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Susan G. Komen® Coastal Georgia was founded in 2006 by a group of passionate breast cancer advocates. Encouraged by Dr. Virginia Hermann, a surgeon specializing in breast cancer, the group submitted an application to the national organization and subsequently received Affiliate status. The Affiliate relied on the dedication of its volunteers until its first staff person, a Mission Outreach Coordinator, was hired in 2009. Since, 2009 the Affiliate has experienced exponential growth. Currently, the Affiliate is governed by an active 12 member Board of Directors, two full time staff (Executive Director and Mission Coordinator), and one part time Affiliate Coordinator.

At the time of incorporation, the Affiliate service area included eight Coastal Georgia counties: Bryan, Camden, Chatham, Effingham, Glynn, Liberty, Long, and McIntosh, and in 2011, the Affiliate adopted Bulloch County, bringing the total to nine counties. An estimated 665,000 people reside in the Affiliate service area, with the majority of residents living in Chatham (278,434), Glynn (81,508), and Bulloch (71,214) Counties. The majority of residents in those counties live in the largest city centers within the county (Savannah, Brunswick, and Statesboro, respectively).

In order to positively impact breast health in Coastal Georgia, the Affiliate has developed robust and impactful mission programs. The Affiliate has invested over $2 million into local programs to give vulnerable populations access breast cancer education, screening, diagnostic, and support services. As a result, 126 breast cancers have been detected and over 7,000 screenings and 1360 diagnostics have been completed.

The Affiliate’s grants program is its largest mission program. In 2015, the Affiliate granted $360,000 to local community organizations to address barriers identified in the previous community profile, including increasing access to breast cancer screenings and increasing navigation services.

The Affiliate also invests in outreach and education. The largest education program, Worship in Pink, provides educational materials to local faith-based organizations which plan events to educate their congregations. Through Worship in Pink, the Affiliate has been able to reach over 30,000 people over the course of three years, primarily in African-American and Rural populations, which tend to experience poorer breast health outcomes than other demographic groups.

Additionally, the Affiliate applied for and received a grant to support the Pink Hair Warrior Program, an education program aimed at addressing the high late-stage breast cancer diagnoses and death rates that Black/African-American Women experience in the Affiliate service area. The Pink Hair Warrior Program trains African-American hair stylists to be lay breast health advisors to their clients and in their communities.

The purpose of the 2015 Community Profile is to understand the breast health and breast cancer issues Coastal Georgia residents experience, and to investigate methods to positively impact breast health in Coastal Georgia. The Community Profile Team collected and analyzed data to learn about areas of need within the nine county service area.

The 2015 Community Profile will guide the Affiliate’s mission work by revealing issues people experience when seeking and receiving breast health care and obstacles they face as they try...
to navigate into and throughout the Continuum of Care. The strategic priorities set forth will ensure that the Affiliate’s resources are making a positive impact in Coastal Georgia.

Quantitative Data: Measuring Breast Cancer Impact in Local Communities

The total female population of the service area is estimated to be 317,604 people, and Chatham County has the largest population of women at over 132,000, followed by Glynn County at over 40,000. Overall, 43.3 percent of women within the service area are aged 40 or older, which is lower than Georgia at 45.5 percent. However, in Glynn and McIntosh Counties, over 50.0 percent of the female population is over the age of 40.

Most residents of the service area identify as white (62.9 percent), followed by Black/African-American (34.1 percent), and Hispanic/Latino (5.3 percent). The Affiliate has a higher percentage of residents who are Black/African-American than the state of Georgia (32.9 percent) and the US (14.1 percent), and Liberty, Chatham, and McIntosh Counties have the highest percentage of residents who identify as Black/African-American.

Overall, the Affiliate service area is more medically underserved than the state of Georgia and the US (46.8 percent versus 37.3 percent and 23.3 percent, respectively). Seven of the nine counties in the Affiliate service area are 100.0 percent medically underserved, which means that the health care resources cannot meet the needs of the residents. In addition to being rural and medically underserved, residents in Coastal Georgia are more likely to experience higher rates of other socioeconomic and demographic indicators associated with poor breast health outcomes than residents of Georgia and the US overall.

Over one quarter of Coastal Georgia residents (25.9 percent) live in rural areas, compared to 24.9 percent statewide, and 19.3 percent nationally. In the Affiliate service area, 38.4 percent of residents live below 250 percent of the Federal Poverty Level, which is higher than Georgia (37.6 percent) and the US (33.3 percent).

As a result of the quantitative data analysis, five target communities were chosen: Bryan County, Glynn County, McIntosh County, Black/African-American Women, and Medically Underserved Women.

In selecting the target communities, the Affiliate considered objectives set by the Healthy People 2020 (HP2020) initiative. HP2020 is a federal health promotion program aimed at improving health indicators in the US by the year 2020. The Affiliate analyzed two objectives relating to breast cancer—to minimize late-stage diagnosis rates to 41.0 or less per 100,000 women, and a death rate to 20.6 or less per 100,000 women. The Affiliate then reviewed projections and trends to better understand which populations are in need of interjections to meet these objectives.

Bryan County has a late-stage diagnosis rate of 55.1 per 100,000 females. This is higher than the rates in the Affiliate service area, Georgia, and the US, and it is increasing by 10.7 percent per year. The death rate in Bryan County is also higher than the HP2020 target (26.6 versus 20.6 per 100,000 women). Furthermore, Bryan County residents are more likely to live in rural and medically underserved areas than the Affiliate service area, Georgia, and the US as a whole, which can lead to poor health outcomes, such as late-stage diagnosis and death.

Glynn County is not on track to meet either of the HP2020 targets. The late-stage rate is 53.2, which is substantially higher than the HP2020 target of 41.0, and is increasing at 6.0 percent
Each year. The death rate is 23.1, but it is decreasing at a rate of 0.4 percent each year. Although the rate is decreasing, the decrease is not substantial enough to put the county in line to meet the HP2020 target.

One factor potentially contributing to poorer breast health outcomes is the age distribution of the population. Glynn County has the second highest percentage of female residents aged 40+ years in the Affiliate service area (51.2 percent), and that percentage is higher than the percentages for both Georgia and the US (45.5 percent and 48.3 percent, respectively). Because breast cancer risk increases with age, the population of women in Glynn County has a higher risk of breast cancer than counties with younger populations.

The late-stage breast cancer incidence rate in McIntosh County is lower than the HP2020 target of 41.0 cases per 100,000 females, but the rate is increasing at 33.9 percent each year. Although data were insufficient to establish a death rate and trend, people who are diagnosed with late-stage disease are more likely to die due to breast cancer than people who are diagnosed in early stages. Because the late-stage diagnosis trend is greatly increasing, the death rate could be higher than the HP2020 target.

Overall, socioeconomic indicators for McIntosh County are more unfavorable than those for the Affiliate service area, Georgia, and the US as a whole. McIntosh County has one of the highest percentages of residents living in poverty, in rural and medically underserved areas, and without health insurance. All of the above socioeconomic indicators are associated with poorer health outcomes, which could be a factor in the high rates of late-stage diagnosis.

Furthermore, McIntosh County has the highest percentage of women aged 40+ years in the Affiliate service area. Because increasing age is associated with an increased risk of breast cancer, women in the county are at the highest risk of developing breast cancer based upon age alone.

On average, Black/African-American Women are more likely to be diagnosed with late-stage disease and die due to breast cancer than white women in the US. This trend is also experienced by Black/African-American Women living in the Affiliate service area. Two of the three counties with the highest percentages of residents who are Black/African-American Women, McIntosh (38.1 percent) and Liberty (45.2 percent), are also 100 percent medically underserved and more rural than Georgia and the US, overall, which can create barriers in access to medical care for Black/African-American Women within those counties.

Seven of the nine counties in the Affiliate service area are considered 100 percent medically underserved: Bryan, Bulloch, Camden, Effingham, Liberty, Long, and McIntosh. Almost 50.0 percent of all Coastal Georgia residents live in medically underserved counties. Although no late-stage diagnosis or death rate data are available for Medically Underserved Women, counties which are 100 percent medically underserved do not have adequate health care resources to meet the needs of their residents. Because of that lack of resources, women in medically underserved areas may experience more barriers to breast health care, which can lead to poorer breast health.

Although the Quantitative Data Report includes information relating to socioeconomic and demographic data, which may be related to poor breast health outcomes, the data does not address barriers that people may experience as they seek breast health care from education through screening, diagnosis, treatment, and survivorship. In order to better understand barriers
to breast health care which could contribute to late-stage diagnosis and death, the Community Profile Team collected and analyzed health systems and public policy data.

Health Systems and Public Policy Analysis

The Affiliate explored health systems and public policy issues which may influence women’s progress through the breast health Continuum of Care. The Affiliate considered the availability of different breast health services throughout the Continuum of Care, geographic location of facilities which offer services, and the laws and policies, such as federal funding for free breast health services and insurance mandates, which may affect health seeking behaviors.

All counties in the Affiliate service area receive funding for the Breast and Cervical Cancer Program (BCCP), which allows uninsured women to receive free breast cancer screening and diagnostic services. Although this funding is available in each county, the program is only available to women over the age of 40, and funding typically runs out before the year end. Because of reduced funding for the BCCP program, the program is not able to serve all at-risk populations in the service area. Because funding is restricted by age and sex and runs out before year-end, the health departments within target communities have historically applied for and received Komen funding to be able to continue to provide breast health services to residents and expand the eligibility guidelines to include women younger than 40 and men.

Each county in the Affiliate service area has at least one health department location, but Bryan County, McIntosh County, and medically underserved counties have very few additional resources for people seeking breast health care. Bryan County residents have access to a hospital offshoot and a mobile mammography unit which periodically serves women within the county. In general, all other breast health care for residents of Bryan County must take place outside their county of residence because there are no other standing facilities in Bryan County which offer more than breast cancer screening.

Except for Bulloch and Effingham Counties which each have a hospital, all other medically underserved counties (including McIntosh County) do not have any standing facilities which offer mammography. The mobile mammography units from two health systems within the service area provide screening mammograms to women in each medically underserved county, however, those units operate on a fixed schedule and are not able to reach all at-risk women and men.

Glynn County residents have access to more breast health care resources per capita than in any other county in the service area. The county has one health system with a designated breast care center which provides services throughout the Continuum of Care (education, screening, diagnosis, treatment, and survivorship), and the health system uses a mobile mammography unit to reach residents throughout Glynn County. Residents also have access to two clinics which provide clinical breast exams and referrals to imaging centers for additional services. Although the county has a wealth of resources compared to others in the Affiliate service area, all resources are located within the city of Brunswick. The mobile unit is able to serve women outside of the city of Brunswick, but it operates on a fixed schedule and is also used to reach women in neighboring counties.

Health systems data for Black/African-American Women was considered because many counties have higher percentages of Black/African-American Women than Georgia and the US. Overall, the service area includes many facilities which offer breast health services through the Continuum of Care, including facilities which serve underinsured people through free and
reduced-cost services. Most facilities are located in city centers, such as Savannah (Chatham County), Statesboro (Bulloch County), Hinesville (Liberty County), and Brunswick (Glynn County), which means that Black/African-American Women who do not live in the city must travel to receive services.

Liberty, Chatham, and McIntosh Counties have the largest percentage of residents who are Black/African-American Women, and Liberty and McIntosh Counties are medically underserved so residents do not have adequate resources to ensure that all women enter into and progress through the Continuum of Care. Black/African-American Women in Chatham County are able to go to two local hospitals, two community health centers, one free clinic and one health department, but those facilities are located in Savannah, the largest city.

Although the quantitative, health systems and public policy data give insight into issues people in the Coastal Georgia community may experience when accessing breast health care, specific barriers related to cost, location, and personal beliefs are necessary to understand issues and how to positively impact them. In order to understand barriers more completely, the Community Profile Team collected and analyzed qualitative data.

**Qualitative Data: Ensuring Community Input**

Qualitative data were collected using key informant interviews, focus groups, and surveys to learn about barriers to breast cancer screening and perceived breast health care needs in target communities which might contribute to poor breast health outcomes. Qualitative data also examined potential improvements to the health care system to encourage women to get screened regularly, which would allow for earlier detection of breast cancer and better prognosis.

**Bryan County, Georgia**

In Bryan County, many key informants and focus group participants revealed that their lack of proximity to facilities which offer services, the high cost of services, and a general lack of knowledge of importance of screening are deterrents to receiving breast health care. Participants mentioned that many women who get screened leave their county of residence because of a lack of facilities, and having to do so creates other barriers related to lifestyle factors. One woman mentioned that getting regular breast cancer screenings is “too much of a hassle” because women in Bryan County have to travel up to an hour to their facility of choice, take time off from work, and find childcare. A mobile mammography unit does serve women in Bryan County, however, key informants and focus group participants agreed many Bryan County residents may not know about the unit or about its schedule.

Bryan County residents may also worry about the cost of breast health services, which could deter women from making and keeping screening appointments. Women who do not have insurance or who have insurance may not have the funds necessary to pay for screening and diagnostic workup out of pocket, so they may avoid health care all together. Additionally, women who have insurance with high deductibles may be less likely to get screened than women who have insurance with lower deductibles. Because insurance may not cover 100 percent of the cost of a diagnostic exam until a deductible is met, women may preemptively decide not to get screened to avoid the cost of diagnostic exams.

Bryan County key informants and focus group participants also cited a lack of knowledge of the importance of screening as a potential barrier. Women who do not understand the importance of regular screening may not be as likely to make an appointment for breast health services as
women who do understand the importance of screening. One key informant noted that there is not a lot of breast health education taking place in Bryan County, and believes that if more women had access to breast health education, they would be more likely to understand the importance of screening and follow through with regular breast health care.

**Glynn County, Georgia**

In Glynn County, data from key informants and survey participants revealed that a general lack of knowledge of available services, the high cost of services, and fears about mammography and breast cancer diagnosis may discourage women from getting screened. Some survey participants stated that providing free services could encourage women to get screened, and because there are free services currently available, this could mean that some women are unaware of the resources in their communities. Key informants also supported this idea – one informant explained that “If [women] knew about free mammograms, they might decide to take advantage of that.”

The cost of services was also a common concern when considering breast health care. Many key informants said that women do not know how they would afford health care if they needed it, so they avoid health care all together. Informants believed that insurance could help women afford screening, but one informant revealed that “even if you can afford health insurance, many times the deductible is so high that you question whether it is cheaper to pay out of pocket,” so women may not get screened because they know they cannot afford diagnostic services.

Finally, fears about pain associated with breast cancer screening and fears of a breast cancer diagnosis may prevent women in Glynn County from reaching out to local health care resources. Women may hear from their peers that mammograms “smash” or “squash” the breast, which could imply that mammograms are painful. Key informants and survey participants mentioned that they or women they know may be afraid of pain during mammogram, so they avoid the procedure. Women may also be afraid of a breast cancer diagnosis itself because of issues that may arise with work, taking care of the family, and finances.

**McIntosh County, Georgia**

In McIntosh County, key informants and focus group participants believed that barriers to screening include a misunderstanding of the medical process, being intimidated by health care, fearing breast cancer diagnosis, and a lack of proximity to available services. Key informants mentioned that many women in McIntosh County may not receive regular health care at all, so they may not be familiar with medical terminology and screening procedures. One key informant explained that she has heard women say that they have had a mammogram, when in reality the woman received a clinical breast exam.

Women may also be afraid of a breast cancer diagnosis and how it could negatively impact their lives, and those women are less likely to receive regular breast cancer screening. Informants and focus group participants repeatedly mentioned that a breast cancer diagnosis could affect your work life, family life, and finances, so women may take on an “out of sight, out of mind” mentality when considering breast cancer screening. Furthermore, informant said that “[breast cancer survivors] want to be seen as women. When women lose their breast, they don’t feel like women anymore,” so women who are afraid of losing a breast may avoid breast health care. Women in McIntosh County may also be intimidated by large institutions of health, like the hospital in Brunswick, which is where many women who receive breast health care travel. Because women may have to drive an hour or more to the hospital or their screening facility of choice, planning for travel, such as getting childcare, taking off of work, and paying for gas may be barriers to making and following through on an appointment for breast health care. One
informant observed “There is not much in this county, and women simply don’t know where to go. Some know there are services at the hospital in Brunswick, but they won’t go because it is too far.” Although the mobile mammography unit serves the county and allows women to receive screening within their county of residence, informants and focus group participants believed that its presence and schedule are probably not common knowledge.

**Black/African-American Women**

For Black/African-American Women, the high cost of services, lack of knowledge of resources and importance of screening, and a fear of breast cancer diagnosis along with a distrust of the health care system may create barriers to receiving breast health care. Women without insurance may not believe that they can afford any medical care, including regular breast cancer screening, so they are less likely to get screened. One informant explained that “For underserved minorities, money is a huge barrier – many African-American women are financially unstable,” so they do not receive regular health care. Although women with insurance may be more likely to get screened regularly, women who have high deductibles may preemptively decide not to get screened in order to avoid costs associated with diagnostic workup. Another informant said that “[Women] already have to make sure their families are taken care of, and now they have to figure out a way to pay for taking care of themselves, too,” when asked about the cost of services.

Additionally, focus group participants and key informants stated that women may not understand the importance of breast cancer screening, so they do not prioritize those services. One informant noted, “There are still a lot of myths in the African-American community about breast health, like hitting your breast will give you breast cancer. They may not understand why they need mammograms.” Informants and focus group participants agreed that more culturally competent breast health education could encourage more Black/African-American Women to get screened regularly.

Participants explained that the past mistreatment of Black/African-American Americans by the health care system, such as the Tuskegee Syphilis Experiment, plus a lack of cultural competence among health care professionals may make Black/African-American Women less likely to get screened. Stories about past mistreatment are circulated, and some Black/African-American Women may not think that their health care providers will respect and understand their cultural beliefs and practices, so those women may be less likely to access breast cancer screening. One informant explained that “Black/African-American women may not always feel like their doctor understands them. If they don’t think their doctor understands them or will try to understand them, they are not going to go.”

**Medically Underserved Women**

For Medically Underserved Women, key informants and survey participants identified the high cost of services, a lack of knowledge of resources, a lack of proximity to resources, and fears of pain and breast cancer diagnosis as barriers to screening. Similarly to other target communities, the cost of services without insurance is more than most women are able to afford out of pocket, and insurance with high deductibles may discourage women from seeking screening because they understand that they would not be able to afford the deductible if they need additional diagnostic workup.

Although each medically underserved county has at least one health department location, many Medically Underserved Women may not be aware of the availability of services through those facilities, so they may not reach out to those facilities for services. Some medically underserved counties are served by mobile mammography units which allow women to get screened in their
county of residence, however, the schedule and location of the units may not be well known for women in medically underserved counties, so those women are less likely to use those services. Additionally, over half of survey participants who indicated that they had never received a mammogram stated that one way to encourage women to get screened for breast cancer would be to offer free mammograms. Since referrals for free services are available, this may mean that those women are unaware of free services in their communities.

Each county has a health department and may be served by a mobile mammography unit, however, many Medically Underserved Women may have to travel out of their county of residence for breast health services, including any necessary diagnostic workup. Women who leave their county of residence for services typically travel to large cities, such as Savannah and Brunswick, for services. Informants mentioned that an hour drive may create barriers related to taking time off of work, arranging for childcare, and paying for gas, all of which may discourage women from making and keeping screening appointments.

Finally, key informants and focus group participants indicated that Medically Underserved Women may be afraid of pain during screening and being diagnosed with breast cancer. Women hear that mammograms flatten the breast and are painful, so they may not receive mammograms to avoid potential discomfort. Women may also be afraid of a diagnosis. One key informant said that “[women] don’t want to hear the “C” word. They’re afraid of a possible diagnosis and treatment,” and they do not know how they would be able to continue caring for and supporting their loved ones, so they avoid breast health care. All participants agreed that women who experience fear would be less likely to get screened than women who do no experience fear.

Mission Action Plan

Bryan County

Problem Statement: Bryan County residents experience a high late-stage diagnosis rate with a high annual trend, so the rate will continue to increase unless action is taken. According to qualitative interviews, women in Bryan do not have adequate resources for breast health services within the county, and women in the county may not be aware of the mobile mammography unit which serves women in the area. In addition to a lack of resources, women often cite cost as a barrier to receiving breast health care, especially for uninsured women. Finally, women in Bryan County may not be aware of the importance of regular breast cancer screening, which can negatively influence women’s screening decisions and lead to later diagnosis.

- **Priority 1:** Increase awareness and visibility of the mobile mammography unit which serves Bryan County.
  - **Objective 1:** From FY16 through FY19, incorporate awareness of mobile mammography unit services and locations in Bryan County through at least one existing Affiliate-based or Affiliate-funded education program each year.
  - **Objective 2:** By August 2016, facilitate discussions with community partners which serve Bryan County to address site location concerns and opportunities for the mobile mammography unit to better serve Bryan County residents.

- **Priority 2:** Reduce barriers related to the cost of breast health services for women who reside in Bryan County.
  - **Objective 1:** From FY16 through FY19, address the financial barriers of Bryan County residents in the Affiliate RFA priorities each year.
• **Priority 3:** Increase knowledge of the importance of breast cancer screening for Bryan County residents  
  o **Objective 1:** Incorporate breast cancer screening information into at least one community education program which serves Bryan County by January 2017.  
  o **Objective 2:** Increase the number of organizations in Bryan County participating in Worship in Pink by at least three each year from FY16 through FY19.

**Glynn County**

**Problem Statement:** Glynn County has a high late-stage diagnosis rate with high annual trend, so people will continue to be diagnosed late-stage unless action is taken. Qualitative data collection revealed that many women cannot afford to pay out of pocket for breast health services, and that they may not be aware of the low-cost resources within their communities. Additionally, women may delay screening because of fears about screening and diagnosis of breast cancer.

• **Priority 1:** Reduce the barriers associated with the cost of breast health services in Glynn County  
  o **Objective 1:** From FY16 through FY19, address the financial barriers of Glynn County residents in the Affiliate RFA priorities each year.

• **Priority 2:** Increase knowledge of free and low cost services in Glynn County for underinsured people  
  o **Objective 1:** From FY16 through FY19, ensure each grantee which serves Glynn County residents has a communications plan in place to educate the community about the availability of resources each year  
  o **Objective 2:** Identify at least one existing education program which serves Glynn County in which the Affiliate can provide and distribute information about local resources in Glynn County by January 2017

• **Priority 3:** Address Glynn County residents’ fears of pain related to mammograms and fears of breast cancer diagnosis  
  o **Objective 1:** Identify at least one community group to serve as peer advocates who can educate Glynn County residents about mammography and breast cancer by January 2017

**McIntosh County**

**Problem Statement:** McIntosh County has a rapidly increasing late-stage diagnosis rate, so although their current rate is lower than all other Coastal Georgia Counties, the annual increase will lead to more breast cancer late-stage diagnoses. Qualitative data collection revealed that women are not knowledgeable about terminology used during breast cancer screening and diagnostic procedures, so they may not know whether or not they have received mammograms. Additionally, women in McIntosh County experience fears related to a breast cancer diagnosis, which could cause them to delay care. Finally, McIntosh County residents typically travel outside of the county for health care. Residents who cannot or do not travel may not be able to receive necessary breast health care.

• **Priority 1:** Increase knowledge of the screening process and terminology associated with screening for McIntosh County residents.  
  o **Objective 1:** Incorporate information about screening and terminology in at least one Affiliate or community program serving McIntosh County residents each year from FY16 through FY19.
• **Priority 2:** Address McIntosh County residents’ fears of breast cancer diagnosis.
  - **Objective 1:** From FY16 through FY19, increase the number of organizations in McIntosh County participating in Worship in Pink by at least one per year.
  - **Objective 2:** Partner with at least one community program which serves McIntosh County to address fears and misperceptions through Affiliate grantmaking, outreach, or education by January 2017.

• **Priority 3:** Address barriers to receiving breast health care related to proximity to breast health services for McIntosh County residents
  - **Objective 1:** From FY16 through FY19, incorporate awareness of mobile mammography unit services and locations in McIntosh County through at least one existing Affiliate-based or Affiliate-funded education program each year.
  - **Objective 2:** By August 2016, facilitate discussions with community partners which serve McIntosh County to address site location concerns and opportunities for the mobile mammography unit to better serve McIntosh County residents.

Black/African-American Women

**Problem Statement:** Black/African-American women experience higher breast cancer death rates and late-stage diagnosis rates than white women within the Affiliate service area. According to key informant interviews and focus groups, the cost of services can deter Black/African-American Women in Coastal Georgia from receiving yearly screening, and women may not be aware of the services available in their communities. Lack of knowledge of the importance of screening plus fears of diagnosis and distrust of the health care system may also negatively influence Black/African-American Women’s decisions on whether or not to get screened.

• **Priority 1:** Reduce barriers related to cost of services for Black/African-American Women in Coastal Georgia.
  - **Objective 1:** From FY16 through FY19, address the financial barriers of Black/African-American Women in Coastal Georgia in the Affiliate RFA priorities each year.

• **Priority 2:** Increase knowledge of local breast health resources for Black/African-American Women in Coastal Georgia.
  - **Objective 1:** From FY16 through FY19, ensure that each grantee receiving funds for screening and diagnostic services whose target populations include Black/African-American Women has a communications plan in place to educate the community about the availability of resources each year.
  - **Objective 2:** Identify existing education programs serving Black/African-American women in which the Affiliate can provide information about local breast health programs by January 2017.

• **Priority 3:** Increase knowledge of importance of breast cancer screening for Black/African-American Women in Coastal Georgia.
  - **Objective 1:** Develop targeted messaging talking points for the Pink Hair Warriors and Worship in Pink education kits to educate participants on the importance of screening and encourage screening by January 2017.
  - **Objective 2:** Identify a community group to serve as peer advocates for Black/African-American Women in the Affiliate service area by January 2017.
• **Priority 4:** Address fears of breast cancer diagnosis and mistrust of the health care system for Black/African-American Women in Coastal Georgia.
  
o **Objective 1:** Develop targeted messaging talking points for the Pink Hair Warriors and to include in Worship in Pink education kits to address fears of breast cancer diagnosis and mistrust of the health care system by January 2017.
  
o **Objective 2:** Identify a community group to serve as peer advocates for Black/African-American Women in the Affiliate service area by January 2017.
  
o **Objective 3:** From FY16 through FY19, address the need for navigation programs to help Black/African-American Women transition through the continuum of care from education through screening and diagnosis in the Affiliate RFA priorities each year.

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**Medically Underserved Women**

**Problem Statement:** People in medically underserved areas are less likely to access breast health care due to lack of resources, which can put them at higher risk of late-stage diagnosis and death due to breast cancer than people who do access regular breast health care. Medically Underserved Women cite the cost of services and lack of knowledge of local resources as deterrents to breast health care. Medically Underserved Women may also experience fears of screening procedures and breast cancer diagnosis, which negatively influences their decisions about breast health care.

• **Priority 1:** Reduce barriers related to the cost of breast health services for people living in the seven counties identified as medically underserved.
  
o **Objective 1:** From FY16 through FY19, address the financial barriers of people living in the seven medically underserved counties in the Affiliate RFA priorities each year.

• **Priority 2:** Increase knowledge of available breast health resources for Medically Underserved Women in Coastal Georgia.
  
o Objective 1: From FY16 through FY19, ensure that grantees which serve medically underserved counties have a communications plan in place to educate the community about the availability of resources each year
  
o **Objective 2:** From FY16 through FY19, update service area resource sheet with information about local breast health services each year.

• **Priority 3:** Reduce barriers to breast cancer screening related to proximity for Medically Underserved Women in Coastal Georgia
  
o **Objective 1:** From FY16 through FY19, increase awareness of the mobile mammography units which serve Camden and Long Counties by providing literature or Komen Coastal Georgia speakers for least one education program each year.

• **Priority 4:** Address fears and misperceptions of pain of mammography and diagnosis of breast cancer for Medically Underserved Women in Coastal Georgia.
  
o **Objective 1:** Form or use an existing advisory board to explore issues involving fears and misperceptions related to breast cancer and breast cancer screening in medically underserved areas by January 2017
  
o **Objective 2:** From FY16 through FY19, address the need for navigation programs to help women living in medically underserved counties transition through the continuum of care from education through screening and diagnosis in the Affiliate RFA priorities each year.

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**Disclaimer:** Comprehensive data for the Executive Summary can be found in the 2015 Susan G. Komen® Coastal Georgia Community Profile Report.
**Affiliate History**

In the fall of 2005, several members of the Coastal Georgia communities organized into a planning group representing area healthcare organizations, cancer survivors, research and foundations. Encouraged by Dr. Virginia Hermann, a surgeon specializing in breast cancer, the group submitted an application to the Susan G. Komen national organization and subsequently received Affiliate status. Initially, the Affiliate was designated as the Southeast Susan G. Komen for the Cure. In order to eliminate confusion with the Southeast Georgia Cancer Alliance, the Affiliate pursued a name change which occurred during the first two years. The Affiliate is now called Susan G. Komen Coastal Georgia. At its inception, the Affiliate served eight counties: Bryan, Camden, Chatham, Effingham, Glynn, Liberty, Long, and McIntosh. The first board of directors met in June 2006. The first Savannah Race for the Cure was held in 2009, and one year later, the Affiliate hired its first staff member – a part-time Mission Outreach Coordinator. In 2011, the Affiliate applied for a service area expansion, and was granted an expansion into Bulloch County.

Since the Affiliate’s inception, it has experienced exponential growth. Currently, the Affiliate has three staff members (a full time Executive Director, a full time Mission Coordinator, and a part time Affiliate Administrator) and a large network of dedicated volunteers, which includes an active 12 member Board of Directors.

The Affiliate’s mission programs are robust and impactful. The Affiliate has invested over $2 million into local programs to give vulnerable populations access breast cancer education, screening, diagnostic, and support services. As a result, 126 breast cancers have been detected and over 7000 screenings and 1360 diagnostics have been completed. The Affiliate’s grants program is its largest mission program. In 2014, the Affiliate granted $320,000 to local community organizations to address barriers identified in the previous community profile, including increasing access to breast cancer screenings and increasing navigation services.

The Affiliate has also invested resources in outreach and education. Currently, the largest education program, Worship in Pink, provides educational materials to local faith-based organizations which plan events to educate and empower their congregations. Worship in Pink has grown from 52 registered organizations in 2011 to 76 in 2014.

In 2014, the Affiliate was awarded a grant to implement the Pink Hair Warrior Program, which trains African-American hair stylists to be lay breast health advisors in their salons and throughout their communities. This program will allow the Affiliate to address the high breast cancer late-stage diagnosis rate seen in African-American women in Coastal Georgia through culturally competent education and encouragement to get screened.

The Affiliate continues to diversify its development programs, enabling it to increase its mission programs each year.

**Affiliate Organizational Structure**

The Affiliate is governed by a 12 member working Board of Directors to ensure that the efforts and initiatives of the Affiliate are aligned with the vision and priorities of the organization. The Board meets once per month, and committee meetings are scheduled as needed. Current committees include Education, Community Profile, Fundraising, Grants, Race, Survivor, and Volunteer.
As of 2014, the Affiliate has two full time staff persons, an Executive Director and Mission Coordinator, and one part time Affiliate Administrator. In order to run efficiently, the Affiliate relies on the support and dedication of its volunteers, including administrative, education, outreach, and race volunteers.

Komen Coastal Georgia seeks to mirror the target populations of its service area through its volunteer program. As a result, the volunteer program is robust, inclusive, and active year-round in the community. The Affiliate strives to engage every volunteer from leadership positions, such as the Board of Directors, to the Race Committee, and Outreach Committee. Volunteers are encouraged to provide insight on the needs they see in the community and how they believe those needs may be reached.

**Affiliate Service Area**

The Affiliate service area includes nine Coastal Georgia counties: Bryan, Bulloch, Camden, Chatham, Effingham, Glynn, Liberty, Long, and McIntosh (Figure 1.1).

The Affiliate service area encompasses approximately 4,500 square miles along the coast of Georgia and includes over 10 islands and 100 miles of general coastline (US Census Bureau, 2012). Because of its proximity to the coast and rich cultural history, the Affiliate service area is a destination for travel/tourism and historical and cultural events. In addition to cities and towns, the Affiliate service area is home to two military bases, which are Fort Stewart in Liberty County and its subsidiary, Hunter Army Airfield in Chatham County.

An estimated 665,000 people live in the Affiliate service area, according to 2013 US Census estimates, with Chatham (278,434 residents), Glynn (81,508 residents, and Bulloch (71,214 residents) Counties having the largest total populations. The majority of residents within those counties live in the largest city centers within those counties (Savannah, Brunswick, and Statesboro, respectively). The counties with the smallest populations include McIntosh (14,007 residents), Long (16,624 residents), and Bryan (33,157 residents) Counties (US Census Bureau, 2013).

The total female population of the service area is estimated to be 317,604 people, and Chatham County has the largest population of women at over 132,000, followed by Glynn County at over 40,000. Overall, 43.3 percent of women within the service area are aged 40 or older, which is lower than Georgia at 45.5 percent. However, in Glynn and McIntosh Counties, over 50.0 percent of the female population is over the age of 40.

The majority of the residents in Coastal Georgia are white (62.9 percent), followed by Black/African-American (34.1 percent), and Hispanic/Latino (5.3 percent). The Affiliate has a higher percentage of residents who are Black/African-American than the state of Georgia (32.9 percent) and the US (14.1 percent), and Liberty, Chatham and McIntosh Counties have the highest percentages of residents who are Black/African-American out of the entire service area at 45.2 percent, 42.2 percent, and 38.1 percent, respectively. In Liberty and Long Counties, over 10.0 percent of residents identify as Hispanic/Latino, both of which are higher than the Affiliate service area (5.3 percent) and the state of Georgia (8.2 percent).

Overall, the service area is more medically underserved than the state of Georgia and the US as a whole (46.8 percent versus 37.3 percent and 23.3 percent, respectively). In fact, seven of the nine counties in the Affiliate service area are 100.0 percent medically underserved, and the health care resources within those counties cannot meet the needs of the residents. In addition
to being medically underserved, the Affiliate service area is more rural and has more residents living in poverty than in Georgia and the US. Over one quarter of Coastal Georgia residents (25.9 percent) live in rural areas, compared to 24.9 percent statewide, and 19.3 percent nationally. In the Affiliate service area, 38.4 percent of residents live below 250 percent of the Federal Poverty Level, which is higher than Georgia (37.6 percent) and the US (33.3 percent).
Figure 1.1. Susan G. Komen Coastal Georgia service area
Purpose of the Community Profile Report

The purpose of the 2015 Community Profile is to understand the issues people in Coastal Georgia face when considering breast health care and breast cancer, including education, screening, diagnosis, treatment, and survivorship. The Community Profile Team collected and analyzed quantitative, health systems, public policy, and qualitative data to learn about areas of need throughout the nine county service area.

The 2015 Community Profile will guide the Affiliate’s mission work for the next four years. The information within the report will allow the Affiliate to strategically target areas of need through culturally competent outreach and education programs, informed advocacy initiatives, and targeted grantmaking to help community members in need access the education and services they need. The priorities set forth in the Community Profile will ensure that the Affiliate’s resources and funding are making the largest impact throughout Coastal Georgia.

The 2015 Community Profile will also inform stakeholders and community members in Coastal Georgia of the issues and areas of need throughout the nine county service area. The report will be distributed to previous, current, and potential Coastal Georgia grantees, collaborators within the community, local health education and health care services providers, and will be posted on the Affiliate’s website so that interested parties can easily access the document.
Quantitative Data Report

Introduction
The purpose of the quantitative data report for Susan G. Komen® Coastal Georgia 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® Coastal Georgia’s Quantitative Data Report. For a full report please contact the Affiliate.

Breast Cancer Statistics

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

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

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

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

- A negative value means that the rates are getting lower.
- A positive value means that the rates are getting higher.
- A positive value (rates getting higher) may seem undesirable—and it generally is. However, it is 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 do not 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/](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

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Incidence Rates and Trends</th>
<th>Death Rates and Trends</th>
<th>Late-stage Rates and Trends</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female Population</td>
<td># of New Cases</td>
<td># of Deaths</td>
</tr>
<tr>
<td></td>
<td>(Annual Average)</td>
<td>Age-adjusted Rate/100,000</td>
<td>(Annual Average)</td>
</tr>
<tr>
<td>US</td>
<td>154,540,194</td>
<td>182,234</td>
<td>122.1</td>
</tr>
<tr>
<td>HP2020</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Georgia</td>
<td>4,838,820</td>
<td>5,997</td>
<td>121.5</td>
</tr>
<tr>
<td>Komen Coastal Georgia Service Area</td>
<td>317,604</td>
<td>380</td>
<td>118.5</td>
</tr>
<tr>
<td>White</td>
<td>200,940</td>
<td>270</td>
<td>122.2</td>
</tr>
<tr>
<td>Black/African-American</td>
<td>108,173</td>
<td>104</td>
<td>111.9</td>
</tr>
<tr>
<td>American Indian/Alaska Native (AIAN)</td>
<td>1,409</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>Asian Pacific Islander (API)</td>
<td>7,082</td>
<td>4</td>
<td>66.5</td>
</tr>
<tr>
<td>Non-Hispanic/ Latina</td>
<td>302,941</td>
<td>374</td>
<td>119.5</td>
</tr>
<tr>
<td>Hispanic/ Latina</td>
<td>14,664</td>
<td>5</td>
<td>75.7</td>
</tr>
<tr>
<td>Bryan County - GA</td>
<td>14,737</td>
<td>19</td>
<td>132.1</td>
</tr>
<tr>
<td>Bulloch County - GA</td>
<td>33,810</td>
<td>34</td>
<td>119.4</td>
</tr>
<tr>
<td>Camden County - GA</td>
<td>24,238</td>
<td>24</td>
<td>112.8</td>
</tr>
<tr>
<td>Chatham County - GA</td>
<td>132,983</td>
<td>175</td>
<td>121.2</td>
</tr>
<tr>
<td>Effingham County - GA</td>
<td>25,406</td>
<td>30</td>
<td>126.2</td>
</tr>
<tr>
<td>Glynn County - GA</td>
<td>40,657</td>
<td>60</td>
<td>121.6</td>
</tr>
<tr>
<td>Liberty County - GA</td>
<td>32,070</td>
<td>24</td>
<td>99.5</td>
</tr>
<tr>
<td>Long County - GA</td>
<td>6,637</td>
<td>4</td>
<td>63.9</td>
</tr>
<tr>
<td>McIntosh County - GA</td>
<td>7,065</td>
<td>10</td>
<td>101.1</td>
</tr>
</tbody>
</table>

*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 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 and incidence trend in the Komen Coastal Georgia service area was slightly lower than that observed in 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 Georgia.

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 APIs and AIANs were lower than for Non-Hispanic Whites and Blacks/African-Americans. The most recent estimated incidence rates for Hispanics/Latinas were lower than for Non-Hispanic Whites and
Blacks/African-Americans. For the Affiliate service area as a whole, the incidence rate was lower among Blacks/African-Americans than Whites 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 incidence rate was significantly lower in the following county:
- Long County

The rest of the counties had incidence rates and trends that were not significantly different than the Affiliate service area as a whole.

It is 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 Coastal Georgia service area was similar to 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 Georgia.

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.

None of the counties in the Affiliate service area had substantially different death rates 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 Coastal Georgia service area was slightly higher than that observed in the US as a whole and the late-stage incidence trend was higher than the US as a whole. The late-stage incidence rate and trend of the Affiliate service area were not significantly different than that observed for the State of Georgia.

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

None of the counties in the Affiliate service area had substantially different late-stage incidence rates 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*

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

*As of October 2015

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

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

The report uses the mammography screening proportion to show if 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 that 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 that 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

<table>
<thead>
<tr>
<th>Population Group</th>
<th># of Women Interviewed (Sample Size)</th>
<th># w/ Self-Reported Mammogram</th>
<th>Proportion Screened (Weighted Average)</th>
<th>Confidence Interval of Proportion Screened</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>174,796</td>
<td>133,399</td>
<td>77.5%</td>
<td>77.2%-77.7%</td>
</tr>
<tr>
<td>Georgia</td>
<td>2,341</td>
<td>1,874</td>
<td>81.0%</td>
<td>78.8%-83.1%</td>
</tr>
<tr>
<td>Komen Coastal Georgia Service Area</td>
<td>130</td>
<td>109</td>
<td>84.8%</td>
<td>74.1%-91.5%</td>
</tr>
<tr>
<td>White</td>
<td>96</td>
<td>79</td>
<td>81.0%</td>
<td>68.6%-89.3%</td>
</tr>
<tr>
<td>Black/African-American</td>
<td>28</td>
<td>25</td>
<td>95.4%</td>
<td>69.0%-99.5%</td>
</tr>
<tr>
<td>AIAN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>API</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>Hispanic/ Latina</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>Non-Hispanic/ Latina</td>
<td>128</td>
<td>107</td>
<td>84.4%</td>
<td>73.5%-91.3%</td>
</tr>
<tr>
<td>Bryan County – GA</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>Bulloch County – GA</td>
<td>13</td>
<td>13</td>
<td>100%</td>
<td>67.2%-100%</td>
</tr>
<tr>
<td>Camden County – GA</td>
<td>12</td>
<td>11</td>
<td>85.4%</td>
<td>46.4%-97.5%</td>
</tr>
<tr>
<td>Chatham County – GA</td>
<td>47</td>
<td>38</td>
<td>81.2%</td>
<td>61.1%-92.2%</td>
</tr>
<tr>
<td>Effingham County – GA</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>Glynn County – GA</td>
<td>30</td>
<td>25</td>
<td>85.9%</td>
<td>59.4%-96.2%</td>
</tr>
<tr>
<td>Liberty County – GA</td>
<td>11</td>
<td>9</td>
<td>81.9%</td>
<td>46.1%-96.0%</td>
</tr>
<tr>
<td>Long County – GA</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>McIntosh County – GA</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
</tbody>
</table>

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

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

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

**Population Characteristics**

The report includes basic information about the women in each area (demographic measures) and about factors like education, income, and unemployment (socioeconomic measures) in the areas where they live (Tables 2.4 and 2.5). Demographic and socioeconomic data can be used to identify which groups of women are most in need of help and to determine 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 were not 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 do not 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

<table>
<thead>
<tr>
<th>Population Group</th>
<th>White</th>
<th>Black /African-American</th>
<th>AIAN</th>
<th>API</th>
<th>Non-Hispanic /Latina</th>
<th>Hispanic /Latina</th>
<th>Female Age 40 Plus</th>
<th>Female Age 50 Plus</th>
<th>Female Age 65 Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>78.8%</td>
<td>14.1%</td>
<td>1.4%</td>
<td>5.8%</td>
<td>83.8%</td>
<td>16.2%</td>
<td>48.3%</td>
<td>34.5%</td>
<td>14.8%</td>
</tr>
<tr>
<td>Georgia</td>
<td>62.8%</td>
<td>32.9%</td>
<td>0.5%</td>
<td>3.7%</td>
<td>91.8%</td>
<td>8.2%</td>
<td>45.5%</td>
<td>31.0%</td>
<td>12.3%</td>
</tr>
<tr>
<td>Komen Coastal Georgia Service Area</td>
<td>62.9%</td>
<td>34.1%</td>
<td>0.5%</td>
<td>2.5%</td>
<td>94.7%</td>
<td>5.3%</td>
<td>43.3%</td>
<td>30.7%</td>
<td>12.5%</td>
</tr>
<tr>
<td>Bryan County - GA</td>
<td>80.6%</td>
<td>16.4%</td>
<td>0.5%</td>
<td>2.5%</td>
<td>94.9%</td>
<td>5.1%</td>
<td>43.8%</td>
<td>28.6%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Bulloch County - GA</td>
<td>67.2%</td>
<td>30.8%</td>
<td>0.4%</td>
<td>1.7%</td>
<td>96.9%</td>
<td>3.1%</td>
<td>35.1%</td>
<td>24.9%</td>
<td>10.3%</td>
</tr>
<tr>
<td>Camden County - GA</td>
<td>75.2%</td>
<td>21.9%</td>
<td>0.6%</td>
<td>2.3%</td>
<td>95.1%</td>
<td>4.9%</td>
<td>42.7%</td>
<td>28.5%</td>
<td>10.5%</td>
</tr>
<tr>
<td>Chatham County - GA</td>
<td>54.4%</td>
<td>42.2%</td>
<td>0.4%</td>
<td>3.0%</td>
<td>95.0%</td>
<td>5.0%</td>
<td>44.6%</td>
<td>32.7%</td>
<td>13.9%</td>
</tr>
<tr>
<td>Effingham County - GA</td>
<td>83.6%</td>
<td>14.8%</td>
<td>0.3%</td>
<td>1.3%</td>
<td>97.2%</td>
<td>2.8%</td>
<td>44.7%</td>
<td>28.9%</td>
<td>10.3%</td>
</tr>
<tr>
<td>Glynn County - GA</td>
<td>69.9%</td>
<td>27.8%</td>
<td>0.5%</td>
<td>1.7%</td>
<td>94.2%</td>
<td>5.8%</td>
<td>51.2%</td>
<td>38.1%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Liberty County - GA</td>
<td>50.3%</td>
<td>45.2%</td>
<td>0.9%</td>
<td>3.6%</td>
<td>89.8%</td>
<td>10.2%</td>
<td>34.0%</td>
<td>21.6%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Long County - GA</td>
<td>68.8%</td>
<td>28.3%</td>
<td>0.9%</td>
<td>2.1%</td>
<td>88.8%</td>
<td>11.2%</td>
<td>36.7%</td>
<td>23.9%</td>
<td>7.7%</td>
</tr>
<tr>
<td>McIntosh County - GA</td>
<td>60.8%</td>
<td>38.1%</td>
<td>0.5%</td>
<td>0.6%</td>
<td>98.6%</td>
<td>1.4%</td>
<td>57.7%</td>
<td>43.8%</td>
<td>18.9%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Less than HS Education</th>
<th>Income Below 100% Poverty</th>
<th>Income Below 250% Poverty (Age: 40-64)</th>
<th>Unemployed</th>
<th>Foreign Born</th>
<th>Linguistically Isolated</th>
<th>In Rural Areas</th>
<th>In Medically Underserved Areas</th>
<th>No Health Insurance (Age: 40-64)</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>14.6%</td>
<td>14.3%</td>
<td>33.3%</td>
<td>8.7%</td>
<td>12.8%</td>
<td>4.7%</td>
<td>19.3%</td>
<td>23.3%</td>
<td>16.6%</td>
</tr>
<tr>
<td>Georgia</td>
<td>16.0%</td>
<td>16.5%</td>
<td>37.6%</td>
<td>9.9%</td>
<td>9.7%</td>
<td>3.3%</td>
<td>24.9%</td>
<td>37.3%</td>
<td>20.7%</td>
</tr>
<tr>
<td>Komen Coastal Georgia Service Area</td>
<td>12.9%</td>
<td>17.9%</td>
<td>38.4%</td>
<td>8.3%</td>
<td>5.0%</td>
<td>1.6%</td>
<td>25.9%</td>
<td>46.8%</td>
<td>20.3%</td>
</tr>
<tr>
<td>Bryan County - GA</td>
<td>12.2%</td>
<td>11.8%</td>
<td>29.7%</td>
<td>6.7%</td>
<td>3.8%</td>
<td>0.9%</td>
<td>52.3%</td>
<td>100.0%</td>
<td>17.7%</td>
</tr>
<tr>
<td>Bulloch County - GA</td>
<td>14.2%</td>
<td>30.5%</td>
<td>45.2%</td>
<td>7.5%</td>
<td>3.7%</td>
<td>1.8%</td>
<td>48.3%</td>
<td>100.0%</td>
<td>22.4%</td>
</tr>
<tr>
<td>Camden County - GA</td>
<td>10.7%</td>
<td>16.2%</td>
<td>34.1%</td>
<td>9.3%</td>
<td>1.6%</td>
<td>1.2%</td>
<td>31.4%</td>
<td>100.0%</td>
<td>17.6%</td>
</tr>
<tr>
<td>Chatham County - GA</td>
<td>12.0%</td>
<td>18.1%</td>
<td>38.3%</td>
<td>7.8%</td>
<td>6.4%</td>
<td>2.0%</td>
<td>4.5%</td>
<td>1.6%</td>
<td>20.8%</td>
</tr>
<tr>
<td>Effingham County - GA</td>
<td>14.7%</td>
<td>10.4%</td>
<td>31.8%</td>
<td>7.4%</td>
<td>2.2%</td>
<td>0.1%</td>
<td>67.1%</td>
<td>100.0%</td>
<td>17.2%</td>
</tr>
<tr>
<td>Glynn County - GA</td>
<td>13.9%</td>
<td>15.8%</td>
<td>33.8%</td>
<td>9.1%</td>
<td>5.4%</td>
<td>1.7%</td>
<td>20.6%</td>
<td>0.0%</td>
<td>19.5%</td>
</tr>
<tr>
<td>Liberty County - GA</td>
<td>10.0%</td>
<td>17.1%</td>
<td>49.1%</td>
<td>10.7%</td>
<td>6.1%</td>
<td>1.5%</td>
<td>23.2%</td>
<td>100.0%</td>
<td>22.2%</td>
</tr>
<tr>
<td>Long County - GA</td>
<td>22.5%</td>
<td>21.5%</td>
<td>53.7%</td>
<td>8.0%</td>
<td>5.7%</td>
<td>2.6%</td>
<td>81.3%</td>
<td>100.0%</td>
<td>26.8%</td>
</tr>
<tr>
<td>McIntosh County - GA</td>
<td>22.5%</td>
<td>15.5%</td>
<td>45.7%</td>
<td>9.1%</td>
<td>0.9%</td>
<td>0.1%</td>
<td>74.3%</td>
<td>100.0%</td>
<td>21.6%</td>
</tr>
</tbody>
</table>

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 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 Coastal Georgia 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 younger than that of the US as a whole. The Affiliate’s education level is slightly higher than and income level is slightly lower than those of the US as a whole. There are a slightly smaller percentage of people who are unemployed in the Affiliate service area. The Affiliate service area has a substantially smaller percentage of people who are foreign born and a substantially smaller percentage of people who are linguistically isolated. There are a substantially larger percentage of people living in rural areas, a slightly larger percentage of people without health insurance, and a substantially 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:
- Chatham County
- Liberty County

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

The following county has a substantially older female population percentage than that of the Affiliate service area as a whole:
- McIntosh County

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

The following county has a substantially lower income level than that of the Affiliate service area as a whole:
- Bulloch County

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

<table>
<thead>
<tr>
<th>Time to Achieve</th>
<th>Time to Achieve Late-stage Incidence Reduction Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death Rate</td>
<td>13 years or longer</td>
</tr>
<tr>
<td>13 years or</td>
<td>Highest</td>
</tr>
<tr>
<td>longer</td>
<td></td>
</tr>
<tr>
<td>7-12 yrs.</td>
<td>High</td>
</tr>
<tr>
<td>0 – 6 yrs.</td>
<td>Medium High</td>
</tr>
<tr>
<td>Currently</td>
<td>Medium High</td>
</tr>
<tr>
<td>meets target</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>Highest</td>
</tr>
</tbody>
</table>

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 does not 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 rates and key breast cancer death determinants such as poverty and linguistic isolation.
Table 2.7. Intervention priorities for Komen Coastal Georgia service area with predicted time to achieve the HP2020 breast cancer targets and key population characteristics

<table>
<thead>
<tr>
<th>County</th>
<th>Priority</th>
<th>Predicted Time to Achieve Death Rate Target</th>
<th>Predicted Time to Achieve Late-stage Incidence Target</th>
<th>Key Population Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bryan County - GA</td>
<td>Highest</td>
<td>NA</td>
<td>13 years or longer</td>
<td>Rural, medically underserved</td>
</tr>
<tr>
<td>Glynn County - GA</td>
<td>Highest</td>
<td>13 years or longer</td>
<td>13 years or longer</td>
<td></td>
</tr>
<tr>
<td>McIntosh County - GA</td>
<td>Highest</td>
<td>SN</td>
<td>13 years or longer</td>
<td>Older, education, rural, medically underserved</td>
</tr>
<tr>
<td>Bulloch County - GA</td>
<td>Medium High</td>
<td>4 years</td>
<td>13 years or longer</td>
<td>Poverty, rural, medically underserved</td>
</tr>
<tr>
<td>Chatham County - GA</td>
<td>Medium High</td>
<td>2 years</td>
<td>13 years or longer</td>
<td>%Black/African-American</td>
</tr>
<tr>
<td>Camden County - GA</td>
<td>Medium Low</td>
<td>NA</td>
<td>1 year</td>
<td>Rural, medically underserved</td>
</tr>
<tr>
<td>Liberty County - GA</td>
<td>Medium Low</td>
<td>7 years</td>
<td>Currently meets target</td>
<td>%Black/African-American, medically underserved</td>
</tr>
<tr>
<td>Effingham County - GA</td>
<td>Low</td>
<td>Currently meets target</td>
<td>3 years</td>
<td>Rural, medically underserved</td>
</tr>
<tr>
<td>Long County - GA</td>
<td>Undetermined</td>
<td>SN</td>
<td>SN</td>
<td>%Hispanic/Latina, education, rural, insurance, medically underserved</td>
</tr>
</tbody>
</table>

NA – data not available.
SN – data suppressed due to small numbers (15 cases or fewer for the 5-year data period).
*Map of Intervention Priority Areas*

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

**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
Three counties in the Komen Coastal Georgia service area are in the highest priority category. One of the three, Glynn County is not likely to meet either the death rate or late-stage incidence rate HP2020 targets. Two of the three, Bryan County and McIntosh County, are not likely to meet the late-stage incidence rate HP2020 target.

McIntosh County has an older population and low education levels.

Medium high priority areas
Two counties in the Komen Coastal Georgia service area are in the medium high priority category. Both of the two, Bulloch County and Chatham County, are not likely to meet the late-stage incidence rate HP2020 target.

Bulloch County has high poverty rates. Chatham County has a relatively large Black/African-American population.

Additional Quantitative Data Exploration

Although no additional quantitative data were collected, the Affiliate researched relationships between socioeconomic and demographic characteristics and their influence on breast cancer diagnosis, late-stage diagnosis, and death. Data were collected through online databases and trusted web sources, such as komen.org. Searches turned up positive correlations between negative socioeconomic indicators and late-stage diagnosis and death, respectively. These data enhance the selection of target communities by providing further insight into issues which may influence breast health outcomes in the communities.

Selection of Target Communities

Susan G. Komen Coastal Georgia has selected five target communities on which to focus its efforts over the next five years. The five communities are selected based upon their estimated progress (or lack thereof) toward Healthy People 2020 (HP2020) objectives for breast health. The HP2020 objectives are target statistics for the US for improving different health indicators,
such as disease and death rates. The improvements should be achieved by 2020. The targets for breast health are:

- Reduced female breast cancer death rate to 20.6 deaths per 100,000 females
- Reduced female late-stage breast cancer incidence rate to 41.0 diagnoses per 100,000 females

Other factors considered during target community selection include, but are not limited to:

- Ethnic and racial make-up of communities
- Income level of communities
- Health insurance status of communities
- Communities considered medically underserved
- Communities considered rural
- Age distribution of communities

The five target communities are (in no particular order):

- Bryan County, Georgia
- Glynn County, Georgia
- McIntosh County, Georgia
- Black/African-American Women
- Medically Underserved Women

**Bryan County, Georgia**

Bryan County is a target community because it is not expected to meet the HP2020 objective for late-stage diagnosis by the year 2020. In fact, the rate of 55.1 per 100,000 females is higher than the rates in the Affiliate service area, Georgia, and the US, and it is increasing by 10.7 percent per year. Unless action is taken to reverse this trend, the late-stage diagnosis rate will continue to increase and will never meet the HP2020 target.

Data are insufficient to establish a trend for female breast cancer death rates, but the average rate in Bryan County from 2006-2010 is almost six points higher than the target rate of 20.6 (see Table 2.8). Because people diagnosed with late-stage breast cancer are more likely to die than people who are diagnosed in early stages (Susan G. Komen, 2014), and Bryan County is not on track to meet the target for late-stage diagnosis, the county may experience higher death rates due to breast cancer than the HP2020 target.

**Table 2.8. Breast cancer statistics – Bryan County**

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Incidence Rates and Trends</th>
<th>Death Rates and Trends</th>
<th>Late-stage Rates and Trends</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of New Cases (Annual Average)</td>
<td>Age-adjusted Rate/100,000</td>
<td>Trend (Annual Percent Change)</td>
</tr>
<tr>
<td>US</td>
<td>182,234</td>
<td>122.1</td>
<td>-0.2%</td>
</tr>
<tr>
<td>HP2020</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Georgia</td>
<td>5,997</td>
<td>121.5</td>
<td>-0.3%</td>
</tr>
<tr>
<td>Komen Coastal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Georgia Service Area</td>
<td>380</td>
<td>118.5</td>
<td>-1.4%</td>
</tr>
<tr>
<td>Bryan County, GA</td>
<td>19</td>
<td>132.1</td>
<td>-4.1%</td>
</tr>
</tbody>
</table>

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.
Furthermore, although Bryan County has less people living in poverty, its residents are more likely to live in rural and medically underserved areas than the Affiliate service area, Georgia, and the US as a whole (see Table 2.9). In general, people who live in rural and medically underserved areas are less likely to access recommended medical care, such as breast screenings (Committee on Health Care for Underserved Women, 2014), which can lead to poor health outcomes, such as late-stage diagnosis and death.

### Table 2.9. Socioeconomic indicators – Bryan County

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Income Below 100% Poverty</th>
<th>Income Below 250% Poverty (Age: 40-64)</th>
<th>In Rural Areas</th>
<th>In Medically Underserved Areas</th>
<th>No Health Insurance (Age: 40-64)</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>14.3 %</td>
<td>33.3 %</td>
<td>19.3 %</td>
<td>23.3 %</td>
<td>16.6 %</td>
</tr>
<tr>
<td>Georgia</td>
<td>16.5 %</td>
<td>37.6 %</td>
<td>24.9 %</td>
<td>37.3 %</td>
<td>20.7 %</td>
</tr>
<tr>
<td>Komen Coastal Georgia Service Area</td>
<td>17.9 %</td>
<td>38.4 %</td>
<td>25.9 %</td>
<td>46.8 %</td>
<td>20.3 %</td>
</tr>
<tr>
<td>Bryan County, GA</td>
<td>11.8 %</td>
<td>29.7 %</td>
<td>52.3 %</td>
<td>100.0 %</td>
<td>17.7 %</td>
</tr>
</tbody>
</table>

**Glynn County, Georgia**

Overall, Glynn County is not on track to meet either of the HP2020 targets, and the statistics for late-stage rates and trends are particularly concerning. The late-stage rate is 53.2, which is substantially higher than the HP2020 target of 41.0, and the rate is increasing at 6.0 percent each year, which is the second highest trend for late-stage diagnosis in the Affiliate service area.

The death rate is 23.1, which is 3.1 points higher than the HP2020 target, but it is decreasing at a rate of 0.4 percent each year. Although the rate is decreasing, the decrease is not substantial enough to put the county in line to meet the HP2020 target (see Table 2.10). The overall incidence rate for breast cancer in Glynn County is 121.6, which is lower than the rate for the US but higher than the rate for Georgia, but it is increasing at an average rate of 0.2 percent per year.

### Table 2.10. Breast cancer statistics – Glynn County

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Incidence Rates and Trends</th>
<th>Death Rates and Trends</th>
<th>Late-stage Rates and Trends</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of New Cases (Annual Average)</td>
<td>Age-adjusted Rate/100,000</td>
<td>Trend (Annual Percent Change)</td>
</tr>
<tr>
<td>US</td>
<td>182,234</td>
<td>122.1</td>
<td>-0.2%</td>
</tr>
<tr>
<td>HP2020</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Georgia</td>
<td>5,997</td>
<td>121.5</td>
<td>-0.3%</td>
</tr>
<tr>
<td>Komen Coastal Georgia Service Area</td>
<td>380</td>
<td>118.5</td>
<td>-1.4%</td>
</tr>
<tr>
<td>Glynn County, GA</td>
<td>60</td>
<td>121.6</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

NA – data not available
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.

The socioeconomic indicators for Glynn County, such as income level, health insurance status, and percent of residents living in medically underserved areas, are generally more favorable.
than the Affiliate service area and Georgia (see Table 2.11), which is surprising considering how unlikely it is to meet the HP2020 targets. However, the percentage of people without health insurance is higher than in the US. Additional factors must be influencing breast health outcomes in Glynn County.

One factor potentially contributing to poorer breast health outcomes is the age distribution of the population. Glynn County has the second highest percentage of female residents aged 40+ years in the Affiliate service area (51.2 percent), and that percentage is higher than the percentages for both Georgia and the US (45.5 percent and 48.3 percent, respectively). Because breast cancer risk increases with age, the population of women in Glynn County has a higher risk of breast cancer than counties with younger populations.

### Table 2.11. Socioeconomic indicators – Glynn County

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Income Below 100% Poverty</th>
<th>Income Below 250% Poverty (Age: 40-64)</th>
<th>In Rural Areas</th>
<th>In Medically Under-served Areas</th>
<th>No Health Insurance (Age: 40-64)</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>14.3 %</td>
<td>33.3 %</td>
<td>19.3 %</td>
<td>23.3 %</td>
<td>16.6 %</td>
</tr>
<tr>
<td>Georgia</td>
<td>16.5 %</td>
<td>37.6 %</td>
<td>24.9 %</td>
<td>37.3 %</td>
<td>20.7 %</td>
</tr>
<tr>
<td>Komen Coastal</td>
<td>17.9 %</td>
<td>38.4 %</td>
<td>25.9 %</td>
<td>46.8 %</td>
<td>20.3 %</td>
</tr>
<tr>
<td>Georgia Service Area</td>
<td>15.8 %</td>
<td>33.8 %</td>
<td>20.6 %</td>
<td>0.0 %</td>
<td>19.5 %</td>
</tr>
<tr>
<td>Glynn County, GA</td>
<td>15.8 %</td>
<td>33.8 %</td>
<td>20.6 %</td>
<td>0.0 %</td>
<td>19.5 %</td>
</tr>
</tbody>
</table>

McIntosh County, Georgia

The late-stage breast cancer incidence rate in McIntosh County is lower than the HP2020 target of 41.0 cases per 100,000 females, but because the average annual percentage change is 33.9 percent, the county will not meet the HP2020 goal. The trend illustrates a great need in McIntosh County because it is substantially worse than the trends for all other counties (see Table 2.12). Given that McIntosh County has the smallest population of all counties in the service area, the data may not be as reliable as the data from other counties.

Data are insufficient to establish a death rate and trend, but people who are diagnosed late-stage are more likely to die due to breast cancer than people who are diagnosed in early stages (Susan G. Komen, 2014). Because the late-stage diagnosis trend is greatly increasing, the death rate could be higher than the HP2020 target.
Table 2.12. Breast cancer statistics – McIntosh County

<table>
<thead>
<tr>
<th>Population Group</th>
<th># of New Cases (Annual Average)</th>
<th>Age-adjusted Rate/100,000</th>
<th>Trend (Annual Percent Change)</th>
<th># of Deaths (Annual Average)</th>
<th>Age-adjusted Rate/100,000</th>
<th>Trend (Annual Percent Change)</th>
<th># of New Cases (Annual Average)</th>
<th>Age-adjusted Rate/100,000</th>
<th>Trend (Annual Percent Change)</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>182,234</td>
<td>122.1</td>
<td>-0.2%</td>
<td>40,736</td>
<td>22.6</td>
<td>-1.9%</td>
<td>64,590</td>
<td>43.8</td>
<td>-1.2%</td>
</tr>
<tr>
<td>HP2020</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>20.6</td>
<td>-</td>
<td>41.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Georgia</td>
<td>5,997</td>
<td>121.5</td>
<td>-0.3%</td>
<td>1,146</td>
<td>23.4</td>
<td>-1.4%</td>
<td>2,253</td>
<td>45.5</td>
<td>-0.4%</td>
</tr>
<tr>
<td>Komen Coastal Georgia Service Area</td>
<td>380</td>
<td>118.5</td>
<td>-1.4%</td>
<td>71</td>
<td>21.9</td>
<td>NA</td>
<td>146</td>
<td>45.7</td>
<td>1.5%</td>
</tr>
<tr>
<td>McIntosh County , GA</td>
<td>10</td>
<td>101.1</td>
<td>1.5%</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>4</td>
<td>36.4</td>
<td>33.9%</td>
</tr>
</tbody>
</table>

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.

Overall, socioeconomic indicators for McIntosh County are more unfavorable than those for the Affiliate service area, Georgia, and the US as a whole. McIntosh County has one of the highest percentages of residents living in poverty, in rural and medically underserved areas, and without health insurance (see Table 2.13). All of the above socioeconomic indicators are associated with poorer health outcomes, which could be a factor in the high rates of late-stage diagnosis.

Furthermore, McIntosh County has the highest percentage of women aged 40+ years in the Affiliate service area. Because increasing age is associated with an increased risk of breast cancer, women in the county are at the highest risk of developing breast cancer based upon age alone.

Table 2.13. Socioeconomic indicators – McIntosh County

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Income Below 100% Poverty</th>
<th>Income Below 250% Poverty (Age: 40-64)</th>
<th>In Rural Areas</th>
<th>In Medically Underserved Areas</th>
<th>No Health Insurance (Age: 40-64)</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>14.3 %</td>
<td>33.3 %</td>
<td>19.3 %</td>
<td>23.3 %</td>
<td>16.6 %</td>
</tr>
<tr>
<td>Georgia</td>
<td>16.5 %</td>
<td>37.6 %</td>
<td>24.9 %</td>
<td>37.3 %</td>
<td>20.7 %</td>
</tr>
<tr>
<td>Komen Coastal Georgia Service Area</td>
<td>17.9 %</td>
<td>38.4 %</td>
<td>25.9 %</td>
<td>46.8 %</td>
<td>20.3 %</td>
</tr>
<tr>
<td>McIntosh County , GA</td>
<td>15.5 %</td>
<td>45.7 %</td>
<td>74.3 %</td>
<td>100.0 %</td>
<td>21.6 %</td>
</tr>
</tbody>
</table>

Black/African-American Women  
The Affiliate as a whole has a larger percentage of Black/African-American residents than the US and Georgia. The counties with the highest percentage of Black/African-American residents are Liberty, Chatham, and McIntosh.

The three counties with the highest priority according to their decreased likelihood of reaching the HP2020 targets (Bryan, Glynn, and McIntosh) also have higher percentages of Black/African-American residents compared to the US, although McIntosh County is the only...
county that has a higher percentage of Black/African-American residents than the Affiliate service area and Georgia (see Table 2.14).

<table>
<thead>
<tr>
<th>Population Group</th>
<th>White</th>
<th>Black/African-American</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>78.8 %</td>
<td>14.1 %</td>
</tr>
<tr>
<td>Georgia</td>
<td>62.8 %</td>
<td>32.9 %</td>
</tr>
<tr>
<td>Komen Coastal Georgia Service Area</td>
<td>62.9 %</td>
<td>34.1 %</td>
</tr>
<tr>
<td>Bryan County, GA</td>
<td>80.6 %</td>
<td>16.4 %</td>
</tr>
<tr>
<td>Bulloch County, GA</td>
<td>67.2 %</td>
<td>30.8 %</td>
</tr>
<tr>
<td>Camden County, GA</td>
<td>75.2 %</td>
<td>21.9 %</td>
</tr>
<tr>
<td>Chatham County, GA</td>
<td>54.4 %</td>
<td>42.2 %</td>
</tr>
<tr>
<td>Effingham County, GA</td>
<td>83.6 %</td>
<td>14.8 %</td>
</tr>
<tr>
<td>Glynn County, GA</td>
<td>69.9 %</td>
<td>27.8 %</td>
</tr>
<tr>
<td>Liberty County, GA</td>
<td>50.3 %</td>
<td>45.2 %</td>
</tr>
<tr>
<td>Long County, GA</td>
<td>68.8 %</td>
<td>28.3 %</td>
</tr>
<tr>
<td>McIntosh County, GA</td>
<td>60.8 %</td>
<td>38.1 %</td>
</tr>
</tbody>
</table>

In general, Black/African-American women have lower rates of breast cancer diagnosis than white women, but Black/African-American women have higher rates of death due to breast cancer than white women (DeSantis, Siegal, Bandi, & Jemal, 2011).

In the Affiliate service area, Black/African-American women are more likely to be diagnosed at late-stage and to die due to breast cancer than their white counterparts (see Table 2.15). The late-stage diagnosis rate for Black/African-American women in the Affiliate service area is almost two points higher than the rate for white women, and it is increasing at 5.2 percent per year. This means that Black/African-American women in the Affiliate service may be less likely to reach the HP2020 target for late-stage diagnosis than their white counterparts if the trend is not reversed.

Additionally, Black/African-American women have a higher death rate than white women. For Black/African-American women in the Affiliate service area, the death rate is over six points higher than the rate for white women. Although data were insufficient to establish a death rate trend, Black/African-American women have been experiencing a higher death rate than white women for decades, and this trend will most likely continue.

Because of poor breast health outcomes, such as high late-stage diagnosis and death rates, Black/African-American women represent a population in need of targeted health promotion efforts.
Table 2.15. Breast cancer statistics by racial breakdown

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Incidence Rates and Trends</th>
<th>Death Rates and Trends</th>
<th>Late-stage Rates and Trends</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of New Cases (Annual Average)</td>
<td>Age-adjusted Rate/100,000</td>
<td>Trend (Annual Percent Change)</td>
</tr>
<tr>
<td>US</td>
<td>182,234</td>
<td>122.1</td>
<td>-0.2%</td>
</tr>
<tr>
<td>HP2020</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Georgia</td>
<td>5,997</td>
<td>121.5</td>
<td>-0.3%</td>
</tr>
<tr>
<td>Komen Coastal Georgia Service Area</td>
<td>380</td>
<td>118.5</td>
<td>-1.4%</td>
</tr>
<tr>
<td>Black/African-American</td>
<td>104</td>
<td>111.9</td>
<td>-0.3%</td>
</tr>
<tr>
<td>White</td>
<td>270</td>
<td>122.2</td>
<td>-2.1%</td>
</tr>
</tbody>
</table>

NA – data not available
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.

**Medically Underserved Women**

The Affiliate as a whole has a substantially larger percentage of people in medically underserved areas than Georgia and the US. Seven of the nine counties in the service area are 100 percent medically underserved (see Table 2.16), which could contribute to the Affiliate’s overall poor projected outcomes for late-stage diagnosis and breast cancer death rates.

People who live in medically underserved areas are less likely to access medical care, such as regular breast screenings, than people who do not live in medically underserved areas (Committee on Health Care for Underserved Women, 2014). Because regular screenings are the best way to detect breast cancer early, the fact that people cannot access them means that those people are more likely to be diagnosed late-stage, which increases the chances of death due to breast cancer.

Two of the highest priority counties (Bryan and McIntosh) are also 100.0 percent medically underserved. Medically underserved women are a target community because of the association between lack of access to health care and poorer breast health outcomes.
### Table 2.16. Percentage of residents in medically underserved areas

<table>
<thead>
<tr>
<th>Population Group</th>
<th>In Medically Underserved Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>23.3 %</td>
</tr>
<tr>
<td>Georgia</td>
<td>37.3 %</td>
</tr>
<tr>
<td>Komen Coastal Georgia Service Area</td>
<td>46.8 %</td>
</tr>
<tr>
<td>Bryan County, GA</td>
<td>100.0 %</td>
</tr>
<tr>
<td>Bulloch County, GA</td>
<td>100.0 %</td>
</tr>
<tr>
<td>Camden County, GA</td>
<td>100.0 %</td>
</tr>
<tr>
<td>Chatham County, GA</td>
<td>1.6 %</td>
</tr>
<tr>
<td>Effingham County, GA</td>
<td>100.0 %</td>
</tr>
<tr>
<td>Glynn County, GA</td>
<td>0.0 %</td>
</tr>
<tr>
<td>Liberty County, GA</td>
<td>100.0 %</td>
</tr>
<tr>
<td>Long County, GA</td>
<td>100.0 %</td>
</tr>
<tr>
<td>McIntosh County, GA</td>
<td>100.0 %</td>
</tr>
</tbody>
</table>

**Conclusions and Plans for Health Systems Analysis**

Overall, the Affiliate is not on track to meet the HP2020 target for late-stage breast cancer diagnosis, but data are insufficient to establish a trend for breast cancer deaths. However, because of the Affiliate’s 1.5 percent annual increase in late-stage diagnosis and the association between late-stage diagnosis and death rates, breast cancer deaths may not be on track to reach the HP2020 target, either.

In order to focus the resources of the Affiliate in the service area, the Affiliate has selected five communities to focus on. The five target communities are: Bryan County, Glynn County, McIntosh County, Black/African-American Women, and Medically Underserved Women.

Bryan, Glynn, and McIntosh Counties are each projected to miss the 2020 deadline for at least one HP2020 target. Black/African-American women experience higher rates of late-stage diagnosis and death due to breast cancer than white women. Medically underserved women are less likely to access regular medical care, which can lead to poor health outcomes.

The high rates of late-stage diagnosis may be due to lack of access to and utilization of regular breast health screening. Because many women in the Affiliate service area live in medically underserved areas, and many residents are below 250 percent of the poverty level, women may be less likely to be screened based upon current recommendations.

The Affiliate will explore how access to and utilization of medical care in the service area may affect breast cancer screening and late-stage diagnosis rates. This will include exploration of possible financial and socioeconomic barriers. Each county in the Affiliate service area receives funding for screening through the Breast and Cervical Cancer Prevention Program, but because of the high rates of late-stage diagnosis and breast cancer death rates in the service area, this program may not be strong enough to serve the needs in the community.

The Affiliate will also explore geographical barriers that might reduce availability of breast health services in each of the priority counties and investigate how medically underserved areas access services. Education about screening recommendations and the availability of breast
health services for medically underserved and poor women will be considered because the more women know about the importance of regular screening and the availability of reduced cost and free resources, the more likely women will enter and progress through the continuum of care.

Through a health systems analysis, the Affiliate hopes to gain a better understanding of the resources available in the service area and possible barriers to accessing and utilizing those resources.
Health Systems Analysis Data Sources

Data were collected through internet searches, online databases such as data.medicare.gov, information from trusted websites, such as the Georgia Comprehensive Cancer Control website and government websites. Data were also collected through telephone conversations with representatives of organizations such as hospitals, health departments, free clinics, and community health centers in the Affiliate service area to identify and confirm the services offered.

Searches and phone calls were conducted using the resources mentioned above and data were collected about services offered at each point in the breast health continuum of care (see section below). Addresses and contact information were also collected for each organization identified, and all information was entered into an Excel spreadsheet for tracking.

Findings were analyzed for the three target counties by considering the location of each organization, the services offered, and the number of organizations offering different breast health services along the Continuum of Care. Findings were analyzed for the two demographic-based target communities (Black/African-American women and medically underserved women) in the Affiliate service area.

Health Systems Overview

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

While a patient may enter the continuum at any point, ideally, a patient would enter the CoC by getting screened for breast cancer – with a clinical breast exam or a screening mammogram. If the screening test results are normal, she would loop back into follow-up care, where she would get another screening exam at the recommended interval. Education plays a role in both providing education to encourage people to get screened and reinforcing the need to continue to get screened routinely thereafter.

If a screening exam resulted in abnormal results, diagnostic tests would be needed, possibly several, to determine if the abnormal finding is in fact breast cancer. These tests might include a diagnostic mammogram, breast ultrasound or biopsy. If the tests were negative (or benign) and breast cancer was not found, she would go into the follow-up loop, and return for screening at the recommended interval. The recommended intervals may range from three to six months for some patients women to 12 months for most patients. 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 patient 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 report determines the best options for treatment, understanding side effects and how to manage them, and helping to formulate questions a patient 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 patients 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 person 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 patient progress through the CoC more quickly.

**Target Community Analysis**

**Bryan County**

**Strengths:**
A hospital off-shoot, health department (with two locations), and a community health center provide breast health services in Bryan County (Figure 3.2). The health department’s two locations and the community health center offer clinical breast exams and refer patients to outside organizations for mammograms and diagnostics. Certain diagnostic services, such as ultrasound and biopsy, are available in Bryan County through a hospital off-shoot located in the county. The hospital, which is based out of Chatham County, has mobile mammography services which set up at varying places in the county.

**Weaknesses:**
The health department has strict eligibility guidelines for patients who can receive breast health services through their programs, and although the health department partners with a hospital to allow women in Bryan County to receive screening mammograms on a mobile mammography unit, the unit only operates in Bryan County one to two times per month. No treatment services are available in Bryan County, which may lead to various barriers to medical care access (such as transportation and financial difficulties) for breast cancer patients. Support and survivorship services are completely lacking in Bryan County, so breast cancer patients who need financial support, side-effect management, support groups, and other services will have to travel to other counties for those services. No certified/accredited organizations provide breast cancer healthcare services in this area, indicating a necessity of service quality improvement. Additionally, screening services are only available in two organizations (among which only one organization provides mammography services), and diagnostic services are only available in
one organization, which indicate that the choices for breast cancer screening and diagnostic services is very limited and there is lack of competition and comparison to encourage service improvement.

Mission Related Partnerships:
The Affiliate works with one of the local health districts through a Community Grant. This grant supplements the Breast and Cervical Cancer Prevention Program (BCCP) funding in three of the nine counties in the Service Area, including Bryan County. The Affiliate also engages faith-based organizations in Bryan County with the Worship in Pink Program every October.
Figure 3.2. Breast cancer services available in Bryan County

Statistics

Total Locations in Region: 4

Service Type

<table>
<thead>
<tr>
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Accreditation Type

- American College of Surgeons CoC Accredited
- American College of Radiology Breast Imaging Ctr. of Excellence
- American College of Surgeons NAPBC Accredited
- NOI Designated Cancer Center

Susan G. Komen® Coastal Georgia
**Glynn County**

*Strengths:*
The main advantages of breast health services in Glynn County are accessibility and quality. Four organizations in Glynn County offer breast health services (Figure 3.3). One of those organizations, a health system, offers breast health services throughout the entire continuum (screening, diagnostics, treatments, support/survivorship services). Patient navigation is provided throughout the entire continuum at that health system. This organization is also accredited by the American College of Surgeons and American College of Radiology Breast Imaging Center. Screening and diagnostic services are separately provided in two other organizations. One mobile health unit also provides mobile mammography screening.

*Weaknesses:*
The choice for treatment and supportive/survivorship services is limited in Glynn County, since only one organization provides those services. All breast health services are located in the Brunswick, which is the largest city in the county. This may negatively affect access to health care for people who live outside of Brunswick because they will have to travel to appointments. Additionally, only clinical breast exams are provided at the health department, free clinic, and the community health center in the county. Uninsured or underinsured patients may have difficulties accessing breast health services, especially at the health department which has eligibility restrictions for screening services.

*Mission Related Partnerships:*
As of 2014, the Affiliate has granted funds to the hospital in Glynn County to improve access to breast health services. The Affiliate also engages faith-based organizations in Glynn County with the Worship in Pink Program in October of every year.
Figure 3.3. Breast cancer services available in Glynn County
**McIntosh County**

*Strengths:*
Basic breast screening services are available in McIntosh County (Figure 3.4). The local health department in McIntosh County provides clinical breast exams and partners with the health system in Glynn County to provide mobile mammography services at two different locations within the county. Patients who need screening outside of clinical breast exams but who do not want to/cannot use mobile mammography services are referred to providers outside of McIntosh County.

*Weaknesses:*
Except for the local health department and its relationship with the hospital in Glynn County, no other providers in McIntosh County provide breast health services of any kind. The health department has strict eligibility guidelines for access to breast health services which limits access to clinical breast exams and referrals for mammography even further. Although the mobile mammography unit does give women access to screening mammograms in McIntosh County, the unit only operates in McIntosh County one to two times per month. Diagnostic, treatment and supportive/survivorship services are completely unavailable in the local area.

*Mission Related Partnerships:*
The Affiliate has worked with the health department in McIntosh County through the Small Grant program. The Affiliate also engages faith-based organizations in McIntosh County with the Worship in Pink Program in October of every year.
Figure 3.4. Breast cancer services available in Glynn County
Black/African-American Women
The Affiliate as whole has a larger percentage of residents who are Black/African-American women than the state of Georgia and the US as a whole (34.10 percent versus 32.90 percent and 14.10 percent, respectively). Services were analyzed for all counties in the service area because many counties have large percentages of residents who are Black/African-American women.

Strengths:
The service area overall has many facilities which provide screening and diagnostic services for people of all races and ethnicities (Figure 3.5). All health departments in the Affiliate service area provide clinical breast exams and can refer women to other providers for mammograms or diagnostic work-up. The service area has seven community health centers which offer clinical breast exams to people who are uninsured and underinsured, and one free clinic in Chatham County which offers free clinical breast exams for uninsured women. All of these facilities are located in the large cities of each county in the service area.

The three counties with the highest percentage of Black/African-American women are Liberty, Chatham, and McIntosh. Chatham County has a large concentration of facilities, including two hospitals, which offer services throughout the continuum of care, including screening, diagnostic, treatment, and support. The Chatham County health department provides women with clinical breast exams and refers women out for mammography and additional diagnostic testing. Chatham County is also home to one free clinic and two community health centers which offer clinical breast exams and refer women to outside organizations for additional breast health services.

Liberty County has a health department and a community health clinic, which provide clinical breast exams and refers patients to outside organizations for any additional breast health services, and two hospitals. One hospital is located on an army base, and the hospital's services are only available to military personnel and their dependents. Both hospitals provide clinical breast exams, mammograms, diagnostics, and treatment. McIntosh County has a health department which offers clinical breast exams and refers women to outside organizations for additional breast health services. Patients in McIntosh County can receive screening mammograms on a mobile mammography unit which sets up at the health department.

Weaknesses:
Although the health departments in Chatham, Liberty, and McIntosh Counties provide patients with clinical breast exams and referrals for additional services, the health department has eligibility restrictions for free and reduced cost services. Patients can only get screening mammograms in McIntosh if they receive services on a mobile mammography unit. Patients in Liberty County can receive clinical breast exams and referrals for mammography through the health department and the community health clinic, and they can receive screening mammograms at the hospital in the county; however, there are no resources located outside of the city of Hinesville, which is the largest city in Liberty County. The majority of facilities that offer breast health services are located in cities throughout the service area. Black/African-American women who live outside of city centers may have to travel to receive services.

Mission Related Partnerships:
The Affiliate currently maintains partnerships with two organizations that provide assistance to Black/African-American women. Assisting Working Women in Need (AWWIN) is a local non-profit which assists single, working, low-income women. The National Black/African-American Leadership Initiative on Cancer – Savannah Coalition provides outreach and education on
cancer for the Black/African-American community. The Affiliate has worked with both organizations in the past as Community Grantees and Small Grantees. The Affiliate also engages faith-based organizations with predominately Black/African-American congregations throughout the service area with the Worship in Pink Program in October of every year.
Figure 3.5. Breast cancer providers who target services for Black/African-American Women
Medically Underserved Women
Because seven of the nine counties in the Affiliate Service Area are 100 percent medically underserved, the health systems analysis will focus on those seven counties, which are Bryan, Bulloch, Camden, Effingham, Liberty, Long, and McIntosh.

Strengths:
All of the seven 100 percent medically underserved counties have health departments which offer clinical breast exams and refer patients out for screening and diagnostic mammography, when appropriate (Figure 3.6).

Patients in Camden, Liberty, Long, and McIntosh Counties can receive screening mammograms on a mobile unit if they have a referral from their physician. Patients in Liberty County can receive diagnostic and treatment services from the hospital in the county, or, if they live on the Fort Stewart Army Base, they can receive those services from the hospital located on-base.

Patients in Bryan County can receive clinical breast exams from the health department, a branch of a hospital based in Savannah, and a local community health clinic. However, the community health clinic only provides clinical breast exams once per week. Patients can receive diagnostic services from a branch of a Savannah-based hospital in Pembroke, but Bryan County has no organizations that provide treatment services to people who are diagnosed.

Patients in Effingham and Bulloch County can receive clinical breast exams from their county health departments. They can receive screening mammograms and diagnostic services from the hospitals located in those counties, and they can receive treatment services if they are diagnosed.

Weaknesses:
All seven counties have limited breast health resources and gaps in the continuum of care. Patients in Long and McIntosh cannot receive screening mammograms in their county of residence unless they use services provided by a hospital’s mobile mammography unit. This unit visits Long and McIntosh Counties one to two times per month. Women in those counties cannot receive diagnostic or treatment services in their county of residence. All health care facilities in the seven medically underserved counties are located in the largest cities of each county. No facilities are located in the rural areas of the counties.

Mission Related Partnerships:
The Affiliate maintains partnerships with all seven county health departments in medically underserved counties. The Affiliate also engages faith-based organizations in all seven medically underserved counties with the Worship in Pink Program in October of every year.
Figure 3.6. Breast cancer providers who target services for Medically Underserved Women
Public Policy Overview

Breast and Cervical Cancer Prevention (BCCP) Program and Medicaid
The Georgia Breast and Cervical Cancer Program (BCCP) provides access to breast and cervical cancer screening and diagnostic services to women who live in Georgia. Services are available for women who live at or below the 200.00 percent federal poverty line, as well as women who are uninsured and underinsured. A woman is eligible to receive services through BCCP if her provider receives federal funding—even if the woman's screening may not have been paid directly through federal funding from the National Breast and Cervical Cancer Prevention Program (NBCCP).

Services provided by BCCP include screening and diagnostic services, such as mammograms, and breast cancer treatment in the event of a positive diagnosis. Women who receive services through BCCP and are diagnosed with breast cancer have the option to enroll in Women’s Health Medicaid to provide them with comprehensive health care coverage.

If a woman is diagnosed with breast cancer and she meets the criteria below, she is eligible to apply for Women’s Health Medicaid, which will cover the costs associated with treatment and can reimburse her for the costs of diagnostic services (if she paid out of pocket).

In order to qualify for Medicaid for breast cancer, a woman must be:
- Diagnosed and in need of treatment for breast cancer
- Low-income (at or below 200.00 percent of the FPL Income Guidelines).
- Uninsured
- Under age 65
- A Georgia resident and
- A U.S. citizen or qualified alien

The Office of Cancer Prevention, Screening, and Treatment, in Georgia Department of Public Health has information for those who wish to learn more about program eligibility and how to enroll. Women who meet the criteria and who wish to use BCCP services must be screened by health department staff in their county of residence. Women who are diagnosed with breast cancer and who wish to receive Women’s Health Medicaid must apply at their county health department.

The Affiliate has a history of granting funds to two local health districts to supplement the already-strained BCCP funding to allow more women to receive free screening services, and will continue to find ways to partner with the local health departments through Community Grants and Small Grants.

Georgia Comprehensive Cancer Control Coalition
The State’s Comprehensive Cancer Control Plan breast cancer objective in Georgia is to ensure that all women are able to access appropriate breast cancer screening, genetic screening, counseling, and preventive services related to hereditary breast cancer.

The targets related to breast cancer control are:
- By 2019, increase the proportion of women aged 50 to 74 who receive breast cancer screenings from 77.0 percent to 81.1 percent based on the most recent US Preventive Services Task Force guidelines.
By 2019, reduce disparities relating to income and insurance coverage in breast cancer screening rates by 10.0 percent.

By 2019, increase by 25.0 percent the proportion of individuals at high risk for breast cancer who receive evidence-based genetic risk assessment and appropriate screening.

The Affiliate does not currently work with the State Comprehensive Cancer Control Coalition, but the priorities of the Coalition do fit within the Affiliate’s mission to end breast cancer forever. Possible partnerships will be considered throughout the next four years.

The Affordable Care Act
The passage of the Affordable Care Act gave states the option of expanding their Medicaid eligibility guidelines to improve insurance coverage rates among residents. Georgia is not expanding Medicaid coverage to low-income adults effective January 1, 2014. As a result, many adults will fall into a “coverage gap” of having incomes higher than Medicaid eligibility allows, but not low enough to receive tax credits through the Marketplace.

Since Georgia did not expand Medicaid eligibility, uninsured residents will either have to consider seeking coverage through the federal Marketplace (Georgia did not create its own Marketplace for residents) or through private insurance companies. According to the Kaiser Family Foundation, 21.66 percent of people in Georgia are estimated to be uninsured prior to the insurance mandate, and this number is estimated to be drop to 18.16 percent after insurance mandate (about 1,870,200 people) (Keirnan, 2014). Of the Georgia residents who do have health insurance, 48.0 percent are covered through their employment. Public programs such as Medicaid and Medicare insure 27.00 percent of the population, and 5.0 percent of Georgia’s residents purchase individual private policies (Kaiser Family Foundation, 2014). In 2011-2012, the estimated number of Georgia women aged 18 to 64 was 31,186,000, and the insurance rate in this population was 26.0 percent, indicating a higher uninsured rate compared with overall population (Kaiser Family Foundation, 2014). Furthermore, in the same period, the uninsured rate among Georgia low-income women aged 18 to 64 is 45.0 percent. The insurance mandate in Georgia may help to increase the insurance coverage, however, the above statistics showed that a specific effort is needed for female population ages 18 to 64, specifically those uninsured with low-income.

In the Affiliate service area five of the nine counties experience higher rates of uninsurance than the state of Georgia and the US as a whole (20.0 percent or more uninsured), and the entire Affiliate service area has a higher uninsurance rate than the US (20.3 percent uninsured versus 16.6 percent uninsured, respectively) (see Table 2.5 in the Quantitative Data Report), so a higher percentage of women who reside in one of the nine Komen Coastal Georgia counties rely on access to breast health services through the BCCP program, sliding scale and free clinics. Because Georgia did not expand Medicaid eligibility, low-income women will continue to rely on government programs to receive essential health care services like screening mammograms.

Insurance coverage of screening mammograms is mandated by the Affordable Care Act, and those services must be offered without a co-pay or deductible in plans that started after August 1, 2012. The Affordable Care Act will provide women with greater access to preventive cancer screenings and treatment; however, gaps will still remain for women who are uninsured or underinsured. Since Georgia will not be participating in the Medicaid expansion, more than 266,000 women will not gain access to any affordable health care coverage in 2014. Women diagnosed through Breast and Cervical Cancer Program (BCCP) gain eligibility for comprehensive treatment services through the Women’s Health Medicaid program. Funding for
the BCCP program will be critical for women who will not be insured through Medicaid, the Marketplace, or private insurers, so that those women can continue to receive breast cancer screening, diagnostic, and treatment services (American Cancer Society Cancer Action Network).

The ACA will affect health care providers by requiring insurance companies to cover 100 percent of the cost of screening mammograms for women over 40; however, the insurance rate in Georgia has not increased substantially since the implementation of the insurance mandate, and many women are still projected to be uninsured.

The Affiliate does not currently participate in Public Policy activities because, according to the 2011 Community Profile, those activities were not a priority. The Affiliate will explore opportunities to influence breast health public policy in the next four years.

Health Systems and Public Policy Analysis Findings

Overall, the Affiliate service area has facilities that provide services through every point on the breast health continuum of care from screening through survivorship, and each county receives limited federal funding through the BCCP program to offer qualified women free services. However, gaps exist in each target community because of the geographic concentration of services in metropolitan areas, the lack of facilities in medically underserved counties and access to affordable health insurance, and the limitations on eligibility for free breast health services.

Bryan County has four total facilities (a hospital off-shoot, two health department locations, and a community health clinic) offering breast health services throughout the continuum of care, including screening, diagnostic, and treatment services. However, one health department location, the hospital off-shoot, and the community health clinic are located in the city of Pembroke, while the other health department location is in the city of Richmond Hill. The concentration of health care services in one place means that residents who live outside of those cities must travel to receive services. Bryan County residents also do not have a choice in providers for diagnostic and treatment services, because the hospital off-shoot is the only facility which offers those services. For patients who wish to receive diagnostic and treatment services at a different facility, they must travel to a surrounding county, which can be up to a one hour drive one-way.

Glynn County has seven total facilities including one hospital with a mobile mammography unit and support services, one health department, one free clinic, two community health clinics, and a local non-profit which offers free wigs to those who are going through breast cancer treatment. Those facilities cover the entire continuum of care from screening and diagnostics to treatment and support services. In spite of the resources located in Glynn County, the rates of adverse breast health outcomes, such as breast cancer death and late-stage incidence, are much higher than in other counties of the service area. One reason for this could be that all of the health care facilities are located in Brunswick, which is the largest city in Glynn County, so patients who live in rural areas of the city must travel to and from any appointments.

McIntosh County has one health department which offers clinical breast exams, but no facilities which offer any other breast health service. The health department partners with a hospital in Glynn County to offer screening mammograms on the hospital's mobile mammography unit, but this unit only visits McIntosh County one to two times per month. Patients who do not or cannot receive screening on the mobile unit must travel to a neighboring county, such as Glynn,
Liberty, or Chatham County to receive screening mammograms, diagnostic services, treatment, and survivorship services. Of the three target counties, McIntosh experiences the most gaps in the breast health continuum of care. There are no diagnostic, treatment, or support services available in McIntosh County. The lack of local breast health services creates a huge burden to breast cancer patients or survivors who need further medical attention or supportive services. Poor breast health outcomes, such as high death and high incidences of late-stage diagnosis could be related to lack of access to care within the county.

Black/African-American women have access to many different health care facilities throughout the Affiliate service area. The service area as a whole has five hospitals that provide comprehensive breast care services throughout the continuum of care. Two of those hospitals have mobile mammography units which offer screening mammograms in Chatham, Bryan, Liberty, Long, McIntosh, Glynn, and Camden Counties. The service area includes nine health departments (three of which have two locations), eight community health centers, and one free clinic that provide clinical breast exams. In spite of the large number of facilities which provide breast health services throughout the continuum of care (especially in Chatham County, which has the highest percentage of residents who are Black/African-American women), Black/African-American women still experience higher death and higher rates of late-stage diagnosis than white women in the service area. Black/African-American women who live in Liberty and McIntosh Counties experience more gaps in the breast health continuum because there are very few options for diagnostic and treatment services in those counties.

Medically underserved women live in areas where there are very few, if any breast health services. Much of the Affiliate service area is medically underserved, which means that patients who live in those areas are less likely to be able to access timely screening and diagnostic exams. The availability of screening and diagnostic services in the local area can help increase the rate of breast cancer screening and early detection. The lack of services could be a contributor to the poor breast health outcomes seen in the Affiliate service area overall, such as high death rates and high late-stage incidences. All seven of the 100 percent medically underserved counties have at least one health department location which provides eligible patients with free clinical breast exams and refers them out for mammography, but patients have to travel to receive those services unless they can make an appointment to use a mobile mammography unit when it is in their county of residence.

Two of the hospitals in the service area use mobile mammography units to give medically underserved women access to screening mammograms. Mobile mammography services may increase the accessibility of breast cancer screening services because mobile units tend to set up at places where women in the service area typically frequent (such as the grocery store). However, those units are only in each medically underserved area one or two days per month maximum, so if patients’ schedules do not allow them to make an appointment on the mobile unit, their screenings could be delayed.

Because the state of Georgia is not expanding Medicaid eligibility, many residents, especially women, will still be uninsured because they fall outside of the current Medicaid eligibility guidelines, and their income is too high to receive a health insurance premium tax credit through the Marketplace. Those women will continue to rely on BCCP services and free and sliding scale clinics for regular screenings, however, those facilities and programs do not have the funds and resources necessary to meet the needs of their communities, which can delay life-saving screenings. Treatment for patients who are diagnosed with breast cancer but who do not have health insurance can be paid for through Women’s Health Medicaid for qualified applicants.
Many women in the Affiliate service area experience large gaps in the breast health continuum, including lack of choice in screening, diagnostic, treatment and support services throughout each target community. Much of the service area is medically underserved, so women have to arrange for travel to and from any appointments, and in some cases, women must leave their county of residence to receive necessary medical care. The two mobile mammography units address this burden by bringing mammography to women where they live, but those units are only able to operate in each county one or two times per month. Additionally, federal funding alleviates some of the financial burden of breast cancer screening through the Breast and Cervical Cancer Prevention Program, but funding and eligibility for the program are limited. Overall, the needs in the Affiliate service area exceed the resources available.
Qualitative Data Sources and Methodology Overview

The Affiliate began data collection for the five target communities in August 2014. In order to be able to triangulate the data, the Affiliate employed two methods of data collection per target community. A combination of focus groups, key informant interviews, and surveys were used.

Focus Groups

Focus groups were used to collect data in the following target communities:

- Bryan County, Georgia: one focus group (nine participants)
- McIntosh County, Georgia: one focus group (eight participants)
- Black/African-American Women: two focus groups (seven participants and eight participants)

Focus groups were chosen as a method of data collection to understand perspectives about breast health from women over 40 within target communities, and to facilitate dialogue among women about breast health issues within those target communities. Key variables considered included the impact of cost of services and insurance status on likelihood to receive breast health services, participants knowledge of location of breast health resources and their proximity to those resources, and their knowledge of breast health and the importance of screening.

Questions asked in each focus group include (see appendix A for full script):

1. Do you get a mammogram or breast exam annually? Why or why not?
2. For those of you who do not get breast exams, do you know where you could go to get them?
3. What are your biggest concerns when considering breast cancer screening?
4. Do you think the women in your community have proper knowledge about the risks of breast cancer and how to detect breast cancer early? If not, what do they need to know?
5. Do you think the medical resources within your community can meet the community’s needs for breast health care? Why or why not?

Participants were recruited through convenience sampling. In McIntosh and Bryan Counties, women over 40 from local churches were recruited to participate. The two focus groups for Black/African-American Women were recruited from a local community group (located in Liberty County, Georgia) and a local, predominately Black/African-American church (located in Bryan County, Georgia). The questions asked for Black/African-American women were the same as those above, but participants were asked specifically about Black/African-American women for questions numbered four and five. Participants also completed demographic forms before the focus group began (see appendix B for form).

All focus groups had at least six women participating and were facilitated by Affiliate staff while the Community Profile Intern took notes. After the focus group ended, all notes were typed in a word document to keep on file for data analysis.

All participants gave informed consent. The purpose of the focus groups, intended use of the data, and voluntary participation were all explained before participants gave verbal and written consent.

Detailed notes were taken during focus groups, and notes were coded separately by two members of the Community Profile Committee. After comparing coded data, an average inter-rater agreement of 92.0 percent was established.
Key Informant Interviews
Key informant interviews were used to collect data in the following target communities:
- Bryan County, Georgia: five key informant interviews
- Glynn County, Georgia: eight key informant interviews
- McIntosh County, Georgia: four key informant interviews
- Black/African-American Women: 10 key informant interviews
- Medically Underserved Women: 12 key informant interviews

Key informant interviews were chosen as a method of data collection to allow the Affiliate to understand perspectives about breast health from health care workers, community advocates, and survivors within target communities. Health care workers included nurses from local health departments and clinics, and breast care navigators at hospital systems. Community advocates included people involved in breast cancer non-profits outside of Susan G. Komen Coastal Georgia, people involved in non-profits dedicated to improving women’s health in Black/African-American populations, and people who are involved in promoting health and wellness, including breast health, in the Coastal Georgia service area. Survivors included breast cancer survivors of all ages and ethnicities who live in the Coastal Georgia service area.

Key variables considered in key informant interviews include the impact of cost of services and insurance status on likelihood to receive breast health care, the community’s knowledge of location and availability of breast health resources, and the community’s knowledge of breast health indicators and the importance of screening. For Black/African-American key informants, additional questions about possible contributors to the high late-stage diagnosis rate and trend seen for Black/African-American Women in Coastal Georgia (see Table 2.15 in the Quantitative Data Report) were asked.

Questions asked of key informants in county-based target communities and Medically Underserved Women include (script and see appendix C for full key informant interview consent form):
1. What are your perceived breast health or breast cancer problems in this community?
2. What are the main barriers for women in this county to access breast healthcare, such as mammography or breast cancer treatments? Do you think there are any available sources in the community that can be used to solve the problem (problems)?
3. Is the affordability of care a general concern for women in this community? If so, what factors are impacting the affordability of their healthcare (insurance or etc.)?
4. Do you think increasing the insurance coverage rate can help to encourage women to seek breast health services? Why?
5. Do you think the medical resources in this community can meet women’s needs for breast healthcare?
6. What other improvements can the healthcare system make to increase the access to care (extended service hours, transportation, translation services)?
7. Do you think women in this community have proper knowledge about the risks of breast cancer and breast cancer prevention (such as mammography)? If not, what is the most important information should they know?
8. What are the healthcare needs of women in the community regarding breast cancer prevention (knowledge, resources and etc.)?
9. What are the general concerns for women who refuse or do not follow recommended screening guidelines?
Questions asked of key informants for Black/African-American Women include (see appendix D for full key informant interview script and consent form):

1. What are your perceived breast health or breast cancer problems among the African-American Women in this community?
2. What are the main barriers for African-American women in this county to access breast healthcare, such as mammography or breast cancer treatments? Do you think there are any available sources in the community that can be used to solve the problem (problems)?
3. Is the affordability of care a general concern for African-American women in this community? If so, what factors are impacting the affordability of their healthcare (insurance or etc.)?
4. Do you think increasing the insurance coverage rate can help to encourage African-American women to seek breast health services? Why?
5. What other improvements can the healthcare system make to increase the access to care (extended service hours, transportation, translation services)?
6. Do you think most African-American women in this community have proper knowledge about the risks of breast cancer and breast cancer prevention (such as mammography)? If not, what is the most important information should they know?
7. What are the healthcare needs of African-American women in the community regarding breast cancer prevention (knowledge, resources and etc.)?
8. What are the general concerns for African-American women who refuse or not follow recommended screening guidelines?
9. We know that the breast cancer late-stage diagnosis rate in African-American women is high, what do you think is the main reason for this disparity?
10. If more and more women in this community begin to follow the recommended screening guidelines, and request breast health services, do you think the healthcare resources in this community can effectively satisfy their needs? What kind of improvement should be expected (staff, facility, technique, etc.)?

Participants were recruited through a combination of convenience and snowball sampling. Initial key informants were identified through convenience sampling, which included partnerships between the Affiliate and community organizations and groups (ex. local health departments, hospitals, other breast cancer organizations, Affiliate outreach volunteers). After interviews, key informants were asked to provide names of other key informants for that target community.

Key informant interviews were executed by Affiliate staff and the Community Profile Intern. Detailed notes were taken during interviews, and all notes were transferred to a word document until data analysis.

All participants gave informed consent. The purpose of the interviews, intended use of the data, and voluntary participation were all explained before key informants gave verbal and written consent.

Detailed notes were taken during key informant interviews, and notes were coded separately by two members of the Community Profile Committee. After comparing coded data, an average inter-rater agreement of 92.0 percent was established.

Surveys

Face to face surveys were used to collect data in the following target communities:

- Glynn County, Georgia: 43 surveys collected
- Medically Underserved Women: 43 surveys collected
Surveys were chosen as a method of data collection to allow the Affiliate to understand breast health issues from women over 40 in population-based perspective. Key variables considered include knowledge of breast health and the importance of screening, barriers to receiving breast screening, and ways to address barriers to breast screening. Distributing surveys face-to-face allowed the Affiliate to collect data more quickly and efficiently than distributing them via mail.

The Affiliate used a confidence interval of 95.0 percent, and a margin of error of 15.0 percent, which corresponds to a sample size of 43 participants.

Page one of the survey collected demographic information of participates (age range, county of residence, race/ethnicity, whether or not participants have a primary care doctor, when participants think women should begin getting mammograms at average risk, survivorship status, time since last breast cancer screening, location of breast cancer screening facility). Page two of the survey collected qualitative data through open-ended questions. Open-ended questions included (see appendix E for full survey):

1. What are your biggest reservations about making an appointment for breast health services, like a mammogram?
2. Please provide one idea of a local program or service that could be developed that would encourage women to seek recommended breast health care, such as mammograms.
3. Tell us your thoughts on ways to reduce your risk of breast cancer.
4. Tell us two different ways to detect breast cancer early, when it is most treatable
5. Please share any additional comments or concerns regarding breast health care.

A combination of convenience sampling and quota sampling was used to recruit survey participants. Community Profile Committee Members handed out surveys to women who reside in Bulloch and Long Counties, which two of the seven Medically Underserved counties within the Affiliate service area. Surveys were distributed at grocery stores within those counties until 43 surveys were collected. The committee handed out surveys to women in Glynn County at a mall within the county until 43 surveys were collected. Participants were told of the nature of the survey and that their responses were voluntary and would be kept anonymous. After receiving all surveys, data were entered in spreadsheet software.

**Qualitative Data Overview**

**Bryan County, Georgia**

Data from Bryan County included coded notes from one focus group including nine women and from five key informant interviews. Data also included focus group participant demographic forms.

**Lack of Proximity to Services**

Overall, key informants and focus group participants agreed that issues in accessing care were barriers for women in Bryan County. First, they stated they do not have adequate access to breast health resources within Bryan County outside of clinical breast exams. They did not know of any standing facilities which offer screening mammograms, diagnostic services, or treatment services. One key informant noted that there are a few breast health resources, like the mobile mammography unit, but they are simply not enough to provide for the community. Furthermore, informants stated that there are not very many health care resources in general, making it common for Bryan County residents to seek most health care services outside of the county. The majority of focus group participants and key informants cited this as a barrier to receiving care.
Second, key informants and focus group participants believed that many women within the county may not want to leave their county of residence for health care, including mammograms because it is not convenient for them to travel. Key informants and focus group participants explained that the possibility that women may have to take off work, find childcare, and travel up to an hour could discourage many women from even making an appointment for a mammogram. In fact, the three focus group participants who had never received a mammogram said that one reason is that “it's too much of a hassle.” All participants who indicated that they receive regular breast health care said that they travel to Savannah, and they said that they have to account for travel, child care, and work scheduling when they make their appointments. All participants agreed that many women within Bryan County, especially those who live in rural and generally less affluent areas of the county outside of Richmond Hill (like Pembroke), would have a longer drive and may not be able to afford to make that drive because issues related to travel, child care, and work scheduling.

Some key informants and focus group participants were aware that a mobile mammography unit from a Savannah hospital visited Bryan County periodically, but they questioned whether or not the unit could serve the needs of the community. None of the key informants or focus group participants knew when the mobile unit was scheduled to be in Bryan County, nor did they know where the unit parked.

Cost of Services

Insurance and cost of services was a common theme for the both key informant interviews and focus groups. Participants believed that the prohibitive cost of mammograms without insurance would deter women from receiving screening. One key informant explained that “without insurance, women will not go to get their mammograms unless they are free.” One focus group participant explained that if a woman cannot afford health insurance, she most likely cannot afford the out of pocket expenses of breast health services. It was further noted that even women who understand the importance of screenings, may think that they cannot afford it, and will therefore not even seek out services.

For women with insurance, affording yearly screenings was not seen as an issue; however, subsequent diagnostic work-up was mentioned as a barrier to care. Because the Affordable Care Act requires all health insurance plans to cover the entire cost of yearly screening mammograms for women over 40, women with insurance do not have to worry about co-pays or deductibles. However, co-pays and deductibles must be met for women with insurance who need diagnostic work-up. One key informant explained that, “even with insurance diagnostic exams are probably way too expensive because we cannot afford to pay our deductibles,” Informants suggest women may avoid necessary screening to preemptively save on future costs. High deductibles very well may discourage women from receiving medical care.

Lack of Knowledge of Importance of Screening

Lastly, many key informants and focus group participants believed that lack of knowledge of importance of screening is a barrier to receiving breast health care. Key Informants and focus group participants mentioned that women who do not understand the importance of yearly screening may not seek breast health care until they experience problems with their breasts.

One informant noted that there is not a great deal of breast health education taking place in Bryan County, and believes that if there was a concentrated effort to educate women on the importance of early detection, more women would seek to obtain screenings. The women in the focus group agreed that in rural or poorer areas of the county, like Pembroke and smaller towns,
residents may not be aware because they may not have been exposed to as much information. One participant said that women in these communities do not think they need mammograms and that they don’t understand why they’re important, so they simply do not get them.

Of the six focus group participants who had been screened, all of them agreed that they prioritize their breast health care because they understand its importance, but agreed that many women do not prioritize their own health above the many other needs in their life. One informant stated, “Women often put everyone else before taking care of their own needs.” Informants and focus group participants believe that if women understood how early detection increases survival rates, more women would be apt to make screenings a priority.

**Glynn County, Georgia**

Data from Glynn County included coded notes from eight key informant interviews and data from 43 surveys.

**Cost of Services**

Key informants identified cost as a barrier to receiving care, and they mentioned that many women may not be aware of the free services available within Glynn County, such as those available through the health department and local hospital. Similarly, survey participants who had never received a mammogram listed cost as a reservation they have when considering breast health care. One key informant said that “women may not get mammograms because they don’t have the money. If they knew about free mammograms, they might decide to take advantage of that.” When asked about how to encourage more women to seek services, key informants believed that resources like free mammograms would encourage women without financial resources to receive yearly screenings.

Lack of insurance also creates a barrier to receiving breast health care. Key informants believed that women without insurance would be much less likely to receive recommended breast health care than women with insurance. Some key informants mentioned that people know that health care is expensive, so without insurance, they will not seek recommended health care until they develop problems that require immediate medical attention. Similarly, survey participants who had never received a mammogram mentioned free services or clinics as one way to encourage women to get screened regularly.

Similarly to Bryan County, Glynn County key informants spoke about the high deductibles and co-pays that many women with insurance must meet in order to receive diagnostic work-up as a barrier. Although insurance will pay for yearly mammograms for women over 40, diagnostic exams may not be covered if women have not yet met their deductibles. Key informants said that women may be discouraged from getting mammograms because, if they needed a diagnostic after, they know that they would not be able to afford it. One key informant explained that “even if you can afford health insurance, many times the deductible is so high that you question whether it is cheaper to pay out of pocket,” so women put off or avoid getting necessary diagnostic work-up all together. She went on to explain that for many, it’s difficult enough to pay the monthly premium, so women with insurance do not have extra income to cover the cost of co-pays and meet their deductibles.

Key informants mentioned that increasing insurance coverage to all women could encourage more women to seek recommended breast health care. They believed that, since insurance would pay for 100 percent of the cost of a yearly mammogram for women over 40, women would be more likely to take advantage of those services. Similarly, survey participants wrote that having insurance would be a way to encourage women to get screening mammograms.
Lack of Knowledge of Local Resources
The fact that the majority of survey participants were aware of the importance of screening suggests that people know that they should be screened, but they do not know where to go to get screened. Since Glynn County does have services that provide free mammograms, this indicates they may not be aware of the free services available in the county. Additionally, key informants in Glynn County agreed that many women may not be aware of the free services available through the local hospital, health department, and clinics. One key informant said that “I don’t think many people know that free services are available, even though [the local hospital] puts it out there. It is particularly difficult to reach the women that don’t qualify for Medicaid and don’t have insurance”. Key informants believed that underserved women who know about free services would be more likely to receive recommended screenings than women who are unaware.

Fear of Mammography and Breast Cancer Diagnosis
Many women may also be afraid of a breast cancer diagnosis. Key informants mentioned that women may worry about the results of a mammogram, so they decide to avoid that worry by not getting mammograms. One informant said that it seems like an “out of sight, out of mind” situation, where women do not address their health at all for fear of something being wrong.

Other key informants brought up issues related to pain during mammography. Women may hear from their mothers and other loved ones about their experiences with mammography. When those experiences include pain, women may be less likely to get screened. One informant said that words like "smash" and "squash" are often used by women to describe the procedure, so women who have never experienced a mammogram are conditioned to think that they are painful. Key informants agreed that women who believe mammograms are painful may be less likely to be screened regularly. Additionally, survey participants wrote that one reason they avoid breast health care is because they think it will be painful.

McIntosh County, Georgia
Data from McIntosh County included coded notes from six key informant interviews and one focus group with eight participants. Data also included focus group participant demographic forms.

Fear of Diagnosis
Key Informants and focus group participants all identified fear of diagnosis as a barrier to receiving breast cancer screening. Common fears related to a diagnosis included fear of removal of the breast, fear of treatment, and fear of dying due to breast cancer. One focus group participant said “They want to be seen as women. When women lose their breast, they don’t feel like women anymore,” so women who are afraid of losing their breast may be less likely to receive yearly screenings.

According to focus group participants and key informants, fear of treatment encompasses both worry about how to afford to pay for treatment and how to continue to take care of the family and household while going through treatment. Key informants and focus group participants said that women may worry about their finances and how they would pay for treatment, and that they also worry about how they will continue to be wives, mothers, and workers as they go through treatment. One focus group participant said “Women worry about everyone and everything else before them. They have to do this and that and take care of the family and clean the house, and they think breast cancer treatment would just add to it.” Finally, key informant and focus group participants identified fear of dying due to breast cancer as a possible reason women choose
not to get screened. One key informant described the fear of dying due to breast cancer as a “what you do not know cannot hurt you” attitude, and explained that women may not understand that breast cancers diagnosed in early stages are more treatable and have higher chances of survival. A focus group participant voiced similar concerns when she said that “women don’t know that breast cancer is beatable, and they think breast cancer just means you’re going to die,” so women who fear breast cancer are not likely to get screened until they understand that early stage breast cancers are easier to treat than later stage breast cancers.

*Lack of Proximity to Services*

Similarly to Bryan County, many key informants and focus group participants brought up lack of convenience to breast cancer screening services. Many women who live in McIntosh County travel to Brunswick (in Glynn County) to receive services. One informant observed, “There is not much in this county, and women simply don’t know where to go. Some know there are services at the hospital in Brunswick, but they won’t go because it is too far”. Another informant noted that many women know they can go to the Health Department for general health, but they must go to a “big city” for a mammogram.

Traveling from McIntosh County to Brunswick or another city creates obstacles for many women. Focus group participants spoke about how it is inconvenient to get their mammograms because they must plan to take time off from work and schedule childcare to accommodate the one hour drive to the hospital in Glynn County. Informants mentioned that many women simply do not want to spend the money on fuel for the two-hour round trip.

During the focus group, participants acknowledged that a mobile mammography unit came to McIntosh, but they stated that it did not come often enough to meet to high demand in the county. They felt that a more frequent mobile unit presence would be able to save women a trip to Brunswick for a mammogram. The focus group participants acknowledged that women living outside of Darien and Townsend may not even be aware that the mobile mammography unit travels through McIntosh County. They mentioned that women in the more rural areas of the county do not get information about happenings within the county unless they learn about through word of mouth, such as at church.

*Distrust of Health Care System/Misunderstanding Process*

The final theme related to being intimidated by the medical care system and misunderstanding the screening process. Overall, McIntosh County is rural, and women from rural areas may be intimidated by the hospital in Glynn County. Key informants and focus group participants indicated that many women in McIntosh County may not want to travel to such a large institution unless it is an emergency. Focus group participants noted that women in rural areas of the county may have never been to hospital unless they were giving birth, so they do not see the hospital or any large institutions of health as places to reach out for regular screenings.

Furthermore, informants indicated that women often do not understand the breast cancer screening process. One informant stated, “Women go to their doctors, and their doctor does a clinical breast exam, and they think are having a mammogram done.” Other informants noted that many women do not understand the terminology being used to describe the procedures related to breast health, which leads to confusion.
Black/African-American Women
Data for Black/African-American Women included coded notes from 10 key informant interviews and two focus groups consisting of seven and eight participants, respectively. Data also included focus group participant demographic forms.

Cost of Services
Similarly to information for other target communities, lack of insurance and the prohibitive cost of services deter women from seeking screening. Key informants mentioned that many Black/African-American Women do not have insurance and cannot afford to pay for the services out of pocket. Another informant noted, “For underserved minorities, money is a huge barrier — many African-American women are financially unstable.” They went on to say some may be single parents and need to make financial choices between breast health services and household needs.

Additionally, for women with insurance, co-pays and deductibles related to diagnostic services may not be affordable, so women may avoid screening preemptively because they know they cannot afford diagnostic services. One key informant said “women with insurance wonder what happens if they need more services – how will they pay? They already have to make sure their families are taken care of, and now they have to figure out a way to pay for taking care of themselves, too.”

Lack of Knowledge of Available Resources
Key informants did not believe that most underserved Black/African-American Women would know of the availability of free services, like free mammograms, so although those services may be available in communities throughout Coastal Georgia, Black/African-American Women may not take advantage of them. Focus group participants overall were not aware of free services available throughout Coastal Georgia. Only two participants out of the two focus groups mentioned free services from the local health departments. The other focus group participants did not know that any free breast health services were available.

Some key informants were aware of free services through the health departments, hospitals, and clinics, however, those key informants questioned whether the availability of these services is common knowledge. One key informant mentioned that organizations should do more to get the word out about resources. Key informants believed that if women knew about the services available within their communities, they would be more likely to use those services and get screened regularly.

Lack of Knowledge of Importance of Screening
Key informants and focus group participants all agreed that many Black/African-American Women, especially Black/African-American Women in rural areas and Black/African-American Women who live in poverty, have not been educated on the importance of regular breast cancer screening, so they may not prioritize screening enough to receive it regularly. They mentioned that women lead busy lives and take care of their families and households before taking care of themselves, so they may not make an effort to make time for screening or seek any breast health care until they experience unusual changes in their breasts.

Informants also suggested that many Black/African-American Women still do not understand breast cancer risk factors, and may be in denial that they need to be screened. This could stem from a general misunderstanding of breast cancer. One informant noted, “There are still a lot of myths in the African-American community about breast health, like hitting your breast will give you breast cancer. They may not understand why they need mammograms.” Several
Informants agreed that if women are more educated about mammograms and understand their importance, they will be more likely to get their mammograms.

**Distrust of Health Care System**

Key informants and focus group participants also brought up fears about seeking medical care. Many key informants mentioned the past mistreatment and misunderstanding of Black/African-American people and culture as a deterrent to seeking medical care. One key informant mentioned that stories of mistreatment live on and influence behavior, so people who know those stories and are put off by them won't go get health care. Key informants brought up events, such as the Tuskegee syphilis experiment, as reasons that Black/African-American Women may not seek recommended medical care, including screening mammograms. Although this experiment ended in the 1960s, stories about the experiment and mistreatment of Black/African-American Americans still discourage people from receiving medical care and create distrust in the health care system. Another key informant explained that, in addition to stories of mistreatment, Black/African-American Women need to know that the people working there will understand their issues and treat them well, or those women may avoid health care altogether.

In addition to unethical practices in the past, key informants mentioned issues relating to cultural competence and representation in health care. Multiple key informants and focus group participants brought up issues relating to feeling misunderstood by medical personnel as a reason women may not get mammograms. One key informant explained that a person's attitude towards institutions of health can influence their health-seeking behavior. She said that “Black/African-American women may not always feel like their doctor understands them. If they don’t think their doctor understands them or will try to understand them, they are not going to go.” Another key informant identified cultural competence as an issue when she explained that health care professionals need to make sure to understand the culture that Black/African-American Women may be coming from, in order to ensure that Black/African-American Women continue through the breast health continuum.

**Medically Underserved Women**

Data for Medically Underserved Women included coded notes from 12 key informant interviews and data from 43 surveys.

**Lack of Proximity to Services**

Key informants stated that Medically Underserved Women typically have many barriers to overcome before they are able to be screened – especially because most Medically Underserved Women do not receive services in their counties of residence. Survey data supported this claim. All survey participants who indicated that they had ever received a mammogram listed cities outside of their county of residence as locations where they received them.

Informants agreed that one of the biggest barriers is having to travel 30 minutes or more to receive breast health services. Medically Underserved Women may have to travel to large cities, such as Savannah and Brunswick, for screening, and for most women, that drive could be up to an hour. Informants explained that, although long travel times are barriers in and of themselves, travel creates other obstacles that women must overcome. Many informants cited worries about the cost of travel, lost wages, and finding affordable childcare as reasons that women may put off or neglect to make an appointment for routine breast health care.
Survey participants experience similar problems. When asked about how to encourage women to get screened, three participants wrote that services should be provided closer to home, and one participant wrote that using the mobile mammography unit within the county would make it easier for women to get screened regularly. When key informants were asked about improvements that could be made to the health care system, many of them mentioned that having the mobile unit more visible or within different medically underserved areas more often could eliminate some of barriers associated with travel.

Lack of Knowledge of Resources Available
Over half of survey participants who indicated that they had never received a mammogram wrote that one way to encourage women to get screened for breast cancer would be to offer free mammograms. Since referrals for free services are available, this may mean that those women are unaware of free services in their communities.

Data from key informants supports this claim. Informants mentioned that women within medically underserved areas may not be aware of the free services available within their counties of residence. They believed that if more women were aware of the services provided through local health departments, clinics, and mobile mammography units, women would be more likely to make appointments for mammograms. They acknowledged this could be because women in rural areas generally do not have much access to information about health resources. They suggested women look to get much of their information about community resources through their church, local grocery store, etc. If the information is not available at one of these locations, they simply do not get it.

Fear of Pain and Diagnosis
Survey participants and key informants, identified fear of pain as a reservation to making an appointment for breast health care. Overall, a quarter of survey participants wrote that fear of pain during mammography is a reservation that discourages them from receiving regular screening. One key informant said that women are afraid that health care professionals will have to flatten the breast tissue so much that it will hurt, and that women do not understand that mammographers try not to surpass an individual’s pain threshold.

Survey participants and key informants also identified fear of breast cancer diagnosis as a barrier to receiving screening. According to key informants fear of diagnosis relates to how to take care of the family after a diagnosis and the possibility of death. One key informant said that “[women] don’t want to hear the “C” word. They’re afraid of a possible diagnosis and treatment,” and they do not know how they would be able to continue caring for and supporting their loved ones. Another informant said that women tend to neglect themselves, even if they are aware that they need medical care, because they do not know who would take care of the family if they die. For those women, a mammogram could identify a problem that they do not think they have the resources to deal with.

Qualitative Data Findings

Bryan County, Georgia
Barriers to screening services identified in key informant interviews and the focus groups, such as lack of proximity to services, not being aware of services within proximity, the high cost of services, and lack of knowledge of importance of screening can contribute to high late-stage diagnosis and death rates. Bryan County key informants and focus group participants mentioned the above issues during discussion as reasons that women may not receive yearly
mammograms, which could mean that women are waiting until they have unusual changes in their breasts to seek health care.

According to the Health Systems and Public Policy data, Bryan County is 100.0 percent medically underserved, and there are no standing facilities in Bryan County which offer screening mammograms, diagnostic services, or treatment services. This corresponds to the information gleaned from the focus group and key informant interviews. Participants were unaware of any screening resources, outside of those that provide clinical breast exams and referrals for mammograms, in Bryan County, and focus group participants who do get screened travel to Savannah for those services. Key informants also said that many women in Bryan County who do get screened probably do so in Savannah. A small minority of women may get screened on the mobile mammography unit used by a hospital based in Savannah, but that unit is not in Bryan County every day.

For women who do not understand the importance of yearly screening, traveling to Savannah or waiting for the mobile unit to set up near where they live may not even be considered. They may not prioritize screening enough to seek different resources.

Based upon data from the Qualitative Data Report (QDR), Health Systems and Public Policy section (HSPP), and the qualitative data discussed in the section above, three major barriers to breast health care in Bryan County are:

1. Lack of proximity to available services (or lack of knowledge of services within proximity) is a barrier to receiving screening
2. High cost of services is a barrier to screening and diagnostic services
3. Lack of knowledge of importance of screening is a barrier to screening

Glynn County, Georgia

Barriers to receiving breast health services in Glynn County, like cost of services and lack of knowledge of local resources, may contribute to the high late-stage breast cancer diagnosis rate in Glynn County (53.2/100,000 women), which is the second highest in all of the Affiliate service area. The annual percent change for the late-stage rate is 6.0 percent, which means that more women are continuing to be diagnosed late-stage year to year.

Although Glynn County is not 100.0 percent medically underserved, the survey responses indicating that free mammograms would encourage women to get screened could mean that women in Glynn County are unaware of services and as a result, do not take advantage of those services.

According to qualitative data, women in Glynn County may not be getting recommended screening because they cannot afford it (lack of insurance), or they are not aware of the free services available within the county. Putting off screening could contribute to the high late-stage diagnosis rate.

In addition to the affordability of care, women may be afraid of pain associated with mammography or afraid of a breast cancer diagnosis itself. According to the qualitative data, those fears may lead to avoidance of screening.

Based upon data from the QDR, HSPP, and the qualitative data discussed in the section above, two major barriers to breast health care which may be related to the high late-stage diagnosis rate and trend in Glynn County are:
1. Lack of knowledge of available services for un and underinsured women is a barrier to screening
2. High cost of services for un and underinsured women is a barrier to screening
3. Fear of mammography and breast cancer diagnosis are barriers to screening

McIntosh County, Georgia
Although the late-stage diagnosis rate in McIntosh County is 36.4/100,000 women and is one of the lower rates in the Affiliate service area, it is increasing at a rate of 33.9 percent per year. This substantial trend is negatively impacting women in McIntosh County, and will continue to be an obstacle to achieving the Healthy People 2020 late-stage objective. Key informants and focus group participants mentioned that women in McIntosh County may not receive services because they are not convenient, and women in the focus group who do get screened travel to Glynn County for those services. Inconvenience of services could dissuade women from receiving regular breast health care, which could contribute to the increasing late-stage diagnosis rate.

Additionally, there are no facilities which offer mammography, diagnostic or treatment services within McIntosh County, according to health systems data. The hospital in Glynn County has a mobile mammography unit which serves women in the county periodically, but based upon information from key informants and focus group participants, most women who do get screened travel to the hospital in Glynn County. Some focus group participants were unaware of the services offered by the mobile unit, so other women in the county may not be aware, which means they may not take advantage of screening mammograms offered.

Lastly, key informants and focus group participants brought up issues relating to intimidation. Women may not be comfortable entering a hospital for a routine test – they may believe that hospitals are places for emergencies. This belief coupled with a misunderstanding of the importance of screening could mean that women are not willing to go outside of their county of residence for breast health care.

Based upon data from the QDR, HSPP, and the qualitative data above, three major barriers to breast health care which may be related to the high annual increase in late-stage diagnoses are:
   1. Misunderstanding of medical process and the fact that medical processes are intimidating are barriers to screening
   2. Fear of a breast cancer diagnosis creates barriers to screening
   3. Lack of proximity to available services (or lack of knowledge of services within proximity) is a barrier to receiving screening

Black/African-American Women
Black/African-American Women in Coastal Georgia have a higher late-stage diagnosis rate and trend due to breast cancer than white women. According to the qualitative data, the high cost of services for un and underinsured women may be a barrier to receiving breast health care which could contribute to poor breast health outcomes.

Key informants mentioned that the most common barrier that Black/African-American women may experience is the cost of screening services. For Black/African-American Women without insurance, breast health services may not be affordable, and, according to key informants, Black/African-American Women who are unaware that free resources exist may continue to go without screening. Overall, Black/African-American Women in focus groups were not aware of
free resources within their communities, except for one woman who knew about the health department’s services.

The counties in the Affiliate service area which have the highest percentage of residents who are Black/African-American Women are Liberty County, Chatham County, and McIntosh County. Based upon health systems data, Liberty and McIntosh County are 100.0 percent medically underserved, so Black/African-American Women in those counties may not have convenient access to the care they need. In all three counties, and possibly for many women throughout the Affiliate service area, cost of services may have a negative impact screening decisions.

The high late-stage rate and trend may also be influenced by lack of knowledge of the importance of screening. Focus group participants and key informants mentioned that Black/African-American Women who are unaware of why women should receive annual breast screenings would probably not prioritize screening.

Finally, because of the mistreatment and misunderstanding of Black/African-American Americans by the health care system, some Black/African-American Women may have a distrust of the health care system, and they may avoid medical care. Key informants and focus group participants also believed that some Black/African-American Women may be afraid of a breast cancer diagnosis and the health care system, so even if they are aware that they should be screened, they may not get screened to avoid a possible diagnosis.

Based upon data from the QDR, HSPP, and the qualitative data above, four major barriers to breast health care which may be related to the high annual increase in late-stage diagnoses are:

1. High cost of services is a barrier to screening
2. Lack of knowledge of available resources is a barrier to screening
3. Lack of knowledge of importance of screening is a barrier to screening
4. Fear of a breast cancer diagnosis and distrust of the health care system are barriers to screening

**Medically Underserved Women**

Medically Underserved Women live in seven of the nine Coastal Georgia counties in the Affiliate’s service area. Based upon data from the health systems analysis, Medically Underserved Women in Long, Camden, Bryan, and McIntosh, do not have access to facilities which offer screening mammograms, diagnostic services, or treatment services. The mobile mammography unit from a hospital based in Savannah serves Bryan County, and the mobile unit from the hospital based in Brunswick serves Camden, McIntosh and Long, but their time within those counties is limited, and thus the services they provide are also limited. Key informants and survey participants were unaware of most resources, like health departments and the services they offer, so what is available within medically underserved counties may be unknown to many residents.

Medically Underserved Women also live in counties with high late-stage diagnosis rates, death rates, and experience higher positive annual trends for those statistics. When key informants were asked about issues that could lead to negative breast health outcomes like those mentioned previously, the high cost of services was the most common answer. For people aware of local resources, a barrier mentioned was lack of knowledge of available resources, such as the Breast and Cervical Cancer Program available at local health departments. As a
follow-up, many medically underserved women who use that program must leave their county of residence to receive their screening mammograms and any necessary diagnostic work up.

This issue leads into another barrier – lack of proximity to available services. Although uninsured women over 40 can receive their screening mammograms free of charge through a referral from the health department, they have to travel out of county to their appointments. According to Health Systems data, most medically underserved counties do not have standing facilities which provide mammograms. For counties that do have facilities which offer screening mammograms, women in rural areas of the counties may still have to travel up to 45 minutes to receive their services.

Based upon data from the QDR, HSPP, and the qualitative data above, four major barriers to breast health care which may be related to poor breast health outcomes for Medically Underserved Women are:

1. High cost of services is a barrier to screening
2. Lack of knowledge of available resources is a barrier to screening
3. Lack of proximity to available services (or lack of knowledge of services within proximity) is a barrier to screening
4. Fears and misperceptions, particularly fear of pain and fear of a breast cancer diagnosis, are barriers to screening

Strengths and Limitations

Key Informant Interviews
Key informant interviews allow people from diverse backgrounds, such as health care workers, community advocates, and survivors to share their insight into issues that may affect women as they enter into and progress through the continuum of care. Data collected from key informant interviews have much more depth than quantitative statistics, and the data provide a more complete picture of the barriers to care that women in Coastal Georgia may face.

In addition to the qualitative data from key informant interviews being more detailed, the inter-rater agreement after coding the data averaged 92.0 percent, which means that the two people scoring the data and drawing themes had the same coding 92.0 percent of the time.

Although key informant interviews allowed the Affiliate to collect in depth data, the Affiliate was unable to obtain the optimal amount of key informant interviews in certain target communities, due to lack of resources in those communities. Because of this, the data may not be as reliable as data that would be analyzed from the optimal amount of interviews. Best practice would have been to obtain at least 12 interviews in each community, however, in certain counties, like Bryan and McIntosh, there are not 12 health care workers and/or community advocates familiar with breast health. So despite fewer interviews, the data presented may be a complete picture of the breast health issues from those two perspectives.

Key informant interviews are also limited by interviewer bias. Although interviews were completed using a carefully developed script, misreading the script, tone of voice, and inflection can change how questions are viewed and answered.

Focus Groups
The Affiliate executed four focus groups, consisting of seven to nine participants, which is within the scope of best practice. The focus groups allowed participants to start a dialogue based upon open-ended questions, and the data collected were more detailed than quantitative data. All five focus group questions were asked and answered at each focus group. After establishing
themes and coding data, the averaged inter-rater agreement for all qualitative data coding was 92.0 percent, which means that the two people who coded the qualitative data coded it the same way 92.0 percent of the time.

Although the Affiliate used focus groups to learn about the issues from women over 40 in a group setting, no more than two focus groups were executed per target community. Because two target communities (Bryan County and McIntosh County) only had one focus group, the data presented may not accurately reflect the breast health issues present in those counties. The data from the two focus groups for Black/African-American Women had very similar themes and little variation between themes, so data for that target community may be more reliable.

Because convenience sampling was used to recruit focus group participants, the data may not be applicable to the entire target communities. For example, each focus group was recruited either through a local church or community group, and those groups may not be representative of the entire community. A focus group participant for Black/African-American Women brought up this issue when she stated “We are well educated. If you go down the road, those people are going to give you different answer. We can’t speak for everyone.”

Lastly, facilitator bias during the focus group could impact the data collected. Although a script was carefully developed for focus groups and all questions were asked as they were written, the facilitator had to guide conversation, and that guidance could be influenced by facilitator bias.

**Surveys**

Surveys allowed many women within target communities to offer input on issues they experience and how they would like to see issues addressed. By using surveys, the Affiliate was able to get insight from women throughout the Medically Underserved community and within Glynn County.

Surveys for Medically Underserved Women were distributed to women in two medically underserved counties (Bulloch and Long) to learn more about issues that women over 40 may face in different medically underserved areas. Surveys were not distributed in each medically underserved county, so data may not be as easily generalized as it would be with surveys from all counties, but the themes from respondents were similar no matter where respondents lived.

Additionally, sample size and sampling methods limit the data. Sample size was calculated using a 15 percent margin of error, so there is a 15.0 percent chance that the answers given are not true for the target communities overall. Because of convenience sampling, the data may not be as easily generalized to the entire target community.

Lastly, some of the 43 surveys per target community were incomplete. Some respondents did not answer some or all of the qualitative questions, which means that their beliefs and opinions were not considered during data analysis.

**Triangulating the Data**

Although the Affiliate was not able to collect best practice amounts of data, comparing data between data sources revealed common themes between data. The commonalities between data from different sources (focus groups and key informant interviews, key informant interviews and surveys) allow the Affiliate to be confident in the conclusions drawn.

Although themes and conclusions were very similar for all forms of data collection, the qualitative questions asked on the survey were different from those asked of focus group
participants and key informants, so certain data from surveys was not able to be cross-referenced. For example, one theme from surveys distributed to women in Glynn County was fear of pain during a mammogram and diagnosis of breast cancer. Because key informants did not mention this theme, the Affiliate was not able to consider it a priority.

Conclusions
Overall, the high late-stage diagnosis rates, high death rates, and their positive trends within each target community may be related to issues in access services (cost, convenience and proximity), lack of breast health knowledge, and fears and misperceptions about breast health care and breast cancer.

The high cost of services is the most common barrier among target communities (all except for McIntosh County), and this barrier is related to lack of insurance. Women without insurance may not be able to afford services, and although women with insurance do not have to pay for yearly mammograms after 40, they may not be able to afford the co-pays and deductibles for diagnostic work-up after screening.

The second most common barrier is lack of proximity to breast health services, and many women clarified their answers to say that planning for an appointment for breast health services is not convenient, especially in medically underserved counties where most women travel out of county to receive those services. Key informants in McIntosh and Bryan Counties brought up the convenience of mobile mammography units but questioned whether not most women within those counties (especially in the rural areas of the counties) were aware of this resource.

Lack of knowledge of resources and the importance of breast cancer screening is also a barrier for target communities. For women who live in areas where there are services available (ex. Glynn County), being unaware of those services, like free mammograms, may discourage women, especially uninsured and underinsured women, from seeking breast health care because they may not believe that they can afford it. Additionally, lack of knowledge of the schedule of the mobile mammography unit in medically underserved counties could keep women from taking advantage of that service.

Finally, fears and misperceptions affect health seeking behaviors of women in three target communities – McIntosh County women, Black/African-American women and Medically Underserved Women. All three target communities may experience fear of a breast cancer diagnosis, but Black/African-American women may also experience distrust of the health care system.
Breast Health and Breast Cancer Findings of the Target Communities

Quantitative Data
The Affiliate chose five target communities on which to focus its resources: Bryan County, Glynn County, McIntosh County, Black/African-American Women in Coastal Georgia, and Medically Underserved Women in Coastal Georgia. All five target communities experience poor breast health outcomes, which may be correlated to socioeconomic and demographic factors present in the Affiliate service area.

All three of the county-based target communities and Black/African-American Women are not expected to reach at least one of two Healthy People 2020 (HP2020) breast health objectives. Those objectives, a late-stage rate of 41.0 per 100,000 women and a death rate of 20.6 per 100,000 women, are health-driven objectives that the US should meet by 2020. All three counties and Black/African-American Women also have positive annual trends for late-stage diagnosis and death rates, which means that those populations will continue to experience increasing rates unless action is taken.

In addition to poor breast health outcomes, all target communities experience higher rates of socioeconomic and demographic indicators associated with poorer overall health. Bryan County and McIntosh County are more rural and medically underserved than Georgia and the US overall, which may create barriers to accessing health care. Although Glynn County is neither medically underserved nor rural, a greater percentage of women in the county are over the age of 40 than in any other county in the Affiliate service area. Increasing age is associated with increased risk of breast cancer; however, increasing age is not associated with higher risk of late-stage diagnosis.

Overall, Black/African-American Women in the US are more likely to be diagnosed as late-stage and have higher rates of death due to breast cancer than white women in the US, and the same is true for Black/African-American Women living in the Affiliate service area. McIntosh and Liberty, two of the three counties with the highest percentages of residents who are Black/African-American Women, are also 100 percent medically underserved and more rural than Georgia and the US, overall, which can create barriers in access to medical care.

Seven of the nine counties in the Affiliate service area are considered 100 percent medically underserved, and almost half of all Coastal Georgia residents live in medically underserved counties. Although no late-stage diagnosis or death rate data are available for Medically Underserved Women, counties which are 100 percent medically underserved by definition do not have adequate health care resources to meet the needs of their residents. Because of that lack of resources, women in medically underserved areas may experience poorer health, including breast health, than women who live in counties that are not medically underserved.

Although the Quantitative Data Report includes detailed information about socioeconomic and demographic data for the service area, the data does not address issues related to entering into and progressing through the Continuum of Care from education through screening, diagnosis, treatment, and survivorship. In order to see a more complete picture of issues in breast health and health care in the Affiliate service area, the Community Profile Team collected and analyzed health systems and public policy data.
Health Systems and Public Policy Data
Based upon information from the Quantitative Data Report, the Affiliate explored health systems and public policy issues which may influence screening behaviors among women in Coastal Georgia, including barriers to entering into and progressing through the Continuum of Care. The Affiliate considered the availability of breast health services throughout the Continuum of Care, geographic location of facilities which offer services, and the laws and policies, such as federal funding for free breast health services, which may affect health seeking behaviors and influence breast cancer late-stage diagnosis rates and death rates.

All counties in the Affiliate service area receive funding for the Breast and Cervical Cancer Program (BCCP), which allows underinsured women to receive free breast cancer screening and diagnostic services. Although this funding is able to help women in each county in the Affiliate service area, the program is restricted to women between the ages of 40 and 64. Additionally, women must go to county health departments to enroll, but funding usually runs out before the fiscal year ends. Because of this, the program is not able to serve all at-risk populations in the service area. This is true for the three county-based target communities and medically underserved counties. Because funding is restricted by age and sex and runs out before year-end, the health departments within target communities have historically applied for and received Komen funding to be able to continue to provide breast health services to residents and expand the eligibility guidelines to include women younger than 40 and men.

Although each county has at least one health department location, Bryan County, McIntosh County, and medically underserved counties have very few additional resources. Additional resources in Bryan County include a hospital offshoot and a mobile mammography unit which periodically serves women in Bryan County. In general, all other breast health care for residents of Bryan County must take place outside their county of residence because there are no other standing facilities in Bryan County which offer more than breast cancer screening. This is also true for residents of McIntosh County and medically underserved counties. Except for Bulloch and Effingham Counties which each have a hospital, all other medically underserved counties (including McIntosh County) do not have any standing facilities that offer mammography. Mobile mammography units from two health systems within the service area provide screening mammograms to women in each medically-underserved county; however, those units operate on a fixed schedule.

In Glynn County, residents have more health care resources per capita than in any other county in the service area. The county has one health system with a designated breast care center which provides services throughout the Continuum of Care, and a mobile mammography unit which services Glynn County residents. Glynn County also has two clinics which provide clinical breast exams and referrals for additional services. Although the county comparatively has a wealth of resources, all resources are located within the city of Brunswick, unless the mobile unit travels to neighboring areas.

Health systems data for Black/African-American Women was considered throughout the Affiliate service area, since many counties have higher percentages of Black/African-American Women than the Coastal Georgia service area and the US. Overall, the service area includes many facilities which offer breast health services through the Continuum of Care, including facilities which serve underinsured people. However, the majority of these facilities are located in city centers. Liberty, Chatham, and McIntosh Counties have the largest percentage of residents who are Black/African-American Women, but Liberty and McIntosh Counties are medically-underserved and do not have adequate resources to ensure that all women enter into and progress through the Continuum of Care. Black/African-American Women in Chatham County
are able to go to two local hospitals, two community health centers, one free clinic and one health department, but those facilities are located in Savannah, the largest city. After considering the quantitative and health systems data for each target community, the Affiliate aimed to learn about the specific barriers to care related to the cost of breast health services, the locations of facilities which offer breast health services, and personal beliefs that could influence a woman’s decision to get screened.

**Qualitative Data**

Qualitative data were collected using key informant interviews, focus groups, and surveys to learn about barriers to breast cancer screening and perceived breast health care needs in target communities which could contribute to poor breast health outcomes. Qualitative data also examined potential improvements to the health care system to encourage women to get screened regularly, which would allow for earlier detection of breast cancer.

In Bryan County, many key informants and focus group participants revealed that their lack of proximity to facilities which offer services, the high cost of services, and a general lack of knowledge of importance of screening are deterrents to receiving breast health care. Participants mentioned that many women who get screened leave their county of residence because of a lack of facilities, and having to leave their county of residence creates other barriers related to lifestyle factors. One woman mentioned that getting regular breast cancer screenings is “too much of a hassle” because women in Bryan County have to travel up to an hour to their facility of choice, take time off from work, and find childcare. A mobile mammography unit does serve women in Bryan County; however, key informants and focus group participants agreed that the unit’s presence and schedule are not well known among women in Bryan County. Additionally, the cost of breast health services may affect screening behaviors. Women who do not have insurance or who have insurance with high deductibles may be less likely to get screened than women who have insurance with lower deductibles. Finally, a lack of knowledge of the importance of screening was identified as a potential barrier. Women who do not understand the importance of regular screening may not be as likely to make an appointment for breast health services as women who do understand the importance of screening. Key informants and focus group participants agreed that the issues discussed above may contribute to poor breast health outcomes in Bryan County.

In Glynn County, data from key informants and survey participants revealed that a general lack of knowledge of available services, the high cost of services, and fears about mammography and breast cancer diagnosis may discourage women from getting screened. Some survey participants wrote that providing free services could encourage women to get screened, and because there are free services currently available, this could mean that some women are unaware of the resources in their communities. Key informants also supported this idea - many believed that some women who do not get screened may not know about the availability of local resources. Additionally, key informants and survey participants identified the perceived high cost of health care as deterrents to breast health care. Many key informants said that women do not know how they would afford health care if they needed it, so they avoid health care at all together. Finally, fears about pain associated with breast cancer screening and fears of a breast cancer diagnosis may prevent women from reaching out to local health care resources. Key informants believed that women who are afraid of screening procedures or a diagnosis would be less likely to get screened than women who understand screening and the importance of early detection.

In McIntosh County, key informants and focus group participants believed that barriers to screening include a misunderstanding of the medical process, being intimidated by health care, fearing breast cancer diagnosis, and a lack of proximity to available services. Key informants
mentioned that many women in McIntosh County may not receive regular health care at all, so they may not be familiar with medical terminology and screening procedures. One key informant explained that she has heard women say that they have had a mammogram, when in reality, the women received clinical breast exams. Additionally, women may be afraid of a breast cancer diagnosis and how it could negatively impact their lives, and those women are less likely to receive regular breast cancer screening. Women may also be intimidated by large institutions of health, like the hospital in Brunswick, which is where many women who receive breast health care travel. Because women may have to drive an hour or more to the hospital or their screening facility of choice, planning for travel, such as getting childcare, taking off of work, and paying for gas may be barriers to making and following through on an appointment for breast health care. Although some key informants and focus group participants were aware of the mobile mammography unit that serves the county, those that knew of it agreed that its presence and schedule are probably not common knowledge.

For Black/African-American Women, the high cost of services, lack of knowledge of resources and importance of screening, and a fear of breast cancer diagnosis along with a distrust of the health care system may create barriers to receiving breast health care. Women without insurance may not believe that they can afford any medical care, including regular breast cancer screening, so they are less likely to get screened. Although women with insurance may be more likely to get screened regularly, women who have high deductibles may preemptively decide not to get screened in order to avoid costs associated with diagnostic workup. Additionally, focus group participants and key informants brought up that women may not understand the importance of breast cancer screening, so they do not prioritize those services. If women do not prioritize their health and receive regular breast cancer screenings, they may be more likely to experience negative breast health outcomes such as late-stage diagnosis and death. Finally, participants explained that the past mistreatment of Black/African-American Americans by the health care system, such as the Tuskegee Syphilis Experiment, plus a lack of cultural competence among health care professionals may make Black/African-American Women less likely to get screened. Stories about past mistreatment are circulated, and some Black/African-American Women may not think that their health care providers will respect and understand their cultural beliefs and practices, so those women may be less likely to access breast cancer screening.

For Medically Underserved Women, key informants and survey participants identified the high cost of services, a lack of knowledge of resources, a lack of proximity to resources, and fears of pain and breast cancer diagnosis as barriers to screening. Similarly to other target communities, the cost of services without insurance is more than most women are able to afford, and insurance with high deductibles may discourage women from seeking screening because they understand that they would not be able to afford the deductible if they need additional diagnostic workup. Although each medically underserved county has at least one health department location, many Medically Underserved Women may not be aware of the availability of services through those facilities, so they may not reach out to those facilities for services. Some medically underserved counties are served by mobile mammography units which allow women to get screened in their county of residence.

However, the schedule and location of the units may not be well known for women in medically underserved counties, so those women are less likely to use those services. Although each county has a health department and may be served by a mobile mammography unit, many Medically Underserved Women may have to travel out of their county of residence for breast health services, including any necessary diagnostic workup. Barriers associated with travel, such as taking time off of work, arranging for childcare, and paying for gas may discourage
women from making screening appointments. Finally, key informants and focus group participants indicated that Medically Underserved Women may be afraid of pain during screening and being diagnosed with breast cancer. All participants agreed that women who experience fear would be less likely to get screened than women who do no experience fear.

**Mission Action Plan**

**Bryan County**

**Problem Statement:** Bryan County residents experience a high late-stage diagnosis rate with a high annual trend, so the rate will continue to increase unless action is taken. According to qualitative interviews, women in Bryan do not have adequate resources for breast health services within the county, and women in the county may not be aware of the mobile mammography unit which serves women in the area. In addition to a lack of resources, women often cite cost as a barrier to receiving breast health care, especially for uninsured women. Finally, women in Bryan County may not be aware of the importance of regular breast cancer screening, which can negatively influence women’s screening decisions and lead to later diagnosis.

- **Priority 1:** Increase awareness and visibility of the mobile mammography unit which serves Bryan County.
  - **Objective 1:** From FY16 through FY19, incorporate awareness of mobile mammography unit services and locations in Bryan County through at least one existing Affiliate-based or Affiliate-funded education program each year.
  - **Objective 2:** By August 2016, facilitate discussions with community partners which serve Bryan County to address site location concerns and opportunities for the mobile mammography unit to better serve Bryan County residents.

- **Priority 2:** Reduce barriers related to the cost of breast health services for women who reside in Bryan County.
  - **Objective 1:** From FY16 through FY19, address the financial barriers of Bryan County residents in the Affiliate RFA priorities each year.

- **Priority 3:** Increase knowledge of the importance of breast cancer screening for Bryan County residents
  - **Objective 1:** Incorporate breast cancer screening information into at least one community education program which serves Bryan County by January 2017.
  - **Objective 2:** Increase the number of organizations in Bryan County participating in Worship in Pink by at least three each year from FY16 through FY19.

**Glynn County**

**Problem Statement:** Glynn County has a high late-stage diagnosis rate with high annual trend, so people will continue to be diagnosed late-stage unless action is taken. Qualitative data collection revealed that many women cannot afford to pay out of pocket for breast health services, and that they may not aware of the low-cost resources within their communities. Additionally, women may delay screening because of fears about screening and diagnosis of breast cancer.

- **Priority 1:** Reduce the barriers associated with the cost of breast health services in Glynn County
  - **Objective 1:** From FY16 through FY19, address the financial barriers of Glynn County residents in the Affiliate RFA priorities each year.
• **Priority 2:** Increase knowledge of free and low cost services in Glynn County for underinsured people
  - *Objective 1:* From FY16 through FY19, ensure each grantee which serves Glynn County residents has a communications plan in place to educate the community about the availability of resources each year
  - *Objective 2:* Identify at least one existing education program which serve Glynn County in which the Affiliate can provide and distribute information about local resources in Glynn County by January 2017

• **Priority 3:** Address Glynn County residents’ fears of pain related to mammograms and fears of breast cancer diagnosis
  - *Objective 1:* Identify at least one community group to serve as peer advocates who can educate Glynn County residents about mammography and breast cancer by January 2017

**McIntosh County**

**Problem Statement:** McIntosh County has a rapidly increasing late-stage diagnosis rate, so although their current rate is lower than all other Coastal Georgia Counties, the annual increase will lead to more breast cancer late-stage diagnoses. Qualitative data collection revealed that women are not knowledgeable about terminology used during breast cancer screening and diagnostic procedures, so they may not know whether or not they have received mammograms. Additionally, women in McIntosh County experience fears related to a breast cancer diagnosis, which could cause them to delay care. Finally, McIntosh County residents typically travel outside of the county for health care. Residents who cannot or do not travel may not be able to receive necessary breast health care.

• **Priority 1:** Increase knowledge of the screening process and terminology associated with screening for McIntosh County residents.
  - *Objective 1:* Incorporate information about screening and terminology in at least one Affiliate or community program serving McIntosh County residents each year from FY16 through FY19.

• **Priority 2:** Address McIntosh County residents’ fears of breast cancer diagnosis.
  - *Objective 1:* From FY16 through FY19, increase the number of organizations in McIntosh County participating in Worship in Pink by at least one per year.
  - *Objective 2:* Partner with at least one community program which serves McIntosh County to address fears and misperceptions through Affiliate grantmaking, outreach, or education by January 2017.

• **Priority 3:** Address barriers to receiving breast health care related to proximity to breast health services for McIntosh County residents
  - *Objective 1:* From FY16 through FY19, incorporate awareness of mobile mammography unit services and locations in McIntosh County through at least one existing Affiliate-based or Affiliate-funded education program each year.
  - *Objective 2:* By August 2016, facilitate discussions with community partners which serve McIntosh County to address site location concerns and opportunities for the mobile mammography unit to better serve McIntosh County residents.
Black/African-American Women

Problem Statement: Black/African-American women experience higher breast cancer death rates and late-stage diagnosis rates than white women within the Affiliate service area. According to key informant interviews and focus groups, the cost of services can deter Black/African-American Women in Coastal Georgia from receiving yearly screening, and women may not be aware of the services available in their communities. Lack of knowledge of the importance of screening plus fears of diagnosis and distrust of the health care system may also negatively influence Black/African-American Women’s decisions on whether or not to get screened.

- **Priority 1:** Reduce barriers related to cost of services for Black/African-American Women in Coastal Georgia.
  - **Objective 1:** From FY16 through FY19, address the financial barriers of Black/African-American Women in Coastal Georgia in the Affiliate RFA priorities each year.

- **Priority 2:** Increase knowledge of local breast health resources for Black/African-American Women in Coastal Georgia.
  - **Objective 1:** From FY16 through FY19, ensure that each grantee receiving funds for screening and diagnostic services whose target populations include Black/African-American Women has a communications plan in place to educate the community about the availability of resources each year.
  - **Objective 2:** Identify existing education programs serving Black/African-American women in which the Affiliate can provide information about local breast health programs by January 2017.

- **Priority 3:** Increase knowledge of importance of breast cancer screening for Black/African-American Women in Coastal Georgia.
  - **Objective 1:** Develop targeted messaging talking points for the Pink Hair Warriors and Worship in Pink education kits to educate participants on the importance of screening and encourage screening by January 2017.
  - **Objective 2:** Identify a community group to serve as peer advocates for Black/African-American Women in the Affiliate service area by January 2017.

- **Priority 4:** Address fears of breast cancer diagnosis and mistrust of the health care system for Black/African-American Women in Coastal Georgia.
  - **Objective 1:** Develop targeted messaging talking points for the Pink Hair Warriors and to include in Worship in Pink education kits to address fears of breast cancer diagnosis and mistrust of the health care system by January 2017.
  - **Objective 2:** Identify a community group to serve as peer advocates for Black/African-American Women in the Affiliate service area by January 2017.
  - **Objective 3:** From FY16 through FY19, address the need for navigation programs to help Black/African-American Women transition through the continuum of care from education through screening and diagnosis in the Affiliate RFA priorities each year.
Medically Underserved Women

Problem Statement: People in medically underserved areas are less likely to access breast health care due to lack of resources, which can put them at higher risk of late-stage diagnosis and death due to breast cancer than people who do access regular breast health care. Medically Underserved Women cite the cost of services and lack of knowledge of local resources as deterrents to breast health care. Medically Underserved Women may also experience fears of screening procedures and breast cancer diagnosis, which negatively influences their decisions about breast health care.

- **Priority 1:** Reduce barriers related to the cost of breast health services for people living in the seven counties identified as medically underserved.
  - **Objective 1:** From FY16 through FY19, address the financial barriers of people living in the seven medically underserved counties in the Affiliate RFA priorities each year.

- **Priority 2:** Increase knowledge of available breast health resources for Medically Underserved Women in Coastal Georgia.
  - **Objective 1:** From FY16 through FY19, ensure that grantees which serve medically underserved counties have a communications plan in place to educate the community about the availability of resources each year
  - **Objective 2:** From FY16 through FY19, update service area resource sheet with information about local breast health services each year.

- **Priority 3:** Reduce barriers to breast cancer screening related to proximity for Medically Underserved Women in Coastal Georgia
  - **Objective 1:** From FY16 through FY19, increase awareness of the mobile mammography units which serve Camden and Long Counties by providing literature or Komen Coastal Georgia speakers for least one education program each year.

- **Priority 4:** Address fears and misperceptions of pain of mammography and diagnosis of breast cancer for Medically Underserved Women in Coastal Georgia.
  - **Objective 1:** Form or use an existing advisory board to explore issues involving fears and misperceptions related to breast cancer and breast cancer screening in medically underserved areas by January 2017
  - **Objective 2:** From FY16 through FY19, address the need for navigation programs to help women living in medically underserved counties transition through the continuum of care from education through screening and diagnosis in the Affiliate RFA priorities each year.


Appendices

Appendix A. Focus Group Questions

Welcome and Introduction:
[Moderator: Welcome and introduce the focus group]

Greetings and welcome to this focus group session. My name is (insert facilitator’s name). I am a (insert position title) at Susan G. Komen Coastal Georgia. My role in today's/tonight's focus group is to facilitate the discussion.

Attending with me today/tonight is (insert name). (Insert name) is a (insert position title) at Susan G. Komen Coastal Georgia. (Insert name) role today/tonight will be to take notes and help document your answers.

(Moderator: If additional people are in the room that are not participating in the focus group, introduce them, their title and organization affiliation, and focus group role)

The purpose of today's/tonight’s focus group is to gather your ideas, views and experiences regarding breast health and breast cancer screening in your community. The information provided by you tonight will assist in the development of Susan G. Komen Coastal Georgia breast health and breast cancer priorities through 2018. Today’s/tonight’s focus group is estimated to last until (insert time).

Your participation in this discussion is strictly voluntary and all responses will be anonymous when the information is presented. You may choose to withdraw from the discussion at any time. However, your collaboration is very important for the success of the final report. In addition, all information will be kept confidential and anonymous in the final report.

(Moderator: Include only if voice recording the session)
Because we want to accurately remember your ideas and thoughts, we will be voice recording this discussion. We are recording this session simply because we cannot write as fast as you talk. The recording will be sent to the affiliate’s analysts to be transcribed into a written report for Susan G. Komen Coastal Georgia.

We encourage you to participate actively and share your ideas freely. We truly appreciate your attendance and participation! Does anyone have any questions about the focus group?

(Moderator: Pause for a brief moment and answer any questions that the participants may have)

At this time, we kindly ask that if you chose to participate in today’s/tonight’s focus group, to please complete the “Focus Group Participant Consent Form” and “Focus Group Participant Demographic Form”.

(Moderator: Pause and allow time for participants to complete consent form and demographic form.)

Ground Rules for Group Interaction:
[Moderator: Begin group by providing ground rules for group interaction.]

To begin, let me lay down some basic ground rules:
1. There are no “right” or wrong answers. Any responses that you share are valuable.
2. We invite your participation and value your input throughout today's/tonight’s session. However please know that we respect your option to choose not to speak on certain topics/questions. Your relationship with Susan G. Komen and the services that you may receive from Komen are in no way linked to your level of participation.
3. Likewise, there are no rewards for higher levels of participation.
4. You do not have to answer every question. For those of you who wish to respond, please respond as completely and accurately as possible.
5. We ask that only one person talk at a time so that all comments can be acknowledged and noted accurately.
6. In addition, please listen to each other and feel free to agree or disagree in a respectful manner.
7. As moderator, I do receive the right to end a discussion or move the discussion along in the interest of time.

**Ice Breaker:**

**[Moderator: Begin with an opening ice breaker to let the group get to know each other]**

Let’s begin by introducing ourselves by first name only and (insert ice breaker question).

**Examples of ice breaker questions:**

- What is one activity that you enjoyed doing this past Summer?
- What is one of your favorite things about Spring?
- 1 or 2 things you’d like to share with us about yourself (e.g. where you are from, your occupation, family, etc.)

**[Moderator: Go around the room and let each participant introduce themselves and answer the ice breaker question]**

**Begin Focus Group Questions:**

**Women over 40:**

1. Do you get a mammogram or breast exam annually? Why or why not?
2. For those of you who did not receive a mammogram, do you know where you can go to get a mammogram?
3. What is your biggest concern when considering breast cancer screening (time, travel, cost, safety of screening/pain, etc)?
4. Do you think women in your community (or the female friends you know) have proper knowledge about the risks of breast cancer and breast cancer prevention (such as mammography, healthy living, etc)? If no, what is the most important information should they know?
5. Do you think the medical resources in this community can meet the community’s needs for breast healthcare? Why and why not?

**Breast Cancer Survivors:**

1. Did you follow the screening guidelines before you were diagnosed? Why did you decide or not decide to do so?
2. Do you think women in your community (or the female friends you know) have proper knowledge about the risks of breast cancer and breast cancer prevention (such as mammography, healthy living, etc)? If no, what is the most important information should they know?
3. What was most difficult for you when you were seeking services for screening, diagnosis and treatment?
4. Did you have any kind of health insurance when you were diagnosed? Do you think affordability is one of your concerns when seeking healthcare services?
5. In your opinion, what improvements can local health services make to increase the access to breast care services which include screening, diagnosis, treatment and supportive services (extended service hours, transportation, translation services, additional health services for survivors, etc)?

**Conclusion:**

*Moderator: Thank the participants for their time.*

Before we close, is there anything else that anyone would want to add to our discussion?

Thank you very much for your participation. We truly appreciate the time that you have invested in assisting Susan G. Komen Coastal Georgia.
Appendix B. Focus Group Participant Demographic Form

- Please select **one of the choices** below that best represents your current age:
  - ____ 39 years of age and younger
  - ____ 40-49 years of age
  - ____ 50-59 years of age
  - ____ 60 years of age and older

- County/Zip Code of Residence: ___________

- Have you ever had a mammogram? □ Yes □ No
  - a. If yes, at what age did you have your first mammogram? ________ years
  - b. How long has it been since you had your last mammogram? **Please check one.**
    - □ Within the past year (anytime less than 12 months ago)
    - □ Within the past 2 years (1 year but less than 2 years ago)
    - □ Within the past 3 years (2 years but less than 3 years ago)
    - □ Within the past 5 years (3 years but less than 5 years ago)
    - □ 5 or more years ago
    - □ Don’t know or not sure

- Have you ever been diagnosed with breast cancer? □ Yes □ No
  - a. If yes, at what age were you diagnosed? ________ years
  - b. What stage of breast cancer were you diagnosed with? **Please check one.**
    - □ Stage 1
    - □ Stage 2
    - □ Stage 3
    - □ Stage 4

- Has anyone else related to you been diagnosed with breast cancer? **Please check all that apply.**
  - □ Grandmother
  - □ Mother
  - □ Sister
  - □ Daughter

- Currently, at what age is it recommended for women to have a mammogram once a year? **Please check one.**
  - □ 30
  - □ 40
  - □ 50
  - □ 60

- What is your primary occupation? **Please check one.**
  - ____ Homemaking
  - ____ Computer/Office
  - ____ Sales
  - ____ Daycare
  - ____ Beautician/Salon
  - ____ Health care- clinical
  - ____ Social Work
  - ____ Housekeeping Services
  - ____ Health care- non-clinical
  - ____ Education
  - ____ Other (please list): __________________________
• What is the highest degree or level of school that you have completed? **Please check one.**
  
  ____ Did not graduate high school
  ____ High school graduate/GED
  ____ Vocational certification
  ____ Some college credit, but less than 1 year
  ____ 1 or more years of college credit, no degree
  ____ Associate’s degree
  ____ Bachelor’s degree
  ____ Master’s degree
  ____ Professional/Doctorate degree

• What language do you most frequently use in writing? _______________________

• What language do you most frequently use in speaking? _______________________

• What is your Race? **Please check all that apply.**
  
  ____ White
  ____ Black or African-American
  ____ American Indian or Alaska Native
  ____ Asian (e.g. Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese)
  ____ Native Hawaiian or Other Pacific Islander (e.g. Native Hawaiian, Guamanian/Chamorro, Samoan)
  ____ Other (please write your race): ___________________________________

• Are you of Hispanic, Latino/a or Spanish origin? **Please check all that apply.**
  
  ____ No, not of Hispanic, Latino/a, or Spanish origin
  ____ Yes, Mexican, Mexican-American, Chicano/a
  ____ Yes, Puerto Rican
  ____ Yes, Cuban
  ____ Yes, another Hispanic, Latino/a, or Spanish origin
  ____ Yes, other (please write your origin): ______________________________

• Where do you receive your health information? **Please check all that apply.**
  
  ____ Church
  ____ Mail delivered to your home
  ____ Shopping
  ____ Television
  ____ Radio
  ____ Newspapers
  ____ Internet
  ____ Social Media (e.g. Facebook, twitter)
  ____ Word of mouth (From whom or where: ______________________________)
• Where or how do you receive community/social information on events?

• What is your household income in (insert year)? Please check one.
  ____ Less than $10,000
  ____ $10,001- $20,000
  ____ $20,001-$30,000
  ____ $30,001-$40,000
  ____ $40,001-$50,000
  ____ More than $50,000
  ____ Don’t know/Not sure
  ____ Would prefer not to disclose

• If you received treatment for breast cancer, how was your treatment paid for? Please check all that apply.
  ____ Private insurance
  ____ Non-profit assistance grant
  ____ Medicaid/Medicare/Government Assistance
  ____ Self-pay
  ____ Don’t know/Not sure
  ____ Would prefer not to disclose

• Do you have one person you think of as your personal doctor or health care provider?
  ____ Yes, only one
  ____ Yes, More than one
  ____ No

• Was there a time in the past 12 months when you needed to see a doctor, but could not because of cost?
  ____ Yes, only one
  ____ Yes, more than once
  ____ No
Appendix C. Key Informant Participant Consent Form

Susan G. Komen- Coastal Georgia

I understand that I am being invited to participate in a key informant interview being conducted by the Susan G. Komen Coastal Georgia. By doing this interview, the Affiliate will gather information about breast healthcare and breast cancer related issues that exist in the community. It is hoped that the information provided by this interview will benefit the community through the improvement of local breast healthcare services. I understand that I am being asked to take part because I am familiar with breast healthcare in the service area of Susan G. Komen Coastal Georgia.

A key informant interview is a discussion between the interviewer and interviewee. The interview will include questions about community’s attitudes, beliefs and behaviors about breast health, the accessibility, utilization and quality of care, and additional breast health and breast cancer related issues. The discussion will last approximately 30 minutes. Notes will be written during the interview. An audio record of the interview may be made. However, the recording can be stopped at the interviewee’s request at any time during the interview.

I understand that I do not have to participate in this key informant interview and choose to end the interview at any time. My participation is voluntary, and I may change my mind at any time. There will be no penalty if I decide not to participate, nor if I start the study and decide to stop early. I understand that my participation in the key informant interview will in no way affect any current or future assistance from the Susan G. Komen Coastal Georgia.

I understand that all information obtained from the key informant interview will be kept strictly anonymous. All identifying information will be removed from the collected materials. In addition, all materials will be kept in a secure place. Only the interviewer and data analysts will have access to this information. Subsequent uses of the records and data will be subject to standard data use policies which protect the anonymity of individuals and institutions.

I understand that there are no physical risks to participating in this key informant interview, but I might not be completely comfortable answering some of the questions being asked. I understand that I am free not to answer any of the questions asked.

I also understand that my words may be quoted directly. With regards to being quoted, I have put my initials next to the following statement that I agree with:

_____ I agree to be quoted directly if my name is not published (I remain anonymous).
_____ I agree to be quoted directly if a made-up name is used.
     Please use this name: __________________________
_____ I do not want my words quoted directly.

By signing this consent form, I am indicating that I fully understand the above information and I agree to participate in the key informant interview.

_________________________ ____________________________ ____________
Participant Printed Name  Participant Signature   Date
Appendix D. Key Informant Script

Introduction:
Hello, my name is _______________. I am assisting Susan G. Komen Coastal Georgia in assessing where there may be barriers to or gaps in breast health services in the Affiliate’s five target areas- Bryan County, Glynn County, McIntosh County, Black Women Community, and Medically Underserved Women Community. The themes that emerge from the interviews will be used to set priorities and inform the efforts of Susan G. Komen Coastal Georgia. The priorities that we establish will help us determine where to target Affiliate grantmaking, as well as help us build community relationships, learn about programs taking place in your community, and address outreach and policy needs.

Your knowledge is valuable and the Affiliate appreciates you making yourself available for an interview. The interview will take about 20-30 minutes. Your participation in the interview is voluntary. You may choose not to participate in the interview at any time. Whether you chose to participate or not participate in the interview will in no way impact your relationship with the Affiliate and the services they provide. If you decide to stop prior to the interview being completed, I will ask you how you would like us to handle the data collected up to that point. If you do not want to answer some of the questions, you do not have to. I will be taking notes during the interview and trying to take down as much information as possible. While we use the themes from the interviews, the interviews themselves are confidential. Do you have any questions about the interview process?

- **Ask for verbal consent:** Do you agree to participate in this study knowing that you can withdraw at any point with no consequences to you? (Document date and time)
- **Ask for written consent:** At this time I kindly ask that you read and sign the provided consent form.

If you have any questions during the interview, please feel free to ask them at any time.

Questions:
1. What are your perceived breast health or breast cancer problems in this community? (eg. screening rate, late-stage diagnosis, mortality, lack of resources, lack of knowledge about the risks)
2. What are the main barriers for women in this county to access breast healthcare, such as mammography or breast cancer treatments? Do you think there are any available sources in the community that can be used to solve the problem (problems)?
3. Is the affordability of care a general concern for women in this community? If so, what factors are impacting the affordability of their healthcare (insurance or etc.)?
4. Do you think increasing the insurance coverage rate can help to encourage women to see breast health services? Why?
5. Do you think the medical resources in this community can meet women’s needs for breast healthcare?
6. What other improvements can the healthcare system make to increase the access to care (extended service hours, transportation, translation services)?
7. Do you think women in this community have proper knowledge about the risks of breast cancer and breast cancer prevention (such as mammography)? If no, what is the most important information should they know?
8. Does your organization have any education program regarding breast cancer prevention? Do you see any effect from this program?
9. What are the healthcare needs of women in the community regarding breast cancer prevention (knowledge, resources and etc.)?
10. What are the general concerns for women who refuse or not follow recommended screening guidelines?
11. What are the health services most needed by breast cancer survivors? Do they have the access of those services in local area? What is the most important service that should be provided for them locally?
12. If more and more women in this community begin to follow the recommended screen guidelines, and request for breast health services, do you think the healthcare resources in this community can effectively satisfy their needs? What kind of improvement should be expected (staff, facility, technique, etc)?

Closing:
Thank you very much for your time. Your knowledge and insights will be very helpful in assisting Susan G. Komen Coastal Georgia identify gaps and unmet needs in the breast health services community.

The 2015 Susan G. Komen Coastal Georgia Community Profile will be completed by (insert month, year) and will be posted online at (insert website address). The 2011 Community Profile can currently be found on the Affiliate website.

Thank you again for your assistance.
Appendix E. Qualitative Data Survey

XXX County Breast Health and Breast Cancer Survey

This survey is to assess the accessibility of breast health services provided to women who live in XXX County. Please answer the following questions with the answer that best describes your practice.

Demographic Information:

1. Please select one of the choices below that best represents your current age:
   - ☐ 39 years of age and younger
   - ☐ 40-49 years of age
   - ☐ 50-59 years of age
   - ☐ 60 years of age and older

2. County of Residence: ______________________

3. Have you ever been diagnosed with breast cancer? ☐ Yes ☐ No

   a. If yes, what stage of breast cancer were you diagnosed with? Please check one.
      - ☐ Stage 1
      - ☐ Stage 2
      - ☐ Stage 3
      - ☐ Stage 4

4. What is your Race? Please check all that apply.
   - ☐ White
   - ☐ Black or African-American
   - ☐ American Indian or Alaska Native
   - ☐ Asian (e.g. Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese)
   - ☐ Native Hawaiian or Other Pacific Islander (e.g. Native Hawaiian, Guamanian/Chamorro, Samoan)
   - ☐ Other (please write your race): ________________________________

Screening Mammograms:

A mammogram is a screening tool that uses X-rays to create images of the breasts to detect early signs of breast cancer.

5. According to your knowledge, at what age should women begin getting mammograms at average risk?
   - ☐ 30 ☐ 40 ☐ 50 ☐ 60

6. Have you ever had a mammogram? ☐ Yes ☐ No

   a. If yes, at what age did you have your first mammogram? _________

   b. How long has it been since you had your last mammogram? Please check one.
      - ☐ Within the past year (anytime less than 12 months ago)
      - ☐ Within the past 2 years (1 year but less than 2 years ago)
      - ☐ Within the past 3 years (2 years but less than 3 years ago)
      - ☐ 3 or more years ago
      - ☐ Don’t know or not sure
7. Please list where you go for your mammogram (name of facility and city/county).
____________________________________________________________________

Your Perspectives in XXX County:

8. What are your biggest concerns about making and keeping an appointment for breast health services, like a mammogram (time, travel, cost/insurance, safety of screening/pain, etc)?
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

9. From your perspective, what types of programs and services are needed to encourage women to seek out and receive recommended breast health care, like mammograms?
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

10. Do you think women in your community know about the risks of breast cancer and how to reduce their risk(such as mammography, healthy living, knowing what's normal for them, etc)? If no, what is the most important information should they know?
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

11. Please share any additional comments or concerns regarding breast health care for women residing in XXX County.
____________________________________________________________________
____________________________________________________________________