

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



SUSAN G. KOMEN®
SOUTH CAROLINA
MOUNTAINS TO MIDLANDS

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Executive Summary

Introduction to the Community Profile Report

Nancy G. Brinker promised her dying sister, Susan G. Komen, she would do everything in her power to end breast cancer forever. In 1982, that promise became Susan G. Komen® and launched the world's largest grassroots network of breast cancer survivors and activists. Susan G. Komen's promise is to save lives and end breast cancer forever by empowering people, ensuring quality care for all, and energizing science to find the cures. In 1995, the first Race for the Cure® was brought to Greenville, South Carolina. In 2000, the Komen Upstate South Carolina Affiliate was established to serve eleven counties. In 2009, the Affiliate expanded to serve 22 South Carolina counties, and was renamed the Susan G. Komen South Carolina Mountains to Midlands. The Affiliate currently serves Abbeville, Aiken, Anderson, Cherokee, Chester, Chesterfield, Edgefield, Fairfield, Greenville, Greenwood, Kershaw, Lancaster, Laurens, Lexington, McCormick, Newberry, Oconee, Pickens, Richland, Saluda, Spartanburg, and Union counties. Since 1995, the Affiliate has awarded over \$4.6 million in funding to local breast cancer screening, treatment, patient support, and breast health education programs. The Affiliate has also funded more than \$1.67 million in innovative, national breast cancer research in the SC community and around the world.

Some people think of Susan G. Komen only as a large national organization. However, this Affiliate remains small, but strong, by the support of the incredible local community that enables the services provided every year. Every dollar raised makes a difference in the lives of people that live in the 22 county service area. Up to seventy-five percent of net funds raised stays in the local community to fund education, survivor and co-survivor support, screening and treatment programs. The remaining 25 percent funds innovative scientific research in the SC community and around the world. The largest fundraiser each year is the Race for the Cure, which draws more than 4,000 people including participants, survivors, and volunteers. The Race for the Cure series is the largest series of 5K runs/fitness walks in the world. Across the country, more than one hundred Race for the Cure events are held each year, and are expected to attract more than one million participants. The event raises significant funds and awareness for the fight against breast cancer, celebrates breast cancer survivorship, and honors those who have lost their battle with the disease. Whether you run, walk, or just enjoy a beautiful day outside Race participants make a difference. Additionally, the Affiliate holds a number of other fundraising events throughout the year, including the annual Laugh for the Cure, a comedy show celebrating breast cancer survivors and raising funds to support the mission to end breast cancer forever. The Affiliate continues to be a leader and expert in the breast health community. Currently, Affiliate staff continue to be leaders in the following organizations: the Cherokee County Late-Stage Breast Cancer Task Force, South Carolina Cancer Alliance (SCCA), SCCA Advocacy Committee, SCCA Breast Health Committee, Non-Profit Alliance, and The Greenville Chamber of Commerce.

The Community Profile Report was compiled for the purpose of allowing the Affiliate to understand the current challenges and barriers to proper breast health that exist in the local counties. Identifying these needs and directly addressing the issues provide an opportunity for the Affiliate to have a part in decreasing late-stage diagnosis and death rates from breast

cancer for women in the Upstate of South Carolina. The data gathering for the profile included statistics, interviews, focus groups, and assessment of public policy and health systems in the target counties identified in the report. The data and analysis displayed in this report creates a strong foundation for this Affiliate to effectively and efficiently serve the community in the coming years.

The completed report will provide a guide for Affiliate policy and strategy for the next several years. By identifying the areas of greatest need, this report shows the Affiliate where help is most needed in the Upstate. This will affect future grantmaking decisions, partnership opportunities, and education efforts. The report will also create an opportunity to focus upcoming fundraising and outreach events throughout the service counties. The Affiliate will use this report to ensure programs are filling identified gaps in service and education, outreach is targeting at-risk populations, and funds are going to the areas needing the most attention. The impact of this profile will be seen across the community for years to come.

Quantitative Data: Measuring Breast Cancer Impact in Local Communities

The Affiliate seeks to use its limited resources wisely in order to maximize the impact in the community. Selecting five target communities allows the Affiliate to concentrate efforts to intervene in these specific areas during the next four years. In order to be labeled as a target community, the data must show the population as increasingly at risk for increased death rates, high volume of late-stage diagnosis rates, voids in breast health services and/or additional obstacles to proper care.

The Affiliate carefully chose the target communities based on their current inability to meet the goals outlined in the major government initiative, Healthy People 2020 (HP2020). This plan provides definitive health objectives for communities and the country to reach within the next six years. This Affiliate specifically studied the goals of reducing late-stage diagnosis rates and decreasing women's death rate from breast cancer. The action steps outlined in this report reflect the desire to intervene in these communities in order to help them achieve the goals relating to breast cancer in the Healthy People 2020 plan.

The Affiliate also reviewed other key indicators of current trends that are affecting women across the state. In order to accurately select target counties, the elements listed below were also explored:

- Diagnosis of breast cancer incidence rates and trends
- Demographics including race, ethnicity, and age
- Death rates and trends
- Late-stage diagnosis rates and trends
- Screening percentages and trends
- Poverty levels
- Lack of health insurance coverage
- Educational level (less than high school education)
- Designation of rural areas

- Unemployment percentages
- Designation of being medically underserved

The following counties have been selected as target communities:

- Anderson County, South Carolina
- Cherokee County, South Carolina
- Edgefield County, South Carolina
- Greenwood County, South Carolina
- Laurens County, South Carolina

These counties were chosen because they are predicted to miss the HP2020 goals for both late-stage diagnosis rates and breast cancer death rates. Each of these counties is characterized by low educational levels, high unemployment, and high minority populations, and has been labeled as 'high priority' based on the quantitative data presented. Additionally, they are mainly rural areas with limited access to medical care which will be addressed in more detail in the Health Systems Analysis (HSA).

Health Systems and Public Policy Analysis

The health systems identified in these five target counties have several strengths and several areas of weakness as women in these communities move throughout the Continuum of Care. Anderson, Cherokee, Edgefield, Laurens and Greenwood counties each have a strong hospital or cancer facility providing support for screening, diagnostics, treatment options, and follow-up care. However, these facilities do not have the capacity to support the entire female population in their regions. In several cases, these hospitals only provided limited treatment options and minimal follow up care. Other resources such as free clinics, community health centers, diagnostic facilities, and other organizations are necessary to support each step in the Continuum of Care. Anderson and Cherokee Counties possess a higher number of facilities who are providing sufficient screening and diagnostic services compared to other regions noted in this report. However, each of the target counties (Anderson, Cherokee, Edgefield, Greenwood and Laurens) identified by this Affiliate are in need of support and additional services at each level of the Continuum of Care.

Currently, many women in these five counties must travel in order to receive proper care or to have a full range of treatment options and support services. This element of distance to receive adequate care for breast health introduces several other barriers to proper screening and maintaining breast health. There are transportation barriers, potential insurance coverage challenges, and/or availability of hours in these neighboring facilities that impede women's ability to move throughout the Continuum of Care. These complications can significantly affect women's breast health, especially when women and their families are living at or below the federal poverty line.

The long term impact of recent public policy legislation such as the Affordable Care Act cannot be fully identified until the policies have been in place for several years. However, several

elements of the ACA appear to align with core Komen mission goals such as increasing education and patient navigation and increasing health care access for low-income women. Ideally, the individual mandate requiring everyone to own health insurance will make it easier for women to have easy access to the services they need to detect and treat breast cancer in the early stages.

The local National Breast and Cervical Cancer Early Detection Program takes the form of the Best Chance Network (BCN) for South Carolina. This program should benefit from recent legislation and appears to interface well with local Medicaid services by providing access to screening and diagnostic services for women all over the state. Medicaid then picks up coverage of treatment options and follow-up services. As the BCN continues to assist uninsured and underinsured women in South Carolina, this Affiliate will continue to partner with their local representatives and educate constituents about the resources available to them.

South Carolina's Cancer Control Coalition has presented several goals to be achieved by the South Carolina Cancer Alliance (SCCA) by 2015. These goals begin with pursuing additional governmental funding for the BCN in order to decrease the number of women being diagnosed with late-stage breast cancer and the time it takes for them to receive the necessary treatment for their disease. The SCCA also continues to support educational objectives through local community leaders. This Affiliate remains very involved with the public policy efforts of the SCCA through committee participation and local lobby days.

Even with the recent advances in health care legislation, gaps still exist within the coverage for low income women who are navigating through the Continuum of Care. South Carolina's decision not to expand Medicaid leaves a significant number of people in the state who make too much money to qualify for Medicaid but not enough to meet basic insurance needs. The Affiliate needs to be especially aware of those who will be navigating through this space and attempting to find services apart from Medicaid. Additionally, many women who are 65+ experience a gap in coverage for screening services. The Affiliate wants to be able to provide assistance to those who do not have the financial ability to get proper screening necessary to maintain proper breast health.

Qualitative Data: Ensuring Community Input

The qualitative portion of this report gathered community input from each target county through interviews of health care professionals, focus groups, and a survey of providers. These collection methods allowed for various perspectives and responses to provide thorough answers to the two key assessment questions.

What barriers exist for women in the target counties to access and move throughout the Continuum of Care?

What factors contribute to the high rates of late-stage diagnosis and death from breast cancer in the target counties?

The answers to these assessment questions identified key areas of concern in each target county. These terms varied from financial and insurance barriers and transportation difficulties to educational gaps and personal fear of results. Some of these challenges presented as barriers to more than one stage of the Continuum of Care, and these concerns present the largest barriers for women in target counties to access and receive proper breast health care and screening.

The data was gathered through six focus groups, 28 key informant interviews, and a survey of providers within Cherokee County. The interviews and focus groups were recorded using detailed notes from either the interviewer or a note-taker in order to retain as many details and quotes as possible. The survey results were identified and managed through the online platform of Survey Monkey. Interview and focus group notes were compiled after the data gathering process in order to effectively identify the main themes from the data.

Greenwood and Edgefield Counties

Each of the five stages of the Continuum of Care were closely studied and present obstacles identified. In the desire to educate women about proper breast health, two major areas were identified in Greenwood and Edgefield Counties: lack of understanding about Clinical Breast Exams and Breast Self-Awareness and a misunderstanding of the necessity of screening for women without a family history of breast cancer. Once women recognize their need for annual screenings, they still have barriers to overcome. Four main impediments emerged for women to receive proper breast cancer screening. Financial and insurance concerns, lack of convenient access, fear of results, and cultural barriers can all prevent women from the recommended evaluations. When seeking diagnostic care, women can face one of three main obstacles in Greenwood and Edgefield Counties. Lack of facilities in Edgefield presents a serious challenge for women in the community, gaps in insurance coverage create financial concerns, and denial and lack of urgency delay important diagnostic testing. Current patients often face additional financial concerns and insurance complications or lack of coverage, transportation challenges, and an overwhelming sense of anxiety connected with a cancer diagnosis. These counties also do not have more than a handful of organizations offering support care and follow up services, so lack of access is a common barrier for women. Additionally, many individuals expressed a desire to see additional resources used to expand patient navigation in these areas.

The qualitative data provided several key conclusions for consideration. All the statements below refer specifically to women, age 40+, who are residents of Greenwood and Edgefield Counties. The statements come directly from the data gathered in these two counties.

- *Women need to be educated about the significance of Clinical Breast and Breast Self-Awareness and importance of annual screenings regardless of family history.*
- *Women face financial and insurance based concerns that keep them from receiving proper screening and treatment for breast cancer.*
- *Transportation difficulties create frequent pragmatic barriers for women to receive screenings, diagnostic services, treatment, and support services.*

- *Current support services, including financial assistance, survivorship programs, patient navigation, etc., are not enough to provide for the women who have been diagnosed with cancer.*

Anderson and Laurens Counties

The data presented current barriers within each of the five elements of the Continuum of Care in Anderson and Laurens Counties. Two common misconceptions about breast health were identified as obstacles to proper education in the community. Currently, there is confusion about the proper age to begin receiving annual screenings and misinformation about the importance of screenings regardless of family history of the disease. While pursuing the necessary screening, women often face one or more of the four barriers identified in this report. Gaps in insurance coverage or lack of any insurance coverage, socioeconomic barriers, lack of convenient access and fear of results can all impact a woman's ability to make and keep a screening appointment. If further testing is needed, women often face transportation difficulties and gaps in coverage for necessary procedures. Current patients in Anderson and Laurens Counties must overcome the financial and insurance concerns that often come hand-in-hand with a breast cancer diagnosis, and women in Laurens County face the daunting task of travelling out of the county for any form of treatment. Additionally, limited support and follow-up care in these counties allow the financial, emotional, and pragmatic challenges for patients to become larger in the face of an uncertain future. To answer the second assessment question, the key factors contributing to high rates of late-stage diagnosis in these counties were identified as financial and insurance concerns, transportation to appointments, lack of proper breast health education, and fear of results.

The qualitative data from these counties provided several conclusions for consideration. The following statements are specific to women age 40+ who are current residents of Anderson and Laurens Counties.

- *Women need proper breast health education about the recommended age to begin screening and the importance of mammograms even without a personal family history of the disease.*
- *Insurance and financial concerns, lack of accessible transportation, and personal fear often impede women's ability to receive necessary annual screenings.*
- *Laurens County specific: Traveling out of the county for cancer treatment creates a substantial barrier for current patients to overcome both practically and financially.*
- *Women need expanded follow-up and support services, especially in the area of patient navigation for current patients.*

Cherokee County

The assessment questions studied in this report looked at the barriers present in the Continuum of Care. Key obstacles were identified in each of the five stages, beginning with education. Women in Cherokee County must overcome misinformation from their doctors, lack of understanding about the necessity of mammograms, and a general distrust of the medical profession. These barriers keep many women from being proactive about their annual screenings. Before they actually receive those screenings, many women must address financial

and insurance concerns, lack of access, and fear of potential test results. If further testing is needed, many women are fearful of what the testing will find, have difficulty affording testing not covered through insurance, and sometimes have transportation concerns when traveling to appointments. Women in the county also face transportation and financial difficulties when entering into treatment after a diagnosis of breast cancer. Also, lack of resources in the county mean there are limited follow-up and support services available for current patients and survivors. The main factors contributing to the significantly higher rates of death and late-stage diagnosis were identified as lack of proper breast health education, low screening compliance, financial concerns, and lack of convenient access to treatment.

The qualitative data leads to several conclusions statements about Cherokee County for further analysis. The statements below are addressing women over 40 who are residents of Cherokee County.

- *Lack of correct and complete breast health education in Cherokee County creates obstacles for women to receive proper and timely screenings.*
- *Lack of finances and lack of complete insurance coverage obstruct women from receiving proper diagnostics, treatment, support, and follow-up care.*
- *Traveling for diagnostic testing and treatment creates a substantial barrier for women both pragmatically and financially.*
- *Women need increased support services and follow-up care in order to handle a cancer diagnosis and continue through survivorship.*

Mission Action Plan

The Affiliate problem statements were developed by the Community Profile Coordinator and presented to the Executive Director and Mission Coordinator for approval. From these statements, priorities were created that reflected the concerns facing the target counties and the ability and resources of the Affiliate. These priorities were then ranked through each member voicing their perspective and a consensus was soon reached by every participant. The final combination of problem statements, priorities, and objectives were then approved through the Board of Directors and established as the Affiliate's mission action plan for the next four years.

Problem Statement: Quantitative Data showed women throughout each of the target counties face financial and insurance based concerns that keep them from receiving proper and timely screening and treatment for breast cancer.

Priority #1: *Partner with local organizations to provide financial resources for individuals in Cherokee, Laurens, Anderson, Greenwood and Edgefield Counties who are uninsured or underinsured to increase ease of access to screening, diagnostic, and treatment services.*

Objectives:

By the end of 2017, hold at least two grant writing workshops for organizations based in Cherokee, Laurens, Anderson, Greenwood and Edgefield Counties for presenting best practices and evidence based goals in applications.

By 2019, increase grant funding for non-profit organizations providing financial services for low income and uninsured/underinsured women in Anderson, Laurens, Greenwood, Cherokee, and Edgefield Counties.

Partner with at least two additional organizations working from Cherokee, Laurens, Anderson, Greenwood, and/or Edgefield Counties to provide materials, education, and support by the end of 2017.

Reach out to past and potential grant applicants from these counties and encourage future application for funding by 2016 in order to increase grant funding in Cherokee, Laurens, Anderson, Greenwood, and Edgefield Counties.

Seek a medical, non-profit, or public health professional from either Cherokee, Laurens, Anderson, Greenwood or Edgefield Counties to join the Board of Directors by 2018 to ensure the needs of these communities are being represented.

Problem Statement: According to the Quantitative Data, Anderson, Cherokee, Greenwood and Laurens counties are unlikely to meet the HP2020 goals for both breast cancer death and late-stage incidence rates, and Edgefield County is not likely to meet the late-stage incidence rate by 2020.

The Qualitative Data showed a lack of correct and complete breast health education creates obstacles for women in Anderson, Laurens, Greenwood, Edgefield, and Cherokee Counties to receiving proper and timely screenings.

Priority #2: *Reduce the rate of late-stage diagnosis in Anderson, Cherokee, Greenwood, Edgefield, and Laurens Counties through proper breast health education.*

Objectives:

Educate women in Anderson, Cherokee, Greenwood, Edgefield, and Laurens Counties through updated literature and information provided through health fairs and the Pink Sunday campaign to teach proper Breast Self-Awareness and proper screening beginning in September 2015 and continuing annually until 2019.

By the end of 2018, seek a partnership to create a pilot program in local school(s) from Anderson, Laurens, or Cherokee county that educates young women about Breast Self-Awareness in order to influence the next generation and clarify current breast health misconceptions.

Reach out to at least one organization (church, school, cancer association, etc.) in Anderson, Laurens, Cherokee, Greenwood, and Edgefield Counties to hold breast cancer community outreach presentations by the end of 2018.

By the end of 2019, increase grant funding for education and proper screening programs for organizations servicing the Anderson, Laurens, Cherokee, Greenwood and Edgefield Counties.

Problem Statement: The Qualitative Data revealed that women in Edgefield, Laurens, and Greenwood Counties have severely limited access to patient navigation and other essential support services. Anderson and Cherokee Counties provide various support services, but the programs cannot reach all of the women in the communities.

Priority #3: *Promote expansion of patient navigation services in Anderson, Laurens, Greenwood, Edgefield, and Cherokee Counties.*

Objectives:

Increase grant funding to organizations providing or building patient navigation in Anderson, Laurens, Greenwood, Edgefield and Cherokee Counties by 2019.

By the end of 2018, work with existing grantees in Anderson, Laurens, Greenwood, Edgefield, and Cherokee Counties to strengthen patient navigation programs and create a measurable system of evaluation.

Engage and educate grantees and partner organizations in Anderson, Laurens, Greenwood, Edgefield and Cherokee Counties about the impact of public policy developments and the upcoming changes and challenges resulting from them by the end of 2019.

By the end of 2017, ensure partner organizations and grantees in Anderson, Laurens, Greenwood, Edgefield, and Cherokee Counties are educated about services offered by nearby organizations in order to create a depth of knowledge about existing assistance already the surrounding communities.

Problem Statement: The Health Systems Analysis and Qualitative Data showed women in Laurens and Edgefield Counties do not have local facilities for treatment following a diagnosis and women in Anderson, Laurens, Greenwood, Cherokee and Edgefield Counties struggle to obtain consistent and reliable methods of transportation for appointments.

Priority #4: *Decrease transportation barriers for individuals in Anderson, Laurens, Cherokee, Greenwood, and Edgefield Counties to gain access to screening, diagnostic, and treatment services.*

Objectives:

Encourage local hospital systems to expand diagnostic and treatment services to Laurens and Edgefield Counties through advocacy and influence by 2019.

Increase funding for mobile mammography units who service the Anderson, Laurens, Greenwood, Cherokee and/or Edgefield Counties by the end of 2019.

Disclaimer: Comprehensive data for the Executive Summary can be found in the 2015 Susan G. Komen® South Carolina Mountains to Midlands Community Profile Report.

Introduction

Affiliate History

Nancy G. Brinker promised her dying sister, Susan G. Komen, she would do everything in her power to end breast cancer forever. In 1982, that promise became Susan G. Komen for the Cure® and launched the world's largest grassroots network of breast cancer survivors and activists. Susan G. Komen's promise is to save lives and end breast cancer forever by empowering people, ensuring quality care for all, and energizing science to find the cures. In 1995, the first Upstate Race for the Cure® was brought to Greenville, South Carolina. In 2000, the Komen Upstate South Carolina Affiliate was established to serve eleven counties. In 2009, the Affiliate expanded to serve 22 South Carolina counties, and was renamed the Susan G. Komen® South Carolina Mountains to Midlands. The Affiliate currently serves Abbeville, Aiken, Anderson, Cherokee, Chester, Chesterfield, Edgefield, Fairfield, Greenville, Greenwood, Kershaw, Lancaster, Laurens, Lexington, McCormick, Newberry, Oconee, Pickens, Richland, Saluda, Spartanburg, and Union counties. Since 1995, the Affiliate has awarded over \$4.4 million in funding to local breast cancer screening, treatment, patient support, and breast health education programs. The Affiliate has also funded more than \$1.45 million in innovative, national breast cancer research in the community and around the world.

Some people think of Susan G. Komen only as a large national organization. However, this Affiliate remains small, but strong, by the support of the incredible local community that enables the services provided every year. Every dollar raised makes a difference in the lives of people that live in the 22 county service area. Seventy-five percent of funds raised stay in the local community to fund education, survivor and co-survivor support, screening and treatment programs. The remaining 25 percent funds innovative scientific research in the community and around the world. The largest fundraiser each year is the Race for the Cure, which draws more than 4,000 people including participants, survivors, and volunteers. The Race for the Cure series is the largest series of 5K runs/fitness walks in the world. Across the country, more than one hundred Race for the Cure events are held each year, and are expected to attract more than one million participants. The event raises significant funds and awareness for the fight against breast cancer, celebrates breast cancer survivorship, and honors those who have lost their battle with the disease. Whether you run, walk, or just enjoy a beautiful day outside Race participants make a difference. Additionally, the Affiliate holds a number of other fundraising events throughout the year, including the annual Laugh for the Cure, a comedy show celebrating breast cancer survivors and raising funds to support the mission to end breast cancer forever. The Affiliate continues to be a leader and expert in the breast health community. Currently, Affiliate staff continues to be leaders in the following organizations: the Cherokee County Late-Stage Breast Cancer Task Force, South Carolina Cancer Alliance (SCCA), SCCA Advocacy Committee, SCCA Breast Health Committee, Non-Profit Alliance, and The Greenville Chamber of Commerce.

Affiliate Organizational Structure

Komen SC Mountains to Midlands is governed by a Board of Directors that sets the vision and direction of all efforts and initiatives for the Affiliate. There are four staff positions (Executive

Director, Marketing and Community Outreach Manager, Mission Coordinator, and Administrative Assistant) that execute the work of the Affiliate. Committees are organized for individual events or fundraising efforts and are essential to the success of the Affiliate. The Organizational Chart in Figure 1.1 represents the structure of Komen SC Mountains to Midlands.

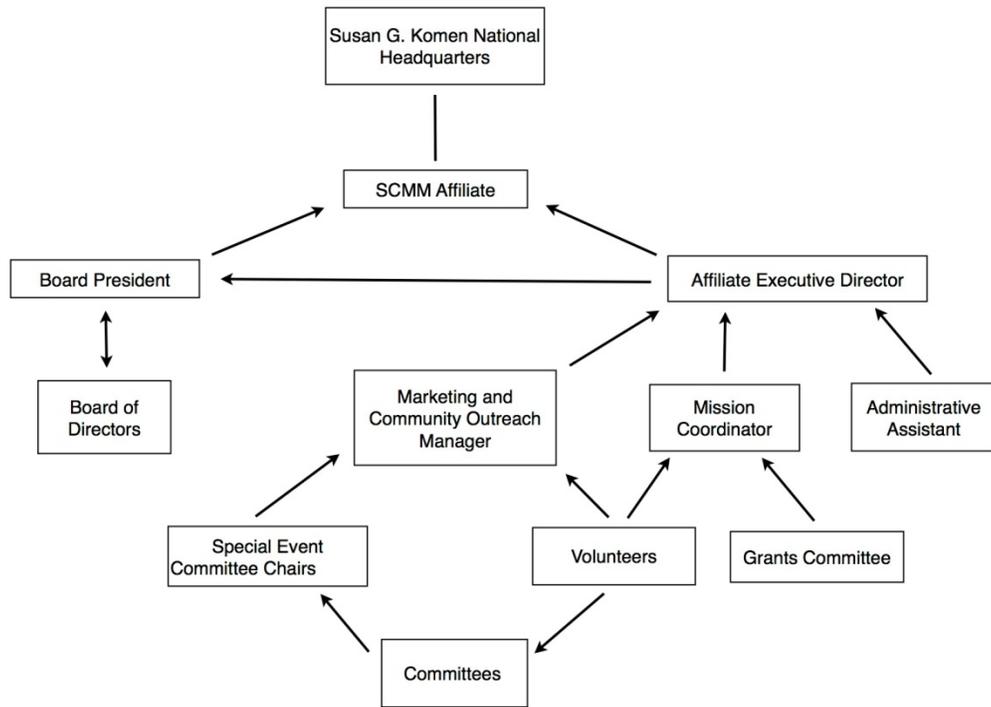
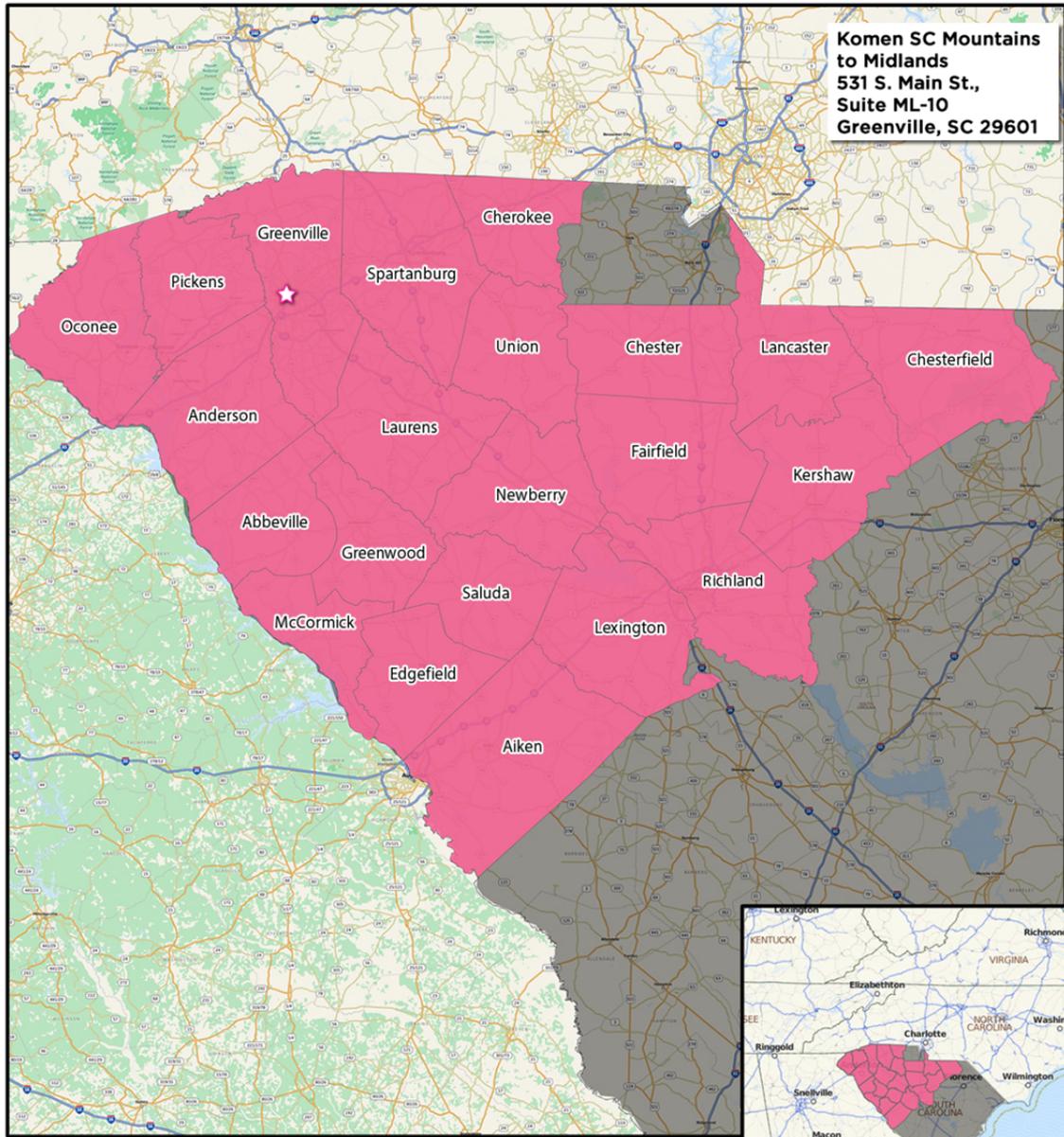


Figure 1.1. Komen SC Mountains to Midlands organizational chart

Affiliate Service Area

Komen SC Mountains to Midlands currently serves 22 counties in the state of South Carolina. As shown and highlighted with pink in Figure 1.2, these counties are Abbeville, Aiken, Anderson, Cherokee, Chester, Chesterfield, Edgefield, Fairfield, Greenville, Greenwood, Kershaw, Lancaster, Laurens, Lexington, McCormick, Newberry, Oconee, Pickens, Richland, Saluda, Spartanburg, and Union.

KOMEN SC MOUNTAINS TO MIDLANDS SERVICE AREA



★ Komen SC Mountains to Midlands Office
 Service Area

Figure 1.2. Susan G. Komen SC Mountains to Midlands service area

These 22 counties are mostly rural in nature and are located in the northwestern half of the state of South Carolina. The total female population of the Affiliate service area is 1,254,891. The main cities are located in Greenville, Spartanburg, Richland, and Anderson Counties. These four areas are decidedly less rural than the other 18 counties in the service area. Of these, Greenville County contains the highest number of women at 224,572. McCormick County has the smallest population of only 4,644 women and the highest percentage of women age 40 and older at 67.8 percent.

The Affiliate service area is predominately White, 71.8 percent, and Black, 26.0 percent, with smaller populations of Hispanic, 4.8 percent, across the area. Fairfield County contains the highest Black/African-American population at 60.5 percent, and Pickens County has the highest White population of 90.8 percent. Abbeville, Chester, Chesterfield, Edgefield, Fairfield, Greenwood, McCormick, Newberry, and Richland all contain higher than average Black/African-American population. While Aiken, Anderson, Cherokee, Greenville, Lancaster, Laurens, Lexington, Oconee, Pickens, and Spartanburg Counties have a higher than average White population. Also, Saluda County has the highest population of Hispanic at 11.8 percent.

The percentage of families in the Affiliate service area living below the poverty level is slightly higher than the national average of 14.3 percent. With an average of 16.4 percent living in poverty, the Affiliate service area also contains an average unemployment percentage of 9.9. Additionally, 16.9 percent of the population have less than a high school education. Chester County has the highest percentage of residents living in poverty at 24.4 percent, while Lexington County has the lowest at 11.6 percent. The number of unemployed is the highest in Chester County with 15.8 percent and the lowest is in Aiken County at 8.3 percent. McCormick County contains a 100.0 percent rural population and all of the residents are considered medically underserved.

Purpose of the Community Profile Report

The Community Profile Report was compiled for the purpose of allowing the Affiliate to understand current challenges and barriers to proper breast health that exist in local counties. Identifying these needs and directly addressing the issues provide an opportunity for the Affiliate to have a part in decreasing late-stage diagnosis and death rates from breast cancer for women in the Upstate and Midlands of South Carolina. The data gathering for the profile included statistics, interviews, focus groups, and assessment of public policy and health systems in the target counties identified in the report. The data and analysis displayed in this report creates a strong foundation for this Affiliate to effectively and efficiently serve the community in the coming years.

The completed report will provide a guide for Affiliate policy and strategy for the next several years. By identifying the areas of greatest need, this report shows the Affiliate where help is most needed in the service area. This will affect future grantmaking decisions, partnership opportunities, and education efforts. The report will also create an opportunity to focus upcoming fundraising and outreach events throughout the service area counties. The Affiliate

will use this report to ensure programs are filling identified gaps in service and education, outreach is targeting at-risk populations, and funds are going to the areas needing the most attention. The impact of this profile will be seen across the community for years to come.

The Community Profile Report will be shared throughout the community through a press release to local media. In the months and years following the official release of the completed profile, the Affiliate will work to ensure this document is in the hands of community leaders across the service counties. This assessment will be used to educate those in the community, including health care workers, political leaders, vulnerable populations, caregivers, local cancer associations, and educators about the current state of breast health in the Upstate and Midlands of South Carolina. Additionally, the Affiliate will use this profile to encourage future advocacy efforts on both the local and state levels. This Community Profile Report serves as a guide to help the Affiliate achieve its mission to save lives and end breast cancer forever.

Quantitative Data: Measuring Breast Cancer Impact in Local Communities

Quantitative Data Report

Introduction

The purpose of the quantitative data report for Susan G. Komen® SC Mountains to Midlands 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® SC Mountains to Midlands' 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	182,234	122.1	-0.2%	40,736	22.6	-1.9%	64,590	43.8	-1.2%
HP2020	.	-	-	-	-	20.6*	-	-	41.0*	-
South Carolina	2,316,194	3,267	122.3	-0.7%	638	23.5	-1.7%	1,212	45.9	-1.0%
Komen SC Mountains to Midlands Service Area	1,254,891	1,791	124.4	-0.6%	348	23.7	NA	655	46.0	-1.5%
White	905,048	1,392	124.4	-0.6%	251	21.4	NA	478	43.6	-1.9%
Black/African-American	325,366	379	123.3	-0.1%	96	32.1	NA	170	54.7	-0.1%
American Indian/Alaska Native (AIAN)	5,080	SN	SN	SN	SN	SN	SN	SN	SN	SN
Asian Pacific Islander (API)	19,398	10	68.9	-0.3%	SN	SN	SN	4	24.2	24.9%
Non-Hispanic/ Latina	1,203,267	1,772	125.4	-0.6%	342	23.6	NA	646	46.3	-1.4%
Hispanic/ Latina	51,624	19	76.8	-8.7%	SN	SN	SN	9	36.6	-17.6%
Abbeville County - SC	13,227	23	137.4	-4.0%	3	20.2	-1.7%	9	53.4	-2.4%
Aiken County - SC	80,761	114	113.9	3.7%	19	18.3	-4.2%	45	46.1	5.4%
Anderson County - SC	95,050	146	127.2	3.3%	30	25.3	-0.2%	54	48.4	4.4%
Cherokee County - SC	28,224	37	110.2	3.8%	8	26.4	0.3%	17	51.0	3.7%
Chester County - SC	17,165	26	121.9	1.2%	7	31.9	0.4%	9	44.2	-8.3%
Chesterfield County - SC	23,730	29	100.8	-6.1%	7	23.8	-2.6%	11	39.5	10.1%
Edgefield County - SC	12,269	19	122.3	-1.6%	4	25.6	NA	7	46.5	8.2%
Fairfield County - SC	12,582	21	140.3	-5.6%	3	23.0	-2.4%	7	47.4	-17.9%
Greenville County - SC	224,572	313	124.5	-1.4%	59	22.8	-1.9%	109	43.4	-4.8%
Greenwood County - SC	36,513	59	135.7	2.1%	13	28.0	-2.5%	22	51.5	6.8%
Kershaw County - SC	30,961	47	122.3	-1.3%	8	21.3	-3.4%	18	46.7	-2.2%
Lancaster County - SC	36,562	52	112.5	-0.8%	9	17.9	-1.9%	20	43.6	0.1%
Laurens County - SC	34,535	53	125.2	2.0%	13	31.7	-0.3%	21	51.0	8.3%
Lexington County - SC	129,402	180	125.8	-0.7%	34	23.8	-1.3%	61	43.1	-0.3%
McCormick County - SC	4,644	9	109.2	5.4%	SN	SN	SN	SN	SN	SN
Newberry County - SC	19,062	31	133.7	0.3%	7	28.4	-1.2%	11	49.0	-11.5%
Oconee County - SC	36,962	65	124.5	-1.3%	11	20.3	-1.6%	23	45.9	-9.6%
Pickens County - SC	58,998	76	117.7	0.5%	12	18.7	-1.9%	25	39.8	-6.1%
Richland County - SC	191,496	260	138.1	-2.4%	47	25.7	-1.8%	100	52.5	-6.8%

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)
Saluda County - SC	9,719	13	109.1	-16.7%	3	27.5	-1.4%	5	43.7	-23.2%
Spartanburg County - SC	143,221	199	121.5	-2.0%	41	23.9	-2.2%	71	43.5	2.4%
Union County - SC	15,235	18	92.2	13.3%	5	24.4	-2.0%	8	38.9	27.2%

*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 SC Mountains to Midlands service area was slightly higher than that observed in the US as a whole and the incidence trend was slightly lower than the US as a whole. The incidence rate and trend of the Affiliate service area were not significantly different than that observed for the State of South Carolina.

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

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

- Richland County

The incidence rate was significantly lower in the following counties:

- Chesterfield County
- Union County

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

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

Death rates and trends summary

Overall, the breast cancer death rate in the Komen SC Mountains to Midlands service area was slightly higher than that observed in the US as a whole and the death rate trend was not available for comparison with the US as a whole. The death rate of the Affiliate service area was not significantly different than that observed for the State of South Carolina.

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

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

- Aiken County

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

Late-stage incidence rates and trends summary

Overall, the breast cancer late-stage incidence rate in the Komen SC Mountains to Midlands 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 and trend of the Affiliate service area were not significantly different than that observed for the State of South Carolina.

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

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

- Richland County

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

Mammography Screening

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

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

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

*As of October 2015

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

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

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

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

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

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

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

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

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

Population Group	# of Women Interviewed (Sample Size)	# w/ Self-Reported Mammogram	Proportion Screened (Weighted Average)	Confidence Interval of Proportion Screened
US	174,796	133,399	77.5%	77.2%-77.7%
South Carolina	5,066	3,875	74.7%	73.1%-76.2%
Komen SC Mountains to Midlands Service Area	2,205	1,680	73.7%	71.3%-76.0%
White	1,638	1,230	72.4%	69.7%-75.0%
Black/African-American	521	419	80.8%	75.7%-85.0%
AIAN	12	6	43.6%	16.8%-74.7%
API	SN	SN	SN	SN
Hispanic/ Latina	28	17	67.4%	37.7%-87.6%
Non-Hispanic/ Latina	2,134	1,632	73.8%	71.3%-76.1%
Abbeville County - SC	71	56	83.1%	70.8%-90.9%
Aiken County - SC	227	176	73.5%	65.5%-80.1%
Anderson County - SC	168	129	74.5%	65.3%-82.0%
Cherokee County - SC	25	17	67.8%	43.4%-85.3%
Chester County - SC	10	5	38.4%	10.4%-76.9%
Chesterfield County - SC	33	21	60.7%	41.2%-77.3%
Edgefield County - SC	91	73	73.9%	61.5%-83.3%
Fairfield County - SC	47	38	91.3%	74.7%-97.4%
Greenville County - SC	294	219	69.5%	62.5%-75.7%
Greenwood County - SC	95	77	83.3%	70.8%-91.1%
Kershaw County - SC	47	39	84.6%	68.5%-93.3%
Lancaster County - SC	32	21	58.0%	38.5%-75.3%
Laurens County - SC	94	68	78.0%	64.2%-87.5%
Lexington County - SC	110	88	77.4%	67.1%-85.2%
McCormick County - SC	SN	SN	SN	SN
Newberry County - SC	25	19	79.7%	58.1%-91.7%
Oconee County - SC	69	51	71.2%	56.8%-82.3%
Pickens County - SC	61	46	68.7%	55.2%-79.6%
Richland County - SC	351	285	82.6%	76.4%-87.4%
Saluda County - SC	71	46	47.1%	32.4%-62.3%
Spartanburg County - SC	257	187	72.4%	64.7%-78.9%
Union County - SC	27	19	68.6%	49.1%-83.3%

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 SC Mountains to Midlands service area was **significantly lower** than that observed in the US as a whole. The screening proportion of the Affiliate service area was not significantly different than the State of South Carolina.

For the United States, breast cancer screening proportions among Blacks/African-Americans are similar to those among Whites overall. APIs have somewhat lower screening proportions than Whites and Blacks/African-Americans. Although data are limited, screening proportions among AIANs are similar to those among Whites. Screening proportions among Hispanics/Latinas are similar to those among Non-Hispanic Whites and Blacks/African-Americans. For the Affiliate service area as a whole, the screening proportion was significantly higher among Blacks/African-Americans than Whites and not significantly different among AIANs than Whites. There were not enough data available within the Affiliate service area to report on APIs so comparisons cannot be made for this racial group. The screening proportion among Hispanics/Latinas was not significantly different than among Non-Hispanics/Latinas.

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

- Saluda County

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

- Richland County

The remaining counties had screening proportions that were not significantly different than the Affiliate service area as a whole or did not have enough data available.

Population Characteristics

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

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

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

- The race, ethnicity, and age data are based on the total female population in the area (e.g. the percent of females over the age of 40).
- The socioeconomic data are based on all the people in the area, not just women.
- Income, education and unemployment data don't include children. They're based on people age 15 and older for income and unemployment and age 25 and older for education.

- The data on the use of English, called “linguistic isolation”, are based on the total number of households in the area. The Census Bureau defines a linguistically isolated household as one in which all the adults have difficulty with English.

Table 2.4. Population characteristics – demographics

Population Group	White	Black /African-American	AIAN	API	Non-Hispanic /Latina	Hispanic /Latina	Female Age 40 Plus	Female Age 50 Plus	Female Age 65 Plus
US	78.8 %	14.1 %	1.4 %	5.8 %	83.8 %	16.2 %	48.3 %	34.5 %	14.8 %
South Carolina	68.2 %	29.6 %	0.5 %	1.6 %	95.4 %	4.6 %	49.5 %	36.0 %	15.5 %
Komen SC Mountains to Midlands Service Area	71.8 %	26.0 %	0.4 %	1.7 %	95.2 %	4.8 %	49.2 %	35.5 %	15.3 %
Abbeville County - SC	69.6 %	29.6 %	0.3 %	0.5 %	99.0 %	1.0 %	54.4 %	41.3 %	18.7 %
Aiken County - SC	72.0 %	26.2 %	0.6 %	1.1 %	95.6 %	4.4 %	52.4 %	38.9 %	17.2 %
Anderson County - SC	81.2 %	17.5 %	0.3 %	1.0 %	97.2 %	2.8 %	51.4 %	37.6 %	16.9 %
Cherokee County - SC	76.7 %	22.2 %	0.4 %	0.7 %	96.7 %	3.3 %	49.2 %	35.3 %	15.5 %
Chester County - SC	59.5 %	39.5 %	0.4 %	0.5 %	98.7 %	1.3 %	52.6 %	38.4 %	16.6 %
Chesterfield County - SC	64.3 %	34.6 %	0.7 %	0.5 %	97.2 %	2.8 %	51.0 %	36.6 %	15.5 %
Edgefield County - SC	62.0 %	37.2 %	0.3 %	0.4 %	97.3 %	2.7 %	54.5 %	40.1 %	16.7 %
Fairfield County - SC	38.8 %	60.5 %	0.3 %	0.4 %	98.4 %	1.6 %	54.9 %	41.1 %	16.8 %
Greenville County - SC	77.7 %	19.4 %	0.5 %	2.4 %	92.5 %	7.5 %	47.9 %	34.0 %	14.5 %
Greenwood County - SC	65.0 %	33.4 %	0.5 %	1.0 %	95.1 %	4.9 %	49.0 %	35.9 %	16.8 %
Kershaw County - SC	72.2 %	26.6 %	0.4 %	0.8 %	96.6 %	3.4 %	52.6 %	38.3 %	16.0 %
Lancaster County - SC	74.5 %	24.3 %	0.4 %	0.9 %	96.0 %	4.0 %	52.5 %	39.0 %	17.9 %
Laurens County - SC	72.1 %	27.0 %	0.3 %	0.6 %	96.2 %	3.8 %	52.4 %	38.3 %	17.2 %
Lexington County - SC	81.8 %	15.9 %	0.5 %	1.8 %	95.1 %	4.9 %	48.9 %	34.5 %	13.8 %
McCormick County - SC	50.1 %	49.2 %	0.1 %	0.5 %	99.1 %	0.9 %	67.8 %	56.4 %	28.8 %
Newberry County - SC	66.2 %	32.4 %	0.7 %	0.7 %	93.3 %	6.7 %	52.3 %	39.4 %	18.4 %
Oconee County - SC	90.5 %	8.4 %	0.3 %	0.8 %	95.8 %	4.2 %	56.6 %	44.0 %	21.0 %
Pickens County - SC	90.8 %	7.5 %	0.2 %	1.6 %	97.1 %	2.9 %	46.8 %	34.2 %	15.5 %
Richland County - SC	48.1 %	48.8 %	0.4 %	2.7 %	95.7 %	4.3 %	43.2 %	29.9 %	11.5 %
Saluda County - SC	68.7 %	29.0 %	1.2 %	1.1 %	88.2 %	11.8 %	52.4 %	38.9 %	18.5 %
Spartanburg County - SC	75.0 %	22.3 %	0.4 %	2.3 %	94.6 %	5.4 %	49.2 %	35.4 %	15.4 %
Union County - SC	67.1 %	32.2 %	0.2 %	0.5 %	99.0 %	1.0 %	55.1 %	41.4 %	18.9 %

Data are for 2011.

Data are in the percentage of women in the population.

Source: US Census Bureau – Population Estimates

Table 2.5. Population characteristics – socioeconomics

Population Group	Less than HS Education	Income Below 100% Poverty	Income Below 250% Poverty (Age: 40-64)	Un-employed	Foreign Born	Linguistic-ally Isolated	In Rural Areas	In Medically Under-served Areas	No Health Insurance (Age: 40-64)
US	14.6 %	14.3 %	33.3 %	8.7 %	12.8 %	4.7 %	19.3 %	23.3 %	16.6 %
South Carolina	16.4 %	17.0 %	39.5 %	10.2 %	4.8 %	1.8 %	33.7 %	41.8 %	19.0 %
Komen SC Mountains to Midlands Service Area	16.9 %	16.4 %	38.3 %	9.9 %	4.9 %	1.9 %	32.8 %	27.8 %	18.3 %
Abbeville County - SC	22.9 %	19.6 %	47.2 %	14.2 %	1.5 %	0.3 %	78.6 %	24.5 %	20.2 %
Aiken County - SC	15.6 %	18.5 %	36.9 %	8.3 %	3.2 %	1.4 %	37.0 %	53.7 %	16.8 %
Anderson County - SC	19.3 %	15.8 %	39.1 %	9.9 %	2.6 %	0.9 %	37.9 %	18.5 %	18.5 %
Cherokee County - SC	25.2 %	20.4 %	48.1 %	14.5 %	2.6 %	1.3 %	61.0 %	0.0 %	20.2 %
Chester County - SC	25.3 %	24.4 %	50.3 %	15.8 %	1.0 %	0.4 %	71.8 %	100.0 %	19.9 %
Chesterfield County - SC	25.7 %	22.3 %	53.0 %	11.1 %	2.5 %	1.0 %	73.8 %	100.0 %	23.1 %
Edgefield County - SC	19.2 %	19.4 %	39.4 %	8.8 %	4.4 %	1.3 %	73.3 %	100.0 %	18.7 %
Fairfield County - SC	21.1 %	21.4 %	48.9 %	10.5 %	0.8 %	0.1 %	78.3 %	100.0 %	18.8 %
Greenville County - SC	15.0 %	14.7 %	34.5 %	8.9 %	8.0 %	3.3 %	12.6 %	8.2 %	18.6 %
Greenwood County - SC	19.4 %	19.0 %	41.6 %	11.4 %	4.3 %	2.0 %	39.8 %	10.1 %	19.2 %
Kershaw County - SC	16.7 %	15.8 %	41.9 %	9.3 %	3.2 %	1.1 %	57.7 %	17.1 %	19.5 %
Lancaster County - SC	19.5 %	20.8 %	41.9 %	12.8 %	3.2 %	1.3 %	50.0 %	100.0 %	20.1 %
Laurens County - SC	24.6 %	19.0 %	46.9 %	12.8 %	2.8 %	1.9 %	64.2 %	0.0 %	19.5 %
Lexington County - SC	12.2 %	11.6 %	30.7 %	7.7 %	5.1 %	2.0 %	25.3 %	26.6 %	17.0 %
McCormick County - SC	20.4 %	14.5 %	42.5 %	12.3 %	1.5 %	0.1 %	100.0 %	100.0 %	16.4 %
Newberry County - SC	24.1 %	16.4 %	42.3 %	9.4 %	5.5 %	2.7 %	67.8 %	52.7 %	18.8 %
Oconee County - SC	17.5 %	18.1 %	39.4 %	11.5 %	3.4 %	0.9 %	64.9 %	0.0 %	18.5 %
Pickens County - SC	18.1 %	18.2 %	39.9 %	10.2 %	4.0 %	1.6 %	35.8 %	46.9 %	19.8 %
Richland County - SC	11.2 %	15.9 %	34.5 %	9.8 %	5.5 %	1.6 %	9.1 %	13.7 %	15.6 %
Saluda County - SC	22.8 %	16.7 %	45.2 %	10.1 %	8.3 %	4.1 %	80.5 %	100.0 %	23.4 %
Spartanburg County - SC	19.6 %	16.2 %	40.0 %	10.0 %	5.9 %	2.5 %	27.4 %	17.5 %	19.3 %
Union County - SC	23.4 %	19.7 %	50.9 %	14.8 %	0.6 %	0.5 %	65.4 %	100.0 %	18.6 %

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

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

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

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

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

Population characteristics summary

Proportionately, the Komen SC Mountains to Midlands service area has a substantially smaller White female population than the US as a whole, a substantially larger Black/African-American female population, a substantially smaller Asian and Pacific Islander (API) female population, a slightly smaller American Indian and Alaska Native (AIAN) female population, and a substantially smaller Hispanic/Latina female population. The Affiliate’s female population is slightly older than that of the US as a whole. The Affiliate’s education level is slightly lower than

and income level is slightly lower than those of the US as a whole. There is a slightly larger percentage of people who are unemployed in the Affiliate service area. The Affiliate service area has a substantially smaller percentage of people who are foreign born and a slightly smaller percentage of people who are linguistically isolated. There is a substantially larger percentage of people living in rural areas, a slightly larger percentage of people without health insurance, and a slightly larger percentage of people living in medically underserved areas.

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

- Chester County
- Chesterfield County
- Edgefield County
- Fairfield County
- Greenwood County
- McCormick County
- Newberry County
- Richland County
- Union County

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

- Saluda County

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

- McCormick County
- Oconee County

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

- Abbeville County
- Cherokee County
- Chester County
- Chesterfield County
- Laurens County
- Newberry County
- Saluda County
- Union County

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

- Chester County
- Chesterfield County

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

- Abbeville County
- Cherokee County
- Chester County
- Union County

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

- Saluda County

Priority Areas

Healthy People 2020 forecasts

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

HP2020 has several cancer-related objectives, including:

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

To see how well counties in the Komen SC Mountains to Midlands 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 SC Mountains to Midlands service area with predicted time to achieve the HP2020 breast cancer targets and key population characteristics

County	Priority	Predicted Time to Achieve Death Rate Target	Predicted Time to Achieve Late-stage Incidence Target	Key Population Characteristics
Anderson County - SC	Highest	13 years or longer	13 years or longer	Rural
Cherokee County - SC	Highest	13 years or longer	13 years or longer	Education, employment, rural
Edgefield County - SC	Highest	NA	13 years or longer	%Black/African-American, rural, medically underserved
Greenwood County - SC	Highest	13 years or longer	13 years or longer	%Black/African-American, rural
Laurens County - SC	Highest	13 years or longer	13 years or longer	Education, rural
Lexington County - SC	High	12 years	13 years or longer	
Spartanburg County - SC	High	7 years	13 years or longer	
Union County - SC	High	9 years	13 years or longer	%Black/African-American, education, employment, rural, medically underserved

County	Priority	Predicted Time to Achieve Death Rate Target	Predicted Time to Achieve Late-stage Incidence Target	Key Population Characteristics
Chester County - SC	Medium High	13 years or longer	1 year	%Black/African-American, education, poverty, employment, rural, medically underserved
Chesterfield County - SC	Medium High	6 years	13 years or longer	%Black/African-American, education, poverty, rural, medically underserved
Newberry County - SC	Medium High	13 years or longer	2 years	%Black/African-American, education, rural, medically underserved
Richland County - SC	Medium High	13 years or longer	4 years	%Black/African-American
Saluda County - SC	Medium High	13 years or longer	1 year	%Hispanic/Latina, education, rural, insurance, medically underserved
Aiken County - SC	Medium	Currently meets target	13 years or longer	Medically underserved
Lancaster County - SC	Medium	Currently meets target	13 years or longer	Rural, medically underserved
Abbeville County - SC	Medium Low	Currently meets target	11 years	Education, employment, rural
Fairfield County - SC	Medium Low	5 years	1 year	%Black/African-American, rural, medically underserved
Greenville County - SC	Medium Low	6 years	2 years	
Kershaw County - SC	Medium Low	1 year	6 years	Rural
Oconee County - SC	Low	Currently meets target	2 years	Older, rural
Pickens County - SC	Lowest	Currently meets target	Currently meets target	Medically underserved
McCormick County - SC	Undetermined	SN	SN	%Black/African-American, older, rural, medically underserved

Map of Intervention Priority Areas

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

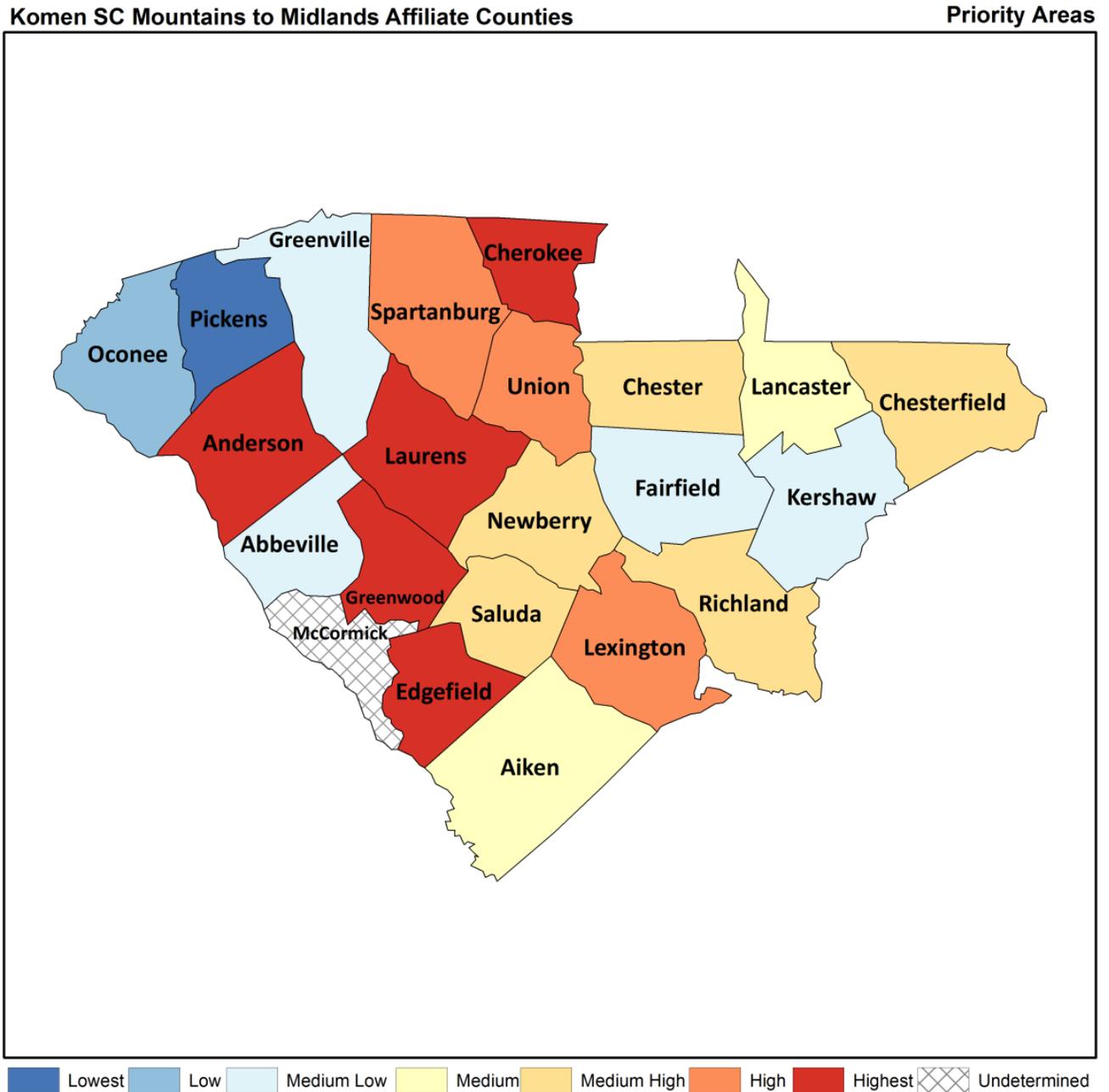


Figure 2.1. Intervention priorities

Data Limitations

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

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

Quantitative Data Report Conclusions

Highest priority areas

Five counties in the Komen SC Mountains to Midlands service area are in the highest priority category. Four of the five, Anderson County, Cherokee County, Greenwood County and Laurens County, are not likely to meet either the death rate or late-stage incidence rate HP2020 targets. One of the five, Edgefield County is not likely to meet the late-stage incidence rate HP2020 target.

Cherokee County has low education levels and high unemployment. Edgefield County has a relatively large Black/African-American population. Greenwood County has a relatively large Black/African-American population. Laurens County has low education levels.

High priority areas

Three counties in the Komen SC Mountains to Midlands service area are in the high priority category. All of the three, Lexington County, Spartanburg County and Union County, are not likely to meet the late-stage incidence rate HP2020 target. Union County has a relatively large Black/African-American population, low education levels and high unemployment.

Selection of Target Communities

Susan G. Komen SC Mountains to Midlands seeks to use its limited resources wisely in order to maximize the impact in the community. Selecting five target communities allows the Affiliate to concentrate efforts to intervene in these specific areas during the next four years. In order to be labeled as a target community, the data must show the population as increasingly at risk for increased death rates, high volume of late-stage diagnosis rates, voids in breast health services and/or additional obstacles to proper care.

The Affiliate carefully chose the target communities based on their current inability to meet the goals outlined in the major government initiative, Healthy People 2020 (HP2020). This plan provides definitive health objectives for communities and the country to reach within the next six years. This Affiliate specifically studied the goals of reducing late-stage diagnosis rates and decreasing women's death rate from breast cancer. All rates presented in the Quantitative Section of this document are per 100,000 people. The action steps outlined in this report reflect the desire to intervene in these communities in order to help them achieve the goals relating to breast cancer in the Healthy People 2020 plan.

The Affiliate also reviewed other key indicators of current trends that are affecting women across the state. In order to accurately select target counties, the elements listed below were also explored:

- Diagnosis of breast cancer incidence rates and trends
- Demographics including race, ethnicity, and age
- Death rates and trends
- Late-stage diagnosis rates and trends
- Screening percentages and trends
- Poverty levels
- Lack of health insurance coverage
- Educational level (less than high school education)
- Designation of rural areas
- Unemployment percentages
- Designation of being medically underserved

The following counties have been selected as target communities:

- Anderson County, South Carolina
- Cherokee County, South Carolina
- Edgefield County, South Carolina
- Greenwood County, South Carolina
- Laurens County, South Carolina

These counties were chosen because they are predicted to miss the HP2020 goals for both late-stage diagnosis rates and breast cancer death rates. Each of these counties is characterized by low educational levels, high unemployment, and high minority populations, and

has been labeled as 'high priority' based on the quantitative data presented. Additionally, they are mainly rural areas with limited access to medical care which will be addressed in more detail in the Health Systems Analysis (HSA).

Demographically, these counties share many characteristics with the entire Mountains to Midlands' service area in South Carolina. As identified by the US Census Bureau, the three largest population groups in the service counties are identified as "White", "Black", or "Hispanic/Latina". The racial makeup of these counties reflect diversity and no single ethnic group stands out as significantly higher than average, with the exception of a higher number of Whites in Anderson county. Also, Edgefield, Greenwood, and Laurens counties have slightly higher rates of Blacks than the average in the Affiliate's service area. Another demographic trend worth noting, all five target communities contain at or slightly above average rates of women of the ages 40 plus, 50 plus, and 60 plus according to both the national average and among the Affiliate's service area. Edgefield County contains the highest of these rates including Cherokee County whose percentages remain right around the average.

The socioeconomic levels in these communities reveal an increasing likelihood of financial and practical barriers to affordable breast health. With the exception of Anderson County, the target areas all contain above average levels of residents functioning at or below the poverty line. All five counties consist of higher levels of those who have not completed high school and all, except Edgefield County, are at or above the national unemployment level. Cherokee County's has the highest unemployment percentage of the five, 14.5 percent. Additionally, all five target communities are significantly rural in nature and three have twice the average amount of residents living in these rural areas.

In the following summary, percentages are used when referring to a section of the population as compared to the total number of people in that community. When the term 'rate' is used, that number refers to the amount of people affected per 100,000 in the targeted area. The difference between these two figures is important to a proper understanding of the quantitative study of these counties.

The Health Systems Analysis (HSA) will create a fuller picture of the services currently available to the women in these communities. The rural nature of these counties and current level of poverty make the identification of free and low-cost services vital to understanding how to reach these women with proper health care.

Anderson County, South Carolina:

Anderson County, South Carolina is a rural area comprised of several small towns located on the border of Georgia in the western area of the state. Containing 98,050 women, Anderson County has the highest new breast cancer incidence rate of the target communities identified and has increased 3.8 percent in the last four years. Of these women, around 80 percent are White, 17.5 percent are Black, and only 2.8 percent are Hispanic/Latina.

Anderson County remains a high priority area for this Affiliate because of the increasing rates of late-stage diagnosis of breast cancer and the number of deaths from breast cancer. These

elements currently put Anderson County on track to miss the HP2020 goals and require significant intervention to stop the ongoing trends. The current death rate of women from breast cancer is slightly higher than the nationwide rate of 22.6 per 100,000 and is currently at 25.3 per 100,000 women in Anderson County. The late-stage diagnosis rate has been increasing the last several years and currently affects a rate of 48.4 of the women in Anderson County. Right now, they will not meet the HP2020 goal of decreasing the late-stage diagnosis to a rate of 41.0 without a significant reversal in the trends.

Many other factors in Anderson County remain around the average for this Affiliate's service area but also signify concerns for those people represented by these numbers. For example, Anderson County currently holds a 9.9 percent unemployment percentage which is higher than the national average of 8.7 percent but in line with the current average for the Affiliate. Also, 15.8 percent of the residents of this county are living below the poverty line which is only slightly higher than the national average of 14.3 percent. The current population contains 18.5 percent of residents who are medically underserved, and this concern guides the Affiliate in the task of reaching as many women as possible in Anderson County.

As women over fifty years of age are at particularly high risk for breast cancer, proper screening remains a vital element to proper breast health. Thankfully, the women in Anderson County are around the national average of those who self-report having a mammogram within the last two years. The current national average is at 77.5 percent, and these women are at 74.5 percent with a confidence interval of around +/-8 points. While the goal is for every woman over 50 to be screened, this study shows a majority of these women in Anderson County are aware of the risks and taking proper precautions.

Because of the increasing rates of late-stage diagnosis in the county; the next step will examine the current services available for low-income women in Anderson. This will clarify the picture surrounding the current trends in data already discussed and identify key gaps or needs in this area. Additionally, the Health Service Analysis will seek to identify if there are any specific geographic populations within Anderson County who make up the 18.5 percent of the medically underserved.

Cherokee County, South Carolina:

Cherokee County, South Carolina is located in the western part of the state and sits on the border of North Carolina. In addition to the 61.0 percent of the population in this county living in a rural area, Cherokee County also includes the larger city of Gaffney. In 2000, the Census Bureau reports 52,537 people residing in Cherokee County, and the average amount of female population is around 28,224. The demographics reflect the average make up of the Affiliate's service area in South Carolina, including 76.7 percent White, 22.2 percent Black, and 3.3 percent Hispanic/Latina.

The increasing late-stage diagnosis rates, new incidence of breast cancer, and death rates from breast cancer in Cherokee County are all above the national average and unlikely to meet the HP2020 goals. Their current late-stage diagnosis rate falls at 51 per 100,000 women which is

significantly higher than the HP2020 target of only 41. Also, the 26.4 death rate from breast cancer remains above the national average of 22.6. The need for intervention and increased attention on this county has determined its status as a target community for this Affiliate.

Other factors in Cherokee County also impact women's ability to gain access to proper health care and treatment. Both the lack of education and higher level of poverty in the county can create a barrier to women's health. Currently, 25.2 percent of the residents in Cherokee County have less than a high school education, and 20.4 percent of the population is living below the poverty line. The 14.5 percent unemployment remains significantly higher than the present 8.7 percent national average. Finally, the current rate of women who self-report having a mammogram within the last year from Cherokee County is only at 67.8 percent and is significantly below the national average of 77.5 percent.

The Health Systems Analysis will explore the ease of access to breast health services, especially for those residing in the rural areas of Cherokee County. It is possible they need additional educational resources to learn about the necessary steps to preventing and treating breast cancer. In order to understand the barriers to early diagnosis and proper screening, the HSA will study the current services offered to low-income, uninsured, and underinsured women in the county.

Edgefield County, South Carolina

Located in the mid-western sector of the state, Edgefield County, South Carolina consists of mainly rural sections and a few small towns across the area. In Edgefield, 62.0 percent of the residents are White, 37.2 percent are Black, and 2.7 percent are Hispanic/Latina. Currently, the female population includes 12,269 women who need direct and easy access to breast health. Overall, 73.3 percent of those living in Edgefield County live in a rural area which can include limited mobility and difficult access to medical care.

Edgefield has been identified as a target community because of several key areas that are currently on track to miss the HP2020 goals. The death rate from breast cancer affects 25.6 of every 100,000 women living in Edgefield, and the HP2020 target rate is at 20.6. Additionally, the late-stage diagnosis rate in the county, 46.5, remains above the stated goal of 41 per 100,000 women. While the numbers of women within Edgefield self-reporting mammograms are on par with the Affiliate average, they are not up to the nationwide median of women.

Edgefield has other concerns considered when being chosen as a target community. The primary challenge remains the lack of medical care available to 100 percent of the residents of this county. Women must be able to receive life-saving screenings before diagnosis and quality treatment and care after a diagnosis in order to increase their chance of survival. Additionally, 19.2 percent of the population holds less than a high school diploma and 19.4 percent are currently living below the poverty level. These statistics aid this report in finding and repairing current flaws and gaps in the health of women in the community.

The primary concern addressed in the Health Systems Analysis will be the identification of any current programs who offer care and service to the women in this community. Since 100 percent of the population is considered medically underserved, the HSA becomes an invaluable tool to providing better breast health services to Edgefield County. Ideally, the HSA will find current health care options that can be expanded into this community easily and/or determine if certain mobile clinics or screening services can be rerouted into Edgefield.

Greenwood County, South Carolina

Greenwood County, South Carolina consists of several unincorporated communities and a few small towns in the western area of the state. The population contains 65 percent White, 33.4 percent Black, and 4.9 percent Hispanic/Latina. The Black/African-American population remains higher in this community than in the Affiliate's service area as a whole. This statistic is important to note because of the increasing rates of breast cancer being diagnosed in minority women across the United States. There are currently 36,513 women living in Greenwood, and 10.1 percent of them are currently medically underserved. Also, 39.8 percent of the residents of the county live in rural areas throughout the region.

There are several significant reasons Greenwood County has been chosen as a target community for this Affiliate. First, the community will not meet the HP2020 goals for either death rates from breast cancer or the late-stage diagnosis estimates. Currently, 28 of every 100,000 women in Greenwood County die from breast cancer, and significant interference is needed to decrease this trend and bring that number down to fewer than 20. Also, women are diagnosed in the late-stages of breast cancer at a rate of 51.5 per 100,000 women. These statistics remain above average in the Affiliate service area and severely off track from reaching the HP2020 goal of a rate of 41. For these reasons, Greenwood County has clear need for assistance and has been labeled a high priority for the Affiliate.

Other key statistics and demographic elements affect the women in Greenwood County. With unemployment at 11.4 percent and 19.0 percent living below the poverty line, families in Greenwood face many challenges that can create barriers to effective medical care. Medical insurance can be invaluable by providing life-saving services to women, but 19.2 percent of the residents age 40-64 in Greenwood are currently without health insurance. Fortunately, the current screening percentages of women in this county are above the national average at 83.3 percent.

By identifying the key health services offered to women in Greenwood County, the HSA will seek to discover what current services are lacking in the community. While surrounding counties offer excellent services, there may be barriers for low-income women to take advantage of these resources. The Health Systems Analysis will map out the service area and identify the geographic locations where the 10.1 percent underserved currently reside.

Laurens County, South Carolina

Located in the middle of the western section of the state, Laurens County, South Carolina consists of primarily rural communities across the area. The average female population remains

around 34,535 as of 2010. The White community comprises 72.1 percent of the county, 27.0 percent are Black, and 3.8 percent are Hispanic/Latina. The Black/African-American population is nearly double the national average, and these women face unique challenges to breast health. Fortunately, in spite of the rural nature, 100 percent of the community currently has access to medical care.

Laurens County was chosen as a target community because of the elevated rates of death from breast cancer and the increasing number of late-stage diagnosis. While the HP2020 goal seeks to decrease the death rate to 20.6, Laurens is currently at 31.7. Also, the county late-stage diagnosis rate settles around 51 which is significantly above the HP2020 rate of 41 per 100,000. The additional factors within the area including a considerably high poverty level, unemployment percentage, and high number of residents lacking of high school education show the importance of devoting resources to this community.

On a positive note, according to the previous data, 78.0 percent of women in Laurens County self-report having a mammogram within the last two years. With a confidence interval of about +/- nine points, this rate is similar to the national average of 77.5 percent and above the average from the Affiliate service area of 73.7 percent. This shows many women are already aware of the need for consistent screening, although there are still more who need an increased awareness about the issue.

The Health Systems Analysis will map out the current gaps in service area and seek to understand the programs available to women in this community. The poverty and unemployment levels could indicate an inability or challenge in accessing transportation to make use of available services. This portion of the report should allow a deeper understanding about the current needs of Laurens County.

Health Systems and Public Policy Analysis

Health Systems Analysis Data Sources

In order to understand the current environment within the targeted counties, the Affiliate must begin with a complete analysis of the available health facilities and the services already provided. Gaining a comprehensive list of existing programs and assistance in the five target counties required the use of numerous data collection techniques.

The Affiliate began using search engines provided through varying governmental programs. The Food and Drug Administration (FDA) maintains a comprehensive list of certified mammogram facilities and identified several clinics and health centers in two of the target counties. The federal Medicare website lists the hospitals registered with Medicare and revealed a few hospitals available in the search areas. The National Association of County and City Health Officials, the Health Resources and Services Administrations, and The National Association of Free and Charitable Clinics also maintain databases of facilities such as local health departments, community health centers, and free clinics. These were extremely helpful sources and gave a great initial survey of services. Although several facilities are located in target counties and provide necessary services, a significant number of the clinics and centers initially identified do not provide specific assistance for breast health and are not included in this Profile.

The existing partnerships with local hospitals and grantees allow the Affiliate access to published materials listing local offerings and services. Additionally, the community involvement of Affiliate staff identified lesser known facilities and provided personal contacts for these centers. These personal connections also led to informative conversations and confirmation of the comprehensive list by health care workers from each county.

The quality of the facilities providing care is also important to ensuring proper health care to women. The next level of data gathering included searching through the databases listing sites who have been accredited through the American College of Surgeons Commission on Cancer, the American College of Radiology Breast Imaging Center of Excellence, the American College of Surgeons National Accreditation Program for Breast Centers, and the National Cancer Institute (NCI) designated cancer centers. While there are no facilities who have obtained the NCI designation, the other three certifications showed several hospitals and screening facilities who have obtained this level of excellence.

The final level of data gathering included internet searches and informal interviews of health care workers in each county to confirm the comprehensive nature of the final list. Several contacts in the community were able to confirm the current listing of facilities was correct and complete. The Affiliate communicated with the majority of the organizations listed by phone to directly confirm services offered and ensure the current nature of the work. As a final step, Internet searches did not reveal any additional programs, at least not any with a presence and visibility on the internet. If there are other services, it would be difficult for women to know about them because of the difficulty locating them through search engines.

Once the list was completed and confirmed, the strengths and weaknesses of the target counties were identified and analyzed. The quantity and quality of organizations in each county was taken into account along with the type of services offered at each location. For example,

several facilities offer Clinical Breast Exams but refer women to other facilities for every other step in the process of screening and identifying potential concerns. These facilities are helpful on an initial level but do not provide enough by themselves for women to access the level of care required for optimal breast health. The Affiliate recognizes the financial and insurance limitations of many women in these rural communities and not every facility offered free or low cost services. These financial concerns factor heavily into the ability of low income and uninsured/underinsured women from accessing services technically offered in their community. Analysis also included determining key gaps in the Continuum of Care, shown in the figure below. Counties could be strong in one or two of the categories (screening, diagnosis, treatment, and follow-up care) but lack sufficient coverage of the remaining phases in the continuum. Two of the counties have so few facilities providing breast health care that there was little data to analyze.

Health Systems Overview

The Breast Health Continuum of Care (CoC) is a model that shows how an individual typically moves through the health care system for breast care (Figure 3.1). An individual 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.

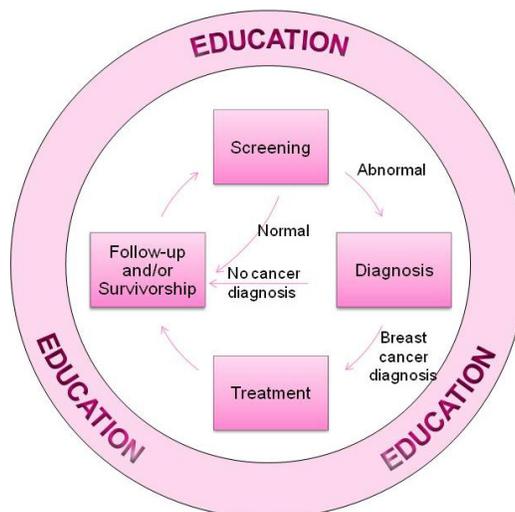


Figure 3.1. Breast Cancer Continuum of Care (CoC)

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

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

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

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

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

The cyclical nature of the diagram illustrates the need for this process to be smooth and uninterrupted, but this ideal method of care has not been experienced by thousands of women across the country. Numerous barriers keep women from receiving vital, life-saving elements of health care services and break this continuum and protection it provides. Language barriers, lack of available transportation, financial concerns including insurance challenges, lack of easily reachable facilities such as community health and certified screening centers, age, modesty, disability, fear, and lack of education all play a part in limiting the access of women to the Breast Health Continuum of Care. The Affiliate uses this model throughout this document to clearly outline the specific areas of weaknesses in the target communities. All of the services offered, or not offered, in these counties fall underneath one of the five categories of services showed in

the continuum. Identifying the gaps within these five phases of care allows the Affiliate to understand specific areas where each target county urgently requires additional resources and/or education in order to better serve the women within the community.

Health Systems Strengths and Weaknesses

Anderson County:

The health systems analysis revealed several strengths in Anderson County (Figure 3.2). There is one main hospital in the community, AnMed Health, providing services within each stage of the continuum of care, screening, diagnostics, treatment, education, and follow-up care. This facility has gained several key quality indicators and remains an essential part of health services in Anderson. Also, the county contains a local facility providing screenings and diagnostic services with quality certifications and a Cancer Association group offering key support/survivorship services. However, with over 95,000 women in the county, these few organizations cannot support the number of women who need quality and timely care.

There are other important weaknesses to note within the continuum of care for women in Anderson County. The most glaring vulnerability comes because only one site is offering any level of treatment options. Also, with a female population of approximately 95,000 in the county, significant need remains for more facilities providing easy and affordable access to screening. Securing more programs providing patient navigation for women who are going through this process could help strengthen the existing instability in this area. Finally, current offerings provide very few options for various support services that are essential for women who are going through treatment.

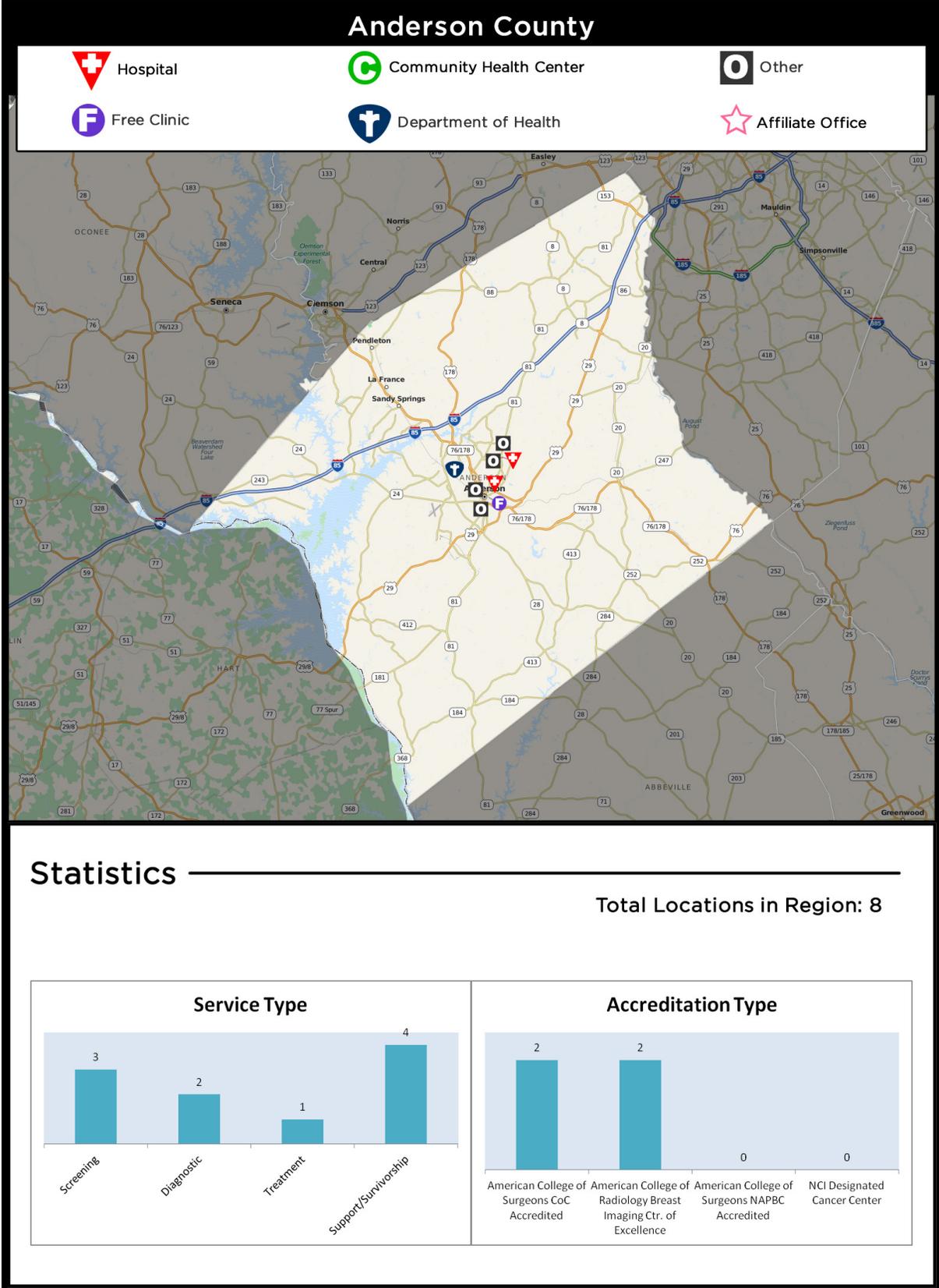


Figure 3.2. Breast cancer services available in Anderson County

Cherokee County:

The health system in Cherokee County contains two main areas of strength (Figure 3.3). First, Gibbs Cancer Center, located in the community, provides services within all five elements of the continuum of care. This facility can be accessed easily by a majority of the community population and also offers financial assistance to qualified patients. This cancer center provides essential, life-giving care to residents of Cherokee County. The second strength comes from the centers providing screening and diagnostic services for women in the area. These three facilities represent two different organizations and give choices for women in the area as they keep up with annual screenings and diagnostic needs as well. However, two of these facilities do not provide financial assistance which could create a barrier for complete coverage.

There are several weaknesses that can impact a woman's ability to travel through the continuum of care with excellent care and minimal challenges. Within Cherokee County, the greatest weaknesses are with the lack of treatment options and the severe lack of follow-up care/support/survivorship services. Currently, only two facilities offer any form of treatment options to women who have been diagnosed with breast cancer and only two others offer support services in any form. Also, only one organization holds any form of certification and identification for the quality of care in their facilities. An additional weakness comes from the geographical location of two facilities servicing Cherokee County. These two cancer centers are located in Spartanburg County which can present transportation and financial barriers to women who have financial difficulties. Finally, with 20.4 percent of the population living below the poverty line, the current health system does not offer significant financial assistance to women in the county. Only one facility currently offers financial assistance to qualified patients, and this can severely impact a low-income woman from successfully navigating through the continuum of care.

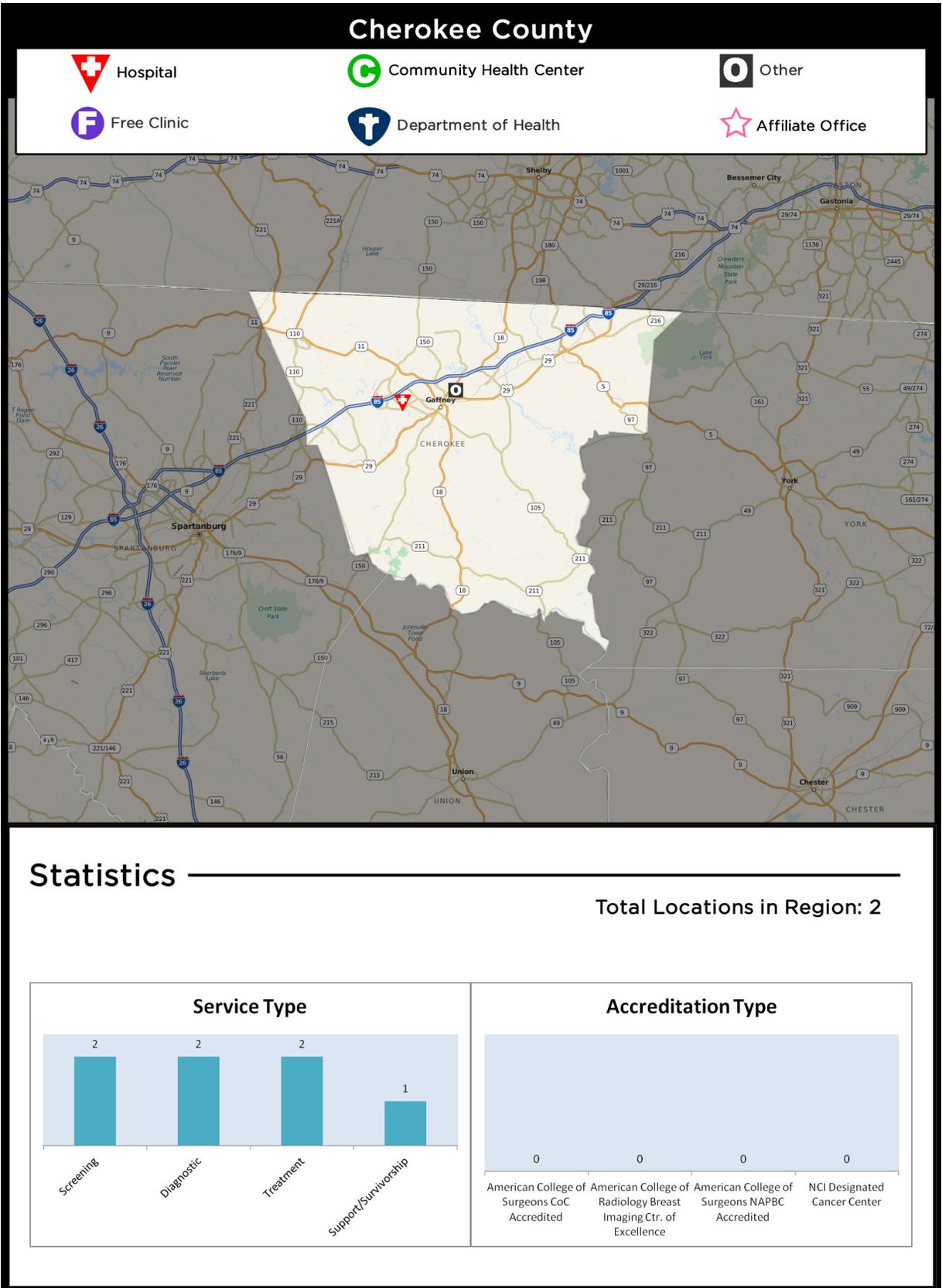


Figure 3.3. Breast cancer services available in Cherokee County

Edgefield County:

Edgefield County has a female population of over 12,000, and 100 percent of the total population are designated as medically underserved. The county is overwhelmingly rural, and currently contains only one hospital providing monthly mammograms through a mobile unit and limited treatment options after a diagnosis (Figure 3.4). Thankfully, Edgefield County Hospital does offer services within each stage of the continuum of care which allows women in the community to have access to essential health services.

However, apart from this hospital, there are no other facilities currently providing for breast health in Edgefield County. This means women have only one facility for screening, diagnostics, treatment, and follow up care. This creates a bleak picture for women who need quality care and assistance to navigate through the continuum of care. With 19.4 percent of the population living below the poverty level, women are in desperate need of financial assistance and support/survivorship services. Currently, the lack of facilities creates several barriers to proper care such as transportation concerns and financial challenges. If women have to travel miles outside of their county to get an annual mammogram, they are unlikely to detect and diagnose breast cancer at the early stages necessary for successful recovery.

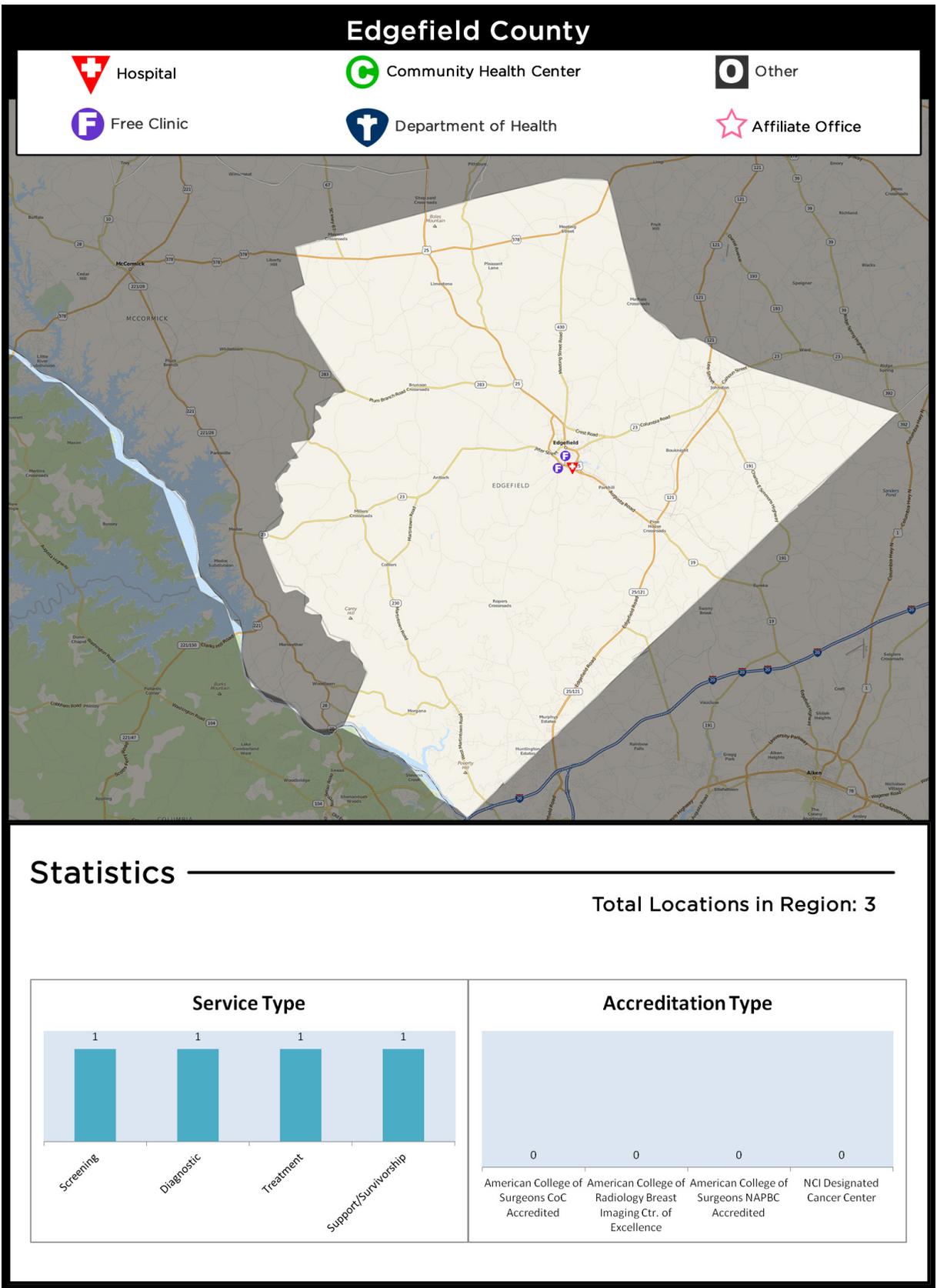
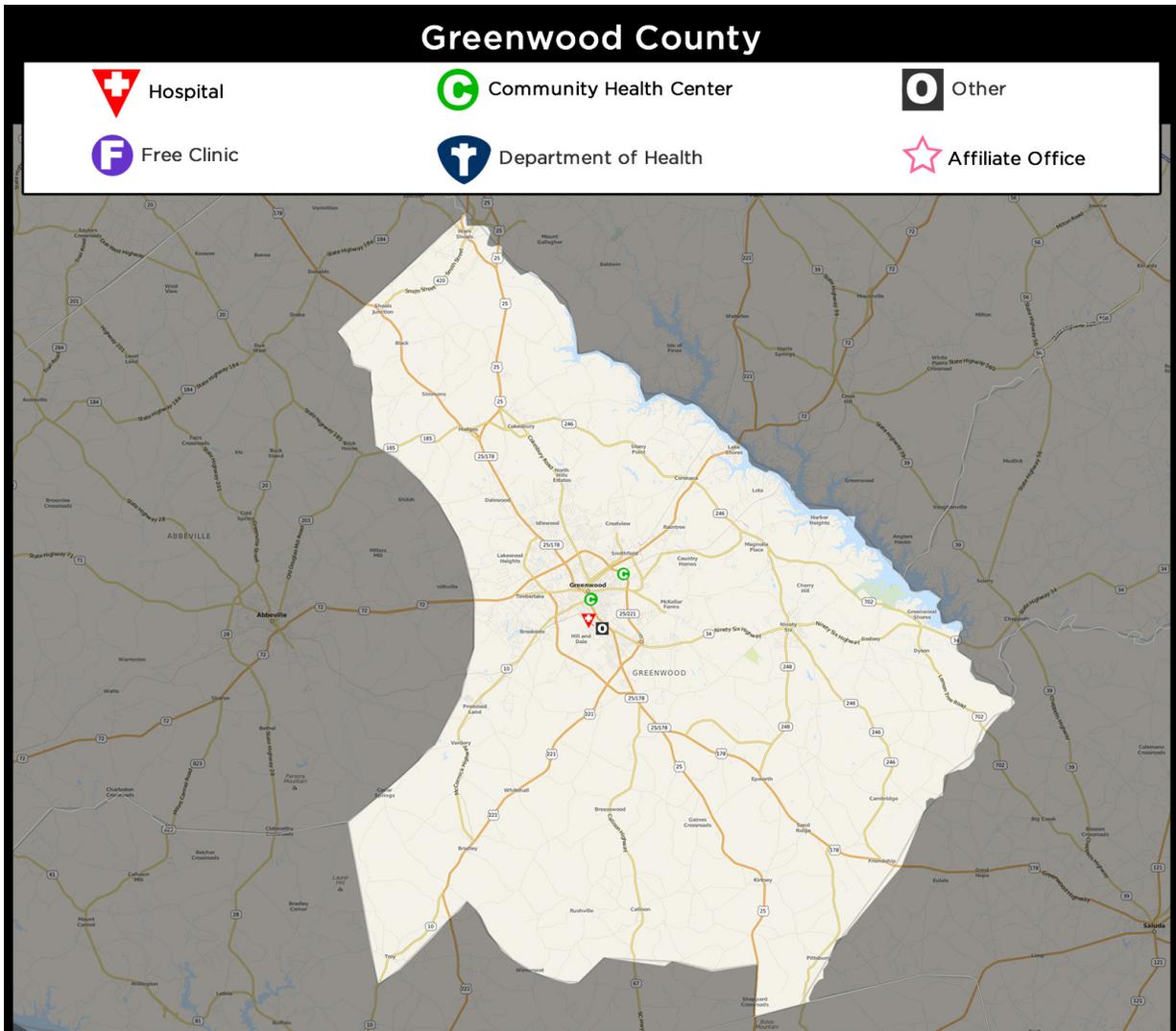


Figure 3.4. Breast cancer services available in Edgefield County

Greenwood County:

The health system in Greenwood County serves approximately 36,513 women which is the second largest of the target counties identified in this report. Currently, one hospital located within the community provides the most complete system of care for these women (Figure 3.5). Self Regional Hospital offers services within each stage of the continuum of care and also operates an additional facility for screening and diagnostics. Both of these centers have key quality of care indicators and are essential to the health of women in the county. Additionally, two community health centers offer clinical breast exams and limited support services within their standard practices. This is a great first step for women who may need further screening, especially for the low income, underinsured in the county.

The key weaknesses within the continuum of care include the lack of local treatment options and support/survivorship services. There is also very little patient navigation in the county for women who may need extra assistance navigation through complicated treatment plans and options. The limited quantity of sites providing screening and diagnostic services could also limit women's ability to receive timely appointments and services. With 19.0 percent of the population living below the poverty level, additional financial assistance is needed within the existing health system of Greenwood County.



Statistics

Total Locations in Region: 5

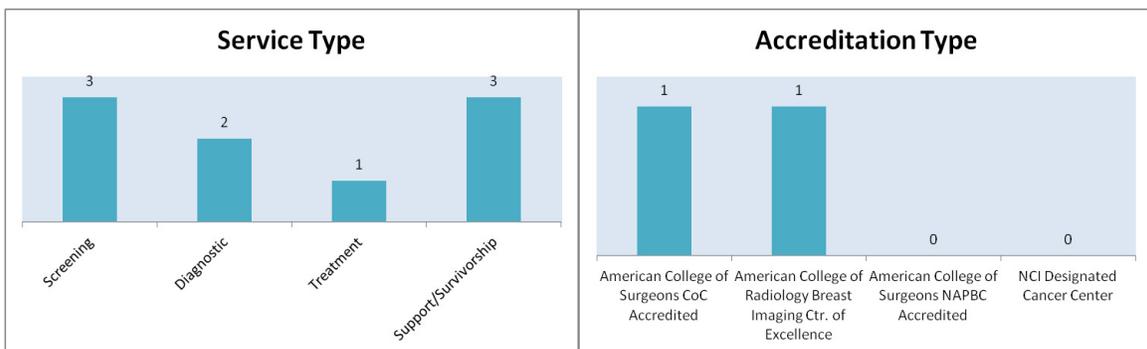


Figure 3.5. Breast cancer services available in Greenwood County

Laurens County:

Containing five facilities, the Laurens County health system is the largest within the target communities identified within this report (Figure 3.6). However, two of these facilities only participate in this analysis because of the clinical breast exam provided during annual physicals. While this is an important initial screening for many women, there are other screening steps that remain essential to breast health. One of the strengths of the current system comes in the form of one local hospital providing screenings, diagnostics, treatment, and support groups. This facility and their community health center work together to provide quick referrals and financial assistance for qualified patients. This is a great assistance to women within Laurens County.

There remain significant weaknesses for women attempting to navigate through the Continuum of Care in Laurens County. First, none of the facilities identified in the county have key qualities indicators and/or certifications. Ideally, these facilities could receive accreditations in order to show their standard of care. Currently, the only facility providing screening mammograms is the local hospital. This has the potential to limit local women in their ability to access lifesaving mammograms. This same hospital is the only provider for diagnostic services in the county and only offers surgery as a treatment option for diagnosed breast cancer. Without any facility providing chemotherapy, radiation, or other therapies, all of the 34,535 women in Laurens County would have no choice but to travel to receive treatment with any stage of breast cancer. Significant needs remain in the area of follow up care and support/survivorship services within the community. After being diagnosed, women need services such as side effect management, complimentary therapies, individual counseling, and other legal and financial assistance. With 19.0 percent of the population living below the poverty level, the area of financial assistance may be the primary concern within this list.

Laurens County



Hospital



Community Health Center



Other



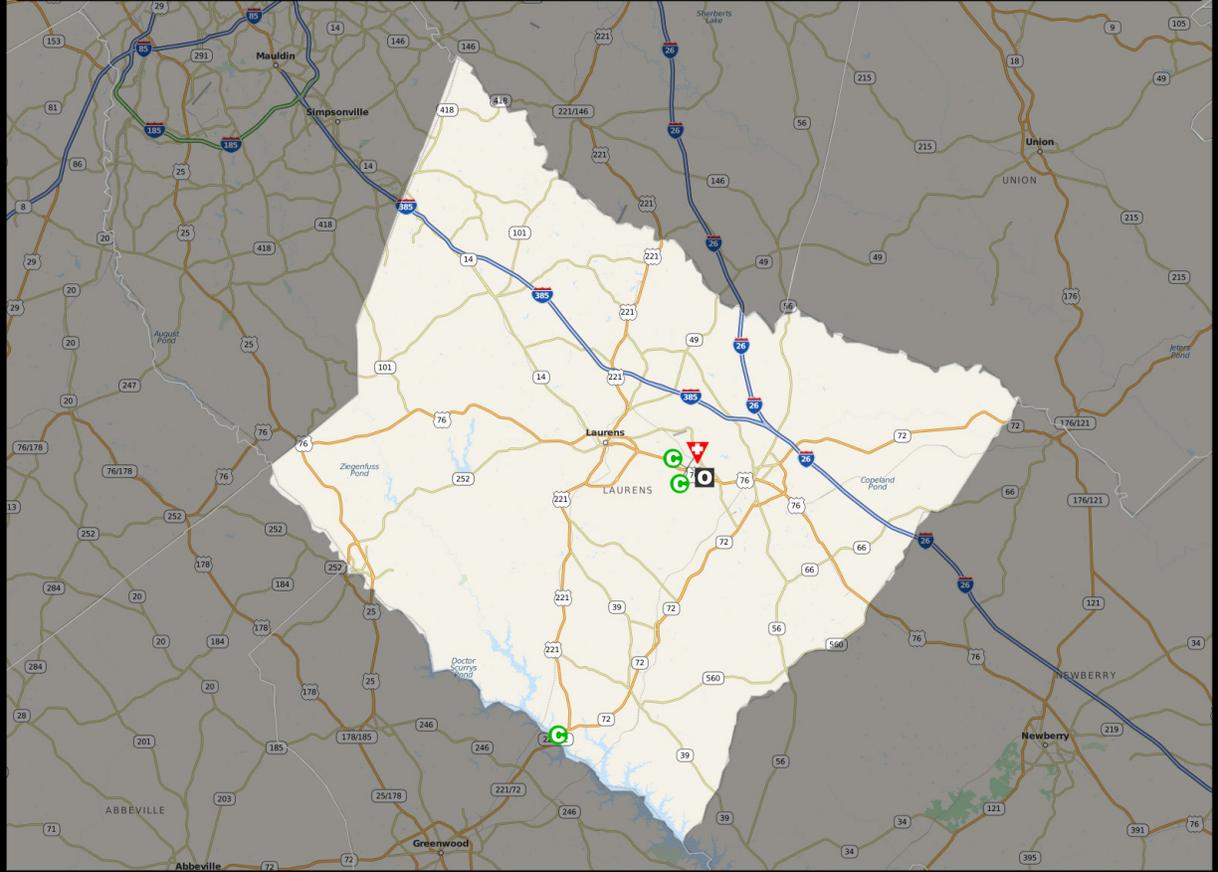
Free Clinic



Department of Health



Affiliate Office



Statistics

Total Locations in Region: 5

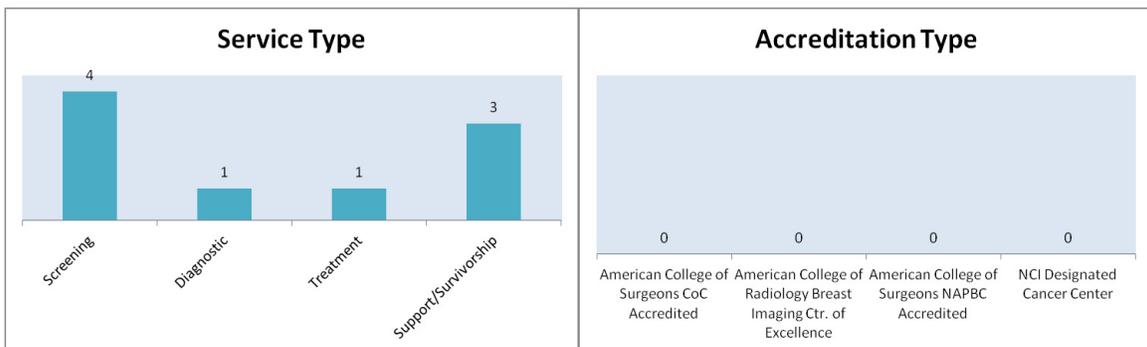


Figure 3.6. Breast cancer services available in Laurens County

Current Mission Related Partnerships

The target community of Anderson County shows a clear need for the Affiliate's presence in the community. For many years, the Cancer Association of Anderson and AnMed Health have been grant recipients, but neither of these organizations currently receives grant funds. Both of these facilities support the Affiliate's annual Pink Sunday initiative, and AnMed Health has been a pick-up site for the program for several years. Pink Sunday uses materials provided by the Affiliate to educate local congregations about the need for breast health screenings, support current patients within their assembly, and recognize survivors.

Cherokee County benefits from grant funds designated for Spartanburg Regional Health care System. Currently, this hospital serves Cherokee County with a mobile mammography unit as well as a second, smaller site located in Cherokee. Also, previous grant funds were given to The Cancer Association of Spartanburg and Cherokee Counties, but they do not currently have a grant. In addition to grant funded relationships, a representative from the Affiliate serves on the Cherokee County Late-stage Breast Cancer Task Force and has for the last five years.

Edgefield County contains the least amount of facilities of the target communities, but the Affiliate does currently have a grant at Lexington Medical Center which services the county through providing free mammograms with a Mobile Mammography Unit. This county needs additional attention to address the lack of facilities for women in this incredibly rural county. In the past, Self Regional Medical Center in Greenwood County has been supplied with grant funds from the Affiliate, but they are not current recipients. With only four facilities identified on the Health Systems Analysis, it becomes clear there are limited chances to connect with organizations in this county because of the scarcity in the area.

Currently, the Affiliate does not have any partnerships in Laurens County. The county is heavily rural and most of the organizations who service the community are located in neighboring areas. There are several opportunities for growth in forging partnerships in this county.

Potential New Partnerships

The Affiliate desires to increase partnership in each of these counties in the upcoming years. While limited resources and grant funds narrow the course of action, the Affiliate believes there are several ways to improve the current relationships in these target communities. There are three main ways the Affiliate hopes to develop new partnerships and strengthen existing relationships in the next several years. Using all three strategies together, all five counties should benefit from this approach.

First, increasing the Pink Sunday presence in all five counties will develop new contacts with community leaders and organizations. The Affiliate can reach out to churches and assemblies to inform them of the program and encourage them to participate. Secondly, previous and potential grantees in Anderson, Cherokee, Edgefield and Greenwood counties will be contacted and invited to submit for grant funds to address the key needs summarized in this profile. This will show these organizations the priority placed on their areas of service and support their efforts in the coming years. Finally, the Affiliate has a strong desire to partner with Laurens County

Cancer Association and other facilities in Laurens County. Since the current partnerships in this area are insufficient, the potential for growth in the county is open wide for the Affiliate.

Public Policy Overview

National Breast and Cervical Cancer Early Detection Program (NBCCEDP)

The National Breast and Cervical Cancer Early Detection Program was created to provide assistance to low-income, uninsured, and underinsured women in gaining access to life saving screening. Research and statistics consistently show the importance of early detection, most often through regular screening, as a key element to survivorship of breast cancer. In the state of South Carolina, the NBCCEDP funds were used to create the Best Chance Network (BCN) to accomplish these same goals of supporting women who would not otherwise be able to afford essential screenings for breast and cervical cancer.

According to their website, the BCN provides “screening services including: clinical breast exams, pelvic exams, Pap tests (if needed) and mammograms; Some diagnostic procedures; Case Management; Community education on breast/cervical cancer and early detection.” The BCN accomplishes this through a network of public and private facilities and providers numbering over 200 across the state. These include “federally-funded primary care centers in the SC Primary Health Care Association; private physicians, including surgeons and gynecologists; laboratories, university sponsored clinics, free clinics, regional medical centers and radiology facilities provide screening and follow up services. American Cancer Society Outreach Workers, volunteers, community partners [including this Affiliate] and members of local task forces also assist women in referring to screening sites.”

Funding for the BCN state program is provided through several government programs. This includes the Centers for Disease Control and Prevention in Atlanta, GA and the state of South Carolina through the Department of Health and Human Services. The program is administrated in coordination with the American Cancer Society.

For a woman in South Carolina to gain services provided by the BCN, several requirements must be met. The program is designed for women who are uninsured or underinsured, between the ages of 40 and 64, and fall below 200 percent of the federal family poverty line. To learn more about the program, the BCN website directs women to call 1-800-227-2345 and ask about the BCN. Currently, there is no online application process made available. Women in South Carolina often learn about these services through recommendation from local facilities, public health offices in their counties, and this Affiliate.

With recent changes in the health care system, women need to be clear about how to access both NBCCEDP and Medicaid services within the state of South Carolina. It is important to note that South Carolina chose Option Three in regards to the Treatment Options in cooperation with the NBCCEDP. This option states “A woman can receive Medicaid services regardless of where she was originally screened, as long as she would otherwise meet the other eligibility requirements.”

In the state of South Carolina, Medicaid has been named “Healthy Connections” and eligibility is determined by factors including age, pregnancy, disability, income and assets, and citizenship or residency. Within Medicaid, their Breast and Cervical Cancer Program directly intersects with the BCN in South Carolina. The requirements for acceptance include age (must be under 65), must have been screened by a physician or through the South Carolina Breast and Cervical Cancer Early Detection Program-Best Chance Network (BCN) and found in need of treatment for one of a specified diagnosis, not have other insurance coverage for the services provided, be at or below 200 percent of the Federal Poverty Level, and not be eligible for other Medicaid service groups.

To cover each stage of the continuum of care, Medicaid’s Breast and Cervical Cancer Program and the Best Chance Network work together to complement each other’s services. The BCN offers assistance in the screening and diagnostic stages, and Medicaid provides support and coverage in the treatment and follow-up stages of the continuum. Once determined as eligible, women in South Carolina have two established programs that provide essential relief from the financial concerns relating to breast health.

This Affiliate partners closely with Best Chance Network in an effort to help individuals in the community enter into and remain in the Breast Health Continuum of Care. Through the partnership with the BCN, the Affiliate works to keep people who need services from “falling through the cracks”. While the local community grants program is directed and governed by the Affiliate and the Affiliate’s evidence-based priorities, these grants also complement the services provided by the BCN. Typically, granted services do not have the same age and income restrictions as the Best Chance Network does. Therefore, the Affiliate is able to provide services to those who otherwise would have no other options. Many of the community grantees provide services funded from the Affiliate as well as the BCN. Thus, an individual in need of services will have a greater likelihood of receiving the care they need whether through the BCN funding or the Affiliate’s local community grants. There is also a reliable referral process in place so that the patient is able to find the services they need. Most women diagnosed through the BCN or through services provided through the Affiliate’s community grants are enrolled in Medicaid for their treatment. The Affiliate continues to encourage the community grant recipients to work with the patient to make this a seamless transition.

The regional representative for the BCN remains very connected with the Affiliate. When applicable, the Affiliate staff is able to refer patients directly to the Affiliate office as well as organizations within the service area in need of support and funding. The Affiliate also partners with the SC DHEC Program Director for the BCN to aid constituents in accessing the program. Both of these partners have come to the Affiliate Lunch and Learn meetings to share about the BCN and available resources with Affiliate grantees.

In the next several years, the Affiliate will maintain the existing relationships with these representatives. The plan for the coming years will focus around improving the way the Affiliate connect grantees with the BCN leaders and services and establishing methods to make constituents more aware of the assistance currently provided through this program. This will

likely mean using the current platform to create informational announcements and campaigns about the BCN.

Comprehensive Cancer Control Coalition

Multiple objectives are revealed in the state's Comprehensive Cancer Control Plan in regards to breast cancer and breast health in South Carolina. The plan calls for these goals to be achieved by 2015 through the South Carolina Cancer Alliance (SCCA), based in Columbia, SC. The Affiliate enjoys a long-standing relationship with the SCCA and works with them for the accomplishment of all nine goals listed below.

The Comprehensive Cancer Control Plan seeks:

- 1. To secure recurring state funding for breast cancer screening through the Best Chance Network program*
- 2. To increase from 83.6 percent to 86 percent the proportion of women age 40 and older who have received a clinical breast exam within the preceding two years*
- 3. To increase from 74.5 percent to 80 percent the proportion of women age 40 and older who have received a mammogram within the preceding two years*
- 4. To reduce the gap in late-stage diagnosis of breast cancer between European Americans and African-Americans from 17.2 percent to 13.8 percent*
- 5. To increase by 20 percent the percentage of women with non-metastatic breast cancer who receive surgical resection*
- 6. To increase by 20 percent the percentage of women under age 70 who receive breast-conserving surgery and radiation therapy within 365 days of their diagnosis*
- 7. To increase by 20 percent the percentage of women under 70 with American Joint Committee on Cancer (AJCC) T1cN0M0, or Stage II or III hormone receptor negative breast cancer for whom combination chemotherapy is considered or administered within 120 days of their diagnosis*
- 8. To increase by 20 percent the percentage of women with AJCC T1cN0M0, or Stage II or III hormone receptor positive breast cancer for whom Tamoxifen or third generation aromatase inhibitor is considered or administered within 365 days of their diagnosis*
- 9. To increase by 20 percent the percentage of patients receiving lumpectomy instead of mastectomy when appropriate*

The SCCA was established to represent the interests of the cancer community as a whole, and their work is not limited to breast cancer. Their organization uses the Healthy People 2020 report to craft their goals for each type of cancer and for each region within the state. One of their main areas of work has been in education and awareness as they teach community leaders how to influence and educate others.

This Affiliate has maintained partnership with the SCCA for many years. Currently, one of the Affiliate staff serves on the Advocacy Committee and on the Breast Health Committee.

Additionally, the Affiliate participates in yearly events, conferences, and lobby days for various public policy issues surrounding breast health. There will be further discussion about this partnership in the Public Policy section because the SCCA remains the primary vehicle for advocacy and public policy.

There are several ways this Affiliate seeks to maintain and strengthen the relationship with the SCCA in the coming years. Primarily, the presence of a staff member from the Komen Affiliate on various committees and at events is essential to preserving the partnership. Through this presence and participation, the Affiliate will seek to cultivate and strengthen the breast health focus within the SCCA's work in the state. Finally, the Affiliate desires to make constituents more aware of the SCCA and their work through promoting them to the Affiliate's current audience throughout various programs and interactions. There will be further discussion about future improvements in the Public Policy section of this report.

Affordable Care Act

The Affordable Care Act passed as a major health care reform bill and has been put into effect in varied stages throughout the past several years. The final stages were put into effect in October 2013 and January 2014. While states can choose various methods of implementation, certain elements are required by federal mandate and others are left to the discretion of the states.

South Carolina state leadership has been vocally dissatisfied with the ACA and the State House passed an amendment criminalizing the execution of its policies. As of March 2014, the state Senate struck down that legislation, and the ACA has to be enforced within the state of South Carolina. The state chose to have their insurance exchange program run through the federal government and not to expand their Medicaid program to cover individuals and families whose income is under 200 percent of the federal poverty level. Several estimates believe around 284,000 uninsured South Carolinians would have been covered by the expansion of Medicaid. However, Medicaid across the country was expanded to increase eligibility for those who make less than 133 percent of the federal poverty level, those who are not pregnant and not otherwise eligible for Medicaid. This new coverage now includes many low-income adults who have never been able to receive Medicaid services.

The ACA mandates health insurance coverage for every individual who brings in enough income to make them ineligible for Medicaid. Because South Carolina turned down the full expansion, individuals making less than about \$14,500 are exempt from the penalty fee if they choose not to follow this insurance mandate. Prior to the implementation of the ACA, approximately 20.0 percent of the state's population of 4,422,869 was uninsured. After the insurance mandate estimates have the percentage of uninsured dropping to about 7.5 percent of the population. However, there are still those who fall in between the coverage offered through Medicaid and the criteria for avoiding the penalty fee from not enrolling in health insurance. These estimates are only initial assumptions at this stage, but there are 194,000 people in the state that fall into this gap of coverage.

Some partners have already expressed concern regarding these gaps in coverage. Several hospital providers have shared experiences with individuals who have received coverage through the ACA, but they remain in the 'underinsured' category because of their inability to afford their deductibles. These partners have found that certain hospital facilities only accept one or two of the ACA plans, and patients in South Carolina are sometimes uninformed about their coverage or the lack of coverage at their local hospital. The Affiliate will continue to work with partners and grantees to continuing learning about how the ACA is playing out and will use this information to be attentive to the gaps in coverage throughout the service area.

The state of South Carolina constructed a program to aid those individuals in families who are left in the void between substantial health insurance coverage. The SC Department of Health and Human services is in the process of implementing the Healthy Outcomes Plan (HOP). HOP will support approved hospitals who apply for coverage by proposing their own delivery plans to provide care for chronically ill, uninsured, high utilizers of emergency department services. To be approved, hospitals must submit an application and proposal. All 58 hospitals and emergency departments who completed this process were accepted into the HOP.

Since South Carolina chose not to expand Medicaid, there will be minimal changes in the way the program interacts with the Best Chance Network. The slightly increased coverage will allow for more women to receive certain treatment and follow-up care provided through Medicaid and should increase women's ability to be approved for services through the BCN. Also, the federally mandated Medicare changes will begin to include free annual physicals for women which could aid in the early detection of breast cancer.

Several elements of the ACA should support Komen's mission in various ways. The education section of the ACA was designed to increase awareness and give women the tools to early detection. The Education and Awareness Requires Learning (EARLY) Act, passed as part of ACA, requires the HHS Secretary to:

- *Establish the Advisory Committee on Breast Cancer in Young Women*
- *Develop an education campaign for young women and health care professionals*
- *Develop an education campaign among physicians and other health care professionals to increase awareness of breast cancer in young women*
- *Conduct prevention research on breast cancer in younger women*

Additionally, the ACA should provide assistance with the increasing Patient Navigation needs in South Carolina. Each state Health Insurance Exchange is required to establish a navigator program to help individuals and businesses make informed decisions regarding purchasing health insurance through the Exchange. The role of these navigators will be to:

- *Provide expertise on eligibility, enrollment and coverage details*
- *Provide information in a fair, accurate and impartial manner*
- *Facilitate the enrollment process*
- *Eligible entities to serve as navigators consist of community groups, professional associations, and insurance brokers*

Without a doubt, the Affordable Care Act will have a significant effect on the health care landscape. Exactly how this change in services will directly impact South Carolina patients is still not totally clear. Some of the benefits that will affect breast health patients are:

- *Prohibition of lifetime dollar limits on health benefits*
- *Prohibition on preexisting condition exclusion*
- *Prohibition on annual limits on essential health benefits*
- *Insurers in individual and small group markets must offer “essential health benefits”*
- *Insurers must cover routine care costs for patients in Phase I, II, III, and IV clinical trials (excludes cost of drug)*

These are important for breast health and breast cancer patients because it provides routine preventative care such as screening mammograms that they may otherwise not receive. It keeps a breast cancer patient from being denied coverage because their breast cancer is considered a “preexisting condition”. The ACA prohibits insurance companies from placing lifetime dollar limits on health benefits. These changes can be the difference in life and death for many people in the communities around South Carolina.

The benefits and challenges of these changes will take time to identify as local health care providers begin to adjust to and learn what these differences look like on a practical basis. The Affiliate will continue to be in close contact with local health care providers to learn how these changes are playing out and in what ways support can be given throughout this process. Most importantly, the Affiliate will continue to keep a watchful eye on where the new gaps in services will be. Because no process is perfect, gaps and problems are expected. The Affiliate also knows that some of these needs will be outside of their influence and reach; however community partnerships with this Affiliate will begin to assist in problems as they arise. With continued relationships and communication with the community, the Affiliate will continue to make every effort to support the Breast Health Continuum of Care in this changing health care landscape. The reality is that no one can yet understand how the Affordable Care Act will affect patients and health care providers as the initial stages are still taking place. The Affiliate will continue to be aware of these changes so that the Affiliate may meet the needs of each service community.

Affiliate’s Public Policy Activities

As a small Affiliate with limited resources, the partnership and membership in the South Carolina Cancer Alliance (SCCA) has been invaluable in the ability to influence public policy and involve the community in advocating for breast cancer related matters in local government. The Affiliate’s Mission Coordinator serves on various committees, attends the conferences and gatherings put on by the SCCA, and organizes local events within that partnership. These events have included a Lobby Day that arranged for community members to advocate for key breast health legislation in both the local and state government. Since this Affiliate does not anticipate gaining the ability to hire a staff member specializing in the area of public policy and lobbying, this alliance with the SCCA provides an excellent ability to remain involved in promoting the issue of breast cancer to local, elected representatives and their constituents.

The Affiliate desires to be more actively involved in local and federal advocacy efforts including partnerships and participation with the South Carolina Cancer Alliance and Komen Advocacy Alliance (KAA). In the future, the partnership with the SCCA will remain the primary means of influencing public policy and participating in local issues. Staff will continue to serve on various committees and participate in coordinating local Lobby Days when applicable. As various local policy issues arise, the Affiliate will continue to encourage constituents to become active in SCCA and KAA advocacy efforts on a local, State, and Federal level. The Affiliate remains open to becoming more active in influencing various elected officials when presented with a specific task or issue that needs the support of the Affiliate staff and organization. Additionally, the Affiliate intends to share the final publishing of this report with both local officials and community leaders to make them aware of the need for funding and support of breast health initiatives in the Affiliate 22 county service area. The Affiliate will continue to seek new and different ways to affect positive change for all constituents through advocacy efforts.

Health Systems and Public Policy Analysis Findings

The conclusions drawn from the Healthy Systems and Public Policy analysis have been made with the best information available to the Affiliate. However, there are limitations to this type of analysis because of the lack of existing comprehensive data on current resources in the target counties identified. It is possible there are additional resources currently available that have not been found or listed in this report because of their lack of online presence or limited visibility among other health care professionals. Also, the most recent developments in public policy in the area of health care have only been implemented recently which means no one can know the long term results of these actions. The Affordable Care Act has already significantly changed the health care system in the United States, but experts continue to debate if the history books will call it a success or not. All of these limitations mean that the conclusions drawn in this report could have certain areas of weakness but have been put together with all of the available information at this time.

The health systems identified in these five target counties have several strengths and several areas of weakness as women in these communities move throughout the Continuum of Care. Anderson, Cherokee, Edgefield, Laurens and Greenwood counties each have a strong hospital or cancer facility providing support for screening, diagnostics, treatment options, and follow-up care. However, these facilities do not have the capacity to support the entire female population in their regions. In several cases, these hospitals only provided limited treatment options and minimal follow up care. Other resources such as free clinics, community health centers, diagnostic facilities, and other organizations are necessary to support each step in the continuum of care. Anderson and Cherokee Counties possess a higher number of facilities who are providing sufficient screening and diagnostic services compared to other regions noted in this report. However, each of the target counties (Anderson, Cherokee, Edgefield, Greenwood and Laurens) identified by this Affiliate are in need of support and additional services at each level of the Continuum of Care.

Currently, many women in these five counties must travel in order to receive proper care or to have a full range of treatment options and support services. This element of distance to receive adequate care for breast health introduces several other barriers to proper screening and maintaining breast health. There are transportation barriers, potential insurance coverage challenges, and/or availability of hours in these neighboring facilities that impede women's ability to move throughout the continuum of care. These complications can significantly affect women's breast health, especially when women and their families are living at or below the federal poverty line.

Key partnerships in these communities have been formed in the past through meeting and training the Affiliate's new grant recipients. Unfortunately, several key partnerships in these target communities do not currently possess these grants anymore. The Affiliate desires to reach out to these past grantees and encourage them to reapply during the next grant cycle. Additionally, new partnership in these counties could come through increased Pink Sunday activities which the Affiliate will be pursuing this year. Newly formed Laurens County Cancer Association provides another opportunity for a new relationship for this Affiliate.

The long term impact of recent public policy legislation such as the Affordable Care Act cannot be fully identified until the policies have been in place for several years. However, several elements of the ACA appear to align with core Komen mission goals such as increasing education and patient navigation and increasing health care access for low-income women. Ideally, the individual mandate requiring everyone to own health insurance will make it easier for women to have easy access to the services they need to detect and treat breast cancer in the early stages.

The local National Breast and Cervical Cancer Early Detection Program takes the form of the Best Chance Network (BCN) for South Carolina. This program should benefit from recent legislation and appears to interface well with local Medicaid services by providing access to screening and diagnostic services for women all over the state. Medicaid then picks up coverage of treatment options and follow-up services. As the BCN continues to assist uninsured and underinsured women in South Carolina, this Affiliate will continue to partner with their local representatives and educate constituents about the resources available to them.

South Carolina's Cancer Control Coalition has presented several goals to be achieved by the South Carolina Cancer Alliance (SCCA) by 2015. These goals begin with pursuing additional governmental funding for the BCN in order to decrease the number of women being diagnosed with late-stage breast cancer and the time it takes for them to receive the necessary treatment for their disease. The SCCA also continues to support educational objectives through local community leaders. This Affiliate remains very involved with the public policy efforts of the SCCA through committee participation and local lobby days.

Even with the recent advances in health care legislation, gaps still exist within the coverage for low income women who are navigating through the Continuum of Care. South Carolina's decision not to expand Medicaid leaves a significant number of people in the state who make too much money to qualify for Medicaid but not enough to meet basic insurance needs. The

Affiliate needs to be especially aware of those who will be navigating through this space and attempting to find services apart from Medicaid. Additionally, many women who are 65+ experience a gap in coverage for screening services. The Affiliate wants to be able to provide assistance to those who do not have the financial ability to get proper screening necessary to maintain proper breast health.

Affiliate Public Policy Actions

Susan G. Komen has several Public Policy goals that each Affiliate strives to fulfill within their local region of influence. This Affiliate continues to support these goals through partnerships with local organizations and relationships with elected officials. Using advocacy and lobby events, constituents are encouraged to raise their voice for specific actions the government can take to support breast health.

The first Komen public policy goal states the desire to protect federal and state funding for the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), to ensure all women have access to potentially lifesaving breast cancer screening. The Affiliate partners with the SCCA and the organizations within the Alliance in an effort to protect state and federal funding for NBCCEDP. Within this partnership, the Affiliate hosts events for the public to learn how to be advocates in this fight as well. Through the SCCA, local policy initiatives are brought to the attention to the state representatives and letters of support requesting continued and/or increased support of NBCCEDP. Both with the SCCA and apart from their programs, the Affiliate promotes education and awareness of the Best Chance Network. Also, partnerships with the local NBCCEDP providers ensure patients enter and stay in the Breast Health Continuum of Care.

Another organizational wide public policy goal works toward requiring insurance companies provide coverage for oral anti-cancer drugs on a basis that is no less favorable than what's already provided for intravenously-administered chemotherapy, to protect patients from high out-of-pocket costs. This Affiliate supports that goal by participating in state level advocacy for the support of oral cancer drug coverage by insurance companies. This strategy has produced several positive outcomes toward the achievement of the overall goal. The Affiliate will continue to partner with the SCCA to educate the public, law-makers, and representatives on the importance of these drugs.

The following public policy goal seeks to ensure the continued federal investment in cancer research through the National Institutes of Health (NIH), National Cancer Institute (NCI) and Department of Defense (DOD), to discover and deliver the cures. This Affiliate desires to re-establish contact and partnership with the local affiliation of the National Cancer Institute in order to fully meet this policy goal.

The final public policy goal desires to influence officials to expand Medicaid coverage to ensure the availability of the full-range of breast health services to low-income women, including cancer screening, diagnostics and treatment. The Affiliate has participated in and will continue to participate in state level advocacy supporting Medicaid Expansion. Several programs will

continue to educate the community and work with SCCA to educate lawmakers on the importance of this expansion. Unfortunately, at this point the state of South Carolina has chosen not to expand Medicaid services.

Qualitative Data: Ensuring Community Input

Qualitative Data Sources and Methodology Overview

Methodology

The qualitative portion of this report gathered community input from each target county through interviews of health care professionals, focus groups, and a survey of providers. These collection methods allowed for various perspectives and responses to provide thorough answers to the two key assessment questions.

What barriers exist for women in the target counties to access and move throughout the Continuum of Care?

What factors contribute to the high rates of late-stage diagnosis and death from breast cancer in the target counties?

The answers to these assessment questions identified key areas of concern in each target county. These terms varied from financial and insurance barriers and transportation difficulties to educational gaps and personal fear of results. Some of these challenges presented as barriers to more than one stage of the Continuum of Care, and these concerns present the largest barriers for women in target counties to access and receive proper breast health care and screening.

The data collection methods utilized in this report were chosen because of the nature of the target counties selected and the ability of the Affiliate to access key informants. All five target counties share a number of similar characteristics including their rural communities, small number of women age 40+, higher than average poverty percentages and average or above average unemployment percentages. Focus groups sought out the average woman over forty for their voices and experiences with breast health and care in their counties. These women were able to address the issues facing their communities and draw attention to concerns they must face daily. The interviews of health care professionals allowed for a depth and breadth of responses since each participant interacts with hundreds of women in the target counties through the services and care they provide. This allows participants to draw from years of experiences in order to identify trends and address key concerns. The survey of providers in Cherokee County was chosen as a collection method because of the limited number of women over forty in the county and the extremely rural nature of the target population.

The collection process took place over the course of four months, including focus groups, interviews, and the survey of providers. All interviews were conducted over the phone by the Community Profile Coordinator who took detailed notes of the answers provided during the conversation. Focus groups were conducted by Community Profile Coordinator and the Affiliate intern took detailed notes for each session. The focus groups were also recorded on the personal computer of the coordinator in order to provide a back-up of responses. These files were saved in a confidential folder protected by a password on the same personal laptop. Because of scheduling conflicts one focus group was led by the Affiliate intern and another by a graduate student in communications who are both trained in qualitative research and leading

focus group discussions. The survey was conducted through the online platform of Survey Monkey and information was stored through their system.

The triangulation of data was achieved through using two collection methods in each target county. Anderson, Laurens, Edgefield, and Greenwood counties were studied through both interviews and focus groups. Interviews and a survey of providers were used to gather data for Cherokee County. All of these methods addressed the same issues determined by the assessment questions and participant responses identified very similar concerns throughout each method. The Quantitative Data Report, Health Systems Analysis and Public Policy Analysis were also used to triangulate the main themes that emerged from the data.

Sampling

The population of interest from the target counties included any women 40 or older who are legal residents of the specified county. This includes survivors, current patients, those who are not receiving annual breast health screenings, and those who follow the annual screening recommendations. The interviews gathered information from health care professionals and community health workers who have experience in working with women fitting this description in some form of breast health care. This included full-time professionals, health care volunteers, clerical workers and schedulers for various diagnostic and doctors' offices, community health advisors, and regional workers for government and non-profit organizations.

Participants were selected using a non-probability/snowball sampling technique. This method was the most practical and effective way of identifying potential contacts because of limited resources of the Affiliate and the scarcity of health care professionals in the target counties. There are minimal facilities providing breast health in these counties as identified in the Health Systems Analysis because of the rural nature of the population and limited financial resources available. The Affiliate used key Affiliate and community contacts in these target areas in order to gain maximum participation in the process. The recommendations from these contacts gave the Community Profile Coordinator lists of potential participants for both focus groups and interviews.

The sources of data collection were chosen because of the resources available to the Affiliate staff and Community Profile Coordinator and the current state of resources operating in the target counties. Focus group participants were included if they met the criteria of gender, county of residence, and age bracket. Interviewees were chosen based on their geographic location, current job title, and frequency of interactions with women in the target population. The survey of current breast health providers in Cherokee County reached out to all four facilities in the area but only received a 25 percent response rate.

Ethics

Informed consent was gathered throughout the process with each participant through both verbal and written confirmation. Before beginning both focus groups and interviews, each individual received an explanation regarding the goal of the Community Profile project and the process undertaken by the Affiliate to study target counties. Their participation was explained as

valuable and essential to the success of the assessment, and each individual was given the opportunity to opt out of participation before the questions began. After verbal consent to continue was given, participants agreed to sign an informed consent form created by the Affiliate. While focus group members received a small gift bag as a token of appreciation, no additional rewards or benefits were given for participation.

Confidentiality was promised to each individual involved in the assessment process, and anonymity was protected throughout the data gathering and analysis stages. In order to ensure this, written notes never included the names of participants and were saved according to a three digit number associated with the interview or focus group. Only one spreadsheet contained the names of interviewees and only the consent forms of focus group members retained the names of those individuals. The survey conducted in Cherokee County also protected the anonymity of respondents through their software which does not associate answers with a name or email address.

During the coding and analysis stages, the confidentiality of the participants was protected through their storage on the personal laptop of the Community Profile Coordinator. The notes from interviews and focus groups were password protected and only accessed for analysis purposes. The data compilation documents used in the coding and writing procedures did not include any personal information and was not connected to an interview number during the analysis. Following the completion of the Community Profile, the fully scrubbed data will be stored in a confidential file in the Affiliate office.

Qualitative Data Overview

The following information was gathered through six focus groups, 28 key informant interviews, and a survey of providers within Cherokee County. The interviews and focus groups were recorded using detailed notes from either the interviewer or a note-taker in order to retain as many details and quotes as possible. The survey results were identified and managed through the online platform of Survey Monkey. Interview and focus group notes were compiled after the data gathering process in order to effectively identify the main themes from the data.

The Affiliate chose this process of data management and analysis given the limited financial and time resources available for the profile means it was the most effective way to obtain an accurate picture of the target counties. The data was structured, gathered, and analyzed by the Community Profile Coordinator in order to minimize the financial impact of the Affiliate. The previous experience of the coordinator in qualitative analysis allowed the project to be effectively managed and completed without external resources.

Themes were generated from the notes by the Coordinator through immersion in the data. Data was organized by county and by grouping of counties used throughout the profile. The process began by identifying 10-15 distinct concepts which were condensed down to six to eight main themes through grouping and analysis. Within each geographic area of assessment, key themes were consistently identified through coding and analysis.

Greenwood and Edgefield Counties

Both Edgefield and Greenwood Counties are located in the mid-western region of state and share many similar characteristics. The counties have a female population of 12,269 and 36,513 respectively, and both contain similar racial and socioeconomic demographics and statistics. The counties are not identical in all areas as 100 percent of the population in Edgefield are designated as medically underserved, and only 10.1 percent of residents in Greenwood share that designation. Also, while 73.3 percent of the residents of Edgefield County live in a rural area, only 39.8 percent of the residents of Greenwood are located in rural areas.

As the first stage in the Continuum of Care, proper education about breast health remains essential for women of all ages. In Greenwood and Edgefield counties, two main themes emerged regarding current gaps in education. First, health care professionals are concerned women in the county do not fully understand the significance of Clinical Breast Exams (CBE) and proper Breast Self-Awareness (BSA). One local physician in the area mentioned this concern by saying *“One issue I have more often is when a patient comes in and they want a mammogram, but they don’t want a CBE. They need to know why a Clinical Breast Exam is important and necessary.”* A common theme among local health care workers was that patients they see are not aware of how they should actively participate in proper Breast Self Awareness. Since both CBE and proper Breast Self-Awareness are an important part of early detection, women in Greenwood and Edgefield need to fully understand how these simple procedures can impact their breast health. The second gap of education noted from the data was the common misconception that a lack of family history of breast cancer relieves a woman from necessary screening. Numerous health care workers mentioned this trend seen in their patients during interviews. One professional simply stated *“some patients think if [breast cancer] doesn’t run in their family, they think they don’t need [a mammogram].”* This myth that some women are exempt from needing annual breast cancer screenings creates a barrier to proper screening when women are not fully educated about their need to be proactive in screening.

Proper education about breast health leads women to a personal commitment to consistent screenings. However, even the most educated women in these counties can miss annual appointments because of financial, personal, pragmatic, or cultural barriers. Throughout interviews and focus groups, four main barriers to proper screening emerged as women spoke frankly about the challenges they must overcome to receive mammograms and annual exams.

Financial and insurance concerns were by far the most common and prominent issue facing women in Greenwood and Edgefield counties. Lack of insurance, low finances, and insufficient insurance coverage was brought up as a main concern in every single interview and focus group. As with many areas of health, lack of breast cancer screenings are often tied to a lower socioeconomic status because many in poverty do not receive annual physicals or have a primary physician. Many who cannot afford proper medical care are only identified once they are in an emergency room because a symptom has become persistent and urgent. Unemployment percentages, education levels, and poverty level closely correlate to an individual access to screening and health care. The next group who are currently not getting

annual screenings are those in the working class who have medical insurance but are classified as “underinsured.” They often cannot meet the out of pocket deductible required for screenings and other necessities not covered by their current health plan. One health care worker summed up the current situation for many women in these counties by saying *“If they have the money, they choose to spend it on their families.”* This serious barrier keeps many women from receiving annual screenings which could provide early detection and diagnosis of breast cancer.

Secondly, many women allow a fear of results to interfere with annual screenings. Nearly every health care professional mentioned this fear as a frequent type of reasoning used by women who are not receiving their mammograms. They used phrases such as *“fear of the unknown”* and *“fear of what it will be”* to describe this barrier. Another practitioner remarked that, *“They just don’t want to know. I think part of the stigma is cultural and old school mentality of not understanding that cancer is not a death sentence. We need to put a face on survivorship. Yes, cancer is absolutely scary... but too often the scary stories get highlighted. We need to educate these women that you can survive!”* This emotional and psychological barrier prevents many women from being proactive and insisting on their annual screenings.

Even women with full insurance coverage and a desire to receive a mammogram can be waylaid by a lack of access to quality facilities. This lack of access includes challenges such as transportation, time off work, family concerns, and convenience of location. Because of the rural layout of Greenwood and Edgefield, transportation concerns affect many of the women who fall into a lower income bracket. Multiple women in focus groups and professionals addressed this in their comments. It was pointed out by one focus group participant that *“8-10 miles is a long while to go when you have transportation issues.”* Another health care worker mentioned about screening in Greenwood County that *“Transportation is huge. [Women] are not able to get [to providers], and don’t have a reliable way to get to places.”* Lack of access can also stem from an inability to receive time off work to make an appointment for an annual screening. Several professionals mentioned this as a barrier, and one brought up that *“working moms are hard to reach.”* One practitioner was describing women who are not currently receiving annual cancer screenings and said, *“It’s those who are in that in-between stage who are working [who are the least likely to be screened annually].”* *Limited access to screening facilities remains an especially critical issue in Edgefield County because of the lack of services offered in the county.*

The final theme that emerged as a current barrier for consistent screening in Greenwood and Edgefield counties was the potential cultural differences between various groups. This includes barriers as mentioned by a health care worker in Edgefield who brought up the *“language barrier with the Hispanic population especially. [We] need to communicate the significance of screenings and educate them about breast health.”* Another professional in Greenwood expressed this concern when she remarked *“I’m glad you will be hearing things directly from these women as you have focus groups. A lady told me she wouldn’t listen to me because I was white. Women need to hear it from someone like them.”* Cultural barriers can create another hurdle for women to overcome in order to receive annual screenings in order to detect and diagnose any potential health concerns.

Once a mammogram is identified as abnormal in any way, women need to receive further diagnostic screenings quickly. However, women in Greenwood and Edgefield face three main barriers to receiving these essential services. First, the lack of facilities in Edgefield makes it difficult for many women to travel out of the county and easily access diagnostic care. Second, women in both counties face a gap of insurance coverage for certain types of further screenings. A health care professional summarized this struggle facing women today by saying, *“sometimes the insurance pays for the screening but not the diagnostic. That’s a challenge for a lot of women because that money will come out of pocket. With our economy, people are having to make decisions they shouldn’t have to make. Mothers will choose their family every time.”* This same concern was identified by another provider who told a story about a memorable interaction with a woman who received an abnormal mammogram. *“I remember one lady in particular who couldn’t afford to come back for the diagnostic services. She said she couldn’t afford to feed her family if she came back in for the tests she needed. We did work through the system to find her funding for what she needed, but I will always remember that conversation.”* Insurance and financial barriers too often keep women from quickly identifying potential cancer in order to begin potentially life-saving treatment.

The final barrier identified by both women in focus groups and professionals is the sense of denial and lack of urgency to follow-up with further testing. One health care worker in Greenwood described the most frequent reason why women do not follow up as, *“Honestly, I just don’t think they realize the importance of follow up.”* Several interviews confirmed this unfortunate pattern when another provider mentioned that *“a lot of women refuse mammograms for a long time or wait for a long time to come in to get something checked out.”* Another local professional explained this barrier by describing the justification she often hears from patients who delay follow up diagnostic testing. *“Sometimes we recommend a biopsy and follow-up with the radiologist. [The official follow-up letter] describes the findings as ‘suspicious’.” Some women may not understand all of the terms used, so they just think they don’t have anything to worry about. They may take it out of context and are in denial.”* This lack of urgency and prompt diagnostic care can allow potential cancer cells to spread while delaying necessary treatment.

Navigating through a cancer diagnosis presents numerous challenges, emotionally, physically and financially. Many of these barriers are not unique to a diagnosis of breast cancer or to women in Greenwood and Edgefield Counties. However, three main barriers to receiving essential and quality treatment were revealed through speaking with women in these counties and with the professionals who work there every day. Again, financial concerns top the list of concerns for women who receive a diagnosis. Insurance coverage, out-of-pocket deductibles, and ability to pay medical bills remains a primary concern for patients throughout their treatment cycle(s). Similarly, those patients who are struggling financially often face transportation barriers while seeking treatment. With no cancer treatment available in Edgefield County, women often face pragmatic and financial concerns about how to get to appointments and how to afford the gas and time off work. Especially when various chemotherapy and/or radiation treatments make patients too sick to drive themselves, women must figure out who can take the time and money to drive 35-45 minutes each way for a treatment session. The final barrier identified through the

data gathering process was the common emotional component of dealing with a cancer diagnosis. One health care worker said the biggest challenge facing newly diagnosis is simply a lack of *“education about all the different scenarios and various treatments.”* Another current patient navigator in Greenwood County addressed this concern as well. *“People will go directly to friends or internet for information after being diagnosed. They just don’t know what to expect. I really encourage them to come in and talk to me so I can educate them about what to expect and sift through the myths that are out there. There is a lack of understanding. Many women don’t get the medical knowledge. They don’t understand there isn’t the cookie cutter mold out there like there was 30 years ago. They don’t understand the options that are out there for them.”* This psychological barrier can lead women to grow fearful of the process of treatment and the outcome, which creates a barrier to proper care.

Follow-up and support services provide emotional, financial, and physical support for current patients and survivors of breast cancer. Because of the lack of facilities in Edgefield County, women must travel to other areas to receive any type of these services. There remains a considerable need for resources in that county. Additionally, several women and health care workers identified patient navigation as an area they would like to see expanded for women in both counties. One practitioner mentioned, *“Navigation plays a huge role, and there are too few navigators in these counties [Greenwood and Edgefield].”* Another health care professional believes *“Navigation is a phenomenal concept that has, and will, continue to grow.”* A focus group participant who is a resident of Greenwood County brought up the same concept by saying *“We need navigation support to help guide people through the process... [patients need] help with various issues that go beyond scheduling.”* Navigation is only one part of necessary follow-up and support services, but a competent and caring nurse or lay navigator can lead women to other essential resources available in the surrounding areas. This may also help overcome other, compounding barriers as navigators educate their patients about local resources.

Anderson and Laurens Counties

Anderson and Laurens Counties are located side-by-side in the western region of the state of South Carolina. With 98,050 and 34,535 women as current residents of the counties respectively, both counties face similar battles in providing easily accessible breast health. However, Anderson County certainly has nearly three times the number of women to provide for within the county. This is mostly due to the mainly rural area of Laurens County. Also, while the racial demographics of Laurens County are comparable to the other Affiliate service counties, Anderson County has nearly double the amount of Black/African-American women compared to the national average. This becomes increasingly critical since minority women are statistically proven to be at higher risk for incidents of breast cancer.

Throughout the data, two main educational barriers emerged as frequent in Anderson and Laurens Counties. First, several women mentioned the misconception that a lack of family history releases them from the need for annual breast health screenings. When asked about common reasons heard from women who are not getting screened, one health care worker said she often hears *“Breast cancer doesn’t run in my family so I don’t need [a mammogram].”* This

myth can lead to late-stage diagnosis of women who believe themselves to have little to no risk of breast cancer. Another common misconception identified by participants is confusion about the age at which a woman should begin having mammograms. One practitioner from Lauren's County mentioned *"They don't know what age to start. I think most women know there is a need for exams because they see it on TV."* This confusion is not surprising given the recent debate among those in the health care profession and government agencies.

Once a woman makes the decision to pursue annual screening, access to screening should be as simplified as possible. However, in both focus groups and interviews, four main areas of difficulty emerged as primary barriers. Insurance coverage, socioeconomic status, lack of access, and fear of results were all clearly seen as issues by those living and working in Anderson and Laurens Counties. These challenges make it difficult for the average woman to consistently receive annual screenings that are essential for early detection and breast health.

The primary concern discussed by women in the focus groups and mentioned by health care professionals addressed the lack of insurance coverage or the gap within insurance policies. Women simply cannot afford to pay for these screenings out of pocket. When asked about what keeps women from getting mammograms, one woman in a focus group mentioned, *"It all goes back to lack of insurance and finances."* Several other participants agreed with her verbally and non-verbally. One health care practitioner from Laurens confirmed this problem and said, *"Right now the lack of insurance certainty is the first reason why people drop off. Mammograms are so important, but it's the first thing they drop [when they can't afford it]. I don't know what we're going to do with these women who need help but can't afford it."* However, the poorest in the community are not the only ones who struggle to afford mammograms and other screenings. When asked to describe women who are least likely to be getting their annual screenings, one health care professional said it is *"a lot of people who are working and they don't have insurance."* Another practitioner from Anderson County said those who are least likely are *"Working, single women. They have insurance but no money for the copay."* This growing category of working class is called the underinsured and, while they face the same struggles as the uninsured, there are less programs and resources available for assistance.

For those with insufficient resources, lack of annual cancer screenings remain one of a long list of socioeconomic limitations. These elements include financial concerns, educational levels which relates to steady employment, and a pattern of inconsistent medical care. One health care worker remarked that *"women who have had [a mammogram] once don't get screened because they don't have money."* A focus group participant mentioned that *"the education level in our county just isn't good."* Unfortunately, lack of finances and steady employment often leads to a reactive approach to health. A practitioner in Anderson County observed *"most of our patients are lax in getting medical care. They don't have financial resources."* This issue is not unique to breast health, and is no small hurdle to overcome in this community.

Because of the rural nature of these counties and the limited resources available, lack of access became another common theme in the data. This includes concerns such as transportation difficulties, ability to take time off work, convenience of locations, etc. Working women face this

issue because of the inconvenience of taking off work to make appointments for screenings. Several professionals addressed this issue saying women often say they *“are working and they can’t take time off the job”, or are “too busy working and can’t lose pay [to come in for a mammogram].”* Additionally, the ability to get to a screening facility can be challenging for some women. A professional from Laurens County says there remains a *“big problem of transportation for those with limited resources.”* These and other concerns maintain the perception of “inconvenience” which women often cite as a reason for missing annual screenings. Multiple interviewees and focus group participants addressed this issue as one of their top three reasons why women are not coming in for a mammogram.

The final barrier to recommended screening is the natural reaction of fear of the unknown. Women fear the pain of the mammogram and the possible results of the test. One health care worker in Anderson said she frequently sees the *“fear factor”*. *“Comfort level with the procedure isn’t there. Patients fear, ‘What if they find something? If I don’t feel anything, I’m probably ok, right?’.”* In the focus group discussions, several women said the *“fear of results”* often impacts a woman’s motivation to make the necessary appointment for her annual mammogram. This instinctual response to a worst case scenario needs to be overcome with knowledge, education, and encouragement from the community.

If anything is identified as abnormal through an annual screening, women must then pursue further diagnostic testing. In Anderson and Laurens Counties, two major challenges are faced by women who need these next steps. First, women in Laurens County face transportation difficulties if their diagnostics cannot be done through Laurens County Community Hospital. An employee from the mammography department in the hospital explained that they *“do some small things in the hospital but send a lot of things to a hospital in another county. We do diagnostic mammograms here at the hospital. Our surgeon works out of somewhere else”*. In both Anderson and Laurens Counties, an increasing number of women cite insurance coverage as why they delay further testing. *“They say their insurance won’t pay”* was repeated several times in interviews. Other women say they will have to pay out of pocket for certain types of diagnostics. A hospital employee from Anderson County said some patients have a fear that, *“[the hospital is] trying to get my money, and I don’t have money. Don’t want to know.”*

When facing a life-altering diagnosis, women with breast cancer need quality treatment to be accessible and convenient. Throughout the data, two main barriers that can limit access to treatment emerged in focus groups and interviews. The first concern is largely specific to Laurens County, and the second addresses a major issue for women in both counties.

Currently, there are no options for chemotherapy or radiation offered within Laurens County, and women who are diagnosed must travel outside of the community for daily or weekly treatment. This theme of the practical difficulty of travelling 45-60 minutes one way for appointments came up in nearly every interview with health care professionals working in the county. Even women with some resources find it challenging to travel the distance needed for care. One practitioner said, *“Transportation always comes to the top here too – not just for those with limited resources, that’s for everyone.”* Another worker agreed when she remarked, *“People*

aren't going to drive an hour and half to get their health care." An interviewee who assists in a local cancer association said the biggest issue facing newly diagnosed women is *"transportation to get to treatments. I had a couple of calls very recently from people needing help to get to appointments. I know of a local organization who can get you to some places, but you have to make appointments far ahead in advance."* Another local practitioner spoke on this issue and said, *"The biggest challenge is transportation to get out of the county for treatment. They have to travel out of the county in order to get radiation and chemo. I had a friend who had to travel over an hour five days a week for a 15 minute radiation treatment for several weeks."* The practical difficulties of affording gas prices, taking time off work, and, sometimes, finding a driver in case the patient is too sick all combine to make transportation one of the biggest concerns facing breast cancer patients in Laurens County. Professionals in the county are discouraged about how the lack of options offered are affecting the women they serve. A health care worker from the county had this to say about the transportation issue: *"It's the biggest thing: we had an oncologist who came in and did chemotherapy here. When we got bought out, they brought someone else in, and they won't do chemo anymore. Our patients can't afford to go back and forth to over an hour each way for treatment! ... It's such a problem for our women."*

When facing weeks or months of treatment, many women are concerned about their ability to pay the stack of medical bills they anticipate facing. The second barrier to proper treatment for women in Anderson and Laurens Counties remains the rising pressure of financial and insurance issues. One focus group participant expressed the main concerns she believes women face after a diagnosis: *"Who is going to take care of my family and kids while I go through treatment? Can I afford to be out of work? Will they hold my job?"* Adequate insurance coverage remains a precious resource to a newly diagnosed woman, but, unfortunately, even many good insurance plans have gaps that leave women stuck with insurmountable bills. One health care professional mentioned she sees women who worry about what is covered by their plan. *"If they have insurance, we have to make sure they are using a facility approved by insurance. The other portion is missing time from work. I serve a lady who just finished up a round of chemo, and she can apply for family medical need, but they don't want to miss a lot of work. We are always trying to get treatments set up so they don't have to miss too much work."* Women who receive governmental assistance still have limitations in what they can receive from their plan. *"If they are a BCN patient, [BCN] will only cover certain things. Things like a mastectomy aren't covered. They can make arrangements with the hospital and apply [for financial aid]."* Financial and insurance problems too often create a seemingly insurmountable barrier for low income women to receive life-saving and quality treatment.

Numerous types and variations of support and follow-up services have proven invaluable to current patients and breast cancer survivors. While Anderson and Laurens Counties could benefit from expanding several of these options, one main desire shone through in the data. Current patients, survivors, women in the community, and health care professionals identified a need for additional patient navigation services. One worker from Laurens County Hospital said *"We don't have a follow up nurse (navigator) and that's really challenging."* Another practitioner from the county knows that local facilities recognize this need because *"they have tried to streamline that with navigators who help women when they are diagnosed. We try to help get*

them set up with oncologists/counseling/ support groups, and try to get them help from the very beginning. People dealing with it alone get lost. They need someone to reach out and be a bridge.” Without the knowledge and emotional support of someone who understands their situation, new patients get easily overwhelmed and intimidated by the challenges facing them after a breast cancer diagnosis. One health care worker who is also a breast cancer survivor mentioned *“patient navigators are so helpful and help [newly diagnosed patients] walk through it.”* Women in Anderson and Laurens Counties would benefit from increased patient navigation services to walk with them through a life-altering diagnosis.

Cherokee County

With a female population of 28,224 as of 2010, Cherokee County is located in the north-western section of the state and shares a border with North Carolina. Currently, 61.0 percent of the population of the county resides in a rural area. An interesting trend explained by several interviewees in the process mentioned the geographic disconnection between the regions of Blacksburg and Gaffney. Women living in Blacksburg rarely “cross the bridge” to services offered in Gaffney, even when these services are free or low cost. The higher rates of poverty and unemployment in Blacksburg have created an apparent isolation of that community from the rest of the county. This information could prove valuable when attempting to reach the women living in Blacksburg with accessible and quality breast health.

Lack of proper education about the significance of breast health easily leads to a cultural ambivalence about annual and preventative screenings. Myths and misinformation about breast cancer can permeate generations and become extremely difficult to correct on a macro level. One of the health care professionals working in Cherokee County expressed this when she remarked *“These old wives tales have been passed down for generations and it’s hard to get that out of people.”* Three substantial barriers to proper education emerged from the interviews of professionals working in Cherokee County. With these common misconceptions held by many women in the county, proper breast health education has become an essential piece of the puzzle in the community.

First, a startling amount of confusion has resulted from some misinformation possibly coming from local and primary physicians in the county. This includes advice about what age to begin screening, how often to receive screenings, and the importance of mammograms and Clinical Breast Exams. This theme was repeated in nearly every interview conducted in Cherokee County. Health care workers relay the confusion they hear from their patients. One practitioner said *“People who see their doctors every year are told they don’t need [a mammogram] until they’re 50 and then only need one if it’s normal.”* This type of advice keeps women from receiving annual screenings which can easily lead to a late detection of cancer cells. Other health care workers say a top reason why women are not getting screened is because *“their doctor says they don’t need it.”* Another interviewee responded that *“Education is driven by the doctor, and they’re being told they don’t need it. [Some of the local physicians] don’t value mobile mammography, or view it as less important.”* Another professional says they often hear, *“the doctors told them they don’t need a mammogram until 50. I think they are waiting too long to get their screening!”* This trend can easily lead to the significantly higher than average late-

stage diagnosis in the county and keep women from understanding the necessity of annual screenings.

Other areas of education where women are misinformed about breast health include the current survival rates of breast cancer and the necessity of screening even without a personal family history of the disease. Professionals who work with women in the county see this lack of education frequently. One mentioned, *“Many don’t understand the rate at which women get breast cancer, and don’t think it will affect them. They don’t realize that an incidence rate of one in eight means you don’t have to have a family history to be diagnosed. They don’t realize it can happen to them.”* This lack of urgency surrounding mammograms can allow early stage breast cancer to go undiagnosed for years. Another reason health care workers often hear from women who have not been scheduling annual screenings comes from the misconception that a lack of family history excludes them from the need for mammograms. This concept was brought up in several interviews, and one professional says she often hears, *“If I don’t have a family history, I don’t need to be seen. If nothing is bothering me, then I don’t need to worry about it. If it’s not broke, don’t fix it.”* Another health care worker says the women she sees are *“not educated about the importance of a yearly mammogram. They think no one in their family has had it so they don’t need it.”*

Similarly, many women have not been taught about the significance of detecting potential cancer early enough to substantially change the prognosis. A health care worker expressed this when she said *“Some don’t understand the stage of diagnosis greatly affects the survival rate.”* Misinformation often leads to a fear surrounding breast cancer because the numbers seem distant and impersonal to the average woman. During an interview, a local practitioner said *“The [lack of] education keeps women from understanding breast cancer statistics and rates. Our navigator is so helpful because she is a survivor and she shows them the face of a survivor.”* This navigator, who spends 20+ hours a week physically in the county interacting with local women, is providing essential care and personal connections with women who need help the most.

The final barrier to proper education in Cherokee County seems to come from a culture of mistrust of those who are considered ‘outsiders’ and those in the medical profession. A lay navigator in the county talked about the struggle to give away free mammograms in the county. *“We struggle to get women signed up for mammograms. A lot of times we hear that, ‘My aunt had a mammogram and she died. So, if I’m going to die anyway, why get a mammogram?’.”* This attitude reflects a suspicion of the necessity of mammograms and an improper connection between the service and the test results. Similar misconceptions are spread through the community, such as this story told by a health care professional. *“A woman we were working with from Cherokee had a mother who died from breast cancer and blames the doctor who operated on her for spreading the cancer. She still believed this old wives tale; she refuses to have a mammogram to this day.”* Unfortunately, when you hold that level of mistrust, it becomes increasingly unlikely for an individual to pursue proactive screenings. Another health care worker summarized it this way: *“Some in Cherokee County have a mistrust of the medical profession. They are very cautious about health providers. They are in a pattern of mistrust, and*

that is tough to break through.” Women are not able to receive proper breast health education if they do not believe the medical professionals who are trying to assist them.

With a significantly low rate of self-reported mammograms, women in Cherokee County clearly face substantial barriers to annual screenings. Throughout the key informant interviews, three themes emerged as the most pressing issues. These three areas include financial and insurance concerns, lack of convenient access, and fear of potential test results. Several professionals addressed the fact that not getting screened seems to be the cultural norm in the county. “*[A woman not receiving annual screening] would be the average person walking down the street*”.

The first and primary concern for many women in the community is the financial difficulties and lack of insurance coverage needed for annual screenings. One local professional says she sees “*so many women come in knowing about a lump or pain who didn’t seek treatment because of financial concerns.*” Many women do not seek treatment for symptoms until they become urgent because of their inability to afford proper care. Another health care worker confirmed this when she said, “*They don’t go to the doctor until something is really bad ... because of insurance.*” Because of the close connection to poverty and socioeconomic status, many believe screening percentages will not improve while the poverty percentages remain at their higher than average rate across the county. In an answer to a question about the top reasons why women are not currently being screened, one professional responded, “*You’re not going to see real change until you improve the overall economic situation in the county. There is so much poverty. They’ve got good county health initiatives and developments to improve the county in general. However, until you see improvement in the bottom line, you won’t see it in screening compliance.*”

Another barrier facing women in Cherokee County when they pursue annual screening is the lack of access, including concerns such as transportation, distance to screening facilities, time off work for appointments, etc. The inconvenience of making and keeping appointments for the appropriate screenings can become obstacles that seem insurmountable for women who are living in poverty. In one interview, a health care worker talked about this issue saying, “*it’s not that women don’t have insurance; it’s that they work six days a week and are tired and working all the time. I have to convince them to help themselves first in order to get them to come in [for a mammogram].*” While there are resources to assist women in this position, many women do not know about these options and instead push off their screenings. Another professional said she sees this all the time in the women she treats. “*We try to make sure they know we can help them with various aspects of care, like transportation, but initially it’s hard to get them in because they are afraid to lose their jobs.*” This lack of convenient access has become a barrier within the Continuum of Care.

Another common barrier that women in the community face is the fear of potential test results. Many women see a cancer diagnosis as an impossible situation and cannot see past to a life without the disease. One health care worker from Cherokee County believes, “*Many don’t know about the resources out there. They don’t ask questions or ask them to the wrong people. They*

don't pursue further information and they walk away [from mammograms]." Another professional said the women she sees in their mobile unit *"are very fearful of mammograms and the pain and fear of finding things. I'm always trying to explain that it's going to be ok."* The concern about the test results also keep some women from even making an appointment.

When faced with an abnormal mammogram, women need further diagnostic testing quickly. However, women in Cherokee County often are not able to move from screening to diagnostic services easily because of three main barriers identified in the qualitative assessment. These barriers need to be explained and addressed in order to assist women who are in this stage of the Continuum of Care.

First, many women refuse further diagnostic screenings because they are afraid of what those tests will find. In an interview, a local health care worker says the women in Cherokee are *"worried about what they will do if we find something. They are so fearful that we will find something, and they will end up having to go through diagnosis and treatment."* This fear is a natural reaction to the potential of a serious diagnosis, but denying the diagnosis is not the solution for women in this situation. Another local professional said she often hears of women who chose not to come back for further testing because they *"fear what it might be. My job is to convince them to go through with it; convince them to get the testing and give them options about getting coverage and help through it. I tell them 'You can't let fear paralyze you through this! You can't leave your family behind to cope without you because you didn't want to know!'"*

When facing further testing, many women learn that their insurance will not pay for certain types of diagnostics. When asked why women do not receive the diagnostics, one Cherokee professional says *"the biggest reason not to come back is financial concerns."* Without insurance coverage, a majority of women cannot afford the stack of bills that comes along with many types of testing. These women can be categorized as 'underinsured' and often are not eligible for certain types of financial assistance. Another health care worker in the county relayed a story of a local woman facing this scenario. *"We had a patient with only catastrophic insurance and refused to get a diagnostic mammogram because she didn't have the money. Eventually, we did get her through our free. Then, she was diagnosed in Category 5."*

The third barrier identified in the data is the difficulty of transportation to the facilities who will perform the diagnostic tests. Travelling 30-60 minutes one way to an appointment presents pragmatic and financial challenges to women who are living on a limited income. One of the professionals who works with women from Cherokee County believes women do not pursue further testing because of this issue. *"Most of the time it's the transportation issue: They either have a vehicle but no money, or no access to a vehicle. We have a local bus system with a bus line working through the hospital, but it doesn't go outside the county. There are no public transportation options to get from Cherokee to Spartanburg."*

Once a concrete diagnosis is given, women must face a host of emotional, physical, and financial challenges while they pursue treatment for their disease. The primary concerns that were addressed in the interviews and the survey of providers in Cherokee involved two main,

interrelated issues. These barriers are financial concerns and transportation difficulties. Transportation issues involve the practical nature of having access to a vehicle for appointments and the money needed for frequent trips out of the county. In response to a question regarding common barriers, one health care worker believes *“They may not have easy access to transportation or money to drive 20-30 min. They are burdened with how to get back and forth to treatment, and a lot of them are working. Cherokee county has a significant amount of women who don’t have jobs. However, those that do are often single moms, and are worried about missing work and keeping their jobs. They are worried about all of the financial concerns.”*

While there are some programs already in place to address these issues, the issues could use further support in the future. Unfortunately, women do not always take advantage of these resources currently being offered. One practitioner who works with women from Cherokee says, *“We’ve worked to eliminate the transportation barrier, but the programs are underutilized.”* A worker from a different facility serving Cherokee County said, *“We try to make sure they know we can help them with various aspects like transportation, but initially, it’s hard to get them in because they are afraid to lose their jobs if they miss work. Women chose not to do certain treatments because of transportation and money.”* Without the finances to cover the medical bills and the resources to drive to their appointments, many women drop out of the Continuum of Care and off the radar of medical resources to fight their disease. Again, women who are classified as ‘underinsured’ often face devastating choices about if they can afford to receive treatment. A health care professional talked about women in this situation. *“Women who are underinsured struggle. If they have an insurance policy with only catastrophic coverage, they can’t afford certain treatments. We have an income based program to help women like that. If they are approved, it covers a large majority of treatment on the outpatient side of things. They can apply for hospital financial aid, for inpatient services, and for other things once the insurance runs out.”* However, women need to know about programs like these that are offered, and gain approval after applying for the aid.

Cherokee County would benefit from the expansion of all types of follow-up and support services for current patients and survivors. Because of the high poverty percentages across the county, there are several religious and community missions that provide various needs for those who qualify. However, they are not exclusive to cancer patients and only provide non-specific items such as gas cards, meals, limited financial assistance, etc. Additionally, there is one cancer association serving both Cherokee and Spartanburg Counties who offer resources such as Ensure, transportation assistance, and even gas cards. Still, all of these areas would benefit from increased support. With all of the barriers within the other four areas of the Continuum of Care, it would be easy to overlook the importance of support and survivorship services for patients in the community. The high poverty percentages and increasing number of late-stage diagnoses in the county mean the women of Cherokee need assistance in both financial and pragmatic issues in order to spend their energy fighting the disease.

Qualitative Data Findings

The qualitative data for this report was gathered using key informant interviews, focus groups, and a survey of providers. Because of limited financial and time resources available, the Affiliate grouped together Anderson and Laurens Counties and also Greenwood and Edgefield Counties for data gathering purposes. Both sets of counties are located next to each other geographically and share similar demographic and statistical patterns that made the grouping valid for assessment purposes. This data represents three focus groups of women residing in and eight interviews from professionals working in Greenwood and Edgefield Counties. These three focus groups were held in Greenwood County at a local church who hosted and assisted in advertising the event. The groups were made up of residents of Greenwood County and each group contained 10, 11, and 12 participants respectively. Additionally, two focus groups were held in Anderson, one focus group in Laurens County and 12 key informant interviews of health care workers in these two counties were conducted. The Anderson focus groups included a group of five women and a second group of 11 participants. The final focus group in Laurens County consisted of six women from the community. The process in Cherokee County included a survey of providers with a 25 percent response rate and eight key informant interviews. The survey was sent and received by all four facilities present in Cherokee County, and one response was collected resulting in the 25 percent response rate.

The methods chosen for this assessment have clear strengths and limitations due to the nature of focus groups and interviews. The interviews gathered from years of experience to share various perspectives about current community struggles and the difficulties women face in these counties every day. The professionals who participated were able to create a vivid picture of the daily workings in their communities and speak about key issues they believe to be most important. The limitations from these interviews include the limited ability to generalize from statements made, the limits of personal perspective, and/or potential interview bias. Focus groups allow for women to express the concerns and perspectives seen in daily life throughout the county. The format allows for women to discuss issues in detail and open up to various difficulties they believe to be happening all around the area. However, focus groups can provide data that becomes difficult to effectively analyze, only capture certain perspectives, and become difficult to generalize to an entire population.

Greenwood and Edgefield Counties

In order to answer the key assessment questions, this profile gathered data from focus groups and interviews to learn more about Greenwood and Edgefield Counties. The answers looked at the current barriers for women to access the Continuum of Care, current programs already in place to address these issues, and the main factors that contribute to the high rates of late-stage diagnosis and death from breast cancer.

Each of the five stages of the Continuum of Care were closely studied and present obstacles identified. In the desire to educate women about proper breast health, two major areas were identified in Greenwood and Edgefield Counties: lack of understanding about Clinical Breast Exams and Breast Self-Awareness and a misunderstanding of the necessity of screening for

women without a family history of breast cancer. Once women recognize their need for annual screenings, they still have barriers to overcome. Four main impediments emerged for women to receive proper breast cancer screening. Financial and insurance concerns, lack of convenient access, fear of results, and cultural barriers can all prevent women from the recommended evaluations. When seeking diagnostic care, women can face one of three main obstacles in Greenwood and Edgefield Counties. Lack of facilities in Edgefield presents a serious challenge for women in the community, gaps in insurance coverage create financial concerns, and denial and lack of urgency delay important diagnostic testing. Current patients often face additional financial concerns and insurance complications or lack of coverage, transportation challenges, and an overwhelming sense of anxiety connected with a cancer diagnosis. These counties also do not have more than a handful of organizations offering support care and follow up services, so lack of access is a common barrier for women. Additionally, many individuals expressed a desire to see additional resources used to expand patient navigation in these areas.

These findings confirmed much of the data presented previously in the Quantitative Data Analysis. With 100 percent of the population of Edgefield County designated as medically underserved, the lack of resources and easy access to breast health services was not surprising. The current death rate in Edgefield County of 25.6 and the late-stage diagnosis rate of 46.5 are on track to miss the Healthy People 2020 goals of a death rate under 20.6 and a diagnosis rate of under 40.0. Additionally, Edgefield County contains a population where 73.0 percent live in a rural area, and Greenwood County has 39.8 percent of its population living in a rural area. With a late-stage diagnosis rate of 51.5 and death rate of 28.0, Greenwood County remains on track to also miss the HP2020 goals. This area contains 19.2 percent of residents age 40-64 who are without health insurance, and 10.1 percent of the entire population is designated as medically underserved. All of these rates and statistics created an accurate picture of Greenwood and Edgefield Counties that was supported by the qualitative data findings. These communities have a lack of resources, high poverty percentages, and a breakdown of the Breast Health Continuum of Care which have led to the high late-stage diagnosis and death rates shown in the data.

The Health Systems and Public Policy analysis identified the severe lack of breast health services in Edgefield County. With only one hospital in the county providing limited services within each stage of the CoC, women in the area must travel outside the community to receive the needed services. The lack of any form of treatment beyond surgery was especially conspicuous and concerning since any current patient must travel to a neighboring county to receive chemotherapy or radiation. In Greenwood County, the HSA described the current lack of support services and limited number of screening and diagnostic facilities. However, the main hospital in the county, Self-Regional Hospital, does provide quality care for their patients. Several women in focus groups expressed great trust in the hospital and gratitude for the level of service provided for their community. The lack of support services was confirmed by the qualitative data and the desire for more navigation expressed by multiple participants echoed the analysis given in the HSA about Greenwood County.

The qualitative data provided several key conclusions for consideration. All the statements below refer specifically to women, age 40+, who are residents of Greenwood and Edgefield Counties. The statements come directly from the data gathered in these two counties.

Women need to be educated about the significance of Clinical Breast and Breast Self-Awareness and importance of annual screenings regardless of family history.

Women face financial and insurance based concerns that keep them from receiving proper screening and treatment for breast cancer.

Transportation difficulties create frequent pragmatic barriers for women to receive screenings, diagnostic services, treatment, and support services.

Current support services, including financial assistance, survivorship programs, patient navigation, etc., are not enough to provide for the women who have been diagnosed with cancer.

These statements are clearly supported by the Quantitative data, Health Systems Analysis, Public Policy Analysis, and qualitative data. Together with these sections, the conclusion statements will form the bases for the Affiliate Action Plan to partner with existing organizations in these communities to reduce the late-stage diagnosis and death rates in the coming years.

Anderson and Laurens Counties

The data presented current barriers within each of the five elements of the Continuum of Care in Anderson and Laurens Counties. Two common misconceptions about breast health were identified as obstacles to proper education in the community. Currently, there is confusion about the proper age to begin receiving annual screenings and misinformation about the importance of screenings regardless of family history of the disease. While pursuing the necessary screening, women often face one or more of the four barriers identified in this report. Gaps in insurance coverage or lack of any insurance coverage, socioeconomic barriers, lack of convenient access and fear of results can all impact a woman's ability to make and keep a screening appointment. If further testing is needed, women often face transportation difficulties and gaps in coverage for necessary procedures. Current patients in Anderson and Laurens Counties must overcome the financial and insurance concerns that often come hand-in-hand with a breast cancer diagnosis, and women in Laurens County face the daunting task of travelling out of the county for any form of treatment. Additionally, limited support and follow-up care in these counties allow the financial, emotional, and pragmatic challenges for patients to become larger in the face of an uncertain future. To answer the second assessment question, the key factors contributing to high rates of late-stage diagnosis in these counties were identified as financial and insurance concerns, transportation to appointments, lack of proper breast health education, and fear of results.

The demographic and statistical data presented in the Quantitative Analysis set the stage for the conclusions identified by residents of these counties and the health care workers that serve

them. Currently, 18.5 percent of the population of Anderson County remains designated as medically underserved. Also, although the county has a higher than average 74.5 percent of women who self-report receiving an annual mammogram, their late-stage diagnosis rates continue to increase to unsafe levels. Within Laurens County, 19.0 percent of the residents are living below the federal poverty line. With 79.0 percent of women over 50 self-reporting an annual mammogram, Laurens County is also above the national average. However, several barriers to proper screening must exist to explain the late-stage diagnosis rate of 51 and death rate of 31.7 in the county. Both of these will miss the HP2020 goals set up of keeping late-stage diagnosis below 41 and death rates under 20.6. These findings were verified by the qualitative data as several key obstacles for proper care emerged from the data.

The Health Systems and Public Policy Analysis began to uncover potential barriers to the Continuum of Care through the number of facilities servicing Anderson and Laurens Counties. In Anderson County, the analysis showed a limited number of sites providing screening, only one local hospital providing treatment services, and a need to expand follow-up and support services throughout the county. Currently, Laurens County only contains one screening facility and no options providing chemotherapy, radiation, or other treatment options beyond diagnostic surgeries. The county also showed a need for more assistance providing follow-up and support services to current patients and survivors. These conclusions were confirmed through the testimonies of women who are residents of both counties and through the opinions expressed by health care professionals who are already working to serve women in Anderson and Laurens Counties.

The qualitative data from these counties provided several conclusions for consideration. The following statements are specific to women age 40+ who are current residents of Anderson and Laurens Counties.

Women need proper breast health education about the recommended age to begin screening and the importance of mammograms even without a personal family history of the disease.

Insurance and financial concerns, lack of accessible transportation, and personal fear often impede women's ability to receive necessary annual screenings.

Laurens County specific: Traveling out of the county for cancer treatment creates a substantial barrier for current patients to overcome both practically and financially.

Women need expanded follow-up and support services, especially in the area of patient navigation for current patients.

These conclusions are drawn from the information gathered in the Quantitative Analysis, Health Systems and Public Policy Analysis, and the qualitative data. They will form the basis for the Affiliate Action Plan that seeks to decrease late-stage diagnosis and death rates in Anderson and Laurens Counties.

Cherokee County

The assessment questions studied in this report looked at the barriers present in the Continuum of Care. Key obstacles were identified in each of the five stages, beginning with education. Women in Cherokee County must overcome misinformation from their doctors, lack of understanding about the necessity of mammograms, and a general distrust of the medical profession. These barriers keep many women from being proactive about their annual screenings. Before they actually receive those screenings, many women must address financial and insurance concerns, lack of access, and fear of potential test results. If further testing is needed, many women are fearful of what the testing will find, have difficulty affording testing not covered through insurance, and sometimes have transportation concerns when traveling to appointments. Women in the county also face transportation and financial difficulties when entering into treatment after a diagnosis of breast cancer. Also, lack of resources in the county mean there are limited follow-up and support services available for current patients and survivors. The main factors contributing to the significantly higher rates of death and late-stage diagnosis were identified as lack of proper breast health education, low screening compliance, financial concerns, and lack of convenient access to treatment.

The qualitative data findings laid the foundation for the qualitative study into Cherokee County. The main elements identified in the previous analysis were confirmed with the qualitative data of key informant interviews and a survey of breast health providers. 61.0 percent of the population of Cherokee are living in a rural area, 20.4 percent of the people are living below the poverty line, and 14.5 percent are unemployed in the county. With only 67.8 percent of women over 50 self-report having an annual mammogram, the county is significantly below the national average of 77.5 percent. These low screening ratio connects to the late-stage diagnosis rate of 51 and the high death rate of 26.4. Cherokee County remains on track to miss the Healthy People 2020 goals of a late-stage diagnosis rate below 41.0 and a death rate under 22.4.

The Health Systems and Public Policy Analysis continued to look at the services already available and the connection to governmental assistance programs and policies. Cherokee County displayed a need for additional financial assistance programs as well as an increase in various types of follow-up and support care for current patients and survivors. The geographic locations of the facilities offering treatment presented potential transportation barriers. The current public policies have create various programs to address key financial concerns, but there are an increasing number of those in South Carolina who are classified as ‘underinsured’ even with the recent legislative changes.

The qualitative data leads to several conclusions statements about Cherokee County for further analysis. The statements below are addressing women over 40 who are residents of Cherokee County.

Lack of correct and complete breast health education in Cherokee County creates obstacles for women to receive proper and timely screenings.

Lack of finances and lack of complete insurance coverage obstruct women from receiving proper diagnostics, treatment, support, and follow-up care.

Traveling for diagnostic testing and treatment creates a substantial barrier for women both pragmatically and financially.

Women need increased support services and follow-up care in order to handle a cancer diagnosis and continue through survivorship.

These conclusions are drawn from the qualitative data, the quantitative results, and health systems and public policy analysis. The Affiliate Mission Action Plan will use these statements to develop next steps for the Affiliate to assist in lowering late-stage diagnosis and death rates within Cherokee County.

Mission Action Plan

Breast Health and Breast Cancer Findings of the Target Communities

Using data collected throughout each of the previous stages of the Community Profile, the Affiliate has identified key challenges existing in the target counties. The Quantitative Data, Health Systems and Public Policy Analysis, and Qualitative Data have built off of and with each other to create an accurate picture of the current strengths and weaknesses of breast health in these counties. The conclusions in each section sought to answer two main questions: (1) *What barriers exist for women in the target counties to access and move throughout the Continuum of Care?* and (2) *What factors contribute to the high rates of late-stage diagnosis and death from breast cancer in the target counties?* The culmination of this data gathering process requires a clear identification of the main challenges facing the target counties and the practical steps this Affiliate will take to address these problem areas.

Anderson and Laurens Counties

Anderson County has been identified as a target county for the Affiliate because of the high rates of late-stage diagnosis and death rates, the rural nature of the population, and the socioeconomic status of many residents. The current death rate of women from breast cancer is slightly higher than the nationwide rate of 22.6 per 100,000 and is currently at 25.3 per 100,000 women in Anderson County. The late-stage diagnosis rate has been increasing the last several years and currently affects a rate of 48.4 of the women in Anderson County. Right now, they will not meet the Healthy People 2020 goal of an average rate of 41.0 without a distinct reversal in the current trends. Additionally, Anderson County contains a 9.9 percent unemployment, 15.8 percent of the population living below the federal poverty line, and 18.5 percent of residents have been designated as medically underserved. These factors combine to show many women in Anderson County likely face financial and pragmatic barriers to easily accessing necessary health services. Following these conclusions, the Health Systems Analysis sought to identify the current organizations providing for women in these circumstances and if any key gaps in necessary services exist for any segment of the population.

Laurens County was also categorized as a target county because of their higher than average rates of late-stage diagnosis and death from breast cancer. While the HP2020 goal seeks to decrease the death rate to 20.6, Laurens remains at a rate of 31.7 per 100,000 women. Also, the county late-stage diagnosis rate settles around a rate of 51.0 which is significantly above the HP2020 rate of 41.0 per 100,000. The additional important factors within Laurens County include a considerably high poverty level, unemployment percentage, and high number of residents lacking a high school education. With many residents facing financial concerns and other compounding challenges, the lack of proper breast health is not a surprising result of these factors. The Health Systems Analysis assessed the local organizations who are already striving to meet the needs of women in poverty, including resources such as transportation assistance, financial help, and support services for the uninsured and underinsured in the community.

After gathering and mapping out the existing resources in Anderson and Laurens Counties, several key strengths and weaknesses emerged for further analysis. Anderson County contains

only one facility offering any treatment services and patient navigation. While this local hospital remains one of the county's greatest strengths through their services and support, one facility cannot effectively reach all 95,000 women residing in the community. There is a clear lack of support services across the county, including additional patient navigation support, and there remains a need for additional screening facilities who can reach the medically underserved and uninsured population. Within Laurens County, the local hospital remains an essential piece of the medical community. They are the only location offering mammograms and limited diagnostic procedures. To receive treatment, women in Laurens County must travel outside the county which produces a multitude of practical and financial difficulties for a majority of patients. Additionally, the county lacks several necessary support and survivorship services including patient navigation, transportation assistance, and financial programs. With 19.0 percent of Laurens County living at or below the poverty line, services like these can make an enormous difference to women fighting an unexpected diagnosis. With these results in hand, the Public Policy Analysis identified the related goals introduced as a part of the Affordable Care Act. However, since South Carolina chose not to expand their Medicare program in partnership with the federal law, many in the state remain in a group called "underinsured" because their income level keeps them from qualifying for coverage.

After identifying the likely barriers to screening, treatment, and support services through the Health Systems Analysis, the Affiliate interviewed health care professionals and held local focus groups to further understand the barriers existing within the CoC and sought to understand the factors contributing to a late-stage diagnosis and high rates of death from breast cancer in Anderson and Laurens Counties. Women identified two barriers to proper breast health education: (1) Frequent confusion about the proper age to begin receiving annual screenings and (2) Common misinformation about the importance of screenings regardless of family history of the disease. In order to receive timely and necessary screening, many women must overcome one or more of the four barriers identified as gaps in insurance coverage or lack of any insurance coverage, socioeconomic barriers, lack of convenient access and fear of results. If further diagnostic testing is needed, women often face transportation difficulties and gaps in insurance coverage for necessary procedures. If a diagnosis is confirmed, women in Anderson and Laurens Counties must overcome the financial and insurance concerns that often come hand-in-hand with a breast cancer diagnosis, and women in Laurens County face the daunting task of travelling out of the county for any form of treatment. Additionally, limited support and follow-up care in these counties allow the financial, emotional, and pragmatic challenges for patients to become larger in the face of an uncertain future. To summarize the findings, the key factors contributing to high rates of late-stage diagnosis and death in these counties were identified as financial and insurance concerns, transportation to appointments, lack of proper breast health education, and fear of results.

Greenwood and Edgefield Counties

Edgefield County was selected as a target county because of the current state of breast health identified in the Quantitative Data. The death rate from breast cancer affects 25.6 of every 100,000 women living in Edgefield, and the HP2020 target rate is at 20.6. Additionally, the late-stage diagnosis rate in the county, 46.5, remains above the stated goal of 41. While the number

of women within Edgefield self-reporting mammograms are on par with the Affiliate average, they are not up to the nationwide median of women. These rates are better understood when examined alongside the demographic statistics for the community. With 100.0 percent of the county designated as medically underserved, it is not surprising that many women are limited in their access to screening and treatment as well as other basic medical services. Also, 19.4 percent of the population currently lives at or below the poverty line and 73.8 percent reside in a rural area which can indicate limited transportation and mobility. The Health Systems Analysis used this information to see how the rural and poor nature of the county affected the availability of breast health services.

Greenwood County shares similar characteristics that made it into the fourth target county. Currently, 28 of every 100,000 women in Greenwood County die from breast cancer, and direct and effective interference is needed to decrease this trend and bring that number down to fewer than 20 by 2020. Also, a rate of 51.5 of every 100,000 women are diagnosed in the late-stages of cancer. These statistics remain above average in the Affiliate service area and severely off track from reaching the HP2020 goal of a rate of 41. The socioeconomic statistics provide a fuller picture of the community. With unemployment at 11.4 percent and 19.0 percent living below the poverty line, families in Greenwood face many challenges lead to multiple barriers to receiving effective medical care. Medical insurance can be invaluable by providing life-saving services to women, but 19.2 percent of the residents age 40-64 in Greenwood are currently without health insurance. With this understanding, the Health Systems Analysis looked for existing resources in the county who are serving and assisting women with various financial and pragmatic needs.

The Health Systems Analysis uncovered the severe lack of services available in Edgefield County. With only one facility offering limited breast health and cancer services, women must frequently travel outside the county to receive essential screenings, diagnostics, treatments and support services. This confirms the data presented in the quantitative section which designates the county as medically underserved. Also, with 19.4 percent of the population living at or below the poverty line, it remains reasonable to assume many cannot easily access many necessary services.

Greenwood County contains a strong, local hospital providing quality care to women across the region. However, this facility is the only one offering mammograms, diagnostics, and limited treatment options. They cannot provide for all 36,500 women residents of the county by themselves, and other options are scarce within the community. The county especially needs additional programs offering comprehensive patient navigation services to women attempting to navigate through the Continuum of Care. Additionally, with 19.0 percent of the population living at or below the poverty line, there is an increasing need for financial assistance programs to serve the local residents.

Through the qualitative data gathering, several current barriers to the Continuum of Care presented themselves through the focus groups and interviews. These finding confirmed the conclusions already drawn in the report and showed foundational challenges facing women in

these counties. In order to access proper breast health education, women often face one or both of two major barriers. This can include a lack of understanding about Clinical Breast Exams and Breast Self-Awareness and a misunderstanding of the necessity of screening for women without a family history of breast cancer. After receiving full education, many women still have challenges in accessing screening. Four main impediments emerged for women to receive proper breast cancer screening. Financial and insurance concerns, lack of convenient access, fear of results, and cultural barriers can all prevent women from the recommended evaluations. When seeking diagnostic care, women can face one of three main obstacles in Greenwood and Edgefield Counties. Lack of facilities in Edgefield presents a serious challenge for women in the community, gaps in insurance coverage create financial concerns, and denial and lack of urgency delay important diagnostic testing. Current patients often face additional financial concerns and insurance complications or lack of coverage, transportation challenges, and an overwhelming sense of anxiety connected with a cancer diagnosis. Additionally, many individuals expressed a desire to see additional resources used to expand patient navigation in these areas.

Cherokee County

Cherokee County demonstrated a need for intervention because of the increasing rates of late-stage diagnosis, low rates of self-reporting mammograms among women above 40, and the high rate of death from breast cancer. Their current late-stage diagnosis rate falls at 51 percent per 100,000 women which is significantly higher than the HP2020 target of only 41. Also, the 26.4 death rate from breast cancer remains above the national average of 22.6. The current rate of women who self-report having a mammogram within the last year from Cherokee County is only at 67.8 percent and is significantly below the national average of 77.5 percent. Both the lack of education and higher level of poverty in the county can impact these rates and percentages. Currently, 25.2 percent of the residents in Cherokee County have less than a high school education, and 20.4 percent of the population is living below the poverty line. The 14.5 percent unemployment remains significantly higher than the present 8.7 percent national average. The Health Systems Analysis studied if these numbers are because of a lack of facilities in the county or if the problem was more complicated than the availability of services.

Cherokee County is served by several quality organizations who are consistently reaching out to the women in the community. The Health Systems Analysis identified three main facilities providing screening, diagnostics, and treatment services as well as additional organizations providing limited support services. However, the geographic locations of these centers could present some challenges to women facing limited transportation options. Within the county, several health care professionals remarked about reluctance of many women to cross from the Blacksburg region to the Gaffney area. With all of the facilities located in Gaffney or the neighboring county of Spartanburg, many of the 20.4 percent of the residents who are living in poverty likely face pragmatic and financial barriers to easily accessing breast health services. Additionally, the lack of support services revealed a need for expanding patient navigation programs within the community.

The qualitative analysis identified key obstacles facing women in Cherokee County in each of the five stages of the Continuum of Care. First, education about proper breast health is often impeded by misinformation from local doctors, lack of understanding about the necessity of mammograms, and a general distrust of the medical profession. These barriers keep many women from being proactive about their annual screenings. Before many can actually receive those screenings, women often must overcome financial and insurance concerns, lack of access, and fear of potential test results. If further diagnostic testing is needed, many women are fearful of what the tests will find, have difficulty affording testing not covered through insurance, and sometimes have transportation concerns when traveling to appointments. Women in the county also face transportation and financial difficulties when entering into treatment after a diagnosis of breast cancer. Also, lack of resources in the county mean there are limited follow-up and support services available for current patients and survivors. The main factors contributing to the significantly higher rates of death and late-stage diagnosis were identified as lack of proper breast health education, low screening compliance, financial concerns, and lack of convenient access to treatment. These findings confirm the data presented in the Quantitative Data report and Health Systems Analysis and present another perspective on the challenges facing women in Cherokee County.

Mission Action Plan

The Affiliate problem statements were developed by the Community Profile Coordinator and presented to the Executive Director and Mission Coordinator for approval. From these statements, priorities were created that reflected the concerns facing the target counties and the ability and resources of the Affiliate. These priorities were then ranked through each member voicing their perspective and a consensus was soon reached by every participant. The final combination of problem statements, priorities, and objectives were then approved through the Board of Directors and established as the Affiliate's mission action plan for the next four years.

Problem Statement: Quantitative Data showed women throughout each of the target counties face financial and insurance based concerns that keep them from receiving proper and timely screening and treatment for breast cancer.

Priority #1: Partner with local organizations to provide financial resources for individuals in Cherokee, Laurens, Anderson, Greenwood and Edgefield Counties who are uninsured or underinsured to increase ease of access to screening, diagnostic, and treatment services.

Objectives:

By the end of 2017, hold at least two grant writing workshops for organizations based in Cherokee, Laurens, Anderson, Greenwood and Edgefield Counties for presenting best practices and evidence based goals in applications.

By 2019, increase grant funding for non-profit organizations providing financial services for low income and uninsured/underinsured women in Anderson, Laurens, Greenwood, Cherokee, and Edgefield Counties.

Partner with at least two additional organizations working from Cherokee, Laurens, Anderson, Greenwood, and/or Edgefield Counties to provide materials, education, and support by the end of 2017.

Reach out to past and potential grant applicants from these counties and encourage future application for funding by 2016 in order to increase grant funding in Cherokee, Laurens, Anderson, Greenwood, and Edgefield Counties.

Seek a medical, non-profit, or public health professional from either Cherokee, Laurens, Anderson, Greenwood or Edgefield Counties to join the Board of Directors by 2018 to ensure the needs of these communities are being represented.

Problem Statement: According to the Quantitative Data, Anderson, Cherokee, Greenwood and Laurens counties are unlikely to meet the HP2020 goals for both breast cancer death and late-stage incidence rates, and Edgefield County is not likely to meet the late-stage incidence rate by 2020.

The Qualitative Data showed a lack of correct and complete breast health education creates obstacles for women in Anderson, Laurens, Greenwood, Edgefield, and Cherokee Counties to receiving proper and timely screenings.

Priority #2: *Reduce the rate of late-stage diagnosis in Anderson, Cherokee, Greenwood, Edgefield, and Laurens Counties through proper breast health education.*

Objectives:

Educate women in Anderson, Cherokee, Greenwood, Edgefield, and Laurens Counties through updated literature and information provided through health fairs and the Pink Sunday campaign to teach proper Breast Self-Awareness and proper screening beginning in September 2015 and continuing annually until 2019.

By the end of 2018, seek a partnership to create a pilot program in local school(s) from Anderson, Laurens, or Cherokee county that educates young women about Breast Self-Awareness in order to influence the next generation and clarify current breast health misconceptions.

Reach out to at least one organization (church, school, cancer association, etc.) in Anderson, Laurens, Cherokee, Greenwood, and Edgefield Counties to hold breast cancer community outreach presentations by the end of 2018.

By the end of 2019, increase grant funding for education and proper screening programs for organizations servicing the Anderson, Laurens, Cherokee, Greenwood and Edgefield Counties.

Problem Statement: The Qualitative Data revealed that women in Edgefield, Laurens, and Greenwood Counties have severely limited access to patient navigation and other essential support services. Anderson and Cherokee Counties provide various support services, but the programs cannot reach all of the women in the communities.

Priority #3: *Promote expansion of patient navigation services in Anderson, Laurens, Greenwood, Edgefield, and Cherokee Counties.*

Objectives:

Increase grant funding to organizations providing or building patient navigation in Anderson, Laurens, Greenwood, Edgefield and Cherokee Counties by 2019.

By the end of 2018, work with existing grantees in Anderson, Laurens, Greenwood, Edgefield, and Cherokee Counties to strengthen patient navigation programs and create a measurable system of evaluation.

Engage and educate grantees and partner organizations in Anderson, Laurens, Greenwood, Edgefield and Cherokee Counties about the impact of public policy developments and the upcoming changes and challenges resulting from them by the end of 2019.

By the end of 2017, ensure partner organizations and grantees in Anderson, Laurens, Greenwood, Edgefield, and Cherokee Counties are educated about services offered by nearby organizations in order to create a depth of knowledge about existing assistance already the surrounding communities.

Problem Statement: The Health Systems Analysis and Qualitative Data showed women in Laurens and Edgefield Counties do not have local facilities for treatment following a diagnosis and women in Anderson, Laurens, Greenwood, Cherokee and Edgefield Counties struggle to obtain consistent and reliable methods of transportation for appointments.

Priority #4: *Decrease transportation barriers for individuals in Anderson, Laurens, Cherokee, Greenwood, and Edgefield Counties to gain access to screening, diagnostic, and treatment services.*

Objectives:

Encourage local hospital systems to expand diagnostic and treatment services to Laurens and Edgefield Counties through advocacy and influence by 2019.

Increase funding for mobile mammography units who service the Anderson, Laurens, Greenwood, Cherokee and/or Edgefield Counties by the end of 2019.

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