susan g. komen®

COMMUNITY PROFILE REPORT 2015

SUSAN G. KOMEN®

NEBRASKA

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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, including Kate Sommer. Susan G. Komen Nebraska dedicates this report and its ongoing, collaborative efforts in memory of Kate Sommer who lost her life to metastatic breast cancer in July 2015. Kate brought the Race for the Cure to Nebraska in 1994 and was instrumental in founding Susan G. Komen Nebraska. She took an active role at the local and national levels of Susan G. Komen that allowed her to share her wisdom and inspiration with many people. Kate was an unrelenting advocate for education and research whose spirit will continue to inspire us for years to come.

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Executive Summary

Introduction to the Community Profile Report

Susan G. Komen Nebraska began like most other Komen Affiliates. Many brave breast cancer survivors worked diligently to bring a Race for the Cure® to their home town. In 1994, this occurred in Omaha, Nebraska. As breast health needs persisted in Nebraska, organizational incorporation soon followed in 2002. Currently, the Affiliate's service area is comprised of 91 out of 93 counties in Nebraska, with Komen Siouxland serving Dakota and Thurston counties near Sioux City, Iowa. With a very large number of counties with dispersed populations in Nebraska, it has been a challenge to address the breast health needs of the state with only volunteers. To answer the call brought forth by this challenge, Komen Nebraska hired its first staff in 2007 and four full-time staff currently operate its Omaha office. To further increase Komen's reach across the state of Nebraska and provide a visible presence outside the eastern part of the state, a second Race for the Cure was added in 2011 in Kearney, Nebraska.

Over two decades, the Affiliate has invested over eight million dollars to improve the breast health services and address the needs of the underserved and uninsured breast cancer survivors across the state. Over six million dollars in grants have helped address breast health education, breast cancer screening and treatment support / survivorship programs for Nebraska women, men and families who have been touched by breast cancer. There have been some notable highlights in awarded grants, including: *A Time To Heal* breast cancer survivorship program first funded by Komen Nebraska; the *Breast Cancer Hotline* conducted by Legal Aid of Nebraska, the second such program in the nation; and the University of Nebraska Medical Center Community *Breast Health Navigator and Cancer Support Program* (again, the second such program in the nation), provides resources for breast cancer patients to empower their own advocacy.

Komen Nebraska is involved in several breast cancer and breast health coalitions across the state, and prides itself on connecting those in need with resources to help with education, screening, treatment support and survivorship programs. Komen Nebraska has brought breast cancer researchers to Nebraska to provide health care practitioners first hand exposure to the latest advances in care. Komen Nebraska is a partner in the Nebraska Breast Cancer Control Partnership, is active with the Metro African-American Breast Cancer Task Force, and participates in the North Omaha and South Omaha Community Care Councils. The Affiliate routinely participates in health fairs and community engagement forums to promote breast health self-awareness.

As resources for overall health continue to evolve and access to care improves, it is important to understand the state of breast health in Nebraska. This Community Profile is the product of assessing the community needs for breast health resources using quantitative, qualitative, health system and public policy analysis. This report identifies the gaps in the breast health system within the target communities to help determine the focused priorities of Komen Nebraska. It will help align strategic and operational plans to drive collective efforts in the Affiliate communities, identify public policy efforts, establish focused grantmaking priorities and educational needs, provide for targeted marketing and outreach, and strengthen sponsorship efforts. This Community Profile is created to be a resource and a guide for Komen Nebraska, breast health stakeholders, and lay community members to direct and commonly align efforts that fight breast cancer morbidity and death in Nebraska. Achieving these goals will help save lives and eventually end breast cancer forever by empowering people, ensuring quality care for all and energizing science to continue its search for cures.

Quantitative Data: Measuring Breast Cancer Impact in Local Communities

The first step in analysis included reviewing the quantitative data for the Affiliate service area. The Healthy People 2020 report (HP2020) was used to prioritize those communities in Nebraska with high breast cancer death and late-stage breast cancer diagnosis. It is important to note that Nebraska as a whole may achieve the HP2020 targets for breast health, but certain counties will not meet these goals. And while these particular counties are singled out, it is also important to note that Nebraska's population is small as compared to other states. There are many counties with small population densities that do not have large enough numbers of breast cancer cases or breast cancer deaths to support the generation of reliable statistics. A similar statistical issue is also seen in screening mammography, as data is derived from a survey of a percentage of the total population; and screening rates may not be available for counties with small populations. The Community Profile team chose the geographical construct of Nebraska's U.S. Congressional Districts as a framework to identify the target communities that would ensure urban, rural and mixed urban/rural areas of the state would be represented regardless of the statistically relevant data available.

The first target community is Saunders County, adjacent to Douglas County in the eastern portion of Nebraska, located within Nebraska's First Congressional District. The data revealed that this county is rural, has a much older population (> 50 years of age), and has a lower overall poverty rate than the rest of the state. The mammography rate is much lower at 65.7 percent than either the Nebraska or U.S. proportion of screened mammography (weighted average). The female breast cancer death rate and late-stage breast cancer diagnostic rate is designated as "high risk" for achieving the Healthy People 2020 goals, i.e., most likely to take more than 13 years to reach the target rates.

The second target community is Douglas County, located within Nebraska's Second Congressional District and including the greater metropolitan area of Omaha and surrounding suburbs. Douglas County is considered urban and has the highest percentage of Black/African-American residents in the state. The county's poverty rate is 8.6 percent overall, but there are smaller areas within the county that have much higher poverty rates. More specifically, Douglas County's northeast quadrant (better known as North Omaha) has the highest concentration of Black/African-Americans and has a poverty rate of 29.6 percent. Furthermore, the breast cancer death rate for Black/African-American women (27.6/100,000) is much higher than the county as a whole (22.1/100,000) and the state (20.2/100,000). The female breast cancer late-stage diagnostic rate is high risk for not achieving the Healthy People 2020 goals, with greater than 13 years to reach the target rate. Given this marked disparity, Black/African-American women who reside in North Omaha are the focus of the study rather than the county as a whole.

The third target community residing in central/western Nebraska is over 200 miles from the other target communities, and is located within Nebraska's Third Congressional District. Custer, Dawson and Lincoln Counties comprise the third target community for the Community Profile, and while they are contiguous, each has similar, yet independent challenges and issues. Custer County is considered rural, has an older population, a much higher poverty rate, and a much higher proportion of the population without health insurance than the rest of the state. The mammography rate (66.0 percent) is much lower than either the Nebraska or U.S. proportion of screened mammography (weighted average). The female breast cancer late-stage diagnostic rate is designated as high risk for not achieving the Healthy People 2020 goal, with more than 13 years to reach the target rate.

Dawson County has a high percentage of Hispanic/Latino(a) residents, which at 30.9 percent is almost three times the state average. Compared to Nebraska averages, the Dawson County population has a lower number of high school graduates, a higher poverty rate, a very high population without health insurance, and a population that is isolated linguistically. The

mammography rate is much lower, and the breast cancer late-stage diagnostic rate is rated high risk for not achieving the Healthy People 2020 goals, with more than 13 years to reach the target rate.

Lincoln County is a mix of both urban and rural communities older than the Nebraska average population. The proportion of persons who are poor, without health insurance, or ethnic/racial minorities are not as great as the other counties in the target community. However, the breast cancer death rate and late-stage diagnostic rate are both rated high risk for not achieving Healthy People 2020 goals, taking more than 13 years to reach the target rates.

Health System and Public Policy Analysis

Once the target communities were identified, the second step in the analysis involved reviewing the health systems for the Affiliate service area and breast health public policy for the entire state.

The Breast Cancer Continuum of Care (CoC) model reflects how a person would typically move through the health care system for breast care. With education surrounding the model as the foundation for each segment, a person would ideally move through the CoC (screening, diagnosis, treatment and survivorship) quickly and seamlessly, receiving timely, quality care in order to have the best breast health outcomes. Education is a key element to all aspects of the CoC. Barriers to progressing through the CoC model can contribute to poorer health outcomes.

These barriers can include, but are not limited to, a lack of transportation, system issues including long waits for appointments and inconvenient hours, language, cultural differences, financial issues, lack of information, distrust or wrong information (myths and misconceptions), and general fear. These and many other reasons were explored during the Community Profile assessment. Across the state of Nebraska, access to health care facilities that specialize in breast health is limited and travel distance is great. For example, in Saunders County, there is one facility for mammography, but other breast health services (e.g. surgery, radiation) have to be completed at locations outside the county. Similar environments in Custer and Dawson Counties reflect the limited scope of breast health resources, with many residents in the counties driving more than 100 miles one way for treatment. On the other hand, Lincoln and Douglas Counties have accredited cancer hospitals that provide all CoC services.

Regarding public policy initiatives, the state of Nebraska does participate in the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) known as the Every Woman Matters (EWM) program. As of the publication of this Community Profile report, Nebraska has elected not to adopt Medicaid expansion and excludes non-citizens from enrolling in the EWM program. According to the EWM office in 2014, approximately one-third of potential EWM enrollees are no longer entitled to services because of changes in eligibility and lack of Medicaid expansion (approximately 54,000 to 80,000 Nebraskans). For breast health / breast cancer needs, these limitations add additional stressors to those trying to access care.

Geographically, Nebraska is a big state with limited overall breast cancer resources, and cost, distance and fear are some factors complicating care. The individuals within the target communities communicated their thoughts in the qualitative portion of the study.

Qualitative Data: Ensuring Community Input

To obtain community perspectives on the state of breast health in the target communities, the Community Profile team used two qualitative data collection methods. Focus groups and key informant interviews were identified by snowball samplings of organizations that cater to local stakeholders for women's health, Komen Nebraska contacts, past grantees and public health organizations. The assessments were conducted over a three-month period in the target communities through one-on-one interviews with key informants (health care providers or those

who provide services to women) and targeted focus groups in the lay community. The intended audiences of the focus groups were women over 40 years of age, and the intended audiences for the key informants interviews were individuals who serve women over the age of 40.

The questions for the focus groups and key informant interviews centered on the knowledge of screening, diagnosis, treatment and survivorship in the communities as components of the CoC. The CoC model was used as a guide to determine why some individuals never enter, delay entry, or fall out of breast health care. This model provides a framework that helps assess the gaps in service availability, identifies the gaps and misunderstanding — or lack of education— about services in the community. This model was used for all qualitative engagements.

Even though the target communities are diverse in age, location (urban vs. rural), race, and number of health facilities readily available, three consistent themes emerged from the focus groups and key informant interviews. First, the qualitative data collection showed that for all the target communities, concern about the affordability of screening and treatment was paramount. Even if the EWM program was known and used, there was concern about the cost of screening and treatment delaying care. For those ineligible for EWM because of citizenship or income status, the concern was even greater.

Secondly, in all the communities there were fears about screening and treatment – how much it hurt and how futile the treatment might be. A number of myths or wrong assertions about current screening and treatment appeared to be the result of misinformation.

Finally, in all groups there was a call to increase access to care, meaning distance to care and availability of care. For women pulled in many directions because of family, work demands, costs, and fear, breast health was not the most important concern.

Mission Action Plan

Using the data collected in the quantitative, health system and public policy analysis, and qualitative sections, a plan of action was developed.

The Community Profile team derived the problem statements from the data obtained in the target communities. There are similar concerns for each of the three target communities, but specific differences do arise. For Saunders County, target community one, the major problems were lack of services and lack of knowledge of local services. Compounding this lack of knowledge were concerns over affordability and the lack of trust in the local services. These same problems were also observed in target community three, Custer, Dawson and Lincoln Counties. Douglas County, target community two, focused on the experiences of Black/African-American women in that county. The data showed that affordability and availability of services for Black/African-American women in North Omaha made it difficult to seek care.

Improving access to care for each specific population in the target communities is the top priority. This priority is for women over 40 who live in all the targeted counties, and for some specific demographic groups, such as Latina women in Dawson or Black/African-American women in Douglas counties.

The objectives for Saunders County over the next four years include partnering with organizations in the community to raise awareness, and providing education classes to address the needs for services and financial support throughout the CoC. Following the education encounters, there should be engagement with health agencies to publicize options to help finance breast health services. And finally, there should be a summit with providers to discuss possible partnerships to increase access to, and seamless progression through, the CoC.

The objectives for Douglas County as target community two include partnering with organizations to discuss breast health outreach and financial options for screening and

treatment within the next two years to improve the breast health for Black/African-American women in North Omaha. The long term objective is to improve access to, and seamless progression through, the CoC through referrals, screenings, treatment programs, and support services, within the county.

As noted previously, the problems for Custer, and Lincoln counties (target community three) are not that different from target community one. Over the next four years, the goals include partnering with organizations in the community to raise awareness and have education classes to address the needs for services and financial support throughout the CoC. Following the education encounters, there should be engagement with health agencies to publicize the option to help finance breast health services. And finally, there should be a summit with providers to discuss possible partnerships to increase access to, and seamless progression through, the CoC. For Dawson County, which has a high percentage of Hispanic/Latina women, there are specific objectives focused on that population. The goal is to provide access to services in a culturally sensitive manner to address the needs for services and financial support. Following the education encounters, there should be engagement with health agencies to publicize the options to help finance breast health services, especially for the target population.

Last, but not least, the Community Profile team highlighted one global problem that spans the entire service area. The problem identified is limited access to breast health services and little to no access to financial support for those with limited ability to pay without Medicaid expansion. One approach to rectify this situation is to increase state legislators' understanding of breast health issues through education. This will be accomplished in the next four years by conducting mailings to legislators to increase Komen's visibility as a resource on breast health. In addition, Komen Nebraska will work with others, including Komen Siouxland, to target public policy efforts, including advocating for increased state funding for breast health.

Disclaimer: Comprehensive data for the Executive Summary can be found in the 2015 Komen Nebraska Community Profile Report

Introduction

Affiliate History

The concept of what would become Susan G. Komen® Nebraska began in July of 1992. Catherine "Kate" Sommer, and a group of trusted breast health stakeholders that included other survivors, community activists, and medical professionals, gathered together in Omaha, Nebraska to contemplate how best to raise awareness about breast cancer in Nebraska. This meeting brought forth an initiative to bring a Susan G. Komen Race for the Cure® to Nebraska. On this group's behalf, a proposal was submitted to the Junior League of Omaha that established a committee of 13 women who were passionate about the risk reduction of breast cancer. With a budget of $3,000, strong will, focused determination, and some good luck, these 13 women powered beyond the obstacles and produced the first race in 1994 where 1,300 runners/walkers (83 survivors) braved the elements at Cancer Survivors Park in Omaha to commemorate the first Nebraska Race for the Cure®. The net proceeds of $36,000 from the race helped support activities of the Nebraska Every Woman Matters Program, the only grantee at the time.

From 1994 through 1998, Cancer Survivors Park in Omaha remained home for the Race. With additional support and expanding notoriety, the Race saw enormous enrollment increases. This growth demanded a move to several venues better suited to embrace the size of the Race. Increasing participation year-over-year also presented the opportunity to expand the impact of the Race beyond Omaha to Kearney, Nebraska. Since 2011, additional races have been held in Kearney.

In 2002, the Nebraska Race for the Cure® incorporated as Susan G. Komen Nebraska. It began to operate as an organization with a governing board and hired its first staff member in 2007. With the primary objective of living the Komen mission, the Affiliate broadened its focus beyond the Race, and set its sights on expanding grant funding to programs across the state of Nebraska. Since its inception, Komen® Nebraska has made great strides in improving breast health services and addressing the needs of the underserved and uninsured breast cancer survivors across the state. The annual grant funding program has invested over eight million dollars in breast health education, breast cancer screening, treatment support and survivorship programs over the past two decades. There have been some notable firsts in awarded grants, including the A Time To Heal breast cancer survivorship program first funded by Komen Nebraska; a Breast Cancer Hotline run by Legal Aid of Nebraska, only the second of such a program in the nation; and the University of Nebraska Medical Center Community Breast Health Navigator and Cancer Support Program — again only the second such program in the nation — that provides resources for breast cancer patients.

Komen Nebraska is currently involved in many breast cancer and breast health coalitions throughout the state, and it prides itself on connecting those in need with resources to help with education, screening, treatment support and survivorship programs. Komen Nebraska collaborated with the authors of the Nebraska Comprehensive Cancer Control Plan (2011 – 2016) and the Nebraska Breast Cancer Control Plan (2011 – 2016), and is actively involved in several community groups. To address disparities within communities, Komen Nebraska is active with the Metro African-American Breast Cancer Task Force and the North Omaha and South Omaha Community Care Councils. Komen Nebraska routinely participates in health fairs to promote breast health self-awareness. In addition, they have visited to the Mexican Consulate in Omaha to provide information in Spanish. Last but not least, Komen Nebraska has consistently funded grants to bring breast cancer researchers to Nebraska so health providers can hear first-hand results and new advances in care.

Affiliate Organizational Structure

Susan G. Komen has headquarters in Dallas, Texas, and is governed by a Board of Directors. Komen Headquarters and all Komen Affiliates, including Komen Nebraska, are separate, distinct legal entities. However, they are mutually interdependent organizations working together in pursuit of the common mission. Komen Nebraska is governed by a 15-member, working volunteer Board of Directors and employs four full-time staff. The community work is accomplished through the activities of four full time staff and community volunteers that include Board members. The Board is comprised of several committees (See Figure 1.1). They are the Executive, the Development, the Governance, and Mission Committees.

Susan G. Komen® Nebraska Board of Directors

Executive Committee:
Board Representatives
- President
- Secretary
- Past President
- Treasurer
- Member at large; non-voting
- Executive Director; non-voting

Development Committee:
Board Representatives:
- Chair

Non-Board members
Staff Representatives
Race Representatives

Governance Committee:
Board Representatives:
- Chair

Staff Representative:
Ad Hoc (Strategic Planning Committee):
Non-Board Members:

Mission Committee:
Board Representatives:
- Chair

Staff Representatives:
Non-Board members:
Ad Hoc (Grants Committee):
Ad Hoc (Community Profile):
Ad Hoc (Conversations for the Cure)

Finance Committee:
Board Representatives:
- Chair

Staff Representatives:

Figure 1.1. Susan G. Komen Nebraska Board of Directors Structure

Affiliate Service Area

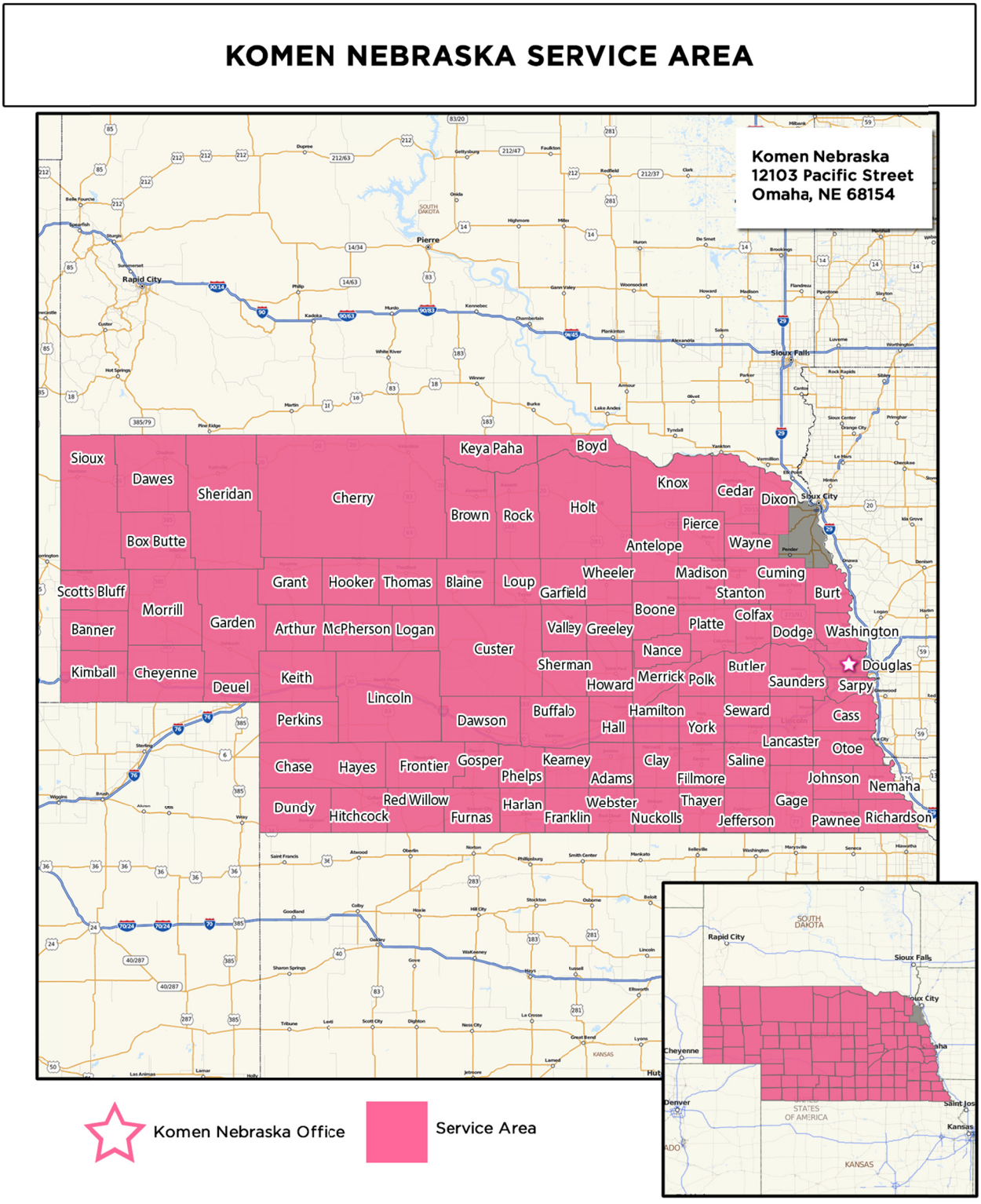


Figure 1.2. Susan G. Komen Nebraska Service Area

Purpose of the Community Profile Report

The climate of breast health in America continues to change. In an attempt to keep pace with the evolving circumstances focused on breast health, and to ultimately save lives, Komen periodically identifies the primary breast health needs of local communities to ensure that its efforts remains relevant. From January 2014 through April 2015, Komen Nebraska conducted a community needs assessment of the state of breast health, including breast cancer and breast health resources in Nebraska. This information resulted in the 2015-19 Community Profile Report that has as its primary goal to identify gaps in breast health. This report helps guide Komen Nebraska toward collective impact by aligning strategic and operational plans that drive inclusion efforts in the communities, by identifying public policy efforts, establishing focused grantmaking priorities, directing marketing and outreach for educational needs, and strengthening sponsorship efforts.

The Community Profile is created as a resource for community members, grantees, partners, sponsors, policymakers, and other stakeholders as a formal attempt to direct and commonly align efforts to fight breast cancer morbidity and death in Nebraska. This report was created to be disseminated into communities across the state of Nebraska and will permeate into local institutions such as health and education systems with a hope of reaching future partners in the fight for breast health in Nebraska. Elemental components of this distribution may include statewide notification through emails and press releases, small group discussions and prominent placement on the Komen Nebraska website. In addition, all groups that participated in generating the information (focus groups, key informants) will receive a copy, along with many public policy entities and public health agencies.

Quantitative Data: Measuring Breast Cancer Impact in Local Communities

Quantitative Data Report

Introduction

The purpose of the quantitative data report for Susan G. Komen® Nebraska 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 were used to identify priorities within the Affiliate's service area based on estimates of how long it would take an area to achieve Healthy People 2020 objectives for breast cancer late-stage diagnosis and death (http://www.healthypeople.gov/2020/default.aspx).

The following is a summary of Komen® Nebraska'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.

		Incidence Rates and Trends			Death Rates and Trends			Late-stage Rates and Trends		
Population Group	Female Population (Annual Average)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of Deaths (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)
US	154,540,194	182,234	122.1	-0.2%	40,736	22.6	-1.9%	64,590	43.8	-1.2%
HP2020	.	-	-	-	-	20.6*	-	-	41.0*	-
Nebraska	907,187	1,251	122.3	-1.7%	224	20.1	-2.6%	426	42.4	-4.3%
Komen Nebraska Service Area	893,341	1,238	122.8	-1.6%	221	20.2	NA	422	42.6	-4.1%
White	820,613	1,181	123.2	-1.8%	211	20.1	NA	399	42.6	-4.2%
Black/African-American	45,141	38	123.2	-0.2%	8	27.6	NA	16	50.6	-5.9%
American Indian/Alaska Native (AIAN)	9,568	5	106.4	-2.1%	SN	SN	SN	SN	SN	SN
Asian Pacific Islander (API)	18,019	7	58.9	33.0%	SN	SN	SN	SN	SN	SN
Non-Hispanic/ Latina	824,705	1,208	123.6	-1.7%	216	20.2	NA	409	42.8	-4.2%
Hispanic/ Latina	68,635	31	98.7	7.1%	5	20.0	NA	13	39.3	3.3%

		Incidence Rates and Trends			Death Rates and Trends			Late-stage Rates and Trends		
Population Group	Female Population (Annual Average)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of Deaths (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)
Adams County - NE	15,690	27	147.3	-0.5%	4	22.1	-2.5%	10	56.5	7.4%
Antelope County - NE	3,368	7	133.2	0.3%	SN	SN	SN	SN	SN	SN
Arthur County - NE	226	SN	SN	SN	SN	SN	SN	SN	SN	SN
Banner County - NE	336	SN	SN	SN	SN	SN	SN	SN	SN	SN
Blaine County - NE	230	SN	SN	SN	SN	SN	SN	SN	SN	SN
Boone County - NE	2,786	5	111.5	10.1%	SN	SN	SN	SN	SN	SN
Box Butte County - NE	5,742	9	117.8	-0.3%	SN	SN	SN	SN	SN	SN
Boyd County - NE	1,084	SN	SN	SN	SN	SN	SN	SN	SN	SN
Brown County - NE	1,636	SN	SN	SN	SN	SN	SN	SN	SN	SN
Buffalo County - NE	22,988	30	125.8	-1.9%	6	24.7	-0.2%	10	43.0	-7.4%
Burt County - NE	3,558	7	120.8	17.1%	SN	SN	SN	SN	SN	SN
Butler County - NE	4,179	7	117.0	12.9%	SN	SN	SN	SN	SN	SN
Cass County - NE	12,595	17	118.3	-13.4%	SN	SN	SN	7	48.1	-23.0%
Cedar County - NE	4,392	5	72.5	-21.8%	SN	SN	SN	SN	SN	SN
Chase County - NE	1,997	SN	SN	SN	SN	SN	SN	SN	SN	SN
Cherry County - NE	2,892	5	129.3	3.3%	SN	SN	SN	SN	SN	SN
Cheyenne County - NE	5,056	8	134.8	10.9%	SN	SN	SN	SN	SN	SN
Clay County - NE	3,288	4	85.8	19.5%	SN	SN	SN	SN	SN	SN
Colfax County - NE	4,967	4	79.9	-1.2%	SN	SN	SN	SN	SN	SN
Cuming County - NE	4,661	6	106.3	2.8%	SN	SN	SN	SN	SN	SN
Custer County - NE	5,532	10	124.3	16.5%	SN	SN	SN	5	63.2	19.5%
Dawes County - NE	4,618	6	114.6	-13.6%	SN	SN	SN	SN	SN	SN
Dawson County - NE	11,963	12	89.5	5.3%	SN	SN	SN	5	37.2	12.0%
Deuel County - NE	1,015	SN	SN	SN	SN	SN	SN	SN	SN	SN
Dixon County - NE	3,010	4	97.1	-16.3%	SN	SN	SN	SN	SN	SN
Dodge County - NE	18,719	33	135.1	-7.8%	6	20.7	-2.2%	10	42.7	-8.1%
Douglas County - NE	257,144	336	129.4	3.3%	59	22.1	-2.2%	117	45.2	0.0%
Dundy County - NE	1,008	SN	SN	SN	SN	SN	SN	SN	SN	SN
Fillmore County - NE	3,038	5	113.5	4.4%	SN	SN	SN	SN	SN	SN
Franklin County - NE	1,619	4	164.1	1.9%	SN	SN	SN	SN	SN	SN
Frontier County - NE	1,390	SN	SN	SN	SN	SN	SN	SN	SN	SN
Furnas County - NE	2,541	5	120.3	21.6%	SN	SN	SN	SN	SN	SN
Gage County - NE	11,535	23	142.1	-0.3%	4	20.0	NA	7	39.3	-1.1%

		Incidence Rates and Trends			Death Rates and Trends			Late-stage Rates and Trends		
Population Group	Female Population (Annual Average)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of Deaths (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)
Garden County - NE	1,015	SN	SN	SN	SN	SN	SN	SN	SN	SN
Garfield County - NE	1,023	SN	SN	SN	SN	SN	SN	SN	SN	SN
Gosper County - NE	1,026	SN	SN	SN	SN	SN	SN	SN	SN	SN
Grant County - NE	292	SN	SN	SN	SN	SN	SN	SN	SN	SN
Greeley County - NE	1,272	SN	SN	SN	SN	SN	SN	SN	SN	SN
Hall County - NE	28,573	34	106.2	-6.4%	6	18.0	-3.6%	12	35.7	-14.1%
Hamilton County - NE	4,603	7	123.5	-5.7%	SN	SN	SN	3	61.1	-5.4%
Harlan County - NE	1,729	4	200.8	-2.3%	SN	SN	SN	SN	SN	SN
Hayes County - NE	464	SN	SN	SN	SN	SN	SN	SN	SN	SN
Hitchcock County - NE	1,481	SN	SN	SN	SN	SN	SN	SN	SN	SN
Holt County - NE	5,297	9	116.0	-17.8%	SN	SN	SN	SN	SN	SN
Hooker County - NE	402	SN	SN	SN	SN	SN	SN	SN	SN	SN
Howard County - NE	3,112	5	107.3	21.0%	SN	SN	SN	SN	SN	SN
Jefferson County - NE	3,924	5	71.8	-1.3%	SN	SN	SN	SN	SN	SN
Johnson County - NE	2,222	4	108.7	13.2%	SN	SN	SN	SN	SN	SN
Kearney County - NE	3,325	5	105.0	-8.0%	SN	SN	SN	SN	SN	SN
Keith County - NE	4,210	6	85.7	7.1%	SN	SN	SN	SN	SN	SN
Keya Paha County - NE	410	SN	SN	SN	SN	SN	SN	SN	SN	SN
Kimball County - NE	1,932	3	125.6	-14.9%	SN	SN	SN	SN	SN	SN
Knox County - NE	4,475	7	115.7	-19.1%	SN	SN	SN	SN	SN	SN
Lancaster County - NE	139,433	182	129.5	-2.0%	25	16.9	-4.4%	52	37.1	-3.7%
Lincoln County - NE	18,317	26	120.0	-5.5%	6	28.2	0.7%	13	60.1	-0.9%
Logan County - NE	381	SN	SN	SN	SN	SN	SN	SN	SN	SN
Loup County - NE	304	SN	SN	SN	SN	SN	SN	SN	SN	SN
McPherson County - NE	265	SN	SN	SN	SN	SN	SN	SN	SN	SN
Madison County - NE	17,481	27	135.1	-9.5%	7	28.7	-0.1%	12	61.2	-10.6%
Merrick County - NE	3,931	7	124.2	-4.9%	SN	SN	SN	SN	SN	SN
Morrill County - NE	2,539	4	121.7	18.2%	SN	SN	SN	SN	SN	SN
Nance County - NE	1,872	SN	SN	SN	SN	SN	SN	SN	SN	SN
Nemaha County - NE	3,726	6	107.5	NA	SN	SN	SN	SN	SN	SN
Nuckolls County - NE	2,335	4	117.6	-30.5%	SN	SN	SN	SN	SN	SN
Otoe County - NE	8,028	11	99.4	-7.7%	SN	SN	SN	SN	SN	SN
Pawnee County - NE	1,412	SN	SN	SN	SN	SN	SN	SN	SN	SN

		Incidence Rates and Trends			Death Rates and Trends			Late-stage Rates and Trends		
Population Group	Female Population (Annual Average)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of Deaths (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)
Perkins County - NE	1,489	SN	SN	SN	SN	SN	SN	SN	SN	SN
Phelps County - NE	4,675	7	103.5	4.3%	SN	SN	SN	SN	SN	SN
Pierce County - NE	3,613	4	72.8	NA	SN	SN	SN	SN	SN	SN
Platte County - NE	15,812	23	121.4	-11.6%	4	18.4	-13.4%	7	39.1	-14.0%
Polk County - NE	2,709	6	148.3	-29.1%	SN	SN	SN	SN	SN	SN
Red Willow County - NE	5,605	8	102.2	7.6%	SN	SN	SN	SN	SN	SN
Richardson County - NE	4,289	8	123.2	-5.2%	SN	SN	SN	3	50.5	-12.0%
Rock County - NE	783	SN	SN	SN	SN	SN	SN	SN	SN	SN
Saline County - NE	7,034	11	126.1	9.3%	SN	SN	SN	SN	SN	SN
Sarpy County - NE	76,583	90	130.8	-2.4%	13	20.6	-2.7%	32	45.9	-9.4%
Saunders County - NE	10,150	14	109.5	3.0%	3	25.3	0.7%	6	50.4	5.0%
Scotts Bluff County - NE	18,962	34	137.2	1.6%	7	26.7	-2.0%	12	49.6	-15.1%
Seward County - NE	8,159	12	113.8	-13.1%	3	25.4	NA	3	35.5	-8.1%
Sheridan County - NE	2,832	4	89.8	-4.5%	SN	SN	SN	SN	SN	SN
Sherman County - NE	1,597	SN	SN	SN	SN	SN	SN	SN	SN	SN
Sioux County - NE	669	SN	SN	SN	SN	SN	SN	SN	SN	SN
Stanton County - NE	3,132	SN	SN	SN	SN	SN	SN	SN	SN	SN
Thayer County - NE	2,690	3	75.5	-7.0%	SN	SN	SN	SN	SN	SN
Thomas County - NE	317	SN	SN	SN	SN	SN	SN	SN	SN	SN
Valley County - NE	2,185	SN	SN	SN	SN	SN	SN	SN	SN	SN
Washington County - NE	10,121	16	131.9	2.0%	SN	SN	SN	6	53.9	-8.0%
Wayne County - NE	4,807	5	113.2	-12.8%	SN	SN	SN	SN	SN	SN
Webster County - NE	1,992	4	156.9	3.6%	SN	SN	SN	SN	SN	SN
Wheeler County - NE	411	SN	SN	SN	SN	SN	SN	SN	SN	SN
York County - NE	7,114	14	142.0	-15.7%	3	30.2	NA	4	40.4	-32.5%

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

Incidence rates and trends summary

Overall, the breast cancer incidence rate in the Komen Nebraska service area was similar to that observed in the U.S. as a whole, and the incidence trend was lower than the U.S. as a whole. The incidence rate and trend of the Affiliate service area were not significantly different than that observed for the state of Nebraska.

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 Asian and Pacific Islanders (APIs) and American Indians and Alaskan 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 about the same among Blacks/African-Americans and Whites, lower among APIs than Whites, and lower among AIANs, than Whites. The incidence rate among Hispanics/Latinas was lower than among Non-Hispanics/Latinas.

The incidence rate was significantly lower in the following counties:

- Cedar County
- Dawson County
- Jefferson County
- Pierce County

Significantly more favorable trends in breast cancer incidence rates were observed in the following county:

- Cedar 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 Nebraska service area was slightly lower than that observed in the U.S. as a whole and the death rate trend was not available for comparison with the U.S. as a whole. The death rate of the Affiliate service area was not significantly different than that observed for the state of Nebraska.

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

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

- Platte 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 Nebraska service area was slightly lower than that observed in the U.S. as a whole, and the late-stage incidence trend was lower than the U.S. 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 Nebraska.

For the United States, late-stage incidence rates in Blacks/African-Americans are higher than among Whites. Hispanics/Latinas tend to be diagnosed with late-stage breast cancers more often than Whites. For the Affiliate service area as a whole, the late-stage incidence rate was higher among Blacks/African-Americans than Whites. There were not enough data available within the Affiliate service area to report on APIs and AIANs so comparisons cannot be made for these racial groups. The late-stage incidence rate among Hispanics/Latinas was slightly lower than among Non-Hispanics/Latinas.

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

- Lincoln County
- Madison County

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

Mammography Screening

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

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

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

*As of October 2015

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

The data have been weighted to account for differences between the women who were interviewed, and all the women in the area. For example, if 20.0 percent of the women interviewed are Latina, but only 10.0 percent of the total women in the area are Latina, weighting is used to account for this difference.

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

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

The number of women who had a mammogram is divided by the number who should have had one. For example, if there are 500 women in an area 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%
Nebraska	7,536	5,194	72.9%	71.6%-74.2%
Komen Nebraska Service Area	4,172	2,972	74.1%	72.4%-75.8%
White	3,921	2,792	74.0%	72.2%-75.7%
Black/African-American	150	114	78.1%	67.8%-85.8%
AIAN	19	11	79.1%	47.3%-94.1%
API	13	8	61.7%	29.6%-86.1%
Hispanic/ Latina	91	65	80.3%	66.4%-89.3%
Non-Hispanic/ Latina	4,075	2,903	73.9%	72.2%-75.6%
Adams County - NE	182	131	73.3%	64.5%-80.6%
Antelope County - NE	SN	SN	SN	SN
Arthur County - NE	SN	SN	SN	SN
Banner County - NE	SN	SN	SN	SN
Blaine County - NE	SN	SN	SN	SN
Boone County - NE	SN	SN	SN	SN
Box Butte County - NE	SN	SN	SN	SN
Boyd County - NE	SN	SN	SN	SN
Brown County - NE	SN	SN	SN	SN
Buffalo County - NE	153	111	73.3%	64.1%-80.9%
Burt County - NE	SN	SN	SN	SN
Butler County - NE	SN	SN	SN	SN

Population Group	# of Women Interviewed (Sample Size)	# w/ Self-Reported Mammogram	Proportion Screened (Weighted Average)	Confidence Interval of Proportion Screened
Cass County - NE	64	49	78.7%	65.1%-87.9%
Cedar County - NE	SN	SN	SN	SN
Chase County - NE	SN	SN	SN	SN
Cherry County - NE	SN	SN	SN	SN
Cheyenne County - NE	SN	SN	SN	SN
Clay County - NE	SN	SN	SN	SN
Colfax County - NE	SN	SN	SN	SN
Cuming County - NE	SN	SN	SN	SN
Custer County - NE	SN	SN	SN	SN
Dawes County - NE	SN	SN	SN	SN
Dawson County - NE	114	69	62.6%	49.7%-73.9%
Deuel County - NE	SN	SN	SN	SN
Dixon County - NE	SN	SN	SN	SN
Dodge County - NE	121	94	80.6%	70.5%-87.8%
Douglas County - NE	1,196	846	76.2%	73.0%-79.1%
Dundy County - NE	SN	SN	SN	SN
Fillmore County - NE	SN	SN	SN	SN
Franklin County - NE	SN	SN	SN	SN
Frontier County - NE	SN	SN	SN	SN
Furnas County - NE	SN	SN	SN	SN
Gage County - NE	115	85	70.6%	59.5%-79.7%
Garden County - NE	SN	SN	SN	SN
Garfield County - NE	SN	SN	SN	SN
Gosper County - NE	SN	SN	SN	SN
Grant County - NE	SN	SN	SN	SN
Greeley County - NE	SN	SN	SN	SN
Hall County - NE	198	138	68.0%	58.8%-76.0%
Hamilton County - NE	SN	SN	SN	SN
Harlan County - NE	SN	SN	SN	SN
Hayes County - NE	SN	SN	SN	SN

Population Group	# of Women Interviewed (Sample Size)	# w/ Self-Reported Mammogram	Proportion Screened (Weighted Average)	Confidence Interval of Proportion Screened
Hitchcock County - NE	SN	SN	SN	SN
Holt County - NE	SN	SN	SN	SN
Hooker County - NE	SN	SN	SN	SN
Howard County - NE	SN	SN	SN	SN
Jefferson County - NE	SN	SN	SN	SN
Johnson County - NE	SN	SN	SN	SN
Kearney County - NE	SN	SN	SN	SN
Keith County - NE	SN	SN	SN	SN
Keya Paha County - NE	SN	SN	SN	SN
Kimball County - NE	SN	SN	SN	SN
Knox County - NE	SN	SN	SN	SN
Lancaster County - NE	381	288	75.2%	69.8%-79.9%
Lincoln County - NE	250	186	73.8%	66.2%-80.2%
Logan County - NE	SN	SN	SN	SN
Loup County - NE	SN	SN	SN	SN
Madison County - NE	171	112	68.7%	59.1%-76.9%
McPherson County - NE	SN	SN	SN	SN
Merrick County - NE	SN	SN	SN	SN
Morrill County - NE	SN	SN	SN	SN
Nance County - NE	SN	SN	SN	SN
Nemaha County - NE	SN	SN	SN	SN
Nuckolls County - NE	SN	SN	SN	SN
Otoe County - NE	84	55	64.1%	51.5%-75.0%
Pawnee County - NE	SN	SN	SN	SN
Perkins County - NE	SN	SN	SN	SN
Phelps County - NE	SN	SN	SN	SN
Pierce County - NE	SN	SN	SN	SN
Platte County - NE	154	118	79.1%	69.9%-86.0%
Polk County - NE	SN	SN	SN	SN
Red Willow County - NE	SN	SN	SN	SN

Population Group	# of Women Interviewed (Sample Size)	# w/ Self-Reported Mammogram	Proportion Screened (Weighted Average)	Confidence Interval of Proportion Screened
Richardson County - NE	SN	SN	SN	SN
Rock County - NE	SN	SN	SN	SN
Saline County - NE	62	45	78.3%	63.3%-88.3%
Sarpy County - NE	373	275	74.6%	68.7%-79.8%
Saunders County - NE	65	45	65.7%	51.5%-77.6%
Scotts Bluff County - NE	263	169	65.6%	58.1%-72.4%
Seward County - NE	88	54	66.0%	52.6%-77.2%
Sheridan County - NE	SN	SN	SN	SN
Sherman County - NE	SN	SN	SN	SN
Sioux County - NE	SN	SN	SN	SN
Stanton County - NE	SN	SN	SN	SN
Thayer County - NE	SN	SN	SN	SN
Thomas County - NE	SN	SN	SN	SN
Valley County - NE	SN	SN	SN	SN
Washington County - NE	54	43	77.9%	62.1%-88.3%
Wayne County - NE	SN	SN	SN	SN
Webster County - NE	SN	SN	SN	SN
Wheeler County - NE	SN	SN	SN	SN
York County - NE	84	59	69.2%	56.3%-79.7%

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 Nebraska service area was **significantly lower** than that observed in the U.S. as a whole. The screening proportion of the Affiliate service area was not significantly different than the state of Nebraska.

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

screening proportion among Hispanics/Latinas was not significantly different than among Non-Hispanics/Latinas.

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

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

It is important to note that the report uses the race and ethnicity categories used by the U.S. 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 Nebraska 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 %
Nebraska	91.2 %	5.2 %	1.4 %	2.2 %	91.1 %	8.9 %	47.1 %	34.6 %	15.3 %
Komen Nebraska Service Area	91.4 %	5.2 %	1.2 %	2.2 %	91.4 %	8.6 %	47.1 %	34.6 %	15.3 %
Adams County - NE	96.5 %	1.0 %	0.7 %	1.7 %	92.6 %	7.4 %	50.2 %	38.2 %	17.9 %
Antelope County - NE	98.6 %	0.6 %	0.3 %	0.5 %	97.2 %	2.8 %	58.3 %	46.6 %	23.4 %
Arthur County - NE	98.3 %	0.8 %	0.4 %	0.4 %	96.6 %	3.4 %	48.9 %	40.9 %	21.1 %
Banner County - NE	99.7 %	0.0 %	0.3 %	0.0 %	96.7 %	3.3 %	67.0 %	52.6 %	24.3 %
Blaine County - NE	99.1 %	0.9 %	0.0 %	0.0 %	100.0 %	0.0 %	61.0 %	44.2 %	19.5 %
Boone County - NE	99.1 %	0.4 %	0.3 %	0.3 %	98.7 %	1.3 %	59.2 %	46.8 %	24.3 %

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
Box Butte County - NE	93.8 %	1.0 %	4.7 %	0.5 %	89.9 %	10.1 %	52.5 %	40.9 %	17.8 %
Boyd County - NE	97.7 %	0.3 %	0.9 %	1.1 %	98.2 %	1.8 %	62.5 %	52.3 %	29.7 %
Brown County - NE	99.4 %	0.2 %	0.1 %	0.2 %	99.1 %	0.9 %	61.4 %	50.2 %	26.9 %
Buffalo County - NE	97.3 %	1.0 %	0.4 %	1.4 %	92.8 %	7.2 %	42.8 %	31.7 %	13.9 %
Burt County - NE	96.8 %	0.8 %	2.0 %	0.5 %	97.7 %	2.3 %	60.5 %	47.5 %	25.6 %
Butler County - NE	98.9 %	0.5 %	0.2 %	0.4 %	97.8 %	2.2 %	57.0 %	43.6 %	21.8 %
Cass County - NE	98.3 %	0.6 %	0.4 %	0.7 %	97.5 %	2.5 %	53.3 %	38.6 %	15.9 %
Cedar County - NE	99.2 %	0.3 %	0.4 %	0.1 %	98.7 %	1.3 %	57.3 %	44.4 %	22.9 %
Chase County - NE	99.4 %	0.2 %	0.2 %	0.1 %	89.4 %	10.6 %	55.8 %	44.0 %	23.6 %
Cherry County - NE	92.1 %	0.5 %	6.9 %	0.5 %	98.0 %	2.0 %	58.8 %	46.1 %	22.6 %
Cheyenne County - NE	97.1 %	0.4 %	0.7 %	1.7 %	93.9 %	6.1 %	52.7 %	38.9 %	17.9 %
Clay County - NE	97.6 %	0.8 %	1.0 %	0.6 %	92.2 %	7.8 %	54.3 %	41.4 %	19.5 %
Colfax County - NE	94.4 %	1.8 %	2.7 %	1.1 %	59.1 %	40.9 %	44.2 %	33.3 %	15.5 %
Cuming County - NE	98.1 %	0.5 %	0.8 %	0.6 %	91.8 %	8.2 %	55.3 %	43.2 %	23.5 %
Custer County - NE	98.7 %	0.4 %	0.6 %	0.3 %	98.0 %	2.0 %	57.4 %	44.9 %	22.7 %
Dawes County - NE	92.8 %	1.5 %	4.0 %	1.7 %	96.2 %	3.8 %	44.4 %	35.1 %	18.1 %
Dawson County - NE	94.1 %	3.0 %	1.8 %	1.1 %	69.1 %	30.9 %	46.2 %	34.3 %	15.9 %
Deuel County - NE	98.1 %	0.5 %	1.0 %	0.4 %	95.5 %	4.5 %	60.0 %	47.6 %	24.3 %
Dixon County - NE	98.1 %	0.9 %	0.7 %	0.3 %	89.4 %	10.6 %	53.0 %	41.4 %	20.6 %
Dodge County - NE	97.2 %	0.9 %	0.9 %	1.0 %	90.5 %	9.5 %	51.8 %	40.1 %	20.7 %
Douglas County - NE	82.7 %	12.9 %	1.2 %	3.1 %	89.3 %	10.7 %	43.1 %	30.4 %	12.1 %
Dundy County - NE	98.0 %	0.3 %	1.2 %	0.5 %	94.0 %	6.0 %	61.5 %	50.4 %	27.2 %
Fillmore County - NE	98.1 %	0.9 %	0.7 %	0.3 %	96.7 %	3.3 %	58.8 %	47.1 %	25.2 %
Franklin County - NE	98.9 %	0.3 %	0.6 %	0.2 %	98.7 %	1.3 %	62.1 %	50.2 %	26.1 %
Frontier County - NE	98.9 %	0.3 %	0.4 %	0.4 %	98.2 %	1.8 %	55.0 %	44.0 %	21.8 %
Furnas County - NE	98.7 %	0.5 %	0.5 %	0.4 %	97.6 %	2.4 %	60.4 %	48.6 %	25.7 %
Gage County - NE	98.3 %	0.5 %	0.7 %	0.5 %	98.2 %	1.8 %	56.5 %	43.6 %	22.0 %
Garden County - NE	98.7 %	0.6 %	0.7 %	0.0 %	96.6 %	3.4 %	66.8 %	53.2 %	29.8 %
Garfield County - NE	99.5 %	0.3 %	0.0 %	0.2 %	98.7 %	1.3 %	63.4 %	51.5 %	28.9 %
Gosper County - NE	98.1 %	1.3 %	0.2 %	0.4 %	97.0 %	3.0 %	60.8 %	49.4 %	23.3 %
Grant County - NE	98.3 %	1.4 %	0.0 %	0.3 %	99.3 %	0.7 %	62.9 %	47.6 %	19.9 %
Greeley County - NE	98.8 %	0.9 %	0.2 %	0.2 %	97.5 %	2.5 %	57.5 %	44.8 %	24.3 %
Hall County - NE	94.6 %	1.9 %	1.8 %	1.7 %	77.8 %	22.2 %	46.4 %	33.7 %	14.9 %

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
Hamilton County - NE	98.9 %	0.4 %	0.3 %	0.4 %	97.9 %	2.1 %	55.4 %	41.7 %	18.8 %
Harlan County - NE	98.7 %	0.2 %	0.6 %	0.4 %	98.5 %	1.5 %	60.9 %	49.5 %	23.1 %
Hayes County - NE	98.4 %	0.0 %	0.7 %	0.9 %	97.8 %	2.2 %	59.5 %	49.0 %	22.9 %
Hitchcock County - NE	98.4 %	0.6 %	0.8 %	0.2 %	98.3 %	1.7 %	60.8 %	48.6 %	25.2 %
Holt County - NE	98.8 %	0.4 %	0.6 %	0.3 %	97.2 %	2.8 %	58.2 %	45.9 %	22.8 %
Hooker County - NE	98.7 %	0.3 %	1.1 %	0.0 %	97.9 %	2.1 %	60.3 %	50.8 %	27.6 %
Howard County - NE	98.2 %	0.7 %	0.7 %	0.4 %	97.9 %	2.1 %	55.6 %	41.3 %	20.4 %
Jefferson County - NE	98.4 %	0.8 %	0.5 %	0.3 %	97.1 %	2.9 %	59.1 %	47.3 %	24.4 %
Johnson County - NE	97.4 %	0.6 %	0.1 %	1.8 %	92.2 %	7.8 %	58.7 %	45.6 %	23.9 %
Kearney County - NE	98.3 %	0.8 %	0.4 %	0.5 %	95.7 %	4.3 %	53.7 %	41.6 %	20.2 %
Keith County - NE	97.8 %	0.7 %	0.9 %	0.6 %	94.1 %	5.9 %	60.4 %	47.7 %	23.0 %
Keya Paha County - NE	99.5 %	0.2 %	0.2 %	0.0 %	99.8 %	0.2 %	62.9 %	50.2 %	25.7 %
Kimball County - NE	96.0 %	1.2 %	1.8 %	1.1 %	93.6 %	6.4 %	58.5 %	46.4 %	25.6 %
Knox County - NE	90.0 %	0.6 %	9.0 %	0.4 %	98.4 %	1.6 %	59.9 %	48.2 %	26.2 %
Lancaster County - NE	91.1 %	3.9 %	1.0 %	4.0 %	94.3 %	5.7 %	42.5 %	30.9 %	12.6 %
Lincoln County - NE	97.3 %	1.1 %	0.9 %	0.7 %	93.1 %	6.9 %	51.0 %	38.9 %	17.7 %
Logan County - NE	98.7 %	0.8 %	0.3 %	0.3 %	97.2 %	2.8 %	52.8 %	39.4 %	16.2 %
Loup County - NE	99.7 %	0.3 %	0.0 %	0.0 %	96.6 %	3.4 %	61.1 %	49.0 %	20.6 %
McPherson County - NE	98.2 %	1.1 %	0.7 %	0.0 %	98.5 %	1.5 %	54.4 %	39.7 %	17.3 %
Madison County - NE	95.7 %	1.7 %	1.8 %	0.8 %	87.8 %	12.2 %	48.7 %	36.7 %	16.9 %
Merrick County - NE	97.8 %	0.5 %	0.5 %	1.1 %	97.2 %	2.8 %	53.8 %	41.0 %	19.9 %
Morrill County - NE	97.0 %	0.8 %	1.7 %	0.5 %	86.2 %	13.8 %	54.1 %	42.4 %	20.8 %
Nance County - NE	98.4 %	0.7 %	0.7 %	0.1 %	97.6 %	2.4 %	55.8 %	43.7 %	22.2 %
Nemaha County - NE	97.7 %	1.1 %	0.4 %	0.8 %	98.1 %	1.9 %	52.8 %	41.2 %	20.3 %
Nuckolls County - NE	98.8 %	0.5 %	0.2 %	0.4 %	97.8 %	2.2 %	62.6 %	52.6 %	29.0 %
Otoe County - NE	98.3 %	0.7 %	0.3 %	0.7 %	94.6 %	5.4 %	55.2 %	42.4 %	21.2 %
Pawnee County - NE	98.6 %	0.5 %	0.4 %	0.4 %	98.4 %	1.6 %	63.9 %	51.7 %	28.9 %
Perkins County - NE	98.6 %	0.8 %	0.3 %	0.2 %	96.6 %	3.4 %	57.1 %	46.2 %	23.6 %
Phelps County - NE	98.8 %	0.3 %	0.3 %	0.6 %	95.6 %	4.4 %	55.6 %	42.6 %	22.0 %
Pierce County - NE	98.6 %	0.5 %	0.6 %	0.3 %	98.5 %	1.5 %	54.5 %	40.6 %	20.4 %
Platte County - NE	97.3 %	0.8 %	1.2 %	0.8 %	86.0 %	14.0 %	49.3 %	36.9 %	16.8 %
Polk County - NE	98.8 %	0.5 %	0.3 %	0.4 %	97.1 %	2.9 %	57.2 %	44.7 %	21.3 %
Red Willow County - NE	98.1 %	1.0 %	0.4 %	0.4 %	95.7 %	4.3 %	54.0 %	42.3 %	21.2 %

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
Richardson County - NE	95.6 %	0.6 %	3.4 %	0.4 %	98.8 %	1.2 %	60.2 %	48.1 %	25.5 %
Rock County - NE	99.1 %	0.1 %	0.5 %	0.3 %	99.6 %	0.4 %	65.5 %	54.9 %	27.3 %
Saline County - NE	95.4 %	1.4 %	1.0 %	2.2 %	80.1 %	19.9 %	46.9 %	34.4 %	16.3 %
Sarpy County - NE	91.4 %	4.7 %	0.8 %	3.1 %	92.8 %	7.2 %	41.6 %	27.1 %	9.8 %
Saunders County - NE	98.5 %	0.4 %	0.4 %	0.6 %	98.1 %	1.9 %	53.5 %	38.8 %	17.4 %
Scotts Bluff County - NE	95.5 %	0.8 %	2.9 %	0.8 %	79.8 %	20.2 %	51.0 %	39.3 %	18.9 %
Seward County - NE	98.3 %	0.6 %	0.4 %	0.7 %	98.2 %	1.8 %	49.9 %	37.3 %	17.0 %
Sheridan County - NE	86.3 %	0.7 %	12.1 %	0.9 %	96.6 %	3.4 %	59.7 %	49.3 %	24.9 %
Sherman County - NE	99.2 %	0.2 %	0.2 %	0.4 %	99.0 %	1.0 %	62.1 %	49.6 %	26.9 %
Sioux County - NE	98.8 %	0.3 %	0.8 %	0.2 %	96.6 %	3.4 %	57.6 %	46.8 %	24.1 %
Stanton County - NE	98.0 %	1.1 %	0.6 %	0.2 %	95.8 %	4.2 %	49.9 %	36.2 %	15.3 %
Thayer County - NE	98.6 %	0.8 %	0.2 %	0.3 %	98.2 %	1.8 %	63.4 %	51.1 %	28.6 %
Thomas County - NE	99.4 %	0.3 %	0.0 %	0.3 %	98.9 %	1.1 %	58.8 %	48.3 %	25.6 %
Valley County - NE	99.0 %	0.4 %	0.2 %	0.4 %	98.5 %	1.5 %	58.4 %	46.2 %	25.1 %
Washington County - NE	98.5 %	0.9 %	0.2 %	0.4 %	97.8 %	2.2 %	53.2 %	38.2 %	16.1 %
Wayne County - NE	96.8 %	1.2 %	0.7 %	1.2 %	95.5 %	4.5 %	39.1 %	29.5 %	14.7 %
Webster County - NE	98.0 %	0.9 %	0.4 %	0.7 %	96.2 %	3.8 %	60.4 %	46.5 %	26.8 %
Wheeler County - NE	99.0 %	0.3 %	0.0 %	0.8 %	99.0 %	1.0 %	56.6 %	46.4 %	22.1 %
York County - NE	96.9 %	1.7 %	0.7 %	0.7 %	95.8 %	4.2 %	53.9 %	41.6 %	20.6 %

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.

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 %
Nebraska	9.7 %	12.0 %	28.2 %	5.4 %	6.0 %	2.4 %	26.9 %	18.9 %	12.2 %
Komen Nebraska Service Area	9.5 %	11.9 %	28.1 %	5.4 %	5.9 %	2.3 %	26.7 %	18.3 %	12.1 %
Adams County - NE	10.6 %	13.2 %	30.8 %	5.3 %	5.0 %	2.8 %	22.5 %	0.0 %	12.7 %
Antelope County - NE	8.5 %	12.1 %	38.2 %	3.0 %	1.1 %	0.8 %	100.0 %	100.0 %	15.8 %
Arthur County - NE	4.8 %	5.1 %	47.1 %	0.0 %	0.4 %	0.0 %	100.0 %	100.0 %	19.1 %
Banner County - NE	7.7 %	17.8 %	37.2 %	1.8 %	2.7 %	0.0 %	100.0 %	100.0 %	18.7 %
Blaine County - NE	3.3 %	17.1 %	57.1 %	1.0 %	0.0 %	0.0 %	100.0 %	100.0 %	25.5 %
Boone County - NE	7.9 %	8.0 %	31.1 %	3.2 %	0.8 %	0.0 %	100.0 %	100.0 %	12.6 %
Box Butte County - NE	10.8 %	16.6 %	27.5 %	4.8 %	1.8 %	0.0 %	25.0 %	0.0 %	11.5 %
Boyd County - NE	11.0 %	6.9 %	43.0 %	1.8 %	0.1 %	0.0 %	100.0 %	100.0 %	20.0 %
Brown County - NE	9.9 %	14.1 %	43.8 %	2.6 %	1.5 %	0.0 %	100.0 %	100.0 %	18.7 %
Buffalo County - NE	7.6 %	12.7 %	26.9 %	4.3 %	4.0 %	1.1 %	32.3 %	0.0 %	11.1 %
Burt County - NE	9.5 %	9.7 %	32.4 %	4.2 %	1.1 %	0.5 %	100.0 %	14.5 %	14.6 %
Butler County - NE	9.5 %	8.8 %	28.3 %	2.6 %	0.8 %	1.3 %	65.7 %	6.1 %	10.8 %
Cass County - NE	6.1 %	5.2 %	21.8 %	5.4 %	1.3 %	0.3 %	73.0 %	31.8 %	10.0 %
Cedar County - NE	8.9 %	10.1 %	33.8 %	2.7 %	0.4 %	0.1 %	100.0 %	100.0 %	15.0 %
Chase County - NE	9.9 %	11.7 %	30.8 %	3.5 %	4.4 %	0.8 %	100.0 %	100.0 %	15.8 %
Cherry County - NE	8.6 %	10.1 %	37.7 %	1.6 %	1.8 %	0.4 %	52.5 %	0.0 %	18.5 %
Cheyenne County - NE	5.6 %	12.9 %	26.0 %	3.8 %	2.5 %	0.7 %	36.3 %	0.0 %	10.1 %
Clay County - NE	10.9 %	8.6 %	32.0 %	4.6 %	2.6 %	0.7 %	100.0 %	100.0 %	14.6 %
Colfax County - NE	28.8 %	14.4 %	35.0 %	7.5 %	21.7 %	13.5 %	40.5 %	19.7 %	18.6 %
Cuming County - NE	12.3 %	8.7 %	29.1 %	2.2 %	5.2 %	2.9 %	65.2 %	0.0 %	15.2 %
Custer County - NE	7.7 %	9.4 %	36.3 %	4.1 %	0.5 %	0.2 %	67.7 %	9.0 %	15.3 %
Dawes County - NE	9.4 %	24.7 %	38.2 %	5.6 %	2.9 %	0.4 %	39.9 %	0.0 %	16.8 %
Dawson County - NE	24.1 %	12.5 %	38.1 %	5.2 %	18.8 %	8.0 %	26.7 %	0.0 %	19.0 %
Deuel County - NE	9.6 %	12.5 %	34.6 %	2.9 %	1.7 %	0.4 %	100.0 %	100.0 %	15.6 %
Dixon County - NE	14.3 %	10.1 %	32.2 %	4.9 %	5.6 %	5.3 %	100.0 %	100.0 %	14.3 %
Dodge County - NE	14.8 %	12.5 %	32.4 %	6.6 %	5.2 %	3.4 %	25.1 %	4.1 %	13.9 %
Douglas County - NE	10.1 %	13.3 %	28.2 %	6.7 %	8.3 %	3.3 %	2.2 %	19.7 %	12.1 %

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)
Dundy County - NE	6.7 %	9.8 %	36.4 %	1.9 %	3.3 %	0.0 %	100.0 %	100.0 %	17.8 %
Fillmore County - NE	6.7 %	10.9 %	29.2 %	2.2 %	0.7 %	0.4 %	100.0 %	100.0 %	12.9 %
Franklin County - NE	8.7 %	14.9 %	34.5 %	3.8 %	0.7 %	0.3 %	100.0 %	0.0 %	14.8 %
Frontier County - NE	6.0 %	11.1 %	32.8 %	5.2 %	0.6 %	0.1 %	100.0 %	100.0 %	15.0 %
Furnas County - NE	13.3 %	17.2 %	36.3 %	2.9 %	1.0 %	0.5 %	100.0 %	100.0 %	15.6 %
Gage County - NE	9.1 %	12.3 %	34.1 %	6.7 %	0.8 %	0.3 %	44.4 %	0.0 %	11.2 %
Garden County - NE	8.8 %	10.1 %	45.2 %	3.9 %	0.4 %	0.0 %	100.0 %	0.0 %	16.2 %
Garfield County - NE	9.1 %	13.7 %	41.3 %	1.7 %	1.2 %	0.8 %	100.0 %	100.0 %	21.8 %
Gosper County - NE	5.0 %	11.6 %	30.1 %	2.1 %	0.2 %	0.0 %	100.0 %	100.0 %	13.1 %
Grant County - NE	6.6 %	15.6 %	38.6 %	2.1 %	0.1 %	0.0 %	100.0 %	100.0 %	16.5 %
Greeley County - NE	7.9 %	12.9 %	43.0 %	2.9 %	0.4 %	0.0 %	100.0 %	100.0 %	18.6 %
Hall County - NE	16.6 %	11.9 %	33.3 %	5.4 %	11.7 %	6.0 %	14.6 %	0.0 %	15.3 %
Hamilton County - NE	6.0 %	8.3 %	25.4 %	3.5 %	0.9 %	0.0 %	51.1 %	0.0 %	10.4 %
Harlan County - NE	9.0 %	10.3 %	32.8 %	1.9 %	0.5 %	0.4 %	100.0 %	6.3 %	15.2 %
Hayes County - NE	10.6 %	10.5 %	40.3 %	1.5 %	3.2 %	0.5 %	100.0 %	100.0 %	20.9 %
Hitchcock County - NE	9.8 %	13.3 %	38.2 %	4.6 %	0.9 %	0.5 %	100.0 %	100.0 %	16.3 %
Holt County - NE	9.9 %	9.0 %	36.9 %	1.5 %	1.7 %	0.3 %	64.7 %	100.0 %	14.8 %
Hooker County - NE	5.9 %	12.0 %	39.0 %	1.8 %	1.4 %	0.0 %	100.0 %	100.0 %	18.0 %
Howard County - NE	9.2 %	10.6 %	32.0 %	5.0 %	0.7 %	0.3 %	100.0 %	4.3 %	13.0 %
Jefferson County - NE	10.5 %	11.0 %	32.5 %	5.5 %	0.5 %	0.2 %	48.2 %	13.9 %	12.7 %
Johnson County - NE	14.0 %	12.8 %	34.0 %	6.1 %	4.2 %	2.8 %	100.0 %	15.7 %	14.1 %
Kearney County - NE	8.0 %	6.2 %	26.3 %	2.1 %	1.8 %	0.6 %	54.6 %	0.0 %	11.0 %
Keith County - NE	10.8 %	10.5 %	32.4 %	3.1 %	2.6 %	2.0 %	47.1 %	0.0 %	14.9 %
Keya Paha County - NE	8.0 %	16.1 %	50.8 %	0.0 %	0.0 %	0.0 %	100.0 %	100.0 %	23.3 %
Kimball County - NE	11.6 %	11.2 %	35.9 %	4.6 %	2.6 %	1.0 %	100.0 %	0.0 %	15.8 %
Knox County - NE	11.9 %	14.5 %	39.1 %	3.4 %	0.8 %	0.0 %	100.0 %	100.0 %	18.8 %
Lancaster County - NE	6.6 %	14.3 %	24.5 %	5.9 %	6.9 %	2.5 %	8.3 %	16.4 %	10.1 %
Lincoln County - NE	7.8 %	10.1 %	29.2 %	5.6 %	1.7 %	0.8 %	30.5 %	0.0 %	10.9 %
Logan County - NE	3.2 %	3.6 %	38.9 %	0.0 %	0.0 %	0.0 %	100.0 %	100.0 %	19.6 %
Loup County - NE	7.7 %	22.6 %	46.8 %	0.0 %	0.3 %	0.0 %	100.0 %	100.0 %	17.7 %
McPherson County - NE	8.4 %	6.3 %	43.8 %	1.2 %	0.0 %	0.0 %	100.0 %	100.0 %	17.6 %

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)
Madison County - NE	13.1 %	13.7 %	30.0 %	4.0 %	7.0 %	3.4 %	27.9 %	0.0 %	13.4 %
Merrick County - NE	10.1 %	11.7 %	33.7 %	5.3 %	0.7 %	0.0 %	58.9 %	53.2 %	13.7 %
Morrill County - NE	14.8 %	15.2 %	38.5 %	5.6 %	3.9 %	0.9 %	100.0 %	0.0 %	15.6 %
Nance County - NE	12.3 %	12.0 %	36.2 %	5.6 %	0.3 %	0.0 %	100.0 %	7.4 %	15.2 %
Nemaha County - NE	8.6 %	10.4 %	28.5 %	6.5 %	1.4 %	0.7 %	52.1 %	11.2 %	11.6 %
Nuckolls County - NE	8.0 %	16.4 %	37.7 %	4.2 %	0.7 %	0.0 %	100.0 %	100.0 %	14.4 %
Otoe County - NE	10.3 %	11.9 %	27.7 %	4.5 %	2.7 %	1.6 %	55.1 %	0.0 %	11.4 %
Pawnee County - NE	10.5 %	12.7 %	39.8 %	4.5 %	2.4 %	0.5 %	100.0 %	100.0 %	15.5 %
Perkins County - NE	7.0 %	5.8 %	29.4 %	2.3 %	0.3 %	0.0 %	100.0 %	0.0 %	12.9 %
Phelps County - NE	6.7 %	10.9 %	26.9 %	3.1 %	1.2 %	0.3 %	41.9 %	0.0 %	10.5 %
Pierce County - NE	9.0 %	7.8 %	29.4 %	3.7 %	0.8 %	0.6 %	100.0 %	0.0 %	13.8 %
Platte County - NE	10.0 %	9.1 %	25.7 %	4.7 %	7.0 %	1.2 %	31.4 %	1.1 %	12.8 %
Polk County - NE	8.2 %	8.2 %	29.5 %	4.0 %	2.0 %	0.3 %	100.0 %	100.0 %	12.4 %
Red Willow County - NE	7.8 %	11.2 %	32.3 %	4.9 %	1.5 %	0.8 %	31.6 %	0.0 %	12.1 %
Richardson County - NE	8.8 %	12.1 %	35.0 %	6.9 %	1.0 %	0.1 %	50.6 %	100.0 %	15.5 %
Rock County - NE	7.8 %	8.3 %	41.4 %	0.6 %	0.6 %	0.0 %	100.0 %	100.0 %	23.1 %
Saline County - NE	16.2 %	15.0 %	30.8 %	6.3 %	11.4 %	5.2 %	51.1 %	100.0 %	13.3 %
Sarpy County - NE	5.4 %	6.0 %	17.1 %	4.9 %	5.2 %	1.7 %	5.3 %	2.9 %	8.5 %
Saunders County - NE	6.9 %	7.4 %	24.6 %	3.0 %	1.3 %	0.6 %	66.5 %	7.3 %	10.3 %
Scotts Bluff County - NE	13.5 %	14.7 %	35.9 %	6.0 %	3.7 %	1.4 %	29.8 %	0.0 %	15.1 %
Seward County - NE	7.6 %	7.2 %	21.1 %	3.4 %	0.8 %	0.6 %	60.4 %	0.0 %	8.5 %
Sheridan County - NE	9.8 %	17.6 %	40.2 %	4.8 %	1.1 %	0.3 %	100.0 %	0.0 %	18.1 %
Sherman County - NE	12.5 %	14.1 %	38.7 %	3.3 %	0.6 %	0.2 %	100.0 %	100.0 %	16.3 %
Sioux County - NE	5.4 %	8.9 %	43.0 %	3.0 %	0.8 %	0.0 %	100.0 %	100.0 %	16.8 %
Stanton County - NE	8.0 %	11.3 %	31.2 %	4.5 %	1.5 %	0.4 %	73.5 %	100.0 %	12.6 %
Thayer County - NE	11.0 %	10.4 %	31.3 %	1.7 %	0.6 %	0.0 %	100.0 %	54.1 %	12.1 %
Thomas County - NE	6.7 %	8.2 %	41.8 %	0.7 %	2.0 %	0.0 %	100.0 %	100.0 %	21.6 %
Valley County - NE	8.5 %	11.7 %	36.9 %	1.3 %	1.3 %	0.4 %	100.0 %	3.4 %	15.1 %
Washington County - NE	6.6 %	5.2 %	19.1 %	3.5 %	1.1 %	0.1 %	61.2 %	0.0 %	8.5 %

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)
Wayne County - NE	8.0 %	17.6 %	28.0 %	7.0 %	2.6 %	1.4 %	42.1 %	3.2 %	11.1 %
Webster County - NE	9.7 %	14.7 %	39.4 %	3.7 %	0.9 %	0.7 %	100.0 %	100.0 %	15.1 %
Wheeler County - NE	3.4 %	13.5 %	43.6 %	1.5 %	1.0 %	0.0 %	100.0 %	100.0 %	19.4 %
York County - NE	8.9 %	9.2 %	26.0 %	1.5 %	3.0 %	1.4 %	44.1 %	0.0 %	10.7 %

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 Nebraska service area has a substantially larger White female population than the U.S. as a whole, a substantially smaller Black/African-American female population, a substantially smaller Asian and Pacific Islander (API) female population, a slightly smaller American Indian and Alaska Native (AIAN) female population, and a substantially smaller Hispanic/Latina female population. The Affiliate's female population is about the same age as that of the U.S. as a whole. The Affiliate's education level is substantially higher than and income level is slightly higher than those of the U.S. as a whole. There is 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 slightly smaller percentage of people who are linguistically isolated. There is a substantially larger percentage of people living in rural areas, a slightly smaller percentage of people without health insurance, and a substantially smaller percentage of people living in medically underserved areas.

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

- Douglas County

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

- Box Butte County
- Cherry County
- Knox County
- Sheridan County

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

- Colfax County
- Dawson County
- Hall County
- Morrill County
- Platte County
- Saline County
- Scotts Bluff County

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

- Antelope County
- Banner County
- Boone County
- Boyd County
- Brown County
- Burt County
- Butler County
- Cedar County
- Chase County
- Cherry County
- Cuming County
- Custer County
- Deuel County
- Dixon County
- Dundy County
- Fillmore County
- Franklin County
- Frontier County
- Furnas County
- Gage County
- Garden County
- Garfield County
- Gosper County
- Greeley County
- Harlan County
- Hayes County
- Hitchcock County
- Holt County
- Hooker County
- Howard County
- Jefferson County
- Johnson County
- Keith County
- Keya Paha County
- Kimball County
- Knox County
- Loup County
- Morrill County
- Nance County
- Nemaha County
- Nuckolls County
- Otoe County
- Pawnee County
- Perkins County
- Phelps County
- Pierce County
- Polk County
- Red Willow County
- Richardson County
- Rock County
- Sheridan County
- Sherman County
- Sioux County
- Thayer County
- Thomas County
- Valley County
- Webster County
- Wheeler County
- York County

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

- Colfax County
- Dawson County
- Dodge County
- Hall County
- Morrill County
- Saline County

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

- Banner County
- Blaine County
- Dawes County
- Furnas County
- Loup County
- Sheridan County

The counties with substantial foreign born and linguistically isolated populations are:

- Colfax County
- Dawson County
- Hall County

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

- Arthur County
- Banner County
- Blaine County
- Boyd County
- Brown County
- Cherry County
- Colfax County
- Dawson County
- Dundy County

- Garfield County
- Greeley County
- Hayes County
- Hooker County
- Keya Paha County
- Knox County
- Logan County
- Loup County
- McPherson County
- Rock County
- Sheridan County
- Thomas County
- Wheeler 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: 41.0 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 Nebraska 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.

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. Both the data and the HP2020 target are age-adjusted.

Identification of priority areas

The purpose of this report is to consolidate evidence from many credible sources and use the evidence (data) to identify the highest priority areas for breast health programs (i.e. the areas of greatest need). Classification of priority areas are based on the time needed to achieve HP2020 targets in each defined area. These time projections depend on both the starting point in time 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 HP2020 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				
Time to Achieve Death Rate Reduction Target		13 years or longer	7-12 yrs.	0 – 6 yrs.	Currently meets target	Unknown
	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 make the determination.

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. In essence, the county area with the greatest need qualifies the geographical area for intervention (intervention priority).

- 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 with other factors that affect breast cancer death rates such as screening rates poverty and linguistic isolation.

Table 2.7. Intervention priorities for Komen Nebraska 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
Custer County - NE	Highest	SN	13 years or longer	Older, rural
Dawson County - NE	Highest	SN	13 years or longer	%Hispanic, education, foreign, language, insurance
Lincoln County - NE	Highest	13 years or longer	13 years or longer	
Saunders County - NE	Highest	13 years or longer	13 years or longer	Rural
Adams County - NE	Medium High	3 years	13 years or longer	
Buffalo County - NE	Medium High	13 years or longer	1 year	Rural
Douglas County - NE	Medium High	4 years	13 years or longer	%Black/African-American
Hamilton County - NE	Medium High	SN	8 years	Rural
Madison County - NE	Medium High	13 years or longer	4 years	
Scotts Bluff County - NE	Medium High	13 years or longer	2 years	%Hispanic
Cass County - NE	Medium Low	SN	1 year	Rural, medically underserved
Dodge County - NE	Medium Low	1 year	1 year	Education
Richardson County - NE	Medium Low	SN	2 years	Older, rural, medically underserved
Washington County - NE	Medium Low	SN	4 years	Rural
Sarpy County - NE	Low	Currently meets target	2 years	
Gage County - NE	Lowest	NA	Currently meets target	Older, rural
Hall County - NE	Lowest	Currently meets target	Currently meets target	%Hispanic, education, foreign, language
Lancaster County - NE	Lowest	Currently meets target	Currently meets target	
Platte County - NE	Lowest	Currently meets target	Currently meets target	%Hispanic
Seward County - NE	Lowest	NA	Currently meets target	Rural
York County - NE	Lowest	NA	Currently meets target	Older, rural
Antelope County - NE	Undetermined	SN	SN	Older, rural, medically underserved

County	Priority	Predicted Time to Achieve Death Rate Target	Predicted Time to Achieve Late-stage Incidence Target	Key Population Characteristics
Arthur County - NE	Undetermined	SN	SN	Rural, insurance, medically underserved
Banner County - NE	Undetermined	SN	SN	Older, poverty, rural, insurance, medically underserved
Blaine County - NE	Undetermined	SN	SN	Poverty, rural, insurance, medically underserved
Boone County - NE	Undetermined	SN	SN	Older, rural, medically underserved
Box Butte County - NE	Undetermined	SN	SN	%AIAN
Boyd County - NE	Undetermined	SN	SN	Older, rural, insurance, medically underserved
Brown County - NE	Undetermined	SN	SN	Older, rural, insurance, medically underserved
Burt County - NE	Undetermined	SN	SN	Older, rural
Butler County - NE	Undetermined	SN	SN	Older, rural
Cedar County - NE	Undetermined	SN	SN	Older, rural, medically underserved
Chase County - NE	Undetermined	SN	SN	Older, rural, medically underserved
Cherry County - NE	Undetermined	SN	SN	%AIAN, older, rural, insurance
Cheyenne County - NE	Undetermined	SN	SN	Rural
Clay County - NE	Undetermined	SN	SN	Rural, medically underserved
Colfax County - NE	Undetermined	SN	SN	%Hispanic, education, foreign, language, rural, insurance
Cuming County - NE	Undetermined	SN	SN	Older, rural
Dawes County - NE	Undetermined	SN	SN	Poverty, rural
Deuel County - NE	Undetermined	SN	SN	Older, rural, medically underserved
Dixon County - NE	Undetermined	SN	SN	Older, rural, medically underserved
Dundy County - NE	Undetermined	SN	SN	Older, rural, insurance, medically underserved
Fillmore County - NE	Undetermined	SN	SN	Older, rural, medically underserved

County	Priority	Predicted Time to Achieve Death Rate Target	Predicted Time to Achieve Late-stage Incidence Target	Key Population Characteristics
Franklin County - NE	Undetermined	SN	SN	Older, rural
Frontier County - NE	Undetermined	SN	SN	Older, rural, medically underserved
Furnas County - NE	Undetermined	SN	SN	Older, poverty, rural, medically underserved
Garden County - NE	Undetermined	SN	SN	Older, rural
Garfield County - NE	Undetermined	SN	SN	Older, rural, insurance, medically underserved
Gosper County - NE	Undetermined	SN	SN	Older, rural, medically underserved
Grant County - NE	Undetermined	SN	SN	Rural, medically underserved
Greeley County - NE	Undetermined	SN	SN	Older, rural, insurance, medically underserved
Harlan County - NE	Undetermined	SN	SN	Older, rural
Hayes County - NE	Undetermined	SN	SN	Older, rural, insurance, medically underserved
Hitchcock County - NE	Undetermined	SN	SN	Older, rural, medically underserved
Holt County - NE	Undetermined	SN	SN	Older, rural, medically underserved
Hooker County - NE	Undetermined	SN	SN	Older, rural, insurance, medically underserved
Howard County - NE	Undetermined	SN	SN	Older, rural
Jefferson County - NE	Undetermined	SN	SN	Older, rural
Johnson County - NE	Undetermined	SN	SN	Older, rural
Kearney County - NE	Undetermined	SN	SN	Rural
Keith County - NE	Undetermined	SN	SN	Older, rural
Keya Paha County - NE	Undetermined	SN	SN	Older, rural, insurance, medically underserved
Kimball County - NE	Undetermined	SN	SN	Older, rural
Knox County - NE	Undetermined	SN	SN	%AIAN, older, rural, insurance, medically underserved
Logan County - NE	Undetermined	SN	SN	Rural, insurance, medically underserved

County	Priority	Predicted Time to Achieve Death Rate Target	Predicted Time to Achieve Late-stage Incidence Target	Key Population Characteristics
Loup County - NE	Undetermined	SN	SN	Older, poverty, rural, insurance, medically underserved
McPherson County - NE	Undetermined	SN	SN	Rural, insurance, medically underserved
Merrick County - NE	Undetermined	SN	SN	Rural, medically underserved
Morrill County - NE	Undetermined	SN	SN	%Hispanic, older, education, rural
Nance County - NE	Undetermined	SN	SN	Older, rural
Nemaha County - NE	Undetermined	SN	SN	Older, rural
Nuckolls County - NE	Undetermined	SN	SN	Older, rural, medically underserved
Otoe County - NE	Undetermined	SN	SN	Older, rural
Pawnee County - NE	Undetermined	SN	SN	Older, rural, medically underserved
Perkins County - NE	Undetermined	SN	SN	Older, rural
Phelps County - NE	Undetermined	SN	SN	Older, rural
Pierce County - NE	Undetermined	SN	SN	Older, rural
Polk County - NE	Undetermined	SN	SN	Older, rural, medically underserved
Red Willow County - NE	Undetermined	SN	SN	Older
Rock County - NE	Undetermined	SN	SN	Older, rural, insurance, medically underserved
Saline County - NE	Undetermined	SN	SN	%Hispanic, education, foreign, rural, medically underserved
Sheridan County - NE	Undetermined	SN	SN	%AIAN, older, poverty, rural, insurance
Sherman County - NE	Undetermined	SN	SN	Older, rural, medically underserved
Sioux County - NE	Undetermined	SN	SN	Older, rural, medically underserved
Stanton County - NE	Undetermined	SN	SN	Rural, medically underserved
Thayer County - NE	Undetermined	SN	SN	Older, rural, medically underserved

County	Priority	Predicted Time to Achieve Death Rate Target	Predicted Time to Achieve Late-stage Incidence Target	Key Population Characteristics
Thomas County - NE	Undetermined	SN	SN	Older, rural, insurance, medically underserved
Valley County - NE	Undetermined	SN	SN	Older, rural
Wayne County - NE	Undetermined	SN	SN	Rural
Webster County - NE	Undetermined	SN	SN	Older, rural, medically underserved
Wheeler County - NE	Undetermined	SN	SN	Older, 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.

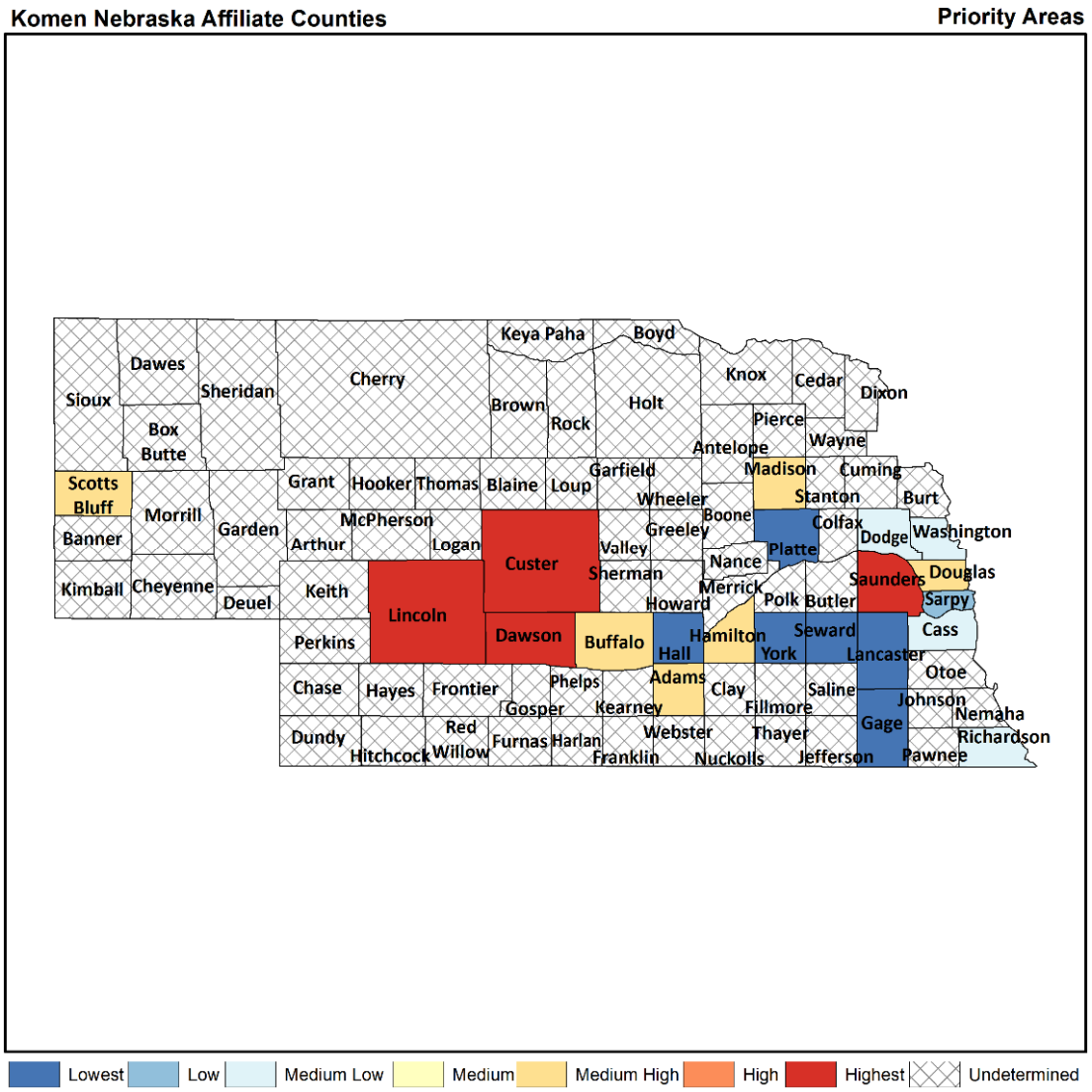


Figure 2.1. Intervention Priorities

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 available.

- 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 Nebraska service area are in the highest priority category. Two of the four, Lincoln County and Saunders County, are not likely to meet either the death rate or late-stage incidence rate HP2020 targets. Two of the four, Custer County and Dawson County, are not likely to meet the late-stage incidence rate HP2020 target.

The late-stage incidence rates in Lincoln County (60.1 per 100,000) are significantly higher than the Affiliate service area as a whole (42.6 per 100,000).

Custer County has an older population. Dawson County has a relatively large Hispanic/Latina population, low education levels, a relatively large foreign-born population and a relatively large number of households with little English.

Medium high priority areas

Six counties in the Komen Nebraska service area are in the medium high priority category. Three of the six, Buffalo County, Madison County and Scotts Bluff County, are not likely to meet the death rate HP2020 target. Two of the six, Adams County and Douglas County, are not likely to meet the late-stage incidence rate HP2020 target. One of the six, Hamilton County is expected to take eight years to reach the late-stage incidence rate HP2020 target.

The late-stage incidence rates in Madison County (61.2 per 100,000) are significantly higher than the Affiliate service area as a whole (42.6 per 100,000).

Douglas County has a relatively large Black/African-American population. Scotts Bluff County has a relatively large Hispanic/Latina population.

Undetermined areas

Several counties in the Komen Nebraska service area have undetermined priorities but may still have substantial needs. Many of the counties with undetermined priorities have substantial minority populations and/or have multiple socioeconomic challenges among the key population characteristics.

Selection of Target Communities

The preceding data helped the Community Profile Team select specific target communities using the HP2020 targets. This information allows Komen Nebraska to focus on the communities with the greatest breast health needs. It is important to recognize that the state of Nebraska as a whole has achieved the HP2020 targets, but there are certain counties that do not meet these goals to date (Susan G. Komen, 2014). It is also important to recognize that the available data for breast cancer interpretation in this report are limited because of the small populations in the majority of the counties in the state. Nebraska's population of 1,826,341 reflects a population density of 23.8 persons per square mile, ranking 43rd in the United States, just ahead of Idaho (IPL2 Information). Eighty-nine percent of the cities in Nebraska have fewer than 3,000 people. Hundreds of towns have a population of fewer than 1,000 (2010 U.S. census). The major Nebraska cities follow geography, and are clustered in the eastern third of the state and along the Platte River (or Interstate 80) running east to west.

Nebraska has many counties with small populations that do not have large enough breast cancer cases or breast cancer deaths to support the generation of reliable statistics. There is a similar limitation on screening mammography as data are derived from a survey of a percentage of the total population, and therefore screening rates may not be available for smaller counties. A large proportion of Nebraska counties (78 out of 93) or 84 percent fall into this category and do not have reliable breast cancer or screening statistics (Susan G. Komen, 2014). To address the breast health needs of Nebraska and take into account the large portion of the state that is sparsely populated, the Community Profile team used the Nebraska U.S. congressional districts geographical construct as the framework for the development of "Focus Areas" (Figure 2.2). This grouping allows Komen Nebraska to address both the priority areas recommended in the HP2020 and the demographic /socio-economic status data provided in the Quantitative Data Report. Focus Area 1 coincides with Congressional District 1 geographic area; Focus Area 2 coincides with Congressional District 2 geographic area; and Focus Area 3 coincides with Congressional District 3 geographic area. The focus areas (i.e. congressional districts) are depicted in Figure 2.2.

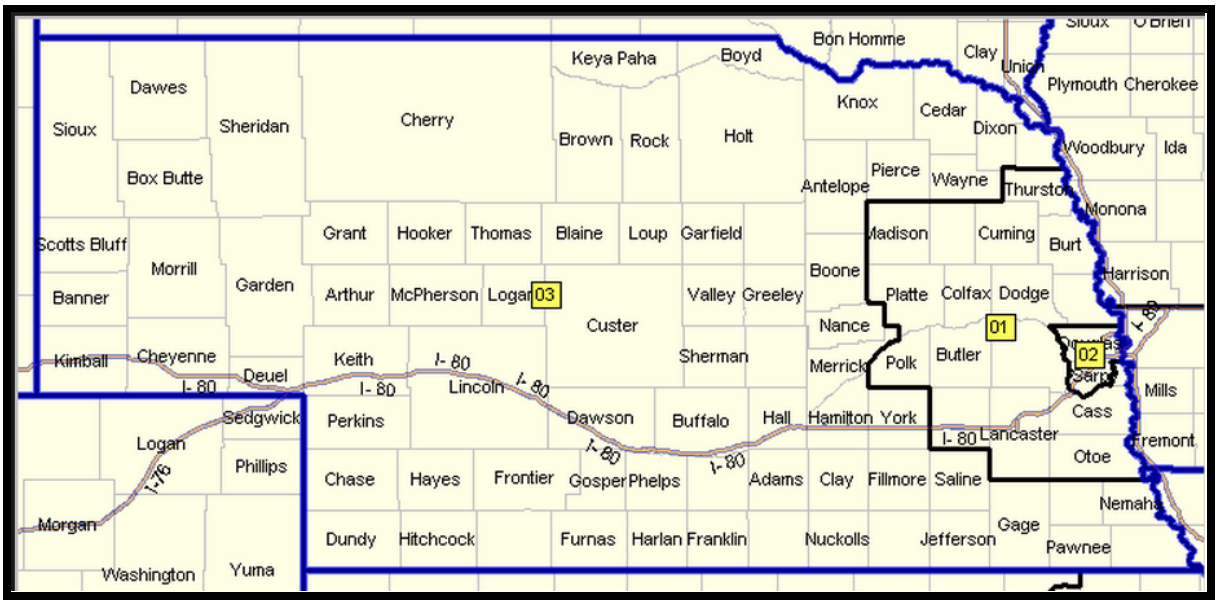


Figure 2.2. Nebraska U.S. Congressional Districts

Utilizing this congressional district construct to establish "Focus Areas" allows for all portions of the state – urban, rural, and mixed urban/rural to be considered by the Affiliate to address the breast health needs of the population, regardless of the statistically relevant data available. In essence, the characteristic make-up of each congressional district provides a great opportunity for the Affiliate to live the Komen mission.
The Community Profile team established the following criteria for selecting target communities:

- The target community must reside within a "Focus Area"
- The target community must be the highest priority rated (H-high or MH-medium high) county within the Focus Area according to Susan G. Komen 2014 QDR

Results:

Focus Area 1 – Burt, Butler, Cass, Colfax, Cuming, Dodge, Lancaster, Madison, Otoe, Platte, Polk, Saunders, Seward, Stanton, and Washington counties.

Target Community Saunders County.

Focus Area 1 is in the eastern part of Nebraska, excluding the major metropolitan city of Omaha and surrounding suburbs. It includes the state capital, Lincoln, and other cities like Columbus, Fremont, and Norfolk. The population is approximately 65.0 percent urban and 35.0 percent rural, with an ethnic/racial composition of 90.5 percent White, 2.6 percent Black/African-American, 1.4 percent American Indian/Alaska Native, 2.2 percent Asian and Pacific Islander, 7.9 percent Hispanic/Latina (Ballotpedia, 2014). The overall unemployment rate is 6.3 percent (Ballotpedia, 2014), compared to the state unemployment rate of 5.4 percent (Susan G. Komen, 2014).

The counties have an overall low mammography rate and the increased incidence rate for breast cancer in the older population of women. Saunders County is not likely to meet either the death rate or late-stage incidence rate of HP2020 targets. Madison County is not likely to meet the HP2020 death rate target and it also has a higher late-stage diagnostic rate. In the Focus Area as a whole, there is a substantially higher Hispanic/Latina female population in Platte and Colfax counties, and Colfax has a relatively large foreign-born and linguistically isolated population. Additionally, Burt, Cuming, Polk, Butler and Otoe counties have a substantially older population than the Affiliate service area as a whole (Susan G. Komen, 2014).

Within this Focus Area, the target community is Saunders County as it is the highest rated (H rated) priority county for HP2020 criteria.

The health system analysis component of this report will take a deeper look at the available breast health services in the target community. This is especially important in light of the low mammography rates and the older population.

Focus Area 2 – Douglas and Sarpy counties.

Target Community Douglas County.

Focus Area 2 encompasses the core of the Omaha metropolitan area. It includes all of Douglas County, which includes Omaha, and the urbanized areas of Sarpy County. The population is 98.0 percent urban and 2.0 percent rural, and has the smallest number of women over 40 (134,454) among the Congressional Districts, according to the U.S. 2010 census. The population is 79.9 percent White, 9.9 percent Black/African-American, 2.8 percent Asian and

Pacific Islander, 10.3 percent Hispanic/Latina, and there are higher percentages of linguistically isolated people (men and women) in both of these counties as compared to other areas in Nebraska (Ballotpedia, 2014). This area's overall unemployment rate is 7.4 percent (Ballotpedia, 2014), compared to the state unemployment rate of 5.4 percent (Susan G. Komen, 2014). The greatest concentration of Black/African-American women is in Douglas County (12.9 percent), more than double the Affiliate percentage, though similar to the U.S. percentage (13.6 percent in 2010). Sarpy County has the second highest percentage of Black/African-American women at 4.7 percent (Susan G. Komen, 2014).

These concentrations of Black/African-American women in Douglas and Sarpy counties are significant due to the higher death rates Black/African-American women experience when compared to other races (27.6/100,000 for Black/African-American Nebraskans compared to 20.2 for all Nebraskans). Both counties have a higher late-stage incidence rate compared to the United States and the Affiliate, and consequently, Douglas County is not likely to meet the HP2020 late-stage incidence rate target and may require 13 years or longer if current trends do not change (Susan G. Komen, 2014).

Within this Focus Area, the target community is Douglas County as it is the highest rated (MH rated) priority county for HP2020 criteria.

Although Douglas and Sarpy Counties are in the metropolitan area where services are more likely to be readily available, adequate use of those services cannot be assumed. Thus, the health system analysis will provide a deeper look at the underserved areas hidden within Douglas County. The analysis will also provide an opportunity to explore the merits of adding services within neighborhoods that are no-cost or reduced cost, culturally sensitive and easily accessible.

Focus Area 3 – Adams, Antelope, Arthur, Banner, Blaine, Boone, Box Butte, Boyd, Brown, Buffalo, Cedar, Chase, Cherry, Cheyenne, Clay, Custer, Dawes, Dawson, Deuel, Dixon, Dundy, Fillmore, Franklin, Frontier, Furnas, Gage, Garden, Garfield, Gosper, Grant, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Jefferson, Johnson, Kearney, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, McPherson, Merrick, Morrill, Nance, Nemaha, Nuckolls, Pawnee, Perkins, Phelps, Pierce, Red Willow, Richardson, Rock, Saline, Scotts Bluff, Sheridan, Sherman, Sioux, Thayer, Thomas, Valley, Wayne, Webster, Wheeler, and York counties.

Target Communities Custer, Dawson, Lincoln counties.

Focus Area 3 encompasses the western three-fourths of the state and covers nearly 65,000 square miles, two time zones and major cities of Grand Island, Kearney, Hastings, North Platte, and Scottsbluff. The population is approximately 46 percent urban and 53 percent rural. Because of the small overall population, most data on breast cancer deaths and late-stage breast cancer incidence rate have been suppressed for 67 out of the 75 counties. Suppressed data due to small numbers is defined as 15 or fewer cases for the 5-year data period. The population is 94.2 percent White, 1.0 percent Black/African-American, 1.0 percent American Indian/Alaska Native, 10.1 percent Hispanic and the overall unemployment rate is 5.1 percent (Ballotpedia, 2014), compared to the state unemployment rate of 5.4 percent (Susan G. Komen, 2014). These counties have been grouped to highlight the high incidence rate, the low mammography rate, and the high late-stage diagnosis rate.

This Focus Area has the greatest number of counties that will likely not meet the HP2020 targets and rated highest priority – Lincoln, Dawson and Custer. Lincoln County will likely not

meet either the death rate or late-stage incidence rate for HP2020, and Lincoln has a significantly higher late-stage incidence rate (60.1 per 100,000) than the Affiliate service area (42.6 per 100,000). Both Dawson and Custer counties are likely not to meet the late-stage incidence HP2020 target. The counties of Adams, Buffalo, Hamilton and Scotts Bluff are rated "medium high" HP2020 priorities and Adams has one of the highest breast cancer incidence rate in the state. There are a very large number of counties that have substantially older women (53 out of 75 counties) and a large number of counties that are medically underserved (39 out of 75). Almost half of the counties (32 out of 75) in this Focus Area are both medically underserved and have a population of older women (Susan G. Komen, 2014).

Within this Focus Area, the target communities are Custer, Dawson and Lincoln Counties as they are the highest rated (H rated) priority counties for HP2020 criteria.

A review of available breast health services in this target community is very important, especially considering the medically underserved, older female population, limited access to care for the immigrant population, and the number of poor, vulnerable and underserved families in this area. Because there are areas with data suppressed due to small numbers between Scotts Bluff and the target communities in Focus Area 3, there will be more scrutiny in these counties to determine if qualitative issues are a factor.

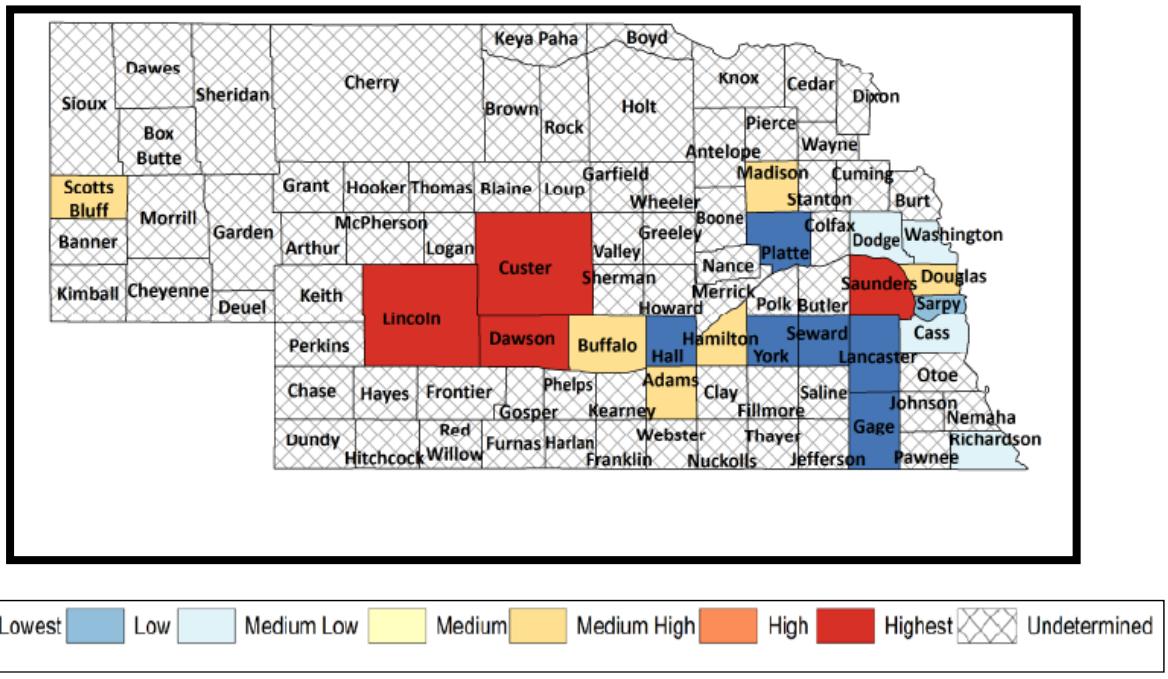


Figure 2.3. Priority Rating of Nebraska Counties

Summary

Susan G. Komen Nebraska has designated the following Nebraska counties as "Targeted communities" for the Nebraska Service Area (Table 2.9):

Target Community 1: Saunders
Target Community 2: Douglas
Target Community 3: Custer, Dawson, Lincoln

Table 2.9. Focus Areas and Target Communities

Focus Area 1	Focus Area 2	Focus Area 3
# Women > 40 = 141,967	# Women > 40 = 134,454	# Women > 40 = 142,918
Saunders County(H)	Douglas County (MH)	Custer County (H)
		Dawson County (H)
		Lincoln County (H)

H=High priority, MH=Medium High priority HP2020

One target community (highest rated priority counties) resides in each of the individual “Focus Areas”.

Health Systems Analysis Data Sources

The Health Systems Analysis portion of Komen Nebraska's Community Profile was compiled using multiple sources. The information and data collected were analyzed in order to create an accurate depiction of the systems and services impacting breast health in the target communities of Komen Nebraska's service area.

Identifying services available in target communities allows Komen Nebraska to understand the strengths and weaknesses of each community. This includes all aspects of breast health and care, revealing where the counties are excelling and identifying any gaps that may be present. The following sources were utilized to identify services available in Susan G. Komen Nebraska's target counties:

- Mammography centers: U.S. Food and Drug Administration (http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfMQSA/mqsa.cfm)
- Hospitals: Medicare (https://data.medicare.gov/Hospital-Compare/Hospital-General-Information/v287-28n3)
- Health Departments: National Association of County and City Health Officials (http://www.naccho.org/about/lhd/)
- Community Health Centers: Health Resources and Services Administrations (http://findahealthcenter.hrsa.gov/Search_HCC.aspxH)
- Free Clinics: National Association of Free and Charitable Clinics (http://www.nafcclinics.org/clinics/search)
- Susan G. Komen. (2014) Nebraska Health System Analysis [Data file]. Unpublished raw data
- Non-Health Centers: Cancer Matters Resource Guide

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

- American College of Surgeons Commission on Cancer **(**http://datalinks.facs.org/cpm/CPMApprovedHospitals_Search.htm)
- American College of Radiology Centers of Excellence **(**http://www.acr.org/Quality-Safety/Accreditation/Accredited-Facility-Search)
- American College of Surgeons National Accreditation Program for Breast Centers (NAPBC) **(**http://napbc-breast.org/resources/find.html)
- National Cancer Institute Designated Cancer Centers (http://www.cancer.gov/researchandfunding/extramural/cancercenters/find-a-cancer-center)
- For full reference list and more information, please see the Reference section of the Community Profile.

Health Systems Overview

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

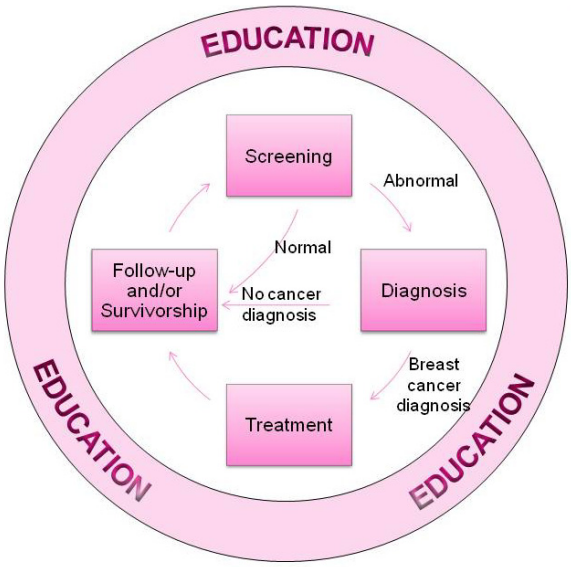


Figure 3.1. Breast Cancer Continuum of Care (CoC)

While a woman may enter the continuum at any point, ideally, she 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 knowledge 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. Again, education plays a role in communicating the importance of proactively getting test results, keeping follow-up appointments, and understanding what it all means, to include empowering a woman to help manage anxiety and fear.

If breast cancer is diagnosed, she would proceed to treatment. Education can cover such topics as treatment options, how the pathology report 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 navigating insurance issues, locating financial assistance, and symptom management (i.e. pain, fatigue, sexual issues, bone issues, 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 (for example, long term hormone therapy).

Unfortunately, there are often delays in moving from one point of the continuum to another that can contribute to poor health outcomes. There are also many reasons why a woman does not

enter or continue in the breast cancer CoC. These barriers can include lack of transportation, system issues including long waits for appointments and inconvenient clinic hours, language barriers, cultural differences, fear, and lack of information, distrust or the wrong information (myths and misconceptions). Education can address some of these barriers and help a woman progress through the CoC more efficiently.

Summary Target Community Health System Strengths and Challenges

Target Community: Saunders County

Saunders County is not likely to meet either the death rate or late-stage incidence rate of HP2020 targets. A review of the health system available in this community finds very few treatment resources (a total of two) and very limited screening services. Saunders Medical Center in Wahoo is the only hospital that provides screening services. However, three major medical centers within 45 miles (Wahoo, county seat, to University of Nebraska Medical Center approximately 36.5 miles) provide all other CoC components.

Reluctance to travel could reduce screening and increase death rate and late-stage incidence rate. The average drive to employment within the county is 26.5 minutes, and this is probably within the confines of the county that has an average population density of 27.7 persons per square mile — quite rural. While there are fewer than 50 miles from the middle of the target community to state-of-the-art medical care, some in the rural county may be reluctant to drive to the city and navigate traffic and unfamiliar surroundings. This reluctance could be especially prominent in the older population, where 39.2 percent of the population is greater than 45 years old (15.3 percent is greater than 65 years old).

Komen Nebraska has few partnerships in this community. There has been only one community grant for this area. The target community is serviced by a grantee that covers 20 other counties to provide screening opportunities for 120 women this year. Future engagement opportunities include delivering education materials for breast health recommendations to community centers and the Saunders Medical Center directly. Komen Nebraska can look for outreach opportunities at churches, schools or community organizations to deliver breast health presentations.

Target Community: Douglas County

Douglas County is most populous of all the Nebraska counties with a 2013 population of 537,256 persons. Both the Black/African-American population (11.6 percent) and Hispanic/Latina population (11.7 percent) is higher than the Nebraska average (U.S. Census). The greatest concentration of Black/African-American women is in Douglas County (12.9 percent), more than double the Affiliate percentage, though similar to the U.S. percentage (13.6 percent in 2010). The Hispanic/Latina population percentage, 10.7 percent, is greater than the Affiliate percentage (8.6 percent), but less than the U.S. percentage (16.2 percent). Breast cancer is the most common cancer among Hispanic/Latina women (Susan G. Komen, 2014).

Black/African-American women in Nebraska have a higher death rate from breast cancer when compared to other races (27.6/100,000 for Black/African-American Nebraskans compared to 20.2 for all Nebraskans). Douglas County also has a higher late-stage incidence rate compared to the United States and the Affiliate, is not likely to meet the HP2020 late-stage incidence rate target, and reaching the target may require 13 years or longer if current trends do not change. (Susan G. Komen, 2014).

The target community has three cancer centers: Alegent Creighton, Methodist Estabrook and University of Nebraska Medical Center. These centers are accredited and provide the full complement of screening, diagnostic, treatment and support / survivorship services. Only UNMC is a National Cancer Institute designated cancer center. To address the medical needs

of low income and disenfranchised individuals, there are two Federally Qualified Health Centers - OneWorld Community Health Center and Charles Drew Health Center in Omaha.

Komen Nebraska has long partnered through both community and small grants with providers in the target community. Creighton University, the Intercultural Senior Center, My Sisters Keeper, and Salem Baptist Church are some of the grantees that have developed programs specifically to generate trust and provide materials that address the issue, "If it doesn't look like me, it doesn't affect me." In addition, the University Of Nebraska Board Of Regents has been a Komen Nebraska grantee for a number of years, and Komen funding helps to facilitate the Breast Health Community Navigator Program, which provides a resource for all women to become their own breast health advocate through education, advocacy and partnerships. OneWorld Community Health Centers have used Komen grant funding to negotiate lower rates for screening mammography so they can provide access to care for thousands of Hispanic/Latina women in Douglas County. The grants Komen provided to the Visiting Nurse Association have helped hundreds of families with financial aid so breast cancer survivors can focus on their treatment and not their bills. A number of small grants have provided treatment support services (e.g. A Time To Heal and YMCA LiveStrong) to many in the target community. Despite all this engagement, there is still a higher late-stage incidence rate in the county and a high death rate for Black/African-American women.

Komen Nebraska has partnered with the Breast Cancer Control Partnership on an Black/African-American task force aimed at reducing the death rate for Black/African-American women in Douglas County. This group has made several recommendations regarding screening reminders, follow up treatment reminders and support services to encourage a healthy lifestyle and follow through on breast health. Komen Nebraska is actively pursuing partners in the local church communities and schools for additional education opportunities, and encouraging development of an education program with local community representatives teaching breast health guidelines.

Target Communities: Custer, Dawson, Lincoln Counties

The Target Communities of Lincoln, Dawson and Custer are the highest rated (H rated) priority counties for HP2020 criteria. Lincoln County will likely not meet either the death rate or late-stage incidence rate for HP2020, and Lincoln has a significantly higher late-stage incidence rate (60.1 per 100,000) than the Affiliate service area (42.6 per 100,000). Both Dawson and Custer Counties are not likely to meet the late-stage incidence HP2020 target.

Within the three counties, there is only one facility that provides cancer treatment, the Great Plains Regional Health Center / Callahan Cancer Center in North Platte, Lincoln County. This facility provides services throughout the middle-western third of the state, including communities of North Platte, Gothenburg, Broken Bow, Grant, Imperial, Lexington and McCook, for medical oncology and radiation oncology. Access to care is problematic because travel distance to each of the cities noted is between 60 and 75 miles from North Platte. For numerous other communities north and south of North Platte, patients would need to travel more than 100 miles for cancer treatment. Good Samaritan Hospital in Kearney provides services east of the target communities, and Regional West Medical Center in Scottsbluff provides services west of the target communities.

There is a higher proportion of elderly adults in Custer County (20.8 percent) than in Nebraska (14.1 percent) that could affect HP2020 goals. Dawson County has a significant Hispanic/Latina population (32.9 percent; overall Nebraska 9.9 percent) that could contribute to late-stage incidence rate, since many Latinas living in the county are uninsured. These factors all contribute to the poor prognosis of attaining the HP2020 goals for death rate or late-stage incidence rate. Additionally, there are separate public health departments for each county in the

target community that could contribute to individuals falling through the cracks and potentially not receiving needed services because of fragmented government responsibilities. Custer is in the Loup Basin Public Health department in Burwell; Dawson is in Two Rivers Public Health department in Holdrege; Lincoln is in West Central Public Health department in North Platte.

Komen Nebraska partnered with the West Central Health District in 2012 with a grant to provide breast health education and clinical breast exams (CBE). This program provided resources to women in a 16-county area (including Lincoln and Custer) providing free CBEs to 475 women and education materials to over 1,000. Central Health Community of Grand Island also partnered with Komen Nebraska to provide breast health education and breast cancer screening in Lexington in 2012 and 2013. This program was successful in addressing the health needs of the immigrant population in Dawson County, educating and providing CBEs to more than 100 rural and minority women. Community Action Partnership of Mid Nebraska (CAP Mid NE) was a Komen grantee in 2012 and 2013 and addressed breast health education for over 100 low-income and minority women. The survivorship support program funded by Komen Nebraska, A Time to Heal, has facilitators in North Platte and Lexington to help breast cancer survivors adapt to the new “normal” following their treatment. Komen Nebraska grantee, the Visiting Nurse Association, helps address the financial needs of treatment support across the state, and has helped breast cancer survivors in Custer and Dawson Counties.

Future engagement is possible with past successful grantees, if grant funds are available. New partnerships are possible using contacts in the Breast Cancer Collaboration Program to deliver education materials to community centers, schools and churches in the target community.

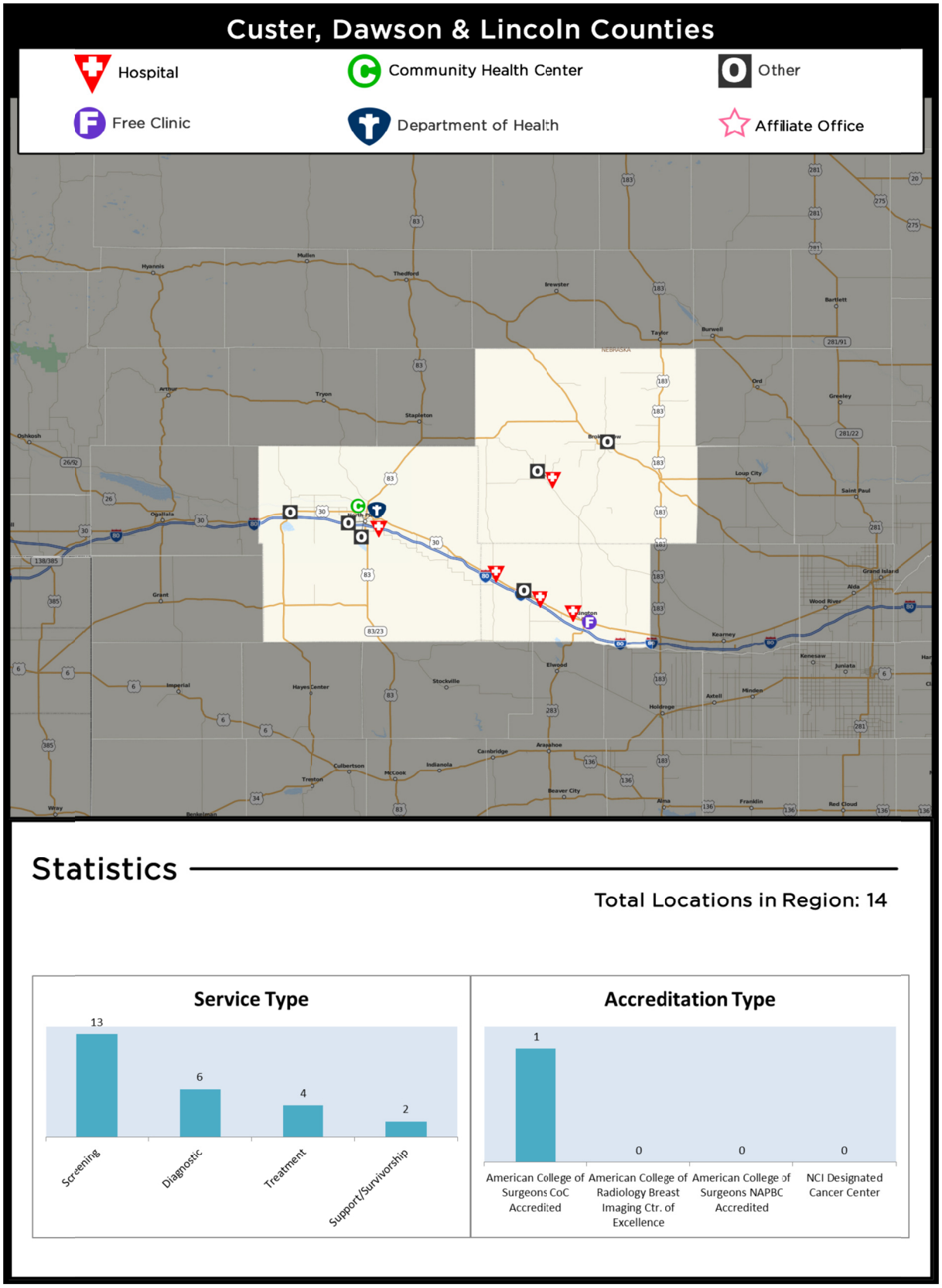


Figure 3.2. Breast Cancer Services Available in Custer, Dawson and Lincoln Counties

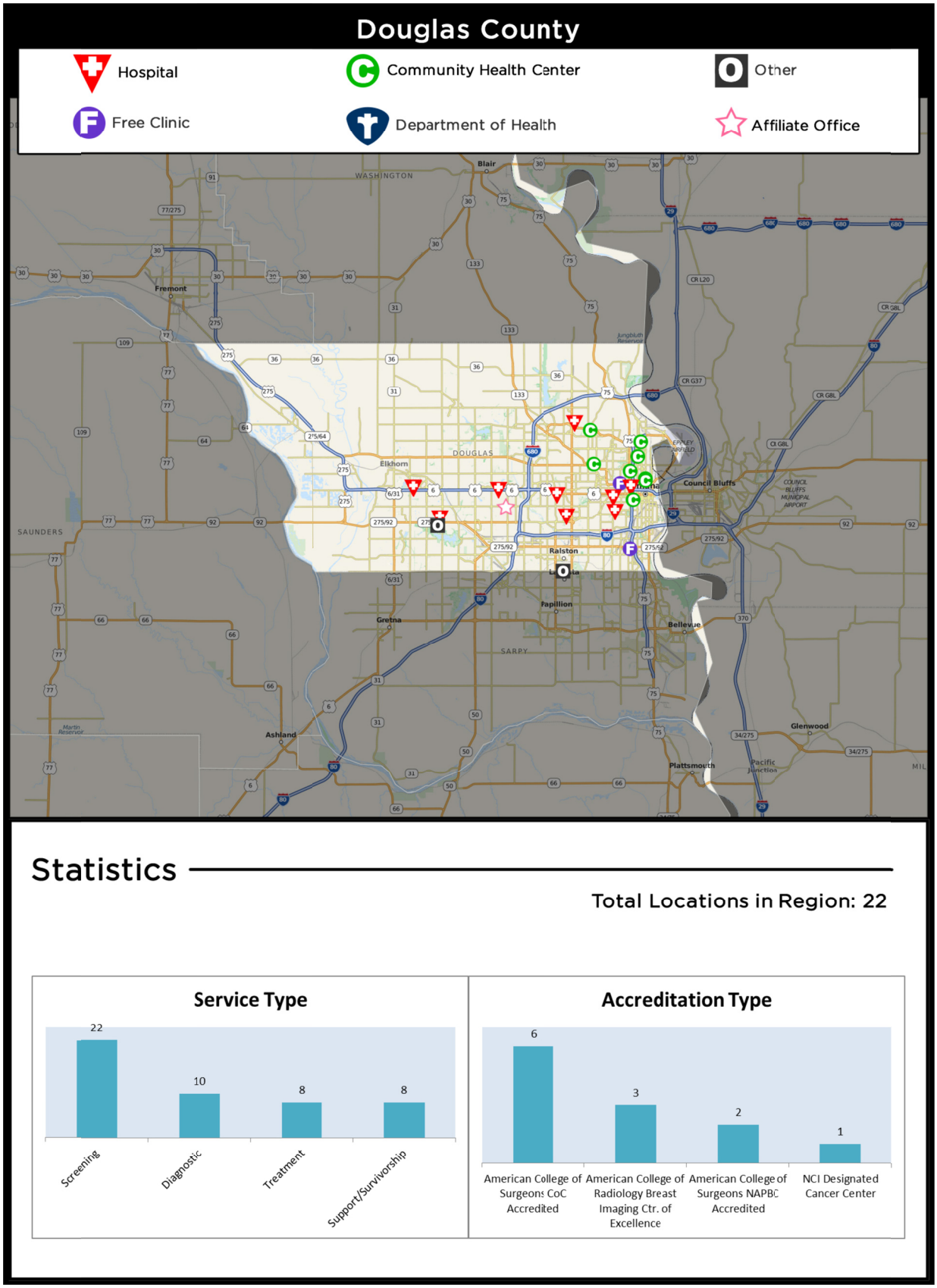


Figure 3.3. Breast Cancer Services Available in Douglas County

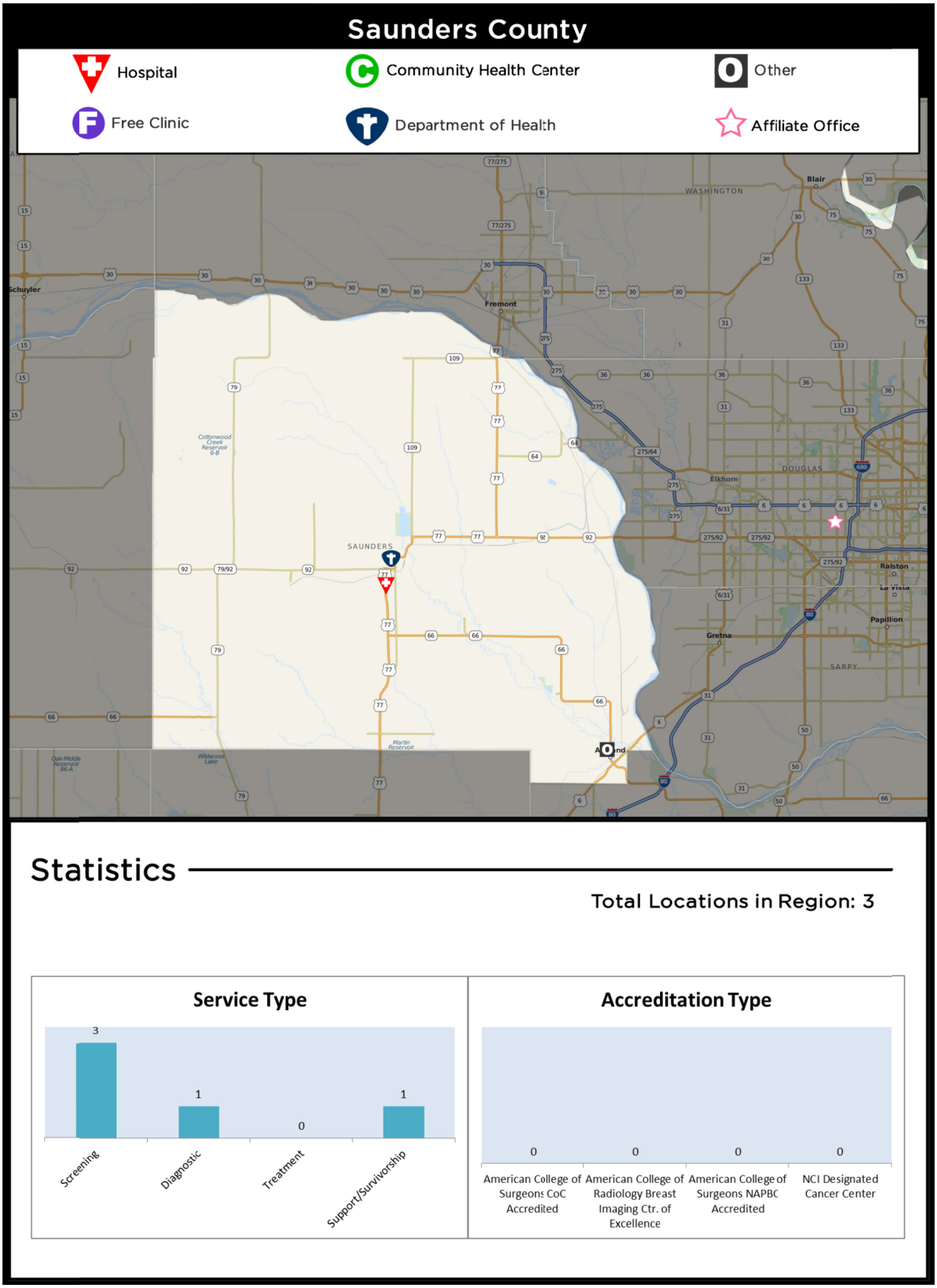
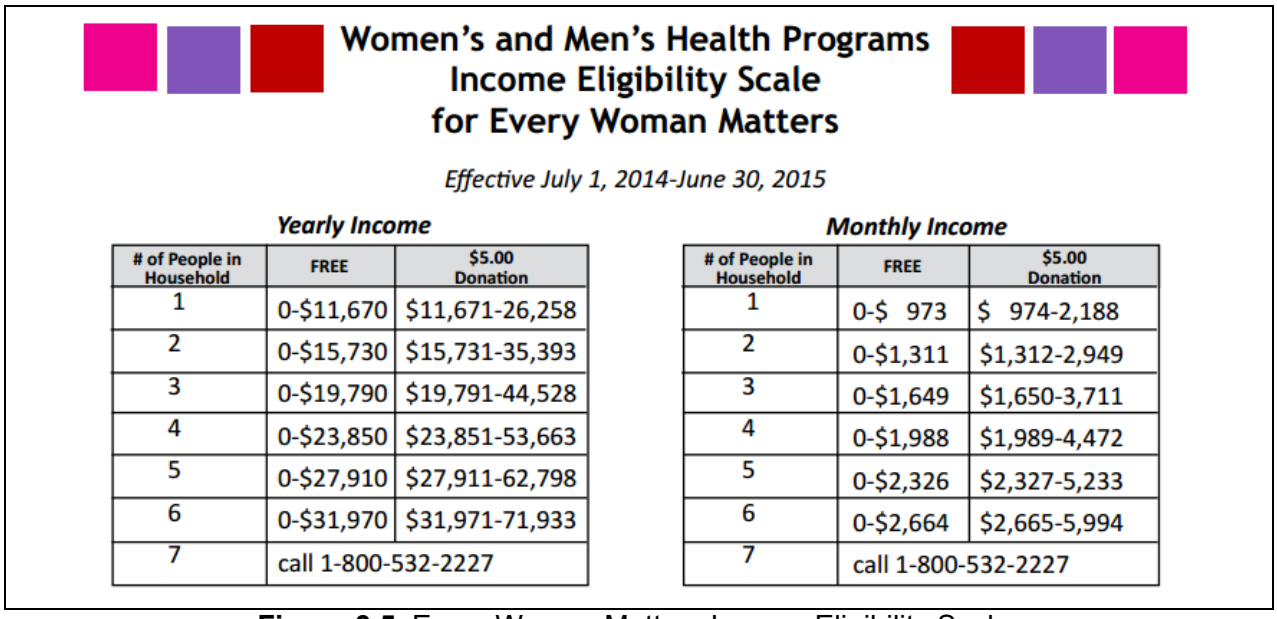


Figure 3.4. Breast Cancer Services Available in Saunders County

Public Policy Overview

National Breast and Cervical Cancer Early Detection Program (NBCCEDP)

The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) in Nebraska is known as the Every Woman Matters (EWM) program. Every Woman Matters is a federally-funded program that pays for office visits with associated clinical breast exams, pelvic exams, Pap tests, and lab fees. Age-appropriate mammography is also covered under the program as well as a limited number of diagnostic tests. Women may be provided office visits and screening services through Every Woman Matters program if they are 40-74 years of age, a U.S. citizen, and meet the program's income guidelines (Figure 3.5).



Women's and Men's Health Programs
Income Eligibility Scale
for Every Woman Matters

Effective July 1, 2014-June 30, 2015

Yearly Income

# of People in Household	FREE	$5.00 Donation
1	0-$11,670	$11,671-26,258
2	0-$15,730	$15,731-35,393
3	0-$19,790	$19,791-44,528
4	0-$23,850	$23,851-53,663
5	0-$27,910	$27,911-62,798
6	0-$31,970	$31,971-71,933
7	call 1-800-532-2227	

Monthly Income

# of People in Household	FREE	$5.00 Donation
1	0-$ 973	$ 974-2,188
2	0-$1,311	$1,312-2,949
3	0-$1,649	$1,650-3,711
4	0-$1,988	$1,989-4,472
5	0-$2,326	$2,327-5,233
6	0-$2,664	$2,665-5,994
7	call 1-800-532-2227	

Figure 3.5. Every Woman Matters Income Eligibility Scale

The Affordable Care Act (ACA) has brought about new changes to EWM enrollment. Rather than having presumptive eligibility, applicants are now required to complete a healthy living questionnaire before further enrollment information is solicited. Eligible participants cannot receive Medicaid benefits, belong to Health Maintenance Organizations (HMOs), or have Medicare Part B, as those programs already pay for screening services. Women may enroll by calling the state office, emailing an application form, or contacting a health care clinics/offices that provides EWM services. Women get access to Medicaid treatment by contacting a Department of Health and Human Services Office or by downloading an application form and mailing it to the nearest Department of Health and Human Services Office.

In recent years, community health hubs have been formed to provide an outreach system within communities to promote evidence-based strategies in clinic preventive services. There are hubs across the state at two FQHCs, including Charles Drew Health Center and OneWorld Community Health Center in Douglas County and the Community Action Partnership of Western Nebraska; and in local health departments such as Central District Health Department, Four Corners Health Department, Public Health Solutions District Health Department, and South Heartland District Health Department.

If a woman is ineligible for EWM, there are few options regarding Medicaid help, but EWM does attempt to connect those women with treatment options. Additionally, EWM has worked to

provide an online Health Navigation website to assist Nebraskans in navigating health care services. EWM estimates that at least 10 percent of applicants have health insurance that covers preventive services outside of EWM, but the applicants are unaware of their coverage. The online course can help Community Health Workers (CHW) connect people to the right health services. The CHW also can access a CHW Registry to assist them in assessing, advocating, and referring individuals to appropriate resources and health care (EWM fact sheet).

If a woman is diagnosed with cancer through the EWM program, she is eligible for Medicaid for her treatment. Enrollment in Medicaid requires additional paperwork on the part of the physician, but for the most part, it is a seamless transition. Approximately 800 health care clinics/offices, hospitals, mammography facilities/radiology groups, and laboratories perform services for Every Woman Matters. All counties in Nebraska are serviced by community partners who promote the availability of the program, enroll eligible clients, and implement health education activities in their local communities.

Komen Nebraska is connected to Every Woman Matters through several task forces, including the screening and education task force and the Metro African-American breast cancer task force. In addition, Komen Nebraska has been asked to participate on the overall state advisory committee. To improve access to education, screening and treatment programs across the state, the Affiliate will continue to partner as resources allow.

State Comprehensive Cancer Control Program

The Nebraska Comprehensive Cancer Control Program (NE CCCP) was established in 2002. NE CCCP receives funding from the Centers for Disease Control and Prevention (CDC) National Comprehensive Cancer Control Program. No funds are received from the Nebraska state government; however, partners contribute substantial in-kind resources — primarily employee time, expertise, and organization space.

The Nebraska Comprehensive Cancer Control Plan (NE CCCP) 2011 – 2016, builds upon the original document from 2003 – 2004. Many statewide stakeholders participated in the revision, and in 2010, the partnership entity of the program became a 501(c)3 non-profit program known as the Nebraska Cancer Coalition (NC2). The NC2 organization is comprised of about 150 groups and organizations represented by about 400 individuals, and it includes cancer survivors and their families. NC2 was formed, in part, to seek additional funding through federal, state, and local sources.

The state cancer plan is focused on the following goals:

- Emphasize cancer risk reduction
- Address public health needs of cancer survivors
- Reduce cancer disparities to achieve health equity
- Promote early detection and appropriate screening
- Increase access to cancer care

The specific breast cancer goals incorporated in the Breast Cancer Control Plan (BCCP) 2011 – 2016:

- By 2016, reduce Nebraska's breast cancer death rate from 19.2 per 100,000 women to 18.0
- By 2016, reduce disparities among demographic groups. Specifically:
    - Reduce the breast cancer death rate for Black/African-American women from 28.4 per 100,000 to 18.0

- Increase the screening rates for women with incomes below $35,000/yr from 61 percent to 70 percent
- Increase the screening rates for rural women from 68 percent to 76 percent

Komen Nebraska operates in the NC2 coalition as a partner through participation in organizational meetings, task force gatherings, and as a potential funder. Komen Nebraska provided a community grant to NC2 in 2012. Komen Nebraska maintains a strong and productive relationship with the Breast Cancer Coalition and continues to interface with its partners to increase visibility of issues and solutions. Komen Nebraska will continue to participate and provide visibility of programs, work issues and provide grants, as appropriate. Komen Nebraska is an active participant in the Partnership Program of BCCP and sends out information to the Komen Nebraska Board of Directors and other interested parties on activities across the state on a regular basis.

Affordable Care Act and State action on Medicaid expansion

Nebraska has not elected to adopt Medicaid expansion. The Nebraska Legislature defeated LB 577, Nebraska Medicaid bill, in March 2014. As proposed, it would bring into the Medicaid program low-income adults without minor children who would not qualify for Medicaid otherwise, and also would have provided coverage for parents and disabled adults whose current income disqualifies them for the program. According to the Every Woman Matters (EWM) Program office, approximately one-third of EWM enrollees are no longer eligible because of the changes in eligibility and failure to advance Medicaid expansion.

Because of this and the newly required screening coverage, Komen grantee priorities may change. Education and patient navigation will be increasingly important to navigate the increasingly complex systems. In addition, the need for diagnostics and treatment will increase as screening rates go up. Providers may need to adjust to higher screening rates that would make it difficult to provide for all women who need these services. However, at this time, the full future impact of ACA is unknown.

The impact of ACA in Nebraska will require Komen Nebraska to be adaptable in the coming years as patients and providers adjust to the changes. Komen Nebraska hopes to provide grants to organizations that provide care to those not eligible for ACA enrollment, un-enrolled Medicaid eligible individuals, those exempt from the mandate, and those who choose not to enroll and will remain without insurance. Because of the failure of Medicaid expansion, there will be more financial stressors on individuals with breast cancer. The Affiliate hopes to continue to provide aid through grantees, like the Visiting Nurse Association and Circle of Light, in collaboration with other community programs to provide relief to those needing assistance.

Affiliate's Public Policy Activities

Komen Nebraska supports the Susan G. Komen® Public Policy Model and the 2014 Advocacy Priorities:

- Protecting federal and state funding for the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), to ensure all women have access to potentially lifesaving breast cancer screening;
- Ensuring continued federal investment in cancer research through the National Institutes of Health (NIH), National Cancer Institute (NCI) and Department of Defense (DOD), to discover and deliver the cures;

- Requiring insurance companies provide coverage for oral anti-cancer drugs on a basis that is no less favorable than what's already provided for intravenously-administered chemotherapy, to protect patients from high out-of pocket costs; and
- Expanding Medicaid coverage to ensure the availability of the full-range of breast health services to low-income women, including cancer screening, diagnostics and treatment.

The following are examples of recent Komen Nebraska's public policy activities:

In the fall of 2008, Komen Nebraska joined forces with the American Cancer Society – Nebraska Chapter to form the Nebraska Cancer Policy Coalition. The Coalition, which now includes ten organizations total, represents individuals and organizations that support public policy initiatives that address cancer research, public education, risk reduction, early detection, and treatment. On March 31, 2009, the Nebraska Policy Coalition held a "Lobby Day" in Lincoln in an effort to inform state senators and the general public about the Coalition's 2009 Legislative priorities, which included continuing the Colon Cancer Screening Program and increasing funding for the Every Woman Matters Program. This program was a great success with nearly 100 individuals attending. Due in part to the Coalition's efforts, the Every Woman Matters Program's appropriation (LB 369) was increased from $125,000 to $250,000 for FY2010 and FY2011, and the Colon Cancer Screening program, called "Stay in the Game" (LB 459) was appropriated $700,000 in FY10 and FY11.

This partnership also lobbied the Governor of Nebraska and requested support in 2012 for LB 882, Oral Treatment Parity Legislation. This bill allows Nebraska residents to obtain their prescribed oral cancer treatments with the same copay or coinsurance that is required for intravenous chemotherapy. The legislature passed this bill and the Governor signed it in 2012.

In 2013, Susan G. Komen® Nebraska followed recommendations from Komen Headquarters and penned letters to all Nebraska members of Congress requesting their support to address the sequestration and fiscal issue and its impact on the National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

Through advocacy efforts and partnerships, Komen Nebraska continues to be a voice for breast health in the state, advocating for funding of breast health education, screening, research, and treatment programs.

Health Systems and Public Policy Analysis Findings: Conclusion

Upon thorough examination, only one target community (Douglas County) has sufficient screening, diagnostic, treatment and support/survivorship services to sustain the construct of the breast health continuum of care model. The remaining two target communities (Saunders; Custer, Lincoln and Dawson) have identifiable health system and CoC needs in the areas of treatment and support/survivorship services. Because of this, key partnerships with state and local public health departments will have to be leveraged in order to fill in gaps created by an incomplete CoC health system. New partnerships will be derived from the unfilled spaces within the CoC health system through the utilization of public health best practices such as MAPP (Mobilizing for Action through Planning and Partnership), a systematic approach to identifying and convening stakeholders for a common cause. These processes will aid Nebraska as it develops a strategy to address the impact of current public policy on breast health care. Komen Nebraska will be positioned to adapt in the coming years as patients and providers adjust to the changes. Komen Nebraska will provide grants to organizations that provide care to any individual who needs assistance with breast health care. The Affiliate will continue to work on policy change that guarantees access to care for all.

Qualitative Data Sources and Methodology Overview

Methodology

The Qualitative Data portion of the Komen Nebraska Community Profile was by far the most challenging to both conduct and analyze. Using the quantitative information about the target communities' breast health, coupled with the health services available in those same areas, Komen Nebraska discussed key breast health issues with the residents of the target communities. The purpose of this portion of the study was to get the community's perspective on the state of breast health in the target areas.

The team used the Breast Health Continuum of Care model as the basis of inquiry (Figure 3.1 - Breast Cancer Continuum of Care) for questions addressing education or knowledge of the four areas – screening, diagnosis, treatment, and follow-up or survivorship. On the outer ring of the continuum, education surrounds the framework to place emphasis on the fact that it should be continual and a part of each component. The Continuum of Care model can be used as a guide when assessing why some individuals never enter or delay entry into the continuum, when discovering gaps in service availability, and when identifying barriers faced when determining what can be done to address gaps and barriers. The key assessment questions included all these variables.

Based on best practice for the collection of qualitative data, the Komen Nebraska Community Profile team utilized two data collection methods: Focus groups and key informant interviews. These methods best aligned with Komen Nebraska organizational capacity and served as the Community Profile team's focused efforts within the target communities. The use of these two methods allowed Komen Nebraska to potentially triangulate (cross-validate) results. The activities involved in the data collection process were as follows: identification of possible participants, recruitment of participants, acquiring a list of survey tools, distribution of surveys/assessment tool, setting up appointments for interviews, scheduling locations/dates/times for focus groups, training data collectors, interaction with individuals or groups, going to the community of the participants, asking detailed questions, as well as detailed documentation.

For the purpose of gaining the voice of health care providers and community members, these individuals were asked to describe the strengths, challenges and opportunities to improve breast health and breast cancer outcomes in Nebraska communities. The assessment was conducted over a three-month period in all target communities of Komen Nebraska, involving one-to-one interviews with key informants and targeted focus groups with the lay community. A sub-committee of the Community Profile team, using instruments provided by the 2015 Komen Community Profile Guidebook, developed the assessment tools. Both the key informant interview and focus group utilized information extraction tools developed specifically for the assessment.

The assessment was conducted by members of the Community Profile team through email, telephone interviews, face-to-face interactions and/or online meetings. The list of target individuals and groups were identified by snowball samplings of organizations that cater to women's health, Komen Nebraska contacts, Komen Nebraska grantees and local public health organizations.

For the purpose of this study, key informants (KI) were defined as health care providers, those who provide care to women, or leaders (formal or informal) in the community. They received surveys via email and, if available, were contacted for follow-up. Their contributions were not anonymous. In addition, a cover letter for the service provider assessment tool was developed

and used to explain the purpose of the assessment and how the information gathered from the assessment would be used.

Focus Groups (FG) were comprised of women in the target communities who routinely gathered for other purposes. The Breast Health assessment sessions were typically an "add-on" to a previously scheduled meetings or gatherings. The FG were not reflective of the demographics of the target community, but were representative of the sub-populations with the greatest breast health burden. FG attendees were given an explanation prior to the start of the meeting on how the information will be secured, and how the anonymity of participants will be protected.

The KI and FG questions are included in the appendix and centered among one's experiences within the continuum of care or what a person has heard in the community. The intended focus groups' audience was women over 40 years of age, while the intended audiences for the key informant interviews were individuals who serve women over the age of 40. Health professionals were sought out for key informant interviews; they were not the sole source.

Sampling

A snowball sampling technique was utilized to gain access to individuals who have knowledge of breast health or individuals at risk for developing breast cancer in Nebraska. The Community Profile team was used as a source of initial contacts for the sampling. All of the persons approached to participate in the assessment were identified either through these key contacts or persons suggested by interviewees. The sampling for focus groups and key informant interviews was terminated once no new contacts could be identified.

Komen Nebraska distributed the KI surveys and conducted the FG. Nursing students from the University of Nebraska Medical Center conducted follow up interviews with one-third of the key informants. Graduate students under the supervision of a public health professional, reviewed the field notes, the recordings of the focus groups, and the key informant surveys. The public health practitioner provided additional support.

At the recommendation of members of the Community Profile team, a small monetary donation of $10 gift cards was provided to all focus group members who participated in the assessment as a "Thank You" contribution. Pursuant to the Komen Community Profile Guidebook, this was in recognition of the time involved for the interviews and the contribution that participants made to the assessment. This contribution was not used as a "lure" and was included in all literature or advertisements.

Per the Komen Community Profile Guidebook, a target community consisting of only one county should have a minimum of three (3) focus groups (sample size 6 – 12 participants) and a minimum of twelve (12) key informant interviews. For the target communities consisting of more than one county, a minimum of one (1) focus group (sample size 6 – 12 participants) and four (4) key informant interviews should be collected per county, with an overall minimum number of three focus groups and twelve key informant interviews.

- In the target community of Saunders County, the focus was placed on women who were older and rural.
- In the target community of Douglas County, the focus was placed on Black/African-American women over the age of 40.
- In the target community of Custer County, the focus was placed on women who were older and rural.
- In the target community of Dawson County, the focus was placed on Hispanic women over the age of 40.
- In the target community of Lincoln County, the focus was placed on women who were older and rural.

Ethics

Consent to participate was determined by receipt of KI survey or signed consent form for FGs. All the interviews and focus groups that were recorded are stored on a secure website. The participants read or were advised of the following:

> *All participants were advised that there were no physical risks to participation, and they were free to not answer any question(s). All information obtained will be kept strictly anonymous, and all identifying information will be removed from the collection materials. All materials will be stored at the Komen Nebraska office in a locked cabinet.*

The FG participants provided optional information about their race, age range, residence, education level, occupation, household income and breast health knowledge. Once all assessments were completed, they were entered into a database, the information provided was aggregated for analysis, and the original assessment instruments retained under lock and key in a secured setting. All this information will be retained to allow review, but destroyed following recommendation from the Community Profile team.

Qualitative Data Overview

The source of the original data for the KI involved (1) receipt of the KI survey, and filing, (2) conducting recorded KI phone interviews (if available), (3) completing a spreadsheet of respondents with name / title / position / phone / date/ time contacted / county, (4) preparing summary of notes and survey responses generating the source for codes and themes.

The source of the original data for the FG followed a similar process that involved (1) recording of responses to FG questionnaire, labeling and filing, (2) generating field notes, (3) completing a spreadsheet of the collected demographic information, (4) preparing summary of notes and responses generating source for codes and themes.

Because this project was done with the assistance of community members/students who were affiliated with different institutions (each with its own system of shared drives), the Community Profile team elected to store the incoming data (recordings of focus groups, returned surveys, demographic data, consent forms, etc.) in a secure “cloud” (Dropbox), store hard copies at the Komen Nebraska offices in the secure file, and also create a digital back up on a portable drive (flash drive). To ensure consistency and to make sure team members were able to follow the latest progress, the cloud drive contained folders with descriptive names. One of the team members regularly alerted the team when vital files (such as demographic forms and participant forms) were updated.

Because these team members had varying degrees of experience with qualitative data analysis software, one team member trained the team on the basics of coding data, and the team elected to input their coding work in simple Excel files and Word charts. Guided by the qualitative codebook in the Komen Community Profile Guidebook, they were able to employ the “constant comparative” method, defining and refining the codes that linked to the other parts of data collection.

The constant comparative method allowed for all team members to provide input, and these conversations helped the team members develop a deeper understanding of the data. Because constant comparative can be a more “conversational” process, it was very accessible to team members who were new to the qualitative process, allowing for no one on the team to feel intimidated. This method was used for the returned KI surveys, the notes from follow up calls with KI, and the recordings and field notes from the FG. Coding was done by county.

Once these codes were created, the public health leader and graduate student members of the team were able to identify categories that helped to form the basis for the picture that emerged

for each county. These categories were a collection of codes that spoke to a larger issue — for example, there might be a number of codes that could be part of the Barriers to Education category (codes around access, health literacy, language, cultural competence). Once the categories were developed, charts were created highlighting some of the most common categories (by incidence) for each county. The common themes follow.

First, in all of the communities, concern about the affordability of screening and treatment was paramount. Secondly, in all of the communities, there were still a number of fears around screening and treatment. Finally, in all of the groups, there was a push to increase access to care. These themes were consistent between KI and FG responses.

Qualitative Data Findings

The 2015 Komen Quantitative Data Report (QDR) for Nebraska defined the target communities based upon risk prioritization for HP2020 targets of breast cancer death and late-stage breast cancer diagnosis. The Health Systems Analysis and the Qualitative Data are linked to the Quantitative Data Report because they represent the focused efforts in the targeted communities defined by the QDR for the community profile assessment. The KI and FGs (focus efforts) were used to generate questions about the Continuum of Care model to provide a comprehensive assessment of breast health in this target community. The focused efforts are specific for each target community.

Limitations of the Qualitative Data

Obtaining the prescribed number of KI and FG within each target community proved difficult in the areas outside of the Komen Nebraska office area (Douglas County). While contacts were initiated and made in the target communities, not having a physical presence in the area made follow up cumbersome. The travel distance was excessive so two FGs were conducted via the internet (Skype) and the KI were conducted via phone or email. Additionally, the small population in Saunders County made the recommended number of assessments harder to complete.

Obtaining the recommended number of participants in the focus groups was also challenging. In several groups the minimum number was not available (although invitations were extended to a much larger number), but the focus group was completed. Because the recommended make-up of the focus groups (focus area) was difficult to obtain, so as a consequence, the sampling size and desired age range does not completely match. In target communities where a small sample size was obtained, responses may not be representative of the larger community. Likewise, because focus group data was collected from groups that were already meeting, these participants may be more likely to be similar than a random sampling from the community and therefore, their responses may not be reflective of the general population.

Target Community: Saunders County

Focus groups

Three focus groups were conducted for Saunders County with a total of 17 participants. Five women were in the 40-49 age range; three were 39 years or younger; and the rest were age 50 and above. The educational level was diverse for this county. Most identified themselves as being White, with a few not identifying themselves in any Race category.

Awareness/Education. In two of the groups — one at the hospital and one at the church — their responses about sources of education were similar: friends, social media, commercials, news, and Every Woman Matters advertisements. In the group with mothers of young children, some indicated they did not hear much unless it had affected someone close to them, and a few noted they heard information through annual reminders or programs at school. All three agreed

that a provider might be a good source for information, however, participants also discussed seeking advice from objective others/pastors. There was some awareness that the Internet can provide information that might be "scary" (scary enough to discourage someone to delay treatment). Each group highlighted a "hard to reach" population—one group emphasized the fact that older population do not use social media, and that rural populations will only go seek care in dire situations. Another group emphasized the fact that one had to get the newspaper to learn about services provided at a local clinic, and pamphlets that encouraged engagement need to be handed out to younger women. The third group mentioned that there was limited access to OBGYN care in the area (only came once a month), so women using that gatekeeper may have to travel or wait.

Screening. When asked about reasons for not getting screened, their answers were as diverse as their population. Some common themes that emerged across the groups were: lack of insurance/lack of clarity of what services are covered, lack of access to transportation, fear of pain of mammogram, inconsistency in recommendations about screening frequency, difficulty transferring films between facilities, lack of awareness of available local resources and constraints on time due to childcare and other family obligations.

Diagnosis/Treatment. A number of respondents were unclear about where to go for treatment and thought they would have to travel to Omaha or Lincoln for services. In all of the groups, there was a discussion of discomfort or lack of trust with some of the services in the local area. Relatedly, the women shared that they would like to have closer services, more providers from which to choose, and help from a case manager to make decisions. Women anticipate transportation, balancing work and treatments, and scheduling as being barriers for treatment.

Survivorship. All of the groups indicated that there were not a lot of known local survivor groups. Some of the reasons for this are that rural cultures are "private" cultures and that women don't talk about breasts in public. There was some awareness of programs that provide wigs and other image recovery, and a general awareness of the Relay for Life.

Key Informants

There were ten key informants in Saunders County. Eight of the ten were connected to health care facilities, and two were connected to a local church.

Awareness/Education. When asked if they thought breast cancer was a priority issue for women in the community, many informants indicated that, although it would be ideal that breast cancer would be a priority, they noticed that breast cancer fell behind other conditions and life circumstances — general concerns about access to basic health care and insurance, heart disease, lung and colon cancers, crime, poverty and unemployment. All of the informants noted the presence of education campaigns during October, through advertisement of the Every Woman Matters program, clinics, hospitals and non-profits. However, the informants were mixed in their views about how well these campaigns reached women. There were concerns that women who do not have children (therefore, not seeing an OBGYN) or who do not have a primary care provider are slipping through the cracks. Women without a regular source of care are hard to reach and make aware of the screening services (often at low cost or free).

Screening. Most of the informants indicated that the Every Woman Matters program is an important source for screening. However, some expressed concerns that women who are unaware of the program, delay screening because they have financial concerns and are uninsured/underinsured. Fear and lack of education about the importance of screenings are cited as other possible reasons for delaying screening.

Diagnosis/Treatment. In this community, there were limited resources for treatment, so women were expected to travel for care. This was a major concern for the key informants, as it may

delay diagnosis and treatment. As a result, lack of reliable transportation and timely follow up to abnormal results were key themes mentioned in the process. Fear was a common theme — the fear stemmed from a number of places — fear of diagnosis, fear of not being able to afford treatment, and the fear of after effects of treatment.

Health Care System Performance. Many of the participants worried that financial woes and lack of awareness about cancer and about programs like Every Woman Matters had an impact on women's participation in the continuum. They also believed that systems and providers needed to take greater steps to ensure free or affordable access to screening and treatment for uninsured/underinsured women, and providers needed to be more diligent about reminding women about the importance of screenings.

The Health System question for Saunders County about travel issues associated with screening and treatment was validated for both the KI and FG. The greater issues associated with a concern about the affordability of screening and treatment was mentioned more frequently.

Target Community: Douglas County

Focus groups

Three focus groups were conducted in Douglas County, specifically in North Omaha, which has a higher population of Black/African-American women. A total of 21 participants were in these groups: Four were in the 40-49 age range; two were 39 or younger; and the remaining were 50 or older. Eleven women had college degrees — with a range of Associate's, Bachelor's, Master's and Doctorate degrees. All but one participant identified as Black/African-American.

Awareness/Education. Many of the women had received education about breast cancer through a local group geared toward Black/African-American women. Women also indicated that physicians, October awareness campaigns on television, cancer patients/survivors, national umbrella cancer organizations, and health fairs were locations where they were getting information about cancer. There was some discussion about including breast health information for younger (middle school aged) girls; there was some discussion in two groups that screenings should start before the age of 40 in the Black/African-American community. There were recommendations to bring breast health information to churches, grocery stores, and to workplaces. In one of the groups, the need for navigators throughout the continuum was discussed.

Screening. There was a suggestion to implement mobile mammograms; to make mammograms readily available, as ubiquitous as flu shots. Some of the barriers to treatment are the need to travel to another part of town to get screened, lack of access to insurance or funds to pay for screening. Women in all groups discussed other life stressors getting in the way of scheduling screening — family obligations, transportation issues, etc.

Diagnosis/Treatment. In one group the role of faith was discussed as a possible reason women delay following up — belief that faith may heal abnormalities, thus rendering further care unnecessary. On the other hand, faith and church communities are also discussed as having great supportive value for women going through treatment. A theme that came up in one of the groups is that cancer is a death sentence (or, at the very least, a very traumatic experience, as witnessed by watching others) and may be hidden (for some time) from the family. Financial constraints were paramount in the groups; lack of insurance and the financial means to weather treatment were major worries. In one group, it was mentioned that it might not be worth knowing a diagnosis if one cannot afford treatment.

Survivorship. Although faith played a negative role in some comments, faith and church communities are also discussed as having great supportive value for survivors. Support of

other survivors, and the support of culturally relevant groups like My Sisters Keeper are vital for Black/African-American women's survival.

Key Informants

Fifteen lay informants participated in the Douglas county portion. All were connected to hospitals, community health centers, or clinics.

Awareness/Education. While most of the KI acknowledged the disparities in the Black/African-American community, many also noted that social concerns, general access to care, other cancers, violence and poverty often took priority in the minds of women in North Omaha. There was some concern among informants that not all women were aware of the disparities, even though the death rates were often as high or higher for cancer as they were for other conditions. The messages were mixed about education — some informants believed that information was getting to women in North Omaha, at least during October; some believed that the messages were missing a lot of women and needed to be spread throughout the year. There was a general agreement that uninsured women and low-income women were likely not being reached with great effectiveness. Because of broader constraints, women were believed to be putting off listening to the messages until they take care of other issues.

Screening. There was universal agreement that two things weighed heavily on the minds of Black/African-American women in North Omaha when considering screening — cost and fear of cancer and/or mammograms. Many informants cited the lack of health insurance and/or understanding of programs such as Every Woman Matters as reasons to avoid screening. Other key issues mentioned were delays in screening — low health literacy and the lack of understanding of the value of screening; misconceptions of one's risk (assuming that no family member with cancer means you will not develop cancer and/or not seeing a "lump" means you are cancer-free), and transportation to and from screening facilities. Mistrust of the medical community and lack of provider referral were also mentioned.

Diagnosis/Treatment. Some of the barriers to diagnosis and treatment for Black/African-American women are: lack of cultural competency, fear of unequal (or racist) treatment, health illiteracy, lack of navigation/slow or no follow-up, fear of lack of support from family/friends, financial strain and/or uninsured/underinsured, strain on family/work schedules, fear to be self-advocate, lack of safe and reliable transportation.

Health Care System Performance. When asked how women fall through the cracks, some common themes for health systems to address were connected to the lack of patient navigation, the complexity of programs such as Every Woman Matters, affordability, the need to facilitate the needs of women under the age of 40 and of elderly women, the need to create opportunities for more education early in the continuum, training in cultural competence, and the expansion of screening times/days.

The Health System question for Douglas County about availability of screening and treatment access (hours of operation) was validated. The greater issues associated with a concern about the affordability of screening and treatment was more frequently cited.

Target Community: Custer, Dawson and Lincoln Counties

Custer County

Focus groups

In Custer County, only one focus group was conducted with four in attendance. This group was all white, and all were 60 years old or older. Only one in this group had a college degree, and one of the members did not graduate high school. This focus group was convened by a cancer

survivor, and was made from a pre-existing group of women who regularly meet to participate in a sport.

Awareness/Education. Having a friend willing to speak freely about her cancer experience helped this group feel comfortable asking questions; they rely on survivors for information. The group discussed the fact that the taboo for talking about breast cancer has been removed, but that the bulk of the talk about cancer seemed to only happen in October. One concern is about the availability of information about financial programs — Every Woman Matters is discussed, but other options are less understood. While other focus groups highlighted the Internet as a source, this group (perhaps due to its age) suggested that information — specific to the local community — be available elsewhere, as the Internet was overwhelming.

Screening. There was a member of the group who had chosen to stop getting screenings (due to pain), but most group members agreed that women were aware of screening, and two major limitations were highlighted. The women in the group agreed that women in outlying areas skip screening because of distance to travel (lose a half days' worth of work) and that the limited hours of screening made it hard to go to screenings. A comment worth exploring, which seems to contradict the earlier one about stigma, was that women might travel to other cities to get their treatment, if they were concerned about others in their small community knowing about their diagnosis.

Diagnosis/Treatment. As with screening, concerns about driving distance (the women indicated that some would need to drive 75-85 miles away for treatment) was a barrier to seeking treatment. There was a perception that appointments are made with little regard to patient schedule/travel time. Financial concerns and family obligation also weighed heavily on the minds of women considering treatment.

Survivorship. There is no longer a support group for survivors in their community as it was disbanded due to lack of interest. One survivor with a recurrence was shunned by her social network.

Key Informant Interviews

In Custer County, there were four key informants who responded to the survey. Three informants worked in the health care industry and one worked for the local University Extension center.

Awareness/Education. In terms of awareness, none of the informants noted that it was especially remarkable, as compared to other conditions. Some mentioned innovative methods of delivery — partnerships with beauty salons, for example, to get out breast health information. Others noted use of pamphlets and newspapers for getting the word out, and one recommended using radio as an option as well.

Screening. A number of participants theorized there were women who weren't getting screened who were eligible, but struggled with determining why this happened. Three mentioned Every Woman Matters as an option for women. In terms of barriers, concerns about financing were mentioned, as well as fear of breast exam/mammogram, and fear of being diagnosed. One other barrier highlighted by half of the participants was the lack of reminders by care providers.

Diagnosis/Treatment. Because services in the area were limited, travel was a concern for all of the informants — specialized treatments were only offered in other cities, which meant a long drive for many women (for screening and treatment). Specialists travel to the area weekly or monthly, but reliable transportation may be needed for ongoing treatment. As with screening, financial concerns may also impact delay in seeking care.

Health Care System Performance. Two common themes came up in suggestions for improvements in the system — one is to have providers do more regular reminders about mammograms and breast health (either through mailings or using alerts in the Electronic Medical Records); and the second theme was about financial issues. Women who are unable to pay due to lack of insurance, women who fall under the age range for some programs, and the lack of free clinics in the area were mentioned as possible system changes needed.

Dawson County

Focus groups

In Dawson County, where there was some difficulty getting participation, the Affiliate used innovative methods to gather information — the only focus group was conducted via Skype. It was conducted in Spanish with assistance from a translator. It had three Hispanic participants. Two were in the 40-49 years of age range and one was younger. All identified as homemakers.

Awareness/Education. In this group, all identified the local clinic as the place where they had gotten information, and where they were most likely to seek information in the future. It should be noted that the translator from this group was from this clinic — the clinic may be perceived as one of the few reliable sources for Spanish-language health education.

Screening, Diagnosis/Treatment. Women in the group thought that 40 was the appropriate age to begin screening, but financial support and potential ineligibility for Every Woman Matters were barriers to seeking screening and follow up testing. Among Latinas, concern about the potential revelation of one's undocumented status is a major deterrent to participating in the continuum. The need for a translator is a major barrier to seeking treatment, as is reliable transportation (women were relying on spouses for rides to facilities outside of town).

Survivorship. There was some awareness of survivors in their social networks, but no awareness of where survivors might seek support.

Key Informant Interviews

Five key informant interviews were conducted in Dawson County. Four of the five were affiliated with the clinic mentioned by the above focus group participants. One was affiliated with another health care facility.

Awareness/Education. In response to education, there was a general sense from most of the informants that breast health was important to members of the community. One informant indicated that she was seeing more women than before come into the clinic for follow up, but that they were poorly educated on the reasons why the follow up was needed. There was a concern expressed by two of the informants that there was a lack of material in Spanish, resulting in a lack of understanding of breast health. One of these KI also noted that there were no Spanish-speaking counselors or support groups for women. There was some awareness of the Every Woman Matters program, but one informant noted recent changes in the paperwork process that made it difficult to do.

Screening. As in other groups, one of the major themes that emerged in regard to screening was cost. All informants noted that lack of insurance and ineligibility for programs (because of lack of documentation) were major hurdles for women needing screening. Many of the informants indicated that lack of education about the role of screening, insurance and cancer played a role in not doing screening. Language barriers were also highlighted by one of the informants.

Diagnosis/Treatment. Because of the lack of services in the area, women are travelling to other cities, so transportation was mentioned as a barrier to treatment. As with screening, all of

the informants highlighted the struggles with payment for women who are uninsured / underinsured, and the ineligibility of undocumented women to qualify for low-income programs. Relatedly, another highlighted that the Latinas in the community may also be facing language barriers and a lack of family support.

Health Care System Performance. All of the KIs were in agreement that cost of services and ineligibility for undocumented women were major concerns that health systems needed to address. Additionally, reliable travel to care and language barriers were mentioned. Another topic mentioned by some of the informants was a lack of education about how the health care system works and mistrust of the system (particularly for those who are not documented).

Lincoln County

Focus groups

Two focus groups were conducted in this county. There were seventeen total participants. All of the participants were white. In these groups, the majority was aged 50 and older, although there were some women in the 40-49 age range, and one woman under age 40. Everyone in these focus groups had at least a high school degree, and six had Bachelor's degrees. The group members were in different places in life — one group was of women with a history of substance abuse, and the other was a group of cancer survivors — but some common themes emerged among them.

Awareness/Education. Both groups found that they had discovered reliable sources of information about breast cancer — providers, television, radio ads, family members, and the Internet. The survivor group suggested that they would like to see information in high schools as well. Relatedly, the members of the recovery group expressed concerns for younger family members and for female children, suggesting that both groups wanted to see more in the earlier part of the life course.

Screening. In the recovery group, there were a number of concerns about ability to pay for screening and treatment, which likely reflects, in part, their struggles with sobriety and the uncertainty that might bring to their lives/employment options. Many in this group also cited fear of pain as a possible barrier. In the survivor group, there was also some discussion about securing screening when one was under the recommended age (some talked about their or loved ones' initial dismissal by providers before a cancer diagnosis due to age) and trouble with reliable transportation. It should be noted that a number of women in the survivor group chose to travel outside of their area for treatments and surgeries. There was some concern in the survivor group that there were not enough qualified specialists to meet the needs of the community; there was a lack of confidence in local services. In the group, the worries about finding cancer, uncertainty about insurance coverage, and lack of clarity about what makes one "at risk" for cancer were cited as other barriers. In the recovery group, there was some discussion about the myth that cancer is spread by surgery, highlighting the women's concerns (that was highlighted in both groups) that the technicalities of cancer treatment are not well understood.

Diagnosis/Treatment. In the survivor group, the members spoke articulately about their ideal treatment, many sharing stories of travelling long distances or travelling to multiple doctors in one day. Many suggested that an ideal treatment would be one that involved provider-to-provider communication and the ability to speak to many providers in one day.

Survivorship. In the recovery group, there was discussion about family history of cancer, and the lack of known survivors to whom one could reach out. This created a sense of isolation and shame among some women; however, some were able to identify survivor groups. In the survivor group, they identified survivor support groups and they also talked about isolation and

loneliness, particularly with dealing with late effects of cancer (like lymphedema). Some mentioned models in other institutions that paired patients with others in the same stage.

Key Informant Interviews

In Lincoln County, the Affiliate was able to get input from six key informants. Four of the informants were connected to health care institutions or other health-related services. Two were members of the broader community, in local government.

Awareness/Education. Overall, there was a sense that breast cancer was a topic that women should be concerned about, but key informants also agreed that sometimes breast cancer is not the priority (with one respondent indicating that mental health issues seemed more important to her population she was serving). One thing all of the key informants in the county were aware of was "pink" events during the month of October — they noted them in various media outlets — online, TV, events in the community, stories in the newspaper. A theme that emerged here was a belief that awareness needed to happen more frequently, throughout the year, which connects to an issue of screening suggested by the group: women not being reminded or told about screening or not being regularly aware of the need.

Screening. Two major themes were echoed by most of the participants in regard to screening: the perceived cost of screening and issues connected to primary care providers. First, women who were uninsured or underinsured were not always educated on the options available to them and were likely to delay seeking screening. Informants seem to believe that information about affordably securing screening is as important as information about cancer itself. Secondly, the key informants had multiple concerns about the perceived gatekeepers of screening — primary care providers. Uninsured or underinsured women might not have a regular source of care, therefore, they do not have anyone to remind them about their possible need for screening. As in the focus group, there was some discussion about transportation as a possible barrier to screening for women in more remote areas. There was a concern expressed that there were limited numbers of primary care providers in the local area, a physician shortage. Additionally, a provider also expressed some concern that providers might be using two different standards for making recommendations — standards that recommend different ages to start screening and different frequencies.

Diagnosis/Treatment. All informants were able to identify by name a place for treatment and diagnosis, so there seems to be awareness of available options; however, all of the informants discussed issues of cost for women. Many believed that cost caused women to delay seeking treatment. Some participants highlighted the work of Every Woman Matters, and some indicated that they were aware of sliding scales and other options for payments. Underinsured/uninsured were still a population of concern, and most made recommendations that the health systems in the area find ways to accommodate women regardless of their ability to pay.

The Health System question for the travel concerns affecting the availability of screening and treatment access (hours of operation) was validated. The greater issues associated with a concern about the affordability of screening and treatment was more frequently cited.

Conclusion

The communities included in this report were quite diverse in age, location (rural vs. urban), race, and access to care, but they were united by a number of themes. First, in all of the communities, a concern about the affordability of screening and treatment was paramount. Even in communities where programs such as Every Woman Matters were utilized and known, key informants and community members all expressed a concern that one's ability to pay caused delays in seeking care. These fears were particularly strong for undocumented women

who were unclear if they were eligible for any of the free- and low-cost programs. Secondly, in all of the communities, there were still a number of fears around screening and treatment. Most communities agreed that better education about the value of screening, culturally and linguistically appropriate social support, and guidance through the continuum would help eliminate some of these fears.

Finally, in all of the groups, there was a push to increase access to care. This took a number of forms — for rural women, it meant creating opportunities for local screening and treatment; for many women (urban and rural) it meant safe and affordable transportation options; for urban women, it meant access to care closer to their communities, and for many women, it meant access to care at later times or on the weekend. For women pulled in many directions because of family and work demands, difficulty in accessing services often meant downplaying the importance of the services and letting them “fall off the radar”.

Breast Health and Breast Cancer Findings of the Target Communities

This final section, the Mission Action Plan, is the roadmap to improve the breast health of Nebraskans. By evaluating the quantitative data, the breast health and breast cancer care assets (and gaps), and reviewing the themes from key informant and focus group surveys, the Community Profile Team has determined the priorities and timeline to improve breast health in Nebraska. A summary of findings for each target community follows, including quantitative data, health system analysis, qualitative issues, and public policy trends across the state.

Geographically, Nebraska is a large state, ranking sixteenth in total size, with a relatively small number of residents, ranking thirty-seventh in total population and forty-third in population density (IPL2.org). The combination of distance and sparse populations create many challenges to provide health services to Nebraskans outside of the major metropolitan areas of Omaha and Lincoln.

Three geographical focus areas, coincide with the three state congressional districts, include the three target communities. The congressional district construct allowed the Community Profile team to assess the breast health needs of the urban, rural and mixed urban/rural areas of the state. The Breast Cancer Continuum of Care model was used throughout the assessments. This model shows how a woman typically accesses the health care system for breast care.

Target Community: Saunders County

The Community Profile team spent a great deal of time and resources in Saunders County, but it was difficult to obtain qualitative data in this county. This community appears to be very supportive of improving breast health in their county and communities — most were very surprised at the quantitative data.

The quantitative data revealed that Saunders County is considered rural, has a much older population, and has a lower overall poverty rate than the rest of the state. The mammography rate is much lower than either the Nebraska or U.S. proportion of screened mammography, at 65.7 percent (weighted average). The female breast cancer death rate and late-stage diagnosis rate are rated at high risk for not achieving the Healthy People 2020 goals, with greater than 13 years to reach the target rates. One interpretation of the data is that age and location might be factors in women's ability to obtain care.

The Health System Analysis revealed only one medical facility that provided mammography screening in the county (Saunders County Medical Center), with limited additional services. Within 45 miles of the county seat, Wahoo, there were six medical facilities that provided more extensive services for breast health located in Fremont, Lincoln and Omaha. The public health department (Three Rivers Health Department) serving Saunders County shares resources with two other counties and has a satellite office in Wahoo. Clinical breast exams are the only breast health services performed at that Title X designated clinic in Wahoo.

Qualitative data from the Key Informant Interviews and Focus Groups showed some common themes: many of those contacted had little knowledge about the services in Saunders County, especially at the Saunders County Hospital; many said that the need to travel to Lincoln or Omaha made access to care difficult. Another recurring issue was a concern about the affordability of screening and treatment, especially for those women who did not qualify for the state program, Every Woman Matters. Other themes included fear of the results, how to pay, and lack of comfort or trust in the local services.

From this compilation of data, the Community Profile team concluded that fear, financial issues, and travel are the major factors in low mammography rates and overall poor breast cancer prognosis. The underlying cause of these issues appears to be a lack of knowledge about availability of services locally, either for screening directly, or transportation to provide assistance, and financial and psycho-social support services for those in need.

Target Community: Douglas County

The Community Profile team was most successful in reaching the population at risk in Douglas County than any other county and understanding the issues and trends since the Komen Nebraska office is located in Omaha. There were many resources such as health care workers, faith groups, and support groups who were accessible to understand the concerns because of proximity.

The quantitative data revealed that Douglas County is considered urban and has the highest percentage of Black/African-American and Hispanic/Latina people in the state. While the overall county poverty rate is 8.6 percent, the rate in North Omaha (greatest concentration of Black/African-American population) is 29.6 percent (United Way of Midlands, 2012). The breast cancer death rate for Black/African-American women (27.6/100,000) is much higher than the Douglas County rate (22.1/100,000) and Nebraska state overall rate (20.2/100,000). The female late-stage diagnosis rate for Douglas County is designated high risk for not achieving the Healthy People 2020 goals, with greater than 13 years to reach the target rate. From this data, the decision was made to focus on Black/African-American women in North Omaha versus the county as a whole.

The Health System Analysis revealed that three medical facilities in Douglas County provide the full complement of breast health services aligned with the Continuum of Care. However, there are no facilities located in North Omaha. There are two Federally Qualified Health Centers (FQHC) in Douglas County, one each in North and South Omaha, providing services on a sliding fee. The FQHC provide initial breast health screening and patient navigation while outsourcing mammograms to major health centers.

The Key Informant Interviews and Focus Groups showed some common themes: a concern about the cost of screening and treatment, fear of the mammogram results and how to pay for the potential cancer treatment. Many interviewed were aware about the disparities of breast cancer in the Black/African-American population such as higher breast cancer death and younger Black/African-American women diagnosed with breast cancer. They were also aware of the many facilities available for screening in Omaha, but commented on the lack of facilities in North Omaha. These facts were often overshadowed by other life challenges (e.g. poverty, lack of education, transportation convenience) that preclude addressing breast health issues.

From this compilation of data, the Community Profile team concluded that fear, financial issues, and accessible transportation to nearby health facilities are major factors in overall poor breast cancer prognosis. The underlying causes of these issues appear to be broader life issues such as poverty, community violence, access to local facilities, and fear of cancer outcome.

Target Communities: Custer, Dawson and Lincoln Counties

The Community Profile team had difficulty in obtaining information in these three communities. Distance from the Affiliate office in Douglas County was a large factor in accessing Key Informants and Focus Groups. While the three counties are contiguous in central / western Nebraska, they each have independent challenges and issues.

The quantitative data for Custer County is very similar to that of Saunders County — it is considered rural, has a much older population, a much higher poverty rate than the rest of the state, and a much higher proportion of people without health insurance. The mammography rate (66.0 percent) is much lower than either the Nebraska or U.S. proportion of screened mammography (weighted average). The female breast cancer late-stage diagnosis rate is designated high risk for not achieving the Healthy People 2020 goals, with greater than 13 years to reach the target rates. From this data, it was suggested that barriers to obtaining care are likely similar to those in Saunders County: age, travel distance, and poverty.

The quantitative data for Dawson County reflects a population with a percentage of Hispanic/Latinas (30.9 percent) that is almost three times the state average. Additionally, the population has a lower percentage of high school graduates, a higher poverty rate, a very high percentage without health insurance, and an eight percent higher linguistically isolated population, compared to state averages. The mammography rate is much lower at 62.6 percent than either the Nebraska or U.S. proportion of screened mammography (weighted average). The female breast cancer late-stage diagnosis rate is designated high risk for not achieving the Healthy People 2020 goals, with greater than 13 years to reach the target rates. This data suggests that poverty, language barriers, and legal status/citizenship might be factors in obtaining care.

The quantitative data for Lincoln County is not as distinct as the other counties in this target region. It is partially rural and has an older population, but does not have a significantly greater number of minorities, number of in poverty, or without health insurance. In addition it is a large transportation hub whose railroad employees impact the counties overall socio-economic characteristics (Census Fact). The female breast cancer death rate and late-stage diagnosis rate are both designated high risk for not achieving the Healthy People 2020 goals, with greater than 13 years to reach the target rates. From this data, it was suggested age and travel distance might be a factor in obtaining care.

The Health System Analysis for the targeted three-county area revealed one comprehensive cancer treatment facility and two facilities that provide mammography screening in each of the three counties, although with limited additional services. Driving distances to access full service care is often greater than 75 miles each direction. There are three public health departments serving the target communities, all of which have limited engagement for breast health services.

While the quantitative data was diverse among the three counties, the qualitative sources of Key Informant Interviews and Focus Groups showed some common themes: a concern about the affordability of screening and treatment and a concern about access to care due to long distances to travel. Other themes included fear, lack of comfort or trust in the local services, and language barriers.

From this compilation of data, the Community Profile team concluded that financial issues and travel, along with fear of mammogram pain and potential cancer, are the major factors that lead to overall poor breast cancer prognosis. The underlying cause of these issues appears to be financial and distance to services, along with citizenship and language barriers.

Mission Action Plan

The summary of findings for each target community led to the creation of the Mission Action Plan for each targeted community. This includes the problem statement, the priorities and objectives and timeline for execution.

PROBLEM STATEMENT Target Community 1 Saunders County

Women in the target community of Saunders County have a late-stage incidence rate and death rate significantly higher than the Komen Nebraska service area as a whole. The Health System Analysis found that breast cancer treatment services were very limited in the county. Breast cancer survivors and health providers indicated that the lack of knowledge of local services available, affordability of preventive services and the lack of trust of local services made it difficult for women to seek care.

PRIORITY Target Community 1 Saunders County

Improve access to breast health screening services for women ≥ 40 years of age who reside in Saunders County.

OBJECTIVES Target Community 1 Saunders County

- By March 31, 2016, partner with at least two community-based health organizations or faith organizations to arrange small group education classes and breast health community outreach presentations to highlight services and financial options for screening and treatment in Saunders County.
- By March 31, 2018, partner with at least one community organization and one health service agency to continually and consistently publicize existing options to finance breast health services in Saunders County.
- By March 31, 2019, hold breast cancer summit with providers in and around Saunders County to discuss the possible partnership opportunities with the goal of increasing access to and seamless progression through the Breast Cancer Continuum of Care.

PROBLEM STATEMENT Target Community 2 Douglas County

Black/African-American women in the target community of Douglas County have a late-stage incidence rate and death rate significantly higher than the Komen Nebraska service area as a whole. The Health System Analysis found that breast cancer treatment services were not available in the geographical area where most Black/African-American women reside in the county. Breast cancer survivors and health care providers indicated that affordability and availability of preventive services in their area of residence made it difficult for Black/African-American women to seek care.

PRIORITY Target Community 2 Douglas County

Improve access to breast health screening services for Black/African-American women ≥ 40 years of age who reside in Douglas County with a particular focus in the North Omaha region.

OBJECTIVES Target Community 2 Douglas County

- By March 31, 2016, meet with at least four community organizations or faith communities that work with Black/African-American women to discuss breast health outreach and financial options for screening and treatment in Douglas County.
- By March 31, 2017, partner with at least one community organization and a health care institution to continually and consistently publicize existing culturally appropriate preventive services for breast health and options to finance breast health services in Douglas County.
- By March 31, 2019, hold at least three collaborative meetings with hospitals, primary care providers, health clinics, especially the federal qualified health centers and community-based organizations to foster the discussion around how to improve access to and seamless progression through the Breast Cancer Continuum of Care -- referral, screening, diagnosis, treatment, and support service -- within Douglas County.

PROBLEM STATEMENT Target Community 3 Custer, Dawson and Lincoln Counties

Women in the target community of Custer, Dawson and Lincoln Counties have a late-stage incidence rate and death rate significantly higher than the Komen Nebraska service area as a whole. The Health System Analysis found that there were few to no breast health services available in Custer and Lincoln counties. Breast cancer survivors and health care providers indicated that the lack of access to care due to distance and lack of trust in the local services made it difficult for women to seek care. The Health System Analysis found that there were few to no breast health services available that were culturally and linguistically appropriate in Dawson County. Breast cancer survivors and health care providers indicated that the lack of access to culturally and linguistically appropriate care due to distance and lack of trust in the very limited local services made it difficult for women to seek care.

PRIORITY Target Community 3 Custer and Lincoln Counties

Improve access to breast health screening services for women $\geq$ 40 years of age who reside in Custer and Lincoln Counties.

OBJECTIVES Target Community 3 Custer County

- By March 31, 2016, partner with at least two community-based health organizations to arrange small group education classes and breast health community outreach presentations in at least two clinics where women are part of the population served.
- By March 31, 2017, partner with at least one community-based organization and one health service agency to continually and consistently publicize existing options to finance breast health services in Custer County.
- By March 31, 2019, hold a breast cancer summit with providers in and around Custer County to discuss the possible partnership opportunities with the goal of increasing access to and seamless progression through the Breast Cancer Continuum of Care.

OBJECTIVES Target Community 3 Lincoln County

- By March 31, 2016, partner with at least two community-based health organizations to arrange small group education classes and breast health community outreach presentations in at least two clinics where women are part of the population served in Lincoln County.
- By March 31, 2017, partner with at least one community-based organization and one health service agency to continually and consistently publicize existing options to finance breast health services in Lincoln County.
- By March 31, 2019, hold a breast cancer summit with providers in and around Lincoln County to discuss the possible partnership opportunities with the goal of increasing access to and seamless progression through the Breast Cancer Continuum of Care.

PRIORITY Target Community 3 Dawson County

Improve access to breast health screening services for women ≥ 40 years of age who reside in Dawson County with a particular focus on Hispanic/Latina women**.**

OBJECTIVES Target Community 3 Dawson County

- By March 31, 2016, partner with at least two community-based health organizations or faith organizations to arrange small group education classes and breast health community outreach presentations targeting Latina/Hispanic women in at least two clinics in Dawson County.
- By March 31, 2017, partner with at least one community based organization and one health service agency to continually and consistently publicize existing options to finance breast health services in Dawson County.
- By March 31, 2019, hold a breast cancer summit with providers in and around Dawson County to discuss the possible partnership opportunities with the goal of increasing access to and seamless progression through the Breast Cancer Continuum of Care.

PROBLEM STATEMENT Komen Nebraska Service Area

Nebraska has a limited number of cancer centers that can provide access to all components of the Komen Breast Cancer Continuum of Care Model. This issue is compounded by sparse population density areas across the state, long distance travel to seek service providers, increase in undocumented persons, and limited access to financial aid for low income individuals due to the denial for Medicaid expansion. These items have led to the population of Nebraska as a whole having limited access to breast health services across the state.

PRIORITY Komen Nebraska Service Area

Increase state legislators' education and understanding of breast health issues in the Komen Nebraska Service Area.

OBJECTIVES Komen Nebraska Service Area

- By March 31, 2017, conduct a biannual mailing to all legislators to increase Komen Nebraska's visibility as a trusted local resource on breast cancer.
- By March 31, 2018, conduct annual conference call with Komen Siouxland to discuss joint public policy efforts and any pending breast cancer legislation, including advocating for maintaining state Breast and Cervical Cancer Screening Program funding.

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Appendices

Key Informant Interview Form (example Custer County)

We are asking for your help in exploring the state of breast health in Custer county. Susan G. Komen Nebraska is conducting a breast health assessment to better understand some of the reasons for late stage breast health diagnosis and breast cancer mortality in your community. You have been identified as a 'Key Informant' in the community, that is someone who has knowledge of issues affecting women's health in Custer county.

We would like your help in completing the attached questionnaire about breast health in your community. There are ten questions related to breast health education, screening, treatment and health systems that we would like your opinion. Please provide as much information that you would like to share, and in some cases, the answer maybe 'not applicable', or 'unknown.' We will follow up with a phone call to discuss your answers and obtain your consent to use your information. We will call you on Wednesday or Thursday (please let us know what is the best day and time to call for a follow up call (10 mins). All information obtained will be kept strictly anonymous and all identifying information will be removed from the collection materials. All materials will be stored at the Komen Nebraska offices in a locked cabinet.

There are no physical risks to participation, and you are free to not answer any questions. We sincerely appreciate your help in gathering this information as it will help Komen Nebraska address the greatest breast health needs across the state, and in turn provide services where that greatest need exists. We are committed to helping all with their breast health needs and a world without breast cancer.

If you have any questions, please contact Komen Nebraska, Karen Daneu, Executive Director, at Karen.daneu@komennebraska.org or 402-502-2979 X206

Thank you in advance for your time.

Once complete, please email your responses and day (next Wed or Thurs) and Time for a follow up call.

Focus Group Interview Questions

We are asking for your help in exploring the state of breast health in your county. Susan G. Komen Nebraska is conducting a breast health assessment to better understand some of the reasons for late stage breast health diagnosis and breast cancer death in your community. Thank you for participating in this focus group to help us understand these issues. We ask that your complete a consent form and a demographic form before the end of the session.

We would like your help in completing questions about breast health in your community. There are eleven questions related to breast health education, screening, treatment and health systems that we would like your opinion. Please provide as much information that you would like to share, and in some cases, the answer maybe 'not applicable', or 'unknown.' All

information obtained will be kept strictly anonymous and all identifying information will be removed from the collection materials. All materials will be stored at the Komen Nebraska offices in a locked cabinet.

There are no physical risks to participation, and you are free to not answer any questions. We sincerely appreciate your help in gathering this information as it will help Komen Nebraska address the greatest breast health needs across the state, and in turn provide services where that greatest need exists. We are committed to helping all with their breast health needs and a world without breast cancer.

If you have any questions, please contact Komen Nebraska, Karen Daneu, Executive Director, at Karen.daneu@komennebraska.org or 402-502-2979 X206

Thank you in advance for your time.

Komen Nebraska

Awareness / Education

1) Is breast cancer a major health concern or problem in your community? How does it compare to other health, mental health or social concerns?
2) Do you feel breast health messages and services get to the women that need them? Please provide an example of how this is done, or not available in your community

Screening

3) What are the main breast health resources available in your county / community?
4) What are the barriers that prevent women from seeking breast cancer screening (clinical breast exams or mammograms) in your community?
5) In your opinion, how does a support network (spouse, partner, family, and friends) influence the decision to seek breast health screening?
6) Where do uninsured women go for breast health services? What are some of the reasons for not getting screened?

Diagnosis / Treatment

7) Describe what the best breast health care looks like once a person has been screened for breast cancer?
8) In your opinion, what factors affect the quality of treatment a person receives?
9) If diagnosed with an abnormal breast screening, what issues would preclude a patient from receiving follow-up care? What is it that affects the ability to get to breast health care or services (preventive/diagnostic/active treatment/post-treatment/follow-up) in your community?
10) Based upon your own experiences, what factors might contribute to late stage diagnosis?
11) What can the healthcare system do to increase the number of women getting breast health care in your community?