

susan g. komen.  **COMMUNITY**
PROFILE REPORT 2015



SUSAN G. KOMEN®
SAN FRANCISCO BAY AREA

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Susan G. Komen® San Francisco Bay Area would like to extend its deepest gratitude to the Board of Directors and the Community Profile Team.

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Introduction

Affiliate History

Susan G. Komen® San Francisco Bay Area is dedicated to combating breast cancer at every front. Up to 75 percent of the Affiliate's net income goes toward funding grants to local hospitals, clinics and community organizations that provide breast health education and breast cancer screening and treatment programs for medically underserved women. The remaining net income (a minimum of 25 percent) supports the Susan G. Komen Research Programs, which funds groundbreaking breast cancer research, meritorious awards and educational and scientific programs around the world.

Komen SF Bay Area has the distinction of being the very first Affiliate of Susan G. Komen. The Affiliate was founded by Joanne Horning, and her husband Rick, in honor of Joanne's mother's battle against breast cancer.

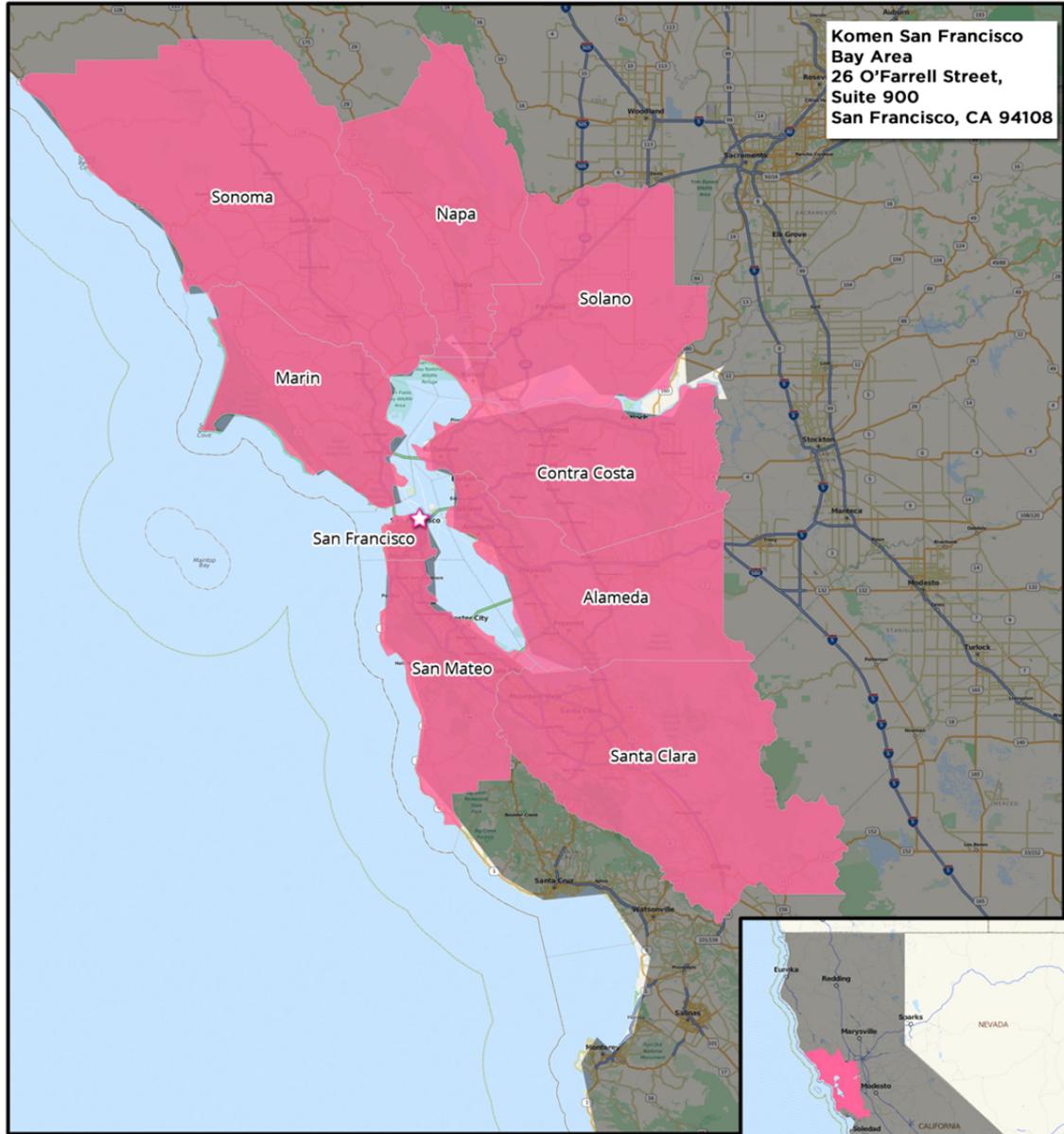
Komen SF Bay Area's service area covers eight Bay Area counties of Sonoma, Napa, Marin, San Francisco, Alameda, Contra Costa, San Mateo, and Santa Clara. Thanks to the thousands of people who participate in the Komen San Francisco Bay Area Race for the Cure® and other Affiliate events each year, dedicated corporate partners and generous donors, Komen San Francisco Bay Area is playing a vital role in fighting breast cancer in the Affiliate community.

Affiliate Organizational Structure

The Board of Directors functions to advise assist and aid in efforts to support breast cancer education and outreach programs serving the service area of Komen San Francisco Bay Area. Komen San Francisco Bay Area has 13 members that represent the Affiliate service area as Board of Directors. The Affiliate has three staff members an Executive Director, Development and Events Manager and Administrative and Social Media Coordinator.

Affiliate Service Area

KOMEN SAN FRANCISCO BAY AREA SERVICE AREA



★ Komen San Francisco Bay Area Office ■ Service Area

Figure 1.1. Susan G. Komen San Francisco Bay Area service area

Purpose of the Community Profile Report

The Community Profile will allow Komen San Francisco Bay Area to:

- Include a broad range of people and stakeholders in the Affiliate's work and become more diverse
- Fund, educate and build awareness in the areas of greatest need
- Make data-driven decisions about how to use its resources in the best way – to make the greatest impact
- Strengthen relationships with sponsors by clearly communicating the breast health and breast cancer needs of the community
- Provide information to public policymakers to assist focusing their work
- Strategize direction to marketing and outreach programs toward areas of greatest need
- Create synergy between Mission-related strategic plans and operational activities

Quantitative Data: Measuring Breast Cancer Impact in Local Communities

Quantitative Data Report

Introduction

The purpose of the quantitative data report for Susan G. Komen® San Francisco Bay Area 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>).

The following is a summary of Komen San Francisco Bay Area's Quantitative Data Report. For a full report please contact the Affiliate.

Breast Cancer Statistics

Incidence rates

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

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

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

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

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

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

Death rates

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

The death rate is calculated as the number of women from a particular geographic area who died from breast cancer divided by the total number of women living in that area. Death rates are shown in terms of 100,000 women and adjusted for age.

Data are included for the annual percent change in the death rate over a five-year period.

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

Late-stage incidence rates

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

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

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

Population Group	Incidence Rates and Trends				Death Rates and Trends			Late-stage Rates and Trends		
	Female Population (Annual Average)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of Deaths (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)
US	154,540,194	198,602	122.1	-0.2%	40,736	22.6	-1.9%	70,218	43.7	-1.2%
HP2020	.	-	-	-	-	20.6*	-	-	41.0*	-
California	18,413,837	23,266	122.0	-0.6%	4,251	21.9	-2.1%	8,287	43.5	-1.7%
Komen San Francisco Bay Area Service Area**	3,529,661	5,115	129.8	-1.8%	861	21.1	NA	1,703	43.4	-2.7%
White	2,281,761	3,790	142.1	-2.0%	646	22.7	NA	1,225	46.4	-2.5%
Black/African-American	283,076	343	122.8	-0.3%	84	30.1	NA	140	49.4	-2.9%
American Indian/Alaska Native (AIAN)	46,320	10	29.8	8.7%	SN	SN	SN	4	10.4	38.0%
Asian Pacific Islander (API)	918,505	938	96.6	-0.5%	129	13.5	NA	326	33.5	-2.6%
Non-Hispanic/ Latina	2,755,897	4,569	134.0	-1.3%	792	22.1	NA	1,491	44.1	-2.5%
Hispanic/ Latina	773,764	546	104.1	-4.4%	68	14.4	NA	213	39.2	-3.8%
Alameda County - CA	753,055	1,004	125.8	-2.7%	176	21.7	-2.2%	352	43.9	-3.1%
Contra Costa County - CA	524,870	790	133.2	-3.1%	135	22.4	-2.4%	267	45.1	-3.0%
Marin County - CA	126,224	259	147.2	-4.8%	38	20.1	-3.2%	81	46.5	-8.8%
Napa County - CA	67,133	103	124.6	-4.5%	20	20.9	-2.2%	30	37.5	-0.3%
San Francisco County - CA	389,451	535	118.4	-0.3%	93	18.6	-2.9%	171	38.2	-4.5%
San Mateo County - CA	358,049	591	139.0	0.5%	93	20.6	-2.6%	184	43.7	-1.4%
Santa Clara County - CA	865,333	1,129	125.9	-1.8%	177	19.6	-2.4%	381	42.5	-2.3%
Sonoma County - CA	240,712	421	143.7	-2.5%	77	24.5	-1.7%	131	45.0	-0.1%

*Target as of the writing of this report.

**Affiliate service data includes data from Solano County which was part of the service area until 10/2014.

NA – data not available

SN – data suppressed due to small numbers (15 cases or fewer for the 5-year data period).

Data are for years 2006-2010.

Rates are in cases or deaths per 100,000.

Age-adjusted rates are adjusted to the 2000 US standard population.

Source of incidence and late-stage data: North American Association of Central Cancer Registries (NAACCR) – Cancer in North America (CINA) Deluxe Analytic File.

Source of death rate data: Centers for Disease Control and Prevention (CDC) – National Center for Health Statistics (NCHS) mortality data in SEER*Stat.

Source of death trend data: National Cancer Institute (NCI)/CDC State Cancer Profiles.

Incidence rates and trends summary

Overall, the breast cancer incidence rate in the Komen San Francisco Bay Area service area was higher than that observed in the US as a whole and the incidence trend was lower than the US as a whole. The incidence rate of the Affiliate service area was **significantly higher** than that observed for the State of California and the incidence trend was not significantly different than the State of California.

For the United States, breast cancer incidence in Blacks/African-Americans is lower than in Whites overall. The most recent estimated breast cancer incidence rates for Asians and Pacific Islanders (APIs) and American Indians and Alaska Natives (AIANs) were lower than for Non-Hispanic Whites and Blacks/African-Americans. The most recent estimated incidence rates for Hispanics/Latinas were lower than for Non-Hispanic Whites and Blacks/African-Americans. For the Affiliate service area as a whole, the incidence rate was lower among Blacks/African-Americans than Whites, lower among APIs than Whites, and lower among AIANs than Whites. The incidence rate among Hispanics/Latinas was lower than among Non-Hispanics/Latinas.

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

- Marin County
- San Mateo County
- Sonoma County

The incidence rate was significantly lower in the following county:

- San Francisco County

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

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

Death rates and trends summary

Overall, the breast cancer death rate in the Komen San Francisco Bay Area service area was slightly lower than that observed in the US as a whole and the death rate trend was not available for comparison with the US as a whole. The death rate of the Affiliate service area was not significantly different than that observed for the State of California.

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

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

- Sonoma County

The death rate was significantly lower in the following county:

- San Francisco County

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

Late-stage incidence rates and trends summary

Overall, the breast cancer late-stage incidence rate in the Komen San Francisco Bay Area service area was similar to that observed in the US as a whole and the late-stage incidence trend was lower than the US as a whole. The late-stage incidence rate and trend of the Affiliate service area were not significantly different than that observed for the State of California.

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

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

- San Francisco County

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

Mammography Screening

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

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

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

*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

Population Group	# of Women Interviewed (Sample Size)	# w/ Self-Reported Mammogram	Proportion Screened (Weighted Average)	Confidence Interval of Proportion Screened
US	174,796	133,399	77.5%	77.2%-77.7%
California	4,347	3,512	81.8%	80.3%-83.2%
Komen San Francisco Bay Area Service Area*	891	749	86.3%	83.4%-88.8%
White	771	645	84.7%	81.4%-87.6%
Black/African-American	43	38	94.5%	81.2%-98.5%
AIAN	13	11	84.3%	44.4%-97.3%
API	61	53	88.3%	78.7%-94.0%
Hispanic/ Latina	69	58	83.6%	70.2%-91.7%
Non-Hispanic/ Latina	821	690	86.6%	83.6%-89.1%
Alameda County - CA	192	167	85.7%	78.4%-90.8%
Contra Costa County - CA	138	113	88.5%	80.7%-93.4%
Marin County - CA	46	35	81.8%	64.3%-91.9%
Napa County - CA	25	18	78.2%	54.6%-91.5%
San Francisco County - CA	65	49	80.1%	67.1%-88.8%
San Mateo County - CA	90	78	90.7%	82.1%-95.4%
Santa Clara County - CA	178	156	88.6%	81.7%-93.1%
Sonoma County - CA	107	89	82.0%	72.6%-88.7%

*Affiliate service data includes data from Solano County which was part of the service area until 10/2014.

SN – data suppressed due to small numbers (fewer than 10 samples).

Data are for 2012.

Source: CDC – Behavioral Risk Factor Surveillance System (BRFSS).

Breast cancer screening proportions summary

The breast cancer screening proportion in the Komen San Francisco Bay Area service area was significantly higher than that observed in the US as a whole. The screening proportion of the Affiliate service area was significantly higher than the State of California.

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

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

Population Characteristics

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

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

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

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

Table 2.4. Population characteristics – demographics

Population Group	White	Black /African-American	AIAN	API	Non-Hispanic /Latina	Hispanic /Latina	Female Age 40 Plus	Female Age 50 Plus	Female Age 65 Plus
US	78.8 %	14.1 %	1.4 %	5.8 %	83.8 %	16.2 %	48.3 %	34.5 %	14.8 %
California	75.1 %	7.3 %	2.0 %	15.6 %	62.5 %	37.5 %	45.5 %	31.5 %	13.1 %
Komen San Francisco Bay Area Service Area*	63.6 %	7.9 %	1.4 %	27.0 %	76.9 %	23.1 %	48.7 %	34.0 %	14.1 %
Alameda County - CA	54.0 %	14.5 %	1.4 %	30.0 %	78.0 %	22.0 %	46.8 %	32.1 %	12.8 %
Contra Costa County - CA	70.0 %	11.1 %	1.2 %	17.7 %	76.0 %	24.0 %	50.0 %	34.8 %	14.2 %
Marin County - CA	88.3 %	2.6 %	1.1 %	7.9 %	85.6 %	14.4 %	60.0 %	44.2 %	19.1 %
Napa County - CA	87.3 %	2.4 %	1.5 %	8.8 %	68.7 %	31.3 %	51.6 %	37.8 %	16.9 %
San Francisco County - CA	53.5 %	6.9 %	1.0 %	38.7 %	85.4 %	14.6 %	48.0 %	34.3 %	15.8 %
San Mateo County - CA	65.2 %	3.6 %	1.0 %	30.2 %	75.1 %	24.9 %	51.2 %	36.0 %	15.4 %
Santa Clara County - CA	59.6 %	3.3 %	1.6 %	35.5 %	73.3 %	26.7 %	46.0 %	30.9 %	12.8 %
Sonoma County - CA	89.9 %	2.2 %	2.5 %	5.4 %	76.1 %	23.9 %	52.6 %	39.0 %	16.1 %

*Affiliate service data includes data from Solano County which was part of the service area until 10/2014.

Data are for 2011. Data are in the percentage of women in the population.

Source: US Census Bureau – Population Estimates

Table 2.5. Population characteristics – socioeconomic

Population Group	Less than HS Education	Income Below 100% Poverty	Income Below 250% Poverty (Age: 40-64)	Un-employed	Foreign Born	Linguistically Isolated	In Rural Areas	In Medically Underserved Areas	No Health Insurance (Age: 40-64)
US	14.6 %	14.3 %	33.3 %	8.7 %	12.8 %	4.7 %	19.3 %	23.3 %	16.6 %
California	19.2 %	14.4 %	35.6 %	10.1 %	27.2 %	10.3 %	5.0 %	16.7 %	20.2 %
Komen San Francisco Bay Area Service Area*	13.1 %	10.1 %	25.0 %	8.6 %	29.9 %	9.7 %	2.2 %	10.6 %	13.3 %
Alameda County - CA	14.0 %	11.8 %	27.7 %	9.2 %	30.7 %	10.3 %	0.4 %	23.4 %	14.6 %
Contra Costa County - CA	11.5 %	9.9 %	22.3 %	9.5 %	23.6 %	6.8 %	0.8 %	4.4 %	12.6 %
Marin County - CA	8.0 %	7.2 %	17.0 %	6.3 %	18.5 %	4.8 %	6.5 %	0.9 %	11.1 %
Napa County - CA	17.4 %	9.8 %	26.9 %	8.0 %	22.1 %	7.4 %	13.4 %	0.0 %	15.6 %
San Francisco County - CA	14.3 %	12.3 %	31.5 %	7.5 %	35.6 %	13.5 %	0.0 %	30.2 %	12.4 %
San Mateo County - CA	11.6 %	7.0 %	20.1 %	7.3 %	34.1 %	9.7 %	1.9 %	4.9 %	11.3 %
Santa Clara County - CA	13.5 %	9.2 %	23.5 %	8.6 %	36.9 %	12.1 %	1.1 %	2.4 %	13.5 %
Sonoma County - CA	13.6 %	10.7 %	28.1 %	8.7 %	16.4 %	4.9 %	12.4 %	0.4 %	15.5 %

*Affiliate service data includes data from Solano County which was part of the service area until 10/2014.

Data are in the percentage of people (men and women) in the population.

Source of health insurance data: US Census Bureau – Small Area Health Insurance Estimates (SAHIE) for 2011.

Source of rural population data: US Census Bureau – Census 2010.

Source of medically underserved data: Health Resources and Services Administration (HRSA) for 2013.

Source of other data: US Census Bureau – American Community Survey (ACS) for 2007-2011.

Population characteristics summary

Proportionately, the Komen San Francisco Bay Area service area has a substantially smaller White female population than the US as a whole, a substantially smaller Black/African-American female population, a substantially larger Asian and Pacific Islander (API) female population, a similar American Indian and Alaska Native (AIAN) female population, and a substantially larger Hispanic/Latina female population. The Affiliate's female population is about the same age as that of the US as a whole. The Affiliate's education level is slightly higher than and income level is higher than those of the US as a whole. There is a slightly smaller percentage of people who are unemployed in the Affiliate service area. The Affiliate service area has a substantially larger percentage of people who are foreign born and a substantially larger percentage of people who are linguistically isolated. There is 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.

The following county has a substantially larger Black/African-American female population percentage than that of the Affiliate service area as a whole:

- Alameda County

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

- Alameda County
- San Francisco County
- San Mateo County
- Santa Clara County

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

- Napa County

The county with substantial foreign born and linguistically isolated populations is:

- San Francisco County

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 San Francisco Bay Area service area are progressing toward these targets, the report uses the following information:

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

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

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

Identification of priority areas

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

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

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

Counties are classified as follows (Table 2.6):

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

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

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

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

Affiliate Service Area Healthy People 2020 Forecasts and Priority Areas

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

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

Trends can change for a number of reasons, including:

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

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

Table 2.7. Intervention priorities for Komen San Francisco Bay Area service area with predicted time to achieve the HP2020 breast cancer targets and key population characteristics

County	Priority	Predicted Time to Achieve Death Rate Target	Predicted Time to Achieve Late-stage Incidence Target	Key Population Characteristics
Sonoma County - CA	High	11 years	13 years or longer	Rural
Alameda County - CA	Medium Low	3 years	3 years	%Black/African-American, %API, medically underserved
Contra Costa County - CA	Medium Low	4 years	4 years	
Marin County - CA	Low	Currently meets target	2 years	
Napa County - CA	Low	1 year	Currently meets target	%Hispanic/Latina, rural
San Mateo County - CA	Low	Currently meets target	5 years	%API
Santa Clara County - CA	Low	Currently meets target	2 years	%API, foreign
San Francisco County - CA	Lowest	Currently meets target	Currently meets target	%API, foreign, language, medically underserved

NA – data not available.

SN – data suppressed due to small numbers (15 cases or fewer for the 5-year data period).

Map of Intervention Priority Areas

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

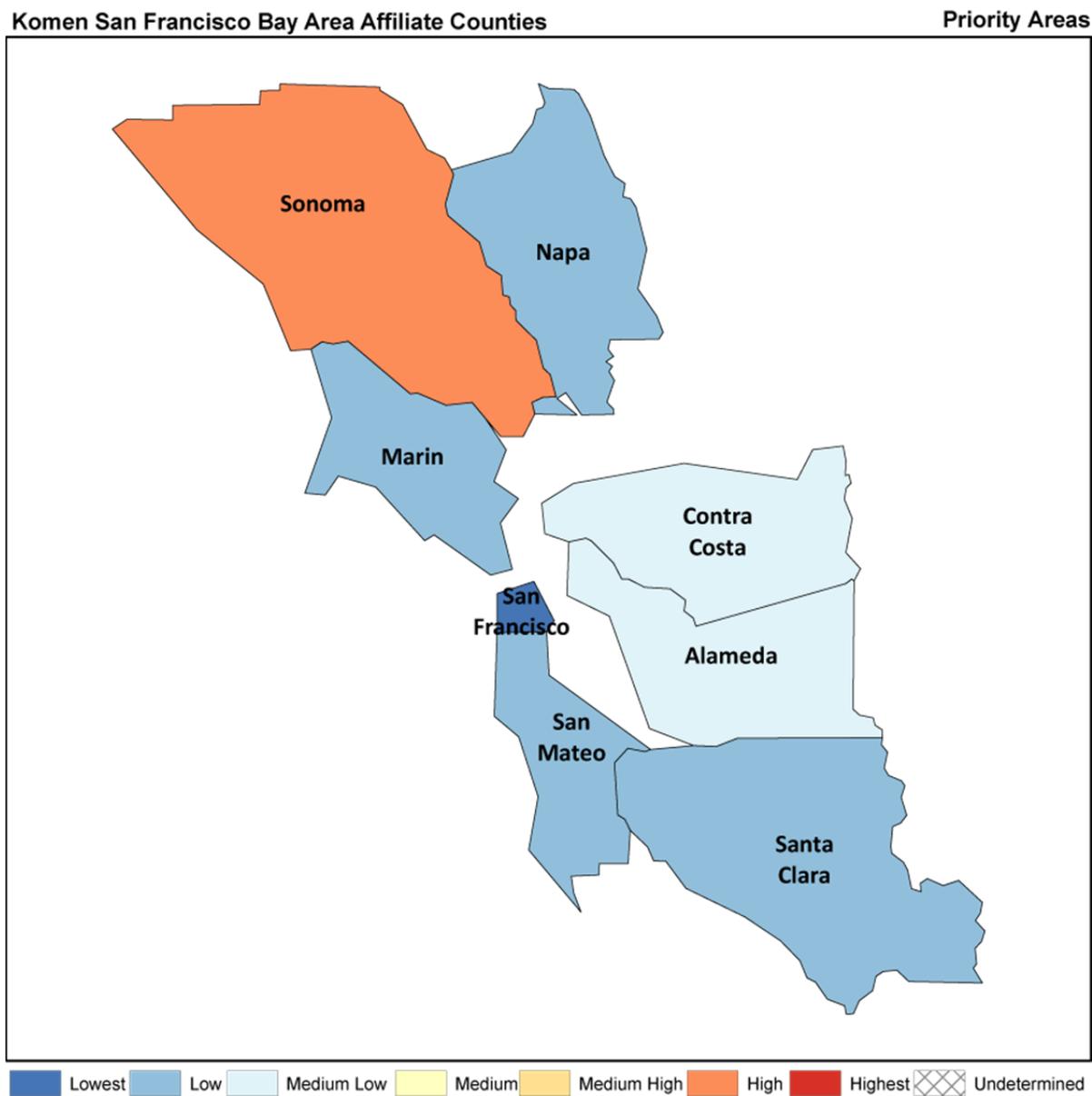


Figure 2.1. Intervention priorities

Data Limitations

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

- The most recent data available were used but, for cancer incidence and deaths, these data are still several years behind.
- For some areas, data might not be available or might be of varying quality.

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

Quantitative Data Report Conclusions

High priority areas

One county in the Komen San Francisco Bay Area service area is in the high priority category. Sonoma County is not likely to meet the late-stage incidence rate HP2020 target.

The incidence rates in Sonoma County (143.7 per 100,000) are significantly higher than the Affiliate service area as a whole (129.8 per 100,000). The death rates in Sonoma County (24.5 per 100,000) are significantly higher than the Affiliate service area as a whole (21.1 per 100,000).

Medium low priority areas

Two counties in the Komen San Francisco Bay Area service area are in the medium low priority category. Both of the two, Alameda County and Contra Costa County, are expected to take from zero to six years to reach both the death rate and late-stage incidence rate HP2020 targets.

Alameda County has a relatively large Black/African-American population and a relatively large API population.

Selection of Target Communities

Susan G. Komen[®] San Francisco Bay Area service area comprises the eight Bay Area counties of Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, and Sonoma.

Using data on female breast cancer death rates, late-stage diagnosis, and the time needed to reach Healthy People 2020 targets, as well as information on barriers to accessing quality breast cancer education, diagnosis and treatment that are prevalent in the service area, three counties; Sonoma, Alameda, and Contra Costa, have been selected to be priority communities.

Sonoma County

Sonoma County has the highest death rate from breast cancer in the Affiliate service area, at 24.5 per 100,000 women, which is significantly higher than the rate in the Affiliate service area as a whole.

Sonoma County is predicted to take 11 years to achieve the Healthy People 2020 female breast cancer death rate target of 20.6 deaths per 100,000 women. Sonoma is the only county within the Affiliate service area that is not likely to meet the Healthy People 2020 late-stage incidence target by 2020. Because of the projected time to achieve these targets, Sonoma County has been identified as a high priority county.

Sonoma County also has a higher rural population, at 12.4 percent, than the Affiliate service area as a whole. This higher proportion of people living in rural areas may present a challenge to accessing high-quality breast cancer education, screening, and treatment.

Contra Costa County

Contra Costa County's breast cancer death rate is higher than the breast cancer death rate of the Affiliate service area as a whole. The late-stage diagnosis rate is also higher in Contra Costa County than in the Affiliate service area as a whole

Contra Costa is expected to take four years to reach Healthy People 2020 targets for death rate and late-stage incidence rate.

Alameda County

Alameda County also has a higher death rate and late-stage diagnosis rate than the Affiliate service area as a whole, with a death rate of 21.7 per 100,000 women and a late-stage diagnosis rate of 43.9 per 100,000

Alameda County is expected to take three years to reach Healthy People 2020 targets for death rate and late-stage incidence rate.

Additionally, Alameda County has the largest percentage of Black/African-American women of the Affiliate service area counties, a group with a higher breast cancer death rate in comparison to White women.

Health Systems and Public Policy Analysis

Health Systems Analysis Data Sources

A primary source for information on providers of breast health and breast cancer services was the California Health System Analysis (Susan G. Komen, 2014). Information from that document was supplemented by searching the websites of the following resources:

- Food and Drug Administration (FDA) Certified Mammography Facilities list (<http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfMQSA/mqsa.cfm>),
- List of all hospitals registered with Medicare (<https://data.medicare.gov/Hospital-Compare/Hospital-General-Information/v287-28n3>)
- Health Resources and Services Administration (HRSA) searchable list of community health centers (http://findahealthcenter.hrsa.gov/Search_HCC.aspx).

To round out the list of organizations, all Komen San Francisco Bay Area grantees in the target communities were called and asked about services in the counties of interest. The Affiliate then searched the websites of all organizations collected to learn which breast health and breast cancer services are available. Hospitals and community health centers with websites that did not include information about screening, diagnostic, treatment, support and survivorship services were called and asked about the services they provide. These phone calls will serve as a foundation for the qualitative data collection section of the Community Profile.

Hospitals, community health centers, and imaging centers were then checked for accreditations at the websites of the following organizations:

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

Health Systems Overview

The Breast Cancer Continuum of Care (CoC) is a model (see Figure 3.1) that shows how a woman typically moves through the health care system for breast care. A woman would ideally move through the CoC quickly and seamlessly, receiving timely, quality care in order to have the best outcomes. Education can play an important role throughout the entire CoC.

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

providing education to encourage women to get screened and reinforcing the need to continue to get screened routinely thereafter.

If a screening exam resulted in abnormal results, diagnostic tests would be needed, possibly several, to determine if the abnormal finding is in fact breast cancer. These tests might include a diagnostic mammogram, breast ultrasound or biopsy. If the tests were negative (or benign) and breast cancer was not found, she would go into the follow-up loop, and return for screening at the recommended interval. The recommended intervals may range from three to six months for some women to 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 it all means. Education can empower a woman and help manage anxiety and fear.

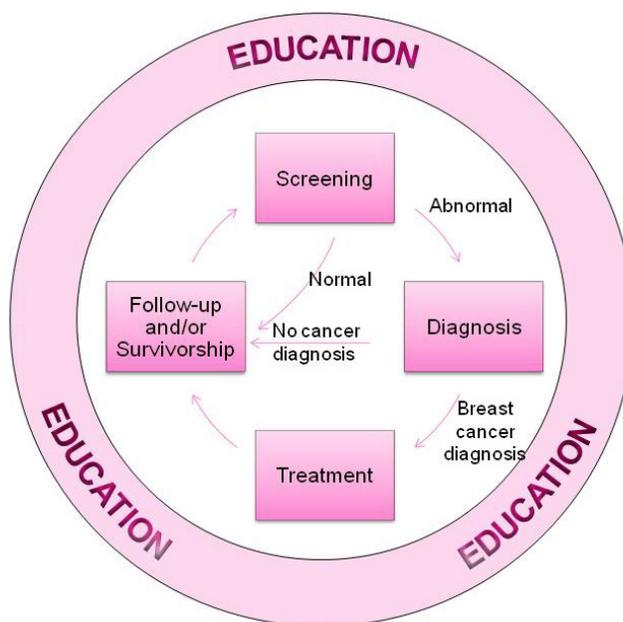


Figure 3.1. Breast Cancer Continuum of Care (CoC)

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

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

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

misconceptions). Education can address some of these barriers and help a woman progress through the CoC more quickly.

Health System Strengths and Weaknesses

The three counties of interest include 27 hospitals, 61 community health centers, one free health clinic, and several other facilities providing direct services such as imaging centers and breast health clinics (Figures 3.2, 3.3 and 3.4). These include nine American College of Surgeons Commission on Cancer accredited facilities, 18 American College of Radiology Centers of Excellence, nine American College of Surgeons National Accreditation Program for Breast Centers (NAPBC) facilities and no National Cancer Institute Designated Cancer Centers.

In the initial searches into available breast health services in Alameda, Contra Costa, and Sonoma Counties, the Affiliate discovered many facilities that provide screening mammograms and/or clinical breast exams, although it will take more in-depth exploration to get a better picture of other services for diagnostic, treatment, support and survivorship that exist in these communities as well as which of these resources are available to under-served women and women with low incomes. The most obviously missing resource that could not be found in any of the targeted counties is a mobile mammography unit. Although it is possible that existing screening facilities are sufficient to meet the screening needs of the three counties of interest, it seems likely that mobile mammography would be a useful resource. Key informant interviews and focus groups will help the Affiliate find the information necessary to know about the gaps in accessible, quality breast cancer and breast health services.

Health and medical facilities offering breast health services appear to be clustered in major cities in all three counties. In Alameda County, more than half of the identified resources are located in one city, Oakland. In Contra Costa County, these services are clustered around four urban centers, while large areas have no services. In Sonoma County, half of all hospitals, community health centers, and clinics are located in the largest city, Santa Rosa. Resource mapping will allow us to get a better picture of how these resources are distributed geographically within these counties.

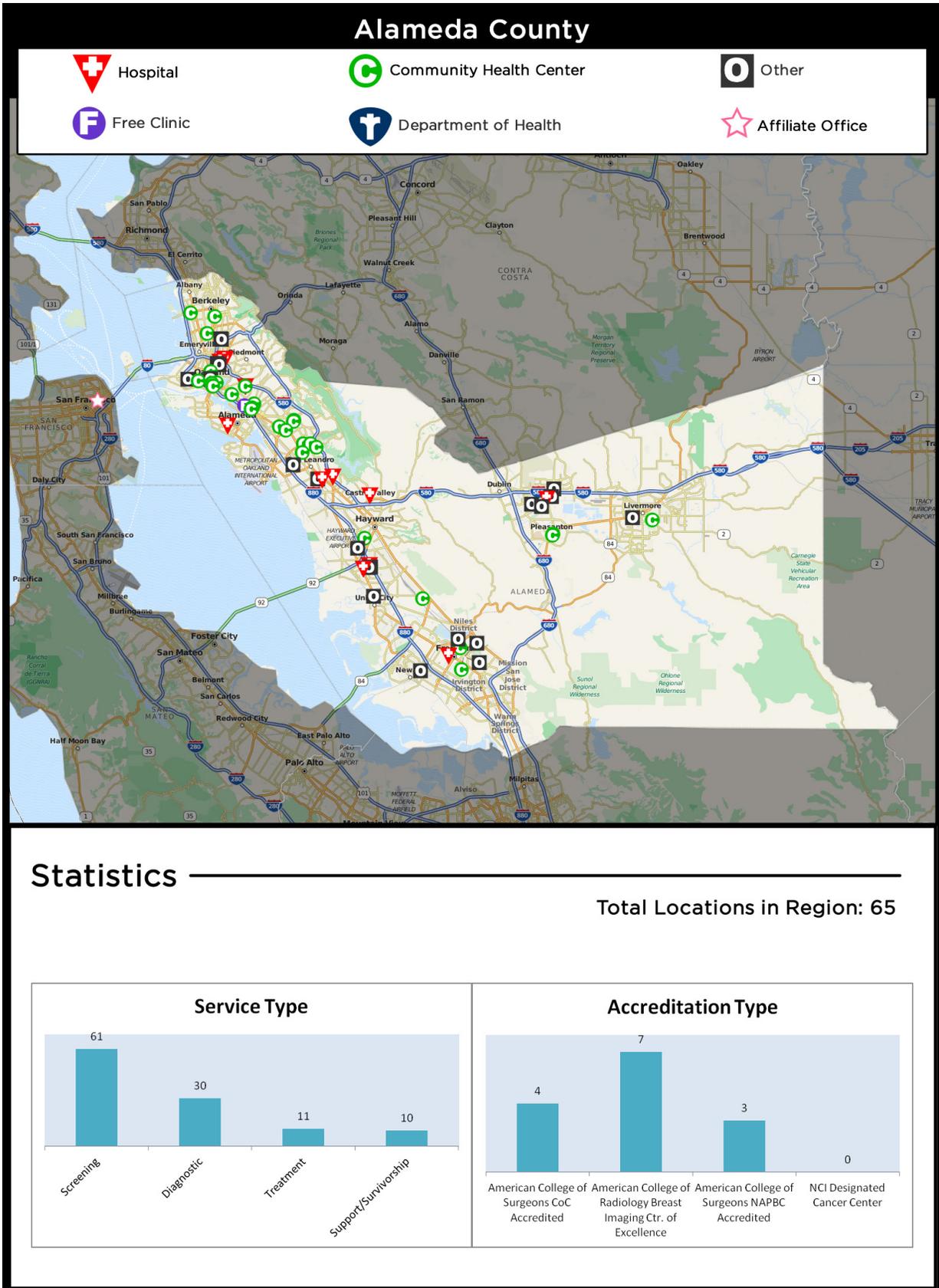
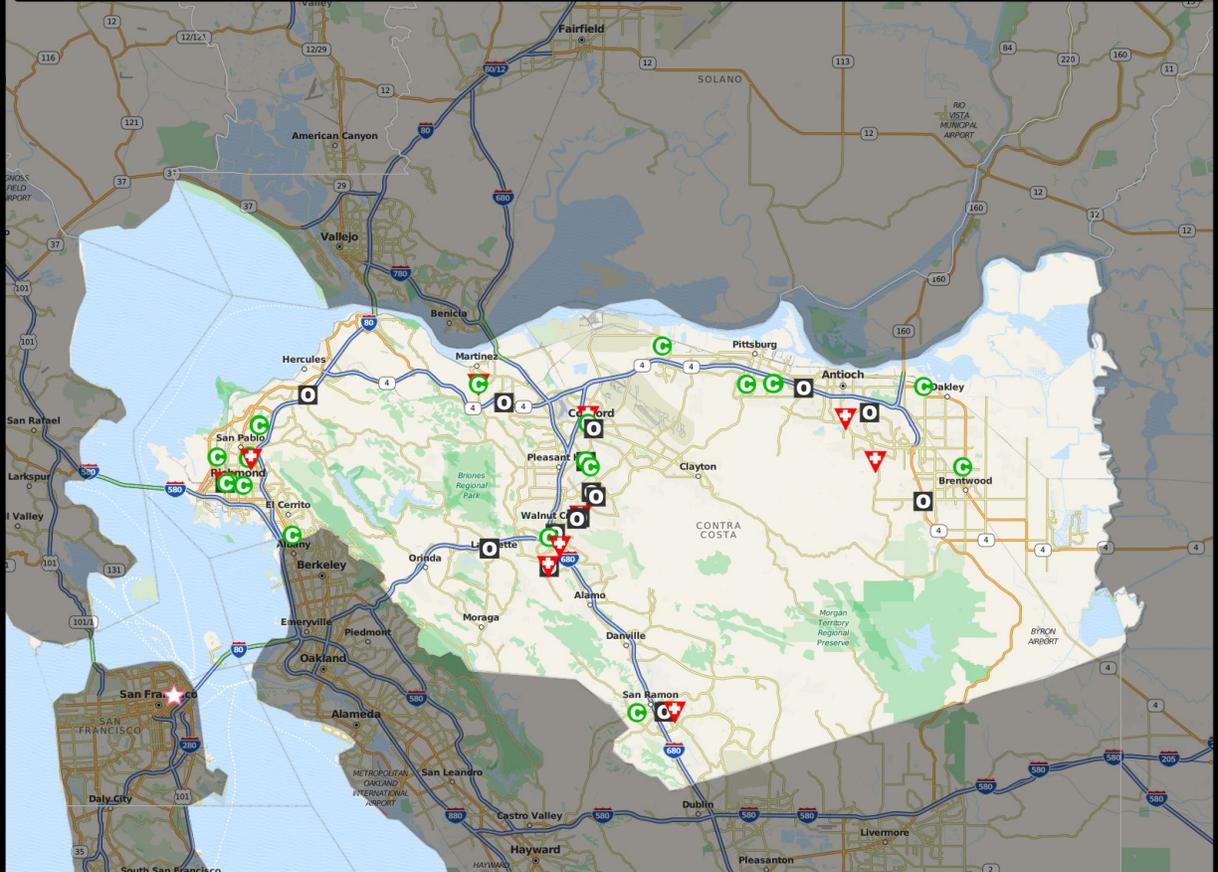
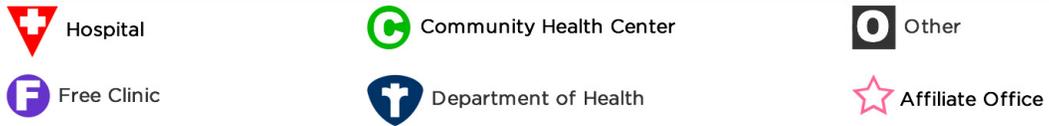


Figure 3.2. Breast cancer services available in Alameda County

Contra Costa County



Statistics

Total Locations in Region: 49

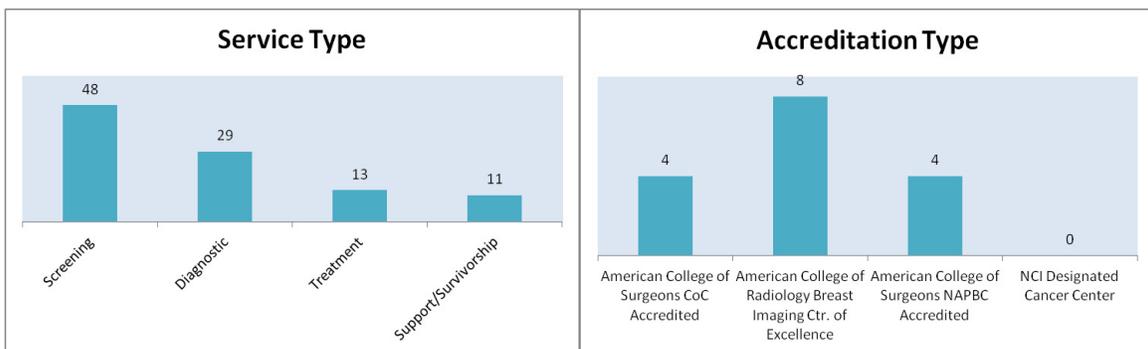


Figure 3.3. Breast cancer services available in Contra Costa County

Mission-related Partnerships in Counties of Interest

Komen San Francisco Bay Area partners with community-based non-profits, educational institutions, and health organizations through an annual community grant making process. The Affiliate funds programs that strengthen the safety net for underserved women who would otherwise be unable to access quality breast health education, screening, diagnosis, treatment, and support services, with priorities directed by the findings of the Community Profile. The Affiliate also serves as a bridge between grantee and other community partners to connect and share resources and best practices. Through many years of partnering with community organizations the Affiliate has developed a large network.

Komen San Francisco Bay Area participates in the Bay Area Women's Health Advocacy Council (BAWHAC), a coalition of San Francisco Bay Area organizations whose common goal is to advocate for increased access for under-served women to breast and cervical cancer screening, diagnostic, and treatment services. Participating organizations serve women in Alameda, Contra Costa, Marin, San Mateo, and San Francisco counties. BAWHAC was founded by Komen SF Bay Area grantee Latina Breast Cancer Agency (LBCA).

As part of the Susan G. Komen® Circle of Promise California Initiative, an effort on the part of the seven California Affiliates to eliminate breast cancer death disparities, Komen San Francisco Bay Area is forging new collaborative relationships. A local community partnership collaborative composed of leaders of churches and community organizations, academics, medical professional and others meets monthly to provide ideas and support the efforts of the initiative.

In the future, Komen San Francisco Bay Area will work together with existing partners to look for new ways to work together to support under-served women in the Bay Area. The qualitative data collection required for the Community Profile will be one source of ideas for potential collaboration.

Public Policy Overview

National Breast and Cervical Cancer Early Detection Program (NBCCEDP)

The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) supports the provision of clinical breast exams, mammograms, Pap tests, pelvic exams, diagnostic testing for women whose screening outcome is abnormal, and referrals to treatment. The program is supported by the Centers for Disease Control and Prevention, which provides a federal grant to each State. In California, the program, referred to as *Every Woman Counts (EWC)*, receives support from general funds and additional support through state tobacco tax revenue (one of two taxes is the Breast Cancer Act of 1994 which levies a two cent per pack tax on cigarettes, of which 50 percent goes to EWC). EWC is part of the Department of Health Care Service's Cancer Detection and Treatment Branch (CDTB) and is separate from Medi-Cal (California's Medicaid program). However, the program uses Medi-Cal billing codes. The mission of the EWC is to save lives by preventing and reducing the devastating effects of cancer for Californians through education, early detection, diagnosis and treatment, and integrated preventive services, with special emphasis on the underserved). In California, EWC has a payer

of last resort requirement, which exhausts all other possible payers before EWC [such as California's Low Income Health Program (LIHP) – through a Medicaid Demonstration Waiver].

The federal eligibility baseline to direct services for this program are to uninsured and underinsured women at or below 200 percent of federal poverty level; ages 21–64 for cervical screening; ages 40–64 for breast screening. In California, a woman can receive Medicaid services regardless of where she was originally screened, as long as she would otherwise meet the other eligibility requirements for the program. Additional program eligibility requirements in California are not getting these services through Medi-Cal or another government-sponsored program and living in California. In California services are provided through regional contractors throughout the state. A 1-800 number is available, Monday to Friday from 8:30am to 5:00pm, in the English, Spanish, Mandarin, Cantonese, Korean and Vietnamese, for program eligibility and referrals to services. Regional contractors can also help to refer individuals to other screening programs, if they are not eligible to EWC.

Treatment is provided to eligible individuals through the Breast and Cervical Cancer Treatment Program (BCCTP). The federal BCCTP provides full-scope Medi-Cal to eligible women who meet all the federal criteria. The state-funded BCCTP only provides cancer treatment and related services to any individual, including men, who does not meet the federal criteria. The State BCCTP program provides no cost breast cancer treatment services for up to 18 continuous months and cervical cancer treatment services for up to 24 continuous months. The application work sheet and required documents for the BCCTP program are available in 11 languages, including English, Spanish, Vietnamese, Cambodian, Hmong, Armenian, Cantonese, Korean, Russian, Farsi and Laotian.

The local Affiliate has begun to work with the local Cancer Detection Program: Every Woman Counts. The Bay Area Cancer Partnership of Every Woman Counts serves Alameda, Contra Costa, Marin, San Francisco, and San Mateo counties, which are part of the Komen San Francisco Bay Area service area, and the Northern California Cancer Partnership includes Sonoma County. The Affiliate also works through the California Policy Collaborative, in partnership with other Affiliates throughout the state, to be aware of changes with the state NBCCEDP.

State Comprehensive Cancer Control Coalition

California's Comprehensive Cancer Control plan is a strategic plan to reduce the burden of cancer in the state. This is the state's second comprehensive plan and focuses on cancer control efforts through 2015. The current strategic plan addresses the cancer continuum and includes primary prevention, early detection and screening, treatment, quality of life and end-of-life care, as well as such cross-cutting issues as advocacy, eliminating disparities, research, and surveillance.

The State Cancer Control plan has two breast cancer objectives:

1. By 2015, increase the prevalence of women 40 years and older who report having both a mammogram and a clinical breast exam (CBE) within the prior two years by 7.5 percent, from a baseline prevalence of 79.1 percent to 85 percent and
2. By 2015, increase the proportion of early-stage diagnoses of breast cancer among all women by 29 percent, from the baseline proportion of 69 percent to 89 percent.

Komen San Francisco Bay Area will reach out to the local Cancer Coalition, ask to attend meetings, and determine the best way to participate as a member.

Affordable Care Act

In 2010, the state of California was the first state in the nation to enact legislation to implement the provisions of the federal Affordable Care Act (ACA), creating *Covered California*⁴. This health care marketplace was established to help Californians choose affordable and quality health care. California also decided to expand its Medi-Cal Program, the state's Medicaid program, and eligibility can also be determined through *Covered California*. California has the greatest number of uninsured of all the states, seven million uninsured. By 2014, about 2.6 million Californians will be able to access financial assistance through *Covered California* to pay for their health insurance, and 1.4 million will be newly eligible for Medi-Cal. However, a large number of individuals (nearly three million) will remain uninsured in California. Approximately 703,000 will be eligible for Medi-Cal and not enroll; 959,000 will be undocumented and ineligible for insurance coverage; and 1.4 million will be eligible for coverage through *Covered California* and not enroll. Of this 1.4 million, 577,000 will be eligible for subsidy but will not take it and 832,000 are not eligible for the subsidy.

The ACA through its marketplace health plans cover the following preventive health services for women, specific to breast health, without charging the patient a co-payment or co-insurance:

- Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer,
- Breast Cancer Mammography screenings every one to two years for women over 40, and
- Breast Cancer Chemoprevention counseling for women at higher risk.

However, individuals who remain uninsured, due to ineligibility or opting not to purchase coverage, will not have access to these preventive health services for women. As a result, the NBCCEDP/EWC program will still be needed to help provide clinical breast exams, mammograms, Pap tests, pelvic exams, diagnostic testing for women whose screening outcome is abnormal, and referrals to treatment for women. While the overall number of women eligible to services through NBCCEDP will decrease due to ACA and Medicaid expansion, a large number of women will remain uninsured and will still need these program services, and funding for the NBCCEDP will only be able to help serve about one-fifth to one-third of those eligible due to limited federal and state appropriations.

While much excitement has surrounded the ACA and the roll out of the health care marketplace, a lot remains undetermined in terms of access and utilization. Some have expressed concerns about the availability of health care providers to respond to an increase of 30 million insured Americans across the country. Some studies report not only a shortfall in health care providers, but also in the health care workforce as a whole, in responding to the ACA changes. While these concerns may be warranted, other efforts are taking place at all levels to ensure collaboration and partnership across providers (safety net providers, private providers, Medi-Cal providers, hospitals, and health systems) to ensure strategies to meet the changing needs of health care delivery.

In the counties that Komen San Francisco Bay Area serves, there will remain a number of uninsured individuals who are in need of breast health services and may need access to NBCCEDP/EWC or Affiliate resources to ensure timely and quality access to breast health services. The Affiliate will continue to work closely with its partners in health and health policy to stay abreast of the breast health needs in the Affiliate service area and respond accordingly in providing support for access to care.

Affiliate's Public Policy Activities

Komen San Francisco Bay Area is a member of the California Policy Collaborative, composed of representatives of each Komen Affiliate in California. The Affiliate stays apprised of key public policy issues in the service area as well as at the state level. In the next year Komen San Francisco Bay Area will explore the possibility of creating a public policy committee which would then determine the course of future involvement in public policy activities.

Health Systems and Public Policy Analysis Findings

Information gathered in the Health System and Public Policy Analysis will help inform the Qualitative Data Collection section of the Community Profile, which will allow the Affiliate to see where the gaps fall in services available to under-served women in Alameda, Contra Costa, and Sonoma counties. Through key informant interviews and focus groups the Affiliate will be able to learn where services are available to low-income and under-served women.

As one of the seven Komen Affiliates in California that form the California Policy Collaborative, Komen San Francisco Bay Area Komen intends to continue to work with the collaborative as well as other local health care partners to ensure quality access to information and services for breast health. The Affiliate will work to identify new partners including local community health, and medical organizations, faith and community groups, academic researchers, and coalitions to further its work in addressing issues regarding access to quality breast health and breast cancer care in the San Francisco Bay Area.

Mission Action Plan

Breast Health and Breast Cancer Findings of the Target Communities

Using data on female breast cancer death rates, late-stage diagnosis, and the time needed to reach Healthy People 2020 targets, as well as information on barriers to accessing quality breast cancer education, diagnosis and treatment that are prevalent in the service area, three counties - Sonoma, Alameda, and Contra Costa - have been selected to be priority communities.

The three counties of interest include 27 hospitals, 61 community health centers, one free health clinic, and several other facilities providing direct services such as imaging centers and breast health clinics. These include nine American College of Surgeons Commission on Cancer accredited facilities, 18 American College of Radiology Centers of Excellence, nine American College of Surgeons National Accreditation Program for Breast Centers (NAPBC) facilities and no National Cancer Institute Designated Cancer Centers. The most obviously missing resource that could not be found in any of the targeted counties is a mobile mammography unit. Although it is possible that existing screening facilities are sufficient to meet screening needs of the three counties of interest, it seems likely that mobile mammography would be a useful resource.

Sonoma County

Sonoma County has the highest death rate from breast cancer in the Affiliate service area, at 24.5 per 100,000 women, which is significantly higher than the rate in the Affiliate service area as a whole.

Sonoma County is predicted to take 11 years to achieve the Healthy People 2020 female breast cancer death rate target of 20.6 deaths per 100,000 women. Sonoma is the only county within the Affiliate service area that is not likely to meet the Healthy People 2020 late-stage incidence target by 2020. Because of the projected time to achieve these targets, Sonoma County has been identified as a high priority county.

Sonoma County also has a higher rural population, at 12.4 percent, than the Affiliate service area as a whole. This higher proportion of people living in rural areas may present a challenge to accessing high-quality breast cancer education, screening, and treatment.

In Sonoma County there were 34 locations that provided breast cancer services varying between screening, diagnostic, treatment, and survivorship. Most locations only provided screening services, with only 14 locations providing diagnostic services and seven locations providing treatment services. In the entire county there were six organizations that provided survivorship services or care.

Contra Costa County

Contra Costa County's breast cancer death rate is higher than the breast cancer death rate of the Affiliate service area as a whole. The late-stage diagnosis rate is also higher in Contra Costa County than in the Affiliate service area as a whole.

Contra Costa is expected to take four years to reach Healthy People 2020 targets for death rate and late-stage incidence rate.

In Contra Costa County there were 49 locations that provided breast cancer services varying between screening, diagnostic, treatment and survivorship. There were 48 locations that provided screening services, 29 locations that provided diagnostic services and 13 locations that provided treatment services. In the entire service area there were 11 organizations that provided survivorship services.

Alameda County

Alameda County also has a higher death and late-stage diagnosis rate than the Affiliate service area as a whole, with a death rate of 21.7 per 100,000 women and a late-stage diagnosis rate of 43.9 per 100,000

Alameda County is expected to take three years to reach Healthy People 2020 targets for death and late-stage incidence rate. Additionally, Alameda County has the largest percentage of Black/African-American women when compared to the Affiliate service area counties. This is important as Black/African-American women have a higher breast cancer death rate in comparison to White women.

In Alameda County there were a total of 65 locations that provided breast cancer services varying between screening, diagnostic, treatment and survivorship. The majority of the locations provided screening services with 61 available locations. There were 30 locations that provided diagnostic services, 11 locations that provided treatment services and 10 locations that provided support/survivorship.

Mission Action Plan

The Mission Action Plan was developed directly from quantitative and health system analysis data. Major themes were drawn from these data and priorities and objectives were set to address the concerns that were identified.

Sonoma County Problem Statement: Sonoma County is categorized as high priority with predicted time to achieve the HP2020 breast cancer targets and key populations characteristics. The county is predicted to take 11 years to achieve death rate targets and 13 years or longer to achieve late-stage incidence targets for Healthy People2020. This county also has a large rural population that may have unique access barriers to breast cancer services.

Priority: Increase access to breast cancer services for women residing in rural Sonoma County.

Objective: From FY2017 through FY2019, Komen San Francisco Community Grant Request for Application (RFA) will specify that evidence-based programs providing assistance for rural women in Sonoma County to access available breast cancer services are a funding priority.

Contra Costa County Problem Statement: Contra Costa is categorized as medium low priority with predicted time to achieve the HP2020 breast cancer targets and key populations characteristics. The County is predicted to take three years to achieve death rate and late-stage incidence targets for Healthy People2020.

Priority: Increase access to breast cancer services for women in Contra Costa County.

Objectives: From FY2017 through FY2019, the Komen San Francisco Community Grant Request for Application (RFA) will specify that evidence-based programs providing assistance for women in Contra Costa County to access available breast cancer services are a funding priority.

Alameda County Problem Statement: Alameda County is categorized as medium low priority with predicted time to achieve the HP2020 breast cancer targets and key populations characteristics. The County is predicted to take four years to achieve death rate and late-stage incidence targets for Healthy People2020. This county also has the largest Black/African-American population within the Affiliate service area that may have unique access barriers to breast cancer services.

Priority: Increase access to breast cancer services for Black/African-American women residing in Alameda County.

Objectives: From FY2017 through FY2019, the Komen San Francisco Community Grant Request for Application (RFA) will specify that evidence-based programs providing assistance for Black/African-American women in Alameda County to access available breast cancer services are a funding priority.

Language & Cultural Barriers Problem Statement: The counties within the Affiliate service area have relatively higher percentages of immigrant populations than California as a whole (a county range of 30-36 percent vs. California average of 26.8 percent). Language barriers were cited by both providers and immigrant women in the service area. Providers see the language barrier as a lack of education materials in multiple languages or the lack of interpreters who can assist in diagnosis and treatment discussions with patients. Immigrant women expressed that language barriers may prevent women from even accessing the continuum at the prevention stage and thus they may be diagnosed at a later stage. Chinese immigrant women indicated that language prevented them from accessing a transportation barrier solution often recommended by providers – taxi scrip. To effectively reduce language barriers, the strategies and solutions should come jointly from providers and women in the community.

Priority: Reduce language and cultural barriers to screening and treatment for foreign-born and non-English speaking populations in the Affiliate service area.

Objective: Partner with organizations focused on involving culturally-competent advocates and survivors in educational efforts, to facilitate collaborations with institutions providing services to underserved women.

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