COMMUNITY PROFILE REPORT

Susan G. Komen for the Cure. Greater Fort Worth

2011

Disclaimer:

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

Dedication

This report is dedicated to the Komen Greater Fort Worth Affiliate survivors whose commitment to our cause and courage in their battle against breast cancer inspires us to find a cure and also to the many dedicated Affiliate volunteers whose passion and diligence in all their contributions bring us closer to our vision of a world without breast cancer.

Acknowledgments

The Affiliate would like to thank the following people for their tireless efforts and exemplary commitment to this project:

Core Committee
Ann Greenhill, Komen Greater Fort Worth Executive Director
Jeanne Ginsberg, Komen Greater Fort Worth Mission Manager
Amy Hatfield, Komen Greater Fort Worth Project Manager and Team Leader
Betty Nethery, Komen Greater Fort Worth Grants Chair
Keith Argenbright, M.D., UT Southwestern/Moncrief Cancer Institute
Claudia Coggin, Ph.D., University of North Texas Health Science Center
Sarah Erekson, Komen Greater Fort Worth Board of Directors
Sue Lurie, Ph. D., University of North Texas Health Science Center
Florastine Mack, MSPH, BSN, Tarrant County Public Health
Jacquelynn Meeks, DrPH, MBA, JPS Health Network; Komen Greater Fort Worth Board of Directors
Jim Stimpson, Ph.D., University of North Texas Health Science Center

Expert Partners
Shannon Sears, The Buxton Company
Sandy Asari Hogan, University of North Texas Health Science Center, Doctoral Student

Translation Assistance
Meti Debra, Translation and Interpretation Network
Rafael Rondon, Translation and Interpretation Network

Data Collection Assistants

Jacquelynn Meeks, DrPH, MBA	Sarah Erekson	Monica Ross
Judy Gonzales	Jacque Lambiase	Carlene King
Elia Saenz	Staff, Moncrief Cancer Institute	

Qualitative Date Sources

US Census Bureau	Behavioral Risk Factor Surveillance System
Area Resource File	Texas Cancer Registry

Table of Contents

Tables

Figures

Executive Summary

Introduction

Susan G. Komen for the Cure® History

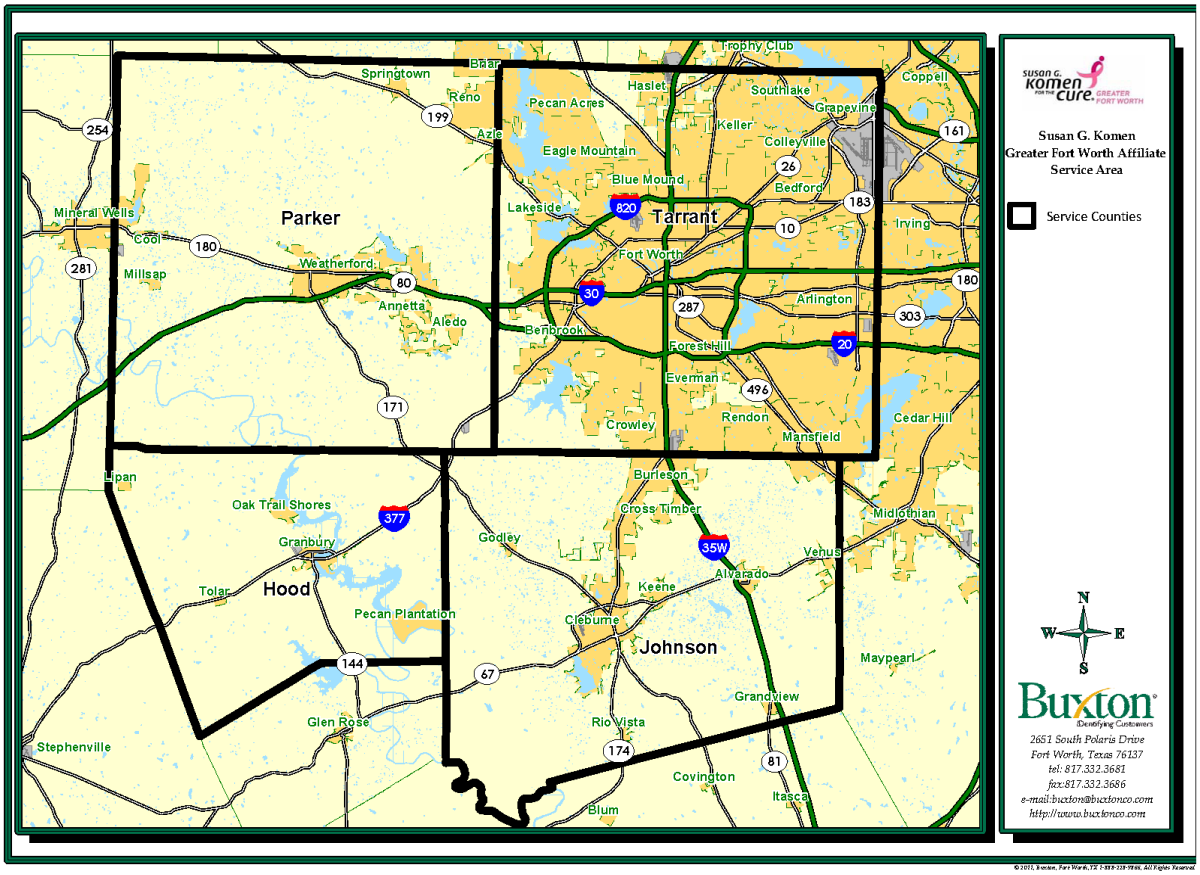
Ambassador Nancy G. Brinker, founding chair of Komen for the Cure, established the organization in honor of her dying sister Susan G. Komen. It was this promise to her sister that she would do everything in her power to end breast cancer that led to what is now the world's largest breast cancer organization and the largest source of nonprofit funds dedicated to the fight against breast cancer. To date, Komen has raised more than $1.3 billion in this fight.

Affiliate History and Background

The Affiliate began in 1992 when Rozanne Rosenthal chartered the Tarrant County Affiliate of Komen in honor of her friend and breast cancer survivor, Joan Katz. Together they inspired grassroots activities and energetic volunteers resulting in the first Race for the Cure in 1993 and raising over $100,000 from 1,800 participants and volunteers. The 2010 Race for the Cure raised over $1.6 million. Since its inception, the Affiliate has funded more than $17 million in local grants for life saving breast health education, screening, treatment and health and social support services. In addition the Affiliate has contributed $3 million to national research initiative to find the cures.

Komen Tarrant County became the Greater Fort Worth Affiliate Susan G. Komen for the Cure® in August, 2010, by adding Parker, Johnson and Hood counties to its service area. The expansion of the service area was driven and supported by the Komen national initiative to serve needs in outlying and rural areas and also by the need expressed by existing Affiliate Grantees for Komen funding in these areas. For Tarrant, Parker, Johnson and Hood Counties, 75 percent of net funds raised support breast health programs to help uninsured or underinsured individuals receive continuous care and treatment. The remaining 25 percent of net funds is allocated to national cancer research initiatives.

Service Area Map



Purpose of the Report

The purpose of the Community Profile report is to gain and present current information on the breast health of communities in the Greater Fort Worth service area. This information is collected to identify and assess local priorities for breast cancer education, screening, treatment and treatment support services (health and social support services) currently provided and needed for the under and uninsured population at greatest risk of breast cancer. The information gathered from the periodic Community Profile effort is used to establish Grant funding priorities and to direct Affiliate Strategic planning with the desired result of effective use and distribution of Affiliate funding and resources for breast health needs.

Statistics and Demographic Review

Methodology

We worked with University of North Texas Health Science Center to gather quantitative data regarding social, breast and women's health issues for the four counties in our Service Area. This process was integral to our community profile because it provides data that cannot be obtained through the anecdotal health systems or qualitative analysis processes and helps to identify gaps in services.

The quantitative portion of the report utilized secondary data collection methods of publically available data from the following sources:

Area Resource File

Behavioral Risk Factor Surveillance System

Texas Cancer Registry

US Census Bureau

Overview of Target Communities Findings

Hood County needs further attention due to the high breast cancer incidence rate, low mortality rate, unknown breast cancer screening rate, and high proportion of uninsured women. Johnson and Parker Counties are underserved for cancer services, since their mortality rates are highest and they have low medical resources (physicians and hospitals). Tarrant County has sufficient health resources, higher screening rates, and lower mortality rates. Efforts need to be directed toward the large number of women without access to care, and the diverse population's needs for cancer screening and treatment.

Table 1.
Female Breast Cancer Incidence and Mortality Age Adjusted Rates by County, 2005-2007

	Tarrant	Johnson	Parker	Hood
Incidence, per 100,000	119.7	99.5	114.5	152
Mortality, per 100,000	21.1	28.5	26.3	19.9

Texas Cancer Registry 2005-2007

Hood County had the smallest and least dense population, with an older population and highest per capita income, but a slightly larger percentage of persons without health insurance. Johnson County appears most economically disadvantaged. Hood, Johnson and Parker Counties are predominantly Caucasian. Tarrant County is the largest and most densely populated with a younger population and a higher educational level, but with the highest number of uninsured women age 40-60 years, and with the most

culturally diverse population. It needs screening and care for a large number of women without access, and a diverse population with special needs.

Based on this aforementioned information, we have selected these four counties, Tarrant, Parker, Johnson and Hood, as target areas.

Health Systems Analysis

The continuum of care provided the conceptual framework for health systems analysis in order to identify and understand gaps, barriers, health and social service issues for women at each phase of screening, diagnosis, treatment, follow-up health care, and financial and social support. Within the context of each county in the Affiliate service area, interrelated factors that affect women across the continuum of care have a potentially significant impact on breast cancer incidence, prevalence, and cancer mortality rates.

Information sources for the health systems analysis included Internet searches, key informant interviews, social services directories, churches, indigent care clinics and food banks, Tarrant County Public Health and ethnically focused organizations such as the Hispanic Chamber of Commerce, the African American Chamber of Commerce and health care providers.

Assets were identified and mapped geographically for each of the target areas in the Affiliate: Tarrant, Parker, Johnson and Hood counties:
1) *Health and social service providers:* cancer centers, Komen grantees, hospitals, public health centers, social services
2) *Mammography providers.*
3) ”*Pink Sunday” churches*

Discussion with public health officials revealed that in the case of mortality, often the death certification process is lacking. For instance, the death of a rural county resident may not always be reported in that county, but in the county where the death occurred. This may give some explanation of why Hood County has a high incidence rate, but a relatively comparative low mortality. Residents of Hood County may be misidentified as residents of Tarrant County where more medical resources are available and thus where the individual is located at the time of death. The Affiliate can play a role in encouraging better reporting methods among the medical providers

Qualitative Data Overview

Methodology

The qualitative analysis portion of the process consisted of conducting key informant interviews over the phone using a recorder. Each key informant group was asked a set questionnaire for data consistency. We also held two focus groups and these women

were asked questions from a specific questionnaire. These focus groups were taped. These interviews and focus group discussions were then transcribed and sent to University of Texas Health Science Center for interpretation and summation.

A pool of 57 key informants were approached for interviews consisting of community leaders, community service providers, breast health providers, educators and navigators as well as women from Hood, Johnson, Parker and Tarrant counties. Of these 43 we were able to be interviewed. Nine were from Tarrant County, 13 from Parker County, 10 from Johnson County and 11 from Hood.

We interviewed 15 women who had received a screening mammogram. Five were from Tarrant County, three from Parker County, one from Johnson County and two from Hood County. Of these 15 women, eleven were Caucasian, 2 were African American and one was Hispanic.

We interviewed nine women who were breast cancer survivors. One was from Tarrant County, three were from Parker County, three were from Johnson County and two were from Hood County. Of these nine women, eight were Caucasian and one was African American.

We conducted two focus groups. The focus group conducted in Tarrant County was comprised of five African American women and one Caucasian woman. The focus group in Hood County was comprised of four Caucasian women.

Overview of Target Communities Findings

Across the targeted counties in the Affiliate Service Area, the continuum of care was found to vary among women according to residential location and access to assets in each county. This has implications for women's health outcomes, and for action planning to raise community awareness and enhance support services.

Findings from qualitative interviews with community leaders, service providers, breast health service providers, educators and navigators in selected counties point to the importance of enhancing the continuum of care. Specific needs are for funding more treatment, expanding screenings, socially and culturally-relevant education, and community awareness of services. Language barriers, fear of diagnosis, cost of care, and lack of transportation hinder access to screening and care. Yet both patients and service providers are aware of and depend on Komen for various kinds of support.

In every instance for all four counties, but especially in the new service area counties, there was welcome acceptance of the Affiliate and expressed willingness to partner by such agencies and organizations as civic groups, churches, Chambers of Commerce, United Way, indigent health care clinics and service organizations. The collaboration with the Affiliate and the CPRIT (Cancer Prevention Research Institute of Texas) funded mobile mammogram units and other screening initiatives funded by Komen is already in place and gives promise of significantly increasing the numbers of screening

mammograms to be provided. Tarrant County Public Health and Moncrief Cancer Institute are both Breast and Cervical Cancer (BCCP) providers in all four counties, and consequently the need for more outreach and education initiatives by the Affiliate is essential. The open reception by civic groups and local and state government officials provides more opportunity for the Affiliate to deliver the message of the importance of policy issues such as continued funding of CPRIT, BCCP and Medicaid Treatment programs.

Conclusions

Overview of Final Findings

Findings from the quantitative data show that Hood County needs further attention due to the high breast cancer incidence rate, low mortality rate, unknown breast cancer screening rate, and high proportion of uninsured women. Johnson County appears most economically disadvantaged. Hood, Johnson and Parker Counties are predominantly Caucasian. Johnson and Parker Counties are underserved for cancer services, since their mortality rates are highest and they have low medical resources (physicians and hospitals). Tarrant County is the largest and most densely populated with a younger population and a higher educational level, but with the highest number of uninsured women age 40-60 years, and with the most culturally diverse population. Tarrant County has sufficient health resources, higher screening rates, and lower mortality rates. Efforts need to be directed toward the large number of women without access to care, and the diverse population's needs for cancer screening and treatment.

Findings from the qualitative analysis show that there are specific needs for funding more socially and culturally sensitive and relevant education, expanded screenings, community awareness of services and expanded treatment across the service area. Barriers to these types of services are fear of diagnosis, cost of care, language barriers and lack of transportation.

Findings from the qualitative analysis show that the continuum of care is uneven for women in the targeted counties, leading to the conclusion that women's disparate health outcomes must be addressed by action planning by the Affiliate to address the barriers stated above.

Narrative of Affiliate Priorities

By taking the time to analyze the current breast health situation in our Service Area, Tarrant, Parker, Johnson and Hood counties, we are able to accurately determine what the needs/gaps are. This in turn allows us to create a timely and relevant action plan and Affiliate priorities.

Based on the findings and analysis, the Affiliate established the following priorities:

1. Increase screening mammograms in the four county service area
2. Develop and implement targeted and culturally sensitive outreach and education programs in FY 2012 and FY 2013
3. Increase fundraising annually by 5% in FY 2012 and FY 2013
4. Promote a vigorous public policy and advocacy program

Priority 1: Increase screening mammograms in the four county service area.
Action Plan

1. Screening mammograms will be the #1 grant funding priority in FY 2012 and FY 2013.
2. Identify mammogram service providers in Parker, Johnson and Hood counties and work with them to increase screening mammograms

Priority 2: Develop and implement targeted and culturally sensitive outreach and education programs in each of the four counties in the service area
Action Plan

1. Identify and train five bilingual education volunteers in the Affiliate service area in FY 2012 to be used in community events to deliver breast health information
2. Offer two training sessions annually for Education volunteers to teach them Komen education messages and breast health information to be used in community events to deliver breast health information. Include training on culturally specific information
3. Develop a plan to measure the outcomes and success of Pink Sunday in FY 2012

Priority 3: Increase fundraising by 5% in FY 2012 and 2.5% in FY 2013.
Action Plan

1. Increase the participation in the Race for the Cure by 2,000 entrants in FY 2012 and FY2013

2. Add nine 3rd Party events in the three new counties in FY 2012 and FY 2013 cumulatively
3. Develop a culture of philanthropy by engaging the Board of Directors in cultivating corporate and individual donors in FY 2012 and FY 2013
4. Write more grants in FY 2012 and FY 2013

Priority 4: Promote a vigorous public policy and advocacy program
Action Plan

1. Attend state Lobby Day in FY 2013 and national Lobby Day in FY 2012 and FY 2013
2. Host an annual event in FY 2012 and FY 2013 for local, state and national politicians including a visit to an Affiliate grantee of their choice.

Introduction

Susan G. Komen for the Cure® History

Ambassador Nancy G. Brinker, founding chair of Komen for the Cure, established the organization in honor of her dying sister Susan G. Komen. It was this promise to her sister that she would do everything in her power to end breast cancer that led to what is now the world's largest breast cancer organization and the largest source of nonprofit funds dedicated to the fight against breast cancer. To date, Komen has raised more than $1.3 billion in this fight.

Affiliate History

The Affiliate owes its inception to one special woman, Rozanne Rosenthal. Rozanne chartered the Tarrant County Affiliate of Susan G. Komen for the Cure in 1992 in honor of her friend and three-time breast cancer survivor, Joan Katz. Working together, Rozanne and Joan went on to inspire grassroots activities and a bounty of energetic volunteers. The first Race for the Cure was held in 1993, and raised over $100,000 from 1,800 participants and fundraisers. The 2010 Race for the Cure raised over $1.6 million. Since its inception, the Affiliate has funded more than $17 million in local grants for life saving breast health education, screening, treatment and health and social support services. In addition the Affiliate has contributed $3 million to national research initiative to find the cures.

In August of 2010 Komen Tarrant County became the Komen Greater Fort Worth Affiliate when it added Parker, Johnson and Hood counties to its service area. The decision to include these three additional counties was driven by Komen Greater Fort Worth and supported by a Komen national initiative to serve the needs in outlying and more rural areas. In addition, Komen Tarrant County grantees expressed a need for Komen funding in these areas.

Seventy-five percent of net funds support breast health programs in Tarrant, Parker, Johnson and Hood Counties. These funds help uninsured or underinsured individuals in our communities receive continuous care and needed treatment. The remaining twenty-five percent of net funds is allocated to national cancer research initiatives.

In 2011, we have worked to maintain the level of BCCP funding in the state budget for the biennium by advocating with Komen volunteers and staff.

We have approved an action plan to identify and to meet with state legislators in our service area. We participated in the February 2011 Komen Texas Lobby Day and visited with many of them. We followed up with them after Lobby Day to solidify the relationships. We identified the office contact who will receive additional Komen statements.

In April, our Affiliate was well represented at the Komen National Lobby Day.

We continue to work to maintain and increase the level of CPRIT funding for screening mammograms in our service area by supporting the efforts of local non-profit mammography centers to receive CPRIT funding. As soon as our 2011 Community Profile is approved, we plan to share data from it and to write letters of support for those applying for funding.

Another initiative of ours is to encourage for-profit mammography centers to develop a program to offer free or reduced cost mammograms for low income, uninsured women. We plan to identify two centers by December 2011 and to meet with representatives by March 2012.

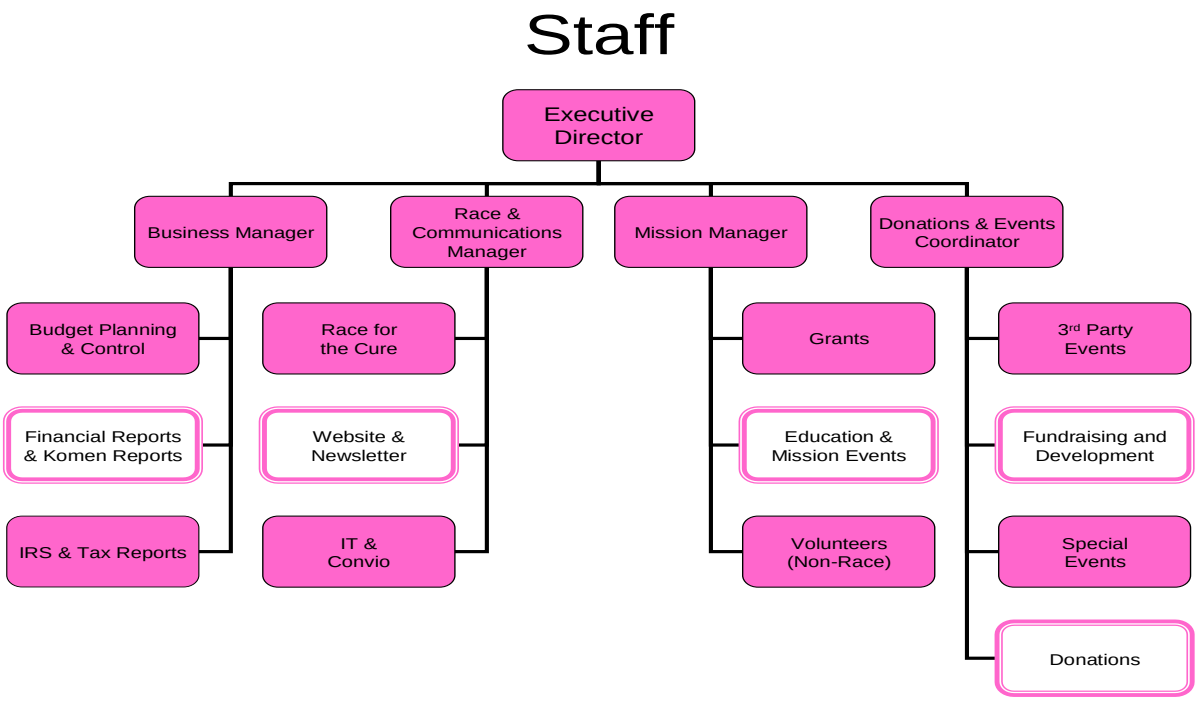
Organizational Structure

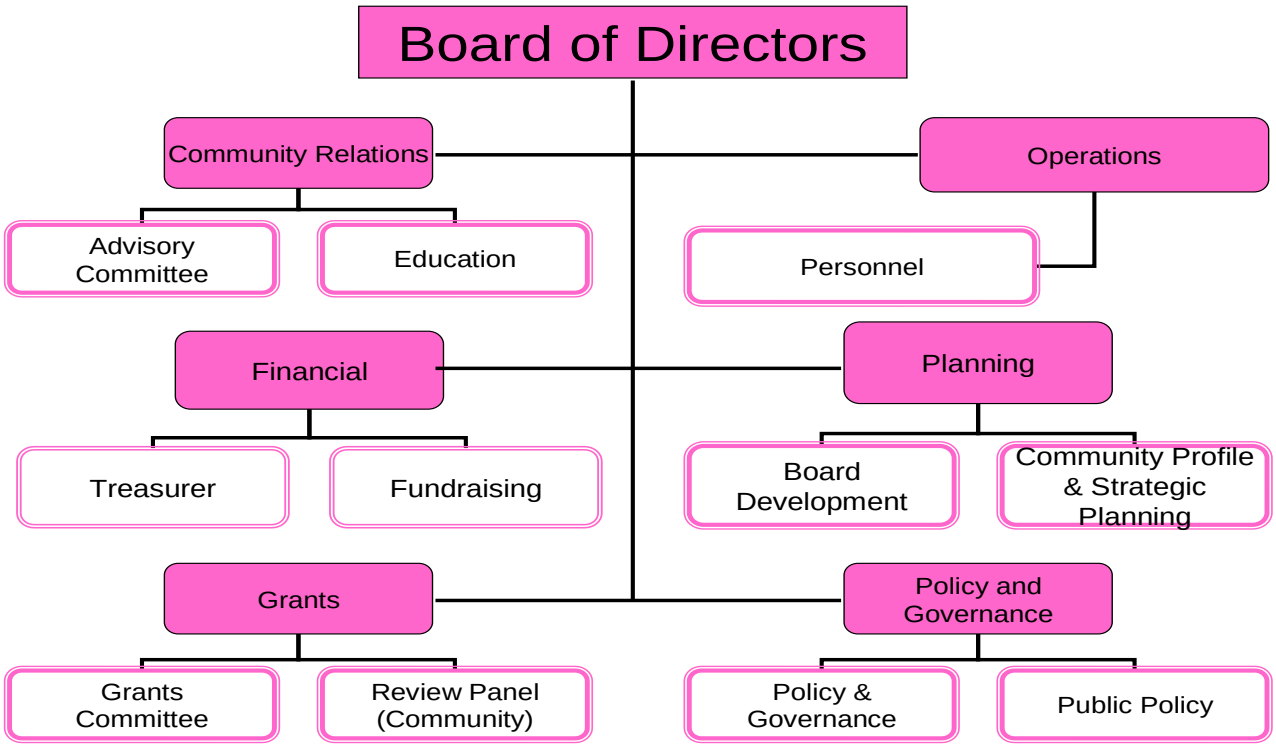
The organization is incorporated in Texas as a nonprofit corporation organized and operated exclusively for charitable, scientific, and educational purposes within the meaning of section 501(c)(3) of the Internal Revenue Code of 1986, as now in effect or as may hereafter be amended, or the corresponding section of any future tax code.

- Staff: The Affiliate staff is comprised of five employees, Executive Director; Business Manager; Race and Communications Manager; Mission Manager; and the Donations and Events Coordinator (See organizational chart below)

- Board Structure: The Board of Directors is currently comprised of 13 members with officers consisting of President, Vice-President, Secretary, and Treasurer. These officers function as the Executive Committee. Other members may serve as Committee Chairs. (See organizational chart below)

Organizational Structure





Description of Service Area

The Affiliate is one of more than 120 in cities and communities around the globe. The service area is comprised of Tarrant, Parker, Johnson and Hood counties in Texas. The Affiliate Service Area is 2,922 square miles with a total population of 2,113,278. Women make up an average of 49.9 percent of this population. (See map below)

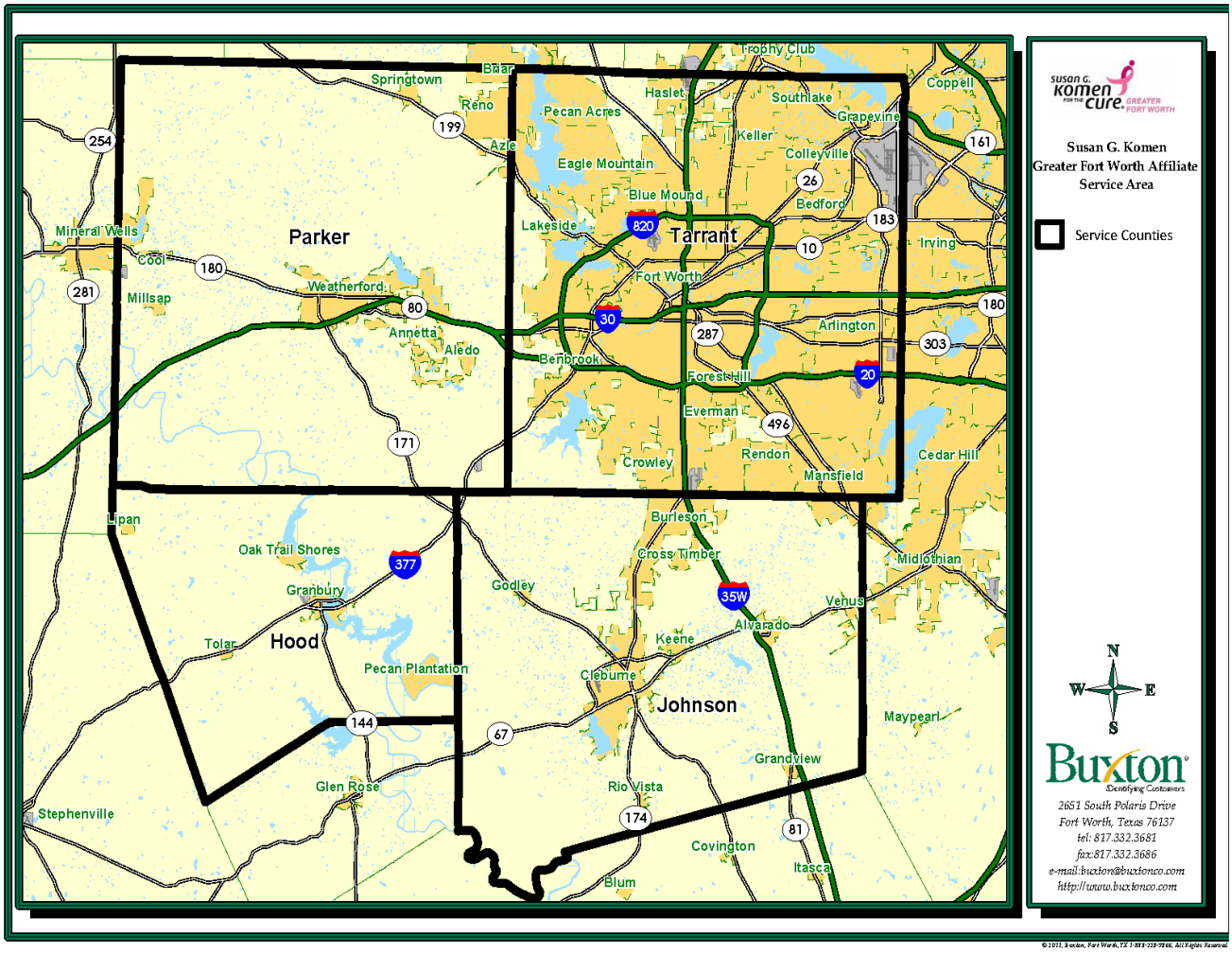
Tarrant County is a thriving, urban area with a diverse economy comprised of energy exploration, industrial and commercial development, and cultural enrichment. Tarrant County, the largest of the 4 counties, is 85 percent of the total population with 1.8 million residents and covering 863 square miles. According to the 2010 U S Census, Tarrant County had a population growth of 25.1 percent in the last decade. It is the third most populous county in the state with Fort Worth as its county seat. Some of the communities in the County showed spectacular growth. For example, Fort Worth's growth of 38.6 percent far outpaced other major cities in Texas. Mansfield had a 101 percent growth rate and Crowley had a 72 percent growth rate.

Parker County covers 904 square miles and is 5.4 percent of the total Affiliate service area population with 114,919 residents, which represents a 16.16 percent growth since 2000. Weatherford is its county seat. Parker County has strong farming and ranching roots.

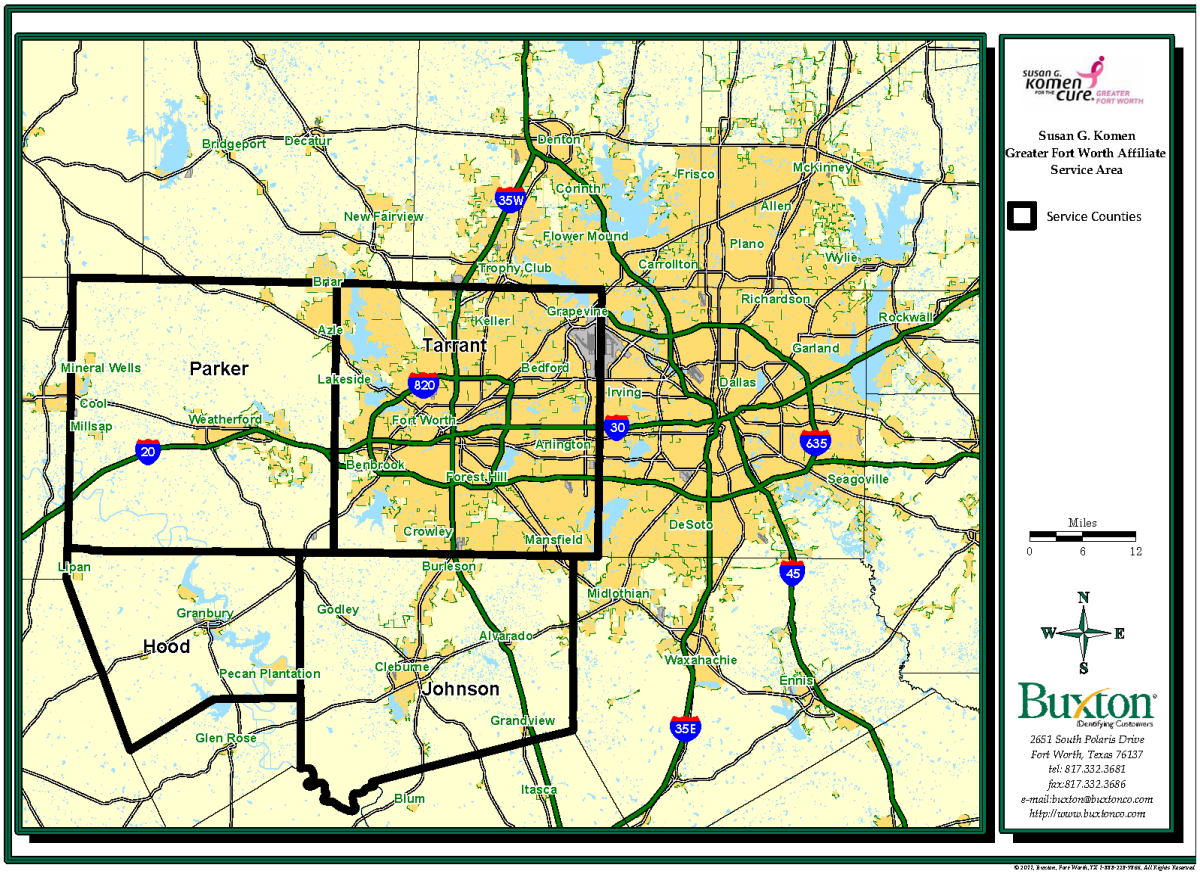
Johnson County, according to the 2010 U S Census data, had a population growth of 19.02 percent with the largest gain in the Hispanic population of 77.68 percent. The Hispanic population now represents 18.1 percent of the population, mirroring a statewide growth in the Hispanic population. Johnson County's population is 156,997, making up 7.4 percent of the Affiliate service area population, and covering 734 square mile area. The county seat is Cleburne. The local government is the largest employer.

Hood County covers 422 square miles. The 2010 U.S. Census shows a population of 51,182 which represents a 24 percent growth rate. Granbury, the county seat, is the largest city and is recognized as a growing retirement community location. Hood County represents 2.2 percent of the Affiliate Service Area.

Service Area Map



Service Area Map



Purpose of the Report

The purpose of the Community Profile report is to gain and present current information on the breast health of communities in the Greater Fort Worth service area. This information is collected to identify and assess local priorities for breast cancer education, screening, treatment and treatment support services currently provided and needed for the under and uninsured population at greatest risk of breast cancer. The information gathered from the periodic Community Profile effort is used to establish Grant funding priorities and to direct Affiliate Strategic planning with the desired result of effective use and distribution of Affiliate funding and resources to better serve breast health needs.

The community profile combined statistical and qualitative data for a comprehensive needs assessment, conducted in collaboration with the School of Public Health at the University of North Texas Health Science Center in Fort Worth and UTSW/Moncrief Cancer Institute in Fort Worth. The investigators created survey instruments, compiled and analyzed quantitative and qualitative data with Affiliate staff and volunteers. This included secondary epidemiological and demographic data from public sources, qualitative data from key informant interviews by Affiliate volunteers with community leaders, health and social service providers, breast health educators and navigators; women screened for breast cancer, breast cancer patients and survivors who are residents of the targeted geographic areas.

The study was reviewed and approved by the Institutional Review Boards at University of North Texas Health Science Center and UT Southwestern. A consent cover letter was used by Affiliates to inform participants about the study. Interview data collected by Affiliate staff, volunteers and service providers was tape recorded and transcribed. Confidentiality of key informants and participants was maintained during the processes of data collection, transfer of responses from the Affiliate to investigators, and transfer back to Affiliates.

Quantitative Data: Breast Cancer Impact in Affiliate Service Area

Data Sources and Methodology Overview

The quantitative portion of the report utilized secondary data collection methods using publicly available data from the following sources:

Area Resource File (http://arf.hrsa.gov/)

Behavioral Risk Factor Surveillance System (http://www.cdc.gov/brfss/)

Texas Cancer Registry (http://www.dshs.state.tx.us/tcr/)

US Census Bureau (http://www.census.gov/)

Limitations of Analysis

Census data is collected for the U.S. population only every ten years.
The specific cause of the paradoxical finding that breast cancer incidence is highest in Hood County in comparison to other counties in the service area, while Hood County has the lowest breast cancer mortality rate, is not known, since data are cross-sectional.

Data on the number of new breast cancer cases and mortalities expected by 2010 are unavailable for Hood County from the Texas Cancer Registry, because they are not reported when 16 or fewer cases are expected. Tarrant County has high incidence but lower mortality.

Quantitative Statistics Overview

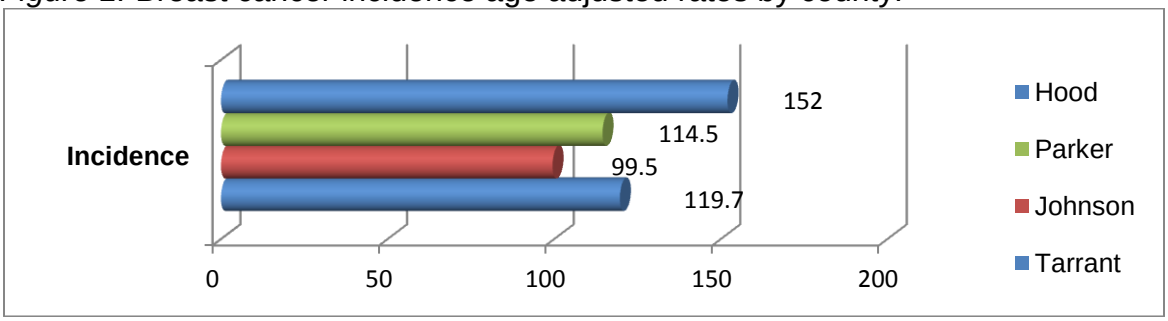
Breast Cancer Epidemiology and Screening

Table 1.
Female Breast Cancer Incidence and Mortality Age Adjusted Rates by County, 2005-2007

	Tarrant	Johnson	Parker	Hood
Incidence, per 100,000	119.7	99.5	114.5	152
Mortality, per 100,000	21.1	28.5	26.3	19.9

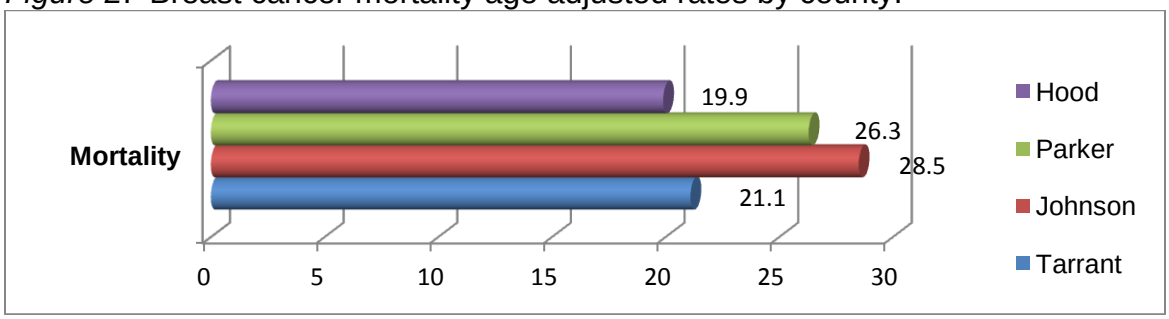
Texas Cancer Registry 2005-2007

Figure 1. Breast cancer incidence age adjusted rates by county.



Texas Cancer Registry 2005-2007

Figure 2. Breast cancer mortality age adjusted rates by county.



Texas Cancer Registry 2005-2007

Breast cancer incidence is highest in Hood County by a large margin in comparison to the other peer counties in the Greater Fort Worth area (see Table 1, Figure 1). However, Hood County has the lowest breast cancer mortality rate (see Table 1, Figure 2). The cause of this paradoxical finding is not known given that the data are cross-sectional. However, we can presume that persons diagnosed with breast cancer in Hood County either (1) have a better survival rate or (2) are migrating to other counties with more cancer care services.

Table 2.
Expected Number of New Breast Cancer Cases and Deaths by County, 2010

	Tarrant	Johnson	Parker	Hood
Cases	1059	118	91	No data
Deaths	183	20	15	No data

Texas Cancer Registry 2005-2007

The expected number of breast cancer cases and deaths for 2010 based on projections from 2005-2007 Texas Cancer Registry may be understated due to the high population growth reported in the 2010 census for all four counties (See Table 2). Data is unavailable for Hood County because the Texas Cancer Registry conceals the number of cases when there are 16 or fewer expected.

Table 3.
Mammograms During the Past 2 Years Among Women 40+ Years of Age by County, 2008

	Tarrant	Johnson	Parker	Hood
%	75	71	71	No data

Behavioral Risk Factor Surveillance Survey 2008

There is no statistically significant difference in the percentage of women receiving mammograms across the Greater Fort Worth area (see Table 3). Data was not collected in Hood County, but the rate is not likely to be lower than 70 percent.

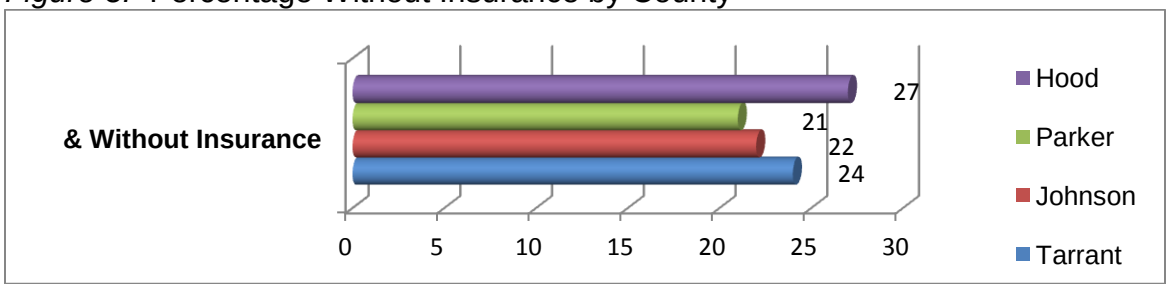
Access to Health Services

Table 4.
Percentage of Persons Without Health Insurance by County, 2009

	Tarrant	Johnson	Parker	Hood
%	24	22	21	27

Area Resource File 2009

Figure 3. Percentage Without Insurance by County



Area Resource File 2009

Hood County has a slightly larger percentage of persons without health insurance although the rate was relatively even across the Greater Fort Worth area (see Table 4, Figure 3).

Table 5.
Estimated Number of Women 40-60 Years of Age Without Health Insurance by County, 2009

	Tarrant	Johnson	Parker	Hood
#	53,000	4,500	3,500	2,000

Area Resource File 2009

These numbers are approximations based on estimates of the population size of women 40-60 years of age in a given county and the percentage of uninsured. These numbers could be used as targets for the need for breast cancer screening and treatment services in each county for women without access to health care (see Table 5).

Social and Economic Characteristics

Table 6.
Population Size and Density by County, 2008

	Tarrant	Johnson	Parker	Hood
Number	1707185	149636	108251	49209
Density (per square mile)	1989	205	120	117

United States Census Bureau 2008

Table 6 above is in descending order of population size and density with Tarrant County the largest county and Hood County the smallest and least dense.

Table 7.
Age of Women by County, 2008

	Tarrant	Johnson	Parker	Hood
Women, %	50	50	50	51
Age 40-49	15	15	16	14
Age 50-59	11	13	15	16
Age 60 +	14	15	17	28

United States Census Bureau 2008

The distribution of gender is equal across the area; however, Hood County has a significantly higher percentage of married women, in part due to the older age structure of the population. The target age group of 40 and older for mammograms is approximately the same across the area (see Table 7).

Table 8.
Race, Ethnicity, and Acculturation by County, 2008

	Tarrant	Johnson	Parker	Hood
Race, %				
White	71	92	94	91
Black or African American	14	4	3	1
Asian or Pacific Islander	5	1	1	1
Am. Indian / Alaska Native	1	1	2	1
Hispanic or Latino	25	16	10	10
Acculturation, %				
Born in the United States	84	94	96	95
English Only at Home	74	87	No data	No data

United States Census Bureau 2008

Tarrant County is significantly more diverse than the other counties in the area with a particularly larger Latino population. In fact, Johnson, Parker, and Hood counties have similar race and nativity profiles with a predominantly White and US born population. There is no data available for language use at home for Hood County because there were too few foreign born persons residing in the county (see Table 8).

Table 9.
Education Level by County, 2008

	Tarrant	Johnson	Parker	Hood
High School Graduate or Higher	83	81	84	86
Bachelor's Degree or Higher	28	16	20	24

United States Census Bureau 2008

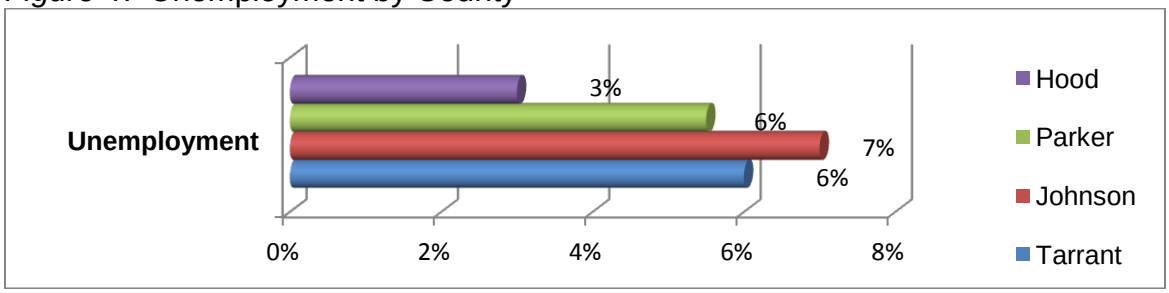
Although the rate of high school graduates is relatively even across the area, Tarrant County has a significantly higher proportion of persons with a college degree or higher followed closely by Hood County (see Table 9).

Table 10.
Employment, Income and Poverty by County, 2008

	Tarrant	Johnson	Parker	Hood
Unemployed, %	6	7	5.5	3
Poverty, %	12	11	9	11
Household Income, $	55425	54161	60477	55527
Per Capita Income, $	27318	23087	25968	29102

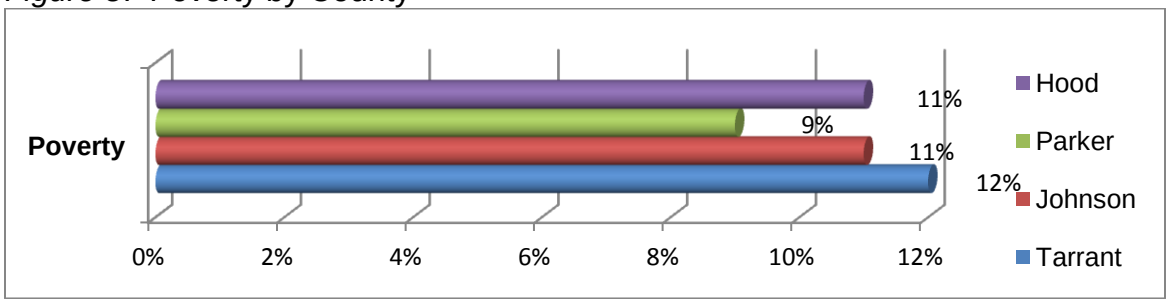
United States Census Bureau 2008

Figure 4. Unemployment by County



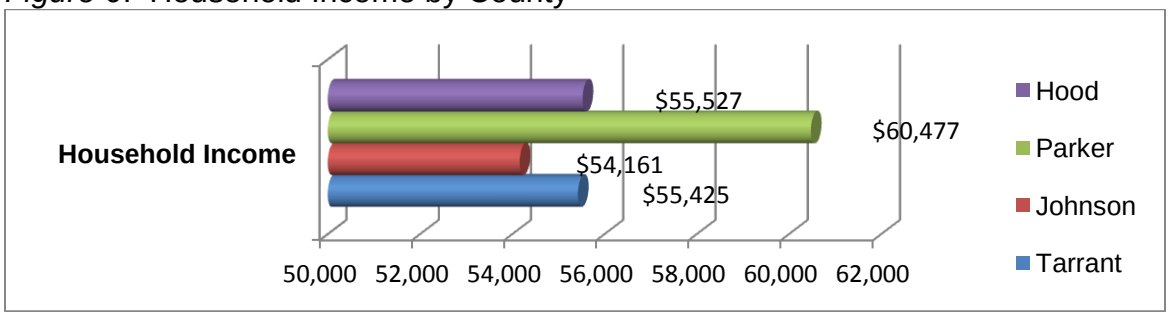
United States Census Bureau 2008

Figure 5. Poverty by County



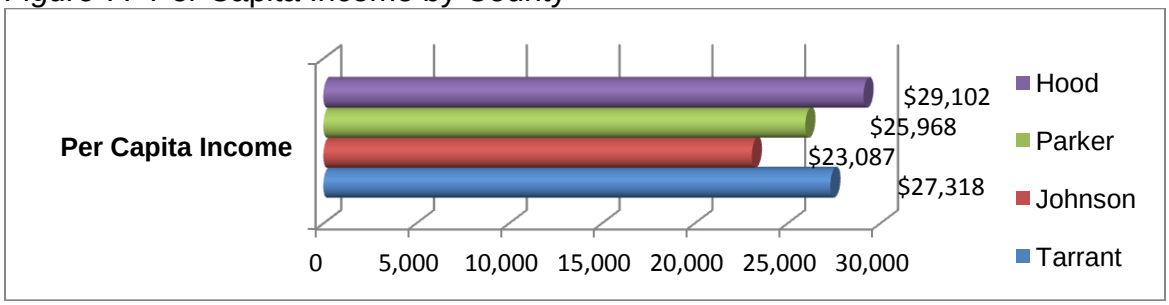
United States Census Bureau 2008

Figure 6. Household Income by County



United States Census Bureau 2008

Figure 7. Per Capita Income by County



United States Census Bureau 2008

The unemployment rate is notably lower in Hood County compared to the other counties in the area (see Figure 4). Parker County has a slightly smaller poverty rate (see Figure 5) and a significantly higher household income level (see Fig. 6). The per capita income is highest in Hood County (see Fig. 7); Johnson County appears to be the most economically disadvantaged (see Table 10).

Counties of Interest: What the Data Shows

Breast cancer incidence is highest in Hood County by a large margin in comparison to other peer counties in the Affiliate area, but this county has a lower mortality rate. The

precise cause of the discrepancy between the incidence and mortality rates is not clear given data limitations and the unknown screening rate.

In Tarrant County, breast cancer screening rates and mortality rates are lower while incidence is higher than in other counties. Health care facilities are sufficient, although they are unevenly distributed.

Key Demographic Variables

Johnson, Parker, and Hood counties have similar race and nativity profiles: overall, they have a predominantly White and U.S. born population.

Johnson County is the most economically disadvantaged. The percentage of persons without health insurance is much higher in Hood County, although the rate of unemployment is lower.

The breast cancer screening rate is unknown for Hood County. Both Johnson and Parker Counties are medically underserved.

Tarrant County has the most plentiful health resources within the service area, but it has the highest number of uninsured women, and many lack access to healthcare. It has both the highest proportion of persons with a college degree or higher, and the most culturally diverse population, including African-, Asian-, Caucasian-, Hispanic-Americans (some undocumented), refugees and immigrants from Southeast Asia and the Middle East. These women tend to have unique needs for breast cancer screening and treatment.

Conclusions

Hood County

Hood County was selected for its high breast cancer incidence rate in comparison to other counties in the Affiliate area, but it has a relatively low mortality rate. While the percentage of persons without health insurance is much higher, the screening rate is unknown.

Johnson County

Johnson County was selected as underserved for cancer services, with the lowest medical resources and the highest mortality rates that may be related. This is the most economically disadvantaged county in the service area.

Parker County

Parker County was selected because it is also medically underserved. Anecdotal evidence may indicate adequate screening rates due to CPRIT funded mobile mammography and locally funded screening mammograms.

Tarrant County

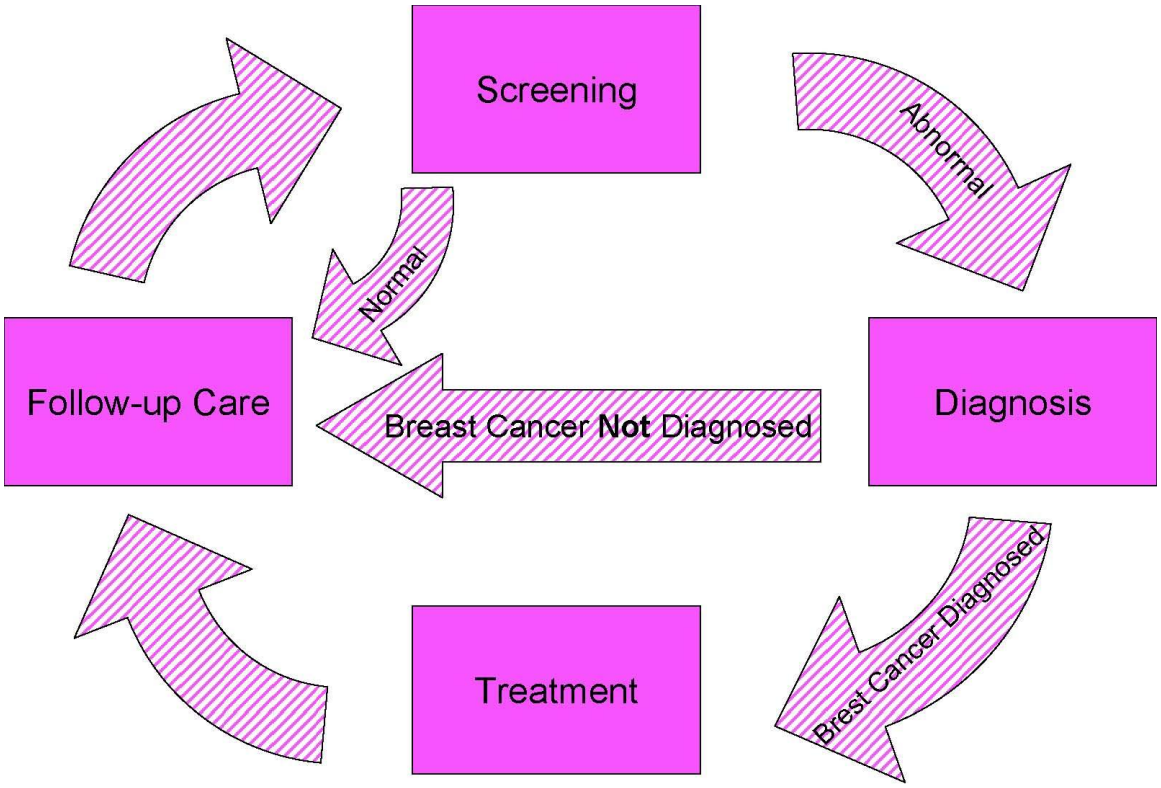
Tarrant County was selected because it has the highest number of uninsured women and the most culturally diverse population.

Health Systems Analysis of Target Communities

We conducted a Health Systems Analysis of the four target counties in order to obtain a complete analysis of gaps, needs and barriers throughout the continuum of care. In addition, this process allowed us to review our community partners and potential partners, as well analyze the current governmental and political issues that surround breast health care and how we play a role in these processes.

Overview of Continuum of Care

Continuum of Care



The continuum of care provided the conceptual framework for the health systems analysis. This model was applied for identifying and understanding the gaps, barriers, health and social service issues for women at each phase: screening, diagnosis, treatment, follow-up health care, financial and social support.

Within the context of each county in the Affiliate area, it was recognized that the interrelated factors that affect women who live in the target communities, in each phase across the continuum of care, have a potentially significant impact on breast cancer incidence, prevalence, and cancer mortality rates.

Methodology

Asset mapping

Assets were identified and mapped geographically for each of the target areas in the Affiliate service area. Information sources for the health systems analysis included Internet searches, key informant interviews, social services directories, churches, indigent care clinics and food banks, Tarrant County Public Health and ethnically focused organizations such as the Hispanic Chamber of Commerce, the African American Chamber of Commerce and health care providers. For each county in the Affiliate service area these assets include the following:

A. Health and social service providers

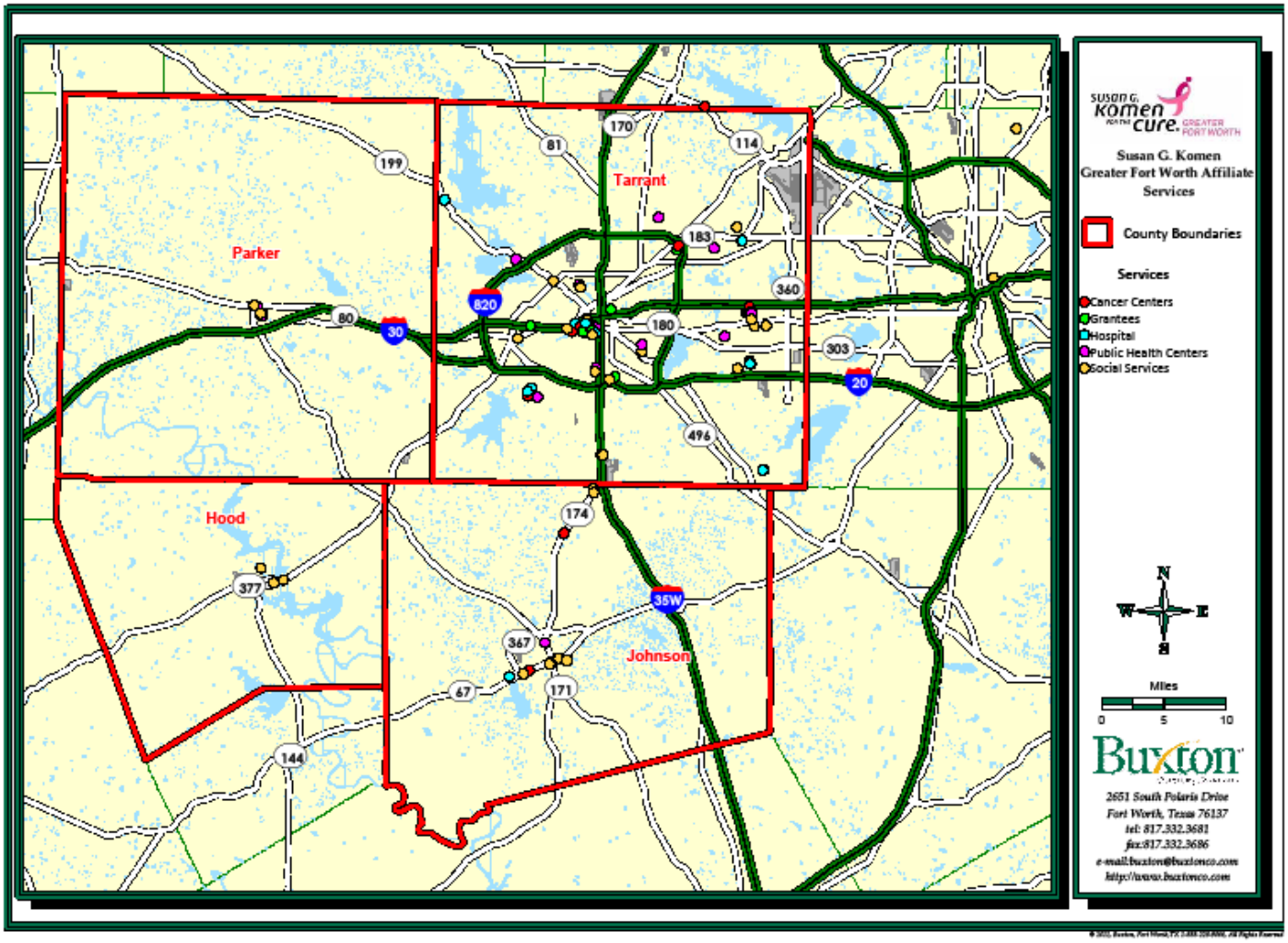
Cancer Centers
Komen Grantees
Hospitals
Public Health Centers
Social Services

B. Mammography Providers

C. "Pink Sunday"

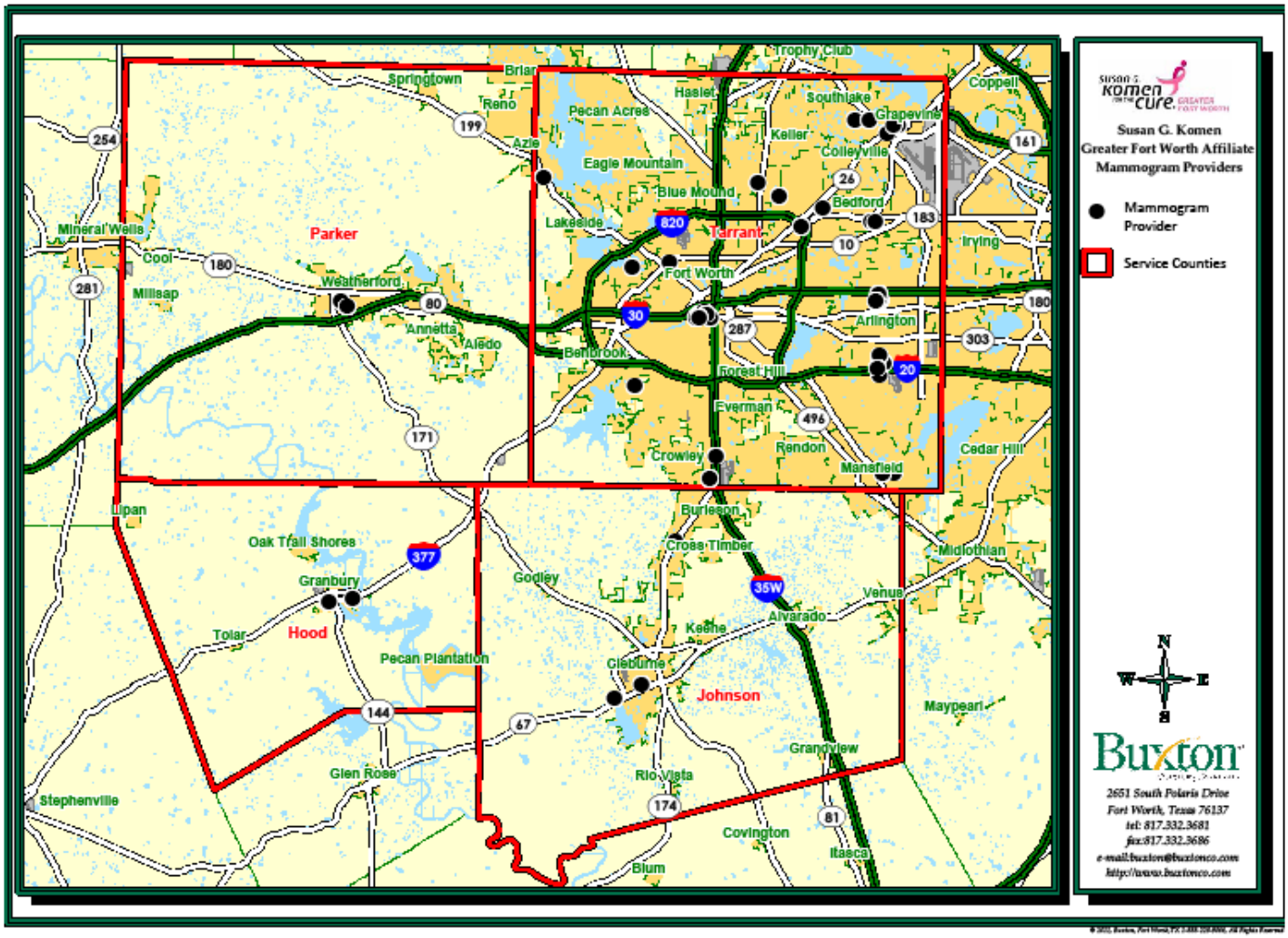
Pink Sunday is an Affiliate program that utilizes churches to promote breast health information. The participation in this program has had significant growth each year since its inception. The majority of Pink Sunday events are located in the Hospital District which has high incidence and mortality rates. (See maps below.)

Health and Social Services



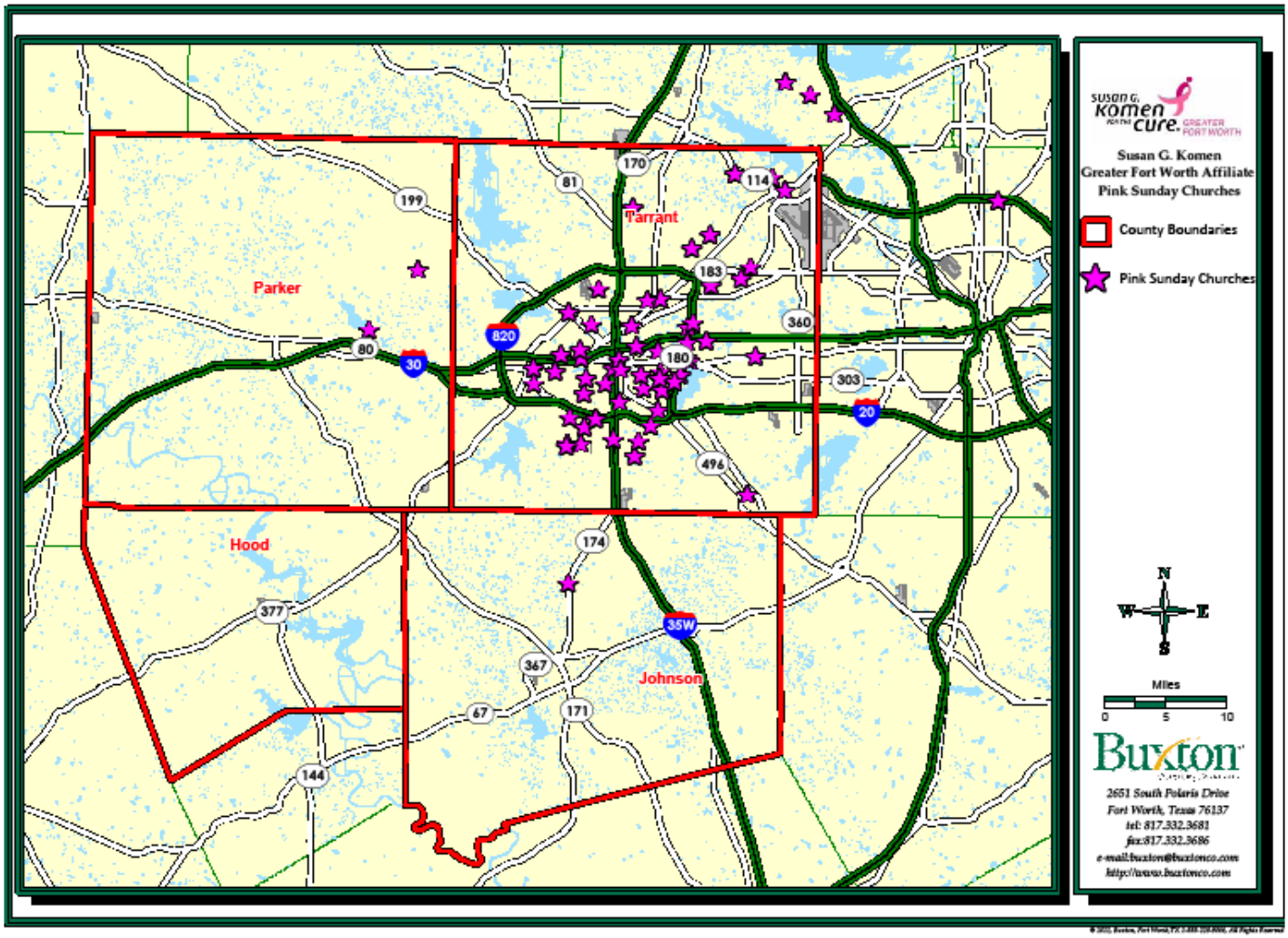
The above map shows the available health and social services in the 4 counties of the Service Area. These include Cancer Centers, Affiliate Grantees, Hospitals, Public Health Centers and Social Services.

Mammogram Providers



The above map shows mammogram provider locations for the 4 counties in the Service Area.

Participating Pink Sunday Churches



Pink Sunday is a Komen program that utilizes area churches to educate parishioners about breast health.

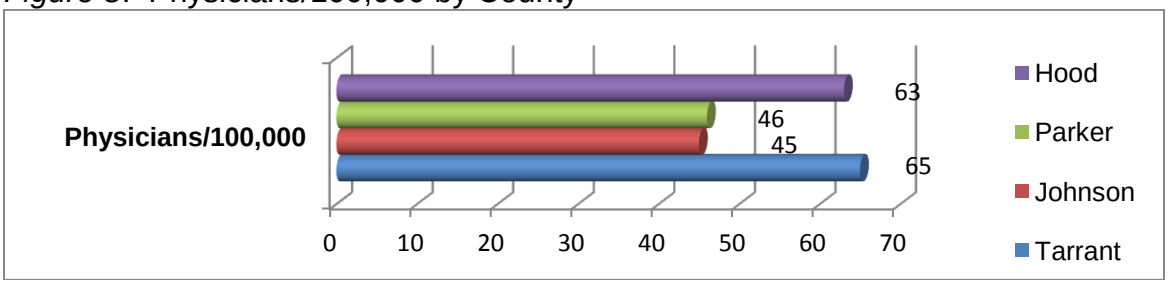
Relevant statistical data

Table 11.
Primary Care Physician Supply by County, 2009

	Tarrant	Johnson	Parker	Hood
Physicians / 100,000	65	45	46	63
Primary Care Shortage Area	Yes	Yes	Yes	No

Area Resource File 2009

Figure 8. Physicians/100,000 by County



Area Resource File 2009

Hood County is the only county without a shortage of primary care physicians. Johnson and Parker counties are substantially underserved (see Table 11 Figure 8).

Table 12.
Number of Hospitals and Ambulatory Surgical Centers by County, 2009

	Tarrant	Johnson	Parker	Hood
Hospitals	28	1	1	1
Ambulatory Surgical Centers	30	2	1	0

Area Resource File 2009

Tarrant County has significantly more hospitals and ambulatory surgery centers (see Table 12). However, these facilities are not evenly distributed in Tarrant County with the majority concentrated in an area of Fort Worth known as the Hospital District.

Key Informants

We conducted key informant interviews in order to gain the perspective of community leaders on the issues that surround breast healthcare. Each of these interviewees has their finger on the pulse of the community in some capacity. It is this knowledge that provided in-depth, real outlooks and extremely relevant information.

Key informants were recruited for individual interviews from the geographic service areas of Hood, Johnson, Parker and Tarrant counties. These areas were selected on the basis of the statistical analysis of demographic and epidemiological data. Key informants were selected to represent community leaders and health and social service

providers in each county in the region. They were interviewed on the following topics: Community health concerns; social issues; perception of breast cancer prevalence; current services available; barriers to breast cancer education and services; location of population served; referral system and use; health services needed; program evaluation; breast cancer services and education for indigent patients; geographic service areas; and perceptions of Komen.

Limitations related to the qualitative data collection

A pool of 57 key informants was approached for interviews consisting of community leaders, community service providers, breast health providers, educators and navigators. The number of key informants who were recruited and participated in interviews varied across the service area, due to variations among counties in community leaders, health, breast cancer and social service providers, and breast cancer educators.

Of these 57, 43 we were able to be interviewed. Nine were from Tarrant County, 13 from Parker County, 10 from Johnson County and 11 from Hood.

Overview of Community Assets

Local social, political, institutional and organizational assets, as well as access to and use of health and social services were found to vary for the population in each county across the service area. This disparity results in variation in both the continuum of care and its effectiveness for women in each community according to their residential locations, occupations, and access and knowledge of services available in each county.

Hood County has few treatment facilities as compared to other counties in the service area. They are, however, the only county without a shortage of primary care doctors. It is common practice to travel to Tarrant County for services, especially treatment, when transportation is available. There is an organization in Hood County, Ruth's Place, that provides indigent health care and where mobile mammography is provided. Follow up with patients is usually done by the organizations providing the mammography, not the local indigent health care organization.

Johnson County does not fare much better when it comes to treatment facilities with only one hospital and two ambulatory surgical centers. Johnson County has the unfortunate distinction of being the most economically disadvantaged county and this is very apparent in the ability of women to find transportation or child care in order to be screened or receive treatment. As in Hood county, there is a not for profit indigent care organization, Hope's Clinic, that provides some health care services and serves a large immigrant population. A partnership with this organization, our Affiliate and the mobile mammogram providers is critical to expanding screening services for the county. Currently our Affiliate funds at a hospital near the county lines of Tarrant and Johnson

Counties a free screening opportunity for indigent populations of all service area counties.

Parker County seems to be adequately served when it comes to screening although the number of hospitals and surgical centers is lower than that of Johnson. Parker has two actively involved screening programs that adequately address the needs of the community. While there are some treatment facilities that are satellites of Tarrant County treatment facilities, it is common place for Parker County residents, as well, to travel to Tarrant County for treatment at the public hospital. The primary asset gaps are transportation to treatment and treatment centers in the county.

Tarrant County has significantly more hospitals and surgical centers. However, these centers are predominately clustered in one area of the county, making these rich resources unavailable to women without adequate transportation. Tarrant County does, however, have a primary care physician deficit. The primary asset gaps in Tarrant County are insurance and transportation to screenings and treatment.

All four counties need more education and outreach efforts. Exploration of possible partners for education and outreach initiatives is needed.

(Role of BCCP in target communities) Gaps

The low number of screening mammograms funded in Texas through BCCP indicates the need for the Affiliate to continue lobbying for funding and promotion and delivery of information to targeted female population groups. The BCCCP Program Manager and Division Manger Community Health Program for TCPH work to qualify women for screening and treatment through BCCP and BCCTP (Medicaid treatment) or outside funding such as the Affiliate Grants.

Key Informant Findings

Insured

Women with insurance self-refer for services, often based on knowledge or advice from others, or receive referrals from physicians. Insurance coverage and out-of-pocket costs for care vary with health care policies.

Uninsured

More Medicaid physicians and services are needed for women who have lost**,** or do not have, health insurance. Some support services may be provided at minimal cost for breast cancer patients. These women often do not quality for BCCP and the Medicaid Treatment program

Undocumented

Service providers may use outreach methods to make patients aware of service availability at minimal or no cost.

BCCP patient

The patient who qualifies for BCCP and Medicaid Treatment is qualified and begins treatment in a short time. The need is to deliver the message to women that these funds are available. One women interviewed had waited ten years since her last mammogram because she did not know of the BCCP screening program.

Legislative issues

In 1990, Congress authorized the Centers for Disease Control and Prevention (CDC) to fund screening and diagnostic services for low-income, uninsured women, which led to the establishment of the National Breast and Cervical Cancer Early Detection Program (NBCCEDP or BCCP). The Breast and Cervical Cancer Prevention and Treatment Act of 2000 was also enacted to allow states to extend Medicaid eligibility to women screened under the Early Detection Program and who need breast or cervical cancer treatment. Screening under the program is defined, at a minimum, as screening paid for with CDC funds.

Under the Breast and Cervical Cancer Treatment Act of 2000, which Texas has opted into, Medicaid coverage is provided to low income, uninsured and underinsured women, age 40- 65 years of age, who have been screened and diagnosed through the NBCCEDP also known as Breast and Cervical Cancer Services (BCCP) programs, and are in need of breast cancer treatment. Additionally, the Texas Legislature, through Senate Bill 10, opted in for the presumptive eligibility option which allows patients who appear to be eligible for Medicaid to enroll in the Breast and Cervical Cancer Treatment Program (BCCTP) and receive treatment on a temporary basis while waiting for their Medicaid application to be processed. The bill also allows any health care provider to refer eligible women in need of treatment directly to Medicaid. This is in great contrast to most states who only allow eligibility to a woman if she is screened through a CDC or NBCCEDP provider. In Texas, the Department of State Health Services (DSHS) manages the program through local and regional health departments.

In the 2009-2010 program year, the Texas DSHS BCCP program provided 15,315 breast screenings, 423 of which detected cancer. Since 1991, the BCCP program in Texas has screened approximately 189, 259 women for breast cancer. A 2009 Government Accountability Office (GAO) report to the Senate Finance Committee estimated that from 2005 through 2006, the BCCS program nationally provided mammograms to 15 percent of eligible women 40 to 64 years of age. About 26 percent of eligible women received screening mammograms from other providers such as free clinics and mobile vans similar to those funded by grants from the Affiliate. The remaining 60 percent of eligible women did not receive a mammogram from any provider. The total number of breast screenings for 2009-2010 of 15,315 for the entire

state of Texas seems grossly inadequate given that at the 26 percent rate of uninsured women in Texas between the ages of 18-64 the number of uninsured women is estimated to be over 3 million women.

The public policy and advocacy emphasis of the Affiliate supports continued funding of the BCCP and the treatment through BCCTP (Medicaid) both with national legislators and Texas legislators for DSHS BCCP. Additionally, on the national level, Affiliate public policy advocates have participated in lobby days to encourage the continuance of the Breast Cancer Research Stamp (The Stamp). Proceeds from the stamp sales fund research at the National Institutes of Health and the Medical Research Program at the Department of Defense. The Stamp, first issued in July, l998, has raised over $71 million for breast cancer research.

The low number of screening mammograms funded in Texas through BCCP is not only a strong indication of the need for the Affiliate to continue lobbying for funding, but also for the grassroots organizations to promote and deliver information to targeted female population groups to publicize the availability of low cost and/or free screening mammograms. The efficacy of government funding and society collaboration (Komen and other breast cancer nonprofit organizations) is critical to saving lives.

The Affiliate has a longstanding relationship with the Tarrant County Public Health Department (TCPH) which manages the BCCP and BCCTP for DSHS. Affiliate grants also fund TCPH for screening and diagnostic procedures for women who do not meet the BCCP and BCCTP criteria for various reasons such as age or too much income. Cheryl Loudermilk, the BCCCP Program Manager and Florastine Mack, Division Manager Community Health Program for TCPH work diligently to qualify women for screening and treatment through BCCP and BCCTP or from outside funding such as the Affiliate grants.

Texas passed Prop 15 in November 2007 which created the Cancer Prevention and Research Institute of Texas (CPRIT). Two Affiliate funded mobile mammogram screening providers, UT Southwestern/Moncrief Cancer Institute and Texas Health Resources have also been jointly funded by CPRIT for screening mammograms in rural counties that include Johnson, Parker and Hood counties in the Affiliate Service Area. The Affiliate, along with all Texas Komen Affiliates, The Lance Armstrong Foundation and the American Cancer Society conducted a vigorous lobbying effort for Proposition 15 and are already seeing beneficial results in the Affiliate service area.

Conclusions

Across the targeted counties in the Affiliate Service Area, the continuum of care was found to vary among women, according to their residential location and access to assets in each county. This has implications for women's health outcomes, and for action planning to raise community awareness and enhance support services.

Findings from qualitative interviews with breast health service providers, educators and navigators in selected counties point to the importance of enhancing the continuum of care, through funding more treatment, expanding screenings and socially and culturally-relevant education for community awareness of services. The key informants find that language barriers, fear of diagnosis, cost of care, and lack of transportation hinder access to screening and care, although many patients are aware of and depend on Komen for support.

Breast Cancer Perspectives in the Target Communities

Information from a community perspective was collected on knowledge, attitudes and beliefs about breast cancer, resources in the target communities, current education and outreach effectiveness, and recommendations to reach other women in the community. Women who participated in screening were interviewed on education, outreach, and screening experiences. Survivors were interviewed to understand the full continuum of care from their perspective and care available after diagnosis, through treatment, follow-up care and support services.

Methodology

Data collection from women in the community

Qualitative data was collected from women in the community, using semi-structured interviews and focus groups.

We interviewed 15 women who had received a screening mammogram. Five were from Tarrant County, three from Parker County, one from Johnson County and two were from Hood County. Of these 15 women, 11 were Caucasian, two were African American and one was Hispanic.

We interviewed nine women who were breast cancer survivors. One was from Tarrant County, three were from Parker County, three were from Johnson County and two were from Hood County. Of these nine women, eight were Caucasian and one was African American.

We conducted two focus groups. The focus group conducted in Tarrant County was comprised of five African American women and one Caucasian woman. The focus group in Hood County was comprised of four Caucasian women.

Participants were recruited in each target community, based on criteria below. They were interviewed either by telephone or in person, using questionnaires on the following topics, or in the case of focus groups, they were led through a discussion using a specific questionnaire:

1)Breast cancer screened persons: perceptions of need for screening, age of first screening, frequency of screening, type of provider, barriers to breast cancer screening, use of breast self-exams, breast cancer education sources used, roles of Affiliates, service provision by Komen.

2)Breast cancer survivors: use of breast self-exams, use of mammograms, screening frequency/barriers, age at diagnosis, stage of cancer, type of breast cancer treatment/provider, breast health navigator use, barriers to breast cancer treatment (time, financial, providers, family roles), health insurance/lack of insurance, use of

community services/resources, treatment/care needs, length of survivorship, support groups, breast cancer education/service needs, Komen and Affiliates' services.

3)*Focus Groups of Screened and Survivors*: most important health issues for women, community health information, where to go for breast health information, who has greatest need for information and services, barriers, how to encourage women to seek breast health screenings, what was your (or someone else's) experience with breast health information and services, Komen services and how to get the word out

Interviews and focus groups were taped and transcribed for analysis by investigators. Participants' responses to interviews and focus group discussions in each category were compared and analyzed for common themes, and variations in women's perceptions and experiences.

Review of Qualitative Findings

Four overall themes emerged from the target community interviews and focus groups. They are as follows:

a. There is a need in the community for targeted, culturally sensitive outreach and education programs and materials. Women interviewed in the community confirmed the need for more education on available breast cancer services and support. Most of those interviewed were not aware of screening mammograms available through Komen Grants, through BCCP or other funding such as CPRIT funding. They tend to have screening mammograms when they have a friend or family member with breast cancer and seek care when they perceive the need. Some, including African-American, Caucasian and Hispanic women, are hindered by fear and by financial, social, economic, cultural and language barriers. One woman waited 10 years between mammograms because she did not know low cost or free mammograms were available. In our focus groups specifically, it became very apparent that women of different social and cultural backgrounds had differing concerns. Some specific cultural groups displayed significant fears surrounding screening and treatment that others groups did not. One woman said she knew many other women from older generations who simply preferred not to know because they were convinced there would be no help if they were diagnosed positive. Women in rural areas often do not have adequate information regarding availability of breast health resources.

b. There is a need for more screening mammograms as well as enhancement of the continuum of care because it varies greatly across residential location and affects access to assets. For example, Tarrant County has a more resources for women as compared to the other three counties. The women in the other three counties were keenly aware of the disparity. Women in focus groups noted they were more likely to seek screening mammograms through mobile unit locations familiar to them such as churches, indigent care clinics, etc. One woman stated that she has been getting her mammogram every year now that the mobile unit

started coming to her church, but this year had to wait until it came for a second time because the program has become so popular.

c. A need exists for greater collaboration among agencies to foster improved working relationships. Throughout the qualitative analysis portion of this process we saw women discovering resources that they were unaware of until it came up in an interview or focus group. This was most common in the focus groups where women were able to have discussions about resources across the continuum of care. Many found out that they were eligible for services at another social service provider and that their current social service provider was unaware of these benefits. We need to encourage cooperation across the continuum of care between providers so that they may synergistically improve their ability to serve the patient.

d. Women recognize a need for more widely available and coordinated patient navigation care as well as funding for treatment in the service area. Breast cancer survivors have found that most health care providers are supportive, and many express appreciation for the essential roles that Komen, Moncrief, John Peter Smith Hospital/Health Network, Harris/Texas Health Resources, and local cancer care centers play in referrals, treatment and financial assistance. Most survivors use their own social support systems, including religious groups, rather than designated support groups. Many rely primarily on family and friends and are advocates for themselves. We as an Affiliate need to make sure that women have access to information regardless of where they enter the continuum of care.

   Family members provide most support, but stress, emotional adjustment and fear of death are problems for some women, especially for those diagnosed at later stages. Women also seek preventive care and nutrition for more complete recovery; some also seek treatment alternatives to chemotherapy. Appearance is a concern for some during treatment, but it is not a major issue for many survivors. The most difficult adjustments after diagnosis and during treatment include medical complications and uncertainty of prognosis, although this varies among survivors.

   While Hispanic women in the area rely on family members, including mature children, for support, they need to be assured of financial and social services. Hispanic women may be more aware of the need for and availability of breast cancer screening and care than Asian or Middle Eastern women who often are recent immigrants.

   Tarrant County is perceived as having the widest range of services, with the need greater in other counties. Transportation, scheduling and availability of screening and care are important issues in rural areas and smaller towns.

Conclusions

The qualitative analysis clearly showed the need for more education outreach that is socially and culturally sensitive and relevant. In addition, once women become more aware we need increased access to screening in a manner that meets the woman "where she is." Mobile units seem to be very popular and women who would otherwise be fearful of getting a screening mammogram tell us that they are less fearful when being screened among their peers. The units also help when transportation is a problem. We also saw a need for increased collaboration across the continuum of care between providers in order to maximize the overall experience of the patient. Lastly, women expressed the need for more widely available patient benefits such as navigation and other health and social services.

Conclusions: What We Learned, What We Will Do

Review of the Findings

Quantitative Data

1. Hood County has need for further assessment to determine needs, given the unknown breast cancer screening rate, high breast cancer incidence rate, low mortality rate, and high proportion of uninsured women..
2. Johnson and Parker Counties have inadequate local medical resources for cancer screening and treatment including physicians and hospitals which may account for their high mortality rates.
3. Tarrant County has sufficient health resources but a high number of uninsured women and a culturally diverse population without access to health care in part due to cultural and language barriers.

Health Systems Analysis Data

1. Findings from interviews and focus groups indicate that the continuum of care is uneven for women in the targeted counties and varies according to residence and access
2. Language, cultural and economic barriers hinder access to screening and care
3. Wider knowledge of available low cost or free screening mammograms is needed
4. Lack of insurance and fear of diagnosis are also barriers for women in all four counties
5. Transportation, scheduling and availability of screening and care are important issues in rural areas and smaller towns.

Qualitative Data

1. There is a need in the community for targeted, culturally sensitive outreach and education programs and materials.
2. Access to screening continues to be a problem throughout the service area, but most specifically in the three outlying counties.
3. Collaboration across the continuum of care hinders access to care and quality of care.
4. Issues of survivorship exist in all four counties. Family, friends and religious groups play a major and primary role in support, but those who have access to and utilize institutional support as well as peer support are most satisfied with their overall experience.

Conclusions

In general, the continuum of care is uneven for women in the targeted counties, leading to the conclusion that women's disparate health outcomes must be addressed by action planning to enhance both community awareness and breast cancer support services. Socially and culturally-relevant health education, screenings, service coordination, and funding for treatment and follow-up care need to be expanded across the service area.

With respect to specific areas, the above findings from quantitative data analysis and the qualitative interviews with key informants and women in the community demonstrate that in-depth assessment of the adequacy of breast cancer services is needed for Hood County. There is an evident need to expand resources for cancer treatment in Johnson and Parker Counties, the most medically underserved.

While Tarrant County has the most plentiful health resources as compared with the other three counties, these are unevenly distributed, and are relatively inaccessible for uninsured women and many in specific population groups. Although overall breast cancer screening rates are higher, and incidence and mortality rates lower than in other counties, services should be directed toward women who lack access to healthcare, and providers need to collaborate with diverse communities and leaders for socially- and culturally-appropriate care.

In particular, language, cultural and economic barriers hinder breast cancer screening and care. There is a growing need to sensitively address women's fear of cancer diagnosis, lack of health insurance, inability to pay for care, and lack of knowledge of available services and financial support by Komen and local providers.

This should be done in coordination with family members, and with community centers and churches, for social services, health education and screening in target areas. More widely available coordinated patient navigation care and funding for treatment should be provided along with more accessible screening and care in rural areas and smaller towns.

While most health care providers are appreciated by women in the service area, greater coordination by Komen with public health and healthcare providers and cancer care centers would enhance the adequacy of treatment and financial assistance. Support services should be available for individual patients and survivors who rely on their own social networks and religious groups to deal with stress and emotional responses to treatment and recovery processes.

To achieve these goals, Komen can expand its presence among socially diverse groups and communities, as well as collaborate with local organizations and leaders. In particular, there is a need to enhance women's awareness of financial services that may be available, while maintaining Komen's recognized role in fostering breast cancer awareness and raising funds for research for effective diagnoses and treatments.

Affiliate Priorities and Action Plan

By taking the time to analyze the current breast health situation in our Service Area, Tarrant, Parker, Johnson and Hood counties, we are able to accurately determine what the needs/gaps are. This in turn allows us to create a timely and relevant action plan and Affiliate priorities.

Based on the findings and analysis, the Affiliate established the following priorities:

5. Increase screening mammograms in the four county service area
6. Develop and implement targeted and culturally sensitive outreach and education programs in FY 2012 and FY 2013
7. Increase fundraising annually by 5% in FY 2012 and FY 2013
8. Promote a vigorous public policy and advocacy program

Priority 1: Increase screening mammograms in the four county service area.
Action Plan

3. Screening mammograms will be the #1 grant funding priority in FY 2012 and FY 2013.
4. Identify mammogram service providers in Parker, Johnson and Hood counties and work with them to increase screening mammograms

Priority 2: Develop and implement targeted and culturally sensitive outreach and education programs in each of the four counties in the service area
Action Plan

4. Identify and train five bilingual education volunteers in the Affiliate service area in FY 2012 to be used in community events to deliver breast health information
5. Offer two training sessions annually for Education volunteers to teach them Komen education messages and breast health information to be used in community events to deliver breast health information. Include training on culturally specific information
6. Develop a plan to measure the outcomes and success of Pink Sunday in FY 2012

Priority 3: Increase fundraising by 5% in FY 2012 and 2.5% in FY 2013.
Action Plan

5. Increase the participation in the Race for the Cure by 2,000 entrants in FY 2012 and FY2013
6. Add nine 3rd Party events in the three new counties in FY 2012 and FY 2013 cumulatively
7. Develop a culture of philanthropy by engaging the Board of Directors in cultivating corporate and individual donors in FY 2012 and FY 2013
8. Write more grants in FY 2012 and FY 2013

Priority 4: Promote a vigorous public policy and advocacy program
Action Plan

3. Attend state Lobby Day in FY 2013 and national Lobby Day in FY 2012 and FY 2013
4. Host an annual event in FY 2012 and FY 2013 for local, state and national politicians including a visit to an Affiliate grantee of their choice.

Reference List

Area Resource File (http://arf.hrsa.gov/)
Provided by the Health Resources and Services Administration of the Department of Health and Human Services, this database contains information on all counties in the United States (N = 3,225) from over 50 sources.

Behavioral Risk Factor Surveillance System (http://www.cdc.gov/brfss/)
The Behavioral Risk Factor Surveillance System (BRFSS) is the world's largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984.

Texas Cancer Registry (http://www.dshs.state.tx.us/tcr/)
Provided by the Texas Department of State Health Services, the Texas Cancer Registry (TCR) is a combination active and passive surveillance system responsible for the collection, maintenance, and dissemination of high quality population-based cancer data.

US Census Bureau (http://www.census.gov/)
The Census Bureau serves as the leading source of quality data about the nation's people and economy.