

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



SUSAN G. KOMEN®  
SOUTH DAKOTA

# Susan G. Komen® Great Plains Prelude

In January 2017 Susan G. Komen® Nebraska, based in Omaha, Neb., and Susan G. Komen® South Dakota, based in Sioux Falls, S.D., joined forces to make a bigger impact in the fight against breast cancer and will operate as one entity – Susan G. Komen® Great Plains.

The consolidated organization serves residents in Nebraska and South Dakota, with plans to expand into North Dakota in the future.

The 2015 Community Profile for Susan G. Komen South Dakota was completed under the previous Affiliate name, but the data and findings are still relevant in Komen Great Plains operations and the Mission Action Plan is germane for priorities and objectives in the area.

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# Acknowledgments

The Community Profile Report could not have been accomplished without the exceptional work, effort, time and commitment from many people involved in the process.

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

**Patty Kussman, LPN, CBPN**  
Board Member  
Susan G. Komen South Dakota

**Mary Kolsrud**  
Executive Director  
Susan G. Komen South Dakota

**Meagan Huisman**  
Affiliate Coordinator  
Susan G. Komen South Dakota

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

- Susan G. Komen Headquarters Community Profile Team
- South Dakota Department of Health

**For Questions Related to the Community Profile Report Contact:**

**Susan G Komen® Great Plains**  
**Sioux Falls Office**  
101 N. Main Ave; Suite 209  
Sioux Falls, SD 57104  
605-271-1751  
<http://komengreatplains.org/>  
Contact: Karen Daneu, Executive Director

# Executive Summary

## **Introduction to the Community Profile Report**

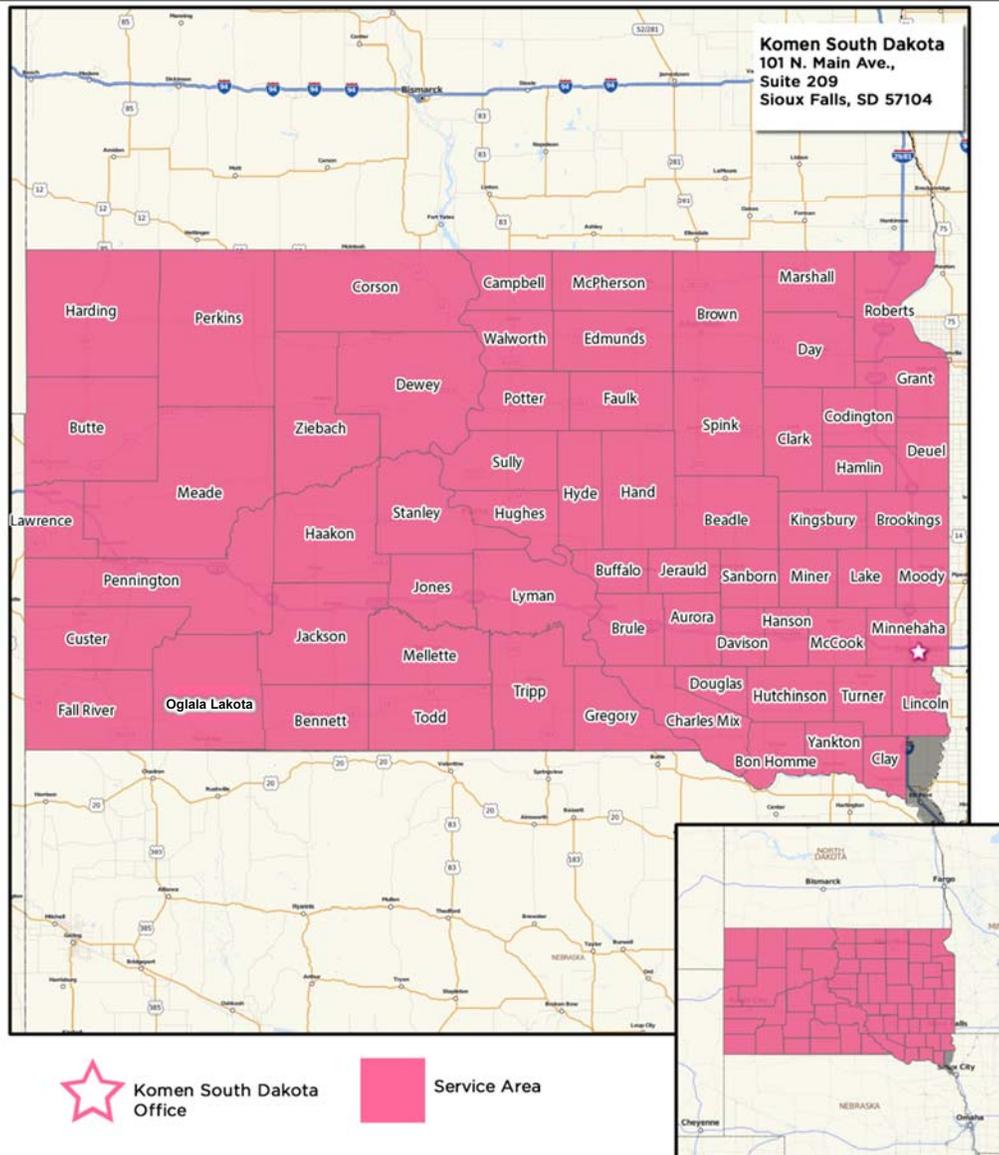
Susan G. Komen® South Dakota (SD) was created in 2005 to carry the Komen vision throughout the State of South Dakota. Since its inception, the Affiliate has granted over \$1.5M to programs across the state which support breast health and breast cancer education, screening and treatment. As a result of the hard work of volunteers and staff members, the Affiliate has positively touched 61 of its 65 counties and impacted the lives of over 39,372 women. More than 7,928 mammograms and clinical breast exams have been provided and 177 cases of breast cancer have been detected as a result of Komen SD funded grants. In 2015, the Affiliate was awarded a grant to start an educational outreach program focused on the Hispanic and Latina population in Sioux Falls with plans to expand the program to rural areas to educate minority populations in 2015.

The Affiliate also collaborates and partners with entities across the state such as the South Dakota Comprehensive Cancer Coalition Program to further eliminate breast cancer disparities. The Affiliate recognizes the importance of further collaboration with new organizations in order to make a greater impact in the state.

The organization is led by an Executive Director and Affiliate Coordinator who oversee all day-to-day responsibilities of effectively operating the Affiliate. The Affiliate also receives considerable support from volunteers across the state to carry out its mission. The Affiliate is governed by the Board of Directors which currently has 11 members who oversee the strategic direction of the Affiliate. Committees of the Affiliate include a Race for the Cure® Committee, Grants Committee, Development Committee and Finance Committee.

Komen South Dakota serves the entire state of South Dakota, less Union County, which is served by Susan G. Komen Siouxland (Figure 1). Geographic distance is something South Dakotans have addressed for years as population has declined, but continued population shifts and fewer services make it more challenging to provide quality, state-of-the-art care and ongoing survivor support programs to people in rural areas. The challenge for breast health and breast cancer support services in South Dakota exists primarily in the rural areas, with low income families, and on American Indian reservations. South Dakota has state-of-the-art breast health and cancer facilities in the metropolitan areas, but the distances that women travel to receive screening and treatment is substantial.

## KOMEN SOUTH DAKOTA SERVICE AREA



**Figure 1.** Susan G. Komen South Dakota service area

To meet Komen South Dakota’s promise, the Affiliate relies on the Community Profile process to guide its work. The Community Profile includes an overview of demographic and breast cancer statistics which highlight target areas, groups or issues. The statistics pinpoint where efforts will have the most impact. To ensure effective and targeted efforts, it is important to also understand what programs and services gaps, needs and barriers exist.

The purpose of this Community Profile Report will not only drive grantmaking priorities but will also:

- 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

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

Overall, the quantitative data showed the breast cancer incidence rate, incidence trend, and death rates were slightly lower than the US as a whole. Furthermore, late-stage incidence rate was similar to that observed in the US as a whole and late-stage incidence trend was higher than the US as a whole. However, it must be noted, much of the service area was not available for comparison as much data were suppressed due to the small sample size of the population base across the state.

An analysis of the quantitative data from communities across the state identified the three highest need areas in which the Affiliate will focus its resources over the next four years. Multiple counties within the service area had data suppressed due to small numbers for breast cancer incidence, death rates and trends; therefore, socioeconomic factors were also relied upon with the addition of supplemental data collected on minority populations within the state. The additional data collected was used to outline both tribal communities and vulnerable populations in the state. The data were also used to further investigate the link between tribal populations, rural regions and subsequent socioeconomic issues in these areas.

Attention was given to where time and resources would make the largest impact with a focus given to both the Healthy People 2020 (HP2020) data and the most vulnerable populations in the service area. The three target communities selected include: Oglala Lakota, Jackson and Bennett Counties with a focus on women living within the Pine Ridge Reservation, Lawrence and Pennington Counties and Beadle County.

As a result of the initial quantitative data review, it was concluded Oglala Lakota, Jackson and Bennett Counties are at high risk of breast cancer disparities due to socioeconomic factors including high unemployment percentages, low education levels, high uninsured percentages and high poverty levels. Further, each of these counties are medically underserved.

Lawrence and Pennington Counties were defined as areas of high and highest priority with respect to the HP2020 initiative. Pennington County is only one year shorter (12 years compared to the baseline 13 years) in its predicted time to achieve death rate target. Also, Pennington County accounts for nearly 12.3 percent of all new late-stage cases in the state.

Finally, a rural county in the Affiliate's service area, Beadle County, was chosen as a target community based on low socioeconomic factors and the high percentage of minority populations. Additionally, it is not predicted to meet the HP2020 initiative for late-stage incidence.

## **Health System and Public Policy Analysis**

After conducting the Health Systems and Public Policy Analysis, it was found that the needs are great across all target communities within Komen South Dakota's service area.

Specifically, the Pine Ridge Indian Reservation has great need throughout the entire CoC because programs and services on the reservation are severely lacking. Continuing to build the outreach programs already in place will decrease the barriers found throughout the CoC in this community.

While great services and programs exist within Lawrence and Pennington Counties through access to its Cancer Care Institute, travel still remains a hurdle for rural women and the late-stage diagnosis rate continues to trend higher than the Affiliate service area as a whole. The partnership with Healing Pathways is important to Komen South Dakota and the Walking Forward program is an area in which the Affiliate could provide assistance. Education could also help eliminate delayed entry into the CoC for this community.

Beadle County offers a medical center with treatment programs, but again, travel in this rural county is an issue and considerable weakness. Through collaboration with Huron Regional Medical Center to address the unique needs of the community and the increasing minority population, gaps in language barriers and entry into the CoC could be addressed.

The Affiliate also dedicates time and resources to advocating for patient rights and continues to look for opportunities to strengthen its policy work. Collaboration between other state organizations including the American Cancer Society Cancer Action Network and the SD Department of Health, among others, will enhance the Affiliate's policy work to educate lawmakers on the importance of breast health issues.

The state has yet to expand Medicaid upon publication of this paper, thereby leaving gaps in coverage for thousands of individuals. Further, with the initial enrollment of ACA, it may be too early to tell the implications of additional insured and what it might mean for patient navigation services as new women enter the CoC.

## **Qualitative Data: Ensuring Community Input**

The qualitative data findings for Oglala Lakota, Jackson, and Bennett Counties are linked to the key assessment question: Why are women living on the Pine Ridge Reservation not utilizing CoC services? It became apparent most women over 40 do not enter the CoC because they do not get screened annually. The largest barriers are lack of Native-specific education, little accessibility to screening services, and lack of trust with providers. If a woman does receive screening, and has an abnormal mammogram, no issues were apparent regarding a woman remaining in the CoC. Therefore, the conclusions drawn in the target community of Oglala Lakota, Jackson and Bennett Counties lead to the fact women are diagnosed at a late-stage because they never enter the continuum due to lack of accessible screening sites and lack of Native-specific education. Women are often unaware of their risk due to low education levels. If they do wish to be screened, it is difficult to pay for transportation to a screening facility in this very rural area. Data collection methods used in this community included document review.

Qualitative data findings for Lawrence and Pennington were directly tied to the key assessment question: Why are women over 40 not getting screened? Fear, discomfort and cost were all determined to be barriers to screening; however, more emphasis was placed on where the responsibility for scheduling screening should be placed. Some women agreed the Primary Care Physician should schedule each patient's screening with the use of a reminder card, yet others noted women over 40 do not attend an annual physical at all, making it difficult for the provider to recommend yearly screening. A larger push for breast cancer education on various media channels was suggested by many focus group participants as a solution to this issue. Therefore, the conclusions drawn from Lawrence and Pennington Counties point to an increased need in education which encourages women to seek screening. Both at the provider level and in the community, awareness and education on the importance of early detection must be a focus. Data collection methods used in this community included focus groups and key informant interviews.

The qualitative data collected in Beadle County was based on the assessment question: Why are women over 40 not getting screened for breast cancer? The Community Profile Team confirmed the qualitative data findings were linked to this question by realizing women are afraid to get screened, have financial constraints or have language barriers which prevent health care. Therefore, the conclusions drawn surround a recent influx of linguistically isolated women including the low-income refugee population, specifically the Karen minority group, and a large Hispanic/Latino population in the community. While translation services are accessible through Lutheran Social Services and clinics such as the James Valley Community Health Center, translators are not always available to be at each appointment with the patient. Additionally, breast health is often not a focus and is outweighed by other, more basic health needs upon initial arrival in the community by refugees. Therefore, translated education must be a focus in this target community. Further, financial constraints are a barrier to care. If a mammogram is referred after a clinical breast exam, oftentimes, a woman will simply not schedule the follow-up appointment out of fear surrounding the ability to pay for it. For this reason, a focus on programs which provide free or low cost screening services must also be a priority. Data collection methods used in this community included key informant interviews and document review.

### **Mission Action Plan**

Triangulation of the data from target communities allowed the Affiliate to develop problem statements and subsequently construct priorities and objectives for each of the target communities.

#### **Oglala Lakota, Jackson and Bennett Counties with a focus on women living within the Pine Ridge Reservation**

**Problem:** The combination of poor health insurance coverage and poverty puts individuals living on American Indian reservations at a tremendous disadvantage to accessing education and screening, as indicated by the quantitative and qualitative data. These barriers are common among all American Indian populations throughout the state.

**Priority: *Support outreach and health programs which provide breast health education and services which break down cultural and language barriers for American Indian women, especially in Oglala Lakota, Jackson and Bennett Counties.***

*Objective 1:* By October 2017, collaborate with the Northern Plains Comprehensive Cancer Program to notify tribal health entities about the Affiliate's RFA and grant funding availability for American Indian reservations. A least one tribal entity who serves Oglala Lakota, Jackson and Bennett Counties will be provided with information about funding opportunities through Komen South Dakota.

*Objective 2:* By FY 2018, partner with appropriate physician education programs and organizations to create and implement a culturally sensitive training program for new and current medical providers that provide services to American Indians. A least one medical provider that serves Oglala Lakota, Jackson and Bennett Counties will complete the training program.

*Objective 3:* By October 2015, revise the Community Grant RFA to give funding priority to programs that use innovative or evidence-based approaches that result in documented linkages to breast cancer screening, diagnostic, treatment and/or supportive services among American Indian women living within Oglala Lakota, Jackson and Bennett Counties and throughout the state.

### **Lawrence and Pennington Counties**

**Problem:** A lack of education on the importance of breast health may be an impediment of early detection for women living in Lawrence and Pennington Counties as indicated by the qualitative data.

**Priority: *Promote early detection and the availability of financial assistance programs for uninsured women.***

*Objective 1:* From 2016-2019 participate in at least two health expos per year in Lawrence and Pennington Counties. Provide 500 pieces of educational material to expo attendees and speak one-on-one with 50 women about the importance of early detection.

*Objective 2:* In FY 2017 offer two 'Lunch and Learn' opportunities with local employers to provide breast health education and the opportunity for women 40+ to sign up for a mammography appointment.

**Priority: Increase provider understanding of breast self-awareness messages supported by Susan G. Komen and knowledge of various referral processes to better navigate their patients through the continuum of care.**

*Objective 1:* Work with the All Women Count! Program in FY 2017 to notify at least 10 providers in Pennington County and at least three providers in Lawrence County about the availability of screening assistance programs in their area.

### **Beadle County**

**Problem:** Women living in Beadle County struggle with language barriers and financial constraints which may prohibit early detection as indicated by the qualitative data.

**Priority: Increase breast health outreach to the Hispanic/Latina and Karen community in Beadle County.**

*Objective 1:* By October 2016 distribute bilingual educational materials to Huron Regional Medical Center, Lutheran Social Services, and at least one other local community partner located in Beadle County.

*Objective 2:* During FY 2016-2017 provide outreach via Affiliate Education Outreach Coordinator to provide 120 women with one-on-one culturally appropriate breast health education. Translate for 10 Spanish speaking women to enable sign up of mammography appointments for Hispanics/Latinas in Beadle County

**Priority: Increase education on screening financial assistance programs available to women in Beadle County.**

*Objective 1:* By October 2016, provide information about availability of financial assistance programs for uninsured women (e.g., All Women Count) to at least three support programs and/or organizations in Beadle County.

*Objective 2:* By October 2017, collaborate with the Comprehensive Cancer Control Program to establish a formal partnership with at least one large employer in Beadle County to conduct an ongoing annual breast cancer screening campaign.

**Disclaimer:** Comprehensive data for the Executive Summary can be found in the 2015 Susan G. Komen® South Dakota Community Profile Report.

# Introduction

## Affiliate History

Nancy G. Brinker promised her dying sister, Susan G. Komen, she would do everything in her power to end breast cancer forever; in 1982, that promise became the Susan G. Komen® and launched the global breast cancer movement. Today, Komen is the world's largest grassroots network of breast cancer survivors and activists.

Susan G. Komen South Dakota was created in 2005 to carry the Komen vision throughout the State of South Dakota. Since its inception, the Affiliate has granted over \$1.5 million to programs across the state which support breast health and breast cancer education, screening and treatment. As a result of the hard work of volunteers and staff members, the Affiliate has positively touched 61 of its 65 counties and impacted the lives of over 39,372 women. More than 7,928 mammograms and clinical breast exams have been provided and 177 cases of breast cancer have been detected as a result of Komen South Dakota funded grants. In 2015, the Affiliate was awarded a grant to start an educational outreach program focused on the Hispanic and Latina population in Sioux Falls with plans to expand the program to rural areas to educate minority populations.

Komen South Dakota also collaborates and partners with entities across the state such as the South Dakota Comprehensive Cancer Coalition Program to further eliminate breast cancer disparities. Komen South Dakota recognizes the importance of further collaboration with new organizations in order to make a greater impact in the state.

## Affiliate Organizational Structure

Komen South Dakota is led by an Executive Director and Affiliate Coordinator who oversee all day-to-day responsibilities of effectively operating the Affiliate (Figure 1.1). The Affiliate also receives considerable support from volunteers across the state to carry out its mission. The Affiliate is governed by the Board of Directors which currently has 11 members who oversee the strategic direction of the Affiliate. Committees of the Affiliate include a Race for the Cure® Committee, Grants Committee, Development Committee and Finance Committee.



**Figure 1.1.** Susan G. Komen South Dakota organizational chart

## **Affiliate Service Area**

Komen South Dakota serves the entire State of South Dakota, less Union County, which is served by the Susan G. Komen Siouxland (Figure 1.2). Geographic distance is something South Dakotans have addressed for years as population has declined, but continued population shifts and fewer services make it more challenging to provide quality, state-of-the-art care and ongoing survivor support programs to people in rural areas. The challenge for breast health and breast cancer support services in South Dakota exists primarily in the rural areas, with low income families, and on American Indian reservations. South Dakota has state-of-the-art breast health and cancer facilities in the metropolitan areas, but the distances that women travel to receive screening and treatment is substantial.

# KOMEN SOUTH DAKOTA SERVICE AREA

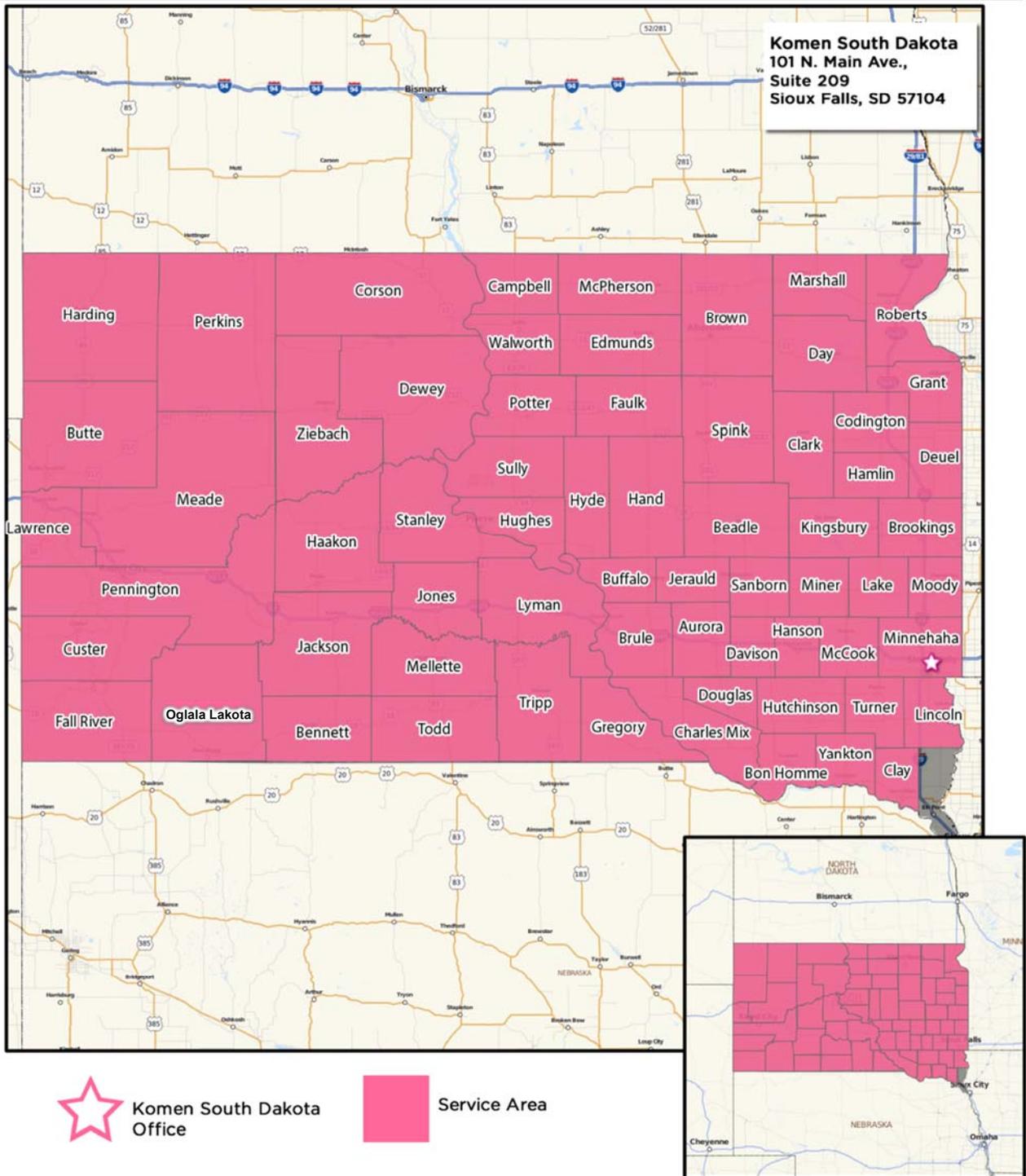


Figure 1.2. Susan G. Komen South Dakota service area

## **Purpose of the Community Profile Report**

To meet the promise, Komen South Dakota relies on the Community Profile process to guide its work. The Community Profile includes an overview of demographic and breast cancer statistics which highlight target areas, groups or issues. The statistics pinpoint where efforts will have the most impact. To ensure effective and targeted efforts, it is important to also understand what programs and services gaps, needs and barriers exist. The purpose of this Community Profile Report will not only drive grantmaking priorities but will also:

- 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

The report will be available for download on the Affiliate's webpage and could also be distributed through channels such as the South Dakota Comprehensive Cancer Control Program and health care systems around the state.

# Quantitative Data: Measuring Breast Cancer Impact in Local Communities

## Quantitative Data Report

### Introduction

The purpose of the quantitative data report for Susan G. Komen® South Dakota 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® South Dakota'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	Female Population (Annual Average)	Incidence Rates and Trends			Death Rates and Trends			Late-stage Rates and Trends		
		# 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	182,234	122.1	-0.2%	40,736	22.6	-1.9%	64,590	43.8	-1.2%
HP2020	-	-	-	-	-	20.6*	-	-	41.0*	-
South Dakota	400,083	548	117.9	-1.0%	105	20.3	-2.2%	200	44.1	-0.3%
Komen South Dakota Service Area	393,137	535	117.3	-0.9%	103	20.3	NA	195	43.7	-0.3%
White	346,323	505	117.9	-0.7%	100	20.6	NA	182	43.8	0.0%
Black/African-American	4,878	SN	SN	SN	SN	SN	SN	SN	SN	SN
American Indian/Alaska Native (AIAN)	37,778	26	115.1	-7.5%	4	17.1	NA	10	43.1	-13.4%
Asian Pacific Islander (API)	4,158	SN	SN	SN	SN	SN	SN	SN	SN	SN
Non-Hispanic/ Latina	383,846	533	117.9	-1.0%	103	20.4	NA	194	44.0	-0.4%
Hispanic/ Latina	9,291	SN	SN	SN	SN	SN	SN	SN	SN	SN
Aurora County - SD	1,354	3	167.9	19.9%	SN	SN	SN	SN	SN	SN
Beadle County - SD	8,411	10	93.7	-1.0%	3	24.4	NA	4	38.9	6.0%
Bennett County - SD	1,751	SN	SN	SN	SN	SN	SN	SN	SN	SN
Bon Homme County - SD	2,954	4	95.1	5.9%	SN	SN	SN	SN	SN	SN
Brookings County - SD	15,313	13	102.1	-11.4%	3	23.0	NA	5	42.3	-15.6%
Brown County - SD	18,531	29	129.4	-10.2%	7	25.6	-2.5%	11	52.2	-0.2%
Brule County - SD	2,627	4	106.1	3.2%	SN	SN	SN	SN	SN	SN
Buffalo County - SD	1,001	SN	SN	SN	SN	SN	SN	SN	SN	SN
Butte County - SD	4,939	7	104.3	3.5%	SN	SN	SN	SN	SN	SN
Campbell County - SD	741	SN	SN	SN	SN	SN	SN	SN	SN	SN
Charles Mix County - SD	4,613	9	156.0	-14.1%	SN	SN	SN	SN	SN	SN
Clark County - SD	1,844	SN	SN	SN	SN	SN	SN	SN	SN	SN
Clay County - SD	7,080	6	101.9	-5.5%	SN	SN	SN	SN	SN	SN
Codington County - SD	13,580	17	101.3	-6.2%	SN	SN	SN	6	34.2	-6.5%
Corson County - SD	1,998	SN	SN	SN	SN	SN	SN	SN	SN	SN
Custer County - SD	4,000	5	82.0	-10.5%	SN	SN	SN	SN	SN	SN
Davison County - SD	9,813	12	97.8	8.8%	3	20.1	NA	6	42.8	-13.0%
Day County - SD	2,858	7	152.0	30.1%	SN	SN	SN	SN	SN	SN
Deuel County - SD	2,146	SN	SN	SN	SN	SN	SN	SN	SN	SN
Dewey County - SD	2,722	SN	SN	SN	SN	SN	SN	SN	SN	SN
Douglas County - SD	1,520	3	157.5	-10.0%	SN	SN	SN	SN	SN	SN
Edmunds County - SD	1,999	3	115.3	NA	SN	SN	SN	SN	SN	SN

Population Group	Female Population (Annual Average)	Incidence Rates and Trends			Death Rates and Trends			Late-stage Rates and Trends		
		# 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)
Fall River County - SD	3,470	7	113.1	-10.1%	SN	SN	SN	SN	SN	SN
Faulk County - SD	1,192	SN	SN	SN	SN	SN	SN	SN	SN	SN
Grant County - SD	3,657	6	106.1	5.6%	SN	SN	SN	SN	SN	SN
Gregory County - SD	2,129	SN	SN	SN	SN	SN	SN	SN	SN	SN
Haakon County - SD	965	SN	SN	SN	SN	SN	SN	SN	SN	SN
Hamlin County - SD	2,876	4	128.5	-2.9%	SN	SN	SN	SN	SN	SN
Hand County - SD	1,726	SN	SN	SN	SN	SN	SN	SN	SN	SN
Hanson County - SD	1,680	SN	SN	SN	SN	SN	SN	SN	SN	SN
Harding County - SD	613	SN	SN	SN	SN	SN	SN	SN	SN	SN
Hughes County - SD	8,677	14	135.1	12.7%	SN	SN	SN	6	57.7	-3.4%
Hutchinson County - SD	3,803	6	104.2	-3.0%	SN	SN	SN	SN	SN	SN
Hyde County - SD	691	SN	SN	SN	SN	SN	SN	SN	SN	SN
Jackson County - SD	1,480	SN	SN	SN	SN	SN	SN	SN	SN	SN
Jerauld County - SD	1,050	SN	SN	SN	SN	SN	SN	SN	SN	SN
Jones County - SD	505	SN	SN	SN	SN	SN	SN	SN	SN	SN
Kingsbury County - SD	2,563	5	126.2	36.9%	SN	SN	SN	SN	SN	SN
Lake County - SD	5,424	9	136.0	0.5%	SN	SN	SN	4	57.2	13.2%
Lawrence County - SD	11,962	15	101.2	-2.1%	6	31.4	3.4%	5	37.4	1.2%
Lincoln County - SD	20,776	24	125.9	-8.3%	4	21.1	-0.8%	9	49.1	-19.5%
Lyman County - SD	1,764	5	222.7	-7.6%	SN	SN	SN	SN	SN	SN
McCook County - SD	2,818	3	93.0	2.5%	SN	SN	SN	SN	SN	SN
McPherson County - SD	1,288	SN	SN	SN	SN	SN	SN	SN	SN	SN
Marshall County - SD	2,138	SN	SN	SN	SN	SN	SN	SN	SN	SN
Meade County - SD	12,332	13	100.8	-8.0%	4	26.7	NA	5	38.9	0.3%
Mellette County - SD	999	SN	SN	SN	SN	SN	SN	SN	SN	SN
Miner County - SD	1,200	SN	SN	SN	SN	SN	SN	SN	SN	SN
Minnehaha County - SD	83,177	123	141.6	2.2%	18	19.2	-3.5%	41	47.7	3.6%
Moody County - SD	3,246	4	107.0	4.9%	SN	SN	SN	SN	SN	SN
Oglala Lakota County - SD	6,769	5	104.9	-2.0%	SN	SN	SN	SN	SN	SN
Pennington County - SD	49,233	71	130.2	-0.6%	14	24.3	-1.4%	27	50.5	-1.2%
Perkins County - SD	1,476	SN	SN	SN	SN	SN	SN	SN	SN	SN
Potter County - SD	1,192	SN	SN	SN	SN	SN	SN	SN	SN	SN
Roberts County - SD	5,031	5	79.8	-28.4%	SN	SN	SN	SN	SN	SN
Sanborn County - SD	1,147	SN	SN	SN	SN	SN	SN	SN	SN	SN
Spink County - SD	3,227	5	97.8	-15.0%	SN	SN	SN	SN	SN	SN
Stanley County - SD	1,449	SN	SN	SN	SN	SN	SN	SN	SN	SN

Population Group	Female Population (Annual Average)	Incidence Rates and Trends			Death Rates and Trends			Late-stage Rates and Trends		
		# 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)
Sully County - SD	662	SN	SN	SN	SN	SN	SN	SN	SN	SN
Todd County - SD	4,873	SN	SN	SN	SN	SN	SN	SN	SN	SN
Tripp County - SD	2,935	5	122.3	-14.0%	SN	SN	SN	SN	SN	SN
Turner County - SD	4,182	7	104.9	-11.6%	SN	SN	SN	SN	SN	SN
Walworth County - SD	2,764	5	116.1	9.4%	SN	SN	SN	SN	SN	SN
Yankton County - SD	10,800	16	113.8	7.8%	SN	SN	SN	4	27.3	7.4%
Ziebach County - SD	1,403	SN	SN	SN	SN	SN	SN	SN	SN	SN

\*Target as of the writing of this report.

NA – data not available.

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

Data are for years 2006-2010.

Rates are in cases or deaths per 100,000.

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

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

Source of death rate data: Centers for Disease Control and Prevention (CDC) – National Center for Health Statistics (NCHS) 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 South Dakota service area was slightly lower than that observed in the US as a whole and the incidence trend was lower than the US as a whole. The incidence rate and trend of the Affiliate service area were not significantly different than that observed for the State of South Dakota.

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

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

- Lyman County
- Minnehaha 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 South Dakota 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 South Dakota.

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 lower among AIANs than Whites. There were not enough data available within the Affiliate service area to report on Blacks/African-Americans and APIs so comparisons cannot be made for these racial groups. Also, there were not enough data available within the Affiliate service area to report on Hispanics/Latinas so comparisons cannot be made for this group.

**Significantly less favorable trends** in breast cancer death rates were observed in the following county:

- Lawrence 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 South Dakota service area was similar to that observed in the US as a whole and the late-stage incidence trend was higher than the US as a whole. The late-stage incidence rate and trend of the Affiliate service area were not significantly different than that observed for the State of South Dakota.

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 about the same among AIANs and Whites. There were not enough data available within the Affiliate service area to report on Blacks/African-Americans and APIs so comparisons cannot be made for these racial groups. Also, there were not enough data available within the Affiliate service area to report on Hispanics/Latinas so comparisons cannot be made for this group.

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

### **Mammography Screening**

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

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

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%
South Dakota	2,816	2,177	77.1%	75.1%-78.9%
Komen South Dakota Service Area	2,123	1,680	79.1%	76.8%-81.2%
White	2,088	1,650	79.3%	77.0%-81.3%
Black/African-American	SN	SN	SN	SN
AIAN	20	18	88.9%	59.8%-97.7%
API	SN	SN	SN	SN
Hispanic/ Latina	16	11	60.5%	23.5%-88.4%
Non-Hispanic/ Latina	2,106	1,669	79.3%	77.0%-81.4%
Aurora County - SD	SN	SN	SN	SN
Beadle County - SD	210	153	78.8%	70.8%-85.1%
Bennett County - SD	SN	SN	SN	SN
Bon Homme County - SD	SN	SN	SN	SN
Brookings County - SD	159	134	81.0%	71.6%-87.8%
Brown County - SD	186	165	89.8%	82.8%-94.1%
Brule County - SD	SN	SN	SN	SN
Buffalo County - SD	SN	SN	SN	SN
Butte County - SD	SN	SN	SN	SN
Campbell County - SD	SN	SN	SN	SN
Charles Mix County - SD	SN	SN	SN	SN
Clark County - SD	SN	SN	SN	SN
Clay County - SD	SN	SN	SN	SN
Codington County - SD	177	142	82.5%	74.1%-88.6%
Corson County - SD	SN	SN	SN	SN
Custer County - SD	SN	SN	SN	SN
Davison County - SD	160	127	78.2%	69.0%-85.3%

<b>Population Group</b>	<b># of Women Interviewed (Sample Size)</b>	<b># w/ Self-Reported Mammogram</b>	<b>Proportion Screened (Weighted Average)</b>	<b>Confidence Interval of Proportion Screened</b>
Day County - SD	SN	SN	SN	SN
Deuel County - SD	SN	SN	SN	SN
Dewey County - SD	SN	SN	SN	SN
Douglas County - SD	SN	SN	SN	SN
Edmunds County - SD	SN	SN	SN	SN
Fall River County - SD	SN	SN	SN	SN
Faulk County - SD	SN	SN	SN	SN
Grant County - SD	SN	SN	SN	SN
Gregory County - SD	SN	SN	SN	SN
Haakon County - SD	SN	SN	SN	SN
Hamlin County - SD	SN	SN	SN	SN
Hand County - SD	SN	SN	SN	SN
Hanson County - SD	SN	SN	SN	SN
Harding County - SD	SN	SN	SN	SN
Hughes County - SD	163	136	84.4%	75.1%-90.7%
Hutchinson County - SD	SN	SN	SN	SN
Hyde County - SD	SN	SN	SN	SN
Jackson County - SD	SN	SN	SN	SN
Jerauld County - SD	SN	SN	SN	SN
Jones County - SD	SN	SN	SN	SN
Kingsbury County - SD	SN	SN	SN	SN
Lake County - SD	SN	SN	SN	SN
Lawrence County - SD	171	127	75.3%	66.2%-82.6%
Lincoln County - SD	139	110	79.6%	70.7%-86.3%
Lyman County - SD	SN	SN	SN	SN
Marshall County - SD	SN	SN	SN	SN
McCook County - SD	SN	SN	SN	SN
McPherson County - SD	SN	SN	SN	SN
Meade County - SD	171	118	69.8%	60.4%-77.7%
Mellette County - SD	SN	SN	SN	SN
Miner County - SD	SN	SN	SN	SN
Minnehaha County - SD	218	179	78.3%	71.8%-83.7%
Moody County - SD	SN	SN	SN	SN
Oglala Lakota County - SD	SN	SN	SN	SN
Pennington County - SD	183	138	75.8%	68.4%-82.0%
Perkins County - SD	SN	SN	SN	SN
Potter County - SD	SN	SN	SN	SN
Roberts County - SD	SN	SN	SN	SN

Population Group	# of Women Interviewed (Sample Size)	# w/ Self-Reported Mammogram	Proportion Screened (Weighted Average)	Confidence Interval of Proportion Screened
Sanborn County - SD	SN	SN	SN	SN
Spink County - SD	SN	SN	SN	SN
Stanley County - SD	SN	SN	SN	SN
Sully County - SD	SN	SN	SN	SN
Todd County - SD	SN	SN	SN	SN
Tripp County - SD	SN	SN	SN	SN
Turner County - SD	SN	SN	SN	SN
Walworth County - SD	SN	SN	SN	SN
Yankton County - SD	181	147	84.5%	76.8%-90.0%
Ziebach County - SD	SN	SN	SN	SN

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

Data are for 2012.

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

***Breast cancer screening proportions summary***

The breast cancer screening proportion in the Komen South Dakota service area was not significantly different than that observed in the US as a whole. The screening proportion of the Affiliate service area was not significantly different than the State of South Dakota.

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 AIANs than Whites. There were not enough data available within the Affiliate service area to report on Blacks/African-Americans and APIs so comparisons cannot be made for these racial groups. The screening proportion among Hispanics/Latinas was not significantly different than among Non-Hispanics/Latinas.

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

- Brown County

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

**Population Characteristics**

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

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

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

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

**Table 2.4.** Population characteristics – demographics

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 %
South Dakota	87.7 %	1.5 %	9.6 %	1.2 %	97.3 %	2.7 %	48.1 %	35.9 %	16.2 %
Komen South Dakota Service Area	87.5 %	1.5 %	9.7 %	1.2 %	97.3 %	2.7 %	48.1 %	35.9 %	16.2 %
Aurora County - SD	97.3 %	0.4 %	1.7 %	0.5 %	97.0 %	3.0 %	54.3 %	42.5 %	22.0 %
Beadle County - SD	92.7 %	1.6 %	1.6 %	4.2 %	92.9 %	7.1 %	52.8 %	40.2 %	19.4 %
Bennett County - SD	34.5 %	0.8 %	63.9 %	0.9 %	97.3 %	2.7 %	39.8 %	28.5 %	11.7 %
Bon Homme County - SD	97.7 %	0.4 %	1.7 %	0.2 %	98.9 %	1.1 %	59.0 %	46.3 %	25.3 %
Brookings County - SD	95.2 %	0.9 %	1.3 %	2.5 %	98.0 %	2.0 %	35.8 %	26.5 %	11.5 %
Brown County - SD	94.3 %	0.7 %	3.7 %	1.3 %	98.6 %	1.4 %	50.2 %	38.4 %	18.0 %
Brule County - SD	88.3 %	0.4 %	11.0 %	0.4 %	98.3 %	1.7 %	52.3 %	39.2 %	18.8 %
Buffalo County - SD	17.7 %	0.4 %	81.6 %	0.3 %	97.0 %	3.0 %	31.5 %	20.8 %	7.6 %
Butte County - SD	96.4 %	0.5 %	2.6 %	0.4 %	97.0 %	3.0 %	52.1 %	39.2 %	16.8 %
Campbell County - SD	98.3 %	0.4 %	0.7 %	0.6 %	98.0 %	2.0 %	67.1 %	52.5 %	29.0 %
Charles Mix County - SD	65.7 %	0.3 %	33.6 %	0.3 %	97.7 %	2.3 %	48.6 %	37.0 %	18.9 %
Clark County - SD	99.5 %	0.2 %	0.2 %	0.1 %	98.2 %	1.8 %	57.3 %	45.8 %	24.5 %
Clay County - SD	92.4 %	1.4 %	4.0 %	2.1 %	97.9 %	2.1 %	32.9 %	24.1 %	11.0 %
Codington County - SD	96.4 %	0.5 %	2.4 %	0.7 %	98.5 %	1.5 %	49.5 %	36.8 %	17.0 %
Corson County - SD	29.9 %	0.2 %	69.3 %	0.5 %	97.2 %	2.8 %	38.3 %	27.4 %	10.8 %
Custer County - SD	95.1 %	0.5 %	3.9 %	0.5 %	97.8 %	2.2 %	65.3 %	53.5 %	22.6 %
Davison County - SD	95.5 %	0.8 %	3.0 %	0.7 %	98.6 %	1.4 %	51.3 %	40.4 %	20.4 %
Day County - SD	88.9 %	0.4 %	10.4 %	0.4 %	99.2 %	0.8 %	60.1 %	47.9 %	25.1 %
Deuel County - SD	99.0 %	0.4 %	0.4 %	0.2 %	97.6 %	2.4 %	56.1 %	42.5 %	21.0 %
Dewey County - SD	23.0 %	0.5 %	76.2 %	0.2 %	98.1 %	1.9 %	39.3 %	26.8 %	10.2 %
Douglas County - SD	97.0 %	0.7 %	2.2 %	0.1 %	98.9 %	1.1 %	59.5 %	48.0 %	26.5 %
Edmunds County - SD	98.9 %	0.2 %	0.6 %	0.3 %	98.6 %	1.4 %	57.8 %	44.2 %	23.0 %
Fall River County - SD	90.6 %	0.7 %	8.1 %	0.6 %	97.4 %	2.6 %	64.8 %	53.5 %	25.4 %
Faulk County - SD	99.3 %	0.3 %	0.2 %	0.2 %	99.2 %	0.8 %	57.7 %	45.8 %	24.3 %
Grant County - SD	98.4 %	0.3 %	0.8 %	0.5 %	98.0 %	2.0 %	57.5 %	44.6 %	21.1 %
Gregory County - SD	91.0 %	0.4 %	8.1 %	0.5 %	99.2 %	0.8 %	61.3 %	50.5 %	27.2 %
Haakon County - SD	96.2 %	1.2 %	2.1 %	0.5 %	99.2 %	0.8 %	58.5 %	50.2 %	25.0 %
Hamlin County - SD	98.6 %	0.5 %	0.5 %	0.4 %	97.8 %	2.2 %	48.1 %	36.6 %	19.8 %
Hand County - SD	98.7 %	0.5 %	0.2 %	0.6 %	99.5 %	0.5 %	61.8 %	49.5 %	27.6 %
Hanson County - SD	98.4 %	0.3 %	0.7 %	0.5 %	99.0 %	1.0 %	45.2 %	32.7 %	14.5 %
Harding County - SD	98.8 %	0.3 %	0.8 %	0.0 %	98.8 %	1.2 %	54.2 %	40.6 %	15.1 %
Hughes County - SD	85.8 %	1.1 %	12.4 %	0.7 %	97.7 %	2.3 %	50.5 %	36.2 %	14.7 %
Hutchinson County - SD	97.9 %	0.8 %	1.1 %	0.2 %	98.5 %	1.5 %	58.4 %	47.6 %	28.1 %
Hyde County - SD	91.3 %	1.0 %	7.4 %	0.3 %	98.8 %	1.2 %	59.6 %	48.1 %	24.7 %

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
Jackson County - SD	42.8 %	1.1 %	56.0 %	0.1 %	97.7 %	2.3 %	41.0 %	29.8 %	13.5 %
Jerauld County - SD	98.3 %	0.8 %	0.4 %	0.6 %	95.7 %	4.3 %	60.2 %	50.5 %	28.8 %
Jones County - SD	96.4 %	0.8 %	2.6 %	0.2 %	98.4 %	1.6 %	56.7 %	44.3 %	22.5 %
Kingsbury County - SD	98.3 %	0.6 %	0.7 %	0.5 %	98.5 %	1.5 %	58.5 %	46.3 %	24.4 %
Lake County - SD	97.4 %	0.8 %	1.0 %	0.9 %	98.7 %	1.3 %	54.1 %	42.5 %	18.9 %
Lawrence County - SD	95.5 %	0.7 %	3.0 %	0.9 %	97.4 %	2.6 %	52.2 %	41.1 %	18.4 %
Lincoln County - SD	97.0 %	1.0 %	0.7 %	1.3 %	98.6 %	1.4 %	39.5 %	26.5 %	10.0 %
Lyman County - SD	60.0 %	0.8 %	38.8 %	0.4 %	98.6 %	1.4 %	49.3 %	37.0 %	17.0 %
McCook County - SD	98.7 %	0.3 %	0.8 %	0.3 %	98.5 %	1.5 %	54.2 %	42.3 %	21.7 %
McPherson County - SD	99.1 %	0.2 %	0.2 %	0.5 %	98.6 %	1.4 %	62.8 %	51.8 %	33.5 %
Marshall County - SD	90.4 %	0.7 %	8.7 %	0.2 %	97.3 %	2.7 %	58.1 %	46.0 %	22.7 %
Meade County - SD	93.9 %	1.7 %	3.4 %	1.0 %	97.0 %	3.0 %	47.6 %	34.8 %	13.7 %
Mellette County - SD	41.9 %	0.8 %	56.9 %	0.4 %	98.0 %	2.0 %	43.1 %	31.0 %	13.8 %
Miner County - SD	98.6 %	0.5 %	0.3 %	0.6 %	98.5 %	1.5 %	59.5 %	47.8 %	26.4 %
Minnehaha County - SD	91.4 %	3.9 %	2.9 %	1.9 %	96.0 %	4.0 %	44.9 %	31.7 %	13.1 %
Moody County - SD	82.1 %	1.1 %	15.6 %	1.2 %	98.1 %	1.9 %	52.1 %	39.4 %	17.3 %
Oglala Lakota County - SD	5.6 %	0.4 %	93.6 %	0.5 %	97.1 %	2.9 %	30.4 %	20.0 %	7.2 %
Pennington County - SD	85.9 %	1.5 %	11.1 %	1.4 %	96.1 %	3.9 %	48.3 %	36.1 %	15.5 %
Perkins County - SD	98.0 %	0.5 %	1.4 %	0.1 %	99.4 %	0.6 %	61.2 %	49.4 %	24.2 %
Potter County - SD	97.8 %	0.6 %	1.1 %	0.6 %	99.2 %	0.8 %	64.4 %	52.6 %	28.8 %
Roberts County - SD	61.7 %	0.5 %	37.4 %	0.4 %	98.4 %	1.6 %	49.6 %	37.6 %	18.6 %
Sanborn County - SD	98.5 %	0.4 %	0.7 %	0.4 %	98.5 %	1.5 %	60.1 %	48.4 %	23.8 %
Spink County - SD	97.7 %	0.6 %	1.5 %	0.2 %	98.9 %	1.1 %	55.8 %	44.1 %	22.3 %
Stanley County - SD	91.3 %	0.5 %	8.0 %	0.2 %	99.2 %	0.8 %	55.4 %	40.1 %	17.0 %
Sully County - SD	98.4 %	0.5 %	1.1 %	0.0 %	99.2 %	0.8 %	59.3 %	45.5 %	21.4 %
Todd County - SD	10.8 %	0.3 %	88.6 %	0.3 %	97.3 %	2.7 %	30.1 %	19.9 %	6.2 %
Tripp County - SD	84.4 %	0.5 %	14.9 %	0.2 %	98.8 %	1.2 %	57.6 %	44.8 %	23.6 %
Turner County - SD	98.5 %	0.3 %	1.0 %	0.1 %	98.5 %	1.5 %	55.7 %	43.0 %	21.6 %
Walworth County - SD	83.8 %	0.5 %	15.3 %	0.4 %	99.0 %	1.0 %	58.3 %	47.6 %	26.3 %
Yankton County - SD	96.0 %	0.9 %	2.4 %	0.7 %	97.8 %	2.2 %	53.5 %	40.8 %	19.6 %
Ziebach County - SD	21.7 %	0.5 %	77.4 %	0.5 %	96.2 %	3.8 %	33.4 %	21.3 %	6.3 %

Data are for 2011.

Data are in the percentage of women in the population.

Source: US Census Bureau – Population Estimates

**Table 2.5. Population characteristics – socioeconomics**

Population Group	Less than HS Education	Income Below 100% Poverty	Income Below 250% Poverty (Age: 40-64)	Un-employed	Foreign Born	Linguistic-ally Isolated	In Rural Areas	In Medically Under-served Areas	No Health Insurance (Age: 40-64)
US	14.6 %	14.3 %	33.3 %	8.7 %	12.8 %	4.7 %	19.3 %	23.3 %	16.6 %
South Dakota	10.2 %	13.8 %	30.0 %	4.8 %	2.4 %	1.0 %	43.3 %	31.0 %	13.0 %
Komen South Dakota Service Area	10.3 %	13.9 %	30.3 %	5.0 %	2.4 %	1.0 %	43.0 %	29.7 %	13.1 %
Aurora County - SD	10.8 %	7.9 %	33.1 %	2.4 %	0.7 %	0.8 %	100.0 %	100.0 %	15.3 %
Beadle County - SD	16.3 %	12.8 %	31.5 %	3.6 %	5.8 %	2.4 %	27.4 %	0.0 %	13.5 %
Bennett County - SD	19.3 %	35.5 %	55.8 %	20.3 %	0.6 %	0.0 %	100.0 %	100.0 %	23.8 %
Bon Homme County - SD	14.6 %	12.1 %	34.5 %	1.9 %	1.2 %	0.5 %	100.0 %	100.0 %	13.4 %
Brookings County - SD	7.6 %	18.8 %	24.3 %	4.5 %	4.0 %	0.9 %	29.7 %	0.1 %	10.8 %
Brown County - SD	8.7 %	9.7 %	25.5 %	2.5 %	1.1 %	0.3 %	28.9 %	25.3 %	10.6 %
Brule County - SD	12.3 %	9.4 %	33.1 %	2.8 %	0.0 %	0.3 %	100.0 %	0.0 %	15.9 %
Buffalo County - SD	21.8 %	40.8 %	68.3 %	28.1 %	1.7 %	0.0 %	100.0 %	100.0 %	24.8 %
Butte County - SD	13.5 %	15.0 %	38.2 %	4.7 %	0.7 %	0.2 %	48.2 %	100.0 %	17.3 %
Campbell County - SD	16.6 %	11.2 %	30.6 %	3.7 %	1.2 %	1.6 %	100.0 %	100.0 %	13.4 %
Charles Mix County - SD	16.1 %	24.1 %	42.5 %	8.1 %	0.4 %	0.2 %	100.0 %	100.0 %	19.2 %
Clark County - SD	13.7 %	15.7 %	33.2 %	3.6 %	1.6 %	0.5 %	100.0 %	100.0 %	15.7 %
Clay County - SD	5.4 %	24.3 %	32.7 %	6.6 %	2.8 %	1.5 %	24.3 %	0.0 %	12.7 %
Codington County - SD	9.9 %	13.0 %	29.2 %	4.2 %	0.9 %	0.1 %	22.5 %	0.0 %	11.5 %
Corson County - SD	15.7 %	38.8 %	59.6 %	20.3 %	0.6 %	0.0 %	100.0 %	100.0 %	24.1 %
Custer County - SD	7.5 %	9.4 %	28.3 %	2.6 %	1.0 %	0.5 %	100.0 %	100.0 %	13.0 %
Davison County - SD	11.1 %	12.0 %	31.2 %	3.3 %	1.4 %	0.8 %	23.3 %	0.0 %	11.8 %
Day County - SD	11.9 %	16.7 %	39.7 %	6.0 %	0.5 %	0.2 %	100.0 %	100.0 %	17.8 %
Deuel County - SD	15.5 %	5.4 %	30.5 %	4.8 %	1.8 %	0.9 %	100.0 %	100.0 %	13.5 %
Dewey County - SD	22.6 %	30.3 %	54.1 %	20.3 %	0.2 %	0.0 %	64.1 %	100.0 %	28.8 %
Douglas County - SD	23.4 %	11.3 %	31.3 %	2.5 %	0.7 %	1.1 %	100.0 %	100.0 %	15.0 %
Edmunds County - SD	14.7 %	12.4 %	26.5 %	1.9 %	0.8 %	3.7 %	100.0 %	100.0 %	12.3 %
Fall River County - SD	10.0 %	14.2 %	36.5 %	6.4 %	2.0 %	0.0 %	50.0 %	4.3 %	15.8 %
Faulk County - SD	14.2 %	16.5 %	29.2 %	2.4 %	1.1 %	0.0 %	100.0 %	100.0 %	13.4 %
Grant County - SD	14.2 %	12.6 %	28.6 %	3.4 %	1.3 %	2.3 %	55.4 %	14.0 %	12.7 %
Gregory County - SD	13.4 %	15.1 %	42.2 %	3.9 %	0.9 %	0.0 %	100.0 %	100.0 %	20.1 %
Haakon County - SD	7.0 %	11.3 %	35.7 %	2.4 %	0.5 %	0.0 %	100.0 %	39.3 %	18.1 %
Hamlin County - SD	11.6 %	7.3 %	31.4 %	4.3 %	1.6 %	0.9 %	100.0 %	100.0 %	14.0 %
Hand County - SD	12.9 %	14.0 %	30.9 %	1.0 %	1.4 %	0.0 %	100.0 %	100.0 %	13.1 %
Hanson County - SD	12.5 %	15.1 %	29.3 %	2.9 %	0.1 %	0.7 %	100.0 %	100.0 %	13.9 %
Harding County - SD	12.0 %	12.8 %	35.8 %	2.0 %	1.6 %	2.1 %	100.0 %	100.0 %	18.2 %
Hughes County - SD	6.6 %	9.7 %	23.1 %	2.0 %	1.3 %	0.6 %	25.3 %	0.0 %	11.4 %
Hutchinson County - SD	18.6 %	11.8 %	28.9 %	1.7 %	1.2 %	0.6 %	100.0 %	100.0 %	13.1 %
Hyde County - SD	13.4 %	10.5 %	30.1 %	3.6 %	0.4 %	1.0 %	100.0 %	100.0 %	14.0 %
Jackson County - SD	14.1 %	31.8 %	55.3 %	18.5 %	0.0 %	0.7 %	100.0 %	100.0 %	25.3 %
Jerauld County - SD	16.6 %	11.1 %	32.2 %	2.6 %	3.6 %	1.4 %	100.0 %	100.0 %	11.6 %
Jones County - SD	10.3 %	10.6 %	38.3 %	4.2 %	1.1 %	0.0 %	100.0 %	100.0 %	20.3 %
Kingsbury County - SD	11.4 %	9.0 %	31.1 %	1.6 %	1.0 %	0.0 %	100.0 %	100.0 %	12.0 %
Lake County - SD	8.3 %	13.1 %	26.3 %	3.9 %	1.6 %	0.4 %	44.9 %	0.0 %	10.2 %

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)
Lawrence County - SD	7.3 %	14.1 %	30.0 %	4.5 %	1.4 %	0.1 %	36.9 %	0.0 %	12.8 %
Lincoln County - SD	4.6 %	5.1 %	16.2 %	2.2 %	1.7 %	0.1 %	29.3 %	0.7 %	7.7 %
Lyman County - SD	14.0 %	17.7 %	44.9 %	12.1 %	0.5 %	0.5 %	100.0 %	100.0 %	22.0 %
McCook County - SD	7.7 %	7.1 %	30.1 %	3.3 %	1.3 %	0.0 %	100.0 %	100.0 %	13.0 %
McPherson County - SD	26.8 %	19.3 %	33.5 %	2.0 %	0.9 %	4.3 %	100.0 %	100.0 %	16.4 %
Marshall County - SD	13.4 %	19.6 %	30.7 %	3.4 %	0.8 %	0.6 %	100.0 %	100.0 %	15.4 %
Meade County - SD	7.6 %	12.1 %	31.7 %	3.9 %	1.8 %	0.8 %	38.0 %	19.0 %	14.2 %
Mellette County - SD	17.4 %	34.2 %	57.5 %	16.1 %	0.3 %	0.0 %	100.0 %	100.0 %	24.8 %
Miner County - SD	11.8 %	7.8 %	29.7 %	2.9 %	0.6 %	0.1 %	100.0 %	100.0 %	12.6 %
Minnehaha County - SD	9.2 %	10.3 %	26.4 %	4.3 %	5.5 %	2.3 %	13.6 %	2.5 %	11.4 %
Moody County - SD	9.9 %	9.9 %	28.8 %	3.5 %	1.6 %	0.8 %	100.0 %	100.0 %	14.5 %
Oglala Lakota County - SD	22.0 %	53.5 %	69.0 %	20.2 %	0.1 %	0.0 %	80.0 %	100.0 %	20.0 %
Pennington County - SD	8.3 %	13.1 %	29.4 %	6.2 %	2.1 %	0.9 %	20.8 %	20.7 %	13.0 %
Perkins County - SD	12.6 %	13.5 %	41.0 %	1.8 %	0.9 %	0.0 %	100.0 %	100.0 %	20.6 %
Potter County - SD	13.1 %	10.7 %	28.0 %	0.8 %	0.6 %	0.7 %	100.0 %	100.0 %	12.5 %
Roberts County - SD	12.7 %	21.2 %	40.8 %	6.8 %	1.1 %	0.4 %	100.0 %	100.0 %	17.9 %
Sanborn County - SD	12.8 %	13.6 %	33.1 %	1.7 %	1.9 %	1.4 %	100.0 %	100.0 %	15.3 %
Spink County - SD	13.5 %	13.9 %	28.1 %	2.0 %	1.4 %	0.8 %	100.0 %	0.0 %	11.9 %
Stanley County - SD	9.1 %	11.5 %	25.9 %	3.8 %	0.3 %	0.0 %	42.5 %	100.0 %	14.0 %
Sully County - SD	7.3 %	7.2 %	23.0 %	1.9 %	1.2 %	0.0 %	100.0 %	100.0 %	12.6 %
Todd County - SD	20.3 %	48.4 %	67.6 %	23.6 %	0.3 %	0.9 %	100.0 %	100.0 %	19.5 %
Tripp County - SD	12.2 %	18.6 %	38.4 %	4.7 %	0.2 %	0.0 %	48.5 %	100.0 %	18.7 %
Turner County - SD	9.1 %	7.3 %	28.4 %	2.2 %	0.5 %	0.6 %	100.0 %	0.4 %	11.9 %
Walworth County - SD	13.7 %	13.7 %	33.5 %	6.3 %	0.8 %	0.8 %	36.4 %	0.0 %	15.6 %
Yankton County - SD	11.0 %	10.4 %	30.8 %	3.5 %	2.2 %	0.6 %	34.8 %	0.0 %	12.6 %
Ziebach County - SD	18.5 %	43.5 %	58.6 %	27.1 %	1.0 %	3.3 %	73.5 %	100.0 %	23.6 %

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 South Dakota service area has a substantially larger White female population than the US as a whole, a substantially smaller Black/African-American female population, a substantially smaller Asian and Pacific Islander (API) female population, a substantially larger American Indian and Alaska Native (AIAN) female population, and a substantially smaller 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 slightly higher than those of the US as a whole. There are a substantially smaller percentage of people who are unemployed in the Affiliate service area. The Affiliate service area has a substantially smaller percentage of people who are foreign born and a substantially 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 larger percentage of people living in medically underserved areas.

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

- Bennett County
- Buffalo County
- Charles Mix County
- Corson County
- Dewey County
- Jackson County
- Lyman County
- Mellette County
- Moody County
- Oglala Lakota County
- Roberts County
- Todd County
- Tripp County
- Walworth County
- Ziebach County

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

- Aurora County
- Bon Homme County
- Campbell County
- Clark County
- Custer County
- Day County
- Douglas County
- Edmunds County
- Fall River County
- Faulk County
- Gregory County
- Haakon County
- Hand County

- Hutchinson County
- Hyde County
- Jerauld County
- Jones County
- Kingsbury County
- McCook County
- McPherson County
- Marshall County
- Miner County
- Perkins County
- Potter County
- Sanborn County
- Spink County
- Sully County
- Tripp County
- Turner County
- Walworth County

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

- Beadle County
- Bennett County
- Buffalo County
- Campbell County
- Charles Mix County
- Corson County
- Deuel County
- Dewey County
- Douglas County
- Hutchinson County
- Jerauld County
- McPherson County
- Mellette County
- Oglala Lakota County
- Todd County
- Ziebach County

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

- Bennett County
- Buffalo County
- Charles Mix County
- Corson County
- Dewey County
- Jackson County
- Mellette County
- Oglala Lakota County
- Roberts County

- Todd County
- Ziebach County

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

- Bennett County
- Buffalo County
- Charles Mix County
- Corson County
- Dewey County
- Jackson County
- Lyman County
- Mellette County
- Oglala Lakota County
- Todd County
- Ziebach County

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

- Bennett County
- Buffalo County
- Charles Mix County
- Corson County
- Dewey County
- Gregory County
- Haakon County
- Harding County
- Jackson County
- Jones County
- Lyman County
- Mellette County
- Oglala Lakota County
- Perkins County
- Todd County
- Tripp County
- Ziebach 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 South Dakota 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 South Dakota 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
Beadle County - SD	Highest	NA	13 years or longer	Education
Lake County - SD	Highest	SN	13 years or longer	
Lawrence County - SD	Highest	13 years or longer	13 years or longer	
Yankton County - SD	Highest	SN	13 years or longer	
Brown County - SD	High	9 years	13 years or longer	
Pennington County - SD	High	12 years	13 years or longer	
Hughes County - SD	Medium High	SN	10 years	
Minnehaha County - SD	Medium	Currently meets target	13 years or longer	
Brookings County - SD	Medium Low	NA	1 year	
Davison County - SD	Medium Low	NA	1 year	
Lincoln County - SD	Medium Low	3 years	1 year	
Codington County - SD	Lowest	SN	Currently meets target	
Meade County - SD	Lowest	NA	Currently meets target	
Aurora County - SD	Undetermined	SN	SN	Older, rural, medically underserved
Bennett County - SD	Undetermined	SN	SN	%AIAN, education, poverty, employment, rural, insurance, medically underserved
Bon Homme County - SD	Undetermined	SN	SN	Older, rural, medically underserved
Brule County - SD	Undetermined	SN	SN	Rural
Buffalo County - SD	Undetermined	SN	SN	%AIAN, education, poverty, employment, rural, insurance, medically underserved
Butte County - SD	Undetermined	SN	SN	Rural, medically underserved
Campbell County - SD	Undetermined	SN	SN	Older, education, rural, medically underserved
Charles Mix County - SD	Undetermined	SN	SN	%AIAN, education, poverty, employment, rural, insurance, medically underserved
Clark County - SD	Undetermined	SN	SN	Older, rural, medically underserved
Clay County - SD	Undetermined	SN	SN	
Corson County - SD	Undetermined	SN	SN	%AIAN, education, poverty, employment, rural, insurance, medically underserved
Custer County - SD	Undetermined	SN	SN	Older, rural, medically underserved

<b>County</b>	<b>Priority</b>	<b>Predicted Time to Achieve Death Rate Target</b>	<b>Predicted Time to Achieve Late-stage Incidence Target</b>	<b>Key Population Characteristics</b>
Day County - SD	Undetermined	SN	SN	Older, rural, medically underserved
Deuel County - SD	Undetermined	SN	SN	Education, rural, medically underserved
Dewey County - SD	Undetermined	SN	SN	%AIAN, education, poverty, employment, rural, insurance, medically underserved
Douglas County - SD	Undetermined	SN	SN	Older, education, rural, medically underserved
Edmunds County - SD	Undetermined	SN	SN	Older, rural, medically underserved
Fall River County - SD	Undetermined	SN	SN	Older, rural
Faulk County - SD	Undetermined	SN	SN	Older, rural, medically underserved
Grant County - SD	Undetermined	SN	SN	Rural
Gregory County - SD	Undetermined	SN	SN	Older, rural, insurance, medically underserved
Haakon County - SD	Undetermined	SN	SN	Older, rural, insurance, medically underserved
Hamlin County - SD	Undetermined	SN	SN	Rural, medically underserved
Hand County - SD	Undetermined	SN	SN	Older, rural, medically underserved
Hanson County - SD	Undetermined	SN	SN	Rural, medically underserved
Harding County - SD	Undetermined	SN	SN	Rural, insurance, medically underserved
Hutchinson County - SD	Undetermined	SN	SN	Older, education, rural, medically underserved
Hyde County - SD	Undetermined	SN	SN	Older, rural, medically underserved
Jackson County - SD	Undetermined	SN	SN	%AIAN, poverty, employment, rural, insurance, medically underserved
Jerauld County - SD	Undetermined	SN	SN	Older, education, rural, medically underserved
Jones County - SD	Undetermined	SN	SN	Older, rural, insurance, medically underserved
Kingsbury County - SD	Undetermined	SN	SN	Older, rural, medically underserved
Lyman County - SD	Undetermined	SN	SN	%AIAN, employment, rural, insurance, medically underserved
McCook County - SD	Undetermined	SN	SN	Older, rural, medically underserved

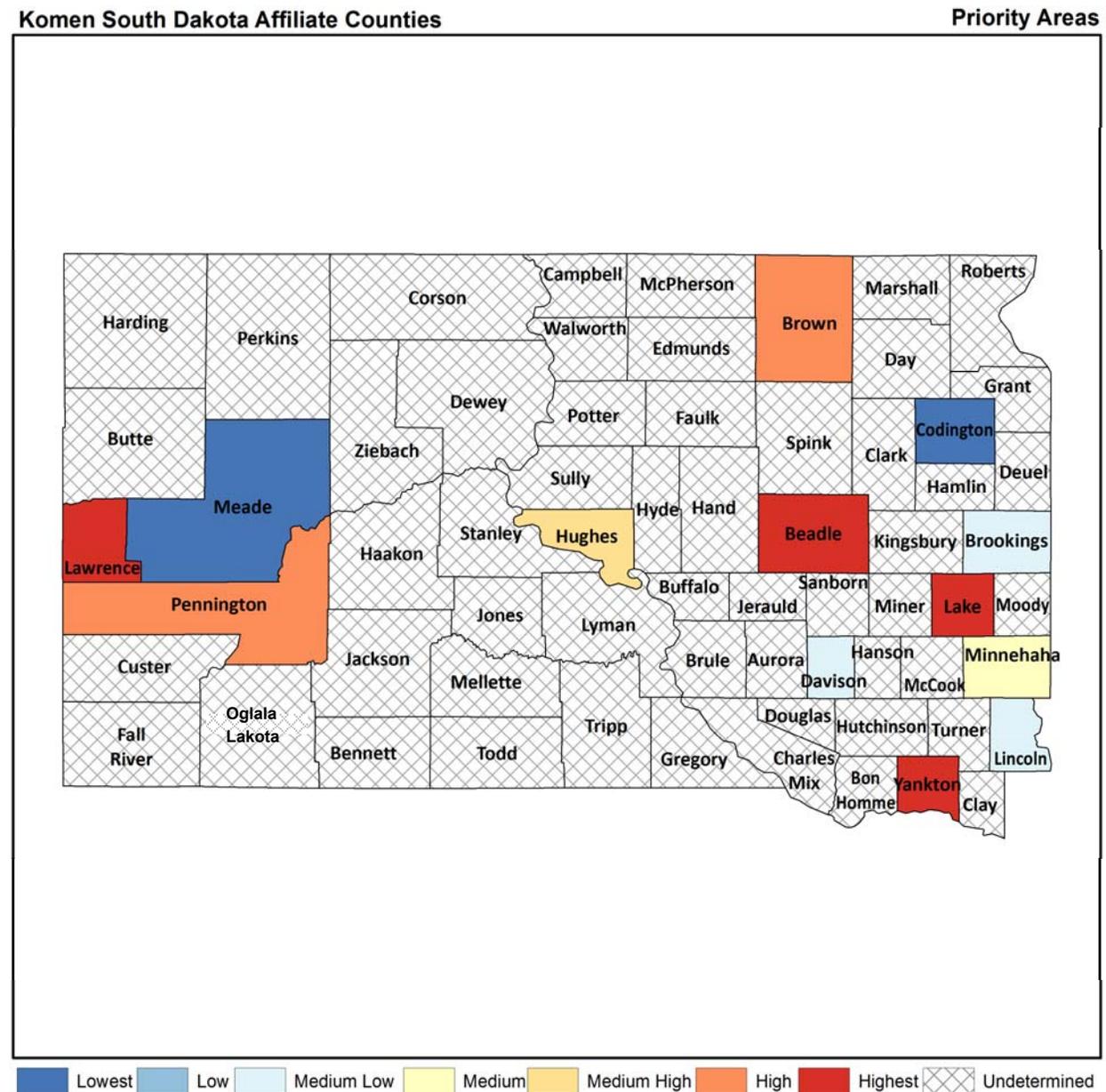
<b>County</b>	<b>Priority</b>	<b>Predicted Time to Achieve Death Rate Target</b>	<b>Predicted Time to Achieve Late-stage Incidence Target</b>	<b>Key Population Characteristics</b>
McPherson County - SD	Undetermined	SN	SN	Older, education, language, rural, medically underserved
Marshall County - SD	Undetermined	SN	SN	Older, rural, medically underserved
Mellette County - SD	Undetermined	SN	SN	%AIAN, education, poverty, employment, rural, insurance, medically underserved
Miner County - SD	Undetermined	SN	SN	Older, rural, medically underserved
Moody County - SD	Undetermined	SN	SN	%AIAN, rural, medically underserved
Oglala Lakota County - SD	Undetermined	SN	SN	%AIAN, education, poverty, employment, rural, insurance, medically underserved
Perkins County - SD	Undetermined	SN	SN	Older, rural, insurance, medically underserved
Potter County - SD	Undetermined	SN	SN	Older, rural, medically underserved
Roberts County - SD	Undetermined	SN	SN	%AIAN, poverty, rural, medically underserved
Sanborn County - SD	Undetermined	SN	SN	Older, rural, medically underserved
Spink County - SD	Undetermined	SN	SN	Older, rural
Stanley County - SD	Undetermined	SN	SN	Medically underserved
Sully County - SD	Undetermined	SN	SN	Older, rural, medically underserved
Todd County - SD	Undetermined	SN	SN	%AIAN, education, poverty, employment, rural, insurance, medically underserved
Tripp County - SD	Undetermined	SN	SN	%AIAN, older, rural, insurance, medically underserved
Turner County - SD	Undetermined	SN	SN	Older, rural
Walworth County - SD	Undetermined	SN	SN	%AIAN, older
Ziebach County - SD	Undetermined	SN	SN	%AIAN, education, poverty, employment, rural, insurance, 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**

### ***Highest priority areas***

Four counties in the Komen South Dakota service area are in the highest priority category. One of the four, Lawrence County is not likely to meet either the death rate or late-stage incidence rate HP2020 targets. Three of the four, Beadle County, Lake County and Yankton County, are not likely to meet the late-stage incidence rate HP2020 target.

The late-stage incidence rate in Lake County (57.2 per 100,000) appears to be higher than the Affiliate service area as a whole (43.7 per 100,000) although not significantly. The late-stage trend in Lake County (13.2 percent) appears to be rising although not significantly compared to the Affiliate service area as a whole (-0.3 percent). The death rate in Lawrence County (31.4 per 100,000) appears to be higher than the Affiliate service area as a whole (20.3 per 100,000) although not significantly. The death rate trend in Lawrence County (3.4 percent per year) is significantly less favorable than the state (-2.2 percent per year). Beadle County has relatively low education levels.

### ***High priority areas***

Two counties in the Komen South Dakota service area are in the high priority category. Both of the two, Brown County and Pennington County, are not likely to meet the late-stage incidence rate HP2020 target.

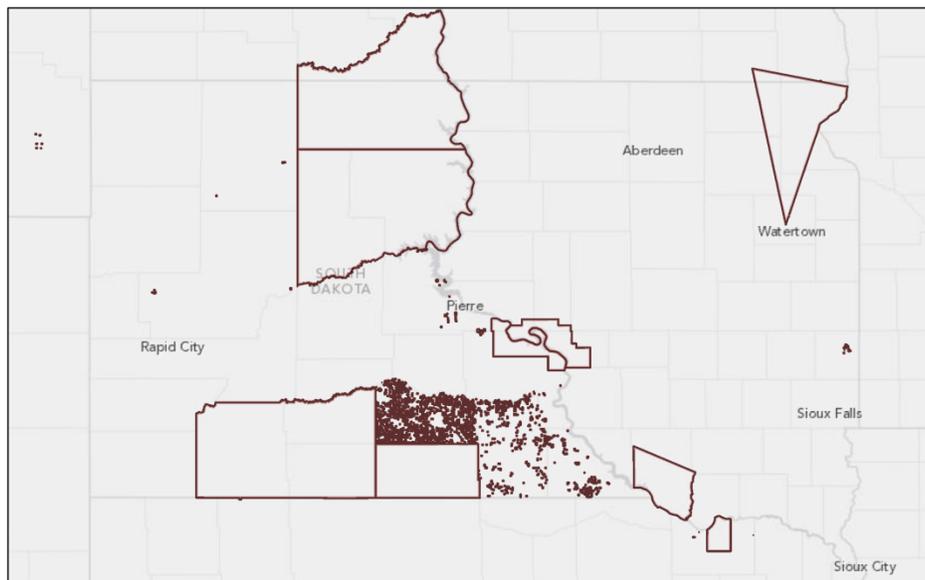
The death rate in Brown County (25.6 per 100,000) appears to be higher than the Affiliate service area as a whole (20.3 per 100,000) although not significantly. The late-stage incidence rate in Brown County (52.2 per 100,000) appears to be higher than the Affiliate service area as a whole (43.7 per 100,000) although not significantly. The death rate in Pennington County (24.3 per 100,000) appears to be higher than the Affiliate service area as a whole (20.3 per 100,000) although not significantly. The late-stage incidence rate in Pennington County (50.5 per 100,000) appears to be higher than the Affiliate service area as a whole (43.7 per 100,000) although not significantly.

## Additional Quantitative Data Exploration

South Dakota represents a diverse demographic profile. Additional exploratory data were collected using the Community Health Needs Assessment website which provides mapping tools and was used to outline both tribal communities and vulnerable populations in the state. The website was also used to further investigate the link between tribal populations, rural regions and subsequent socioeconomic issues in these areas. Additionally, the US Census Bureau's website was utilized to collect information on the rural versus urban populations in the service area. This data collection supplements the demographic data presented in Table 2.4 and highlights population characteristics, including the largest minority, American Indians, and the poor socioeconomic issues which exist within tribal boundaries at a deeper level.

### **Tribal Lands and Socioeconomic Indicators**

The first area of additional exploration is the correlation of American Indian reservations and counties with poor socioeconomic factors as a way of indicating potentially vulnerable populations in the state. The vast majority of South Dakotans are White (87.5 percent) with American Indians comprising the largest minority (9.7 percent), according to Table 4. Compared to the United States population characteristics, Komen South Dakota's service area has a higher percentage of American Indians at 9.7 percent than the US as a whole at only 1.4 percent. Therefore, additional exploration of the minority group comprising of American Indians must be explored. Figure 2.2 outlines American Indian reservation land in South Dakota.



March 31, 2014

1:4,006,015  
0 30 60 120 mi  
0 55 110 220 km  
Copyright ©2014 Esri, DeLorme, HERE

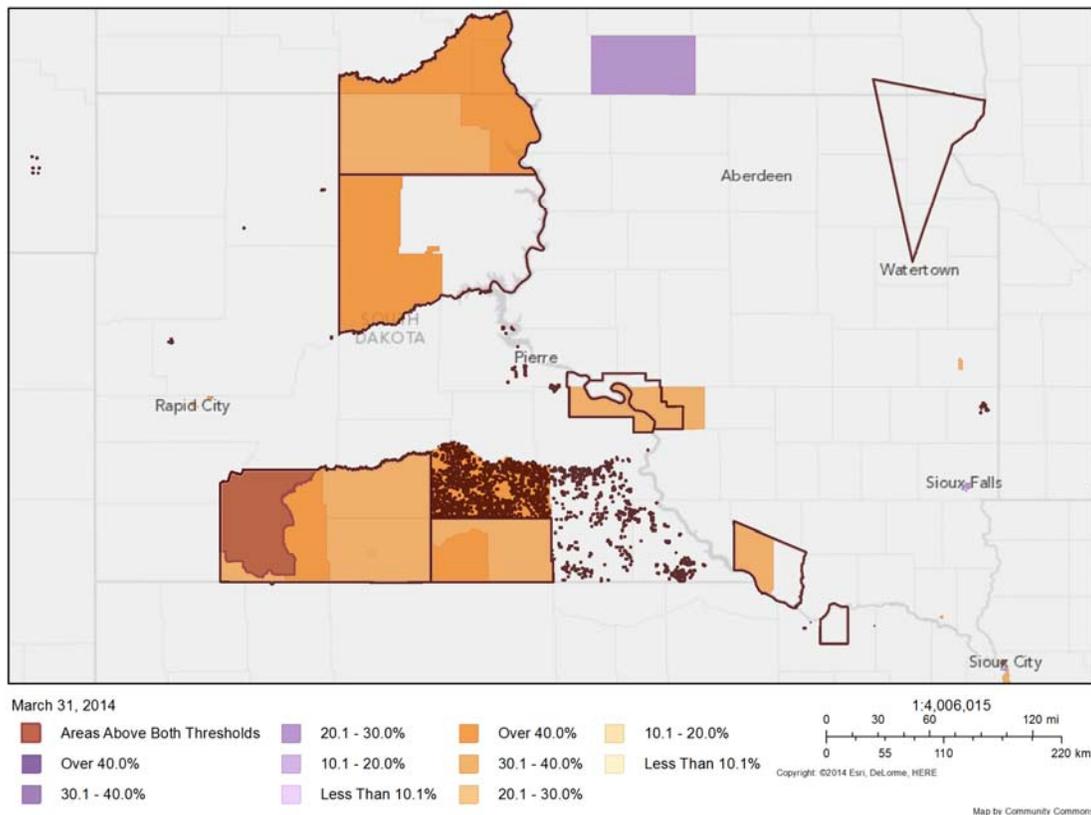
Map by Community Commons

Source: Community Health Needs Assessment.

**Figure 2.2.** South Dakota American Indian reservations

Tracking of population characteristics, health issues and socioeconomic indicators by individual tribes within tribal borders have not been found and limits data; however, use of data at the county level within which reservations are wholly or partially located is used to create a footprint

of potential vulnerable populations in the state. Figure 2.3 highlights counties which have populations with greater than 30.0 percent at or below the poverty level and greater than 25.0 percent with less than a high school education within the state. Correspondingly, the counties which contain the most vulnerable populations in South Dakota fall wholly or partially within American Indian reservations which are outlined in Figure 2.3.



Purple shading: high school education.  
 Orange shading: below poverty level.  
 Source: Community Health Needs Assessment.

**Figure 2.3.** Counties with vulnerable populations

Another alarming socioeconomic factor is those living without health insurance within tribal boundaries. Figure 2.4 highlights the uninsured population by county. Those counties with greater than 20.0 percent of its population living without health insurance fall within a county in which an American Indian reservation is wholly or partially located. In comparison with Table 2.5, the service area as a whole represents a population with 13.1 percent of citizens (Ages 40-64) having no health insurance.

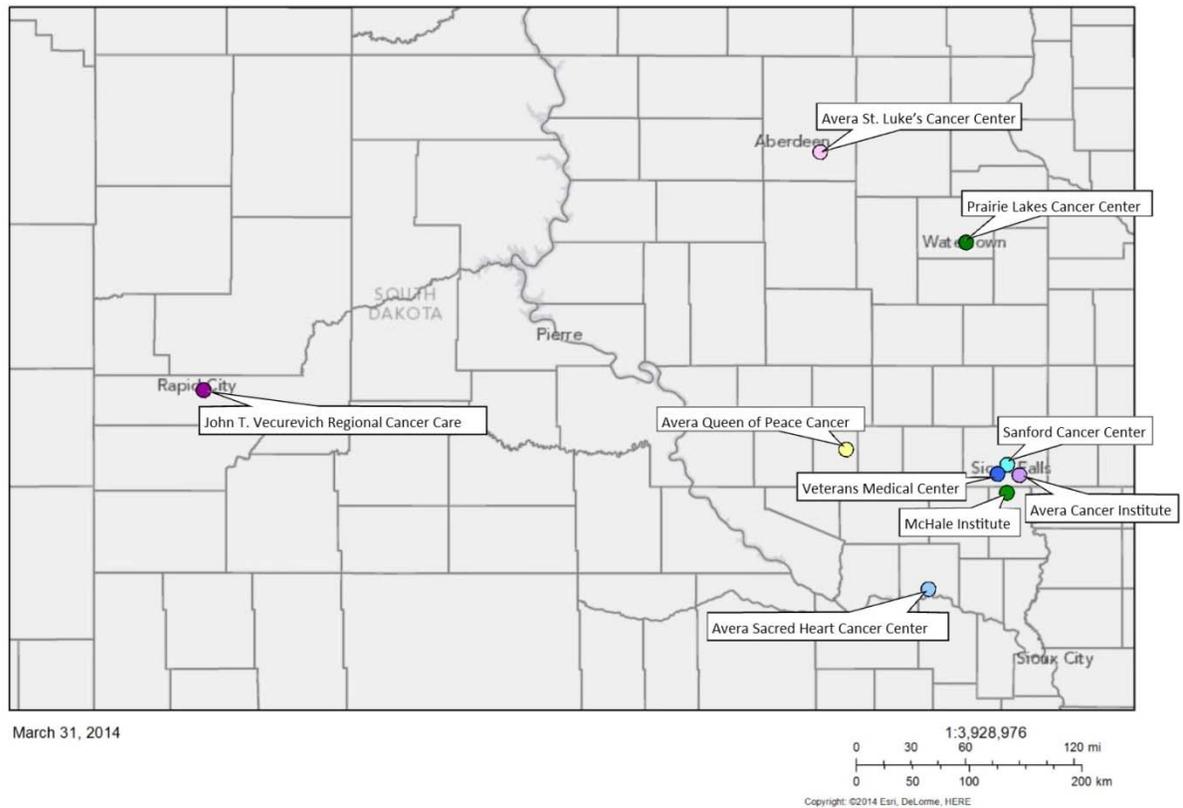


Source: Community Health Needs Assessment.

**Figure 2.4.** Uninsured population

### Frontier and Rural Populations

Another noteworthy area of exploration for Komen South Dakota includes the remoteness of individuals living in the service area which results in long distances between services, including health care providers. According to the 2012 US Census Bureau, 43.3 percent of South Dakotans live in a rural area, compared to an average of 19.3 percent for the US as a whole (Census Bureau, 2010). This rural geographic area indicates a gap between populations and cancer care centers in the state. Figure 2.5 depicts the six cancer care centers in the state, located primarily in the far eastern and western sides, creating accessibility issues to breast health care for many individuals.



Source: South Dakota Comprehensive Cancer Control Program, 2014.

**Figure 2.5. Cancer care centers**

**Selection of Target Communities**

Komen South Dakota has identified three target communities and priorities in which to focus its resources over the next four years. Multiple counties within the service area had data suppressed due to small numbers for breast cancer incidence, death rates and trends; therefore, socioeconomic factors were also relied upon with the addition of supplemental data collected on minority populations within the state. Attention was given to where time and resources would make the largest impact in the state with a focus given to both the HP2020 data and the most vulnerable populations in the service area.

The selected target communities are:

- Oglala Lakota County, Jackson and Bennett Counties with a focus on women living within the Pine Ridge Reservation
- Lawrence and Pennington Counties
- Beadle County

**Oglala Lakota, Jackson and Bennett Counties with a focus on women living within the Pine Ridge Reservation**

While individual tribal information is not available, the nine American Indian reservations located within the service area comprise mostly of entire counties or partial counties. Given this county level data, socioeconomic factors in these counties illustrate populations with high unemployment percentages, low education levels, high uninsured percentages and high poverty

levels. Further, population characteristics indicate each of these counties are medically underserved in addition to their poor socioeconomic indicators.

The Pine Ridge Reservation is home to the Oglala Sioux Tribe with approximately 38,000 enrolled members living within its borders (SDSU, 2014). Oglala Lakota, Jackson and Bennett Counties have a high percentage of the population with income below 100 percent of the poverty level at 31.8 percent, 53.5 percent and 35.5 percent respectively. Because of its poor socioeconomic conditions, great attention must be given to this reservation and the women living within its borders.

Because the Affiliate does not have tribal relationships with each of the nine reservations and cultural barriers to entry impose a time constraint, Oglala Lakota, Jackson and Bennett Counties were chosen as part of the Pine Ridge Reservation partly because of the programs and work already being done in this area in conjunction with current a Susan G. Komen South Dakota grantee, Gundersen Health.

The Health Systems Analysis, in part, will focus on the Indian Health Service (IHS) hospitals and satellite clinics which provide services to this reservation. Furthermore, programs and services which address American Indian screening efforts and treatment for breast cancer patients will be assessed.

### **Lawrence and Pennington Counties**

Lawrence and Pennington Counties were listed as highest and high priority areas with respect to the HP2020 initiative. Pennington County is only one year shorter (12 years compared to the baseline 13 years) in its predicted time to achieve death rate target, so the Affiliate will consider it a high priority based on the single year difference. Lawrence and Pennington Counties have been grouped together as one target community based on their geographic proximity to one another.

While socioeconomic indicators for this targeted community are not significantly different from the service area as a whole, 27 new cases of late-stage breast cancers are detected annually in Pennington County. With a total of 195 late-stage annual detections of breast cancer in women in the service area as a whole, Pennington County accounts for nearly 12.3 percent of all new late stage cases in the state.

The focus of the health systems analysis will stress the importance of services available in the western part of the state in Lawrence and Pennington counties. Though both counties are located close to a metropolitan area, many women may not be willing to make the trip to receive screening services because of the large geographic area of the counties.

### **Beadle County**

Beadle County is listed as not meeting the predicted time to achieve the late-stage incidence target for the HP2020 initiative. Further, Beadle County has the highest population of Hispanic/Latina women in the state at 7.1 percent. This percentage is much higher than the Affiliate service area as a whole at 2.7 percent. Further, the county also has a higher than average Asian and Pacific Islander (API) population with 4.2 percent, compared to 1.2 percent for the service area as a whole. Notably, the percentage of linguistically isolated households is higher than average at 2.4 percent.

Therefore, Beadle County will be a target population for the Affiliate because of its demographics which pose a potential language barrier issue for breast health services and education. The health systems analysis will focus on the services available in Beadle County, a predominantly rural area. Although its largest city Huron is a micropolitan city with a population of 12,500 (Census Bureau, 2010), many women within the county live in rural areas, potentially creating a barrier throughout the continuum of care.

## **Health Systems Analysis Data Sources**

Data for the programs and services in the Affiliate's target communities were collected using various methods. An internet search was conducted in conjunction with accessing provider's websites to find services for each target community. Government and various health websites were also utilized in the search.

The internet search for providers included:

- FDA Mammography Facilities
- The National Association of County and City Health Officials
- US Department of Health and Human Services, Health Resources and Services Administration
- The National Association of Free & Charitable Clinics
- Huron Regional Community Needs Assessment
- All Women Count! Breast & Cervical Cancer Screening Primary & Mammography Providers
- Regional Health Provider Directory
- Indian Health Services

The internet search for accreditation included:

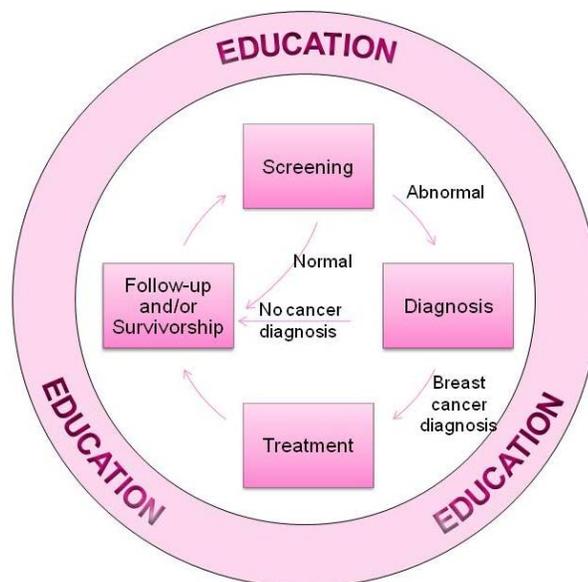
- American College of Surgeons Commission on Cancer
- American College of Radiology Centers of Excellence
- American College of Surgeons National Accreditation Program for Breast Centers
- National Cancer Institute Designated Cancer Centers

Additionally, community partners and key stakeholders including Komen South Dakota grantees and board members were called upon to develop a thorough understanding of programs and services in each stakeholder's respective community. Further, individual hospitals, clinics and other providers were personally contacted to further understand the services available at each location within the target communities. It should be noted there could be limitations to the data found. The completed template may have missed some breast health/cancer providers and information about services provided by the health care providers could be incomplete.

Review of each target community revealed both strengths and weaknesses of programs and services and is discussed in the following section. The various aspects in each community were ultimately analyzed in relation to the continuum of care and studied for where women could potentially fall through the gaps in service due to barriers in care such as geographic distance and lack of services offered.

## Health Systems Overview

The Affiliate examined each target community's services and programs, analyzed current partnerships, and the need for potential new partnerships in order to increase access to care. This analysis is central to determining how the Affiliate will invest its resources to improve the quality of care in its service area. An integral part of this process is the Breast Cancer Continuum of Care (CoC) which is utilized to define how a woman should move through the health system to be screened for breast cancer, receive any necessary diagnostic care, get treatment if breast cancer is diagnosed and receive follow-up care after treatment. Education plays a crucial role throughout the continuum, as outlined in Figure 3.1.



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

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.

Utilizing this CoC model as a tool for assessing and understanding why some women never enter or delay entry into the continuum, finding gaps in service availability, identifying barriers faced and what can be done to address those gaps and barriers is central to the Affiliate's understanding of breast health needs in its service area. Each target community was explored in relation to the CoC and the findings within each community are summarized below.

### **Oglala Lakota, Jackson and Bennett Counties with a focus on American Indian women living within the Pine Ridge Reservation**

The Pine Ridge Reservation severely lacks major health systems and is only served by Indian Health Services (IHS) (Figure 3.2). Screening services, including CBEs and screening mammograms are available at the Pine Ridge Hospital, but due to lack of reliable transportation, women are often unable to make it to the hospital to receive services. The Aberdeen Mobile Unit travels to more rural locations including the Kyle and Wanblee Health Centers for a limited time each June to provide mobile mammography services. The Gundersen Health Mobile Unit, out of LaCrosse, Wisconsin, also makes a regular trip to the area, but due to lack of funding and issues with women not showing up to their appointments, these screening visits often get postponed or cancelled and are consequently difficult to rely on. All women living on the Pine Ridge Reservation must go to one of these locations to receive free or discounted screening through Indian Health Services (IHS). The Pine Ridge Hospital also offers diagnostic services in the form of ultra-sound or biopsy, but all women needing treatment are referred to Dakota Radiology located off the Reservation in Rapid City, SD. Women living off the reservation, in Bennett County, may receive CBEs at the Community Health Center located in Martin, SD.

Because mammography is only provided at limited times with a mobile truck in the rural areas of the reservation and a lack of transportation often prevents travel to the IHS, women may never enter or may delay entry into the CoC for screening. Further, if breast cancer is diagnosed, travel to Rapid City may be an impediment to care. Additionally, education may be another barrier with limited resources available on the reservation.

Although limited services and programs exist on the reservation itself, two programs provide outreach to Pine Ridge Reservation.

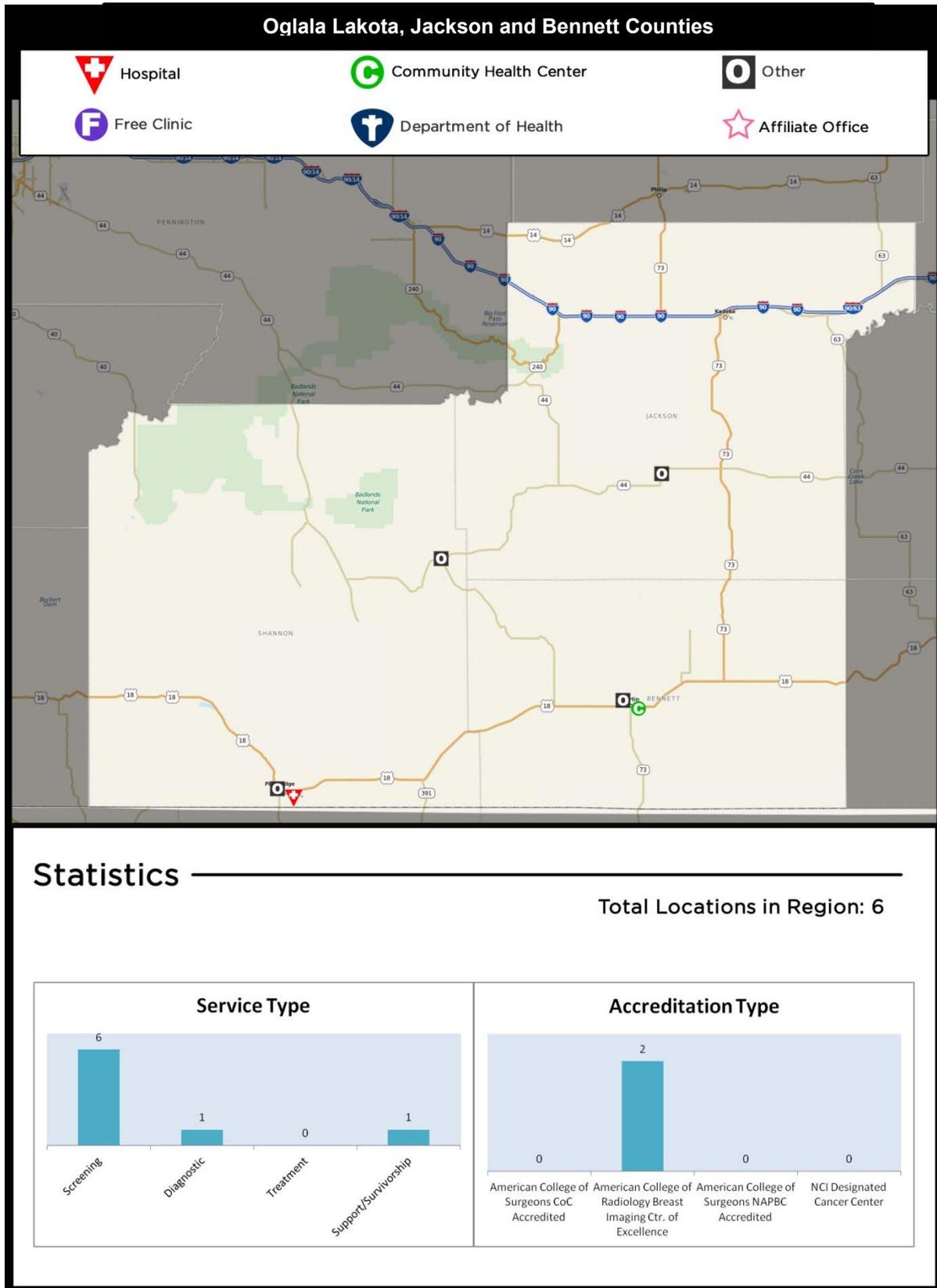
The Walking Forward Program, which is funded by the National Institute of Health, strives to increase cancer survival rates among American Indians in western South Dakota. This is facilitated through cancer education, culturally tailored patient navigation services to American Indian cancer patients treated at the Rapid City Regional Hospital's Cancer Care Institute and increasing access to clinical trials. The goal of the educational portion of the program is to increase cancer screening percentages among American Indians and promote early detection of cancer. Further, the Cancer Care Institute offers participation in several clinical trials and the Walking Forward program strives to increase participation of American Indians in these trials. The patient navigation program assists American Indian cancer patients with logistical, emotional and social support during and after their treatment. This multipronged approach aims to help stem the increasing cancer rates in this population and endeavors to improve quality of life for American Indian cancer patients (Regional Health, 2014). While the Affiliate is aware of the program, it has not officially collaborated on efforts. Through a partnership and working together, the Affiliate and the Walking Forward program could leverage their knowledge and resources to further increase the scope of success.

Gundersen Health, located in LaCrosse, Wisconsin, serves the Pine Ridge Reservation as one of its outreach priority areas. The Affiliate has provided funding to Gundersen Health to mobile mammography services and outreach within the Pine Ridge Reservation. Their mobile mammography unit and staff travel annually to the Pine Ridge Reservation for six days to provide free mammograms, clinical breast exams, and breast health education to approximately 125 women ages 40-65 that are uninsured or underinsured. As a result of the trip, Gundersen Health expects women who participate will stay in the continuum of care and return for annual screening. Through the distribution of breast health education brochures, Gundersen Health also expects their screening percentages will increase by 10 percent each year. Gundersen Health works with the Walking Forward program to ensure no duplicative services are provided and offers referrals in case of diagnosis.

The Affiliate should continue to strengthen and enhance its partnership with Gundersen Health. Because Gundersen Health already has a relationship with the women living on the reservation, it would benefit both parties to continue moving forward in providing services and help along the entire CoC for women living on the reservation.

Even with the Walking Forward program and Gundersen Health's mobile mammography truck, women may still not successfully enter into the CoC at the preventive screening point because of the distance to travel and the cultural sensitivity surrounding breast health within their culture. Diagnostic and treatment may also be an issue because of the lack of service providers and the distance to travel outside the reservation. Further, education is limited throughout the

continuum. With limited programs on the reservation tailored specifically for American Indian women, education is another weakness for this community.



**Figure 3.2.** Breast cancer services available in Oglala Lakota, Jackson and Bennett Counties

## **Lawrence and Pennington Counties**

The breast health services found in Pennington County provide services for many rural women who must drive considerable distances to receive care (Figure 3.3). Specifically, the region's largest provider, Rapid City Regional Cancer Care Institute, provides outpatient oncology services for breast cancer patients including radiation therapy and chemotherapy, supportive laboratory and imaging services, and related clinical research trials. Regional Cancer Care Institute also offers support programs including a Breast Health Patient Navigator, who specializes in all areas of breast health, including breast cancer, image restoration programs including a wig recovery program and other support programs. Further, Dakota Radiology also offers screening and diagnostic services to women in Rapid City. Many other clinics exist in Rapid City which provide clinical breast exams and then refer women who require a mammogram to either Regional Cancer Care Institute, Rapid City Medical Center or Dakota Radiology. Outside of the Rapid City metropolitan area, Regional Medical Clinics in Wall and Hill City round out the providers in this county.

In addition to receiving services in Pennington County, women living in Lawrence County can seek breast health services found in Spearfish which include the Spearfish Regional Hospital and Queen City Regional Medical Center. The Family Health Education Services in Spearfish offers clinical breast exams, but refers mammography patients to other providers in town. The other provider in this county is located in Deadwood. The Lead-Deadwood Regional Medical Clinic is part of the Regional Health's community network of clinics and hospitals and provides screening mammography along with MRI and ultrasound.

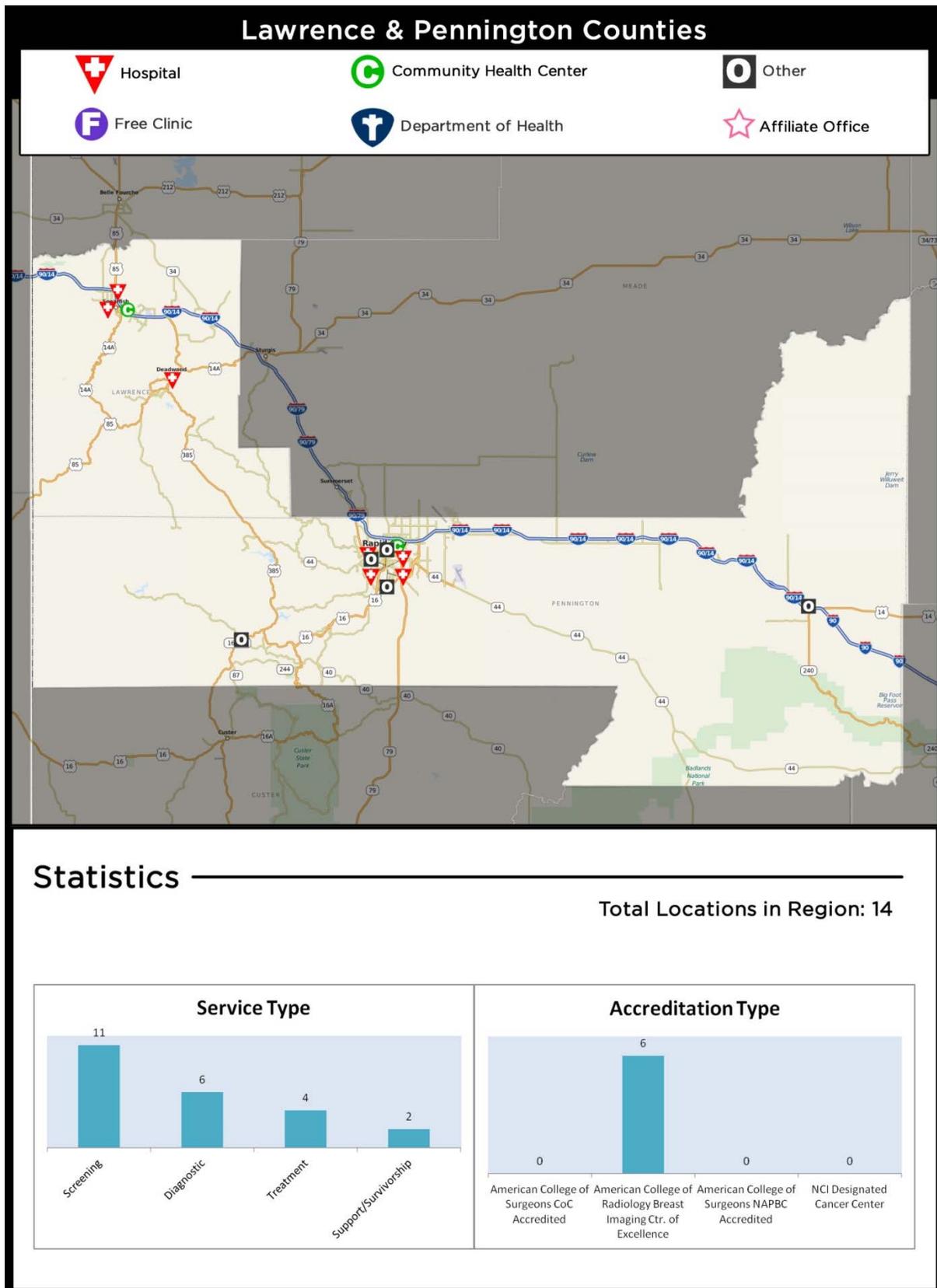
The strength of this target community is that it offers many providers which provide breast health services to women. However, though breast screening is available at many locations, treatment is only found in Spearfish and Rapid City, creating a gap in service for those women living in rural areas if transportation is limited.

Because of this issue, Healing Pathways is a program created to help women in rural areas in Western South Dakota overcome barriers to receiving treatment. The program targets rural women who receive their treatment at the Rapid City Regional Cancer Care Institute and includes CoC support which begins with an individual's initial diagnosis and continues through the entire treatment process and beyond. The program provides patients with educational materials, food, transportation and lodging support, and one-on-one follow-up to ensure patients attend necessary appointments and treatments. It also ensures women receive all of the information they need to make informed decisions about their treatment plan. Survivorship is also a key element in this program; ensuring patients are provided with long-term survivorship care and address their ongoing concerns. The Affiliate has provided funding to assist Healing Pathways in providing services to rural women.

The Affiliate has partnered with the Healing Pathways program in the past and should continue to work with this program in order to reach the rural women who are at risk because of the distances they must travel for treatment. Further, the Affiliate would benefit from collaborating with Rapid City Regional Cancer Care Institute to provide assistance for women throughout the entire CoC.

While travel and access to treatment is a weakness for this target community, it still must be determined why the late-stage diagnosis is much higher than the rest of the service area as a

whole. A potential factor is an education barrier, creating an issue for women who delay entry into the CoC for various reasons.



**Figure 3.3.** Breast cancer services available in Lawrence and Pennington Counties

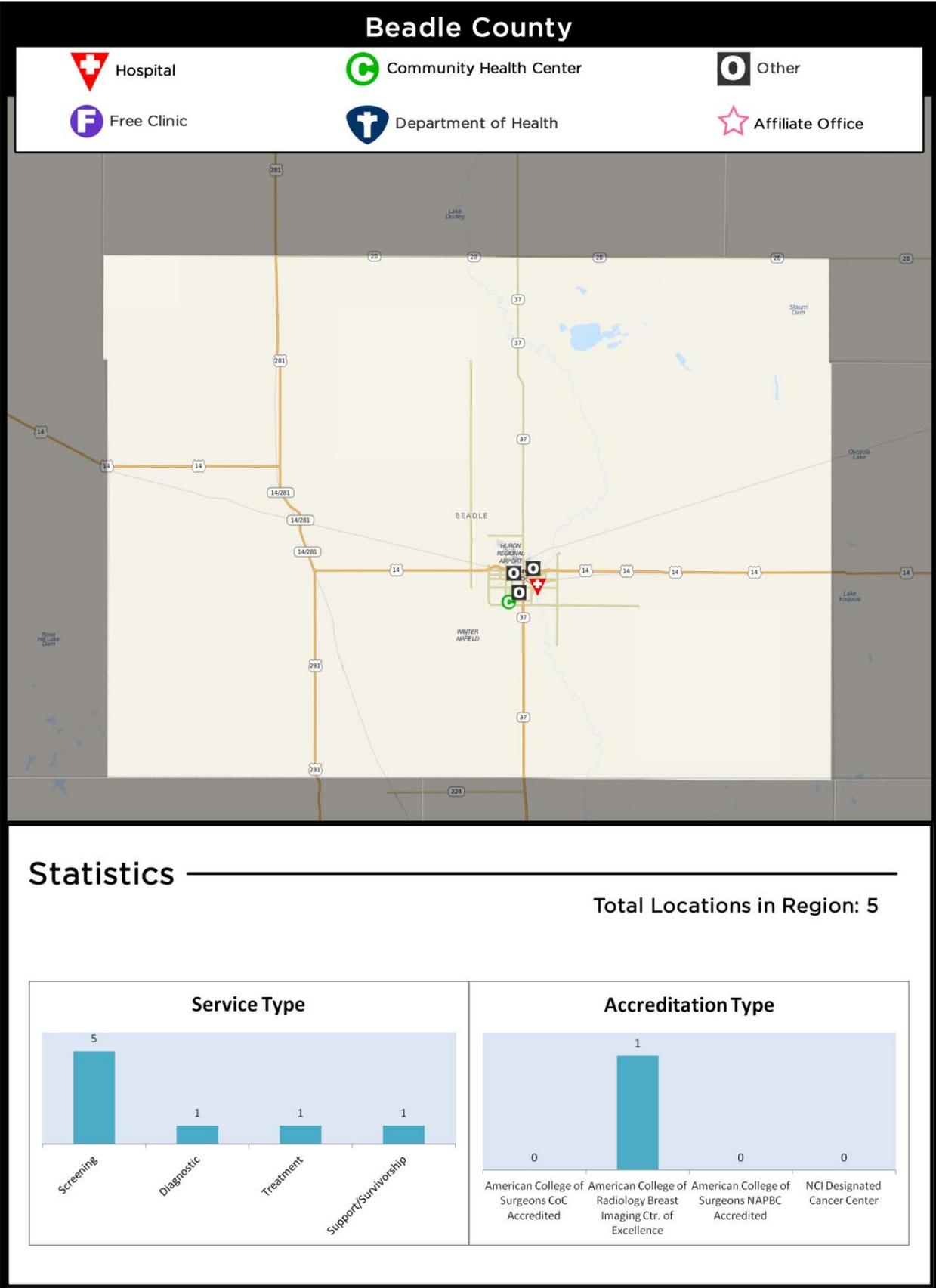
## **Beadle County**

Huron Regional Medical Center (HRMC) provides a variety of breast health services to Beadle County and the surrounding seven-county area (Figure 3.4). HRMC provides access to digital mammography and clinical breast exam services. In addition to the medical imaging services, HRMC provides outreach education at various health fair events and speaking engagements on the importance of early detection. HRMC also provides diagnostic and treatment of breast cancer including open biopsy, stereotactic biopsy and sentinel node biopsy, lumpectomy, mastectomy, breast reconstruction and chemotherapy.

The other clinics in the target community include Belyea Balvin, Women's Wellness Center, Tschetter & Hohm Clinic, Huron Family Planning and James Valley Community Health Center; all centers offer clinical breast exams but refer mammography services to HRMC.

An existing program in this community is the Breast Cancer Prevention Fund, funded and operated by the HRMC Foundation. This financial assistance program is designed to help women who are not eligible for other financial assistance within the state by covering the cost of important screening and diagnostic mammograms. (HRMC Community Health Needs Assessment, 2013). Other programs include HRMC's 'No Excuses Mammo' which provides discounts to those women who have not had a mammogram in two years and the bi-monthly 'Look Good...Feel Better' sessions hosted at HRMC to help women manage the side-effects of chemotherapy.

Opportunities are available for new partnerships between the Affiliate and HRMC to provide additional resources and education to the linguistically isolated women located in this target community. Additionally, because HRMC provides service to the seven-county area, there is a potential to develop travel assistance for rural women seeking screening or care with limited public transport available. Further, there are language, social and custom barriers which need to be identified before breast health education can be delivered (HRMC Community Health Assessment, 2013). These issues could be addressed through collaborative efforts in order to reduce the barriers found within the CoC.



**Figure 3.4.** Breast cancer services available in Beadle County

## **Public Policy Overview**

### **National Breast and Cervical Early Detection Program**

The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) is funded through the All Women Count! (AWC!) Program within the South Dakota Department of Health. Low income women aged 30-64 who are uninsured or underinsured are eligible to enroll in the breast and cervical screening program through various participating clinics across the state and the program reimburses the participating clinics at the Medicare B rate. AWC! does not provide eligibility for screening reimbursement to those women who receive Medicaid assistance. If a woman is diagnosed with breast or cervical cancer through screening in the AWC! program and is uninsured, she could be eligible for Medicaid treatment coverage. Women in South Dakota will get access to these Medicaid treatments by meeting the previous requirement of screening through AWC! along with meeting the program's income eligibility guidelines. Eligibility coverage ends when a woman's course of treatment is completed or the state has determined she no longer meets the criteria for this eligibility category. The Affiliate continues its mission partnership with the AWC! program through its collaboration by providing funding to cover those women in the AWC! program between the ages 30-49.

### **Statewide Cancer Coalitions**

Another important program in the state is the South Dakota Comprehensive Cancer Coalition (SD CCCP). Its vision is to reduce the human and economic impact of cancer on South Dakotans through the promotion and support of collaborative, innovative, and effective programs and policies for cancer prevention and control. With its 2011-2015 cancer plan, the SD CCCP outlines objectives and strategies which cover prevention, early detection, treatment and quality of life. Specifically, the breast cancer objectives include increasing screening and early detection through mammography screening for women aged 40+, eliminating disparities in screening among rural and minority women and finally, providing information about treatments for breast cancer.

Komen South Dakota has a strong relationship with the SD CCCP and works closely to achieve synergy in the organizations similar goals in improving screening and increasing cancer care. The Affiliate's Executive Director has served on the SD CCCP steering committee since 2012 and works closely with the program to meet its objectives and goals. The Affiliate will continue to grow this relationship, realizing the importance of working in collaboration in order to make an impact on breast cancer disparities in South Dakota.

Additionally, the Northern Plains Comprehensive Cancer Control Program (NPCCCP) works to increase cancer education, prevention, screening, treatment, palliative, end of life, and survivorship care through a variety of workgroups, community grant projects, and education and training opportunities. NPCCCP is committed to enhancing and increasing the quality of life and survivorship of cancer for American Indians in the Northern Plains by providing a forum for input, advocacy, education, collaboration, planning, and action along the CoC. This group of tribal and community stakeholders works to achieve all of their goals in a manner that values the importance of traditional healing and medicine, embraces the spiritual components of life for many, and above all else respects individual, tribal, and cultural differences. The NPCCCP is an area in which the Affiliate could increase its collaboration and partnership to meet the breast health needs of the American Indian and their entry into the CoC.

## **Affordable Care Act Overview**

With new insurance guidelines and mandates, the Affordable Care Act (ACA) is an important part of both how the AWC! Program and SD CCCP operate. These guidelines also impact how Komen South Dakota directs its focus for the foreseeable future. The state of South Dakota has opted to not expand Medicaid, thereby leaving gaps in coverage for those who have incomes above Medicaid eligibility levels but not enough to qualify for Marketplace tax credits (Kaiser, 2014). Had South Dakota elected to expand Medicaid, these individuals would have been newly eligible to receive coverage. Of concern, 23.0 percent, or 25,000 uninsured individuals in the state would have been eligible for Medicaid if the state had expanded. Therefore, these individuals have potentially fallen into a coverage gap (Kaiser, 2014).

Since ACA enrollment opened, 13,104 individuals in South Dakota had made marketplace plan selections as of March 31, 2014 (ASPE 2014). Of the individuals who selected marketplace plans, 54 percent were female. Though a high enrollment may be considered a positive result of the ACA, small, rural health systems have provided feedback which draws attention to the adverse side effects of the ACA. For instance, many rural clinics are already under-staffed in the Affiliate's service area. What will happen to demand on rural clinics when the newly insured seek care because of newly claimed health insurance? Will the optimal level of care decrease for each patient because of increased load on the system? With these questions in mind, focus needs to be spent on the entry point in the CoC with preventive care, such as screenings and mammograms, to lessen the number of escalated cases of patients. While it is too early to tell the actual impact of the ACA on health systems, it may lead to an increase in demand which providers in the service area could struggle to handle.

Again, while it may be too early to tell, implications on the Affiliate as a result of the ACA may create an increase in need for education and patient navigation. While individuals could have their screening paid for through the ACA, education on this important preventative measure must be communicated. Further, if additional women get screened and ultimately more women's breast cancers are detected as a result, an increase in patient navigation may rise to the top as a priority for the Affiliate.

## **Affiliate's Public Policy Activities**

Komen South Dakota realizes the importance of patient advocacy at both the state and national level and actively participates in matters of policy which positively impact access to breast cancer screening and treatment services. In 2015, the Affiliate successfully helped pass Oral Parity legislation in South Dakota to ensure fairness in insurance coverage for oral and IV chemotherapy medications for cancer patients. The Affiliate will continue to collaborate with partners such as the American Cancer Society-Cancer Action Network to grow its public policy activities.

## **Health Systems and Public Policy Analysis Findings**

The needs are great across all target communities within Komen South Dakota's service area. Specifically, the Pine Ridge Indian reservation has great need throughout the entire CoC because programs and services on the reservation are severely lacking. Continuing to build the outreach programs already in place will decrease the barriers found throughout the CoC in this community. While great services and programs exist within Lawrence and Pennington Counties through access to its Cancer Care Institute, travel still remains a hurdle for rural women and the

late-stage diagnosis rate continues to trend higher than the Affiliate service area as a whole. The partnership with Healing Pathways is important to Komen South Dakota and the Walking Forward program is an area in which the Affiliate could provide assistance. Education could also help eliminate delayed entry into the CoC for this community. Finally, Beadle County offers a medical center with treatment programs, but again, travel in this rural county is an issue and considerable weakness. Through collaboration with HRMC to address the unique needs of the community and the increasing minority population, gaps in language barriers and entry into the CoC could be addressed.

Key partnerships for the Affiliate should continue to focus on the patient navigation system in all target communities and address the specific needs of women and the barriers to entering the CoC. Partnerships including the Healing Pathways program in Rapid City should be enhanced while others, like the Walking Forward program, should be targeted as a new potential partnership. The SD CCCP and NPCCCP are all important programs within the state and collaboration between all entities for their success is vitally important. The Affiliate will continue to build its relationships with these entities in order to carry out its mission in South Dakota.

Again, the Affiliate will continue to build its advocacy program and look to strengthen its partnership with the American Cancer Society-Cancer Action Network and other patient advocacy groups across the state.

# Qualitative Data: Ensuring Community Input

## Qualitative Data Sources and Methodology Overview

Qualitative data were collected to further understand the breast health disparities and issues which exist in each target community. Methodologies, sampling insights and ethics for each target community are outlined in the following sections.

The information collected in each of the three target communities utilized two separate collection methods to reveal patterns and conclusions. Ultimately, this qualitative data, combined with the quantitative data and health systems analysis will allow for triangulation of the results and final analysis which will give the Affiliate further insight into each community to inform the Affiliate's Mission Action Plan.

### **Oglala Lakota, Jackson and Bennett Counties with a focus on women living within the Pine Ridge Reservation**

As a result of the initial quantitative and health systems analysis review, it was concluded Oglala Lakota, Jackson and Bennett Counties are at high risk of breast cancer disparities due to socioeconomic factors including high unemployment percentages, low education levels, high uninsured percentages and high poverty levels. Further, each of these counties are medically underserved. Therefore, it was determined the key assessment question to be utilized in collecting qualitative data is: Why are women living on the Pine Ridge Reservation not utilizing breast cancer services throughout the continuum of care? The variables within this question include access to screening, cultural beliefs toward breast health, and education.

Due to the rural nature and cultural behaviors of the women living on the Pine Ridge Reservation, document review was used to collect qualitative data in order to help answer the key assessment question. First, six documents would be reviewed by Affiliate staff to gain insight into what women in the target area think about breast cancer, background information, and other information which would otherwise be difficult to observe by the Community Profile Team. Several documents focused on breast cancer and American Indians were located with the help of the Komen Headquarters Community Profile Team which related to the key assessment question to be used in the document review. These documents were utilized to support the key informant interviews conducted.

The six key documents used for review were:

- Engelman, K. K., An assessment of American Indian women's mammography experiences
- Burhansstipanov, L., An Innovative Path to Improving Cancer Care in Indian Country
- Daley, C., Breast cancer screening beliefs and behaviors among American Indian women in Kansas and Missouri; a qualitative inquiry.
- Tolma, E., American Indian Women and Screening Mammography: Findings from a Qualitative Study in Oklahoma
- Filippi, M. K., Breast Cancer Screening Perceptions among American Indian Women under Age 40
- Watson-Johnson, L. C., Mammography adherence: a qualitative study

As a second qualitative data resource, key informant interviews were planned in this community; however, the Great Plains Institutional Review Board is reviewing the Affiliate's ability to conduct these interviews. Multiple providers and key stakeholders were contacted, but were unable to speak with the Affiliate until tribal approval for the Community Profile Team to gather information had been granted. At the time of this narrative, approval by the Review Board is still pending.

### **Lawrence and Pennington Counties**

Lawrence and Pennington Counties were defined as areas of high and highest priority with respect to the HP2020 initiative. Pennington County is only one year shorter (12 years compared to the baseline 13 years) in its predicted time to achieve death rate target. Also, Pennington County accounts for nearly 12.3 percent of all new late-stage cases in the state. Therefore, the key assessment question to assist in collecting qualitative data in these communities is: Why are women over 40 not getting screened? Variables within this question include availability of breast health education and utilization of screening services.

Focus groups and key informant interviews were chosen as the most effective methods for collecting qualitative data because they would gain the greatest insight with the resources available in the area. Three focus groups, two in Lawrence County and one in Pennington County, were held at various times with six to eight women over the age of 40 participating in each session. Komen South Dakota staff prepared relevant discussion questions centered on the key assessment question and developed consent forms for all focus group attendees to control the confidentiality of all participants. In addition, refreshments were served at each focus group to encourage participation. The focus groups in this target community were led by an Affiliate Board Member who lives and works in Pennington County.

The second qualitative data collection method, key informant interviews, were conducted by Komen South Dakota staff via telephone as a cost effective strategy. The sources were gathered utilizing the snowball effect by starting with an initial key informant interview with a local patient navigator who then recommended several community leaders, health professionals, patients, survivors and co-survivors to contact. At least six interviews were collected in each Lawrence County and Pennington County. Relevant questions and a consent form were utilized for the phone interviews.

### **Beadle County**

A rural county in the Affiliate's service area, Beadle County was chosen as a target community based on low socioeconomic factors and the high percentage of minority populations. Additionally, it is not predicted to meet the HP2020 initiative for late-stage incidence. Therefore, the key assessment question for this community to assist in collecting qualitative data is: Why are women over 40 not getting screened for breast cancer? The variables identified within this question included access to screening, education on breast health and utilization of the screening options available in the community.

The methodologies chosen for this community to collect further information were 13 key informant interviews and document review. Both methods were chosen by the Community Profile Team because important insight could be gained from direct interviews and it was a cost-effective way to collect data based on the distance of the community from the Affiliate's home office. Document review was chosen as a second method because literature often identifies

gaps in both knowledge and provision of care and it was readily available by utilizing internet search methods.

The five documents reviewed were:

- Depke, J.L., & Onitilo, A. A., Coalition Building and the Intervention Wheel to Address Breast Cancer Screening in Hmong Women
- Huron Regional Medical Center, *2013 Community Health Needs Assessment and Implementation Plan*
- McAlearney, A.S., Reeves, K.W., Tatum, C., & Paskett, E.D., Cost as a barrier to screening mammography among underserved women
- Nguyen, T.N., Tran, J. H., Kagawa-Singer, M., & Foo, M. A., A qualitative assessment of community-based breast health navigation services for Southeast Asian women in Southern California: recommendations for developing a navigator training curriculum
- Purtzer, M. A., A Transformative Decision-Making Processes for Mammography Screening Among Rural, Low-Income Women

For key informant interviews, the following sources were questioned: providers, key stakeholders throughout the continuum of care, community leaders and women over 40. Thirteen sources were asked one of two different sets of six questions, tailored to both providers and non-providers, to provide insight from the provider standpoint and the general population in the community to get a broad look across the spectrum. Komen South Dakota staff conducted the key informant interviews which started by contacting a past grantee in the target area and subsequently utilized the snowball method to conduct additional interviews. Prior to each interview, the purpose of the interview was stated, the source gave their consent to participate and the staff member ensured confidentiality of the source in the final report.

Additionally, document review was utilized by Affiliate staff as a collection method. EBSCOhost and Google were utilized in conjunction with the terms 'breast cancer', 'rural', and 'South Dakota'. A focus on qualitative data in the search results allowed for additional dissection and triangulation for insight into the community.

### **Qualitative Data Overview**

The qualitative data collected in each community was analyzed and linked to the original key assessment question in each community by developing a list of common themes. The findings are outlined below for the three target communities.

#### **Oglala Lakota, Jackson and Bennett Counties with a focus on women living within the Pine Ridge Reservation**

Six document review resources were collected in the form of online published articles and abstracts. This qualitative resource was analyzed using Hand Analysis Coding. Due to limited time and resources, this was determined to be the most effective method for identifying patterns and themes in the data to answer the key assessment question. Documents were reviewed for key words and reduced into seven meaningful themes between all documents. The common themes are as follows:

- Fear
  - Women are afraid to seek breast health services on their own.

- Cost
  - Families will spend money on food, alcohol or gas and have not enough left to get to a clinical breast exam or mammogram.
- Accessibility
  - Because American Indian reservations are often very rural, women have difficulty finding transportation to get to clinics. Clinics also have very unpredictable hours and long wait times.
- Discomfort
  - Mammography will hurt or women feel dissatisfied with the service they received so they will not return for an annual screening the next year.
- Social Support
  - Spiritual, emotional and mental support from family and friends is extremely important to breast cancer survivors and those going through treatment.
- Native-Specific Resources
  - There is a lack of culturally sensitive breast health education on American Indian reservations.
- Trust
  - Women often need to feel a strong sense of trust with the provider before they will feel motivated to receive breast cancer screening.

### **Lawrence and Pennington Counties**

Data collected from the three focus groups and 12 key informant interviews were recorded by hand and then typed for better legibility. The same Hand Analysis coding method as mentioned previously was used due to the same restrictions. The common themes identified were:

- Primary Care Providers Responsibility
  - It should be your doctor's responsibility to make sure you are receiving your annual mammogram.
- Annual Physical
  - Women are 'falling between the gaps' and not going to the doctor unless something is wrong.
- Discomfort
  - Pain, embarrassment, and fear are barriers to screening.
- Cost
  - Women do not know about financial assistance programs available or they do not qualify because of their income.
- Education
  - There is a lack of year-round education. Women would like to see more breast health education on various media channels.
- Support
  - Family and community support is very important to women who have been diagnosed with breast cancer.

### **Beadle County**

The collection methods for Beadle County included 13 key informant interviews which were recorded with hand-written notes. The five documents were reviewed for common themes and both qualitative resources were analyzed using Hand Analysis Coding. Again, due to limited time and resources, this was determined to be the most effective method for identifying patterns and themes in the data to answer the key assessment question. The themes found from both methods were reduced into five meaningful themes. The common themes found were:

- Fear of Results
  - Fear of screening results, would rather not know the result of a mammogram

- Financial Concerns
  - Uninsured and scared of the cost, not knowledgeable on financial assistance available.
- Language Barriers
  - English is not first language of many; some are illiterate in native tongue. General consensus the Karen refugee population is growing rapidly and outpaces the last Census number.
- Travel Issues
  - If women get screened at a mobile unit which travels from out of town, women must then travel long distances for the diagnostics instead of going to local community provider.
- Navigation
  - No cancer navigation for patients.

### **Qualitative Data Findings**

A brief summary of the qualitative data findings are outlined below for each of the three target communities. Each conclusion is linked to the original key questions and the limitations of the data within each target community are discussed.

#### **Oglala Lakota, Jackson and Bennett Counties with a focus on women living within the Pine Ridge Reservation**

The qualitative data findings are linked to the key assessment question: Why are women living on the Pine Ridge Reservation not utilizing continuum of care services? It has become apparent most women over 40 do not enter the continuum of care because they do not get screened annually. The largest barriers are lack of Native-specific education, little accessibility to screening services, and lack of trust with providers. If a woman does receive screening, and has an abnormal mammogram, no issues were apparent regarding a women remaining in the continuum of care.

Therefore, the conclusions drawn in the target community of Oglala Lakota, Jackson and Bennett Counties lead to the fact women are diagnosed at a late-stage because they never enter the continuum due to lack of accessible screening sites and lack of Native-specific education. Women are often unaware of their risk due to low education levels. If they do wish to be screened, it is difficult to pay for transportation to a screening facility in this very rural area.

#### *Limitations of the Qualitative Data*

Although the document review technique was a successful method in collecting qualitative data, the Community Profile Team experienced many difficulties in collecting data through key informant interviews for this target community. Komen South Dakota staff were able to initially contact providers and community leaders living on the reservation; however, when asked if these individuals would participate in an interview, approval by the Great Plains Institutional Review Board was required before moving forward. This approval process is lengthy, cumbersome and oftentimes at a complete standstill. Unfortunately, approval to conduct interviews in order to gain insight on breast cancer disparities for American Indian women within the reservation has not yet been granted to the Affiliate by the Great Plains Institutional Review Board at the time of this narrative. The lack of ability to collect qualitative data using a variety of methods limits the ability to generalize the information to the target population.

## **Lawrence and Pennington Counties**

Qualitative data findings for Lawrence and Pennington are directly tied to the key assessment question: Why are women over 40 not getting screened? Fear, discomfort and cost were all determined to be barriers to screening; however, more emphasis was placed on where the responsibility for scheduling screening should be placed. Some women agreed the Primary Care Physician should schedule each patient's screening with the use of a reminder card, yet others noted women over 40 do not attend an annual physical at all, making it difficult for the provider to recommend yearly screening. A larger push for breast cancer education on various media channels was suggested by many as a solution to this issue.

Therefore, the conclusions drawn from Lawrence and Pennington Counties point to an increased need in education that encourages women to seek screening. Both at the provider level and in the community, awareness and education on the importance of early detection must be a focus.

### *Limitations of the Qualitative Data*

Minimal limitations were found in collecting qualitative data for Lawrence and Pennington Counties. Many women were interested in contributing and due to a very organized data collection process, attendance and participation in both collection methods were extremely successful. However, because of the general geographic size of the target community, and the fact the focus groups were conducted primarily with women who had previously been screened, the data may be skewed to their opinions over others who did not attend the focus groups. Also, with both the key informant interviews and focus groups, because the sample size was small compared to the population as a whole, it is a concern the results may not be generalized to the larger population. However, because key informant interviews were conducted in addition to the focus groups, the Affiliate feels broad opinions were collected.

## **Beadle County**

The qualitative data collected was based on the assessment question: Why are women over 40 not getting screened for breast cancer? The Community Profile Team confirmed the qualitative data findings were linked to this question by realizing women are afraid to get screened, have financial constraints or have language barriers which prevent health care.

Therefore, the conclusions drawn surround a recent influx of linguistically isolated women including the low-income refugee population, the Karen, and a large Hispanic/Latino population in the community. While translation services are accessible through Lutheran Social Services and clinics such as the James Valley Community Health Center, translators are not always available to be at each appointment with the patient. Additionally, breast health is often not a focus and is outweighed by other, more basic health needs upon initial arrival in the community by refugees. Therefore, translated education must be a focus in this target community. Further, financial constraints are a barrier to care. If a mammogram is referred after a clinical breast exam, oftentimes, a woman will simply not schedule the follow-up appointment out of fear surrounding the ability to pay for it. For this reason, a focus on programs which provide free or low cost screening services must also be a priority.

### *Limitations of the Qualitative Data*

Limitations of the data for this target community include not capturing the voice of the refugee population; however, key community leaders who work with the refugees were interviewed and

therefore this viewpoint is reflected via a third party. Further, it is hard to generalize the larger population from a small number of interviews. However, it should be noted key informant interviews were a strong asset and provided great insight because it allowed the Community Profile Team to explore the topic in great depth. Additionally, the document review could limit the data collected by nature of its methodology because qualitative data collected through documents may be limited in its comprehensive scope.

# Mission Action Plan

## **Breast Health and Breast Cancer Findings of the Target Communities**

### **Quantitative Data Report Summary**

An analysis of the quantitative data from communities across the state identified the three highest need areas in which the Affiliate will focus its resources over the next four years. Multiple counties within the service area had data suppressed due to small numbers for breast cancer incidence, death rates and trends; therefore, socioeconomic factors were also relied upon with the addition of supplemental data collected on minority populations within the state. Attention was given to where time and resources would make the largest impact with a focus given to both the HP2020 data and the most vulnerable populations in the service area. The three target communities selected include: (1) Oglala Lakota, Jackson and Bennett Counties with a focus on women living within the Pine Ridge Reservation, (2) Lawrence and Pennington Counties and (3) Beadle County.

As a result of the initial quantitative data review, it was concluded Oglala Lakota, Jackson and Bennett Counties are at high risk of breast cancer disparities due to socioeconomic factors including high unemployment percentages, low education levels, high uninsured percentages and high poverty levels. Further, each of these counties are medically underserved.

Lawrence and Pennington Counties were defined as areas of high and highest priority with respect to the HP2020 initiative. Pennington County is only one year shorter (12 years compared to the baseline 13 years) in its predicted time to achieve death rate target. Also, Pennington County accounts for nearly 12.3 percent of all new late-stage cases in the state.

Finally, a rural county in the Affiliate's service area, Beadle County, was chosen as a target community based on low socioeconomic factors and the high percentage of minority populations. Additionally, it is not predicted to meet the HP2020 initiative for late-stage incidence.

### **Health Systems and Public Policy Analysis Summary**

After conducting the Health Systems and Public Policy Analysis, it was found the needs are great across all target communities within Komen South Dakota's service area. Specifically, the Pine Ridge Indian Reservation has great need throughout the entire CoC because programs and services on the reservation are severely lacking. Continuing to build the outreach programs already in place will decrease the barriers found throughout the CoC in this community.

While great services and programs exist within Lawrence and Pennington Counties through access to its Cancer Care Institute, travel still remains a hurdle for rural women and the late-stage diagnosis rate continues to trend higher than the Affiliate service area as a whole. The partnership with Healing Pathways is important to Komen South Dakota and the Walking Forward program is an area in which the Affiliate could provide assistance. Education could also help eliminate delayed entry into the CoC for this community.

Finally, Beadle County offers a medical center with treatment programs, but again, travel in this rural county is an issue and considerable weakness. Through collaboration with Huron Regional

Medical Center, to address the unique needs of the community and the increasing minority population, gaps in language barriers and entry into the CoC could be addressed.

Key partnerships for the Affiliate should continue to focus on the patient navigation system in all target communities and address the specific needs of women and the barriers to entering the CoC. Partnerships including the Healing Pathways program in Rapid City should be enhanced while others, like the Walking Forward program, should be targeted as a new potential partnership. The South Dakota Cancer Control Plan and the Northern Plains Comprehensive Cancer Control Program are all important programs within the state and collaboration between all entities for their success is vitally important. The Affiliate will continue to build its relationships with these entities in order to carry out its mission in South Dakota. The Affiliate also dedicates time and resources to advocating for patient rights and continues to look for opportunities to strengthen its policy work. Collaboration between other state organizations including the American Cancer Society Cancer Action Network and the South Dakota Department of Health, among others, will enhance the Affiliate's policy work to educate lawmakers on the importance of breast health issues.

### **Qualitative Summary**

The qualitative data findings for Oglala Lakota, Jackson, and Bennett Counties are linked to the key assessment question: *Why are women living on the Pine Ridge Reservation not utilizing CoC services?* It became apparent most women over 40 do not enter the CoC because they do not get screened annually. The largest barriers are lack of Native-specific education, little accessibility to screening services, and lack of trust with providers. If a woman does receive screening, and has an abnormal mammogram, no issues were apparent regarding a woman remaining in the CoC. Therefore, the conclusions drawn in the target community of Oglala Lakota, Jackson and Bennett Counties lead to the fact women may be diagnosed at a late-stage because they never enter the continuum due to lack of accessible screening sites and lack of Native-specific education. Women may often be unaware of their risk due to low education levels. If they do wish to be screened, it is difficult to pay for transportation to a screening facility in this very rural area.

Qualitative data findings for Lawrence and Pennington Counties were directly tied to the key assessment question: *Why are women over 40 not getting screened?* Fear, discomfort and cost were all determined to be barriers to screening; however, more emphasis was placed on where the responsibility for scheduling screening should be placed. Some women agreed the Primary Care Physician should schedule each patient's screening with the use of a reminder card, yet others noted women over 40 do not attend an annual physical at all, making it difficult for the provider to recommend yearly screening. A larger push for breast cancer education on various media channels was suggested by many focus group participants as a solution to this issue. Therefore, the conclusions drawn from Lawrence and Pennington Counties point to an increased need in education which encourages women to seek screening. Awareness and education on the importance of early detection must be a focus at the provider level and in the community.

The qualitative data collected in Beadle County was based on the assessment question: *Why are women over 40 not getting screened for breast cancer?* The Community Profile Team confirmed the qualitative data findings were linked to this question by realizing women are afraid to get screened, have financial constraints or have language barriers which prevent health care.

Therefore, the conclusions drawn surround a recent influx of linguistically isolated women including the low-income refugee population, specifically the Karen minority group, and a large Hispanic/Latino population in the community. While translation services are accessible through Lutheran Social Services and clinics such as the James Valley Community Health Center, translators are not always available to be at each appointment with the patient. Additionally, breast health is often not a focus and is outweighed by other, more basic health needs upon initial arrival in the community by refugees. Therefore, translated education must be a focus in this target community. Further, financial constraints are a barrier to care. If a mammogram is referred after a clinical breast exam, oftentimes, a woman will simply not schedule the follow-up appointment out of fear surrounding the ability to pay for it. For this reason, a focus on programs which provide free or low cost screening services must also be a priority.

## **Mission Action Plan**

### **Oglala Lakota, Jackson and Bennett Counties with a focus on women living within the Pine Ridge Reservation**

**Problem:** The combination of poor health insurance coverage and poverty puts individuals living on American Indian reservations at a tremendous disadvantage to accessing education and screening, as indicated by the quantitative and qualitative data. These barriers are common among all American Indian populations throughout the state.

**Priority: *Support outreach and health programs which provide breast health education and services which break down cultural and language barriers for American Indian women, especially in Oglala Lakota, Jackson and Bennett Counties.***

*Objective 1:* By October 2017, collaborate with the Northern Plains Comprehensive Cancer Program to notify tribal health entities about the Affiliate's RFA and grant funding availability for American Indian reservations. A least one tribal entity who serves Oglala Lakota, Jackson and Bennett Counties will be provided with information about funding opportunities through Komen South Dakota.

*Objective 2:* By FY 2018, partner with appropriate physician education programs and organizations to create and implement a culturally sensitive training program for new and current medical providers that provide services to American Indians. A least one medical provider that serves Oglala Lakota, Jackson and Bennett Counties will complete the training program.

*Objective 3:* By October 2015, revise the Community Grant RFA to give funding priority to programs that use innovative or evidence-based approaches that result in documented linkages to breast cancer screening, diagnostic, treatment and/or supportive services among American Indian women living within Oglala Lakota, Jackson and Bennett Counties and throughout the state.

## Lawrence and Pennington Counties

**Problem:** A lack of education on the importance of breast health may be an impediment of early detection for women living in Lawrence and Pennington Counties as indicated by the qualitative data.

**Priority:** *Promote early detection and the availability of financial assistance programs for uninsured women.*

*Objective 1:* From 2016-2019 participate in at least two health expos per year in Lawrence and Pennington Counties. Provide 500 pieces of educational material to expo attendees and speak one-on-one with 50 women about the importance of early detection.

*Objective 2:* In FY 2017 offer two 'Lunch and Learn' opportunities with local employers to provide breast health education and the opportunity for women 40+ to sign up for a mammography appointment.

**Priority:** *Increase provider understanding of breast self-awareness messages supported by Susan G. Komen and knowledge of various referral processes to better navigate their patients through the continuum of care.*

*Objective 1:* Work with the All Women Count! Program in FY 2017 to notify at least 10 providers in Pennington County and at least three providers in Lawrence County about the availability of screening assistance programs in their area.

## Beadle County

**Problem:** Women living in Beadle County struggle with language barriers and financial constraints which may prohibit early detection as indicated by the qualitative data.

**Priority:** *Increase breast health outreach to the Hispanic/Latina and Karen community in Beadle County.*

*Objective 1:* By October 2016 distribute bilingual educational materials to Huron Regional Medical Center, Lutheran Social Services, and at least one other local community partner located in Beadle County.

*Objective 2:* During FY 2016-2017 provide outreach via Affiliate Education Outreach Coordinator to provide 120 women with one-on-one culturally appropriate breast health education. Translate for 10 Spanish speaking women to enable sign up of mammography appointments for Hispanics/Latinas in Beadle County

**Priority: Increase education on screening financial assistance programs available to women in Beadle County.**

*Objective 1:* By October 2016, provide information about availability of financial assistance programs for uninsured women (e.g., All Women Count) to at least three support programs and/or organizations in Beadle County.

*Objective 2:* By October 2017, collaborate with the Comprehensive Cancer Control Program to establish a formal partnership with at least one large employer in Beadle County to conduct an ongoing annual breast cancer screening campaign.

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