



# COMMUNITY PROFILE REPORT

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Orange County Affiliate of Susan G. Komen for the Cure®



# 2011

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## **Executive Summary**

### **Introduction**

The purpose of the 2011 Community Profile (CP) report is to provide up-to-date information on the status of breast health services and cancer in Orange County (OC). This report provides information on breast health issues with a particular focus on understanding awareness levels and understanding the complex issues impacting the breast health continuum of care. Furthermore, recommendations have been made as to how to best reach underserved communities and make an impact on specific populations at increased risk of late stage diagnoses and breast cancer mortality in OC.

Since its founding, the OC Affiliate of Susan G. Komen for the Cure® has raised and invested over \$27 million in breast cancer prevention screening, education, support programs, and research. In fiscal year 2010-2011, the Komen OC Affiliate invested more than \$1.3 million in grants to non-profit organizations and clinics to address the breast health needs of the county's diverse communities; including breast cancer patients, survivors and underserved populations. Grants to clinics cover the cost of diagnostic breast health services for women who do not qualify for other state or federally funded programs. Additionally, in collaboration with other community partners, the Affiliate conducts special outreach and education initiatives designed to address disparities and gaps in the breast health continuum of care.

The Affiliate is comprised of a diverse and multi-lingual staff and board. There is a 12-person board of directors; active committees made up of knowledgeable community leaders; and a staff of 14 professionals covering the areas of fundraising, public health programming, grants management, marketing, finance and data management. In addition, the organization relies on the generosity of more than 3,000 volunteers who provide nearly 23,000 hours, and an estimated \$400,000, of volunteer work every year.

### **Statistics and Demographic Review**

OC is the third most populated county in California with an estimated three million residents. An urban county covering 948 square miles, it borders four other populous counties (Los Angeles, San Bernardino, Riverside and San Diego) and has a diverse population that is 45.5 percent non-Hispanic white, 34.2 percent Hispanic, 16.6 percent Asian/Pacific Islander, 2 percent African American, 0.9 percent American Indian or Alaska Native, and 0.4 percent Native Hawaiian and other Pacific Islander (NHPI) (United States (U.S.) Census Bureau, 2010c).

The data compiled for this report was gathered, accessed and/or analyzed during 2010. This CP report has been built upon prior quantitative and qualitative data. It includes an expansion of new topics as well as thorough analyses of specific communities and population groups. Data collection for the CP began with a Komen/University of California, Irvine Data Project that was conducted to identify local breast cancer disparities using California Cancer Registry data. The project resulted in four monograph reports on select breast health topics that are publicly available at [www.komenoc.org](http://www.komenoc.org).

The demographic and statistical information collected from the data project revealed that African American women, Hispanic women of Mexican descent, NHPI women, as well as uninsured women are at increased risk of late stage diagnoses and breast cancer mortality. In addition to specific population groups, geographic areas in North OC, which has a high percentage of residents with a lower socioeconomic status, were also found to have higher rates of late stage diagnoses (Marshall, Ziogas, & Anton-Culver, 2009a).

### **Health Systems Analysis**

The breast health continuum of care (screening, diagnosis, treatment and follow-up) was utilized as the framework to determine where the assets, needs, and gaps exist in health services as they relate to the priority populations. Assets were identified in each of the target geographic areas by the Orange County Health Care Agency using the geographic information system (GIS) mapping tool. The maps focused on the priority zip code areas selected by the CP team and included an overlay of primary breast health care services available for the underserved, hospitals, grantees, as well as outreach and engagement opportunities. An inventory of services included an in-depth examination of the current grants slate, taking into account services that are provided to the respective priority areas by the grantees.

An analysis of these maps suggests there is some disconnect between the assets of the community and its constituents. For example, there are a high number of primary care providers in the local vicinity to administer breast health care services to the population of interest; however, many of the community clinics within the local area are at-capacity with wait times of approximately six to eight weeks for a non-urgent visit. Furthermore, treatment services in OC have continually been challenged by the limited number of hospitals that will accept Medi-Cal (California's Medicaid program) patients. Currently, only three out of 44 hospitals in the entire county accept the state and federally funded Breast and Cervical Cancer Treatment Program (BCCTP). It should be noted that OC does not have a county hospital.

### **Qualitative Data Overview**

Following the asset analysis, the needs of these communities were examined using the findings from key informant interviews that provide robust contextual information to better understand the needs and identify opportunities to minimize potential gaps in the provision of breast health care services. The Affiliate conducted a series of interviews that include stakeholders of the African American community; representatives of NHPI organizations; and representatives of organizations or agencies that play a critical role in the administration and provision of health care services in OC. In addition to key informant interviews, focus groups consisting of, African American women as well as breast cancer survivors, and Hispanic women of Mexican descent were conducted. The findings from the focus groups and key informant interviews provide a comprehensive understanding of the beliefs, perceptions, needs, and barriers to breast health among these population groups, and recommendations were developed to bridge the gaps.

## **Conclusions**

Based on detailed analyses of the demographics and breast cancer data, the CP team identified population groups at greater risk of late stage diagnoses and breast cancer mortality, which include African American women, Hispanic women of Mexican descent, NHPI women, as well as women that are low income, uninsured and/or on Medi-Cal. However, upon further analyses of the data, as well as the Affiliate's programmatic emphasis to address the high rates of late stage diagnoses and breast cancer mortality that exist in these specific communities, the CP team decided to narrow the focus of the report on African American women and Hispanic women of Mexican descent, as well as the NHPI communities.

Although accounting for the smallest racial/ethnic population in OC, the CP team chose to include NHPI communities to better understand the needs, barriers and gaps in services, and to identify opportunities for collaboration to make an impact on addressing these breast health disparities. The CP team also chose to narrow the focus on specific geographic areas that consist of cities that are underserved and are comprised of a greater percentage of these population groups, specifically Anaheim, Buena Park, La Palma, and Santa Ana.

After completion of the data collection, the CP team discussed common themes and issues, and developed the following priorities:

- 1)** Increase partnerships and outreach to faith-based organizations and other key strategic partners for African American, Hispanic, and NHPI communities in order to build awareness, address barriers and increase breast cancer screening.
- 2)** Provide and/or develop culturally and linguistically appropriate materials and messages in order to increase breast health awareness; increase knowledge of local resources; and to motivate women to action for mammography screening as it relates to these priority population groups.
- 3)** Increase the Affiliate's visibility and presence among the target communities.
- 4)** Develop strategies to increase provider awareness and cultural competency, and promote provider/hospital participation in safety-net programs and BCCTP in order to fill service gaps to better address barriers to care and serve the needs of the target communities.
- 5)** Increase the number of grantees that serve these communities particularly in geographic areas with high concentrations of underserved.
- 6)** Continue to remain up to date on health reform and allocate time and resources to key advocacy issues, as well as educate providers and consumers on current and upcoming changes that may impact access to care.

## **Introduction**

### **Affiliate History**

The Orange County Affiliate of Susan G. Komen for the Cure<sup>®</sup> was founded in 1991, the same year as the first Race for the Cure<sup>®</sup> in Orange County (OC). The Komen OC Affiliate was founded by Dr. Dava Gerad, a female breast cancer surgeon. In its first year, the Affiliate's Race for the Cure raised \$150,000 with the support of 3,800 participants. Nineteen years later in 2010, the Race was attended by over 30,000 participants and raised \$3 million.

Since its founding, the Affiliate has raised and invested over \$27 million in breast cancer prevention screening, education, support programs and research. For fiscal year 2010-2011, the Affiliate invested \$1.3 million in grants that address the breast health needs of the county's diverse communities. Through community-based grant programs, other OC non-profit organizations reach women ranging from breast cancer survivors to the underserved populations in the region. Additionally, the Komen Fund for Breast Health Care grants program provides funds to local community clinics and hospitals that serve as the vital safety-net of breast cancer diagnostic services for uninsured and underinsured women; particularly for women under age 40, and ineligible for other state or federally-assisted programs. The participating clinics and hospitals become the medical home to many women that utilize this program.

To complement our grant programs, the Affiliate conducts special outreach and education initiatives targeting populations at greatest risk. The Affiliate provides awareness and education about breast health, including the importance of breast self-awareness; and connects people to services/resources when dealing with a breast cancer diagnosis. Furthermore, the Affiliate provides new or gently used wigs and hats to women in OC who have temporarily lost their hair due to breast cancer treatment.

The Affiliate is one of seven affiliates that comprise the California Public Policy Collaborative that advocates on behalf of federal and state key legislative issues that impact breast health care services and access to care. For information about the Affiliate's programs and services please contact the office at (714) 957-9157 or visit [www.komenoc.org](http://www.komenoc.org).

### **Organizational Structure**

The Affiliate has a diverse and multi-lingual staff and board. There is a 12-person board of directors; active committees made up of knowledgeable community leaders; and a staff of 14 professionals covering the areas of fundraising, public health programming, grants management, marketing, finance, and data management. The organization also relies on the generosity of more than 3,000 registered volunteers who provide nearly 23,000 hours, and an estimated \$400,000, of volunteer work every year.

### **Description of Service Area**

OC is the third most populous county in California, after Los Angeles (LA) and San Diego counties, with an estimated three million residents within only 948 square miles (see Figure 1). With 34 incorporated cities, OC is home to a diverse group of residents; an estimated 45.5 percent non-Hispanic white, 34.2 percent Hispanic, 16.6 percent

Asian/Pacific Islander, 2 percent African American, 0.9 percent American Indian or Alaska Native, and 0.4 percent Native Hawaiian and other Pacific Islander (NHPI) (U.S. Census Bureau, 2010c). A mostly suburban county, OC is surrounded by LA County to the north, San Bernardino and Riverside Counties to the east, San Diego County to the south, and more than 42 miles of coastline on the Pacific Ocean.

OC is considered to be a “minority majority county” with a larger percentage of minorities than non-Hispanic white residents. Thirty percent of the population is foreign born and forty-five percent of the residents speak a language other than English at home (U.S. Census, 2010c). It is important to note that OC does not have a county hospital; therefore the area relies on a safety-net of community clinics, non-profit organizations, and the Affiliate to collaborate and provide breast health care for uninsured women. Services provided range from outreach, education, clinical breast exams, mammography, patient navigation, diagnostics, and enrollment in state-provided/funded programs for treatment.

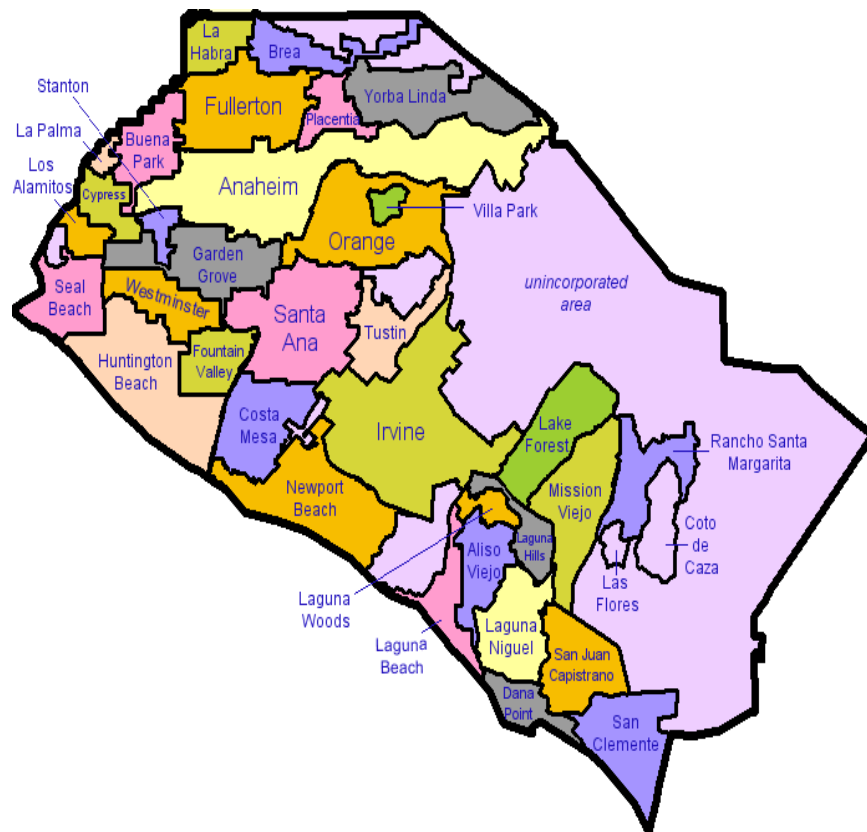


Figure 1. Map of Orange County Cities.  
MarsRover, 2008

**Purpose of Report**

Nancy G. Brinker promised her dying sister, Susan G. Komen, she would do everything in her power to end breast cancer forever. In 1982, that promise became Susan G. Komen for the Cure®, which is the world’s largest breast cancer organization and the largest source of nonprofit funds dedicated to the fight against breast cancer with more

than \$1.3 billion invested to date. For more information about Komen for the Cure, breast health or breast cancer visit [www.komen.org](http://www.komen.org) or call 1-877-GO KOMEN.

Komen's promise is to save lives and end breast cancer forever by empowering people, ensuring quality care for all and energizing science to find the cures. To meet this promise, the Affiliate relies on information obtained through the Community Profile (CP) report to guide the accomplishment of the promise in its communities. The CP relies on the generosity and dedication of key stakeholders at every step of the process. The report is produced by an advisory team of experts and professionals who volunteered their time to provide guidance on the process. In addition, the CP also relies on community members to support the effort by participating in surveys, interviews or focus group activities.

The information collected through the report guides the Affiliate through the following activities:

- Promotion of inclusion efforts in the breast cancer community
- Guidance in grant priorities
- Informing public policy efforts
- Determining outreach and education needs
- Informing fundraising and marketing efforts

This information can also be used by other community organizations for the following:

- Program planning and service delivery
- Grant writing
- Opportunities for expanded referrals and inter-agency collaborations

In summary, the CP not only serves to inform the Affiliate, but the entire breast health/cancer community in OC. The final report provides a snapshot of breast health/cancer in the Affiliate's service area, and serves as a road map for future strategic and program planning.

## Breast Cancer Impact in Affiliate Service Area

### Methodology

A quantitative approach was used to collect and analyze data to identify the impact of breast cancer in Orange County (OC) as it relates to the demographics of the Affiliate service area. It was determined by the Community Profile (CP) team to include analyses of data that cover breast cancer disparities; incidence and mortality rates specific to race/ethnicity and age<sup>1</sup>; and screening mammography behaviors to provide the current landscape of breast health outcomes of women in OC. The analysis of breast cancer disparities in OC involved reviewing the collection of findings from four monograph reports produced in 2008, and updated in 2009<sup>2</sup> through a collaborative data project with the Department of Epidemiology at the University of California, Irvine. Additionally, California Cancer Registry data and Census population estimates were used to analyze race/ethnicity and age.

Moreover, population projections for 2010 and 2020 prepared by the California Department of Finance were used for trend analysis and projecting the impact from health reform changes (2007). The CP team also analyzed screening mammography behavior in OC by reviewing breast cancer screening data from the California Health Interview Survey<sup>3</sup> (CHIS). The illustrations in this report have been derived from statistical analyses and graphs taken from the data project; the data sources and methodologies have been cited in the four monograph reports, and not repeated in this report.

### Overview of Affiliate Service Area

#### Demographics & Poverty Levels

There are 1,509,941 women in OC: 45.5 percent non-Hispanic white, 34.2 percent Hispanic, 16.6 percent Asian/Pacific Islander, 2.2 percent are two or more races, 2 percent African American, 0.9 percent American Indian or Alaska Native, and 0.4 percent Native Hawaiian and other Pacific Islander (United States (U.S.) Census Bureau, 2010c). Additional information on OC diversity is found in Table 1.

Table 1.

*Hispanic, Asian and Pacific Islander Subgroups of Men and Women in Orange County, 2010*

Subgroup	Number	Percent
Mexican	900,034	29.70%
Vietnamese	167,830	5.50%
Korean	75,067	2.50%
Chinese	75,362	2.50%
Filipino	62,064	2.10%
Asian Indian	47,549	1.60%
Japanese	31,640	1.00%
American Indian and Alaska Native	14,537	0.50%
Puerto Rican	10,319	0.30%

<sup>1</sup> Note that race/ethnicity was aggregated into five groups in order to match the categories used by the Census.

<sup>2</sup> In 2009, only monographs I through III was revised to include updated data.

<sup>3</sup> CHIS is the nation's largest random-dial telephone self report survey conducted every two years on a range of health topics.

*Native Hawaiian and Other Pacific Islander	15,846	0.50%
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United States Census Bureau, 2010

Note: \*Indicates subgroups did not meet the criteria for data acquisition of 20,000 respondents to be displayed in the survey.

Nineteen percent of adult women over the age of 18 do not have health insurance and the average poverty level in OC is 10.7 percent (U.S. Census Bureau, 2010c). In Table 2, the poverty levels vary by race/ethnicity within OC. Hispanics have the highest poverty level at 17.3 percent, followed by African Americans (13 percent). Non-Hispanic whites have the lowest poverty level at 5.8 percent (U.S. Census Bureau, 2010c).

Table 2.

*Poverty Levels for Ethnic/Racial Groups in Orange County, 2010*

<b>Subgroup</b>	<b>Percent below poverty level</b>
Hispanic	17.3%
African American	13.0%
Vietnamese	12.7%
Korean	11.6%
Chinese	9.9%
Filipino	6.4%
Japanese	9.9%
*Native Hawaiian and Other Pacific Islander	NA
Non-Hispanic white	5.8%
<b>Average in OC</b>	<b>10.7%</b>

United States Census Bureau, 2009

Note: \*Indicates subgroups did not meet the criteria for data acquisition of 20,000 respondents to be displayed in the survey.

The age demographic is experiencing a steady increase in the number of older women living in OC, which is mostly attributed to the aging baby boomer generation (see Figure 2). For example, the number of women aged 55-69 years is predicted to increase by 60 percent from 2005 to 2020, and the number of women aged 70 years or older will increase by 47 percent (Marshall, Ziogas, & Anton-Culver, 2008). By 2020, OC will become more diverse with six percent fewer non-Hispanic white women, a slight increase in the female African American population (five percent), and larger increases in Asian and Pacific Islander (39 percent), and Hispanic (76 percent) populations (Marshall et al., 2008).

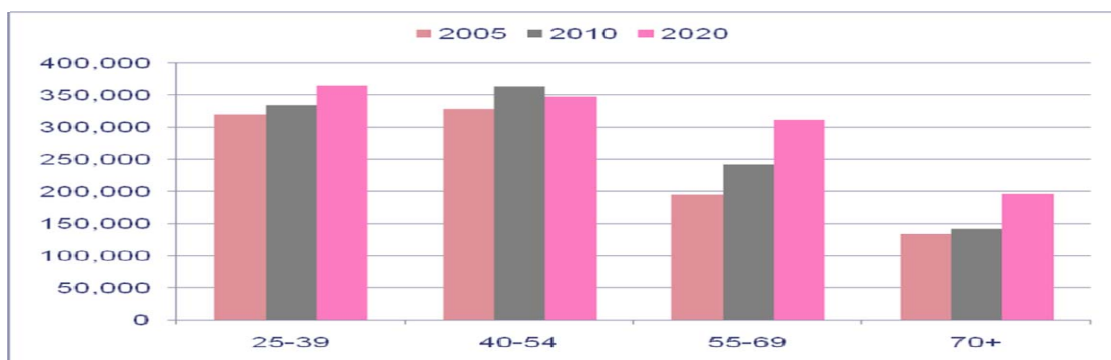


Figure 2. Actual and Projected Female Population in Age Groups in Orange County, 2005-2020. Marshall, Ziogas, & Anton-Culver, 2008

### Prevalence & Incidence Rates of Breast Cancer

From 2004-08, 11,628 women were diagnosed with breast cancer in OC; 2,162 *in situ* and 9,466 invasive cancers (California Cancer Registry, 2010). The annual age-adjusted rates were 28 *in situ* and 123 invasive cancers per 100,000 women (California Cancer Registry, 2010). If California counties are ranked by incidence of invasive breast cancer, with one being the area of highest incidence. OC ranks 22<sup>nd</sup> out of 47 (California Cancer Registry, 2010). In other words, breast cancer incidence in OC is slightly higher than the state average. Incidence varies by race/ethnicity and is higher for non-Hispanic white women (172 per 100,000) and African Americans (136), than for Hispanics (109) or Asian and Pacific Islanders (110) (California Cancer Registry, 2010).

### Mortality Rates

In OC, more than 300 women die of breast cancer each year (California Cancer Registry, 2010). During the period from 2004-08, the age-adjusted mortality rate for breast cancer in OC was 20 deaths per 100,000 women (California Cancer Registry, 2010). In California, the rate was 24 deaths per 100,000 women, which makes OC's breast cancer mortality rate slightly lower than the state average (California Cancer Registry, 2010). Nevertheless, it continues to be the second leading cause of cancer deaths for women in OC (California Cancer Registry, 2010). Since 1990, the mortality rate has steadily decreased, which is likely due to the advances in imaging technology, the adoption of mammographic screening in conjunction with public education campaigns and provider recommendations (Ikei et al., 2007; Marshall, Ziogas, & Anton-Culver, 2009b). Despite a decrease in overall mortality rates, considerable disparities remain for women from certain ethnic groups and who are low-income (California Cancer Registry, 2010; Marshall et al., 2009b).

For example, a relative risk analysis found that African American breast cancer patients had a 44 percent higher risk of dying from their breast cancer diagnosis than non-Hispanic white women, and uninsured women had more than a 93 percent increase in risk of breast cancer mortality within five years of diagnosis compared to women with managed care, HMO, or PPO coverage (Marshall et al., 2009b). Women covered by MediCal (California's Medicaid program) had

more than a 59 percent increased risk; and Medicare patients had a 24 percent increased relative risk of five-year breast cancer mortality compared with women with managed care coverage (Marshall et al., 2009b). Likewise, women from the lowest socioeconomic neighborhoods or educational levels had a 28 percent increase in relative risk of mortality (Marshall et al., 2009b). The analysis also found that women aged younger than 40 years were twice as likely as older women to die within five-years of their breast cancer diagnosis (Marshall et al., 2009b).

### Stage at Diagnosis

An early stage diagnosis is associated with a better prognosis, which is commonly detected through regular screening practices. In a relative risk analysis, the results found that women aged younger than 55 years are less likely to be diagnosed with breast cancer but among those diagnosed, the chance of a late-stage diagnosis is higher than in older women (Marshall et al., 2009a). Correspondingly, the likelihood of a late-stage diagnosis varied by race/ethnicity: African Americans were 56 percent more likely; and NHPI's were more than twice as likely to be diagnosed at a late-stage than non-Hispanic white women, even after other factors such as socioeconomic status were adjusted (Marshall et al., 2009a).

Among low income Hispanic women, especially those of Mexican descent, 61 percent were reported to be more likely to be diagnosed at a late-stage. Respectively, Hispanic women living in lower socioeconomic neighborhoods were 32 percent more likely to be diagnosed at a late-stage (Marshall et al., 2009a). Moreover, the risk of a late-stage breast cancer diagnosis was 92 percent higher for women without health insurance, and it was also more likely for women living in cities to the north of the county (see Figure 3) (Marshall et al., 2009a).

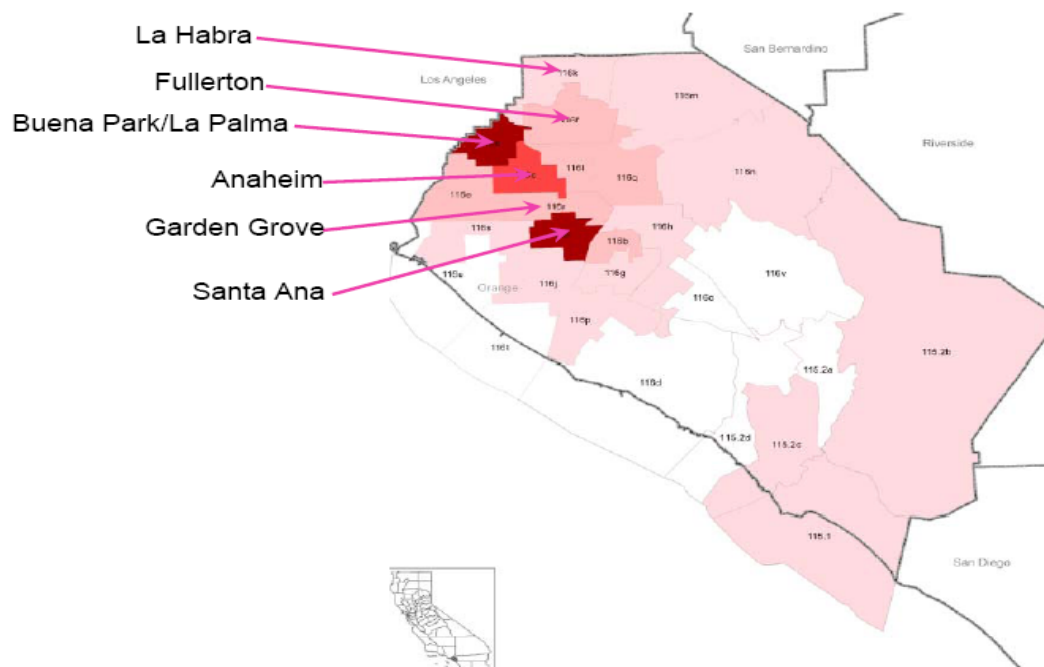


Figure 3. Map of Areas with Higher Rates (darker areas) of a Late-Stage of Breast Cancer Diagnosis, 2009. Marshall, Ziogas, & Anton-Culver, 2009a

## Mammography Screening Behavior

Susan G. Komen for the Cure<sup>®</sup> recommends that women of average risk aged 40 or older should be screened annually. In California, screening behavior varies by race/ethnicity as well as by insurance status and poverty levels. For example, Hispanic women had the highest percentage responding to never having a mammogram, and Asian women had the lowest percentage of those that reported being screened within the last two years (see Figure 4)<sup>4</sup> (CHIS, 2007, 2009). However, self-reported screening behavior for African American women in California was 79.2 percent for having had a mammogram within the last two years (CHIS, 2007, 2009). Women without insurance and those in the lower poverty levels are less likely to report having had a mammogram (CHIS, 2007, 2009).

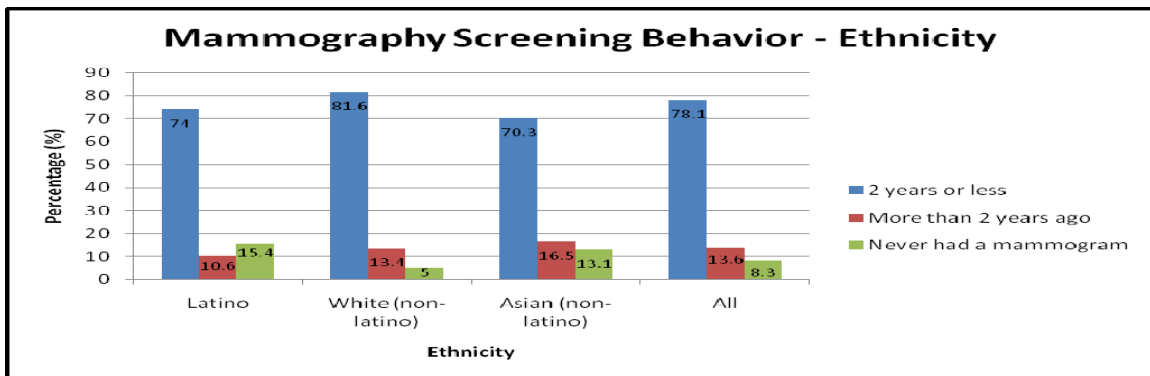


Figure 4. Mammography Screening Behavior by Ethnicity, 2005, 2007.

California Health Interview Survey, 2007, 2009

## Communities of Interest

Based on high rates of late-stage diagnoses that exist among these population groups, the Affiliate has been focused on developing programmatic initiatives over the last two years to address this health concern. Therefore, the CP team decided to narrow the focus of the report on African American women, and Hispanic women of Mexican descent.

Although accounting for one of the smallest racial/ethnic population groups in OC, the NHPI communities have the highest rates of late stage diagnoses (Marshall et al., 2009b). Organizations that serve these communities have not always been reflected in the Affiliate's grant slate. As a response, the CP team also decided to focus a section of the report to include a better understanding of the needs, barriers and gaps in services that exist with these communities as well as identify opportunities for collaboration to make an impact on this disparity.

## Conclusions

The CP team chose to narrow the focus on specific geographic areas in cities that are underserved and have a greater percentage of these population groups. Based on demographic and breast cancer statistics, including the map of areas with high rates of late-stage diagnoses from the 2009 and 2011 report, the team selected seven cities for further analyses, which include: Anaheim, Buena Park, Fullerton, Garden Grove, La

<sup>4</sup> The sample size was too small to report screening behavior on African American women in OC therefore; they are not represented in Figure 4.

Habra, La Palma, and Santa Ana. Several indicators were selected to assist in making the decision regarding the target cities including: racial/ethnic breakdown, poverty level, language other than English, percent of uninsured, and late-stage diagnoses.

Among the seven cities, Anaheim and Santa Ana had the highest percentage of Hispanics, as well as higher rates of poverty, and higher rates of uninsured and late-stage diagnoses, therefore these two cities were selected as focus areas for Hispanic women. Another decision was made by the CP team to focus on specific zip codes within these cities that have higher percentages of Hispanic women of Mexican descent since these areas are so densely populated. The second community of interest is African American women. The greater North OC region of Buena Park and La Palma are reported to have the highest percentage of African Americans as well as higher rates of late-stage diagnoses, which was the basis to target this population group in this specific geographic area (U.S. Census Bureau, 2010c).

## **Health Systems Analysis of Target Communities**

### **Overview of Continuum of Care**

The breast health continuum of care (screening, diagnosis, treatment and follow-up) was utilized to determine where the assets, needs, and gaps exist in breast health services as it relates to the priority populations. It is important that women enter this cycle, have access to services once in the cycle, and go through the continuum regularly and are supported throughout.

### **Methodology**

Quantitative and qualitative analyses of the health systems identified by the Community Profile (CP) team were used. The quantitative analysis examined the assets and needs of target geographic areas and population groups through the partnership with the Orange County Health Care Agency by using the geographic information system (GIS) mapping tool. The maps provide an overlay of primary breast health care services for the underserved, hospitals, and grantees, as well as outreach and engagement opportunities. An inventory of current grantee programs shows who and what services are being provided to the respective priority populations.

The qualitative component of this analysis was explored through the use of key informant interviews either face-to-face or via telephone. All interviews were audio recorded for transcription. The interviews were used to discover the health systems, barriers, needs and assets that are unique to Orange County (OC) and to determine the role the Affiliate can play in addressing these issues.

Three groups of interviews were conducted: first, representatives from four Native Hawaiian and Pacific Islander (NHPI) organizations; second, with 21 African American stakeholders in the greater Long Beach and North OC region. Interviews with stakeholders from research, healthcare, faith-based, and community-based organizations were conducted to better understand beliefs, perceptions, needs and barriers that exist as they relate to breast health<sup>5</sup>. The key informants were meant to draw recommendations for building bridges and successful partnerships to make an impact as well as gather their perceptions of Susan G. Komen for the Cure<sup>®</sup> as an organization.

Lastly, given the current and upcoming healthcare changes related to the passage of the Affordable Care Act (ACA) interviews were conducted with representatives from organizations or agencies that are expected to play a critical role in the dissemination of information and the administration of health care services locally: 1) The Cancer Legal Resource Center; 2) The Coalition of Orange County Community Health Centers (COCCHC); and 3) the MediCal (California's Medicaid program) administrator in OC, CalOptima. The purpose of these interviews was to better understand the opportunities and challenges that health reform will make on breast health services locally, and gather recommendations on how the Affiliate and other community partners can assist in preparing for these changes.

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<sup>5</sup> In 2010, the Affiliate partnered with the Los Angeles (LA) Affiliate to examine the breast health disparity of African American women living in North OC and Long Beach area.

## Overview of Community Assets

The CP team chose to use GIS mapping to visually display key assets in the priority communities that have a high percentage of residents within each of the target population groups. The first map (see Figure 5) specifically focuses on services provided to Hispanic women in the Santa Ana area, which includes health care services, grantees, local catholic churches, and ethnic supermarkets as identified assets/strategies to reach and engage the Hispanic community.

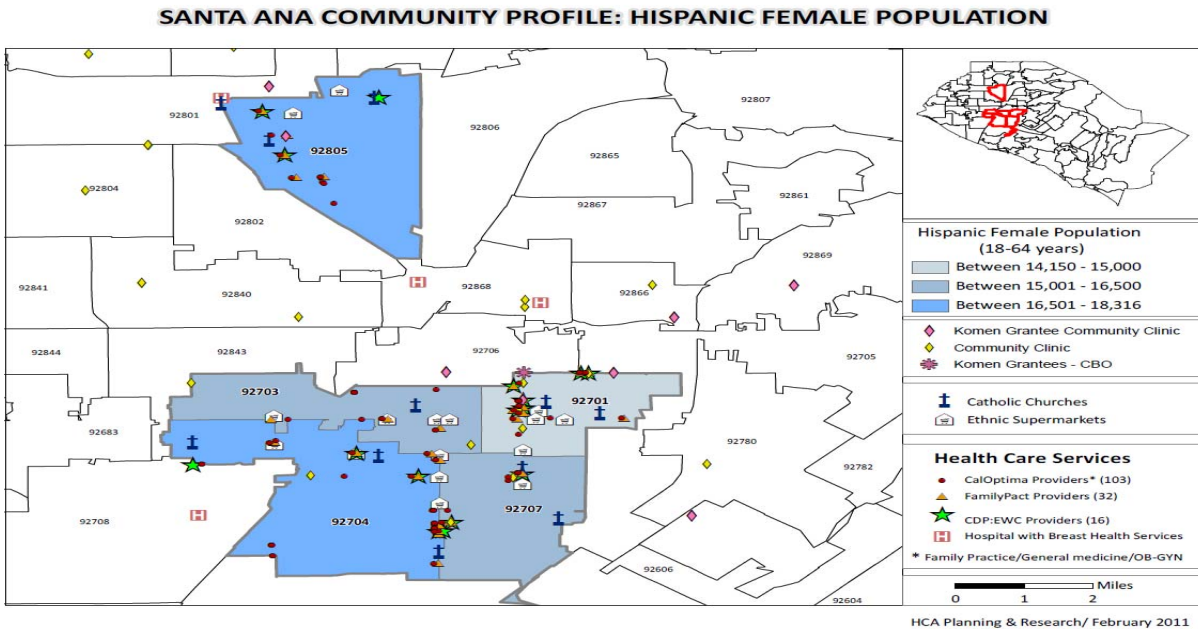


Figure 5. Hispanic Female Population, 2011.  
Orange County Health Care Agency, 2011

## ANAHEIM/BUENA PARK COMMUNITY PROFILE: AFRICAN AMERICAN FEMALE POPULATION

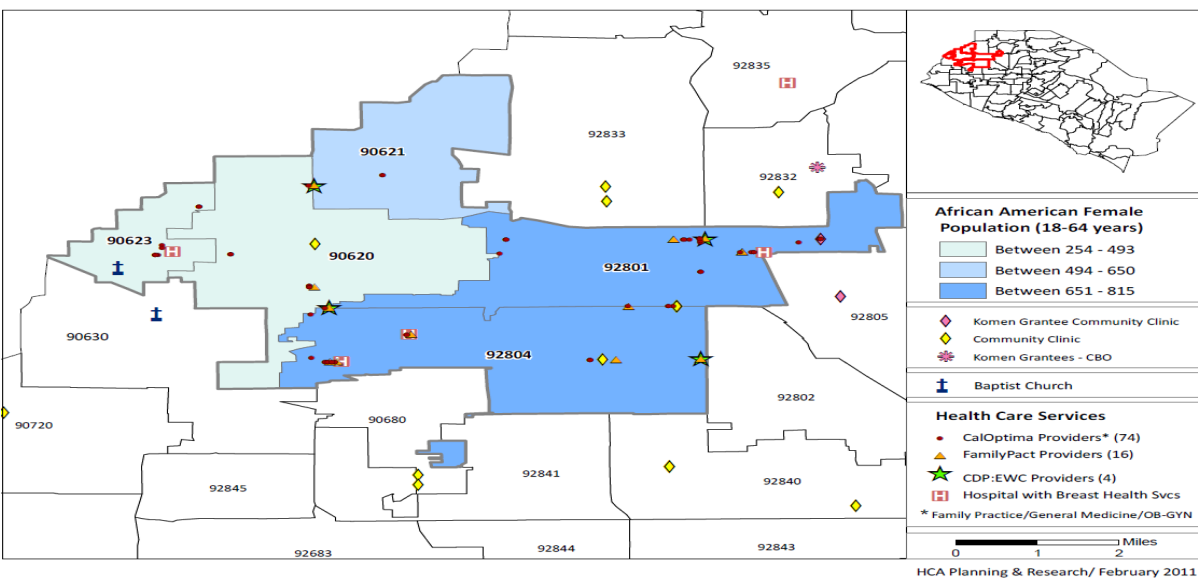


Figure 6. African American Female Population, 2011.  
Orange County Health Care Agency, 2011

In Figure 6, the map includes health care services, grantees, and Baptist churches as identified assets to the African American community in the cities of Anaheim and Buena Park.

These maps suggest there is an uneven distribution of breast health services. Although there are numerous primary care providers to administer breast health services, many of the community clinics bear the burden causing them to be at maximum-capacity with wait times of approximately six to eight weeks for a non-urgent visit (Personal communication, January 20, 2011). The rates of late-stage diagnoses are considerably higher for MediCal women than for the privately insured (OR 1.49) (Marshall et al., 2009a). As for treatment services, OC has been challenged with a limited number of hospitals that will accept MediCal patients. Currently, only three out of 44 hospitals in the county accept the state and federally funded Breast and Cervical Cancer Treatment Program (BCCTP). Approximately 15 women are enrolled into BCCTP each month and referred to one of the designated hospital systems that accept these patients (Personal communication, January 30, 2011). In order to meet the continued demand for treatment services through this program, the Affiliate needs to help encourage additional hospitals to participate in this program.

### **Legislative Issues in Target Communities**

A program such as the *Cancer Detection Program: Every Woman Counts*, which provides breast cancer screening and diagnostic services to low income uninsured women continues to be vulnerable to state and federal changes to the budget and policies. The Affiliate needs to be involved on the advocacy front to ensure access to quality of care for all populations.

### **Key Informant Findings**

#### **African American Key Informant Summary of Findings**

African American women locally were confused as to when to start and how often to get a mammogram. Many were plagued by economic barriers, supporting their families on their own, and the need to meet the "needs of the day" first, often putting their own health last. There was also a level of fear and stigma tied to breast cancer that could prevent women from entering the screening cycle. The lack of insurance was found to be an issue, particularly for low income women as well as not knowing the available resources and how to navigate through the fragmented healthcare system.

The African American community does understand how funds and services are benefiting their community locally. Many mentioned Komen for the Cure as "strong and mighty," although there is still the perception that the organization is predominantly white with an overall disconnect in understanding how Komen benefits the African American community locally.

Recommendations for how the organization can best partner with the community and make an impact included the following: a) involving the community from the start on any efforts; b) developing a collaborative/coalition; c) tapping into existing health organizations, hospitals, and other community-based groups/stakeholders to assist in addressing the needs within this local region; d)

bring more awareness to the community through a local campaign with visuals and ads that relate to African American women; and e) develop partnerships with churches, particularly women and women's groups that are gateways to a significant cross-section of the community.

### **NHPI Key Informant Summary of Findings**

OC is home to five main NHPI populations including Chamorro, Marshallese, Native Hawaiian, Samoan, and Tongan. Accounting for only 0.4 percent of the total population in OC, NHPI women are more likely to be diagnosed late-stage, and therefore at greater risk of breast cancer mortality (U.S. Census Bureau, 2010c; Marshall et al., 2009b).

The needs and barriers related to the breast health continuum of care varied dependent on the community. Common themes from the interviews include the following: focus on intergenerational family, see community as extended families; community focused culture, with food and community-based gatherings/festivals as a way to bring people together; majority of the communities are entry-level workers with limited incomes; lack of sufficient in-language and culturally appropriate materials; lack of prioritization of their own health, families come first; talking about breasts is seen as a taboo subject; important to have a female physician to conduct screenings; need for mobile mammography in order to provide convenient and culturally sensitive care; and struggle with navigating the system and getting to health care appointments.

The differences among the populations include: a) for Marshallese and Tongans have limited to no access to state and federally funded health programs such as Medicare and MediCal due to their citizenship status, and b) for the Marshallese, Samoans, and Tongans: faith and the church were found to be an integral part of their lives.

Recommendations regarding how the Affiliate can support and partner to make an impact in these communities include having a stronger presence in NHPI community via participation or sponsorship of community based events and festivals; provide funding for and/or partner with organizations to translate materials; assist in the facilitation or coordination of a mammography day to make screening more accessible and comfortable for women; work with the churches particularly for Marshallese, Samoan, and Tongan communities; and continue to play a role in advocacy to ensure access to care and include representatives of these communities.

### **Health Reform Key Informant Summary of Findings**

Changes mandated by the ACA will occur gradually from 2010 to 2020 with the biggest changes to be implemented in 2014. The CP team explored the potential impact of these changes to the current health systems in OC. A number of the current and future healthcare changes that will impact breast health and cancer care were clarified, as well as the identification of potential issues related to the capacity to provide care locally.

The COCCHC and CalOptima are preparing for the influx of members/patients from the upcoming expansion of MediCal from 100% Federal Poverty Level (FPL) to 133% FPL. It is estimated that this change will increase the number of CalOptima members by 145,000 (Personal communication, January 20, 2011). Many of these individuals currently do not have insurance or are covered by other state or federally funded programs that may or may not have full scope benefits. This change will (in theory) provide greater healthcare access for those that are currently underserved. However, additional findings directed to capacity issues need to be addressed in OC's current healthcare system for the underserved. Currently, the community clinics are operating at 95 percent staffing (provider) capacity and about 75 percent physical capacity (Personal communication, January 20, 2011). This translates to not having enough medical providers to handle the influx of new patients despite having some room to see more patients in most clinics.

In order to effectively handle the influx of patients, the COCCHC is working closely with CalOptima to open new clinics, increase number of providers, and look at alternative models with expanding hours and days that clinics are open to meet the demand (Personal communication, January 20, 2011). Another challenge is the lack of Federally Qualified Health Centers (FQHC) wherein OC ranks last in California. Currently, only 20 percent of community clinics (aka health centers) have the FQHC designation. This designation means a higher federal reimbursement rate for health care services provided to the MediCal eligible population, which provides additional financial stability and sustainability for the health centers. There are four FQHC grant applications pending, which will increase the percentage of clinics with this designation. Moreover, CalOptima is focused on conducting assessments to get to know this new population, their health care utilization patterns and preventative care needs over the next few years. CalOptima also anticipates the need for increased and enhanced partnerships with the community to effectively enroll patients, overcome barriers that exist in accessing care, as well as promote and encourage healthy preventative behaviors.

## **Conclusions**

In summary, more emphasis should be placed on working with the community and existing infrastructures and organizations to develop a comprehensive plan to address the unmet needs. The asset maps present opportunities to build and strengthen relationships with local primary care providers in the region to help address the high rates of late-stage diagnoses within these populations.

Efforts to engage the community include partnering with local ethnic supermarkets and churches for outreach efforts. A greater level of outreach and educational services are needed to reach the North OC region, specifically for African American women. There needs to be more awareness in the communities, and the information disseminated should be conducted in a culturally and linguistically appropriate manner through messengers like survivors, community and church leaders. Low income African American and NHPI women need to know how to access mammography screening

resources available in the community as well as support throughout the breast health continuum of care.

Finally, in terms of health systems, all of the agencies felt that the Affiliate needs to keep a steady pulse on health reform as well as play a role in the education and dissemination of information related to health reform to community providers and the greater public. The Affiliate can play a vital role as discussions ensue regarding anticipated breast health service needs for the population and become a strategic partner when health reform changes are implemented. Such as assist with conducting public awareness campaigns and develop strategies for overcoming barriers to care and ensuring women are screened regularly.

## **Breast Cancer Perspectives in the Target Communities**

### **Methodology**

In order to qualitatively assess levels of breast health awareness, barriers to care, and perceptions and knowledge of Susan G. Komen for the Cure<sup>®</sup>, the Affiliate conducted a series of focus group interviews with African American women and breast cancer survivors, as well as Hispanic women of Mexican descent.

#### **African American Lay Women and Breast Cancer Survivors**

In collaboration with the Los Angeles (LA) County Affiliate of Susan G. Komen for the Cure<sup>®</sup>, the Affiliate contracted a consultant to conduct a series of five focus group interviews in North OC and the Long Beach region of LA County to further understand knowledge, attitudes, behaviors and beliefs related to breast health and breast cancer. Additionally, women were asked about their perceptions and familiarity with Komen for the Cure as an organization.

Three 90 minute focus group interviews were conducted with 24 lay African American women; and two 90 minute focus group interviews were conducted with 16 African American breast cancer survivors. A discussion guide was developed and used for each focus group. The women were recruited via flyers posted at churches, hair salons, grocery stores and community centers as well as through known contacts within the community. Participants received a monetary incentive for their time. The recruitment criteria and characteristics of the participants were between 18-70 years old, with a majority between the ages of 40-55, less than half were uninsured, and the income levels were lower than \$40,000/year. Audio recordings were transcribed and reviewed to identify emerging themes and key findings. These were then developed into two comprehensive reports that were presented to the Affiliate for review, discussion, and further analyses.

#### **Hispanic Women of Mexican Descent**

The Affiliate contracted with a local Hispanic advertising agency, alPunto, to conduct focus groups with Mexican women for the purpose of understanding awareness levels as well as gain consumer reaction to potential social marketing messages and visuals. A total of three focus groups were conducted by a professional facilitator in June, 2010 with a total of eight women in each group. A discussion guide was developed and used for each focus group. The women were recruited by a professional research company with specific and detailed recruitment criteria and received a monetary incentive for their time.

Participants consisted of women that were low income, un-aculturated, Spanish-language dominant, foreign born, aged 35-65, and the majority being Mexican (80 percent). Women were not eligible to participate in the study if they had a personal history of cancer or a family member affected by breast cancer. The focus group sessions were videotaped and the facilitator along with staff at the consulting advertising firm analyzed the data for emerging themes and summarized the key findings and themes in a comprehensive report that was presented to the Affiliate for review, discussion and further analyses.

## Review of Qualitative Findings

### Responses from African American Women – Lay Participants

#### ***attitudes regarding health.***

- Many of the participants had diabetes or knew someone with diabetes which was a motivating factor to eat better, exercise and maintain a healthy weight.
- Cancer and heart disease concerned them as they were aware that African Americans are disproportionately affected by these conditions

#### ***experience accessing healthcare.***

- Appointment wait times too long and challenges finding locations that provide free services for uninsured
- Frustrations navigating the system with an HMO (lose freedom of choice)
- Doctors who stereotype African American women and/or criticize them for being overweight and not focusing on their own health concerns

#### ***breast cancer knowledge, attitudes, and beliefs.***

- Pain was strongly associated with breast cancer and mammography screening
- Fear and fatalism was a barrier to getting regular screenings
- High level of awareness of what breast cancer is and how to detect it
- Confusion regarding when to start a mammogram and how often

#### ***how to disseminate breast cancer messages.***

- Distribute posters and flyers in community. Locations mentioned included: parks, churches, libraries, grocery stores, restaurants, hair salons
- Use billboards and radio
- Send screening information home with children
- Message needs to come from someone that had "walked in those shoes" a survivor, or someone they trusted

#### ***how to motivate women to get screened.***

- More messages in low socioeconomic areas
- Health fairs and educational workshops in the community by survivors
- Offer incentives, such as childcare, to attend workshop or to get screened using mobile mammography
- Community needs to talk about it, "part of everyday conversation"
- Their motivations for receiving one was through a recommendation through their doctor or encouragement of a family member or friend

#### ***perceptions of the organization.***

- Most were familiar with the organization
- Most felt that the organization was not very present in their community

## **Responses from African American Women - Breast Cancer Survivors**

### ***how they were diagnosed.***

- Most women found their breast cancer on their own and/or a routine mammogram
- All of the participants were receiving annual mammograms at the time of their diagnoses

### ***emotional experience after diagnosis.***

- Many were upset, shocked and angry
- Some women delayed telling others until they were fully informed while others had to cope with the fear of dying and many turned to prayer to help them through

### ***access to support and resources.***

- Many were given informational materials and provided referrals to support groups and took advantage of them
- God and family played a big role in feeling supported through the journey
- Most did not feel adequate information regarding clinical trials was given

### ***health care experience.***

- Overall the participants had a positive health care experience
- Confidence in their physicians and surgeons made it a lot less stressful
- Those without health insurance felt their access to certain services was limited as compared to those with insurance
- Many participants emphasized the importance of doing your own research and being your own advocate
- Barriers that impact overall health care experience included long wait times for appointments and side effects of treatment

### ***major challenges to overcome.***

- Overwhelming top response was finances due to missing work
- Dealing with paperwork and navigating the system to receive disability benefits, etc
- Role as being head of household but being too fatigued to take care of family.
- Needed family or social support to get through the day to day and many women don't have that support

## **Responses from Hispanic Women of Mexican Descent**

### ***attitudes on health.***

- Believed that being healthy is not having a chronic disease or serious illness
- Associated healthy foods, good diet and exercise to better health
- About 1/3 of women said that medical check-ups is another way to stay healthy and specifically mentioned mammograms

***sources of health information.***

- Doctors, doctor referrals to health programs, and magazines at pharmacies
- Church services and classes
- Colleges, schools, community based organizations, and health fairs

***breast cancer attitudes and beliefs.***

- The word cancer brings to mind "death", "incurable", "painful" and "something I fear"
- Many myths and misconceptions regarding what causes breast cancer (being hit in the breast area, underwire bras and germs)
- Many women believed it ran in families (hereditary)

***awareness of mammograms.***

- Unaided, about half the women referred to mammogram as "mamografia" and the other half "mamograma," and all knew that a mammogram had to do with breast cancer detection
- All but one of the older women had at least one mammogram, most stated they do it regularly, and all the women wanted a female provider to conduct the exam
- Most women felt shame or embarrassment on going for their first mammogram but felt better on subsequent ones
- Multiple women had heard that mammograms can actually cause cancer

***review of messages and visuals.***

Seven ads were presented to the women and they were asked what each communicated and then asked to pick two as a group that were most convincing to motivate women to get a mammogram.

Overall, the ads that the participants preferred were visuals that evoked some fear to remind or inform them that cancer does not discriminate as well as visuals that show family, reminding women that a good caretaker must also take care of her own health.

Most associated the pink ribbon and Komen with cancer but needed to be prompted to specify breast cancer; many have seen the pink ribbon on cars and food products (specifically mentioned "yogurt"); and when shown the organization's logo, no one recognized it and they did not know who Susan was or what she represented.

**Conclusions**

**African American Women**

Pain, fear and fatalism were discussed in all groups as a significant barrier for women. Specific to survivors, having faith and a relationship with God as well as a supportive family structure got them through their breast cancer treatment. All stressed the importance of regular mammography screening and being your own patient advocate. Many of them struggled with finances and navigating the system of disability paperwork and processes. Most of the women were familiar with Susan G. Komen for the Cure, except many did not know how the

organization is benefiting them locally. Additionally, there is still the perception that the organization is predominantly comprised of white women serving white women.

All agreed that breast cancer messages should be more prevalent in the community and the messenger should "look like them." The most powerful messenger is a breast cancer survivor. The topic needs to be discussed more among women and the greater community through churches, community events, and radio to motivate women to get screened. For low income women, mammography screening needs to be convenient and accessible. Incentives and childcare assistance would help motivate screening behavior. For survivors, there needs to be more programs and support in place to help a women overcome the financial hurdles related to breast cancer. A support structure needs to be available for survivors that do not necessarily have one at home. These findings are for the most part congruent with the findings from the key informant interviews.

### **Hispanic Women of Mexican Descent**

Being healthy is a goal for most Hispanics; however most do not practice the steps to being healthy due to lack of time and expense of healthy foods. Those with some type of insurance appear to be more likely to have regular check-ups; however more outlets for free screening services are needed for those without insurance. The most commonly used source for health information was magazines, specifically at local pharmacies and free health fairs and events. More health care resources are needed in the community to convey important breast health messages. Most of the women felt that the health information they receive is not always accurate or consistent, however they ultimately trust the doctor the most. Most felt that breast cancer is only hereditary or caused by trauma to the breast area. These misperceptions may be leading women to postpone getting a mammogram because they do not feel at risk. Many women were afraid of getting a mammogram and viewed it as a painful procedure, which might also be a barrier to screen regularly. It is evident that women need to know that breast cancer can be survivable, especially when detected early. Mass media seems to be confusing these women about breast cancer and mammography.

The Affiliate should partner with Spanish-language media outlets to help disseminate trusted and correct information. Hispanic women need to be informed about when to start having a mammogram and where there are local resources to get low or no cost screenings. Images should be straight-forward or serious, but not extremely fear inducing. All social media must provide an action outlet connected to the breast health message so that it is seen as a real resource for their well being. A separate layer of communication should focus on educating the Hispanic community about Komen. The pink ribbon still needs further penetration and needs to be visible at the "street level" including commercial entities, transit shelters, health fairs, etc.

## **Conclusions: What We Learned, What We Will Do**

### **Review of the Findings**

The data collected and analyzed in this assessment gleaned key areas that are crucial to make an impact on late-stage diagnoses and breast cancer mortality for the priority populations referenced in this report. The findings reinforce the importance of early detection and ensuring women of higher risk are entering the breast health continuum of care.

#### **African American Women**

The African American population is small and geographically dispersed in Orange County (OC) with a higher concentration of the population living in North OC. Many of these women do not see the Affiliate boundary in terms of accessing services; therefore the OC and the Los Angeles County Affiliates of Susan G. Komen for the Cure<sup>®</sup> teamed up to further explore the needs and opportunities. From this partnership, the Komen Affiliates discovered that there is still a stigma tied to the word "cancer" in the community and this perpetuates a "culture of silence" when it comes to bringing awareness of the disease at the community level. For many, the words "breast cancer" translates to fear and a death sentence. Additionally, many African American women are single parents and are often overwhelmed with meeting everyday demands, such as taking care of their families that many neglect their own health needs.

#### **Hispanic Women of Mexican Descent**

Through the asset mapping and focus groups, the Komen OC Affiliate learned that there appears to be a basic level of awareness about breast cancer and mammography, but there still continues to be a lack of clarity as to when to begin and how often to start a mammogram. Myths and misperceptions about breast cancer persist. Many women did not perceive themselves to be at risk since there was no apparent family history of the disease. And culturally, the health needs of the family outweigh their own health needs. In order to provide breast health information and screening services, a concerted effort must be made to bring services to places where they live, work, play and worship.

#### **Native Hawaiian and Pacific Islanders (NHPI)**

There are five population groups that reside in OC including the Chamorro, Marshallese, Native Hawaiian, Samoan, and Tongan. There are many cultural similarities across these population groups, but also many differences that can impact screening behavior and approaches to providing education and services. Many NHPI women face barriers related to awareness and education, as well as transportation and access to health care.

#### **Health Reform**

A critical look at the current and upcoming changes related to health reform allowed the Affiliate to develop a better understanding on how these changes will impact breast health and cancer care in OC. While many of these changes will provide greater and more comprehensive health care for the community, there is still significant work that needs to be done to ensure that there is the capacity to meet the need. Additionally, health reform may uncover new gaps in services for

specific populations and/or issues. Lastly, the Affiliate needs to continue to be aggressively involved on the advocacy front to ensure no one is left behind.

## **Conclusions**

After analyzing all of the findings, the Community Profile (CP) team determined the following priorities for the Affiliate over the next two years.

- 1) Increase partnerships and outreach to faith-based organizations and other key strategic partners for African American, Hispanic, and NHPI communities in order to build awareness, address barriers and increase breast cancer screening.
- 2) Provide and/or develop culturally and linguistically appropriate materials and messages in order to increase breast health awareness; increase knowledge of local resources; and to motivate women to action for mammography screening as it relates to these priority population groups.
- 3) Increase the Affiliate's visibility and presence among the target communities.
- 4) Develop strategies to increase provider awareness and cultural competency, and promote provider/hospital participation in safety-net programs and the Breast and Cervical Cancer Treatment Program in order to fill service gaps to better address barriers to care and serve the needs of the target communities.
- 5) Increase the number of grantees that serve these communities particularly in geographic areas with high concentrations of underserved.
- 6) Continue to remain up to date on health reform and allocate time and resources to key advocacy issues, as well as educate providers and consumers on current and upcoming changes that may impact access to breast health care.

## **Action Plan**

The Mission committee which encompasses outreach and education initiatives, grants, and public policy modified their strategic plan and developed the following action plan with SMART (specific, measurable, achievable, realistic, and timely) objectives.

**Goal:** Increase the number of individuals utilizing quality breast health services.

**Outcome Objective:** By March 2014, increase mammography use by 5% each year among underserved women in OC.

### **Objective 1**

By March 2014, conduct innovative or evidence-based measurable initiatives that address the priority areas identified in the CP.

#### ***strategies for African American women.***

- I. By March 2014, increase breast health awareness and improve screening behavior in the African American community.
- II. By March 2014, continue to collaborate with the Los Angeles County Affiliate, community-based organizations, and key stakeholders to discover best practices to develop an effective breast health-communication campaign to the African American community in the priority areas identified in the CP.
- III. By March 2014, coordinate and collaborate with community partner organizations to increase awareness of Komen OC, and breast health information and services to a minimum of 300 African American contacts.

***strategies for Hispanic women of Mexican descent.***

- I. By March 2014, increase breast health awareness and improve screening behavior in the Hispanic/Latino community.
- II. By March 2014, continue to collaborate with the *Unidos Contra el Cáncer de Seno* coalition, other community-based organizations, and key stakeholders to conduct a linguistically and culturally appropriate breast health-communication campaign to the Hispanic/Latino community in the priority geographic areas identified in the CP.
- III. By March 2014, coordinate and collaborate with community partner organizations to increase awareness of Komen OC, and breast health information and services to a minimum of 10,000 Hispanic/Latino contacts, and directly link a minimum of 600 low-income Hispanic/Latino women to mammography screening.

***strategy for the NHPI communities.***

- I. By March 2014, increase and strengthen partnerships with key community stakeholders within five of the Native Hawaiian/Pacific Islander communities: Chamorro, Marshallese, Native Hawaiian, Samoan, and Tongan to increase awareness of breast health and improve screening behavior.

**Objective 2**

By March 2014, Mission initiatives will continue to give priority to grant programs that use innovative or evidence-based approaches that result in documented linkages to breast cancer screening, diagnostic, and/or treatment and supportive services among the priority population groups and target geographic areas identified in the CP as well as taking into account emerging external threats and opportunities.

***strategies for grants programs.***

- I. March 2014, establish mechanisms that foster collaboration among grantees to ensure the continuity of the breast health continuum of care.
- II. By March 2014, cultivate new applicants to the Affiliate's grant programs that meet our priority areas based on the CP findings, which are also highlighted in the statement of need in the Request for Applications.
- III. By March 2014, strengthen the outcome evaluation of grant projects to improve the overall quality of their projects, as well as clearly demonstrate grantee impact to community stakeholders.
- IV. By March 2014, engage, educate, and empower grantees to be adaptable and responsive to changes in the external environment that may impact their breast health programs, and create gaps or provide additional assets in the breast health continuum of care (i.e. EWC cuts, Health Reform).

### **Objective 3**

By March 2014, Mission initiatives will have a positive influence on policy and legislation on the national, state, and local level to make the necessary system changes to support earlier detection, access to treatment for breast cancer, and increase funding for research.

#### ***strategies for public policy.***

- I. By March 2014, expand the number of public policy advocates in order to extend the sphere of influence in advocating for policy and legislative initiatives on the national, state, and local level.
- II. By March 2014, continue to advocate and actively support national and state legislation.
- III. By March 2014, develop strategic alliances with organizations that share mutual goals.
- IV. By March 2014, identify and engage in public policy events.
- V. By March 2014, develop stronger relationships with legislators and governmental entities (like the CA Department of Public Health) that can help move Komen's mission forward.
- VI. By March 2014, increase the visibility of public policy on a local level through media.

### **Objective 4**

By 2014, Mission initiatives will continue to engage and build strategic alliances with stakeholders, health care providers/organizations to improve access and quality of breast health care.

#### ***strategies.***

- I. By March 2014, continue to attend and participate in community meetings, advisory councils, and coalitions to advance and inform our Mission initiatives.
- II. By March 2014, identify and engage to build strategic alliances with new collaborative partners and key community stakeholders to further advance and inform our Mission initiatives.
- III. By March 2014, collaborate with other organizations/agencies to inform and educate providers about available breast health care resources, as well as important cultural considerations in dealing with specific priority population groups as identified in the CP.

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