

susan g.  
komen.



# COMMUNITY

PROFILE REPORT 2015



SUSAN G. KOMEN<sup>®</sup>  
DALLAS COUNTY

# Table of Contents

<b>Table of Contents</b> .....	<b>2</b>
<b>Acknowledgments</b> .....	<b>3</b>
<b>Executive Summary</b> .....	<b>5</b>
Introduction to the Community Profile Report .....	5
Quantitative Data: Measuring Breast Cancer Impact in Local Communities.....	6
Health Systems and Public Policy Analysis .....	8
Qualitative Data: Ensuring Community Input .....	10
Mission Action Plan .....	12
<b>Introduction</b> .....	<b>16</b>
Affiliate History .....	16
Affiliate Organizational Structure.....	16
Affiliate Service Area .....	18
Purpose of the Community Profile Report.....	21
<b>Quantitative Data: Measuring Breast Cancer Impact in Local Communities</b> .....	<b>22</b>
Quantitative Data Report.....	22
Additional Quantitative Data Exploration.....	44
Selection of Target Communities .....	48
<b>Health Systems and Public Policy Analysis</b> .....	<b>54</b>
Health Systems Analysis Data Sources .....	54
Health Systems Overview .....	55
Public Policy Overview .....	61
Health Systems and Public Policy Analysis Findings.....	66
<b>Qualitative Data: Ensuring Community Input</b> .....	<b>69</b>
Qualitative Data Sources and Methodology Overview .....	69
Qualitative Data Overview.....	72
Qualitative Data Findings .....	78
<b>Mission Action Plan</b> .....	<b>81</b>
Breast Health and Breast Cancer Findings of the Target Communities.....	81
Mission Action Plan .....	85
<b>References</b> .....	<b>89</b>

# Acknowledgments

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

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

**Ruth Schlesinger, MPH**

Mission Manager

Susan G. Komen Dallas County

**Susan M. Wolfe, PhD**

Founder

Wolfe & Associates

Community Profile Interns

**Sara Jabeen, MPH**

**Amelia Robinson**

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

**Key Informants**

- Thomasine Beck – Patient Navigator – UT Southwestern Screening our Sisters
- Martha Blaine – Executive Director – Community Council of Greater Dallas
- Allison Collazo RN, MSN – Nurse Supervisor, Nurse Family Partnership – YWCA of Metropolitan Dallas
- Sylvia Dunnavant – Founder – The Celebrating Life Foundation
- Rebecca Fritze – Senior Program Manager, Financial Empowerment – YWCA of Metropolitan Dallas
- Charla Gauthier, MPH – Supervisor, Cancer Program Administration - Methodist Dallas Medical Center
- Elizabeth Guzman – Patient Navigator – Bridge Breast Network
- Vicki Hallum, RN, CBCN - Oncology Nurse Navigator - Methodist Charlton Medical Center
- Phyllis Harris – Lay Health Educator – UNT Health Science Center
- Vickie Henry – Community Development Specialist - Parkland Health & Hospital
- Audrey Hughes – Breast Cancer Survivor and Advocate
- Cheryl Kidd - Senior Director of Health & Quality of Life - Urban League of Greater Dallas and North Central Texas
- Camille Lafayette – Lead Lay Health Educator – UNT Health Science Center
- Jana Munoz - Team Leader, Women's Imaging - Methodist Charlton Medical Center
- Linda Munoz – Program Manager – YW Women's Health – YWCA of Metropolitan Dallas
- Jennifer Paxton, LCSW, OSW-C - Clinical Oncology Social Worker, Patient Navigator – American Cancer Society
- Karin Petties – Project Manager – UNT Health Science Center

- Coqueace “Koco” Powell – Breast Cancer Survivor and Advocate
- Lisa Quirk – MPH Candidate - UNT Health Science Center, Graduate Intern – Cancer Support Community of North Texas
- Esther Ricks – Breast Cancer Survivor and Advocate
- Evelyn Rosales – Patient Navigator – Parkland Health & Hospital
- Lisa Rose – Program Coordinator – UT Southwestern Medical Center Dallas
- Beverly Rush – First Lady – Inspiring Body of Christ Church (IBOC)
- Susan Smithson – Chief Program Officer – YWCA of Metropolitan Dallas
- Cheryl Wesley, M.Ed. – First Lady – Antioch Missionary Baptist Church
- Gail Winn – Founder and President – Pretty N’ Pink Dallas
- Phyllis Yount - Program Manager – Cancer Support Community of North Texas

### **Quantitative Data Resources**

- David R. Risser, PhD, MPH – Epidemiologist - Texas Cancer Registry
- Brad Walsh, MPH –Strategic Planning Project Administrator - Parkland Health & Hospital

### **Resources and Support**

- The Bradie James Resource Center at Methodist Dallas Medical Center
- Cancer Support Community of North Texas
- Cedar Hill Recreation Center
- East Gate Missionary Baptist Church
- Kroger
- Lancaster Veterans Memorial Library
- Kim Linnear, MPA – Associate Director – UNT Health Science Center
- Lynne Haze and Smooth R&B 105.7
- Pretty N’ Pink Dallas
- YWCA of Metropolitan Dallas

Thank you also to those individuals and organizations who wished their participation to remain anonymous.

### **Report Prepared by:**

**Susan G Komen® Dallas County**

5310 Harvest Hill Road

Suite 120

Dallas, TX 75230

214-750-7223

[www.komen-dallas.org](http://www.komen-dallas.org)

# Executive Summary

## Introduction to the Community Profile Report

Susan G. Komen® Dallas County was founded in 1992 to serve the breast health needs of Dallas County residents. The Affiliate's vision is for every person in Dallas County to have access to breast health education and breast cancer screening, treatment, and support. Dallas is the birthplace of the Susan G. Komen® organization and the original Susan G. Komen Race for the Cure® was held in Dallas in 1983 with 800 participants. Komen Dallas County is honored to continue this legacy that began more than 30 years ago and the Komen Dallas Race for the Cure® continues to this day as the Affiliate's largest annual fundraiser.

As of 2015, the Affiliate has invested more than \$23.5 million into 223 local community grants since its founding. These grants have provided breast cancer screenings and treatment for Dallas County residents in addition to funding financial and patient support programs. Between 2010 and 2015 Komen Dallas County funded 26,530 screening mammograms and 4,130 diagnostic tests. These services aided in the detection of 353 breast cancers in women who otherwise may not have had access to this medical care. In addition to funding local community grants, Komen Dallas County also contributes to the Susan G. Komen research program. Since its founding, the Affiliate has provided nearly \$8 million for national research.

Susan G. Komen Dallas County is the local source for funding breast cancer education, screening and treatment in Dallas County, serving thousands of women each year. Komen Dallas County strives to be seen as the local authority on breast health resources and information. The Affiliate works toward this goal by participating in year-round community outreach at health fairs and speaking engagements. In fiscal year 2015, Komen Dallas County participated in 56 breast health education outreach events. The Komen Dallas Race for the Cure attracts more than 16,000 participants each year and is the area's largest breast health awareness event.

To ensure it is serving the breast health needs of Dallas County, the Affiliate conducts a needs assessment every four years that results in the Community Profile. An effective Community Profile enables Komen Dallas County to align its community outreach, grantmaking, and public policy activities toward the same mission goal.

The Community Profile will allow Komen Dallas County to:

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

The Affiliate will use the Community Profile and the Mission Action Plan to guide its grantmaking and outreach strategies. Based on the findings of the Community Profile, the Affiliate will develop a request for applications for its community grants program that is responsive to the community's breast health needs. The Affiliate will seek out new potential partners and grantees to fill the gaps in care and support identified through the Community Profile process. The Affiliate will prioritize outreach efforts to reach individuals living in the Affiliate Target Areas.

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

The first step of the Community Profile process included an in-depth review of the available quantitative data related to breast health and demographics. The information presented in the Quantitative Data Report shows a disparity in late-stage diagnoses and death rates being experienced by Black/African-American women living in Dallas County. The *National Cancer Institute (NCI)* defines "cancer health disparities" as adverse differences in cancer incidence (new cases), cancer prevalence (all existing cases), cancer mortality (death), cancer survivorship, and burden of cancer or related health conditions that exist among specific population groups in the United States (2008). The breast cancer death rate experienced by Black/African-American women is 1.4 times higher than the combined rate for all women living in Dallas County. Black/African-American women in Dallas County have higher death rates per 100,000 women than any other population group.

Not only are Black/African-American women facing a higher death burden than other population groups in Dallas County, they are also more likely to receive a late-stage breast cancer diagnosis. Similar to the disparity in death rates, Black/African-American women experience a greater burden of late-stage diagnoses than any other population group in the county. The late-stage diagnosis rate of Black/African-American women in Dallas County is 1.2 times higher than the rate experienced collectively by all women in the county.

To consider this information and deliberate over the selection of target communities, the Affiliate convened a panel of local community health professionals. During this meeting the group considered the breast cancer data, information presented from a literature review, and had a discussion about the challenges experienced by the different communities within the county. Based on the breast cancer late-stage diagnosis and death data, it was determined that the target population would be Black/African-American women. From there, the group worked to come to a consensus on which geographic communities within the service area the Affiliate should focus on during qualitative data collection.

Demographic data played a key role in the next phase of the target community selection. The Black/African-American population of each geographic area was analyzed in order to find the communities with the largest percentage of Black/African-American residents. The communities with the largest Black/African-American population base include: Cedar Hill, DeSoto Lancaster, and South Dallas. With the exception of one zip code (75226) in South Dallas, the remaining 13 zip codes that comprise these communities have substantially larger Black/African-American female population percentages than that of the Affiliate service area as a whole.

The group continued its analysis of the county by considering breast cancer death rates broken down into 13 geographic communities provided by Parkland Health & Hospital System. Reviewing the six years of available data, Cedar Hill, DeSoto Lancaster, and South Dallas were consistently among the communities experiencing the highest breast cancer death rates.

### **Cedar Hill**

Three zip codes make up the community of Cedar Hill: 75104, 75137, and 75249. Cedar Hill has a total population of 77,607, 3.3 percent of the county's population. The majority racial group of Cedar Hill is Black/African-American, comprising 47.7 percent of the community's population with 37,029 residents, according to the 2010 US Census.

Despite having one of the lowest 2010 per capita incomes at \$14,200, only six percent of residents were unemployed and only 4.2 percent were living in poverty. Nearly 90 percent of the residents of Cedar Hill have graduated from high school (Edwards et al., 2012).

Similar to DeSoto Lancaster, Cedar Hill has positive health indicators in that none of the residents are considered to live in medically underserved areas, and overall women aged 40-64 are more likely to have health insurance than the average Dallas County female in their age group. Notwithstanding these positive demographic trends related to health status, Cedar Hill is still experiencing disparities related to breast cancer death. The breast cancer death rate in Cedar Hill is higher than the breast cancer death rate for Dallas County in every year that data is available. From 2008 to 2010, 156 women living in Cedar Hill received a breast cancer diagnosis, 50 (32.1 percent) of these women received a late-stage diagnosis.

### **DeSoto Lancaster**

The community of DeSoto Lancaster comprises three zip codes: 75115, 75134, and 75146. DeSoto Lancaster represents 3.7 percent of the population of Dallas County, with 87,146 residents (US Census, 2010). In the 2010 US Census, the majority of residents in DeSoto Lancaster identified themselves as Black/African-American, comprising 68 percent of the total population of the community, with 59,276 residents.

The economic and health indicators of DeSoto Lancaster are more favorable than those found in South Dallas. Nearly 85 percent of adults living within DeSoto Lancaster have graduated high school. Per capita income in 2010 was \$23,000 with low unemployment and only eight percent of residents living below the Federal Poverty Limit (Edwards et al., 2012). None of the residents of this community are considered to be living in a medically underserved area. Additionally, the percentage of female residents aged 40-64 in this community without health insurance is lower than the county average of 29.1 percent.

Even with these more favorable health indicators, DeSoto Lancaster is still experiencing disparities related to breast cancer. Women in this community experience higher death rates as compared to the rest of the women living in Dallas County. Of the 187 breast cancer diagnoses in DeSoto Lancaster between 2008 and 2010, 82 were found at the distant or regional (late) stage. The county average for late-stage diagnosis of breast cancer during this time was 35.5 percent compared to the DeSoto Lancaster rate of 43.85 percent.

## South Dallas

The community of South Dallas consists of eight zip codes 75203, 75210, 75215, 75216, 75226, 75232, 75237, and 75241. In 2010, the total population for this area was 163,622, 6.9 percent of Dallas County's population. The majority of residents in South Dallas are Black/African-American according to the 2010 US Census, comprising 69.1 percent of the area's population, a total of 113,064 people.

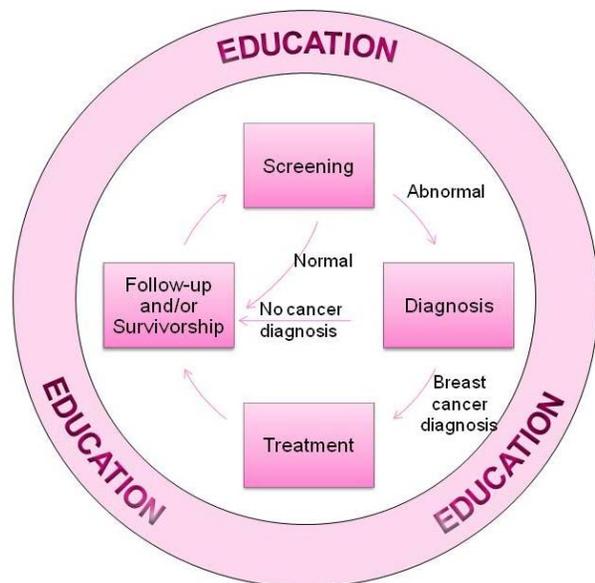
South Dallas has the lowest economic indicators of all Dallas County communities with a per capita income of \$13,400, an unemployment rate of 13.1 percent, and 25 percent of residents living below the Federal Poverty Limit (Edwards et al., 2012). Nearly 36 percent of South Dallas adults have not graduated from high school. Six of the eight South Dallas zip codes consist of a large percentage of residents considered to be medically underserved. This is compounded by the fact that more than 30 percent of female residents aged 40-64 do not have health insurance.

Every year, from 2007-2012, the female breast cancer death rate was higher in South Dallas than for the county as a whole. Between 2008 and 2010, 341 females were diagnosed with breast cancer from this community. Of those diagnoses, 135 women received a late-stage diagnosis, meaning 39.59 percent of all diagnoses in South Dallas during this time were late-stage.

Komen Dallas County has a history of seeking to serve the residents of South Dallas through its community grants and outreach initiatives. In the last Affiliate Community Profile published in 2011, zip codes 75210, 75215, 75216, 75232, and 75241 were identified target areas for the Affiliate's mission-based efforts. The most recent data available indicates that these five zip codes, in addition to the remaining areas in the community of South Dallas, continue to experience disparities related to breast cancer diagnosis and death.

## Health Systems and Public Policy Analysis

The Community Profile Team began the Health Systems Analysis by looking at resources available in the Affiliate service area as a whole. Dallas County is resource rich with 98 organizations providing direct breast health services for those in need, including 12 organizations that offer the full continuum of breast cancer services housed within a single organization. The Breast Cancer Continuum of Care (CoC) is a model that shows how a woman typically moves through the health care system for breast care (Figure 1). A woman would ideally move through the CoC quickly and seamlessly, receiving timely, quality care in order to have the best outcomes. Education can play an important role throughout the entire CoC.



**Figure 1. Breast Cancer Continuum of Care**

Categorizing the organizations into the specific offerings along the CoC, the Community Profile Team identified 73 locations offering breast cancer screenings - 24 offering both screening mammograms and clinical breast exams, 19 offering only clinical breast exams, and 30 offering only screening mammograms. Dallas County is home to four mobile mammography units that travel the 871 square miles of the county, in addition to serving neighboring counties. For patients who receive an abnormal result from their screening mammogram, there are 42 locations in Dallas County offering breast cancer diagnostic testing. Patients with a breast cancer diagnosis can choose from 27 entities offering breast cancer treatment options and 43 organizations offering some form of survivorship support.

While Dallas County offers an abundance of resources, these resources are concentrated in areas outside of the Affiliate's Target Areas located in the southern sector of the county. Only 11 organizations that offer breast health resources are found in the Affiliate Target Areas: eight in South Dallas, two in Cedar Hill, and one in DeSoto Lancaster.

Without nearby locations to receive breast health services, women may need to take additional hours off work, spend additional time and money traveling for appointments, and/or find childcare to cover the additional time needed to attend appointments, amongst other barriers that may arise. For breast cancer patients, this extra travel time compounded with the fatigue from treatment can make adherence to their recommended treatment more challenging. For women without their own means of transportation, access to care becomes even more difficult, as no public transportation bus or rail routes are located in Cedar Hill and women living in DeSoto Lancaster have access to one bus route. Public transportation is more abundant in South Dallas, however ready access varies from one resident to the next depending on the location of their home.

A strength of the health system in Dallas County is the presence of four mobile mammography units. During the 2013 fiscal year grant cycle, the Affiliate funded 43 mobile mammography events throughout the Target Areas: four in Cedar Hill, five in DeSoto Lancaster, and 34 in South Dallas. More frequent mobile mammography visits to South Dallas with Affiliate funding can be attributed to the Affiliate's focus on funding projects in South Dallas and are a testament to the power the Affiliate's funding mechanisms have to make a difference in the availability of care in the Target Areas. Another strength is the presence of a robust mass transit program in the Dallas area, while there is not an extensive public transportation network in the Affiliate Target Areas – the infrastructure for a mass transit system exists, the community must work to extend it into the southern stretches of the county.

Recognizing the role that public policy plays in the health of the community, Komen also examined how the Affordable Care Act (ACA) and government-funded programs were likely to impact access to breast health services in Dallas County. Prior to the ACA's insurance mandate, more than 6.2 million people were uninsured in Texas, comprising about 24 percent of the total population - the highest rate of uninsured people in the nation. The ACA insurance mandate for individuals went into effect January 2014; its impact on the current uninsured rate in Texas is still being determined.

Texas elected not to take part in the ACA's provision for the expansion of Medicaid coverage for those with incomes up to 133 percent of the Federal Poverty Level. This expansion would have increased access to breast health and breast cancer care for approximately 900,000 Texas women. Texas also forfeited its option to run a state insurance exchange. As a result, consumers in the state select coverage using the federally-facilitated marketplace.

The state offers two safety-net programs to assist eligible, low-income, uninsured women in need of breast cancer screening, diagnostic testing, and treatment. The Texas Department of State Health Services (DSHS) Breast and Cervical Cancer Services (BCCS) program funds clinic sites across the state to provide quality, low-cost, accessible breast and cervical cancers screening and diagnostic services. These services help women receive routine screenings, which is the best method to detect breast and cervical cancers in their earliest stages increasing a woman's chance of survival. While this program is vital, it alone cannot meet the need as the program currently serves only six percent of eligible women.

Low-income, uninsured women diagnosed with breast or cervical cancer in need of treatment may qualify for medical assistance through the state funded Medicaid for Breast and Cervical Cancer (MBCC) program. Women accepted into the program gain full Medicaid coverage beginning on the day after the date of diagnosis and eligibility continues as long as the Medicaid treatment provider certifies that a woman requires active treatment for breast or cervical cancer.

The implementation of the ACA has had minimal impact on the BCCS program as most BCCS clients do not qualify for marketplace subsidies because their incomes are too low. With Texas electing not to expand Medicaid coverage, the Affiliate's grantees have not conveyed any changes to their current outreach strategies or patient demographics. The prevalence of access to care issues indicate that Komen Dallas County will continue to serve high volumes of uninsured and underinsured constituents through community-based grants.

The Health Systems and Public Policy Analysis revealed a scarcity of breast health and transportation services available in the Affiliate Target Areas accompanied with a state screening program that is overextended and cannot meet the needs of eligible women. Through qualitative data collection, Komen Dallas County sought to understand how the shortage of local providers combined with other challenges experienced by women in these communities resulted in late-stage breast cancer diagnosis and death disparities.

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

The Affiliate focused its qualitative data collection on the following key variables: barriers and access to care, availability of existing breast health programs, and identifying community strengths and assets. The Affiliate sought to learn from women and breast cancer survivors living in Cedar Hill, DeSoto Lancaster, and South Dallas and also from community leaders and health care providers serving these areas. Komen Dallas County ultimately sought the answers to these questions:

- What factors are contributing to breast cancer disparities in the Affiliate Target Areas?
- What factors are contributing to breast cancer survivorship in the Affiliate Target Areas?
- What assets already exist in the Affiliate Target Areas that can be built upon to eliminate these disparities?

To gather feedback from local breast cancer survivors, community members, and breast health providers, the team conducted 37 key informant interviews, five focus groups with a total of 43 participants, and a modified Appreciative Inquiry session with 10 local breast health providers.

Barriers to screening, diagnosis, and treatment included lack of knowledge, fear and denial, complexity of the health care system, and financial, cultural, and practical issues. Among the most commonly cited barriers to screening and diagnosis by interview and focus group respondents were knowledge barriers, with the knowledge of service availability and resources as the most frequently mentioned. Many women are not aware of the existence of low-cost or no-cost breast health services and how to access these programs. A lack of general breast health knowledge can result in a delayed diagnosis as women do not follow up when they are notified of abnormal screening results because they either do not realize the need to, or lack the knowledge necessary to navigate the health care system. This limited knowledge of breast health in general can also lead to delays in treatment as women do not realize the need to act promptly when they are diagnosed.

Fear was the next most frequently given reason women do not get mammograms or do not follow up with diagnostic testing following abnormal screens. Some women have a fatalistic viewpoint and feel that if they have cancer, there is little chance they will survive, so they would rather not know. Others fear treatment and its side effects. Fatalistic attitudes about cancer lead many women to think there is no point to going through treatment. Some women deny the significance of the diagnosis and fail to act. Some women are afraid of the impact a cancer diagnosis may have on their families.

Lack of social support was another barrier to screening, diagnosis, and treatment. Family and friends are often relied upon for transportation and assistance with daily chores and meals. Survivors considered emotional support and religious beliefs as necessary for overcoming barriers to treatment. Churches, survivor support groups, family, friends, co-workers, and one-on-one interactions with other survivors were all important for coping during treatment. Some women stated a wish to avoid risking an abnormal screen and diagnosis because there would be nobody to support them as they navigate treatment. Women who do not have this support network may not be able to comply with treatment, especially if they do not have their own transportation and live in an area where there is limited or no public transportation. Financial barriers were also frequently acknowledged. Many women are low income, have no health insurance, or lack the money for diagnostic testing and treatment if their mammograms indicate they are necessary. Some women with health insurance are unable to meet the deductibles and co-pays associated with additional testing and treatment. For this group of women, free screenings are not an incentive because they perceive little or no options available if there is a cancer diagnosis.

The paucity of screening and diagnostic centers in the Affiliate Target Areas is especially problematic for women with no means of transportation. Some areas of southern Dallas County have no public transportation available, including the cities of Cedar Hill and DeSoto. These two factors combine to limit women's access to screening and diagnostic follow-up.

Another theme that arose was practical considerations. Many women are juggling work and family responsibilities and do not prioritize their own health. Some women have difficulties

finding time to schedule a mammogram, while others are strongly discouraged from taking time off work for medical appointments at the risk of losing wages for doing so.

Consistent with the viewpoint that knowledge deficits and difficulties navigating the health care system are barriers to screening, diagnosis, and treatment, more patient navigation was the most frequently cited improvement that could be made to the current health care system to ensure a more seamless continuum of care for women who are diagnosed with breast cancer. Beyond funding for more services, educational outreach was identified as the most pressing need. Suggested education included community workshops and events about the availability of health care resources and increasing educational materials available throughout the community. Increasing partnerships with community gatekeepers and community leaders would also contribute to sustainable change in the lives of individuals in regards to breast health, with the goal of longer, higher quality lives. Assistance with transportation was also recommended, as well as increasing the number of mobile units in the target communities, with more marketing promoting their availability and predictable schedules, which could increase the number of women screened.

Knowledge barriers were similar across communities. Women in all three communities want more information about screening, diagnostic, and treatment opportunities that are available and accessible. They also need additional educational opportunities related to breast health and the benefits of screening and early detection. Such knowledge may be helpful to reduce fear and denial, two psychological factors that were named in focus groups and can create barriers that contribute to delayed screening and diagnosis. Women who care for the needs of their families over their own needs will be more likely to adhere to regular screening if they have a better understanding about how doing so is relevant to caring for their families. There is also a need for increased social and practical support for women who are diagnosed with breast cancer and undergoing treatment in the Affiliate Target Areas.

### **Mission Action Plan**

Komen Dallas County developed a Mission Action Plan to address the needs identified through the Community Profile process. This plan is the culmination of more than one year's effort by the Affiliate and aims to be reflective of the needs voiced by community residents and providers. This plan was presented to the following outside stakeholders for their feedback: the Dallas Cancer Disparities Community Research Coalition, Parkland Health & Hospital's Coming Together for the Cures Committee, and the Program Directors Leaders Circle group at the Center for Nonprofit Management. Affiliate staff also provided input into the capacity of the organization to achieve the stated objectives within the designated timeline. The final plan incorporating the feedback from community stakeholders and staff was presented to the Affiliate Board of Directors for formal approval.

**Problem: According to the Health Systems Analysis data gathered, African American women living in Cedar Hill, DeSoto Lancaster, and South Dallas have limited access to breast health services.**

**Priority 1: Improve access to and timely utilization of breast health services through the Continuum of Care for African American women living in Cedar Hill, DeSoto Lancaster, and South Dallas.**

**Objective 1: Beginning in FY16, emphasize funding programs through the Affiliate community grants program that provide medical care and support services to eliminate barriers to care for residents of Cedar Hill, DeSoto, Lancaster, and South Dallas, with an emphasis on funding mobile mammography and patient navigator programs.**

**Objective 2: In FY16, identify and promote the Komen Dallas County community grants program to at least three organizations that provide programs offering financial assistance, support groups, childcare assistance, or transportation assistance to serve the women of Cedar Hill, DeSoto Lancaster, and South Dallas.**

**Problem: Based on information learned from focus groups and key informant interviews, African American women living in Cedar Hill, DeSoto Lancaster, and South Dallas and health care providers identify low levels of breast health knowledge and low awareness of available resources as a contributing factor to late stage diagnosis and breast cancer mortality rates.**

**Priority 1: Increase breast health outreach to African American women living in Cedar Hill, DeSoto Lancaster, and South Dallas.**

**Priority 2: Increase the visibility of breast health resources available to African American women residing in Cedar Hill, DeSoto Lancaster, and South Dallas.**

**Priority 3: Include members of the community in the Affiliate’s efforts to eliminate breast health disparities in Cedar Hill, DeSoto Lancaster, and South Dallas.**

**Objective 1:** Beginning in FY16, through the Affiliate community grants program support funding breast health educational outreach programs incorporating the use of community health workers to reach the women residing in Cedar Hill, DeSoto Lancaster, and South Dallas.

**Objective 2:** By the end of FY 18, identify 1-3 groups of influence in the target areas of Cedar Hill, DeSoto, Lancaster and South Dallas to present the 2015 Community Profile findings to.

**Objective 3:** In FY16 develop new, collaborative relationships and meet annually with at least three community-based organizations that serve the women of Cedar Hill, DeSoto Lancaster, or South Dallas.

**Objective 4:** By the end of FY18, partner with at least one community-based organization and a health care institution to provide a culturally appropriate breast health event where women aged 40 and up can sign up to receive a mammogram in either Cedar Hill, DeSoto, Lancaster, or South Dallas.

**Objective 1:** By the end of FY16, create an online mammography calendar detailing all Affiliate funded screening events which will be posted on the Affiliate website.

**Objective 2:** Beginning in FY16, proactively distribute resource listings to at least 30 locations (local businesses, churches, clinics, etc.) in Cedar Hill, DeSoto Lancaster, and South Dallas each fiscal year in order to increase the visibility of available breast health resources in the Target Areas.

**Objective 1:** By the end of FY18, the Komen Dallas County Board of Directors will include at least one member who resides in either Cedar Hill, DeSoto Lancaster, or South Dallas.

**Objective 2:** By the end of FY18, identify and train at least six volunteers residing in Cedar Hill, DeSoto Lancaster, or South Dallas to support the Affiliate’s breast health outreach efforts.

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



# Introduction

## **Affiliate History**

Susan G. Komen® Dallas County was founded in 1992. Dallas is the birthplace of the Susan G. Komen® organization and the original Susan G. Komen Race for the Cure® was held in Dallas in 1983 with 800 participants. Since then, the Komen Race for the Cure Series has spread throughout the United States and the world. Komen Dallas County is honored to continue the legacy started more than 30 years ago and the Komen Dallas Race for the Cure® continues to this day as the Affiliate's largest annual fundraiser.

As of 2015, the Affiliate has invested more than \$23.5 million into 223 local community grants since its founding. These grants have provided breast cancer screenings and treatment for Dallas County residents in addition to funding financial and patient support programs. Between 2010 and 2015 Komen Dallas County funded 26,530 screening mammograms and 4,130 diagnostic tests. These services aided in the detection of 353 breast cancers in women who otherwise may not have had access to this medical care.

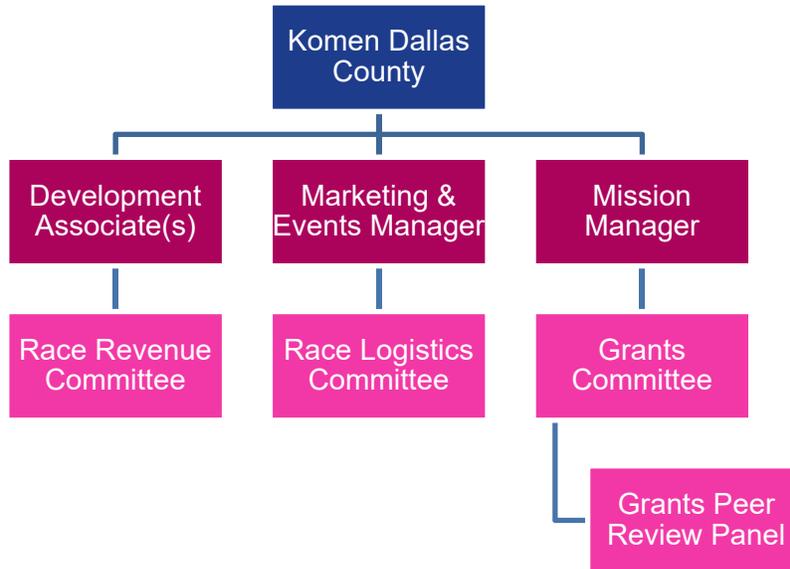
In addition to funding local community grants, Komen Dallas County also contributes to the Susan G. Komen research program. Since its founding, the Affiliate has provided nearly \$8 million for national research. Over the past 30 years, this investment has fueled research in all areas of breast cancer, from basic biology to prevention to treatment and to survivorship. Thanks to the generosity of sponsors and donors, Susan G. Komen has granted more than \$800 million to more than 2,500 researchers around the globe searching for the cures to breast cancer.

Susan G. Komen Dallas County is the local source for funding breast cancer education, screening and treatment in Dallas County, serving thousands of women each year. Komen Dallas County strives to be seen as the local authority on breast health resources and information. The Affiliate works toward this goal by participating in year-round community outreach at health fairs and speaking engagements. In fiscal year 2015, Komen Dallas County participated in 56 breast health education outreach events. The Komen Dallas Race for the Cure attracts nearly 16,000 participants each year and is the area's largest breast health awareness event. Komen Dallas County is an active member of coalitions seeking to improve the health of the medically underserved including: the Breast Health Collaborative of Texas, the Cancer Alliance of Texas, the Komen Texas Advocacy Collaborative, Dallas County District 3 Public Health Advisory Council, University of North Texas Cancer Disparities Community Research Coalition Community Advisory Board, and the Dallas County Patient Navigator Action Coalition.

## **Affiliate Organizational Structure**

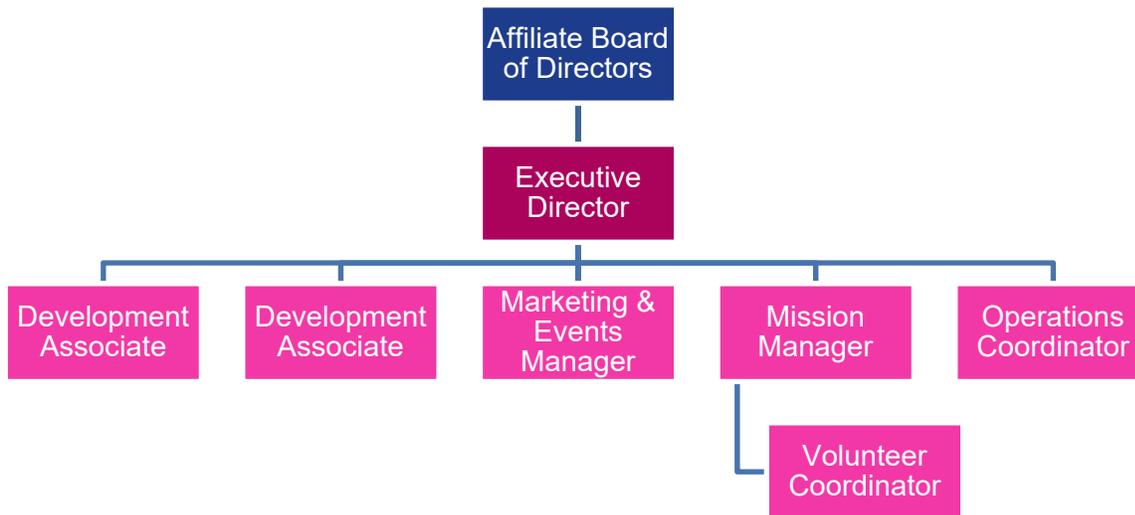
Susan G. Komen Dallas County is led by a volunteer board of directors. The board is a governing body providing strategic vision and fiduciary oversight to the Affiliate. Komen Dallas County is supported by a team of volunteers, ranging from committee members to year-round administrative and outreach support players to Race day event volunteers. These contributions

enable the Affiliate to extend its financial resources, and ultimately, increase its mission investment. Komen Dallas County has three primary volunteer committees: Race Revenue Committee, Race Logistics Committee, and the Grants Committee (Figure 1.1). The Race Revenue and Logistics Committees work directly with Affiliate development and operations staff to promote fundraising efforts and the execution of all activities related to the Komen Dallas Race for the Cure. The Grants Committee works with Affiliate mission staff to support the oversight of the grantmaking process, including developing the request for applications (RFA) and monitoring grantee performance through site visits. The grants chair provides leadership to the committee and is responsible for recruiting individuals to serve as peer reviewers and convening the grant application review panel meeting.



**Figure 1.1.** Komen Dallas County volunteer committee structure

As of the writing of this report, Komen Dallas County has seven staff members (Figure 1.2). The executive director oversees fundraising efforts, mission work, and daily operations through the management of the Affiliate staff. The executive director reports to and maintains regular communication with the board of directors. Two development associates implement the Affiliate’s fundraising initiatives, including: sponsor solicitation, third party fundraisers, and cultivation of grassroots donors. The marketing and events manager is responsible for the execution of Affiliate events and communications efforts. The mission team oversees grantmaking, education and outreach, the Community Profile, advocacy efforts, and the Affiliate’s volunteer program. The operations coordinator is responsible for Affiliate financial reporting, processing donations, and technology needs.



**Figure 1.2.** Komen Dallas County organizational chart

**Affiliate Service Area**

Dallas County is home to nearly 2.4 million residents, comprising 9.4 percent of the population of the state of Texas (Figure 1.3) (US Census, 2010). Covering 871 square miles, Dallas County is an urban and suburban area with few rural locales. It is the ninth largest county in the United States by population (Edwards, Pickens, Schultz, Erickson & Dykstra, 2012). Between 2000 and 2010, the population increased more than 20 percent. Most of Dallas County’s growth occurred in suburban areas with the City of Dallas population increasing less than one percent during this time. Growth can be attributed to a strong economic environment, business expansion, and employment opportunities (Edwards, et al., 2012).

# KOMEN DALLAS COUNTY SERVICE AREA

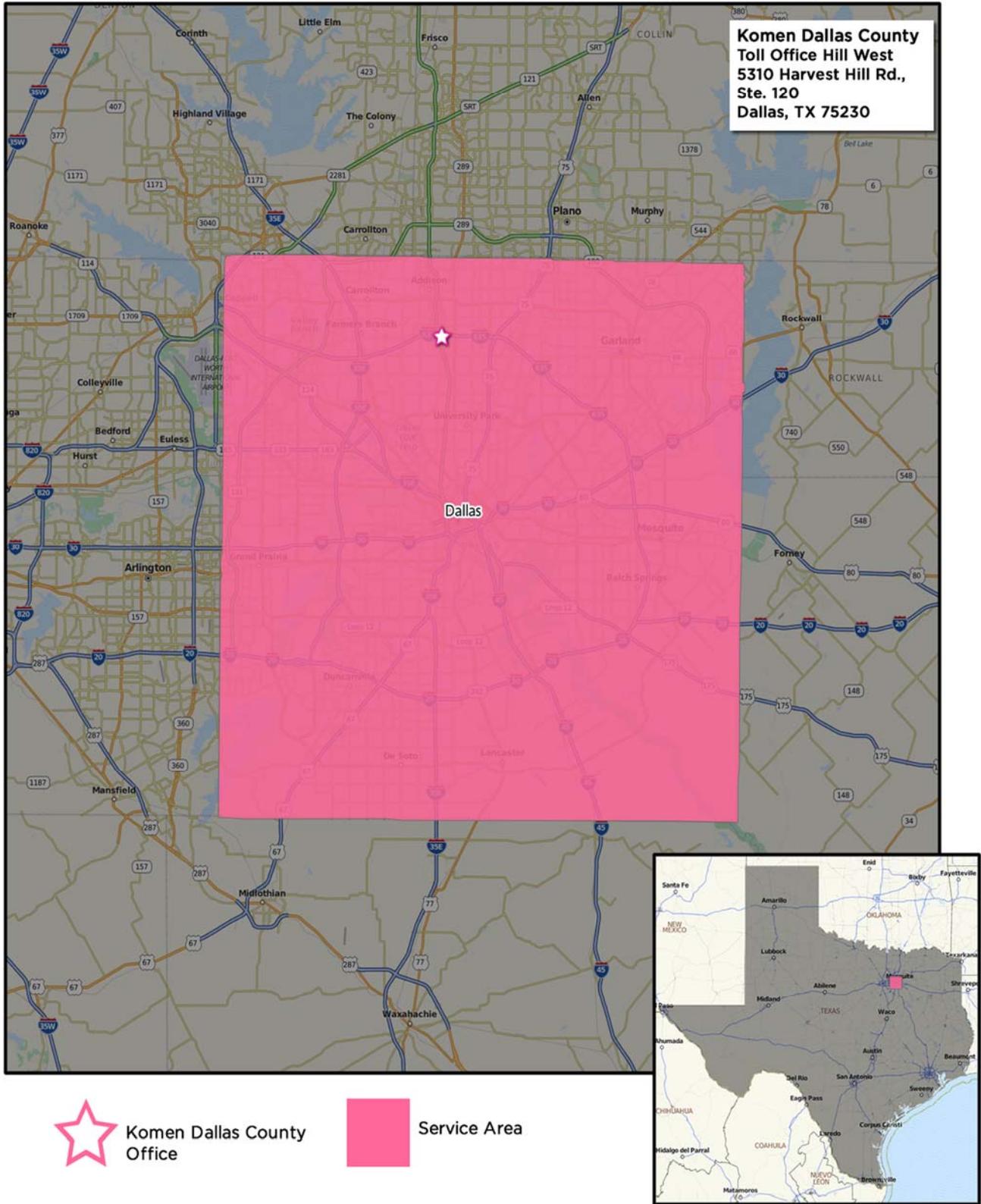
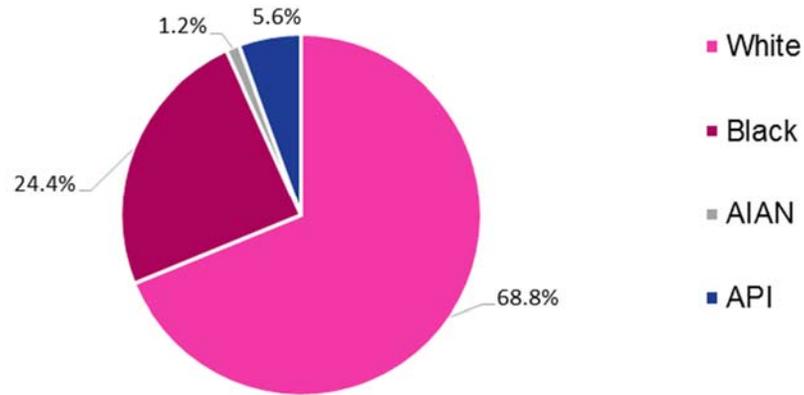


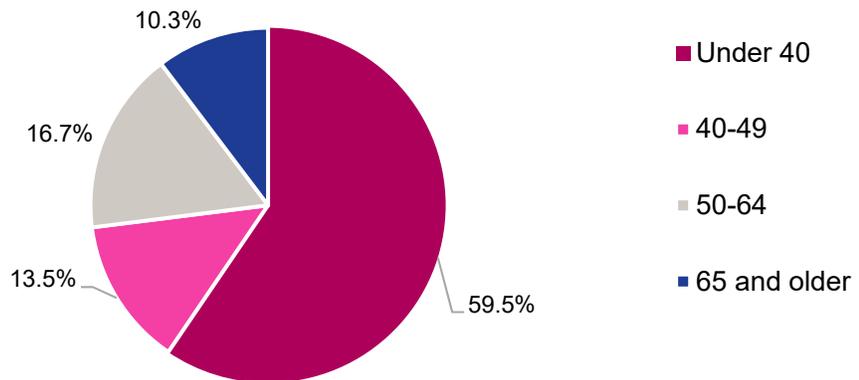
Figure 1.3. Susan G. Komen Dallas County service area

Females account for 50.6 percent of the county population, 1,197,137 residents as of the 2010 US Census. Of these women, 480,485 are over the age of 40 (40.14 percent). Dallas County females are racially and ethnically diverse. The female population is comprised of 68.8 percent White, 24.4 percent Black/African-American, 5.6 percent Asian Pacific Islander, and 1.2 percent American Indian or Alaskan Native women. Hispanic/Latinas comprise 37.1 percent of the female population. Nearly a third of women age 40-64 (29.1 percent) are without health insurance, higher than the national rate of 16.6 percent and the Texas state rate of 24.7 percent.



Source: US Census Bureau – Population Estimates and Census 2010  
 AIAN – American Indians and Alaska Natives  
 API – Asians and Pacific Islanders

**Figure 1.4.** Population characteristics – Race of Dallas County females



Source: US Census: US Census Bureau July 2011 Estimates and US Census Bureau, 2010

**Figure 1.5.** Population characteristics – Age distribution of Dallas County females

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

An effective Community Profile will enable Komen Dallas County to align its community outreach, grantmaking, and public policy activities towards the same mission goal.

The Community Profile will allow Komen Dallas County to:

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

The Affiliate will use the Community Profile and the Mission Action Plan to guide its grantmaking and outreach strategies. Based on the findings of the Community Profile, the Affiliate will develop a request for applications for its community grants program that is responsive to the community's breast health needs. The Affiliate will seek out new potential partners and grantees to fill the gaps in care and support identified through the Community Profile process. The Affiliate will prioritize outreach efforts to reach individuals living in the Affiliate Target Areas.

The Community Profile will be shared with local stakeholders including: legislators, health care systems, nonprofit organizations, Affiliate constituents, and the media. The Affiliate will host a public event to share the findings of the Community Profile and plans for ongoing engagement through a series of smaller town hall meetings. The Affiliate will leverage existing media relationships to promote the findings of the Community Profile and encourage the community to take action to eliminate breast health disparities in Dallas County.

# Quantitative Data: Measuring Breast Cancer Impact in Local Communities

## Quantitative Data Report

### **Introduction**

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

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

The following is a summary of Komen® Dallas County's Quantitative Data Report. For a full report please contact the Affiliate.

### **Breast Cancer Statistics**

#### ***Incidence rates***

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

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

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

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

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

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

### ***Death rates***

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

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

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

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

### ***Late-stage incidence rates***

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

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

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

Population Group	Incidence Rates and Trends				Death Rates and Trends			Late-stage Rates and Trends		
	Female Population (Annual Average)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of Deaths (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)
US	154,540,194	198,602	122.1	-0.2%	40,736	22.6	-1.9%	70,218	43.7	-1.2%
HP2020	-	-	-	-	-	20.6*	-	-	41.0*	-
Texas	12,251,113	13,742	114.4	-0.4%	2,610	21.8	-1.8%	4,905	40.7	-3.2%
Komen Dallas County Service Area (Dallas County-TX)	1,171,221	1,330	124.5	0.9%	247	23.6	-1.9%	491	45.4	-1.3%
White	809,910	960	125.0	0.6%	164	21.2	NA	336	43.6	-3.2%
Black/African-American	286,521	314	128.4	2.7%	79	34.2	NA	136	54.1	1.6%
American Indian/Alaska Native (AIAN)	12,885	4	58.3	-19.6%	SN	SN	SN	SN	SN	SN
Asian Pacific Islander (API)	61,905	43	77.9	10.4%	3	6.3	NA	15	27.5	40.2%
Non-Hispanic/ Latina	761,262	1,151	133.3	1.8%	222	25.5	NA	406	47.3	0.0%
Hispanic/ Latina	409,959	179	85.5	-1.9%	25	13.8	NA	85	38.2	-4.1%

\*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 Dallas County service area was slightly higher than that observed in the US as a whole and the incidence trend was higher than the US as a whole. The incidence rate of the Affiliate service area was **significantly higher** than that observed for the State of Texas and the incidence trend was not significantly different than the State of Texas.

For the United States, breast cancer incidence in Black/African-Americans is lower than in Whites overall. The most recent estimated breast cancer incidence rates for APIs and AIANs were lower than for Non-Hispanic Whites and Black/African-Americans. The most recent estimated incidence rates for Hispanics/Latinas were lower than for Non-Hispanic Whites and Black/African-Americans. For the Affiliate service area as a whole, the incidence rate was slightly higher among Black/African-Americans than Whites, lower among APIs than Whites, and lower among AIANs than Whites. The incidence rate among Hispanics/Latinas was lower than among Non-Hispanics/Latinas.

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***

Overall, the breast cancer death rate and trend in the Komen Dallas County service area was similar to that observed in the US as a whole. The death rate of the Affiliate service area was not significantly different than that observed for the State of Texas.

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

### ***Late-stage incidence rates and trends***

Overall, the breast cancer late-stage incidence rate in the Komen Dallas County service area was slightly higher than that observed in the US as a whole and the late-stage incidence trend was slightly lower than the US as a whole. The late-stage incidence rate of the Affiliate service area was **significantly higher** than that observed for the State of Texas and the late-stage incidence trend was not significantly different than the State of Texas.

For the United States, late-stage incidence rates in Black/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 Black/African-Americans than Whites and lower among APIs than Whites. There were not enough data available within the Affiliate service area to report on AIANs so comparisons cannot be made for this racial group. The late-stage incidence rate among Hispanics/Latinas was lower than among Non-Hispanics/Latinas.

### **Mammography Screening**

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

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

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

\*As of October 2015

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

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

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

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

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

Because the screening proportions come from samples of women in an area and are not exact, Table 2.3 includes confidence intervals. A confidence interval is a range of values that gives an

idea of how uncertain a value may be. It's shown as two numbers—a lower value and a higher one. It is very unlikely that the true rate is less than the lower value or more than the higher value.

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

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

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

Population Group	# of Women Interviewed (Sample Size)	# w/ Self-Reported Mammogram	Proportion Screened (Weighted Average)	Confidence Interval of Proportion Screened
US	174,796	133,399	77.5%	77.2%-77.7%
Texas	3,174	2,348	72.0%	69.9%-74.0%
Komen Dallas County Service Area (Dallas County-TX)	138	112	76.3%	66.7%-83.8%
White	96	75	74.2%	62.6%-83.1%
Black/African-American	33	29	78.0%	58.8%-89.8%
AIAN	SN	SN	SN	SN
API	SN	SN	SN	SN
Hispanic/ Latina	13	9	56.4%	29.6%-80.0%
Non-Hispanic/ Latina	124	102	80.2%	70.8%-87.2%

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 Dallas County service area was not significantly different than that observed in the US as a whole. The screening proportion of the Affiliate service area was not significantly different than the State of Texas.

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

## **Population Characteristics**

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

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

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

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

**Table 2.4.** Population characteristics – demographics

Population Group	White	Black/ African- American	AIAN	API	Non- Hispanic /Latina	Hispanic /Latina	Female Age 40 Plus	Female Age 50 Plus	Female Age 65 Plus
US	78.8 %	14.1 %	1.4 %	5.8 %	83.8 %	16.2 %	48.3 %	34.5 %	14.8 %
Texas	81.5 %	12.9 %	1.1 %	4.5 %	62.5 %	37.5 %	42.9 %	29.4 %	11.7 %
Komen Dallas County Service Area (Dallas County-TX)	68.8 %	24.4 %	1.2 %	5.6 %	62.9 %	37.1 %	40.5 %	27.0 %	10.3 %
ZIP code 75001	66.9 %	12.9 %	1.2 %	8.7 %	74.0 %	26.0 %	36.4 %	24.0 %	7.4 %
ZIP code 75006	64.2 %	8.3 %	1.3 %	8.1 %	53.2 %	46.8 %	43.7 %	29.1 %	10.4 %
ZIP code 75019	73.5 %	5.0 %	1.0 %	17.3 %	88.7 %	11.3 %	46.9 %	25.6 %	5.9 %
ZIP code 75038	34.8 %	27.3 %	1.4 %	27.3 %	77.1 %	22.9 %	29.1 %	16.6 %	4.3 %
ZIP code 75039	52.5 %	11.8 %	0.8 %	29.8 %	87.6 %	12.4 %	24.6 %	13.1 %	1.9 %
ZIP code 75040	56.2 %	15.4 %	1.3 %	10.7 %	58.0 %	42.0 %	41.3 %	26.5 %	9.4 %
ZIP code 75041	63.0 %	9.4 %	1.8 %	2.2 %	43.1 %	56.9 %	37.9 %	25.5 %	11.6 %
ZIP code 75042	50.3 %	11.2 %	1.6 %	13.1 %	48.6 %	51.4 %	38.3 %	25.0 %	10.3 %
ZIP code 75043	58.4 %	22.2 %	1.5 %	6.9 %	72.1 %	27.9 %	44.6 %	30.6 %	11.0 %
ZIP code 75044	59.2 %	14.1 %	1.2 %	18.0 %	81.1 %	18.9 %	49.8 %	33.6 %	10.9 %
ZIP code 75048	71.6 %	9.6 %	1.5 %	12.2 %	86.1 %	13.9 %	40.7 %	22.8 %	6.3 %
ZIP code 75050	59.7 %	14.2 %	1.4 %	3.2 %	49.5 %	50.5 %	36.5 %	23.3 %	8.4 %
ZIP code 75051	54.8 %	16.2 %	1.7 %	3.2 %	41.1 %	58.9 %	35.4 %	23.3 %	10.0 %
ZIP code 75052	47.7 %	26.6 %	1.3 %	10.8 %	66.4 %	33.6 %	38.2 %	22.1 %	5.9 %
ZIP code 75060	63.2 %	6.4 %	2.0 %	6.0 %	44.4 %	55.6 %	40.0 %	26.0 %	9.7 %
ZIP code 75061	57.1 %	9.6 %	1.5 %	3.5 %	37.3 %	62.7 %	36.2 %	23.0 %	9.5 %
ZIP code 75062	57.1 %	13.5 %	1.6 %	9.2 %	57.6 %	42.4 %	39.6 %	25.9 %	10.7 %
ZIP code 75063	42.6 %	15.8 %	1.0 %	37.0 %	88.3 %	11.7 %	32.1 %	18.2 %	4.6 %
ZIP code 75080	74.5 %	6.4 %	1.2 %	9.0 %	79.0 %	21.0 %	46.5 %	33.6 %	17.3 %
ZIP code 75081	59.9 %	14.1 %	1.1 %	19.0 %	84.6 %	15.4 %	48.4 %	34.6 %	13.5 %
ZIP code 75088	75.3 %	11.9 %	1.4 %	5.6 %	84.0 %	16.0 %	50.6 %	32.2 %	9.6 %
ZIP code 75089	68.0 %	16.3 %	1.1 %	9.0 %	82.8 %	17.2 %	41.3 %	22.3 %	6.5 %
ZIP code 75104	35.2 %	53.2 %	1.2 %	2.6 %	81.4 %	18.6 %	42.6 %	26.0 %	7.7 %
ZIP code 75115	23.0 %	69.6 %	0.9 %	1.3 %	87.9 %	12.1 %	49.0 %	33.5 %	11.9 %
ZIP code 75116	53.2 %	23.5 %	1.3 %	2.3 %	57.6 %	42.4 %	42.8 %	30.3 %	13.2 %
ZIP code 75134	16.6 %	72.8 %	0.9 %	0.8 %	82.0 %	18.0 %	37.6 %	23.1 %	7.4 %
ZIP code 75137	47.2 %	38.0 %	1.4 %	2.1 %	72.8 %	27.2 %	49.5 %	35.1 %	12.6 %
ZIP code 75141	45.1 %	39.8 %	1.6 %	0.4 %	65.8 %	34.2 %	40.3 %	26.8 %	9.3 %
ZIP code 75146	27.1 %	63.1 %	1.0 %	0.5 %	82.6 %	17.4 %	42.4 %	26.9 %	8.7 %
ZIP code 75149	60.0 %	22.0 %	1.4 %	3.2 %	67.1 %	32.9 %	40.1 %	26.0 %	10.1 %

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
ZIP code 75150	61.1 %	18.8 %	1.7 %	3.9 %	66.0 %	34.0 %	42.2 %	28.3 %	11.7 %
ZIP code 75154	64.2 %	24.1 %	1.4 %	0.9 %	78.8 %	21.2 %	42.5 %	26.4 %	8.2 %
ZIP code 75159	71.3 %	15.0 %	1.6 %	1.0 %	71.6 %	28.4 %	41.9 %	28.6 %	11.3 %
ZIP code 75172	49.3 %	21.9 %	1.5 %	0.9 %	47.6 %	52.4 %	36.3 %	20.7 %	7.2 %
ZIP code 75180	50.8 %	25.3 %	2.1 %	1.3 %	54.2 %	45.8 %	33.5 %	20.9 %	7.3 %
ZIP code 75181	51.7 %	31.9 %	1.5 %	5.7 %	74.9 %	25.1 %	40.2 %	21.0 %	5.5 %
ZIP code 75182	68.4 %	6.3 %	0.9 %	22.2 %	91.3 %	8.7 %	54.6 %	36.7 %	11.6 %
ZIP code 75201	73.4 %	17.2 %	1.2 %	4.9 %	88.9 %	11.1 %	24.6 %	14.7 %	4.0 %
ZIP code 75202	74.6 %	16.5 %	1.8 %	4.0 %	86.5 %	13.5 %	25.3 %	13.8 %	2.8 %
ZIP code 75203	29.0 %	35.5 %	1.5 %	0.7 %	40.5 %	59.5 %	34.6 %	22.9 %	9.5 %
ZIP code 75204	65.2 %	14.3 %	1.2 %	6.8 %	72.3 %	27.7 %	24.1 %	14.8 %	4.8 %
ZIP code 75205	91.7 %	1.7 %	0.7 %	4.1 %	94.0 %	6.0 %	42.4 %	27.7 %	10.1 %
ZIP code 75206	74.4 %	6.7 %	1.3 %	6.2 %	71.7 %	28.3 %	30.7 %	19.9 %	7.2 %
ZIP code 75207	51.5 %	46.9 %	0.1 %	0.7 %	82.0 %	18.0 %	30.3 %	7.3 %	0.0 %
ZIP code 75208	65.7 %	4.7 %	1.6 %	1.0 %	27.3 %	72.7 %	38.7 %	25.5 %	9.0 %
ZIP code 75209	70.1 %	17.5 %	0.7 %	2.9 %	80.8 %	19.2 %	49.7 %	35.4 %	15.5 %
ZIP code 75210	10.3 %	71.8 %	0.8 %	0.4 %	72.5 %	27.5 %	41.1 %	28.4 %	12.8 %
ZIP code 75211	58.3 %	7.2 %	1.3 %	1.2 %	17.0 %	83.0 %	31.2 %	19.2 %	7.1 %
ZIP code 75212	38.2 %	30.6 %	1.0 %	1.5 %	33.1 %	66.9 %	34.1 %	22.5 %	9.4 %
ZIP code 75214	81.2 %	5.5 %	1.2 %	2.6 %	78.4 %	21.6 %	44.7 %	30.7 %	13.5 %
ZIP code 75215	12.0 %	79.4 %	1.1 %	0.6 %	86.1 %	13.9 %	51.5 %	36.9 %	16.0 %
ZIP code 75216	14.3 %	67.1 %	0.8 %	0.4 %	69.2 %	30.8 %	45.8 %	33.7 %	17.0 %
ZIP code 75217	38.1 %	28.3 %	1.4 %	0.5 %	35.8 %	64.2 %	32.4 %	20.3 %	6.7 %
ZIP code 75218	79.6 %	7.3 %	1.2 %	2.3 %	78.5 %	21.5 %	53.6 %	38.0 %	16.1 %
ZIP code 75219	69.3 %	9.1 %	1.1 %	6.4 %	66.8 %	33.2 %	38.0 %	26.3 %	10.4 %
ZIP code 75220	55.8 %	3.8 %	1.3 %	1.0 %	20.8 %	79.2 %	29.8 %	17.4 %	5.8 %
ZIP code 75223	48.1 %	13.0 %	1.3 %	1.5 %	29.0 %	71.0 %	35.9 %	22.5 %	7.3 %
ZIP code 75224	41.8 %	28.6 %	0.9 %	1.9 %	39.8 %	60.2 %	34.7 %	23.3 %	9.0 %
ZIP code 75225	95.9 %	0.7 %	0.5 %	2.4 %	96.8 %	3.2 %	58.5 %	42.6 %	21.5 %
ZIP code 75226	52.5 %	18.5 %	1.2 %	5.7 %	62.7 %	37.3 %	23.3 %	10.7 %	1.6 %
ZIP code 75227	38.3 %	31.1 %	1.1 %	1.0 %	41.1 %	58.9 %	35.0 %	21.8 %	7.2 %
ZIP code 75228	49.8 %	23.1 %	1.4 %	3.2 %	50.5 %	49.5 %	39.2 %	26.5 %	11.4 %
ZIP code 75229	78.4 %	3.6 %	1.1 %	3.1 %	57.3 %	42.7 %	47.8 %	33.2 %	14.5 %
ZIP code 75230	80.3 %	7.5 %	1.2 %	4.4 %	82.4 %	17.6 %	58.1 %	44.9 %	22.1 %
ZIP code 75231	44.7 %	23.0 %	1.3 %	7.9 %	56.6 %	43.4 %	32.5 %	20.9 %	7.5 %

<b>Population Group</b>	<b>White</b>	<b>Black/ African- American</b>	<b>AIAN</b>	<b>API</b>	<b>Non- Hispanic /Latina</b>	<b>Hispanic /Latina</b>	<b>Female Age 40 Plus</b>	<b>Female Age 50 Plus</b>	<b>Female Age 65 Plus</b>
ZIP code 75232	15.6 %	67.5 %	0.8 %	0.4 %	72.5 %	27.5 %	47.2 %	34.8 %	13.6 %
ZIP code 75233	38.3 %	36.4 %	1.2 %	0.8 %	46.0 %	54.0 %	39.8 %	28.1 %	12.2 %
ZIP code 75234	72.8 %	4.5 %	1.3 %	4.0 %	49.5 %	50.5 %	47.8 %	34.4 %	16.9 %
ZIP code 75235	57.3 %	12.2 %	1.1 %	6.2 %	34.2 %	65.8 %	32.3 %	20.9 %	7.5 %
ZIP code 75236	31.8 %	44.3 %	1.1 %	3.7 %	58.0 %	42.0 %	31.5 %	17.7 %	5.0 %
ZIP code 75237	9.1 %	83.1 %	0.9 %	0.7 %	86.5 %	13.5 %	34.2 %	20.6 %	5.8 %
ZIP code 75238	65.4 %	16.3 %	1.0 %	3.3 %	70.6 %	29.4 %	41.6 %	28.9 %	13.3 %
ZIP code 75240	52.7 %	11.2 %	1.7 %	4.2 %	41.3 %	58.7 %	33.3 %	21.7 %	10.0 %
ZIP code 75241	5.0 %	88.7 %	0.7 %	0.3 %	90.7 %	9.3 %	45.5 %	32.9 %	16.5 %
ZIP code 75243	37.1 %	41.3 %	1.1 %	8.0 %	74.4 %	25.6 %	37.4 %	24.3 %	8.7 %
ZIP code 75244	71.2 %	9.2 %	1.2 %	6.8 %	74.0 %	26.0 %	47.2 %	34.3 %	15.9 %
ZIP code 75246	50.9 %	17.3 %	1.3 %	2.9 %	44.2 %	55.8 %	37.6 %	25.6 %	11.3 %
ZIP code 75247	55.3 %	38.3 %	1.3 %	1.5 %	84.4 %	15.6 %	80.7 %	71.1 %	57.2 %
ZIP code 75248	78.9 %	8.8 %	1.1 %	5.7 %	86.4 %	13.6 %	55.4 %	41.3 %	17.2 %
ZIP code 75249	31.1 %	49.5 %	1.2 %	3.4 %	67.6 %	32.4 %	37.6 %	22.1 %	5.5 %
ZIP code 75251	68.6 %	13.7 %	1.0 %	11.4 %	86.4 %	13.6 %	32.8 %	24.4 %	15.7 %
ZIP code 75253	61.1 %	11.9 %	2.0 %	0.7 %	41.7 %	58.3 %	29.3 %	17.3 %	5.8 %
ZIP code 75254	55.0 %	20.0 %	1.2 %	5.9 %	63.2 %	36.8 %	32.8 %	21.1 %	8.3 %

US, state, and county data are for 2011; ZIP code data are for 2010.

Data are in the percentage of women in the population.

Source: US Census Bureau – Population Estimates and Census 2010.

**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	Linguistically 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 %
Texas	19.6 %	17.0 %	37.1 %	7.3 %	16.2 %	8.2 %	15.3 %	32.2 %	24.7 %
Komen Dallas County Service Area (Dallas County-TX)	23.3 %	18.3 %	40.9 %	8.2 %	23.0 %	10.9 %	0.7 %	9.0 %	29.1 %
ZIP code 75001	11.1 %	14.9 %	NA	4.4 %	23.3 %	7.2 %	0.0 %	0.0 %	24.5 %
ZIP code 75006	24.5 %	13.2 %	NA	7.2 %	30.5 %	11.7 %	0.0 %	0.0 %	28.0 %
ZIP code 75019	3.5 %	3.3 %	NA	3.9 %	19.0 %	3.0 %	0.0 %	0.0 %	7.6 %
ZIP code 75038	10.5 %	15.8 %	NA	9.3 %	38.1 %	12.1 %	0.0 %	0.0 %	24.9 %
ZIP code 75039	2.2 %	7.4 %	NA	3.1 %	30.0 %	4.2 %	0.0 %	0.0 %	13.1 %
ZIP code 75040	27.4 %	15.2 %	NA	9.7 %	28.2 %	9.3 %	0.0 %	0.0 %	28.7 %
ZIP code 75041	34.7 %	19.6 %	NA	10.4 %	33.4 %	14.3 %	0.0 %	0.0 %	37.2 %
ZIP code 75042	33.2 %	23.5 %	NA	11.9 %	35.8 %	19.9 %	0.0 %	0.0 %	40.1 %
ZIP code 75043	15.7 %	11.5 %	NA	9.7 %	18.7 %	5.0 %	0.0 %	0.0 %	21.5 %
ZIP code 75044	12.5 %	7.0 %	NA	8.2 %	25.6 %	6.6 %	0.0 %	0.0 %	22.0 %
ZIP code 75048	8.1 %	5.5 %	NA	5.2 %	15.3 %	3.4 %	1.8 %	0.0 %	13.7 %
ZIP code 75050	24.0 %	17.8 %	NA	8.1 %	22.8 %	11.3 %	0.0 %	32.4 %	33.1 %
ZIP code 75051	36.6 %	22.4 %	NA	13.1 %	25.6 %	15.8 %	0.0 %	38.4 %	33.9 %
ZIP code 75052	15.1 %	10.8 %	NA	8.3 %	18.7 %	7.4 %	0.0 %	0.0 %	21.2 %
ZIP code 75060	33.9 %	19.3 %	NA	12.2 %	31.1 %	15.8 %	0.0 %	0.0 %	33.2 %
ZIP code 75061	35.5 %	21.8 %	NA	8.8 %	36.4 %	20.1 %	0.0 %	0.0 %	37.3 %
ZIP code 75062	21.2 %	17.7 %	NA	7.8 %	27.7 %	13.4 %	0.0 %	0.0 %	27.7 %
ZIP code 75063	4.2 %	5.8 %	NA	6.7 %	36.3 %	8.1 %	0.0 %	0.0 %	15.0 %
ZIP code 75080	12.0 %	16.0 %	NA	6.9 %	22.1 %	9.6 %	0.0 %	0.0 %	20.4 %
ZIP code 75081	8.4 %	9.0 %	NA	8.5 %	22.2 %	6.9 %	0.0 %	0.0 %	19.2 %
ZIP code 75088	10.0 %	5.7 %	NA	8.8 %	12.0 %	1.4 %	0.0 %	0.0 %	18.5 %
ZIP code 75089	10.0 %	4.4 %	NA	6.5 %	11.2 %	2.0 %	0.5 %	0.0 %	13.5 %
ZIP code 75104	9.1 %	9.3 %	NA	8.0 %	8.0 %	2.6 %	6.7 %	0.0 %	17.5 %
ZIP code 75115	7.2 %	9.7 %	NA	7.8 %	5.4 %	1.1 %	0.0 %	0.0 %	16.9 %
ZIP code 75116	19.6 %	14.4 %	NA	7.4 %	16.6 %	7.9 %	0.0 %	0.0 %	27.4 %
ZIP code 75134	15.9 %	19.0 %	NA	14.4 %	7.2 %	4.5 %	0.1 %	0.0 %	26.3 %
ZIP code 75137	12.5 %	9.9 %	NA	6.3 %	11.4 %	5.9 %	0.0 %	0.0 %	16.8 %
ZIP code 75141	29.9 %	22.7 %	NA	7.8 %	11.6 %	10.3 %	17.9 %	0.0 %	40.1 %
ZIP code 75146	13.7 %	9.4 %	NA	6.4 %	6.9 %	2.2 %	14.6 %	0.0 %	18.9 %
ZIP code 75149	23.5 %	15.4 %	NA	7.4 %	14.5 %	6.3 %	0.0 %	0.0 %	25.3 %
ZIP code 75150	18.0 %	15.2 %	NA	8.3 %	15.6 %	5.5 %	0.0 %	0.0 %	27.1 %

Population Group	Less than HS Education	Income Below 100% Poverty	Income Below 250% Poverty (Age: 40-64)	Un-employed	Foreign Born	Linguistically Isolated	In Rural Areas	In Medically Under-served Areas	No Health Insurance (Age: 40-64)*
ZIP code 75154	13.9 %	10.7 %	NA	8.1 %	7.5 %	4.1 %	6.5 %	41.5 %	21.2 %
ZIP code 75159	21.1 %	12.4 %	NA	4.6 %	11.5 %	6.5 %	27.8 %	0.0 %	22.7 %
ZIP code 75172	39.1 %	26.8 %	NA	3.6 %	18.8 %	9.7 %	10.9 %	0.0 %	29.8 %
ZIP code 75180	33.9 %	31.0 %	NA	7.4 %	20.3 %	13.3 %	0.0 %	0.0 %	33.8 %
ZIP code 75181	15.3 %	12.8 %	NA	5.3 %	14.9 %	6.3 %	2.7 %	0.0 %	14.4 %
ZIP code 75182	10.3 %	1.8 %	NA	5.2 %	19.8 %	3.7 %	38.2 %	0.0 %	7.4 %
ZIP code 75201	4.3 %	11.2 %	NA	2.4 %	12.3 %	2.4 %	0.0 %	47.9 %	17.8 %
ZIP code 75202	2.7 %	6.5 %	NA	3.1 %	11.2 %	0.0 %	0.0 %	45.7 %	13.7 %
ZIP code 75203	48.1 %	39.8 %	NA	8.9 %	33.1 %	27.7 %	0.0 %	36.1 %	44.5 %
ZIP code 75204	16.5 %	21.7 %	NA	6.5 %	20.1 %	7.3 %	0.0 %	42.7 %	24.2 %
ZIP code 75205	2.3 %	9.6 %	NA	6.9 %	6.9 %	1.7 %	0.0 %	0.0 %	7.4 %
ZIP code 75206	13.0 %	19.4 %	NA	5.9 %	17.8 %	8.5 %	0.0 %	15.8 %	22.3 %
ZIP code 75207	32.6 %	16.8 %	NA	10.5 %	6.2 %	0.0 %	0.0 %	17.8 %	19.5 %
ZIP code 75208	44.1 %	25.5 %	NA	6.6 %	33.4 %	25.8 %	0.0 %	35.3 %	41.8 %
ZIP code 75209	10.7 %	13.4 %	NA	6.4 %	12.6 %	3.7 %	0.0 %	0.0 %	17.5 %
ZIP code 75210	40.2 %	53.3 %	NA	19.8 %	13.5 %	9.1 %	0.0 %	90.8 %	40.5 %
ZIP code 75211	50.3 %	26.9 %	NA	9.7 %	36.0 %	25.3 %	0.1 %	66.9 %	41.1 %
ZIP code 75212	55.3 %	35.2 %	NA	16.8 %	26.6 %	19.8 %	0.0 %	89.3 %	37.5 %
ZIP code 75214	9.1 %	12.4 %	NA	5.4 %	12.1 %	5.1 %	0.0 %	4.5 %	18.6 %
ZIP code 75215	28.7 %	37.9 %	NA	21.2 %	3.5 %	1.6 %	0.2 %	70.4 %	31.2 %
ZIP code 75216	36.0 %	39.0 %	NA	12.4 %	13.5 %	9.0 %	0.3 %	33.0 %	32.6 %
ZIP code 75217	47.5 %	31.9 %	NA	15.1 %	29.9 %	17.0 %	1.4 %	26.4 %	40.8 %
ZIP code 75218	7.4 %	9.1 %	NA	3.1 %	9.5 %	2.5 %	0.0 %	0.0 %	20.6 %
ZIP code 75219	17.6 %	17.6 %	NA	6.4 %	24.6 %	9.3 %	0.0 %	9.0 %	24.0 %
ZIP code 75220	47.1 %	26.7 %	NA	10.7 %	46.8 %	33.8 %	0.0 %	0.0 %	47.8 %
ZIP code 75223	47.2 %	28.4 %	NA	11.3 %	34.8 %	18.8 %	0.0 %	46.8 %	46.0 %
ZIP code 75224	41.1 %	31.5 %	NA	8.8 %	27.0 %	21.3 %	0.0 %	3.5 %	35.9 %
ZIP code 75225	1.0 %	3.0 %	NA	6.1 %	4.1 %	1.0 %	0.0 %	0.0 %	3.4 %
ZIP code 75226	25.6 %	23.9 %	NA	6.3 %	26.4 %	14.1 %	0.0 %	87.6 %	34.3 %
ZIP code 75227	39.0 %	24.6 %	NA	11.5 %	28.7 %	14.6 %	0.0 %	20.9 %	39.8 %
ZIP code 75228	33.6 %	28.4 %	NA	12.4 %	26.1 %	11.8 %	0.0 %	0.0 %	33.8 %
ZIP code 75229	22.9 %	14.3 %	NA	8.4 %	26.9 %	13.4 %	0.0 %	0.0 %	29.2 %
ZIP code 75230	8.4 %	10.7 %	NA	6.5 %	15.9 %	6.9 %	0.0 %	0.0 %	15.1 %
ZIP code 75231	24.5 %	29.8 %	NA	4.6 %	34.1 %	18.3 %	0.0 %	2.7 %	38.3 %
ZIP code 75232	19.7 %	22.6 %	NA	13.0 %	11.1 %	4.7 %	0.0 %	0.0 %	24.1 %
ZIP code 75233	31.6 %	21.9 %	NA	10.6 %	27.2 %	14.4 %	0.0 %	41.8 %	32.6 %

Population Group	Less than HS Education	Income Below 100% Poverty	Income Below 250% Poverty (Age: 40-64)	Un-employed	Foreign Born	Linguistically Isolated	In Rural Areas	In Medically Underserved Areas	No Health Insurance (Age: 40-64)*
ZIP code 75234	23.7 %	12.8 %	NA	9.6 %	24.7 %	9.4 %	0.0 %	0.0 %	25.4 %
ZIP code 75235	33.0 %	31.7 %	NA	9.1 %	36.8 %	14.7 %	0.0 %	0.0 %	35.2 %
ZIP code 75236	28.6 %	21.4 %	NA	12.6 %	23.6 %	13.1 %	1.8 %	2.4 %	34.4 %
ZIP code 75237	17.9 %	28.4 %	NA	12.9 %	8.0 %	5.0 %	0.0 %	0.0 %	29.6 %
ZIP code 75238	14.7 %	14.9 %	NA	3.4 %	21.8 %	9.5 %	0.0 %	0.0 %	26.7 %
ZIP code 75240	32.0 %	26.6 %	NA	9.9 %	42.5 %	28.4 %	0.0 %	0.0 %	43.8 %
ZIP code 75241	19.2 %	30.9 %	NA	13.9 %	3.1 %	1.6 %	1.3 %	32.0 %	23.8 %
ZIP code 75243	17.6 %	24.7 %	NA	6.6 %	27.5 %	11.0 %	0.0 %	10.2 %	34.1 %
ZIP code 75244	11.9 %	11.4 %	NA	5.9 %	22.1 %	7.6 %	0.0 %	0.0 %	21.4 %
ZIP code 75246	40.5 %	31.2 %	NA	5.6 %	33.2 %	15.0 %	0.0 %	39.3 %	50.6 %
ZIP code 75247	28.1 %	58.3 %	NA	60.3 %	2.8 %	0.0 %	0.0 %	0.0 %	49.7 %
ZIP code 75248	5.0 %	8.2 %	NA	7.5 %	16.4 %	6.8 %	0.0 %	0.0 %	17.1 %
ZIP code 75249	12.5 %	13.9 %	NA	10.7 %	12.9 %	4.4 %	0.0 %	0.0 %	19.6 %
ZIP code 75251	5.9 %	7.0 %	NA	0.9 %	23.9 %	3.3 %	0.0 %	0.0 %	12.9 %
ZIP code 75253	43.7 %	29.2 %	NA	7.0 %	25.8 %	22.9 %	4.4 %	0.0 %	40.8 %
ZIP code 75254	15.7 %	16.4 %	NA	9.4 %	32.8 %	14.1 %	0.0 %	0.0 %	34.1 %

\* Health Insurance coverage data for ZIP codes are for all ages.

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 and American Community Survey (ACS) for 2008-2012.

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 and 2008-2012.

### ***Population characteristics summary***

Proportionately, the Komen Dallas County service area has a substantially smaller White female population than the US as a whole, a substantially larger Black/African-American female population, a slightly smaller Asian and Pacific Islander (API) female population, a slightly smaller American Indian and Alaska Native (AIAN) female population, and a substantially larger Hispanic/Latina female population. The Affiliate’s female population is slightly younger than that of the US as a whole. The Affiliate’s education level is substantially lower than and income level is slightly lower than those of the US as a whole. There are a slightly smaller percentage of people who are unemployed in the Affiliate service area. The Affiliate service area has a substantially larger percentage of people who are foreign born and a substantially larger percentage of people who are linguistically isolated. There are a substantially smaller percentage of people living in rural areas, a substantially larger percentage of people without health insurance, and a substantially smaller percentage of people living in medically underserved areas.

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

- ZIP code 75104
- ZIP code 75115
- ZIP code 75134
- ZIP code 75137
- ZIP code 75141
- ZIP code 75146
- ZIP code 75181
- ZIP code 75203
- ZIP code 75207
- ZIP code 75210
- ZIP code 75212
- ZIP code 75215
- ZIP code 75216
- ZIP code 75227
- ZIP code 75232
- ZIP code 75233
- ZIP code 75236
- ZIP code 75237
- ZIP code 75241
- ZIP code 75243
- ZIP code 75247
- ZIP code 75249

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

- ZIP code 75001
- ZIP code 75019
- ZIP code 75038
- ZIP code 75039
- ZIP code 75040
- ZIP code 75042
- ZIP code 75044
- ZIP code 75048
- ZIP code 75052
- ZIP code 75062
- ZIP code 75063
- ZIP code 75080
- ZIP code 75081
- ZIP code 75089
- ZIP code 75182
- ZIP code 75251

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

- ZIP code 75006
- ZIP code 75041
- ZIP code 75042
- ZIP code 75050
- ZIP code 75051
- ZIP code 75060
- ZIP code 75061
- ZIP code 75062
- ZIP code 75116

- ZIP code 75172
- ZIP code 75180
- ZIP code 75203
- ZIP code 75208
- ZIP code 75211
- ZIP code 75212
- ZIP code 75217
- ZIP code 75220
- ZIP code 75223
- ZIP code 75224
- ZIP code 75227
- ZIP code 75228
- ZIP code 75229
- ZIP code 75231
- ZIP code 75233
- ZIP code 75234
- ZIP code 75235
- ZIP code 75240
- ZIP code 75246
- ZIP code 75253

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

- ZIP code 75080
- ZIP code 75209
- ZIP code 75215
- ZIP code 75216
- ZIP code 75218
- ZIP code 75225
- ZIP code 75230
- ZIP code 75234
- ZIP code 75244
- ZIP code 75247
- ZIP code 75248

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

- ZIP code 75041
- ZIP code 75042
- ZIP code 75051
- ZIP code 75060
- ZIP code 75061
- ZIP code 75141
- ZIP code 75172
- ZIP code 75180
- ZIP code 75203
- ZIP code 75207
- ZIP code 75208
- ZIP code 75210
- ZIP code 75211
- ZIP code 75212
- ZIP code 75215
- ZIP code 75216
- ZIP code 75217
- ZIP code 75220

- ZIP code 75223
- ZIP code 75224
- ZIP code 75227
- ZIP code 75228
- ZIP code 75233
- ZIP code 75235
- ZIP code 75236
- ZIP code 75240
- ZIP code 75246
- ZIP code 75253

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

- ZIP code 75042
- ZIP code 75172
- ZIP code 75180
- ZIP code 75203
- ZIP code 75208
- ZIP code 75210
- ZIP code 75211
- ZIP code 75212
- ZIP code 75215
- ZIP code 75216
- ZIP code 75217
- ZIP code 75220
- ZIP code 75223
- ZIP code 75224
- ZIP code 75226
- ZIP code 75227
- ZIP code 75228
- ZIP code 75231
- ZIP code 75235
- ZIP code 75237
- ZIP code 75240
- ZIP code 75241
- ZIP code 75243
- ZIP code 75246
- ZIP code 75247
- ZIP code 75253

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

- ZIP code 75042
- ZIP code 75051
- ZIP code 75060
- ZIP code 75134
- ZIP code 75210
- ZIP code 75212
- ZIP code 75215
- ZIP code 75216
- ZIP code 75217
- ZIP code 75223
- ZIP code 75227
- ZIP code 75228
- ZIP code 75232

- ZIP code 75236
- ZIP code 75237
- ZIP code 75241
- ZIP code 75247

The ZIP codes with substantial foreign born and linguistically isolated populations are:

- ZIP code 75041
- ZIP code 75042
- ZIP code 75060
- ZIP code 75061
- ZIP code 75203
- ZIP code 75208
- ZIP code 75211
- ZIP code 75217
- ZIP code 75220
- ZIP code 75223
- ZIP code 75227
- ZIP code 75231
- ZIP code 75235
- ZIP code 75240
- ZIP code 75246
- ZIP code 75254

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

- ZIP code 75041
- ZIP code 75042
- ZIP code 75061
- ZIP code 75141
- ZIP code 75203
- ZIP code 75208
- ZIP code 75210
- ZIP code 75211
- ZIP code 75212
- ZIP code 75217
- ZIP code 75220
- ZIP code 75223
- ZIP code 75224
- ZIP code 75226
- ZIP code 75227
- ZIP code 75231
- ZIP code 75235
- ZIP code 75236
- ZIP code 75240
- ZIP code 75246
- ZIP code 75247
- ZIP code 75253

## **Priority Areas**

### ***Healthy People 2020 forecasts***

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

HP2020 has several cancer-related objectives, including:

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

To see how well counties in the Komen Dallas County service area are progressing toward these targets, the report uses the following information:

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

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

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

### ***Identification of priority areas***

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

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

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

Counties are classified as follows (Table 2.6):

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

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

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

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

***Affiliate Service Area Healthy People 2020 Forecasts and Priority Areas***

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

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

Trends can change for a number of reasons, including:

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

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

**Table 2.7.** Intervention priorities for Komen Dallas County service area with predicted time to achieve the HP2020 breast cancer targets and key population characteristics

<b>Population Group</b>	<b>Priority</b>	<b>Predicted Time to Achieve Death Rate Target</b>	<b>Predicted Time to Achieve Late-stage Incidence Target</b>	<b>Key Population Characteristics</b>
Dallas County - TX	Medium High	8 years	8 years	
ZIP code 75001	NA	NA	NA	%API
ZIP code 75006	NA	NA	NA	%Hispanic/Latina, foreign
ZIP code 75019	NA	NA	NA	%API
ZIP code 75038	NA	NA	NA	%API, foreign
ZIP code 75039	NA	NA	NA	%API, foreign
ZIP code 75040	NA	NA	NA	%API, foreign
ZIP code 75041	NA	NA	NA	%Hispanic/Latina, education, foreign, language, insurance
ZIP code 75042	NA	NA	NA	%API, %Hispanic/Latina, education, poverty, employment, foreign, language, insurance
ZIP code 75044	NA	NA	NA	%API
ZIP code 75048	NA	NA	NA	%API
ZIP code 75050	NA	NA	NA	%Hispanic/Latina, medically underserved
ZIP code 75051	NA	NA	NA	%Hispanic/Latina, education, employment, language, medically underserved
ZIP code 75052	NA	NA	NA	%API
ZIP code 75060	NA	NA	NA	%Hispanic/Latina, education, employment, foreign, language
ZIP code 75061	NA	NA	NA	%Hispanic/Latina, education, foreign, language, insurance
ZIP code 75062	NA	NA	NA	%API, %Hispanic/Latina
ZIP code 75063	NA	NA	NA	%API, foreign
ZIP code 75080	NA	NA	NA	%API, older
ZIP code 75081	NA	NA	NA	%API
ZIP code 75089	NA	NA	NA	%API
ZIP code 75104	NA	NA	NA	%Black/African-American, rural
ZIP code 75115	NA	NA	NA	%Black/African-American
ZIP code 75116	NA	NA	NA	%Hispanic/Latina
ZIP code 75134	NA	NA	NA	%Black/African-American, employment
ZIP code 75137	NA	NA	NA	%Black/African-American
ZIP code 75141	NA	NA	NA	%Black/African-American, education, rural, insurance
ZIP code 75146	NA	NA	NA	%Black/African-American, rural
ZIP code 75154	NA	NA	NA	Rural, medically underserved
ZIP code 75159	NA	NA	NA	Rural
ZIP code 75172	NA	NA	NA	%Hispanic/Latina, education, poverty, rural
ZIP code 75180	NA	NA	NA	%Hispanic/Latina, education, poverty
ZIP code 75181	NA	NA	NA	%Black/African-American
ZIP code 75182	NA	NA	NA	%API, rural
ZIP code 75201	NA	NA	NA	Medically underserved
ZIP code 75202	NA	NA	NA	Medically underserved

<b>Population Group</b>	<b>Priority</b>	<b>Predicted Time to Achieve Death Rate Target</b>	<b>Predicted Time to Achieve Late-stage Incidence Target</b>	<b>Key Population Characteristics</b>
ZIP code 75203	NA	NA	NA	%Black/African-American, %Hispanic/Latina, education, poverty, foreign, language, insurance, medically underserved
ZIP code 75204	NA	NA	NA	Medically underserved
ZIP code 75206	NA	NA	NA	Medically underserved
ZIP code 75207	NA	NA	NA	%Black/African-American, education, medically underserved
ZIP code 75208	NA	NA	NA	%Hispanic/Latino, education, poverty, foreign, language, insurance, medically underserved
ZIP code 75209	NA	NA	NA	Older
ZIP code 75210	NA	NA	NA	%Black/African-American, education, poverty, employment, insurance, medically underserved
ZIP code 75211	NA	NA	NA	%Hispanic/Latino, education, poverty, foreign, language, insurance, medically underserved
ZIP code 75212	NA	NA	NA	%Black/African-American, %Hispanic/Latino, education, poverty, employment, language, insurance, medically underserved
ZIP code 75215	NA	NA	NA	%Black/African-American, older, education, poverty, employment, medically underserved
ZIP code 75216	NA	NA	NA	%Black/African-American, older, education, poverty, employment, medically underserved
ZIP code 75217	NA	NA	NA	%Hispanic/Latino, education, poverty, employment, foreign, language, insurance, medically underserved
ZIP code 75218	NA	NA	NA	Older
ZIP code 75220	NA	NA	NA	%Hispanic/Latino, education, poverty, foreign, language, insurance
ZIP code 75223	NA	NA	NA	%Hispanic/Latino, education, poverty, employment, foreign, language, insurance, medically underserved
ZIP code 75224	NA	NA	NA	%Hispanic/Latino, education, poverty, language, insurance
ZIP code 75225	NA	NA	NA	Older
ZIP code 75226	NA	NA	NA	Poverty, language, insurance, medically underserved

<b>Population Group</b>	<b>Priority</b>	<b>Predicted Time to Achieve Death Rate Target</b>	<b>Predicted Time to Achieve Late-stage Incidence Target</b>	<b>Key Population Characteristics</b>
ZIP code 75227	NA	NA	NA	%Black/African-American, %Hispanic/Latina, education, poverty, employment, foreign, language, insurance, medically underserved
ZIP code 75228	NA	NA	NA	%Hispanic/Latina, education, poverty, employment
ZIP code 75229	NA	NA	NA	%Hispanic/Latina
ZIP code 75230	NA	NA	NA	Older
ZIP code 75231	NA	NA	NA	%Hispanic/Latina, poverty, foreign, language, insurance
ZIP code 75232	NA	NA	NA	%Black/African-American, employment
ZIP code 75233	NA	NA	NA	%Black/African-American, %Hispanic/Latina, education, language, medically underserved
ZIP code 75234	NA	NA	NA	%Hispanic/Latina, older
ZIP code 75235	NA	NA	NA	%Hispanic/Latina, education, poverty, foreign, language, insurance
ZIP code 75236	NA	NA	NA	%Black/African-American, education, employment, insurance
ZIP code 75237	NA	NA	NA	%Black/African-American, poverty, employment
ZIP code 75240	NA	NA	NA	%Hispanic/Latina, education, poverty, foreign, language, insurance
ZIP code 75241	NA	NA	NA	%Black/African-American, poverty, employment, medically underserved
ZIP code 75243	NA	NA	NA	%Black/African-American, poverty
ZIP code 75244	NA	NA	NA	Older
ZIP code 75246	NA	NA	NA	%Hispanic/Latina, education, poverty, foreign, language, insurance, medically underserved
ZIP code 75247	NA	NA	NA	%Black/African-American, older, poverty, employment, insurance
ZIP code 75248	NA	NA	NA	Older
ZIP code 75249	NA	NA	NA	%Black/African-American
ZIP code 75251	NA	NA	NA	%API
ZIP code 75253	NA	NA	NA	%Hispanic/Latina, education, poverty, language, insurance
ZIP code 75254	NA	NA	NA	Foreign, language

NA – data not available.

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

## **Data Limitations**

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

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

## **Quantitative Data Report Conclusions**

### ***Medium high priority areas***

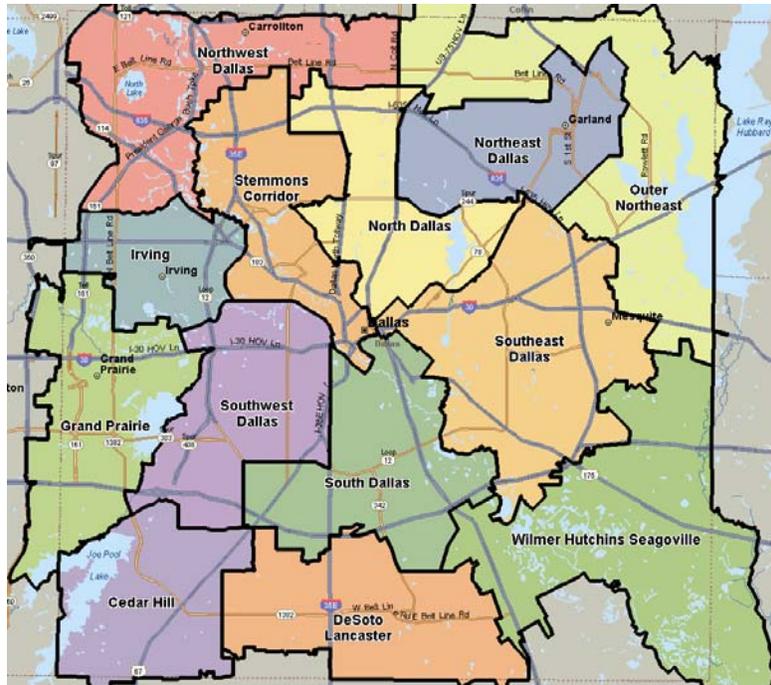
The Komen Dallas County service area is in the medium high priority category. Dallas County is expected to take eight years to reach both the death rate and late-stage incidence rate HP2020 targets.

### **Additional Quantitative Data Exploration**

The information provided in the preceding Quantitative Data Report provides breast cancer data at the county level for the Affiliate service area. Since Komen Dallas County serves a single county, collecting sub-county level data was necessary in order for the Affiliate to identify the communities within their service area that are experiencing a disproportionate burden of breast cancer.

Prior to collecting sub-county level data, the Affiliate considered the best methods to examine the county at this more detailed level, categories considered included: zip codes, census tract data, neighborhoods, city council districts, and county commissioner districts. The Affiliate ultimately determined that as a county-level organization it was most prudent to use the same service areas as other institutions serving the same area. Dallas County has traditionally been divided into 13 geographic communities defined by the Dallas County Hospital District d/b/a Parkland Health & Hospital System (Figure 2.1). These areas were designated after analysis of demographic patterns of similar communities with like characteristics. Natural boundaries and travel patterns were also considered in defining these service areas.

These 13 communities are outlined in *Horizons: The Dallas County Community Health Needs Assessment* (Edwards, Pickens, Schultz, Erickson & Dykstra, 2012) which is used as the planning document for Dallas County Health & Human Services and Parkland Health & Hospital System. *Horizons* is also referenced in the community health needs assessments of Methodist Dallas Medical Center (2013) and Baylor University Medical Center at Dallas (2013). The Affiliate will use these same 13 geographic communities for the purposes of the Community Profile and subsequent strategic planning in order that the Affiliate's efforts are aligned with other leading public health agencies in the area. This alignment will lend itself to easier collaboration, coordination of efforts, and evaluation of impact on the overall health of the community.



**Figure 2.1.** Geographic communities of Dallas County

Komen Dallas County worked with other health agencies to gather relevant sub-county data. Working with an epidemiologist within the Department of Strategic Planning and Population Management at Parkland Health & Hospital System, the county tax-supported hospital in the Affiliate service area, the Affiliate was able to gather age-adjusted female breast cancer death rates broken down into the defined 13 geographic communities (Table 2.8).

**Table 2.8. Female breast cancer death rates in Komen Dallas County service area 2007-2012**

Geographic Community	2012		2011		2010		2009		2008		2007	
	Rate	Deaths										
Dallas County	28.28	301	22.81	227	23.27	246	22.31	231	25.59	252	27.58	254
Cedar Hill	46.10	15	**	**	28.40	7	41.31	12	29.98	10	46.81	16
DeSoto Lancaster	27.22	14	25.28	12	25.52	12	34.21	15	39.95	16	30.06	12
Grand Prairie	22.51	15	20.59	14	15.74	9	17.30	11	25.57	13	17.11	9
Irving	28.80	16	28.94	16	14.90	8	15.90	9	20.12	11	15.50	8
North Dallas	18.19	27	15.69	19	13.20	19	21.31	30	22.63	32	22.90	26
Northeast Dallas	32.19	36	22.62	21	23.41	26	13.70	15	18.44	20	28.42	27
Northwest Dallas	22.33	21	10.36	9	17.73	13	12.58	9	27.86	16	11.60	11
Outer Northeast	25.97	29	24.31	28	25.88	29	17.98	21	21.48	26	27.49	29
South Dallas	39.97	34	40.37	32	28.45	26	33.55	28	35.42	29	39.94	27
Southeast Dallas	27.44	39	23.46	35	24.17	35	32.70	47	26.89	37	27.55	37
Southwest Dallas	24.13	19	32.28	23	27.83	23	19.72	16	25.63	19	37.98	23
Stemmons Corridor	24.63	17	16.82	10	20.09	14	12.19	8	24.61	15	17.98	11
Wilmer Hutchins Seagoville	39.54	9	31.88	6	46.16	13	**	**	18.56	5	46.68	10

\*\* – data suppressed due to small numbers (less than five deaths)

Age-Adjusted Deaths per 100,000 Women

Source of death rate data: Bureau of Vital Statistics, Texas Department of State Health Services via the Department of Strategic Planning and Population Management at Parkland Health & Hospital.

Working with an epidemiologist at the Texas Cancer Registry, the Affiliate was able to gather the incidence of breast cancer by stage for the defined 13 geographic communities (Table 2.9). The table below provides the counts of new cases for the years 2008 through 2010 combined. The presentation of data as a cumulative three year total is keeping with the Texas Cancer Registry’s data release guidelines in place to protect the privacy of patients. As this is count data and not rates, the Affiliate is not able to make comparisons among the geographic areas that will aid in the ultimate determination of target areas. This is nonetheless valuable descriptive data that provide insight into the burden of breast cancer in Dallas County. Additionally since these data have been combined for the years 2008-2010, the Affiliate was not able to analyze trends that may have occurred during this time period.

**Table 2.9.** Female breast cancers newly-diagnosed in Komen Dallas County service area 2008-2010

<b>Geographic Community</b>	<b>Early Stage (Localized)</b>	<b>Late-stage (Regional + Distant)</b>	<b>Unknown Stage</b>	<b>All Stages</b>	<b>% of Late-stage Cancers</b>
Dallas County	2,473	1,505	261	4,239	35.50%
Cedar Hill	99	50	7	156	32.05%
DeSoto Lancaster	95	82	10	187	43.85%
Grand Prairie	131	108	18	257	42.02%
Irving	106	90	17	213	42.25%
North Dallas	360	168	35	563	29.84%
Northeast Dallas	224	133	19	376	35.37%
Northwest Dallas	225	117	27	369	31.71%
Outer Northeast	374	192	48	614	31.27%
South Dallas	182	135	24	341	39.59%
Southeast Dallas	323	203	26	552	36.78%
Southwest Dallas	138	101	15	254	39.76%
Stemmons Corridor	165	81	8	254	31.89%
Wilmer Hutchins Seagoville	51	45	7	103	43.69%

Malignant Cases Only, SEER Summary Stages Early (Localized), Late (Regional and Distant), Unknown, and All Stages Combined  
 Prepared by the Texas Department of State Health Services, Cancer Epidemiology and Surveillance Branch, Texas Cancer Registry

An initial review of the data presented in the Quantitative Data Report indicated that Black/African-American women were experiencing higher death and late-stage diagnosis rates than other groups in the Affiliate service area. Based on this finding, Komen Dallas County conducted a literature review to gain further insight into breast cancer disparities experienced by Black/African-American women. This review revealed that these disparities are not unique to Black/African-American women living in Dallas County. Black/African-American women have the highest breast cancer death rates of all racial and ethnic groups and are 41 percent more likely to die of breast cancer than White women (Susan G. Komen, 2014). While White women are more likely to be diagnosed with breast cancer, Black/African-American women are more likely to die from it (Hunt, Whiteman, & Hurlbert, 2013).

While there have been great gains in recent history in the treatment and survivorship of those afflicted with breast cancer, these gains have not been distributed equitably. In a study examining 107,273 control matched White and Black/African-American patients, using the SEER-Medicare database, Silber and colleagues (2013) found that racial differences in breast cancer survival did not substantially change among women diagnosed between 1991 and 2005. In a study of the breast cancer death rates for the 50 largest cities in the United States between 1990 and 2009, Hunt, Whitman and Hurlbert (2013) found that in 35 cities, the disparity in breast cancer death had increased between White and Black/African-American women. Black/African-American women were not experiencing the improved survival that White women were. In the 20 years that the authors examined, the White death rate decreased by about 20 percent more than the Black/African-American rate during this period (Hunt et al., 2013). The authors state that there are 1,710 excess Black/African-American deaths a year in the United

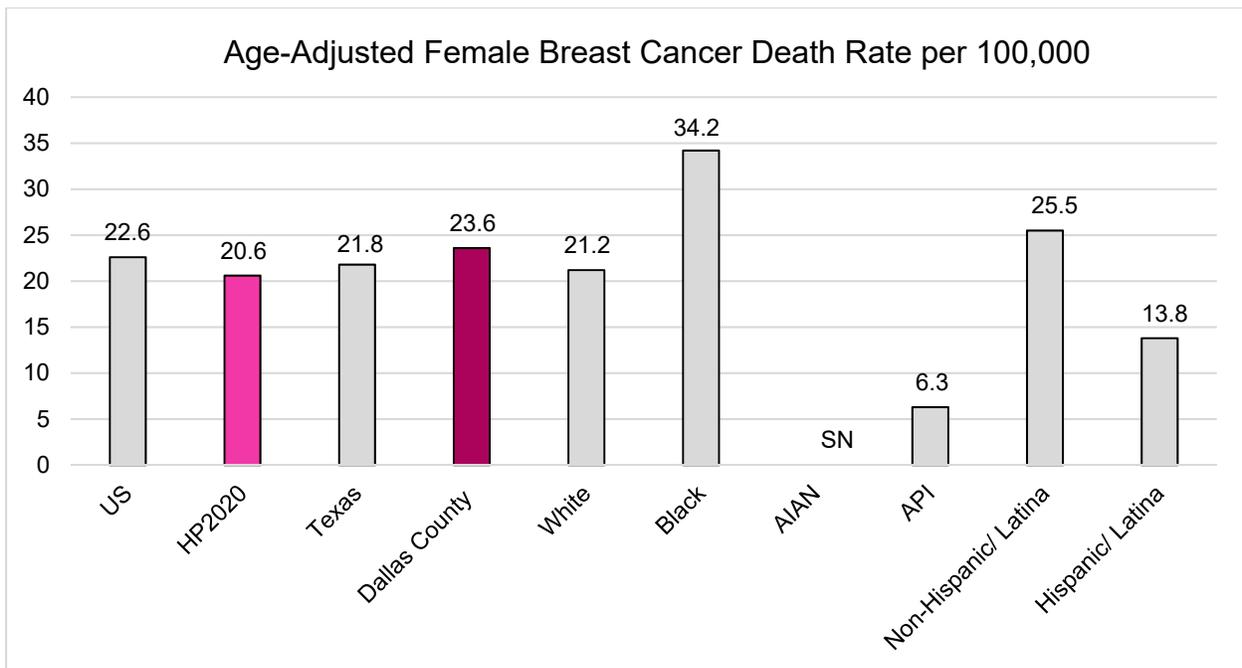
States due to this disparity – almost five deaths every day. In the city of Dallas alone, the authors estimate that 17 additional Black/African-American women are dying each year due to breast cancer death disparities (Hunt et al., 2013).

The Centers for Disease Control and Prevention (CDC, 2012) *Vital Signs* report on breast cancer states that for every 100 cases of breast cancer in Texas, Black/African-American women had 10-12 more deaths compared to White women. The CDC attributes these death disparities in part to delays in receiving follow-up care and treatment, in addition to differences in the breast cancer treatment experiences of Black/African-American women when compared to White women.

These supplementary data will be used to complement the findings of the Quantitative Data Report and are not meant to replace the information provided in the opening section of the Community Profile. These sub-county level data enhance the quantitative analysis because they allow the Affiliate to pinpoint the areas experiencing disparities using breast cancer statistics, rather than relying solely on zip code level demographic data to extrapolate target areas using known risk factors and barriers that contribute to breast cancer disparities, e.g. insurance status, access and availability of services, household income, and so forth. The limitations to this data beyond those explained above are comparable to the limitations listed in the Quantitative Data Report. Due to Affiliate capacity and access to resources, the literature review is not an exhaustive analysis of all available academic literature. The literature review is meant to provide insight into breast cancer disparities research in the United States and identify common themes and potential causes for these disparities that can be investigated further through the Community Profile process.

### **Selection of Target Communities**

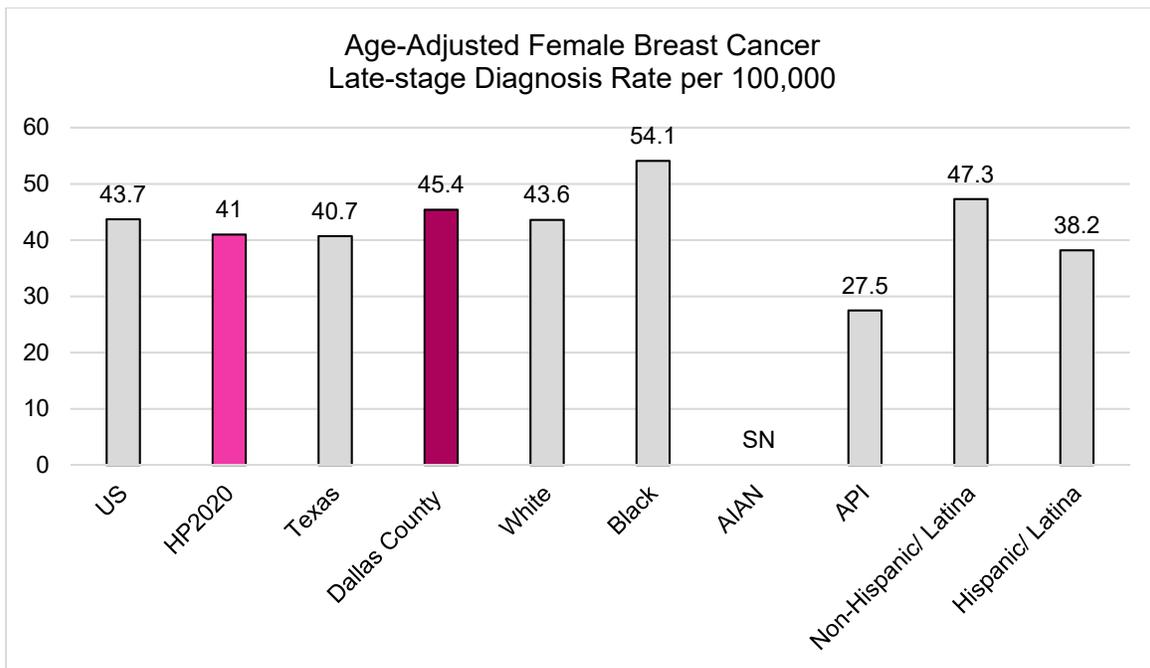
The information presented in the Quantitative Data Report shows a disparity in late-stage diagnoses and death rates being experienced by Black/African-American women living in Dallas County. The National Cancer Institute (NCI) defines "cancer health disparities" as adverse differences in cancer incidence (new cases), cancer prevalence (all existing cases), cancer death (death), cancer survivorship, and burden of cancer or related health conditions that exist among specific population groups in the United States (2008). The breast cancer death rate experienced by Black/African-American women is 1.4 times higher than the combined rate for all women living in Dallas County. Black/African-American women in Dallas County have higher death rates per 100,000 women than any other population group. When compared to White women, the rate is 1.6 times higher and 5.4 times higher compared to Asian and Pacific Islander women. The rate experienced by Black/African-American women is 1.3 times higher than for Non-Hispanic/Latina women, and 2.5 times higher than for Hispanic/Latina women. It is worth noting that the non-Hispanic/Latina group contains a large portion of the women that are in the Black/African-American group and these Black/African-American women may be contributing to the elevated death rate among Non-Hispanic/Latina women. In the 2010 US Census, only two percent of respondents from Dallas County that identified as Hispanic/Latino were Black or African-American alone or two or more races. Figure 2.2 illustrates the death data presented in Table 2.1 of this report.



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

**Figure 2.2.** Age-adjusted female breast cancer death rate by population group

Not only are Black/African-American women facing a higher death burden than other population groups in Dallas County, they are also more likely to experience a late-stage breast cancer diagnosis. As indicated earlier in this report, a higher breast cancer stage at diagnosis often leads to poorer survival outcomes. Similar to the disparity in death rates, Black/African-American women experience a greater burden of late-stage diagnoses than any other population group in the county. The late-stage diagnosis rate of Black/African-American women in Dallas County is 1.2 times higher than the rate experienced collectively by all women in the county. The rate experienced by Black/African-American women is 1.2 times higher than the late-stage diagnosis rate of White women, nearly two times higher than Asian and Pacific Islander women, 1.1 times higher than Non-Hispanic/Latina women, and 1.4 times higher than Hispanic/Latina women. Figure 2.3 illustrates the late-stage diagnosis data presented in Table 2.3 of this report.



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

**Figure 2.3.** Age Adjusted female breast cancer late-stage diagnosis rate by population group

To consider this information and deliberate over the selection of target communities, the Affiliate convened a panel of local community health professionals. In addition to the Affiliate executive director and mission manager, this group included: Susan Wolfe, PhD a community psychologist with extensive experience working with underserved communities in Dallas County, Kim Linnear, MPA an associate director at the University of North Texas Health Science Center (UNTHSC), and Karin Petties, program director of the UNTHSC breast health outreach program. During this meeting the group considered the breast cancer data, information presented from the literature review, and had a discussion about the challenges experienced by the different communities within the county. Based on the breast cancer late-stage diagnosis and death data, it was determined that the target population would be Black/African-American women. From there, the group worked to come to a consensus on what geographic communities within the service area the Affiliate should focus on during qualitative data collection.

Demographic data played a key role in the next phase of the target community selection. The Black/African-American population of each geographic area was analyzed in order to find the communities with the largest percentage of Black/African-American residents. The communities with the largest Black/African-American population base include: Cedar Hill, DeSoto Lancaster, and South Dallas. With the exception of one zip code (75226) in South Dallas, the remaining 13 zip codes that comprise these communities have substantially larger Black/African-American female population percentages than that of the Affiliate service area as a whole.

The group continued their analysis of the county by considering the breast cancer death rates broken down by the 13 geographic communities provided by Parkland Health & Hospital System. Reviewing the six years of available data, Cedar Hill, DeSoto Lancaster, and South Dallas are consistently among the communities experiencing the highest breast cancer death rates.

The group proceeded to discuss the challenges experienced by the geographic communities as a whole throughout the Affiliate Service area. While there are pockets of need throughout the county, the group agreed that based upon the breast cancer death data, the Affiliate must focus on Black/African-American women. Black/African-American women are most likely to be found in Cedar Hill, DeSoto Lancaster, and South Dallas – additionally, these communities also experienced higher death rates than other communities in the county when considering data since 2007.

## **Description of Selected Target Communities**

### ***Cedar Hill***

Three zip codes make up the community of Cedar Hill: 75104, 75137, and 75249. Cedar Hill has a total population of 77,607, 3.3 percent of the county's population. In Cedar Hill, Black/African-Americans represent the majority of residents comprising 47.7 percent of the community's population with 37,029 residents. White is the next most common group making up 37.6 percent of the population with 29,189 residents, followed by Hispanic/Latina with 17,923 residents making up 23.1 percent of the population.

Despite having one of the lowest 2010 per capita incomes at \$14,200, Edwards and associates (2012) found that only six percent of residents were unemployed and only 4.2 percent were living in poverty. Nearly 90 percent of the residents of Cedar Hill have graduated from high school (Edwards et al., 2012).

Similar to DeSoto Lancaster, as shown in Table 2.5 above, Cedar Hill has positive health indicators in that none of the residents are considered to live in medically underserved areas, and overall women aged 40-64 are more likely to have health insurance than the average Dallas County female in their age group.

Notwithstanding these positive demographic trends related to health status, Cedar Hill is still experiencing disparities related to breast cancer death. As shown in Table 2.8, the breast cancer death rate in Cedar Hill is higher than the breast cancer death rate for Dallas County in every year that data is available. From 2008 to 2010, 156 women living in Cedar Hill received a breast cancer diagnosis, 50 (32.1 percent) of these women received a late-stage diagnosis.

### ***DeSoto Lancaster***

The community of DeSoto Lancaster comprises three zip codes: 75115, 75134, and 75146. DeSoto Lancaster represents 3.7 percent of the population of Dallas County, with 87,146 residents (US Census, 2010). In DeSoto Lancaster, Black/African-Americans represent the majority of residents comprising 68.0 percent of the total population of the community with 59,276 residents identifying as Black/African-American in the 2010 US Census. White is the next most common group with 22.5 percent of the population, 19,613 residents, followed by Hispanic/Latina comprising 14.6 percent of the population with 12,677 residents.

The economic indicators of DeSoto Lancaster are more favorable than those found in South Dallas. Nearly 85 percent of adults living within DeSoto Lancaster have graduated high school. Per capita income in 2010 was \$23,000 with low unemployment and only eight percent of residents living below the Federal Poverty Limit (Edwards et al., 2012).

DeSoto Lancaster's health indicators are more positive than those found in South Dallas. As evidenced in Table 2.5 above, none of the residents of this community are considered to be living in a medically underserved area. Additionally, the percentage of female residents aged 40-64 in this community without health insurance is lower than the county average of 29.1 percent.

Even with these more favorable health indicators, DeSoto Lancaster is still experiencing disparities related to breast cancer. As shown in Table 2.8, women in this community experience higher death rates as compared to the rest of the women living in Dallas County. Of the 187 breast cancer diagnoses in DeSoto Lancaster between 2008 and 2010, 82 were found at the distant or regional (late) stage. The county average for late-stage diagnosis of breast cancer during this time was 35.5 percent compared to the DeSoto Lancaster rate of 43.85 percent. This finding is not surprising given the recent research cited above that there are many barriers to quality breast health care, with insurance status being only one piece of the puzzle. During the Affiliate's qualitative data collection this will be further explored.

### **South Dallas**

The community of South Dallas consists of eight zip codes 75203, 75210, 75215, 75216, 75226, 75232, 75237, and 75241 according to the most recent working definition provided by Parkland Health & Hospital System. In 2010, the total population for this area was 163,622, 6.9 percent of Dallas County's population. In South Dallas, Black/African-Americans represent the majority of residents with 69.1 percent, 113,064, of residents identifying as Black/African-American in the 2010 US Census. Hispanic/Latina is the next most common group with 26.1 percent, 42,677, residents followed by White with 14.5 percent of residents, 23,639 people.

South Dallas has the lowest economic indicators of all Dallas County communities with per capita income of \$13,400, an unemployment rate of 13.1 percent and 25 percent of residents living below the Federal Poverty Limit (Edwards et al., 2012). Edwards and colleagues (2012) also found that nearly 36 percent of South Dallas adults have not graduated from high school. As described in the population characteristics summary in the Quantitative Data Report, zip codes 75215 and 75216 in South Dallas have substantially older female population percentages than that of the Affiliate service area as a whole.

The US Department of Health & Human Services Health Resources and Services Administration (HRSA, 2014) defines Medically Underserved Areas/Populations as those areas or populations designated having: too few primary care providers, high infant death, high poverty and/or high elderly population. As shown in Table 2.5, in six of the eight South Dallas zip codes a large percentage, more than 30 percent, of the population is considered medically underserved. In fact, in zip codes 75210, 75215, and 75226 more than 70 percent of the population is considered medically underserved.

In five of the South Dallas zip codes (75203, 75210, 75215, 75216, 75226), more than 30 percent of female residents aged 40-64 do not have health insurance. The role of health insurance coverage and overall health has been well-established. In 2002, the Institute of Medicine (IOM) released a report stating that working-age Americans without health insurance are more likely to receive too little medical care and receive it too late; be sicker and die sooner;

and receive poorer care when they are in the hospital (IOM, 2002). The National Center for Health Statistics (2013) reports that in 2010 only 36 percent of uninsured women aged 40-64 reported receiving a mammogram in the past two years, compared to 74.1 percent of insured (private insurance and Medicaid) women that reported receiving a mammogram over the same time period. The benefits of screening mammography and improved breast cancer outcomes have already been detailed in this report.

Every year from 2007-2012 the female breast cancer death rate was higher in South Dallas than for the county as a whole, as shown in Table 2.8. Between 2008 and 2010, 341 females were diagnosed with breast cancer from this community. Of those diagnoses, 135 women received a late-stage diagnosis, meaning 39.59 percent of all diagnoses in South Dallas during this time were late-stage.

Komen Dallas County has a history of seeking to serve the residents of South Dallas through their community grants and outreach initiatives. In the last Affiliate Community Profile published in 2011, zip codes 75210, 75215, 75216, 75232, and 75241 were identified target areas for the Affiliate's mission-based efforts. The most recent data available indicates that these five zip codes, in addition to the remaining areas in the community of South Dallas, continue to experience disparities related to breast cancer diagnosis and death.

While these three communities share the common thread of having a large portion of their community being comprised of Black/African-American residents, they differ demographically when considering educational attainment, income, unemployment, and insurance status. The Health Systems Analysis will allow the Affiliate to explore the impact the Affordable Care Act might have on these communities. Part of this exploration will include examining how the burden of breast cancer may change as more residents are able to acquire health insurance. However, insurance status is not the only factor when considering an individual's overall health, utilization of care, and treatment outcomes. The Health Systems Analysis will provide the Affiliate the opportunity to investigate quality of care issues including the access and availability of breast health services.

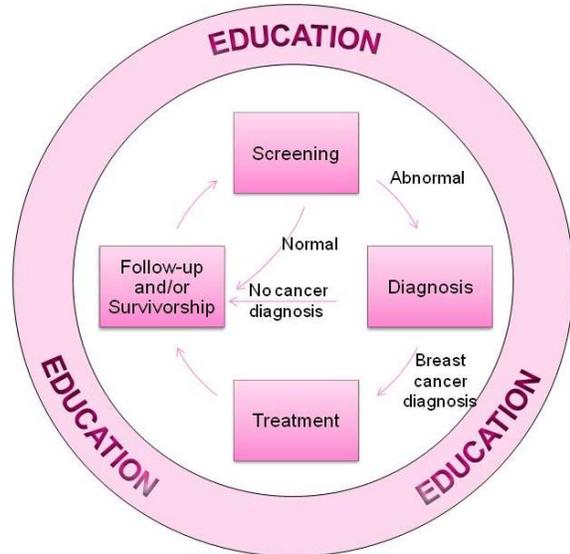
# Health Systems and Public Policy Analysis

## Health Systems Analysis Data Sources

Komen Dallas County conducted an extensive assessment to identify breast health services available to constituents in their service area. The Community Profile Team used online search portals that provided detailed information on community health centers, free clinics, hospitals, accredited breast care centers, and local health departments. Additionally, the Affiliate used existing organizational resource listings, the Komen Grants eManagement System, and internet searches to identify organizations providing breast health and breast cancer services to Dallas County residents. The open access databases searched included:

- American College of Radiology Centers of Excellence
- American College of Surgeons National Accreditation Program for Breast Centers
- American College of Surgeons Commission on Cancer
- Lone Star Association of Charitable Clinics Directory
- National Cancer Institute Designated Cancer Centers
- National Association of County and City Health Officials Directory of Local Health Departments
- US Center for Medicare Services (CMS) Hospital Search
- US Food & Drug Administration (FDA) Mammography Facility Database
- US Health Resources and Services Administrations (HRSA) Health Centers and Look-Alikes Directory

After identifying potential sites to include in the analysis through these databases and online searches, contact information along with the services provided at each location were confirmed through a review of the organization's website and a verification phone call. Organizations not providing breast health services were excluded from the assessment. The findings from this detailed search were compiled and available services were evaluated by type, location, comprehensiveness of offerings, and quality of care indicators. Using the diagram of the Breast Cancer Continuum of Care (CoC) (Figure 3.1), the team then reviewed the findings for each target community in terms of potential gaps in services, and other barriers to access, in particular, geography.



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

## **Health Systems Overview**

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

While a woman may enter the continuum at any point, ideally, she would enter the CoC by getting screened for breast cancer with a clinical breast exam (CBE) and/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 information to encourage women to get screened and reinforcing the need to continue routine screening thereafter.

If the screening test results are abnormal, 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, breast MRI, or biopsy. If the tests are negative (or benign) and breast cancer is not found, she would go into the follow-up loop, and return for screenings at the recommended interval. The recommended intervals may range from three to six months for some women to 12 months for most women. Education plays a role in communicating the importance of proactively getting test results, keeping follow-up appointments, and understanding the information provided. Education can empower a woman and help her to manage anxiety and fear.

If breast cancer is diagnosed, a woman would ideally proceed quickly to treatment. Education can cover such topics as treatment options, how a pathology report determines her 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 begin after treatment ends, they actually may occur at the same time. Follow-up and survivorship may include: navigating insurance issues, locating financial assistance, and managing symptoms, such as pain, fatigue, sexual issues, bone health, etc. Education may address topics including: making healthy lifestyle choices, long-term effects of treatment, managing side effects, the importance of follow-up appointments, and communication with providers. Most women will return to screening at a recommended interval after treatment ends or during treatment for some women (such as those taking long-term hormone therapies).

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

## **Dallas County**

The Community Profile Team began the Health Systems Analysis by looking at resources available in the Affiliate service area as a whole (Figure 3.2). Dallas County is resource rich with 98 organizations providing direct breast health services for those in need, including 12 organizations that offer the full continuum of breast cancer services housed within a single organization. Patients at these facilities are able to receive breast cancer screening, diagnostic testing, treatment, and support services seamlessly within one entity. The locations providing a full continuum of breast cancer services are: Baylor Medical Center at Carrollton, Baylor Medical Center at Garland, Baylor Medical Center at Irving, Baylor University Medical Center, Dallas VA Medical Center, Medical City Hospital, Methodist Charlton Medical Center, Methodist Dallas Medical Center, Methodist Richardson Medical Center, Parkland Health & Hospital System, Texas Health Resources Presbyterian Hospital of Dallas, and UT Southwestern Simmons Cancer Center, the only National Cancer Institute (NCI) designated cancer center in the Affiliate's service area.

Categorizing the organizations into the specific offerings along the CoC, the Community Profile Team identified 73 locations offering breast cancer screenings - 24 offering both screening mammograms and clinical breast exams, 19 offering only clinical breast exams, and 30 offering only screening mammograms. Dallas County is home to four mobile mammography units that travel the 871 square miles of the county in addition to serving neighboring counties. The mobile mammography units are owned and managed by Baylor Health Care System, Methodist Health System, Parkland Health & Hospital System, and UT Southwestern. For patients who receive an abnormal result from their screening mammogram, there are 42 locations in Dallas County offering breast cancer diagnostic testing. Patients with a breast cancer diagnosis can choose among 27 entities offering breast cancer treatment options and 43 organizations offering some form of survivorship support.

# Dallas County



Hospital



Community Health Center



Other



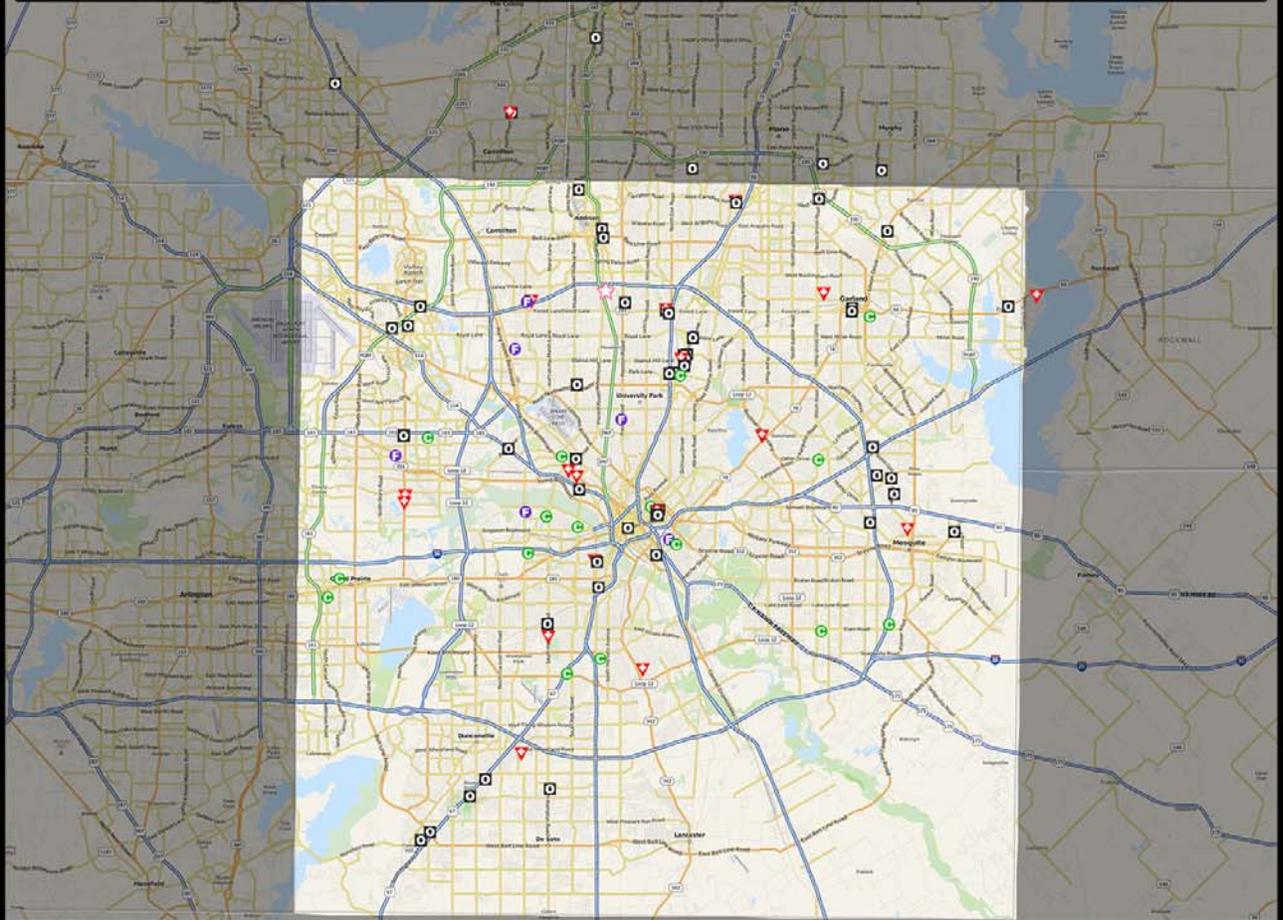
Free Clinic



Department of Health

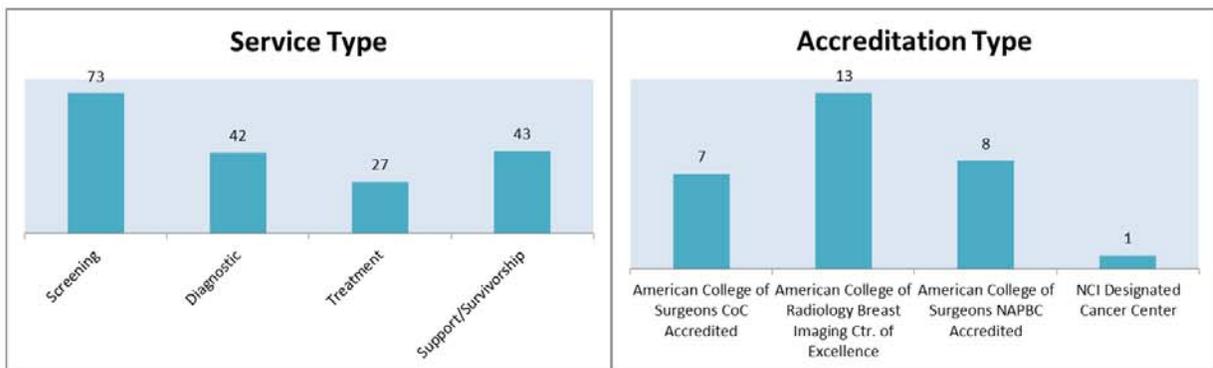


Affiliate Office



## Statistics

Total Locations in Region: 98



**Figure 3.2.** Breast cancer services available in Dallas County

## **Cedar Hill**

While Dallas County offers an abundance of resources, these resources are concentrated in areas outside of the Affiliate's target areas located in the southern sector of the county. Cedar Hill is home to two organizations that offer breast health services of any kind. Women living in Cedar Hill have the option to have a clinical breast exam or a screening mammogram within their community. Planned Parenthood of Greater Texas Cedar Hill Health Center offers women clinical breast exams on-site. As a Texas Breast and Cervical Cancer (BCCS) provider, Planned Parenthood can refer eligible women for no-cost screening mammograms and diagnostic testing at other partner locations (Texas Department of State Health Services, 2014). Additionally, as a BCCS provider, Planned Parenthood can help eligible women with a breast cancer diagnosis apply for the state Medicaid for Breast and Cervical Cancer program (MBCC). Baylor Breast Imaging Center at Cedar Hill offers digital screening mammograms and is an American College of Radiology Breast Imaging Center of Excellence. Women screened at this clinic that receive an abnormal result are referred to imaging facilities in Southeast or Northeast Dallas (see Figure 3.2).

Women living in Cedar Hill are not able to access the full CoC within their own community. Without nearby locations to receive breast health services, women may need to take additional hours off work, spend additional time and money traveling for appointments, and/or find childcare to cover the additional time needed to attend appointments, amongst other barriers that may arise. For breast cancer patients this extra travel time compounded with the fatigue from treatment can make adherence to their recommended treatment more challenging. For women without their own means of transportation, access to care becomes even more difficult, as no public transportation bus or rail routes are located in Cedar Hill (Dallas Area Rapid Transit (DART), 2013).

Overall, the breast health services available in Cedar Hill are a weakness for women living in the community. There is only one location where a woman can have a screening mammogram and if her insurance is not accepted there or the cost is prohibitive, she must travel outside of her community to be screened. Uninsured and underinsured women living in Cedar Hill have access to a Planned Parenthood clinic for clinical breast exams and referrals for mammograms and diagnostics as needed; however, they would need to travel to other parts of the county to receive these services. The lack of public transportation only adds an additional layer of challenges for women seeking breast health services.

To address the gaps in services available in Cedar Hill, the Affiliate will have to work with other organizations to achieve change. The Affiliate is a member of the District 3 Public Health Advisory Council, which is focused on the health needs of the southern sector of Dallas County. Membership on this council allows the Affiliate the opportunity to network with other health agencies working in these communities and to stay abreast of local programs and happenings that may offer the potential for collaboration. The Affiliate will work with its community grant recipients and address the need for increased mobile mammography outreach in Cedar Hill. During the most recent grant cycle, Komen Dallas County funded four mobile mammography events in Cedar Hill. The Affiliate will explore with its grantees how this outreach can be increased, if through qualitative data exploration this proves a need. Additionally the Affiliate can begin a dialogue with imaging providers in the county to discuss the dearth of services available in the southern sector.

Cedar Hill is a new area of focus for the Affiliate and at this time the appropriate organizations and community leaders to partner with is unknown. During its qualitative data exploration, the Community Profile Team will seek to identify new partnerships in the community through key informant interviews and focus groups. Potential partners for future collaboration and community outreach include the city of Cedar Hill government, Cedar Hill Chamber of Commerce, Cedar Hill Recreation Center, African-American sororities, and area churches.

### **DeSoto Lancaster**

The city of DeSoto has one organization, Advanced Imaging, providing breast health services within the community boundaries. Advanced Imaging provides screening mammograms and diagnostic services including: diagnostic mammograms, breast MRI, ultrasounds, and biopsies. Women living in the city of Lancaster have no local breast health resources and must travel outside of their home community to receive any service – from a clinical breast exam to breast cancer treatment. The Komen Dallas County grantees hosted five mobile mammography events funded by the Affiliate in DeSoto Lancaster during the most recent grant cycle.

For underserved women without access to their own means of transportation, this lack of services is compounded by the fact that there are no available bus or rail routes in DeSoto (DART, 2013). Women living in Lancaster have access to one bus route (DART, 2013). Using the Google (2014) transit tool online, the Community Profile Team studied the travel time to Methodist Charlton Medical Center, the nearest hospital offering services. Once a woman arrives at a stop along the only bus route available in Lancaster, her travel time is expected to be one hour and 37 minutes and includes one transfer. For a woman unable to access services at this hospital due to insurance coverage or cost, travel to Parkland Health & Hospital, the county's tax-supported hospital, is estimated to be one hour and 51 minutes with two transfers and a half-mile walk. These examples are provided to illustrate the challenges that a lack of local services and a lack of a personal automobile can cause for a woman seeking a screening or diagnostic test, to say nothing of a woman seeking radiation treatment for breast cancer undergoing this trek five days a week, for multiple weeks in a row.

DeSoto Lancaster's available breast health services are a major weakness for women living in this community as there are so few local services available. In addition to all of the demands on a woman's time and finances, a lack of local resources only makes it harder for women to adhere to the steps identified in the Breast Cancer Continuum of Care. The access and availability of services is yet another barrier that must be overcome in order to ensure women in this community are able to receive the necessary care to reduce the late-stage diagnosis and breast cancer death rates experienced in this community.

The Affiliate will need to align with organizations with similar goals to improve the health of women living in DeSoto Lancaster in order to achieve change that results in the elimination of the breast health disparities experienced by women in this community. DeSoto Lancaster lies within the area served by the District 3 Public Health Council described above. Similar to Cedar Hill, DeSoto Lancaster is a new area of focus for Komen Dallas County. The Community Profile Team will work to identify potential organizations and key leaders through qualitative data collection. In addition to the activities described above, the Affiliate will work with current grantees and imaging providers to improve service delivery in DeSoto Lancaster. Other

potential partners include the cities of DeSoto and Lancaster, the DeSoto and Lancaster Chambers of Commerce, the DeSoto and Lancaster Recreation Departments, African-American sororities, area churches, and Crescent Medical Center Lancaster, an eighty-four bed acute care general hospital not currently offering any breast health services.

### **South Dallas**

South Dallas is home to three organizations offering services along the full CoC: Methodist Charlton Medical Center, Methodist Dallas Medical Center, and the Dallas VA Medical Center. Methodist Dallas and Methodist Charlton are both American College of Radiology Breast Imaging Centers of Excellence. Methodist Dallas Medical Center and the Dallas VA Medical Center received the American College of Surgeons Commission on Cancer accreditation. Methodist Dallas is also a member of National Accreditation Program for Breast Centers (NAPBC). It is important to note that patients at the Dallas VA Medical Center must meet the eligibility requirements set forth by the US Department of Veterans Affairs.

In addition to the hospitals offering services along the full continuum, South Dallas is home to three organizations offering clinical breast exams and one site that provides screening mammograms in addition to CBE for a total of seven local screening providers. There are not any providers of diagnostic testing or breast cancer treatment outside of the three hospitals described above. The Women's Health Boutique provides support services for side effect management in the form of wigs, scarves, and prosthetics. The majority of South Dallas residents have access to bus and rail routes offered by Dallas Area Rapid Transit (DART, 2013). During the 2013 - 2014 community grant cycle, Komen Dallas County grantees hosted 34 mobile mammography events in South Dallas using Affiliate funds.

The presence of three hospitals offering the full continuum of breast cancer services is a great strength for the community of South Dallas. However, the Dallas VA Medical Center is only available to veterans meeting specific eligibility criteria. Additionally, because South Dallas spans a vast geographic area, access to Methodist Dallas and Methodist Charlton may be challenging for women not living in close proximity to these hospitals.

The presence of multiple locations to receive a screening and enter into the continuum is another strength of this community. However, these services are clustered in the northern reaches of South Dallas and are a considerable distance from those women living in the outer boundaries of this community. South Dallas is the most economically disadvantaged of the three target communities in terms of income and insurance status. As such, access to resources to pay for and facilitate receiving care (child care, paid-time off benefits through an employer, ownership of a personal vehicle) is likely to be a barrier for the women of South Dallas.

South Dallas has been a focus of the Affiliate's community outreach and funding priorities since 2006 based on the findings of earlier Affiliate Community Profile reports. The Affiliate is fortunate to have a network of relationships in South Dallas due to this history. The Affiliate serves on the UNT Health Science Center Dallas Cancer Disparities Research Coalition - Community Advisory Board. This coalition's work began in South Dallas and has since spread to the rest of the county. The District 3 Public Health Council is a key partner for the Affiliate's work in South Dallas, in addition to: the Urban League of Greater Dallas and North Central

Texas, Bluit-Flowers Community Oriented Primary Care Clinic, Foremost Family Health Clinic – Martin Luther King, Jr., and the Affiliate’s community grant recipients.

The Affiliate will work to continue to nurture and develop these existing relationships while identifying new avenues for partners through the qualitative data collection process. Potential groups to work with include the Dallas Black Chamber of Commerce, area YMCAs, the Dallas Parks and Recreation Department, African-American sororities, and area churches. The findings from the qualitative data collection and analysis will ultimately inform the future direction of the Affiliate.

## **Public Policy Overview**

### **National Breast and Cervical Cancer Early Detection Program (NBCCEDP)**

To improve access to screening, the US Congress passed the Breast and Cervical Cancer Death Prevention Act of 1990, which directed the Centers for Disease Control and Prevention (CDC) to create the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) (CDC, 2014). Currently, the NBCCEDP funds all 50 states, the District of Columbia, five US territories, and 11 American Indian/Alaska Native tribes or tribal organizations to provide screening services for breast and cervical cancer. The program helps low-income, uninsured, and underinsured women gain access to breast and cervical cancer screening and diagnostic services. These services include: clinical breast exams, mammograms, pap tests, pelvic exams, Human papillomavirus (HPV) tests, diagnostic testing if screening results are abnormal, and referrals to treatment. In 2000, Congress passed the Breast and Cervical Cancer Prevention and Treatment Act, which gives states the option to offer women who are diagnosed with cancer in the NBCCEDP access to treatment through Medicaid. To date, all 50 states and the District of Columbia have approved this Medicaid option (CDC, 2014).

The Texas Department of State Health Services Breast and Cervical Cancer Services (BCCS) program is funded by a mix of resources from the Centers for Disease Control and Prevention (CDC), the Temporary Assistance for Needy Families (TANF) program, and state general revenue. CDC funds are allocated from federal cancer prevention and control programs for state, territorial, and tribal organizations. Texas opts to convert a portion of its federal Temporary Assistance for Needy Families (TANF) funds to Social Services Block Grant (Title XX) funds which can be used for clinical women’s health services. The funding from the state general revenue is allocated by the Texas legislature.

BCCS services are provided through contracts with local health departments, community-based organizations, private nonprofit organizations, Federally Qualified Health Centers (FQHCs), hospitals, and hospital districts. Contractors bill the Department of State Health Services (DSHS) on a fee-for-service basis. In fiscal year 2013, 43 organizations contracted with DSHS to provide BCCS services at 212 clinics across the state. Breast and cervical cancer screening services are available through health care providers across Texas. A list of contractors and the counties they serve is available at <http://www.dshs.state.tx.us/bccscliniclocator.shtm>. As of the writing of this report, the two BCCS providers in Dallas County are Parkland Health & Hospital System and Planned Parenthood of Greater Texas.

The Texas BCCS program offers low-income women, ages 18 - 64, access to screening and diagnostic services for breast and cervical cancer. To qualify, a woman must be:

- Low-income- at or below 200 percent of the Federal Poverty Income Guidelines (Table 3.1)
- Uninsured or underinsured
- Age 40 – 64 years for breast cancer screening and diagnostic services
- Age 21 – 64 years for cervical cancer screening services
- Age 18 – 64 years for cervical cancer diagnostic services

*High Priority Populations*

- Breast Cancer: Ages 50 - 64
- Cervical Cancer: Ages 21 - 64 years

**Table 3.1.** 2014 Federal Poverty Income Guidelines  
All States (Except Alaska and Hawaii) and D.C.

Family Size	200% of Poverty Guideline
1	\$23,340
2	\$31,460
3	\$39,580
4	\$47,700
5	\$55,820
6	\$63,940
7	\$72,060
8	\$80,180

Source: Center for Medicaid and CHIP Services (CMCS), 2014

BCCS contracted health clinics are the gateway to cancer treatment and determine a woman’s eligibility for the Texas Department of State Health Services Medicaid for Breast and Cervical Cancer (MBCC) program. BCCS contractors are required to: 1) collect the verifying documents for identity, income, and qualifying diagnosis; 2) complete the MBCC application; and 3) send all the documents to DSHS for review of the qualifying diagnosis.

To be eligible for MBCC, a woman must be:

- Diagnosed and in need of treatment for one of the following biopsy-confirmed definitive breast or cervical diagnoses (CIN III, severe cervical dysplasia, cervical carcinoma in-situ, invasive cervical cancer; Ductal carcinoma in situ or invasive breast cancer, as defined by BCCS policy); **and**
- Have family gross income at or below 200 percent of the Federal Poverty Income Guidelines, as defined by BCCS policy  
[www.dshs.state.tx.us/bcccs/eligibility.shtm#income](http://www.dshs.state.tx.us/bcccs/eligibility.shtm#income)
- Uninsured, that is, she must not otherwise have creditable coverage (including current enrollment in Medicaid); **and**
- Under age 65; **and**
- A Texas resident; **and**
- A US citizen or qualified alien.

To enroll, a woman must contact a BCCS contractor in her area. The BCCS contractor will screen for eligibility and, if applicable, complete the Medicaid Medical Assistance Application (form 1034). The BCCS contractor will review and collect required documentation of eligibility. DSHS will verify the patient's qualifying diagnosis and send Form 1034 to the Health and Human Services Commission (HHSC). HHSC Centralized Benefits Services will make the final Medicaid eligibility determination.

A woman is entitled to full Medicaid coverage beginning on the day after the date of diagnosis. (Services are not limited to the treatment of breast and cervical cancer.) Medicaid eligibility continues as long as the Medicaid treatment provider certifies that the woman requires active treatment for breast or cervical cancer. Should a woman have a recurrent breast or cervical cancer, the BCCS contractor must reapply in order for the woman to be eligible for Medicaid.

The Public Policy Committee of the Komen Texas Advocacy Collaborative (KTAC) maintains communication with the Texas Breast and Cervical Cancer Services (BCCS) program, run by the Department of State Health Services. BCCS provides budget, service and policy updates to KTAC as needed, and is aware of the Collaborative's goals of advocating for the uninsured in Texas and all people affected by breast cancer. The Collaborative's relationship with BCCS is new. Susan G. Komen® Headquarters managed this relationship in the past, but with recent advocacy program changes at the national level, KTAC is taking over the responsibility of communicating and working with the agency to ensure advocacy interests are met.

The KTAC Public Policy Committee is working to develop a relationship with Medicaid, through the Texas Health and Human Services Commission, in order to stay informed of changes with MBCC and other policy changes of interest to the mission of Komen.

The advocacy efforts of KTAC for the next four years include increasing communication with the BCCS program and learning methods of how Komen can be helpful in ensuring BCCS serves more of the working poor. While this program is vital, it alone cannot meet the need in the state and the program currently serves only six percent of eligible women. In Dallas County, during the BCCS funding cycle that ran July 1, 2012 – August 31, 2013, BCCS provided 1,026 screenings and diagnosed 15 breast cancers. Between April 1, 2013 and March 31, 2014, Komen Dallas County funded 4,437 mammograms and the detection of 65 cancers through its community grants program. This information is shared to illustrate the limited resources available to the women of Dallas County through BCCS and the need for additional support for the medically underserved.

### **State Comprehensive Cancer Control Coalition**

In 2012, the Cancer Prevention and Research Institute of Texas (CPRIT) submitted the *Texas Cancer Plan* to the state's residents. The plan identifies the challenges and issues that affect Texas and presents a comprehensive set of goals, objectives, and strategic actions to help inform and guide communities in the fight against cancer (CPRIT, 2012).

The *Texas Cancer Plan* priority areas for 2012 - 2016 include:

- Decrease tobacco initiation and use, and exposure to secondhand smoke
- Increase screening and early detection for breast, cervical, and colon and rectum cancers
- Reduce pain and suffering from cancer through coordinated supportive care
- Reduce cancer health disparities
- Increase opportunities to access and participate in clinical trials

Specific to breast cancer, the *Texas Cancer Plan* (2012) has a stated goal to increase the proportion of early stage diagnosis through screening and early detection to reduce deaths from breast cancer. The objectives to achieve this goal are to increase the proportion of women who receive breast cancer screening according to national guidelines and to reduce the late-stage (regional and distant) diagnosis of breast cancer. Among the strategic actions to achieve these objectives are increasing and improving access to care by reducing structural and financial barriers and using evidenced-based interventions to provide education and decrease disparities. These objectives and strategies align with the work and overall goals of the Affiliate.

The *Texas Cancer Plan* encourages community-based organizations and stakeholders to pursue the following objectives:

- Raise constituents' awareness about cancer prevention and control programs in your district and help establish new programs when needed
- Sponsor or support legislation and funding that promotes cancer research, prevention, and control
- Ensure that all Texans have access to health care and to screening and early detection services
- Ensure that tobacco settlement funds are used for reducing tobacco use and for cancer control purposes

Komen Austin, Dallas County, Houston, and North Texas, from the Komen Texas Advocacy Collaborative (KTAC), are members of the Cancer Alliance of Texas (CAT)—the state cancer coalition. The Cancer Alliance of Texas (CAT) exists to promote, enhance, and expand all public and private partners' efforts to implement the *Texas Cancer Plan* (Cancer Alliance of Texas, 2014). The aim of CAT is to advance cooperative efforts that focus on cancer prevention, early detection, screening, and other related or supportive efforts among the population of Texas, which advance the goals of the *Texas Cancer Plan*. Member Affiliates share responsibility of attending quarterly calls and updating KTAC on developments.

The Komen Texas Advocacy Collaborative goals related to the state cancer coalition are to encourage more Affiliates to become Cancer Alliance of Texas members and to integrate cancer policy objectives into the KTAC Advocacy agenda. With budget and staffing limitations, KTAC Affiliates will seek ways to collaborate with other CAT agencies for policy advocacy, especially those working on Medicaid Expansion and issues relating to increasing access to care.

### **Affordable Care Act**

Texas forfeited its option to run a state insurance exchange. As a result, consumers in the state can choose coverage from a federally run marketplace. Insurance offerings from providers vary

from county to county (US Centers for Medicare Services, 2014). Texas did not expand Medicaid coverage for those with incomes up to 133 percent of the poverty level. Expansion would have increased access to breast health and breast cancer care for about 900,000 Texas women (Susan G. Komen, 2013). Medicaid Expansion could also mean an overall increase in economic activity through the infusion of federal funds for the program (Executive Office of the President, 2014).

Prior to the insurance mandate, more than 6.2 million people were uninsured in Texas, making up about 24 percent of the total population (Kaiser Family Foundation, 2014). The Affordable Care Act (ACA) insurance mandate for individuals went into effect January 2014; its impact on the current uninsured rate is still being determined. The office of the US Department of Health and Humans Services Assistant Secretary for Planning and Evaluation (2014) reports that 733,757 Texas residents enrolled for health insurance during the initial ACA open enrollment period (October 1, 2013 – March 31, 2014) through the Health Insurance Marketplace. Enrollment numbers outside of the marketplace through both individual and employer plans is unknown.

There has been minimal impact to the BCCS program by the implementation of the ACA as most BCCS clients do not qualify for marketplace subsidies because their incomes are too low. The impact of health reform for health care providers varies among states, with some exchange plans offering a larger network of providers. Currently, challenges exist for patients with lower-cost exchange plans attempting to access specialty care like oncology (Feibel, 2014). Those with lower incomes tend to choose exchange plans with lower premiums and higher deductibles resulting in problems affording care when a health issue arises. Some consumers face cultural barriers and literacy challenges to understanding plans (Sun, 2014).

Texas has the highest rate of uninsured people in the nation. According to the Kaiser Family Foundation (2014), 53 percent of the uninsured population in Texas report being uninsured for at least five years and 31 percent of the uninsured report never having coverage in their lifetime. Looking at the uninsured in Texas, 40 percent have incomes below the poverty level. Without Medicaid Expansion in Texas, which would have eased eligibility requirements, over one million Texans remain uninsured (Kaiser Family Foundation, 2014). The Affordable Care Act provisions for preventive services—including mammograms—without cost sharing, restrictions on annual and lifetime limits, restraints on out-of-pocket costs and required coverage of pre-existing conditions could alleviate barriers to health care access for those who fall in the coverage gap in Texas. The federal health exchange provides tax subsidies to people making between 100 percent and 400 percent of the poverty level to help offset insurance costs through the marketplace (Internal Revenue Service, 2014).

Increased community outreach efforts may be needed to connect the eligible uninsured to insurance access through the marketplace, especially with 31 percent of the uninsured reporting never having coverage in their lifetime (Kaiser Family Foundation, 2014). However, with over one million uninsured people in the state who are unable to access affordable insurance even with Affordable Care Act provisions and tax credits, health care centers and nonprofits will continue to serve a large population in need. The overall impact of the Affordable Care Act in Texas on the uninsured will take time. In the meantime, thousands of women will still need breast cancer screening, treatment, education, and aftercare services.

With Texas electing not to expand Medicaid coverage, the Affiliate's grantees have not indicated any change in their current outreach or patient demographics. The prevalence of access to care issues means that the Texas Komen Affiliates will continue to serve high volumes of uninsured and underinsured constituents through community-based grants. Working in collaboration with Affordable Care Act outreach programs, Komen Dallas County might be able to use grant funding more efficiently by ensuring that those without insurance options receive resources and that those eligible for subsidies through the Health Insurance Marketplace are able to enroll and begin taking advantage of preventive cancer screenings. Komen Dallas County may consider including ACA information as part of their outreach efforts to ensure women know of the law's inclusion of mammography as a covered benefit for general audiences, and more specific information about lifetime caps and pre-existing condition changes for survivors.

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

Most KTAC Affiliates, including Komen Dallas County, maintain relationships with local and federal-level elected officials to ensure Komen's policy priorities are reinforced, and have become comfortable contacting policymakers. At Komen Dallas County, the primary method of communication is through mailed correspondence several times a year and, as resources allow, face to face meetings. Komen Dallas County has hosted legislative events to promote breast cancer awareness with local legislators and secure their support of Komen. The Affiliate will continue to host these events in the future as opportunities that fit with the mission and strategic goals of the organization arise.

The Collaborative convenes conference calls as needed, while the Public Policy Committee conducts bi-monthly calls to discuss updates from state health agencies and advocacy organizations. The Committee is responsible for public policy planning and decides KTAC's role for local advocacy. Komen Dallas County is a member of both the Collaborative and the Public Policy Committee.

With advocacy program changes at Komen Headquarters, KTAC is assuming more state level advocacy and public policy roles. Most of the Affiliates are ready to engage legislators beyond initial contact, with more emphasis on policy changes affecting breast cancer patients and survivors. Komen Affiliates would like to strengthen the Collaborative structure through public policy, especially through volunteers willing to support KTAC's legislative goals. Future goals include working with more cancer and health coalitions to learn about patient issues and to develop Komen's advocacy presence in the state.

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

Overall, Dallas County has a strong foundation in place to build upon to meet the needs of women in the target communities of Cedar Hill, DeSoto Lancaster, and South Dallas. There are gaps in the Continuum of Care and barriers to care that will require collaborative solutions to resolve. There is promise that gaps in the provision of screenings in the targeted areas can be addressed by the four mobile units already operational in the county. Increasing access to diagnostic testing and breast cancer treatment will be more challenging to address since these services are almost always provided in stationary locations that require large investments of capital. Diminishing barriers related to transportation and hours of operation may prove to be an effective medium-term solution until new facilities open in the target areas.

The Affiliate's existing relationships with its grantees and membership on the District 3 Public Health Council and the UNT Health Science Center Dallas Cancer Disparities Research Coalition Advisory Boards will continue to be integral in working to eliminate breast cancer death disparities in the target areas. The Affiliate will continue to nurture relationships with the Urban League of Greater Dallas and North Central Texas, Bluit-Flowers Community Oriented Primary Care Clinic, and the Foremost Family Health Clinic – Martin Luther King, Jr. location. African-American sororities and the Dallas Black Chamber of Commerce are potential partners for future collaboration. Many area churches participate in the Affiliate's annual Komen Dallas Race for the Cure®. Engaging with these churches more consistently with mission-based communication will be a potential strategy for the Affiliate to pursue. Cedar Hill and DeSoto Lancaster are new areas of focus for the Affiliate and partnerships will be imperative to having an impact in these communities.

The qualitative data collected during key informant interviews and focus groups with community residents and breast cancer survivors in the next phase of the Community Profile will be critical in helping to identify the appropriate organizations and leaders for the Affiliate to partner with on this important task. Likewise, this information will inform the work the Affiliate undertakes to address health systems deficiencies. While the Community Profile Team has identified potential gaps and barriers in services offered through the Health Systems Analysis, these findings may not match the experiences of the women living and working in these communities.

The importance of public policy on breast health cannot be overstated. At the federal level, the power of policy can be seen through the NBCCEDP. This program has screened more than 4.5 million women since 1991 and diagnosed more than 62,121 breast cancers in women who otherwise may not have had access to such services (CDC, 2014). Since 1991, approximately 210,463 Texas women have been screened for breast cancer through the state BCCS program. During the 2011 - 2012 program year alone, 24,610 breast screenings were provided and 453 breast cancers were detected (BCCS, 2013). These BCCS services are vitally important to the medically underserved women in Texas, especially those women who live in an area not served by a Komen Affiliate that cannot access the Affiliate-funded community grant programs. In Dallas County, the Affiliate's grant funding alone cannot meet the growing demand for breast health services, nor can the BCCS program. Working together, these agencies can serve more women and work toward their common goal to prevent late-stage diagnosis and reduce breast cancer death.

A coalition of cancer organizations, survivors, and advocates championed a constitutional amendment, which was approved in 2007 establishing the Cancer Prevention and Research Institute of Texas (CPRIT) and authorizing the state to issue \$3 billion in bonds to fund groundbreaking cancer research, prevention programs, and services in Texas (CPRIT, 2014). Since 2010, CPRIT has funded 544 awards for cancer research, product development, and prevention. The total amount awarded thus far is \$1,020,947,235 (CPRIT, 2014). This investment would not be possible without the work of individual citizens and organizations collaborating to effect change at the policy level. Locally, this has resulted in 30 funded grants to Dallas-based organizations totaling a \$16,925,411 investment. This funding has brought programs offering lymphedema therapy, screenings, diagnostic tests, education outreach, genetic screening, patient navigation, and clinical research to the Dallas-Fort Worth Metroplex area.

Komen Dallas County will continue to maintain a line of communication with local officials to ensure they know the Affiliate is available to serve as a resource to them and their constituents. The Affiliate will work to ensure that elected officials are aware of the programs the Affiliate is funding in the community, as well as the vital investment Komen is making into research institutions in the state of Texas. The Affiliate will share the impact of Komen locally and globally – through the stories of grant recipients, survivors, and co-survivors.

The Affiliate will promote the Komen Advocacy priorities to protect federal funding to ensure all women have access to lifesaving breast cancer screenings, the continued federal investment in cancer research, promote the passage of oral chemotherapy parity at the federal level, and the expansion of Medicaid coverage. Komen Dallas County will continue to be an active member of the Komen Texas Advocacy Collaborative, as the member Affiliates work to share a collective, united voice to advocate for the health of the medically underserved and breast cancer survivors in the state.

# Qualitative Data: Ensuring Community Input

## **Qualitative Data Sources and Methodology Overview**

### **Methodology**

#### ***Key Assessment Questions and Variables Identified***

The Affiliate focused its qualitative data collection on the following key variables: barriers and access to care, availability of existing breast health programs, and identifying community strengths and assets. The Affiliate sought to learn from women and breast cancer survivors living in Cedar Hill, DeSoto Lancaster, and South Dallas and also from community leaders and health care providers serving these areas. Komen Dallas County ultimately sought the answers to these questions:

- What factors are contributing to breast cancer disparities in the Affiliate Target Areas?
- What factors are contributing to breast cancer survivorship in the Affiliate Target Areas?
- What assets already exist in the Affiliate Target Areas that can be built upon to eliminate these disparities?

Komen Dallas County aimed to learn from women and breast cancer survivors living in the Affiliate Target Areas about the barriers they experience when seeking breast health services, how they learn about breast health and available resources, whom they identify as credible sources of breast health information and services, and what they believe can be done to eliminate breast health disparities in their community. The Affiliate looked to breast health providers and community leaders to gain insight into the barriers they perceive women must overcome to seek care, the factors they believe contribute to late-stage diagnosis, and potential solutions to eliminate these disparities. Each individual providing feedback was asked what they believe are the community's strengths, factors that contribute to survivorship, and efforts Komen Dallas County could join or replicate to improve the breast health outcomes in Cedar Hill, DeSoto Lancaster, and South Dallas.

#### ***Data Collection Methods Used and Rationale***

The Affiliate utilized key informant interviews, focus groups, and Appreciative Inquiry to gather qualitative data. The Affiliate interviewed 37 individuals as part of this process. Key informants included: local breast health providers, nonprofit staff, community leaders, faith-based leaders, grantee service recipients, breast cancer survivors, support service providers, and patient navigators. The Affiliate hosted five focus groups: two for African-American breast cancer survivors living in Dallas County and one in each of the Affiliate Target Areas. Lastly, Komen Dallas County hosted a modified Appreciative Inquiry session for breast health providers caring for the medically underserved of Dallas County.

The Affiliate chose these research methods because each would allow the Affiliate to gain perspective from individuals living and working in these communities. These efforts enabled the Affiliate to hear directly from the people it aims to serve and to build trust in the community that will be an integral part of the success of future efforts. This process gave Komen Dallas County the chance to nurture existing connections with providers and community leaders and to build new relationships, especially in the newly expanded targeted communities of Cedar Hill and DeSoto Lancaster.

Key informant interviews allowed the Affiliate to gain detail-rich feedback from a group of constituents in a specific geographic area. Dallas County is home to a number of diverse program offerings and key informant interviews allowed the Affiliate to talk to many providers, gaining input from a wide-ranging group. Key informant interviews allowed the Affiliate to ask in-depth and probing questions of participants in a private setting in a manner that could be tailored appropriately for each individual. This process enabled the Affiliate to gain a better understanding of breast cancer statistics and how they translate in the community.

The Affiliate chose to host focus groups to gain feedback from residents of the Affiliate Target Areas. This method made it possible to hear from many community members at the same event and allowed for the spontaneous generation of ideas and discoveries that are a hallmark of the group process – feedback that might not be revealed in an interview with a lone individual. Focus groups are an efficient way to collect information and a range of ideas from a group of people. When executed properly in an environment of trust and respect, focus groups can encourage individuals to share openly. The representatives from the Affiliate Target Areas that attended the focus groups provided the Affiliate with insight into the barriers they encounter when seeking care and other factors that influence motivation and behavior to seek breast health care.

The Affiliate hosted a modified Appreciative Inquiry session to bring together breast health providers of the medically underserved in Dallas County. This session allowed the Affiliate to gain insight from providers as a group and discover the solutions providers devised when working collaboratively. The Affiliate was able to conduct two of the five steps of the Appreciative Inquiry process during this modified session: the dream and design phases. This process focused specifically on the assets in the community, rather than a traditional deficit view of what is lacking. Building on existing successes and strengths in the community is a cornerstone of the Affiliate's outlook when considering its mission-based outreach. The Affiliate aims for long-term sustainable change and this can most successfully be achieved by meeting the community where they are, rather than infusing short-term solutions when long-term change is needed to eliminate breast health disparities.

### ***Components Associated with Each Data Collection Method***

Qualitative data collection was conducted by Susan M. Wolfe, PhD, a community psychologist with extensive qualitative research experience working with underserved populations. Dr. Wolfe was supported by two Community Profile interns. The qualitative data collection team was rounded out with Amelia Robinson, a health and wellness professional with academic training in health education, and Sara Jabeen, MPH, an epidemiologist now working in clinical cancer research. Sara and Amelia were provided with targeted training in both key informant interviews and focus groups prior to beginning their work in the community. The focus groups and Appreciative Inquiry session were led by Dr. Wolfe and the key informant interviews were conducted by all three members of the qualitative data collection team. Both interns were joined by Dr. Wolfe for official observation of their process to ensure they were following proper research protocols.

Prior to initiating the qualitative data process, Affiliate staff and the team worked together to design the data collection instruments, including: interview guides for key informants tailored by category (community partners, health care providers, patient navigators, and program

participants), focus group guides (specific to breast cancer survivors or community residents), and an Appreciative Inquiry guide. Sessions were recorded with participant consent, however, in the event a participant did not wish to be recorded, detailed notes were taken during the interview. Following each session the team would note their immediate thoughts about the interview, including: tone, body language, and other interactions that a voice recording would not capture. A written report would be completed after each interview, which was then shared with the entire team. These reports were reviewed regularly so that all team members could keep a pulse on findings throughout the process.

The use of focus groups, key informant interviews and Appreciative Inquiry allowed the Affiliate to learn about the contributing factors to breast cancer disparities in the Affiliate Target Areas. By speaking to a diverse group of providers, community leaders, community residents, and breast cancer survivors the Affiliate will be able to compare and contrast the different perspectives related to breast health disparities in the Affiliate Target Areas.

### **Sampling**

The Affiliate conducted five focus groups, two for breast cancer survivors and three for women living in the Affiliate Target Areas. The population of interest for the survivor groups was African-American breast cancer survivors living in Dallas County. The Affiliate conducted focus groups in each of the communities represented in the Affiliate Target Areas (Cedar Hill, DeSoto Lancaster, and South Dallas) for African-American women aged 40 and older residing in these communities. Based on Affiliate resources, the Affiliate relied on purposive convenience sampling for recruitment. In order to increase participation in the focus groups the Affiliate advertised that sessions would include refreshments and a gift bag. Focus groups were promoted through multiple channels including: flyers distributed to 83 local businesses and community contacts, emails to Affiliate constituents residing in the zip codes of the Affiliate Target Areas (n= 1,132), PSAs on local radio stations, an on-air interview with Affiliate staff on Smooth R&B 105.7, and dissemination through public health networking groups. All focus group participants were prescreened prior to participation to ensure they met the minimum qualifications of age, race, residency, and survivorship status. A total of 43 women participated in the focus groups.

The Affiliate used purposive and snowball sampling to identify key informants. Key informants were selected based on the insight they could provide into the Affiliate Target Areas. At the onset of strategizing and planning for qualitative data collection, Affiliate staff and the qualitative data collection team identified key contacts to be included as part of the process. The team then worked to schedule interviews with each of these initial contacts. At the end of each interview the participant was asked if there was anyone they felt the Affiliate should speak to about breast health in the Affiliate Target Areas. When appropriate, these additional contacts were scheduled for an interview. As the process went on additional groups were revealed that would be valuable to include, such as: African-American sororities, additional faith-based leaders, and new community partners. The Affiliate continued with this iterative process of identifying and reaching out to key informants until a saturation point was reached and no new ideas were being generated. Komen Dallas County worked with 37 individual key informants during this phase of data collection.

Participants were selected for the modified Appreciative Inquiry session using purposive sampling. Komen Dallas County enlisted the support of the membership of the YWCA of Metropolitan Dallas' Patient Navigator Action Coalition (PNAC), of which the Affiliate is also a member. The PNAC membership includes a variety of breast health and support service providers who care for the medically underserved. The Affiliate also included organizations providing cancer support services that are not current PNAC members, but could provide valuable insight to this process. Ten local breast health providers participated in the modified Appreciative Inquiry session.

## **Ethics**

Consent to participate was secured from all participants. Individuals were given the option to remain anonymous, to use a pseudonym, or to have their name included in the report. Participants were asked if they would allow the Affiliate to quote them directly or use their feedback in a more general way. The qualitative data collection team received approval from the participants to record the sessions. All participants were provided with a copy of the consent form along with the contact information of Affiliate staff in the event they wanted to follow up on any matters in the future. All electronic Community Profile files are saved on a password protected server and all paper files are stored in a locked filing cabinet at the Affiliate office.

## **Qualitative Data Overview**

While Komen Dallas County recognizes the uniqueness of Cedar Hill, DeSoto Lancaster, and South Dallas, the qualitative data process revealed that these three communities are experiencing similar barriers and challenges related to accessing breast health information and services. Due to the close proximity of the three Affiliate Target Areas within Dallas County and the fact that they share many of the same providers, resources, and challenges, the qualitative data findings are presented for the communities as a whole, to be referred to as the Affiliate Target Areas.

The Affiliate began the qualitative data analysis phase by transcribing all responses using the digital recordings and written notes. The transcripts from each interview and focus group were then compiled into a single document with all responses grouped together by question. The Affiliate selected this method based on the resources available and the recommendation of Dr. Wolfe, qualitative data consultant, who has used this method with success throughout her professional career. Dr. Wolfe conducted in-depth training with the qualitative data collection team on how to capture the appropriate information for reports and reviewed each report to ensure it was robust and complete.

The data collection team met and reviewed statements collaboratively and developed broad categories based on the identified themes. A spreadsheet was developed with a page for each question. Themes and specific categories were recorded in the first column. Respondent names were listed across the top row and a "1" was placed in the box corresponding to the appropriate category and respondent name to record the appearance of each theme. The last column included a tally of the number of times a theme was coded to provide the frequency of each theme per question. For the first response question two team members coded responses and compared to reach agreement. For the remainder of the data, one team member coded

responses and two others checked them for agreement. The team discussed discrepancies until they reached consensus.

There was a high level of agreement regarding key issues across data collection methods. Responses received from professionals who participated in key informant interviews were consistent with those obtained from survivors and community members who participated in the focus groups. Clear and repetitive themes emerged across groups and individuals.

### **Barriers to Screening and Diagnosis**

Barriers to screening and diagnosis included lack of knowledge, fear and denial, complexity of the health care system, and financial, cultural, and practical issues.

Among the most commonly cited barriers to screening and diagnosis by interview and focus group respondents were knowledge barriers, with the knowledge of service availability and resources as the most frequently mentioned. Participants commented that women are often unaware of the availability of low or no cost mammograms. There are few screening and diagnostic facilities in the Affiliate Target Areas so women often rely on mobile mammography units, however, information regarding the times and locations where units will be is not readily available to all women residing in these communities. Many women do not follow up when they are notified of abnormal screening results because they either do not realize the need to, or lack the knowledge necessary to navigate the health care system. Another knowledge barrier was women's lack of understanding of breast health. Many women do not realize the significance of breast self-awareness and having clinical breast exams performed. Additionally, there is confusion about what age to begin annual screening mammography. Also identified among knowledge barriers was a general lack of knowledge regarding health and health care. Participants revealed that there is sometimes misinformation shared among many women regarding risk factors; for example, the perception that a lump should hurt if it is cancer.

Fear was the second most frequently given reason women do not get mammograms, or follow-up with diagnostic testing following abnormal screens. Some women have a fatalistic viewpoint and feel that if they have cancer, there is little chance they will survive, so they would rather not know. Others fear treatment and its side effects. Some women are afraid of the impact a cancer diagnosis may have on their families. Another psychological barrier is lack of social support and a wish to avoid risking an abnormal screen and diagnosis because there would be nobody to support them as they navigate treatment. Fear of the costs involved in receiving treatment was also discussed. A different psychological response that was expressed is denial. Rather than fear of an abnormal screen, some women deny the possibility that they could get breast cancer so they see no need to be screened.

The shortage of breast screening and diagnostic resources in the Affiliate Target Areas can result in demand for services exceeding the supply. Mobile units in Dallas County serve the entire county, a population of more than 1.1 million women. Facilities must allocate resources throughout the county and are limited to the number of events they can host in the Affiliate Target Areas. Additionally, mobile mammography units have a limited capacity for the number of women they can screen at a given event, ranging from 22–45 screenings depending on the provider. There are fewer low or no cost mammograms available compared to the number of women in need. Also mentioned were issues of trust and relationships with health providers.

Many women have not established a trusting relationship with providers in these areas. A perception that the health providers in northern Dallas County are of higher quality was brought up on more than one occasion. For example, one focus group member shared an example whereby staff at a facility based in southern Dallas County referred a woman to a facility in North Dallas because they believed she could get better care there.

Another set of barriers frequently acknowledged were financial barriers. Many women are low income, have no health insurance, or lack the money for diagnostic testing and treatment if their mammograms indicate they are necessary. Some women with health insurance are unable to meet the deductibles and co-pays associated with additional testing and treatment. For this group of women, free screenings are not an incentive because they perceive little or no options available if there is a cancer diagnosis.

The paucity of screening and diagnostic centers in the Affiliate Target Areas is especially problematic for women with no means of transportation. Some areas of southern Dallas County have no public transportation available, including the cities of Cedar Hill and DeSoto. These two factors combine to limit women's access to screening and diagnostic follow-up.

Another theme that arose was practical considerations. Many women are juggling work and family responsibilities and do not prioritize their own health. Some women have difficulties finding time to schedule a mammogram and others are strongly discouraged from taking time off work for medical appointments at the risk of losing wages for doing so. Cultural barriers, such as language and religious beliefs were declared by a smaller number of respondents. The belief that "it is in God's hands" was indicated as a barrier to seeking diagnostic services.

### **Increasing the Number of Women Screened**

Respondents proposed several tactics to increase the number of women screened. Consistent with the finding that lack of knowledge is a barrier, the most frequently cited strategy was to create more awareness of resources and to build breast health knowledge. Respondents suggested creating more awareness about health services and providing breast health education to residents of the Affiliate Target Areas through a variety of efforts. Outreach events at faith-based institutions, schools, and throughout the community at the grassroots level was the most commonly recommended strategy. Marketing efforts and public service announcements on key television and popular radio stations would also help to spread the word. Health fairs were referenced as being successful in the past at providing education. Word of mouth dissemination was also recommended. Participants suggested making more mobile units available throughout the area with evening, early morning, and weekend hours. Also recommended was identifying approaches that build trust and strengthen relationships within the community. Examples to develop trust included developing an outreach model where caregivers are active participants in outreach and "do the hard foot work" to communicate effectively with community members.

### **Contributors to Late-Stage Diagnosis**

Contributors to late-stage diagnosis were similar to the barriers to screening and diagnostic testing. Knowledge deficits about breast health and health in general and navigating the health care system were noted, as well as the proliferation of misinformation. Women fear finding out they have breast cancer due to fatalistic attitudes about the disease, the cost of treatment, and

the effects it may have on their families, so they delay diagnosis. Another frequent contributing factor to late-stage diagnosis was practical considerations, particularly women's competing priorities for childcare and meeting family needs. Access to care was provided as a cause due primarily to lack of local providers and public transportation in the area. Also mentioned by fewer participants was financial considerations, trust in health care providers, a lack of social support, and cultural barriers.

### **Women Who Have Problems Accessing Screening and Other Services**

The interviewees and focus group participants identified characteristics of the women who were least likely to get regular screenings. Low-income women and women with competing priorities were the most common. Many respondents in the focus groups particularly shared that the women in the Affiliate Target Areas tend to prioritize the needs of family members over their own. Consistent with low-income women, uninsured and underinsured women were also named. Young women with lower educational attainment and less breast health knowledge were recognized as the least likely to be screened regularly. Descriptions of patients who have problems accessing treatment and other services were similar – low-income, limited or no transportation, African-American, and uninsured.

### **Barriers to Treatment**

Barriers to treatment were consistent with the barriers already described. Once again, knowledge was the most common obstacle. After diagnosis women must navigate the treatment system and many women are unaware of the availability of services and resources. Breast cancer survivors described assistance from patient navigators or breast cancer survivors as helpful to overcoming this challenge. Limited knowledge of breast health in general leads to women not realizing the need to act promptly when they are diagnosed and seek treatment. Many women fear treatment and its side effects. Fatalistic attitudes about cancer lead many women to think there is no point to going through treatment. Some women deny the significance of the diagnosis and fail to act. The scarce availability of breast cancer services in the Affiliate Target Areas results in a limited supply of care that is accessible. Many women in the survivor focus groups had received their care at facilities north of the Trinity River.

Lack of social support was another barrier to treatment. Family and friends are often relied upon for transportation and assistance with daily chores and meals. Survivors considered emotional support and religious beliefs as necessary for overcoming barriers to treatment. Churches, survivor support groups, family, friends, co-workers, and one-on-one interactions with other survivors were all important for coping during treatment. Survivors who did not have such support noted that it would have been helpful to have more information about support services, access to survivors, a support hotline, and basic help with activities of daily living and transportation. Women who do not have this support network may avoid treatment, especially if they do not have their own transportation and live in an area where there is limited or no public transportation.

Financial issues were also impediments to seeking timely care. Low-income women often lack insurance and were not aware of resources that may be available to defray the costs of treatment. Women with insurance often have high co-pays and deductibles to meet that can be unaffordable. Breast cancer survivors described financial assistance with health care costs and daily living costs as being helpful for them to overcome financial barriers. Lastly, trust issues

and a lack of relationships with health care providers were another barrier for women with a breast cancer diagnosis that sought treatment.

### **Perceived Contributors to Survival**

Breast cancer survivors described several factors they perceived as contributing to their survival. Having emotional support was cited frequently as important for surviving breast cancer treatment. The care of family and friends was most crucial, although support groups with survivors also played an important role. Taking the initiative to learn about breast health and the benefits of early screening, treatment options, the health care system, and available resources made a difference. Survivors credited God and their religious beliefs as playing a role in their recovery. Having patient navigators available to connect patients to information, providers, and support services was valued. Personal behaviors and characteristics such as compliance with treatment regimens and having “grit” or a strong will were also credited with supporting survivorship. Participants also stressed the importance of developing a good relationship with health care providers.

### **Breast Health Information and Outreach**

Women receive breast health information from a variety of resources and usually reference using more than one source. The most commonly named ways to access breast health information were friends and family, health care providers, and the Internet. Print media, such as newspapers and magazines, church and faith-based events, television, and other entertainment, were also referenced. Few participants listed academic publications, pamphlets and flyers, hospital newsletters, direct mail, television news, or health fairs and events as sources of information.

The participants provided a variety of proposed strategies for how to disseminate breast health information. While pamphlets and flyers were seldom mentioned as sources of breast health information, distributing these printed materials throughout the community was revealed to be one of the most desired means to receive information. Educational sessions, either one-on-one, formal lectures or presentations, classes, videos, or forums, were another way women would like to receive breast health information. Church-based educational programs were noted, as well as providing education that builds one-on-one relationships and uses interactive activities. Participants described large events such as conferences, fairs, and female-centric gatherings as successful strategies to reach women. Building relationships with community gatekeepers was also recommended.

Based on the findings from the key informant interviews, the most frequently utilized outreach methods by area providers are community and church events, distribution of printed materials, and partnering with community organizations to reach at-risk women. Methods currently being used for outreach by providers are consistent with those described by community members as effective.

Similar to the focus group participants, key informants report there is a need for more breast health and general health education available in the community. Types of information suggested as necessary include that which promotes available resources and education to dispel myths and fears associated with breast cancer. They recommended more breast health event-based

grassroots outreach that specifically targets African-American women. They also suggested survivor and mental health outreach for affected women.

### **Service Needs**

Consistent with the viewpoint that knowledge deficits and difficulties navigating the health care system are barriers to screening, diagnosis, and treatment, participants in focus groups and key informant interviews most frequently suggested that more patient navigation services, follow up with patient tracking, and appointment reminders would help to get more women diagnosed and into treatment earlier. Assistance with transportation was also recommended. Increasing the number of mobile units in the target communities, with more marketing promoting their availability and predictable schedules could increase the number of women screened. Participants also recognized a need for more funding for education and outreach, breast health medical care, and assistance for women in treatment to meet daily expenses.

More patient navigation was the most frequently cited improvement that could be made to the current health care system to ensure a more seamless continuum of care for women who are diagnosed with breast cancer. Participants believe that better communication among health care providers would support higher quality and timelier care. Increased and more effective follow-up, appointment reminders, and patient tracking are also needed. Simplifying and streamlining the health care system was recommended.

Beyond funding for more services, educational outreach was identified as the most pressing need. Suggested education included community workshops and events about the availability of health care resources and increasing educational materials available throughout the community. Health care provider education is also needed. Increasing partnerships with community gatekeepers and community leaders would also contribute to sustainable change in the lives of individuals in regards to breast health, with the goal of longer, higher quality lives. Building trust and relationships between providers, patients, and community members would facilitate this process.

### **Community Assets and Past Successes**

The Affiliate Target Areas have needs, but they also have a number of assets that providers can draw upon. There is a strong faith-based community presence, and churches are engaged in education and outreach. There are robust and active school and community groups, resilient families, and overall a strong sense of community. More health care facilities are in the area than in the past and more are coming, including a new Parkland Community Oriented Primary Care (COPC) clinic planned for South Dallas. Community members are eager to learn about health and breast health and to help spread the word. There is an existing network for word-of-mouth dissemination of information. Many large nonprofits work in the area and businesses based here are involved in the community. Participants described area residents as caring and having strong faith in God.

There have been successful health-based efforts in the Affiliate Target Areas in the past, including mobile mammography events. Church-based outreach and education has worked well. Health fairs and other community events were also described as successful. Other efforts that have worked include grassroots level health efforts, school-based outreach, large health

campaigns, hospital-community collaborative events, and programs that come into the community and are well promoted.

Participants recommended that Komen Dallas County partner with organizations that are already working in the community. Most frequently mentioned was churches. There is a strong church presence and a desire to learn about health and breast health through church-based events. Other frequently recommended partnerships were with community leaders and sororities and fraternities.

### **Qualitative Data Findings**

The key question that arose from the review of quantitative data was why did African-American women in Dallas County have substantially higher rates of late-stage breast cancer diagnosis and subsequently die from breast cancer at higher rates compared with all other groups. The qualitative data collection questions focused on barriers to screening, diagnosis, and treatment for women in the three areas of southern Dallas County that had the highest concentrations of African-American women, and high late-stage diagnosis and death rates.

Knowledge barriers were similar across communities. Women in all three communities need more information about screening, diagnostic, and treatment opportunities that are available and accessible. They also need additional educational opportunities related to breast health and the benefits of screening and early detection. Such knowledge may be helpful to reduce fear and denial, two psychological factors that reportedly create barriers that contribute to delayed screening and diagnosis. Women who care for the needs of their families over their own needs will be more likely to adhere to regular screening if they have a better understanding about how doing so is relevant to caring for their families.

There is a need for increased social and practical support for women who are diagnosed with breast cancer and undergoing treatment in all three communities. Survivors described difficulties with tasks such as cleaning their homes, shopping, and cooking while they were in treatment. Some had friends and family members who helped, but others struggled. Proper nutrition and a clean environment are essential while women are in treatment and the absence of these resources can compromise recovery.

While all three communities shared similar barriers, some of them likely play out differently in South Dallas compared with Cedar Hill and DeSoto Lancaster. Health care resources differ across communities. South Dallas is a high poverty, medically underserved community. There are limited health care resources within the community for women to draw upon for preventive health care, screenings, diagnostics, and treatment. Many survivors described having to travel to northern Dallas County for diagnostic and treatment services. Cedar Hill and DeSoto Lancaster are not designated as medically underserved and there are ample primary health care providers, but there are limited resources specific to breast health. There is also very limited or no public transportation available in these communities.

Financial barriers also differ across communities. South Dallas has the highest poverty and unemployment rates in Dallas County with rates of women ages 40-64 without health insurance ranging from 23-44 percent. While Medicaid in Texas covers breast cancer treatment for women

in this age group, the eligibility is restrictive. Women must have a gross income at or below 200 percent of the Federal Poverty Income Guidelines, be uninsured, and have already been diagnosed. While there are some resources available in the community for free screenings, the cost of diagnostic testing is likely out of reach. Both DeSoto Lancaster and Cedar Hill have better economic and health indicators than those in South Dallas, but the women living in these communities still face financial barriers. One key informant described many of the families as having stretched themselves financially to live in a nicer community with better schools for the sake of their children. As a result, they lack the resources to cover added expenses from co-pays and high deductibles. The women in these communities described themselves as putting family needs before their own. Limited financial resources can result in not following through with diagnostic testing. Additionally, most of these women work and many commute some distances, which leaves even less time for them to allocate for self-care.

### **Data Source and Method Strengths and Weaknesses**

The greatest strength of the qualitative data collection was the consistency of themes across sources and respondents. The needs and assets described by key informants and providers matched those described by community members and breast cancer survivors. A strength was the use of solid interview and focus group methodologies including: standardized protocols and questions, recorded responses, and formal training on interview skills and the specific interview protocols. In addition to audio recordings there were two note-takers at each focus group to observe and record non-verbal behaviors and the general tone of the sessions. All focus groups were facilitated by a professional facilitator who has considerable experience conducting such groups and collecting data in southern Dallas County specifically. Analyses were performed systematically and by more than one person, helping to eliminate an individual coder's bias.

Perhaps the greatest limitation was the low turnout for focus groups conducted in Cedar Hill and DeSoto Lancaster. Although the groups were highly publicized and held in central and easily accessible locations, turnout was less than desirable. Focus groups were held on a weeknight around dinnertime and likely around the time many women who work downtown or in northern Dallas County were just returning from work. Many of the women in these communities have jobs outside of the home and have busy professional and family lives. They were described as putting family first and making little time for their own health and needs, which would also suggest that attending such focus groups would be low priority for them. Responses from the women who attended and professionals working in these communities were consistent, so it is likely the needs and assets described reflect those of the communities as well.

The Affiliate Target Areas have ample needs in regard to women's breast health and breast cancer screening, diagnosis, and treatment. First and foremost is a shortage of resources for general health care and breast health. Many women must rely upon mobile units that visit the community, which requires knowing when and where they will be and trying to match schedules so that women can be screened. While mobile units are a valuable stopgap measure, they are no replacement for dedicated centers with regular and accommodating hours. Additionally, mobile units do not offer diagnostic or treatment services. A single location and staff would contribute to a more seamless continuum of care. The Affiliate Target Areas are in need of more health care resources in general, and all three communities would benefit from more screening, diagnostic, and treatment services along with more of a sense of priority for women's breast health throughout the community.

In addition to the paucity of health care resources, there is a need for other supportive resources for women who are diagnosed with breast cancer. For some women this means they drive over an hour for treatment and support. Lack of knowledge of services and how to navigate the system was one barrier women experience related to diagnosis and treatment. One source of information many found useful was breast cancer survivors. If they were able to meet in the community they would be more available to share their knowledge and provide newly diagnosed women with information and support.

The Affiliate Target Areas have numerous assets that could be better mobilized to promote screening and educate women in the community. There is a robust sense of community and strong churches throughout all the Affiliate Target Areas. While there have been faith-based efforts, such as educational programs and mobile units visiting churches, they are hit and miss. The community would benefit from a more systematic and sustained effort to engage churches and other community resources. The church plays an influential role in many women's lives in these areas. Programs might work with churches to find ways to wield their influence to give women permission to prioritize their own health and to dispel fears and the sense of fatalism.

One effective information dissemination vehicle within the communities is word-of-mouth. This requires developing mechanisms to tap into informal networks to share information. This can be best accomplished by identifying key individuals and influencers and collaborating with them to develop strategies to build the communities' internal capacity to address breast cancer and other health disparities. There are many educated and engaged individuals within each community who could be brought to the table to learn about these needs and be included in identifying and implementing solutions. Larger, more established organizations might partner with grassroots efforts to provide infrastructure, guidance, and support for funding applications, planning, and implementing efforts.

Some of the barriers contributing to breast cancer disparities are the same ones that contribute to other health disparities in the Affiliate Target Areas. The infrastructure and economy are substantial contributors that will require policy changes and greater investments in these communities. There is no public transportation in the southern suburbs. Most jobs held by residents of these areas are in downtown Dallas or further north, which requires working adults in the household to have a car, adding to families' financial burdens. The shortage of good jobs locally requires long commutes which further limits women's time to care for themselves. Policymakers might benefit from education regarding the importance of addressing infrastructure not only for economic benefit, but for health benefits as well.

# Mission Action Plan

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

### **Quantitative Data Report Summary**

The Quantitative Data Report revealed a disparity in late-stage breast cancer diagnosis and death rates experienced by Black/African-American women living in Dallas County. The late-stage incidence rate of 54.1 per 100,000 Black/African-American women is higher than the overall rate of 45.4 for Dallas County females and significantly higher than the state of Texas rate of 40.7. The late-stage breast cancer diagnosis rate of Black/African-American women in Dallas County is 1.2 times higher than the rate experienced collectively by all women in the county. Additionally, while the late-stage breast cancer diagnosis trend is falling for women in the US, Texas, and Dallas County, it is rising at an annual rate of 1.6 percent among Black/African-American women in Dallas County.

The higher late-stage diagnosis rate for Black/African-American women is coupled with a higher breast cancer death rate. The breast cancer death rate among Black/African-American women is 1.4 times higher than the combined rate for all women living in Dallas County. Black/African-American women in Dallas County have higher breast cancer death rates per 100,000 women than any other population group.

These facts led Komen Dallas County to further investigate how breast cancer is affecting Black/African-American women living in its service area. To consider this information and deliberate over the selection of Affiliate Target Areas, Komen convened a panel of local community health professionals to identify the areas which would be the focus of the Community Profile.

Demographic data played a key role in the selection of the Affiliate Target Areas. The Black/African-American population of each geographic area in the county was considered in order to identify the communities with the largest percentage of Black/African-American residents. The communities with the largest Black/African-American population base include: Cedar Hill, DeSoto Lancaster, and South Dallas. Not only are Black/African-American women most likely to be found in Cedar Hill, DeSoto Lancaster, and South Dallas – the residents of these communities also experienced higher breast cancer death rates than other areas in Dallas County.

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

#### ***Health Systems Analysis***

Komen Dallas County then conducted an extensive assessment to identify breast health services available to constituents in its service area. The findings from this detailed search were compiled and available services were evaluated by type, location, comprehensiveness of offerings, and quality of care indicators. Using the Breast Cancer Continuum of Care (CoC), the team reviewed the findings for each of the Affiliate Target Areas in terms of potential gaps in services and other barriers to access, in particular, geography.

The Community Profile Team initiated the Health Systems Analysis by looking at resources available in the Affiliate service area as a whole. Dallas County is resource rich with 98

organizations providing direct breast health services, including 12 organizations that offer the full continuum of breast cancer services housed within a single organization. Patients at these facilities are able to receive breast cancer screening, diagnostic testing, treatment, and support services seamlessly within one entity.

While Dallas County offers an abundance of resources, these resources are concentrated in locales outside of the Affiliate Target Areas in the southern sector of the county. Women living in Cedar Hill have just two organizations providing breast health services within their community – one providing screening mammograms, the other clinical breast exams. For women living in Cedar Hill, any additional testing or breast cancer treatment would be at a provider outside of their home community. The city of DeSoto has one organization providing screening mammograms and diagnostic services including diagnostic mammograms, breast MRIs, ultrasounds, and biopsies. The women of DeSoto would still need to travel for breast cancer treatment and support services. Women living in Lancaster have no local breast health resources and must travel outside of their home community to receive any service – from a clinical breast exam to breast cancer treatment.

These women are not able to access the full CoC within their own communities. Without nearby locations to receive breast health services, women may need to take additional hours off work, spend added time and money traveling for appointments, and/or find childcare to attend appointments, amongst other barriers that may arise. For breast cancer patients this extra travel time compounded with the fatigue from treatment can make adherence to their recommended treatment more challenging. For women without their own means of transportation, access to care becomes even more difficult, as no public transportation bus or rail routes are located in Cedar Hill or DeSoto, and women in Lancaster have access to only one bus route.

South Dallas is home to three hospitals offering services along the full CoC, three locations providing clinical breast exams (CBE), and one site that provides screening mammograms via mobile mammography in addition to CBE for a total of seven local screening providers. There are not any providers of diagnostic testing or breast cancer treatment outside of the three hospitals described above. The presence of multiple locations to receive screenings and enter into the CoC is a strength of this community. However, these services are clustered in the northern reaches of South Dallas and are a considerable distance from those women living in the outer boundaries of this community. South Dallas is the most economically disadvantaged of the Affiliate Target Areas in terms of income and insurance status. As such, access to resources to pay for and facilitate receiving care (child care, paid-time off and insurance benefits through an employer, ownership of a personal vehicle) is likely to be a barrier for the women of South Dallas.

Overall, Dallas County has a strong foundation in place to build upon to meet the needs of women in Cedar Hill, DeSoto Lancaster, and South Dallas. These gaps in the CoC and barriers to care will require collaborative solutions to resolve. There is promise that gaps in the provision of screenings in these areas can be resolved in the short-term by the four mobile units already operating in the county. Increasing access to diagnostic testing and breast cancer treatment will be more challenging to address since these services are almost always provided in stationary locations that require large investments of capital. Diminishing barriers related to transportation

and hours of operation may prove to be an effective medium-term solution until new facilities open in the Affiliate Target Areas.

### ***Public Policy Analysis***

Recognizing the role that public policy plays in the health of the community, Komen also examined how the Affordable Care Act (ACA) and government-funded programs were likely to impact access to breast health services in Dallas County. Prior to the ACA's insurance mandate, more than 6.2 million people were uninsured in Texas, comprising about 24 percent of the total population - the highest rate of uninsured people in the nation. The ACA insurance mandate for individuals went into effect January 2014; its impact on the current uninsured rate in Texas is still being determined.

Texas elected not to take part in the ACA's provision for the expansion of Medicaid coverage for those with incomes up to 133 percent of the Federal Poverty Level. This expansion would have increased access to breast health and breast cancer care for approximately 900,000 Texas women. Texas also forfeited its option to run a state insurance exchange. As a result, consumers in the state select coverage using the federally-facilitated marketplace.

The state offers two safety-net programs to assist eligible, low-income, uninsured women in need of breast cancer screening, diagnostic testing, and treatment. The Texas Department of State Health Services (DSHS) Breast and Cervical Cancer Services (BCCS) program funds clinic sites across the state to provide quality, low-cost, accessible breast and cervical cancer screening and diagnostic services. These services help women receive routine screenings, which is the best method to detect breast and cervical cancer in their earliest stages increasing a woman's chance of survival. While this program is vital, it alone cannot meet the need as the program currently serves only six percent of eligible women.

Low-income, uninsured women diagnosed with breast or cervical cancer in need of treatment may qualify for medical assistance through the state funded Medicaid for Breast and Cervical Cancer (MBCC) program. Women accepted into the program gain full Medicaid coverage beginning on the day after the date of diagnosis and eligibility continues as long as the Medicaid treatment provider certifies that a woman requires active treatment for breast or cervical cancer.

The implementation of the ACA has had minimal impact on the BCCS program as most BCCS clients do not qualify for marketplace subsidies because their incomes are too low. With Texas electing not to expand Medicaid coverage, the Affiliate's grantees have not conveyed any changes to their current outreach strategies or patient demographics. The prevalence of access to care issues indicate that Komen Dallas County will continue to serve high volumes of uninsured and underinsured constituents through community-based grants.

The Health Systems and Public Policy Analysis revealed a scarcity of breast health and transportation services available in the Affiliate Target Areas accompanied with a state screening program that is overextended and cannot meet the needs of eligible women. Through qualitative data collection, Komen Dallas County sought to understand how the shortage of local providers combined with other challenges experienced by women in these communities resulted in late-stage breast cancer diagnosis and death disparities.

## Qualitative Data Findings Summary

The Affiliate focused its qualitative data collection on the following key variables: barriers and access to care, availability of existing breast health programs, and identifying community strengths and assets. The Affiliate sought to learn from women and breast cancer survivors living in Cedar Hill, DeSoto Lancaster, and South Dallas and also from community leaders and health care providers serving these areas. Komen Dallas County ultimately sought the answers to these questions:

- What factors are contributing to breast cancer disparities in the Affiliate Target Areas?
- What factors are contributing to breast cancer survivorship in the Affiliate Target Areas?
- What assets already exist in the Affiliate Target Areas that can be built upon to eliminate these disparities?

To gather feedback from local breast cancer survivors, community members, and breast health providers, the team conducted 37 key informant interviews, five focus groups with a total of 43 participants, and a modified Appreciative Inquiry session with 10 local breast health providers.

Barriers to screening, diagnosis, and treatment included lack of knowledge, fear and denial, complexity of the health care system, and financial, cultural, and practical issues. Among the most commonly cited barriers to screening and diagnosis by interview and focus group respondents were knowledge barriers, with the knowledge of service availability and resources as the most frequently mentioned. Many women are not aware of the existence of low-cost or no-cost breast health services and how to access these programs. A lack of general breast health knowledge can result in a delayed diagnosis as women do not follow up when they are notified of abnormal screening results because they either do not realize the need to, or lack the knowledge necessary to navigate the health care system. This limited knowledge of breast health in general can also lead to delays in treatment as women do not realize the need to act promptly when they are diagnosed.

Fear was the next most frequently given reason women do not get mammograms or do not follow up with diagnostic testing following abnormal screens. Some women have a fatalistic viewpoint and feel that if they have cancer, there is little chance they will survive, so they would rather not know. Others fear treatment and its side effects. Fatalistic attitudes about cancer lead many women to think there is no point to going through treatment. Some women deny the significance of the diagnosis and fail to act. Some women are afraid of the impact a cancer diagnosis may have on their families.

Lack of social support was another barrier to screening, diagnosis, and treatment. Family and friends are often relied upon for transportation and assistance with daily chores and meals. Survivors considered emotional support and religious beliefs as necessary for overcoming barriers to treatment. Churches, survivor support groups, family, friends, co-workers, and one-on-one interactions with other survivors were all important for coping during treatment. Some women stated a wish to avoid risking an abnormal screen and diagnosis because there would be nobody to support them as they navigate treatment. Women who do not have this support network may not be able to comply with treatment, especially if they do not have their own transportation and live in an area where there is limited or no public transportation.

Financial barriers were also frequently acknowledged. Many women are low income, have no health insurance, or lack the money for diagnostic testing and treatment if their mammograms indicate they are necessary. Some women with health insurance are unable to meet the deductibles and co-pays associated with additional testing and treatment. For this group of women, free screenings are not an incentive because they perceive little or no options available if there is a cancer diagnosis.

The paucity of screening and diagnostic centers in the Affiliate Target Areas is especially problematic for women with no means of transportation. Some areas of southern Dallas County have no public transportation available, including the cities of Cedar Hill and DeSoto. These two factors combine to limit women's access to screening and diagnostic follow-up.

Another theme that arose was practical considerations. Many women are juggling work and family responsibilities and do not prioritize their own health. Some women have difficulties finding time to schedule a mammogram, while others are strongly discouraged from taking time off work for medical appointments at the risk of losing wages for doing so.

Consistent with the viewpoint that knowledge deficits and difficulties navigating the health care system are barriers to screening, diagnosis, and treatment, more patient navigation was the most frequently cited improvement that could be made to the current health care system to ensure a more seamless continuum of care for women who are diagnosed with breast cancer. Beyond funding for more services, educational outreach was identified as the most pressing need. Suggested education included community workshops and events about the availability of health care resources and increasing educational materials available throughout the community. Increasing partnerships with community gatekeepers and community leaders would also contribute to sustainable change in the lives of individuals in regards to breast health, with the goal of longer, higher quality lives. Assistance with transportation was also recommended, as well as increasing the number of mobile units in the target communities, with more marketing promoting their availability and predictable schedules which could increase the number of women screened.

Knowledge barriers were similar across communities. Women in all three communities want more information about screening, diagnostic, and treatment opportunities that are available and accessible. They also need additional educational opportunities related to breast health and the benefits of screening and early detection. Such knowledge may be helpful to reduce fear and denial, two psychological factors that were named in focus groups and can create barriers that contribute to delayed screening and diagnosis. Women who care for the needs of their families over their own needs will be more likely to adhere to regular screening if they have a better understanding about how doing so is relevant to caring for their families. There is also a need for increased social and practical support for women who are diagnosed with breast cancer and undergoing treatment in the Affiliate Target Areas.

### **Mission Action Plan**

Komen Dallas County developed a Mission Action Plan to address the needs identified through the Community Profile process. This plan is the culmination of more than one year's effort by the Affiliate and aims to be reflective of the needs voiced by community residents and providers.

This plan was presented to the following outside stakeholders for their feedback: the Dallas Cancer Disparities Community Research Coalition, Parkland Health & Hospital's Coming Together for the Cures Committee, and the Program Directors Leaders Circle group at the Center for Nonprofit Management. Affiliate staff also provided input into the capacity of the organization to achieve the stated objectives within the designated timeline. The final plan incorporating the feedback from community stakeholders and staff was presented to the Affiliate Board of Directors for formal approval.

**Problem: According to the Health Systems Analysis data gathered, African American women living in Cedar Hill, DeSoto Lancaster, and South Dallas have limited access to breast health services.**

**Priority 1: Improve access to and timely utilization of breast health services through the Continuum of Care for African American women living in Cedar Hill, DeSoto Lancaster, and South Dallas.**

**Objective 1: Beginning in FY16, emphasize funding programs through the Affiliate community grants program that provide medical care and support services to eliminate barriers to care for residents of Cedar Hill, DeSoto, Lancaster, and South Dallas, with an emphasis on funding mobile mammography and patient navigator programs.**

**Objective 2: In FY16, identify and promote the Komen Dallas County community grants program to at least three organizations that provide programs offering financial assistance, support groups, childcare assistance, or transportation assistance to serve the women of Cedar Hill, DeSoto Lancaster, and South Dallas.**

**Problem: Based on information learned from focus groups and key informant interviews, African American women living in Cedar Hill, Desoto Lancaster, and South Dallas and health care providers identify low levels of breast health knowledge and low awareness of available resources as a contributing factor to late stage diagnosis and breast cancer mortality rates.**

**Priority 1: Increase breast health outreach to African American women living in Cedar Hill, DeSoto Lancaster, and South Dallas.**

**Priority 2: Increase the visibility of breast health resources available to African American women residing in Cedar Hill, DeSoto Lancaster, and South Dallas.**

**Priority 3: Include members of the community in the Affiliate's efforts to eliminate breast health disparities in Cedar Hill, DeSoto Lancaster, and South Dallas.**

**Objective 1:** Beginning in FY16, through the Affiliate community grants program support funding breast health educational outreach programs incorporating the use of community health workers to reach the women residing in Cedar Hill, DeSoto Lancaster, and South Dallas.

**Objective 2:** By the end of FY 18, identify 1-3 groups of influence in the target areas of Cedar Hill, DeSoto, Lancaster and South Dallas to present the 2015 Community Profile findings to.

**Objective 3:** In FY16 develop new, collaborative relationships and meet annually with at least three community-based organizations that serve the women of Cedar Hill, DeSoto Lancaster, or South Dallas.

**Objective 4:** By the end of FY18, partner with at least one community-based organization and a health care institution to provide a culturally appropriate breast health event where women aged 40 and up can sign up to receive a mammogram in either Cedar Hill, DeSoto, Lancaster, or South Dallas.

**Objective 1:** By the end of FY16, create an online mammography calendar detailing all Affiliate funded screening events which will be posted on the Affiliate website.

**Objective 2:** Beginning in FY16, proactively distribute resource listings to at least 30 locations (local businesses, community based organizations, churches, clinics, etc.,) in Cedar Hill, DeSoto Lancaster, and South Dallas each fiscal year in order to increase the visibility of available breast health resources in the Target Areas.

**Objective 1:** By the end of FY18, the Komen Dallas County Board of Directors will include at least one member who resides in either Cedar Hill, DeSoto Lancaster, or South Dallas.

**Objective 2:** By the end of FY18, identify and train at least six volunteers residing in Cedar Hill, DeSoto Lancaster, or South Dallas to support the Affiliate's breast health outreach efforts.

# References

- Baylor University Medical Center at Dallas. (2013). *Community Health Needs Assessment: July 1, 2013 – June 20, 2016*. Retrieved May 7, 2014 from: [http://www.baylorhealth.com/SiteCollectionDocuments/Documents\\_BHCS/Community%20Benefits/FY%202014-2016%20CHNAs/Uploaded%20June%2028/FINAL%20BUMC%20CHNA.pdf](http://www.baylorhealth.com/SiteCollectionDocuments/Documents_BHCS/Community%20Benefits/FY%202014-2016%20CHNAs/Uploaded%20June%2028/FINAL%20BUMC%20CHNA.pdf).
- Cancer Alliance of Texas. (2014). *About The Cancer Alliance of Texas (CAT)*. Retrieved July 29, 2014 from: <http://www.cancerallianceoftexas.org/about/>
- Cancer Prevention Research Institute of Texas (CPRIT). (2014). *About CPRIT*. Available from: <http://www.cprit.state.tx.us/about-cprit/>.
- Cancer Prevention Research Institute of Texas (CPRIT). (2014). *Funded Grants*. Retrieved July 30, 2014 from: <http://www.cprit.state.tx.us/funded-grants/>.
- Cancer Prevention Research Institute of Texas (CPRIT). (2012). *Texas Cancer Plan 2012: A statewide call to action for cancer research, prevention and control*. Available from: [http://www.cprit.state.tx.us/images/uploads/tcp2012\\_web\\_v1.pdf](http://www.cprit.state.tx.us/images/uploads/tcp2012_web_v1.pdf)
- Centers for Disease Control and Prevention (CDC). (2012). *CDC Vital Signs: Breast Cancer*. Available from: <http://www.cdc.gov/vitalsigns/breastcancer/index.html>
- Centers for Disease Control and Prevention (CED). (2014). *National Breast and Cervical Cancer Early Detection Program*. Available from: <http://www.cdc.gov/cancer/nbccedp/about.htm>.
- Center for Medicaid and CHIP Services (CMCS). (2014). *Eligibility*. Retrieved July 29, 2014 from: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Eligibility.html>.
- Dallas Area Rapid Transit (DART). (2013). *DART System Map*. Retrieved July 28, 2014 from: <https://www.dart.org/maps/pdfmaps/DARTSystemMap04nov13.pdf>
- Edwards, J., Pickens, S., Schultz, L., Erickson, N., Dykstra, D. (2012). *Horizons: The Dallas County Community Health Needs Assessment*. Dallas, TX: Dallas County Health and Human Services and Parkland Health and Hospital System. Available from: [http://www.dallascounty.org/department/hhs/documents/FINALCHNA\\_000.pdf](http://www.dallascounty.org/department/hhs/documents/FINALCHNA_000.pdf).
- Executive Office of the President, The: Council of Economic Advisers. (2014). *Missed Opportunities: The Consequences of State Decisions Not to Expand Medicaid*. Available from: [http://www.whitehouse.gov/sites/default/files/docs/missed\\_opportunities\\_medicaid\\_0.pdf](http://www.whitehouse.gov/sites/default/files/docs/missed_opportunities_medicaid_0.pdf)
- Feibel, Carrie. (2014, July 16). Patients With Low-Cost Insurance Struggle To Find Specialists. *Texas Public Radio*. Retrieved from: <http://tpr.org/post/patients-low-cost-insurance-struggle-find-specialists>.
- Google. (2014). Google Maps Transit. Available from: <http://maps.google.com/intl/en/landing/transit/#mdy>.

- HP 2020. Healthy People 2020. US Department of Health and Human Services. December 2, 2010. Available online at <http://www.healthypeople.gov/2020/about/> (accessed 8/2/2013).
- Hunt, B.R., Whitman, S., & Hurlbert, M.S. (2013). Increasing black: white disparities in breast cancer mortality in the 50 largest cities in the United States. *Cancer Epidemiology*, 38, 118-123. doi.org/10.1016/j.canep.2013.09.009.
- Institute of Medicine (U.S.). (2002). *Care without coverage: Too little, too late*. Washington, D.C: National Academy Press. Available from: <http://www.iom.edu/Reports/2002/Care-Without-Coverage-Too-Little-Too-Late.aspx>
- Internal Revenue Service. (2014.). *Questions and Answers on the Premium Tax Credit*. Retrieved July 15, 2014, from: <http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-the-Premium-Tax-Credit>.
- Kaiser Family Foundation. (2014). *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*. Retrieved July 17, 2014 from: <http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.
- Kaiser Family Foundation (2015.) *Health Insurance Coverage of Adults 19-64*. Retrieved February 4, 2015: <http://kff.org/other/state-indicator/adults-19-64/>.
- Kaiser Family Foundation. (2014). *Health Insurance Coverage of the Total Population*. Available from <http://kff.org/other/state-indicator/total-population/>.
- Kaiser Family Foundation. (2014). *The Uninsured Population in Texas: Understanding Coverage Needs and the Potential Impact of the Affordable Care Act*. Retrieved July 17, 2014, from: <http://kff.org/uninsured/report/the-uninsured-population-in-texas-understanding-coverage-needs-and-the-potential-impact-of-the-affordable-care-act/>.
- Methodist Dallas Medical Center. (2013). *Community Health Needs Assessment: September, 2013*. Retrieved May 7, 2014 from <http://www.methodisthealthsystem.org/workfiles/CHNA/Dallas-Community-Health-Needs-Assessment.pdf>.
- National Cancer Institute. (2008). *National Cancer Institute FactSheet: Cancer Health Disparities*. Retrieved May 7, 2014 from <http://www.cancer.gov/cancertopics/factsheet/disparities/cancer-health-disparities>.
- National Center for Health Statistics. (2013.) *Health, United States, 2012: With Special Feature on Emergency Care*. Hyattsville, MD. 2013. Available from <http://www.cdc.gov/nchs/data/hus/hus12.pdf#082>
- SEER Summary Stage. Young, J.L. Jr., Roffers, S.D., Ries, L.A.G., Fritz, A.G., Hurlbut, A.A. (eds). *SEER Summary Staging Manual - 2000: Codes and Coding Instructions*, National Cancer Institute, NIH Pub. No. 01-4969, Bethesda, MD, 2001. Available online at <http://seer.cancer.gov/tools/ssm/> (accessed 8/2/2013).
- Silber, J.H., Rosenbaum, P.R., Clark, A.S., Giantonio, B.J., Ross, R.N...& Fox, K.R. (2013). Characteristics associated with differences in survival among black and white women with breast cancer. *Journal of the American Medical Association*, 310, 389-397. doi:10.1001/jama.2013.8272

- Sun, Lena. (2014, July 16). New challenge for Obamacare: Enrollees who don't understand their insurance plans. *The Washington Post*. Retrieved from: [http://www.washingtonpost.com/national/health-science/new-challenge-for-obamacare-enrollees-dont-understand-their-insurance-plans/2014/07/16/056d044a-fe33-11e3-932c-0a55b81f48ce\\_story.html](http://www.washingtonpost.com/national/health-science/new-challenge-for-obamacare-enrollees-dont-understand-their-insurance-plans/2014/07/16/056d044a-fe33-11e3-932c-0a55b81f48ce_story.html)
- Susan G. Komen. (2014). *Breast Cancer Disparities*. Available from <http://ww5.komen.org/BCDisparities.html>.
- Susan G. Komen. (2013). *Medicaid Expansion Fact Sheet: Texas*.
- Texas Cancer Registry, Cancer Epidemiology and Surveillance Branch, Texas Department of State Health Services. (2014). *Female breast cancers newly-diagnosed in Komen Dallas County service areas [Data file]*.
- Texas Department of State Health Services, Breast and Cervical Cancer Services (BCCS). (2013). *Breast and Cervical Cancer in Texas*. Retrieved July 29, 2014 from: <http://www.dshs.state.tx.us/bcccs/default.shtm>
- Texas Department of State Health Services, Bureau of Vital Statistics. (2014). *Female Breast Cancer Mortality Rates in Komen Dallas County Service Area*. Available from <http://www.dshs.state.tx.us/vs/default.shtm>.
- Texas House of Representatives (2014.) *Texas Legislature Online: Bill Lookup*. Available from: <http://www.legis.state.tx.us/tlodocs/82R/billtext/pdf/HB02102F.pdf>.
- US Centers for Medicare & Medicaid Services. (2014). *Health Insurance Marketplace*. Available from <https://www.healthcare.gov/>.
- US Census Bureau. (2010). *American FactFinder: Community Facts*. Retrieved April 21, 2014 from <http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>.
- US Census Bureau (2010). *State and County QuickFacts*. Retrieved July 29, 2014 from <http://quickfacts.census.gov/qfd/states/48/48113.html>.
- US Department of Health and Human Services Assistant Secretary for Planning and Evaluation (ASPE). (2014). Profile of Affordable Care Act Coverage expansion enrollment for Medicaid/CHIP and the Health Insurance Marketplace 10.1.2013 to 3.31.14: Texas. Retrieved July 30, 2014 from <http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/pdf/tx.pdf>.
- US Department of Health & Human Services Health Resources and Services Administration. (2014). *Find shortage areas: MUA/P by state and county*. Retrieved May 12, 2014 from <http://muafind.hrsa.gov/>