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Introduction to the Community Profile Report

Susan G. Komen® Central Indiana began its work in central Indiana in 1992 with the first Race for the Cure® under the auspices of the Junior League of Indianapolis. In 2001, leaders envisioned that this effort could be more than a Race and incorporated as an Affiliate of the Susan G. Komen organization. Led entirely by volunteers, the organization was raising more than one million dollars annually, before hiring its first paid staff member in 2003. In 2011, the Affiliate’s name was changed from the Indianapolis Affiliate to Susan G. Komen Central Indiana to reflect the Affiliate’s broader service area. In 2015, the Affiliate merged with the Susan G. Komen Wabash Valley Affiliate, broadening its reach even further throughout the State of Indiana.

Komen Central Indiana reaches out to the community to educate breast cancer survivors, family and friends, caregivers, and the public by organizing and attending local events, offering presentations, developing written communications, and collaborating with other organizations serving the community.

The greatest part of the money received by Komen Central Indiana remains in the community as a source of help for Hoosiers in need. It goes to pay for services—including screenings, diagnostic testing, education, and patient navigation—that benefit local women and men. Komen Central Indiana has granted more than $16 million to local nonprofit organization carrying out these services. In the 2014-2015 grant cycle, $848,000 funded 11 local breast health programs that provided nearly 40,000 services to more than 25,000 unduplicated individuals.

Additionally, a meaningful portion of the money received by Komen Central Indiana funds Susan G. Komen Research Program endeavors to discover breast cancer causes, treatments, and, ultimately, the cures. Susan G. Komen has funded, in part, many advancements in breast cancer research in the last 30 years.

Komen Central Indiana strives to be a local expert and leader in the breast cancer movement in central Indiana. The organization is an active member of the Indiana Cancer Consortium and received the 2013 award for Outstanding Contributions to Cancer Control. In 2014, Komen Central Indiana launched a coalition of local leaders committed to addressing the disparity in breast cancer deaths between Black/African-American and White women in Indianapolis. Representatives from the Komen Central Indiana staff and Board of Directors serve with numerous local agencies and organizations to advocate for and strengthen systems and resources for women, men, and families who face breast cancer in the local community.

The Affiliate service area includes 41 counties across Indiana and Illinois. Counties served include: Bartholomew, Blackford, Boone, Brown, Clay, Clinton, Decatur, Delaware, Fayette, Fountain, Franklin, Grant, Greene, Hamilton, Hancock, Hendricks, Henry, Howard, Jay, Johnson, Madison, Marion, Monroe, Montgomery, Morgan, Owen, Parke, Putnam, Randolph, Rush, Shelby, Sullivan, Tippecanoe, Tipton, Union, Vermillion, Vigo, Warren, and Wayne Counties in Indiana and Clark and Edgar Counties in Illinois (Figure 1).
Figure 1. Susan G. Komen Central Indiana service area
The Affiliate service area includes the metropolitan areas of Indianapolis-Carmel, Lafayette, Anderson, Terre Haute, Bloomington, Muncie, Kokomo, and Columbus (in order of population). Indianapolis is the largest urban area in the service area, while those who live in rural areas comprise 16.4 percent of the population and 16.89 percent live in medically under-served areas.

**Purpose of the Community Profile Report**

The Community Profile is an assessment process completed every four years by Susan G. Komen Central Indiana, in order to understand the state of the breast cancer burden and needs in the service area. The information outlined in the report is vital to Komen Central Indiana for developing grant funding and programming priorities.

The Community Profile is actively used as a framework to identify the prevalence of breast cancer on a local level, recognize service gaps in breast health and breast cancer needs, and develop priorities to address those needs. The Community Profile serves to:

- Align strategic and operational plans
- Drive inclusion efforts in the community
- Drive public policy efforts
- Establish focused granting priorities
- Establish focused education needs
- Establish directions for marketing and outreach
- Strengthen sponsorship and development efforts

The final Community Profile Report will be shared with the community through a press release and made available via the Susan G. Komen Central Indiana website.

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

The purpose of the quantitative data report for Susan G. Komen Central Indiana 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 Komen Central Indiana’s service area based on estimates of how long it would take an area to achieve Healthy People 2020 objectives for breast cancer late-stage diagnosis and death rates ([http://www.healthypeople.gov/2020/default.aspx](http://www.healthypeople.gov/2020/default.aspx)).

**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. 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. 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 used in the Community Profile Report.

Overall, the breast cancer incidence rate in the State of Illinois was slightly higher than that observed in the US as a whole and the incidence trend was similar to the US as a whole. The
breast cancer incidence rate in the State of Indiana was slightly lower than that observed in the US as a whole and the incidence trend was similar to the US as a whole.

The incidence rate was significantly lower in Brown, Decatur, Fayette, Franklin, and Wayne Counties in Indiana. The incidence rate was significantly higher in Fountain and Jay Counties in Indiana. Tipton County in Indiana had an incidence rate trend that was significantly less favorable relative to the State of Indiana. The rest of the counties had incidence rates and trends that were not significantly different than their respective states or did not have enough data available.

**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. 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. To show trends in cancer deaths, data for the annual percent change in the death rate over a five-year period were used.

Overall the breast cancer death rate in the State of Illinois was similar to that observed in the US as a whole and the death rate trend was lower than the US as a whole. The breast cancer death rate in the State of Indiana was slightly higher than that observed in the US as a whole and the death rate trend was similar to the US as a whole.

None of the counties in Komen Central Indiana’s service area had substantially different death rates than their respective state as a whole or did not have enough data available.

**Late-stage diagnosis:** 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. Trends are calculated by the annual percent change in late-stage diagnosis rates between 2006 and 2010.

Overall, the breast cancer late-stage incidence rate in the State of Illinois was significantly 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 breast cancer late-stage incidence rate in the State of Indiana was significantly lower 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 was significantly lower in Henry, Madison, and Wayne Counties in Indiana. The rest of the counties in Komen Central Indiana’s service area had late-stage incidence rates and trends that were not significantly different than their respective state as a whole or did not have enough data available.

**Mammography Screening:** Getting regular screening mammograms (and treatment if diagnosed) lowers the risk of dying from breast cancer. Screening mammography can find breast cancer early, when the chances of survival are highest. Mammography screening proportions show whether the women in an area are getting screening mammograms when they should.
The breast cancer screening proportion in the State of Illinois was not significantly different than that observed in the US as a whole. The breast cancer screening proportion in the State of Indiana was significantly lower than that observed in the US as a whole.

None of the counties in Komen Central Indiana’s service area had substantially different screening proportions than their respective states as a whole.

**Population Characteristics:** 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. Marion County has a substantially larger Black/African-American female population percentage than that of the State of Indiana as a whole. Clinton County has a substantially larger Hispanic/Latina female population percentage than Indiana as a whole. Fayette and Parke Counties have substantially lower education levels than Indiana as a whole. Delaware and Fayette Counties have substantially lower income levels than Indiana as a whole, and together with Blackford County, they have substantially lower employment levels than Indiana as a whole.

**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. In line with HP2020 cancer-related objectives, the report incorporates county breast cancer death rate and late-stage diagnoses data for years 2006 to 2010 and estimates for the trend (annual percent change) in county breast cancer death rates and late-stage diagnoses for years 2006 to 2010. Areas were compared and categorized from highest to lowest priority, based on a projection for how many years it will take for each county to meet the HP2020 objectives.

Four counties in Komen Central Indiana’s service area are in the highest priority category. Boone and Vigo Counties are not likely to meet either the death rate or late-stage incidence rate HP2020 targets. Rush and Vermillion Counties are not likely to meet the late-stage incidence rate. Two counties in Komen Central Indiana’s service area are in the high priority category Shelby and Wayne Counties are not likely to meet the late-stage incidence rate HP202 target.

**Selection of Target Communities**

The Community Profile Team examined the data provided by Komen Headquarters in the Quantitative Data Report with a special concentration on the Healthy People 2020 (HP2020) target for late-stage diagnosis and death rates. The Team also focused on counties that are likely to reach the HP2020 objectives but are shown to have higher minority populations that are at risk for experiencing barriers to accessing quality health care and completing the continuum of care.

The Community Profile Team analyzed the following for each county:

- Incidence rate
- Death rate
- Late-stage diagnosis
- Screening proportions
- Residents having an income less than 250 percent of the poverty level
- Residents (ages 40-64) living without health insurance
- Unemployment percentages
The three selected target communities are:
- Boone, Rush, Shelby, and Vermillion Counties
- Vigo and Wayne Counties
- Marion County

Boone, Rush, Shelby, and Vermillion Counties were selected as a target community because they are not predicted to meet the HP2020 targets for late-stage incidence rates. The target for late-stage incidence rate is 41.0 per 100,000; each of these counties is predicted to take 13 years or longer to reach this target. Boone and Shelby Counties are also not predicted to meet the HP2020 targets for death rates. Rush and Vermillion Counties’ data around death rates were suppressed due to small numbers. The target for death rate is 20.6 per 100,000. Boone County is predicted to take 13 years or longer to reach this target, and Shelby County is predicted to take eight years or longer.

Vigo and Wayne Counties were selected as a target community because neither is predicted to meet the HP2020 late-stage incidence rate or death rate. The target for late-stage incidence rate is 41.0 per 100,000, and both of these counties are predicted to take 13 years or longer to reach this target. The target to meet the female breast cancer death rate is 20.6 per 100,000. Vigo County is expected to take 13 years or longer to reach this target; Wayne County is expected to take eight years or longer. Interestingly, both counties currently meet the target for late-stage diagnosis rate, but with increasing trends, both counties are not expected to meet the target. Both counties have screening proportions lower than state and national levels.

Marion County was selected as a target community because the predicted time to meet the HP2020 death rate target is 13 years or longer. The target to meet the female breast cancer death rate is 20.6 per 100,000 and Marion County is at 26.1 per 100,000. Marion County was also selected due to its high percentage of minorities and the higher percentage of those living in poverty and without health insurance. According to Hunt et al., Marion County also ranked tenth of the 50 largest cities where non-Hispanic Black/African-American women face disparity in breast cancer deaths.

Health System and Public Policy Analysis

Several resources were used to identify health care facilities that provide breast health services in the three target communities, including clinical breast exams, screening mammograms, diagnostic screenings, treatment, financial assistance, and patient navigation. The analysis also identified the scope and impact of national and state level public policy and programs on breast health services.

The Health Systems Analysis highlights several needs in target communities related to health systems and the Breast Cancer Continuum of Care (CoC).

Boone, Rush, Shelby, and Vermillion Counties: Potential barriers to care could result from the lack of public transportation available in these mostly rural counties. Additional barriers to care include few medical providers for low income, under/uninsured women and lack of dedicated patient navigators responsible for guiding women through breast health screenings at the diagnostic level.
**Vigo and Wayne Counties:** There are several options for women to access breast health services in these counties. However, Komen Central Indiana needs to develop relationships in these counties to further understand what barriers may be facing women living here.

The analysis highlights the need to have a stronger presence and collaborative relationships with partners in these counties to ensure women are completing the CoC. Komen Central Indiana must also stay informed of the ever-changing health care environment following rollout of the ACA and the Healthy Indiana Plan 2.0.

**Marion County:** There are many options for women to access breast screenings in Marion County, but the systems are all quite large, which can be daunting for individuals who have no primary health care provider or health insurance.

**Qualitative Data: Ensuring Community Input**

To further assess the breast health and breast cancer issues highlighted by the quantitative data, Susan G. Komen Central Indiana conducted a qualitative data assessment in each of the three target communities.

Qualitative data collection lasted several months and involved key informant interviews, focus groups, surveys, and a literature review. In total, 33 key informant interviews, six focus groups, one survey with 31 responses, and a literature review were conducted. The Team generated four categories of themes: 1) system barriers to receipt of breast health services; 2) individual barriers to receipt of breast health services; 3) facilitators for obtaining breast health services; and 4) specific vulnerable populations.

Variables, including breast cancer screening, occurrence, diagnosis, treatment, the completion of the CoC, and the presence of specific vulnerable populations in these counties, guided the selection of key assessment questions for the analysis.

The Qualitative Data Analysis highlighted specific system barriers to care, individual barriers to care, facilitators to care, and vulnerable populations in the three target communities.

**Boone, Rush Shelby, and Vermillion Counties:** Commonly cited system barriers for these counties include difficulty obtaining diagnostic services (including accessibility of these services), lack of insurance or lack of understand of insurance benefits, and failure of primary care physicians to provide or refer to routine screenings. Commonly cited individual barriers to care for these counties included fear of the unknown, perceived risk, competing priorities, lack of education, underinsurance, and lack of understanding of available community resources. Facilitators to care for this target community include location of available resources, perceived risk, access to education about breast cancer risk, and an increase in comfortable medical facilities. Vulnerable populations identified through the focus groups and key informant interviews in this target community include Black/African-American, Hispanic/Latina, post-menopausal/pre-Medicare, rural women, young women, women with a family history of breast cancer, Amish women, language minorities and un/underinsured women.
**Vigo and Wayne Counties:** In Wayne County, system barriers included lack of physician referral for screening, lack of insurance, and lack of access to care. Individual barriers to care include lack of understanding of insurance benefits, prohibitive out-of-pocket expenses, and competing priorities in women’s lives. The only facilitator to care mentioned for this county was translation services that are available to language minorities. Minority populations, rural women, and women who use illegal drugs were identified as particularly vulnerable populations in this community.

Despite repeated efforts, the Community Profile Team was unable to gather community input in Vigo County. As such, a literature review of relevant issues, including breast cancer and survivorship, access to care, and uninsured populations, was conducted. This review revealed common system and individual barriers, including access to care in more rural areas of these counties, competing priorities, and lack of quality insurance.

**Marion County:** The complexity of the health insurance system is a critical barrier to receiving screening, diagnostic, and treatment services. Thus, it is not only women without health insurance who face insurance-related issues when considering or seeking health care services. It is the perception of both providers and patients that, even with insurance, women face obstacles such as not understanding the coverage provided by their policy, prohibitive copays, deductibles, and a lack of knowledge as to how to access services under the Affordable Care Act and the Healthy Indiana Plan 2.0. Individual barriers were rooted in a lack of resources, including both personal finances and education/knowledge/awareness. Finances play a pivotal role in women’s decisions to seek care. Low-income women may not be able to afford to take off work to seek breast health services, and are likely to have financial priorities above that of their breast health—such as money to care for their children, pay utilities, etc.

The overwhelming majority of survey respondents (predominantly Black/African-American women) in Marion County indicated that there are no cultural barriers that prevent them from seeking care. However, the perspective of key informants was strikingly different, as they perceive that Black/African-American women in Marion County face more barriers to breast health care. Similarly, providers and nonprofit professionals indicate disparities in care between Black/African-American women and White women.

The most common findings across the qualitative data in the target communities were inextricably linked to the key questions of knowledge of, access to, and utilization of screening services as well as ability to navigate through the complexities of the Continuum of Care following a diagnosis. A majority of the system and personal barriers to obtaining breast health care identified by the qualitative data in the seven target counties are driven by a lack of income and finances. A second, widespread barrier revealed by the qualitative data is a lack of diagnostic services or a lack of knowledge of the available diagnostic services available within these communities. In particular, key informants, focus group participants, and survey respondents made it clear that Komen Central Indiana needs to further its work in promoting available screening services in these communities in order to improve access to care and screening percentages.

An overarching conclusion is that Komen Central Indiana needs to develop more effective strategies, including enhanced partnerships, in these communities to not only ensure access to
screening services, but to ensure utilization of screening services and completion of the continuum of care.

**Mission Action Plan**

After completion of the Quantitative Data Report, the Health Systems and Public Policy Analysis, and the Qualitative Data Report, Komen Central Indiana identified the most urgent challenges facing each of the target communities and connected these challenges to a specific problem expressed through a problem statement.

For each problem statement, priorities communicate the goals that will be achieved by Komen Central Indiana in order to effectively address the challenges and needs identified in the problem statement.

Finally, under each priority falls a range of objectives that specify how the goals set in the priorities will be met. The objectives set forth the strategic actions that will be taken by Komen Central Indiana and are specific, measurable, attainable, realistic, and time-bound.

Together, the problem statement, priorities, and objectives provide a road map to Komen Central Indiana for effective interventions for improving breast health in the target communities.

**Problem Statement: Boone, Rush, Shelby, and Vermillion Counties** are highest and high priority counties due to the fact that they are not predicted to meet Healthy People 2020 targets related to late-stage incidence and death rates. These counties share the key population characteristic of being primarily rural; hence, they were grouped together as one target community. Quantitative and qualitative data indicate poverty, unemployment, and lack of insurance as potential contributors to comparatively high late-stage incidence and death rates. Qualitative data and the Health Systems Analysis suggest a lack of breast health services, underutilization of breast health services, and insufficient funding for breast health services as potential barriers that may impede receiving care.

**Priorities and Objectives**

1. Facilitate community awareness, education, and mobilization efforts aimed at reaching women living in low-income, rural areas.
   a. In the RFAs for FY17 through FY19, in order to improve late-stage incidence rates, a funding priority will be to provide evidence-based education guiding women to the screening and diagnostic services most appropriate for them based on their payer (private insurance, HIP 2.0, uninsured safety nets, etc.).
   b. In FY18, establish a supply chain of Komen educational materials targeting low-income, low-education, rural women, delivered through local breast health service providers and community-based organizations in these counties.
   c. In FY18 through FY19, provide a series (at least one session per county) of educational sessions for employers, encouraging these employers to participate in initiatives that will make it easier for their employees to take time away from work to receive appropriate screening tests.
2. Increase the capacity of existing health care systems to provide seamless transition for women who are screened to diagnostic and treatment services.
   a. In the RFAs for FY17 through FY19, in order to improve death rates, a funding priority will be to provide evidence-based patient navigation from the point a patient enters the continuum of care through their cancer journey by ensuring the patient has the resources necessary to overcome barriers to receiving care.
   b. In FY18, hold a series of collaborative meetings (at least one per county) among local community organizations, churches, schools, etc. in rural, low-income areas to identify and develop cooperative relationships to better map available resources for reducing barriers to care in each community.

**Problem Statement:** Despite a screening percentage higher than Komen Central Indiana’s service area as a whole, Marion County has higher late-stage incidence and death rates. Additionally, Marion County is not expected to achieve the HP2020 target for late-stage incidence rate for 13 years or longer. Qualitative and quantitative data indicate high unemployment, a high uninsured population, and low income levels may contribute to barriers to breast health services. Marion County has the largest populations of Black/African-American and Hispanic/Latina women (in real numbers) in Komen Central Indiana’s service area, and barriers to services are especially prominent for these populations.

**Priorities and Objectives**

1. Facilitate community awareness, education, and mobilization efforts aimed at Black/African-American women, with an emphasis on reducing the disparity in breast cancer death rates between Black/African-American women and White women, with specific messages and services relating to an increase in access to services and increased awareness within the community.
   a. In FY18 through FY19, in partnership with community-based organizations, government agencies, churches, schools, etc. develop culturally relevant awareness, education, and outreach resources targeting the uninsured within the Black/African-American population in Marion County, guiding them to insurance enrollment and screening services.
   b. In the RFAs for FY17 through FY19, in order to improve late-stage diagnosis rates, a funding priority will be to provide evidence-based education guiding women to the screening and diagnostic services most appropriate for them based on payment method (private insurance, HIP 2.0, uninsured safety nets, etc.).
   c. In FY18, establish a supply chain of Komen educational materials targeting low-income, low-education, Black/African-American, and/or Hispanic/Latina women, delivered through local breast health service providers and community-based organizations in Marion County.

2. Increase the capacity of existing health care systems to provide seamless transition for women who are screened to diagnostic and treatment services.
   a. In the RFAs for FY17 through FY19, in order to improve death rates, a funding priority will be to provide evidence-based patient navigation from the point a patient enters the continuum of care through their cancer journey by ensuring the patient has the resources necessary to overcome barriers to receiving care.
b. In FY18, hold a series of collaborative meetings (at least three) among local community organizations, churches, schools, etc. in Marion County to identify and develop cooperative relationships to better map available resources for reducing barriers to care.

**Problem Statement: Vigo and Wayne Counties** are not expected to reach HP2020 targets related to death and late-stage incidence rates for eight to 13 years or longer. These two counties are new to the Komen Central Indiana service area, and as such, qualitative data was weaker than other target communities. However, lack of insurance, lack of physician referrals for annual mammograms, and competing priorities were identified as possible barriers to care. Additionally, through the Health Systems Analysis, the Community Profile team learned that there is a lack of breast health services in these counties outside the cities of Terre Haute and Richmond.

**Priorities and Objectives**

1. Facilitate community awareness, education, and mobilization efforts aimed at reaching women living in low-income and possibly rural areas of these counties.
   a. In the RFAs for FY17 through FY19, in order to improve late-stage incidence rates, a funding priority will be to provide evidence-based education guiding women to the screening and diagnostic services most appropriate for them based on their payer (private insurance, HIP 2.0, uninsured safety nets, etc.).
   b. In FY18, establish a supply chain of Komen educational materials targeting low-income, low-education, older women delivered through local breast health service providers and community-based organizations in these counties.
   c. In FY18 and FY19, hold a series of educational sessions (at least one per county) to share Community Profile data with health care providers and educate providers on available resources for free and reduced cost screening for their patients.
   d. In FY18 through FY19, determine what resources are available for specialized populations within these counties (i.e., Amish) to receive screening services and meet with resource providers to learn how Komen Central Indiana can enhance their work.

2. Increase the capacity of existing health care systems to provide seamless transition for women who are screened to diagnostic and treatment services.
   a. In the RFAs for FY17 through FY19, in order to improve death rates, a funding priority will be to provide evidence-based patient navigation from the point a patient enters the continuum of care through their cancer journey by ensuring the patient has the resources necessary to overcome barriers to receiving care.
   b. In FY18 and FY19, hold a series of collaborative meetings (at least one per county) among local community organizations, churches, schools, etc. in these counties to identify and develop cooperative relationships in order to better map available resources for reducing barriers to care in each community and create a referral pipeline to these resources.

**Disclaimer:** Comprehensive data for the Executive Summary can be found in the 2015 Susan G. Komen® Central Indiana Community Profile Report.
Affiliate History

In the fight to end breast cancer forever, Susan G. Komen® Central Indiana is the locally led and empowered Affiliate of Susan G. Komen, a global organization whose name is synonymous with its cause.

Susan G. Komen Central Indiana began its work in central Indiana in 1992 with the first Race for the Cure® under the auspices of the Junior League of Indianapolis. In 2001, leaders envisioned that this effort could be more than a Race and incorporated as an Affiliate of the Susan G. Komen organization. Led entirely by volunteers, the organization was raising more than one million dollars annually, before hiring its first paid staff member in 2003. In 2011, the Affiliate’s name was changed from the Indianapolis Affiliate to Susan G. Komen Central Indiana to reflect the Affiliate’s broader service area.

Komen Central Indiana reaches out to the community to educate breast cancer survivors, family and friends, caregivers and the public by organizing and attending local events, offering presentations, developing written communications and collaborating with other organizations serving the community.

The greatest part of the money received by Komen Central Indiana remains in the community as a source of help for Hoosiers in need. It goes to pay for services – including screenings, diagnostic tests, education and patient navigation – that benefit local women and men. Komen Central Indiana has granted more than $15 million to local nonprofit organizations carrying out these services. In the 2014-2015 grant cycle, $848,000 funded 11 local breast health programs that provided nearly 40,000 services to more than 25,000 unduplicated individuals.

Additionally, a meaningful portion of the money received by Komen Central Indiana funds Susan G. Komen Research Programs that endeavor to discover breast cancer causes, treatments and, ultimately, the cures. Susan G. Komen has funded, in part, many advancements in breast cancer research in the last 30 years.

Komen Central Indiana strives to be a local expert and leader in the breast cancer movement in central Indiana. The organization is an active member of the Indiana Cancer Consortium and received the 2013 award for Outstanding Contributions to Cancer Control. In 2014, Komen Central Indiana launched a coalition of local leaders committed to addressing the disparity in breast cancer deaths between Black/African-American and White women in Indianapolis. Representatives from the Komen Central Indiana staff and Board of Directors serve with numerous local agencies and organizations to advocate for and strengthen systems and resources for women, men and families who face breast cancer in the local community.
**Affiliate Organizational Structure**

The activities of Susan G. Komen Central Indiana are led by a local Board of Directors. Members are community leaders and representatives from diverse industries and professional fields. The Board governs the work of the organization and oversees the Executive Director, who supervises a staff of four full-time employees and one part-time employee to manage daily operations. Staff members include the Executive Director, Mission Director, Development Director, Development and Volunteer Manager, Communications and Marketing Coordinator and part-time Finance Coordinator.

More than 500 volunteers are actively engaged in the organization’s events and work. Among these volunteers are members of numerous committees that offer energy and expertise to carry out the work of Komen Central Indiana in the community. Committees and working groups convened at the time of this report include the Grant Review Panel, the Community Profile Team, the Race for the Cure Executive Committee and Committee, the Pink Tie Ball Committee, the Project Pink Fashion Show Committee and the Pink Ribbon Celebration Survivor Luncheon Committee.

**Affiliate Service Area**

The Affiliate service area includes 21-counties in Central Indiana. Counties served include: Bartholomew, Boone, Brown, Clinton, Decatur, Delaware, Grant, Hamilton, Hancock, Hendricks, Henry, Howard, Johnson, Madison, Marion, Montgomery, Morgan, Rush, Shelby, Tippecanoe and Tipton (Figure 1.1).

The Affiliate service area includes the metropolitan areas of Indianapolis-Carmel, Lafayette, Anderson, Muncie, Kokomo and Columbus (in order of population). Indianapolis is the largest urban area in the services area, while those who live in rural areas comprise 16.4 percent of the population, and 16.9 percent live in medically under-served areas.

The service area includes a population of more than 2.5 million and female population of nearly 1.3 million. The population is 83.8 percent White, 13.2 percent Black/African-American, 0.4 percent American Indian and Alaska Native and 2.5 percent Asian Pacific Islander. The population is 5.3 percent Hispanic/Latina and 94.7 percent Non-Hispanic/Latina.

In the service area, 12.3 percent of the population has less than a high school education, and 14.0 percent live at or below 100 percent of the federal poverty level with 31.4 percent at or below 250 percent of the federal poverty level. An average 1,628 new cases of breast cancer are diagnosed annually in the service area.
**Figure 1.1. Susan G. Komen Central Indiana service area**
Purpose of the Community Profile Report

The Community Profile is an assessment process completed every four years by Susan G. Komen Central Indiana, in order to understand the state of the breast cancer burden and needs in the service area. The information outlined in the report is vital to Komen Central Indiana for developing grant funding and programming priorities.

The Community Profile is actively used as a framework to identify the prevalence of breast cancer on a local level, recognize service gaps in breast health and breast cancer needs and develop priorities to address those needs. The Community Profile Report serves to:

- Align strategic and operational plans
- Drive inclusion efforts in the community
- Drive public policy efforts
- Establish focused granting priorities
- Establish focused education needs
- Establish directions for marketing and outreach
- Strengthen sponsorship and development efforts

The final Community Profile Report will be shared with the community through a press release and made available via the Susan G. Komen Central Indiana website. On an ongoing basis, Komen Central Indiana representatives will reference the report in media interviews, presentations, programs and partnerships with organizations and health care systems.
Quantitative Data: Measuring Breast Cancer Impact in Local Communities

Quantitative Data Report

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

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

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>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>Female Population (Annual Average)</td>
<td># of New Cases (Annual Average)</td>
<td>Age-adjusted Rate/100,000</td>
</tr>
<tr>
<td>US</td>
<td>154,540,194</td>
<td>182,234</td>
<td>122.1</td>
</tr>
<tr>
<td>HP2020</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illinois</td>
<td>6,492,949</td>
<td>9,039</td>
<td>126.4</td>
</tr>
<tr>
<td>White</td>
<td>5,102,174</td>
<td>7,501</td>
<td>127.8</td>
</tr>
<tr>
<td>Black/African-American</td>
<td>1,038,205</td>
<td>1,207</td>
<td>123.4</td>
</tr>
<tr>
<td>AIAN</td>
<td>37,841</td>
<td>5</td>
<td>22.0</td>
</tr>
<tr>
<td>API</td>
<td>314,728</td>
<td>250</td>
<td>85.8</td>
</tr>
<tr>
<td>Non-Hispanic/ Latina</td>
<td>5,559,497</td>
<td>8,567</td>
<td>129.7</td>
</tr>
<tr>
<td>Hispanic/ Latina</td>
<td>933,451</td>
<td>472</td>
<td>87.2</td>
</tr>
<tr>
<td>Indiana</td>
<td>3,260,368</td>
<td>4,287</td>
<td>117.4</td>
</tr>
<tr>
<td>White</td>
<td>2,867,623</td>
<td>3,901</td>
<td>117.1</td>
</tr>
<tr>
<td>Black/African-American</td>
<td>323,657</td>
<td>320</td>
<td>117.6</td>
</tr>
<tr>
<td>AIAN</td>
<td>13,284</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>API</td>
<td>55,804</td>
<td>27</td>
<td>71.2</td>
</tr>
<tr>
<td>Non-Hispanic/ Latina</td>
<td>3,090,982</td>
<td>4,225</td>
<td>118.4</td>
</tr>
<tr>
<td>Hispanic/ Latina</td>
<td>169,386</td>
<td>62</td>
<td>70.9</td>
</tr>
<tr>
<td>Clark County - IL</td>
<td>8,476</td>
<td>12</td>
<td>110.2</td>
</tr>
<tr>
<td>Edgar County - IL</td>
<td>9,643</td>
<td>16</td>
<td>122.6</td>
</tr>
<tr>
<td>Bartholomew County - IN</td>
<td>38,387</td>
<td>50</td>
<td>110.3</td>
</tr>
<tr>
<td>Blackford County - IN</td>
<td>6,563</td>
<td>9</td>
<td>94.8</td>
</tr>
<tr>
<td>Boone County - IN</td>
<td>27,834</td>
<td>41</td>
<td>133.8</td>
</tr>
<tr>
<td>Brown County - IN</td>
<td>7,679</td>
<td>9</td>
<td>81.9</td>
</tr>
<tr>
<td>Clay County - IN</td>
<td>13,735</td>
<td>22</td>
<td>131.5</td>
</tr>
<tr>
<td>Clinton County - IN</td>
<td>16,842</td>
<td>18</td>
<td>94.1</td>
</tr>
<tr>
<td>Decatur County - IN</td>
<td>12,940</td>
<td>13</td>
<td>84.8</td>
</tr>
<tr>
<td>Delaware County - IN</td>
<td>60,910</td>
<td>87</td>
<td>129.9</td>
</tr>
<tr>
<td>Fayette County - IN</td>
<td>12,450</td>
<td>14</td>
<td>86.9</td>
</tr>
<tr>
<td>Fountain County - IN</td>
<td>8,740</td>
<td>19</td>
<td>166.5</td>
</tr>
<tr>
<td>Franklin County - IN</td>
<td>11,624</td>
<td>6</td>
<td>46.1</td>
</tr>
<tr>
<td>Grant County - IN</td>
<td>36,459</td>
<td>57</td>
<td>123.5</td>
</tr>
<tr>
<td>Greene County - IN</td>
<td>16,608</td>
<td>22</td>
<td>99.8</td>
</tr>
<tr>
<td>Hamilton County - IN</td>
<td>133,552</td>
<td>158</td>
<td>124.1</td>
</tr>
<tr>
<td>Hancock County - IN</td>
<td>34,608</td>
<td>51</td>
<td>131.1</td>
</tr>
<tr>
<td>Hendricks County - IN</td>
<td>70,202</td>
<td>81</td>
<td>110.9</td>
</tr>
<tr>
<td>Henry County - IN</td>
<td>24,390</td>
<td>36</td>
<td>110.9</td>
</tr>
<tr>
<td>Howard County - IN</td>
<td>43,251</td>
<td>63</td>
<td>117.0</td>
</tr>
<tr>
<td>Jay County - IN</td>
<td>10,899</td>
<td>21</td>
<td>149.9</td>
</tr>
<tr>
<td>Johnson County - IN</td>
<td>69,202</td>
<td>86</td>
<td>115.0</td>
</tr>
</tbody>
</table>
### Incidence Rates and Trends

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Female Population (Annual Average)</th>
<th># of New Cases (Annual Average)</th>
<th>Age-adjusted Rate/100,000</th>
<th>Trend (Annual Percent Change)</th>
<th># of Deaths (Annual Average)</th>
<th>Age-adjusted Rate/100,000</th>
<th>Trend (Annual Percent Change)</th>
<th># of New Cases (Annual Average)</th>
<th>Age-adjusted Rate/100,000</th>
<th>Trend (Annual Percent Change)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Madison County - IN</td>
<td>65,827</td>
<td>94</td>
<td>112.6</td>
<td>3.5%</td>
<td>19</td>
<td>21.2</td>
<td>-2.3%</td>
<td>27</td>
<td>32.7</td>
<td>8.1%</td>
</tr>
<tr>
<td>Marion County - IN</td>
<td>461,040</td>
<td>572</td>
<td>122.1</td>
<td>0.4%</td>
<td>123</td>
<td>26.1</td>
<td>-1.6%</td>
<td>201</td>
<td>43.2</td>
<td>-2.8%</td>
</tr>
<tr>
<td>Monroe County - IN</td>
<td>67,600</td>
<td>74</td>
<td>123.1</td>
<td>-2.9%</td>
<td>14</td>
<td>22.7</td>
<td>-1.1%</td>
<td>25</td>
<td>41.3</td>
<td>-0.9%</td>
</tr>
<tr>
<td>Montgomery County - IN</td>
<td>18,949</td>
<td>24</td>
<td>99.0</td>
<td>-13.4%</td>
<td>4</td>
<td>17.9</td>
<td>-3.0%</td>
<td>8</td>
<td>36.1</td>
<td>-9.3%</td>
</tr>
<tr>
<td>Morgan County - IN</td>
<td>34,558</td>
<td>51</td>
<td>127.7</td>
<td>-4.4%</td>
<td>9</td>
<td>22.8</td>
<td>0.7%</td>
<td>19</td>
<td>47.9</td>
<td>-5.3%</td>
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<tr>
<td>Owen County - IN</td>
<td>10,837</td>
<td>14</td>
<td>106.6</td>
<td>-0.9%</td>
<td>4</td>
<td>30.8</td>
<td>0.0%</td>
<td>5</td>
<td>41.3</td>
<td>-3.2%</td>
</tr>
<tr>
<td>Parke County - IN</td>
<td>9,235</td>
<td>13</td>
<td>117.0</td>
<td>-18.1%</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>5</td>
<td>41.7</td>
<td>-15.2%</td>
</tr>
<tr>
<td>Putnam County - IN</td>
<td>18,015</td>
<td>23</td>
<td>109.2</td>
<td>-6.2%</td>
<td>5</td>
<td>22.3</td>
<td>-2.5%</td>
<td>10</td>
<td>46.5</td>
<td>-3.0%</td>
</tr>
<tr>
<td>Randolph County - IN</td>
<td>13,338</td>
<td>21</td>
<td>118.5</td>
<td>1.4%</td>
<td>4</td>
<td>21.8</td>
<td>-3.3%</td>
<td>6</td>
<td>35.7</td>
<td>7.5%</td>
</tr>
<tr>
<td>Rush County - IN</td>
<td>8,882</td>
<td>10</td>
<td>94.4</td>
<td>1.3%</td>
<td>3</td>
<td>27.7</td>
<td>NA</td>
<td>4</td>
<td>42.5</td>
<td>1.3%</td>
</tr>
<tr>
<td>Shelby County - IN</td>
<td>22,245</td>
<td>30</td>
<td>115.6</td>
<td>10.8%</td>
<td>6</td>
<td>23.6</td>
<td>-1.8%</td>
<td>11</td>
<td>45.6</td>
<td>10.7%</td>
</tr>
<tr>
<td>Sullivan County - IN</td>
<td>9,872</td>
<td>12</td>
<td>94.1</td>
<td>-4.4%</td>
<td>5</td>
<td>36.8</td>
<td>NA</td>
<td>4</td>
<td>36.0</td>
<td>-26.0%</td>
</tr>
<tr>
<td>Tippecanoe County - IN</td>
<td>82,470</td>
<td>86</td>
<td>119.8</td>
<td>5.4%</td>
<td>17</td>
<td>23.0</td>
<td>-3.1%</td>
<td>29</td>
<td>40.9</td>
<td>-3.1%</td>
</tr>
<tr>
<td>Tipton County - IN</td>
<td>8,198</td>
<td>10</td>
<td>93.1</td>
<td>20.1%</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>Union County - IN</td>
<td>3,762</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>Vermillion County - IN</td>
<td>8,322</td>
<td>13</td>
<td>111.1</td>
<td>13.0%</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>4</td>
<td>38.0</td>
<td>18.3%</td>
</tr>
<tr>
<td>Vigo County - IN</td>
<td>53,140</td>
<td>79</td>
<td>127.4</td>
<td>0.8%</td>
<td>17</td>
<td>25.1</td>
<td>-1.5%</td>
<td>25</td>
<td>40.3</td>
<td>12.9%</td>
</tr>
<tr>
<td>Warren County - IN</td>
<td>4,285</td>
<td>4</td>
<td>73.2</td>
<td>-11.5%</td>
<td>SN</td>
<td>S N</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>Wayne County - IN</td>
<td>35,642</td>
<td>44</td>
<td>94.8</td>
<td>-3.6%</td>
<td>12</td>
<td>23.4</td>
<td>-1.6%</td>
<td>14</td>
<td>30.1</td>
<td>3.7%</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.

### Incidence rates and trends summary

Overall, the breast cancer incidence rate in the State of Illinois was slightly higher than that observed in the US as a whole and the incidence trend was similar to the US as a whole. The breast cancer incidence rate in the State of Indiana was slightly lower than that observed in the US as a whole and the incidence trend was similar to the US as a whole.

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

For the State of Indiana, the incidence rate was about the same among Blacks/African-Americans and Whites and lower among APIs than Whites. There were not enough data available within the state to report on AIANs so comparisons cannot be made for this racial group. The incidence rate among Hispanics/Latinas was significantly lower than among Non-Hispanics/Latinas.

The following counties had an incidence rate **significantly higher** than their respective state as a whole:
- Fountain County, IN
- Jay County, IN

The incidence rate was significantly lower in the following counties:
- Brown County, IN
- Decatur County, IN
- Fayette County, IN
- Franklin County, IN
- Wayne County, IN

**Significantly less favorable trends** in breast cancer incidence rates were observed in the following county:
- Tipton County, IN

The rest of the counties in the Affiliate service area had incidence rates and trends that were not significantly different than their respective state 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 State of Illinois was similar to that observed in the US as a whole and the death rate trend was lower than the US as a whole. The breast cancer death rate in the State of Indiana was slightly higher than that observed in the US as a whole and the death rate trend was similar to the US as a whole.

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 State of Illinois, the death rate was significantly higher among Blacks/African-Americans than Whites and significantly lower among APIs than Whites. There were not enough data available within the state to report on AIANs so comparisons cannot be
made for this racial group. The death rate among Hispanics/Latinas was significantly lower than among Non-Hispanics/Latinas.

- For the State of Indiana, the death rate was significantly higher among Blacks/African-Americans than Whites and significantly lower among APIs than Whites. There were not enough data available within the state to report on AIANs so comparisons cannot be made for this racial group. The death rate among Hispanics/Latinas was significantly lower than among Non-Hispanics/Latinas.

None of the counties in the Affiliate service area had substantially different death rates than their respective state 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 State of Illinois was significantly 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 breast cancer late-stage incidence rate in the State of Indiana was significantly lower than that observed in the US as a whole and the late-stage incidence trend was higher than the US as a whole.

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 State of Illinois, the late-stage incidence rate was significantly higher among Blacks/African-Americans than Whites and significantly lower among APIs than Whites. There were not enough data available within the state to report on AIANs so comparisons cannot be made for this racial group. The late-stage incidence rate among Hispanics/Latinas was lower than among Non-Hispanics/Latinas.
- For the State of Indiana, the late-stage incidence rate was higher among Blacks/African-Americans than Whites and significantly lower among APIs than Whites. There were not enough data available within the state to report on AIANs so comparisons cannot be made for this racial group. The late-stage incidence rate among Hispanics/Latinas was significantly lower than among Non-Hispanics/Latinas.

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

- Henry County, IN
- Madison County, IN
- Wayne County, IN

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

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

<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 Hispanic/Latina, but only 10.0 percent of the total women in the area are Hispanic/Latina, weighting is used to account for this difference.

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Population Group</th>
<th># of Women Interviewed (Sample Size)</th>
<th># w/ Self-Reported Mammogram</th>
<th>Proportion Screened (Weighted Average)</th>
<th>Confidence Interval of Proportion Screened</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>174,796</td>
<td>133,399</td>
<td>77.5%</td>
<td>77.2%-77.7%</td>
</tr>
<tr>
<td>Illinois</td>
<td>2,253</td>
<td>1,703</td>
<td>76.4%</td>
<td>74.0%-78.6%</td>
</tr>
<tr>
<td>White</td>
<td>1,974</td>
<td>1,484</td>
<td>75.8%</td>
<td>73.3% - 78.2%</td>
</tr>
<tr>
<td>Black/African-American</td>
<td>213</td>
<td>167</td>
<td>80.0%</td>
<td>71.6% - 86.3%</td>
</tr>
<tr>
<td>AIAN</td>
<td>10</td>
<td>7</td>
<td>74.7%</td>
<td>40.1% - 92.9%</td>
</tr>
<tr>
<td>API</td>
<td>23</td>
<td>18</td>
<td>73.3%</td>
<td>50.4% - 88.1%</td>
</tr>
<tr>
<td>Hispanic/ Latina</td>
<td>87</td>
<td>69</td>
<td>79.8%</td>
<td>65.1% - 89.4%</td>
</tr>
<tr>
<td>Non-Hispanic/ Latina</td>
<td>2,156</td>
<td>1,628</td>
<td>76.1%</td>
<td>73.7% - 78.3%</td>
</tr>
<tr>
<td>Indiana</td>
<td>3,249</td>
<td>2,306</td>
<td>69.5%</td>
<td>67.5% - 71.5%</td>
</tr>
<tr>
<td>White</td>
<td>2,786</td>
<td>1,958</td>
<td>69.8%</td>
<td>67.6% - 71.9%</td>
</tr>
<tr>
<td>Black/African-American</td>
<td>375</td>
<td>290</td>
<td>70.5%</td>
<td>63.3% - 76.8%</td>
</tr>
<tr>
<td>AIAN</td>
<td>28</td>
<td>15</td>
<td>38.9%</td>
<td>18.5% - 64.1%</td>
</tr>
<tr>
<td>API</td>
<td>11</td>
<td>8</td>
<td>66.7%</td>
<td>28.8% - 90.9%</td>
</tr>
<tr>
<td>Hispanic/ Latina</td>
<td>50</td>
<td>33</td>
<td>43.7%</td>
<td>26.3% - 62.8%</td>
</tr>
<tr>
<td>Non-Hispanic/ Latina</td>
<td>3,182</td>
<td>2,261</td>
<td>70.0%</td>
<td>68.0% - 72.0%</td>
</tr>
<tr>
<td>Clark County - IL</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>Edgar County - IL</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>Clay County - IN</td>
<td>18</td>
<td>12</td>
<td>64.0%</td>
<td>36.1%-84.9%</td>
</tr>
<tr>
<td>Clinton County - IN</td>
<td>16</td>
<td>10</td>
<td>54.7%</td>
<td>28.2%-78.8%</td>
</tr>
<tr>
<td>Decatur County - IN</td>
<td>11</td>
<td>9</td>
<td>76.8%</td>
<td>41.5%-93.9%</td>
</tr>
<tr>
<td>Delaware County - IN</td>
<td>48</td>
<td>35</td>
<td>72.2%</td>
<td>54.4%-85.0%</td>
</tr>
<tr>
<td>Fayette County – IN</td>
<td>16</td>
<td>11</td>
<td>68.2%</td>
<td>38.5% - 88.0%</td>
</tr>
<tr>
<td>Fountain County -IN</td>
<td>25</td>
<td>20</td>
<td>84.4%</td>
<td>60.0% - 95.2%</td>
</tr>
<tr>
<td>Franklin County - IN</td>
<td>12</td>
<td>9</td>
<td>78.9%</td>
<td>40.6% - 95.4%</td>
</tr>
<tr>
<td>Grant County - IN</td>
<td>38</td>
<td>30</td>
<td>82.1%</td>
<td>62.6%-92.6%</td>
</tr>
<tr>
<td>Greene County - IN</td>
<td>17</td>
<td>10</td>
<td>62.8%</td>
<td>33.6%-84.9%</td>
</tr>
<tr>
<td>Hamilton County - IN</td>
<td>58</td>
<td>44</td>
<td>77.0%</td>
<td>61.0%-87.8%</td>
</tr>
<tr>
<td>Population Group</td>
<td># of Women Interviewed (Sample Size)</td>
<td># w/ Self-Reported Mammogram</td>
<td>Proportion Screened (Weighted Average)</td>
<td>Confidence Interval of Proportion Screened</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------------------------------</td>
<td>------------------------------</td>
<td>----------------------------------------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>Hancock County - IN</td>
<td>14</td>
<td>11</td>
<td>72.9%</td>
<td>40.0%-91.6%</td>
</tr>
<tr>
<td>Hendricks County - IN</td>
<td>34</td>
<td>26</td>
<td>73.8%</td>
<td>51.5%-88.2%</td>
</tr>
<tr>
<td>Henry County - IN</td>
<td>27</td>
<td>24</td>
<td>91.0%</td>
<td>70.1%-97.7%</td>
</tr>
<tr>
<td>Howard County - IN</td>
<td>44</td>
<td>32</td>
<td>78.1%</td>
<td>59.0%-89.9%</td>
</tr>
<tr>
<td>Jay County - IN</td>
<td>22</td>
<td>13</td>
<td>58.7%</td>
<td>32.9%-80.4%</td>
</tr>
<tr>
<td>Johnson County - IN</td>
<td>47</td>
<td>34</td>
<td>73.7%</td>
<td>55.9%-86.0%</td>
</tr>
<tr>
<td>Madison County - IN</td>
<td>60</td>
<td>38</td>
<td>60.0%</td>
<td>43.9%-74.1%</td>
</tr>
<tr>
<td>Marion County - IN</td>
<td>450</td>
<td>342</td>
<td>75.4%</td>
<td>69.8%-80.3%</td>
</tr>
<tr>
<td>Monroe County - IN</td>
<td>38</td>
<td>31</td>
<td>81.0%</td>
<td>62.2%-91.7%</td>
</tr>
<tr>
<td>Montgomery County - IN</td>
<td>16</td>
<td>12</td>
<td>78.4%</td>
<td>48.7%-93.3%</td>
</tr>
<tr>
<td>Morgan County - IN</td>
<td>27</td>
<td>21</td>
<td>71.8%</td>
<td>50.2%-86.6%</td>
</tr>
<tr>
<td>Owen County - IN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>Parke County - IN</td>
<td>18</td>
<td>11</td>
<td>49.3%</td>
<td>24.3%-74.7%</td>
</tr>
<tr>
<td>Putnam County - IN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>Randolph County - IN</td>
<td>42</td>
<td>29</td>
<td>71.4%</td>
<td>52.5%-85.0%</td>
</tr>
<tr>
<td>Rush County - IN</td>
<td>28</td>
<td>21</td>
<td>76.8%</td>
<td>53.9%-90.4%</td>
</tr>
<tr>
<td>Shelby County - IN</td>
<td>19</td>
<td>12</td>
<td>67.9%</td>
<td>42.3%-85.9%</td>
</tr>
<tr>
<td>Sullivan County - IN</td>
<td>12</td>
<td>8</td>
<td>66.0%</td>
<td>33.8%-88.0%</td>
</tr>
<tr>
<td>Tippecanoe County - IN</td>
<td>52</td>
<td>41</td>
<td>73.6%</td>
<td>55.4%-86.3%</td>
</tr>
<tr>
<td>Tipton County - IN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>Union County – IN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>Vermillion County - IN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>Vigo County – IN</td>
<td>41</td>
<td>26</td>
<td>63.6%</td>
<td>43.8%-79.7%</td>
</tr>
<tr>
<td>Warren County – IN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>Wayne County - IN</td>
<td>36</td>
<td>24</td>
<td>61.7%</td>
<td>40.8%-79.0%</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**

Overall, the breast cancer screening proportion in the State of Illinois was not significantly different than that observed in the US as a whole. The breast cancer screening proportion in the State of Indiana was **significantly lower** than that observed in the US as a whole.

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 State of Illinois, the screening proportion was not significantly different among Blacks/African-Americans and Whites, not significantly different among APIs and Whites, and not significantly different among AIANs and Whites. The screening proportion
among Hispanics/Latinas was not significantly different from the proportion among Non-Hispanics/Latinas.

- For the State of Indiana, the screening proportion was not significantly different among Blacks/African-Americans and Whites, not significantly different among APIs and Whites, and significantly lower among AIANs than Whites. The screening proportion among Hispanics/Latinas was significantly lower than among Non-Hispanics/Latinas.

None of the counties in the Affiliate service area had substantially different screening proportions than their respective state 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>
<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>Illinois</td>
<td>78.2%</td>
<td>16.0%</td>
<td>0.7%</td>
<td>5.2%</td>
<td>84.7%</td>
<td>15.3%</td>
<td>47.6%</td>
<td>33.9%</td>
<td>14.4%</td>
</tr>
<tr>
<td>Indiana</td>
<td>87.4%</td>
<td>10.2%</td>
<td>0.4%</td>
<td>1.9%</td>
<td>94.2%</td>
<td>5.8%</td>
<td>48.0%</td>
<td>34.6%</td>
<td>14.8%</td>
</tr>
<tr>
<td>Clark County - IL</td>
<td>98.5%</td>
<td>0.8%</td>
<td>0.2%</td>
<td>0.5%</td>
<td>98.9%</td>
<td>1.1%</td>
<td>54.7%</td>
<td>40.9%</td>
<td>20.4%</td>
</tr>
<tr>
<td>Edgar County - IL</td>
<td>98.6%</td>
<td>0.9%</td>
<td>0.2%</td>
<td>0.3%</td>
<td>98.9%</td>
<td>1.1%</td>
<td>55.1%</td>
<td>43.3%</td>
<td>21.2%</td>
</tr>
<tr>
<td>Bartholomew County - IN</td>
<td>93.4%</td>
<td>2.5%</td>
<td>0.5%</td>
<td>3.7%</td>
<td>94.6%</td>
<td>5.4%</td>
<td>49.3%</td>
<td>35.8%</td>
<td>15.9%</td>
</tr>
<tr>
<td>Blackford County - IN</td>
<td>98.5%</td>
<td>0.9%</td>
<td>0.3%</td>
<td>0.3%</td>
<td>98.9%</td>
<td>1.1%</td>
<td>55.7%</td>
<td>42.2%</td>
<td>20.4%</td>
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<tr>
<td>Boone County - IN</td>
<td>96.4%</td>
<td>1.4%</td>
<td>0.2%</td>
<td>2.1%</td>
<td>97.7%</td>
<td>2.3%</td>
<td>49.4%</td>
<td>33.1%</td>
<td>12.8%</td>
</tr>
<tr>
<td>Brown County - IN</td>
<td>98.2%</td>
<td>0.9%</td>
<td>0.4%</td>
<td>0.6%</td>
<td>98.8%</td>
<td>1.2%</td>
<td>60.9%</td>
<td>47.2%</td>
<td>18.4%</td>
</tr>
<tr>
<td>Clay County - IN</td>
<td>98.7%</td>
<td>0.7%</td>
<td>0.2%</td>
<td>0.4%</td>
<td>98.9%</td>
<td>1.1%</td>
<td>51.5%</td>
<td>38.1%</td>
<td>17.1%</td>
</tr>
<tr>
<td>Clinton County - IN</td>
<td>98.6%</td>
<td>0.7%</td>
<td>0.4%</td>
<td>0.3%</td>
<td>87.4%</td>
<td>12.6%</td>
<td>48.8%</td>
<td>36.1%</td>
<td>16.6%</td>
</tr>
<tr>
<td>Decatur County - IN</td>
<td>98.1%</td>
<td>0.6%</td>
<td>0.3%</td>
<td>1.0%</td>
<td>98.6%</td>
<td>1.4%</td>
<td>50.4%</td>
<td>36.9%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Delaware County - IN</td>
<td>90.4%</td>
<td>7.8%</td>
<td>0.3%</td>
<td>1.4%</td>
<td>98.2%</td>
<td>1.8%</td>
<td>45.7%</td>
<td>34.4%</td>
<td>16.4%</td>
</tr>
<tr>
<td>Fayette County – IN</td>
<td>97.7%</td>
<td>1.8%</td>
<td>0.2%</td>
<td>0.4%</td>
<td>99.0%</td>
<td>1.0%</td>
<td>53.0%</td>
<td>40.4%</td>
<td>18.5%</td>
</tr>
<tr>
<td>Fountain County – IN</td>
<td>98.6%</td>
<td>0.6%</td>
<td>0.4%</td>
<td>0.4%</td>
<td>97.9%</td>
<td>2.1%</td>
<td>54.8%</td>
<td>41.0%</td>
<td>20.3%</td>
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<td>99.0%</td>
<td>0.6%</td>
<td>0.2%</td>
<td>0.3%</td>
<td>99.0%</td>
<td>1.0%</td>
<td>52.0%</td>
<td>37.4%</td>
<td>16.3%</td>
</tr>
<tr>
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<td>91.1%</td>
<td>7.7%</td>
<td>0.5%</td>
<td>0.8%</td>
<td>96.7%</td>
<td>3.3%</td>
<td>50.6%</td>
<td>38.4%</td>
<td>18.1%</td>
</tr>
<tr>
<td>Greene County - IN</td>
<td>98.7%</td>
<td>0.5%</td>
<td>0.3%</td>
<td>0.4%</td>
<td>99.0%</td>
<td>1.0%</td>
<td>53.7%</td>
<td>39.4%</td>
<td>18.0%</td>
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<td>90.1%</td>
<td>4.2%</td>
<td>0.3%</td>
<td>5.4%</td>
<td>96.5%</td>
<td>3.5%</td>
<td>44.5%</td>
<td>27.6%</td>
<td>9.8%</td>
</tr>
<tr>
<td>Hancock County - IN</td>
<td>96.0%</td>
<td>2.5%</td>
<td>0.3%</td>
<td>1.2%</td>
<td>98.1%</td>
<td>1.9%</td>
<td>50.6%</td>
<td>35.0%</td>
<td>14.0%</td>
</tr>
<tr>
<td>Hendricks County - IN</td>
<td>92.0%</td>
<td>5.0%</td>
<td>0.4%</td>
<td>2.6%</td>
<td>97.0%</td>
<td>3.0%</td>
<td>46.9%</td>
<td>31.4%</td>
<td>12.4%</td>
</tr>
<tr>
<td>Henry County - IN</td>
<td>98.0%</td>
<td>1.3%</td>
<td>0.2%</td>
<td>0.5%</td>
<td>98.7%</td>
<td>1.3%</td>
<td>54.4%</td>
<td>40.6%</td>
<td>19.2%</td>
</tr>
<tr>
<td>Howard County - IN</td>
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<td>7.8%</td>
<td>0.4%</td>
<td>1.2%</td>
<td>97.5%</td>
<td>2.5%</td>
<td>53.0%</td>
<td>40.0%</td>
<td>18.5%</td>
</tr>
<tr>
<td>Jay County - IN</td>
<td>98.8%</td>
<td>0.6%</td>
<td>0.1%</td>
<td>0.5%</td>
<td>97.4%</td>
<td>2.6%</td>
<td>50.5%</td>
<td>37.1%</td>
<td>17.2%</td>
</tr>
<tr>
<td>Johnson County - IN</td>
<td>95.7%</td>
<td>1.6%</td>
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Data are for 2011.
Data are in the percentage of women in the population.
Source: US Census Bureau – Population Estimates
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### Population characteristics summary

Proportionately, the State of Illinois has a slightly smaller White female population than the US as a whole, a slightly larger Black/African-American female population, a slightly smaller Asian and Pacific Islander (API) female population, a slightly smaller American Indian and Alaska Native (AIAN) female population, and a slightly smaller Hispanic/Latina female population. The state’s female population is slightly younger than that of the US as a whole. The state’s education level is slightly higher than and income level is slightly higher than those of the US as a whole. The state’s unemployment level is slightly larger than that of the US as a whole. The state has a slightly larger percentage of people who are foreign born and a slightly larger percentage of people who are linguistically isolated. 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.

Proportionately, the State of Indiana has a substantially larger White female population than the US as a whole, a slightly smaller Black/African-American female population, a substantially smaller Asian and Pacific Islander (API) female population, a slightly smaller American Indian and Alaska Native (AIAN) female population, and a substantially smaller Hispanic/Latina female population. The state’s female population is about the same age as that of the US as a whole. The state’s education level is slightly higher than and income level is slightly higher than those of the US as a whole. The state’s unemployment level is slightly larger than that of the US as a whole. The state has a substantially smaller percentage of people who are foreign born and a slightly smaller percentage of people who are linguistically isolated. There are a substantially larger percentage of people living in rural areas, a slightly 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 their respective state as a whole:
- Marion County, IN

The following counties have substantially larger API female population percentages than that of their respective state as a whole:
- Hamilton County, IN
- Monroe County, IN
- Tippecanoe County, IN

The following counties have substantially larger Hispanic/Latina female population percentages than that of their respective state as a whole:
- Clinton County, IN

The following counties have substantially older female populations than that of their respective state as a whole:
- Clark County, IL
- Edgar County, IL
- Blackford County, IN
- Fountain County, IN

The following counties have substantially lower education levels than that of their respective state as a whole:
- Fayette County, IN
- Parke County, IN

The following counties have substantially lower income levels than that of their respective state as a whole:
- Delaware County, IN
- Fayette County, IN

The following counties have substantially lower employment levels than that of their respective state as a whole:
- Blackford County, IN
- Delaware County, IN
- Fayette County, IN

**Priority Areas**

**Healthy People 2020 forecasts**

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

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

To see how well counties in the Komen Central Indiana 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>High</td>
</tr>
<tr>
<td>Medium</td>
<td>Medium High</td>
</tr>
<tr>
<td>Medium</td>
<td>Medium Low</td>
</tr>
<tr>
<td>Highest</td>
<td>Medium High</td>
</tr>
<tr>
<td>7-12 yrs.</td>
<td>High</td>
</tr>
<tr>
<td>Medium</td>
<td>Medium High</td>
</tr>
<tr>
<td>Medium</td>
<td>Medium Low</td>
</tr>
<tr>
<td>Medium</td>
<td>Medium Low</td>
</tr>
<tr>
<td>0 – 6 yrs.</td>
<td>Medium</td>
</tr>
<tr>
<td>Medium</td>
<td>Medium Low</td>
</tr>
<tr>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Lowest</td>
<td>Lowest</td>
</tr>
<tr>
<td>Currently meets target</td>
<td>Medium High</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>
<tr>
<td>Medium</td>
<td>Medium High</td>
</tr>
<tr>
<td>Medium</td>
<td>Medium Low</td>
</tr>
<tr>
<td>Lowest</td>
<td>Lowest</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 Central Indiana 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>Boone County - IN</td>
<td>Highest</td>
<td>13 years or longer</td>
<td>13 years or longer</td>
<td>Rural</td>
</tr>
<tr>
<td>Rush County - IN</td>
<td>Highest</td>
<td>SN</td>
<td>13 years or longer</td>
<td>Rural</td>
</tr>
<tr>
<td>Vermillion County - IN</td>
<td>Highest</td>
<td>SN</td>
<td>13 years or longer</td>
<td>Rural</td>
</tr>
<tr>
<td>Vigo County - IN</td>
<td>Highest</td>
<td>13 years or longer</td>
<td>13 years or longer</td>
<td>Rural</td>
</tr>
<tr>
<td>Shelby County - IN</td>
<td>High</td>
<td>8 years</td>
<td>13 years or longer</td>
<td>Rural</td>
</tr>
<tr>
<td>Wayne County - IN</td>
<td>High</td>
<td>8 years</td>
<td>13 years or longer</td>
<td>Rural</td>
</tr>
<tr>
<td>Bartholomew County - IN</td>
<td>Medium High</td>
<td>1 year</td>
<td>13 years or longer</td>
<td>Rural</td>
</tr>
<tr>
<td>Fountain County - IN</td>
<td>Medium High</td>
<td>13 years or longer</td>
<td>2 years</td>
<td>Older, rural, medically underserved</td>
</tr>
<tr>
<td>Hancock County - IN</td>
<td>Medium High</td>
<td>4 years</td>
<td>13 years or longer</td>
<td></td>
</tr>
<tr>
<td>Hendricks County - IN</td>
<td>Medium High</td>
<td>2 years</td>
<td>13 years or longer</td>
<td></td>
</tr>
<tr>
<td>Johnson County - IN</td>
<td>Medium High</td>
<td>4 years</td>
<td>13 years or longer</td>
<td></td>
</tr>
<tr>
<td>Madison County - IN</td>
<td>Medium High</td>
<td>2 years</td>
<td>13 years or longer</td>
<td></td>
</tr>
<tr>
<td>Marion County - IN</td>
<td>Medium High</td>
<td>13 years or longer</td>
<td>2 years</td>
<td>%Black/African-American, foreign, medically underserved</td>
</tr>
<tr>
<td>Morgan County - IN</td>
<td>Medium High</td>
<td>13 years or longer</td>
<td>3 years</td>
<td>Rural</td>
</tr>
<tr>
<td>Owen County - IN</td>
<td>Medium High</td>
<td>13 years or longer</td>
<td>1 year</td>
<td>Rural, medically underserved</td>
</tr>
<tr>
<td>Randolph County - IN</td>
<td>Medium High</td>
<td>2 years</td>
<td>13 years or longer</td>
<td>Rural</td>
</tr>
<tr>
<td>Clay County - IN</td>
<td>Medium</td>
<td>13 years or longer</td>
<td>Currently meets target</td>
<td>Rural, medically underserved</td>
</tr>
<tr>
<td>Decatur County - IN</td>
<td>Medium</td>
<td>13 years or longer</td>
<td>Currently meets target</td>
<td>Rural</td>
</tr>
<tr>
<td>Delaware County - IN</td>
<td>Medium</td>
<td>8 years</td>
<td>3 years</td>
<td>Poverty, employment</td>
</tr>
<tr>
<td>Greene County - IN</td>
<td>Medium</td>
<td>13 years or longer</td>
<td>Currently meets target</td>
<td>Rural</td>
</tr>
<tr>
<td>Henry County - IN</td>
<td>Medium</td>
<td>13 years or longer</td>
<td>Currently meets target</td>
<td>Rural</td>
</tr>
<tr>
<td>Monroe County - IN</td>
<td>Medium</td>
<td>9 years</td>
<td>1 year</td>
<td>%API, foreign</td>
</tr>
<tr>
<td>Clark County - IL</td>
<td>Medium Low</td>
<td>SN</td>
<td>1 year</td>
<td>Older, rural</td>
</tr>
<tr>
<td>Edgar County - IL</td>
<td>Medium Low</td>
<td>8 years</td>
<td>Currently meets target</td>
<td>Older, rural, medically underserved</td>
</tr>
<tr>
<td>Jay County - IN</td>
<td>Medium Low</td>
<td>SN</td>
<td>2 years</td>
<td>Rural</td>
</tr>
<tr>
<td>Parke County - IN</td>
<td>Medium Low</td>
<td>SN</td>
<td>1 year</td>
<td>Education, rural</td>
</tr>
<tr>
<td>Putnam County - IN</td>
<td>Medium Low</td>
<td>4 years</td>
<td>5 years</td>
<td>Rural</td>
</tr>
<tr>
<td>Grant County - IN</td>
<td>Low</td>
<td>2 years</td>
<td>Currently meets target</td>
<td></td>
</tr>
<tr>
<td>Hamilton County - IN</td>
<td>Low</td>
<td>6 years</td>
<td>Currently meets target</td>
<td>%API</td>
</tr>
<tr>
<td>Howard County - IN</td>
<td>Low</td>
<td>6 years</td>
<td>Currently meets target</td>
<td>Medically underserved</td>
</tr>
<tr>
<td>Tippecanoe County - IN</td>
<td>Low</td>
<td>4 years</td>
<td>Currently meets target</td>
<td>%API, foreign, medically underserved</td>
</tr>
<tr>
<td>County</td>
<td>Priority</td>
<td>Predicted Time to Achieve Death Rate Target</td>
<td>Predicted Time to Achieve Late-stage Incidence Target</td>
<td>Key Population Characteristics</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------------</td>
<td>-------------------------------------------</td>
<td>-------------------------------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Brown County - IN</td>
<td>Lowest</td>
<td>SN</td>
<td>Currently meets target</td>
<td>Rural, medically underserved</td>
</tr>
<tr>
<td>Clinton County - IN</td>
<td>Lowest</td>
<td>Currently meets target</td>
<td>Currently meets target</td>
<td>%Hispanic/Latina, rural</td>
</tr>
<tr>
<td>Fayette County - IN</td>
<td>Lowest</td>
<td>Currently meets target</td>
<td>Currently meets target</td>
<td>Education, poverty, employment, rural</td>
</tr>
<tr>
<td>Montgomery County - IN</td>
<td>Lowest</td>
<td>Currently meets target</td>
<td>Currently meets target</td>
<td>Rural</td>
</tr>
<tr>
<td>Sullivan County - IN</td>
<td>Lowest</td>
<td>NA</td>
<td>Currently meets target</td>
<td>Rural</td>
</tr>
<tr>
<td>Blackford County - IN</td>
<td>Undetermined</td>
<td>SN</td>
<td>SN</td>
<td>Older, employment, rural</td>
</tr>
<tr>
<td>Franklin County – IN</td>
<td>Undetermined</td>
<td>SN</td>
<td>SN</td>
<td>Rural, medically underserved</td>
</tr>
<tr>
<td>Tipton County - IN</td>
<td>Undetermined</td>
<td>SN</td>
<td>SN</td>
<td>Rural</td>
</tr>
<tr>
<td>Union County – IN</td>
<td>Undetermined</td>
<td>SN</td>
<td>SN</td>
<td>Rural</td>
</tr>
<tr>
<td>Warren County - IN</td>
<td>Undetermined</td>
<td>SN</td>
<td>SN</td>
<td>Rural</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 parishes in the Affiliate service area. When both of the indicators used to establish a priority for a parish are not available, the priority is shown as “undetermined” on the map.

![Map of Intervention Priority Areas](image-url)
Data Limitations
The following data limitations need to be considered when utilizing the data of the Quantitative Data Report:

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

Quantitative Data Report Conclusions

Highest priority areas
Four counties in the Komen Central Indiana service area are in the highest priority category. Two of the four, Boone County, IN and Vigo County, IN are not likely to meet either the death rate or late-stage incidence rate HP2020 targets. The other two, Rush County, IN and Vermillion County, IN are not likely to meet the late-stage incidence rate HP2020 target.

The incidence rates in Boone County, IN (133.8 per 100,000) and Vigo County, IN (127.4 per 100,000) appear to be higher than the State of Indiana as a whole (117.4 per 100,000) although not significantly. The death rates in Boone County, IN (31.8 per 100,000) and Vigo County, IN (25.1 per 100,000) appear to be higher than the State of Indiana as a whole (23.9 per 100,000) although not significantly.

The late-stage incidence trends in both Boone County, IN (10.5 percent per year), Rush County, IN (1.3 percent per year), Vermillion County, IN (18.3 percent per year) and Vigo County, IN (12.9 percent per year) indicate that late-stage incidence rates may be increasing.

High priority areas
Two counties in the Komen Central Indiana service area are in the high priority category. Shelby County, IN and Wayne County, IN are not likely to meet the late-stage incidence rate HP2020 target.
The late-stage incidence rates in Shelby County, IN (45.6 per 100,000) appear to be higher than the State of Indiana as a whole (40.0 per 100,000) although not significantly. The late-stage incidence trends in Shelby County, IN (10.7 percent per year) and Wayne County, IN (3.7 percent) indicate that late-stage incidence rates may be increasing.

**Selection of Target Communities**

The Community Profile Team examined the data provided by Komen Headquarters in the Quantitative Data Report with a special concentration on the Healthy People 2020 (HP2020) target for late-stage incidence and death rates. Areas were compared and categorized from highest to lowest priority. HP2020 has several cancer-related objectives, which include reducing women’s death rate from breast cancer and reducing the number of breast cancers that are found at late stage. There are several central Indiana counties not expected to reach either the predicted time to achieve death rate target or the predicted time to achieve the late-stage incidence target.

In order to be the most efficient stewards of resources, Susan G. Komen Central Indiana has chosen three groups of target communities within the service area. The Affiliate will focus strategic efforts on these target communities over the course of the next three years. Factors that the Affiliate reviewed when selecting target communities included, but were not limited to:

- Incidence rate
- Death rate
- Late-stage incidence rate
- Screening proportions
- Residents living below 250 percent of the federal poverty level
- Residents (ages 40-64) living without health insurance
- Unemployment percentages

The selected target communities are:

- Boone, Rush, Vermillion, and Shelby Counties;
- Vigo and Wayne Counties; and
- Marion County

**Boone, Rush, Shelby and Vermillion Counties:** These four counties are located throughout the Affiliate service area and have been combined into one target area for the purpose of this report. These counties are segmented from other counties due to their key population characteristic of being primarily rural and their status as highest priority based on HP2020 data. Between 34.4 percent and 61.2 percent of the population of these counties lives in rural areas (Table 2.5). The average female population ranges from 8,322 to 27,834 (Table 2.1). The female population over the age of 40 residing in these counties ranges from 49.4 percent to 55.6 percent (Table 2.4). The majority of the female population in these targeted counties, between 96.4 percent and 98.6 percent, is White (Table 2.4)

The breast cancer incidence rate in the State of Indiana is slightly lower than the US as whole and the incidence trend was similar to the US as a whole. The incidence rates for these counties range between 94.4 and 133.8 per 100,000 (Table 2.1). As seen in Table 2.1, the incidence rate trend is rising in all four counties, ranging from an increase of 1.3 percent to 13
percent. The breast cancer death rate in the State of Indiana is slightly higher than the US as whole, and the death rate trend was similar to the US as whole. The death rate for Boone, Shelby, and Rush Counties ranges from 23.6 to 31.8 per 100,000. The death rate for Vermillion County is suppressed due to small numbers (Table 2.1). The death rate decreased in both Boone County (-0.1 percent) and Shelby County (-1.8 percent) (Table 2.1). There were not enough data to report for Rush County, and the data were similarly suppressed due to small numbers for Vermillion County. The breast cancer late-stage incidence rate in the State of Indiana was significantly lower than the US as whole and the late-stage incidence trend was higher than the US as a whole. The late-stage incidence rate is rising in all four counties, ranging between 1.3 percent to 18.3 percent (Table 2.1).

These counties were collectively selected as a target community because it is likely that they will not meet the HP2020 targets. Boone County is at the highest priority level because the predicted time to achieve death rate target and late-stage incidence target is 13 years or longer. Rush and Vermillion Counties are both at the highest priority level because the predicted time to achieve the late-stage incidence rate is 13 years or longer. Shelby County is at a high priority level because the predicted time to achieve the death rate target is eight years, and the predicted time to achieve late-stage incidence rate is 13 years or longer (Table 2.7).

Screening percentages for Boone, Rush and Shelby counties average between 67.1 percent and 76.8 percent for women between ages 50 and 74. This is slightly lower than the United States percentage of 77.5 percent, and similar to the 69.5 percent for Indiana (Table 2.3). Vermillion County’s screening data were suppressed due to small numbers (fewer than 10 samples). After further assessment, it will be clearer what barriers are keeping women from receiving mammography screening and not achieving HP2020 objectives.

**Vigo and Wayne Counties:** Vigo and Wayne Counties have been grouped together as one target community for purposes of this Community Profile because of their shared characteristics. While Wayne County has a smaller population size, both counties have similar demographic characteristics. Both counties have similar percentages of women over the age of 40, residents living below 250 percent of the federal poverty level, and residents living without health insurance.

In Vigo County, 91.2 percent of the population is White (Table 2.4). The county has a female population of 53,140, with 47.5 percent of the female population being over the age of 40 (Table 2.4). Individuals with incomes below 250 percent of the federal poverty level account for 40 percent of the total population of Vigo County. This is higher than both the national and state percentages of people living below 250 percent of the federal poverty level (33 percent and 30 percent respectively) (Table 2.5). Of the residents living in Vigo County, 15.9 percent are living without health insurance (Table 2.5).

Vigo County is not likely to meet the HP2020 targets for death rate or late-stage incidence rate. The target to meet the female breast cancer death rate is 20.6 per 100,000. Vigo County currently has a female breast cancer death rate of 25.1 per 100,000 (Table 2.1). It is expected that Vigo County will take 13 years or more to meet this target (Table 2.7). The target for late-stage incidence rate is 41.0 per 100,000. Vigo County is currently at 40.3 per 100,000, but has an increasing trend of almost 13 percent annually (Table 2.1). Therefore, it is expected to take
13 years or longer to meet the target late-stage incidence rate (Table 2.7). Vigo County has a screening proportion for women between the ages of 50-74 of 63.6 percent, which is lower than both state and national proportions (Table 2.3).

In Wayne County, 92.7 percent of the population is White (Table 2.4). The county has a female population of 35,642, with 52.6 percent of the female population being over the age of 40 (Table 2.4). Individuals with incomes below 250 percent of the federal poverty level account for 40 percent of the population of Wayne County. This is higher than both the national and state percentages of people living below 250 percent of the federal poverty level (33 percent and 30 percent, respectively) (Table 2.5). Of the residents living in Wayne County, 16.6 percent are living without health insurance (Table 2.5).

Wayne County is not likely to meet the HP2020 targets for death rate or late-stage incidence rate. The target to meet the female breast cancer death rate is 20.6 per 100,000. Wayne County currently has a female breast cancer death rate of 23.4 per 100,000. It is anticipated that Wayne County will take eight years to achieve this target (Tables 2.1 and 2.7). The target for late-stage incidence rate is 41.0 per 100,000. Wayne County is currently at 30.1 per 100,000, but has an increasing trend of 3.7 percent annually (Table 2.1). Because of this increasing trend, it is expected to take 13 years or longer for Wayne County to meet the target late-stage incidence rate (Table 2.7). Wayne County has a screening proportion for women between the ages of 50-74 of 61.7 percent, which is lower than both state and national proportions (Table 2.3).

Both Vigo and Wayne Counties have a high female breast cancer death rate that is unlikely to reach the HP2020 target rate within the next 8-13 years or longer. Interestingly, both counties currently meet the target for late-stage diagnosis rate, but with increasing trends, both counties are not expected to meet the target. Both counties have screening proportions lower than state and national levels. Further assessment will provide a clearer understanding of why the counties have increasing late-stage diagnosis rates.

Marion County: Marion County, whose largest city is Indianapolis, is the largest county in the State of Indiana and the Affiliate service area in terms of population. Marion County has the highest percentage of Black/African-American women and the highest population of Black/African-American women in real numbers. Marion County also has the highest population of Hispanic/Latina women in real numbers in the Affiliate service area (Table 2.4). In Marion County, 29.3 percent of the population is Black/African-American, which is higher than the national average at 14.1 percent and the Indiana average at 10.2 percent. The population of Hispanics/Latinas in Marion County is 8.6 percent, which is lower than the national average at 16.2 percent but higher than the Indiana average of 5.8 percent (Table 2.4).

Marion County’s female population is 461,040 with 43.7 percent being over the age of 40 (Table 2.1). The population in Marion County consists of 15.8 percent having less than a high school education (Table 2.5). Those with income below 250 percent of the federal poverty level account for 39.3 percent of the population (Table 2.5). Marion County residents living without health insurance comprise 17.9 percent of the population (Table 2.5). The rates for those living below the federal poverty level and without health insurance are higher than the national and state averages. Marion County also has a higher percentage of foreign-born individuals at 8.2 percent, which is lower than the national average of 12.8 percent but higher than the state average of 4.5 percent (Table 2.5).
Marion County was selected as a priority community because the predicted time to meet the HP2020 target death rate is 13 years or longer (Table 2.7). The target to meet the female breast cancer death rate is 20.6 per 100,000, and Marion County is at 26.1 per 100,000 (Tables 2.1 and 2.7). Marion County was also selected due to its high percentage of minorities and the higher percentage of those living in poverty and without health insurance. According to Hunt et al., Marion County ranked 10th of the 50 largest cities where non-Hispanic Black/African-American women face disparity in breast cancer deaths.

The incidence rates in Marion County are comparable to the national average and slightly higher than the state average (Table 2.1). Marion County has the ninth highest death rate in the state, which is higher than the national rate. Additionally, the county’s late-stage incidence rate is the eighth highest within the Affiliate service area and higher than the state average, but comparable to the national rate.

In Marion County, 75.4 percent of the female population between the ages of 50 and 74 reported having a mammogram in the last two years (Table 2.3). This is slightly lower than the United States percentage of 77.5 percent, and higher than the statewide screening percentage of 69.5 percent. This is intriguing when comparing to the death rate, which is higher than the national and state averages. The primary focus will be to gain a better understanding of why the death rate is higher than the national and state averages. Studying Marion County will also offer insight to the barriers Black/African-American women face as they navigate the health care system, as well as a deeper understanding of why women in Marion County experience a high breast cancer death rate, even though their screening proportions are comparable to the national average.
**Health Systems Analysis Data Sources**

Several resources were used to identify health care facilities that provide breast health services including clinical breast exams, screening mammograms, diagnostic screenings, treatment, financial assistance and patient navigation. The following resources enabled the team to have a comprehensive understanding of the programs and services that exist in priority areas:

- Mammography centers
- Federally qualified health centers (FQHCs)
- Hospitals
- Local health departments
- Free clinics
- American College of Surgeons Commission on Cancer
- American College of Radiology Centers of Excellence
- American College of Surgeons National Accreditation Program for Breast Centers (NAPBC)
- National Cancer Institute Designated Cancer Centers

For a list of the resource websites, please visit the reference page at the conclusion of the Community Profile.

In addition to these resources, the Team also contacted providers within the priority areas to provide a clearer understanding of the services that are provided. Komen Central Indiana also worked closely with the Indiana Breast & Cervical Cancer Program (IN-BCCP) to identify IN-BCCP providers in the priority areas.

**Health Systems Overview**

The Breast Cancer Continuum of Care (CoC) (Figure 2.1) is a model that shows how a woman typically moves through the health care system for breast care. A woman would ideally move through the CoC quickly and seamlessly, receiving timely, quality care in order to have the best outcomes. Education can play an important role throughout the entire CoC.

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

If a screening exam resulted in abnormal results, diagnostic tests would be needed, possibly several, to determine if the abnormal finding is, in fact, breast cancer. These tests might include a diagnostic mammogram, breast ultrasound or biopsy. If the tests were negative (or benign) and breast cancer was not found, she would go into the follow-up loop, and return for screening at the recommended interval. The recommended intervals may range from three to six months for some women to 12 months for most women. Education plays a role in communicating the importance of proactively getting test results, keeping follow-up appointments and understanding what results and recommendations mean. Education can empower a woman and help to manage anxiety and fear.

If breast cancer is diagnosed, she would proceed to treatment. Education can cover such topics as treatment options, how a pathology reports determines the best options for treatment, understanding side effects and how to manage them, and helping to formulate questions a woman may have for her providers.

For some breast cancer patients, treatment may last a few months, and for others, it may last years. While the CoC model shows that follow up and survivorship come after treatment ends, they actually may occur at the same time. Follow up and survivorship may include things like navigating insurance issues, locating financial assistance, symptom management, such as pain, fatigue, sexual issues, bone health, etc. Education may address topics such as making healthy lifestyle choices, long-term effects of treatment, managing side effects, the importance of follow-up appointments and communication with providers. Most women will return to screening at a recommended interval after treatment ends, or for some, during treatment (such as those taking long-term hormone therapy).

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

**Boone, Rush, Vermillion, and Shelby Counties**

**Boone County** (Figure 3.2)
Boone County Community Clinic (BCCC) is a state-funded, nurse-managed, independent, 501c(3) Community Health Center. BCCC provides access to basic medical services including clinical breast exams and genetic testing for residents who are under/uninsured and have limited financial resources. BCCC works closely with Witham Medical Imaging services to provide the majority of screening and diagnostic services with financial support from IN-BCCP, the YWCA of Greater Lafayette and Susan G. Komen Central Indiana. These partnerships
ensure women who are in need of breast health care have the financial resources to complete the CoC.

Boone County has one hospital, Witham Memorial Hospital, located in Lebanon, Indiana. Imaging services include digital mammography, ultrasounds, MRI, ultrasound guided biopsies, traditional wire biopsies and stereotactic needle biopsies. Women diagnosed with breast cancer can receive treatment at the Cancer Institute located at Witham Hospital and in partnership with St. Vincent Hospital. The Cancer Institute provides oncology and radiation oncology. The Hospital has received accreditation from the American College of Radiology Center of Excellence. The Women’s Center is a Breast Center of Excellence. Witham also provides monthly support groups for patients, survivors, family members and friends. Witham Hospice Care is provided to patients who are terminal, and is coordinated with local hospice care providers. Witham Hospital is also an IN-BCCP site. The hospital does not employ a patient navigator, so women in need of diagnostic imaging and further screening and treatment must navigate the health system independently.

There are few options for public transportation in Boone County, but several barriers seem to exist in patients accessing these resources. Most of the transportation options in Boone County are run by non-profit agencies as opposed to local government, so patients may not be aware of the available resources. On the other hand, there are several transportation options that patients know and trust; these programs often have a demand for services that they cannot fulfill. Bone County is very rural in nature, and Witham Hospital and the Boone County Community Clinic are both situated in the heart of Lebanon, making it difficult for individuals to access screenings. An additional barrier could be that there are no late evening, or early morning, screening options. The latest screening appointment is 6:00 p.m. and the earliest is 7:30 a.m., which can make it difficult for women who are working full time or have childcare needs.

While Komen Central Indiana has a strong collaborative relationship with BCCC, the relationship with Witham Hospital needs to be developed to ensure timely care and opportunities for future collaborative initiatives. This partnership is needed to reduce the death and late-stage diagnosis rates and to increase survivorship with a special focus on HP2020 objectives.
Figure 3.2. Breast cancer services available in Boone County
Rush County (Figure 3.3)
Rush County has one hospital, Rush Memorial Hospital (RMH), located in Rushville, Indiana. Rush Memorial Hospital is the only medical provider for low income, under/uninsured women and is a Susan G. Komen Central Indiana grant recipient. RMH provides digital mammography, ultrasounds, MRI and breast biopsies. The Sheehan Cancer Center offers surgical oncology, radiology and medical oncology. Through the Komen grant, RMH receives funding for breast health services and has a full-time navigator working with women who enter the continuum of care and are under/uninsured to ensure the completion of the CoC. RMH has a foundation and a fund called “Brian’s Cause”, which is a cancer treatment relief fund. The RMH Patient Financial Assistance program offers charity care for those individuals who qualify. For individuals who have limited income, are living without insurance or are underinsured, clinical breast exams are provided at a sliding scale at Meridian Health Services.

RMH is the only medical provider in Rush County offering comprehensive breast health services. Women who are in need of breast reconstruction are referred to Indianapolis, which is over an hour drive. This can be a serious barrier for women who are interested in completing the CoC into survivorship. There are also no active IN-BCCP providers in Rush County. The only funding available for screening, for those without health insurance is through the Komen Central Indiana grant. Grant funding from Komen is never a guarantee, and individuals who are under/uninsured may have difficulty accessing affordable breast screenings should Komen dollars no longer exist within the community. It is important that RMH diversify their funding sources to ensure women within their community who are in need of affordable screenings have assistance.

Future partnerships could be developed with local food pantries to conduct outreach and education regarding the importance of breast self-awareness. In addition to the food pantries, developing a relationship with the Meridian Health Clinic will help to ensure that women enter the continuum of care with clinical breast exams and complete all necessary screening and diagnostic services.
Figure 3.3. Breast cancer services available in Rush County
Shelby County (Figure 3.4)
Shelby County has one hospital, Major Hospital, located in Shelbyville, Indiana. The hospital provides screening and diagnostic digital mammography, as well as MRI, ultrasounds and stereotactic biopsies. Breast surgeries, including mastectomy and lumpectomy, are performed onsite with reconstructive breast procedures. The Beneese Oncology Center, located at Major Hospital, provides treatment. The hospital contracts with Little Red Door, a Komen Central Indiana grantee, and IN-BCCP to pay for breast screenings for women who meet eligibility guidelines.

The Shelby Community Clinic is a free clinic staffed by a women's health nurse practitioner. Free clinical breast exams are provided for any woman who doesn’t have health insurance. For women under the age of 40, the clinic works with Little Red Door to fund clinical breast exams.

A deeper exploration will occur through key informant interviews and focus groups to help identify gaps in care and barriers to completion of the CoC. One possible issue is the lack of a dedicated patient navigator responsible for guiding women through breast health screenings at the diagnostic level. Organizations in Shelby County also lack an outreach educator, responsible for raising awareness about the importance of breast health screenings, and how to access affordable and low cost imaging.

Little Red Door, which is located in Indianapolis, is the only partner Komen Central Indiana currently has that provides services in Shelby County. Future collaborative opportunities with Shelby Community Clinic and Major Hospital are imperative as the Affiliate continues to explore problems and solutions to increase the survival rate in Shelby County.
Figure 3.4. Breast cancer services available in Shelby County
**Vermillion County (Figure 3.5)**

Vermillion County has one community health center and one hospital. Union Hospital Clinton offers screening, diagnostics, treatment, and support services for women in Vermillion County, including those who are low income. Their advanced services are limited, so patients that are in need of advanced facilities for treatment are referred to Union Hospital in Terre Haute for those services. Terre Haute is less than 20 miles from Clinton, but for those patients who require frequent trips to the hospital for treatment, the cost of this travel could prove to be a barrier to seeking care.

The Cayuga Clinic located in Cayuga, Indiana, and is a part of the Vermillion-Parke Community Health Center. The clinic offers screening for the rural, low income women in this county. Vermillion-Parke Community Health Center offers screening to rural, low income women. It is part of the Vermillion-Parke Community Health Centers network and it is open year round. It serves the population in Clinton and surrounding cities. Both clinics offer clinical breast exams, which help women enter into the CoC.

There are many possible barriers that could explain why women in Vermillion County may not move from one point to the other in the CoC. Lack of a public transit can be a barrier because most women in Vermillion County are living in rural areas. Terre Haute, where most of the patients in Vermillion County are referred, is about fifteen miles away from Clinton. As mentioned above, this distance could become a barrier to those requiring frequent trips to Terre Haute. Women who live outside of Clinton may have even more difficulty accessing services, as they have even fewer resources in their local communities.

Komen Central Indiana will need to explore partnership opportunities in Vermillion County, including possibly partnering with local churches and the local community action program to educate Vermillion County residents about breast health and resources available in their community. Vermillion County is less than 300 square miles, yet there are eleven churches as well as the Community Action Program of Western Indiana located within Vermillion County which could provide Komen Central Indiana platforms from which to educate women and help them enter the CoC.
Figure 3.5. Breast cancer services available in Vermillion County
Vigo and Wayne Counties

Vigo County (Figure 3.6)

Vigo County has two major hospital systems: Terre Haute Regional Hospital and Union Hospital, which includes the Clara Fairbanks Center for Women, Clara Fairbanks Thomas Plaza, and the Hux Cancer Center. Through these hospital systems, women in Terre Haute and the surrounding communities have access to the continuum of care, from screening through treatment, including support services. The Clara Fairbanks Center for Women is a Komen Central Indiana grantee, and uses their Komen funds to provide screening and diagnostic services to women who otherwise would not be able to afford them. Additional funds are available to women in Vigo County through Komen Central Indiana’s partnership with the YWCA of Greater Lafayette, whose Komen Central Indiana grant provides funding for education, screening, diagnostics, and patient transportation.

Vigo County is also home to the Wabash Valley Health Center and the Pace Health Connection. The Wabash Valley Health Center is a Community Health Center, and the Pace Health Connection is a Title X clinic. Both of these centers provide screening services to women as part of their primary care model.

Vigo County is home to Indiana State University, who, in partnership with Union Hospital, is opening a genetic testing and counseling center. This center is funded in part by Komen Central Indiana. Komen funds will be used for genetic counseling for women who lack insurance coverage for this service. This will enable women to better understand their and their family’s risk of developing breast cancer and to seek the best treatment plan available.

While Komen Central Indiana has a relationship with Union Hospital and a new relationship with Indiana State University, these relationships will need to be strengthened in order to ensure that women in Vigo County receive access to care. Additionally, Komen Central Indiana will need to develop relationships with Terre Haute Regional Hospital to ensure that women in Vigo County have access to services regardless of which hospital system they use.
Figure 3.6. Breast cancer services available in Vigo County
Wayne County (Figure 3.7)
Wayne County has one hospital system, Reid Hospital and Health Care Services. Reid Hospital provides screening, diagnostic services, treatment for breast cancer, and support services in the form of financial assistance. Reid is accredited by the American College of Surgeons and is an American College of Radiology Breast Imaging Center of Excellence.

Komen Central Indiana has recently expanded its service area, and has not previously worked in Wayne County. Therefore, relationships with the local hospital, county health department, and other resources that women may use to seek breast health care will need to be developed. A deeper exploration of county resources will occur through key informant interviews to help identify gaps in care and barriers to completion of the CoC.
Figure 3.7. Breast cancer services available in Wayne County
Marion County (Figure 3.8)
Marion County has four hospital systems, including Community Health Network, St. Vincent Health, St. Francis Hospital and Indiana University Health, which includes Eskenazi Health, IU Simon Cancer Center and Methodist Hospital. The health systems all provide mammography screening, diagnostic imaging, breast biopsies, breast surgery, radiation, chemotherapy, hospice and survivor support. The health institutions provide patient navigation at the point of diagnostic services, with the exception of Eskenazi Health, which begins navigation at screening mammograms for all patients referred from the Eskenazi clinics. Indiana University Health and Methodist Hospital have received accreditation from the American College of Surgeons CoC and American College of Radiology Breast Imaging Center of Excellence. Community Health has received accreditation from the American College of Surgeons CoC and American College of Surgeons NAPBC. St. Francis and St. Vincent Hospitals have received accreditation from American College of Surgeons CoC, American College of Radiology Breast Imaging Center of Excellence and the American College of Surgeons NAPBC. Eskenazi Health has received accreditation from the American College of Radiology Breast Imaging Center of Excellence. There are also several stand-alone imaging centers that provide mammography and diagnostic screening.

There are 21 community health centers and four free health clinics in Marion County. These organizations provide health care regardless of the patient’s ability to pay, but are restricted to those who are under/uninsured and have limited or no access to primary health care.

There are many options for women to access breast screenings in Marion County, but the systems are all quite large, which can be daunting for individuals who have no primary health care provider or health insurance. Komen Central Indiana has strong collaborative relationships with health care providers and clinics within Marion County. Komen Central Indiana works closely with the Indiana University Health and Community Health Network hospital systems. Collaboration has diminished in recent years with St. Vincent Hospital, which provides the area’s only mobile mammography unit, and St. Francis Hospital. Komen Central Indiana maintains working relationships with providers in these hospital systems. Komen Central Indiana grantees offering services in Marion County include Gennesaret Free Clinic, the Eskenazi Health Embrace Program, HealthNet and Little Red Door Cancer Agency. Komen Central Indiana has partnered with other nonprofit organizations to further explore and address breast cancer disparities for Black/African-American women in Marion County.
Figure 3.8. Breast cancer services available in Marion County
Public Policy Overview

National Breast & Cervical Cancer Early Detection Program (NBCCEDP)
The Indiana Breast and Cervical Cancer Program (IN-BCCP) partners with health systems to implement evidence-based interventions including provider assessment and feedback; provider reminders; client reminders; small media; one-on-one education; and/or reducing structural and financial barriers to increase breast and cervical cancer screening among rarely or never screened women, increase follow-up on all abnormal cancer screenings, and increase the timely and appropriate initiation of breast and cervical cancer treatment by providing patient navigation, addressing barriers to completing care and follow-up, and implementing evidence-based strategies to increase cancer screening proportions. The IN-BCCP reduces financial barriers by providing access to breast and cervical cancer screening and diagnostic services to uninsured or underinsured women between the ages of 30 to 64, who fall at 200 percent of the federal poverty level or below. Women are recruited through regional coordinators, or enrolled at the offices of providers who participate in the program. Women are tracked via a data management system, and providers are reimbursed at Medicare rates. Women are matched with case managers if abnormal diagnoses are found to ensure timely and appropriate follow-up and diagnosis. If women are diagnosed with breast or cervical cancer, they are enrolled into Medicaid and receive full coverage for the duration of their treatment.

IN-BCCP patient navigators transition women enrolled in IN-BCCP into the Medicaid Treatment Program if diagnosed with breast or cervical cancer. The Indiana State Department of Health (ISDH) supports a full-time position to coordinate the Option 3 Treatment Program application process with the Medicaid Office for women diagnosed with breast or cervical cancer outside of the IN-BCCP.

IN-BCCP has a Memorandum of Understanding with the Family and Social Services Administration (FSSA), including the Office of Medicaid Policy and Planning and the Division of Family Resources, to implement the provisions of the Breast and Cervical Cancer Prevention and Treatment Act of 2000, Public Law 106-354, to ensure eligible women diagnosed with breast or cervical cancer through IN-BCCP or by another provider receive Medicaid to cover treatment. ISDH ensures that women meet the eligibility requirements, and FSSA provides final eligibility determination and coverage.

Susan G. Komen Central Indiana has a strong collaborative working relationship with IN-BCCP. The Director of IN-BCCP and the Komen Central Mission Director serve together on the Indiana Cancer Consortium (ICC) Early Detection Committee. This Committee has developed a provider flow chart to ensure that limited funds are used appropriately and a state map highlighting the providers for IN-BCCP, the Indiana Breast Cancer Awareness Trust, Susan G. Komen Central Indiana grantees in Indiana and federally qualified health clinics. The two organizations have also partnered in developing webinars for providers, nurse practitioners and patient navigators and collaborated on presentations and programs to measure outcomes and increased survivorship.

Susan G. Komen Central Indiana will continue to partner with IN-BCCP, focusing on increasing access to care and reducing breast cancer deaths.
State Comprehensive Cancer Control Coalition
Komen Central Indiana has a collaborative relationship with the Indiana Cancer Consortium (ICC). A representative from Komen Central Indiana was a subject matter expert in developing the breast cancer objectives for the 2010-2015 Indiana Cancer Control Plan. Susan G. Komen Central Indiana received the 2013 ICC Outstanding Contributions to Cancer Control Organization Award. A representative from Komen Central Indiana authored and served as a subject matter expert for the 2015 Indiana Cancer Facts & Figures breast cancer section.

This collaborative relationship will continue to focus on the Cancer Control Plan’s breast cancer and early detection objectives. ICC has developed a provider flow chart and asset map, which identifies Komen Grantees, IN-BCCP providers, Indiana Breast Cancer Awareness Trust grantees, and Affordable Care Act navigators, clearly identifying free or reduced-cost breast screenings. In addition to the asset map, the Employer Gold Standard will provide accreditation to employers that implement best practice policies, encouraging employees to obtain breast health screenings.

Komen Central Indiana supports the collaborative nature and systemic approach of the ICC and intends to continue partnering with this group.

Affordable Care Act (ACA) and Health Indiana Program 2.0 (HIP 2.0)
The ACA has the potential to provide health care coverage for uninsured Hoosiers, potentially reaching over 800,000 individuals, who were living without insurance prior to the rollout. Indiana is currently operating a federal health exchange model. There are 229,815 individuals who are eligible to enroll in a marketplace plan and 155,961 who can receive financial assistance to enroll in a marketplace plan. As of June 2016, there are 168,884 who have enrolled.

The expansion of Medicaid was included as an option for each state in the 2011 Affordable Care Act, and this option was intended to provide health care coverage to individuals who fall in the gap between receiving ACA subsidies and those eligible for traditional Medicaid. While individuals earning above 138 percent federal poverty level may receive financial assistance in the form of subsidies for marketplace coverage through the Affordable Care Act, individuals below this income threshold are not entitled to subsidies. Prior to Medicaid expansion in Indiana, adults ages 19-64 who earn 138 percent of the federal poverty level or less and did not qualify for Medicaid fell into a coverage gap.

In January 2015, the Indiana Executive Branch in Indiana and the Centers for Medicare and Medicaid Services reached an agreement to expand Medicaid coverage in Indiana by expanding and further developing HIP. HIP 2.0 was developed from the existing Medicaid Waiver program and expands eligibility to residents 19 to 64 years old who are earning up to 138 percent of the federal poverty level. As of July 2015, approximately 370,000 people had enrolled in HIP 2.0, including 270,000 new participants. About 500,000 Indiana residents are likely eligible for the plan.

Differing from traditional Medicaid, HIP 2.0 is a consumer-driven model, which resembles that of a health savings account and requires participants to make financial contributions into their POWER accounts. POWER account contributions are based on a sliding scale fee, limited to two percent of household income, but not less than one dollar, whichever is greater, and are to
be used to pay deductible expenses. Employers will be allowed to contribute up to 50 percent of a participant’s required POWER account contribution. Mammograms and preventive screenings are covered by the plan up to $500.00.

The Indiana State Department of Health hired a consultant to assess the impact of HACA and HIP 2.0 on IN-BCCP, as well as any other program that provides direct services. While IN-BCCP eligibility, which currently serves women ages 40 to 64, under or uninsured at or below 200 percent of the federal poverty level, has not changed, new eligibility guidelines are being developed in response to the impact of HIP 2.0.

For many, accessibility to screening services, diagnostic services, and treatment is unattainable without the assistance from Komen Central Indiana, IN-BCCP, and other foundations. Komen Central Indiana remains focused on removing the barriers which stop women from entering into and completing the CoC. Komen Central Indiana is acutely aware of the fact that, while individuals may purchase health care through the ACA marketplace or enroll in HIP 2.0, new barriers might emerge, ranging from providers not accepting the health plan to diagnostic screenings not being covered until very high premiums and out-of-pocket costs are met. Komen Central Indiana will actively educate collaborative partners, grantees, and community members regarding the limitations and barriers newly insured individuals will face. Komen Central Indiana will monitor the ever changing health care landscape and will amend funding priorities as needed over time to ensure all women have access to timely and quality breast health care. Komen Central Indiana will encourage its grantees to remain up-to-date on knowledge regarding the ACA and to be flexible in providing assistance to individuals in need of assistance.

Providers are finding that the ACA gives back their power in treating patients, rather than the insurance deciding what treatments are appropriate and reimbursable. The ACA encourages preventive screenings and also recognizes the current shortage of doctors and nurses by providing incentives.

Public Policy Activities
Susan G. Komen announced the following 2016 Advocacy Priorities, and this is the platform Komen Central Indiana presents when working with policymakers:

- Support for expanded federal funding for biomedical research, especially breast cancer research at the National Institutes of Health (NIH) and the Department of Defense (DOD);
- Support state and federal funding for the Centers for Disease Control and Prevention’s (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP);
- Advocate for policies to improve insurance coverage for breast cancer treatments and screening, specifically pertaining to increased access to drug therapies and limiting out-of-pocket costs for diagnostic mammography; and
- Evaluate state and federal policies to increase awareness, education and access to clinical trials for all patient populations.

Komen Central Indiana has met with representatives from local government, including state representatives, and members of Congress to encourage them to support these priorities. Komen Central Indiana will continue to support these initiatives and will partner with local officials to ensure the success of the priorities.
Komen Central Indiana will partner with the ICC to encourage health systems to develop a system which automatically orders mammography screening reminders within primary care settings. With the ICC, Komen Central Indiana will advocate for a policy change that would require providers to report on dates between screening to diagnostic to diagnosis and ultimately treatment. Komen Central Indiana will meet with the Senator who originally authored the MA-12 treatment bill to encourage an amendment to the current language to allow women who have been diagnosed with triple negative breast cancer to remain enrolled in Medicaid until a physical determines treatment is completed. The law currently states that survivors are to remain on Medicaid until all treatment is completed. This excludes triple negative women as treatment is considered “complete” upon finishing radiation.

**Health Systems and Public Policy Analysis Findings**

The Health Systems Analysis highlights several needs in target communities related to health systems and the CoC. First, patient navigation is imperative to the completion of the CoC in Boone and Shelby Counties. Having a dedicated individual working with low-income, underinsured and/or uninsured women within the health system will ensure women who enter the CoC complete all necessary screenings. Second, despite other available resources, a current grant from Komen Central Indiana provides the only coverage for health services to under/uninsured women in Rush County. Third, in Marion County, women have multiple options for care but can easily fall out of the CoC resulting from the presence of many different health institutions and the absence of a single provider monitoring care. Komen Central Indiana will focus on solutions to ensure monitored care and timely treatment. Furthermore, Komen Central Indiana will need to identify reasons Black/African-American women are facing a disparity in death rate compared to White women and work collaboratively to identify solutions and decrease disparities. Finally, deeper exploration will need to be done to determine what barriers to care women in Vermillion, Vigo, and Wayne Counties may be facing to entering and completing the CoC.

While Komen Central Indiana partnerships are strong in communities with existing Komen Central Indiana grantees and in Marion County where the Komen Central Indiana office is located, relationships in the smaller, rural counties need to be strengthened. The analysis highlights the need to have a stronger presence and collaborative relationships with partners in Boone, Rush, Shelby, and Vermillion Counties to ensure women are completing the CoC. Specifically, Komen Central Indiana will seek to build relationships with local hospitals and Community Health Clinics to ensure that women access timely screenings and breast cancer care and are aware of the importance of early detection and financial resources. In Marion County, Komen Central Indiana will work to maintain existing partnership and to build new relationships. Komen Central Indiana will work to develop new relationships with community partners in Vigo and Wayne Counties to ensure that the highest-need women in the service area have access to care.

Komen Central Indiana must also stay informed of the ever-changing health care environment following rollout of the ACA and the proposal for HIP 2.0. Komen Central Indiana will represent the voice of those served by Komen’s mission to ensure adequate, timely and affordable health care. While the ACA may increase availability to screening and care, Komen Central Indiana will
need to stay vigilant of other issues, like provider shortage and new barriers as a result of high-deductible insurance plans. This will be accomplished through continued partnerships with ICC, IN-BCCP, grantees, community partners, navigators and communications with federal and state representatives.
Qualitative Data Sources and Methodology Overview

To further study the breast health and breast cancer issues highlighted by the quantitative data, Susan G. Komen Central Indiana conducted a qualitative data assessment. Equally important to the quantitative data, this exploration into the observations and opinions of health care providers and lay community members helped the Community Profile Team to more deeply understand the needs of the communities it serves.

Following completion of thorough quantitative data analysis, Komen Central Indiana selected three priority communities for qualitative data collection and review: Boone, Rush, Shelby, and Vermillion Counties; Marion County; and Vigo and Wayne Counties. Variables, including breast cancer screening, occurrence, diagnosis, treatment, the completion of the Breast Cancer Continuum of Care (CoC), and the presence of specific vulnerable populations in these communities, guided the selection of the target communities and the key assessment questions for the analysis.

Because quantitative data revealed that Komen Central Indiana’s service area has a significantly lower breast cancer screening percentage than that observed in the United States as a whole, the Community Profile Team identified access and utilization of screening services as key topics for its qualitative studies. Key assessment questions related to these two variable were intended to help Komen Central Indiana pinpoint the barriers to breast health services (both system-level and individual), as well as facilitators for obtaining breast health services—ultimately revealing observations that could improve Komen Central Indiana’s ability to increase the number of women seeking preventive care, diagnostic, and treatment services.

In addition, Komen Central Indiana identified the quality and quantity of its relationships with local partners serving women in priority areas as a key variable impacting women’s ability to complete the CoC, with a particular need for bolstering these relationships in Boone, Rush, Shelby, Vermillion, Vigo, and Wayne Counties. Key assessment questions related to this aim were intended to guide Komen Central Indiana as to how to most effectively build a stronger presence and greater collaborative partnerships outside of its home base of Marion County.

Komen Central Indiana also sought to better understand its service area’s especially vulnerable populations through this analysis by targeting high priority populations, such as Black/African-American women, rural women, and older women.

Komen Central Indiana used key informant interviews and focus groups to collect qualitative data from its target communities. In addition, surveys were used as a tactical response to overcome limitations of focus group data in Marion County and key informant interview data in Vigo and Wayne Counties. The Community Profile Team, which included staff members of Komen Central Indiana, a professor from Butler University, a local cancer policy and research director, a local cancer prevention and evaluation specialist, as well as a Butler University student, led key informant interviews, moderated the patient/consumer focus groups and developed the survey.
The selected collection methods were intended to encompass a broad range of community perspectives, from those who work in women’s health to those who make up central Indiana’s underserved populations.

Qualitative, in-depth key informant interviews with women’s health professionals in each target area were chosen as a data collection method for the ability to deliver critical insight from the viewpoint of health care providers and nonprofit professionals with an interest in breast health. Key informants provided valuable observations, not just from their own perspectives, but also from the perspectives of the women they serve. Key informant interviews were executed through a script created by the Community Profile Team and encompassed questions relating to the identified key variables. The interviews were intended to evoke thoughtful, critical information from those most capable of identifying barriers to breast health and breast cancer services in central Indiana.

The Community Profile Team selected focus groups as a complementary method of qualitative data collection in order to elicit critical information from the other side of the care equation, i.e., the consumer/lay community member. Focus groups were designed to provide qualitative assessment through analysis of the target populations’ perceptions, opinions, beliefs, and attitudes towards breast health and breast cancer.

Drafted with the viewpoint of health care providers, administrators, or those who deliver support services in mind, the Community Profile Team developed a script for key informant interviews. Every key informant interviewer used the written script (“interview guide”) to guide their conversation with interviewees. Each interview assessed the key informant’s:

- Length of involvement in the breast cancer field;
- Observations as to changes in breast cancer occurrence, diagnosis, or treatment in their community;
- Reasoning for working in their locale;
- Thoughts as to why their community is experiencing low screening percentages and/or higher late-stage diagnosis or death rates;
- Perceived obstacles that slow down the progress made between screening, diagnostic services, and treatment for women in their community;
- Thoughts on why women in their service area do not follow recommended screening guidelines;
- Insight as to why women do not use available screening facilities;
- Insight as to community members’ feelings toward the health care system;
- Observations as to specific populations that seem left out of screening and diagnosis in their community;
- Opinion as to what factors impact the affordability of care in their community/county (including the impact of insurance);
- Opinion as to what factors impact access to care in their community/county;
- Observations as to particular populations who have poorer survival and why;
- Observations as to language being a barrier to care;
- Observations as to physician insensitivity and its impact on care; and
- Observations as to gaps in resources within the Continuum of Care in their community/county.
All interviews were recorded and transcribed verbatim. The transcripts were then analyzed and coded by members of the Community Profile Team.

Similarly, the Community Profile Team developed a script to lead the focus groups into a meaningful discussion about breast health and breast cancer. A Community Profile Team member acted as a moderator in each of the focus groups, utilizing the prepared script ("focus group moderator's guide") to evoke participants’ perceptions, opinions, beliefs, and attitudes as to:

- The most important health problems for women in their community;
- The meaning of breast cancer;
- The rank of breast cancer as a daily concern in their lives;
- The availability and convenience of breast health services in their community;
- The cultural barriers to seeking breast health services;
- Changes that could be made in their community to ensure breast health messaging and services get to those who need them;
- Where women in their community get health information and where they can get credible health information;
- What motivates women to seek screening services and annual screening services thereafter;
- What hinders women from seeking screening services;
- Barriers within their community that prevent women from seeking or receiving screening services;
- The role of their support network in influencing them to seek breast health screenings;
- Experiences related to barriers to follow-up care following an abnormal mammogram result;
- The advantages and disadvantages of getting a mammogram;
- Whether providers are respected and valued in their community; and
- The trustworthiness of the health care system and physicians.

All focus group discussions were recorded and transcribed verbatim. The transcripts were then analyzed and coded by members of the Community Profile Team.

The use of multiple data sources and collection methods allowed for a systemic review that revealed patterns and conclusions that can assist Komen Central Indiana in better serving the women of central Indiana. The data collection methods were not only meant to propel such triangulation of the various types of qualitative data itself, but also to support triangulation of the Quantitative Data Report, Health System and Public Policy Analysis, and Qualitative Data Report collectively. It is only by bringing all of this data together that Komen Central Indiana can determine the gaps to access, utilization, and quality of care in its service area.

Specifically, verbatim transcripts from key informant interviews and focus groups, as well as responses to written surveys, allowed the Community Profile Team to code the data and extract recurrent or related themes.
In an effort to understand barriers to access, screening, diagnostic services, and treatment, the Community Profile Team selected health care providers, as well as public health and nonprofit professionals, as key informant data sources because these community experts have first-hand knowledge of the communities they serve and the problems they face. These key informants were recruited through Komen Central Indiana’s relationships with hospitals, health clinics, state/county departments of health, and community-based organizations. Key informants included individuals representing both Komen Central Indiana grant recipients and non-grantees. The Community Profile Team believed it was important to include not only perspectives of grantees, but also representatives of organizations who are less intimately familiar with Komen Central Indiana’s work or involvement in the community.

Specifically, the Community Profile Team interviewed 33 central figures in the breast cancer community throughout the target communities for key informant interviews. Examples of the key informants’ roles and positions include physicians, nurses, and administrators in hospitals and community clinics; administrators and program staff in government agencies such as the county or state departments of health; and nonprofit agencies that serve cancer patients, special populations, or the communities in general. Members of the Community Profile Team personally arranged the interviews, which were conducted by telephone, in person, or by filling out an online survey.

With the intention of gleaning insight from women who were not breast cancer survivors and not closely tied to Komen’s mission, the Community Profile Team targeted women reflective of the general population, age 40 and over who would fall into recommended screening guidelines for its focus groups. Specifically, since quantitative data revealed that the Affiliate service area has significantly lower breast cancer screening percentages than that observed in the United States as a whole, Komen Central Indiana was interested in reaching “everyday” women of the general population to help answer key questions related to access and utilization of breast cancer screening services.

However, based on quantitative data pointing to high priority populations, Black/African-American women in Marion County were also targeted as a population of interest for focus groups. Marion County has the largest Black/African-American population in Komen Central Indiana’s service area, and Black/African-American women in the service area have higher rates of death and late-stage incidence than White women.

To recruit focus group members, the Community Profile Team posted flyers in several sites throughout each target county, including churches, community organizations, hospitals, and clinics. Komen Central Indiana issued a press release specific to each county and promoted the opportunity to participate in focus groups via social media. The team created a focus group script which explained the participants’ voluntary participation, their privacy rights, and the purpose of the focus group.

Ultimately, 23 women ages 28 to 60 participated in focus groups in Boone, Rush, Shelby, and Vermillion Counties, with a majority of the women being over the age of 40. Members of the Community Profile Team moderated the focus groups.
As a result of poor focus group turnout in Marion County (explained in more detail later in this section), the Community Profile Team developed an electronic survey consisting of 18 substantive questions related to women’s health, breast cancer, and access to care. This survey was conducted in lieu of focus groups but intended to gather the same perspective as the planned focus groups. This electronic survey was distributed to female members of churches with predominantly Black/African-American congregations, and there were 31 respondents.

Due to the newness of relationships between Komen Central Indiana and community partners in Vigo and Wayne Counties, and despite several efforts to engage community members in the qualitative data collection process, members of the Community Profile Team were unable to secure any focus group participants in these counties. The Community Profile Team conducted four key informant interviews in Wayne County. In lieu of community-based qualitative data for Vigo County, a literature review was conducted to determine potential barriers to and facilitators of care. This literature review focused on key demographic and socioeconomic traits of Vigo County.

The sample of sources for key informant interviews, focus groups, and written surveys were selected primarily by convenience. Key informant and focus group participants were those who responded to requests by Komen Central Indiana, promotion for focus groups or subsequent surveys. Key informants were recruited through Komen Central Indiana’s relationships with hospitals, health clinics, state/county departments of health, and community-based health organizations—making them a convenient and effective source. Members of the Community Profile Team personally arranged the interviews, which were conducted by telephone and in person.

Sample size for both key informant interviews and focus groups varied from county to county and was determined by ease of scheduling (willingness of key informants to participate) and turnout rate (how many community members reported to focus groups).

Scripts for both key informant interviews and focus groups, as well as the introduction to the written survey, explained the participants’ voluntary participation, their privacy rights, and the purpose of the interview/focus group. Emphasis was placed on the fact that all answers would be kept confidential and that no actual names or organizations would be identified or used in the coding process or subsequent publications. Focus group participants completed a consent form that outlined the voluntary and confidential nature of participation.

**Qualitative Data Overview**

As shown in Table 4.1, qualitative data collection lasted several months and included 33 key informant interviews, six focus groups, and one survey with 31 responses were conducted across six of the seven focus counties. Key findings from a literature review supplemented qualitative data when such data sources were lacking for a county. The raw data from key informant interviews and focus groups was in the form of verbatim transcripts (transcribed after voice recording). The raw data from written surveys was submitted via SurveyMonkey and contained respondents’ verbatim answers to 18 questions.
Table 4.1. Qualitative data collection participants

<table>
<thead>
<tr>
<th>County</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boone County</td>
<td>1 focus group</td>
</tr>
<tr>
<td>Rush County</td>
<td>8 key informant interviews</td>
</tr>
<tr>
<td>Shelby County</td>
<td>3 key informant interviews</td>
</tr>
<tr>
<td>Vermillion County</td>
<td>2 focus groups</td>
</tr>
<tr>
<td>Vigo County</td>
<td>1 focus group</td>
</tr>
<tr>
<td>Wayne County</td>
<td>4 key informant interviews</td>
</tr>
<tr>
<td>Marion County</td>
<td>31 survey respondents</td>
</tr>
<tr>
<td>Marion County</td>
<td>13 key informant interviews</td>
</tr>
</tbody>
</table>

The Community Profile Team met in person to compile notes and conduct a detailed review of transcripts from key informant interviews and focus groups. The team generated four categories of themes:

1. System barriers to receipt of breast health services;
2. Individual barriers to receipt of breast health services;
3. Facilitators for obtaining breast health services; and
4. Specific vulnerable populations.

Findings within the qualitative data are summarized in Table 4.2 in relation to the four identified themes, from which common findings are then discussed in detail.

Several themes from the qualitative data cut across all target communities, and from both health care providers and community lay persons alike, particularly when it comes to barriers to screening, diagnosis, and treatment.

Table 4.2. Findings within qualitative data

<table>
<thead>
<tr>
<th>System Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of health insurance or inadequate insurance</td>
</tr>
<tr>
<td>Uncertainty with the Affordable Care Act</td>
</tr>
<tr>
<td>Medicaid limitation</td>
</tr>
<tr>
<td>Lack of diagnostic services</td>
</tr>
<tr>
<td>Inability to provide timely breast health services</td>
</tr>
<tr>
<td>Lack of transportation</td>
</tr>
<tr>
<td>Lack of care coordination across the continuum</td>
</tr>
<tr>
<td>Location of screening facilities</td>
</tr>
<tr>
<td>Appearance of facilities</td>
</tr>
<tr>
<td>Disparities in services from location to location</td>
</tr>
<tr>
<td>Barriers to effective patient-provider communication</td>
</tr>
<tr>
<td>Prohibitive guidelines</td>
</tr>
<tr>
<td>Restrictive hours for services</td>
</tr>
<tr>
<td>Conflicting health messages/information as to guidelines and curability</td>
</tr>
<tr>
<td>Navigation issues</td>
</tr>
<tr>
<td>Language barriers</td>
</tr>
<tr>
<td>Lack of primary care providers or failure to make quick referrals</td>
</tr>
<tr>
<td>Quality of care</td>
</tr>
<tr>
<td>Difficulty obtaining or affording diagnostic and/or treatment services</td>
</tr>
<tr>
<td>Lack of awareness of health care professionals of resources available in community</td>
</tr>
</tbody>
</table>
### Individual Barriers
- Competing priorities in patients’ lives (family, work)
- Lack of financial resources (income)
- Emotional barriers/assumptions concerning breast cancer
- Lack of education
- Lack of knowledge of diagnostic resources
- Transportation
- Mistrust of health care system and providers
- Fear of the unknown
- Perceived risk
- Perception that one is invincible/denial
- Anticipated discomfort
- Perceived lack of quality care

### Facilitators
- Health insurance
- Optimism
- Perceived risk if there is a family history
- Income
- Education
- Faith
- Appearance of facilities
- Sufficient locations
- Effective patient-provider communication
- Psychosocial support
- Medical home (primary care provider)
- Access all through the Continuum of Care
- Improved treatments/medical advancements
- Awareness through consistent national-level messaging
- Targeted community approaches to vulnerable populations

### Vulnerable Populations
- Black/African-American women
- Triple negative diagnosis
- Hispanic/Latina women
- Post-menopausal/pre-Medicare women
- Language minorities
- Immigrants (undocumented)
- Rural women
- Those with a family history or genetic propensity
- Young women
- Amish women

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### Boone, Rush, Shelby, and Vermillion Counties

**Boone County**
The most common system barrier found throughout the qualitative data from Boone County was related to a lack of or difficulty obtaining diagnostic services. Specific rationales for this difficulty varied across sources, from complaints about higher quality providers being located outside Boone County to trouble getting preventive care services covered for the uninsured (even under the Indiana Breast and Cervical Cancer Program). That said, review of the qualitative data also indicated conflicting perceptions of the quality of local care, revealing somewhat of an identity crisis for breast health providers in Boone County. Contingent to Marion County and inclusive of a large Indianapolis suburb, the perception is that a large number of Boone County women seek follow-up services in Marion County; on the other hand, lower-income women in the more rural parts of the county are more likely to seek care through the local hospital. Some women are
more satisfied and comfortable with the care received locally, while others perceive Marion County as a source of higher quality services.

The most common findings across all qualitative sources in Boone County related to individual barriers were fear of the unknown and perceived risk. Women know once they take the leap to their first mammogram that they are opening themselves up to potentially undesirable news about their health. As summarized by one key informant, “no news is good news” to many women. Both key informants and focus group members also pointed to lack of education as an individual barrier to seeking care.

Even though perceived risk is often a barrier, it can also act as a motivator to seeking screening services, as it was identified as a facilitator to care by both qualitative data sources in Boone County. Likewise, as previously mentioned, some women were very satisfied with the care choices and the care itself among Boone County providers and viewed the location of available resources as a facilitator to care.

Unfortunately, focus groups did not shed any light on perceptions related to vulnerable populations in Boone County. However, key informants noted several populations as vulnerable, including Black/African-American women, Hispanic/Latina women, poste-menopausal/pre-Medicare women, and women residing in rural areas of the county.

**Rush County**

Despite other possible resources, a current grant from Komen Central Indiana provides the only coverage for health services to under/uninsured women in Rush County. Review of the qualitative data confirms that the community views the primary system barrier to seeking breast health services in Rush County to be lack of insurance. With the perception that services are only available at the one hospital in the county, women do not believe they have ample care options for care in Rush County.

Common individual barriers recited by qualitative data sources in Rush County included women’s competing priorities, lack of education, lack of finances, and fear of the unknown. Both key informants and focus group participants observed that women put everyone else in their lives before themselves. Women with financial constraints, especially single mothers, will choose to spend their limited resources on their children and necessities. As stated by one key informant, “If it’s either buying food for her kids or getting a mammogram, then she’s going to buy the food.”

Some women are so busy in their roles as caregiver to children, parents, and/or siblings that the thought of getting a mammogram has never crossed their mind—they do not have enough awareness of breast cancer for screening to make their list of priorities. It was also observed that even if a woman made the time to try to schedule a screening appointment, her competing priorities would limit her availability and she may not be able find a screening facility to accommodate her schedule. The bottom line is that it is difficult for many women to put their health first.

The qualitative evidence also suggests a strong lack of knowledge of screening and diagnostic resources in Rush County. Thus, despite the local hospital’s promotion of free mammograms
through the Komen program, the under- and uninsured are either unaware of the program’s existence or still believe there will be a cost to them. One focus group participant shared that she had gone without a mammogram for 12 years because she was not aware of any free services in the county. Key informants believe they have observed a great number of women with late-stage diagnoses as a result of these barriers.

Additionally, it is perceived that the women of Rush County are not educated as to the risk of breast cancer or aware of free programs that will screen them for breast cancer. Furthermore, many of the uninsured women face financial barriers that make transportation to a screening facility difficult.

All of these barriers are compounded by the overwhelming qualitative evidence that women have substantial fear of the unknown. With so many others depending on them, as well as the stress of limited financial resources, low-income women are often too scared to find out if something is wrong with them. They fear there will be no one to provide for or take care of their loved ones if something happens to them. On the other hand, providers in Rush County also believe there is a received lack of risk among many women in the service area, suggesting they are not aware that breast cancer should be a concern.

Taking into consideration the findings related to barriers to screening and diagnosis in Rush County, the qualitative evidence reveals that greater insurance coverage and an expansion of screening facilities would positively impact women’s decisions to get screened. In addition, perceived risk was seen as a motivator to obtaining breast health care and the perception that a lot of women in the area have breast cancer was a cross-finding among data sources. In particular, key informants perceive there to be a greater incidence of breast cancer among younger women in their community, and they believe this perceived risk is motivating women to talk about breast cancer. Specifically, one key informant noted, “Now talking isn’t going and getting screening, but talking may lead to that.”

While focus group participants did not elaborate on vulnerable populations within Rush County outside of the uninsured, key informants cited three groups of women as seemingly vulnerable to breast cancer: 1) the county’s Amish population; 2) women with a family history; and 3) young women.

Shelby County
Shelby County key informants and community members cited the following as system barriers to receiving breast health care: lack of health insurance, lack of understanding of benefits under the Affordable Care Act, lack of diagnostic services or lack of knowledge of diagnostic resources, and the failure of primary care providers to screen routinely or inform patients of the importance of regular mammograms.

Specifically, focus group participants noted that lack of insurance keeps them from seeking regular screenings, and key informants stressed the difficulty experienced by those low-income women who fall in the insurance gap—they do not qualify for indigent care, but they cannot afford the co-pays or deductibles associated with insurance. There was also a perception among both groups that the Affordable Care Act has caused great barriers to health care, with focus groups citing immense frustration with enrollment and key informants perceiving that the
ACA is actually making mammograms less affordable. This it was noted that “health insurance doesn’t mean access to care.”

In addition, qualitative sources revealed that knowledge about screening and diagnostic resources in Shelby County is low. Many low-income women are not aware of existing free breast health services. Key informants were equally aware that breast health providers in Shelby County are not reaching the women who need their services. Key informants were also particularly concerned with the lack of diagnostic services available following an abnormal mammogram result—not only are community resources low to perform these services, but women’s finances are often too low to support completion of the CoC following a questionable exam or mammogram.

A more unique system barrier exposed by the qualitative data in Shelby County is the failure of primary health care providers to inform patients about screening guidelines and free resources. Key informants noted that providers are not stressing the importance of mammograms to their patients, are not ordering annual mammograms for patients, and are not checking in with patients to be sure they adhere to a regular screening plan. Focus group participants noted that everything seems to cost more when they go through a primary care provider, so they have stopped using these providers for their basic care.

Key informants and focus group participants named competing priorities, income/finances, perceived risk, and fear of inequities in care as individual barriers to obtaining breast health services. Specifically, focus groups highlighted the difficulty of working women to take time off to receive health care services. “Is there somewhere that is going to be open at 7:00 at night?” asked one participant. Directly related, another common personal barrier to care discussed was lack of income among Shelby County residents, who many perceived as “unemployable.”

In addition, the community is seen as older—not just in terms of age, but also in that they are stuck in old health habits which have resulted in high rates of obesity and smoking. Residents are perceived to not be in a mindset of healthfulness and thus are not in tune with the importance of preventive care. This mindset is once again attributed to low incomes, education, and socioeconomic status.

Perceived risk was also noted as an individual barrier to obtaining breast health services. Women in Shelby County perceive their risk of having breast cancer as very low; this, it is not worth expending their limited time and resources to get screened. Fear of the unknown was also cited by both groups as a deterrent. As stated by one focus group participant, “ignorance is bliss.”

Some issues concerning the perception of quality of care in the area were also raised by qualitative data sources in Shelby County. Key informants lack confidence in the area’s ability to see women through the CoC, believing that the community lacks a referral “hub” and patient navigation services. Focus group participants believe low-income women do not believe they will be offered the same treatment as women with more financial resources.

There were no common findings across the two groups of qualitative sources in Shelby County related to facilitators to obtaining breast health services. Key informants suggested better
access along the CoC and primary care provider education as ways to improve breast health care and screening percentages in the community. Community members cited both perceived risk and psychosocial support as positive influences to seeking breast screenings. Specifically, it was noted by focus group participants that as women get older, they become more cautious of their health and are prompted to seek care because they believe their risk is increasing as they age. It was also noted that women’s spouses could be motivators to seeking care if men were more educated about breast cancer.

There were also no common findings related to vulnerable populations in Shelby County; however, key informants identified language minorities and rural women as particularly vulnerable.

**Vermillion County**

The Vermillion County focus group participants cited that costs and lack of insurance for screening were systems barriers. For example, participants discussed concerns for those who are uninsured, particularly the need to cover the cost for those who are unable to afford breast cancer screening services. Some patients do not understand the coverage provided to them by their health insurance to know if certain services will be provided. Others understand their coverage and have screening services covered under their plans, but cannot afford the deductibles they face if the need to seek diagnostic services or treatment arose.

The lack of accessibility and transportation were also identified as systems barriers for patients in Vermillion County. With few breast screening service providers near the geographic location of patients, it can be difficult for patients to receive or continue care. With Vermillion County having a high rural population, the hardships of not having a public transit system to health care facilities serves as an ongoing barrier. Many focus group participants mentioned a lack of support on the part of their employers for employees to leave work for screening, diagnostics, or treatment.

It was also revealed through the qualitative data that the participants were concerned about the lack of awareness regarding screening guidelines and free resources by referring physicians. This was reiterated by participants as a common barrier for women in Vermillion County.

Vermillion County focus group participants acknowledge several different individual barriers that patients face, including income/finances, accessibility, and lack of awareness of community resources. Several focus group participants also discussed the desire to choose a “more natural” approach to treatment first, the length of paperwork, procrastination in seeking services, stubbornness, lack of comfort with a male performing breast cancer screenings, and pain experienced during a mammogram as reasons they did not enter or complete the CoC.

Fear was reported as a major theme among the focus group participants. In particular, participants mentioned that there exists a fear of a breast cancer diagnosis and what that may mean for a woman’s future. One participant summarized this sentiment by saying she “don’t want to know what is going to happen to me.”

Vermillion County focus group participants recognized the need for education for their community about breast cancer risk factors. Many said that having educational material on
breast cancer present in their community and having someone they trust that they could talk to about breast cancer would be beneficial. One woman indicated that receiving treatment at home or in a more comfortable facility may prompt others to access treatment at higher rates. Another focus group participant expressed that the option of receiving oral medication as opposed to intravenous treatment may encourage women to seek treatment. Additional facilitators to treatment seeking included social gathers and events where women could meet to discuss breast cancer and events with giveaways related to breast cancer. The health professionals in Vermillion County also discussed the importance of providing educational materials to women in their communities through group gatherings.

There were no common findings related to vulnerable populations in Vermillion County, however the focus group participants identified rural women and un/underinsured women as particularly vulnerable.

Vigo and Wayne Counties

Vigo County

A literature review was conducted to determine potential barriers to and facilitators of care in populations similar to Vigo County. Through this review, several systems barriers emerged, specifically lack of specialty care for breast cancer patients and underinsurance of the population.

Vigo County is characterized by a mid-size city (Terre Haute) surrounded by a more rural setting throughout the rest of the county. While the city of Terre Haute proper has two major hospital systems and several other community health centers, there are no other breast health services in the county. As such, women must choose between seeking care in Terre Haute or using their primary care physician for their breast health care. According to Dawes et al, “[o]nly a small percentage of PCPs provide the multidimensional services laid out by the Institute of Medicine, including monitoring for disease recurrence, identifying late treatment effects, and managing emotional health” (Dawes et al 2014). While Dawes and colleagues were speaking specifically about the role primary care physicians play in breast cancer survivorship treatment plans, it is reasonable to infer that these same providers may aid in screening for breast cancer through clinical breast exams, but that patients needing more advanced services must seek this care from another provider. In the case of women living in Vigo County, this would often mean travelling to Terre Haute or another city in an adjoining county.

A study by Wong and Regan corroborates these findings. In focus groups with rural Canadians, these researchers found that “participants described the challenges posed by geographical location in terms of (1) making tradeoffs… (2) continuity of care and… (3) efficiency with health care delivery” (Wong and Regan 2009). These researchers found that their rural community members either could not afford to travel to regional medical centers or cited safety concerns associated with the travel.

Lack of insurance or lack of quality insurance was identified in the literature as an additional barrier to seeking care. Forty percent of Vigo County’s population live below 250 percent of the Federal Poverty Level, and nearly 16 percent live without insurance. Even for the 84 percent of the population that does have insurance, they may be underinsured, resulting in high out-of-pocket deductibles, co-pays, and co-insurance costs. As Zafar and colleagues say in one paper,
“Health insurance does not eliminate financial distress or health disparities among cancer patients” (Zafar et al 2013). Zafar and colleagues found that patients who were underinsured (defined in this study as paying between 10 and 20 percent of their annual household income in medical costs) were more likely to reduce spending on basic needs such as food and clothing, report noncompliance with care, and exhaust personal savings and incur debt to pay for their treatment than those study participants who felt they were adequately insured.

The literature suggested that increasing local access to care and telemedicine could be facilitators to residents of Vigo County seeking care. Wong and Regan report one of their focus group participants saying:

> Why couldn’t that X-ray have got done in [small nearby town with X-ray machine], sent by courier to the specialist and then he could look. [Instead] I have to come in [travel to the specialist], the specialist could have phoned [my family doctor] and I could have been there…My time and money are wasted.

This patient’s frustration with the requirement to travel to a specialist when the same effect could have been achieved through technology indicates that patients living in more rural communities could be open to exploring more virtual treatment options which would save them time and money.

**Wayne County**

There were several systems barriers identified through the qualitative data collection for residents of Wayne County. One such barrier was the lack of physician referral for an annual mammogram. Several of the key informant interviewees mentioned that physicians do not regularly refer women for their screening mammograms. Without a physician referral, women may not seek care, particularly in light of confusion surrounding new screening guidelines. Women rely on their physicians to direct them to necessary services, and if the physicians are not ordering an annual mammogram, women may believe that they do not need one.

Another group of barriers to receiving care for women in Wayne County relate to insurance. Some women in Wayne County still lack insurance, though one key informant mentioned that the enactment of the Healthy Indiana Plan 2.0 (HIP 2.0) should help alleviate some of these barriers. “There are great options for coverage under the new HIP plan,” she said. For women who have insurance, many lack an understanding of what benefits their plan covers. Education about what services their plan provides will be necessary to ensure that women are receiving their screening tests.

Another system barrier is lack of access to care. There is only one screening facility in the county, so women who live outside the largest city in the county may have to travel great distances to receive care. One interviewee mentioned that “we could really use a stand-alone radiology center” to better serve the women in this community. Further, it appears that health care professionals may not know about the resources available in their county. When asked where they would refer patients who need free or low cost screening, one interviewee stated that he would refer women to a clinic in another county. Upon further research, it appears that this facility would not serve women from Wayne County. Therefore, there appears to be a need
for education among the health care professionals in Wayne County regarding where they can refer women to better access services.

Many individual barriers to seeking care seemed to revolve around socioeconomic status. Unemployment (and therefore potential lack of insurance), high out-of-pocket expenses even for those insured, and lack of indigent care programs in the county were all cited as reasons why individual women may not seek care. Transportation, child care, and not being able to take time away from work were other reasons that key informants felt women in Wayne County may not be getting screening.

Another individual barrier that was mentioned by several key informants was that prevention is not seen as a high priority among women in Wayne County. These key informants believed that women do not seek screening because they do not want to know if there is a problem. In the words of one interviewee, “If you aren’t diagnosed, you don’t have to deal with it.”

Interpretation services in Wayne County serve as a facilitator to care for those who need them; almost every key informant mentioned that interpreters were provided for patients who needed them. No other facilitators to seeking care were mentioned by the key informants.

There were a few vulnerable populations mentioned by key informants, including minority populations, rural women, and women who use illegal drugs. Several key informants said that women of racial and ethnic minorities may struggle more than other women to seek services. Another key informant, however, said that in her practice, she only sees about 5-10 percent of the population representative of racial minorities. Many of the key informants noted that, while Wayne County is not considered rural, much of the county land outside the city of Richmond is rural. The women who live in the rural areas of the county have a more difficult time accessing services, most of which are centered in Richmond. Finally, one key informant mentioned that there is a sizable population of women in Wayne County who use illegal drugs, and that these women represent a very vulnerable population that can be difficult to reach. She cited the comorbidities that these women may present with, noting in particular a high rate of Hepatitis C. Special efforts will need to be made to ensure that these highest-risk women have access to the care they need.

**Marion County**

The complexity of the health insurance system is a critical barrier to receiving screening, diagnostic, and treatment services. Thus, it is not only women without health insurance who face insurance-related issues when considering or seeking health care services. It is the perception of both providers and patients that, even with insurance, women face obstacles such as not understanding the coverage provided by their policy, prohibitive copays, deductibles, and a lack of knowledge regarding how to access services under the Affordable Care Act.

Patient-provider communication was also identified as a common barrier to receiving services. Patients want to be provided consistent information they can understand, and just as importantly, they want the information delivered in a caring manner. From physician to physician, there are differences in the way breast health and breast health services are communicated. Time constraints can lead physicians and their staff to not thoroughly explain a
patient’s options. As a result, some patients are turned off by confusion or insensitivity and do not follow through with receiving complete breast health care.

Individual barriers were rooted in a lack of resources, including both personal finances and education/knowledge/awareness. Finances play a pivotal role in women’s decisions to seek care. Low-income women may not be able to afford to take off work to seek breast health services, and are likely to have financial priorities above that of their breast health – such as money to care for their children, pay their utilities, etc. And despite enactment of the Affordable Care Act, finances are still a determinant of insurance status and health care expenses are still a deterrent to receiving care.

Related to finances, transportation was identified as a personal barrier to care by both key informants and survey respondents in Marion County. Women may have a desire to be screened, but cannot get there. In addition, women in treatment may reach a point where transporting themselves is problematic, creating a gap in the CoC.

Additional individual barriers included lack of education/knowledge/awareness. Women are not educated about the factors that can lead to breast cancer and are often not knowledgeable enough to be proactive about their own health. Neither their community nor their employers are educating them as to the importance of breast health. Thus, they are missing the foundational blocks that would prepare them to ask the right questions about breast health and are particularly lacking the knowledge of where to obtain information and services. These gaps in knowledge exist all along the CoC, as women also do not understand the importance of follow-up services even if initial screening services are obtained.

Another common individual barrier noted throughout the qualitative data in Marion County was fear of the unknown. Surveys indicated that women have great anxiety and fear attached to the issue of breast cancer – fears that they have breast cancer, may get breast cancer and may not be able to access quality care for breast cancer. From the provider perspective, women’s fear drives their resistance to completing the CoC. Similar to fear, fatalistic ideation and women’s perceived risk of getting breast cancer - particularly if they have a family history of breast cancer – act as personal barriers to seeking screening services. On the flip side, providers noted that perceived risk by some women that breast cancer is no longer a deadly disease has made women less concerned with their breast health and more likely to delay the beginning of a healthy breast monitoring routine.

In addition, while identified as a facilitator by Black/African-American lay women in Marion County, providers actually noted that a woman’s faith can be an obstacle to following recommended breast health services. Black/African-American women may be more likely to trust in their deep faith in God than in their health care providers or medicine. Survey responses supported this notion, as social support and prayer came in as a very close second most common response when Marion County women were asked what a friend’s diagnosis would mean to them. While 10 women responded that a friend’s diagnosis would prompt them to be screened themselves, eight women responded that a friend’s diagnosis would prompt them to support her and pray for her.
Qualitative data sources from Marion County, whether health care providers or lay community members, indicated that survivor strength is a facilitator to obtaining care. Survivors are a valuable resource to women in any stage of the CoC and are an effective marketing and awareness vehicle for breast health.

In addition, both groups of qualitative respondents (key informants and survey respondents) highlighted the importance of a woman’s support network - one survey respondent referring to psychosocial support as her “lifeline” and her “everything.” It was also noted that psychological support can help women overcome other barriers, including financial. Despite the cost, having psychosocial and emotional support from a strong network of family, friends, and community can increase a woman’s adherence to a diagnostic or treatment plan. Providers particularly recognize that traditional treatment alongside psychosocial support improves treatment adherence.

And while perceived risk was noted as a barrier in some instances, it was also identified as a motivator to seeking screening services. A woman’s strong family history or having a friend diagnosed with breast cancer may make her more proactive in educating herself as to guidelines, symptoms and early detection methods.

The overwhelming majority of survey respondents (predominantly Black/African-American women) in Marion County indicated that there are no cultural barriers that prevent them from seeking care. However, the perspective of key informants was strikingly different, as they perceive that Black/African-American women in Marion County face more barriers to breast health care. Similarly, providers and nonprofit professionals indicate disparities in care between Black/African-American and White women. Many key informants emphasized the impact of cultural differences, including a higher prevalence of mistrust of the medical community by Blacks/African-Americans and a greater need for clear messaging that breast cancer does exist among Black/African-American women.

Another polar response between key informants and Black/African-American women in Marion County concerned the importance Black/African-American women place on breast cancer as an issue within their community. While more than half of survey respondents indicated breast cancer, or cancer in general, as the most important health problem for women in their community, key informants perceived that a lack of knowledge of the prevalence and importance of familial basis of breast cancer among Black/African-American women contributes to a cultural de-prioritization of the issue. In addition, key informants believe that due to unique biological and physiological differences, as well as high-risk health behaviors, Black/African-American women have a greater propensity for breast cancer. While this is perception, as the quantitative data does not support this, the data does support disparities in late-stage incidence and death rates.

Thus, a conclusion could be drawn that while Black/African-American women are keenly aware of breast cancer, they are delaying screening or not following through with regular screenings. Key informants seem to believe that even though Black/African-American women are a high priority population, they get lost in the campaign against breast cancer by messaging that only speaks to White women. One key informant recalled hearing a Black/African-American woman say, “Well, this is probably just another program for White people.”
Qualitative Data Findings

The most common findings across the qualitative data in the target communities were inextricably linked to the key questions of access and utilization of breast health services identified by Komen Central Indiana in the Quantitative Data and Health Systems and Public Policy analysis. These services span the entire Continuum of Care, from screening to diagnostics, treatment, and survivorship. Additionally, education of the availability of resources is needed on both a consumer and provider level. The qualitative data were particularly helpful in identifying system barriers and facilitators to obtaining breast health care.

As such, qualitative sources repeatedly identified finances and lack of quality insurance as impediments to accessing breast health care services in their communities. Whether they are uninsured or underinsured, women do not believe they have the resources to afford breast care. In addition, they perceive that they especially do not have the resources to successfully complete the Breast Cancer Continuum of Care should they be diagnosed with breast cancer.

The qualitative data also made it apparent that access to and utilization of navigation and support services are hindered by women’s perception that their communities lack ample and affordable resources. Many women lack knowledge of resources available in their area.

Perceived risk, while sometimes referenced as a barrier, was commonly mentioned as a facilitator for women to seek screening and breast health services. Both key informants and focus group participants acknowledged an increased awareness of breast cancer in recent years, whether due to national awareness campaigns or due to the diagnosis of one or more individuals nearby. Data sources believed this awareness and the resulting perceived risk translates into women being more likely to seek services.

While qualitative data sources may not have made specific references to the quality and quantity of relationships with Komen Central Indiana partners, the data overwhelmingly revealed gaps in care that can be filled by enhancing these relationships. The data not only show the need for these relationships to be enhanced in order to increase access and utilization of screening services, but in particular, to increase the likelihood of women completing the CoC. Aside from Marion County, follow-up care in these target communities may be fragmented and inconvenient due to additional resources being located outside the county.

In addition, the qualitative data shed light on the issues concerning the vulnerable populations within these target communities. In Marion County, there is a discrepancy between what Black/African-American women believe they are doing to stay on top of their breast health and the outcomes they actually face according to the quantitative data. In rural counties, vulnerable populations included language minorities, Amish women, and the un/underinsured.

The Community Profile Team experienced both quantitative and qualitative limitations in its data sources and methods. Quantitative limitations included small sample sizes for key informant interviews and focus groups. Additionally, despite repeated efforts to engage Vigo and Wayne Counties in the qualitative data collection, the Community Profile Team did not receive more than four responses from people willing to complete key informant interviews. A literature review
was necessary to supplement the low number of people from these two counties able to participate in the data collection process.

In reviewing verbatim transcripts from the key informant interviews and the focus groups, the Community Profile Team also noted qualitative limitations due to stylistic differences between the interviewers and focus group moderators. Questions were not framed identically by the interviewers or focus group moderators. Rather, different techniques set different tones for key informant responses and focus group feedback.

Despite these seemingly critical weaknesses in qualitative data, the Community Profile Team uncovered evident themes across the target communities using the various methodologies. Ultimately, a majority of the system and personal barriers to obtaining breast health care identified by the qualitative data in the target communities relate to income, finances, and lack of quality insurance. Low-income women who are un- or under-insured face competing priorities that lead them to put their jobs and families first. With their limited resources, low-income women in these communities are not choosing their health as a spending priority.

A second, widespread barrier revealed by the qualitative data is a lack of diagnostic services or a lack of knowledge of the available diagnostic services available within the target communities. In particular, key informants and focus group participants made it clear that Komen Central Indiana needs to further its work in promoting free services in these communities in order to improve access to care and completion of the Continuum of Care. Women lack confidence in navigating from an abnormal screening to their diagnostic test, and beyond.

On an individual level, whether they perceive their risk as low or high, women are finding reasons to not be screened. The conclusion is that women in these high priority areas need to be provided health messaging that will alleviate their fears related to breast cancer, emphasizing that early detection can take substantial fear and anxiety out of the process. Women and their health care providers need to know what resources are available to them in their communities.

An overarching conclusion is that Komen Central Indiana needs to develop more effective strategies, including enhanced partnerships and partnerships that span the Affiliate’s newly expanded service area, in these communities to not only ensure access to screening services, but to ensure utilization of these screening services and entry into and completion of the entire Continuum of Care.
Breast Health and Breast Cancer Findings of the Target Communities

Communities with the most pressing needs for breast health interventions were identified and targeted through the findings in the Quantitative Data Report for the 41 counties served by Komen Central Indiana. The Community Profile Team collected data from a variety of credible sources and tracked indicators measuring breast cancer rates, indicators measuring breast health services, and indicators contributing to, or directly related to, breast cancer rates. Each county was compared to state and national averages, and to Komen Central Indiana’s service area as a whole.

After the target communities were identified, the Community Profile Team dug deeper into the challenges facing these specific communities through a Health Systems and Public Policy Analysis and a Qualitative Data Report. The Health Systems and Public Policy Analysis identifies existing healthcare providers currently providing services, resources for breast health services and public programs affecting breast health services. The Qualitative Data Report allowed Komen Central Indiana to hear directly from healthcare providers and lay people in the community and identify common themes relating to the trends highlighted through the Quantitative Data Report and key issues identified in the Health Systems Analysis and Public Policy Analysis.

Quantitative Data Report
While a range of indicators were tracked and included in the Quantitative Data Report, the Community Profile Team placed an emphasis on the counties with the longest predicted time to reach the HP 2020 targets for death rates and late-stage incidence rates, and actual death, late-stage incidence, and incidence rates, as well as the four-year trends for each. Emphasis was also placed on screening rates, residents ages 40-60 living without health insurance, residents with income less than 250 percent of the poverty level, unemployment rates, and percentages of the population that are African American and Hispanic/Latino. This analysis allowed Komen Central Indiana to highlight areas of concern geographically and target counties with the highest level of need.

Of the 41 counties in Komen Central Indiana’s service area, seven counties were identified as priority counties and grouped into three target communities:
1. Boone, Rush, Vermillion, and Shelby Counties (High/Highest Priority)
2. Vigo and Wayne Counties (High/Highest Priority)
3. Marion County (Medium High Priority)

Health Systems and Public Policy Analysis
The Health Systems and Public Policy Analysis connected the areas of concern identified in the Quantitative Data Report to the availability of services and resources in each of the target communities. The Community Profile Team identified healthcare facilities in the targeted communities that provide breast health services, including clinical breast exams, screening mammograms, diagnostic screenings, treatment, financial assistance, and patient navigation.
The team also analyzed the impact of the Affordable Care Act and the Healthy Indiana Plan 2.0, and the changing healthcare environment, taking into account the potential for an increase in individuals with health insurance, the gaps that will continue to prevent women from entering the CoC despite having insurance, and challenges relating to patient navigation.

Through the Health Systems and Public Policy Analysis, Komen Central Indiana determined:
1. Patient navigation is imperative for the completion of the CoC.
2. Women in rural counties may lack options for healthcare services, or may face systemic barriers related to travel and time away from work when seeking quality breast health care.
3. Marion County women have many options for healthcare services and providers, but easily fall out of the CoC.
4. There is a need for Komen Central Indiana to stay informed of the ever-changing healthcare environment following the rollout of the ACA and HIP 2.0.
5. There is a need for a stronger presence and deeper partnerships with services in Boone, Rush, Shelby, Vermillion, Vigo, and Wayne Counties.

**Qualitative Data Report**

Equally important to the quantitative data, this exploration into the observations and opinions of healthcare providers and lay community members helped Komen Central Indiana more deeply understand the needs of the communities it serves.

Because quantitative data revealed that the Komen Central Indiana service area has significantly lower breast cancer screening rates than those observed in the United States as a whole, Komen Central Indiana identified access and utilization of screening services as key topics for its qualitative studies. Key assessment questions related to these two variables were intended to help Komen Central Indiana pinpoint the barriers to breast health services (both systemic and individual), as well as facilitators for obtaining breast health services—ultimately revealing observations that could improve Komen Central Indiana’s ability to increase the number of women entering into and completing the Continuum of Care.

In addition, Komen Central Indiana identified the quality and quantity of its relationships with local partners serving women in priority areas as a key variable impacting women’s ability to complete the CoC, with a particular need for bolstering these relationships in Boone, Rush, Shelby, Vermillion, Vigo, and Wayne Counties. Key assessment questions related to this aim were intended to guide Komen Central Indiana as to how to most effectively build a stronger presence and greater collaborative partnerships outside its home base of Marion County.

Komen Central Indiana also sought to better understand its service area’s especially vulnerable minority populations through this analysis by targeting a high priority population in one target community.

Komen Central Indiana used key informant interviews and focus groups to collect qualitative data from the target communities. In addition, surveys were used as a tactical response to overcome limitations of focus group data in Marion County. Finally, a literature review was conducted in lieu of gathering qualitative data in Vigo County.
The selected collection methods were intended to encompass a broad range of community perspectives, from those who work in women’s health to those who make up central Indiana’s underserved populations.

The most common findings across the qualitative data in the target communities were inextricably linked to the key questions of access and utilization of screening services identified by Komen Central Indiana in the Quantitative Data and Health Systems and Public Policy Analysis. Qualitative sources repeatedly identified a lack of income and finances as impediments to accessing breast health care services in their communities. Lack of awareness of resources, both on the patient and provider levels, was also identified as a barrier to seeking care in the target communities. The data also show that women are being held back from seeking screening services by their own fear of the unknown and their perceived risk of getting breast cancer.

**Mission Action Plan**

After completion of the Quantitative Data Report, the Health Systems and Public Policy Analysis, and the Qualitative Data Report, Komen Central Indiana identified the most urgent challenges facing each of the target communities and connected these challenges to a specific problem expressed through a problem statement.

For each problem statement, priorities communicate the goals that will be achieved by Komen Central Indiana in order to effectively address the challenges and needs identified in the problem statement.

Finally, under each priority falls a range of objectives that specify how the goals set in the priorities will be met. The objectives set forth the strategic actions that will be taken by Komen Central Indiana and are specific, measurable, attainable, realistic, and time-bound.

Together, the problem statement, priorities, and objectives provide a road map to Komen Central Indiana for effective interventions for improving breast health in the target communities.

**Problem Statement: Boone, Rush, Shelby, and Vermillion Counties** are highest and high priority counties due to the fact that they are not predicted to meet Healthy People 2020 targets related to late-stage incidence and death rates. These counties share the key population characteristic of being primarily rural; hence, they were grouped together as one target community. Quantitative and qualitative data indicate poverty, unemployment, and lack of insurance as potential contributors to comparatively high late-stage incidence and death rates. Qualitative data and the Health Systems Analysis suggest a lack of breast health services, underutilization of breast health services, and insufficient funding for breast health services as potential barriers that may impede receiving care.

**Priorities and Objectives**

1. Facilitate community awareness, education, and mobilization efforts aimed at reaching women living in low-income, rural areas.
   a. In the RFAs for FY17 through FY19, in order to improve late-stage incidence rates, a funding priority will be to provide evidence-based education guiding
women to the screening and diagnostic services most appropriate for them based on their payer (private insurance, HIP 2.0, uninsured safety nets, etc.).

b. In FY18, establish a supply chain of Komen educational materials targeting low-income, low-education, rural women, delivered through local breast health service providers and community-based organizations in these counties.

c. In FY18 through FY19, provide a series (at least one session per county) of educational sessions for employers, encouraging these employers to participate in initiatives that will make it easier for their employees to take time away from work to receive appropriate screening tests.

2. Increase the capacity of existing health care systems to provide seamless transition for women who are screened to diagnostic and treatment services.

a. In the RFAs for FY17 through FY19, in order to improve death rates, a funding priority will be to provide evidence-based patient navigation from the point a patient enters the continuum of care through their cancer journey by ensuring the patient has the resources necessary to overcome barriers to receiving care.

b. In FY18, hold a series of collaborative meetings (at least one per county) among local community organizations, churches, schools, etc. in rural, low-income areas to identify and develop cooperative relationships to better map available resources for reducing barriers to care in each community.

Problem Statement: Despite a screening percentage higher than Komen Central Indiana’s service area as a whole, Marion County has higher late-stage incidence and death rates. Additionally, Marion County is not expected to achieve the HP2020 target for late-stage incidence rate for 13 years or longer. Qualitative and quantitative data indicate high unemployment, a high uninsured population, and low income levels may contribute to barriers to breast health services. Marion County has the largest populations of Black/African-American and Hispanic/Latina women (in real numbers) in Komen Central Indiana’s service area, and barriers to services are especially prominent for these populations.

Priorities and Objectives

1. Facilitate community awareness, education, and mobilization efforts aimed at Black/African-American women, with an emphasis on reducing the disparity in breast cancer death rates between Black/African-American women and White women, with specific messages and services relating to an increase in access to services and increased awareness within the community.

a. In FY18 through FY19, in partnership with community-based organizations, government agencies, churches, schools, etc. develop culturally relevant awareness, education, and outreach resources targeting the uninsured within the Black/African-American population in Marion County, guiding them to insurance enrollment and screening services.

b. In the RFAs for FY17 through FY19, in order to improve late-stage diagnosis rates, a funding priority will be to provide evidence-based education guiding women to the screening and diagnostic services most appropriate for them based on payment method (private insurance, HIP 2.0, uninsured safety nets, etc.).
c. In FY18, establish a supply chain of Komen educational materials targeting low-income, low-education, Black/African-American, and/or Hispanic/Latina women, delivered through local breast health service providers and community-based organizations in Marion County.

2. Increase the capacity of existing health care systems to provide seamless transition for women who are screened to diagnostic and treatment services.
   a. In the RFAs for FY17 through FY19, in order to improve death rates, a funding priority will be to provide evidence-based patient navigation from the point a patient enters the continuum of care through their cancer journey by ensuring the patient has the resources necessary to overcome barriers to receiving care.
   b. In FY18, hold a series of collaborative meetings (at least three) among local community organizations, churches, schools, etc. in Marion County to identify and develop cooperative relationships to better map available resources for reducing barriers to care.

Problem Statement: **Vigo and Wayne Counties** are not expected to reach HP2020 targets related to death and late-stage incidence rates for eight to 13 years or longer. These two counties are new to the Komen Central Indiana service area, and as such, qualitative data was weaker than other target communities. However, lack of insurance, lack of physician referrals for annual mammograms, and competing priorities were identified as possible barriers to care. Additionally, through the Health Systems Analysis, the Community Profile team learned that there is a lack of breast health services in these counties outside the cities of Terre Haute and Richmond.

**Priorities and Objectives**

1. Facilitate community awareness, education, and mobilization efforts aimed at reaching women living in low-income and possibly rural areas of these counties.
   a. In the RFAs for FY17 through FY19, in order to improve late-stage incidence rates, a funding priority will be to provide evidence-based education guiding women to the screening and diagnostic services most appropriate for them based on their payer (private insurance, HIP 2.0, uninsured safety nets, etc.).
   b. In FY18, establish a supply chain of Komen educational materials targeting low-income, low-education, older women delivered through local breast health service providers and community-based organizations in these counties.
   c. In FY18 and FY19, hold a series of educational sessions (at least one per county) to share Community Profile data with health care providers and educate providers on available resources for free and reduced cost screening for their patients.
   d. In FY18 through FY19, determine what resources are available for specialized populations within these counties (i.e., Amish) to receive screening services and meet with resource providers to learn how Komen Central Indiana can enhance their work.
2. Increase the capacity of existing health care systems to provide seamless transition for women who are screened to diagnostic and treatment services.
   a. In the RFAs for FY17 through FY19, in order to improve death rates, a funding priority will be to provide evidence-based patient navigation from the point a patient enters the continuum of care through their cancer journey by ensuring the patient has the resources necessary to overcome barriers to receiving care.
   b. In FY18 and FY19, hold a series of collaborative meetings (at least one per county) among local community organizations, churches, schools, etc. in these counties to identify and develop cooperative relationships in order to better map available resources for reducing barriers to care in each community and create a referral pipeline to these resources.
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