
<td>Highest</td>
<td>13 years or longer</td>
<td>SN</td>
<td>Rural</td>
</tr>
<tr>
<td>Leavenworth County - KS</td>
<td>Medium High</td>
<td>11 years</td>
<td>NA</td>
<td>Rural</td>
</tr>
<tr>
<td>Cass County - MO</td>
<td>Medium High</td>
<td>5 years</td>
<td>13 years or longer</td>
<td>Rural</td>
</tr>
<tr>
<td>Buchanan County - MO</td>
<td>Medium</td>
<td>7 years</td>
<td>1 year</td>
<td>Medically underserved</td>
</tr>
<tr>
<td>Platte County - MO</td>
<td>Medium</td>
<td>Currently meets target</td>
<td>13 years or longer</td>
<td></td>
</tr>
<tr>
<td>Johnson County - KS</td>
<td>Medium Low</td>
<td>3 years</td>
<td>NA</td>
<td>Rural</td>
</tr>
<tr>
<td>Atchison County - KS</td>
<td>Undetermined</td>
<td>SN</td>
<td>NA</td>
<td>%AIAN, older, poverty, rural</td>
</tr>
<tr>
<td>Brown County - KS</td>
<td>Undetermined</td>
<td>SN</td>
<td>NA</td>
<td>Older, rural, medically underserved</td>
</tr>
<tr>
<td>Doniphan County - KS</td>
<td>Undetermined</td>
<td>SN</td>
<td>NA</td>
<td>%AIAN, rural, medically underserved</td>
</tr>
<tr>
<td>Jackson County - KS</td>
<td>Undetermined</td>
<td>SN</td>
<td>NA</td>
<td>Rural, medically underserved</td>
</tr>
<tr>
<td>Jefferson County - KS</td>
<td>Undetermined</td>
<td>SN</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Miami County - KS</td>
<td>Undetermined</td>
<td>NA</td>
<td>NA</td>
<td>Rural, medically underserved</td>
</tr>
</tbody>
</table>

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

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

Data Limitations

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

- The most recent data available were used but, for cancer incidence and deaths, these data are still several years behind.
- For some areas, data might not be available or might be of varying quality.
- Areas with small populations might not have enough breast cancer cases or breast cancer deaths each year to support the generation of reliable statistics.
• There are often several sources of cancer statistics for a given population and geographic area; therefore, other sources of cancer data may result in minor differences in the values even in the same time period.
• Data on cancer rates for specific racial and ethnic subgroups such as Somali, Hmong, or Ethiopian are not generally available.
• The various types of breast cancer data in this report are inter-dependent.
• There are many factors that impact breast cancer risk and survival for which quantitative data are not available. Some examples include family history, genetic markers like HER2 and BRCA, other medical conditions that can complicate treatment, and the level of family and community support available to the patient.
• The calculation of the years needed to meet the HP2020 objectives assume that the current trends will continue until 2020. However, the trends can change for a number of reasons.
• Not all breast cancer cases have a stage indication.

Quantitative Data Report Conclusions

Highest priority areas
Six counties in the Komen Greater Kansas City service area are in the highest priority category. Two of the six, Clay County, Missouri, and Jackson County, Missouri, are not likely to meet either the death rate or late-stage incidence rate HP2020 targets. Three of the six, Douglas County, Kansas, Wyandotte County, Kansas, and Bates County, Missouri, are not likely to meet the death rate HP2020 target. One of the six, Johnson County, Missouri, is not likely to meet the late-stage incidence rate HP2020 target.

Wyandotte County, Kansas, has a relatively large Black/African-American population, a relatively large Hispanic/Latina population, low education levels, high poverty level, high unemployment, a relatively large foreign-born population and a relatively large number of households with little English. Bates County, Missouri, has an older population and low education levels. Jackson County, Missouri, has a relatively large Black/African-American population.

Medium high priority areas
Two counties in the Komen Greater Kansas City service area are in the medium high priority category. One of the two, Cass County, Missouri, is not likely to meet the late-stage incidence rate HP2020 target. One of the two, Leavenworth County, Kansas, is expected to take 11 years to reach the death rate HP2020 target.

Selection of Target Communities

In order to be efficient stewards of resources, Susan G. Komen Greater Kansas City has chosen five target communities within the service area. The Affiliate will focus their strategic efforts on these target communities over the course of the next five years. Target communities are those communities which have cumulative key indicators showing an increased chance of
vulnerable populations likely at risk for experiencing gaps in breast health services and/or barriers in access to care.

When selecting target communities, the Affiliate reviewed Healthy People 2020, a major federal government initiative that provides specific health objectives for communities and the country as a whole. Specific to Komen Greater Kansas City’s work, goals around reducing women’s death rate from breast cancer and reducing the number of breast cancers found at a late-stage were analyzed. Through this review, areas of priority were identified based on the time needed to meet Healthy People 2020 targets for breast cancer.

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

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

The selected target communities are:

- Clay County, Missouri
- Jackson County, Missouri
- Johnson County, Missouri
- Northeast Kansas Region (Atchison, Brown, Doniphan, Jackson Counties)
- Wyandotte County, Kansas

Conclusions

**Clay County, Missouri**

Clay County is located within the immediate metropolitan area of Kansas City, Missouri. The annual average female population is 110,058. White women make up approximately 91 percent of the population; six percent of women are Black/African-American. Additionally, 5.7 percent of the population identify themselves as Hispanic/Latina.

Clay County has been chosen as a target community due to breast cancer death rates and trends, as well as the breast cancer incidence and late-stage diagnosis of breast cancer rates. It is also a high priority county based on the intervention times needed to meet Healthy People 2020 goals.

The county’s breast cancer incidence, death, and late-stage diagnosis rates are all higher than the United States, as well as the service area’s averages. Additionally, trends in data show these incidence rates and late-stage diagnosis rates are getting higher. Simultaneously, the breast cancer death rates are lowering.
The increasing trend of late-stage diagnosis rates is concerning. This suggests a substantial likelihood that more women will be diagnosed at a late-stage. Late-stage diagnosis complicates treatment and can lead to a poorer prognosis for survival.

On the plus side, Clay County women (ages 50-74) self-reported obtaining a screening mammogram within the last two years at a rate higher than the service area and the United States averages. The increase in incident rate may be correlated to the above average mammography screening percentage in Clay County.

A health systems review will analyze the availability of services in Clay County. Although it is located in the immediate metropolitan area, many residents are not able or prefer not to make the trip to central Kansas City, Missouri, where many no/low cost breast health services are available. An accurate picture of what services are available north of the river to residents in the service area is needed.

**Jackson County, Missouri**

Jackson County, Missouri, is in the immediate metropolitan area of Kansas City, Missouri, and is a high priority county in regards to meeting the Healthy People 2020 goals. Jackson County has been chosen as a target community due to rates and trends regarding breast cancer deaths, as well as the rates of breast cancer incidence and late-stage diagnosis. Additionally, Jackson County residents reflect a diverse population with many women who may be more vulnerable to breast cancer due to known poorer prognosis rates (i.e., late-stage diagnosis or more aggressive cancers). Finally, compared to the service area average, more residents in this county are living below 250.0 percent poverty, have higher unemployment, and are less likely to have health insurance making affordable access to breast health care potentially difficult.

The female population in Jackson County is 344,786. The county has the largest female population of any county in the Affiliate service area. It represents 31.0 percent of the service area’s total female population; and is more diverse than many of the other counties. For instance, 26.2 percent of females in the county are Black/African-American. This is almost double the service area average and is also substantially higher than the United States average. Additionally, 7.9 percent are Hispanic/Latina.

Data for Jackson County show the breast cancer death and late-stage diagnoses rates are currently higher than both the United States’ and the service area’s average rates. However,
there are promising trends in the rates of incidence, deaths from breast cancer and late-stage diagnoses. All categories are expected to show lowering rates in upcoming years.

<table>
<thead>
<tr>
<th></th>
<th>Jackson County</th>
<th>Service Area Rate</th>
<th>US Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidence Rate*</td>
<td>123.4</td>
<td>126.7</td>
<td>122.1</td>
</tr>
<tr>
<td>Death Rates*</td>
<td>26.7</td>
<td>24.9</td>
<td>22.6</td>
</tr>
<tr>
<td>Late-stage Rates*</td>
<td>49.9</td>
<td>47.5</td>
<td>43.7</td>
</tr>
</tbody>
</table>

*Rates are age-adjusted and are figured per 100,000 women

Women in Jackson County, ages 50-74, have reported obtaining a screening mammogram at a rate comparable to the service area average. This is positive since mammography can facilitate early detection.

**Johnson County, Missouri**

Johnson County, Missouri, is located at the far eastern edge of the service area and is considered to be a rural county. It has been chosen as a target community due to higher than average breast cancer death rates, late-stage diagnosis rates and an increasing trend in incidence rates. In the Affiliate’s 17-county service area, Johnson has one of the highest death rates and the highest rates of late-stage breast cancer diagnosis. Consequently, Johnson County has also been identified as a high priority county due to the amount of time needed to meet the Healthy People 2020 goals.

The female population of the county is 25,795. White females make up 91.9 percent of the county population; 5.1 percent are Black/African-American; and 3.4 percent identify as Hispanic/Latina. When comparing demographics, both of these latter percentages are below the service area averages.

Johnson County currently has breast cancer incidence rates lower than both the United States and service area averages. However, trends show incidence rates increasing. Also problematic, both breast cancer death and late-stage diagnosis rates are above the United States and service area averages, with an increasing trend for late-stage diagnosis. No data are available for trends related to the death rates from breast cancer.

<table>
<thead>
<tr>
<th></th>
<th>Johnson County</th>
<th>Service Area Rate</th>
<th>US Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidence Rate*</td>
<td>117.7</td>
<td>126.7</td>
<td>122.1</td>
</tr>
<tr>
<td>Death Rates*</td>
<td>30.6</td>
<td>24.9</td>
<td>22.6</td>
</tr>
<tr>
<td>Late-stage Rates*</td>
<td>50.6</td>
<td>47.5</td>
<td>43.7</td>
</tr>
</tbody>
</table>

*Rates are age-adjusted and are figured per 100,000 women

With a screening percentage in Johnson County below the United States and service area averages, it is possible women are experience barriers to receiving mammography screening. This may be associated with higher rates of late-stage diagnoses and more women dying from breast cancer. It may also explain the lower rates of incidence.
Review of available breast health services in Johnson County is crucial. Although Warrensburg, Missouri, is located within Johnson County; many residents still live in rural areas and may not have easy access to health centers. Additionally, many residents are unable or prefer not to come to the metropolitan area to seek services. The ability to receive no cost services through the Missouri Show Me Healthy Women program (National Breast and Cervical Cancer Early Detection Program) will be explored in the health systems analysis.

**Northeast Kansas Region, Kansas**  
*(Atchison, Brown, Doniphan, Jackson Counties, Kansas)*

Due to small population sizes, data have been suppressed for many of Northeast Kansas counties. These counties have been combined into one region for the purpose of this report and for the Affiliate’s targeted efforts. The Northeast Kansas Region is located in eastern Kansas and aligns with the Missouri state border. All counties in the region are considered rural.

These counties have been chosen due to low screening percentages, unique population demographics, and identification as medically underserved and having lower income levels.

Although, the demographic makeup of this region’s female residents is primarily White; several American Indian reservations are located in the region. In the past, breast cancer in American Indians was rare. Unfortunately, the last two decades have seen large increases in both incidence and death rates for this group of women. Incidence and death rates are still lower than among white or African-American women, and rates do vary according to where in the country women live (Komen, 2014). American Indian women make up 9.1 percent of women residing in Jackson County, Kansas, and 9.9 percent of women living in Brown County, Kansas. This is nine times higher than the service area average and substantially higher than the United States average.

Due to small numbers, reported screening percentages for many of the region’s counties are not available. However, Atchison County has significantly lower screening levels than any other county in the Affiliate’s entire service area. Only 49.8 percent (Confidence interval 30.4 percent-69.2 percent) of women 50-74, living in Atchison has reported a screening mammogram within the last two years.

Finally, socioeconomic characteristics of the region indicate a potential concern about women’s access to affordable breast health care. All counties in the region, with the exception of Jackson County, Kansas, have substantially higher percentages of residents living below 250 percent poverty income than the service area average. Additionally, Doniphan County is considered to be in a medically underserved area compounding potential barriers to breast health care. Only two providers in the entire region participate in the National Breast and Cervical Cancer Early Detection Program; and one of those providers is limited to only providing services to American Indian women.
The health systems analysis component of this report will take a deeper look at the available breast health services in the region. Due the region’s rural nature and one county being designated as medically underserved, it is vitally important to gain a clear understanding of how accessible breast health services are in the region.

**Wyandotte County, Kansas**

Wyandotte County, Kansas is comprised largely of the city of Kansas City, Kansas. It is an urban county located adjacent to the Missouri border. The county’s 78,840 women represent the most diverse population in the service area. Of these women, 27.8 percent are Black, a rate higher than the national average and double that of the service area average. This is significant due to the high death rates Black/African-American women experience from breast cancer when compared to other races. Additionally, 24.9 percent of the county is Hispanic/Latina, 7.2 percent are linguistically isolated, and 14.2 percent are foreign born. All of these percentages are substantially higher than the service area’s averages.

Wyandotte has been identified as a high priority county due to the amount of intervention time needed to achieve the HP2020 targets. For instance, the county’s death rate of breast cancer was 28.5 per 100,000 women. This is higher than the United States rate (22.6), as well as the service area’s rate (24.9).

The death rate is expected to decrease over the next few years. But currently, the county continues to have one of the highest rates of breast cancer death in the service area. Data showing late-stage diagnosis rates and trends were not available for this county.

The screening percentage in Wyandotte County is lower than the United States; and service area averages and socioeconomic data for the county show several concerning areas. Wyandotte residents are substantially more likely to have less than a high school education, an income below 250.0 percent poverty, and be unemployed than others in the United States and the service area. Wyandotte County residents are also the least likely in the service area to have health insurance.

Although Wyandotte County is in the immediate metropolitan area where services are more likely to be readily available, a health systems analysis will provide a deeper look at any underserved areas in Wyandotte County. Based on shared data regarding diversity and trends in Wyandotte County, it appears many residents would benefit from services within their neighborhoods that are no-cost or reduced cost, culturally sensitive, and easily accessible. The actual availability of these services will be reviewed in a health systems analysis.
Health Systems Analysis Data Sources

Komen Greater Kansas City utilized multiple sources to collect data for an analysis on the breast health systems of the service area. The information and data collected from these resources were obtained and analyzed in order to create an accurate depiction of the systems and services impacting breast health in the target communities of the Greater Kansas City area.

Identifying services available in target communities allows Komen Greater Kansas City to understand the strengths and opportunities for growth in each county. This includes all aspects of breast health and care, revealing where the counties are excelling and any gaps that may be present. The following sources were utilized to identify services available in Susan G. Komen of Greater Kansas City’s target counties:

- **Mammography centers**: U.S. Food and Drug Administration (http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfMQSA/mqsa.cfm)
- **Hospitals**: Medicare (https://data.medicare.gov/Hospital-Compare/Hospital-General-Information/v287-28n3)
- **Health Departments**: National Association of County and City Health Officials (http://www.naccho.org/about/lhd/)
- **Community Health Centers**: Health Resources and Services Administrations (http://findahealthcenter.hrsa.gov/Search_HCC.aspx)
- **Free Clinics**: National Association of Free and Charitable Clinics (http://www.nafcclinics.org/clinics/search)

Analyzing the quality of care available is vital in order to grasp the state of breast health in a community. The following sources were utilized to identify the Quality of Care Certifications and Accreditations of the facilities:

- **American College of Surgeons Commission on Cancer** (http://datalinks.facs.org/cpm/CPMApprovedHospitals_Search.htm)
- **American College of Radiology Centers of Excellence** (http://www.acr.org/Quality-Safety/Accreditation/Accredited-Facility-Search)
- **American College of Surgeons National Accreditation Program for Breast Centers (NAPBC)** (http://napbc-breast.org/resources/find.html)
- **National Cancer Institute Designated Cancer Centers** (http://www.cancer.gov/researchandfunding/extramural/cancercenters/find-a-cancer-center)

Finally, public policy has a major impact on breast health. The following sources were utilized to analyze the public policies impacting Komen Greater Kansas City’s service area:

- Kaiser Family Foundation
- Early Detection Works
• Show Me Healthy Women
  (http://health.mo.gov/living/healthcondiseases/chronic/showmehealthywomen/)
• MO Cancer (http://www.mocancer.info)
• Cancer Kansas (http://www.cancerkansas.org/cancer_plan.htm)

For full reference list and more information, please see the References section of the Community Profile.

**Health Systems Overview**

**Continuum of Care**

Assurance of quality care is vital to successful breast cancer outcomes. The Breast Cancer Continuum of Care (CoC) provides a protocol of care for breast cancer services from screening to follow-up care (survivorship) (Figure 3.1). Although not all organizations are able to provide all breast health services, organizations should be able to refer a patient, as needed, to the appropriate resource.

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

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

The CoC begins with education. Education on breast self-awareness should lead to women entering into the CoC by getting screened. Women with normal results should be given follow-up care, including reminders to return annually to be screened. However, if a woman receives an abnormal reading in the screening process, she should be moved to the diagnosis stage which may include further imaging and/or a biopsy. If a diagnosis is made, the woman should be moved into the treatment phase of the continuum. Once treatment is finished, she should receive follow-up care, including support and survivorship, and continue to receive screening at the recommended intervals. If a woman does not receive a diagnosis, she too will return to the follow-up care phase. Education covering all aspects of breast health and breast cancer should be integrated into each stage of the continuum.
Through the lens of the Breast Cancer Continuum of Care, target communities can be analyzed based on their health system’s ability to follow through with quality breast health care and treatment. This is vital in understanding where gaps and barriers in services lie. These gaps and barriers can influence breast cancer statistics and survival rates.

**Analysis by Target Community**

**Clay County, Missouri**

Clay County has a substantial amount of breast health services available to residents (Figure 3.2). Multiple hospitals provide a full CoC for breast cancer. However, Clay County also has a relatively high number of breast cancer deaths and late-stage diagnosis rate. However, considering that the screening percentage in this county is not significantly different than the service area’s average, a strong emphasis must be placed on navigation, diagnosis, and treatment of breast cancer. In addition, the analysis reveals that the majority of breast health services, particularly treatment, are in the Southwest region of the county, centered in North Kansas City and Liberty. Those in other regions of the county have very few readily accessible breast health services. Perhaps priorities in the future may need to focus on removing nonfinancial barriers to care and looking at ways to easily extend services to the entire county. Additional partnerships with hospitals serving Clay County, health centers, and other non-profits need to be explored.

**Jackson County, Missouri**

As seen through mapping of services, Jackson County has breast health resources all along the CoC (Figure 3.3). Kansas City, Missouri, and the immediate area have numerous health centers providing screening, diagnostics, treatment, and support. However, urban Jackson County remains a target area due to late-stage diagnosis rates, education levels, poverty levels, and hard to reach populations. Therefore, Komen Greater Kansas City works with multiple partners to provide better access to breast health to the least reached populations of Jackson County.

Komen Greater Kansas City grantee and partner Samuel U. Rodgers Health Center provides breast cancer screenings to underserved populations. This program serves women who are uninsured and underinsured and primarily targets Black/African-American, Hispanic/Latina, Vietnamese, and Somali populations. Samuel U. Rodgers also provides community outreach and education, diagnostic services, referrals, and case management. Komen Greater Kansas City also partners with Truman Medical Center to reduce barriers to care in Jackson County. Truman Medical Center’s Patient Navigator program is dedicated to ensuring that individuals receive support and guidance throughout the CoC. Truman Medical Center provides women with a variety of support services including financial assistance, language interpretation, nutritional and physical fitness, and transportation.

Through these partnerships, Komen Greater Kansas City hopes to create a community where those below the poverty line have equal access to care. Komen Greater Kansas City has begun to create partnerships throughout the metropolitan area with non-health organizations to reach low-income women in their communities, at their residences, and through organizations at which
they seek other types of financial support. These types of partnerships will continue to be developed in the community.

**Johnson County, Missouri**

Johnson County, Missouri, lacks the breast health services of the metropolitan regions of Komen Greater Kansas City’s service area. With the only health department and hospital located in Warrensburg, Missouri, any residents not living in this city lack convenient access to services (Figure 3.4). Western Medical Center in Warrensburg partners with Saint Luke’s Hospital to provide diagnostic and screening services, as well as a biweekly oncology clinic providing physicians, infusion therapy, and labs. However, patients needing radiation therapy are sent to Saint Luke’s East in Lee’s Summit, Missouri. Residents in Johnson County, Missouri, have limited access to treatment and survivorship services, forcing them to travel to the nearby cities in order to receive adequate care. Johnson County Cancer Foundation provides financial assistance to cancer patients. However, barriers such as transportation are not only financial in nature.

Johnson County Missouri is the only target community that Komen Greater Kansas City does not have a strong presence in. Although Komen Greater Kansas City has established partnerships with the local hospital and has served on the community health needs assessment committee, establishing additional long-lasting relationships is a priority. Komen Greater Kansas City hopes to find partners in this community in the future to provide breast health education and barrier-reducing services. Central Missouri State University, health centers, and other non-profit organizations will be key to making changes to breast health trends in this community.

**Northeast Kansas**

Atchison, Brown, Doniphan, and Jackson Counties make up the target community of the Northeast Region of Kansas. This rural area of Kansas, while having a hospital and health department in each county, lacks readily accessible services along the complete CoC (Figure 3.5). Residents of this area without independent transportation would most likely be unable to receive any breast care without assistance. In addition, Atchison County, Kansas has the lowest screening level in Komen Greater Kansas City’s entire service area.

Komen Greater Kansas City partners with the University of Kansas Endowment - Healthy Living Kansas program. This program promotes screening education in the rural areas of Kansas and creates awareness while reducing access barriers for those in this underserved region. Additionally, a strong partnership exists between Komen Greater Kansas City and Atchison Hospital. While these efforts are vital, Komen Greater Kansas City hopes to create more partnerships that remove barriers to care in Northeast Kansas such as those focusing on transportation and patient navigation. Partnerships in counties outside of Atchison County, Kansas will need to be strengthened to impact women in all areas of the community. Partnerships to be explored include relationships with local health departments, American Indian reservations, and other health providers.

**Wyandotte County, Kansas**
As seen through mapping of services, Wyandotte County has breast health resources all along the CoC (Figure 3.6). Komen Greater Kansas City partners with several organizations to ensure these services are funded. Despite the resources available, breast health screening percentage and late-stage diagnosis in Wyandotte County remain a concern. Low income, racial and ethnic disparities, and lack of insurance continue to create barriers in this area.

Komen Greater Kansas City has identified these barriers and provides partnership and funding to multiple organizations in Wyandotte County. Socioeconomic concerns are addressed through Komen Greater Kansas City grantees. Komen Greater Kansas City funds the Kansas Department of Health and Environment's Early Detection Works Program, which provides breast cancer screening and diagnostic services to Kansas women who qualify based on income guidelines. Unified Government Public Health Department also has Komen funded programming focusing on the limitations that uninsured and socioeconomically challenged women in Wyandotte County have in accessing preventative screening services. Komen grants funding to Cancer Action- an organization located in Wyandotte County that provides survivorship support services to women with breast cancer. Cancer Action also reduces barriers to care by providing financial assistance and transportation to care.

Multiple Komen partnerships focus on ethnic and racial groups that are underserved in Wyandotte County. The Latina population in Wyandotte County has many barriers to accessing breast health including the lack of culturally sensitive breast health education. Komen grantee Coalition of Hispanic Women Cancer provides a comprehensive breast cancer program to increase awareness and knowledge among Latinas about breast cancer risk reduction, early detection, cancer screenings, and available community resources. KU Endowment- Healthy Living Kansas also has breast health education efforts in Wyandotte County focusing on removing barriers for Latina Women. In addition, Komen grantee YMCA of Greater Kansas City provides health education to Hispanic/Latino men and women and reduces fragmentation in the breast cancer continuum through effective partnerships in Wyandotte County. Komen Greater Kansas City has a goal to partner with these groups to create a more comprehensive, cohesive system of navigating the COC for Latina women.

Komen Greater Kansas City was also a founding organization of a Wyandotte County breast health taskforce focusing on the disparities impacting African-Americans in Wyandotte County. Komen Greater Kansas City is working with over 20 organizations to identify and remove barriers of care to this underserved population. Komen Greater Kansas City will continue to build on these partnerships in order to create a Wyandotte County with accessible breast health for all.
Figure 3.2. Breast Cancer Services Available in Clay County
Figure 3.3. Breast Cancer Services Available in Jackson County
Figure 3.4. Breast Cancer Services Available in Johnson County
Figure 3.5. Breast Cancer Services Available in Northeast Kansas
Figure 3.6. Breast Cancer Services Available in Wyandotte County
Public Policy Overview

National Breast and Cervical Cancer Early Detection Program (NBCCEDP)
The Centers for Disease Control and Prevention (CDC) provides low-income, uninsured, and underserved women access to timely, high-quality screening and diagnostic services through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). Through the NBCCEDP, uninsured women under age 65 who are diagnosed with cervical or breast cancer may have access to full Medicaid benefits under the Breast and Cervical Cancer Prevention and Treatment Act of 2000.

Missouri
Show Me Healthy Women (SMHW)
The NBCCEDP in Missouri, Show Me Healthy Women (SMHW), is managed by the Department of Health and Senior Services. The objective of the SMHW program is to offer screening services to women who are considered high risk. Show Me Healthy Women defines a woman to be at “high risk” if she meets one of the following criteria: women with low income, women over 50, women with no or little insurance, women who have rarely or never been screened, rural women, women of color, and women with disabilities.

Show Me Healthy Women is funded through a federal grant provided by the CDC. It also receives funding from the state general fund and has previously been funded by Komen Affiliates. Additionally, Missouri also has a pink license plate fund which is administered by the Department with a portion of proceeds being donated back to the program.

Women are enrolled into Show Me Healthy Women through a visit with a qualified provider of the program. Providers can be found by calling the Show Me Healthy Women hotline number or visiting the Show Me Healthy Women website. The qualified provider will be able to enroll women by answering questions regarding their age, income, and insurance status. The following women are eligible for SMHW:
- Age 35 to 64, or older if they do not receive Medicare Part B, and
- No insurance to cover program services
- Meeting the following incomes:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>2014 Poverty Guideline (Yearly Income)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$23,340</td>
</tr>
<tr>
<td>2</td>
<td>$31,460</td>
</tr>
<tr>
<td>3</td>
<td>$39,580</td>
</tr>
<tr>
<td>4</td>
<td>$47,700</td>
</tr>
<tr>
<td>5</td>
<td>$55,820</td>
</tr>
<tr>
<td>6</td>
<td>$63,940</td>
</tr>
<tr>
<td>7</td>
<td>$72,060</td>
</tr>
<tr>
<td>8</td>
<td>$80,180</td>
</tr>
</tbody>
</table>

For families/households with more than eight persons, add $8,120 for each additional person. Based on the U.S. Census Bureau population estimates in 2012, 119,364 Missouri women aged
35-64 (10.1 percent) are eligible for SMHW services. Statewide, SMHW provides services for about 9,000 to 10,000 women each year, identifying about 200 breast cancer cases.

SMHW has worked closely with the MO HealthNet (Missouri Medicaid) program since 2001, when legislation was signed for Missouri to participate in the Missouri Medicaid program. Since this time, free diagnostic or treatment services are available through MO HealthNet to women who are U.S. citizens and diagnosed with breast or cervical abnormalities or cancer by a Show Me Healthy Women provider. Once enrolled, the women are qualified for full MO HealthNet benefits along with medical services for cancer care during their need for treatment.

Komen Greater Kansas City is officially listed as a partner of SMHW, as are Susan G. Komen’s Mid-Missouri and St. Louis Affiliates. In addition, Komen Greater Kansas City’s Community Outreach Director has been serving as the Show Me Healthy Women Advisory Board Chair as of 2014. Both current partnerships and future endeavors allow the Affiliate to provide input on the state screening program, assist women with finding a provider to enroll into the program with, and advocate for the program at the state and federal level. All of these action items will strengthen collaborative efforts with SMHW.

**Kansas**

*Early Detection Works (EDW)*

NBCCEDP in Kansas, Early Detection Works (EDW) is managed by the Kansas Department of Health and Environment (KDHE). The EDW program components include public and professional education, screening, diagnosis, case management, quality assurance and referral for cancer treatment. The educational component is directed toward all women who are residents of Kansas. Additionally, low-income, medically underserved women are provided with cancer screenings free of charge. If screening results are abnormal, EDW will pay for some diagnostic procedures. If breast cancer is diagnosed after a documented woman is enrolled in EDW, an expedited referral to Medicaid for temporary coverage during treatment will occur.

EDW is funded through a grant from the CDC. They also receive some funding from the State of Kansas general fund. Additionally, Komen Greater Kansas City has been funding EDW since 2009. EDW currently covers women ages 40 – 64 who do not have health insurance or inpatient only insurance with a high, unmet deductible. Women are enrolled into EDW by calling a toll-free number, or local number for their regional office, and completing an eligibility screening over the phone. Women who are eligible for the program are then connected with a participating provider that is closest to them.

The Early Detection Works program pays for breast and cervical cancer screening services for Kansas women who:

- Are at least 40 years old but no more than 64 years. *(limited services for women under 40)*
- Do not have insurance or have a major medical hospitalization only with a $250 unmet deductible. Women who have Medicare Part B or Medicaid/MediKan are not eligible.
• Have this much family income or less (Add an additional $8,150 for each person):

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Annual Income Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$23,925</td>
</tr>
<tr>
<td>2</td>
<td>$32,075</td>
</tr>
<tr>
<td>3</td>
<td>$40,225</td>
</tr>
<tr>
<td>4</td>
<td>$48,375</td>
</tr>
<tr>
<td>5</td>
<td>$56,525</td>
</tr>
<tr>
<td>6</td>
<td>$64,675</td>
</tr>
<tr>
<td>7</td>
<td>$72,825</td>
</tr>
<tr>
<td>8</td>
<td>$80,975</td>
</tr>
</tbody>
</table>

Currently, in order to enroll for the program, women must call the state toll free number and complete a questionnaire over the phone. At that time, if she qualifies, an eligibility number will be provided in order for her to receive services at a qualifying health center. As the state continues to transfer over to an electronic records system, providers will be able to directly enroll women at their health centers in the near future.

Komen Greater Kansas City currently has a strong working relationship with EDW. Komen Greater Kansas City transfers community screening inquiry phone calls directly to EDW to screen for eligibility and enroll if possible. The Affiliate also serves on several taskforces and coalitions with staff from EDW allowing partnerships to occur on many levels. Early Detection Works also provides a direct link to many of the providers in Kansas, particular in Northeast Kansas, where strong relationships are ready to be established in the near future. Komen Greater Kansas City intends to continue to foster this relationship in the years to come.

**State Comprehensive Cancer Control Coalitions**

The CDC started the National Comprehensive Cancer Control Program (NCCCP) to help states, tribes, and territories form coalitions to fight cancer. Missouri and Kansas both have State Comprehensive Cancer Control (CCC) Coalitions. These coalitions create and implement action plans in order to reduce cancer and enhance survivorship in their respective states.

The Missouri Cancer Control Unit is managed through the Missouri Department of Health and Senior Services. This Unit released “The Burden of Cancer in Missouri- A Comprehensive Analysis and Plan” for the years 2010-2015. This plan includes one objective relevant to breast cancer screening:

*GOAL: Increase early detection and appropriate screening for cancer using evidence-based guidelines*

**Objective 1:** Increase the percentage of women who receive regular breast cancer screenings

**Measure:** Women over 50 who receive a screening mammogram in the past one or two years from 83.9 percent in 2008 to 90.0 percent in 2015 (BRFSS)
**Target Audience:** Missouri women ages 40 and over

**Strategies:**
1. Promote evidence-based interventions and recommended screening/early detection exams according to the American Cancer Society (ACS) guidelines
2. Disseminate information about Show Me Healthy Women and other breast and cervical screening services to all Missourians
3. Promote statewide and local media campaigns about the need for recommended breast and cervical cancer screening exams according to ACS
4. Increase health care providers’ awareness of current cancer screening guidelines and follow-up recommendations
5. Analyze health insurance coverage for cancer screening/early detection exams to determine coverage needs in legislative process
6. Disseminate culturally sensitive information related to cancer screening/early detection
7. Identify geographic disparities to increase utilization

The Missouri Cancer Control Unit also aligns its goals with Healthy People 2020 objectives, including a goal to decrease late-stage breast cancer diagnosis in Missouri from 43.9 to 41.0 per 100,000 by the year 2020.

The Kansas Comprehensive Cancer Control and Prevention Program, through Kansas Department of Health and Environment, aligns their goals with their “Kansas Cancer Prevention and Control Plan” for years 2012-2016. The following objectives contained in the plan directly impact breast cancer:

- **Objective:** Increase the percent of women who receive breast cancer screening based on nationally recognized guidelines.
- **Objective:** Increase the percentage of adults with a family history of cancer who have discussed with their health care provider whether or not to receive genetic counseling.
- **Objective:** Decrease the time between initial visit with a suspicious finding to a definitive diagnosis and treatment to less than 30 days.

While both Kansas and Missouri Cancer Control and Prevention Plans have objectives related to breast cancer, these State Cancer Control Coalitions currently have a strong emphasis on smoking cessation. Komen has representatives in both Kansas (Komen Kansas representative) and Missouri (Komen Greater Kansas City representative) working with these coalitions, monitoring efforts and engaging in breast-health relevant meetings and discussions. Komen Affiliates in both states work closely together to keep each other informed on the state cancer plans and situations in which a strong Affiliate presence is needed. Particularly in Kansas, Komen Greater Kansas City works closely with Komen Kansas who serves on many of the cancer committees. Komen will continue to build on this relationship and serve as an advocate for breast cancer to the states.
**Affordable Care Act**

The Affordable Care Act (ACA) works to expand access to care through insurance, enhance the quality of health care, improve coverage for those with insurance, and make health care more affordable. ACA mandates health insurance for Americans (with a few exemptions). ACA prohibits denying coverage based on pre-existing conditions, annual or lifetime caps, and rescinding coverage. It also establishes minimum benefit standards and coverage for preventative services. In both Kansas and Missouri, a federally administered plan was chosen as the method for the insurance exchange program.

For breast cancer, ACA impacts all parts of the continuum of care. ACA includes breast cancer education for young women, mammography as a required benefit, and increased access to clinical trials and patient navigation. Eliminating pre-condition exclusions and lifetime and annual caps are also vital for breast cancer treatment and follow-up care.

Despite these positive changes, gaps will still exist. Undocumented immigrants, un-enrolled Medicaid eligible individuals, those exempt from the mandate, and those that choose not to enroll will remain without insurance. It is estimated that this will make up 30 million Americans that will remain uninsured in 2016.

Because Missouri and Kansas chose not to expand Medicaid, a coverage gap is left of people making too little to qualify for federal help (Figure 3.7). The authors of ACA intended these individuals to be covered by Medicaid expansion, but both states in the Affiliate service area opted to not expand. Therefore, most of Kansas and Missouri’s poorest, working-age residents — those under age 65 and below the poverty line of $11,490 for an individual and $15,510 for a couple — aren’t eligible for government help. In Kansas, there are currently 369,000 uninsured individuals- 78,000 in Kansas (21.0 percent of uninsured) who would have been eligible for Medicaid if the state expanded will fall into the coverage gap. In Missouri, 93,000 of the 834,000 uninsured adults (11.0 percent of the uninsured) will fall into this gap.

![Figure 3.7. Insurance Eligibility](image-url)
This coverage gap, as well as the previously mentioned exempt groups, will be a target population for Komen Greater Kansas City as the Affordable Care Act goes into full effect. The Affiliate will likely find the need to re-strategize due to implications of the ACA. 1.7 million American women will remain uninsured and will be eligible for breast screening through NBCCEDP. These women will most likely be more difficult to reach than those currently using these services (i.e., undocumented women may have limited English). Because of this and the newly required coverage of screening, Komen Greater Kansas City’s funding priorities may change. Education and patient navigation will be increasingly important to navigate the increasingly complex systems as well as the need for financial assistance with diagnostic services not covered by the ACA.

Additionally, it will be important to continually educate the public on how the ACA has affected programs such as NBCCEDP. It is known that the implementation of ACA will not eliminate the need for Early Detection Works and Show Me Healthy Women program. It will be important for Komen Greater Kansas City and other partners to continue to educate on the need for sustainable funding of these programs in the future.

In addition, providers will find major changes to their practices based on ACA. The need for breast cancer diagnostics and treatment will increase as screening levels go up. Providers may need to adjust to higher screening percentages, creating difficulties with the ability to provide for all women who seek these services. Electronic Medical Records are also required through the ACA which causes need for new equipment, further funding, and new training of employees. However, at this time, the full future impacts of ACA are unknown. This will require Komen Greater Kansas City to be adaptable in the coming years as patients and providers adjust to the changes.

**Affiliate’s Public Policy Activities**

Komen Greater Kansas City continues to be an active advocate for public policy initiatives that will further breast health care, research and treatment. This includes maintaining relationships with representatives in both Missouri and Kansas. In addition, Komen Greater Kansas City works to establish and strengthen relationships with other cancer advocacy groups, collaborating to create the most efficient advocacy efforts.

In 2013, Komen Greater Kansas City became a part of The Missouri Coalition for Cancer Treatment Access, a coalition focusing on coverage for oral anti-cancer drugs. Leukemia and Lymphoma Society established this coalition, with Komen Greater Kansas City representatives being a partner from its conception. Other organizations involved in The Missouri Coalition for Cancer Treatment Access include St. Louis Breast Cancer Coalition, International Myeloma Foundation, American Cancer Society Cancer Action Network, Komen St. Louis, and Komen Mid-Missouri. Together, these organizations educated and urged state legislators to pass legislation to assure that oral cancer treatments had equal out-of-pocket costs as Intravenously Infused (IV) medications. In March 2014, these efforts led to a bill being passed through Missouri lawmakers for the governor to sign into law.
An ongoing advocacy initiative for Komen Greater Kansas City has been a focus on maintaining state and federal BCCCEDP funding-to both Missouri SMHW and Kansas EDW. Komen Greater Kansas City works with grantees and partners to leverage these funds, making continued funding vital. In order to ensure that this resource is fully utilized and supported, Komen Greater Kansas City makes sure to discuss the program components in every presentation and often meets with local and federal representatives to discuss the importance of the program.

In the future, Komen Greater Kansas City will continue to monitor legislation and other advocacy related items which may need attention. As Komen Greater Kansas City has made great progress on immediate goals such as oral parity, the Affiliate will look towards the future and continue advocating for federal funding of breast cancer research and the possibility of Medicaid expansion in the states for the benefit of the women the Affiliate is here to serve. It is vital that a continued federal investment in cancer research through the National Institutes of Health (NIH) and Department of Defense (DOD) remains and the work to protect federal and state funding for the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), to ensure all women have access to potentially lifesaving breast cancer screening.

**Health Systems and Public Policy Analysis Findings**

Komen Greater Kansas City's target communities each face different but equally challenging barriers to breast health. While Clay, Jackson, and Wyandotte counties have various services available in all areas of the Continuum of Care (CoC), women are not accessing these services fully. Neither Johnson County, Missouri, nor the Eastern Kansas region has readily available services in all areas of the CoC. Residents of these counties face the barrier of traveling to other counties for many of their necessary screening, diagnostic, treatment, and survivorship services.

Komen Greater Kansas City has created many strong breast health partnerships in the service area through grantees, coalitions, and multi-organizational initiatives. Komen Greater Kansas City has worked with Cancer Matters to create a breast cancer resource guide detailing all the breast-health services available in the Greater Kansas City area.

Komen Greater Kansas City also has recently designed and implemented programming partnering with non-health organizations throughout the service area, such as housing complexes. These partnerships will aid in educating women that typically do not have access to breast health education. Komen Greater Kansas City continues to educate women through community outreach efforts including Komen Greater Kansas City breast health ambassadors, community and regional webinars, and the provision of funding which will create new and innovative outreach programs to the public at large.

Public Policy and government programs are estimated to create more access to screenings in the near future; however, some gaps remain. Funding priorities will shift to focus on reaching diverse populations and covering an increased amount of diagnostic and treatment services.
Komen Greater Kansas City is prepared to be adaptable as ACA is fully implemented. Komen Greater Kansas City currently has few grantees and partners focused on treatment, so this will be an emphasis as the need grows.

Through advocacy efforts and partnerships, Komen Greater Kansas City continues to be a voice for breast health in both Missouri and Kansas. Komen Greater Kansas City advocates for funding of breast health screening, research, and treatment programs.
Qualitative Data: Ensuring Community Input

Qualitative Data Sources and Methodology Overview

Target areas were identified through analysis of the quantitative data. The target counties/regions are:

**Missouri:**
- Clay
- Jackson
- Johnson

**Kansas:**
- Wyandotte
- Northeast Kansas Region (Atchison, Brown, Doniphan, and Jackson counties)

In order to gain a deeper understanding of the communities above, qualitative data were collected through focus groups and contacts with community providers. The use of two different data collection methods as well as the efforts to have multiple groups from each target area assisted with triangulation of the data. This allowed for the community to be directly involved in assessing the needs and issues, as well as potential solutions, to the initial findings from the quantitative data. By directly working with those living in the communities targeted, the Affiliate explored beliefs and behaviors around disparities, knowledge of breast health, access to services, utilization of services and more regarding breast health and breast cancer care. This process allowed for comments by the community on what is working and what can be improved.

Focus Groups

**Methodology**

Focus groups were led by one of three women associated with the local Affiliate. Each focus group utilized a standard procedure. Groups started with an introduction of the focus group, introductions of group attendees, rules/guidelines for participation in the focus group, and the completion of a consent form and survey. A standard set of questions were utilized. These key assessment questions discussed overall health such as, “Why do you see a doctor?” and “What are the biggest things that keep you from seeking health care?” as well as “When you need a doctor, where do you go for care?” Questions then transitioned to a breast health focus with a discussion around the causes of breast cancer, what is being done to get breast cancer awareness messages to the public, are the tactics working, describe your experiences with receiving a mammogram and clinical breast exam, etc.

Sampling

Fourteen focus groups were conducted throughout the target counties. Three groups were conducted for each target area with the exception of Johnson County, Missouri where only two focus groups were successfully conducted (see limitations). Participation demographics for the entirety of the focus groups are as follows: 56.0 percent White, 31.0 percent Black/African-American, 11.0 percent American Indian, and 2.0 percent identifying as another minority (Asian
or Bi-racial). These statistics represent a solid sample when compared to the Affiliate’s service area demographics.

Women living in the target communities were recruited to participate in focus groups. A quota method was used in order to select individuals. Those interested in participating, who met the focus group requirements, were selected to join. The characteristic requirements were the basis of selection for the focus groups and those included: being female, age 35 or older, and living in the target county. Focus group selection was opened to a variety of women from those who had never had a mammogram to those who were survivors of breast cancer. This is the population to whom the focus group questions were targeted in order to document what needs and barriers to accessing breast health services exist. This was done in order to gain a complete perspective from all women in the counties. 9.6 percent of participants were breast cancer survivors. Of the women participating in focus groups, 19.0 percent of the women in the focus groups had never received a mammogram. Of the women who have been screened, 37.0 percent hadn’t received a mammogram in over a year.

Focus group recruitment varied depending on the particular community and the host site. Recruitment methods included word-of-mouth, fliers, and e-mails to community organization leaders. Some focus group participants were recruited by focus group site staff. Although this created some participant selection bias, it was necessary for meeting Affiliate deadlines in the data collection timeline. A few younger women attended the focus groups and were permitted to participate. Focus groups were composed of approximately 8-15 women, although the group size ranged from three to over 20 women. These sample sizes were large enough to approach saturation of data. Compensation to focus group participants included a meal and a $20 gift certificate to Wal-Mart.

**Ethics**

All focus groups were conducted in private areas and participants were given the opportunity to choose to leave at any time or to not answer any question. Consent forms were completed after the purpose of the group was identified, rules discussed, and questions answered. The three topics of questions were overall health, overall breast cancer, and breast health services. Latino focus groups were moderated in Spanish. All questions were open-ended and follow-up questions were asked as necessary.

All focus groups were audio taped on an iPad, transcribed, and then coded inductively. Focus groups were recorded to ensure accuracy. Participants were made aware of the recording and informed only the Komen staff would be reviewing the recordings. Data remained at the Affiliate after focus groups were conducted. Notes from each focus group were typed and analyzed along with transcribing the recordings. All personal identification information was removed from the scripts. A standard text analysis was conducted to identify themes and subthemes in the data.
**Provider Interviews**

**Methodology**

Provider Interviews were conducted by one of two women associated with the local Affiliate. Each interview utilized a standard procedure. Data were collected with one of three methods: in-person interview, over the phone interview, or online survey. Data were stored using notes, recordings of conversations, or direct response from the online survey. The rationale behind diversifying data collection methods was due to the nature of providers intensive work schedules. The online survey contained the same questions asked in both the in-person and phone interviews. Questions asked were both specific to providers along with some overlapping questions asked to women participating in focus groups. In order to gain full understanding of the health care issues in the target counties, feedback from each party was necessary.

Key assessment questions asked of the providers were designed to gather more information about the various health organizations providers worked in, the counties the patients they see reside in, and the types of patients they see at the health center (i.e. health coverage, etc.). Questions discussed the availability of breast health materials and education to the patient, formal policies around educating patients at visits, formal policies around providing or referring for breast health services at visits, and follow up procedures for missed appointments. Barriers and alternative methods to increase use of screening and diagnostic services were also discussed.

**Sampling**

Providers were selected through a purposive technique based on their involvement with the target counties and the breast health continuum of care. Provider’s positions include but are not limited to navigator, breast oncologist, radiologist, nurse practitioner, and mammographer. Feedback was received from 12 providers from each county who identified that they served the targeted areas with the exception of the Johnson County, Missouri, where responses were received from 11 providers.

**Ethics**

Providers were given a consent form and a chance to have any questions answered before the surveys and interviews took place. Surveys were sent via email and respondents were notified that their responses would be kept anonymous. In person interviews were recorded via iPad and notes were taken during the discussion. All providers were given the opportunity to choose to stop at any time or to not answer certain questions. Data will remain housed at the Affiliate for safekeeping.

**Qualitative Data Overview**

Once focus groups and provider interviewers were completed, the recorded data and handwritten notes of the moderator were reviewed. Additionally, the surveys completed by the focus group participants were reviewed. From these, themes were discovered and statistics were aggregated. Each piece of data were reviewed and codes were created such as uninsured, transportation, etc. From there, meaningful themes were created through the
examination of the most frequently discussed codes, surprising codes, and those that would be expected when examining breast health discussions.

The common themes discussed further on in this report were found to be shared across all focus groups and provider interviews, regardless of the county in which the participant resided in. Therefore, findings have been reported in themes and should be considered to reflect the data from all target communities except in instances where it was otherwise noted.

**Common Findings Focus Group**

**Cost**

In each focus group, cost was noted as the number one barrier to receiving health care. It was the general consensus that if someone did not have insurance, they did not go to the doctor. Even with insurance, it was still common to hear that it was inadequate in covering medical costs. There was the belief that one never knows how much a hospital visit might cost. Those without insurance are more likely to get treated with more expensive options, such as urgent care or the emergency room. The idea of the bills pilling up and fear of being turned into collections was enough to discourage women from accessing health care.

For those who had insurance, it was brought up numerous times that the co-pay was still too much and they were unable to cover the cost. A concern women had was not being seen by a provider if they are unable to cover their co-pay upfront. Women were also uncertain what procedures were covered by insurance, causing more stress and anxiety when it came to paying. Feedback for what could be done to improve health care generally revolved around free screening or more free clinics, confirming cost as a barrier to health care.

**Lack of Knowledge**

Women in the focus groups were generally lacking knowledge in two areas when it came to breast health care; one being general breast health information and the other was awareness of treatments options, which could include cost or where uninsured women can receive health care. There was confusion about general breast health information such as what is breast cancer, what causes breast cancer, when to be screened and what the symptoms are. Myths about breast cancer are still circulating and many women rely on word of mouth as a source of knowledge rather than health care providers (see section on communication).

Women are not lacking knowledge because they are unconcerned; rather individuals do not know where to look for credible information. When asked where to send a woman without insurance, there was a lack of knowledge for the state National Breast and Cervical Cancer Early Detection Programs in Kansas and Missouri (Early Detection Works and Show Me Healthy Women). It is difficult for one to seek out programs such as these if it is unknown they exist.

When asked what messages are being shared pertaining to breast health, responses were centered on fundraising for breast cancer or breast cancer awareness month. The initial responses were not usually information pertaining to breast cancer facts and guidelines.
Women felt like breast cancer awareness information was, “Like Thanksgiving, it only comes around once a year.” Although the Affiliate does provide education to women every month, messages are only strongly shared during October by the wide masses. In almost every focus group, women suggested that a large advertising campaign would be the best way to get messages across to the public, although there was no consistent media outlet that was thought to be the best strategy (i.e. television, billboards, print ad, etc.). At least four groups specifically discussed the Centers for Disease Control and Preventions “Terrie’s Story” advertisement where the harsh realities of smoking are graphically shown. One woman specifically noted that this ad (Terrie’s Story) brought the consequences of smoking to the forefront and did not hide the unpleasant realities of continued tobacco use. Although smoking is a choice and breast cancer is not, the focus group participant felt that women need to understand the truth of late-stage diagnosis and the opportunities that early detection through screening could provide. She stated, “The more it is in your face, the more you are going to take notice of it.”

Access
Access was discussed as a problem in three different forms: appointment scheduling and wait time, transportation, and proximity. Those with an established primary care provider did not have issues scheduling an appointment. In contrast, those without a provider reported wait time could be up to three weeks to see a primary care doctor for a concern. Usually those without health insurance did not have an individual they considered their primary care provider. Women in this category reported going to urgent care or the emergency room for care, which as previously mentioned have higher costs. Another issue for those without health insurance is the limited time slots available at the free clinics. Women described the frustration with going to a clinic to wait, only to be turned away at the end of the day.

Transportation was another barrier for women in most counties. This barrier is due to individuals having no vehicle and then relying on others to take them to an appointment. In this situation, not only is the individual who needs health care potentially missing work but so is the person responsible for taking them to their appointment. Public transportation provides another hurdle as it does not always take women to the places they need to go and travel time is lengthy.

In the target communities lying outside of the immediate metropolitan area, the issue of proximity for health care access was a problem. Individuals felt that for one reason or another, the health care nearby was inadequate. There was a mixed consensus on how far one would be willing to travel for health care. Some women said they would be willing to travel however far was necessary for trustworthy health care, while others would not travel more than ten minutes. It was often personal preference, the problem being they were either hesitant to drive in metro areas or insecure with the health care in their county. Mobile mammograms were often suggested in conjunction with these concerns. There was also confusion about where individuals can access free or reduced health care especially in relation to the border issue with Kansas and Missouri or county borders.
**Communication**

One reason for the lack of trust in nearby health care options as noted by focus group participants stems from a perceived lack of communication. Being able to trust and connect with one’s provider is crucial. Those women who had found a primary care provider they trusted tend to stick with them for multiple years and report a much more positive experience with health care overall.

Women who felt frustrated with the health care system often referred to a negative experience with a provider. One woman summarized her health care experience and relationship with physicians as, “a doctor is seen more as a last resort rather than someone you can trust.” This sentiment was shared by other women as they described negative experiences with medical personnel. Women often will put off going to a doctor because they have had a negative experience or have heard about a negative experience, yet they get to a point where their health concern cannot be ignored so they go in. If at this point they have another “bad experience” they feel like the visit was pointless (waste of time, money, etc.) and that incident compounds on to their previous sentiments of health care. This only furthers their thought cycle of not utilizing preventative health care.

Negative experiences include feeling disrespected, being stereotyped by one’s culture, doctors rushing through the appointment, patients being unable to understand English, or a lack of information for either what is going on or why a certain treatment was prescribed. One woman described her visit as the “10 minute shuffle,” meaning the doctor is just trying to get you in and out the door as quickly as possible. This lack of time left women feeling that their needs had not been met. One woman shared, “When the doctor says, ‘I think you have...’, wait a minute, how do you not know?” It was also said multiple times that women had to be proactive by bringing in their own specific questions or list of needs they wanted to discuss with the provider. If this was not done, they did not feel confident in the prescribed treatment, or lack of treatment in some cases. This can be problematic for those who are unaware of the questions they need to be asking.

Another flaw in the communication between patient and providers is due to the wait time for information and testing. In regards to abnormal mammograms, women reported waiting up to three weeks for their results. Also, women reported being scared or confused when a provider would ask the woman to come back for another mammogram in six months rather than a year. In this situation and many others, women felt further explanation of what is being done and why it is being handled that specific way was crucial. Due to the lack of trust and respect they feel from the provider, they fail to ask follow-up questions and the cycle repeats.

In the focus groups when women were able to open up and share their experience as well as hear the importance of getting screened, they were both motivated and inspired make it a priority to get screened. A woman even shared, “If there was a machine behind that screen [referring to the partition in the meeting room] to get a mammogram, I’d get one right now.” Other women who had a relationship of trust with their provider noted that if their doctor recommended a screening or continued to discuss screenings with them regularly, they would...
be more likely to go and get it done. A need to understand and also to be heard could help bridge the gap in communication that women are experiencing.

**Mammograms not a priority**

Women by nature tend to put their needs second. They are sacrificial when it comes to their family and in particular their children. When questioned about why a woman had not received a mammogram within the recommended guidelines the automatic response was usually due to kids, work, paying the bills, etc. When asked about why they seek medical care it was common to hear responses saying they finally went when the pain was too much or they became desperate. One woman noted, “As women we tend to put ourselves last, and we always will.” When deciding between getting screened for breast cancer or feeding a child, a mammogram was not even considered as an option.

**Fear**

When asked what thoughts came to mind when one hears the words “breast cancer,” scary was the number one response. In one focus group a woman said scary and another responded with “you took the words right out of my mouth.” Several different forms of fear acted as a barrier for women. When asked what the women were afraid of it was typically a fear of diagnosis. Along with a fear of being diagnosed, women fear what was to follow after the diagnosis; whether it was the cost of treatment, anxiety about the pain of screening or treatment, or even reconstruction and the aesthetic changes. When discussing the cost associated with being diagnosed one woman shared “I can’t afford to be sick. If I wait a little bit, it’ll go away.” The fear of paying for treatment outweighed the desire to get screened.

Generally speaking, a mammogram brought the women fear and anxiety because there are so many unknown factors. One woman claimed, “I’ll cancel the appointment three times before going!” Apart from all the other issue listed such as access or cost, fear is a very real barrier in preventing women from getting screened or treated. Often times a response to these fears was denial. Instead of attempting to overcome the barriers they faced in receiving health care, women expressed a theme of denial. In one instance a woman went as far as to say, “If I’m gonna die, then I’m gonna die. I don’t want to know.”

**Provider Interview Findings**

Similar themes between providers and focus groups were discovered as well as some discord, which when identified, has the potential to be useful in correcting issues that lead to frustration and barriers among women in the five target counties. Similar to the women in the focus groups, providers too listed cost as the number one barrier to women accessing health care. Along with cost, education, access and mammograms as a priority were also addressed as issues. One notable difference was providers did not see a lack of communication as a barrier to health care, while that was a common theme discussed in the focus groups. Providers did recognize the need to be trained on various issues, which could help to fix this communication barrier.
Common Findings: Provider Interviews

Costs
Every provider mentioned cost as an issue. While providers cited cost as the number one barrier for most women who did not seek health care, only 30.0 percent of the providers interviewed knew where to send women without insurance. In the area of training, many providers requested more information on this topic (see more under theme of training). When asked what could be done to motivate women to receive health care, 65.0 percent suggested free screenings and 20.0 percent suggested incentives. Commonly the issue was getting the women in the door to be treated in the first place. This was confirmed in the focus groups as women said they had a fear of the bills pilling up and not being able to pay for other necessities as well as general difficulties in getting in for primary care concerns if not already an established patient.

Education
Seventy-five percent of the providers listed a lack of education as a barrier for the women in their counties. This was generally related to either being unaware of the need or misinformed on various topics. While all of the providers said they had educational materials available to the women in their waiting room/office, it was common to hear that the women did not take or did not read the information unless someone took the time to walk through it with them personally. Only 60.0 percent of the providers have a formal policy regarding breast health during primary care visits. Also, as mentioned previously there is an issue getting women into see a provider for any health concern so educational materials in lobbies are not readily available to everyone. Many women listed their source of education as word of mouth or social media, not primary care providers or doctors. Providers noted a lack of education as one of the reasons why 30 percent of women do not follow the screening guidelines (other reasons include busy schedules or being uninsured).

Access
55.0 percent of providers thought transportation was an issue for the women. They discussed many of the obstacles the women themselves brought up; not owning a vehicle, finding someone to drive you, etc. Public transportation was not seen as a reliable or efficient form of commute because of the inconvenience in locations for some hospitals and also due to the time it takes with all the stops along the way. Along with free screenings, providing transportation was suggested by providers.

Motivation for Health Care Use
One question asked in provider interviews was what would motivate women to seek health care. Suggestions included: free screenings, transportation, incentives, and bi-lingual services. Apart from issues such as cost or transportation, some providers felt that women had no desire to receive medical attention. Nearly 50.0 percent stated lack of knowledge/lack of motivation as a reason one doesn't seek breast health care. Providers also touched on another common theme, which was women putting themselves second. It wasn’t that the women had a lack of desire but rather that so many other areas of their life took precedence over their health.
When motivating or reminding women to see a provider, 50.0 percent of the providers listed calls as an effective form of communication. All the providers say they follow up with no shows, either via a phone call or letter, and sometimes both. Interestingly, only 30.0 percent use a system which triggers them to make the call after a no show occurs instead of relying on staff remembering to call. Even less, 20.0 percent use a reminder system for scheduling annual mammograms. This brings about the concern that some women may be getting lost in the shuffle.

**Training**
At the end of the provider interview, the question was asked if providers thought any training would be helpful. All of the providers answered with a resounding yes, while the topics for training varied. Two of the biggest requests for training include update on newest information and procedures, and where to send women without insurance. Only the providers who regularly saw people that do not have insurance were aware of these programs, such as Show Me Healthy Women or Early Detection Works. It was common to hear that providers wanted continued updates on the latest trends in breast health as well as topic specific courses such as how to read a mammogram report, etc. A comprehensive overview of breast health care in the Kansas City area was highly recommended.

**Qualitative Data Findings**

**Linkage of Data to Key Questions Generated**
After reviewing the quantitative data, questions around the low use of mammography screening came to the forefront, particularly in Northeast Kansas, Wyandotte County, Kansas, and Clay County, Missouri. Insight from focus group participants identified barriers to screening such as cost, access, general lack of evidence-based knowledge, fear, and putting off screening as a priority which may contribute to these lower rates. Furthermore, the Health Systems Analysis may confirm the ease of access to facilities providing mammography in these counties.

When looking at high rates of late-stage diagnosis of breast cancer and deaths from breast cancer, the findings above also correlate as early detection of breast cancer through mammography screening often leads to a better survival prognosis. Additionally, the focus groups confirmed the findings from the Health Systems Analysis, particularly in counties not in the immediate metropolitan area; women had a harder time accessing services for early detection and treatment of breast cancer. Provider response confirmed many of these findings, particularly as it relates to the costs of screenings, screenings as a priority, and the ability to access a screening due to transportation.

**Data Limitations**
Some data limitations occurred during the collection of qualitative data both in focus groups as well as provider interviews. In order to obtain saturation of data, the Community Profile Team identified a goal of three focus groups per target area. This goal was met in all target areas with the exception of Johnson County, Missouri. Due to limited contacts and barriers in obtaining
participants, only two successful focus groups were held in the target county. A third group was planned with no attendees present.

Additionally, during the data collection with providers, a range of methods were used in order to accommodate the busy schedules of medical professionals. Although the same questions were asked of each provider, providers responded in different formats. When providers responded via online response format, it was unclear as to which specific providers were responding due to the allowance for anonymous responses. Providers who did respond may be providers who had a special interest either with breast health or Susan G. Komen, and therefore their responses might not be reflective of the general population of providers. The Affiliate’s goal when identifying a plan for data collection was twelve responses per county, therefore, all providers were asked to respond with the counties they see patients from. A minimum of 12 responses per county were received with the exception for Johnson County, Missouri where 11 responses were received.

Conclusions
Similar themes often correlated between focus group findings and provider interview findings. Barriers were often confirmed by both parties, such as cost of health care and access to transportation. In some instances one data source (focus groups or providers) were unaware or did not commonly express that certain barriers existed for the other party. For example, the women in the community repeatedly expressed frustration with the communication from providers but the providers did not note that time with the patient or communication of health information with the patient was an issue. Providers listed a lack of desire to access health care as a barrier. Some women in the focus groups shared they didn’t want to go to the doctors, but not because a lack of desire to receive health care. Rather, they expressed a lack of confidence in the providers stemming from a negative experience as the rationale behind not seeking care. The combination of information from each party led to a deeper understanding of key issues.

Some questions asked of focus group participants touched on key issues such as access to health care, such as where individuals go when they need to see a doctor and what are perceived barriers to accessing health care. 16.0 percent listed they had no one they considered their primary care giver. A lack of trust with a health care provider can bring about added anxiety and stress when seeking health care. Additionally, 55.0 percent of women disclosed they had not seen a doctor in the past year due to cost. Of those 55.0 percent of women, 32.0 percent had not seen a doctor more than one time in the last year because of cost. Cost was always listed as the number one factor in preventing women from accessing health care.

Fortunately, the Affiliate has strong National Breast and Cervical Cancer Early Detection Programs on either side of the service area state line. However, it is clear that women and providers are unaware of the resources that this program provides. Furthermore, for women who do have insurance, there is little known about the recent provisions in the Affordable Care Act which often times remove the copay for preventative services such as mammograms. With
cost being the biggest barrier for many women, it is imperative that time and education is spent around what is already available to those who cannot or think they cannot afford a mammogram.

It is also clear, by the numerous discussions around breast health education, that women realize they are at risk for breast cancer but are still unaware of their personal risk factors and the things they can do to lower their risk for breast cancer. On a positive note, women do tend to share health information with their friends and family. However, it is important that educators are getting accurate material to women so they do not share false information. Continued year-long education around breast self-awareness and other evidence based information is needed to be delivered to the community in an innovative way that people will retain. Additionally, bringing the education to the appointment itself, whether by the nurse or physician, seems to have strong potential for making a larger impact on patients instead of relying on them to digest materials available in the lobby.

Access to health care stems from systematic issues that are difficult to change swiftly. However, small changes can be made in order to accommodate those facing challenges. Examples could include extended hours for screenings and streamlining of services such as clinical breast exams and mammograms at the same appointment. Additionally, there was a strong desire for mobile mammography to be brought back to the area, particularly in geographic locations without nearby access to mammography services. However, in order to be of most use to the community, a mobile program would need to work in partnership with the National Breast and Cervical Cancer Early Detection Programs. When available, additional subcontracts for the state programs may also provide benefit to the service area.

One of the biggest barriers women face is their personal mindset. It is vital for women to understand that their personal health is a key component to their entire family and that it is ok to take care of themselves as they take care of others. Addressing the resounding fear of a mammogram and fear of a breast cancer diagnosis is also imperative but difficult. These fears are ingrained in the community and although the five-year survival rate for early stage breast cancer is now 99.0 percent, many women still feel that breast cancer, regardless of when found, is deadly.

Lastly, providers reacted positively to the notion of additional training around breast health. It may be useful to find a way to communicate directly with providers to supply the most up to date breast health information whether it is in the form of education to patients, knowledge around new techniques and treatments, or other forms of learning. While providers do have a strong desire for this information, the strong demand and time constraints placed on providers make it difficult to find the most effective way to reach them.

In the words of one focus group participant when discussing why someone would access breast care, “It’s either going to be inspiration or desperation.” The Affiliate needs to continue to find relevant ways to inspire women so they don’t wait until desperation occurs.
Breast Health and Breast Cancer Findings of the Target Communities

In order to gain a complete picture of the service area and the needs to be addressed related to breast health, the Affiliate utilized quantitative and qualitative data as well as a review of the health systems in the area. In order to prioritize the highest needs counties (aka target communities), the Affiliate reviewed Healthy People 2020 goals and objectives as well as specific county-level data. Healthy People 2020 is a major federal government initiative that provides specific health objectives for the country as a whole.

When selecting key indicators, the following were taken into account:
- Incidence rates and trends
- Death rates and trends
- Late-stage rates and trends
- Below average screening percentages
- Residents living below poverty level
- Residents living without health insurance
- Unemployment percentages
- Residents who are linguistically isolated and/or foreign born

Upon review of the indicators above, the following were identified as target communities:
- Clay County, Missouri
- Jackson County, Missouri
- Johnson County, Missouri
- Northeast Kansas Region (Atchison, Brown, Doniphan, and Jackson Counties)
- Wyandotte County, Kansas

Each of these communities faces unique circumstances in comparison to the service area or national averages regarding certain breast health and/or demographic trends. After quantitative data were reviewed a health systems and public policy analysis was conducted for each selected target community. The information and data collected from these resources was obtained and analyzed in order to create an accurate depiction of the systems and services impacting breast health in the target communities of the Greater Kansas City area.

Additionally, a deeper understanding of the target communities was obtained through qualitative data collection. Focus groups and contacts with community providers served as the outlet for community feedback. This allowed for the community to be directly involved in assessing the needs and issues, as well as potential solutions, to the initial findings from the quantitative data.

Conclusions Per Target Community

Clay County, Missouri

The data in Clay County showed that incidence, death and late-stage diagnosis rates of breast cancer were all above the US and service area averages. Furthermore, the incidence rates and late-stage diagnosis rates are expected to increase in upcoming years. Meanwhile, death from breast cancer is declining. Clay County women have self-reported obtaining mammograms at a
higher rate than the service area and US averages which may be a direct correlation to higher incidence rates (more women getting screened relates to more women having the chance to be diagnosed), as well as lowered death rates.

There are multiple hospitals in Clay County who provide the full breast cancer continuum of care (education through survivorship). However, a majority of these services are available in the Southwest section of the county, primarily in the cities of North Kansas City and Liberty. This may make access to services more challenging for those living outside those cities.

**Jackson County, Missouri**

The breast cancer death rate and late-stage diagnoses rate of breast cancer are higher in Jackson County than they are in both the US and the service area. The trends are showing that a decrease in incidence, deaths and late-stage diagnosis are expected. Women residing in the county are receiving mammograms at a rate that is comparable to the service area average. However, Jackson County residents are more diverse than other counties in the service area and many women who reside in the county may be more vulnerable to poorer prognosis rates. Residents in Jackson County are more likely to be living in poverty, have higher unemployment, and are less likely to have health insurance.

Jackson County, MO primarily is located within Jackson County. Therefore, residents have greater access to hospitals and health care facilities that can provide the full continuum of care. It is much easier for one to obtain a mammogram, diagnostic work up, or even breast cancer treatment in Jackson County than it is for other counties in the service area.

**Johnson County, Missouri**

Johnson County, Missouri shows several areas of concerning statistical data. The county has a higher than average breast cancer death rate as well as a higher than average late-stage diagnoses rate. Trends also show an expected increase in the incidence rate of breast cancer. More so, Johnson County has one of the highest death rates and late-stage diagnoses rates in the Komen Greater Kansas City 17 county service area. Additionally, mammography screening levels are lower than the service area average.

Much of Johnson County can be considered rural. The town of Warrensburg, located in the county, is home to the only health department and hospital in the area. Residents do not have the ease of access regarding all breast health services that the Kansas City metropolitan area offers. Although many of the services are available at the hospital, there is limited access to treatment and survivorship services for breast cancer survivors.

**Northeast Kansas Region**

The counties in the northeast Kansas region are combined together in order to gain access to data. Much of the data at the county level is suppressed due to population size. From the data that can be obtained, it is known that screening percentages are significantly lower than the entire service area. Additionally, a higher percentage of residents in the area are living below
the federal poverty level and Doniphan County has been identified as a medically underserved community.

Each county in the area does have a health department and a hospital but not all are able to provide the entire breast cancer continuum of care. The residents who live in these communities have access to just two Early Detection Works providers, the state breast and cervical screening program, and may encounter travel barriers to reach these providers. If a breast cancer diagnosis is made, many may find themselves facing transportation barriers to treatment or survivorship care.

**Wyandotte County, Kansas**

Wyandotte County is the most diverse county in the Komen Greater Kansas City service area. They also have a higher death rate from breast cancer than the US and service area average. While this is expected to decrease over time, it is currently one of the highest rates in the service area. Data regarding late-stage diagnosis and trends were not available for Wyandotte County. However, the socioeconomic data are of concern with residents being less likely to have a high school education and have an income level below 250.0 percent of the federal poverty level. Residents are also more likely to be unemployed and are the least likely in the entire service area to have health insurance.

While there is access to all services along the continuum of care in Wyandotte County, transportation and ease of access to these services may be a barrier for many women due to locations and acceptance of uninsured patients.

**Qualitative Data**

Upon review of the quantitative data and health systems analysis, key questions were formed to explore individual community’s biggest needs and barriers to care. Several focus groups and provider interviews were conducted in each target community. Although some counties showed specific needs in relation to access to care (see Health Systems and Public Policy Analysis section), the top needs of the target communities, as identified during qualitative data collection, seemed to remain the same.

Cost remains the number one barrier to health care in all counties. Even if a resident had health insurance, cost still often kept them from receiving health services and more specifically breast health services. Women who had insurance were unsure about which procedures were covered by insurance, making it less likely that they would receive the procedure or screening. Women who did not have insurance were unsure where they could obtain a free screening or if those opportunities even existed. Women who did not have a primary care provider often noted using urgent care or the emergency room for health services. This type of care is not conducive to receiving preventative referrals. Those who did utilize free clinics in the area noted that wait times and limited spots for appointments were a barrier.
Medical providers agreed that cost was the biggest barrier to women receiving breast health care. Providers noted that it was hard to get women in for any kind of preventative care appointments, physicals and to refer them out for breast health specific screenings. Providers often had questions themselves about where to send women for no cost screenings if they were uninsured; they were not aware of the National Breast and Cervical Cancer Early Detection Programs.

Some women showed a general lack of knowledge about breast health. Most women were aware that they were at risk for breast cancer just by being female. However, many overestimated or underestimated their personal risk for breast cancer based on misleading information that had been shared with them. They also noted that they continually heard more messaging around funding for breast cancer assistance instead of education, especially during the month of October. They felt that large advertising campaigns were the best way to get breast health messaging out to women.

Providers and patients both identified that health services were not a priority in women’s lives, but for different reasons. Providers often felt that women were not motivated to take preventative action on their health, while women noted that families, bills, work, etc., took precedence over their own health care. Regardless, when women did not make it into a provider’s office, they were unable to receive any breast health referrals and often were not able to take advantage of the education the providers had available, albeit limited.

**Mission Action Plan**

Once all data were combined and each county was reviewed for a total picture of the state of breast health, the Affiliate began strategic planning to address the needs found in each county. The Mission Action Plan provides the opportunity to make plausible connections regarding the issues in each county and the establishment of Affiliate priorities in the counties. In order to effectively and efficiently move forward with notable change in each county, the Affiliate has created the Mission Action Plan. For each county, a problem statement is presented based on the review of the available data for each community. Then, priorities of intervention have been selected. Priorities were selected after careful review of the data available and analysis of potential solutions to address the problems. Each priority was selected as a direct effort to address a need from the problem statement. Finally, each priority has measurable objectives that will be implemented over the next several years. The plan to address the objectives will be developed, monitored, and executed by Affiliate staff, volunteers, and the Board of Directors.

**Problem Statement: Clay County, Missouri**

Women in Clay County have incidence rates, death rates and late-stage diagnosis rates that are higher than the US and service area averages. Incidence and late-stage diagnosis rates are expected to increase. The health system analysis found that there are multiple hospitals providing the full breast cancer continuum of care but the majority of those services are available in the Southwest region of the county (North Kansas City and Liberty).
In order to address the issues identified in Clay County, the Affiliate plans to focus efforts around patient navigation support, provision of Affiliate-based education to individuals, and raising awareness amongst the health system of the needs in the county. Komen Greater Kansas City has set the following objectives for work in the community:

- Beginning with FY17, a key funding priority will be developing or improving patient navigation programs targeting Clay County women.
- By the end of FY19, a minimum of 15 outings will be conducted in Clay County using the Affiliate’s Connecting for a Cure curriculum.
- In FY16, hold at least two collaborative meetings with health care providers in Clay County to develop a plan on how to improve breast health needs.

**Problem Statement: Johnson County, Missouri**

Women in Johnson County, Missouri, have high breast cancer death rates & late-stage diagnosis rates. Mammography screening percentage is below average. Johnson County can be considered "rural" and outside of Warrensburg, the county has no additional hospitals or health departments. Residents have to travel to the metropolitan area in order to receive the full continuum of care.

To address the high needs in Johnson County, Missouri, the Affiliate will work diligently to increase the number of women getting preventative breast health screening. The Affiliate will also work to pull together the health systems to discuss transitions for treatment of women diagnosed with breast cancer. Additionally, the Affiliate will work to increase presence in the county as well as increase capacity to provide individual education to women in the area.

- By the end of FY16 identify the best plan for women to receive services from Show Me Healthy Women.
- By the end of FY17, develop and implement a campaign encouraging women to make their health care a priority.
- By the end of FY17, develop and implement a campaign to educate the population and those who work directly with them on Show Me Healthy Women as well as the breast health provisions outlined with the Affordable Care Act.
- In FY16, hold at least two collaborative meetings with health care providers and community organizations to develop a plan on how to improve the breast cancer treatment process.
- Beginning with FY17, a key funding priority will be developing or improving patient navigation programs targeting Johnson County women.
- By the end of FY19, a minimum of eight outings will be conducted in Johnson County using the Affiliate’s Connecting for a Cure curriculum.
- By the end of FY19, a minimum of six members will be recruited and remain active in the Komen Greater Kansas City “Pink Army.”
- Recruit and retain a minimum of one Board Member who resides in Johnson County, Missouri during FY18.
**Problem Statement: Jackson County, Missouri**

Women in Jackson County have breast cancer death and late-stage diagnosis rates which are higher than the US and service area averages and a higher level of residents who are vulnerable to a poorer prognosis of breast cancer survival. Additionally, more residents are living below poverty, have higher unemployment and are less likely to have health insurance.

The Affiliate’s work in Jackson County will continue to expand with a strong focus on providing meaningful education to individuals in the community. The Affiliate will also work with the health systems to discuss the found breast needs and collaboratively create a plan to further address those needs. The Affiliate will also work tirelessly to increase the number of women obtaining preventative breast health screenings in the county.

- In FY16, hold at least two collaborative meetings with health care providers in Jackson County to develop a plan on how to improve breast health needs
- By the end of FY18, a minimum of 20 outings will be conducted in Jackson County using the Affiliate’s Connecting for a Cure curriculum
- By the end of FY19 hold at least one local "Mammacare" training event for providers
- By the end of FY19, in partnership with other entities, hold at least five breast health screening events for the public
- By the end of FY17, develop and implement a campaign encouraging women to make their health care a priority
- By the end of FY17, develop and implement a campaign to educate the population and those who work directly with them on Show Me Healthy Women as well as the breast health provisions outlined with the Affordable Care Act

**Problem Statement: Northeast Kansas Region**

Women living in Northeast Kansas have the lowest screening levels in the entire service area. The area is considered to be "rural" and full breast health services are not available along the continuum of care in the region. Additionally, there are only two Early Detection Works providers in the entire region.

The Affiliate will continue to work in the area with efforts to increase the number of women receiving preventative breast health screenings as well as increase the region’s capacity to provide breast health care in Northeast Kansas. Lastly, the Affiliate will work to increase educational outreach to women in the community.

- By the end of FY 2019, a minimum of eight outings will be conducted in Northeast Kansas using the Affiliate’s Connecting for a Cure curriculum
- Work with local resources and key influencers in NE Kansas to hold a minimum of four screening events by March, 2019
- By the end of FY17, develop and implement a campaign to educate the population and those who work directly with them on Early Detection Works as well as the breast health provisions outlined with the Affordable Care Act
- Identify and assist with recruiting of one additional Early Detection Works Provider in NE Kansas by October, 2017
By the end of FY17, a key funding priority will be developing or improving patient navigation programs targeting Northeast Kansas Women

Problem Statement: Wyandotte County, Kansas
Women in Wyandotte County have a higher death rate than the US and service area averages. Women are receiving mammography screenings at a rate that is lower than the comparable averages. The socioeconomic data of the county is concerning with residents being less likely to have a high school education, income below 250.0 percent of the poverty level, and the least likely to have health insurance in the area. Residents also are more likely to be unemployed.

In Wyandotte County, the Affiliate will implement strategies to increase the number of women obtaining a preventative breast health screening. The Affiliate will also enhance the work to provided education to women residing in the county. Lastly, the Affiliate will meet with key players in the health system to discuss the needs of the county and potential ways to address those needs.

- In FY16, hold at least two collaborative meetings with health care providers in Wyandotte to develop a plan on how to improve breast health needs
- By the end of FY19, a minimum of 15 outings will be conducted in Wyandotte using the Affiliate’s Connecting for a Cure curriculum
- By the end of FY18 partner with at least two non-health organizations to coordinate comprehensive education and screening events
- By the end of FY17, develop and implement a campaign to educate the population and those who work directly with them on Early Detection Works as well as the breast health provisions outlined with the Affordable Care Act
References


